Menu of Services

Vision: Patient-centred, Coordinated and Flexible Care

Western Queensland Health Care Homes provide proactive patient-centred, coordinated and flexible care with a team of professionals working together to make sure the patient receives care based on their needs

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Support for Uptake Strategy

Introduction

During 2017 the Western Queensland Primary Health Network (WQPHN) consulted stakeholders across their catchment (and beyond) to consider how best to commission Health Care Home (HCH) principles within the Western Queensland context[1]. This was supported by the Maranoa Accord which aimed to support an appropriate framework through which to deliver a comprehensive primary health care strategy for Western Queensland. Informed by the consultation, and the review of national and international models and evidence, the HCH model of care clearly demonstrated the greatest contemporary framework through which to build the capacity and capability of general practice networks within Western Queensland.

This document outlines the support for uptake of the WQ HCH program, and combined with a coordinated focus on implementation, will help to ensure the roll-out of a program will support the alignment with the Quadruple Aims.

Policy Context

The Australian Government's policy environment creates a new landscape for primary care that is based on coordinated care through the announcement of the Health Care Homes Stage 1 Implementation and the Healthier Medicare initiative. Our region and PHN were not included in the stage 1 implementation, however given the policy environment, extensive consultation across the region and strengths of the HCH model, it was determined that a WQ HCH model of care be developed, tailored to the unique features of Western Queensland.

How is the Program rolling out?

Seven general practices including one Aboriginal and Torres Strait Island Community Controlled Health Service (AICCHS) participated in the Early Adopter Program (EAP) from September 2018 to June 2019. This included a 9-month WQ HCH transition program where the tools and resources were tested along with an evaluation by the University of Queensland (UQ), Centre for Rural and Remote Health (CRRH) and James Cook University (JCU). Changes have been made to the program based on outcomes of the evaluation and feedback from practices.

WQPHN have commenced a staged roll out of the Program from July 1, 2019 with the program available to other eligible practices interested in participating. WQ HCH Coordinators will continue to provide support for uptake of the program based on the capacity of practices to implement change initiatives as identified in the self-assessment tool (Maturity Matrix).

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What are the benefits to providers?

Around the world there is growing emphasis on making health systems more integrated and efficient and Australia is no exception with changes and reforms an ongoing part of healthcare life. Given the changing landscape, Western Queensland Primary Health Network (WQPHN) have taken a proactive approach to leading change through the development of a model of care that is unique to Western Queensland.

The Western Queensland Health Care Home (WQ HCH) Model of Care has emerged from the Patient Centred Medical Home (PCMH) model from the US, UK and New Zealand and modified based on feedback from the Ernst and Young consultation and review undertaken in Western Queensland in 2017. The WQ HCH provides a more integrated multidisciplinary team-based model for an enrolled patient population that connects individuals with the broader health and social care system. The model places an emphasis on supporting general practice to operate at scale, with efficiency and greater capacity with the patient at the centre of care. Explicitly paying attention to achieving a better clinician and provider experience can be an important driver of changing the health system. The benefits can be thought of in terms of:

- **Professional satisfaction**
- **Fulfilling the goal of helping patients**
- **Making life easier for clinicians**
- **More efficient business**

What are the benefits to General Practice?

Change Management

- Regular use of patient feedback systems allows the practice to adjust and make improvements
- The practice and clinicians are supported to test ideas to make the service better
- There is a culture of quality improvement

Primary Care Partnerships

- The clinicians have all the information they need from other care providers, when they need it
- Clinicians have easy, rapid access to specialist advice as they need it, reducing the number of referrals needed

Connecting Care

- Improved care co-ordination and outcomes for patients
- Patients are more confident in their care team as they experience the team working well together including the complementary roles of the multidisciplinary team
- Better trained and supported patient self-care means they are better at looking after themselves and following advice
- The IT systems support more discussions and collaboration between clinicians for complex cases

