



November 29, 2018

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The Rural Expert Panel thanks the CPSO for requesting input on the Continuity of Care Draft Policy; a document which looks at Managing Tests, Availability and Coverage, Transitions in Care and Walk-In Clinics.

We applaud the College revisiting issues that impact care, such as management of test results and expectations of walk-in clinics. We are concerned this document reflects a viewpoint that is largely blind to the rural physician, patient and system. Rural areas in Ontario face doctor shortages and thus differ from urban environments with adequate numbers of family doctors. The College alludes to wanting a balance between physician burnout (which impacts patient safety and care) and direct patient safety, but does not outline how this is achievable in an underserved system. We will outline how complying with this policy will be an impossible burden on rural physicians, who are already stretched to capacity, and will result in reduced patient care, reduced patient access to services, and reduced patient satisfaction within rural and remote Ontario.

1) In the Availability and Coverage document, the College outlines the expectation that “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.”

Additional staffing resources will be required to adopt this practice of 24/7 capabilities for phone messaging, the additional workload of keeping outgoing messages up to date, retrieving and transcribing voicemail, acting appropriately on the content of the voicemail and communicating both internally and with the patient. In rural areas, it can be challenging to find qualified office personnel. Moreover, in order to offset the cost of this additional staffing, we estimate a family

physician in a capitation model would have to increase her roster by between 60 and 190 patients. This increase in roster size would further dilute access to the physician for her group of patients or would require her to spend even longer hours in clinic. Many rural physicians work their offices around operating room schedules, emergency room coverage, hospitalist care, home visits, long-term care and hospice/palliation. Provision of some of these critical services may need to be discontinued by an individual doctor in order to accommodate the increased office demand. Alternatively, physicians may cease office work as the cost-benefit ratio becomes too prohibitive. In any or all of these scenarios, patient care will be negatively affected.

Patients who need immediate care need to access an emergency department. In rural communities these are staffed by family physicians who need to balance office workload so time is available to cover the ER. Patients who are unsure of the urgency of their concerns need to contact Telehealth (an existing provincial program that provides after hours health assistance to patients). Only patients who are confident that their concerns are not urgent should utilize voicemail and it is unclear why that such patients can not wait for business hours to call their doctor. Allowing patients to inappropriately triage themselves to an office voicemail is a formula for delayed care and undesirable outcomes.

2) The College draft also outlines that “Physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues” and specifically references consideration of adopting same-day access appointments for urgent care within family practice.

We view this through a rural lens as an overly simple and often wrong solution to a complex problem. In a large city with adequate FP numbers and multiple hour waiting times for deferrable visits to the ED, it makes sense to shift these patients to family practices. In small rural areas where physician-patient ratios are less than half that of cities, it is the office visit which is at a premium. In between, optimal use of office, walk-in, urgent care and EDs is dependent on multiple factors.

Although same day office appointments continue to resonate as a theme among health policy makers, the data indicates that increasing the number of spots for same-day access does not

translate into improved patient experience or satisfaction. In fact, there is an 8% decrease in satisfaction for every 10% increase in same day access spots¹ or decreased number of emergency room visits². The Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries indicated that longer times to reach primary and emergency care were likely due to the fact that "Canadians consult with physicians more often than people in other countries" and that Canadians "visit emergency departments more often than people in other countries"³. What the literature shows is that what patients want most is to schedule an appointment at a convenient time for them; this is more important to them so than having speed of access, unless experiencing a brand new issue¹. This is reflected in findings that show patients generally attend walk-in clinics for convenience, not due to lack of access. In Szafran, et al "Of the 106 patients who attended walk-in clinics, 43.3% attended during weekdays (ie, Monday to Friday 9:00h to 17:00h) when their family physicians' offices were open, 52.8% did not call their own physicians before attending the clinics, and 10.4% went to walk-in clinics within a week of seeing their own family physicians."⁴ Access to primary care in Ontario is already generally regarded as favourable⁵ and is comparable to levels of care in other countries³.

Ensuring a doctor has a supply of same day appointments necessitates the loss of pre-booked appointments and, through simple mathematics, it is apparent there can be an overall net loss of patient access to the physician if same-day appointments go unwanted and unfilled.

Another unintended consequence can arise with FPs filling same day spots with patients who require urgent lab and imaging which may delay appropriate treatment, leading to time inefficient care for both the clinician and patient.

