Frequently Asked Questions about PaCT

Patients Collaborating with Teams (PaCT) has started testing potentially better practices - Phase One is underway with seven Innovation Hubs (PCNs) across the province. From Fall 2017 - Fall 2018, the Innovation Hubs will be testing ways to implement the model care planning process in their member practices. Stay tuned for regular updates to supplement this FAQ.

To jump to the question you are most interested in, use the table of contents (ToC) on the next page to click on the topic of interest. If you have any questions about PaCT not addressed here or would like to speak with a team member about the initiative, contact us at pact@albertadoctors.org.

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Do you have questions not answered here?

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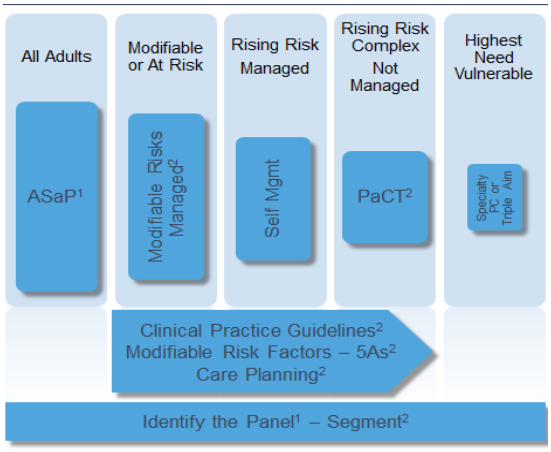
What is PaCT?

PaCT (Patients Collaborating with Teams) builds on the foundational work underway in Primary Care Networks (PCNs) and member clinics in implementing the Patient's Medical Home. It adds to improvements in access and screening care, and in identifying and maintaining patient panels.



Further, PaCT will address improvements to care for another, specific group of patients within primary care clinics; patients who require significant support to maintain their health because they are at risk for or have complex health needs.

PaCT is a partnership with Primary Care Networks (PCNs), the Alberta Medical Association - Toward Optimized Practice (AMA TOP) and Alberta Health Services (AHS) supported by patient representatives, the Health Quality Council of Alberta (HQCA) and the Alberta Cancer Prevention Legacy Fund (ACPLF).

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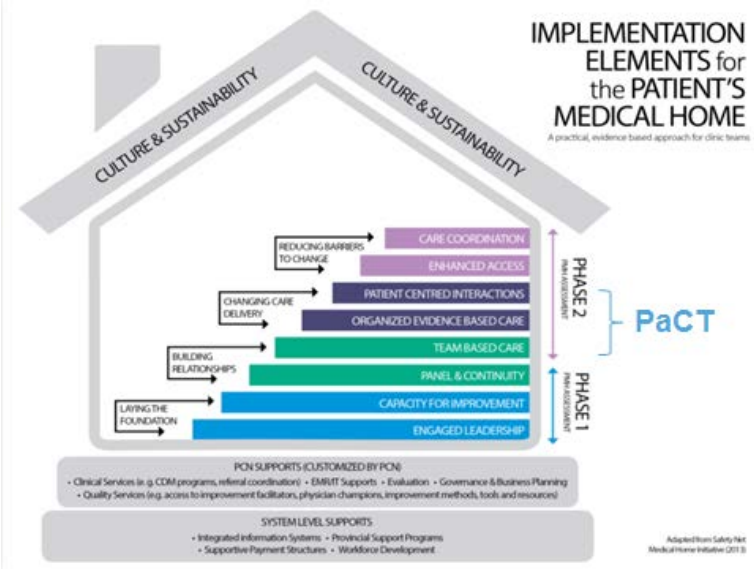
Why is PaCT important?

PCNs have devoted significant resources, including team members, to care for patients with complex health needs. As the demand continues to grow, we need to try new evidence-based ideas to systematically address care planning.



Building on the panel and screening work already underway in Alberta, PaCT will support PCNs and their member clinics in patient-centered care planning with patients already identified as being part of a physician's panel.

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Updated: September 26, 2017

What is Phase One?

For the first year (until the fall of 2018), seven (7) PCNs in four (4) zones have agreed to be an "Innovation Hub" and work with some of their member practices to test ideas designed to implement the model care planning process.

With support and guidance, each Innovation Hub will develop adaptable, but systematic processes that support member clinics. The Innovation Hubs will share their activities, ideas, and innovations in the care planning process to spread promising ideas to other PCNs and member clinics.

