

December 9, 2018

[REDACTED]
Registrar
The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario
M5G 2E2

Re: *Continuity of Care Consultation*

[REDACTED]

The Section on General and Family Practice of the Ontario Medical Association (SGFP or Section), represents approximately 14,000 practicing general physicians and family doctors in the province, and is the largest clinical Section within the Ontario Medical Association, comprising almost half of the total membership. Ontario's family doctors serve over 155,000 patients per day.

The SGFP appreciates the opportunity to provide comments on the draft Continuity of Care policy of the College. [REDACTED]

[REDACTED]

[REDACTED] Better policy is created when both patient and provider perspectives are considered.

The CPSO's policy interventions on health care need to be developed with the same rigour as applied to any other medical intervention that affects patient health and outcomes. For this reason, the College needs to frame its policy within a quality improvement perspective. Each of the requirements that the College is proposing needs to take a balanced 'outcome vs risk to patient care' approach: evaluate the value of the proposed requirement against the potential unintended harm to patient safety. The SGFP does not see this approach being applied here with respect to what the College is proposing as its Continuity of Care policy and we fear that these proposals may detract from a patient-centred focus.

We welcome the opportunity to discuss these points in greater detail with the Registrar.

In the meantime, our input to the College is divided into 2 distinct parts:

- General comments
- Specific comments related to each of the four pillars of the College's policy:
 - Availability and Coverage;
 - Managing Tests;
 - Transitions in Care; and
 - Walk-In Clinics

General Comments

- **In 2016, the College appeared to have embraced the definition that continuity of care did not mean continuous or 24/7 access but it appears the College is backtracking from that definition now.**

When we presented to the policy working group in 2016, we emphasized that continuity of care referred to the longitudinal relationship a family doctor has with his/her patient and this definition appeared to resonate with the working group members at that time.

What we read in the current draft, however, and what we fear could be easily misinterpreted by patients is this: if you (as the professional) believe in the concept of a sustained (i.e., longitudinal) relationship, then naturally you would accept the College's expectations of you as they relate to coordination of care, ensuring 'real time' access as it relates to managing critical test results, providing daytime and after-hours availability, any hour of the day or night. This essentially reinforces the College's original 2016 expectation of Ontario's family doctors providing 24/7 oversight and management of care, but now within the context of the sustained relationship between doctor and patient. This is neither feasible nor workable from both a provider and patient safety perspective.

- **Ontarians need their family doctors to be awake, alert and attentive to their needs.** The current policy proposed by the College undermines those goals by increasing the likelihood of physician exhaustion, moral distress, and burnout. Creating unattainable expectations means there will certainly be failures in meeting those requirements in an unpredictable way which threatens patient safety and outcomes. Safer solutions would allow for predictable boundaries and requirements for family doctors that would allow them to develop viable solutions to achieve reasonable access to care.
- **The College is trying to emulate policy that exists in other provinces without acknowledging that the system supports that exist in those provinces don't exist in Ontario.** Although the College conducted an inter-provincial review of continuity of care policies to determine if what it is proposing for Ontario is in line with continuity of care policies in other provinces, this review did not extend to looking at the underlying system level supports in place within those other provinces. Ontario's family doctors feel this is a critical flaw in the CPSO process because the College may be trying to emulate policy that exists in other provinces without acknowledging that the system supports that exist in those provinces do not exist in Ontario. For example, Ontario does not have a Telehealth system with physicians on call who can appropriately triage after-hours care needs of patients, thereby precluding the need for after-hours voicemails in individual physicians' offices.

The College knows there are significant system level barriers and deficits in Ontario that inhibit continuity of care. By not properly identifying and acknowledging them, the College's proposed solution is to make individual family physicians the Most Responsible Provider for patient health care across the disjointed sectors of care. Ontario family doctors, in particular, feel the College is placing inordinate expectations on them to provide 24/7 seamless oversight

and management of care that in reality is the joint responsibility of system funders, regulators, policy makers, providers and the patient.

The SGFP maintains that any revisions being considered following the close of this College consultation period must incorporate a system resources review and a commitment to work with the relevant partners, including the Ministry and the OMA, to identify and develop workable solutions that address these system gaps appropriately.

