CPSO Proposed Continuity of Care Policies

November 2018

Introduction

The Ontario Medical Association is pleased to respond to the College of Physician and Surgeon's (CPSO) consultation regarding its proposed suite of continuity of care policies. We appreciated the decision of the CPSO Council to accept the OMA's request to extend the consultation period so we can adequately understand from our members:

1) What elements of the proposed policies are reasonable and effective in the present environment?
2) What elements of the proposed policies could be reasonable and effective with appropriate resources and/or staging?
3) What elements of the proposed policies are unreasonable or ineffective?

The response was fruitful and consultation activities with members included:

- Establishing a dedicated inbox and inviting written comment from all members;
- Targeted communication to OMA Sections inviting written comment;
- Two online focus groups;
- Meetings with OMA Sections;
- Dialogue with the Rural Expert Panel and Primary Care Solo Physicians Interest Group;
- Use of the OMA's Hospital Issues Committee and Health Policy Committee.

We were also pleased to meet with other relevant system stakeholders to jointly review the draft policies.

Over the past six months we have appreciated the CPSO's willingness to engage in dialogue and the stated receptivity to the OMA's feedback. Along with regular meetings between our leadership, staff have had numerous opportunities to interact and share the OMA's perspective on key issues. We also appreciated the opportunity to participate in two stakeholder summits and trust that nothing contained within this submission will be a surprise to the CPSO. Our focus has been on understanding the intention of various elements of the proposed policies and offering feasible alternatives where possible.

Physicians strongly support continuity and coordinated care delivery. It is well recognized that continuity of care supports patient safety and quality. While physicians are leaders in health-care delivery, they find themselves operating as single actors in a multi-layered health-care system. Any regulatory action should be reasonable and applicable within the physician's span of control. In addition, the mandate of protecting the public interest should contemplate the patient's role in the co-management of care.

Taken from the OMA's 2016 submission to the CPSO during its preliminary consultation on continuity of care:

> *The first step in addressing continuity of care is defining it. The Quality Council of Alberta offers a useful description:*
>
> *Continuity of care is the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs*

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and personal context. (Health Quality Council of Alberta, Continuity of Patient Care Study, October 2015)

It takes an organized system to provide continuity of care. Individual physicians cannot be expected to achieve this on their own. To have a comprehensive discussion about continuity of care, we will need to engage in a discussion about quality, team-based care, and patient involvement in care. Continuity of care does not necessarily mean that patients will have access to their physician at any time. Instead, it means that physicians will be reasonably available to their patients and have means to communicate effectively with patients and other health care providers. There are currently barriers that challenge physicians' efforts to ensure continuity of care. These barriers include both system and resource factors as well as more specific practice level issues.

Physicians are dedicated to effective communication and collaboration with the patient and other health-care providers. Whether through facilitating patient engagement or ensuring the patient is kept informed of decisions and recommendations related to their health, physicians are supportive of a system that ensures the patient journey is seamless. The CPSO proposes that physicians "… recognize that patient interactions within the health-care system are best viewed not as discrete events, but rather as a set of interactions that require oversight and management." However, the College further indicates that it's "… focused on setting out policy expectations related to those elements of continuity of care where physicians have a role to play." The OMA is concerned that the proposed companion policies shift an unbalanced proportion of oversight and management onto physicians. Just as health-care providers need to view patient interactions with the health-care system as a series, the oversight and management of care is shared among the system (funders, regulators, policy-makers), the environment (social determinant of health), the providers and the patient.

The very fact that there is a perceived need for these policies underscores the fact that the system is not functioning optimally. If the system functioned appropriately (e.g. was integrated, efficient, made optimal use of technology, and was adequately resourced) we would likely not need a continuity of care policy. The CPSO is trying to tackle a system issue at the wrong level. Mandating unreasonable expectations that are unable to be implemented at the present time will deepen pressures on the system; create confusion among providers and the public; and negatively impact the delivery of care. The feasibility and probable effectiveness of continuity of care recommendations must be considered.

