PATIENT'S MEDICAL NEIGHBOURHOOD

IMPLEMENTATION KIT

Ontario

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

Centre for Effective Practice

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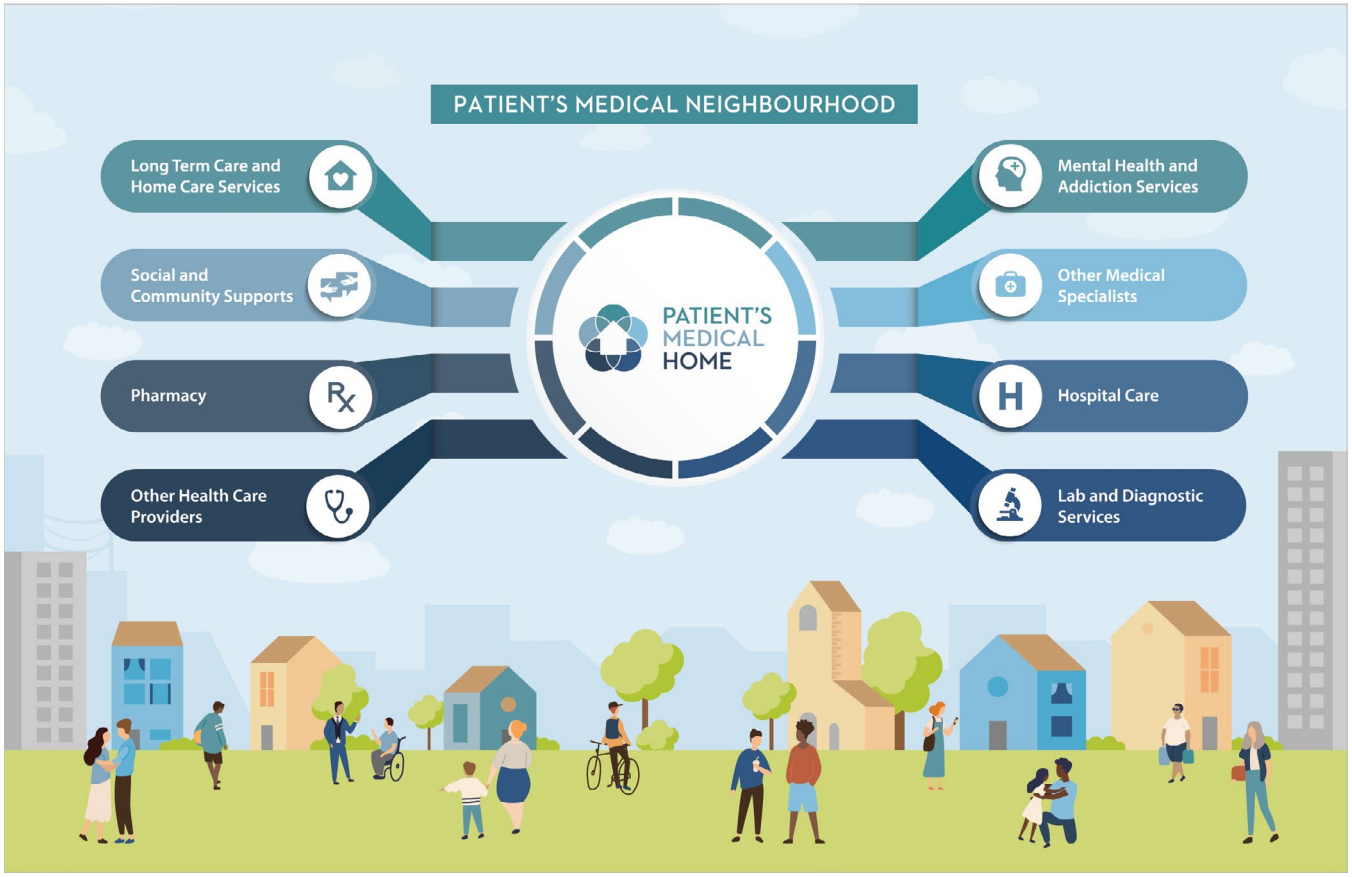
The Patient's Medical Home (PMH) is the vision for the future of family practice in Canada put forward by the College of Family Physicians of Canada (CFPC).[1] The PMH emphasizes the role of the family practice and team-based care in providing high-quality, compassionate, and timely care. However, family 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, hospitals, 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 Ontario, the Neighbourhood concept is being operationalized via the development of Ontario Health Teams (OHT).[2] Participation in an OHT will greatly help practices further align themselves with the Neighbourhood vision. For information about how you can earn

Mainpro+® credits for your participation in an OHT, consult the Ontario College of Family Physicians (OCFP)'s OHT Planning and Delivery of Integrated Care Program.[3]

This Implementation Kit is intended to complement the CFPC's Best Advice guide for the Patient's Medical Neighbourhood. Participating in an OHT is the most efficient way of aligning your practice with the principles of the Neighbourhood. However, suggestions in this document are helpful for practices outside of OHTs looking to become more interconnected within the health care system.

