PaCT Change Package (draft Jan 25, 2018)

Improvement Focus Legend:	Optimize the Patient Experience	Optimize the Team	Optimize the EMR

	FOUNDATIONAL: Identify, Maintain, and Manage the Panel	**Phase 1: IDENTIFY**	**Phase 2: PREPARE**	**Phase 3: PLAN**	**Phase 4: MANAGE**
Foundational Panel Work	0a. Establish panel identification and maintenance processes				
	0b. Ensure access and continuity for paneled patients				
Care Planning		1a. Define complex health needs and select a population of patients for care planning	2a. Prepare the care team	3a. Engage patient in care planning	4a. Set actionable reminders in the EMR to support follow-up
		1b. Use EMR to identify specific patients with complex health needs	2b. Prepare the patient	3b. Engage speciality and community	4b. Coordinate care
		1c. Build patient awareness and offer care planning		3c. Utilize EMR to document and share care plan	4c. Follow-up with the patient

The PaCT Change Package is divided into the four phases of the Model Care Planning process, plus a foundational element on creating, maintaining, and managing the panel. Within each phase (identify, prepare, plan, manage) there are key activities and suggested practices or PDSAs that practices may choose to test over the course of the Patients Collaborating with Teams (PaCT) initiative. For ease of use, the activities and their related suggested activities are grouped in three main areas of improvement focus: optimize the patient experience, optimize the team, and optimize the EMR.

The key activities and suggested practices have been drawn from evidence-based literature, Alberta research, and improvement stories. The change package is meant to be modified over time. As more is learned from the PaCT initiative about what works and doesn't work, the change package will evolve.

The change package will serve as a roadmap for Improvement Facilitators and teams, and will be used to derive ideas that will be introduced during the initiative's share-and-learn webinars over the year.

Foundational: Identify, Maintain, and Manage the Panel		
Key Activities	**Potentially Better Practices to Test (PDSAs)**	**Measures**
0a. Establish panel identification and maintenance processes	• At every interaction ask the patient to verify his/her primary provider. • Record confirmed panel identification information in the EMR and date stamp it. • Regularly review and maintain a clean panel list. • Utilize the panel list to plan care delivery.	**Panel Confirmation Rate**: Percentage of patients presenting to the provider in the previous two (2) months who have confirmed their attachment to an individual provider. Percentage: • *Numerator:* Number of patient records with attachment confirmed within the previous 2 months • *Denominator:* Number of patients presenting to the provider within the previous 2 months
0b. Ensure access and continuity for paneled patients	• Create access for patients with the primary care provider and care team for care planning. • Use the Central Patient Attachment Registry when it becomes available to verify that the patient is not attached to another primary provider in the province.	

Phase 1: IDENTIFY		
Key Activities	**Potentially Better Practices to Test (PDSAs)**	**Measures**
1a. Define complex health needs and select a population of patients for care planning	• Review suggested identification criteria for patients with complex health needs. Develop a shared definition (gradually expand definition). • Prioritize and select patient population for care planning. • Start with patients not presenting for care.	**Defining Complex Health Needs**: The operational definition of "complex health needs", as defined by the provider and team that is used to systematically identify patients who would benefit from care planning. **No Recent Appointment:** The number of patients on the panel who did not have an appointment with their provider in the previous 12 months. **Patients with Complex Health Needs**: The number of patients on an individual provider panel that have been identified as having complex health needs in the EMR. **Prioritized Population for Care Planning:** The number of patients identified as a priority for care planning.

1b. Use EMR to identify specific patients with complex health needs	• Create list of patients with complex health needs:
	  ○ Outreach: Search EMR to identify patients with complex health needs per shared definition. To start, identify patients not presenting for care (with no visit/contact with team in previous 12 months) that meet team shared definition.
	  ○ Opportunistic: Search daily schedule to identify patients with complex health per shared definition.
	• Review the list as a team.
	• Select your first cohort of patients.
	• Mark the patient's EMR record "complex health needs" in an area that is searchable.	

1c. Build patient awareness and offer care planning	• Develop a process to offer care planning either via outreach or opportunistically. • Create and use scripts for each role that interacts with patient to explain care planning and its benefits. • Invite patients to request a care planning visit. • Offer and schedule a care planning appointment.	

Phase 2: PREPARE		
Key Activities	**Potentially Better Practices to Test (PDSAs)**	**Measures**

2a. Prepare the care team	• Define and coordinate care team roles, processes and interactions (who will do what, when).
	• Select a care plan template.
	• Ensure the entire care planning team has access to the EMR.
	• Assign a team member to:
	  ○ Populate the care plan template by routinely and systematically pulling relevant data from the EMR & Netcare: medications, screening, lab results, diagnostics, other MD visits, and any relevant assessments (review with primary provider).
	  ○ Generate any required lab/diagnostic imaging requisitions in advance of the encounter (review with primary provider).
	  ○ Prepare relevant resources and information in advance of patient encounter (community resources, program information).
	  ○ Identify and append appropriate assessment tools to the record to be used at the care planning visit.
	  ○ Send assessment tools and requisitions to patient in advance of encounter if appropriate.
	• Assign a care team member to the care planning process (other than to the primary provider). Pair the team member assigned ownership of the care planning process with a clinic team member if this individual is not co-located within the clinic.
	• Coordinate and plan daily work using visual boards, huddles, virtual messaging, or any other process preferred by the team.
	• Consider who else is involved in the patient's care outside of the primary care team. Invite Alberta Health Service specialty programs, specialists, and community to share relevant information to include in the care plan.
		Offer of Care Planning: The number of patients with complex health needs with a documented offer of a joint care planning service.

