Frailty management in primary care: a **quality improvement** toolkit

phn NORTHERN SYDNEY
An Australian Government Initiative

SYDNEY NORTH Health Network

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INTRODUCTION

Sydney North Health Network (SNHN) is delighted that your practice has committed to participate in the Frailty Identification and Management Quality Improvement Program (FIMQIP).

The aim of the FIMQIP is to encourage and support general practices within SNHN's catchment area to improve practice processes, resulting in better health outcomes for patients and provide sustainable quality improvement for General Practice. This will be achieved by identifying measurable and achievable key indicators within your practice setting.

The FIMQIP will focus on Frailty, looking at the following indicators:

1. Frailty - Number of patients in the frailty module with frailty indicators that have not been screened
2. Frailty - Register (patients with a Frailty Score of 3 or above)
3. Frailty - Number of patients 65 years and older
4. Frailty - Health Assessments (over 75 Health Assessment)
5. Frailty - My Health Record (current Health Summary uploaded)
6. Frailty - Number of Medication reviews completed
7. Frailty - Carer identified (person most responsible and support provided)
8. Frailty - Number of falls
9. Frailty - Frailty recorded in past history
10. Frailty - Frailty screening recorded in conditions

The program will provide support to participating practices to analyse current frailty identification, care management, and develop individualised improvement plans to support implementation of evidence-based best practice care.

The Aged Care team at SNHN welcomes your practice to the FIMQIP and we are confident that this will prove to be a beneficial and worthwhile journey in helping to enhance and develop the management of patients with chronic disease and more specifically identifying people who are frail.

What is frailty?

Frailty is a common syndrome that occurs from a combination of de-conditioning and acute illness on a background of existing functional decline that is often under recognised. Many of the causes of frailty can be managed and, in some cases reversed to create better health outcomes and quality of life. It is therefore important to identify older people who are living with frailty.

Calculated frailty estimates from 2016 census data found that over half of the 3.7 million Australians aged 65 years, or more were either frail (415,769) or pre-frail (1,577,362).

Frailty can affect up to 25% people aged 70 and over. This equates to approximately 26,000 people residing in Northern Sydney.

Current health guidelines suggest that people over the age of 70 should be screened routinely. In Northern Sydney we recommend the use of 'The Frail Scale' to identify a level of frailty. A score of 1 to 2 indicates pre-frailty and a score of 3 or more indicates frailty. Frailty is more common in females and the risk of frailty increases with age.

The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty

These guidelines can be viewed at https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2018/12/Asia-Pacific-Frailty-Guidelines-2017.pdf and have 7 key recommendations:

1. A validated measurement tool be used to identify frailty
2. Older adults with frailty be referred to a progressive, individualised physical activity program that contains a resistance training component
3. Polypharmacy be addressed by reducing or de-prescribing any inappropriate/superfluous medications
4. Persons with frailty are screened for reversible causes of fatigue
5. Older adults with frailty who exhibit unintentional weight loss should be screened for reversible causes and considered for protein and caloric supplementation/food fortification
6. Vitamin D be prescribed for older adults found to be deficient in vitamin D
7. Provision of an individualised support and education plan for older adults with frailty

We aim to build capacity within general practice to better understand the needs of people and their carers, living with frailty to navigate our complex health system.

The "Thinking" Part

THREE FUNDAMENTAL QUESTIONS WHEN UNDERTAKING QUALITY IMPROVEMENT

QUESTION 1
WHAT ARE WE TRYING TO ACCOMPLISH?

