

Optimizing Clinic & PCN Team Supports to Enhance Patient Care Using Panel Management Processes Webinar

May 1, 2020

Supporting Resources and Q&A Summary

Tools and Resources

- CII Information:
 - [CII Specialist FAQ](#)
 - [CII Specialty Tools and Resources](#)
 - Email: mci-specialty@albertadoctors.org
- [Meeting Patient's Needs Algorithm for Today's Primary and Specialty Care Teams](#):
 - [Virtual Care Appointment Guide](#)
 - [Know Your Practice Checklist for Specialists](#)
- AMA Virtual Care Tools and Resources:
 - [AMA Virtual Care Homepage](#)
 - [Essentials for Getting Started with Virtual Care](#)
 - [EMR Integrated Tool Table](#)
 - [Privacy Tips](#)
 - [Privacy Checklist in Relation to Adoption Virtual Care technology during Pandemic](#)

Questions & Answers

Clinic Processes:

It was great to hear Dr. Greyvenstein (Urban Family Physician, Calgary) talk about how the Calgary Zone PCNs are structured and all the resources that they have. The North Zone is trying to do the same work with more limited resources. How can the North Zone build teams around them to achieve the same results as the Calgary zone?

The Calgary Zone recognizes that resource availability varies across the province. For example, within the Calgary Zone, some PCNs are much smaller than other PCNs. Calgary Zone PCNs, therefore, try to carry the burden for each other because they know that what happens in a rural PCN will ultimately impact what happens in an urban PCN.

Not everything mentioned for the Calgary Zone will be applicable to all zones. There are, however, things that are applicable and that can be used and scaled. The Calgary Zone is more than willing to and has already shared their tools and processes freely. Most of the established Calgary Zone processes will also be rolled out in future AHS communications. This includes things that are being adapted provincially, with the recognition that one size doesn't fit all and there needs to be flexibility in each PCN and zone.

Clinic Processes (Cont'd):

Is there anything that the physicians on this webinar are doing at their clinics to help offset the anticipated demand surge later on?

Dr. Smith (Rural Family Physician, Edson):

- “Hold for days”: four spaces per physician per day for same day access for any problem.
- “Fast-track appointments”: appointments that are double-booked into the clinician's day and used for short, fast things that physicians should be able to address very quickly (e.g., UTI, fever, rash, asthma, HTN, contraception, etc.).
- “Using the clinic team”:
 - *Clinic nurse*: patients know they can walk in and see the clinic nurse to give her a pee sample, get a strep throat swab, get an STI check, have their BP taken, etc. For positive results, the nurse can activate a visit with the patient's family physician, if available, or one of the other physicians in the clinic.
 - *MOAs*: as part of the clinic's panel management processes, patients are called by the MOAs to organize lab requisitions, referral letters, pap smears, mammograms, etc., without having to see a physician. For instance, if a patient's colonoscopy is due, the clinic MOA calls the patient, asks them "any weight loss, any blood in stools, any change in bowel movements?" and then generates a referral letter. This letter is reviewed with the physician prior to sending and no visit is needed to get this patient back for their routine scheduled colonoscopy.

Dr. Greyvenstein (Urban Family Physician, Calgary):

- Proactively screening as many of the clinic's patients as possible.
- Using data from HQCA reports (<https://www.hqca.ca/health-care-provider-resources/panel-reports/request>) to:
 - Compare screening rates, panelled vs. unattached patients, emergency department and hospital utilization rates, and hospital length of stay
 - See the impact that the clinic (i.e. patient centered medical home) is having on system outcomes.
- Clinics must start thinking rapidly about post-COVID and the continuing management of patients in a new environment. This is an opportunity to adopt more patient centered approaches.

CII/CPAR:

The ACTT website says that Wolf is live for CPAR, but Med Access is coming soon, do you know when this will go live for Med Access EMR?

Med Access is already live on CII-CPAR and, starting Monday, May 4, Med Access participants will see e-notifications like in Wolf.

Do need to contact our PCN to get set-up on CII/CPAR?

Yes, contact your PCN to tell them you are interested. Their teams have been trained to assist. You can get started with learning about it here: <https://actt.albertadoctors.org/PMH/panel-continuity/CII-CPAR/Pages/default.aspx>

Billing Codes:

If a patient wants to see their family doctor virtually after a "loneliness check in" by an allied care provider, is that still considered "patient generated" by Alberta Health?

Yes, if a PCN of clinic staff member talks to a patient first, and then the patient requests a virtual appointment with their physician, the visit would be seen as patient initiated and, therefore, be claimable. This would be a billable service through 03.01AD or 03.03CV or 08.19CW, depending on physician-patient direct time, and whether patient has a mental health problem. For mental Health problems, use 08.19CW

Physician Advocacy:

My greatest wish would be for UCP/all MLAs to see the incredible value of all that has been done and move forward/work together. There is a need to collaborate with all parties (PLP, HQCA Panel Reports, CME&PD-CPD etc.).

Dr. Smith (Rural Family Physician, Edson) has sat in a room with her MLA (pre-covid) to tell him how awesome their clinic is. Her clinic also has an Edson Medical Centre Facebook Page used to communicate with the community.

Peer Tips from the Chat:

Tips for Determining Who is Part of Your Team & What Really Matters to Your Group of Patients or Community.

1. Do some preliminary work to identify patient target groups from your panel. For example:
 - Rising risk patients (i.e., patients whose conditions are not optimally managed)
 - Emergency department utilization (see HQCA report)
 - Hospital admissions (see HQCA report)
2. Build a team based on the patient needs identified. Use data from your panel to advocate for support from your PCN and Health Neighbourhood (e.g., Mental Health, Home Care, Pharmacy, etc.).
3. Form an improvement team. People who do the work should change the work.
4. Include patient representatives on your improvement team, where possible.
5. The EMR should be the hardest working member of your team; optimize your EMR while you optimize your clinical team (think about who does what, when, where and how).