WAPHA
WA Primary Health Alliance

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Translating national policies into urban and rural state planning:

Commissioning better outcomes

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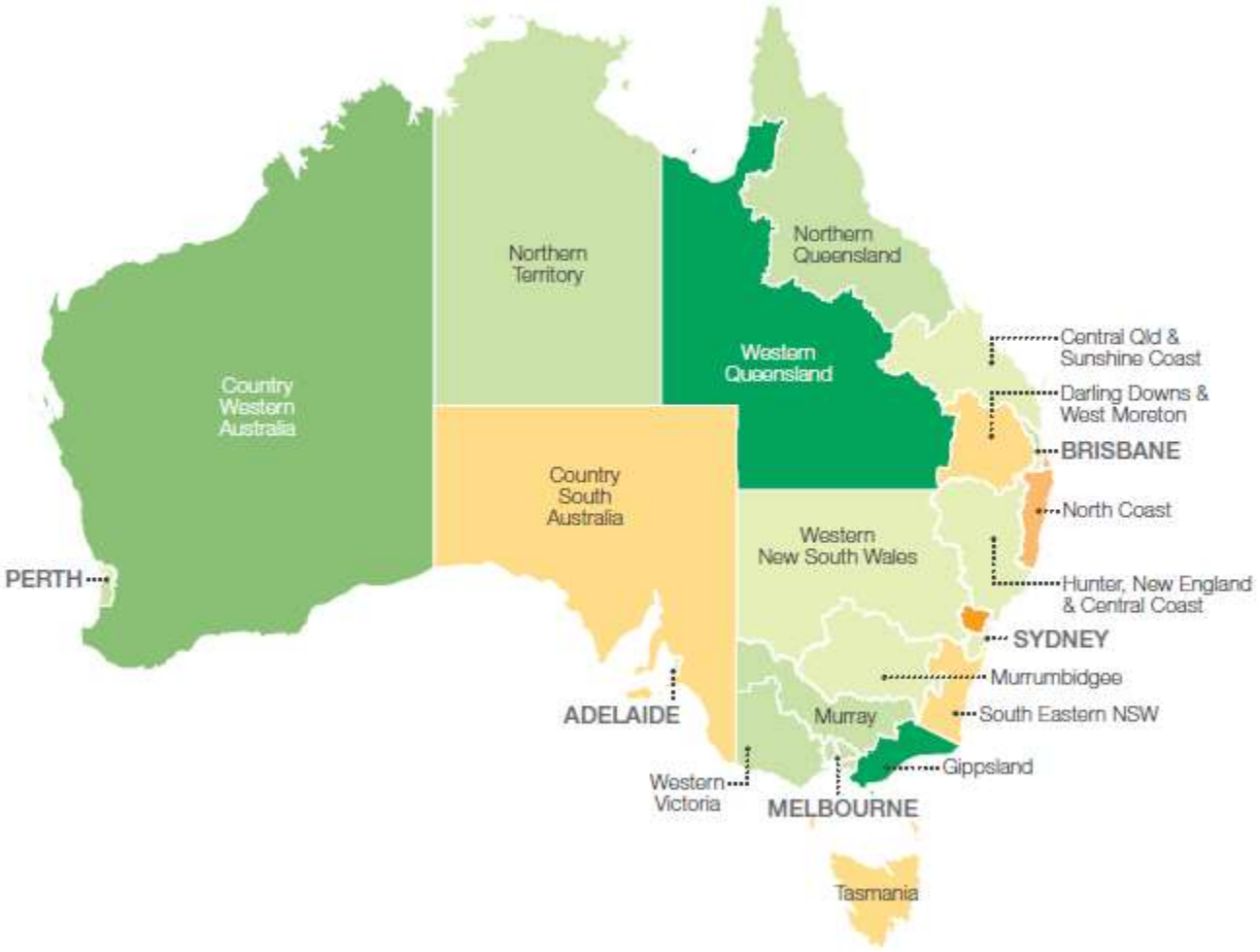
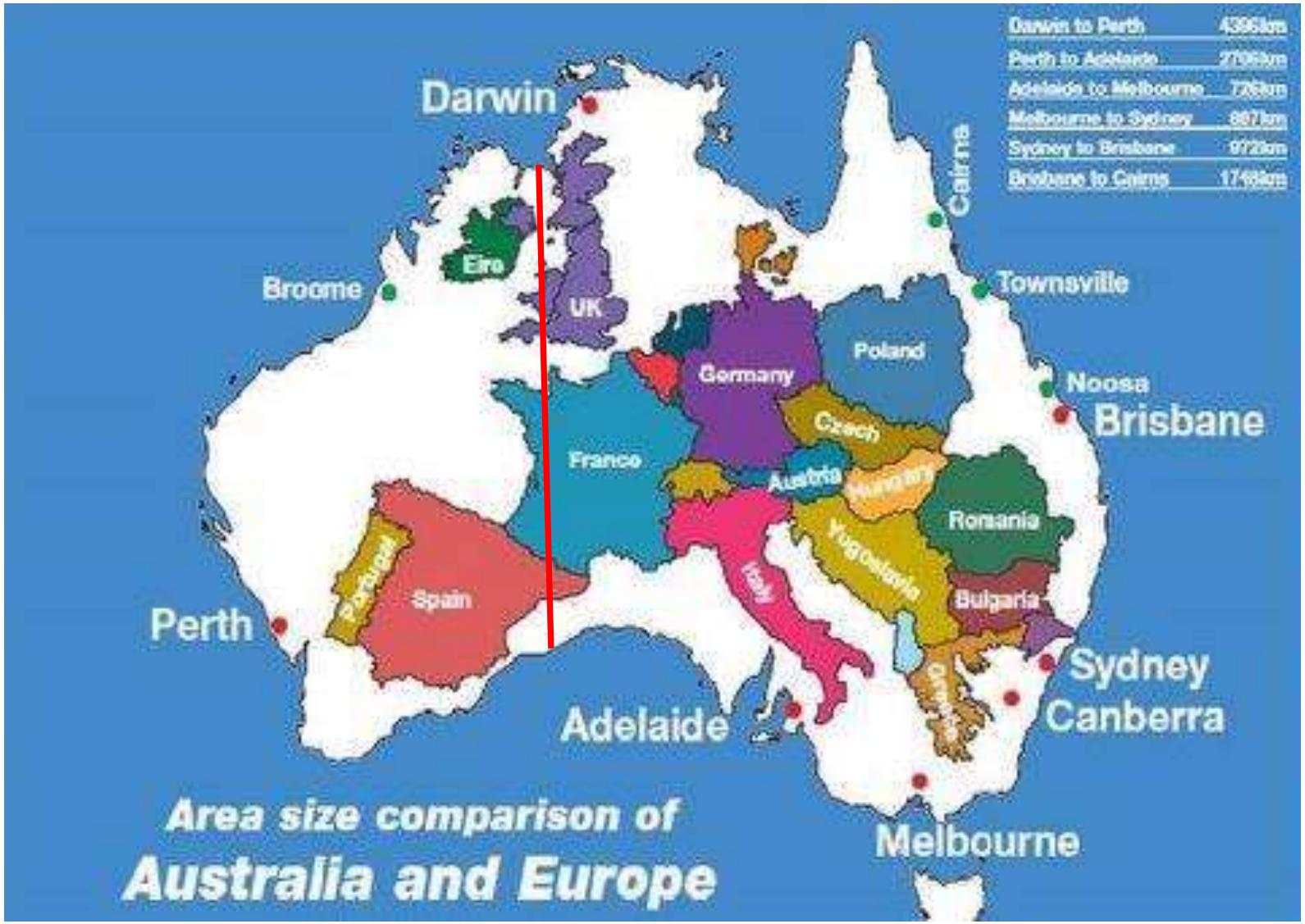
31PHNs, 32 LHNs

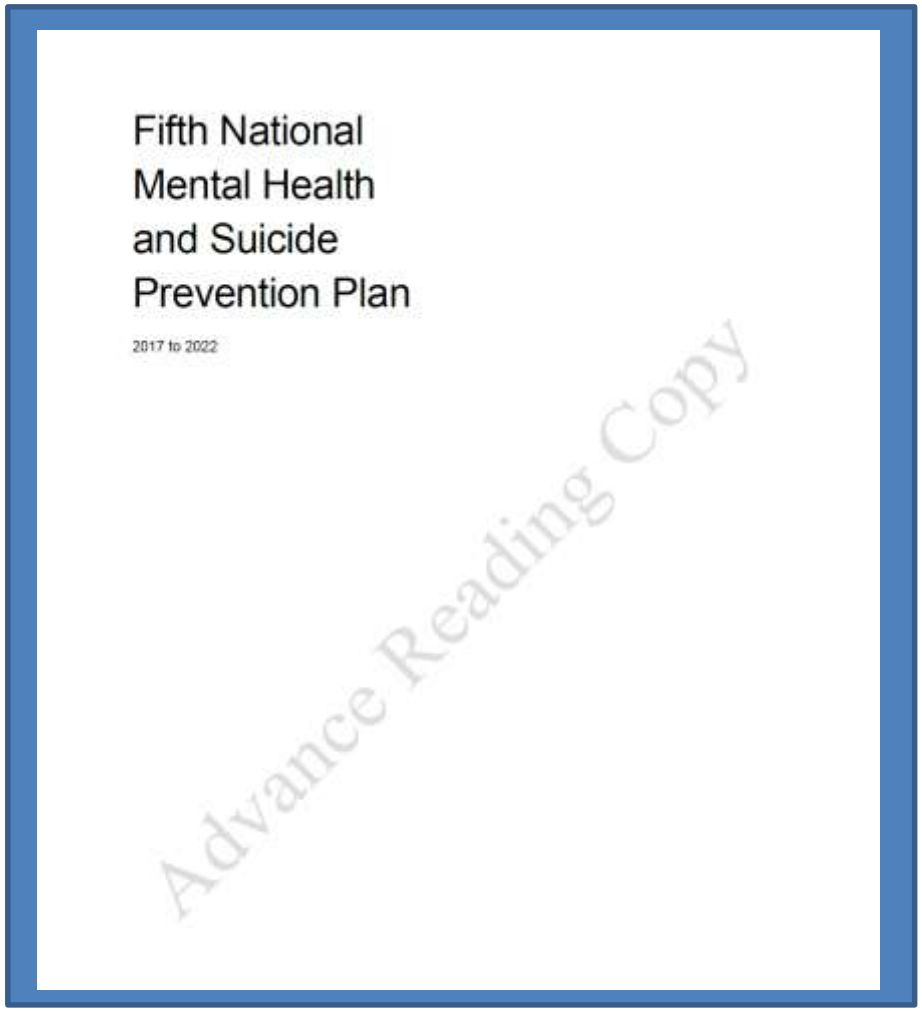



Darwin
Broome
Perth
Adelaide
Melbourne
Sydney
Canberra
Brisbane
Noosa
Townsville
Cairns
Eire
UK
France
Germany
Poland
Czech
Austria
Hungary
Romania
Yugoslavia
Bulgaria
Italy
Spain
Portugal
Darwin to Perth 4396km
Perth to Adelaide 2709km
Adelaide to Melbourne 726km
Melbourne to Sydney 867km
Sydney to Brisbane 972km
Brisbane to Cairns 1749km
Area size comparison of
Australia and Europe

