Innovation Hubs Test Box #1

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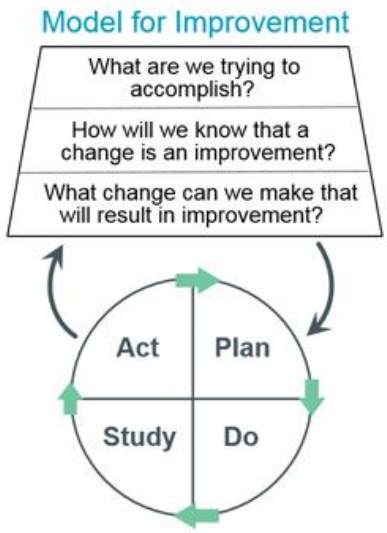
Writing an Aim Statement

What?

An aim statement clarifies a team's improvement goal. The aim should be time-specific and measurable, and it should also define the specific population of patients that will be affected. It answers the first question in the Model for Improvement:



Why?

Setting an aim statement requires teams to discuss and agree upon a common goal. This helps them to become aligned and clear on the intention. It also provides a visual reminder to help keep the group focused on the intent of the work.

Tips

It is strongly recommended that teams select this item from the test box, as it provides a strong foundation for the innovation hub work to follow.

A strong aim statement clearly defines:

- The patient population you are aiming to affect
- What you are specifically you are planning to improve
- How much you plan to improve it (baseline to goal)
- The date by which you plan to reach the improvement goal

While it's good to set SMART goals ((Specific, Measureable, Attainable, Realistic, Timely), it's also important to not limit the team by setting a goal that may be too easy to reach. Sometimes we don't realize how much is possible and we limit our success. Don't be afraid to stretch!

It's important to determine the baseline measure before starting to test changes. If you don't know where you started, it's hard to know how far you've come. It's also important to determine the baseline before writing the aim statement, since this helps to define the desired change.

Example:

We will increase the number of annual care plans initiated for patients 75+ years old who haven't had a visit in the past year from 41% (23/56) to 84% (47/56) by October 31, 2018.

PaCT Fact

An aim statement answers 'what?', 'by how much?', and 'by when?'.

Consider:

☐ Determining the baseline measure before making any changes.

☐ Setting a 'stretch goal' beyond results that should be fairly easy to attain.

☐ Revisiting the aim often – perhaps include it as a header on your meeting agendas, or display it somewhere that the team can see it.

Using the Current State Process Map for Care Planning

What?

The current state process map provides a visual record of the steps a team currently takes during a care planning appointment with a patient. It becomes a valuable tool for identifying opportunities for improvement.

Why?

The current state process map can have several purposes:

- Identify areas for improvement focus (e.g., bottlenecks, repetition)
- Develops a shared understanding of a process among team members
- A visual tool for training new team members in clinic procedures
- Clarify roles and responsibilities
- Identify steps where cross training would be valuable
- Pinpoint areas where measurement would be helpful

PaCT Fact

A process map allows each team member to see the 'big picture' and how their role fits in the process. It can increase understanding of the roles of others and foster mutual respect among team members.

The current state process map will be used in several test boxes, so it's an important foundational tool. As you test and make changes to your care planning process, consider updating your process map. At the end of the innovation hub year, you may have several versions of your care planning process map, each reflecting an update in your process as you test and adopt new approaches to care planning.

Tips

After the team has agreed that the process map accurately reflects the current care planning process, ensure that it is documented in a permanent way. This might mean creating a printable version using PowerPoint, MS Word, Visio, etc., or it could simply mean taping the post-it notes down on the larger sheet of paper or taking a picture and printing it.

Test

If you select this test box, review your current state process care planning map, and consider:

- ☐ Is there anything we do that doesn't add value for the patient or the team (e.g. repetition, unnecessary steps, etc.)?
- ☐ How do we ensure that the patient has all the information and understanding they need to decide to accept the offer for a care planning appointment? Will they have accurate expectations coming in the appointment? *(If not, consider reviewing the 'Scripting' section of the Test Box.)*
- ☐ Are there steps in the process that could be more patient-centered (e.g. extra waiting, unclear explanations on documents, sending the patient back for labs, etc.)?
- ☐ Are there steps in the process that could be done by another team member (e.g., someone other than the physician checking blood pressure, etc.)?
- ☐ Where do interactions occur in the current state process where the patient may have questions or require information? Do the team members potentially involved in those interactions have all the information they need to provide clear and consistent responses? *(If not, consider reviewing the 'Scripting' section of the Test Box.)*

