March 2024

Care Planning in Continuing Care – Fundamentals

Learner Workbook

For more information
ahs.ca/continuingcare

Seniors Health & Continuing Care
Policy, Practice, Access & Case Management

March 2024

This report has been prepared by AHS Provincial Seniors Health and Continuing Care (PSHCC) in partnership with the Care Planning Education Development Working Group.

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Disclaimer

References to continuing care (including home care, designated supportive living, long term care and hospice) may not reflect the updated language or terms found in the new Alberta Continuing Care Act which is anticipated to take effect April 1, 2024. Please refer to the definitions/glossary section of the document or website for updated terms.

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Definitions

Continuing Care Home

Continuing care home means a facility or part of a facility where facility-based care is provided to residents, some of whom must be eligible residents.

Facility-Based Care

Facility-based care means the group of goods and services that is provided on an ongoing basis to residents of a continuing care home and that is made up of the following: prescribed accommodation goods and services, prescribed health goods and services, and prescribed other goods and services.

Home and Community Care

Home and community care means the prescribed health goods and services and prescribed other goods and services that are provided by a home and community care provider to an eligible individual in the individual's home or community, but does not include facility-based care or supportive living services.

Supportive Living Accommodation

Supportive living accommodation means buildings or units in buildings that are intended for permanent or long term residential living; where supportive living services are provided to assist residents to live as independently as possible. Does not include a continuing care home or a private dwelling where an individual provides care or services only to the individual's family members or friends.

This workbook accompanies the Care Planning in Continuing Care – Fundamentals Presentation.

Learning Objectives

By the end of this course, you will be able to:

1. **Define** the core concepts of care planning.
2. **Identify** accountabilities for care planning.
3. **Demonstrate** person-centred care, personhood, and strength-based approach in care planning
4. **Describe** the care planning process.
5. **Associate** care planning and quality improvement.
6. **Summarize** care planning resources

Workbook

Reading

Discussion Question

Writing

Practice in Connect Care

Toolkit/Resource

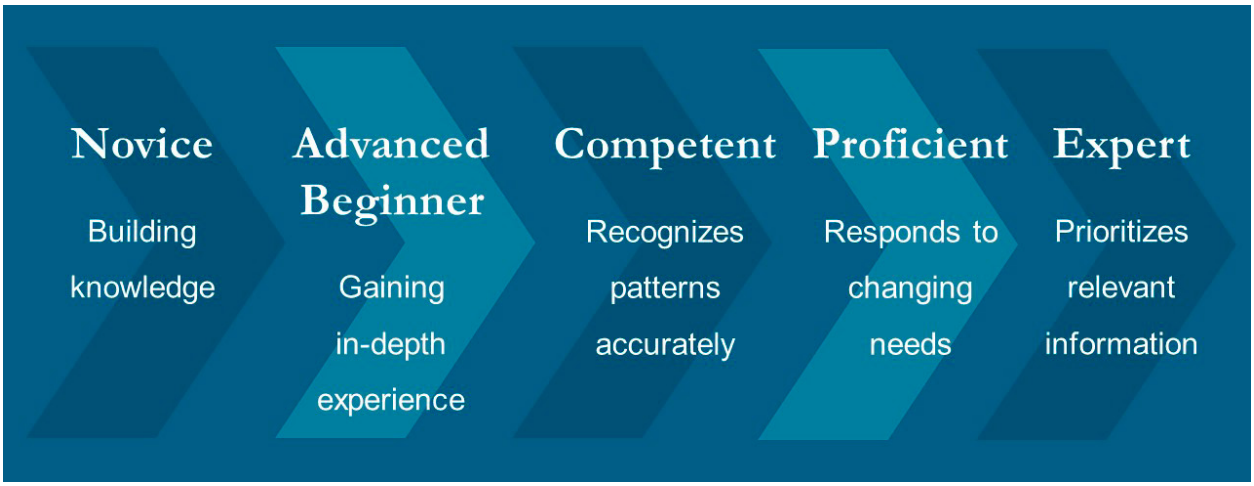
Care Plan Process Steps
(a different section and color represents a different step)

Continuing Care Home

Home and Community Care

Introduction

Identifying Your Proficiency



- ☐ I am a **Novice** because:
- ☐ I am an **Advanced Beginner** because:
- ☐ I am **Competent** because:
- ☐ I am **Proficient** because:
- ☐ I am an **Expert** because:

What is Care Planning?

Care planning is guided by the Alberta Health Services (AHS) Patient First Strategy which establishes a framework for ensuring clients and families/support persons “are at the centre of all that we do and every decision we make.”

