Alberta Doctors' Digest

Do your patients experience gaps in care?

"Having a family doctor, being able to access the family doctor, and most importantly, continuity of care with a family doctor, is probably the single most important thing a health care system can provide to its population."

– Dr. Richard Lewanczuk, Senior Medical Director, Enhancing Care in the Community, AHS

An important implementation step toward the patient's medical home model involves recognizing and advancing relational continuity. Relational continuity is 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. This continuity results in improved health outcomes, decreased mortality, better quality of care, reduced health care costs, increased patient and provider satisfaction, and fewer ER visits and hospital admissions. A summary of evidence for these results may be found here.

Alberta has made progress in improving continuity of care, yet there is still opportunity to improve.

To support physicians, teams and patients in achieving the benefits of relational continuity, Toward Optimized Practice has developed a *Relational Continuity Clinical Practice Guideline* to provide recommended practice behaviors for improvement.

The guideline describes how adoption of the following practice behaviors can improve relational continuity:

- patient-centered care
- panel identification and maintenance
- scheduling via a booking hierarchy
- access improvement
- team-based care
- measuring and tracking progress to continuity goal

This clinical practice guideline (CPG) represents a journey and a goal to strive toward. These recommendations are systematically developed statements to assist practitioner and patient decisions about appropriate care within the context of relational continuity. Achieving relational continuity in our dynamic health care environment is a challenge. However, the strong evidence for relational continuity means that implementing even some of these changes will have positive impacts. As with any CPG, these practice behaviors should be used as adjuncts to sound clinical decision-making.

"Imagine a health care system where there is clarity around which patients share relationships with specific primary care providers, with two-way data flow between community clinics and the provincial Netcare record. "

To learn more about how the practice behaviors can improve relational continuity, access the continuity CPG here. An accompanying change package has been developed to aide physicians and their teams in testing and adopting new behaviors and processes based on CPG recommendations. The change package can be found here.

In an ideal setting, relational continuity is supported by the timely sharing of information between providers (informational continuity) and the coordination of care for patients (management continuity). How can these be put into practice?

Imagine a health care system where there is clarity around which patients share relationships with specific primary care providers, with two-way data flow between community clinics and the provincial Netcare record. This is now a reality with the Community Information Integration/Central Patient Attachment Registry (CII/CPAR) which is a technical enabler of relational continuity of care and informational and management continuity.

A key practice behavior identified in the Relational Continuity CPG is patient panel identification and maintenance. This is an area where participation in CII/CPAR can play a crucial role. Primary care clinics submitting panels to CPAR can identify patients panelled to other participating physicians anywhere in Alberta and receive notice of deceased patients, further enhancing their ability to clearly identify and maintain their panels.

CII/CPAR is the chosen vehicle to integrate community EMRs with two-way data flow. Participating community specialists are appreciating the efficient upload of their consult reports to Alberta Netcare and the value of contributing to a more complete record in Netcare. Many patients are very ill, and now other providers in their circle of care may access the consult reports. Emergency room physicians are just beginning to see the value of access to the consult reports of community physicians and the Community Encounter Digests, which show past encounters in CII-enabled clinics.

As of the end of May, 35 PCN and clinic resources from 13 PCNs and AHS have been trained to support clinics implementing CII/CPAR. Currently, 96 community physicians (specialists and family practitioners) in 31 clinics are live on CII/CPAR, and over 35,000 unique patients have Community Encounter Digests in their Netcare record, informed from over 101,000 encounters in CII-enabled clinics. That number continues to grow, and while there is early value for current participants, many are excited about eNotifications, which will be enabled later this year in the first of the four CII-conformed EMRs. Physicians participating in CPAR will receive notification directly in their clinic EMR when one of their panelled patients has had an emergency department visit, hospital admission or discharge, or day surgery.

Specialists using a Healthquest, Wolf, Med Access, PS Suite or Accuro EMR who are interested in participating can get more information here and may contact the Alberta Health eHealth Support Services Team at eHealthSupport@cgi.com to move forward with participation.

Primary care physicians can get more information here and should contact their PCN regarding their interest in participating. Clinic teams and facilitators can learn more about how CII/CPAR works and what implementation involves with support from videos and other resources.

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