ACI NSW Agency for Clinical Innovation

The Patient-Centred Medical Home: Background Paper

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Introduction

This background paper defines the features of a patient-centred medical home (PCMH), outlining the structure and operation of the model, key change concepts in transforming practices from traditional models, and frameworks for PCMH implementation. The benefits of implementing the model and potential barriers to success are also identified. The background paper seeks to bring together existing evidence-based work in this area, both in Australian and international contexts.

A PCMH Working Group was established in December 2014 comprising ACI and Primary Health Network (PHN) representatives from across NSW. The Working Group meets every two months and aims to support the development of resources and events that support effective patient-centred primary health practice for primary care and Local Health Districts (LHDs).

The PCMH has been proposed as one model for transforming primary care and improving efficiency and effectiveness in the health care system (1). It seeks to provide 'whole person' health care by ensuring that patients, particularly those with ongoing and complex needs, have a continuing relationship with a chosen general practitioner (GP) and a care team that is supported by an integrated primary healthcare team and system enablers such as eHealth. The PCMH is valued and integrated into the broader health care system and is especially useful when considering integrated care initiatives.

PCMHs are a strong basis for care teams to partner with the patient, their carer and family (where appropriate), and to establish, coordinate and oversee a medical neighbourhood in which clinicians and service providers work together to wrap services around the patient so their needs are met as close to home as possible. This is illustrated by the Canterbury, New Zealand model in Figure 1 (2).

Figure 1. Patient-centred care in Canterbury, New Zealand. Reproduced with permission from (2).

The PCMH is responsible for ensuring that the patient receives comprehensive, continuous and coordinated whole person care as they journey through the health care system. This approach involves shared care: where care is not handed over, but is shared with the patient and among members of the multidisciplinary team. The patient's home care provider is kept involved and informed about all health care decisions.

Aboriginal Health Impact Statement

Please note: an Aboriginal Health Impact Statement has not been completed for this document as it has been produced to provide background and technical information on this model of primary health practice. However, ACI will now consult with the Directors and Managers of Aboriginal Health and the Aboriginal Health & Medical Research Council of NSW (AH&MRC) with a view to amending or supplementing the document, or producing a related resource, in accordance with their advice.

The PCMH model has many commonalities with the models of service delivery used by Community Controlled Health Services. During 2015, the ACI supported an improvement project with the Awabakal Aboriginal Medical Service in Newcastle that included analysis of the Service's existing practice and advice on where improvement could be made. Some of the recommendations of that project related to PCMH principles. For more information please contact the ACI.

What is a patient-centred medical home?

In practice, the PCMH has been interpreted in many ways, from formal programs to adoption of systems and operational concepts, such as the '10 building blocks of high performing health care' (3) (outlined further in this paper). These concepts usually have features that have long been identified with strong health care systems, focusing on the important role of primary care, and achieving better health outcomes. In more recent times, these outcomes have been measured against the Triple Aim (5): higher quality, lower cost, and improvement in the person's and provider's experience of (health) care.

Key features of the model

The Australian Centre for the Medical Home identifies and describes the following attributes of the PCMH (6).

Accountability

The medical home partners with a patient and their family in being responsible for the provision of care even when the patient is not physically present. The medical home is proactive in providing for the care needs of patients and will assist them to navigate the health system and participate in informed decision-making.

Comprehensive, whole person care

The medical home will be the custodian of a patient's whole health story. It will either provide care itself or make sure that the patient can access the most appropriate provider for all their health needs.

Continuity of care

People benefit from a long term relationship with one GP or another generalist primary care provider if a GP is not available.

Team based care

A medical home adopts a team-based approach that includes practice nurses in the role of care managers and other allied health providers.

Self-management

A medical home will have systems to foster self-management of each person's health.

Patient participation

Patients will be able to participate in the design of their own care and services that a medical home offers.

Accessibility

A medical home will actively manage its appointment systems to improve the provision of timely routine appointments. It will have systems to provide proactive chronic disease management and preventative health care. It will be accessible for patients with acute care needs when required and will either provide after-hours acute care or have clear arrangements in place for its patients to access after-hours care.

Excellent clinical information

A medical home will have a systematic approach to curating each patient's medical history and will ensure that there is appropriate information available to all providers of care. It will make full use of eHealth technologies.

System-based approach and participation in quality improvement

A medical home will have a system-based approach to make sure that each patient receives best practice care. It will participate in quality improvement initiatives to improve the care it provides.

Connections to the medical neighbourhood

A medical home will have good relationships with other providers in the community. It will act as a gateway to the health system and will have developed systems to make sure that all providers in a patient's care are part of an integrated care team, with clear roles, goals and communication pathways.

