PaCT Coaches Prep

June 11, 2018

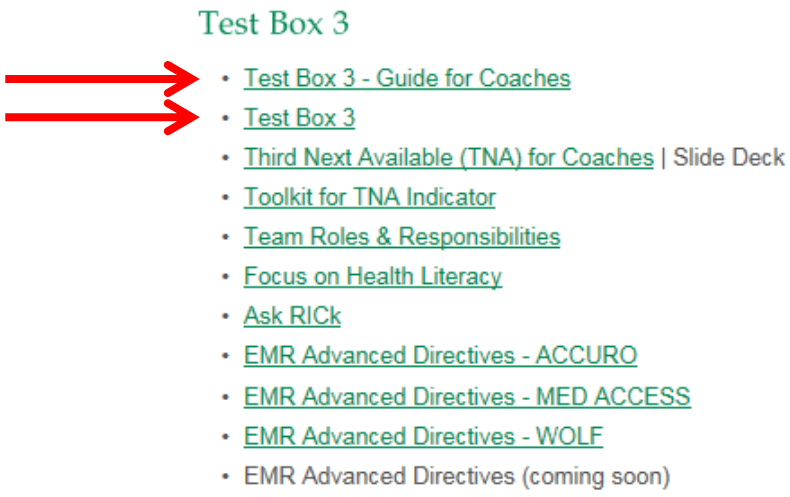
WebEx Quick Reference

- **Mute/unmute** on your phone or using ***6**
- Chat to "***All Participants***"
- Chat to "***Host***" for technology issues

Welcome!

Please add the names of everyone attending in the chat box

Tools Available on TOP Website



http://www.topalbertadoctors.org/pact/toolsresources/

Discussion

Team Assessment

PaCT: Team Assessment

Panel Identification, Maintenance and Management

We do not identify patients with complex health needs systematically using our EMR. →				Our team's panel list in the EMR clearly identifies those with complex health needs.
1	2	3	4	5
We don't know which of our patients are most likely to benefit from care planning. →				Our team has identified priority patients for care planning (e.g., complex health needs, rising risk, not managed, without a visit in the last year).
1	2	3	4	5
At appointments the physician manages only the issues identified at the visit. →				Our team prepares for each patient visit to proactively address health needs that may not be the primary reason for the patient's visit.
1	2	3	4	5

Test Box 3 contents

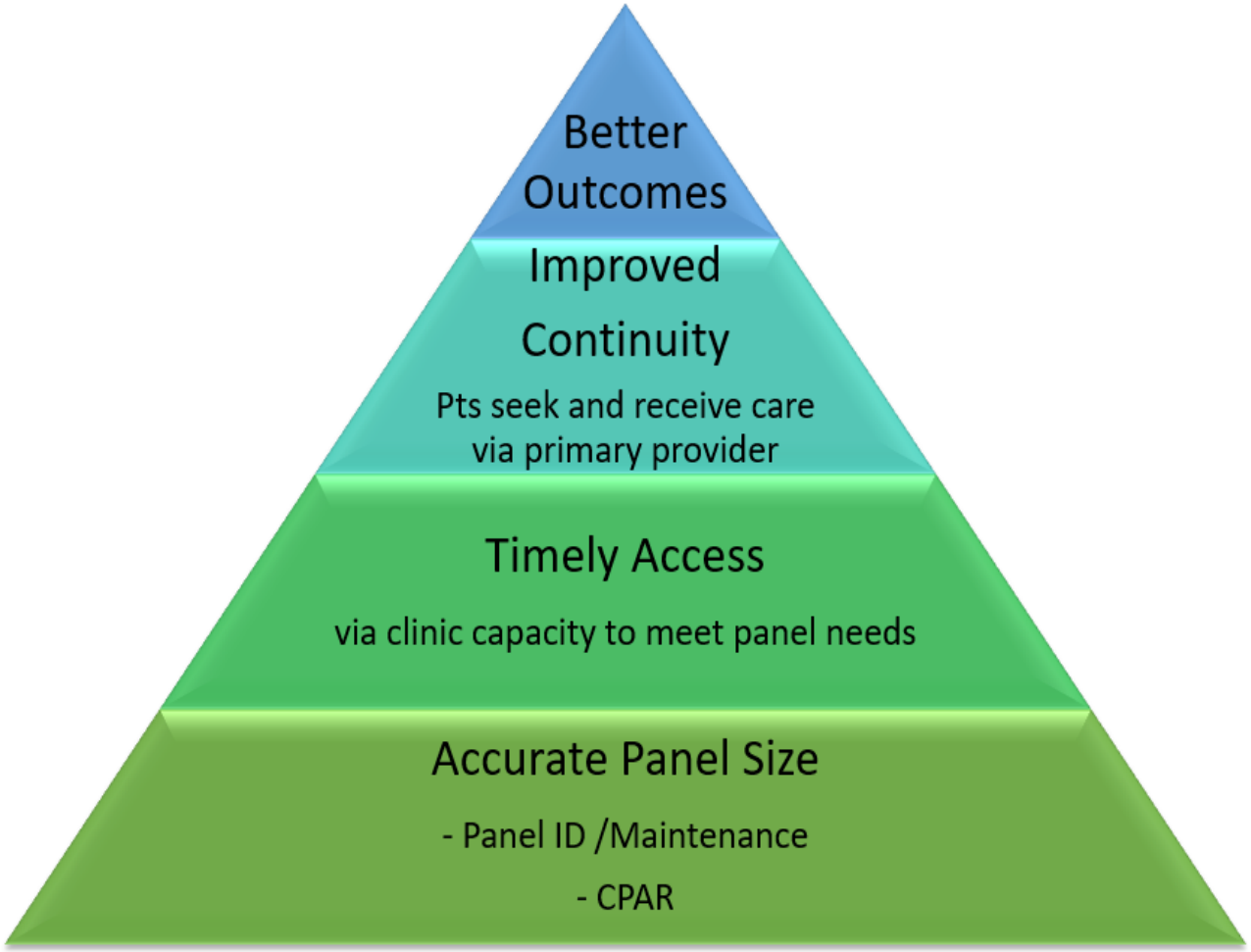
‘Potentially Better Practices’ to choose from:

- Timely access & continuity
- Engaging patients in care planning
- Team roles & responsibilities
- Standardizing data entry for team-based care

Timely Access & Continuity

PaCT
Patients Collaborating with Teams

Access – A Key Driver for Continuity



Third Next Available – Develop a Shared Understanding

Same time/same day every week

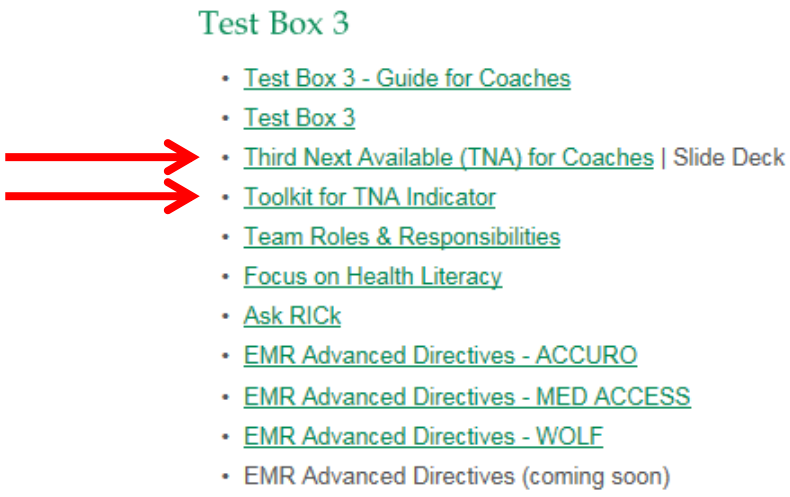
Carve-outs; don't count them

Patient's perspective; every day counts

Record the data

Improvement NOT judgment

Tools Available on TOP Website

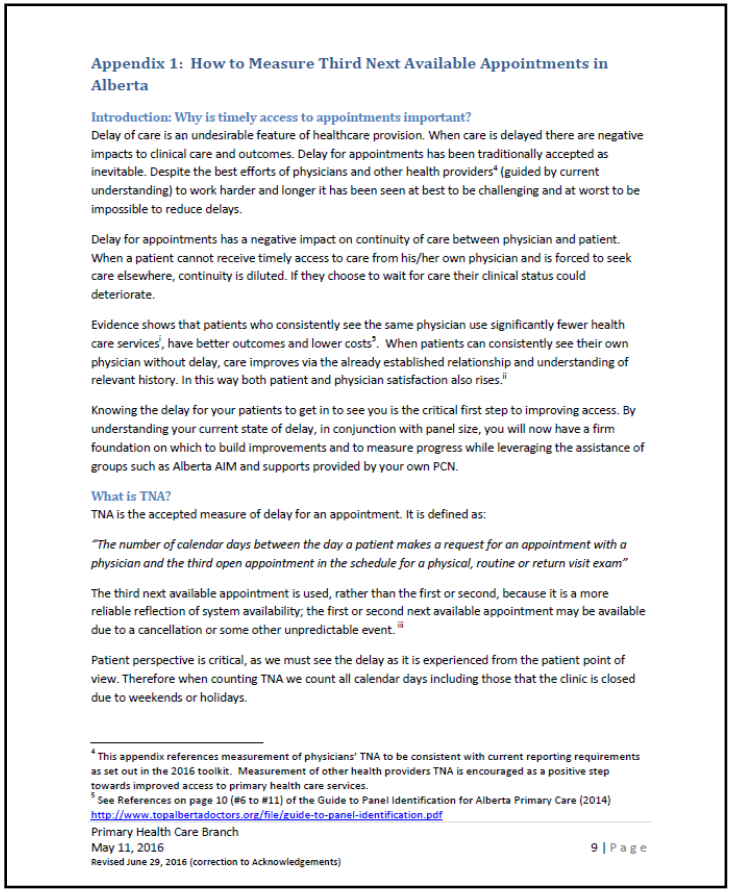


http://www.topalbertadoctors.org/pact/toolsresources/

Toolkit for TNA Appointment – May 2016

Standardized Steps to Measuring TNA

- Determine the length of the smallest "building block" of time you schedule appointments
- Identify any Carve Outs – don't count these
- Measure from the "Patient Perspective" – count all days including days the clinic is closed
- On the same day, same time, every week, count the number of days until you find the third empty "building block" for each physician in the clinic
- Record the value in a tool to create run charts showing data over time and analyze



Appendix 1: How to Measure Third Next Available Appointments in Alberta

Introduction: Why is timely access to appointments important?

Delay of care is an undesirable feature of healthcare provision. When care is delayed there are negative impacts to clinical care and outcomes. Delay for appointments has been traditionally accepted as inevitable. Despite the best efforts of physicians and other health providers[4] (guided by current understanding) to work harder and longer it has been seen at best to be challenging and at worst to be impossible to reduce delays.

Delay for appointments has a negative impact on continuity of care between physician and patient. When a patient cannot receive timely access to care from his/her own physician and is forced to seek care elsewhere, continuity is diluted. If they choose to wait for care their clinical status could deteriorate.

Evidence shows that patients who consistently see the same physician use significantly fewer health care services[i], have better outcomes and lower costs[5]. When patients can consistently see their own physician without delay, care improves via the already established relationship and understanding of relevant history. In this way both patient and physician satisfaction also rises.[ii]

Knowing the delay for your patients to get in to see you is the critical first step to improving access. By understanding your current state of delay, in conjunction with panel size, you will now have a firm foundation on which to build improvements and to measure progress while leveraging the assistance of groups such as Alberta AIM and supports provided by your own PCN.

What is TNA?

