Reducing Impact of Financial Strain (RIFS) Potentially Better Practices:

Rationale, Evidence, and Implementation Advice

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1. IMPROVE THE PATIENT EXPERIENCE

1.1 Establish a multidisciplinary quality improvement team and consider including a patient with lived experience

Rationale

"Those who do the work change the work."

Involving team members on a quality improvement team empowers them to own the work. Team members are an important source of solutions as they are experts in their own workflow. Bringing in members from all areas of the team allows for the most effective decision making because everyone brings their perspective to the table.[1] Teams who work **effectively** together are better able to implement improvements to patient care. Research suggests that teams with greater cohesiveness are associated with better clinical outcome measures, lower burnout, and higher patient satisfaction.[2–5]

For optimal care to occur, both patients and clinicians need to be involved.[6] Patients and their families bring personal knowledge on their life circumstances and preferences, while clinicians offer guidance and advice on treatment and intervention options. Patient-centered care occurs when clinicians engage patients in a way that builds trust, motivation, and confidence.

This potentially better practice encourages meaningful engagement of patients as advisors or participants on quality improvement teams. Persons with lived experience can be a patient or a family member of a patient.[7] In Alberta, teams that engage patients when developing and implementing practice changes report stronger patient-centered processes that incorporate lived experience results in greater benefits to patients. [8,9]

Implementation advice

1. **Form an improvement team**[10]
    - Ensure cross-sectional representation of clinic roles
    - Ensure that you have someone with decision making authority on the team (e.g. physician champion and office manager)
    - Ensure that you include someone with quality improvement facilitation skills
    - Consider including an external stakeholder (e.g. a patient or family member of a patient)

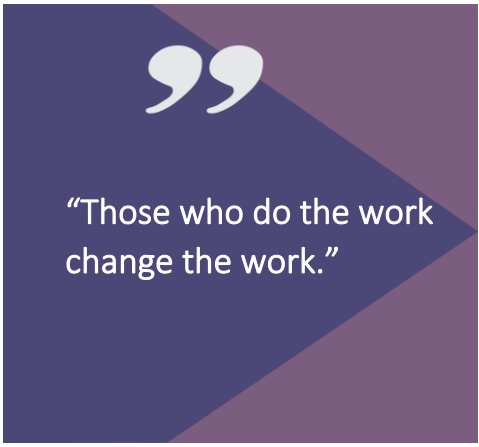
    How can we create a 'safe space' for the team to discuss potential biases, beliefs and assumptions that could have a negative impact (stigmatizing experience) on the individuals experiencing financial strain?[7]

2. Engaging individuals with lived experience[7]

Assume patients are the experts on their own experience and that they have information you need to hear and act on. Know that families are primary partners in a patient's experience and health.

Things to consider include:

- How can we ensure a safe and welcoming environment for all patients?
- Do patients require any accommodations to participate? (e.g. childcare, transportation) This is especially important to consider for individuals experiencing financial strain.
- What matters most to patients?
- How can we use patient experience to create linkages to community resources and improve our processes?



Evidence

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9. Evaluation findings from phase 1: Patients Collaborating with Teams (PaCT). Accelerating Change Transformation Team; 2019 May.
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1. IMPROVE THE PATIENT EXPERIENCE

1.2 Incorporate a patient-centered care approach

Rationale

Care planning* is defined as "the *process* by which healthcare professionals and patients discuss, agree upon, and review an action plan to achieve the goals or behavior change of most relevance and concern to the patient."[1] Care planning is usually done to improve patient self-management, communication, and coordination between multiple healthcare providers** involved in the longitudinal care of patients with complex health needs. [1] A patient centered approach to primary care may positively affect patient satisfaction & activation, and perceived quality of care.[2–4]

An Alberta based initiative called Patients Collaborating with Teams (PaCT) found implementing care planning and use of a patient-centered care plan template helped primary care teams transform their processes and strengthen their relationships with patients to enable improved relational, informational, and management continuity of care.[5–8]

A biopsychosocial-spiritual approach can be helpful for patients experiencing financial strain because social factors such as the ability to afford medications, access transportation, and manage competing priorities are known to significantly impact health outcomes. Addressing and documenting social history in the care plan is critical if we hope to improve outcomes, reduce overall costs, and improve patient satisfaction. Although providers may not be able to alleviate all issues, demonstrating empathy and concern shown can strengthen the therapeutic alliance.[9]

