SYDNEY NORTH Health Network

PERSON CENTRED CARE PROGRAM

A guide to implementation in general practice

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(Last updated: May 2022)

phn NORTHERN SYDNEY

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PERSON CENTRED CARE PROGRAM

At Sydney North Health Network (SNHN) 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.

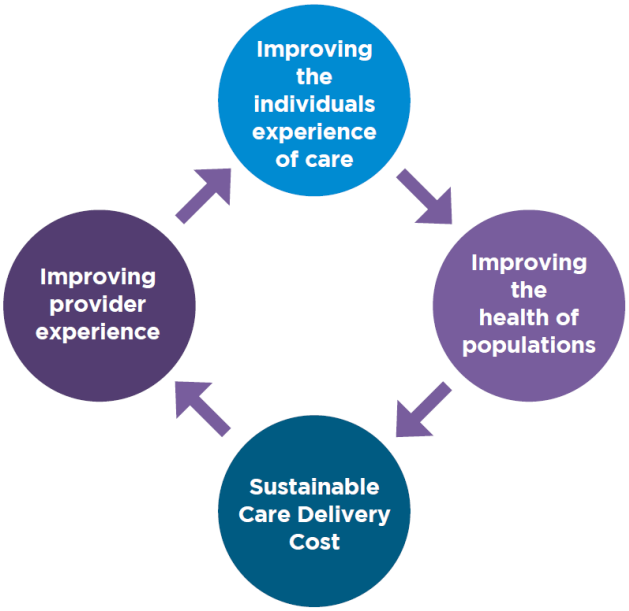
Against a backdrop of strong population growth for our region, an ageing population, potential healthcare workforce shortages and greater numbers of hospitalisations and GP visits over the next 15 years, SNHN continues to focus on innovative and sustainable solutions that shift the focus of care out of hospitals and into the hands of primary healthcare. To achieve this, we have developed a program in our region called Person Centred Care Program (PCCP), otherwise known as 'patient centred medical home' or 'medical home'.

A Person-Centred Care approach 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 Person-Centred Care Program aims to assist practices with small step-by-step changes they choose to make. Practices are invited to participate in a range of person-centred care initiatives, which are offered throughout the year.

SNHN will provide support and education to help the practice achieve the Quadruple Aim:

- Enhancing the patient experience of care
- Improving systems and efficiencies
- Optimising population health and wellbeing
- Improving the work life of health care clinicians



The Quadruple Aim

PRINCIPLES OF PERSON CENTRED CARE

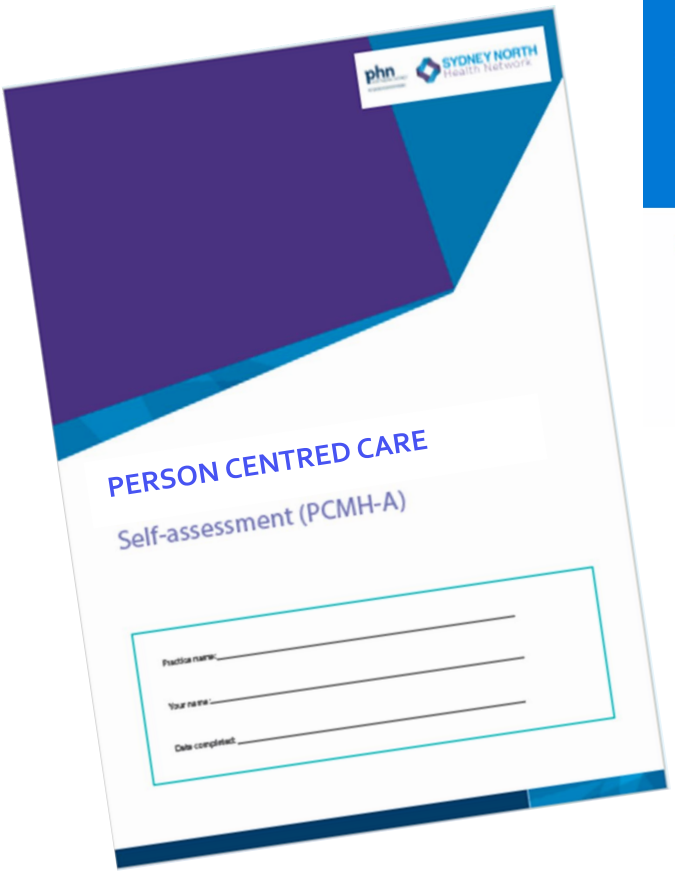
Person centred care is at the heart of an integrated health system that wraps around the patient and embraces these key features:

