Prioritizing Coordination of Primary Healthcare: A Case Report

Vaidehi Misra BHSc, Kimia Sedig BHSc, David R. Dixon MD, Shannon L. Sibbald PhD

Acknowledgements: Healthcare Providers of the Team

Western HealthSciences

PRIMARY CARE CONNECTIONS (PCC)

The Family Health Team (FHT) in the study provides primary care to patients in Ontario. A clinic under the FHT piloted the Primary Care Connections (PCC) model to improve care coordination. The model involved a care coordinator, a care coordination liaison, and physician(s).

One care coordinator was assigned to the clinic (later on 1 more coordinator was added) and ensured that patients received the care they needed when they needed it. The coordinator had access to the electronic medical record (EMR) used by the clinic.

The care coordination liaison mediated communication between the physicians, the coordinator, and patients. The liaison was a healthcare provider (HCP) working at the clinic. The liaison had access to the Client Health & Related Information System (CHRIS) database and the clinic's EMR..

Physicians engaged with the liaison and coordinator to address patients' care needs. This took the form of information transfers, provision of care, or planning of care.

OBJECTIVE

This study presents the PCC as a case report through which successes, challenges, and potential steps forward are described and explored. This case can act as a resource for decision makers pursuing similar improvements in their own sectors of care.

METHODS

This paper approaches the PCC as a case report (n=1) which focused on descriptive and exploratory findings (Rowley, 2002) that emerged during semi-structured interviews with the three actors participating in the intervention (Rowley, 2002). The interviews the experiences and insights gained by the actors during development, during implementation, and following implementation of the PCC.

FINDINGS

SUCCESSES

Improving the relationship between HCPs and patients

Patients grew to trust both the coordinator and the liaison because they were associated with a trusted family doctor. This association combated misconceptions of care coordinators being **outsiders** with access to patients' private information.

Improving communication

The coordinator and liaison shared databases; the increased accessibility to patient information reduced the likelihood of HCPs lacking necessary information to address patient needs and concerns. Improved communication increased efficacy of the clinic and contributed positively to the HCP – patient relationship.

Improving standard of care

The liaison's knowledge of the healthcare system's history, various communication channels, and patient cases positioned them to address patient concerns/questions in a timely manner. This in turn prevented patients' conditions from progressing into acute stages.

CHALLENGES

Establishing positive relationship dynamics

The model depended largely on the relationship between the coordinator, the liaison, and clinic staff. Coordinators exhibited high turnover rates. As a consequence, working relationships with coordinators difficult to sustain.

Ensuring sustainability of the intervention

Implementation required a change in the culture and routines of the clinic staff. It took the clinic approximately two years to establish the liaison as the internal authority on care coordination issues.

Determining evaluation metrics

Establishing evaluation metrics to measure the success of the PCC was challenging. A majority of data was experiential and there was a lack of validated tools for measurement.

ANALYSIS

The PCC incorporated multiple strategies for care coordination to improve patient health and satisfaction (OPCC, 2016; Jones et al., 2017), and its gradual implementation allowed for adjustments to be made during implementation (Jones et al., 2017; OPCC, 2016; Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2013).

THE THREE PILLARS

The FHT clinic highlighted three core elements to be used as a guiding framework when adapting the PCC to new clinics:

Time management and Communication

The care coordinator and liaison had large workloads and limited time available, consequently, they required time management skills to fulfill their roles and responsibilities. Compartmentalization of time enabled the care coordinator and liaison to prepare for anticipated issues, and prevented the PCC from disrupting their daily activities.

Bridging silos

Prior to the PCC, clinic staff contacted the former CCAC to address queries about patient care. This was time consuming, resource intensive, and an example of the silo-ization of healthcare in Canada. Under PCC Coordinators had access to the CHRIS and the liaison could to direct queries to the coordinator which allowed for timely access to patient information.

Navigational skills

A coordinator and a liaison with extensive experience with and knowledge of the system were valuable assets. There was a period during implementation where the coordinator lacked sufficient knowledge to be able to manage the needs of the clinic. When the assigned coordinator was changed to an individual with a more robust skillset, the effectiveness of the model improved.

CONCLUSION

The PCC is a concrete example of a care coordination strategy and demonstrates that care coordination can be improved by facilitating communication within and across sectors, leveraging existing resources, and streamlining existing organizational structures. There is no "one-size-fits-all" approach, even within one clinic. However, this case is a resource for other clinics and health organizations pursuing similar improvement in care coordination.

REFERENCES

Jones, C. D., Jones, J., Richard, A., Bowles, K., Lahoff, D., Boxer, R. S., ... & Wald, H. L. (2017). "Connecting the Dots": a qualitative study of home health nurse perspectives on coordinating care for recently discharged patients. *Journal of general internal medicine*, *32*(10), 1114-1121.

Ontario Primary Care Council. (2016). Position Statement: Care Co-ordination in Primary Care. Retrieved from https://www.allianceon.org/sites/default/files/documents/Position%20statement_care%20coordinaton%20in%20primary%20care.pdf

Rowley, J. (2002). Using case studies in research. *Management research news*, *25*(1), 16-27.

Taylor, M. J., McNicholas, C., Nicolay, C., Darzi, A., Bell, D., & Reed, J. E. (2014). Systematic review of the application of the plan–do–study–act method to improve quality in healthcare. *BMJ Qual Saf*, *23*(4), 290-298.