Population-Based Integrated Care

The Healthy Homes and Neighbourhoods Integrated Care Initiative

John Eastwood

Healthy Homes and neighbourhoods

Overview

- Models of Integrated Care
- Individual Focused
- Group Focused
- Population-based
- Healthy Homes and Neighbourhoods

Healthy Homes
and neighbourhoods

Models of Integrated Care

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Models of Integrated Care

- Individually focussed models of integrated care
- Group and disease-specific models
- Population-based models

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Individual Models

- Individual coordination of care for high risk patients with multiple conditions and their carers
- Aim to facilitate the appropriate delivery of health care services and overcome fragmentation between services
- Extend beyond one episode of care and embraces the life-course.

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Case-management

To ensure coordination of a patient's care through the assignment of a case manager. The primary tasks of a case manager are to:

1. assess the patient's and carer's needs,
2. develop tailored care plan,
3. organize and adjust care processes accordingly,
4. monitor quality of care and
5. maintain contact with the patient and carer

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Patient-centred medical home

Some times referred to as primary care medical home. It is a physician-directed group practice that can provide care which is:

1. accessible,
2. continuous,
3. comprehensive
4. coordinated
5. delivered in the context of family and community

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Group and Disease Models

Chronic Care Model best known. Six Domains:

1. community
2. health system
3. self-management support
4. delivery system design
5. decision support
6. clinical information systems.

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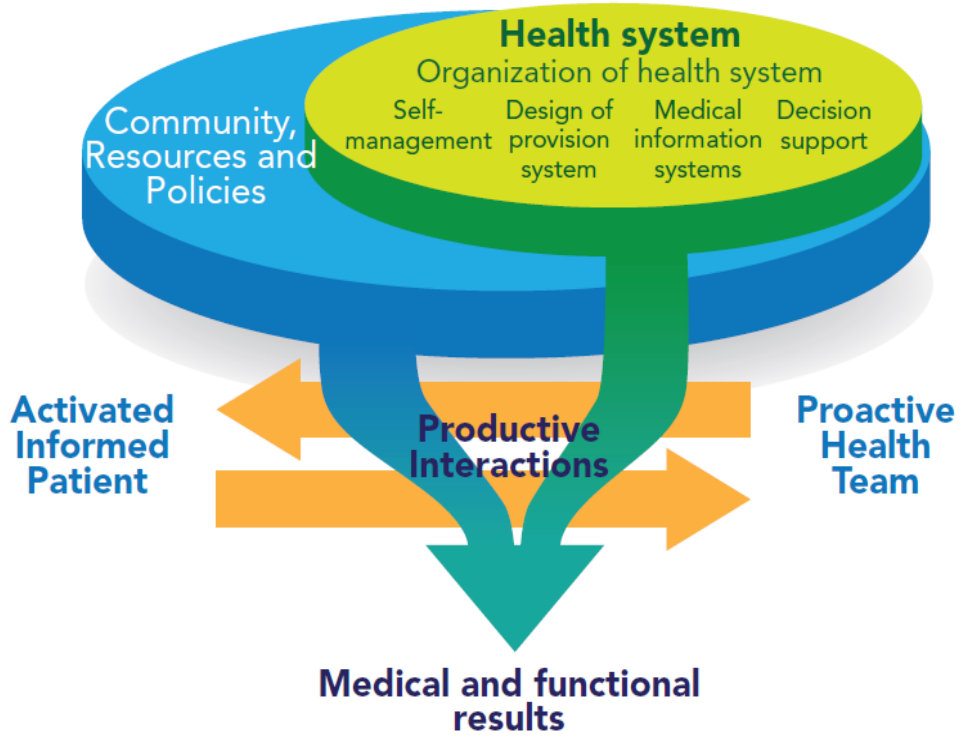
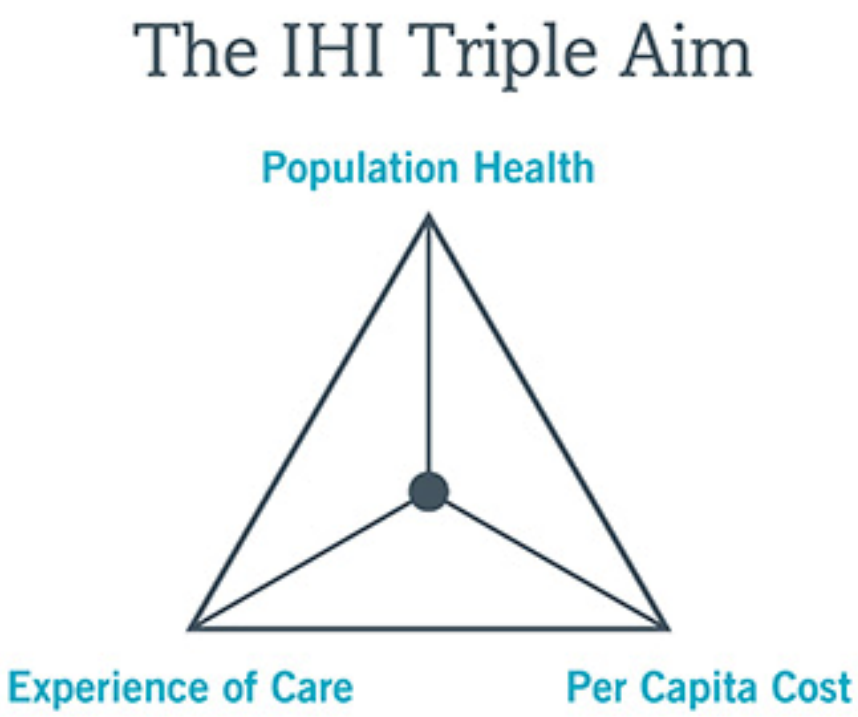
Chronic Care Model

Adaptation of the care model for Chronic Patients in the Basque Country



Source- Developed by Ed Wagner and collaborators from the MacColl Institute for Healthcare Innovation. Adapted by O+berri Basque Institute of Health Innovation