Implementation advice

Use a standard care plan template to document biopsychosocial-spiritual factors to enable whole-person care

To get to know a patient, and what is going on in their world, it can be helpful to inquire about some of the social aspects of their life. Social factors may be a root cause for a patient either following or not following health recommendations. (e.g. lack of financial means to purchase their medication, or uncertainty of how they may get to their next follow-up appointment)

Scripting can help guide conversations

Many people consider financial matters private information and may have difficulty discussing these openly. This can make it uncomfortable for providers to ask if patients are experiencing financial strain. Using scripting samples can be helpful when incorporating this new process into practice to help guide the conversation and ensure all the team members are giving consistent messages.

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* Not limited to the previous annual Complex Care Plan (CCP; 03.04J billing code)

** Not limited to coordination between health care providers within a clinic, PCN, community health services, specialty services, and tertiary care. These could include the multi-sector teams from the health neighbourhood.

Evidence

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1. IMPROVE THE PATIENT EXPERIENCE

1.3 Create a culture that allows for open conversation with patients about financial strain

Rationale

Culture is an important aspect of clinical care as it affects how clinics operate and contributes to the overall safety and health outcomes of patients.[1] Culture can be defined as "norms, values, and basic assumptions of a given organization".[2] Culture affects both the behaviour of people who work in the clinic and the patients who access services.[3]

Financial strain is a sensitive topic for both patients and providers because it is often associated with stigma.[4] Creating an open culture that encourages discussion about financial strain can help improve patients' experiences. It is important to discuss and explore potential biases, beliefs and assumptions within the project team to minimize potential for unintended influence or negative impact (stigmatizing experiences) on the individuals experiencing financial strain.[5] Ensuring that all clinic members are on the same page in their knowledge, beliefs, and attitudes will help create a culture open to the realities of patients experiencing financial strain.

Evidence shows that the challenges around poverty screening in primary care include the potential lack of knowledge of health professionals about the impact of poverty on health and what they can do, lack of time during a visit to ask about social needs and possible confusion in documenting and billing this type of service.[4]

Language used to discuss financial strain matters, and may have an effect on how willing patients are to discuss this. Teams should be aware of their verbal conversations (e.g. scheduling an appointment, having a discussion with the patient) and written text (e.g. EMR documentation, posters on the clinic walls, or a patient handout).

Implementation advice

Conversations within clinic team:

1. Have a conversation with the clinic team to increase awareness of how income is one of the most significant social determinants of health for influencing the health outcomes of patients. Consider sharing the "What makes people sick" image. Discuss the role of primary care can have in identifying patients experiencing financial strain and review patient panel data such as the HQCA report.
2. As a team, facilitate the Team Assessment tool to identify areas of strength and opportunities for improvement.

Conversations between clinic team members and patients:

1. Test and implement patient-centered scripting to support conversations.
2. Use tools (e.g. posters, questionnaires) to engage patients and invite a conversation about financial strain.

Evidence

1. The Health Foundation. Evidence scan: Does improving safety culture affect patient outcomes? [Internet]. London, UK: The Health Foundation; 2011 Nov. Available from: https://www.health.org.uk/publications/does-improving-safety-culture-affect-patient-outcomes
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2. IDENTIFY PANELED PATIENTS

2.1 Define segment of paneled patients who would most benefit from an assessment of financial strain

Rationale

A panel lists the unique patients that have an established relationship with a physician and where there is an explicit agreement that the identified physician will provide primary care services to the patient. This two-way relationship is a key enabler for relational continuity.

Once a physician's panel is identified, processes must be put in place to maintain the list as patients may come and go. Active panel maintenance allows for panel management, which is a fundamental element of high-performing primary care; panel management has been associated with improved quality and care process outcomes.[1–5] Panel management has been shown to be an important first step in the adoption of clinical practice guidelines to improve quality of care (as demonstrated by the Alberta Screening and Prevention Initiative).[6] Once panel processes are in place, it enables teams to establish lists in the EMR, which is one of the foundations of organized evidence-based care.[7].