The entire health care team, with the client at the centre, works collaboratively to develop an integrated and comprehensive care plan. Care planning is focused on the strengths of the client, rather than the perceived needs which facilitates informed choice.

> The process by which health care professionals and patients discuss, agree, and review an action plan to achieve the goals or behaviour change of most relevance to the patient.

Burt et al. as cited in AMA 2016

Philosophy of Care Planning

A care plan philosophy is a framework of values that helps clients make the best choices for care provision with the support of health care professionals.

Why is a care plan philosophy important?

- Helps healthcare providers to think critically, to reflect on how their own values influence practice and promotes discussion with clients.
- Promotes the ability for clinical judgement and evidence-based practice to be balanced with client choice and the right to accept, modify, or refuse care.

What if our values do not match the clients?

- Non-adherence or non-compliance are not a real thing: the client may have a different goal at that moment regardless of the established plan.
- Clients always have the right to accept, modify, or refuse care at any time; we must ensure this is an informed choice.
- If you are unable to answer the client's questions, you must direct the client to the best resource to answer the question and ensure the client has time to understand risks and benefits and ask further questions before making a choice.
- Look for opportunities to be creative.
- Think about if you are care planning to the staff needs vs client needs i.e., convenience vs need.

Accountabilities


Source: Freepik.com

Care planning is also guided by legislative requirements and accreditation standards. Knowledge of the Continuing Care Health Service Standards (CCHSS) and your required organizational practices is foundational. It is supported by interRAI standardized assessments which contribute to the knowledge healthcare teams have as part of the care planning process. It also provides a foundation for continuous quality improvement.

System level	CCHSS Standard 1 legislates care planning in continuing care.
	Accreditation Canada Standards ensure care planning is addressed and honoured.
Organizational level	Alberta Health Services (AHS) Patient First Strategy ensures clients, and their supports are "at the centre of all that we do and every decision we make."
	Operators' Required Organizational Practices provide the foundation for care planning.
	Clinicians provide holistic care of client, which includes care planning and is guided by professional responsibilities.
Client level	Care planning ensures appropriate goals, interventions, and desired outcomes are identified and addressed.

Review

- Care planning is the process that supports clients to make informed choices for care with the support of healthcare professionals.
- Care planning is interdisciplinary and collaborative.
- Care planning focuses on the strengths of the client.

Notes:

Priorities in Care Planning

Holistic Care

Holistic care focuses on more than function.

Write a few words that describe the emotion you would feel if you were receiving care from a health care provider.

Share with the group. What does holistic care mean to you?

Strength-Based Care

Strength-based care is both a philosophy and approach that acknowledges every client's inherent strengths. It is a way to work with individuals, families, and organizations while considering the knowledge and resources the client has, the client's ability to learn new skills to address assessed needs, and the ability to be involved in the process of healing and self-health.

Questions you might ask the client

- What matters to you?
- What do you consider to be your strengths?
- What are some of the things that you do to take care of yourself?

Personhood

Source: Freepik.com

> The distinct personality of an individual, how the individual identifies in relationships and as a social being, identity, culture, strengths, abilities, likes/dislikes.
>
> AHS, 2022

Why is personhood important?

It establishes:

- A culture of dignity and respect between the client and the healthcare provider.
- Encourages open communication.
- Enhances development of strengths.

Respecting and responding to a client's personhood can improve case managers' satisfaction in their work. In the home setting, there is increased flexibility to honour personhood as it is the client's domain. In a continuing care home, there may be limitations in the ability to fully recognize everyone's personhood. There is a need to balance an individual's medical needs, assessed needs, and goals with potential risks. This may include balancing the needs of the individual with the needs of the community they live in. Routine activities such as mealtimes, and recreation, etc., required practices such as cleaning, infection control etc., and environment such as shared rooms, noise, space in the building, etc. need to be considered.

Each member of the health care team (e.g., case manager, social worker (SW), recreational therapist (RecT), occupational therapist (OT), physiotherapist (PT), health care aide (HCA) etc., may need to gather information to understand who the person is. A good relationship with the client is necessary to provide effective care, prevent a crisis from developing, and potentially causing harm to the client. Improved care at the client level improves care and system integration. It is our job to identify and remove barriers that impact clients' lives. Focusing on personhood over perceived barriers and traditional boundaries provides opportunities for **quality improvement** and **system change.**

Person-Centred Care

Incorporating a strength-based approach and personhood leads to person-centred care. These practices:

- Empower clients to identify and meet their health goals.
- Recognize the individual, not the diagnosis.
- Focus on the strengths of the client instead of perceived needs.
- Support collaboration between all members of the healthcare team, especially **the client.**
- Optimize consistent care delivery and communication.

