PRACTICE DEVELOPMENT & QUALITY IMPROVEMENT FRAMEWORK

We are committed to working with primary care and key partners to achieve our vision of healthier communities, empowered individuals and a sustainable primary health care workforce and system.

November 2018

CONTENTS

01: WENTWEST OVERVIEW

Since 2002 WentWest has been part of the western Sydney community, delivering support and education to primary care and working with key partners to progress the region's health system. From 1st July 2015, WentWest incorporated the role of Western Sydney Primary Health Network (WSPHN), this new era has seen WentWest continue to work with its partners to deliver better health outcomes for the region.

VISION

Healthier communities, empowered individuals, sustainable primary health care workforce and system.

MISSION

Working in partnership to lead better system integration and coordination, strengthening equity and empowerment for western Sydney communities and the people who care for them.

WENTWEST'S OPERATING PRINCIPLES

- WentWest supports the provision of person-centred, integrated and coordinated care, reflecting Medical Home Principles;
- WentWest strengthens quality, scope, connectedness and capability in general practice and primary health care;
- WentWest promotes innovation, integration and continuous improvement to increase quality, safety and equity in all health care;
- WentWest enhances health literacy and self-care capabilities for individuals, families and communities;
- WentWest leads the design of locally responsive and equitable services by working with local communities to build on what already exists;
- WentWest works across sectors to influence socioeconomic determination of health;
- WentWest integrates teaching and research into health service planning, delivery and evaluation.

ADDRESSING HEALTH PRIORITIES

In its role as the WSPHN, WentWest is focused on both regional and national health challenges to identify gaps and commission solutions particularly, but not limited to, the priority areas of:

- Aboriginal Health
- Aged Care
- Child and Family
- Chronic Disease
- Mental Health
- Population Health
- Alcohol and Other Drugs

Together, these priorities ultimately address the national PHN priorities of:

- Reduced avoidable hospitalisation
- Reduced avoidable ED presentation
- Improved health outcomes for people with complex chronic conditions

Underpinning these priorities are four health enablers:

- eHealth
- Workforce Planning and Development
- Clinical Pathways
- Principles of the Patient Centred Medical Home (PCMH), together with health professionals and partners from both the health and hospital sector.

QUADRUPLE AIM

Underpinning all that WentWest's delivers is the Quadruple Aim. The Quadruple Aim serves as a template in both the design and evaluation of health interventions and allows WentWest to ensure it is considering the four key elements: Patient Experience; Population Health; Sustainable Costs; and provider wellbeing in all that it undertakes.

02: THE CASE FOR CHANGE

When you're finished changing, you're finished.

BENJAMIN FRANKLIN

Today's health care needs are very different. Three quarters of Australians over the age of 65 have at least one chronic condition, putting them at risk of serious complications and premature death. Nearly a million Australians have been diagnosed with diabetes, however only a quarter get the care that is recommended each year (Swerissen, H., Duckett, S., and Wright, J., 2016, Chronic failure in primary medical care, Grattan Institute). Australians living in western Sydney experience lower socioeconomic status, higher burden of disease and reduced access to health care compared to other parts of Sydney. The burden of disease has shifted to chronic illnesses.

The case for high performing primary care has never been stronger – as repeatedly articulated in international literature and practice. Australian primary care can have a stronger role to prevent and manage chronic disease. The current model of Australian health care focuses on "the diagnosis and treatment of acute episodes of illness by medical practitioners" (Horvath, J. (2014) Review of Medicare Locals, Department of Health).

The components of Australia's health care system "reflect the pattern of illness and medical knowledge of the time that they were established – 40 years ago" (Horvath, J. (2014) Review of Medicare Locals, Department of Health). Primary health organisations and general practices working in partnership have a significant role in evolving and transforming the way health care is delivered.

Quality Improvement extends beyond Continuous Process Improvement (CPI). It requires dedicated attention to change management. A recent McKinsey survey highlighted that setting clear and high aspirations for change was the most significant tactic in organisational transformation. Findings of Annual ProSci Best Practices in Change Management surveys (1998-2016) consistently report that the number one greatest contributor to success was active and visible leadership.

Transforming health care will require sustained effort at all levels of the health system, but what is clear is that there is significant long term international evidence that the way in which primary care development takes place really does matter. WentWest positions itself as a leader; an interpreter, influencer and coach in bridging the gap between policy, strategy and practical implementation of health care change in the community.

