Members of the OMA Section on Hospital Medicine reviewed the proposed CPSO *Continuity of Care* policy. We agree that it is an essential component of patient-centered care.

Our response is from the perspective of hospital medicine physicians who provide care to hospitalized patients, typically in the role of the “Most Responsible Physician” (MRP). Hospitalists have a practice model distinct from office-based physicians; as a result, we would face certain challenges to implementing the policies proposed under the CPSO *Continuity of Care* umbrella policy.

The most pertinent distinction is that logistical and administrative support for Hospitalists is largely determined by the hospital in which they practice. While each program is unique to the individual hospital, all hospital medicine physicians will experience significant challenges in fulfilling the expectations of the CPSO proposed Continuity of Care policy. Decisions regarding clerical and administrative support, electronic medical records, lab management systems and cross-coverage of patients are made at the hospital governance level. Hospitalists have limited influence over these decisions, which are based on hospital administrators working within Ministry funded models. Most hospitalists do not have outside offices and rely solely on what is provided by their hospital for administrative support. Implementation of many of the elements contained within this draft policy would require a significant increase in resources, not likely to occur in the present climate of fiscal restraint in Ontario hospitals.

In addition, Hospital Medicine practice is episodic and therefore not continuous beyond the hospitalization. Continuity of care is optimized during the acute illness with intensive clinical management and contiguous days including weekends. The patient is then returned to their primary care provider for ongoing care, review of pending tests and consultations. Some of the proposals within this draft would require ongoing and
overlapping involvement of the hospitalist and the primary care provider. This duplication of care provision will have fiscal consequences with no clear benefit.

While there are some proposals contained in the draft CPSO Continuity of Care policies that we do aim to support, there are many which are not reasonable or could not be implemented without appropriate staging and/or sufficient resources. The CPSO white paper addressing system-level issues impacting continuity of care will be particularly pertinent to Hospitalists.

In response to the proposed suite of Continuity of Care policies, members of the OMA Section on Hospital Medicine evaluated selected topics and expectations from the draft policy that are relevant to hospitalist practice. Below is the summary of how the Section members evaluated each part as one of the following: reasonable, not reasonable, or reasonable with adequate resources.

**SUMMARY: RESPONSE FROM OMA SECTION ON HOSPITAL MEDICINE TO THE PROPOSED SUITE OF CONTINUITY OF CARE POLICIES**

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**AVAILABILITY AND COVERAGE**

*Being Available by Telephone – REASONABLE WITH ADEQUATE RESOURCES*

When patients are admitted to hospital, they are assigned to a Most Responsible Physician. Health care teams may contact the MRP through usual locating protocols.
After hours, there should be an on-call physician available to manage urgent clinical concerns.

Some Hospitalists do not have an office, therefore it would be NOT REASONABLE to expect them to have an office telephone or voicemail. If an office telephone or voicemail is required for hospital medicine physicians, hospitals need to provide adequate clerical support to enable this availability.

Hospital Medicine physicians are primarily responsible for hospitalized patients. Any subsequent communication to discharged patients should be limited to the acute episode of care related to their hospitalization. Enquiries regarding other clinical matters should be directed back to the primary care provider.

**Being Available and Responding to Other Healthcare Providers – REASONABLE WHEN ON SERVICE**

Hospitalists should be expected to respond in a timely and professional manner when contacted by physicians or other health-care providers when they are actively in the MRP role.

**Coordinating After-Hours Coverage for Test Results – REASONABLE WITH ADEQUATE RESOURCES**

It is expected that hospital laboratories and Diagnostic Imaging departments have a critical test results management system to inform ordering physicians and MRPs regarding urgent results.

**MANAGING TESTS**

**Test Results Management System – REASONABLE WITH ADEQUATE RESOURCES**

Hospitalists are not typically responsible for choosing the hospital’s test results management system. Results for tests ordered in hospital by MRPs or by consultants should be delivered in a reliable manner by the hospital in order to ensure appropriate medical review and potential action. Hospital based physicians will require adequate clerical resources to facilitate certain actions with respect to test result management as oftentimes such patients are discharged from hospital at the time of the results are published.
Tracking Tests - NOT REASONABLE
The proposed policy expects physicians to track test results for high-risk patients and use professional judgement to determine whether to track a test result for non-high-risk patients. The Section questioned the definition of a “high-risk” patient, which could have a different meaning to different physicians. Hospitalists do not provide ongoing care on after a patient’s discharge from hospital. Patients usually follow up with their own family physician. Hospitalists do not typically have the administrative support to follow up to ensure that patients have completed a test that was ordered for them. The responsibility for test completion should be shared between the patient and the primary care provider.

Communication of Test Results - REASONABLE
When patients are admitted to hospital, they all have a MRP. This MRP will follow up on test results and communicate them to the patient in a timely fashion, usually within the following day in hospital, or earlier depending on the time-sensitive nature of the result. This is reasonable while patients are remain admitted to the hospital.