Reviewing your panel as a team can be helpful to identify which patients could benefit the most from a financial strain assessment. Ideally, you want to identify a very small group of patients to start testing the new processes with to learn from before expanding to more patients or providers.

Poverty is not always apparent: In Alberta, 6.5% of families live in poverty in 2018.[8]

Implementation advice

1. In order to identify and maintain accurate panel lists, teams should work through the STEP Checklist and establish a process for checking panel confirmation rates. The confirmation rate should be used in the clinic for improvement.
2. Consider having a team discussion about which patients you want to test the screening processes with. Some ideas may include:
    a. Review your HQCA report. There may be some helpful information in the following sections: social deprivation data, continuity, ER or urgent care use
    b. Consider patient characteristics such as single people aged 45 to 64, single parents, recent immigrants, Indigenous people, people with disabilities and LGBTQIA2S+
    c. Consider clinic operations such as is there a good day of the week, time of the day or provider to test out the processes with at the beginning
    d. Once you have a tested process that works for your practice team, consider expanding the inclusion criteria to include more paneled patients
3. Use the maintained panel to generate lists so that patients who are experiencing financial strain may be quickly identified in the EMR.
4. Consider uploading panel data to CII/CPAR which can help the team provide better quality care efficiently due to increased continuity of care.

Evidence

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3. Loo TS, Davis RB, Lipsitz LA, Irish J, Bates CK, Agarwal K, et al. Electronic medical record reminders and panel management to improve primary care of elderly patients. Arch Intern Med. 2011 Sep 26;171(17):1552–8.

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2. IDENTIFY PANELED PATIENTS

2.2 Generate lists of patients who have been identified as needing an assessment for financial strain and review it with team

Rationale

With established panel processes in place, clinic teams can leverage their EMR to proactively manage groups of patients (or panel segments). Optimizing the EMR to help coordinate care for a panel segment creates:

- A systematic approach for screening to provide preventative care[1]
- More productive opportunistic encounters by having pertinent patient information at readily available
- Tracking of patients who have been screened and those still needing to be screened
- Tracking of care plans and follow-up reminders
- Planned care, e.g. intervening early to preempt acute crisis situations

Implementing process improvements may be more manageable if practices start with a panel segment, test the impact of changes, and spread successful solutions. Segmenting the panel starts with defining key criteria that is searchable in the EMR.

Primary care practices may not currently know of any patients who are experiencing financial strain. However, there is a missed opportunity to identify at-risk patients and offer them the appropriate care if it is not documented.

Implementation advice

The team will benefit from integrating screening into existing workflows. Starting with a process map of the current process can be helpful. Team members can identify the changes they would need to make to include the financial strain screening. Can this process be mirrored after another process already used in the clinic? Given the sensitively of the topic, making sure these conversations take place privately will be important for patients to feel comfortable sharing this information.

Having consistent documentation from all team members will help make the EMR lists generated more robust. The EMR specific guides some suggested documentation processes but you may need to adapt the suggested processes to fit the existing clinic processes. Opportunistic and outreach documentation strategies are also outlined in the EMR guides too.

3. STANDARDIZE DOCUMENTATION

3.1 Define the social determinants of health that team will use for care provision and standardize documentation in the EMR

Rationale

Once established panel processes are in place, teams can leverage the EMR to proactively manage populations (or panel segments). Optimizing the EMR for population health management benefits the practice teams and patients by enabling:

- A systematic approach for preventative care
  - Utilizing evidence-based activities to offer care and coordinate follow up
- More productive opportunistic encounters by having pertinent patient information at the point-of-care
- Comprehensive care that can meet patient needs when they want or need it
- Processes for coordinated care management in the medical home & health neighbourhood
- Clean and accurate lists to provide insightful data for quality improvement

Many Albertans (9.4%)[1] are impacted by financial strain, but individuals may not disclose financial difficulties without being prompted/screened due to feelings of shame or fear of stigmatization.

Regular screening of all adults on a panel for financial strain and documenting the results in the EMR is the ultimate goal. However, implementing process improvements may be more manageable if practices start with a small sample population to test the impact of changes and spread successful solutions. Segmenting the panel starts with defining key criteria for a population that is searchable in the EMR.

Implementation advice

Start with a team discussion to identify the sample population with whom to test the financial strain questions.

