PaCT Share & Learn

November 23, 2017

12 noon – 1 pm

Agenda

Welcome and recap

Chat-in questions

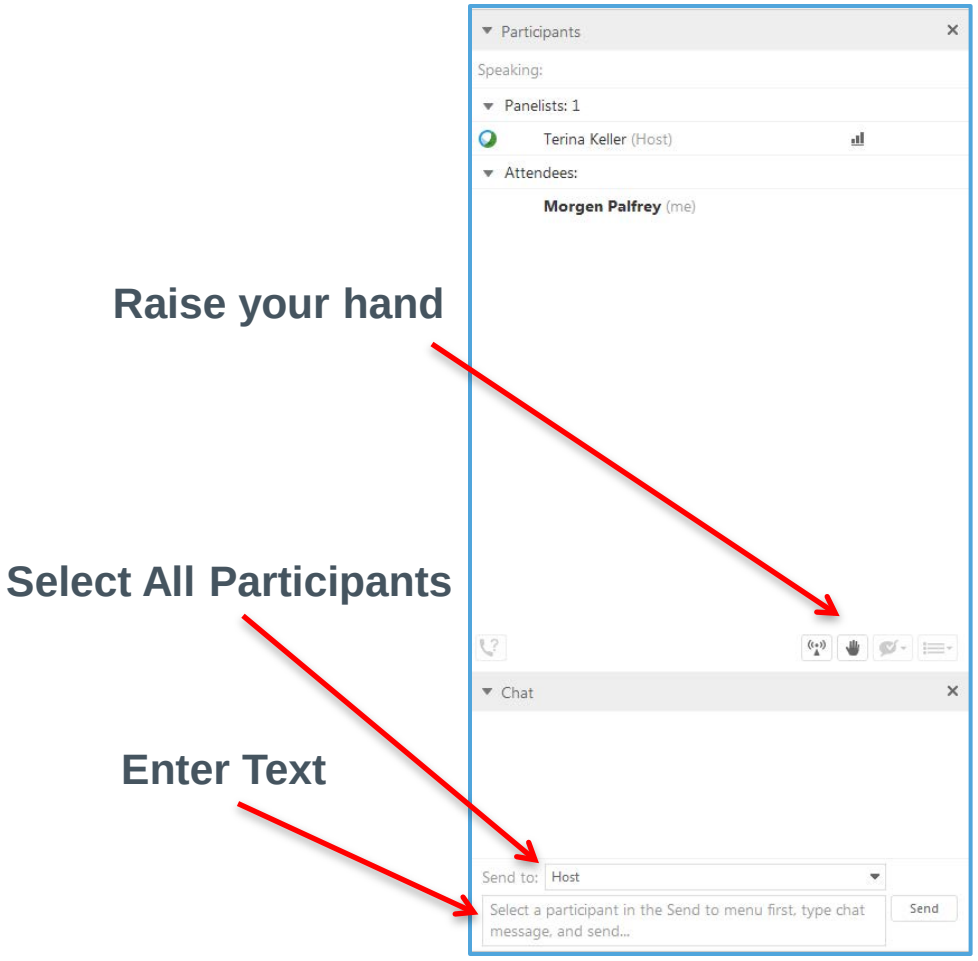
Field stories

- Riverside Medical
- St. Albert Medical

Next steps and upcoming dates

WebEx Quick Reference

- **Mute and unmute** on your phone or using ***6** *(no hold music please)*
- Please use chat to "***All Participants***" for discussion & questions
- For technology issues only, please chat to "***Host***"



Innovation Hub Participants

What makes your clinic unique?

→ Life Medical – McLeod River

→ St. Albert Medical Clinic – St. Albert & Sturgeon

→ Wheatlands Medical and Mid Town Medical Clinics – Kalyna Country

→ Kneehill and Riverside Clinics – Big Country

→ Sunridge Family Medicine Teaching Center and Good Samaritan Medical – Mosaic

→ Heritage Medical, Gateway Medical, Good Samaritan Seniors Centre, Ottewell Medical Clinic, Nova Medical Centre, Grey Nuns Family Medicine Centre – Edmonton Southside

Brief Recap

Starter Test Box

- Confirm target patient population
- Team assessment
- Team meetings
- Current state process map
- EMR

