

Scenario for Method 2: Longitudinal Care Alignment

Population-level Example: Increasing rates of adult vaccinations with focus on influenza and pneumovax

Why: Rates of adult influenza vaccination (42% nationallyⁱ vs. 35% in clinicⁱⁱ and for those aged 65 years and over 70% nationally and 50% in clinic) and pneumovax for patients age 65 years and older (37% nationallyⁱⁱⁱ and 30% in clinic) are suboptimal; reasons could be inadequate information, lack of offering, documentation or communication of receipt. It was not clear if patients knew about the need for these vaccinations. Although prior to COVID-19, patients had received the influenza vaccine from their local pharmacist, many had not had received pneumovax which was also being offered by their local pharmacy.

How: The patient-centered measurement (PCM) was a brief checklist for older patients asking about their knowledge, willingness, vaccination completion and location, and satisfaction with care for immunizations. A mailer was sent to patients' email addresses for annual completion of the checklist. Patients who did provide an email were sent the checklist with a self-addressed envelope. The checklist was also available at the pharmacist for patients to complete on their own and bring to their provider.

Who: This was a shared responsibility of the care team, consisting of the patient, nurse, pharmacist and medical office assistant. After discussion with the clinic staff and pharmacist, the clinic created a standing order for the nurse administrator to provide a prescription for vaccine and administration through the local pharmacy based on a simple checklist of eligibility. The medical office assistant entered the paper-based results into the electronic health record. The nurse contacted the patients who had not received pneumovax over the past five years to recommend a booster shot. The pharmacist provided copies of the checklist.

When: The checklist would be provided for all visits or contacts with all patients over age 65 years old during the flu season.

Where: The checklist was delivered in-person, over the phone, while in the virtual waiting room and at the pharmacy. An educational article was also created about the two different vaccines and made available at the clinic and, pharmacy and through the online portal.

Outcome: The clinic sent the checklist to 80% of their patients who were over the age of 65, and half were completed. The team learned that some of their patients had not obtained the flu shot last year due to worries about COVID-19, but most were satisfied with getting their vaccinations at the pharmacy and would do so this year. Very few were aware of the need for pneumovax and it was suggested that the medical office assistant might be best to administer the eligibility form, with the nurse sending the prescription to the local pharmacy. By spring 2022, the rate of influenza vaccination for older patients in the clinic was at 80% and 50% had obtained their pneumovax.

Patient-level Example: Working with a patient with Cerebral Palsy (CP) and restricted mobility

Why: Your patient with CP has been feeling exhausted at the end of her work day and, as a result, finds herself unable to prepare meals or complete her exercises. During the discussion to switch from use of forearm crutches at work to a wheelchair, you suggest monitoring her fatigue level to see if this change is having the desired effect. The PROMIS measure on fatigue is chosen for this purpose.

Who: The patient agrees to complete the measures in-between visits, and the doctor will discuss significant changes during the clinic visit. In the team discussions, it is agreed that the medical office assistant would be the best for scheduling the measure to go out through the portal and enter the results into the electronic health record.

When: During the initial clinic visit, the patient expresses interest in completing the measure every two weeks over a four-month period to see how recent changes are affecting her energy level. The medical office assistant will be sent a notification when a measure is completed.

Where: The patient will complete the measure in the patient portal. As the patient portal and electronic health record are not yet connected, the medical office assistant will transfer the score into the electronic health record.

How: In this example, the patient portal is being used to deliver the measure and provide a graph that tracks the changes over time. As the portal is not yet integrated into the electronic health record, the medical office assistant is providing the role of transferring over the scores. During the visit, the patient and doctor have the electronic health record open so that they can review the results and trends together.

Outcome: The data show that her fatigue has improved and she is exercising more regularly, but meal preparation is still a problem and she remains underweight. You will focus on this concern next using a similar cycle of trying dietary and diet support options and monitoring weight and fatigue.

ⁱ <https://www.canada.ca/en/public-health/services/immunization-vaccines/vaccination-coverage/2019-2020-seasonal-influenza-flu-vaccine-coverage.html>

ⁱⁱ Based on query of electronic health records for clinic patient panel

ⁱⁱⁱ <https://www.cfp.ca/content/cfp/65/9/625.full.pdf>