



Western Queensland Health Care Home Model of Care



Contents

1. Western Queensland Vision for Health Care Homes?	3
2. What is the Western Queensland Health Care Home?	9
3. Western Queensland Health Care Home Model of Care Key Features	13
4. Western Queensland Health Care Home Domains	14
5. What are the Benefits of Health Care Homes for patients?	17
6. Support for uptake from WQPHN	18
7. Foundations	22
8. The Future of WQ HCH Practice	26
9. Measuring Success	28
References	29



Western Queensland Vision for Health Care Homes?

1.

INTRODUCTION

We recognise a more cohesive and systematically coordinated model of care is necessary to enable greater sustainability and appropriateness of primary health care. This includes one where consumers are at the heart of their local primary care system and lifestyle and other health risk factors are identified early, and people with chronic disease are proactively managed by a team of health professionals. We are committed to integrating care, particularly for more vulnerable populations who find it hard to navigate the system, and for people who experience geographic isolation or economic disadvantage and have complex care needs.

We want to remove the organisational and professional barriers that impact care and prevent better coordination across social, primary and acute care settings. We aim to support shared approaches to care, activation of shared health intelligence and better uptake of eHealth solutions to enable timely exchange of important patient information. We need a system that is easy for consumers to navigate and delivers greater self-management and independence.

The Western Queensland Health Care Home (WQ HCH) will be the primary enabler to strengthen and transform general practice at the heart of comprehensive primary health care, centred on the needs of individuals and their families. In the WQ HCH, General Practice offers continuity of holistic care, delivered close to peoples' homes; where individuals, families and carers are informed and active partners in their care journey. General Practice provides the gateway to the wider health system through access to community-based multi-disciplinary team-based care, early intervention services, and to hospital and specialist services where these are required.

BACKGROUND

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) foundations within the Western Queensland context¹. 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.

“We want to remove the organisational and professional barriers that impact care”

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.

CASE FOR CHANGE – HEALTH INEQUALITIES

WQPHN covers a vast landscape (55% of total land mass of Queensland) where long distances are required to access services. The rural and remote (and very remote) populations face a unique set of challenges that require a unique solution. The health system is failing some communities and urgent changes are needed including greater collaboration to manage the current burden of illness and the need to shift the current health trajectory to secure better long term well-being outcomes for the populations of Western Queensland.

In some pockets of our PHN, severe yet reducible health inequalities have persisted for at least a decade². We need to work together to address the unacceptable health inequality and provide an opportunity to better target health and broader services to those most in need.

Our newly developed health intelligence infrastructure and WQPHN Health Needs Assessment provides a stark insight into disease burden and health status of people living in WQPHN³.



Chronic Conditions

- Premature death from ischemic heart disease and circulatory system disease for people living in the WQPHN is nearly **double** compared to Queensland and Australia
- WQPHN has the **highest incidence rate of cancer** compared to all other PHNs in Australia. Lung cancer is the fourth most common cancer in WQPHN, but the leading cause of cancer mortality
- Our PHN has the **highest proportion of daily smokers**, compared to other PHNs in Queensland
- 53% of Aboriginal and Torres Strait Islander women in WQPHN smoke during pregnancy
- COPD in WQPHN is the third leading cause of death among people aged 45 years and older
- Asthma hospitalisation rates in WQPHN are **3 times higher** when compared to Queensland
- Diabetes Mortality rates and hospitalisation rates in WQPHN are **3 times higher** that of other Queenslanders
- WQPHN have the **highest rate of mental health overnight hospitalisations** for drug and alcohol use in the country
- WQPHN have **double** the number of Alcohol and Other Drug treatment episodes compared to Queensland averages
- WQPHN has the **highest suicide rate nationally**
- WQPHN suicide rate for 15–24 age group is **4.7 times higher** than the Queensland rate for the same age group
- The risk factors that caused the most burden and ill health were tobacco use, high body mass, high alcohol use, physical inactivity and high blood pressure

Hospitalisations

- WQPHN had the **highest aged standardised hospitalisation rates** (2016–2017) compared to other PHNs in Queensland for asthma, COPD, coronary heart disease, diabetes, pneumonia, influenza and road transport injuries

Potentially preventable hospitalisations (PPH)

- WQPHN has the **second highest rate of combined PPHs** compared to all other PHNs
- Diabetes complications accounted for 24.1% of potentially preventable hospitalisations
- Persistent potentially preventable hot spots for chronic preventable conditions include Carpentaria, Mount Isa region, Charleville region, Far South West regions and Balonne

The WQ HCH provides a platform on which to better integrate the Western Queensland health system, break down silos of care, and firmly focus on outcomes for consumers

It provides a framework through which to collaborate, co-design with service providers, clinicians and consumers, and achieve a greater team-based care approach

CASE FOR CHANGE – HEALTH CARE HOME

The WQ HCH provides a platform on which to better integrate the Western Queensland health system, break down silos of care, and firmly focus on outcomes for consumers. It provides a framework through which to collaborate, co-design with service providers, clinicians and consumers, and achieve a greater team-based care approach.

