Toward Optimized Practice

RELATIONAL CONTINUITY

Clinical Practice Guideline | June 2019

OBJECTIVE

Primary care physicians and the teams they work with will understand the value of relational continuity and therefore adopt practice behaviors that result in increased relational continuity

TARGET POPULATION

All patients

EXCLUSIONS

None

IMPLEMENTATION TOOL: Refer to the Continuity Change Package

Note: Strongest evidence exists to support continuity to physicians. As such the focus of this guideline is physician continuity. However, the value and essential role of the primary care team to continuity, of which physicians are members, has been anecdotally and substantively demonstrated. This has therefore been acknowledged and reflected.

PRACTICE POINT

Relational continuity is defined as:

The ongoing, trusting therapeutic relationship between a patient and a primary care physician and their team, where the patient sees this primary care physician the majority of the time and

results in

improved health outcomes, decreased mortality, better quality of care, reduced healthcare costs, increased patient and provider satisfaction, fewer ER visits and hospital admissions.

RECOMMENDATIONS

RECOGNIZE THE VALUE

- ✓ Recognize the benefits and importance of relational continuity between patients and primary care physicians.
- ✓ Understand that relational continuity is the foundational building block for achieving management and informational continuity.
- ✓ Recognize that elderly patients, vulnerable populations, and those with complex needs or multiple chronic conditions may benefit most from improved continuity.
- ✓ Recognize that all patients benefit from continuity.

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Context

Relational continuity is a key implementation step for Patient's Medical Home success. This change package has been designed as an accompanying tool to the TOP Relational Continuity Clinical Practice Guideline. The change package serves to further expand upon the recommendations in the relational continuity guideline by identifying actions and tools for practice teams to test. This document is best viewed in electronic format with internet connectivity so links contained can be accessed.

Foundation of Quality Improvement Knowledge, Skills and Culture is Essential for Progress Toward the PMH

Improving continuity is a multi-facetted exercise in quality improvement that with focused efforts will improve incrementally over time. Quality improvement skills used for improvements to relational continuity can be used to accelerate improved clinical care or processes in any area with greater success (e.g., more reliable screening and prevention or improving outcomes for patients with specific clinical conditions). A quality improvement offers a structured process and sequences of steps that reduce the risk and disappointments of traditional change efforts which are typically not well organized or designed. Refer to Appendix A for tools and resources related to quality improvement knowledge and skills.

Improvement Facilitation

This change package has been designed to optimally be delivered in primary care clinics via improvement facilitator (IF) support. However, there are numerous potentially better practices that can be leveraged for improvements that can be tested and implemented by clinic teams independently. Contact your PCN to inquire if IF support is available to you.

High leverage changes	Potentially better practices	Tools	Notes and tips
1. Recognize the Value	• Plan regular team meetings to review the benefits and importance of relational continuity between patients and primary care physicians and to begin planning around how to apply to your clinic context. • Develop a plan to work as a team to create processes to strengthen relational continuity, with recognition that it is the foundational building block for achieving management and informational continuity. • Identify elderly patients, vulnerable populations, and those with complex needs or multiple chronic conditions who may benefit most from improved continuity. • Apply knowledge into practice that recognizes that all patients benefit from relational continuity.	TOP Relational Continuity Clinical Practice Guideline HQCA-Primary Healthcare Panel Report: Understanding Continuity Data TOP Evidence Summary - Value-of-Continuity An Alberta Perspective - IHE Innovation Forum (Continuity Data Video)	• **TOP Relational Continuity CPG –** Review as a team and discuss in the context of your practice. • **HQCA Primary Healthcare Panel Report: Understanding the Data –** Have each team member complete the HQCA module (typical time to complete 15 minutes) and discuss as a team or complete the module as a team. • **TOP Evidence Summary –** Review for more information on evidence to support continuity. • **An Alberta Perspective video –** To further understanding of the impact of continuity watch video (approx. four min) and discuss as a team.
2. Foster Patient/Provider	• Make explicit agreement with the patient that the identified primary care physician will provide and/or coordinate their healthcare needs.	Guide to Panel Identification	• **Guide to Panel Identification –** Provides a high-level explanation of principles of panel identification. Review as a team and see High

