PATIENT'S MEDICAL NEIGHBOURHOOD

IMPLEMENTATION KIT

Northwest Territories, Nunavut, and Yukon

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA
Centre for Effective Practice

How to cite this document:

College of Family Physicians of Canada. *Patient's Medical Neighbourhood Implementation Kit: Territories*. Mississauga, ON: College of Family Physicians of Canada; 2021.

The College of Family Physicians of Canada (CFPC) thanks all organizations and other contributors for their invaluable assistance in developing this Implementation Kit.

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.

This Implementation Kit has been designed by the CFPC and is intended to complement the CFPC's Best Advice guide for the Patient's Medical Neighbourhood.[2] 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.

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 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 to enhance patient screening are available through the following organizations:
   - » *Poverty: A Clinical Tool for Primary Care Providers*: A primary care tool that can be used to screen and support patients' living situations and socioeconomic concerns as part of their overall health. Individual tools are available for the Northwest Territories, Nunavut, and Yukon[3,4,5]

» 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. Consult Your Health System is 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.[7]

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[8]

» Is Your Space Positive?: A self-assessment to help you make your organization more inclusive to people of all sexual orientations and gender identities[9]

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.[10]

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.[11]

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[12,13]

» Saskatchewan Health Quality Council's primary health care survey[14]

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. If you are practising in Nunavut, direct your patients to 211 Nunavut, an online database of government, health, and social services that can be searched by location and/or category (e.g., food and clothing, employment).[15] Note that 211 telephone service is not available at this time in Nunavut, and online 211 services are not available in Yukon or the Northwest Territories.

Build 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:
    - » Create an online database of community resources, and/or a Google map of community resources, using the Community Map Prototype and Database tool[16]
    - » Ask other service providers (i.e., your Neighbours) to confirm or complete details about their services using the Community Resource Cards tool[17]
3. For additional templates of internal documents for your Neighbourhood, consult the Appendix of the CFPC's Best Advice guide.[2]
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 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 Physicians[18]
    - Referral-Consultation Process: A guideline for standardizing referral processes developed by the College of Physicians and Surgeons of British Columbia.[19] 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[20]

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[17,21]

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 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.[22]

2. Complete the Essentials to Getting Started with Virtual Care Checklist, a concise checklist of steps to follow before you engage in virtual care.[23]

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).[24]

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

4. The ACTT has developed multiple resources to help 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[25]
    - » Panel Maintenance Tool: A tool to help clinics develop and assess their own processes for maintaining panel lists[26]
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).[24]

References

1. College of Family Physicians of Canada. *A new vision for Canada: Family Practice—The Patient's Medical Home 2019*. Mississauga, ON: College of Family Physicians of Canada; 2019. Available from: https://patientsmedicalhome.ca/files/uploads/PMH_VISION2019_ENG_WEB_2.pdf. Accessed December 1, 2020.

2. College of Family Physicians of Canada. Best Advice guide: *Patient's Medical Neighbourhood*. Mississauga, ON: College of Family Physicians of Canada; 2020. Available from: https://patientsmedicalhome.ca/resources/best-advice-guides/the-patients-medical-neighbourhood/. Accessed December 1, 2020.

3. Centre for Effective Practice. *Poverty: A Clinical Tool for Primary Care Providers (NT)*. Toronto, ON: Centre for Effective Practice; 2016. Available from: https://cep.health/tool/download/40/. Accessed December 1, 2020.

4. Centre for Effective Practice. *Poverty: A Clinical Tool for Primary Care Providers (NU)*. Toronto, ON: Centre for Effective Practice; 2016. Available from: https://cep.health/tool/download/39/. Accessed December 1, 2020.

5. Centre for Effective Practice. *Poverty: A Clinical Tool for Primary Care Providers (YT)*. Toronto, ON: Centre for Effective Practice; 2016. Available from: https://cep.health/tool/download/49/. Accessed December 1, 2020.

6. BETTER. The BETTER Program website. 2015. http://www.better-program.ca/home. Accessed December 1, 2020.

7. Canadian Institute for Health Information. Your Health System website. 2019. https://yourhealthsystem.cihi.ca/hsp/?lang=en&_ga=2.19268538.366093388.1583512489-596764714.1583512489. Accessed December 1, 2020.

8. Georgetown University National Center for Cultural Competence. *Promoting Cultural and Linguistic Competency: Self-assessment checklist for personnel providing primary health care services*. Washington, DC: Georgetown University National Center for Cultural Competence; 2009. Available from: https://nccc.georgetown.edu/documents/Checklist%20PHC.pdf. Accessed December 1, 2020.

