# Standard of Practice

# Episodic Visits, House Calls, and Walk-in Primary Care

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Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All members must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

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## PREAMBLE

CPSM has responsibility to set standards and policies that result in high quality care for patients regardless of their point of contact with registrants in the health care system. For reasons of lack of access or convenience of hours, patients often turn to episodic services such as walk-in or ''no-appointment'' visits in clinics. Registrants are expected to manage these episodic encounters to provide optimal continuity of care for patient safety. CPSM recognizes that geographic impediments to accessing continuous primary care from registrants may exist for distant rural and remote and First Nations communities and that episodic and walk-in treatment may be the only medical care available.

The *Code of Ethics and Professionalism* provides the ethical basis for this Standard.

> *2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.*

## DEFINITIONS

**Episodic Care** refers to an isolated primary care medical encounter with a patient focussed on presenting concern(s), identified medical conditions(s), where neither the registrant nor the patient have the expectation of an ongoing general primary care relationship.

**Walk-in Clinic** refers to medical practices that provide care to patients where there may be no existing association between the patient and the practice, where there may be no requirement to book appointments, and where the care provided is generally, although not always, episodic in nature. **House Calls** refers to a medical encounter performed while visiting the patient's home (or property where residing including hotel, shelter, or temporary lodgings)

## PART 1. APPLICATION

1.1 This Standard applies to primary medical care provided through episodic care, walk-in clinics, and house calls (including episodic care clinics such as sports medicine clinics, minor injury clinics, Public Health Clinics including for Sexually Transmitted Infections, Contraceptive Clinic etc.).

1.2 This Standard does not apply to care provided in:

- 1.2.1. hospital or institutional settings.
- 1.2.2. long-term care facilities such as personal care homes.
- 1.2.3. palliative and end-of-life care, including medical assistance in dying.
- 1.2.4. consultations with specialists. Standard of Practice Collaborative Care
- 1.2.5. travel medicine clinics.

## PART 2. STANDARD OF CARE

2.1. Registrants must provide the same standard of care to patients appropriate to the clinical circumstance irrespective of the practice setting in which such care is provided and irrespective whether the patient is, or is not, a regular patient of the clinic where the registrant works.

2.2. Registrants must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner. For example, registrants practising in a walk-in clinic must conduct any assessments, tests, or investigations that are required for them to appropriately provide treatment. Registrants must also provide or arrange for appropriate follow-up care in the clinical circumstance.

2.3. Registrants who limit the care or services they provide due to the episodic nature of their care must only do so in good faith[1].

2.4. Registrants must communicate any limitations of episodic care to patients in a clear and straightforward manner; and communicate appropriate next steps to patients, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care.[2]

## PART 3. PRIMARY CARE PROVIDER

3.1. Patients must be asked if they have a primary care provider who they currently see for care and, if able to provide a name and clinic, both must be recorded on the patient's record.

3.2 The registrant must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider where:

- the patient consents and
- using clinical judgment, it is reasonable to expect the information in the copy or summary will be useful to the primary care provider for the ongoing care of the patient or if requested by the patient. [3]

## PART 4. SUPPORTING PATIENTS

4.1. If primary care providers are present in the community, registrants must use their professional judgment to determine whether it would be appropriate to advise patients:

4.1.1. That there are differences between episodic care and care that is provided as part of a sustained primary care provider-patient relationship; and

4.1.2. About the benefits of seeing their primary care provider for care or encouraging them to seek one out, if they don't already have one.

[1] For example, a sports medicine physician may limit care to musculoskeletal conditions, or a family physician may limit pre-natal care if that is not within their scope of practice. However, no general family physician can refuse to treat patients in pain or with common chronic conditions.

[2] Special consideration should be taken for patients that might experience difficulties in such communication, including those with intellectual disabilities, limited English (or other same language), or patients with a mental illness that might limit effective communication.