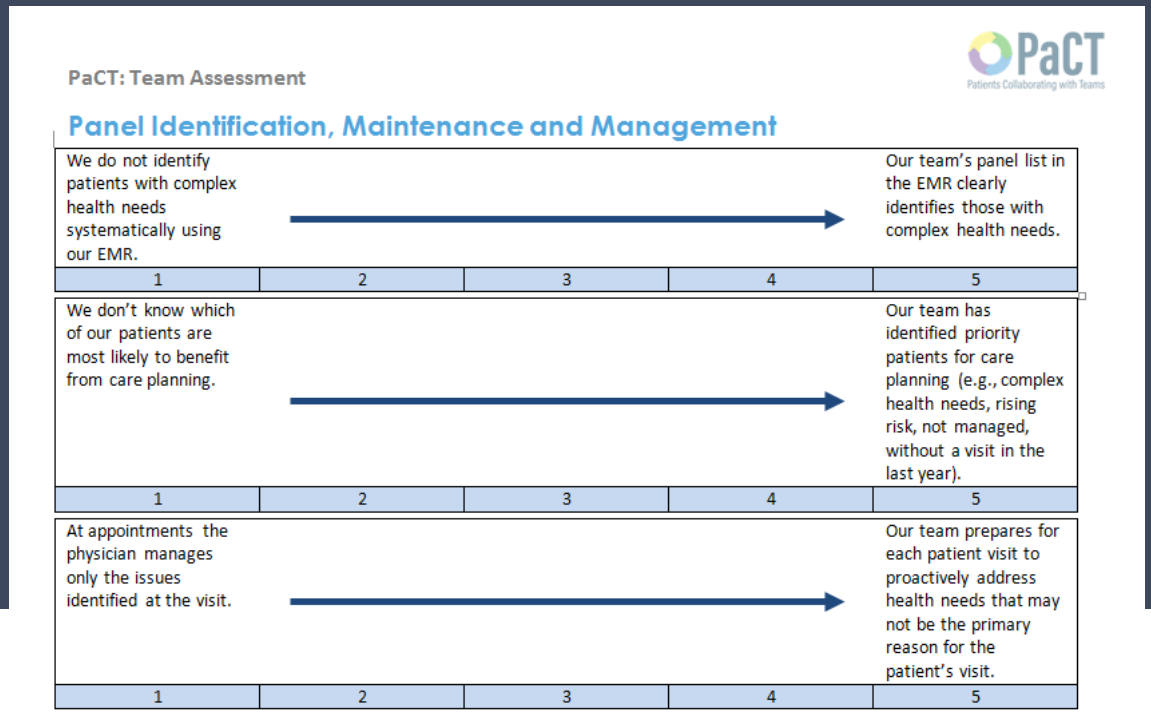
Chat In to All Participants

Which patient population(s) is your clinic targeting for care planning?

PaCT
Patients Collaborating with Teams

Chat In to All Participants

What “a-ha” moment or learning did you have as a result of your baseline team assessment?



PaCT: Team Assessment

PaCT Patients Collaborating with Teams

Panel Identification, Maintenance and Management

We do not identify patients with complex health needs systematically using our EMR. →				Our team’s panel list in the EMR clearly identifies those with complex health needs.
1	2	3	4	5
We don’t know which of our patients are most likely to benefit from care planning. →				Our team has identified priority patients for care planning (e.g., complex health needs, rising risk, not managed, without a visit in the last year).
1	2	3	4	5
At appointments the physician manages only the issues identified at the visit. →				Our team prepares for each patient visit to proactively address health needs that may not be the primary reason for the patient’s visit.
1	2	3	4	5

PaCT Patients Collaborating with Teams

Riverside Medical

What we have tried….

- Aside from the ‘usual’ (e.g. form an improvement team & start meeting regularly, completing our team assessment, etc.) here are some things we have done that we thought might be of interest to others.

