Healthicare

Healthicare

PROSPECTUS

your local health hub

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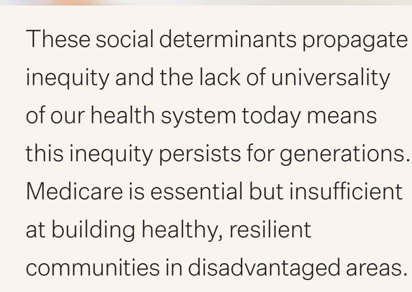
01

Case for Change

Healthicare: a new approach to the delivery of health care, with links to social, education, disability, housing and other services, is required to address the social determinants of poor health outcomes for vulnerable communities.

Despite significant improvements in health care over the last few decades, an individual's social determinants still play a significant role in their health and life outcomes.

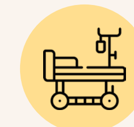
These social determinants propagate inequity and the lack of universality of our health system today means this inequity persists for generations. Medicare is essential but insufficient at building healthy, resilient communities in disadvantaged areas.



Whilst there are multiple factors contributing to these disparities in outcomes,a major contributor is access to high quality, proactive, preventative, multidisciplinary primary care services. Evidence shows that there is not only an undersupply of GPs in disadvantaged communities but also that the type of services provided are not always fit for purpose. A combination of health and social services are required to address the needs of vulnerable families*.

Health and social outcomes

People living in the lowest socio-economic areas have significantly worse health and life outcomes compared to the highest socio-economic areas[2,3]:



1.3 X
more likely to have a preventable hospital admission

1.4 X
more likely to have a preventable emergency department (ED) attendence

30%
more likely to have a low birthweight baby

2 X
as likely to have at least two chronic conditions

2 X
as likely to die from diabetes

Vulnerable children and young adults transitioning to adulthood are[3]:

4.3 X
more likely to be admitted to hospital for alcohol and drug issues

13.8 X
more likely to enter custody

50 X
more likely to receive an out-of-home-care (OOHC) placement

Under supply of GP services

People living in socio-economically deprived areas have the greatest health needs, but general practice is 'under-doctored' in these areas. Current fee-for-service models do not incentivise GPs to establish or grow practices in the area of greatest need and do not appropriately reimburse services delivered outside of the routine transaction-based care models.

10 years ago, 50% of medical graduates went into general practice, where as now it is 15%.

Avoidable costs

Evidence* suggests that if the health gap between the most and least disadvantaged was closed, Australia could save[1,3 &4]:

$2.3BN
Annual hospital costs

$5.3M
Pharmaceutical benefits scheme prescriptions

$1.3BN
Mental health costs

$2.0BN
Youth unemployment

$5.9BN
Child protection

$2.7BN
Youth crime

Total Costs

$15.2BN
Nationally

$4.6BN
NSW

01

Why, Western Sydney, specifically outer Western Sydney?

Western Sydney faces intergenerational, socio-economic disadvantage and low levels of community and health engagement.

The **Healthi**care site sits within the Blacktown Local Government Area (LGA), which makes up 37% of the region that WentWest, as the Western Sydney Primary Health Network (WSPHN), covers. Within Blacktown LGA there are significant demographic, social and economic challenges that impact the health and wellbeing of children, young people, families, and local communities. Key statistics of the Blacktown LGA are presented below:

Population of **403,000** people

Over **11,782** individuals within the community identify as being Aboriginal or Torres Strait Islander

4% higher than the state average for low birthweight babies

7.3% unemployment rate

40.4% of the population are born overseas

41% speak a language other than English at home

11.3% of families are single parent families with children aged less than 15 years

55.3% have completed year 12 or equivalent

Overweight and obesity for secondary school students aged 12-17 years is **4%** higher than the state average

SEIFA score of **986**^ for Blacktown LGA

Infant mortality (rate per 1,000 births) is **0.6%** higher than the state average

Full immunisation for children aged 1 year: **0.5%** lower than the state average; **1.2%** lower than the state average for indigenous children

Adequete physical activity for children aged 5-15 years is **8.4%** lower than the state average

^ Socio-economic Indexes for Areas (SEIFA) is standardised against a mean of 1,000 with a standard deviation of 100. Therefore, any score less than 1,000 is indicitive of socio-economic disadvantage.

The number of GPs per 100,000 population for the suburbs surrounding the **Healthi**care clinic are well below NSW and specifically, the broader Blacktown LGA. This evidence supports commentary by GPs surrounding the difficulties in attracting and retaining GPs to the area and emphasises the gap in primary care service delivery in the area surrounding the **Healthi**care local health hub. WentWest is not aware of one GP that has moved to this region in over 10 years.

The existing practice composition is changing:

> 37% of general practices are solo, with many of GPs expected to retire in the coming years. A number of these smaller practices do not appear to have succession plans in place which presents risks relating to maintaining a skilled workforce capable of caring for the community.

> Employment preferences of younger GPs have shifted to opting to be employed by corporates rather than take on practice ownership. This is associated with their desire to have greater job flexibility, increased work life balance and a lack of desire to manage a small business. Incentives do not exist to attract corporates into the region, just as they do not make it attractive for new entrants to set up practices or acquire practices from retiring GPs.

Further opportunity...

Despite representing 10% of the local population, extremely disadvantaged* people in Western Sydney currently account for 60% of ED attendances and 25% of all hospital admissions.

