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Coordinare PCMH Symposium
29 April 2017

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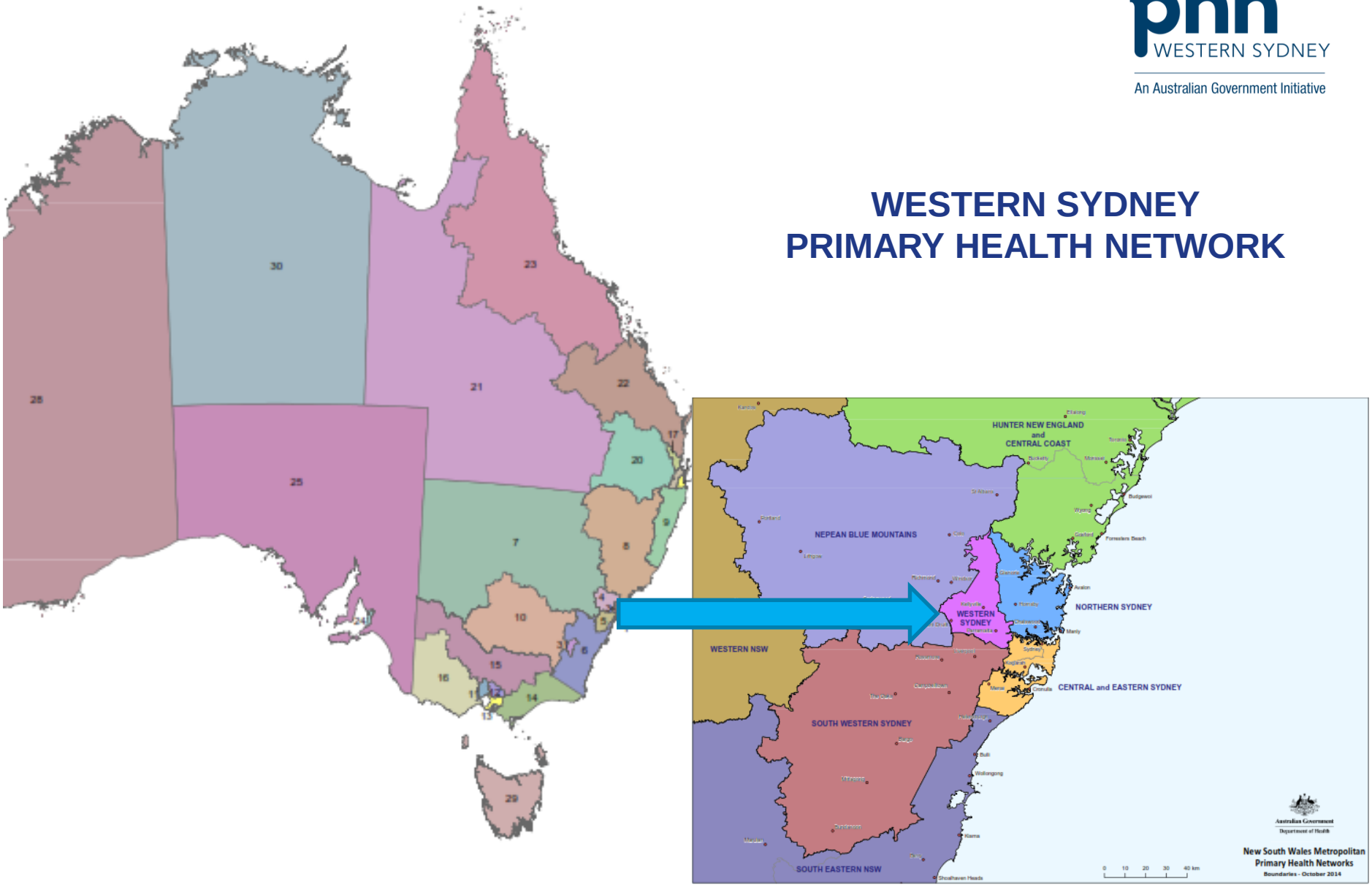
WESTERN SYDNEY PRIMARY HEALTH NETWORK



Source: Department of Health – September 2015

A Patient Centred Medical Home "under construction"

