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GETTING THE MOST FROM MANAGEMENT PLANS

DAVID MENZIES

MANAGER CHRONIC DISEASE

SEMPHN

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WELCOME

What is a Primary Health Network?

Established in 2015 by the Australian Government, Primary Health Networks (PHNs) are focussed on improving primary care and keeping people out of hospital.

Key objectives:

1. Increase efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes
2. Improve coordination of care - *right care, right place, right time*

Content

- Evidence
- What matters to you/Personalised care
- Care Co-ordination /Care Planning
- Integrated Care
- Lessons learnt Care Co-ordination Capacity building/HCHs
- System supports
- Evaluation
- Summary

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Why care planning?

Cochrane Review

The effects of personalised care planning were greater when

- more stages of the care planning cycle were completed
- contacts between patients and health professionals were more frequent
- patient's usual clinician was involved in the process.

Personalised care planning

- leads to improvements in certain indicators of physical (BSLs, BP, asthma control)
- psychological health status (Depression)
- Improved people's capability to self-manage their condition when compared to usual care.

- The intervention needs to be comprehensive, more intensive, and better integrated into routine care.

Personalised care planning for adults with chronic or long-term health conditions

Cochrane Systematic Review - **Intervention** Version published: 03 March 2015 see what's new

https://doi.org/10.1002/14651858.CD010523.pub2

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ask what matters • listen to what matters • do what matters

what matters to you?

www.whatmatterstoyou.scot

Personalised Care

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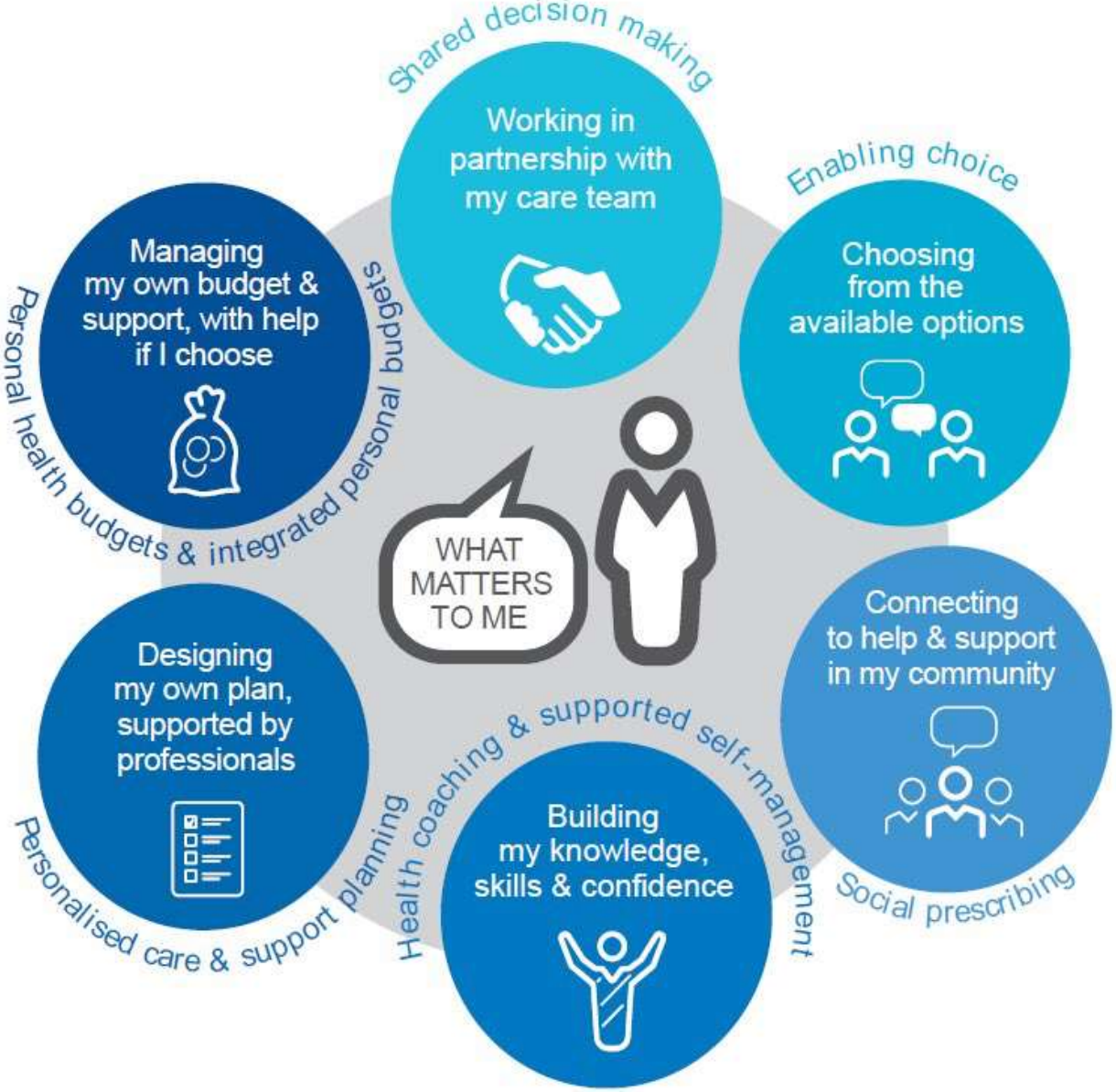