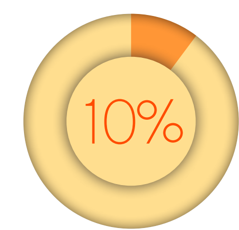
Healthicare will be the centre of the integrated health care neighbourhood. Aligned to the recommendations in the Primary Health Care 10-Year Plan, this neighbourhood would be aimed at building the primary health care workforce in the region and would be tailored to the community, working in partnership with other providers, to deliver affordable, accessible, preventative, quality health care.

This integrated health care neighbourhood complements private practice where it is hard to attract and retain GPs and primary health care teams, while ensuring effective coordination of services using a community-led, place-based approach to break cycles of disadvantage.

POPULATION

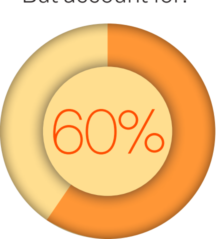
There are approximately 80,000 people in Western Sydney who are **socio-economically disadvantaged* and living with two or more chronic conditions.**

These individuals represent:

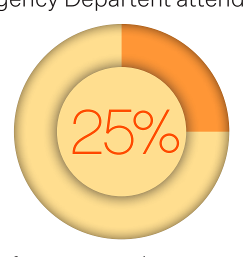


of the local population

But account for:



of all Emergency Departent attendances and

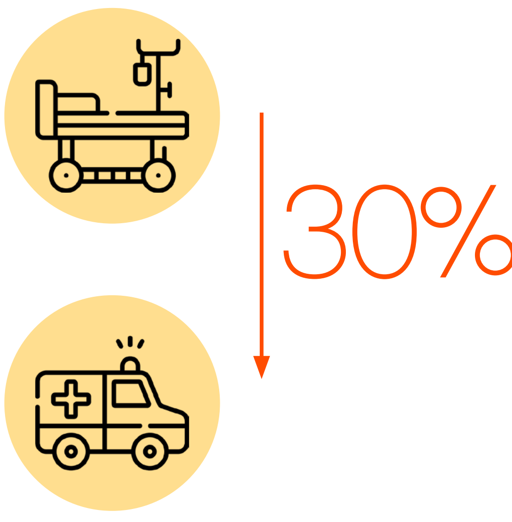


of inpatient admissions

INTERVENTION

Healthicare aims to deliver enhanced primary care services to approximately 8,000 patients from this socially disadvantaged population on an ongoing basis.

By providing more holistic and accessible services, **Healthi**care aims to reduce secondary/tertiary care usage for this group by:



This is believed to be a reasonable target given similar models of care have achieved similar results at a whole of population level. The **Healthi**care clinic will target those with a greater opportunity for improvements [5-7].

143 NSW Average

VS

100 Deprived Location

Per 100,000 Population

02

The Consultation Phase

Extensive consultation has been undertaken with GPs across outer Western Sydney, primarily with members of the Mt Druitt Medical Practitioners Association (MDMPA), and their care teams, in the region surrounding the site.

This is an area, consisting of a high proportion of solo/cottage practices. We heard first-hand from the members about the challenges they face … asking the question,
why can't we have nice things?

This is why we can't have nice things:

- Lack of funding and high costs
- Lack of team members
- Lack of health workers
- Fragmented communications
- Lack of awareness and utilisation of existing services
- Patient fear
- Patient adherence
- Perception of relevance
- Fear and resistance to change
- Focus on treatment rather than prevention
- Poor culture
- Lack of long term vision
- Lack of engagement from patients
- Lack of reward for complex care
- Low patient registration
- Outdated/inefficient systems
- Lack of integration of care
- Busy, time poor
- Lack of clear data
- Lack of community health literacy
- Lack of primary care curriculum in medical training
- Burn out
- Feeling powerless
- Lack of junior doctors considering careers in general practice
- Unnecessary complexity of billing systems
- Limited access to allied health
- Lack of trust

This is what we need to have nice things:

- **Look for alternatives to MBS**
- **Restructure medical training**
- **Personalised engagement, regularly and with technology**
- **Clinical support, support for health care providers**
- **Local GP clusters**
- **Demonstratable models of value based care**
- **Health savings fund**
- **Proactive messaging to patients - with coupons**
- **Greater political representation for primary health care**
- **Flexible funding**
- **Improved access to health information**
- **Locum support for GPs**
- **More funding for complex care**
- **Team funding**
- **More bulk billing specialists**
- **Increase Medicare rebate**
- **Mix specialists and primary care in one location**
- **Understanding consumer needs and managing expectations**
- **Increase patient registration**
- **Use more technology**

02

What if we had a Neighbourhood Health Hub to support what we do?

Healthicare can offer:

Usual Care

Healthicare will embrace the core aspects of the Patient Centred Medical Home (PCMH) model to provide usual care. This includes care delivery that is patient-centred, accessible, comprehensive, coordinated, continuous and committed to quality and safety. The **Healthi**care approach is underpinned by the 10 Building Blocks of High Performing Primary Care.

Key aspects of usual care are as follows:

Focus on patients with no usual GP, or patients referred by their usual GP for review who could transition to the **Healthi**care clinic for a short, medium, or longer term if preferred by the usual GP and the patient. Conversely, new patients at **Healthi**care may be best cared for by neighbouring general practices.

