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An Australian Government Initiative

SYDNEY NORTH Primary Health Network

PERSON CENTRED MEDICAL HOME PROGRAM – 2019

A Guide to Implementing PCMH into General Practice

"Insert Practice Name"

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CONTENTS

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 have developed 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.

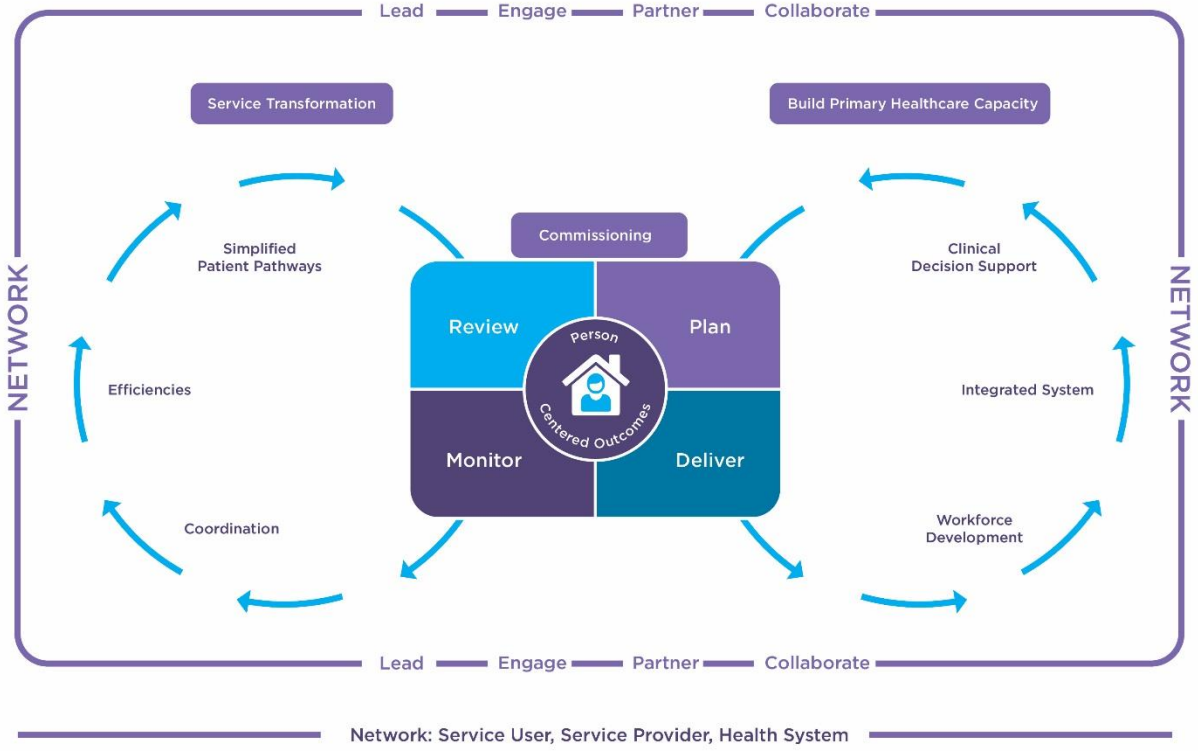
SNHN will provide support and education to the healthcare team to help the practice achieve the quadruple aim:

- 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 by the PHN Primary Care Team team to maximise use of enabling tools and technology, such as: Cat 4 Data Extraction Tool, Secure Messaging, Shared Care Platforms and Sydney North HealthPathways