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When will PaCT be operational?

Phase One, testing of potentially better practices, is underway until the fall of 2018. After testing ideas in the first year, all PCNs will be invited to participate in either Phase Two (fall 2018 - fall 2019) or Phase Three (fall 2019 to fall 2020).

Timeline	Activity
Fall 2017 – Fall 2018	Phase One: Innovation Hub Changes tested, refined and implemented
Fall 2018 – Fall 2019	Phase Two: Open to all PCNs Changes tested, refined and implemented
Fall 2019 – Fall 2020	Phase Three: Open to all PCNs Changes tested, refined and implemented

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What model is PaCT based on?

A made in Alberta model for care planning was developed by the HQCA and a group of family physicians. It is based on evidence in the literature and was validated through interviews with physicians and team members. It is called the Model for Care Planning Process and has been used in the design of PaCT.

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What is the Model Care Planning Process?

Care planning is a process where healthcare professionals and patients collaboratively create an action plan to achieve the goals or behaviour changes most relevant to the patient.[1] A **care plan** is the document, written or electronic, that records the outcome of care planning.[1] Care planning is usually done to improve patient self-management and to improve communication and coordination between multiple healthcare providers involved in the care of a patient with complex health needs. When done well, care planning:

- Is proactive and anticipatory
- Is a team activity with defined roles and tasks for each healthcare team member
- Promotes shared decision making which is an essential aspect of a true collaborative process
- Promotes evidence-based care while respecting patient preferences
- Supports patients to take an active role in managing their health

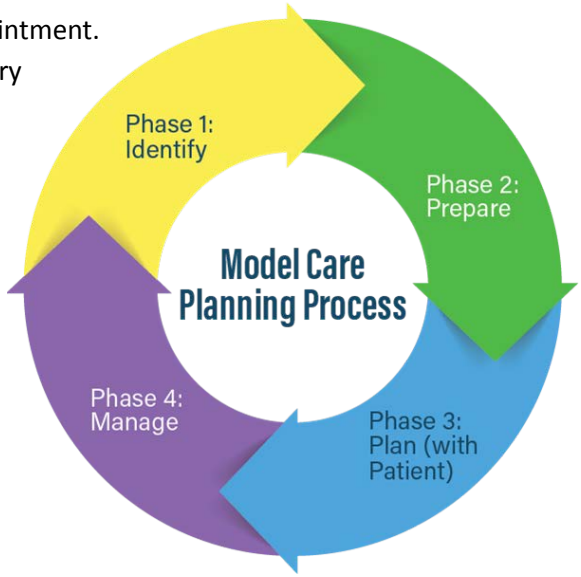
Care planning improvements target the four phase of the care planning process model and will consider which process changes are required to support the team approach – who does what, when, and how.

Phase 1: Identify – Determine which patients are most likely to benefit from comprehensive care planning and arrange a care planning appointment.

Phase 2: Prepare – Update the patient profile, form a preliminary medical care plan for discussion with the patient, and select patient assessment tools, if needed.

Phase 3: Plan – Complete patient assessments, develop a shared understanding (patient knowledge about their condition, values, beliefs, concerns and outcome preferences), set goals collaboratively, and develop an action plan for both the patient and team.

Phase 4: Manage – Take action as per the plan and follow-up to support the patient in their self-management activities. Review and revise the plan at each visit.



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What is meant by patient co-design?

Patient co-design means to collaborate with patients in the various design elements that ultimately impact the outcome of their care. To do so, PaCT is asking PCNs to include patient representatives in the development of their local strategies.

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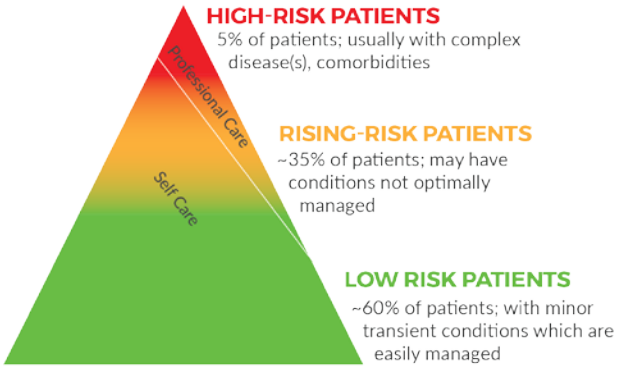
[1] Burt J et al. Care plans and care planning in long-term conditions: a conceptual model. Primary Health Care Research & Development 2014;15:342-354.

