phn WESTERN QUEENSLAND

An Australian Government Initiative

What is the **Western Queensland Health Care Home**?

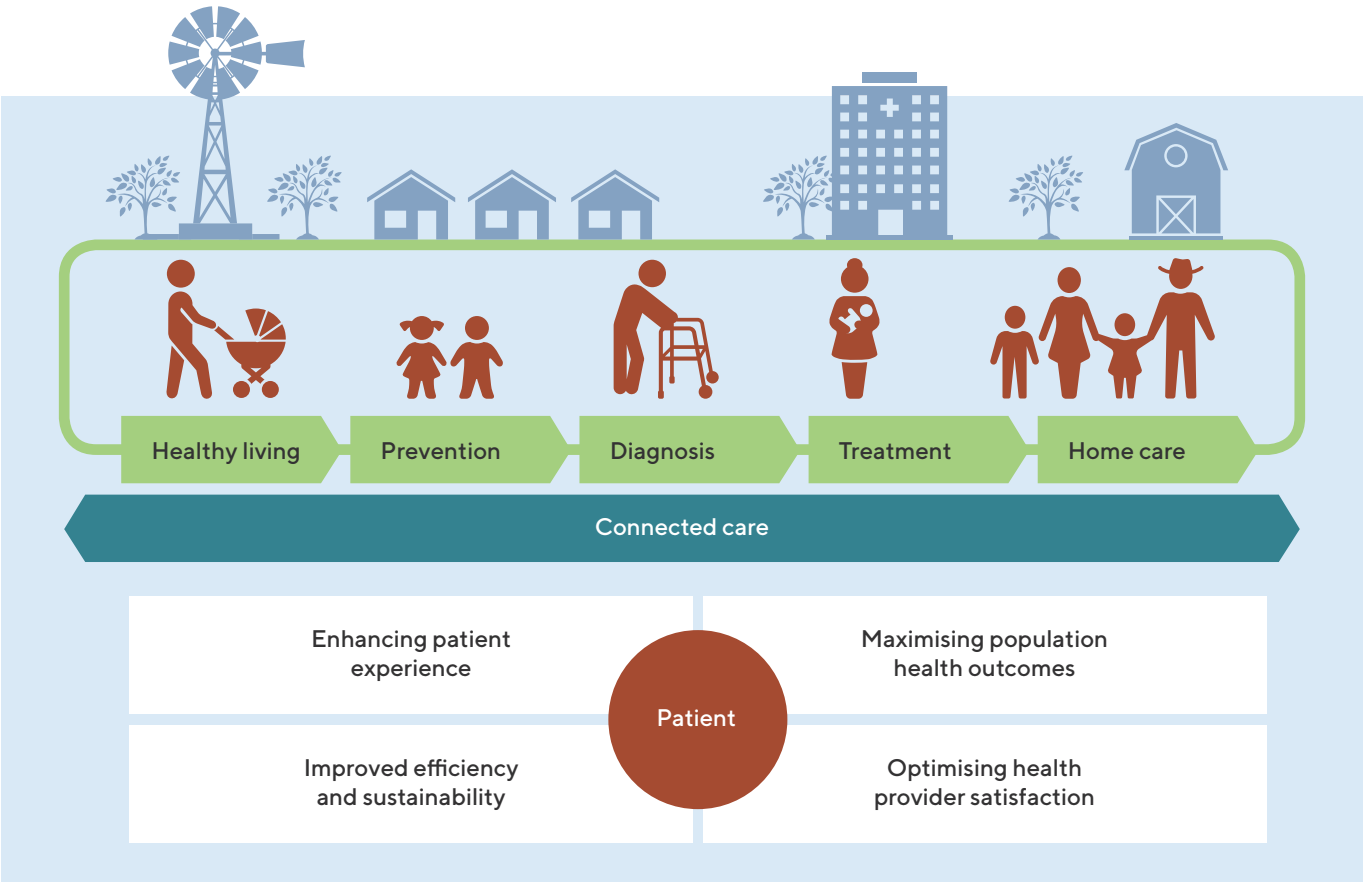
A vehicle for change, primary care performance and sustainability

WQ HCH 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.

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 implement the model of care as well as continuously measure outcomes and evaluate the impact of the HCH model within WQ localities and regions.



Western Queensland Health Care Homes (WQ HCH) is an evidenced-based model of care aimed at improving population outcomes, a better patient experience, a more satisfied and sustainable workforce, and greater efficiency. Health Care Homes are existing general practices or Aboriginal Controlled Community Health Organisation (AICCHO), 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 makes the most of the existing health care workforce and infrastructure, re-orientated to provide a more seamless treatment approach, and better patient outcomes for patients with two or more chronic conditions. The Health Care Homes team consists of a range of health care providers (such as GPs, specialists, practice nurses, allied health professionals, practice managers and Aboriginal Health Practitioners/ Workers) all working together with each patient to shape their 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".

Health Care Homes ensure that all relevant information about the patient and his or her treatment is shared amongst the whole team, including the patient and families / carers, so that everyone involved in caring for the patient has access to all the necessary information, thereby reducing delays and duplications in treatment.

WHY CHANGE?

The case for change has never been stronger - as continually repeated in international literature. Nationally, Commonwealth and State government policy points to a new landscape for primary care that is based on team based coordinated and connected care that is underpinned by principles of patient-centred care.

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

The WQ HCH provides a platform 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 practice.

The 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.

Concepts for the future of primary care

CARE CURRENTLY	CARE WITHIN A HEALTH CARE HOME
My patients are those who make appointments to see me	Our patients are those who are registered in our Health Care Home
Patients' chief complaints or reasons for visit determines care	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet health needs, with or without visits
Care varies dependent on memory and scheduled time of doctor	Health care providers have access to evidence-based guidelines to build the right care plan
Patients are responsible for coordinating their own care	A prepared team of professionals supports the coordination of a patient's care
Patients are passive recipients of care	Patients play an active role in making decisions about their care and are empowered to better manage their conditions
I know I deliver high quality care because I'm well trained	We measure our quality and make changes to improve it
It's up to the patient to tell us what happened to them	We track tests and consultations, and follow-up after visits to other services (e.g. ED visits or specialist appointments)
Clinic operations centre on meeting the doctor's need	An interdisciplinary team work at the top of their professional capacity to serve patients

Source: Adapted with permission from F. Daniel Duffy, MD, MACP, Senior Associate, Dean for Academics, University of Oklahoma School of Community Medicine.

At a practice level HCHs provide a systematic approach to building capacity and capability in a General Practice and AICCHO settings by developing sustainable business models and improved systems of care. It recognises that each practice is at a different stage of the journey and therefore is flexible and not a one size fits all model. It helps practices track progress towards practice change and improvement at regular intervals enabling the team to re-imagine care delivery and how they interact with patients.

Practice leaders are fundamental to facilitating the transformation by charting the course for change and supporting and sustaining change efforts. This includes providing the necessary time and resources, removing barriers and providing continuous inspiration and motivation for staff. Leaders will need to guide staff by providing protocols for risk stratification of patients, address pushback as care team members' roles change, find ways to protect time for care coordination, and encourage a quality improvement agenda. Practices enrolled in the WQ HCH will have support from WQ HCH Primary Health Care Coordinators who will help them on their transformation journey.