BEST ADVICE

PATIENT'S MEDICAL NEIGHBOURHOOD

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

For a complete list of endorsements, please visit the **Patient's Medical Home** website.

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PURPOSE OF THE GUIDE

This guide will help family practice teams improve their connections with colleagues in other care settings both within the health care system and social services more broadly.

It is designed to be used by family practice teams across a variety of settings and circumstances. It provides guidance for family practices that act or wish to act as leaders and coordinators of care for patients accessing services beyond the practice setting. It includes specific advice for urban, rural, and remote practices that considers the unique circumstances of each. It describes challenges, opportunities, and practical steps for both geographically co-located and virtual Patient's Medical Neighbourhoods.

The guide is also accompanied by province- and territory-specific implementation kits* that will direct your practice to resources specific to your region. The team can use the guide and implementation kits to develop an approach for setting up the Neighbourhood that best suits the unique needs of your practice, as well as the patients and community you serve.

INTRODUCTION

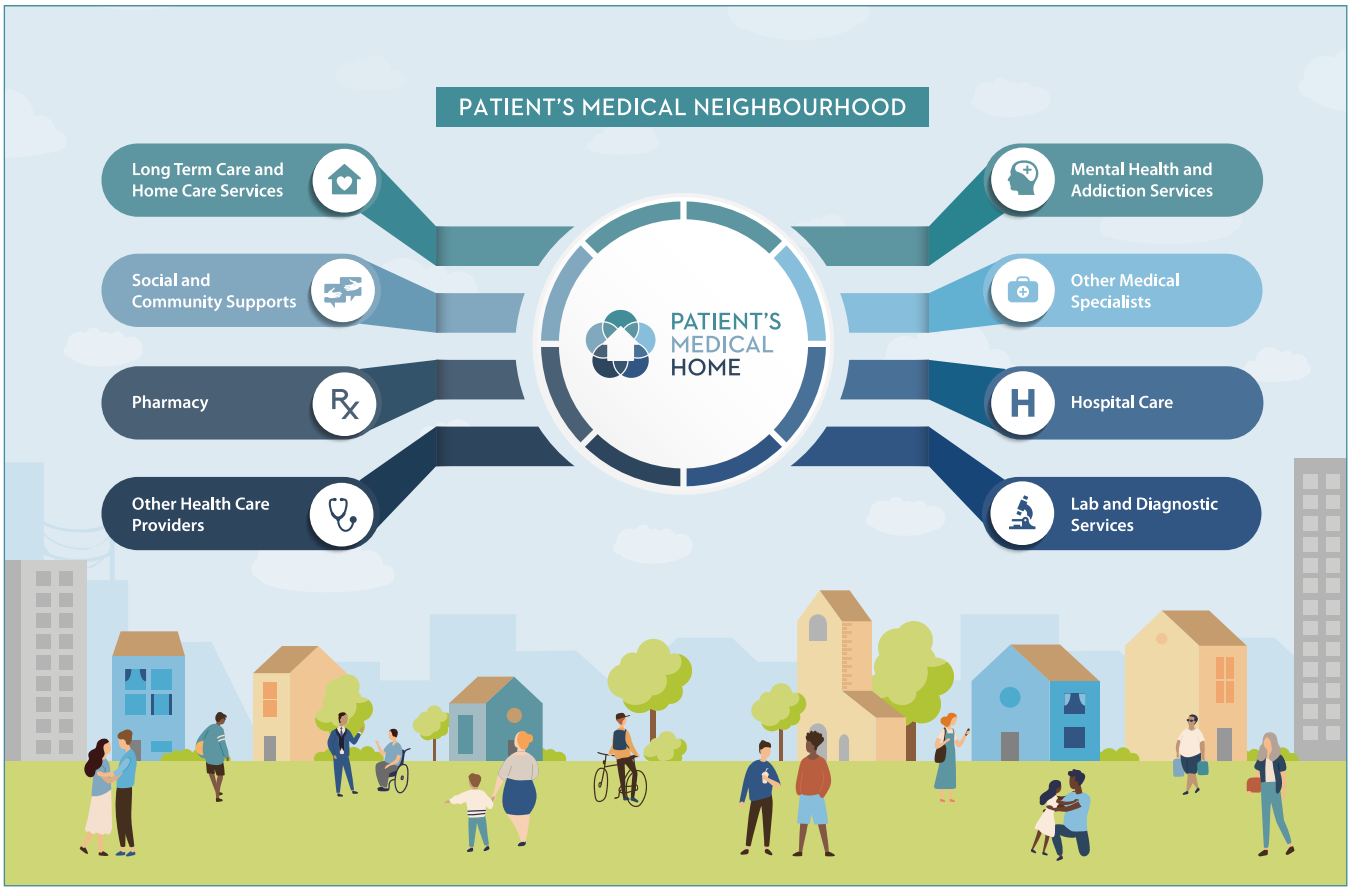
The Patient's Medical Home (PMH) is the vision for the future of family practice in Canada put forward by the College of Family Physicians of Canada (CFPC). The PMH emphasizes the role of the family practice and team-based care in providing high-quality, compassionate, and timely care. However, family practices are not the only settings involved in a patient's care. The concept of the Patient's Medical Neighbourhood 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. Within this model, the PMH acts as a hub for coordinating care within the Neighbourhood.[1] 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 to broader social and community supports such as community-based mental health and addictions supports and other social services.