03: FOUNDATION FOR CHANGE

THE 10 BUILDING BLOCKS OF HIGH-PERFORMING PRIMARY CARE

BODENHEIMER, T,GHOROB, A, ET AL. THE 10 BUILDING BLOCKS OF HIGH-PERFORMING PRIMARY CARE. ANNALS OF FAMILY MEDICINE 2014: 12:166-171

A conceptual model, that identifies and describes the essential elements of primary care to facilitate high performance. The building blocks include FOUR foundational elements:

Engaged Leadership:

High performing practices have leaders fully engaged in the process of change. Even natural leaders learn the science of how to facilitate organisational transformation.

Data-Driven Improvement:

Monitoring progress towards objectives requires the second building block, data systems that track clinical (e.g. cancer screening and diabetes management), operational (continuity of care and access) and patient experience metrics.

Patient Registration:

Patient registration enables the practice to determine whether each clinician and team has a reasonable balance between patients demand for care and the capacity to provide that care. Patient registration allows practices to adjust the workload among clinicians and teams, and to improve continuity of care.

Team-Based Care:

High-performing practices view teams as a necessity, providing recommended acute, chronic and preventive care. Many exemplar practices have created teams with well-trained non-clinicians who add primary care capacity. Building teams that add capacity is called "sharing the care".

These foundational elements support the implementation of the other six building blocks:

Patient-team partnership: An effective partnership recognises the expertise that patients bring to the medical encounter as well as the evidence based and medical judgment of the clinician and team.

Population management: High-performing practices understand the needs of their patient cohort and design team roles to match those needs.

Continuity of care: Is associated with improved preventive and chronic care, greater patient and clinician experience and lower cost. Practices plan and deliver care outside episodic encounters.

Prompt access to care: Access is closely linked to patient satisfaction and is a prominent objective for many practices. Though the science of access is well-developed, practices frequently fail in their efforts to reduce patient waiting or access to relevant interventions.

Comprehensiveness and care coordination: This refers to the capacity of a practice to provide most of what patients need. Another pillar – care coordination – is the responsibility of primary care to arrange for services that primary care is unable to provide. When a patient's needs go beyond primary care practice's level of comprehensiveness, care coordination is required with the other members of the medical neighbourhood, such as hospitals, pharmacies, and specialists.

Quality General Practice of the Future: The crown of the building blocks is the template of the future. Few practices have achieved this ultimate goal, a daily schedule that does not rely on the 15-minute in-person clinician visit but offers patients a variety of e-visits, telephone encounters, group appointments and visits with other team members. Clinicians would have fewer and longer in-person visits and protected time for e-visits and telephone visits. With a team empowered to share the care, clinicians would be able to assume a new role – clinical leader and mentor of the team.

04: QUALITY IMPROVEMENT

It is not enough to do your best; you must know what to do, and then do your best.

EDWARDS DEMING, 2000

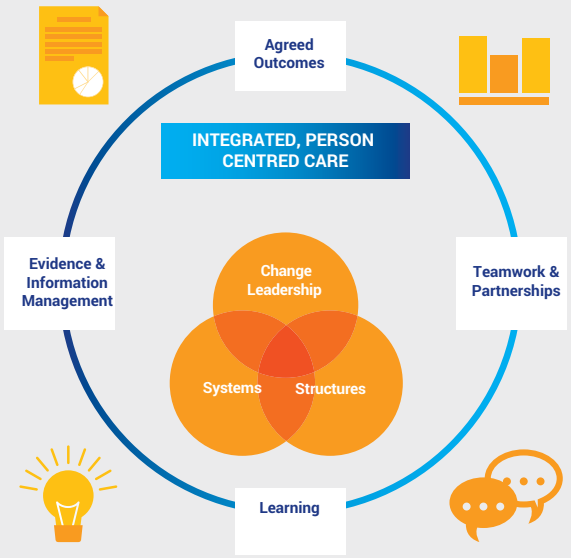
WentWest's approach to quality improvement is deeply rooted in the science of improvement. According to Associates in Process Improvement (Langley GL et al. *The Improvement Guide: A Practical Approach to Enhancing Organisational Performance* (2nd Edition). San Francisco: Jossey-Bass Publishers; 2009) the Science of Improvement "includes the interaction of systems thinking, understanding variation, psychology of change and the theory of knowledge that are applied to improve the performance of processes, products, services, organisations and communities."

WentWest draws upon knowledge from local and international experience and is based upon the principles of thought leaders such as Edwards Deming and Donald Berwick, and leading institutions such as the Institute for Healthcare Improvement (IHI) and Associates in Process Improvement (API).

