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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

ADVICE TO THE PROFESSION

Continuity of Care

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA Standards of Practice. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

Advice to the Profession documents are dynamic and may be edited or updated for clarity at any time. Please refer back to these articles regularly to ensure you are aware of the most recent advice. Major changes will be communicated to our members; however, minor edits may only be noted within the documents.

Contents

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CPSA's Advice to the Profession documents cannot capture every potential scenario a member may encounter. Regulated members are expected to consider standards of practice and advice documents in the context of individual patients in each care encounter. Regulated members are expected to do their best to meet the spirit and intent of the standards and advice, while focusing on providing the best quality care possible.

Preamble

The *Continuity of Care* standard of practice applies to **all** regulated members: those who practice as primary care physicians or Royal College specialists, those in solo or group practice, and those in walk-in clinics through to long-term care environments.

Patients who receive greater continuity of care have better health outcomes, higher satisfaction rates and the care they receive is more cost effective. Continuity of care is achieved in two principle ways:

- Through a *continuous caring relationship* with an identified health care professional; and

- Through a *seamlessly integrated service* (e.g., team-based care[1]) enabled by the coordination and sharing of information between different providers.

Continuity of care does not mean regulated members need to personally be available at all times to provide continuous access or on-demand care to patients. Doing so would compromise

[1] **Team-based care:** the provision of health programs and services by two or more healthcare providers who work collaboratively with patients and their circle of care to deliver coordinated, high-quality health service. For the purpose of this standard, team-based care requires processes outlining clear expectations for each team member's responsibilities and accountabilities. [From the Institute of Medicine's Core Principles & Values of Effective Team-Based Health Care discussion paper (October 2012).]

the health of regulated members and negatively impact the quality of care provided to patients.

The intent of the standard is to enhance the care of patients while respecting the needs of regulated members to develop work-life balance, avoid burnout and minimize risk to their own health.

Ordering investigations

It can be challenging to balance appropriate care, patient expectations and not ordering unnecessary investigations. It is important for members to consider why they are ordering an investigation if there are no concerns to address (e.g. "routine" blood work done when not medically indicated).

CLEAR COMMUNICATION

Regulated members need to ensure their patients understand why an investigation or referral to another healthcare provider is ordered. Confirming the patient is aware of the importance of the tests is helpful in ensuring they are done in a timely manner.

RISK OF CLINICALLY SIGNIFICANT RESULTS

For the purpose of the standard, we have defined "clinically significant" test results to include any result determined by a reasonable healthcare provider to be one which requires follow-up in a timely fashion, urgently if necessary, in order to guide further care decisions. Regulated members are not expected to track every test ordered, but to determine the significance of a test result using their clinical judgment and knowledge of the patient's clinical features (i.e., symptoms or physical findings), previous test results and differential diagnosis based on their knowledge of the patient and their history.

While there is potential for any result to be clinically significant, members must have a system in place to track results that are suspected to be clinically significant when they are not received when expected. When an investigation is ordered, members must be prepared to review outcomes, even when they look "normal," and be prepared to follow up, as there is always the possibility of an unexpected outcome (e.g., evidence of microscopic hematuria could indicate bladder cancer). Results must be reviewed and followed up on in a timely manner to ensure appropriate care can be provided.

Regulated members are accountable for tracking results, but staff can assist with tracking results. A clear policy/procedure manual outlining expectations is strongly recommended. Members could also work with their electronic medical record (EMR) providers to see what the EMR's capabilities are as far as tracking or reminder functionality.

This ties in to the importance to ensuring patients understand the significance of an investigation and the importance of having tests done in a timely manner. When results are not received in a timeframe commensurate with the urgency of the health concern, members need to follow up with the patient to determine why the investigation has not been done and encourage them to do so as soon as possible. Any attempts to follow-up with the patient, including failed attempts, must be documented in the patient's record.

This is also an opportunity to encourage patients to obtain access to their own results through online portals such as MyHealth Records and MyAHS Connect. Being able to see their test results is an important way to help prevent results from slipping through the cracks, empowers patients in their own care and may be added incentive for some patients to complete tests in a timely fashion.

EXAMPLE SCENARIOS

Example 1:

You see a middle-aged, long-time female patient who is complaining about mild, non-specific upper abdominal pain without red flags to suggest urgent testing or treatment is required. Further information and examination does not point to a definite diagnosis. After discussing options with her, you order a CBC, liver enzymes and lipase, and recommend she go to the lab within the next few days.

You explain and document the reasons for your advice. Because you do not anticipate the results will require "follow-up in a timely fashion, urgently if necessary," you do not specifically track whether the result is received when expected.

Note: this would meet the CPSA expectations of a "reasonable physician," independent of whether the results of her tests are normal or critically abnormal.

