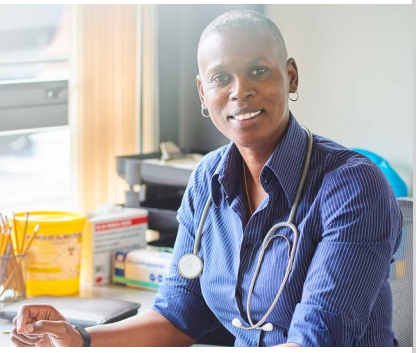
HEALTH CARE HOMES NEWSLETTER

Supporting Primary Care transformation to Health Care Homes

ISSUE
SEPTEMBER 2018

WHAT'S IN THIS ISSUE?



Norma's Story

My mother, Norma joined the Health Care Homes program in May 2018. In the past 2 and a half months of being on the program, we have noticed significant health improvements. As her carer I feel a sense of peace and comfort that someone is supporting us with her chronic and complex conditions.

In her prime years, my mother was a chief mechanical engineer in Port Sudan. In 1995, we migrated to Australia and she tried to renew her degree but was unable to do so due to an undetected 10 year old benign brain tumour. She was forced to work as a factory processor worker to make ends meet and suffered from multiple conditions caused by the brain tumour. These included depression, hypertension, multiple facial paralysis, chronic migraines and memory loss. With inconsistent doctors, an undetected tumour and being over medicated her health quickly deteriorated.

At the age of 64, she now lives with multiple other chronic and complex conditions including COPD, diabetes type 2, IBS, arrhythmia and restless leg syndrome. Caring for my mother was difficult and at times I struggled to assist her with her various conditions and medications.

In beginning of 2018, I recommended that she start to see another local doctor. The doctor took the time to assess her conditions and in May suggested joining the Health Care Homes program. He clearly communicated to her about the Care Team and how they work together to help her manage her conditions. At the start of the program, my mother had two long appointments with the Practice Nurse who put together a GP Management Plan (and Team Care Agreement), set goals, performed spirometry, updated her immunisations and taught her to correctly use her multiple inhaler devices. She always felt looked after as the doctor reviewed all the plans and tests that had been done and continued to encourage my mum to meet her health goals. They also gave her clear action plans when she has any COPD exacerbations, which has been extremely helpful over the winter period.

As part of the Health Care Homes program, a pharmacist visited our home and conducted a medication review. This was very beneficial for my mother as they helped amend her medications and further educated her about her conditions. For example, the pharmacist taught my mother how to use her blood glucose monitor and to manage her levels.

My mother was pleasantly surprised the other day when her Care Coordinator (Medical Assistant) contacted her to see if she needed medication scripts. This was perfect timing as she had just run out of her medication and needed a doctor's appointment. Instead, the Care Coordinator took down her request and prepared her scripts without her having to see the doctor. She was extremely grateful that someone was helping her coordinate her care and was looking after her even when she forgets. My mother said to me "even the receptionist is caring for me and looking after my health".

Because of the Health Care Homes trial, we no longer feel alone managing her conditions but supported by a team.

Consent was received from the Patient and her Carer prior to sharing. Nepean Blue Mountain PHN Practice Facilitator – Maha Sedhom

Practice Facilitation Corner

Population Management

The rapid changes of the last five to seven years in policy-level decision making, potential changes in payment structures, potential introductions to the Quality PIP can lead to a shift in focus from care provided and being paid for at an individual level, to managing and paying for health care services for a discrete or defined population – an approach known as population management (or population medicine or practice-based population health).

The term population management should be clearly distinguished from population health (which focuses on the broader determinants of health). It is the design, delivery, coordination, and payment of high-quality health care services to manage the Quadruple Aim for a population using the best resources we have available within the health care system. Much of the efforts today such as the risk stratification methods, patient registries, Patient Centred Medical Home, and other models of team-based care are all part of a comprehensive approach to population medicine.

The enablers to Population Management call for new partnerships among providers and payers, integrated data support, redesigned IT structures, a focus on non-traditional health care workforce, new care management models. Another consideration that is becoming more and more apparent is the possible introduction of blended payments which may include fee-for-service, bundled payments and capitation. While the concept of population management is relatively new to Australia. The issues being addressed internationally in other developed countries, such as fee for service funding, duplication and waste, and resistance to change resonate with the Australian health system, and this presents an opportunity to bring what has worked overseas into the development of practice-based population health management.

So, what are the key principles to Population Management and are the Health Care Home practices and health services embedding these principles?

Principle 1: Population-based care

Population-based care focuses on the health of an entire patient population by systematically assessing, tracking, and managing the group's health conditions and treatment response across the entire target group, rather than just responding to the patients who actively seek care. Practices or health services need staff assigned to actively and systematically assess, track, and manage the group's health conditions and treatment responses.

Principle 2: Data-driven care

Practices or health services engaged in population management are continuously engaged in collecting, organising, sharing, and applying objective, valid clinical data to guide treatment. Practices or health services can learn more about data driven improvement in the foundational online training module.

Principle 3: Evidence-based care

Evidence-based care is a core principle of Population Management. It means using the best available evidence to guide treatment decisions and delivery of care.

