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# PERSON CENTRED MEDICAL HOME PROGRAM – 2017

## A Guide to Implementing PCMH into General Practice

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# 1. PERSON CENTRED MEDICAL HOME IN SYDNEY NORTH

At Sydney North Primary Health Network (SNPHN) we work together to create a connected experience for health providers and deliver healthcare in a way that responds to community needs, is patient-centred and has a focus on prevention and wellness.

Against a backdrop of strong population growth for our region, an ageing population, potential healthcare workforce shortages and greater numbers of hospitalisations and GP visits over the next 15 years, SNPHN will be concentrating on innovative and sustainable solutions that shift the focus of care out of the hospitals and into the hands of primary healthcare. To achieve this, we are trialling a program in our region called **Person Centred Medical Home (PCMH)**, otherwise known as patient centred medical home or medical home.

A Person Centred Medical Home combines the traditional core values of family medicine – providing comprehensive, coordinated, integrated, quality care – that is easily accessible and based on an ongoing relationship between a person and their health care team.

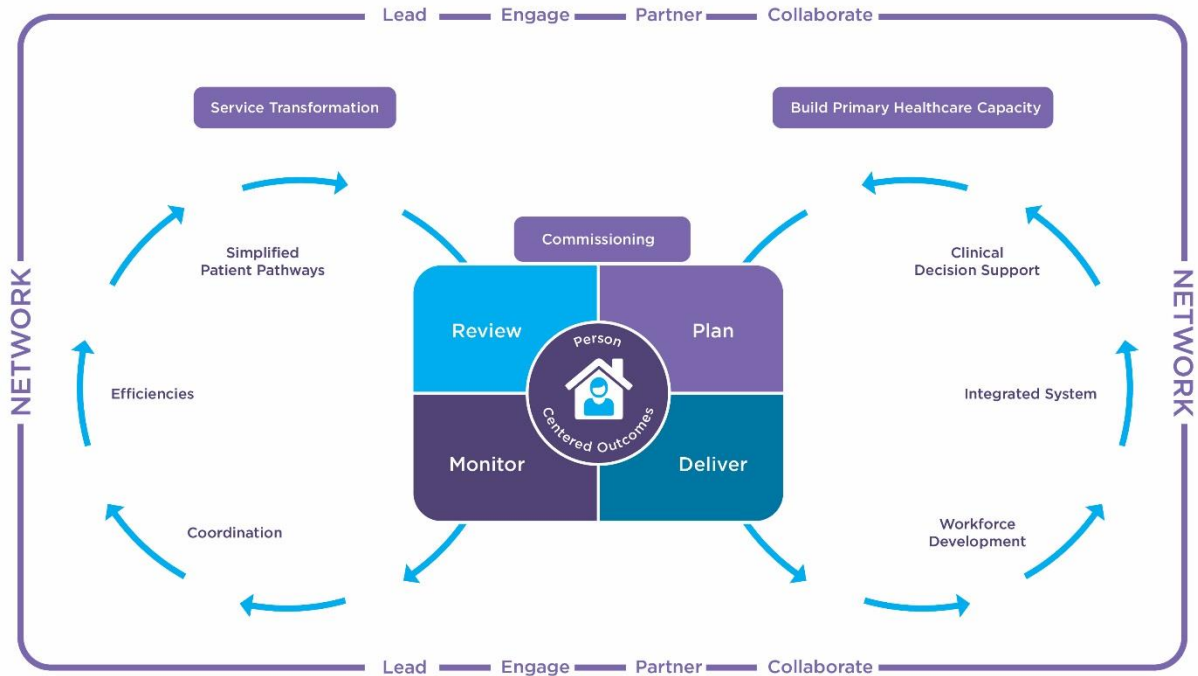
SNHN will provide support and education to the healthcare team to help the practice achieve the quadruple aim:

- Enhance the patient experience of care.
- Improve systems and efficiencies.
- Optimise population health and wellbeing.
- Improve the work life of health care clinicians.

SNPHN will provide participating practices with a 12 month program including education, support and tools. The education will be based on the 10 Building Blocks of high performing care.

