Instruction Guide: PaCT Measures

Contents

Introduction

The PaCT measures, as described in this document, compose a portion of the overall evaluation indicators for this initiative. These measures are proposed as a set of common measures across all participating Innovation Hub PCNs.

These measures were selected to inform evaluation of PaCT but also to add value to the participating clinics. We anticipate that these measures will help clinic teams track their progress on improving the care planning process. Clinic teams are encouraged to use these measures as a learning tool (e.g., for PDSAs). Run charts are included in the data collection form that will auto-populate when data are entered. While the actual values of the measures may be useful to clinic teams, the process of capturing these measures will also build capacity within teams to measure for improvement.

From an evaluation perspective, these measures provide context to planned qualitative data captures and supplement learnings about process and behaviour change. They will help the PaCT Implementation team to develop an understanding of the pace of change, the pace in achieving co-developed care planning processes, and the impact to Albertans.

Phase 1 of PaCT is focussed on innovation, discovery and testing of evidence-based strategies to improve care planning. Therefore, feedback on the collection and use of these measures is desired to inform changes to the measurement package that will be developed for subsequent phases of PaCT. If you have any comments about the measures, please email Dr. Bonnie Lakusta at bonnie.lakusta@topalbertadoctors.org

There is no existing benchmarking for these measures, that is, there is no goal and no comparison. These data will not be used for judgment, but for learning. It is possible that for some measures an appropriate value is 0. It is also possible that appropriate measures vary considerably by PCN and participating clinic, dependent, in particular, on the chosen population.

These measures align with:

- The PaCT Charter
- The PaCT Evaluation Plan
- The Model Care Planning Process

PaCT Measures Summary

1. Panel Confirmation Rate

Percentage of patients presenting to the provider in the previous two months who have confirmed their attachment to an individual provider.

2. 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.

3. No Recent Appointment

The number of patients on the panel who did not have an appointment with their provider in the previous 12 months.

4. 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.

5. Prioritized Population for Care Planning

The number of patients identified as a priority for care planning.

6. Completed Care Plans

The number of patients with complex health needs who completed a co-developed care plan.

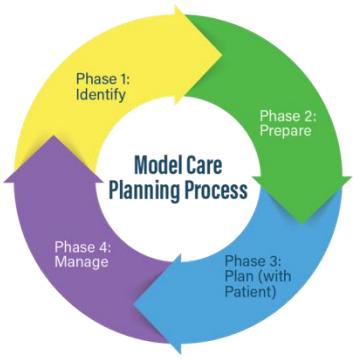
7. Over-Due for Follow-Up

The number of patients who have participated in a joint care planning process that have not participated with established follow-up by the expected date plus thirty days.

Timing and Methodology

All measures will be collected approximately bi-monthly (i.e., every two months), to align with Share and Learn webinars, or more frequently as tracked by individual clinics. The data will be entered in a data collection form and shared with the PaCT team. In this way, data will be available to inform the feedback loop with the test boxes.

Care Planning



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

These measures align with the four phases of the Model Care Planning Process.

Panel

A patient panel, or roster, lists the unique patients that have an established relationship with a provider. There is an implicit or explicit agreement that the identified physician will provide primary care.

For PaCT Measures the entire panel is used as the base measure.

Example

For the Measure "No Recent Appointment": The number of patients on the panel who did not have an appointment with their provider in the previous 12 months, this number we be taken from the entire *panel.*

Central Patient Attachment Registry Implementation

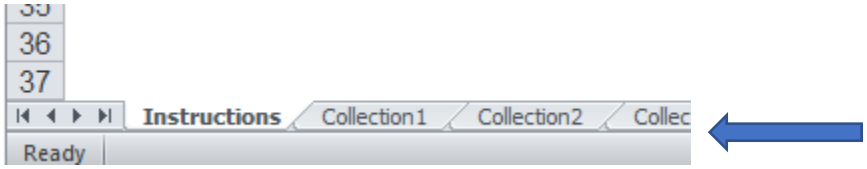
When the Central Patient Attachment Registry is implemented and used by participating providers, the definitions of some measures (e.g., panel-based measures) may change.

Data Collection Form

A different data form should be completed for each participating provider, that is, the data are at the provider level, not per clinic. Data will be collected ~every 2 months and entered in an Excel data form. The completed form will be emailed as an attachment to pact@albertadoctors.org.

