

# WINSTON CHURCHILL MEMORIAL TRUST

Exploring the different models of community based care for those with complex health needs.

Dr Luke Skelton  
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## Acknowledgements

The Winston Churchill Memorial Trust Fellowship has given me the opportunity to spend four weeks visiting exciting projects in Melbourne, Australia and California through which I have developed personally and professionally. Undertaking the project meant widening my professional horizons, representing my field abroad in very different health systems and furthering my understanding of the health needs of a population whom I have always passionately sought the best care for.

I would like to thank the organisations that welcomed me with open arms and provided me with honest and transparent views of their experience providing health care for patients with complex health needs. I met an enthusiastic and forward thinking workforce who instilled confidence into me that despite the constant challenges faced, it is possible to make positive change happen.

Thank you to my now fiancé, who supported me throughout the experience, the late night and early morning calls across time zones and then at the end of the project agreed to do this for the rest of our lives by accepting my proposal to marry me.

Finally, this would not have been possible had it not been for the support of the WCMT staff and without the man behind the organisation, Winston Churchill.

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## About the Author

### *Professional work*

Dr Luke Skelton graduated in 2012 with an MBChB in Medicine and BSc in Psychology after studying at the University of Sheffield and the University of Leeds, respectively. He completed his junior medical training in and around London NHS Trusts before working within acute medicine for 2 years whilst completing an MSc in Palliative Care. He then went on to specialise in the field of psychiatry due to a long standing passion for delivering quality mental health care and a desire to provide equality of care for those in need of psychological support. He currently works as an ST3 Psychiatrist for South London and the Maudsley NHS Trust and is a member of the Royal College of Psychiatrists (MRCPsych).

It is because of this breadth of experience that Luke had a particular interest in those with complex health needs; chronic conditions, mental illness and palliative diagnoses. Much of his academic work has been focussed on those with multiple health needs with the overarching question of how to best improve both the quality of care this patient group and their lived experience of navigating an often complicated journey through the NHS.

In addition to his clinical practice, Luke acts as a representative for trainees within his NHS Trust and has an active role as a group leader in a teaching program which aims to engage medical students in psychiatry and reduce the stigma towards those with mental illness. He has worked on several quality improvement and research projects which have focussed on effective care delivery for those with complex health needs.

### *Personal*

Luke would like to think of himself as a football player, captaining his local 6-a-side team. He cycles to everywhere he can, including a refugee fundraising cycle for 500 miles through northern Italy, where he contributed to a team total of over £50,000!

## Disclaimer

The views and opinions expressed in this report and its content are those of the author and not of the Winston Churchill Memorial Trust or its partners, which have no responsibility or liability for any part of the report.

## **Executive Summary**

### ***What was researched?***

The overall aim of my fellowship was to visit Melbourne, Australia and California, United States to explore the use of the different versions of Patient-Centred Medical Care Home to provide health care to those patients with complex health needs. The Australian government were rolling out the Health Care Homes model from October 2017 in trial sites across the country. The plan was to learn about the approaches being used within their health system, compare this to services within the United States where the model was first developed and to bring back learnings to the United Kingdom; where the Primary Care Home model was also being rolled out across pockets of primary care in the UK.

Certain questions were asked of the organisations visited:

- Is your organisation using the Health Care Home model in its practice?
- What were the pre-existing strategies in place to ensure those in need of extra support received the care they need?
- How do you highlight your patients with complex health needs?
- How many of those patients were enrolled in the Health Care Homes program or Patient-Centred Medical Care Home?
- What are the benefits/drawbacks that patient's involved report?
- What are the benefits/ drawbacks for the service provider?
- How is your service funded?
- What is your overall impression of this model of care?
- How do you think the care for this group of people could be improved?

### ***Major Findings:***

The Health Care Homes program being trialled in Melbourne and other regions of Australia was far behind where it had forecast by November 2018 when I visited organisations in Melbourne. Despite being in its infancy there were positive changes taking place across primary care services in the area, and with the difficulties faced by the program during its roll out, there were lessons to be learnt. There was a consensus amongst the General Practitioners, Clinicians and team managers that although a shift towards highlighting and tailoring the care for those with complex health needs was positive, and that the initial aims of the program would have likely been beneficial, Health Care Homes are currently falling short of delivering that. The different funding sources that exist in Australia and the United States can present difficulties in ensuring the needs of the wider population; particularly those with multiple health and social issues. This has also contributed to organisations and care providers thinking more laterally about how they can provide a holistic service for their population. I visited a number of organisations who were providing a unique, wrap around service to their patients with the focus being on patient engagement and experience. These community mental health organisations offered valuable learnings that could be

implemented within UK services. Health technology can be used with this patient group, their families and the often multiple health care professionals involved in delivering care to promote effective care coordination, collaborative working and patient-centred care.

***Recommendations:***

- It is recommended that those patients with complex health and social needs would benefit from coordination of their care by a health care professional known to them.
- Patients have difficulty accessing health care or struggle to attend different health service appointments (young people, those with drug and alcohol addiction, older adults, those with chaotic social circumstances) benefit from an 'all under one roof' service which addresses all of their health needs.
- Child and Adolescent Mental Health Services as organised in the UK could benefit from a shift towards Youth Services (12-25years), to ensure continuity through key life transition points.
- Drug and Alcohol services in the UK could incorporate legal aid and housing support into their service to provide for the wider social needs of this population group.
- Dementia 'boot camps' provide a space to educate and advise groups of patients and their loved ones about their dementia diagnosis. The groups have the opportunity to offer peer-to-peer support and make lasting connections through the session.
- Health technology and mobile apps offer a way to remotely monitor the health of patients, whilst providing an electronic hub for the care professionals to share information, with the lead taken by a designated care coordinator.

## Introduction

### ***Background to this project***

The author of this project works as a psychiatrist in London and witnesses first hand the problems patients face when trying to navigate a fragmented health service. Those with complex physical health, mental health and social needs are often receiving care from multiple services, all of whom have their own agenda. The consequences of this is that all too often the patient's agenda can be lost in this noise, and this potentially vulnerable group of patients disengage or receive sub-optimal care. Below is a case vignette to highlight this problem:

*Marie is a 68-year-old lady who was diagnosed with Bipolar Affective Disorder aged 23 years and had managed well on medications prescribed by her psychiatrist for many years. Over the last 5 years Marie had developed osteoarthritis in her right hip and required a hip replacement. After the operation she had a small heart attack and now sees a cardiologist who prescribes her cardiac medication. She sees the orthopaedic surgeon every 3 months for a check up. She lives alone and now requires some adaptations to her home to manage the stairs. She has one younger brother who helps support her but she often forgets important information about her health and so he is often left in the dark. She has had difficulties organising all the different health care appointments and she sees a different GP each time she visits her practice. All of her specialist letters get sent to the GP, but there can often be a delay in getting the correct medication prescribed and often the psychiatrist recommends medication that the cardiologist advises the GP to avoid. Due to missing her appointments she has been discharged by the orthopaedic surgeon.*

Those with serious mental illness have shown to have a shorter life expectancy than the general population by approximately 20 years because of preventable physical disorders.<sup>1</sup> There is an increased prevalence of cardiovascular disease and Type 2 Diabetes in this patient group both of which are major causes of death and impaired quality of life. Patients with chronic mental illness are most likely to receive their physical health care from their GP, with mental health teams and specialist services providing some input and advice as required. Conversely, despite a greater need to access wider health services this patient group can often under utilise primary care services or specialist services. This is likely to be for a number of reasons such as lack of understanding and insight, which are difficult to modify, however disorganisation is also likely to be a factor and care coordination through a model such as the patient-centred medical home would help this.