Triple Aim



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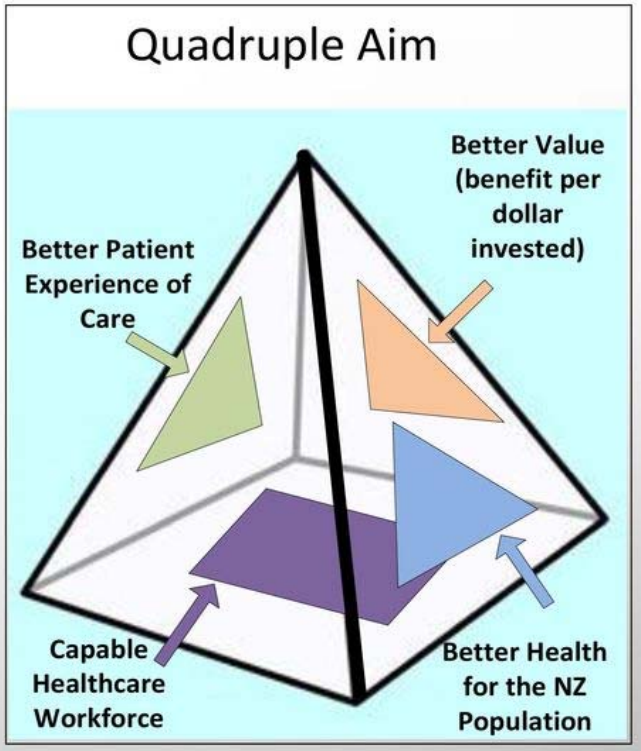
Quadruple Aim (NZ)

THE COMPONENTS OF OUR 'COLLABORATIVE QUADRUPLE AIM'

- ✓ BETTER PATIENT EXPERIENCE OF CARE
- ✓ BETTER HEALTH FOR THE NZ POPULATION
- ✓ BETTER VALUE
- ✓ A CAPABLE HEALTHCARE WORKFORCE



Population Based