Informed choice

With person-centred care, the healthcare professional has validated that the client understands the risks and benefits of every option, has had an opportunity to ask questions about all options, and understands the answers to those questions.

- Recognizes that a client may choose a different option later. This considers the client's needs, strengths, and understands preferences may change over time.
- "Non-adherence" and "non-compliance" are value statements; they suggest the client is expected to follow a defined plan.
- Ensures clients can (and do) challenge healthcare teams to adapt best practice care that is informed by the individual needs, wants and desires.

Case Management

Case management provides structure and system navigation. Note there is a difference between case management and a case manager.

Case Manager

A regulated healthcare provider qualified to provide case management (CCHSS Standard 2.0); may have a different role title. They are responsible for:

- oversight
- developing and/or implementing the care plan and care planning process
- ensuring continuity of care

> Case Management is a collaborative, person-centred strategy for the provision of quality health and supportive services through the effective and efficient use of available resources to support the patient's achievement of goals.
>
> Continuing Care Case Management Framework & Guidelines 2011

Case Management

Case management is a collaborative team approach undertaken by all members of the healthcare team in supporting clients to manage their chronic conditions, improve/maintain functional status, and achieve health-related goals. This includes strength-based care, providing care based on the client's direction and on identified assessed needs that focuses on their strengths and abilities. This includes coordination of care, and everyone needs to be involved.

AHS offers comprehensive case management training; contact your manager to find out how to attend.

Collaborative Practice

The first word in the definition of case management is **collaborative**.

Collaborative practice:

- Has clear, effective communication and decision making.
- Is a complimentary partnership between client and healthcare professionals from similar and different disciplines.
- Establishes clear priorities, roles, and responsibilities for all involved.
- Enables healthcare providers to deliver high-quality, safe person-centred services to achieve the best possible individual health outcomes.

Collaborative Care vs Collaborative Practice

- Collaborative care is **what** we are trying to achieve.
- Collaborative practice is **how** we achieve it.

Write a list of people involved in collaborative practice.

Watch the video(s) applicable to the education you are taking:

Home and Community Care

Crystal's Story-Working Together

Continuing Care Home

The Good Daughter – Harmony's Story - YouTube

The Big Leap – Marfe's Story - YouTube

Share who else might be a part of this collaboration.

Review

- Holistic care focuses on more than function.
- Strength-based care is both a philosophy and approach that empowers the health care team to support the client with coaching to self-advocate.
- Person-centred care focuses on the strengths of the client instead of perceived needs.
- Case management incorporates a collaborative team approach to establish clear priorities, roles, and responsibilities for all involved.
- Please check the additional resources available at the end of the workbook.

Notes:

The Care Plan Process

The Process

The care plan process includes:

- Assessment
- Decision-Making
- Planning
- Communication
- Evaluation

Steps of the care plan process are meant to be fluid and not linear. The image on the left identifies the elements of care planning and the continuous nature of the process.

The care plan process includes everyone involved in the client's care:

- client
- informal supports
- healthcare providers
- volunteers
- other site staff, etc.

All team members can support in any step of the care planning process. With that in mind, your program may benefit from well-defined timelines, roles, and responsibilities to ensure complete care planning.

The care planning process integrates collaborative practice, strength-based care, personhood, and person-centred care. This process may be a culture shift in some programs and is a learning opportunity for all involved including the client.

Assessment

Our clients often come to us with a list of diagnoses and other issues. An assessment helps identify the client's strengths, challenges, and assessed care needs. Assessments should be comprehensive, exploring all domains: physical, mental, emotional, social, intellectual, spiritual, and medical. All care team members can offer assessment findings, and collectively provide a holistic view of the client.

Consider information and observation from both formal and informal caregivers when completing assessments and ask the client “What’s important to you” and document their exact words.

In continuing care, assessments are completed at different intervals.

- **Home and Community Care:** admission, annually and with any significant change in status.
- **Type B Continuing Care Home:** admission, annually and with any significant change in status.
- **Type A Continuing Care Home:** on admission, quarterly and with any significant change.

Share with the group one to two resources used to ensure comprehensive assessment at your site.

Describe how different disciplines contribute to assessments.

Decision-Making

There are **two** distinct parts to decision-making:

Analysis

Analysis is the process of identifying actual assessed needs of the client and how different needs might be related. It is necessary to understand the client's preference about meeting needs (or not) and understanding the root cause of each need. We can dig deeper by asking the 'Five Whys'. The purpose of the 'Five Whys' is identifying and addressing the root cause. This process helps to eliminate bias and assumptions when attempting to determine the root cause. View the examples from the video scenario you have watched based upon the care setting.