TNA is the accepted measure of delay for an appointment. It is defined as:

"The number of calendar days between the day a patient makes a request for an appointment with a physician and the third open appointment in the schedule for a physical, routine or return visit exam"

The third next available appointment is used, rather than the first or second, because it is a more reliable reflection of system availability; the first or second next available appointment may be available due to a cancellation or some other unpredictable event. [iii]

Patient perspective is critical, as we must see the delay as it is experienced from the patient point of view. Therefore when counting TNA we count all calendar days including those that the clinic is closed due to weekends or holidays.

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[4] This appendix references measurement of physicians' TNA to be consistent with current reporting requirements as set out in the 2016 toolkit. Measurement of other health providers TNA is encouraged as a positive step towards improved access to primary health care services.

[5] See References on page 10 (#6 to #11) of the Guide to Panel Identification for Alberta Primary Care (2014) http://www.topalbertadoctors.org/file/guide-to-panel-identification.pdf

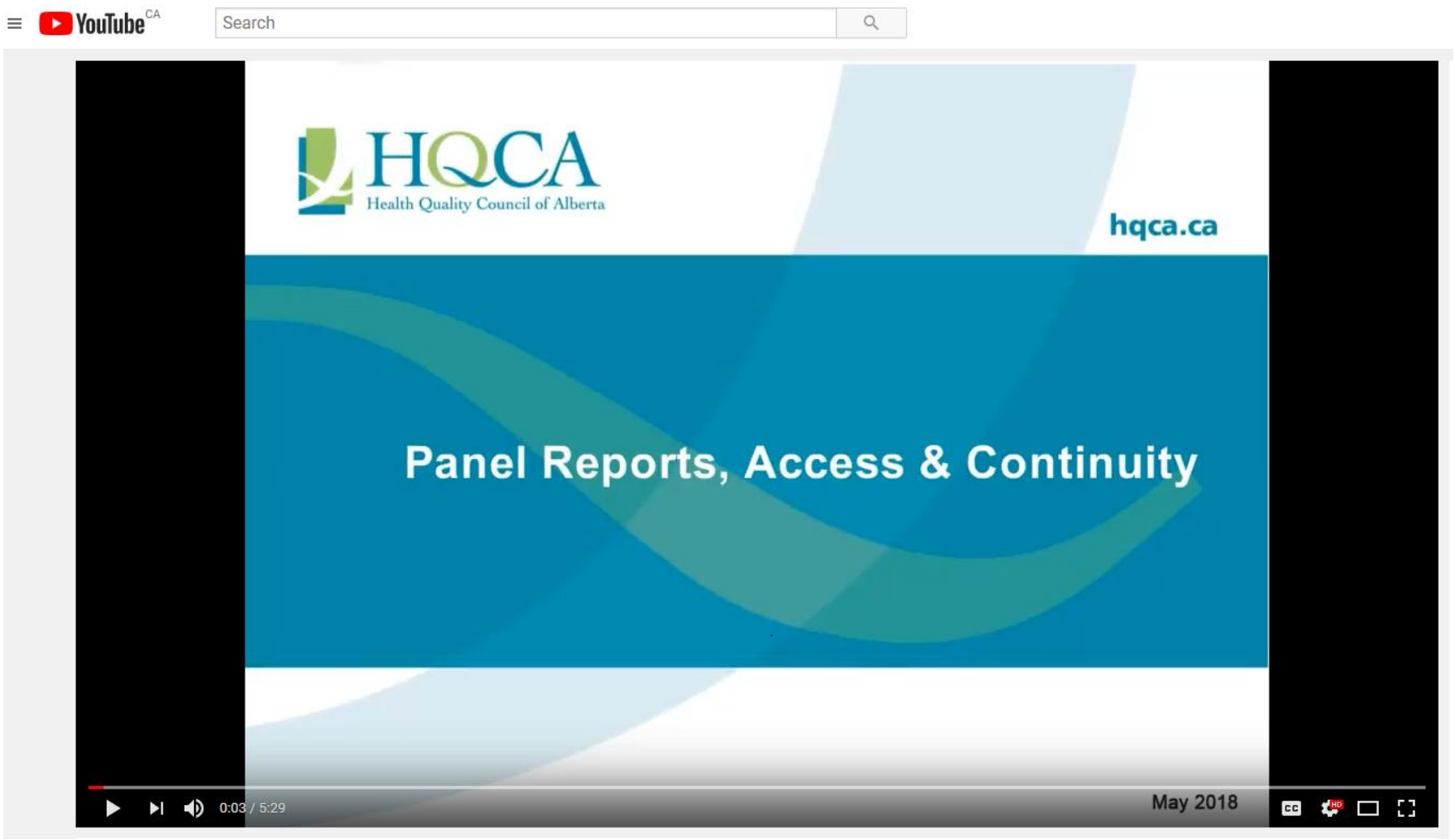
Primary Health Care Branch
May 11, 2016
Revised June 29, 2016 (correction to Acknowledgements)

9 | Page

Recommendations from the Measurement and Evaluation Working Group for measuring TNA in the province

Tools for Coaches – Powerpoint on TNA

Tools for Coaches – HQCA Video



AIM Alberta

www.aimalberta.ca

Contact Us | Online Measurement Tool | Learning Portal | News Feed

AIM Access Improvement Measures Alberta

Building Your Medical Home Together

WHO WE ARE | WHY WORK WITH AIM | HOW WE HELP | SELF-SERVE RESOURCES | STORIES

What is AIM

WHO WE ARE/WHAT IS AIM

AIM's Vision: *Accessible, effective healthcare for all Albertans.*

AIM's Mission: *To support healthcare teams to create a culture of improvement through the use of evidence informed principles, resulting in access to care that is both timely and effective.*

Overview

AIM Alberta is a quality improvement initiative that enables healthcare teams to achieve their potential. AIM equips these teams with the tools to identify roadblocks to success and create their own solutions to enhance patient access, efficiency and clinical care. We work with healthcare teams that are empowered to build key components of the Patient's Medical Home (PMH) together for the benefit of patients, providers and staff.