WentWest works at varying levels across the western Sydney general practice landscape and invests at numerous levels. This work has required a long-term and ongoing investment by GPs and their practices, in partnership with WentWest. The intensity of effort required to transform care cannot be underestimated.

Our **Quality Improvement Framework** as illustrated on page eight, summarises WentWest's approach to quality improvement. **Change Leadership, Systems & Structures** are at the core of supporting and improving capacity in primary care.

QUALITY IMPROVEMENT FRAMEWORK: CHANGE LEADERSHIP, SYSTEMS & STRUCTURES



The Model for Improvement is based on Edwards Deming's work and is a simple yet effective tool for bringing about positive change. It asks three simple questions to establish a clear and succinct "plan" and achieves accelerated change through the implementation of Planning, Do, Study, Act (PDSA) cycles.

In a time of inevitable change in primary care, the demand on PHN support activities increases. Practices are recognising the need for change and are seeking out greater support from WentWest, as they move away from traditional program implementation and strive for practice transformation.

(LANGLEY GL ET AL. THE IMPROVEMENT GUIDE: A PRACTICAL APPROACH TO ENHANCING ORGANISATIONAL PERFORMANCE (2ND EDITION). SAN FRANCISCO: JOSSEY-BASS PUBLISHERS; 2009)

05: OUR APPROACH

Our approach first and foremost is to understand the needs of our community. WentWest as the WSPHN undertake regular Needs Assessments, the outcomes of which support us in developing appropriate programs in response to identified needs.

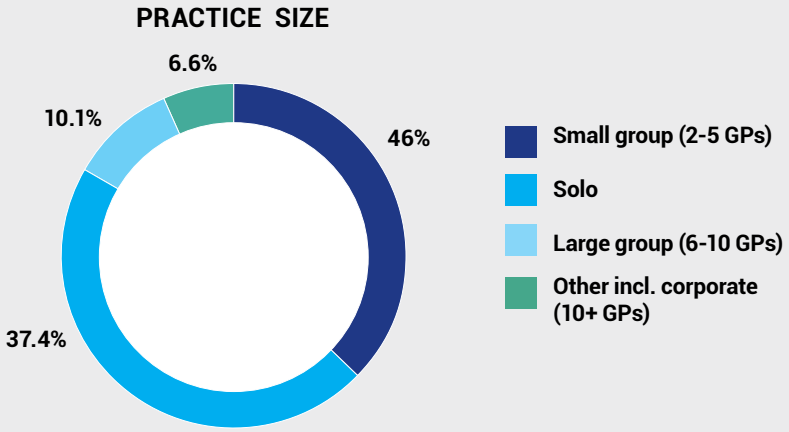
Of equal importance is our partnership with general practice and primary care. This is key to understand the needs and focus of each of the 350+ general practices in our region, as well as the numerous pharmacies and allied health and community health providers. Like our needs assessment, we regularly survey general practice and allied health. It is a combination of these processes and our collective experience working with western Sydney practices i.e. **practice size, workforce capacity, IT infrastructure** that assists us to deliver the **right program at the right time**.

GENERAL PRACTICE COMPOSITION IN WESTERN SYDNEY, 2018

PRACTICE SIZE

Western Sydney practices are diverse and range from small solo GP practices through to larger group practices.

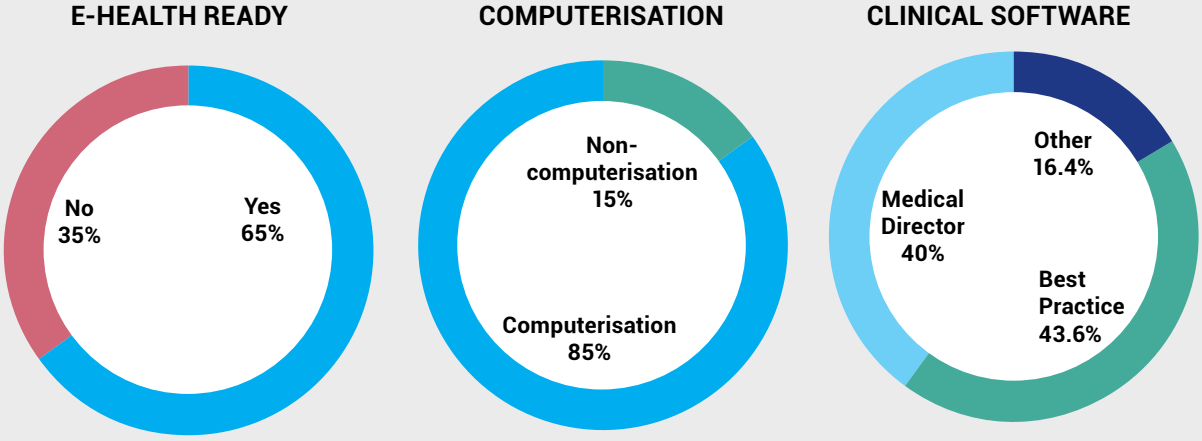
The size of a practice can contribute to their capacity and capability in terms of transformation



