



A Conceptual Framework for Medicare Local Collaboration

June 2013

Medicare Local Collaboration

Context

Across Australia, 61 Medicare Locals have been created as part of the National Health Reform agenda to improve coordination of primary health care and tackle local health needs and service gaps. To do this, Medicare Locals will need to undertake collaborative initiatives with a spectrum of stakeholders across the often complex and fragmented health, social, and community sectors.

Scope and purpose

What this framework is about:

- Providing a practical guide to help structure the way Medicare Locals engage in collaborative initiatives with different types of organisations across their local health community, using the resources under their control or influence
- Collaborating on end-to-end optimisation initiatives of the local health community
- Working with Medicare Locals, hospital providers, and a number of other health system organisations and stakeholders from across Australia to develop the framework.

What this framework is not about:

- Collaboration in the general or behavioural sense, or within primary care only
- Collaboration between Medicare Locals and/or different general practices, although Medicare Locals are encouraged to engage with one another to share experiences and insights
- Developing an academically perfect solution without full consideration of resource constraints
- Providing a prescriptive 'one size fits all' methodology to undertaking collaborative initiatives

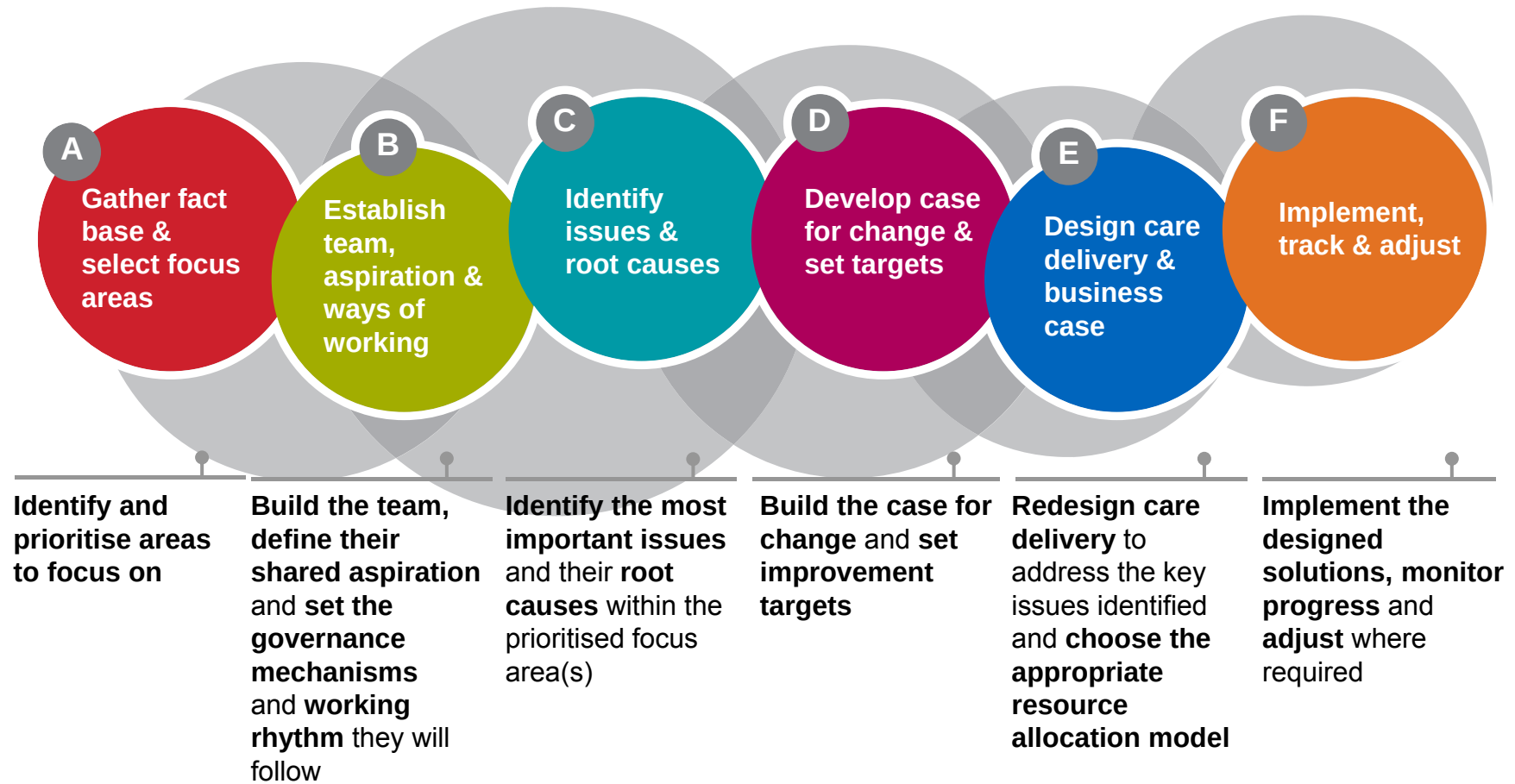
What this document contains

For each of the six steps of the framework, this document describes:

- A summary of the step, including its objective, why it is important, common pitfalls to avoid, and where you should be at the end of the step
- An overview of the key questions to be answered
- Examples of tools and techniques to help answer the key questions.

It is acknowledged certain skills, expertise and access to data are critical to the successful implementation of the framework and access to these skills should be ensured before starting any collaborative project.

The six steps to establishing effective collaboration across local health communities



Although the framework is illustrated as a linear sequence, you may want to complete the steps in a different order, complete multiple steps in parallel, or revisit and iterate the steps partway through the process as you learn more about the initiative you are undertaking

Step A

Gather fact base and select focus areas

Note that the collaborative process should start even before this step: invest in building relationships in your local health community to help pave the way for future initiatives.

Objective of this step

Develop a fact-based understanding of your population's health needs and prioritise the areas to focus on that will deliver the greatest impact

Why this step is important

- Appropriate prioritisation will ensure resources are allocated to the areas where they will have the most impact
- Getting broad input from the local health community will help ensure stakeholders are aligned on the established priorities
- It identifies what initiatives are already underway in your community

Common pitfalls

- Selecting too many health needs to focus on and not having the resources to address them adequately
- Prioritising focus areas without an objective fact base
- Not involving critical stakeholders, such as clinicians and patients, in setting priorities
- Not explicitly agreeing the prioritisation criteria among stakeholders

By the end of this step you should...

- ☐ Understand the major health needs of your local health community
- ☐ Have a prioritised list of potential initiatives and focus areas which are agreed upon by all stakeholders
- ☐ Know which projects and initiatives are already underway in your local health community

Step A. Gather fact base and select focus areas



Key questions to answer	Approach	Want to know more?
A1 What are your community's health care needs?	▪ Use existing data sources to understand your population's characteristics ▪ Engage with a broad set of stakeholders in the health sector to understand the local epidemiology ▪ Review case examples and consult with experts to establish what best-practice healthcare looks like ▪ Collaborate with stakeholders to review existing health services for gaps ▪ You should now be able to identify what your community's major health care needs are	▪ Consult the comprehensive Medicare Local Needs Assessment Framework (in development).
A2 What are the key priorities in your local health community?	▪ Collaborate with a broad group of stakeholders in your local health community to develop a suite of potential initiatives to address the gaps identified ▪ Conduct an assessment of the potential impact and feasibility of each potential initiative ▪ Agree prioritisation criteria with stakeholders and select initiatives using a prioritisation methodology ▪ Ensure stakeholders agree that the selected initiatives and the underlying health focus areas they address are correct	▪ Consult the comprehensive Medicare Local Needs Assessment Framework (in development).
A3 What is already happening in your local health community?	▪ Identify the projects and initiatives already underway in your local health community for the selected focus areas ▪ Develop your network of potential partners ▪ Reach out to other Medicare Locals to see if you can leverage previous work and/or determine if you should work together on common priorities	

Step B

Establish team, aspiration and ways of working

By now, you will know which focus area(s) to target, the next step is to build the team that will lead the project.

Objective of this step

Establish the team and galvanise them around a shared aspiration

Why this step is important

- A shared aspiration will ensure everyone is aligned on what the project aims to achieve
- An effective team rhythm means that the process will generate energy and maintain momentum, with participants focusing on what they have to do rather than renegotiating the next interaction

Common pitfalls

- Not identifying the full set of relevant stakeholders to involve
- Not recognising misaligned incentives and motivations of project team members
- Failing to agree a shared aspiration
- Not agreeing on ways of working until a few weeks into the project
- Not assigning clear roles and responsibilities and agreeing on them explicitly with team members
- Not recognising early enough when the project is going off track

By the end of this step you should ...

- ☐ Have elected team members and understood their underlying motivations
- ☐ Have aligned the team around a common aspiration
- ☐ Have a clear governance structure and agreement on ways of working
- ☐ Have mechanisms in place to help track and adjust the working approach if required

Step B. Establish team, aspiration and ways of working



Key questions to answer

Approach

B1 Who should be in the team and what are their underlying motivations?

- Identify relevant team members, potentially including representatives from health and social care providers, funders, patient groups, academia, NGOs, government etc. Think beyond the familiar stakeholders, (e.g., to those potentially involved in implementation), and engage with organisations planning or undertaking similar initiatives (this can be challenging but it is necessary)
- Determine the level of involvement for each stakeholder e.g., a part of the project team, part of the steering committee, needs to be consulted, or needs to be informed about the project
- Understand the underlying motivations of individual team members

B2 What is the shared aspiration of the team?

- Articulate a shared aspiration that is compelling and motivating to all stakeholders, and addresses the needs and values of each individual
- Ensure the team understands the role that each member plays, and the need to work collaboratively with respect for the opinions of other team members
- Consider ways to incorporate stakeholders who may be negatively impacted, e.g., organisations focused on a similar topic

B3 What is the governance structure and team working rhythm?

- Reach common agreement on the governance structure, decision making process, and escalation process
- Ensure the governance structure addresses both executive and operational governance
- Agree how the team will work together, including aligning on goals, priorities, roles and expectations, team norms and commitments, individual development goals, ways of communication, and working rhythm and calendar
- Conduct a risk assessment of the project

B4 What mechanisms will be used to track and adjust the approach?

- Put in place mechanisms to help regularly track team satisfaction and impact, e.g., weekly team barometer
- Use the tracking mechanisms to conduct feedback conversations and adjust the approach if required

Step C

Identify issues and root causes

By now, you will have established your project team, and defined a common aspiration around the selected focus area. The next step is to understand key issues.

Objective of this step

Identify issues and their underlying root causes along the focus area's pathway or system, using both quantitative and qualitative evidence

Why this step is important

- Understanding the root causes of issues within a pathway or system will help ensure that designed solutions address the heart of an issue, not merely symptoms of it
- A fact-based approach will help ensure resources are allocated where they can make the biggest difference

Common pitfalls

- Oversimplification—this step is often very challenging and will require right capabilities and sufficient time to complete
- Failing to identify true root causes
- Missing important issues by narrowing down too quickly
- Not prioritising where to focus and trying to do too much
- Focusing solely on structural root causes and failing to identify root causes addressable by local stakeholders, despite the structural constraints

By the end of this step you should...

- ☐ Understand the high-level stages of your chosen pathway or system
- ☐ Have identified areas of underperformance within the chosen pathway or system
- ☐ Know the key issues along the pathway
- ☐ Have identified the underlying root causes of the key issues

Set C. Identify issues and root causes

Key questions to answer

Approach

C1 What does your focus area's pathway or system look like?

- For the focus area identified in Step A, draw the high-level stages of the pathway or system
- Make sure stakeholders agree on the depiction of the pathway or system

C2 How does your local health community perform along the pathway or system?

- Compare your performance against benchmarks which are agreed upon by stakeholders, such as performance of top quartile peers, clinical guidelines, or national targets
- Measure performance of both outcome metrics (the consequences of actions) and process metrics (the actions themselves)
- Consider combining required metrics (e.g., NHPA indicators) with metrics which are focused on your local health community (e.g., access to health services for veterans)

C3 What are the main issues along your chosen pathway or system?

- Brainstorm issues for each stage of the pathway or system. Focus on areas of weakness highlighted by the data and refer to any existing research
- Engage widely with stakeholders, especially consumers and providers, to understand issues from first-hand experiences
- Begin to identify and group key issue themes

C4 What are the root causes which underlie the identified issues?

- Identify the root causes which underlie each of the key issues and group them into a manageable number of core themes
- Make sure stakeholders agree that the final list of key issues and their underlying root causes are correct and comprehensive
- Identify the stakeholders who have the most influence over the root cause and should lead and/or be involved in its resolution

Step D

Develop case for change and set targets

For your focus area, you will now have identified the issues along the pathway or system and their root causes. Next you will build the change story.

Objective of this step

Develop and communicate a case for change that is tailored to different stakeholder groups and set SMART improvement targets

Why this step is important

- Developing a strong case for change will help drive stakeholder engagement (the 'change story')
- Setting SMART (targets will allow all stakeholders to agree on the measures of success)

SMART targets are

- Specific,
- Measurable,
- Actionable,
- Relevant and
- Timely

Common pitfalls

- Anticipating a flat baseline (i.e., no change from today)
- Not quantifying the problem or the improvement potential
- Failing to turn facts into a compelling narrative for each stakeholder group
- Neglecting to tailor the change story to each stakeholder's needs
- Setting vague or unrealistic targets – be ambitious but also realistic about constraints in the short term
- Not setting aspirations over multiple time frames

By the end of this step you should...

- ☐ Understand what is likely to happen if you do nothing
- ☐ Have set an agreed target for improvement
- ☐ Know who the relevant stakeholders are, and their underlying motivations
- ☐ Have developed a case for change for each stakeholder, tailored to their needs and motivations

Step D. Develop case for change and set targets

Key questions to answer

Approach

D1 What is likely to happen if you do nothing?

- Illustrate the 'do nothing' baseline, projecting forward historic trends for the most appropriate metrics (e.g., cost, disease burden, quality of care, access to care). Stratify for sub-populations if appropriate
- Gather qualitative evidence (e.g., personal experiences of patients and clinicians) to support the quantitative metrics

D2 What is your improvement target?

- Consider using a variety of sources to triangulate to a target, including:
 - International best practice guidelines (it is ideal to choose an example from a country which has a similar health system structure)
 - Improvements seen in similar initiatives
 - Performance of successful peers
 - Targets set by regulatory or professional bodies
- Set targets that are SMART (Specific, Measurable, Actionable, Relevant and Timely)
- Ensure stakeholders are committed to achieving the targets and identify who will be accountable for the target

D3 Who are the relevant stakeholders and what are their underlying motivations?

- Explicitly identify relevant stakeholders, and understand their motivations and any barriers to change
- Understand how different stakeholder motivations will impact the focus messaging of the change story

D4 What is the case for change?

- Create a compelling case for change using the 'do nothing' story, and lay out a clear aspiration
- Tailor the change story for specific stakeholders to appeal to different motivations
- Determine the most appropriate delivery medium(s) for the change story

Step E

Design care delivery and business case

By now, you will have developed a case for change and set improvement targets. In this step, you will decide how to achieve them.

Objective of this step

Design a collaborative care delivery model that addresses underlying root causes, and determine a sustainable resourcing mechanism

Why this step is important

- Approaching solution design in a structured and comprehensive way ensures that the solution tackles underlying root causes and delivers the greatest impact
- Choosing the most appropriate resourcing model is key to creating medium and long-term sustainability of the initiative

Common pitfalls

- Oversimplification—this is often very challenging and requires right capabilities and sufficient time
- Initiating a series of disjointed tactical fixes rather than considering the overall operating model
- Not considering enablers as part of the solution
- Not quantifying costs and benefits
- Limiting ambition or impact by only relying on new funding sources
- Only considering resources required in a pilot phase and not for sustainable at scale implementation

By the end of this step you should...

- ☐ Have designed a future-state care delivery model supported by enablers such as payment models
- ☐ Have created a business case primarily focused on achieving improvements from increasing the efficiency of the current system

Step E. Design care delivery and business case

Key questions to answer

Approach

E1 What does the future-state delivery model look like?

- Engage a broad group of stakeholders to identify potential solutions which address each of the underlying root causes
- Use the list of potential solutions to design a holistic care delivery model, including consideration of necessary enablers such as information technology, financial incentives, organisation design and performance management

E2 What is the business case?

- Determine the benefits of the future delivery model including both economic and quality benefits
- Determine the resources required and costs (both in the design and implementation phase and in the ongoing running phase)
- Determine how the future delivery model can be achieved using currently available resources – an option within this may be reallocation of resources
- As a final option, only after you have demonstrated how to maximise efficiency using the current resources, explore options for seeking additional funding

Step F

Implement, track and adjust

Before beginning this step, go back and review the previous steps to ensure the foundations are in place for successful implementation.

Objective of this step

Implement the new care delivery model following a well-designed action plan with regular tracking and adjustment

Why this step is important

- Implementation is the culmination of all previous steps; the hard work and good intentions of the project can fail to materialise into improved outcomes if this step is not carefully planned
- Implementation rarely goes exactly to plan, so it is important to track progress and make adjustments
- Careful consideration of implementation is required to ensure the sustainability of initiatives

Common pitfalls

- Understating the science/ art of implementation—robust processes must be complemented with strong change management capabilities
- Not clearly allocating roles and responsibilities, or contingency plans for people leaving
- Not creating transparency on performance and progress
- Not adjusting plans as the project unfolds
- Failing to anticipate early in the project the data required to monitor - it may take time to gather

By the end of this step you should...

- ☐ Have developed a change management plan to create sustainable change
- ☐ Have designed and agreed upon an action plan for implementation
- ☐ Have set up performance tracking mechanisms
- ☐ Have set up processes to make adjustments and improvements

Step F. Implement, track and adjust



Key questions to answer

Approach

F1 What is the change management plan?

- Use the influence model to design a holistic change management plan with actionable modules
- To change behaviours you will need to create buy-in to the change required, establish role models, build the capabilities required for change, and form formal mechanisms that reinforce the change

F2 What is the action plan for implementation?

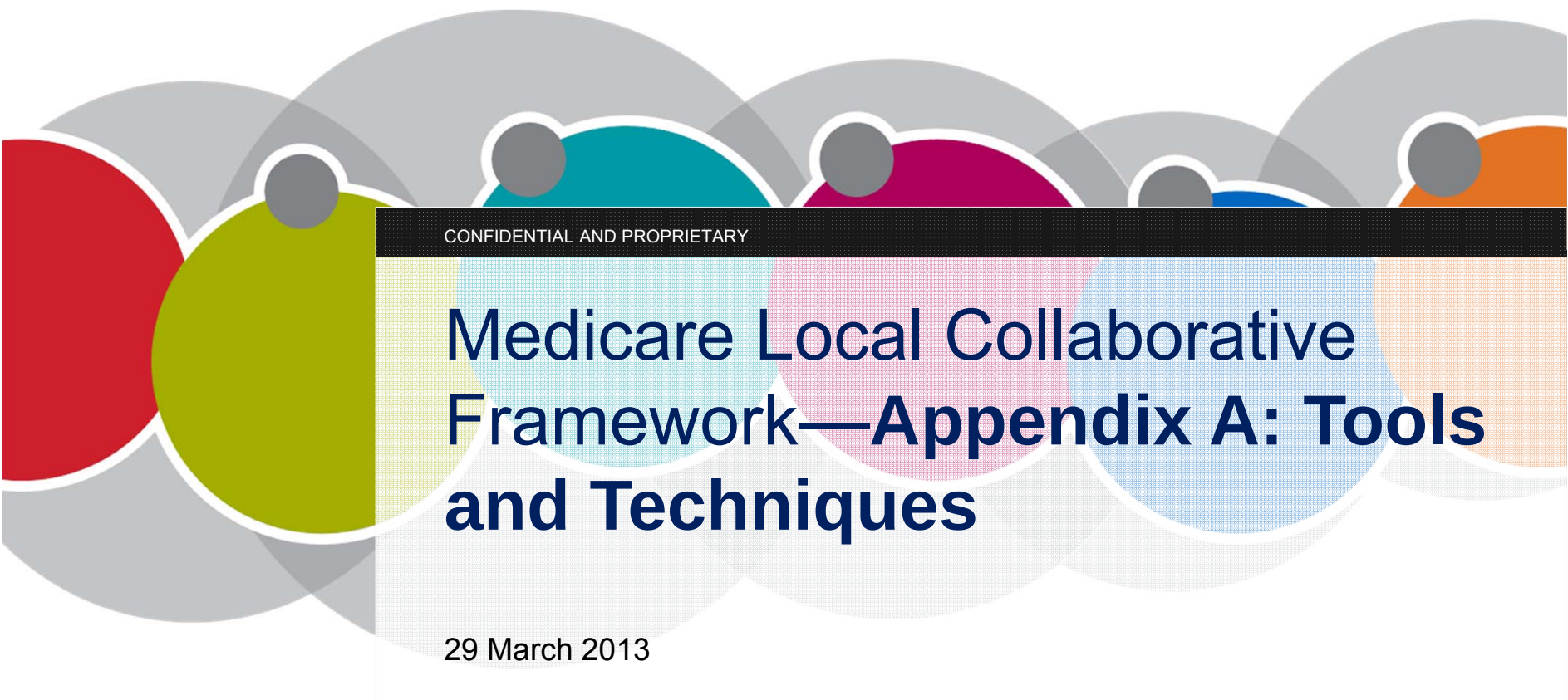
- Determine how fast to roll out the initiative in terms of the staging of functionality, geography and patient/clinician sub-populations
- Develop an action plan for implementation with clear roles and responsibilities (including a contingency plan), activities and timelines. The discrete activities of the action plan should map to the modules of the change management plan.
- Ensure stakeholders understand and are committed to the action plan

F3 How will progress be tracked?

- Agree with stakeholders on how performance will be monitored, including which metrics to use (both outcome and process) and how often the results will be reported

F4 How will adjustments and improvements be made?

- Conduct regular quality improvement reviews and feedback sessions with all stakeholders
- Adjust the implementation approach as required
- Celebrate successes along the way



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Medicare Local Collaborative Framework—Appendix A: Tools and Techniques

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Contents

APPENDIX A: Collaborative framework tools and techniques

- **Step A**— Gather fact base and select focus areas
- **Step B**— Establish team, aspiration and ways of working
- **Step C**— Identify issues and root causes
- **Step D**— Develop case for change and set targets
- **Step E**— Design care delivery and business case
- **Step F**— Implement, track and adjust

A framework to guide Medicare Local Needs Assessments

The following activities are necessary for Medicare Locals to undertake to assess health care needs in their respective regions and prioritise amongst various initiatives:

- Collect data and information to develop an understanding of the characteristics and health status of their populations
- Identify opportunities to improve their population's health and address service gaps
- Assess existing health care services to determine what is working, what could be improved, and where resources could be used differently
- Triangulate qualitative and quantitative data and service mapping
- Systematically evaluate, through robust and transparent processes, competing opportunities to improve health and reduce inequalities within their populations, in order to to determine their priorities and the priorities of the local primary health care system

A framework is under development to guide Medicare Locals on how to perform these activities. The framework will be available later in 2013.

Contents

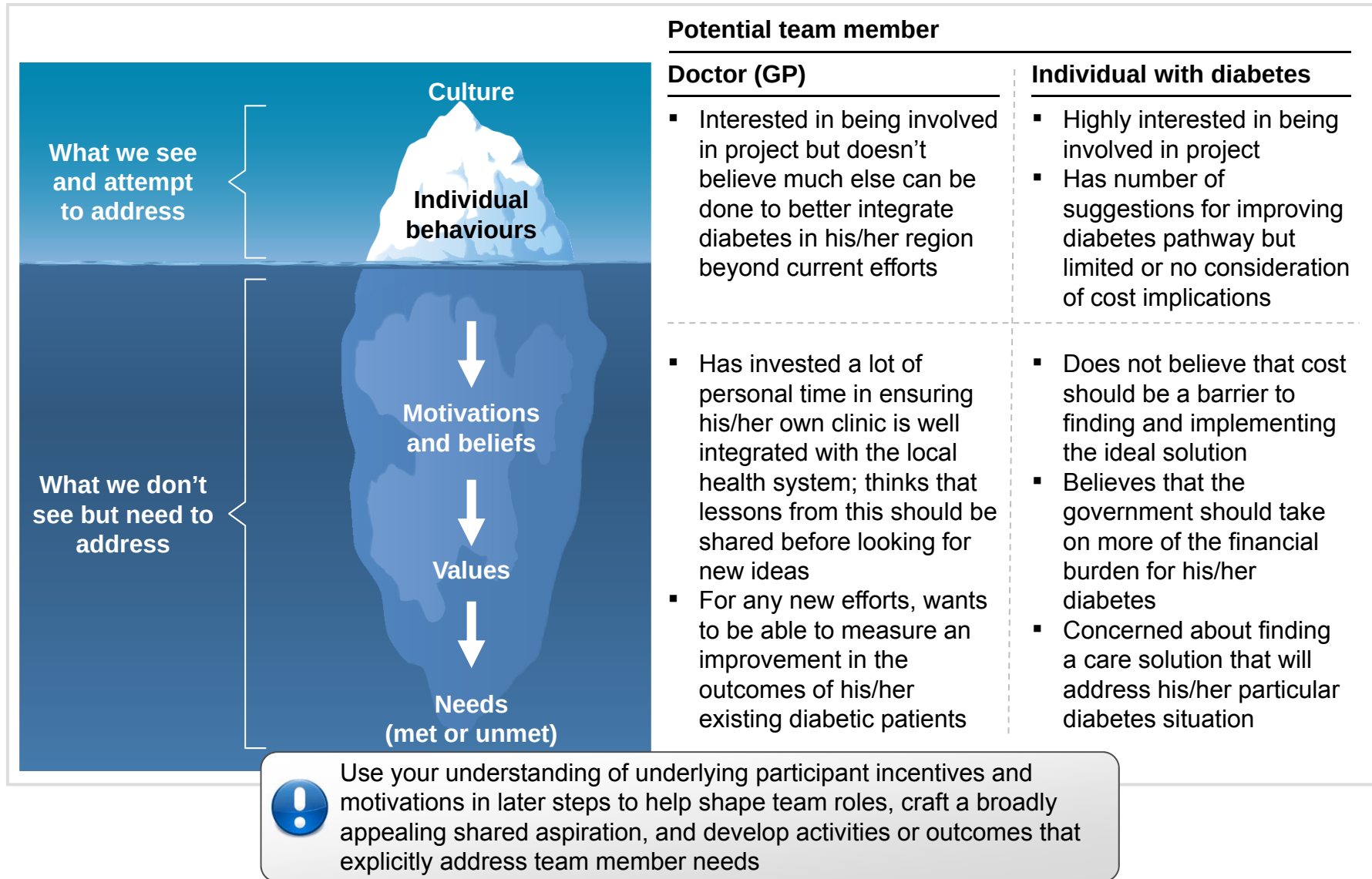
APPENDIX A: Collaborative framework tools and techniques

- **Step A**— Gather fact base and select focus areas
- **Step B**— Establish team, aspiration and ways of working
- **Step C**— Identify issues and root causes
- **Step D**— Develop case for change and set targets
- **Step E**— Design care delivery and business case
- **Step F**— Implement, track and adjust

Understand the incentives of potential team members

Example 'Iceberg model' for a diabetes integrated care project

ILLUSTRATIVE



Identify the common aspiration to galvanise the team

ILLUSTRATIVE

Use a group process to uncover elements of the project that matter to each participant

Potential workshop activities

▪ Post it notes

- Get each participants to write their project aspiration(s) on post it notes and place on the wall
- Group together common themes and use to form the basis of the group aspiration



▪ Draw it out

- Give participants 10 minutes each to draw a picture of their aspiration for the project
- Get them to explain to larger group
- Note common themes and use to help form the basis of the group aspiration



▪ Getting out of bed

- Get everyone to stand up and tell the group in under 1 minute what would 'get them out of bed' in the morning on this project
- List common themes and use to help form the basis of the group aspiration



What might a shared aspiration sound like?

We all want to achieve health system improvements that will bring breast cancer survival rates in our region **in line or better than national average**

We want to know that **if any of our kids had leukaemia**, they would have simple and timely access to the end-to-end care needed

We need to **save \$6M of cost** without decreasing the quality of care

We want to **close the gap** on Indigenous eye health in our region, and **be the knowledge leaders** in this space



The high-level aspiration should address the various incentives and motivations of the team and keep the patient journey front of mind

Demonstrate the need for cross health-system collaboration within the team

ILLUSTRATIVE

Suggested workshop activities

Activity

Instructions

Skit: From bad to good



- Split workshop participants into **two groups**. In each group, assign one person to be the patient, and the other participants to be different types of providers along your prioritised disease pathway (make sure people act as a different provides to what they are in real life)
- Group 1:** Act out a really **poor patient journey**, with no collaboration between providers
- Group 2:** Act out a **best practice patient journey**, with seamless collaboration between providers
- Plenary:** Discuss the difference between the 'good' and the 'bad' patient journeys. How does collaboration improve the patient journey? What happens when there is no provider collaboration?

Patient pathway whispers



- Split workshop into **small groups**
- Assign one person to be the 'Patient', and the other participants to represent different pathway providers/stakeholders (e.g., GP, hospital, community carer)
- The patient starts with a message** (~1 paragraph long, needs to be prepared beforehand) explaining their disease background, current treatment and medication, concerns, and some personal details.
- In a separate area /room where the group can't hear, the **Patient relays the message to Provider #1** (who cannot write anything down). The Patient leaves and Provider #2 then enters the room. **Provider #1 must repeat what he/she remembers of the message** to Provider # 2. Provider 2 relays to provider #3 and so on until all participants have heard the message (or a version of it)
- Plenary:** The **last person** to receive the message **repeats what they heard back to the group**. Discuss how similar/different it is from the original message. If the message has changed a lot, why was this the case? How could collaboration along the patient pathway improve the quality of the message? What other lessons were there from this exercise?

Draw it out



- Split workshop participants into **two groups**.
- Group 1:** Use whiteboards or large sheets of paper to draw out the stages and patient experiences of the system today
- Group 2:** Draw out the stages and patient experiences of a **best practice patient journey** that they would like to see

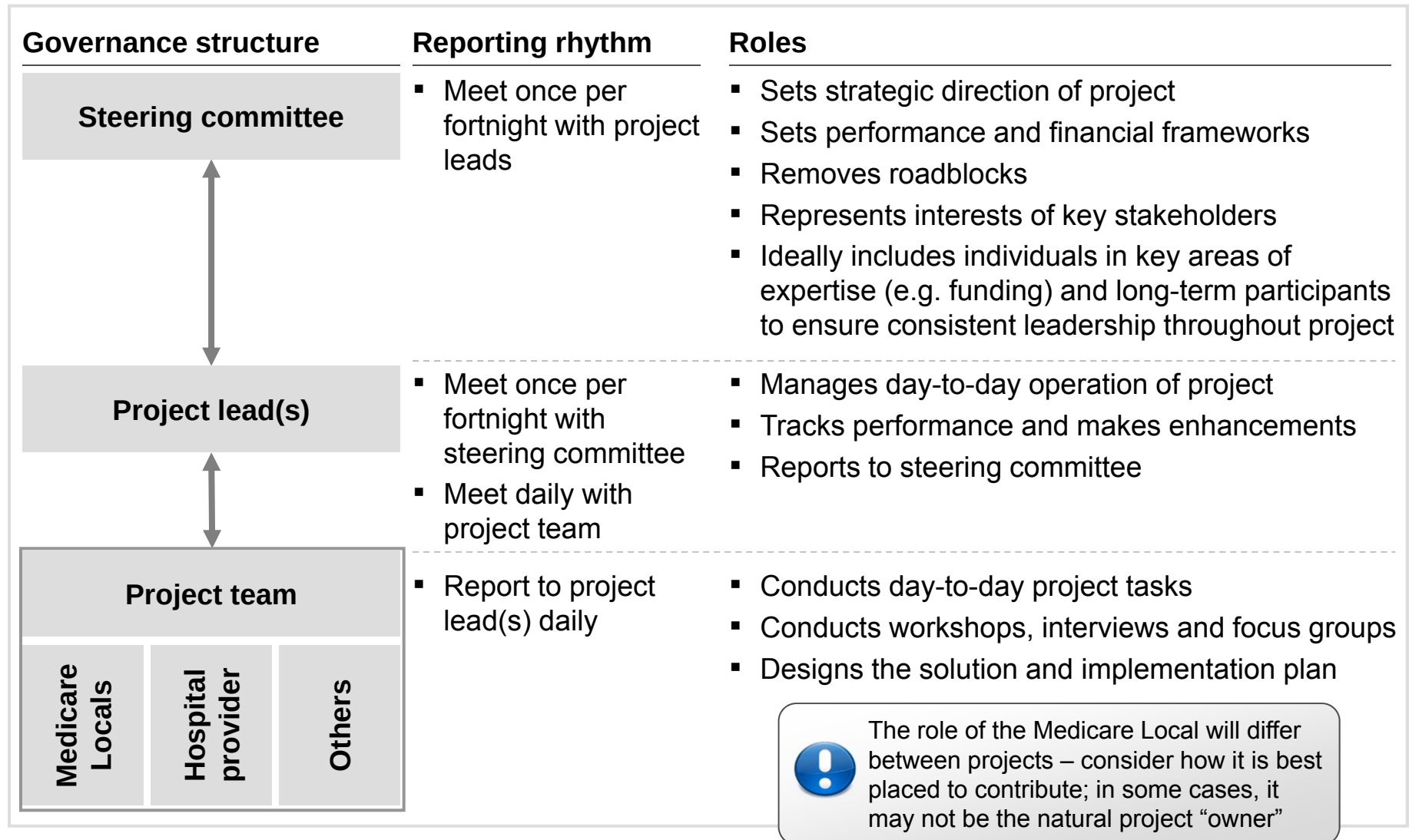


Modify suggested activities or introduce new activities as appropriate for the given group

Set the project's governance structure with clearly defined roles

Example governance structure

ILLUSTRATIVE



Hold a formal team kick off meeting to establish ways of working for both the project team and steering committee

Agenda item	Actions
Establish and align on project charter	Define the project charter which should include the problem definition, objectives, criteria for success, and scope, and ensure team members have a common understanding of the charter
Agree team roles	Define team structure and make sure each team member agrees on their role in the team, expected time commitment and associated responsibilities. Agreeing on these elements upfront can help to identify resource gaps that will need to be filled
Team norms	Discuss together, agree, and document the team's working norms (e.g., working hours, approach to iteration, foreseeable future commitments). It is important that each team member contributes to this discussion to create the right collaborative atmosphere
Team commitments	Discuss, agree, and document commitments made by each team member to the team and by the team to each participating stakeholder. This step will set out the appropriate expectations for the team going forward eg. Respect and commitment to leadership
Individual profiles	Ask individuals team members to discuss their working style preferences and project goals, and the way the team can help them achieve these goals. The project team lead should document these profiles and use them for development conversations
Working calendar and rhythm	Set a calendar with major project milestones and team meeting rhythm (e.g., how often will the team check in with each other? What is the primary communication channel?)



Venue and materials are important components of a successful team kick off. Ensure you have a private room in a quiet, interruption free location, boardroom style seating, a printable whiteboard, flipchart, and refreshments

Conduct a risk assessment to identify key risk factors and mitigating actions

ILLUSTRATIVE

Example risk assessment

Categories	Project success factor	Current situation	Evaluation of risk	Mitigating actions
Strategy and stakeholders	▪ Aligned objectives/aspiration	▪ Stakeholders unable to describe shared aspiration and expected outcomes or benefits	High	▪ Hold meeting to discuss objectives/aspiration and document
	▪ Aligned deliverables	▪ No clear timeline of deliverables	High	▪ Draft list of deliverables and circulate for agreement
	▪ Clear roles	▪ Project duties clearly defined and agreed on	Med	▪ Continue to revise and refine roles at monthly progress reviews
	▪ Leadership support	▪ Strong support from leadership of major stakeholders	Low	
Technology and content	▪ Standardised, proven technology	▪ Lack of standard, shared software; limited access to data	High	▪ Agree project technology strategy; invest in training if required
	▪ User involvement	▪ Moderate % of requisite users skilled	Low	
Team and capabilities	▪ Experienced project manager	▪ Project leaders on both sides quite strong and experienced	Low	
	▪ Qualified and motivated project team	▪ Team motivated, most necessary qualifications gathered, though limited data expertise	Med	▪ Add additional team member with data expertise; upskill team



Identify all risks relevant to the project. Medicare Locals may have an existing risk assessment process to follow.

Put mechanisms in place to track team satisfaction

Example team barometer from a diabetes integrated care project

ILLUSTRATIVE

Please rate the following dimensions	Strongly disagree 1	2	3	4	Strongly agree 5	No answer
Direction - I am clear about the objectives, timeline and deliverables of the project	☐	☐	☐	☐	☐	☐
Roles - I understand my role and the roles of project team members	☐	☐	☐	☐	☐	☐
Impact - I believe the project on track to deliver significant impact to patients and the health system	☐	☐	☐	☐	☐	☐
Personal excitement - I am excited to be working on the project	☐	☐	☐	☐	☐	☐
Personal development - I am receiving regular coaching/feedback and find it useful	☐	☐	☐	☐	☐	☐
Team atmosphere - The team has an atmosphere of trust, openness and fun	☐	☐	☐	☐	☐	☐
Work/life balance - I'm able to maintain a good balance between my work and private life	☐	☐	☐	☐	☐	☐
Capability - I have the right skills to help the team and practices achieve the project's objectives	☐	☐	☐	☐	☐	☐
Communication - We are communicating efficiently as a team and across the consortium	☐	☐	☐	☐	☐	☐
Effective team - This team is working really well together, including in problem solving and meetings	☐	☐	☐	☐	☐	☐
Resourcing - The team has the right resources to deliver the desired results	☐	☐	☐	☐	☐	☐
Practice relationships - We are developing strong relationships with practices	☐	☐	☐	☐	☐	☐
Practice performance - Our enrolled practices are actively improving their patients' clinical metrics	☐	☐	☐	☐	☐	☐
Recognition - I feel that my contribution to the project is recognised	☐	☐	☐	☐	☐	☐
Please add any further comments you may have.						

- Questions can be modified based on what metrics are most relevant for the team
- Results should be tracked over time in order to identify trends or changes
- If required, actions must be taken on the basis of results



Automate sending of barometer and collect results electronically (e.g., via [surveymonkey.com](https://www.surveymonkey.com))

Regularly review project impact

Example project checklist (for team lead)

ILLUSTRATIVE

Is the team having impact on the project?

- ☐ Is there a compelling and motivating story?
- ☐ Is the team engaging others across the organisation and community?
- ☐ Does team frequently spotlight success?

Is the team role modeling the desired mindsets and behaviours?

- ☐ Are stakeholders and patients drawing inspiration from the team's actions?
- ☐ Is the team making symbolic actions to send transformation messages?
- ☐ Is the team sending any mixed messages?

Is the team strong and committed to the transformation?

- ☐ Is the team taking steps to ensure they are motivated and developing the right capabilities?
- ☐ Is the team aligned on the transformation and their role as a team vs. individuals?
- ☐ Is team time being spent effectively (e.g., 80% solving problems, 20% sharing information)?

Has the team aligned and mobilised all the stakeholders?

- ☐ Has the team aligned and mobilised all stakeholders?
- ☐ Are all stakeholder expectations realistic and under control?

Contents

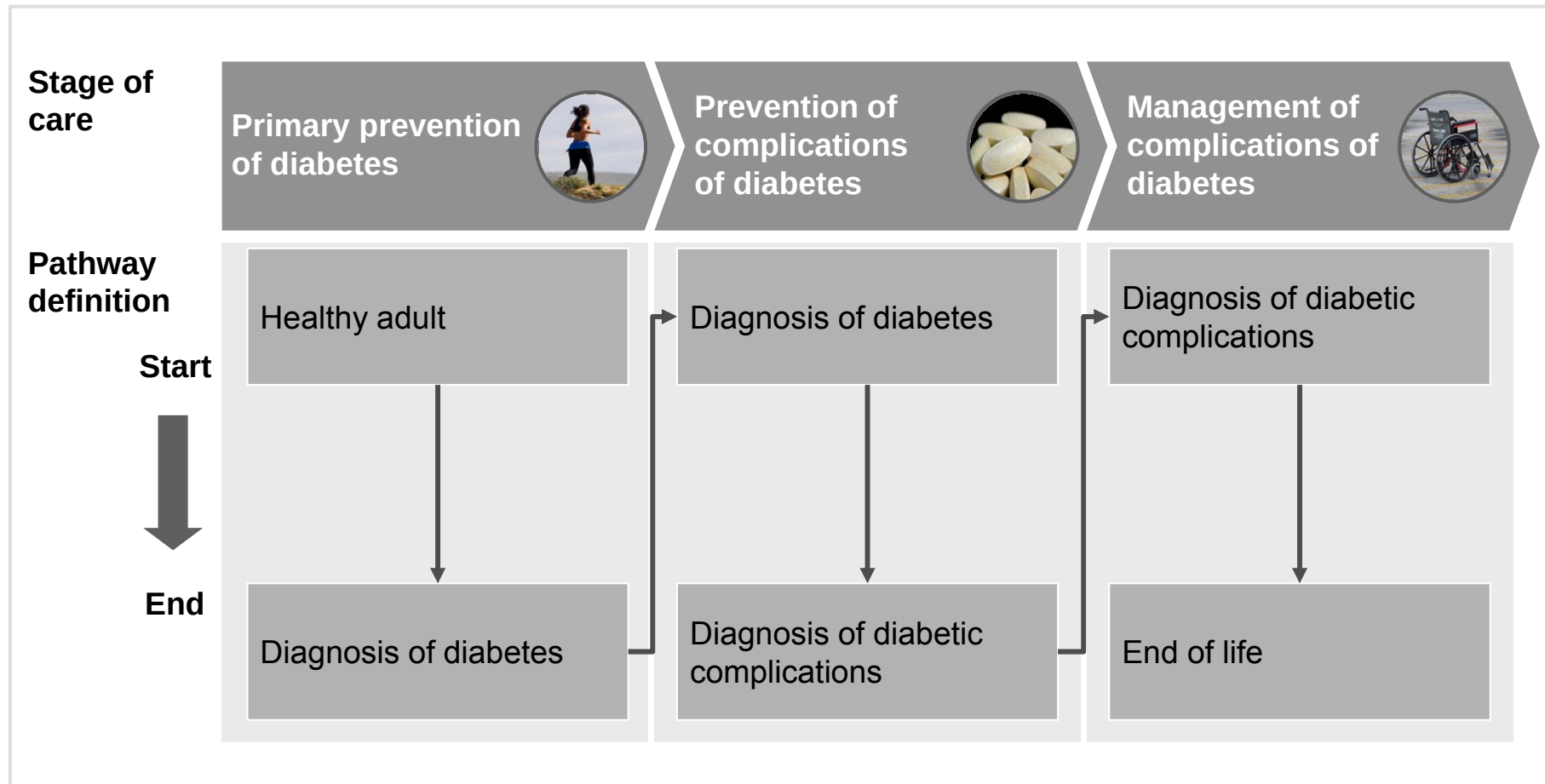
APPENDIX A: Collaborative framework tools and techniques

- **Step A**— Gather fact base and select focus areas
- **Step B**— Establish team, aspiration and ways of working
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- **Step F**— Implement, track and adjust

Draw the high-level stages of the focus pathway or system

Example pathway for diabetes integrated care project

ILLUSTRATIVE



You can also draw the pathway using settings of care (i.e., primary, secondary and tertiary)

Compare your performance for outcome and process metrics along the pathway

Example metrics for diabetes integrated care project

ILLUSTRATIVE

- >10% above target
- 0-10% above target
- Below target

	Primary prevention of diabetes 	Prevention of complications 	Management of complications 
Outcome metrics	O1a Diabetes incidence ●	O3 Prevalence of retinopathy ●	O10 Incidence of amputations ●
	O1b Diabetes incidence without complications ●	O4 Prevalence of foot ulcers ●	O11a Prevalence of CHD ●
	O2 Diabetes prevalence ●	O5 Prevalence of elevated micro albumin ●	O11b Incidence of Stroke ●
		O6 Prevalence of elevated cholesterol ●	O11c Incidence of MI ●
		O7 Prevalence of elevated blood pressure ●	O12 Incidence of avoidable hospitalizations ●
		O8 Prevalence of neuropathy ●	O13 Prevalence of renal failure ●
		O9 Prevalence of BMI > 30 (Obesity) ●	O14 Prevalence of serious vision loss ●
Process metrics	P1 % of asymptomatic adults receiving regular BMI check ●	P2a % of diabetics receiving regular HbA1c testing ●	 One way to identify the most relevant metrics is to derive them from the highest priority interventions under each broad stage of pathway based on existing literature review and clinical guidelines
		P2b HbA1c level at or below 7 or national standard ●	
		P3a % of diabetics receiving annual retinopathy screening ●	
		P3b % of diabetics receiving annual foot exam ●	
		P3c % of diabetics receiving annual cholesterol screening ●	
		P3d % of diabetics receiving annual urine micro albumin excretion screening ●	
		P3e % of diabetics receiving annual blood pressure screening ●	

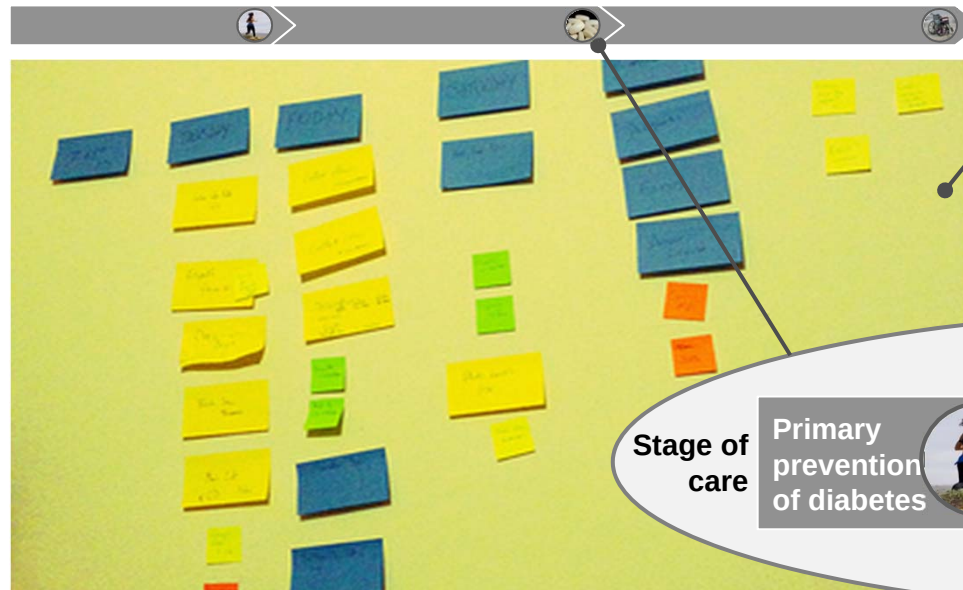
Engage with stakeholders to identify issues along the pathway

Example approach for issue identification

ILLUSTRATIVE

Conduct a workshop...