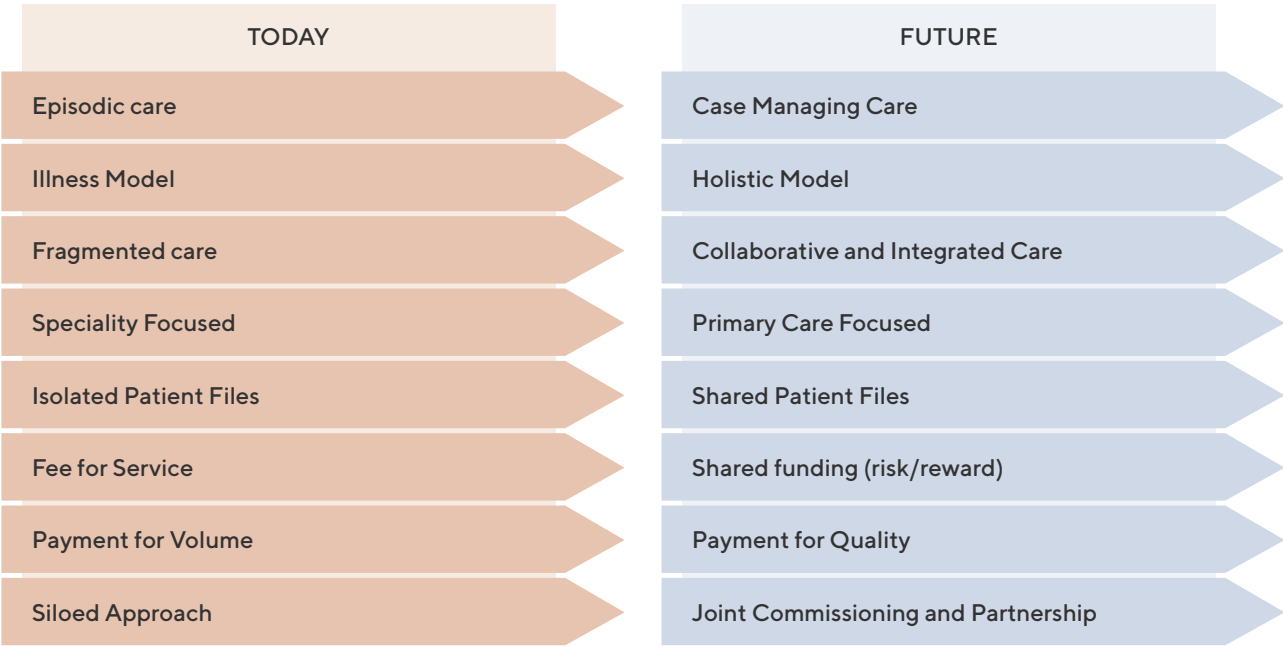
The case for change is urgent and reinforced in our review of national and international literature and also in practice⁴⁻⁸. The increasing burden of chronic disease, ageing population, remoteness and rural decline, fragile service provider networks, high health care costs, poor uptake and utilisation of digital technology, health inequity and poor alignment of funding and incentives, are significant challenges that impact on better health outcomes and more sustainable systems of care.

This evidence supports a paradigm shift to enable primary health care organisations and general practice networks to harmonise patient centred approaches and transform the way health care is delivered. This will require sustained change efforts at all levels of the health system, along with engaged leadership so that administrators, service providers and consumers have confidence in the new direction.

The WQ HCH model of care model presents the strategic direction for development of primary care services in the region, and in particular for strengthening the role of General Practice at the core of our health system. WQPHN's population, geography and disease burden means that well-coordinated, culturally competent, and clinically effective primary health care is of critical importance for ensuring timely access to health services, and improved personal and population health outcomes.



Concepts for the future of primary care



Adapted from Bodenheimer, et al (2014) Annals of Family Medicine Vol 12 Number 2 March/April

The Western Queensland Health Care Home model offers a solution that breaks down existing barriers to improved care, provides practice population risk stratification, an emphasis on integrated care and activation of service frameworks to better configure care around the patient within their local community.





What is the Western Queensland Health Care Home?

2.

A vehicle for change, primary care performance and sustainability

The WQ HCH has been developed in consultation with Western Queensland stakeholders and is based on contemporary evidence based models for achieving better patient and system outcomes^{1,4-8}. It represents a real opportunity for a brave and consistent step-change that would be the most significant new investment that has been made in primary care in the last 20 years.

The HCH model of care is now the model of choice in New Zealand⁶, UK⁷ and USA⁸ as it shows clear impacts to improved and proactive patient centred care. This has been demonstrated through increased patient access to services and better patient experience, improved population health outcomes, reduced hospital and ED presentations, a more satisfied workforce and improved health systems efficiency.

The WQ HCH model of care has been drawn from information developed from the national HCH trials, other PHN models, AGPAL HCH readiness assessment and the New Zealand Pinnacle Health HCH model. WQPHN acknowledges the support of these organisations and willingness to share knowledge and resources to inform the development of our WQ HCH model of care.