Workbook Style

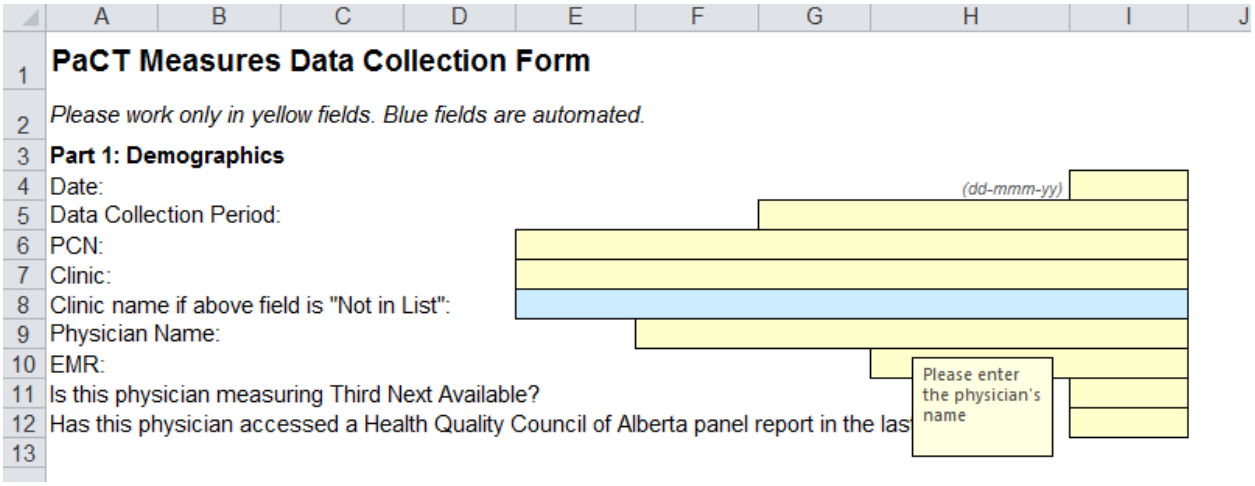
The data form was created as a Workbook. This means that one Excel form has several tabs.



The first tab includes instructions for completing the form. The next several tabs, "Collection1, Collection2, etc.", are for data entry over two-month intervals. The last tab, "Charts" includes auto-populated run charts. This same form can be used for each data collection period.

Demographics

The first section of each "Collection" tab is called "Part 1: Demographics." This section of the form will only be completed once. Once it is completed, subsequent tabs will auto-fill with the same information.



The data collection period is a two-month interval that **best reflects the two months over which the data was collected**.

Example

Today is February 1st, if you collected these data over November 1st – December 31st, select November – December 2017.

Today is February 1st, if you collected these data over December 1st – January 31st, select November – December. Select the earliest collection period that covers your actual collection period.

Measures

1. Panel Confirmation Rate

Percentage of patients presenting to the provider in the previous two months who have confirmed their attachment to an individual provider.

Rationale

The ability to produce a panel confirmation rate shows that the practice engages in consistent panel identification and maintenance processes. Having panel identification processes in place provides confidence that patients with complex health needs can be identified. Being able to easily determine your panel confirmation rate and deciding that the rate itself is satisfactory ensures that the target population for care planning are patients of the participating provider.

Model for Care Panning Process

The panel confirmation rate aligns with the first phase of the Model for Care Planning Process; Identify. This measure ensures that the population identified is appropriate.

Definitions

- Confirmed attachment – The process of documenting and date stamping attachment within the Electronic Medical Record
- Attachment – An attachment is the expression of a continuous longitudinal relationship between individuals ("patients") and their primary provider. Attachment relationships support continuity of care.
- Provider – The provider(s) most responsible for providing comprehensive primary care longitudinally over time to a panel of patients.

Eligible

All patients presenting to the practice for primary care services

Methodology

Calculation

The panel confirmation rate is a percentage:

- **Numerator**: Number of patient records with attachment confirmed within the previous two months
- **Denominator**: Number of patients presenting to the provider within the previous two months

EMR support

See videos or tip sheets for specific EMRs below:

EMR	Video	Tip Sheet
Healthquest	Healthquest: Confirmation Rate	Healthquest Tip Sheet
MedAccess	MedAccess: Confirmation Rate	MedAccess Tip Sheet
PS Suite	PS Suite: Confirmation Rate	PS Suite Tip Sheet
Accuro		Accuro Tip Sheet
Telin	Telin: Confirmation Rate	Telin Tip Sheet
Wolf	Wolf: Confirmation Rate	Wolf Tip Sheet

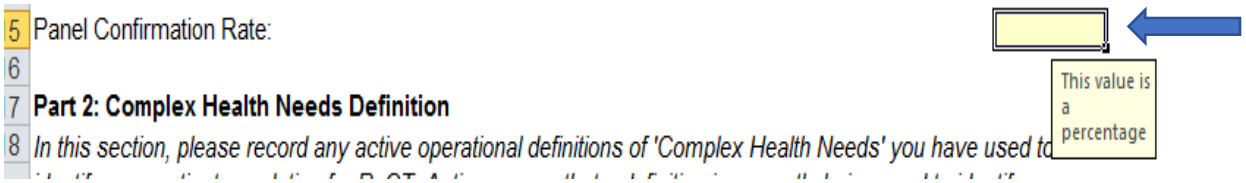
NOTE: The videos may describe a three-month panel confirmation rate. Panel confirmation rates can be calculated for any time period. For PaCT, the interval is two months to align with the two-month cycles of test box release and share and learn webinars.

NOTE: The videos may refer to a “Panel Verification rate”. This is the same measure.