Resources:

Sample process map
(for those using PowerPoint, can be used as a 'starting point' and adapted)

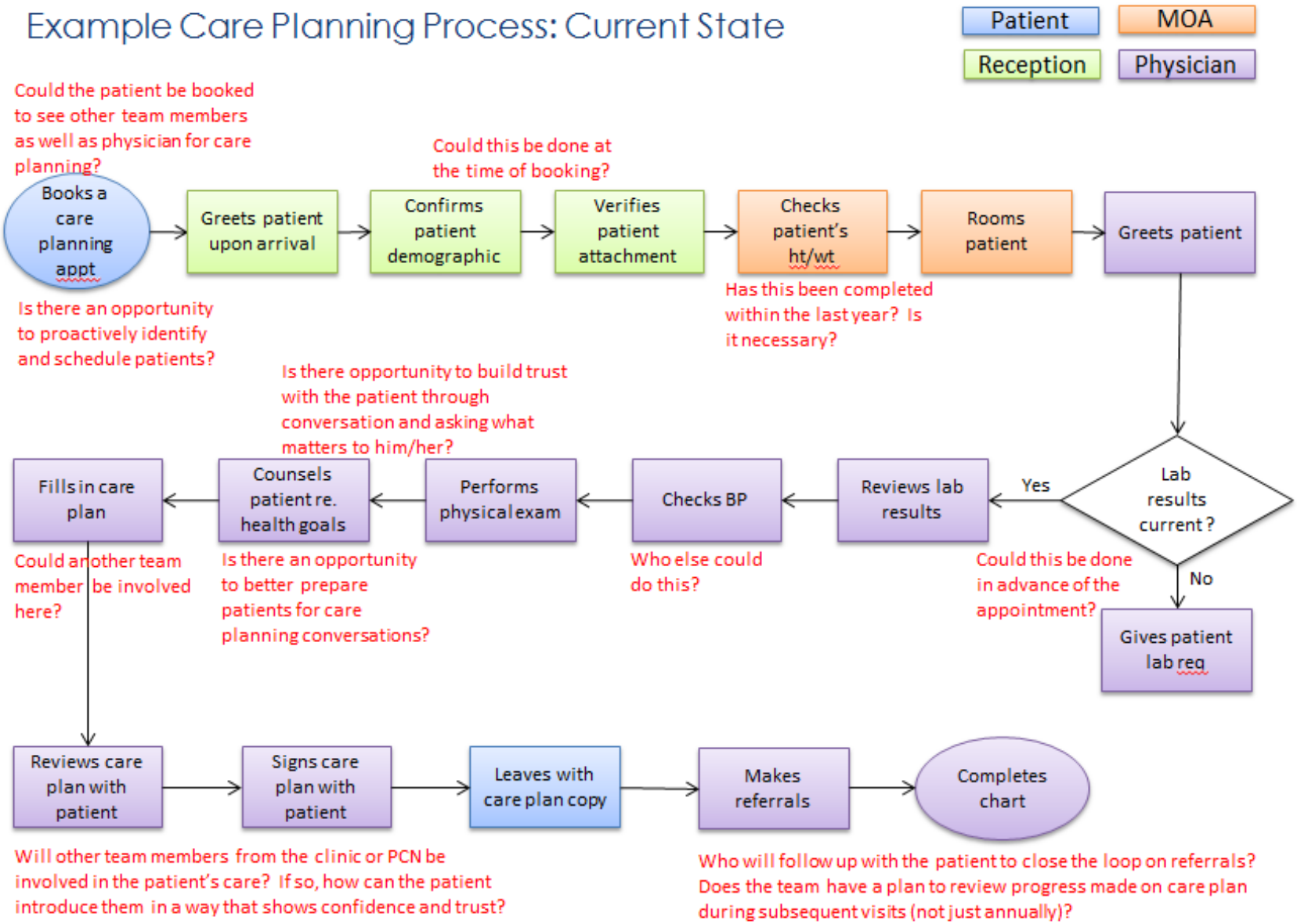
For information on how to create a process map, refer to:

Process Mapping Guide

Improvement Facilitator training materials

TOP Quality Improvement Guide: https://www.topalbertadoctors.org/file/quality-improvement-guide.pdf

Example Care Planning Process: Current State



PaCT
Patients Collaborating with Teams

Setting the Scene for Care Planning

What?