- Involve stakeholder representatives from across the focus pathway
- For each stage of the pathway, brainstorm issues identified from first-hand experience



Lack of population knowledge about risks

Poor oversight of service providers

Lack of communication between providers

Stage of care

Primary prevention of diabetes



Prevention of complications of diabetes



Management of complications of diabetes



Conduct root cause analyses on key issues

Example tools for conducting root case analyses

ILLUSTRATIVE

Title of tool	Description
5 Whys	This framework guides structured problem solving and root cause identification by asking 'Why?' five times (or more/less as needed), and focuses the discussion on first-hand data and facts. The framework can be useful to prevent acting on false assumptions when designing solutions for the pathway
Fishbone diagram	A fishbone diagram is a method to discover the root causes of a given situation. The issue is placed at the 'head' of the diagram and the ends of the 'bones' help prompt discussion/thought about potential root causes. The categories to consider include People, Process, Information, Infrastructure, Measurement and Environment
Process mapping	A pathway process map shows the flow of the patient journey and care provider interactions for each stage of the pathway. Arrows are used to show how a patient would navigate the various providers along the pathway and also represent collaborative interfaces between providers. Better understanding of the patient journey and provider interfaces can help trigger identification of root causes



In conducting root cause analyses, it is important to test your assumptions with consumers and providers

Contents

APPENDIX A: Collaborative framework tools and techniques

- **Step A**— Gather fact base and select focus areas
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Illustrate the 'do nothing' cost baseline

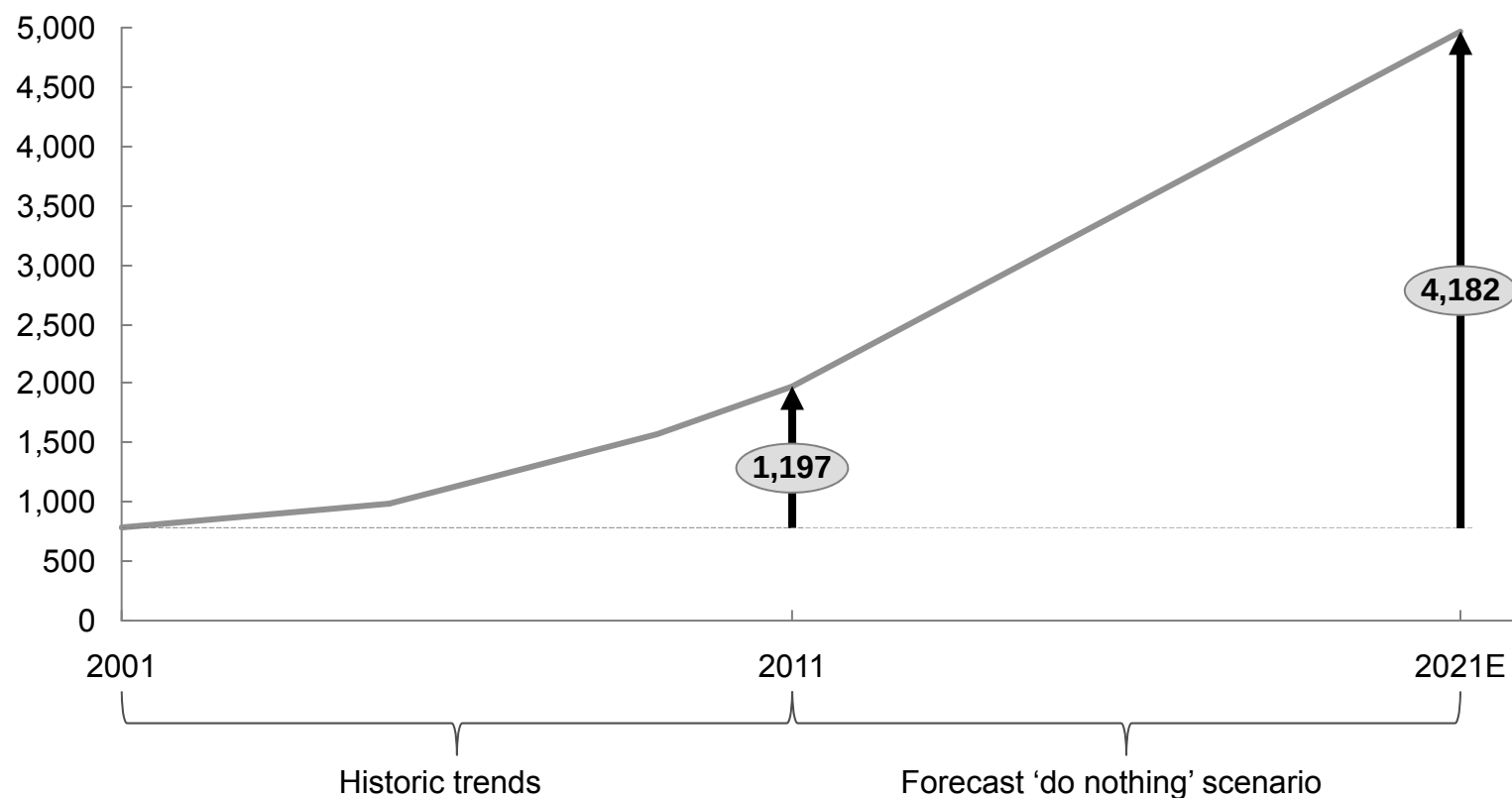
Example of a 'do nothing' cost baseline

ILLUSTRATIVE

Assuming historic trends continue, total spending allocated to diabetes mellitus in Australia is expected to be \$5 billion by the end of the decade

Total national spending allocated to diabetes mellitus

\$m



Illustrate the 'do nothing' disease burden baseline

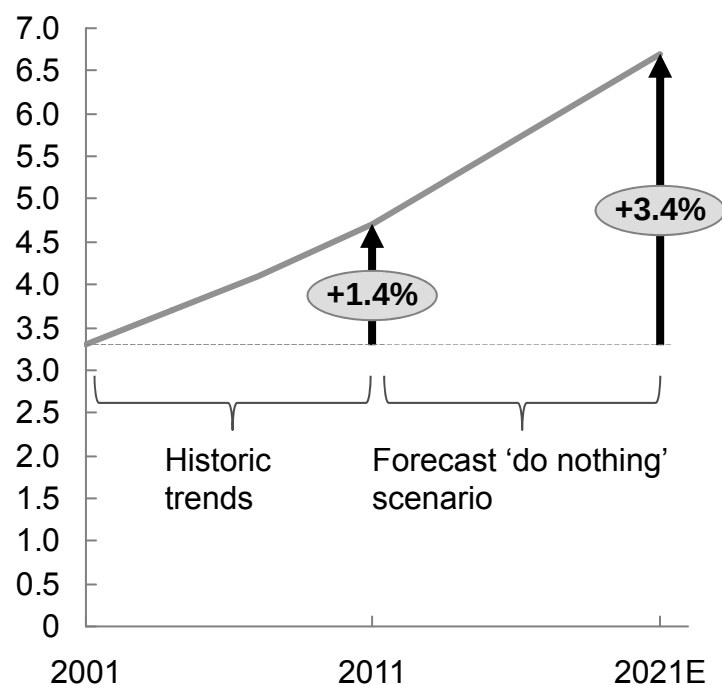
Example from diabetes integrated care project

ILLUSTRATIVE

Assuming historic trends continue, diabetes will affect almost 7% of the Australian population and cause a 30% increase in avoidable hospitalisations by the end of the decade in a 'do nothing' scenario

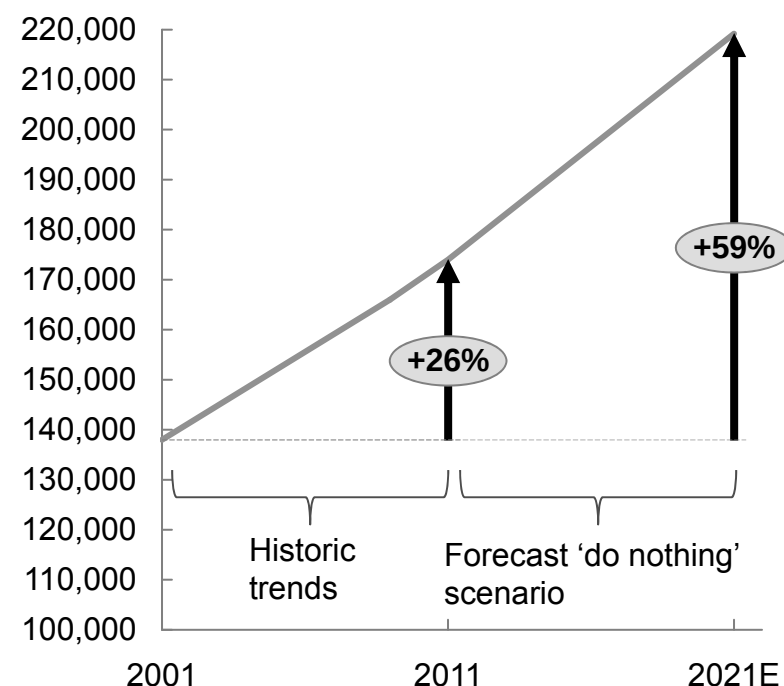
Prevalence of diabetes

% of population



Avoidable hospitalisations from diabetes related complications

annual



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SOURCE: AIHW, 2011; Australian Hospital Statistics 2009-10; AIHW, 2012; Prevalence of diabetes; Public Health Information Development Unit (2007), Atlas of Avoidable Hospitalisations in Australia: Ambulatory care-sensitive conditions

Set 'SMART' improvement targets

Example of target setting

ILLUSTRATIVE

Benchmarks suggest a target savings range for Region X of 24-40%

Estimation approach	Findings	Potential savings	Relevant context	Implications for XYZ target savings
If Region X reduces variability between practices	11–15% reduction in non-elective admissions across XYZ if all poor performers meet top quartile performance	11–15% (across entire population)	Reduction involves performing better within current system with limited changes to care delivery model and enablers	Range too low
If Region X meets national top performers	- Gap to national top performer for over 65s: 17–28% (Gap to national top decile for over 65s: 36–44%)	17-28% (for over 65s)	- Most national peers are not integrated care systems - Indicative of lower range of savings	Minimum impact: 24% (midpoint between 17 and 28%)
If Region X meets global evidence base on integrated care	- Research on global IC evidence base across 50+ organisations shows reductions of 25-40% - Organisation 1: 25% reduction in per capita costs - Organisation 2: 30% lower emergency admissions - Organisation 3: 54% reduction in acute beds	25-40%	Higher end of savings comes from focus on most elderly patients and those with long-term conditions	Maximum impact: 40%

SMART¹ Target:

Reduce annual cost across primary and acute care for region XYZ by 24-40% in 5 years



Suggested ways identify potential and set targets include:

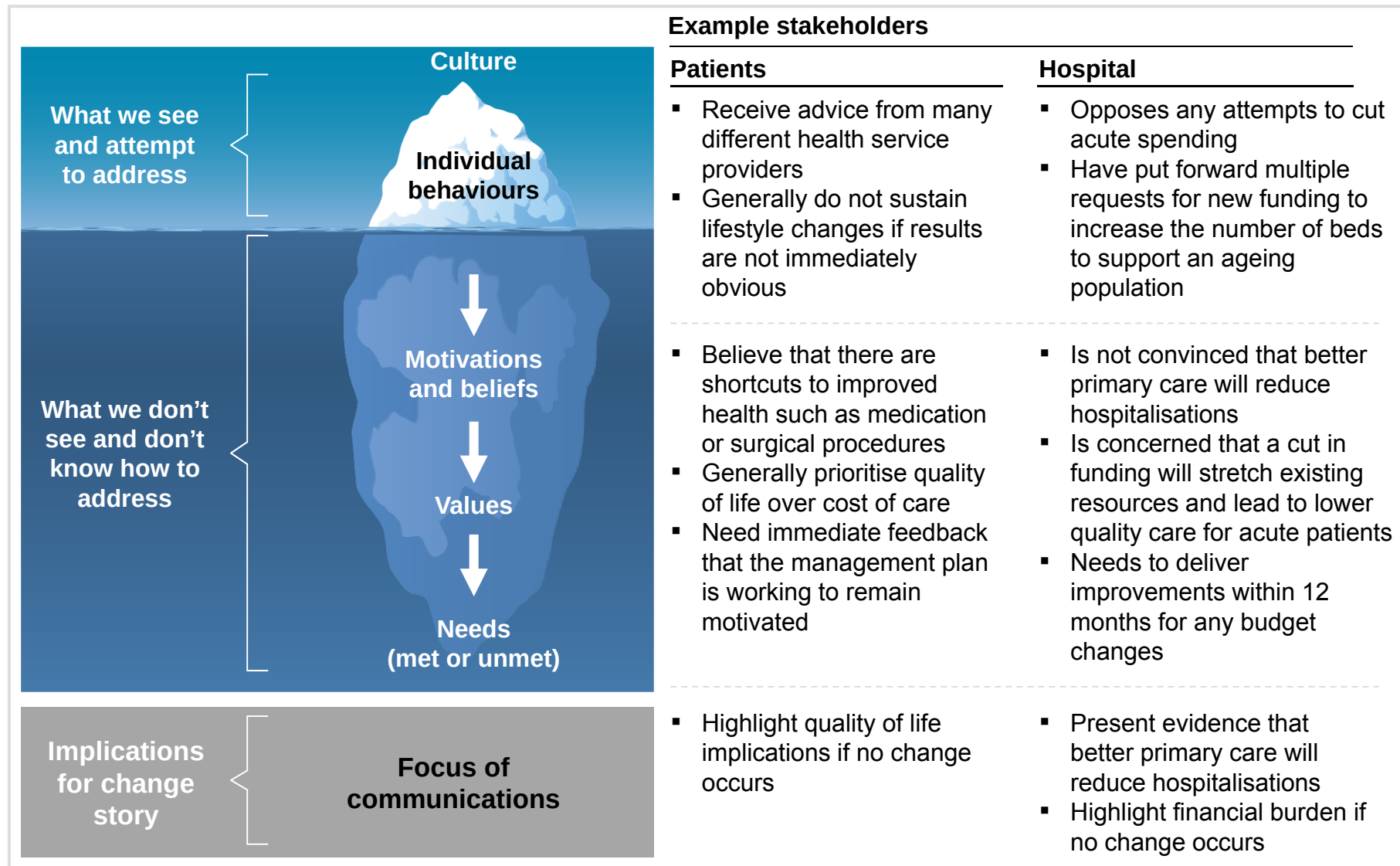
1. Reduce region variability by improving poor performers within a region
2. Aim for national benchmark
3. Aim for benefits achieved by similar initiatives elsewhere

¹ Acronym for Smart, Measurable, Actionable, Relevant, Timely

Identifying stakeholder motivations and implications for change story

Example 'Iceberg model' for chronic disease integrated care project

ILLUSTRATIVE



Use creative ways to communicate the case for change

Example of visual case for change for diabetes integrated care project

ILLUSTRATIVE

We asked clinicians and patients to draw the current state...



...and what they would like the system to be



Tailor the case for change to different stakeholders motivations

Example of case for change for integrated care project

ILLUSTRATIVE

'Do nothing' implications for example stakeholders

Patients	Hospitals	Government
- Poorer health outcomes for individuals - Reduced access to services, with longer operation and social care wait times - Less flexibility in treatment options, e.g., forced to switch to more expensive drugs and treatment options	- Major financial challenges leading to a need to reduce ward, bed, and staff numbers - Increasing challenge of delivering more with less; mismanagement will result in increased wait times for patients and missed quality targets	- Increased spending on acute services at the expense of social and prevention activities, leading to a long term crisis of untreated and undiagnosed illnesses - Disputes with providers, leading to poorer outcomes for patients and missed opportunities to deliver the best care possible

Example case for change: The patient perspective: current and potential future state



Meet David

David is 82 and lives alone in Hammersmith. He has usually stable Parkinson's disease and walks with a stick. He has developed an urinary tract infection which has led to him becoming confused. Recently, his niece, Joanna, visited him and, concerned by his behaviour, takes him to the Emergency Department. In hospital, David felt even more confused and became aggressive towards the nurse who is trying to care for him....

How could David's care be delivered in an integrated care system

David's GP has already placed him on an integrated care plan which his shared with his family and carers

On a visit, David's nurse finds he has a urinary tract infection (UTI). The nurse coordinates care for him

Over the next week a district nurse regularly visits and a care agency brings meals, changes clothes and gives baths. His GP is kept informed.

David's confusion abates and he recovers from UTI at home. He is booked into see his GP who approves recovery



When sharing the case for change be mindful of your audience: certain aspects should be emphasised for certain audiences (e.g., cost component for payors)



Think of different ways to creatively communicate the case for change (e.g., waiting room videos, local radio stations), depending on the audience

Contents

APPENDIX A: Collaborative framework tools and techniques

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Engage with a broad group of stakeholders to identify potential solutions

Suggested approaches for solution generation

Methods of idea generation	Description	Benefits	Challenges
Interviews 	Conduct interviews with experts, clinicians, and patients to determine whether there have been interventions for similar issues in the field	▪ Easy to set up and conduct ▪ Can deeply discuss experiences and relevance for project	▪ May not have access to appropriate experts
Case studies 	Search for both international and domestic case studies to find examples of how other health systems have tackled similar issues in the past	▪ Provides documented evidence of success or failure ▪ Rigorous and well-referenced	▪ Time and resource intensive ▪ May not have access to international case studies
Workshops 	Conduct workshops involving cross-health system representatives and patients to brainstorm collaborative and creative solutions to each identified issue	▪ Broad stakeholder engagement	▪ Time and resource intensive to set up and convene ▪ Potentially costly
Focus groups 	Conduct focus groups with particular segments of the healthcare system (e.g., GPs, Medicare Locals pursuing similar initiatives) and brainstorm potential solutions involving their particular segment	▪ Cheaper than workshops ▪ More targeted discussion	▪ Time consuming ▪ Drawing common themes between focus groups

Identify potential solutions to address root causes

Example of potential solution identification for diabetes integrated care project

Step 1: List issues and root causes prioritised in Step C

Issue/root cause

- Lack of an integrated patient medical record means that patients have to explain their treatment history to each provider
- Specialist attendances in the region are lower than target because there is no follow up by referring clinician, and no communication with community and social workers
- ...

Step 2: Identify potential solutions for each issue

Solution(s)

- Integrate patient medical history into a single patient registry
- Assign responsibility to GPs to coordinate the patient's journey along the pathway
- Assign responsibility to GPs to coordinate the patient's journey along the pathway
- Appoint care facilitators to follow up on referrals
- ...

Step 3: Identify which stakeholder(s) are impacted by each solution

Stakeholders impacted

- All providers
- GPs
- GPs
- Care co-ordinator (new role)

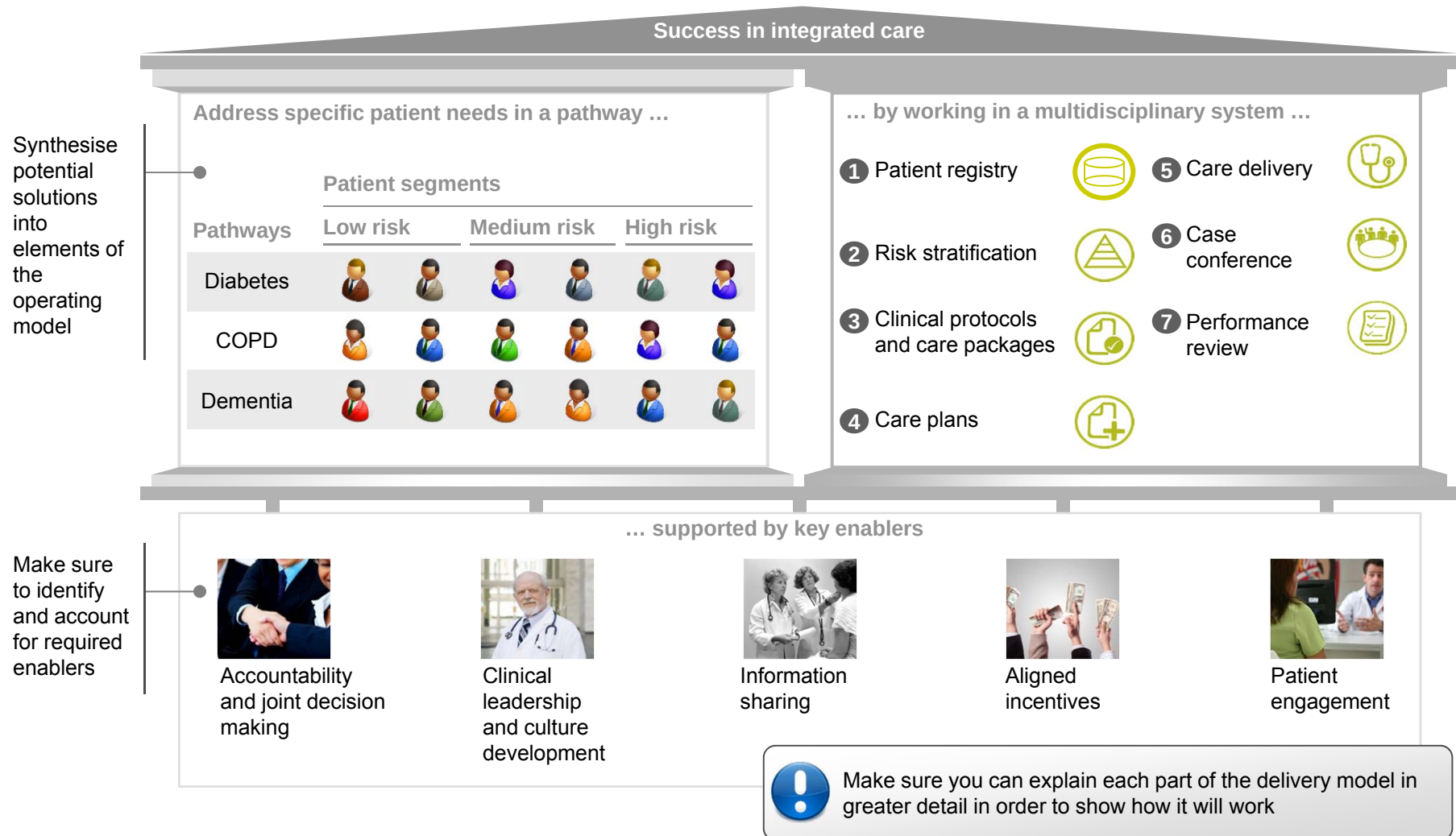


Brainstorm as many ideas as you can. If the same solution appears many times for different root causes, then it should be considered as an integral part of the new care delivery model

Design a holistic future-state care delivery model

Example of future-state delivery model for chronic disease integrated care project

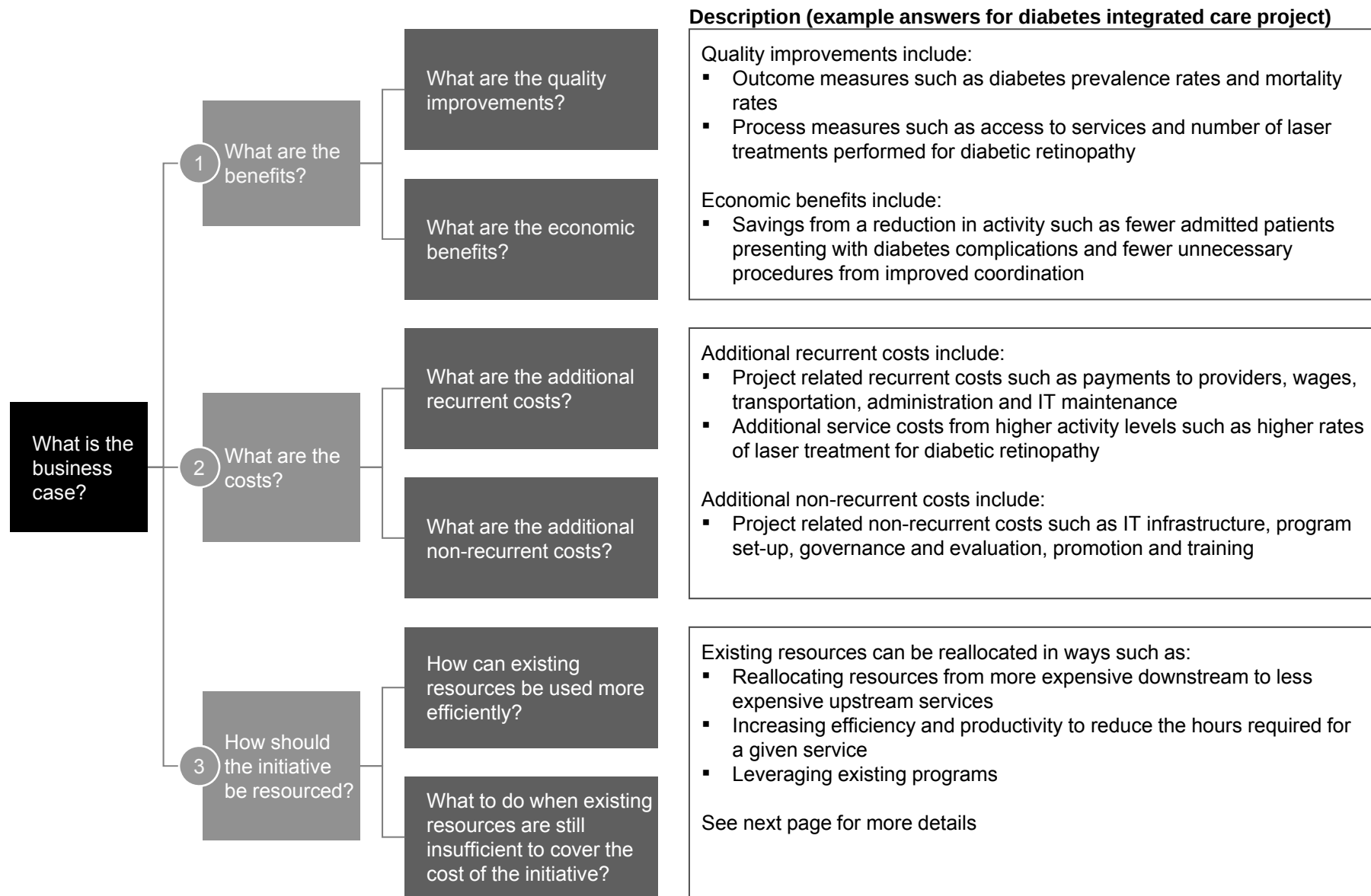
ILLUSTRATIVE



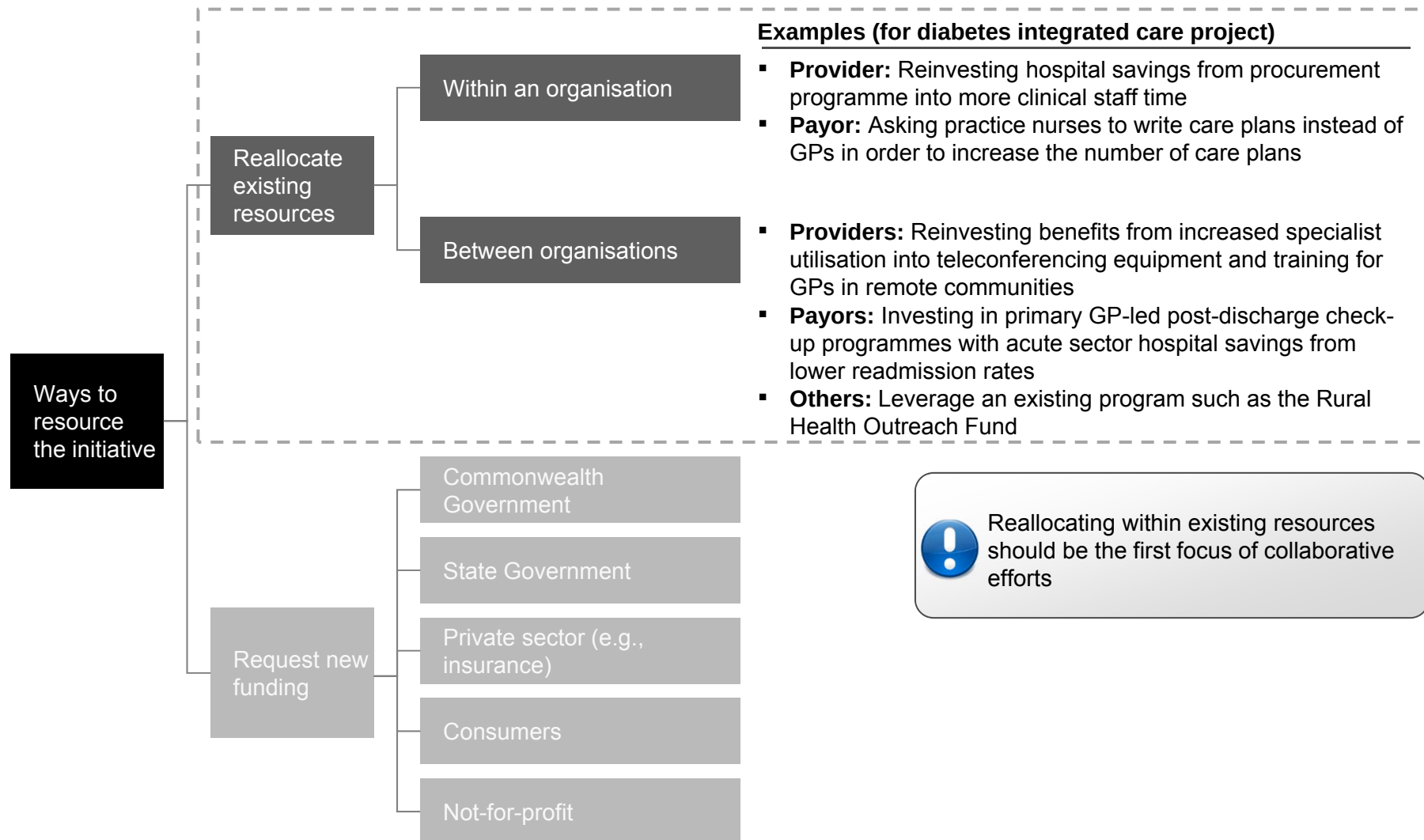
Ensure incentives are aligned by selecting the appropriate payment models

	Payment model	Configuration of design elements	Works best for ...
Increasing physician/health system risk ↓	A Activity-based reimbursement	▪ Performance metric: Reimbursement for specific service provided to a patient, where each individual service (or procedure, intervention or piece of equipment) is billed and paid for separately ▪ Pricing: Amount paid for services is negotiated between insurers, payors and providers; or, in the case of government payors, based on defined rates determined by a formula or funding levels ▪ Other: Additional payment can be made for capital contribution or care management	▪ One-off incidents where driving throughput is important
	B Pay for performance (P4P)	▪ Performance metric: Activity-based reimbursement, with a bonus payment to hospitals or physicians based on achieving defined and measurable goals related to access, continuity of care, patient satisfaction and clinical outcomes ▪ Target setting: P4P is a reward mechanism accounting for 5-10% of total payments; it is not used as a main basis for compensation to protect against perverse incentives ▪ Pricing: Reverse P4P can be employed to exchange price for volume	▪ Combining with activity-based reimbursement for longer-term conditions
	C Upside and downside risk-sharing model (optional: upside risk-sharing only)	▪ Performance metric: Physicians are paid a risk-adjusted percentage of costs saved, but also penalised for additional costs incurred that can be attributed to the physicians' effort ▪ Target setting: Quality thresholds exist to prevent withholding of care	▪ Creating an incentive model to address hospital avoidance activities, especially for long-term conditions
	D Episode or bundled payments	▪ Performance metric: Single payment for a group of services related to a treatment or condition that may involve multiple providers in multiple settings	▪ Planned care or conditions requiring end-to-end care (e.g., pre-op, per-op, and post-op)
	E Capitation or total cost of care payment	▪ Performance metric: Single risk-adjusted payment for the full range of health care services needed by a specified group of people for a fixed period of time ▪ Other: Total cost of care payment is very similar to capitation, but with the use of more sophisticated risk-adjustment methodologies, limits on risk exposure, and incorporation of quality measurement)	▪ Long-term conditions or elderly care where multiple health system interactions are required and providers need to be incentivised to think about the best allocation of resources

Address the following questions when building the business case



Consider different ways to resource the initiative with a focus on reallocating existing resources



Identify how much of the solution can be implemented using existing resources

Examples of how existing resources could be used to fund a diabetes integrated care project

	Description	Payor
Medicare Local flexible funding	Allocate Medicare Local flexible funding toward implementation of project; this could involve pooling flexible funding between multiple Medicare Locals where benefits accrue across regions	Medicare Local(s)
Cost benefits from reduced prevalence	Reduction in diabetes related complications will lead to fewer Medicare item claims	Commonwealth Government
Appropriate utilisation of Medicare items	Appropriate and full utilisation of Medicare item claims (e.g., items claims for chronic disease management can be used for diabetes care coordinators)	Commonwealth Government
Reallocate resources from downstream to upstream	Earlier intervention for diabetes patients in the primary care setting can reduce later complications in the acute sector; the acute sector could therefore help fund primary interventions	State and Commonwealth Government
Reallocate resources from other disease areas	Repurpose budget from other health initiatives to fund diabetes project (e.g., from heart disease to diabetes. Note that this can be highly sensitive and will require an appropriate communications strategy)	Contingent on program
Better utilise existing programs	Better utilise funds available through existing Commonwealth and State/Territory programs (e.g., Indigenous Chronic Disease Package, allocated COAG funding)	Contingent on program
Efficiency gains	Higher productivity of resources leading to cost savings (e.g., reduced time for surgeries to treat diabetes complications leads to lower theatre costs)	State and Commonwealth Government

Contents

APPENDIX A: Collaborative framework tools and techniques

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Use the Influence Model to design a holistic change management plan

Change management often involves dealing with a shift in mindsets and behaviours. The Influence Model states that to address this, four change levers must be addressed. Each change lever can be broken into a number of more actionable categories.

Lever categories

- Leadership actions
- Opinion shapers
- Interactions

- Talent management
 - Hiring
 - Replacing
 - Retaining
- Learning
 - On-the-job development
 - Training
 - Action learning

Role-modeling

"I see superiors, peers, and subordinates behaving in the new way"

Fostering understanding and conviction

"I know what is expected of me – I agree with it, and it is meaningful"

Mindset & behaviour shifts

Developing talent and skills

"I have the skills and competencies to behave in the new way"

Reinforcing with formal mechanisms

"The structures, processes, and systems reinforce the change in behavior I am being asked to make"

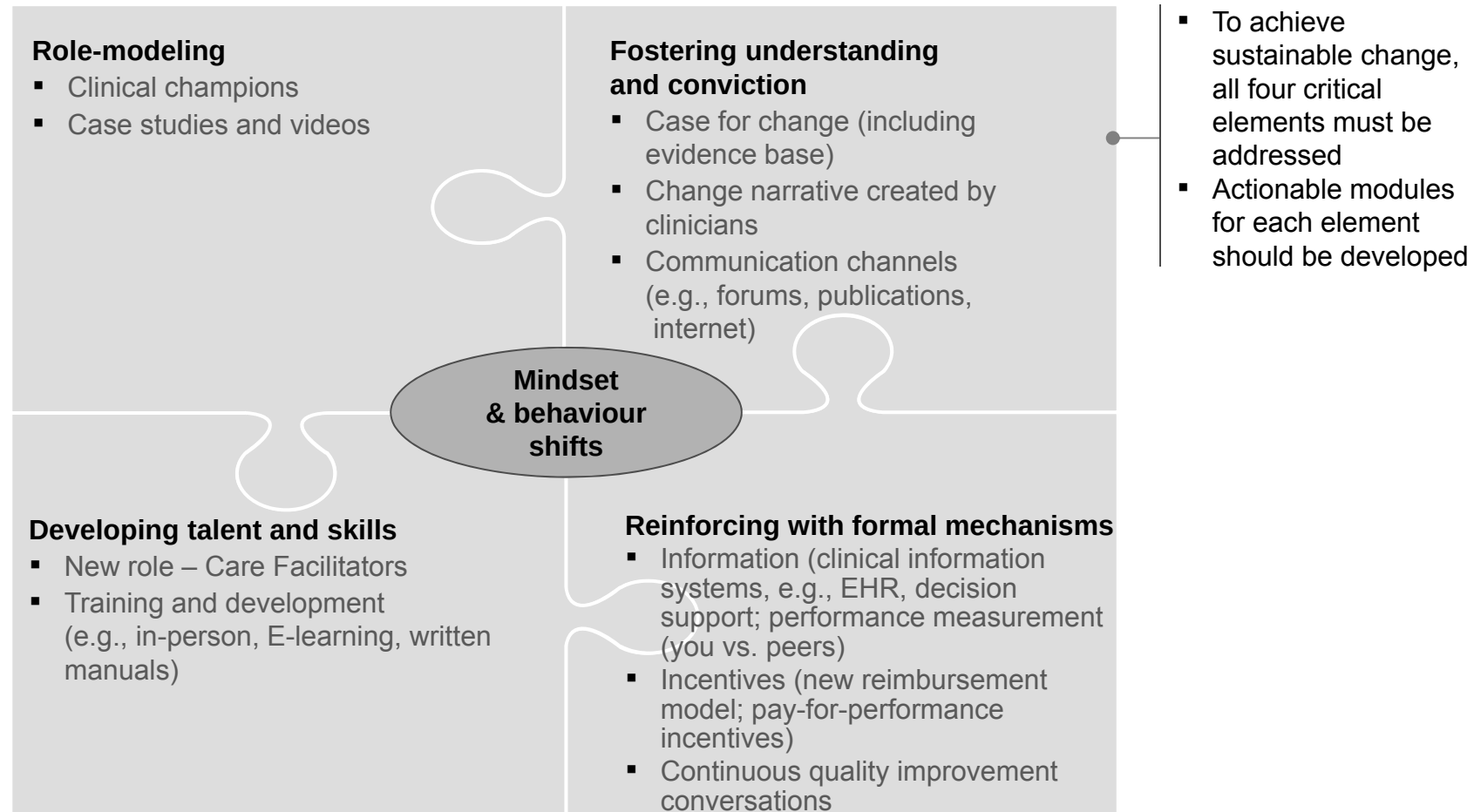
Lever categories

- Story development (includes all the key elements, e.g., values, strategy, case for change)
- Story delivery (across relevant levels, i.e., organizational, employee, functional)

- Organisation structure
- Targets and metrics
- Management processes
- Business processes
- Rewards, recognition and consequences
- Information systems

Include actionable modules for each change lever

Example of change management plan for diabetes integrated care project



Develop an action plan for implementation with clear timelines and assignment of responsibilities

ILLUSTRATIVE

Example action plan for diabetes integrated care project



Ensure to syndicate actions and timing with the individuals who have been assigned responsibilities and note potential “sticking points”

Agree how performance will be monitored including which metrics will be tracked and at what reporting intervals

Example performance dashboard for diabetes integrated care project

Displayed in user friendly format

Key metrics clearly tracked

Visual cues and colours used to quickly identify status

Objectives	KPIs		Units	Period	Period Status	Target		Overall Performance			Intervention Group		
						Overall Goal	Date	Baseline	This Period	Period Change	Baseline	This Period	Change
Key operating model activities													
Clinical processes	Total Care Plans approved	%	Weekly	🟢	82%	1/03/13		77.0%	+3.0%		77.0%	+3.0%	
	Out-of-range Care Plans approved	%	Weekly	🔴	90%	31/12/12		78.5%	+3.9%		78.5%	+3.9%	
	Within-range Care Plans approved	%	Weekly	🟢	70%	1/03/13		75.0%	+1.8%		75.0%	+1.8%	
	Accurate and timely data	%	Weekly	🔴	90%	1/03/13		77.4%	-0.1%		77.4%	-0.1%	
	Care Plan completeness	%	Weekly	🟢	50%	1/03/13		73.9%	-0.2%		73.9%	-0.2%	
	Case meetings conducted	#	Monthly	🔴	14	1/06/13		0	0		0	0	
Change Management	Communications - Out-of-range patients contacted	#	Monthly	🔴	20			0	0		0	0	
	Continuous quality improvement meetings conducted in past three months	%	Monthly		80%								
	Cases submitted	#	Monthly		14								
Team Development	Personnel training sessions attended	%	Monthly		80%	21/12/12							
Key study outcomes													
Clinical outcomes	Median HbA1c	%	Weekly	🔴	6.4%	31/03/14	6.9%	6.9%	0.0%	6.9%	6.9%	0.0%	
	Median HbA1c for patients with HbA1c > 7.5%	%	Weekly	🔴	7.9%	31/03/14	8.4%	8.4%	0.0%	8.4%	8.4%	0.0%	
	Median HbA1c for patients with HbA1c < 7.5%	%	Weekly	🟢	6.5%	31/03/14	6.5%	6.5%	0.0%	6.5%	6.5%	0.0%	
	Patients with out-of-range risk stratification metrics	%	Weekly	🔴			57%	58%	-0.0%	57%	58%	-0.0%	
Patient and practitioner experience	Practice withdrawal rate	%	Monthly	🟢	10%			8%	0%		8%	0%	
	Patient withdrawal rate	%	Monthly	🟢	10%			2%	0%		2%	0%	
Economic sustainability	Hospitalisations per 1000 trial people	#	Monthly		20% below baseline								

Conduct performance reviews and adjust implementation as required

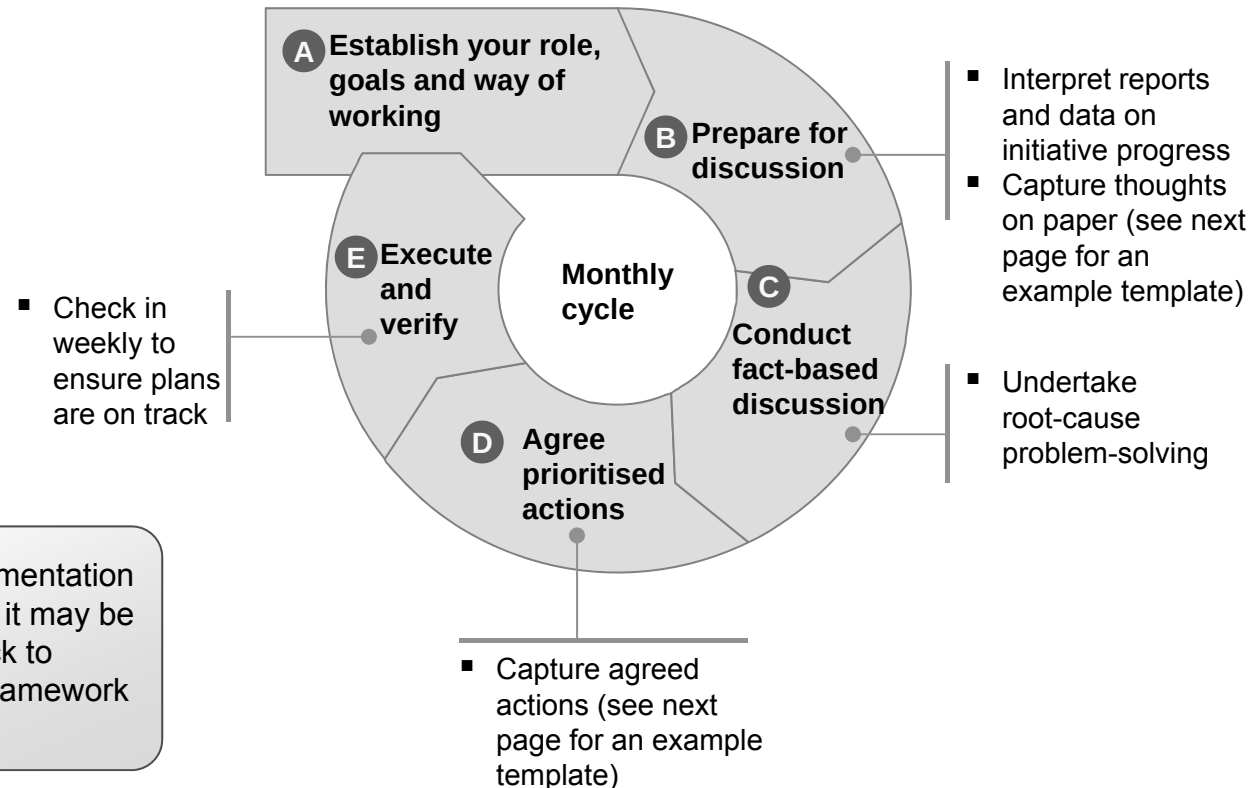
ILLUSTRATIVE

Example tool—Continuous Quality Improvement conversations

What it is

Continuous Quality Improvement conversations are a tool that can be used to help formalise discussions about progress and set clear actions that will help to further refine and improve an initiative

How it works



Conduct performance reviews and adjust implementation as required

| ILLUSTRATIVE

Continuous Quality Improvement—conversation template

Highlights

- Main achievements of last period – celebrate these!
- Can cover any KPI category
- Keep it short and simple
- Must have at least one!

Issues to be resolved

- Things
 - The lead should know
 - You need help resolving
 - That need escalation
- If not resolved, will become 'lowlight'

What I need from you

- Outlines a direct action the participant requires of the lead, usually outside the control of the participant

[illegible]

Lowlights

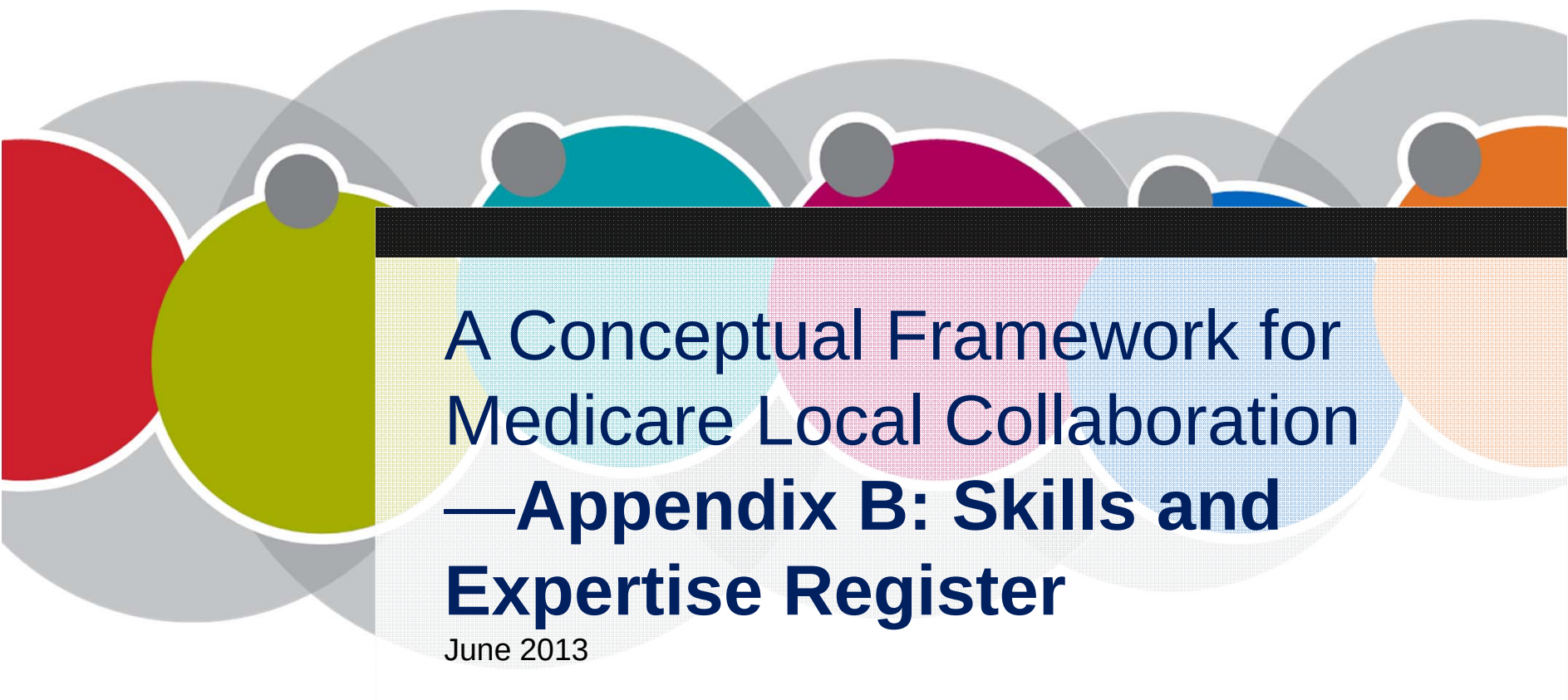
- Main shortfalls of last period
- Can cover any KPI category
- No need to labour the point!

Top priorities

- Key priorities for next period(s)
- Link to KPIs and trends
- Keep to the 'precious few'
- Confirm each with lead

Actions

- Link to 1) KPI variance, 2) issues and 3) priorities
- Begin actions with effective verbs
- Each action should have a single point of accountability



A Conceptual Framework for Medicare Local Collaboration —**Appendix B: Skills and Expertise Register**

June 2013

Skills & expertise required for Medicare Local Collaboration

The purpose of this register is to identify the skills and expertise required to successfully collaborative and indicates useful resources for accessing these skills. Note that one of the best sources of help is other Medicare Locals; reach out to your peers to find out how they may have tackled similar challenges

Skills and expertise	Steps	Specific skill elements	Useful resources
Leveraging existing or planned initiatives Leveraging and building on the experiences of others in your own region, or beyond	All	Identifying similar initiatives or regions with similar interests; connecting with individuals who have relevant experience; leveraging opportunities to work together on shared priorities	Australian Medicare Local Alliance (amlalliance.com.au); Medicare Local contacts
Local / regional knowledge Possessing knowledge of how the local context impacts on the project	A, B, E	Understanding what interventions are underway and what resources have already been allocated; knowing who key stakeholders are in local region; understanding how the disease pathway or system varies in the local context;	Local hospital providers (e.g., www.slhd.nsw.gov.au); community health organisations (e.g., National Aboriginal Community Controlled Health Organisation— www.naccho.org.au); local government
	E	Possessing up-to-date knowledge of local and national regulatory frameworks; understanding contracting process and sources of legal advice; understanding barriers to different funding allocation arrangement	Department of Health and Ageing (www.health.gov.au); state health departments (e.g., www.health.nsw.gov.au ; www.health.vic.gov.au)
Patient & community engagement Developing links with and ensuring active involvement of patients and key community members	All	Identifying key people; listening to patient and community perspectives and incorporating feedback into designing solutions; extracting contributions (especially from marginalised stakeholders)	Consumer Health Forum (www.chf.org.au) Australian Council of Social Services (www.acoss.org.au)

SKILLS & EXPERTISE REGISTER

Skills and expertise	Steps	Specific skill elements	Useful resources
Health economics expertise Conducting rigorous economic evaluation of health system initiatives and policies	A,	Assessing potential focus areas using objective quantitative analysis	Research institutions and academia
	E	Developing economically rigorous business case; quantifying benefits and identifying parties that are beneficiaries	Research institutions and academia
Clinical expertise Possession of clinical knowledge regarding the practice of both primary and acute stages of care	C, E, F	Understanding best practice interventions and clinical guidelines; identifying barriers to clinician uptake	Research institutions and academia; professional bodies (e.g., Australian Medical Association— www.ama.com.au , Royal Australian College of Physicians— www.racp.edu.au)
Epidemiological expertise Medical understanding of the incidence, prevalence, and control of disease within a population	C, E, F	Developing the disease pathway; selecting most appropriate outcome and process metrics along the pathway	Research institutions and academia; peak consumer and professional bodies (e.g., australiandiabetescouncil.com)
Data collection & analysis Collecting quantitative and qualitative data and undertaking analysis to reach fact-based insights...(continued)	A, C, D, E	Sourcing and systematic collection of appropriate data (including metrics for disease cost, burden, key outcome and process indicators, and national targets); ability to conduct sessions for the collection of primary data (e.g., focus groups, interviews, designing questionnaires); rapid analysis to reach insights from collected data; understanding of statistics; use of data analysis tools (e.g., Microsoft Excel); communicating analysis to facilitate decision making	Australian Institute of Health and Welfare (www.aihw.gov.au); National Health Performance Authority (www.nhpa.gov.au); Census population statistics including births, deaths, life expectancy etc. (www.abs.gov.au); General practice databases (e.g., disease registers, prescription data); Hospital databases (e.g., presentations, bed days etc.)