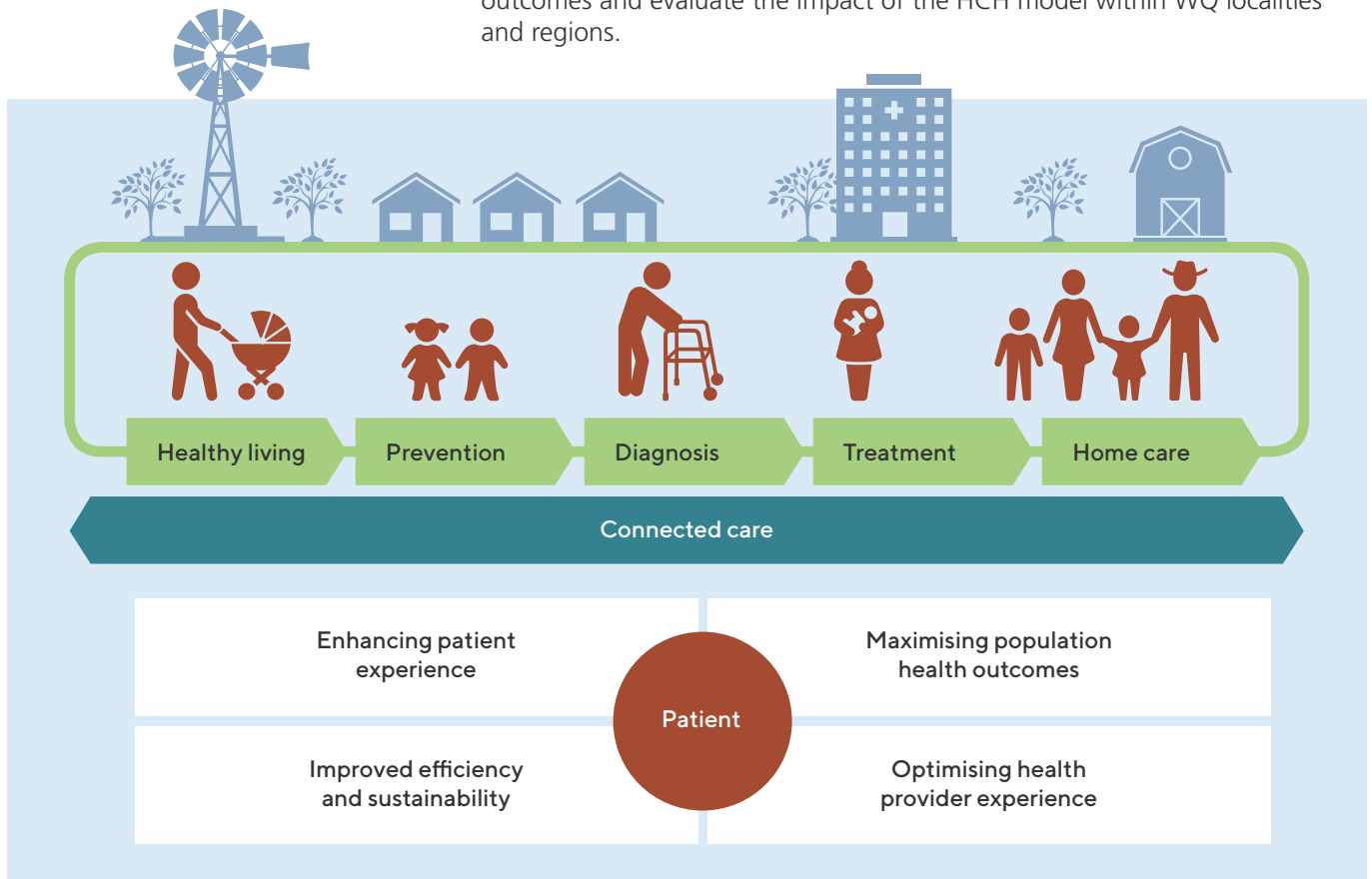
WESTERN QUEENSLAND HEALTH CARE HOME DEFINITION

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.

With an ethos of team-based care, it will support primary care clinicians and activate technology to enable convenient, comprehensive and continuous health and social care with the goal of supporting individuals to obtain their best possible health trajectory.

QUADRUPLE AIMS

The WQ HCH model of care places an emphasis on supporting general practice to operate at scale, with efficiency and greater capacity. We will use a Quadruple Aim approach to the implementation and continuously measure outcomes and evaluate the impact of the HCH model within WQ localities and regions.



Health Care Homes are built around local general practices and Aboriginal and Islander Controlled Community Health Services, providing better coordinated and more flexible care that:

- is team-based
- is GP-led
- is coordinated
- and, places the patient at the centre of care

Health Care Homes make the most of the existing health care workforce and infrastructure, re-orientated to provide a more seamless treatment approach, and better patient outcomes. The Health Care Home team consists of a range of health care providers (such as practice managers, GPs, practice nurses, allied health and nursing professionals, Aboriginal Health Practitioners/Workers, social care support workers and Specialists,) supported to work together with each patient to configure care according to their specific needs. The team encourages patients to participate in and direct their care, enabling the patients to be *"informed partners in their own care"*.

The WQ HCH model of care is built on a systematic approach that moves beyond individual service and provider needs, to creating an ecosystem with a more consumer-based focus using connected networks and platform capabilities. As a result, the consumer feels connected and a key partner with their health care 'home'.

A NEW DIRECTION OF TRAVEL – WQ HCH MODEL OF CARE

Creating a new direction of travel that secures long term sustainability, a greater emphasis on patient centeredness, seamless integration across care settings and a focus on better health outcomes will re-engineer the current state to enable a dynamic, collaborative and cohesive service culture, on which future developments and innovation can flourish.

