



# COORDINARE

## Patient Centred Medical Home Innovation Project Evaluation

### **SUMMARY REPORT - 29 JUNE 2018**

Report prepared for COORDINARE by the General Practice Academic Unit, School of Medicine, University of Wollongong.

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## INTRODUCTION

COORDINARE funded and facilitated general practitioner (GP) practices to develop Innovation Projects. These projects focused on implementing Patient Centred Medical Home (PCMH) change and were trialled between June 2017 and June 2018. The University of Wollongong (UOW) was commissioned to conduct an evaluation of the effectiveness of COORDINARE in facilitating PCMH change in GP practices through these projects. Intrinsic to the aim of the evaluation was to assess the utility of COORDINARE's PCMH pre-implementation program logic in assisting GP practices to implement change towards PCMH goals.

## METHODS

A multi-site case study methodology was used as the primary research approach, with each GP practice representing one site. A case study relies on multiple sources of evidence and in this instance was based on a mix of qualitative and quantitative sources. This evidence was collated to present a detailed examination of a subject of study (COORDINARE Innovation Projects), as well as its related contextual conditions. Thus, the UOW research officer was immersed in the implementation of the Innovation Project in each practice over the 12 months of the evaluation, through multiple points of contact including conducting workshops in each practice, direct observation in the practices, presence at meetings, review of meeting minutes, field notes, phone calls, email, one-to-one interviews and analysis of aggregated project outcome data.

## RESULTS

Seven Innovation Project GP practices were recruited into the UOW evaluation. Evaluation workshops were conducted with 17 GP staff in the 7 practices (GPs n=5, Practice managers n=6, Practice nurses n=5, Allied Health n=1) and six COORDINARE staff. A total of 49 semi-structured interviews were conducted between November 2017 and June 2018. GP practice interviewee participants included: five GPs, seven practice managers, five practice nurses and one pharmacist. In-practice observations of the projects were conducted at three sites during the Innovation Project evaluation. Observation notes were also taken from 17 COORDINARE contacts with the respective sites. Aggregated outcomes data were collected from each practice.

Most of the practices were highly engaged with the COORDINARE activities and were grateful for the opportunity that the COORDINARE funding gave to focus on an area they wanted to change and improve in their practice. The Innovation Projects provided practices with an opportunity to enhance roles and responsibilities of staff and nurses in practices and engage patients in shared decision making around their care.

COORDINARE support for the Innovation Projects when viewed through the lens of program logic was largely a successful process. Other factors that drove the success of the Innovation Projects were pre-existing motivation, enthusiasm and flexibility in practices to undertake PCMH change. Infrastructure and space were also important to practices' existing capacity to implement change.

It is evidenced from the seven general practice Innovation Project data that all seven practices are in the process of implementing the ten building blocks of high-performing primary care, particularly the foundational elements of engaged leadership, data driven-improvement and team based care. Additional building blocks that were highly representative in the seven projects included the patient-team partnership and population health.

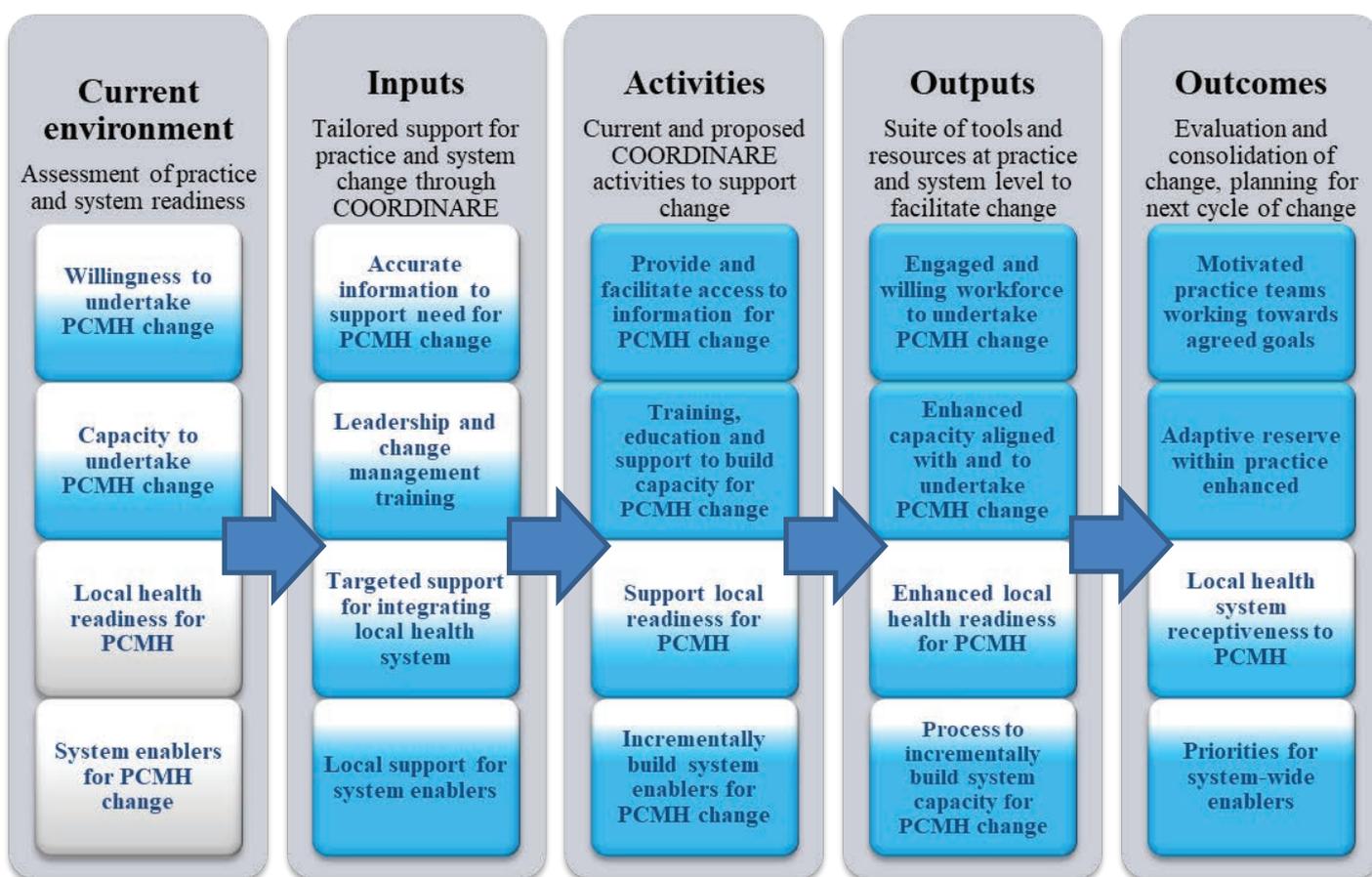
A summary of the components of the program engaged by each practice and key learnings from each of the sites are presented below.

