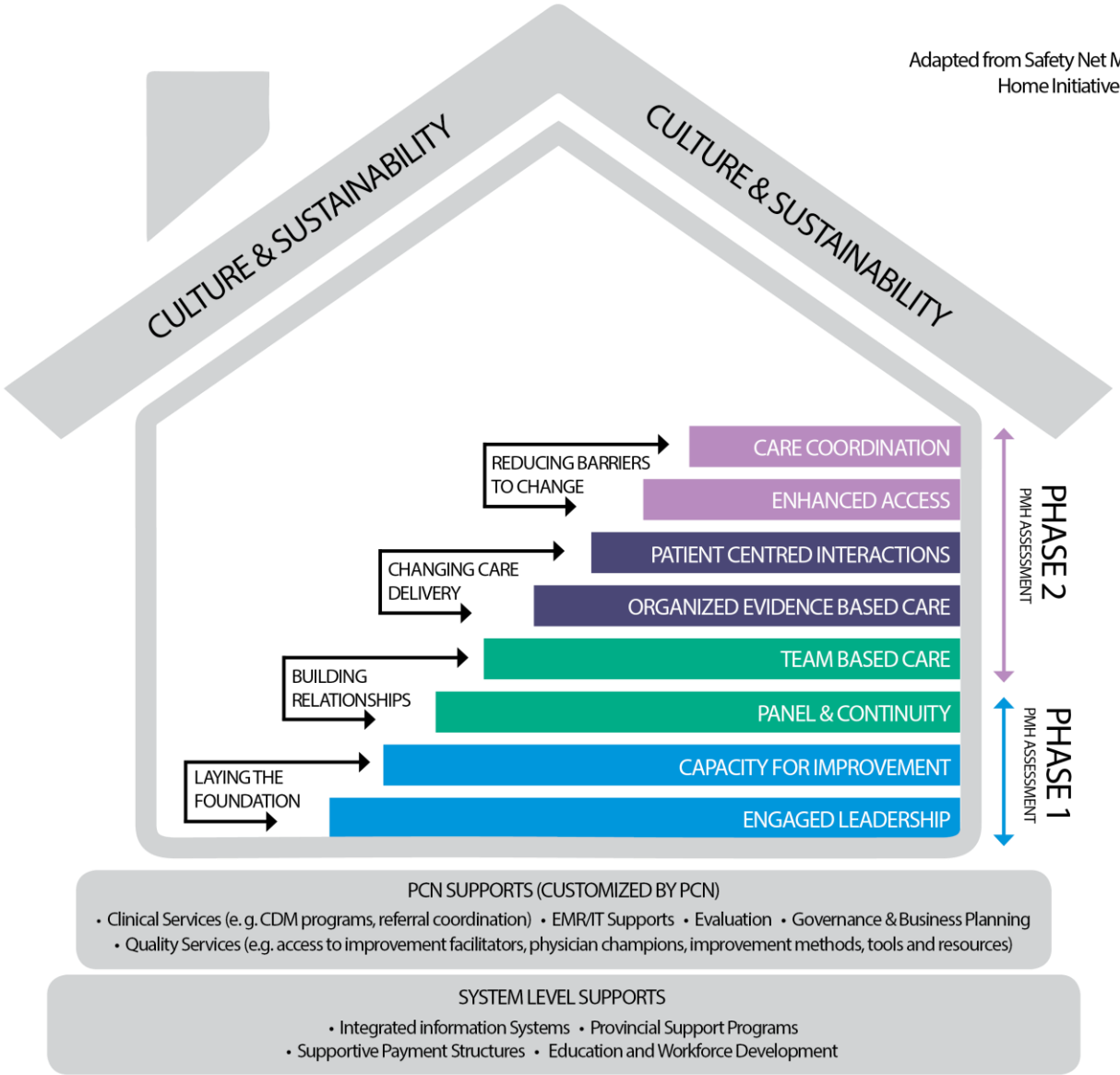
Implementation Elements for the Patient's Medical Home:
A Guide for Family Practices



Laying the Foundation

Engaged Leadership

WHAT?
An engaged leader sets goals and objectives, and provides a supportive work environment for those transforming the clinic to a patient's medical home.

WHY?
Without engaged leaders, practices struggle to make and sustain the key changes required for transformation.

HOW?
- ❑ Clarify team roles and responsibilities
- ❑ Remove barriers so that clinic team can make continuous progress
- ❑ Provide protected time and resources for those learning new skills
- ❑ Develop clear communication strategies - the "what, why & how"
- ❑ Identify and mentor champions

Capacity For Improvement

WHAT?
A quality improvement (QI) strategy is a structured approach to change.

WHY?
Having a QI strategy gives clinics teams confidence, skills and a specific approach to making changes.