Learn More!

This *Best Advice* Guide is accompanied by practical, province- and territory-specific resources to support implementing a Patient's Medical Neighbourhood in your practice. These CFPC member-only resources will be available on the Patient's Medical Home website* and are useful supports in the practical application of the advice in this Guide.

*The provincial and territorial implementation kits will be available in Fall 2020.

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.



Who's Who in the Neighbourhood

This guide is aimed at family practices wishing to provide more collaborative care to meet the needs of their patient populations. The practices may be clinics or work within different health care settings or community sites. Providing collaborative care often involves working with a number of different providers, health care settings, and social services beyond the family practice. Throughout the guide, the term **specialist** refers to medical professionals other than family physicians who may operate out of their own practices or within other health care settings such as hospitals. Patients are often referred to or seek care from these providers to deal with specific health issues. The guide also frequently refers to **community resources** or **social services**. These terms refer to agencies or services within the community that, while not directly health care related, provide services or supports that impact a person's social determinants of health. This includes legal aid, employment services, food banks, housing services, social assistance, community support groups, and more. These services are equally important to be considered within a Patient's Medical Neighbourhood and patients may be referred to the services for help with non-medical needs that impact their health and well-being.

BACKGROUND

The concept of a Patient's Medical Neighbourhood expands the PMH vision of coordination within a single practice. Within the Neighbourhood, family practices partner with other providers to coordinate care as part of a larger integrated network. The providers in this network collaborate and share responsibility for providing comprehensive care to a given patient.[2] Similar networks have been formed across Canada and around the world with the goals of providing improvements to patient outcomes, safety, and experience; lower costs through reduced duplication of services; improved delivery of preventive services; and more evidence-based patient care.[3]

Implementing a Patient's Medical Neighbourhood may be met with different challenges. These may be systemic (e.g., remuneration models, limited health information technology infrastructure and interoperability, practice norms that encourage acting in silos) or practice-level (e.g., meeting the needs of marginalized populations, lack of staff and time to invest in coordination efforts, communication barriers).[3,4] This guide aims to help practices address both sets of challenges by using practical advice that can be tailored to practices across the country, focusing on barriers related to communication and the coordination of care and responsibility. In dealing with these barriers, this guide addresses the important role of health information technology (IT) and **virtual care** to the success of a Patient's Medical Neighbourhood. We also acknowledge that some of the systemic barriers facing practices are outside of the practice's influence and are the responsibility of policy-makers to address. The guide appendix includes a policy checklist for advocacy purposes to help address some of the systemic barriers.

CASE STUDIES

Across Canada, provincial and territorial governments, health authorities, and individual practices are making progress embodying Neighbourhood principles in the care they provide.

