FREQUENTLY ASKED QUESTIONS: PART I & II

VALUE PROPOSITION

WHY IS THIS INITIATIVE IMPORTANT FOR PCNS AND PHYSICIANS?

- It will help optimize management and care for patients living with advanced stage chronic diseases.
- It's a unique opportunity in Canada, this has not been done before. An opportunity to participate in a high-quality evidence-based initiative, a type of innovative Clinical Trial (iCT) that can demonstrate the value of PCNs to the health system and accelerate supports to the Patient's Medical Home (PMH).
- Demonstration of success will lead to a financial reward, allowing for reinvestment in ongoing practice supports. The greater the impact, the greater the reinvestment.
- Opportunity to get practical supports such as decision aids embedded into EMR, to help manage patients with advanced stage chronic diseases.
- Resources to support practice level change management.
- Engagement of community based resources to support management of for patients with advanced stage chronic diseases.

PARTICIPATION COMES WITH SEVERAL UNIQUE OPPORTUNITIES:

- Co-designing integrated supportive care & processes with providers, caregivers, and for patients' with advanced stage chronic diseases.
- Access to additional Practice Facilitator supports for participating PCNs.
- Opportunity for Practice Facilitators to receive customized training, tailoring how they engage and support practice teams to implement the Integrated Supportive Care Initiative and other practice changes.
- A chance to highlight the effectiveness of good care planning processes for patients living with advanced stage chronic diseases. It will be the first time where the demonstration of success will lead to a financial reward allowing for reinvestment in ongoing practice supports.

FREQUENTLY ASKED QUESTIONS: PART I & II

IS THE INITIATIVE GENERIC OR DISEASE SPECIFIC?

The Integrated Supportive Care Initiative is disease inclusive, with an initial focus on advanced lung, heart, liver, and kidney disease, as well as end-stage cancers, bringing together universal components related to advanced chronic conditions.

WHAT IS THE TERM FOR THIS PILOT PROJECT?

12 months for co-development and 2/2.5 years for implementation.

RECRUITMENT

WHAT ARE THE RECRUITMENT/PARTICIPATION GOALS?

- Preference will be to recruit whole clinics rather than individual physicians for the most effective use of resources i.e. Practice Facilitators, study and clinic staff.
- **Total 300-350 physicians.**
- **10-15 patients per physician – to demonstrate impact.**
- **3 year commitment with co-development, training and implementation.**
- **Two groups** - We have until **July 1, 2021 to recruit group 1** and until **January 1, 2022 to recruit group 2**. These are the implementation start dates.
- Recruitment will close for each group at implementation start so we can establish baseline measures. Progress and success will be measured against baseline at 6 month intervals.

HOW WILL PHYSICIANS BE RECRUITED?

- PCNs are encouraged to identify clinical leaders (physician) and Practice Facilitators to help initiate physician engagement.
- The project team will support PCNs to recruit individual physicians (and clinics).

WHAT SUPPORTS WILL PCNS RECEIVE TO RECRUIT PHYSICIANS?

- Engagement materials have been developed and will be provided to PCNs for inclusion in communications with physician members.

- The project team will provide engagement presentations for co-delivery with local physician champions and/or web based sessions.
- PCN Practice Facilitators will be provided with information and training about the Integrated Supportive Care Initiative, in order to assist in recruiting physicians & teams in their PCNs.
- Communications in PC news, MD Scope and other AMA and Alberta Health Services (AHS) communications will support aligned recruitment messages.

SUPPORTS FOR PCNS/CLINICS/PATIENTS

- The Health Quality Council of Alberta (HQCA) will help physicians by providing a panel report and a list of patients to review & determine if they would benefit from the Integrated Supportive Care Initiative.
- Practice Facilitators will work with the clinic to standardize documentation for ongoing identification of patients with advanced stage chronic diseases.