By answering this question you will develop your goal

QUESTION 2
HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

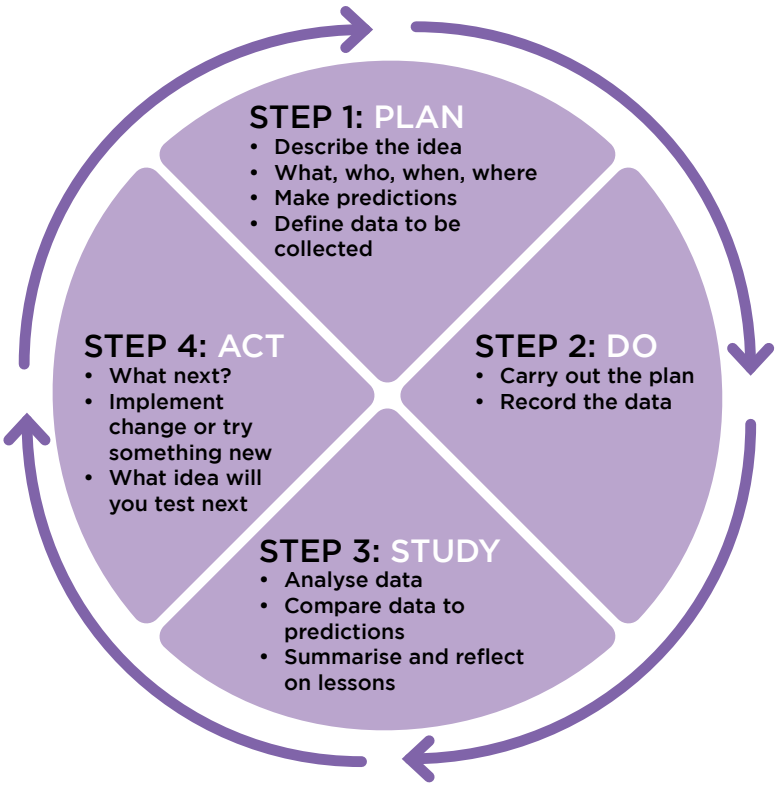
By answering this question you will develop measures for tracking your goal

QUESTION 3
WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN IMPROVEMENT?

By answering this question you will develop ideas for change

The "Doing" Part

PLAN, DO, STUDY, ACT



You will find through PDSA cycles that some changes lead to improvements. If so, these improvements can be implemented on a wider scale. You may also find that some improvement ideas are not successful. Analyse why they didn't work and learn from this. By carrying out small tests in PDSA cycles, you have avoided implementing unsuccessful change on a wider scale.

THE TOOLS

The Frail Scale

Northern Sydney Frail Scale is based on the Fried et al's frailty phenotype and was introduced as part of the Frailty joint initiative between the Northern Sydney Local Health District and the Primary Health Network. It was introduced into general practices as a pilot project in 2020, it has since been used across several participating general practices. The frail scale is used in conjunction with a frailty management /decision support tool, which recommends interventions for the identified frail person.

FRAIL SCALE RISK ASSESSMENT

	QUESTION	SCORING	RESULT
F	**FATIGUE** How much of the time during the past 4 weeks did you feel tired? A = All or most of the time B = Some, a little or none of the time	A = 1 B = 0	
R	**RESISTANCE** In the last 4 weeks by yourself and not using aids, do you have any difficulty walking up 10 steps without resting?	Yes = 1 No = 0	
A	**AMBULATION** In the last 4 weeks by yourself and not using aids, do you have any difficulty walking 300 metres OR one block?	Yes = 1 No = 0	
I	**ILLNESS** Did your Doctor ever tell you that you have? ☐ Hypertension ☐ Diabetes ☐ Cancer (not a minor skin cancer) ☐ Chronic lung disease ☐ Heart attack ☐ Congestive Heart failure ☐ Angina ☐ Asthma ☐ Arthritis ☐ Kidney disease ☐ Stroke	0 - 4 answers ✔ = 0 5 - 11 answers ✔ = 1	
L	**LOSS OF WEIGHT** Have you lost more than 5kg or 5% of your body weight in the past year?	Yes = 1 No = 0	
		TOTAL SCORE	

SCORING: ROBUST = 0 PRE-FRAIL = 1-2 FRAIL = >3

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Frailty Management/Decision Tool