The largest bottleneck for out-of-hospital care is in specialty wait times³ and this is not mentioned within this draft policy. Family physicians in both urban and rural areas have little to no information about specialist wait times and triage for acuity. Sometimes it can take weeks to learn that a requested consult has been declined for some reason. CPSO efforts to better integrate primary care with consultants, for example by facilitating communication, would be far more productive for continuity of care than targeting under-supported rural physicians with isolating, unrealistic expectations for issues frankly beyond their control.

Based on this data, it would make more sense for energy to be expended at decreasing Canadians overall health care usage through education, rather than providing even more access to the detriment of patient safety due to dilution of physician supply and patient satisfaction.

3) The College states, “Physicians providing care as part of a sustained physician-patient relationship must have a plan in place to coordinate care for patients outside of regular operating hours. The nature of the plan will depend on a variety of factors.”

This statement is overly vague yet prescriptive. Is the intention here that a patient with a routine question about a medication he has been on for 10 years should be able to reach his physician or her colleague at 3 o'clock in the morning? If this is the intent, we will need many more health staff in Ontario to manage non-urgent issues at all hours of the day while we try to stave off physician burnout. Emergency rooms are open 24/7 and patients can easily find them for urgent/emergent issues.

What if, as a result of remote geography, specialty or care model, you are not part of a call group? Who do you get to provide after-hours call with you? For example, a physician might be the only opiate-replacement provider for a one hour radius. Who can a physician reasonably team up with to ensure that patients can call at all times of day and night without putting undue burden on the physician? Who will help facilitate this? Is the answer to simply stop providing that service all together? This is another example where the realms of physician burnout and patient care may collide.

As previously discussed, Telehealth already exists in Ontario and provides after hours information for patients; these nurses can direct patients to local emergency rooms through a clinical triage system or suggest an appropriate time frame the patient should have the issue addressed in primary care. This existing coverage should be quite adequate for issues outside of regular clinic operating hours.

It is our view that the CPSO should not push for doctors to go beyond reasonable expectations for after hours availability. The risk of triggering burnout is very real and physicians will vote with their feet pointing away from rural communities. In order to provide sustainable care, the CPSO

should advocate for providing patients with the tools for appropriate self triage in an over-stressed system.

4) The College also states in its draft policy “During temporary absences from practice physicians providing care as part of a sustained physician-patient relationship must make coverage arrangements for patient care, the nature of which will depend on a variety of factors, and all physicians must make coverage arrangements for test results.”

In areas of Ontario that struggle with finding locums (either in advance or unexpectedly, in the case of physician or family illness), the boots on the ground are already stretched to breaking due to a lack of physician providers⁷—this particular expectation is likely unattainable in the current environment. Vulnerable rural Ontario patients may once again be left behind as physicians find they cannot keep up with the rising personal and economic costs of providing care in these areas. Without a plan in place to assist rural and remote physicians to meet these requirements, rural patients will again be negatively impacted.

We recognize that the mandate of the CPSO involves only physician regulation, but we ask that the CPSO be mindful that policies such as this may disadvantage rural physicians, relative to other health care providers in Ontario who do some of the same work, setting them up for burnout. We suspect that, quite reasonably, other professional regulatory bodies and representative organizations would not require the same degree of onus on their members regarding test management, availability and coverage. Inter-professional team work has become more common, but in this policy it is not clear whether continuity of care provided by the collective is the responsibility of only the physicians.

We applaud the patient-centered safety mindedness of these draft policies and envision improvements in continuity of care with some of the suggested material. However, we feel it is an unfair burden on generalists in rural and remote Ontario to compel broad-reaching 24/7 coverage without providing the infrastructure on which to build such coverage.

It is past time for the CPSO to stop trying to use the hammer of physician regulation to deal with the many screws and fasteners of system deficiencies. Physicians, especially rural generalists, are already compensating for system problems and sometimes failing despite their best efforts.

The cost of this is measured in longer wait times, poor patient outcomes, physician burnout and reduced retention.

In addition to revamping system infrastructure, we need to empower patients with additional health and system knowledge so that they can help doctors provide them the best, safest care as close to home as possible in an appropriate time frame.

Sincerely,

The Rural Expert Panel

Sent via email

CC: Rural Expert Panel Members

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