THE INTEGRATED SUPPORTIVE CARE INITIATIVE WILL SUPPORT PRIMARY CARE BY:

- Engaging Community Care to support patients with advanced stage chronic diseases to live well in their community.
- Co-designing supports to assist in patient decision making and process design for reliable integrated care.
- Enabling access to a health care provider portal to facilitate just-in-time information support.
- Co-designing a patient portal to access educational materials and support patients with preparation to be “better patients”. The portal will be designed around an integrated approach to disease inclusive and culturally adapted resources.
- Providing materials and processes to facilitate effective patient care planning reflecting patient/family needs, preferences and goals resulting in a written Supportive Complex Care Plan.

FREQUENTLY ASKED QUESTIONS: PART I & II

- The project team will provide customized training and mentorship for Practice Facilitators to support practices with the implementation of Integrated Supportive Care Initiative while advancing the PMH.

WHAT IF A PCN DOESN'T HAVE ONSITE PRACTICE FACILITATION SUPPORT?

PCNs will receive funding to resource this position.

DOES THE GRANT SPECIFY WHAT FULL-TIME EQUIVALENT (FTE) THESE NEW HIRES WOULD HAVE TO BE?

- The grant was designed to provide approximately 10 FTE Practice Facilitators. Actual funding will flow to PCNs based on physician enrolment that can be applied to practice facilitation, measurement, and EMR support.

WOULD PCNS BE ABLE TO TOP UP EXISTING STAFF TO FILL THESE POSITIONS (LIKE THE OPIOID GRANT IS DOING WITH OPIOID RESPONSE COORDINATORS)?

Yes - this is an opportunity to use funds to backfill for junior appointments and offer more experienced Practice Facilitator's customized training.

IF THIS IS A SUCCESSFUL PILOT, IS THERE A PLAN TO SUSTAIN IT?

Yes - if successful, additional resources will be committed to supporting ongoing practice change through Practice Facilitators. A signed funding agreement is in place with AHS.

IF THIS IS SUCCESSFUL, IS THERE A PLAN TO ROLL IT OUT TO ALL PCNS?

Yes - a business case will be developed post-funding (grant). This will be built into AHS budget and planning cycles if successful.

WILL A PCN HAVE TO DO A BUSINESS PLAN AMENDMENT AND WOULD THEY HAVE TO REPORT THEIR PARTICIPATION IN THEIR ANNUAL REPORTS?

This provincially supported work aligns with existing PCN priorities such as chronic disease management and panel management etc. A business plan amendment would only be required if considered a major change of focus relative to your PCNs existing business plan. If in doubt please contact (Lynn.Toon@albertadoctors.org to arrange a consultation). Your PCN will be required

to sign a memorandum of understanding specifying how funds will be used, for what activities, and the duration of funding.

IS THERE ADDITIONAL WORKLOAD INVOLVED?

FOR PCNS:

Yes –measurement, project management, participation in training, project meetings and evaluation activities. However there are supports available to minimize the effort:

- There will be administrative and project management support for all participating sites.
- PCN Practice Facilitators will be provided with information and training regarding the Integrated Supportive Care Initiative in order to:
  - ✓ Assist in recruiting PCN and physician participants.
  - ✓ Advise on development and implementation of the initiative and tools for primary care practices.
  - ✓ Advise on processes to support primary care and coordinate with AHS programs, services, and medical specialties.

FOR PHYSICIANS/CLINICS:

Yes - participation in one World Café for 4 hours, participation in clinic team meetings, sharing learnings events and participation in measurement and evaluation. We anticipate, on average, physicians will have 10-15 patients in their panel who would benefit from this initiative.

WHAT IS INVOLVED IN THE TRAINING PROVIDED?

Practice Facilitators will receive core training support for the co-development of this intervention. Customized training will also be offered to Practice Facilitators to increase the effectiveness of implementing this initiative, and advancing the Patient Medical Home.

IS THIS INITIATIVE HERE TO STAY?

Yes - this program aligns with existing initiatives to enhance continuity of care and system transformation toward the Patients Medical Home. It builds on work that clinics are already doing:

- Continuity – the initiative promotes continuity of care (relational, informational and management) for patients with advanced stage chronic diseases.