FRAILTY MANAGEMENT/ DECISION TOOL

	Assessment Score	Intervention	Referral/Follow up
	FRAIL scale 0 = robust	• Encourage ongoing activity levels • Provide Staying Active and on your feet and Eating Well resource	• Re-do FRAIL scale in 12 months • Community exercise with balance/resistance component. Try NSLHD Stepping On and Healthy Lifestyle classes. • Example of exercises in Staying Active and On Your Feet booklet and NSW exercise venues: ww.activeandhealthy.nsw.gov.au
	FRAIL scale	**If Frailty Score is positive, address underlying causes as suggested below**	
F	**Feeling fatigued most or all of the time**	• Consider screening for reversible causes of fatigue (sleep apnoea, depression, anaemia, hypotension, hypothyroidism, B12 deficiency) • Use EPWORTH scale, K10 or Geriatric Depression scale in Health Assessment	• Consider referral to Geriatrician /Specialist for complex care patients • Consider referral to Occupational Therapy for functional and home review • Consider referral Psychologist using Mental Health Care Plan • Consider referral to Aged Care organisation for loneliness support (isolation can be a cause of fatigue!)
R	**Resistance against gravity - Difficulty walking up 10 steps without resting**	• Consider referring to an individualised progressive exercise program with resistance and strength component	• Physiotherapy or Exercise Physiologist for exercise prescription • If has diabetes-> group session Medicare funded ex. physiologist • Healthy Lifestyle for group exercise prescription and/or Stepping On • Get Healthy for free telephone-based health coaching • NSHNS Safe and Steady program
A	**Ambulation- Difficulty walking 300 metres unaided**	• Consider referring to an Individualised progressive exercise program with resistance and strength component	• Physiotherapy or Exercise Physiologist for exercise prescription • Healthy Lifestyle for group exercise prescription and/or Stepping On • Get Healthy for free telephone-based health coaching • Exercise options https://www.activeandhealthy.nsw.gov.au
I	**Having 5 or more Illnesses**	• Review indication, side effects and use of medication (evidence for use of some medicines changes after 75!) • Consider discussing with pharmacist • Consider reducing/de-prescribing superfluous medication	• Pharmacist for comprehensive medication review, (HMR item 900) • Occupational Therapy for functional and home safety review • Self-management support from aged care org volunteer
L	**Loss of > 5% weight in 12 months**	• Consider screening for reversible causes of weight loss and consider • Protein and caloric supplementation/food fortification (75mg protein per day required- range of products available at pharmacy) • Advice and encourage healthy eating; provide "Eating Well" resource	• Weigh and assess BMI – record in patient record • Dietician for diet review and management • Add Sustagen • Meal Delivery Services • Speech pathologist for swallowing review • Dentist for dental review (pain/infection/ill fitting dentures) • Occupational Therapy for functional and home cooking ability review

The Frail Scale and the Frailty Management/Decision Tool can be found on the SNHN website along with other resources and templates that have been developed. This includes the frail scale in the over 75 Health Assessment template for your clinical software.

Primary Sense

Primary Sense is a Primary Health Network (PHN) owned and operated population health management, clinical decision support and data extraction tool.

Designed by GPs, data experts and researchers, Primary Sense extracts de-identified general practice data and uses evidence-based algorithms to provide GPs with real-time medication alerts, reports, and patient care prompts. It also provides general practices and Primary Health Networks (PHNs) with on-demand reporting to help with population health management.

See the SNHN Primary Sense webpage here: https://sydneynorthhealthnetwork.org.au/quality-improvement-program/

THE FRAILTY MANAGEMENT REPORT

This report within Primary Sense identifies patients with frailty indicators that may require review or confirmation of their frailty status.

The patients that are included in this report are:

- Patients 65 years and over with frailty indicators (including falls, nutrition issues, lethargy and feeling depressed) recorded in the past two years or marked as active conditions
- Patients with a frailty score from the Johns Hopkins ACG tool (including inconti-nence, decubitus skin ulcers and dementia)
- Frail patients who may be at risk of seasonal respiratory infections
- Patients in residential aged care homes are excluded where possible

The FIMQIP is based on a similar program, the Australian Primary Care Collaboratives (APCC), which has been running since 2005 across Australia. The APCC program has been highly successful in developing the processes involved when delivering services to patients with chronic illnesses. Some of the chronic disease conditions addressed during the APPC programs have included diabetes, chronic heart disease, and chronic kidney disease.

A collaborative

A collaborative is a way for practices to work together to explore solutions to identifying early interventions for patients with chronic and complex needs. The collaboration involves trialling solutions through small scale rapid changes at the practice level, measuring the success of those trials and sharing what has or has not worked.

The Frailty Identification Management Improvement Program (FIMQIP) will help support you and your team to deliver improvements in the quality of services you provide to your patients identified as frail and with other health care needs.