Participating practices will be supported to maximise use of enabling tools and technology, such as the soon to be launched Sydney North HealthPathways portal to assist with navigation of local services, shared care planning tools that assist with coordination of team-based care and secure messaging, to support ease of electronic communication between care providers.

# Sydney North Primary Health Network Primary Healthcare Integrated Commissioning



Network: Service User, Service Provider, Health System

## 1. PLAN

- Stakeholder Engagement
- Identify Need
- Service Co-design

## 2. DELIVER

- Co-delivery
- Build Capacity
- Support

## 3. MONITOR

- Informatics
- Challenge Quality
- Drive Improvement

## 4. REVIEW

- Outcomes
- Impact
- Inform Re-design

## 2. KEY PRINCIPLES OF THE PERSON CENTRED MEDICAL HOME MODEL

### Person Centred

A Person Centred Medical Home (PCMH) partners with patients, families, and the health care team to be responsible for the provision of care even when the patient is not in the practice. The PCMH encourages self-management and patient involvement in care planning.

### Accessible

A PCMH manages appointment systems to provide timely access through routine appointments and arrangements for acute care needs and after hour's care. They also manage a proactive appointment plan to ensure patients with chronic conditions are regularly addressing their health care needs.

### Comprehensive

A PCMH considers a patient's continuous whole of person needs and ensures needs are met by the most appropriate care providers. A shared care strategy with effective communication between the patient and team care providers is employed for successful patient management.

### Quality & Safety

A PCMH systematises processes for quality improvement activities and data management using reliable and secure eHealth technology.

**Reading:** RACGP – Standards for Patient Centred Medical Home

<http://www.racgp.org.au/download/Documents/Standards/RACGP-Standards-for-Patient-Centred-Medical-Homes.pdf>

## HOW CARE COULD BE DELIVERED IN THE FUTURE

Today's Care		Person Centred Medical Home Care
My patients are those who make appointments to see me	➔	Our patients are those who are registered in our medical home
Care is determined by today's problem and time available today	➔	Care is determined by a proactive plan to meet health needs, with or without visits
Care varies by scheduled time and memory or skill of the doctor	➔	Care is standardized according to evidence-based guidelines and clear pathways
I know I deliver high quality care because I'm well trained	➔	We measure our quality and make rapid changes to continuously improve it
Patients are responsible for coordinating their own care	➔	A prepared team of professionals coordinates all patients' care
It's up to the patient to tell us what happened to them	➔	We track tests and consultations, and follow-up after ED and hospital
Clinic operations centre on meeting the doctor's needs	➔	An interdisciplinary team works at the top of our capability to serve patients

**Resource:** Navigating the Health Care Neighbourhood

<https://www.aci.health.nsw.gov.au/nhn>

### 3. THE QUADRUPLE AIM



**Reading:**

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider  
<http://www.annfammed.org/content/12/6/573.full.pdf+html>

## 4. PCMH – PRACTICE ASSESSMENT



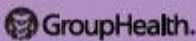
SAFETY NET MEDICAL HOME INITIATIVE

PATIENT-CENTERED  
MEDICAL HOME ASSESSMENT  
(PCMH-A)