- Team-based care improvements – it promotes effective use of clinical and extended care teams (PCN, AHS and community) in delivering coordinated integrated care.
- Evidence-based care – co design of disease inclusive decision making aids and EMR clinical decision supports.
- It will support enhanced specialty care transitions.
- Alignment of existing tools e.g. EQ5D to help build capacity and reach of tools in practice.

This is an opportunity to **PROVE** in an iCT that PMH Chronic Disease Management supports make a difference to managing patients living with advanced stage chronic diseases.

WHAT SUPPORTS WILL PRACTICES RECEIVE TO ENGAGE THEIR PATIENTS IN CARE PLANNING?

- Physicians will receive a panel report and a list of patients to review and determine if they would benefit from this intervention.
- Direct access to all the tools and best practice supports, such as symptom management algorithms, including terminal symptom management; nutrition optimization; and a systematic approach to Advanced Care Planning and our provincial Goals of Care Designations to ensure that patients' wishes are known and documented.
- Streamlined referrals to home care, palliative home care and other community supports will be incorporated.
- The Supportive Complex Care Plan will live in the electronic medical record, and as a hard copy with the patient.

THE PROJECT TEAM WILL PROVIDE:

- Patient FAQ
- Patient Script for Clinic Staff and Physicians
- Informational Posters/Brochures – including value to patients
- Use Health Unlimited TV (HUTV) to Inform Patients

FREQUENTLY ASKED QUESTIONS: PART I & II

WHAT SUPPORTS DO PATIENTS GET?

Patients living with advanced stage chronic diseases will benefit by receiving an enhanced care plan they can share with their care team. Patients will be able to access resources and educational materials, including:

- Interactive patient decision aids, co-developed around key challenging treatment decisions, such as for example: “Is dialysis right for me?”; “Will a left ventricular assist device help me?” to facilitate informed, shared decision-making.
- Tools to help patients with advanced stage chronic diseases make decisions about the care they desire e.g. Dialysis.
- Enhanced community supports such as end-of-life care and crisis management.

WHAT DO PATIENTS THINK ABOUT SHARING THEIR INFORMATION?

Patients expect their care teams to know about them and can choose not to take part.

AMA ACTT will provide:

- Patient FAQ
- Patient Script for Clinic Staff and Physicians

PRIORITY ALIGNEMENT

WHAT WILL BE GAINED FROM PARTICIPATING IN INTEGRATED SUPPORTIVE CARE PATHWAY (ISCP)?

1. Access to secured funds to build capacity at the PCN and practice level to further advance the patients’ medical home.

2. Manage complexity over time rather than in one single encounter. Providing a workable solution to the potential changes to the complex modifier code; so physicians can see patients and bill appropriately with additional support using a Chronic Disease Management (CDM) team along with Practice Facilitators and other change agents.

3. Participating in ISCP will help you deliver the care to your patients that you desire, the initiative is not recommending standardized clinic practices.

4. The first year (2020) is about preparing to make change and designing the right tools for primary care, implementation will occur in 2021.

5. The long term benefit and value to clinics and practices participating is:
   - ✓ Capacity building at the physician, clinic and PCN level
   - ✓ Customized training for Practice Facilitators/Liaisons and participants
   - ✓ Dedicated time protected by PCN for Practice Facilitators/Liaisons or alternative compliment of PCN/clinic staff to ensure objectives are met using available funds
   - ✓ Senior Project Manager and Senior Clinical Improvement Consultant from project team provide extended support to participating clinics directly or indirectly
   - ✓ CME accreditation for physician participation in training and learning sessions once they have committed to participate in implementation
   - ✓ Strengthen patient and MD continuity and move forward with complex care planning

HOW DOES SUPPORTIVE CARE ALIGN WITH OTHER PCN PRIORITIES?

Supportive Care aligns with ongoing PCN priorities helping to further advance the Patients Medical Home through 1) process re-design, 2) gathering practice level measures over time, 3) building templates for EMR, and 4) designing a shared-care plan.