- Start with a small group of patients and then add additional populations until you have captured all adult patients on a panel if that is your team's goal.

Have a team discussion to confirm the screening questions you want to include.

- Financial strain screening involves asking a single question but experience from pilot sites and the literature identifies the opportunity to use a bundling approach to screen for other social determinants of health. The pilot sites often 'bundled' questions together to also ask about challenges with medication costs, transportation to appointments, safety at home and social supports.
- The EMR guides provide suggested documentation process for the potentially better practices so that measures can be successfully pulled from the EMR with ease.

* Implementing any of the potentially better practices in the 'Optimize care management' section of the RIFS change package will be facilitated by optimizing the EMR

Evidence

1. Statistics Canada. Table 11-10-0135-01: Low income statistics by age, sex and economic family type [Internet]. 2020 Sep [cited 2020 Oct 13]. Available from: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110013501

4. OPTIMIZE CARE MANAGEMENT

4.1 Use a process to assess patients for financial strain

Rationale

This potentially better practice advocates for routinely assessing all adult patients for financial strain. Albertans and many other people are experiencing financial challenges where they can struggle to pay bills and provide food for their family. Assessing if a person is experiencing financial strain is an important component of whole-person care. Evidence indicates that social determinants can have a long term impact on a person's overall health.[1–4] Identifying patients who are experiencing financial strain creates the opportunity to help connect them to needed resources. Patients have indicated that they are okay with being asked about social determinants of health, including financial strain.[5]

Implementation advice

Assess adult paneled patients using a validated tool

The Centre for Effective Practice has created an evidence-informed tool to help teams in Alberta implement a screening process for financial strain.

Practical considerations for using a validated tool include deciding as a team:

- Who on the team will ask the question?
- When will the question be asked?
- How will the question be asked (paper, verbally)?

See our sample patient questionnaires and script samples for some additional ideas.

Use the EMR to measure patients assessed for financial strain

The EMR can be used to organize evidence-based care and enable relational and informational continuity.[6] Standardized documentation in the EMR will help teams understand where process improvements can be made.

Practical considerations for documenting the patient response in the EMR include deciding as a team:

- Who on the team will document the patient response in the EMR?
- When will documented response in the EMR occur?
- How with the documented response be entered in the EMR?

See the RIFS EMR guide for recommendations. Note: The EMR guide recommendation to rescreen every 18 month or as appropriate given a specific patient's context is expert opinion consensus.

Evidence

1. Hwang SW. Homelessness and health. CMAJ Can Med Assoc J J Assoc Medicale Can. 2001 Jan 23;164(2):229–33.
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4. Fitzpatrick T, Rosella LC, Calzavara A, Petch J, Pinto AD, Manson H, et al. Looking Beyond Income and Education: Socioeconomic Status Gradients Among Future High-Cost Users of Health Care. Am J Prev Med. 2015 Aug;49(2):161–71.
5. Alberta Health Services. An Environmental Scan to Investigate the Feasibility of a Clinical Poverty Screening Tool in Alberta. Edmonton, AB: Population, Public and Indigenous Health, Healthy Public Policy Unit.; 2018.
6. Menachemi N, Collum TH. Benefits and drawbacks of electronic health record systems. Risk Manag Healthc Policy. 2011 May 11;4:47–55.

4. OPTIMIZE CARE MANAGEMENT

4.2 Use a process for responding to patients with financial strain

Rationale

Assessing if a person is experiencing financial strain is an important component of whole-person care. Evidence indicates that social determinants can have a long term impact on a person's overall health.[1–4] Teams must have a plan for how they will respond to patients with financial strain prior to implementing a screening process. With appropriate planning and preparation, teams will be able to support patients in a caring way and reduce feelings of shame or stigmatization that a patient may experience from disclosing these private matters.

Implementation advice

Prepare in advance

Knowing the resources available to support patients experiencing financial strain in the health neighbourhood is a critical step. Preparing the team to initiate and manage the conversation to discuss financial strain with the patients is important. See our patient handouts and scripting sample tools for ideas.