# How to interpret logic model figures

The program logic model was co-created by UOW and COORDINARE with the intention that COORDINARE use the model to support the development of the COORDINARE Innovation Projects. UOW has used the program logic model as a lens to present the data observed in each Innovation Project case studies.

In this summary report a figure will be presented at the of each Innovation Project case study site summary to highlight the sections of the logic model that were achieved for each project (Appendix H). The evaluators have used this figure to represent the global assessment of progress through the logic model using all available data collected in the individual case studies. An example of how to interpret these figures is detailed below.

**Figure 1 Example logic model figure**

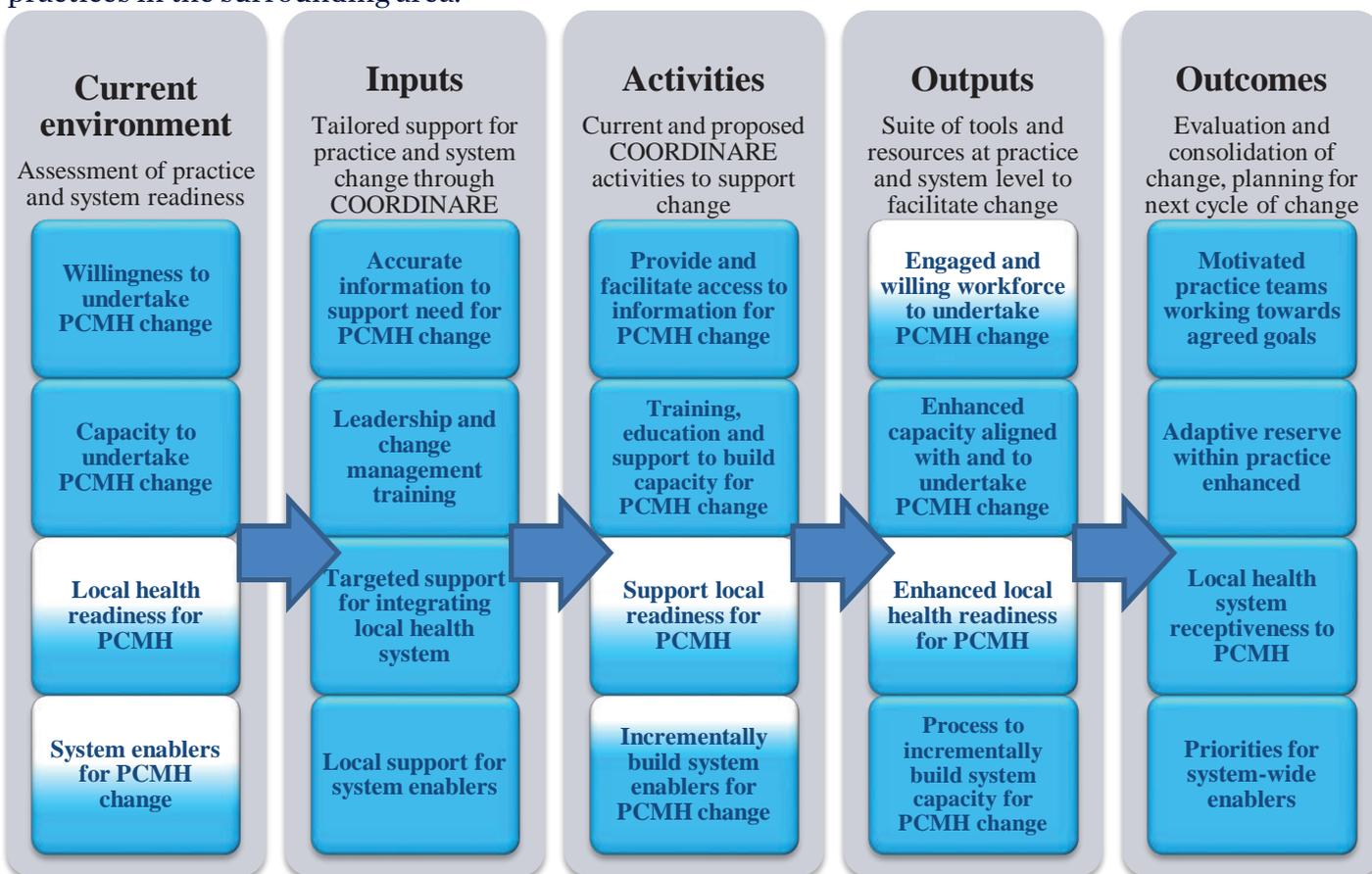


## Legend

Not achieved	Some components achieved	Most outcomes achieved	Completely achieved

# Case Study 1 Summary

This outer regional GP practice has been running a Teen Clinic model, a nurse led drop-in service for young people in rural towns for two years (2015-present) prior to the availability of COORDINARE Innovation Project grant funding. The funding was used to expand the model to four other general practices in the surrounding area.



