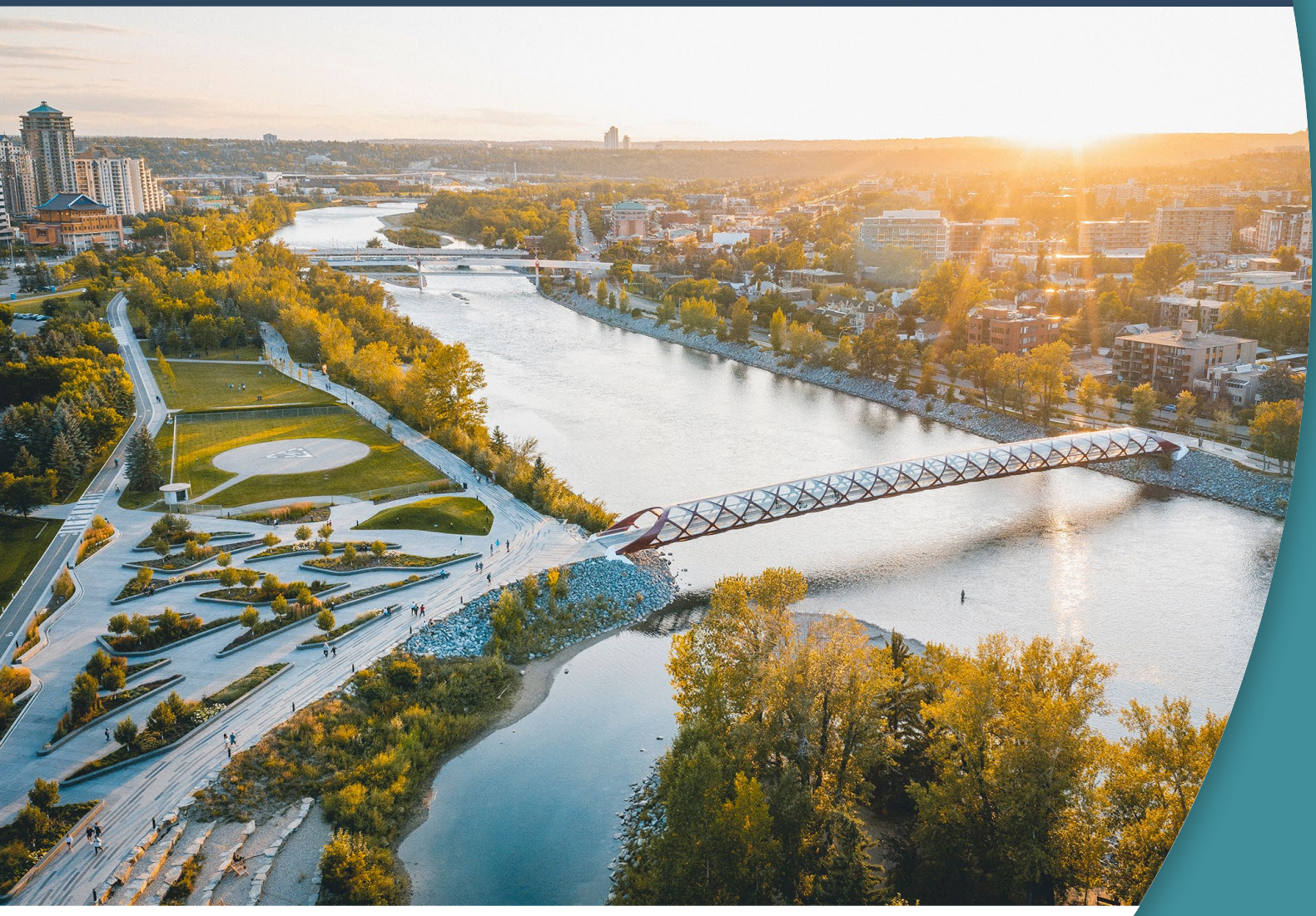
PATIENT'S MEDICAL NEIGHBOURHOOD

IMPLEMENTATION KIT

Alberta College of Family Physicians



THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
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Centre for Effective Practice