[3] An exception exists for treating 2SLGBTQ+, birth control, or other sexual health matters that the patient may want to be private.

4.2. The patient's choice in obtaining episodic, house calls, or walk-in care must be respected.

## PART 5. CONTINUITY OF CARE AND/OR FOLLOW-UP CARE

5.1. A registrant must generally assume responsibility for medical care and provide medical follow-up to investigations, diagnosis, treatment, and test results (whether critical or other) for that encounter in accordance with the provisions in the Standard of Practice for Good Medical Care and subject to the care being within their scope of practice.

5.2. A registrant providing care must not rely upon the patient's primary care provider or other health care provider involved in the patient's care to provide or coordinate follow-up for tests they have ordered or referrals they have made, unless the other provider has agreed to assume responsibility.

5.3. Notwithstanding the above 5.1 and 5.2, for chronic disease medical encounters:

5.3.1. if the patient has a family doctor/primary care provider, provide the necessary short-term care and refer them back to the family doctor at the earliest possibility.

5.3.2. if the patient does not have a family doctor/primary care provider, then initiate treatment of the chronic disease and support the patient in accordance with section 4.1, including advising the patient to seek a family care provider. The registrant is not required to take the patient on into their family practice.

## PART 6. PRESCRIBING

6.1. To mitigate risk of harm as appropriate using clinical judgment, registrants must use reasonable efforts (recognizing there may not be internet connectivity throughout the province) to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN.

6.2. Registrants prescribing opioids, benzodiazepines, and Z-drugs, and authorizing cannabis must comply with the relevant *Standard of Practice for Prescribing Opioids*, the *Standard of Practice for Prescribing Benzodiazepines and Z-Drugs*, and the *Standard of Practice for Authorizing Cannabis for Medical Purposes*.

## PART 7. VIRTUAL EPISODIC AND "WALK-IN" CARE

7.1. The Standard of Practice for Virtual Medicine is applicable to virtual episodic and walk-in care, in so far as possible.

# Contextual Information and Resources

# Episodic Visits, House Calls, and Walk-in Primary Care

The Contextual Information and Resources are provided to support members in implementing this Standard of Practice. The Contextual Information and Resources do not define this Standard of Practice, nor should it be interpreted as legal advice. It is not compulsory, unlike a Standard of Practice. The Contextual Information and Resources are dynamic and may be edited or updated for clarity, new developments, or new resources at any time.

## FOLLOW UP CARE

If your patient requires follow-up for their medical condition, the expectation is to follow them for that one condition and only until addressed or stable or another primary care provider takes over. The expectation is not to take that patient on in your general family practice. The care must be within your scope of practice.

Typical clinical treatments that would not normally require follow up care includes generally healthy individuals with simple UTIs, flu/colds, minor traumas, contact dermatitis. Examples of more difficult cases that would generally require follow up care include instances where the diagnosis is unclear such as abdominal pain or fatigue; requests for refills of medications where the underlying chronic condition is poorly controlled; diagnosing and initiating pharmacologic treatment for anxiety and/or depression. Follow-up would also include where there are abnormalities found in diagnostics that flow from the episodic encounter, including incidental findings such as cardiomegaly or pulmonary nodule seen on a chest x-ray ordered to assess pneumonia.

The transfer back to the primary care physician does not require a formal referral. It may be an informal email, phone call, text.

## PATIENT DOES NOT HAVE A FAMILY PHYSICIAN

Many patients do not have a family physician or other primary care provider such as a Nurse Practitioner. There is nothing in this Standard that requires you to become their family doctor. Similar to the follow-up care, you are to provide follow-up care for that particular medical condition and only until addressed or stable or another primary care provider assumes responsibility. This might mean a few visits to stabilize diabetes, it does not require longitudinal care for diabetes. Similarly, a prescription to treat COPD may not require further treatment of COPD where the patient is not experiencing a current exacerbation, though part of good medical care requires counselling the patient about the importance of smoking cessation in the management of their illness.

