
Innovation Hubs Test Box #2

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Getting Ready for Continuity

What?

Continuity of care is the consistency over time to where, how, and by whom each person's medical care needs are addressed throughout the course of his or her life. Continuity occurs when care is provided by a patient's own physician or care team whenever possible.

Why?

The benefits of attachment and continuity in primary care:

- Improved health
- Improved self-management
- Improved adherence to treatment
- Improved satisfaction
- Improved preventative care
- Lower utilization and hospitalization
- System cost savings

[\(Continuity Evidence Summary – full document\)](#)



Why Focus on Continuity?

Here is what the **Alberta data** tells us:

- When a patient sees a family doctor rather than going the Emergency Room, that patient is **10 times** less likely to be hospitalized for that **same condition**.
- 20% of hospitalizations are due to the clinical state of the person while **80%** are due to their **social circumstances**
- In Alberta, when patients see a primary care provider **75%** of the time or more:
 - Hospitalization is **6 times** less likely
 - The cost to the healthcare system is **10 times** less
 - Cost of care is also reduced for those patients with multiple chronic conditions and complex health needs
 - Length of stay in hospital is considerably less
 - Patients are less likely to die

PaCT Fact

If we could only do one thing...

“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, Primary Health Care, AHS

(Check out the [“Continuity of Care Challenge”](#) to see the data.)

Potentially Better Practices:

Teams have a shared understanding of the importance of continuity

All team members in a clinic are critical contributors to patient continuity, and it is important for them to understand the evidence, as well as how their roles contribute to continuity.

Teams use data to understand the practice’s continuity from the patient perspective

Panel reports can be used to inform a team about their continuity. Consider the following:

- EMR panel reports and searches
- HQCA Proxy Panel Report
- HQCA Confirmed Panel Report

Teams have a shared understanding of the provider behaviors that contribute to continuity

A Clinical Practice Guideline is currently in development for continuity. Resources and a toolkit will be available later in 2018. In the meantime, teams would benefit from considering some of the provider behaviours that contribute to continuity.

Teams are preparing to participate in the Central Patient Attachment Registry (CPAR)

CPAR is a technical enabler of Continuity and will launch in the Spring of 2018. Teams can prepare for CPAR by:

- Reviewing clinic panel identification and maintenance processes
- Using the **Panel and CPAR Readiness Checklist** and the **Roles and Responsibilities of a CPAR Panel Administrator**
- Continue to confirm patients at check-in

Test

Discuss as a team:

- Do we confirm the patient's primary provider at every encounter and document it in the EMR with a date stamp?
 - *For more on this, see the section "Determining and Monitoring Panel Confirmation Rates" included in this Test Box.*
- Do we make every effort to schedule a patient with their primary provider and/or care team when they are seeking care?
- How often are patients seen by other providers in our clinic because we are not available?
- Do we provide patients access to appointments at the right time when care is needed?
- Are some patients seeking care elsewhere (i.e. walk-in, emergency department) because they are not able to get an appointment with us?
 - Consider checking with the reception team regarding how often patients call for an appointment, but end up not booking because they can't be seen soon enough.
 - These patients will often book somewhere else or visit walk-in, urgent care, ER.
 - Patients who book the appointment anyway – 'just in case' – and still go somewhere else for more immediate care will often be a 'no show' if their problem has been resolved elsewhere.
- Do we regularly measure our access from the patient's perspective (Third Next Available) and regularly discuss the measures as a team?
- Do we regularly maintain and review our panel list?
- Do we utilize the panel list to plan care delivery?
- Do we regularly run searches to identify those patients that have not been into the clinic for the last year?
 - *For more on this, see the section "Running EMR Searches" included in this Test Box*
- What are our HQCA Panel Reports telling us about our continuity?

Activity

Test your knowledge by taking the Continuity Challenge! This quiz can be used in a number of ways. For instance, you may want to use it to inform the larger clinic team about the importance of continuity, and how it relates to Patient's Medical Home, panel management, access/TNA measures, etc.

TIP: Get creative in how you use the quiz. Perhaps break it down – one question per week. Or, maybe a game format with a prize!

Resources:

Continuity Challenge PowerPoint: [Continuity of Care Challenge](#)

Value of Continuity: [Value of Continuity](#) (Infographic and Summary - Updated 2017!)

