ALBERTA MEDICAL ASSOCIATION

After Hours Support for Continuity of Care

A few good ideas for meeting the Standard of Care

A. INTRODUCTION

In June 2015, the College of Physicians & Surgeons of Alberta (CPSA) released an updated Standard of Practice with respect to *Continuity of Care* (Appendix One), as well as a companion document *Advice to the Profession* (Appendix Two).

The standard was discussed at the spring 2015 meeting of the Alberta Medical Association (AMA) Representative Forum. Some members were concerned in particular with their ability to meet the requirements for continuity of care after hours.

A motion was passed calling on the AMA to work with the CPSA to provide more information for physicians about how to comply with the standard. Many physicians successfully do so and, by sharing their experiences, we hope to generate positive ideas for physicians who are seeking some suggestions for consideration in their particular circumstances.

What we did

To assist with this task, the CPSA contacted physicians with whom they had already had discussions about the standard. They were asked if they had best practices or tips that they would like to share with other physicians.

From that group we identified eight sample practices, attempting to provide a range of practice types:

- Practice types:
  - Four in group practices (from two to 20 physicians)
  - Four in solo practices
- Specialties:
  - General practice/family medicine
  - Orthopedic surgery
  - Otolaryngology
  - Pediatrics
  - Emergency medicine
- Office type:
  - Two fully hospital-based, no office
  - Two community-office-based
  - Three office based in hospital site
  - One office based in assisted living site
- Locations:
  - Calgary
  - Edmonton
  - Stony Plain
  - Fort McMurray/Fort MacKay
- Primary care network affiliation: four

B. SUGGESTIONS FOR MEETING THE STANDARD

The purpose of this document is to share what our eight sample practices are doing based on four scenarios/questions that arise from the standard of practice.

There is nothing revolutionary here. Relatively simple processes are being used in these particular practices to meet the standard of practice.

We recognize that no single solution will fit every situation. You may recognize some of your own current practices and be reassured. We hope that if you are concerned about your practice's compliance with the standard of practice, still other suggestions will point to a way forward.

Scenario 1: What happens when a patient calls your office after hours?

The requirements for this situation are covered in Section 1 of the Standard of Practice, particularly clauses 1(b) through 1(e).

Solo practice solutions:

- The physician's cell phone number, given directly to the patient or on the office answering system.
- Health Link number in addition to the physician's number.
- Referral to a PCN after-hours clinic. (If you are not a PCN physician, then you would need an agreement with your local PCN to do this.)
- Referral to local emergency department PLUS a phone number and directions to ask for specialist on call (for post-surgical patients). (This must also occur by formal agreement.)

Group practice hospital-based solutions:

- Refer to:
  - Nursing through the hospital (hospitalists and emergency medicine groups)
  - Answering service that connects the patient with an on-call physician.

Note that none of the respondents are involved in a formal, after-hours agreement with a healthcare provider or referral service, although that is an option suggested by CPSA.

Scenario 2: What happens when critical test results are received after hours or during an absence?

The requirements for this situation are covered in Section 1 of the Standard of Practice, particularly clauses 1(c) and Section 2.

Solo practice solutions:

- These physicians directly receive and follow up on critical test results themselves.
  - Most provide their cell phone numbers to all related services and staff.
  - One specialist solo practitioner provides a written note to the family physician, advising of an absence and whom to call should the result be critical or abnormal.

Group practice solutions:

- These groups work with their on-call physician, alerting him/her to the expected arrival of test results and the need to contact the ordering physician.
- In some cases, the alert is sent to hospital staff, e.g., nursing or a clinical associate.

Scenario 3: What do you do when patients do not understand what is "routine" vs. what can't wait for normal office hours?

Generally, respondents don't attempt to educate their patients or apply guidelines regarding what types of medical situations require immediate attention. The overall view is "better safe than sorry." Most patients, they say, have pretty good instincts pertaining to their own or their families' medical issues. There is concern that structured efforts to provide education aimed at preventing such contact will shift the focus (as one physician put it) "to becoming barriers instead of healers."

Responding physicians indicated that they felt abuse of their time after hours was rare or non-existent.

Scenario 4: If you are going to be unavailable/away for an extended period of time, how do you manage any issues to be addressed in your absence, such as the results of an urgent investigation?

The requirements for this situation are covered in Section 3 of the Standard of Practice.

A variety of approaches among the respondents utilize the same basic processes (in both group and solo practices as well as community- and hospital-based):

- Locums to cover the absent physician.
- Practice colleagues to cover the absent physician.
- Coverage by the absent physician using staff triage, direct patient contact or EMRs/web technology for alerts or monitoring.
- Coordinating physicians in an on-call group so a physician is available at all times.
- Relaying test results with discharge summary and transferring care to the community physician (and making the information available on Netcare).

