

Share, Learn & Celebrate! Patient Collaborating with Teams (PaCT)

January 24, 2019



Celebration!

Estimate of Time	Item	Speaker
10:00 – 10:15 am	Welcome and Thank You	Brad Bahler (Video) Mark Watt (Calgary) Cindy Grand (Edmonton)
10:15 – 10:30 am	Introductions Teams introduce selves and share a one sentence 'headline' that summarizes their PaCT experience.	Jennifer Alexander (Calgary) Julie Robison (Edmonton)
10:30 – 11:00 am	PaCT Evaluation Key findings	Bonnie Lakusta (Edmonton)
11:00 – 11:15 am	BREAK	
11:15-11:45 am	Innovation Hubs Share Highlights from PaCT Experience <ul style="list-style-type: none"> Calgary, Central, Edmonton, North 	Sue Peters (Edmonton) Michele Hannay (Calgary)
11:45 – 12:30 pm	LUNCH	
12:30 – 1:45pm	Innovation Hubs Share Highlights of PaCT Experience <ul style="list-style-type: none"> Continued 	Sue Peters (Edmonton) Michele Hannay (Calgary)
1:45 – 2:00 pm	What's next for PaCT?	Mark Watts (Calgary) Cindy Grand (Edmonton)
2:00 – 2:15 pm	BREAK Cake and refreshments Patient videos	
2:15 – 2:45 pm	Patient Voice and Q&A Patients invited to share their thoughts on the work completed by teams. Followed by an open question and answer session open to all participants.	Jennifer Alexander (Calgary) Julie Robison (Edmonton)
2:45 – 3:00 pm	Recognition and celebration	Sue Peters (Edmonton) Michele Hannay (Calgary)
3:00 pm	Adjourn	

Thank you



Message from Dr. Brad Bahler



What's an Innovation Hub again?



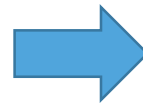
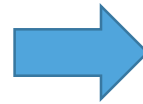
Photo credit: <http://onthejob.45things.com/2016/08/how-to-create-innovative-culture.html>



Learnings

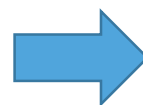


Opioid Response Initiative

Phase	Phase 1: IDENTIFY	Phase 2: PREPARE	Phase 3: PLAN	Phase 4: DELIVER
1	1.1. Establish a team to identify patients and providers	2.1. Prepare the patient	3.1. Engage specialists and resources	4.1. Coordinate care
2	1.2. Review systems and coordinate the patient's care	2.2. Prepare the patient	3.2. Engage specialists and resources	4.2. Coordinate care
3	1.3. Use RAN to identify patients with complex health needs	2.3. Prepare the patient	3.3. Engage specialists and resources	4.3. Coordinate care
4	1.4. Use RAN to identify patients with complex health needs	2.4. Prepare the patient	3.4. Engage specialists and resources	4.4. Coordinate care

Improve Focus Legend:	Optimize the Patient Experience	Optimize the Team	Optimize the EHR
Foundational Phase Block	1a. Establish a team to identify patients and providers	2a. Prepare the patient	3a. Engage specialists and resources
Foundational Phase Block	1b. Review systems and coordinate the patient's care	2b. Prepare the patient	3b. Engage specialists and resources
Foundational Phase Block	1c. Use RAN to identify patients with complex health needs	2c. Prepare the patient	3c. Engage specialists and resources
Foundational Phase Block	1d. Use RAN to identify patients with complex health needs	2d. Prepare the patient	3d. Engage specialists and resources



Introductions



A meme featuring Will Ferrell as the character Tim Allen from the movie 'Straw Dogs'. He is dressed as a news anchor in a dark suit, white shirt, and striped tie, with a serious expression. The background is a blue wall with a repeating pattern of the 'Channel 4 News Team' logo. The text 'BREAKING NEWS' is overlaid at the top, and 'INNOVATION HUBS MAKE CARE PLANNING HISTORY!' is overlaid at the bottom.

BREAKING NEWS

**INNOVATION HUBS MAKE
CARE PLANNING HISTORY!**

Share your headline

1. Innovation Hubs: Create a one sentence 'headline' that describes your PaCT experience
2. Report back to the larger group:
 - Who is here today?
 - What is your headline?



Who else is in the room?



PACT EVALUATION FINDINGS



Innovation

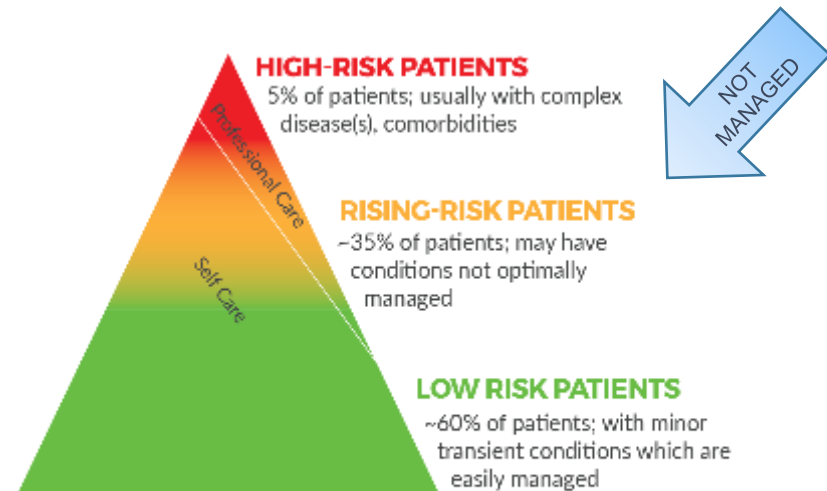


PaCT Refresher

What patients keep us awake at night?

Patients with complex health needs

Is there a better way?