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

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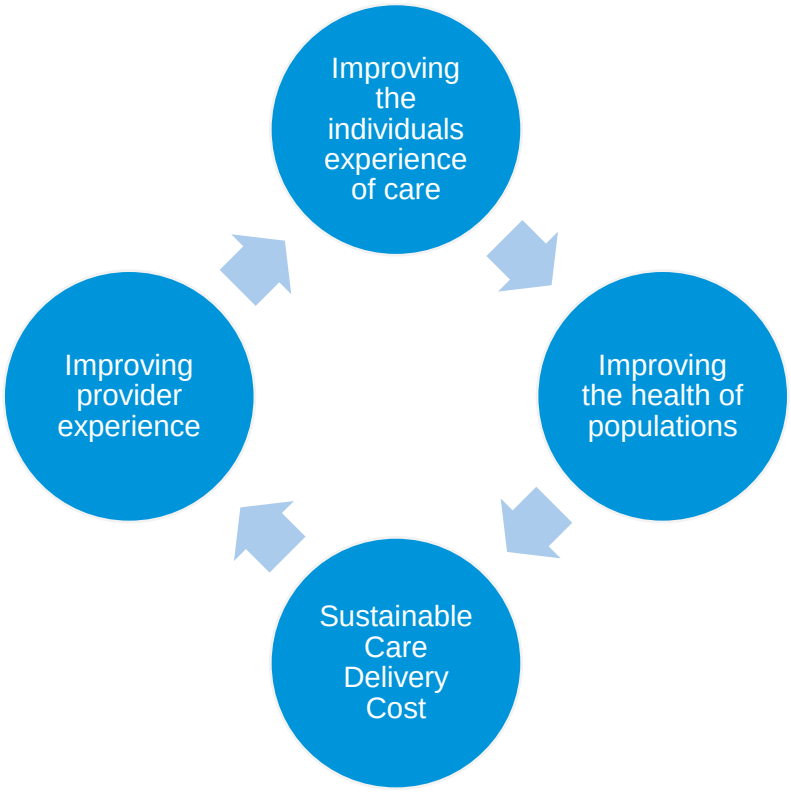
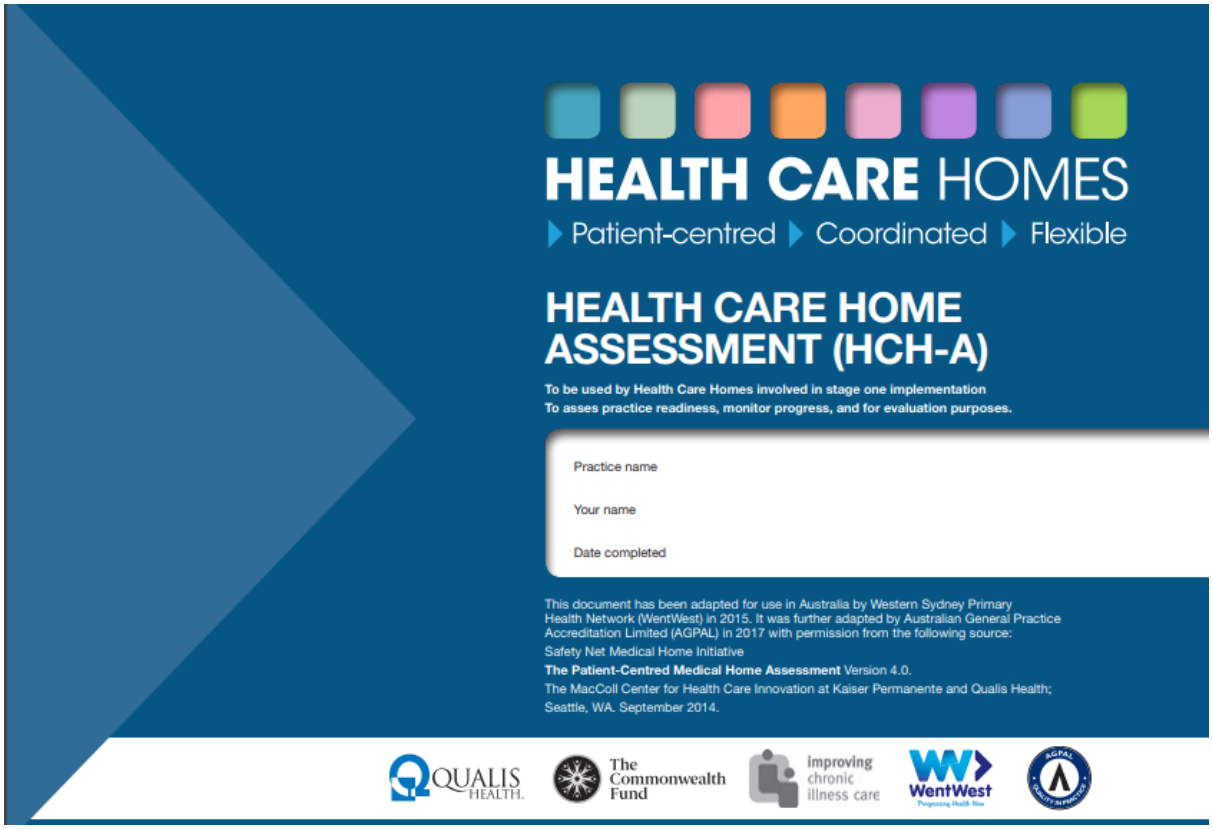
3. THE QUADRUPLE AIM