Assess patient readiness to change before making a referral

It is important to ask the patient if they would like help addressing the problem before automatically generating a referral to resource. According to the transtheoretical model of change, people must pass through specific stages before they become ready to make a personal change.[5] Optimizing the offer of care involves offering treatment to a patient who is ready to change. Patients who are not ready to change would benefit from other approaches to enhance self-efficacy and motivation, and re-offered care at a later time.[6–8]

Use the EMR to track offers of care (e.g. care planning focused on the patient's goal, referrals)

The EMR can be used to organize evidence-based care and automate the tracking of offers of care to enable relational and informational continuity.[9] A person experiencing financial strain will often require care coordination with other providers in the health neighbourhood. Standardized documentation in the EMR will help teams understand where process improvements can be made, as both provider behaviours (e.g. patient centeredness) and patient behaviours (e.g. readiness to change) the affect the outcome of an offer.

Practical considerations for documenting the patient response in the EMR include deciding as a team:

- Who on the team will document the patient response in the EMR?
- When will documented response in the EMR occur?
- How with the documented response be entered in the EMR? See the RIFS EMR guide for recommendations. Note: The EMR guide recommendation to rescreen every 18 month or as appropriate given a specific patient's context is expert opinion consensus.

Evidence

1. Hwang SW. Homelessness and health. CMAJ Can Med Assoc J J Assoc Medicale Can. 2001 Jan 23;164(2):229–33.
2. Tarasuk V, Cheng J, de Oliveira C, Dachner N, Gundersen C, Kurdyak P. Association between household food insecurity and annual health care costs. CMAJ Can Med Assoc J J Assoc Medicale Can. 2015 Oct 6;187(14):E429–36.
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4. Fitzpatrick T, Rosella LC, Calzavara A, Petch J, Pinto AD, Manson H, et al. Looking Beyond Income and Education: Socioeconomic Status Gradients Among Future High-Cost Users of Health Care. Am J Prev Med. 2015 Aug;49(2):161–71.
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4. OPTIMIZE CARE MANAGEMENT

4.3 Use a process for ongoing review of patient-centered goals and care coordination

Rationale

Once the time has been invested to create a meaningful patient goal as part of the care planning process, it will be important to create a follow up plan and check in with the patient to see if they were able to implement the plan. If they encountered any barriers, it is an opportunity to get them connected to resources that can help meet their needs. The reassessment period needs to be individualized depending on the patient's circumstances and needs. Developing systems and processes to ensure the patient does not fall through the cracks are also essential. Implementing the suggested processes outlined in the EMR guides helps create a safety net.

Implementation advice

Incorporate proactive reassessment & use EMR reminders for reassessment when a patient is identified as experiencing financial strain

The EMR can be used to organize evidence-based care and track needed follow up.[1] A person experiencing financial strain will often require care coordination with other providers in the health neighbourhood so tracking referrals is helpful. This is possible when standardized documentation processes are used by the team.

Some practical things to consider and discuss as a team is who, how and when will you document referrals made and when follow up is needed. The RIFS EMR guides provide recommendations for the how to do this.

Prepare in advance

Knowing the resources available to support patients experiencing financial strain in the health neighbourhood is a critical step.

Preparing for reassessment visits ahead of time with the care team can help to ensure that all documents and tools are ready and available at the point-of-care in the EMR. Ensure that the entire care planning team has access to the EMR and assign a team member to:

- Populate a care plan by routinely and systematically pulling relevant data from the EMR & Netcare.
- Prepare relevant resources (e.g. patient resource handouts) in advance of patient encounter.
- Identify and have appropriate assessment tools (e.g. questionnaires) ready to use.

Evidence

1. Menachemi N, Collum TH. Benefits and drawbacks of electronic health record systems. Risk Manag Healthc Policy. 2011 May 11;4:47–55.

5. COORDINATE CARE IN THE MEDICAL HOME

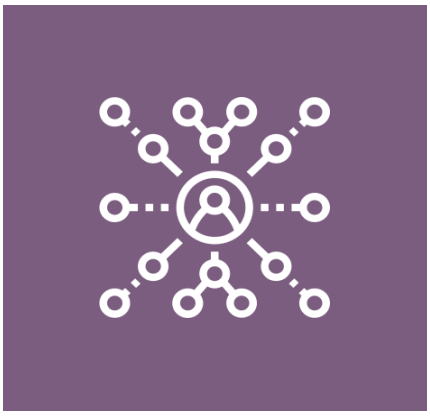
5.1 Establish clear roles and responsibilities for supporting patients with financial strain amongst the medical home team