SKILLS & EXPERTISE REGISTER

Skills and expertise	Steps	Specific skill elements	Useful resources
Data collection & analysis (continued from previous)	F	Selecting tracking metrics and determining appropriate reporting intervals; making data transparent and widely accessible; automating reporting wherever possible; evaluating and determining areas of weakness for correction	
Project management Providing direction for the overall project and having oversight of all project components	All	Planning of overall project and individuals' work; mapping together discrete pieces of work into unified project; identifying and securing resources; people management; time management; direction and objective setting	
Relationship building and management Identifying key stakeholders and developing a common vision and shared responsibilities	All (esp. B)	Networking with and managing key stakeholders within project team; developing new relationships with potential partner organisations; gaining alignment on outcomes and vision	
Team building Understanding team dynamics and facilitating effective working	All (esp. B)	Identification of individuals' strengths and weaknesses; skill development; leadership; communication; facilitation	
Communication & presentation Creating and delivering compelling communications tailored to different stakeholders	All (esp. D)	Tailoring messages for different audiences; delivering engaging communication through multiple formats (e.g., speeches, written documents); effective health messaging to community and providers	Public health campaigns (e.g., www.quitnow.gov.au) and peak bodies (e.g., www.drugfree.org.au)
Change management Designing and executing a change management plan	F	Experience with designing and executing a change management plan consisting of: ▪ Creating conviction and buy-in ▪ Establishing role models ▪ Building capabilities ▪ Developing formal mechanisms	Medicare Local board of directors

The following organisations have contributed to the development of the Conceptual Framework for Medicare Local Collaboration

Medicare Locals

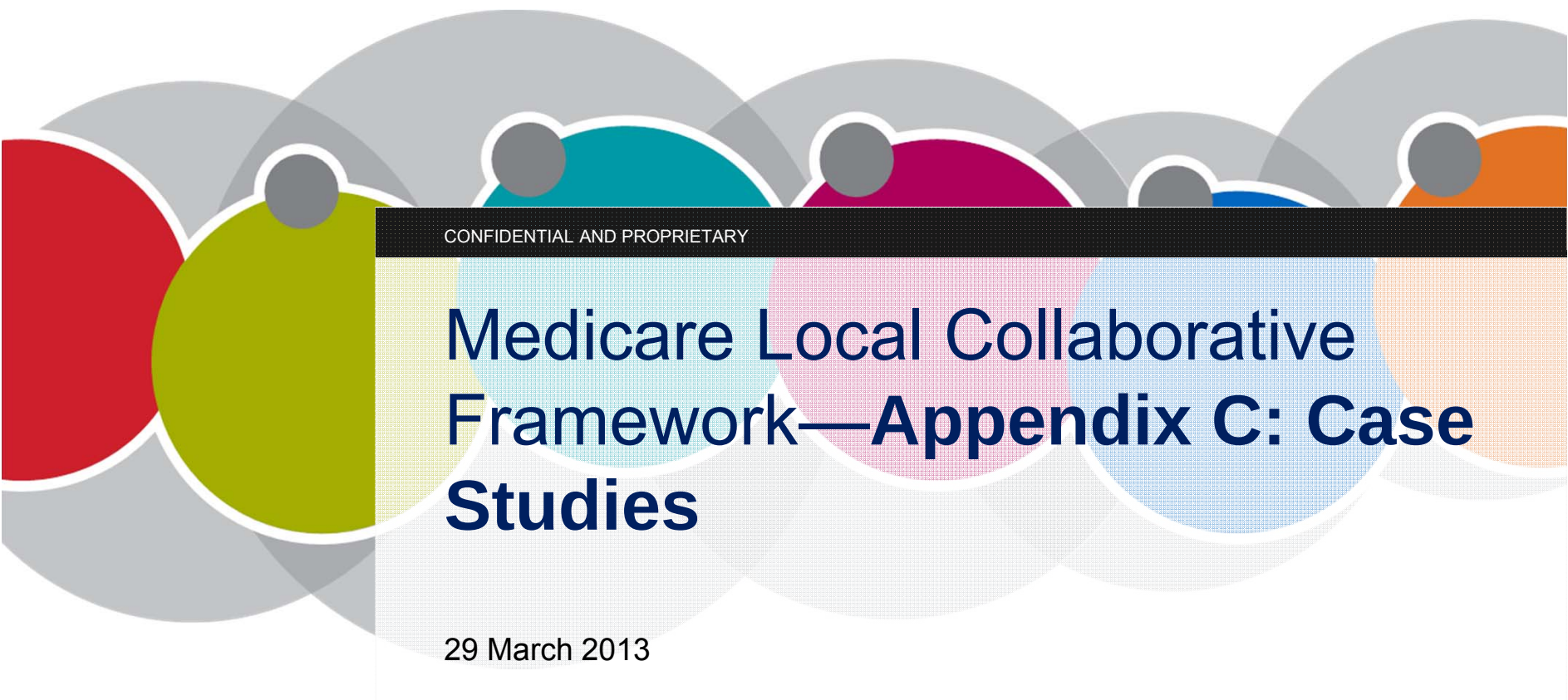
- ACT Medicare Local
- Far West NSW Medicare Local
- Goldfields Midwest Medicare Local
- Greater Metro South Brisbane Medicare Local
- Kimberley Pilbara Medicare Local
- Metro North Brisbane Medicare Local
- Nepean and Blue Mountains Medicare Local
- New England Medicare Local
- Northern Territory Medicare Local
- South East Melbourne Medicare Local
- Toowoomba Medicare Local
- Townsville Medicare Local
- Western Sydney Medicare Local

Hospital providers

- Alice Springs LHN
- Metro North Brisbane HHS
- Nepean and Blue Mountains LHD
- South Australia Health
- Sydney LHD
- Townsville Hospital (QLD Health)
- Western Sydney LHN

Other organisations

- Aboriginal & Torres Strait Islander Community Health Service (ATSIC)
- Aboriginal Vision Program
- Australian Association of Allied Health Professionals
- Australian Medicare Local Alliance (AMLA)
- Australian Council of Social Services
- Australian Royal College of Physicians
- Consumer Health Forum
- Department of Health and Ageing (DoHA)
- Fred Hollows Foundation
- IRIS
- Lions Eye Institute WA
- NACCHO
- National Aboriginal & Torres Strait Islander Health Worker Association
- National Lead Clinicians Group
- NSW Council of Social Services
- Optometrist Association Australia
- RACGP (Royal Australian College of General Practitioners)
- University of Melbourne
- Vision 20/20



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Medicare Local Collaborative Framework—Appendix C: Case Studies

29 March 2013

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Contents

APPENDIX C: Case studies

- Australian case studies to illustrate steps of the framework
- Case studies of collaborative initiatives

Overview of case studies

<u>Case study</u>	<u>Medicare Local</u>	<u>Description</u>	<u>Relevant steps</u>
1 Medicare Local and Local Hospital District shared governance	Nepean Blue Mountains (NBML)	NBMML and NBMLHD are working together to embed a joint governance and planning model into their day-to-day business	Step A
2 headspace Townsville	Townsville Mackay (TMML)	headspace Townsville provides early intervention mental health services to youth supported by health, social recovery, and vocational services	Step B
3 Partners in Recovery	Kimberley Pilbara (KPML)	Partners in Recovery aims to integrate mental illness services and support in Australia	Steps B and F
4 Aboriginal Community Sharing and Learning Circle	Nepean Blue Mountains (NBML)	A one-day forum was conducted with participants from the local community to discuss and prioritise key health issues	Step C
5 Asylum seekers integrated healthcare sessions	South East Melbourne (SEMML)	Health information sessions for asylum seekers introduced in conjunction with Australia Red Cross and Southern Health	Steps C and E

Illustrative example of collaboration between primary and acute care to jointly plan and share governance

1 Background

Medicare Local: Nepean Blue Mountains Medicare Local (NBMML)

Start date: 2013

Contact: Sheila Holcombe, CEO, NBMML

Key players:

- Nepean Blue Mountains Medicare Local
- Nepean Blue Mountains Local Hospital District (NBMLHD)

Relevance to framework:

- Step A: Gather fact base & select focus area(s)

2 Initiative details

Challenge:

- NBMML and NBMLHD share a common population and geographical jurisdiction which results in shared population health needs. The ML and LHD has identified an opportunity to work closely together to reduce acute care costs and improve patient outcomes through better delivery of primary care

Description of initiative:

- NBMML and NBMLHD has embedded a joint governance model with three levels of interaction:
 - Monthly meetings between CEO of ML and CE of LHD to discuss joint initiatives and priorities. In addition, CEO of ML sits on the LHD board
 - Annual joint planning days involving the boards of both ML and LHD
 - NBMML employed local health planner will sit in the LHD planning unit to facilitate joint planning
- Future direction of initiative:
 - Joint KPIs for ML and LHD boards

Relationship to framework:

- **Step A:** To identify priority focus areas, Medicare Locals cannot work independently of their local health communities. NBMML and NBMLHD has avoided this pitfall by integrating their planning teams to conduct needs assessments

3 Learnings

- Find creative ways to share planning processes and to create a collaborative forum for discussion of population health needs
- Do not avoid collaboration because of logistical difficulties
- Integrating planning processes can work even if your geographical jurisdiction does not overlap with that of your local health district

1. MEDICARE LOCAL AND LOCAL HOSPITAL DISTRICT SHARED GOVERNANCE

Position description of the proposed Primary Health Care Health Planner



medicare local
NEPEAN-BLUE MOUNTAINS
Connecting health to meet local needs

POSITION DESCRIPTION

Position Title:	Primary Health Care Data Analyst / Health Planner
Location:	Population Health Building, Nepean Hospital, Kingswood, NSW
Reporting to:	Chief Executive Officer/ Director of Planning, Strategy and Epidemiology Nepean Blue Mountains Local Health District
Conditions of Employment:	Nepean Division of General Practice Enterprise Agreement 2010 & Nepean Blue Mountains Local Health District Workers Health and Safety and relevant staff policies.
Hours:	Part Time 45.6 hours per fortnight

1. Purpose of the Position

The Primary Health Care Data Analyst / Health Planner is a senior position with the Nepean-Blue Mountains Medicare Local which is based in the Planning, Strategy and Epidemiology Directorate of Nepean Blue Mountains Local Health District. (NBMLHD).

This is a jointly managed position by the Nepean Blue Mountains Medicare Local (NBMML) and Local Health District. This position is part of a team that focuses on the NBMLHD acute care sector and community based services and population epidemiology. This new position will focus on the NBMML primary health care service needs and work as part of the NBMLHD planning team.

2. Key Outcomes

In conjunction with other members of the NBMLHD Planning, Strategy and Epidemiology Directorate:

- 1.1. Identify the primary health care needs of the local region to inform the development of locally focused primary health care services.
- 1.2. Update annually the NBMML health needs assessment to inform primary health care services.
- 1.3. Undertake data collection and analysis to inform the NBMLHD and NBMML population health database/s and population health profiles.
- 1.4. Undertake data collection and analysis to measure inappropriate and inefficient service utilisation and hospital avoidance.
- 1.5. Actively participate and inform the annual joint planning activities of the NBMLHD and NBMML.
- 1.6. Inform business cases and for funding submissions with relevant primary health care and population health data as required by NBMLHD and NBMML.
- 1.7. Meet NBMML contractual milestones and key performance indicators (KPIs) in relation to primary health care planning for the region.

3. Key Responsibilities

The Primary Health Care Data Analyst / Health Planner is responsible and accountable for:

- 3.1. Providing expert NBMML/NBMLHD wide direction to the development and communication of quality primary health care service and related information.
- 3.2. Delivery of high quality, comprehensive, systematic and accessible knowledge base/s to inform primary health care directions and population health initiatives in the NBMML/NBMLHD.

1 | Position Description - Primary Health Care Data Analyst / Health Planner - February 2013

- 3.3. Being a reference point within the NBMML/NBMLHD for primary health care information and data including general practice and the interface with aged care and the acute sector and NBMLHD community based services.
- 3.4. Facilitating quality technical analyses of primary health care information, critical literature reviews and research to inform decision making and planning processes across the NBMML/NBMLHD and to promote the most effective and strategic areas for action in primary health care and its interface with the NBMLHD acute sector.
- 3.5. Developing and contributing to high quality Service Plans for the NBMML/NBMLHD in the context of NSW Ministry of Health and Commonwealth Government requirements.
- 3.6. Critically reviewing Ministry of Health, Commonwealth, LHD-wide and other policies for implications for primary health care and new models of care for the implementation across the NBMML/NBMLHD.
- 3.7. **General**
 - 3.7.1. Comply with contractual obligations and deliverables as contained in relevant funding agreements.
 - 3.7.2. Respect the confidentiality of patients and general practice in line with the organisation's related policies, procedures and the *Privacy Act 1988* (Cth).
 - 3.7.3. Comply with the NBMML and NBMLHD organisation's policies and procedures.
 - 3.7.4. Comply with NBMLHD Code of Conduct and Ethics Policy.
 - 3.7.5. Participate in the NBMML Accreditation requirements.
 - 3.7.6. Understand and commit to NBMML EEO principles and anti-discrimination laws in the workplace.
 - 3.7.7. Ensure the safety of yourself and others in line with the NBMML and NBMLHD Workplace Health and Safety policies and procedures and the *Workplace Health and Safety Act 2011*.
 - 3.7.8. Comply with NBMLHD Workplace Health and Safety responsibilities.
 - 3.7.9. Undertake other duties commensurate with the role as directed.

4. Delegations & Authority

Delegations and authorities for this position are as per NBMML "Delegations of Authority Policy 2.3" and NBMLHD Delegations Manual.

2 | Position Description - Primary Health Care Data Analyst / Health Planner - February 2013

Illustrative example of governance structure and articulating a shared aspiration

1 Background

Medicare Local: Townsville-Mackay Medicare Local (TMML)

Start date: 2008

Contact: Julie Scheuber, CEO, TMML

Key players:

- Townsville-Mackay Medicare Local
- Townsville Hospital and Health Service, Queensland Health
- Townsville City Council
- Department of Education, Training and Employment
- Mental Illness Fellowship NQ
- Advance Employment (Not-for-profit employment agency)

Relevance to framework:

- **Step B:** Establish team, aspiration & ways of working

2 Initiative details

Challenge:

- Existing youth health services in Townsville, especially for mental health, were not sufficient, and did not provide adequate prevention and support programs to meet the community's needs

Description of initiative:

- Focus groups were set up to discuss the gaps and issues, and key organisations and individuals were engaged around shared values and vision
- The **headspace** model was identified as a useful framework to collaboratively deliver key youth services, especially for mental health, in Townsville, and a consortium was established
- The **headspace** Townsville Consortium includes public and private providers in the areas of mental health, drug and alcohol, primary care and education, and training and employment
- **headspace** National Youth Mental Health Foundation Ltd is funded by the Australian Government Department of Health and Ageing under the Youth Mental Health Initiative Program and is regionally operated via a Lead Agency and Consortium model

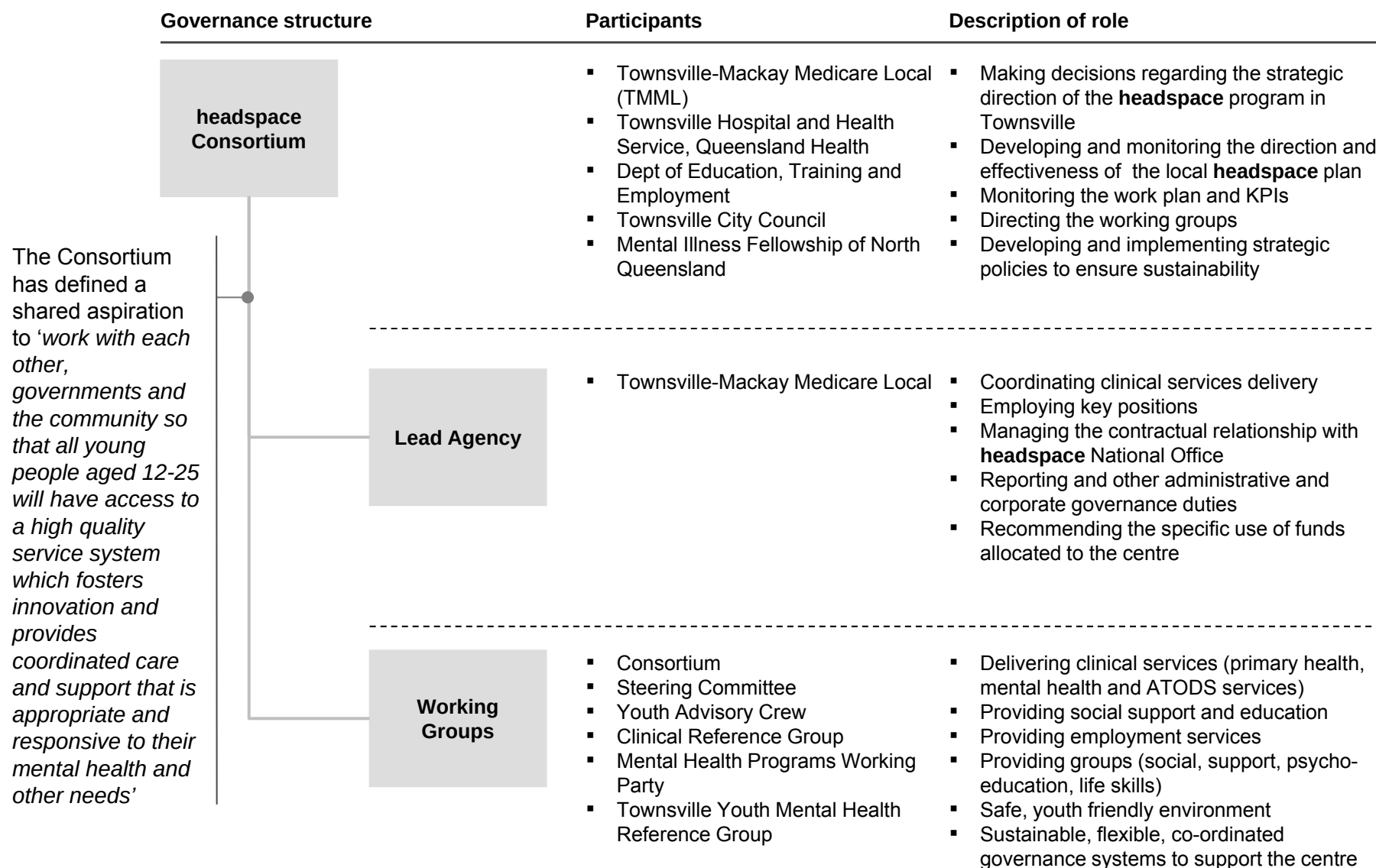
Relationship to framework:

- **Step B:** The project team established a governance structure with clear roles and responsibilities to support the initiative, and aligned on a common set of goals with a broad group of stakeholders

3 Learnings

- Align on goals and aspirations with all stakeholders early in the project
- Establish a clear governance structure and roles
- Link to existing service structures rather than creating them from scratch
- Find shared values, work on vision and direction with open and honest discussions
- Think outside the square and form partnerships with agencies and individuals from beyond traditional health backgrounds
- Identify discord early and acknowledge differing agendas
- Maintain respectful, open communication and value all contributors

Governance structure and aspiration of headspace Townsville



Illustrative example of governance structure and action planning

1 Background

Medicare Local: Kimberley Pilbara Medicare Local (KPML)

Start date: 2012

Contact: Dale Thompson, Clinical Service Director, KPML

Key players:

- Kimberley Pilbara Medicare Local
- Broome Regional Aboriginal Health Service
- Kimberley Mental Health & Drug Service
- Pilbara Health Network
- Western Australia Country Health Service
- Patient representatives

Relevance to framework:

- Step B: Establish team, aspiration & ways of working
- Step F: Implement, track & adjust

2 Initiative details

Challenge:

- Almost 20% of the population in the Kimberley and Pilbara region are of Aboriginal and Torres Strait Islander descent. There is a high prevalence of chronic disease amongst Aboriginal people and high rates of associated mental illness
- The remoteness of the region poses significant barriers to people accessing mental health services

Description of initiative:

- Partners in Recovery (PIR) is a government funded mental health initiative that aims to facilitate better coordination of and more streamlined access to the clinical and support needs of people experiencing severe and persistent mental illness with complex needs requiring a cross-system response
- Permanent support facilitators will be put in place to help coordinate the patient along the pathway
- PIR integrates the array of mental illness programs provided by federal, state government and NGOs

Relationship to framework:

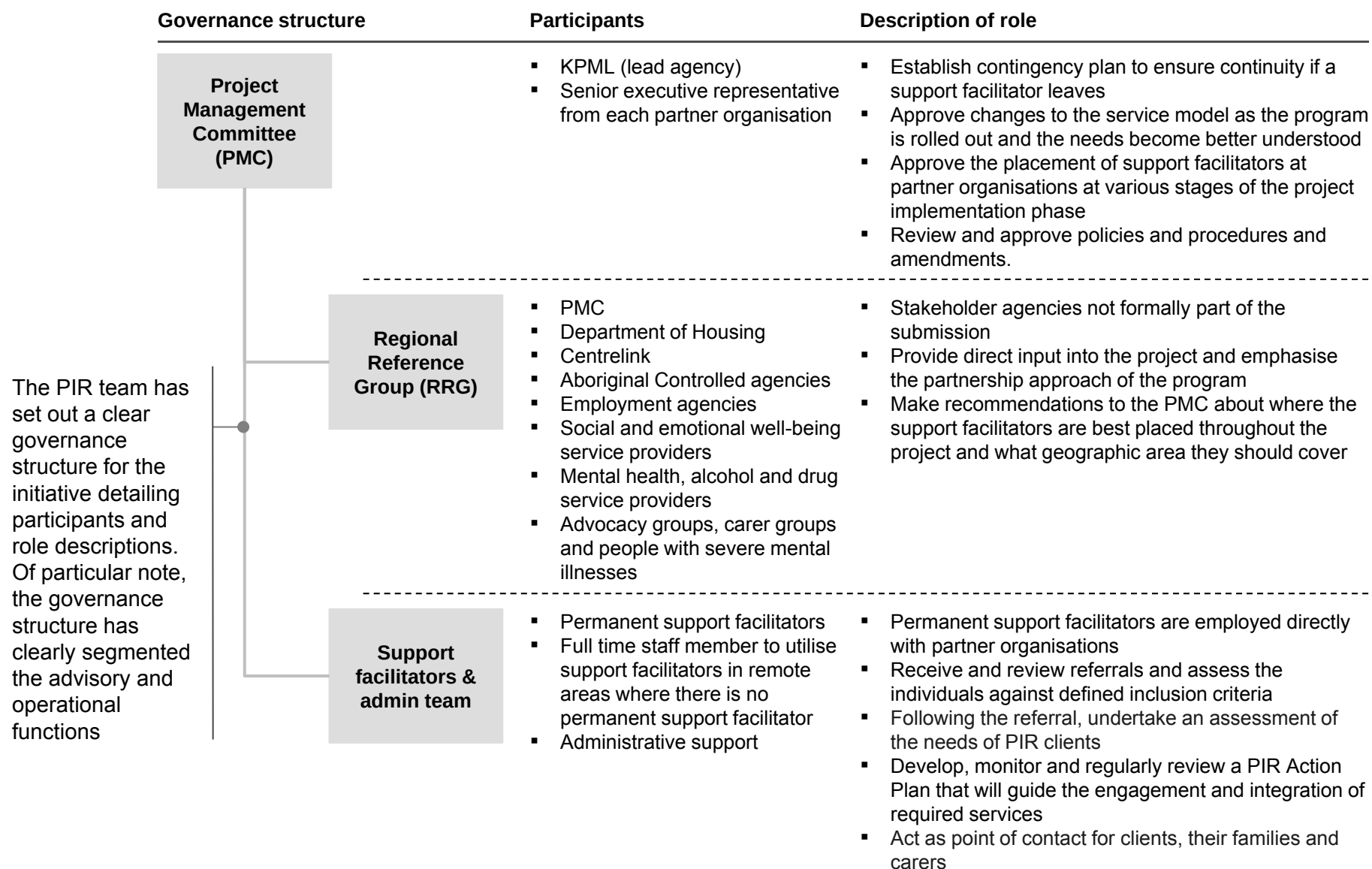
- **Step B:** In their clearly set out project governance structure, KPML and four partner agencies form the Project Management Committee (PMC). Two functionally separate levels branch from the PMC: support facilitators (operational) and Regional Reference Group (advisory). See supporting pages
- **Step F:** The project team has also developed an overall action plan including a communication strategy. See supporting pages

3 Learnings

- Establish a clear governance structure, and demarcate operational and advisory functions
- Work with a broad group of stakeholders to design the process of implementation and make adjustments based on regular reassessments of needs
- Involve patient representatives
- Recognise the work of other organisations and leverage existing services wherever possible
- The funding arrangement and policy should align with the goals of the project, and aid in the deployment of resources to areas where they are most needed (see supporting pages for more information on the funding arrangement of PIR)

3. PARTNERS IN RECOVERY

Governance structure detailing roles and responsibilities



3. PARTNERS IN RECOVERY

High level action plan divided into major phases

		2012-13		2013-14				2014-15				2015-16	
		Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2
Establishment	Establish governance structure and employ program coordinator												
	Develop protocols and PIR templates												
	Complete service mapping and gap analysis process												
	Use the information generated to build capacity in the service delivery system												
	Build shared goals, shared knowledge and mechanisms to promote increasingly improved communication												
Establishment of a referral system	Consult with partners and identify preferred mechanism												
	Gain endorsement and approval from PMC												
	Implement referral system												
	Continuously review and improve the system												
Stage One	Report on effectiveness, risks and successes of system												
	Partner agencies employ a support facilitator (one per agency)												
	Communication plan implemented and stakeholders engaged in service												
	Build shared goals, shared knowledge and mechanisms to promote increasingly improved communication												
	Report on program data to PMC and respond to trends and learned lessons												
Stage Two	Report on program data to RRG, receive input from RRG and provide ideas to PMC												
	Deploy additional support facilitators based on evidenced need and recommendations of RRG and endorsement of PMC												
	Continuously monitor, evaluate and improve processes, partnership arrangements and effectiveness of service delivery												
	Develop training and education materials												

The PIR action plan has listed specific and detailed activities, and divided them into major phases of work to clearly mark out the beginnings and ends of each phase

The PIR action plan is in a Gantt chart format. This makes it easier to visualise what needs to be done and by when

3. PARTNERS IN RECOVERY

Action plan with details on timeframe, responsible party and anticipated outcome

EXTRACTED FROM ACTION PLAN

Activities / Tasks	Start date	End date	Who is responsible?	Who else will be involved?	Risks and Mitigations	Outcome Measure
Establish governance structure and employ program coordinator	Execution of funding agreement	June 2013	KPML	In partnership with the four partner organisations and via consultation with the wider group stakeholders	No suitable candidate can be identified for employment as program coordinator and an existing KPML staff member will be identified to commence activities until a person can be employed	Program coordinator employed, terms of reference complete and endorsed by partner organisations
Develop protocols and PIR templates	Execution of funding agreement	June 2013	KPML	In partnership with the four partner organisations and via consultation with the wider group stakeholders		Protocols and templates developed and ready for implementations
Complete service mapping and gap analysis process	Employment date of coordinator	June 2013	KPML	In partnership with the four partner organisations and via consultation with the wider group stakeholders	Essential services not available in required locations, requiring increased expenses on purchasing necessary services throughout the project period	Services mapped and gap analysis complete and endorsed by PMC
Consult with partners and identify preferred referral mechanism	Execution of funding agreement	June 2013	KPML	In partnership with the four partner organisations and via consultation with the wider group stakeholders	Agreement cannot be reached on preferred system. PMC Chair will make an informed final decision.	Referral system identified and endorsed by PMC
Implement referral system	May 2013	June 2013	KPML	In partnership with the four partner organisations and via consultation with the wider group stakeholders	Partner agencies require assistance to overcome organisation barriers to use of system. Assistance will be provided.	Referral system in place and utilised
Partner agencies employ stage one support facilitators	June/July 2013	December 2013	Partner agencies	KPML and other partner agencies	Suitable candidates cannot be identified or not enough funding is provided to PIR to ensure suitable candidates can be employed. Only suitable candidates will be employed and the number will be entirely dependent on appropriate allocation of funds by DoHA	Support facilitators employed
Partner agencies employ stage two support facilitators	January 2014	May 2014	Partner agencies	KPML and other partner agencies	DoHA don't allocate appropriate levels of funding allow for employment of additional support facilitators. No further staff will be employed if funds aren't available	Support facilitators employed

These activities map back to the activities in the high level action plan (see previous page)

In the PIR action plan, the starting and ending date has been laid out for each activity, followed by the responsible party.

The PIR action plan defines outcome measures for each activity to track when the activity has been completed

3. PARTNERS IN RECOVERY

Communication strategy describing content and frequency

As part of their communication strategy, the PIR team has started by defining an overall aim or objective

4.0 COMMUNICATION STRATEGY

Aim: This strategy outlines how PIR will be appropriately marketed in the KPML region in a way that encourages:

- Appropriate referrals (minimising the risk of high numbers of ineligible client referrals) and so that PIR is not considered a 'new case manager service';
- Engagement and support from all relevant sectors, services and supports within the region; and
- Awareness about the initiative and how consumers, carers and families can benefit.

Who <i>Describe the target audiences</i>	What <i>List the key messages for this target</i>	How <i>Method and tools to reach this group</i>	When <i>What is the timing and frequency for communications</i>
PMC Lead agency and consortium partners	Reports on progress of project implementation	• PMC meetings • Electronic newsletters • Individual and group email • Teleconferences/videoconferencing • Electronic newsletters	• Monthly • Annually • Biannually • As required
RRG	information sharing and exchange, consultation evaluation	• meetings • individual and group email • teleconferences/videoconferencing • electronic newsletters	• Quarterly • As required • As required • As required
Stakeholders (includes all case managers, services providers, and the general community)	information sharing and exchange, consultation provision of feedback and advice to PIR	• Annual Stakeholder forum • meetings • individual and group email • teleconferences/videoconferencing • electronic newsletters	• Annually • As required • As required • As required

And then for each stakeholder, the strategy describes what messages to deliver, what channels to employ, and how often the communications need to be made

Funding arrangement for Partners in Recovery

Aims for PIR flexible funding

- To build system capacity rather than divert responsibility from existing service providers
- To utilise the existing service delivery system and make its integration more effective, rather than to establish new service delivery functions
- However, where required services are not directly or immediately available, a funding pool managed by the PIR organisation will enable the short term buy-in of these services

Organisation of funding

- Attached to PIR organisation rather than individual clients
- Can be combined to address essential regional service gaps or used for short term expenses, such as:
 - access to clinical care (e.g. health or dental care)
 - urgent accommodation support
 - vocational skills
 - peer support
 - counselling/behavioural management
 - connection to social activities and recreation
 - transport to services (e.g. taxi and bus fares)
 - respite
 - assistance with financial management
 - parenting support and skills development
- Clear parameters to ensure consistency in use
- Established expectation that PIR clients will be serviced by the existing network of providers and not be reliant upon PIR funding

Illustrative example of issue identification with stakeholders

1 Background

Medicare Local: Nepean Blue Mountains Medicare Local (NBMMML)

Start date: 2008

Contact: Sheila Holcombe, CEO, NBMMML

Key players:

- NBMMML (formerly Blue Mountains Division of General Practice)
- Nepean Blue Mountains Local Health District (formerly Sydney West Area Health Service)
- Blue Mountains Aboriginal Culture and Resource Centre
- Aboriginal Elders
- Local GPs
- Community organisations
- Community members

Relevance to framework:

- Step C: Identify issues & root causes

2 Initiative details

Challenge:

- 945 people identified as Aboriginal and Torres Strait Islander in the Blue Mountains in 2008
- The unique geography, ribbon development, availability of services, and transport limitations means that access to services is limited and often costly

Description of initiative:

- The Aboriginal Community Sharing and Learning Circle was a way to identify health issues and needs of the Aboriginal population in a culturally appropriate setting. It was the first step in a larger process that led to the establishment of the Blue Mountains Aboriginal Health Coalition and the funding of the Blue Mountains Healthy for Life Program
- The initiative involved a one-day forum (12th March 2008) with around 60 participants from the local community to discuss and prioritise key health issues
- The event was publicised through the Blue Mountains Gazette and word-of-mouth

Relationship to framework:

- **Step C:** In a large sharing circle, the participants brainstormed health issues and challenges for the local Aboriginal community which were then synthesised and categorised under immediate, medium term and long term issues (see next page)

3 Learnings

- Involve the community as soon as possible
- Be culturally sensitive when engaging certain sub-populations
- Set clear and achievable goals at the time of consultation with the Aboriginal community
- When brainstorming, use a format which gives every participant a voice in a non-hierarchical setting
- Draw out the main themes from the list of identified solutions and then conduct a root cause analysis

4. ABORIGINAL COMMUNITY SHARING AND LEARNING CIRCLE

Aboriginal health issues identified in the Sharing and Learning Circle (1/4)

Summary of issues raised by the Aboriginal Community at the Sharing and Learning Circle	
Inter-cultural communication	
Visible recognition of Aboriginal Community (Aboriginal friendly & Welcoming)	
No attention from reception staff at general practice	
Attitude of staff at GP - user friendly health service – especially for Aboriginal Community	
High need for culturally appropriate training for health staff & health providers	
How to welcome and encourage Aboriginal community to use existing services.	
Local Aboriginal people to train staff at GP	
Takes time to take down the barriers.	
Opportunity for immediate feedback at GP	
Aboriginal staff	
More Aboriginal workers in health services.	
Aboriginal GP to join local practices.	
Aboriginal Health worker employed through allied health	
Aboriginal representative on Boards of Health service/Division	
Transport and access	
Transport to out of area services.	
Barriers to access of local services	
Aboriginal Community awareness of local services	
Health/Aboriginal services	
Holistic approach to health	
Lack of local dental services	
Mainstream health services to recognise difference in life expectancy	
Aboriginal Culture and Resource Centre need more accessible and visual location (support from BMCC).	
Aboriginal Health clinic in the Blue Mountains.	
Money for GP Super Clinics to include Aboriginal health	
Self-identification	
Aboriginal identity papers.	
Health services need to ask if Aboriginal (trained how to ask the question of identity/cultural background).	
Health and Wellbeing issues	
Health issues dental, obesity, mental health, hearing, use of drugs, smoking (large tobacco issue)	
Develop better links with existing Health services	
Other	
Feedback from this consultation.	
Need for immediate solutions not just in the future.	
Justification of why Blue Mountains Aboriginal Community needs the funding.	

Issues that required immediate attention

See 'Aboriginal health issues identified in the Sharing and Learning Circle (2/4)'

Issues that required medium term action

See 'Aboriginal health issues identified in the Sharing and Learning Circle (3/4)'

Issues that required long term action

See 'Aboriginal health issues identified in the Sharing and Learning Circle (4/4)'

4. ABORIGINAL COMMUNITY SHARING AND LEARNING CIRCLE

Aboriginal health issues identified in the Sharing and Learning Circle (2/4)

Issues that required immediate action			
Issues	Strategies	Barriers	Outcomes to date
Ensuring the outcomes of the consultation are progressed	Form a Consortium/Aboriginal Governance body.		The Blue Mountains Aboriginal Health Coalition formed and operational (monthly meetings).
Culturally appropriate training for health services staff around Aboriginal community.	- Market the need for/provide cultural training for Blue Mountains GPs, Practice staff and Community Health staff - Seek advice from the Aboriginal Health Coalition on cultural issues. - Support the creation of Aboriginal culturally welcoming health environments - Liaise with Blue Mountains Aboriginal Culture and Resource Centre - Link into existing educational events - Educate all services and workers, not just GPs	- The time for busy health services staff to attend ongoing training in this area, and cost for staff attending training out of work hours. - The lack of educational opportunities staff have had on Aboriginal culture/issues/needs in the past. - The beliefs staff have around Australia being a "level playing field", and discomfort around affirmative action.	- Five Aboriginal Cultural Awareness Training sessions run for BM Health and Allied Health staff. - HFL staff provide on the job training. - One "Meet the Elders" training session provided for a GP site. - Culturally-specific brochures and posters on display in BM Health services. - GP sites purchasing local Aboriginal artworks for display. - Increased number of Aboriginal people accessing mainstream health services. - Increased number of Aboriginal Health Assessments and Care Plans.
Aboriginal specific health services that support access to mainstream health services in the BM.	- The Aboriginal Health Coalition apply (through Consortium Members) for government funding for these services. - Awareness campaign - ALO at facilities - Make copies of Aboriginal press available to GP sites - Health professionals education	- The process for applying for recurrent funding can sometimes be complex. - Lack of appropriately skilled/qualified Aboriginal health staff in the BM. - Friendly identification must be at the entrance of services. - Attitudes of scrutiny if attending programs.	- Funding granted for the BM Aboriginal Healthy for Life Program, Closing the Gap Project, Care Coordination and Supplementary Services Program (NBMML as Lead Agency). - The NBMML employs two Aboriginal staff members in the Aboriginal Healthy for Life Program.
Increase awareness of what services are available	- Use community radio - Aboriginal Newsletter – add a list of services - Pamphlets - Interface strengthened - Bulk billing signs - GP list of who will bulk bill for the Aboriginal community	- No specific Aboriginal health program available to distribute information - Have a program to partner with Aboriginal agencies in the Blue Mountains.	- Funding granted for the BM Aboriginal Healthy for Life (HFL) Program, Closing the Gap Project, Care Coordination and Supplementary Services Program (NBMML as Lead Agency). - HFL Program has produced Aboriginal promotional health service materials, and a quarterly health newsletter for the BM Aboriginal community.

4. ABORIGINAL COMMUNITY SHARING AND LEARNING CIRCLE

Aboriginal health issues identified in the Sharing and Learning Circle (3/4)

<u>Issues that required medium term action</u>			
Issues	Strategies	Barriers	Outcomes to date
Importance of Aboriginal Health Workers in services. Aboriginal health workers to be well networked into community	Review worker's roles and look for opportunities to employ more Aboriginal workers in the Blue Mountains.	- Funding - Recognition of need	The NBMML employs three Aboriginal staff members in the Aboriginal Healthy for Life and BM Closing the Gap Programs.
How to justify the numbers for funding of positions	Encourage identification at hospitals, GP practices etc.	Discrimination	
Health programs in the Mountains: ❖ Funding (AMS) ❖ Flexible appointments system	Look at services extending to Mountains e.g. AMS	Service resources and recognition of the BM community	
GP training through Division (now NBMML)	Engage Aboriginal services/workers to provide education to both GPs and their staff	Time required	
Transport			
Special fitted out bus – mobile bus service	To address one stop shop and accessibility for the community. Needs to be accessible across the Mountains and not just in one location	- Funding - Engagement and organisation with other services, GPs etc.	

4. ABORIGINAL COMMUNITY SHARING AND LEARNING CIRCLE

Aboriginal health issues identified in the Sharing and Learning Circle (4/4)

Issues that required long term action			
Issues	Strategies	Barriers	Outcomes to date
Blue Mountains Aboriginal Culture and Resource Centre (ACRC) relocated	Lobby Council for location in an accessible location	Availability of building	ACRC close to being relocated to more suitable premises in 2013 – thereby becoming a more accessible meeting place for the BM Aboriginal community, and possibly increasing service provision.
One stop shop for Aboriginal health	GP Clinic proposal	Funding	At present the BM Aboriginal Healthy for Life Program is a central service that facilitates and promotes access to mainstream health services.
Aboriginal health worker at Katoomba hospital	Lobby for worker (24 hrs a day)		No Aboriginal ALO at Katoomba Hospital yet.
Holistic approach to health ❖ Transport ❖ Housing ❖ Medical ❖ Cultural/spiritual	Enhance recognition of needs in the BM/increase numbers through identification	Being seen as a large number requiring services and a priority	- Promotional materials encouraging self-identification have been created and distributed by the HFL Program (NBMMML). - The Aboriginal patient numbers in 3 HFL GP Sites have increased substantially over the past 2 years, as have the number of Aboriginal Health Assessments undertaken by GPs in the Mountains.
Blue Mountains identified Aboriginal specific funding	As above		- Funding granted for the BM Aboriginal Healthy for Life Program, Closing the Gap Project, Care Coordination and Supplementary Services Program (NBMMML as Lead Agency). - NBMLHD have organised an Aboriginal-specific Dental Clinic at Katoomba Hospital - NBMMML has been granted funding for a part time Community Psychiatric Clinic that gives priority of access to Aboriginal clients.
Collective approach to lobbying for change	Voice through joint planning – committee with NBMMML and NBMLHD to coordinate a united voice.		NBMMML and NBMLHD worked in partnership with the BM Aboriginal-Controlled agencies in the to create the BM Aboriginal Health Coalition.

Illustrative example of root cause analysis and calculating cost

SEMML Asylum seekers integrated healthcare sessions

1 Background

Medicare Local: South-East Melbourne Medicare Local (SEMML)

Start date: 2012

Contact: Anne Peek, CEO, SEMML

Key players:

- South East Melbourne Medicare Local
- Southern Health (including Cardinia Casey Community Health Service and Dandenong Hospital Emergency Department)
- Australian Red Cross (ARC)
- Local GPs and Refugee Health Nurses
- Interpreters
- Asylum seekers

Relevance to framework:

- Step C: Identify issues & root causes
- Step E: Design care delivery & resource allocation model

2 Initiative details

Challenge:

- Increased number of asylum seekers arriving in Greater Dandenong region with unprecedented demand for health services
- A large number of asylum seekers were presenting at Emergency Departments post detention

Description of initiative:

- The ARC was providing newly arriving asylum seekers with fortnightly orientation sessions based in Dandenong. At each session approximately 40–100 asylum seekers were provided with an orientation to living in the community, assistance with their visa applications, and registration with Centrelink and Medicare, but no health assessment was undertaken
- Collaborative initiative undertaken by the ARC, SEMML and Southern Health to implement new healthcare pathway that includes health assessment at ARC orientation sessions and triaging of patients to increase primary care treatment

Relationship to framework:

- **Step C:** The project team conducted root cause analysis on the issue and discovered that a lack of awareness of available health services and language barriers meant very little primary care was provided to the sub-population
- **Step E:** The project team also carefully estimated the cost of facilitating these health assessments (see next page)

3 Learnings

- Do not stop at the issue but understand the root causes underlying the issue
- Leverage existing programmes and initiatives currently running in the local health economy, rather than starting from scratch
- Carefully estimate the cost of the initiative and be as comprehensive as you can

5. ASYLUM SEEKERS INTEGRATED HEALTHCARE SESSIONS

Cost estimate of asylum seeker healthcare sessions

The following schedule of activities and costs are based on the delivery of one Integrated Healthcare session (IHS) for 50 Asylum Seekers per month

	Week 1	Week 2	Week 3	Week 4
Monday	Follow up on previous appts; attendance rates and process invoices; receive calls from practice managers and red cross re appts	Follow up on previous appts; attendance rates and process invoices	Printing client labels; printing appointment letters; printing GP labels; printing client spreadsheet	Follow up on previous appts; attendance rates and process invoices; receive calls from practice managers and red cross re appts
	1x Admin 7.6 hrs x \$26.00 p/h = \$197.60	1x Admin 7.6 hrs x \$26.00 p/h = \$197.60	1x Admin 7.6 hrs x \$26.00 p/h = \$197.60	1x Admin 7.6 hrs x \$26.00 p/h = \$197.60
Tuesday	Service management	Liaise with GPs and practice managers re pre-arranged appts; prepare appt register	Integrated Healthcare Session 3x Admin 7.6 hrs each (one for appointments; one for data entry; one for coordination across services)	Service management
	1x Admin 7.6 hrs x \$54.00 p/h = \$410.40	1x Admin 7.6 hrs x \$26.00 p/h = \$197.60	2x Admin 7.6 hrs x \$26.00 p/h = \$395.20 1x Admin 7.6 hrs x \$54.00 p/h = \$410.40	1x Admin 7.6 hrs x \$54.00 p/h = \$410.40
Wednesday			Photocopying triage tools; faxing GPs and confirming appts/cancelling appts; finalising client spreadsheet; 1x Admin 7.6 hrs	
			1x Admin 7.6 hrs x \$26.00 p/h = \$197.60	
Thursday/Friday				
Total for week \$	\$608.00	\$395.20	\$1,200.80	\$608.00
Total monthly eft expenses:				\$2,812.00 (incl. oncosts)
Additional Resource costs (including photocopying, stationary, telephone.fax) \$200 per session				
TOTAL COST FOR ONE IHS FOR 50 PERSONS				\$3,012.00

Make cost calculations
transparent

Be as detailed and comprehensive as possible, even minor costs should be accounted for



To build a business case, it is important to quantify both **savings and costs**

1 The costs shown represent those of SEMML and does not include costs incurred by Southern Health or Australian Red Cross

Contents

APPENDIX C: Case studies

- Australian case studies to illustrate steps of the framework
- Case studies of collaborative initiatives

Lessons from case studies of collaboration

Framework element

Lessons from case studies

A Gather fact base & select focus areas	- Involve stakeholders from across the local health economy in selecting focus areas - Provide quantitative data to inform choices about where to focus - Look at performance across major care pathways to see how services may be better integrated
B Establish team, aspiration & ways of working	- Invest in building a guiding coalition that involves the most influential leaders needed to carry out a particular initiative - Take time to understand the incentives of different stakeholders and try to craft a common aspiration that aligns them - Set up clear governance structures, roles and responsibilities and agree ways of working together up front
C Identify issues & root causes	- Be systematic in finding issues and gaps—don't narrow down too quickly - Uncover the real root causes of problems, not just the symptom on the surface - Be prioritised in selecting where to focus resources
D Develop case for change & set targets	- Work out the 'do nothing' baseline—don't just assume today's situation will persist - Create a compelling case for change that can be tailored for each stakeholder group - Quantify improvement potential and set targets to aim for
E Design care delivery & business case	- Don't just put in place disjointed, tactical fixes—consider how the whole operating model will work - There are 5 critical enablers needed in most systems: aligned incentives; accountability and joint decision making; clinical leadership and culture development; information sharing; and patient engagement - Quantify expected costs and benefits to make the business case - Look for ways to reallocate existing resources before considering new funding sources
F Implement, track & adjust	- Invest in creating a robust change management plan that addresses the required motivation and behaviour shifts - Allocate implementation roles and responsibilities to specific individuals - Track progress using simple quantitative tools and make performance transparent to participants

Overview of case studies of collaborative initiatives

Case study	Location	Description
National disease management	Germany	Germany designed a national disease management program that improved outcomes and reduced costs
Acute stroke services	UK	NHS London reconfigured acute stroke services to improve quality and efficiency of care
Discovery Health's Vitality program	South Africa	Discovery Health's Vitality program has achieved cost savings through uniquely incentivising healthy behaviours
Royal Marsden Hospital2Home program	UK	Royal Marsden's Hospital2Home program allows more patients to die in their chosen setting
Geisinger's Medical-Home – Chronic conditions	USA	Geisinger's medical-home approach to chronic conditions led to reductions in hospital admissions and medical costs
Segmenting urgent care	UK	South Central England segmented patients to optimise urgent care services
Patient-centred medical homes	USA	The 'patient-centered medical home' health care model reduces healthcare spend
Healthcare for London	UK	NHS London developed a strategy called 'Healthcare for London' to save £1bn in healthcare spend
Diabetes Care Project	Australia	Australian Diabetes Care Project enhanced integrated care for people with diabetes
Closing the Gap	Australia	Queensland is taking a collaborative approach to 'Closing the Gap' in Aboriginal and Torres Strait Islander health



Case summary: Germany designed a national disease-management program that improves outcomes and reduces costs

1 Background

Region: Germany

Health system: German statutory health insurance system

Start date: 2002

Challenge

- Management of long-term conditions in Germany was costly and ineffective
- 20% of patients caused more than 80% of costs; most of these patients suffer from chronic diseases
- Large variations existed in treatment, which did not conform to guidelines
- Disease-management programs were needed on a national scale to improve care pathway design and educate beneficiaries

2 Initiative details

Goals

- Improvement of quality of care for people with chronic diseases
- Cost-containment through better coordination of care and the overcoming of sectoral separation
- Financial incentive for sickness funds to prevent risk selection