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Population-Based

- Kaiser Permanente
- Rainbow Model of Integrated Care
- Primary Health Care
- Health Promotion
- Population Health

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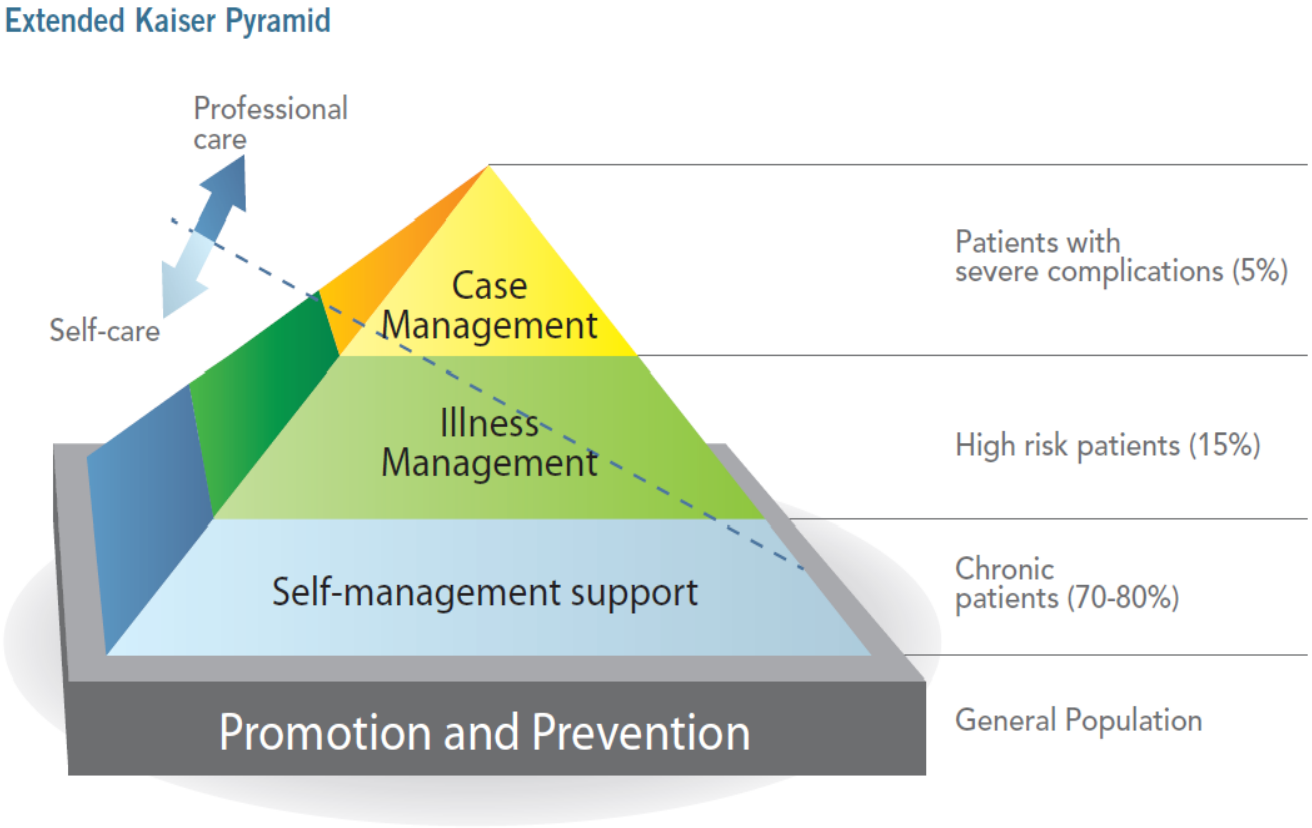
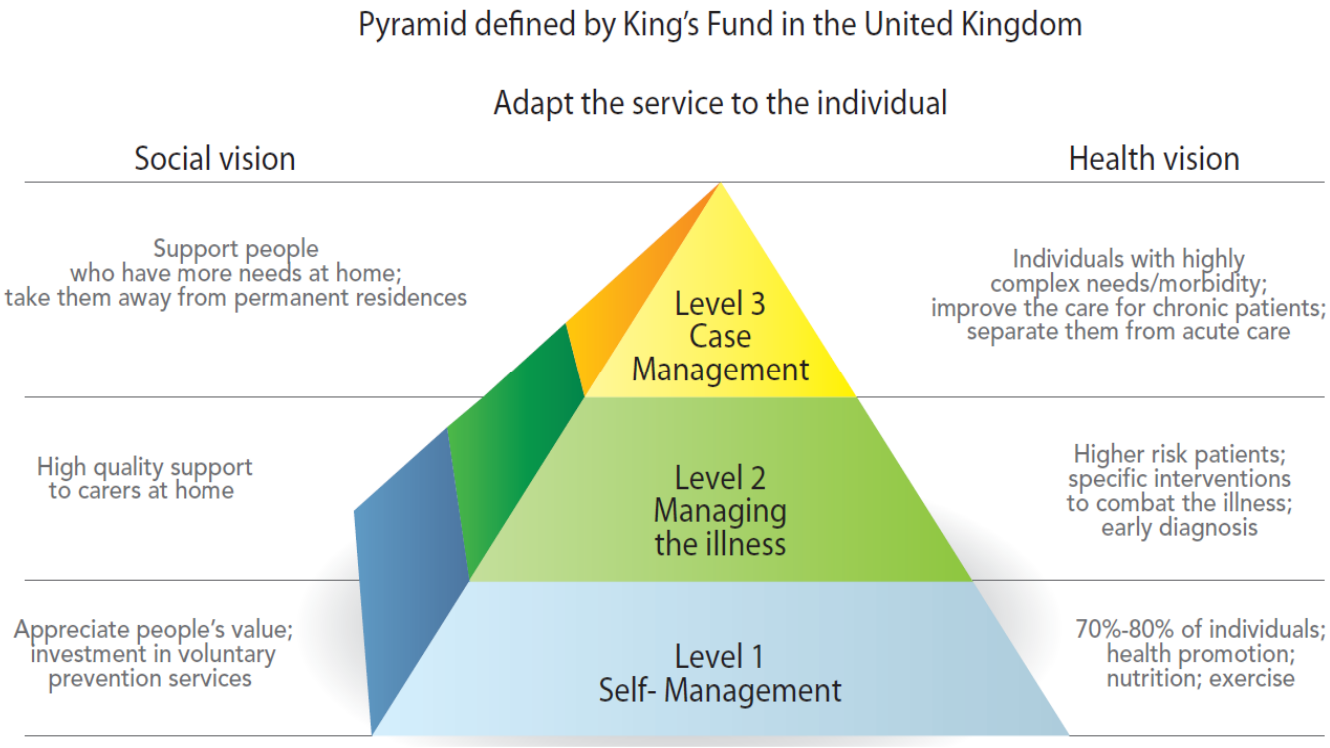
Kaiser Pyramid (Population Stratification)



