DEVELOPING A ‘CARE PLANNING PATHWAY’ FOR PRIMARY CARE

Anila Hussaini, AMA-TOP
Dale Wright, HQCA
APCC - November 18, 2017
Disclosure

Presenters:
Anila Hussaini
Dale Wright

Relationships that may introduce potential bias and/or conflict of interest:
No relationships to declare
Presentation Overview

- Why develop a ‘care planning pathway’?
- What did we do?
- What is the ‘Model Care Planning Process’?
- What does the literature say?
- How can others use what we learned?
Why a ‘care planning pathway’?

Care pathway:

- Evidence-based management guidelines, often in flow chart form
- Organizes processes of care, facilitates coordination and communication, guides the patient’s journey of care
- Typically condition-focused
Why a ‘care planning pathway’?

What if we could develop a care pathway to support ‘whole person care’ in patients with multiple chronic conditions?
What does the literature say?

**Care planning**

“The process by which healthcare professionals and patients discuss, agree, and review an action plan to achieve the goals or behavior change of most relevance and concern to the patient.”

**Care plan**

“A written document that records the outcome of the care planning process.”

(Burt et al., 2014)
What does the literature say?

| Collaborative care planning process with patient? |
|------------------|------------------|
| Yes              | No               |

<table>
<thead>
<tr>
<th>Care plan created?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>‘Gold standard’ Planning WITH the patient to create a patient-focused care plan</td>
<td>Condition-focused care plan - little or no patient input Often target driven</td>
</tr>
<tr>
<td>No</td>
<td>Common typical care for long term conditions</td>
<td>Poor quality care for long term conditions</td>
</tr>
</tbody>
</table>

(Burt et al., 2014)
Developing a ‘care planning pathway’

- Physician survey
- Literature scan
- Interviews with teams
- Consultation with patients

Model care planning process
Developing a ‘care planning pathway’: Literature scan

- What patients are most likely to benefit?
- What aspects of the care planning process are important?
- What is the best way to set patient goals?
- What should be included in a care plan? What do patients want in a care plan?
- What other elements of care planning are important? E.g., follow-up, case manager
Developing a ‘care planning pathway’: Team interviews

- Care planning:
  - administrative task to bill for CACP OR
  - collaborative process to co-create action plan
- EMR support important
- Teams talked about activities in each phase
Putting it together:
A model care planning process
Model care planning process

- Define target patient groups for comprehensive care planning
- Identify and select patients to whom comprehensive care planning will be offered
- Offer care planning – explain
- Confirm an appointment

Team approach - Who does what when and how?
Model care planning process

- Update the EMR patient profile
- Form an initial medical care plan to be negotiated/modified with the patient
e.g., suggested targets, screening, treatments, monitoring, referrals
- Select patient assessment tools if applicable
  - * Assessment may be part of ‘Prepare’
e.g., Senior’s Hub

Team approach - Who does what when and how?
Model care planning process

- Patient assessments as needed
- Develop shared understanding
- Set priorities collaboratively – medical goals and targets AND patient priorities
- Create an action plan collaboratively
  - Actions for team, actions for patient, patient coping plan, follow-up plan
- Confirm shared understanding
  - Written care plan document

Team approach - Who does what when and how?
Model care planning process

- Medical team and patient take action per the plan
  - E.g., Medical team follow-up/contact with other healthcare providers – continuity

- Follow-up with patient – initiated by medical team or patient per the plan

- Clinician and patient review plan regularly, revise as needed (at least yearly)

Team approach - Who does what when and how?
Developing a ‘care planning pathway’:
Patient consultation

- HQCA Patient and Family Safety Advisory Panel
- SCN Patient Engagement Reference Group

What is important to patients and families in each phase?
What does the literature say?

What is the goal of care planning?

- Improve patient self-management?
- Improve clinical management?
- Improve communication and coordination between healthcare providers?

Reduce costs to the health system?
What does the literature say?

Who benefits . . . ?

- 3 systematic reviews, 60 unique studies
- Variety of interventions, target populations, evaluation strategies, outcomes

Overall . . .

- Small positive benefits at patient level e.g., HbA1C, BP, depression scores, self-efficacy, satisfaction
- Little or no benefit to larger health system e.g., utilization, costs, morbidity
What does the literature say?

Benefits are more likely if:

- Goal is clear – what do you want to achieve with care planning?
- Intervention is designed to achieve the goal
- Target population is clearly defined
  - Health system benefits more likely if patient trajectory can be changed
- Local context is considered
  - Structural and operational features of the practice
  - Commitment of team to implementing as planned
What does the literature say?

Benefits are more likely if:

- Family MD is involved
  - Integrate with usual care - patients want to know their MD is supportive
- Team is involved
  - Family MD can’t do this alone!
  - Changing care delivery & involving team is more effective than patient education only
  - Co-location of the team seems to be important – respect, trust, ease of communication
  - If co-location isn’t possible, what can be done to strengthen the relationship between MD and MDT members?
- Patient is involved!
  - Effective care planning is done WITH the patient, not to or for the patient!
What does the literature say?

Patients want . . .

- Collaborative goal negotiation & action planning
  - Consider goals and management options within the patient’s life context
  - Negotiate goals and medical targets with the patient
  - Co-create action plans for patient and the medical team

- Action plan composed of small, short term goals
  - Actions for patient and team, patient confident in achieving, targets and dates

- Written plan in clear, patient-oriented language

- Monitoring and follow-up
  - Positive reinforcement & recognition of success, help getting back on track
What does the literature say?

- The more complete the care planning process, the greater likelihood of benefit
- Follow-up (care plan management) is important!
What does care planning look like in your practice?