1. Many challenges
2. What are we trying to achieve
3. Laying the foundations
4. Future outlook

Optimising the solution = disregarding boundaries

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Western Sydney GPs reported challenges

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- Fee for service (FFS) model:
  - does not serve chronic disease patient
  - does not reward quality practice, it rewards high throughput medicine
  - is gamed and aggravated by Federal Government policies such as freezing of rebates
  - useful for patients with acute care needs
- High rate of "bulk billing" in the area makes it difficult to wean patients off it due to expectation (unrealistic) and the culture has been set for a long time
- Patients tend to delay appropriate treatment if they have to pay
- Older cohort of GPs providing traditional provision of care getting close to retirement, will be replaced by the younger GPs who tend to practise in large corporate centres, potentially losing the culture of continuity and comprehensiveness of care
- Hard to attract and recruit young GPs, especially in the areas outside of District

Western Sydney GP reported challenges cont…

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- Population in Western Sydney, in terms of health and wellbeing is significantly worse than the population elsewhere in Australia, with highly complex chronic diseases, mental issues, social and financial stresses
- Influx of migrant and refugee population present unique challenges such as language barriers, culture specific issues etc
- Dysfunction and fragmentation in the health care system
- System is designed to react to acute diseases, not equipped to serve emerging health problems, complex chronic diseases and ageing population
- Poor communication across the various silos
- No incentives for GPs to work after-hours
- Government term not long enough to create a long-term sustainable change

A challenge for our times?

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Working now for a corporate and offering quality service to my patients already, I have several concerns with the Health Care Homes model.

First, how will the money received by the practice be divvied up? What percentage of the payment from the government will be passed on by my corporate 'employer' to the GPs working for them?

Will I receive a single cent if I see a patient on behalf of a colleague while they are away?

Will the amount paid by the government match what we would have earned seeing the patient under a fee-for-service model? Some of our chronic patients are in the surgery every day, so I seriously doubt it.

Integration Care = Person Centred Care

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Care, which imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless

Lloyd & Wait 2005

System challenge – GP's & Allied Health

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There is a need for general Practice to adapt rapidly so that it operates at a scale that can provide a platform for integrated care

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Primary care does a lot of good for people

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Focus on the course of a person's health over time - even through a life:

"This potential for incremental medicine to improve and save lives, however, is dramatically at odds with our system's allocation of rewards"

"The incrementalists 'contribution is more cryptic than the rescuers'"

"This is a problem for our health-care system. It doesn't put great value on care that takes time to pay off"

Atul Gawande – The New Yorker Jan 2017

Continuity of care: caring for you not just because you're in front of me

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Continuity of care is a complex, multifaceted concept, with four domains:[4]

- **Interpersonal continuity:** the subjective experience of the caring relationship between a patient and their health care professional.
- **Longitudinal continuity:** a history of interacting with the same health care professional across a series of discrete episodes.
- **Informational continuity:** the availability of clinical and psychosocial information across encounters and professionals.
- **Management continuity:** the effective collaboration of teams across care boundaries to provide seamless care.

Patient Centered Medical Home
A new paradigm

Patient-Centered Primary Care COLLABORATIVE

Today	Future
Treating Sickness / Episodic	Managing Populations
Fragmented Care	Collaborative Care
Specialty Driven	Primary Care Driven
Isolated Patient Files	Integrated Electronic Records
Utilization Management	Evidence-Based Medicine
Fee for Service	Shared Risk/Reward
Payment for Volume	Payment for Value
Adversarial Payer-Provider Relations	Cooperative Payer-Provider Relations
“Everyone For Themselves”	Joint Contracting