Approach

- National disease-management program (DMP) was designed and implemented based on physician-led best-practice treatment and regional payor buy-in
- Total administrative costs are ~€280mn per year:
 - 53% of costs for administration
 - 47% for documentation

3 Process and impact

Process

- Redesigned programs for chronic patients based on physician-led, evidence-based treatment protocols
- Changed risk-adjustment compensation structure to account for patient morbidity in addition to age, gender, and income

Impact

- 13% reduction in cost of care for diabetics in DMP vs. those not in DMP; 20% overall reduction in hospital costs for DMP patients
- Reductions in hospitalisations, amputations and mortality compared to non-DMP participants
 - Among AOKs, reduced systolic blood pressure by 7.2% among diabetic patients with hypertension over 3.5 years
 - Reduction in HbA1c by 2% over 1.5 years
 - Reduction in diabetic foot cases by 63% over 2.5 years
- In some payors, DMP participants have shown **1.34 times higher** survival rate compared with those that did not participate in DMP

4 Key success factors

- Sufficient scale to implement (including adequate public awareness of initiative)
- Strong collaboration among stakeholders (e.g., using physician-led protocols along with active payor enrollment)
- Appropriate incentives for physicians, payors, and patients
- Use of information technology for documentation and tracking of protocol compliance and patient outcomes

5 Key players

- German statutory health insurance system
- Advisory Council on the Assessment of Developments in the Health Care System (gave impetus for implementation of DMPs)
- statutory health insurance (SHI) sickness funds
- GPs and Regional Physicians' Association
- Patients with chronic conditions

SOURCE: See subsequent slides for greater detail

1 Background: A growing number of people with diabetes underpinned the need for a disease-management program

Unbalanced risk structure between different sickness funds

- The risk-structure compensation scheme, coordinated by the Federal Insurance Office, used to redistribute funds to sickness funds primarily based on their members' age, gender, and income
- Without adjusting for morbidity, funds were not adequately compensated for patients with chronic diseases like diabetes
- As sickness funds compete for patients primarily based on price, this scheme disincentivized enrollment of chronically ill patients

Political will driven by health care costs and variation in treatment

- Public recognition that change is needed because of:
 - High health care costs, driven primarily by people with chronic diseases (e.g., typical high-morbidity payor costs for diabetics are around one-third of total costs)
 - realisation that current reimbursement scheme was providing incentives to avoid chronically ill patients
 - Evidence of economic inefficiencies because of variation in treatment and avoidable hospital admissions for most chronic diseases

High diabetes prevalence:

- In 2001, 7% prevalence of diabetes across the country¹
- It is estimated that an additional 2mn-3mn people are living with the disease undiagnosed

¹ Data from 20% of all members of the largest health insurance company in Germany, AOK, showed 8.79% prevalence; correcting for national population, this translated to 7% national prevalence

3 Initiative details: a redesigned disease-management program was bolstered by a change in the risk-adjustment compensation

Main components of disease-management program design

a Restructuring of chronic disease management

- Design chronic disease management using evidence-based treatment guidelines and proactive physician and patient engagement
- Execute through information technology for data tracking and incentives for patients and physicians

b Revised risk-adjustment compensation scheme

- Adjust reimbursement algorithm to account for differences in morbidity structure (in addition to age and income)
- Decrease financial incentives for risk-selected enrollment among chronically ill patients

Overall implications

For patients:

- Access to qualified DMP clinics with support from specially qualified physicians
- Active training, e.g., on diabetes and blood pressure

For physicians:

- Clear, best-practice care protocols
- Interdisciplinary cooperation with clinics and outpatient physicians

For payors:

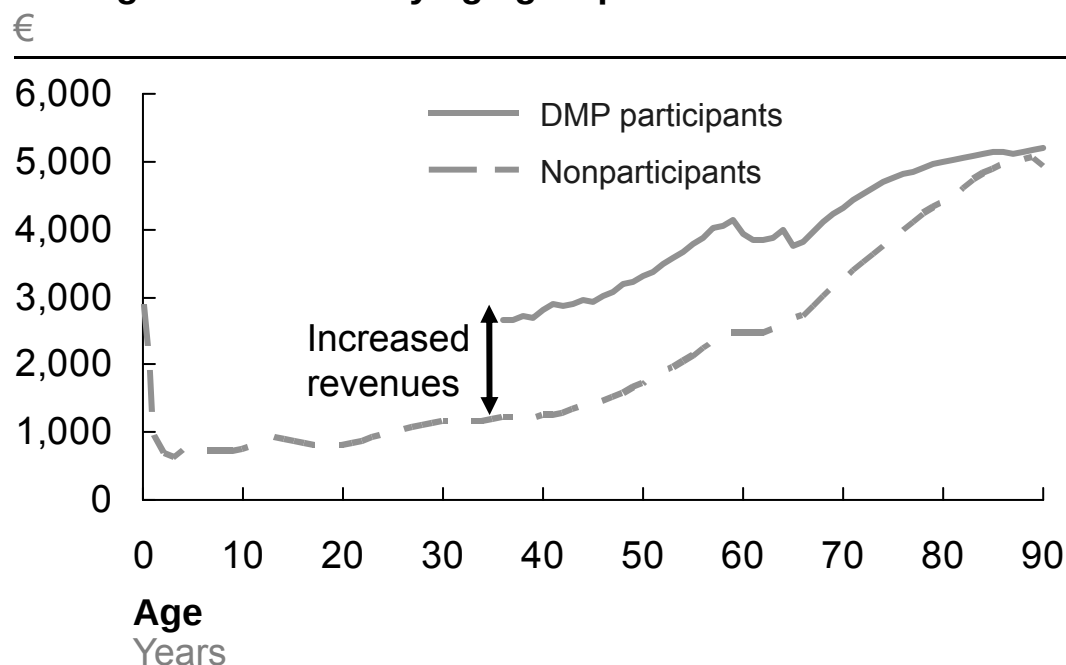
- Decrease losses from chronically ill patients
- Incentives for enrollment in DMP

3 Restructuring of chronic disease management rested on appropriate design and execution processes

Description									
Design	▪ Physician-led development of best-practice guidelines for chronic disease care ▪ Payors proactively drive enrollment through physician and patient outreach: – Informative events targeting physicians and patients separately – Patient recruiting through physicians and nursing homes								
Execution	▪ Documentation processes using information technology: – Ensured compliance with protocols and tracking of patient activity and outcomes ▪ Incentives for providers and patients:								
Stakeholders									
Incentives	<table><tr><th>Providers</th><th>Patient</th></tr><tr><td> ▪ For GPs: – Capitated payment of €40-€50/patient plus salary bonus for a greater number of patients ▪ For specialists: – Subsequent visits incur less revenue per patient, incentivising greater GP care ▪ For hospitals: – Fee per patient for educational workshop provision </td><td> ▪ Waived practice fees to attract enrollment </td></tr><tr><td> ▪ Better patient outcomes through systematized best-practice treatment protocols </td><td> ▪ Access to regular training sessions ▪ Access to best-in-class specialists and treatment processes </td></tr><tr><td>Non-financial</td><td></td></tr></table>	Providers	Patient	▪ For GPs: – Capitated payment of €40-€50/patient plus salary bonus for a greater number of patients ▪ For specialists: – Subsequent visits incur less revenue per patient, incentivising greater GP care ▪ For hospitals: – Fee per patient for educational workshop provision	▪ Waived practice fees to attract enrollment	▪ Better patient outcomes through systematized best-practice treatment protocols	▪ Access to regular training sessions ▪ Access to best-in-class specialists and treatment processes	Non-financial	
	Providers	Patient							
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	▪ Better patient outcomes through systematized best-practice treatment protocols	▪ Access to regular training sessions ▪ Access to best-in-class specialists and treatment processes							
Non-financial									

3 Revised risk-adjusted compensation scheme decreased the revenue gap between DMP and non-DMP participants

Average annual cost by age group



Appropriate risk-adjustment compensation incentivises payors to enroll their chronically ill patients

- For every DMP member, sickness funds received a base payment determined by sex, age, and income as well as morbidity premium depending on the disease
- Former losses generated by the chronically ill are compensated for by DMP enrollment
- Across all age groups, increased revenues can be expected from DMP participants

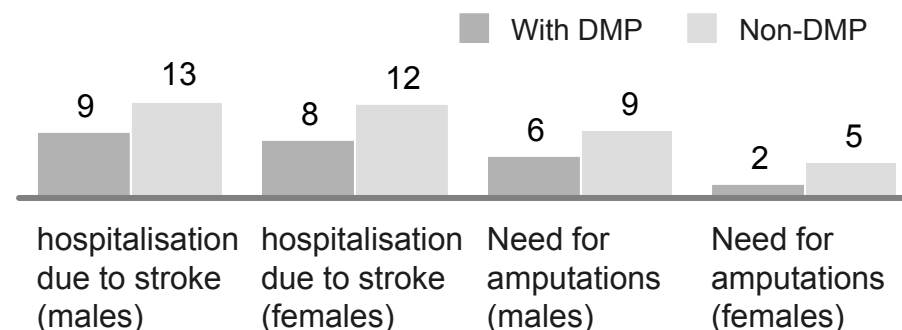
3 Impact: As DMP patient enrollment increased, there were notable improvements in quality and costs

Quality:

- Reductions in hospitalisations and amputations
- Reduction in mortality rate from 12% (non-DMP) to 10% (DMP)
 - Among AOKs, reduced systolic blood pressure by 7.2% among diabetic patients with hypertension over 3.5 years
 - Reduced HbA1c by 2% over 1.5 years
 - 63% reduction in diabetic foot over 2.5 years

Barmer Ersatzkasse (payor)

Patients per 1,000 pop¹.

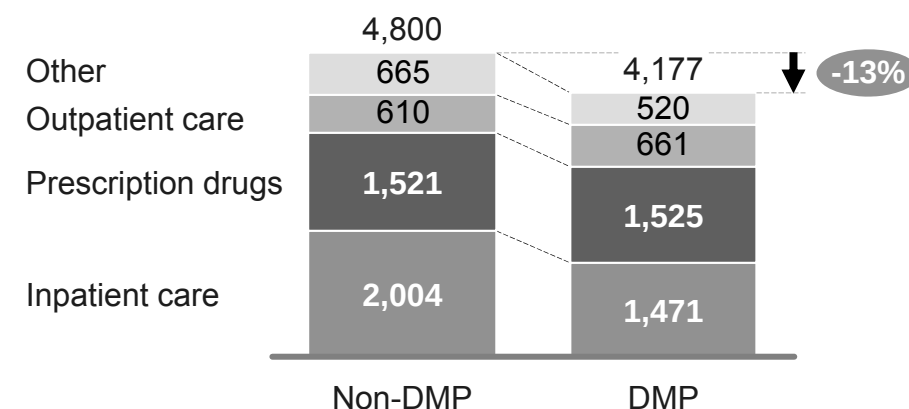


Cost:

- Compared with non-DMP participants, the costs of care for DMP patients with diabetes is 13% lower
- Drug spend has increased by ~5%
- Hospital costs have decreased by 10%-20%

Cost of care for patients with diabetes

€ per year, 2006



1 Risk-adjusted, n = 1,927 DMP participants and 1,927 DMP nonparticipants

Additional references

- 1 “Implementing Disease Management Programs for Type 2 Diabetes in Germany,” Nagel H. et al., *Managed Care*
- 2 “Disease Management Programs In Germany’s Statutory Health Insurance System,” Busse R., *Health Affairs*, 23 (3): 56-67 (<http://content.healthaffairs.org/cgi/content/full/23/3/56>)
- 3 “Quality Improvement Through Competition: The German Experience on Implementing Disease Management Programs,” Lauterbach K., lecture at Health Care, the Market, and the Public’s Needs and Interests International Seminar, Warsaw (<http://www.aktualnosci.pan.pl/images/stories/pliki/wydarzenia/2008/06/seminarium/prezentacje/warsaw020608.pdf>)
- 4 “The Health System in Germany: Combining Coverage, Choice, Quality, and Cost-Containment,” Busse R., presentation at Technical University of Berlin (http://www.mig.tu-berlin.de/fileadmin/a38331600/2008.lectures/Washington_2008.04.11_rb_GermanHealthCare.pdf)
- 5 “Versorgungsmerkmale des Diabetes mellitus in Disease-Management-Programmen,” Ullrich W, Marschall U., Graf C., *Diabetes, Stoffwechsel und Herz*, 407-414 (in German only), (http://www.barmer.de/barmer/web/Portale/Versichertenportal/Presse-Center/PresseArchiv/2007_2010_20bis_2012/071125_20DMP/Versorgungsmanagement,property=Data.pdf)

Case summary: NHS London reconfigured acute stroke services to improve quality and efficiency of care

1 Background

Region: London, England

Health system: National Health Service (NHS) London

Start date: 2007

Challenge

- Stroke is the second leading cause of death in London and most common cause of disability
- London hospitals admit more than 11,000 stroke patients each year
- A few years ago, only 53% of patients were being treated in a dedicated stroke unit
- Many hospitals still do not have the specialist staff or equipment needed to provide high-quality stroke care 24/7
- London hospitals fell short on several key indicator benchmarks in the 2006 Sentinel Stroke Audit

2 Initiative details

Goals

- All patients with suspected stroke should be taken to a hyper-acute stroke unit (HASU) for the first 72 hours, where they will receive highly specialised, 24/7 care
- Once established, the patients should be transferred to a stroke unit where they are rehabilitated and, eventually, discharged to care in the community

Approach

- London NHS took a system-level policy approach to improve its delivery of high-quality specialised services for patients with acute stroke
- London NHS is investing £23mn to improve these services

3 Process and impact

Process

- London NHS set objectives, goals and a clear vision for acute stroke services
- It undertook a massive media campaign to convince all key stakeholders of need for change
- New services were designated by a Joint Committee following a bidding and evaluation process
- Stroke Networks assist the strategy delivery
- 8 HASUs were established in different parts of the city to provide immediate, high-intensity care
- Stroke units receive patients transferred from the HASUs for rehabilitation until discharge

Impact

- In London, hospitals with HASUs perform better in stroke care than hospitals without HASUs
 - In 2008, 82% of patients in HASU hospitals were given an emergency brain scan within 24 hours of stroke compared to 71% in non-HASU hospitals
- 75% of London's HASUs (6 of 8) now meet all 7 national standards for acute stroke care

4 Key success factors

- Gained commitment from and engagement of key stakeholders (commissioners, clinicians, and public) by building and communicating a strong case for change
- Developed a clear strategy and tendering process for individual providers in the system
- Engaged clinical leadership by appointing a senior doctor to spearhead the initiative

5 Key players

- National Health Service (NHS) London
- London Hospitals and services providers (e.g., Ambulance Service)
- Commissioners and clinicians
- Patients and public
- Joint committee (composed of representatives from London's PCTs and NHS South West Essex)
- Stroke Networks

1 Stroke was the second leading cause of death in London, yet existing hospital services were performing poorly

Technological advances have made interventional treatment increasingly important in acute stroke care

- Multiple studies have shown that stroke patients who rapidly undergo CT scanning followed by thrombolytic treatment within 90 minutes of symptom onset are more than twice as likely to have favourable outcomes at 3 months than other stroke patients
- High-quality interventional treatment requires skilled staff and dedicated technologies
- One UK investigation showed that the odds of in-hospital death were reduced by 11% when stroke patients were treated in specialist units

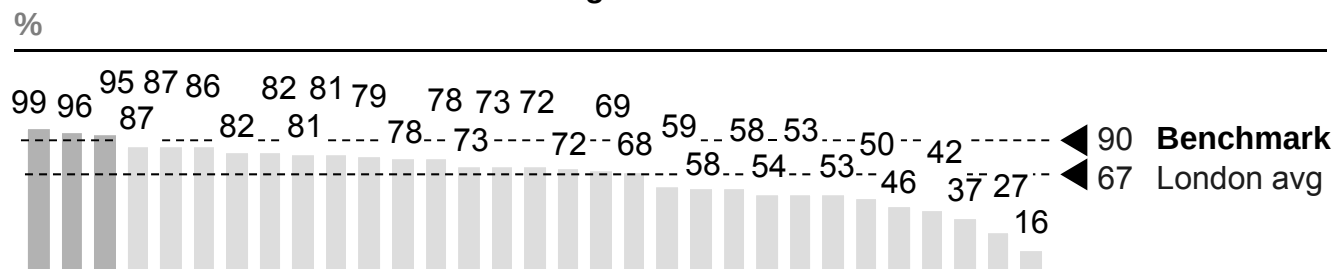
In London, availability of adequate stroke care services was highly variable and performed poorly against benchmarks and peers

- In London, stroke is the second leading cause of death, most common cause of disability; more than 11,000 stroke patients are admitted each year
- Only 53% of patients were treated in dedicated stroke units
- London's 32 acute care trusts, which deliver hospital services, performed poorly in England's 2006 Sentinel Stroke Audit:
 - Only 3 met the benchmark that 90% of stroke patients should be treated in an acute stroke/interventional unit
 - Only 7 met the benchmark that 90% of patients should receive physiotherapist assessment within 72 hours of admission
 - None met the benchmark of 90% of patients getting a brain scan within 24 hours

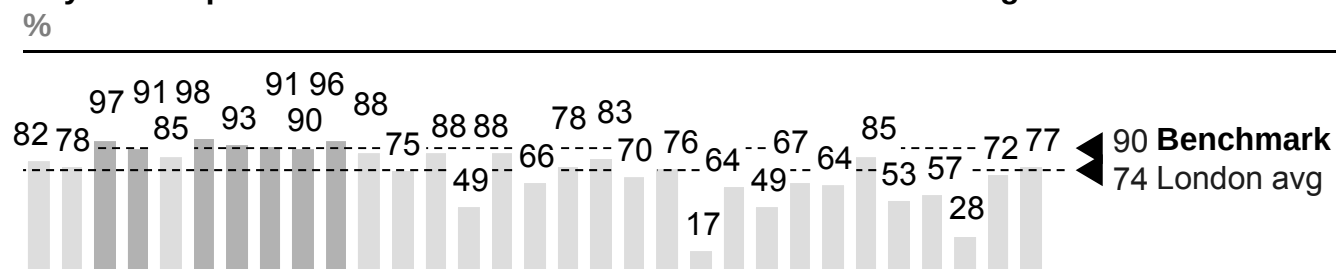
1 The 2006 Sentinel Stroke Audit showed that stroke services in London were suboptimal

■ At or above benchmark

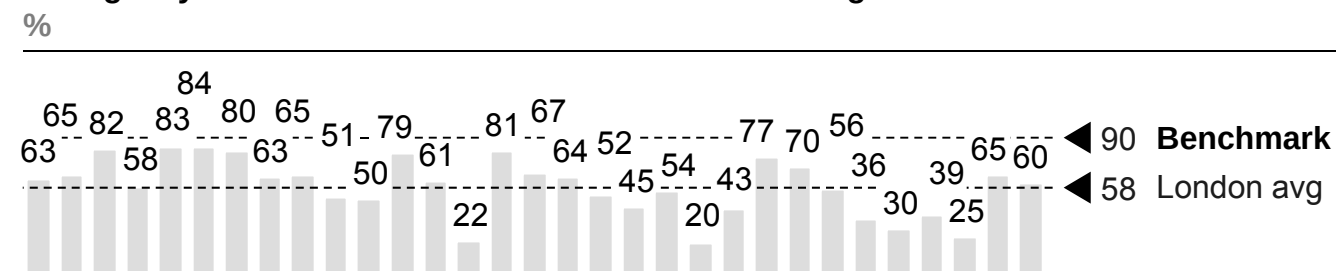
Patients treated in a stroke unit among London trusts



Physiotherapist assessment within 72 hours of admission among London trusts



Emergency brain scan within 24 hours of stroke among London trusts¹



- Only 3 trusts met the benchmark that patients should be treated in an acute stroke/ interventional unit
- Only 7 met the benchmark that patients should receive physiotherapist assessment within 72 hours of admission
- None met the benchmark that patients should get a brain scan within 24 hours
- These results were worse than those found in the 2004 audit**

2 London's approach included setting objectives, goals and creating a clear vision of the services

Focus of case study

London set key objectives and goals...

The objectives included:

- delivering world-class stroke care and ensuring its provision throughout London

Major goals for improving stroke services included:

- Prevention
- Acute Care – Creating high-quality hyper-acute specialist stroke centres, stroke units, and TIA¹ services that are easily accessible to all Londoners
- Rehab

And created a vision for acute stroke services...

- All stroke patients taken by London Ambulance Service to the nearest HASU, not more than 30 minutes away
- On arrival, each patient assessed by a specialist and access to CT and thrombolysis) within 30 minutes
- Stroke patients transferred to a HASU bed with high-dependency care for first 72 hours
- Once stabilised, patients transferred to a stroke unit – either in same hospital or closer to home
- Patients rehabilitated in stroke unit and discharged to appropriate community care

The vision included 3 types of acute stroke services

Hyper-acute stroke units (HASUs)

- Immediate response, primary intervention, and stabilisation
- Typically, 72 hours of stay

Stroke units

- Multi-therapy rehabilitation and supervision after hyper-acute stabilisation
- Length of stay dependent on patient condition

TIA assessment services

- Rapid diagnostic assessment and access to a specialist within 24 hours for high-risk patients and 7 days for low-risk patients

NHS London estimated 130 HASU beds and 550 stroke unit beds would be needed; total planned investment was ~£23mn

1 Transient ischaemic attack

③ NHS London obtained commitments from key stakeholders then designated new services through a bidding and evaluation process

Buy-in was obtained as part of a 2008 pan-London effort

New services were designated following a bidding and evaluation process

The pan-London effort

- 'Consulting the Capital', ran from Nov 2007 to March 2008
 - To reach city residents, London undertook a massive marketing campaign, including websites, newspapers, local media briefings and targeted marketing
 - 37 road shows attracted ~4,000 people
 - A 'chalk and cheese' campaign reached ~10mn people
 - 65,000 documents and 355,000 summaries in 16 languages were created and distributed centrally by the 'Healthcare for London' programme and locally by primary care trusts (PCTs)

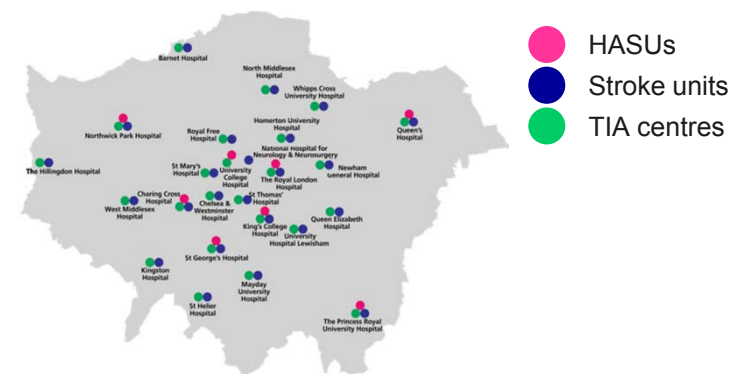
Widespread support

- Over 5,000 responses
- More than two-thirds of respondents supported plans to create more specialised centres for the treatment of stroke

Joint Committee

- A joint committee composed of representatives from London's PCTs and NHS South West Essex was established in 2009 to make final decisions on the designation of services
 - The joint committee of primary care trusts (JCPCT) met twice in public
- Providers in London put in bids to become a HASU or stroke unit; the bids were evaluated by a panel of international experts

Designated stroke providers in the London region



3 Key challenges were identified in the delivery of acute stroke care; proposed solutions were included in the new model

Areas of focus ¹	Challenges	Proposals in new model
Workforce and skills	Lack of specialists available 24/7	- Recognise stroke services as a speciality to make it an attractive career path - Give responsibility for skill development to stroke networks in London (e.g., through rotational posts)
IT	Information to assess quality of care not routinely available	- Define performance standards to enable collection of the right data - Use integrated care records (e.g., during transfers of care)
Infrastructure	Lack of access to CT scans and stroke unit beds	- Use hyper-acute stroke units with 24/7 access to imaging - Ensure all patients are treated in a stroke unit
Transfer of care	Inconsistent procedures used to transfer patients within or between institutions	Develop teams responsible for ensuring that patients are transferred between settings at the right time and that all relevant information is transferred with the patient
Linkages in care	Coordination is varied and best practices are not universally implemented	Use stroke networks with clear goals to spread best practices among all stroke providers
Finance	True costs of stroke care are unknown with no tariffs for hyper-acute care	Conduct a detailed analysis of costs and design incentives in the tariff model to encourage patient flow across care settings

¹ Key areas were identified using site visits and a pan-London event with 200 delegates.

3 Stroke networks were created to assist delivery of the strategy: there are now 28 across England with 5 covering London

Role of the stroke networks in key aspects of the stroke strategy

Innovation

Networks will play a key role in supporting, undertaking, and facilitating improvements in service delivery and the sharing of best practices within and across networks

Audit

Networks will use a registry to create an on-going data set for stroke to allow continuous measurement of improvement and alert providers and networks to any reductions in the quality of service at an early stage

Clinical leadership

Each network will have a nominated lead stroke clinician to spearhead the planning and development of stroke services. Clinical leadership will promote cooperation and work across service boundaries

Education/training

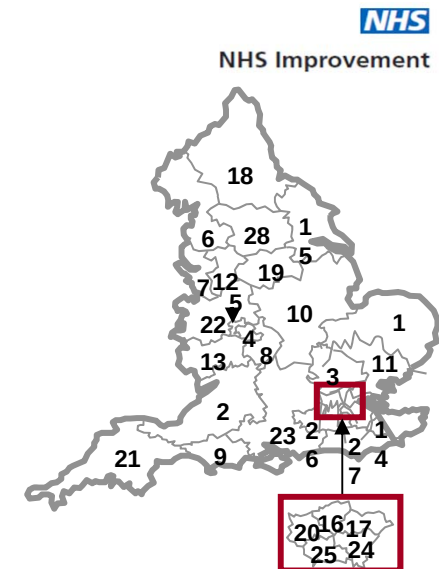
Networks can deliver value by providing staff with skill development in different parts of the stroke pathway. Additionally, networks may offer local-level training and sharing of best practices across networks

Quality

Networks will monitor performance and gather data on key aspects of stroke care delivery. The advantage of using networks for quality monitoring is that they are in a unique position to assess performance along the length of the pathway

Stroke networks would be supported by a £2.4mn investment over 3 years

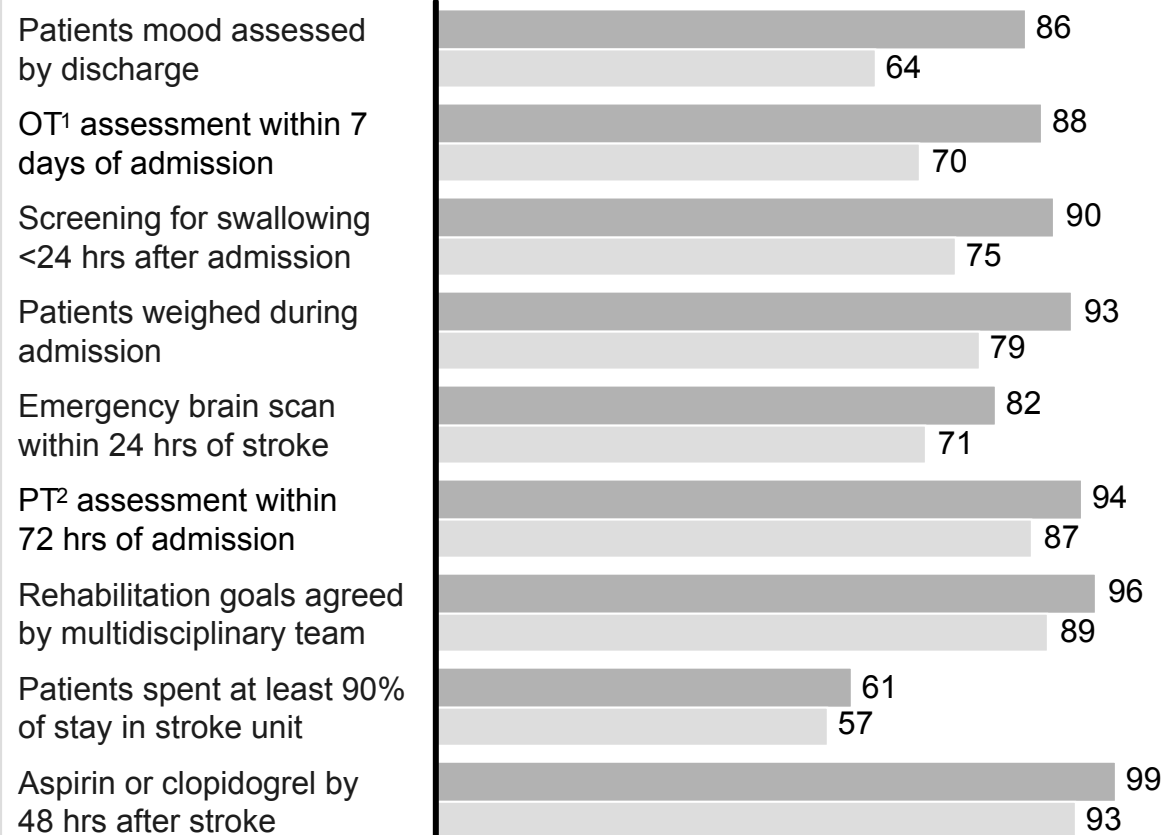
- 1 North Central London
- 2 North East London
- 3 North West London
- 4 South East London
- 5 South West London



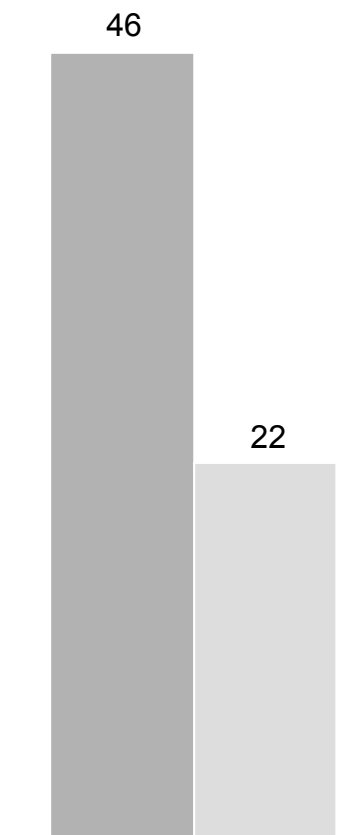
4 Impact: In London, hospitals with HASUs have stronger performance in stroke care than hospitals without HASUs

■ Hospitals with HASUs ■ Hospitals without HASUs

Stroke process indicators for London hospitals with and without HASUs
% of patients



Patients receiving all 9 indicators (bundle of care)
% of patients

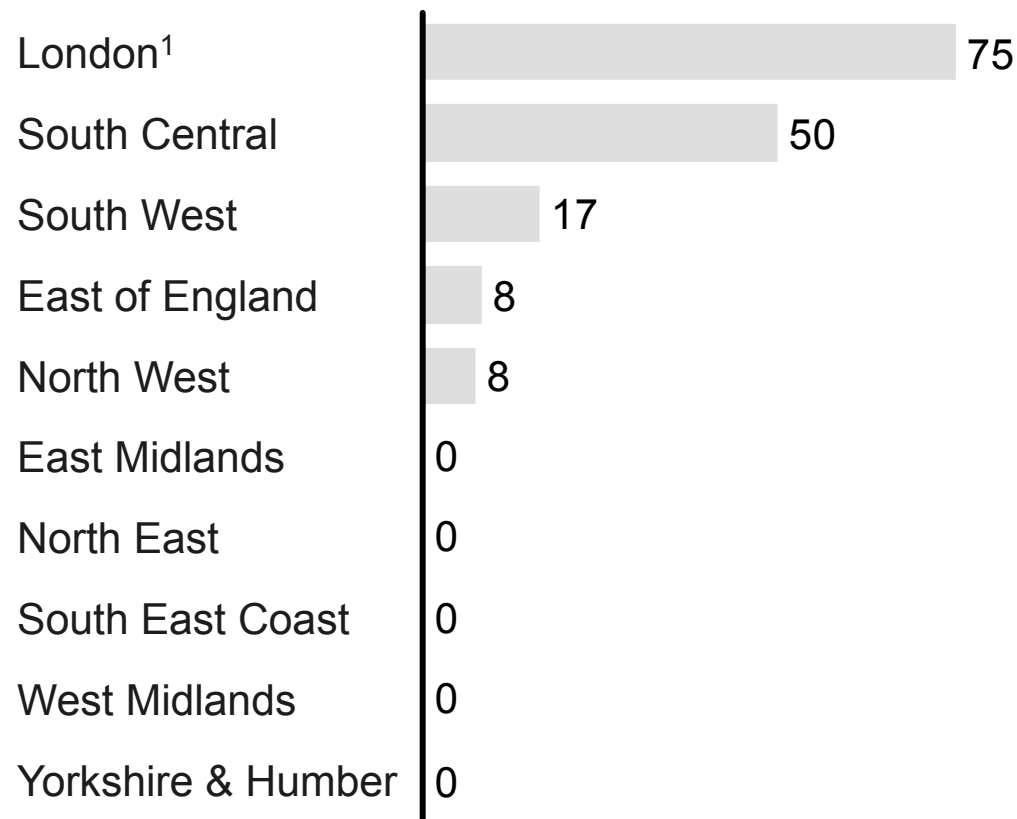


1 Occupational therapy

2 Physiotherapy

4 75% of London's hyper-acute stroke units (6 of 8) now meet all 7 national standards for acute stroke care

% of trusts by SHA achieving all 7 criteria for acute stroke care



- All hyper-acute stroke units in London are in the top quartile of national performance on acute stroke care
- 6 of London's 8 hyper-acute stroke units (75%) achieve all 7 national standards for acute stroke care; only 7% of trusts providing acute stroke care nationally do so

¹ London trusts include hyper-acute stroke units only

Case summary: Discovery Health's Vitality program has demonstrated cost savings through unique incentives for healthy behaviours

1 Background

Region: South Africa

Health system: Discovery (payor)

Start date: 1998

Challenge

- Discovery is a South African payor and a market leader, with 39% market share
- Discovery is part of the small but highly competitive private insurance market in South Africa; many struggle to achieve operating profits
- In South Africa, lifestyle diseases contribute to a large share of healthcare costs

2 Initiative details

Goals

- The health and well-being of their clients
- Reduced healthcare costs associated with lifestyle diseases

Approach

- Since 1998, Discovery has linked healthy behaviours (including preventive measures) with meaningful incentives, based on the concept that healthy people cost less
- Membership in the Vitality wellness program is voluntary
- Discovery started this program in South Africa in 1998 (with 200,000 members), but now has joint ventures (JVs) with similar programs in the US and UK (1.6mn members by 2008)

3 Process and impact

Process

- The program has three simple steps for members:
 - Know how healthy you are – individual health review with easy-to-use tools
 - Set personal health goals – guidance and support
 - Enjoy rewards – tangible incentives; e.g., discounts on movie tickets or travel

Impact

- A study tracking nearly 1mn patients from 2003 to 2007 showed participation is associated with ~15% lower overall healthcare costs
 - Fewer admissions per patient – 9.6% lower in highly active individuals vs. inactive individuals
 - Reduced length of stay – 0.57 days shorter for highly active vs. inactive individuals
 - Reduced cost per patient admission – £300 lower for highly active vs. inactive individuals
- Increased and sustained engagement – participants increased from 51% to 80% from 2003 to 2007
- Memberships grew to 1.6m by 2008 across South Africa and the US

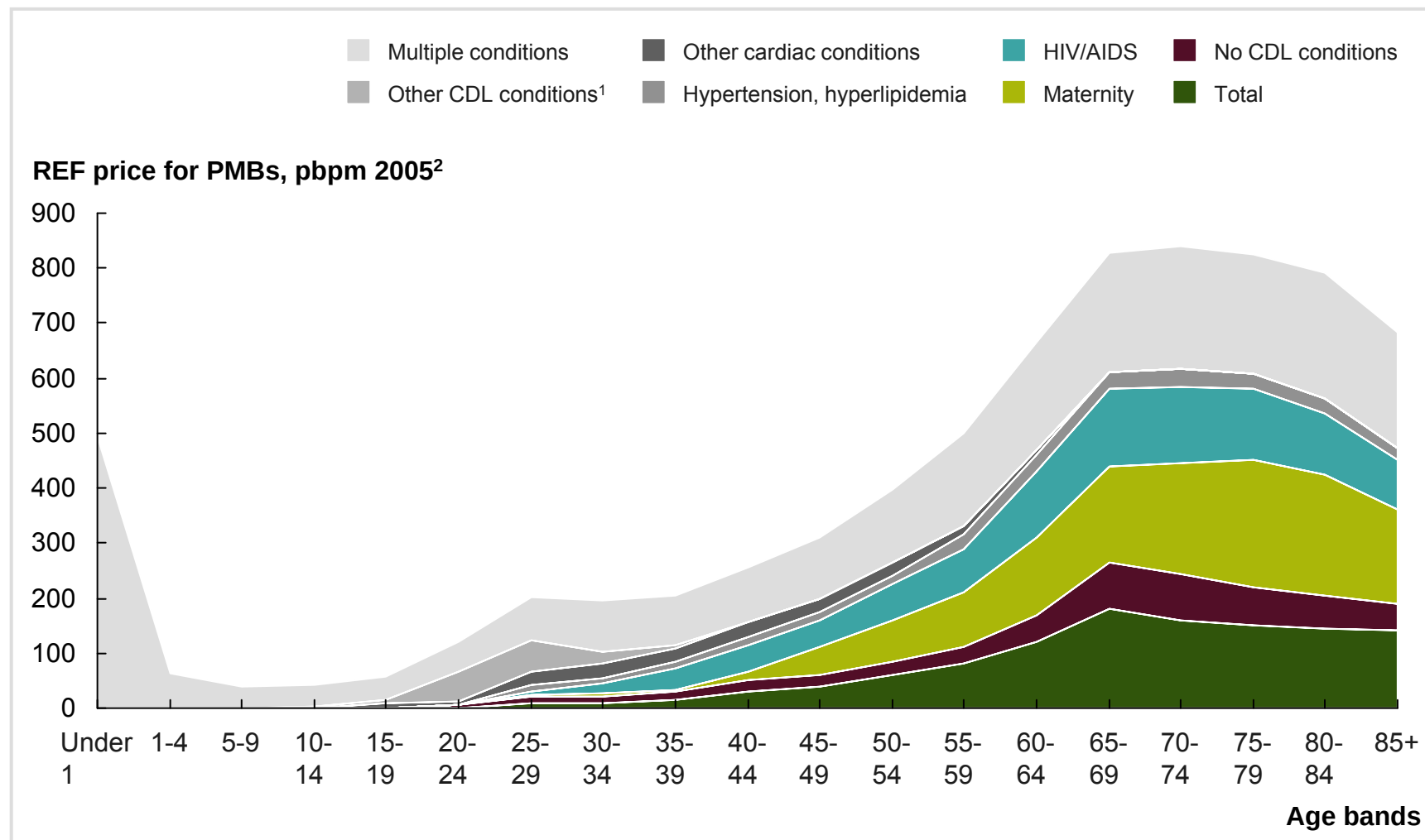
4 Key success factors

- Create clarity on personal health status
- Support customers in living a healthier lifestyle
- Motivate healthy behaviour with meaningful consumer incentives, targeted at specific profiles

5 Key players

- Discovery
- Members of Discovery's medical insurance scheme
- Program partners e.g., Pick n Pay
- Health care institutions

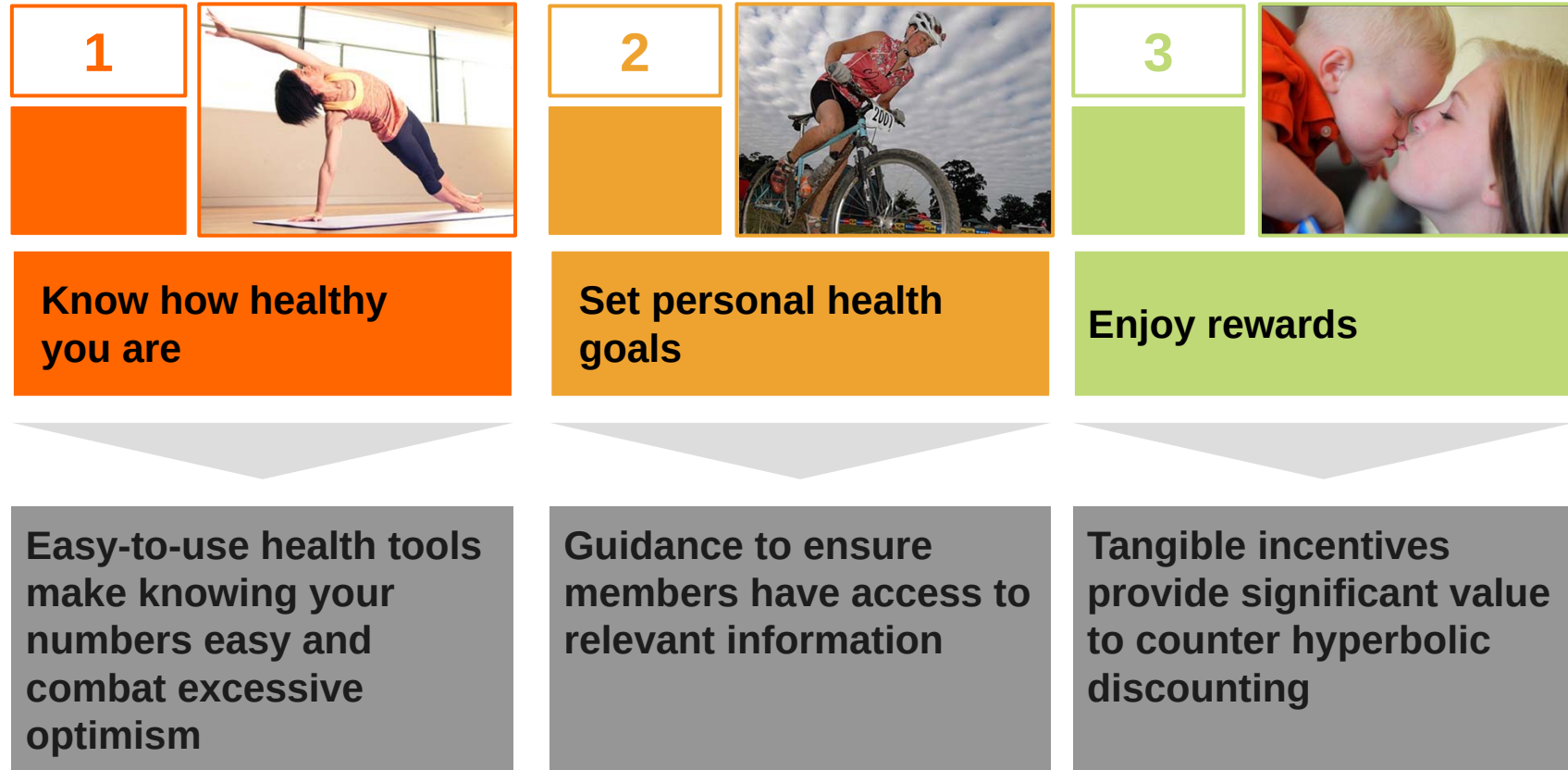
1 Background: Lifestyle diseases contribute to a large share of healthcare costs



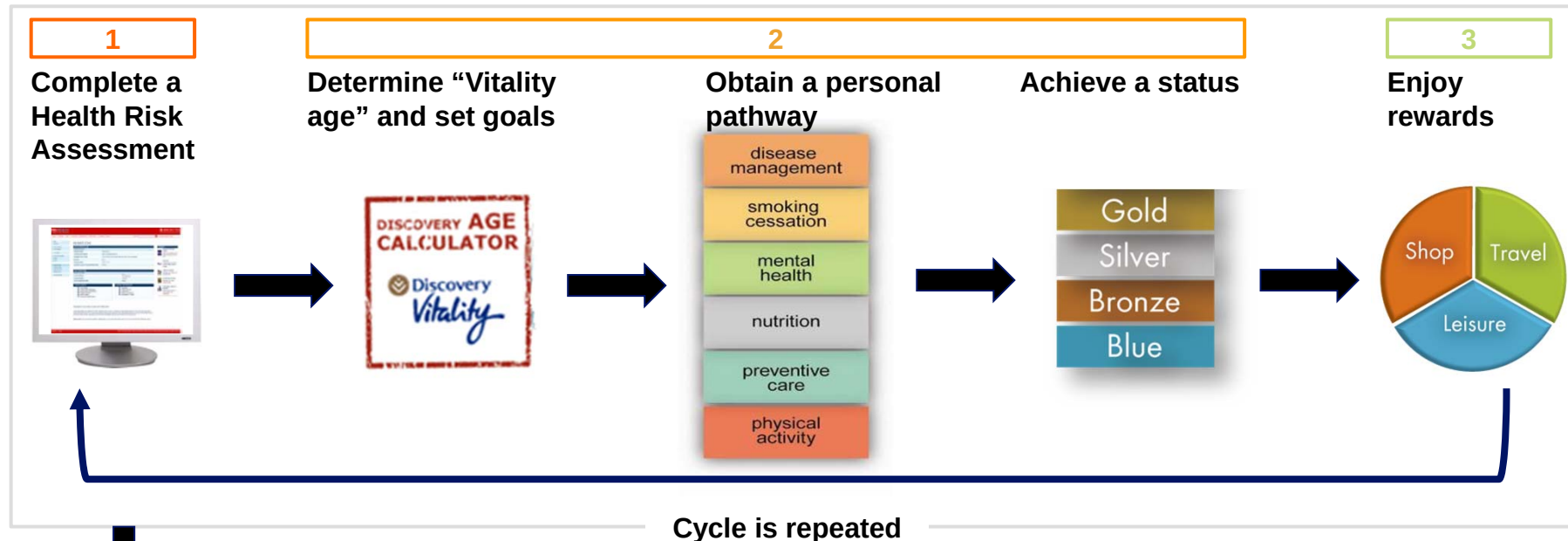
1 CDL: chronic disease list. This list includes diseases such as diabetes, CAD, HIV/AIDS, and hypertension

2 PMB: prescribed minimum benefits; pbpm: per-beneficiary-per month

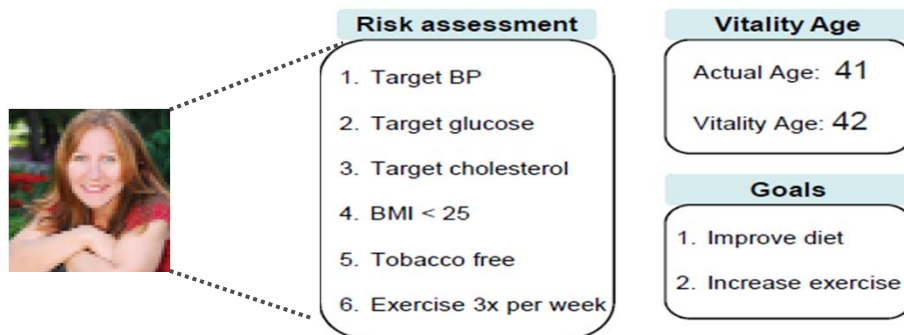
3 The Vitality wellness program consists of 3 steps, as mechanisms to address behavioural challenges



3 The program focuses on personalised engagement centered around clear goals



Example Health Risk Assessment



Following personal risk assessment, **members are assigned to personal pathways**, with care plans that include physical activity, nutrition, and lifestyle patterns around disease- management programs and mental health

3 The program provides unique rewards as incentives, designed to appeal to a range of aspirations

Rewards

- The rewards are based on the Vitality status – a measure of how much you interact with Vitality to get healthier
- Program offers a broad range of benefits tailored to specific customer segments
- Accumulating Vitality points leads to enhanced status and premium discounts
- Vitality's rewards include travel, lifestyle, and online and shopping rewards

Example of partnership for member benefits – Pick n Pay

- Pick n Pay (No. 1 grocery retailer, with 33% market share) JV¹ set up at the end of 2008
- Dual JV objectives:
 - Lower health risk within Discovery's insured population
 - Open up Discovery's clients to Pick n Pay and build loyalty
- Discovery's Vitality members can receive a HealthyFood discount of 15%-25%² on 6,000 selected healthy food items from certain Pick n Pay stores; they also receive cash back, depending on their Vitality status (blue, bronze, silver, or gold)
- In a survey of members of Discovery's medical insurance scheme, Discovery Health, 62% of respondents thought healthy food was expensive
- The initiative aims to
 - increase consumer awareness about what constitutes healthy food
 - lower the barriers to a healthy diet, such as price considerations
- 71,500 Vitality members activated this benefit in the first six weeks

Patient Vitality status



Rewards



1 JV: Joint venture

2 25%, if member has completed an online HRA

Additional references

- 1 Comparative health systems - What can we learn from other nations?" Duncan IG, et al. Presentation at Society of Actuaries meeting
- 2 Wellness programs and PMI. Stipp EJ. Presentation at Society of Actuaries meeting (<http://www.actuaries.org.uk/?a=149504>)
- 3 Discovery Vitality website (<https://www.discovery.co.za>)
- 4 Incentives can have dramatic impact on health behaviours new research reveals. PruHealth (https://www.pruhealth.co.uk/presales/about_pruhealth/press_centre/pdf/press_incentives05.pdf)
- 5 Fitness-related activities and medical claims related to hospital admissions – South Africa. Lambert EV, et al. CDC Preventing Chronic Disease (http://www.cdc.gov/PCD/issues/2009/oct/08_0226.htm)
- 6 Pick n Pay and Discovery's Vitality program - How to activate your HealthyFoods benefit on Vitality website (<http://www.cbn.co.za/pressoffice/vitality/fullstory/1414.htm>)

Case summary: Royal Marsden's Hospital2Home program allows more patients to die in their chosen setting

1 Background

Region: London, UK

Health system: Royal Marsden Hospital (RMH) NHS Foundation Trust

Start date: 2007

Challenge

- A majority of UK cancer patients prefer to die at home, but most still die in hospital
- Hospital care can be more expensive than well-defined community care¹
- RMH sees 40,000 cancer patients each year and provides inpatient, day care, and outpatient services
- Only 39% of cancer patients died at home
- 73% of admissions to RMH (for pain and symptoms) could have been avoided with adequate community services, enabling acute beds to be used for active oncological treatment unavailable elsewhere

2 Initiative details

Goals

- To address the obstacles to palliative care at home:
 - Poor integration / information transfer across providers and services
 - patient uneasiness due to, e.g., limited access to 24-hour care
 - Lack of physician and nurse training in palliative care
 - Oncologists' lack of confidence in community services

Approach

- Royal Marsden's Hospital2Home (H2H) program allows palliative care at home by improving infrastructure, training, and communication between providers and community services

3 Process and impact

Process

- Trained and hired H2H clinical nurse specialists
- Trained hospital palliative care consultants, GPs, community-support staff, London Ambulance Service
- Implemented and trained all relevant providers on electronic care records
- Developed new system of physician referrals; clinical nurse specialist assessment of patient; case conference with GP and community staff; preparation of discharge summary, care plan and ambulance form; GP responsibility for care; Patient Summary Record accessible through central IT system

Impact

- Since 2007, 78% of patients in H2H have died at home and/or a hospice (22% nationally)
- Patients/ caregivers report less emotion and anxiety
- Potential savings of 5% nationally in cancer care¹ by redistributing costs from acute care to community
- Up to 40% savings per patient in last fortnight of life, using defined community-care packages

4 Key success factors

- Hiring and training dedicated clinical nurse specialists
- Training hospital physicians, GPs, community-support staff, and ambulance staff
- IT system that captures patient information and is accessible to all main stakeholders
- centralised processes (e.g., contract with a provider of medical equipment)

5 Key players

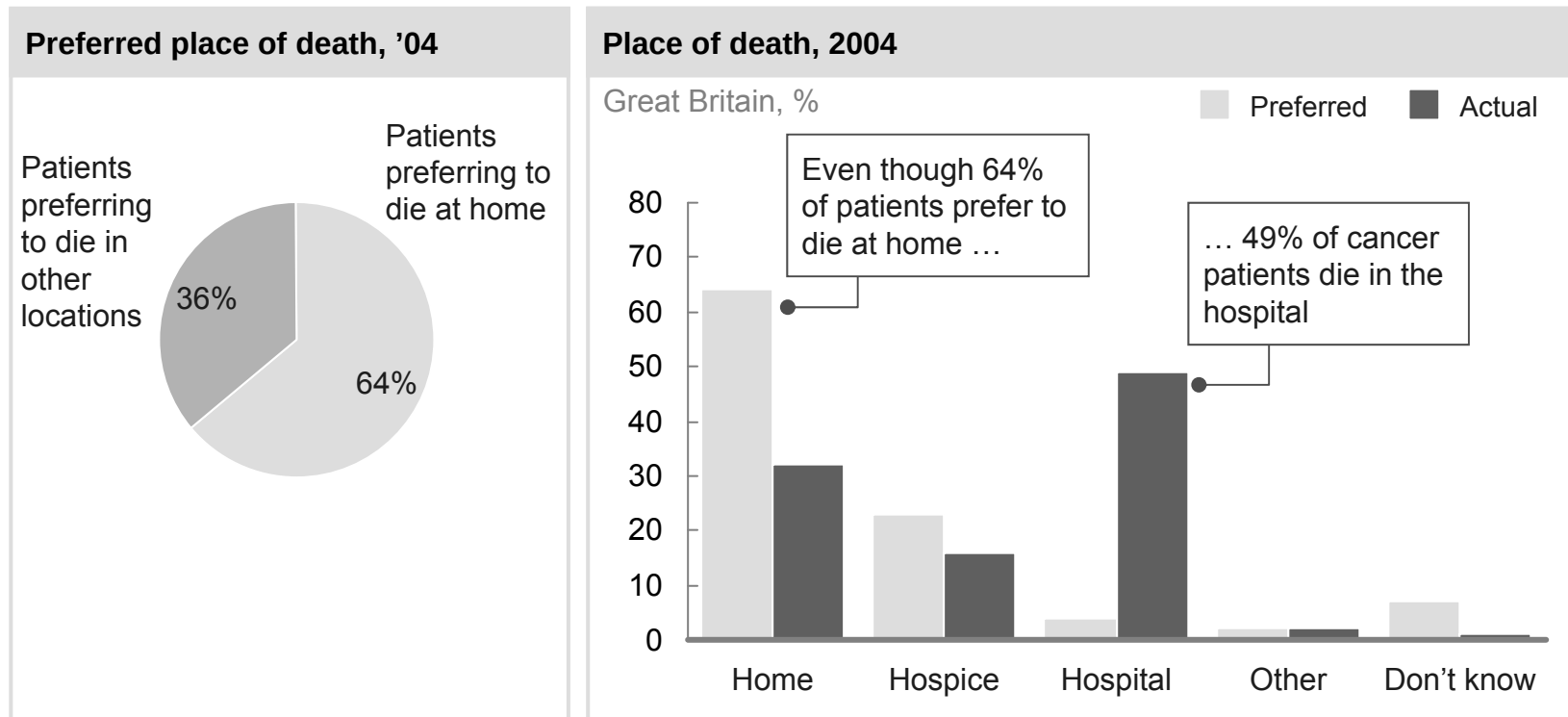
- Royal Marsden Hospital NHS Foundation Trust
- Clinical nurse specialists
- Hospital palliative care consultants, GPs, community-support staff
- London Ambulance Service
- Department of Health's national IT program (Connecting for Health)
- London Program for IT

¹ Estimates from National Audit Office costing model outline £222 per diem for hospital costs, compared with £28 per diem for community

SOURCE: Specialist job description. Royal Marsden NHS Foundation Trust, 2007; See subsequent slides for greater detail.