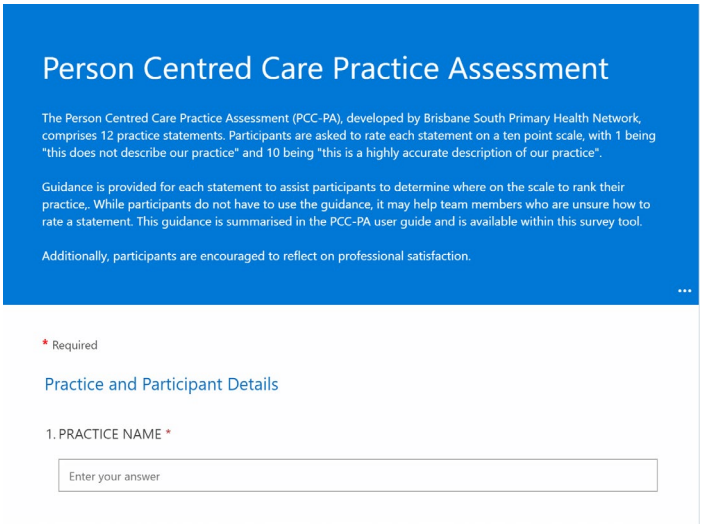
- Person centred: supports the patient and family to be involved in decision making
- Comprehensive: consist of a team of providers both inside and outside the medical home
- Coordinated: care is organised across the entire health system, including transitioning between sits of care, to encompass the healthcare 'neighbourhood'
- Continuous: continuity of care is facilitated through a team approach, with a GP as the team leader
- Accessible: Timely access to a team member with the proactive use of digital technologies
- Committed to quality and safety: demonstrated commitment to quality improvement

PERSON CENTRED CARE PRACTICE ASSESSMENT

Before starting out, it can be beneficial for practices to take a baseline survey to help ascertain current level of understanding of PCCP principles and identify potential opportunities for improvement.

The survey is designed to be a conversation starter. After completing the survey, set up a time for everyone at the practice to meet together to discuss the results as a group and develop an action plan for priority improvement areas. A simplified version of the assessment is also available – we can work with you to choose the assessment option that is most suitable for your practice. Your Primary Care Coordinator can guide you through this process and provide you with an online version that can be used at the practice.





BUILDING BLOCKS AND CHANGE CONCEPTS

Sydney North Health Network's practice program is based on the 10 Building Blocks of High Performing Care, which is well documented and researched and advocates enhanced patient access to comprehensive, coordinated, evidence-based, interdisciplinary care (see figure 2).

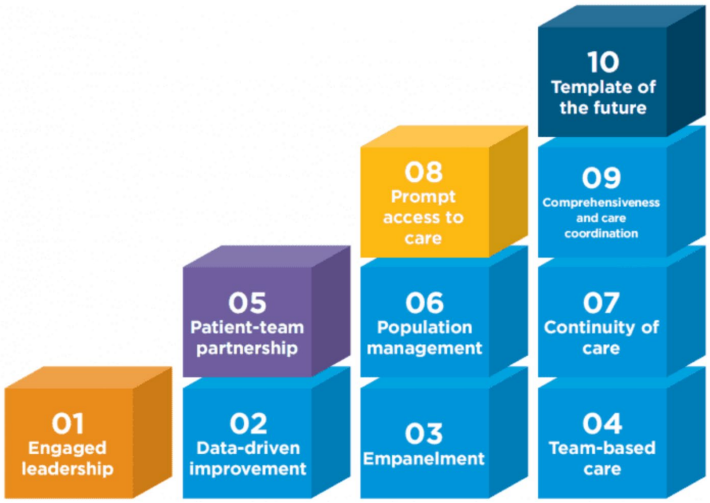


Figure 1: 10 Building Blocks of High Performing Primary Care (Bodemheimer et al, 2014)

Similarly, the program draws upon the Change Concepts for Practice Transformation, a framework developed by the Safety Net Medical Home Initiative (SNMHI) to help primary care practices through the PCCP transformation process (see figure 3 for sequential change concepts).

Figure 2: Change concepts for practice transformation (SNMHI, 2013)

NOTE: In Australia, the term 'empanelment' is more commonly referred to as patient registration.

