PaCT Informational Call

April 20, April 25 & May 2, 2017

PaCT
Patients Collaborating with Teams

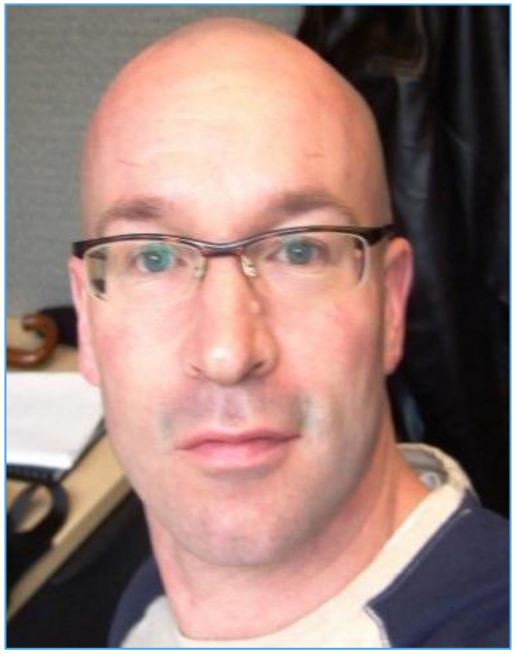
Agenda

- Welcome & Introductions
- What is the challenge?
- What is PaCT?
- What is the Model for Care Planning?
- What are Innovation Hubs?
- Next Steps
- Questions

Today's Hosts

Marion Relf, RN, MHSA
AMA – TOP

Dale Wright, BSP, MSc
HQCA



Paul Weaver, MA
AHS

What is the Challenge for Primary Care?

What patients keep us awake at night?

When do we worry that we haven't done enough?

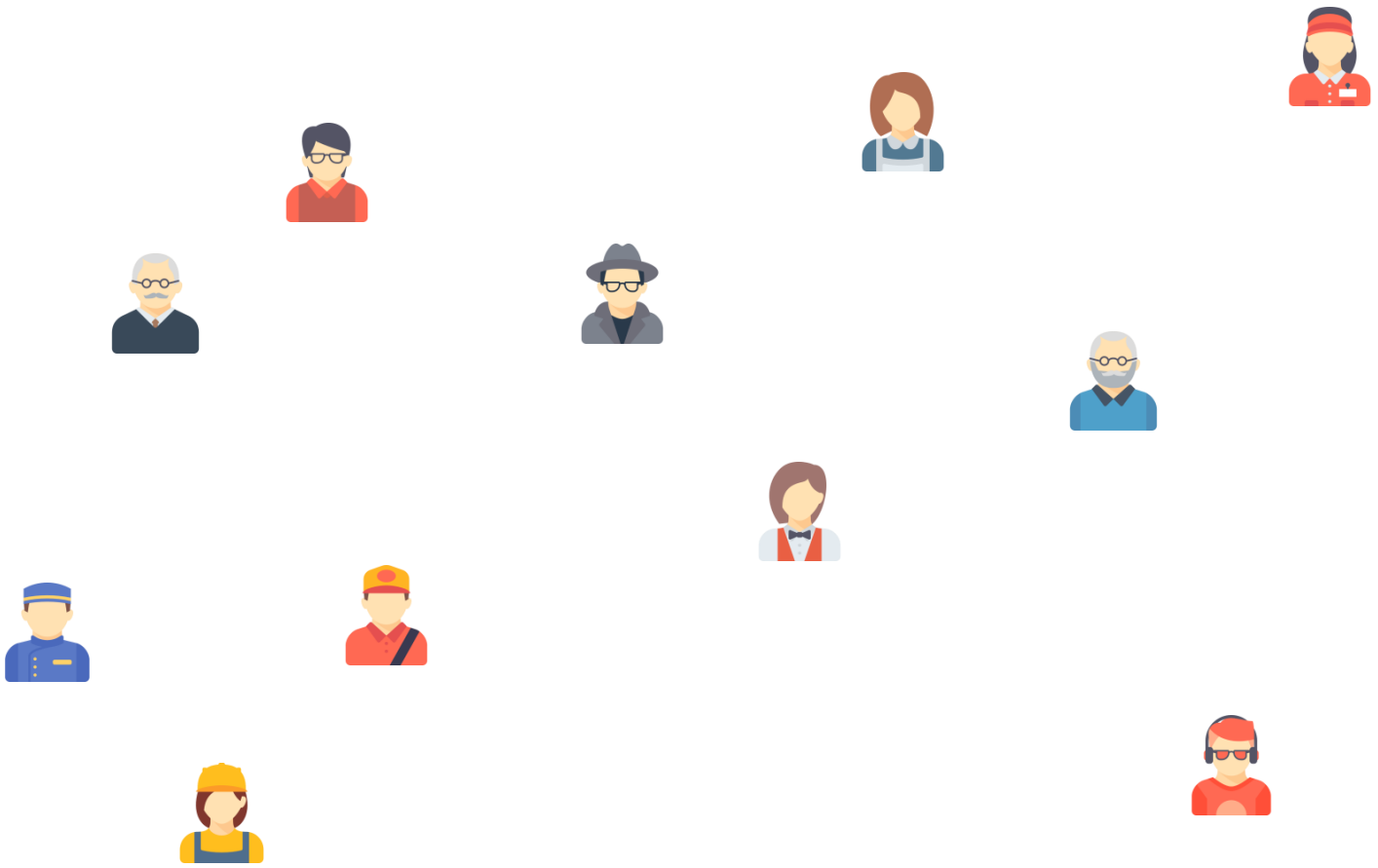
Patients with complex health needs and those with multiple chronic conditions