## LESSONS LEARNT

- Strong practice nurse and practice manager teams during the set-up and facilitation of the Teen Clinic model, in other practices, was inherent to the transferability of the model.
- It was observed by the Practice that the management of project funds is very different from everyday budget management in practices. Clear parameters regarding project funding and advice about setting up project funds for transparent reporting is required in future iterations of this type of COORDINARE project funding.
- This extra support for budget management (particularly in advising other practices about budgets) and advice about marketing and promotion would have enhanced the project's success.
- Transferring a model of care peer to peer is time consuming and impacts on everyday practice workload. A lot of in-kind support and practice drive was provided that was not costed into the original budget.
- Regular peer communication, as well as clear processes and procedures were vital to the success of transferring the Teen Clinic model to other practice environments.
- Community support and awareness were highly important to activate patients to engage with local health services.



**UOW APPRAISAL OF THE BUILDING BLOCKS REPRESENTED IN THIS INNOVATION PROJECT DERIVED FROM THOSE INDICATED IN THE PRACTICE PROJECT PLAN:**

**Block 1: Engaged leadership, creating a practice-wide vision with concrete goals and objectives**

**Block 2: Data driven improvement using computer-based technology**

**Block 4: Team-based care**

**Block 6: Population management**

**Block 7: Continuity of care**

**Block 8: Prompt access to care**

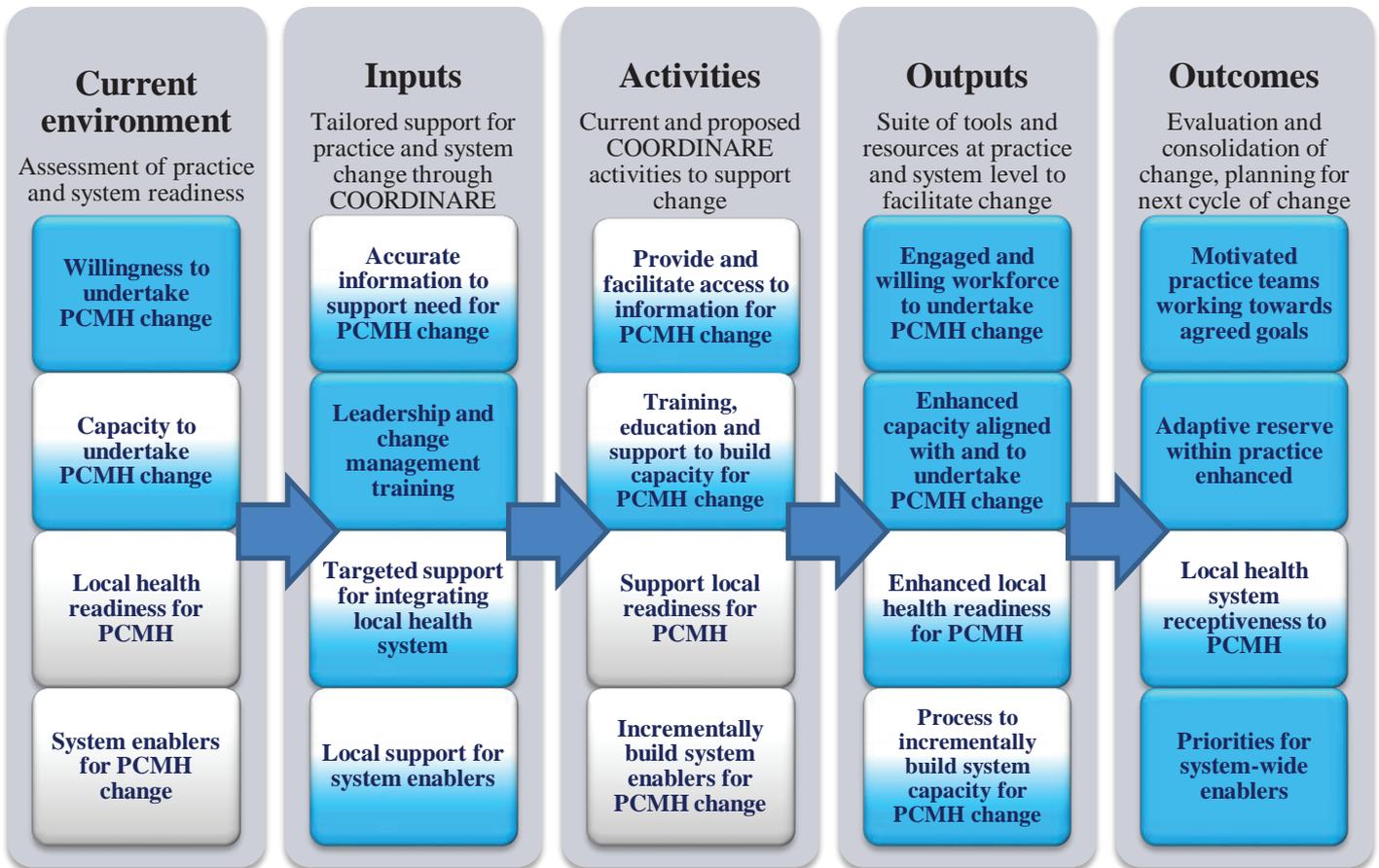
**Block 9: Comprehensiveness and care coordination**

**Block 8: Prompt access to care**

**Block 9: Comprehensiveness and care coordination**

# Case Study 2 Summary

This outer regional practice, was one of the four GP practices implementing the Teen Clinic model in their practice, after being approached by the GP Principal from case study 1.