In adopting the Western Queensland Health Care Home *Model of Care*, the following aims and outcomes are anticipated:

- ▶ **Improved access, responsiveness and support** for patients through activated clinical triage, increased virtual consults, improved and proactive care planning for high need patients
- ▶ **Increased capacity** in general practice teams through re-engineering clinical and business processes and ensuring all staff are working to the top of their clinical scope
- ▶ **Increased practice productivity and business sustainability** through tailored health and financial intelligence and informatics
- ▶ **Expanded core teams** including private, public and Hospital and Health Services, allied health, nursing specialists, clinical pharmacists, social workers and mental health workers, all working as an interdisciplinary team
- ▶ Creating additional practice capacity to better **customise support for people with greatest social, clinical or physical needs**
- ▶ **Proactive** management of whole-of-population health risk factors within the practice population
- ▶ **Reduce demand on hospital care** for preventative and chronic and complex care by ensuring shared care and active referral networks, and linkages to primary and social care in community settings
- ▶ Enabling **patients with more complex conditions to have more control** over their self-care and care choices by providing them with direct access to their own health information, a dedicated health practitioner and digital technologies to support self-management and independence
- ▶ Health and social care provision **integrated around the individual** patient and family needs enabled with a single health record
- ▶ **Maximised use of technology** to support and connect care across inter-disciplinary and multi-sector domains
- ▶ Emphasising **lifestyle risk factor management** approaches into service delivery
- ▶ Creating an efficient, functional and attractive working environment to **develop a sustainable workforce**

With engagement and commitment to the *model of care*, the core elements within WQ HCH of providing primary care across the care continuum can be realised, delivering an improved patient experience and reorientating the system towards integrated primary care that reduces the need for further investment in hospital infrastructure and workforce.

With engagement and commitment to the model of care, the core elements within the HCH concept of providing primary care across the care continuum can be realised



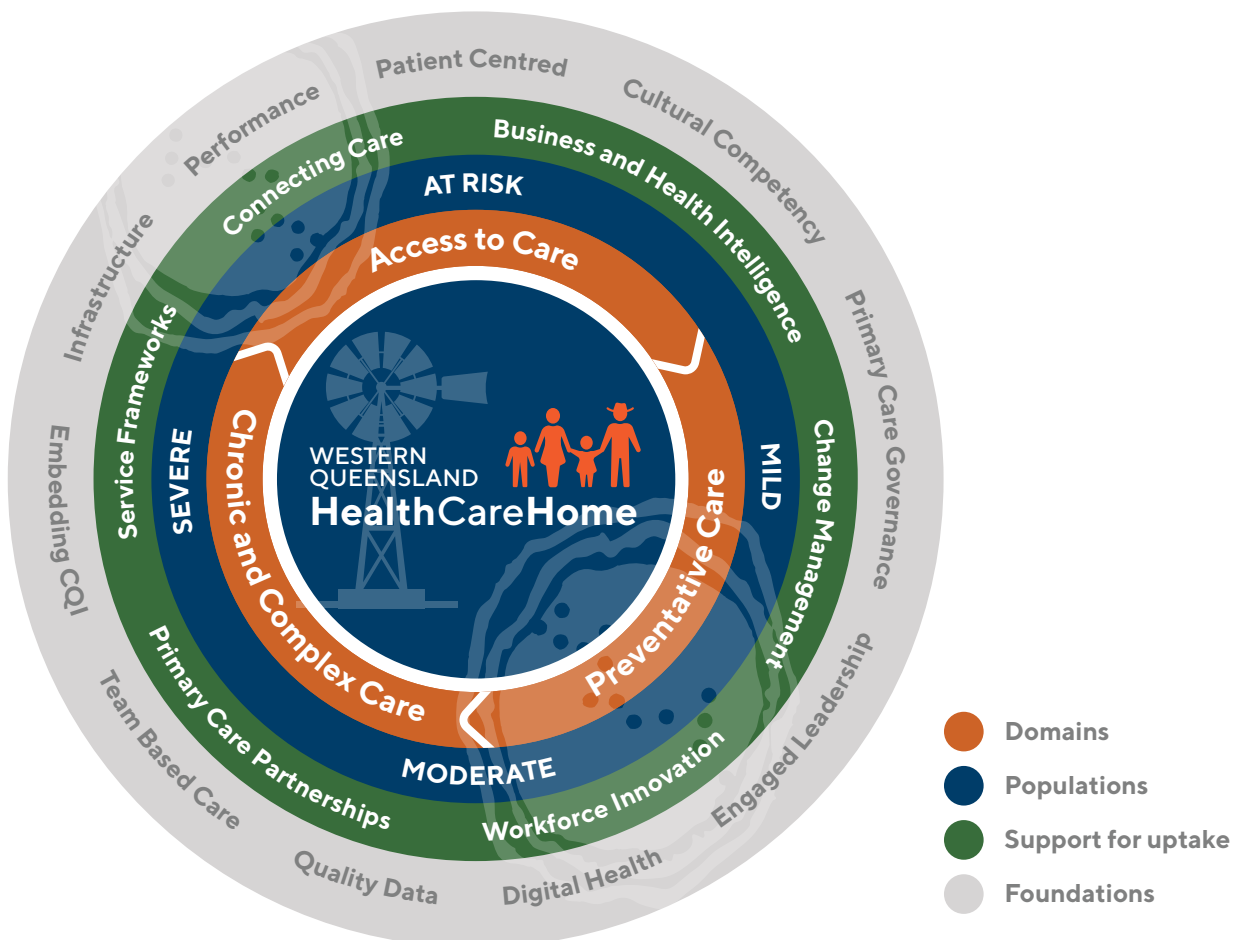
Western Queensland Health Care Home Model of Care Key Features

3.