Interdependence	Organisational Support	Staff Focus
Ed & Training	Patient Focus	Market Focus (Community)
Performance results	Process Improvement	IT

High Performing practices

What attributions do Australian high-performing general practices make for their success? Applyin the clinical microsystems framework: a qualitative study
BMJ Open Apr 2018, 8 (4) e020552; DOI: 10.1136/bmjopen-2017-020552

Care Coordination

Involves numerous participants including providers from health, social and community setting's

Is necessitated by interdependence among participants and activities

Requires knowledge and respect of others' roles and resources

Relies on information exchange

Aims to facilitate appropriate healthcare delivery (right person, right time, right place)

Integrated Care Team

As care needs change, the Care Team gains additional members. It is not a different team.

National Voices

Person Centred Co-ordinated care

“I can plan my care with people who work together to understand me and my carer(s) allow me control, and bring together services to achieve the outcomes important to me”

Care coordination: patient centeredness

- Being guided by the individual care needs of the client
- Comprehensive assessment and care planning – sustainable & living
- Ensuring consistency and continuity in the client's care
- A self-management approach
- Psycho-social issues management
- Addressing barriers to engagement
- Supporting both client self-management and the carer/family.

Support care co-ordination

- Recall and reminders
- Polices and procedures strategic plan and vision
- Spread CC role across all staff in the practice (clinical and non clinical)
- Ask patients **what matters to them**
- Create a sense of belonging for the patient to clinic and care team
- Maximise funding opportunities
- Work with Practice Manager to identify gaps (were not utilising MBS) better use GPs time

Care Plan Checklist

- Was the patient actively involved in the development of the plan
- Are the patients goals SMART? Are they prioritized?
- Has the patients motivation been accessed? Readiness Importance confidence.
- Is the action list clear and concise?
- Is the plan written in a way the patient can understand?
- Was the purpose and importance of the plan discussed and explained to the patient?
- Could they teach it back to you?
- Has the patient read the plan and were they able to ask questions?

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Annual Care Map	Date	Patient Name .....
TASK	**When Due**	**COMPLETED**
Phone call: review understanding of care plan - answer questions re action plans, discuss progress	End Feb	
SMS reminder: Read materials re managing stress and breathing techniques	Begining March	
Phone call: Health education/engagement, managing diet and exercise with COPD, Confirm pulmonary rehab booking and ability to attend		
Attend Clinic - Flu Vax, ECG	Mid April	
Attend Clinic - Mental Health assessment/ planning/education	Mid May	
SMS re Health goals e.g. social activity helps people feel better	Beginning June	
Phone call: Health goals, Using Action plans, recognising symptoms	Mid June	
Phone call: appointment needed for clinical review	Beginning Aug	
Attend Clinic - clinical review, Cat Score, Medication review	Mid August	
SMS: Health goals e.g. Being active everyday	Mid Sept	
Phone call: discuss goal item	Oct	
Phone call: Fill next prescription, physical activity, issues, general health, managing stressors	December	
SMS reminder: managing moods, health goals/action plan	December	
Phone call: Educational materials update, Blood test due, appt for clinical review	late January	
Assessment and care planning Care coordinator/ GP, Inc - Aims, Spiro, action plan, CAT Score, mental health, ACP,	February	