The ideas included in this handbook are those that we currently know will have the greatest impact on achieving improvements in this program. We acknowledge, however, that you may have practical approaches and examples that can improve on these ideas. As the program progresses, we will work together to enrich the original ideas, add innovative ideas and update examples from your successes and the experiences of all participating Practice teams.

This resonates with the philosophy behind the collaborative methodology; of people working together to share, learn, apply, and improve best practice to deliver better patient care. Together we can stimulate innovation and improvement in this area.

We hope you find this handbook to be a practical resource in supporting the work of you and your team, and we look forward to your contribution to future editions of this work.

THE MODEL OF IMPROVEMENT

This section will teach you about the Model for Improvement1 (MFI) and how this tool can help you become more effective at introducing improvements to your Practices. The MFI can be used in a myriad of settings, from primary healthcare to manufacturing, and can assist with large organisational changes at the macro level and smaller, micro-level changes. Once you know how to use the MFI, you can apply this tool to every area of your work and life.

Change can often seem threatening and overwhelming. The MFI breaks change down into small, less threatening steps, which are tested to ensure that things are improving, and that no effort is being wasted.

By making small, incremental changes, you can test the change on a small scale and learn about the risks and benefits before implementing the change more widely. Remember that while every improvement is certainly a change, not every change is an improvement.

The MFI is a simple approach to making changes and if you memorise it, practice it and build it into the way you work, you will be able to lead change for the better within your organisation, and your life.

The MFI is a tried and tested approach to achieving successful change. It offers several benefits, including:

- A simple approach to making change that anyone can apply.
- A method to plan, develop and implement change.
- Reducing risk by testing minor changes before wider implementation
- Less resistance to change by starting small.
- Team unity around common goals
- Maximising individual creativity and ideas from team members.

Experience has shown that the MFI will work best when you define the problem – success is all in the preparation! Understanding what the problem is and thinking about why there is a problem helps in developing your goals. Tools that can assist you with effectively defining the problem include:

- Five Whys (root cause)
- Process Mapping
- Ishikawa (fish diagram)
- Brainstorming and Affinity
- Six Thinking Hats
- Context Map

Three fundamental questions

QUESTION 1: WHAT ARE WE TRYING TO ACCOMPLISH?

It is amazing how often we launch into change without stopping to think about what we are trying to achieve. The first question provides an opportunity to consider exactly what it is you are seeking to change. Once you and your team have agreed on the goal, it will guide you and keep you focused and motivate the team. To answer the first of the three fundamental questions, you will need to write a clear and concise goal for improvement.

KEY MESSAGES

- Set bold but realistic goals that are specific and have a defined timeframe.
- Use language that is simple enough for everyone to understand.
- Include information that will help keep the team focused (for example, the location of the test and a focus on certain patient populations).

An effective goal uses the elements of the SMART acronym, i.e. it is specific, measurable, achievable, relevant, and timely. Less effective goals are vague, hard to measure, unrealistic, irrelevant, or open ended.

QUALITY IMPROVEMENT TOOLS

- Quality Improvement tools that may help you answer the first fundamental question:
- Brainstorming and Affinity
- Ishikawa (Fishbone Diagram)
- Process Mapping
- Six Thinking Hats
- Pareto Analysis
- Decision Tree Analysis

QUESTION 2: WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN IMPROVEMENT?

By answering this question, you will develop ideas for change.

