OMA Group on College and University Student Health

December 7, 2018

The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON, M5G 2E2
continuity@cpso.on.ca

Re: Feedback on the Draft Continuity of Care Policies

On behalf of Student Health physicians across the province, we would like to thank you for the opportunity to participate in the consultation process for the CPSO’s proposed update to the Continuity of Care policy. While we agree strongly with the spirit of the policy, our concern is that the vagueness of the requirements coupled with the high burdens associated with them will force student health organizations into either a non-compliant status or further our recruitment challenges for new physicians.

It may surprise you to know that student health remains an area of need for physicians – the lower reimbursements and high mental health burden has made it relatively unpopular for family medicine. However, our practices play an important role in young adult healthcare in the province. There are an estimated 500,000 university students and 230,000 college students in Ontario today, approximately 10% of whom are international students.

The policies, as written, would be devastating to our practices and we kindly request the College to reconsider some of the specifics to take into account ours’ and other “non-classical” practices across the province.

Availability and Coverage – Draft Policy

Holidays

Most university and college family medicine practices across the province are closed during school holidays. Some of us have no choice in the matter – the university controls access to the building and locks the doors. Furthermore, many of us no control over our staff’s contracts – they are negotiated directly with the university, and employment during the holidays is not an option.

The requirement for us to maintain voicemail, e-mail, and patient care coverage during school holidays and periods where we are closed is currently impossible for us to meet.

Compounding this concern is the vague terms that the policy uses – requiring us to often make judgments using the “worst case scenario” interpretation. Does it suffice to have a voicemail outlining our closure, the location of the nearest walk-in clinic, and that messages will not be answered during the holidays? As it is written, the policy suggests otherwise.

Electronic Communication

Many clinics have policies which allow for, and even encourage, communications with our young adult patients via e-mail. We now receive booking requests, minor questions, and prescription renewal requests electronically, at all times of the day. Notwithstanding that all of these e-mails are not reimbursed and yet take up a significant proportion of the day, to what extent are we allowed to be backlogged? How timely is “timely”? Without further defining this requirement, our fear is that it will have a chilling effect on physicians allowing for electronic communication with their patients out of concern that our responses will not be timely enough.
**Critical Test Results**

The requirement for critical test results to be reported 24/7 puts the burden solely on providers. However, we would encourage the College to consider involving laboratories in this process. Some have lists of provider personal contact information which would be helpful, along with backups to reach if the original provider cannot be reached. Perhaps it might be easier to encourage this sort of process as opposed to putting the onus solely on providers as currently suggested.

**Alternate Coverage**

In situations where student health is a group practice, the policy for alternate coverage during temporary absences is typically already fulfilled. Our concern is situations where student health is run by solo or dual physicians – how could this be met in those clinics? It is very challenging in rural and remote parts of the province to get locum coverage, particularly in short notice. Additionally, unplanned temporary absences occur due to any number of reasons, and it could be detrimental to physician wellbeing to add the additional stress of finding someone rapidly to what might already be an extremely stressful situation. We are extremely concerned that requiring temporary coverage plans will strongly discourage solo / dual practices (which do comprise a number of student health organizations, particularly at non-urban colleges) given that compliance with this policy may be impossible for them.

**Managing Tests – Draft Policy**

Our concern is that the policy implies that the onus for test tracking and reporting falls solely on the shoulders of physicians. Many EMRs do not currently have the capability of creating a list of tests that are ordered but have yet to be completed by the patient, or have results reported. While this would be the ideal – and indeed, I suspect the majority of us set reminders and trackers for high-risk results – the policy provides minimal guidance as to what is considered “high-risk” and creates a high bar to meet in the context of EMRs that just are not there yet.

Furthermore, the policy creates an unfortunate catch-22. It requires physicians to subjectively determine the importance of communicating a test result (including surmising its perceived importance *from the patient’s perspective*) while also restricting the ways it can be communicated (ex: see footnote 10).

To what extent can we expect the patient to shoulder some of the burden for following through on completing the test, and following-up with the clinic on its results (particularly if they feel anxious about it)? As written – none.

There is also suggestion of new documentation requirements which will add to paperwork burdens. Do we need to document that we emphasized to our patients the significance of the test? Are we expected to make note of informing the patient of a “no news is good news policy” in *every* encounter?

**Walk-in-Clinics – Draft Policy**

Are Student Health organizations across the province walk-in-clinics? If you asked most of us, the answer would be a firm, no.

However, the definition under the policy includes us. Yes, the care is often episodic in nature – these are young adults we are talking about. Our patients may not be required to book appointments – there is often a walk-in atmosphere in our clinics. And, indeed, there may be no existing (or even ongoing) association with the practice. Finally, many of our patients maintain relationships with their external primary care providers, describe them as their family physicians, and may even remain rostered throughout their university period.
On the converse, a substantial percentage see us as their family physician. This is the first time they seek medical care on their own – and they choose the provider they want to see. They live at university for four, sometimes ten, years and our site becomes their primary access to the healthcare system.

The policy, as written, puts us in an impossible situation.

If the College sees us as walk-in clinics, we are in trouble.

- The paperwork burden of forwarding all tests, visits, and consultations to the patient's family physician will be overwhelming both for us and the family physician office. It would simply be impossible – particularly given 10% of students in the province are international – to feedback all of that information to primary care providers.
- Furthermore, many students enjoy that we are separate from their family physician. Particularly as it relates to mental health appointments, many patients appreciate and, in fact, request that their family physician will never receive their mental health notes, as they care for their entire family and there is fear of breaches of confidentiality. Frequently, patients decline to have consultation notes forwarded back. Following the policy recommendation to feedback all notes would have a chilling effect on patients opening up to us.

If the College, instead, sees us as the patient's primary care provider, then we are caught in the non-compliant situation for our organizations to provide coverage when we are closed – particularly during school holidays where we are locked out of our buildings, and are without staff, for weeks at a time. It also creates the reverse question – should patient’s primary care providers be faxing over all their records from the summer holidays back to our clinic to complete the continuity of care? The true solution to this problem is a province-wide electronic medical record system – but until then, full compliance with the policy is an impossibly high bar to meet for clinics in our relatively unique situation.

**Conclusion**

Ultimately, the policy puts us an impossible scenario – if fully implemented, we would have no choice but to drastically change our practices, fail to be fully compliant with the policy’s requirements, or increase the financial burdens on our clinic that will further discourage physicians from entering a practice of medicine that serves over 700,000 students across the province.

We urge the College to either more specifically outline the expectations required (to avoid decisions based on "worst interpretation"), reduce the burdens required by including patients and laboratories in responsibility for health-care, or make exceptions for organizations such as ours (and surely other non-classical practices in the province).

We cannot underscore our firm belief that continuity of care is important – but as written, this policy will be impossible to implement in our practices across the province.

Thank you for your kind consideration of these comments and for including us in this important process.