ACI NSW Agency for Clinical Innovation

The Patient-Centred Medical Home: Background Paper DRAFT ONLY

Primary Care and Chronic Services

The NSW Agency for Clinical Innovation has identified an opportunity to partner with Primary Health Networks in NSW to support the development and implementation of Patient-Centred Medical Home models within Local Health Districts.

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AGENCY FOR CLINICAL INNOVATION

Level 4, Sage Building
67 Albert Avenue
Chatswood NSW 2067

PO Box 699 Chatswood NSW 2057
T +61 2 9464 4666 | F +61 2 9464 4728
E info@aci.nsw.gov.au | www.aci.health.nsw.gov.au

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Introduction

The NSW Agency for Clinical Innovation (ACI) has identified an opportunity to partner with Primary Health Networks (PHNs) in NSW to support the development and implementation of Patient-Centred Medical Home (PCMH) models within Local Health Districts (LHDs). This partnership aims to enhance primary care provision by incorporating the principles and features of the PCMH in line with the Health Insurance Act 1973 (1).

A PCMH Working Group was established in December 2014 including ACI and PHN representatives from across NSW. The Working Group meets every two months and aims to support the development of an ACI-hosted online resource centre for primary care and LHDs. The resource centre would link with components of models of care, outline model benefits to LHDs and provide the following information resources: an introduction to PCMH; change management components and strategies; and a central repository for relevant Australian and international literature.

This background paper defines the features of a 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 realised by implementation of the model and potential barriers to success are also identified. The background paper seeks to bring together existing evidence-based work in this area, in both Australian and international contexts.

The PCMH has been proposed as a model for transforming primary care and improving efficiency and effectiveness in the health care system (2). It provides 'whole person' health care by ensuring that people, and particularly those with ongoing and complex needs, have a continuing relationship with a chosen GP and care team which 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 person, their carer and family (where appropriate), to establish, coordinate and oversee a medical neighbourhood; whereby clinicians and service providers work together to wrap services around the person so their needs are met as close to home as possible.

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

What is a Patient-Centred Medical Home?

In practice, the PCMH has been interpreted in many ways, from formal programs such as those seen in the United States to adoption of systems and operational concepts, such as the 10 building blocks of high performing health care (4) (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 the achievement of better health outcomes. In more recent times, these outcomes have been measured by the achievement of 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 (7).

Accountability

The medical home partners with a patient and their family to be responsible for their care even when that person is not standing in front of them. It will be proactive in providing for the care needs of its patients. It will assist patients to navigate the health system and share in their informed decision making.

Comprehensive, whole person care

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

Continuity of care

People benefit from a long term relationship with a particular general practitioner 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 their 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 and they will participate in training health professionals – not only within their disciplines but also 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 (6) (7).

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.

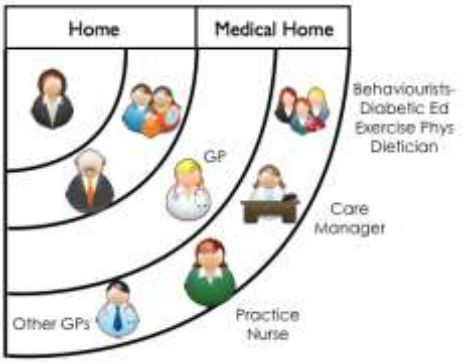
Lembke identifies the four circles of the health system in building care around the patient. These are outlined below (7).

1. The home

Under this model, the health system will be designed to have the person and their needs at the center.

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

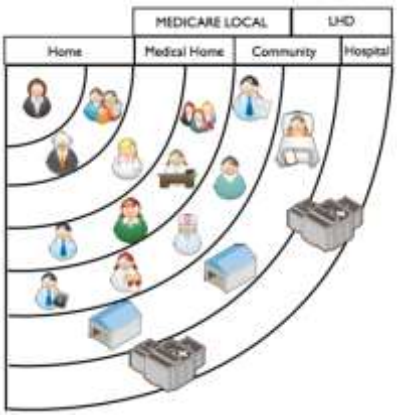
As a person's need for care increases they benefit from extending their care team by adding new members. The expanded team may include medical specialists, physiotherapists, community pharmacists, optometrists, psychologists, and other allied health providers. It may also include community nursing, home 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 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, this care team will expand to include different members. As acuity diminishes or better control is achieved, the team will contract.

Therefore, 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 person 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 and services 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 own health outcomes, reduces the availability of specialised care when it is required, and escalates costs unnecessarily (7).