1 Background: Throughout the UK, a majority of cancer patients would die at home if given the choice, but most die in hospital

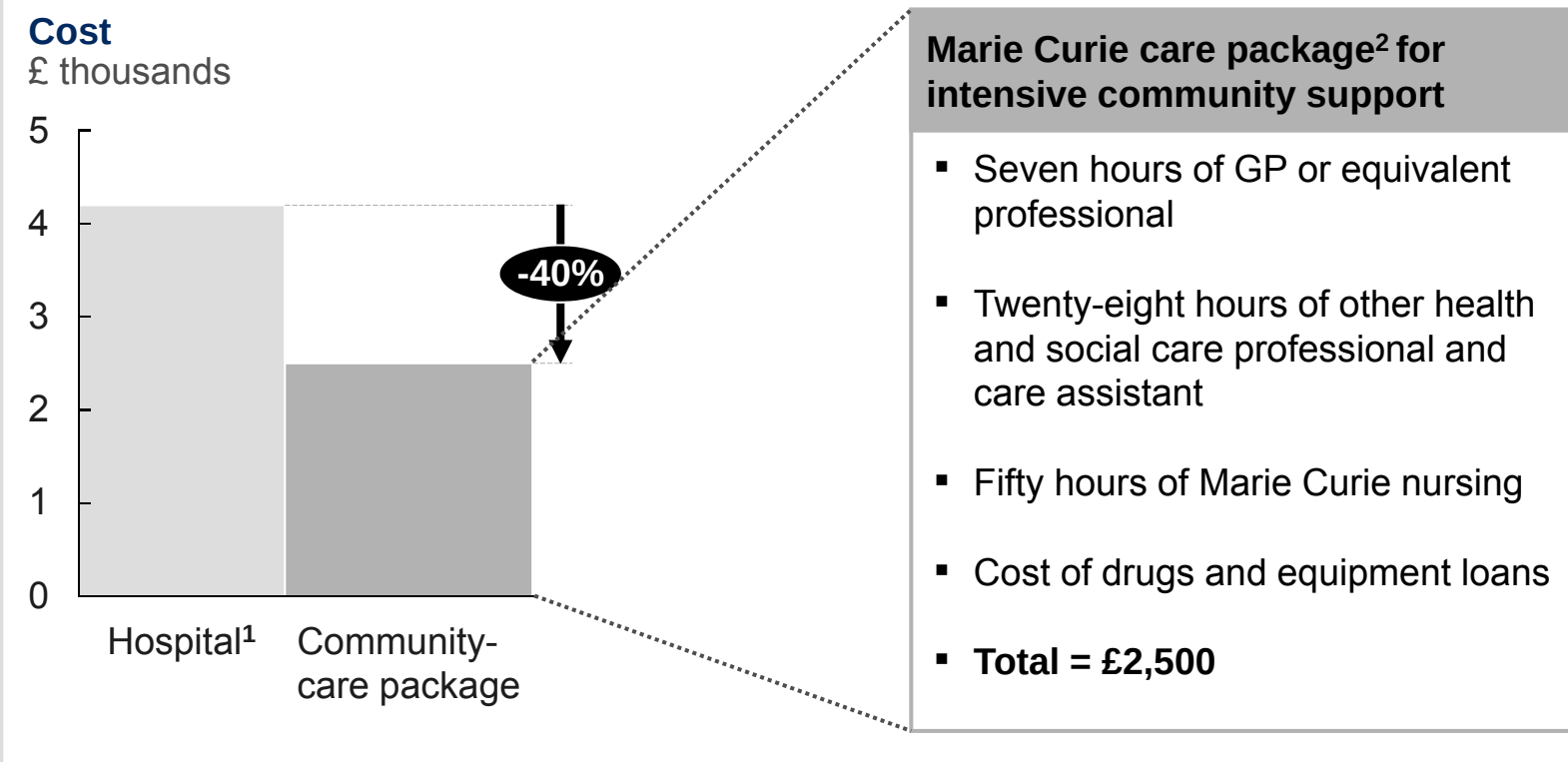
Marie Curie Cancer Care, one of the UK's largest charities, conducted a survey of the general public in 2004, regarding their views about dying at home



1 Furthermore, it is more expensive to care for patients in hospital than at home, when the right package of community care is defined

Example analysis from Marie Curie report

Cost of a cancer patient during last fortnight of life



¹ Assumption of 14 days in hospital = £300 per diem, total = £4200 in 2003/04 prices based on SchARR study findings, and DoH evidence to the Health Select Committee

² Marie Curie nurses are funded through Marie Curie's charity efforts and are separate from the NHS. Assumptions: GP visits £60ph, health and social care professional £30ph, Marie Curie nurse £20ph drugs/equipment loans up to £240. Hourly costs include indirect administrative, training, etc. Costs of GP, nursing, and other professional and care assistant time are inflated to allow for travel, management, and other overhead costs. Marie Curie meets two-third of the nursing costs, meaning total cost to NHS for this package would be £2,000

1 The UK National Audit Office estimates 5% savings in cancer care nationally by redistributing hospital costs to the community

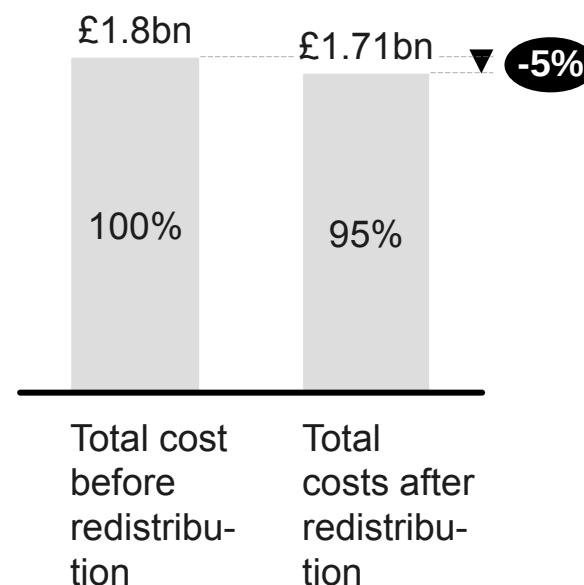
The costing model

- The National Audit Office (NAO) worked with RAND Europe to produce a model that simulates a patient's journey around a simplified health system over the course of the last year of life
- The model assesses potential savings and the utility of a more integrated approach to palliative care

Key assumptions for cancer patients

- Model estimates cancer patients in the last year of their life cost around £1.8bn nationally, but around £104mn could be saved by
 - 10% reduction in emergency admissions, avoiding 126,000 admissions
 - saving, on average, 4.1 days per patient
 - saving hospital cost of £2221 per diem
 - reinvestment into community care at £281 per diem

Potential savings in cancer care



1 Cost is calculated using NAO's model, assuming all costs are met by the NHS – detailed assumptions are not outlined

3 The program's success largely lies in developing a care plan with the patient, which is available to all relevant care providers

Overall approach of Royal Marsden

- Training and hiring of H2H clinical nurse specialists
- Training of hospital palliative care consultants, GPs, community-support staff, and the London Ambulance Service
- Implementation and training on electronic care records for all relevant providers

Clear process for all palliative-care patients

	Patient referral	Assessment of patient	Care conference	Handover to GP	IT system
Task	Physicians and nurses determine whether patients have reached end of treatment	Nurse specialist assesses patient's needs in the community and sets up care conference	Draws up patient Care Plan with agreement of all parties	Nurse e-mails Discharge Summary, Care Plan & Ambulance Form to GP	GP uploads Patient Summary Record onto central IT system; patient agreement on detail
Resources	All physicians and nurse specialists trained for the H2H initiative	Nurse specialist	Patient plus family/friend, nurse specialist, GP/other community staff	Nurse specialist, GP	GP and providers including hospice, ambulance, patient, equipment supplier, other community staff

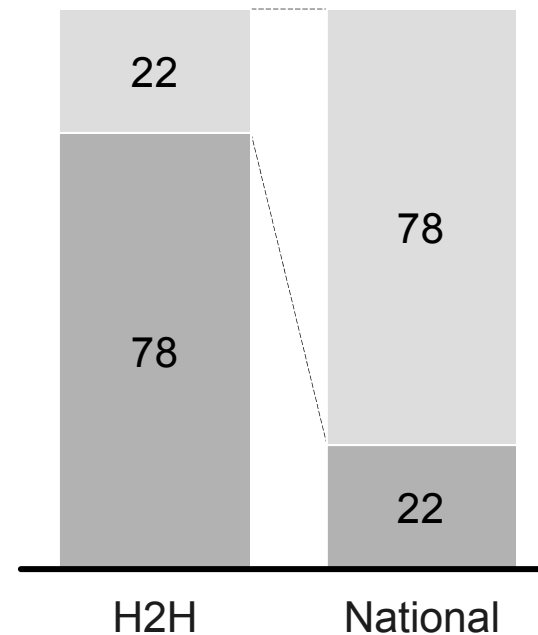
3 Impact: The H2H program has led to an increase in the number of people who die in their preferred place of death

■ Hospital/other
■ Home and hospice

H2H impact

Since its inception in 2007, H2H program has **resulted in an increase in the number of people dying in the preferred place of death from 39% to 78%**, compared with only 22% nationally

% by place of death, 2009



3 Quality of patient care, along with physician and overall system satisfaction, has improved

Patients

[Royal Marsden delivers] choice of care and takes away the anxiety and emotion



Caregivers

Feels emotional peace of mind because care is coordinated professionally: "I didn't know he was dying until we were told"



Professionals

Feel better informed and more empowered to make better clinical decisions

NHS

- Better use of resources; e.g., decreased unnecessary admissions and death
- Fewer complaints to CQC¹ (54% of complaints are about end-of-life care)
- Meeting patient wishes supported by auditable data

¹ Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England

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- 2 Marie Curie report: Valuing choice – Dying at home. Office of National Statistics
- 3 End of life care. National Audit Office
(http://www.nao.org.uk/publications/0708/end_of_life_care.aspx)
- 4 Job description for clinical nurse specialist. Royal Marsden NHS Foundation Trust
- 5 Hospital2Home, Technologies to Support End-of-Life. GP Education Day, presentation by Dr Julia Riley (<http://mediazone.brighttalk.com/comm/Haymarket/26ed54ac34-15393-3335-16532>)
- 6 Julia Riley on care of the dying. Health Service Journal (<http://www.hsj.co.uk/julia-riley-on-care-of-the-dying/1766340.article?sm=1766340>)
- 7 Hospital2Home. Royal Marsden Cancer Campaign
- 8 Case conferencing – an answer to improving end-of-life care? Experience from Royal Marsden Hospital. Riley, J. British Medical Journal. 2008;337:a2290
(http://www.bmj.com/cgi/content/extract/337/oct27_2/a2290)

Case summary: Geisinger's medical-home approach to chronic conditions led to reductions in hospital admissions and medical costs

1 Background

Region: Pennsylvania, US

Health system Geisinger Health System (GHS) (integrated system)

Start date: 2006

Challenge

- A 215,000-member health plan, serving a population of 2.5mn
- 700 GHS-employed physicians in 55 clinical-practice sites, but 60% of care delivery provided by non-Geisinger physicians
- GHS's 2.5m patients are, on average, poorer, older, and sicker than the patients nationally
- Chronic care diseases are the leading cause of death and disability in Pennsylvania, accounting for
 - 80% of state healthcare costs and hospitalisations
 - 76% of physician visits
 - 91% of filled prescription

2 Initiative details

Goals

- Improve outcomes and cost management for patients with chronic diseases

Approach

- Geisinger implemented an advanced medical home approach to improve outcomes and cost management for patients with chronic diseases
- With the medical home, primary care is organised around the relationship between patient and personal clinician
- A pilot program for two sites initially, if successful, to be rolled out to ten additional practice sites and one non-Geisinger practice

3 Process and impact

Process

- A pilot program for two sites, including
 - 24-hour access to care services (enhanced through the use of nurse care coordinators, care management support, and home-based monitoring)
 - patient access to electronic health records (EHRs), allowing patients to view lab results, schedule appointments, receive reminders, and e-mail providers
- Practice-based payments to compensate for extra work and additional staff
- Performance reports to monitor results

Impact

- 20% reduction in hospital admissions
- 7% savings in medical costs
- Based on this success, Geisinger is expanding the initiative to ten additional practice sites and one non-Geisinger practice

4 Key success factors

- Align incentives with physicians in care settings and from different health systems
- Apply EHR platform to ensure knowledge transfer throughout the system, and to those who know how to use and maintain it

5 Key players

- GHS acute care hospitals, specialty hospitals, ambulatory surgery campuses and 700 employed physicians in 55 clinical-practice sites
- Non-Geisinger physicians
- 2.5mn patients
- Nurse care coordinators, care management support, and home-based monitoring staff
- IT providers

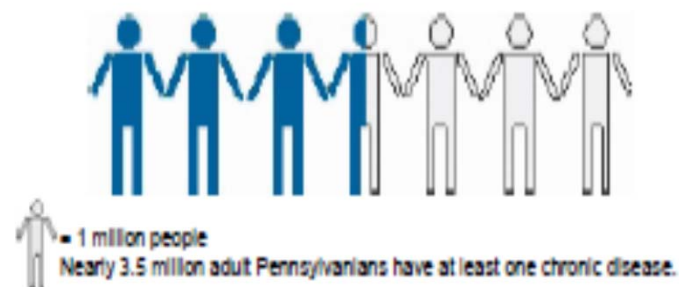
SOURCE: See subsequent slides for greater detail

| 53

1 Chronic disease is a serious challenge in Pennsylvania, contributing to more than 40,000 avoidable hospitalisations per year

- Pennsylvania's admission rates for chronic heart disease are nearly three times higher than the national average of 612 per 100,000
 - This accounts for 15,000 avoidable hospitalisations annually
- Admission rates for asthma are three times than those in best-performing states, with more than 19,000 avoidable hospitalisations annually
- Diabetes admission rates are four times the rate of hospital admissions in best-performing states, with 14,000 avoidable hospitalisations

50% of All Pennsylvanians Age 18 – 65 Have at Least One Chronic Disease



Chronic-disease patients account for 80% of all healthcare costs and hospitalisations, 76% of all physician visits, and 91% of all filled prescriptions

These chronic-disease conditions are exacerbated in Pennsylvania by

- **obesity:** overweight and obesity incidence increased nationally by 19% from 1992 to 2002
- **an older population:** 1 in 5 Pennsylvanians is older than 60

3 Geisinger used a 'medical home' model to achieve its objectives of improving outcomes and processes for chronic conditions

What is a medical home?

First championed by the American Academy of Pediatrics, a medical home is broadly defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective

History of patient-centered medical home

Developed by four primary care specialty societies in the US, representing more than 30,000 internists, family physicians, pediatricians, and osteopaths

Joint principles of the patient-centered medical home

- Personal physician
- Whole-person orientation
- Safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology)
- Enhanced access to care
- Payment that recognises the added value provided to patients who have a patient-centered medical home

3 Medical-home programs have previously been implemented by different organisations in the US

MeritCare, North Dakota

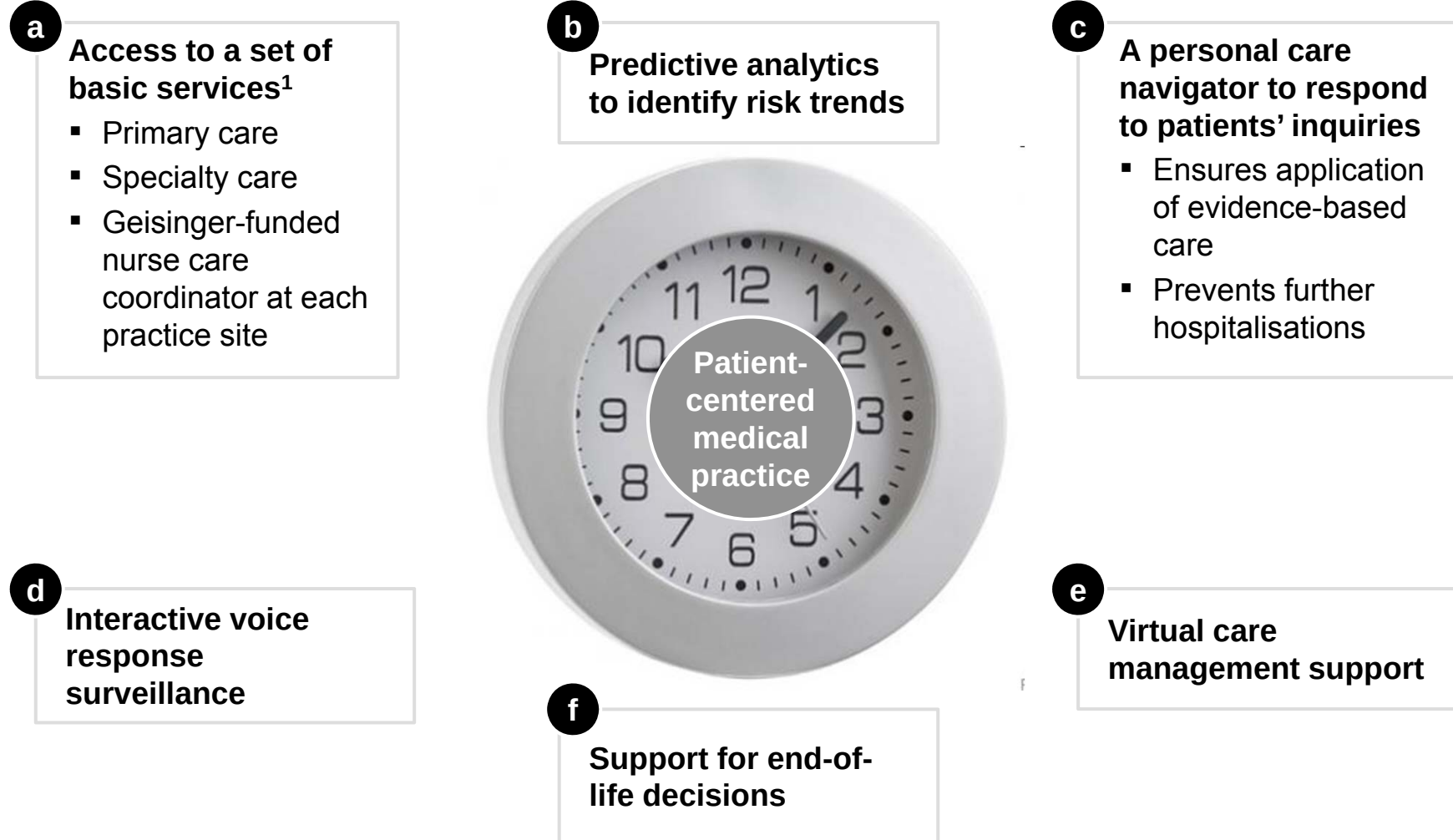
- MeritCare is the state's largest integrated, nonprofit healthcare delivery system
- In 2005, MeritCare partnered with Blue Cross Blue Shield of North Dakota to implement a chronic-disease management pilot program to test the assumption that it is best to care for chronic diseases through a medical-home approach
- Diabetes patients were assigned to a medical home, using EHRs and chronic-disease management approach
- **Results:**
 - Over two years, there was an 18% increase in the proportion of patients who received a "complete care" bundle of five recommended services
 - Outcomes for patients at the intervention site were 5%-15% better on four of five ambulatory measures
 - Total costs per member per year were \$530 lower than expected in the intervention group based on historical trends, saving an estimated \$102,000 for 192 patients in the pilot



Bridges to Excellence (BTE)

- BTE, a nonprofit, coalition-based organisation, rewards and recognises healthcare providers that demonstrate innovation in patient care
- In 2008, BTE launched a BTE Medical Home program, which rewards physicians who use this approach with chronic-care patients
 - Through participation, physicians can receive an annual bonus payment of \$125 for each patient covered by a participating employer
- **Estimated results:**
 - The average potential savings per covered life would be approximately \$250 a year

3 Initiative details: Geisinger's ProvenHealth Navigator is an advanced medical-home approach, ensuring round-the-clock access to a wide range of services



1 Services are provided by Geisinger and vetted non-Geisinger referral providers

3 Services are underpinned by electronic health records (EHR) system, physician incentives, and performance management

1 EHR system

Description

- Available to non-Geisinger referring physicians and patients through customised Web portals
- Patient features include Internet-based lab results, clinical reminders, self-scheduling, secure e-mail with providers, prescription refills, and educational content

2 Practice-based payments

- Geisinger Health Plan (GHP) offers \$1,800 per month to each physician, as compensation for expanded scope of work
- Additionally, GHP offers monthly stipends of \$5,000 per thousand Medicare members to support additional staff for extended hours
- Incentive payments are split among individual providers and the practice, to fill the gap between expected and actual costs of care for medical-home enrollees
- Actual payments are prorated based on the percentage of targets met for ten quality indicators

3 Performance reports

- Monthly performance reports of quality and efficiency results are provided to each medical-home practice and reviewed by an integrated GHP practice site team
- During the review, which includes senior managers from the community practice, challenges and opportunities are identified, and plans are adjusted

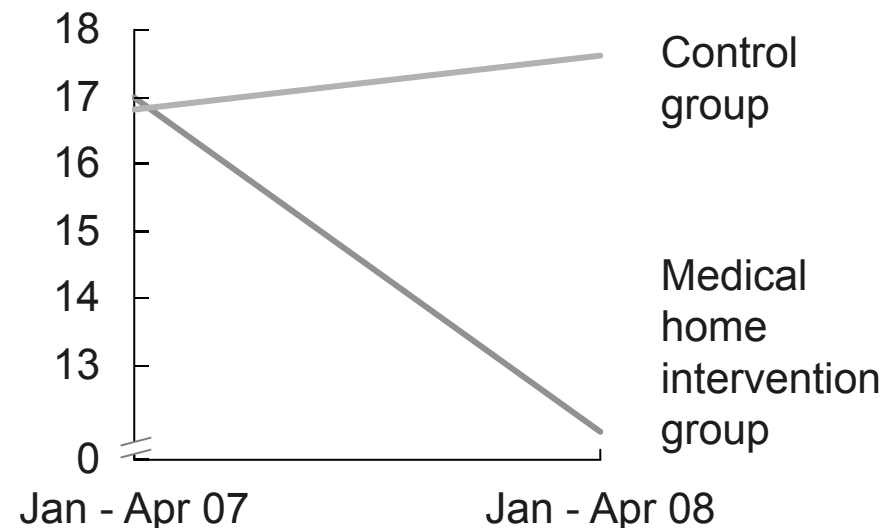
3 Impact: After 1 year, preliminary results show significant achievements

- In phase one (2006-2007), medical costs decreased by 4% for the entire population
- Return on investment was 250%

“Preliminary data show **20% reduction in hospital admissions and 7% savings in total medical costs**”

In phase two, primary target outcome was reduced hospital use

Readmission rates among two pilot sites
Percent of cases



Based on this success, Geisinger is expanding the initiative to ten additional practice sites and one non-Geisinger practice to cover more than 25,000 Medicare Advantage and fee-for-service Medicare patients

4 Key success factors: Successful implementation depends on the alignment of incentives among stakeholders and the EHR system

Align incentives with physicians in care settings and from different health systems

- Create value by linking financial budgets and quality outcomes, paralleling pay-for-performance initiatives
- Encourage, engage, and adequately reward clinician champions – at all levels – who support transformation

Adopt a functional EHR platform to ensure knowledge transfer throughout the system, and to those who know how to use and maintain it

- Recognise that realising benefits of implementation, adoption, and usability comfort takes time
- Empower patients through home use of the system to make appointments and track health information
- Automate care, remove geographic barriers, and improve reliability

Additional references

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(<http://content.healthaffairs.org/cgi/content/abstract/27/5/1235>)

- 2 Geisinger quality – Striving for perfection. Steele G. Lecture at Health System Reform Summit at the American College of Cardiology
([http://qualityfirst.acc.org/events/Documents/2009 Health System Reform Summit Slides/GEISINGER ACC Health System Reform Summit.2.2.09.ppt](http://qualityfirst.acc.org/events/Documents/2009%20Health%20System%20Reform%20Summit%20Slides/GEISINGER%20ACC%20Health%20System%20Reform%20Summit.2.2.09.ppt))

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(<http://www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf>)

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(<http://www.commonwealthfund.org/Content/From-the-President/2009/Can-Patient-Centered-Medical-Homes-Transform-Health-Care-Delivery.aspx>)

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- 7 A 2020 vision of patient-centered primary care. Davis K, et al. Journal of General Internal Medicine
([http://www.commonwealthfund.org/~media/Files/Publications/In the Literature/2005/Oct/A 2020 Vision of Patient Centered Primary Care/868_Davis_2020_patient centered_care_JGIM_10 2005_ pdf.pdf](http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2005/Oct/A%2020%20Vision%20of%20Patient%20Centered%20Primary%20Care/868_Davis_2020_patient_centered_care_JGIM_10_2005_.pdf))

- 8 Toward higher-performance health systems: Adults' health care experiences in seven countries. Schoen C, et al. Health Affairs
(<http://content.healthaffairs.org/cgi/reprint/26/6/w717>)

- 9 Geisinger Health System website (http://www.geisinger.org/news/in_news.html)

- 10 Closing the divide: How medical homes promote equity in health care: Results from the Commonwealth Fund Health Care Quality Survey. Beal AD, et al. Commonwealth Fund (www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Closing-the-Divide--How-Medical-Homes-Promote-Equity-in-Health-Care--Results-From-The-Commonwealth-F.aspx)

Case summary: South Central England segmented patients to optimise urgent care services

1 Background

Region: South Central England

Health system: Sponsored by South Central Strategic Health Authority (SCSHA), regional National Health Service management body, delivered through alliance of nine payors

Start date: 2008

Challenge

- All A&E¹ departments in South Central face non-emergency attendances – average of 40% of total attendances
- SCSHA saw significant variance in use of urgent and emergency care with differences of ~52% across PCTs² in emergency care
- Alternative urgent care facilities existed but usage was low and value proposition not understood by patients

2 Initiative details

Goals

- Use urgent care social marketing insight to influence services provided in the future
- Utilise data and information for improved health outcomes, service improvement and redesign
- ~25% reduction in emergency attendances

Approach

- Applying social marketing tools in nine payors (known as South Central PCT Alliance) to provide targeted messages to different patient segments based on behavioural drivers
- Build on existing PCT capabilities

3 Process and impact

Process

- Mapped services and utilisation of urgent and emergency care for each of the South Central PCTs
- Segmented patients based on use of urgent care services: six segments of non-emergency A&E users
- Identified interventions to change behaviour through key influencers in the segments
- Facilitated a shift in behaviour and/or services to ensure appropriate and timely urgent care
- Engaged PCTs in social marketing project, particularly as a pilot on social marketing

Impact (prediction – based on nine PCTs)

- ~25% reduction in emergency attendances
- Net benefit £6.7m–£10.4m yearly [8%-13% savings]³
- Year-on-year cost reduction (40%-55% depending on PCT teams)
- A similar approach applied in Tower Hamlets contributed to a 6% reduction in A&E admissions

NOTE: Difficult to disaggregate outcomes from social marketing interventions

4 Key success factors

- Ensure appropriate third-party providers for research and quantitative and qualitative research methodology for rich insights
- On-going capacity-building support through peer-to-peer shared learning, counselling, and progress reviews
- Full alignment within organisation about key interventions, impact, and recognition that behaviour change is a long-term investment
- Ensure actual change and reflect stakeholders concerns

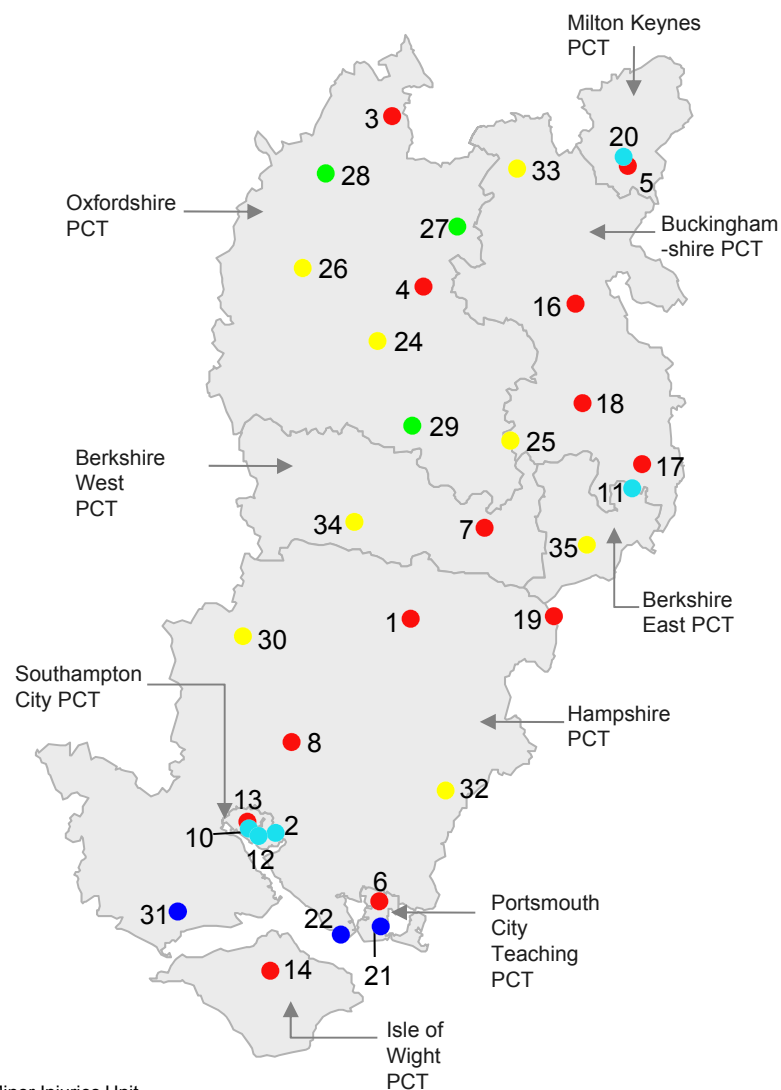
5 Key players

- South Central Strategic Health Authority
- Accident and emergency departments in South Central
- Social marketing professionals
- Quantitative and qualitative research organisations
- Primary Care Trusts
- Urgent care users

1 Accident and emergency; 2 Primary Care Trusts 3 Based on accident and emergency spend in 2006/2007

SOURCE: See subsequent slides for greater detail

1 Background: There are a variety of urgent and emergency care facilities in South Central PCTs



1 MIU - Minor Injuries Unit

No.	A&Es	Location
1	Basingstoke and North Hampshire Hospital Accident and Emergency	Basingstoke
3	Horton Hospital Emergency Department	Banbury
4	John Radcliffe Hospital Emergency Department	Oxford
5	Milton Keynes General Hospital Accident and Emergency	Milton Keynes
6	Queen Alexandra Hospital Accident and Emergency	Cosham
7	Royal Berkshire Hospital Accident and Emergency	Reading
8	Royal Hampshire County Hospital Accident and Emergency	Winchester
13	Southampton General Hospital Accident and Emergency	Southampton
14	St Mary's Hospital Accident and Emergency	Newport
16	Stoke Mandeville Hospital Accident and Emergency	Stoke-Mandeville
17	Wexham Park Hospital Accident and Emergency	Slough
18	Wycombe Hospital Emergency Medical Center	High Wycombe
19	Frimley Park Hospital	Frimley
Walk-in Centers		
2	Bitterne NHS Walk-in Center	Southampton
10	Shirley NHS Walk-in Center	Southampton
11	Slough NHS Walk-in Center	Slough
12	Southampton (Central) NHS Walk-in Center	Southampton
20	Milton Keynes Walk-in Center	Milton Keynes
Minor Injury Units		
24	Care Center Abingdon Hospital	Abingdon
25	Out Patients Dept Townlands Hospital	Henley-on-Thames
26	Out Patients Dept Witney Hospital	Witney
30	Andover MIU, Andover War Memorial Hospital	Andover
32	Petersfield MIU, Petersfield Hospital	Petersfield
33	Buckingham Community Hospital	Buckingham
34	West Berkshire Community Hospital	Thatcham
35	Heatherwood Hospital	Ascot
First Aid Units		
27	Bicester Community Hospital	Bicester
28	Chipping Norton Community Hospital	Chipping Norton
29	Wallingford Hospital	Wallingford
Other		
21	St Mary's Treatment Center	Portsmouth
22	Haslar Accident Treatment Center	Portsmouth
31	Lymington Urgent Care Centre	Lymington

1 Close to 40% of attendances relate to non-emergency conditions

By triangulating from presenting conditions, outcome of visit, and patient perception, we can estimate non-emergency attendances

Presenting conditions that do not fall into the nine main categories of an emergency condition on the NHS website

Outcome of visit: patients not admitted and who reported they were given no treatment¹

Patients interviewed who felt that their ailment/injury was not worrying and did not need treatment immediately

40% of all A&E attendances could be considered non-emergency

In South Central PCTs, there is a wide range of evidence on non-emergency attendance

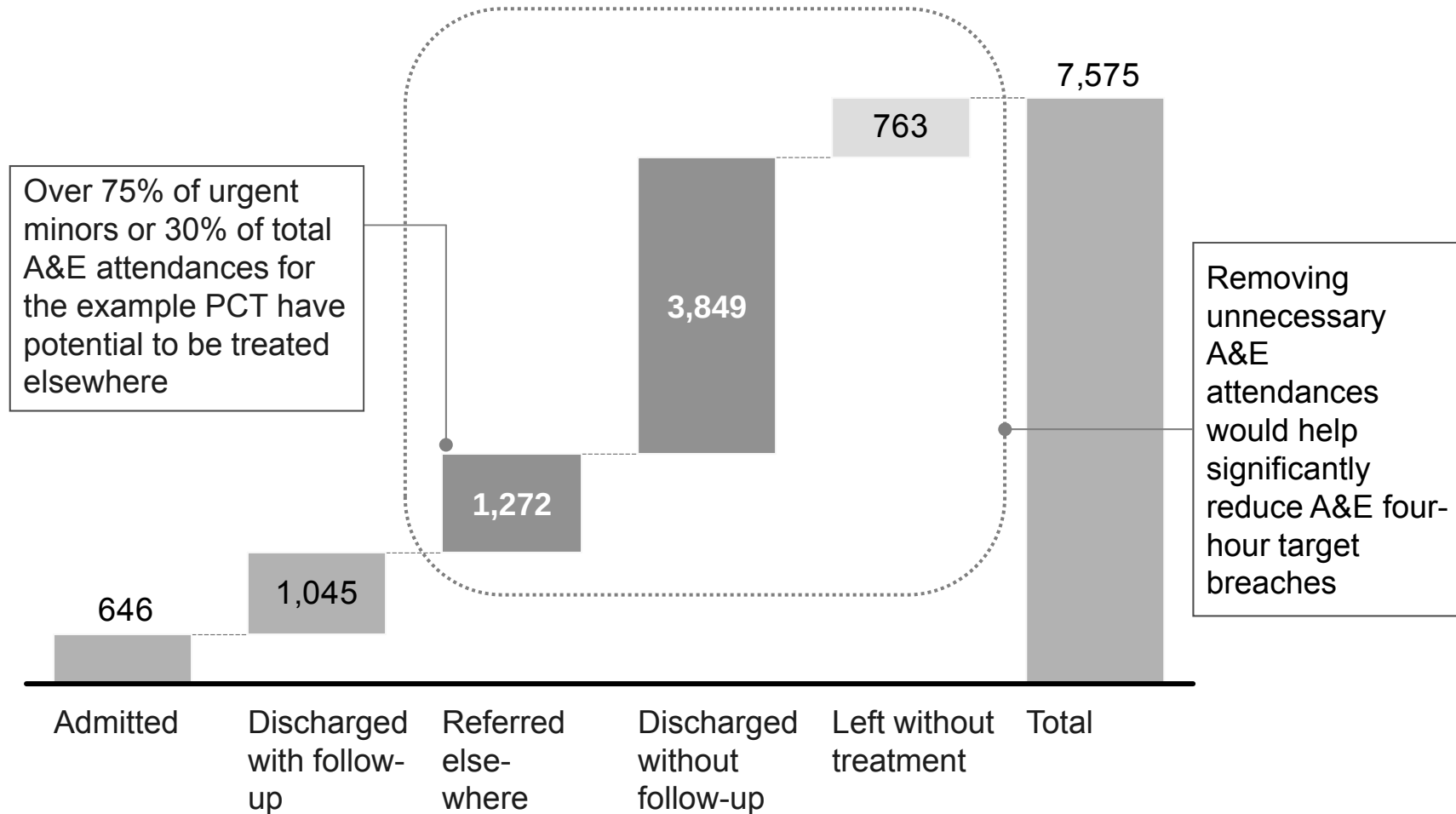
- In one PCT, 40% to 50% of A&E activity can be treated in primary care if a skilled GP is co-located with the A&E
- In another, nearly 25% of all A&E attendances are for non-ambulance, self-referred minors
- 57% of all attendances in one PCT were triaged into “standard” or “non-urgent” categories
- In the A&E survey:
 - 70% of people questioned in A&E were not particularly worried about their condition
 - 71% did not believe that they needed treatment immediately

¹ Patient reported outcome as ‘referred to’ another facility, told to go home, given only a prescription with no treatment, and other

1 Most attendances could have been treated elsewhere

PCT EXAMPLE

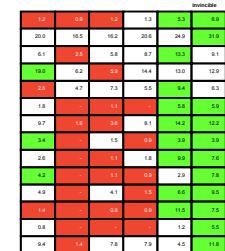
- Part of this could have been treated elsewhere
- Could have been treated elsewhere



3 Social marketing tools were used to assess the drivers of behaviour that cause patients to attend A&E inappropriately

What is social marketing?