Key Messages: [Key messages - The value of relational continuity](#)

Central Patient Attachment Registry (CPAR) Tools & Resources: <http://www.topalbertadoctors.org/CPAR/>

Continuity Challenge: [Continuity Challenge](#)

Effective Communication for Care Planning

What?

Effective **communication** allows for the exchange of thoughts, feelings and ideas, and leads to mutual understanding and rapport between two or more people. Application of specific communication principles can help guide individuals and teams to compose effective communication messages.

Why?

Teamwork and good communication are essential to providing high quality care. Effective care planning involves many instances where critical information must be accurately communicated. Team collaboration is essential. When healthcare professionals are not communicating effectively with each other or patients, engagement and safety can be put at risk.

Test

If you choose this item from the test box, then as a team:

1. Reflect on what guides your communication as a team and what guides your communication with your patients.

- What previous trainings or education have you and the team accessed to support your communication (e.g., motivational interviewing, solution focused counselling or cognitive behavioural therapy)? Is there consistency across the team in what you know about patient-centred communication?
- Is there consistency with how you communicate with your patients, or are you all doing things a bit differently? What do you think the impact is on patient experience? How do you think using consistent communication principles across the team would support continuity?

PaCT Fact

What do people want from their healthcare team?

Providers who:

- *listen to them*
- *are caring and compassionate*
- *explain well*

(Wen & Tucker, 2015)

2. Identify common team practices that support patient-centred care and good communication.

- Refer to the accompanying [HealthChange® resources](#) to guide your discussions and testing (PDSA)
- Start out by learning and experimenting with these four principles:
 - First ask, then offer
 - Wait til 8
 - Invite the client to write
 - Trial & error
- Select one or two principles to focus on at first. If appropriate, consider asking a team member to observe your interaction with a patient to provide feedback on how you used the principle(s).

- After testing (PDSA) the use of a principle, reflect on how it impacted your interaction with that individual. Consider asking the patient about their experience. Was the person more engaged? Did using the principle change the conversation in any way? Consider using a brief huddle to share your learnings with team members.

Resources:

[HealthChange® Person-Centred Practice Principles](#) (Interactive PowerPoint)

[Enhancing patient-centred practice: a focus on four principles](#) (One page document)

Examples – Invite to Write

Example for use of "invite to write" with a team member:

"Cindy, we have a crazy morning and I'm hoping you can help me do an urgent referral. (Cindy agrees to assist) Feel free to jot down the details for the referral."

Example for use of "invite to write" with a patient in care planning:

"Frank, as I've just shared, we're going to spend the next 30 minutes working through your care plan. Some patients find it helpful to take their own notes as we talk. Feel free to write down anything that's meaningful for you as we work through this process together."

Example – Trial & Error

Example for use of "trial & error" with a team member:

"Claire, we're trying out this new care plan template with two of our patients today. Things might not go quite as planned and it might take a few tries to find the right approach. Take note of anything that gets in the way of you carrying out the care planning process or visit. We can huddle at the end of the day and work through solutions together. It's important to figure out what will work best for our team."

References:

Wen LS, Tucker S. What do people want from their health care? A qualitative study. *Journal of Participatory Medicine*. 2015 Jun 18; 7:e10.

Coordinating Today's Work Together

What?

Coordinating today's work in a busy clinic can involve more than just having a daily schedule. Brief, informal meetings - or 'huddles' - can be very helpful for team members to plan the day ahead or manage unexpected events that threaten to disrupt the flow. Huddling can also be an effective method for providing proactive patient care. For example, a brief pre-clinic huddle to review the schedule for the day ahead may reveal a patient with complex needs, who rarely books appointments, and could benefit from care planning. The team can quickly plan a strategy for engaging this patient in coming back for a care planning appointment.

EMR messaging systems can also be an effective communication tool for coordinating activity when face-to-face time is difficult to organize.

Why?

Clinics are typically busy places, and it's often rare that the daily schedule goes as planned. A team must be responsive and flexible to meet the needs of their patient panel. A clinic team caring for complex patients must communicate and coordinate efforts among its members on a regular basis. Implementing brief 'touch points' at least once or twice per day can help to ensure an efficient clinic day with fewer surprises, and also create the opportunity for proactive care by engaging patients in care planning (or other) appointments.