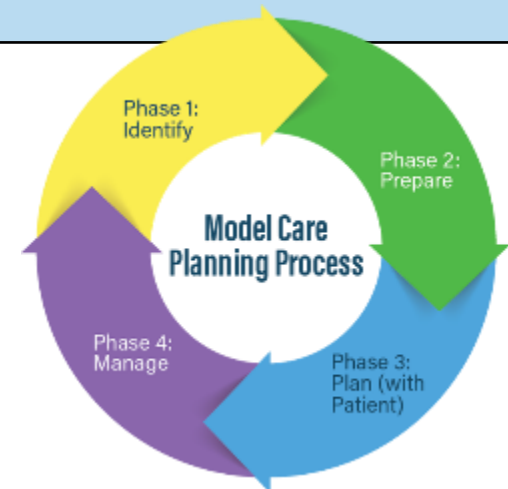
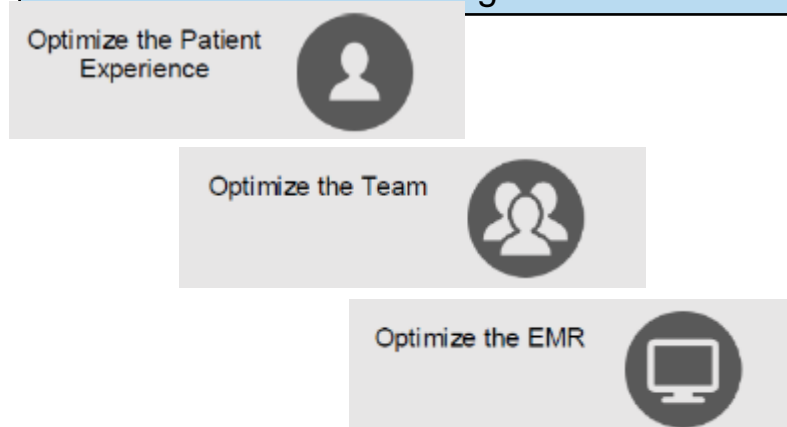
15% - 35% of rising risk patients may not have their conditions optimally managed.



PaCT Refresher

GOAL 1: **Optimize continuity** for patients with complex health needs through the care planning process so that patients and the primary care team value and commit to each other as partners in care.

GOAL 2: Systematically improve the patient and primary care team's **joint care planning** and shared decision making



Evaluation Sources

PCN Executive Director interviews (6)

Improvement Facilitator interviews (7)

Clinic visits (3)

Test Box Survey (5)

PaCT Central Interview and focus groups

Patients

- 4 patients who had participated in a care planning process

- 3 Steering Committee patient representatives

- 2 QI team patients representatives at the site visits



Context-based Innovations

- Patient experience survey
- Using patient representatives to share a new perspective
- Changing the physical layout of the meeting room
- Reflecting on language in scripting, invitation letters
- Engaging teams in health literacy exercises to understand the patient perspective
- Sending patients information before their visit, preparing them for the visit
- Inviting patients to bring family members
- Using new billing codes
- Customizing the care plan template
- Using warm handoffs and huddles
- Building relationships
- Doing outreach to attach unattached patients
- Using team members differently – change to roles and responsibilities
- Using health system utilization data to identify patients in your community
- Using technology differently (EMRs, tablets, health systems)
- Giving out “homework” to clinic teams
- Creating workshops to engage clinics in new care planning processes
- Sharing care plans with pharmacy, long term care, social workers, etc.
- Sharing your journey at APCC
- +++



Patients

Valued

More time

Better supported in managing their health

Better cared for

Frequent follow-ups

Felt better access, they could reach out whenever they wanted to

Felt connected to a multidisciplinary team

Helps them be a better patient

“This PaCT program seems to bring the humanity out, it brings it back to the forefront, that humanity and compassion that should go along with patient care.”



Patients

“[PaCT is creating a] ...more equitable power balance between physicians/teams and the patient.”





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CARE PLANS

Measurement

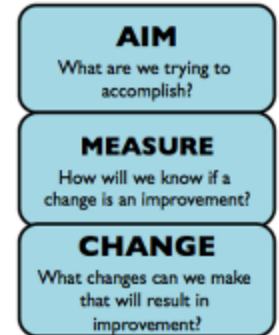
Meaningful

Missed co-design

What are you already measuring?

Timing: was it too early to measure?

Challenges: capacity, time, EMR



Test Boxes

Which activities were used most often (themed)?



EMR



Team

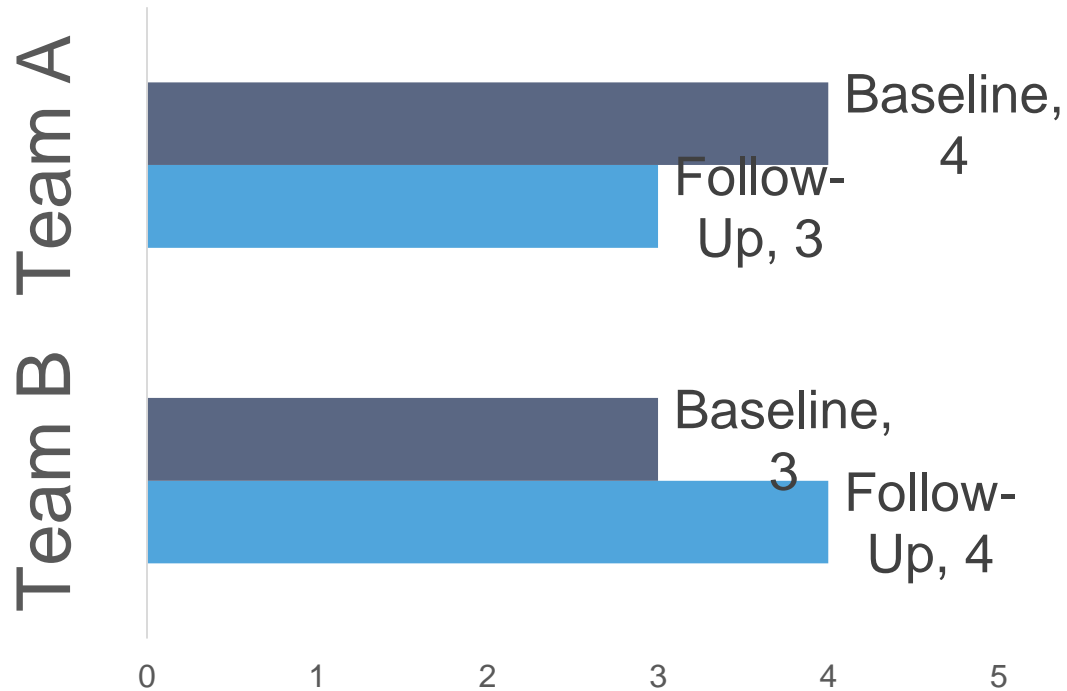


Patient-centred care

Continuity & Access



Team Assessments



Access for patients is limited by the physician's schedule, resulting in wait times for appointments

Patients can access the most appropriate member of the care team, in a timely manner, when they need or want an appointment