QUESTION 3: HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

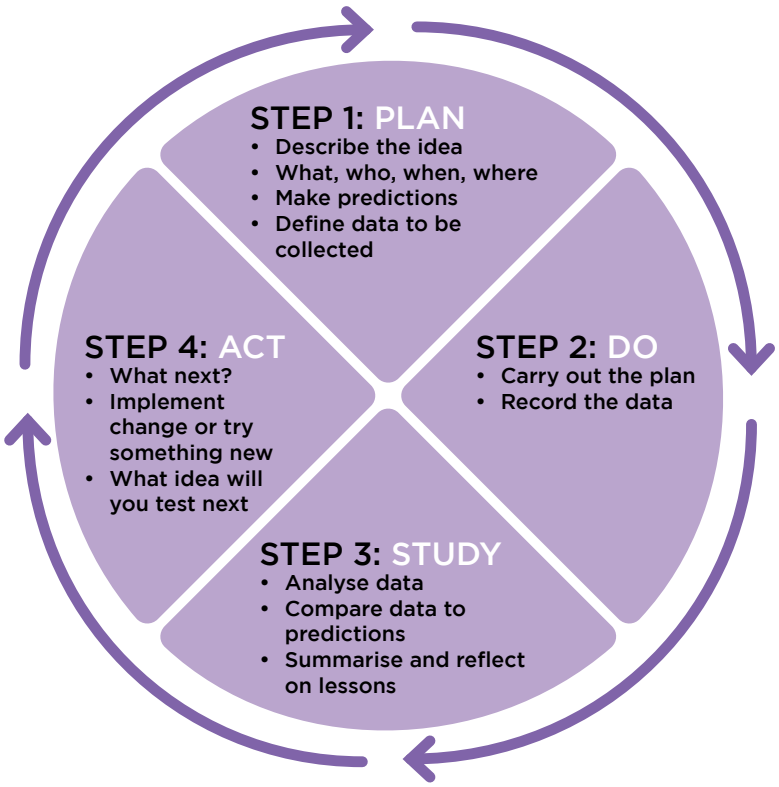
Without measurement it is impossible to know whether the change you are testing is leading to an improvement. The measures you select in the second fundamental question will tell you if you are progressing towards your goal.

There are a variety of measures that can be monitored, including the monthly measures that are submitted in the FIMQIP Program. However, when choosing measures for this question, it is important to ensure they directly measure progress towards the goal you are trying to achieve.

KEY MESSAGES

- Measurement is essential for quality improvement as it provides feedback on your improvement efforts. For this reason, it is important to obtain data at baseline (how the process or system is preforming before a change is tested) and then at regular intervals to determine if the change is leading to an improvement.
- Measurement is a powerful tool for change. However, for measurement to be useful, everyone needs to know what you are measuring, how, when and who is responsible for collecting the data.
- Do not make data collection complicated. Collect data in a simple, easy to access manner. For example, use the FIMQIP measures to track improvement monthly.
- The purpose of measurement is for learning, not for judgment.
- Decide on the best way to display the data so they are easily understood by everyone, (e.g. graphical representation).
- Seek usefulness, not perfection. A common pitfall is to spend too much time trying to get the perfect measurement system.

THE PDSA



PLAN:
A well developed plan includes what, who, when, where, predictions on the possible outcome, and the data to be collected. This can be achieved by answering the following questions:

- What exactly will you do? Remember to only test one small idea.
- Who will carry out the plan?
- When will it take place? This should be in a short timeframe, generally no more than a week.
- Where will it take place?
- What do you predict will happen?
- What data/information will you collect to know whether there is an improvement? These data should be specific to the change being tested. It is likely that data required to test your change idea will differ from the data collected for the second fundamental question, which measures progress towards your overall goal.

When you plan your PDSA cycle, it is important to be as clear and thorough as possible. Your results are dependent on how good your plan is.

DO:
Write down what happens when the plan is implemented, documenting observations, and recording data.

STUDY:
Reflect upon what happened. Think about and summarise what you have learnt, analysing the data collected and comparing the data to your predictions. If there was a difference between your predictions and what happened, consider why this was the case.

ACT:
Considering the results from your test, will you implement the tested change, amend it, or try something else? Write down the next idea you will test. What will you do differently? Be sure to start planning the next cycle sooner rather than later so that your improvement momentum continues.

DOING PART

When working with PDSA cycles remember:

- Anyone can use a PDSA cycle in any area.
- No PDSA cycle is too small (in fact they are often too big)
- You should expect to complete a series of PDSA cycles to achieve your goal.
- PDSA cycles can build upon one another to achieve rapid results.
- PDSA cycles help you learn from your work.
- Documenting PDSA cycles is a terrific way of motivating the team and sharing your information and learnings with other people.
- You will learn as much from something that did not go well as you can from something that did!
- You continue to test your ideas from the three fundamental questions using PDSA cycles until you are confident that you have achieved your goal.

