THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Continuity of Care

General Consultation Survey Report

Introduction

The College's Continuity of Care policy suite was released for public consultation between May and December 2018. The suite includes the foundational Continuity of Care draft policy (referred to as the umbrella policy), and four companion policies which set out expectations regarding Availability & Coverage; Managing Tests[1]; Transitions in Care; and Walk-in Clinics.

Invitations to participate in the consultation were sent to stakeholders, including the CPSO membership, and a notice was posted on the CPSO website and social media platforms.

Feedback was collected via regular mail, email, an online discussion forum, and an online survey, all of which are posted online.

This report summarizes only the stakeholder feedback that was received through the online survey.

Interpretation Notes:

1. Participation in this survey was voluntary. As such, no attempt has been made to ensure that the sample of participants is "representative" of any sub-population.
2. The stakeholder feedback received in response to open-ended survey questions has been summarized to capture the key themes and ideas and is not reported verbatim.

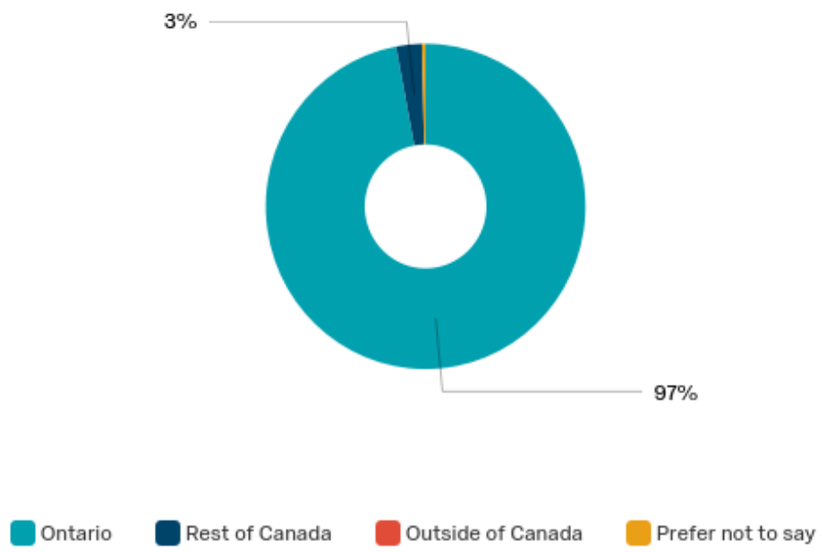
[1] Please note the Managing Tests draft policy is a revision of the College's Test Results Management policy.

Contents

Demographic Questions

Question 1:

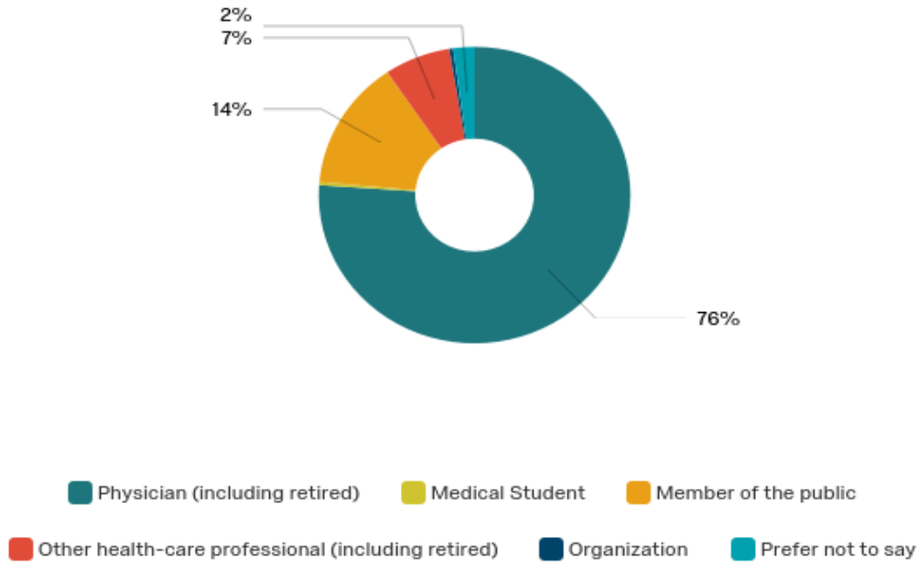
Do you live in...?



Total Respondents	542

Question 2:

Are you a....?



Total Respondents	539
Organizations included :	
iamsick.ca	

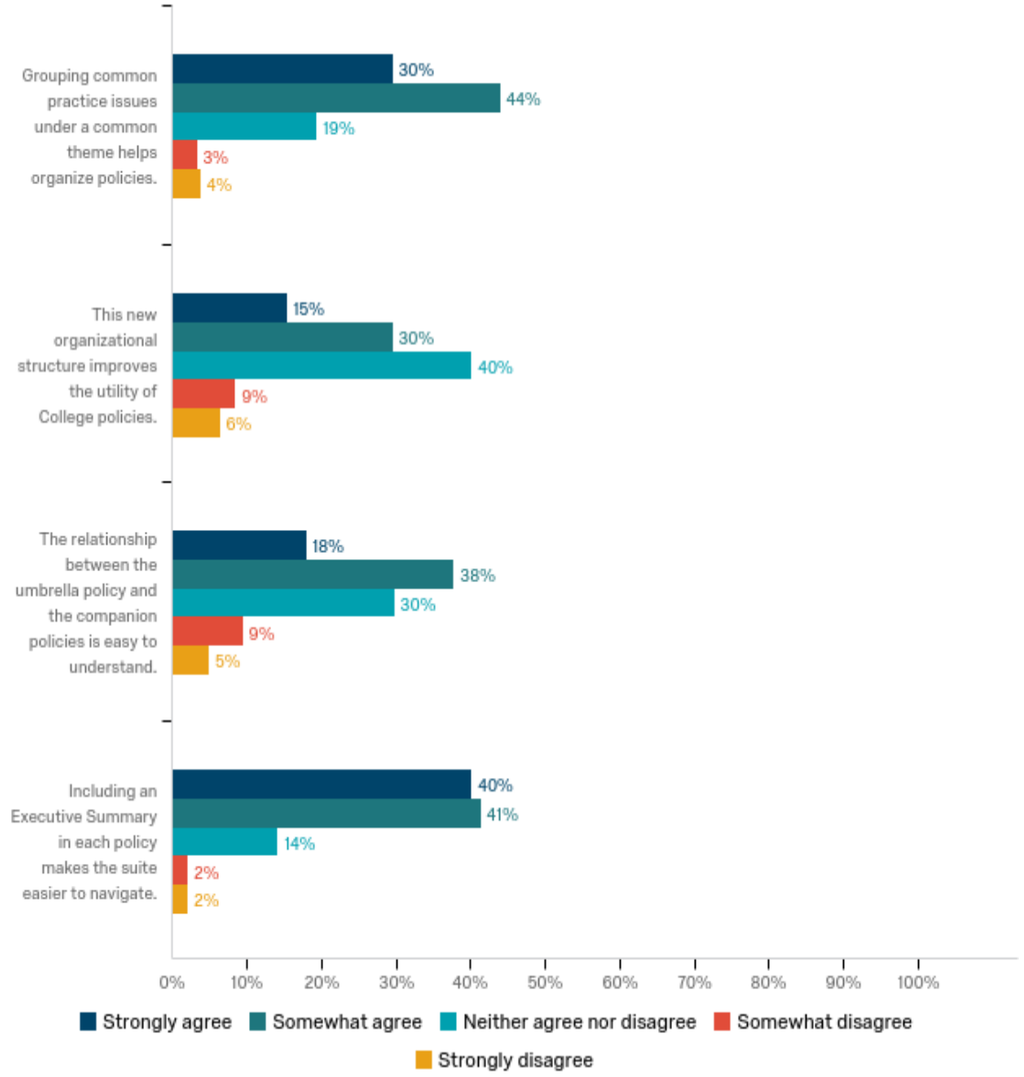
Policy Approach

Question 3:

The suite of draft policies is comprised of a foundational Continuity of Care draft policy, referred to as the umbrella policy, as well as four companion draft policies: Availability and Coverage; Managing Tests; Transitions in Care; and Walk-in Clinics. The Continuity of Care umbrella draft policy sets out the principles of professionalism that underpin the suite of policies, as well as general expectations that have broad application. The companion draft policies then set out expectations regarding specific elements of practice. This is a new organizational approach. Rather than developing one long policy that addresses a number of continuity of care issues, our aim with this new approach was to organize related practice issues under one common theme, while setting out specific expectations in separate and shorter documents. The goal is to make it easier to find what you're looking for. With this in mind, we'd like to hear from you about this new organizational structure. **Please indicate the extent to which you agree or disagree with each of the following statements:**

1.	Grouping common practice issues under a common theme helps organize policies.
2.	This new organizational structure improves the utility of College policies.
3.	The relationship between the umbrella policy and the companion policies is easy to understand.
4.	Including an Executive Summary in each policy makes the suite easier to navigate.
Total Respondents	**423**

Figure 1: Statements 1-4



Question 4:

Please feel free to elaborate on your answers above. (Optional)

- Respondents felt that the structure of the policies were clear, though some concerns raised included:
  - Policies are lengthy and time consuming to read.
  - The policies do not adequately consider the variety of practice models across Ontario.
  - Some expectations may be impossible considering resources available.

- Respondents expressed concern that these policies will lead to further burnout. Comments included concerns that the policies would add to the administrative burden of physician offices and could be untenable for many physicians.

- Some suggestions from respondents included:
  - There may be benefit in differentiating chronic and acute conditions.
  - The policies may not have been appropriately "grouped".

Question 5:

We'd like your thoughts on whether the suite of draft policies is, in general, comprehensive. **Please indicate the extent to which you agree or disagree that the suite of draft policies addresses the most important issues relating to continuity of care.**

Strongly agree (13%, 48)
Somewhat agree (35%, 129)
Neither agree nor disagree (23%, 86)
Somewhat disagree (17%, 63)
Strongly disagree (12%, 44)

Total Respondents	370

Question 6:

How can the suite be made more comprehensive? What issues did we miss? (Optional)

- Respondents highlighted the following factors in response to this question:
  - The policies could place greater emphasis of the system factors, such as electronic health infrastructure, limited availability of specialists to provide coverage, legislation, and resources available to physicians which are beyond the control of the physician.
  - Capable patients' are able to help manage their own health; a greater focus would reduce the perception that physicians are being held accountable for patient actions.
  - Respondents indicated that physicians practising in a hospital may not be able to meet all of the expectations due to the nature of their practice. Though some respondents indicated a desire for expectations pertaining to communication between hospital based physicians and family doctors.
  - The policy doesn't really address non-emergency yet urgent care.
  - Include other free-standing clinics (e.g. methadone) in the recommendation to copy the encounter report to the primary care provider.
  - Policy could consider the lack of central resources to support physicians in meeting expectations to identify coverage and patient information (e.g. EHR). Continuity of care is greatly improved with increased access to information.

- ## Question 7:

The remaining questions of the survey pertain to each of the draft policies within the suite. You can answer questions about any or all of the draft policies. **Please indicate which of the draft policies you'd like to provide feedback on.**

#	Answer	%	Count
1	**Continuity of Care (Umbrella)**	19%	222
2	**Availability and Coverage**	23%	276
3	**Managing Tests**	21%	252
4	**Transitions in Care**	19%	227
5	**Walk-in Clinics**	16%	192
6	**None**	1%	8
	Total Respondents		**1177**

Continuity of Care: Umbrella Policy

Question U1:

Please indicate the extent to which you agree or disagree with each of the following statements and/or expectations:

1.	It is important for physicians to see patient experiences with the health-care system as a set of interactions requiring oversight and management, not as discrete events.
2.	In their role as health advocate, physicians are advised (but not required) to respond to and participate in opportunities to improve continuity of care in both the local and broader health systems in which they work.
3.	Patient engagement can supplement and support physicians' efforts to facilitate continuity of care.
4.	Patient engagement is an important element of patient-centred care.
5.	Physicians are advised (but not required) to support patient engagement as a means of facilitating continuity of care.
6.	Technology can facilitate continuity of care.
7.	Physicians are advised (but not required) to adopt technological solutions in their practice that can help facilitate continuity of care.
8.	Physicians' responsibilities to facilitate continuity of care exist whether or not there are technological solutions that can assist and whether or not those solutions are adopted.
Total Respondents	**203**

Figure 2a: Statements 1-4.