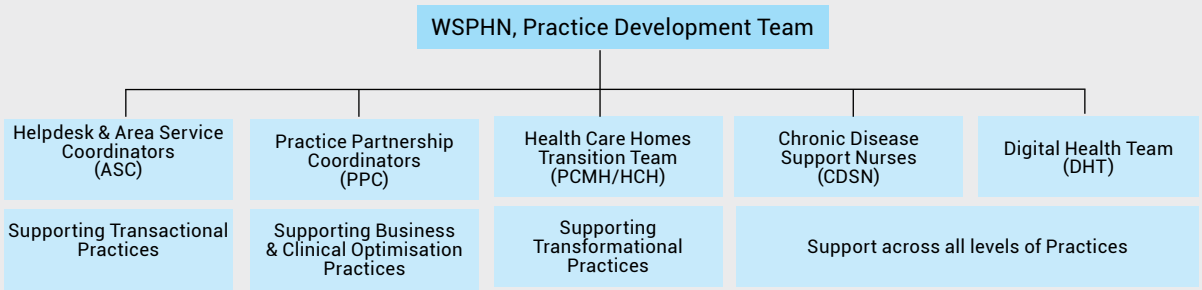
WORKFORCE

GPs	PRACTICE NURSES	PRACTICE MANAGERS
1,254	420	224
GPs – FEMALE	**PRACTICES WITH A NURSE**	**PRACTICES WITH A MANAGER**
50.1%	49.3%	55.9%

IT INFRASTRUCTURE



Our **Practice Development Team**, consisting of both **clinical** and **non-clinical staff**, are high skilled and trained in the WSPHN Quality Improvement Framework & Change Management principles. The Practice Development Team are at the forefront, partnering with GP Principals, business owners and practice staff in **leading for change**.



THE TRANSFORMATION CONTINUUM & IT'S PRACTICE SEGMENTATION

What is transformation? In an organisational context, a process of profound and radical change that orients an organisation in a new direction and takes it to an entirely different level of effectiveness.

Applying our knowledge of practices in western Sydney, we segment them on the **Transformation Continuum** and deploy our **Practice Development Team** accordingly.

TRANSFORMATION CONTINUUM →

TRANSACTIONAL	BUSINESS & CLINICAL OPTIMISATION	TRANSFORMATION
Practice Focus Ad-hoc requests	**Practice Focus** Business & Clinical Operations plans for improvement and adopting the principles of the Patient Centred Medical Home	**Practice Focus** Whole of practice transformation - improved delivery of patient-centric and integrated health services to individuals and their Carers, through a coordinated set of care interventions that ensure the right care is provided in the right place, at the right time.
Practice Current Needs › Business as usual	**Practice Current Needs** › Identifying and driving Quality Improvement Activities › Access to support programs to assist them on their transformation journey	**Practice Current Needs** › Quality Improvement Support › Access to patient support programs and support integrating programs into practice models of care › Workforce development
WSPHN Development Team › WSPHN Helpdesk Support › Area Service Coordinators › Chronic Disease Support Nurses › Digital Health Team	**WSPHN Development Team** › WSPHN Helpdesk Support › Practice Partnership Coordinators › Chronic Disease Support Nurses › Digital Health Team › General Practice Pharmacists › Care Facilitators (WSICP Program)	**WSPHN Development Team** › WSPHN Helpdesk Support › PCMH/HCH Transition Team › Chronic Disease Support Nurses › Digital Health Team › General Practice Pharmacists › Care Facilitators (WSICP Program)

BUSINESS AND CLINICAL SUPPORT PROGRAMS FOR GENERAL PRACTICE

As shown below, practices with a quality improvement focus, adopting and working through the **10 Building Blocks** of High Performing Primary Care, over time develop a greater capacity to adopt the many business and clinical programs available.