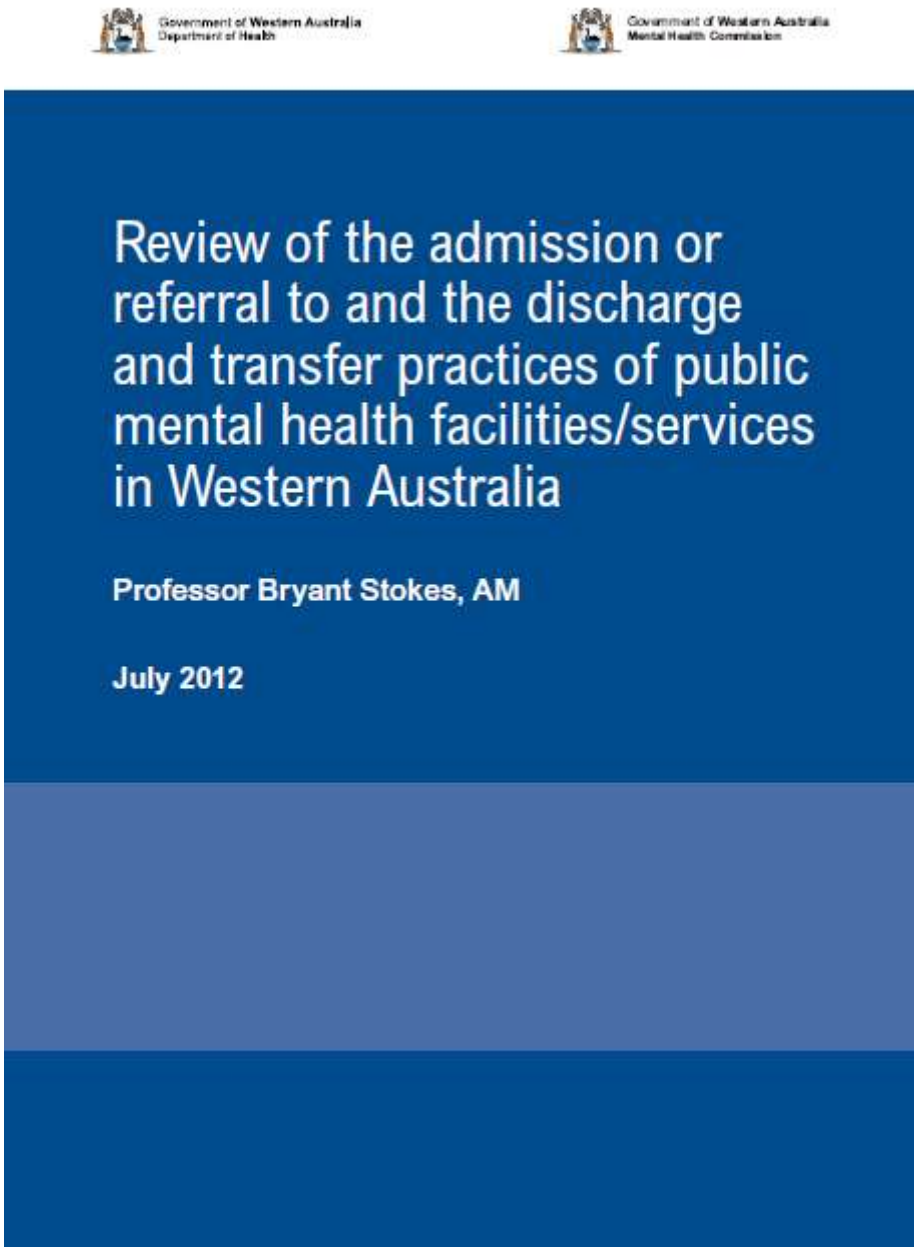
PHN guidance

1. Stepped Care
2. Low Intensity Mental Health Services for Early Intervention
3. Psychological Therapies Provided by Mental Health Professionals to Underserviced Groups
4. Primary Mental Health Care Services for People with Severe Mental Illness
5. Regional Approach to Suicide Prevention
6. Aboriginal and Torres Strait Islander Mental Health Services
7. Child and Youth Mental Health Services
8. Consumer and Carer Engagement and Participation

The “fifth” plan

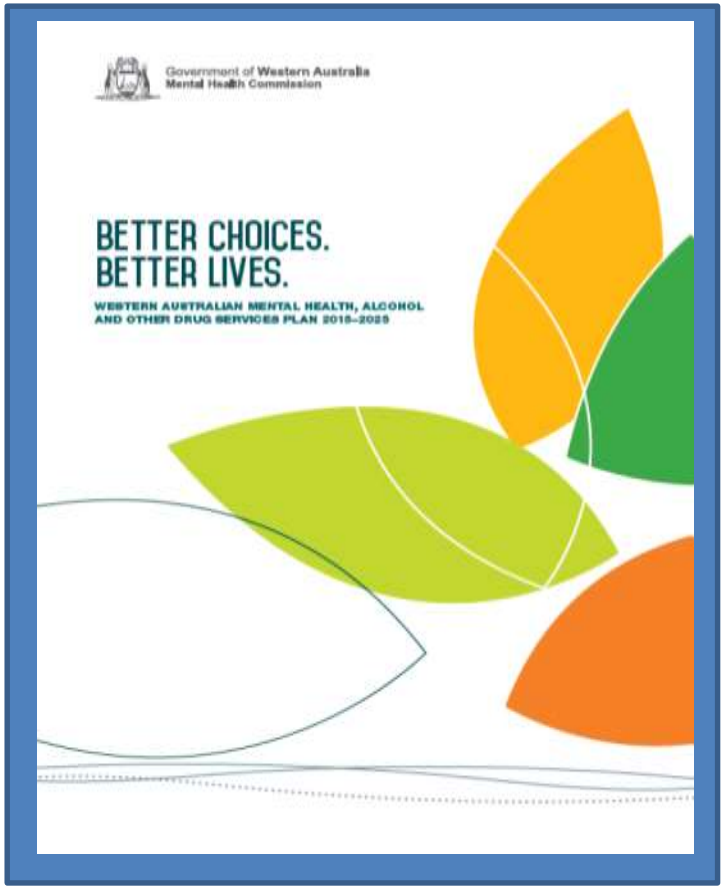


NMHSPF PHN version

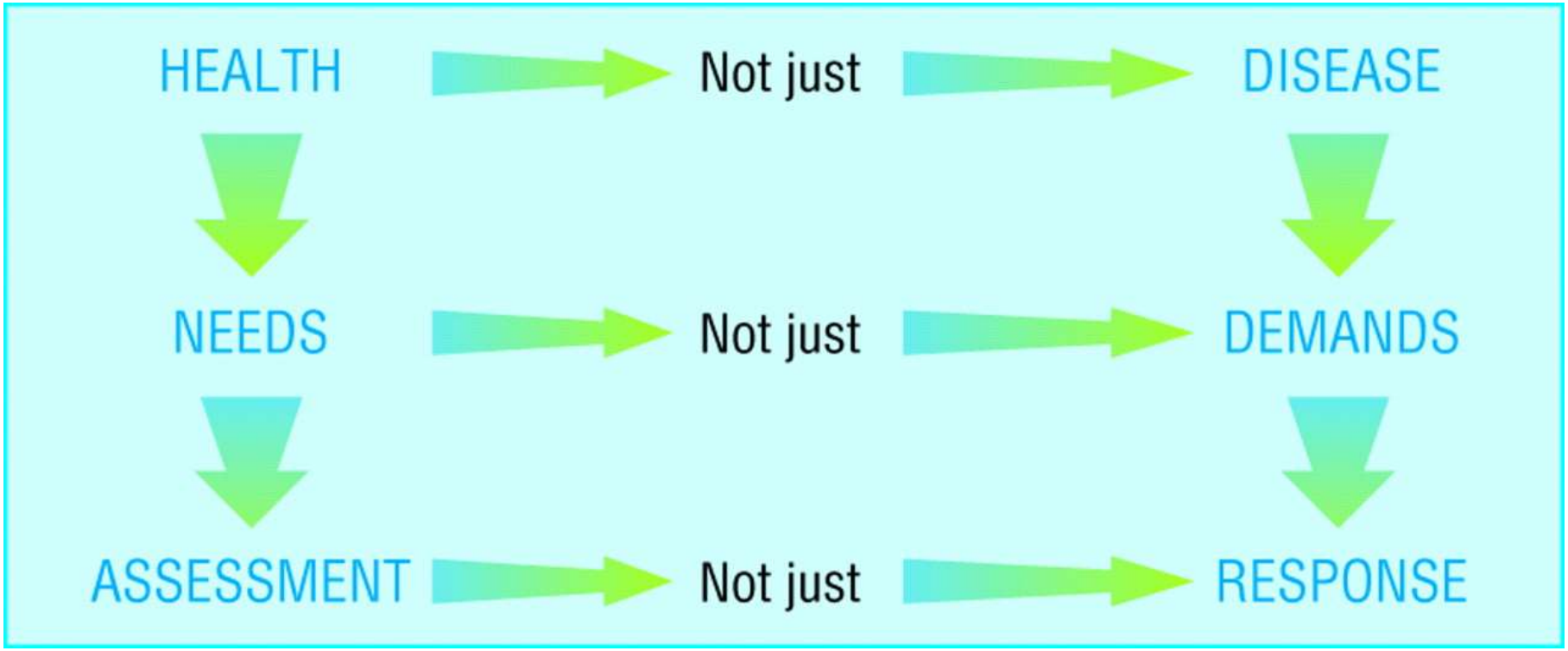


- The integration and alignment of health services so that people in need receive definitive care without delay (i.e. demand is met)

WA MH & SP plan


Government of Western Australia
Mental Health Commission
BETTER CHOICES.
BETTER LIVES.
WESTERN AUSTRALIAN MENTAL HEALTH, ALCOHOL AND OTHER DRUG SERVICES PLAN 2015–2025

Care according to need not identity



Wright J et al. BMJ 1998;316:1310-1313

BMJ

Advance summary

- If we want to improve the service we need to change the system
  - it is the system (and the system conditions), not people, that determine performance.
  - The system causes its own behaviour
- The current health and social service structures (the way we organise the work) focus on economies of scale, but it is economies of flow (end-to-end) that provide value in a health service
- We invest in the wrong things, believing them to the right things
  - Often plausible, but nearly always they create waste, not value

What is required?

