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CONFERENCE ABSTRACT

The Practicalities of developing a Patient Centered Medical Home (PCMH) for Diabetes Care in an Australian Corporate Medical Centre Setting

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Primary Health Care Limited (Primary), an Australian corporate organization with 71 medical centres, providing healthcare services to 2 million patients per annum. All Primary centres include a range of collocated services that support a Patient Centred Medical Home (PCMH), such as GPs, Specialists, Allied Health, Pathology Collection, Diagnostic Imaging and Pharmacies.

Historically due to high patient volumes within the extended hours medical centres the demands placed on the health care practitioners (HCPs) has resulted in episodic care being the predominant model of care.

Using Bodenheimer's 10 building blocks for high performing medical centres, a program to implement protocols for the conversion of the episodic care focused centres to an integrated care model that often is a collocated model, is described.

The Fairfield Chase Medical and Dental centre was the trial site. Primary developed a corporate based integration model with protocols and areas of responsibility utilized to support the integration process .

Chronic Care Coordinators recruited patients by trolling the database or were referred patients by the treating practitioners. Preset protocols agreed to by the primary care physicians and team members were implemented for standardization.

At regular team meetings data retrieved utilising the centre's software had an emphasis on the completion of diabetic annual health assessments, bio metric analyses, cycles of care, GP management programs, and team based programs. Increased vigilance in detecting undiagnosed diabetics was another focus point.

This protocol has subsequently been implemented for other chronic conditions, and across other target populations, as with Syrian Refugees.

Outcomes have shown that there has been an improvement in data recording in the patient history together with improved monitoring of the patient holistically. Communication between team members has been enhanced, and consistency in management via the protocols developed have been noted.

Difficulties have been that the care coordinator in a corporate organization requires their activities to be defined and boundaries not crossed. This can be restrictive in delineating areas of responsibility. Clinicians can find it difficult to move from the treating clinician role to a coordinating role. Large organizations need to restrict the CCC as moving freely between these roles impacts on rostering and thus accessibility to clinical nursing or the CCC.

Another problem encountered has been staff seconded from other organizations, (Area Health) with their transfer leaving shortfalls in important team members in a collocated model.

It can take time for clinicians to join the movement. By monitoring the data, a data spike in activity can be used as a positive reinforcer in the team meetings for progressing team integration.

Clinicians and the CCC have modified this system to incorporate other chronic care conditions. Fairfield is an area with a high refugee intake . The integrated care program has been used to support refugee health assessments and integration of their care when gaps in their care are identified.

Primary has supported this model change process by developing an integrated care team at the Executive level. Training and subsequent reinforcing activities were promoted within the medical centre teams and is now being expanded into other centres.

Keywords: integration; corporate; patient centered medical home; diabetes