Organization name

Site name

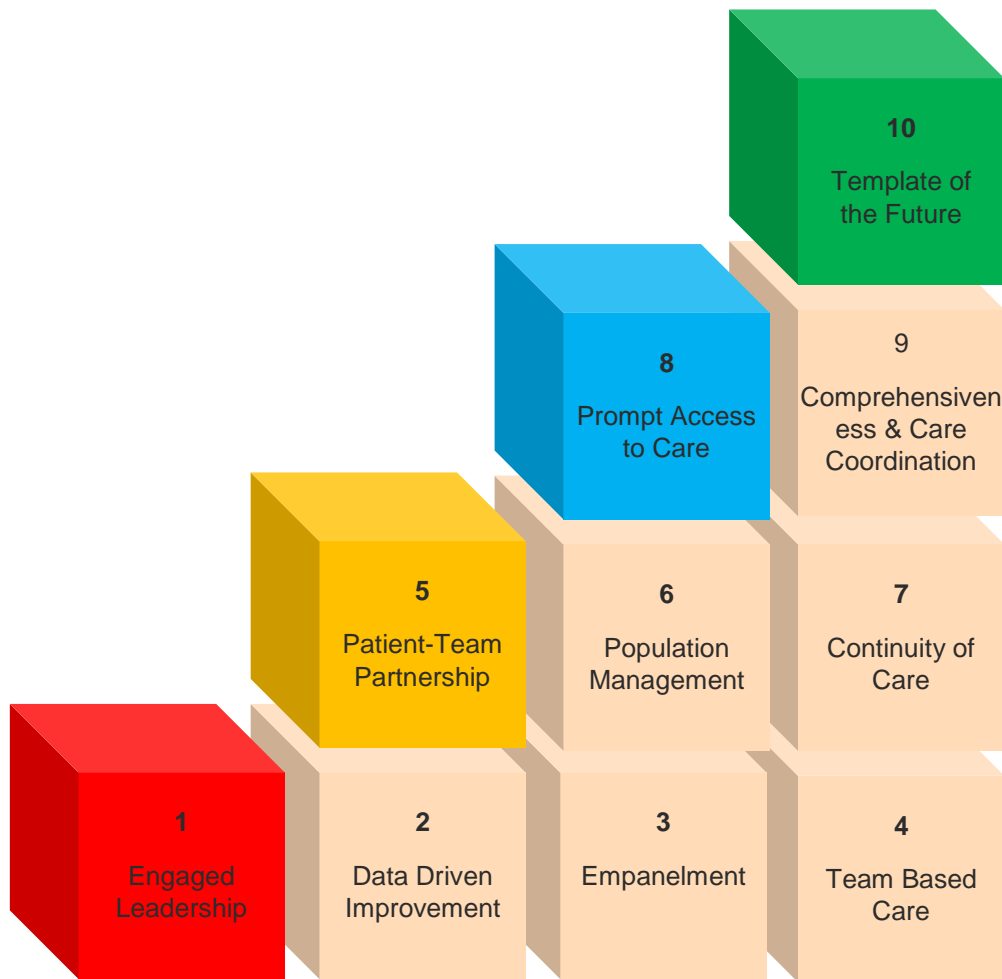
Date completed

    
MacColl Center for Health Care Innovation

**Action:** Each staff member to complete the survey and results to be discussed as a group.

**Link to assessment:** <http://www.improvingchroniccare.org/downloads/pcmha.pdf>

## 5. THE BUILDING BLOCKS



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The 10 Building Blocks of High-Performing Primary Care

Thomas Bodenheimer, MD, Amireh Ghorob, MPH, Rachel Willard-Grace, MPH and Kevin Grumbach, MD. Ann Fam Med March/April 2014 vol. 12 no. 2 166-171

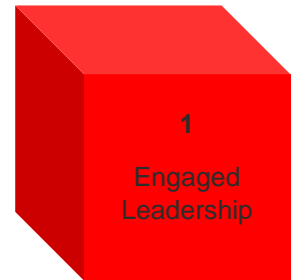
**Reading:** Building Blocks of High Performing Care

<http://www.annfammed.org/content/12/2/166.full?sid=fa194c23-f046-4ed0-9b3f-1d1742b1607d>



## 5.1 ENGAGED LEADERSHIP

The importance of leadership is fundamental in dealing with the opportunities and challenges facing primary care today. How well do you know your leadership style and the effect it has on your health care team? Everyone is a leader, however in the medical home General Practitioners are central to the success of driving change and achieving outcomes. Creating a vision for your practice and involving each member is the first step in leading meaningful change. How do you motivate your team to share your vision and achieve better patient outcomes?



