



PATIENT'S MEDICAL NEIGHBOURHOOD

IMPLEMENTATION KIT

New Brunswick College of Family Physicians



THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA



Centre for Effective Practice

THE NEW BRUNSWICK
COLLEGE OF
FAMILY PHYSICIANS



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU NOUVEAU-BRUNSWICK

A CHAPTER OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
UN CHAPITRE DU COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

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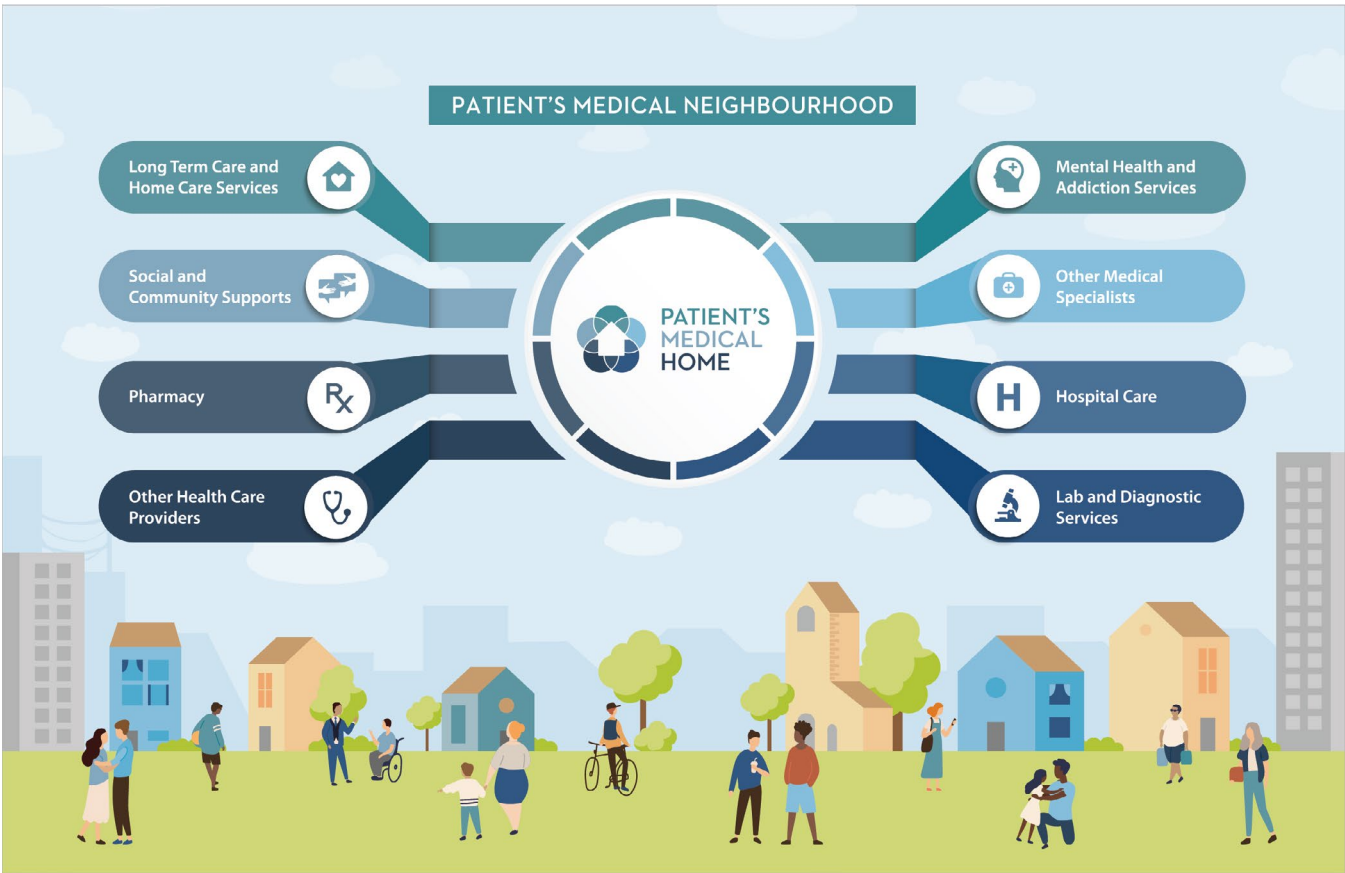
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The Patient’s Medical Home (PMH) is the vision for the future of family practice in Canada put forward by the College of Family Physicians of Canada (CFPC).¹ The PMH emphasizes the role of the family practice and team-based care in providing high-quality, compassionate, and timely care. However, family practices are not the only settings involved in a patient’s care.

The concept of the Patient’s Medical Neighbourhood (Neighbourhood; Figure 1) takes this idea of team-based care in the PMH further to describe and reinforce a network of care involving multiple providers and services outside of the clinic.