Healthicare may guide patients without a GP to choose a local GP well-suited to their individual and family needs.

Healthicare is a hub for general practitioners, GP registrars, nurse practitioners, registered nurses, allied health providers, Pharmacist in General Practice and patient advocates to provide team-care.

Given the location within the Blacktown Exercise and Sports and Technology (BEST) hub, minor injury management and referral pathways to radiology and adjacent allied health services (for sporting injuries) will form part of the usual care.

The **Healthi**care initiative aligns and builds on the Kids Early Years (KEYS) Network investment, supporting hundreds of vulnerable families in Western Sydney partnerships.

Beacon/ Specialised Care

Healthicare offers an extended primary care model ('Beacon' care), led by GPs with special interest/ expertise in child and family, supported by the core PCMH team and visiting providers.

The specialised primary care model will deliver child and family services, within and external to the hub with reference to vulnerable families, in partnership with visiting providers operating from **Healthi**care.

Healthicare will demonstrate 'Beacon'/Specialised Care features through:

- Use of GPs with a special interest in child and family and enhanced employment opportunities.
- Investment in care, which engages practitioners and providers within the neighbourhood in an integrated manner.
- Non-dispensing pharmacists to support medication management of complex patients (usual care).
- On-site pathology.
- Physical and technological investment to support enhanced care and patient experience.
- Addressing broader care requirements of these vulnerable cohorts by providing services such as domestic violence assistance, alcohol and other drugs services, and additional psychological support to parents, children, and adolescents (including adolescents).
- A service model that will adopt a Healthcare Neighbourhood (HCN) approach. This establishes preferred provider partnership arrangements enabling integrated care for services within **Healthi**care and services referred out.
- Training and uplift programs to support local practices and the broader community.
- Shared care that is evidence-based and outcomes-focused.
- Multidisciplinary.

Enhanced Professional and General Practice Support

Likely scenarios for broader clinical support will include:

Non-child and family-specific support:

Healthicare may host positions that would not be feasible for a single practice, such as Indigenous Cultural Support Workers, Aboriginal Health Workers , social workers and Pharmacist in General Practice.

Child and family-specific support:

Given the specialised nature of service delivery, child and family providers delivering services within **Healthi**care will support neighbouring practices through:

- Providing direct training/ development, i.e., hosting learning and development events/forums.
- Outreaching or providing telehealth to local practice's patients (without adopting shared care arrangements).
- Supporting secondment opportunities in practice to enable further learning and development.

Non-clinical support:

Non-clinical support will primarily focus on operational management support for surrounding practices that may wish to outsource these functions. This will include:

- Practice management – general practice and back-office support provided to the surrounding practices. It could consist of financial services, HR services, marketing, bookkeeping and legal services.
- IT services – eHealth, web-hosting and search engine optimisation.

02

There is an opportunity over time, that **Healthi**care can be positioned as a centre of excellence for training, mentoring and research through the clinic's work. Ways in which this has been contemplated and built into the service model include:

> Obtaining GP registrars who will work out of the clinic.

> The development of the nursing team allowing trainee nurses to be trained within the **Healthi**care clinic to create a strong team of supportive care for GPs.

> Non-chargeable time for GPs and nurses built into the service model to allow for training and mentoring to take place within the **Healthi**care clinic.

> Broader support work to neighbouring practices, as detailed above.

> Partnering with tenants of the building, Australian Catholic University, Sydney West Sports Medicine, Blacktown Council and WentWest to explore research opportunities.

> Ensuring a culture of continuous improvement to primary care through technology and data analytics for decision-making that will allow **Healthi**care to measure health impacts.

The BEST site will explore the Internet of Things (IoT) technologies like QR codes and Near Field Technology (NFT)

> We aim to continue this experience in **Healthi**care, our Neighbourhood Health Hub, where clinicians and patients make informed choices together via an interactive experience including health literacy, the development of care plans with easily reachable goals and team care. We aim to support families well beyond the Hub with a healthy-life journey utilising preventative health tools and apps, with a new innovative approach to maximise physical, mental and spiritual wellbeing.

> We encourage you to partner with **Healthi**care, taking advantage of our resources to improve your patients' life expectancy and quality of life by proactively engaging your patients in connecting their physical environment to the digital, reducing barriers to access and encouraging and nurturing healthy habits.

Core Team

Healthicare is a hub for general practitioners, GP registrars, nurse practitioners, registered nurses, allied health providers, Pharmacist in General Practice and patient advocates to provide team-care.

The Core Team will consist of:

> GPs.

> Practice nurses (PNs).

> Practice support team (including practice manager and receptionists).

> Social worker.

> Psychologist.

> Psychiatrists.

> Select allied health providers, including Sydney West Sports Medicine (SWSM), who are located within the building.

These team members will deliver both usual care and child and family services and will be based within the BEST hub. The core team has been selected on the basis that the skillsets are aligned to service model requirements. Sydney West Sports Medicine clinic (located within the BEST hub) will be integrated into the core team for allied health (where appropriate and agreed), to minimise duplication and competition whilst strengthening collaboration and partnership within BEST.

A social worker with a counselling skillset will have the most prominent allied health involvement within the core team to support navigation of social issues for health-related issues of the patients.

Visiting providers will include (but not be limited to) a:

> Paediatrician.

> Drug and alcohol nurse.

> Midwife.