Creating services that do not fit in the existing relationships of the patient-centered 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 center of the circle as possible (5).

Bodenheimer and Sinsky (5) 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, 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 while going home earlier.

- 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.
- To avoid shifting burnout from physicians to practice staff, ensure that staff who assume new responsibilities are well-trained and understand that they are contributing to the health of their patients and that unnecessary work is reengineered out of their practice.

Identifying benefits of the model

As care is delivered closer to the centre of the circle (8):

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

Framework for the model

The Patient-Centred Primary Care Collaborative (2) 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-centered, 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.

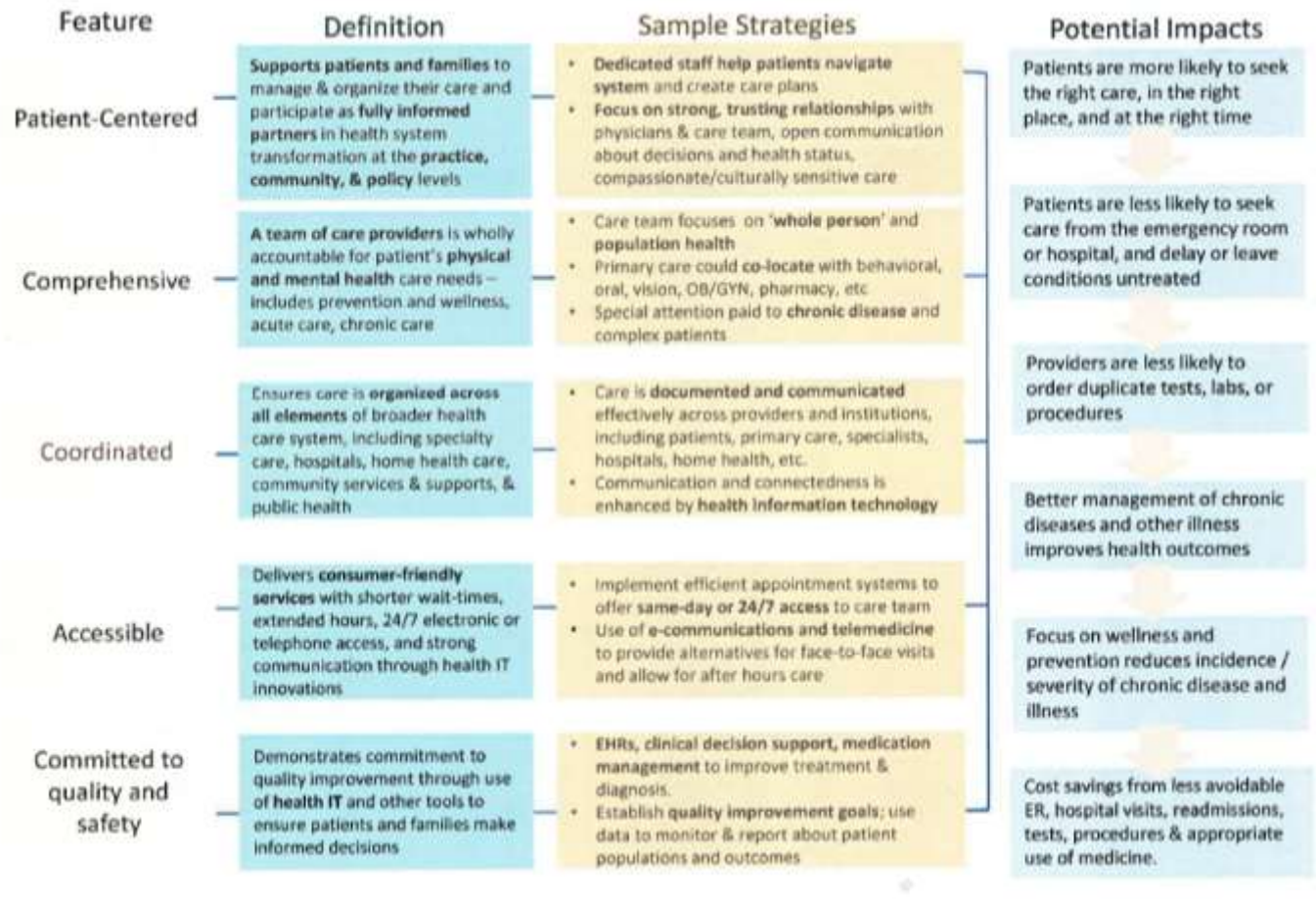


Figure 2: ***Why the Medical Home Works: A Framework*** **(2)**

Managing change: from traditional practice models to PCMH

1. Key change concepts

Wagner et al (10) outlines and describes 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 (11) 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 help staff envision a better organisation and improved care, establish a quality improvement apparatus and culture, and ensure that 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. This practice functions as their 'home' care provider to provide a single point of contact for the provision of care in the primary setting and coordination with other health services.	• 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
Continuous and team-based healing relationships	Robust and lasting patient-clinician relationships are at the centre of the medical home. Begins with defining critical roles and tasks involved, assigning them to the most appropriate member of the team (clinical and non-clinical) and ensuring they are trained to perform them well.	• Establish and support care delivery teams. • Link patients to provider and care team. • Assure patients see their provider. • Distribute roles and tasks among team.
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	Increase patients' involvement in decision-making, care and self-management. Respecting a patient's needs, preferences and values, and working 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 so that patients understand. • Provide self-management support at every encounter. • Obtain patient and family feedback and use in quality improvement.
Enhanced access	Patients have the ability to contact their care team during and after office hours.	• Ensure that patients have 24/7 access to care team. • Provide appointment scheduling options.
Care coordination	Helping patients find and access high-quality service providers, ensuring that appropriate information flows between the PCMH and other providers, and tracking and supporting patients through the process.	

2. 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 (4). It identifies and describes the essential elements of primary care that facilitate exemplary performance. The framework was developed using information from site visits, experiences of practice facilitators, and a review of existing models and research on primary health care improvement. It is underpinned by existing frameworks for understanding the key attributes of high-performing primary care, including:

- Starfield's 4 pillars of Primary Care (12)
- *Joint Principles of the Patient-Centred Medical Home*
- *Patient-Centred Medical Home Recognition Standards*

and research on practice transformation; and recognises and addresses some of the limitations of these models.