FUNDING

WHAT FUNDS WILL THE PCN RECEIVE FOR PARTICIPATING AND HOW CAN THE FUNDS BE USED? WHAT % OF PRACTICE FACILITATORS WILL GO TO PARTICIPATING PHYSICIANS?

Funds will be distributed to participating PCNs as one or more lump sums based on a pre-determined physician recruitment target between each PCN and the ISCP Team. The PCN will be responsible for allocating funds to ensure ISCP objectives and timelines are met as per the agreed terms and conditions of the funding. PCNs will be entrusted to the allocation of funds and related personnel to ensure participating physicians receive the necessary support to be

successful and funds are distributed efficiently to align with work already taking place within the PCN as part of their current business and service plans.

Practice Facilitators/Liaisons and/or other change agents designated by the PCN are considered the mostly likely PCN personnel to help build capacity for this work within the PCN and to support the practices and/or physicians implementing ISCP. Personnel can be shared across multiple clinics to do related work.

WILL PCNS GET FUNDING IF SUCCESSFUL, TO SUPPORT PFS MOVING FORWARD?

If outcomes are achieved there will be access to additional resources for the PCN to implement ISCP with other physicians and continue to build capacity at a clinic level (Practice Facilitators/Liaisons or alternative). Additional funding is tied to outcomes through a contract with Alberta Health Services and the ISCP Team.

IS THERE FUNDING FOR PHYSICIANS TO ATTEND THE WORLD CAFÉS?

Funding for physician engagement is limited but we can support a maximum agreed number along with commitment from the PCN to participate in implementation prior to hosting a local World Café. The total funds distributed to participating PCNs for implementing ISCP in their PCN will be used by the PCNs to pay physicians for participating in a single World Café.

OTHER

CAN WE ATTEND A WORLD CAFÉ VIRTUALLY?

No this is an interactive session which can only be attended in person. For smaller & remote centers we may organize a focus group style meeting rather than a World Café.

NOTE: Due to the COVID-19 pandemic, future World Café events will not take place. Findings from the two completed World Cafés will inform this work and we will seek alternative forms of engagement for co-design.

FREQUENTLY ASKED QUESTIONS: PART I & II

HOW IS THE ISCP TEAM COORDINATING WITH AHS STRATEGIC CLINICAL NETWORKS™ (SCNS) TO ALIGN WITH CURRENT PATHWAY WORK AND WHAT HAS ALREADY BEEN DONE?

We have commitment from the relevant SCNs including the Cancer SCN and the Provincial Tumor Teams. Where possible we will be using already developed clinical content, guidelines and processes from the specific disease areas and adapt it for use by primary care. Through the co-design process with primary care (i.e. World Cafés, focus groups, demos, etc.) the ISCP Team will coordinate best evidence with specialty care via clinical working groups while adapting and prioritizing pathway content base on primary care feedback (e.g. specific decision tools for complex cases, quick links, etc.).

WHAT DOES PRACTICE READINESS LOOK LIKE?

Practice readiness will be determined through conversations with the Improvement Team Program Managers, PCN leadership and other members to understand how the PCN currently organizes their work. This may include discussions around panel readiness, care planning processes, complex care management, team composition and role clarity, EMR use/type, and participation in other initiatives such as PaCT, CPAR/II, etc.

HOW DOES THIS PROJECT TIE INTO PACT?

Participation in PaCT is not a requirement for ISCP implementation, however PaCT participation will provide a level of clinic readiness and foundational skill set to implement ISCP as the two strongly align. Evidenced based care planning for specialist and primary care coordination using an online standardized tool is a logical next step.

WHAT DEFINES THE CARE TEAM?

We understand that each team will look different for each practice, so processes will be tailored at the practice level to fit within the existing team to meet you where you are at.

ARE PRESENTATIONS TO THE BOARD STILL ON THE TABLE?

We presented directly to some PCN Boards early in our engagement and held two webinars in February. The webinars were recorded and will be shared with you to engage your PCN.

FREQUENTLY ASKED QUESTIONS: PART I & II

We can provide documentation to support Executive Directors conversations with board members and if questions arise we can arrange a call with members to address questions.