Providers are motivated to achieve alignment between their available services and the needs of their future patients. It is crucial to ensure that the number of patients is sufficient in relation to the room capacity of **Healthi**care within a primary care setting.

Healthicare will refer patients to service providers through a neighbourhood of preferred partners using HealthPathways. This approach will be strengthened through existing preferred provider agreements. **Healthi**care's objectives will be supported by consistent care delivery and continuity. Implementing the beacon aspect of service delivery through the establishment of a community of practice within child and family will also support **Healthi**care objectives.

03

Core Principles

Value - building a sustainable ecosystem for general practitioners within our local health community, assisting with the complexity of disease management.

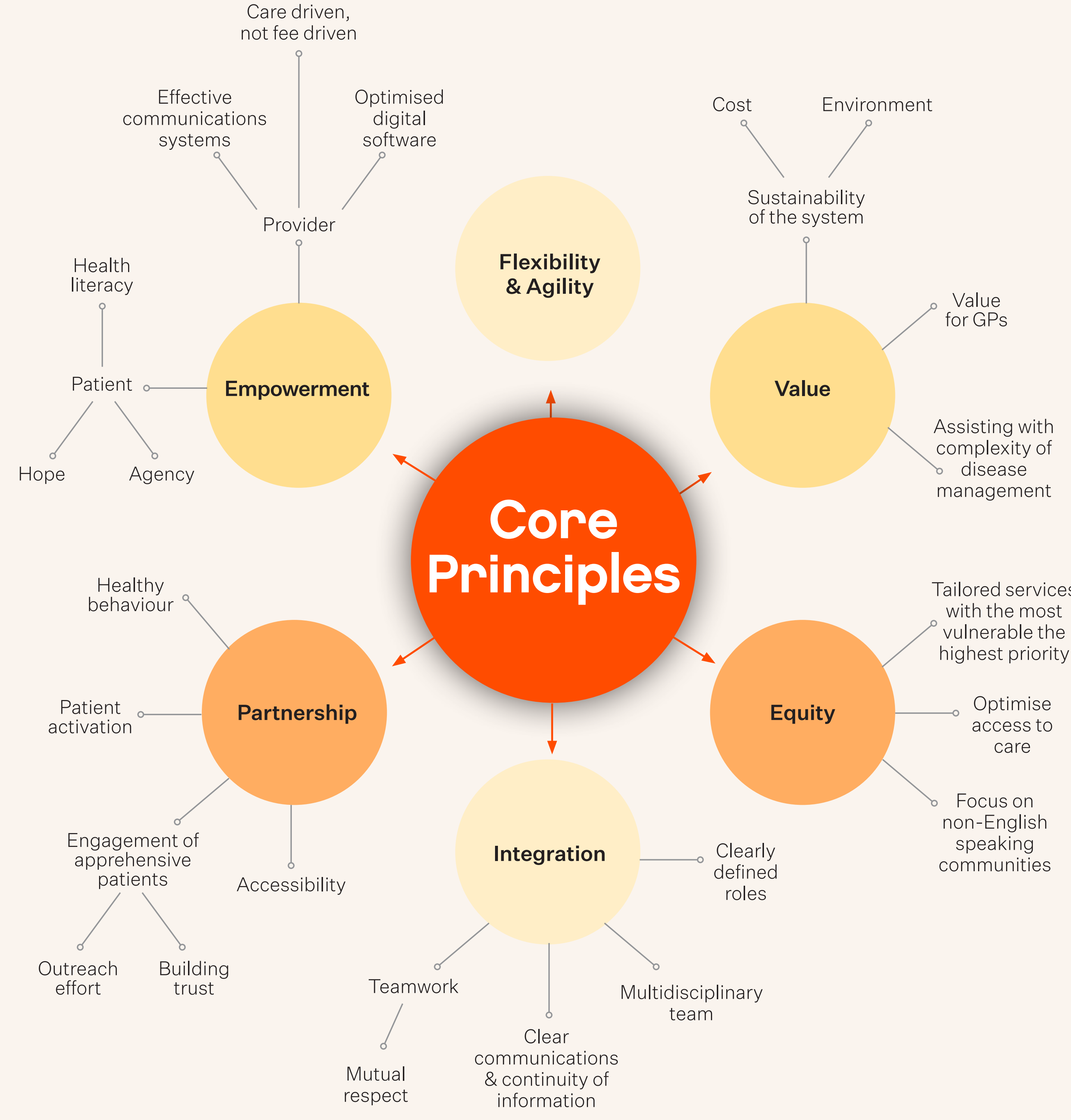
Equity - providing access to quality health care and health literacy for all children and families to build healthier communities and empowered individuals.

Integration - a multidisciplinary team of coordinated care between general practice and your local hub.

Partnership - improving coordination of care for children and families at risk of poor health outcomes to ensure patients receive the right care, in the right place, at the right time.

Empowerment - increasing the efficiency and effectiveness of medical services for patients.

Flexibility and Agility - the ability to adapt and change for the local community and in extended support for surrounding practices.



04

Service Model

Healthicare will deliver targeted and integrated primary care services, through a transformative collaborative neighbourhood-based model of care to improve the health and social outcomes of the most vulnerable families.

The service model will:

> Deliver high quality evidence-based and patient-centred primary health care aligned to the Patient Centred Medical Home (PCMH) and enhanced 'Beacon' models of care.

