Mary Baldwin
General Manager, Apollo Medical Centre

Dr Khalid Hikmat
General Practitioner

Dr Andre George
General Practitioner

IFHCs- Do we have a working model?

Friday, 21 June 2013 | Start 12:20pm | Duration: 20mins | Baytrust

Mary Baldwin General Manager

Medical Centre @ Apollo

An Integrated Family Health Centre- do we have a working model?

Aim of Founding Owner Doctors of Apollo Medical 2003

- Provide a better service for our patients
- Create a better environment for our staff
- Operate a more sustainable business model

Helen MacDonald Clinical Director

Apollo Health and Wellness Centre opened 2005

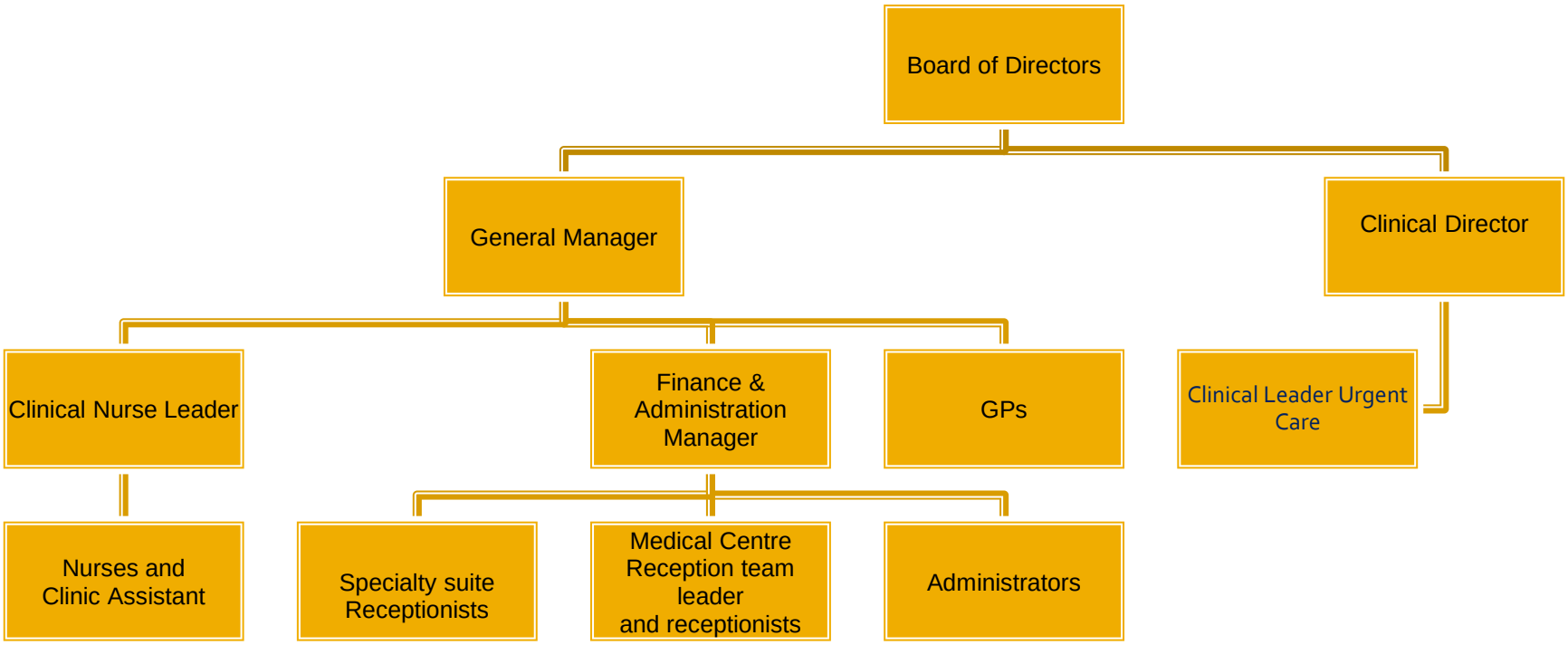
Co-located Services of Apollo Health and Wellness Centre

