QUALITY EXCHANGE

Committed to Improvement in Primary Healthcare

HQCA Health Quality Council of Alberta

June 2020

Improving relational continuity

In relational continuity, several primary care networks (PCNs) in Alberta have shown improvement, or have been performing above the provincial average, according to recent data on the Health Quality Council of Alberta's FOCUS on Healthcare website.

Taking into consideration factors like rural vs. urban settings, emergency department visits for minor conditions, and size, we identified several PCNs with an improvement story.

The HQCA met with leadership from Bighorn, Wood Buffalo, Edmonton Oliver, Chinook, and Wolf Creek PCNs to see what's driving their efforts.

HERE'S WHERE THEY **INVEST** THEIR TIME:

- ☑ Improving office and scheduling practices to more efficiently verify patient panels and improve access
- ☑ Using full EMR capabilities to set flags, reminders, and facilitate better information sharing and management continuity
- ☑ Focusing on routine clinical processes such as screening to drive improvements in paneling and continuity
- ☑ Fostering physician and healthcare team participation to support quality improvement, measurement, and teamwork

The actions of these PCNs align closely to the Toward Optimized Practice (TOP) clinical practice guidelines for increasing continuity.

TOP Recommendations

1. Recognize the value of continuity
2. Foster patient/provider (team) relationships
3. Advise and advocate for continuity
4. Identify and manage patient panels
5. Enable continuity via office processes
6. Balance demand for care with capacity (supply)
7. Measure baseline continuity and track progress
8. Optimize the patient care team to improve and support continuity
9. Optimize all potential improvements in all contexts

Click **here** for a summary of the TOP Relational Continuity Clinical Practice Guideline, and **here** for the full report.

Continuity 101

There are three interdependent types of continuity in healthcare.

Relational

Refers to an ongoing, trusting therapeutic relationship between a primary healthcare provider (which can include a team) and a patient. Relational continuity helps create a Patient's Medical Home – a family practice where the patient feels most comfortable to discuss their personal and family health concerns.

Informational

Refers to the communication of facts and opinions across team, institutional, and professional boundaries, and between providers and patients. It's often enabled by clear communication processes and technology.

Management

The co-ordination and handoff of care between relevant care providers using a shared care plan in a way that is both consistent and flexible to meet patient needs. It involves the integration of primary and acute care.[1]

"Continuity of care with a family doctor is probably the single most important thing a healthcare system can provide to its population."

– Dr. Richard Lewanczuk, Sr. Medical Director, Primary Healthcare, AHS

WHY DOES CONTINUITY MATTER, why is it important to imitate what these PCNs have done, and why follow the nine TOP recommendations?

Because even small improvements in continuity can make a big impact. This is particularly true in the care of patients with ongoing conditions, such as chronic obstructive pulmonary disease (COPD).

COPD is responsible for the highest number of patient hospitalizations and lengths of stay in Alberta.[2] A COPD exacerbation causes lasting damage, reduces quality of life, increases the risk of future exacerbation and hospitalization, and costs approximately $10,000 on average per hospital admission.[3] Medical professionals wouldn't be surprised by those findings.

