



Transforming Primary Care PART I

The Patient Centred Medical Home in Western Sydney



WentWest: Progressing Health Now

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About WentWest, Western Sydney Primary Health Network

Advocating and supporting innovation in primary care through Patient Centred Medical Home Principles and their development

WentWest Strategic Plan, 2016-2019

Since 2002 WentWest has been part of the western Sydney community, delivering support and education to primary care and general practice. WestWest works with key partners on shared health priority areas to improve equity and health outcomes for the region's diverse communities.

From July 1 2015, WentWest took on the role of Western Sydney Primary Health Network (WSPHN). Primary Health Networks (PHN's) are a Federal Government health initiative, established with the key objective of increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

WentWest has structured its PHN role at three (3) levels all of which are actively supported by long term relationships with General Practice and Allied Health Leaders, the Western Sydney Local Health District (WSLHD) and Sydney Children's Hospital Network (SCHN), Consumers and Community organisations, and also national and international experts in primary care.

At the heart of this regional role is improving capacity and capability in primary care and general practice. This role has been articulated in our Strategic Plan 2016-2019 with a focus on supporting practices to deliver on the principles of the Patient Centred Medical Home (PCMH).

WESTERN SYDNEY PRIMARY HEALTH NETWORK: HEALTH SYSTEM IMPROVEMENT OPPORTUNITIES

WHOLE-OF-SYSTEM (MACRO LEVEL)

Enhanced structural integration, system redesign and transformation across the various health services serving the population of western Sydney and covering both private and public health sectors.

CARE/POPULATION GROUPS (MESO LEVEL)

Enhanced service integration for targeted health initiatives including local and national priority focus areas and/or sub-populations that have been identified as a result of PHN planning population needs analysis.

PATIENT-CENTRIC AND COORDINATED CARE (MICRO LEVEL)

Improved delivery of patient-centric and integrated health services to individuals and their carers through a coordinated set of care interventions that ensure the right care is provided in the right place at the right time.

A case for change

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 a strong team working, both within and across organisational boundaries.

Learning to Work as a Team, Primary Care Workforce Commission, UK 2015

Australia's health needs, including and particularly those in areas like western Sydney, continue to change across a diverse socio economic landscape. The case for high performing primary care has never been stronger – as repeatedly articulated in international literature and practice. Various reports including, A Model for Australian General Practice Discussion Paper¹ have looked closely at the challenges and possible solutions that could be led by primary health care

organisations and general practices working in partnership to evolve and transform the way health care is delivered.

Transforming health care will require sustained effort at all levels of the health system but what is clear is that there is significant long term international evidence that the way in which primary care development takes place really does matter.

CONCEPTS FOR THE FUTURE OF PRIMARY CARE

TODAY	FUTURE
Treating Sickness/Episodic	Managing Populations
Fragmented Care	Collaborative Care
Speciality Driven	Primary Care Driven
Isolate Patient Files	Integrated Electronic Records
Utilisation 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

Patient Centred Medical Home 101 (Source: PCPCC - 2015)

¹ <http://www.wentwest.com.au/news-publications/reports/item/551-a-model-for-australian-general-practice-the-australian-person-centred-medical-home>

Why a Patient Centred Medical Home

The principles of a Patient-Centred Medical Home (PCMH) were developed in the USA² in anticipation of the very same challenges we are facing in Australia today.

These principles are universal; they also reflect longstanding principles of quality general practice by colleges in Australia, the UK and elsewhere.³

Many of these elements exist in our health system today. WentWest's role has been to comprehensively strengthen these principles and elements in close partnership with general practice, primary care and the broader health system.

The quality general practice of the future will continue to see its primary purpose as the provision of general practitioner led, patient centred, continuing, comprehensive, coordinated whole person care to individuals and families in their communities

A quality general practice of the future (Source: RACGP – 2012)

FEATURE	DEFINITION
Patient-Centred	Supports patients and families to manage and organise their care and participate as fully informed partners in health system transformation at the practice, community, and policy levels.
Comprehensive	A team of care providers is wholly accountable for patient's physical and mental health care needs - includes prevention and wellness, acute care, chronic care.
Coordinated	Ensures care is organised across all elements of broader health care system, including specialty care, hospitals, home health care, community services and supports, and public health.
Accessible	Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations.
Committed to quality and safety	Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions.