- Conceptual clarity
  - purpose
- Contextual anchors
  - policy framework
- Measurement model
  - hierarchical constructs
  - orthogonality
  - parsimony

Goal of care provision

- Place-based self sufficiency (equity v equality)
  - Population-level
  - Person-level

  - SCALE AND SCOPE
    - New platforms (portals)
      - PORTS
      - MH Connext

Place-based versus program-based

- Need to move beyond internal measures “how we are doing”
  - Internal consistency doing the right thing

≠

- External validators requires a system view

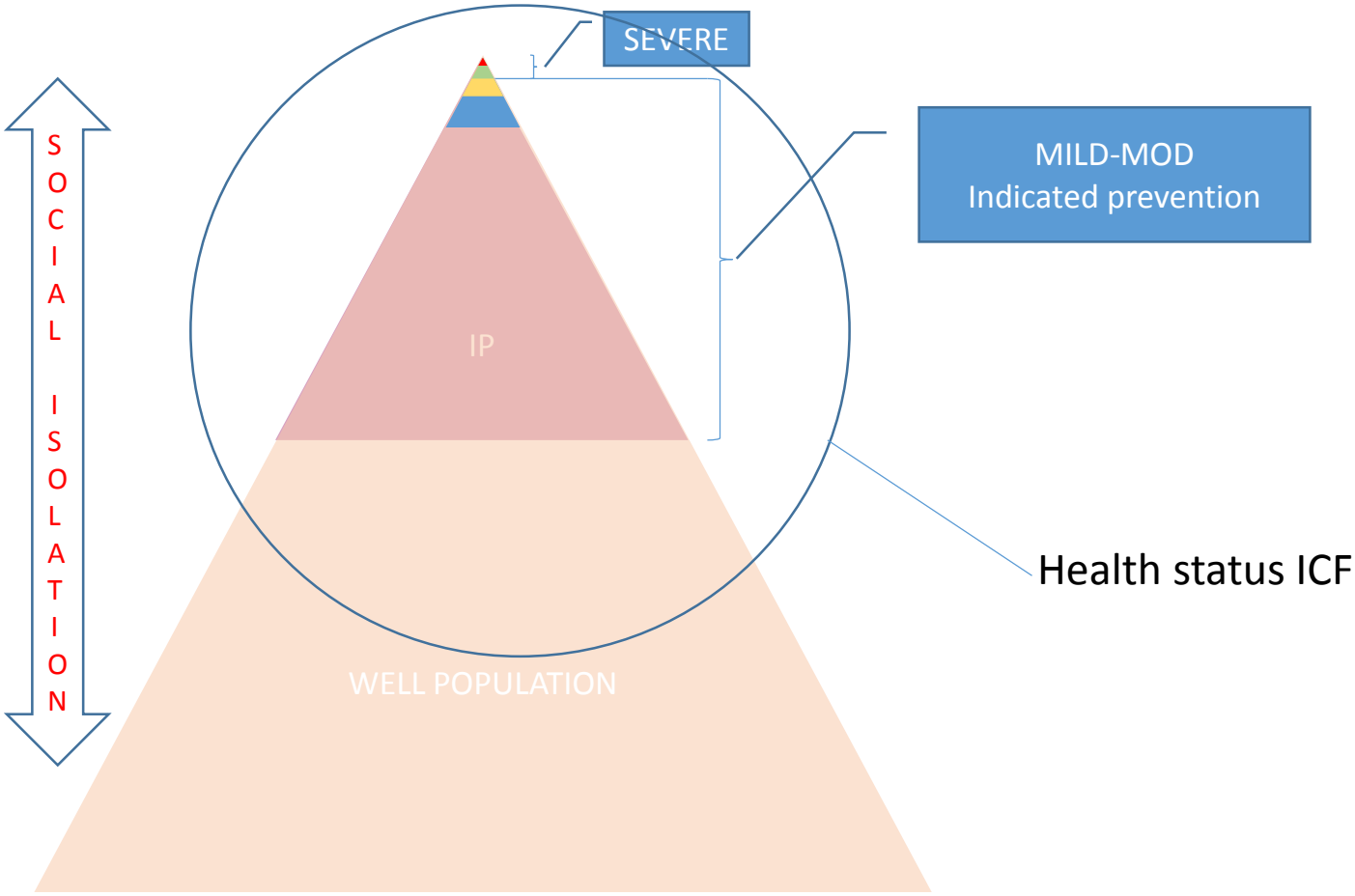
RISK STRATIFICATION

Risk Stratification is one step in the process of facilitating timely provision of appropriate care to people, closer to their home

Risk prediction tools or models in isolation have no impact on health outcomes

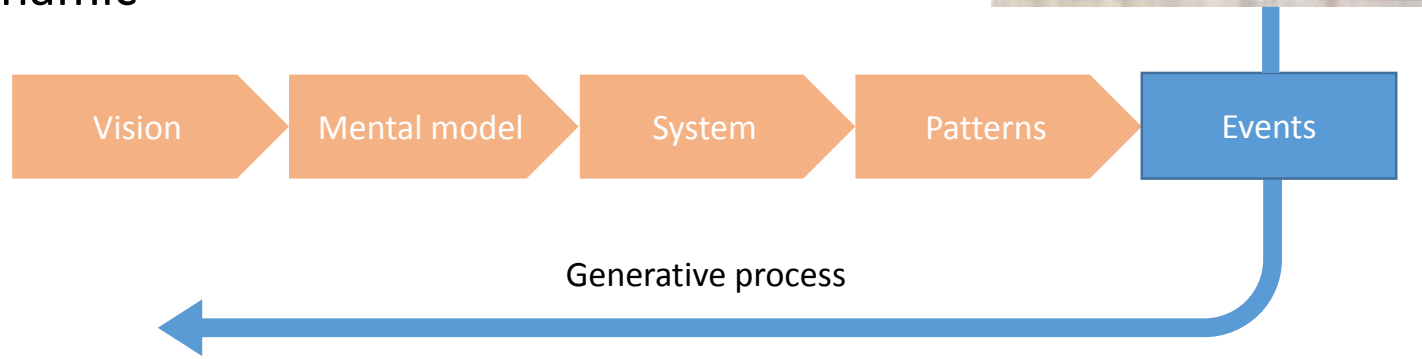
Their effectiveness depends on the interventions performed with identified patients

Haas LR, Takahashi PY, Shah ND, Stroebel RJ, Bernard ME, Finnie DM, et al. Risk-stratification methods for identifying patients for care coordination. The American journal of managed care. 2013;19(9):725-32


SEVERE
MILD-MOD
Indicated prevention
IP
WELL POPULATION
SOCIAL ISOLATION
Health status ICF

Levels of perspective

- Event oriented world
  - Dominates our thinking
  - Is our day-to-day reality
- Masks the underlying system and its dynamic



What essential ingredients are needed to make a palatable primary care pie?

- Treatment (somatic)
- Therapy (psychological)