- P.S. we can share our resources if anyone is interested

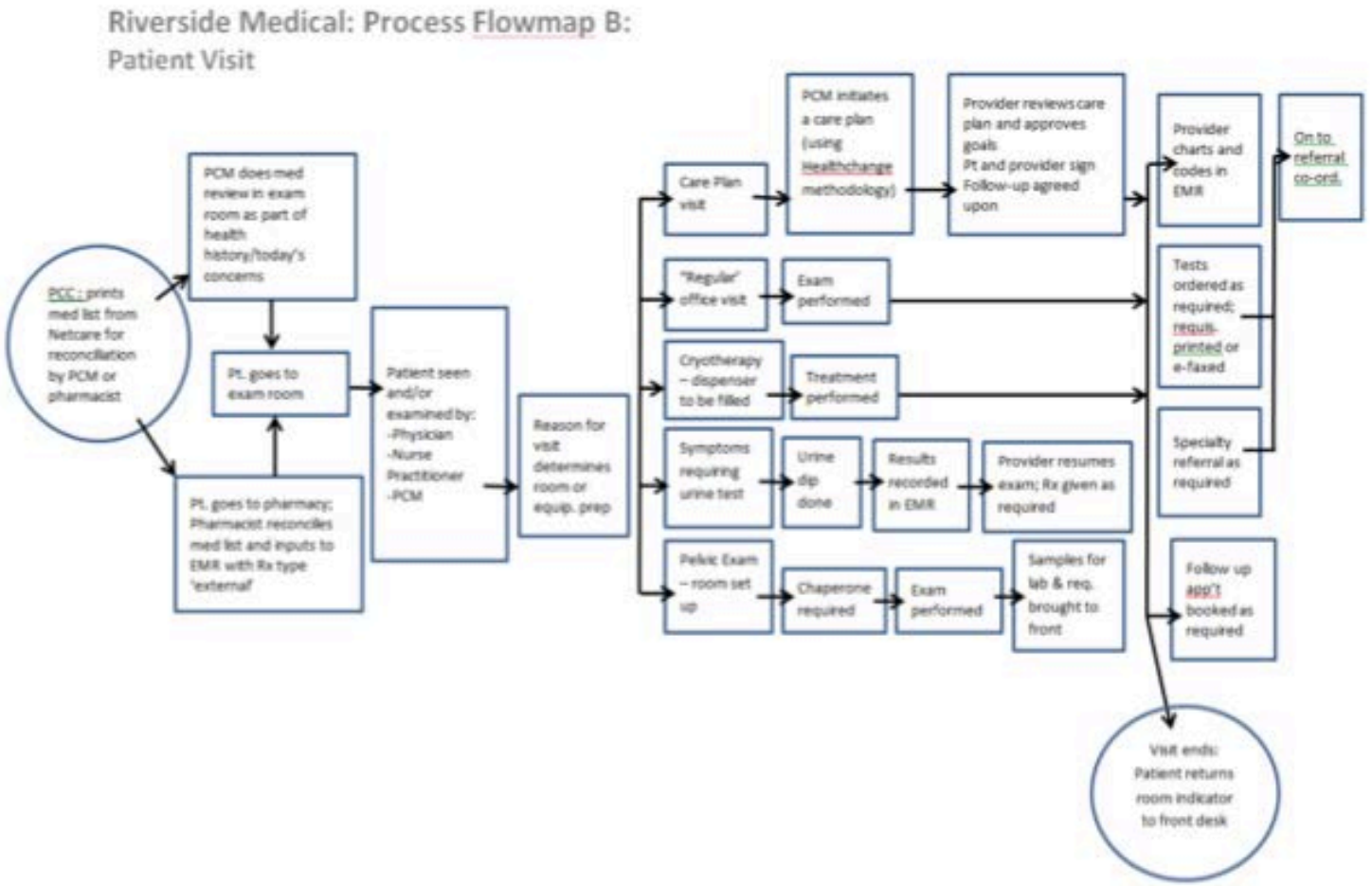
Action Plan Template

Today's Meeting	Date: Nov 29/17	Time: Noon	Location: RM	Facilitator:	Candace Baxter	Minute Taker:	Ashlyn Herzog
Next Meeting	Date:	Time: Noon	Location: RM	Facilitator:		Minute Taker:	
Team Members	Patient Rep	Rithesh Ram	Ashlyn Herzog	Ray Ainscough	Jennifer Danielsen		
(bold are present today)	Candace Baxter	Jessie Hansen	Kathy Stark	Veronique Ram	Amanda Panisiak		
Today's Agenda Items				**Next Meeting Agenda Items**		**Potential Problems Raised**	
1. Aim Statement				1		1	
2				2		2	
3				3		3	
Administrative/General Information and Issues							
Information for Team, or Issue for Team to Address			Discussion/Decision/Task			Who?	By When?
Problem-Solving Action Plan					Implementation and Evaluation		
Precise Problem Statement (What,When,Where,Who,Why)			Solution Actions		Who?	By When?	PDSA
Evaluation of Team Meeting (Mark your ratings with an X)					Our Rating		

Flow Mapping

Completed flow map of current patient visit process then added proposed process for a visit for complex patients

Flow Map


Riverside Medical: Process Flowmap B:
Patient Visit
PCC : prints med list from Netcare for reconciliation by PCM or pharmacist
PCM does med review in exam room as part of health history/today's concerns
Pt. goes to exam room
Pt. goes to pharmacy; Pharmacist reconciles med list and inputs to EMR with Rx type 'external'
Patient seen and/or examined by: -Physician -Nurse Practitioner -PCM
Reason for visit determines room or equip. prep
Care Plan visit
PCM initiates a care plan (using Healthchange methodology)
Provider reviews care plan and approves goals Pt and provider sign Follow-up agreed upon
"Regular" office visit
Exam performed
Cryotherapy – dispenser to be filled
Treatment performed
Symptoms requiring urine test
Urine dip done
Results recorded in EMR
Provider resumes exam; Rx given as required
Pelvic Exam – room set up
Chaperone required
Exam performed
Samples for lab & req. brought to front
Provider charts and codes in EMR
Tests ordered as required; requis. printed or e-faxed
Specialty referral as required
Follow up appt booked as required
On to referral co-ord.
Visit ends: Patient returns room indicator to front desk

Patient Population of Focus

- Our clinic is new (only open 6 months), our EMR has a lack of ‘historical patient data’.
- We could not search for patients that have not been seen the last year or more.
- We decided to search for patients with ‘known chronic diseases’ and review the list as a team to decide who might be good candidates to trial our new care plan process.

Inviting Patients to a Care Planning Visit

We have been working on an invitation letter for applicable patients which would…

- Confirm attachment to provider & update demographics
- Introduce the PaCT initiative
- Describe care planning and its benefits
- Outline expectations of the patient.
- Inform patients who makes up the healthcare team and what the patient can expect from them.

Letter of Invitation to Patients

PaCT Information for Patients

What is the PaCT Initiative?

Toward Optimized Practice (TOP) is a support resource for the *Alberta Medical Association (AMA)* who assists physicians in implementing evidence-based improvement strategies into their clinics. TOP has established the PaCT (Patients Collaborating with Teams) initiative, to test and develop ideas to systematically support patients with complex needs. Our clinic has chosen to be an Innovation Hub for the PaCT Initiative for the next year. Evidence shows that patient involvement equals greater success in health outcomes, with that in mind we have chosen a select sample group of patients based on their current health needs to trial a provincial care planning initiative with.

What is Care Planning?

A care plan is a comprehensive tool that many health professionals use to better understand and manage their patient's health. We will test evidence-based care planning with our patients and the perceived benefits of this tool on overall health. This care planning process is designed for patients who have complex care needs or may be rising risk, including those patients with new diagnoses, uncontrolled illnesses, or who visit the emergency department frequently.

Benefits of the Pact Initiative for the Patient:

- Comprehensive care from a healthcare team: including your Family Physician, Nurse Practitioner, Nurse, Clinical Pharmacist, and Registered Psychologist.
- Feeling *heard*
- Opportunity to practice patient-centred goal setting
- Receive health teaching and guidance through evidence-based resources and health information
- And, of course, improved health outcomes!

Expectations of the Patient:

Our Patient Care Coordinators will schedule you in for an appointment with your healthcare team to initiate the care planning process. This initial care planning visit will likely be facilitated by our Patient Care Manager, Ashlyn, and will include a review of your medical profile, your current and past health conditions, medications, allergies, etc. We will also discuss what health goals you may want to set for yourself over the next year. Your family physician will join the appointment to review your health concerns and care plan.