2b. Prepare patients	• Invite patients to bring a trusted friend or family member with them to appointment. • If appropriate, send selected assessment tools and requisitions in advance of appointment for patient to complete and bring to care planning visit. • Ask patients to bring relevant information to the appointment (medications, etc.). • Consider use of a patient reflection tool to help the patient identify what matters the most to them (concerns, health/life style priorities). E.g. use of "today I want to talk about" cards.	

Phase 3: PLAN		
Key Activities	**Potentially Better Practices to Test (PDSAs)**	**Measures**

3a. Engage patient in care planning	• Build trust:
	  ○ Set the stage for the care planning visit (explain your role, purpose of visit, what to expect, what not to expect).
	• Build importance:
	  ○ Check patient understanding of conditions, medications, and treatments.
	  ○ Review or perform cognitive, physical, and psychosocial assessments.
	  ○ Invite patient to share values, beliefs, concerns, outcome preferences, lifestyle factors, priorities, and goals ("what matters the most to me?").
	  ○ Review the broad lifestyle, treatment and referral categories that the patient may choose to work on over time to improve their health.
	  ○ Collaborate with patient to prioritize the categories.
	• Build confidence:
	  ○ Discuss options the patient may have for taking action in the prioritized categories.
	  ○ Set personalized care goals collaboratively: medical, health, and life goals.
	  ○ Create an action plan collaboratively that includes medical, self-management, barriers and coping plan, referrals, and follow-up. Involve family member or friend.
	  ○ Confirm shared understanding of action plan.
	  ○ Assess patient confidence in ability to follow through.
	  ○ Create clear follow-up plan for next steps and next visit.
	  ○ Ensure follow-up appointments are booked with team members as appropriate.
	  ○ Provide relevant materials (printed/electronic) so the patient has information needed to support self-management.
	  ○ Introduce team members involved in the patient's care using a warm-hand off.
		Completed Care Plans: The number of patients with complex health needs who completed a co-developed care plan.

3b. Engage speciality and community	• Invite the primary care team, Alberta Health Service specialty programs, specialists, and community who are involved in the patient's care to contribute to the care plan and update the care plan on an ongoing basis. Consider sharing, consulting, and collaboration.	
3c. Utilize EMR to document and share care plan	• Review care plan with the primary provider. • Document all aspects of the plan in the care plan template. • Set an actionable reminder in the EMR for care plan follow-up. • Share a copy of the care plan with patient. • Share a copy of the care plan with primary care team members and others supporting the patient (AHS specialty programs, specialists, community, etc.).	

Phase 4: MANAGE		
Key Activities	**Potentially Better Practices to Test (PDSAs)**	**Measures**
4a. Set actionable reminders in the EMR to support follow-up	• Create reminders in the EMR for follow-up team tasks. • As part of continued panel management, use the EMR to mark the patient as part of a specific population to support population health planning and redesign.	**Due for Follow-Up:** The number of patients who have participated in a joint care planning process that have <u>not</u> participated with established follow up by the expected date plus thirty days.
4b. Coordinate care	• Assign a dedicated team member to follow-up on actionable items. • Follow-up on referrals (referral sent, referral received, visit scheduled, visit happened, report generated, report received). • Have processes in place to share the care plan and updates on information in the care plan with others involved in the care that are outside of the primary care walls (AHS specialty programs, specialists, community, etc.). • When possible, introduce team members that will be involved in the patient's care using a warm-hand off. • Give updates to the primary provider during scheduled review of patients or as needed. • Have an updated inventory of community resources available at the practice. • Evaluate patient and care team satisfaction with community resources and referrals.	
4c. Follow-up with the patient	• Assign a team member(s) to review follow-up items with the patient. • Set a time frame and manner that engages the patient most effectively (visit, group visit, phone, portal, text or email) to assess progress towards agreed upon goals and actions. • Identify information (what, how, when) the patient and family will provide the medical home (i.e. self-monitoring). • Work closely with the patient to support and build his/her confidence in making health behavior changes as actions of the care plan are underway by advocating, reassessing, and connecting with other members of the team. • Ensure that the patient can access the most appropriate member of the care team, in a timely way, when they need or want an appointment. • Rely on the care plan as a living document that is revisited and revised regularly through discussion with the patient, and provide the patient an updated copy.	