Source: Kaiser Permanent. Adapted

KP Pyramid
Health and Social

Pyramid defined by King's Fund in the United Kingdom



Source: King's Fund (C.Ham)

Rainbow Model of Integrated Care

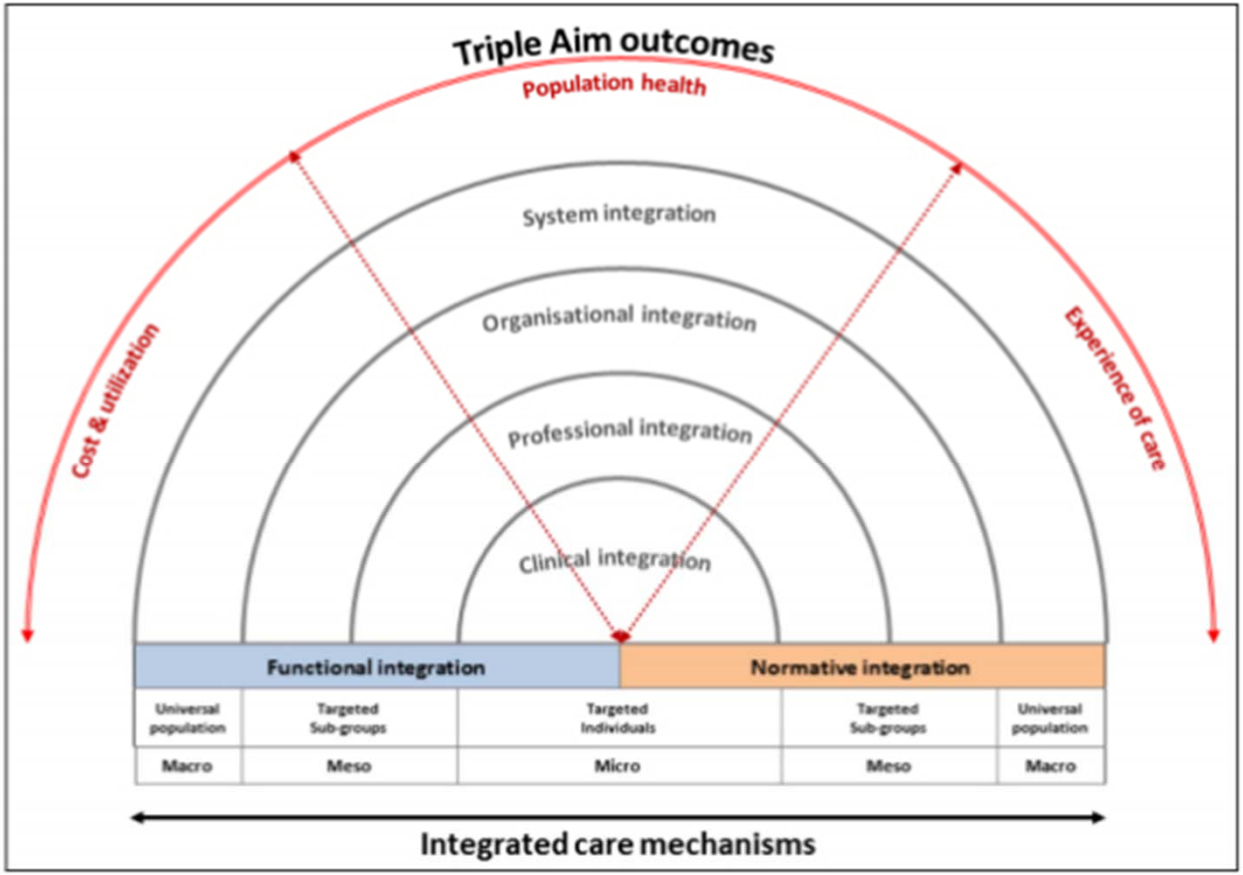
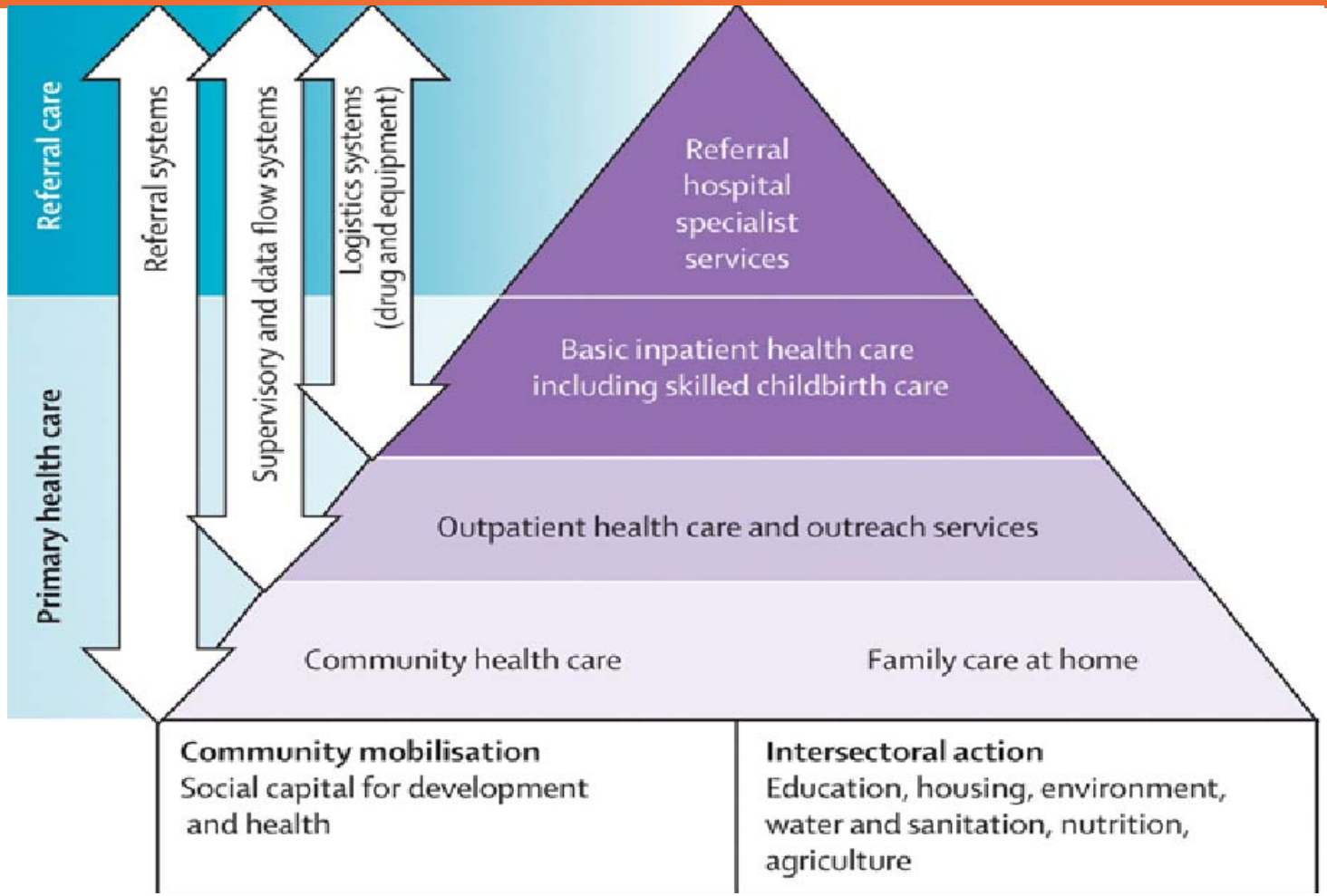


Figure 1: The revised RMIC, value-based integrated care. Source: Valentijn (p. 160, 2015).