We recognize that the ultimate mandate of the CPSO is to protect the public interest. While elements of the policy conceptually make sense, placing unreasonable expectations on physicians will have unintended consequences leading to poorer quality of care. For example, many of the proposed requirements will take time away from clinical care; stretch thin resources and contribute to increases in physician burnout.

The following submission is setup to provide several overarching recommendations, followed by a detailed analysis of specific areas of the proposed policies.

Recommendations

Recommendation #1: *The CPSO should create separate advisory documents and transfer any advisory statements and clinical practice direction from the draft policies into these documents. Doing so respects the unique nature of medical-care delivery and will prevent a one-size-fit-all approach.*

As previously indicated, the CPSO is proposing policy with a significant degree of specificity that is not seen elsewhere in the country. The OMA has noted a number of instances where it appears that the CPSO is providing clinical practice direction (e.g. structure/contents of discharge summaries and consultants' reports). It is unclear what evidence underpins this direction and as such, we do not believe that this is appropriately placed in regulatory policy. Rather, the focus should be on ensuring and supporting evidence-informed physician practice.

It is unclear to the OMA how the proposed policy will be enforced. We are concerned that the proposed policy will increase the volume of complaints (possibly frivolous in nature) regarding issues beyond the control of the physician. This will demand significant resources from the CPSO and place a personal and professional toll on impacted physicians. Effective policy requires a transparent, fair and effective enforcement mechanism. Given that the CPSO has recognized the existing challenges in the complaints and investigations process, this should be an important consideration in policy implementation.

Recommendation #2: *The CPSO must consider that the technological capacity of each practice in Ontario will vary and revise the proposed policies to reflect this.*

Physicians are strongly advised by the CPSO to capitalize on advances in technology to facilitate continuity of care. Much of what the CPSO is proposing cannot be accomplished without the assistance of accessible and connected technology at the point of care and elsewhere within the medical practice. This is problematic because Ontario is not at the technological stage where many of the CPSO's proposed requirements are feasible. In addition, many physicians lack the resources and support needed to adopt and embrace technology.

Recommendation #3: *The CPSO should ensure consistency with the standards and approaches undertaken by other regulatory colleges.*

It would be unreasonable to impose significant requirements onto physicians if there is not consistency in the approaches undertaken by other regulated health professions (e.g. nurse practitioners, dentists and pharmacists). Doing so provides consistency for the public's awareness and enables providers to work most effectively together. Section 3(1) of the Health Professions Procedural Code under the *Regulated Health Professions Act* requires cross-regulator collaboration as an object of each College. This may be done through the appropriate channels, such as the Federation of Health Regulatory Colleges of Ontario.

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Recommendation #4: *The CPSO must consider a phased-in change management approach towards policy implementation. This approach needs to recognize that in many instances physicians are currently experiencing, or on the verge of, burnout and exhaustion. Healthy physicians promote safety and high quality care delivery.*

There are thousands of physicians in Ontario and the diversity of practice environments needs to be recognized. The composition and structure of their practices vary significantly. The OMA is concerned that many of the proposed requirements would be hardest to implement by those physicians operating outside of groups; those in tertiary centres servicing large geographic catchment areas and those in rural/northern communities. Although the mandate of the College is not necessarily to implement policies, it must be sympathetic to the challenges and changes needed for its members. Physicians want to ensure that the CPSO is considering a change management approach throughout because the proposed policies will, in many instances, have a significant impact on the operation of a practice. Policy on the books that is unimplemented or not implementable does nothing to serve the public interest nor physicians.