9. Hamilton Family Health Team. *Is Your Space Positive?* Hamilton, ON: Hamilton Family Health Team; 2015. Available from: https://docs.hamiltonfht.ca/dsweb/Get/Document-2926. Accessed December 1, 2020.

10. College of Family Physicians of Canada. *Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada*. Mississauga, ON: College of Family Physicians of Canada; 2016. Available from: https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Resources/_PDFs/SystemicRacism_ENG.pdf. Accessed December 1, 2020.

11. Alberta Health Services. *Sexual Orientation, Gender Identity & Gender Expression (SOGIE): Safer Places Toolkit*. Edmonton, AB: Alberta Health Services; 2019. Available from: https://www.albertahealthservices.ca/assets/info/pf/div/if-pf-div-sogie-safer-places-toolkit.pdf. Accessed December 1, 2020.

12. Health Quality Ontario. *Primary Care Patient Experience Survey*. Toronto, ON: Health Quality Ontario; 2015. Available from: https://www.hqontario.ca/Portals/0/documents/qi/primary-care/primary-care-patient-experience-survey-en.pdf. Accessed December 1, 2020.

13. Health Quality Ontario. *Primary Care Patient Experience Survey: Support Guide*. Toronto, ON: Health Quality Ontario; 2015. Available from: http://www.hqontario.ca/Portals/0/documents/qi/primary-care/primary-care-patient-experience-survey-support-guide-en.pdf. Accessed December 1, 2020.

14. Saskatchewan Health Quality Council. Health System Performance: Measuring the patient experience website. 2020. https://hqc.sk.ca/health-system-performance/measuring-the-patient-experience. Accessed December 1, 2020.

15. 211 Nunavut. 211 Nunavut website. 2020. http://www.nu.211.ca/. Accessed December 1, 2020.

16. Health Commons Solutions Lab. *Community Map Prototype and Database*. Toronto, ON: Health Commons; 2020. Available from: https://www.healthcommons.ca/s/CommunityMapPrototypeTool-j8dz.pptx. Accessed December 1, 2020.

17. Health Commons Solutions Lab. *Tool: Community Resource Cards*. Toronto, ON: Health Commons; 2020. Available from: https://www.healthcommons.ca/s/CommunityResourceCardsTool-hccj.pptx. Accessed December 1, 2020.

18. American College of Physicians. *Sample Care Coordination Agreement Referrals, Consults, Co-management General: for all patients*. Philadelphia, PA: American College of Physicians; 2014. Available from: https://www.acponline.org/system/files/documents/clinical_information/high_value_care/clinician_resources/hvcc_toolkit/hvcc_project/sample-care-coordination-agreement.pdf. Accessed December 1, 2020.

19. College of Physicians and Surgeons of British Columbia. *Professional Guideline – Referral-Consultation Process*. Victoria, BC: College of Physicians and Surgeons of British Columbia; 2020. Available from: https://www.cpsbc.ca/files/pdf/PSG-Referral-Consultation-Process.pdf. Accessed December 1, 2020.

20. Accountable Health Partners. *Referral Agreement between Practice A and Practice B*. Rochester, NY: Accountable Health Partners; 2017. Available from: https://ahpnetwork.com/wp-content/uploads/2017/06/Referral-Agreement-Template.pdf. Accessed December 1, 2020.

21. Health Commons Solutions Lab. *Tool: Provider Profile Cards*. Toronto, ON: Health Commons; 2020. Available from: https://www.healthcommons.ca/s/ProviderProfileCardsTool-b3lw.pptx. Accessed December 1, 2020.

22. Doctors of BC. *Virtual Care – Toolkit*. Vancouver, BC: Doctors Technology Office; 2020. Available from: https://www.doctorsofbc.ca/sites/default/files/dto_virtual_care_toolkit.pdf. Accessed December 1, 2020.

23. Alberta Medical Association. *The Essentials to Getting Started with Virtual Care Checklist*. Edmonton, AB: Alberta Medical Association. Available from: https://www.albertadoctors.org/e-health/essentials-getting-started-checklist.pdf. Accessed December 1, 2020.

24. Health Commons Solutions Lab. *TOOL – Panel Management: Steps to Pull a List of Patients*. Toronto, ON: Health Commons; 2020. Available from: https://www.healthcommons.ca/s/PanelManagementTool.pptx. Accessed December 1, 2020.

25. Accelerating Change Transformation Team. *Panel Processes*. Edmonton, AB: Accelerating Change Transformation Team. Available from: https://actt.albertadoctors.org/file/panel-process-change-package.pdf. Accessed December 1, 2020.

26. Accelerating Change Transformation Team. *Panel Maintenance Tool*. Edmonton, AB: Accelerating Change Transformation Team. Available from: https://actt.albertadoctors.org/file/panel-maintenance-tool.pdf. Accessed December 1, 2020.