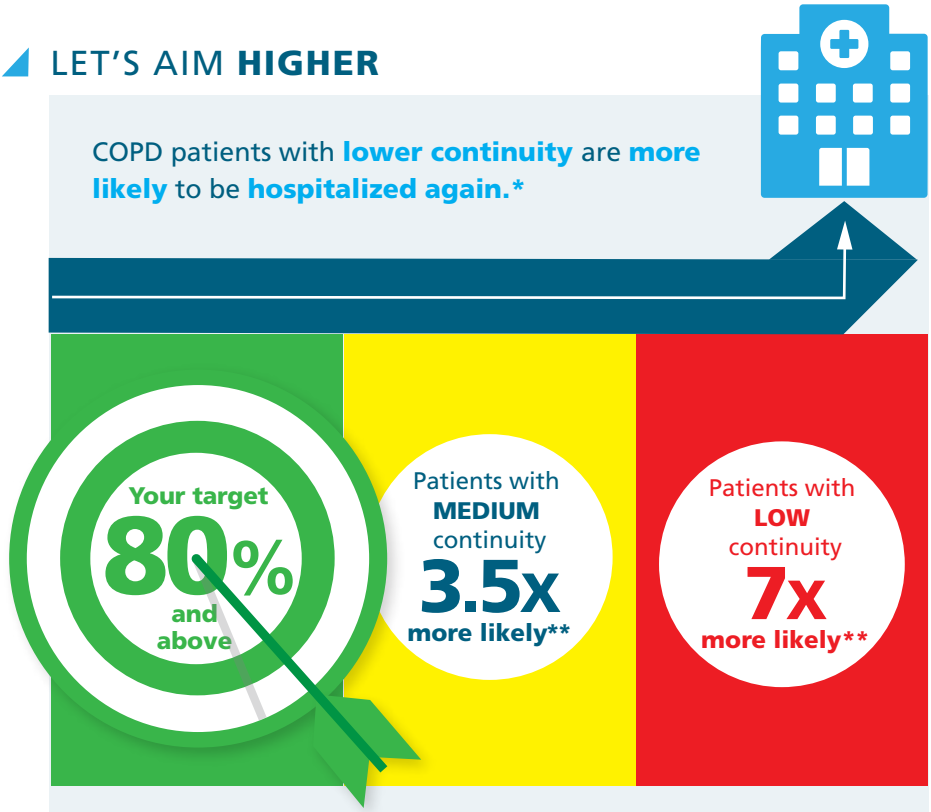
After returning home from a hospital stay due to COPD, approximately **1 in 5** Canadian patients will be **readmitted within 30 days**.[4]

"It has made a big difference to better identify and proactively manage our high-risk patients, rather than waiting for a crisis that can often lead to a hospital admission," said one family physician from a large urban PCN.

Another practitioner told the HQCA: "Many of our patients with chronic health conditions have told us that having a close relationship with their family physician, and care team, has significantly reduced the level of anxiety they feel as they live with the highs and lows of their illness. As they manage their care, they say that these strong connections provide them with a real peace of mind."

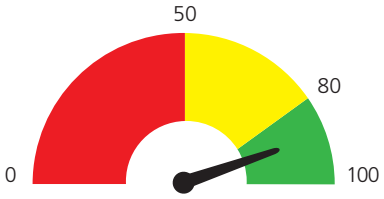
LET'S AIM **HIGHER**

COPD patients with **lower continuity** are **more likely** to be **hospitalized again.***



***Source:** Administrative data from 2012/13 to 2016/17.
****When compared to COPD patients with high continuity**

Highs and lows of continuity



HIGH

if your patients see you 80% or more of the time.

MEDIUM

if your patients see you between 50% and 80% of the time.

LOW

if your patients see you less than 50% of the time.

EMMA'S STORY

The best way to understand the value of relational continuity is to hear the experiences of patients. This is Emma's story.

It took Emma several years, but she is finally feeling more at peace with her medical care. And she credits that to the consistency of her family physician, and supporting team.

Emma (not her real name) is a patient with COPD living in a small community northwest of Edmonton.

Her diagnosis with COPD in 2012 was difficult. "At that time, I was trying to figure out the new realities of my illness. Not being able to do simple things like sweeping the floor, or enjoying a walk outside, or having to rely more heavily on my husband and other people. Things felt so different. I also needed to be more conscious of my breathing, and aware of things like the length of my oxygen tubing, and the amount of air in my canister," she says. "I've always felt the worst part about COPD is not being able to do things that I used to take for granted."

During those initial years, along with navigating life with this new illness, Emma was also trying to find a family doctor who truly knew her – someone she could feel comfortable with and rely on.

Family doctors, though, seemed to come and go in her town. And if she couldn't get in to see one physician, she'd just go somewhere else – each time having to start all over again, re-explaining her needs, medications, and symptoms.

With no consistent relationship, there was no plan to manage her care. A common default was to seek care through the emergency department (ED), which often led to an admission to hospital.

Things started to improve for Emma once she finally made a strong connection with a family physician who was new to the community, and connected to a Primary Care Network.

This physician, along with a chronic disease management (CDM) nurse and a support team, were driven by the following mantra when first connecting with Emma:

What matters to you?
Your provider should:

- **Ask what matters.**
- **Listen to what matters.**
- **Do what matters.**

From here, although complicated by a few other medical challenges, the team worked hard to understand what mattered most to Emma. Her COPD was diagnosed, and a corresponding care plan was built to best meet her needs. A consistent single point of contact to the clinic was provided through the CDM nurse, who also taught regular COPD education sessions.