> Provide a full spectrum of holistic primary care services and referrals to social services required to support vulnerable families.

> Have a dedicated on-site multidisciplinary clinical and non-clinical team supplemented by a range of visiting and neighbourhood-based service providers.

> Provide collaborative referral pathways to and from neighbourhood and other service providers to increase access and availability of services.

> Provide dedicated case coordination.

Target cohort

> Extremely socio-economically disadvantaged* patients with multiple co-morbidities.

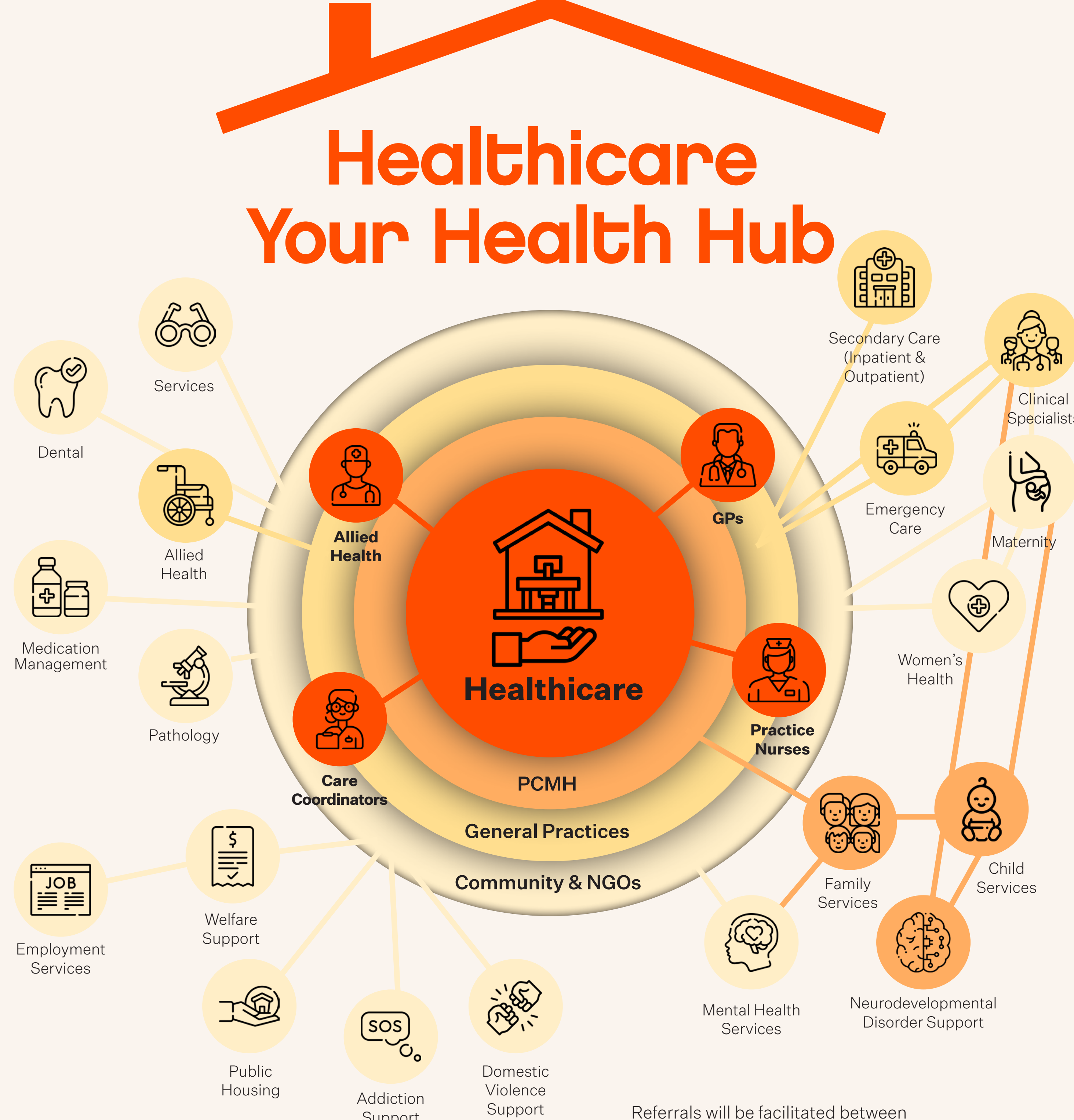
> Estimated 8000 patients after six years.

Funding

> Funded through an innovative mechanism that combines capitation, outcome and investor funding

Access costs

> No out-of-pocket costs for service users to minimise barriers to accessing services.



Referrals will be facilitated between providers of social support services such as; **housing, welfare, employment services, addiction support and domestic violence.** These services play a crucial role in addressing the social determinants of health and would not currently form part of primary health referral pathways.

04

What will change for vulnerable families and the health system under the Healthicare model?

Healthicare will enable the necessary shift from the current state of primary care services to a more integrated, accessible, and impactful service that creates better outcomes for service users and enhanced employment opportunities for primary care professionals.

Benefits of the model

The primary beneficiaries will be **Healthi**care service users, **specifically vulnerable families.** The health system will also be a significant beneficiary; an opportunity exists to make considerable cost savings through **prevention** and **early intervention** to avoid more costly care and services further downstream.