Tips

Huddles

Huddles are typically:

- Brief (< 15 minutes long)
- Focused – ensure everyone knows the purpose of the huddle ahead of time
- Done while standing (at EMR, if applicable)
- Same time every day (e.g., pre-clinic), **and/or**
- As needed (e.g., PDSA check-in)
- Inclusive – every team member present can speak up

Topics typically discussed in pre-clinic huddles:

- Who is coming in today? Any cancellations?
- What can be prepped ahead of time and by whom? (e.g., pull in results from Netcare, set up for pap, etc.)
- Is there anything we should know? (e.g., patient is grieving)

- Is the patient due for anything we can deal with opportunistically – ‘while they’re here’? Examples:
 - Patient needs but has never had a care planning appointment (first time ‘engagement’)
 - Care plan needs follow-up
 - Prescription renewal coming up (avoid another appointment)
 - Screening appointment coming up (provide with requisitions in advance)
 - An appointment with a team member would be helpful (e.g. pharmacist for a med reconciliation) – engage and book
- Contingency planning to manage the day when a team member is off sick or on vacation

Resource: [Sample Huddle Checklist](#)

EMR Messaging

The EMR is another option for communicating during the day. Every EMR is a little different in what they offer, but here are a few general tips to consider:

- If you message a phrase more than once per day, you may be able to set it as an ‘auto-replace text/macro’ to save time typing
- Auto replace text can be as short as a phrase, or as long as a paragraph
- Text in messages in Wolf & PS Suite are searchable, which offers an additional opportunity for creating searches around an “auto-replace text”
- Most EMR users have one or two team members they message most often - some EMRs have a ‘my favourites’ setting for convenient and efficient messaging

EMR-specific Tips

Med-Access

- ‘Tasks’ - a clinical task message that is associated with the patient and can be viewed by others
- ‘EMR Messenger’ – not associated with a patient so do not form part of the patient record, and appear only in the ‘message box’ of the person who sends or receives the message; therefore, not recommended for clinical activity

Accuro

- There really isn’t an ‘instant’ message capability in Accuro, just regular messaging which can be in the form of a message, task, lab, etc.
- Messages can be associated with a chart, or not, by clicking a box (i.e., click the box and it associates the message with the chart which is currently open)

Wolf

- ‘Messages’ - searchable and tracked
- ‘Follow-ups’ - not searchable, but tracked

Healthquest

- ‘Insta-messaging’
- ‘Worklists’ - a clinical task message that is associated with the patient and can be viewed by others; not searchable, but tracked

PS Suite

- 'Messages' are best used for 'clinical' purposes and can be part of the patient's progress notes
- Messages are not searchable in 'Searches', but within an individual patient chart, Cntl/Cmd"F" can be used to find key words
- 'Stamps' can be added into messages to make them searchable
- 'Instant Messages' are good for quick communication to another user in the clinic where the information does not need to be appended to the patient chart

Example Scenario – Opportunistic Offer of Care

At the pre-clinic huddle, the team is reviewing the schedule for the day. Jasmine (panel manager) comments that Mrs. Singh is coming in for a prescription refill and her name came up on the EMR query for patients with complex health needs who are over 65 and haven't been in to the clinic for more than a year. Dr. Lee responds that it would be very beneficial to engage her in attending a care planning appointment, but anticipates that he may be running late at that point – the patient before her is coming in for a counselling appointment. Nancy (LPN) offers to talk to Mrs. Singh when she rooms her, and invite her for a care planning appointment. She'll review the script ahead of time to refresh her memory on the key points to mention. Dr. Lee says that he'll touch on it briefly, when he sees Mrs. Singh, to reinforce what Nancy has said. Beth from reception suggests that Nancy send a quick EMR message if Mrs. Singh is agreeable about coming in for care planning so that the reception team can ask Mrs. Singh if she'd like to book before she leaves the clinic.

Test

Plan: Discuss who should be there, as well as when and where it would make the most sense for your team to huddle. **Example:** Fifteen minutes before the first appointment of the day, at the EMR in exam room 1, Dr. Lee, Jasmine, Nancy, one person from reception, PCN MDT as applicable that day – i.e., CDM RN (Tuesdays), BHC (Wednesdays).

Do: Try your huddle plan.

Study: Debrief on how it went and what might add more value for the time spent. Repeat until you have a process that works for all. **Example:** During the first PDSA cycle, our huddle seemed too unstructured. Next PDSA cycle we'll test out using a checklist and assigning a 'huddle lead'.

Act: Repeat until you have a process that works for all.