Example 2:

You see a 67-year old man at the walk-in clinic who has noticed increased fatigue, approximately 5 kg weight loss and worsening shortness of breath over about 1-2

months. At the conclusion of your assessment, your differential diagnosis is still quite wide and includes COPD, tuberculosis, lung cancer, possible cardiac disease, etc. After discussing options with him, you order a chest X-ray and explain its importance to rule-out serious conditions, along with other tests.

You are unsure whether the clinic "has a system in place to track results when they are not received when expected" and write a message to the clinic manager and/or lead physician asking how to track this patient's test results, as well as how to contact the clinic's EMR vendor for support with this.

NON-COMPLIANT PATIENTS

If the importance of an investigation is explained to the patient, but they choose not to complete the test, this is not the member's responsibility. In these situations, it is vitally important to thoroughly document the conversation in the patient's record.

MISDIRECTED RESULTS

The nature of human error means investigation results are sometimes sent to the wrong healthcare provider (e.g., similar name) or location (e.g., a retired physician's former clinic). Members need to take reasonable steps to notify the lab, DI facility, etc. as soon as possible to ensure the results can be routed to the ordering healthcare provider. It is also common for members to by CC'd on an investigation for a patient who is no longer in their care.

While members are generally only responsible for following up on investigations they have ordered, there is a duty of care to make a reasonable attempt to rectify the situation, particularly where results are outside the "normal" range. CPSA acknowledges the administrative burden of responding to misdirected results, but this is an important step in reducing the risk of a patient "falling through the cracks."

Members could consider maintaining a record of when misdirected results are received and the action they took.

After-hours care

All members, regardless of practice specialty, must have an after-hours service to triage patients effectively to the appropriate services and before being sent to ER. Patients cannot be sent to ER as the default without an agreement with the ER: members would

need to send patients in accordance with the *Referral Consultation* standard (i.e., call ahead with pertinent information).

Responsibility for continuous availability is contextual. It does not apply to every regulated member who has ever had contact with a given patient, but only to those physician-patient relationships where there is a reasonable expectation of ongoing care (e.g., where there has been recent direction, a procedure performed or investigation). Starting a patient on a new medication, providing a therapeutic service, recent assessment, evaluation or treatment adjustment for a chronic condition are all relevant. For example, a regulated member who sees a patient for the first time at a walk-in clinic and provides the patient with a new medication must be available to respond to the patient about any concerns arising from the new medication. However, a regulated member is not expected to be continuously available to the patient when:

- they have not seen the patient for a prolonged period of time; or
- they see the patient for a diagnostic consult during which:
    - no medication is changed;
    - no investigations are ordered;
    - no procedures are provided; or
    - no other intervention is performed or recommended.

After-hours availability is primarily for triage purposes. It may be met directly (i.e., face-to-face) or indirectly (i.e., by phone). Particularly when addressing a colleague's patient through indirect means, if in doubt as to whether the concerns can be safely managed without patient contact, the regulated member should direct the patient to a location where full evaluation is available, either by the regulated member or a colleague. There will be times when it is best to direct the patient to an emergency service; this **does not** require a formal agreement. All regulated members have unique skills and experiences – a family physician in community practice has a different perspective on the need for acute interventions for a patient with chronic disease than an ER physician used to seeing more acute presentations; regulated members should take whatever action they feel is in the best interests of their patients, informed by their medical knowledge and experience. The

member must document the steps taken to communicate with the receiving healthcare provider or facility about the rationale for the decision to refer to the patient.

An option – not a requirement – of the standard is for a large group of regulated members to form a relationship with a service agency such as Health Link (this would be separate from and in addition to Health Link's availability to the public as a resource). Many groups have already identified Health Link as a valuable partner in facilitating timely triage and continuity of care. While CPSA considers Health Link an exemplar of this type of service in Alberta, this does not preclude the development of innovative alternatives. Indeed, Health Link does not have unlimited capacity and may not be the best option for all practice groups.

CPSA views these types of services not as an opportunity for regulated members to download their responsibilities but rather as partnerships where the parties collaborate to develop evidence-informed triage protocols and mechanisms for enhancing continuity of care that meet the expectations of both patients and regulated members. The acceptance of **mutual responsibilities** is key to a partnership that benefits both parties and, consequentially, patients as well.

Formalizing the relationship in a written agreement is best practice to ensure responsibilities are clear and transparent. If there is no written agreement, documentary evidence to confirming the agreement must be provided upon request (e.g., an email between colleagues, or a letter from the other party outlining coverage details).

EXAMPLES OF AFTER-HOURS COVERAGE OPTIONS

- Participation in a call rota (on-call rotation): solo practice is still an acceptable alternative; practice in isolation is not. Collaborating with colleagues to develop a call rota not only addresses patients' needs for 24/7 access to care (unreasonable for any one member to fulfill), but also creates the opportunity for increased collegiality, greater engagement by all physicians and better patient care.