ENGAGED LEADERSHIP

In a nutshell:

Creating a practice-wide vision with concrete goals and objectives. Practice Leaders are fully engaged in the process of change.

Rationale:

High-performing practices have leadership at all levels of the organisation. Medical practice assistants, receptionists, clinicians, and other staff take on the mantle of changing how they and their colleagues do their work. Some engage patients in leadership roles calling upon them as experts in the health care experience to identify priorities for improvement. Leaders create concrete, measurable goals, and objectives.

Reading and reasources :

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/

Goals:

- ☐ To provide visible, sustained leadership to lead overall culture change
- ☐ To ensure that Person-Centred Care transformation has allocated time and resources and that providers and other care team members have protected time for quality improvement beyond direct patient care
- ☐ To build the practice's vision of creating a 'person centred care model' into staff recruitment and training processes

Improvement ideas:

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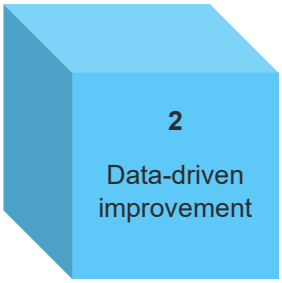
DATA DRIVEN QUALITY IMPROVEMENT STRATEGY

In a nutshell:

Using computer-based technology, general practice data systems track clinical, operational and patients' experience metrics to monitor progress towards achievement of goals and objectives.



Rationale:

Monitoring progress towards objectives requires the second building block, data systems that track clinical (e.g., cancer screening and diabetes management), operational (continuity of care and access) and patient experience metrics. Performance measures are often drilled down to each clinician and care team and are regularly shared with the entire staff to stimulate and evaluate improvement.

Reading and reasources

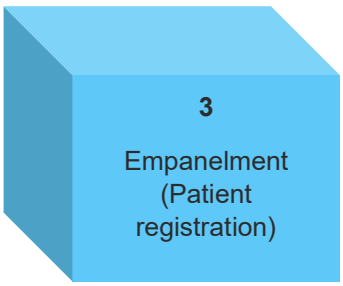
Reach out to your primary care coordinator for guidance with the latest digital health and program software for your practice.

Goals:

- ☐ Prioritize the collection and cleaning of data and summarise performance data to drive effective action
- ☐ Using data to facilitate the movement from data to action e.g at staff meeting to identify organisational goals .
- ☐ Be stratigic with what to measure ,validate and analyse.

Improvement ideas:

PATIENT REGISTRATION



In a nutshell:

Linking each patient to a general practice care team and primary care clinician to strengthen relationships and enable continuity of care.

Rationale:

Patient registration enables the practice to determine whether each clinician and team has a reasonable balance between patients demand for care and the capacity to provide that care. It allows practices to adjust the workload among clinicians and teams to maintain and improve continuity of care.

Reading and resources:

http://www.safetynetmedicalhome.org/change-concepts/empanelment

Goals:

☐ 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 condition, risk status, self-management capability, community, and family need.

Improvement ideas:

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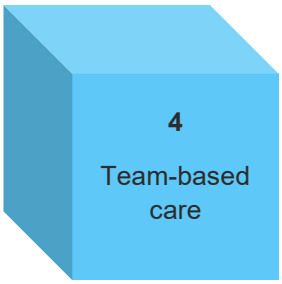
TEAM-BASED CARE



In a nutshell:

General practices organise teams to share responsibility for the health of their patients according to their needs.

Rationale:

High-performing practices view teams as a necessity, providing recommended acute, chronic, and preventive care. Many exemplar practices have created teams with well-trained non-clinicians who add to primary care capacity. Building teams that add capacity is called “sharing the care”.

Reading and resources:

Building the Team

http://www.improvingprimarycare.org/

Teamwork

http://www.heti.nsw.gov.au/Courses/Team-Work---Personalities-and-Flexible-Team-Interactions/

Goals:

☐ Build a high functioningteam - that can share the care and work to the top of their scope.

☐ Develop prinicples - Shared Visionand concrete goals to guide decisions and functions

☐ Define workflow that is transparent and clearly mapped.

☐ Facilitate communication via regular team meetings to discuss prinicples, goals, problems. Daily huddles are key to prepare for the daily schedule and anticipate patients needs

☐ Establish clinician approved standing orders based on defined workflows empowering non-clinical team members to share in the care of their patient population.