*Be a role model for staff; be the change you want to see!*

### **Online Education:**

Steps Forward – Leading Change

<https://www.stepsforward.org/modules/practice-transformation>

Practice Teams and Leadership (module 6)

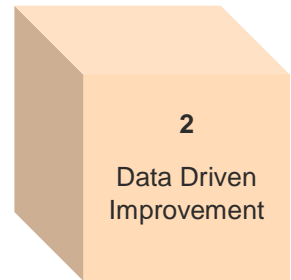
<http://www.racgp.org.au/your-practice/business/managementtoolkit>

Business Management (module 5)

<https://www.racgp.org.au/your-practice/business/managementtoolkit/module5/>

## 5.2 DATA DRIVEN IMPROVEMENT

To drive and manage effective improvement requires the second building block: data systems that track clinical and operational activities. Using a data extraction tool alongside clinical software to understand the practice patient population is invaluable when managing the requirements of the person centred medical home. Measuring and tracking changes over time and sharing this with staff can be a strong motivator. Make data part of the work life.



Quality data metrics tell us:

- Where we are?
- Where we are going?
- Where we want to go?
- How we get there?

Online Education: Pen Cat Webinars Tuesdays and Thursdays 1:00pm-1:30pm  
<http://www.pencs.com.au/support/>

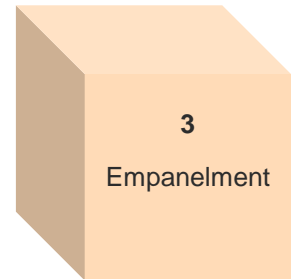
### **Actions:**

- Proactively and regularly use the Pen Cat Data Extraction Tool to understand the practice data, plan quality improvement activities and track the changes.
- Ensure staff who will be managing the data have adequate training. Contact Pen Clinical Systems **1800 762 993** or SNPHN **9432 8250** for additional information and support

### 5.3 EMANELMENT (PATIENT REGISTRATION)

Empanelment involves linking each patient with a primary care provider and care team. To improve continuity and establish a strong patient-team partnership it is important that patients and the care team know each other and plan the care together.

Empanelment helps with managing the cohort of patients, allocating the necessary resources, and balancing the workload among General Practitioners and the care team.



**Reading:** <http://www.safetynetmedicalhome.org/change-concepts/empanelment>

**Online Education:** Steps Forward – Patient Registration

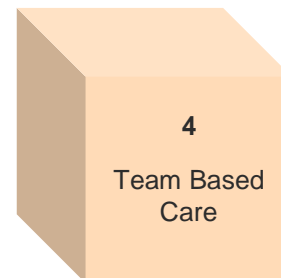
<https://www.stepsforward.org/modules/patient-pre-registration>

**Actions:**

- Assign identified patients to a primary care provider and health care team. Review and update panel assignments and team capacity on a regular basis. Balance patient load accordingly.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, and family need.

## 5.4 TEAM BASED CARE

High performing primary care practices are finding that creating more effective practice teams is the key to becoming a patient-centred medical home, improving patients' health, and increasing productivity. A team-based approach can lead to markedly improved care, efficiency, and job satisfaction.



