Readiness Activities for Innovation Hubs: July – September 2017

Welcome to the Patients Collaborating with Teams (PaCT) initiative! As an Innovation Hub, you join a cohort of energized and capable PCNs, committed to improving care planning processes for patients with complex health needs.

We are slated to launch in October 2017 as a collective group of Innovation Hubs. In the meantime, we share with you a set of readiness activities to help PCNs and participating practices get ready for the launch. As a PCN, you can use this checklist to guide your work with your participating practices. It may not be feasible to complete all suggestions before the launch, but working through this will optimally set you up for success in October. We hope to learn from you which of these activities are most needed, what we have missed and your experience in working with member practices to set the stage for success.

The readiness activities are divided into two categories – one set for PCNs and one set for the participating practices. Within each category, there are two sections, a Part A and a Part B. It is anticipated that Part A activities will be worked on from July to mid-August and Part B activities will be worked on from mid-August through the end of September. These timelines will vary for each PCN and their participating clinics.

The main readiness activities include:

- Recruitment of PaCT champions at the PCN level
- Recruitment of clinic improvement teams at the practice level, including a patient representative.
- Identification and collection of baseline measures.
- Identification of a population or populations of focus for care planning using clinical team judgement and simple search criteria, including priority patients within that population.
- EMR optimization to reliably and continuously identify patients with complex health needs based on clinical criteria, risk factors and utilization parameters.

	Primary Care Network (Part A)
Yes / Working On / Not Yet	
	Recruitment
☐☐☐	Identify PCN champions for PaCT – including a clinical lead/physician lead and an improvement facilitator (IF) lead • These lead resources will be essential to support practices in implementing PaCT but also support ongoing spread of PaCT throughout your PCN. • The leads are expected to be participants in Phase 1 and will likely grow in their role as leaders over the first year.
☐☐☐	Recruit desired number of clinics and physicians within those clinics. We recommend two to six clinics to start depending on capacity (e.g. IF support).
☐☐☐	Identify and assign PCN IFs to the clinic.
☐☐☐	Discuss opportunities to work with your local AHS leaders and related AHS program teams to support your population of interest.
	Evaluation and Measurement
☐☐☐	Identify your PCN evaluator and meet with PaCT evaluation team to identify initial measures.
	Spread
☐☐☐	Prepare a plan to spread PaCT– how many clinics and physicians are in your PCN? How many would you like to see enroll in PaCT over time? In what time frame?
☐☐☐	Think through the strategies you will use to spread promising practices within your PCN.

	Primary Care Network (Part B)
Yes / Working On / Not Yet	
	Recruitment
☐☐☐	Identify training needs of PCN team members to support participating teams.
☐☐☐	Plan to attend training opportunities provided by PaCT initiative.
	Evaluation and Measurement
☐☐☐	Establish processes to gather measures.
☐☐☐	Track baseline measures prior to launch.
	Spread
☐☐☐	Embed PaCT into relevant strategic and business plans for the PCN.
☐☐☐	Establish processes to provide regular updates to the PCN Board, leadership, clinics and zone.

	Participating Practices (Part A)
Yes / Working On / Not Yet	
	Set the Stage for Success
☐ ☐ ☐	Introduce PaCT and the model care planning process to clinic teams.
☐ ☐ ☐	Share key supports available through PaCT, including the opportunity to collaborate with other clinics in the province.
☐ ☐ ☐	Introduce the concept of including a patient on the PaCT improvement team.
	Recruitment
☐ ☐ ☐	Identify an improvement team at the clinic that represents all areas of the clinic. At minimum, that would include one physician, one other co-located health professional, MOA and/or receptionist and a patient.
	Assess Readiness to Begin
☐ ☐ ☐	Identify which EMR(s) are used in each of the clinics and the EMR champion for each clinic.
☐ ☐ ☐	Complete **STEP Tool Checklist** *(Must be able to answer 'Yes' to all points in Level 1):* http://www.topalbertadoctors.org/file/step-checklist.pdf
☐ ☐ ☐	If applicable, support additional panel work to increase readiness.
	Identify Patients with Complex Health Needs – Rising Risk, Not Managed
☐ ☐ ☐	Discuss with participating clinics the opportunities to search for patients who might benefit most from care planning due to complex health needs that are not well managed.

	Participating Practices (Part B)
Yes Working On Not Yet	
	Establish Improvement Team Meetings
☐☐☐	Discuss expectations for meetings (including agenda creation, frequency, team roles).
☐☐☐	Determine facilitation expectations and team norms.
☐☐☐	Review basics of improvement methodology (e.g. PDSAs) with team members.
☐☐☐	Identify ongoing communication strategies with others at the clinic.
☐☐☐	Invite a patient representative to be part of the improvement team.
	Assess Readiness to Begin
☐☐☐	Review current care planning process and identify areas that are working well.
☐☐☐	Identify current team roles and responsibilities as it relates to your care planning process and opportunities for shared responsibility.
☐☐☐	Review Patient-centred Interactions and Team-based Care sections of PMH-Assessment, and guide team to consensus: http://www.topalbertadoctors.org/file/pmh-assessment-for-practices--phase-2.pdf
☐☐☐	Assess current care plan templates and introduce PaCT care plan template where appropriate (PaCT template will be provided).
☐☐☐	Identify training needs and opportunities for team members.
☐☐☐	Plan to attend training opportunities provided by PaCT initiative.
	Identify Patients with Complex Health Needs – Rising Risk, Not Managed
☐☐☐	Support practices in developing processes to identify patients with complex health needs and record it in the EMR: • Start by interviewing providers and teams to generate a list of patients that are top of mind. • Review a list of patients over 75 years with no clinic visits in the past year.
☐☐☐	Request or review HQCA reports to identify population of patients with complex health needs within the practice panel (e.g. CRG 6-7 patients, no visit within last year).
☐☐☐	Consider identification guidelines provided by the TOP EMR team for the population of focus: • Search using agreed parameters. • Team review of list to prioritize patients for care planning. • Document in the chart, in a standard way, that these patients have "complex health needs" and would benefit from the model care planning process.
☐☐☐	Identify standardization needs in data entry and begin to implement with team.
	Patient Engagement
☐☐☐	Support clinic improvement teams in selecting patient representatives to be part of the improvement team.