Education and training

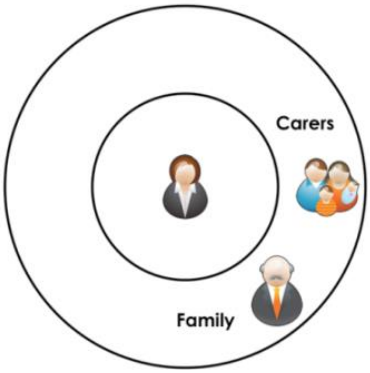
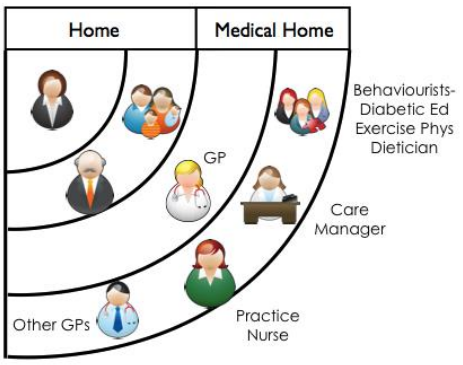
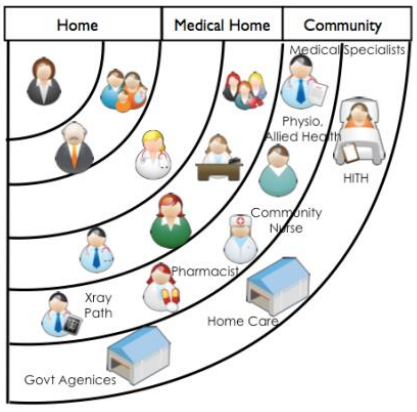
'Giving back' to the next generation of clinicians is an important role for the medical home care team. They will participate in training health professionals, in their disciplines, as well as in the skills needed to work in a medical home model.

The 4 circles of the health system: building care around the patient

Literature demonstrates that the PCMH model is an effective and efficient way to achieve the Institute for Healthcare Improvement's Triple Aim: higher quality, lower cost, and improvement in the person's and provider's experience of (health) care (5) (6).

In the PCMH model, health services are designed around the patient's needs with community and hospital care providers partnering with the medical home team as required. Care from the patient's point of view should feel connected or integrated. All members of the care team should be working with the knowledge of the complete set of goals for each patient and be aware of their own role in helping to achieve these goals.

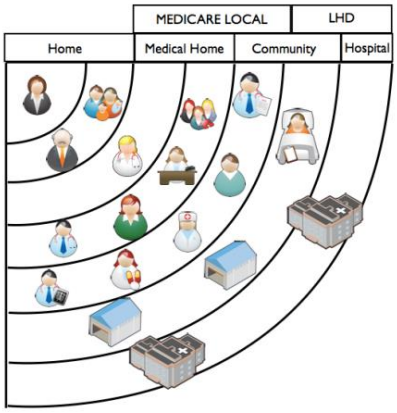
Lembke identifies four circles of the health system in building care around the patient. These are outlined below (6).

1. The home Under this model, the health system will be designed to have the person and their needs at the centre.	
2. The medical home People benefit from having an ongoing relationship with a particular general practitioner. This relationship is supported by a practice team, forming the medical home.	
3. Community-based care As a person's need for care increases, they benefit from extending their care team by adding new members. The expanded team may include medical specialists, physiotherapists, community pharmacists, optometrists, psychologists, and other allied health providers. It may also include community nursing, home care and personal care providers. The medical home has a special role in coordinating care, and in maintaining a source of accurate, consistent and complete clinical information about each person.	

4. Hospital-based care

When required, hospital-based care should be accessible in a timely manner. The health system requires an efficient, effective, and safe hospital system to deliver inpatient services and emergency care.

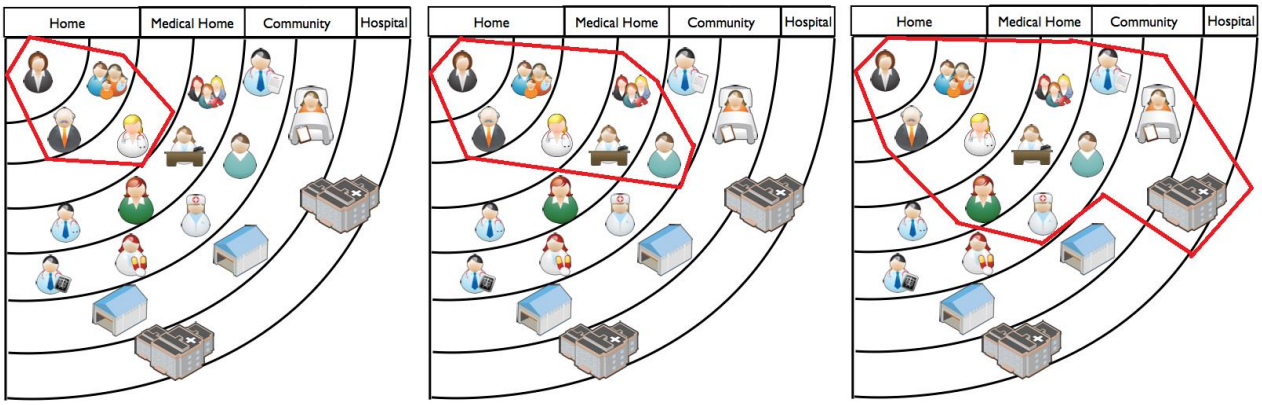
Over and above the provision of acute and/or highly specialised care, the role of the hospital is to support care in the community. Cost and safety are greatly improved when hospital-based care is connected to ongoing community-based care. It would be logical for the usual healthcare provider to be involved in the care planning for the patient at the time of admission, during the inpatient period, and at discharge.