### Online Education:

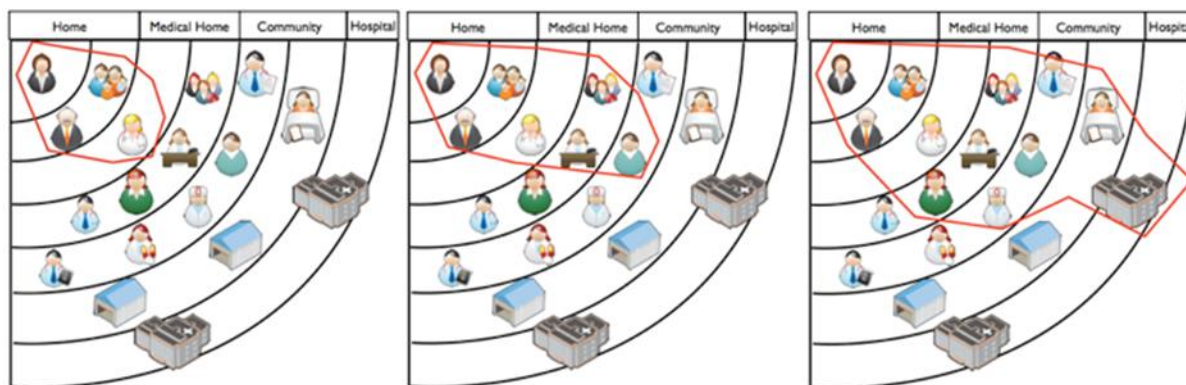
Building the Team

<http://www.improvingprimarycare.org/>

### Actions:

- Complete education modules, review current capacity and plan the team based on the registered cohort of patients. Train and/or upskill existing staff as needed.
- Utilise the [Sydney North HealthPathways](#) website to access local health services and referral pathways for patients.
- Username: healthpathways Password: gateway

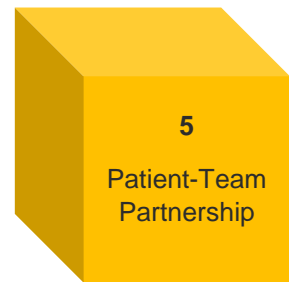
### Building the tools and blocks towards supporting team based care



As care needs change, the Care Team gains additional members. It is not a different team.

## 5.5 THE PATIENT TEAM PARTNERSHIP

An effective partnership recognises the expertise that patients bring to the medical encounter as well as the evidence base and medical judgment of the clinician and team. Patients are not told what to do but are engaged in shared decision making that respects their personal goals. For patients with chronic conditions, health coaching provides a framework for self-management support.



The key changes for Patient-Centred Interactions are:

- Respect patient and family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behaviours, and self-management.
- Communicate with patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through goal setting and action planning.
- Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement

**On-line Education:** Putting the Focus on The Patient

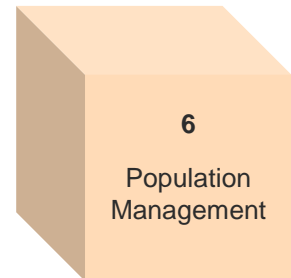
<http://c-learning.com.au/studio/aapm/Putting%20the%20focus%20on%20patients/shell.html>

Patient Centred Interactions

<http://www.safetynetmedicalhome.org/change-concepts/patient-centered-interactions>

## 5.6 POPULATION MANAGEMENT

High-performing practices stratify the needs of their patient panels and design team roles to match those needs. Three population-based functions provide major opportunities for sharing the care: panel management, health coaching, and complex care management. Panel management involves a staff member, usually a practice manager, medical assistant or nurse, periodically checking the practice registry to identify patients who are due for routine services (e.g. mammograms, colorectal cancer screening, and HbA1c, or low-density lipoprotein cholesterol laboratory work).



Alternatively, the panel manager can check the health maintenance screen on the electronic medical record before a huddle or medical visit to look for care gaps for these services. Standing orders enable panel managers to address care gaps without involving the clinicians. In some practices, most routine care is completed before the clinician enters the examination room, so that visits can focus on patient concerns, issues requiring the clinician's level of expertise, treatment options and shared care plans. For patients with chronic conditions, health coaching entails assessing patient's knowledge and motivation, providing information and skills, and engaging patients in behaviour-changing action plans known to improve outcomes. Diabetes patients working with health coaches, whether medical assistants or other patients with diabetes, may have better outcomes than patients without health coaches. When medical assistants, nurses, health educators, or pharmacists act as health coaches, they usually are given protected time to assume this time-consuming function.

Complex care management has emerged to address patients' needs that are medically and psychosocially complex, as well as patients who are high utilisers of expensive services. Teams headed by registered nurses or social workers have been shown to improve care and reduce costs for patients needing complex care management. Health coaching and complex care management take considerable time, and small practices can benefit from outside organisations assisting them with these functions.