HOW?
- ❑ Learn about the Model for Improvement (www.instituteforhealthcareimprovment.org), or
- ❑ Consider joining an Alberta AIM collaborative (www.albertaqim.ca), or
- ❑ Contact your PCN (many have Improvement Facilitators who are trained in QI strategies)
- ❑ Ask the following:
  - *What are we trying to accomplish? (AIM)*
  - *How will we know if a change is an improvement? (MEASURE)*
  - *What changes will we make that will result in an improvement? (CHANGE)*

Adapted from Safety Net Medical Home Initiative 2013[1]

Building Relationships

Panel & Continuity

WHAT?

A panel is the group of patients who consider a physician to be their primary care provider, and that physician agrees.
Continuity occurs when care is provided by a patient's own physician or care team whenever possible.

WHY?

When clinics know precisely whose care they're responsible for, they can:

- provide care proactively vs. reactively (e.g. complex care planning)
- 'Design' the care team based on panel needs

HOW?

- ❑ Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis
- ❑ Book patients with their own provider or team whenever possible
- ❑ Use panel information to: proactively manage preventive care, recall groups of patients (e.g., chronic disease management, medication changes, etc.), organize patients by disease or risk status, etc.

Team Based Care

WHAT?

- A care team is a small group of clinical and non-clinical staff who, together with a physician, are responsible for the health and well-being of a panel of patients
- Who is on the care team will vary based on panel characteristics and practice organization
- The patient is at the centre of the care team

WHY?

- Well-functioning care teams have been shown to improve practice efficiency, quality of care, and overall job satisfaction
- Physicians alone do not have the time to provide all needed care services to a full patient panel

HOW?

- ❑ Meet regularly – optimally, weekly with brief "huddles" between
- ❑ Evaluate tasks for opportunities to improve - Does it have value? Who has the relevant skills and could or should be doing it? How will we document changes? What is our re-evaluation plan?

Adapted from Safety Net Medical Home Initiative 2013[1]

Changing Care Delivery

Organized Evidence Based Care

WHAT?
Evidence-based guidelines are embedded into daily clinical practice and are shared with patients. Each encounter is designed to meet the patient's preventive and chronic illness needs, using planned interactions and ensuring appropriate follow-up care.

WHY?
Planned visits address many predictable health issues by using available resources more efficiently to reliably meet patients' most important needs.

HOW?
- ❑ Use the EMR to anticipate care needs, and to prompt when care is due (regardless of reason for visit)
- ❑ Identify key clinical tasks associated with evidence-based care (e.g., diabetic foot exam)
- ❑ Decide who on the team should perform each task, and consider standing orders for non-physicians
- ❑ Consider enrolling in Alberta Screening and Prevention www.topalbertadoctors.org/asap

Patient Centred Interactions

WHAT?
The practice is designed to respect patients' values and preferences, including communication in a language and at a level that the patient can understand.
Patients and their families are actively involved in every aspect of their care.

WHY?
Patient-centred interactions encourage patients to expand their role in decision-making, health-related behavior change, and self-management.

HOW?
- ❑ Survey patient population to gather data to inform planning (e.g., language, culture, preferences)
- ❑ Use plain language, and offer materials in the patient's primary language
- ❑ Invite patients to write information and recommendations down at appointments
- ❑ Use brief motivational interviewing techniques to develop patient-identified goals and action plans
- ❑ Collaborate with patients and families when designing programs, facilities, QI plans, etc.
- ❑ Visit www.cihi.ca for information and examples of patient experience surveys

Adapted from Safety Net Medical Home Initiative 2013[1]

Reducing Barriers to Change

Enhanced Access

WHAT?

Clinics with enhanced access can respond to patients' needs in a timely manner (e.g., same-day appointments, telephone and/or email access, group visits)

WHY?

When patients face waits or delays in receiving care they are more likely to:

- skip appointments, which blocks another patient from care and wastes valuable resources
- forego care, resulting in missed opportunities for early diagnosis and/or treatment
- go to another practice or facility for care, which compromises continuity

HOW?

- ❑ Balance supply of appointments with demand for appointments
- ❑ Increase capacity (e.g., using care teams, applying no-show reduction strategies, identifying inefficiencies, optimizing the EMR, using telephone/email, etc.)
- ❑ Consider joining an Alberta AIM (Access Improvement Measures) collaborative www.albertaaim.ca

Care Coordination

WHAT?

A strategy to ensure all providers involved in a patient's care share important clinical information and have clear, shared expectations about their roles.
Relationships exist between the medical home clinic and key specialist groups, hospitals, and community agencies, and protocols to support successful referrals, transitions and information transfer.

WHY?

Care coordination reduces communication breakdowns that can lead to unnecessary hospitalizations, duplicate tests and procedures, medical and medication errors, etc.

HOW?

- ❑ Delegate and train staff to coordinate referrals and transitions of care
- ❑ Develop relationships and agreements with key specialist groups, hospitals and community agencies
- ❑ Standardize information in referral requests to meet agreed upon expectations

Adapted from Safety Net Medical Home Initiative 2013[1]