



# Western Queensland Health Care Home Program Logic

The Western Queensland Health Care Home (WQ HCH) program logic design includes the two logic models including the foundation pillars and the implementation phase. The aim was for the logic models to support good program design and evaluation along with helping develop an understanding of what is expected and what must happen to achieve that.

The program logic outcomes measures highlight the importance of the quadruple aims of the model centred on improved health outcomes and practice population health, improved patient and provider experience and improved efficiency and sustainability. Given the focus on the new national PHN Performance Framework outcomes, the program logic also reflects the outcomes themes in the national PHN Framework.

In developing the logic model, the elements that differentiate the model from what should just be considered good primary care are described in the activities and outputs to highlight how this will be achieved in the model. Key activities described in the logic model are collected under the ten WQ HCH foundation pillars including:

- Patient centred
- Primary care governance
- Digital health
- Team based care
- Infrastructure

- Cultural competency
- Engaged leadership
- Quality data
- Embedding CQI
- Performance

The logic model describes the inputs, activities through to outputs and ultimately outcomes. Outcomes are grouped under the Quadruple Aim categories of:

- Health outcomes and practice population health
- Patient experience
- Provider experience
- Efficiency and sustainability

## Program logic – Foundation Pillars

Appetite for new models

Appetite for efficiency within a

Program objectives		clinical and structural redesign through a Western Queensland Health Care Home <i>Mo</i> efficiency and sustainability.	odel o	of Care to improve health outcomes and practice population health, qua	lity patient and provider experience and	
Theory of change	To apply a	systematic and structured continuous quality improvement methodology to support a	adopt	ion across 10 foundations that underpin patient-centred, integrated co	mprehensive primary health care in Western Q	
Inputs		Activities		Outputs	Outcomes	
Funds investment in change		Patient Centred • Patient/family/caregivers are engaged in care journey and have access to	<b> </b>	Increased access, utilisation and uptake of lifestyle programs,		
Vorkforce Existing staff Trainees		proactive seamless services that are coordinated around patient needs  Cultural Competency		preventative health resources and patient self-management		
Evidence - Existing international and national		Cultural training, patient feedback mechanisms and barriers to care are managed	<b>→</b>	PREMs and PROMs used to make improvements including workforce changes to address cultural needs	Health Outcomes & Practice Pop Heal • Informed identification, prevention a management of population health fact	
evidence on PC and HCH Australian Policy	CMH	Primary Care Governance • Systematic processes are established to provide proactive comprehensive care directed to patient need	-	<ul> <li>Proactive assessment, care planning and care coordination processes in place including quality improvement activities undertaken</li> </ul>	<ul> <li>Needs of underserved and high-risk populations are addressed</li> </ul>	
- HCH Trial - PHN Performal and Quality Framework	nce	Engaged Leadership  • HCH leadership team are accountable, embrace change, provide protected time and training for staff and use data to inform strategy and business planning for continuous improvement and sustainability	>	Clinical leads and managers provide workforce support to the HCH team to implement improvements and enable staff to work at the top of their scope of practice	Patient Experience • Improved patient/family/caregiver experience and satisfaction	
Existing infrastructure - Facilities - IT Systems - Telehealth capability		Digital Health • Electronic processes and systems for online appointments, secure messaging, telehealth and MHR (digital health strategies) are established	>	Digital health strategies in place	Health care is culturally appropriate integrated around the individual pation and family needs	
afety and Quality Accreditation Determinants o		Quality Data  • Utilise data to inform population health planning along with practice data to inform risk stratification and diary management	<b>→</b>	Practice uses data to assess performance, patient wait times and to identify and track high-risk populations to reduce preventable hospitalisations	Provider Experience • Positive provider experience and	
Unique rural and setting High Aboriginal a	remote	Team Based Care  • Develop chronic disease management systems to support care coordination function through team based care, upskilling and new workflows	<b>→</b>	Training implemented and structured processes in place to support care planning and workflows	satisfaction with clinicians working at t top of their scope of practice	
Strait Islander po Aging population workforce Increasing burder disease & preven	n and n of chronic ntable hospital	Embedding CQI  • Clinical information systems in place, processes to track and monitor patients and processes in place to coordinate with the wider HCH neighbourhood	<b>-</b> >	Interdisciplinary team working together to support patient care pathways, access to resources and integration of services into the HCH	Efficiency & Sustainability  • Digital health enables better coordinates care and informed treatment decisions  • General practices and wider HCH	
admissions &dem Fragile service pro networks Poor alignment o incentives High health care o	ovider	Infrastructure  • Building facility and design supports model of care (workflows, consulting rooms, self-management supports) and integration of external health providers, telehealth infrastructure and co-location of providers	→	Enhanced availability of clinical spaces, maximised use of telehealth services and visiting services integrated into the model to support case management and follow-up care	neighbourhood use data to improve care • Reduced demand on hospital care for unplanned or low acuity care • Financial viability	
Poor uptake and digital technology	utilisation of	Performance		Practice Performance Analysis (PPA) used to inform call		