Northwest Territories

Health care delivery in the Northwest Territories operates as an integrated Patient's Medical Neighbourhood. In 2016 the territory took major steps to enhance the coordination of care, including amalgamating health authorities within the territory. All providers in the territory use the same electronic medical record (EMR) system, creating an unparalleled network of care for consistency and continuity. Practices across the Northwest Territories have also been innovating and aligning with the PMH vision. This has included initiatives to improve continuity of care using virtual care. Changes in language and attitude that foster culturally safe care and physician retention within the broader Patient's Medical Neighbourhood have also been adopted.

The Role of the Family Practice in the Patient's Medical Neighbourhood

Implementing a Patient's Medical Neighbourhood requires the leadership of a strong family practice, ideally one that embodies the principles of the PMH vision. Within a Neighbourhood, the PMH should be supported as the provider of whole-person primary care to the patient, and as being responsible for ensuring coordination of care by all involved physicians, nurses, and other care providers. More resources about how a practice can adopt the principles of the PMH are in the PMH Implementation Tool kits.

Prince Edward Island

Primary care in Prince Edward Island is delivered through five primary care networks across the province, which ensure that each resident is within 30 kilometers of a health team.[5] Each primary care network is run by a network manager, clinical nurse lead, medical director, and administrative support. These primary care networks bring together different health care professionals including family physicians, nurse practitioners, registered nurses, diabetes educators, licensed practical nurses, and clerical staff. Some networks include other health providers such as dieticians and social workers.[6] While many providers operate as a core team located in a specific health centre, nurses with specialties in areas such as chronic obstructive pulmonary disease, diabetes, smoking cessation, primary mental health, and other conditions also conduct outreach to family practices outside the health centre (often fee-for-service family practices). Health centre primary care providers also collaborate with other programs including home care and palliative care and augment primary care services on reserves in First Nations health centres. In addition to face-to-face collaborative care, primary care networks in the province use videoconferencing to connect patients in rural areas with family physicians and other specialists in other parts of the province, as well as to services outside of Prince Edward Island.

Saskatchewan

In Saskatchewan, health networks are being developed as part of a large-scale change in how health care is provided within the province. These health networks consist of collaborative teams of health professionals, including physicians and community partners providing fully integrated services to meet the health needs of individuals and communities.[7] The vision for the health networks is one in which evidence informs the services offered and the programs developed to best meet the needs of individuals and communities wherever possible in the geographic areas closest to the need. Patients are served by consistent teams of providers who each work to the breadth of their scope and are cross-trained when appropriate. These networks are supported in providing seamless care in the community using integrated technology and processes including EMRs, e-referrals, and shared care plans.[8] The networks are still being developed but promise improvements in connected care with team-based care as the foundation.[9] The process of developing these networks has included a robust physician engagement strategy and learning from areas in Saskatchewan that are already doing this work. In this implementation, Saskatchewan is embracing the quality improvement philosophy that development will be an iterative process that will adjust according to new findings.[10]

ACTIONS TO FOSTER COLLABORATION WITHIN THE PATIENT'S MEDICAL NEIGHBOURHOOD

Building community links

Establishing a Patient's Medical Neighbourhood begins with identifying and building community links. All staff within the family practice can reflect on the needs of their practice and patient population. This stage should prioritize consultation with patients. Any existing patient advisory groups should be involved in this process. Other modes of consultation that include surveys or informal discussions with patients can also be helpful for incorporating patient perspectives. You might also review resources from educational and research institutions such as universities and colleges, as well as municipal and provincial governments to help identify the needs of your practice population. Consider the kinds of referrals you often make, what conditions are presenting most often, and what gaps the practice may have in the care currently on offer. Ensure that social services agencies—such as emergency shelters, social assistance, legal aid, community service providers, life skills training programs, or others that help to support the unique needs of the practice's patient population—are considered as well.

