Primary Health Care

The Winds of Change

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Photographs: Nicole Harwood, Health Service Manager, Cunderdin
WA Country Health Service Map

Healthier country communities through partnerships and innovation

Values  Community |  Compassion |  Quality |  Integrity |  Justice
Wheatbelt Map
Understand your challenges
Keep abreast of the interest groups

• Anxiety about “any change at all”
• Angst about closing the hospital.
• A local aged care solution – living at home for longer – how would that be possible in a rural setting?
• Provision of respite and palliative care - where would that happen?
Start by asking the “Why” question?

• Why would we want to change this Model of Service Delivery (MOSD)?
• Many members of the community (despite their health status) had absolutely no contact with the health service > very poor access and limited opportunity to influence health outcomes.
• The wards off the back corridor of a 1930’s relic hospital is no place to grow old.
Establish what you value

**Giving the Best Care in the Best Place**

- No wrong door
- Person centred approach
- Motivated workforce, competent in health centre services
- Focus on better health status: improving the health of people in the community
- A multi-disciplinary approach involving consumers and carers
- Evidence-based care linked with WA Health models of care, policy and frameworks

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Get to the interesting. How? Know where you’re headed.

WA COUNTRY HEALTH SERVICE (WACHS) PRIMARY HEALTH & PRIMARY CARE FRAMEWORK
Core Service Areas and relationship between Primary and Secondary Services

COMMONWEALTH
The Commonwealth’s role in funding and delivering GP and primary health care and aged care and that the Commonwealth works in partnership with the States to enable patients to receive the care they need when and where they need it—and if doing so, take pressure off public hospitals.

NATIONAL HEALTH REFORM AGREEMENT 2011 Recognises that:

STATE
The States are the system managers of the public hospital system, take a lead role in public health, and are the sole managers of the Local Hospital Network relationship.

CORE SERVICES
- Antecedent and Maternity Services
- Child & School Health Services
- Youth & Adolescent Health Services
- Women's & Men's Health Services
- Healthy Ageing & Aged Care Services
- Oral Health Services
- Chronic Conditions Coordination
- Mental Health Services
- Alcohol & Other Drug Services
- Domestic Violence Services
- Pharmacy Services
- Cancer & Palliative Care Services
- Acute Care and Emergency Management
- Hospital Liaison, Discharge & Patient Travel
- Primary Disability, Rehabilitation & Sub-Acute Care Services
- Public Health (including Environment & Communicable Disease Control)

PREVENTING ILLNESS & HOSPITALISATION
- Primary Prevention
- FIRST step in avoiding illness through Public Health programs
- Health promotion
- Disease prevention
- Identification of early SECONDARY PREVENTION
- Care giving
- Client advocacy
- Chronic conditions management
- TERTIARY PREVENTION
- Rehabilitation
- Health maintenance & rehaulation

HOSPITAL SETTING GIVE THE RIGHT CARE AND MINIMISE HOSPITALISATION BY:
- Providing safe, evidence-based health care
- Care of patients in the hospital
- Identifying and responding to early secondary prevention
- Communicating discharge planning
- Encouraging and supporting the patient during discharge
- Coordination of care across a range of services
- Epidemiology & infection control
- Modifying risk factors
- Selecting effective treatments
- Increasing health literacy
- Enhancing good communication
- Accessing effective community services
- Providing comprehensive care
- Improving access to primary care
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CONSUMER, FAMILY, COMMUNITY FOCUSED CARE AS A JOURNEY ACROSS THE HEALTH CONTINUUM

ACCESSING THE RIGHT CARE AT THE RIGHT TIME IN THE RIGHT PLACE

EQUITABLE CARE: EQUAL LIFE & HEALTH CHANCES
ACCOUNTABLE CARE: PROVIDERS PAID FOR QUALITY OF CARE NOT QUANTITY

ENABLER FOR ACCESS

System & service redesign
Partnerships, Collaboration & Communication
Health Informatics and Telehealth
Workforce
evidence-based models of care
Infrastructure & Co-location
Community - Health literacy, Capacity & Readiness