Alberta College of Family Physicians

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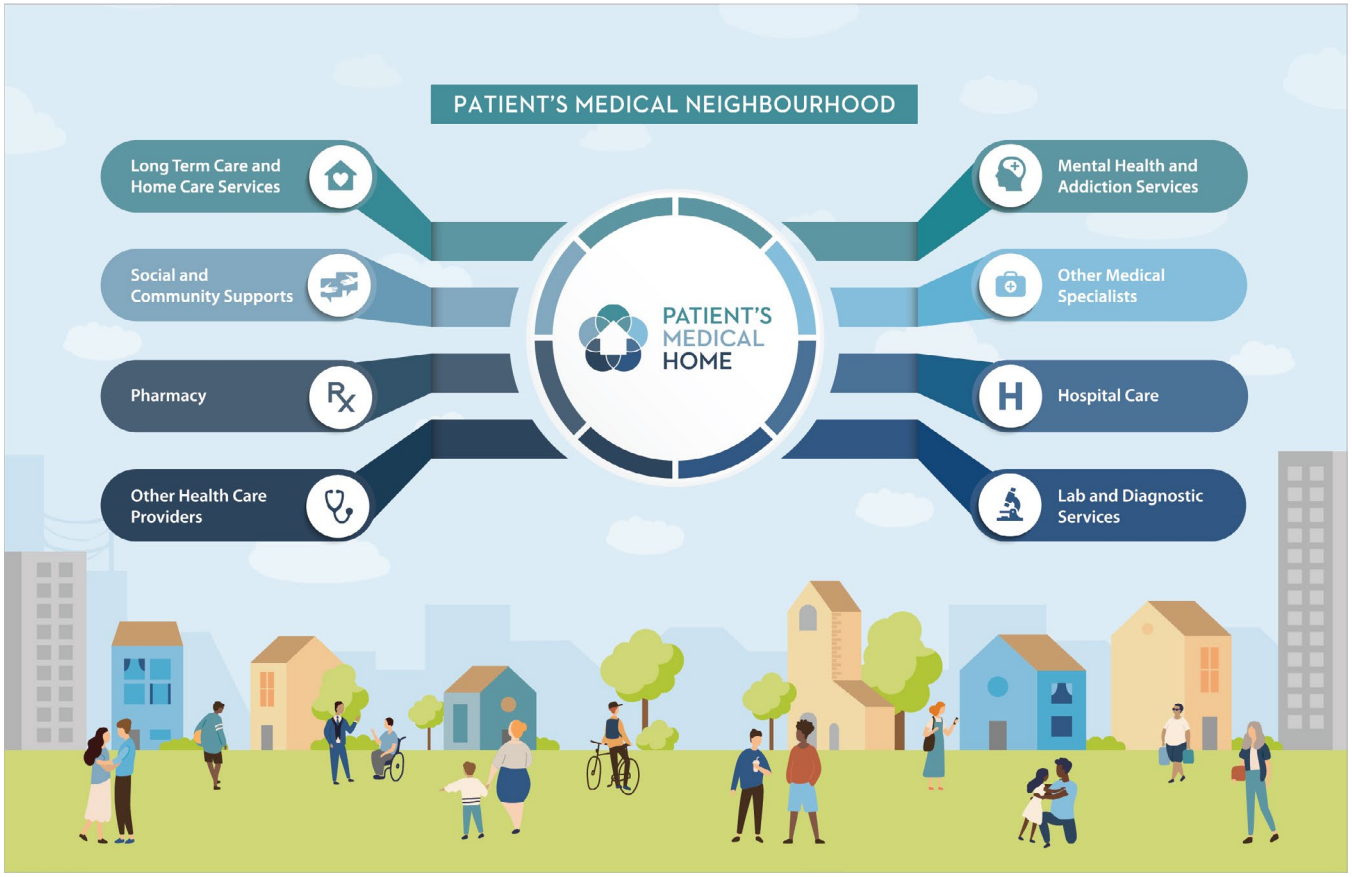
The Patient's Medical Home (PMH) is the vision for the future of family practice in Canada put forward by the College of Family Physicians of Canada (CFPC).[1] The PMH emphasizes the role of the family practice and team-based care in providing high-quality, compassionate, and timely care. However, family 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. In Alberta, primary care networks (PCNs) have evolved to better align with the PMH vision.[2] New initiatives, such as the Primary Health Care Integration Network, will help PCNs to further encompass the Neighbourhood principles of system integration and continuity of care.[3]

This Implementation Kit has been collaboratively designed by the CFPC and the Alberta College of Family Physicians (ACFP) and is intended to complement the CFPC's Best Advice guide for the Patient's Medical Neighbourhood.[4] 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 working to implement the Neighbourhood principles in your practice, the steps outlined in this kit will help you do that. 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 Alberta PMH Implementation Kit before consulting this kit.[5]

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. You can find citation details—including document titles and website links—in the References section at the end of the document.

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 on 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 Alberta*: A primary care tool for screening and supporting patients' living situation and socioeconomic concerns as part of their overall health.[6]

» 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 patients.[7]

2. Leverage provincial and national health indicator data to better understand your community's overall health needs:

» Interactive Health Data Application: An interactive tool developed by Alberta Health that contains health indicator data for topics such as demographics, mortality, chronic and infectious disease, and children's health.[8,9] Data can be filtered based on geography and may be presented as a map or graph.