Universal

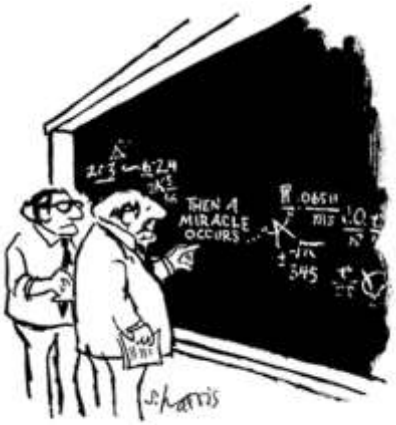
- Community support

Local

Components of care

Goal of PHNs

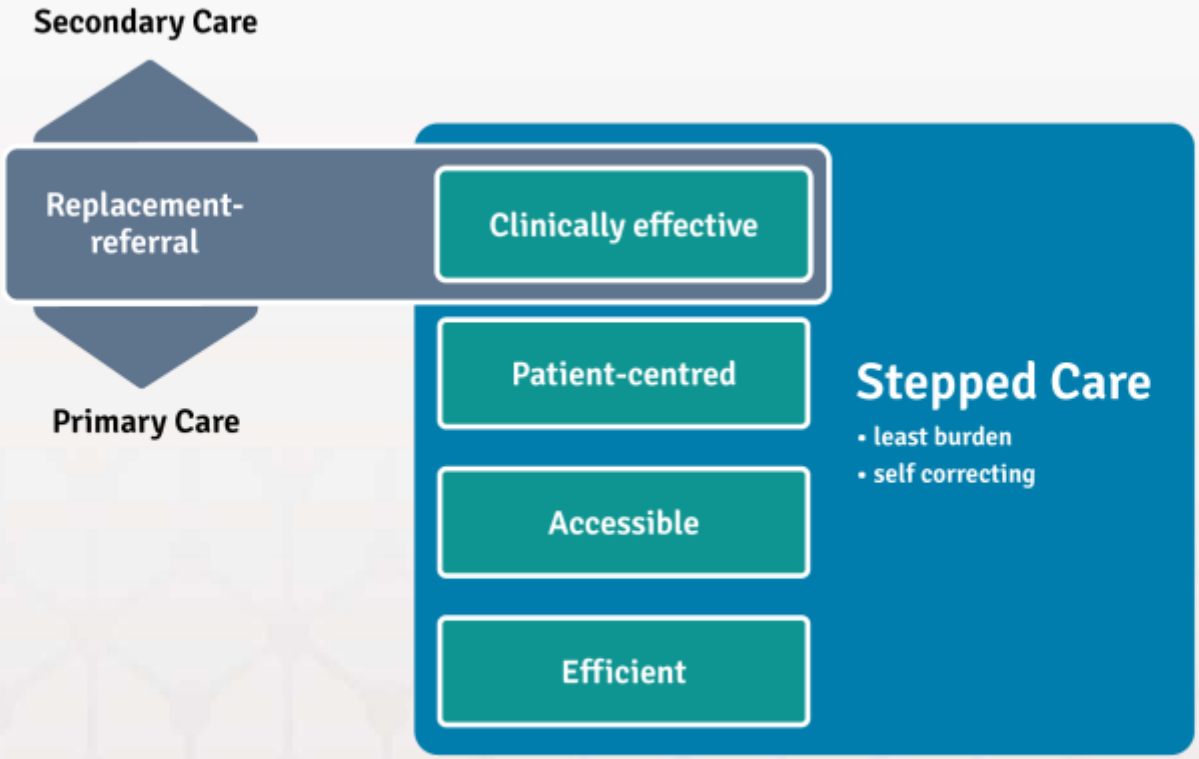
Design and commission a primary healthcare system that will generate the kinds of events – the kind of future – we want.



"I think you should be more explicit here in step two."

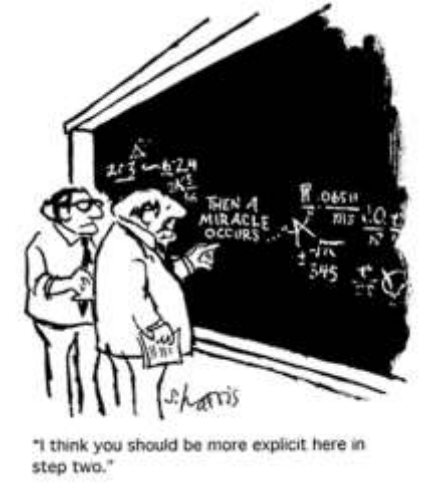
Data drought: Projections NE forecasts NE predictions

“Business as usual” versus “stepped care”



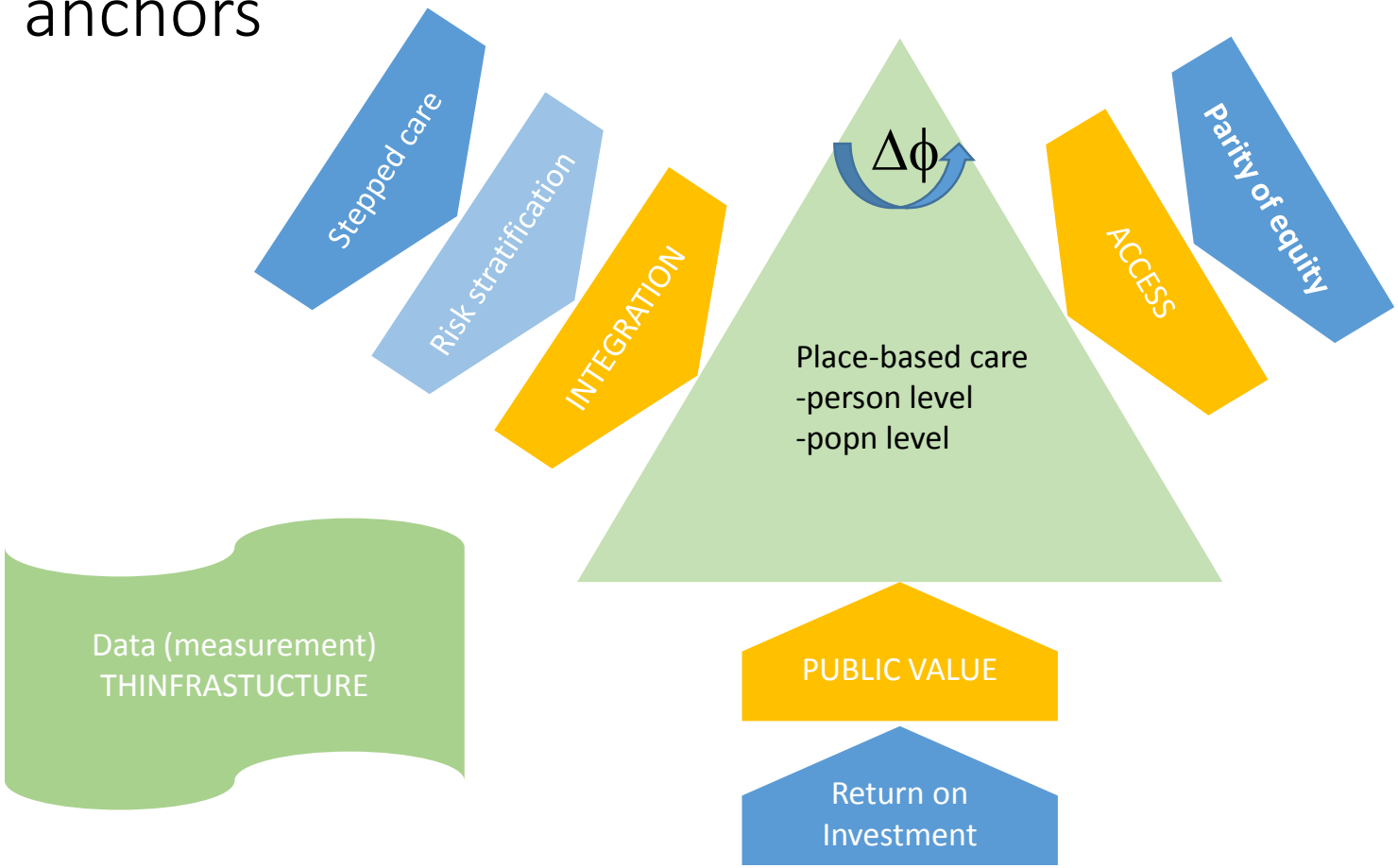
Goal of PHNs

Design and commission a primary healthcare system that will generate the kinds of events – the kind of future – we want.

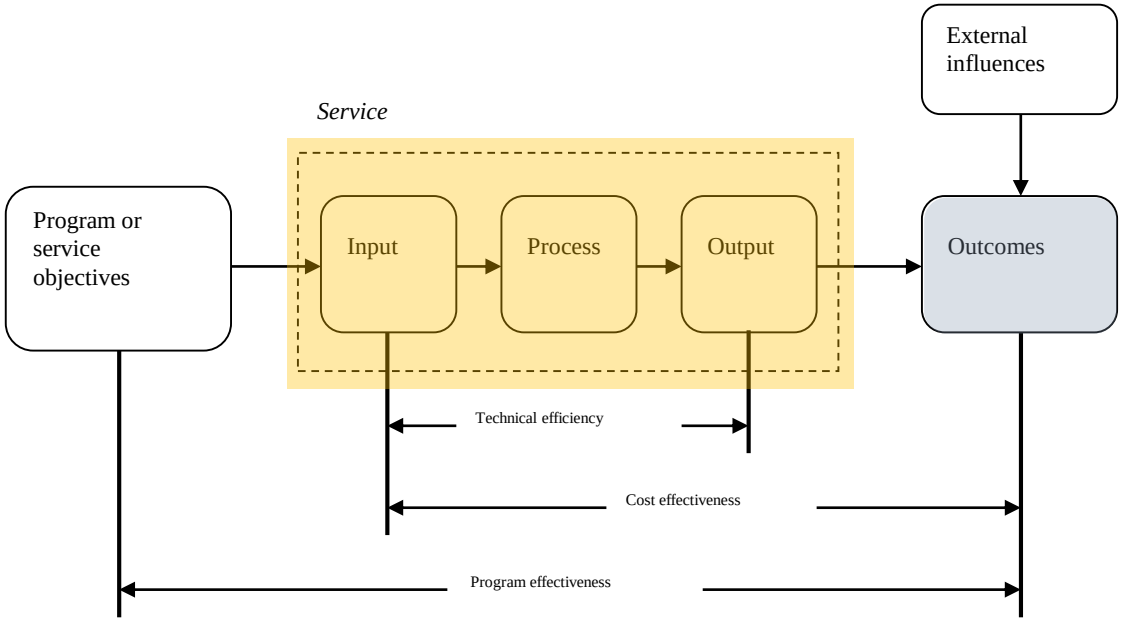


Harding, 2011: Measurement-based care in psychiatric practice: a policy framework for implementation