## SPORTS MEDICINE

CPSM recognizes that sports medicine clinics are created to provide focussed primary and referral based musculoskeletal care by leveraging i) specialized infrastructure, ii) close working relationships with specialists including orthopedics and physical medicine, iii) expertise of primary care physicians with an additional competency.

Sports medicine doctors should limit their care to their scope of practice and what is in their knowledge, skill, and judgment. As one example, while blood pressure may be taken in the work up for low back pain, and the patient found to be moderately hypertensive, the sport medicine physician is not responsible for the treatment or further investigation and management of hypertension. Rather, the sports medicine physician should advise the patient to attend to their primary care provider or another general family doctor for further investigation and management. Sports medicine physicians may not be practicing outside of this defined scope and this Standard is not intended to have them practice within the wide-ranging scope of a family medicine practice.

## RAAM CLINICS

Rapid Access to Addiction Medicine (RAAM) Clinics are specifically designed as easy access walk-in clinics for people seeking care related to substance use without an appointment or referral. RAAM clinics provide addiction medicine assessments and temporary substance use disorder care until patients can be connected to an appropriate long-term care provider, including their family physician or primary care provider. RAAM clinics do not provide general primary care, nor management of acute or chronic pain, or mental health concerns in the absence of addiction. The Standard does apply to the care provided in RAAM Clinics and the follow-up and continuity of care provisions only apply to addiction medicine.

## HYBRID CLINICS or EPISODIC CARE WITHIN THE SAME CLINIC

Many clinics offer both general family practice and episodic care/walk-in care. This Standard applies only to the episodic/walk-in care provided in that clinic.

Many true group family practices permit walk-in appointments limited to the patients of that group practice. In that instance, follow-up care should be provided by the regular family doctor, but the transfer of care must still be accepted to ensure continuity of care. The notification must be more than a flag in an EMR – it can be a message through the EMR messaging system to accept care and follow-up.

## NORTHERN REGIONAL HEALTH AUTHORITY

The NRHA has the unique advantage of having its own EMR connecting all NRHA run clinics and private clinics through an agreement so patient information is easily shared and accessed throughout the NRHA. Additionally, due to the geography, climate, and remoteness of many communities with no resident physician, a group shared practice may exist in some communities with rotating physicians. For registrants located and practicing in the NRHA CPSM recognizes the unique practice setting and patient demographics in the application of this Standard and the expansive definition of a group practice setting. As always, good medical care is required.

## SEARCHING DPIN OR eCHART

The requirement for a DPIN or eChart search for other prescriptions is "as appropriate". This means using your clinical judgement and what is reasonable in the circumstances. Depending upon the medical condition of the patient, their co-morbidities, the patient's ability to recount their medical history, the drugs under consideration for prescription, and additional factors, good medical care may require a review of all other prescriptions. Any prescription for opioids and benzodiazepines requires a review of the DPIN or eChart in accordance with those Standards of Practice. There are many instances when there will be no need to review the prescribing history such as for antibiotics in an otherwise healthy patient.

For patients travelling into Manitoba, a call to their home pharmacy in another province or state may be required, depending upon the above factors.

CPSM recognizes that internet connectivity is not always possible, and you may wish to note that in the chart if this poses an issue.

## LOCATING THE PRIMARY CARE PROVIDER

To assist in locating the primary care provider and address, eChart provides a primary care provider tab. Once logged into eChart, selected the "clinical Documents" header from the top portion of the screen. Next, click on the "+" sign to the left of "Primary Care Home Clinic" folder. This will allow you to see the name and practice location of the patient's primary care provider if they are currently enrolled with one in the province. Your office can search that to assist or prompt the patient if they are experiencing memory difficulties.

## RESOURCES

CMPA "Walk-In Clinics: Unique Challenges to Quality of Care, Medical-Legal Risk"