CPSO Proposed Continuity of Care Policies
November 2018
Introduction

The Ontario Medical Association is pleased to respond to the College of Physician and Surgeon's (CPSO) consultation regarding its proposed suite of continuity of care policies. We appreciated the decision of the CPSO Council to accept the OMA's request to extend the consultation period so we can adequately understand from our members:

1) What elements of the proposed policies are reasonable and effective in the present environment?
2) What elements of the proposed policies could be reasonable and effective with appropriate resources and/or staging?
3) What elements of the proposed policies are unreasonable or ineffective?

The response was fruitful and consultation activities with members included:

- Establishing a dedicated inbox and inviting written comment from all members;
- Targeted communication to OMA Sections inviting written comment;
- Two online focus groups;
- Meetings with OMA Sections;
- Dialogue with the Rural Expert Panel and Primary Care Solo Physicians Interest Group;
- Use of the OMA's Hospital Issues Committee and Health Policy Committee.

We were also pleased to meet with other relevant system stakeholders to jointly review the draft policies.

Over the past six months we have appreciated the CPSO's willingness to engage in dialogue and the stated receptivity to the OMA's feedback. Along with regular meetings between our leadership, staff have had numerous opportunities to interact and share the OMA's perspective on key issues. We trust that nothing contained within this submission will be a surprise to the CPSO. Our focus has been on understanding the intention of various elements of the proposed policies and offering feasible alternatives where possible.

Physicians strongly support continuity and coordinated care delivery. It is well recognized that continuity of care supports patient safety and quality. While physicians are leaders in health-care delivery, they find themselves operating as single actors in a multi-layered health-care system. Any regulatory action should be reasonable and applicable within the physician's span of control. In addition, the mandate of protecting the public interest should contemplate the patient's role in the co-management of care.

Taken from the OMA's 2016 submission to the CPSO during its preliminary consultation on continuity of care:

*The first step in addressing continuity of care is defining it. The Quality Council of Alberta offers a useful description:*

*Continuity of care is the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs*
and personal context. (Health Quality Council of Alberta, Continuity of Patient Care Study, October 2015)

It takes an organized system to provide continuity of care. Individual physicians cannot be expected to achieve this on their own. To have a comprehensive discussion about continuity of care, we will need to engage in a discussion about quality, team-based care, and patient involvement in care. Continuity of care does not necessarily mean that patients will have access to their physician at any time. Instead, it means that physicians will be reasonably available to their patients and have means to communicate effectively with patients and other health care providers. There are currently barriers that challenge physicians’ efforts to ensure continuity of care. These barriers include both system and resource factors as well as more specific practice level issues.

Physicians are dedicated to effective communication and collaboration with the patient and other health-care providers. Whether through facilitating patient engagement or ensuring the patient is kept informed of decisions and recommendations related to their health, physicians are supportive of a system that ensures the patient journey is seamless. The CPSO proposes that physicians “...recognize that patient interactions within the health-care system are best viewed not as discrete events, but rather as a set of interactions that require oversight and management.” However, the College further indicates that it’s “...focused on setting out policy expectations related to those elements of continuity of care where physicians have a role to play.” The OMA is concerned that the proposed companion policies shift an unbalanced proportion of oversight and management onto physicians. Just as health-care providers need to view patient interactions with the health-care system as a series, the oversight and management of care is shared among the system (funders, regulators, policy-makers), the environment (social determinant of health), the providers and the patient.

The very fact that there is a perceived need for these policies underscores the fact that the system is not functioning optimally. If the system functioned appropriately (e.g. was integrated, efficient, made optimal use of technology, and was adequately resourced) we would likely not need a continuity of care policy. The CPSO is trying to tackle a system issue at the wrong level. Mandating unreasonable expectations that are unable to be implemented at the present time will deepen pressures on the system; create confusion among providers and the public; and negatively impact the delivery of care. The feasibility and probable effectiveness of continuity of care recommendations must be considered.

We recognize that the ultimate mandate of the CPSO is to protect the public interest. While elements of the policy conceptually make sense, placing unreasonable expectations on physicians will have unintended consequences leading to poorer quality of care. For example, many of the proposed requirements will take time away from clinical care; stretch thin resources and contribute to increases in physician burnout.

The following submission is setup to provide several overarching recommendations, followed by a detailed analysis of specific areas of the proposed policies.
Recommendations

Recommendation #1: The CPSO should create separate advisory documents and transfer any advisory statements and clinical practice direction from the draft policies into these documents. Doing so respects the unique nature of medical-care delivery and will prevent a one-size-fit-all approach.

As previously indicated, the CPSO is proposing policy with a significant degree of specificity that is not seen elsewhere in the country. The OMA has noted a number of instances where it appears that the CPSO is providing clinical practice direction (e.g. structure/contents of discharge summaries and consultants' reports). It is unclear what evidence underpins this direction and as such, we do not believe that this is appropriately placed in regulatory policy. Rather, the focus should be on ensuring and supporting evidence-informed physician practice.

