Care Planning

ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

Purpose:

To assist primary care clinics in optimizing a care planning processes for paneled patients with rising complex health needs.

Outcome Measure:

The number of patients with rising complex health needs with a documented care planning offer within the last twelve months.

Prerequisite Tools

Aim Statement:

By a specific date, the clinic team will have completed a specific number of care plans using a patient-centered approach.

Balancing Measure:

The time to the third next available (TNA) appointment.

Prerequisite Change Packages

- Panel Processes Change Package
- Relational Continuity Change Package

Search our collection of premium tools in AMA's Resource Centre.

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Searchable Tools
1. Improve the patient experience	1.1 Establish a multidisciplinary quality improvement team and consider including a patient advisor	Regularly scheduled team meetings	• Patient Representative Guide
2. Identify paneled patients for care planning	2.1 Prioritize and select a patient population for care planning	Develop a definition of eligible patients.	• HQCA Primary Healthcare Panel Report • Identifying Patients with Complex Health Needs
	2.2 Generate lists of patients eligible for care planning and review as a team	The number of patients eligible for care planning	• EMR Resources
3. Optimize care planning processes	**Prepare for care planning**		
	3.1 Define and coordinate care team roles, processes, and interactions		• Team Assessment - Care Planning • Roles and Responsibility Template • Process Mapping • Introductions with Intention

Continued over

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Searchable Tools
3. Optimize care planning processes (cont.)	3.2 Offer eligible patients a care planning appointment and invite them to bring a trusted friend or family member to the appointment	The number of patients offered care planning	• Scripting Elements
	Plan the care		
	3.3 Test a process for asking patients what matters to them		
	3.4 Engage the patient in the care planning process and setting patient-centred goals	The number of patients with care plans completed in the last 12 months.	• Care Plan Template with Prompt • Setting Effective Patient-Centred Goals Guide
4. Standardize documentation	4.1 Create processes in the EMR to identify the patient as part of a specific population for care planning	The number of patients eligible for a care plan	• EMR Reources
	4.2 Document all aspects of care plan in care plan template	The number of patients with care planning template in chart	• Care Plan Template with Prompt
	4.3 Use reminders in your EMR to establish a process for care planning with outreach and opportunistic strategies for follow up activities	The number of patients with care plan completed due for a follow up	• EMR Reources
5. Coordinate care in the medical home	5.1 Ensure completed care plan is made available to all team members who care for the patient within the medical home	The number of other providers the care plan has been shared with	• Team Huddles Guide
6. Coordinate care in the health neighbourhood	6.1 Provide the patient with a copy of their care plan (if not connected in patient portal)	A care plan is printed for the patient.	
	6.2 Establish a process to share the care plan with other providers outside of the primary care clinic (AHS, specialty programs, specialists, community, etc.)	The number of other providers the care plan has been shared with	• Process Mapping