Contextual anchors



Outcomes

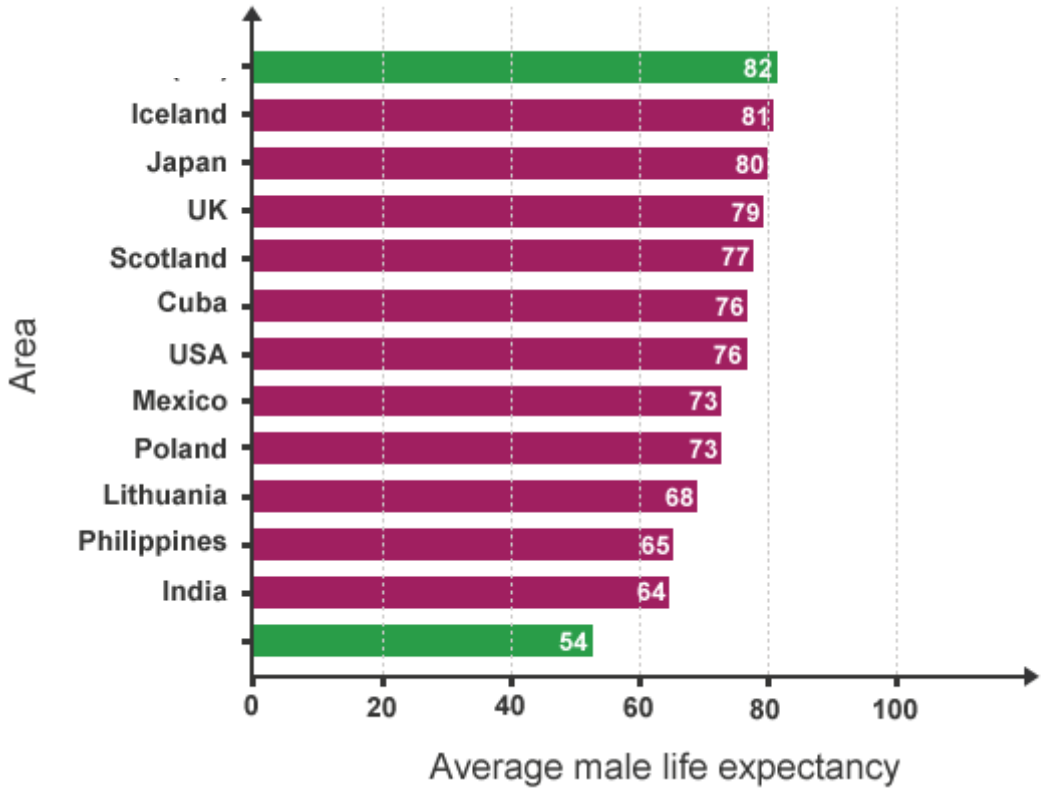

External influences
Service
Program or service objectives
Input
Process
Output
Outcomes
Technical efficiency
Cost effectiveness
Program effectiveness

EUROPEAN ALLIANCE AGAINST DEPRESSION

Hegerl, U., Wittenburg, L., and the European Alliance Against Depression Consortium (2009). The European Alliance Against Depression: A multilevel approach to the prevention of suicidal behavior. Psychiatric Services, 60 (5), 596- 599.

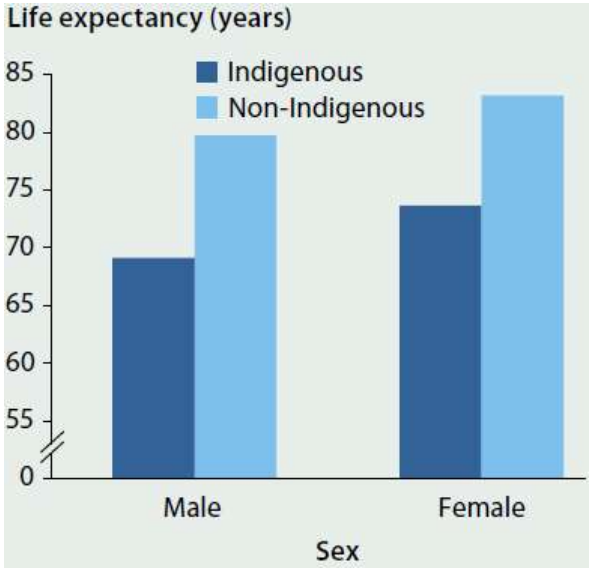
The idea of Place

- Where all meaningful variation occurs – cross sectional and over time
- Where the gradients of relative disadvantage are most keenly recognised/felt
- Where human-scale community is expressed
- Where people live and belong



Source: http://www.bbc.co.uk/education/guides/zspttfr/revision/2

Life expectancy at birth, by Indigenous status and sex, 2010-2012 (*Source:* ABS 2013a)



Source: http://www.aihw.gov.au/indigenous-data/health-performance-framework/

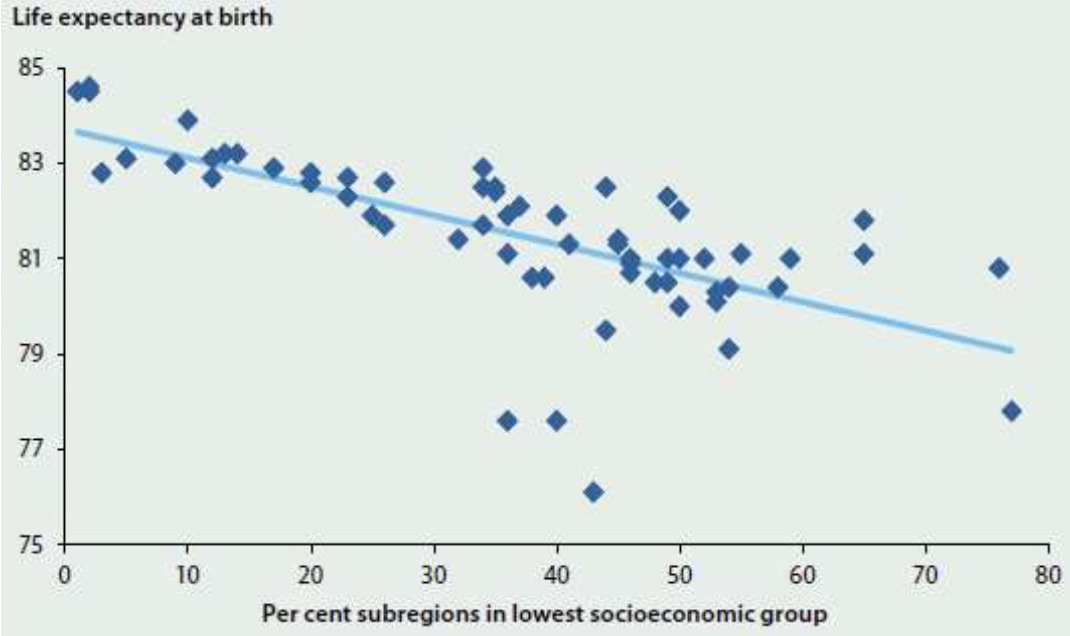
Glasgow Centre for Population Health

- A relatively high percentage of the male deaths in Calton were drug-related or suicides. Excluding the drug-related deaths might raise the estimate to around 58 years; and excluding the suicides as well would raise it to about 59 years.

- The other main causes of deaths of males aged up to 74 in Calton at that time were ischaemic (coronary) heart diseases, alcohol dependence and chronic liver disease, malignant neoplasms (cancers) and diseases of the respiratory system.

Source: http://www.sphsu.mrc.ac.uk/research-programmes/mh/hsco/glasefct.html

Proportion of health subregions in the lowest socioeconomic group and life expectancy at birth, Australia, 2009–2011



Note: Each point represents a Medicare Local administrative health region. These consist of smaller subregions based on ABS Statistical Areas Level 1 (SA1), which were classified using the ABS Index of Relative Socio-economic Disadvantage. The line through the scatterplot is based on regression analysis which has been used to determine the best fit through the observed data.

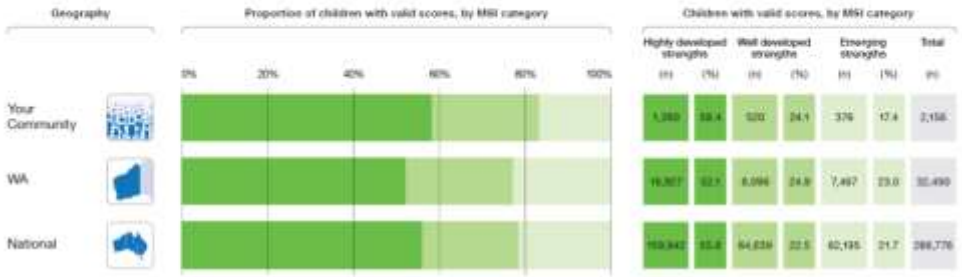
Source: National Health Priority Areas 2013, based on ABS Causes of Death and Life Tables 2009–2011


A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE
UPSTREAM
DOWNSTREAM
SOCIAL INEQUITIES
Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation
INSTITUTIONAL INEQUITIES
Corporations & Businesses
Government Agencies
Schools
Laws & Regulations
Not-for-Profit Organizations
LIVING CONDITIONS
Physical Environment
Land Use
Transportation
Housing
Residential Segregation
Exposure to Toxins
Economic & Work Environment
Employment
Income
Retail Businesses
Occupational Hazards
Social Environment
Experience of Class, Racism, Gender, Immigration
Culture - Ads - Media
Violence
Service Environment
Health Care
Education
Social Services
RISK BEHAVIORS
Smoking
Poor Nutrition
Low Physical Activity
Violence
Alcohol & Other Drugs
Sexual Behavior
DISEASE & INJURY
Communicable Disease
Chronic Disease
Injury (Intentional & Unintentional)
MORTALITY
Infant Mortality
Life Expectancy
Strategic Partnerships Advocacy
Community Capacity Building
Community Organizing
Civic Engagement
Individual Health Education
Health Care
Case Management
POLICY
Emerging Public Health Practice
Current Public Health Practice

Multiple Strength Indicator 2015

AEDC Community Summary for **Joondalup, WA**

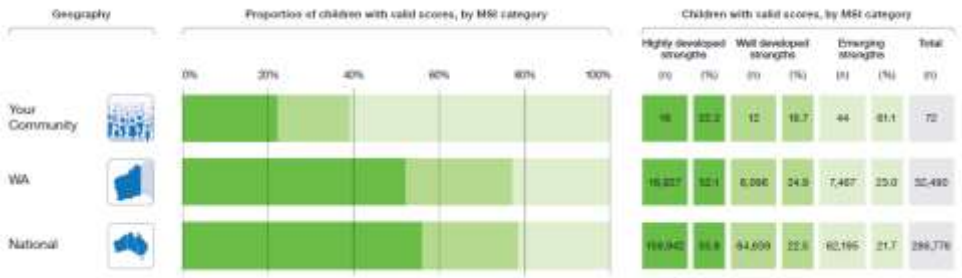
The Multiple Strength Indicator (MSI) is a summary indicator that measures developmental strengths in social and emotional development such as self-control, pro-social skills, respectful behaviour towards peers, teachers and property, and curiosity about the world. The indicator also includes children who have advanced literacy skills, a particular interest in reading, numeracy and memory, and very good communication skills.