TRANSFORMATION CONTINUUM

PROGRAMS AND SERVICES

TRANSACTIONAL	BUSINESS & CLINICAL OPTIMISATION	TRANSFORMATION
General Practice Support › Accreditation › Recalls & Reminders › Staff Training (i.e. infection control, cold chain, sterilisation and spills) › Health Assessments › CDM and Cycles of Care › Practice Incentive Payments	**General Practice Support** › Accreditation › Recalls & Reminders › Staff Training (i.e. infection control, cold chain, sterilisation and spills) › Health Assessments › CDM and Cycles of Care › Practice Incentive Payments › Practice Quality Improvement Plans › PHN Data Dashboards	**General Practice Support** › Accreditation › Recalls & Reminders › Staff Training (i.e. infection control, cold chain, sterilisation and spills) › Health Assessments › CDM and Cycles of Care › Practice Incentive Payments › Practice Quality Improvement Plans › PHN Data Dashboards
Comprehensive Education	**Comprehensive Education**	**Comprehensive Education**
Curriculum Practice Workforce	**Curriculum Practice Workforce**	**Curriculum Practice Workforce**
Digital Health Solutions › PenCS for Data Driven Improvement › TopBar › My Health Record	**Digital Health Solutions** › PenCS for Data Driven Improvement › TopBar › My Health Record › Electronic Shared-Care Planning Tool › Risk Stratification Tool	**Digital Health Solutions** › PenCS for Data Driven Improvement › TopBar › My Health Record › Electronic Shared-Care Planning Tool › Risk Stratification Tool
Mental Health Suite of Services › PMHC (formerly ATAPS) › Patient Self Mx Apps › Clinical Tools i.e. MindGuide	**Mental Health Suite of Services incl. AOD** › PMHC (formerly ATAPS) › Patient Self Mx Apps › Clinical Tools i.e. MindGuide	**Mental Health Suite of Services incl. AOD** › PMHC (formerly ATAPS) › Patient Self Mx Apps › Clinical Tools i.e. MindGuide
HealthPathways	**HealthPathways**	**HealthPathways**
GoShare	**GoShare**	**GoShare**
GP Support Line	**GP Support Line**	**GP Support Line**
Rapid Access Stabilisation Service	**Rapid Access Stabilisation Service**	**Rapid Access Stabilisation Service**
	NSW Data Linkage Project	**NSW Data Linkage Project**
	Integrated Care Program	**Integrated Care Program**
	Specialist Case Conferencing › Diabetes › Cardiology › Respiratory	**Specialist Case Conferencing** › Diabetes › Cardiology › Respiratory
	Integrated Care Program	**Integrated Care Program**
	General Practice Pharmacy Program	**General Practice Pharmacy Program**
	Psychiatric Liaison Service (pilot)	**Psychiatric Liaison Service (pilot)**
		Health Care Homes Trial
		PCMH-A and HCH-A
		Clinical Re-Design Facilitation
		Enhancing Team Based Care
		HealthCare Neighbourhood Mapping
		Community of Practices

06: MEASURING THE EFFECT

WentWest has adopted the Quadruple Aim Framework to contextualise outcomes in our data dashboard. By aligning collected data to the Quadruple Aim, we can ensure that practices are achieving improvements that matter across the entire health ecosystem.

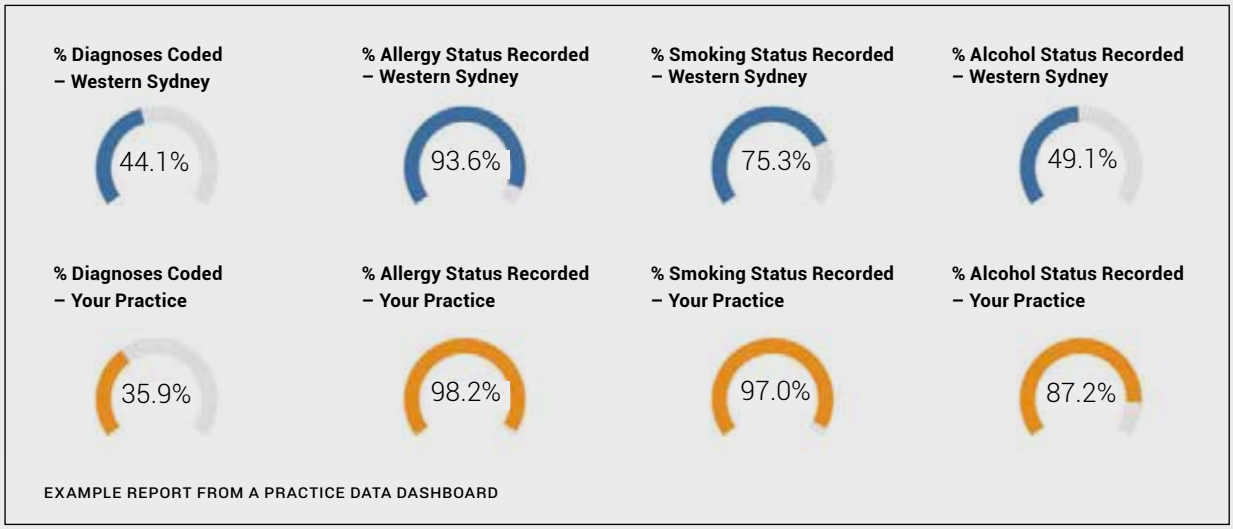
One such way of measuring is the provision of the **Data Dashboard** to practices on a quarterly basis. The Dashboard gives a practice oversight of their Data Quality and Completeness Indicators, patient population and prevalence of disease states. It also serves to assist practices in identifying areas for quality improvement. It is a companion document to the Practice Quality Improvement Plan.

