PaCT
Patients Collaborating with Teams

Innovation Hubs
Test Box #5/6

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Continuity: Informational & Management

What?

As we know, there are 3 types of continuity: relational, informational and management. Panel processes and open access support good relational continuity. Informational and management continuity, particularly as it relates to care planning, centers on the care plan document and how it's shared.

Why?

For patients with complex care needs in particular, care starts in the medical home, but it typically extends beyond to the medical neighbourhood. Without clear processes in place, gaps in communication and care can occur, leaving the patient unsupported and unsure where to go for help. The family doctor should be aware of every aspect of care that the patient is receiving; it's the family physician's role to care for the 'whole' patient. Missing pieces of information can impact the medical home's ability to provide optimal care and support, which can impact the patient's health and well-being.

One Physician's Story

Watch this brief video in which Dr. Sarah Smith from Edson describes her experience with sharing the care plan document with other providers as a means to coordinate care and share information.

Tips

Think about the types of care your patients are receiving outside of the clinic, and how it might be helpful to forge lines of communication to know what is happening and to coordinate care. For example, if a dentist were scheduling a patient for oral surgery, it may be helpful for him or her to know certain aspects of the patient's history when prescribing for pain management. Conversely, it may also be helpful for the family physician to know that the patient has been diagnosed with periodontal disease, as this could impact cardiac health.

You may want to consider inviting feedback on the care plan document itself – especially if you are still finalizing the design of your care plan template. For example, a pharmacist could be asked how much information he/she considers adequate for effective collaboration. Expectations can be clarified, including how best to communicate back and forth using the template. In most cases, just one meeting to plan and discuss should be adequate.

Another consideration is inviting your patient advisor to provide input. It's important that the document has value and is easily understood by patients, as well as other providers.

Test

As a PDSA, select <u>one patient</u> who is scheduled for a care planning appointment.

1. Review any planned referrals and ask the patient about other providers from whom they may be receiving care.
   NOTE: *it's important to first inform the patient that you're asking because the team would like to extend an invitation to work together with those individuals to make sure the patient's care is coordinated as much as possible. A patient might worry that they'll be 'in trouble' for seeing another provider (e.g., chiropractor or massage therapist) without the physician knowing.*

2. Determine which provider it would make the most sense to share the care plan with, and invite input and feedback from.

3. Obtain the patient's permission to share the care plan with the selected provider.

4. Decide how you will share the care plan and ask the recipient for input/feedback. Will you give a copy of the care plan to the patient with an introductory note to give to the provider? Or, send the care plan to the provider with an invitation to provide feedback and input? Other ideas? At the very minimum, just encouraging the patient to share his/her care plan with new providers can result in positive outcomes.

5. Give it a try, review the results, adapt and try again! Once you have a process that works, consider making a plan to gradually extend more care plan invitations to more providers.

Sample Invitation

As a care partner in *(insert patient name)*'s health, we wanted to ensure that you have as much information as possible. With the patient's permission*, we have attached the care plan document. It outlines *(insert patient name)*'s medical and social history, as well as his/her health goals and action plan. We invite you to:

- review the care plan for your own information
- add details that may be helpful for us, *(insert patient name)*'s medical home team, to know.

*(*Include patient's signature)*

PaCT Fact

"The care plan is like my health passport."

~ Al
(PaCT patient)

Collaborative Goal Setting & Action Planning

What?

Collaborative goal setting and action planning are common behaviour change techniques used by healthcare providers and teams. The goal setting process can be complex when accounting for a patient's emotions, daily activities and social influences[1]. The goal should relate to a positive change and the actions should make sense to the person within their life.

Why?

Professionals' sense of responsibility to care for medical aspects may lead to reluctance to set non-medical goals focused on social and emotional self-management. This can impede a provider's ability to actively involve the patient in the goal setting process. Setting collaborative goals requires providers and patients to build connections between medical and social or emotional needs. Patients are more likely to stick with a plan that they are part of designing.