Service Frameworks

- Practices are supported to implement WQPHN Service Frameworks e.g. Child and Maternal Health, Diabetes Service Framework

Business and Health Intelligence

- Training tools, resources and support.
- Increase practice performance (financial and patient outcomes)
- The Maturity Matrix tool allows practices to assess their WQ HCH readiness and continuous improvement journey including connectivity with the wider HCH neighbourhood
- WQ HCH Data Dashboard – showing progress tools, MBS and patient data which can be used to track changes and make improvements in the practice

Workforce Innovation

- Opportunities for workforce capacity building

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- Each staff member in the practice are clear about their role in patient care, what they should focus on, and what part others will cover
- Patients are supported by care coordinators (new role or changes to existing roles) who have a role in helping the different services work more efficiently together
- All staff in the practice are encouraged to build their skills and knowledge leading to more interesting, challenging and valuable work

Benefits of Integrated Care

- **Right patient at right time.** Providing integrated care means that patients get to the right services at the right time.
- **Clarity of roles and responsibilities.** Having clarity of roles ensures that each staff member understands the importance of his/her contributions to patient care and transformation efforts.
- **Collaborative care.** The WQ HCH, including care coordination roles, help facilitate better collaborative care including patient input and connectivity with the wider HCH neighbourhood.
- **Right information at the right time.** The WQ HCH neighbourhood share responsibility for ensuring that the information clinicians need is provided so that they are able to deliver their particular services.
- **Safe transition of care.** All members of the HCH team and broader Neighbourhood are responsible for patient care and have a clear understanding of each clinician's role to ensure safe care transitions.
- **Care coordination.** Care coordination not only helps smooth out logistics and timeliness of services but helps those services work together more effectively.
- **Emphasis on patient-reported experience and outcomes.** Patient reported experience measures adds to quality, and ultimately to value of the service.

- **Emphasis on self-care.** Greater use of what is probably the biggest un-tapped resource in healthcare. Patients better trained and supported for self-care.

Benefits of WQ HCH for patients

Western Queensland Health Care Homes provide proactive patient-centred, coordinated and flexible care with a team of professionals working together to make sure the patient receives care based on their needs. Health Care Homes gives patients a better experience through:

- **Patient Centred Care** – each patient has a care plan which is tailored to their individual needs and preferences
- **Improved Care Coordination** – better linkages with hospitals, allied health and other community care providers means a more seamless experienced for the patient
- **Improved Personalised Care** – a patient-nominated clinician (usually their GP or remote nurse) leads the care team to conduct a health assessment or develop a formalised, tailored care plan, which is shared with all team members, including the patient and their family/carer
- **Improved Access to Services** – patients can access a member of their care team during the day for support, remotely by phone or email. They do not always need to make an appointment with their GP to get information about their condition
- **Long-term approach to Disease Management**– Health Care Homes provides support, prevention and health promotion to improve health outcomes, rather than a reactive approach which focuses solely on treating unwell patients

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What is WQPHN role in the WQ HCH?

The WQ HCH Coordinators work intensively with practices to identify and understand their unique support service requirements. This includes the use of benchmarking tools to determine the areas of greatest need for development. Based on this, WQ HHC Coordinators work with practices to develop their Implementation Plan and identify what menu of service offerings and initiatives they will implement.

How will the success of the program be measured?

An evaluation framework has been developed to understand the impact the program is having in each practice and to capture learnings so that improvements can be made to support activities. WQPHN are working with tertiary partners including the Mater Research Institute - University of Queensland, Centre for Rural and Remote Health and James Cook University to evaluate the program using the Quadruple Aims to measure the performance and success of the WQ HCH approach. Each practice can also able to access their bi-yearly results from the WQ HCH Data Dashboard.