» 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 Information (CIHI).[10,11]

Improve your ability to care for individuals who are members of vulnerable and marginalized populations, such as those with chronic conditions, as well as 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 attitudes[12]

» Is Your Space Positive?: A self-assessment to help you make your organization more inclusive to people of all sexual orientations and gender identities[13]

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.[14]

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.[15]

Learn more about your patients' care preferences and experiences

6. Use the Health Quality Council of Alberta (HQCA)'s Primary Care Patient Experience Survey. To participate, clinics or PCNs need to sign up with the HQCA so their patients can participate in the survey.[16]

7. Use patient experience surveys from other jurisdictions that do not require sign-up to better understand where your practice can improve:

   - » Health Quality Ontario's Patient Experience Survey and Support Guide[17,18]
   - » The Saskatchewan Health Quality Council's Primary Health Care Survey[19]

8. 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 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 211 Alberta, an online database of government, health, and social services that can be searched by location and/or category (e.g., food and clothing, employment).[20] This service is also available by telephone (dial 2-1-1).

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 tool[21]
    - » Ask other service providers (i.e., your Neighbours) to confirm or fill out details on their services using the Community Resource Cards tool[22]
3. For additional templates of internal documents for your Neighbourhood, consult the Appendix of the CFPC's Best Advice Guide.[4]
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 Patient's Medical Neighbourhood. Signing collaborative care agreements that clearly delineate Neighbours' responsibilities and expectations can help 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
- » Digital health functions that are available and how they will be used to coordinate patient care
- » An 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 specialist practices (Neighbours), developed by the American College of Physicians[23]
- » Referral-Consultation Process: A guideline for standardizing referral processes, developed by the College of Physicians and Surgeons of British Columbia.[24] 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 Partners[25]

4. Focus on building and maintaining relationships in instances where a collaborative care agreement is not being developed (e.g., if either party is uncomfortable with signing). Tools from the Health Commons Solutions Lab can help you achieve this:

- » Ask other service providers to confirm or fill out details about their services using the Community Resource Cards tool or Provider Profile Cards tool[22,26]

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 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 improve integration, referral and consultation processes with other service providers in your Neighbourhood

1. Leverage the eReferral program, which allows Alberta Netcare users to create, submit, track, and manage referrals with other specialists throughout the province. Consult the Getting Started guide to begin using the program.[28]

2. Enroll in CII/CPAR, Alberta's technical enabler for sharing health care information between family physicians and other health care providers in the Neighbourhood.[29] The Accelerating Change Transformation Team (ACCT) has developed a series of primary care tools and resources to help you optimize your participation in CII/CPAR.[30]

3. If you are practising in an Edmonton or North zone PCN, use ConnectMD, a program that connects family physicians with over 30 local specialty groups for routine patient advice over the phone.[31] For more information, refer to their Family Physician FAQ.[32]

4. If you are practising in the Calgary area, use Tele-Advice, a service developed by Specialist LINK in which family doctors are connected to other specialists via telephone.[33] It is available Monday to Friday, from 8:00 a.m. to 5:00 p.m., and calls are returned within one hour.

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

5. The Accelerating Change Transformation Team (ACCT) 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 panel[34]

    - Panel Maintenance Tool: A tool to help clinics develop and assess their own processes for maintaining panel lists[35]

6. Sign up for the free Primary Healthcare Panel Reports from the HQCA, which provide detailed information on topics such panel characteristics, chronic conditions, and pharmaceuticals.[36] Physicians who are participating in CII/CPAR are automatically sent a report that is based on their confirmed patient list from CPAR.

7. Use the Health Commons Solutions Lab's Panel Management Tool to learn how to pull a patient list from three EMRs (Telus PS Suite, Accuro, and OSCAR).[37]

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

8. Leverage resources from the Alberta Medical Association as you implement virtual care in your practice:

- » Virtual Care Toolkit: A comprehensive tool kit adapted for Alberta from the Doctors of BC's tool kit, providing advice about virtual care workflows, available technologies, patient communication tips, and more[38]
- » Essentials to Getting Started with Virtual Care Checklist: A concise checklist of steps to follow before you engage in virtual care[39]

9. Consult the Accelerating Change Transformation Team's EMR tip sheets for providing virtual care using select EMRs (Wolf, Med Access, Healthquest, Accuro, or PS Suite).[40]

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

10. Consult the *Patient's Medical Home Implementation Kit: Alberta* for advice on starting quality improvement projects that are manageable in scope and size for your practice.[5]

11. Consult the HQCA website to learn about current quality improvement initiatives in Alberta.[41] The HQCA's Quality Exchange contains inspiring initiatives that have been undertaken by practices within the province. [42]

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