### ***Why this is important?***

As medical treatments improve and life expectancy increases, more people will be living with multiple health problems for longer.<sup>2</sup> A significant shortage of GP's and a rise in practice size means that where patients would previously have had a single GP guiding their

care this is often no longer possible.<sup>3</sup> NHS specialist services have become further sub-specialised, meaning that secondary and tertiary services are often more fragmented with the GP no longer able to function as the lynch pin. Close liaison between medical and mental health specialities is crucial for achieving cohesive care for patients already managing multiple health and social difficulties. As suggested by Simon Stevens (NHS England Chief Executive), *'There is arguably no more important job in modern Britain than that of the family doctor... A growing and ageing population, with complex multiple health conditions, means that personal and population-orientated primary care is central to any country's health system.'*<sup>4</sup>

It is important to explore and draw upon the knowledge and experience of those around us when considering the direction in which to drive positive change. There is no one, quick solution to the problems set out here, they require change at a health systems level which comes at both a financial and time cost.

The Patient-centred Medical Home is a model of delivering care which aims to provide high quality health care to patients through wrap-around care; coordinated by a primary physician and with close working between the different health care professionals and an engaged patient at the centre. This model of care was first described in the United States in 1967 by the American Academy of Paediatrics as a central source of medical information for children, particularly those with special needs.<sup>5</sup> Over the following decades it has evolved into a model of care delivery suited to primary care provision and has been adapted by many countries and health care systems under a variety of names (Primary Care Home (UK), Health Care Home (New Zealand, Australia)).<sup>6,7</sup>

In the UK, the Primary Care Home was developed by the National Association of Primary Care and launched by NHS England Chief Executive Simon Stevens in October 2015. After starting in 15 test sites this is now in place across 200 sites. The Australian Department of Health announced in 2017 that they planned to trial a version of the model called Health Care Homes. The program specified that any patient with a serious mental illness would be eligible for enrolment in the trial; this was what drew my interest to the program.<sup>6</sup>

### ***Aim and Objectives of the Fellowship***

The overarching aim of the Fellowship was to learn about the various adaptations of the Patient-Centred Medical Home model being used in Australia and the United States and draw upon the learnings overseas to improve the services I work in and add to the existing observations made in the UK through the role out of the Primary Care Home.

The objectives for the Fellowship were:

- To establish aspects of the different medical home models which have been successful and propose how these could translate into UK service provision; with a particular focus on the learnings which would benefit those with mental illness.



- Explore how different services manage the primary care needs, mental health provision and wider health and social needs of 'complex patients' with a view to strengthening the links between the community mental health team (CMHT), inpatient mental health services, primary care and general hospitals in the local area.
- To use case studies of exemplary service provision as a means of proposing and developing improvements for local and wider practice.

A further purpose of the Fellowship was one of personal professional development; using my privileged position as a Winston Churchill Fellow to be able to forge professional relationships with those driving advances in the field, inspiring me to continue to push for the best possible care for those who can often fall between the cracks.

### ***Fellowship Approach***

The approach of the project was to identify to other health systems using a medical home model to provide care for complex patients. Australia was identified as the Health Care Homes Model was in its infancy and therefore offered unique insights at the successes and difficulties faced by implementation of multi-agency program. The United States was chosen as a place of interest as the medical home model was established here, therefore much of the research and education materials have been developed here. Both Australia and the United States have similar demographics to the UK and as a result face the same difficulties in providing good quality, cost effective care to patients with complex health and social needs. Despite being comparable demographically; there are stark differences in the way that the health care systems are organised in these two countries and the UK and so factors such as funding sources and availability of services were also considered.

South East Melbourne was chosen by the Australian Department of Health as a trial site for the new Health Care Homes program and therefore the focus of this Fellowship was in this region. Multiple primary care and mental health providers were visited, and interviews undertaken with the practice leads and clinicians. In addition to independently contacting these health care providers contact was made with the South Eastern Melbourne Primary Care Network who were overseeing the trial and they were able to facilitate further meetings and provide their perspective.

Due to the time limitations of the Fellowship, the geographical spread and complexities of the health care system in the United States, the focus of the time there was given to a dementia care program for people with Alzheimer's disease based in Los Angeles. The Patient-centred Medical Home was developed in the United States in response to a lack of joined up care in the paediatric medical speciality but now is used across many medical settings and has been widely researched. Due to the model having been around for many years, this type of working has been adapted by different organisations who manage those with complex health needs; one of the most significant cohorts being those with dementia. The UCLA Dementia Care Program had taken many aspects from the medical home model

and used it alongside other unique approaches to engage and support those with dementia. In addition, they were researching and publishing the results from their interventions. Visiting the program would give me a greater understanding, add context to their research findings and provide me with the insight to implement tangible change within the services I work for. A further visit was spent at Centre for Excellence in Primary Care in the San Francisco General and Trauma Hospital where I could see how primary and secondary care linked up within the US health care system.

For each of the organisations visited the questions below were used to guide discussion and spark further conversation of interest:

- Is your organisation using the Health Care Home model in its practice?
- What were the pre-existing strategies in place to ensure those in need of extra support received the care they need?
- How do you highlight your patients with complex health needs?
- How many of those patients were enrolled in the Health Care Homes program or Patient-Centred Medical Care Home?
- What are the benefits/draw backs that patient's involved report?
- What are the benefits/ draw backs for the service provider?
- How is your service funded?
- What is your overall impression of this model of care?
- How do you think the care for this group of people could be improved?

In addition to this information and partly supplemented by online materials, information about the organisations history, principles and scope were gathered. Below is a list of the organisations visited.





### ***Report Overview***

This report will now focus on the following areas:

- An overview of the Australian and United States healthcare systems compared to the NHS.
- An outline of the Health Care Homes program as set out by the Australian Department of Health.
- The difficulties and limitations encountered during the Health Care Homes trial.
- A case study example of a drug and alcohol service.
- A case study example of a Youth community mental health service.
- A case study example of an Alzheimer's dementia service.
- How health technology could be utilised within this patient group.
- Other organisations visited and comments.
- Conclusions.
- Recommendations for UK practice.
- What are the next steps?