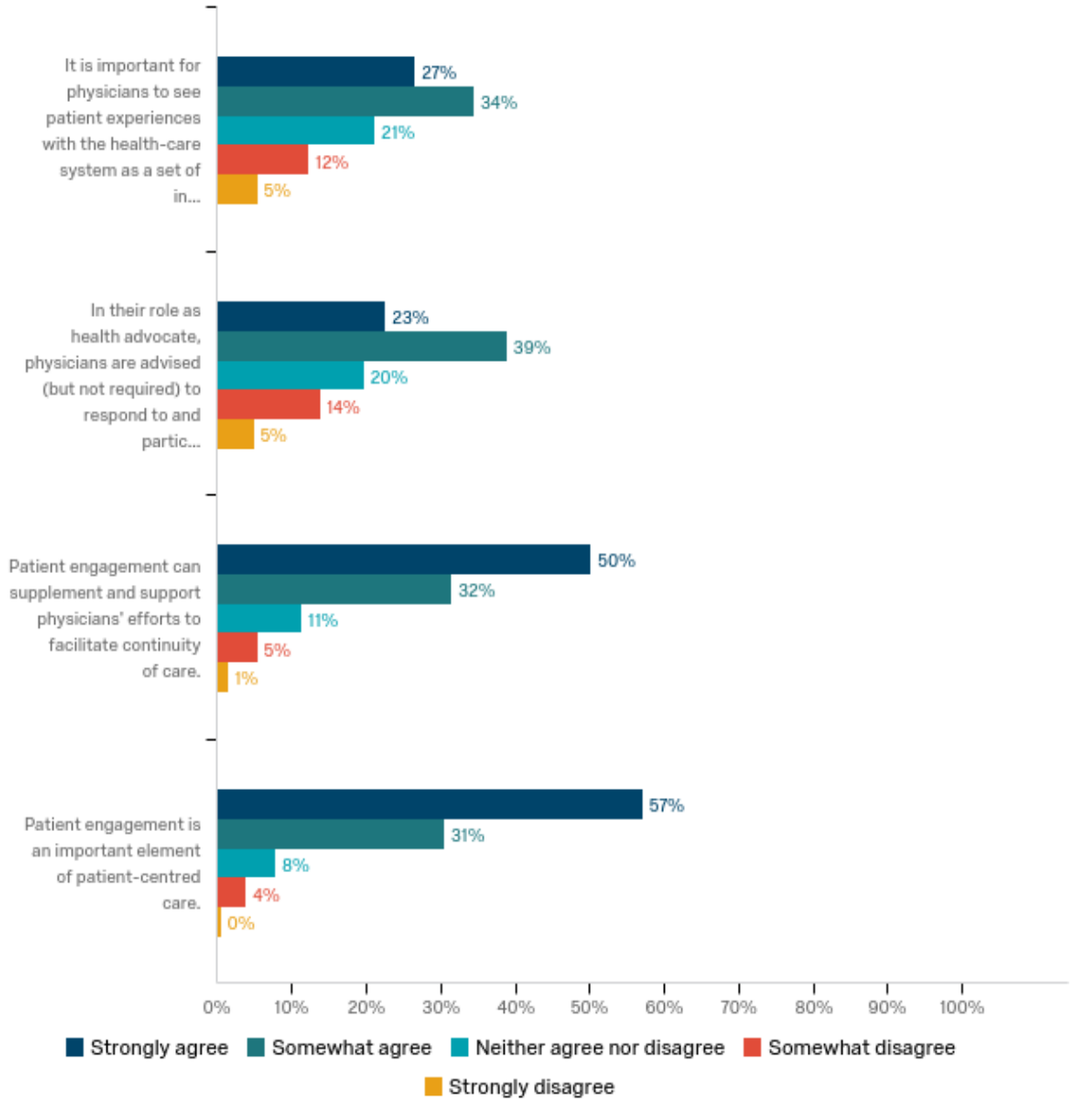
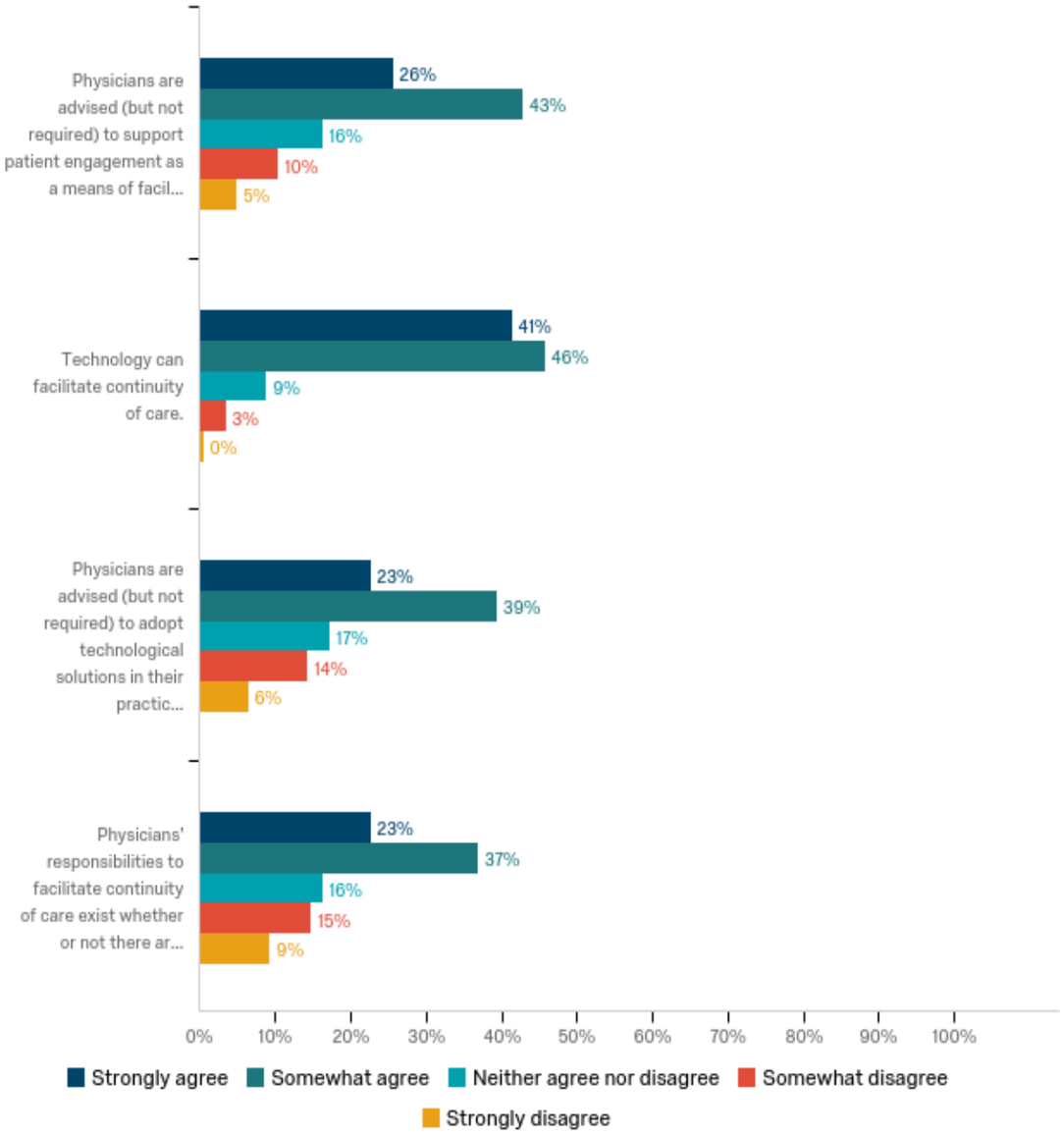


Figure 2b: Statements 5-8



Question U2:

Please feel free to elaborate on your answers above. (Optional)

- Respondents were generally supportive of the concept of continuity of care however, raised issues regarding the feasibility of the expectations set out in the draft policies.

- Respondents were divided on the efficacy of technology to facilitate continuity of care.
  - Some respondents indicated that, when used appropriately, technology can reduce the administrative burden of communicating with patients.
  - Respondents flagged that the current digital health infrastructure is insufficient to create system-wide efficiencies and, in some instances the costs of implementation is prohibitive.

- Respondents generally supported the idea of patient engagement, but many also felt that capable patients should be at least equally responsible for their health-care decisions (e.g. communicating with physician, following care plans, following-up on test results). Some respondents expressed concerns that the policies placed too much onus on the physician to manage patient care.

- There was sentiment that patients require additional education on “the appropriate use of the health-care system” and additional supports to select the appropriate care setting (e.g. ER or primary care provider) to address their care needs.

- Some concerns were raised highlighting system level issues, such as resources available, restrictive privacy legislation, and Ontario Health Insurance Plan (OHIP) or Ontario Drug Benefit (ODB) coverage.

- Respondents expressed concerns related to achieving the articulated expectation with limited resources.

- One respondent indicated that increased number of inter-professional health care teams would reduce the pressure on physicians and provide patients with greater continuity of care.

Total Respondents	56

Continuity of Care: Availability and Coverage

Question AC1:

The draft policy sets out expectations pertaining to the availability of physicians to patients and other health-care providers. **Please indicate the extent to which you agree or disagree with each of the following statements and/or expectations:**

1.	Physicians must have an office telephone that is answered (e.g., by office staff) and/or a voicemail that allows messages to be left during operating hours.
2.	Physicians' office telephone must have a voicemail that allows messages to be left outside operating hours.
3.	Physicians must ensure that their office voicemail outgoing message is up to date and accurate.
4.	It is ideal for patients to see physicians with whom they have a sustained physician-patient relationship for care that is within their physician's scope of practice, rather than relying on walk-in clinics or emergency rooms.
5.	Physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues.
6.	Physicians must respond in a timely and professional manner when contacted by health-care providers who want to communicate or who request information pertaining to a patient.
7.	Physicians must ensure that voicemail messages are reviewed and responded to in a timely manner (e.g., by office staff where appropriate).
Total Respondents	**252**

Figure 3a: Statements 1-3

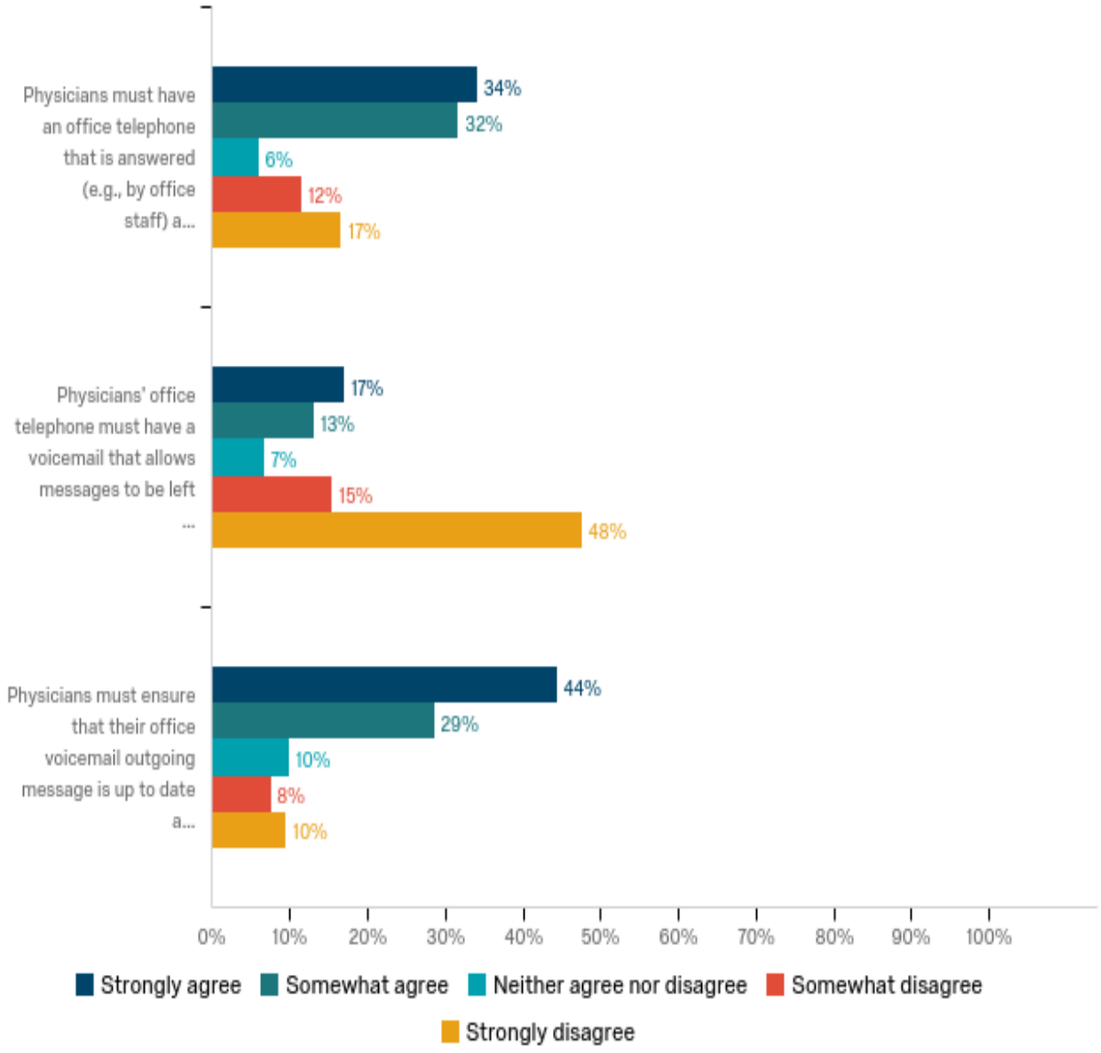
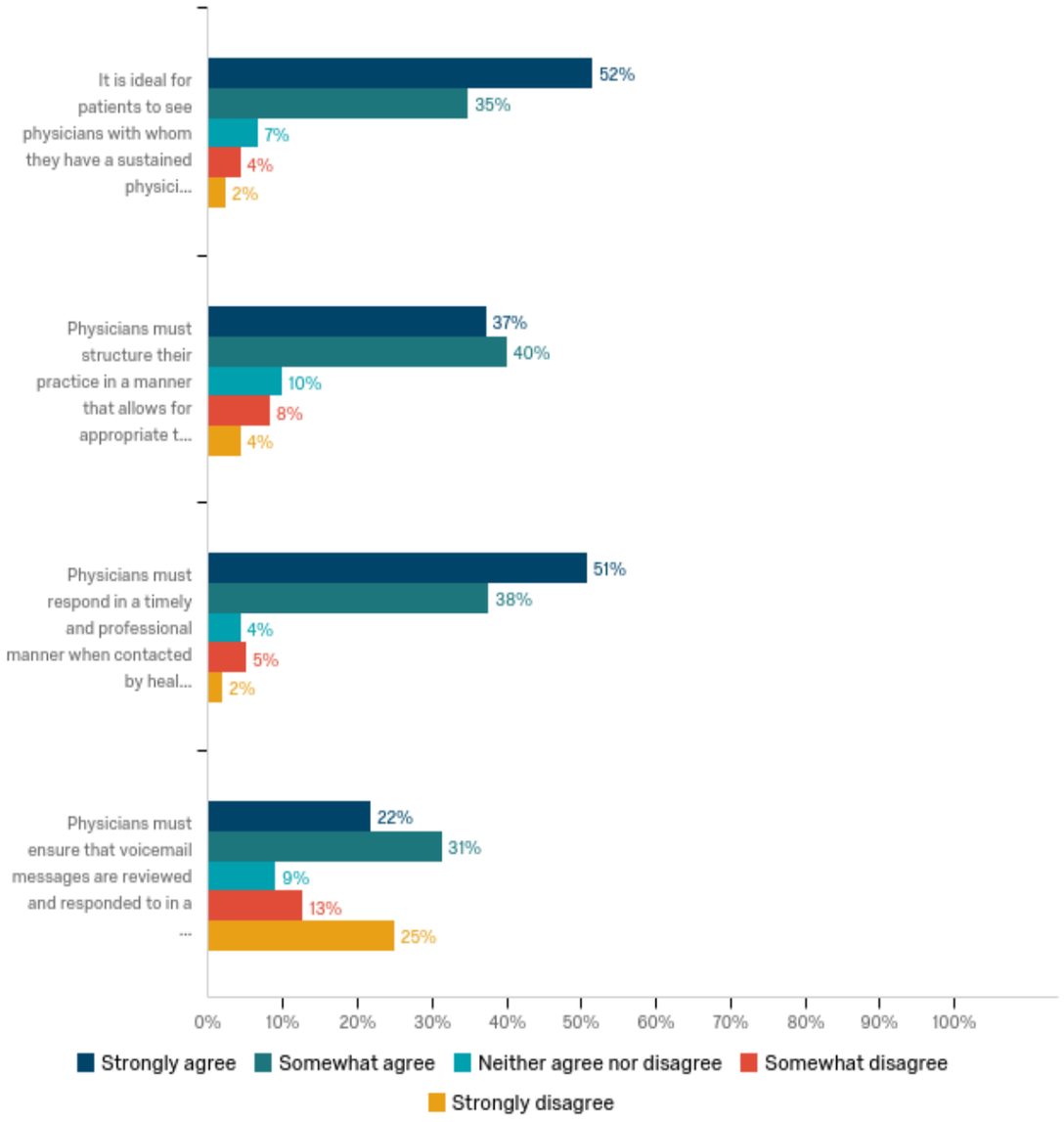


Figure 3b: Statements 4-7



Question AC2:

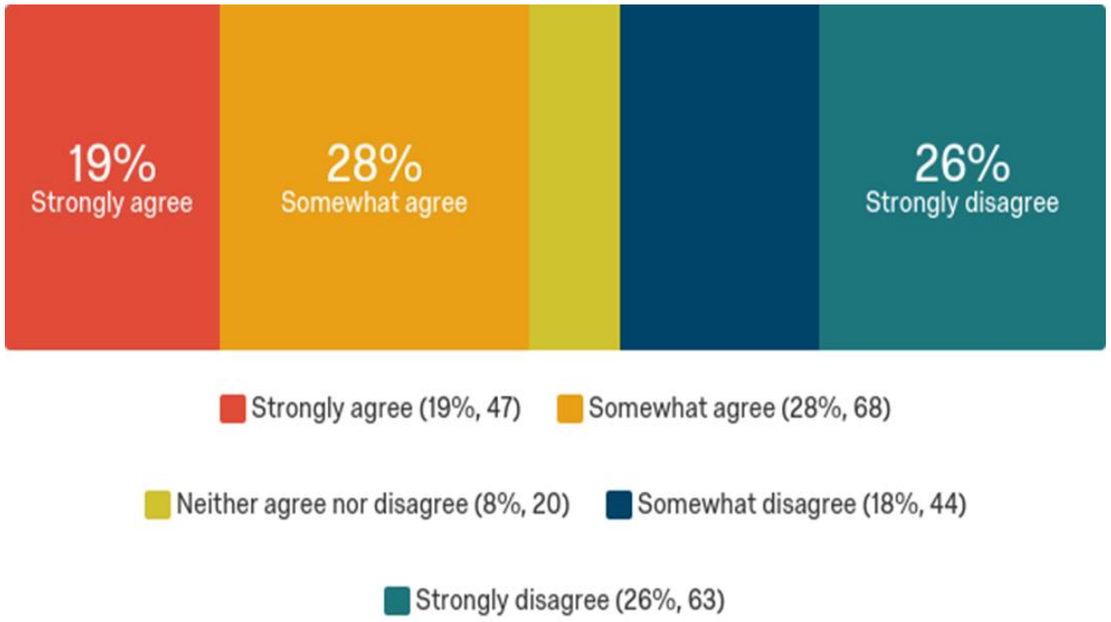
Please feel free to elaborate on your answers above. (Optional)

- Respondents expressed concerns that expectations pertaining to voicemail will overburden existing office staff, will significantly increase costs, and may not be appropriate for all practice environments.
- Some respondents noted that directing resources to managing voicemail systems would divert attention away from patient care.
- Respondents also raised questions about their liability when a patient does not provide adequate contact information on voicemails.
- While respondents generally agreed physicians should have an office phone which is answered during office hours, some commented on the appropriateness of an afterhours voicemail system. Key comments included pointing to available community resources that are more appropriate to provide emergency care (e.g. telemedicine, hospital), and expressed concerns about risks to patients who may leave urgent health information on voicemails.
- While respondents agreed that often it is preferable for patients to meet with physicians with whom they have a sustained patient-physician relationship, they indicated there are circumstances (e.g. emergencies, low resource environments) where this may be impossible.