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

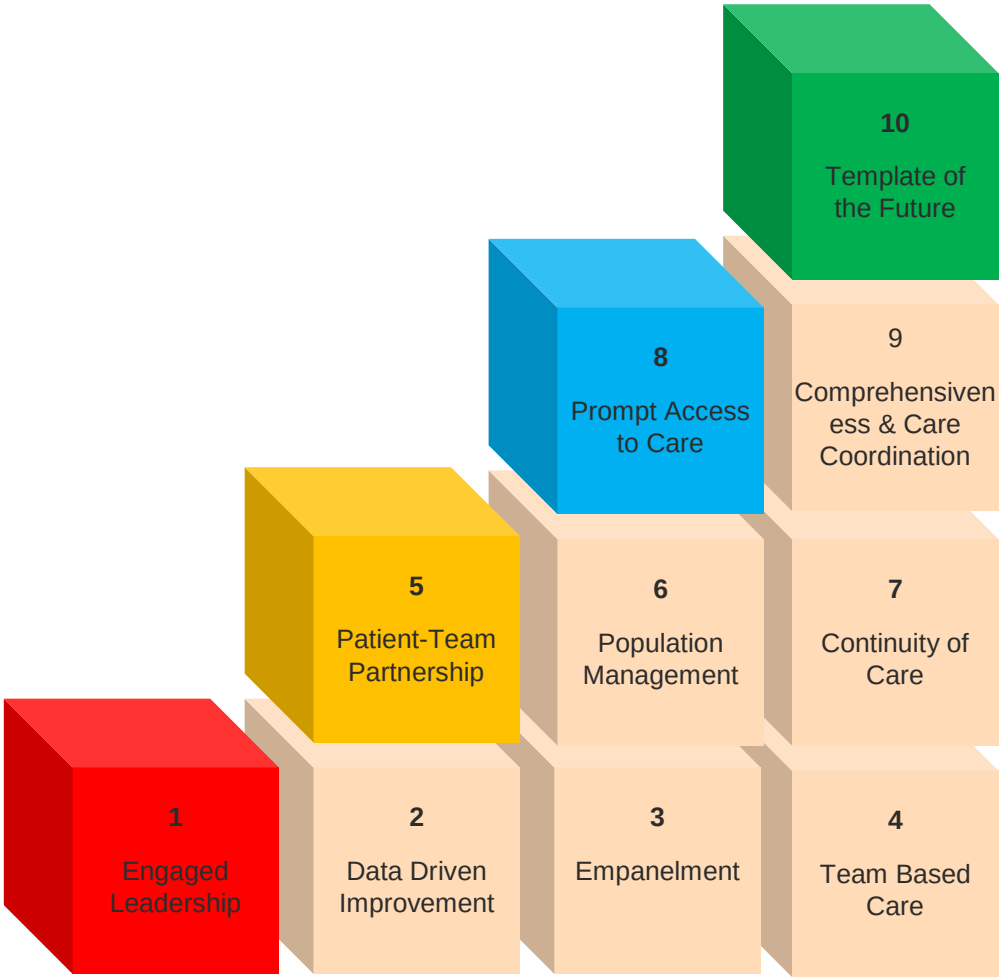


Note: At the beginning of the program, it is beneficial to take a base-line survey to help practices understand the current level of understanding of PCMH principles and opportunities for improvement. Your PHN Coordinator named on the front of this program manual can guide you through this process and provide you with an electronic version of this assessment.

Action: Contact the PHN Coordinator for the electronic version (.xcel) of this assessment. Download and save the Assessment Tool. Each staff member to complete the survey and results to be discussed as a group.

Link to assessment: https://www.hchevaluation.com/images/Practice_resources/HCH-A_2017.pdf.