Continuity of care ⇨ Teams

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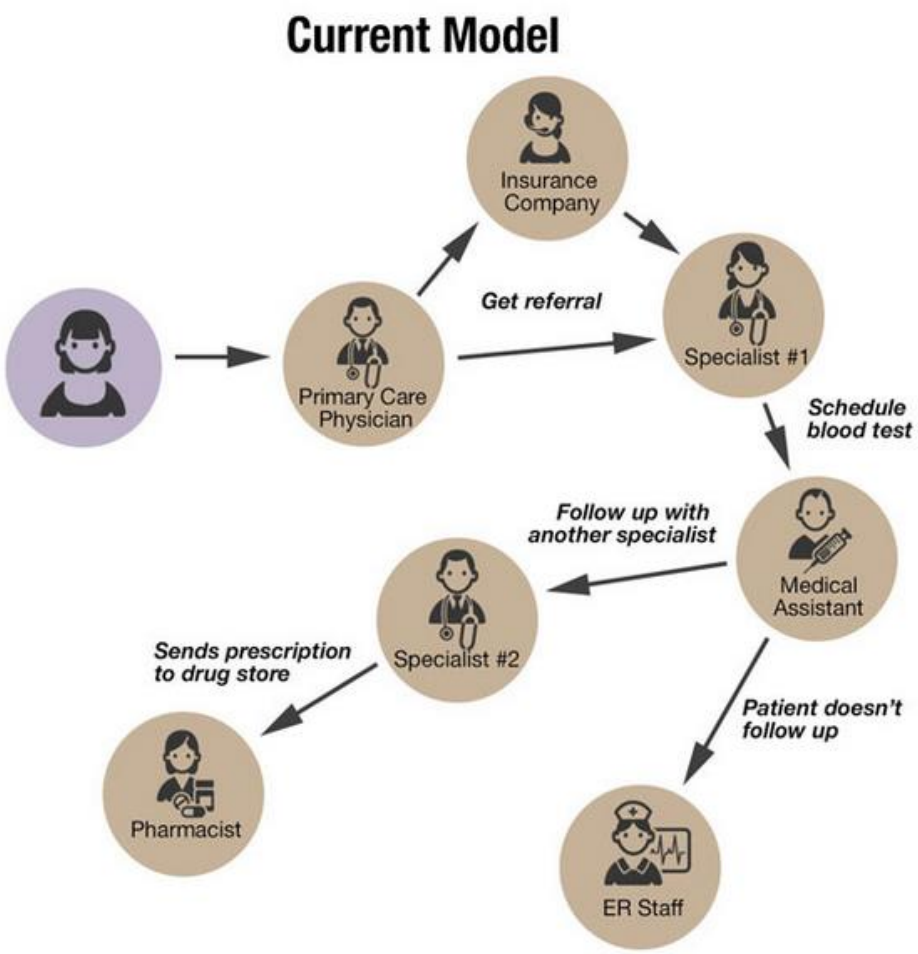
Clear communication and effective coordination among health care providers are vital for patient health, but the current primary care structure makes collaboration incredibly difficult. See the difference:



UCSF

UCSF Center for Excellence in Primary Care. http://www.ucsf.edu/news/2014/08/116856/team-based-approach-primary-care

A medical home is not a building or a place

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"Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. This patient-focused approach will require collaboration between professionals and strong team working, both within and across organisational boundaries."

The future from a GP

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- Patient centred, work in partnership with patient
- Convenient for patients
- Offer a variety of services
- Maximum use of skills of every team member
- Timely care
- Good communication – electronic
- Transparent
- Data driven

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Building Blocks for High-Performing Primary Care *