What does a "patient with complex health needs" mean?

The definition of a patient with complex health needs will be determined by each primary care team based on criteria meaningful to their clinic. It is estimate that 15% - 35% of rising risk patients may not have their conditions optimally managed.

Primary care teams may consider focusing on those patients who screen positive (through ASaP or other means) on some modifiable risk factors, or those with multiple chronic conditions and other factors impacting health outcomes. PaCT will provide guidance on how teams might use search parameters within the EMR to find those who are the focus of the team's plan.

As with all improvement strategies, we will encourage primary care teams to start with a few patients and over time broaden their reach.



15% - 35% of rising risk patients may not have their conditions optimally managed.

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Why is PaCT targeted to PCNs instead of family physicians and clinics?

PCNs are already instrumental in supporting member clinics as they make improvements to care and implement the Patient's Medical Home. As with other improvements, provincial partners are committed to work with PCNs to further build capacity and develop expertise. This commitment, paired with PCN and physician leadership, will yield the most desirable outcomes.

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What if the PCN or clinic does not have health professionals co-located at the physician clinic?

Research in primary care identifies the importance of a team that works together side-by-side in providing care for a panel of patients, engaging in shared planning for patients and building trust in each other. In Phase One, the Innovation Hubs have been asked to co-locate team members on at least a part-time basis. In Phase Two and Three, we expect that what we have learned will be adaptable to all team compositions.

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Will participation in PaCT impact clinic or PCN resources?

Each PCN will need to answer this question individually as business and strategic plans may already include priorities for improving care for patients with complex health needs. If that's the case, working together may move you forward faster and support the priority for identified clinical work. Other PCNs may have defined other priorities for their clinical improvements in the next year or two. The PCN may consider how best to include further improvements to caring for those with complex health needs in future strategic and business plans when updating.

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How does PaCT fit with PCNe (PCN Evolution) and PMH objectives?

PCNe is laying the groundwork for every Albertan to have a medical or health "home" anchored by a physician with the support of a broader health care team for improved access, increased services and ultimately better care. In the PMH model, the patient's values, beliefs and wishes guide treatment plans co-developed with the physician and health care team. The patient is at the centre of a team-based approach to providing ongoing, timely, appropriate and comprehensive care. PaCT will help your PCN and member clinics achieve the goal of a medical home by supporting PMH implementation elements such as team based care, organized, evidence based care and patient centred interactions.

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How will engagement with AHS zone representatives help to strengthen a PCN's PaCT experience?

AHS zone representatives can mobilize resources to help strengthen partnerships with community-based programs and specialty services. Most often patients who have complex health needs are seen in primary care clinics and also by AHS services and programs. We need to jointly work to support patients across the continuum of care. AHS team members may add to the care plan when they are part of the patient's team outside the physician clinic.

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What are some of the key activities to prepare for participation in the future (i.e., Phase Two or Three)?

While the Innovation Hubs are testing ideas in the first year, there are important steps all PCNs can take to continue to support clinics in building the Patient's Medical Home. For example:

1. Implementing a written plan that supports member practice development as medical homes.
2. Increasing improvement capacity through Improvement Facilitator training. Contact TOP – top@topalbertadoctors.org.
3. Supporting member clinics as they identify patient panels and build strategies to maintain their patient lists. Contact TOP – top@topalbertadoctors.org.
4. Continuing to support member clinics in improvement activities such as ASaP to give teams practical experiences relevant to their clinical population. Contact TOP – top@topalbertadoctors.org.
5. Continuing to support primary care teams in improving access to services. Contact AIM Alberta http://aimalberta.ca/
6. Providing training opportunities to improve teamwork.
7. Training PCN and clinic staff in how to shift conversations to be more patient centred – e.g., HealthChange Methodology workshops. (contact AHS at http://www.albertahealthservices.ca/assets/info/hp/cdm/if-hp-ed-cdm-healthchange-training.pdf)
8. Becoming familiar with some of the community based and peer supports that are available to patients in your area for those living with multiple chronic conditions or other complex health needs. Some of these are AHS programs and services; others are health and social support groups. Contact AHS at Alberta Healthy Living Program: http://www.albertahealthservices.ca/info/Page13984.aspx

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