IMPROVED PATIENT EXPERIENCE OF CARE
- Care tailored to the needs of an individual
- Coordinated and comprehensive care
- Safe and effective care
- Timely and equitable access
- Increased skills and confidence to manage one's own care

IMPROVED HEALTH OUTCOMES AND POPULATION MANAGEMENT
- Reduced disease burden
- Increased focus on prevention
- Improved quality of care
- Improvement in individual behavioural and physical health

IMPROVED COST EFFICIENCY AND SUSTAINABILITY IN HEALTH CARE
- More efficient and effective service delivery
- Increased resourcing to primary care
- Improved access to primary care, reducing demand on hospitals

IMPROVED HEALTH CARE PROVIDER EXPERIENCE
- Increased clinician and staff satisfaction
- Increased flexibility and scope for innovation
- Evidence of leadership and team based approach
- Quality improvement culture in practice

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WQ HCH Practice of the Future

To inform the overall strategy and purpose of the WQ HCH Model of Care, we have defined what we believe a successful WQ HCH of the future should look like.

1 The practice has a **suitably skilled, integrated, and multi-disciplinary** care team, which enables clinicians to **work to the top of their scope**, and results in a high level of patient, clinician and staff **satisfaction**

2 There is an **adaptive and agile leadership team** which can respond to changing patient needs

3 The GP has a **personalised relationship** with each patient, their family and carers, and **works together** with patients to make care delivery decisions

4 The patient is health literate, and is an **active participant** in their health care

5 There is **a customer service focus** at all levels, which encourages the patient's loyalty to their GP and the practice

6 The practice makes **use of data**, and this data enables **continuous quality improvement** and drives decision making

7 The practice leverages **data and care plan sharing** opportunities

8 The practice **uses technology** to optimise business performance and team care plans, and where applicable to increase the ease of accessibility of their services to patients

9 The practice has a **sustainable business model** which is **adaptable to changes** in the health system and patient needs

Concepts for the future of primary care

CARE CURRENTLY	CARE WITHIN A HEALTH CARE HOME
My patients are those who make appointments to see me	Our patients are those who are registered in our Health Care Home
Patients' chief complaints or reasons for visit determines care	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet health needs, with or without visits
Care varies dependent on memory and scheduled time of doctor	Health care providers have access to evidence-based guidelines to build the right care plan
Patients are responsible for coordinating their own care	A prepared team of professionals supports the coordination of a patient's care
Patients are passive recipients of care	Patients play an active role in making decisions about their care and are empowered to better manage their conditions
I know I deliver high quality care because I'm well trained	We measure our quality and make changes to improve it
It's up to the patient to tell us what happened to them	We track tests and consultations, and follow-up after visits to other services (e.g. ED visits or specialist appointments)
Clinic operations centre on meeting the doctor's need	An interdisciplinary team work at the top of their professional capacity to serve patients

Source: Adapted with permission from F. Daniel Duffy, MD, MACP, Senior Associate, Dean for Academics, University of Oklahoma School of Community Medicine.

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WQ HCH Program Establishment and Implementation

A key objective of the WQ HCH Program is to build the capacity and capability of GP practice/remote clinic teams. In doing so, it is essential that we engage and establish group of WQ HCC practices that have a level of readiness, and then actively support them in the successful implementation of the program initiatives most applicable to them.

To ensure appropriate WQ HCH practices are selected and then supported to succeed, we:

1. **Select and recruit WQ HCH practices**
   - We invite general practices who meet selection criteria based on the WQ HCH 10 foundations to take part in the program by working with the WQ HCH Coordinators and other support networks to participate. This includes distribution of fact sheets, a range of communications, and in-principle agreement to participate in the program through an EOI. Once approved Service Level Agreements (SLA) are signed prior to commencing the pre-implementation phase.
   - We follow up with the practice owners to discuss the benefits of the practice becoming a WQ HCH practice and answer any queries.