Total Respondents	**124**

Question AC3:

The draft policy requires physicians providing care as part of a sustained physician-patient relationship to "have a plan in place to coordinate care for their patients outside of regular operating hours." Physicians are responsible for determining what plan would work best for their practice. The draft policy explicitly states that physicians must use their professional judgment to determine what after-hours plan will best suite their practice and their patients, taking into account the following factors: 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. **Please indicate the extent to which you agree or disagree with the requirement that physicians establish an after-hours plan as set out in the draft policy and summarized above.**



Total Respondents	**242**

Question AC4:

If you disagree with this expectation, please tell us how you think physicians should coordinate after-hours patient care. (Optional)

- Physicians pointed to alternative community health care access points (e.g. ER or walk-in clinic) which may be more appropriate venues to address urgent or emergent patient concerns. This rationale was applied as a counter argument to requirements to provide “after-hours” care and vacation coverage.
    - In contrast, one respondent identified as an ER physician expressed frustration with dealing with the trivial issues which fall on them when physicians are on holiday.

- Despite the fact that the policy is not intended to require physicians to maintain 24/7 coverage, respondents expressed concerns that coverage requirements (with specific reference to 24/7) for physicians would place additional demands on family physicians and would contribute to physician burnout.

- Respondents noted that physicians are not compensated for the additional coverage requirements established in this policy.

- Rural physicians flagged their involvement with many care environments (e.g. local ER coverage) may prohibit them from being available to their family practice patients after-hours.

- Respondents raised the issue of the role of the patient in coordinating their own care.

- Respondents noted that given the nature of continuity of care a broad systemic approach is required (e.g. funding structures), and expressed frustration that physicians were being held responsible to address gaps in system coverage.

Total Respondents	**123**

Question AC5:

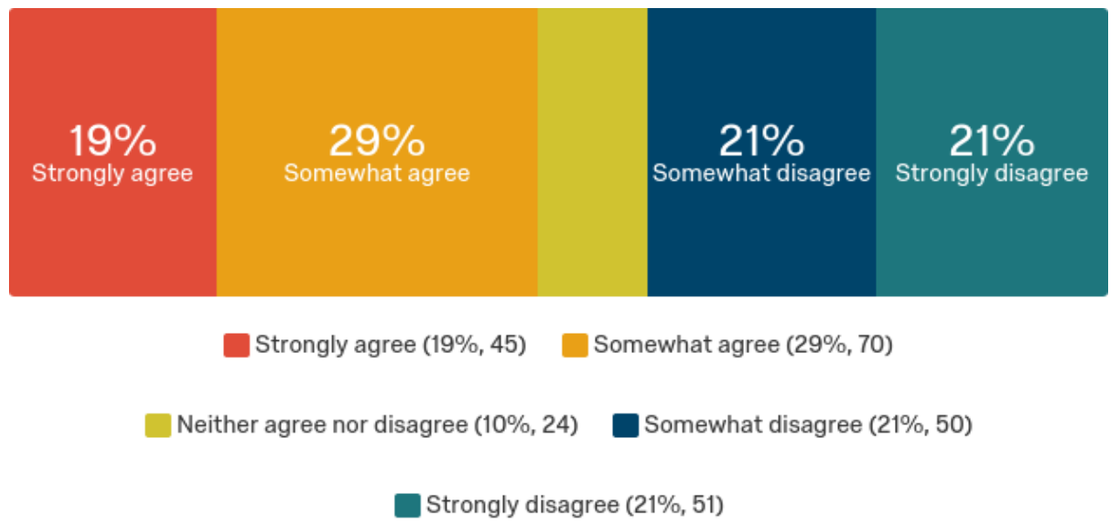
Are there other factors not listed above that physicians should consider when developing an after-hours plan? (Optional)

- Respondents highlighted the following factors in response to this question:
    - Available community health resources (specialists, ER departments, walk-in clinic etc.);
    - patient responsibility and accountability;
    - Funding and cost to physicians;
    - Patient barriers to health care access (e.g. employment hours vs. office hours of physicians);
    - Policy should consider the variance in practice set up as the expectations set out in the suite may not be feasible for all physicians; and,
    - Some respondents noted there could be some benefit to broad system solutions rather than rely on individual physicians (e.g. LHIN based solutions).

Total Respondents	74

Question AC6:

The draft policy requires physicians who are providing care as part of a sustained physician-patient relationship to "arrange for another health-care provider(s) to provide patient care during temporary absences from practice." Temporary absences from practice include vacations and leaves of absence (e.g., parental leave, educational leave, suspension of a physician's certificate of registration), but also unplanned absences due to, for example, illness or family emergency. Physicians are responsible for determining what coverage arrangements would work best for their practice. In formulating their coverage arrangements, physicians will need to rely on their professional judgment and take into account the following: whether the absence is planned or not, the needs of the physician's patients (including the need for follow-up care during the absence), and the health-care provider and/or health system resources in the community. **Please indicate the extent to which you agree or disagree with the requirement that physicians establish coverage arrangements for patient care during temporary absences from practice as set out in the draft policy and summarized above.**



Total Respondents	240

Question AC7:

If you disagree with this expectation, please tell us how you think patient care should be coordinated and/or provided during temporary absences from practice. (Optional)

- It was generally accepted that physicians should find coverage for long-term absences, though many respondents expressed concerns of the feasibility of these requirements for short term or emergency absences.

- Respondents sought clarification as to what constitutes a short term absence, appropriate coverage for short term absences (e.g. locum vs. colleague coverage), where the responsibility of the physician ends and, how the expectations apply to hospital based physicians.

- Respondents expressed fears of repercussions if they are unable to source coverage for temporary absences and expressed desire for guidance and flexibility in these circumstances.

- Respondents expressed concerns that limited available coverage options could lead to physicians not taking vacation time for fear of repercussions, and ultimately contribute to burnout in the profession.

- Concerns pertaining to burnout were extended to colleagues in a group-practice environment as requirements to cover for absent colleagues would put undue pressure on physicians providing coverage.

- Respondents felt it was unnecessary and burdensome for physicians to make coverage arrangements for short term absences. Respondents cited limited resources, the nature of a family practice (i.e. dominantly addressing Non-Urgent issues) and available care alternatives (e.g. walk-in clinic or hospital) as rationale for this position.

- Respondents raised concerns regarding the feasibility of coverage expectations for physicians working in low resource areas, solo practice, or in the event of an emergency absence.

- A few respondents suggested the College could provide support to physicians seeking coverage (e.g. locum pool).

Total Respondents	**110**

Question AC8:

Are there factors not listed above that physicians should consider when formulating a coverage arrangement for patient care during temporary absences from practice. (Optional)

- Respondents suggested the following factors for consideration:

    - Prescription refills should be explicitly mentioned
    - Coverage requirements disproportionately impact rural physicians
    - Coverage requirements are challenging for some practice structures (e.g. solo practice)
    - Emergency absences may not be foreseeable
    - There are other health-care resources available to provide coverage for short term absences (telemedicine, walk-in clinics etc.)
    - Coverage resources available to physicians are limited (e.g. financial and human)
    - Given limited resources physicians are limited to a reasonable attempt to arrange coverage, as this may not be possible in all circumstances
    - Systemic solutions to limited resources may be required (e.g. Health Force Ontario, LHIN)

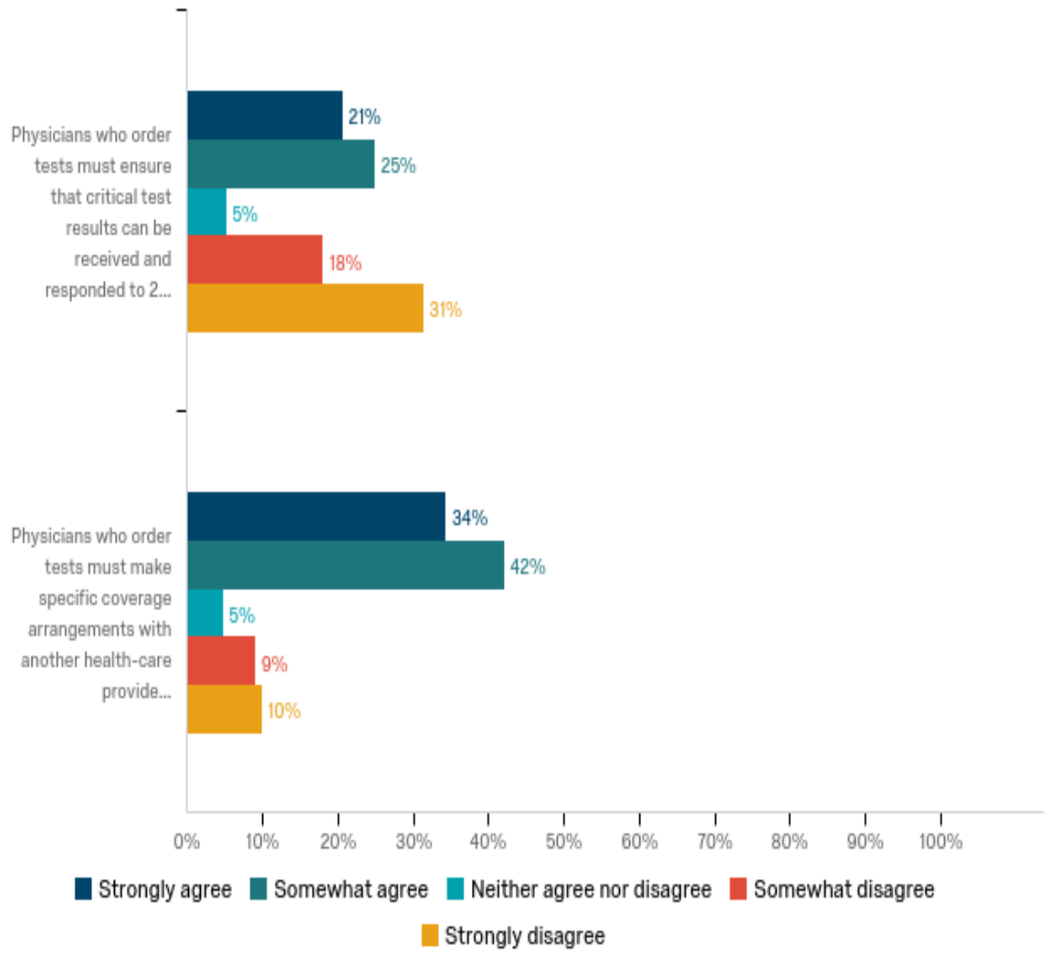
Total Respondents	**58**

Question AC9:

The draft policy also sets expectations in relation to coverage for test results. The current Test Results Management policy includes expectations regarding the communication of critical test results, both during and after-hours. These expectations have been updated and moved to this draft policy given that they relate to making coverage arrangements. **Please indicate the extent to which you agree or disagree with each of the following expectations.**

1.	Physicians who order tests must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week (which will necessitate establishing coverage arrangements when physicians are unavailable).
2.	Physicians who order tests must make specific coverage arrangements with another health-care provider(s) to provide coverage during temporary absences to ensure that all tests results are received, reviewed, and followed up appropriately.
Total Respondents	**233**

Figure 4: Statements 1-2



Question AC10:

Please feel free to elaborate on your answers above. (Optional)

- Respondents expressed support for critical test result coverage in theory, but perceptions that that physicians must now be available 24/7/365, were seen as untenable.
- Respondents noted that patients are also responsible for completing investigations ordered by the physician.
- Respondents questioned the feasibility of these expectations for physicians working in solo-practice environments.
- Increased burdens on physicians would contribute to physician burnout which may pose risks to patient care.
- Respondents noted that it should be the responsibility of the ordering physician to follow up with critical or urgent results as they are best placed to interpret the results.
- Advancements in EMR interoperability can support the feasibility of these expectations, although for others referenced EMRs and electronic notifications as a source of increased work for primary care proivders.
- Respondents expected that if a critical test result is identified in a lab, the lab contacts the ordering physician. When the physician is not available the lab should contact the patient and direct them to seek care.
- Some expressed concern that arranging coverage for critical test results for temporary absences may increase the risk to the patient as the person providing coverage may not know the clinical context and may not be able to evaluate the urgency of the test result. More broadly respondents highlighted that the concept of a critical test result is highly subjective and reliant on other clinical indicators.
- Respondents suggested that systemic and inter-professional solution is required to facilitate communication between physicians and the laboratories rather than placing the burden on individual physicians. For example, respondents noted laboratories should commit to reasonable turnaround, improved provincial EMRs.
- Some respondents indicated noted that they expect to be reimbursed to be available 24/7/365 for test results.