It is unclear to the OMA how the proposed policy will be enforced. We are concerned that the proposed policy will increase the volume of complaints (possibly frivolous in nature) regarding issues beyond the control of the physician. This will demand significant resources from the CPSO and place a personal and professional toll on impacted physicians. Effective policy requires a transparent, fair and effective enforcement mechanism. Given that the CPSO has recognized the existing challenges in the complaints and investigations process, this should be an important consideration in policy implementation.

Recommendation #2: The CPSO must consider that the technological capacity of each practice in Ontario will vary and revise the proposed policies to reflect this.

Physicians are strongly advised by the CPSO to capitalize on advances in technology to facilitate continuity of care. Much of what the CPSO is proposing cannot be accomplished without the assistance of accessible and connected technology at the point of care and elsewhere within the medical practice. This is problematic because Ontario is not at the technological stage where many of the CPSO’s proposed requirements are feasible. In addition, many physicians lack the resources and support needed to adopt and embrace technology.

Recommendation #3: The CPSO should ensure consistency with the standards and approaches undertaken by other regulatory colleges.

It would be unreasonable to impose significant requirements onto physicians if there is not consistency in the approaches undertaken by other regulated health professions (e.g. nurse practitioners, dentists and pharmacists). Doing so provides consistency for the public’s awareness and enables providers to work most effectively together. Section 3(1) of the Health Professions Procedural Code under the Regulated Health Professions Act requires cross-regulator collaboration as an object of each College. This may be done through the appropriate channels, such as the Federation of Health Regulatory Colleges of Ontario.
**Recommendation #4:** The CPSO must consider a phased-in change management approach towards policy implementation. This approach needs to recognize that in many instances physicians are currently experiencing, or on the verge of, burnout and exhaustion. Healthy physicians promote safety and high quality care delivery.

There are thousands of physicians in Ontario and the diversity of practice environments needs to be recognized. The composition and structure of their practices vary significantly. The OMA is concerned that many of the proposed requirements would be hardest to implement by those physicians operating outside of groups; those in tertiary centres servicing large geographic catchment areas and those in rural/northern communities. Although the mandate of the College is not necessarily to implement policies, it must be sympathetic to the challenges and changes needed for its members. Physicians want to ensure that the CPSO is considering a change management approach throughout because the proposed policies will, in many instances, have a significant impact on the operation of a practice. Policy on the books that is unimplemented or not implementable does nothing to serve the public interest nor physicians.

In addition to burnout and workplace exhaustion, the prevalence of moral injury is increasing rapidly and is cause for concern. Physicians enter their profession to help others attain the greatest level of health possible through the provision of quality patient care. Moral distress is created when physicians operate in a system that frequently fails to deliver safe and quality care. This is further complicated when new requirements, with the best intentions, are thrust onto physicians. The OMA has heard loud and clear from its membership that physician health and wellness are key priorities for positive patient outcomes. We are unable to support any proposed requirement that directly or indirectly mandates individual practising physicians to provide 24/7 coverage. In addition, the OMA is concerned that the CPSO may not have considered the resource requirements, including adequate physician remuneration, for the new responsibilities being proposed. This is important to maintain the ongoing sustainability of physicians’ practices.

**Recommendation #5:** As the representative of the public interest, the CPSO should strengthen the patient’s role in the proposed policies to include shared responsibility for care processes and outcomes.

Physicians deeply value their fiduciary duty to their patients and want to help people. Each person and their health-care experience is unique. It is confusing to observe the level of specificity provided in the proposed companion policies and the onerous responsibilities tied to physicians. This is happening during a recognized shift by policy-makers, educators and researchers from a paternalistic approach to medicine to one that is more patient-centred. The CPSO indicates that patient engagement is meant to be a supplement or a support to physicians’ efforts to facilitate continuity of care. While recognizing that physicians have unique medical expertise and a fiduciary duty to their patients, the OMA is concerned that framing patient engagement as a "support" is insufficient. Rather the focus should be on, to the greatest extent possible, facilitating the effective co-management of care and examining the appropriate patient role needed to achieve this.
Recommendation #6: The CPSO adopt the changes proposed by the OMA in the accompanying table below.

The following table is the product of extensive consultation conducted by the OMA. We have broken down the problematic areas of the proposed policies and thoughtfully attempted to ascertain the CPSO's policy intention. We then identify corresponding issues being raised by members and the OMA's analysis. Finally, we propose acceptable alternate solutions and specific wording changes that we expect to see in the finalized policies.

Once again, the OMA appreciates the opportunity to review the draft CPSO policies and we hope to see our feedback adopted to ensure the ongoing provision of high quality medical care in Ontario.