Population-Based Integrated Care

The Healthy Homes and Neighbourhoods Integrated Care Initiative

John Eastwood
Overview

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

- Individually focussed models of integrated care
- Group and disease-specific models
- Population-based models
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.
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
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
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.
Chronic Care Model

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

Health system
- Organization of health system
  - Self-management
  - Design of provision system
  - Medical information systems
  - Decision support

Medical and functional results

Activated Informed Patient

Productive Interactions

Proactive Health Team

Community, Resources and Policies

Source: Developed by Ed Wagner and collaborators from the MacColl Institute for Healthcare Innovation. Adapted by O+berri Basque Institute of Health Innovation
The IHI Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost

Healthy Homes and Neighbourhoods
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
Population-Based

- Kaiser Permanente
- Rainbow Model of Integrated Care
- Primary Health Care
- Health Promotion
- Population Health
Kaiser Pyramid
(Population Stratification)
Pyramid defined by King’s Fund in the United Kingdom

Adapt the service to the individual

Social vision

- Support people who have more needs at home; take them away from permanent residences
- High quality support to carers at home
- Appreciate people’s value; investment in voluntary prevention services

Health vision

- Individuals with highly complex needs/morbidity; improve the care for chronic patients; separate them from acute care
- Higher risk patients; specific interventions to combat the illness; early diagnosis
- 70%-80% of individuals; health promotion; nutrition; exercise

Level 1
Self-Management

Level 2
Managing the illness

Level 3
Case Management

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
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
Population Health
Canada 2001

Population Health Key Elements

- Stronger Evidence / Knowledge Development
- Multiple Strategies
- Public Involvement
- Accountability for Outcomes
- GOALS
  - Improve health of population
  - Decrease health status inequities

1. Measure Population Health Status
2. Analyze Determinants of Health
3. Base Decisions On Evidence
   - health status
   - determinants
   - interventions
4. Analysis of Health Issue
5. Priority Setting
6. Taking Action
7. Evaluating Results

Legend:
- Population Health Key Elements
- Generic Process Steps
Healthy Homes and Neighbourhoods
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
Population-Based Stratification

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

Intensive Multi-Agency Support
A Few Families

Ongoing Additional Support
Some Families, All of the Time

Early Intervention & Targeted Support
Some Families, Some of the Time

Prevention & Universal Services
All Families, All of the Time
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
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
Family Care At Home

Local Hubs

Family Health Improvement

Network Capacity Building

Share Care App Pathways to care

GP Engagement

Patient Reported Measures

Whole of family coordinated care
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
People-centered Care-Co-ordination

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

- Patient reported outcomes
- HealthPathways
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
Community Literacy

Healthy

Safe Communities

Healthy living for you means that you can have any information in this text block that briefly explains this entire section for you...
Social Media
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
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
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
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?”
Questions
Quadruple Aim without Population