- Bring all current medications, including prescription and over-the-counter, to your initial care planning appointment.
- Be an active member of your health team; bring your concerns with you and advocate for your health goals.
- Attend all reasonable appointments with your healthcare team, as well as appointments with other healthcare disciplines, if warranted.
- Provide feedback throughout the course of the care planning process. Feedback allows your healthcare team to provide more patient-centered care.
- Depending on the complexity of your conditions, a member of your healthcare team may request that you return for a follow-up appointment(s) in order to meet all of your health needs.
- If your provider has sent you for labwork or other investigations, please contact our Patient Care Coordinators for results. They will direct you whether you require follow-up with the physician regarding your results.

Patient Script

Invitation to the PaCT Care Planning Initiative

First, just to keep our records up to date, is Dr. Ram, still your family doctor? Yes / No
Please confirm the following demographic information for our records:

- DOB:
- Mailing Address:
- Email Address:
- Phone Number:

Have you heard about our PaCT Initiative for care planning?

a) If Yes – "Great! We would like to invite you to participate in this care planning process, as you fall into the criteria for the PaCT Initiative. You have been chosen by your healthcare team to participate in this initiative, in recognizing that you have demonstrated a willingness to learn and manage your health responsibly – an essential ingredient to the PaCT Initiative. Here is a handout with information regarding the PaCT Initiative that you can take home to review. Do you have any questions at this time?"

b) If No – "No worries. However, We would like to invite you to participate in this Initiative. I will send you home with some information today to help you decide whether or not you would like to participate. You have been chosen by your healthcare team to participate, in recognizing that you not only meet the criteria for this care planning process, but that you have demonstrated a willingness to learn and manage your health responsibly – an essential ingredient to the PaCT Initiative. Here is a handout, take this home with you today, then I will call you in one week's time to answer any questions that may arise during that time regarding the initiative."

Benefits to the Patient:

There are many benefits to care planning – a few of which are listed on your handout. At the end of the care planning process, we hope to hear feedback around how the care planning process and multidisciplinary approach has improved patients' quality of life. For example:

"Because Dr. Ram and his team helped me to decrease my blood sugar levels in the target range, I felt well enough to attend my granddaughter's wedding."

OR

"It was important to me to be able to engage in play with my children, but I just couldn't because of my pain. My care plan helped me develop a plan with my family physician and his team to better manage my pain, and now I am able to run and play with my children whenever I want."

Follow-Up:

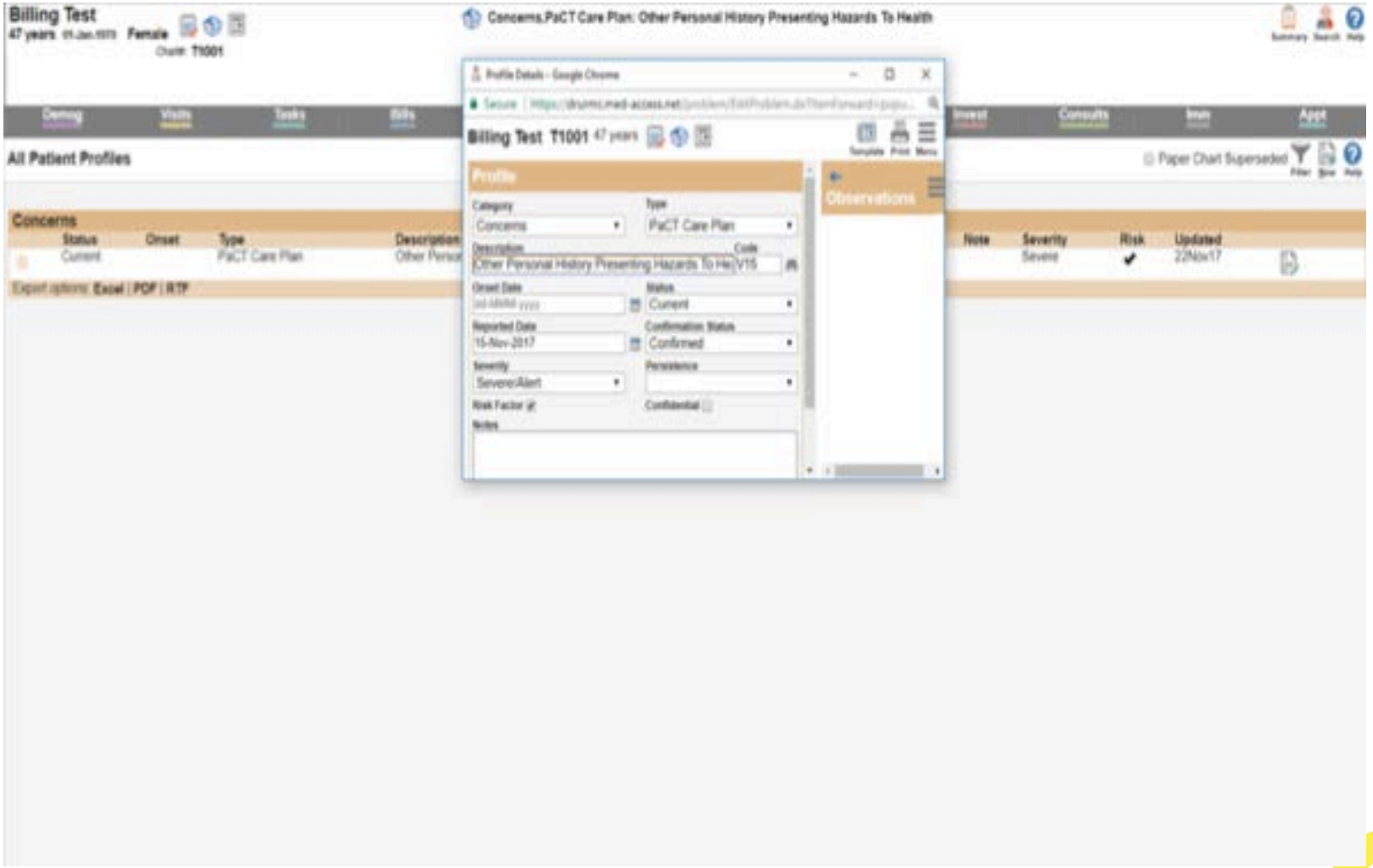
Let's arrange a follow-up appointment for you to come back in to discuss your decision, whether you would like to participate in the care planning process or not.