If you have specific questions that the tip sheets or videos do not answer don’t hesitate to call your EMR vendor’s support team.

Data Form

The calculated percentage is entered into the data form on line 15. Pop-up help indicates that this must be a percentage.



2. 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.

Rationale

Recording the definition of complex health needs promotes consistent documentation of the active definition(s) and provides a “home” for the definition that can be referenced by the team as necessary. Recording this definition will show the progression of the modification or expansion of the definition over time. This will help clinic teams and the evaluation team to understand the pace of change.

Model for Care Panning Process

The definition of complex health needs aligns with the first phase of the Model for Care Planning Process; Identify. This measure ensures documentation of a specific target population for care planning.

Eligible

Any active definition of “complex health needs” that is shared amongst the care team for the purposes of identifying patients. It is possible to have more than one definition active at the same that, that is, more than one definition that identifies a subpopulation of the panel that are prioritized for care planning. The data form currently allows for two active definitions. If a definition of “complex health needs” has been used, but no longer defines those patients who are prioritized for care planning, it should no longer be documented on the data form.

Methodology

See “EMR Guide for PaCT Coaches” document handed out at Coaches training. This document and the menu below are guidelines.

Menu

Clinical Criteria	***Risk Factors***	***Utilization Parameters***
☐ People with advanced illness ☐ Complex Conditions: (Multiple Sclerosis or Parkinson's Disease, Lupus) ☐ Dementia ☐ Multiple Chronic Conditions (e.g., 3 or more) ☐ Patient eligible for a Complex Care Plan ☐ Multiple medications ☐ Functional impairment ☐ Adults under 65 with disabilities	☐ Age (e.g., > 85, or > 75) ☐ Frailty ☐ Modifiable risk factors ☐ *Social risk factors* ☐ High risk (using predictive risk assessment tool)	☐ Many visits (e.g., > 10) in the last year ☐ Hospitalizations (2 or more within the past year) ☐ ER visits (3 or more) in the past year ☐ Had a care plan in the past but not in the last year ☐ Receiving home health services ☑ No visits to the clinic in the last year (with risk factors or a chronic condition)

Example

Patients of Dr. X, over the age of 65, with a diagnosis of COPD.

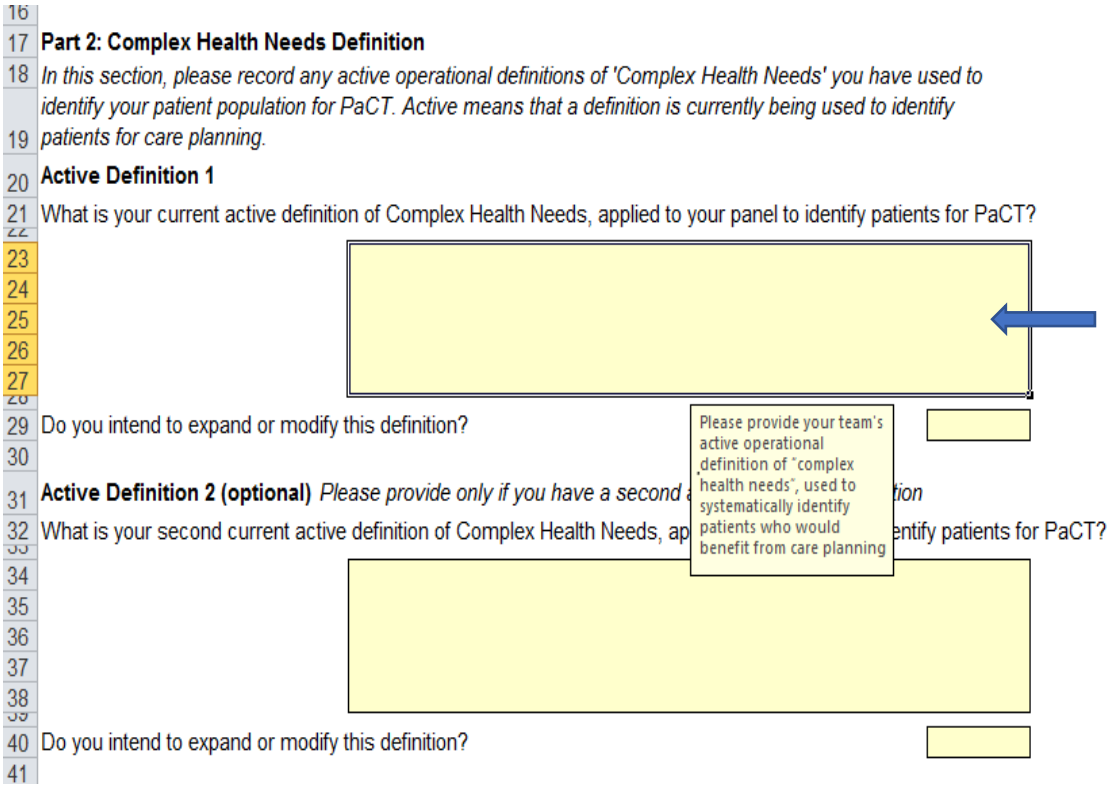
Patients with depression, and two or more other chronic conditions.

