Person-Centred Care Practice Programs

Brisbane South PHN Initiative

Brisbane South PHN in partnership with AGPAL (Australian General Practice Accreditation Limited) and national primary care leaders is offering two distinct programs to help general practices in the region build effective teams, allow for sustainable growth and improve interactions and outcomes for patients. The two programs have been designed to support practices to proactively prepare for national primary care policy change and meet the requirements of the Royal Australian College of General Practice accreditation and the Practice Incentive Program for Quality Improvement (PIP QI). This initiative builds on learnings from the previous Person-Centred Care Practices programs offered by BSPHN (click here to watch a case study of a past Person Centred Care Practice).

The two programs available to general practices within the Brisbane South region are:

- People, Leadership and Teams; and
- Optimal Care Quality Improvement

To assist understanding the difference between the two programs refer to the supplementary break down of change concepts details in the appendix. Both of these programs support the adoption of the Change Concepts (general ideas used to stimulate specific, actionable steps that lead to improvement) that underpin the Patient-Centred Medical Home (PCMH) Model. Evidence shows that the Patient-Centred Medical Home Model is associated with high performing primary care and better outcomes for patients and providers. Figure 1 outlines the PCMH approach.

Each element of this program has been designed in a manner to allow for sustainable growth within your practice, ensuring these tools and learnings can be carried well beyond the life of the program.

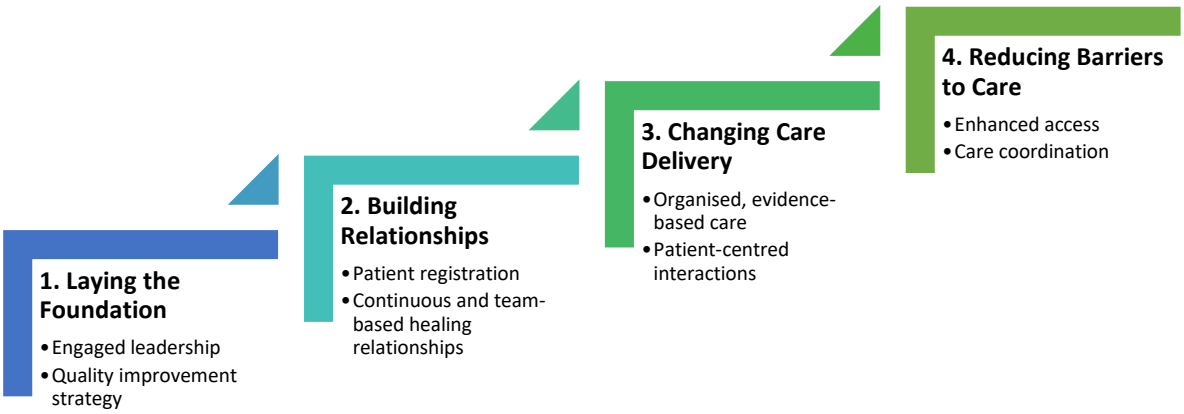

FIGURE 1 - PATIENT-CENTRED MEDICAL HOME CHANGE CONCEPTS

Person-Centred Care Practice Program (PCCPP) sessions and resources

The table below provides an overview of the program sessions and resources available to practices along with a guide on participation and time commitment required.

Program sessions and resources	Purpose	Practice participation	Time commitment guide
Person-Centred Care Toolkit - Online Module	Introduction to the Change Concept	Practice Leaders, and wider practice team	1-2 hours per module
Face to face learning workshops	Explore the change concept with other general practice peers, and commence change concept activities	Practice Leaders	3.5 hours per workshop
Online practice plan	Document progress on Plan-Do-Study- Act (PDSA) cycles using a SMART goals framework	Practice Leaders, and wider practice team	1-2 hours
Follow-up coaching session	Maintain momentum and action with practice leaders to complete and reflect on change concepts and PDSAs, and work through challenges, barriers and successes	Practice Leaders	1-2 hours

Time commitment for participating practices

Participating practices will be asked to sign a Statement of Commitment outlining the responsibilities of both the practice and Brisbane South PHN.