2. **On-board each practice during the pre-implementation phase**
   - Obtain registration for practices to have access to the secure WQ HCH portal.
   - We complete the on-boarding process as part of the pre-implementation phase over a four-week period. Part of this process is supporting practices to undertake benchmarking using the WQ HCH-MM, staff Team Health Check and Practice Performance Analysis (PPA) to support their understanding of their current capabilities in relation to their readiness to become a WQ HCH.
   - Support practices to collect data for the patient satisfaction survey.

3. **Identify practice needs and work with practices to develop an Implementation Plan**
   - We aggregate the results and then host a workshop/webinar to present the findings from the pre-implementation assessments and patient satisfaction survey.
   - Practices use the information to determine the areas of highest need and to inform the development of the practice implementation plan.
   - We also assist the practice to use the model for improvement and Plan-Do-Study-Act (PDSA) cycles.
   - We discuss with practices which elements of the Menu of Services (see pages 8-13) are best suited to support their needs.

4. **Implement, monitor, review and support WQ HCH Practices**
   - We support the WQ HCH practices to implement their initiatives and meet (virtual or face to face) at least monthly, or as nominated by the practice, to support the implementation of these initiatives.
   - We work with the practices to implement PDSA cycles and reflect and build on the learnings and if necessary, implement successive cycles of change. We review PDSAs regularly to measure the effects of the change.
   - We meet with the Practice Owners, GPs and the practice team on a quarterly basis to review and report on progress against the Implementation Plan and PDSAs and seek their feedback on new or continuing initiatives in line with the practice's needs.

5. **Review and implement feedback to improve support**
   - We have regular workshops, provide coaching, link practices through a Community of Practice (CoP) network and consistently collect feedback from WQ HCH practices to ensure they feel engaged and enabled, and are being appropriately supported.
   - We implement any such feedback to ensure our relationship and efforts result in practices becoming successful WQ HCH practices.

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Menu of Services

The Service Offerings accessible to practices are the foundation elements of the WQ HCH model of care and will allow practices to become effective Western Queensland Health Care Home practices of the future.

To ensure appropriate Service Offerings, we have:

1. Developed a detailed WQ HCH menu of Service Offerings that is based on the 10 foundation

- We have developed objectives and service menu offerings for each foundation, which will build the capacity and capability of the practice teams.
- The offerings are customised for each practice informed by the benchmarking activity in the on-boarding pre-implementation phase. These offerings include WQ HCH practice support, training programs, workforce development, procured and commissioned services, and tools and techniques.

To ensure appropriate service offerings, we:

1. Ensure offerings are relevant and impactful by co-developing and designing with the involved practices

- We use individual practice sessions and Communities of Practice to test and validate the Menu of Services with practices and make any adjustments accordingly.
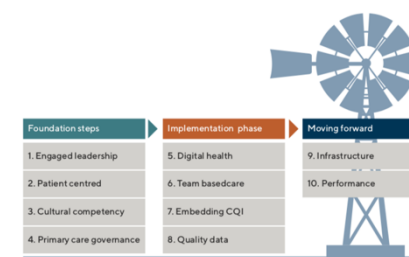
2. Leverage relationships with other PHNs nationally to learn successful initiatives

- We utilise established relationships to obtain and share practice ready resources and other tools.
- WQPHN would like to acknowledge the support of **Western Australian Primary Health Alliance (WAPHA**) who provided access to their CPC Strategy which this Support for Uptake document is based.

Aligning Accreditation and Support for Uptake:

The Implementation Plan template provides links to relevant standards in the 5th Edition RACGP Standards that align with 10 foundation elements. An additional resource is also provided to practices which maps the 10 foundation elements with the 5th Edition RACGP Standards, so any progress made towards improving in the foundation elements may also contribute to efforts in preparing for accreditation. It is all about systematically and incrementally improving to achieving patient centred high performing quality primary care.

The Menu of Services are split into three phases including foundation steps, implementation phase and moving forward. The Menu of Services are designed to support each phase as the practices steadily progresses along the transformation journey.

