Introduction to the Care Plan Template: Background, Methods and Design Principles

Background

PaCT is a primary care initiative designed to: i) test and implement the model care plan process for patients with complex health needs and ii) to promote the creation of co-developed patient-centric care plans.

Currently there are two care planning templates that have been socialized in primary care in Alberta:

- The Comprehensive Annual Care Plan (CACP) template developed by Alberta Health. This is often used in relation to billing for patients who qualify for 03.04J billing. Many PCNs and member clinics have modified this template for their needs.
- The HealthChange Personal Self-Management Plan template. This template has been successfully used by a Calgary Family Care Clinic.

Objective

To design a care planning template for patients with complex health needs that follows the Model Care Planning Process that can be tested by Innovation hubs and clinics participating in the PaCT initiative.

Methods

To design the care plan template, a small team:

- reviewed a list of care plan data elements suggested by primary care physician innovators involved in developing the model care planning process,
- scanned literature for promising care plan templates,
- identified three templates which best met the physicians' requirements,
    - North East Toronto Health Link coordinated care plan template
    - patient-centered care plan referred to in the Council et al. paper
    - HealthChange personal self-management plan
- gathered feedback about the promising templates from patients,
- created a draft care plan template with the assistance of patients,
- incorporated feedback from PaCT physician leads,
- incorporated feedback from an AMA Scientific Committee that was convened to ensure care plan content was evidence-based, and
- shared the finalized template with PaCT Innovation Hubs for testing.

Principles

A set of principles were used to guide the care plan template development. The care plan template should be:

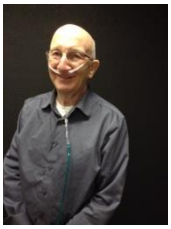
- useable by patients and allow patients to participate in their own care,
- written in patient-centric language,
- evidence-informed where possible (e.g., question prompts, screening, history taking),
- aligned with primary care team needs,
- pre-populated with fields from the EMR where possible,
- a dynamic document that can be updated over time,
- used to promote informational and relational continuity, and
- useable for billing under the 03.04J billing code.

Working group members:

- Dale Wright, Senior Lead - Reporting, HQCA
- Neil Linton, EMR Advisor, AMA
- Anila Hussaini, Quality Improvement Consultant, AMA
- Diane Ellerbeck, PaCT Patient Advisor
- Jennifer Alexander, Manager for Transformative Learning, AHS
- Julie Robison, Senior Advisor of Behaviour Change Methodologies, AHS
- Emily McKenzie, Research Associate, ACPLF
- Vicki Deutsch, Project Coordinator, AMA

Patient feedback:

"After seeing this [care plan], I realized for the first time that this document is for me. This whole time I thought this was something that my doctors had to do for their records. I will use this – it is like my health passport."



Al – Patient Member of the PaCT Improvement Team at Life Medical Clinic

PaCT care plan template:

http://topalbertadoctors.org/pact