Frequently Asked Questions about PaCT and Innovation Hubs

Thank you for expressing interest in the Patients Collaborating with Teams (PaCT) initiative. These questions are intended to address areas of interest about the first phase of testing for PaCT, called Phase One: Innovation Hubs.

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?

Email: pact@albertadoctors.org

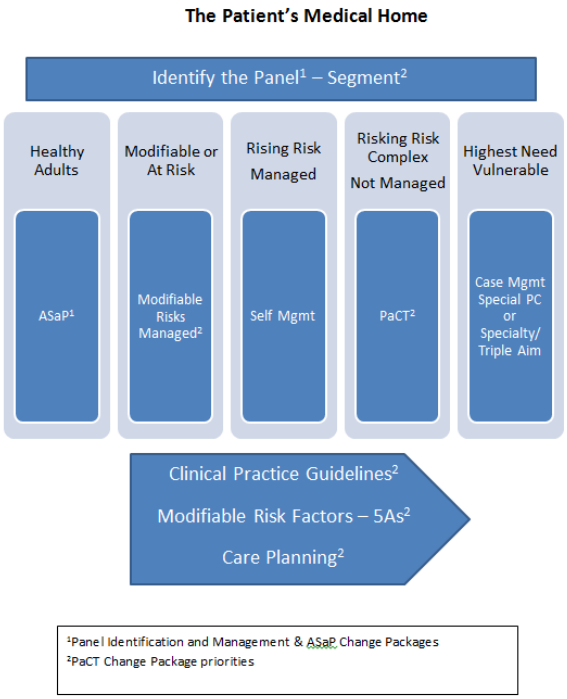
Toll free: 1-866-505-3302 or Marion Relf directly at 780-868-6300

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 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).



[1]Panel Identification and Management & ASaP Change Packages
[2]PaCT Change Package priorities

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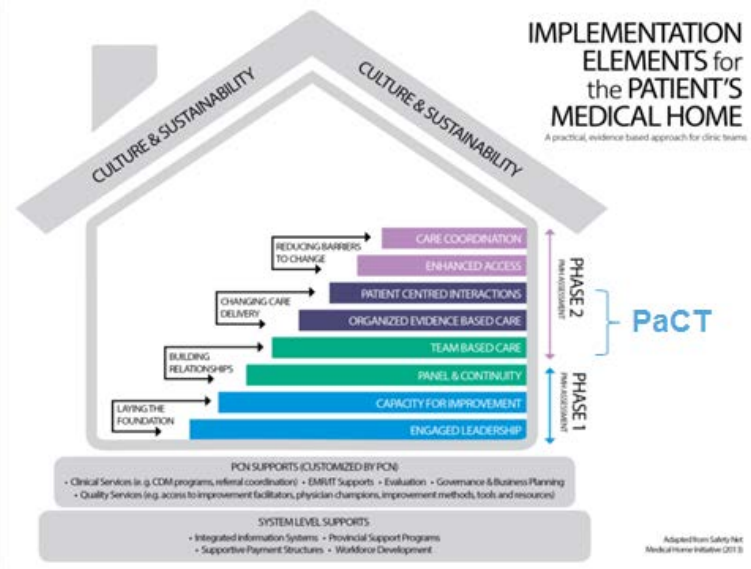
Why is PaCT important?

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 to test ideas as *Innovation Hubs.* PCNs and their member clinics will be supported in patient-centered care planning with patients already identified as being part of a physician's panel.



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Updated: April 26, 2017

What is an Innovation Hub?

An Innovation Hub is a PCN and a few of their member clinics who agree to be part of Phase One. 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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What support will PCNs receive if they participate as an Innovation Hub?

Some of the resources and supports Innovation Hubs can expect are:

- EMR team (TOP) to help build capacity of PCN supports in identifying the target patient groups within physicians' panels
- Continued training and support for Improvement Facilitators and other Change Agents (Clinical Leaders, Physician Champions) as they build their capabilities to support clinics
- A practical toolkit of resources to implement the proposed changes (e.g., a care plan template, EMR resources, team engagement ideas, patient engagement and activation ideas)
- Clinical decision support tools built for primary care teams by primary care health professionals
- Resources and support when including patients in co-design
- Quality Improvement tools and methods
- Shared learning from other PCN Innovation Hubs
- Common set of measures for reporting
- Tools to support the collection of practice-based measures

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When will PaCT be operational?