The integrated care team

As the patient's acuity and needs increase, the care team will expand to include different members. As acuity diminishes or better control is achieved, the team will contract.

Patients are not transferred from one team to another team. The medical home always remains a central part of their core care team.



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

** Images reproduced with permission from T Lembke (2014)*

When the integrated care team functions in the above manner, most care can be delivered in the home, with each patient managing their own care to their optimal extent with the support of their family and carers. Each individual connects with a 'medical home' to allow comprehensive service delivery for prevention, acute care and chronic disease management. A range of accessible, community-based providers are available to be members of a person's integrated care team. Safe, efficient and integrated hospital services are accessible when required, with frequency of need diminished through improvements in community-based services.

The aim is to strengthen each layer of the health system to deliver optimal care, making each of the concentric circles as capable as possible. In a high-functioning health system, each person requires less care in the outer layers of the circle, but that care is readily accessible when required. If people

drift into receiving care in the outer circles inappropriately, it is detrimental to their health outcomes, reduces the availability of specialised care when required, and escalates costs unnecessarily (6).

Creating services that do not fit with existing relationships in the patient-centred model of care can disrupt the system and produce worse health outcomes. The most efficient and effective way to improve the system is to place resources as close to the centre of the circle as possible (6).

Bodenheimer and Sinsky (4) advocate the inclusion of a fourth aim: 'care of the provider', in addition to the three identified by the Institute for Healthcare Improvement. Improving the work-life balance of clinicians reduces burnout, dissatisfaction and excess stress, thereby improving chances of success in achieving the Triple Aim. The following suggestions are made to assist in caring for clinicians and practice staff.

- Implement team documentation. Team documentation has been associated with greater physician and staff satisfaction, improved revenue, and the capacity of the team to manage a larger panel of patients without working extra hours.
- Use pre-visit planning and pre-appointment laboratory testing to reduce time wasted on the review and follow-up of laboratory results.
- Expand roles, allowing nurses and medical assistants to assume responsibility for preventative care and chronic care health coaching under physician-written standing orders.
- Standardise and synchronise workflows for prescription refills.
- Co-locate teams so that physicians work in the same space as their team members.
- Ensure that staff who assume new responsibilities are well trained and have the skills required to contribute to the health of their patients.

Identifying benefits of the model

As care is delivered closer to the centre of the circle (7), it is:

- more generalist rather than specialist
- more whole person focused, rather than disease or organ specific
- delivered closer (physically) to the patient's home
- based on long term relationships, rather than episodic encounters
- more focused on patient self-management: things done *by* the patient rather than *to* the patient
- more preventative and proactive, rather than reactive
- less costly to provide.

When care can be delivered in the inner circles, we are more likely to achieve the Triple Aim (9):

- generating improvement in health outcomes – care is more effective
- improving the patient experience – patient preference is more closely met
- reducing the cost of care provision– care is cheaper to deliver and more efficient.

Implementation strategies

It is important to note that the various elements of the PCMH do not need to be implemented concurrently. Rather, implementing the principles should be viewed as a staged journey. Implementation needs to take into account the local service contexts. This may require a flexible approach to implementing the building blocks and principles.

Framework for the model

The Patient-Centred Primary Care Collaborative (1) has developed a framework to explain the benefits and strategies associated with delivering patient-centred primary care. Figure 2 is organised according to the five key features of the medical home model: patient-centred, comprehensive, coordinated, accessible, and committed to quality and safety. It includes definitions for each of these features, sample strategies used by health professionals, employers, and payers, and their collective impact on the health system.