Improvement ideas:

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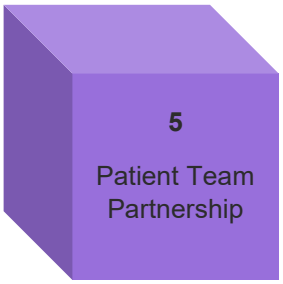
PATIENT TEAM PARTNERSHIPS



In a nutshell:

Recognition of the expertise that the patient brings, as well as the evidence base and clinical judgment of the clinician and team. Patients are engaged in shared decision-making.

Rationale:

An effective partnership recognises the expertise that patients bring to the medical encounter as well as the evidence-based 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.

Reading and resources:

Person Centred Interactions

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

Goals: 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

Improvement ideas:

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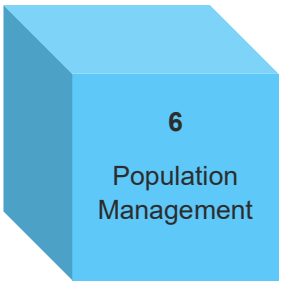
POPULATION MANAGEMENT



In a nutshell: Design roles to meet needs of patients

General practices are encouraged to understand the needs of their whole patient base. This assists in ensuring the care team can identify opportunities for health improvement on an ongoing basis.

Rationale:

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.

Reading and resources:

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

Goals:

☐ 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).

☐ Self-management support (health coaching/case coordinator) involves assessing patient's knowledge and motivation, providing information and skills, and engaging patients in behaviour-changing action plans known to improve outcomes. E.g., education around smoking cessation, goal setting for diabetic patients

☐ Complex care management has emerged to address patients' needs that are medically and psychosocially complex.

Improvement ideas:

CONTINUITY OF CARE

In a nutshell:

General practices taking continuous responsibility for their patients. This is associated with improved preventative and chronic care, greater patient and clinician experience, and affordable provision of care.

Rationale:

Continuity of care is associated with improved preventive and chronic care, greater patients and clinician experience, and affordable provision of care. Practices plan and deliver care outside episodic encounters.

Reading and resources:

Continuous & Team-Based Healing Relationships :
http://www.safetynetmedicalhome.org/change-concepts/continuous-team-based-healing-relationships
Information on Continuity of Care:
https://www.aafp.org/about/policies/all/continuity-of-care-definition.html
Care Continuity research report:
https://www.rti.org/sites/default/files/resources/care_continuity_in_patient-centered_medical_homes.pdf

Goals:

- ☐ 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

Improvement ideas:

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PROMPT ACCESS TO CARE

In a nutshell:

General practices measure and control demands on their time and services. Focus is placed on building workforce capacity and capability to ensure patients receive the right care when it's needed.

Rationale:

Access is closely linked to patient satisfaction and is a prominent objective for many practices. Though the science of access is well-developed, practices often struggle in their efforts to reduce patient waiting or access to relevant interventions.

Reading and resources:

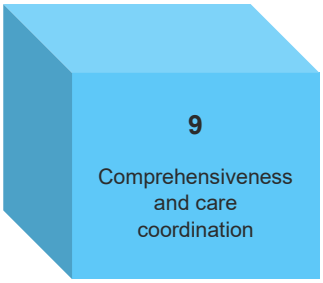
http://www.safetynetmedicalhome.org/change-concepts/enhanced-access

Goals:

- ☐ Balance demand and capacity- right sizing panels and implementing team based care that adds capacity
- ☐ Develop a scheduling system to accommodate patient access
- ☐ Offer access though mulitple channels e.g. phone, web based, group visits and non clinician staff members who are empowered to provide care based on their scope of practice and standing orders

Improvement ideas:

COMPREHENSIVE AND COORDINATED CARE



In a nutshell:

When patient needs go beyond the general practice team's level of comprehensiveness, care coordination is required with other members of the medical and social neighbourhood.

Rationale:

This refers to the capacity of a practice to provide most of what patients need. Another pillar – care coordination 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, specialists and community and social worker care.