## **An overview of the Australian and United States healthcare systems compared to the NHS**

It's probably important to provide an overview of the key differences between the three health care systems not for the purpose of claiming one is good and the other bad, but to allow the organisations visited to be contextualised as part of a larger picture. Firstly, to recap on the UK's healthcare system; primarily, the NHS. There are many that will criticise the UK healthcare system, with the rhetoric usually centred on waiting times. Unlike the other two countries; the NHS is a government funded health care provider, paid for by the tax-payer and for UK citizens is free for all who need it. Private healthcare does exist in the UK, but it forms a smaller proportion of the overall healthcare provision and should they want it, the population are able to access state provided healthcare. Not for profit and charitable organisations work alongside the NHS and can often fill gaps in service availability. To focus on primary care and community mental health; money is allocated to care commissioning groups and NHS Trusts to allocate for spending based on population need. The NHS is driven by the concept of cost effective care as there are limited resources. New strategies to improve patient care must be cost effective.

Secondly let's consider Australia. The three levels of government that exist in Australia; federal, state and local are responsible for funding and delivering universal healthcare. The federal government provides funding for the states and subsidises primary care through the Medicare system and Pharmaceuticals Benefits System. The states use the funding from the federal government plus additional resources to take responsibility of community health services, mental health services, public hospitals and ambulance services. Local government has a role in preventative health programs. The organisation and delivery of primary care and mental health care will be covered in more detail due to the relevance to this report.

The federal government funds Medicare; a universal public health insurance program providing free or subsidised care for Australian residents. This is in part funded by a government tax-levy for its citizens. Private health insurance is readily available and in 2016, nearly half of the Australian population had private hospital coverage. The government encourage people to have private health care insurance with tax rebates and if person's earnings are above a threshold they receive a penalty for not having private health insurance.

With regard to primary care; GPs are typically self-employed and pay to use the the building and facilities a practice offers. Registration with a GP is not required and patients are able to pick their GPs and can often have multiple GP's who they attend. Some practices offer GP consultations at the same rate at which Medicare reimburse; at others there is a gap between what a practice charges and what Medicare will pay out, with the amount supplemented by the patient. A bulk-billing system also exists in which a medical professional can directly bill Medicare for a service to a patient. Medicare requires the patient to have been seen by the GP to reimburse the cost of the consultation, even if the encounter is led by a different member of the multi-disciplinary team. The federal government offers financial incentives through the Practice Incentives Program which seeks

to promote multidisciplinary working, care coordination, formation of ‘super clinics’ and Primary Health Networks (local organisations to support effective and efficient care).

State governments fund and deliver acute mental health and psychiatric care in hospitals and community-based services. Public hospital-based care is free to public patients. GPs provide some community mental health care and then can refer to specialists which are then subsidized by Medicare.<sup>8</sup>

The United States health care coverage is fragmented and consists of many public and private sources with gaps across the US in those with insurance cover. The Affordable Care Act 2010 aimed to improve access to affordable and good quality health care insurance by establishing shared responsibility of employers, the government and individuals. Public health programs cover nearly 40% of residents in the US. The main two providers are Medicare and Medicaid and they provide coverage to often overlapping populations. Medicare offers coverage for being hospitalised, seeing a physician and some prescription drugs. It only offers coverage for ‘post acute care’ whilst Medicaid offers longer term care coverage. Medicare is funded and administered at federal government level, where Medicaid is at state level.

Primary care physicians are not gate-keepers as per in Australia and the UK. Again, people can choose their GP as in Australia. Physicians are paid by private and public insurance and also via incentives by programs such as Medicare. Insured patients are usually responsible for some part of their GP payment and uninsured are responsible for all of it. Mental health care is provided by a mixture of profit and not-for-profit organisations. The Affordable Care Act sought to improve access to mental health and substance abuse care by making it an essential health care benefit.<sup>9</sup>

### **An outline of the Health Care Home (HCH) program as set out by the Australian Department of Health<sup>10</sup>**

The overall aims of the HCH program are to improve patient outcomes for patients with chronic disease, improve the experience of primary care for patients enrolled in the program and better control health care costs. The program provides patients with complex needs; continuous, coordinated multidisciplinary-based care and gives the health care providers more flexibility to tailor the care to the needs and goals of the patient who has an active role in their own care. As well as nominating a GP or nurse to lead the patients care, the allied health care professionals such as pharmacists, specialists, dieticians and physiotherapists are referred to and closely link to the patient’s care.

The patient should have enhanced access and flexibility to how they use their HCH practice. This will be achieved by shifting to a bundled payment rather than a fee for service payment, meaning that the patient does not have to see the GP as is stipulated by the Medicare system but instead can have a consultation with the most appropriate MDT member, have a

telephone consultation or get a remote prescription. There would be team based care through care plan sharing and on going data collection to improve care going forward. The program sets out to encourage proactive disease management through wrap around care for the patient.

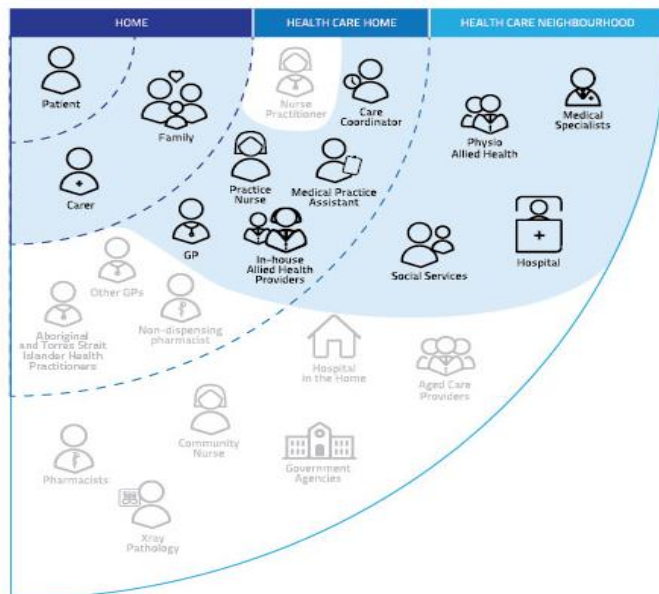


Figure 1. This diagram shows how a patient's care team might look; showing those in the HCH and the wider healthcare neighborhood.

The HCH handbook produced by the Department of Health sets out for primary care practices some guidance on how the program could be implemented. The document sets out possible agreements and relationships with the wider care neighborhood that would expedite referrals where appropriate and improve coordination of care. Shared care planning is essential to the HCH program, and the program uses an electronic shared care plan to facilitate the care team to share information in real time and aims to reflect the current and long term goals of the patient.<sup>11</sup> In addition to the HCH shared care plan, patients are encouraged to have My Health Record. The My Health Record system is accessible to all health care providers, including those not normally involved in their care.<sup>12</sup>

The evaluation of the HCH program commenced on 1 October 2017 and will end on 30 December 2019. Up to 200 primary care practices are being recruited to participate, drawn from 10 regions aligned with Primary Health Networks (PHNs). Up to 65,000 patients are expected to be enrolled. Once enrolled, practices will receive a monthly bundled payment for these patients for care provided in for their chronic diseases.