- An agreement between a regulated member or practice group and healthcare provider or service: evidence of this agreement (e.g., an email) must be provided to CPSA on request.

- An arrangement with Health Link: before considering an agreement, Health Link requires regulated members to:

  - organize into a large clinical group (e.g., a PCN, specialty group provincially or by zone); and
  - identify and standardize across the clinical group:
    - a centralized point of contact for Health Link (e.g., single phone/fax number)
    - after-hours services the group will provide and the hours available
    - broad categories of calls the group will receive from Health Link after-hours.

- Have member(s) identified to take after-hours calls from patients referred by Health Link nurses (Note: an arrangement with Health Link does **not** relieve regulated members of the requirement to ensure their patients have access to care by a physician after-hours, for example through an on-call rota or after-hours clinic).

- Specialists only: be prepared to work collaboratively with Health Link on the development and application of evidence-informed assessment, triage and referral protocols to support Health Link nurses in providing effective advice to their patients.

- Have a system in place for receiving and responding to critical diagnostic test results. (Health Link is **not** able to manage diagnostic test results, and Health Link nurses do not have access to Netcare or other EMRs.)
  - Contact Health Link at healthlink@albertahealthservices.ca to inquire.
  - **Important note:** Health Link and AHS emergency services are available to all Albertans at all times, and the *Continuity of Care* standard is not intended to create a barrier to patients accessing these services. A regulated member who refers patients to Health Link or an AHS emergency service after-hours with no agreement in place **must also** provide direct contact information to themselves or an on-call physician to ensure timely response to urgent medical needs or critical test results.

When on-call for a group of colleagues during the day and/or after-hours, a regulated member is expected to be reasonably available and clearly communicate contact information to all those who might be expected to have a need to contact the member in this role.

- When handing over to a colleague providing coverage, let your colleague know of any special circumstances involving your patient population that might be expected to

result in a patient requiring continuity of care. Also, ensure your patients know when and how to contact your colleague; this shows respect for both your colleague and patients while ensuring excellent care.

- When requesting a lab test and you expect the result to be outside the reported normal range (e.g., potassium 5 to 6 in a patient with chronic renal failure, elevated WBC in a patient with CML), identify this on the requisition. A colleague covering for you or another provider assessing the patient will appreciate having this information.

- When directing patients to the ER or another facility such as an after-hours medical clinic, provide a courtesy notification to your colleagues to not only enhance care, but also relationships and professional respect as well.

Collaborating with colleagues offers a secondary opportunity for quality improvement arising from respectful feedback, shared experiences and mutual support, while the use of a service enables collaboration on the development of evidence-informed triage protocols. The time invested will pay dividends in time saved – both in process and enhanced patient care – and also assist the continued development of the shared patient record, as the IT infrastructure needed to support this will be dependent on such protocols.

Good communication is paramount to continuity of care. Regulated members are responsible for informing patients of after-hours care arrangements and to differentiate for them the types of medical issues for which they should seek after-hours care or when another means is more appropriate (e.g., timely follow-up). Providing clear guidance will help patients and all those involved in their care. If a patient in your practice consistently abuses reasonable processes to access care, it is your responsibility to inform the patient of their responsibility to be an accountable user of the healthcare system; such direction to a patient should be documented in the medical record.

CPSA COMMITMENT

CPSA recognizes that expecting regulated members to form call rotas with colleagues to address the need for continuity of care may be perceived as an affront to solo practitioners that does not respect unique environments. This is not the case. Rather, the intent is to encourage collaborative relationships that help our members balance the needs of patients with their own personal health.

CPSA is committed to working with members to support a level of awareness and implementation that finds the right balance. CPSA understands that physicians want to provide the best care for their patients, and the *Continuity of Care* standard is part of this

understanding. CPSA staff is available to discuss individual circumstances and help members identify how to adhere to the spirit of this standard.

As with all CPSA standards, failure to comply with this standard will be considered unprofessional behavior under Section 1(1)(pp)(ii) of the *Health Professions Act* (*HPA*), and any complaint will be managed as per *HPA* requirements. CPSA is primarily focused on quality improvement in managing complaints; however, repeated violations could result in a complaint being directed to a disciplinary hearing.

Team-based care environments

"Team-based care" is considered to be the provision of health programs and services by two or more healthcare providers who work collaboratively with patients and their circle of care to deliver coordinated, high-quality health service. For the purpose of this standard, team-based care requires processes outlining clear expectations for each team member's responsibilities and accountabilities[2].

When working in a team-based care environment, it is paramount to ensure there are processes in place to reduce risk of patient harm where review and follow up of investigation results are concerned. Miscommunication or lack of clarity regarding who is responsible for reviewing results or following patients puts patients at significant risk of falling through the cracks.