- General Practice
- Urgent Care
  - Fracture clinic
- Specialty suite
  - Cardiology
  - Dermatology
  - Midwifery
  - Orthopaedics
  - Paediatrics
  - Urology
  - ENT
  - Skin cancer
  - Speech therapy
- Pharmacy
- Radiology
- Labtests
- Psychotherapy
- Physiotherapy
- Fertility Services
- Travel Medicine
- Dentistry
- Podiatry
- Ophthalmology
- Audiology
- And others

Business Model of Apollo Medical

- 7 Share Owner Doctors
- Board of Directors (including external director)
- General Manager & Clinical Director
- Associate GPs (make up 65% of the doctor fte)
- Primary Care Nurses
- Reception and Support Staff

Organization Structure



Vital statistics

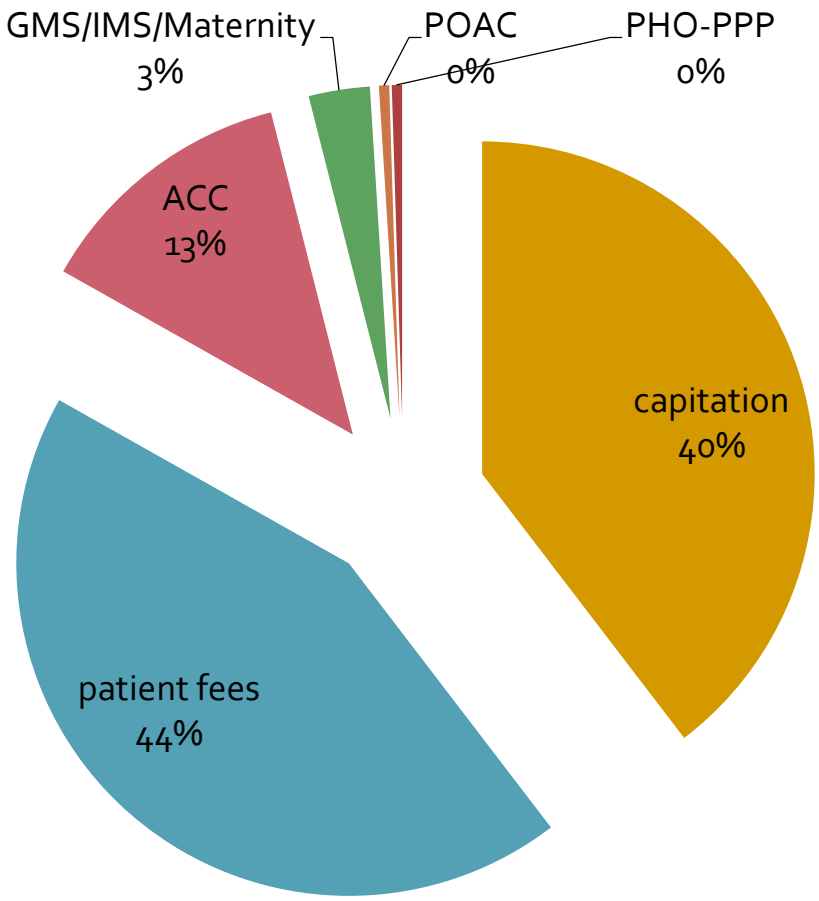
PATIENTS

- 17,000 (circa) Enrolled Patients
- 1,000 Visitor attendances per month
- About 60,000 consultations per annum
- Aged Care Hospital 47 patients- three rounds per week

STAFF

- 22 Doctors (11fte)
- 16 Nurses (13fte)
- 15 Receptionists (11fte)
- 4 Admin & Manager(3.8fte)

Revenue Split



The Strengths of Apollo

- Access to Services
  - General Practice
  - Urgent Care 12 hours per day 7 days per week
  - Onsite specialist services
- Clinical Governance Quality Improvement Model
  - Accredited with Cornerstone and College of Urgent Care
- Large Collegial Multi-disciplinary Team with focus on Professional Support and Development
- Teaching practice
  - GP
  - Urgent Care
  - Nurses