WQ HCH model of care will support practices to provide the **right care**, in the **right place** at the **right time** by the **right team**. At the heart of the model is a whole-of-system integration approach that is focused on improving patient outcomes and experience.

The WQ HCH model of care is conceptualised within three core domains of care including: Ready Access to Care; Proactive Preventative Care; Engaged Chronic and Complex Care.

Western Queensland Health Care Home model of care



4.

Western Queensland Health Care Home Domains

*WQPHN covers
a vast landscape
(55% of total
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READY ACCESS TO CARE

Whether it be urgent, unplanned or routine care a WQ HCH will prioritise patients and improve access to care through contemporary appointment systems to optimise patient flow and demand.

Core elements of this domain include:

- Managing appointments (call demand) and alternatives to face-to-face
- Daily team meetings to plan and evaluate
- Triage and patient prioritisation
- Identifying high cycling patients
- Optimise and manage patient flow
- Proactive encouragement and support of patient support portals
- Appropriate spaces for clinical practice
- Process efficiencies and clinical workflows
- Continual improvement process
- Visual displays for all staff to monitor practice performance and quality outcomes

PROACTIVE PREVENTATIVE CARE

A WQ HCH will enroll patients and assess their care needs, involve patients in decision-making and identify risk factors for preventative care early.

Core elements of this domain include:

- Registers for priority populations to target early interventions
- Linking patient to lifestyle risk factor management support
- Systematic and efficient scheduling of care – health plan for everyone
- Pre-consult work up by team
- Systematic focus on quality indicators and improvement
- Performance measured
- Patient Experience Survey
- Managing barriers to care
- Health literacy



ENGAGED MANAGEMENT OF COMPLEX AND CHRONIC CARE

A WQ HCH will facilitate integrated health and social care through risk stratification, proactive assessment, care planning and care coordination to support individuals with complex care needs.

Core elements of this domain include:

- Population stratification
- Interdisciplinary care meetings
- Coordinated care management services for high-risk patients
- Care planning undertaken
- Electronic shared care plans
- Expanded care teams attached to general practice
- Named care coordinator for each patient
- Referral pathways and protocols in place
- Follow-up care is completed
- Power BI dashboards
- Self-management and goal setting
- Health coaching/App 'prescribing' to support self-care
- Real time feedback – portal app surveys and Push my Button devices






What are the Benefits of Health Care Homes for patients?

5.

WQ HCH provides proactive patient-centred, coordinated and flexible care with a team of professionals working together to make sure the patient receives the care based on their needs.

For patients with a chronic illness or with complex care needs, WQ HCH 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 experience for the patient
	IMPROVED PERSONALISED CARE – a patient-nominated clinician (usually their GP) leads the care team to 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
	A 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

The health system is failing some communities and urgent changes are needed

6.

Support for uptake from WQPHN

WQPHN is focused on supporting practices to deliver on the quadruple aims of the WQ HCH within a localised Comprehensive Primary Care model

CHANGE MANAGEMENT

WQ Practice Support Teams will work with WQ HCH practices to help prepare and support individuals and teams in undertaking system change. Managing change in care delivery, practice innovation and workforce development is challenging but also pivotal to making practices and systems function better.

Clinical leadership, active clinician involvement and patient engagement are key to supporting the change process. Key objectives include:

- Support for practices to embed continuous quality improvement (CQI) programs into business efficiencies through model for improvement change processes
- Utilise the WQ HCH maturity matrix to support improvement and transformation efforts
- Provide leadership to lead culture change along with strategies to improve quality and spread to sustain change
- Ensuring that WQ HCH transformation efforts have the appropriate time and resources needed to be effective and successful

PRIMARY CARE PARTNERSHIPS

Partnerships between primary care services and organisations are critical to the success of Health Care Homes. Successful partnerships strengthen the capacity of services to broaden their reach, engage more stakeholders, achieve shared objectives and benefit the patient.

WQPHN will work with commissioned service providers and partner organisations to co-design services to support the uptake of the WQ HCH model.



