PaCT Innovation Hubs

Test Box #3 – Guide for Coaches

The Coaches' Webinar for test box 3 is scheduled for June 11, 2018, and the Share & Learn webinar session with clinics is planned for July 26, 2018. As always, please reassure your team(s) that they're not expected to take on every potentially better practice (PBP) in each test box. That being said, we're getting the message that teams see the value in all of the PBPs and find it difficult to pick and choose. We're prepared to support that feedback, as we see it as a very encouraging sign! To that end, we pushed back the timing of test box 3 because we recognized that some teams are still testing potentially better practices from the first two test boxes.

The theme of Test Box 3 is **'Roles, Engagement and Assessing Readiness'.**

To start, review the PBPs in the test box 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, and lessons learned…even if it was in the past.

For the activities that the team is not already doing, select which ones they would like to test. (More in-depth descriptions of each activity and how to support the team follows.) If a team is having difficulty deciding what to take on, consider doing an impact/effort grid exercise with them (refer to Test Box #2 – Guide for Coaches for instructions).

'Potentially Better Practices' to choose from:

- ☐ Timely access & continuity
  - *Understand the relationship between continuity and access*
  - *Measuring and monitoring access and continuity using data*
    - *Third next available (TNA) appointment*
    - *HQCA Panel Report*
- ☐ Engaging patients in care planning
  - *Patient centred practices to build trust and rapport*
  - *Practice tips for assessing health literacy and readiness*
  - *Considerations for developing and using a care plan template – what you say, how you say it and the order in which you do it can impact patient engagement*

- ☐ Team roles & responsibilities
    - *Distribute the workload and assign care planning process tasks to the most appropriate team members*
    - *Identify opportunities for cross-training*
    - *Warm hand-offs: introducing team members with intention*
- ☐ Standardizing data entry for team-based care
    - *Focus on standardized entry for three target areas – problem list (current conditions), BMI/BP, and advance care planning*
    - *How to file and search for care plan documents*

Timely Access & Continuity

The top three factors that influence Albertan's overall satisfaction with care are:

1. Quality of the health care services
2. Access to healthcare services
3. How well healthcare professionals coordinate their efforts to meet patient needs[1]

Contents in this test box aim to support improvement in each of these areas. The first section is focused on access and its impact on continuity. Questions to ask the team are "Can your patients with complex health needs access the care team when needed? How do you know?"

Alberta Health's Schedule B requirement to measure median time to third next available (TNA) appointment has significantly increased measurement and reporting of this targeted measurement of access. However, PCNS are only required to report on physician TNA measures. Some clinics have adopted a whole system/clinic approach by tracking TNA data for all providers that schedule appointments. The question remains, do all clinic staff members understand what TNA is and why it is important?

Build a common understanding

TNA

Contents and items to test in this section aim to build a common understanding of access and continuity across the team. Start by talking to a few key members to determine what has been previously communicated to the team about access measurement. Is TNA data collection occurring for all providers or select providers? What processes are in place to review and interpret the data?

A short slide deck was created for coaches as a resource to support communication with clinic teams about TNA. Coaches are encouraged to review Appendix A of the Toolkit for Time to Third Next Available Appointment (TNA) Indicator – May 2016.

Panel Reports

The HQCA panel reports are another tool that can be used to interpret physician access and continuity. Encourage every physican participating in PaCT to request their individual report. Use the information included in the HQCA video to look at the different data elements included in the report that can help interpret physician access. Explore opportunities to share and discuss this data as a clinic team to build a common understanding of what access issues might exist.

TIP:
Focus on the What and the Why with teams. What is access and why is it important for continuity. What we measure and why is it important to have a common understanding of the data and trends.

Note: Work completed in this test box will set the team up well for the next test box (TB4) which will focus on tips to address common access issues.

Reference

[1]Health Quality Council of Alberta (HQCA). 2014. Satisfaction and Experience with Healthcare Services: A Survey of Albertans.*https://d10k7k7mywg42z.cloudfront.net/assets/5488d3b2c0d67162f7006ec7/2014_Listening_to_Albertans_120814__FINAL.pdf*

Engaging Patients in Care Planning

We've heard from physicians and health care providers that care planning visits are often structured around the care plan template. Many providers appreciate having a tool that prompts them to collect and convey key information during a visit. What is important for care teams to understand that ***what they say***, ***how they say it*** and ***the order in which they say it*** can all impact engagement and rapport.

A well-designed care planning template or tool is a key supportive structure for teams to translate patient-centred care into practice. This test box encourages teams to review their care planning tools and talk about potential improvements that can be made to more meaningfully engage patients.