Principle 4: Care management — Putting Population Management into action

Practices or health services need to engage in care management to be successful with population management. Care management functions can be taken on by different members of the practice or health services team (for example this role could be assigned to a Practice Nurse or Aboriginal Health Worker or Social Worker). The initial consultation with a Care Manager would include a health risk assessment followed by patient education about their conditions, how to manage them, and recommended best treatments.

Are there examples that Practice Facilitators can share (via the Forum) of how practices and health services are working towards Population Management?

Sources:

Dawda,P. Bundled payments: Their role in Australian primary health care. Australian Healthcare and Hospital Association. 2015

Green, L., Chang, H., Markovitz, A & Paustain, M (2017) The Reduction in ED and Hospital Admissions in Medical Home Practices Is Specific to Primary Care–Sensitive Chronic Conditions. Health Research and Educational https://www.pubfacts.com/detail/28255992/The-Reduction-in-ED-and-Hospital-Admissions-in-Medical-Home-Practices-Is-Specific-to-PrimaryCare-Se

Transformation Tips

Force Field Analysis

Force Field Analysis (Decision Making Tool)

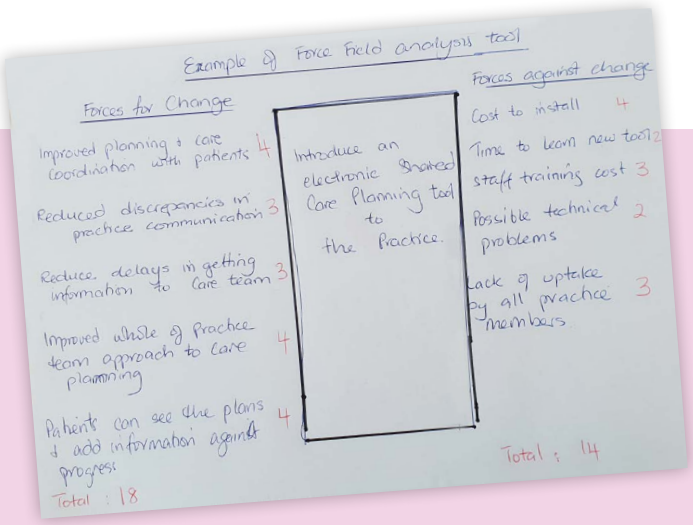
Analysing the Pressures For and Against Change

What is Force Field Analysis?

When you're making difficult or challenging decisions, it pays to use an effective, structured decision-making technique that will improve the quality of your decisions and increase your chances of success. Force Field Analysis is one such technique.

About the Tool

Force Field Analysis was created by Kurt Lewin in the 1940s. Lewin originally used it in his work as a social psychologist. Today, however, it is also used in business, for making and communicating go/no-go decisions.



Example of Force Field Analysis Tool

How to Use the Tool

Step 1: Describe Your Plan or Proposal for Change

Define your goal or vision for change and write it down in a box in the middle of the page.

Step 2: Identify Forces for Change

Think about the kinds of forces that are driving change. These can be internal and external.

Step 3: Identify Forces Against Change

Now brainstorm the forces that resist or are unfavourable to change.

Step 4: Assign Scores

Next, score each force, from, say, one (weak) to five (strong), according to the degree of influence each one has on the plan, and then add up the scores for each side (for and against).

Step 5: Analyse and Apply

Now that you've done your Force Field Analysis, you can use it in two ways:

1. To decide whether to move forward with the decision or change.
2. To think about which supportive forces you can strengthen and which opposing or resisting forces you can weaken, and how to make the change more successful.

An example force field analysis worksheet can be found on the Forum site.

Check out the Youtube video:

https://www.youtube.com/watch?v=Rwpp53uq1o8

Quality Improvement Challenge

Challenge of the month

WINNING TEAM

Hawkesbury Family Practice HCH Care Team (Practice Nurse, Owner, Practice Manager) working collaboratively with the PHN staff to help empanel diabetes patients and to manage the continuity of care process. The practice has used the Model of Improvement and PDSA templates to set SMART goals to test out their ideas with HCH enrolled patients, their doctor and neighbourhood providers. Once the change idea has been studied, the practice hopes to carry this forward to the whole practice and the other GPs.

Their goal was to improve the pro-active care for diabetes HCH patients (12) within 3 month.

- First idea - Engage the team in re-assigning tasks usually performed by the GP to the practice nurse including the Diabetes Annual Cycle of Care and patient education.
- Second idea - Improve accuracy of their clinic database including their diabetes register and building a proactive system for reminders/recalls to enhance care coordination and access.
- Third idea - Proactively coordinating care between neighbourhood providers and making sure the doctor receives health summaries from these providers.

The practices biggest room for improvement was their first idea and creating a care team that can communicate regularly and better coordinate the care for HCH patients. The second idea tested was the most beneficial as there are 8 GPs at their practice and only one participating in the HCH program.

From the left:
Leanne McConville, Practice Manager,
Eng Foley, Owner
Anthea Wallace, Practice Nurse and
Georgina McHugh, NBMPHN Practice Support Officer – Clinical Services Development.

Health Care Homes update

3583 patients enrolled across **174** HEALTH CARE HOMES

as at 30 August 2018

Contact us

For further information or to speak to your National Practice Facilitator contact our team:

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