5. THE BUILDING BLOCKS



The 10 Building Blocks of High-Performing Primary Care

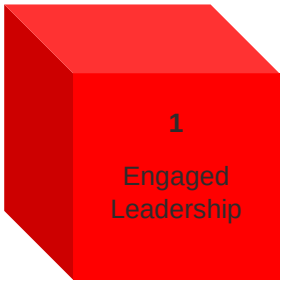
Thomas Bodenheimer, MD, Amireh Ghorob, MPH, Rachel Willard-Grace, MPH and Kevin Grumbach, MD. Ann Fam Med **March/April 2014** vol. 12 no. 2 **166-171**

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) Log-in required

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

Business Management (module 5) Log-in required

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

Face to Face Education:

Business and Clinical Leadership Course (over 9 months)

3 x 1 day workshops (9th Feb, 22nd June, 21st Sept)

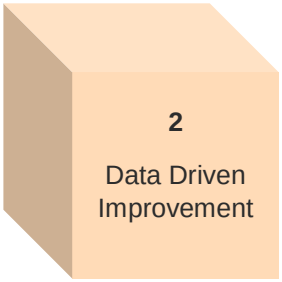
6 x 30 minute telephone mentoring sessions

Actions:

- GP's, Practice Manager and/or Practice Nurse to attend Business and Clinical Leadership workshops. Complete pre-reading and activities prior to workshop.
- Arrange for other staff to complete brief online education modules for Leadership component as appropriate (Refer to online Education links above).

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/

Face to Face Education:

Data Driven Improvement Workshops

- Beginners – 5th March
- Intermediate – 13th March
- Advanced – 18th May (TBC)

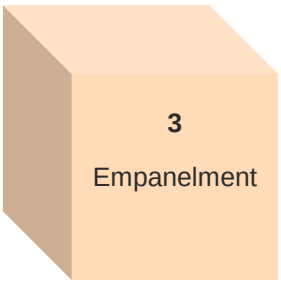
Actions:

- 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 support

5.3 EMPANELMENT (ASSIGNING A PROVIDER AND CARE TEAM)

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

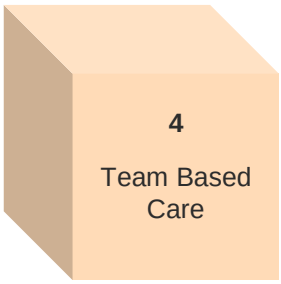
Face to Face: Discuss this process with your PHN Primary Care Coordinator

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/

Using a Team Approach

http://www.practicecoaching.com.au/

Face to Face Education: Team Based Care – 27th August (TBC)

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.

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:

Patient Centred Interactions

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

Performance Coaching in clinical practice online (Cost)

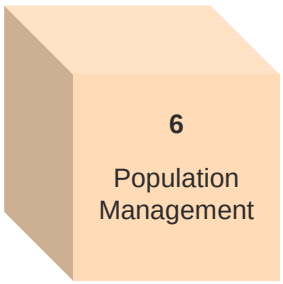
https://www.lifestylemedicine.org.au/product/performance-coaching-in-clinical-practice-online-workshop

Face-to-Face Education:

Introduction to Lifestyle Medicine – 30th April

Introduction to Performance Coaching in Clinical Practice – 8th August

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

The Care Coordination Course - http://www.carecoordination.com.au/courses/care-coordination/

Face to Face Education: Data Driven Improvement (Advanced) 18th May (TBC) Performance Coaching – 8th Aug. Team Based Care – 27th July (TBC)

5.7 CONTINUITY OF CARE

Continuity of care is associated with improved preventative and chronic care, greater patient and clinician experience, and sustainable 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 assigned and for the care team to be available.

Online Education:

Continuity and Team Based Care

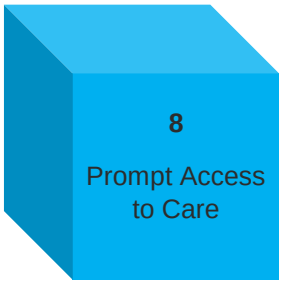
http://www.safetynetmedicalhome.org/change-concepts/continuous-team-based-healing-relationships

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.



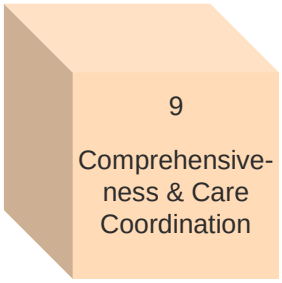
Resource: Enhanced Resource Implementation Guide

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.
- Ensure patients are aware and have access to after-hours services when the practice is closed.