Patients with multiple sclerosis over the age of 70.

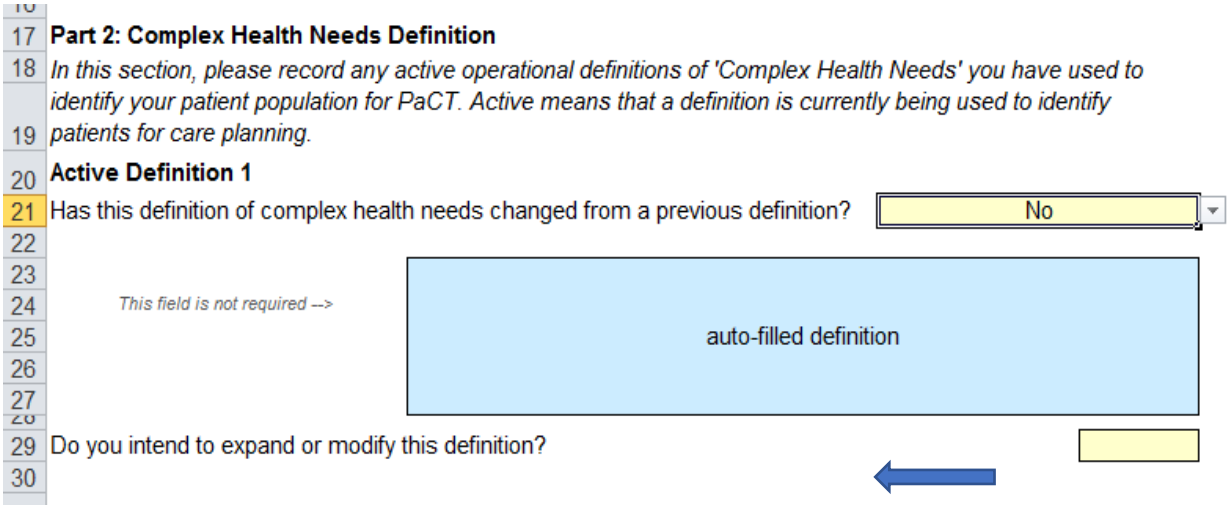
Patients over the age of 65 with hypertension, dementia and/or mental health issues.

Data Form

The active definition(s) used over the previous two months can be entered into a text box on the data form. There is room on the form for two active definitions. Pop-up help provides additional details.

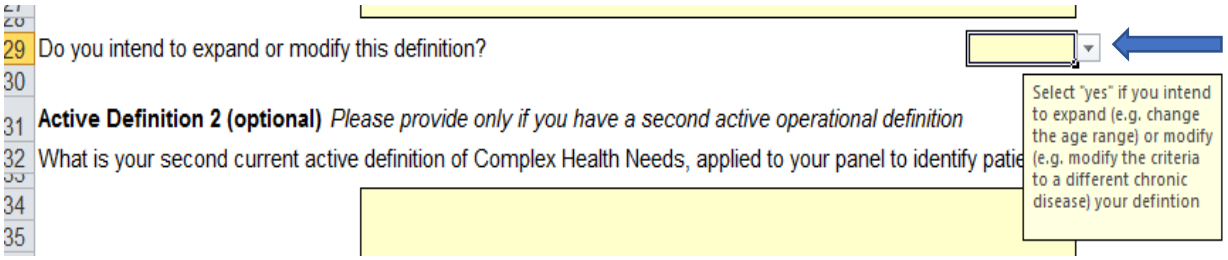


If this is the first time entering a definition, that is, if you are entering data into the Collection 1 tab, you will be asked to record your definition. In subsequent tabs (Collection 2 – 5) first you will be asked “Has this definition of complex health needs changed from a previous definition?”. If you are continuing to use the same definition of complex health needs, answer “No” in the drop down menu and the text box will auto-fill with your previous definition.



If you have changed your definition and the first definition is no longer active, answer “Yes” in the dropdown menu and type the new definition in the test box. If you are retaining the older definition but have added a new one, the new definition can be added in the Active Definition 2 (optional) space.

For each definition, you are asked “Do you intend to expand or modify this definition?”. Pop-up help provides additional clarity.



Select “Yes” from the drop down menu if your definition has defined a subset of your panel with complex needs that you intend to expand over time. *For example: “Patients with diabetes over the age of 70” may be expanded over time to include “Patients with diabetes over the age of 60.”*

3. No Recent Appointment

The number of patients on the panel who did not have an appointment with their provider in the previous 12 months.

Rationale

This measure emphasizes a focus on patients who are not currently well managed (e.g., not seen in the previous 12 months). This number distinguishes those who may have complex health needs (as identified in the panel) but may be managed appropriately and should not be part of the cohort most likely to benefit from co-developed care planning.