Foundation steps	Implementation phase	Moving forward
1. Engaged leadership	5. Digital health	9. Infrastructure
2. Patient centred	6. Team basedcare	10. Performance
3. Cultural competency	7. Embedding CQI	
4. Primary care governance	8. Quality data	

The full Menu of Services of the WQ HCH practice support are detailed in the following pages

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WQ HCH Menu of Services: Foundation Steps

	Foundation 1 **Engaged Leadership**	Foundation 2 **Patient Centred**
Key Objectives	**Key objectives:** 1) Practice leaders provide visible and sustainable leadership to lead overall cultural change, as well as specific strategies to improve quality to spread and sustain change 2) Ensuring that transformation efforts have the appropriate time and resources needed to be successful 3) Ensuring the practice and care teams have protected time 4) WQ HCH vision and practice values embedded into staff recruitment and training	**Key objectives:** 1) Adequate practice training on WQ HCH and changes applicable to the practice 2) Patient Centred Principles are embedded into practice activities 3) Patient education is in the forefront of Health Promotion in the practice 4) Care coordination is embedded into practice procedures 5) Proactive care planning is customised to patient needs and preferences 6) Encouraging patients to expand their role in decision-making, health related behaviours and self-management

Key Services	**Menu of Service offerings available include:**
	• WQ HCH Model of Care orientation workshop/webinar
	• Advisory services, continuous training and workshops in practices
	• Practice Performance Analysis and implementation plan advice
	• Change management education and training
	• Provide guidance for the development of new service delivery models through the access and care redesign program and patient enrolment.
	• CQI training, resources and programs:
	   ○ WQ HCH handbook
	   ○ WQ HCH QI Guide
	• Data management program
	• WQPHN CPD events
	• WQ HCH funding
	• Scope of WQ HCH requirements through completing the WQ HCH Maturity Matrix
	• Directing to workforce support (e.g. ACRRM, RACGP, HWQ)
	• Accreditation support
		Menu of Service offerings available include:
		• WQ HCH marketing material and techniques, to aid with patient enrolment
		• Access to initiatives that build staff capacity to support patients to manage their own health, e.g. Go Share
		• Access to Chronic Disease Management education and training including self-management programs/services with goal setting
		• Systems, tools, resources and processes to collect patient feedback and using patient feedback for quality improvement
		• Support for PIP After Hours registration and uptake
		• My Health Record (MHR) registration and support
		• Registered and up to date details on My Community Directory
		• My Health for Life Program
		• MBS guide
		• Training for care planning and Motivation Interviewing training
		• Patient Centred Principles

Practice Core elements	• Use PDSA Cycles for quality improvement	• Use PDSA Cycles for quality improvement
	*Information in the *Key Objectives* has been adapted from the *Safety Net Medical Home Initiative* and the *Western Australia Primary Health Alliance - CPC Strategy*	

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WQ HCH Menu of Services: Foundation Steps