- Often lack a consistent approach, coordination, timeliness
- Patient's ability to self-manage impacts outcomes
- Many clinical issues: following specialist guidelines is challenging
- Social issues are often unknown and hard to address
- Lifestyle or modifiable risks could make a difference but we don't know where to start or patient seems overwhelmed

Is there a better way?

Shifting Behaviors

What differences in provider team behaviors are expected?



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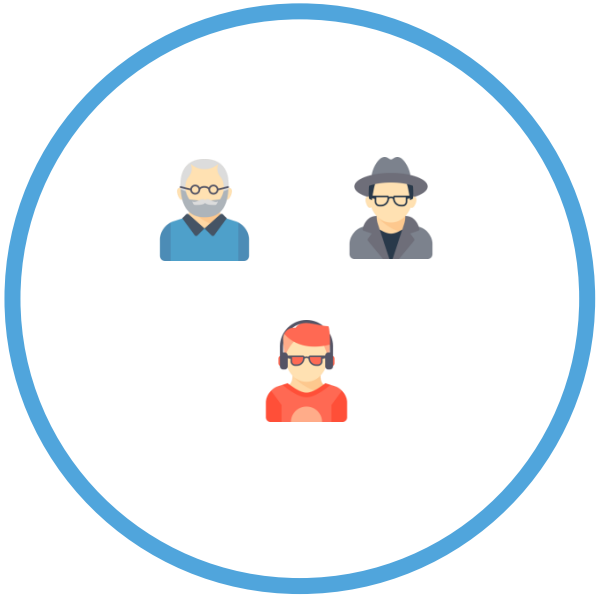
Patients with chronic disease or conditions identified and contacted regularly.



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Primary care team members and the patient work collaboratively with each other using multiple contact methods to maintain continuity and timely access.

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Patients confidently manage their care through effective use of shared self-management tools that are revisited and revised regularly.