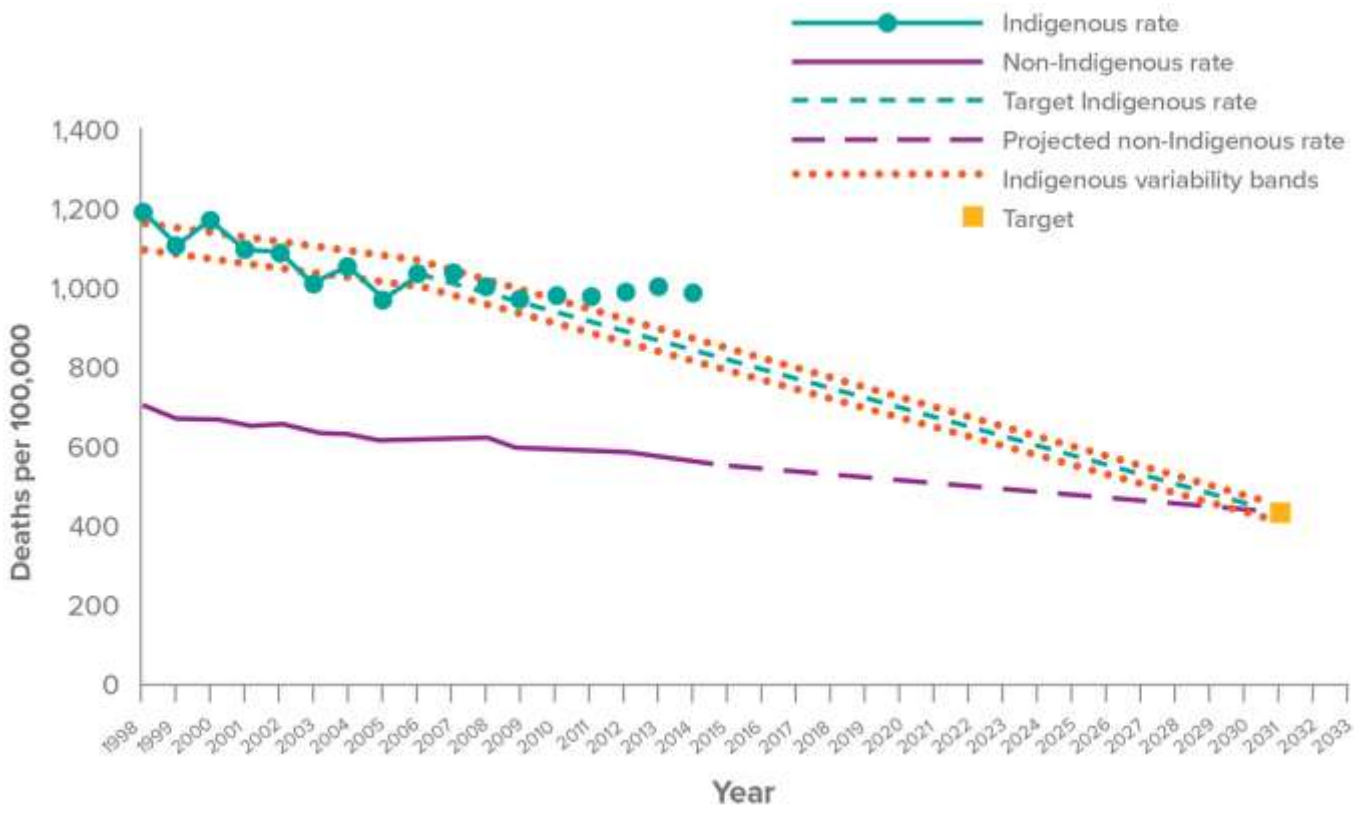


Multiple Strength Indicator 2015

AEDC Community Summary for **Halls Creek, WA**

The Multiple Strength Indicator (MSI) is a summary indicator that measures developmental strengths in social and emotional development such as self-control, pro-social skills, respectful behaviour towards peers, teachers and property, and curiosity about the world. The indicator also includes children who have advanced literacy skills, a particular interest in reading, numeracy and memory, and very good communication skills.

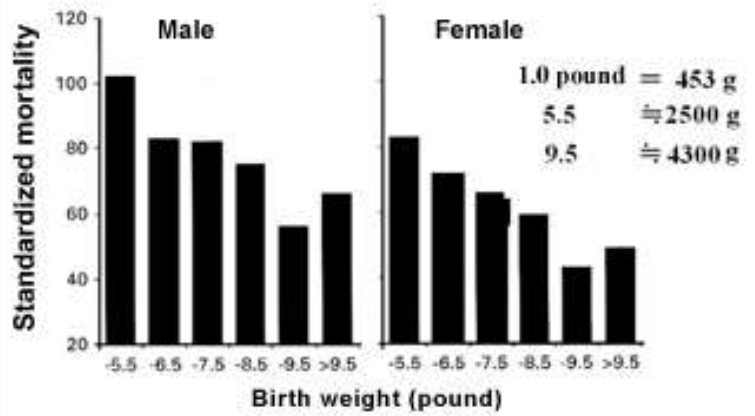




Source: Department of the Prime Minister and Cabinet, *Closing the Gap Prime Minister's Report 2016*, Commonwealth of Australia, Canberra 2016

Foetal Origins of Adult Disease (FOAD)

Correlation between birth weight and mortality from ischemic heart disease



Modified from *Osmond C. D. Barker, BMJ 307: 1519, 1993*

Diseases clearly linked to birth weight

1) Ischemic heart disease
2) Type 2 diabetes
3) Hypertension
4) Metabolic syndrome
5) Cerebral infarction
6) Dyslipidemia
7) Neurodevelopmental abnormality

Modified from *de Boo HA and JE Harding, Austral New Zealand J Obstet Gynecol. 2006; 46: 4-14*

DISEASES AND DISORDERS OF ADULTS

Disease/Disorder

- Coronary Artery Disease
- Liver Disease or jaundice
- Skeletal Fractures
- Chronic Obstructive Lung Disease (Chronic bronchitis or emphysema)
- Auto immune disease
- Somatic symptoms with unknown medical etiology
- Depression and suicide attempts
- Hallucinations
- Prescriptions for anti depressants, anti psychotics, anti anxiolytics
- Impaired memory of childhood
- Cancer
- Premature death

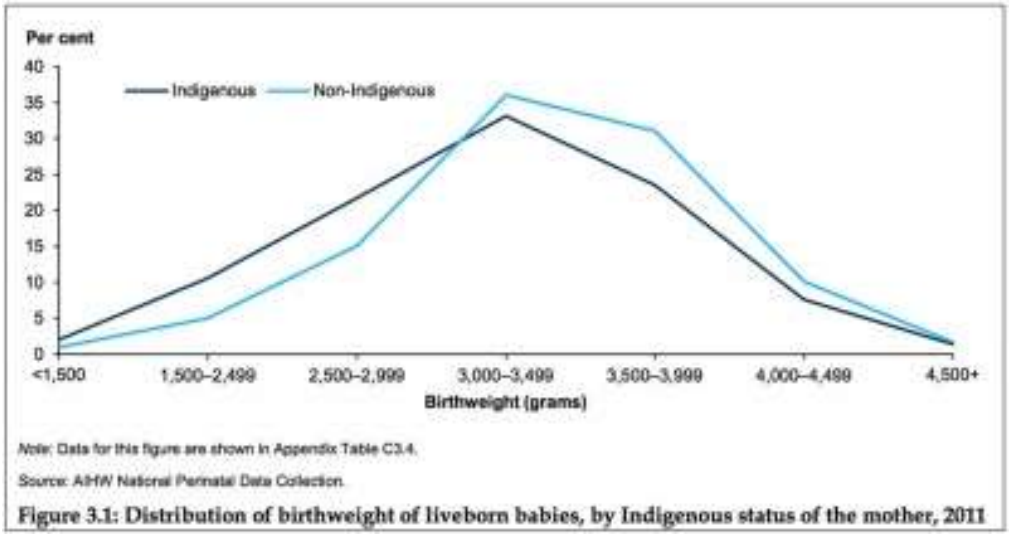
Health Threatening Behaviour

- Obesity
- Smoking
- Alcoholism
- Married an alcoholic
- Injection related drug abuse
- Multiple sexual partners
- Intercourse by 15
- Teenage pregnancy and abortion
- Teenage Paternity
- Physical inactivity

Low Educational Achievement

- Poor self-rated job performance
- Absenteeism (>/= 2 days a month
- Serious financial Problems
- Serious job problems

Felitti VJ, Anda RF et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. Am J Pres Med 1998;14(4) 245-258.



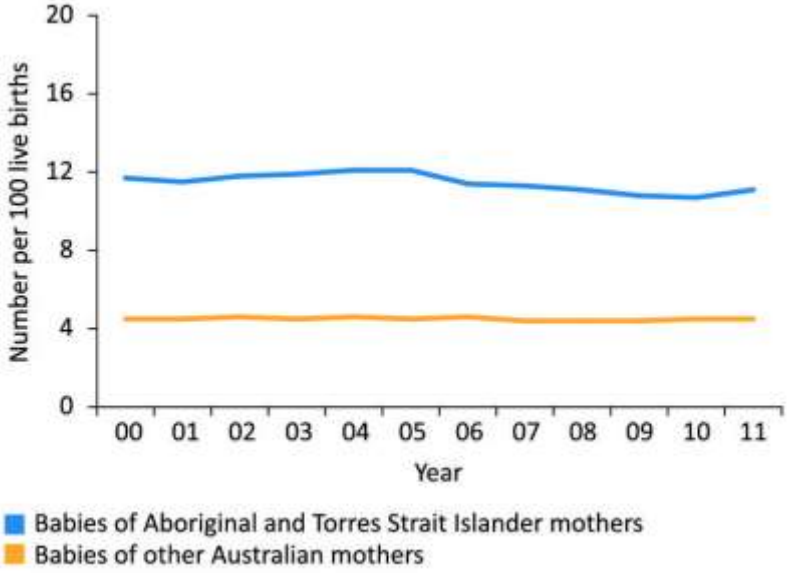
Note: Data for this figure are shown in Appendix Table C3.4.