Take 3 minutes . . .
Use the care planning worksheet to jot down some collaborative care planning processes you use in your practice.

Take 5 minutes . . .
To share one idea with your neighbor.
How can others use what we learned?

PaCT
Patients Collaborating with Teams
Stakeholders

- Patient and family representatives
- Family Physicians
- Primary Care Networks
- Alberta Medical Association
- Alberta Health Services
- Health Quality Council of Alberta
- U of A – Department of Family Medicine
- Alberta Cancer Prevention Legacy Fund
PaCT Goals

How will care planning look different if PaCT is successful?
Panel is not in place, maintained or used for identifying patients with complex health needs

Patients with complex health needs identified and regular follow-ups planned
Care is directed by the physician based on most urgent medical need; may be referrals to other team members.

Primary care team members and the patient work collaboratively with each other using multiple contact methods to maintain continuity and timely access.
Advice on self-management is general without full patient participation in setting goals without planned regular review.

Patients confidently manage their care through effective used of shared self-management tools that are revisited and revised regularly.
Referrals to specialists and community resources are sent without reliable communication regarding status or outcome.

Patient and primary care physician/team collaborate with specialty and community resources, are informed and updated in real time on status and outcomes.
Complex health needs patients

**HIGH-RISK PATIENTS**
5% of patients; usually with complex disease(s), comorbidities

**RISING-RISK PATIENTS**
~35% of patients; may have conditions not optimally managed

**LOW RISK PATIENTS**
~60% of patients; with minor transient conditions which are easily managed

15% - 35% of rising risk patients may not have their conditions optimally managed.
Different from complex care plan patients?

Comprehensive Annual Care Plan for a patient with complex needs

"Complex needs" means a patient with multiple complex health needs including chronic disease(s) and other complications. The patient must have at least two or more diagnoses from group A or one diagnosis from group A and one or more from group B in order to be eligible.

<table>
<thead>
<tr>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hypertensive Disease</td>
<td>• Mental Health Issues</td>
</tr>
<tr>
<td>• Diabetes Mellitus</td>
<td>• Obesity</td>
</tr>
<tr>
<td>• Chronic Obstructive Pulmonary Disease</td>
<td>• Adult = BMI 40 or greater</td>
</tr>
<tr>
<td>• Asthma</td>
<td>• Child = 97 percentile</td>
</tr>
<tr>
<td>• Heart Failure</td>
<td>• Addictions</td>
</tr>
<tr>
<td>• Ischemic Heart Disease</td>
<td>• Tobacco</td>
</tr>
<tr>
<td>• Chronic Renal Failure</td>
<td></td>
</tr>
</tbody>
</table>


Which is the complex health needs patient?

Person A:
- Hypertension
- Diabetes
- Stable employment with robust benefits plan
  - Rx plan - adherence
- Reliable transportation

Person B:
- Depression
- Multiple sclerosis
- Tobacco user
- Unstable employment and income
  - Difficulty $ Rx
- Difficulty accessing transportation
Clinical criteria: Clinical risk grouper

Clinical Risk Grouper – 6 and 7

- 3. Single minor chronic
- 4. Multiple minor chronic
- 5. Single dominant or moderate chronic
- 6. Pairs – multiple dominant/moderate chronic
- 7. Triples – multiple dominant chronic
- 8. Malignancies
Continuity vs. cost by clinical risk grouper

Slide Credit: Dr. Richard Lewanczuk MD, PHD
Phase One: PaCT participants

- McLeod River PCN
- Big Country PCN
- Mosaic PCN
- Edmonton Southside PCN
- St. Albert & Sturgeon PCN
- Kalyna Country PCN
## PaCT: Team Assessment

### Panel Identification, Maintenance and Management

<table>
<thead>
<tr>
<th>Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do not identify patients with complex health needs systematically using our EMR.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our team’s panel list in the EMR clearly identifies those with complex health needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We don’t know which of our patients are most likely to benefit from care planning.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our team has identified priority patients for care planning (e.g., complex health needs, rising risk, not managed, without a visit in the last year).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At appointments the physician manages only the issues identified at the visit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our team prepares for each patient visit to proactively address health needs that may not be the primary reason for the patient’s visit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
“After seeing this [care plan], I realized for the first time that this document is for me. This whole time I thought this was something that my doctors had to do for their records. I will use this – it is like my health passport.”

AI – Patient Member of the PaCT Improvement Team at Life Medical Clinic
# The change package

## PaCT Change Package

### Improvement Focus

<table>
<thead>
<tr>
<th>Legend:</th>
<th>Optimize the Patient Experience</th>
<th>Optimize the Team</th>
<th>Optimize the EMR</th>
</tr>
</thead>
</table>

### FOUNDATIONAL: Identify, Maintain, and Manage the Panel

- **0a. Ensure panel identification and maintenance processes in place**
  - 1a. Define complex health needs and select a population of patients for care planning
  - 2a. Prepare the care team
  - 3a. Engage patient in care planning
  - 4a. Set actionable reminders in the EMR to support follow-up

- **0b. Ensure access and continuity for paneled patients**
  - 1b. Use EMR to identify specific patients with complex health needs
  - 2b. Prepare the patient
  - 3b. Utilize EMR to document and share the care plan
  - 4b. Coordinate care

- **1c. Build patient awareness and offer care planning**
  - 4c. Follow-up with the patient
Patients Collaborating with Teams (PaCT)
Thank you

Dale Wright
Senior Lead, Reporting, HQCA
dale.wright@hqca.ca

Anila Hussaini
Quality Consultant, TOP
anila.hussaini@topalbertadoctors.org