Model for Care Panning Process

The number of patients with no recent appointment aligns with the first phase of the Model for Care Planning Process; Identify. This measure ensures that focus for the prioritized population for care planning is on those most likely to benefit and those who are not well managed.

Eligible

Eligible patients include those who:

- Have not attended the practice for a scheduled or unscheduled encounter
- Have not had contact with a care team member for ongoing monitoring/management of care under the direction of the provider
- Have received one-way communication (e.g., Voice message left for patient)

Methodology

EMR support

See videos or tip sheets for specific EMRs below:

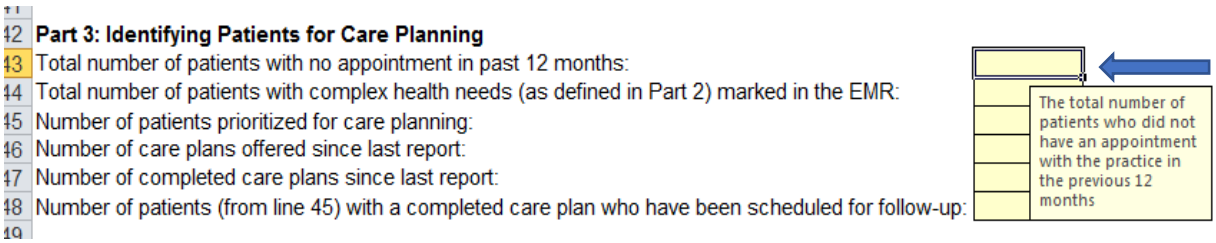
EMR	Video	Tip Sheet
Healthquest		Healthquest Tip Sheet
MedAccess	MedAccess - no appointment	MedAccess Tip Sheet
PS Suite		PS Suite Tip Sheet
Accuro		Accuro Tip Sheet
Telin		Telin Tip Sheet
Wolf		Wolf Tip Sheet

If you have specific questions that the tip sheets or videos do not answer don't hesitate to call your EMR vendor's support team.

Note that this measure is taken from the *entire* patient panel.

Data Form

The number can be entered into line 43 of the data form. Pop-up help provides additional clarity. If the participatipng provider has no patients that have not had appointments in the last 12 months, this number will be 0.



4. 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.

Rationale

This measure ensures optimized use of the EMR by marking the records of those most likely to benefit from co-developed care planning. Marking the records also allows for additions to the prioritized population through opportunistic addition. Marking the records may lay the foundation for linking complex health needs patients with administrative data sets or stratification by other characteristics (e.g., clinical risk group).

Model for Care Panning Process

The number of patients with complex health needs aligns with the first phase of the Model for Care Planning Process; Identify. This measure

ensures use of the EMR in identifying patients most likely to benefit from care planning.

Methodology

Though a search of patients who have not had an appointment in the past 12 months identifies those who are most likely to benefit from care planning and from increased continuity, opportunistic additions to the Complex Health Needs list are also appropriate. *For example, a patient comes in to the office for an appointment and the clinic team or provider recognize that he/she meets the criteria for complex health needs, and despite having an appointment, is not well managed. This patient's record should also be marked in the EMR.*

EMR support

How you search for these patients will depend on where in the EMR you've recorded their "Complex Health Needs" status.

See videos or tip sheets for specific EMRs below:

EMR	Video	Tip Sheet
Healthquest	Healthquest - Complex Health Needs	Healthquest Tip Sheet
MedAccess		MedAccess Tip Sheet
PS Suite		PS Suite Tip Sheet
Accuro		Accuro Tip Sheet
Telin		Telin Tip Sheet
Wolf	Wolf - Complex Health Needs	Wolf Tip Sheet

Example

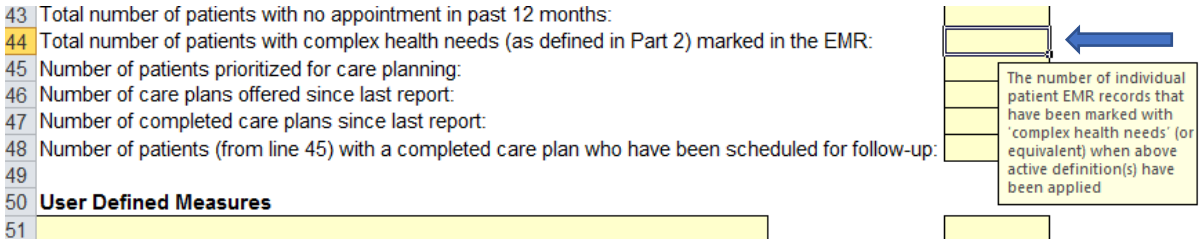
If there are two or more definitions of complex health needs actively being applied, the number entered in the data form will be the sum of all *unique* patients identified by all active definitions.

> Definition 1. Patients over the age of 80 with hypertension and dementia.
>
> Definition 2. Patients over the age of 75 with a mental health diagnosis and COPD.
>
> Definition 1 may yield 100 patients. Definition 2 may yield 50 patients, but when used together, the total is 125, because 25 patients fit the criteria under both definitions; 125 is the number that would be entered into the form.