Going forward…

To make sure we have good, sustainable processes to ID patients for care plans in the future, we;

- have decided how to ID complex patients in the EMR (Med Access)
- have standardized **charting** processes to enable EMR optimization to further ID patients in the future

Med Access Profile Tab – marking those invited



An Innovative PDSA

Based on HealthChange suggestions,

- When patients check in at the desk, they are given a sheet that asks "**What Matters to You Today?**" and are encouraged to write responses to help the team to focus, at the visit, on what is important to the patient.

What Matters to You?

RIVERSIDE MEDICAL

Your Healthcare Team wants to hear from you.
What matters to you about your visit today?
Feel free to jot down your thoughts.

1
2
3
4
5
6
7

RIVERSIDE MEDICAL

What Matters to You List

Your Healthcare Team wants to hear from you.
What matters to you about your visit today?
Feel free to jot down your thoughts.

1
2
3
4
5
6
7
8

QUESTIONS?

St. Albert Medical Clinic

Our Quality Improvement Team

- Four physicians involved
- **Physician Lead:** Dr. Fisher
- **Nurse:** Kerri Coles
- **Pharmacist:** Corey Jefferies
- **Nurse Lead:** Charlotte Douglas
- **Clinic Manager:** Debbie Makymic

Team Assessment

PaCT: Team Assessment

Date: Nov 9, 2017

Team Name: Team Awesome

- What did your team assessment reveal?
- What are some next steps you are planning as a result?

Aim – Patient Centred

- Identify patients who are at risk of becoming high users of the health care system related to increasing frailty
  - maintain their independence
  - decrease acute care episodes
  - collaborate with care partners to provide/enhance supportive community services

Aim – Medical Home Action Plan

- Recall of 3 patients per physician for the project
- Timeline: recalled by December 31st 2017
- Revisions to process with these small numbers
- Project will continue to December 31st 2018