“No News is Good News” Strategies - REASONABLE
Patients, or Substitute Decision Makers, in the hospital may ask for results from their MRP. Some hospitals now have online patient portals that allow patients to access their own results online.

Receiving Test Results in Error or Incidentally - REASONABLE WITH ADEQUATE RESOURCES
If physicians receive a critical or clinically significant test result in error, the policy expects the physician to inform the ordering health-care provider. The Section members were not clear on the definition of a “critical or clinically significant test result”, as one physician may not deem the same result as urgent as another physician. In any case, results may be received in a variety of manners, e.g. by mail, electronically, fax, or verbally. Physicians may not be aware of the delivery of all test results if they are not expected, therefore it would not be reasonable for them to respond in such a case. However, if a Hospitalist does receive in error what they believe to be a critical or clinically significant test result, then it would be reasonable for the Hospitalist to inform the ordering physician by fax or phone with the assistance of administrative support.

Patient Engagement - REASONABLE
It is proposed that physicians can engage patients in two ways: informing patients of the significance of the test and getting it done, and the importance of complying with the pre-test instructions. Physicians are also advised to encourage patients to discuss test
results with their physicians, ask questions, and follow up. These practices are part of a Hospitalist’s professional practice, and this is therefore a reasonable expectation.

TRANSITIONS IN CARE

Keeping Patients Informed - REASONABLE WITH ADEQUATE RESOURCES

The Section felt it was reasonable for physicians to coordinate with other health-care providers and with healthcare institutions and facilities administration to keep patients aware about who is their MRP. While physicians and health care providers are expected to do their best to keep patients aware about who is their MRP, facility-specific systems should be implemented to ensure that patients and their families can reference who the MRP is. Such systems may include an updated whiteboard at the patient’s bedside and updated electronic record keeping by clerical staff or by software. Oftentimes, patients are covered on the weekend or evenings by on-call physicians. Hospitals should play a role in keeping patients aware that covering physicians may act as MRP during weekends and after hours.

The Section felt that it was reasonable that consultant physicians must also discuss with inpatients the nature of their role in providing and managing care.

Managing Handovers in Hospitals and Health-Care Institutions - REASONABLE WITH ADEQUATE RESOURCES

The Section felt that it was reasonable with sufficient resources to set time aside to allow for a real-time and personal exchange of information between MRPs. The Section felt it would be difficult to achieve real-time and personal exchange of information to on-call providers who could be looking after hundreds of patients after hours. For example, at large Ontario community hospitals, one physician may be on-call for 200-400 inpatients. It would be technically impossible for an on-call physician to receive real-time and personal exchange of information on hundreds of patients and then for that on-call physician to communicate such information back to the various MRPs the following morning.

The Section felt it would be reasonable for physicians to approach patient handovers by providing focused verbal handover whenever clinically necessary to on-call physicians for those patients who are anticipated to have medical compromise.
The Section urges hospitals to build and support IT solutions that may further strengthen patient handovers and to have such information exchange documented in the medical record.

**Completing and Distributing Discharge Summaries - REASONABLE WITH ADEQUATE RESOURCES**

As part of their routine practice, Hospitalists dictate a discharge summary for all in-patients upon discharge from the hospital. Most hospitals have a Health Information Management team that sends out reminders to physicians to dictate discharge summaries for any incomplete charts. Therefore, this expectation is felt to be reasonable for Hospitalists.

**Making and Acknowledging a Referral - NOT REASONABLE**

The referrals section of the proposed CPSO Continuity of Care Policy has a few areas that will not be feasible for physicians practicing hospital medicine. Because a Hospitalist’s practice is in the hospital, we do not have an office with administrative staff to follow up on the status of referrals to specialists. Therefore, we cannot track if a referral has been received and acknowledged. These referrals are often made on the day of discharge, after which the Hospitalist is no longer involved in the care of the patient. It would not be possible to convey information from a specialist’s office to the patient days or weeks after the patient has been discharged. We believe it should be the responsibility of the specialist to reach out to the patient and inform them of their appointment date and time.

**Distributing Consultation Reports - REASONABLE**

There may be some situations where hospitalists act as consultants, in which case it would be reasonable for them to dictate consultation reports, which would then be distributed by the hospital’s health information management system.
In summary, the practice of Hospital Medicine is distinct from that of office-based physicians for a variety of reasons, including practice setting, available administrative resources, and varying levels of resources and support provided by individual Ontario hospitals. While there are some elements of the proposed suite of CPSO Continuity of Care policies that are relevant and reasonable for Ontario’s Hospitalists, there are others which our Section members deem either unreasonable, or reasonable if adequate resources or supports are available. We value the efforts undertaken in the draft Continuity of Care policy however there remain some aspects which will be difficult for physicians to execute without the appropriate supports in place to enable a seamless care experience for patients.

Thank you for your consideration.

Please do not hesitate to contact us if you have any further questions.

Regards,

OMA Section on Hospital Medicine Executive