When asked if they typically inform patients about pending absences and arrangements that are made for their continuity of care:

- Most respondents do not do so, because their practice partners, office staff, primary care clinic and other providers (e.g., pharmacist) assure continuity.
- One hospital-based physician reported that he informs his patients about who will take over and/or he outlines a roster of doctors who will be involved from the outset of the patient's stay.
- Prescriptions are provided ahead of time or, where geography and/or a collaborative relationship exist, patients are directed to local pharmacists for prescribing for a certain period with the physician available if necessary by phone for consultation.

C. WHAT WOULD YOU SUGGEST? WHAT HAVE YOU LEARNED IN PRACTICE?

If you and your colleagues have developed other solutions or have any learnings to share about solutions suggested in this document, please let us know. Email shannon.rupnarain@albertadoctors.org

If you would like to consult with CPSA regarding how well your existing practices comply with the Standard of Practice, please Email chantelle.dick@cpsa.ab.ca

APPENDIX ONE

College of Physicians & Surgeons of Alberta

Category: Physician-Patient Relationship
Under Review: No
Issued by Council (*After-Hours Access to Care and Preventing Follow-Up Care Failures*): January 1, 2010
Reissued by Council (*Continuity of Care*): June 11, 2015

Continuity of Care

The **Standards of Practice** of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

(1) A regulated member whose practice includes established physician-patient relationships[1] must:

(a) have a system in place to:

(i) review test results and consultation reports in a timely manner;

(ii) arrange any necessary follow-up care;

(iii) notify a patient of any necessary follow-up care; and

(iv) document all contacts with a patient, including failed attempts to notify a patient about follow-up care;

(b) directly provide or arrange for continuous after-hours care to be provided through an appropriate healthcare provider(s) and/or service with capacity to assess and triage care needs;

(c) ensure handover of relevant patient information to the after-hours healthcare provider(s) or service when a patient's need for after-hours care is reasonably foreseeable;

(d) inform patients how to access the after-hours care;

(e) if using a recorded message to direct patients to a healthcare provider or service such as but not limited to Health Link, an emergency service or after-hours medical clinic, have a written agreement with the identified healthcare provider or service; and

(f) notwithstanding subsection (1)(e), immediately refer a patient with an emergent or life-threatening condition to an appropriate emergency service if unable to render care.

(2) A regulated member must have arrangements in place for receiving and responding to critical diagnostic test results reported by a laboratory or imaging facility after regular working hours or in the regulated member's absence, which include:

(a) clearly identifying on the test requisition documents and informing the patient when the results are expected to fall in the critical range; and

(b) ensuring the laboratory or imaging facility is able to reach a regulated member or a regulated member's designate, either by:

(i) participating in a call rota available to the laboratory or imaging facility that identifies who to contact in the regulated member's absence and their direct contact information; or

(ii) providing direct contact information to the laboratory or imaging facility for the regulated member or the regulated member's designate.

(3) A regulated member whose practice includes established relationships with patients who is going to be unavailable for an extended period(s) of time must:

(a) enter into an agreement with an appropriate healthcare provider(s) and/or service to provide ongoing care during periods of unavailability and ensure handover at the start and conclusion of the coverage, including management of:

(i) outstanding tests and test results;

(ii) outstanding referrals and consultation reports; and

(iii) any follow-up care required as a result of the above;

(b) provide proof of this agreement to the College on request; and

(c) inform a patient of ongoing care arrangements where a patient would have a reasonable expectation of being informed.

[1] In an established physician-patient relationship, both the regulated member and patient have a reasonable expectation the care provided will extend beyond a single encounter. These relationships include, but are not limited to:

(d) longitudinal relationships, based on the identification of a regular attending physician or clinic; and

(e) sessional relationships for a defined period of time, based on a presenting concern(s), referred consultation or identified medical condition.

APPENDIX TWO

Continuity of Care

Related Standard of Practice: *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.

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CPSA Advice

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, those in walk-in clinics through to long-term care environments. 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.

1. Regulated members are expected to manage their practice (workload) to balance the best interests of their patients and their own health and well-being. The College acknowledges these interests may sometimes compete, but both need to be managed.
2. While primarily for triage purposes, assuring continuity of care through after-hours does, at minimum, require regulated members to manage some problems and conditions over the phone, even if just to triage to the right care environment.
3. Regulated members are required to have a system in place to assure continuity of care. Such a system may include:
    - 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), it also creates the opportunity for increased collegiality, greater engagement by all physicians and better patient care.
    - An agreement between a practice group and healthcare provider or service such as Health Link. Before pursuing such an agreement, the practice group should be well-organized and have consistent processes in place (including for after-hours access) and actively collaborate with the service in the development and application of assessment, triage and referral protocols. If an agreement is established, the collaboration should be ongoing – this is not a downloading of member continuity of care responsibilities, but rather a partnership where all parties share the obligation to balance the needs of patients and providers according to their scopes of practice.

