What is One:carepath?

One:carepath, is a provincial research project that takes a proactive and co-managed approach to care planning with patients who have advanced/decompensated/non-curative COPD, heart failure, cirrhosis, kidney disease, and stage 3 or 4 solid organ cancers.

It includes a co-designed shared care plan template and online digital support tool focusing on optimizing a patient's quality of life and functional status through careful attention to symptom management, avoiding aggressive treatments where appropriate, and determining a patient's values and preferences for care. All with the goal to increase informational, relational, and management continuity among all those involved, and reduce hospital admissions and emergency department visits.

Although this research project is focusing on some specific disease processes, the provincial long-term goal is to support any patient who can benefit from care planning.

Who can take part?

Study Title: *One:carepath Implementation: Implementation and Evaluation of an Innovative Integrated Conservative (Non-Dialysis) Kidney Management Pathway by Community Care Providers across Alberta, and the Development, Implementation and Evaluation of an Innovative Integrated Supportive Care Pathway by Primary Care across Alberta (Pro001222633)*

We are looking to partner with family physicians and their clinic improvement teams to care plan with complex patients in their panel who are identified by applying our cohort criteria. The care plan is embedded in provincial EMRs.

Family physicians participating in this implementation for up to 18 months (duration is dependent on start date) will be remunerated at a flat rate of $5,500. Remuneration and related activities are detailed in an agreement (MOU) which each participating provider will be required to sign. The expectation of participating providers is to access and use resources available to engage and support patients in care planning.

Your participation in this project can be used as part of your PPIP-CPSA QI requirements.

What will you be asked to do?

1.	Attend two 45 min virtual meetings (arranged at your convenience) with project team: 1) to discuss high-level overview of implementation e.g. project goals and what participation involves; 2) to discuss in more detail the steps of your participation
2.	Read & sign a participation agreement (MOU) & consent form
3.	Optional - Identify a facilitator/liaison within the clinic team to act as the main contact for the study team
4.	Share your PRACID in the REDCap platform. This will enable a) the AHS AB SPOR Data analytics team to identify a study patient panel; and b) the independent AHS Audit team to ensure there are no duplicate participant registrations
5.	Confirm your study panel using the REDCap platform
6.	Complete care planning with complex patients over the study period. Ask patient if they consent to sharing their email address with HQCA in order to be sent a patient experience survey. If they do, enter email address in secure RedCap portal.
7.	Attest the number of completed care plans using the REDCap platform
8.	Following care plan completion (~18 months) if chosen through a random selection process, agree to share copies of care plans with the independent AHS audit team for review and validation of completion via AHS secure transfer protocol
9.	Following completion of the study complete a survey asking for feedback on the care plan and online digital support tool

For more information or to get involved, contact Lynn Toon at toon@ualberta.ca and/or Tanya Barber at tkbarber@ualberta.ca for details.