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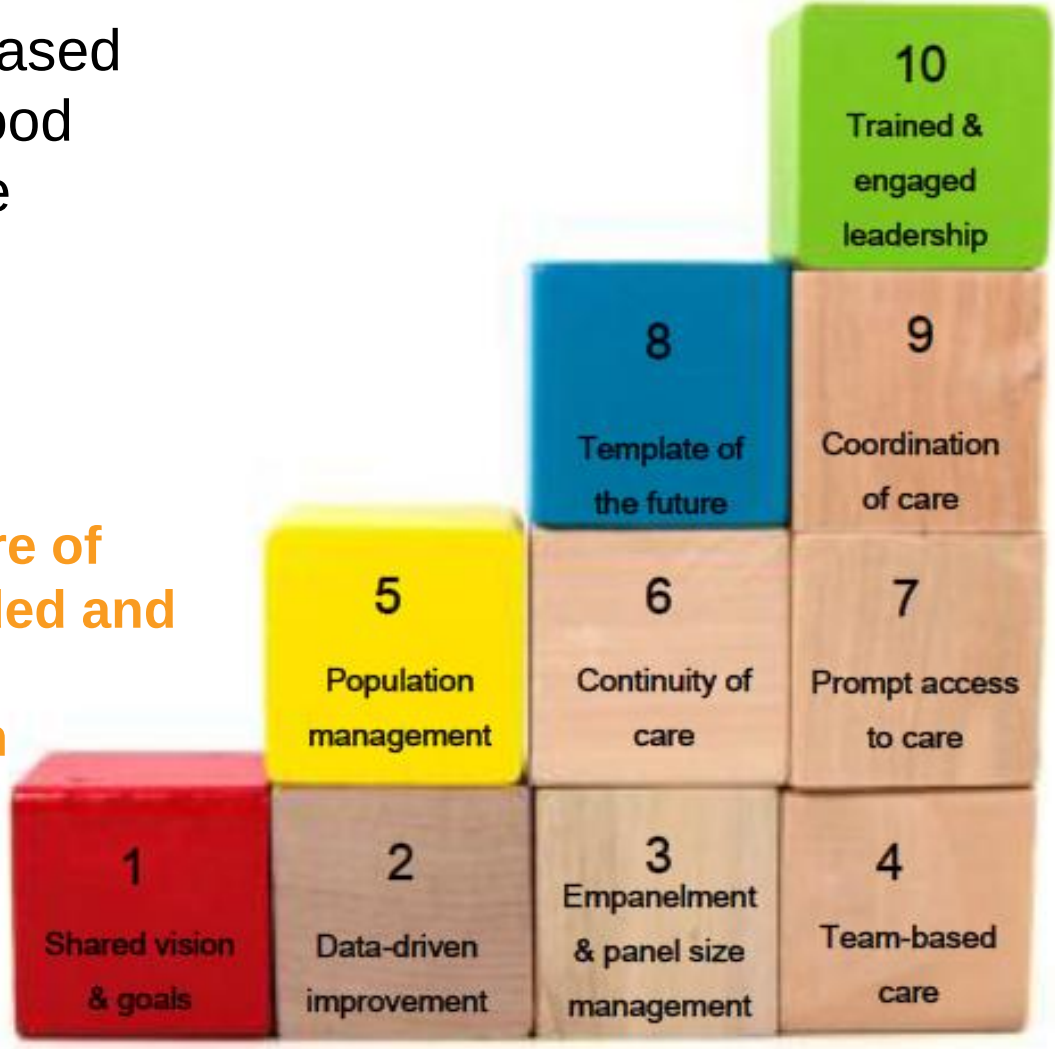
- Adoption of an evidence based approach to developing good quality primary care for the community
- Engaging and investing in leadership at all levels
- Linking the model to:
  - **What we do/can do more of**
  - **What changes are needed and how we can make them**
  - **A primary care platform for integrated care**
- Network & partner
- Sustaining the effort



Activities to strengthen the foundation building blocks

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1. GP Leaders group-early adopters
2. Defining a model for GP of the future
3. PHN strategic framework-quadruple aim
4. Partnerships for integrated care

Clinical leadership

1. Clinical audit tool investment - PDSAs
2. Development of QAim dashboards
3. Consumer experience measurement
4. Large scale data linkage

Linking performance to payment

1. Workforce development
2. Specialist case conferencing - diabetes
3. Investing in team members - pharmacists
4. Enabling structures – shared care planning, HealthPathways

Working "top of licence"

- Clinical leadership = GP practice leadership
- Basis for a integrated medical neighbourhood

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"What would you do differently if commencing this PCMH journey now?"

"I would be much clearer and learn much more about leadership and change management before embarking on any of it. Leadership is paramount and change management is crucial. I would learn more about enabling my team in working out tasks to achieve goals. But I would start with a clear vision and strategy to achieve that vision"

2

Data-driven improvement

- "Knowing your population" fundamental
- Good quality care – show me
- Higher level of satisfaction and reward should follow from better care