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 pathways.
- Ensure communication between the care team and medical neighbourhood is effective using secure messaging and shared care tools.
- Encourage upload of Health Summaries using My Health Record

Online Education:

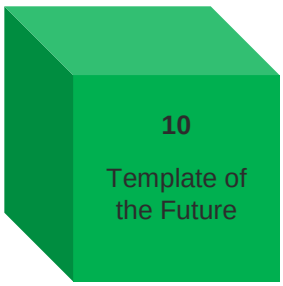
My Health Record - https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources

Face To Face: Digital Health Training Events available throughout the year.

SNHN Events Calendar - https://sydneynorthhealthnetwork.org.au/education-events/

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/

6. EDUCATION OUTLINE

Person Centred Medical Home **Education Outline**

(Note: Dates and venues subject to change. Event updates will be sent to your practice via email. Registration required.)

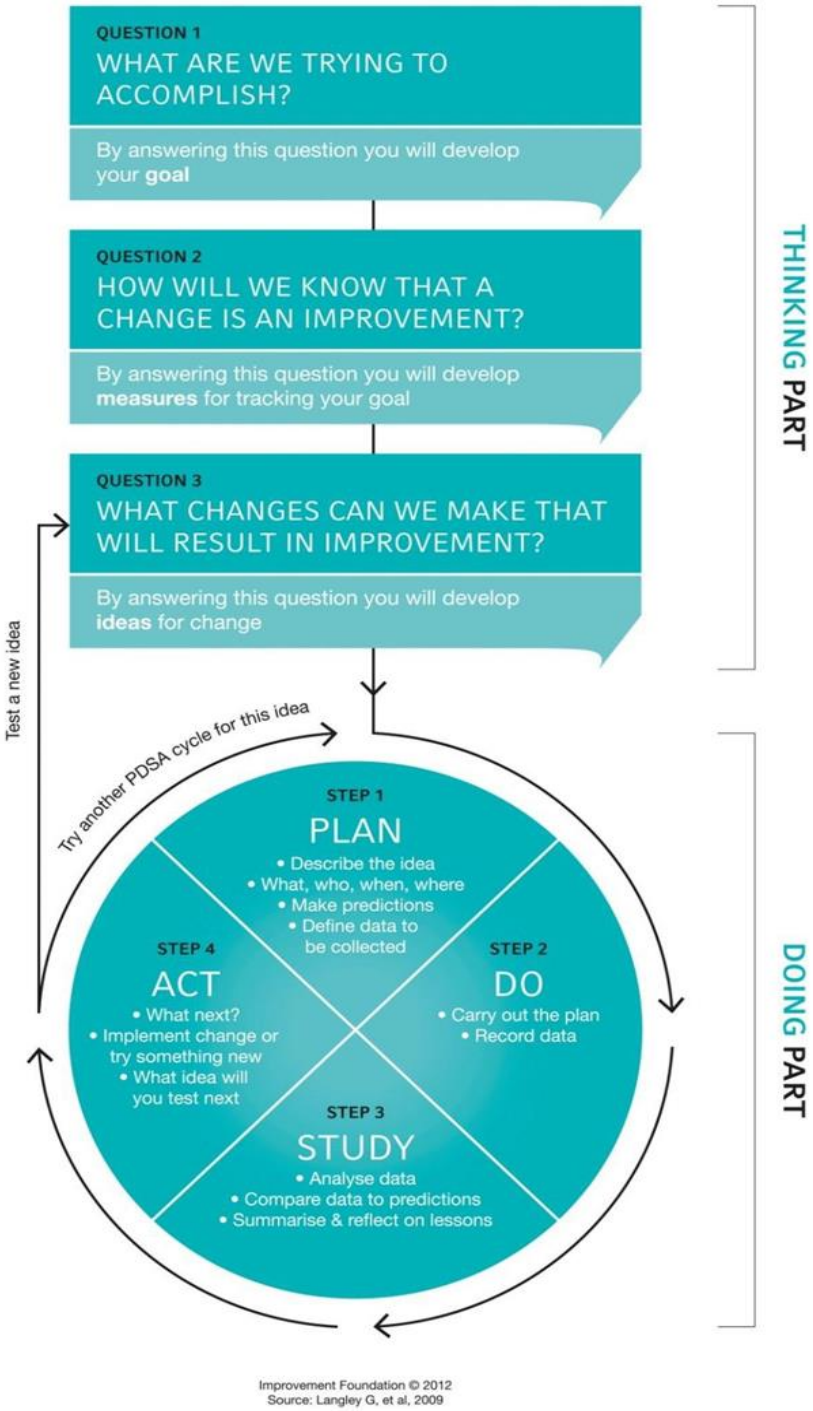
DATE	MODULE	TIME	VENUE
Sat 9 Feb (Full day)	**Business and Clinical Leadership** Workshop 1	8.30am-4.30pm	The Epping Club, Epping
Tues 5 March	Data Driven Improvement – Beginners	6.30-9.00pm	The Kolling Building, RNSH, St Leonards
Wed 13 March	Data Driven Improvement – Intermediate	6.30-9.00pm	The Kolling Building, RNSH, St Leonards
Sat 18 May (TBC)	Data Driven Improvement - Advanced	8.30am-4.30pm	TBC
Thurs 30 April	Person Centred Care – Introduction to Lifestyle Medicine	6.30-9.30pm	The Kolling Building, RNSH, St Leonards
Sat 22 June (Full Day)	**Business and Clinical Leadership** Workshop 2	8.30-4.30pm	The Kolling Building, RNSH, St Leonards
Thurs 4 July	PCMH Practice Network Meeting	6.30-9.00pm	SNHN Training Rooms, Chatswood