Total Respondents	121

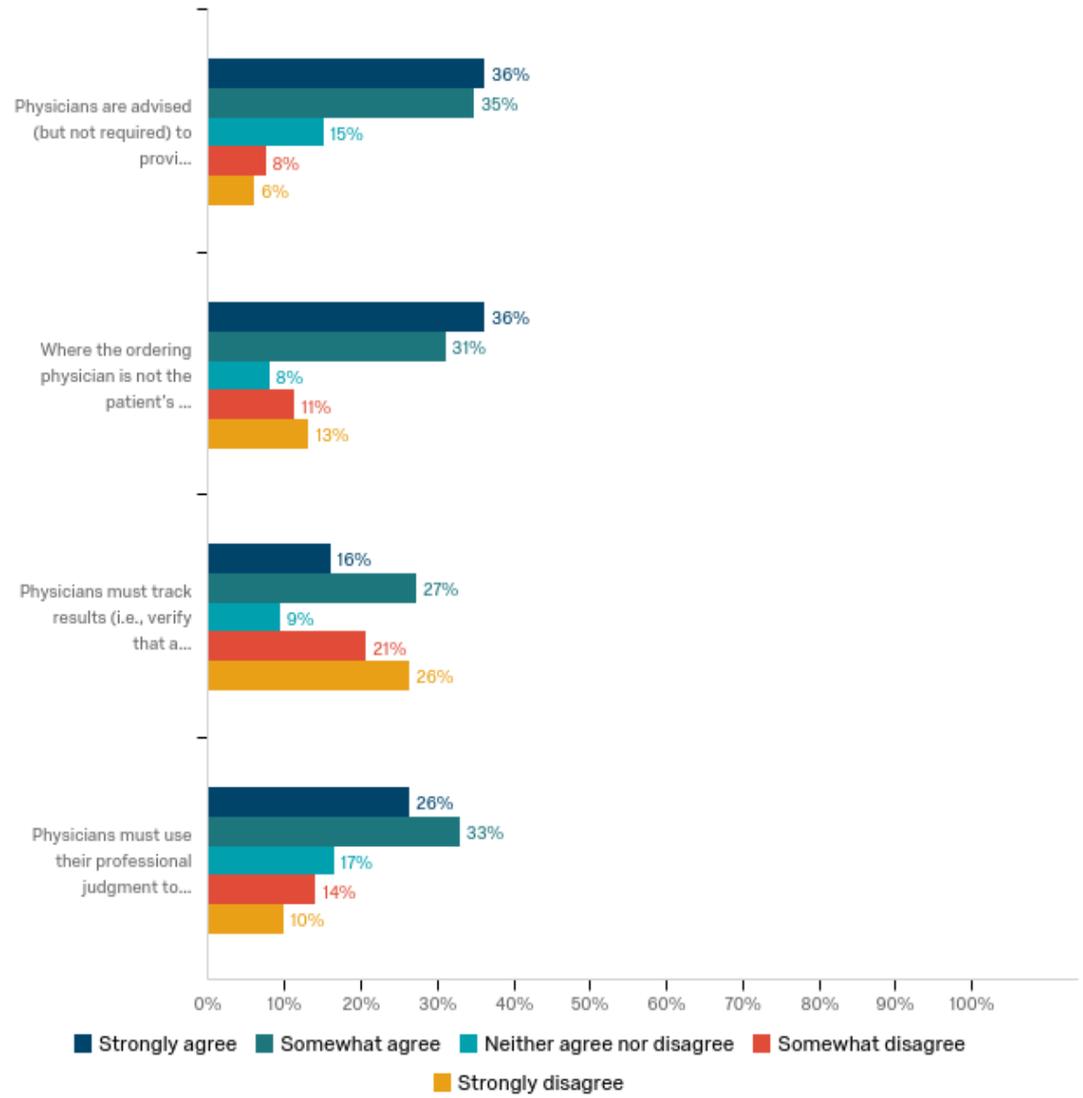
Continuity of Care: Managing Tests

Question MT1:

The draft policy sets out expectations with respect to ordering and tracking (i.e., verifying that a test has been done and results have been received) of all types of tests. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	Physicians are advised (but not required) to provide sufficient relevant patient health information on test requisition forms in order to assist laboratories and/or diagnostics facilities in interpreting the test result.	
2.	Where the ordering physician is not the patient's primary care provider, the ordering physician must copy the patient's primary care provider on the requisition form.	
3.	Physicians must track results (i.e., verify that a test has been done and results have been received) for high-risk patients.	
4.	Physicians must use their professional judgment to determine whether to track a test result for patients that are not high-risk.	
	Total Respondents	**212**

Figure 5: Statements 1-4



Question MT2:

Please feel free to elaborate on your answers above. (Optional)

- Respondents were concerned that the expectation for primary care providers to be copied on all test requisition forms would significantly increase the workload of physicians and decrease availability for patient care. They were divided on whether reports would be of value to patients and clinicians, specifically referencing the volume of testing when the patient is in a hospital.
    - Respondents noted that when a primary care provider is copied it would be best to indicate who is responsible for follow up. Most often respondents felt it was most appropriate for the ordering physician to follow up on results because they have greater insight to the clinical context of the test.

- Respondents expressed that the examples of tracking a high risk patient (i.e. verify that a test has been done and results have been received) were paternalistic, resource intensive, exclusive of patient autonomy, and vague. Many respondents felt capable patients must take charge of their own health and are responsible for the choice to or not to perform investigations ordered by their health care providers.

- Respondents were amenable to the expectation to track high risk patients and critical test results however saw it as overly burdensome to track all patients. Advances in technology were perceived as prerequisites for effective tracking of test results. As digital systems become more integrated (e.g. OLIS) it will become less burdensome for physicians to track or access test results.

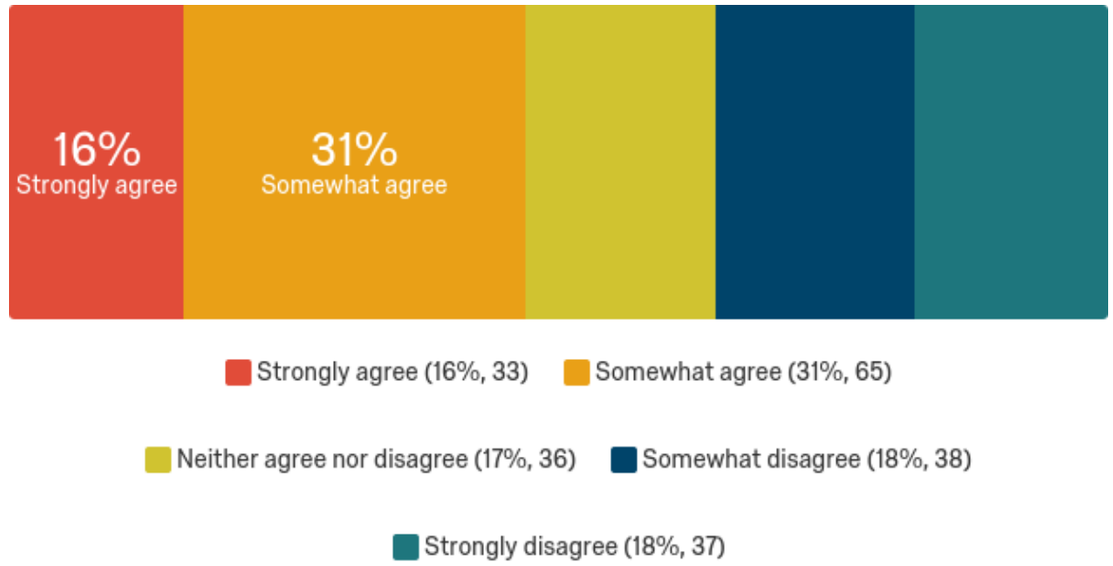
- Respondents also noted that a patient must provide express consent for their primary care provider to be copied on their test results, and that some types of clinics (e.g. sexual health clinics) should be considered exempt from this expectation to protect patient privacy.

- Respondents agreed with the expectation that requisition forms provide sufficient information to assist laboratories and/or diagnostic facilities in interpreting the result.

Total Respondents	**133**

Question MT3:

As indicated in the previous question, the draft policy does not require physicians to track test results for patients who are not high-risk. For these patients, physicians are required to use their professional judgment to determine whether to track test results. The draft policy sets out factors that physicians must consider when deciding whether or not to track test results. This includes: the nature of the test, the patient's health status, whether the patient is anxious/has expressed anxiety about the test; and the significance of the potential result. **Please indicate the extent to which you agree or disagree with the factors listed above.**



Total Respondents	**209**

Question MT4:

Please feel free to elaborate on your answer above. (Optional)

- Many respondents felt that patients are generally anxious about test results, sometimes justified, others not. These respondents did not see patient anxiety as a viable factor for consideration. Some respondents indicated they do consider the anxiety level of the patient however do not feel this should not be "mandated" through College policy.

- Many respondents felt that family physicians do not have the resources required to follow up with all non-critical tests and felt that capable patients should be responsible for their own health.

- Respondents expressed concern about the definition of "high-risk" patient.

Total Respondents	**80**

Question MT5:

Are there factors not listed above that physicians should consider when deciding whether or not to track a test result. (Optional)

- Some respondents expressed agreement with the factors listed in the policy.
- Respondents suggested the following factors for consideration:
    - Patient capacity
    - Responsibilities of other actors within the circle of care
    - Available resources (e.g. EMR, staff)
    - Patient agency to choose whether they compete requisitioned tests or not;
    - Pending tests when a clinic closes
    - Inter-provincial practice (e.g. Ottawa/Gatineau region)

Total Respondents	**42**

Question MT6:

The draft policy sets out expectations with respect to the follow-up of test results. Follow-up includes communicating test results to patients and taking clinically appropriate action in response to test results. **Please indicate the extent to which you agree or disagree with each of the following statements and/or expectations:**

1.	When in receipt of a clinically significant test result, physicians must always communicate the result to their patients in a timely fashion.
2.	For test results that are not clinically significant, physicians must use their professional judgment to determine whether and when (if the decision is to communicate) to communicate the test result.
3.	Physicians must use their professional judgment to determine how to best communicate a test result (e.g., over the phone, at the next appointment).
4.	Physicians must document in the patient record all attempts that were made to communicate the test result to the patient (e.g., attempts to book a follow-up appointment).
5.	Informing patients that they can receive their results through a portal does not discharge physicians' obligations to communicate test results as set out in the policy.
6.	If physicians receive a critical or clinically significant test result in error they must inform the ordering health-care provider, the patient's primary care provider, or the patient of the test result.
7.	If physicians become aware of a critical or clinically significant test result incidentally and have reason to believe that the ordering health-care provider will not get the result, they must make reasonable efforts to inform the ordering health-care provider or the patient of the test result.
Total Respondents	**206**

Figure 6a: Statements 1-4

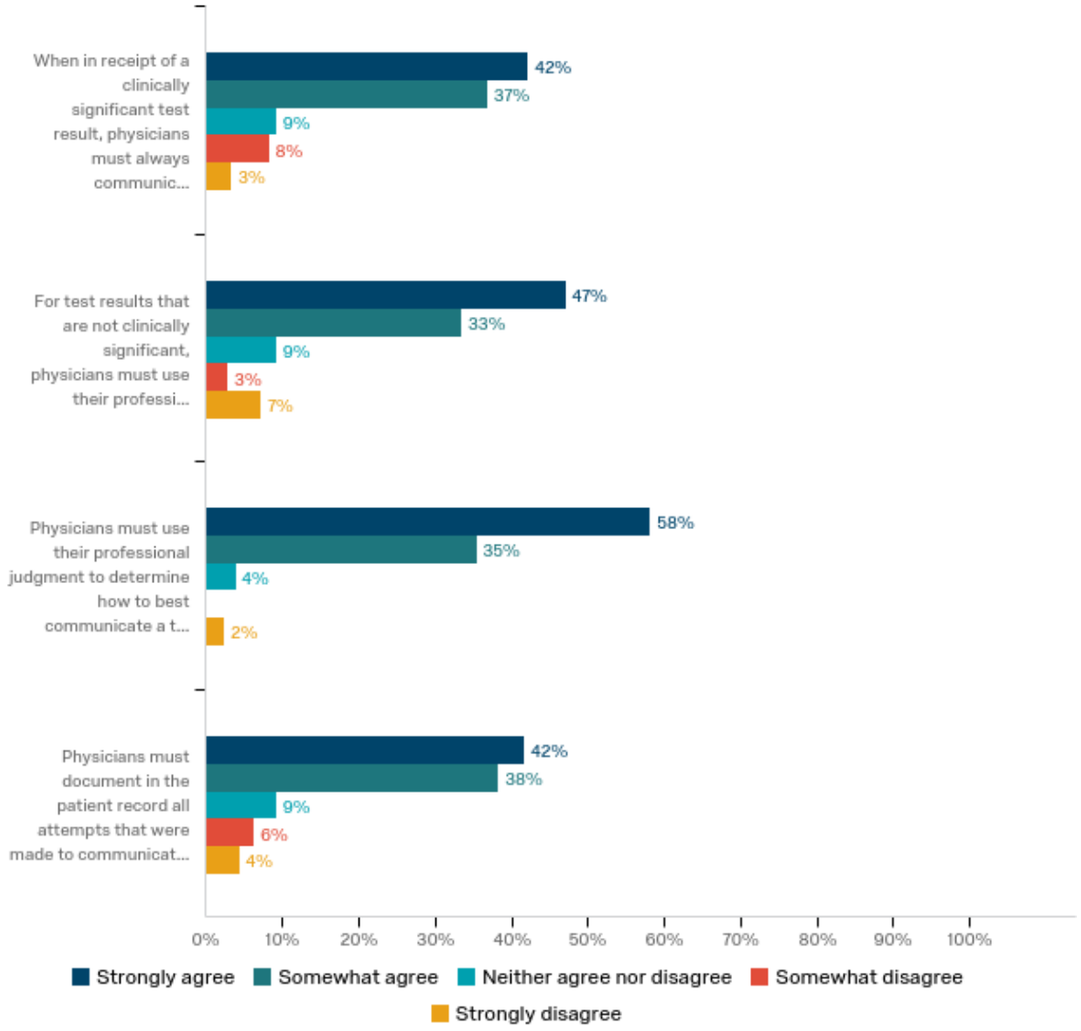
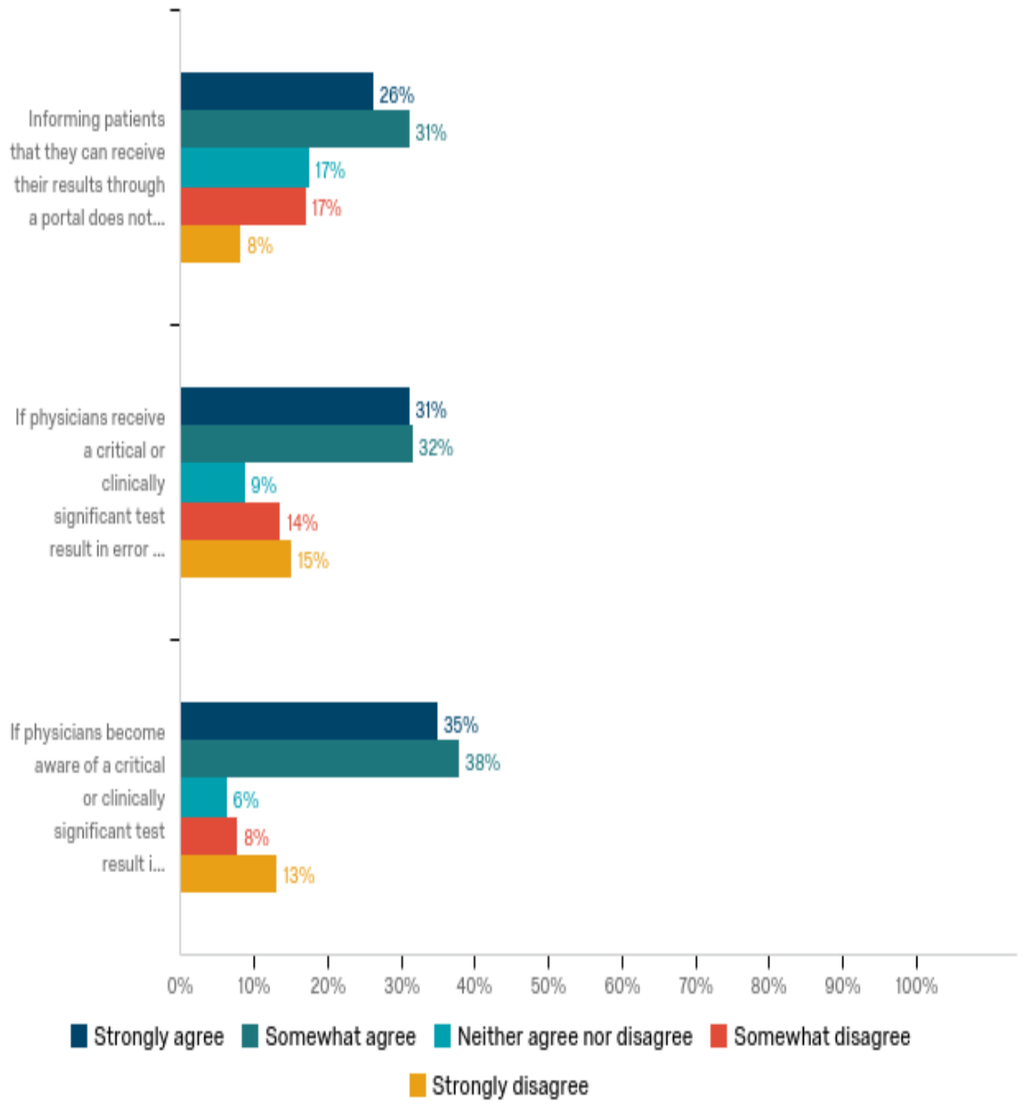