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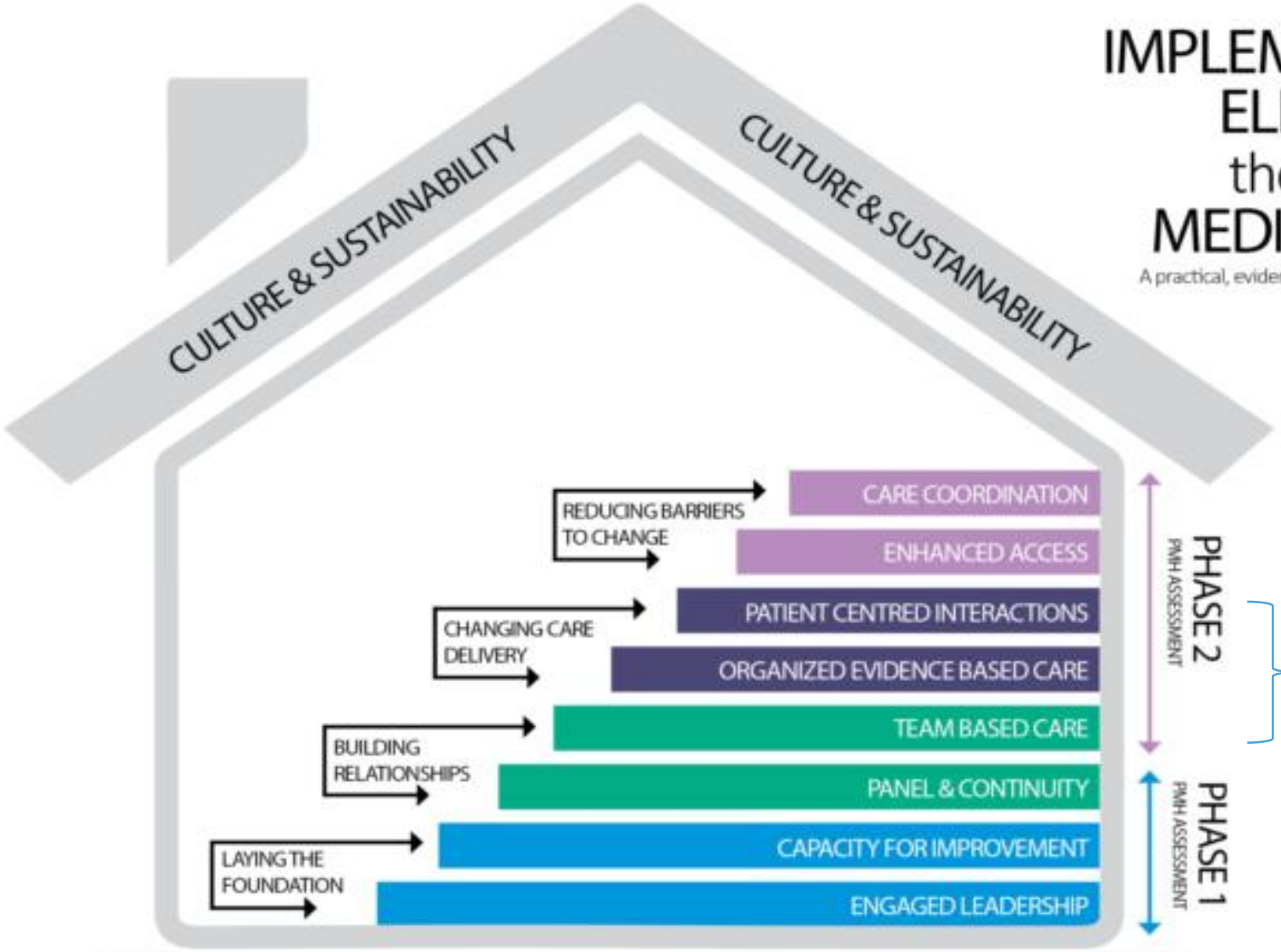
IMPLEMENTATION ELEMENTS for the PATIENT'S MEDICAL HOME

A practical, evidence based approach for clinic teams



PaCT

PCN SUPPORTS (CUSTOMIZED BY PCN)