- 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

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 (demographics, health concerns, satisfaction with care, and required supports) will help 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 their access to services. Tools are available through the following organizations to enhance patient screening:
   - » *Poverty: A Clinical Tool for Primary Care Providers in Ontario*: 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 provincial and national health indicator data to better understand your community's overall health needs:

» System Performance Indicators: Health Quality Ontario has developed a series of reports on topics such as hospital patient safety, wait times, population health, primary care performance, and more[7]

» 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[8]

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 attitudes[9]

» Is Your Space Positive?: A self-assessment to help you make your organization more inclusive to people of all sexual orientations and gender identities[10]

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.[11]

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.[12]

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[13,14]

» Saskatchewan Health Quality Council's primary health care survey[15]

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 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 Ontario, which provides a database of community, social, non-clinical health, and related government services that are searchable by location.[16] A related database is also available that specifically covers Toronto and the regions of Peel, York, and Durham.[17] Both 211 services are also available by telephone (dial 2-1-1).

2. Direct your patients to The Health Line, a directory of local health and community services across Ontario that is searchable by postal code or Local Health Integration Network.[18]

Build in-house knowledge of available community resources

3. Create internal documents to track community resources in 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[19]

» Ask other service providers (i.e., your Neighbours) to confirm or complete details about their services using the Community Resource Cards tool[20]

4. For additional templates of internal documents for your Neighbourhood, consult the Appendix of the CFPC's Best Advice guide.[4]

5. 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. If you are participating in an OHT some of these relationships will be formalized during your OHT's development and maturation.

Develop collaborative care agreements with other service providers in your Neighbourhood

1. Ask service providers to whom you regularly refer how they view their relationship with your practice. Determine whether they would like to formalize their participation in the Neighbourhood, and if you are participating in an OHT determine whether these providers will be part of your OHT.

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 Physicians[21]
   - » Referral-Consultation Process: A guideline for standardizing referral processes developed by the College of Physicians and Surgeons of British Columbia.[22] The guideline's appendices provide templates for referral requests and confirmations.[23]
   - » 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[23]
4. If you are participating in an OHT, consult the *Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System*, a guidance document that can help providers establish collaborative decision-making arrangements as a team, and facilitate effective relationship-building. [24]
5. 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, which may or may not be formalized in the future. Tools from the Health Commons Solutions Lab can help you achieve this:
   - » Ask other service providers to confirm or complete details about their services using the Community Resource Cards tool or Provider Profile Cards tool[20,25]

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

1. Participate in the Ontario eConsult program, which consists of four programs: Ontario eConsult service, Champlain BASE™ regional service, and the Ontario Telemedicine Network (OTN)'s Teledermatology and Teleophthalmology.[26] All programs use secure, web-based platforms that allow family physicians to submit non-urgent, patient-specific questions to other specialists.

2. Sign up for the Ocean eReferral Network, an electronic medial record (EMR)-integrated technology that allows family doctors to search for other specialists, view wait times and locations, and create and submit referrals electronically.[27] With integrated EMRs, referrals are sent, tracked, and updated right from the patient's chart.

3. Use ONE Mail Direct, a free and secure email service that allows users to securely and confidentially exchange patient information with other ONE Mail users.[28]

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

4. Join the OTN's OTNhub, a private and secure community for practising virtual care and communicating with patients.[29] OTNhub is free for health care practitioners who receive 50 per cent or more of their funding from the Ministry of Health or the Ontario Health Insurance Plan.

5. Consult the *How to use Virtual Care with Your Patients* document developed by OntarioMD, which provides advice about which virtual tools to use, how to properly communicate with your patients, and how to bill for virtual visits.[30]

6. 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.[31]

7. Consult the Accelerating Change Transformation Team (ACTT)'s EMR tip sheets for providing virtual care using select EMRs (Wolf; Med Access; Healthquest; Accuro; PS Suite).[32]

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

8. Consult the OCFP's web page on patient rosters/panels for a list of resources that will help you identify and manage your patient panel.[33]

9. The ACTT has developed multiple resources to help with 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]

10. 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).[32]

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

11. Use the i4C Advisory Service, a program developed by OntarioMD that provides service support to primary care practices by offering coaching on the use of the i4C Dashboard for population health management, as well as the efficient use of EMRs and digital tools.[36]

12. Consult the Patient's Medical Home Implementation Kit for Ontario for advice on starting quality improvement projects that are manageable in scope and size for your practice.[37]

13. Consult the Health Quality Ontario website to learn about current quality improvement initiatives in Ontario.[38]

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