SEARCH

LATEST POST

Important changes to our OMT website

JULY 13, 2017

Increasing access remains essential to the healthcare system

FEBRUARY 24, 2017

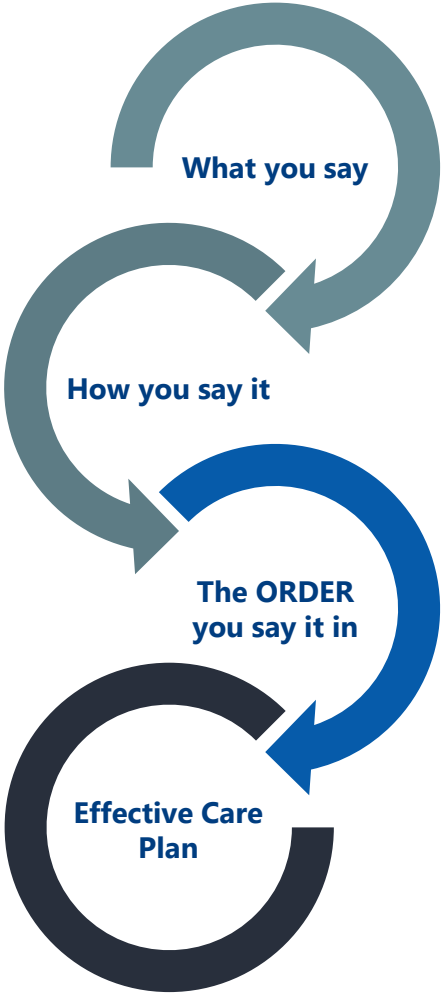
AIM Alberta Launches

Questions/Discussion

Engaging Patients in Care Planning

PaCT
Patients Collaborating with Teams

Engaging Patients



What care plan template is being used by teams?

1. PaCT template
2. Modified PaCT template
3. Clinic created template
4. Other
5. Not sure

Potentially Better Practices

Resources

PaCT

HEALTHCHANGE Inspired

A Focus on Health Literacy: The *What* and the *Why*

Building motivation to make change can be difficult. As providers, it is our job to focus on helping patients uncover their own personal motivation. The information we provide and the way we deliver these messages can greatly impact a patient's decision to change or take action.

In Canada, **health literacy** is defined as the *"ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course"*.[1] Evidence shows that "60% of adults and 88% of seniors in Canada are not health literate".[2] Poor health literacy is "a stronger predictor of a person's health than age, income, employment status, education level and race".[3]

The HealthChange® Methodology identifies the essential ingredients for promoting health literacy, the what and the why. Patients not only need to understand what their health conditions are and what can be done to manage them, but also understand why taking specific actions will help improve their health and their ability to do the things that are personally important to them.

	What (Information)	Why (Motivation)
Health Condition	☑	☑
What can be done to manage this condition	☑	☑

If we sequence our messaging and questions, to highlight the four components of the *What* and the *Why*, as outlined below, we can help build our patient's motivation and health literacy.

Health Condition

1. The What:
Ask: *What's your understanding of (your condition(s))?* Fill in any gaps in knowledge, such as:
   - Typical course of the condition over time
   - Clinical indicators for health
   - Common misconceptions

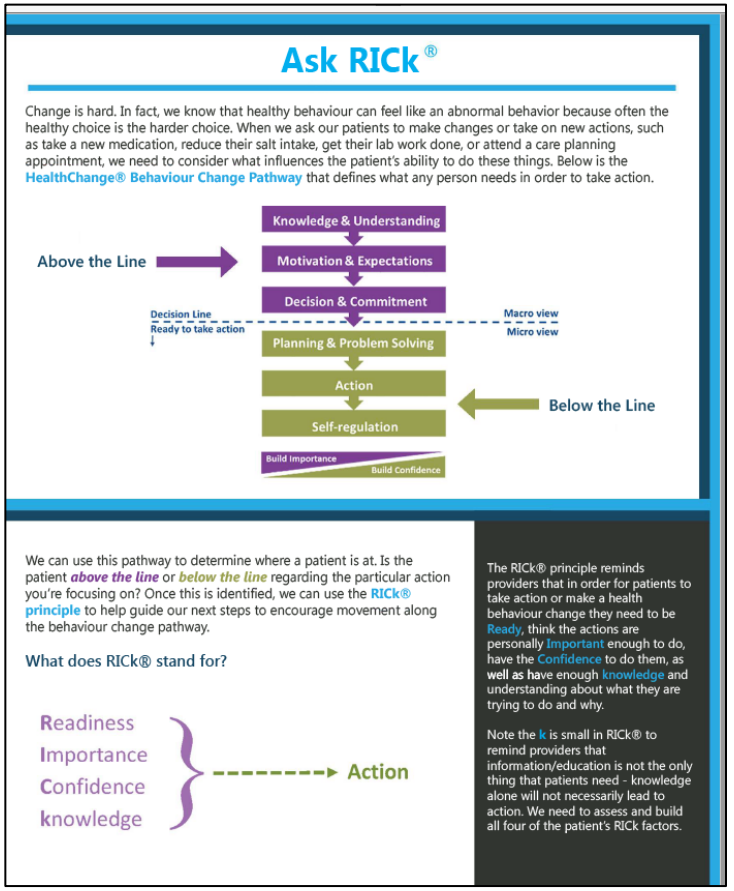
2. The Why:
Ask: *How does having (the condition) impact you personally? How does (the condition) impact the things that are personally important to you (ie: family, friends, work, social life)?*

Condition Management

3. What:
Ask: *I don't want to cover information you're already aware of. So could you tell me what you already know about the things a person with (condition) can do over time to have better health?* Fill in any gaps in knowledge of the general treatment, lifestyle and referral categories and correct any misinformation.