In addition to burnout and workplace exhaustion, the prevalence of moral injury is increasing rapidly and is cause for concern. Physicians enter their profession to help others attain the greatest level of health possible through the provision of quality patient care. Moral distress is created when physicians operate in a system that frequently fails to deliver safe and quality care. This is further complicated when new requirements, with the best intentions, are thrusted onto physicians. The OMA has heard loud and clear from its membership that physician health and wellness are key priorities for positive patient outcomes. We are unable to support any proposed requirement that directly or indirectly mandates individual practising physicians to provide 24/7 coverage. In addition, the OMA is concerned that the CPSO may not have considered the resource requirements, including adequate physician remuneration, for the new responsibilities being proposed. This is important to maintain the ongoing sustainability of physicians' practices.

Recommendation #5: *As the representative of the public interest, the CPSO should strengthen the patient's role in the proposed policies to include shared responsibility for care processes and outcomes.*

Physicians deeply value their fiduciary duty to their patients and want to help people. Each person and their health-care experience is unique. It is confusing to observe the level of specificity provided in the proposed companion policies and the onerous responsibilities tied to physicians. This is happening during a recognized shift by policy-makers, educators and researchers from a paternalistic approach to medicine to one that is more patient-centred. The CPSO indicates that patient engagement is meant to be a supplement or a support to physicians' efforts to facilitate continuity of care. While recognizing that physicians have unique medical expertise and a fiduciary duty to their patients, the OMA is concerned that framing patient engagement as a "support" is insufficient. Rather the focus should be on, to the greatest extent possible, facilitating the effective co-management of care and examining the appropriate patient role needed to achieve this.

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Recommendation #6: *The CPSO adopt the changes proposed by the OMA in the accompanying table below.*

The following table is the product of extensive consultation conducted by the OMA. We have broken down the problematic areas of the proposed policies and thoughtfully attempted to ascertain the CPSO's policy intention. We then identify corresponding issues being raised by members and the OMA's analysis. Finally, we propose acceptable alternate solutions and specific wording changes that we expect to see in the finalized policies.

Once again, the OMA appreciates the opportunity to review the draft CPSO policies and we hope to see our feedback adopted to ensure the ongoing provision of high quality medical care in Ontario.

Table One: Detailed Review of the CPSO's Proposed Continuity of Care Policies

Area	Issues	Possible Solutions	Proposed Wording Change
Sharing information among health care providers ➢ *Information from walk-in encounters; test results and consultants shared with primary care provider and others.*	• Patients accessing walk-in clinics may not want the record shared with other providers. • Identifying and verifying accuracy of family physician contact information (especially for out-of-province patients). • Increased administrative demand to coordinate the delivery of reports. • Lack of clarity surrounding the depth of information and type of record needing to be shared.	• Standardized patient consent forms and education about their role in sharing health information.[a] • Accessible national/international health-care provider registry that can be integrated with existing electronic medical records. • Financial support for increased administrative demand. • Greater adoption of interoperable electronic medical records. • Standardized reporting form of health encounters that is developed with the OMA, along with an appropriate remuneration structure.	Walk-In Clinic Policy: Physicians practising in a walk-in clinic, ~~must~~ may, at their discretion, provide the patient's primary care provider, if there is one, with ~~a record of~~ information on the encounter that is relevant to ongoing care delivery. ~~Physicians practising in a walk-in clinic must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from knowledge of the encounter and provide them with a record of the encounter as well.~~ Test Management Policy: ~~In addition, where ordering physicians are not the patient's primary care provider, they must copy a patient's primary care provider on the requisition form.~~

[a] *During the OMA's consultation family physicians expressed an interest in staying connected and many welcome notification of walk-in clinic visits. However, the OMA feels that the proposed approach by the CPSO needs to be reconsidered.*