Figure 6b: Statements 5-7



Question MT7:

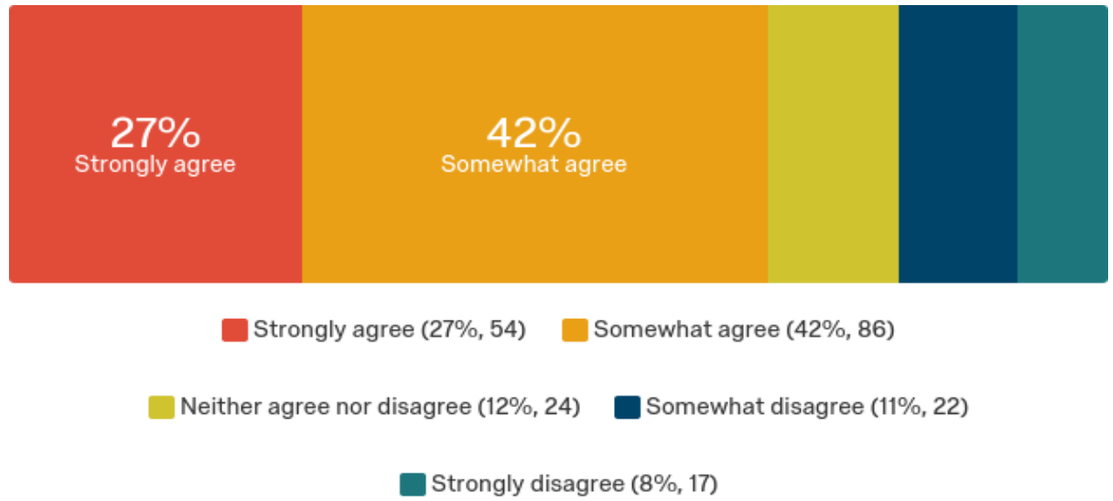
Please feel free to elaborate on your answer above. (Optional)

- Most respondents expressed a belief that the physician who ordered the test is best placed to follow up with the patient.
- Many respondents expressed the opinion that physicians should only be responsible for alerting the diagnostic facility that the results were received in error. Respondents expressed concern that physicians required to follow up on a results received in error may not be privy to the clinical context of the results.
- Respondents were divided on the expectation for physicians to contact the patient if there is reasonable belief that the ordering physician will not receive the rest results. Despite understanding how this could be beneficial in certain circumstances, many felt it was not feasible in all cases (e.g. no phone number for patient, or clinical context for result).
- Respondents expressed a desire for patient portals or other technical solutions to facilitate patient notification to be more widely available. Some responded also indicated that portals can cause additional stress for patients who lack the clinical knowledge to evaluate their results. Respondents indicated this can result in increased anxiety on behalf of the patient and increased administrative work for the physician, as patients seek insight into all results.
- Several respondents indicated their agreement with the statements included in the question, however expressed a desire for clarification on key definitions such as “timely”, “high-risk”, and “significant.”

Total Respondents	77

Question MT8:

As indicated in the previous question, the draft policy requires physicians to use their professional judgment to determine how to best communicate a test result. The draft policy sets out factors that physicians must consider when making this decision. These factors are: the nature of the test; the significance of the test result; the complexity and implications of the result; the nature of the physician-patient relationship; patient preferences/needs; and whether the patient appears anxious or has expressed anxiety about the test. **Please indicate the extent to which you agree or disagree with the factors listed.**



Total Respondents	203

Question MT9:

Please feel free to elaborate on your answer above. (Optional)

- Respondents felt that the importance and nature of the test result in terms of urgency for medical care should be considered above patient anxiety.
- Generally respondents did not agree with the inclusion of anxiety as a factor for consideration when considering how to communicate test results to a patient.
- One respondent expressed that it is the responsibility of the health care system, not only the physician to ensure that the patient's needs are met.

Total Respondents	**38**

Question MT10:

Additionally, are there other factors not listed above that physicians should consider when deciding how to best communicate a test result. (Optional)

- Respondents suggested the following factors for consideration:
  - Barriers for patients to come to the office (e.g. distance, transportation)
  - Access to different communication methods (e.g. e-mail, fax, cell phones etc.)
  - OHIP reimbursement policies
  - Human resources available to the physician
  - Who determines what is considered important, the patient's concern or the clinical judgement of the physician?

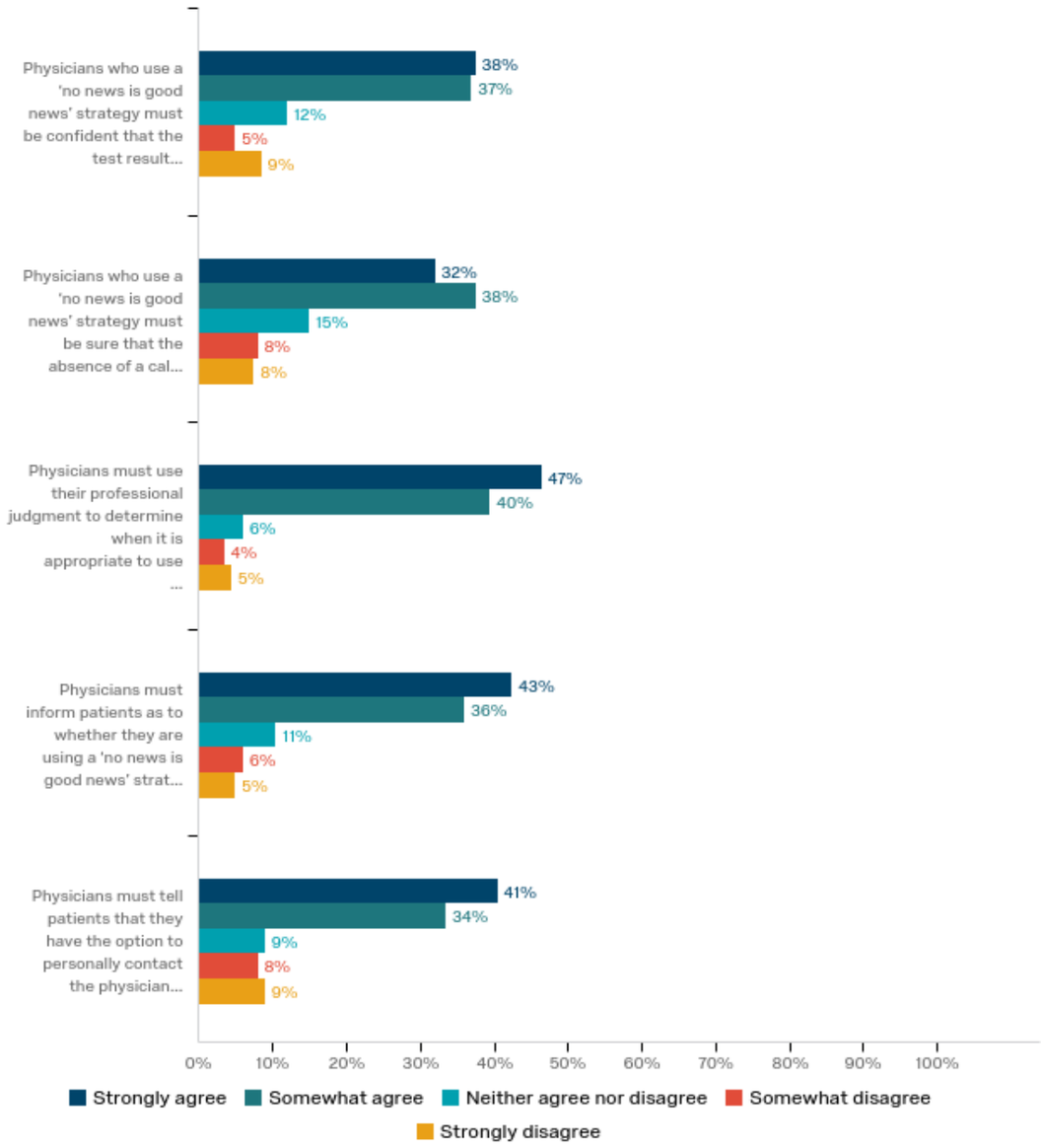
Total Respondents	**12**

Question MT11:

Physicians are permitted to use a 'no news is good news' strategy in managing test results but the policy does set expectations in relation to such strategies. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	Physicians who use a 'no news is good news' strategy must be confident that the test result management system in place is sufficiently robust to ensure that no test results will be missed.
2.	Physicians who use a 'no news is good news' strategy must be sure that the absence of a call back to the patient means that the test result was received, reviewed and a determination was made that no follow-up was required.
3.	Physicians must use their professional judgment to determine when it is appropriate to use a 'no news is good news' strategy.
4.	Physicians must inform patients as to whether they are using a 'no news is good news' strategy.
5.	Physicians must tell patients that they have the option to personally contact the physician's office for the test result.
Total Respondents	**200**

Figure 7: Statements 1-5



Question MT12:

Please feel free to elaborate on your answer above. (Optional)

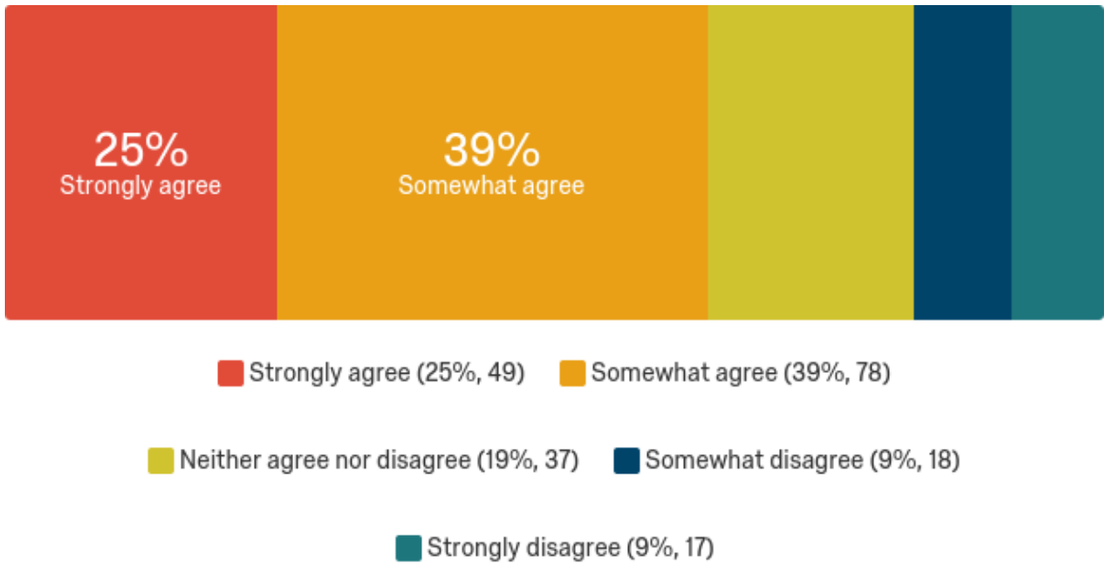
- Respondents acknowledged that the "no news is good news strategy" risks missed results, and many felt it was insufficient; however many felt that given the current system limitations (e.g. resources) and volume of tests ordered, these strategies are the only viable option without broad system interconnectivity (e.g. shared EHR with patient access).

- Respondents also noted that there are multiple health-care providers who contribute medical testing (e.g. patients and labs) a more systemic approach is required to reduce the limitations of a "no news is good news" strategies.

Total Respondents	54

Question MT13:

As indicated in the previous question, the draft policy requires physicians to use their professional judgment to determine when it is appropriate to use a 'no news is good news' strategy. The draft policy also sets out factors that must be considered as part of this decision. This includes: the nature of the test; the significance of the test result; the complexity and implications of the result; the nature of the physician-patient relationship; patient preferences/needs; and whether the patient appears anxious or has expressed anxiety about the test. **Please indicate the extent to which you agree or disagree with the factors listed.**



Total Respondents	199

Question MT14:

Please feel free to elaborate on your answer above. (Optional)

- Respondents suggested the following factors for consideration:
    - Respondents disagreed with the inclusion of patient anxiety as a factor determining whether a 'no news is good news strategy' is used. If a patient is anxious about results they can schedule time to meet with the physician.
    - Some respondents felt that 'no news is good news' strategies are the only feasible strategy to deal with the volume of patient test results they receive on a daily basis.
    - One respondent felt the 'no news is good news' strategy is insufficient and leads to cracks in the system.
    - Respondents expressed concerns that the requirement to communicate all results to patients would result in an unmanageable amount of work for themselves and staff. Respondents indicated this burden may lead to greater burnout in the profession.

Total Respondents	29

Question M15:

Are there other factors not listed above that physicians should consider when deciding when to use a 'no news is good news' strategy? (Optional)

- Respondents suggested the following factors for consideration:
  - Human error
  - Nature of the test (e.g. routine monitoring vs. key diagnostic test)
  - Feasibility in practice environment, including human resources
  - One felt it should not be an option
  - Given patients can access their own records, it should not be required to deliver "normal" test results
  - The receipt of the request for the test has been confirmed

Total Respondents	**9**

Question MT16:

The draft policy sets out examples of ways in which physicians can support patient engagement with respect to test results. **Please indicate the extent to which you agree or disagree with the following statements and/or expectations:**

1.	Physicians are advised (but not required) to inform patients of the availability of patient portals.
2.	Physicians must inform patients of the significance of the test ordered.
3.	Physicians must inform patients of the importance of getting the test done in a timely manner.
4.	Physicians must inform patients of the importance of complying with instructions on test requisition forms.
5.	Physicians are advised (but not required) to encourage patients to discuss test results with them (e.g., booking follow-up appointments where necessary).
6.	Physicians are advised (but not required) to encourage patients to ask questions about the test results.
7.	Physicians are advised (but not required) to encourage patients to follow-up with the physician after receiving a test result if they continue to fell unwell, regardless of the test result.
Total Respondents	**197**

