BENEFITS REALIZATION:

CDPM REFERRALS FROM PRIMARY CARE

The System Coordinated Access (SCA) program is working to create a seamless experience for patients and providers moving between different parts of our complex health care system, by leveraging existing infrastructure and an innovative technology solution to connect referral sources to providers in a timely, barrier-free manner. The end goal of these system planning efforts is to create a model that will support faster access to services and more coordinated, integrated care for our residents.

In 2016, the SCA program transitioned to the eHealth Centre of Excellence (eCE), a division of the Centre for Family Medicine Family Health Team (CFFM FHT).

Benefits realization (BR) is a key component of the projects supported through the eCE. The BR team has adopted an approach to evaluation that is linked with the change management and adoption process. The purpose is to identify the processes that produce organizational and clinical value in health workflows and how the use of different e-tools can yield increased value. The BR team examines academic research and documented best practice guidelines to understand the clinical value propositions that should motivate specific clinical workflows to adopt change.

This BR case is part of a series of case studies which describe the clinical value of adopting a new referral process within the Waterloo Wellington Local Health Integrated Network (WWLHIN). The work of the eCE BR program is ongoing as the SCA program evolves. Many of the BR cases raise questions which invite further investigation, and clinicians are encouraged to participate in that dialogue in order to develop the answers.

Value Statement

The Guelph Family Health Team (FHT) is actively involved in managing care for patients with chronic disease(s). The ability to refer and book appointments to community supports through an online system enables the clinicians to anchor the continuity of care for patients and ensure that they are receiving the necessary supports. In this way, e-referrals produce clinical value for the patient and their caregivers.

Clinical Best Practice for Primary Care CDPM Referrals

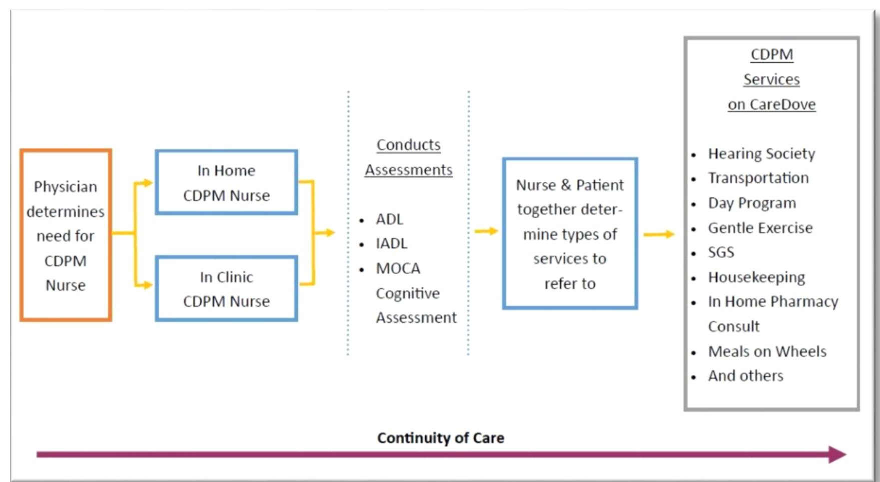
When primary care (PC) clinicians take an active role in chronic disease prevention and management (CDPM) by making linkages to community services and supports for their patients, the continuity of care is increased [1, 2]. Most patients have a trusting relationship with their PC clinician and are therefore more likely to accept community supports that have been booked or referred by the clinician [3, 4]. Due to this existing relationship, there is a need for CDPM referrals to originate with the PC clinician, and for the referrals to happen in an expedient and thoughtful way.

Currently, active CDPM care does not happen consistently across primary care practices due to time constraints and practice variation. The opportunity to refer and book services through the CDPM and Community Support Services (CSS) portals within Caredove (an online booking and referral system) is enabling PC clinicians to create linkages to community supports together with their patients, which directly aligns with the WWLHIN's priority to connect patients and "*deliver better coordinated and integrated care in the community, closer to home*" [5].

Continued on next page

At the Guelph FHT, patients identified with certain chronic diseases are referred for care coordination to a CDPM health care provider (e.g. RN, RPh, RD, Mental Health Counsellor). Dependent on the condition(s) the patient is dealing with, the clinician will conduct appropriate physical and/or cognitive assessments in order to help determine which community supports would provide the best continuity of care for the patient.

Figure 1: CDPM Workflow at Guelph FHT



Historically, it has been difficult to complete CDPM referrals according to best practice as clinicians were without a full listing of community services, and were unable to book appointments or complete referrals for their patients. Although information on appropriate services was provided, it was up to the patient or caregiver to follow through with accessing those services, and adherence to these recommendations was variable. The introduction of Caredove has provided an opportunity for PC clinicians to take an expanded role in CDPM care, enabling PC clinicians to refer and book appointments for their patients, and thereby anchoring the continuity of care.

Testimonial

"Caredove is a valuable part of establishing a comprehensive care plan for patients working through their chronic disease management. The community support service is brought right to the patient in their home with a date of contact made at the time of referral that suits the patient and/or caregiver. The referrer is also notified when the patient is contacted and service has been discussed, thereby closing a part of the feedback loop so essential to care planning and comprehensive chronic disease management."

- Heather Kuemmling, R.N., B.N, Primary Care at Home Geriatric Nurse, Guelph FHT

For questions, comments, or to participate in eCE's BR program, please contact:
Lori-Anne Huebner, BR Lead, eCE at lori-anne.huebner@ehealthce.ca

References

1. Bodenheimer, T., Wagner, E., & Grumbach, K. (2002). Improving primary care for patients with chronic illness. JAMA, 288 (14).
2. Etz, R. S., Cohen, D. J., Woolf, S. H., Holtrop, J. S., Donahue, K. E., Isaacson, N. F., Olson, A. L. (2008). Bridging primary care practices and communities to promote healthy behaviors. Am J Prev Med, 35 (5 Suppl), S390-397. doi: 10.1016/ j.amepre.2008.08.008
3. Jordan, J., & Osborne, R. (2007). Chronic disease self management education programs: Challenges ahead. MJA, 186 (2).
4. Thom, D. H., Hall, M. A., & Pawlson, L. G. (2004). Measuring patients' trust in physicians when assessing quality of care. Health Affairs, 23(4), 124-132. doi:10.1377/hlthaff.23.4.124
5. WWLHIN (2016). Integrated Health Services Plan 2016-2019. Found at: http://www.waterloowellingtonlhin.on.ca/goalsandachievements/ihsp.aspx

The information in this document is not to be reproduced without written permission from eCE.
Published: August 2016