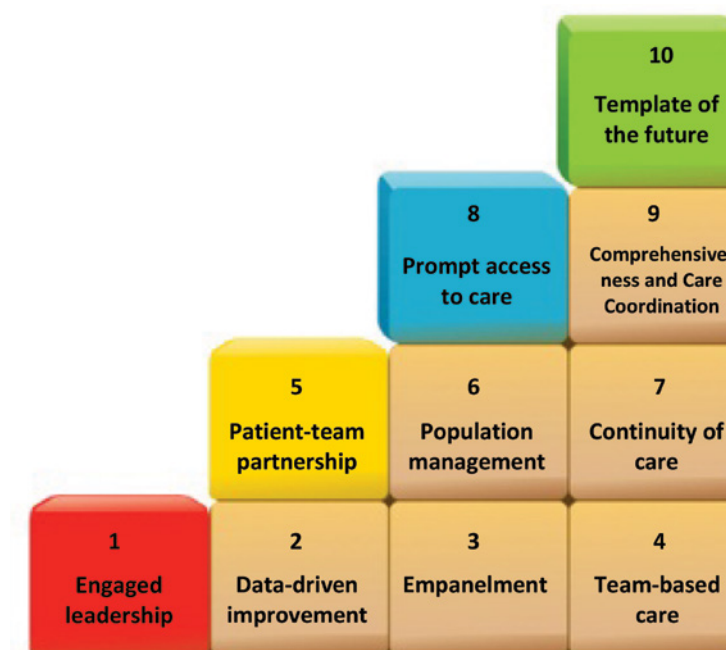
(Source: PCPCC – 2015)

² Relates to diagram - Framework for PCMH (Source: PCPCC – 2015)

³ Relates to quote from - RACGP - 2012

The 10 Building Blocks

The '10 building blocks of high-performing health care' is a conceptual model described by Bodenheimer et al. It identifies and describes the essential elements of primary care that facilitate exemplary performance. WentWest – working closely with its General Practice Leaders and leveraging off international learnings, has used this as a framework to plan and implement its approach to PCMH.



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Block 1: Engaged leadership – creating a practice-wide vision with concrete goals and objectives. GP Leaders are fully engaged in the process of change.

Block 2: Data-driven improvement – using computer-based technology, general practice data systems track clinical, operational and patients' experience metrics to monitor progress towards achievement of goals and objectives.

Block 3: Empanelment [patient registration] – linking each patient to a general practice care team and primary care clinician to strengthen relationships and enable continuity of care.

Block 4: Team-based care – general practices organise teams to share responsibility for the health of their patients according to their needs.

Block 5: The patient-team partnership – recognition of the expertise that the patient brings, as well as the evidence base and clinical judgment of the clinician and team. Patients are engaged in shared decision-making.

Block 6: Population management – general practices are encouraged to understand the needs of their whole patient base. This assists in ensuring the care team can identify opportunities for health improvement on an ongoing basis.

Block 7: Continuity of care – general practices taking continuous responsibility for their patients. This is associated with improved preventative and chronic care, greater patient and clinician experience, and lower costs.

Block 8: Prompt access to care – general practices measure and control demands on their time and services, and build capacity while also enhancing teams, and ensure patients receive care when it's needed.

Block 9: Comprehensiveness and care coordination – when patient needs go beyond the general practice team's level of comprehensiveness, care coordination is required with other members of the "medical neighbourhood".

Block 10: Template of the future – requires payment reform that does not reward primary care simply for in-person clinician visits. Moving from "volume to value" needs to be properly defined and implemented.

Transforming Primary Care

WentWest as the WSPHN works at varying levels across the western Sydney general practice landscape and invests at numerous levels. This work has required a long term and ongoing investment by GPs and their practices, in partnership with WentWest. The intensity of effort required to transform care cannot be underestimated.

BUILDING BLOCK 2: DATA-DRIVEN IMPROVEMENT

**Riverstone Family Medical Practice,
RACGP 2014 General Practice of the Year**

Paul Grundy MD, referred to as the Godfather of the Medical Home, often talks about the PCMH being a "home for the data". Riverstone Family Medical Practice and its principals Drs Sharon Muir and Michelle Crockett have made this a virtue using their practice management software and the PEN Clinical Audit Tool to fully understand and continuously plan the needs of their patient population. The practice team "huddle" around how they can most effectively respond to what the data tells them. They have recently extended capability by installing LinkedEHR a shared care planning tool that makes vital patient information available to team members not physically based at the practice.