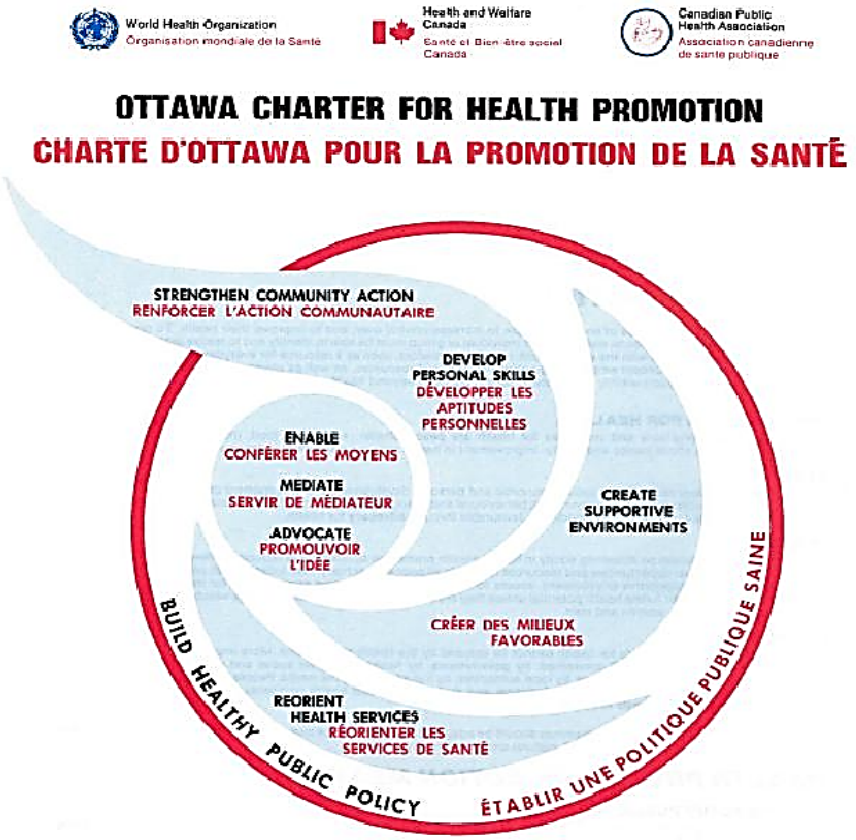
Alama Ata Declaration 1978



Enable

Mediate

Advocate



Strengthen Community Action

Develop Personal Skills

Create Supportive Environment

Reorient Health Services

Build Healthy Public Policy

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Ottawa Charter Adapted

Equity

Partnerships

Action across the continuum

Culture Change

Supportive Environments

Community Participation

Evidence Informed Practice

Determinants of Health

Drug and Health Development, Wellington, NZ

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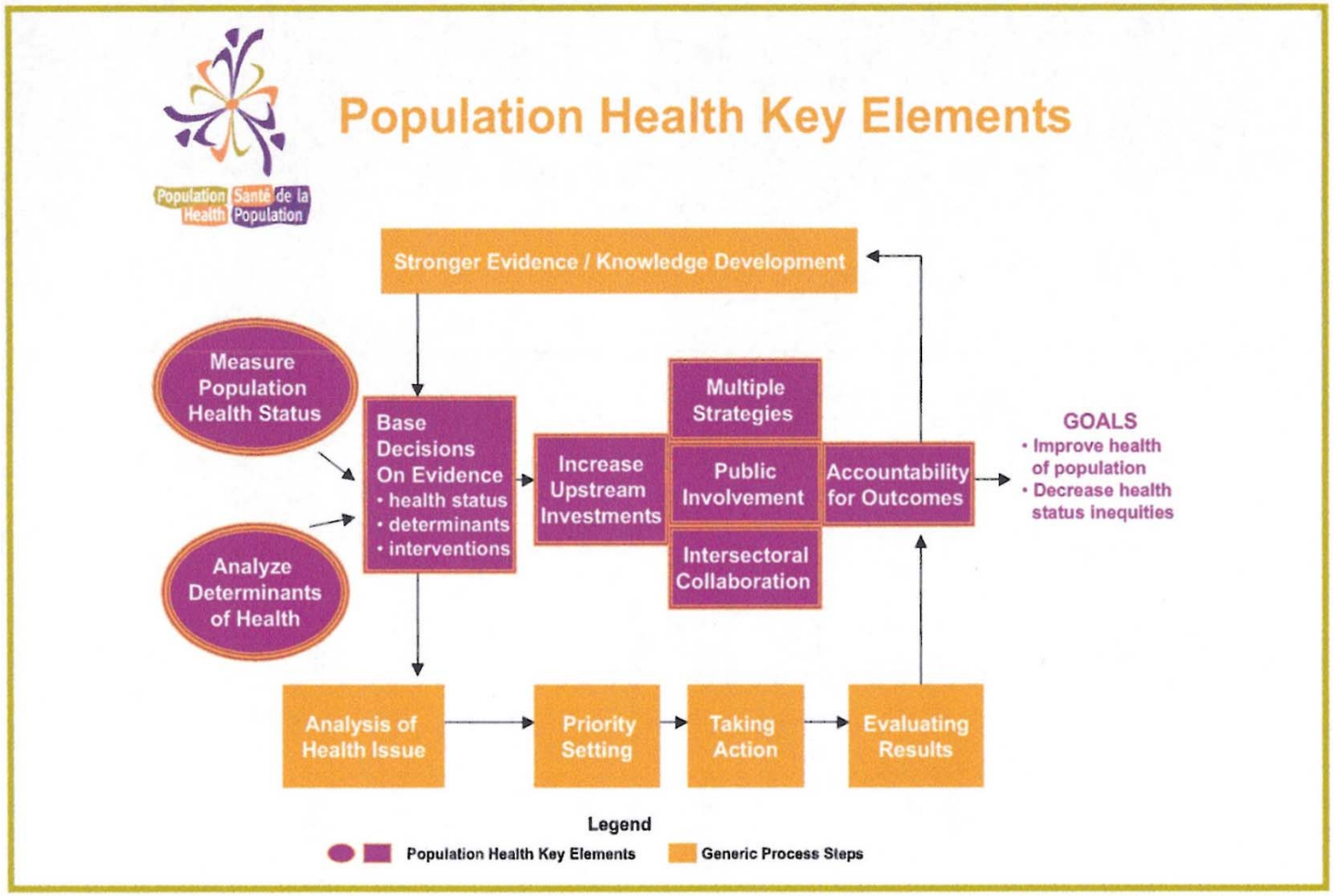
Population Health Canada 2001



Healthy Homes and Neighbourhoods

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Core Components

1. Risk Stratification
2. Care Coordination
3. Evidence informed capacity building
4. General Practice engagement and support
5. Family Health Improvement
6. Place-based hubs
7. System Change
8. Outcome monitoring
9. Complex evaluation