RESPONSBILITY FOR FOLLOW-UP

It is common practice for healthcare providers to carbon-copy ("CC") another healthcare provider on an investigation. However, it is important to note that doing so does not absolve the ordering provider of the responsibility to follow up with the patient, even in a team-based care environment.

Responsibility only transfers when another healthcare provider formally agrees to follow up with the patient (please refer to the *Transfer of Care* standard of practice for more information).

[2] From the Institute of Medicine's Core Principles & Values of Effective Team-Based Health Care discussion paper (October 2012).

Member absences

Regulated members are expected to have a process in place for receiving and responding to critical investigation results, both after hours and in the member's absence (e.g., illness, holiday). Please see the "After hours care" section for more information.

PATIENT NOTIFICATION

"Temporary absence" (clause 7 of the standard) is contextual. When a regulated member will be away from practice for a length of time that reasonably requires incoming information to be addressed in their absence, the member needs to make arrangements – verbal is acceptable, written ideal – with a colleague to review and triage the information (e.g., the results of an urgent radiological investigation).

Coverage arrangements also need to be communicated to any patient who has a reasonable expectation of care during the period of absence (e.g., the patient undergoing the urgent radiological investigation or a patient with an acute condition that requires close monitoring). For a stable patient who typically seeks care only once or twice a year, the requirement to communicate coverage arrangements might reasonably apply only if the member's absence will exceed six months.

CONTINGENCY PLANNING

Having a contingency plan in place will help mitigate risk of harm. Contingency planning involves identifying and monitoring the risks, vulnerabilities and capacities of your practice location(s)[3].

Members should consider access to patient records, clear messaging on office hours, and alternative sources of care and what patients should do in an emergency. Additional considerations include office staff and general office/business-related matters. Any correspondence that would normally come to a member's attention (e.g., phone messages, faxes, EMR alerts, consult reports, mail) must still be adequately addressed.

Contingency plans will look different based on whether a member works in a rural or urban setting. Members could work with colleagues in neighbouring towns or working with AHS or PCNs to ensure a plan is in place.

[3] From The World Health Organization's Guidance for Contingency Planning.

Ordering investigations in another healthcare provider's name

It is never acceptable to order an investigation in another healthcare provider's name, nor alter an investigation issued by another healthcare provider, without their knowledge and agreement. Since the "ordering" healthcare provider is responsible for reviewing and following up on investigation results, this puts colleagues in an untenable position in which they could be liable for a negative patient outcome. However, CPSA understands there are circumstances in which ordering under a colleague's name is necessary.

If a member finds themselves in the position of needing to order an investigation under another healthcare provider's name, they must also CC themselves **and** have evidence of an agreement with the healthcare provider to do so.

Agreements will differ from situation to situation and can be as simple as an email, but should generally include the names of the member who is ordering investigations, the healthcare provider whose name they are ordering under, and a clear acknowledge of who is responsible for follow up. Both healthcare providers should retain a copy of the agreement.

LOCUM COVERAGE

Depending on the length of coverage, it is possible that a locum physician may not have an EMR account set up to order investigations under their own name before they move on. It is unreasonable to prohibit them from ordering investigations and potentially puts patients at risk.

An agreement is needed in which the locum is granted permission to order in the name of the regulated member for whom they are covering **and** in which the regulated member (whose name is being used for diagnostic tests or referrals) formally acknowledges and accepts responsibility for all associated follow up once the coverage period ends.

POST-GRADUATE TRAINING PROGRAM PARTICIPANTS

An agreement is needed in which the resident physician is granted permission to order in the name of the supervising physician with whom they are practising **and** in which the supervising physician (whose name is being used for diagnostic tests or referrals) formally acknowledges and accepts responsibility for all associated follow up.

TEAM-BASED CARE ENVIRONMENTS

Ordering investigations under another healthcare provider's name must be done in accordance with clause (2) of the standard and the "Team-based care" section of this document.

A formal process, preferably in writing, is necessary to establish when diagnostic tests or referrals are ordered in the name of an identified healthcare provider or service **and** in which the identified healthcare provider or service accepts responsibility for all associated follow up.

Resources

Questions? CPSA team members are here to help. For more information, please email standardsofpractice@cpsa.ab.ca.

RELATED STANDARDS OF PRACTICE

- *Continuity of Care*
- *Episodic Care*
- *Patient Record Content*
- *Responsibility for a Medical Practice*
- *Transfer of Care*

COMPANION RESOURCES

- Advice to the Profession documents:
  - Continuity of Care
  - Episodic Care
  - Physicians as Custodians
  - Responsibility for a Medical Practice
- AMA's After-Hours Support for Continuity of Care
- CMPA's The Most Responsible Physician
- Health Link's FAQs for Clinical Groups