ENABLER FOR ACCESS

Environment (e.g., Housing)
Education
Food security & quality
Social capital & support
Transport

SOCIAL DETERMINANTS OF HEALTH, e.g.
Healthier country communities through partnerships and innovation

Values
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Tips for leading change the PHC Way
Take your hands off and step away from the car

• Plant the seed of a new idea – possibility.
• Give permission to experiment.
• Don’t rush things.
• Be the process advocate and keep the sweat rugs handy for nervous Managers.
• Be honest, elastic, resilient and maintain perspective with humour.
• Market your achievements (be the local vocal).
Innovation and Agility

• Discover and understand the real issues.
• Find the most creative and workable solution.
• Use stretch thinking as a motivator for testing new ways of doing old things.
• Never underestimate potential and support talent.
• Don’t sweat the small stuff.
• Reward courage.
Cunderdin Primary Health
WHO ARE WE NOW?

Data from July ’15 - June ’16

Community Packages (average hours/month)
205

Repite patients
23

Primary Health Clinics, eg college, women’s, continence, asthma
28

Meals on Wheels
3241

Short admissions
61

36 staff
7 days worked in the community each week

Cunderdin Health Service is transitioning into a Primary Health Centre which means we are now providing more services in the community setting.

Community Aged Care Packages hours represent an average number, since this changes weekly depending upon client needs, from 170-240 hours per month.

Clinic Information includes Asthma Clinic, Pap Smear Clinic and Continence Clinic.

Staff numbers include casuals and people on leave.

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Cunderdin Primary Health Centre
Strategic Plan 2016–2020

Enhance access to a wide range of community based services
Supporting strategies

- To deliver nursing and home based services to clients in their home.
- Continue to establish private partnerships and agreements within a consumer directed environment.
- Respond to patients and families end of life wishes.
- Establish procedures to support home visiting and admission of clients to ‘hospital in the home’ settings.
- Services delivered for end of life management of patients.
- Maintain and establish an adequate vehicle fleet to support current and planned expansion of services.
- Establish telehealth services that support staff to work safely in the community.

Provide and facilitate access to services that preserve, promote and protect wellbeing
Supporting strategies

- Improve health outcomes by providing a primary health service based on local community needs and health priorities.
- Increase Primary Health Clinics
- Facilitate access to external private providers

Develop a motivated workforce competent in provision of health services
Supporting strategies

- Initiate transitional workforce planning to ensure services are delivered according to community needs.
- Facilitate access to ongoing training to ensure optimal client health outcomes.
- Strengthen volunteer workforce.
- Develop staffing model.

Identify further opportunities for broad engagement with partners
Supporting strategies

- Services continue to be driven by the needs of the community.
- Maintain inclusive service design processes supported by collaborative partnerships with local consumers.
- Establish partnerships with external agencies to expand services.

Provide timely and safe access to emergency care
Supporting strategies

- The Emergency Department will continue to provide emergency care for patients suffering from medical conditions and/or injury.
- To harness the latest available modern technology in conjunction with access to medical expertise.
- The ED will continue to deliver non-urgent care in a planned, coordinated and integrated way.
- Review pathology, radiology, pharmacy and equipment needs for transition to the new centre.

Our Values: Community | Compassion | Quality | Integrity | Justice

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Values

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The What?

- A brand new and sparkly multi-purpose, integrated Primary Health Care Centre
- Aged Appropriate accommodation units with a mix of configurations to enable best flexible and support more specialized care
Lessons learnt...........(so far!)

“That you need to be passionate, enthusiastic, part of a team and resilient (always be prepared to get knocked down) and flexible enough to change the change you thought was right.”
Lessons Learned

“When you think you know how to lead change – think again and be prepared to learn on your feet. Be flexible, consultative and genuinely listen. As a visible community leader, be prepared to invest yourself.”