## LESSONS LEARNT

- A nurse led Teen Clinic can increase teenage patient’s access to medical care and support to rural Australian practices.
- Practice nurse professional development and autonomy was fundamental to enhancing nurses to work at top of scope.
- Regular peer communication, as well as clear processes and procedures were vital to the success of transferring the Teen Clinic model to this new practice environment.
- Raising awareness of the clinic and community support facilitated teenage patients to engage with the clinic.
- Leadership support, especially from the practice manager and nurse, is important for the successful setup and implementation of the Teen clinic model within a practice based setting.
- Sustainability and continuation the Teen clinic model is reliant on GP support and cost-effectiveness.



**UOW APPRAISAL OF THE BUILDING BLOCKS REPRESENTED IN THIS INNOVATION PROJECT DERIVED FROM THOSE INDICATED IN THE PRACTICE PROJECT PLAN:**

**Block 2: Data driven improvement using computer-based technology**

**Block 4: Team-based care**

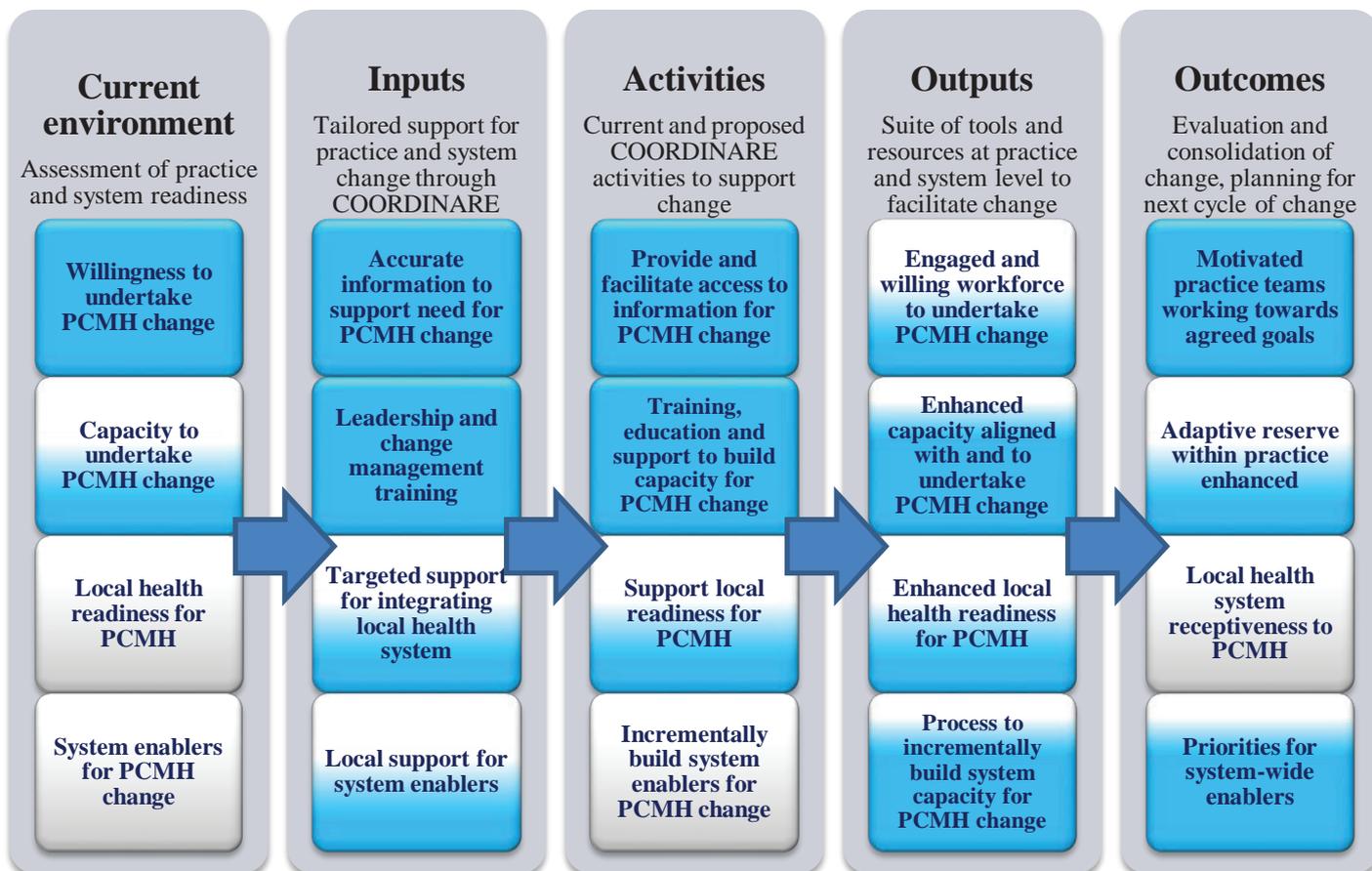
**Block 6: Population management**

**Block 7: Continuity of care**

**Block 8: Prompt access to care**

# Case Study 3 Summary

This long standing practice Innovation Project aimed to develop resources based on a Shared Medical Appointment model, to assist general practices when supporting newly-arrived Arabic speaking refugees. The key goal of this project was to support the psychosocial needs of refugee patients.