- **Much of what the College is expecting is beyond the scope or control of Ontario's family doctors.** Physicians can only fulfill what is expected of them if they have the appropriate system enablers to do so. This proposed policy provides none of the requisite tools or resources but articulates all of the expectations, many of which are beyond the scope or control of individual physicians to provide. As such, if left unaltered, this policy will only increase the significant workload and administrative responsibilities already assumed by Ontario's family doctors and lead to even greater levels of physician burnout which is not in patients' best interests.
- **The College's proposed Continuity of Care policy is predicated on a model of care delivery for family practice that the Ministry is actively aiming to dismantle.** All those vital services and functions underpinning the proposed College policy that resonate most with patients, and that patients want - for example, non-face-to-face patient interactions like email and text communication or virtual care, team-based care, and co-ordination of care among providers – are largely under threat of elimination during this current OMA – MOHLTC negotiations and arbitration process. The Ministry's position during this arbitration is clear: if you can't physically measure and quantify a service, such as an office visit for each and every issue including simple test results, it has no value.

It's not just the loss of these vital services that patients want (e.g., virtual care) that are of concern to Ontario's family doctors, it's the loss of family doctors who will opt out of family practice altogether. Family doctors will leave because of moral distress: what the College wants to make them do (eg., track whether patients had their tests) detracts from what they want and should be doing – providing direct patient care. This is not in patients' best interests.

We are already seeing a distressing decline in new medical graduates choosing family medicine as their preferred specialty. We fear these proposed policies will worsen this trend.

If family doctors were to opt out of family practice because of the College's policies as currently constructed, and new graduates avoid it altogether, one of the few key threadbare filaments holding this disjointed health care system in place will disappear and with it, a key foundation underpinning much of the College's policy. No one wins in this scenario.

- **Effective College policy cannot be created in a vacuum.** There is an ongoing negotiations process in place between the Ministry and the OMA, that ensures that whatever system issues and associated health human resource demands that are proposed for Ontario's doctors have the appropriate funding and system supports behind them to ensure that patients are able to

get the best care possible. The results of this bilateral process can then go to the College for framing policy.

For the College to be effective in promoting a functional Continuity of Care policy, it would need to be viable within the context of available system supports. Therefore, we urge the College to wait until the current negotiations / arbitration process is completed. This policy has been in the works since 2004. Waiting a few more months is not going to make that much difference from a time perspective, but it would ensure that what is being proposed for Ontario with respect to continuity of care is reasonable, viable, feasible, appropriately supported and respectful of the system's strengths and limitations.

Specific Comments Related to the Four Pillars of the College’s Proposed Policy

Availability and Coverage

- We have read the submission of our parent organization, the Ontario Medical Association and agree with the OMA’s suggested rewording of the College’s policy as it relates to “coordinating after- hours coverage for patients” (lines 90 -98).

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~~ make patients aware of urgent care options outside of regular operating hours. ~~This is often referred to 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.~~

- The College’s expectation of family doctors to coordinate care “after hours” with the view to minimizing patient use of ERs and walk-in clinics is unrealistic for a number of reasons:
 - In some communities, the ERs and walk-in clinics are that community’s after-hours solution: negating their use poses a viable threat to patient safety in those communities.
 - A more robust Telehealth system, similar to what exists in other provinces, could be used here to direct people to appropriate care after regular office hours.
 - Recent research conducted by Dr. Tara Kiran illustrates that it doesn’t matter how much access a family doctor provides, patients choose to use ERs and walk-in clinics regardless and the greatest use of these care settings is during regular daytime hours not after-hours.
- This brings us to the issue of patient accountability. We agree and support the concept of patient engagement in the management of his /her care. But a true family doctor – patient partnership implies shared ownership and shared risk. If family doctors make their patient aware of urgent care options that are available to him / her outside of regular operating hours, it is up to the patient to pursue those options appropriately. That is the implicit agreement that exists between doctor and patient. It is not the responsibility of the family physician to minimize inappropriate utilization of emergency rooms or walk-in clinics, nor should the family doctor be penalized through the regulatory college if patients fail to live up to their implicit accountabilities.
- It is unreasonable for the College to expect that family doctors will be available 24/7 to:
 - answer after-office hours voicemails;
 - triage patients with time-sensitive issues; and

- review, manage and convey critical test results to patients; or that
- they must have a plan in place to ensure coverage during temporary (including unplanned or even 1-day) absences.