	Foundation 3 **Cultural Competency**	Foundation 4 **Team Based Care**
Key Objectives	**Key objectives:** 1) Comprehensive culturally sensitivity practice team training embedded within practice policy 2) Culturally diverse patients identified via practice register 3) Health Promotion activities incorporate languages groups reflective of practice population 4) Development of a Reconciliation Action Plan (RAP) 5) Communicating with patients in a culturally appropriate manner, in a language and at a level that the patient understands	**Key objectives:** 1) Defining roles and distributing tasks among the care team, to reflect skills, abilities and credentials of team members (staff working at the top of their scope of practice) 2) Stakeholder relationships are managed with a patient centric approach 3) Linking patients to a provider and care team so both patients and providers recognise each other as partners in care 4) Ensuring that patients can see their provider and care team whenever possible
Key Services	**Menu of Service offerings available include:** • Cultural awareness training and reflection • Systems, tools, resources and processes to collect patient feedback and using feedback for quality improvement • Provide PREMS and PROMS • MBS guide • Health literacy training • Culturally secure health programs and services that create better relationships with culturally diverse patients, eg. culturally and linguistically diverse resources	**Menu of Service offerings available include:** • Access to Continuous professional development (CPD) to upskill current practice staff to become multi-disciplinary team working together • Access to allied health initiatives that build and enhance the care team eg. Diabetes Allied Health Support Programs • Sample position descriptions • Administration training • Advice and resources on communication methods within the HCH • PREMS and PROMS • Guide to Principles of Patient Centred care (resource) • PPA report • Chronic disease registers • Provide resources on Quadruple Aims
Practice Core	• Use PDSA Cycles for quality improvement • PREMs and PROMs	• Review of position descriptions • Integrate care coordination function/role into practice • Patient nominated lead clinician
	*Information in the *Key Objectives* has been adapted from the *Safety Net Medical Home Initiative* and the *Western Australia Primary Health Alliance - CPC Strategy*	

WQ HCH Menu of Services: Implementation

	Foundation 5 **Primary Care Governance**	Foundation 6 **Embedding Continuous Quality Improvement**
Key Objectives	**Key objectives:** 1) Data is used to better understand disease cohorts in the practice and region 2) Systems are in place to enable coordination of patient care, both within and externally to the practice (according to clinical guidelines) 3) Increase the number of enrolled patients with a nominated clinician 4) Review of practice systems to monitor patient flow and care 5) Health assessments are tracked to enable more response patient care 6) Increase patient access to their records through the My Health Record (MHR) App 7) Measure access and demand to guide appointment scheduling and care redesign	**Key objectives:** 1) Practice staff have CQI as a KPI and performance reviews 2) Quality Improvement is embedded within Practice agenda 3) Adequate opportunity for staff upskilling against QI techniques and methodology (2 scheduled in-house QI training - specifically on PDSA cycles) 4) Working as a practice team to develop SMART goals 5) Establish a practice workflow that will sustain QI activity. 6) Clinical Information systems/patient records protocols developed for patient and for population health management

Key Services	**Menu of Service offerings available include:**
	• Admin POPGUNS training & resources
	• CQI training, resources and programs:
	• WQ HCH handbook
	• Diabetes Collaborative handbook
	• WQ HCH QI Guide
	   o Including: Model for Improvement and PDSA training
	   o Register development
	   o Recall and reminder systems
	• Data management program including:
	   o Licence to CAT 4 Plus and TopBar and training
	   o CAT 4 Plus roadmap and recipes
	   o Practice Data Reports: Basic, Diabetes and Mental Health
	   o Data cleansing activities
	WQPHN Service Frameworks
		Menu of Service offerings available include:
		CQI training, resources and programs:
		   o WQ HCH handbook
		   o WQ HCH QI Guide
		Data management program including:
		   o Licence to CAT 4 Plus and TopBar and training
		   o CAT 4 Plus roadmap and recipes
		   o Practice Data Reports: Basic, Diabetes and Mental Health
		Data Cat 4 & 5 presentation to hospital to track trends
		Education and resources
		Health pathways

Practice Core	• Register development • Use PDSA Cycles for quality improvement	• Use of Cat 4 Plus tool and TopBar • Use of handbooks provided to embed QI processes in practice
	*Information in the *Key Objectives* has been adapted from the *Safety Net Medical Home Initiative* and the *Western Australia Primary Health Alliance - CPC Strategy*	

