PaCT Innovation Hubs

Test Box #1 – Guide for Coaches

The Share & Learn webinar session with the innovation hub clinics is planned for January 2018. Between now and then, teams are encouraged to work on the foundational activities in Test Box #1. **As in all PaCT test boxes, teams are not required to do all activities, but we hope that they will consider doing as many as possible.** The activities in Test Box #1 will provide a strong foundation for future care planning activities.

Review the activities with the team. If they've already completed any of them, you can check those off. Consider reminding the team that PaCT Central will be interested to hear about how they incorporated these activities, lessons learned, etc. For the activities that the team is not already doing, review each and discuss which ones they would like to test. (More in depth descriptions of each activity and how to support the team follows.)

Suggested test box activities:

- ☐ Writing an aim statement
- ☐ Using the current state process map
- ☐ Setting the scene for care planning
- ☐ Scripting for patient-centred care planning
- ☐ Shifting the conversation
- ☐ Standardized data entry for care planning

TIP

As a reminder, it's helpful to think about the recommended steps for quality improvement work:

1. Form a team with representation from all areas of the clinic
2. Set a measurable aim
3. Map the current process
4. Identify measures and determine the 'baseline'

5. Identify 'potentially better practices' (PBPs) to test
6. Test PBP (starting with 1 patient), review results, and adapt as necessary (PDSA)
7. Adopt successful PBPs
8. Periodically measure to ensure the practice is sustained
9. Spread the practice by sharing with others
10. Celebrate successes!

Writing an Aim Statement for Patients with Complex Health Needs

EXAMPLE
We will increase the number of annual care plans initiated for patients with complex health needs, 75+ years old without a visit in the past year from 41% (23/56) to 84% (47/56) by October 31, 2018.

It's important to spend some time as a team to set the goal or aim before starting to make changes in how care planning is done. It doesn't need to take a long time, but it will help keep everyone focused on the same goal.

TIPS

1. Ask the team **what**, specifically, they're trying to achieve. The aim statement should incude an 'action' word like 'increase', 'decrease', 'improve', etc.

2. It helps to know the baseline measurement – where is the team starting from? Then, ask the team where they would like to get to. **How much** are they aiming to improve?

   Ask the team questions about how realistic the goal is. If it seems 'very do-able', could they stretch and aim a little higher? Sometimes teams will limit their success by setting a goal that's too easy to reach. Encourage them to determine what they think is reasonable, then aim a little higher…

   Aim statements typically involve a percent improvement, or a statement of the baseline and the goal numbers. It's important to specify 'how much' they're planning to improve a process.

3. The third component of an aim statement is '**by when**' they are planning to reach their goal. This date can be adjusted, if need be.

Using the Current State Process Map

- We'll be referring back to this map frequently over the next year. The sample process map provided has been created in PowerPoint, so if you'd like, you can use it as a template to create one for your team(s).

- Once the team has agreed that the current state has been accurately captured, it can be used to look for areas to improve. As the team tests, adapts and adopts changes, you can capture the new overall process by updating the map and saving it as a different version. This way, a team can look back at their progress from the baseline 'current state' to wherever they end up. For this reason, you may want to save the electronic versions of the maps with the date or version number in the name.

- For Test Box #1, the current state process map will be used to look for opportunities where different members of the team interact with patients during care planning. For example, is there an opportunity to use a script to ensure that the messages given to patients are consistent and clear?

TIP

Initially, you may need to 'bring the team back' to the process map until they become accustomed to using it as a planning (and documenting) tool.

Setting the Scene for Care Planning

This element of the test box is intended to encourage teams to think critically about the patient's experience with care planning appointments – from the physicial surroundings to the information they're given during interactions in the clinic.

Activity 1: During the activity (see description in test box), teams may come up with aspects of the physical environment that could be made more patient-friendly during care planning. Ask the team questions to guide them in brainstorming ideas for improvement. Examples:

- Narrow chairs with armrests that some patients may have difficulty fitting in.
  (Possible solution: have chairs without armrests available.)
- Patient seated across the desk and unable to see the EMR.
  (Possible solution: arrange seating so that patient is involved and can view documents.)
- Scale is in a 'public' area of the clinic, and could cause self-concsiouness or embarrassment.
  (Possible solution: move the scale to a more private spot.)

TIP

If the team has engaged a patient to be part of the PaCT team, consider starting with this activity to initiate his/her involvement.

Activity 2: This activity is intended to get clinic members thinking about how they explain care planning to patients. The patients who often need care planning the most are the ones who don't book appointments often. Therefore, if the team is planning to contact these patients and invite them for care planning, they need to be prepared to present the concept in a way that will encourage the patient to say yes (and then show up!).

While it may be a particular team member who makes the invitation calls, encourage the team to think about scenarios where others should be familiar with the key messages. How could they share these among the team? (Scripting is one of the other items in this test box that might be handy here!)

Encourage the team to invite a patient to be involved in the process!

Scripting for Care Planning

To set the tone for this section, ask 2 team members to role play the two versions of the script that are in the test box.

(**NOTE:** The second version is quite long, so you may not need to go all the way through it for the team to get the point. Also, you may want to 'play' the patient so that you can select one of the patient's responses where there are multiple options. Someone who hasn't reviewed the script may have trouble with this!)

If the team already uses scripts, ask the team to consider revewing them with the 'elements to consider' in mind. Perhaps there are areas for improvement.

If the team has <u>not</u> used scripts before, review the 'elements to consider' with them, and make a plan to devise and test one or more scripts. (A patient advisor can helpful here!)

A good first script is the one that will be used to invite patients for care planning. The sample script provided can be used as a starting point. But, the team may want to develop and test other scripts, as well.

Shifting the Conversation

For this test box item, the team is asked to examine their process around asking the patient what matters to him/her. For some teams, only the physician will have been doing care planning, and he or she may not have been asking this directly. *(Tread lightly here. Asking questions like this of the patient is not the traditional approach, and some people may feel concerned that they're being judged.)*

Other clinics may already be taking a team approach. Review the questions in the test box. They may choose to work on their process around documenting what's important to the patient, if it's something they already do routinely.

Standardized Data Entry for Care Planning

As clinics proceed with PaCT, consistent entering of data will be critical when that data will be:

- measured by the EMR
- mapped from a chart area to the care plan
- used to inform a population-wide reminder
- searched, and/or
- quickly and easily found in the chart by team members

Depending on the current state of data standardization, the team needs to take on a portion of this that is attainable and sustainable. It may not be a one time-change but an incremental change. Having said that, leaving some of these changes to later in the innovation could impede measurement by EMR search and require chart reviews to find.

Having a good understanding of the current state will help frame the scope of change.

TIP:
Start at the beginning of the care planning process, IDENTIFY, and move forward from there. Are all the charts of patients with complex needs marked the same way? Can it be searched by the EMR search/query tool? Have they created documentation to support the new standard? A job aid (a document that sits at workstations where this new work is done) can be a reminder to team members of the new standard.