HEALTH CARE HOMES

DAVID MENZIES,
MANAGER OF CHRONIC DISEASE PROGRAMS
SEMPHN
SEMPHN at a glance

One of 31 federally funded Primary Health Networks (PHNs) focussed on improving primary care in South Eastern Melbourne

Key objectives:
1. Increase efficiency and effectiveness of medical services for patients particularly those at risk of poor health outcomes
2. Improve coordination of care -> right care, right place, right time

Priority areas:
• Mental health
• Aboriginal and Torres Strait Islander health
• Population health
• Health workforce
• Digital Health
• Aged care
Our catchment

1.5m residents
2000 GPs
479 general practices
341 pharmacies
Health Care Homes at a glance

- Australian Government initiative announced in 2016 aimed at improving care for patients with chronic and complex conditions.

- A Health Care Home (HCH) is a medical practice that provides those with chronic conditions with ‘wrap around’ care, with a local health care team acting as the home base for the patient’s co-ordination, management and ongoing support.

- Practices receive an annual fee for caring for each patient (rather than being billed for individual services). The amount depends on each patient’s complexity.

- SEMPHN is one of 10 PHNs to take part in Health Care Home Stage One implementation.
Where we are today:

- 26 practices
- 21 practices have enrolled 252 patients
Good mix and geographic spread
Strengthening the inner circle

As care needs change, the Care Team gains additional members. It is not a different team.
Unique role in building the HCH bridge

DoH
State Health Depts
Hospitals
Allied Health

GPs
Patients
Carers
Practice nurses
Pharmacy

Medical Specialists
Practice managers
HOW WE APPROACHED CHANGE: THE FOUR P's
1. Planning (design thinking)

- Who are the users?
- What do they need?
- Which problems do users want help solving?
2. Processes

• Imperative to get practice systems and processes right before starting

• Practicalities first, practice change second

“We encourage practices to start slowly, build on successes, and make changes in line with research and guidelines... developing workflows with support, input and expertise of the PFs to encourage, talk through and then trial with patients.”
3. People - experienced bridge builders

- Eight months of prep work
- Team of four Practice Facilitators (PFs) recruited with 40+ years combined practice experience
- Daily and weekly contact with practices
4. Practice Centred approach

• Practices feeling overwhelmed

• Difficulty adapting concepts to practice

• Reluctance to share innovations

• Fear of losing Dollars
Success Story

Carrum Downs Medical Centre

• Strong resistance at first
• Discussion, lots of listening, encouraged to try – realisation Models of Care were already familiar
• Population health approach
• Direct mail out to people with diabetes
• Now SMAs, walking groups, lifestyle modification support
Where to from here?

• Stage One of Health Care Home implementation will run until 30 June 2019.

• Further rollout will be decided following evaluation of Stage One.
Fundamental: The Transition from Volume to Value

- Variable
- Individual patient focus
- Issue-focused
- Volume-based
- Silo work
- Fee for service
- Uncoordinated
- Facility based
- Team-based care
- Safe
- Improved quality
- Engaged physicians
- Transparency
- Innovation
- Care coordination
- Team accountability
- Standardization
- Cost containment
- Patient-centric
- Reactive
- Information technology

One

Carolina HealthCare System
Looking to the future

The reforms promise a new future in chronic disease care. “This is exciting and we feel like we are on the cusp of something big”.

Dr Walid Jamal
Hills Family General Practice Western Sydney