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.

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.

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.

Foster patient/provider (team) relationships

- ✓ Make an explicit agreement with the patient that the identified primary care physician will provide and/or coordinate their healthcare.

- ✓ Seek opportunities to partner with patients for shared decision making and explore their values and preferences.

- ✓ Ensure your primary care team members respect and honor shared decision making and family involvement.

Advise and advocate continuity

- ✓ Promote and advocate the value of continuity to all patients, in practice, in the community, and within the health system.

  - o Advocate within health system by communicating and raising awareness of the value
  - o Educate and empower patients, families and caregivers to resolve discontinuity

Identify and manage your panel

- ✓ Take steps to identify your panel of unique, unduplicated patients (those with whom you have a trusting, ongoing therapeutic relationship).

  - o Develop processes for panel identification and ongoing verification and maintenance
  - o 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).

  - o Develop processes to identify patient lists of clinical need
  - o Routinely review patient lists (whether patients still belong there or not)

Enable continuity via office processes

✓ Aim to have your patients visit their own primary care physician >80% of the time, by adopting practice behaviors that facilitate increased continuity.

✓ Understand that when patients cannot see their own primary care physician that continuity can be maintained based on a hierarchy of booking for continuity and access. See table below.

Hierarchy of booking routine appointments
1. Book to patient's own primary care physician (or most appropriate team member) for today.
2. Book to patient's own primary care physician (or most appropriate team member) in the future.
3. Book for today but not with own primary care physician (or most appropriate team member).
4. Patient seeks care outside clinic (patient and provider are consciously aware of need to close the loop).

Balance demand for care with capacity (supply)

✓ Improve access for appointments by exploration of the following:

    o Match appointment demand to supply available.
    o Optimize the care team to enhance and maximize capacity.
    o Address scheduling complexities to maximize use of appointment time.
    o Utilize contingency planning for both scheduled and unscheduled time away.

Measure baseline continuity and track progress

✓ Understand your current rate of continuity to achieve a baseline from which to improve

✓ Develop, as a team, a common understanding of clinic goals that focus on the value of continuity and patient-centered care which is shared across the clinic team.

✓ Measure, share and display your progress toward a goal of >80% continuity at baseline and on a continuing basis.

Optimize the patient care team to improve and support continuity

✓ Share care for complex patients as an interdisciplinary team.

✓ Engage with patients as a member of their own care team.

✓ Create processes to support team-based care (e.g., algorithms, shared EMR, interdisciplinary huddles, regular meetings to discuss care and care coordination).

✓ Develop roles and responsibilities where the skill, knowledge and training of all team members is optimized.

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.