Setting the scene for care planning ensures that the physical space is set up, as much as possible, with the patient in mind. In particular, that the space is conducive to collaboration so that the patient can be fully involved and comfortable during the appointment. It also ensures that the patient has a solid understanding of:

- the purpose of care planning
- whom he/she may work with during the process
- what he/she can expect to happen and not to happen
- what he/she can expect as a participating member of the 'care team'

PaCT Fact

A patient representative on the team can give first hand opinions and feedback when planning tests of change.

Why?

When patients are comfortable and prepared for the care planning appointment, they are more likely to have a sense of involvement, trust and rapport with the team, which is critical for collaborative care planning. As well, patients may be more likely to keep (or show up for) appointments.

Test

For this test box, teams are encouraged to:

1. **Take an objective look at the physical space(s) where care planning occurs.**

   - Are there aspects of the physical environment that could be made more patient-friendly during care planning appointments?
   - Is there anything that may make an individual feel physically uncomfortable? Emotionally uncomfortable? Not part of the collaborative team?
   - Is the room where care planning occurs set up so that the patient can view the care plan as it is being developed?
   - Does the patient have what they need to be able to make notes for themselves? If not, will we provide paper and pens? Will we ensure the patient is asked and reminded to bring something to take notes with?
   - Do we currently invite the patient to bring a family member or friend, if they'd like? If they do, is there space in the room?

2. **Consider:**

   - If any member of the team were asked a question about care planning, would he or she be able to provide a consistent response that reflects the clinic's care planning process? Are we all clear on the purpose of care planning with our patients? What to tell the patient about what they can expect from the process? How the patient is involved in the process?
   - If not, how can we ensure that all team members are up to date on the clinic's processes and goals for collaborative care planning? *(Tip: consider reviewing the 'Scripting' section of the Test Box.)*

Resources:

HealthChange® Set the Scene and Explain Your Role

Scripting for Patient-centred Care Planning

What?

Scripting offers guidance for clinic team members to communicate with patients in an effective, efficient and patient-centred manner.

Why?

Scripting enables a care team to:

- Be consistent in messaging to patients around care planning among all members of the clinic team
- Reinforce a culture of patient-centred interactions
- Test and improve messaging as the team progresses through PDSA cycles
- Onboard new team members with ease

Test

If you choose to select this item from the test box, then as a team:

☐ Discuss how scripting is currently being used among team members.

☐ Consider which team members interact with patients around care planning and may need a script.

☐ Role-play each of the two examples of scripts for inviting patients for a care planning visit. Considering the following after each:

- What was positive about that call?
- What might be some potential drawbacks on that call?
- What might make it better?

☐ Create your own script for inviting patients for care planning and start your PDSA with one patient.

☐ Optimize the script and continue to test it with patients.

☐Consider other scripts to create around care planning.

Scripting elements to consider:

In-Person Scripts

1. Consider using 'key points' versus a word-for-word script so that the user sounds natural.
2. Practice ahead of time – don't read from a paper.
3. If the patient doesn't know you, make sure that you start by introducing yourself, including your role in the clinic.
4. If applicable, make sure the patient knows that you're conveying information on behalf of their physician or other healthcare provider.
5. Consider your language – are you using medical terminology or acronyms that may not be familiar to the patient?
6. Build in opportunities for the patient to provide input. *Example: Has someone already talked to you about this? Is this something you're interested in hearing more about? Does that make sense for you? etc.*

Telephone Scripts

1. Briefly review the patient chart beforehand, as it may not always be appropriate to phone. *Example: patient has dementia, language barrier, etc.*
2. Consider your language – will the patient understand what you're talking about? Are the words you're using familiar to them? *Example: "routine tests to keep you healthy and well" vs. "preventive screening maneuvers"*
3. Make sure you are actually speaking to the patient before you continue.
4. Identify who you are and the doctor or provider you're calling on behalf of.
5. Ask the patient if this is a good time to talk. If not, make arrangements to call back.
6. Be clear that the purpose of your call is not urgent – it's just a routine part of their care.
7. Don't imply that you've been looking in the patient's chart – the doctor reviewed it and asked you to contact the patient on his/her behalf.
8. Be clear about what is expected of the patient, for example:
    - Call back and ask for this person at this number between these times
    - Come to the clinic to pick up a requisition
    - Make an appointment with the physician or a care team member
    - Make an appointment at the lab/diagnostic imaging within a certain timeframe
9. Your script document could have ideas for handling different situations, should they arise. *Example: answering machine, chatty patient, clinical questions, etc.*

Example Script for Calling Patients re: Care Planning

Version A – Non-Patient-centred

"Good morning Mrs. Brown. This is Blue Meadows Clinic calling. You are overdue for a complex care plan visit. We have an appointment for you on December 19th at 2:00."