Improvements



Patient-Centredness

Collaboration with patients

Stronger relationships

Shifting the conversation

Continued growth



Team-Based Care



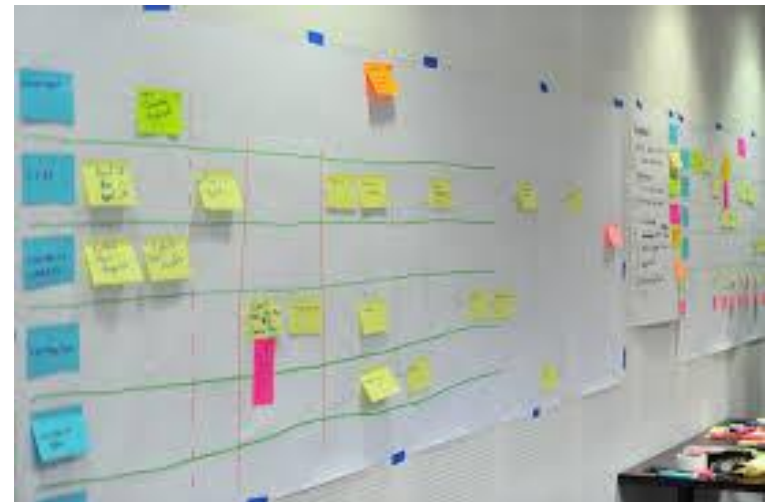
Foundational

Communication strategies

Strong use of QI tools to support innovation:
Process mapping, huddles, etc.

Strengthened relationships

New roles/responsibilities



EMR-optimization

Measurement

Foundational processes

Embedding the care plan template



Care Plan Template

Recruitment tool

Customization is important

Value of the patient perspective

Trouble incorporating into the EMR

Sharing outside the primary care clinic

Patients need more support



Value

Advancing the PMH

Building capacity

Repurposing tools/skills

Engaging clinic teams

Shifting the conversation

Integration/community supports

Attachment

Collaboration, Relationships



Spread and Scale



We are students too!

Our Innovations

Test Boxes

Share and Learns

Innovation Hubs

Partnering



Balance prescriptive/flexibility

Timing/pace, prioritization

Co-design vs evidence-based



Thank
you!



Morning Break



SUNRIDGE FAMILY MEDICINE TEACHING CENTRE

Mosaic Primary Care Network

SFMTC PaCT Working Group

- 3 Physicians
- 2 Registered Nurses
- 1 Patient Representative
- 1 Manager
- 1 Primary Care Coordinator
- 2 Improvement Facilitators

- Meetings were held bi-weekly for 45 minutes, with action items followed up on in-between meetings.

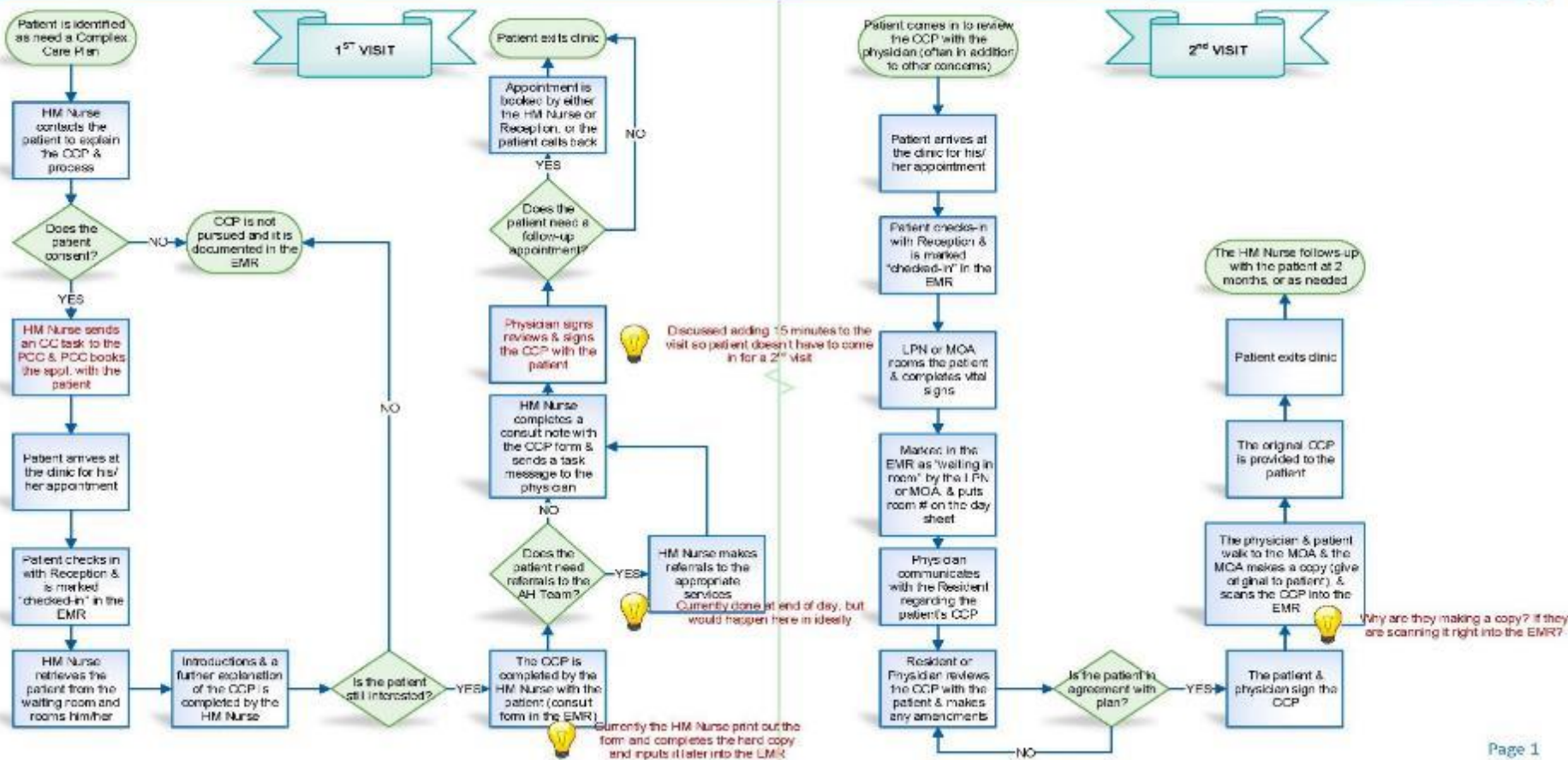


AIM Statement: By December 4, 2018, we will complete 20 CCPs of patients who are eligible or due to have a CCP completed.