BUILDING BLOCK 4: TEAM-BASED CARE

Mt Druitt Medical Centre

Dr Kean-Seng Lim, RACGP 2015 General Practitioner of the Year, and the Mt Druitt Medical Practitioners Association have led the integration of a clinical pharmacist into their general practice as team member. They actively participate in some of the most fundamental preventative interventions; identifying target patients, reviewing medication regimes, providing patient advice and options education, and reporting outcomes. Early signs are demonstrating the effectiveness enhancing the general practice team with these skills, something that is being formally evaluated by University of Technology, Sydney.

BUILDING BLOCK 9: COMPREHENSIVENESS AND CARE COORDINATION

Hills Family General Practice

Ensuring the general practice is integrated into a medical neighbourhood requires practices to have many of the Building Blocks in place. The Hills Family General Practice has worked tirelessly to achieve this through the leadership of Dr Walid Jammal and Mrs Madeline Jammal. Amongst other things the practice has joined the Western Sydney Integrated Care Program which has implemented a number of methods to better connect primary and secondary care such as

Care Facilitation, HealthOne, Shared Care Planning, Rapid Access, and Specialist Case Conferencing, to keep a track of patients and their needs in what is sometimes a fragmented health system. Working with the Agency for Clinical Innovation (ACI), the Hills Family Practice has also been at the forefront of the use of Patient Reported Measures to understand and evaluate the patient experience and outcomes.

SUPPORTING AND ENHANCING GENERAL PRACTICE SUPPORT IN WESTERN SYDNEY

325*	Practure Support, HealthPathways and continuing education
186	eHealth "enabled"
120	Data cleansing, extraction, eHealth support and quality improvement
61	Integrated Care Demonstrator Project services including LinkedEHR capability
30	PCMH and GP Leaders group
8	PCMH Transformation Pilot Practices (TPP)**

*Representing the total number of general practices in the western Sydney PHN region. **1. Hills Family General Practice 2. Alpha Medical Centre 3. Mt Druitt Medical Centre 4. Riverstone Family Medical Centre 5. Bridgeview Medical Practice 6. Twinkle Medical Centre 7. Winston Hills Medical Centre 8. Richmond Road Family Practice



**Better Health
Together**

Western Sydney Integrated Care Program

A long term partnership approach to integrating care for Western Sydney.

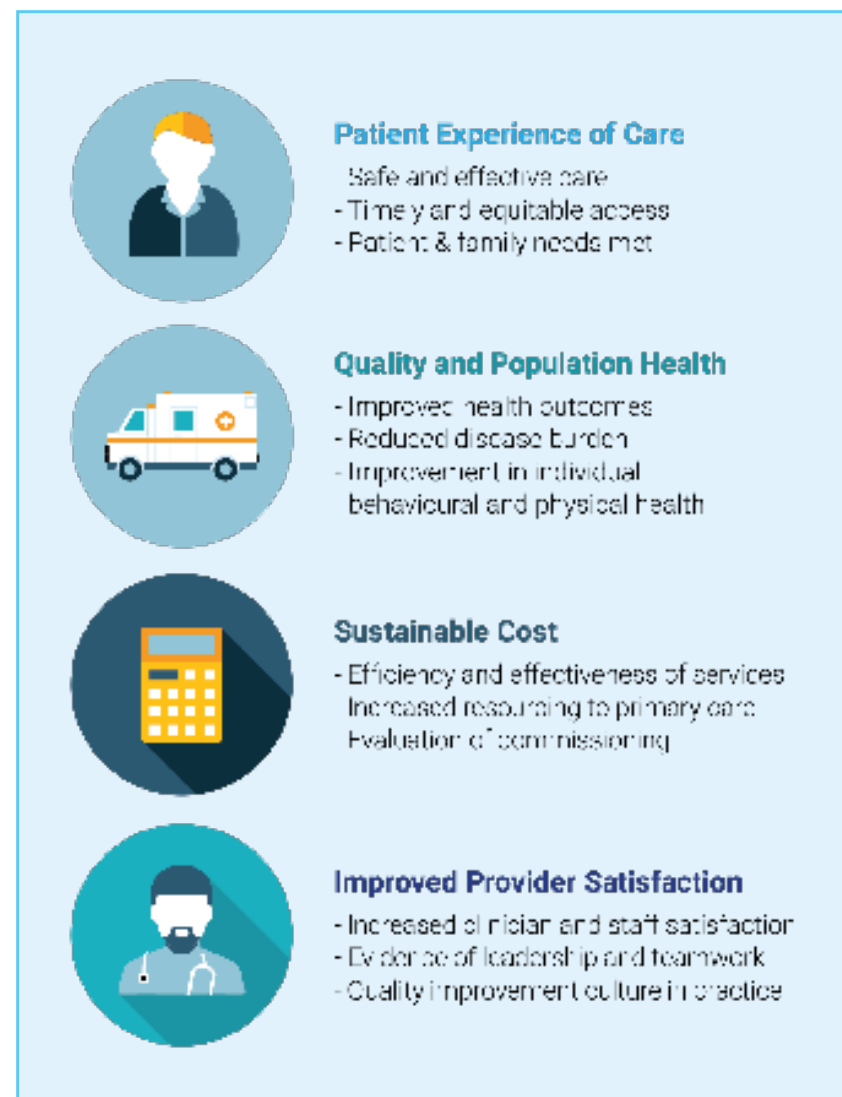
Practice Manager, Denise Whitehead and the team from Twinkle Medical Centre are among eight practices across western Sydney undertaking the PCMH transformation journey.