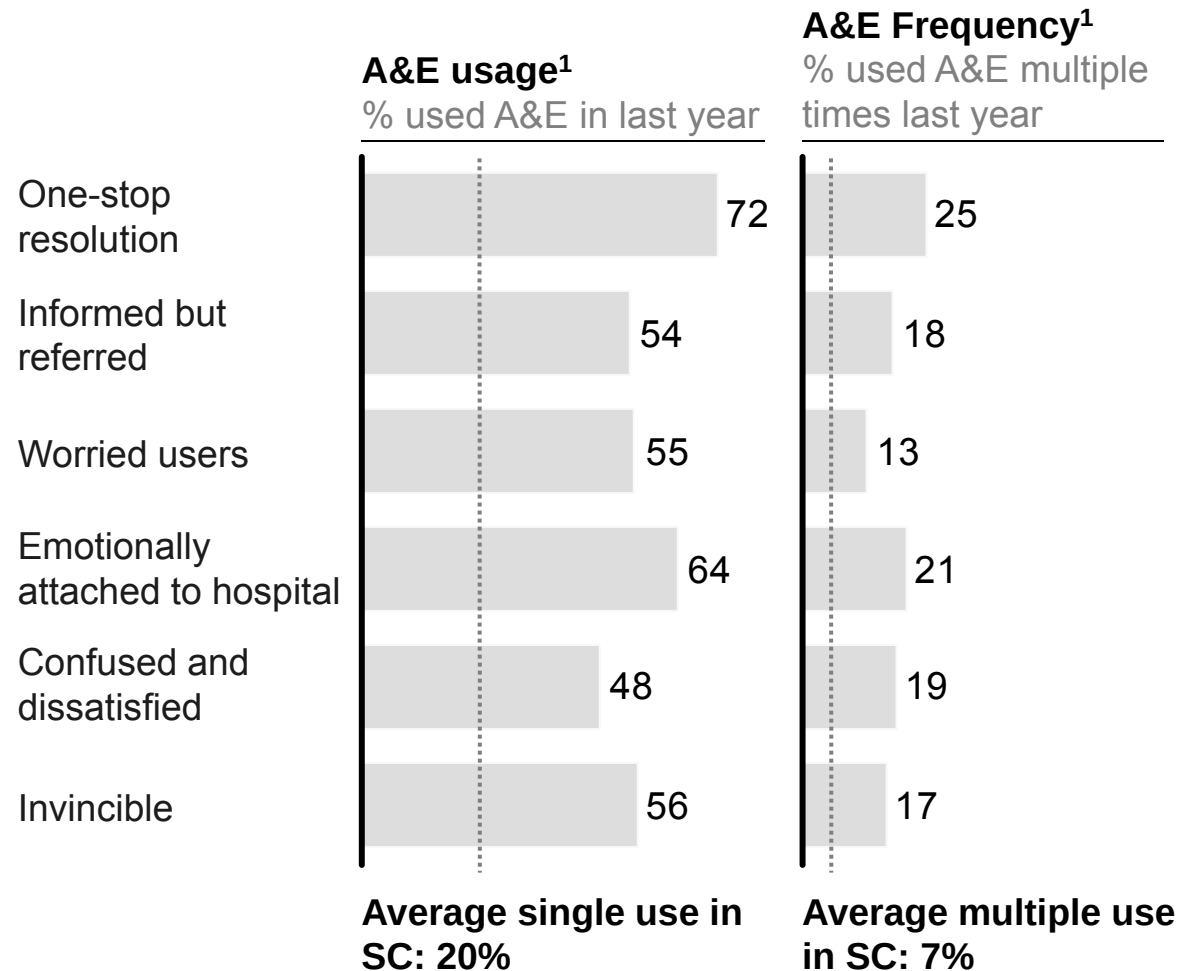
Social marketing is the application of marketing principles and techniques to influence a target group to change behaviour for the social good

	Qualitative interviews	Quantitative surveys	Factor analysis	Cluster analysis leading to segmentation																																							
Activities	40 patient interviews (in A&E and patient homes) to gain insight into patient behaviour - Clinician interviews 	- Survey design - Phone survey of 1600 households (general population) - In situ survey in A&E and WICs of 600 patients 	- Review factor loading (correlation) to understand how different attitudes are associated with one another - Select factors for segmentation <table><thead><tr><th>Factor1</th><th>Factor2</th><th>Factor3</th></tr></thead><tbody><tr><td>0.73</td><td>0.04</td><td>0.08</td></tr><tr><td>0.68</td><td>-0.14</td><td>0.13</td></tr><tr><td>-0.59</td><td>0.02</td><td>0.09</td></tr><tr><td>-0.31</td><td>-0.15</td><td>-0.13</td></tr><tr><td>-0.28</td><td>0.72</td><td>0.00</td></tr><tr><td>-0.11</td><td>0.67</td><td>0.13</td></tr><tr><td>0.04</td><td>0.62</td><td>0.47</td></tr><tr><td>0.32</td><td>0.40</td><td>0.13</td></tr><tr><td>-0.03</td><td>0.07</td><td>0.81</td></tr><tr><td>0.23</td><td>0.05</td><td>0.74</td></tr><tr><td>-0.02</td><td>0.20</td><td>0.72</td></tr><tr><td>0.38</td><td>0.35</td><td>-0.42</td></tr></tbody></table>	Factor1	Factor2	Factor3	0.73	0.04	0.08	0.68	-0.14	0.13	-0.59	0.02	0.09	-0.31	-0.15	-0.13	-0.28	0.72	0.00	-0.11	0.67	0.13	0.04	0.62	0.47	0.32	0.40	0.13	-0.03	0.07	0.81	0.23	0.05	0.74	-0.02	0.20	0.72	0.38	0.35	-0.42	- Create a set of clusters based on those who express similar attitudes - From the clusters derive segments (fewest number of segments that still provide differentiation) 
Factor1	Factor2	Factor3																																									
0.73	0.04	0.08																																									
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0.38	0.35	-0.42																																									
Output	Hypotheses on attitudinal statements and behaviours to test	Responses on attitudes and influencers	Clarity on most appropriate factors	Segmentation																																							

3 6 distinct segments of non-emergency A&E users were identified

Segments	Size	Brief description of attitudes and behaviours
One-stop resolution	22%	▪ Come to A&E because it is more convenient – no wait for appointment, always open, can get everything resolved at once ▪ Do not have good perception of GP or A&E quality
Informed but referred	19%	▪ Generally well-informed older patients who know the alternatives ▪ Most of these patients were referred by someone of authority, often GPs ▪ Have a sense of guilt for using A&E
Worried users	17%	▪ Main driver is worry. Believe that their condition is serious emergency ▪ Most females in this segment are carers worried about a child or an elderly relative ▪ Also tend to use GPs and other services fairly often
Emotionally attached to hospital	14%	▪ Feel that A&E doctors are more qualified than GPs ▪ Have an emotional attachment to hospital because of relatives or others treated there ▪ Feel hospitals are a dependable resource
Confused and dissatisfied	14%	▪ Don't know alternatives – only know GP or A&E ▪ Higher proportion of immigrants to the UK ▪ Feel that they are treated poorly at hospital
Invincible	13%	▪ Young group, mostly male ▪ Believe that for minor things they should self-treat and A&E is for major injuries – no in between ▪ Tend toward DIY self care (like gluing cuts)

3 All segments overuse A&E relative to their peers, with consequences for A&E performance and quality of patient care



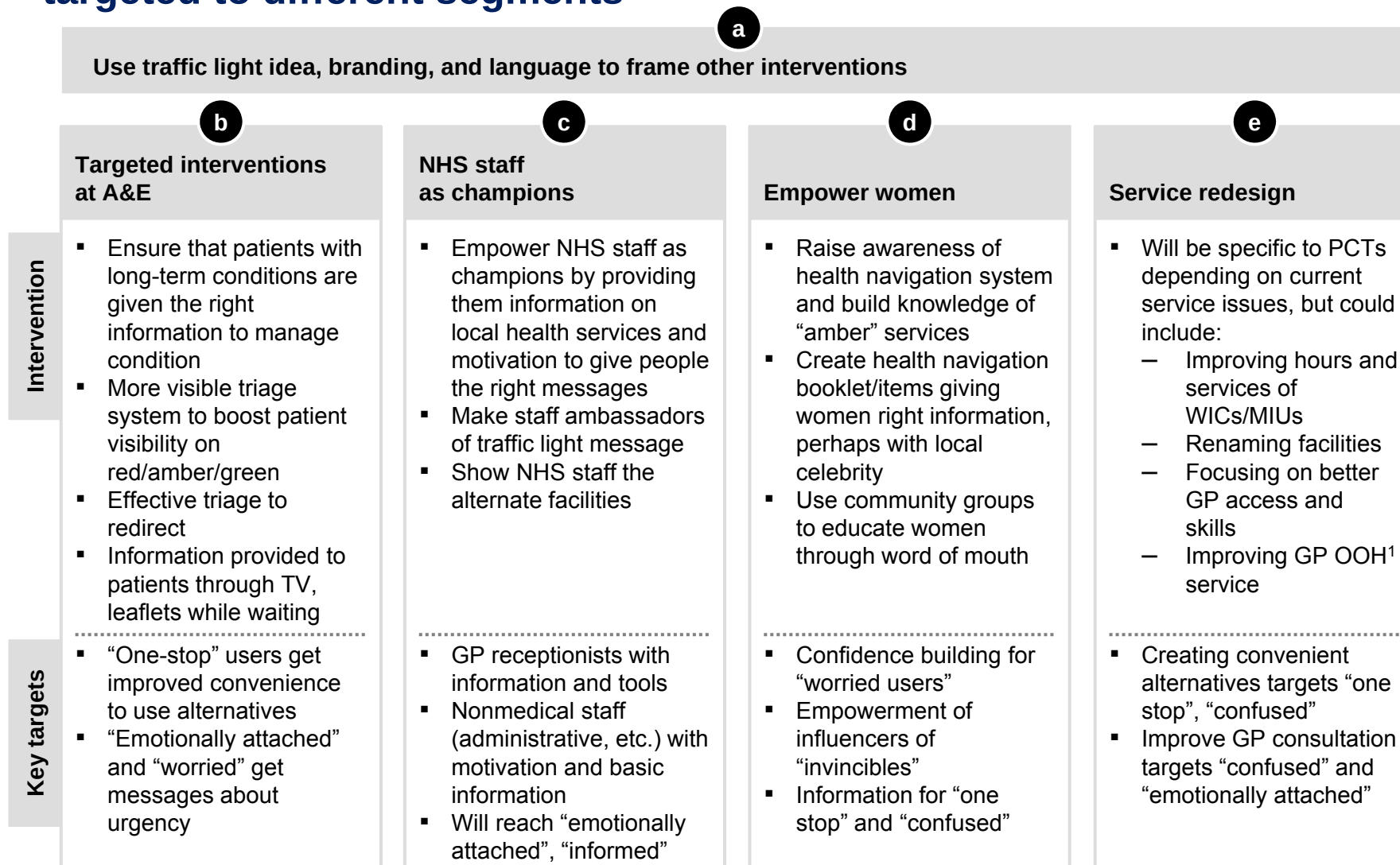
Consequences include:

- Difficulty in meeting four-hour wait time target
- Strain on A&E during peak hours
- Longer wait times for patients who could have been seen elsewhere
- Financial implications for PCT paying for care

If usage for these six segments alone were brought to average A&E use, we could achieve a 30% reduction in A&E attendances in South Central (SC)

¹ Based upon response to question 'How many times prior to this visit have you visited A&E in the last year'. Consequently, this is an under estimate of attendance (does not include current visit)

3 A portfolio of interventions was developed around 5 themes and targeted to different segments



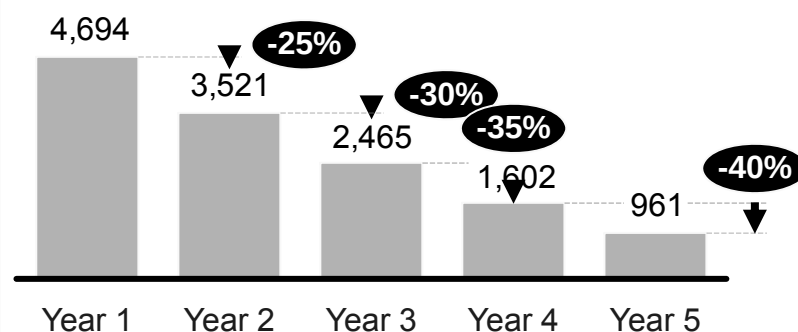
1 OOH – Out of hours

3 Impact: Costs of interventions are phased out over a 5-year horizon while net benefits increase – South Central-wide example¹

INDICATIVE

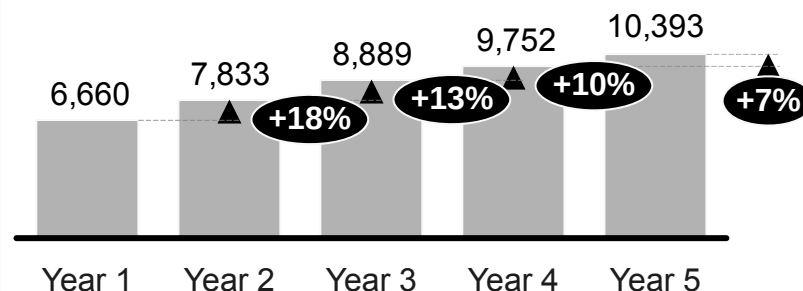
Year-on-year cost reduction

£ thousand



Year-on-year increase in net benefit

£ thousand



Predicted impact in South Central

- Reductions in A&E attendance up to 25%
- The benefit of these interventions could reach £51.3mn over five years in the SHA [~0.2% of total budget over five years]
- High ROI: net benefit £6.7mn–£10.4mn yearly (8% to 13% savings)²
- Over £43.5mn cumulative savings in five-year horizon
- Potential for year-on-year cost reduction 40% to 55% depending on PCT teams' capacity and capability (to discuss with each PCT)
- Immediate application potential for LTCs with similar benefit potential

NOTE: It is difficult to disaggregate improvements in outcomes from social marketing interventions when other interventions are applied

¹ Estimates based on South Central-wide adoption – 9 PCTs. To be tailored by PCT once interventions have been selected locally

² Based on A&E spend in 2006/07

Additional references

- 1 Communities and neighborhoods. Indices of deprivation. UK Communities & Local Government (<http://webarchive.nationalarchives.gov.uk/+http://www.communities.gov.uk/communities/neighborhoodrenewal/deprivation/deprivation07/>)
.....
- 2 Not just a matter of time: A review of urgent and emergency care services in England. Healthcare Commission
.....
- 3 Ambitions for health: a strategic framework for maximizing the potential of social marketing and health-related behaviour. UK Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090348)
.....
- 4 NHS next stage review: Acute care – urgent and emergency care. South East Coast Strategic Health Authority
.....
- 5 Six step guide: An interim resource to support urgent and emergency care workforce planning. NHS National Workforce Projects
.....
- 6 Taking healthcare to the patient: Transforming NHS ambulance services. UK Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114269)

Case summary: The 'patient-centered medical home' health care model reduces healthcare spend

1 Background

Region: USA

Health system: Patient-Centered Primary Care Collaborative (PCPCC)

Start date: 2006

Challenge

- The American College of Physicians developed the Advanced Medical Home model in 2005 and the PCPCC was founded in 2006 by a group of large employers and the major primary care physician associations
- In 2008, the Joint Principles of the Patient-Centered Medical Home (PCMH) were endorsed and accreditation programs launched
- The Commonwealth Fund five-year Safety Net Medical Home Initiative helped 65 community health centres transform into patient-centred medical homes

2 Initiative details

Goals

- An effective and efficient health system built on a strong foundation of primary care and PCMHs
- The PCMH approach to delivering and organising primary care helps achieve the goals of the Triple Aim:
 - improve the experience of care
 - improve the health of populations
 - reduce per capita health care cost

Approach

- The PCPCC achieves its mission through its 5 Stakeholder Centres, (volunteer groups)
- PCMH primary care is patient-centred, comprehensive, accessible, and committed to quality and safety
- It coordinates the broader health system, including speciality care, hospitals, home health care, and community services and supports

3 Process and impact

Process

- Several approaches can be taken to the integrative model, in terms of payment, payer type, use of technology, and use of care/case coordination (e.g., onsite/off-site; general/ disease-specific focuses)
- A PCMH achieves the Triple Aim by adopting new technologies, care delivery methods and relationships with patients and their families that encourage primary care to be patient-centered, comprehensive, coordinated, accessible and committed to quality and safety
- It is supported by information technology, provider payment reform, and team-based education and training of the health workforce

Impact

- As of January 2012, 41 states had adopted PCMH¹
- Providers, health systems, health plans, employers and state Medicaid programs demonstrate up to²:
 - 70% reduction in emergency room visits
 - 40% fewer hospital readmissions
 - Hundreds of millions of health care dollars saved

4 Key success factors

- Physician / manager with vision, ability to sell, skills to implement
- Resources – time and money; ongoing revenue stream
- Physician-patient partnership and engagement; community integration
- Competent Management and Finances
- Expert and Facilitated Assistance – consultants, other PCMHs etc
- Well-designed electronic health record systems
- Redefining Professional and Staff Roles and Training

5 Key players

- Patient-Centered Primary Care Collaborative
- Primary care physician associations
- The Commonwealth Fund (Safety Net Medical Home Initiative)
- Stakeholder Centres
- Providers – hospitals, community health centres, speciality care, hospitals, home health care, community services and supports

1 According to National Academy for State Health Policy MD, How to Scale Up Primary Care Transformation: What We Know and What We Need to Know?

2 Data from 46 PCMH initiatives

3 Charles J. Homer MD, MPH, Richard J. Baron

1 Joint principles of the PCMH are not prescriptive, but rather define a basic set of attributes

PCMH principles

Personal physician providing all levels of care

Physician-directed medical practice: leading a care team at the practice level

Whole person orientation: physician responsible for providing healthcare needs or arranging care with other professionals

Care is coordinated and/or integrated

Quality and safety are hallmarks of the medical home

Enhanced access to care is available

Payment appropriately recognises added value provided to patients

**Base principles
leave room for
interpretation
and offer
minimal
guidance on
implementation**

3 There are different flavours of PCMH/team-based care

● Case studies follow

Provider-led

- 1 Massachusetts General Hospital Care Management Program
- 2 Camden Coalition of Healthcare Providers
- 3 Baltimore HealthAccess
- 4 WellMed ACO
- 5 Johns Hopkins
- 6 Chen Medical

Integrated delivery network-led

- 10 Greater Rochester Independent Practice Association
- 11 AtlantiCare Medical Center
- 12 Group health of Puget Sound
- 13 Intermountain Healthcare Medical Group PCMH model
- 14 HealthPartners Medical Group Best Care PCMH model

Payor-led

- 7 Community Care of North Carolina
- 8 Boeing Intensive Outpatient Care Program
- 9 Genesee Health Plan HealthWorks PCMH model

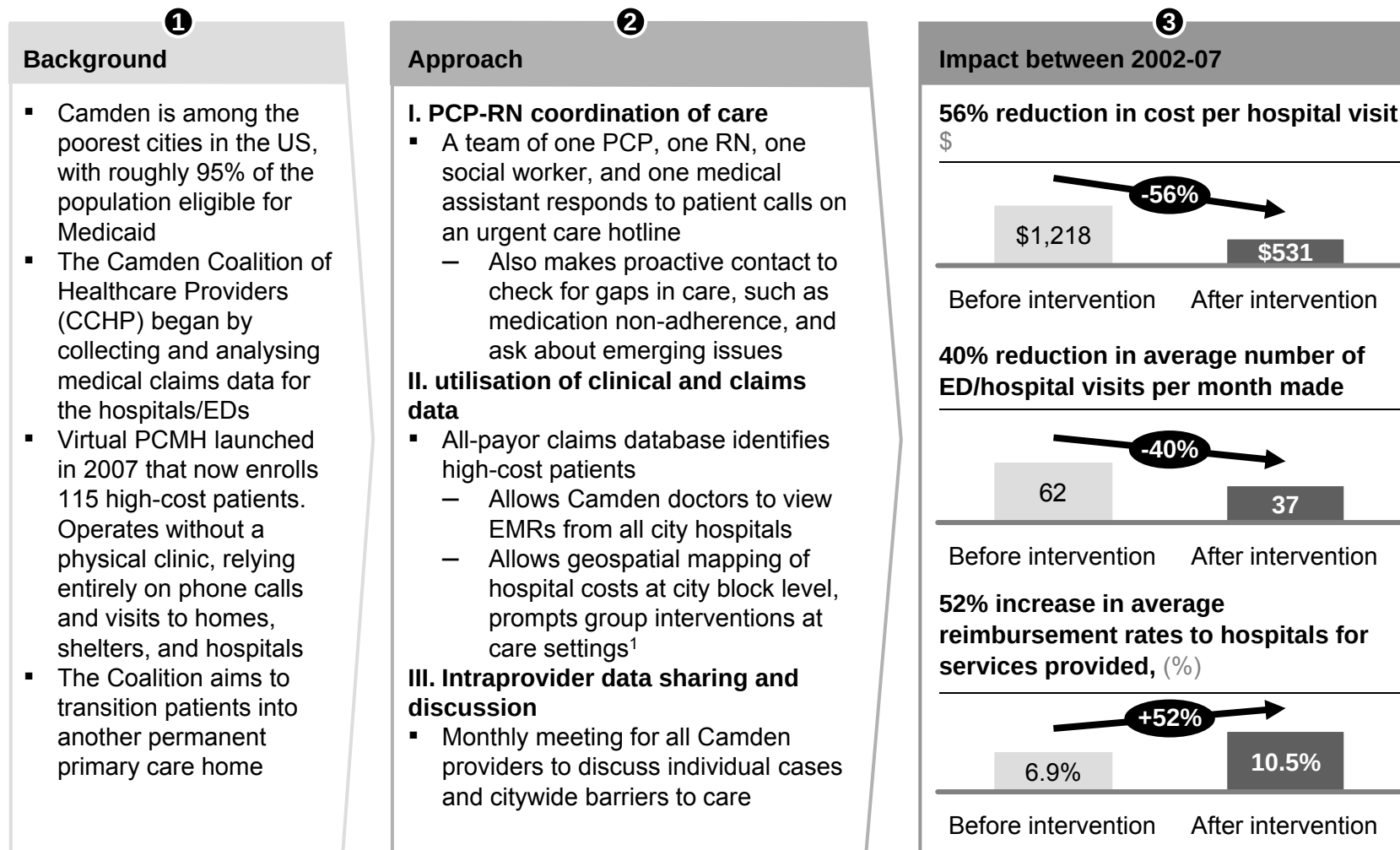
Other relevant case-studies, prior research

- Kaiser Permanente, Hawaii: Special Care Initiative
- Geisinger Health System Proven Health Navigator PCMH model
- Blue Shield of California

3 The results are positive

	Cost improvements	Quality improvements
Provider-led initiatives		
2 Camden Coalition of Healthcare Providers	56% reduction in costs per hospitalisation	40% reduction in ER visits
3 Baltimore HealthAccess	\$933 per-patient, per-month savings (EMS alone)	32% reduction in transport EMS responses
Payor-led initiatives		
7 Community Care of North Carolina	\$400mn in savings per year for the highest risk (disabled, blind, etc.) \$135mn in savings per year in the low-income population	16% decrease in ER visits 40% reduction in asthma hospitalisations 15% improvement in DM quality measures
Integrated delivery network-led initiatives		
10 Greater Rochester Independent Practice Association	\$120,000-\$180,000 savings per patient over three years	10% of DM pop improved blood sugar 95% patients satisfaction
Other relevant case studies		
Geisinger Health System Proven Health Navigator PCMH model	7% savings in total medical costs	20% reduction in total hospital admissions 25% reduction in readmissions

3-2 Camden Coalition of Healthcare Providers: Virtual medical home drawing high-cost patients from throughout city



1 Care settings include nursing homes, public housing, and other settings associated with disproportionate medical costs. CCHP seeks to establish on-site presence in these settings

SOURCE: Gawande, A. The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? The New Yorker, 2011; Hirsch, D. Coalition helping patients. Courier-Post, 2008

3-3 Baltimore HealthAccess Operation Care: High-touch case management for EMS super users

Description

- Baltimore HealthAccess, a city-run nonprofit, enrolled 10 of the top 20 EMS users in an intensive case management program. Although nine out of 10 were insured, every patient had at least two chronic diagnoses
- One case manager conducted comprehensive intake assessments of medical, psychosocial, and insurance needs. She visited each patient at least weekly, arranged their primary and secondary care, referred them to social services, and verified 100% attendance at referrals
- Intervention lasted 8-12 weeks per patient

Key innovations

- EMS data captured acute care episodes throughout Baltimore, irrespective of payor and provider, due to the fire department transporting two-thirds of the city's emergency transport patients
- High-touch case management included weekly in-person meetings and, on average, one medical or social referral per patient every three weeks. Through focused effort on a small panel, the case manager achieved and verified 100% referral attendance

Impact

- 32% reduction in transport EMS responses
- 79% reduction in nontransport EMS responses
- Reductions in ER/inpatient admits not investigated

**\$933 per-patient
per-month savings
from EMS alone**

3-7 Community Care of NC (Medicaid/SCHIP): Model coordinates care throughout practices to increase accountability

① Background	② Approach	③ Impact
- Smaller physician groups struggle to fund changes for PCMH model - Community Care of NC (CCNC) model started in 1998 to coordinate care among large and small physician practices - Now a collaboration between the state and 14 nonprofit, regional community-care networks that coordinate care for 750,000 Medicaid and SCHIP individuals - Nonprofit hub of network is responsible for managing enrollees' care	I. Partnership - Local providers in the program include hospitals, PCPs, county health and social services departments, and other stakeholders - They hire local care managers and each network elects a physician to serve as a clinical director - Director is responsible for working with a statewide board of directors to organise disease and care management initiatives throughout the networks II. Population health management - Case management nurses to support high- risk patient care needs and implement disease management programs² - Allows patients access to acute and preventive services and after-hours coverage III. Accountability - Participating networks receive an enhanced care management fee of \$3 PMPM¹	I. Costs - Total annual savings to the Medicaid and SCHIP programs are calculated to be \$400mn for the aged, blind, and disabled populations - Programs are calculated to be \$135mn for "TANF-linked" population II. Better quality 16% lower ER visit rate 94% of patients with asthma received maintenance medications and 40% decrease in hospitalisations for asthma - Diabetes quality measures improved by 15% 21% increase in the number of staged asthma patients and 112% increase in asthmatic patients receiving flu vaccine

1 Or \$5 PMPM for elderly/disabled, tied to reporting

2 CCNC's pharmacy home project provides medication management and coordination tools to pharmacists, nurses, and other allied health professionals who are involved in CCNC's pharmacy projects and initiatives

3-10 Greater Rochester Independent Practice Association: Small offices linked by IT and incentives to use evidence-based medicine

Description

- Association of 800 PCPs and specialists in small, independent practices serving a mixed urban and rural population in the Rochester, NY area. GRIPA provides administrative and clinical support
- Doctors collaborate work in advisory groups to develop and implement standardized evidence-based clinical protocols throughout GRIPA
- Care managers and multidisciplinary care coordination teams make 8,000 annual phone calls and home visits to high-risk patients

Key innovations

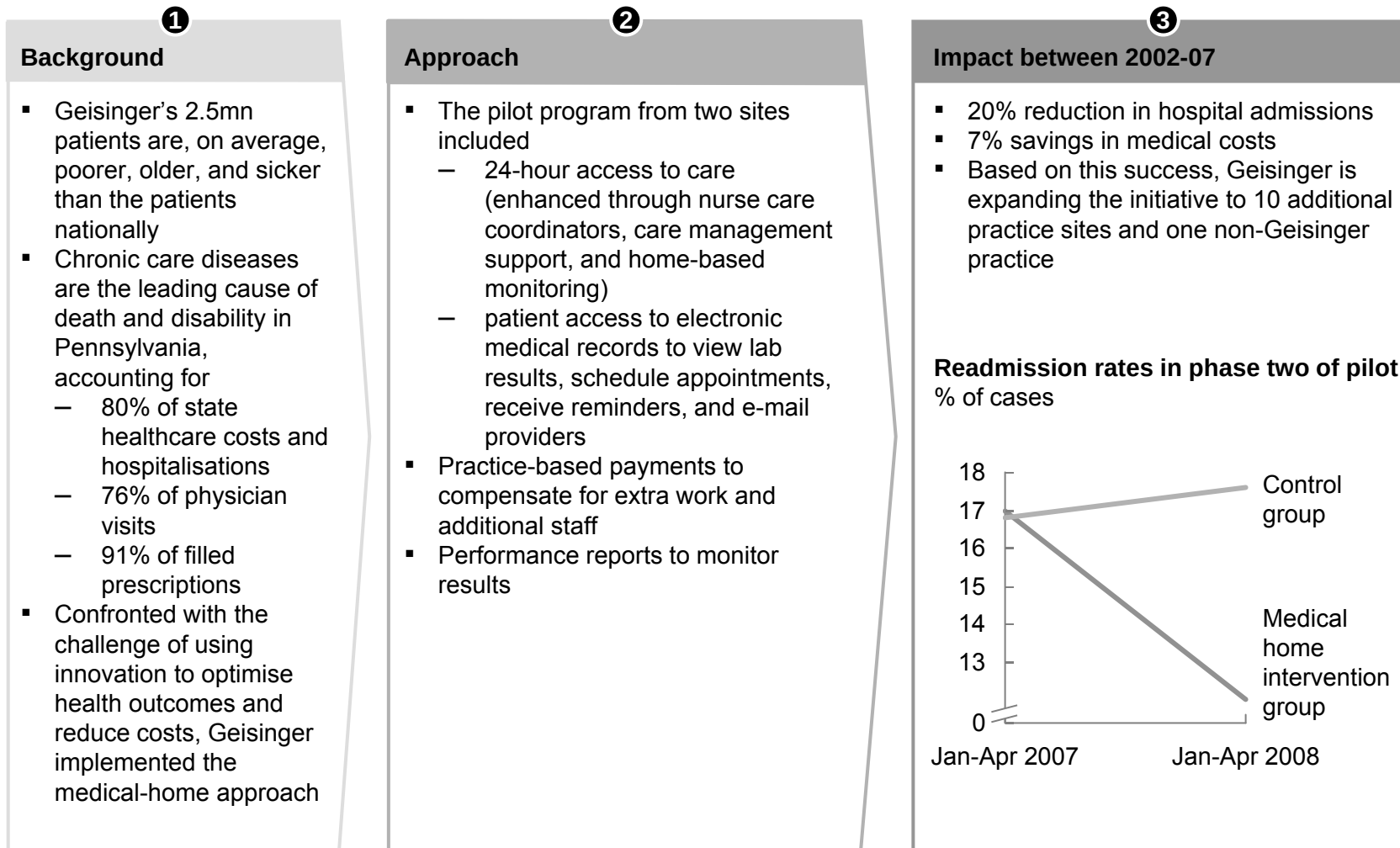
- Incentive payments are linked to care quality and use of evidence-based protocols
 - Highest performers receive 70% higher payments than lowest performers, who receive corrective action plans from a quality assurance council of randomly selected doctors
 - Council can withhold shared savings payments or expel practices, though it has never done so
- Web-based portal operates alongside existing paper and electronic records
 - Physicians and patients have secure access to EMRs
 - Providers have tools to analyse data for individuals and populations
- Point-of-care prompts alert doctors in real time of gaps in care based on evidence-based medicine
- e-prescribing enables GRIPA pharmacists to recommend less costly medication when appropriate

Impact

- 10% increase in well-controlled blood sugar among diabetics: estimated \$120,000-180,000 savings per patient over three years, 770 extra total life years, 1,230 sight years, and 925 years without kidney disease
- 1% annual increase in pharmacy costs vs. 9% area average
- 70% of patients believe GRIPA improved their health

**95% patient
satisfaction**

3 Geisinger¹: Medical home approach to chronic conditions led to reductions in hospital admissions and medical costs



1 See complete Geisinger case study for more information

References

Case studies	Source
2 Camden Coalition of Healthcare Providers	Atul Gawande. The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? The New Yorker. January 24th, 2011. Care Management Program: An Initiative to Reduce Unnecessary ED utilisation in Camden. http://www.camdenhealth.org. Deborah Hirsch. Coalition helping patients. Courier-Post
3 Baltimore HealthAccess	Michael L. Rinke et al. Operation care: a pilot case management intervention for frequent emergency medical system users. The American Journal of Emergency Medicine
7 Community Care of North Carolina	Steiner, Beat, et al. Community Care of North Carolina: Improving Care through Community Health Networks. Annals of Family Medicine
10 Greater Rochester Independent Practice Association	Rebecca Rosen et al. Integration in Action: Four International Case Studies. Nuffield Trust. July 2011. GRIPA. 2010 Value Report (http://www.gripa.org)
Geisinger Health System Proven Health Navigator PCMH model	Abrams MK, et al. Can PCMHs transform health care delivery? Commonwealth Fund

Case summary: NHS London developed a strategy called 'Healthcare for London' to save £1bn in healthcare spend

1 Background

Region: London, UK
Health system: NHS London
Start date: 2006

Challenge

- London's health system faced variable clinical outcomes, poor patient satisfaction, over-reliance on the hospital setting, long waiting times, low levels of productivity
- In 2006, NHS London commissioned Lord Darzi to produce 'The Case for Change' for why healthcare in London has to change – it also included identification of inequalities in health and healthcare, rationale for why hospital is not always the answer, description of need for more specialised care, and identification of ineffective use of resources

2 Initiative details

Goals

- Improve clinical outcomes
- Increase patient and provider satisfaction
- Not increase direct healthcare costs

Approach

- Following The Case for Change, Darzi reviewed London's health services and developed a vision for next 5-10 years
- He worked with local and international clinical experts, held public and staff events, and conducted an opinion survey
- Healthcare for London: A Framework for Action (2007) set out how healthcare will need to change, common principles for future healthcare services, models of how care should be organised; and instructions on how to make it a reality
- NHS London commended it to PCT boards

3 Process and impact

Process

- Developed a compelling case for change
- Identified London's future health needs
- Selected optimal care pathways
- Ascertained the delivery models required to meet the needs of patients
- Defined the business case to prove the feasibility of the strategy
- Designed the enablers to ensure the strategy would lead to change on the ground
- Project supports were established including frameworks, research and workshops
- Project management approaches implemented including defining what success looks like and a clear governance and working structure

Impact

- Estimated saving of £1bn in healthcare spend (10% of total healthcare spend in London)
- Final report endorsed by all 31 Primary Care Trusts
- Health Care London joint venture created
- PCTs signed up to 150 polyclinics over next decade

4 Key success factors

- Strengthened clinical and managerial leadership to drive change
- Strengthened commissioning to ensure quality and productivity
- Transparent publication of routinely collected information on clinical process and outcomes, patient experience and productivity
- Incentives to support dramatic improvement
- IT systems that support delivery of integrated care
- Better communications to engage public and stakeholders on need

5 Key players

- Primary Care Trusts
- Strategic Health Authority
- Clinical Advisory Group (clinical leaders)
- Representatives of primary care, urgent care, outpatients services, diagnostics and minor procedures, local hospitals, major acute hospitals and specialist centres
- NHS London

3 A strong case for change and understanding of future needs were developed

Development of 'case for change'

- The case was based on respected, established sources of clinical data
- It was extensive, covering clinical quality, patient satisfaction and use of resources
- It was widely tested, discussed and debated with clinicians in workshops, conferences and small group discussions
- The implications of the data cited were clearly drawn out and the information was presented in a way that would be easy for everyone to understand, whether or not they had a specialist medical or academic background

Identifying future health needs

- The aim was to understand how the expected mix and volume of future activity was likely to compare to the current day and to understand what was driving this
- Insight helped prioritise recommendations

3 Optimal care pathways and their delivery models were selected

Selecting optimal care pathways

- Healthcare for London focused on a small number of fairly high level pathways which were deliberately chosen to be intuitive, easy to communicate and cover the entire spectrum of care
- They covered from 'cradle to grave' and prevention through to complex tertiary services
- For each pathway, over a period of 3-4 months a group of leading clinicians met for half a day every 4 weeks to compare current practices to international benchmarks and to develop recommendations to achieve desired patient outcomes

Ascertaining the delivery models

- Ascertaining the delivery models required to meet the needs of patients was based on a principle of "Decentralise where possible, centralise where necessary"
- Six defined settings of care to implement the new care pathways were developed
 - Home
 - Polyclinics (integrated community care with primary and urgent care, outpatients services, diagnostics, minor procedures)
 - Local hospitals
 - Major acute hospitals
 - Specialist centres

3 A business case was defined and enablers designed

Defining the business case

- To prove the feasibility of the strategy, based on an understanding the future needs of patients, the business case modelled:
 - Future activity levels at each setting of care
 - Total cost of provision of services under different scenarios
 - Capacity requirements across the system

Designing the enablers

- In order to ensure the strategy would lead to change on the ground the requirements for success were laid out, including
 - Workforce development,
 - Information and IT,
 - Strong commissioning of services,
 - Clinical leadership

3 Key project support and management approaches were developed

Key project support elements

- A framework to develop the strategy and project plan/processes to support execution
- Research and analysis (quantitative and qualitative) to support case for change, including identification of international best practice and strong base of clinical evidence
- Extensive interaction with stakeholders through workshops, international conferences, and small group discussions
- Thought partnership to co-develop insights and recommendations
- Detailed financial modelling to test recommendations under different scenarios
- Stakeholder engagement, communications strategy

Key project management approaches

- Clear and agreed definition of what success looks like
- Detailed work-plan with milestones, agreed with project leadership; maintenance of a risk register and risk tracking system
- Clear governance structure and meeting plan to track progress and escalate issues when necessary
- Specific work streams with clear questions to answer and tasks to perform
- Stakeholder analysis and prioritization approach grounded in understanding importance of individuals and groups, urgency with which to engage them, messages to deliver and approached to engage them

3 The initiative is expected to lead to an estimated £1bn in healthcare savings

Impact – outcomes and benefits

- Final report endorsed by public consultation and adopted by all 31 Primary Care Trusts across London as their strategy
- Creation of Healthcare for London – a joint venture between PCTs and Strategic Health Authority to support implementation of the strategy and improve quality of care, access and efficiency
- PCTs signed up to implement 150 polyclinics over the next decade
- Service reconfigurations across London to support better quality care, starting with designation process and public consultation for reconfiguring stroke and trauma services
- Creation of a group of clinical leaders (Clinical Advisory Group) to ensure clinicians remain at the heart of service development and improvement

Impact – cost

- Estimated that implementing the recommendations would save £1.0bn in healthcare spend, which could be freed up to invest in other areas (10% of total healthcare spend in London)

Case summary: Australian Diabetes Care Project enhanced integrated care for people with diabetes

1 Background

Region: Australia

Health system: National Health and Hospitals Reform Commission (NNHRC)

Start date: 2011

Challenge

- 50% of people with diabetes have HbA1c, cholesterol or blood pressure above recommended levels but 60-80% don't have a multidisciplinary care plan
- Fee-for-service primary care funding model does not encourage population health
- Information sharing and co-ordination between clinicians is sub-optimal

2 Initiative details

Goals

- Improve clinical outcomes
- Increase patient and provider satisfaction
- Not increase direct healthcare costs

Approach

- Sponsored by Australian Government
- Pilots program covers ~10,000 people with diabetes, if successful, rolled out nationally to ~1mn people
- Expected to increase primary care spend by ~\$370 per patient and is cost neutral if hospital costs are reduced by 15%

3 Process and impact

Process

- The NNHRC defined reform priorities and convened a National Diabetes Advisory Group (including ~20 diabetes-related peak bodies) to guide the design
- A consortium (~20 organisations including state govts, primary care organisations, universities, research organisations, IT companies) design, implement and evaluate pilots
- Clinical Reference Groups, made up of doctors, allied health professionals and patients, provided input and some became clinical champions
- Extensive project awareness campaign including presentations at clinical and consumer conferences, media coverage, healthcare publications, a website and online education modules

Impact

- 165 practices and 7,500 patients have been enrolled in 6 months—twice the rate of comparable studies
- It is too early to measure impact however model is being well received by clinicians and patients

4 Key success factors

- Strong leadership coalition in the Diabetes Advisory Group ensured stakeholder views were represented
- Heavy stakeholder involvement in design phase to develop integrated care model
- Regular performance feedback to consortium members including DCP dashboard on progress

5 Key players

- National Health and Hospitals Reform Commission
- National Diabetes Advisory Group
- Consortium (state govts, primary care organisations, universities, research organisations, IT providers)
- Clinical Reference Groups (doctors, allied health professionals and patients)
- GP practices and people with diabetes

2 The program determined key objectives and goals

Key objectives were set for the program

- Improve clinical outcomes
- Increase patient & provider satisfaction
- Not increase direct healthcare costs

Clear goals identified for major system changes

Flexible funding model

- Practices receive up-front funding for each patient that is enrolled, adjusted for their severity level (although they still also get paid a fee-for-service each time they see the GP)

Rewards for improvement

- Practices are eligible for additional payments that promote patient experience and clinical quality improvement

Better information and communication

- New IT systems used to automate care planning and patient referral processes; provide transparency on population health changes; and allow practices to evaluate their performance

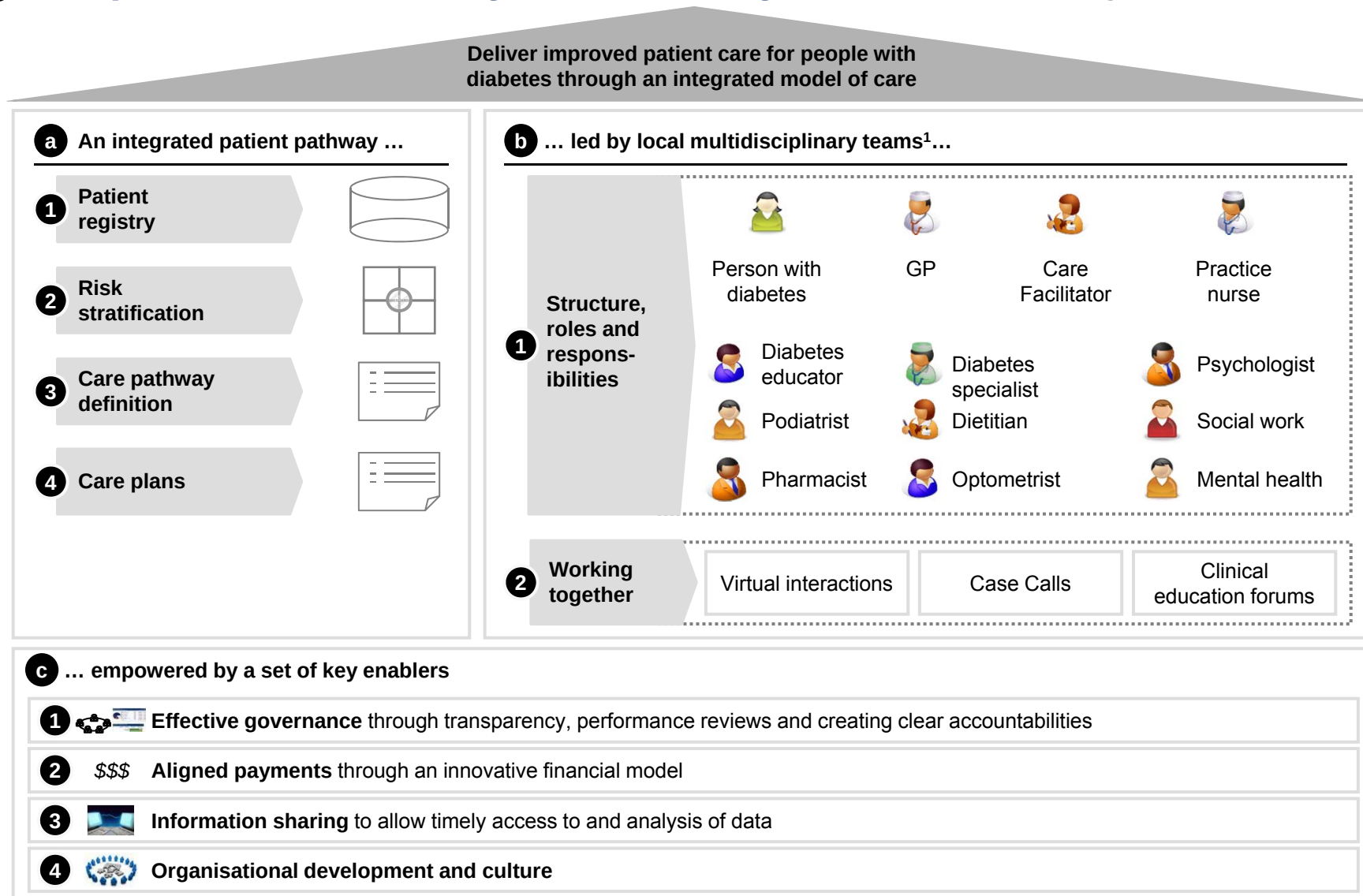
A dedicated Care Facilitator

- Promote timely, risk-based intervention for those in need; reduce the time spent on administrative tasks by general practices; and improve ways of working and communicating within care teams

A performance framework

- Primary care organisations have been established to monitor practice performance, engage practice staff in quality improvement conversations and help them improve

3 The process involved significant changes to care delivery



1 Not exhaustive—the composition of the MDT will be dependant on the needs of the patient

3 The patient registry identifies need and enrolled patients are then stratified based on risk and complexity

Patient registry

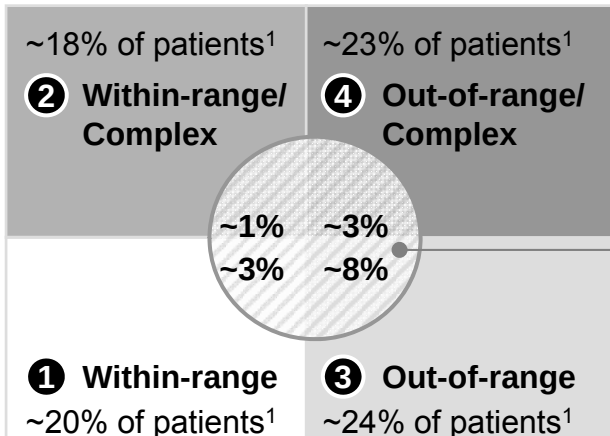
- The patient registry holds details of all patients who choose to enrol in the program with a given practice
- It can be accessed via the IT tool to provide a quick overview of patient status and identify those at highest risk
- Data available in the overview list includes: risk factors (e.g. smoking status, HbA1c, BP, weight, hospitalisation frequency)

Example patient registry listing

The screenshot shows a web application interface for a patient registry. At the top, there's a navigation bar with links like 'Patients', 'Reports', 'Surveys', 'Resources', 'Preferences', 'Help', and 'Log Out'. Below this, a search bar and a 'Search' button are visible. The main content area displays a table of patient data with columns for Patient Demographics, GP, Clinical Metrics, Comorbidities, and DCP. The table lists several patients with their details, including names, dates of birth, GP names, and various clinical metrics like HbA1c, Blood Pressure, and Cholesterol. The table is filtered to show patients managed by the current user.

Attention	Name	Date of Birth	Smoker	Referring GP	HbA1c	Blood Pressure	Cholesterol	BM	New Complications in the Last 6 Months	Risk
	Aaron Cui	6-Apr-1969	No	Dr DCP TestB	7.4	140/80	3.6	36		Within-range, complex
	Aaron CuiB	15-Jul-1966	No	Dr DCP TestB	7.4	140/80	3.6	36	Depression	Within-range, complex
	Bernice CuiB	5-May-1940	No	Dr DCP TestB	7.4	140/80	3.6	36	Depression, Diabetes Mellitus, Type 2	Within-range, complex, newly diagnosed
	David CuiB	13-Dec-1969	No	Dr DCP TestB	7.4	140/80	3.6	36	Diabetes Mellitus, Type 2	Within-range, newly diagnosed
	Evan CuiB	3-Jul-1947	No	Dr DCP TestB	7.4	160/80	3.6	36		Out-of-range, complex
	Faye CuiB	8-Mar-1965	No	Dr DCP TestB	7.4	160/80	3.6	36	Depression, Diabetes Mellitus, Type 2	Unknown
	Jamie CuiB	6-Apr-1969	No	Dr DCP TestB	7.4	140/80	3.6	36		Within-range, complex

Risk stratification



Complex

One or more complications: Eye, limb, heart or kidney; Depression

Not complex

No listed complications

Out-of-range

Any of:

- HbA1c > 7.5%
- BP > 150/80
- Cholesterol > 5 mmol
- BP > 140/80 and cholesterol > 4.5 mmol

Within-range

Not "out-of-range"

+ Newly diagnosed overlay

- Diagnosed in last 12 months
- Receive support from their segment plus **additional introductory needs**

1 Limb and eye complications are not included in segment size approximations

SOURCE: Clinician and expert interviews; Data based on 4,120 observations from Brisbane South Division and GPLWB with relevant information; Clinical Reference Groups (South Australia and Queensland)

3 Patients are managed according to a base care pathway¹ matched to their risk segment

Screenshot of example base care pathway

	Interaction	Description	Provider	Months												Minimum time per interaction ¹ Minutes
				01	03	05	07	09	11	13	15	17	19	21	23	
Practice interactions	Prepare care plan	–	GP/PN	◆												n/a
	Review care plan	–	GP/PN				◆			◆			◆			n/a
Core interactions	Diabetes foot exam	Yearly exam as per clinical guidelines	Podiatrist	◆						◆						20
	Individual diabetes education	As per existing MBS item 10951	Credentialed Diabetes educator		◆											20
Other interactions subsidised by flexible funding	Assessment for group interactions	–	Educator, physiologist or dietitian		◆											45
	Group diabetes education	As per existing MBS item 81105	Credentialed Diabetes educator			◆					◆					60
	Group diabetes exercise physiology	As per existing MBS item 81115	Exercise physiologist			◆						◆				60
	Group dietetics	As per existing MBS item 81125	Dietitian				◆						◆			60
	Individual mental health service	As per existing MBS item 10956	Mental health worker	◆												20
	Individual dietetics	As per existing MBS item 10954	Dietitian							◆						20
	Individual diabetes education follow up	Phonecall follow up with patient	Credentialed Diabetes educator					◆				◆		◆		10
	GP consult	–	GP			◆			◆			◆			◆	20
	Diabetes eye exam	–	Optometrist		◆										◆	15
	Home medicine review	–	GP/Pharmacist													n/a

- Practice based interactions supported by flexible funding
- Recommendations provided, but care is flexible based on requirements of patient

- Core interactions with AHPs supported by flexible funding
- No tailoring of interactions noted is available

- Other interactions with AHPs supported by flexible funding
- Must be tailored based on patient choice and individual requirements to provide the best possible assistance for managing the patient's conditions

- Additional interactions which continue to be supported by existing Medicare systems and guidelines
- Must be added to by GP as required to manage the patient's conditions, e.g. specialists such as nephrologist, cardiologist and rheumatologist

¹ Base care pathways are designed to be consistent with best practice clinical guidelines from bodies such as the NHMRC, peak medical groups such as the RACP and RACGP and allied health associations.