Access to Primary Care Services

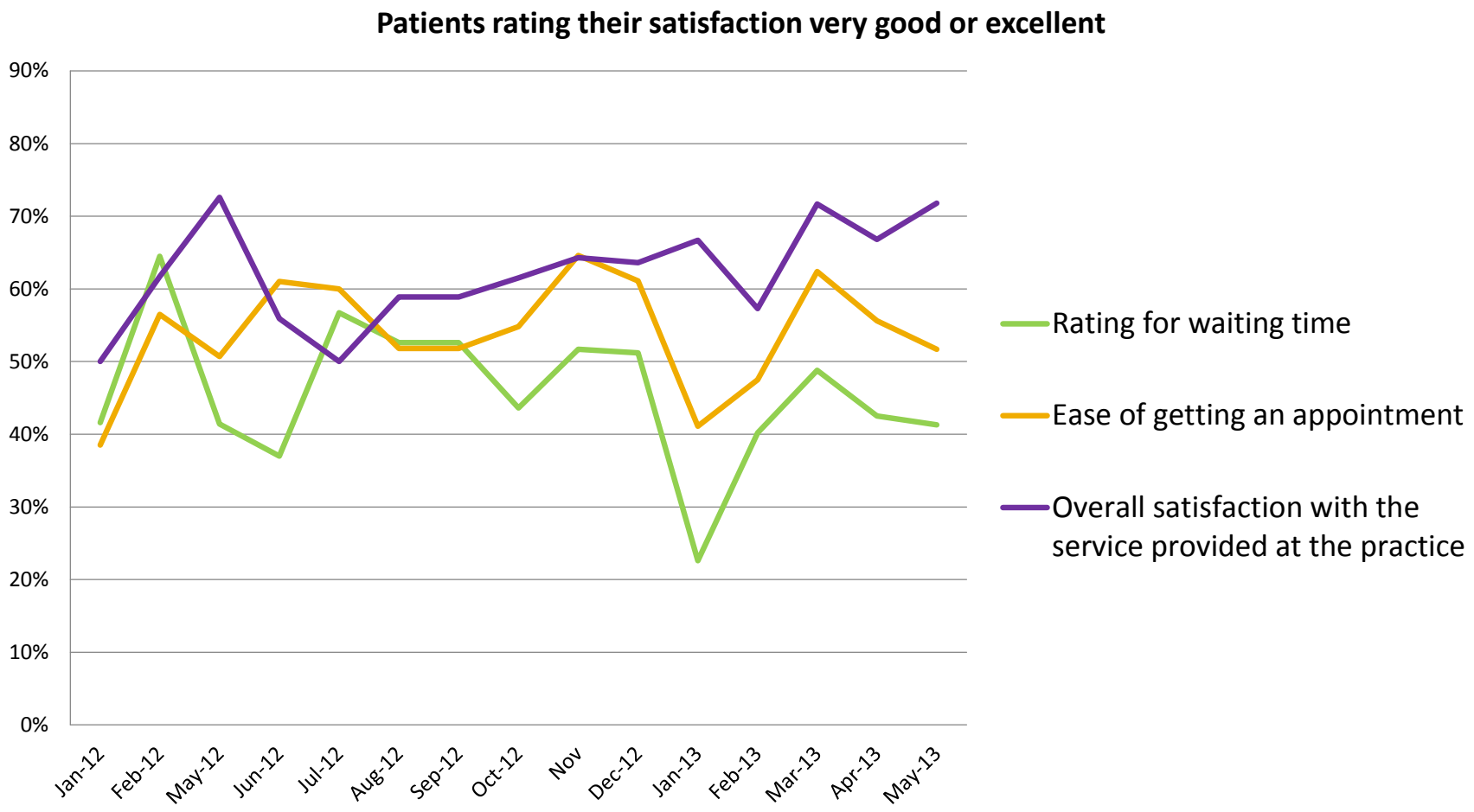
- Range of services
  - General Practice
  - Primary Care Nurses
  - Urgent care (sick GP patients are transferred to the UC)
  - Fracture clinics
  - Home visits
  - Minor surgery and procedures
  - Primary Options (we can observe and treat patients for several hours)
  - Access to diagnostics (radiology, ultra sound, urgent labs)
  - Same day private specialist advice/ consultations
- Hours of operation
  - General Practice 8-6 pm weekdays
  - Urgent Care 8-8 pm 7 days per week
- Highly specified and equipped facility