Key objectives include:

- Developing partnerships such as the Maranoa Accord and Nukal Murra Alliance to enable data sharing, knowledge transference, leverage of funds and making the most of shared opportunities
- Developing and implementing the Canterbury Model of Health Pathways with HHS, AICCHSs and general practice partners
- Partnering with Non-Government Organisations to promote and enable place and practice based commissioning of services both for the WQ HCH and the Health Care Neighbourhood
- Encouraging practices to build patient-team partnerships so that patients, carers and family are active in decision-making processes

WQPHN will support practices to provide connected and coordinated care

CONNECTING CARE

A key feature of the WQ HCH is the support provided to enable practices to provide connected and coordinated care. This includes support to improve integrated systems efficiency as well as building linkages with hospitals and providers to provide a more seamless experience for the patient. Key objectives include:

- Building stronger, more engaged teams who are responsive to improving quality and are able to implement and sustain change
- Integrating care around individual patients by supporting pathway design and interfaces between acute and primary care
- Linking patients to a provider and care team through enrolment and risk stratification so all parties work together as partners in care
- Supporting practices to build patient self-management and engagement activities to encourage patients to expand their role in decision-making
- Supporting seamless, integrated care through shared information platforms including My Health Record and patient information exchange through secure, reliable interoperability across providers and care settings

SERVICE FRAMEWORKS

In moving the Western Queensland health system towards more sustainable models of care, changes are required that enable customisation in service design and delivery around the unique needs of rural and remote populations. WQPHN Service Frameworks will be used to guide the local system and implementation of models that best suit patients in their primary care journey. Key objectives include:

- Developing and implementing service frameworks for priority population groups (Child and Family Health, Diabetes and Mental Health) through the Health Care Home program

Embedding service frameworks into the WQ HCH model of care and strengthening primary care partnerships by using CQI and business modelling

- Supporting a practice-based commissioning approach to guide investment, performance targets and outcome measures
- Ensuring cultural competency as a foundation of care capability and quality



BUSINESS AND HEALTH INTELLIGENCE

WQ HCH will support individually tailored practice business modelling through the Practice Performance Analysis (PPA), to provide information to effectively plan for improved service delivery and workforce design based on population and care needs. The data dashboard is also providing customised health intelligence and visibility to practices on progress against the quadruple aims of the program. Key objectives include:

- Support practices to continuously improve business and clinical systems and processes to optimise their business performance
- Support practices to understand the characteristics of their practice population, illness burden, comorbidity index and utilisation patterns
- Assist practices to measure quality improvement, to benchmark for changes and program evaluation purposes
- Optimise the acquisition, aggregation and analysis of health data to understand the patient population needs
- Support meaningful use of the Health Intelligence Portal

WORKFORCE INNOVATION

WQ HCH aims to best configure workforce roles and scope to provide an improved health care provider experience. Working together in a team-based manner means sharing the load as it not only reduces some of the burden on GPs and nurses, it also allows other members of the health care team to utilise the full extent of their health care training and maximise their professional capacity. This collaborative, team-based approach to care has been shown to increase job satisfaction and provide a better work-life balance. Key objectives include:

- Support for workforce planning and business modelling
- Ensuring the practice and care teams have protected time to conduct improvement activities beyond direct patient care
- Supporting funding to build practice workforce capacity
- Develop and implement systems and processes that strengthen clinical networks, build 'communities of practice' and contribute to greater satisfaction and sustainability in the workplace



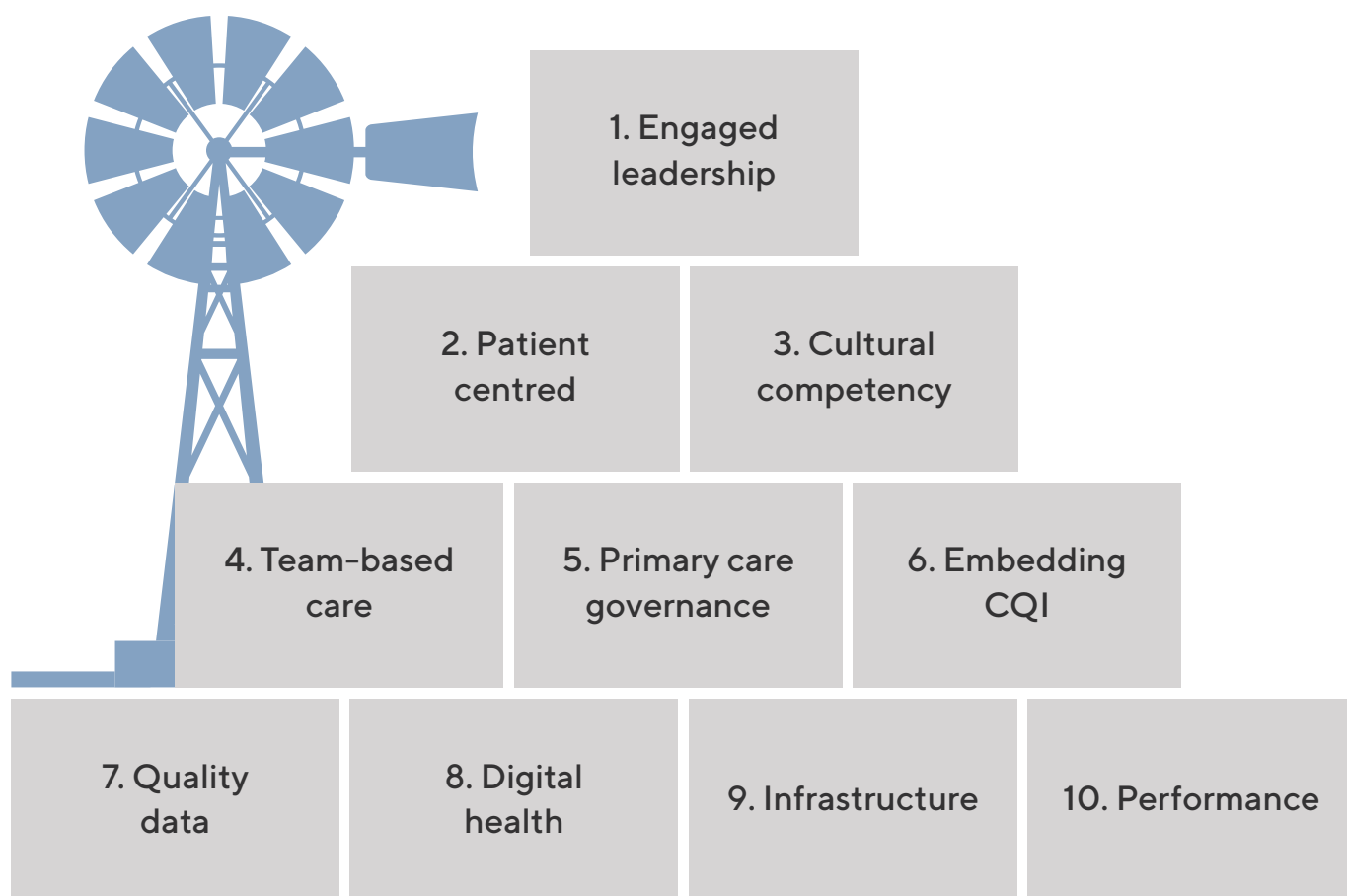
7.