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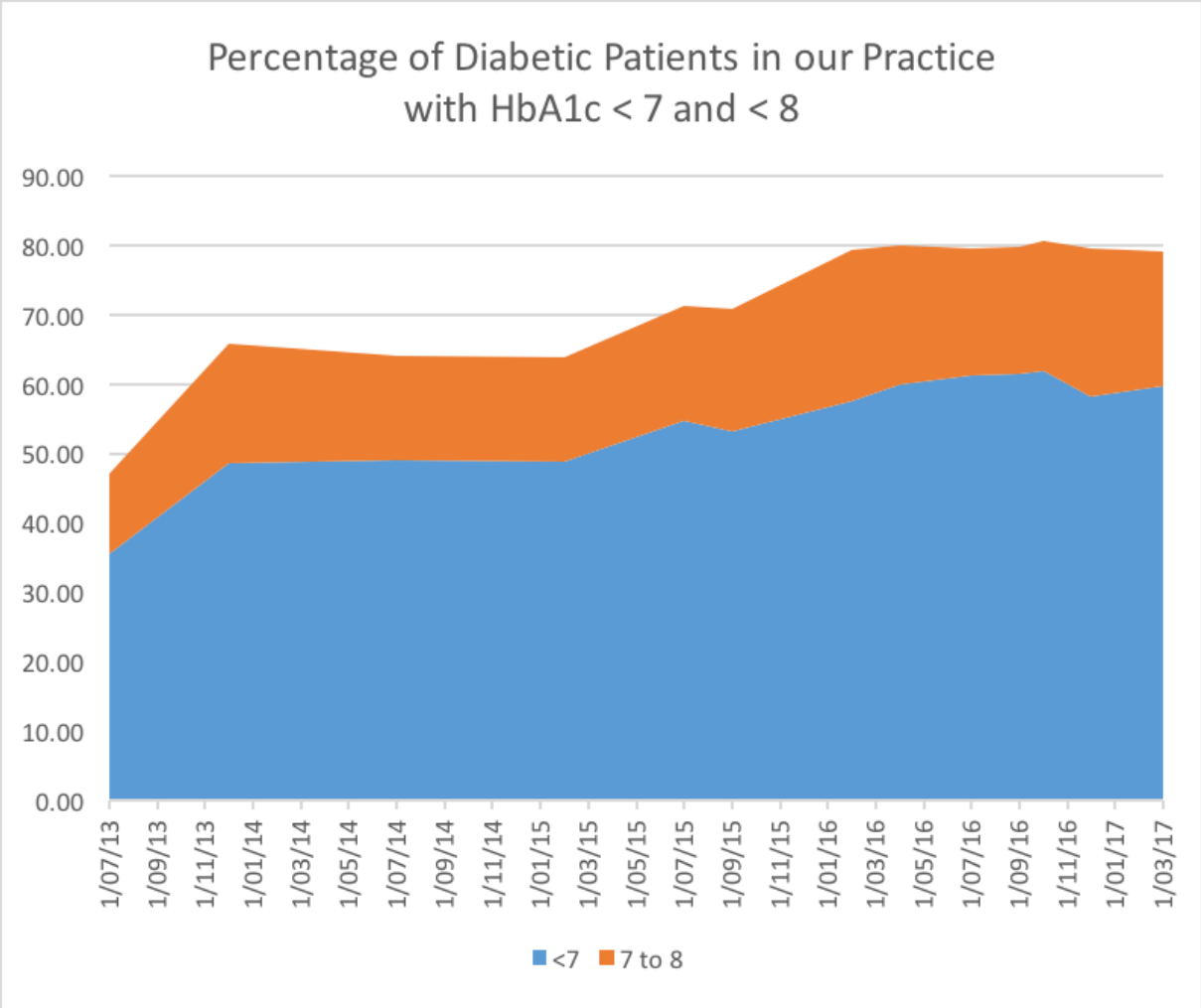

