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RE: Response to request for comment on Continuity of Care Policy

Thank you very much for soliciting feedback on the Continuity of Care policies. Centretown Community Health Centre (CCHC) has collected the team responses to the policy changes proposed. CCHC is a multidisciplinary community health centre with a high volume inner city primary care practice in downtown Ottawa. We are grateful for the care and consideration that has gone into this policy review.

While we feel that many of the proposed changes will enhance care, we have concerns about some of the suggested changes from a primary care perspective. We reviewed the policy looking at the best way to respect excellent patient care, privacy and autonomy with consideration of current practice and resource constraints.

In many instances the policy expectations that are introduced impose a significant administrative burden to primary care clinics. However, with no additional resources to implement these changes and manage the workload, primary care clinics are faced with the dilemma of either not successfully upholding these policy standards or redirecting resources from much-needed existing clinical and/or support duties in order to endeavour to meet the expectations. The latter may decrease patient access to necessary medical care. Furthermore, in some instances the new policy expectations are overlaid on existing system constraints/deficiencies beyond a primary care provider's control, thereby compounding the burden of responsibility for the primary care provider.

Please find our fulsome response attached, which provides examples for the above outlined concerns as well as other details. [REDACTED]

Thank you again for the opportunity to provide comment, and we appreciate your consideration of our feedback.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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Please find our specific responses to your document, first outlining the lines in each respective policy on which we have concerns, followed by our comments.

Policy: Transitions in Care

Line 210 – 218: Communicating with Patients

*Referring physicians **must** communicate the estimated or actual appointment date and time to the patient unless the consultant physician has indicated that they have already done so or intend to do so.*

Consultant physicians must communicate any instructions or information to patients that they will need in advance of the appointment, unless the referring physician has agreed to assume this responsibility. Consultant physicians must also communicate any changes in the appointment date and time with the patient directly and must allow patients to make changes to the appointment date and time directly with them

Our Response:

- We believe, for reasons that we will outline, that the consulting physician should let the patient know when the appointment is. We agree that it would be helpful for the referring physician to know appointment information and wait times as well, though it is not their responsibility to inform the patient. This information would be helpful in order to decrease each respective physician's administrative work and increase patient safety by providing clarity on when the appointment will be and assurance that the referral has not gotten lost.
- By the referring physician having information on when the appointment is they can help reinforce consistent messaging and therefore hopefully decrease patient confusion on referral information. This may lead to decreased missed consultant appointments and/or decreased lack of compliance on instructions due to information being relayed incorrectly or incompletely.
- Communication is a huge challenge between consulting physicians and referring physicians. Our common experience is that we are told that the consulting physician will triage and let the patient know when the appointment is. It would not be realistic for referring physicians to provide patients with an "estimated appointment date" given the current context, unless this information is available on an easily accessible public site.
- Placing responsibility with the referring provider to communicate consult appointment information would impose a significant administrative burden to primary care clinics.

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Policy: Availability and Coverage

Line 45 – 51: Being Available by the Telephone

To facilitate good communication and collaboration, physicians must have an office telephone that is answered and/or a voicemail that allows messages to be left during operating hours and a voicemail that allows messages to be left outside of operating hours. Physicians must ensure that voicemail messages are reviewed and responded to in a timely manner. What is timely will depend on a variety of factors including, but not limited to, the impact to patient safety that may be caused by a delay in responding and when the message was left (e.g., after-hours, weekend, holiday, etc.).

Our Response:

- We are concerned that voicemail that allows messages to be left outside of operating hours would be dangerous for patient care, in addition to a major administrative burden in primary care practices. Adding an extra layer of communication between the patient and the health care provider leads to the potential for calls to be missed or not addressed in a timely manner. We believe an effective after-hours on call system whereby patients can have direct communication with a health professional will allow for medically urgent issues to be dealt with in a timely manner.

Lines 89 – 98: Coordinating After-Hours Coverage for Patients

Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters must have a plan in place to coordinate care for their patients outside of regular operating hours. This is often referred to as after-hours. The nature of the plan will depend on the time of day and type of day (i.e., weekday, weekend, and holiday), the needs of their patients, as well as on the health-care provider and/or health system resources in the community. Physicians must use their professional judgment to determine how best to structure their plan and must act in good faith, making a reasonable attempt to minimize uncoordinated access to care and the inappropriate utilization of emergency rooms or walk-in clinics.