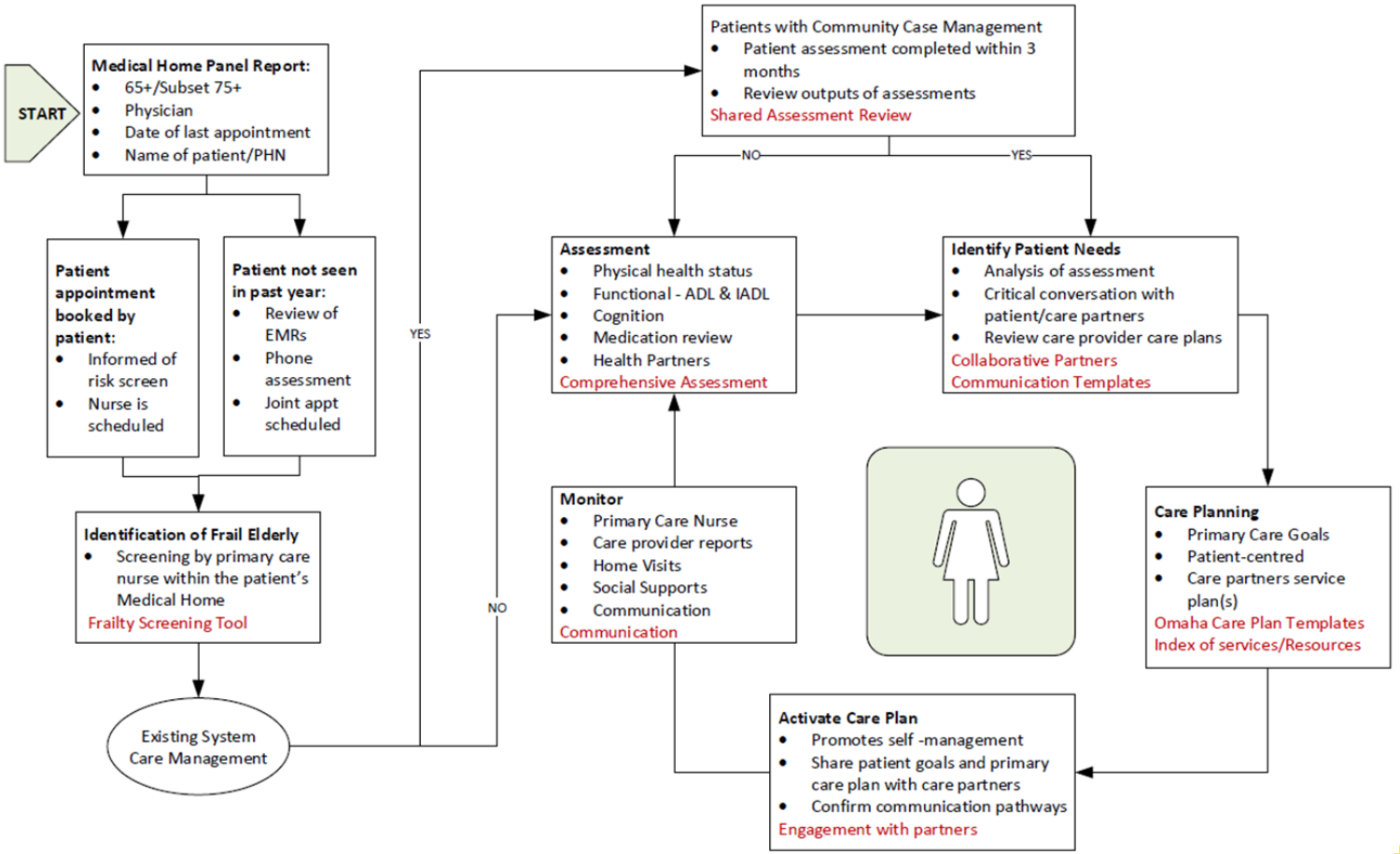
Our Target Population

Patients who are 65 years plus who qualify for the Edmonton Frailty Score

- How did your team decide to select this population?
- How many individuals did you identify in this population?
- What is your process for identifying the individuals?

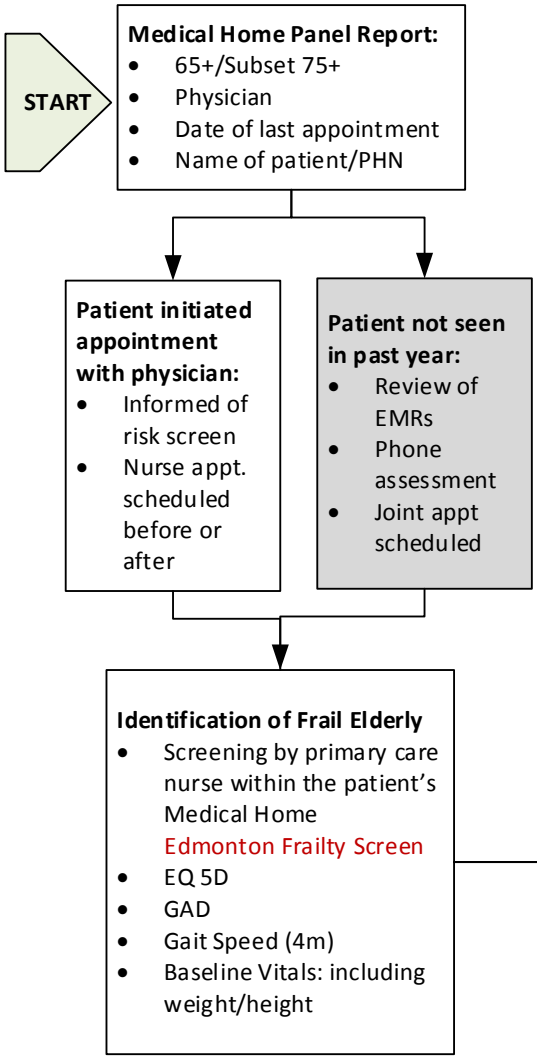
Our Process

- Kerri, our nurse, is reviewing the patients on a weekly basis and recalling patients as required
- 10 patients have been screened
- 1 patient scored as “mildly frail”