Identify Root Cause: 5 Whys:

Home and Community Care Example - Crystal's Story Working Together

1	Why are Mr. & Mrs. Jones at risk of having Psychosocial well-being concerns?	Mr. & Mrs. Jones are at risk of increased stress and reduced coping.
2	Why are Mr. & Mrs. Jones at increased risk of stress and reduced coping?	Mr. Jones is responsible for the full-time caregiving of Mrs. Jones.
3	Why is Mr. Jones responsible for the full-time caregiving of Mrs. Jones?	Mr. and Mrs. Jones do not have any other support.
4	Why do Mr. & Mrs. Jones not have any other support?	They are not aware of formal supports available & their informal support (family) live far away.
5	Why are Mr. & Mrs. Jones not aware of formal support options?	Home care has just assessed their needs & has not provided the information yet.

Continuing Care Home Example - The Good Daughter & The Big Leap

1 Why is Carol calling her family in the middle of the night?	Carol cannot fall asleep.
2 Why can't Carol fall asleep?	Carol does not have a regular bedtime routine.
3 Why doesn't Carol have a bedtime routine?	The staff do not know Carol very well.
4 Why do the staff not know Carol very well?	Staff assignments are rotated monthly. It takes time to know how to care for a new group of clients.
5 Why does the assignment change every month?	This was best practice 5 years ago: gives staff a chance to work with all clients; reduces staff fatigue; provides equitable workload.

Goal Setting

Clients can often tell you what they want (e.g., I want to be able to go on outings with my family. I want to be healthy enough to attend bingo and visit with my friends.) These wants are very specific. Healthcare teams may need to build on the specific wants to define how often, how much, by when, and over what time frame, with the client. Healthcare providers may need to engage in difficult conversations with the client when exploring whether the goal is reasonable/realistic and achievable. Healthcare teams may need to work with the client to explore alternatives or other options for achieving their goals when they move into planning (e.g., establishing interventions and implementation of the care plan). Consideration needs to be given to whether goals align with the client's advance care planning and goals of care. Advance care planning conversations may need to be updated if there has been a change. Goal setting may not necessarily happen at a face-to-face care conference/IDT conference/family conference. There may be other informal ways that goal setting occurs, for example, there may need to be multiple conversations with the client to accurately develop SMART goals. This will get easier over time as the team builds competence with care planning and gains a more holistic knowledge of the client. Remember that there are requirements/timelines within which you must complete care plans. The care plan can always be revised according to new information obtained and is representative of all disciplines and the client.

Ensure you:

- Give the client and family the opportunity to participate and provide input.
- Allow the client to invite individuals of their choosing to participate and provide input.
- Hold an interdisciplinary team (IDT) conference.

***Note:** There may be varied practices based on capacity and ability to have everyone at the table. Think about how this can still be collaborative if not everyone can be included. Evidence will need to be provided of the involvement with each IDT member.)*

S	M	A	R	T
Specific	**Measurable**	**Achievable**	**Realistic**	**Timely**
Defined outcome *The client's goal is …*	Determine progress *We will track progress by …*	Attainable *We will achieve this goal by doing the following…*	Appropriate for the client and situation *This goal helps the client because …*	Defined timeline *We will complete this goal by …*

Write a SMART goal that addresses the need of the client.

S	*The client's goal is:*	
M	*We will track progress by:*	
A	*We will achieve this goal by doing the following:*	
R	*This goal helps the client because:*	
T	*We will complete this goal by:*	

Planning

Right care, right place, right provider

- Encourage client independence and participation.
- Honour the client's privacy and comfort.
- Ensure the right person is performing the task.
- Planning connects goals with interventions to support those goals.
- Interventions should encourage client involvement and independence, are outcome-focused and specific to the client goal.
- Creative care planning may be appropriate, consider alternatives and novel ideas.

Interventions

Interventions should relate to goals. Remember, more than one intervention may relate to each goal, and one intervention may address multiple goals.

- Ensure that interventions are **specific to the client.**
- Interventions should be measurable, achievable, and realistic. They are meant to support goal achievement, so consider which health care team members can best support the client.
- Timely – specified frequency and target timeline for outcome.
- Identify how effectiveness will be evaluated.

Interventions evolve as client status and preferences change; a client may identify a new priority after the care plan is integrated. Consider interventions that are not hands-on including: teaching, self-report, monitoring and evaluation.