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	• Uncertain accountability and responsibility of physicians who are copied on reports/tests (e.g. family doctor in receipt of abnormal test results ordered by specialist). • Identifying and sharing information with "other relevant providers" is challenging for physicians operating in a large health-care system. Moreover, there is a range of non-regulated 'health-providers' that patients are seeking out and physicians may have concerns sharing information with them. • Increased volume of information can negatively impact patient safety from missed clinically significant results.	• Clarity from the CPSO on the accountability and responsibility of physicians copied on reports. • Empowering and supporting patients to share records of their health-care encounters (e.g. paper copies or electronic portals). • Focus on sharing information that is most relevant and pertinent to patient care delivery.	<u>Transitions in Care Policy</u> Consultant physicians must send consultation reports to the referring health-care provider ~~and the patient's primary care provider. Consultant physicians must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from awareness of the consultation and share consultation reports with them as well.~~
Critical test result ➢ *Critical test*	• Ambiguity in the proposed definition of a 'critical test result'. • Difficulty to ensure 24/7 coverage, especially in	• Better illustration and examples of what a critical test result means. • Align the requirement to appropriate urgency instead	All physicians who order tests must ensure that critical test results can be received and responded to ~~24 hours a day, 7 days a week~~ with the appropriate urgency considering the patient's condition and nature of the physician's practice.

Area	Issues	Possible Solutions	Proposed Wording Change
results are acted upon in a timely fashion.	smaller centers. • Difficulty in contacting patients after hours.	of 24/7. • Electronic medical records with lab connectivity. • Appropriate physician remuneration is needed to facilitate coverage.	
Voicemail ➢ *Urgent issues are addressed urgently.*	• Significant patient safety concerns regarding after-hours messages for issues that should be urgently addressed in the emergency department. • Limited resources to monitor voicemail.	• Patients should be encouraged to contact Telehealth after hours or go to their nearest emergency department. Appointment changes and scheduling can be done during business hours. • Appropriate physician remuneration structures to acquire administrative support.	To facilitate good communication and collaboration, physicians must have communication options that are responsive and appropriate for their patient population(s) and community. At minimum this must include 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~~.
Tracking Test Results ➢ *Tests that are ordered should be completed.*	• Requirements to verify whether patients take tests will be challenging for physicians to monitor and significantly time consuming. • Contacting the patient may be challenging, especially for those who do not have regular telephone access or a fixed address.	• Patient education and support to make informed and prioritized decisions about their care, including completing ordered tests. • Definition of a 'high risk' patient.	~~Tracking test results involves verifying that the patient has taken the test and ensuring that the laboratory and/or diagnostic facility has sent the test result to the physician. Physicians must track test results for high-risk patients to ensure that their test results are not lost or missed. For example, if physicians do not receive a test result for a high-risk patient, they must follow-up with the patient to verify that the patient has had the test and/or follow-up with the laboratory and/or diagnostic facility to verify that the laboratory and/or diagnostic facility has the test result. For~~

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	• Physicians may not be familiar with lab/diagnostic centre contact information; which location is visited or the parameters associated with the contact (e.g. how many times should a physician call?).	• Provincial laboratory test results system that can be easily accessed by every physician.	~~patients that are not high-risk, physicians must use their professional judgment to determine whether to track a test result. In making this determination, physicians must consider the following factors:~~ ~~• The nature of the test that was ordered;~~ ~~• The patient's current health status;~~ ~~• If the patient appears anxious or has expressed anxiety about the test; and~~ ~~• The significance of the potential result.~~ ~~Physicians must either personally track test results or assign this task to others.~~

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Coordinating After Hours Coverage for Patients ➢ *After hours care should consider all providers involved in care.*	• The proposed requirement to 'coordinate care for patients outside of operating hours' is vague and not feasible. • For patients with co-morbidities there may not be clarity regarding which physician should be contacted for after-hours care needs. Moreover, involvement from multiple parties increases the risk for communication errors. • Limited availability of health-care resources (e.g. lack of backup coverage in smaller communities). • Excessive after-hours coverage requirements would strain physician health and wellness.	• More precise definition of 'coordinating care' from the CPSO. • Utilization of a central telephone system (e.g. telehealth). • Provincial interoperable EMR that can be shared and accessed easily. • In many instances, use of the emergency department is warranted (e.g. rural). • Increased utilization and promotion of virtual care/telemedicine. • Public education on after-hour health care options. • Meaningful consultation with representative front-line physicians to gauge and respond to the impact that the proposed requirements have on physician well-being.	Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters must have a plan in place to ~~coordinate care for their patients~~ make patients aware of urgent care options outside of regular operating hours. ~~This is often referred to after-hours.~~ The nature of the plan will depend on 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. Physicians must use their professional judgment to determine how best to structure their plan and must act in good faith~~,~~ ~~making a reasonable attempt to minimize uncoordinated access to care and the inappropriate utilization of emergency rooms or walk-in clinics~~.