Rationale

Patients who are experiencing financial strain can benefit from the care of a multidisciplinary team. In the patient's medical home (PMH) model, care may be provided by a variety of team members (e.g., nurses, mental health consultants, social workers, pharmacists, kinesiologists, dietitians, etc.). When a patient is experiencing financial strain, this can impact many aspects of their life and provide challenges with regards to mental health, arranging transportation to attend appointments and affording medications. Having a team to help coordinate care and get the patient linked to the needed resources is ideal so the burden does not fall all on one provider or the patient & their caregivers & supports. In addition to the provider benefits, there will also be benefits to the patient as they will be receiving whole person care resulting in a more satisfying experience.

True team-based care is achieved when multidisciplinary team members collaborate in their efforts. This requires a shift in mental model* from a 'physician-centric' referral approach to a collaborative 'team based' approach to provide optimal patient-centered care.[1] When mental models are misaligned, team effectiveness can be significantly reduced.

To implement team-based care, team members must distribute the workload.[1] This then enables patients to experience better access to care, team members to work to the full scope of their practice, which is more challenging and rewarding, and physicians have time to see the more complex patients. High-functioning teams exhibit higher levels of satisfaction, experience less burnout, and achieve higher quality of care.[2–5] Research shows that team based care results in improved quality and outcomes of care and enables successful implementation of primary care innovations.[6–9] The stronger the teamwork among the patient's providers, the better the outcomes. After investing in team development, studies reported improved patient outcomes, and improved team processes and morale.[2,4,5,10]



Implementation advice

1. Assess the functioning of your team using the team assessment
   - A Practice Facilitator can help your team by providing constructive feedback, facilitate a discussion with your team, and suggest improvement ideas.

2. Consider reviewing your process map and team roles and responsibilities to identify opportunities for optimizing team members' roles. Are there situations where team members other than physicians could lend a hand?
   - Balance the distribution of work so no one is overloaded.
   - Identify areas in the clinic that rely on a single person and consider cross-training.
   - Introduce patients to the concept of having care provided by multiple team members, not just the physician. The 'Introductions with Intention' tool provides helpful advice on how to do this.
   - Explore virtual care alternatives to "face to face" visits with patients if appropriate

3. Clinics are typically busy places, and it's often rare that the daily schedule goes as planned. A clinic team needs to communicate and coordinate efforts among its members on a regular basis. Implementing brief 'touch points' – or 'huddles' - once or twice per day can help to ensure an efficient clinic day with fewer surprises. Huddling can also be an effective method for providing proactive patient care. The team can quickly plan a strategy for engaging this patient so they can help surround them with the resources that they need.

Evidence

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6. COORDINATE CARE IN THE HEALTH NEIGHBORHOOD

6.1 Establish processes that facilitate effective transitions of care

Rationale

As a healthcare system we want to provide whole person care and help patients address what matters most to them, but we can't do this on our own. Sometimes the team members and resources needed by our patients can't be accessed from within the patient's medical home (PMH), and that is where the health neighbourhood comes in. The health neighbourhood has the patient's medical home at the center but is a is a multi-sector team that encompasses the services provided by all healthcare sectors and community supports such as the hospital, specialists, a primary care network, allied health providers in the community like community pharmacists or psychologists and community programs like the local food bank or Family & Community Support Services (FCSS). The evidence shows that strong links between partners and sharing of information in the health neighbourhood results in improved patient outcomes, safety, and experience; lower costs through reduced duplication of services; improved delivery of prevention services; and more evidence-based patient care.[1]

Just like in the PMH, a high functioning team is able to distribute the workload amongst the various roles.[2] This can be more challenging to coordinate in the health neighbourhood as team members may not be co-located or interact with each other on a frequent basis but having these conversations is a critical step. Teams that are able to distribute the work exhibit higher levels of satisfaction, experience less burnout, achieve a higher quality of care, work to the full scope of their practice, which is more challenging and rewarding, and physicians have time to see the more complex patients.[3–6] This enables patients to experience better care.