3 An individual patient care plan is generated

Care plan reviews and changes:

- Decisions to adjust the care plan should focus on compliance, clinical outcomes and patient satisfaction
- Base care pathway sets pre-defined care pathway review dates - up to 6 times per year for patients with most challenging needs – frequency can be increased if required
- Care plan updates can be made by any member of the MDG team via the IT tool

Screenshot of IT tool care plan (illustrative)

Care Plan
Medical Conditions: Diabetes Mellitus Type II
GPMP (721) - [Awaiting your approval](#) [Approve GPMP](#)

General

Goal	Task	Responsible	How Often	Last	Next	Comment	Actions
Clear understanding of conditions Target: Patient has received education	Diabetes Management in General Practice (from The Royal Australian College of General Practitioners)		Every year		Due Jul 2011		Add Task

Lifestyle

Goal	Task	Responsible	How Often	Last	Next	Comment	Actions
Maintain healthy diet Target: Patient maintaining healthy diet	Education	Ms B. Que (Dietitian)	Every 2 years		Due Jul 2011		Add Task
	Action to achieve target	Patient	Ongoing		Ongoing		Add Task
	Education and review	Dr V. Morrison (GP)	Every year		Due Jul 2011		Add Task
Maintain physical activity Target: 30 Minutes per day of selected exercise 5 days per week, within patient limitations	Action to achieve target	Patient	Ongoing		Ongoing		Add Task
	Education and review	Dr V. Morrison (GP)	Every year		Due Jul 2011		Add Task
	Consider deferring physical activity	Dr V. Morrison (GP)	As required		As required		Add Task
Manage body weight Target: Weight < 111.0 kg	Counselling and review	Dr V. Morrison (GP)	Every 6 months		Due Jul 2011		Add Task
	Assessment and Counselling	Ms B. Que (Dietitian)	Every 2 years		Due Jul 2011		Add Task
	Action to achieve target	Patient	Ongoing		Ongoing		Add Task

Goals:

- Split into:
 - General: e.g. under-standing of condition
 - Lifestyle: e.g. diet
 - Biomedical: e.g. control of BP
- Defined target set

Tasks:

- Series of tasks to support achievement of target

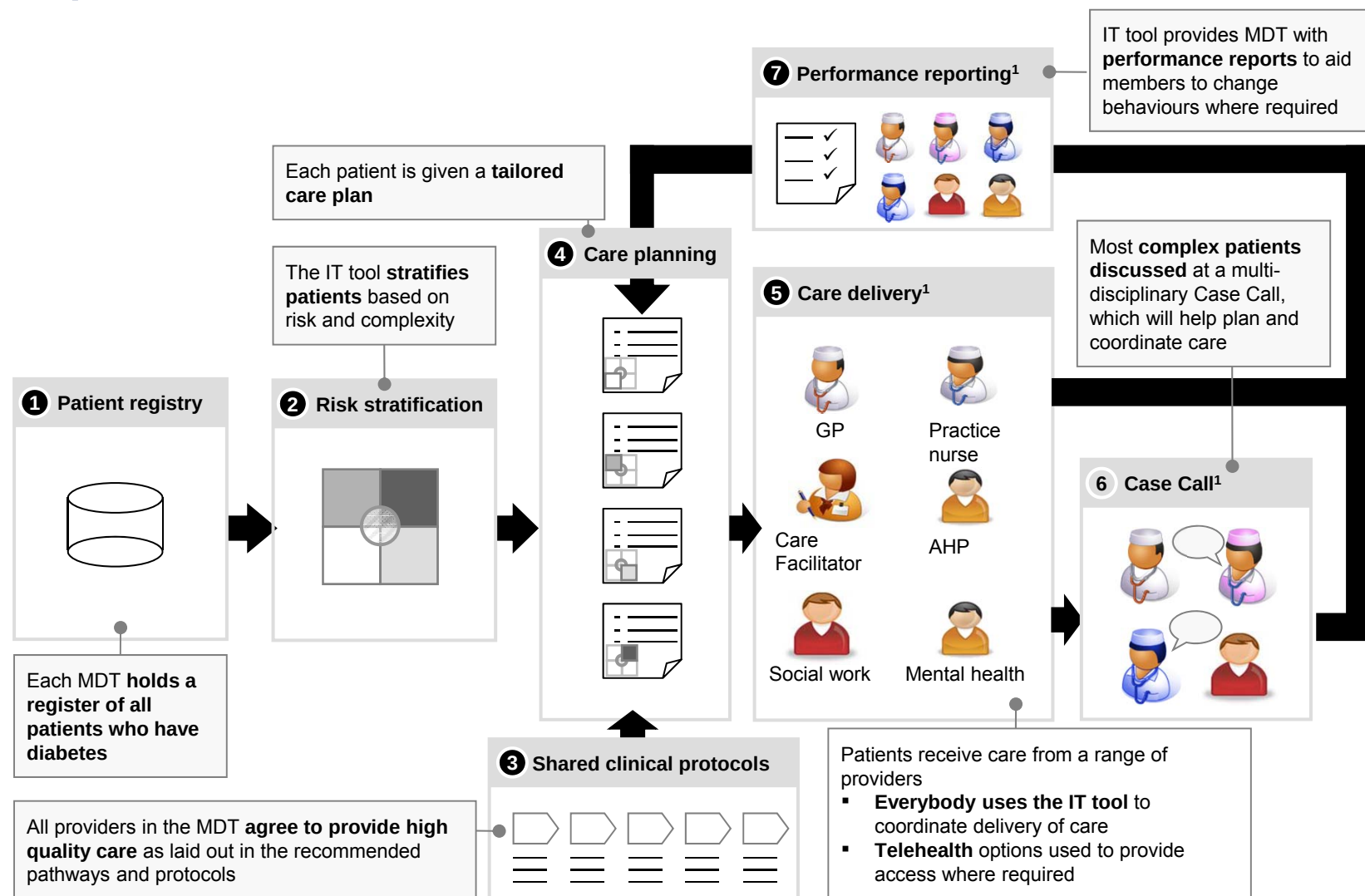
Responsibilities:

- Person – patient, GP, AHP, nurse – nominated to ensure task is followed through

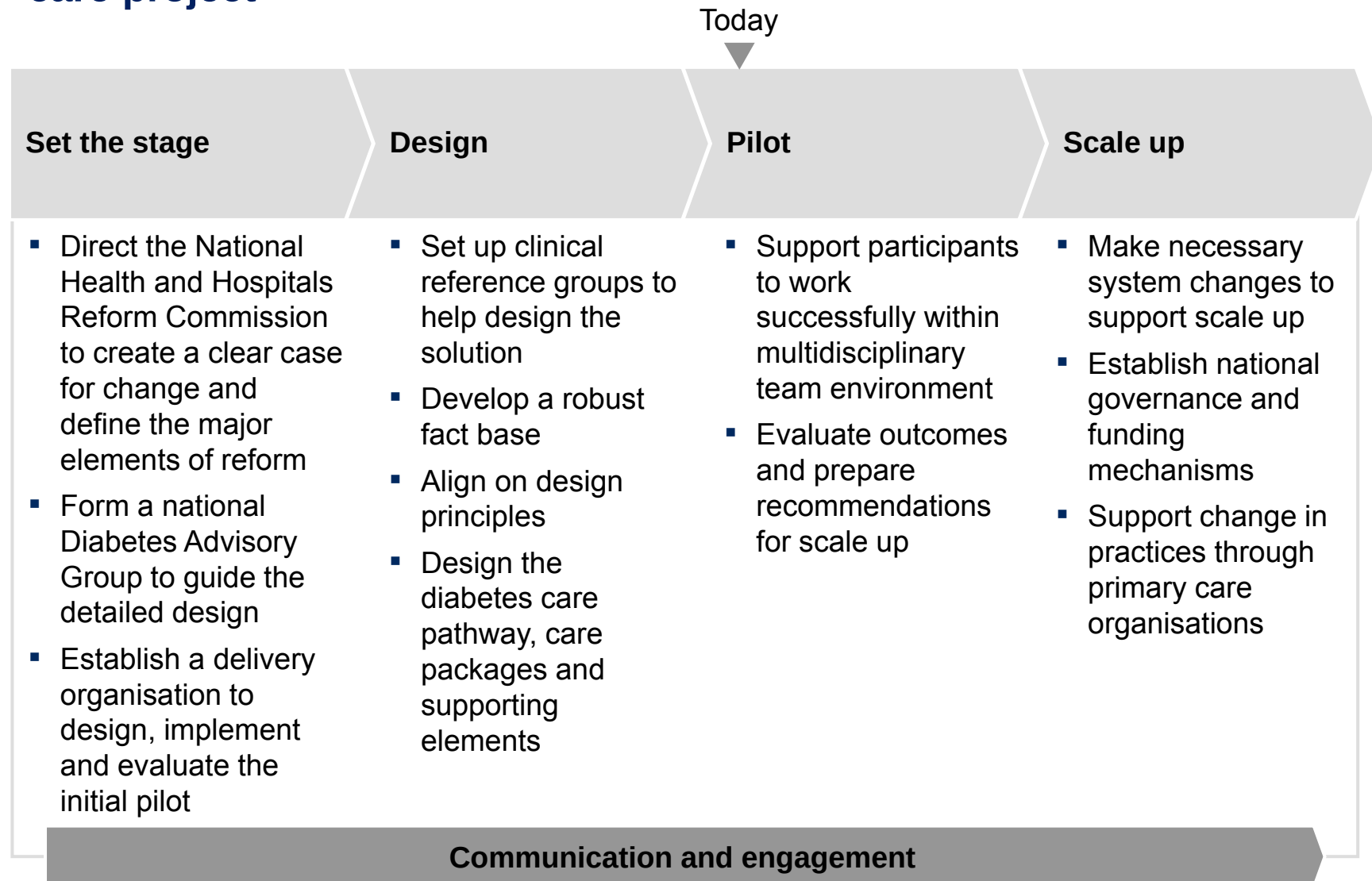
Frequency and monitoring:

- Regularity of the task
- Date when task is next due to be carried out

3 The project outlined the role of the multidisciplinary team throughout the patient's care



3 Phases were determined for implementation of the integrated care project



Case summary: Queensland is taking a collaborative approach to 'Closing the Gap' in Aboriginal and Torres Strait Islander health

1 Background

Region: Australia

Health system: General Practice Queensland (GPQ)

Start date: 2010

Challenge

- There continue to be significant gaps between health of Aboriginal and Torres Strait Islander (ATSI) people and other Australians:
 - A 2½ times greater burden of disease
 - Non-communicable (eg. chronic) diseases explain 70% of the gap
- The Australian government made commitments to closing these gaps through the COAG 'Closing the Gap' reform

2 Initiative details

Goals

- To help clinical teams work together to reduce lifestyle risk, improve clinical outcomes and help maintain good health for all ATSI peoples in Queensland

Approach

- The Collaborative is a primary health care quality improvement initiative
- Partnership between the Queensland Aboriginal and Islander Health Council (QAIHC) and GPQ supported by the Improvement Foundation (IF)
- Primary health care services (Aboriginal and Islander Community Health Services (AICCHSs) and mainstream practices) play a significant role

3 Process and impact

Process

- Collaborative based on *Australian Primary Care Collaborative*, which is based on the Breakthrough Series Collaborative methodology developed by the USA Institute of Healthcare Improvement
- The collaborative is practical and effective, including flexible orientation and participation for services/practices; short, focused quality improvement cycles with fully flexible implementation; and monthly data reports to monitor progress accessible through a web portal
- A range of strategies have been adopted to improve access and care, including cultural awareness training for staff; identifying inactive clients; improving recall of 'at-risk' clients; and dedicating one day per week for health assessments

Impact

- 62% of 21 AICCHSs with medical clinics and 17 general practices participating, and improving results – more clients seen (~25% by AICCHSs in one year); increased ATSI health assessments (17% pts, adults in one year)

4 Key success factors

- A fully functioning information platform with electronic extraction, transmission, analysis and graphic display of de-identified, routinely collected client clinical data to measure effectiveness
- Support for change for services and practices, including through:
 - Commitment and leadership within the three partner organisations
 - Network of support officers working 'at the coalface' in services
 - Workshops; electronic discussion forums and newsletters

5 Key players

- General Practice Queensland
- Queensland Aboriginal and Islander Health Council
- Improvement Foundation
- Aboriginal and Islander Community Health Services (primary health care services)
- Mainstream general practices (primary health care services)
- Aboriginal and Torres Strait Islander people



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Example application of the Medicare Local Collaborative Framework to Indigenous eye health

29 March 2013

Medicare Local Collaborative Framework for Indigenous eye health (IEH)

Purpose of this document

What is it?

A six-step framework (the 'collaborative framework') has been developed to help guide the way that Medicare Locals and other organisations approach collaborative projects in their local health communities. In this document, the framework has been tailored to the Indigenous eye health (IEH) disease pathway.

Purpose

The purpose of this document is twofold:

1. To prompt Medicare Locals and other health organisations to look at the IEH pathway in their region and assess whether they could collaborate better to improve patient outcomes
2. To demonstrate how the collaborative framework can be tailored to a specific Medicare Local region and disease pathway

What does it contain?

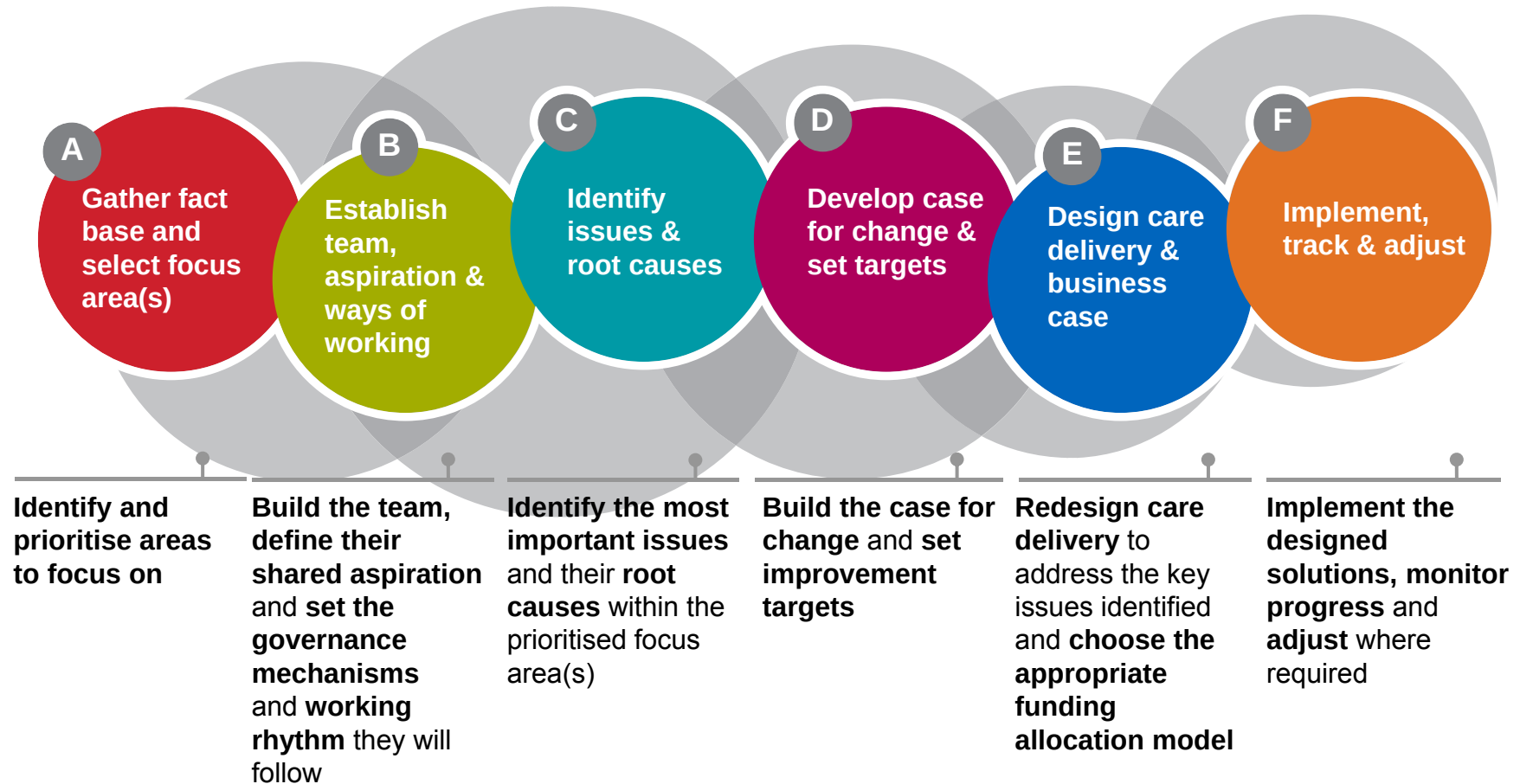
For each step of the framework, this document describes:

- A summary of the step, including an overview of the key questions to be answered
- An illustrative example of how the framework can be applied to an individual region, using the Kimberley/ Pilbara in Western Australia

Selection of the Kimberley/ Pilbara as an example region

- **Indigenous eye health is a key priority in the region**
 - 28% of the region's population is Indigenous (~28,000 individuals)
 - Approximately 37% of Indigenous adults in the Kimberley/ Pilbara have diabetes (~3,500 individuals), and 13% of those are visually impaired (~450 individuals)
 - The rate of blindness for Indigenous adults in the Kimberley/ Pilbara is approximately 4 times higher than the national average
- **There is already good momentum on eye health initiatives in the region**
 - *The Roadmap to Close the Gap for Vision* has drawn attention to the importance of IEH – “Vision loss is 11% of the Indigenous health gap” (January 2013 Summary)
 - A number of stakeholders and organisations are motivated to make changes in this space
 - There has been significant improvement in key metrics (e.g., surgical throughput) since 2009 due to the involvement of an optometrist operating in a coordinating capacity
- **There is a sense of urgency to create a sustainable system, and the Medicare Local could play a role in this**
 - Currently, the Medicare Local does not play a significant role in the region's IEH coordination
 - The optometrist currently playing a coordinating role will leave in June 2013
 - In light of this, there may be a role for increased involvement of the Medicare Local in helping to create a sustainable IEH system
- **NOTE: The Kimberley/ Pilbara example depicted in this document is illustrative only, for the purposes of demonstrating how the framework might be applied to a specific region and health pathway. Information presented in this document does not reflect work that is either currently being undertaken or is committed to be undertaken by the Kimberley/ Pilbara Medicare Local.**

Overview of the Medicare Local Collaborative Framework



Although the framework is illustrated as a linear sequence, you may want to complete the steps in a different order, complete multiple steps in parallel, or revisit and iterate the steps partway through the process as you learn more about the initiative you are undertaking

Step A

Gather fact base and select focus areas

Note that the collaborative process should start even before this step: invest in building relationships in your local health community to help pave the way for future initiatives.

Objective of this step

Develop a fact-based understanding of your population's health needs and prioritise the areas to focus on that will deliver the greatest impact

Why this step is important

- Appropriate prioritisation will ensure resources are allocated to the areas where they will have the most impact
- Getting broad input from the local health community will help ensure stakeholders are aligned on the established priorities
- It identifies what initiatives are already underway in your community

Common pitfalls

- Selecting too many health needs to focus on and not having the resources to address them adequately
- Prioritising focus areas without an objective fact base
- Not involving critical stakeholders, such as clinicians and patients, in setting priorities
- Not explicitly agreeing the prioritisation criteria among stakeholders

By the end of this step you should...

- ☐ Understand the major health needs of your local health community
- ☐ Have a prioritised list of potential initiatives and focus areas which are agreed upon by all stakeholders
- ☐ Know which projects and initiatives are already underway in your local health community

Step A. Gather fact base and select focus areas

Key questions to answer

Approach

A1 What are your community's health care needs?

- Use existing data sources to understand your population's characteristics
- Engage with a broad set of stakeholders in the health sector to understand the local epidemiology
- Review case examples and consult with experts to establish what best-practice healthcare looks like
- Collaborate with stakeholders to review existing health services for gaps
- You should now be able to identify what your community's major health care needs are

A2 What are the key priorities in your local health community?

- Collaborate with a broad group of stakeholders in your local health community to develop a suite of potential initiatives to address the gaps identified
- Conduct an assessment of the potential impact and feasibility of each potential initiative
- Agree prioritisation criteria with stakeholders and select initiatives using a prioritisation methodology
- Ensure stakeholders agree that the selected initiatives and the underlying health focus areas they address are correct

A3 What is already happening in your local health community?

- Identify the projects and initiatives already underway in your local health community for the selected focus areas
- Develop your network of potential partners
- Reach out to other Medicare Locals to see if you can leverage previous work and/or determine if you should work together on common priorities



As Indigenous eye health has been pre-selected as the priority focus area for this work, steps A.1 and A.2 do not need to be completed. On occasion, you may have your priority areas pre-selected by outside bodies, or have already completed these steps in undertaking your population needs assessment

Kimberley/ Pilbara: Understand the major eye health conditions

ILLUSTRATIVE

EXAMPLE: Understanding the major eye health conditions in the Kimberley/ Pilbara region

Major conditions ¹	Description	Current direct annual cost for Indigenous population	Estimated disease burden
Diabetic retinopathy	A disease occurring to people with diabetes where the blood vessels of the retina swell and leak liquid into the retina, blurring vision and sometimes leading to blindness	TBD	~3,500 Indigenous adults with diabetes requiring annual eye exam (37% of population aged >40 years) ~420 Indigenous adults with diabetes requiring laser surgery each year (12% of patients with diabetes)
Refractive error	A defect in the ability of the lens of the eye to focus an image accurately, causing either (or both) near sightedness and far sightedness	TBD	~1,030 Indigenous people who require glasses each year
Cataract	A cloudiness or opacity in the normally transparent crystalline lens of the eye that can cause a decrease in vision and may lead to blindness if left untreated	TBD	~171 Indigenous people who require cataract surgery each year

¹ Diabetes, refractive error, and cataract conditions account for 93% of preventable vision loss in Indigenous adults

Kimberley/ Pilbara: Determine what work is already being undertaken in your region

Conduct an environment scan to identify projects and initiatives already underway in your local health economy.

Ensure to reach out to other Medicare Locals to see what similar initiatives they have conducted or where you could work together.



Discuss with key stakeholders what work is already underway

Determine what role the Medicare Local should play to best enhance collaboration

EXAMPLE: A number of activities to address the IEH pathway area are already underway in the Kimberley/ Pilbara region

Organisation/ activity	Description	Current ML involvement
Lions Eye Institute	- Research institute run out of the University of WA with focus on blindness prevention and treatment - Hosted the Lions Outback Vision Eye Health Conference in Feb 2013 to facilitate eye care partnerships across Western Australia's Indigenous and remote communities and prompt alignment around regional priorities	Low
North-West Optometry Program	- Program providing specialised optometry services to the Kimberley/ Pilbara region of WA since 2000 - Run by Margie O'Neill who coordinates the delivery of all eye services; manages the Australian Government's Visiting Optometrists Scheme (VOS), and delivers services under the WA Spectacle Subsidy Scheme	Low
Kimberley Diabetic Eye Care Program	- Program to provide regular eye screening and access to treatment for diabetes sufferers in rural, remote, and Indigenous communities in the Kimberley region - The program collaborates closely with Kimberley Aboriginal Medical Services Council (KAMSC), local optometrists, and country hospitals	Low
Indigenous and Remote Eye Health Service (IRIS)	- Joint initiative of the Australian Society of Ophthalmologists and the Australian Government, established in 2010 - A taskforce is working to improve national co-ordination of funding and delivery of eye health services in rural and Indigenous communities	Low

In applying this section of the framework to Indigenous eye health, participants discovered ...

Section A of the framework is important because...

- *It ties with the population needs assessment required to be completed by Medicare Locals and updated annually*
- *It reminds you to do a proper scan of what is already happening in the region and consider where there are health care gaps in your population*

The parts we found particularly difficult were...

- *Knowing what we don't know in terms of healthcare pathways we should consider*
- *Finding the right data to help us understand the cost and burden for each major condition – we don't know how to access quality, quantitative health data*
- *Accessing Medicare item and Patient Assisted Transport Scheme (PATs) data*

The key things we learnt about our pathway were...

- *There is a lot of good work that has already been done; we're not starting from a blank slate when looking at improving collaboration*
- *We need better visibility of the skills and resources available in our region*
- *We have a disconnected data collection system in our region, especially between different service providers like community health and Aboriginal medical services*

Next time we use the framework we will...

- *Talk to our neighbouring Medicare Locals to see what they are doing and get ideas for our framework*
- *Think about other healthcare priorities we can use it for*
- *Be flexible in our approach to setting benchmarks*

Step B

Establish team, aspiration and ways of working

By now, you will know which focus area(s) to target, the next step is to build the team that will lead the project.

Objective of this step

Establish the team and galvanise them around a shared aspiration

Why this step is important

- A shared aspiration will ensure everyone is aligned on what the project aims to achieve
- An effective team rhythm means that the process will generate energy and maintain momentum, with participants focusing on what they have to do rather than renegotiating the next interaction

Common pitfalls

- Not identifying the full set of relevant stakeholders to involve
- Not recognising misaligned incentives and motivations of project team members
- Failing to agree a shared aspiration
- Not agreeing on ways of working until a few weeks into the project
- Not assigning clear roles and responsibilities and agreeing on them explicitly with team members
- Not recognising early enough when the project is going off track

By the end of this step you should ...

- ☐ Have elected team members and understood their underlying motivations
- ☐ Have aligned the team around a common aspiration
- ☐ Have a clear governance structure and agreement on ways of working
- ☐ Have mechanisms in place to help track and adjust the working approach if required

Step B. Establish team, aspiration and ways of working



Key questions to answer	Approach
B1 Who should be in the team and what are their underlying motivations?	- Identify relevant team members, potentially including representatives from health and social care providers, funders, patient groups, academia, NGOs, government etc. Think beyond the familiar stakeholders, (e.g., to those potentially involved in implementation), and engage with organisations planning or undertaking similar initiatives (this can be challenging but it is necessary) - Determine the level of involvement for each stakeholder e.g., a part of the project team, part of the steering committee, needs to be consulted, or needs to be informed about the project - Understand the underlying motivations of individual team members
B2 What is the shared aspiration of the team?	- Articulate a shared aspiration that is compelling and motivating to all stakeholders, and addresses the needs and values of each individual - Ensure the team understands the role that each member plays, and the need to work collaboratively with respect for the opinions of other team members - Consider ways to incorporate stakeholders who may be negatively impacted, e.g., organisations focused on a similar topic
B3 What is the governance structure and team working rhythm?	- Reach common agreement on the governance structure, decision making process, and escalation process - Ensure the governance structure addresses both executive and operational governance - Agree how the team will work together, including aligning on goals, priorities, roles and expectations, team norms and commitments, individual development goals, ways of communication, and working rhythm and calendar - Conduct a risk assessment of the project
B4 What mechanisms will be used to track and adjust the approach?	- Put in place mechanisms to help regularly track team satisfaction and impact, e.g., weekly team barometer - Use the tracking mechanisms to conduct feedback conversations and adjust the approach if required

Kimberley/ Pilbara: IEH projects should have cross health system representation

ILLUSTRATIVE

Relevant groups may include both health and non-health organisations; some key stakeholder groups may not have clear leadership, so choose representatives from the field

Identify all stakeholders relevant to IEH in your region, which may include...

Potentially relevant IEH groups

- Medicare Local
- Aboriginal Medical Services
- Local Hospitals
- Community & Public Health Services
- Optometrists
- Ophthalmologists
- General practices
- Patients / community
- Academia / research institutions
- Non-government organisations

EXAMPLE: some of the organisations who may be represented in a Kimberley/ Pilbara project, in various roles, include ...

Potential team members Organisation	Role (e.g., Project Team, Steering Committee)
▪ Kimberley/ Pilbara Medicare Local	▪ TBD
▪ Derby Aboriginal Health Service	▪ TBD
▪ Derby Hospital	▪ TBD
▪ Kimberley Population Health Unit	▪ TBD
▪ Private practice	▪ TBD
▪ Lions Eye Institute	▪ TBD
▪ General Practice, Derby Hospital	▪ TBD
▪ N/A	▪ N/A
▪ Lions Eye Institute	
▪ RANZCO Eye Foundation	

- | | |
|-------------------------------------|-------|
| ▪ Kimberley/ Pilbara Medicare Local | ▪ TBD |
| ▪ Derby Aboriginal Health Service | ▪ TBD |
| ▪ Derby Hospital | ▪ TBD |
| ▪ Kimberley Population Health Unit | ▪ TBD |
| ▪ Private practice | ▪ TBD |
| ▪ Lions Eye Institute | ▪ TBD |
| ▪ General Practice, Derby Hospital | ▪ TBD |
| ▪ N/A | ▪ N/A |
| ▪ Lions Eye Institute | |
| ▪ RANZCO Eye Foundation | |



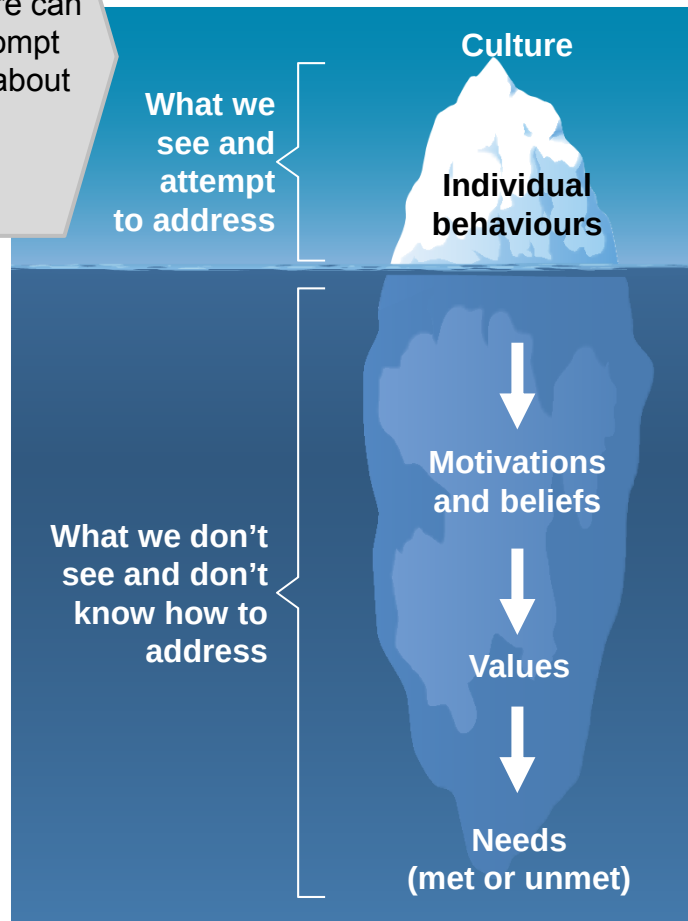
In your region, it may not be appropriate to select representatives from every category. Consider the capacity in which each potential participant may be best utilised to determine their role / involvement

Kimberley/ Pilbara: Understand the underlying motivations of potential team members

ILLUSTRATIVE

The 'Iceberg Model' worksheet populated here can be a good prompt to help think about individuals' underlying motivations

EXAMPLE: Understanding potential members of the Kimberley/ Pilbara team might look like...



Lions Eye Institute (Angus Turner)

- Interested in leading (with others) a campaign to make WA a national 'best case' example of Closing the Gap on eye health

- Has invested a lot of time in building a successful visiting ophthalmologist program to remote WA, including relationships with optometrists and local health centers
- Values grass-roots collaboration between participants in pathway
- Needs support on business case, high-level funding and support systems

North-West Optometry Program (Margie O'Neill)

- Interested in establishing a sustainable legacy of successful collaboration in the NW region before leaving the role in 2013

- Has substantially invested in integrating the NW WA eye health pathway including screening, assessment and ophthalmology
- Achieved significant integration without support; values involvement by "on the ground" participants
- Needs sustainable funding, integrated IT / administrative support

Kimberley/ Pilbara: Build a shared aspiration around which to galvanise the team

ILLUSTRATIVE

EXAMPLE: Kimberley/ Pilbara unified their aspirations at a cross-health system conference

- 1 Representatives from all stages of the patient pathway attended, including:
 - Aboriginal Medical Service health workers
 - Local hospital nurses
 - Optometrists
 - Ophthalmologists
 - Other associated organisations
- 2 Plenary sessions for sub-groups facilitated discussions regarding:
 - Issues faced in delivering patient care
 - Potential solutions to those issues
 - Common aspirations for the future delivery of Indigenous eye health care
- 3 A planning forum synthesised the issues, solutions and common aspirations to articulate a regional aspiration

Their aspiration is...

“To close the gap on IEH in our region and be leaders in collaborative care over all eye health metrics, including increasing the screening rates for diabetic retinopathy to over 80% for Indigenous people”



High-level aspirations should address the various incentives and motivations of the team and keep the patient journey front of mind

Kimberley/ Pilbara: Set a clear governance structure with defined roles to guide the project

ILLUSTRATIVE

A clear governance structure should include identification of roles and reporting rhythms, and separate advisory from operational functions

EXAMPLE: The governance structure for Kimberley/ Pilbara IEH project could look like...

Structure	Who	Role	Reporting rhythm
<pre> graph TD RC[Steering Committee] <--> RRG[Regional Reference Group] RC <--> PMT[Project Management Team] PMT <--> REN[Regional eye network] subgraph REN [Regional eye network] direction TB O[Optometrists] OP[Ophthalmologists] AH[Aboriginal health workers] end </pre>	High level eye health stakeholders and/or experts at project helm	- Set strategic direction of project - Make decisions on key issues including resource allocation	Meet monthly to review progress and agree next steps
	See Step B.1 for potential participants including NGOs, academics etc.	Consult on issues to Steering Committee as representatives of stakeholder groups	Ad hoc contribution via conferences, consultations etc.
	Dedicated staff work on project day-to-day: represent AHWs, optometrists and ophthalmologists	Manage day to day operations of project	Monthly report to Steering Committee
	Regional eye network, including	- Contribute to issue identification and solution development - Play significant role in roll out of solutions	Ad hoc contribution via conferences, consultations etc.
	- Optometrists - Ophthalmologists - AHWs		



The role of the Medicare Local will differ between projects – consider how it is best placed to contribute; in some cases, it may not be the natural project “owner”

Kimberley/ Pilbara: Both project and steering committee teams should align on ways of working

ILLUSTRATIVE

A kick-off meeting is a good forum for agreeing ways of working

Ways of working should include...

Alignment on project objectives

Team roles

Team norms

Team commitments

Individual profiles

Working calendar & rhythm

EXAMPLE: Team norms for a Steering Committee and /or Project Team in a Kimberley/ Pilbara IEH project could include...

Working times

- Members of the team have different day-job hours, so:
 - Give timely notice for required meetings
 - Give 24 hours' notice where feedback is required
 - Don't expect weekend replies to weekend emails

Working structure

- Due to other commitments, a flexible working structure is required:
 - Intermediate conversations in sub-groups and reporting back to Steering Committee
 - Teleconference attendances acceptable and expected

Communication

- Steering Committee members to report to chair two days prior to monthly Steering Committee meeting, including:
 - Outcomes of designated work
 - Key input received from Regional Reference Group
 - Concerns and proposed solutions
 - Priority actions for upcoming month



At this stage, it is good practice to conduct a risk assessment of the project. You may also conduct a risk assessment later in the project to assess potential solutions.

Kimberley/ Pilbara: Mechanisms should be put in place to track satisfaction over time

ILLUSTRATIVE

EXAMPLE: A team barometer for the Kimberley/ Pilbara IEH project could look like...

Please rate the following dimensions	Strongly disagree 1	2	3	4	Strongly agree 5	No answer
Direction – I am clear about the objectives, timeline and deliverables of the project	☐	☐	☐	☐	☐	☐
Roles – I understand my role and the roles of other team members	☐	☐	☐	☐	☐	☐
Impact – I believe the project on track to deliver significant impact to patients	☐	☐	☐	☐	☐	☐
Personal excitement – I am excited to be working on the project	☐	☐	☐	☐	☐	☐
Personal development – I am receiving regular coaching/feedback and find it useful	☐	☐	☐	☐	☐	☐
Team atmosphere – The team has an atmosphere of trust, openness and fun	☐	☐	☐	☐	☐	☐
Work/life balance – I'm able to maintain a good balance between my work and private life	☐	☐	☐	☐	☐	☐
Capability – I have the right skills to help the team and practices achieve the project's objectives	☐	☐	☐	☐	☐	☐
Communication – We are communicating efficiently as a team and across the network	☐	☐	☐	☐	☐	☐
Effective team – This team is working well together, including in problem solving and meetings	☐	☐	☐	☐	☐	☐
Resourcing – The team has the right resources to deliver the desired results	☐	☐	☐	☐	☐	☐
Provider relationships – We are developing strong relationships with providers	☐	☐	☐	☐	☐	☐
Provider performance – Our enrolled providers are actively improving their patients' clinical metrics	☐	☐	☐	☐	☐	☐
Recognition – I feel that my contribution to the project is recognised	☐					
Please add any further comments you may have.						



Modify or add questions as appropriate for your team. Ensure to take actions based on responses; don't just collect for the sake of collecting

In applying this section of the framework to Indigenous eye health, participants discovered ...

Section B of the framework is important because...

- *It made us realise that we hadn't formally agreed any meeting rhythm within the project team, and that was contributing to frustration felt by the team*
- *It reminded us that having clear roles can make working relationships more streamlined and effective*

The parts we found particularly difficult were...

- *Understanding the roles of existing organisations and the relationships between them*
- *Identifying a representative from stakeholder groups which don't have clear leadership*
- *Understanding the underlying motivations of all of the team members*
- *Finding commonly acceptable ways of working in a team of professionals with primary obligations elsewhere*

The key things we learnt about our pathway were...

- *There is a wide range of stakeholders we need to engage with – it is challenging to determine who is the best suited to be involved and in what capacity*
- *There is a lack of communication and sometimes conflicts of interest between stakeholders – the Medicare Local could potentially play a leadership role in bringing these parties to the table*

Next time we use the framework we will...

- *Get more people involved in helping us shape our aspiration so that we know it truly reflects the region's needs*
- *Consider and engage relevant stakeholders earlier in the process to help guide the direction of the project*
- *Ensure we understand the patient journey well before defining our shared aspiration*

Step C

Identify issues and root causes

By now, you will have established your project team, and defined a common aspiration around the selected focus area. The next step is to understand key issues.

Objective of this step

Identify issues and their underlying root causes along the focus area's pathway or system, using both quantitative and qualitative evidence

Why this step is important

- Understanding the root causes of issues within a pathway or system will help ensure that designed solutions address the heart of an issue, not merely symptoms of it
- A fact-based approach will help ensure resources are allocated where they can make the biggest difference

Common pitfalls

- Oversimplification—this step is often very challenging and will require right capabilities and sufficient time to complete
- Failing to identify true root causes
- Missing important issues by narrowing down too quickly
- Not prioritising where to focus and trying to do too much
- Focusing solely on structural root causes and failing to identify root causes addressable by local stakeholders, despite the structural constraints

By the end of this step you should...

- ☐ Understand the high-level stages of your chosen pathway or system
- ☐ Have identified areas of underperformance within the chosen pathway or system
- ☐ Know the key issues along the pathway
- ☐ Have identified the underlying root causes of the key issues

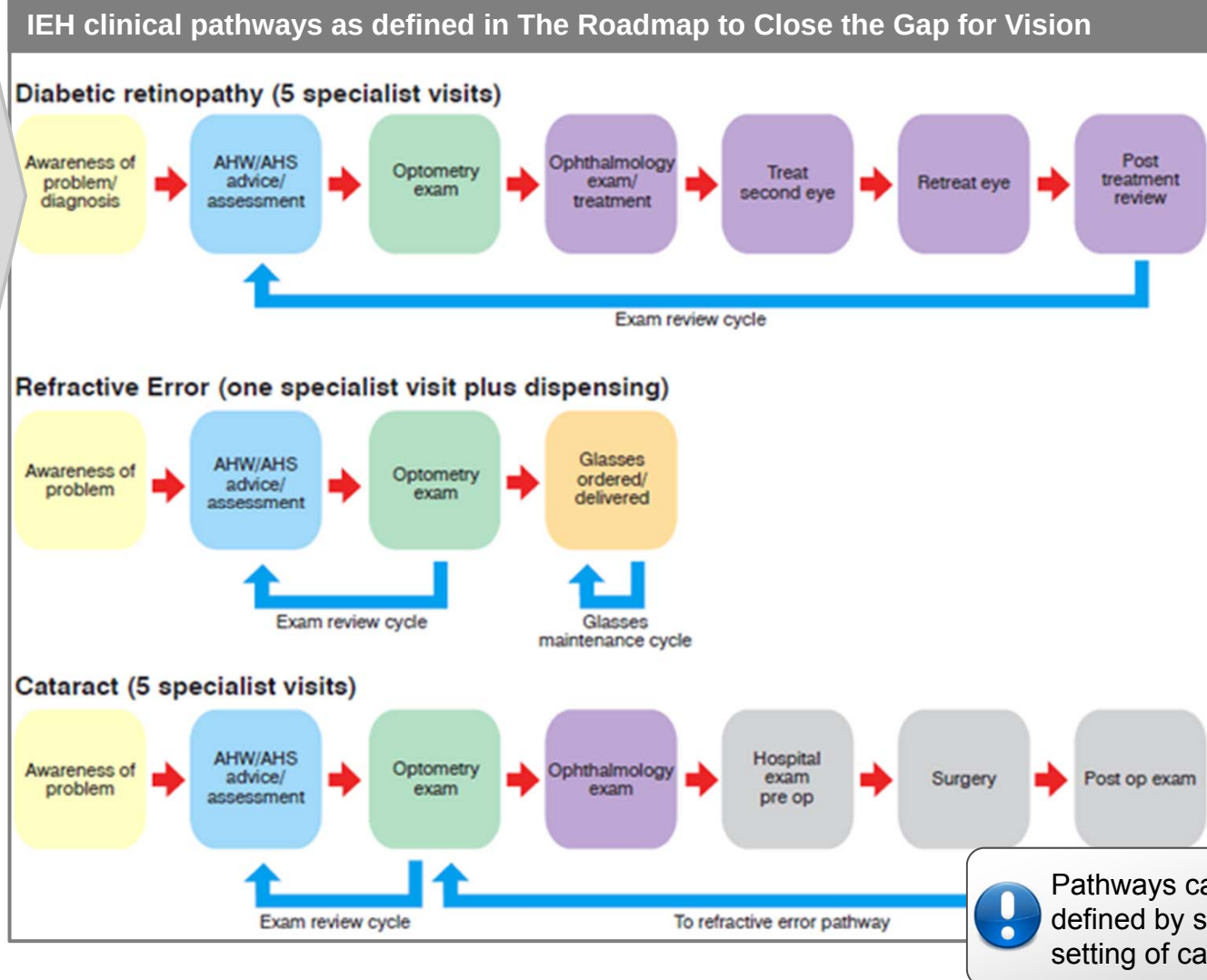
Set C. Identify issues and root causes

Key questions to answer	Approach
C1 What does your focus area's pathway or system look like?	- For the focus area identified in Step A, draw the high-level stages of the pathway or system - Make sure stakeholders agree on the depiction of the pathway or system
C2 How does your local health community perform along the pathway or system?	- Compare your performance against benchmarks which are agreed upon by stakeholders, such as performance of top quartile peers, clinical guidelines, or national targets - Measure performance of both outcome metrics (the consequences of actions) and process metrics (the actions themselves) - Consider combining required metrics (e.g., NHPA indicators) with metrics which are focused on your local health community (e.g., access to health services for veterans)
C3 What are the main issues along your chosen pathway or system?	- Brainstorm issues for each stage of the pathway. Focus on areas of weakness highlighted by the data and refer to existing research - Engage widely with stakeholders, especially consumers and providers, to understand issues from first-hand experiences - Begin to identify and group key issue themes
C4 What are the root causes which underlie the identified issues?	- Identify the root causes which underlie each of the key issues and group them into a manageable number of core themes - Make sure stakeholders agree that the final list of key issues and their underlying root causes are correct and comprehensive - Identify the stakeholders who have the most influence over the root cause and should lead and/or be involved in its resolution

Kimberley/ Pilbara: High level clinical pathways have been defined for major IEH conditions

ILLUSTRATIVE

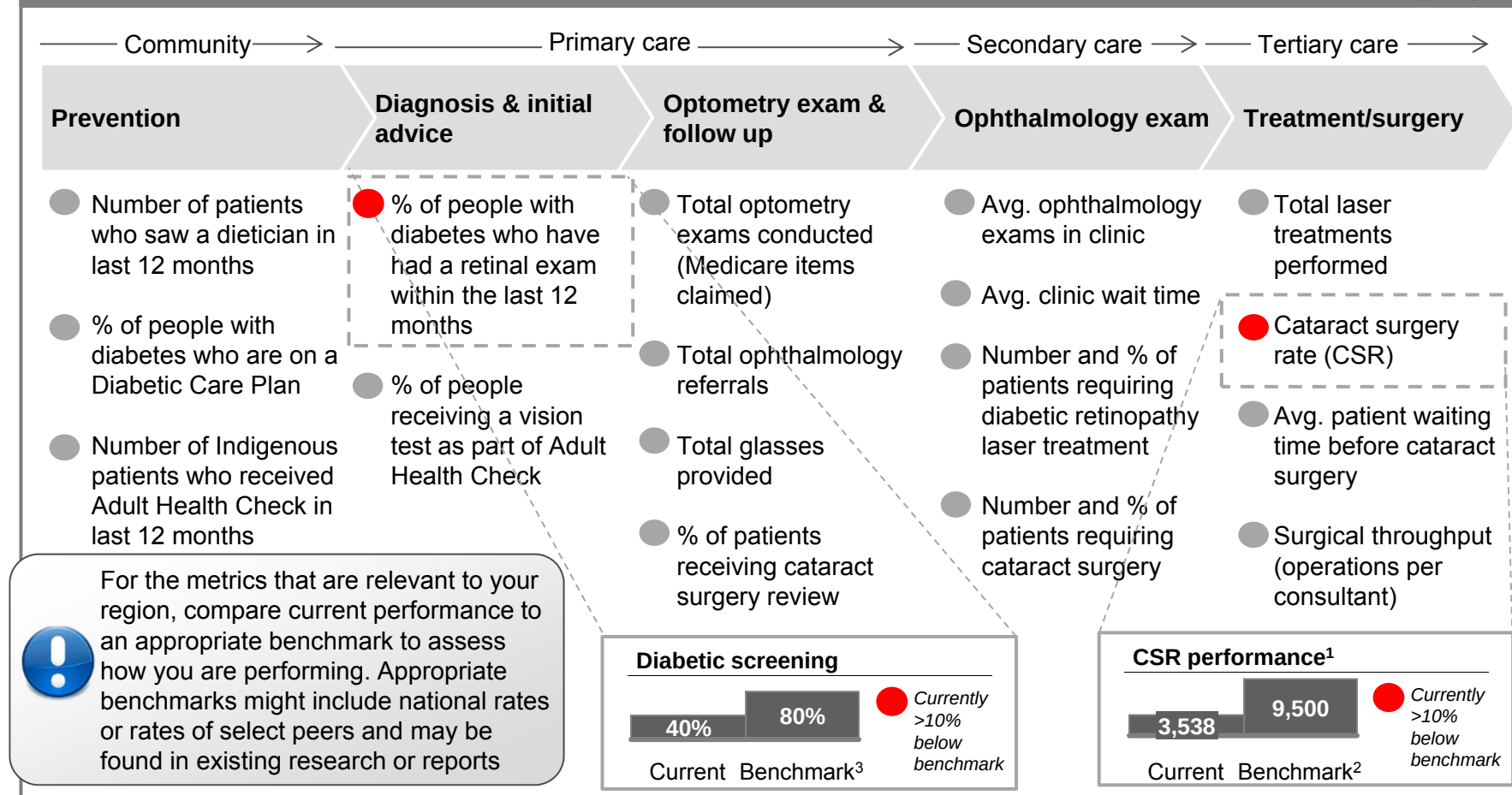
Tailor the pathway to your individual region, e.g., in the Kimberley/ Pilbara, initial advice and assessment may be provided by AHWs, GPs, or optometrists (see next page)



Kimberley/ Pilbara: Performance indicators at each step of the pathway should be used to identify opportunities for improvement

EXAMPLE: In the Kimberley/ Pilbara, performance indicators may include...