Process Map: Before...

SFMTC Complex Care Plan Process

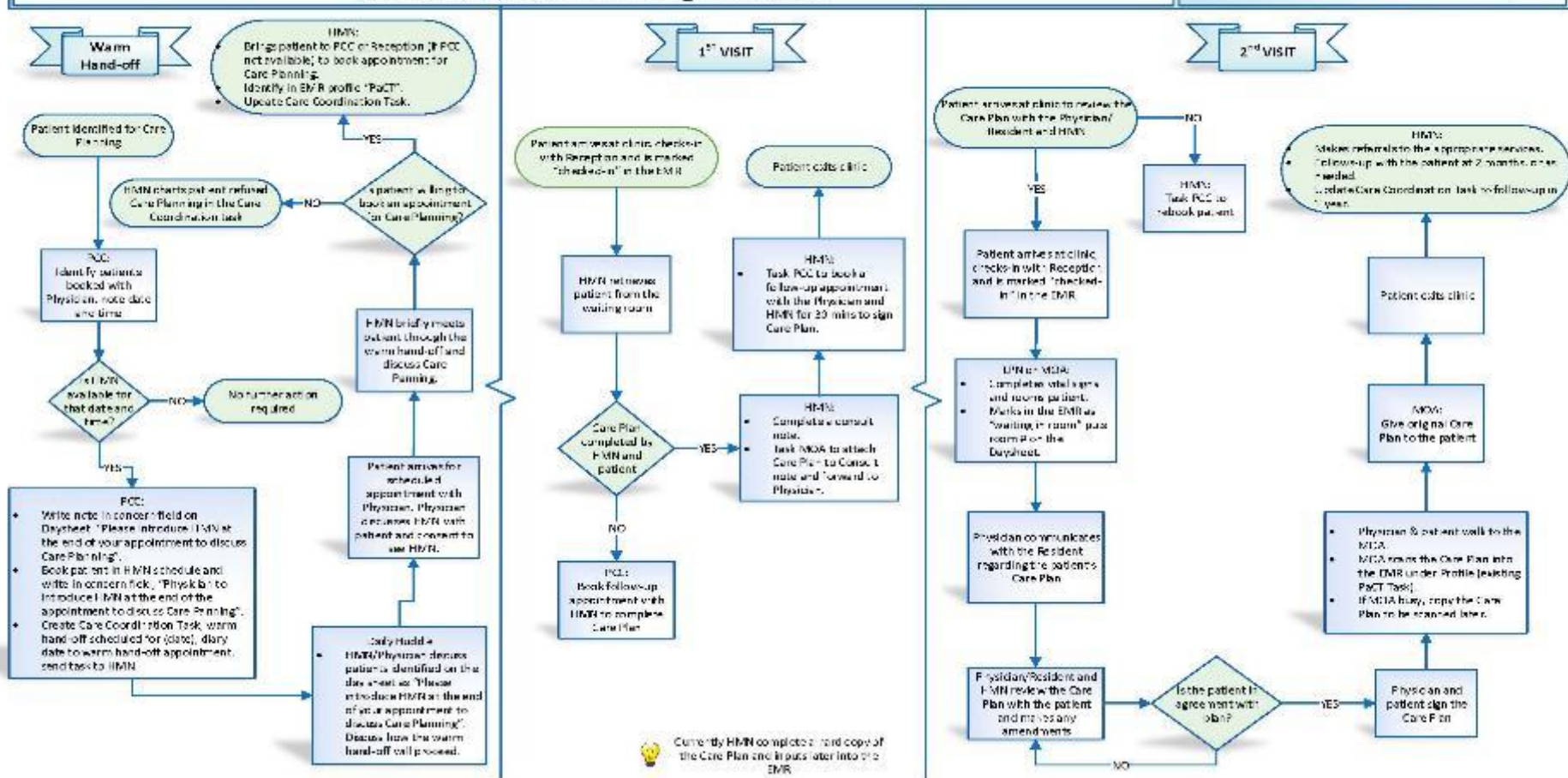
January 11, 2018



Process Map: After...

SFMTC Care Planning Process

Revised January 16, 2019



Photovoice



Warm Handoff



Engaged patients through a warm handoff where the physician introduced the patient to the Health Management Nurse and a discussion formed around the benefits of a care plan.

- Increased number of patients participating
- Better buy-in if initially introduced by the physician

Huddle



the Health Care Team to review patients scheduled for the patient's visit.

patient care
Health Care Team

be flexible

needed to be a part of the huddle, Licensed Practical

Patient-Centered Care Plan



- The Care Plan was simplified and revised to focus on what matters to the patient.
- Rearranged and enhanced areas to improve the flow and content
- Patient driven, focused and portrays what matters to the patient.
- Communication tool of what is important to the patient, includes their medical, social history and goals.
- Located in the Profile section in the EMR, easily accessible by the Health Care Team to assist in care of the patient.
- Patients receive a hard copy of their Care Plan which can be used when they access appointments outside the Sunridge clinic, including urgent care or the hospital.

Favourite Tools



Patient Name: _____ Preferred Name: _____
 Address (street, care number): _____ Date of Birth: _____

HEALTH TARGETS
 Identify tools you use to help understand whether a health condition is well managed. Understanding where your numbers are now and what you can learn from them will help manage you or inform what is required for you.

HEALTH TARGETS FOR CONDITIONS YOU LIVE WITH
 List the health targets for each condition you live with. For each target, list the target value, the unit of measurement, and the frequency of measurement. You can also list the target value, the unit of measurement, and the frequency of measurement.

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Revised: Nov 8, 2016 Page 1 of 4

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Revised: Nov 8, 2016 Page 2 of 4

Patient Name: _____ Preferred Name: _____
 Address (street, care number): _____ Date of Birth: _____

Involvement of Health Care Professionals
 What other health care professionals are involved in your care?

Professional	Active or Planned	Contact Information	Additional Information
Family Physician			

Modifiable Lifestyle or Risk Factors
 Specify lifestyle or risk factors, such as tobacco use, regular physical activity and diet that can impact a person's health. Is there anything that you would like to share with me about what you are doing well in these areas or what you would like to improve?