4. Why
Ask: *If you work on these things, how could it have a positive impact on the people in your life or the things you really value? Would there be any benefit to you in the long term?*

[1] A Vision for a Health Literate Canada :Report of the Expert Panel on Health Literacy. Rootman & Gordon-El-Bihbety (2008). Canadian Public Health Association.
[2] https://www.canada.ca/en/public-health/services/chronic-diseases/health-literacy.html
[3] Report on the Council of Scientific Affairs, Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, AMA. JAMA, Feb 10, 1999.



Ask RICk®

Change is hard. In fact, we know that healthy behaviour can feel like an abnormal behavior because often the healthy choice is the harder choice. When we ask our patients to make changes or take on new actions, such as take a new medication, reduce their salt intake, get their lab work done, or attend a care planning appointment, we need to consider what influences the patient's ability to do these things. Below is the **HealthChange® Behaviour Change Pathway** that defines what any person needs in order to take action.

We can use this pathway to determine where a patient is at. Is the patient ***above the line*** or ***below the line*** regarding the particular action you're focusing on? Once this is identified, we can use the **RICk® principle** to help guide our next steps to encourage movement along the behaviour change pathway.

What does RICk® stand for?

Readiness
Importance
Confidence
knowledge
→ Action

The RICk® principle reminds providers that in order for patients to take action or make a health behaviour change they need to be Ready, think the actions are personally Important enough to do, have the Confidence to do them, as well as have enough knowledge and understanding about what they are trying to do and why.

Note the k is small in RICk® to remind providers that information/education is not the only thing that patients need - knowledge alone will not necessarily lead to action. We need to assess and build all four of the patient's RICk factors.

YouTube CA

Tools Available on TOP Website

Test Box 3

- Test Box 3 - Guide for Coaches
- Test Box 3
- Third Next Available (TNA) for Coaches | Slide Deck
- Toolkit for TNA Indicator
- Team Roles & Responsibilities
- Focus on Health Literacy
- Ask RICk
- EMR Advanced Directives - ACCURO
- EMR Advanced Directives - MED ACCESS
- EMR Advanced Directives - WOLF
- EMR Advanced Directives (coming soon)

http://www.topalbertadoctors.org/pact/toolsresources/

Tips for Coaches

Review current clinic template. Are targeted PBPs reflected?

Explore opportunities to make small changes. Use “how might we” phrasing.

Encourage use of a PDSA approach. Consider involving patient reps in the process.

Identify potential barriers to change. Talk about risks and benefits.

Questions/Discussion

Team Roles & Responsibilities

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Review the process

Patient Name:	Preferred Name:
AB Health Card No.:	Date of Birth:
Primary Care Provider:	Primary Provider Contact No.:
Emergency Contact:	Contact No.:

This document was created on: *and last updated on:*

Introduction to Your Care Plan and Care Planning Visit

During the course of this visit, this document (called a care plan) will be filled out by you and your health care team. A care plan is useful when you have several people involved in your care or you have ongoing health conditions. It helps keep everyone on the 'same page' as to what matters to you (your goals, values and preferences). It also helps keep track of what you and your healthcare team have planned or are working on for the next 12 months to improve your health and wellbeing.

It is designed to help everyone involved in your health to know:

PART A: Medical Summary

In order to better understand your health conditions and how you are currently managing them, questions about your health, medications, medical history, and treatments, etc. are discussed in the section below.

Current Health Conditions

Please name your current health conditions. What do you know about them? What more would you like to know about them?

Impact of Health Conditions

How do your health conditions impact you, your daily life and the things that are important to you (e.g., medication cost, personal and work obligations, transportation)?

Health Target(s)

Specific tests are used to help understand whether a health condition is well managed. Understanding where your numbers are now and what you can work towards will help ensure you can achieve what is important to you.

Test Results	My Current Number	Where I Need to be
BMI (height and weight calculation)		
Blood Pressure (BP)		

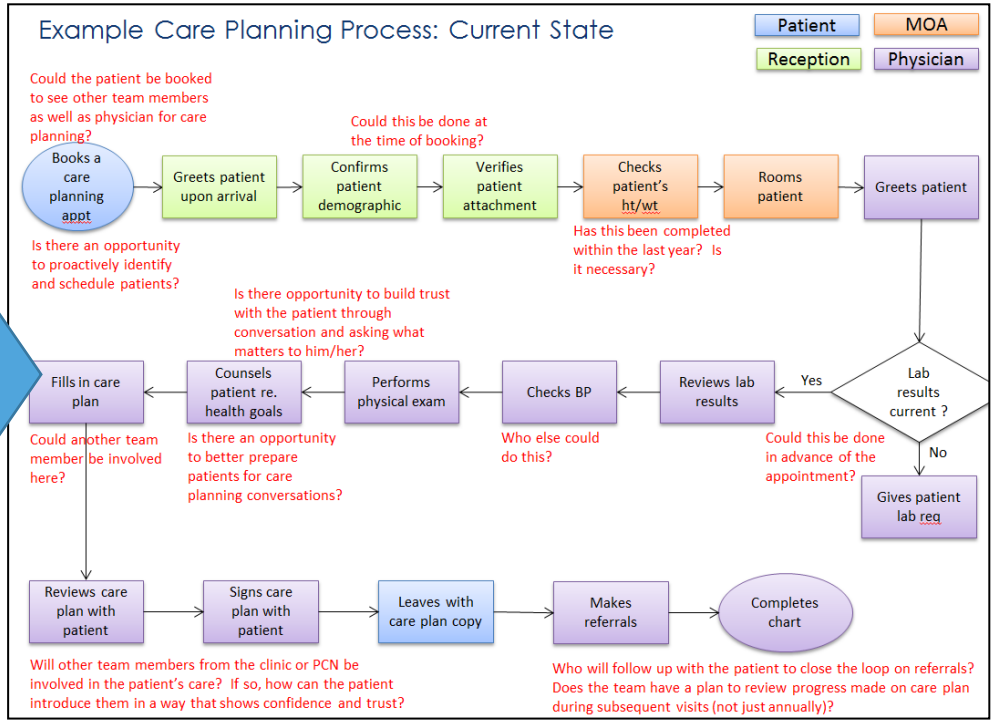
Current Medications

Please name the medications you are currently taking. How and why do you take them?