### The difficulties and limitations encountered during the Health Care Homes trial

By using the set of questions described in the introduction, I was able to use informal thematic analysis to infer consensus on both the successes and difficulties of the HCH program. This section of the report will expand on the difficulties faced during the trial of



HCH program and how this impacted the project, and consequently changed the focus. At the point of my visit in November 2018 there were approximately 6000 patients enrolled in the HCH program, significantly less than the figure proposed. From the interview I undertook, there were several factors that seemed to have contributed to this.

Some of the factors which limited the uptake of the HCH were specific to Australian health care; in particular, the primary health care system whereas others were universal and therefore offer learning more generalisable to the UK and similar populations.

One of the issues that was repeatedly presented by the organisations involved was that GPs felt that the shift towards bundles payment meant that they were financially worse off. In the existing set up, GPs would be paid each time one of their complex patients has a consultation. In the case of those with complex health needs this could be on a weekly basis. All of those that I spoke to felt the bundle payment (based on a 3 tier stratification of patient complexity) was not adequate to see the same patients as much as they had previously. Most felt that even the most complex and therefore highest funded tier was in reality not suitable for those with one or more chronic condition or mental illness; those it was proposing to target. In many of the practice I spoke with, only one of the GPs had taken on the program and began enrolling patients, others chose to continue as usual. This dramatically affected the numbers of patients enrolled in each practice. Of the GPs I interviewed; they had decided to embrace the program as they had hoped that it may lead to a change in the delivery of primary care services. Most felt disappointed at the perceived lack of financial viability.

A second major issue that the HCH faced was its association with My Health Record. This is an electronic notes system that allows for health professionals to access patient's records, including those that are not previously involved in a person's care. My Health Record aims to provide a centralised, online summary of a person's health record allowing clinicians to access someone's past medical history and medications. Between July 2018 and January 2019 there was an opt-out period for My Health Record, after which point each Australian would have one created. The current participation rate is 90.1%.<sup>12</sup> As well as those in favour of digitalisation of health information, My Health Record received criticism due to arguments around privacy, security and reliability. The research literature has been mixed for the scheme.<sup>13</sup> The scheme gained increased public interest through media coverage, with varying levels of understanding. Although HCH was a different health initiative, the initial information disseminated to primary care suggested they would need a My Health Record to proceed in the trial, and this had put off many patients and families. Many of the practices I visited had a significant amount of eligible patient's decline enrolment for this reason. The unfortunate crossover in timings of the two schemes discouraged uptake in the HCH trial and contributed to the limited success of HCH during its trial period.

Thirdly primary care providers felt there was a lack of top down information delivery to guide the roll out process of HCH. The program involved a change to the internal processes within a practice; software changes, funding changes and organisation re-structuring. Many of these changes were happening during the enrolment period, meaning many of the staff

at the practices were having to adapt their practice on a weekly basis. The individuals I visited reported having received very little top down guidance on how to implement the changes. For this reason, all of the primary care practices I visited only had one GP responsible for HCH. Due to the varying size and services available at the primary care practices a much more tailored approach to the roll out would have been required. The Primary Health Networks provided on the ground support for the GPs and primary care facilities, which clearly helped with the trial, but the lack of guidance and transparency of the future of HCH clearly left practices behind their target enrolment numbers. From my point of view, one of the most exciting opportunities that HCH provided was a linking up between primary, secondary and tertiary care providers to have joint up working and prevent those with complex needs falling through the net. Unfortunately, during my visit it became apparent that these links had not been made. One GP explained how she had frequent conversations with hospitals in the area when referring HCH patients for admission; but none of them had working knowledge of the trial or had access to the shared health record. The structural systems were not established linking hospitals and primary care prior to the HCH role out and the education of those working in secondary care came primarily from the GP.



## Case Study One: First Step; an addiction and mental health service with a difference

Along with the rest of Melbourne, St Kilda has become a very expensive place to live and this has contributed to an increase in the prevalence of homelessness and the health related consequences of this.



The First Step base is an unassuming, Victorian property just set back from the street. As I walked into the building, this homely, non-clinical feel extended into the waiting area which had a box piled high with pastries for those waiting. I was met by Patrick Lawrence, the CEO of First Step who gave me a guided tour and filled me in on some of the background to the organisation and later joined by Gayle Wood, the Operations Manager.

Figure 2. The residential approach to the First Step practice.

*First Step is a not-for-profit organisation and was founded in the year 2000. It was initially set up as an acute detox facility for those addicted to heroin and has evolved over the last 18 years to broaden its services to become more in line with a medical model, and cement itself as a valuable part of the local community. Patrick has been with First Step for 12 years and described the organisation as an “open-armed, wrap-around service” and I began to see why. All out of the one modest building they deliver management for hepatitis B and C, liver cancer, alcohol and drug addiction, physical and mental health, as well as providing in-house free legal services, art therapy, a women’s group, mental health boot camp and a range of support for those who have experienced domestic violence.*

First Step had put themselves forward for inclusion in the HCH trial, but just before my visit they had withdrawn from the program. During the interview with Patrick, he explained how they had been impressed by the potential benefits of the program but explained there had been a few reasons for their withdrawal. Firstly, there was no lead GP to take on the project. As explained previously the HCH roll out benefits from a GP overseeing the program. Secondly, due to the level of complexity of First Step’s case load, the majority fell into Tier 3 of the HCH program, meaning it was impossible to enroll a cohort of patients spread across the complexity tiers. In addition, due to the often chaotic lives of the patient base; it was difficult to have patients adhere to the structure of the program. Finally, First Step already used an MDT approach to patient management, using care coordination, and had established links to local detox beds in the Alfred Hospital. Not dissimilar to the other organisations I visited, although First Step supported the ideas behind HCH, the

administrative complexities and lack of financial incentives meant implementation was halted.

First Step now manages a case load of over 5000 patients with complex needs and has a multidisciplinary team including GPs, a psychiatrist, mental health nurses, care coordinators, therapists and a legal team and is the largest opioid substitution provider in Victoria. The moment I walked into the building and met with the team at First Step it felt like a warm place, with enthusiastic and motivated staff driving it forward and seeking out new and necessary programs that they could offer. First Step have found that patients are engaged to keep coming back to have their holistic needs met, which is often not the case for this patient group elsewhere due to the way primary care services are set up in Australia. It makes sense to have a one-stop-shop for patients who may not have the means or support to make it to multiple appointments, with multiple agencies, across multiple locations and as a result often disengage from follow up. Whereas services in the UK are often fragmented and compartmentalized, this model of service delivery is tailored to meet the range of needs of its service users.