HOW ARE WE COMMUNICATING WITH ACUTE CARE SO WHEN PATIENTS COME HOME, THEY ARE NOT ON A DIFFERENT CARE TRAJECTORY?

Communication processes and shared-care responsibilities will be addressed during co-design. Engaging end-users to understand what is working well and not so well is the first step to identify solutions to address specific challenges. Wherever possible we will leverage existing processes valued by participating practices.

WHEN WILL AN EDMONTON AREA WORLD CAFÉ TAKE PLACE?

World Cafes are held if we have interest and a commitment to participate in ISCP implementation in a local area.

NOTE: Due to the COVID-19 pandemic, future World Café events will not take place. Findings from the two completed World Cafés will inform this work and we will seek alternative forms of engagement for co-design.

WHAT WILL BE MEASURED? HOW IN-DEPTH WILL THE EVALUATION BE?

The primary outcome measures are directly tied to Rewarding Success funding:

- ✓ **Q1. VOLUME:** Number of physicians recruited to participate in the intervention
- ✓ **Q2.** Percentage of eligible patients that complete a supportive complex care plan (SCCP) by the end of the intervention
- ✓ **Q3a. Emergency Department (ED) Visits** = Average Number of ED visits (adjusted) per eligible patient per physician
- ✓ **Q3b. Hospital Length of Stay (LOS)** = Average LOS in days (adjusted) per eligible patient per physician

Plans for evaluation are built around existing processes and reporting mechanisms for primary care. We have partnered with the HQCA to provide Physician Panel Reports for participating physicians. (Appendix, Figure 1). Participating physicians will be required to sign a modified **HQCA Information Sharing Agreement** so the ISCP Team can complete the evaluation. Additional performance measures we be collected as part of the overall research evaluation

framework. The ISCP Team will be responsible for the overall evaluation and will collaborate with AHS Enterprise Data Warehouse to collect this data.

HOW MUCH WILL THE EVALUATION RELY ON PATIENT SURVEYS?

A Patient Satisfaction Survey will been one reporting component. This is already built into HQCA reporting using an electronic patient survey distributed via email and tracked through patient demographics. Completion rates are relatively high already and only a small subset of a physicians confirmed panel would be eligible for the ISCP intervention. With a shared care model between patients and providers and the frequency of visits over the implementation period we anticipate the population would be motivated to complete the Patient Satisfaction Survey and the burden to patients would not be substantial.

IS THERE CRITERIA FOR THE PATIENT THAT IS CONSIDERED COMPLEX?

Yes, refer to Appendix: Table 1

WHAT HAPPENS AFTER THE WORLD CAFÉS? WHAT DOES PARTICIPATION LOOK LIKE AT THE PCN AND PHYSICIAN LEVEL?

Refer to Appendix: Figure 2

WHAT IF THIS COMMITMENT CONFLICTS WITH OTHER INITIATIVES THAT WE ARE WORKING ON, ARE WE HELD TO THIS?

We understand the current challenges facing primary care and the ISCP Team will work with PCN leadership to help address any issues as they arise.

Given the alignment of this work with other priority work we anticipate PCNs will be able to leverage the skills and increased capacity to achieve success related to other areas of their business plan. PCNs are required to sign a contract agreeing to specific terms and conditions before funding is released. We need commitment over the period of funding to complete implementation and achieve the primary outcome measures. If PCNs are unable to recruit the agreed number of physicians prior to implementation, funding will be adjusted to reflect overall physician participation.