When you complete your PDSA cycles the PHN may provide feedback to promote your understanding of the methodology. After consulting with you, the PHN may also share de-identified PDSA cycles as examples of improvement with other participating practices. This enables the sharing of ideas and helps to create innovative approaches to improvement in the topic areas.

A template of the PDSA is located on the SNHN website: https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2019/07/QI-PDSA-Resource-2pp-020719.pdf

TEAM BUILDING

Develop your team's skill set. When allocating tasks, you might realise that there are some skill gaps within your team. It may be useful to conduct a skills audit to identify the current strengths and gaps. This is an opportunity for training existing staff to fill the skill gaps, or to employ new staff, particularly where staff turnover occurs.

Training can be supported in several ways, including:

- Formal courses
- Time off to attend training.
- Payment or co-payment towards the cost of training
- Access to government funding for training (e.g. traineeships)
- On-the-job development (e.g. mentoring arrangements for junior staff)
- Online learning.

Effective teams regularly reflect on and review how they are functioning, their team membership and outcomes to changes that are being tested. Your team will be more successful if they know that the achievement of goals and expectations is going to be assessed.

Reflection can be as simple as considering your team's responses to the following questions for any given task or objective:

- What is working and what is not?
- What should we do more of?
- What should we do less of?
- Is there anything that we should stop doing?
- What have we achieved? How does this compare with what we expected or hoped to achieve?
- Reflecting on and reviewing what you are doing can include:
  - Reviewing progress towards your agreed goals
  - Recognising and acknowledging a job well done.

Teams are the foundation of an organisation. By working through the ideas presented in this section, you will introduce changes to your team that will have a positive effect on your organisation. Building your team in this way will also help to ensure you are ready to take on other change ideas in an environment that is more conducive to, and accepting of, change. However, the development of a team is not a linear process. You will need to regularly revisit the ideas above to ensure your team is working optimally.

PATIENT-CENTRED MEDICAL HOME MODEL OF CARE

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.

The quintuple aim

This is an extension of the Quadruple Aim, adding an additional dimension to the healthcare framework. It emphasises the importance of optimising the overall healthcare system to establish health equity. In the context of value-based care, the Quintuple Aim becomes even more critical as it aligns with the core principles and goals of value-based care models.

Below are five reasons why the quintuple aim is essential in value-based care. (Source: https://www.chesshealthsolutions.com/2023/08/01/the-quintuple-aim-what-is-it-and-why-does-it-matter/)

PATIENT-CENTERED CARE

Value-based care improves patient outcomes and experiences by providing patient-centred care. The Quintuple Aim supports this goal by emphasising the importance of enhancing the patient experience, fostering trust, communication, and engagement between patients and healthcare providers. By putting patients at the centre of care, value-based care models can tailor treatments and interventions to individual needs, leading to better health outcomes.

POPULATION HEALTH MANAGEMENT

Value-based care goes beyond individual patient care and focuses on improving the health of entire populations. The Quintuple Aim aligns with this objective by recognising the significance of addressing social determinants of health and implementing preventive measures to promote wellness within communities. By managing population health effectively, value-based care models can reduce the burden of chronic diseases and improve overall community wellbeing.

COST EFFICIENCY

One of the primary goals of value-based care is to control healthcare costs while maintaining high-quality care. The Quintuple Aim's "Reduce Costs" dimension complements this goal by encouraging healthcare organisations to identify areas of inefficiency, reduce waste, and optimise resource allocation. This ensures the cost savings achieved through value-based care can be invested in improving patient care and outcomes.

PROVIDER WELLBEING AND ENGAGEMENT

Value-based care models can lead to increased administrative burdens and performance pressure on healthcare providers. The Quintuple Aim's focus on "Improve Provider Wellbeing" is crucial in this context, as it recognises that healthcare professionals' satisfaction and engagement are essential for delivering high-quality care. When providers are supported, and their wellbeing is prioritised, they are more likely to be motivated and dedicated to providing patient-centred care.