To highlight how First Step operates, and how it feels a part of the community, I would like to include a case vignette passed on to me by Gayle:

*The previous week a man had been collapsed on the tram tracks and was found by a local lady and her two children. She helped him to his feet and drove him round to the First Step door at 5pm on a Friday evening. The man had a psychotic illness and multiple physical health problems. He was seen by a GP, the nursing team and supported to stay at home over the weekend before seeing a psychiatrist and receiving legal aid the following Monday.*

The First Step Program are doing a fantastic job at delivering wrap around care to patients with complex health needs and I would like to thank Patrick and Gayle for taking the time to show me their work.

## Case Study Two: Headspace; a youth mental health centre



My next visit took me down to towards the Mornington Peninsula to visit Frankston, home to the largest of the Headspace services where I met Courtney Gould to hear a little bit more about their service and the team's involvement in the Health Care Homes (HCH) program. They only had small numbers signed up to HCH program when I visited, as consent had proven to be a sticking point for many of the youths, who really valued the confidentiality of the space. That said, there was a clear gain to be made by signing up to the HCH program as it offered access to department of health funding to a service which currently relies on the Headspace

organisation, some primary health funding and individual tenders. I met with Courtney Gould, a manager at the service and discussed the history, expansion and goals of the service and how it fitted in with the HCH program.

*Headspace is an organisation which began in 2006 and was born out of a need to plug the gap in services by providing tailored and holistic mental health support for 12-25 year olds. With a focus on early intervention they aim to change the trajectory of the youths attending the service and enabling them to better manage their difficulties. The organisation now has over 100 sites across Australia and remains a not-for-profit organisation.*

Frankston Headspace sees over 1500 youths a year and is facing an increasing demand as state funded programs have declined and the pressures on A&E departments have increased. As a result, the team find they are getting more and more referrals from clinicians, in addition to being a popular service for youths to self-refer to. They currently have four GPs, 6 counsellors, youth workers and nurses and they offer an all under one roof service.

Courtney told me that this age group are a difficult cohort to access, let alone to motivate to keep returning for appointments, and so Headspace Frankston have streamlined how they operate in response. All of the services that a youth may need to access have been made available under one roof; they have access to a sexual health clinic, GP services (who complete their own pathology), drug and alcohol services, mental health services, group therapy, counselling, an early intervention psychosis service as well as youth programs and work and study services. They aim to get their patients seen by as many relevant allied health professionals as quick as possible, and it works. They find that individuals not only come back for their follow up, but they bring a friend for check ups, and so the case load grows. Courtney told me that in the previous week alone, they had received 70 referrals.

Headspace Frankston was a trial site for the HCH program. The reason they applied to be involved in the trial was to better serve their young people with complex health and social

needs. At the point of my visit, they had enrolled only four patients in the HCH program. These four patients had a mixture of mental and chronic physical health needs, and the GPs at the centre took the role as care coordinators for these patients. Courtney was positive about the impact it could have for these individuals as the secure, bundled funding meant that they were able to plan preventative health care provisions for these individuals as well as having MDT led care and team meetings which would previously have not been funded through Medicare. As with other practices, they were yet to see clear links to secondary care organisations but due to the in-house services this had not been a limitation. The main limiting factor in enrolling patients to the service had been consent. The youth's using the Headspace service valued the confidentiality and many felt that the link to My Health Record would potentially jeopardize that for them and therefore refused to enroll in the program.

I currently work with a Child and Adolescent Mental Health (CAMHS) service in London and it can often become convoluted when trying to patients to the different allied health services and patients can be left in the dark trying to navigate which professional they see for which complaint. This approach solves that. Secondly, due to the structuring of psychiatric services in the UK, there can often be a difficult transition period when an adolescent turn 18 and is no longer suitable to access a CAMHS team but is often much closer in emotional maturity and disease progression those individuals in CAMHS than in general adult services. In addition to this, many don't then meet the criteria to be managed by an adult community mental health team leaving them without support at a very important life stage. This approach provides a good solution.

Headspace Frankston offered a school 'in-reach' as part of a suicide prevention and postvention program. If a young person takes their life, Headspace take a team and visit the school which they attended, as well as any sports or social groups to offer support and debrief for the people that were in close contact with the individual, to help with the processing of their grief. I thought that this was a fantastic intervention.



Figure 3. The service-user designed waiting area with the clinical areas being in the background using tinted glass.

Finally, the building in which Headspace Frankston resides is testament to the interest of the youth being at its core. Set across one level, in a somewhat open plan layout the building was designed by a youth team paired up with the architects. In a bid to remove the clinical coldness of a health environment there was no white, all of the clinical rooms had colour, exposed brick and clever lighting, with as much natural light as possible. There were washing machines, showers and a food area the young people could access. The waiting areas were set up as to socialise those waiting in them, and the building had the overall feel of a cleverly designed art space that managed to meet the privacy needs for its function. Making a clinical space inviting for its target group acts to remove a barrier in accessing help, very little attention is given to this in the UK and given that rates of missed appointments is higher in the child and adolescent group this could be a means towards increasing accessibility and reducing the number of missed appointments.



### Case Study Three: UCLA Alzheimer's and Dementia Care Program



During my time in the US I had the opportunity the UCLA hospital campus to meet with Leslie Evertson (Lead Dementia Care Manager) and Dr Tan Zaldy (Medical Director) to hear more about their award winning program. As with all of the services I have visited, I was drawn to the program as they offered something 'extra' for patients in need of additional support. Having worked in a memory clinic for 6 months in the UK, I was in a good position to be able to compare and contrast the services provided in vastly different health care systems.

Figure 4. UCLA Health headquarters.

*The UCLA Alzheimer's and Dementia Care program was launched in 2012 and is designed to help patients and their families with the complex medical, behavioral and social needs of Alzheimer's disease and other types of dementia. All patients are monitored at least annually to ensure that ongoing and emerging needs are met and any visits are covered by Medicare and at no cost to the patient. One of the eligibility criteria at this stage is having an UCLA primary care physician as the program works closely with them to coordinate their care. They offer 24 hours, 365 days a year advice for patients and care givers. The team comprises of two Physicians, four Dementia Care Managers and several assistant case managers but care plans include consultation with neurologists, psychiatrists and geriatricians. Interestingly, support groups are co-facilitated by Ronald Regan's daughter, Patti Davis.*

UCLA Alzheimer's and Dementia Care Program accepts patients referred from their community team (family doctor/GP) with a diagnosis of dementia already in place. They then undergo a thorough assessment to review their current support need and plan for the future, which is not dissimilar to UK practice. Dementia Care Managers are at the heart of the program and work with primary care physicians to develop and implement a personalised care plan. Where the program does differs from both the UK and Australia, is in its provision of care coordination, education, carer support, liaison between community and specialist care, advance care planning and linkage to community resources. The program has close links to the resources in the area such as the Jewish Family Service and ONEgeneration, as well as organising local support groups for patients and their families. The service allows the care for that individual to be proactive, rather than reactive, with medication planning, advance care planning and open and ongoing discussion with the service users.