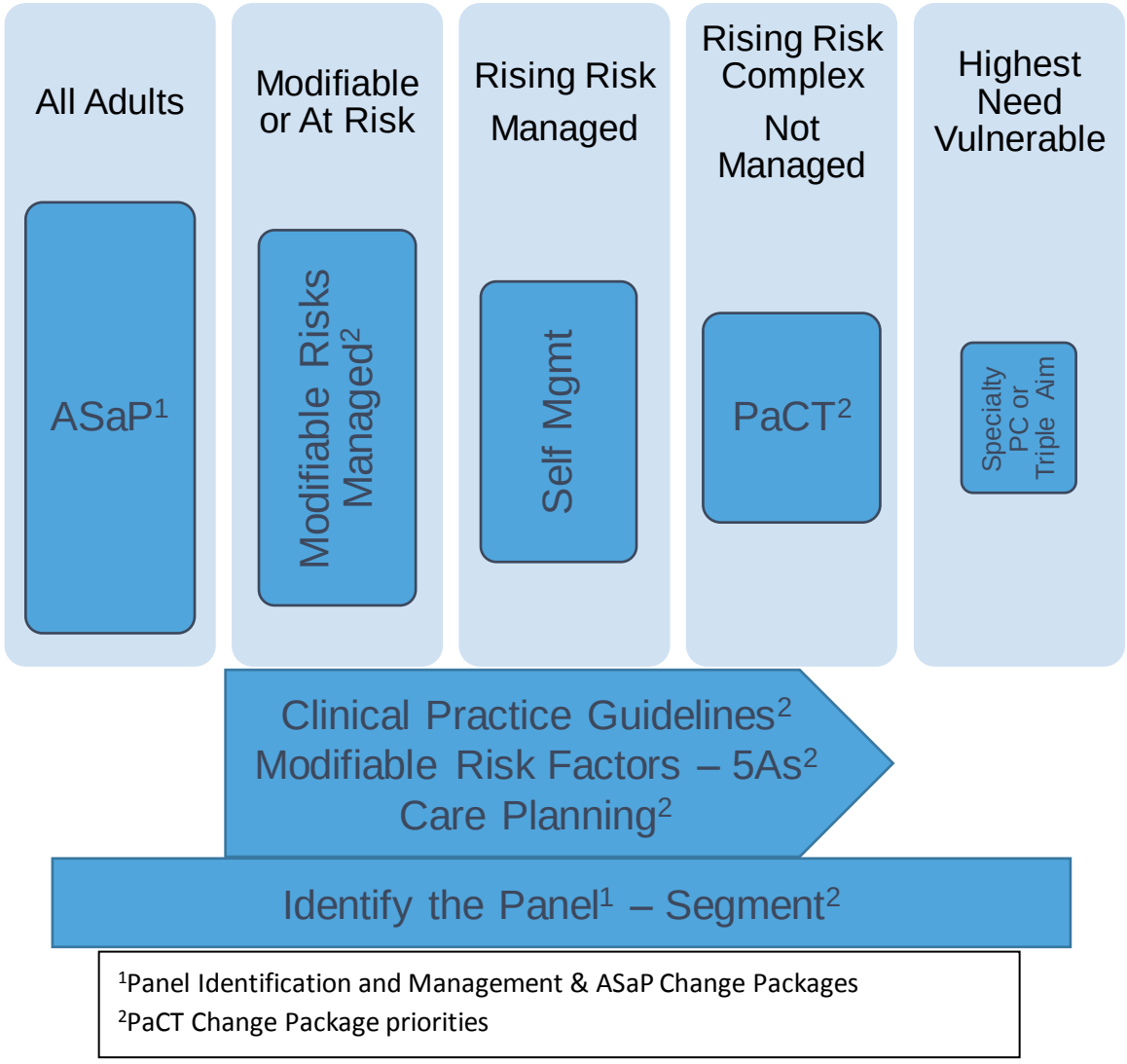
- Clinical Services (e. g. CDM programs, referral coordination) • EMR/IT Supports • Evaluation • Governance & Business Planning
- Quality Services (e.g. access to improvement facilitators, physician champions, improvement methods, tools and resources)

SYSTEM LEVEL SUPPORTS

- Integrated information Systems • Provincial Support Programs
- Supportive Payment Structures • Workforce Development

Adapted from Safety Net Medical Home Initiative (2013)

Alignment with Other Work



[1]Panel Identification and Management & ASaP Change Packages

[2]PaCT Change Package priorities

What is PaCT? The Next Step in PMH

An evidence-based, systematic approach to support primary care teams in clinics to address the needs of patients with complex health needs.

- Significant PCN and practice resources are spent on supporting patients with complex health needs, but the demand continues to grow.
- Builds on to foundational work (panel, access, screening) underway by PCNs and member clinics in the Patient's Medical Home.
- Next step to support the Patient's Medical Home implementation in physician clinics in your PCN.

Care Planning

Dale Wright - HQCA

Why Care Planning in PaCT?

- Collaboration between patients and care providers is crucial to chronic illness care
- Formal care planning achieves collaboration – together, patients and care providers:

  - ✓ Define problems
  - ✓ Set priorities
  - ✓ Establish goals
  - ✓ Create treatment plans
  - ✓ Solve problems encountered along the care journey

Care Planning vs Care Plan

Care planning

"The process by which healthcare professionals and patients discuss, agree, and review an action plan to achieve the goals or behavior change of most relevance and concern to the patient."

Care plan

"A written document that records the outcome of the care planning process."

(Burt et al., 2014)