Collaborative goal setting and action planning encourages patients to:

- reflect on what is important in their life
- make a plan to get there
- consider what might get in the way of carrying out the plan
- move into action and sustained change

Goal Setting & Action Planning Conversation

In the last two test boxes we talked about how a well-designed care planning template or tool is a key supportive structure for teams to translate patient-centred care into practice. What you say, how you say it and the order in which you say it all matter for effective care planning. The goal setting process can be complex, and professionals can struggle to actively involve patients in the process. Part C of the PaCT Care Plan template was designed with prompts to guide you and your team through the goal setting and action planning conversation.

Click here to access a video "Patient-Centred Care Planning: Goal Setting & Action Planning" for a brief overview of key elements and considerations for collaborative goal setting and action planning.

PaCT Tip

To fulfill your vision of a better life, you must formulate a plan of action. Effective planning involves identifying and prioritizing those actions that will move you most efficiently towards your goal.

– Stedman Graham

Review of Goal Setting

The Four Aspects of Goal Setting principle was introduced in Test Box 4 to help you and your team collaboratively set meaningful and relevant goals with patients. Once a patient focuses in on a meaningful goal, the next step is to build a relevant action plan that outlines specific tasks that a person needs to do to achieve his/her goal. To better understand the difference between goals and actions, check out this resource: "Goal Setting & Action Planning".

Language Matters – "Goal"

Be mindful that the word "goal" may not be ideal language for all patients. Patients report feeling overwhelmed and pressured to set "goals" that may not be attainable or align with their needs. If you notice that a patient is negatively responding to the word "goal", consider using different language to reframe their mindset on this section of the care planning conversations. For example:

- Aim
- Target
- Achieve — *e.g., "Please share what matters to you personally and what you want to achieve"*
- Work towards

Tips for Creating a Successful Action Plan

1. Choose actions that are meaningful to the patient and make sense for their life.
    - *When appropriate, invite patients to bring a family member, friend or support person to strengthen the action planning process or reinforce the supportive network your patients have around them.*
2. Identify and address potential barriers.
    - *Ask the patient what might get in the way of them following through with agreed upon actions. If issues are identified, consider using a problem solving tool with patients to support skill building so that issues that come up in between visits can be worked through independently. (Considering reviewing the problem solving tool example for guidance.)*
3. Try to narrow in on specific behaviours or tasks.
    - *Consider using SMART as a guide – specific, measurable, attainable, realistic, timely.*
4. Check in on the patient's confidence to achieve the goal and actions.
    - *A confidence rating of 7 or more out of 10 generally indicates that the patient believes that they can and will follow through with the agreed upon actions. If the patient reports a confidence level less than 7, ask what changes could be made to the actions to increase their confidence and make adjustments to the plan as needed. Schedule more frequent follow-up with patients that appear less confident to troubleshoot issues and/or revise plan.*
    - *Using a 'trial and error' approach at the end of the care planning conversation can provide reassurance to patients and increase the likelihood of their success. It is important to normalize that changing behaviours can be difficult and share what resources and supports are available for follow up. This will reinforce a non-judgmental approach and ensure trust is maintained.*

- *If you (or your team) are unable to provide follow-up, consider referring your patient to a community-based or online self-management program (such as Better Choices, Better Health®) where goal setting, action planning and problem solving skills are practiced weekly to help participants achieve their health and wellness goals.*

Video Demonstrations – Goal Setting & Action Planning

Setting collaborative goals doesn't need to take long. Different members of the team can be involved and the PaCT Care Plan template has been designed to support this. Check out these short video demonstrations of how care planning conversations can sound using the PaCT Care Plan Template:

- Goal Setting and Action Planning - HealthChange® Inspired
- Goal Setting using Menu of Options Cards – HealthChange® Inspired

Activities

- Ever wonder what the difference is between provider set goals and patient-directed goals? Let's find out with a short activity that you can complete with 1 or 2 patients. When preparing for an upcoming care plan visit, think about what goals and actions you would recommend for your patient if it were up to you to decide. Take 5 minutes to write out a goal statement and one or two actions on a piece of paper. After the care plan visit, compare the *collaborative* goals and actions set with the patient to the ones you had selected before the visit.
    - *What are the similarities and differences you notice when making the comparison? Reflect on the language, specificity, and relevance to the patients' current situation. Share any reflections with your team.*
- Many of you have had the chance to use the PaCT Care Plan Template or adapted template. Discuss as a team how you go about introducing the goal setting and action planning process to patients. What are the key elements? Reflect on whether the 'script' can apply to all patients, or whether slight adjustment to the language is needed for specific population groups. Consider involving your patient advisor(s) in developing or adjusting the 'script' you and your team uses.
- Review the demonstration video as a team and discuss how you might incorporate category cards with your patients? Consider how this visual and tactile tool may engage your patients in the goal setting process. Test the cards during one care planning conversation and share your experience with your team at an upcoming huddle.