There are evidence-based tools that teams and organizations can use to continue the development of the health neighbourhood. The Alberta Healthy Communities Approach (AHCA) is a continuous step-by-step process based on developing connections and collaborating with others. The Healthy Communities Approach originated in Canada in the late 1980s and is currently used across Canada and in communities worldwide. The approach encourages community groups and leaders to build on existing strengths by engaging all its members through conversations on local priorities. These conversations give community members and partners a voice, helping to identify local assets and priorities, ultimately leading to innovative and create solutions for specific needs.

This model has a 5-step implementation process. The first step is about finding other enthusiastic and passionate people to work with to foster change and includes the creation of a terms of reference to ensure partners are aligned on the purpose and goals.

Implementation advice

Things your team will need to consider when starting health neighbourhood work:[1]

- **Identify your Neighbourhood:** Consider other specialist practices, health care providers, and social services that would meet the needs of your patients. (use the 'Who Can Help' framework as a template)

- **Define partner roles and develop collaborative care agreements if appropriate:** These documents outline the mutually agreed upon roles and responsibilities of each provider related to the care needs of patients transitioning within the Health Neighbourhood. This can include expectations of partners related to 2-way information sharing, packaging of information, appropriate access targets for services and warm hand-offs at transition points. Collaborative Care Agreements can be created between primary care, acute and community partners to facilitate transition processes such as those from Home to Hospital to Home (H2H2H) as well as between primary care and community specialists or programs.

- **Leverage information technology:** Electronic medical records (EMRs) and virtual care tools can improve communication between providers. Aim to align health information technologies with partners for seamless interaction. CII/CPAR is a great tool that can help facilitate this and includes eNotifications which provide information about key healthcare events such as emergency room visits and hospital admissions or discharges to primary care providers.

- **Agree on what constitutes an effective referral:** Establish guidelines with partners, standardize communication processes, and agree on resources to facilitate effective referrals and information sharing. This information would be included in the collaborative care agreement if applicable. Using the QURE guidelines might be a helpful tool to start this discussion.

- **Partner with patients:** Work with patients and communities to design and evaluate the Neighbourhood by seeking their views through surveys and other engagement opportunities. The 'Including a Patient Partner on an Improvement Team' contain helpful and concise advice on this topic.

- **Recognize that developing a Neighbourhood is iterative:** Performance evaluations, reporting on their findings, and implementing changes will help to constantly improve the quality of care delivered by a Neighbourhood. This can be achieved using available practice resources such as EMR data, self-assessments, practice-based research networks, and others.

- **You don't have to do it all:** Community development can be led by citizens in partnership with health neighbourhood organizations. Learn about what the community coalitions in your area are already doing and explore how how you can participate. Healthy public policy is also a good lever for change. Although policy change is difficult, finding ways to partner with municipalities and community groups to support the development of healthy policies can have a big impact.

Implementation advice continued

1. You can see there are so many places you could start when developing the health neighbourhood but how do you keep it manageable for the team? Just pick one partner organization to do a PDSA (plan-do-study-act) cycle with. First, create a process map to outline the process for coordinating patient care. Once it's complete, review your process map with the team and see if there are additional ways to clarify team roles and responsibilities. When you are reviewing the process map here are a few things to consider:

    - Are there situations where team members other than physicians could help coordinate care? Try to balance the work so no one is overloaded.
    - Who on the team will be responsible for coordinating referrals? Standardize documentation so that it's easy for team members to follow-up (referral sent, referral received, visit scheduled, visit happened, report generated, report received).
    - Has your zone or PCN already created an agreement that outlines responsibilities with a health neighbourhood partner that you could leverage?
    - Is there a process to share the care plans with health neighbourhood partners? Would it be beneficial to review patient cases together as a team on an as needed or regular basis?
    - How could you track patient and care team satisfaction with community resources and referrals?

    Have a discussion with the partner organization and identify one thing that you could do differently that would improve care for the patient such as confirming the receipt of the referral and test it out. Based on the results you can adopt, adjust or abandon the idea.

2. Once you know who is in your Health Neighbourhood and you have established referral pathways with outlined roles and responsibilities, then you need create introductions with intention and set aside some time for huddles. In the health neighbourhood your huddles might not be in-person - consider options like the phone or a virtual meeting and experiment with the frequency to find the right balance in your community. The principles are all the same that you learned about for developing your team in the PMH but they work well in the Health Neighbourhood too!

Evidence

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