PaCT Innovation Hubs

Test Box #5/6 – Guide for Coaches

The Coaches' Webinar for test box 5/6 is scheduled for **October 25, 2018**, and the Share & Learn session with clinics will be incorporated into the Wrap-up/Celebration in-person event on **January 24, 2019 (Calgary & Edmonton)**. We're really looking forward to getting together to celebrate all of the hard work in developing an Alberta team approach to patient-centred collaborative care planning. We also know that there's more for us to learn and gather from you and your teams as we work to finalize the care planning package that will be offered to teams in the future. We're hoping that your teams will prioritize sending representation to the session to bring forward feedback and learnings. We also want to hear your and your team's thoughts and ideas about how we can spread this care planning approach broadly across primary care in Alberta.

The theme of Test Box 5/6 is **'Enabling Action'.**

To start, review the PBPs in the test box with the team. If they've already completed any of them, you can check those off. Consider reminding the team that PaCT Central will be interested to hear about how they incorporated these activities, and lessons learned - even if it occured in the past.

For the activities that the team is <u>not</u> already doing, select which ones they would like to test. (More in-depth descriptions of each activity and how to support the team follows.)

'Potentially Better Practices' to choose from:

- ☐ Continuity: informational & management
  - *Sharing the care plan document to inform care partners and invite input*

- ☐ Collaborative goal setting & action planning
  - *Efficient strategies for working with the patient to set effective goals and create action plans.*

- ☐ Coordinating care
  - *Ensuring that follow-up is planned and supported after care planning*
  - *Having strategies to organize and manage referrals*

- ☐ Using EMR reminders for follow-up
  - *Using the EMR to remind, or trigger, team members to follow up with the patient after care planning*

- ☐ Team reflection & maintaining momentum
  - *Looking back on what has been accomplished and planning to carry the good work forward*

Continuity: Informational & Management

Improving informational and management continuity can seem like an enormous and complex undertaking. This item in the test box encourages teams to take small steps in the right direction. As their coach, encourage the team not to feel overwhelmed. The first steps are small, and they can build over time!

Consider watching the embedded video with the team and discussing it. The featured physician, Sarah Smith, is not a PaCT innovation hub participant, but she is a local Alberta doctor who stumbled into sharing the care plan with an external provider, and ended up changing the way she approaches care planning as a result.

The key message for coaches with this potentially better practice is to make sure that the team starts small with their PDSA. Sometimes teams get enthusiastic and want to make bigger changes, which can result in a sense of overwhelm. Remind the team that one external provider for one patient who has a care plan is a great place to start. Over time, they can expand the process.

Once the team has selected the patient and the external provider related to that patient, help the team brainstorm and decide how they would like to invite input on the care plan. There are several options, and they may need to try out a couple before they find the one that works for them.

TIP

Once the team tests and decides to implement a process for sharing the care plan with other providers, encourage and assist the team to update their care planning process map to document the changes.

Collaborative Goal Setting & Action Planning

As highlighted in the last two testboxes, a well-designed care planning template or tool can help to translate patient-centred care into practice. This test box focuses on key considerations and potentially better practices for collaborative goal setting and action planning.

Goal setting and action planning is likely not a new concept to members of the clinic team. However, what may be new is the use of tools, tips and techniques introduced in the test box to efficiently and effectively co-create a goal that the patient wants to achieve, and related actions that help break down detailed steps. It's important to emphasize that collaborative goal setting and action planning can be effectively completed within the timeframe of a short consultation, and different team members can be involved in the work. A couple of videos were created and included in this test box to demonstrate how the collaborative goal setting and action planning conversation can sound using the PaCT care planning template as a guide. You may want to watch one or both of the videos with your team(s), and point out that the goal setting and action planning process in each takes approximately 6 minutes. (Not bad!)