Once a list of potential partners is established, take an inventory of the providers and community resources the

practice already accesses. This should reveal current gaps in partnerships and what services can fill these gaps in the Neighbourhood. Identifying potential partners may involve approaching another specialist practice or social service you refer to frequently to discuss formalizing their participation in the Neighbourhood. It might mean reaching out to a specialty association or community resource group for suggestions of specialists and services in your community or that you could connect and collaborate with remotely. It may also mean researching community resources in your province or territory that you may not have been aware of such as youth mental health services, preventive care programs for at-risk populations, and patient empowerment programs. You might want to consult with the providers to get a sense of how they perceive their relationship with the family practice and its patients, as well how they would like to see the Neighbourhood evolve to meet their needs. It is important to remember that this process looks different depending on the context of the practice. It may take time to establish connections and decide what relationships with providers you need for the Neighbourhood you wish to build.

Success Stories: Primary care case management in Prince Edward Island

The Primary Care Case Management Program is intended to improve the health of residents who access the health care system the most (in the top five per cent), while improving the experience of care and controlling costs. More than 400 of the over 8,000 eligible residents have participated in the program to date. The participants have frequent emergency department visits (five or more), hospital admissions (three or more), and/or walk-in clinic/office visits (10 or more) during a 12-month period and have issues with social determinants of health. They spend an average of 265 days in the program. Referrals to the program come from family physicians and other clinical care providers, as well as community and other government organizations. Primary care case managers collaborate with partner clinicians and social services to address issues affecting patient health such as income, disability, housing, transportation, navigation of services, chronic illness, and mental health. Health care costs associated with program participants have been reduced by approximately half within nine months, and there have been significant improvements in their self-rated health and functional status and their ability to self-manage care, thanks to effective collaboration between case managers, clinicians, and social services.

Source: Health PEI. *Primary Care Case Management: An IHI Triple AIM Initiative*. Charlottetown, PE: Health PEI; 2019.

After identifying potential partners, approach them to establish a collaborative care agreement. Much of the literature on interconnected care using Neighbourhood-style models emphasizes the importance of setting out a clear agreement and delineation of each provider's roles as the foundation of a successful Neighbourhood.[11] You can conduct this through in-person meetings or using virtual tools like teleconferences or videoconferences. Drafting a collaborative care agreement involves different elements based on the unique context of each practice, provider, and patient population. Make sure to include expectations for pre-consultation exchange between the referring physician and the partner, consultation with the patient, and co-management of the patient over time, including which responsibilities fall on which provider.[11] Examples of what a collaborative care agreement may include or look like are in the provincial implementation kits and in the Appendix of this guide.

USING INFORMATION TECHNOLOGY FOR MORE EFFECTIVE COMMUNICATION

At its core, a well-functioning Neighbourhood requires effective communication and coordination functions.[11] IT can play a significant role, particularly considering the growing interest in using artificial intelligence and virtual care tools.