Communication

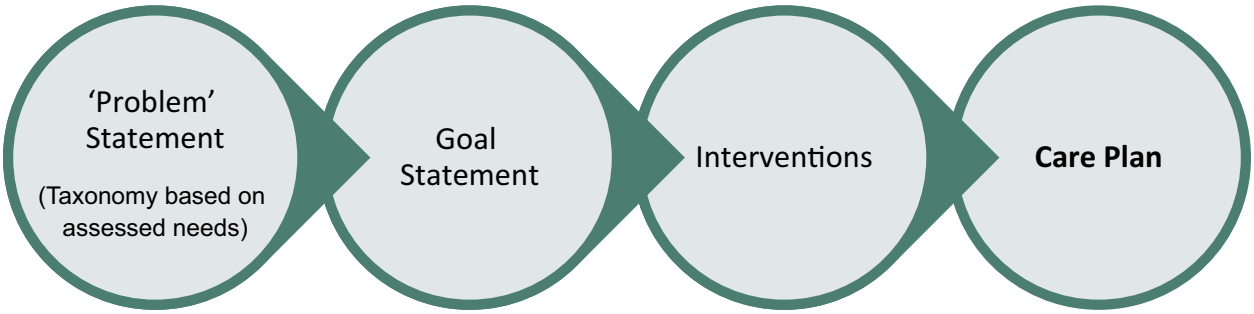
Communication is key to implementation. To enable clear, effective communication, all steps of the care plan process must be documented. Nothing in the care plan should be a surprise if the right people were involved in the planning process, this includes ensuring the client is offered a copy of the care plan (to meet Standard 1 of the CCHSS).

The healthcare team and the client should understand that the care plan represents the client and **evolves** with the client. Clear and consistent documented changes help improve client outcomes. This includes trends between care plan updates which can lead to proactive care.

NOTE: *The healthcare team includes the contracted service providers where involved.*

Remember:

- Communication is often written or verbal.
- Remind the team of client goals where appropriate.



Write down the different ways you communicate within your team.

Share with the group what is most important to communicate during shift report.