The organisation runs a program called 'Time Out', an intergenerational group whereby older adults mentor enthusiastic students at UCLA, giving their caregivers a much needed break. The program aims to promote meaningful conversation and socialisation as the students learn from the older adults whilst providing companionship in the process.

One impressive project that the organisation coordinates is a dementia bootcamp for caregivers (UCLA I-CareD Caregiver Bootcamp). These run in the local community from 8am-5pm on a Saturday and have space for around 30 care-givers each session. Care-givers were predominantly family members but this was not a requirement. They offered a multi-component caregiver education, training and support program. The education topics were decided upon by surveying the most common challenging and difficult issues that had been brought to the dementia care managers. The sessions were then designed to increase accessibility for caregivers. They took place on a weekend, in several local areas with availability of on-site respite for care recipients. The program consisted of interactive large and small-group sessions with interspersed panel discussion. The covered topics included: epidemiology, signs/symptoms and stages of dementia, home safety, caregiver self-care, care site options (e.g. hiring home health care professionals, adult day and long-term care); and behavioral and medication management interventions for problem behaviors. The bootcamp also included an on-site support group and had a patient role-play session that allowed participants to practice and demonstrate skills learnt in the session with with trained patient actors.

The boot camp has sessions with occupational therapists, physiotherapists, clinicians, psychologists and marriage therapists as well as peer support groups giving individuals chance to tell their story and encourage learning. The idea of providing all of this specialist health education in such an open and supportive environment is very unique and gives carers a chance to have their voice heard while fostering learning and relationship building. To my knowledge there are no programs providing a similar intervention and having worked within memory services it would be really beneficial and well received.

The program collected pre and post data on carer competence, knowledge as well as evaluating the carer's confidence in delivering care to their loved one. For the cohort included in the trial of the bootcamp program, 85% of participants rated the program as excellent.<sup>14</sup>

## **How can health technology be utilised within this patient group?**

Health technology is the integral component of connected and collaborative care. Health care providers need to have a platform through which to communicate with all the members of the team without the inconsistencies and delays by traditional methods such as scanning, faxing or letters. Joined-up working through shared care plans ensures that both patient and anyone providing care to patients can be fully informed at all times.

Whilst in Melbourne I met with the founder of Precedence Health Care, Professor Michael Georgeff. Precedence provide digital health technology with a focus on care planning and coordination technologies for tackling the growing challenge of chronic illness and other complex conditions. This organisation produced the health care platform cdmNet which was used by the HCH program for their shared care plans. They produced the Commonwealth-mandated Health Care Homes Risk Assessment Tool for enrolling and risk stratifying patients to the program and use technology to target at risk population groups.

Their software allows for alerts and notifications of patient needs and overdue actions to ensure the team around the patient are able to provide proactive and timely care, which prevents patients falling between the cracks. Patients have access to their file and are able to upload new information or link the software directly to connect digital devices or wearables. As well as providing a real-time view of the care that a patient is receiving it is able to link to provide prompts to patients via mobile applications which are tailored to their data and health needs. The software is linked to educational videos on topics such as diabetes management, exercise or dietary information. It can also disseminate the appropriate education for individual needs, based on blood results, diagnostic information or patient completed questionnaires.

I visited Precedence Health Care at the end of my time in Melbourne and therefore I discussed HCH with Professor Georgeff, having already started to formulate some of my own views on the trial. In his view the limitations had been the bureaucracy and additional work burden placed on GPs, the small enrollment numbers and the difficulty in changing the work culture of GPs in Australia; which included a shift towards digital services and the changing financial landscape. Professor Georgeff explained that there were many positives to arise thus far from the HCH trial. The program went somewhat in getting primary practices digitalized, through the use of shared care records. The program encourages practices and GPs to think more closely about instigating follow up, leading to more coordinated and proactive care delivery. It has opened up discussion about a shift in culture with Australian primary care and led to an increased awareness of the benefits of a patient-centered medical home model which he feels will be the way that health care shifts in Australia.

In order to provide fully coordinated, patient centered care there needs to be a move towards embracing health technology. This is a population group who would benefit from additional prompting and guidance and whom would benefit from all care providers having the most up-to-date medical record to guide their future management.



Below is the Precedence Health Care model of care delivery which brings aligns with what the HCH program was meant to provide for its patients. Unfortunately at the time of my visit, it had fell short in providing this seven part model but the digital services were in place for the HCH program to use. This shift towards care providers liaising closely through digital platforms with patient and family input should be at the heart of a model aiming to provide wrap around, intuitive care.

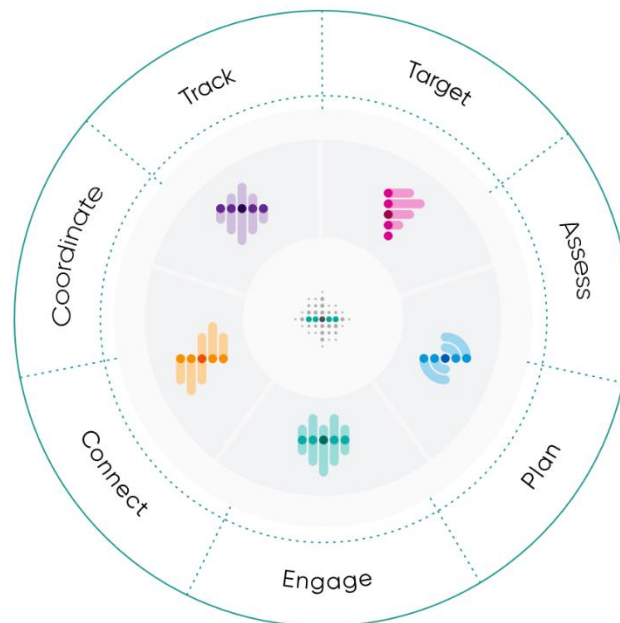
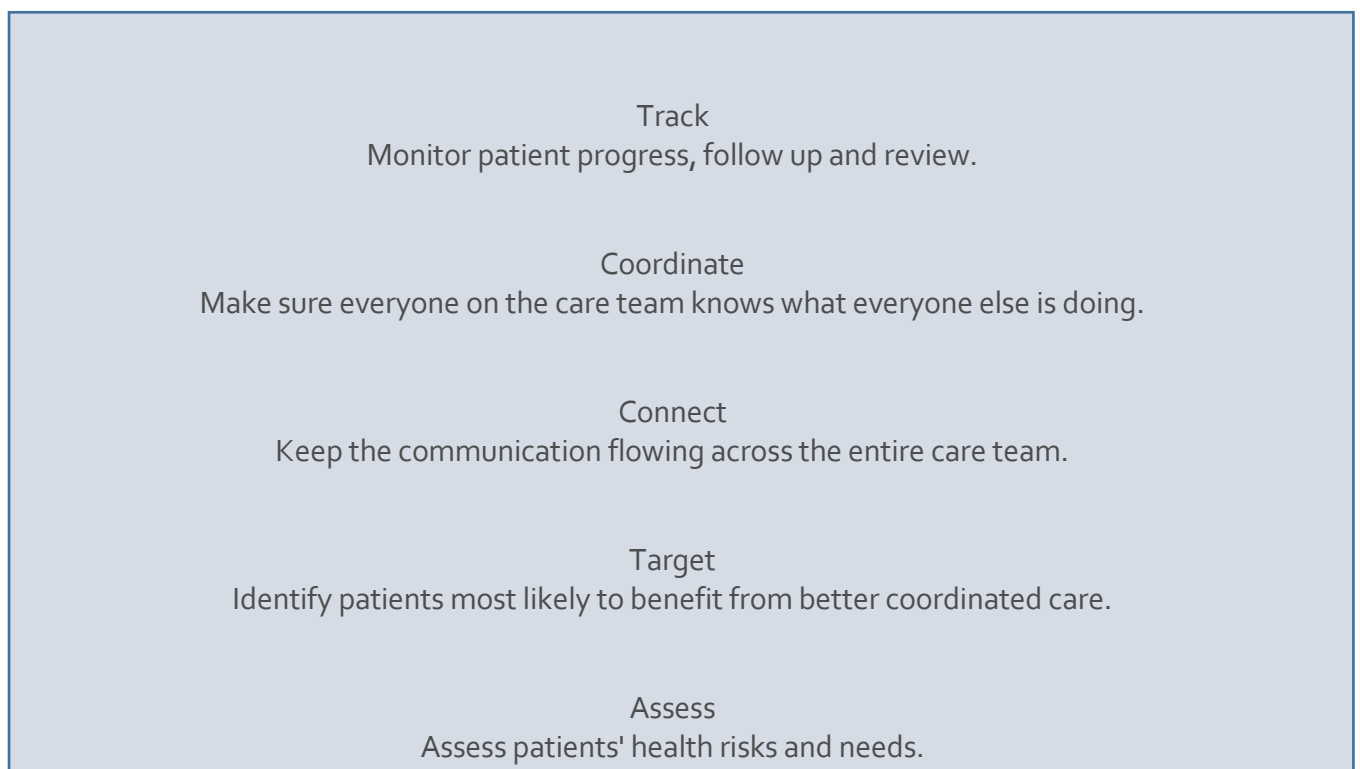


