



# Summary of the Patient Centred Medical Home Service Provider Consultation Findings

**COMMISSIONED BY COORDINARE**

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## INTRODUCTION

International experience suggests that transition to the Patient Centred Medical Home (PCMH) model requires substantial transformational change. (1) In Australia, the willingness and capacity of general practices to successfully implement alternative models of chronic care management are largely untested. To maximise the chance of success, COORDINARE, the South-Eastern NSW Primary Health Network (PHN), commissioned the University of Wollongong to undertake a consultation with key stakeholders, practices and COORDINARE staff to gauge their motivation and capacity for PCMH change.

## METHODS

Qualitative data were collected from workshops, semi-structured interviews and focus groups held with key stakeholders over a 6 month period (November 2016 – April 2017). Key stakeholders were representative of the geographic footprint of COORDINARE and consisted of: key informant general practitioner (GP) practices; locally based private health insurance companies (PHI); representatives from the Illawarra/Shoalhaven and Southern NSW Local Health Districts (LHD); allied health professionals (AHPs) and COORDINARE staff. A total of 173 individuals participated in either focus group discussions or interviews. Consumer and Aboriginal and Torres Strait Islander health services consultations are currently underway and will be reported separately, at a later date.

## FINDINGS

There were four overarching categories that emerged from the qualitative data: ‘willingness to engage with PCMH change’; ‘capacity to undertake change’; ‘local health system readiness’; and ‘system enablers for PCMH change’. According to our stakeholders contemplating complex organisational change, human factors such as trust, relationships, communication and values were key factors.

### WILLINGNESS TO ENGAGE WITH PCMH CHANGE

We identified that willingness to undertake PCMH transformation/change may be negatively impacted upon by a practice’s current understanding and measurement of high quality care, rather than by the potential impact of the change to patient flow or finances. The implication of this is that high performing and efficient practices paradoxically may be reluctant to contemplate PCMH change. This reluctance may be compounded, if promotion of PCMH change is perceived as an indictment of their current high quality care. The case for, and expectations of, PCMH change will therefore need to be very carefully articulated to avoid alienating potential clinical champions.

Continuity of care was also valued as an important component of high quality general practice care. Disruption to relationships and reduced patient related continuity of care were seen as significant deterrents to PCMH change by some respondents. It was therefore perceived that effective

consultation and training concerning team based care arrangements would be required to bring practices along. Similarly, COORDINARE will be required to commit to improving communication and relationship building over the long-term.

### CAPACITY TO UNDERTAKE CHANGE

GP practices were articulated as being busy, dynamic environments, with significant pressures, comprised of varied personalities with differing goals and attitudes. A dominant sentiment expressed about PCMH change, according to the data, was that workload demands and financial pressures would increase pressure on practices. There was also concern about their capacity to undertake significant organisational change.

A particular characteristic of the contemporary Australian general practice workforce that may impact on these sentiments is the individual contractor GP. These GPs may be contracted by a general practice, over different time periods, to care for patients, but are not permanent employees of the practice. In these circumstances, practice principals remarked that creating an environment for practice-wide change would be very challenging, as contractors effectively act as independent practitioners renting practice resources. They believed that changes which might disrupt workflow or re-direct payments towards the practice, rather than fee for service for the contractor, were likely to be met with significant resistance.

Previous international research suggested that larger general practices found PCMH change more achievable than smaller general practices. (2, 3) In contrast, our findings suggested that larger practices felt they may be under more pressure in comparison to small practices, due to the higher patient load which would be imposed upon them by PCMH change. Respondents felt that this pressure could be further elevated if the larger practices had a higher proportion of contracted GPs. Therefore, an evaluation of the impact of PCMH change on contracted GPs in Australia needs to be considered.

### LOCAL HEALTH SYSTEM READINESS

It has been recognised that the local health system in which a practice is situated plays an essential role in influencing, and being influenced by practice PCMH change. (2, 3) Our data highlighted that there was a sense of disconnection between general practices and LHDs, and stressed a need for improved two way communication between the two in order to build better collaborative relationships. Peer networking and interdisciplinary meetings were identified as a role that COORDINARE could assist in coordinating effective local health communication.

From a local health system readiness perspective, allied health professionals (AHPs) were considered critical to chronic disease management and integral to PCMH change. More often than not, respondents suggested that AHPs had good relationships with GPs in their area and that they were able to phone GPs if they had an urgent enquiry about a patient. A perceived benefit of PCMH change was that it would allow communication channels between GPs and AHPs to be streamlined, and that it would enable a better



integrated system building better relationships between health service providers.

## SYSTEM ENABLERS FOR PCMH CHANGE

One of the most frequently mentioned system enablers for PCMH change was the progression of shared electronic health records (EHRs). Linking or having a shared patient record was seen as an important way to improve the information links between GP practices and hospitals, as well as improving continuity of care between hospital and primary care settings.

While international literature describes PCMH change as requiring major investments in time and finances to establish EHRs and prescribing, (3, 4), this did not appear to be a concern of the practices included in the consultation process. The practices we consulted had mature EHR systems and many were already using shared clinical data via secure messaging or My Health Record. COORDINARE were also supporting practices in building capacity for meaningful use of their EHR data. GPs and practice staff acknowledged that they may need to seek assistance with increasing their capacity to use these systems to improve patient care, coordination of care and communication, but believed that these electronic systems would make the transition to PCMH change much easier.

Other system enablers for PCMH change identified in the consultation included aware and motivated patients.

Based on the evidence that improving general practice involves a complex interplay of physicians, patients and practice staff (4), it is clear that engaging patients in understanding all aspects of PCMH change is an important part of the transition process. All key informants in our consultation process agreed that patient engagement and awareness of PCMH change was vital to avoid patient confusion, particularly among the elderly. Therefore, patient education was seen as an essential component of PCMH change.

## CONCLUSION

The findings from the consultation describe the current environment for PCMH transformation in primary care in south-eastern NSW and the supports that key stakeholders seek from COORDINARE to undertake that transformation. The main conclusions arising from the consultation are summarised below:

1. PCMH transformation in south-eastern NSW will be very challenging but there exists sufficient motivation, commitment and leadership within the primary care sector in the region to suggest that progress is achievable.
2. PCMH change will be disruptive to practices. The consultation indicated that many of COORDINARE's current supporting activities will be well placed in COORDINARE's PCMH toolkit. However, COORDINARE will need to adapt to be sustainably effective as PCMH transformation brings new challenges.
3. Relationship building between and across the sector appears critical. There is a need to engage LHDs and private allied health in working with general practice as part of the move towards PCMH change. Engaging local clinical change champions

to assist in building relationships and trust between stakeholders and provide pro-active input into COORDINARE's PCMH activities.

4. The support for PCMH transformation sought by stakeholders included: accurate information regarding PCMH change (including financial implications); leadership and change facilitation; as well as practice data and IT use capacity building.
5. All stakeholders recognise the need to engage patients in education surrounding PCMH change, and what it means to them as individuals.

## LIMITATIONS

This consultation has limitations arising from time pressures and the scope of the project. Most significantly, the consumer and Aboriginal and Torres Strait Islander health consultation components are ongoing. The research team strongly believed that consultation with these two critical groups should not be restricted by the timelines of the initial phase of the project. In addition, while we were confident that data saturation had been reached in analysing the data collected, the sample is susceptible to responder bias, in that practices more interested in PCMH transformation may have been more likely to respond. If the non-responders were either under too much pressure to take part in the consultation, or simply disinterested in PCMH, then the overall receptiveness to change in the region will be lower than that portrayed in our results.

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