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PCN SUPPORTS
(CUSTOMIZED BY PCN)

STEM LEVEL SUPPORTS
Agenda

1. Why develop a clinical practice guideline
2. Proposed guideline context, scope and outline
3. Discussion and feedback to this proposed guideline
Your thoughts matter…

• How can we create a “guideline” on Continuity that will be an effective tool for physicians?
  • Would you and your colleagues read it, use it?
  • What would make it user friendly? (e.g. – tools, length, linkages to other continuity work etc.)
  • What are some key behaviours/ behaviour change recommendations physicians need to know?

• If a guideline is not an effective tool, what alternatives would you suggest?

• Additional feedback?
If we could only do one thing…

“Having a family doctor, being able to access the family doctor, and most importantly, continuity of care with a family doctor, is probably the single most important thing a health care system can provide to its population.”

• Dr. Richard Lewanczuk, Senior Medical Director, Primary Health Care, AHS
As Continuity Increases, Utilization Decreases
As Continuity Increases, Cost Decreases
(particularly in complex cases, defined by CRG)
As Continuity Increases, Mortality Decreases
Can Relational Continuity be framed as a Clinical Practice Guideline?

Can “Relational Continuity” be thought of in terms of a typical clinical practice guideline intervention?

- If we had a pill that decreased a disease by up to 50%, wouldn’t we develop a CPG and emphasize this as best practice?

- We know Relational Continuity can decrease mortality by up to 50%, therefore, is it possible to think of relational continuity as a true clinical intervention?
Is developing a CPG on Relational Continuity the right thing to do?

• A guideline alone doesn’t directly influence desired practice behaviour, but:
  • It can serve as an important foundational tool for behaviour change within the overall continuity campaign

• Clinical practice guideline development methodology will ensure recommendations are:
  • Evidence informed, primary care behaviour-focused, reflective of Alberta context, simplified, practical for testing and implementation
  • written by physicians for physicians

(To our knowledge and inquiry there is no other CPG in existence on the this specific topic)
Guideline Committee Members

Co-Chairs:
- Dr. Richard Lewanczuk (Senior Medical Director, Primary Health, AHS)
- Dr. Rick Neuls (Family Physician, AIM Faculty)

Members:
- Dr. Ernst Greyvenstein (Family Physician, PCN Phys. Exec. Lead – Calgary)
- Dr. Lee Green (Family Physician, Prof. & Chair. Dept. of Family Medicine – U of A)
- Dr. Tobias Gelber (Family Physician, SRM President, AMA Board)
- Dr. Jordan LaRue (Family Physician, President Wolf Creek PCN)
- Dr. Charles Leduc (Family Physician, Head of Dept. Family Medicine – U of C)
- Dr. Brad Bahler (Family Physician, Medical Director - PCN Evolution)
- (June Austin) (Senior Consultant AMA – link to associated Continuity work, Access/ Continuity SME)
TOP Relational Continuity Guideline

• Focus:
  • **Relational Continuity** as it is foundational to patient-focused care and positive health outcomes
  • Management and informational continuity will be included in the context of supporting and linked to relational continuity

• Targeted users:
  • Primary care physicians and their teams

• Objective:
  • Primary care physicians will understand the value of relational continuity and therefore adopt practice behaviours that result in relational continuity.

• Timeline:
  • Complete by June 2018
Table Discussion

• Take 10 min to chat with your colleagues about what you’ve just heard
• Prepare to share 1 or 2 key thoughts / ideas that emerge
Your thoughts…

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• Additional feedback?