Person Centred Medical Home **Education Outline**

DATE	MODULE	TIME	VENUE
Sat 27 July (TBC)	Team Based Care	8.30am-4.30pm	TBC
Thurs 8 Aug	The Patient Team Partnership	6.30-9.00pm	Kolling Building, RNSH, St Leonards
Sat 21 Sept Full Day	**Business and Clinical Leadership** Workshop 3	8.30am-4.30pm	Roseville Golf Club, Roseville
Thurs 28 November	**PCMH Practice Network Meeting** Joy In Work – Provider Wellbeing	6.30-9.00pm	TBC

(Continued)

7. THE MODEL FOR IMPROVEMENT



Improvement Foundation © 2012
Source: Langley G, et al, 2009

8. QUALITY IMPROVEMENT ACTIVITIES (PDSA'S)

Practices may complete Plan Do Study Act cycles and attract an incentive payment. Discuss this with your PHN Primary Care Coordinator. A template will be provided and PDSAs will be aligned with RACGP – Standards for Patient-Centred Medical Homes. Practices are required to submit de-identified data to the Sydney North PHN using Cat 4 Data extraction software.

PDSA Submission

Practice Name	
Date submitted	
Step 1	**Consider the 3 Fundamental Questions when developing a PDSA Cycle**
1	**What are we trying to accomplish?**
	By answering this question you will develop your Goal.
2	**How will we know that a change is an improvement?**
	By answering this you will develop measures for your tracking your Goal.
3	**What changes can we make that will lead to an improvement?**
	By answering this question you will develop ideas for change.
Step 2	**Complete the PDSA Cycle**
Plan	**What exactly will you do? Include what, who, when, where, predictions and data to be collected.**
Do	**What happened? Document record observations and any unexpected events or problems.**
Study	**Analyse & reflect on the results, if there is a difference between your predictions & what happened, consider why?**
Act	**What will you take forward from the cycle? (What is your next step/PDSA cycle).**

9. FREQUENTLY ASKED QUESTIONS

1. **Q.** Why become a Person Centred Medical Home?

A. To support patients to manage care and participate as informed partners within the practice setting.

2. **Q.** Will I be paid for participating in the program?

A Practices may submit PDSA cycles to attract an incentive payment of $200 per PDSA (up to 12). 6 submissions are due by 15th June, 2019. Another 6 PDSAs may be submitted up to 15 December, 2019

3. **Q.** What if I don't attend all 3 workshops of the leadership course for reasons that may include, illness, family crises etc?

A. Workshop places are transferable to another person in the practice, this allows for flexibility and to ensure the practices receives all benefits of the course.

4. **Q.** What are the requirements of the PDSA cycles and is there a template?

A. Yes, there is a template for completing PDSA cycles with suggestions aligned with PCMH Standards.

5. **Q.** How long is the PCMH program running and will it continue beyond the allocated timeframe, and if so what support will be given from the PHN?

A. The timeframe for the program is 12 months, the program should give practices the tools to take the PCMH concept beyond the timeframe to build upon further. SNPHN will continue to support practices as needed to build upon the ideas and concepts of an established PCMH practice.

7. **Q.** Does PCMH model provide coordinated care for my patients?

A. PCMH provides patients with a team of care providers at the practice (medical home).