Medication	Dosage	When I Take It	What I Take It For

Past Medications

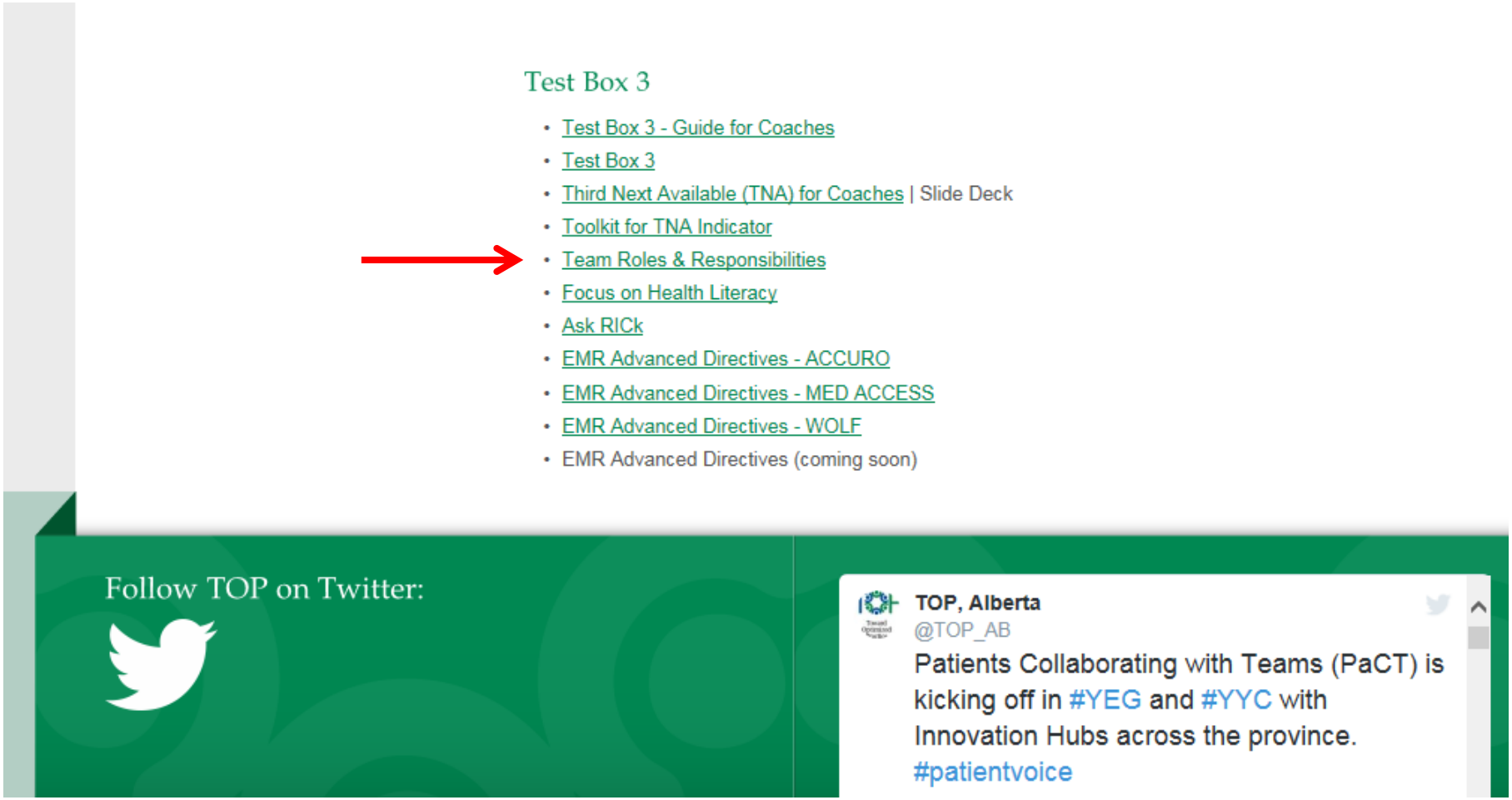
Are there any medications that you have taken in the past that you want your doctor to be aware of (e.g., failed medications or cases where one medication was replaced with another medication)?



Roles & Responsibilities Tool

	Process Steps		Who? could do it (in scope)	has interest/ experience/availability	RESPONSIBLE	CROSS-TRAIN
ID	Identify patients for care planning (CP) appointments	Could benefit (new)				
		Due (recurrence)				
	Contact patient to offer care planning appointment (explain benefits, etc.)					
PREPARE	Update EMR from Netcare/other					
	Invite patients for CP appointments					
	Pre-populate medical history in care plan for review with patient					
	Determine labwork/tests needed in advance of appointment					
	Coordinate with patient to complete 'pre-work' (assessments, labs, etc.)					
PLAN	Review medical summary with patient (e.g., health conditions & targets, medications, allergies, family & medical Hx, care outside of clinic, modifiable risk factors, assistive devices)					
	Gather social history with patient (e.g., finances, housing, support systems)					
	Discuss and collaboratively prioritize goals and actions					
	Action plan with patient					
	Proactively plan for addressing barriers					
MANAGE	Plan for follow-up with patient					
	Follow-up with patient					
	Coordinate follow-up among team (internal)					
	Coordinate sharing of care plan with external care providers					