Smoking status: Non-smoker Former smoker Other, specify _____
 Smoker actively smoking Smoker who has quit at the time Other, specify _____

Alcohol: Yes No Other, specify _____
 Occasional drinker Yes No Other, specify _____

Physical Activity: Yes No Other, specify _____
 Regular Occasionally Never Other, specify _____

Comments: _____

Revised: Nov 8, 2016 Page 3 of 4

Patient Name: _____ Preferred Name: _____
 Address (street, care number): _____ Date of Birth: _____

PART B: Social History
 Now that you have provided your medical history, the section captures other aspects of your life that may impact your ability to manage your health such as your finances, housing, and support systems. Is there anything in those areas that are impacting your health?

Do you ever have difficulty making ends meet (during your 30th at the end of the month)? Is there anything about your current employment situation or finances that would impact your health and wellness? Who covers the cost of medications and other services?

Living Situation:
 Is there anything you would like you care team to know about your housing situation? Do you feel safe where you live?

Support System:
 Do you feel you have enough support at the time to manage your health? Can you tell me more about your support? Are there any community resources or services that you use (e.g., transportation services, food services, group support meetings, etc.)?

Revised: Nov 8, 2016 Page 4 of 4

Patient Name: _____ Preferred Name: _____
 Address (street, care number): _____ Date of Birth: _____

PART C: Current Medication Plan
 List all current medications, including over-the-counter, herbal, and natural products, and any supplements you are taking.

Medication	Dosage	When to take it	What to take it for

Pharmacist's Role:
 How do you feel about your pharmacist's role in your care?

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 How do you feel about your pharmacist's role in your care?

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Patient Name: _____ Preferred Name: _____
 Address (street, care number): _____ Date of Birth: _____

PART D: Decision
 How do you feel about your decision to use the tool?

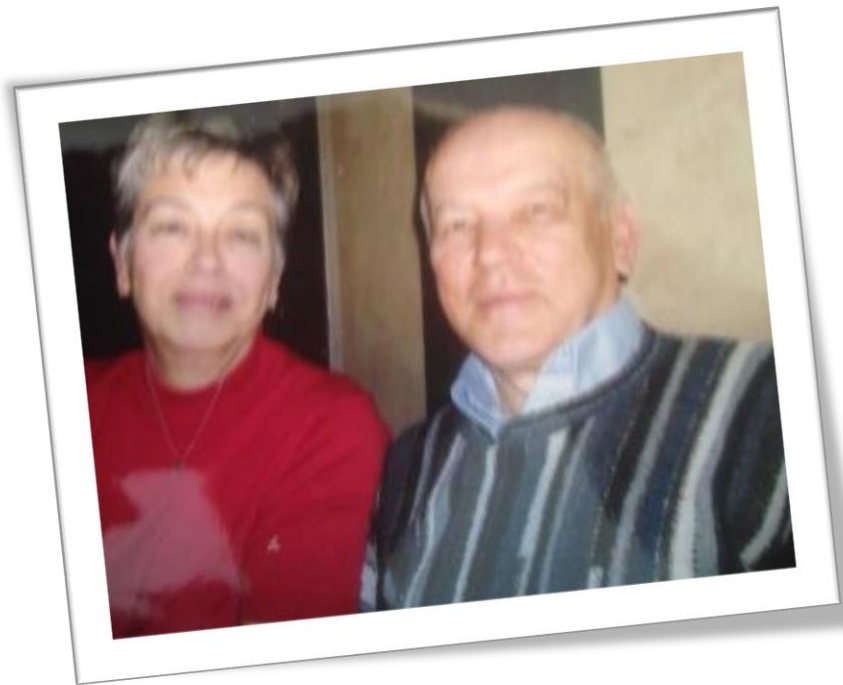
How do you feel about your decision to use the tool?
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Patient Story





Learnings

- Cold calling patients not effective
- Care Planning can take several appointments
- Huddles provide improved communication amongst the Health Care Team
- 16 PaCT Care Plans completed

UNIVERSITY OF CALGARY
2014-2015 FACULTY OF MEDICINE
Department of Family Medicine

Patients Collaborating with Teams (PaCT)
An Innovation Hubs Experience
Gally Blazzer, Marnie O'Leary, Nicole Phillips, Dawn Hildago,
Lara Pickett, Debra Gaudesoni, Madhvi Ashtari,
Dr. Carmen Roberts, Dr. J. Michael Smith, Dr. Leahy Wang

INTRODUCTION

- Patients are the most important stakeholders in the patient care process.
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OBJECTIVES

- Establish a patient-centered care model for the PaCT program.
- Establish a patient-centered care model for the PaCT program.
- Establish a patient-centered care model for the PaCT program.

IMPLEMENTATION

- Establish a patient-centered care model for the PaCT program.
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- Establish a patient-centered care model for the PaCT program.

RESULTS

- Establish a patient-centered care model for the PaCT program.
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CONCLUSIONS

- Establish a patient-centered care model for the PaCT program.
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Future Research

- Establish a patient-centered care model for the PaCT program.
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Alberta Health Services
PaCT Program
Calgary, Alberta



A person's hands are holding a small, square chalkboard with a light-colored wooden frame. The chalkboard has a black surface with the words "ANY" and "questions?" written in white chalk. The word "ANY" is in all caps and a larger font size than "questions?". The background is a solid, medium blue color.

ANY
questions?

Riverside Medical



Midtown Clinic



Sylvan Lake Family Health



Edmonton Southside PCN



Fall 2017

Cohort 1

Choose your
own adventure



First one!

Winter 2018

Cohort 2

Opioid



Content Expert

Fall 2018

Cohort 3

COPD



**+EMR Component
+Homework
+Patient Representative**

Spring 2019

Cohort 4

Older Adults/
Dementia?

St. Albert Medical Clinic



Life Medical Clinic





What's Next?

What's next?