To get the most out of this program, we encourage practices to consider the time commitment required of Practice Leaders to participate in workshops, online learning and coaching, and for the wider practice team to complete online learnings and PDSA activities in the practice. Here are some considerations:

- *The program will engage the whole practice* to some extent. Some activities will require participation of all members of your practice team.
- *Each practice will identify and nominate two or three **Practice Leaders*** (for example, a clinical lead such as a practice principal GP or senior clinician, and a business or administration lead such as a practice manager or owner) who are able to act as change champions and coordinate practice team engagement in the practice. These practice leaders will also need to be confident they can commit to online learning modules and coaching sessions and evening workshops every 6-8 weeks (i.e. three workshops and coaching sessions).
- *Each practice will identify one to two **Data Support People** to conduct searches and generate reports* using CAT4 (PenCS Suite). Brisbane South PHN will provide training, support and step by step guides.

National Primary Care Leaders Delivering the Program

Brisbane South PHN have engaged AGPAL who bring an exciting line-up of national experts in Person-Centred Care and Patient-Centred Medical Homes to deliver this program in partnership with our teams. Previous subject matter Experts (SME) have included Dr Paresh Dawda, Dr Kean-Seng Lim, Dr Walid Jammal and Tracey Johnson.

Dr Paresh Dawda

Paresh is Director and Principal of Prestantia Health, a practicing GP with a diverse portfolio of leadership, academic and consulting roles including Honorary Associate Professor at ANU and Adjunct Professor at University of Canberra

Dr Kean-Seng Lim

Kean-Seng is a General Practitioner, AMA (NSW) Vice President, Deputy Chair of AMA Council of General Practice and a Board Member of WentWest, Western Sydney PHN and the Mt Druitt Medical Practitioners Association

Dr Walid Jammal

Walid is the principal GP at Hills Family practice in Sydney, Senior Medical Advisor for a medical indemnity provider, a Lecturer at the University of Sydney and a Conjoint Senior Lecturer at School of Medicine, Western Sydney University

Tracy Johnson

Tracy is CEO of Inala Primary Care, a charitable, teaching and research active practice in Queensland's most disadvantaged suburban location

Evaluation of the programs

Brisbane South PHN has developed a Person-Centred Care Evaluation Framework. Information will be collected throughout the programs to continue to improve program delivery and to evaluate outcomes.

Each program will use a range of data from the practice to inform, plan and measure outcomes which may include:

- Practice self-assessment surveys completed before and after the program
- Benchmark Reports (general practice aggregated de-identified patient information)
- Patient Reported Experience Measures (PREMS)
- Online Practice Plans (including PDSA's and SMART goals)
- Online Learning Modules

Contact Us

For more information regarding the Person-Centred Care Practice Programs or how the Brisbane South PHN can support your practice please contact support@bsphn.org.au

Appendix

The following table details the change concepts covered in each program.

People, Leadership and Teams Program	
Change Concept	**Purpose/intent of change concept**
Engaged Leadership	Throughout this foundational change concept, practices will participate in activities which look beyond direct patient care, and build upon the practice's values and team culture to work towards a more person-centred approach. Leadership encompasses overall culture within general practice and-specific strategies that support sustaining positive change; improving quality of care and team collaboration will be explored
Continuous and Team Based Healing Relationships	Looks at the relationships the practice team have with patients, and with their own team members. Activities ensure that everybody within the practice has a defined role and tasks are distributed to the most appropriate team member and they have been trained to perform them well. This will work towards connecting patients more closely to their identified care team, and enhancing patient interactions and outcomes within the practice
Patient-Centred Interactions	Takes a deep dive into the interactions the practice has with patients and different patient groups, and how the practice invites and responds to patients. Culturally appropriate conversations, health literacy and ensuring people feel respected and valued are also explored

Optimal Care Quality Improvement Program	
Change Concept	**Purpose/intent of change concept**
Quality Improvement Strategy	Will address the way general practices use data to drive quality improvement activities that engage patients and the practice team. The practice will be provided tools and resources to support them to reflect on their own data, identify trends, test ideas for change, and review the results of quality improvement activities
Patient Registration	Identifies ways general practice can more proactively engage with patients. Including, how to improve the process of patient assignment to providers and care teams; and better manage supply and demand to create more sustainable, predictable patient flows that deliver better preventative and chronic illness care. Further considerations such as; community population health needs will be unpacked to ensure the practice is equipped to respond accordingly
Organised Evidence Based Care	Ensures care is planned, appropriate and evidence-based so that all patients receive the care they need, when and how they need it. Practices will identify at-risk patients to ensure they are receiving the care and case management necessary to support them optimally; improve processes and support staff to anticipate the care needs of particular patient groups; and patients with chronic illness beyond the life of the program

Note: It is recommended practices are only enrolled in one program at a time.