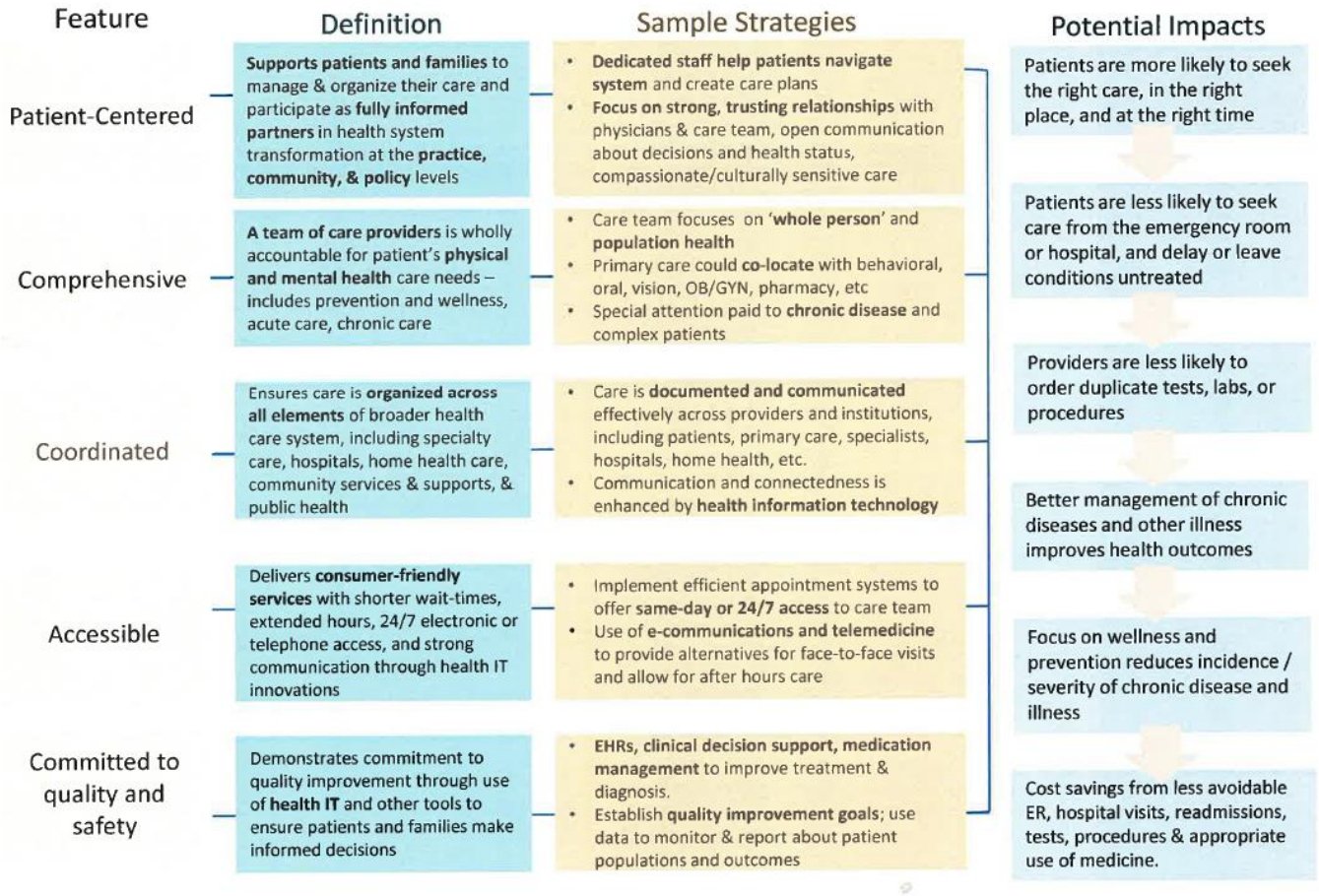


Figure 2. ***Why the medical home works: a framework*** **(1).**

Key change concepts

Wagner *et al* (9) outline and describe the changes that most medical practices would need to make to become a PCMH. These include: engaged leadership, quality improvement strategy, empanelment, continuous and team-based healing relationships, organised, evidence-based care, patient-centred interactions, enhanced access, and care coordination. The change concepts and associated key

changes are being tested through a five-year demonstration project in 65 practices in the United States as part of the Safety Net Medical Home Initiative (10), conducted through the Commonwealth Fund, Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute. This experience will provide insight into what it takes for busy practices to implement these ideas and become a PCMH. Change concepts are general ideas used to stimulate specific, actionable steps that lead to improvement.