Resources:

Patient-Centred Care Planning: Goal Setting & Action Planning | Video
Goal Setting & Action Planning | Info sheet
Problem Solving | Practice Support Tool
Problem Solving EXAMPLE Practice Support Tool
Category Cards | Practice Support Tool

References: Lenzen, S.A. (2015). What does it take to set goals for self-management in primary Care? Family Practice, 33(6), 298-703. Doi: 10.1093/fampra/cmw054

Coordinating Care

What?

Coordinating care can mean a lot of things, but in the care planning context, it refers to such actions as:

- Assigning a dedicated team member to follow-up on actionable items, like referrals (referral sent, referral received, visit scheduled, visit happened, report generated, report received)
- Having an updated inventory of community resources available at the practice
- Evaluating patient and care team satisfaction with community resources and referrals.

Why?

When patients encounter external barriers – like a referral to a program that has a long wait time - it can dramatically decrease their ability and confidence to achieve health goals. For teams, having up-to-date and clear information on referral processes can save time and increase efficiency.

Tips

Check-ins

It can be beneficial to specifically assign a member of the team to be responsible for following up and 'checking in' with the patient at regular, pre-determined and mutually agreed upon intervals after the care planning appointment. It can be as simple as a 5 minute phone call. There are no rules, per se; the important thing is that the patient knows that someone will be there for guidance if he or she runs into any road blocks. Having a follow-up plan also lets the patient know that care planning isn't just an exercise to put a check in a box; knowing that someone will be following up shows that the team believes that the actions are important, and they will be accountable for their part (e.g., making referrals). The patient also tends to feel increased accountability for what they've committed to doing when they know the team is invested.

Referral Management

Some teams keep an inventory of programs and resources that are available to support patients. These inventories only have value if they are kept up to date, including processes and procedures for referral, as well as patient and team member satisfaction feedback where possible.

While some aspects of the inventory may be straight forward to gather and update (e.g., PCN programs being offered), others are less simple. In many cases, the information resides in team members' heads from previous experience referring patients to a particular program or specialist. Documenting this knowledge to share with others can be helpful.

Some clinics use the EMR by modifying the specialist database to record information such as waitlist times, preference for fax or phone referrals, information about a practice or program re-locating, etc. The information becomes connected to the referral letter or form in the EMR, and comes up when the specialist or program is selected. This way, expectations of wait times, location, etc. can be considered when making decisions with patients about referral options.

Test

1. As part of care planning, ensure the patient knows who will be following up on action items. As well, take a few moments to plan when the follow-ups will occur (e.g., 2 weeks, 6 weeks, 3 months) and how (e.g., phone call, appointment, or maybe even a text exchange!). The next section of this test box relates to using the EMR to remind or 'trigger' follow ups which may complement your work here if approached in tandem.

2. As a team, discuss what information about referrals would be valuable to have documented. Where could you find more information about what's available and what the processes are for referring? Are there programs or specialists that you frequently refer to? How could you streamline your referral processes with these 'favourites'? How can you use the EMR to help with organization and efficiency?

3. Consider involving patients in your referral inventory information. What can you do to ensure that patients have a good experience with referrals? Do you currently get feedback from patients about referral experiences? If so, do you document it? How might this information be helpful in the future? Similarly, can you document team member feedback about referrals?

4. Consider a PDSA for assigning a person to be in charge of organizing a referral inventory. It could be a rotating role, or it may be one team member's 'passion project'! (If that's the case, make sure they cross-train at least one person, or at minimum, document what they do.)

TIP

Make it fun! One clinic has a role they call 'Referral Queen' that certain team members rotate in and out of. (It comes with a 'sparkle lanyard' to signify royal status.) Who's your referral royalty?

Using EMR Tools to Trigger Follow-up on Care Planning Activities

What?