Reading and resources:

Coordinating Care Challenges and Solutions:

https://www.ahrq.gov/sites/default/files/wysiwyg/ncepcr/tools/PCMH/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf

Innnovative approach in Primary Care Practices:

https://www.ajmc.com/view/innovative-approach-to-patient-centered-care-coordination-in-primary-care-practices

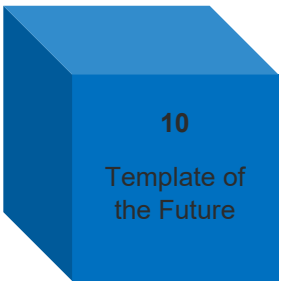
Goals:

☐ 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

Improvement ideas:

A TEMPLATE FOR THE FUTURE



In a nutshell:

For practice to provide continuity, access, patient experience,

clinical quality and finacial viability

Rationale:

Increase health outcomes/ patient , provider and staff satisfaction

Reading and resources:

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

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

https://www.pcpcc.org/content/why-it-works

Case study showcasing PCCP practice style

https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Mrs.%20Chen%20and%20the%20Building%20Blocks%20Exercise.pdf

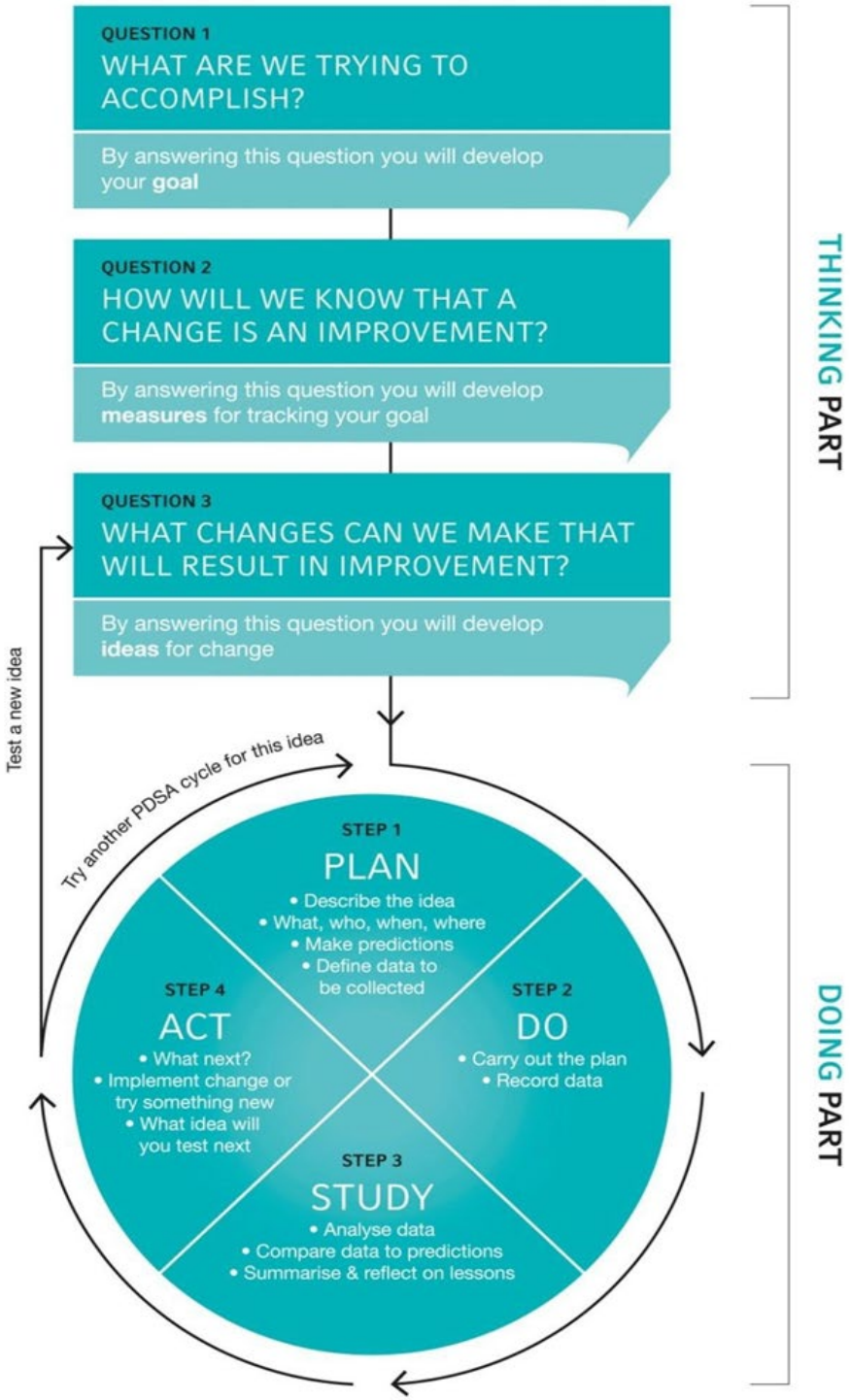
Building block of high-Performing Primary Care: lessons from the field

https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingBlocksPrimaryCare.pdf