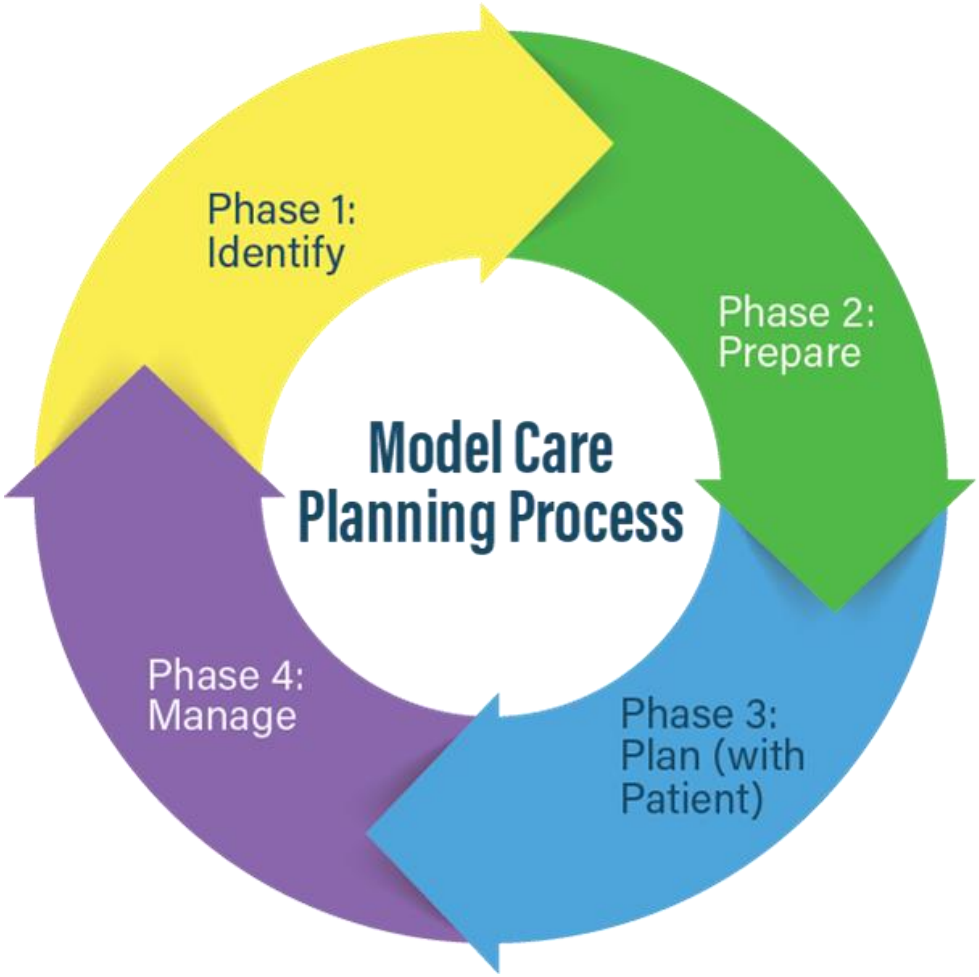
Care Planning . . .

- Is anticipatory rather than reactive
- Is a team activity - defined roles and tasks for each team member including patient
- Supports patients to take an active role in managing their own health
- Promotes shared decision making
- Promotes care that is both evidence-based and respects patient's preferences

Care Planning and Care Plans

		Collaborative care planning process with patient?	
		Yes	**No**
Care plan created?	**Yes**	‘Gold standard’ Patient-focused care plan ***Goal of PaCT***	Condition-focused care plan - little or no patient input Often target driven
	No	Common typical care for long term conditions	Poor quality care for long term conditions

PaCT – Model Care Planning Process



Model Care Planning Process

- Define target patient groups for comprehensive care planning
- Identify and select patients to whom comprehensive care planning will be offered
- Offer care planning
- Confirm an appointment

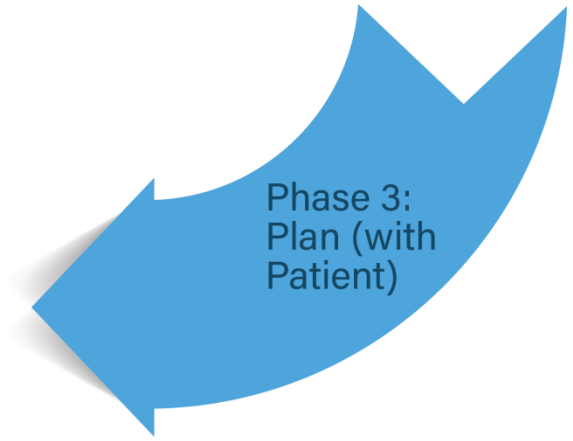
Team approach - Who does what when and how?

Model Care Planning Process

- Select patient assessment tools if applicable
- Update the EMR patient profile
- Form an initial medical care plan to be modified in discussion with the patient (e.g., suggested targets, screening, treatments, monitoring, referrals)

Team approach - Who does what when and how?