Source: AIHW National Perinatal Data Collection.

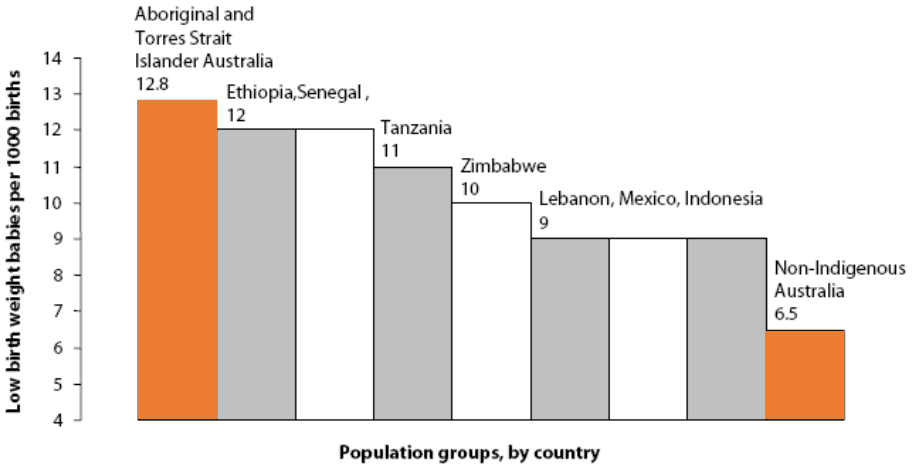
Figure 3.1: Distribution of birthweight of liveborn babies, by Indigenous status of the mother, 2011

Source:. Birthweight of babies born to Indigenous mothers. AIHW 2014 Cat. no. IHW 138. Canberra

Low Birth Weight



Source: Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report

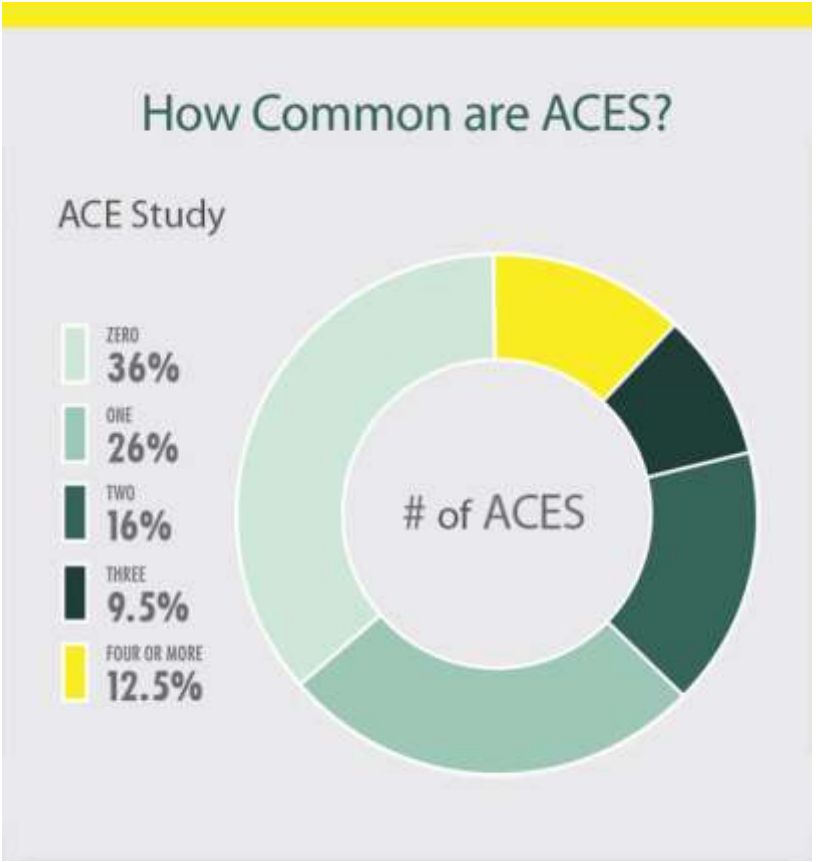


Source: Social Justice Report 2003: Appendix one: A statistical overview of Aboriginal and Torres Strait Islander peoples in Australia

Adverse childhood experiences (ACEs)

(ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being.

These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian.



Source: https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html

Developing the evidence base

- Taking an evidence based approach means finding the best possible evidence
  - It does *not* mean
    - relying on or privileging only one kind of evidence
    - there is only one hierarchy of evidence

- The strength of evidence, on its own, is not sufficient
    - solutions cannot be universally applied to all contexts
    - salience and the extent to which evidence is transferable must be considered
    - The causes and dynamics whereby different groups respond differentially to health initiatives, and the ways in which health damaging effects operate need to be specified
    - The “causes of the causes” are located in the lifecourse and lifeworlds of individuals and their interactions

- Explicate bias
    - All science is socially constructed and therefore subject to bias
    - Acknowledge this fact and seek to make biases explicit

Evidence does not equal action

- Evidence into action requires different players
  - Players do not necessarily inter-relate

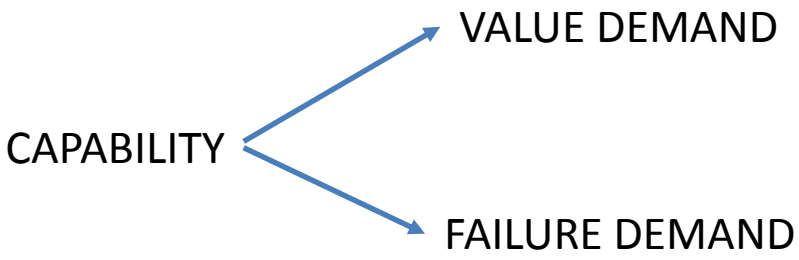
    or if the do
  - It will not be in a linear or even cyclical fashion

  - More likely they inter-relate in iterative and uneven ways, which involve elements of
    - knowledge transfer
    - political process
    - opportunism
    - serendipity
    - power influence

Source: Kelly MP, Morgan A, Bonnefoy J, Butt J, Bergman V. The social determinants of health: developing an evidence base for political action. 2007

Work and waste

- Organisational capability = work + waste
  - Work = value demand: met need
  - Waste = failure demand: unmet need



Integration

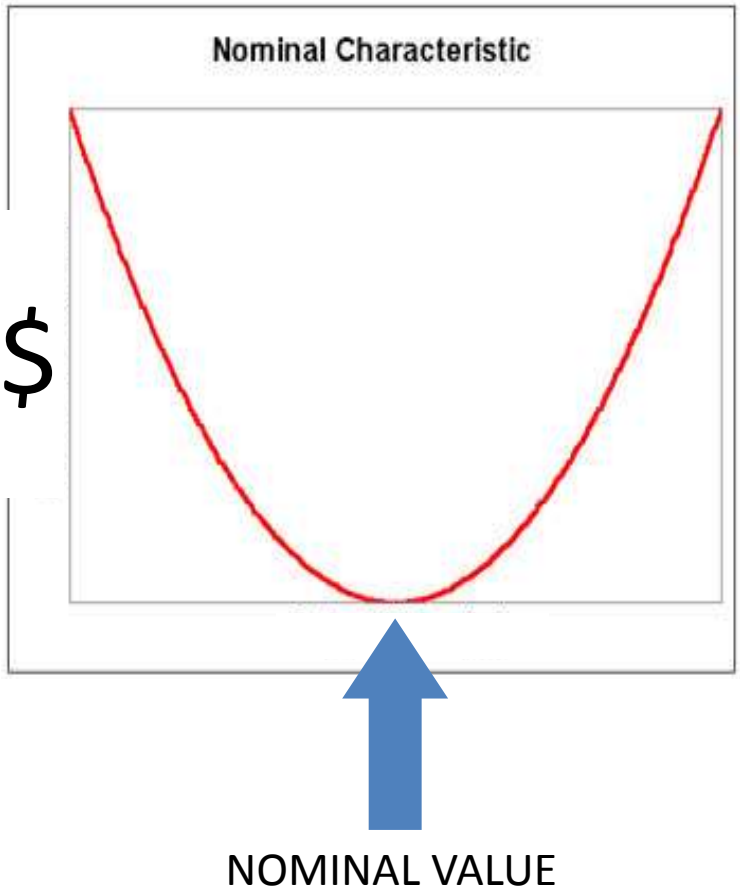
- **providing person-centred care** (placing the patients requirements at the centre of organisational and clinical decision making),
- **reducing clinical variance** (including the elimination of multiple ad hoc processes),
- **organising the care continuum** (including the provision of enhanced decision support and information sharing),
- **process improvement and removing duplication** (especially procedural duplication, such as re-triaging, referral),

Organising the care continuum

- We focus on scale, when we need to focus on flow

  - people view the systems performance as the “sum of waits” – delay, inaction, failure to meet need – and so they should, as should we