Figure 8a: Statements 1-4

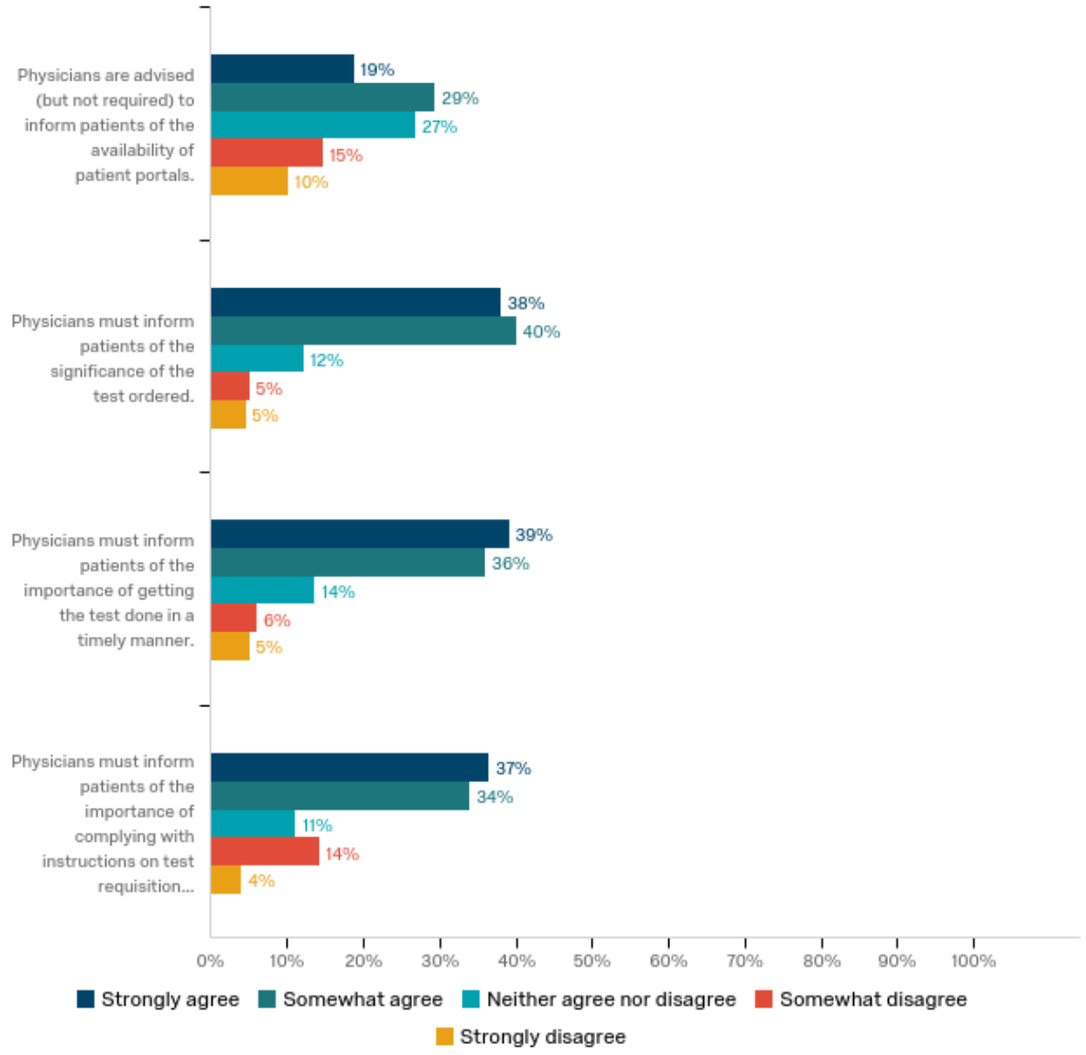
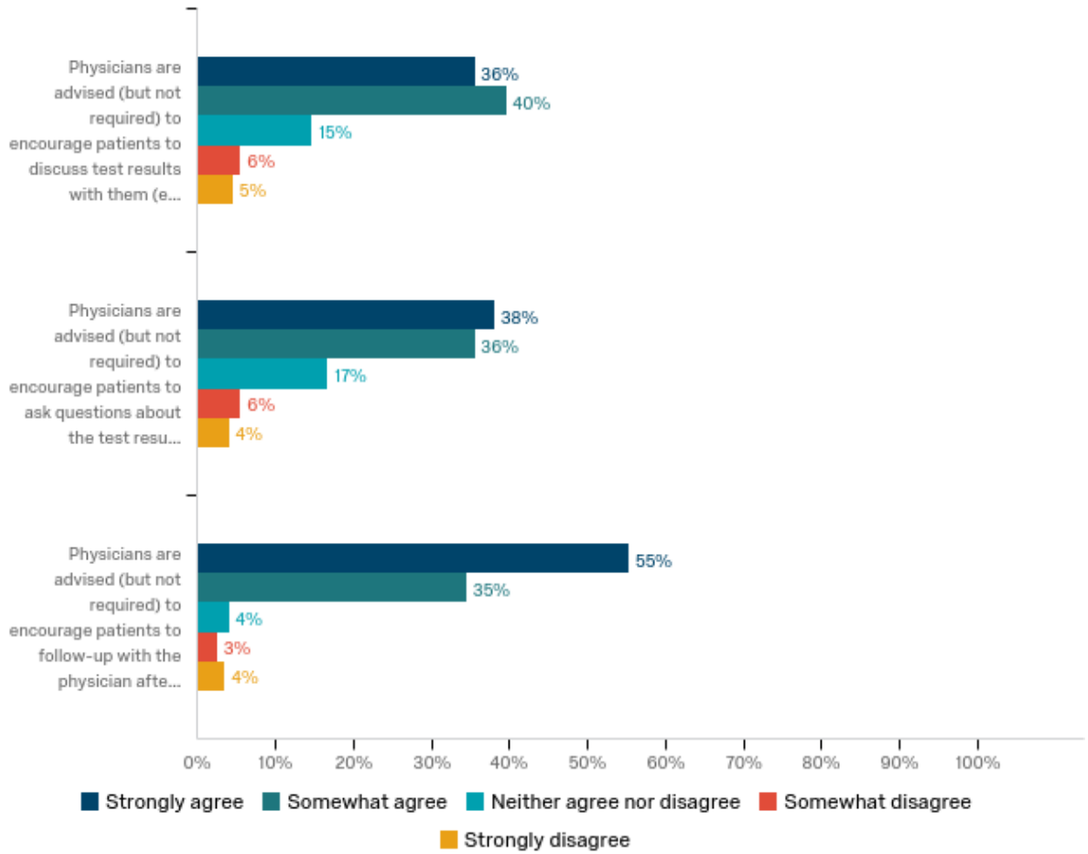


Figure 8b: Statements 5-7



Question MT7:

Please feel free to elaborate on your answer above. (Optional)

- Respondents felt that requiring physicians to respond and inform patients of normal results has little clinical value, stresses limited resources, and takes away from more critical patient care.

- Respondents felt that if the patient portal is operated by the physician or the physician's office the physician can inform the patient. If they are operated by the lab it is the lab's responsibility to inform the patient. Respondents noted that in some instances access to portals may increase anxiety for some patients.

- Most respondents expressed that patients should take responsibility for their own health. It is onerous for physicians to be responsible for ensuring the patients complete ordered investigations.

- Respondents felt that given available resources and current workload it is necessary to prioritize more critical results, it is not feasible for physicians to follow-up will all normal results.

- A minority of respondents felt that physicians should be required to inform patients of the availability of patient portals and to discuss test results. Some respondents noted that the physician should use their clinical judgement to determine which tests require explanation of their importance.

- Respondents agreed that these are best practices however expressed concern that the expectations are too onerous.

Total Respondents	**52**

Continuity of Care: Transitions in Care

Question TC1:

The draft policy sets out expectations to help keep patients informed about who is responsible for their care and managing patient handovers in hospitals and health-care institutions. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	Physicians in a hospital or health-care institution must coordinate with other health-care providers to keep patients informed about who is their most responsible provider.
2.	Referring physicians must clearly communicate to patients what their anticipated role will be in managing the patient's care during the referral process.
3.	Consultant physicians must discuss with patients the nature of their role in providing care to a patient, including explaining which elements of care they are responsible for and the anticipated duration of care.
4.	Within hospitals or health-care institutions, physicians are advised (but not required) to approach patient handovers in a systematic manner.
5.	Within hospitals or health-care institutions, physicians are advised (but not required) to set aside time for patient handovers in order to exchange information with the health-care providers who are assuming responsibility for patient care.
6.	Within hospitals or health-care institutions, when handing over patient care, physicians are advised (but not required) to exchange information with health-care providers who are assuming responsibility for patient care in real-time (e.g., in-person, telephone, etc.) rather than passively (e.g., leaving notes behind).
	Total Respondents **171**

Figure 9a: Statements 1-3

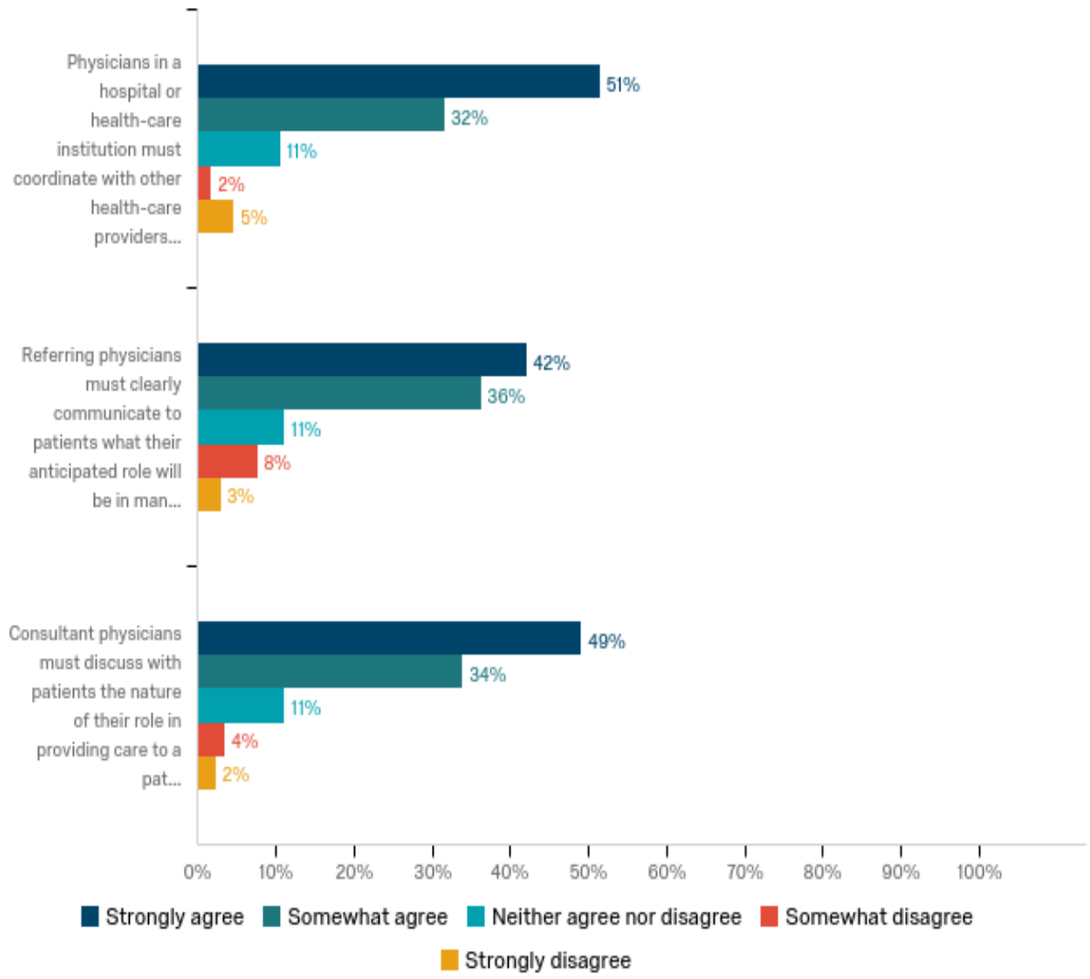
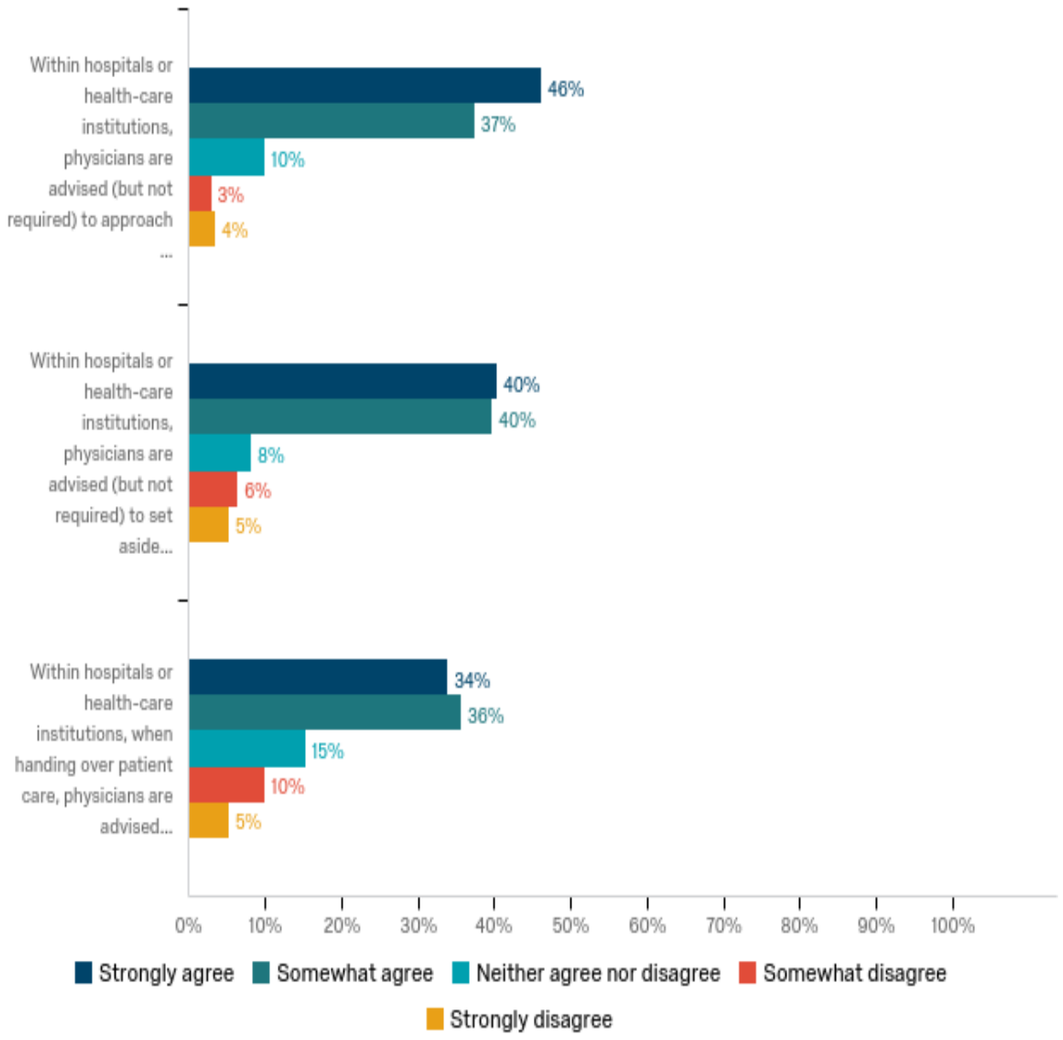


Figure 9b: Statements 4-6



Question TC2:

Please feel free to elaborate on your answer above. (Optional)

- Respondents indicated that improvements in communication between services (e.g. hospital and family practice) or between providers are welcomed.
- Many respondents raised concerns regarding the time required to conduct face to face transitions or handovers and noted that this may not be possible in all circumstances. And requested that institutions set aside dedicated time for physicians to complete patient handovers.
- Respondents indicated that in many instances a written handover note would be sufficient. However, the transition or handover note must include all information pertinent to patient care
- Respondents were generally in agreement that transitions and handovers for more complex and high acuity patients benefit most from face to face conversations. Written handovers for higher acuity patients may not be sufficient. One example provided was when a patient is transferred from the ER back to their long-term care facility. Given the complexity of the patient and the number of health care providers and family members involved in care person-to-person may be necessary.
- Some respondents indicated a desire to see stronger expectations by eliminating the “but not required” in expectations, while other respondents felt that “must” was too strong.