CHANGE CONCEPT	DESCRIPTION	KEY CHANGES
Engaged leadership	Requires visible leadership that can establish a quality improvement apparatus and culture, help staff envision a better organisation and improved care, and ensure staff have the time and training to work on system change.	• Visible leadership for culture change and quality improvement. • Ensure time and resources for transformation. • Ensure protected time for quality improvement. • Build PCMH values in staff hiring and training.
Quality improvement strategy	Relies on routine performance management to identify opportunities for improvement and uses rapid-cycle change methods to test ideas for change. Obtains and uses patient experience data to inform improvement efforts to make the practice more responsive to patient needs and preferences. Practices put in place information systems that support performance management, provider alerts and reminders, computerised order entry, and population management.	• Use formal quality improvement model. • Establish metrics to evaluate improvement. • Involve patients, families, and staff in quality improvement. • Optimise use of health information technology.
Empanelment [patient registration]	Care provided by the same clinician and care team over time results in positive outcomes. Linking each patient and family with a provider facilitates continuity of relationship and is a cornerstone of the PCMH model. Practice teams can monitor their panel to identify patients requiring more attention and services. In the Australian health care environment, empanelment, whereby an individual is linked to a specified practice, has been referred to as patient registration. The practice the patient is linked to functions as	• Assign all patients to a provider panel. • Assess supply and demand to balance patient / case loads. • Use panel data to manage patient populations by tracking and monitoring care needs and health status.

CHANGE CONCEPT	DESCRIPTION	KEY CHANGES
	their 'home' care provider and is a single point of contact for the provision of care in the primary setting and coordination with other health services.	
Continuous and team-based healing relationships	Robust and lasting patient-clinician relationships are at the centre of the medical home. This begins with defining critical roles and tasks involved, assigning them to the most appropriate member of the team (clinical and non-clinical), and ensuring the team member is trained to perform them well.	• Establish and support care delivery teams. • Link patients to provider and care team. • Ensure patients see their provider. • Distribute roles and tasks among team members.
Organised, evidence-based care	Includes planned care and decision support. Information system tools enable practices to identify gaps in care for patients before they visit. Decision support systems improve care by alerting providers when services are needed and helping them make evidence-based choices.	• Use planned care according to patient need. • Manage care for high-risk patients. • Use point of care reminders. • Use patient data to enable planned interactions.
Patient-centred interactions	Increases patients' involvement in decision-making, care and self-management. Respects a patient's needs, preferences and values, and works to ensure patients understand what is being communicated to them.	• Respect patient and family values and needs. • Encourage patient involvement in health and care. • Communicate clearly so that patients understand. • Provide self-management support at every encounter. • Obtain patient and family feedback and use for quality improvement.
Enhanced access	Ensures patients have the ability to contact their care team during and after office hours.	• Ensure patients have 24/7 access to care team. • Provide appointment scheduling options.
Care coordination	Helps patients find and access high-quality service providers, ensures that appropriate information flows between the PCMH and other providers, and tracks and supports patients through the process.	

The 10 building blocks of high-performing health care

The '10 building blocks of high-performing health care' is a conceptual model described by Bodenheimer *et al* (3). It identifies and describes the essential elements of primary care that facilitate exemplary performance. The model was developed using information from site visits, experiences of practice facilitators, a review of existing models, and research on primary health care improvement and practice transformation. It is underpinned by existing frameworks for understanding the key attributes of high-performing primary care, and recognises and addresses some of their limitations. Such frameworks include:

- Starfield's 4 Pillars of Primary Care (11)
- Joint Principles of the Patient-Centred Medical Home
- Patient-Centred Medical Home Recognition Standards.