Tools Available on TOP Website



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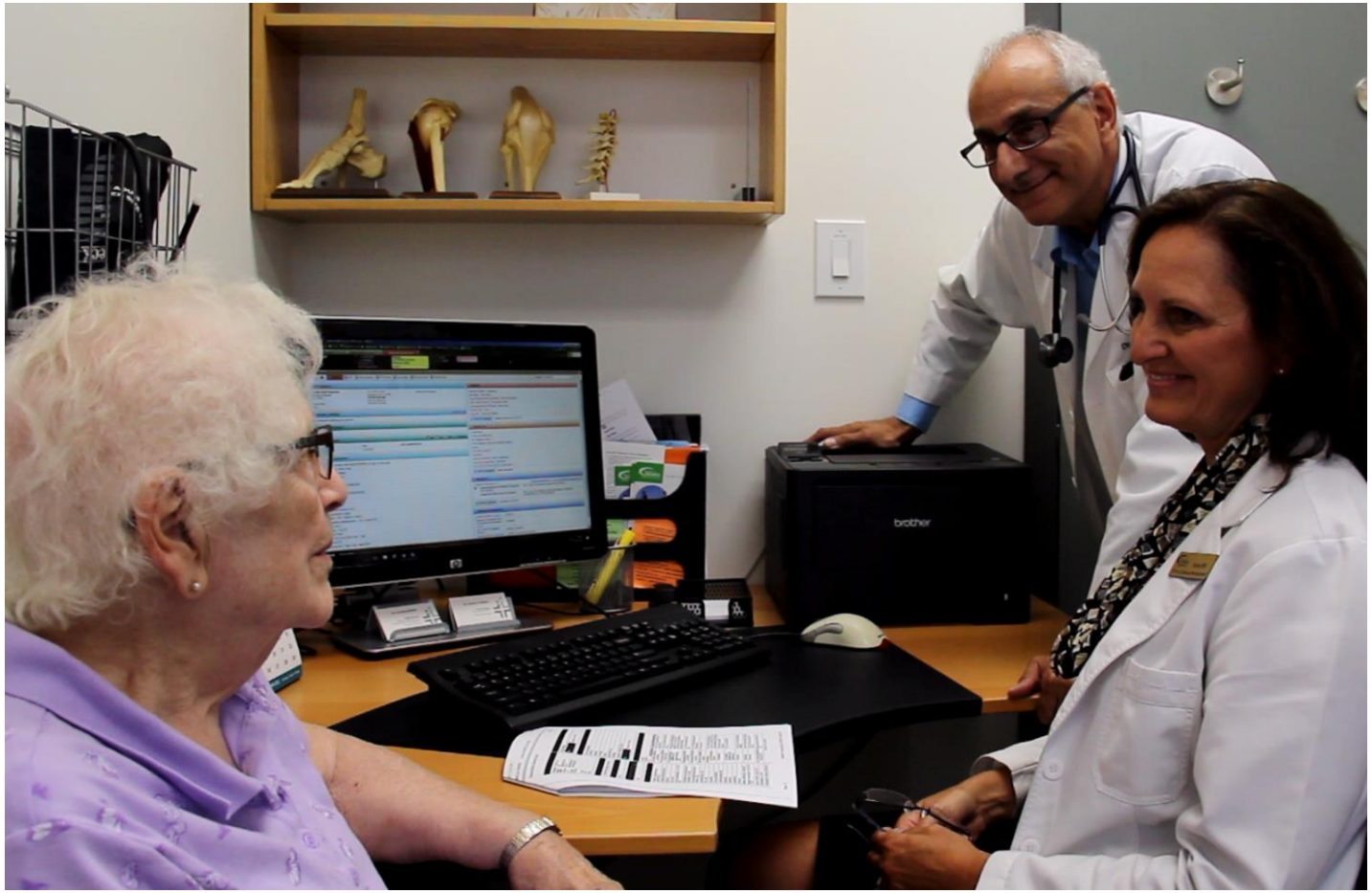
For Physicians: Warm Handoffs



Discussion Tool (from Test Box)

Example

'Traditional Handoff':

Physician: *Mrs. Cardinal, to learn more about managing your medications, I'd like to refer you to our PCN clinical pharmacist.*

'Warm Handoff':

Physician: *Mrs. Cardinal, to learn more about managing your medications, I'd like you to meet with Sue. She's here today - we can stop by and I'll introduce you on the way out. She's a fantastic pharmacist who works with us and knows all about the medications you're taking, and how to take them safely so that they work as well as possible. Our patients say that they find the extra support from Sue really helpful. She'll keep me up to date on what you talk about, and I'll still see you whenever you need to. How does that sound?*

Introducing Your Role with Intention

Discussion Tool (from Test Box)

Example

Introduction 1:
Hi Mr. Jones – I'm Paula the CDM-RN from the PCN. Dr. Chan asked me to see you about managing your diabetes.

Introduction 2:
Hi Mr. Jones – I'm Paula. I'm a nurse with special training in chronic diseases like diabetes. I work with several patients here at the clinic to help them better understand their conditions and what they can do to be as healthy as possible. Dr. Chan thought that you and I could work together on managing your diabetes. If you're interested in working with me, I'll make sure that Dr. Chan is kept up to date on what we discuss, and you can see him whenever you need to – just like always. My role isn't to tell you what to do. Instead, together we can find options and strategies that will work for you in your unique situation. Does that sound alright?

Questions/Discussion

Data Entry and Standardization

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(More) EMR Standardization

Continuing to focus data standardization efforts on the fields in the care plan template

In this section:

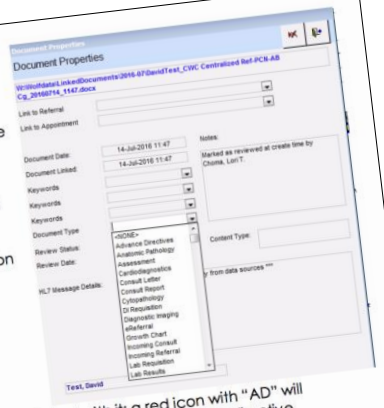
- Health Targets
  - BP, BMI
- Problem Lists
- Advance Care Directives