Emma attended many of these classes, and came to better understand her illness. She learned more about the things in her control, and the importance of making strong connections with other services - like home care and her community pharmacist. In the last year, Emma hasn't required any visits to the hospital, and her medical visits (including some home-visits) have been with her family doctor and support team almost 100 per cent of the time.

"I now have great confidence that someone knows my medications, my needs, and what matters most to me," she says. "And that's important to me. It helps me manage my COPD and other health concerns better, and brings me so much peace of mind."

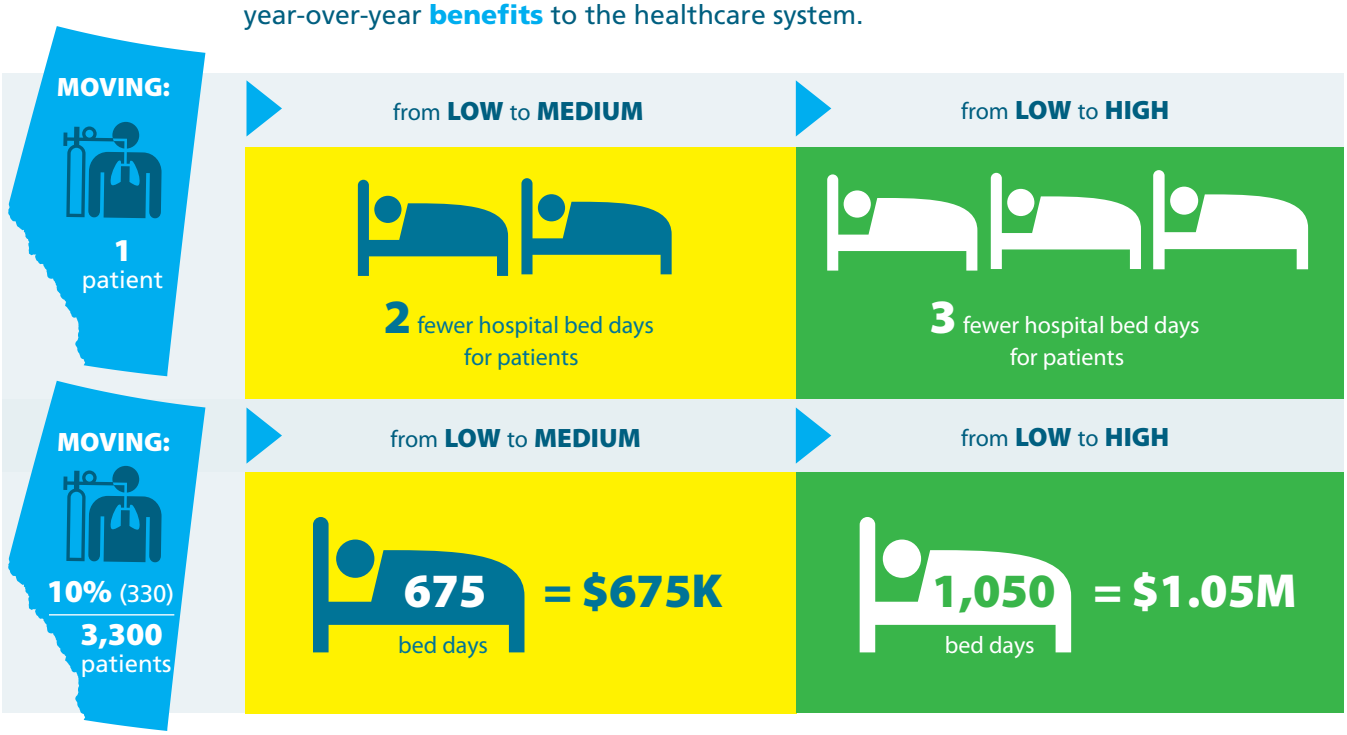
TAKE **ACTION,** MAKE A **DIFFERENCE**

Approximately five per cent of Albertans over the age of 40 are living with COPD,[5] and many will require hospitalizations in a given year. Roughly 3,300 of these patients, who have had a prior admission to hospital, are seen by the same family physician less than 50 per cent of their visits. This low continuity group represents the most 'at-risk'. With these 3,300 patients, though, there is great opportunity to make meaningful improvements.