Figure 1. The Patient’s Medical Neighbourhood. The services shown here are not exhaustive but indicate the types of broad health services found in a Neighbourhood connected with a PMH.



Within this model, the PMH acts as a hub for coordinating care within the Neighbourhood. The Neighbourhood includes the many realms of health care outside of primary care, such as referrals to other medical specialists, health care providers, hospital, long-term care, and home care structures or broader social and community supports such

as community-based mental health and addictions supports and other social services. Within New Brunswick, the Neighbourhood vision aligns with the Primary Health Care Steering Committee’s recommendation for enhanced community-specific team-based care, as per the Primary Health Care Framework for New Brunswick.²

This Implementation Kit has been collaboratively designed by the CFPC and the New Brunswick College of Family Physicians, and is intended to complement the CFPC's Best Advice guide for the Patient's Medical Neighbourhood.³ The kit is organized around a number of tangible actions you can take right now to further align your practice with the Neighbourhood vision, without relying on systemic change or more resources (e.g., financial, human resources):

- Get to know your patients' health care needs and preferences
- Connect your patients to community resources
- Build interprofessional relationships to provide more continuous care

- Leverage digital health and virtual care to enhance your practice

If you and your clinic team are implementing the Neighbourhood principles in your practice, the steps outlined in this kit will help. If you are just beginning to implement the more foundational PMH principles in your practice, you may wish to consult the steps outlined in the Patient's Medical Home Implementation Kit for New Brunswick before consulting this kit.⁴

The following list of resources is not exhaustive. Resources are hosted by external organizations, and as such the accuracy and accessibility of their links are not guaranteed.

Get to know your patients' health care needs and preferences

Knowing the breakdown of your patient population (e.g., age, social determinants of health), what health concerns are most relevant to each patient group, their satisfaction with the level of care they receive, and what supports they need will help to inform your practice organization. Particular attention should be paid to individuals with different needs or who experience challenges accessing care, such as people with disabilities, multiple comorbidities, and/or members of LGBTQ+, immigrant, or racialized communities.

Learn more about your patient panel and find opportunities to enhance your knowledge of your patients' health needs

1. Add and use screening tools to obtain more detailed information about your patients' health and access to services. Tools are available through the following organizations to enhance patient screening:
 - » *Poverty: A Clinical Tool for Primary Care Providers in New Brunswick: A primary care tool for screening and supporting patients' living situation and socioeconomic concerns as part of their overall health*⁵

- » Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Primary Care (BETTER): Evidence-based recommendations for chronic disease prevention and screening including an algorithm for targets and care pathways adjusted for diabetic and non-diabetic patients⁶
- 2.** Leverage municipal, provincial, and national health indicator data to better understand your community's overall health needs:
- » My Community at a Glance 2017: A set of 33 community profiles in New Brunswick providing information on demographics, health determinants, and health outcomes developed by the New Brunswick Health Council (NBHC)⁷
 - » Communities, Health Zones, and NB: A database of population health and health system quality indicators developed by the NBHC that is searchable by community⁸
 - » Your Health System: A set of interactive tools that allow users to view regional health indicator data from across the country, developed by the Canadian Institute for Health Information⁹

Improve your ability to care for individuals who are members of LGBTQ+, immigrant, or racialized communities

- 3.** Complete self-assessments to determine the extent to which you and your clinic provide culturally competent care.
- » Promoting Cultural and Linguistic Competency: A self-assessment checklist for primary care providers to assess the cultural competency of their physical office environment, communication skills, and attitudes¹⁰
 - » Is Your Space Positive?: A self-assessment to help you make your organization more inclusive to people of all sexual orientations and gender identities¹¹
- 4.** Consult the fact sheet developed by the CFPC's Indigenous Health Committee to better understand the role that systemic racism can play in shaping an Indigenous patient's clinical experience, and what you can do better to help address this.¹²
- 5.** Consult the Safer Places Toolkit, a comprehensive resource developed by Alberta Health Services that provides physicians and their staff with tips to increase awareness, encourage self-reflection, and build skills to create more welcoming and safer care for LGBTQ+ patients and their families.¹³

Learn more about your patients' care preferences and experiences

6. Use existing patient experience surveys to better understand where your practice can improve:
 - » Health Quality Ontario's Patient Experience Survey and Support Guide^{14,15}
 - » Saskatchewan Health Quality Council's primary health care survey¹⁶
7. Create an anonymous comment box for your waiting room and an anonymous form for your practice website, placed in locations that are easily found by your patients, and set up a process to regularly review what comes in.

Connect your patients to community resources

Connecting your patients to appropriate community resources can improve their overall health and well-being by addressing their social determinants of health. Understanding which community resources are available to your patients will help you to tailor your approach to each patient's specific needs.