Goals:

- ☐ Working alongside a team empowered to share the care
- ☐ Defines workflows and roles with training opportunites to expand roles
- ☐ Escape for the 15- Minute visits
- ☐ Stable team with strong communication
- ☐ Data system to drive drive improvement towards goals realting to improved patient outcomes

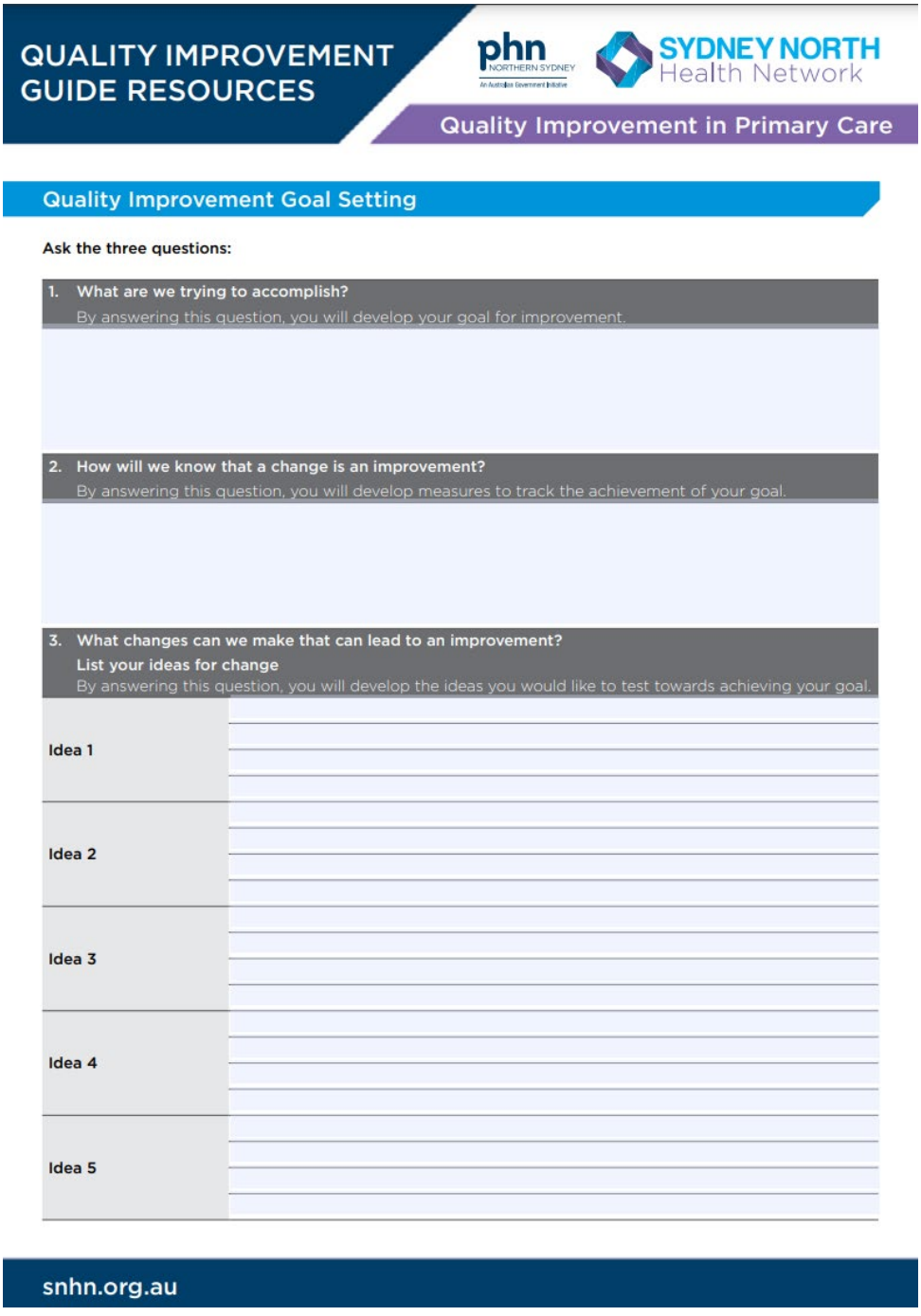
THE MODEL FOR IMPROVEMENT



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

PLAN, DO, STUDY, ACT (PDSA) CYCLES

THE THINKING PART



QUALITY IMPROVEMENT GUIDE RESOURCES

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SYDNEY NORTH Health Network

Quality Improvement in Primary Care

Quality Improvement Goal Setting

Ask the three questions:

1. **What are we trying to accomplish?**
   By answering this question, you will develop your goal for improvement.