Our Response:

- While we agree with the importance of providing coordinated after hours care we have the following questions that need clarification: What is the definition of “coordinate care for...patients outside of regular operating hours”? How much information has to be shared with the health care provider providing after hours access?
- Our concern is that this would greatly increase the administrative burden in relaying patient information as we often share after hours call with other physicians who do not work in our physical setting and do not have access to our patients’ records.
- In speaking to “sustained physician-patient relationship[s]”, there are already existing system pressures on primary care providers due to downloaded care and clinical

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administrative work, even when there is an ongoing specialist-patient relationship.

Examples include the following:

- Patients who have a specialist care plan in place with yearly follow-up yet are required to provide a new referral each year
- The management of routine follow-up on investigations (ex. colonoscopy, PSA) that are part of a specialist's care plan, thereby decreasing the specialist's overall responsibility, including after hours.

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Policy: Managing Tests

Line 59-60 Ordering

When ordering a test, providing contextual patient information to laboratories and or diagnostic facilities is important

Our Response:

- Providing context for diagnostic imaging and pathology is important, but is rarely relevant for blood work. Adding more context to each blood work request would increase physician administrative burden, thereby reducing direct patient clinical care time. It may also lead to privacy breaches if the requisition ends up being seen by someone outside of the circle of care (e.g. if the patient loses their lab requisition). Since most laboratory tests are done by a machine, it is not clear how the contextual patient information would benefit patient care.

Line 35-37 and line 69 - 73 High-risk patients

*Patients who present with serious clinical symptoms, who have been diagnosed with a life-threatening illness, or **who have been identified as high-risk by their physicians.***

*Physicians **must** track test results for high-risk patients to ensure that their test results are not lost or missed. For example, if physicians do not receive a test result for a high-risk patient, they **must** follow-up with the patient to verify that the patient has had the test and/or follow-up with the laboratory and/or diagnostic facility to verify that the laboratory and/or diagnostic facility has the test result*

Our Response:

- Clarity needs to be given on the definition of “high-risk patients”. Patients who are considered high risk due to their social determinants of health need to be explicitly excluded from the expectations. These patients can be challenging to follow for many reasons, including the reality that some vulnerable patients choose not to pursue investigations, and there is often not a reliable channel to communicate with them (e.g. lack of a telephone, transient addresses, etc.). The administrative burden imposed with trying to reconcile who has followed through on recommended tests would be significant. If not revised, this policy section will potentially result in physicians avoiding complex or high risk patients in their practice so as to avoid liability resulting from missing results.
- We recommend clarification on the definition of a high risk patient versus a high risk result. When outlining a “high risk patient” in the policy, is the intent to actually refer to high risk test *results*, i.e “risk to life and limb”?

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- Define when physicians can reasonably stop follow up efforts to obtain results and/or contact patients. There needs to be a reasonable balance between time spent following up/reconciling test results and direct patient care. Consider changing "must follow-up" to "must demonstrate reasonable effort to follow-up" or clarify what is "must" and what is "shall".

Line 122-126: No News is Good News' Strategies

*Physicians who want to use a 'no news is good news' strategy for test results management **must be confident that the test result management system in place is sufficiently robust to ensure that no test results will be missed and that no news really means good news.** That is, the absence of a call back to the patient means that the test result was received, reviewed and a determination was made that no follow-up was required.*

Our Response:

- It needs to be recognized that the existing test result system of "no news is good news", albeit flawed, is "sufficiently robust" since there is no realistic alternative available. It is the long-standing, widespread, routine and customary practice in most clinics, both community and hospital based. The current state is resource based and respectful of both the providers' and patients' time. The reality is that a percentage of test results do get missed for a variety of reasons but mostly due to systems issues, such as when results fail to make it back to the ordering provider. An improved system for results management is ideal, and greater gains would be made by focusing on quality improvement initiatives within laboratories, diagnostic imaging centres and hospitals, as opposed to making individual providers responsible for systems issues for which they have no control. Clarification is also needed on other facilities' responsibilities: Are there any requirements on the facility for assuring abnormal results are received by the ordering provider? There should be a legislative way for shared responsibility with the facilities at which tests are done and reported.
- As previously mentioned, the reality is that often test results do get lost. Large amounts of administrative time would have to go into "**ensur[ing] that no test results will be missed and that no news really means good news.**" This is not practical or sustainable in current primary care environments with limited resources. Again, if implemented, it may result in valuable resources being redirected from direct patient care.
- When a test result is ordered by a specialist and cc'd to the primary care provider, and the result is out of scope for a primary care provider to interpret, the specialist should be responsible for ensuring communication of that result to the patient.