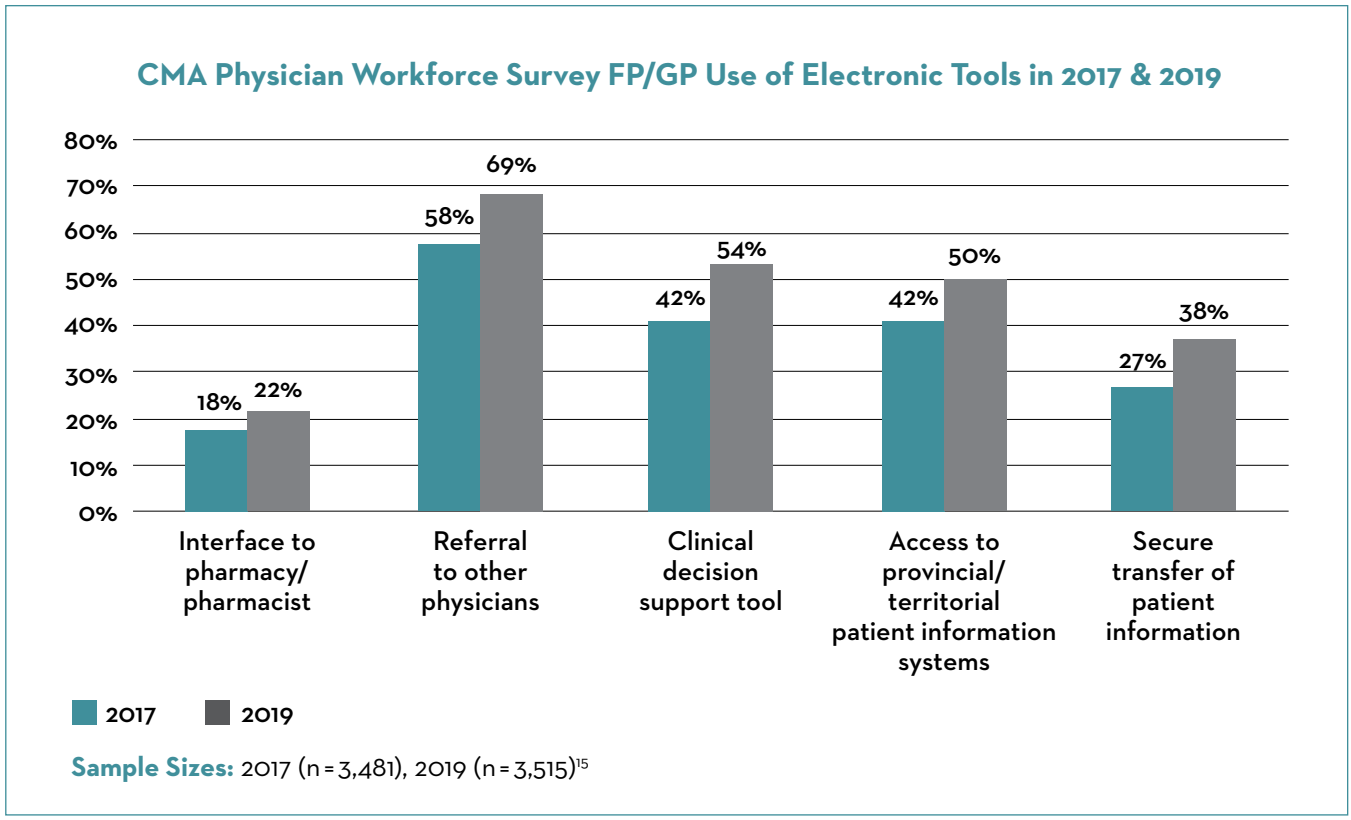
Compatible EMRs shared by all members of the Neighbourhood facilitate communication and are important for overall success.[11] This streamlining can enhance the integration of primary care providers and specialists within the Neighbourhood.[11] Health records should also be shared as appropriate with patients, and relevant family members and caregivers with patient permission.

Tools such as e-prescribing, e-referrals, and e-consults may be available through EMR systems, which offer access to data sharing and supporting patient care.[12] In some cases, including rural and remote locations, high quality pre-consultative exchange and virtual co-management between primary care providers and other specialists using these tools are an effective alternative to in-person appointments.[13] In fact, a 2018 survey found a growing preference among patients for accessing virtual care options, with 69 per cent of Canadians saying that they would take the opportunity to have a virtual visit if this option were available.[14]

Success Stories: Northwest Territories

With much health care delivery in the Northwest Territories relying on locums, continuity of care can be difficult to achieve. Through adoption of a single EMR across the territory, all providers can access patient records, allowing for significant improvements in consistency. In addition to in-person visits, care is also supported through telehealth, EMRs, and community nurses with expanded scope. As a result, in many communities patients can identify and connect with their own family doctor and receive consistent care despite remoteness and often vast geographic distances.

Tip: This stage closely aligns with the PMH's Pillar 5: Community Adaptiveness and Social Accountability. For more guidance on how to undertake this work within your practice, refer to the Patient's Medical Home 2019 Vision.



Source: CMA Physician Workforce Survey 2017 & 2019. Ottawa, ON: Canadian Medical Association.

When establishing a collaborative care agreement, discussions should include what EMR or virtual care functions are available and accessible, as well as how they can be used to coordinate patient care. It is also important to ensure that the technologies and workflow used account for the technological capacity, accessibility needs, and digital health literacy status of a patient population.[16] In the collaborative care agreement the practices should have a mutually agreed upon plan for how technologies are used in patient care, as well as what privacy supports are in place to protect patient data.