Also be sure to take a look at the goal setting and action planning resource. It's important not to confuse an action plan with a goal. Working with patients to make an action plan will get them practicing the use of this valuable self-management support technique, and possibly lead to them using the technique between visits to set and accomplish other actions.

Care plan template and potentially better practices

Discuss as a team what factors or conditions help or hinder their ability to collaboratively set goals and actions with the patient. In particular, ask team members to reflect on what aspects of their current care plan template helps or hinders the conversations.

Encourage team members to view this short video "Patient-Centred Care Planning: Goal Setting & Action Planning". Discuss which highlighted practices would be beneficial for the team to adopt. Use a PDSA approach to test new team practices and explore opportunities to obtain feedback from patients.

Tips for creating successful action plans

Four key tips are highlighted within the test box.

1. Choose actions that are meaningful to the patient and make sense for their life
2. Identify and address potential barriers
3. Narrow in on specific behaviours or tasks
4. Check in on patient's confidence to achieve the goal and actions

The activities included in this section of the test box were designed to encourage clinic team members to reflect on their current practices and identify one or two actions they can take to enhance their practice and interaction with patients during the goal setting and action planning process. Encourage self-compassion during this reflection process and continue to facilitate a learning environment where it is safe to fail using a trial and error approach.

TIP

Many providers have experience with setting specific health-related goals with patients but they may not be familiar with digging deeper into an action plan. Normalize this change in practice and help build importance to go further than developing just a single goal statement with their patients. Discuss with the team how doing action planning can benefit the patient and help them achieve their goals.

Coordinating Care

If your team chooses to work on this item of the test box, as always, encourage them to start small and build their processes over time. Of all of the components of care planning, coordinating care can be one of the most challenging.

Encourage the team to use Question 1 in this section of the test box to start a conversation related to designating one member of the team for each individual patient to follow up on what happens after the care planning appointment - for the duration of the year. While this may seem like a lot, using the EMR as a reminder tool makes it simpler. For this reason, you may want to encourage your team to simultaneously work on the test box component entitled 'Using EMR Tools to Trigger Follow-up on Care Planning Activities'.

It's also important that the patient is made aware of what to expect after the care planning appointment. Having someone follow up may be a new experience. If the team has a patient advisor, it might be helpful to ask for their insight on the patient experience here.

Another aspect of this section is related to creating a list of referral resources and keeping it up to date. Encourage the team to use questions 2-4 of the "Test" section to drive discussion. The questions will stimulate thought about information would be valuable for them to have. For example, sometimes clinics hear that patients with a particular condition get more value out of one community program versus another. This may be discussed, but not documented, so other providers may inadvertently refer to the less effective program for that condition. Similarly, when looking for a program for a patient who has an immediate need, it may be helpful to know at a glance which ones have no wait times. Another patient may not mind waiting for a program that's conveniently located along a bus route.

Encourage the team to have a discussion about what would be helpful to them with referrals. What would make their part more efficient? How can they ensure their patients have the best experience?

Your clinic may also want to PDSA gathering feedback from patients after referrals have occurred – what worked and what didn't? Do they have any suggestions for making the process smoother? A patient advisor can provide their own insight related to referrals, but also to the clinic's process for surveying patients, e.g., Is the language understandable? Will it make sense to the average patient?, etc.

This is not necessarily an easy process, but even if the team can document and share the information that may be living in team member's heads, it's a great first step! As well, encourage the team to brainstorm about how they could use the EMR to help store and share information about programs and specialists that are referred to frequently.

Using EMR Reminders for Follow-up

Individual Reminders:

Most of the EMRs have individual reminder functions. Your team may be using a different way to communicate about patient needs (e.g. assigning tasks), and that's okay. As long as it is a standardized and reliable process that will work how you need it to for PaCT. Start the discussion with your team here about how they currently track individual patient care tasks.

Individual reminders are a great place to start if your team has not been using reminders at all. They lend themselves well to PDSA cycles and can be tested one at a time and ramped up as commonly recommended (e.g., try it with one patient, and if successful then 5, then 25, then scale).