## LESSONS LEARNT

- A bilingual social worker can make an important contribution to the psychosocial issue of Arabic speaking refugees who have experienced trauma.
- Flexible patient engagement is important due to the complexity of refugee health but it takes time to find the right solution.
- What's App appears to be an acceptable format to build patient trust and provide patients with support and access to important health messages.
- A lot of in-kind support was provided by the practice manager/social worker to support participant needs that was not costed into the original budget. A lot of time was spent on set-up and development of resources which was unexpected.
- External refugee service support would aid future iterations of the Innovation Project. It is a time consuming but important component to have these services engage in a new model for patient care.



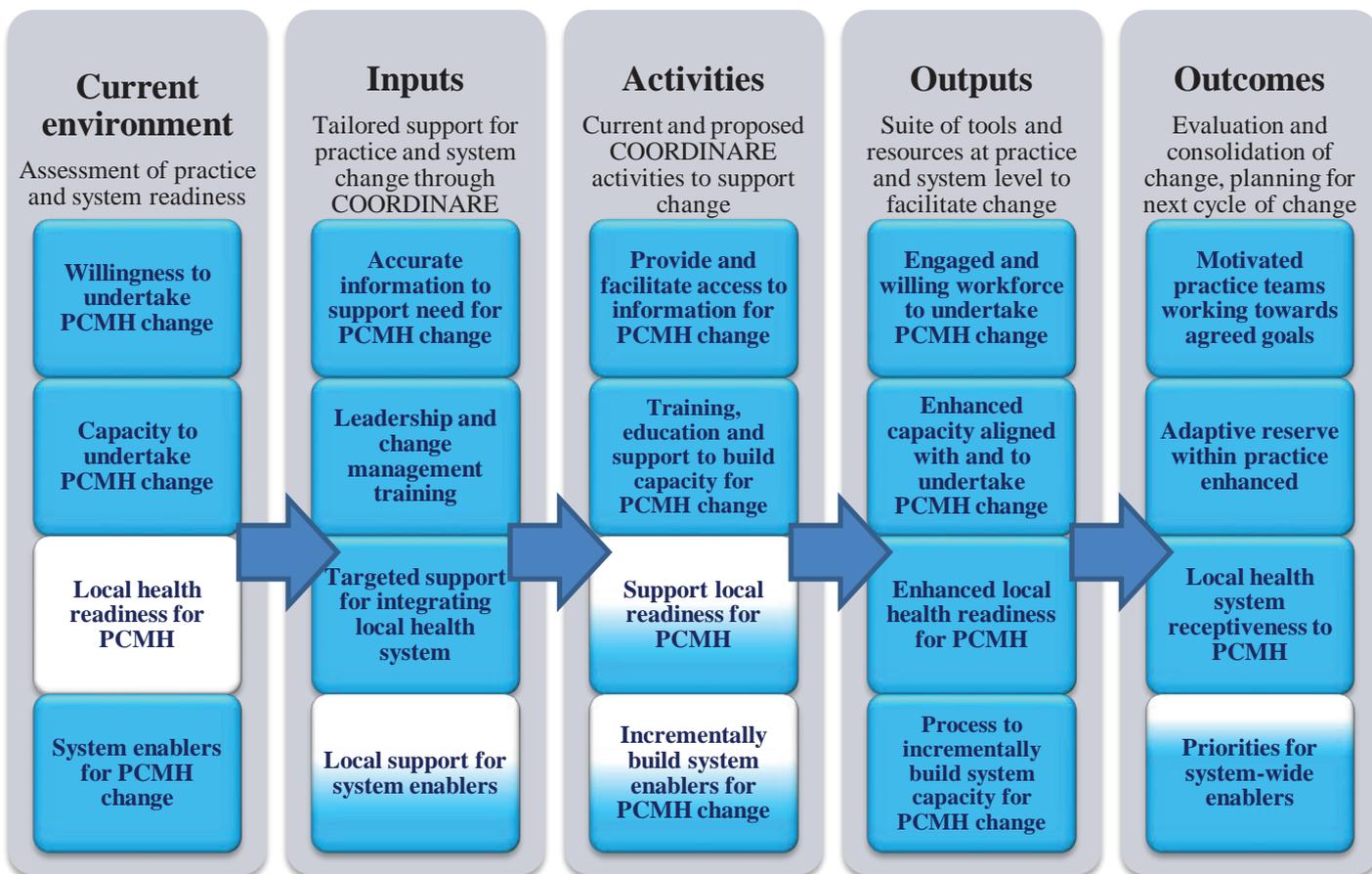
**UOW APPRAISAL OF THE BUILDING BLOCKS REPRESENTED IN THIS INNOVATION PROJECT DERIVED FROM THOSE INDICATED IN THE PRACTICE PROJECT PLAN:**

**Block 1: Engaged leadership, creating a practice-wide vision with concrete goals and objectives**

**Block 5: The patient-team partnership**

# Case Study 4 Summary

Set in a large regional practice, the aim of the Innovation Project was to provide group education sessions, involving their GPs and allied health staff, to educate and empower older patients (70 years of age or over) about how to recognise and/or avoid health complications associated with Osteoporosis.



## LESSONS LEARNT

- Targeted Osteoporosis education sessions can help to identify and educate patients ‘at risk’ of Osteoporosis.
- Patient consultation is important to building a targeted health program that suits their needs.
- Comprehensive processes help to ensure the success of change in practice. However, initial set-up can be time consuming. The practice nurse put a lot of in-kind work into the set-up and implementation that was not included in the original budget.
- Coordinated patient care and team-based care can be enhanced by providing professional development opportunities to build on the competencies of reception and nursing staff within the practice.
- Relationship building with local health services and allied health professionals can enhance patient care management outside of the practice.