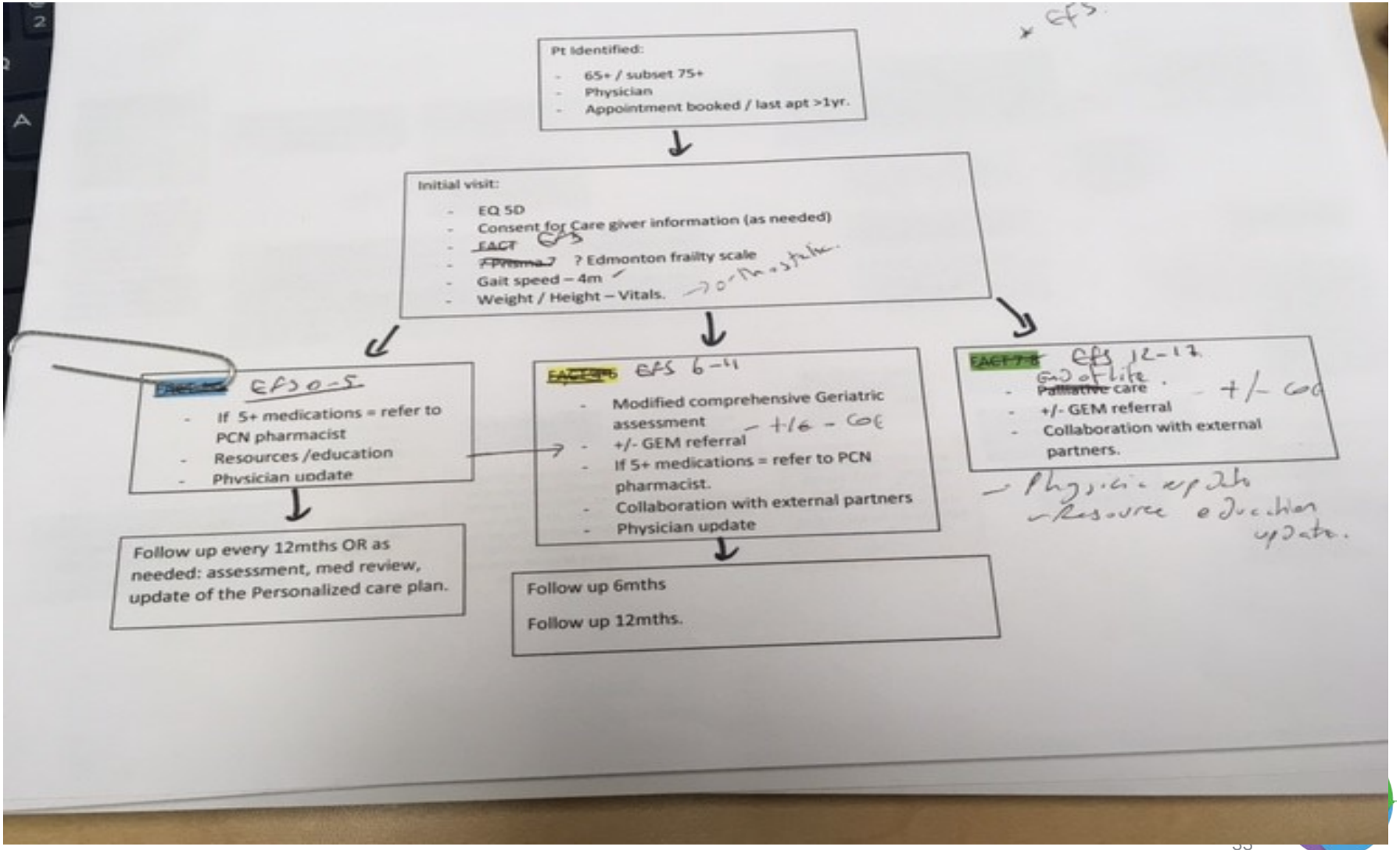

START
Medical Home Panel Report:
65+/Subset 75+
Physician
Date of last appointment
Name of patient/PHN
Patient appointment booked by patient:
Informed of risk screen
Nurse is scheduled
Patient not seen in past year:
Review of EMRs
Phone assessment
Joint appt scheduled
Identification of Frail Elderly
Screening by primary care nurse within the patient's Medical Home
Frailty Screening Tool
Existing System Care Management
YES
NO
Patients with Community Case Management
Patient assessment completed within 3 months
Review outputs of assessments
Shared Assessment Review
NO
YES
Assessment
Physical health status
Functional - ADL & IADL
Cognition
Medication review
Health Partners
Comprehensive Assessment
Identify Patient Needs
Analysis of assessment
Critical conversation with patient/care partners
Review care provider care plans
Collaborative Partners
Communication Templates
Monitor
Primary Care Nurse
Care provider reports
Home Visits
Social Supports
Communication
Communication
Care Planning
Primary Care Goals
Patient-centred
Care partners service plan(s)
Omaha Care Plan Templates
Index of services/Resources
Activate Care Plan
Promotes self -management
Share patient goals and primary care plan with care partners
Confirm communication pathways
Engagement with partners

Patient Identification

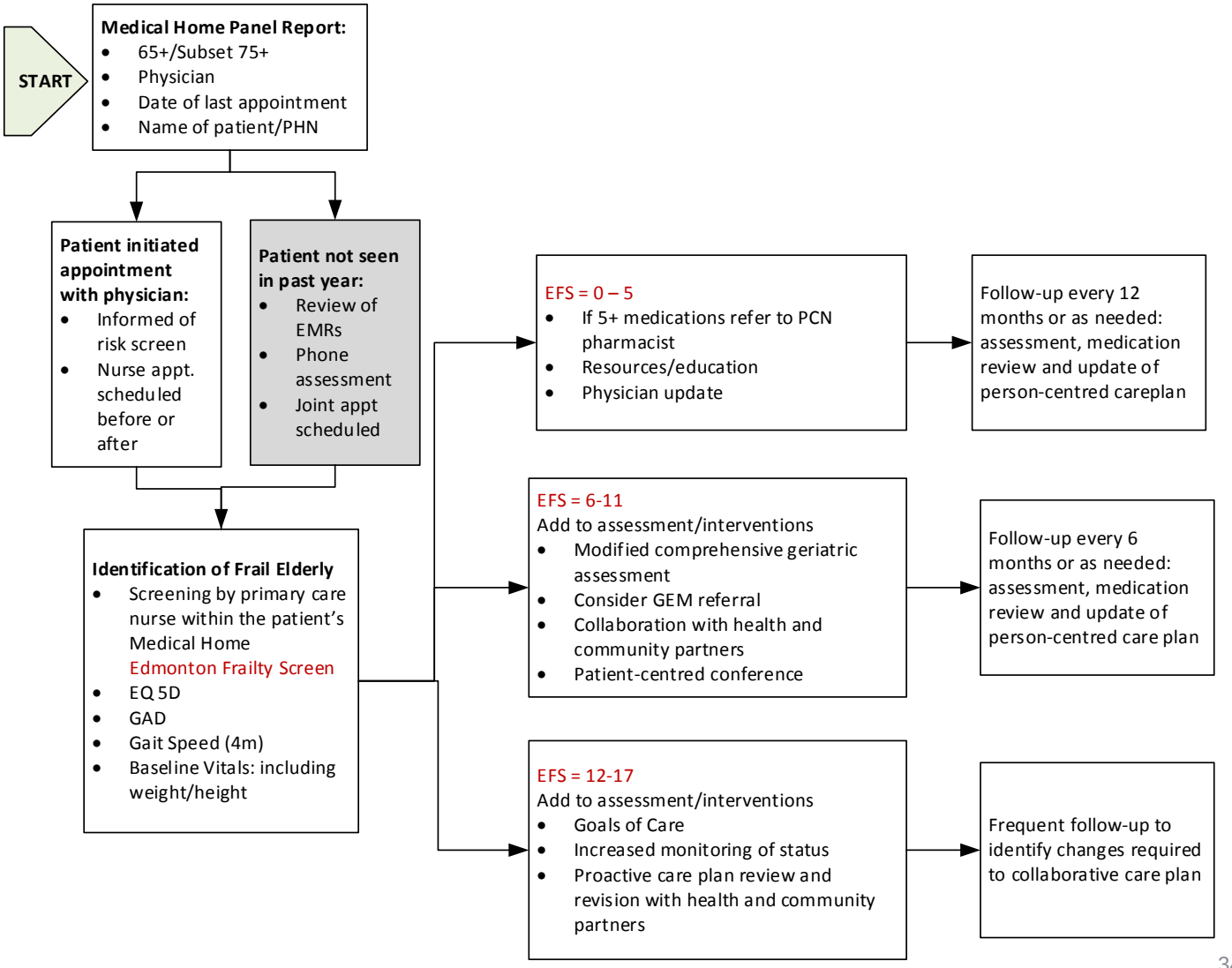
Primary care nurse will use the Edmonton Frailty Scale to identify both the presence of frailty and the amount of associated risk.