Figure 5. Precedence Health Care model of care delivery.<sup>15</sup>



### Plan

Develop a unique care plan for each patient centered on their needs and preferences.

### Engage

Involve patients and their families in managing their own care.

#### Other organisations visited:

**HealthMint** – I had the pleasure of visiting a primary care practice south-east of Melbourne. The practice was a trial site for the HCH program and had enrolled 11 patients at the time of my visit. This was a primary care practice that prided themselves on using a patient experience model of delivering care. They placed importance on the environment in which patients received care and the impact this had on their wellbeing and the wellbeing of the staff around them.

The practice was very impressive to look at. There was calming music playing in the waiting area which then followed the patient through to the consultation room. The waiting area was airy and full of space and natural light. There were plants throughout it and the seating was practical and comfortable with space between the patients. The doctor's consultation rooms did not appear like clinical environments. There was colour on the walls and large windows to provide light. They had gotten rid of the traditional doctor's desk and instead removed any barrier between the doctor and patient to facilitate openness and collaboration. I spoke with two GPs, the practice manager and a nurse practitioner and each of them felt the environment had a positive impact on patients and their own wellbeing. Given the increasing body of evidence to support the link between pleasant health care environments and health outcomes, UK primary care practices should be encouraged to take note of such examples.

**Star Health** – This was a large primary care provider which was a trial site for the HCH program. At the point of my visit they had 49 patients enrolled in the program. This large practice provided an all services under one roof approach. They had in house alcohol and drug services, child and family services, domestic abuse services, GPs, mental health support groups and 'health promotion' services. This practice had shifted towards nurse-led identification for the HCH program and this had been successfully implemented. They too agreed that the complexity tiers meant that those with multiple complex needs were not suitable for the program, despite it being targeted at them. Star staff felt that HCH had led to the nurses and GPs having a much clearer idea of how patient's health fluctuated throughout the year, which allowed for more effective monitoring. They too felt it led to more proactive care delivery. The main limitations highlighted by the practice were that of difficulties in recruitment and lack of top down information.

In addition, I was able to visit the following organisations. To avoid repetition and ensure the report is concise, I will not include a description for each organisation however the information gleaned from visiting the below organisations has informed the conclusions and recommendations made in this report.

*Pearcedale Primary Care Practice – Dr Farza (GP Practice Lead) -*

*<https://www.pearcedalemedical.com.au>*

*South Eastern Melbourne Primary Health Network – David Menzies (Manager of Chronic Disease Program) - <https://www.semphn.org.au/>*

*North Western Melbourne Primary Health Network – Michaela Lodewyckx (Coordinator Primary Care Improvement) - <https://nwmpnhn.org.au/>*

*The Alfred Hospital, Melbourne – Lucy Bassett (Project Manager, Victorian Integrated Care Model) - <https://www.alfredhealth.org.au/>*

*Centre for Excellence in Primary Care in the San Francisco General and Trauma Hospital – Rachel Willard-Grace (MPH) - [cepc.ucsf.edu](http://cepc.ucsf.edu)*



## Conclusions

The overall aim of my Fellowship was to visit Melbourne, Australia and California, United States to explore the use of the different versions of Patient-Centred Medical Care Home to provide health care to those patients with complex health needs. Across the four-week period of my Fellowship I met a range of organisations who all had a role in delivering effective care to a complex group of patients. Through the Fellowship I met many organisations passionate about ensuring patient care is at its best and this left me feeling motivated to drive for positive change.

Using the range of questions laid out above I was able to draw conclusions about which aspects of the HCH program had been successfully implemented along with the limitations of the model and how this manifested itself in clinical practice. The HCH trial was significantly behind its projected numbers and as a result many of the processes which had been planned for had not yet been implemented. This had an impact on the scope of this project but also provided useful learning on difficulties faced when attempting to change the culture within the medical profession. What became apparent during the visit was that many of the organisations I visited had structured their service provision to best suit their complex caseload independently of the public health strategies being introduced.

Health Care Homes represents a big shift in the way that primary care in Australia cares for those with complex health needs. Having spoken to many motivated organisations, all of them supported a change towards provision of patient-centred, coordinated and preventative care which is at the root of the HCH model. Many felt that the existing strategies and care plans in place within primary practices relied heavily on patient engagement and organisation; two behaviours that can be more difficult in this patient population. The HCH structured, prospective care planning marks a step-forward in primary care provision. Closely linked to this is the increased utilisation of the practice nurses and allied health care professionals within a primary care practice. Currently, for those not enrolled in the HCH program they must have a face-to-face consultation with a GP to access Medicare funding. This increases the workload for GPs and fails to harness the breadth of skills and knowledge of the wider multidisciplinary team. The nurses I spoke to during my visit had really embraced the HCH program as it had empowered them to take more control in care planning and management of patients. Likewise, the change to bundled funding means this is much greater scope for family planning meetings, telecommunication and remote prescribing.