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- The responsibility for test result management should be clearly stated in this section to pertain only to results ordered by the provider i.e. “...**ensure that no test results ordered by you will be missed and that no news really means good news.**”

Line 127-133: No News is Good News’ Strategies

Even with a robust test results management system, a ‘no news is good news’ strategy may not always be appropriate. Physicians must use their professional judgment...Physicians must consider the following factors in making this determination:

- *The nature of the test that was ordered;*
- *The patient’s current health status;*
- ***If the patient appears anxious or has expressed anxiety about the test; “***

Our Response:

- The above bolded part “If the patient appears anxious or has expressed anxiety” should be removed because the appearance of anxiety is subjective, and the expectation to follow up directly with patients to communicate results would, again, impose a significant administrative burden on primary care clinics to execute. Instead, all patients should be informed on where they can access results on patient portals. Patients should be informed to follow up with their clinic on their results if they are anxious or worried.

Line 160-168: Clinically Appropriate Action Following Receipt of Test Results

If physicians receive a critical or clinically significant test result in error (i.e. they have not ordered the test and have received the result in error because they have the same or a similar name as the ordering physician or the same address as the ordering physician), they must inform the ordering health-care provider, the patient’s primary care provider, or the patient of the test result. Physicians or those acting on their behalf must also inform the laboratory or diagnostic facility of the error.

Our Response

- Two separate concepts are being referred to in this section: a) wrong provider receiving information, and b) right provider receiving erroneous information. Clarification is needed around these two separate concepts.
- The provider should not be responsible for anything beyond informing the sending facility of the error as soon as possible. The burden of accuracy should be on the facility processing the result and that, once an inaccuracy is brought to their attention, the facility is responsible for sending the results to the correct provider. The facility should also take responsibility to contact the patient to disclose any associated privacy breaches and/or significant delays in results management due to misdirected results.

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- This policy raises the concern that many facilities processing results allow only one practice address per provider. Placing the responsibility of addressing wrong lab results on physicians allows this dysfunctional system to continue. CPSO's leadership would be valuable in advocating for organizations to accommodate providers having multiple practice addresses.
- While this section does not deal with incidental reports (i.e. cc'd results) on our own patients, clarification is needed on what the copied physician's responsibilities are with respect to managing these results. We feel strongly that the ordering physician should ensure that the result be addressed. In a consult note, the consulting physician should indicate clearly the follow-ups required and by whom. It cannot be assumed that a primary care provider is able to action results that may be outside of their scope. The volume is also untenable.

Line 152-153 Patient Portals

As part of actively involving patients in their own care, physicians are advised to inform patients of the availability of patient portals.

Our Response:

- It needs to be the responsibility of the facility that provides the portal to inform the patients how use them and how to access them. Part of the reason is that physicians cannot be expected to be aware and up to date on all new patient portals that are available.

Line 169-175: Receiving Test Results in Error or Incidentally

Additionally, physicians who become aware, even incidentally (e.g., physicians who are cc'd on a report), of a critical or clinically significant test result where they have reason to believe that the ordering health-care provider did not or will not get the test result, must make reasonable efforts to inform the ordering health-care provider or the patient of the test result. The physician must also make reasonable efforts to contact the laboratory and/or diagnostic facility that sent the test result.

Our Response:

- As previously outlined in response to lines 160-168, labs/DI facilities should have greater accountability for ensuring the correct results get to correct providers in a timely manner. Physicians' responsibility should be limited to notifying the facility from which the test result was sent of any errors.
- The ordering physician has a responsibility to ensure that there is a system in place in their own office for checking results in a timely manner. This policy inappropriately supports the transference of workload from specialists to primary care providers by implicating the cc'd provider in accountability for follow up, and allowing specialists who don't have results management safety mechanisms in place to abdicate this responsibility.