Your teams will have to coordinate on:

- ***Who*** is responsible for developing the reminders?
  - *Is it done by the team lead for each patient?*
  - *Is it done by another team member who is likely not a part of the appointment with a patient? (This will require more coordination.)*
- ***When*** the reminders get created?
  - *The risk if not completed right away is the reminder getting lost. Develop processes*
- ***How*** the reminders get followed up?
  - *Depending on the EMR, it may or may not specify who on the care team is responsible for the patient follow up.*

Taking a PDSA approach will help to work through the processes above.

Population-Wide Reminders:

Many clinics who have participated in ASaP have probably used the population-wide reminders in their clinic. If they have, check in with the team on their experience of using them. Some teams may never have used them, others will have plenty of them in use already, while others may have tried them and had a negative experience.

As with the individual reminders, know your starting point. In any case, the suggestions apply to all teams regardless of their starting point.

1. Discuss when a population reminder is preferable over an individual reminder.

TIP: Follow up appointment reminders might be generated per patient. Consider if there is an event or a time frame after care plan development that you might put a reminder in for all care plan patients?

2. Once you decide to build one, decide whose job it is to action the reminder.
3. Discuss as a team (or a subset of the team) the criteria for the reminder.
4. Build the reminder one critierion at a time.
5. Test your reminders.

TIP: Start with your simple panel report - does it run correctly? Add another critierion to the reminder and study the results by doing a chart audit. Then add another on and repeat the process. The more criteria you have, the more likely the error. This might be a limitation of the search engine or indicate that data input for certain fields needs to be standardized.

6. Turn on the reminders with just one physician to test it for a few days.
7. Have someone gathering feedback on how well it is working.
8. Once the team feels comfortable that the reminder is working well, you can turn it on for more providers (let them know first) and start adding more as the team feels comfortable.

Team Relection & Maintaining Momentum

Well…that's a wrap! The last PaCt test box delivered to the PaCT innovation Hubs. This final section encourages teams to reflect back on their journey over the last year. Team-based reflection can be a powerful tool to reinforce new practices and apply insights to future work together.

Completion of this last section will be most valuable if all team members come together to do the activities. Consider throwing a team PaCT finale party with snacks and awards to get people all in one room to finish off this last component. Who says it can't be fun!

We recognize that getting everyone together can be a challenge for some clinic teams. If the stars aren't aligned, consider making alternative plans. One option could be to allow each individual to respond independently. Another option is to have a smaller representative group come together to do the work. For some activities, it may work for you, as the coach, to respond based on the input you received from the team to date. If you choose this last option, be sure to validate your responses with the team. We will leave this in your capable hands to make arrangements for this final section.

Please submit the team assessment to bonnie.lakusta@topalbertadoctors.org by November 30, 2018. Analysis of the aggregated responses will be included at the final wrap-up/celebration galthering, as well as in the evaluation report.

Final Share and Learn

For the wrap-up/celebration scheduled for January 24th, we would love to feature a story from each clinic team. How they share their story is up to them, and we encourage creativity! Perhaps it's related to a particular patient experience, and they bring the patient or capture their response on video. It's totally up to them!

We also want to have a 'show & tell' – teams can bring tools or resources that have proved valuable, or something they created or adapted for care planning. We'd really like to see what teams have done with the PaCT care plan template or see what template is working for them. In general, how has the work on PaCT resulted in improved efficiency and/or effectivenss?

Our goal is to 'harvest' the learnings and experience from the last year to use moving forward as we develop the provincial offering for collaborative care planning with complex patients.

It's truly been an amazing journey this last year. From the bottom of our hearts at PaCT Central we thank you for your dedication, patience and brilliance in helping to roll out this new model of delivery for improvement work. We wish you and your team much success as you continue to look for ways to better work as a team and partner with patients!