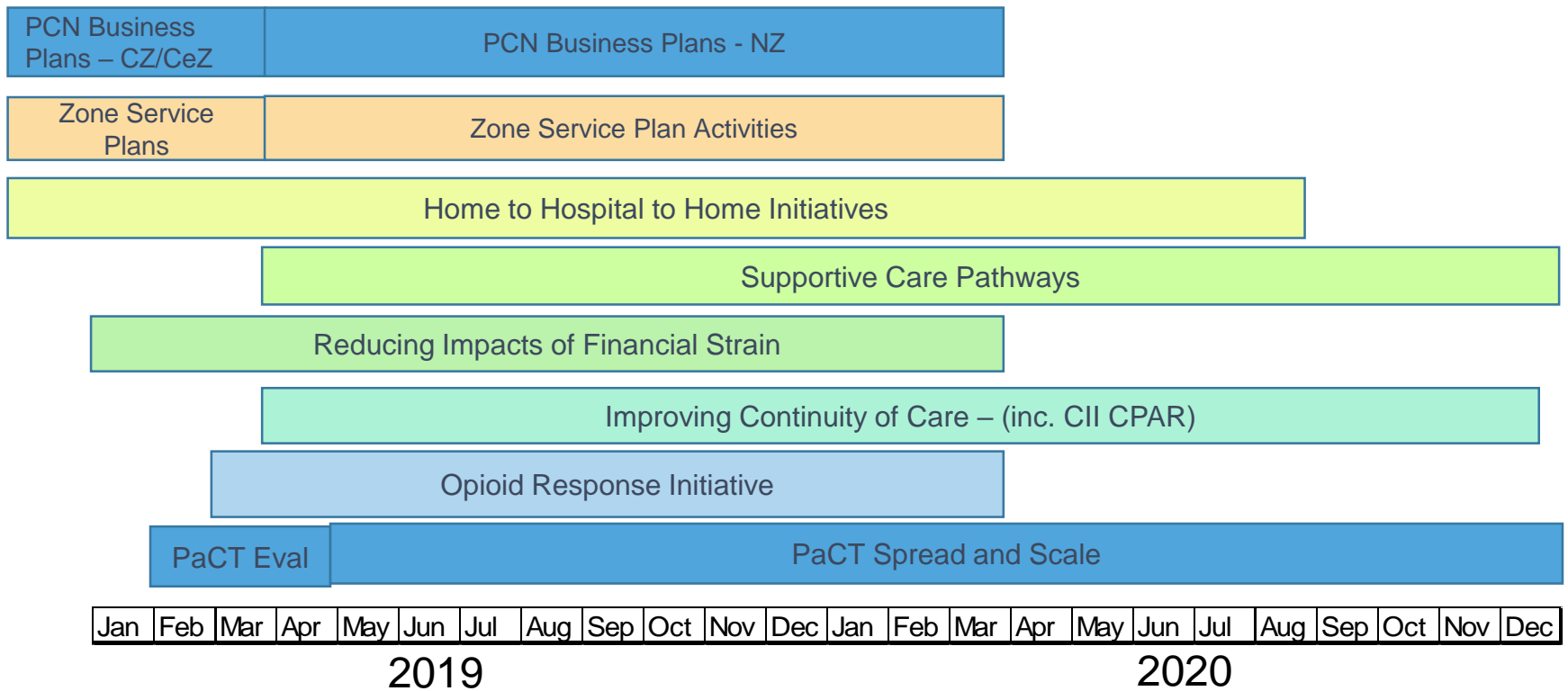


“You didn’t
come this
far to only
come this
far.”

quote by: Mick Kremling



Timelines – In context



Phase II

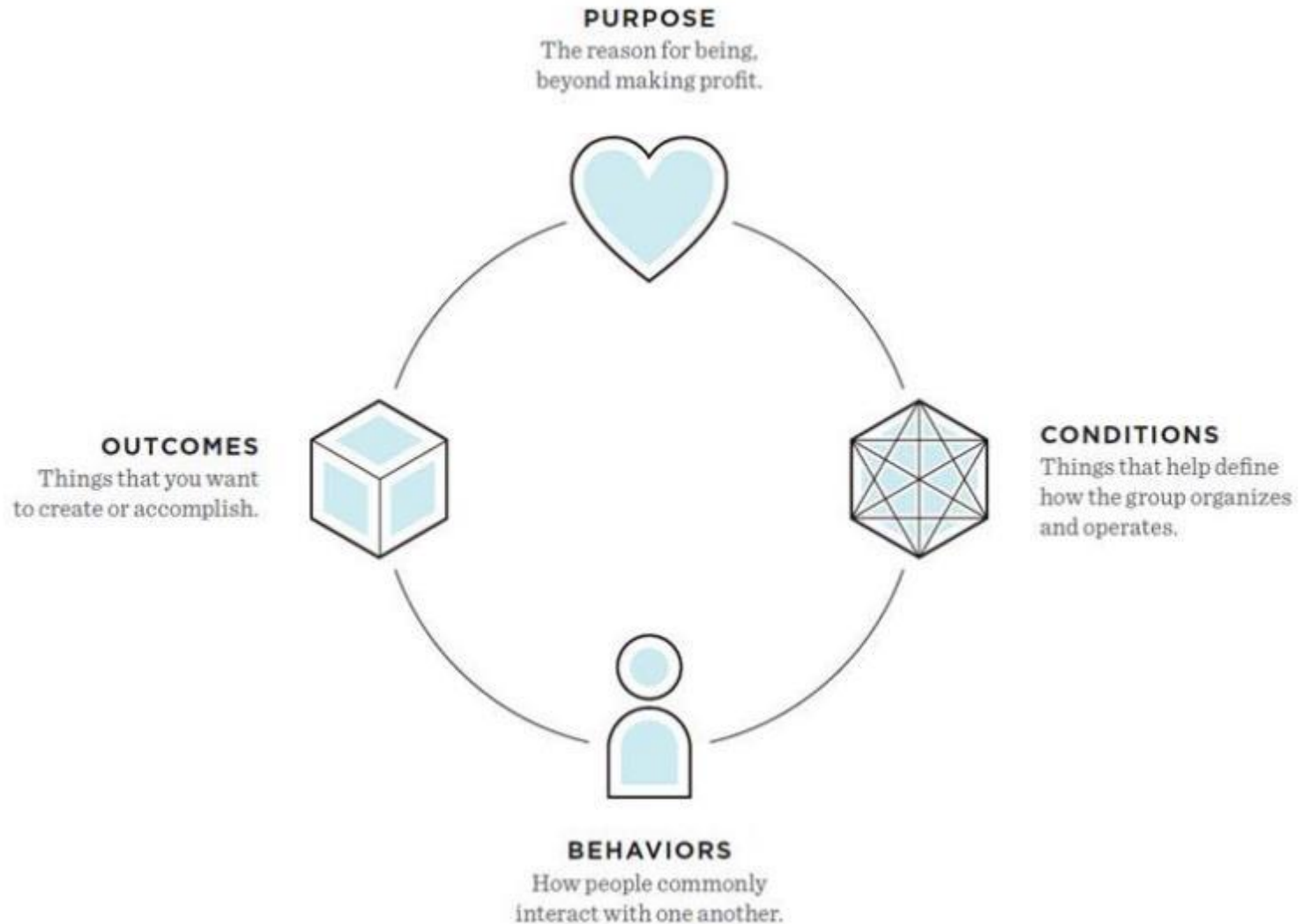
Further analysis and synthesis of evaluation findings

Input from Innovation Hubs and Patient Advisors on what conditions need to be in place for a successful PaCT journey

April to mid-May for next iteration



Designing for Change



What's next for PCN / Coaches

- Engagement and Spread Support
- System level and Enabling Support
- Conditions for success



What's next for PaCT Participants

- Leadership and involvement in related initiatives
- Inform sustainability of processes
- Conditions for success in your practice



What's next for Patient Advisors

Thank you!!