WQ HCH Menu of Services: Implementation

	Foundation 7 **Quality Data**	Foundation 8 **Digital Health**
Key Objectives	**Key objectives:** 1) Data quality/cleaning is built into all population management strategies 2) Using health data to optimise practice and business performance and maximising patient health outcomes 3) Practice regularly extracts patient data to and understand patient population, patient outcomes and patient requirements 4) Practice data helps the team highlight areas for improvements and where the improvements were captured 5) A shared learning environment is engaged through data	**Key objectives:** 1) WQ HCH practices work towards developing a Digital Health Strategy 2) Registration and meaningful use of MHR and other digital systems including secure messaging are embedded in all staff practice 3) Practice optimises the use of digital technology including increasing telehealth consults online appointments and telehealth coordination and MHR uploading, secure messaging and an online patient portal 4) Use of TobBar to provide targeted improvements through PMS
Key Services	Menu of Service offerings available include: Stage 1 -Training and support to assess, manage and cleanse practice data to maintain currency and accuracy Stage 2 -Monthly standardised practice level data reports (clinical perspective) and guidance on using date for quality improvement. Reports displayed in practice for all staff to have input into making improvements. Stage 3 - Customised tools and reports that model patient data to maximise outcomes, eg. recalls, care planning. Stage 4 – Use of PPA to optimise business performance, eg. SIP, PIP & MBS items Stage 5 – WQ HCH data dashboard uses to track and benchmark practice data. CQI training, resources and programs: • WQ HCH handbook • WQ HCH QI Guide Data management program including: • Licence to CAT 4 Plus and TopBar and training, and CAT 4 Plus roadmap and recipes • Practice Data Reports: Basic, Diabetes and Mental Health • RACGP Red book and access to prevention Red Book and risk assessment e.g Cardio Risk Assessment guidelines	Menu of Service offerings available include: • WQPHN digital strategy (Telehealth resources, secure messaging support, MHR education, Patient portal, Social media strategy) • Support for uploading shared health summaries • Support for registering for ePIP • Fact sheets on how to enrol patients • Patient App • Service Frameworks
Practice Core	• Use PDSA Cycles for quality improvement • Data sharing with WQPHN • Use of My Health Record • Use of CAT 4 Plus and TopBar	• Practice registration to My Health Record system • Practice registration to ePIP • Telehealth and secure messaging processes enabled

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WQ HCH Menu of Services: Moving Forward

		Foundation 9 **Infrastructure**	Foundation 10 **Performance**
Key Objectives		**Key objectives:** 1) Workforce strategy and plan developed with emerging new roles 2) Innovative programs are planned through consultation with Patients 3) Systems in place for case conferencing, Telehealth and billing 4) Consult rooms are set up so that workflows are standardised including access to shared clinical space 5) WQ HCH neighbourhood are integrated into the practice to support chronic disease management and follow-up care	**Key objectives:** 1) Practice Performance Analysis reviewed regularly and Maturity Matrix used to guide transformation efforts 2) Access and demand (including care redesign and call demand) are measured and used for scheduling and planning (patient flow and wait times) 3) Data quality is part of health system strategy and used to monitor performance to ensure the WQ HCH practice is meeting the quadruple aims
Key Services		**Menu of Service offerings available include:** • Telehealth resources • Resources and advice • Resources and education • Role description for care coordination • Information of International and National HCH Infrastructure changes and initiatives	**Menu of Service offerings available include:** 1) Working with the WQ HCH Coordinators develop an action plan to roll our recommendations outlined by the Practice Performance Analysis • Support for CQI processes to measure access and demand • Audit calls • Practice Performance Analysis (PPA) • Maturity Matrix • Workshops to develop the Implementation Plan • PREMs/PROMs
Practice Core		• Registration and up to date details on My Community Directory • Review of position descriptions • Integrate care coordination function/role into practice • Review of systems for telehealth and case conferencing • Develop workforce strategy and plan for emerging new roles	• Completion PPA, Maturity Matrix, PREMs/PROMs • Use of PDSA cycles for quality improvement • Review processes to assess efficiency, complaints, near misses, errors and adverse events in clinical care
*Information in the *Key Objectives* has been adapted from the *Safety Net Medical Home Initiative* and the *Western Australia Primary Health Alliance - CPC Strategy*			

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