Consider:

- Documenting the huddle process that works for you to make orienting new team members easier
- Using the huddle time to give a brief 'shout out' to a team member who went above and beyond
- Adding an element of fun to start the day off on a high note!
- A PDSA of huddles beyond the morning, for example:
 - End of day or 'crazy day' debrief huddle - review what went well, what didn't, what could be handled differently to manage better next time
 - Regroup huddle – if something unexpected comes up in the middle of the day, very briefly meet to plan how to minimize disruption

Panel Confirmation Rate

What?

The panel confirmation rate is a measure that shows how often the team is recording that they have confirmed patient attachment (and demographics) in the EMR.

Why?

The definition of a panel that we use in Alberta is:

The group of patients who consider a particular physician (or nurse practitioner) to be their primary provider, and that provider agrees.

By definition, for a patient to be included on a panel, both the patient and provider agree to the relationship. If there is no record of the patient agreeing, there is no way to produce an accurate panel list to use to plan care delivery.

Although it may seem as easy as confirming with the patient one time, in reality the primary care relationship needs to be confirmed at least annually. For example, some patients see more than one physician, and may consider someone else to be their 'primary' care provider. Most teams find it simplest to just add a question, such as, "Who is your family doctor?" when confirming the patient's demographics (address, phone number) at reception. Doing this every time versus annually is usually simpler for the team members doing the work, and just becomes part of the 'routine'.

PaCT Fact

As with all quality improvement measures this measure is for improvement, not for judgement.

Panel Confirmation and CPAR: When submitting a panel to CPAR, one of the data requirements is a 'confirmation date'. If a patient is not confirmed, their name will not go into the registry. The confirmation rate will help clinics see how well their confirmation processes are working so all patients that have verbally confirmed attachment are noted in the EMR, and can then be uploaded into CPAR.

Panel Confirmation and PaCT: Care planning is intensive for patients and clinic teams. You do not want to care plan on a patient who may have already had a care plan completed elsewhere! This results in poor quality of care for the patient, frustration for providers, and is expensive for the system.

Tips

- Team members will become more willing to take this step if they understand the importance of it. Take time as a team to talk about how 'attaching' patients is a benefit to patients, teams and the healthcare system. Taking a regular process measure and displaying it on a 'run chart' will show all team members how important the confirmation step is.
- For many teams, the provider confirmation step eventually becomes "the way we do things around here". For teams where this step is new, the panel confirmation rate is an important check on team processes.
- Taking this process measure regularly will reinforce the importance of confirmation to all team members.
- Make panel confirmation a team sport. If many individuals are responsible for confirming patients, discuss how you can work as a team to improve everyone's confirmation rates.
- Some teams have used incentives, such as contests or inexpensive 'prizes', to help team members remember this new process addition. For example, the receptionist with the highest confirmation rate each month wins a gift card. This incentive adds an element of fun, and is usually only required until the process becomes habit (e.g., 3 months).

There are 4 key steps related to panel confirmation:

1. Ask the patient to confirm his/her primary provider (optimally, at every interaction)
2. Record and date stamp the confirmation in the EMR
3. Maintain and review the list
4. Use the confirmed panel list to plan care delivery

There are detailed instructions in each of the EMR Guides (Microquest-Healthquest; QHR/Telin-Mediplan; Telus-MedAccess; Telus-PS Suite; Telus-Wolf; QHR-Accuro) on:

- How to record the patient confirmation
- How to calculate the patient 'confirmation rate'

Once on this page on the TOP website, select the tab with the EMR product you are looking for:

<http://www.topalbertadoctors.org/tools--resources/emrsupports/#1>

In quality improvement language, the confirmation rate is a 'process measure'. A process measure tells us how well the things we're doing that will lead us toward a particular outcome are working. In this case, our outcome is a confirmed panel list and confirmation rate will tell us how likely we are to reach our goal of a confirmed panel.

Test

If confirming patient attachment and recording it in the EMR are NOT established processes in your clinic, this is an important starting point for your team. The [STEP Documents](#) are excellent resources to help your clinic establish the simple processes necessary.

Once you have a process for confirming patient attachment established, you will want to begin to measure your **panel confirmation rate**.

How often: When starting out, you will want to take the measure fairly often so that you can get some early traction with it. On the ambitious end, some clinics take the measure daily. If this is not feasible, consider taking it at least weekly. It is recommended to maintain a daily/weekly frequency until you are near 100% and maintaining this rate.