**UOW APPRAISAL OF THE BUILDING BLOCKS REPRESENTED IN THIS INNOVATION PROJECT DERIVED FROM THOSE INDICATED IN THE PRACTICE PROJECT PLAN:**

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**Block 2: Data driven improvement using computer-based technology**

**Block 4: Team-based care**

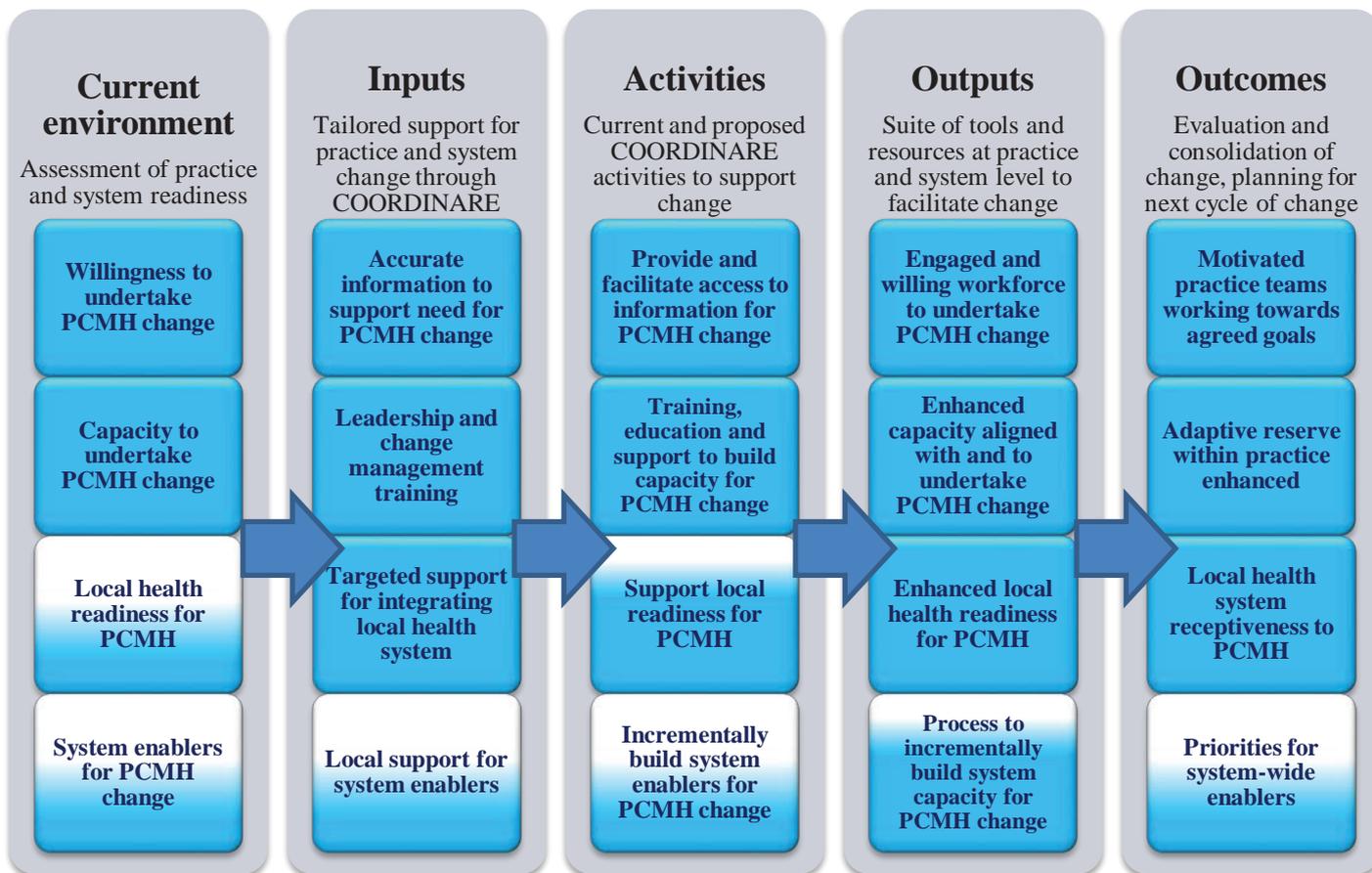
**Block 5: The patient-team partnership**

**Block 6: Population management**

**Block 7: Continuity of care**

# Case Study 5 Summary

Set in a large regional practice, this Innovation Project aimed to trial an integrated care approach for patients with respiratory diseases (Asthma and COPD). The model used in this approach was similar to the ‘Geriatricians-in-Practice’ shared care model (2) used in the Shoalhaven. The project involved a respiratory clinical nurse consultant (CNC), and a general practice nurse leader who accompanied a GP in providing an integrated GP/CNC appointment that was easily accessible for patients in a general practice setting.



## LESSONS LEARNT

- A strong GP, practice nurse and practice manager team is important for driving change and integrating change into existing workflows.
- Successful shared care models require good collaborative relationships between the general practice and the local health services.
- Dedicated practice nurse time is required to achieve a coordinated practice change.
- Patient population management was enhanced through professional development opportunities and in-house data management training with the practice nurse leader in the practice.
- Regular whole practice meetings, communications and reflections help to enhance practice change processes by providing opportunities to review and refine the practice change.