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Coverage during temporary absences ➢ *Patients have access to care when their physician is unavailable.*	• Unclear what 'coordinate care' refers to. • Will be problematic for many, especially solo physicians and those in rural and northern settings.	• More precise definition of 'coordinate care' from the CPSO. • Availability of health human resources, including appropriate physician remuneration and travel costs for rural/northern locums.	Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters have a responsibility to ~~coordinate care~~ consider alternative access points to care for their patients during temporary absences from practice. This includes, vacations and leaves of absence (e.g., parental leave, educational leave, suspension of a physician's certificate of registration), but also includes unplanned absences due to, for example, illness or family emergency. ~~To discharge this responsibility, physicians must arrange for another health-care provider(s) to provide patient care during temporary absences from practice. The specific nature of the coverage arrangement will depend on the length of the absence, 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.~~ Physicians are also advised to proactively plan for how to manage unplanned temporary absences from practice.

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Interim provision of comprehensive primary care at a walk-in clinic ➢ *Patients receive comprehens-ive primary care.*	• Walk-in clinics are not setup to deliver the same level of comprehensive primary care that a traditional family practice offers.	• Walk-in clinics are currently servicing a multitude of needs for episodic care in many communities. A broader discussion is needed at the health system policy level to address patients without a family physician and the future role of walk-in clinics.	~~Some patients may, however, experience difficulty finding a primary care provider and may regularly attend the same walk-in clinic for all of their primary care needs. In these instances, physicians practising in a walk-in clinic are advised to offer, where their scope of practice permits and in coordination with other physicians in the practice, comprehensive primary care to the patient as an interim measure.~~
Triaging of patients ➢ *Facilitate timely access to care.*	• The resourcing and setup of many physicians' offices are not consistent with guidelines/protocols that enable effective time-sensitive triage systems. • Some physicians operate their practice independently and others rely on staff (possibly non-regulated medical assistants) who are not adequately trained in triage.	• Adequate resourcing to implement appropriate triaging requirements. • Training modules and support for physicians and their staff on triage guidelines and protocols.	~~In order to facilitate timely access to care and continuity of care, physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues.~~
Test results received in error ➢ *Ensure that clinically*	• Physicians erroneously receiving test results are unlikely to have the contact information for, or possibly knowledge of, the ordering physician,	• Maintain the current requirement that physicians must contact the laboratory/diagnostic center to report the error. This ensures consistency and a	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~~ laboratory/diagnostic facility.

Area	Issues	Possible Solutions	Proposed Wording Change
significant test results are responded to.	primary care provider and patient. • Beyond the ordering physician or primary care provider, it is unlikely that other physicians will have sufficient knowledge of the patient to interpret a clinically significant test result. • It is the laboratory's responsibility to ensure that test results are accurately distributed to the correct physicians.	single contact point for physicians.	
Physicians incidentally becoming aware of significant test results ➢ *Ensure that clinically significant test results are responded to.*	• Unclear how physicians are expected to have reason to believe (or not) that the ordering physician will receive the test result. • Will result in duplication and inefficiency. • Blurs accountability and leadership for care delivery.	• Test result management systems in place at each practice. • Provincial interoperable EMR that can be shared and accessed easily. • Clarification that the ordering physician is responsible for follow-up.	~~Additionally, physicians who become aware, even incidentally (e.g. physicians who are cc'd on a report), of a critical or clinically significant test result where they have reason to believe that the ordering health-care provider did not or will not get the test result, must make reasonable efforts to inform the ordering health-care provider or the patient of the test result. The physician must also make reasonable efforts to contact the laboratory or diagnostic facility that sent the test result.~~
Patients contacting physician for test results	• Physicians can order hundreds of tests a week. 'No News' strategies are essential to the effective operation of many	• Increased administrative support to handle requests. • Additional health human resources to provide patient education to understand	Physicians must inform patients as to whether they are using a 'no news is good news' strategy ~~and must tell patients that they have the option to personally contact the physician's~~