Measuring Outcomes

Measuring outcomes from the investment in PCMH investments being made by WentWest and general practices in western Sydney is an important consideration. This needs to consider the impact of both WentWest's traditional approach to supporting general practice and also its responsibility as a PHN being broader than general

practice alone. As part of its Strategic Plan, WentWest has adopted the Quadruple Aim framework founded in the work by the Institute for Healthcare Improvement, Triple Aim⁵, and complemented by Bodenheimer and Sinsky⁶. This framework is being used to conceptualise outcomes.

DEFINING THE QUADRUPLE AIM



⁵ IHI Triple Aim Initiative: <http://www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx>

⁶ From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider: <http://www.annfamned.org/content/12/6/573.full>

Specifically in relation to PCMH transformation and in the partnership with the TPP, a staff self-assessment of their overall achievement against the 10 Building Blocks of High Performing Primary Care (Bodenheimer et. al. 2014) has been introduced. The PCMH-A (Assessment) was originally developed by the MacColl Centre for Health Care Innovation at the Group Research Institute and Qualis Health for the Safety Net Medical Home Initiative in the United States. It has been adapted by WentWest to reflect the Australian context and implemented on a quarterly basis in each practice across practice teams.

More broadly and in addition to this internally driven evaluation, WentWest utilises the expertise of the Partnership for Education, Evaluation and Research (PEER) to both assess evaluation methodologies and participate in primary care research that can inform how investments can be most effective. As part of this partnership Western Sydney University is conducting an ongoing evaluation of PCMH in western Sydney.



WHAT AND WHY ARE WE MEASURING PRACTICES PROGRESS TOWARDS PCMH TRANSITION?

The effectiveness of general practice is something well documented in literature, but how can individual practices show that their care is making a difference?

Numerous PHN activities to support practices, starting with data quality and completeness, are a foundation. This investment allows us to identify opportunities for improvement to administrative processes and cleanse data to ensure practices are working with data that can be relied upon.

Together with the TPP, WentWest has now developed a dashboard of clinical metrics based upon Australian Clinical Best Practice measures relating to chronic disease. These consist of such things as Blood Pressure, HbA1c and initiation of ACE inhibitors of Beta Blockers and will focus quality improvement efforts even further. These are supplemented by population health, patient experience and outcome measures.

Further, and in collaboration with NSW Health and the use of shared care planning (LinkedEHR) and mobile applications, it is hoped that such patient centred data will begin to inform a full continuum of care based around a PCMH, the "medical neighbourhood".



Western Sydney GPs with representatives from Kaiser Permanente Southern California, 2015. Since 2014, WentWest has been working with leading PCMH experts worldwide on the establishment of the model within the Australian context.



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We acknowledge Aboriginal people as the traditional owners of the land. We also pay respect to our Aboriginal Elders past and present, and extend that respect to include Aboriginal people for today.