



Abstract Title: Building a patient medical home using a data-driven, physician-led approach

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Introduction/Background

In September of 2011, the College of Family Physicians of Canada released a report outlining the vision for the future of Canadian primary care. The report advocated for the creation of patient medical homes (PMHs) in all primary care practices by 2022 (The College of Family Physicians of Canada, 2011). The province of Alberta shares a similar vision of building team-based, comprehensive primary care for patients. The creation of PMHs is a provincial goal that Primary Care Networks (PCNs) play a crucial role in achieving.

Purpose

The PMH model is associated with a range of benefits, particularly in regard to the Triple Aim goals of achieving better health, better care, and better value. However, there is no 'one size fits all' structure for those looking to build a PMH. An effective PMH ought to remain fluid and responsive to the needs of the patient population that it serves. At the Calgary West Central Primary Care Network (CWC PCN), we use a data-driven and physician led approach to determine these needs and to provide better care.

Approach or Action

The identification of targeted and specific goals is an important component for our PMH practices. We use a collaborative and data driven approach to identify goals with individual and groups of physicians that are dependent on the needs of the patient population. Once goals have been identified, we use a 'Plan Do Study Act' (PDSA) approach to inform and guide the quality improvement process. Data is extracted from the EMR at baseline, and at agreed upon follow up intervals once the improvement plan has been implemented. Data are analyzed and presented back to clinical staff to assess whether the improvement plan is working, or if it needs to be modified, on an ongoing basis. This data driven approach promotes evidence informed decision making.

Outcomes

We are constantly working with our physicians to measure, adjust and make improvements to processes and patient care. In one real-life example, several physicians in a clinic identified mental health as a topic of interest. Data was extracted from the EMR and reported back to the physicians. Through this process, the

physicians learned that they had a large number of patients with prescriptions for anti-anxiety or anti-depressive medication that had not been screened for a mental health disorder. Upon identifying this issue, new processes were developed and implemented to a) review whether these prescriptions are current and b) screen and record flagged patients' PHQ-9 scores.

Conclusion

At the CWC PCN, we have found that a PMH needs to be built from the ground up and that the work needs to be flexible, dynamic and responsive to the needs of the physician and the practice. While there have been successes to date, this process of engaging physicians in PMH activities is relatively new. Research indicates that as collaborative care teams mature, stronger outcomes will be achieved (Jabbapour et al, 2017) (Dinh et al, 2014). We foresee this being the case for our teams moving forward.

References

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