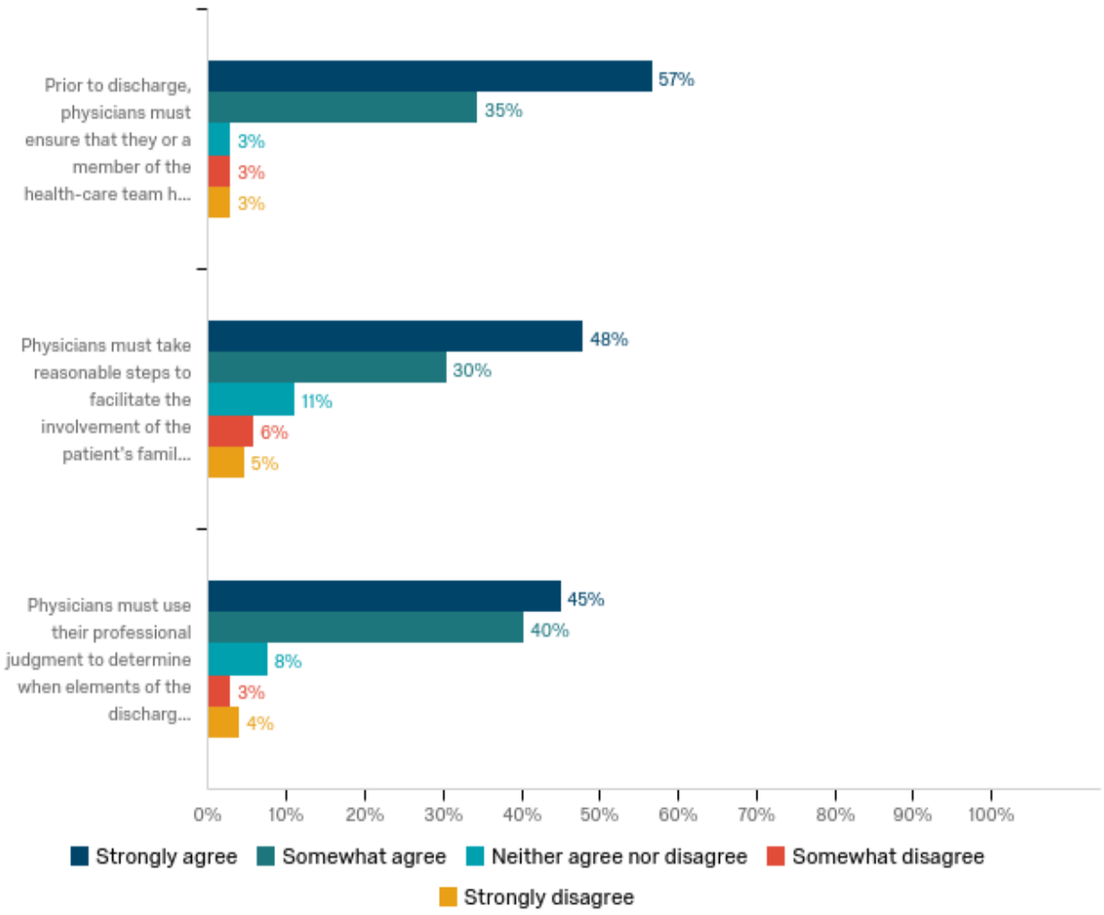
Total Respondents	30

Question TC3:

The draft policy sets out expectations related to preparing patients for discharge from hospital. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	Prior to discharge, physicians must ensure that they or a member of the health-care team has a discussion with the patient and/or substitute decision-maker about, for example, symptoms that require monitoring and where to go if complications arise.	
2.	Physicians must take reasonable steps to facilitate the involvement of the patient's family and/or caregivers in discharge discussions (where there is consent to do so).	
3.	Physicians must use their professional judgment to determine when elements of the discharge discussion should be captured in writing.	
	Total Respondents	**171**

Figure 10: Statements 1-3



Question TC4:

Please feel free to elaborate on your answer above. (Optional)

- Most respondents agreed that some written information should be provided to patients to ensure they remember the care plan.
- One respondent expressed concern that involving the family in discharge discussions may not be appropriate for all patients. One specific example was the provision of health care to military members, who may face other barriers to involving non-military family members into care plans.
- Respondents noted that discharge discussions can be delegated to nurses or other members of the health care team.

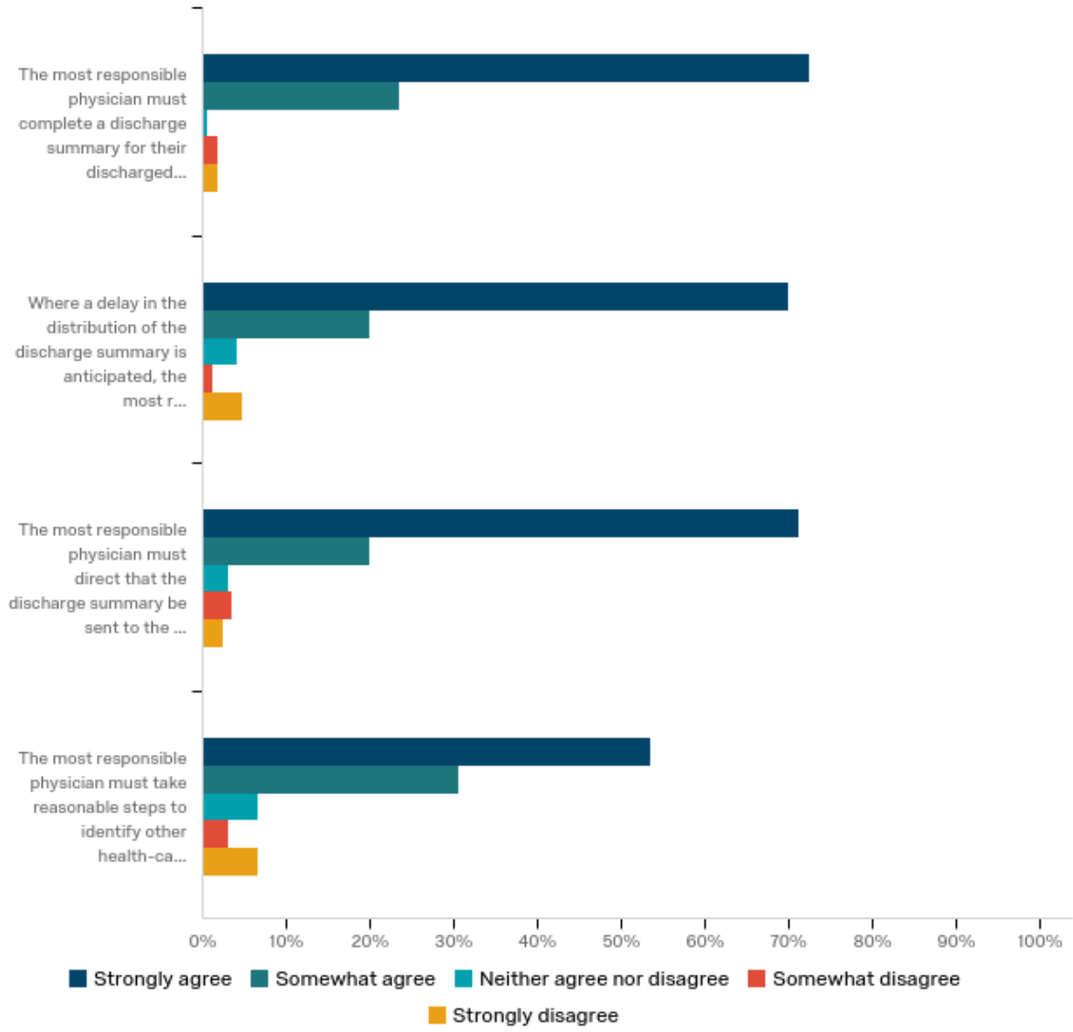
Total Respondents	**20**

Question TC5:

The draft policy sets out expectations related to completing and distributing discharge summaries when in-patients are discharged from hospital. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	The most responsible physician must complete a discharge summary for their discharged in-patients in a timely manner.
2.	Where a delay in the distribution of the discharge summary is anticipated, the most responsible physician must provide, in a timely manner, a brief summary of the hospitalization to those health-care providers responsible for follow-up care.
3.	The most responsible physician must direct that the discharge summary be sent to the patient's primary care provider (e.g., by directing hospital administrative staff to do so).
4.	The most responsible physician must take reasonable steps to identify other health-care providers who would benefit from knowledge of the hospitalization and direct that the discharge summary be sent to them (e.g., by directing hospital administrative staff to do so).
Total Respondents	**170**

Figure 11: Statements 1-4



Question TC6:

Please feel free to elaborate on your answer above. (Optional)

- Respondents agreed that it is important to ensure primary care physicians have copies of discharge summaries in a timely manner. Although there was desire for “timely” to be clearly defined, one respondent even suggested a 48 hour timeline.

- Many respondents indicated a desire for these processes to be automated by hospital system.

Total Respondents	**30**

Question TC7:

The draft policy sets out expectations of referring and consultant physicians during the referral and consultation process. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	Referring physicians must take reasonable steps to confirm that the patient's care needs are within the consultant physician's scope of practice.
2.	Referring physicians are advised (but not required) to be mindful of whether the consultant physician is accepting patients.
3.	Referring physicians are advised (but not required) to be mindful of whether the consultant physician's practice is accessible to the patient (e.g., location, physical accessibility, etc.).
4.	Referring physicians must have a mechanism in place to track that the referral has been received and that an acknowledgment of the referral will be provided.
5.	Consultant physicians must acknowledge referrals in a timely manner, but no later than 14 days after receiving the referral (i.e., indicating whether they can accept the patient and, if so, give an actual or estimated appointment date).
6.	Consultant physicians must distribute consultation reports in a timely manner, but no later than 30 days following an assessment, new finding or change in the patient's management plan
7.	Consultant physicians must distribute consultation reports to the referring health-care provider and the patient's primary care provider, if different
8.	Consultant physicians must take reasonable steps to identify other health-care providers who would benefit from awareness of the consultation and share consultation reports with them as well.
Total Respondents	**169**

Figure 12a: Statements 1-4

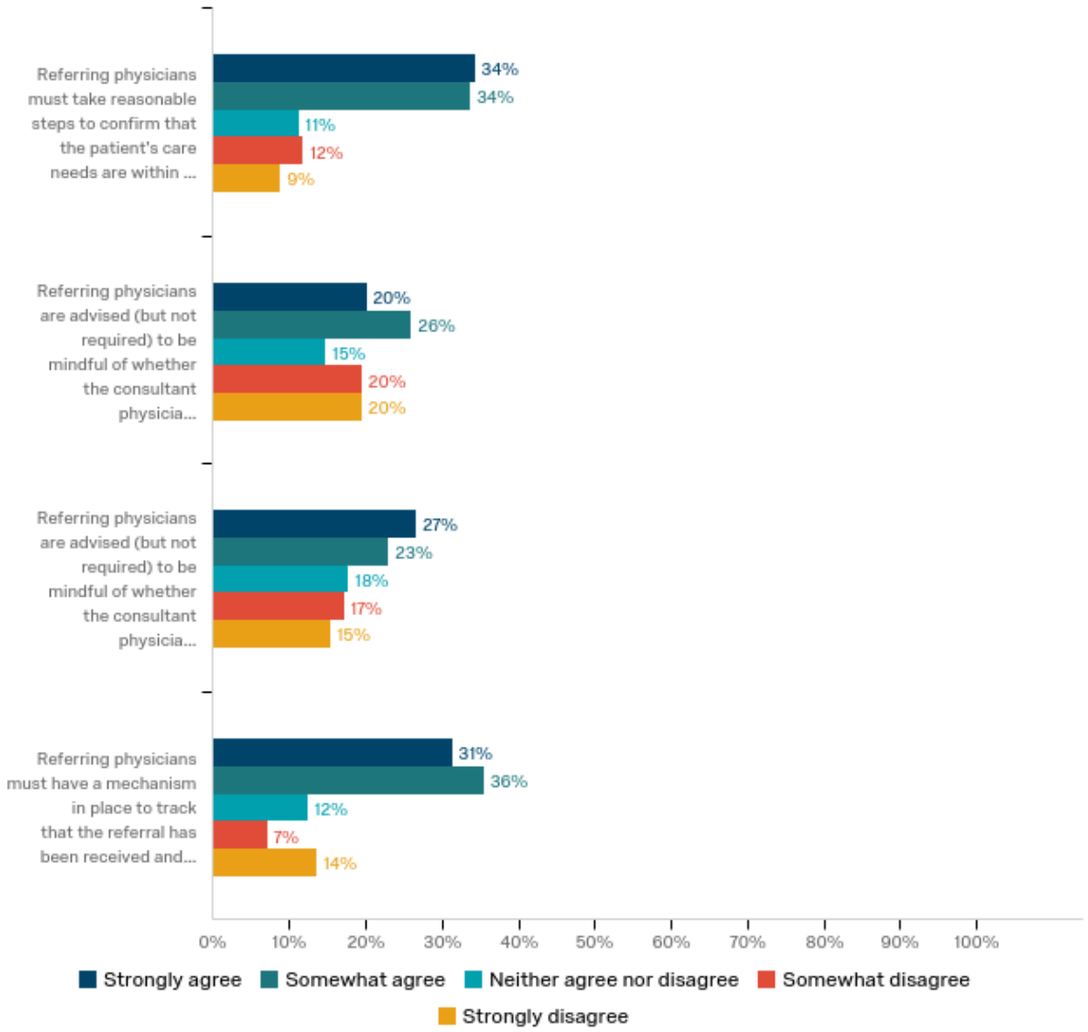
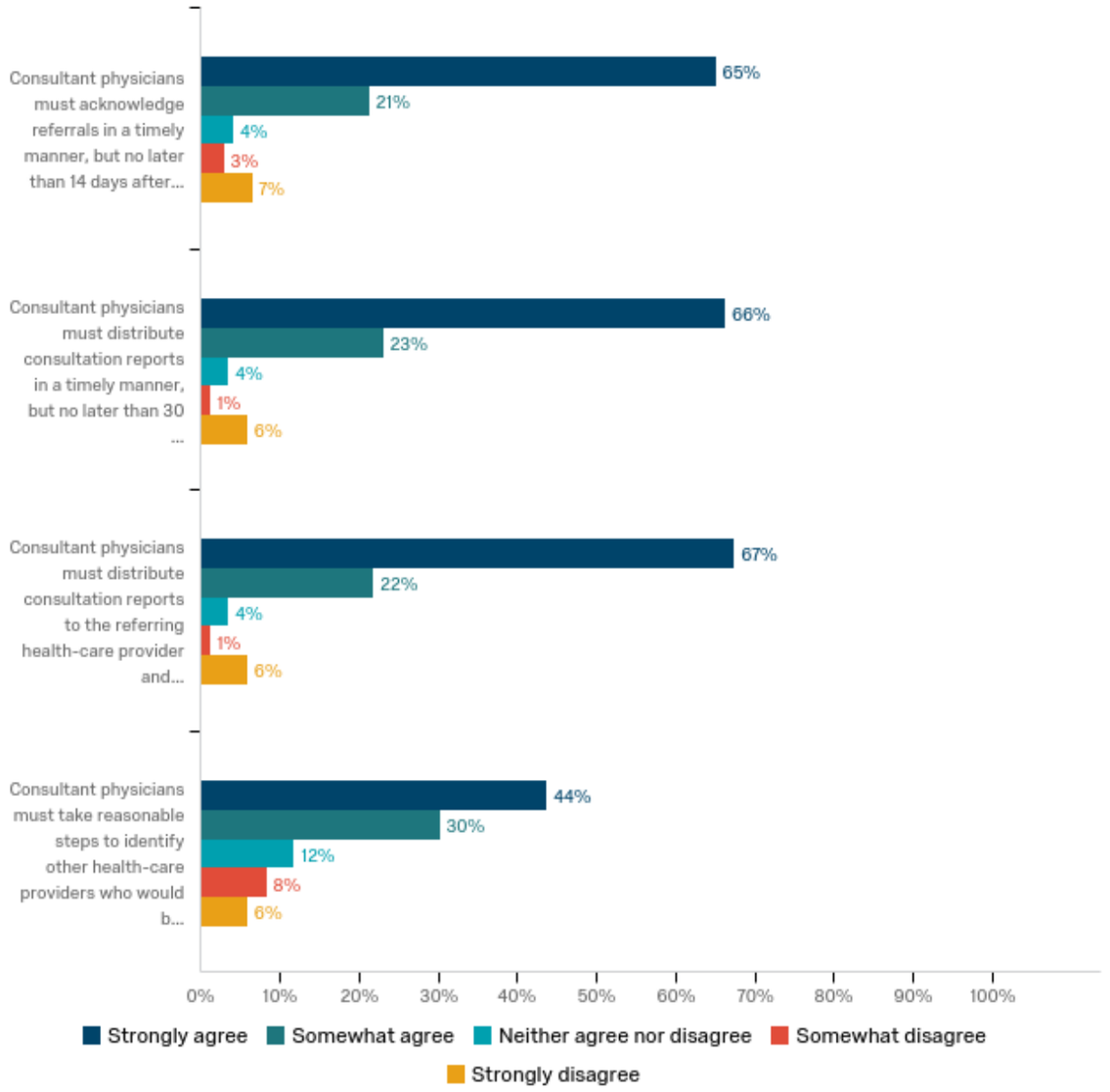


Figure 12b: Statements 5-8



Question TC8:

Please feel free to elaborate on your answer above. (Optional)

- Physicians felt that referral reports should include sufficient information for consultant physician to triage and accept referred patients.
- There was a general agreement that consulting physicians must acknowledge the receipt of the patient referral.
- Respondents felt that it is the responsibility of the consultant physician to get back to the referring physician if they are unable to accept patients. Many respondents expressed desire for a centralized referral or specialist database (including scope of practice, accepting patients) to assist their referral processes.
- May respondents felt that tracking referrals was too resource intensive for physicians, and expressed a desire for additional resources to be provided to support these requirements.
- Respondents indicated that 30-days for a consultant reports is too long.
- Some respondents felt that 14-days for patient acceptance is too long and that referring physicians have no way to know whether an office is taking patients.