If you have specific questions that the tip sheets or videos do not answer don't hesitate to call your EMR vendor's support team.

Data Form

The number can be entered into line 44 of the data form. Pop-up help provides additional clarity.



5. Prioritized Population for Care Planning

The number of patients identified as a priority for care planning.

Rationale

This measure targets the population that will be the priority for co-developed care planning. This identifies the first cohort of those most likely to benefit from care planning so that outreach activities can be planned.

Model for Care Panning Process

The Prioritized population for care planning aligns with the first phase of the Model for Care Planning Process; Identify. This measure creates a list of patients from the provider's panel where it would be appropriate to use outreach strategies to initiate care planning.

Methodology

If you are using your Definition of Complex Health Needs patients, narrowed by those who have not had an appointment in the last 12 months, the EMR can be used to identify this population by combining the searches previously conducted. If, however, your Prioritized Population for Care planning is comprised of other indicators (e.g., other utilization parameters) you may have a unique methodology for identifying this population.

If you are opting not to focus on individuals with no appointment in the last 12 months, it is possible that your Definition of Complex Health Needs identifies a small portion of your panel and you are not narrowing the focus, in which case the number entered in line 44 "Patients with Complex Health Needs" may be the same as your "Prioritized Population for Care Planning".

Finally, opportunistic additions to this population are possible. Therefore, you may have a unique methodology that identifies this subgroup of patients.

EMR support

How you search for these patients will depend on where in the EMR you've recorded their "Complex" status and the other parameters that define priority.

See videos or tip sheets for specific EMRs below:

EMR	Video	Tip Sheet
Healthquest	Healthquest - Complex Health Needs	Healthquest Tip Sheet
MedAccess	Building Searches in Med-Access	MedAccess Tip Sheet
PS Suite		PS Suite Tip Sheet
Accuro		Accuro Tip Sheet
Telin		Telin Tip Sheet
Wolf	Wolf - Complex Health Needs	Wolf Tip Sheet

If you have specific questions that the tip sheets or videos do not answer don't hesitate to call your EMR vendor's support team.

Data Form

The number can be entered into line 45 of the data form. Pop-up help provides additional clarity if your prioritized population comes from those with no appointment and those meeting your complex health needs definition.

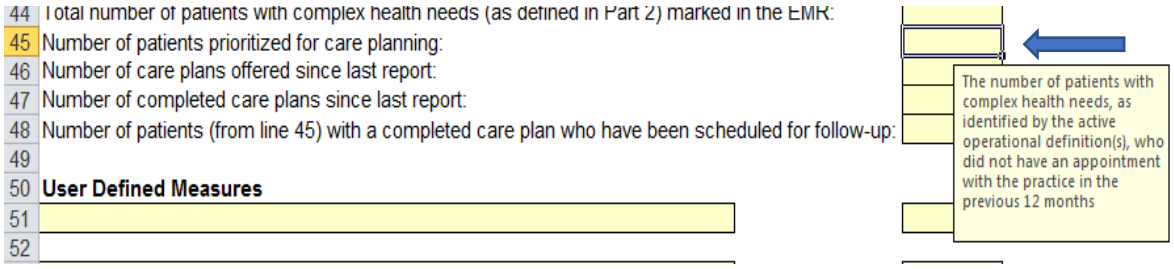
6. Completed Care Plans

The number of patients with complex health needs who completed a co-developed care plan.

Rationale

The number of completed care plans will provide insight into the pace at which co-developed care plans can be completed, as well as help to identify the impact to Albertans.

NOTE: The goal is not to increase the number of care plans completed by a provider, but to change the process to a joint, patient-centred care planning process.



Model for Care Panning Process

The number of completed care plans aligns with the third phase of the Model for Care Planning Process; Plan. This measure captures the activity that is the primary outcome of this initiative: co-developed care planning.

Definitions

- Co-developed care plan – A written (electronically or paper) care plan designed to support the *patients*' goals of care
  This excludes care plans where the patient was not involved, and care plans that are not provided to the patient.

Methodology

Dependent on your process for completing care plans, there are a number of methods to capture completed care plans.

NOTE: The focus of this measure is to capture the number of care plans completed by a care planning process that uses patient-centred behaviours.

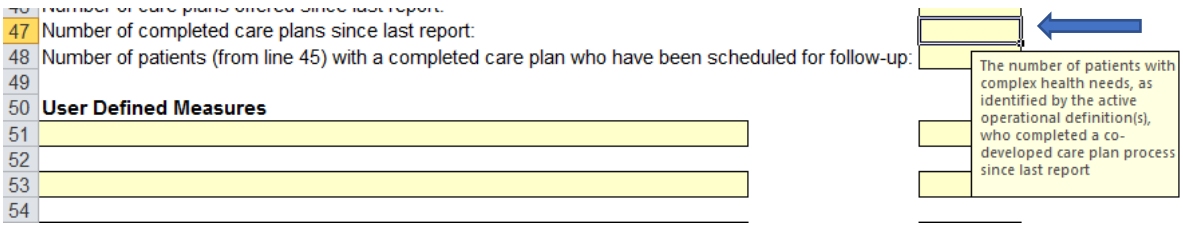
If you are using the care plan template designed for PaCT, or if you are using any new care plan template for your new care planning processes, the EMR can be searched for any completed care plans using that new template.