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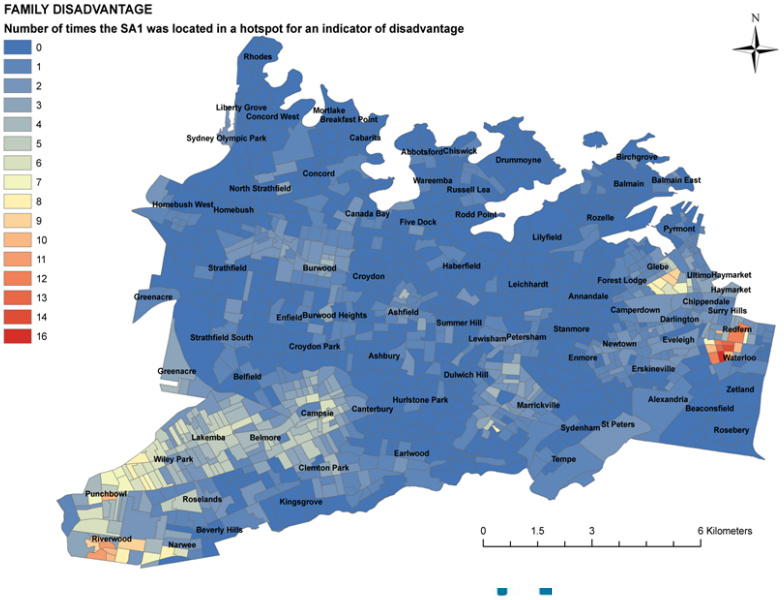
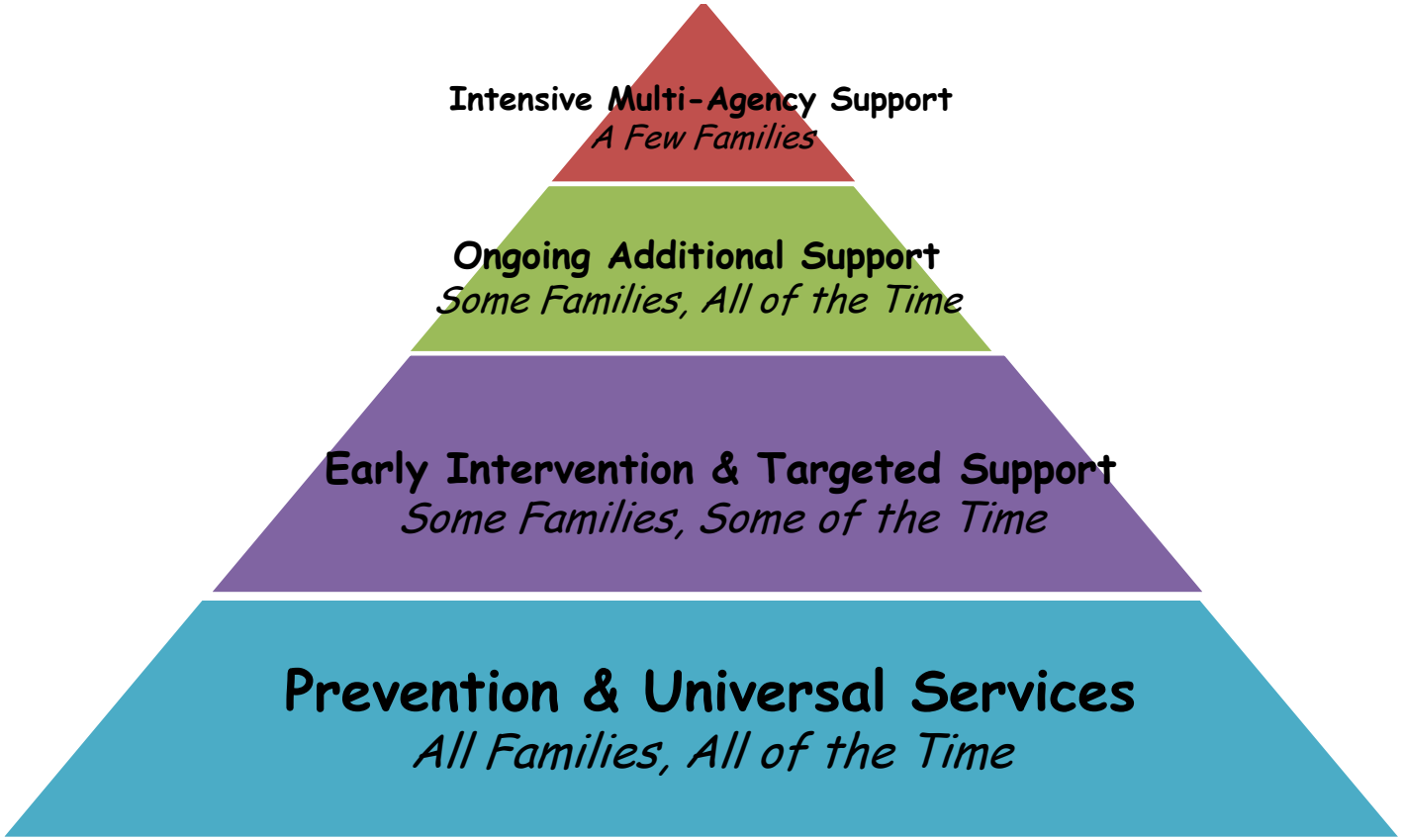
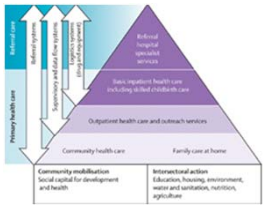
Population-Based Stratification

- Population Needs Analysis
- Analysis of Determinants of Health
- Population Risk Stratification
- Evidence-informed Interventions



Population-Based Stratification





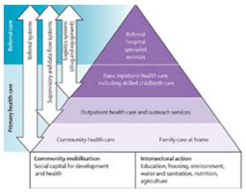
healthy families children

Healthy Homes and neighbourhoods

Inter-sectoral Action

- SLHD (Community Health, Mental Health, Drug Health, Chronic Disease)
- Family & Community Services (Housing, Child Protection)
- CESPHN
- SDN Children's Services – Brighter Futures
- The Infants' Home Ashfield – Child and Family Services
- Barnardos – Family Referral Service
- The Benevolent Society – Child and Family Services
- Jannawi Family Centre
- Education
- Tresillian
- Sydney Children's Hospital Network

NSW GOVERNMENT Health
Sydney Local Health District



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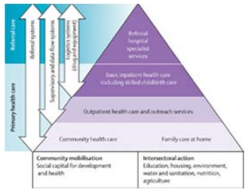
Community Mobilisation

- Find a local “hub” for community engagement
- Tap into existing local networks
- Support the community to identity needs and solutions
- Allow model of care coordination to emerge over time
- Model to meet needs of the population and to inform other enabler projects