2. **How will we know that a change is an improvement?**
   By answering this question, you will develop measures to track the achievement of your goal.

3. **What changes can we make that can lead to an improvement?**
   List your ideas for change
   By answering this question, you will develop the ideas you would like to test towards achieving your goal.

Idea 1	
Idea 2	
Idea 3	
Idea 4	
Idea 5	

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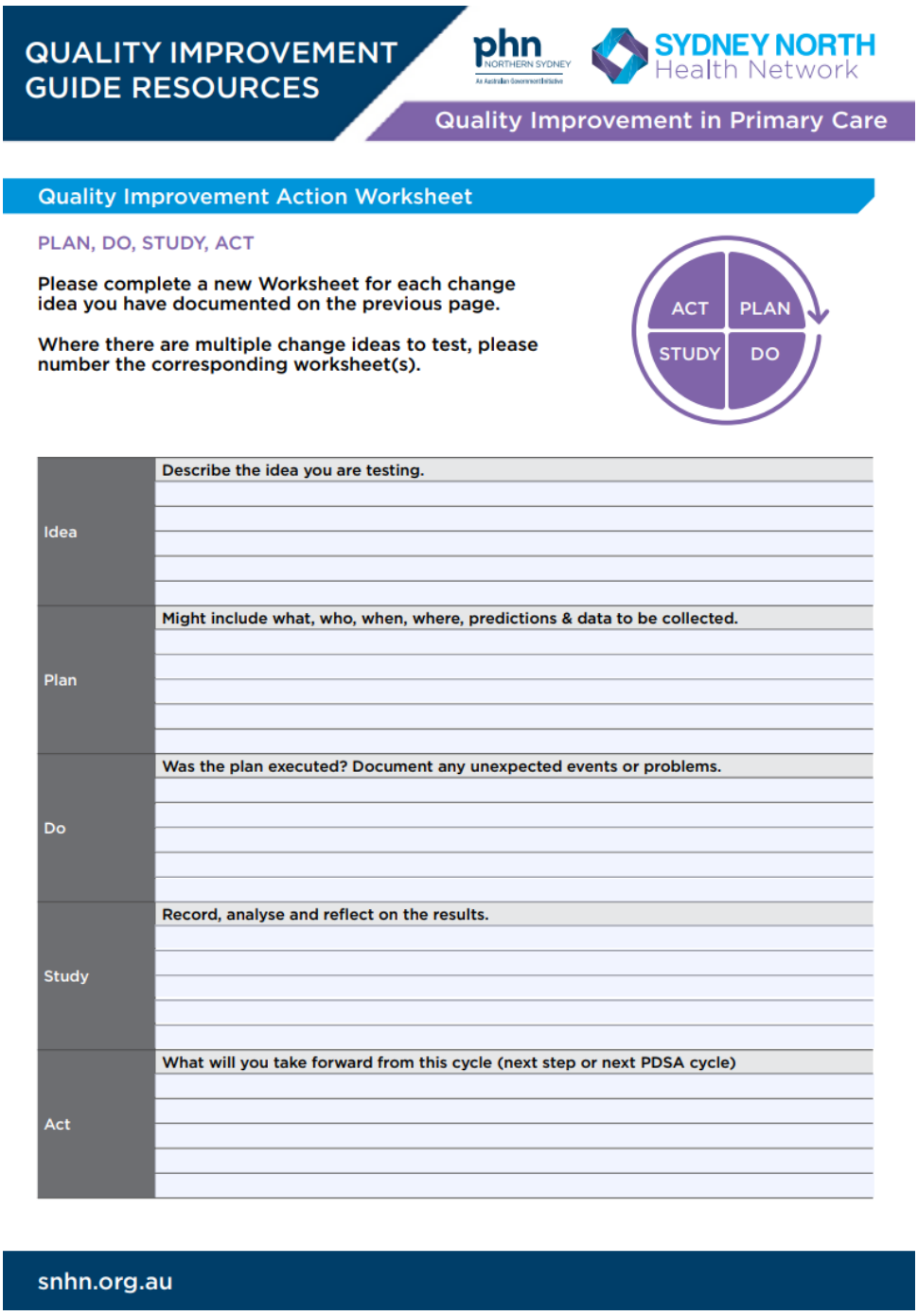
Source: https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2019/07/QI-PDSA-Resource-2pp-020719.pdf