To adopt or adapt…that is the question

A video *"Designing a Care Plan with the Patient in Mind"* was created to help teams better understand the better practices that were built into the PaCT Care Plan template. From there teams can consider adopting the PaCT Care Plan template or parts of it or adapting their clinic template to reflect some or all of the key practices. The target practices in this test box are focused on helping providers:

- Build trust and rapport
- Strengthen health literacy
- Assess readiness

Supportive resources are hyperlinked throughout the test box document. Two new resources were included to build a common understanding of health literacy and approach for assessing readiness across the team. Also note the connections to previous test box contents. These are meant to reinforce previous learning and strengthen application of practices that where targeted in test boxes 1 and 2.

When talking about using or modifying a template, explore with the team:

- potential barriers or resistance that may arise when making documentation changes
- possible risks that might come with choosing not to adapt or adopt new
- benefits that might come with making some changes and the potential impact that might have on their interactions with patients
- opportunities to ask patients for feedback on care planning tools, as well as check in on patient experience as new practices are tested.

TIP:
Consider using **"how might we"** phrasing when problem solving with your teams to generate innovative solutions.

For example:

- How might we sequence our messaging and questions to incorporate the *What* and the *Why* to build our patient's motivation and health literacy?
- How might we build prompts into our EMR to remind our team to *Ask RICk*?
- How might we go about asking patients for feedback on our new care plan template?

Team Roles & Responsibilities

1. To begin this work with your clinic team, review the care planning 'current state process map' that you worked on earlier. Now is the time to think critically about the steps – are any missing? Is our process as good as it can be?

   Tips:

   - *Consider reviewing the PaCT care plan template with the team. Even if they have chosen not to adopt it, it flows through an optimal, evidence-based process for care planning that can be helpful to guide process redesign.*

2. Another tool provided for you is the Team Roles & Responsibilities: Care Planning document. It can be adapted to mirror the team's care planning process, if needed. Review the tips on page one of the tool, then use the grid to guide the conversation and decision-making.

   Tips:

   - *Continually remind the team that the goal is always to distribute work amongst team members so everyone's time is well spent. For example, redistributing work from the physician to another team member, so that the physician can focus their energy on the work that only a doctor can do.*

   - *Think about efficiency – what can be done ahead of time?*

   - *Think about patient-centredness – how can we make sure the patient's experience is optimal?*

   - *Really encourage the team to take the cross-training aspect to heart. Ultimately, team members should be able to cover for each other or step in if someone is sick or away. It also supports professional development and growth.*

   - *A new process step may require testing before it's adopted. Don't forget to guide the team in doing PDSAs where appropriate.*

3. It may be that the revised process involves someone other than the physician seeing the patient as part of care planning. Or, that may have been the process all along. Either way, a discussion about 'warm handoffs' can be very valuable. The test box includes two sets of comparative dialogues for discussion – one for a warm handoff from a physician to a team member, and one for a team member introducing their role to a patient. Consider reviewing the dialogues with the team and discussing the questions listed after each.

   Tips:

   - Plan some additional questions to ask the team to get them thinking about warm handoffs. For example:
     - What are your patients' expectations about who they'll see when they come to the clinic?
     - Will it be a surprise to some patients to be seeing someone other than their doctor? How might they react? What could you try to reduce anxiety for the patient?

    - Do you already have a process for introducing patients to being cared for by other team members? Is it documented? How do you share it with new team members?

- Remind the physician(s) that they have great influence with patients. Actively demonstrating the trust and respect they have for other team members when introducing them as part of the patient's team of providers cannot be over-stressed.

4. In test box 1, the concept of 'introducing your role' was presented. The team may feel that they have covered this adequately. If not, this is an optimal time to focus on how team members are introducing their role to patients – especially if patients are not used to seeing anyone but the physician for care. As with the previous section, consider reviewing the example conversation and having a discussion based on the questions provided.

Standardizing Date Entry for Team-based Care

The work of EMR standardization began in the PaCT Starter Box. There isn't anything new to consider here from the perspective of entering data into the EMR in a standardized way. We continue to build on the various data fields that we believe will be of benefit to teams participating in PaCT.

As stated before, 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 ability to conduct searches and lead to time consuming chart reviews.

In test-box 3 we are looking at standardizing 3 specific areas from the care plan template. What you can consider in these areas specifically are:

1. Blood Pressure and BMI: These are an easy place to start as all EMRs have a standard way to enter this information.

2. Problem List: This will be a work in progress for any provider who has not had a process for updating and maintaining problem lists. Encourage PDSA's for this work.

3. Advance Directives: This is new territory for many of us. When we set out to prepare for this work, we had few examples from clinics who have standard processes for documenting these documents. We have created what we believe are best practices for documentation for 4 EMRs. We look forward to your feedback on these. If the processes work well for clinics based on your feedback, we plan to embed these ideas into the TOP EMR Guides.

For the final section on filing and searching for the care plan documents there may be new processes for clinics, even for those who have good processes for data standardization. This is because in some EMRs they will update an existing document, not creating a new one each time. This will depend on the EMR as well as on how the template is set up. Ask the team about their processes for this work and if they have a process already. If not, help them to consider the options that will work best for the team and their EMR.