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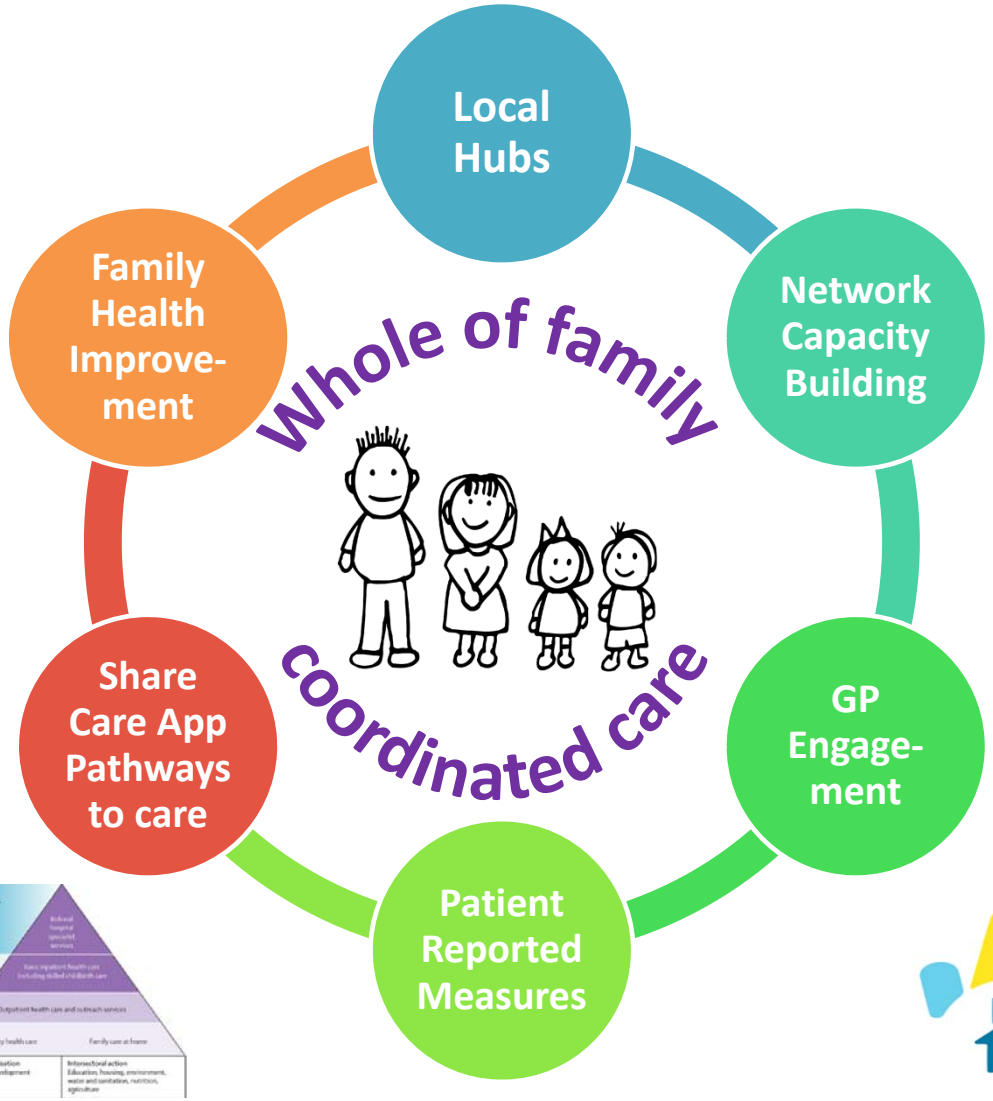
Family Care At Home



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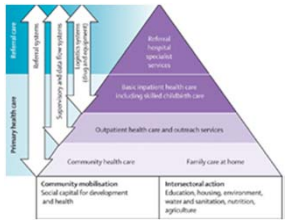
Community Health and Social Care

- Co-location at Red-Link
- Engaging directly with community and local services
- Engage with community events
- Identifying community needs
- Providing whole of health care coordination from Red-Link site



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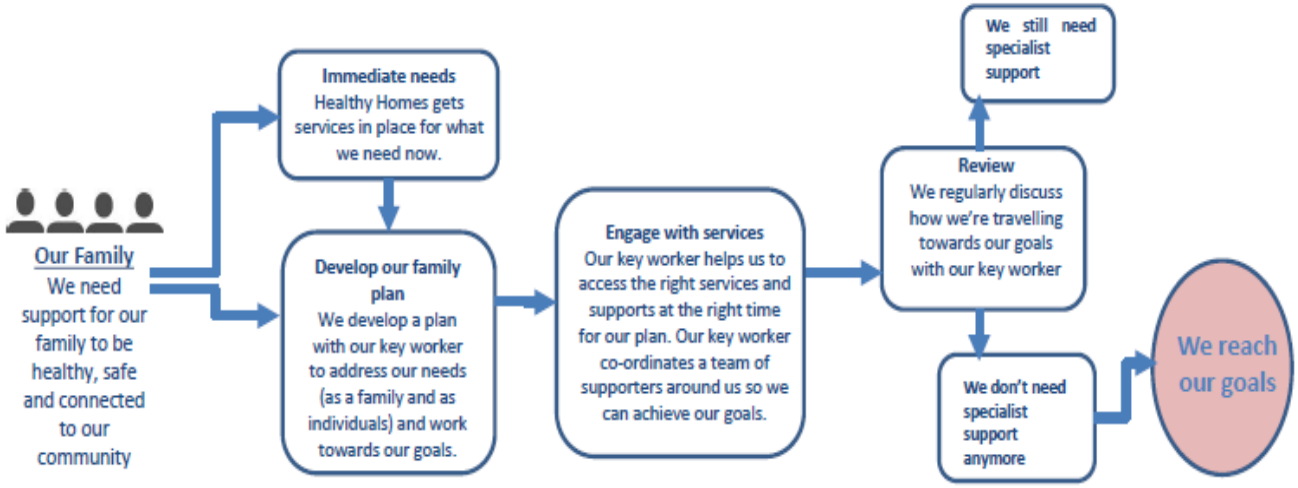
People-centered Care-Coordination



