



PRIMARY HEALTH CARE
INTEGRATION NETWORK 

WHAT MATTERS TO HIM?

Patients Collaborating with Teams (PaCT) takes a proactive approach to enable patients to manage their care when they have, or are at risk for having, multiple chronic diseases or other complex health needs. PaCT takes the next step in the Patient’s Medical Home by furthering the panel and chronic disease management work already underway in PCNs and primary care clinics.

At the heart of PaCT, providers and their teams are supported to reach those patients that keep them up at night by shifting the conversation from, “What’s the matter?” to “What matters to you?”

BACKGROUND

-  Advances in evidence-based medicine create opportunities to improve care for patients with complex health needs.
-  Practice-level collaborative care-planning approaches are effective in supporting patients with complex health needs.
-  Research tells us that using team-based care improves patient outcomes.
-  ‘Many hands make light work’: When teams share skills and knowledge to care for those with complex health needs, the work is not as challenging for any one person.
-  Alberta data indicates that many practices have a significant number of patients with complex health needs who do not seek adequate care.
-  PaCT will build on panel identification and maintenance processes already embedded in practices and facilitate spread of excellent care processes to all primary care practices.

PaCT is a new joint initiative planned with patient representatives and the following partners to assist PCNs in support of practice groups:

- Alberta Medical Association (AMA)
- Alberta Health Services (AHS)
- Health Quality Council of Alberta (HQCA)
- Alberta Cancer Prevention Legacy Fund (ACPLF)

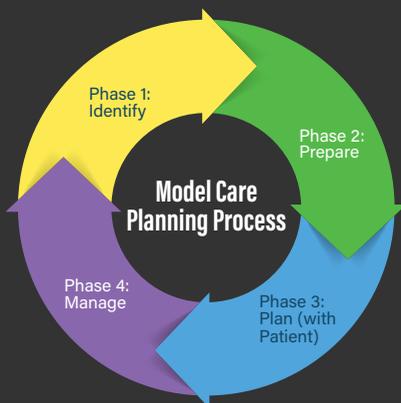


KEY SUPPORTS

-  Additional tools, resources and training to support patient collaboration to develop a meaningful, achievable care plan.
-  Practical, evidence-based tools that are relevant for both primary care and the patient, using a ‘whole person’ approach.
-  Support in optimizing the EMR as an effective tool for identifying and staying in touch with patients.
-  Ideas to further develop roles and strengthen the team.
-  Opportunity to collaborate with other participating practices across the province.
-  Guidance to optimize use of PCN Improvement Facilitators to support changes using evidence-based improvements.

MODEL CARE PLANNING PROCESS

A group of Alberta family physicians worked with the Health Quality Council of Alberta to develop an approach to care planning that could be used with all patients, but especially with those who have complex health needs.



1

Identify: Identify and select patients to whom comprehensive care planning will be offered

2

Prepare: Gather pertinent information to form a medical care plan outline; to be modified in discussion with the patient

3

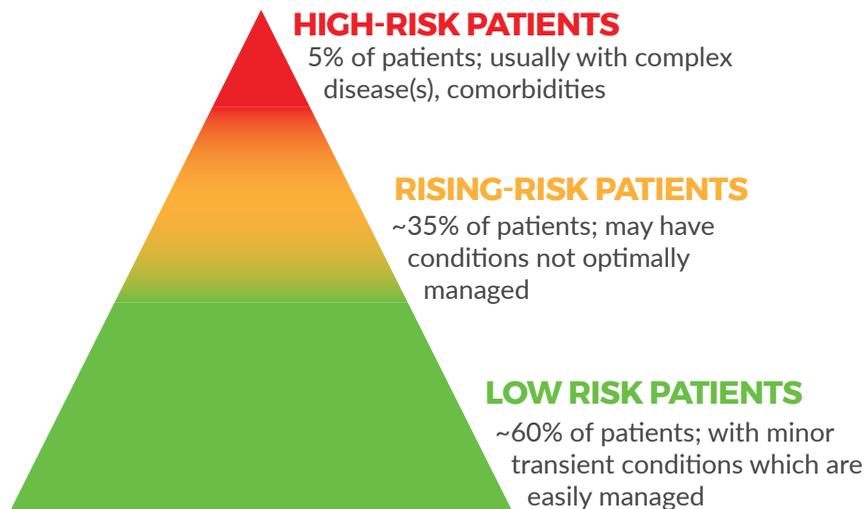
Plan with Patient: Create an action plan collaboratively and confirm mutual understanding; share written care plan

4

Manage: Follow-up with patient and with other healthcare providers as planned



WHO BENEFITS FROM PaCT?



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

WHAT ARE THE TIMELINES FOR PaCT?

PaCT is currently in Phase One with Innovation Hubs identified across the province. Building on the panel and screening work already underway in Alberta, Innovation Hubs will test ideas for improvement that systematically support their patients with complex needs. As of September 2017, the seven PCNs who have expressed interest and are participating in readiness activities are: McLeod River, St. Albert & Sturgeon, Edmonton Southside, Kalyna Country, Big Country, Highland and Mosaic. These PCNs will work with a small number of member clinics to test evidence-based care planning approaches for identifying, planning and managing care with those patient who would benefit most.



Stay tuned for progress reports as ideas are tested and an invitation to participate after year one!

CONTACT INFORMATION

For more information on PaCT, contact pact@albertadoctors.org or call 1.866.505.3302. For more information on the Primary Health Care Integration Network, contact PHC.IntegrationNetwork@ahs.ca.