Current State Map – 1



Current State Map – 2



Now Learning to Explore

- Patients who do score as at risk for frailty may become with frail with one change to their health or function.
  - For example: a fall on the ice

- What can we to prevent or prepare for these unpredictable factors?

QUESTIONS?

Next Steps

PaCT
Patients Collaborating with Teams

Upcoming Dates

Nov 30 – *Coaches' Prep (Test Box 1)*

First week of Dec – *Test Box 1 delivery*

Jan 25 – *Share & Learn (Test Box 1)*

Share & Learns - Structure

Chat Questions

- *What did you test?*
- *What did you learn? (Adopt/Adapt/Abandon)*
- *What would you recommend for other teams?*

Featured Teams

- *Share your story*

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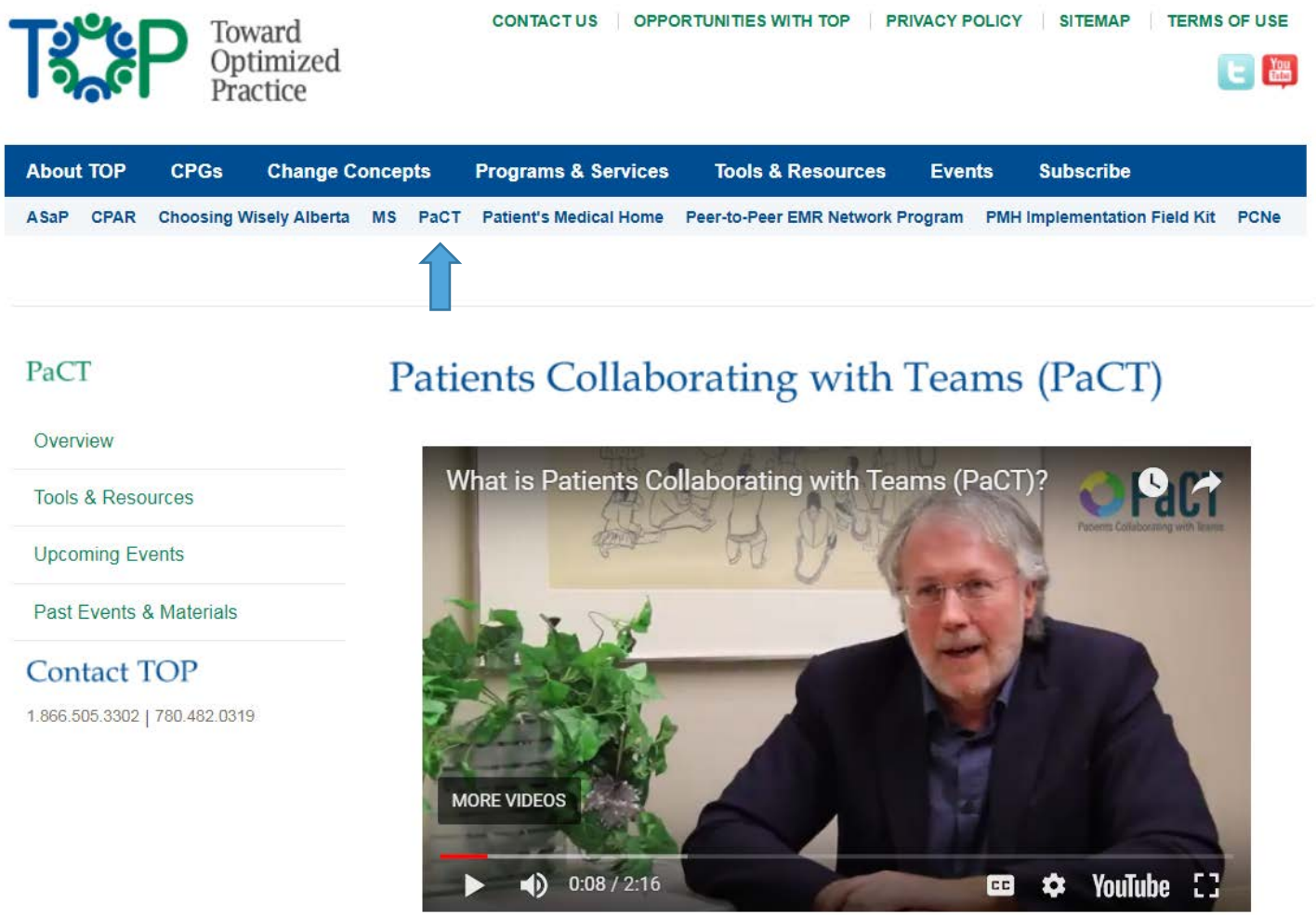

Fail forward

It’s all about what you do next…

How was the session today?

On a scale of 1 (low) to 5 (high) how valuable was the Share and Learn session today?

- Use the poll to record your answer

Thank you for joining!