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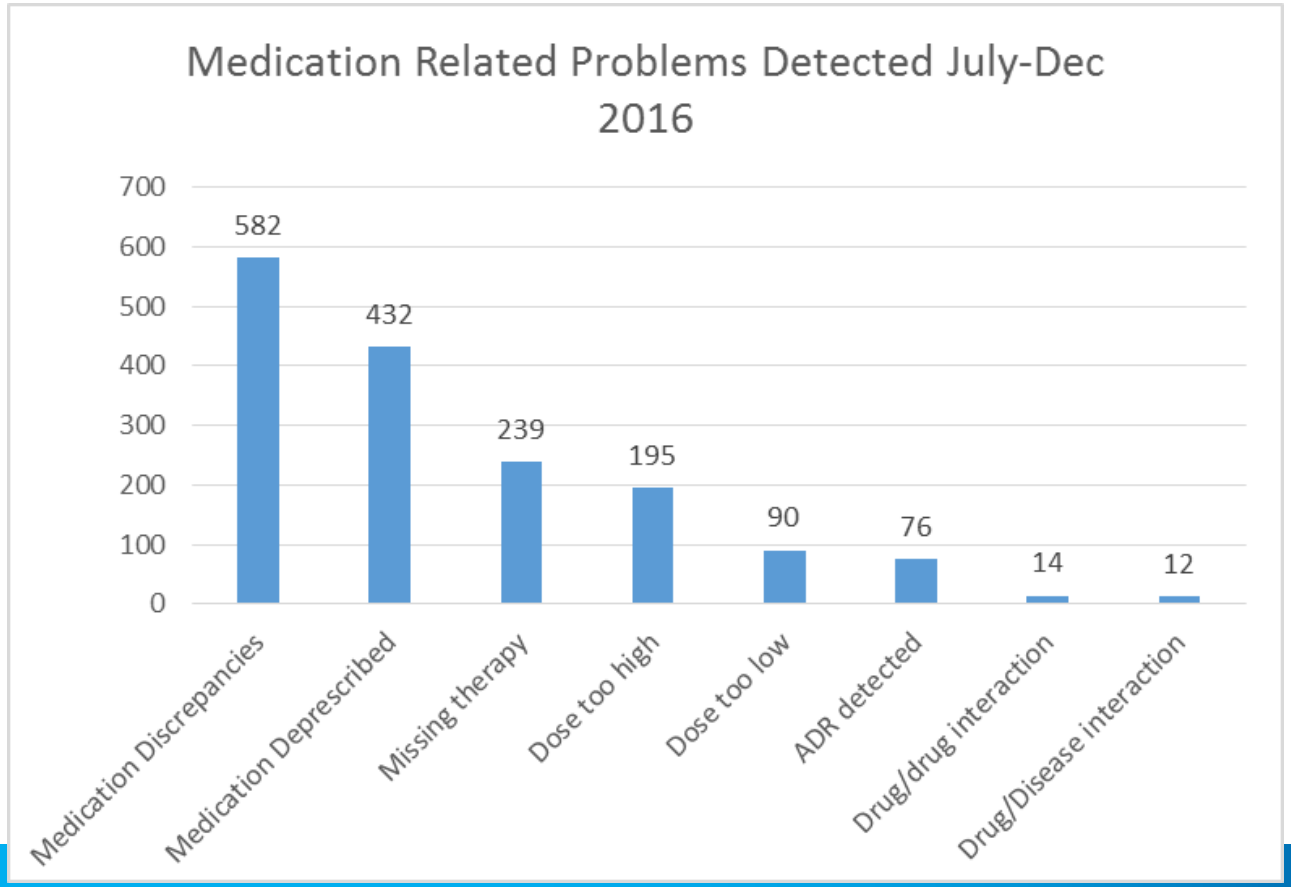
Team-based care

- GP teams need GP leadership – including role clarity
- Build a team incrementally investing in "value adding" functions
- Enablers to improve coordination and communication *can* make a difference



COMPREHENSIVE

CHANGES	MEASURES
• Multi-disciplinary care-top of license • Chronic disease • Holistic care	• Data registries • Quality improvement • "defect lists"

CONTINUOUS

CHANGES	MEASURES
• Care integration • Empanelment • Team pods	• Hospital admission reports • Continuity rates for team and provider

ACCESSIBLE

CHANGES	MEASURES
• Extended hours • Patient portals • Same day access • Panel management	• Access reports • PREMs

Improve Patient care quality & experience	**Improve Population Health**
Reduce Cost of Care	**Joy in Practice**

PATIENT FAMILY CENTRED

CHANGES	MEASURES
• Patient advisory panels • Cultural competency • Focus groups	• PREM • Patient comments

COORDINATED

CHANGES	MEASURES
• Follow up phone calls • Care integration • Risk stratification • Panel management	• Discharge reports • Nurse management lists • Disease registries