Could you identify at least one of these patients on your panel? What would the impact be if multiple clinics were able to identify a few of these patients, and move them to higher levels of continuity?

SMALL CHANGES IN CONTINUITY CAN MAKE A **BIG DIFFERENCE**

Moving patients to **higher continuity reduces** repeat hospital admissions, and offers year-over-year **benefits** to the healthcare system.



Source: Administrative data from 2012/13 to 2016/17.

"It is impossible to deliver coordinated care to our most vulnerable patients without having them strongly attached to a specific primary healthcare physician. Through a collaborative approach, we can achieve strong levels of satisfaction, high quality of care, and lower levels of hospital readmission."

– Family physician, small rural PCN

HOW CAN A DIFFERENCE BE MADE IN THE CLINICAL SETTING?

Practical tips

Know your patients – create a disease registry
- Know your panel, and identify a sub-group of at-risk patients.
- Use your *HQCA Primary Healthcare Panel Report* to better understand your patients' overall continuity.

Form a team – be committed to quality improvement
- Who are the right people in your clinic to identify at-risk patients? Who is best to proactively reach out to these patients? Who is best to provide care for these patients?

Streamline office processes – focus on your most at-risk patients
- Be proactive. Use things like electronic medical record (EMR) reminders to routinely book these patients in, and leverage your multidisciplinary team.

Evaluate improvement efforts – measure and monitor for success
- Are at-risk patients being seen regularly?
- Are patients' experiences with care stable or improving?
- Are any of these patients being seen in the emergency department or admitted to hospital?
  - If yes, are there further strategies or processes that can be implemented?

Did you know?

An **average panel** size for a physician in Alberta is approximately **1000 patients,** and each could potentially have **20 people with COPD.** With COPD, or any chronic condition, **improving continuity** for even just **10%** of these patients could have a **significant impact** on quality of life, ED visits, hospitalizations, and cost to the healthcare system.

Not just COPD

While COPD has been used to **help illustrate** the effect of **increasing continuity**, similar improvements can be made for **other common conditions**. **Small steps. Small changes. Small improvements. You can make a big difference.**

RESOURCES TO SUPPORT RELATIONAL CONTINUITY

Toward Optimized Practice (TOP)

Toward Optimized Practice develops Clinical Practice Guidelines for use by physicians and their teams. Follow the links below for resources related to relational continuity.

- **Relational Continuity Clinical Practice Guideline**
- **Relational Continuity Change Package**

HQCA Primary Healthcare Panel Reports

Upon request, the HQCA provides Primary Healthcare Panel Reports to family physicians across Alberta. This free resource is an invaluable tool to support and inform panel management, and can also assist in identifying low continuity patients in your panel.

- **Learn more about the panel reports and request a report**
- **Primary Healthcare Panel Reports – understanding continuity data**

HQCA FOCUS on Healthcare Website

The HQCA's **FOCUS on Healthcare** website is a resource for reliable information about what patients experience in Alberta's healthcare system. Specifically, the primary healthcare section shows several measures related to continuity, as well as data related to clinical care, and patient experience. Measures can be viewed and compared at a PCN, zone, and provincial level.

- **Check out FOCUS on Healthcare: Primary Care to see continuity related data**

HQCA Primary Care Patient Experience Survey

What are your patients thinking? Are their needs being met? What could physicians and their team do differently? The HQCA's Primary Care Patient Experience Survey was developed with patients, specifically for Alberta's primary care physicians and their teams to provide feedback that is standardized, actionable, and reliable. Then include these bullets:

- **See a step-by-step guide to surveying your patients –**
- **Review a physician report sample**
- **Sign-up so your patients can participate in the survey**

CII/CPAR

This resource is the chosen vehicle to integrate community EMRs with two-way data flow. Community Information Integration (CII) is a system that enables the sharing of select patient information between community Electronic Medical Records (EMRs) and other members of the patient's care team through Alberta Netcare. The Central Patient Attachment Registry (CPAR) is a provincial system that captures the confirmed relationship of a primary provider and their paneled patients.

- **Learn more about CII/CPAR**

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