PLAN, DO, STUDY, ACT (PDSA) CYCLES

THE DOING PART



QUALITY IMPROVEMENT GUIDE RESOURCES

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SYDNEY NORTH Health Network

Quality Improvement in Primary Care

Quality Improvement Action Worksheet

PLAN, DO, STUDY, ACT

Please complete a new Worksheet for each change idea you have documented on the previous page.

Where there are multiple change ideas to test, please number the corresponding worksheet(s).

Idea	Describe the idea you are testing.
Plan	Might include what, who, when, where, predictions & data to be collected.
Do	Was the plan executed? Document any unexpected events or problems.
Study	Record, analyse and reflect on the results.
Act	What will you take forward from this cycle (next step or next PDSA cycle)

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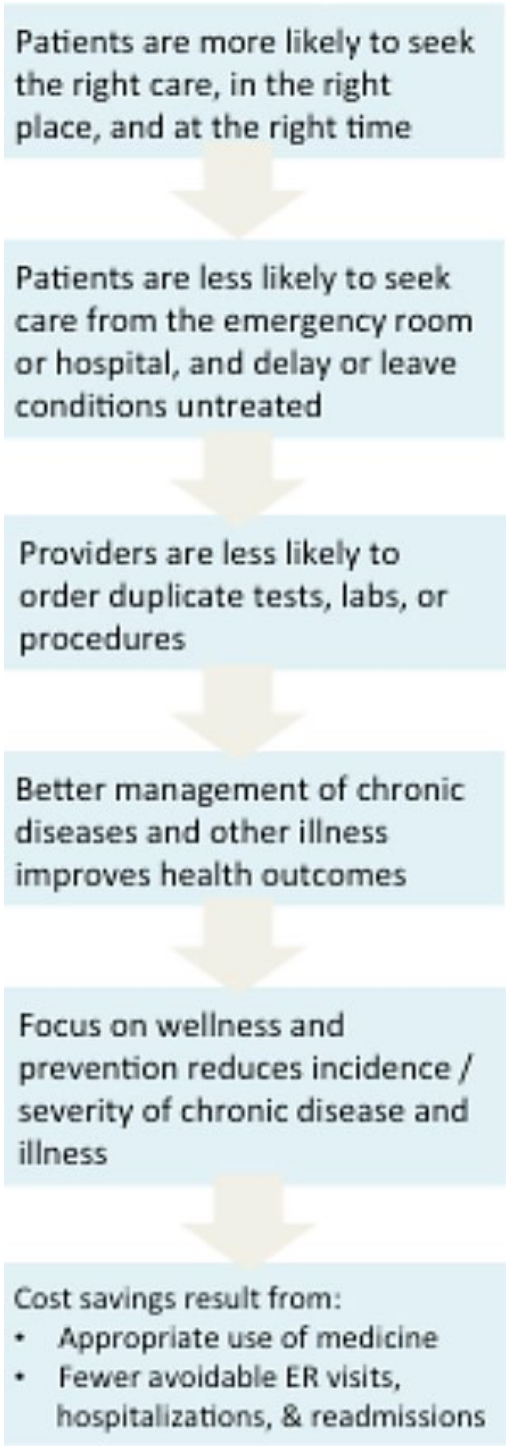
Source: https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2019/07/QI-PDSA-Resource-2pp-020719.pdf

POTENTIAL IMPACTS



https://longspeakfamilypractice.com/family-practice/pcmh/

HOW PERSON CENTRED CARE COULD BE DELIVERED

Today's Care		Person Centred 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

https://aci.health.nsw.gov.au/nhn

HELP AND SUPPORT

FOR MORE INFOIRMATION OR TO GET STARTED WITH THIS PROGRAM

PLEASE CONTACT: PRIMARY CARE SUPPORT TEAM

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