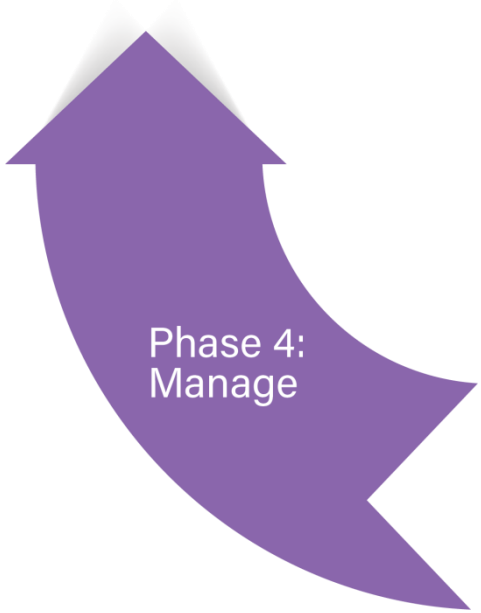
Model Care Planning Process



- Patient assessments as needed
- Develop shared understanding
- Set priorities collaboratively – medical goals and targets AND patient priorities
- Create an action plan collaboratively – actions for team, actions for patient, patient coping plan, follow-up plan
- Confirm shared understanding - share written care plan document

Team approach - Who does what when and how?

Model Care Planning Process



- Medical team and patients take action per the plan
- Follow-up with patient – initiated by medical team or patient per the plan
- Medical team follow-up/contact with other healthcare providers per plan – continuity
- Clinician and patient review plan regularly, revise as needed (at least yearly)

Team approach - Who does what when and how?

The Literature Suggests . . .

Benefits of care planning – systematic reviews

- Small positive benefits: HbA1C, systolic BP, depression scores, patient self-assessed health status, self-efficacy
- Little or no benefit: utilization of health services, total costs of providing care, mortality, patient health-related behaviours

Benefit is likely context and intervention dependent . . .

The Literature Suggests . . .

Utilization & cost benefits may be seen when . . .

- Goals/desired outcomes of the intervention are clearly defined
- Target patient population is clearly defined
- Intervention is designed to achieve the goals
- Intervention is implemented as designed!!

Which patients benefit the most?

- Variety of interventions & outcomes makes it difficult to generalize

The Literature Suggests . . .

What aspects of care planning are important?

- Integration with usual care and involvement of patient's family MD
- Multidisciplinary team – usually co-located teams
- Patient involvement in goal-setting, action planning, self-management - **collaboration**
- Patient follow-up & support - Care plan **management** is important!

The Literature Suggests . . .

What do patients need/want?

- Collaborative goal negotiation & action planning
  - Consider what patient needs to manage their health within their life context
  - Negotiate patient goals and medical targets
  - Co-create action plan for patient and the medical team
- Action plan composed of small, short term goals
- Patient is confident in achieving, actions for patient and team, target dates
- Written plan in clear, patient-oriented language
- Monitoring and follow-up – positive reinforcement & recognition of success, help getting back on track

Reference

Burt J et al. Care plans and care planning in long-term conditions: a conceptual model. Primary Health Care Research & Development 2014;15:342-354.

Phase One – Innovation Hubs

What is an Innovation Hub?

A PCN and 3-5 member clinics who participate in PaCT's first year to:

- Test and implement promising ideas for patient-centred care planning
- Help others in subsequent years adopt practices that have worked for them

Our Commitment

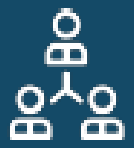
Supports

EMR Support

Systematic approaches to identify complex patients

Toolkit

Practical resources to implement changes



Training

Team-based Model Care Planning training and on-going support

Measurement

Common set of measures to support strategies and reporting

Your Commitment

- Include patient(s) in the co-design of patient-centered care planning
- Provide clinics with Improvement Facilitator and EMR support
- Co-locate team members in physician clinics to assist with care planning
- Share openly with other PCN and partners
- Contribute to measurement support and evaluation

Timelines


Phase 1
April - May 2017
Expression of Interest (due May 5, 2017)
Follow-up discussion with interested PCNs
June - August 2017
Readiness Activities and Start Up
September 2017 - August 2018
Innovations Implementation, Learning Cycles and Spread
Phase 2
June 2018 - August 2019
Open to all PCNs
Phase 3
June 2019 - August 2020
Open to all PCNs

Next Steps

- Expressions of Interest by May 5, 2017
- Contact us directly with further questions or comments at pact@albertadoctors.org
- Discussions Planned – May/June
  - With those who have submitted an EOI
- Readiness activities will start in June for Phase One

Questions & Comments

For Further Information

www.topalbertadoctors.org/pact

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