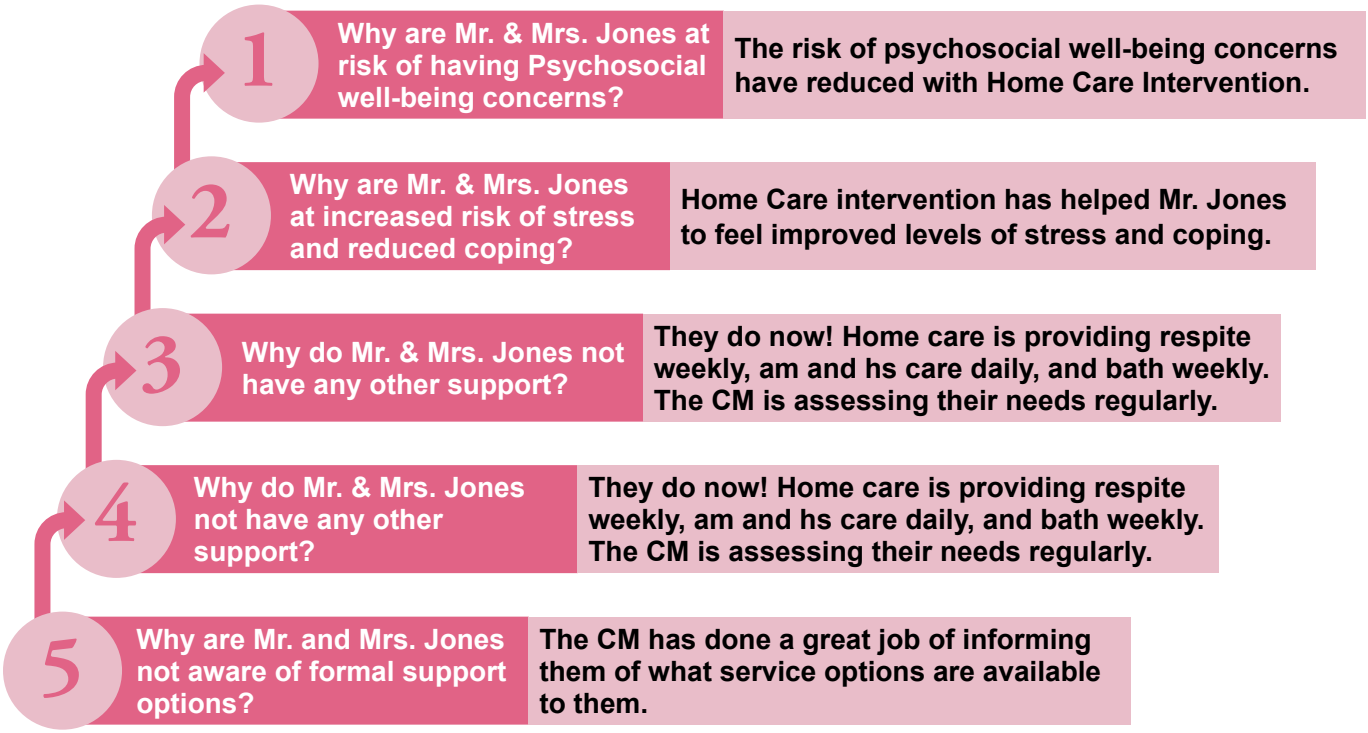
Evaluation

Evaluation is an important step in the process, as it determines if the care plan is effective. Are the interventions supporting the client's goals? Evaluation provides an opportunity to identify the changing needs of the client and determine what progress if any is being made.

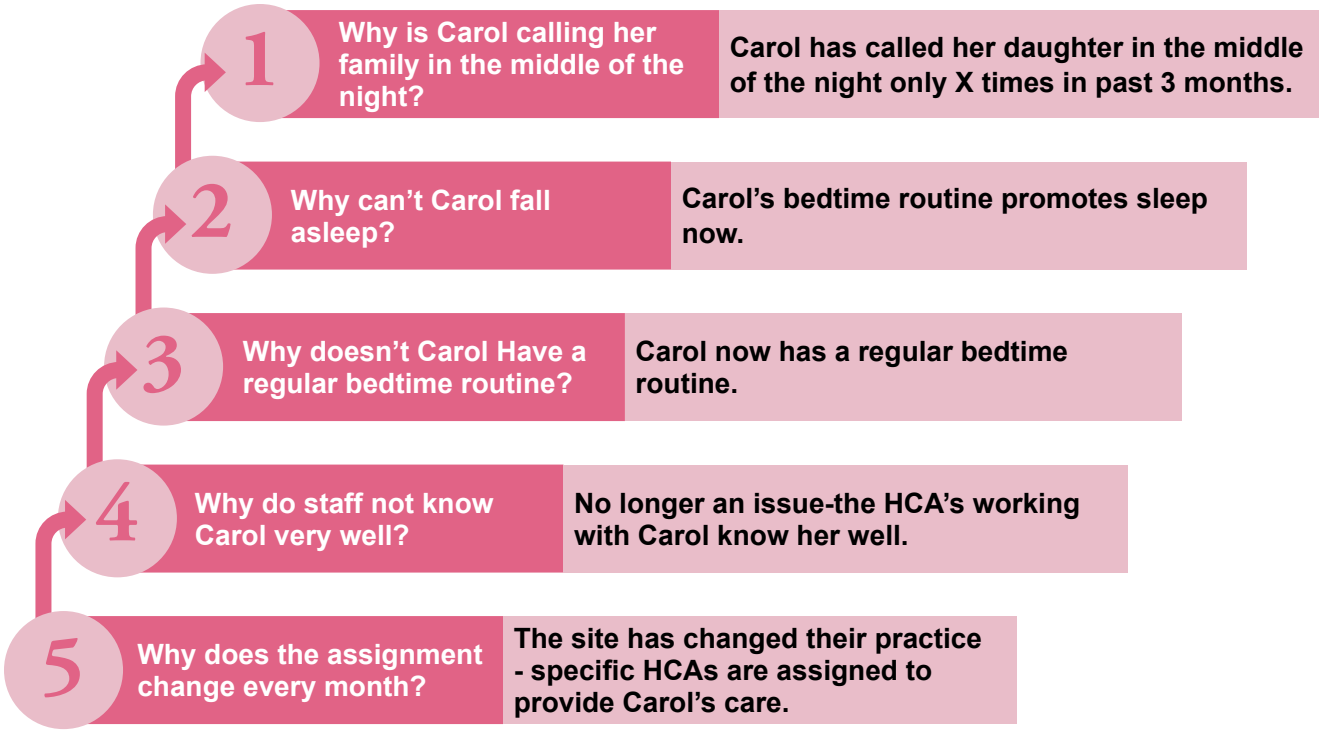
Closing the Loop

Remember our earlier example of asking the 'Five Whys'? Here is how we closed the loop regarding evaluation:

Home and Community Care Example - Crystal's Story Working Together



Continuing Care Home Example – Five Why's-The Good Daughter & The Big Leap



Evaluation should be completed with **every assessment** and with any significant change.