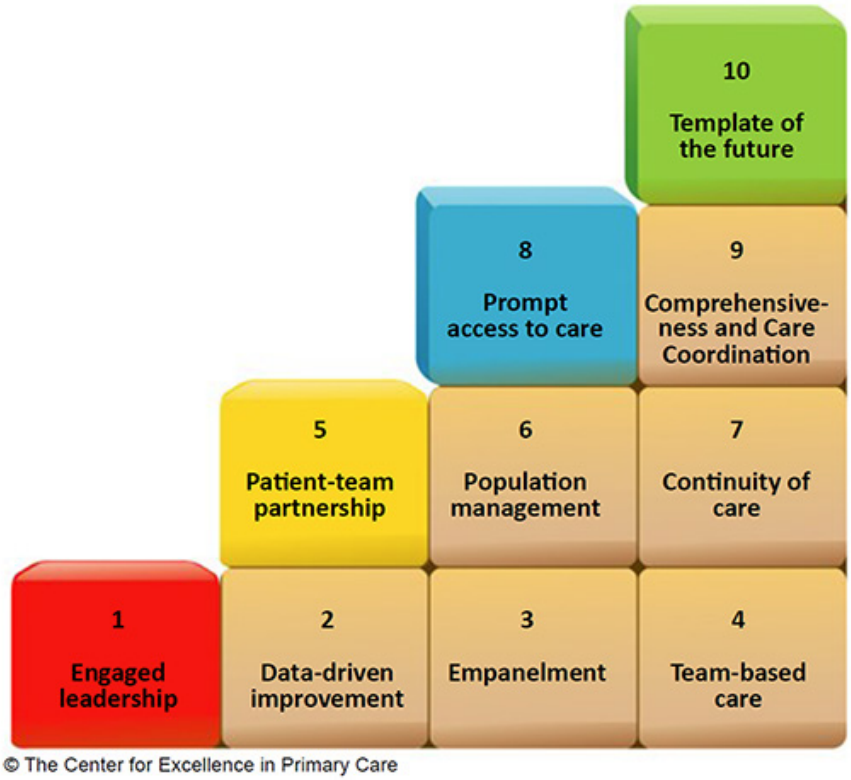
ENHANCE CARE TEAM SATISFACTION AND COLLABORATION

Health equity in value-based care involves fostering a collaborative and inclusive care team environment. When care teams work together to address health disparities and provide equitable care, patient outcomes and team satisfaction can improve. Furthermore, recognising the impact of social determinants of health on patients' wellbeing can enhance communication and collaboration among care team members, enabling them to develop comprehensive care plans that consider the unique needs of each patient.
By integrating health equity into the Quintuple Aim, value-based care models can work towards creating a more just and equitable healthcare system. Health equity improves the overall health of populations, enhances patient experiences, promotes provider wellbeing, and ensures all members of the community have an equal opportunity to access high-quality healthcare services. Health equity is not only an ethical imperative but also a critical factor in achieving better health outcomes and a more sustainable healthcare system.

By addressing all five dimensions of the Quintuple Aim, value-based care models can create a more sustainable healthcare system. When patient outcomes improve, population health is managed effectively, costs are controlled, providers are engaged, and care teams collaborate efficiently, the healthcare system becomes more resilient and better equipped to meet the needs of the population over the long term.

Source: Yates Lennon, MD, MMM, President at CHESS Health Solutions. https://www.chesshealthsolutions.com/2023/08/01/the-quintuple-aim-what-is-it-and-why-does-it-matter/

THE TEN BUILDING BLOCKS OF HIGH-PERFORMING PRIMARY CARE



Source: 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. Building Blocks of High Performing Care, http://www.annfammed.org/content/12/2/166.full?sid=fa194c23-f046-4ed0-9b3f-1d1742b1607d

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!

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

3: EMPANELMENT (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

4: TEAM BASED CARE

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

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/carers about their healthcare experience and use this information for quality improvement.

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 staff 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 patients' knowledge and motivation, providing information and skills, and engaging patients in behaviour-changing action plans known to improve outcomes. Patients working with health coaches, whether medical assistants or other patients, 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 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.

7: CONTINUITY OF CARE

Continuity of care is associated with improved preventative and chronic care, greater patient and clinician experience, and lower cost. Achieving 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.

8: PROMPT ACCESS TO CARE

Access is 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 in the diagram above) and build capacity-enhanced teams (block 4 in the diagram above). 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

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.

10: TEMPLATE OF THE FUTURE

The crown of the building blocks is the template of the future. Few practices have achieved this 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 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.