In this section we will discuss how to use the EMR to remind, or trigger, team members to follow up with the patient (as decided by the patient and team) after the care plan is completed. Each EMR has tools to help teams keep on top of every patient's needs.

Why?

Each patient with a care plan is going to be on a unique journey; each will have different care needs and a custom plan for next steps. It would be impossible for a clinician to remember each detail for every patient, but not impossible for an EMR! The EMR is your tool to recall each detail and to remind you of it.

Tips

Each EMR has reminder functions (they all go by a different name: rules, reminders, goals, CDS notifications or triggers). These can be set as population-wide reminders where criteria are set up to find a set of patients who meet the criteria for your reminder.

There are also individual patient reminders where the reminder applies to one patient at a time. Your team will probably use a combination of the two to optimize care for patients, once you get the hang of using them.

Test

1. **Using Individual Reminders:**

The first test is to create individual patient reminders with patients who have a care plan. Start by using reminders for *one* patient and as you get used to using them, scale up to use them with *5* patients, then *25* patients until you have worked out all of the processes. Then use them with every care planning patient. Some things to consider when creating the process to do this are:

a. **Who** is responsible for creating the individual reminders?
   - *Does the care team member who is leading the process create the reminders? Does the task of building the reminders get passed off to another team member in the clinic who has not seen the patient?*

b. **When** do the reminders get built?
   - *Do the reminders get built during the appointment or after the appointment with the patient?*
   - *Do they get built by a team member at a different time, perhaps a weekly task?*

c. **How** do the reminders get followed up (i.e., what is the process)?
   - *Someone needs to be assigned to 'action' each reminder. Make sure that everyone knows their roles.*

Some examples of individual reminders you may wish to build:

- Next appointment
- Lab or DI Test follow ups
- Routine check-ins (phone calls to patient as per the plan)

2. Using Population-wide Reminders

The second test is to create population-wide reminders. As opposed to creating individual reminders patient by patient, these reminders are created based on criteria you choose; the tool will look across the whole EMR to find patients who meet the criteria you ask for. Population-wide reminders work well when you want to search for something consistently, like a lab result or document type.

Testing individual reminders first may help you to determine what to create as a population-wide reminder. If you are creating the same individual reminder over and over again, perhaps you may want to consider if it could be built as a population-wide reminder.

The considerations for building the process for population-wide reminders are similar to individual reminders:

a. **Who** builds the population reminder?
b. **Who** follows up on the reminders?

Population-wide reminders should also be scaled up. Don't turn on too many at one time or make the inclusion criteria too broad; team members tend to ignore them if this is the case. As these reminders turn on for many patients at once, it is difficult to scale them up in the same way as you can for individual reminders.

A suggested process for building these is to build the reminder one criterion at a time and test that the criteria work as planned. Once you have your search, validate it by looking at the list it creates and auditing a few charts to make sure that it picks up the correct patients. If you are aware of a few patients it should be picking up, validate that the reminder function catches them too.

TIP

Don't forget to make sure that you have a process for 'marking' charts so that patients who have had a care plan created can be easily searched for monitoring and follow-up.

Resources:

Microquest-Healthquest EMR:

Information on Population-wide point of care reminders and individual reminders can be found in the TOP EMR Guide for Healthquest on pages 42-52:

http://www.topalbertadoctors.org/file/healthquest-emr-guide-for-pmh-2018-03.pdf

Additional support is available in the TOP video library:

Introduction to CDS Notifications:
https://www.youtube.com/watch?v=3D0mKRQNtPw&feature=youtu.be
Simple CDS Notification – Mammogram in Healthquest:
https://www.youtube.com/watch?v=3I1J1MldVIs&feature=youtu.be
Complex CDS Notification – Diabetes in Healthquest
https://www.youtube.com/watch?v=qm3LQgrk5ac&feature=youtu.be
Using Expanded Notes in Healthquest:
https://www.youtube.com/watch?v=QyY1jBbitX4&index=9&list=PLf486cdx9WgLSa6UEly3HQG09Nd3xGFMZ

Telus-Med Access:

Information on Population-wide point of care reminders and individual reminders can be found in the TOP EMR Guide for Med Access on pages 52-53 & 69:

http://www.topalbertadoctors.org/file/med-access-emr-guide-for-pmh.pdf

Additional support is available in the TOP video library:

Using Clinical Decision Support Triggers:
https://www.youtube.com/watch?v=t116q3GVKzs&feature=youtu.be
Creating a CDS Trigger – Tobacco Use in Med Access
https://www.youtube.com/watch?v=3NNlNhn41XM&feature=youtu.be&list=PLf486cdx9WgJ_YO2fVBVlUv25JO02eYg7

Telus-Wolf:

Information on Population-wide point of care reminders and individual reminders can be found in the TOP EMR Guide for Wolf on pages 43-44:

http://www.topalbertadoctors.org/file/wolf-emr-guide-2018-1.pdf

Additional support is available in the TOP video library:

Saving a search as a rule
https://www.youtube.com/watch?v=oRYWUTzmWUY&feature=youtu.be&list=PLf486cdx9WgljTeALz9ax2PznPxLCguRG

QHR-Accuro:

Information on Population-wide point of care reminders and individual reminders can be found in the TOP EMR Guide for Accuro on pages 43-44:

http://www.topalbertadoctors.org/file/accuro-emr-guide-for-pmh.pdf

Team Reflection and Maintaining Momentum

What?

Reflection allows team members to express thoughts, feelings and opinions about a shared experience to strengthen learning and application of insights to future work.

Why?

Building a trusting environment where team members can openly and critically reflect on changes implemented can generate shared meaning, facilitate problem solving, strengthen relationships and enhance coordination and communication.

Pact Quote

Reflection is one of the most underused, yet most powerful, tools for success.

-Richard Carlson

Team Assessment: Old to New Behaviours

At the beginning of your PaCT journey, teams were asked to complete a short team assessment. Teams used a 5-point rating scale to describe their current practices or behaviours in five areas:

- Panel identification, maintenance and management
- Team activities
- Patient self-management strategies
- Evidence-based clinical decisions
- Transitions in care

Activities

- As a team, repeat the assessment without looking at the responses captured at the beginning of your PaCT journey.
    - Identify key changes to practice that contributed to your current scoring selections.
- Retrieve a copy of the team assessment you completed at the beginning of your PaCT journey. Compare your current responses to those captured on the original assessment. What stands out? Does the comparison reflect what you and your team experienced over the last year?
- Look back on the aim statement your team created at the beginning of PaCT. How successful was your team at achieving the aim? Will your team continue to focus on that aim or set a new aim?
- Capture 'current state' by updating the care planning process map you created at the beginning of your PaCT journey. Discuss as a team what changes had the most impact. Use the analysis questions included on the back of the process map resource to identify improvement areas to target next. What new practices and processes had the greatest impact on team/clinic efficiency? (i.e., reduced bottle necks)

Maintaining Momentum

As you look forward, think about what is needed to sustain the new practices that are working for your patients and team. Consider using the team assessment to identify areas that still need attention and invite patients to voice their experience, concerns, and ideas in order to maintain momentum. Contribute to the collective strength of your community by continuing to partner with community members and organizations that offer services that can help your patients and complement the work of you and your team.

Invite the 'Patient Voice'

Creating a safe space for patients to share their feelings, thoughts and concerns can help you and your team stay in tune with the needs of the people you serve.

Here are some ideas for framing questions to invite the 'patient voice' at your clinic:

- How are you feeling about our conversation so far?
- How do you feel leaving this appointment?
- Is there anything we missed talking about today?
- Is there anything that is still unclear that we can talk about more?
- What is one thing our team could have done to improve your experience at the clinic today?
- What matters to patients, matters to us. What can we do to make you and other patients feel heard and safe to voice concerns and ideas that will make our services better?
- What questions do you have?

Don't have time to ask at the end of an appointment? Ask a team member, such as the receptionist or MOA, to check in with patients before leaving the clinic or by phone the next day.

Resources:

Team Assessment | Reflection tool

References:

1. Shaw, E.K., Howard, J., Etz, R.S., Hudson, S.V., and Crabtree, B.F. (2012). How team-based reflection affects quality improvement implementation: A qualitative study. *Quality Management in Health Care, 21*(2), 104-113. Doi: 10.1097/QMH.0b013e31824d4984