APPENDIX

Table 1: *The Supportive Care Pathway Algorithms to Identify the Study Cohort*

Disease Cohort	Inclusion Criteria **All patient MUST meet these criteria AND where applicable, have survived EOC* to discharge**
Advanced-state heart failure (HF)	1. One hospital admission with a primary diagnosis of HF 2. Age ≥18 years
Advanced-state chronic obstructive pulmonary disease (COPD)	1. 2 hospitalizations with COPD as primary diagnosis within 12 months OR 2. 1 hospitalization with COPD as a primary diagnosis AND one of: • All-cause readmission** ≤30 days from discharge date • Includes an ICU admission during hospital stay • + 1 ED visits within 12 months **OR** 3. 2 ED ≤6 months apart with a primary diagnosis of COPD 4. Age ≥18 years
Advanced-state (decompensated) cirrhosis	1. One hospitalization with a primary diagnosis of decompensated cirrhosis 2. Age ≥18 years
End stage kidney disease (ESKD)	1. 2 eGFRs ≤15 ml/min/1.73m^2 ≥90 days apart AND 2. ≥ 65 years of age
Advanced-state solid organ cancer	Age ≥18 years

*EOC: Episode Of Care: defined as the combination of all records associated with a visit after accounting for inter-hospital transfers. Transfer: defined by last discharge time – next admit time ≤12 hours for a different site within the same zone, or last discharge time – next admit time ≤24 hours for between zones.

** All-cause readmission: defined as emergent or urgent non-elective readmission to an acute care hospital (admission category = U) for any cause following a previously recorded COPD hospitalization where the admission date on readmission record - discharge date on last record of index episode of care is ≤30 days.

FREQUENTLY ASKED QUESTIONS: PART I & II

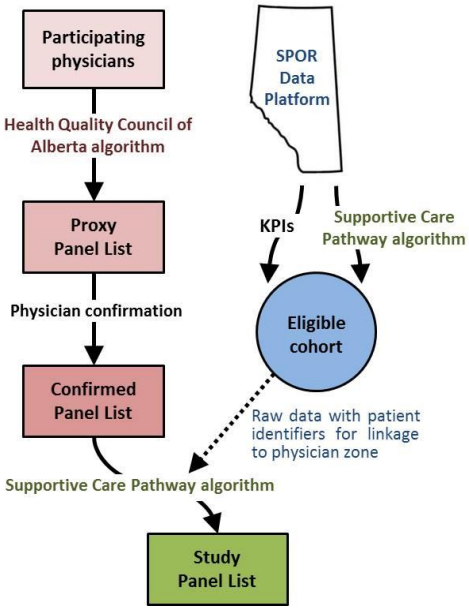

Figure 1. *Process for Establishing Eligible Patients (Study Panel Lists)*

Phase I	Phase II	Phase III	Phase IV	Phase V
Initiation, Planning & Communications • Communication to PCN EDs & Physician Leads • **Key Messages & FAQs** shared • Board &/or clinic presentations & Webinars • Engagement with Liaison/PF leads begins • **PCN Readiness explored**	**Engagement & Co-design** • Verbal commitment signaling PCNs commitment to participate in implementation • Introduced customized training option • **Operational planning** with Liaison/PF leads begins • PCN identifies **physician champions**	**Physician Recruitment** • **Letter of Understanding** - establish roles, expectations, & targets with PCN • Liaisons/PFs begin **customized training** to assist with recruitment** • PCN with support from Liaisons/PFs begin **recruiting physicians** ***optional value-add activity*	**Pre -Implementation** • Participating physicians sign **Information Sharing Agreement** • Clinics participate in Supportive Care **Demo & training on pathway & processes** • Eligible patients identified from confirmed patient panel	**Implementation** • Physicians & clinic staff participate in ongoing **learning sessions** (tailored to clinic) • Physicians **complete shared-care plan** for eligible patients*** (those identified at baseline) by end of implementation cycle (2-2.5 years) • Participate in regular reporting through HQCA ****refer to Figure 1*
Sep – Dec 2019	**Jan – Dec 2020**	**G1: Nov 2020 – Apr 2021** **G2: Jan 2021 – Sep 2021**	**G1: Apr – Jun 2021** **G2: Oct – Dec 2021**	**G1: Jul 2021 – Jan 2024** **G2: Jan 2022 – Jan 2024**

Figure 2. Phases of Integrated Supportive Care
*Timeline updated **July 29, 2020**. Implementation start date has been **extended** 6 months to reflect changes in the environment as a result of COVID-19. Overlap in activities across phases anticipated up to Phase V*