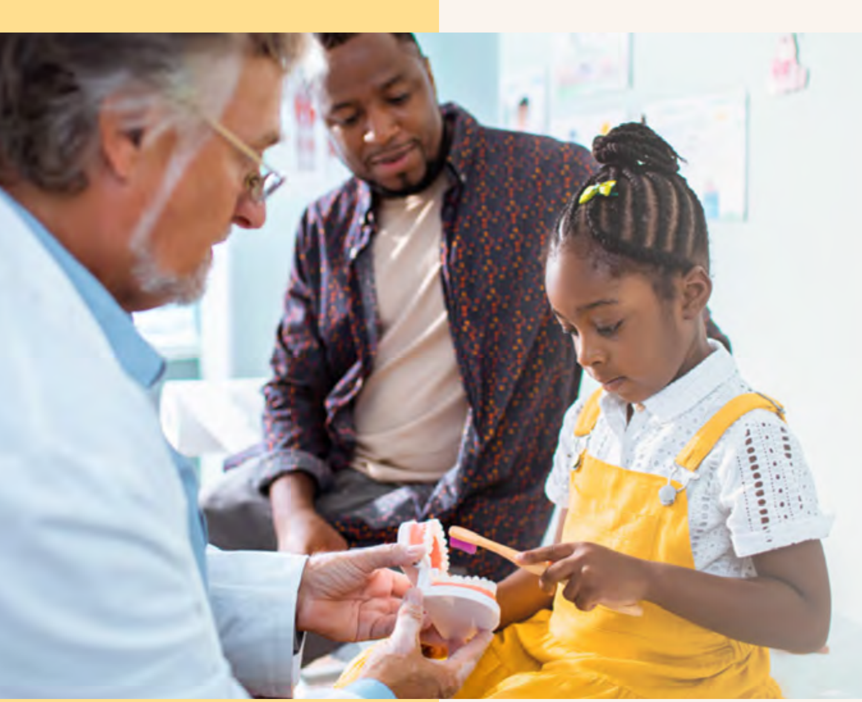
Beneficiary	Potential Benefits
Vulnerable Families	Breaking the cycle of disadvantage for the 8000 individuals that will access **Healthi**care services by directly improving their individual health and social outcomes and helping families stay together and thrive.
Health Care	Effective implementation of PCMHs have shown to: > **Reduce total hospital admissions by 23% across** a seven year period [5] > **Reduce Emergency Department attendance by 20%-30%** [5,6]
Social and Community	Early targeted interventions aimed at vulnerable families has been shown to: > Reduce the likelihood of OOHC by up to 14.3 times [8] > Reduce Child Protection costs by up to $480,000 per family who have up to three or more risk factors [7] > Reduce Justice costs by up to $105,000 per family who have up to three or more risk factors [7]
Education	Access to services targeted at vulnerable children can: > Enable children to stay engaged and complete school (31% increase in Year 12 student retention) [9]
Housing	Integrated health and social services can provide referrals for families at risk of homelessness to ensure they receive the right support to stay safe and to stay together [11]
Economic	Better access to health care services can improve chronic disease management and increase participation in the workforce: > Reduce welfare usage by up to 5% associated with loss of productivity [10]
Safety and Crime	Redirecting funding to preventative, targeted interventions has been shown to: > Reduce charges across the top five juvenile offence categories by 38% [9]

05

Partnering In Reform

WentWest and general practices have been working together to reform health care for 20 years. **Healthi**care can take us to the level of service delivery and build a first of its kind.

Commonwealth policy reform is focused on outcome-based care. There is a concerted effort to move away from transactional care with the establishment of Health Care Homes (2017-2021). The Primary Health Care 10-Year Plan development was completed in 2021. It is envisaged that these reforms will translate into new funding approaches that are outcome-based and support Patient Centred Medical Home (PCMH) and flagship models like **Healthi**care.



This is further supported by the Roadmap for Reform that was produced as a result of the Primary Health Care Reform Leaders Summit in May 2022. This Summit, co-covened by all Primary Health Networks and the Consumers Health Forum, had over 30 national and state peak organisations present. One of its prerequisites for reform was:

> Establish integrated health care neighbourhoods beginning with a focus on areas of relative socio-economic disadvantage, and rural and remote areas.

These neighbourhoods will be aimed at building a primary health care workforce that is more responsive to the particular needs and circumstances of communities in delivering affordable, accessible, preventative, quality health care. They will complement private practice in areas where it is hard to attract and retain GPs and primary health care teams, while ensuring effective coordination of services using a community-led, place-based approach to break cycles of disadvantage.

What if?

- We could attract the next generation of GPs, allied health and other health professions to the region.
- We could show an evidence-based generational change in reducing family violence.
- We could show a drop in urgent care and emergency department utilisation.
- We could work together to reduce hospital admissions.
- We could decrease specialist utilisation.
- We could contribute towards a reduction in primary care utilisation.
- We could work together to document the highest childhood immunisations for Australia.
- We could reduce the incidence of diabetes with HbA1c below 7%.
- We could reduce the employee turnover rate in primary care.
- We could show higher customer and staff overall satisfaction.
- We could show clear clinical data improvements for the health of the most significant urban refugee and Aboriginal and Torres Strait Islander population in NSW.

