PATIENT'S MEDICAL NEIGHBOURHOOD

IMPLEMENTATION KIT

British Columbia College of Family Physicians

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Centre for Effective Practice

BC COLLEGE OF FAMILY PHYSICIANS
The home of family medicine

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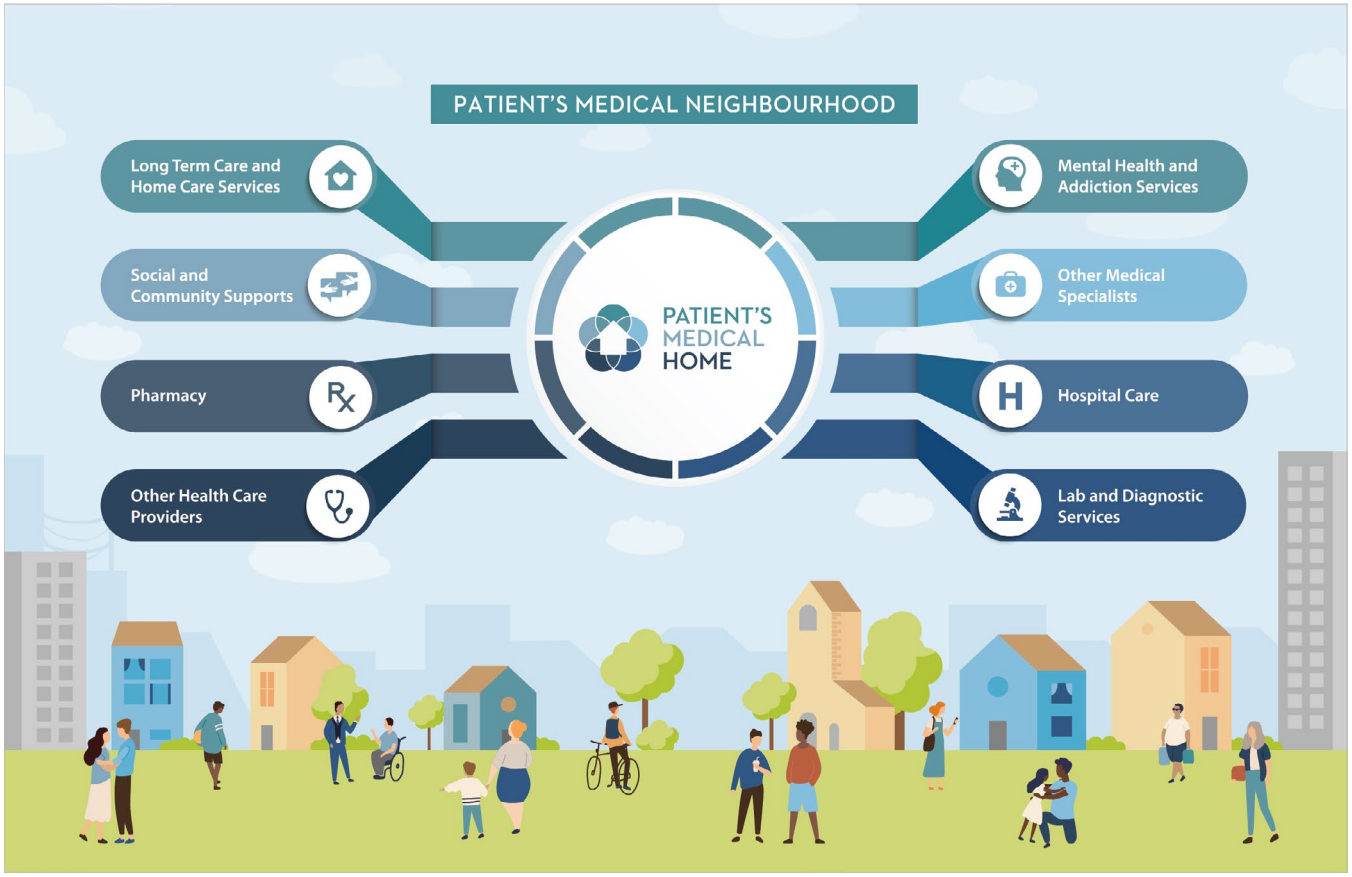
The Patient's Medical Home (PMH) is the vision for the future of family practice in Canada put forward by the College of Family Physicians of Canada (CFPC).[1] The PMH emphasizes the role of the family practice and team-based care in providing high-quality, compassionate, and timely care. However, family 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 British Columbia, divisions of family practice, health authorities, and community partners are working to establish primary care networks (PCNs) that align with the Patient's Medical Neighbourhood vision.[2]