We really struggle with how the average family doctor, including solo practitioners, part-time practitioners, or those practicing in small urban, rural or northern settings could meet these College expectations. Many of these practitioners do not have the necessary resources and back-up supports, such as available locums (replacement physicians) or appropriately trained office staff.

- We want to raise particular concerns about the College’s proposed ‘after-hours voicemail’ requirement. This opens up a whole new element of risk for patients. Whereas now patients with an urgent concern will be guided by instinct to seek appropriate care immediately, leaving an after-hours voicemail may provide them with a false sense of security that their urgent matter will be picked up in time. During the October 30 consultation session, the College indicated calls would most likely be picked up during the next business day, which for many offices could be the Monday after a Friday voicemail is left – too late for some patients, which poses a viable risk to their safety.
- This offloading onto family doctors of what we really see here as system deficiencies packaged as the College’s aspirational goals is unacceptable and contrary to the Quadruple Aim, a set of health system goals that recognizes the need to ensure provider health and wellbeing. If College policy produces the effect that physicians are constantly checking for voicemails or test results for fear of being called before the College, then they are not getting the rest they need to serve their patients. This pattern of practice is not sustainable. Ontarians need their doctors to be awake, alert and attentive to their needs. Patients’ health care needs are best served by family doctors who are not burnt out or overworked.
- Finally, we firmly believe that the College’s highly-prescriptive policy, as currently written, has the potential for decreasing patient access overall. In an effort to mitigate risk to patient safety and physician liability, family doctors may well bring more of their patients into the office because it’s difficult to assess someone as high risk or having an urgent care need if he / she isn’t physically present before you. So College policy that is presumed to be drafted to facilitate access may produce the opposite effect.

Managing Test Results

- This pillar of the College policy is fraught with vague definitions (“high-risk patient”, “critical test results”) and unrealistic expectations e.g., physicians should “track tests for high risk patients and use professional judgment in all other cases” that have the potential to significantly contribute to physician burnout.
- As we heard during the October 30 CPSO consultation, what the College is trying to tackle through policy is really a system issue:

- Private labs like Lifelabs or Dynacare process their blood work during the night so how can they expect a physician to be available to receive and respond to results 24/7?
 - Moreover, private labs do not have a reliable mechanism to flag high risk results other than looking at values against a defined range. Doesn't OLIS, the province's laboratory information system, provide a history of patient lab values? OLIS should be utilized to its maximum capacity to ensure labs can access important patient data after hours.
 - As reported by the private lab representatives, the total volume of criticals is approximately 2500 / month and they do about 200 callbacks /week. The groups identified by the private labs as being the most difficult to reach with these results are walk-in clinics and nurse practitioners. This suggests a targeted approach rather than one that blankets all physicians might be the better solution.
- If the goal is patient safety, expecting family doctors and their office staff to ensure patients actually have their recommended test(s) distracts them from what they should really be focusing on: providing direct patient care.
 - Ensuring patients actually have their test really is an issue of patient accountability which is another system issue. As articulated by participants at the October 30 consultation, how does one verify that a patient had the test? Which lab did they go to? It is for this reason that we concur with the editorial rewording suggested by our parent organization, the Ontario Medical Association, as it relates to lines 67 – 73 of the Managing Tests draft policy. Therein, all that remains as suggested by the OMA is the following: *“Physicians are advised to convey to their patients the importance of taking a test and advising patients to book a follow-up appointment for test results.”*
 - This suggested rewording speaks to the larger issue, namely, at what point can the family doctor say “I have tried” when patient choice is resulting in a less optimum plan of care? This includes circling back with the family doctor (i.e., responding to a call from the family doctor's office, or attending their scheduled visit to learn the results in person). Several family doctors on the SGFP Executive cited identical experiences: *The patient is called to come into the office. He /she doesn't come in. The office calls them. No response from the patient. The office tries again. Again, no response.* At what point can the family doctor stop being responsible? What does the CPSO advise in these instances?
 - This desire to limit the family doctor's responsibility to what can reasonably be expected of him / her also extends to the question of who is expected to provide patient follow-up for abnormal test results. The SGFP maintains this would be the responsibility of the ordering physician. Too frequently, consultant specialists offload this responsibility onto the family doctor by copying them on the test requisition. Follow-up should be conducted by the physician who ordered the test: he or she understands the background rationale for why the test was ordered and what the results actually mean.