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➢ *Patients have access to information concerning their health.*	practices. • Providing the option for patients to contact the practice for test results will increase the administrative load on the practice. • Patients will likely require assistance interpreting the test result.	test results. • Patient portals that provide access to test results.	~~office for the test result.~~
Referrals ➢ *Planning for a referral to minimize unnecessary delays.*	• Confirming scope of practice, availability, and accessibility of specialists will be challenging without one centralized system that accurately maintains this information. • Time spent collecting and monitoring information will take time away from clinical care.	• A central database of consulting physicians that is updated regularly by specialists and accessible to all physicians. • Protected time and/or additional health human resources.	~~In order to minimize unnecessary delays that may compromise patient safety, referring physicians must take reasonable steps to confirm that the patient's condition(s) is (are) within the scope of practice of the consultant physician to whom they intend to refer the patient. This may involve, for example, being mindful of sub-specialties and/or areas of focus to which physicians may choose to limit their practice. Physicians are also advised to be mindful of whether the consultant physician is accepting patients and whether the consultant physician's practice is accessible to the patient (e.g., location, physical accessibility, etc.).~~
➢ *Making a referral with a sufficient*	• Incomplete or inconsistent referrals create delays, inefficiencies and miscommunication.	• Development of a standardized form by a joint OMA/CPSO Work Group.	Referrals must be made in writing and signed by the referring physician, using a standardized

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exchange of information.	• Lack of an integrated EMR means relying on out-dated technology (e.g. fax).	• Development of an integrated Electronic Health Record.	OMA Referral Form where available. If urgent, a verbal request may be appropriate, but must be followed by a written request.
➢ *Tracking the status of a referral.*	• There is varying capacity among referring physicians in Ontario to track the status of significant referral volumes.	• Interoperable electronic medical records. • Increased administrative support. • Enable patients to self-monitor the status of their referral.	~~Referring physicians must have a mechanism in place to track that the referral has been received and that an acknowledgement of the referral will be provided. The urgency of the referral will determine the degree to which the referring physician must monitor the referral request.~~
➢ *Acknowledging a referral in a timely manner.*	• Many consultant physicians in Ontario receive tens/ hundreds of referrals each week. It is unfeasible to mandate an arbitrary 14 day turnaround time.	• Increased resourcing to improve specialist availability in Ontario.	Physicians who are asked to consult on a patient's care must acknowledge the referral in a timely manner, urgently if necessary~~, but no later than 14 days from the date of receipt~~. ~~If consultant physicians are able to accept the referral, they must provide an estimated or actual appointment date and time to the referring health-care provider. They must also indicate whether they have communicated an appointment date and time with the patient directly or intend to do so.~~ If consultant physicians are not able to accept