Foundations

In some pockets of our PHN, severe yet reducible health inequalities have persisted for at least a decade

TRANSFORMING PRIMARY CARE

WQPHN is working with general practice and commissioned service providers, partner organisations and expert private and public advisory networks to support the adoption and application of key Foundations that underpin the delivery of comprehensive primary health care in the region. These Foundations are widely supported in national and international literature as fundamental enablers that assist transformation toward future state capability of the WQ HCH model of care.



1. Engaged leadership

In order for WQ HCH practices to be successful there is a need for sustained leadership to activate change practices and redesign and contribute to quality improvement approaches informed by evidence and contemporary outcome measures. Within a WQ HCH there are opportunities for clinical and operational leadership and harnessing this potential will require training and protected time to conduct activities beyond the immediate patient care and administration.

2. Patient centred

Patients take an active role in a WQ HCH model by taking a leading role in setting and meeting their own health care goals. The patient-partnership approach also means the practice has a 'plan' for each patient, depending on their health status and risk factors, and care approaches are customised and tailored to their individual needs and preferences. Managing patients in this way is widely recognised as producing better outcomes, and reducing the likelihood of urgent, ad-hoc treatment. This proactive care can lead to better self-management, patient empowerment, and efficient scheduling of patient appointments.

3. Cultural competency

The Western Queensland health system will benefit from better access to cultural awareness programs and tools to build improved competency and safety in primary health care services for Aboriginal and Torres Strait Islander peoples. An important vehicle for building greater cultural competence and service customisation will be drawing on the cultural knowledge of the Nukal Murra Alliance partners and building on this co-commissioning framework. Cultural competency is a foundational element in quality, access and service equity and is articulated in individual and organisational capabilities and supported by system design, workforce and clinical service domains.

4. Team-based care

Providing support for health professionals to better define roles and distribute tasks within a team-based approach and build proficiency of team members to reflect the skills, abilities, and credentials necessary to achieve individual and practice population outcomes. This allows practices to nurture clinical leadership, ensure staff are working to full scope of practice, expand or creating new roles, link with partners or third party organisations and ultimately improve the work life of health care providers and contribute to more customised and appropriate care.

5. Primary care governance

The WQ HCH model of care will place an emphasis on planning to ensure the patient receives the right care in the right place at the right time by the right team. Planning enables practices to be proactive in their care, which in turn allows more preventative measures to be implemented. Informed through quality patient data, risk stratification and prioritisation, and supported by shared care plans and interoperability, proactive planned and structured care will better connect and coordinate the extended care team around those people with unstable or more complex care needs.

We need to work together to address the unacceptable health inequality and provide an opportunity to better target health and broader services to those most in need

6. Embedding CQI

Through embedding Quality Improvement strategies into daily workflows, builds practice capability to deliver responsive patient centred care, that empowers patients to be informed and engaged in the management of their own health care. This will be achieved by using the Model for Improvements Plan, Do, Study, Act (PDSA) cycle as a structured approach to quality improvement that is considered best practice and is used in Health Care Homes and by RACGP. The PDSA cycle is used to improve processes, implement change and is a simple measurement tool that can be used to monitor the effects of change over time.

7. Quality data

Robust and reliable information regarding the population health status and how these needs are changing over time is essential to support effective place-based commissioning and inform service design and delivery options. Primary Care Commissioning in Western Queensland will be informed by local, regional and national health indicators. Supported through good data governance to guide data acquisition, aggregation and analysis, applied health intelligence that will validate and inform evidence-based approaches and quality improvement.