Transitions in Care – Consultations and Referrals

- The SGFP is pleased the College is revising its policy such that the consultant physician must communicate in a timely manner the estimated or actual appointment date and time to the patient directly and that the family doctor should hear from the consultant when the appointment has been made.
- We would agree with the College’s proposal that consultant specialists must acknowledge within 14 days whether they can accept the referral, and if they cannot (e.g., wait list too full, is not the right specialist for that patient’s needs), the consultant specialist should help the referring physician find an alternative.
- With respect to timeliness of receipt of the consult report, we appreciate the College’s intent to put some structure around what often is a black hole experienced by family doctors. 30 days for receipt of a consult note as suggested by the College may be too late in some instances. If family doctors are expected to see patients who present with urgent, time-sensitive issues after their hospitalization or visit with the consultant specialist, then family doctors need to know what happened in hospital or at the appointment because often the patient doesn’t know or can’t explain.
- Moreover, we question the value of consult reports and the content therein when the consultant specialist delays. How can the specialist possibly remember all the details of the appointment if they wait a month to dictate the note?
- We would suggest that, for time-sensitive, urgent cases, consult notes should be available in 14 days or less if the note adds to the clinical management of the patient or is relevant to ongoing care delivery.
- Of course, the right system-level supports here could preclude the need for policy to manage the gaps in care currently experienced in Ontario.
 - An up-to-date provincial registry or database of consultant specialists complete with specialty and sub-specialty focus would enable family doctors to more easily find the right consultant specialist for his /her patient’s needs.
 - Moreover, if this province had a robust, smart card system that could track the patient’s care journey, including test results, much of the uncertainty around ensuring continuity of care and seamless transitions of care would be moot and the onus would rightly rest on government’s shoulders, not that of the individual physician.

Transitions in Care – Discharge Process

- During the November 5 stakeholder consultation, the College was primarily focused on the question of what does a good discharge process and discharge summary look like? We would contend the College should go back one step further and ask: what constitutes a good discharge?
- Within that context, we would agree with what was suggested by one of the patient advocacy representatives at the November session: *“there needs to be a culture shift here where the discharge process is seen as an integral part of the treatment and the discharge summary, therefore, is integral to the discharge process, not treated as an afterthought or administrative burden”*.
- If this was the case:
 - The emphasis would be on safe medical and social discharge i.e., the patient would be medically stable and the necessary supports (home care, primary caregiving, discharge summary, etc) would be in place prior to discharge.
 - There would be better alignment of care standards across the system i.e., if family doctors are expected to follow-up with the patient within 48 hours post-discharge, they should have the discharge summary at hand when they see that patient.

And CPSO policy and institutional (hospital) policies would be aligned, such that the necessary institutional supports (e.g., transcription services) would be in place to enable the consultant specialist to comply with the CPSO standard.

Walk-In Clinics

- Although this fourth pillar was not addressed during either the October 30 or November 5 consultation session, the SGFP offers the following comments:
 - The proposed requirement that walk-in clinics should provide comprehensive care to those patients who do not have a family doctor avoids the real solution i.e. more patients should be attached to a comprehensive care family physician.
 - Ironically, there is a government restriction right now that prevents more patients from being attached. The College is creating policy here to skirt this system issue by expecting walk-in clinics to provide comprehensive care.
 - Walk-in clinics struggle to meet this expectation because they are primarily designed to provide urgent, episodic care. Mandating them to provide comprehensive care will likely result in some walk-in clinic physicians choosing to abandon this choice of practice which may result in walk-in clinics closing altogether thereby putting even greater pressure on hospital emergency departments.

Summary Comments

Regulatory College guidelines are to provide guidance for practicing physicians, not prescriptive clinical directives. Nor should College policy hold individual physicians accountable for system issues and gaps that are beyond their control or scope to resolve. Ontario's family doctors are fearful that highly-prescriptive, and non-viable government and College policy will work against the best interests of patients and may result in family physicians opting out of family practice and new graduates avoiding family practice altogether. Neither good for patient care or patient safety.

We trust you find these comments useful. We welcome the opportunity to meet with the Registrar and discuss these issues and comments more fully.

You can contact us at sgfp@oma.org