- Below benchmark(<10%)
- On benchmark(+/-10%)
- Above benchmark(>10%)



¹ Based on 2012 data: ratio applied to Kimberley/ Pilbara's 276 cataract surgeries in population of 78,184 (equal to 3,538 surgeries in 1m population)

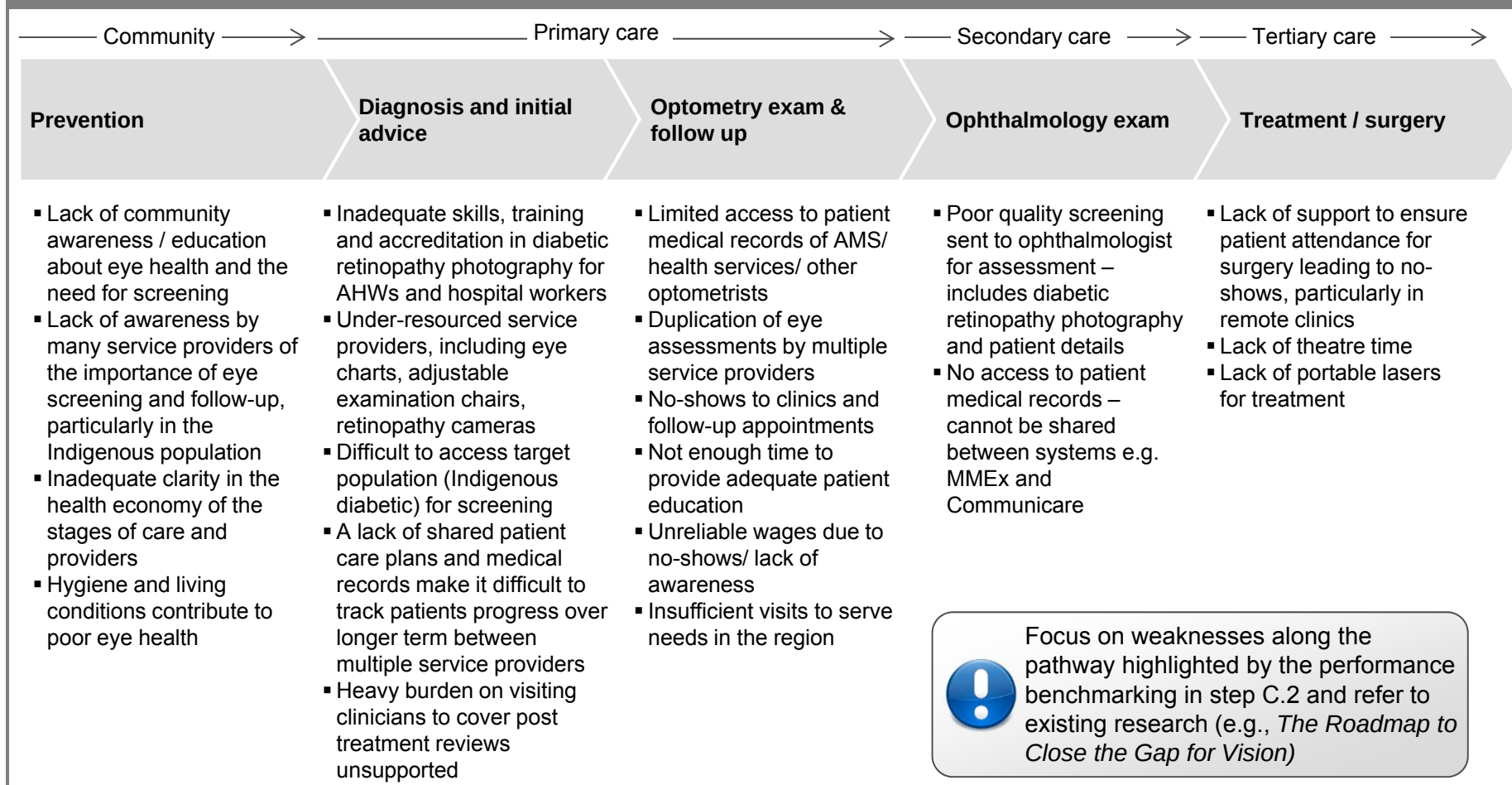
² Average Australian CSR is 9,500

³ Benchmark set based on expert advice

Kimberley/ Pilbara: Engage with a broad range of stakeholders to identify issues along the pathway in your region

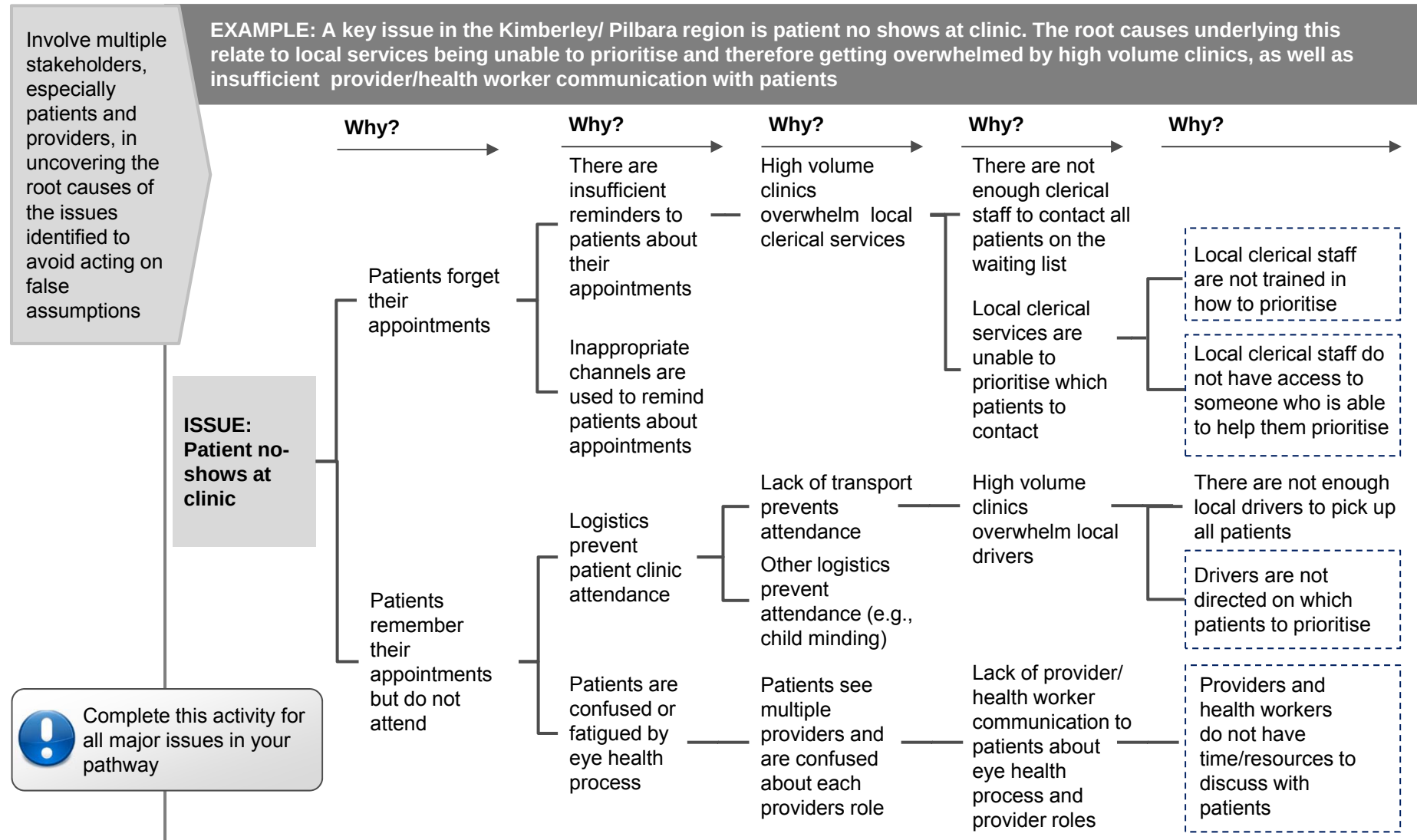
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EXAMPLE: Issues along the pathway for the Kimberley/ Pilbara region were identified using workshop sessions at the Lions Outback Vision Conference and through conducting a review of IEH literature



Kimberley/ Pilbara: Dig beneath surface level issues to identify true root causes

ILLUSTRATIVE



In applying this section of the framework to Indigenous eye health, participants discovered ...

Section C of the framework is important because...

- *It helped us focus on solving the underlying weaknesses in the system, not just patching the symptoms*
- *It helped us look at the health system holistically and understand how all the stages interact in the pathway of care*

The parts we found particularly difficult were...

- *Understanding what the root causes of issues were, not just the surface symptoms*
- *Determining benchmarks to measure ourselves against*
- *Agreeing on what were the key issues for our pathway*
- *Finding the time and resources to dedicate to the Collaborative Framework analysis*

The key things we learnt about our pathway were...

- *We haven't been assessing ourselves against external benchmarks or targets so we do not understand how we are performing relatively*
- *There are common causes to some of our identified issues which are therefore key to any potential solutions*

Next time we use the framework we will...

- *Be prepared to dedicate resources to conducting a comprehensive root cause analysis as it is critical to properly understanding the issues in our pathway*
- *Share what we learnt with other Medicare Locals to help them with their own analyses*
- *Tap into existing resources such as research / reports on the subject and peak bodies*
- *Test our assumptions in the root cause analysis with patients and service providers*

Step D

Develop case for change and set targets

For your focus area, you will now have identified the issues along the pathway or system and their root causes. Next you will build the change story.

Objective of this step

Develop and communicate a case for change that is tailored to different stakeholder groups and set SMART improvement targets

Why this step is important

- Developing a strong case for change will help drive stakeholder engagement (the 'change story')
- Setting SMART (targets will allow all stakeholders to agree on the measures of success)

SMART targets are

- Specific,
- Measurable,
- Actionable,
- Relevant and
- Timely

Common pitfalls

- Anticipating a flat baseline (i.e., no change from today)
- Not quantifying the problem or the improvement potential
- Failing to turn facts into a compelling narrative for each stakeholder group
- Neglecting to tailor the change story to each stakeholder's needs
- Setting vague or unrealistic targets – be ambitious but also realistic about constraints in the short term
- Not setting aspirations over multiple time frames

By the end of this step you should...

- ☐ Understand what is likely to happen if you do nothing
- ☐ Have set an agreed target for improvement
- ☐ Know who the relevant stakeholders are, and their underlying motivations
- ☐ Have developed a case for change for each stakeholder, tailored to their needs and motivations

Step D. Develop case for change and set targets

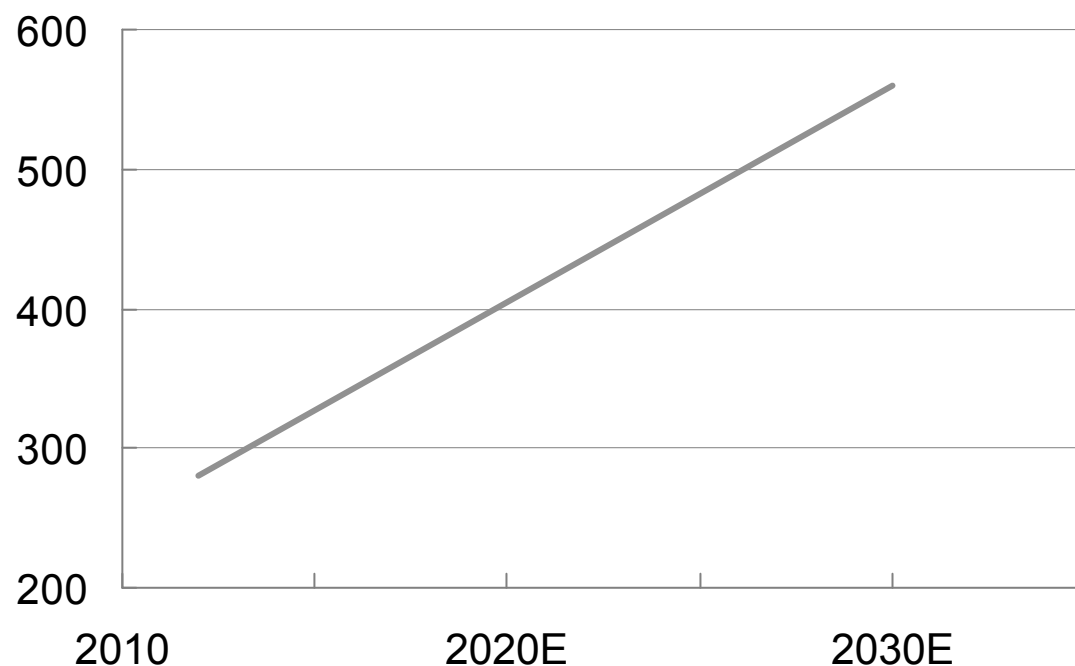
Key questions to answer	Approach
D1 What is likely to happen if you do nothing?	▪ Illustrate the 'do nothing' baseline, projecting forward historic trends for the most appropriate metrics (e.g., cost, disease burden, quality of care, access to care). Stratify for sub-populations if appropriate ▪ Gather qualitative evidence (e.g., personal experiences of patients and clinicians) to support the quantitative metrics
D2 What is your improvement target?	▪ Consider using a variety of sources to triangulate to a target, including: – International best practice guidelines (it is ideal to choose an example from a country which has a similar health system structure) – Improvements seen in similar initiatives – Performance of successful peers – Targets set by regulatory or professional bodies ▪ Set targets that are SMART (Specific, Measurable, Actionable, Relevant and Timely) ▪ Ensure stakeholders are committed to achieving the targets and identify who will be accountable for the target
D3 Who are the relevant stakeholders and what are their underlying motivations?	▪ Explicitly identify relevant stakeholders, and understand their motivations and any barriers to change ▪ Understand how different stakeholder motivations will impact the focus messaging of the change story
D4 What is the case for change?	▪ Create a compelling case for change using the 'do nothing' story, and lay out a clear aspiration ▪ Tailor the change story for specific stakeholders to appeal to different motivations ▪ Determine the most appropriate delivery medium(s) for the change story

Kimberley/ Pilbara: Project the region's 'do nothing' baseline for IEH

ILLUSTRATIVE

Kimberley/ Pilbara's 'do nothing' baseline for diabetic retinopathy might look like...

Number of Indigenous people in the Kimberley/ Pilbara region with diabetes related visual impairment¹



The rate of Indigenous people with diabetic retinopathy related visual impairment is forecast to double by 2030

¹ Based on population data from census; Indigenous population data from Your Health government website; Hugh Taylor forecast of vision loss to 2030

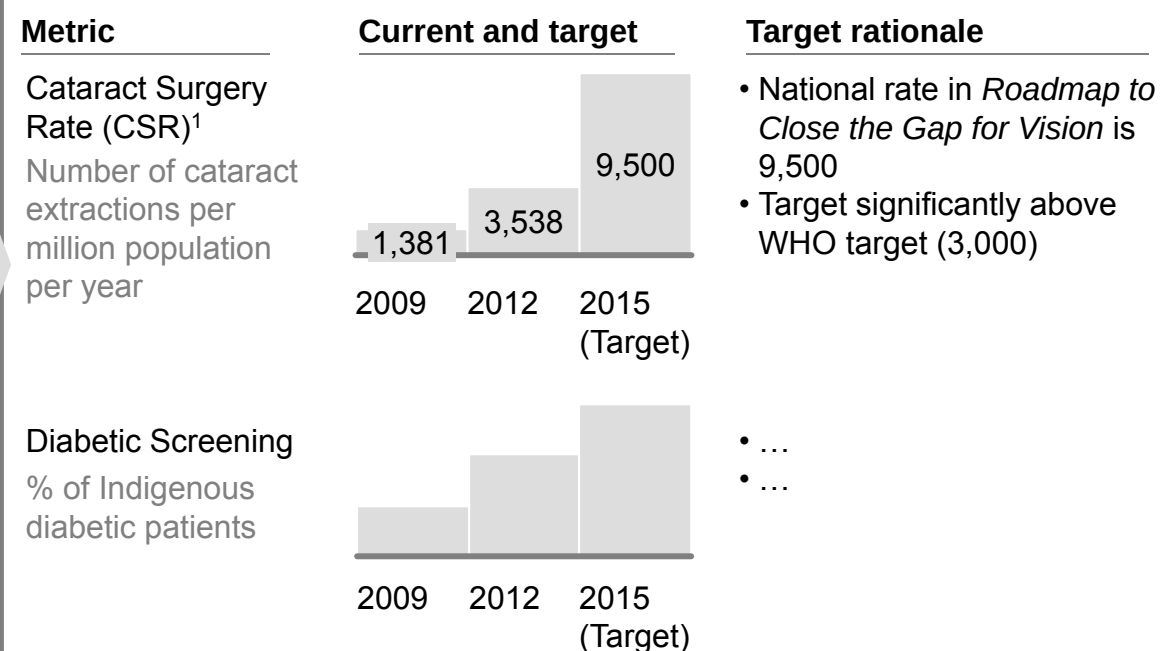
Kimberley/ Pilbara: Set Indigenous eye health targets for the region

ILLUSTRATIVE

There are many methods for setting targets, including:

- 1 Adjust international best practice guidelines to your context and compare
- 2 Aim for a national benchmark
- 3 Aim to match improvements seen in similar initiatives
- 4 Aim to match performance of successful peers
- 5 Use targets set by regulatory or professional bodies
- 6 % improvement based on experience/local expertise
- 7 % improvement based on trajectory

EXAMPLE: By setting percentage improvements based on experience, the Kimberley/ Pilbara region could set targets for eye health including...



1 Ratio applied to Kimberley/ Pilbara's 108 cataract surgeries (in 2009) and 276 cataract surgeries (in 2012) in population of 78,184 – proportionate to 1,381 surgeries (in 2009) and 3,538 surgeries (in 2012) in 1m population

2 Average Australian CSR is 9,500

Kimberley/ Pilbara: Prepare a case for change tailored to major stakeholder groups, based on their underlying motivations

ILLUSTRATIVE

EXAMPLE: Case for change to providers—the patient journey



Meet Sarah

Sarah is 35 and lives in Derby. Four years ago she was diagnosed with type 1 diabetes. She doesn't realise that her diabetes could lead to eye health complications, so she has never discussed eye health with the GP who manages her diabetes care plan. When her AHW tells her she needs an eye screening, she decides not to follow it up because she doesn't want glasses and it is too difficult to get into town.

How Sarah's eye health journey could be different...

Sarah's GP notices that Sarah is due for her annual eye test and helps organise an appointment for her with the regional eye health worker

The eye worker confirms the appointment with Sarah the day before, and conducts the retinal screen which shows Sarah has early stages of retinopathy

Sarah is referred to an ophthalmologist, and the eye worker follows up to make sure she is booked in for the next visiting clinic

The ophthalmologist has access to Sarah's full eye care history and provides appropriate laser treatment. Sarah avoids vision impairment and feels gratitude to all her providers

EXAMPLE: Case for change to patients—education about their role in eye health

- **What:** The 'Bad Sugars, Bad Eyes' video was developed as part of a partnership between RANZCO, the Lions Eye Institute and a number of other Indigenous and eye health stakeholders
- **Why:** The objective is to help patients understand their condition and the associated health risks, as well as the need for a retinal photograph
- **Tailoring to the stakeholder:** The video was specifically designed with the Australian Indigenous population in mind: the narrators are Indigenous health workers and community members from the Kimberley/ Pilbara region
- **Delivery:** The video is intended for use as a form of community and patient education, to be shown in waiting rooms of health clinics and also to patients before retinal photograph are taken



Think of different ways to creatively communicate the case for change (mediums of delivery may include waiting room videos, local radio and National Indigenous Television) depending on the audience

In applying this section of the framework to Indigenous eye health, participants discovered ...

Section D of the framework is important because...

- *It made us realise how important it is to make a change, and helped us crystalize what we want to achieve*
- *It can be a lot of work and energy to make a change, so it is essential to motivate stakeholders and encourage them to take ownership of the project*

The parts we found particularly difficult were...

- *Finding data in our own region and at a national level, to set targets against*
- *Distilling the facts and figures into a compelling change story – medical based messaging need to be very particular and requires a degree of expertise*
- *Ascertaining the best mode(s) for delivery for our change story considering the diversity and geographic dispersion of our population*

The key things we learnt about our pathway were...

- *Our weaknesses are focused toward the first stages of the patient pathway*
- *We have a lot of committed stakeholders who are motivated to improve the pathway – we do not need to ‘change’ all mindsets, just inspire them into action*
- *There are limited national indicators to measure ourselves against*
- *It is essential to communicate appropriately, especially to our Indigenous population*

Next time we use the framework we will...

- *Focus on building a database of relevant statistics to continue to measure ourselves against and to set reasonable but aspirational targets*
- *Dedicate more lead time to finding sufficient data*
- *Share our experiences of what worked well with other Medicare Locals to help prompt thinking and demonstrate that it is a good use of time and resources*

Step E

Design care delivery and business case

By now, you will have developed a case for change and set improvement targets. In this step, you will decide how to achieve them.

Objective of this step

Design a collaborative care delivery model that addresses underlying root causes, and determine a sustainable resourcing mechanism

Why this step is important

- Approaching solution design in a structured and comprehensive way ensures that the solution tackles underlying root causes and delivers the greatest impact
- Choosing the most appropriate resourcing model is key to creating medium and long-term sustainability of the initiative

Common pitfalls

- Oversimplification—this is often very challenging and requires right capabilities and sufficient time
- Initiating a series of disjointed tactical fixes rather than considering the overall operating model
- Not considering enablers as part of the solution
- Not quantifying costs and benefits
- Limiting ambition or impact by only relying on new funding sources
- Only considering resources required in a pilot phase and not for sustainable at scale implementation

By the end of this step you should...

- ☐ Have designed a future-state care delivery model supported by enablers such as payment models
- ☐ Have created a business case primarily focused on achieving improvements from increasing the efficiency of the current system

Step E. Design care delivery and business case

Key questions to answer	Approach
E1 What does the future-state delivery model look like?	▪ Engage a broad group of stakeholders to identify potential solutions which address each of the underlying root causes ▪ Use the list of potential solutions to design a holistic care delivery model, including consideration of necessary enablers such as information technology, financial incentives, organisation design and performance management
E2 What is the business case?	▪ Determine the benefits of the future delivery model including both economic and quality benefits ▪ Determine the resources required and costs (both in the design and implementation phase and in the ongoing running phase) ▪ Determine how the future delivery model can be achieved using currently available resources – an option within this may be reallocation of resources ▪ As a final option, only after you have demonstrated how to maximise efficiency using the current resources, explore options for seeking additional funding

Kimberley/ Pilbara: Brainstorm potential solutions to address the root causes identified in Step C

ILLUSTRATIVE

□ Focus of worked example

Engage with key stakeholders including GPs, optometrists, ophthalmologists, AHWs, and patients to brainstorm potential solutions for each root cause

EXAMPLE: The Kimberley/ Pilbara region conducted workshops with a broad range of stakeholders and used the expertise of local providers to brainstorm issues and solutions

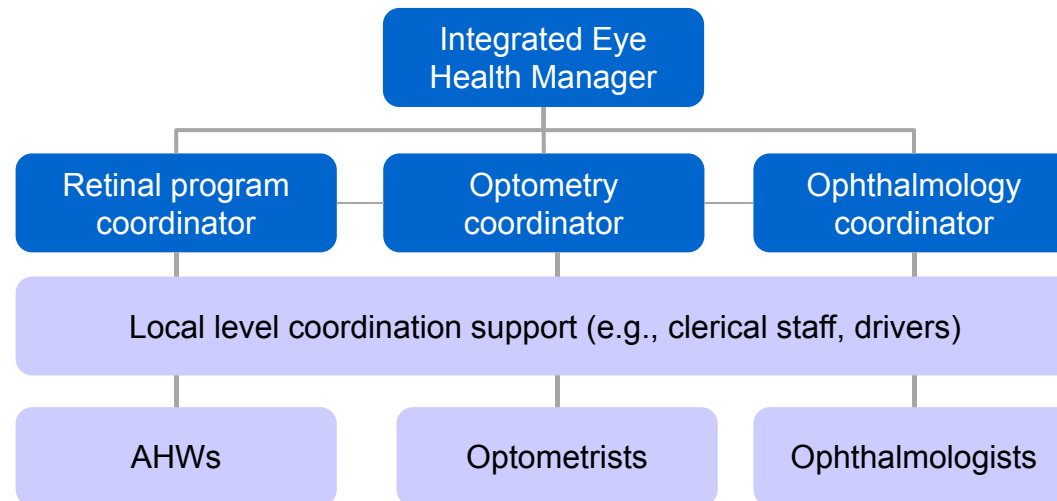
Issue	Root cause	Potential solution	Stakeholders
Patient no-shows at clinic	Clerical staff unable to prioritise which patients to book/remind for clinic	Introduce coordination roles	GPs; Optometrists; ophthalmologists; AHWs; patients; local clerical staff
	Lack of education about the patient's role in their eye health journey	Produce pamphlets educating patients and the community about their own health responsibilities	Patients; AHWs
	Patients relocate frequently	Introduce individual case coordinators to manage mobile patients	GPs; optometrists; ophthalmologists; AHWs
Patient no-shows at surgery	Insufficient care coordination to support surgery attendance	Introduce case management coordination roles	GPs; optometrists; ophthalmologists; AHWs; patients
	Lack of transport options for remote communities	Increase the number of drivers servicing remote communities	Patients; drivers; AHWs
	Insufficient explanation of surgery to patients	Develop video to alleviate patient fears/concerns regarding surgery	GPs; patients; AHWs
Duplication of patients seeing more providers than necessary	Insufficient visibility over patient/provider interactions	Introduce patient case management coordination roles to manage referral process	GPs; optometrists; ophthalmologists; AHWs; patients
	A platform for sharing medical records does not exist	Introduce a central patient eye health record	Patients; drivers; AHWs

Introducing roles to manage and coordinate clinic, surgery and referral processes appears repeatedly as a potential solution, suggesting that it should be part of the new delivery model

Kimberley/ Pilbara: Design what the region's future-state IEH care delivery model looks like

ILLUSTRATIVE

EXAMPLE: For Kimberley/ Pilbara, a potential model to address a lack of pathway coordination could look like...



Introduce eye health coordinators...

- An Integrated Eye Health Manager oversees coordination along the entire eye health pathway for the region
- Dedicated coordinators (x3) oversee the major stages of care, working with local level coordination support staff to improve eye care service delivery

Supported by appropriate incentives and enablers...

- Examples of potential incentives and enablers:
- A recognition program for practitioners and regions that demonstrate significant improvement in key metrics (e.g., throughput rates)
 - Central patient eye health record to improve access to patient records

To achieve both health and economic benefits

- Health benefits:
- Better coordination resulting in higher clinical and surgical throughput rates, with flow-on effects to lower prevalence of blindness
- Economic benefits (assumptions):
- Halving of duplicate and unnecessary consultations from 10% to 5%

Kimberley/ Pilbara: Determine the benefits from enhancing coordination from both quality and economic perspectives

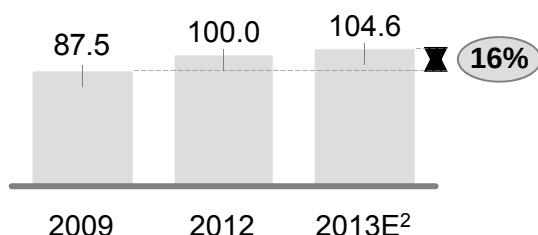
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NOT EXHAUSTIVE

EXAMPLE: Quality benefits from introducing eye health coordinators in the Kimberley/ Pilbara could include...¹

Clinical process improvements

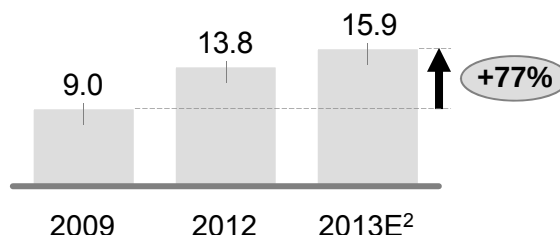
Clinical throughput

Clinic exams per consultant week



Surgical throughput

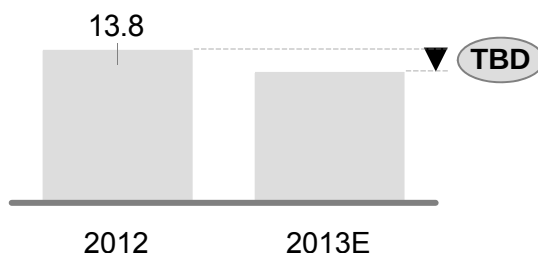
Cataract surgeries per ophthalmologist week



Clinical outcome improvements

Prevalence of vision impairment in Kimberley/ Pilbara Indigenous adult population

% of Indigenous adults who have low vision or blindness



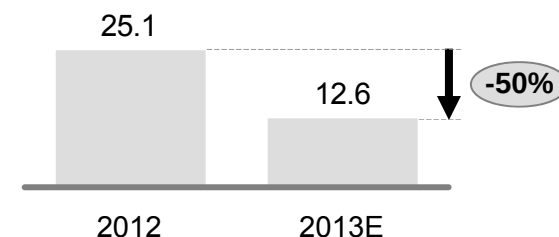
Be sure to identify sufficient operational and economic benefits to justify the investment required

EXAMPLE: Economic benefits could include...

Savings to the health care system

Reduction in unnecessary clinic visits

\$'000 spend on Medicare items for unnecessary visits



Assumes that better coordination will reduce the number of unnecessary clinic visits (i.e. visits that have been duplicated). This would typically represent a saving for Medicare, but due to special arrangements in WA, the savings accrue to the WA State Government.



Note that some clinical improvements will also have economic benefits (e.g., increasing surgical throughput will reduce the cost per cataract)

¹ All figures are for the entire Kimberley/ Pilbara population unless explicitly stated

² Calculated by extrapolating the 3-year improvement in throughput from 2009-12

Kimberley/ Pilbara: Determine the costs to introduce eye health coordinators

ILLUSTRATIVE

EXAMPLE: Determining the costs to employ four additional eye health coordinators in the Kimberley/ Pilbara might look like...

	Item	Estimated cost (\$'000)
Additional annual recurrent costs	▪ Wages for coordinators	390
	▪ Travel expenses for coordinators	90
	▪ Other project costs (e.g., hiring a clinical consultant, diabetic screening program reviews, and on-costs)	211
	Total additional recurrent costs (p.a.)	691
Additional non-recurrent costs	▪ Change management (includes training, promotion and recruitment)	5
	▪ Project costs (includes governance and evaluation)	5
	Total additional non-recurrent costs	10
Additional Medicare and State health care costs before reduction in unnecessary visits ⁴	▪ 5% increase in clinical throughput @ \$120 per clinic visit ¹	11
	▪ 15% increase in surgical throughput @ \$1,700 per surgical procedure completed ²	71
	▪ Total additional Medicare and State health care costs	82

¹ Equal to \$60 Medicare item claim and \$60 assumed State consumables and on cost.

² Weighted average of cost to State Government and Medicare for admitted and non-admitted patients respectively

Note: Does not include costs for enablers that may be required to administer the solution (e.g., shared patient medical records)

⁴ Note that increase is from 2012 to 2013 only

Kimberley/ Pilbara: Identify how much of the solution can be implemented using existing resources

ILLUSTRATIVE

EXAMPLE: A number of different ways to reallocate existing resources could be considered and evaluated...

	Example of what this might look like for IEH in the Kimberley/ Pilbara	Payor
Medicare Local flexible funding	Allocate Medicare Local flexible funding toward implementation of project; this could involve pooling flexible funding between multiple Medicare Locals where benefits accrue across regions	Medicare Local
Cost benefits from reduced item claims	Reduction in unnecessary clinic visits will lead to fewer Medicare item claims	Australian Government ¹
Efficiency gains	Increasing the efficiency of each clinic translates to potential consolidation of existing clinics	Australian Government ¹
Appropriate use of Medicare items	Use Medicare item for chronic disease management which can be claimed for extra eye health coordinators	Australian Government ¹
Reallocate resources from downstream to upstream	Earlier intervention for diabetes patients can potentially reduce blindness caused by diabetic retinopathy and higher cost downstream interventions such as laser treatment	WA and Australian Government ¹
Reallocate resources from other disease areas into eye health	Repurpose travel budget from other health initiatives to fund coordinators' travel	Contingent on program
Better utilise existing programs	Better utilise funds available through existing Commonwealth and State/Territory programs (e.g., Indigenous Chronic Disease Package, allocated COAG funding, see next page)	Contingent on program (primarily Australian government)

¹ Due to special arrangements in WA, Medicare savings and costs accrue to the WA State Government

Kimberley/ Pilbara: Identify existing programs which can be leveraged

ILLUSTRATIVE

Consider how funds that have already been allocated under existing programs can be best used to support the initiative

EXAMPLE: Existing IEH programs include...

Program	Description
COAG, Close the Gap	Joint Commonwealth/ state/ territory funding of \$1.57 billion over four years ¹ to reduce the burden of chronic disease on ATSI Australians: - Commonwealth contribution through <i>Indigenous Chronic Disease Package</i> (ICDP) - ICDP includes the <i>Care Coordination and Supplementary Services (CCSS) Program</i> offering care coordination provided by qualified healthcare workers and supplementary services to assist patients receiving care coordination
Medicare Local – flexible funding	Flexible funding provided to all Medicare Locals, through the Regionally Tailored Primary Health Care Initiatives through the <i>Medicare Locals Fund</i> to fill service gaps identified in their needs assessments
Rural Health Outreach Fund (formerly MSOAP)	A flexible pool of funding to support initiatives aimed at improving access to medical specialists, GPs, allied health professionals, and other health providers in regional , rural and remote parts of Australia.
Indigenous and Remote Eye Health Service (IRIS)	A program to evaluate facilities and services that currently exist pertaining to Indigenous eye health and to recommend improvements or expansions. IRIS is the current MSOAP fund holder for ophthalmology
Visiting Optometrists Scheme (VOS)	A program to support optometrists to delivery optometric services to remote and very remote locations
WA Spectacle Subsidy Scheme	A program to deliver affordable access to spectacles by providing a subsidy of \$50 towards the cost of every pair of glasses for disadvantaged people
Patient Assisted Travel Scheme (PATS)	Provides financial assistance to eligible patients who need to travel long distances to obtain specialist medical treatment
Fred Hollows Foundation	A charity aiming to provide vision-restoration surgery to remote and underprivileged communities

¹ This funding is through the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. Other National Partnership Agreements exist as part of the COAG, Closing the Gap initiative

In applying this section of the framework to Indigenous eye health, participants discovered ...

Section E of the framework is important because...

- *It is critical to impact – without a good solution, we will not improve the pathway*
- *It is critical in determining whether or not the ideas and solutions get the funding required to turn them into realities*

The parts we found particularly difficult were...

- *Quantifying social benefits and quality of life*
- *Quantifying outcome metrics which will have a long lead time*
- *Building incentives into the proposed solution*
- *Knowing what is available in terms of funding and how to access it*
- *Coordinating across all our business cases for different conditions*

The key things we learnt about our pathway were...

- *The same solutions came up time and time again, indicating they would help address multiple issues in the system*
- *We don't properly understand our region's existing local and national services*
- *Our existing processes encourage silo thinking, particularly in relation to funding*
- *We have underdeveloped skills and capabilities in cost analysis and business cases*

Next time we use the framework we will...

- *Reach out to others in our region who have prepared business cases before, particularly for comparable healthcare pathways*
- *Focus on identifying how we can reallocate existing funding to use it more efficiently*
- *Think of ourselves more as a 'business' - undertake more quantitative analysis and business case development*

Step F

Implement, track and adjust

Before beginning this step, go back and review the previous steps to ensure the foundations are in place for successful implementation.

Objective of this step

Implement the new care delivery model following a well-designed action plan with regular tracking and adjustment

Why this step is important

- Implementation is the culmination of all previous steps; the hard work and good intentions of the project can fail to materialise into improved outcomes if this step is not carefully planned
- Implementation rarely goes exactly to plan, so it is important to track progress and make adjustments
- Careful consideration of implementation is required to ensure the sustainability of initiatives

Common pitfalls

- Understating the science/ art of implementation—robust processes must be complemented with strong change management capabilities
- Not clearly allocating roles and responsibilities, or contingency plans for people leaving
- Not creating transparency on performance and progress
- Not adjusting plans as the project unfolds
- Failing to anticipate early in the project the data required to monitor - it may take time to gather

By the end of this step you should...

- ☐ Have developed a change management plan to create sustainable change
- ☐ Have designed and agreed upon an action plan for implementation
- ☐ Have set up performance tracking mechanisms
- ☐ Have set up processes to make adjustments and improvements

Step F. Implement, track and adjust



Key questions to answer

Approach

F1 What is the change management plan?

- Use the influence model to design a holistic change management plan with actionable modules
- To change behaviours you will need to create buy-in to the change required, establish role models, build the capabilities required for change, and form formal mechanisms that reinforce the change

F2 What is the action plan for implementation?

- Determine how fast to roll out the initiative in terms of the staging of functionality, geography and patient/clinician sub-populations
- Develop an action plan for implementation with clear roles and responsibilities (including a contingency plan), activities and timelines. The discrete activities of the action plan should map to the modules of the change management plan.
- Ensure stakeholders understand and are committed to the action plan

F3 How will progress be tracked?

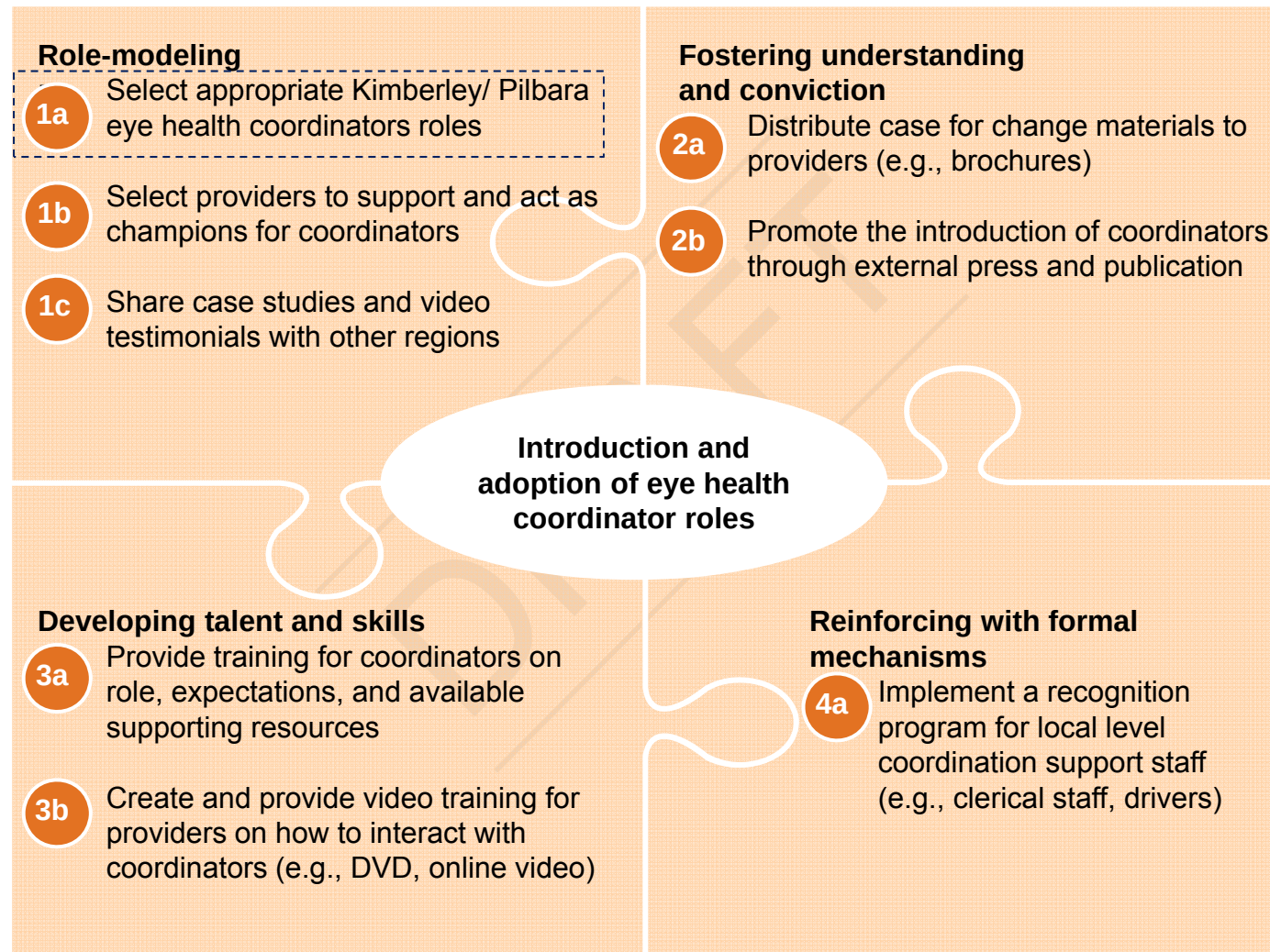
- Agree with stakeholders on how performance will be monitored, including which metrics to use (both outcome and process) and how often the results will be reported

F4 How will adjustments and improvements be made?

- Conduct regular quality improvement reviews and feedback sessions with all stakeholders
- Adjust the implementation approach as required
- Celebrate successes along the way

Kimberley/ Pilbara: The change management plan should include actionable modules to address four critical elements

ILLUSTRATIVE



Discussed on next page

Kimberley/ Pilbara: Clearly define the purpose and intended outcome of each action module

ILLUSTRATIVE

1a EXAMPLE: Select appropriate Kimberley/ Pilbara eye health coordinators

What is it?

- There will be one Integrated Eye Health Manager who will oversee the entire eye health coordination program in the Kimberley/ Pilbara region
- There will be three dedicated coordinators for each of the major pathway areas
 - Retinal program
 - Ophthalmology
 - Optometry
- This module is concerned with the appropriate selection and recruitment of individuals for those roles

Why is it important?

- The capabilities of the selected coordinators will be critical to the overall success of the project and the delivery of improved eye health outcomes for Indigenous and non-Indigenous Australians in the Kimberley/ Pilbara region
- In addition to individual capabilities, sufficient integration and cooperation between the coordinators is required for the initiative to be sustainable

How will it work?

- The process of selecting coordinators begins with the identification of appropriate and willing organisations, followed by the selection of an individual within each organisation, and ending in the drafting and execution of employment contracts supported by appropriate incentives
- There are two key considerations when selecting coordinators:
 - Determine if 'natural owners' of the coordinator roles already exist (i.e. individuals/ organisations already acting in a coordination capacity). If none exist, then a public recruitment process may be required
 - Choose organisations and/or individuals who are able to demonstrate an appropriate level of integration and cooperation amongst each other

Kimberley/ Pilbara: Design the rollout plan for the initiative

ILLUSTRATIVE

Set clear activities and timelines against all modules in the change management plan (see previous step) – plan for potential stumbling points

EXAMPLE: An action plan for implementing eye health coordinators in the Kimberley/ Pilbara region could look like...

Action	2013												2014				Responsible
	03	04	05	06	07	08	09	10	11	12	01	02	03	...			
1a. Select appropriate coordinators																	TBD
Identify potential organisations	..																TBD
Public recruitment process (if necessary)																	TBD
Select and evaluate potential candidates																	TBD
Draft and execute employment contracts																	TBD
1b. Select providers to support and act as champions for coordinators																	TBD
Select and screen potential champions																	TBD
Provide coaching to provider champions																	TBD
Conduct follow-ups to gather feedback																	TBD
Visit other providers and provide coaching																	TBD
1c. Promotion through external press and publication																	TBD
Develop promotional materials																	TBD
Conduct promotional campaign																	TBD
2b. Share case studies and video testimonials with other regions																	TBD
Identify appropriate case studies																	TBD
Compile case studies / film testimonials																	TBD
Distribute material to practices and publish online																	TBD
.....																	

Kimberley/ Pilbara: Set performance metrics and track progress

ILLUSTRATIVE

Develop a performance dashboard and automate it as much as possible to track key process metrics and outcomes

EXAMPLE: A performance dashboard for implementing eye health coordinators in the Kimberley/ Pilbara region could look like...

Date

6/03/2013

Objectives	KPIs	Units	Period	Period Status	Overall Performance		Baseline	This Period	Period Change
					Overall Goal	Date			
Key project activities									
Coordinator roles filled	Integrated Eye Health Manager	Y/N	Weekly	☺	Y	1/07/13			
	Ophthalmology coordinator	Y/N	Weekly	☺	Y	1/07/13			
	Optometry coordinator	Y/N	Weekly	☺	Y	1/07/13			
	Retinal programme coordinator	Y/N	Weekly	☺	Y	1/07/13			
Team Capability	One-on-one provider training sessions held	#	Monthly	☺	4	1/07/13			
	Number of CQI sessions held	#	Monthly	☹	4	12/12/2013			
Provider champions	Number of provider champions identified	#	Monthly	☹	5	1/08/2013			
	Number of provider champions trained	#	Monthly	☹	5	1/09/2013			
	Number of feedback sessions conducted	#	Monthly	☹	5	16/12/2013			
	Number of coaching-related visits to other providers	#	Monthly	☹	15	12/12/2013			
Key health outcomes									
Clinical outcomes	Cataract surgery rate	#	Monthly	☹		31/03/14			
	Diabetic screening rate	%	Monthly	☺		31/03/14			
	Vision check rate	%	Monthly	☺		31/03/14			
Patient and practitioner experience	Clinical throughput (per consultant week)	%	Monthly	☺		31/03/14			
	Surgical throughput (per consultant week)	#	Monthly	☹		31/03/14			
	% of clinic visits that are unnecessary or duplicates	%	Monthly	☹		31/03/14			

Displayed in user friendly format automated as much as possible

Key metrics clearly tracked at regular intervals

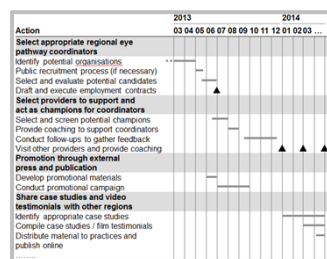
Visual cues and colours used to quickly identify status

Kimberley/ Pilbara: Include mechanisms to help regularly adjust and improve the implementation of the initiative

ILLUSTRATIVE

Hold regular conversations to review data and evaluate progress. For example, implementation of eye health coordinators could be tracked through continuous quality improvement conversations guided by templates similar to the one below:

Date: 1/03/2013									
Measure	KPI	Units	Period	Target	Actual	Score	Weight	Notes	Owner
Key project outcomes									
Integrated Eye Health Manager	100%	Units	1/03/2013	100%	100%	100%	100%		
Coordinating coordinator	100%	Units	1/03/2013	100%	100%	100%	100%		
Operational coordinator	100%	Units	1/03/2013	100%	100%	100%	100%		
Programme coordinator	100%	Units	1/03/2013	100%	100%	100%	100%		
One-to-one coaching sessions held	100%	Units	1/03/2013	100%	100%	100%	100%		
Number of CQI sessions held	100%	Units	1/03/2013	100%	100%	100%	100%		
Number of provider champions identified	100%	Units	1/03/2013	100%	100%	100%	100%		
Number of provider champions trained	100%	Units	1/03/2013	100%	100%	100%	100%		
Number of coached sessions conducted	100%	Units	1/03/2013	100%	100%	100%	100%		
Number of coaching sessions to other providers	100%	Units	1/03/2013	100%	100%	100%	100%		
Key health outcomes									
Crash course completion	100%	Units	1/03/2013	100%	100%	100%	100%		
Diabetes coverage rate	100%	Units	1/03/2013	100%	100%	100%	100%		
Visual health gap	100%	Units	1/03/2013	100%	100%	100%	100%		
Change through for (one coordinator role)	100%	Units	1/03/2013	100%	100%	100%	100%		
Support through for (one coordinator role)	100%	Units	1/03/2013	100%	100%	100%	100%		
% of sites where an unnecessary or duplicate	100%	Units	1/03/2013	100%	100%	100%	100%		



Continuous Quality Improvement

Participants: Integrated eye health manager with Kimberley/ Pilbara ML Date: 1/03/2013

Looking back

Highlights

Reduced unnecessary visits by 3% this period
Visited 5 providers with local provider champion and provided coaching

Lowlights

Completed only 1 out of 3 CQI conversations with dedicated coordinators
7 out of 10 provider champion roles have not yet been filled

Looking forward

Issues to be resolved

Need to focus on selecting more providers to help support and champion
Need to plan ahead for CQI conversations with dedicated coordinators

Top priorities

Identifying and training local provider champions

What I need from you

Support and time to develop plan to identify potential provider champions
List of local contacts to begin the selection process

Weekly actions

KPI	Action	By Who	By When	Status
CQI conversations	Conduct two remaining CQI conversations with dedicated coordinators	Integrated Eye Health Manager	8/03/2013	Done
Provider champions	Identify potential provider champions from Broome	Integrated Eye Health Manager	8/03/2013	Not Yet Due
	Continue to run coaching sessions with provider champions	Kimberley/ Pilbara Medicare Local	8/03/2013	Not Yet Due
	Discuss the provision of part-time support to help identify, screen and train additional provider champions	Integrated Eye Health Manager	8/03/2013	Not Yet Due

EXAMPLE:

Improvement conversations and review of the coordinator roles reveal that the process of identifying local provider champions requires more resources and time than previously imagined.

An adjustment action might be to provide a part-time person to assist the Integrated Eye Health Manager to identify, screen, and train potential provider champions.

In applying this section of the framework to Indigenous eye health, participants discovered ...

Section F of the framework is important because...

- *We often don't invest enough time and resources into planning implementation and the success of our initiatives often suffers because of it*

The parts we found particularly difficult were...

- *Anticipating all the action items for the roll-out plan*
- *Establishing systems to track performance metrics with limited resources and experience in this area, particularly in relation to technology*
- *Determining how we could set up independent evaluation processes*
- *Finding resources to dedicate to implementation and monitoring*

The key things we learnt about our pathway were...

- *It is often difficult to know who to hand over 'ongoing' ownership of an initiative to (i.e. ownership beyond the project team)*
- *We have limited resources and capabilities in coordination and project tracking areas*
- *Having some consistent leadership throughout the life of the project is very beneficial*
- *The pathway we are looking at will often only be one part of our stakeholders business*

Next time we use the framework we will...

- *Try and think ahead to get the people who will be involved in implementation on board earlier in the process*
- *Celebrate our successes along the way to keep the team motivated*
- *Look for synergies and opportunities to integrate with existing programs and systems eg. training*

Back-up

Refer to suggested co-ordination and service requirements when estimating population needs

The Roadmap to Close the Gap for Vision suggests requirements on a per 10,000 population basis – the ratios can be applied to your region...

Eye Care Co-ordination and Service Requirements for a 'Region' and a 'Community'

		10,000 people ('Region')					500 people ('Community')			
		Community (days)	Visiting Service (days)	Hospital (days)	Total (days)	EFT for 10,000 people	Community (days)	Visiting Service (days)	Hospital (days)	Total (days)
Optometry Clinics										
Patient organisation	2 hr/pt (spec 1 hr)	531.5			531.5	2.5	26.6			26.6
Transport	1 hr/patient	307.8			307.8	1.5	15.4			15.4
Clinic organisation	4 hr/clinic day	109.8			109.8	0.5	5.5			5.5
Team organisation	4 hr/clinic day		106.3		106.3	0.5		5.3		5.3
Clinic support	8 hr/clinic day	132.9	132.9		265.8	1.3	6.6	6.6		13.3
Ophthalmology Clinics										
Patient organisation	2 hr/pt	78.6	44.0		122.7	0.6	3.9	2.2		6.1
Transport	1 hr/pt	46.4			46.4	0.2	2.3			2.3
Clinic organisation	4 hr/clinic day	23.3			23.3	0.1	1.2			1.2
Team organisation	4 hr/clinic day		23.3		23.3	0.1		1.2		1.2
Clinic support	8 hr/clinic day	23.3	23.3		46.6	0.2	1.2	1.2		2.3
Hospital										
Patient organisation	2 hr/pt (3 hr preop)	60.5		60.5	121.0	0.6	3.0		3.0	6.1
Transport	1 hr/pt			15.0	15.0	0.1			0.7	0.7
Hospital organisation	4 hr/clinic day			13.1	13.1	0.1			0.7	0.7
Team organisation	4 hr/clinic day		6.6	6.6	13.1	0.1		0.3	0.3	0.7
						8.3				
Optometrist					213	1.0				11
Ophthalmologist					73	0.3				4
			(People)	(People)	(People)			(People)	(People)	(People)
Number of optometry exams					1700					85
includes glasses exams			640					32		
diabetic exams			962					48		
other eye exams			98					5		
Number of ophthalmology referrals					243					12
includes diabetic laser			112					6		
cataract surgery				95					5	
trichiasis surgery				36					2	