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High leverage changes	Potentially better practices	Tools	Notes and tips
(Team) Relationships	• Partner with patients for shared decision making and explore their values and preferences. • Develop modes of communication and care plans where all primary care team members respect and honor patients and families as team members in shared decision making.	Setting Effective Patient Centered Goals Tool ➢ Coming soon	Leverage Change #4 in this change package for additional details around panel identification process development. • **Setting Effective Patient Centered Goals –** The HealthChange® principle Four Aspects of Goal Setting can act as a guide to setting effective patient centred goals and are found in this tool. Consider how you could build these four aspects into care plan conversations with your patients and their families.
3. Advise and Advocate Continuity	• Promote and advocate the value of continuity to all patients and within the health system. ○ Within practice, within community ○ Advocate within health system by communicating and raising awareness of the value. ○ Educate and empower patients, families and caregivers to resolve discontinuity.	Printable Continuity Posters for Patients Continuity Advocacy Tool	**Continuity Posters for Patients** • Print and display these posters in patient areas, use to generate discussion regarding the value of continuity with patients. ○ Note: Three different messages – post one of each. **Continuity Advocacy Tool** • All members of the healthcare team are encouraged to promote and advocate the value of continuity to patients, to colleagues within their clinics, in the community, and within the health system. This tool outlines how to capitalize on opportunities to do so at different system levels.
4. Identify and Manage Your Panel	• Take steps to identify your panel of unique patients (those with whom you have a trusting, ongoing therapeutic relationship). ○ Develop processes for panel identification and ongoing verification and maintenance. ○ Ask your patients at every opportunity, document consistently, review your list. • Review and actively manage your panel size. • Identify and focus on sub populations who may benefit most from continuity (e.g., elderly patients, vulnerable populations, and those with complex needs or multiple chronic conditions). ○ Develop processes to identify patient lists of clinical need.	Guide to Panel Identification STEP (Supportive Tools for Every Panel) Documents: • Step Checklist • Step Toolkit • Step Workbook • Step Webinar Part I (video) • Step Webinar Part II (video) CII/CPAR (Community Information Integration / Central Patient Attachment Registry) What are CII and CPAR?(video)	**STEP Tools –** Summarize activities and outputs for panel identification and panel management screening in a checklist format • **Step Checklist –** Shortened version of full toolkit, intended as a guide for panel and screening activities, includes only activities and outputs. Useful for clinic teams, improvement facilitators or PCNs to monitor/document progress; as a tool to assess training needs; and/or to define and prioritize future goals. • **STEP Toolkit –** Activities and outputs of panel identification and panel management screening with suggested tools and related links. Also specifies how each activity relates to the Patient's Medical Home and 'implementation elements' necessary for transformation to a high functioning PMH. • **Step Workbook –** Intended for use at the clinic level, each activity in the toolkit is briefly explained and includes an exercise component with reflective questions and suggested activities.

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	○ Routinely review patient lists (whether patients still belong there or not).	Guiding Principles – Effective Use of EMR for PMH Work EMR Tip Sheets and Videos by Vendor	• **Step Webinar Part I –** Introduction to STEP Documents for Alberta Improvement Facilitators, can also be useful for clinics to view independently. • **Step Webinar Part II –** Panel Management: Screening Activities for Alberta Improvement Facilitators – leveraging panel and EMR to improve screening, can also be useful for clinics to view independently. • **CII/CPAR Overview (access links to tools in previous column for more information):** ○ Enables healthcare info sharing between patient's family physician and other providers in patient's circle of care and sharing of consultation reports. ○ Identifies relationships between patients and primary providers, allowing family physicians to ID when patients are on multiple panels and enables validated patient-family physician info to be available on Alberta Netcare. ○ Supports notification of primary providers of patient hospitalizations or ER visits. ○ Contact your PCN about receiving facilitation support for CII/CPAR participation. **Guiding Principles-Effective Use of EMR for PMH Work** **EMR Tip Sheets and Videos** • Leverage the power of your EMR to assist in panel identification, maintenance and clinical management of sub populations who may benefit most from continuity and team-based care.
5. Enable Continuity via Office Processes	• Test and adopt office processes to improve continuity with a goal where your patients visit their own primary care physician >80% of the time. ○ Test and apply hierarchy of booking processes to maintain continuity when patients cannot see their own primary care physician.	**Hierarchy of Booking Tool**	**Hierarchy of Booking** • It may not always be possible for patients to see their own primary care physician on the day they request despite best efforts to maintain good access. However, some degree of continuity can be maintained based on a scheduling appointments using a hierarchy of booking. • Use the tool to begin discussions around how to plan and coordinate appointment scheduling, in such a way as to promote care delivery by those who have some degree of relationship with the patient within the patient's medical home.