Regardless of the reason for change which may be due to a change in an intervention (i.e., trial of medication) or change in frequency of an intervention (i.e., behaviour support reduces from every 2 hours to every 4 hours).

- Review client goals
- Review documentation and confirm how often intervention was integrated in care (especially for "as needed" interventions)
- Re-assess and validate assessed needs
- Update care plan as needed.

NOTE: *The healthcare team includes the contracted service providers.*

Review

- The care plan process is meant to be fluid and not linear. It is an interdisciplinary process that includes the client as part of the healthcare team.
- Right care, right place, right provider.
- Remember the 'Five Whys', SMART goals and to document decisions.

- Evaluation determines if the care plan is effective.
- Please check the additional resources available at the end of the workbook.

Notes:

Quality Improvement

Quality improvement is more than just meeting the minimum standards and passing an audit. As a process, quality improvement honours **Just Culture** and the **Patient First Strategy**. Within this environment, staff feel supported as they are treated with care, compassion, respect, and dignity. When staff feel safe, they are enabled to discuss quality and safety concerns before, during and after an adverse event.

Quality Indicators

Quality Indicators are measures that enable you to quantify the quality of care and services provided.

Examples in continuing care include:

- interRAI outcomes and quality indicators
- RLS
- Accreditation Surveys
- Client and employee immunization rate reports
- Infection Prevention and Control reports
- CCHSS audits
- Trending of client and family feedback and/or survey reports

These measures are identified, tracked, trended, and reviewed by provincial, zone or site accountable leaders in collaboration with the healthcare team. Resident and Family Councils, and Quality Councils identify improvement opportunities at the individual and program level.

The Assessment and Care Planning are the beginning of the ripple out effect:

- Care planning is supported by interRAI standardized assessments.
- Outputs from interRAI assessments provide validation of client needs and the care plan addresses those needs.
- Leads to improved client experiences.
- Improved individual experiences may lead to quality improvement at the program level.
- Outputs also provide a foundation for continuous quality improvement as required by the CCHSS Standard 19: Quality Improvement Reporting.

Clients & Quality Improvement

As an employee in continuing care, you may encounter times when quality improvement initiatives are undertaken in response to formal indicators (e.g. RLS, interRAI outputs, HQCA surveys) and informal indicators (concerns, feedback), which help identify priority issues.

Quality improvement initiatives bring knowledge and expertise from other perspectives, facilitating potential solutions for implementation.

Forums where quality improvements are initiated in home and community care include:

- Resident and Family Councils in continuing care home or supportive living accommodation
- Quality Councils (or working groups) in home care offices
- Patient Relations (responds to concerns, suggestions, commendations and feedback from patients, families, and the public)

Reporting and Learning System

Alberta Health Services has a single, province-wide system for patient safety reporting. The Reporting & Learning System for Patient Safety (RLS) supports a just culture that includes reporting and learning as key elements. Consistent reporting of hazards, close calls and adverse events is encouraged to learn about and improve patient safety throughout the health care system. This practice supports AHS's commitment to providing a quality health system for Albertans. The Patient Safety Reporting team provides administration of the RLS system and is supported by the Reporting of Clinical Adverse Events, Close Calls and Hazards Procedure. AHS staff can visit the RLS Education & Training Resources Insite page for more information.

Examples of RLS report submissions include falls, medications, pressure injury/skin, wound, medical device incidents or problems, laboratory or blood product problems, to name a few.

Health Quality Council of Alberta (HQCA)

HQCA is Alberta's go-to resource about what clients experience in our health care system. The council believes that reporting about what's happening in our healthcare system can lead to quality improvement and a better healthcare system in Alberta. (HQCA, 2023)

For More Information go to:

Health Quality Council of Alberta | Improving Healthcare in Alberta (hqca.ca)

- FOCUS: Home Care - HQCA Focus
- FOCUS: Long Term Care - HQCA Focus
- FOCUS: Designated Supportive Living - HQCA Focus

Canadian Institute for Health (CIHI)

The Canadian Institute for Health Information (CIHI) provides comparable and actionable data and information that are used to accelerate improvements in health care, health system performance and population health across Canada.

Quality Management Reports

Quality Management Reports (QMR) for Home and Community Care and Continuing Care Homes display information that includes CIHI-RAI Adjusted Quality Indicators for operators. These are available on **Tableau**, the platform AHS uses to make data easy to see and understand, so that the data can inform decisions and improve quality.