Despite the benefits of streamlining EMR use, full interoperability of EMRs has not been achieved consistently across Canada. There must be more standardization between systems to effectively share information within and between provinces and territories, since patients may receive care in different regions. When EMRs are not compatible or are unavailable, such as with social services outside the health care sector, discussions with partners may include establishing systems for referrals, consultations, and information sharing outside of EMR technology. This may include other virtual care tools, videoconferencing, teleconferencing, etc., and using a region's electronic health records (EHR). For more guidance on using EMRs and health IT in the Patient's Medical Neighbourhood, refer to **Module 2 of the CFPC's Best Advice Guide on Advanced and Meaningful Use of EMRs** and the **Report of the Virtual Care Task Force**.

EFFECTIVE CONSULTATIONS AND REFERRALS

When working with other specialists, effective referrals can help ensure that there are no delays due to collecting patient data.[17] When establishing a collaborative care agreement, discussing with partners the kind of information they need for an effective referral is crucial to ensuring timely access and providing quality care. This may include establishing guidelines and standardizing the communication processes for referrals and recommendations.[17]

You can find examples from across Canada of how Neighbourhoods can provide more effective referrals in the CFPC's Innovation in Primary Care series issue **Effective Primary/Secondary Care Interface**. Regions across Canada have applied ideas such as care pathways and group visits to reduce wait times and the need for face-to-face consultation with specialists. IT resources—such as EMRs, telehealth, and **eConsult**—may help facilitate effective referrals, providing family physicians with timely access to other specialists, reducing the need for in-person consults, and reducing the number of emergency department visits.[18] The implementation resources that accompany this guide provide more tools to help make referrals and interactions with other providers more efficient and effective by using resources available in your region.

Success Stories: Northwest Territories

Dr. David Urquhart lives in Inuvik, Northwest Territories. He has a close relationship with the people and care providers in Ulukhaktok, a remote community on Victoria Island that lies above the Arctic Circle. The concept of being adopted by a community speaks to the importance of relationship building to provide more rewarding and efficient care. The health care team, including Dr. Urquhart, has built an understanding of not only the care their patients need, but also the obstacles to receiving this care. These obstacles include the cost and difficulty of travel to and from Ulukhaktok for investigations and specialist consultation, limited technical and human resources, and in some cases language or cultural barriers. To improve timely access in such a remote setting, Dr. Urquhart and the care team use services such as telemedicine. Unnecessary travel is limited in cases where written or verbal communication is most appropriate. When travel is necessary, Dr. Urquhart and a team of staff will communicate with multiple parties to facilitate coordinating testing and scheduling appointments. The nearest specialist consultants and CT scanner are more than 900 km away, in Yellowknife. By coordinating care and using referrals and consultations effectively, the team can advocate for and provide effective care to their patients.

When establishing collaborative care agreements, it is important to consider the tools each partner accesses and how they can be leveraged to ensure that consultations and referrals are as effective as possible. Finally, agreements should determine a protocol for continued responsibility of care that includes how referrals will be monitored, how information will be shared with the family physician, and how responsibilities will be allocated between the family physician and other specialists as the patient receives care.

PATIENT-PARTNERED CARE

Developing a Patient's Medical Neighbourhood is meant to improve patient care by improving coordination and continuity of care and delivering more effective treatment through collaboration between all providers involved in a patient's care. Patients' voices are crucial in this process. There is a growing body of evidence that patient activation and engagement has a positive impact on health outcomes and care experiences.[19] You can foster this kind of engagement by working with your team to ensure that your practice is an open and engaging environment for patient participation and partnership. By involving patients in the development of the Neighbourhood through consultations, surveys, advisory groups, or other mechanisms, practices can be more confident that the Neighbourhood will be more effective in meeting patients' needs.

Patient partnership should be prioritized from the beginning of the Neighbourhood development process. Patients who participate in the development should be representative of your practice population. Depending on how a patient is impacted by the social determinants of health, this may affect their health outcomes and experiences of the health system. Pay special attention to people who have different needs or experience challenges accessing care (e.g., people with disabilities or intersectional identities, or members of LGBTQ+, immigrant, or racialized communities).