Key objectives

- To deliver evidence-based and patient-centred primary health care by drawing on general practitioners with special interests and multidisciplinary teams' skills and integrating these skills with social and community services.

This will include:

- Developing and delivering targeted and integrated primary care services that provide improved outcomes for vulnerable children and families.
- Enabling access to services that improve patient outcomes for disadvantaged or multimorbid groups.
- Supporting the health care workforce by promoting skills uplift within the local health neighbourhood in the provision of services targeted to children and families and through the development of workforce career pathways for general practitioners.
- Supporting general practice and primary care providers in outer Western Sydney* to establish a scalable, sustainable, and evidence-based approach to primary-led integrated care.
- Increasing the skills of persons already working in primary health care and training and equipping the next generation of clinicians.

Evidence from around the world shows practices operating a true **Patient Centred Medical Home** (PCMH) are well-positioned to deliver and support the changes required across the broader health system to deliver the right care in the right place at the right time.

Healthicare embodies the Patient Centred Medical Home (PCMH) as well as aspects of a primary care supporting usual care, beacon/specialised care, and enhanced general practice support services, that would benefit the neighbourhood.

05

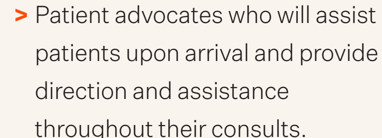
Benefits for your General Practice and Patients

"The Healthcare Neighbourhood Health Hub is a place for health practitioners to embrace working smarter, not harder."

Consider the following direct support for your practice: **The core team consists of:**

> GPs.

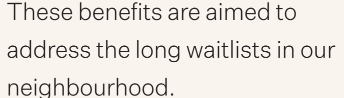
> Practice nurses (PN) and practice manager who will co-coordinate the management of **Healthi**care.



> Patient advocates who will assist patients upon arrival and provide direction and assistance throughout their consults.

> Psychiatrists, psychologist, counsellors and social workers who will avail themselves for the spot consults.

> Allied health providers, including Sydney West Sports Medical (SWSM), located within the building. These team members will deliver usual care and child and family services and be based within BEST.



These benefits are aimed to address the long waitlists in our neighbourhood.

Providers are motivated to achieve alignment between their available services and the needs of their future patients. It is crucial to ensure that the number of patients is sufficient for the room capacity of **Healthi**care within a primary care setting.

Neighbourhood of providers:

We invite you to work at the **Healthi**care hub and/or refer patients to service providers through a preferred partner neighbourhood using HealthPathways. We aim to strengthen our health ecosystem through existing preferred provider agreements.

Consistent care delivery and continuity and implementing the beacon aspect of service delivery through establishing a community of practice within child and family will support **Healthi**care objectives.

Key referral (to and from the hub) and service delivery partnerships will encompass:

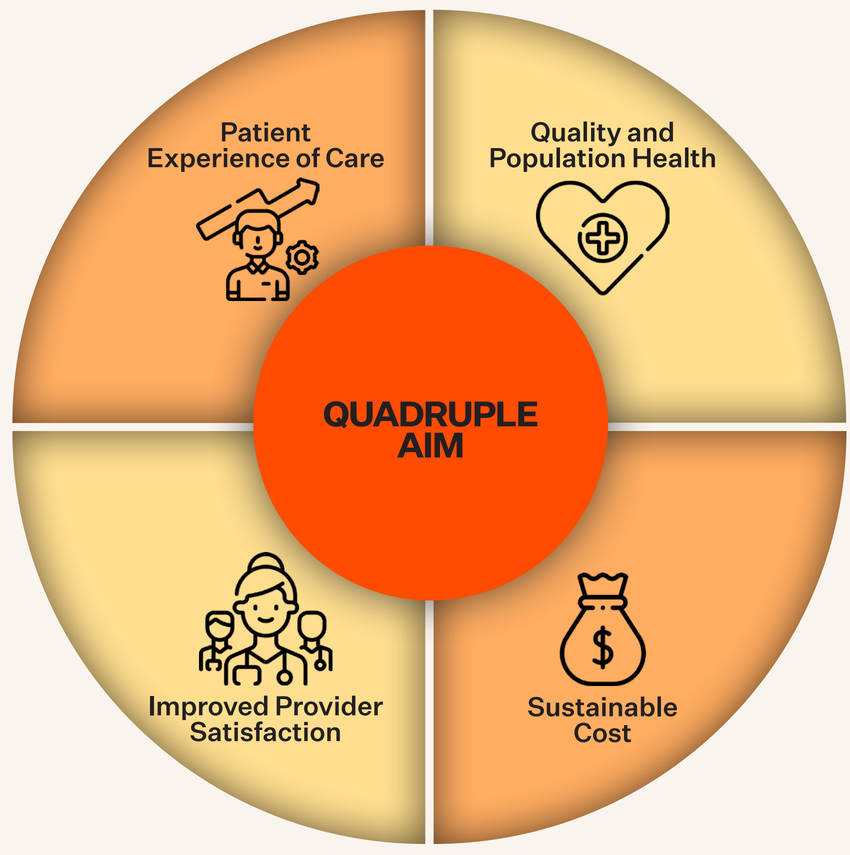
1) Local radiology providers – practices that provide radiology services near **Healthi**care.

2) Local hospitals/LHD community services – local hospitals and LHD community services as required, typically for more complex or acute care.

3) Other primary care providers – to support ongoing management (for example, dental and the local general practice).