Important note: Health Link and AHS emergency services are available to all patients at all times; this standard is not intended to create a barrier to patients accessing these services. Clause 1(f) allows discretionary referral to these types of services without an agreement; however, this does not absolve a regulated member of the responsibility to have a system in place that assures continuity of care.

4. 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.
5. Good communication is paramount to continuity of care. Regulated members are responsible to inform 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.
6. "Extended period of time" (clause 3 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 his/her 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.
7. Regulated members are expected to collaborate with colleagues in developing evidence-informed triage guidelines to help patients understand how best to access after-hours care.
8. The College will proactively enforce this standard with a quality improvement focus.

CPSA Perspective

The College perspective informs the advice and flows from these sections of the Code of Ethics:

1. Consider first the well-being of the patient.

Continuity of care enables the best care, in both primary and consultant environments. Both the patient and system benefit when the patient can access the right provider at the right time. Long waits in emergency rooms are reduced, patients worry less and the frustration of ER physicians is alleviated by the context provided by the primary provider or a colleague covering their practice.

The ethical responsibility of regulated members is fiduciary to one patient at a time. To suggest that extending this responsibility to after-hours care reduces the number of patients that can be seen and thereby increases waiting lists is not an acceptable reason to set limits on the care provided to an individual patient. While regulated members are encouraged to participate in strategies to address population health needs, this does not deflect their primary duty of care to the individual patient with a quality focus.

Regulated members have a role advocating for and taking reasonable steps to inform patients about how to access the healthcare system in relation to the care they provide.

19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.

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 (i.e., 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. Examples include:

- 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.

- A regulated member who has just operated on a patient should be available to answer questions relating to the surgical care rather than telling the patient to follow-up with their family physician (unless there is an agreed model of care supporting this between the physicians).

However, a regulated member who has not seen a patient for a prolonged period of time, or who sees a patient for a diagnostic consult during which no medication is changed, no investigations ordered, nor any procedure provided is not expected to be continuously available to the patient.

After-hours availability is primarily for triage purposes. It may be met directly (i.e., face-to-face) or indirectly (e.g., by phone). Particularly when addressing a colleague's patient through an 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.

An option (not a requirement) of the standard is for a 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 the College 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.

The College 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, too. The standard recommends formalizing such relationships in written agreements so responsibilities are clear and transparent.

52. Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect.

While the allocation of medical service fees and healthcare system resources are both outside the scope of the College, we expect our members to collaborate with each other and the system. Working together as a collective focused on patient care allows for optimal distribution of resources in a fair and just manner.

Govern your actions by what you would want to know if you were your colleague. For example:

- 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, if you expect a "normal" result for your patient will likely 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.

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.

As noted earlier, adequately informing patients about how to appropriately access healthcare services is part of the role of a regulated member. If a patient in your practice consistently abuses reasonable processes to access care, it is your responsibility to inform the patient of his/her responsibility to be an accountable user of the healthcare system; such direction to a patient should be documented in the medical record.

54. Protect and enhance your own health and well-being by identifying those stress factors in your professional and personal lives that can be managed by developing and practicing appropriate coping strategies.

The College considers participating in a call rota with colleagues to be an appropriate coping strategy to address the expectation of continuity of to care. A regulated member in solo practice is expected to identify colleagues to set up a call rota and assure after-hours availability is sustainable. While 24/7 availability is unreasonable for any individual member and also not good for patients, deferral to "the system" is also unacceptable.

A solo specialist practitioner in a rural setting is expected to identify reasonable coverage alternatives for the unique circumstances of his or her practice. Options may include an identical specialist in a geographically separate location, a similar but not identical specialist nearby, or a local family physician with a practice interest in the specialist's discipline. Other members of the care team, such as nurse practitioners or physician assistants, may also be involved where relevant. When geographically separated, the expectation is individual practitioners will identify for colleagues the resources available locally; maintaining this information will also benefit the regulated member and his/her staff. Good communication is essential.

CPSA Commitment

The College 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.

The College is committed to working with members to support a level of awareness and implementation that finds the right balance. The College understands that physicians want to provide the best care for their patients and the Continuity of Care standard is part of this. College staff is available to discuss individual circumstances and help members identify how to adhere to the spirit of this standard.

As with all College 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. The College is primarily focused on quality improvement in managing complaints; however, repeated violations could result in a complaint being directed to a disciplinary hearing.