New EMR Guide Content

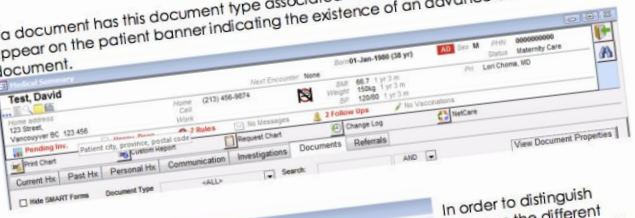
Filing Advance Directive Documents

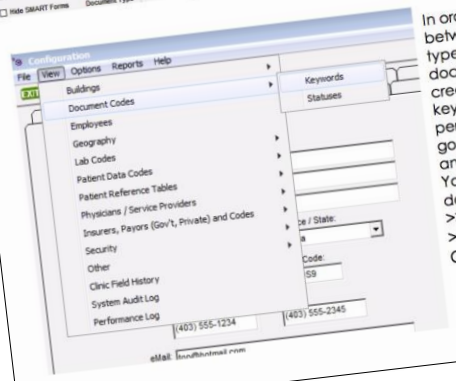
For advance directive documents brought to the clinic, or created at the clinic with the patient, you will want to scan and save them into the EMR. In Wolf EMR, there is a **"document type"** called **"Advance Directives"**. This can be selected when an advance directive document is saved.

In the picture to the right, it is the first option in the drop-down list.



If a document has this document type associated with it; a red icon with "AD" will appear on the patient banner indicating the existence of an advance directive document.

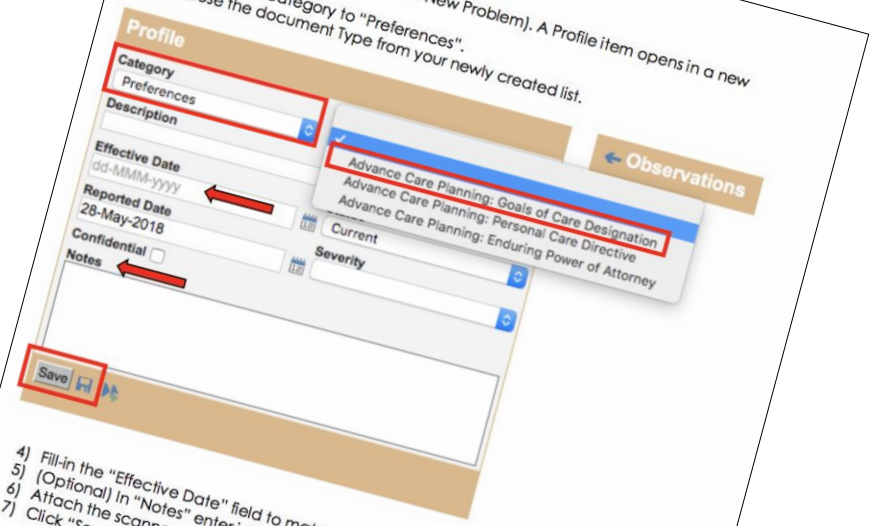




In order to distinguish between the different types of advance directive documents, you can create 3 new document keywords for each of personal care directive; goals of care designation; and, power of attorney. You can configure document keywords by >>Configuration menu >> View >> Document Codes >> Keywords

Creating a Profile Entry from the Profile Tab:

1) In the Profile tab, click (Create New Problem). A Profile item opens in a new window.
2) Change the Category to "Preferences".
3) Choose the document Type from your newly created list.



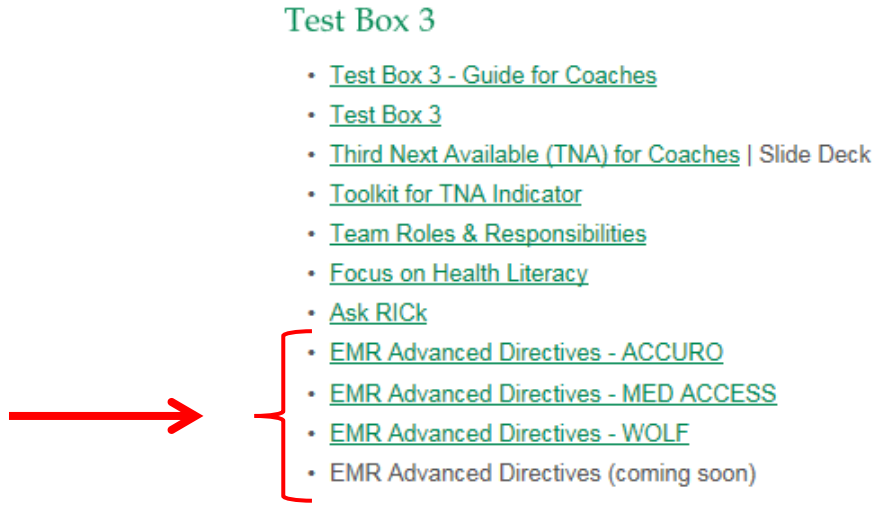
4) Fill-in the "Effective Date" field to match the date that the document was signed.
5) (Optional) In "Notes" enter information to display in summary view (e.g. M1)
6) Attach the scanned Advance Care Planning document to the profile entry.
7) Click "Save".

Expiry of a Profile Item:

When a newer version of an Advance Care Planning document is to be entered, any previous entry should first be expired.

1) In the Profile tab, click (Edit) on the line which corresponds with the item that is to be expired.
2) In the Status field, select "Past" from the dropdown.
3) Click "Save".

Tools Available on TOP Website



http://www.topalbertadoctors.org/pact/toolsresources/

Filing & Searching the Care Planning Documents

- Standard Naming Convention
- Dating convention
- Searching documents

We want to hear from you if you encounter challenges with managing versions of the care planning template.

Questions/Discussion

What's next….

PaCT
Patients Collaborating with Teams

Accelerating Primary Care Conference

What matters most to patients, providers and the system when it comes to continuity of care?

Important dates ahead

- Test Box 3 materials
  - www.topalbertadoctors.org/pact
  - "Tools and Resources"
- Test box delivery to clinic teams
- Test Box 3 Share & Learn webinar: **July 26, 2018**
- Test Box 4 Coaches' Prep webinar: **August 2, 2018**