4) KEYS – families that may meet the vulnerability criteria. Conversely, KEYS families will be referred to **Healthi**care for clinical services.

Quadruple Aim



Quadruple Aim - key elements of high quality primary health care

06

About Healthicare

Healthicare is an independent not-for-profit established to promote the prevention and control of disease in children and adults, especially disease and chronic conditions prevalent in low socio-economic populations, such as diabetes, cardiovascular disease, alcohol and drug dependence, obesity and mental illness (collectively, the **Purpose**).

In order to achieve this, **Healthi**care will:

> Have direct responsibility for the planning and delivery of community-wide health care services to achieve the Purpose.

> Deliver evidence-based, patient-focused primary health care and related services by drawing on the skills of multidisciplinary teams and integrating health care with other social and community services.

> Improve access to services that further the Purpose for disadvantaged or multimorbid groups.

> Disseminate health information to consumers and the people that directly care for them in the community to contribute to better health outcomes towards the Purpose.

> Support general practitioners and primary care providers to foster an integrated and high functioning primary care system in working towards the Purpose.

> Develop, participate in, and foster partnerships to continually build and expand upon the evidence base as to how to further the Purpose through research, innovative uses of technologies, financial innovations and multidisciplinary, integrated care approaches.

> Provide advice to stakeholders and policy makers to facilitate change at a system level to improve accessibility, suitability, and sustainability for health care services in relation to the Purpose.

> Promote clinical governance, benchmarking, and business systems and through partnerships, provide education and training to the primary health care sector to support continuous improvement, use of consumer centric approaches, equip the next generation of clinicians and improve safety regarding the Purpose

What does this mean for GPs working in the Healthicare hub?

A new outcome-based funding model for general practice?

Healthicare provides a new opportunity for general practitioners in the primary care setting to shift from the transactional fee-for-service (FFS) model to support the implementation of an evidence-based community care model that improves patient health and social outcomes and reduces health care costs at the system level. Part-time, full-time and Visiting Medical Officer (VMO) opportunities will be available and we anticipate staff to be on contract and salaried. An initial GP to nurse ratio of 1:2 will be in place, with a view to add additional care team members over time. It is also an opportunity to influence the future direction of Primary Care Reform, including Commonwealth investment in integrated primary care and we continue to pursue funding to add outcome incentives to contracts within the first three years to augment salaries.

The **Healthi**care Core team will support Clinical and Operational Leadership of the Neighbourhood Health Hub (NHH).

Healthicare Board

CEO

Medical Director (GP Leader) — Practice Manager (PM) — Registered Nurse (RN)

The Medical Director (GP Leader) is pivotal. This role supports both clinical services, but also has a significant role in driving **Healthi**care's overall mission and core principles.

This position will be pivotal in partnering with surrounding practices, leading a team of supportive health carers collaborating with a vast network of stakeholders from WentWest, **Healthi**care, consumers, community leaders, external consultants, marketing agencies, government departments and the broader health sector, both public and private.

What are the benefits for GPs of surrounding medical practices?

> Financial gain and access to the latest state-of-the-art equipment for the benefit of your practice and patients under your care.

> Working with like-minded health professionals, supported by a true multidisciplinary team, individuals working to the top of their licence providing.

> An opportunity to participate in our primary care planning for outer Western Sydney. It's time to level the playing field, be leaders, influencers, and coaches, bridging the gap between policy, strategy, and practical implementation of health care change in the community.

> To value add to the service you are already offering to your patients today.

> Connecting you to all our commissioned services so that you have the comfort/trust of knowing that past success will continue.

> Access to three key offerings of **Healthi**care;

- Usual Care
- Beacon/Specialised Care
- Enhanced Professional and General Practice Support

07

Business Model

We have developed a vision for a novel and transformative approach to deliver value-driven, integrated community health and social care services from a purpose-built Neighbourhood Health Hub, **Healthi**care.

Healthicare will provide:

> A solution to the poor GP-to-patient ratios seen in the most deprived suburbs.

> Preventative, targeted and integrated primary care to those who stand to benefit the most.

> Cost savings and cost avoidance (by reducing secondary care usage).

> Sustainable funding model based on a combination of capitation and outcome payments.

By moving away from a fee-for-service model, to a blended payment model, an opportunity exists to fund the implementation of a patient centred, integrated and evidence-based care model that improves patient health and social outcomes and reduces health care and other government costs at the system level.

Table 2: Number of GPs per 100,000 population

	NSW	Blacktown LGA	Suburbs surrounding NHH Clinic
No. of GPs per 100,000 population	143	133	100
No. of GPs	–	529	164
Population	–	395,000	164,146

VS

143 NSW Average

100 Deprived Location

Per 100,000 Population

Team-based Care

Implementing care teams is a critical element of transforming the way care is delivered.

A care team is a small group of clinical and non-clinical staff who, together with a provider, are responsible for the health and wellbeing of a population of patients. Who is on the care team and their specific roles will vary based on the practice and the patient needs. High-performing practices view teams as a necessity, providing recommended acute, chronic and preventive care.

Building teams that add capacity is called 'sharing the care' and provides upskilling opportunities. Many exemplar practices have created teams consisting of both non-clinical and clinical members, providing access to health care professional and practice administration education, resulting in both business and clinical optimisation.

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WentWest
Healthicare