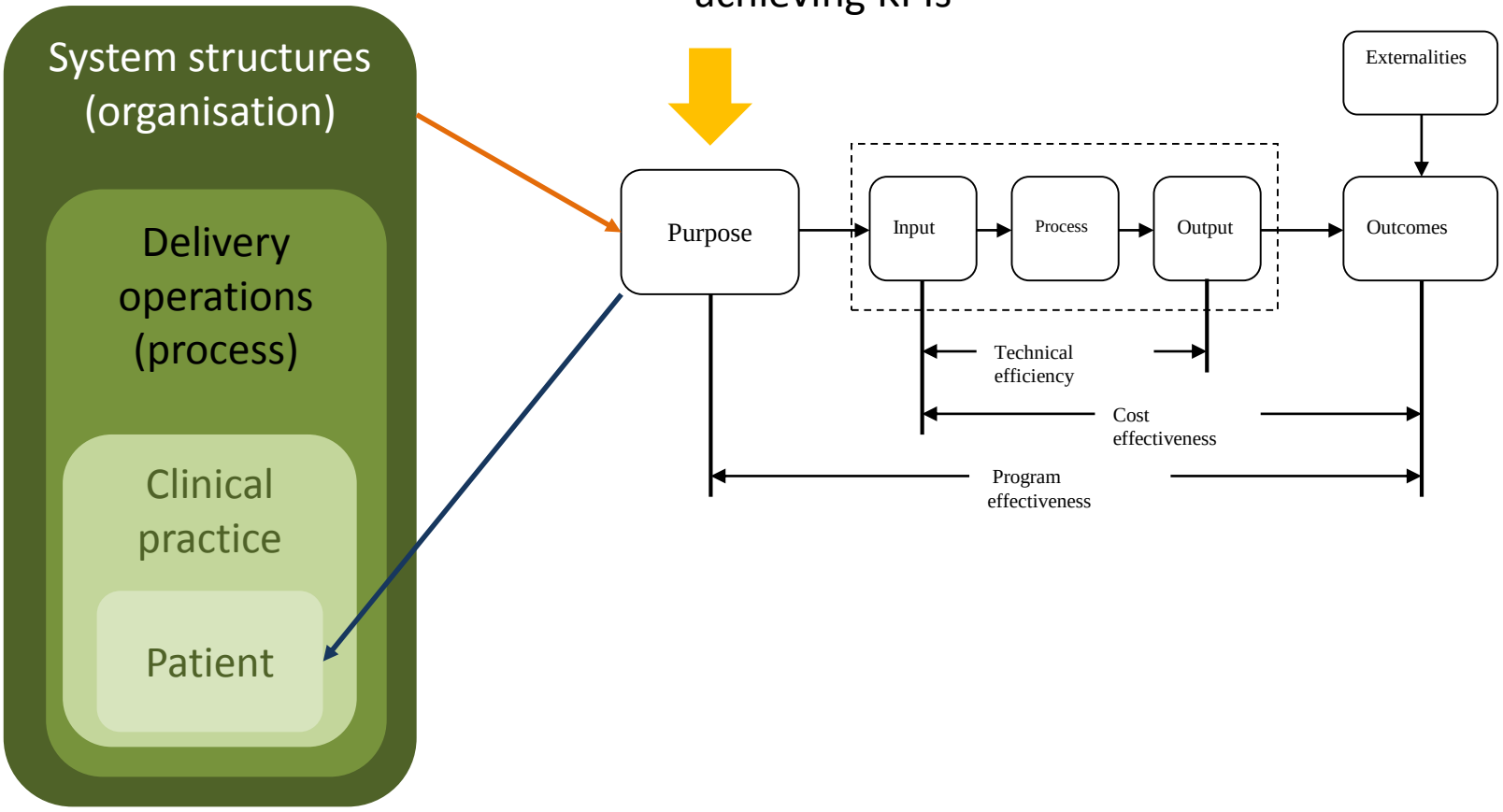
Who's value?



- In healthcare organisations it is the patient who sets the nominal value
- A healthcare organisation should be designed for patients to "pull" or recoup value from the system – have their needs met without delay
- Do this and costs fall

Purpose is inverted, and derived from the system structure

- meeting targets
- achieving KPIs



Command and control

	BUREAUCRATIC THINKING
PERSPECTIVE	Top down, hierarchical
DESIGN	Functional specialisation
DECISION-MAKING	Separated from work
MEASUREMENT	Outputs, targets, standards, budgetary
ATTITUDE TO CUSTOMERS	Contractual
ATTITUDE TO OTHERS	Contractual
ROLE OF MANAGMENT	Manage people and budgets (resources)
ETHOS	Control
CHANGE MANAGEMENT	Reactive, projects
MOTIVATION	Extrinsic

- Staff seem unmotivated and uninterested in their work
- Workforce lack the skills and knowledge to adjust to new jobs
- People do what they are told to do, but “cheat” to make work easier
- Communication is lacking
- Teams argue, get into jurisdictional “disputes”, and pull up the drawbridge

Built in demand failure

- Badged as “solutions”
- Hard wired and difficult to remove
- Potent system constraints
- Take the value out of work

From program to place based

- Improvement efforts should focus on systems, processes, and methods, not on individual workers. Those efforts that focus on improving the attentiveness, carefulness, speed, etc., of individual workers — without changing the systems, processes, and methods — constitute a low-yield strategy with negligible short-term results

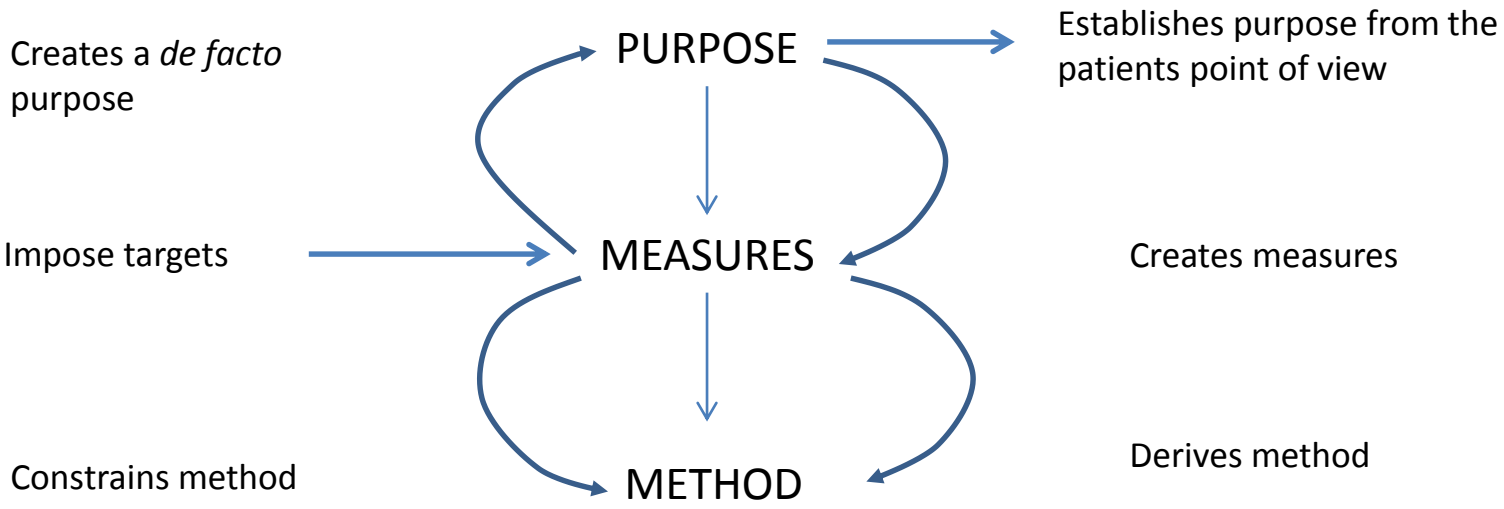
  - Scholtes “Total quality or performance appraisal: choose one” (2005)

	SYSTEMS THINKING
PERSPECTIVE	Outside in, system
DESIGN	Demand, value, and flow
DECISION-MAKING	Integrated with work
MEASUREMENT	Capability, variation, related to purpose
ATTITUDE TO CUSTOMERS	Set normative value
ATTITUDE TO OTHERS	Cooperative
ROLE OF MANAGMENT	Act on the system
ETHOS	Learning
CHANGE MANAGEMENT	Adaptive, emergent, integral
MOTIVATION	Intrinsic

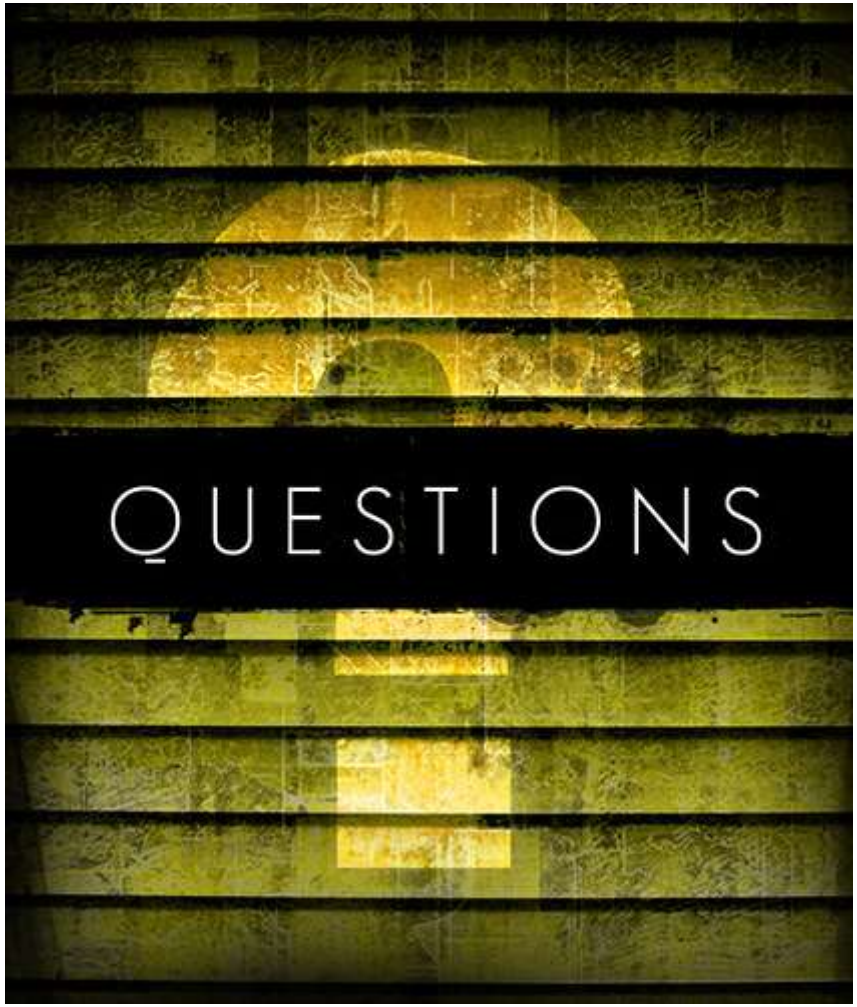
- *A system must have an aim, without an aim there is no system*
  - Deming

CONTROL and COMMAND THINKING

SYSTEMS THINKING



Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it.


QUESTIONS