The Practice Data Dashboard is a Qlik Sense Application developed by the WentWest Health Intelligence Unit. The app ingests de-identified, aggregated general practice data extracted by the PenCAT tool, shared with agreement from participating general practices on a monthly basis, from the PATCAT database which is securely governed by WentWest.

The reports produced are based on several sets of indicators including:

- Quadruple Aim
- PCMH Group developed indicators

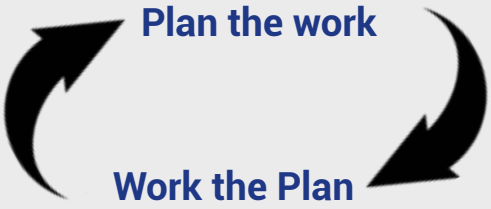
These reports segment patient cohorts based on multiple variables and can be grouped if needed by program type (e.g. Integrated Care, Health Care Homes etc.)



EXAMPLE REPORT FROM A PRACTICE DATA DASHBOARD

PRACTICE QUALITY IMPROVEMENT PLAN

As the name suggests, the Practice Quality Improvement Plan is a tool designed to assist General Practice in identifying key areas for improvement. A living document that clearly outlines the identified activity; person/s responsible for the activity; resources required; and timeframes for review and/or completion of the activity.



STRATEGIC DIRECTION*

STRATEGY 1
Population health – Understanding our community

STRATEGY 2
Ensure high level patient outcomes through access from our Medical Neighbourhood

STRATEGY 3
General Practice and Primary Care Workforce Development

*EXTRACT FROM A PRACTICE QUALITY IMPROVEMENT PLAN

ACTION PLAN*

A course of action that leads to the achievement of goals of an organisation's strategy.

STRATEGY 1 Population Health – Understanding our community

1.1 Identify areas of improvement using the data quality dashboard					
	Ensure the patient's diagnosis is coded correctly	PN, GP	CAT4, Topbar, Best Practice	Quarterly	
	Ensure data quality indicators are in line with the expected percentage	PM	CAT4	Quarterly	
	Ensure COC and HA are completed	GP, PN	Best Practice, Cat4	Ongoing	

*EXTRACT FROM A PRACTICE QUALITY IMPROVEMENT PLAN

In addition to its key role in guiding systematic practice improvements, the Practice Quality Improvement Plan is a valuable tool that assists general practices to meet accreditation requirements.

07: FUTURE DIRECTIONS

The intent of this document is to not only draw on the evidence supporting the case for change in primary care, but to also demonstrate the many ways in which WentWest are supporting general practices in western Sydney on their transformation journey.

Our future goals include:

- Access to real-time data dashboards for practices facilitating increased uptake of the Practice Quality Improvement Plans
- Understanding the patient experience by way of deployment of PROMS and PREMS
- Building effective Healthcare Neighbourhoods
- Building on our Integrated Care Program
- Fostering the changing face of primary care in western Sydney and supporting practices in adopting the 10 building blocks of high performing primary care and the patient centred medical home principles.

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WentWest would like to acknowledge the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We value their culture, identity, and continuing connection to country, waters, kin and community. We would like to acknowledge and give our respect to Elders past, present and future. We are committed to making a valued contribution to the wellbeing of all Aboriginal and Torres Strait Islander peoples.