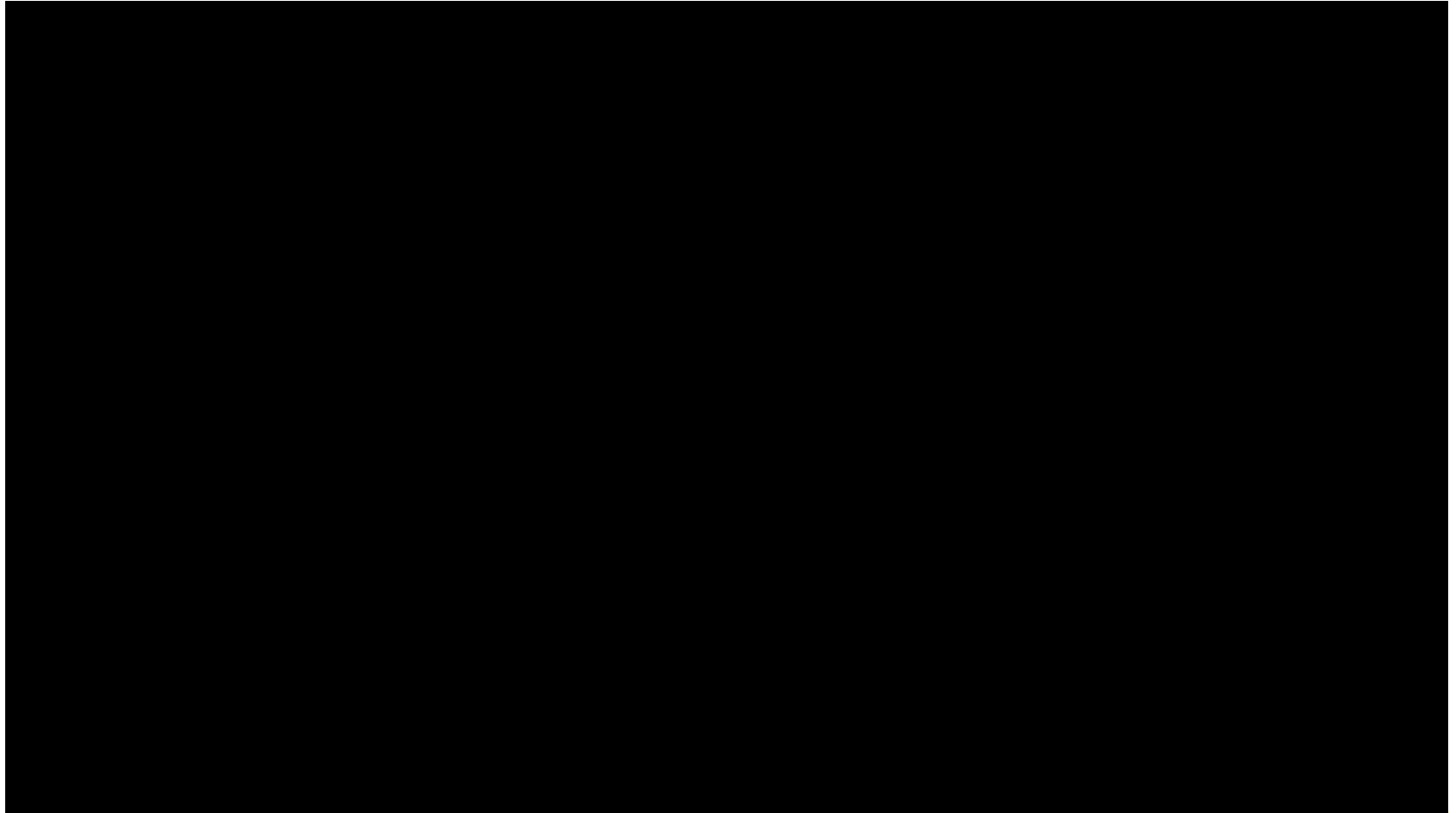
- Debrief of today
- Conditions for Success/Next iteration
- Mid March Steering Committee