If you are using an existing care plan template, but you know the date after which providers were engaging in a new care planning process, the EMR can be searched for any care plan completed after this date.

Finally, if the new care planning process has not been consistently implemented since a certain date (that is, some care plans are completed with the new methodology and some are not), and a new care plan template has not been used, the best method may be a manual tally or count.

Data Form

The number can be entered into line 47 of the data form. Pop-up help provides additional clarity.



7. Over-Due for Follow-Up

The number of patients who have participated in a joint care planning process that have not participated with established follow up by the expected date plus thirty days.

Rationale

Appropriate follow-up after care planning promotes continuity between patient and care team. Ensuring the team has capacity to engage in follow-up activities is an important part of the care planning process

Model for Care Panning Process

The number of patients due for follow-up aligns with the fourth and last phase of the Model for Care Planning Process; Manage. This measure ensures the primary care team has capacity to engage in the last phase of the Model for Care Planning Process, which is a critical step in offering high-quality care planning.

Definitions

Note, this measure reflects those who are over-due for their follow-up appointment. A "grace period" of 30 days is given before a patient is considered over-due. If a patient has completed the initial care planning visit but is not yet due for a follow-up, that patient would not be counted in this measure.

- Follow up – A contact or encounter with a purpose to review overall goals and progress with the co-developed care plan.
- Expected date – The date agreed upon by patient and care team.

Methodology

Follow-up intervals will vary depending on patient needs. An appropriate value for this measure may be 0 for the first collection cycles. This measure captures the patients who are over-due for their follow-up appointment (given a 30-day grace period).

Example

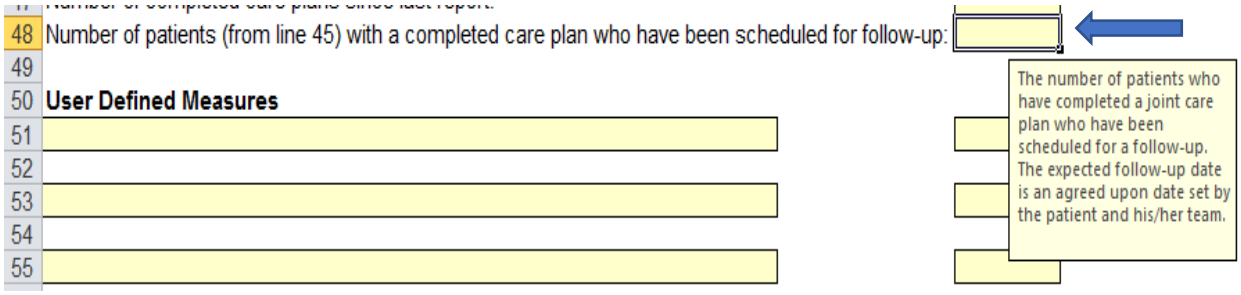
Patient John completed a care planning process and is due for his follow-up appointment on March 1st. By April 1st, he has not come in for his follow-up appointment. This would be "1" for this measure. If he had completed his follow-up appointment my April 1st, he would not count (e.g., he would be a "0") for this measure.

EMR

It is possible to use the EMR to set up follow-up tasks for each patient. The methods to determine if the follow-up has been completed by the recommended date (+ 30 days) will vary by EMR. In many cases, automation of this measure may be possible. If you have specific questions don't hesitate to call your EMR vendor's support team.

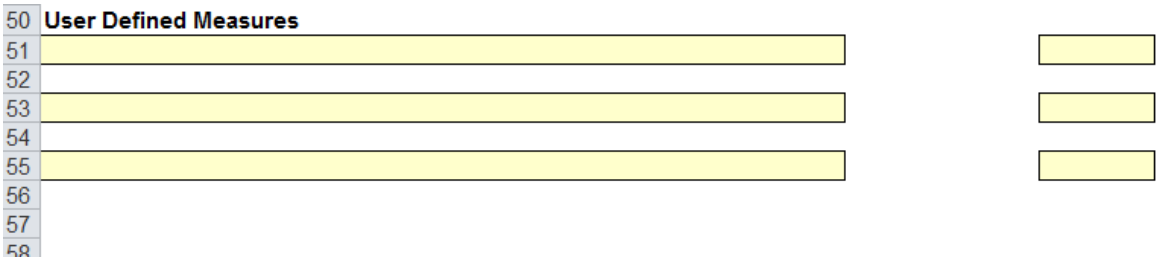
Data Form

The number can be entered into line 48 of the data form. Pop-up help provides additional clarity.