**UOW APPRAISAL OF THE BUILDING BLOCKS REPRESENTED IN THIS INNOVATION PROJECT DERIVED FROM THOSE INDICATED IN THE PRACTICE PROJECT PLAN:**

**Block 1: Engaged Leadership, creating a practice-wide vision with concrete goals and objectives**

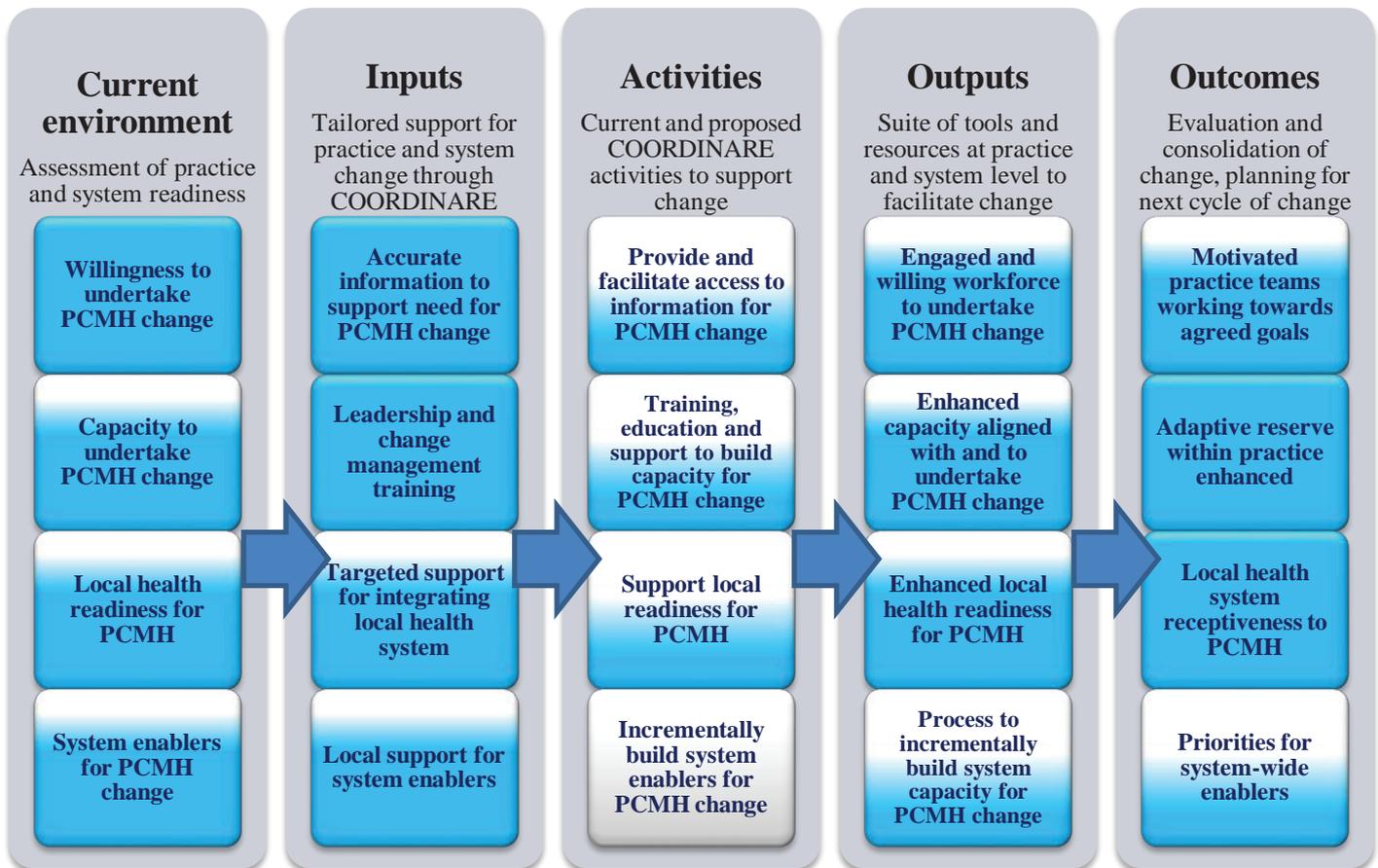
**Block 2: Data driven improvement using computer-based technology**

**Block 4: Team-based care**

**Block 6: Population management**

# Case Study 6 Summary

This project which involved the inclusion of a consultant pharmacist within a busy general practice, investigated the impact that the pharmacist had on de-prescribing and optimal medication outcomes for patients, over the age of 75 taking five or more medications.



## LESSONS LEARNT

- Consultant pharmacy services within a general practice setting can help to improve patient knowledge and understanding about their medications and medication adherence.
- In-house pharmacist advice around medications can support patient medication adherence by providing the GP/Pharmacist team an opportunity to consult and develop a clear, consistent message around medication taking with patients.
- Consultations with pharmacist regarding medication management and adherence issues can be time consuming.
- Infrastructure to support new services (e.g. private room) and co-location of GPs and pharmacists is important for the success of the program.
- Consultant Pharmacist access to electronic health records can help to improve patient medication management by providing additional information to their GPs.
- Willingness and flexibility to fit into current practice workflow structures was important to the success of the consultant pharmacist in practice model