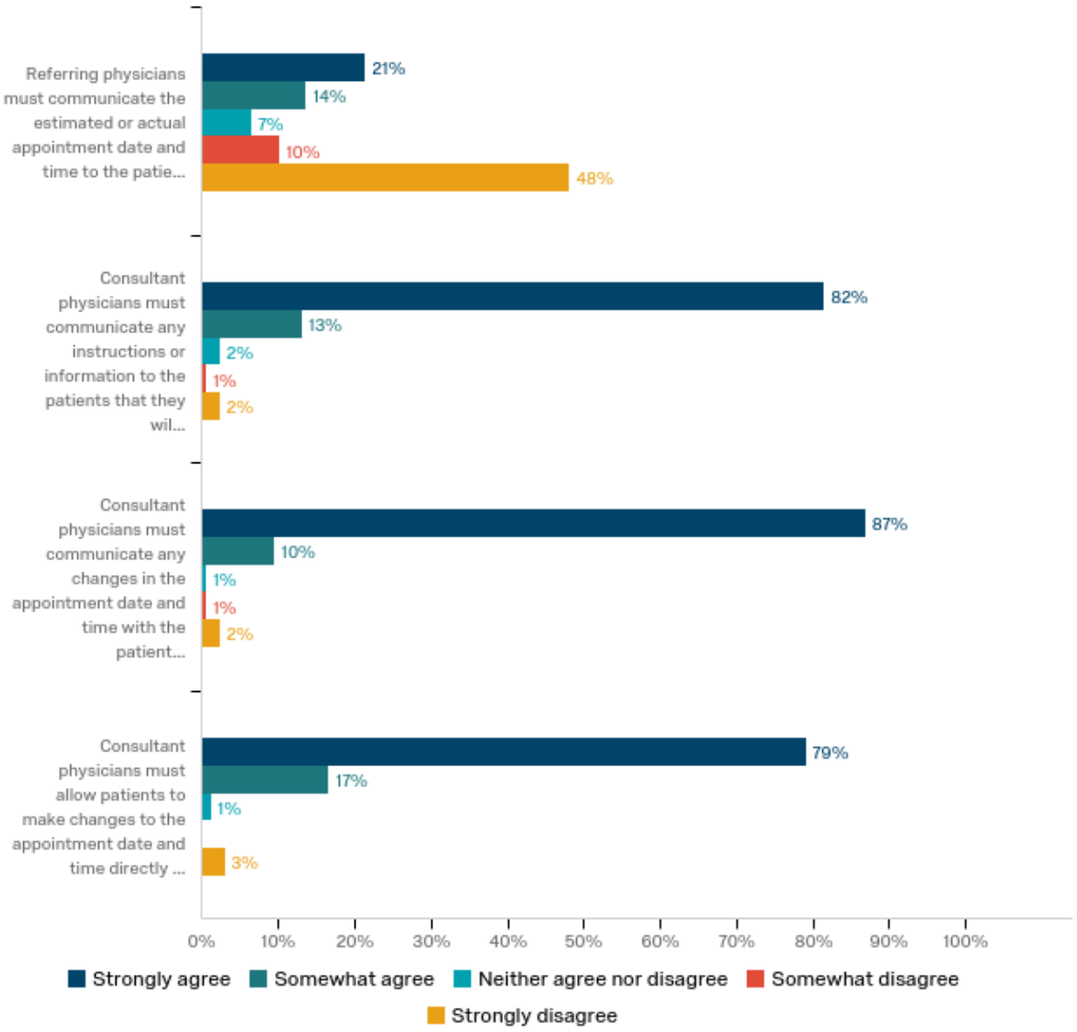
Total Respondents	**74**

Question TC9:

The draft policy sets out expectations related to completing and distributing discharge summaries when in-patients are discharged from hospital. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	Referring physicians must communicate the estimated or actual appointment date and time to the patient unless the consultant physician has indicated that they have already done so or intend to do so.
2.	Consultant physicians must communicate any instructions or information to the patients that they will need in advance of the appointment (e.g., fasting, office policies, etc.), unless the referring physician has agreed to assume this responsibility.
3.	Consultant physicians must communicate any changes in the appointment date and time with the patient directly.
4.	Consultant physicians must allow patients to make changes to the appointment date and time directly with them.
Total Respondents	**168**

Figure 13: Statements 1-4



Question TC10:

Please feel free to elaborate on your answer above. (Optional)

- Respondents overwhelmingly felt that it is the responsibility of the consulting physician (specialist) to coordinate appointment times, appointment instructions and ensure office accessibility for patients. Respondents raised the primary concerns of patient safety due to increased risk of miscommunication, OHIP billing policies and the burden of additional work as primary reasons for their disagreement with the expectation as written.

- Some respondents indicated that they would appreciate being notified that the referred patient has an appointment scheduled.

Total Respondents	77

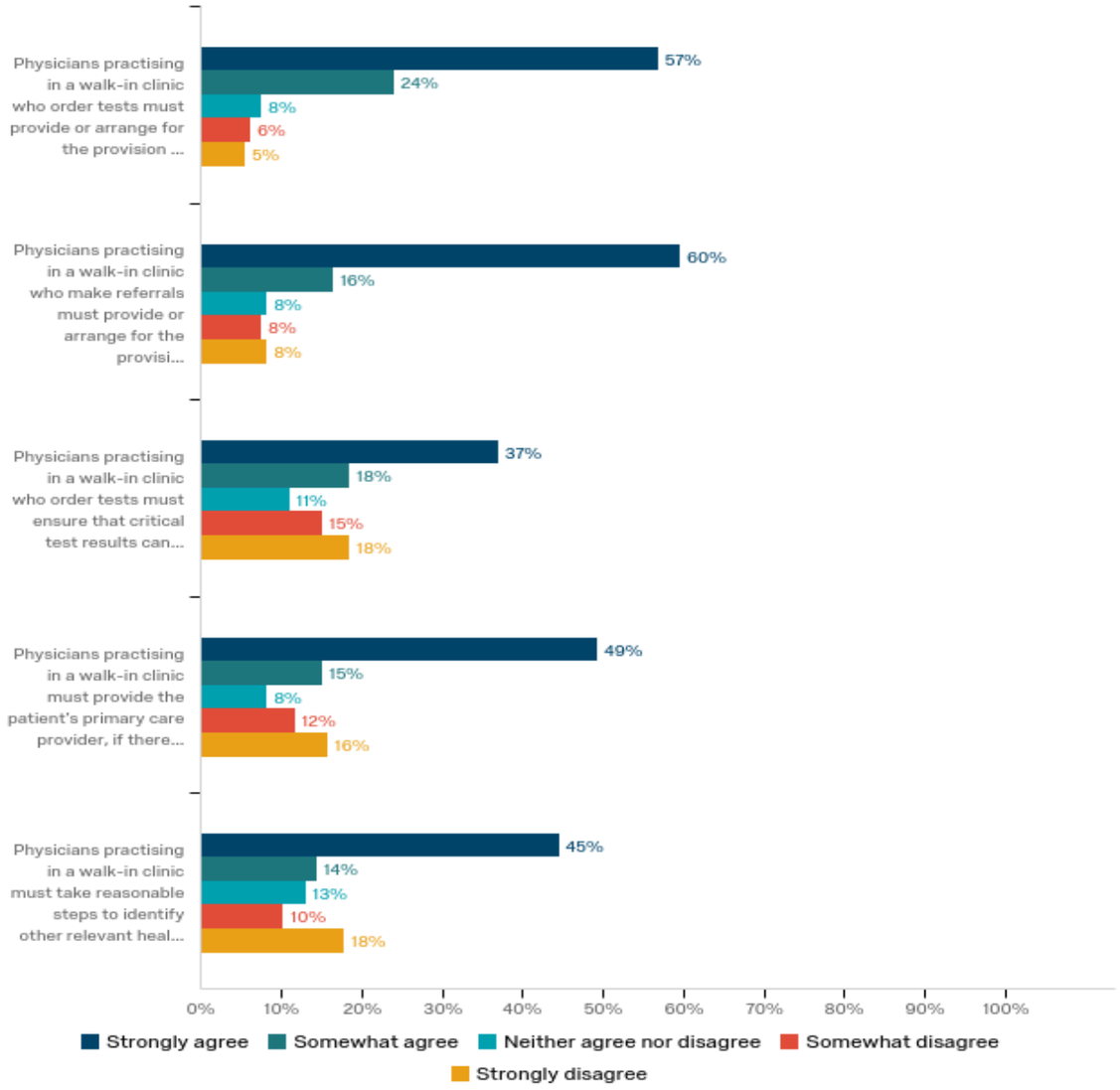
Continuity of Care: Walk-in Clinics

Question WC1:

The draft policy sets out expectations related to completing and distributing discharge summaries when in-patients are discharged from hospital. **Please indicate the extent to which you agree or disagree with each of the following expectations:**

1.	Physicians practising in a walk-in clinic who order tests must provide or arrange for the provision of appropriate follow-up care.
2.	Physicians practising in a walk-in clinic who make referrals must provide or arrange for the provision of necessary follow-up care, including reviewing consultation reports
3.	Physicians practising in a walk-in clinic who order tests must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week (which will necessitate making coverage arrangements when physicians are unavailable).
4.	Physicians practising in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter.
5.	Physicians practising in a walk-in clinic must take reasonable steps to identify other relevant health-care providers who would benefit from knowledge of the encounter, and provide them with a record of the encounter as well.
Total Respondents	**146**

Figure 14: Statements 1-5



Question WC2:

Please feel free to elaborate on your answer above. (Optional)

- Respondents were split on the expectation to share encounter reports with primary care providers. Respondents noted there are many reasons why patients may choose the anonymity of the walk-in clinic for care (e.g. STI testing, second opinion). Further, many felt that it was only appropriate to share reports from walk-in clinic encounters with other health care providers (e.g. primary care physician) with express consent form the patient.
    - Respondents felt encounter sharing reports was more important when there was a high-risk situation which requires monitoring, follow-up or longer term care, however may not be necessary for less urgent issues (e.g. cough, cold, rash).
    - Many respondents felt that the requirement would cause an undue burden of administrative work on the walk-in clinic. Sharing all encounter reports with the primary care provider will cause an increase the physician's work load and divert time from patient care to more administrative duties.

- Many respondents commented on the nature of a walk-in clinic as an alternative to the ER or, as a health care access point when primary care physician is unavailable.

- Respondents felt that walk-in clinic physicians should only be required to follow-up with patients when the patient's primary care provider is unavailable or where a patient is unattached. Otherwise, it is reasonable to direct the patient to follow up with their primary care provider if needed.

- Respondents also felt that as primary care providers, if they are asked to follow-up with a patient on care provided in a walk-in clinic detailed encounter notes are required to provide adequate care.

Total Respondents	**54**

Question WC3:

Some patients in Ontario do not have a primary care provider but frequent the same walk-in clinic for all their primary care needs. These patients are sometimes referred to as "unattached patients". The draft policy recommends that physicians practising in a walk-in clinic offer comprehensive primary care to unattached patients when doing so is within their scope of practice. The draft policy also notes that this may require coordinating with other physicians in the walk-in clinic. **Please indicate the extent to which you agree or disagree with this recommendation.**

Strongly agree (20%, 29)
Somewhat agree (23%, 33)
Neither agree nor disagree (15%, 22)
Somewhat disagree (16%, 23)
Strongly disagree (27%, 39)

Total Respondents	**146**

Question WC4:

Please feel free to elaborate on your answer above. (Optional)

- Walk-in clinic were seen as a resource to address system gaps in primary care. Many respondents felt that the walk-in clinic was an inappropriate setting to provide on-going patient care. The lack of primary care resources in the province is seen as a systemic issue which should be addressed by the Ministry of Health and Long-Term Care.

- A minority of respondents agreed with the expectations as stated.

Total Respondents	43

Question WC5:

Additionally, if you disagree with this recommendation, what role do you think walk-in clinics can play in helping unattached patients receive the comprehensive primary care they need? (Optional)

- Respondents felt that walk-in clinics can play the following roles in helping unattached patients received primary care:
    - Provide care for urgent issues
    - They do not fill a role any greater than the ER
    - Refer patients to Health Care Connect or the LHIN to find a primary care provider
    - Walk-in clinics should be required to take on a minimum number of patients for comprehensive care

- Respondents also expressed a desire for broad systemic improvements (e.g. more resources, more physicians) at the Ministry level to fill gaps in primary care rather than rely on episodic care clinics.

Total Respondents	40

Follow-up Questions

Question F1:

As noted at the outset of this survey, the College has focused on setting out policy expectations related to only those elements of continuity of care where physicians have a role to play. We have committed to setting out recommendations regarding broader systems issues in a separate 'white paper' at a later date. **Are there any issues you'd like to see the College address in this white paper? (Optional)**

- Respondents requested the college consider the following in a white paper:
  - It is important to balance laudable goals with the realities of the current health care system and available resources
  - Patients should be held accountable for their own health care and have a better understanding of the appropriate level of care required (e.g. ER, family doctor) for their concern
  - Physicians should not be expected to shoulder the burden of the broad system improvement which is required to facilitate communication between health care providers. Polices should reflect changing landscape of health care delivery and adapt them to team-based health care delivery models
  - In a white paper the CPSO should partner with other stakeholders such as HQO, OMA, OHA and academics
  - Potential technological innovation to facilitate communication/knowledge transfer amongst health care professionals
  - Impact of these policies on physician workload/burnout
  - Considerations of Integration and inter-professional collaboration in primary care
  - Changing communication landscape (e.g. instant messaging/e-mail)
  - Unattached patients should be addressed
  - Interactions and continuity with allied health professionals
  - Physician system capacity
  - Considerations for physicians who work in non-standard clinical contexts (e.g. remote and military)

Total Respondents	93

Question F2:

If you have any additional comments that you have not yet provided pertaining to any element of any of the draft policies, please provide them below, by email or through our online discussion forum.

- Respondents left the following comments:
  - More transparency regarding suspensions and restrictions is required
  - The CPSO needs to develop a better relationship with the profession
  - Respondents expressed concerns, frustration with broader system issues in Ontario (e.g. billing policies, digital health infrastructure, or physician compensation) which are not within the mandate of the CPSO
  - Patient/public education on how the system works and the appropriate venue for care is needed

Total Respondents	26