Undertake business planning to support efficiency and sustainability of the

• Practice Performance Analysis (PPA) used to inform call

management, unplanned demand, systems efficiencies and

increased income streams (Implementation Plan completed)

## Program logic – Implementation Phase

Program objectives	To activate clinical and structural redesign through a Western Queensland Health Care Home <i>Model of Care</i> to improve health outcomes and practice population health, quality patient and provider experience and improved efficiency and sustainability.
Theory of change	To apply a systematic and structured continuous quality improvement methodology to support adoption across 10 foundations that underpin patient-centred, integrated comprehensive primary health care in Western Qld.

Inputs Activities Outputs Outcomes

Governance working group Model of Care development WQ HCH Coordinator training Recruitment of practices and signed agreement Patient enrolment Register development of high-risk patients Maturity Matrix (MM) PREMS/PROMOS & Team Health Check Practice Performance Analysis (PPA) Practice workshop

Practices recruited Patients enrolled WQ HCH training implemented Register developed Risk stratification mechanisms implemented Evaluation measures implemented (MMM, PREMS/PROMS, Team Health Check) Practice workshop completed PPA completed and Implementation Plan developed Modifications made based on emerging issues and outcomes of PPA

Improvements to practice systems and processes Program viability assessed Evaluation successfully collects and analyses

for WQ HCH implementation

through 'Support for Uptake' services

Change management plan implemented to support transition

Website development

Risk stratification tool implemented

Survey tools embedded electronically into portal to

capture transformation journey (Maturity Matrix),

patient and provider experience Support for Uptake of services provided

Research ethics and evaluation plans implementated Performance Dashboard development

Communication to different audiences implemented

Partnership links identified

Change management plan implemented Portal and Website developed

Tools to gather survey data implemented into website WQ HCH Coordinators provide Support for Uptake of

WQ HCH Coordinators assist with patient enrolment Evaluation implemented

Performance Dashboard used to track and monitor

Assistance with linking to other initiatives to support WQ HCH implementation

Research outcomes used to guide future program Improved practice efficiency following participation

Practice performance assessed through PPA Performance Dashboard provides clinical and organisational outcomes that track changes over the course of the EAP implementation phase

CONTEXT

**Funding** Socio-economic characteristics **Quality Improvement Initiatives** Population health data

#### **WQ HCH Measures**









#### **HCH Measures**

### **Health Outcomes and Practice Population Health**

Hospital admissions

**GP Style ED hospital admissions** 

Potentially preventable hospitalisations

Screening participation & immunisation rates

Proportion of clients who are recalled for follow up appointments

Change to the number of referrals

Clinical outcomes

Proportion of patients with complex needs with Health Checks, GPMP, TCAs & MHTP

Continuity of care (registers, high-risk stratification groups, complex patients with care plans, ATSI receiving care, rate of discharge summaries uploaded to MHR, provider viewing of MHR)

#### **Patient Experience**

Patient satisfaction score (PREMs)
Quality of life, daily functioning,
dimensions of health (PROMs)

Patient wait times in facility

Call response rates

Proportion of F2F visits, phone and email consults

Patient Portal use and use of online

#### **Provider Experience**

Team Health Check survey score (workforce satisfaction)

Implementation Experience (qualitative)

#### **Efficiency & Sustainability**

Practice Performance Analysis

Practice patient occasions of service

Hospital activity measures

- ED admissions
- Inpatient admissions
- Unplanned/frequent readmission

Staff turn over

Financial performance measures

#### **Outcomes**

#### **Processes**

#### **Patient Centred**

- Access to care
- Self-care & management
- Care planning processes

#### **Cultural Competency**

- Cultural respect
- Cultural training & competency

#### **Primary Care Governance**

- Registers of high need patients
- Clinical pre-work
- Age appropriate health assessments

#### **Engaged Leadership**

- Leadership training
- Data & WQPHN Frameworks used to inform QI and strategy
- Policies & procedures
- Practice recruitment & training

# Maturity Matrix Progressive Scores

#### **Digital Health**

- Electronic systems & systems
- Online appointments, secure messaging, telehealth & MHR
- WQPHN Apps (wave 2)

#### **Quality Data**

- Risk stratification
- Diary management
- Data reports used to inform planning

#### **Team Based Care**

- Principles of patient centred care
- Structured telephony & phone triage
- Workforce training
- CDM systems to support care coordination into systems

#### **Embedding CQI**

- Health Pathways
- Integrated health & social care
- Clinical information systems

#### Infrastructure

- Consult rooms & workflows
- Telehealth infrastructure
- External providers integrated into systems

#### Performance

- Access and demand
- Quality business planning
- Self-assessment & improvement

#### Continual QI and Safety supported by accreditation

#### **Cultural Respect**

Equity