Appointments			
Date	time		
Date	time		
Date	time		
Date	time		
Date	time		
Patient Goals			
Review Date	time		

Skills and supports

- Motivational interviewing
- Health Coaching
- Asking better questions
- Shared Medical appointments
- CDM clinics
- Lifestyle support programs
- Social Prescription
- Peer Support groups
- Shared electronic care planning
- POLAR Population health analysis and reporting tool

Social Prescription

- Refer people to a range of local, non-clinical services.
- Combat physical social and emotional problems
- Improve self confidence
- Overcome loneliness
- Impact on lifestyle behaviours

Neigbourhoood Houses Social & Recreational Activities

- Accounting
- Art and craft
- Children's classes
- Computers and technology
- Cooking
- Exercise and Fitness and Dancing
- Health and wellbeing
- Language
- Literature and writing
- Music
- Social activities and games
- Wood Working

SEMPHNs Research

- Completed a literature review
- 50 in-depth interviews with service providers in 2017-18
- Conversations with a majority of general practices in the catchment
- Validation of patient journey process maps
- Analysis of geo-spatial mapping of service providers
- Documented patient experiences by Consumer Health Forum
- Evaluated previous chronic disease management SEMPHN-funded activities

CDM Programs

- **Health Care Homes** (HCH) A HCH is a general practice or ACCHS that coordinates comprehensive care for enrolled patients with chronic and complex conditions

- **Wellnet** The WellNet Integrated Care Program is a suite of GP-led programs providing targeted and coordinated chronic disease management delivered through a PCMH model

- **CDM1** Build general practice capacity to support care coordination for chronic and complex conditions

- **CDM2** Improve health outcomes for priority population groups with complex and chronic conditions

improved their data collection and analysis (POLAR)

introduced or improved care coordination-related policies and procedures

improved practice team collaboration, communication processes

improved patient communication processes (including IT based such as online appointments)

introduced or improved connections to Allied health, including in-house, and increased referrals

Enablers

Barriers

staff retention and recruitment, including recruitment of nurses with requisite skills for care coordination

patient engagement with self-management – still common for many to be unwilling to engage

change management – doctors, receptionists etc are unwilling to change what they do/how they do it and most practices do not have skills in change management.

Often one person is leading change/innovation and if they move, or personnel within the practice changes, that can derail process.

Business management – practices in many cases do not appear to have used MBS CDM payments to their benefit

PAMs, PROMs and PREMS

Patient activation measures

PAM determines an individual's level of health activation (knowledge, skills and confidence) for self-managing health and healthcare issues

Patient reported outcome measures

They ask for the patient's assessment of how health services and interventions have, over time, affected their quality of life, daily functioning, symptom severity, and other dimensions of health which only patients can know.

Patient reported experience measures

Allows patients to provide direct feedback on their care to drive improvement in services

https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0003/253164/Overview-What_are_PROMs_and_PREMs.pdf NSW Centre for Clinical Innovation

https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/ NHS England

10 Building blocks of high performing primary care

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The quadruple aim of effective primary care