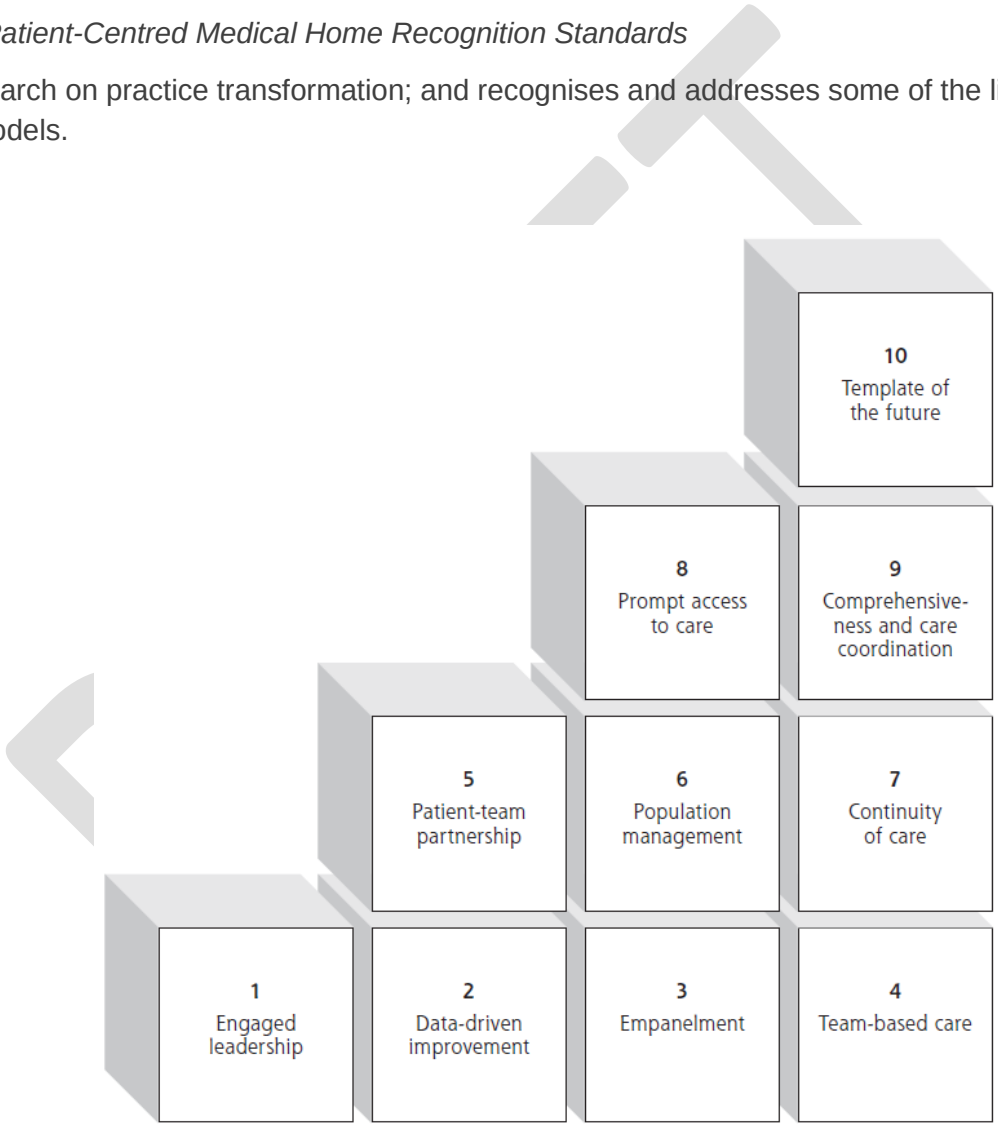


Figure 2: The 10 Building Blocks of High Performing Health Care (4)

The building blocks include four foundational elements (engaged leadership, data-driven improvement, empanelment, 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 – linking each patient to a care team and primary care clinician. Empanelment 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). It allows practices to adjust the workload among clinicians and teams.

Block 4: Team-based care – teams are a necessity for the survival of adult primary care. Practices often organise their teams in 'teamlets' – a pairing of a clinician and clinical assistant/s 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 – associated with improved preventative and chronic care, greater patient and clinician experience, and lower costs. Requires empanelment and reception staff 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 decide which the priority is.

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. More transformative is 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 can reduce emergency presentation and hospital costs.

Role delineation

Tony Lembke recognises the importance of this partnership between primary and acute care, and describes the role of the PHN and LHD in the implementation of PCMH model principles (7).

The Primary Health Network

The Primary Health Network 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 person's needs, and to ensure that every person and their family can partner with the care team that they need to better manage their health.

The Primary Health Network plays a role in commissioning and in so doing 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.

Local Health Districts

The LHD is responsible for safe, accessible, effective and efficient hospital-based care, including inpatient and emergency services, and to ensure that this care is integrated with ongoing community based care. It therefore works across the hospital and to some extent the community 'circles'.

To achieve person-centred, continuing, comprehensive and coordinated care in the community requires the Primary Health Network and the LHD to work in close partnership and to be well connected to other sector services and their communities.

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* (14). The report clearly defined the benefits of a Patient Centred Medical Home, the core features of the model and provided recommendations to support 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.

Whilst the concept of the medical home has widespread support, the RACGP recognises that the practicalities of introducing the medical home requires significant discussion and planning to ensure that the model is both realistic and acceptable to the health professions, 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.