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6. Balance Demand for Care with Capacity (Supply)	• Apply the following principles and strategies for access improvement: ○ Match appointment demand to supply available. ○ Optimize the care team to enhance and maximize capacity. ○ Address scheduling complexities to maximize use of appointment time. ○ Utilize contingency planning for both scheduled and unscheduled time away.	**Improving Access Primary Care Strategies** **Tools and supports for improving primary care access** ➢ Under construction	**Improving Access Primary Care Strategies** • This tool provides your team with numerous proven strategies to test and implement to improve access under the following topic areas: ○ Balance Supply and Demand for Appointments ○ Reduce Demand ○ Optimize the Care Team to Increase Supply ○ Reduce Scheduling Complexity ○ Contingency Plans ○ Backlog Reduction
7. Measure Baseline Continuity & Track Progress	• Obtain data to know your current rate of continuity and identify a baseline from which to improve. • Develop, as a team, a goal (aim statement) that focuses on improving continuity. • Continue to measure, share and display your progress toward a goal of >80% continuity. • The following measure of continuity can be accessed via HQCA Primary Healthcare Panel Reports: ○ **Physician Continuity –** the number of patients' visits to primary care physician divided by the total number of all family physician visits ○ **Average physician continuity –** the sum of all individual patients' physician continuity divided by the total number of patients in the physician panel ○ **Facility continuity –** the number of family physician visits to a primary care facility divided by the total number of all facility visits	**HQCA Primary Healthcare Panel Reports**	**HQCA Primary Healthcare Panel Reports** • Individual physicians can request their panel report from Health Quality Council of Alberta (HQCA) and are encouraged to share with their team for improvement purposes. Measures to support continuity are found in these reports as well as more data that provide insights into panel behaviours and characteristics to aid in all areas of improvement. Details about the reports and how to use the data can be found at the link provided. **Develop an aim statement for improving continuity** • Ensure the following SMART components **S –** specific **M –** measurable **A –** achievable **R –** relevant **T –** time sensitive ○ For example: "We the, ___Clinic team will improve our rate of average physician relational continuity from baseline of 65% to >80% by December 1, 2019.

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High leverage changes	Potentially better practices	Tools	Notes and tips
	• **General practitioner sensitive condition visits –** average number of general practitioner visits to the emergency department (ED) by a specific patient population		
8. Optimize the Patient Care Team to Improve and Support Continuity	• Develop processes to engage with patients as a member of their own care team. • Create processes to support team-based care (.e., algorithms, shared EMR, interdisciplinary huddles, regular meetings to discuss care and care coordination). • Develop roles and responsibilities where the skills, knowledge and training of all team members is optimized.	Cambridge Health Alliance Team-Based Care Toolkit	**Team-Based Care Toolkit** • Team-based care allows provision of care in a safe, accessible, effective, efficient, patient-centered care manner, with the patient acting as a member of their own care team. • Sharing patient care across an interdisciplinary team enables primary care physicians to provide care for more patients and results in increased patient access to their primary care physician. • Work though the team-based care toolkit to redefine roles and responsibilities, develop processes for communication and care coordination.
9. Optimize All Potential Improvements in All Contexts	• Follow the above recommendations, particularly around access improvement to exercise all possible strategies to improve continuity. • Understand that relational continuity still holds value in all contexts and may require more innovative strategies including engagement with other groups to creatively problem solve together. • Recognize that improving continuity is a multifactorial pursuit that optimally requires effort in all areas of recommendations and despite challenges some levels of improvement can be achieved in all contexts. • Address each recommendation based on context and capacity with the support of Alberta resources including the Continuity Change Package, PCN and other provincial supports	• As per tools listed in all previous sections.	• As per all previous sections.

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Appendix A – Quality Improvement Tools for Skill and Knowledge Development

Building a culture of quality improvement is integral to supporting improvements toward PMH. The following tools have been developed as resources for clinic teams to build skill and knowledge.

Tools and Resources	Notes
Quality Improvement Guide	• Review the Quality Improvement Guide as a team. • Foundational quality improvement skills used for improvements to continuity can be used to improve care or processes in any area; e.g. - more reliable screening and prevention of patients or improving outcomes for patients with specific clinical conditions. They offer a structured process and sequences of steps that reduce the risk and disappointments of traditional change efforts which are typically not well organized or designed.
Physician Leaders Network Webinar Series	• Watch pre-recorded Webinars: Physicians Engaging in QI, Teams Leading QI, Patient's Medical Home and Your Practice for practical tips and advice on quality improvement in your practice and how to do this as a team. Each webinar is maximum 1 hour in length. Ideally, view together as a team and discuss how you can apply in your own clinic.
PCN Improvement Facilitators (IF)	• Contact your PCN to inquire about IF support available to your clinic.