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	• It is beyond the scope of consultants' role to maintain an understanding of alternative health-care providers who may be able to accept referrals.	• A central database of consulting physicians that is updated regularly by specialists and accessible to all physicians. • In many urgent cases, the emergency department is the appropriate entry point to the system	the referral, they must communicate their reasons for declining the referral to the referring health-care provider.[18] ~~Where a consultation is urgently needed, consultant physicians must provide suggestions to the referring health-care provider of alternative health-care provider(s) who may be able to accept the referral, and are advised to do so for non-urgent referrals as well.~~
➢ *Communicate appointment details to patients.*	• Confusion regarding roles and responsibilities, e.g. physician 'X' communicates the appointment date unless physician 'Y' has already agreed to do so. • Inefficient and duplicate use of administrative resources (e.g. family physician using administrative resource to facilitate a specialist booking).	• Clear direction regarding who does what with respect to patient communications is needed. • Recommend consistency with communication process in other provinces (e.g., BC, Alberta, Manitoba, Nova Scotia, New Brunswick, Yukon have referral and/or transitions in care policies in place.).	~~Referring~~ Consultant 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.~~ Consultant physicians must communicate any instructions or information to patients that they will need in advance of the appointment, ~~unless the referring physician has agreed to assume this responsibility.~~ Consultant physicians must also communicate any changes in the appointment date and time with the patient directly and must allow patients to make changes to the appointment date and time directly with them.

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➢ *Timely preparation and distribution of consultation reports.*	• The structure and composition of consultants' reports will depend on the specific patient; questions raised by the referrer and the nature of the consultants practice. • Timely consultation reports are important. However, an arbitrary 30 day timeframe does not consider the realities of high volumes for consultants, nor the specific urgency of the communication.	• Attempts to standardize communication must take into consideration an element of flexibility. Consider removing this section from official policy and repositioning it into a companion advisory statement. • Increased resourcing to improve specialist availability in Ontario. • Emphasize the need for timeliness.	The consultation report ~~must~~ may include a combination of the following: … Follow-up consultation reports ~~must~~ may include a summary of: Consultant physicians must distribute the consultation report and any subsequent follow-up reports in a timely manner, urgently if necessary~~, but no later than 30 days after an assessment or after a new finding or change in the patient's management plan.~~
Hospitals and Health-Care Institutions ➢ *Facilitating good handovers.*	• Need to ensure alignment with institutional handover policies. • Mandating a real-time interaction between physicians transferring care is not often realistic. • The handover process is going to vary significantly depending upon patient	• The off-loading physician can be available for critical follow up questions in some other manner (email, text, etc.)	Physicians handing over patient care to another health-care provider are ~~strongly~~ advised, ~~wherever possible~~, when patient condition warrants and in accordance with relevant institutional policy, to have a real-time and personal exchange of information that includes an opportunity for a discussion to occur and for questions to be asked.[5] When this is not possible, physicians should indicate their accessibility for critical follow up questions

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	complexity (e.g. ALC) and medical speciality (e.g. dermatology vs. neurosurg).		in some other manner, such as e-mail, text, etc. Physicians are also advised to approach patient handovers in a systematic manner and to set time aside for the information exchange process. This may mean, for example, utilizing standardized or structured communication approaches or tools[6] that help focus information sharing practices.
➢ *Preparing patients for discharge; completing discharge summaries and distributing discharge summaries.*	• The policy puts undue onus on the physician regarding issues/processes that are the responsibility of the institution. • Inconsistent with the CPSO's attempt to draft policy that addresses factors within the physician's control. • Discharge processes and documentation requirements are already provided in local institutional policy. • The distribution of discharge summaries is the responsibility of the institution. Physicians	• Form a multi-stakeholder working group to review relevant institutional policies and procedures to ensure consistency and more effective and safer patient transitions. • Provide the patients and/or substitute decision makers with a copy of the discharge summary and recommend that they	Prior to discharging a patient from hospital, physicians must fully co-operate in relevant institutional processes that ~~ensure that they or a member of the health-care team has a~~ involve discussions with the patient and/or substitute decision-maker about their post-discharge health-care management plan and contribute, when needed, to the timely completion of a discharge summary. All other text in these three sections deleted.

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	cannot be held responsible for institutional processes that may not be timely.	provide copies of it to other healthcare providers in their circle of care.	
	• It may be challenging and administratively time consuming for the MRP to identify other health-care providers who would benefit from having a copy of the discharge summary.	• Ask the patients and/or substitute decision makers to complete a form with the names and contact information of the health-care providers with whom the patient would like their information shared by the institution.	