Resident and Family Councils

Resident and Family Councils support quality improvement at long term care and licensed supportive living facility settings serving more than 4 people (Government of Alberta, 2023) by helping identify priority issues and potential solutions. These councils bring knowledge and expertise from many perspectives. *Example (based on Marfe's Story):* The Resident and Family Council at Father Lacombe was very involved in quality improvement and ensured that:

- everyone has access to information that will inform quality improvements.

- everyone has an opportunity to engage – everyone has a voice in decision making.
- virtual and teleconference meetings allow long-distance Resident and Family Council members to participate.

Quality Improvement in Action

We all have a responsibility to quality improvement. Our shared goal is to continually improve client experiences. Effective improvement strategies must identify the desired outcome and how it will be measured.

Watch the video applicable to the education you are taking as an example of how to put this into practice.

Home and Community Care Video

Old Ways & New Doors: Wilma's Story – YouTube

Continuing Care Home Video

Walkers Gone Wild

Share with the group how this example had impact:

Review

- Quality improvement is more than just meeting the minimum standards and passing an audit.
- Quality improvement honours AHS Just Culture and the AHS Client First Strategy.
- Staff feel safe, encouraged, and enabled to discuss quality and safety concerns before, during, or after an adverse event.
- Quality indicators may be informal and issues may require creative solutions.
- Please check the additional resources available at the end of the workbook.

Next Steps

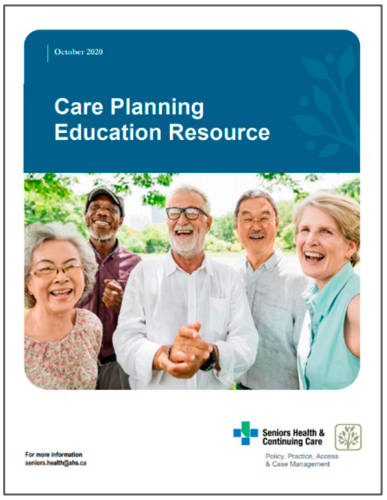
We hope this education has provided the building blocks to help you better implement care planning in your work. This change comes from you and your ability to practice these values in an environment that prioritizes them.

Further Your Knowledge

Courses

- Enroll in scenario-based learning that supplements the Care Planning in Continuing Care – Fundamentals Course (or E-module). Contact your Zone Program educator or manager for information.

> Successful organizations understand the importance of implementation, not just strategy, and, moreover, recognize the crucial role of their people in the process.
>
> Jeffrey Pfeffer



Learning Tools

- Care planning Education Resource
- Includes best practice information and guidance
- Various links are included in this workbook

Learning Opportunities

- Alberta Health Case management Training courses
- Connect Care courses
- interRAI Instruments

Ongoing Support

- Superusers, educators, managers

Source: Freepik.com

Final Review

Congratulations! You have completed Care Planning in Continuing Care - Fundamentals. We invite you to reflect on the learning objectives and ask yourself if you can:

- Define the core concepts of care planning?
- Identify accountabilities for care planning?
- Demonstrate person-centred care, personhood, and strength-based approach in care planning?
- Describe the care planning process?
- Associate care planning and quality improvement?
- Summarize care planning resources?

Notes:

Additional Resources

Links to Learn More

Access additional links to complement your learning and build capacity.

Priorities in Care Planning

- Draw from the Case Management Toolkit and learn the **Strengths-based Approach**.
- Find more information on quality in continuing care information
  - Continuing Care | Alberta Health Services.
- Read more about how Two Hills and Wetaskiwin Health Care Centers were able to bring comfort to residents living with dementia with an ABBY system. (insite.ahs.ca)

Learning in Action

The Care Plan Process

- Users of Connect Care (AHS & affiliates) can get started by using the **Quick Start Guide Template** (https://insite.albertahealthservices.ca/Main/assets/cistr/tms-cis-tr-ltc-ccs-care-plan-problems-goals-list.pdf)
- Assess persons in Home and Community Care and Continuing Care Homes using the relevant interRAI Assessment Instrument

Quality Improvement

- Case Management Toolkit | Continuing Care Connection
  - Practice the **Keep, Start, Stop, Improve** method to structure your feedback discussions and communicate constructive solutions.
  - Incorporate multiple perspectives in decision-making using the **Six Thinking Hats** technique.
- Be up to date on Resident and Family Councils | Alberta.ca

References

Accelerating Change Transformation Team: Alberta Medical Association (AMA). *Model care planning process – Overview. (*November 2016). model-care-planning-process-explanation--update-november-2016.pdf (albertadoctors.org)

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