Optional Measures

These empty cells in the data collection form provide a space for a clinic or provider to document or track any measure that is not part of the proposed set. This allows for the opportunity to track the changes to metrics that may be unique or of specific interest to the provider or care team.



Run-charts

Once your data has been entered into the data form, the charts located in the final tab, “Charts” will auto-populate with your own data. Over time, these will be automated run charts of your own data.

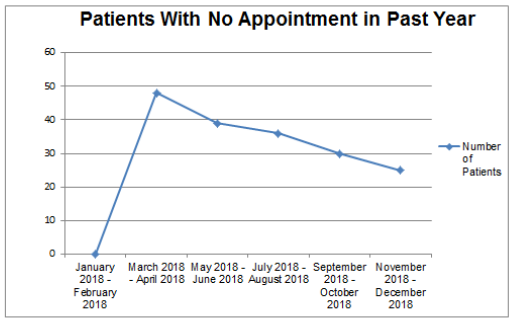
Charts are for:

- Patients with no appointment in the last 12 months
- Patients meeting the definition of Complex Health Needs
- Patients prioritized for care planning
- Completed care plans
- Panel confirmation rate

Example

Patients With No Appointment in Past 12 Months

Period	Number of Patients
January 2018 - February 2018	
March 2018 - April 2018	48
May 2018 - June 2018	39
July 2018 - August 2018	36
September 2018 - October 2018	30
November 2018 - December 2018	25



Depending on your clinic's unique approach to defining a population for care planning, these run charts may provide value and insight. You are encouraged to enter data more frequently than the two-month cycles if you wish to see changes in your data more frequently.

Process

Some notes for data entry:

- It is possible that a value will be 0 (zero). If this is the case, please enter the 0; do not leave the cell blank.
- Blank cells will indicate that the measure was not captured.
- No fields are mandatory.
- The TOP website has resources available to support specific EMRs.
- Do not hesitate to contact your EMR vendor for additional support.

We encourage you to use your data as a discussion point at the Share and Learns, and to review the data as a team to identify if they meet your expectations.

The data form is completed per participating provider. Because the measures are based on the provider's unique patient panel, the numbers are likely different per provider. However it is very possible that **Definition of Complex Health Needs** may be the same for multiple providers within the same clinic, or even PCN.

Some measures are based on the provider's entire panel, and some identify subsets of the panel. For clarity, here is a summary:

Measures that are based on the entire panel

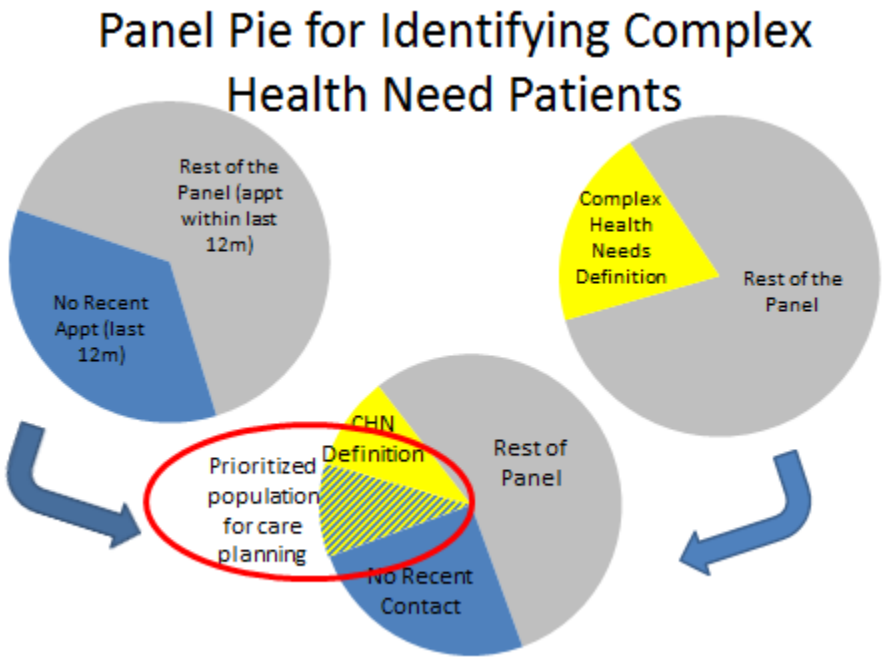
- Panel Confirmation Rate
- No Recent Appointment
- Patients with Complex Health Needs

Measures that are based on, or identify a subset of the panel

- Prioritized Population for Care Planning
    - This measure comes from "Patients with Complex Health Needs"

- Completed Care Plans
    - This measure comes from “Prioritized Population for Care Planning”
- Over-Due for Follow-Up
    - This measure comes from “Prioritized Population for Care Planning”

The image below, taken from the training webinar, visually depicts a potential breakdown of panel for these measures. This may vary based on each provider’s definition of Complex Health Needs, which may or may not include those with no recent appointment.



Once your data has been entered into the data form, you can email the form as an attachment to: pact@albertadoctors.org.