Who: Once you decide how often to take the measure, designate who in the clinic is responsible to take the measure. Remember, you are taking the measure frequently for the short term until you have established your panel confirmation processes. Taking a frequent confirmation rate measure is temporary; once the process of confirming attachment is established and part of the routine, only periodic checks will be necessary.

Measure: The calculation for a weekly measure looks like this:

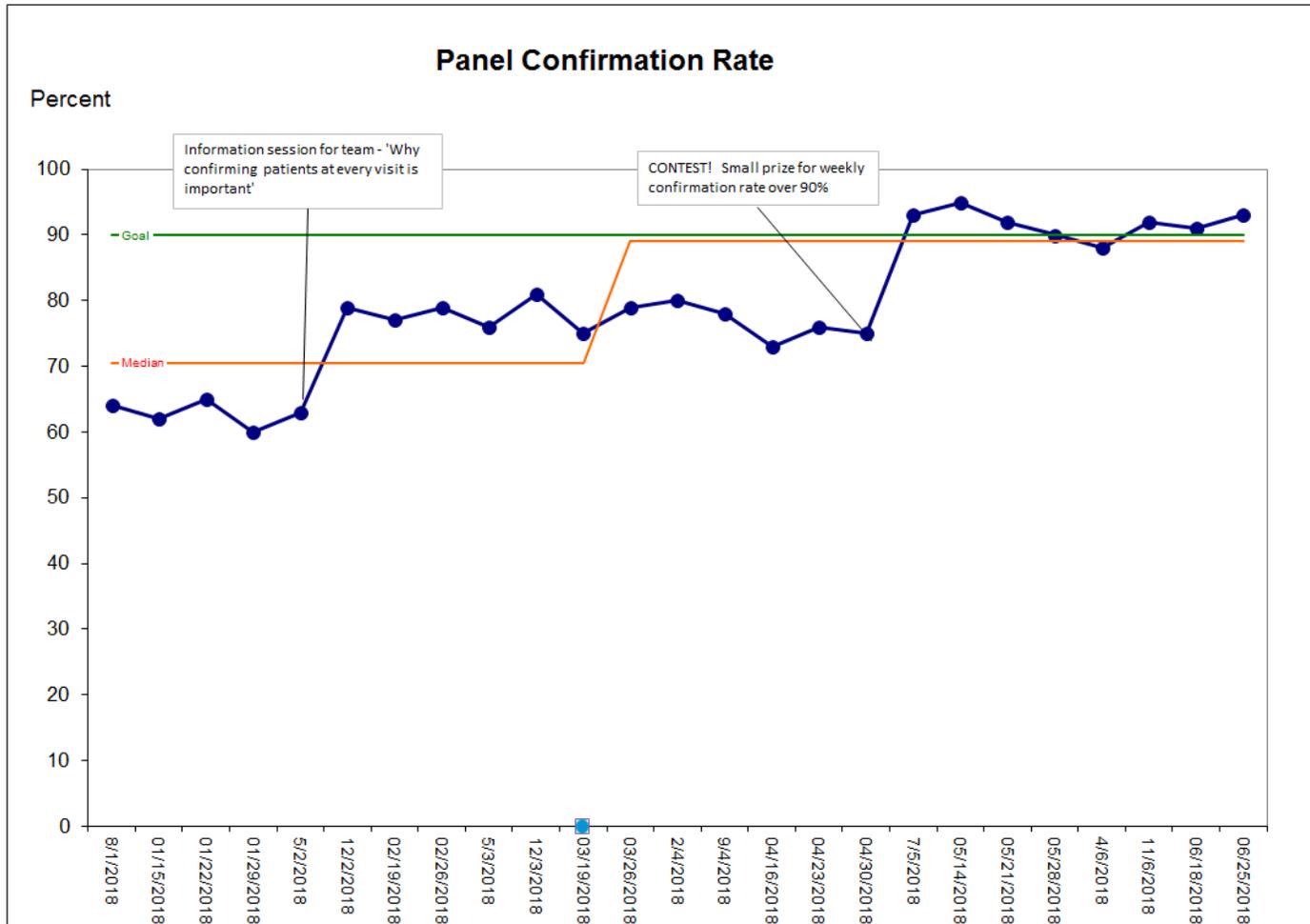
$$\frac{\text{\# of patients confirmed this week}}{\text{\# of patient visits this week}} \times 100 = \text{Confirmation Rate \%}$$

The [EMR Guides](#) on the TOP website have detailed instructions on how to search for both the # of patients confirmed as well as the # of patient visits in each EMR. If you decide upon a different interval for your measurement, simply adapt the above equation and your EMR searches accordingly (e.g., daily, monthly, etc.).