A move towards shared electronic medical records is perceived as a positive shift for most health care professionals as it facilitates access to real time patient information and better informs decision making. It also allows for better risk stratification and consolidation of patient data. This streamlining of processes remains in its infancy and represents a cultural shift for both health care providers and patients but will no doubt have many benefits for those with multiple health needs. One of the key limiting factors for the HCH program and in turn my Fellowship was the parallel roll out period and association with My Health

Record. Although towards the end of my visit it became apparent that it was not necessary to have a My Health Record to be enrolled in the HCH program, many of the practices I visited had thought this and therefore met significant resistance from patients. One practice reported that only 2/10 potential patients enrolled for the HCH program with the other eight quoting uncertainty over My Health Record as the main factor. In the UK setting, digital services are often provided on a local level, causing problems when trying to link up the care provided across primary, secondary and tertiary care. It is likely that care providers and receivers would welcome a shift towards information sharing between health care professionals.

From my interviews with the GPs involved in HCH, all of them had felt that the bundled payments based on a tiered system for complexity was not financially viable in the long term. This was primarily as they felt that those with Tier 3 complexity needed more face-to-face appointments than the payment would allow for, meaning that GPs would be at a loss when managing these patients. Clearly, something would have to change in order for GPs to fully support the program as without them a shift towards this new model of care would not be possible. I discussed this with individuals at the Primary Health Networks and it was felt that the lower complexity Tier 1 patients funding would offset the costlier care provision of Tier 3 patients and a shift towards involvement of nursing staff in patient care should reduce the burden on GPs within the practice. It is possible that this could be the case, however another commonly reported problem with the HCH program was a lack of top down, clear information for GPs and primary care practices. Clearly this issue encountered during the HCH trial would not be relevant for UK primary care given the funding differences, but it does raise the question of ensuring that the correct patients are targeted to make sure a clinician's time is meaningfully spent.

It was clear from my visit the importance of clear and transparent top down information from those responsible for implementing the program is essential. All of the practices I visited felt inadequately educated about the practical implementation of the program, the administrative burden and methods of evaluation of the program. This had led to disengagement and confusion which undoubtedly contributed to the poor enrolment statistics. Practices were expected to dramatically increase their workload, through additional admin and HCH training for their staff but without being clearly informed about the trajectory of the trial, the evaluation and how the future would look for primary care. Without motivated and informed primary care practices this was always going to be a struggle as a lack of advertising of the program to the general population meant that GPs are solely responsible for educating and engaging patients.

From speaking with GPs, patients enrolled in the HCH program had found it a positive experience. They had more frequent scheduled contact from their GP, their family were able to contact the practice for discussion (particularly in the elderly population) and they could speak on the phone to GPs. It is likely that this would be well received in a UK population given the shortage of GPs and therefore difficulty in getting appointments. Taking a more structured and prospective approach to delivering appointments may alleviate patient stress in getting timely GP reviews. Most reported that patients were

unclear as to the purpose of the HCH program which again signals a lack of clear health promotion information for patients.

### **Recommendations:**

When visiting the different organisations across Melbourne and California I at all times had in mind how my findings could be interpreted to ensure they were relevant for practice in the UK. It is possible to understand these in terms of what the findings add to the existing literature about patient-centred medical home models and their use in the patient group and how the findings can inform local service changes within my area of practice, mental health services.

### **Patient-Centred Medical Home Model**

Many health systems around the world are beginning to adopt the model in order to redesign and strengthen primary care. There is an emerging literature from the different countries trialling use of these models. The HCH trial continues in Australia and the findings have therefore yet to be published however there were key learnings which are of relevance in the UK as the 'Primary Care Home' model further develops.

- The whole multidisciplinary team, the primary care practice, patients and their families value coordinated proactive care provision. This should be executed through clear communication, with the patient at the centre. All patients with multiple, chronic health needs would benefit from this approach being taken.
- Clear guidance and education of all staff involved in the implementation of such programs is essential to enable care providers to be motivated and able to inform patients whilst driving improved clinical outcomes.
- Clinicians emphasise the importance of seamless relationships with secondary and tertiary care providers and social care. The structures, processes and relationships between care providers should be established before the model is implemented.
- The financial and clinical drivers for the model need to be aligned ensuring practices can perform to their best without feeling constrained.
- Health technology and electronic shared healthcare plans provide streamlined communication between health care professionals and the patient. Implementation of this technology will allow for effective coordination of care and will facilitate expansion of the program.

## Delivery of care within community mental health services

In addition to reviewing the HCH model, I visited many organisations who had organised their practice in a way that truly benefits those accessing it. Access to mental health services needs to always consider those that use it, as any barriers to engaging with services has the potential to detrimentally affect this group more than others. This is particularly significant when considering those with both physical and mental health needs. In light of this, there are recommendations that can be made for community mental health teams and clinical commissioning groups based on the findings of the Fellowship.

- Within UK Child and Adolescent Mental Health Services (CAMHS) the current organisation of services is that children and adolescents are only seen up until the age of 18 years. At this time, if they require further mental health support they would be referred to adult mental health services. Further consideration should be given to reorganising services that deliver a 'youth' service which provides mental health input until an individual has reached their early twenties. This would better meet the needs of this population, allowing for a focus on education, employment, sexual health and life transitions. The transition to adult services at 18 years can often be very difficult and traumatic for those accessing services, particularly for those who are less emotionally matured.
- Hub-based working models, where multiple services are provided by one practice improves patient engagement, particularly for those with addiction, or complex health and social needs. It also improves collaborative working between professional disciplines and better meets the needs of the patient population. It is recommended that clinical commissioning groups consider funding team bases that have services tailored to the wider health and social needs of complex patient groups.
- It is recommended that as part of community mental health memory clinics, a carer education and training program be established to improve the knowledge and skill base for those caring for people with dementia. This could empower families and reduced admissions to hospital related to carer burnout.
- It is recommended that those managing patients with complex health needs have access to electronic shared care plans, and that where possible allied health trusts facilitate access to electronic patient records.

## What Next?

I have put in place plans to present my findings locally to the Child and Adolescent Mental Health Team, to promote the idea of a 'youth service' and the successes that the Frankton Headspace organisation have achieved. There is currently very little linking between the

other services our young people access and this discussion can serve as a place to generate ideas for how this can be achieved within our service.

I currently work closely with the older adults Clinical Trials department at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) and through this I plan to consider the possibility of a bootcamp similar to that undertaken at UCLA. I continue to have communication with the medical lead for the program who has agreed to help facilitate any project we may start in the UK.

Following the submission of my report, I plan to condense down my findings in order to produce an article for submission for a medical journal.

To further supplement my findings, it would be good to be able to visit one of the trial sites for the Primary Care Home, the UK version of the model, to be able to draw comparison to further support my recommendations.



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