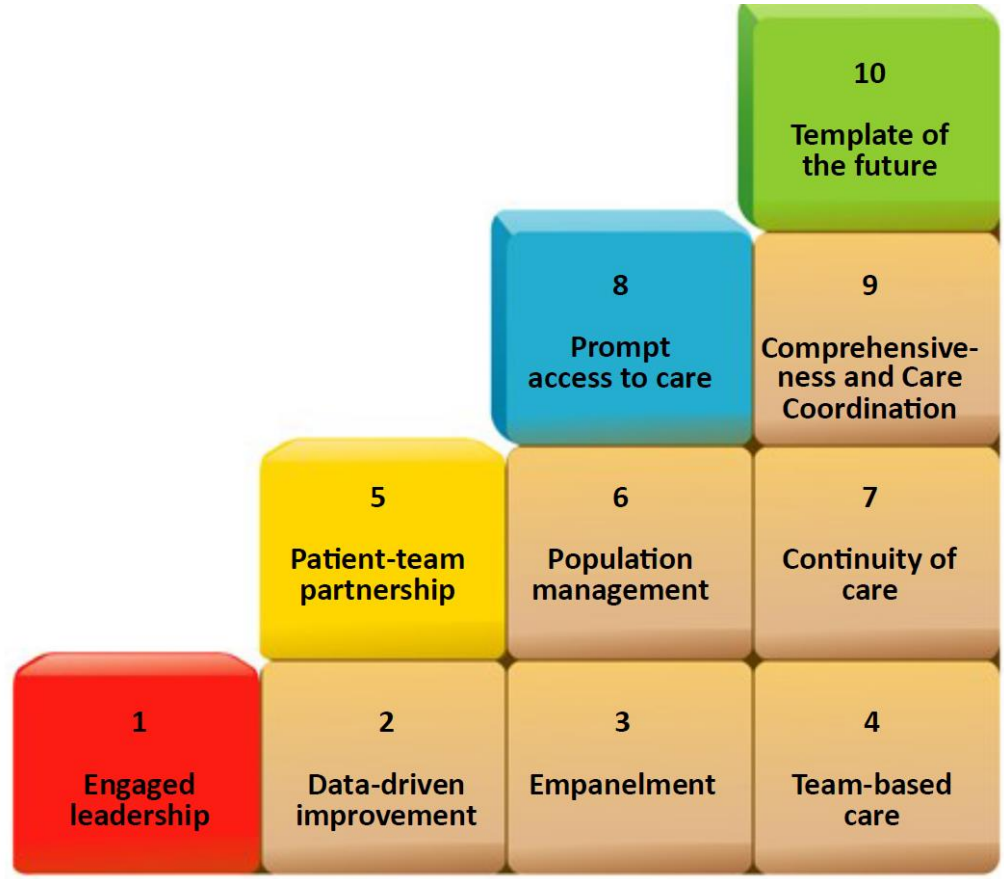


Figure 3. The 10 building blocks of high performing health care (3).

The building blocks in the model include four foundational elements (engaged leadership, data-driven improvement, empanelment [patient registration], and team-based care) that assist the implementation of the other six building blocks (patient-team partnership, population management, continuity of care, prompt access to care, comprehensiveness and care coordination, and a template of the future).

Block 1: Engaged leadership – creating a practice-wide vision with concrete goals and objectives. Leaders are fully engaged in the process of change. High-performing practices have leadership at all

levels of the organisation and some engage patients in leadership roles. Leaders create concrete, measureable goals and objectives.

Block 2: Data-driven improvement – using computer-based technology. Data systems that track clinical, operational and patients' experience metrics monitor progress towards achievement of goals and objectives. Performance measures are often set for clinicians and care teams within the primary care practice (by the practice), and are shared across organisation staff to stimulate and evaluate improvement. Data charts can be displayed in the practice and discussed at team meetings.

Block 3: Empanelment [patient registration] – linking each patient to a care team and primary care clinician. Patient registration enables the practice to calculate panel size (which determines whether each clinician and team has a reasonable balance between patients' demand for care and capacity to provide that care), and allows practices to adjust the workload among clinicians and teams.

Block 4: Team-based care – Practices often organise their teams in 'teamlets', which are a pairing of a clinician and clinical assistant who work together and share responsibility for the health of their panel. Practices co-locate clinicians and non-clinical staff in common work areas.

Block 5: The patient-team partnership – recognises 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.

B**lock 6: Population management** – practices stratify the needs of their panels and design team roles to match needs. Three population-based functions provide major opportunities for sharing the care including panel management, health coaching and complex care management. To manage the panel, a staff member periodically checks the practice registry to identify patients who are due for routine services. Health coaching aims to assess patients' knowledge and motivation, provide information and skills, and engage patients in behaviour-changing action plans known to improve outcomes. Complex care management acknowledges that empanelled patients are often regularly utilising high cost services and addresses the fact that patient needs are medically and psychosocially complex.

Block 7: Continuity of care – is associated with improved preventative and chronic care, greater patient and clinician experience, and lower costs. It requires patient registration to be in place and reception staff need to be engaged to encourage patients to see the clinician to whom they are empaneled.

Block 8: Prompt access to care – practices measure and control panel size and build capacity-enhancing teams. Access and continuity may be in tension, and patients have a role in deciding what the priority is for a consultation.

Block 9: Comprehensiveness and care coordination – when patients' needs go beyond primary care's level of comprehensiveness, care coordination is required with other members of the medical neighbourhood. Practices include a care coordinator whose sole responsibility is care coordination.

Block 10: Template of the future – requires payment reform that does not reward primary care simply for in-person clinician visits. Some practices receive non-visit based care coordination and pay-for-performance dollars to support new models of patient encounters. It is more transformative to pay for primary care on a risk-adjusted comprehensive fee per patient, with adjustments for quality and patient experience. Practices could receive a portion of cost-savings if they reduce emergency presentation and hospital costs.

Role delineation

Lembke (6) recognises the importance of the partnership between primary and acute care. The role of the PHN and LHD in implementing PCMH model principles are described below.

The Primary Health Network

The PHN is a meso level primary health organisation that seeks to improve the capacity and capability of primary care. It works across the home, medical home and community 'circles' of the health system. Its aim is to facilitate integrated care – care that is delivered around the patient's needs, and to ensure that every patient and their family can partner with the care team to better manage their health (6).

The PHN plays a role in commissioning and improving access to services, and assists providers to improve capacity and quality of care. It has an important role in identifying and closing service gaps, particularly for vulnerable and disadvantaged people. (6)

PHNs are key to driving change in the primary care practices in their territory.