To achieve this proposed model, 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.

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 for 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 they should not prevent Western Sydney health practitioners and administrators from working toward their vision (15).

Principles from the WentWest Strategic Plan 2012-2017 (16) to support the PCMH building blocks include the following.

- Support for the provision of person-centred, integrated, coordinated care reflecting Medical Home Principles to strengthen the quality, scope, connectedness and capability in general practice and primary health care.
- Promotion of innovation, integration and continuous improvement to increase quality, safety and equity in all health care.
- Enhancement of 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 Integrates 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/GP component of the NSW Integrated Care Demonstrator Project. It is subject to an ongoing program of roll out based on the Bodemheimer Building Blocks Model and resources publicly available through the *Medical Home Safety Net Initiative* (11).

HealthOne NSW Series

The HealthOne NSW service model is an example of a PCMH model practiced by some LHDs in NSW (17) (18). 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 2006/7 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	5. Service and capital planning. 6. Information and communication technology. 7. Governance and sustainability. 8. 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. The two compulsory service elements are:

1. **Partnerships** – at a minimum, HealthOne NSW should have strong links between General Practice and community health.
2. **Designated Communicator/s** – are important for the operational and clinical aspects of a service. Clients who require a higher level of care co-ordination should also have a single contact point. These designated communicators can be within a single role or split across several roles.

In addition, services are also urged to consider the following service elements.

3. **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.

4. **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.
5. **Case conference**s – case conferencing provides an opportunity to improve the management of clients with complex needs.
6. **Care plan** – any care plan should be agreed in partnership with the client and their multidisciplinary team.
7. **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 including: co-located services, hub and spoke, and virtually integrated services (17).

Conclusion

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

The change concepts outlined in this paper offer guidance for the development of 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 implementation.

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