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07 December 2018

To Whom It May Concern:

RE: Review of CPSO *Continuity of Care* draft policy

The Division of General Internal Medicine at Western University reviewed the draft CPSO continuity of care policy at its last divisional meeting. I am submitting our feedback regarding the policy on behalf of our Division.

Overall, our group is very supportive of much of the policy, and we believe that it will enhance care in many ways. Dialogue about the policy has prompted us to review our processes and to implement more specific divisional policies around these issues.

We felt strongly, however, that some of the proposed requirements represented standards that could not reasonably be met by most physicians and their administrative assistants. Our specific concerns are outlined below according to section.

Availability and Coverage:

Overall we felt that most of these items could be easily implemented and we will clarify our practices through the development of divisional policies.

We believe that the wording in the proposed document around the “timely manner” in which these tasks must be done is vague and requires clarification.

Managing Tests:

There was consensus that the ‘tracking’ tests requirements represent a standard that cannot be met. Our patient care record does not have the capacity to flag and then contact the provider regarding missed tests. As drafted, we believe that the policy is too onerous, and it is also unclear.

What constitutes a “high-risk” patient? Our group sees many members of vulnerable populations, and they are often difficult to contact. If the burden to track test compliance is placed on physicians, we are concerned that vulnerable populations may be further marginalized. We believe that many physicians are already reluctant to see these patients, and this added requirement may add a further disincentive to do so.

Transitions in Care:

The requirement that most aspects of the transitional care plan must be captured in writing and given to the patient is something we are already doing through our “PODS” (patient-oriented discharge summary) initiative. Our group agrees that this is critical to safe transitions and we are supportive of this policy.

We do not support the expectation that members would be required to track the status of their referrals made at discharge. This is too onerous, especially on busy clinical teaching services. We make referrals to many different services/providers, each with their own logistical practices for receiving, triaging, communicating, and booking. At the time of discharge, we have no way of knowing which specialty provider will ultimately receive the referral request as these are often triaged. We cannot be expected to follow-up on all of these referrals after 14 days.

Summary:
Although our group is supportive of efforts to improve communication amongst patients and their care providers, we believe the draft proposal requires amendment. In particular, there needs to be revision of the sections on “tracking tests” and “tracking referrals” for the reasons stated above. Further definition of key terms, such as “high-risk patient” and “timely manner” is also strongly recommended.

Thank you for the opportunity to comment on this draft policy. We hope you find our feedback helpful, and look forward to reviewing the next draft when it is available.

Respectfully submitted on behalf of the Division of General Internal Medicine (Western),

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[redacted] Schulich School of Medicine and Dentistry
Western University

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