Local Health Districts

The LHD is responsible for safe, accessible, effective and efficient hospital-based care, including inpatient and emergency services. In addition to public hospitals, LHDs are responsible for community, family and children's health centres, ambulance services and an extensive range of specialty services including mental health, dental, allied health, public health, Aboriginal health and multicultural health services (17). In the four circles of the health system (6), LHDs operate in both the hospital and community space.

Achieving person-centred, continuing, comprehensive and coordinated care in the community requires the PHN and the LHD to work in close partnership and to be well connected to other sector services and their communities.

Case studies from New South Wales

WentWest Primary Health Network and Western Sydney Local Health District

In August 2014, WentWest Primary Health Network hosted a workshop for local general practitioners and health leaders to discuss the future role of general practice and primary care in Western Sydney and Nepean Blue Mountains LHDs. The workshop was an opportunity to review some of the most recent discussions and evidence relating to the PCMH approach. There was strong consensus from over 40 participants that good quality general practice must ensure patient-centred, quality care that is comprehensive, coordinated and accessible.

Workshop participants agreed on a series of PCMH building blocks to form the foundation of the future of primary care, based on international experience and analysis. WentWest has invested resources in working through the concept of building blocks, their relevance to the Australian environment, local experience of actually implementing the building blocks in practices, and planning on how the gaps can be filled for practices. There was strong consensus that while some fundamental barriers such as

payment systems exist, these should not prevent Western Sydney health practitioners and administrators from working toward their vision (13).

WentWest Operating Principles (14) to support the PCMH building blocks include the following.

- Supporting the provision of person-centred, integrated, coordinated care reflecting medical home principles.
- Promoting quality, scope, connectedness and capability in general practice and primary health care.
- Promoting innovation, integration and continuous improvement to improve quality, safety and equity in all health care.
- Enhancing health literacy and self-care capabilities for individuals, families and communities.
- Leading the design of locally-responsive and equitable services by working with local communities and building on what already exists.
- Working across sectors to influence the socio-economic determinants of health.
- Integrating teaching and research into health service planning, delivery and evaluation.

The PCMH model, which has now been adopted, forms the basis of the primary care component of this NSW Integrated Care Demonstrator Project. It is subject to an ongoing program of roll-out, based on the 10 building blocks of high-performing health care and resources publicly available through the Medical Home Safety Net Initiative (10).

HealthOne NSW

HealthOne NSW is a service model that demonstrates many of the key features of PCMH which operates in some LHDs in NSW (15) (16). HealthOne NSW is an integrated primary and community health initiative that brings together GPs with community health and other health professionals in multidisciplinary teams. Since 2006, the NSW Government has committed more than $45 million of capital funds to the development of HealthOne NSW services, with a further $3.3 million per annum to support nursing, allied health and service integration positions within HealthOne NSW and other primary and community health services.

The HealthOne NSW program has four key features, five key objectives and four enablers.

Key features	1. Integrated care provided by general practice and community health services. 2. Organised multidisciplinary care. 3. Care across a spectrum of needs from prevention to continuing care. 4. Client and community involvement.
Key objectives	1. Prevent illness and reduce the risk and impact of disease and disability. 2. Improve chronic disease management in the community. 3. Reduce avoidable admissions (and unnecessary demand for

	hospital care). 4. Improve service access and health outcomes for disadvantaged and vulnerable groups. 5. Build a sustainable model of health care delivery.
Key enablers	1. Service and capital planning. 2. Information and communication technology. 3. Governance and sustainability. 4. Workforce development.

Service elements

For all HealthOne NSW services, the goal is to create a system that delivers integrated, client focused, multidisciplinary care across a spectrum of needs. To implement this type of care, there are two compulsory service elements and an additional five service elements that LHDs are urged to consider when designing and developing configurations.

Compulsory service elements

- Partnerships – at a minimum, HealthOne NSW should have strong links between general practice and community health.
- Designated communicators – these are important for the operational and clinical aspects of a service. Clients who require a higher level of care coordination should also have a single contact point. Designated communicators can be within a single role or split across several roles.

Additional service elements

- **Enrolment based on criteria** – this enables clear identification of the client. At a minimum, services without a formal enrolment process should have a system for ensuring clients consent to the sharing of their health information.
- **Provision of specific services** – examples of specific services include clinics in wound care, foot care, maternal and child health, and immunisations. Additionally, HealthOne NSW can function as a platform for health promotion activities such as healthy eating and smoking cessation.
- **Case conferencing** – case conferencing provides an opportunity to improve the management of clients with complex needs.
- **Care plan** – any care plan should be agreed in partnership with the client and their multidisciplinary team.
- **Ongoing monitoring** – at a minimum, those clients who have a care plan will require ongoing monitoring.

Three broad service configurations have been described for HealthOne NSW services. These include co-located services, hub and spoke, and virtually integrated services (15).