- Patient will likely ask if this is like a check-up.
- Response: "Yes, plus Dr. Green and his team will do a care plan for you. This visit will take about an hour. Dr. Green and his team will want to meet with you once per year for these visits."

"See you on December 19th at 2:00."

QUESTIONS TO CONSIDER:

- What was positive about this call?
- What might be some potential drawbacks about this call?
- What might make it better?

Example Script for Calling Patients re: Care Planning

Version B – Patient-centred

"Good Morning, am I speaking with Mrs. Brown? *(Yes)* Hi, Mrs. Brown - this is _____ from Dr. Green's office. I'm a Medical Office Assistant, and part of my role is to connect with patients over the phone on behalf of the doctors and team here at the clinic. Is this a good time for you to talk?

Dr. Green has asked me to call and invite you to come in for a 1-hour care planning visit with him and your health care team. Has anyone talked with you before about what a care planning visit is all about? "

Patient may say: **"No, they haven't. What's a care planning visit?"**

Possible Response:

- "I can explain everything to you. Would you like to get a pen and paper to jot down any notes as we talk?
- It's approximately a 1-hour visit for you to talk with your doctor and some members of your health care team, such as the nurse (anyone else?) about your health and what's important to you.
- It allows dedicated time for you to ask questions, tell them about your health goals, and discuss any concerns you may have. They'll also review your health history, the medications you take, and any recent test results.
- Together, you'll make up a care plan that fits your needs and lifestyle to help guide your health plans and decisions over the coming year."

Patient may say: **"Yes, I have one every 6 months with Dr. Green"**

Possible Response:

- "That's great to hear Mrs. Brown. Do you have any questions about the care planning visit?
- Would you like to book an appointment now for your care planning visit with Dr. Green?"

Patient may say: **"Is this is like a check-up?"**

Possible Response:

- "A check-up usually just reviews your physical health, but a care planning visit is much more in-depth, and the team will work with you to plan your health care needs for the coming year. *(Consider adding responses from above if the patient would like more detail).*"

"Do you feel you have enough information to book an appointment for your care planning visit with Dr. Green?"

- If yes, offer choices of dates and times and book appointment.
- If no, ask, "Can I answer some questions for you? Or would you prefer to meet with your doctor to discuss care planning and how it might benefit you?

Once appointment is booked:

- *Example Option:* "We would like you to complete a questionnaire prior to your visit that will help the team focus on what's important to you. I can send it out to you by mail or you can pick it at our office. When you fill it in ahead of time and bring it with you, it allows for more time to talk with your team during the hour appointment. Would this work for you?"
- *Example Option:* "Our team would like you to complete some lab work a week before your appointment so that we can go over the results with you when you come in. The lab results will help the team to understand what is going on for you and help us make some decisions together about your care. I can fax the form to the lab for you. Please call the lab to book an appointment to have the lab work done. If you have a pen I can give you the lab booking number now so you can call them to set that up. Would that work for you?"

Applicable to all patients:

- "Please bring in a list of all of your medications *(or the containers?)* with you to the visit. This would include everything you take: vitamins, supplements or herbal preparations, as well as any prescription medications. This will help your healthcare team to better understand what you're currently taking and how this may impact the rest of your care."
- "Some patients find it helpful to bring a friend or family member to their appointment for support. Please feel free to do so."
- "That's a lot of information all at once. Would you like me to summarize it for you? Would you like to write it down, or would you prefer a follow-up summary letter to be mailed to you? Please feel free to contact us with any questions."

"You have a 1-hour appointment booked to see your healthcare team on ___*(date)* at ___*(time)* for a care planning visit."

- *Example Option:* "I'll send you the questionnaire we spoke about. Please complete it and bring it along with you to the appointment."
- *Example Option:* "Please book an appointment to complete your lab work one week prior to your _____ (date) visit."