**Online Education:** Organised Evidence-based Care

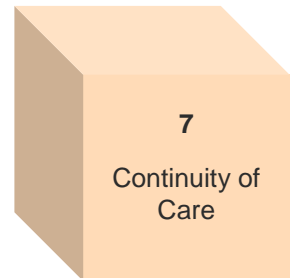
<http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care>

**Resources:** RACGP list of resources that support evidence based practice

<http://www.racgp.org.au/standards/141>

## 5.7 CONTINUITY OF CARE

Continuity of care is associated with improved preventative and chronic care, greater patients and clinician experience, and lower cost. To achieve continuity requires empanelment which links each patient to a clinician and team. High-performing practices measure continuity for each clinician and achieve continuity goals of 75% to 85%. Reaching these goals requires the front desk staff to encourage patients to see the clinician to whom they are empanelled.



### **Online Education:**

Continuity and Team Based Care

<http://www.safetynetmedicalhome.org/change-concepts/continuous-team-based-healing-relationships>

### **Actions:**

- Create patient panels so the patient, provider, and care team recognize each other as partners in care.
- Monitor Registered Patients
- Meet as a team regularly for evaluation and planning processes
- Ensure that time and space is available for teams to meet in quick daily huddles and longer weekly quality improvement meetings

## 5.8 PROMPT ACCESS TO CARE

Access is closely linked to patient satisfaction and is a prominent objective for many practices. Though the science of access is well-developed, practices frequently fail in their efforts to reduce patient waiting time. Our experience has been that practices are more successful at improving access in a sustainable way when they first measure and control panel size (block 3) and build capacity-enhanced teams (block 4). Access and continuity may be in tension if patients prefer to see any clinician today than their own clinicians next week. High-performing practices allow patients to decide which takes priority.



Resource: Enhanced Resource Implementation Guide

<http://www.safetynetmedicalhome.org/change-concepts/enhanced-access>

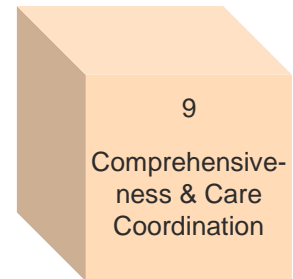
### **Action:**

- Promote and expand access by ensuring that established patients have continuous access to their care teams via phone, email or in-person visits.
- Provide scheduling options that are patient and family-centred and accessible to all patients.



## 5.9 COMPREHENSIVENESS AND CARE COORDINATION

This refers to the capacity of a practice to provide most of what patients need. Another pillar – care coordination – is the responsibility of primary care to arrange for services that primary care is unable to provide. When a patient's needs go beyond primary care practice's level of comprehensiveness, care coordination is required with the other members of the medical neighbourhood, such as hospitals, pharmacies, and specialists.



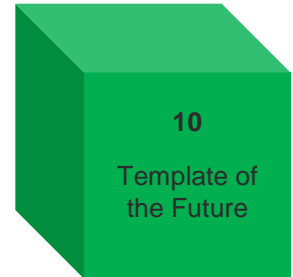
In high performing systems, clinicians automatically learn when their patients have been discharged from the hospital, and specialist's referrals are used to their greatest capacity because diagnostic studies are secured in advance by the primary care clinician. Improving care coordination requires teams because busy clinicians lack the time required to coordinate care for every patient with every health care institution. High-performing practices often include a care coordinator or referral coordinator whose sole responsibility is care coordination.

### **Action:**

- Utilise Sydney North HealthPathways website for referral network.
- Ensure communication between the care team and medical neighbourhood is effective using secure messaging and shared care tools.

## 5.10 TEMPLATE OF THE FUTURE

The crown of the building blocks is the template of the future. Few practices have achieved this ultimate goal: a daily schedule that does not rely on the 15-minute in-person clinician visit but offers patients a variety of e-visits, telephone encounters, group appointments, and visits with other team members. Clinicians would have fewer and longer in-person visits and protected time for e-visits and telephone visits. With a team empowered to share the care, clinicians would be able to assume a new role – clinical leader and mentor of the team. Full implementation of this future template requires payment reform that does not reward primary care simply for in-person clinician visits.



### **Further Reading:**

Transforming Physician Practices to Patient-Centred Medical Homes: Lessons from The National Demonstration Project

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140061/>