Conclusion

The PCMH model was developed in response to service fragmentation and depersonalisation, and ensures accountability for confirming care is comprehensive, continuous, accessible, coordinated and patient-centred. It is an amalgamation of the core principles of primary care and the established model of chronic care. These models are complementary, comprising structural and functional enhancements in health care provision that support planned, proactive care to improve patient outcomes in both chronic diseases and preventative care.

The concepts outlined in this paper offer guidance for developing local practice changes, allowing for the unique needs, capabilities, structure and culture of each practice organisation. They may be viewed as the goals of practice change rather than the method, and provide opportunities for adaptation and innovation in their implementation.

Appendix 1: Progressing the PCMH: Next steps from the Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP) submitted a report to the Minister for Health discussing the *Health and Ageing Budget for 2013 – 2014* (12). The report clearly defined the benefits and core features of the patient-centred medical home model and provided recommendations to support its implementation in the NSW health system. These recommendations included: voluntary patient registration, point of care pathology testing, and specified frameworks for chronic and complex disease management.

While the concept of the medical home has widespread support, the RACGP recognises that significant discussion and planning is needed to ensure that the model implemented is both realistic and acceptable to health professionals, consumers, and government.

In discussion with the government, the wider profession, and other stakeholders, the RACGP proposed that the future stages of the medical home will include:

- improved support for preventive activities
- a review of the Practice Incentives Program (PIP) to review how PIP funding could be better utilised to support the medical home
- other practice support payments to recognise and support a range of practice initiatives and practice systems, including recognition of socio-economic characteristics, the delivery of comprehensive services, quality and safety, and a range of associated activities
- improved team care arrangements, with flexible models to support all practice sizes and locations from metro to rural and remote
- the strengthening of information technology and data management systems to support clinical decision-making and communication across the healthcare continuum
- increased availability of team-based education and training resources
- expansion of point of care pathology testing.

The RACGP recommends structured and planned discussions with relevant stakeholders – including government representatives, health professionals, primary care health providers and consumers – to propose a service and funding model to support sustainable implementation of the PCMH model.

References

1. Patient Centred Primary Care Collaborative. Why the medical home works: a framework [Internet]. 2015. Available from: https://www.pcpcc.org/content/why-it-works
2. Canterbury District Health Board. Canterbury Health System recognised on world stage [Internet]. 2015. Available from: http://www.cdhb.health.nz/What-We-Do/Projects-Initiatives/kings-fund/Pages/default.aspx
3. Bodenheimer T, Ghorob A, Willard-Grace R *et al*. The 10 building blocks of high performing primary care. *Annals of Family Medicine* 2014;12(2):166-171.
4. Bodenheimer, T and Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider.*Annals of Family Medicine* 2014; 12(6):573-576.
5. Institute for Healthcare Improvement. IHI Triple Aim Initiative [Internet]. 2015 [cited 15 July 2015]. Available from: http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx
6. Lembke, T. *The person-centred health system and the medical home* [Internet]. WordPress, 2014 [cited 15 July 2015]. Available from: http://medicalhome.org.au/the-person-centred-health-system-and-the-medical-home/
7. Nielsen M, Langner B, Zema C *et al* . *Benefits of implementing the primary care patient-centred medical home: A review of cost and quality results*. Patient-Centred Primary Care Collaborative; 2012.
8. Stout S. *The PCMH experience at Cambridge Health Alliance.* Boston, USA; 2015.
9. Wagner E, Coleman K, Reid RJ. *Guiding transformation: How medical practices can become patient-centred medical homes.* The Commonwealth Fund; 2012.
10. Safety Net Medical Home Initiative. Project Description [Internet]. 2015 [cited 15 July 2015]. Available from: http://www.safetynetmedicalhome.org/about-initiative/project-description
11. Starfield B. *Primary care: Balancing health needs, services, and technology.* New York: Oxford University Press; 1998.
12. The Royal Australian College of General Practitioners. *RACGP submission to the Minister for Health: Federal Budget 2013-2014: Laying the foundations for the medical home.* RACGP; 2012.
13. Crampton, RM. Western Sydney Integrated Care Program. Paper presented at the 2nd World Congress on Integrated Care; 2014; Sydney, Australia.
14. WentWest. *WestWest Ltd Annual Report 2014-15*. [Internet]. 2016 [cited 14/3/2016]. Available from http://www.wentwest.com.au/images/Annualreport/WW_Annual_Report_2015.pdf
15. NSW Health. *Guidelines for Developing HealthOne NSW Services.* 2012.
16. Health System Planning and Investment Branch. Policy Directive PD2012_034. Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative. NSW Health; June 2012.
17. NSW Health. Services [Internet]. 2015 [cited Nov 2015]. Available from: http://www.health.nsw.gov.au/services/Pages/default.aspx