CARE PLANNING CHANGE PACKAGE
(adapted from PaCT)

Purpose: To assist primary care clinics in optimizing a care planning processes for paneled patients with rising complex health needs.

Aim Statement: By X date X clinic team will have completed X # of care plans using a patient-centered approach.

Outcome Measure: # of patients with rising complex health needs with a documented care planning offer within the last 12 months.

Balancing Measure: Time to third next available appointment.

High Impact Changes	Potentially Better Practices	Process Measures	Tools
Improve the patient experience	Establish a multidisciplinary quality improvement team and consider including a patient advisor	Regularly scheduled team meetings	Patient Representative Guide
Identify paneled patients for care planning	Prioritize and select a patient population for care planning	Definition of eligible patients	HQCA Primary Healthcare Panel Report Identifying Patients with Complex Health Needs
	Generate lists of patients eligible for care planning and review as a team	# of patients eligible for care planning	EMR Guide
Optimize care planning processes	**Prepare for care planning**		
	Define and coordinate care team roles, processes, and interactions		Team assessment – behaviours old to new Roles and Responsibility Guide Process Map Guide Introducing team members with intention
	Offer eligible patients a care planning appointment and invite them to bring a trusted friend or family member to the appointment	# of patients offered care planning	Scripting

continued over →

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High Impact Changes	Potentially Better Practices	Process Measures	Tools
Optimize care planning processes (con't)	**Plan the care**		
	Test a process for asking patients what matters to them		
	Engage the patient in the care planning process and setting patient-centered goals	# of patients with care plan completed in last 12 months	Care planning template Setting Effective Patient-Centred Goals Guide
Standardize documentation	Create processes in the EMR to identify the patient as part of a specific population for care planning	# of patients eligible for a care plan	EMR Guide
	Document all aspects of care plan in care plan template	# of patients with care planning template in chart	Care Planning Template
	Use reminders in your EMR to establish a process for care planning with outreach and opportunistic strategies for follow up activities	# of patients with care plan completed due for a follow up	EMR Guide
Coordinate care in the medical home	Ensure completed care plan is made available to all team members who care for the patient within the medical home	# of other providers the care plan has been shared with	Sample Huddle Checklist
Coordinate care in the health neighbourhood	Provide the patient with a copy of their care plan (if not connected in patient portal)	Care plan printed for patient	
	Establish a process to share the care plan with other providers outside of the primary care clinic (AHS, specialty programs, specialists, community, etc.)	# of other providers the care plan has been shared with	Process Map Guide