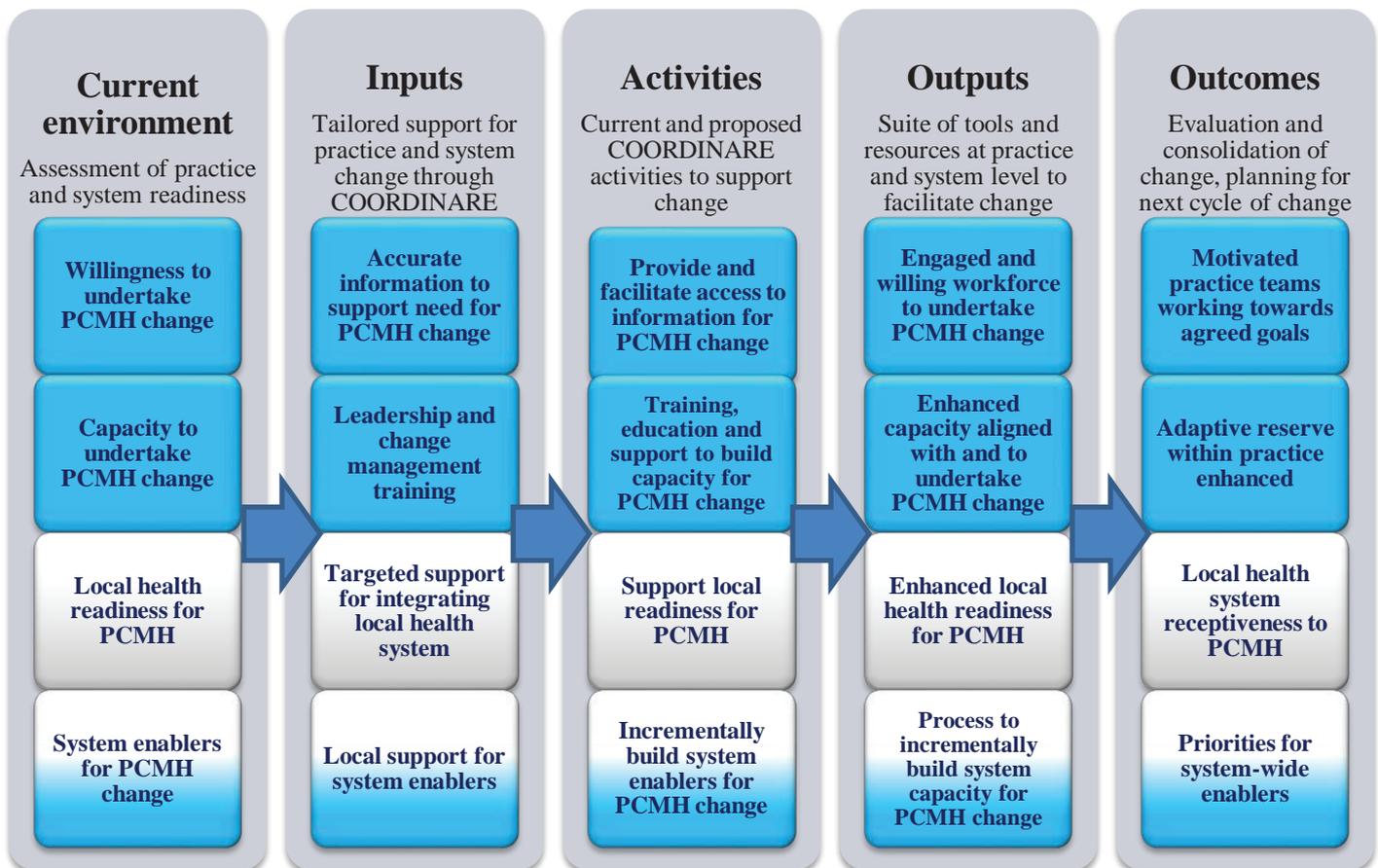
**UOW APPRAISAL OF THE BUILDING BLOCKS REPRESENTED IN THIS INNOVATION PROJECT DERIVED FROM THOSE INDICATED IN THE PRACTICE PROJECT PLAN:**

**Block 2: Data driven improvement using computer-based technology**

**Block 5: The patient-team partnership**

# Case Study 7 Summary

This project aimed to implement a comprehensive, coordinated diabetes management care plan, which focused on a practice nurse led review of diabetes patients, aged between 50 to 60 years of age, residing in a low socio-economic area.



## LESSONS LEARNT

- A strong GP/practice nurse team was important in driving change in the practice.
- Practice change is not a straightforward process and requires a lot of time and planning to successfully integrate with everyday practice workflow
- Regular scheduled catch-ups between the GP and the practice nurse leader were important in establishing team based care in the Innovation Project.
- Engaging patients in practice changes requires patients to be well informed and that the information needs to be available in a variety of forums e.g. via the practice website, posters in the reception area, and a targeted mail-out.
- Extra nursing staff is required to target all diabetic patients in one practice. One part-time nurse is not enough to manage patients with a chronic disease.



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**Block 6: Population management**

## CONCLUSIONS

The following key learnings can be taken from the evaluation of the COORDINARE Innovation Projects using the PCMH pre-implementation program logic:

- The program logic was a useful a mechanism for designing and evaluating PCMH change efforts in this context
- Practice motivation for change was a universal pre-requirement for engagement in PCMH change efforts across all sites
- The findings indicated that a variety of change leadership models could be accommodated in implementing PCMH change in GP practices
- Practices perceived patient acceptance as key and were motivated by the desire to improve patient outcomes
- COORDINARE staff saw practice acceptance as key and were motivated to assist practice change
- The role of the Health Coordination Consultants (HCC) could be seen as a conflicted role as they covered both practice assistance and monitoring. Delineating support and monitoring roles for HCC ahead of time would be useful in future projects
- Positive movement towards establishing Bodenheimer’s PCMH building blocks (1) within a relatively short period of time is achievable with Primary Health Network support
- Longer term monitoring and practice support is important to promote and gauge sustainability; and sustainability will be the critical test of the effectiveness of the Innovation Projects

## REFERENCES

1. Stake RE. Multiple Case Study Analysis. New York: Guilford Publications; 2014.
2. PHN C-SEN. Geriatrician in the Practice 2015 [Available from: <http://www.coordinare.org.au/news/geriatrician-in-the-practice/>].
3. Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. *Annals Of Family Medicine*. 2014;12(2):166-71.





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