IMPROVED PATIENT EXPERIENCE

IMPROVED PROVIDER EXPERIENCE

POPULATION HEALTH

SUSTAINABLE COST

Resources

What matters to you Institute for Healthcare Improvement

http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx

https://www.whatmatterstoyou.scot/stories-asking-matters/

Victorian Integrated Care Training Modules

https://victorianintegratedcare.training/signin/

Health Change Australia

http://www.healthchange.com/

MINT

https://motivationalinterviewing.org/

NHS Involving people in their own care

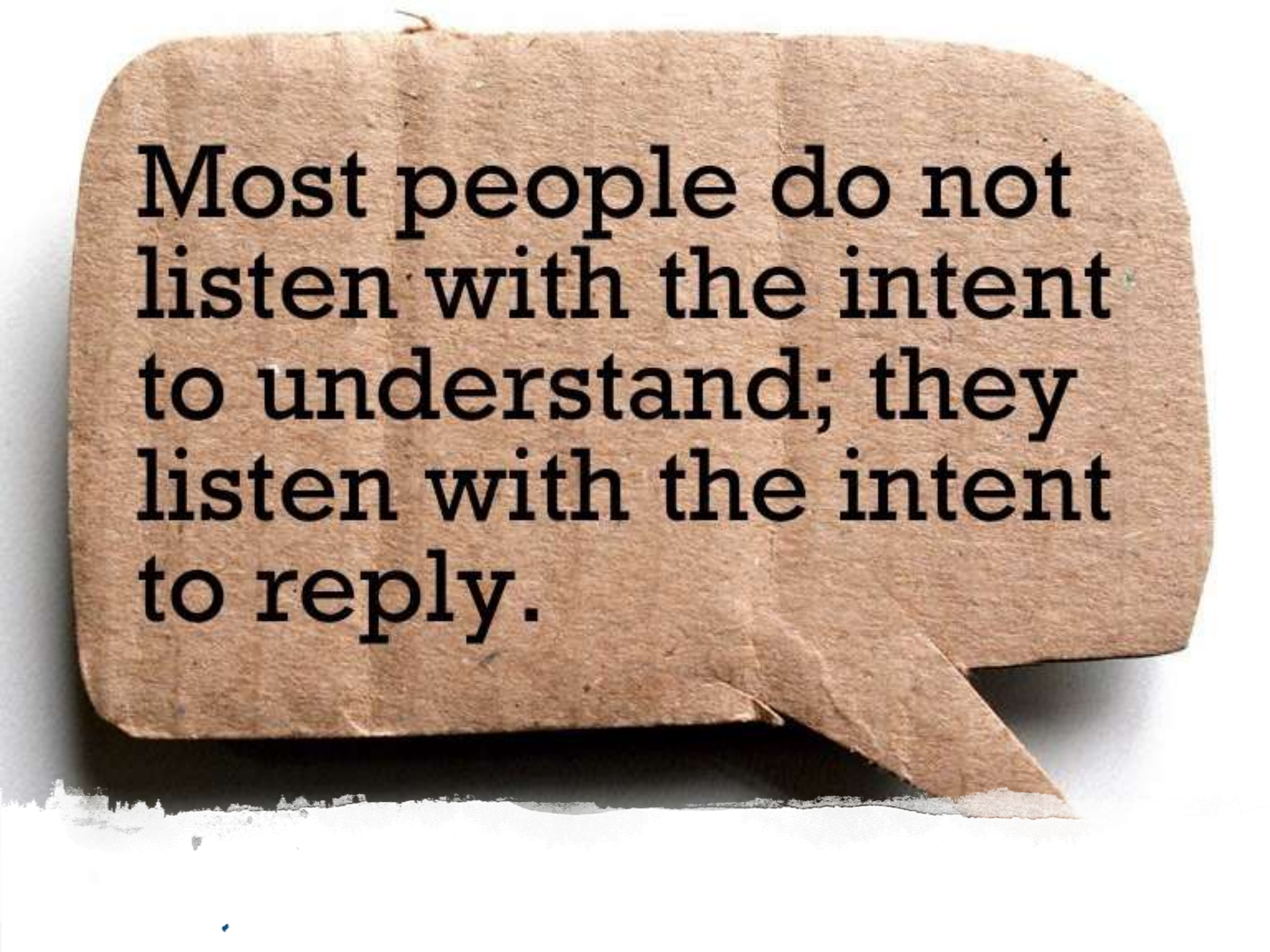
https://www.england.nhs.uk/ourwork/patient-participation/

Ask Izzy (For people in crisis)

https://askizzy.org.au/

Info exchange Service Seeker

https://www.serviceseeker.com.au/


Most people do not
listen with the intent
to understand; they
listen with the intent
to reply.