All patients receiving care through the Patient's Medical Neighbourhood model should be informed of the new system and how the changes will affect them. You can do this through print or virtual means but should also follow up in a timely manner with in-person, phone, or video conversations with a member of the care team the patient knows and trusts. Discuss how referral processes work, the role of the patient within the Neighbourhood, and how patients can express feedback on how the Neighbourhood model is working for them.[19] Ensure you also discuss how and when their feedback will be addressed and what processes are in place to ensure accountability.

The effectiveness of care within the Patient's Medical Neighbourhood requires cultural change that supports all providers focusing on the patient's preferences and cultural competency. This includes involving the patient in making decisions, ensuring all care decisions are informed by the patient's needs and preferences, and communicating them effectively with the patient, their families or caregivers, and any support persons involved in their care.[19]

Lastly, it is important to be aware of a patient's communication and access needs. This means being aware of cultural and language differences, literacy levels, and accessibility needs. You may include translators experienced in medical terminology, American Sign Language interpreters, or other communication experts within your Neighbourhood if there is a need for these services within your patient population. You can find tools online or through telephone services that help facilitate effective communication between providers and patients. Additional resources are in the province-specific implementation tool kits that accompany this guide as well as in the **Best Advice Guide on Health Literacy**. Mobility needs and lack of access to transportation may prevent some patients from accessing health care services. Connections with health care transportation, patient advocates, and public transit resources should be discussed with patients who may require assistance.

PERFORMANCE MEASUREMENT

Performance measurement is key to a successful Patient's Medical Neighbourhood, both system-wide and practice-level monitoring of how the Neighbourhood is meeting its patients' needs. The appendix includes a policy checklist that can be used to inform advocacy for support at the government level. This includes support for conducting and reporting on performance evaluations, as well as resources for implementing changes informed by the results of these evaluations. Refer to the Appendix as well as the province-specific implementation kits for more information on how to contribute to advocacy efforts for system-wide improvements in performance measurement.

Although a large-scale performance measurement process may be challenging to execute with limited resources, tools like **EMRs** and the **Patient's Medical Home Self-Assessment** may help you assess how the Patient's Medical Neighbourhood has facilitated better care for your patient populations. Work with patients to ensure their perspectives about their experience, outcomes, safety, and adherence to care are monitored and adjustments are made accordingly based on these findings. The Patient's Medical Neighbourhood may also include connections that support performance measurement, such as connections to academia, **health quality councils** and **practice-based research networks**.

Success Stories: Saskatchewan Health Quality Council

The Saskatchewan Health Quality Council has helped shape Saskatchewan's health care system, including the development of health networks in the province. This includes providing tools, training, and resources for performance measurement within the province. One useful tool for family physicians and their networks is the **Primary Care Panel Report**, which allows family physicians to access reports generated through provincial billing and administrative data. These reports provide information such as the percentage of patients visiting emergency departments, being admitted to hospital, and using benzodiazepines and/or opioids. These reports are accompanied by a survey and reflection that can be completed for CPD credits and can serve as a useful tool for measuring the performance of the practice and how the patients access services within a broader health network.

It is important to remember when establishing a Patient's Medical Neighbourhood that it is an ongoing and iterative process. Findings from both system-wide and practice-level performance measurement initiatives should be made publicly available to patients and governance bodies and be incorporated into strategies to implement changes to how the Neighbourhood operates. Performance measurement at both levels will help the health care system, your practice, and all the partners in the Neighbourhood to continue providing collaborative, effective, and efficient care to patients.

CONCLUSION

Overall improvement of the links between family practices in the primary care environment and secondary and tertiary health care levels will deliver better health outcomes for patients, as well as make Canada's overall health care system more effective at a lower cost.[20-23] The Patient's Medical Neighbourhood offers a promising model for delivering better care in collaboration with other medical specialists, health care providers, and social and community supports. The appendix in this guide includes a worksheet to help guide conversations with your practice, as well as a checklist of recommended policies for policy-makers to undertake in support of enabling a Patient's Medical Neighbourhood model. In addition, province- and territory-specific implementation tool kits have been developed to further support your practice in applying the recommendations of this guide.