This Implementation Kit has been collaboratively designed by the CFPC and the British Columbia College of Family Physicians (BCCFP), 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 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 Patient's Medical Home Implementation Kit for British Columbia 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. 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 (BC)*: 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 patients[6]

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

» BC Community Health Data: Developed by the BC Centre for Disease Control, this tool kit contains four tools for viewing health indictors in communities throughout British Columbia; many results can be viewed in chart, graph, table, and map formats[7]

» Your Health System: A set of interactive tools that allows users to view regional health indicator data from across the country, developed by the Canadian Institute for Health Information[8]

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. Consult one-pagers from the Care During COVID-19 Series developed by the BCCFP that provide guidance, reminders, and links to trusted resources relevant to caring for specific populations throughout the COVID-19 pandemic.[9]

4. 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[10]

» Is Your Space Positive?: A self-assessment to help you make your organization more inclusive to people of all sexual orientations and gender identities[11]

5. 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]

6. 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

7. Sign up to use the Patient Experience Tool, a General Practice Services Committee (GPSC) initiative in which patients complete surveys on tablets provided by the program.[14] Patients are asked about topics such as wait times, office hours, and coordination of care.

8. 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[15,16]
   - » Saskatchewan Health Quality Council's primary health care survey[17]

9. 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 bc211, an online database of government, health, and social services that can be searched by location and/or category (e.g., food and clothing, employment).[18] This service is also available by telephone (dial 2-1-1).

2. Use the Pathways Community Service Directory, which provides quick access to current and accurate referral information for physicians and staff, as well as access to hundreds of community services and resources.[19]

3. Consult Fetch (For Everything That's Community Health), a searchable resource containing information on local resources including counselling, crisis intervention, employment assistance, and more.[20]

4. Connect families of persons with disabilities with community resources using findSupportBC, a searchable database based on patient age, type of disability, and location. [21]

Build in-house knowledge of available community resources

5. 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[22]

   » Ask other service providers (i.e., your Neighbours) to confirm or fill out details on their services using the Community Resource Cards tool[23]

6. Consult the Appendix of the CFPC's Best Advice guide for additional templates of internal documents for your Neighbourhood.[3]

7. 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. Tailor collaborative care agreements appropriately for 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[24]
    - 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 Partners[26]

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

1. Leverage the Rapid Access to Consultative Expertise (RACE) program, which provides direct access to consultations with other specialists by calling 604-696-2131, or 1-877-696-2131 (toll-free). The service is available Monday-Friday from 8:00 a.m. to 5:00 p.m. Both physicians are eligible to bill for their services.[28]
2. Use the Pathways Community Service Directory, which provides quick access to current and accurate referral information for physicians and staff.[19] The Pathways Referrals Tracker, a dashboard where family physicians and other specialists can track patient referral status, will soon be available across the province.[29]

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

3. Use the Virtual Care Toolkit, developed by the Doctors of BC, which provides detailed advice on topics such as virtual care workflows, available technologies, and communication.[30]
4. Consult other virtual care resources provided by the Doctors of BC, including videos and slide presentations containing tips on using webinar platforms, information on available technology subsidies, and more.[31]
5. In advance of virtual appointments, email patients the Preparing For Your Video or Phone Appointment with Your Family Doctor guide, developed by the BCCFP.[32]

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

6. Consider leveraging the Panel Development Incentive provided by the GPSC.[33] Physicians who complete the Panel Management Workbook are eligible to receive the $6,000 incentive in three installments, in addition to MainPro+® credits. Once completed, the Workbook can serve as a manual for current and future team members.

7. The Accelerating Change Transformation Team (ACCT) has developed multiple resources to aid in panel management, that do not require you to sign up:

- » 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]

8. 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).[36]

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

9. *Consult the Patient's Medical Home Implementation Kit: British Columbia* for advice on starting quality improvement projects that are manageable in scope and size for your practice.[4]

10. Consult the BC Patient Safety & Quality Council website to learn about current quality improvement initiatives in BC.[37]

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