Learn more about the community resources available to you and your patients that can improve their overall health and well-being

1. Direct your patients to resources from the Saint John Human Development Council, which provides a searchable database of government and community resources in New Brunswick.^{17,18} Region-specific databases are also available for those living in the Saint John, Charlotte County, and Fredericton regions.^{19,20,21}

Build in-house knowledge of available community resources

2. Create internal documents to keep track of community resources that you consider part of your Neighbourhood. The Health Commons Solutions Lab has developed tools to help you achieve this:
 - » Create an online database of community resources, and/or a Google map of community resources, using the Community Map Prototype and Database tool²²
 - » Ask other service providers (i.e., your Neighbours) to confirm or complete details about their services using the Community Resource Cards tool²³
3. For additional templates of internal documents for your Neighbourhood, consult the Appendix of the CFPC's Best Advice guide.³
4. Consider making certain members of your staff responsible for maintaining internal documents and contacts with other service providers in your Neighbourhood.

Build interprofessional relationships to provide more continuous care

Relationships between your clinic (i.e., the PMH) and other service providers (i.e., Neighbours) are the foundation of a successful Neighbourhood. Signing collaborative care agreements that clearly delineate Neighbours' responsibilities and expectations can help to formalize these relationships and increase continuity of care by streamlining communication and referral processes.

Develop collaborative care agreements with other service providers in your Neighbourhood

1. Ask service providers to whom you regularly refer about how they view their relationship with your practice. Determine whether they would like to formalize their participation in the Neighbourhood.
2. Collaborative care agreements should be tailored appropriately to your practice, the service provider you are working with, and your patient population. Components of successful collaborative care agreements include:

- » Specific details about what information is required to make an effective referral
 - » Referral platform(s) to use for communicating requests
 - » Expectations about communicating the urgency of a request
 - » Expectations for ensuring timely access to consultations and appointments, and sharing results
 - » What digital health functions are available and how they will be used to coordinate patient care
 - » Outline of each party's roles and responsibilities in managing patient care
- 3.** Use the following examples of interprofessional agreements as guides for building your own collaborative care agreements:
- » **Sample Care Coordination Agreement:** An example of a collaborative care agreement outlining the expectations of family physicians and other specialist practices (Neighbours) developed by the American College of Physicians²⁴
 - » **Referral-Consultation Process:** A guideline for standardizing referral processes developed by the College of Physicians and Surgeons of British Columbia.²⁵ The guideline's appendices provide templates for referral requests and confirmations.
 - » **Referral Agreement Between Practice A and Practice B:** A modifiable referral agreement between a primary care practice and other specialist practice developed by Accountable Health Partners²⁶
- 4.** In instances where a collaborative care agreement is not being developed (e.g., if either party is uncomfortable with signing), focus on building and maintaining relationships. Tools from the Health Commons Solutions Lab can help:
- » Ask other service providers to confirm or complete details about their services using the Community Resource Cards tool or Provider Profile Cards tool^{23,27}

Leverage digital health and virtual care to enhance your practice

Digital health tools are invaluable resources for developing an effective Neighbourhood. Leveraging available tools can help you to streamline communication and referral processes between you and your Neighbours, improve the management of your patient panel, make it easier to communicate with your patients, and improve your ability to conduct quality improvement initiatives within your practice.

Use digital health tools to provide virtual care and communicate more effectively with your patients

1. Consult the Virtual Care Toolkit, a comprehensive tool kit developed by the Doctors of BC that provides detailed advice on topics such as virtual care workflows, available technologies, and patient communication.²⁸
2. Complete the Essentials to Getting Started with Virtual Care Checklist, a concise checklist of steps to follow before you engage in virtual care.²⁹
3. Consult the Accelerating Change Transformation Team (ACTT)'s electronic medical record (EMR) tip sheets for providing virtual care using select EMRs (Wolf; Med Access; Healthquest; Accuro; PS Suite).³⁰

Use digital health tools to start or improve management of your patient panel

4. The ACTT has developed multiple resources to aid in panel management:
 - » Panel Processes Change Package: A comprehensive tool kit for panel management that provides tools for identifying patients on the panel, maintaining panel processes, and optimizing care management of patients on the panel³¹
 - » Panel Maintenance Tool: A tool to help clinics develop and assess their own processes for maintaining panel lists³²
5. Use the Health Commons Solutions Lab's Panel Management Tool to learn how to generate a patient list from three EMRs (Telus PS Suite, Accuro, and OSCAR).³³

Use digital health tools to conduct performance measurement and research projects in your practice

6. Consult the Patient's Medical Home Implementation Kit for New Brunswick for advice on starting quality improvement projects that are manageable in scope and size for your practice.⁴
7. Consult the New Brunswick Health Council website to learn about current quality improvement initiatives in New Brunswick.³⁴

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