Share: The power in your improvement measures is in the sharing of the results so the team can reflect and take action if needed. Changes over time are best displayed in a **run chart**. The time interval goes along the x-axis and the percentage (confirmation rate) goes along the y-axis. If your processes are working well, you will see improvement over time.

A run chart can be drawn using graph paper, or you can use a simple web-based [run chart tool](#).

Example Run Chart:



Continue to take this measure until you are confident you have processes established; this will vary for each clinic. Discuss how often you may check in after you successfully establish your processes. It may be a good check in to take this 3-4 times per year for some, or when you have a new staff member responsible for patient confirmations.

EMR Searches

Why?

In many clinics, the EMR is the most sub-optimized member of the team. When data is entered in a standardized way (see [test box 1](#)), the searches you create will give you accurate results. You can then use these results to help you with care planning activities, as well as monitoring and measuring the work you do.

Many team members start using their EMR search engines by asking complex questions and then getting frustrated when they do not get accurate results. Take time to learn how the search engine in your EMR works. Every EMR search engine has a 'logic', and every search engine has limitations; knowing these will help you build successful searches and to know how complex you can get with future searches.

We also want to systematically identify patients. While care teams can often identify patients who would benefit from care planning, we want to shift to having the EMR identify all patients who may benefit, based on the chosen criteria.

Tips

If you do not have solid patient identification and maintenance processes in place, any search you run may not be as accurate as you would like.

The last test box EMR content focused on data standardization. If you are trying to run lists using criteria where the data may not be standardized yet, your lists won't be as accurate.

Once you run a search in your EMR, you can add additional columns to the search output and sort the information you get from your searches. In some EMRs you can do this within the EMR; for others you must export the data to a program like MS Excel® and manipulate it there.

Test

If you are new to using your EMR's search engine, consider starting with simple searches and working your way up in complexity. This helps you to understand how the search engine works. It also helps you to understand where the EMR finds the data for each search, which can assist with knowing what data you need to standardize.

An example of a search to identify a patient population for PaCT is:

- Patients who have not had a clinic visit in the past 1 year
- Who are over 65 years old; and
- Who had 2 or more ER visits in the past year

If you are seasoned with using your EMR search engine and you are confident that records of ER visits are entered into the EMR systematically, you will likely be able to create and run an accurate search.

If you are new to your EMR search engine, follow these suggested steps:

1. Run a search for **patients who have not had a clinic visit in the past 1 year.**
 - o Run this list and review it for accuracy by auditing a few of the charts of patients showing up on the list. Or, you can add a column to your search output that includes the date of last visit and scan through.
2. Next, run a search for **patients over 65 years old.**
 - o Again, you can add a column to your search output that has the patient's age. A quick scan of this column will tell you if there are any patients on the list that shouldn't be there. Also keep an eye on whether you think anyone may be missing. Investigate the cause if data is not correct. 9/10 times it is an issue with your data and not the EMR search function.
3. Layer #1 & 2 above by running a search for **patients who have not had a clinic visit in the past 1 year AND who are over 65 years old.**
 - o Review the list against the 2 lists above to verify the accuracy.
4. Run a search for **patients who had 2 or more ER visits in the past year.**
 - o This data relies more heavily on standardized data entry at your clinic. Once you know how this is captured (e.g., scanned document named "ER Visit Summary") then you can search it.
5. Finally, combine **all 3 criteria** into your search.
 - o Once again, review the list for accuracy.
6. Using the list you ran above, consider **reviewing and marking the appropriate charts "complex health needs"**.
 - o HINT: Another simple search to run is all of the patients whose charts are marked "complex health needs".
7. Consider running a search based on the criteria your team selected for your target patient population for your PaCT innovation hub work.

PaCT Fact

The [TOP EMR Guides](#) contain EMR-specific info on:

- o how to use the search engine
- o How to perform basic searches, such as the ones suggested here

Outreach

Consider using your lists to identify as a team **which patients you will reach out to** with an offer of a care planning appointment. When you print the list, you can have the EMR include the patient's phone number. Then, when the designated team member(s) have free time, they can contact the patients on the list and invite them to come in for a care planning visit. (TIP: Refer to the 'Patient-centred sample script for calling patients for care planning' provided in [Test Box 1.](#))