APPENDIX

Worksheet and checklist

With your practice staff, develop a goal statement for your Patient's Medical Neighbourhood:

What are some assets and opportunities within your practice, your community, etc., that can help achieve success within your Patient's Medical Neighbourhood?

What are some challenges you may face in implementing a Patient's Medical Neighbourhood?
How will you mitigate them?

What are some future ideas to explore?

Questions to ask potential partners:

- What IT tools do you use in your practice?
- What do you need to know about a patient for a successful referral?
- How do you want to communicate about a patient's care?
- When and how should we reassess our collaborative care agreement?
- How will we measure success in this partnership?
- How will we share findings about the performance of our Patient's Medical Neighbourhood with patients, the public, or governance bodies?
- How will we accommodate changes in capacity to accept referrals and consultations, or other changes in the partnership?
- How do we partner with patients (and families and caregivers) in their care?

Checklist for building a Patient's Medical Neighbourhood

- ☐ Develop a patient engagement and partnership strategy
- ☐ Brainstorm for potential partners
- ☐ Establish a collaborative care agreement with partners
- ☐ Develop a health IT communication plan
- ☐ Develop a performance management strategy
- ☐ Share results of the performance evaluation

Examples of providers to include in a Patient's Medical Neighbourhood

Type of Provider	Provider Name	Provider Contact Information	Collaborative Care Agreement? Yes/No
Hospital			
Long-Term Care			
Home Care Agency			
Pharmacist			
Social Worker			
Mental Health Care			
Dietician			
Social Service Agency			
Physiotherapist			
Occupational Therapist			
Addiction Specialist			
Palliative Care			
Radiology			
Legal Clinic			
Speech Language Pathologist			

Policy checklist

Building a collaborative, interprofessional care network must be complemented by supportive policy. The following policy actions should be pursued in consultation with practices (including through provincial Chapters) to support the development of a Patient's Medical Neighbourhood.

☐	Consider **remuneration models** (e.g., salary, capitation, blended payment models) that offer flexibility and encourage innovation in how practices organize their care and collaborate with other specialists, providers, and community services.
☐	Support practices across specialties throughout the region for accessing interoperable EMR systems to facilitate collaboration and information sharing.
☐	Enact and support policies that standardize EMRs within Canada so that information can be shared within and between provinces and territories via interoperable EMR systems.
☐	Support more effective referrals such as standardized referrals, centralized referral management, and use of telehealth or e-consult technologies.
☐	Conduct, or support using, evaluations to determine the performance of Patient's Medical Neighbourhoods in achieving improved health outcomes.
☐	Report publicly on the results of performance measurement evaluations to ensure patients are informed and health care systems and providers are held accountable.
☐	Support strategies to improve Patient's Medical Neighbourhoods and implement changes based on evidence from performance measurement evaluations.
☐	Create opportunities for sharing successes to translate and scale Patient's Medical Neighbourhood strategies and innovations.

Topics for Collaborative Care Agreements

This outline is an adaptation of an existing agreement.[11] Examples of Collaborative Care Agreements used by institutions within your region may also be available in the provincial implementation kits.

	The family physician agrees to	The consulting specialist agrees to
During the pre-consultation exchange	• Clearly state the clinical question • Use an agreed upon referral platform to communicate the request • Triage the urgency of consultation requests to the best of their ability	• Have a single point of access • Respond to requests within specified time frame using a common referral platform
During the consultation	• Clearly state the reason for consultation using the common referral platform • Explain to the patient the purpose of the consultation • Order appropriate tests prior to consultation	• Use a single method for obtaining consultation that is consistent with other departments (open access) • Adhere to access time frames • Send a consult note to the referring physician within a specified number of days
	Both parties agree to	
During co-management	• Concur on who manages medications, monitors laboratory test results, and handles related issues • Notify each other of major interventions, emergency department visits, and hospitalizations by using EMRs or other communication methods • Offer urgent visits to patients within a set time frame • Send all visit notes to each other within a specified number of days, or sooner if urgent issues have arisen • Confer with each other prior to ordering additional referrals related to the patient's condition	

Things to include in an agreement:

- Referral platform 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
- Outline of each party's roles and responsibilities in managing patient care
- Other [to be specified]

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