- Wrap-around model
- Family Group Conferencing
- Family Partnership
- Shared-care planning
- Clinical review

- Patient reported outcomes
- HealthPathways

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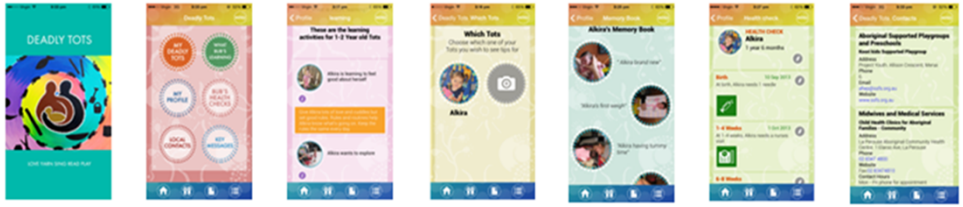
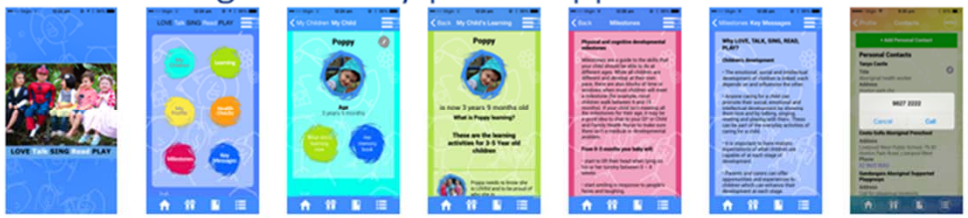
Self-care and Family Health Education

- Deadly Tots phone app



- Love Talk Sing Read Play phone app



- Love Talk Sing Read Play mobilised website

Family and Practitioner Knowledge and Skills

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NSW Health Sydney Local Health District

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Community Literacy

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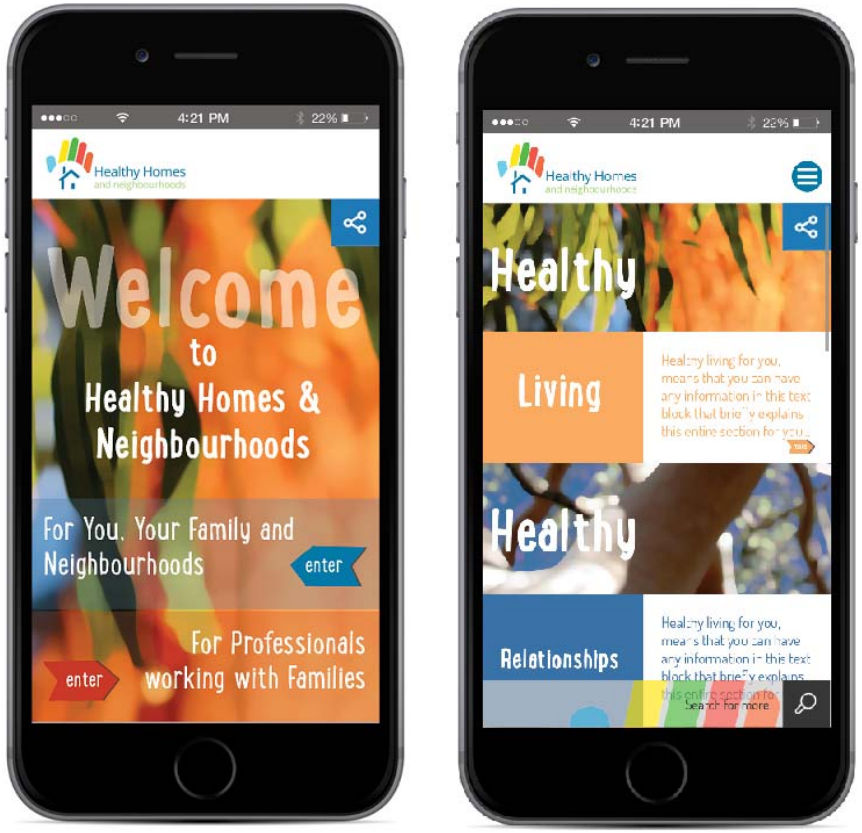
Social Media



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Primary Care Home

- Project in partnership with CESPHN.
- Compiled database of **853** General Practices in SLHD area (and border suburbs).
- **Engaged over 40** GPs to accept referrals for vulnerable families and work in partnership with HHAN.
- Commenced GP research project – identifying barriers and enablers for GPs to work well with vulnerable children and their families; utilisation of Medicare Item Numbers; training needs assessment.
- GP CPD and eLearning module development.

"Healthy Homes and Neighbourhoods:
- *Makes it easy for GPs to refer vulnerable families to the services that they need;*
- *Explicitly includes the family's GP in the team of providers that support vulnerable families;*
- *Provides useful and timely feedback and support to GPs and others involved in the care and support of vulnerable families"*

- Michael Moore, CEO CESPHN

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Preparing and Supporting Staff

- IC is a change to professional practice:
  - Our own staff
  - Their interactions with staff from other services and organisations
  - Expect “push back” and support your staff to manage this
- Complexity of clients who have encountered system failure over many generations
- Vicarious trauma

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Relationships and Trust

- Do not underestimate the time and effort it takes to build relationships and trust with stakeholders and the community – plan for this in timeline; difficult to measure in real-time
- Co-location can assist in developing trust, partnerships and knowledge transfer

"...And I guess it also takes time, you can't just expect people to trust you overnight, and trust you with everything..." – Client

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Evaluating a complex intervention

- Limitations of traditional approaches
- Realist: analysis of the Contexts, Mechanisms and Outcomes underlying the program

“What works for whom in what circumstances, in what respects, how and why?”

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Questions

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Quadruple Aim without Population

Our Mission

The Quadruple Aim

Quality

Enhance how care is provided to help patients to achieve better outcomes

Cost

Increase Operational Efficiencies

Patient-Centered

Improve patient experience by allowing caregivers to be Patient Centered

Experience

Improve the caregiver experience by improving workflow and empowering care teams