

CONFERENCE ABSTRACT

Demonstrating the Practicalities of a Patient Centred Medical Home (PCMH) for Diabetes Care in an Australian Corporate Medical Centre Setting

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Introduction: Primary Health Care Limited (Primary), is an Australian corporate organisation with 71 medical centres nationally, providing primary healthcare services to 2 million patients per annum. All Primary medical centres include a range of co-located services that support a Patient Centred Medical Home (PCMH), such as GPs, Specialists, Allied Health, Pathology Collection, Diagnostic Imaging and Pharmacies onsite. Due to high patient numbers and the demands placed on the health care practitioners (HCPs) there has been a tradition of focussing on episodic care.

Many Primary medical centres are located in low socioeconomic areas where patients have multiple chronic complex conditions. Episodic care fails the long term management of those patients.

Short description of practice change implemented: Using Bodenheimer's 10 building blocks of high performing primary care, and developing a PCMH model for diabetes care, Chronic Care Co-ordinators have been commenced to implement workflows and progress GP management plans and team care arrangements as well as preventative care and health coaching programs.

GP small group meeting were commenced fortnightly to review the workflows, the referral programs as well as interconnectivity within the centres Gps, specialists and allied health practitioners.

A baseline data analysis of the completion of diabetic annual health assessments, including biometric analysis, cycles of care, GP management programs and team based programs will be reviewed on a de-identified practitioner and discussed at the GP small group meetings on a monthly basis. Education on the use of the AUSDisk audit tool for assessing the risk levels of developing diabetes in the high risk undiagnosed diabetic population. This will trigger health assessments by the CCC, as well as investigations to determine a diagnosis of current diabetes in that patient population.

Interconnectivity has been provided by a Centre level Medical software solution where all health practitioners on site will have access to the documentation of any conferencing, patients notes, test results, prescriptions and external hospital or specialist reports.

On the completion of the program a Patient satisfaction and GP approval assessment will be undertaken.

This is a program to focus on the change management process for diabetics and pre-diabetics as well as a review of the patient outcomes within the Fairfield Centre.

Aim and the theory of change: The aim is to establish a chronic care workflow protocol for diabetes care, which could be transferred to other chronic conditions presenting in Primary's Fairfield Medical Centre. This could then be transposed into as many as possible of the 71 Primary medical centres.

Targeted population and stakeholders: Initially the diabetic patients in the Fairfield Medical Centre database are targeted to identify failure to initiate comprehensive care in accordance with the Royal Australian College of General Practice (RACGP) best practice guidelines. Currently this entails 1800 patients. Thresholds for workflow referrals have been developed.

Timeline: The program commenced 1st Oct 2016 and the program assessment will be completed in April 2017.

Highlights: This project has supported the interconnectivity between the GPs, Specialists and Allied Health care practitioners resulting in the formation of a comprehensive PCMH Diabetes clinic in a socially disadvantaged region where healthcare traditionally has been episodic rather than part of an organised chronic care program.

Conclusions: Bodenheimer's 10 building blocks of high performing primary care has been the basis of the development of a PCMH for diabetes care at the Fairfield Medical Centre. In a clinical corporate setting, the principles of change management and interprofessional and interorganisational trust have supported the progress of this project.

Discussion: Primary's PCMH model for diabetes care has formalised a workflow and interconnectivity culture where the model can be expanded to become a generic chronic care management tool. This can be transposed into other Primary Medical Centres.

Once the Fairfield program has been fully developed and implemented then a program of integrating with the local Primary Health Networks, Local Area Health and local Government Council can be commenced where life coaching, healthy life and community programs will be promoted.

Keywords: integration; corporate; patient centred medical home; bodenheimer's 10 building blocks