ACCOUNTABLE

CHANGES	MEASURES
• Panel management • Quality improvement • Care review	• Record audits • Data dashboards

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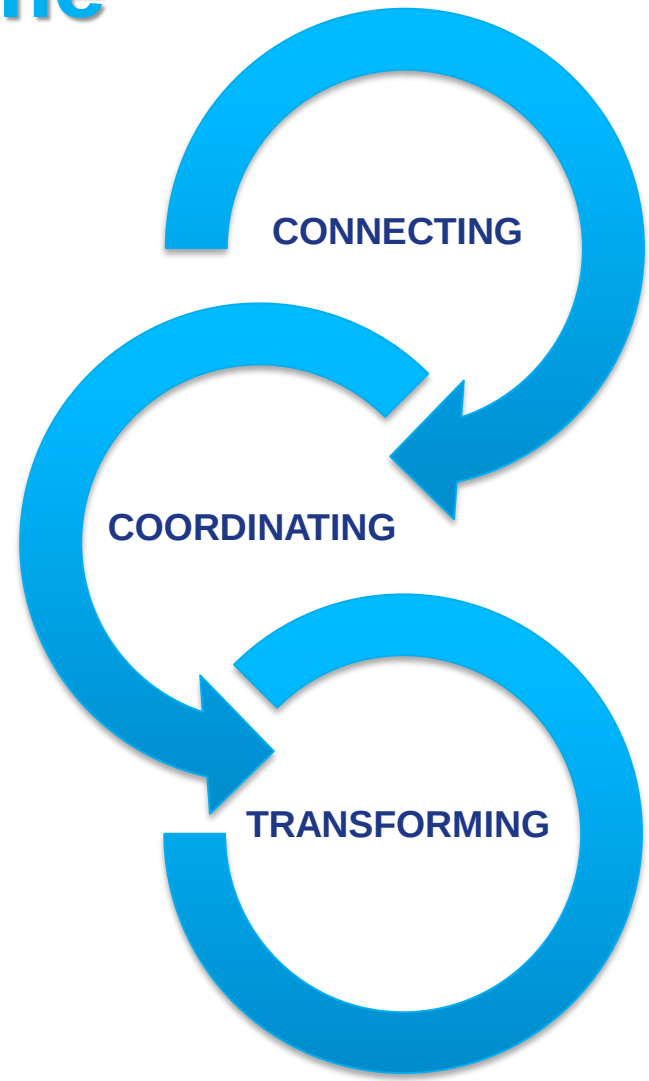
Our system was built for a different time



In an era of change

The way we practice medicine is **changing**

Governments and society are **questioning** how health care is valued

We must **lead** to be able to **adapt**

We must **adapt** to payment models by **doing things differently**

Everything we do must be **transparent**

We must learn to **measure**, and measure only what **matters**

Learn to **continuously improve,** and improve by **continuously learning**

Hold the patient at the heart of care delivery

Appreciate that a coordinated team is vital to patient centred care

Thank you

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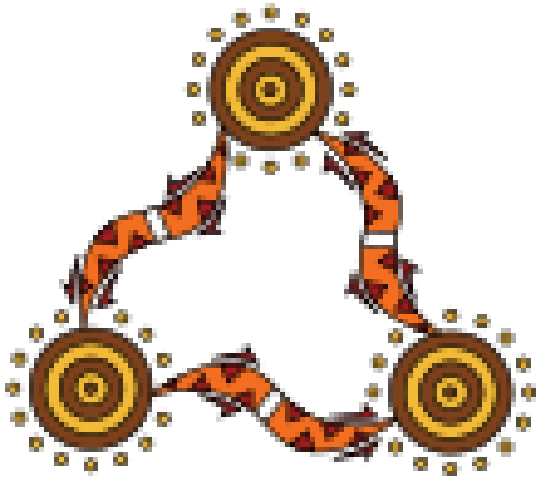

@WKmet

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Progressing Health Now

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As the Western Sydney Primary Health Network, WentWest is focused on addressing both regional and national health challenges. Together with health professionals, partners from both the health and hospital sector, consumers and the broader community, WentWest seeks to identify gaps and commission solutions for better health outcomes.