8. Digital health

Engagement in digital transformation is essential to inform and activate patients, to securely share personalised care plans across teams, and to use population health information to underpin quality improvement and resource allocation. Digital technology can be applied to boost telehealth consults for those that do not need face-to-face consultations and also support patient portals for health tracking, appointments and self-management support. Supporting widespread application of appropriate infrastructure and technology and moving towards more interoperable systems will contribute to improved patient outcomes and system performance and efficiency.

9. Infrastructure

Health infrastructure is a key enabler to supporting more comprehensive and accessible primary health care. Considering how general practice settings can be further developed or reconfigured to optimise efficiency, patient flow, service integration and coordination is a key consideration when activating the WQ HCH model of care. There may also be opportunities to create value for service users and providers through consolidation of health (and potentially social) care services on a single campus as a 'health precinct' or to accommodate the practice and multidisciplinary team (MDT) in a single facility. Creating more multi use clinical space, seamless access to telehealth and virtual clinic's, and reclaiming passive waiting room floor space for active use; have been identified as important infrastructure considerations within a WQ HCH.

10. Performance

For a WQ HCH to be successful it must be underpinned by long term sustainability and a business plan that integrates critical investments including staffing and infrastructure, with patient and population health improvement outcome measures. The WQ HCH transition will be supported by a comprehensive analysis of the practice population



health status against contemporary MBS, DVA and private income considerations. This Practice Performance Analysis (PPA) will be annualised to provide measurable targets linked to population health outcomes and productivity, and also guide staffing ratio's and quality improvement Incentive payments. The Annual PPA will be customised for individual practices and integrate key business and health intelligence to assist the monitoring and evaluation of performance.

The Future of WQ HCH Practice

The WQ HCH Maturity Matrix will be used to take practices on a journey to support integrated care planning

The Western Queensland Health Care Home model of care was developed from international and national evidence, including key learnings from the Pinnacle Health, Health Care Home model of care⁶. The Western Queensland Health Care Home – Maturity Matrix (WQ HCH-MM) is being used to take practices on a journey to support integrated care planning. The WQ HCH-MM was developed from a number of tools that have previously been modified including the New Zealand Health Care Home model of care Requirements, Patient Centered Medical Home and the Australian General Practice Accreditation Limited (AGPAL) Health Care Home Assessment (HCH-A) tool⁹.

Supported through a Continuous Quality Improvement (CQI) architecture, the WQ HCH-MM will help practices understand their current level of “Health Care Home Readiness” and identify opportunities for improvement. The maturity matrix will support self-guided progress and assist change principles when measuring improvement against relevant ‘standards’ and other peer practices.

The WQ HCH-MM will also be supported by a comprehensive Practice Business Plan based on the Practice data and health intelligence that will underpin a quadruple aim approach and transformation.

WQPHN would like to acknowledge Pinnacle Health Executive colleagues John Macaskill Smith and Helen Parker who have shared their ideas, resources and international experiences which have significantly informed the WQ HCH model of care.

The overall strategy and purpose of the WQ HCH model of care is the transition to value-based healthcare that improves the comprehensiveness and sustainability of the WQ HCH, but also directly contributes to a better experience for the patient and the experience of delivering care for healthcare practitioners.

The WQ HCH model of care forward view will demonstrate;

- Strengthening of the relationship between the person and their preferred general practice (and nurse-led primary care in remote communities) through a process of registration, in which both parties commit to an ongoing partnership to achieve better outcomes
- Patients are health literate, and active participants in their health care
- The practice has a better understanding of the illness burden and risk factors to guide clinical decision-making and to enable smooth patient journeys
- The practice has a skilled and multi-disciplinary care team who are working at the top of their scope, which results in a high level of patient, clinician and staff satisfaction
- The practice has nurtured clinical leadership with GP and other members of the multidisciplinary team enabling better planned and coordinated care.
- Extending the general practice workforce to include new roles, such as the mental health nurse, lifestyle health coach, social worker, and the medical assistant
- The practice has quality patient data and this data drives improvement and decision making, clinical prioritisation, patient enrolment, risk stratification and resource allocation
- The practice leverages data sharing opportunities with hospitals and wider social care providers and utilises clinical pathways to optimise management of common conditions
- Greater interoperability and communication between practice systems and healthcare professionals and a more holistic view of the patient's health needs to better inform personalised care plans and patient self-management
- The practice promotes digital technology and a transition toward a shared responsibility between the patient and practitioner for better access, prevention and proactive management of chronic and complex care
- The practice has a sustainable business model which is adaptable to changes in the health system and patient needs
- The practice demonstrates alignment with the Western Queensland's service frameworks for chronic conditions; diabetes; mental health, and alcohol and drug services; and maternal and child health services
- Where feasible, new service configurations that co-locate the practice and MDT within a single 'health precinct' to maximise interdisciplinary collaboration, cross-clinical supervision, and team-based patient-centred approaches

*Western
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Measuring Success

An evaluation framework has been developed to ensure we understand the impact the program is having in each practice and to capture learnings so that improvements can be made to support activities.

The evaluation framework uses the Quadruple Aims to measure the performance and success WQ HCH approach:

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



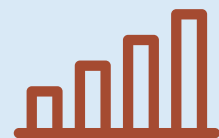
IMPROVED HEALTH OUTCOMES AND POPULATION MANAGEMENT

- 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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Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community.



We pay our respect to them and their cultures and to elders past and present.