Afternoon Break



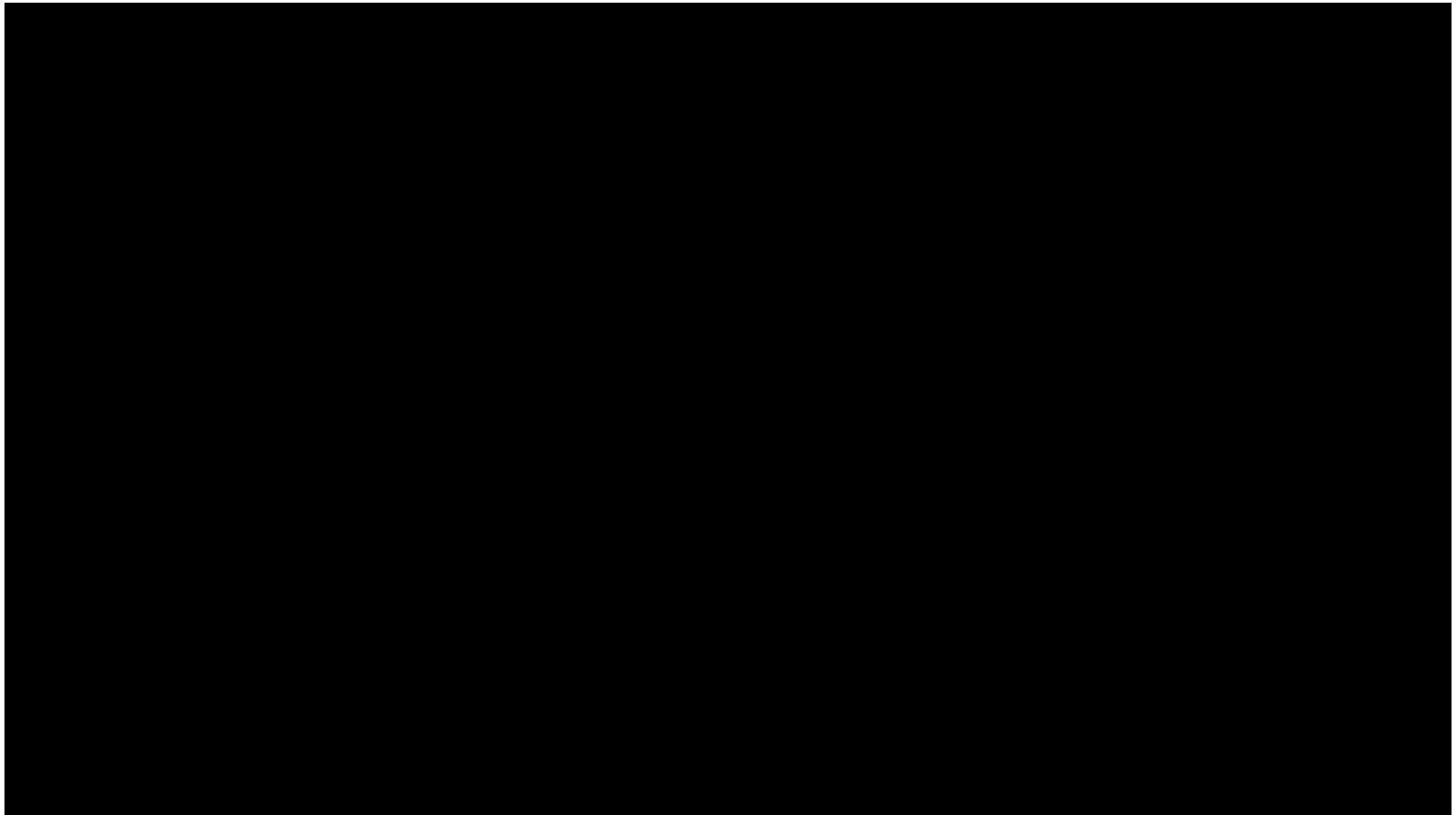
Patients said...



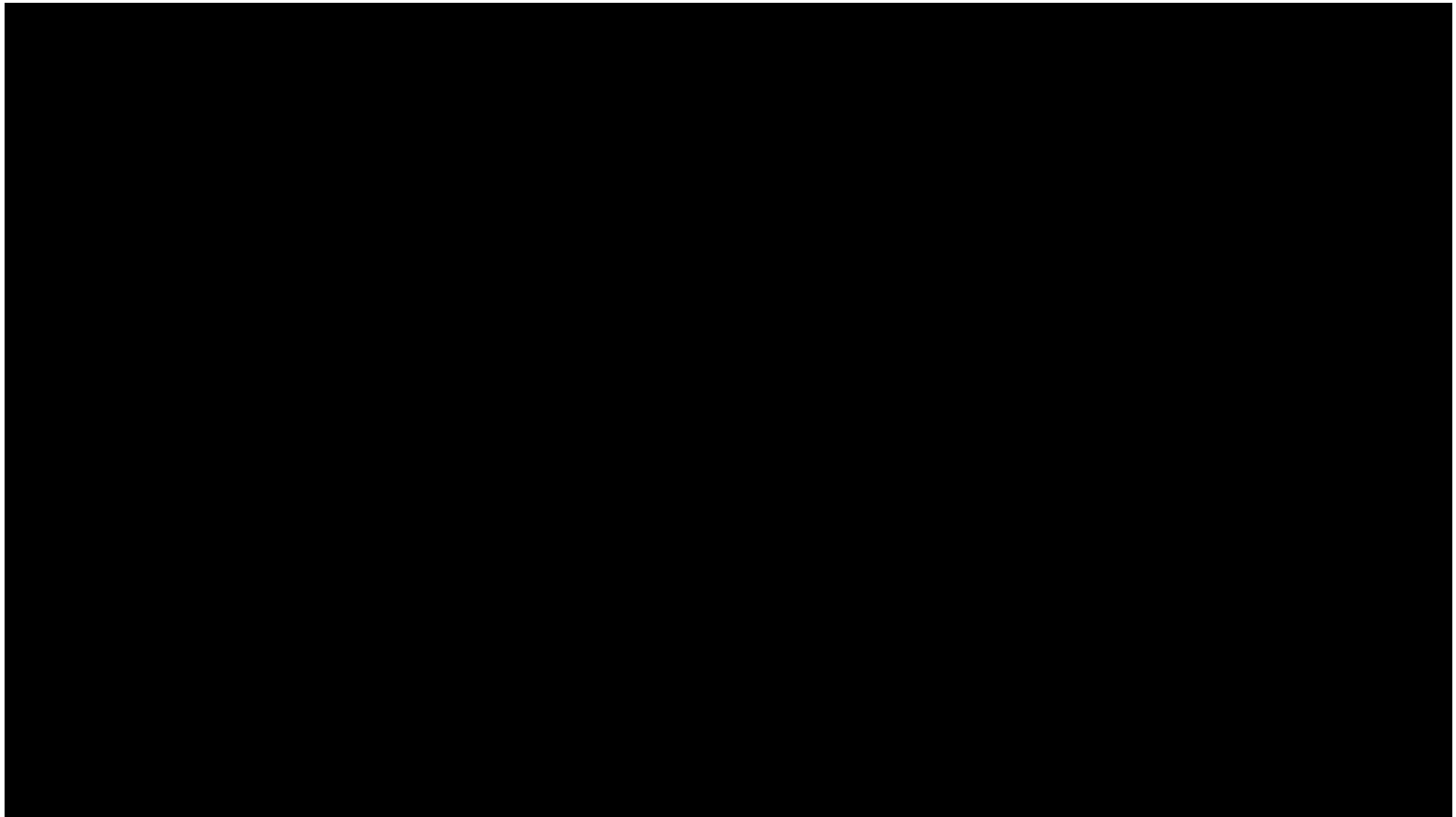
Patients said...



Benefits of a Patient Advisor



Teamwork in Care Planning



Patient Voice and Q&A

Patient Voice



Open Question & Answer

Questions

Advice

Comments

Needs



Recognition & Celebration!