We anticipate PaCT will occur in three phases (see a projected timeline below) over a three-year period. Phase One will start in June 2017 with up to seven PCNs who wish to participate as Innovation Hubs. Each of those PCNs will in turn work with a few of their member clinics during Phase One. However, after testing ideas, it is intended that all PCNs would be invited to participate in either Phase Two (June 2018 to August 2019) or Phase Three (June 2019 to August 2020).

Timeline	Activity
April 20 April 25, or May 2	**Learn More: Information Teleconferences/Webinars** • April 20, 12:00 – 1:00 p.m. • April 25, 4:00 – 5:00 p.m. • May 2, 8:30 – 9:30 a.m. **Please see website for login information.** **Can't attend? Please call for individual** discussions Marion Relf at 780.868.6300 or toll-free to 1.866.505.3302 **or email** pact@albertadoctors.org
May 5	Completed Expression of Interest (EOI) due
May 8 - June 2017	On-site discussions at the PCN between PaCT representatives and PCN/Zone representatives and confirmation of Innovation Hubs
June 2017 – August 2017	Readiness activities for Innovation Hubs (EMR optimization, team formation, baseline measures)
Sept 2017 – Aug 2018	Phase One: Innovation Hub 90 day cycle of changes tested and implemented
June 2018 – August 2019	Phase Two: Open to all PCNs 90 day cycle of changes tested and implemented
June 2019 – August 2020	Phase Three: Open to all PCNs 90 day cycle of changes tested 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

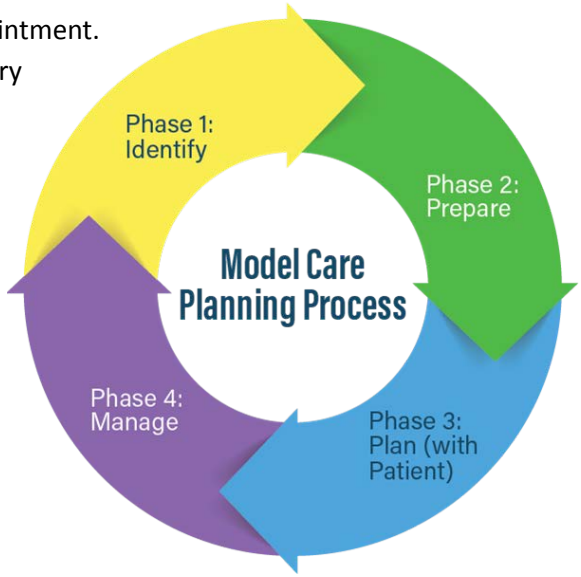
Care planning improvements target the four phase of the care planning process model and will consider which process changes are required to support the team approach – who does what, when, and how.

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. Tips from others who have successfully achieved planning in this way will be available to support the Innovation Hubs.

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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.

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 as they test promising ideas.

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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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Who will recruit primary care clinics to work with the Innovation Hub PCN?

Each PCN will recruit those member clinics best positioned to participate during Phase One. See the Expression of Interest submission form for "guiding statements" which outline readiness considerations for member clinics to participate in Phase One.

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How many member clinics should a PCN recruit? What type of clinics?

A PCN may consider three to five clinics. PaCT needs ideas that work in all types of clinics so the more the test sites mirror average family physician clinics in Alberta, the better.

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

In Phase One, we want to ensure ideas are tested with a team that includes at least one other health professional besides the physician and the clinic MOA/receptionist. 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 Two and Three, we expect that what we have learned will be adaptable to all team compositions.

If your PCN does not currently have a co-located health professional in a physician clinic (and the physician clinic has not hired such staff), we would ask you to consider co-location of team members for care planning while your PCN participates as an Innovation Hub. Co-location may be on a part-time basis.

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Can we withdraw or terminate our participation as an Innovation Hub prior to the end of the Phase?

Yes. While we hope to work with the same group of Innovation Hubs throughout Phase One, if circumstances change please let us know and we can talk about future participation in PaCT.

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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. Others may have already defined priorities for their clinical improvements in the next year or two. If that is the case, we encourage you to think about what you have already committed to do and let's talk further if you think participating as an Innovation Hub might be possible.

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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 developed by 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 the implementation elements of the Patient's Medical Home.

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How will engagement with AHS zone representatives help to strengthen a PCN's Expression of Interest (EOI) for PaCT?

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 also strengthen the care plan if they are part of the patient's team outside the physician clinic walls.

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

If your PCN isn't ready to participate as an Innovation Hub, there are important steps you 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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