- "When you come here for your appointment, please bring a list of (or a bag with) all the medications and supplements you're currently taking.
- Does this work for you?
- If you have any questions that come up between now and your visit, please give us a call and we would be happy to help.
- Thank you for your time today. We'll see you on _____(date) at ____ time."

QUESTIONS TO CONSIDER:

- What was positive about this call?
- What might be some potential draw backs on this call?
- What might make it better?

Resources:

HealthChange® Set the Scene and Explain Your Role

Shifting the Conversation

What?

Truly collaborative and patient-centred care planning includes the patient as a member of the healthcare team. The first step is asking what matters to the patient. For example, if the patient says that being able to play with his grandchildren is most important to him, care planning can strike a balance between planning for managing his clinical issues and helping him reach his personal goals.

Why?

When the care team understands the patient's needs and desires, collaborating to design a care plan that is meaningful to the patient is easier. When patients can connect the goals of care with their own personal goals, they tend to be more motivated to take action and self-manage.

Test

If you choose to select this item from the test box, review your care planning process:

- ☐ Do you routinely ask the patient what matters to him/her? At what point in the care planning process? Could it be earlier?
- ☐ Where is the patient's answer documented? Are all involved team members aware of the patient's response?
- ☐ In what ways do you incorporate the patient's response in care planning?
- ☐ Are there other ways you can think of to elicit from the patient what matters to them (vs. asking verbally at the beginning of the appointment)?

If asking the patient what matters is new to your team, consider a PDSA of adding it to your existing process. Or, if you already ask patients what matters to them, consider testing other methods for determining and incorporating the patient's wants and desires for their health and life in the care planning process.

Standardizing Data Entry for Team-Based Care in PaCT

What?

Standardized data entry refers to deciding where and how information will be entered in the patient record so that the EMR can be optimized for care planning.

Why?

Standardized data entry will enable the care team to:

- Produce a list of all patients identified as having complex health needs
- Know where to consistently find information
- Create population-wide reminders for care coming/over due
- Map data directly to the care planning template, thereby reducing duplicate data entry
- Take quality improvement measures

Test

Discuss as a team areas where data entry is not yet standardized in your clinic. Select one or more items to work on. Some may be easy changes; others may take considerable effort and time. Consider using the Model for Improvement to guide your discussion and changes.

Questions for Teams:

- Consider the population you have identified for PaCT. Are you documenting which patients have complex health needs consistently so that you can produce a list of patients? Are you charting in your EMR in a standardized way that enables you to take your improvement measures?

  An example may be a patient population where you are using a risk assessment tool. Is the tool use being logged in such a way that it is searchable? Do you just need to know that the tool was completed or do you need to be able to search the result(s) of the tool? How and where is this being recorded, and is it reliably searchable?

- Below is a list of fields in the care planning template; most EMRs can be mapped to auto-populate these fields which reduces the need for duplicate entry (i.e. more work and more risk of error). Review and discuss which of these fields you are consistently recording in and confirm if the way they are

recorded can be mapped to the care planning template (assistance available in resources listed below).

An example is the use of the problem list. Is this area of the EMR being used consistently and kept up to date?

Resources:

The document "Guiding Principles for Effective Use of EMR for PMH Work" contains information on some of the topics outlined below. There are also EMR specific guides (coming soon) available that cover tips for each EMR. There is also a video series where many of the processes are outlined per EMR; please see the EMR Section of the TOP website and click on the tab for your EMR to access these.

Data entry fields to consider in your discussion:

General data entry:

- Scanning (see page 17 of the general guide)
- Manual labs (see page 17 of the general guide)

Data that most EMRs will map to the care planning template:

- Emergency contact information
- Current problems (see page 26 of the general guide)
- Current medications/failed medications
- Allergies
- Family medical history
- Significant historical medical events
- Tests and treatments
- Labs
- Diagnostic Imaging
- Modifiable risk factors (tobacco, alcohol, exercise, obesity (BMI), fruit & vegetable intake) (see page 22 of the general guide)

Other data items for consideration:

- Care team members
- Medical Team members
- Social history
- Medical and/or assistive device
- Personal care directives
- Goals of care
- Follow ups

Data items specific to the population you have selected:

- Results of predictive risk tool
- Hospital discharge summaries
- Other…

PaCT Fact

The data you get out from your EMR is only as reliable as the data that goes in. Standardized data entry by everyone who charts is critical for accuracy and reliability.