Clinical Governance- Focus on quality improvement

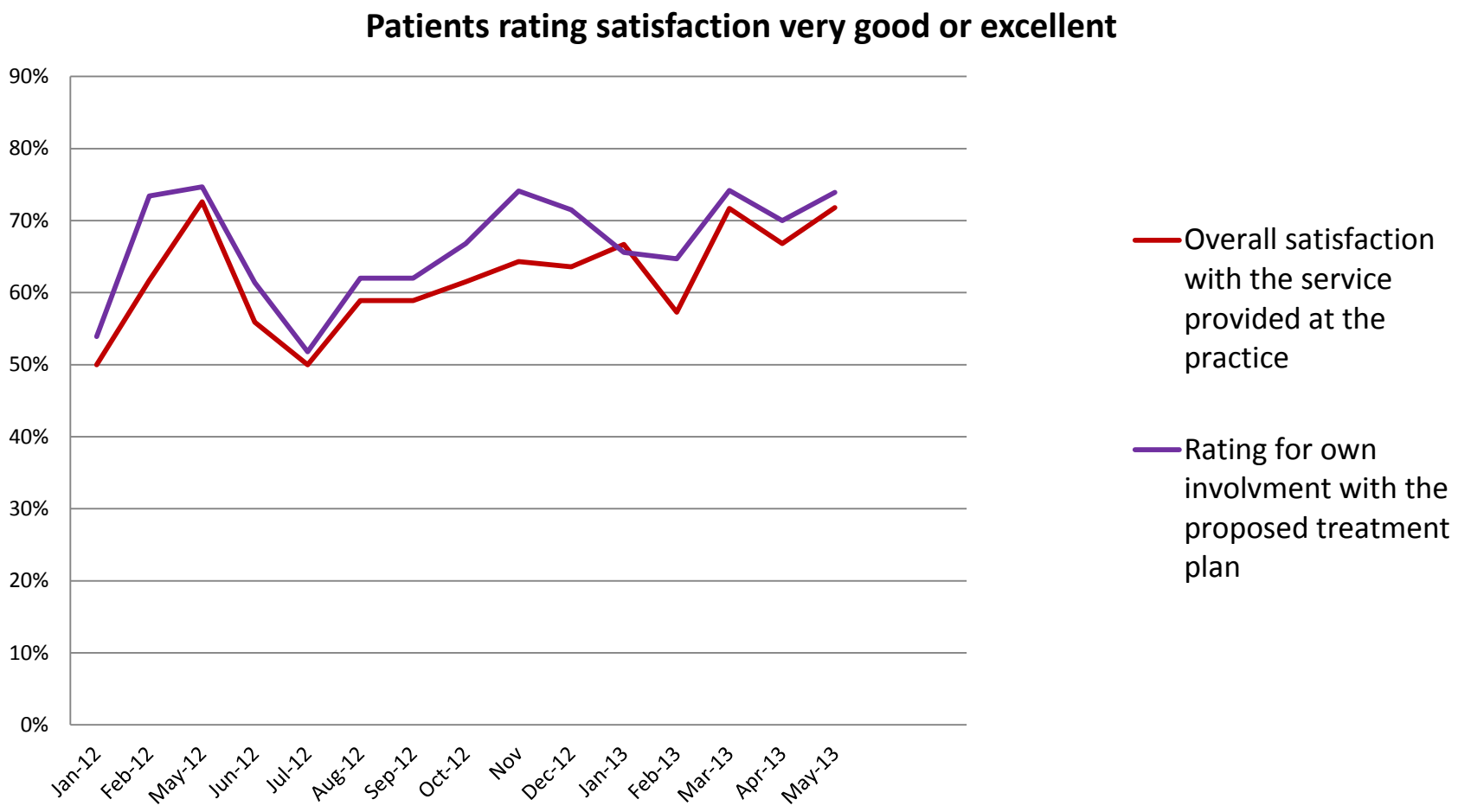
- Clinical Director
- Involve everyone in quality improvement
- Focus on our patients
- Measure performance
- Professional development and support for all staff

Monthly Quality Improvement meeting- full practice meeting

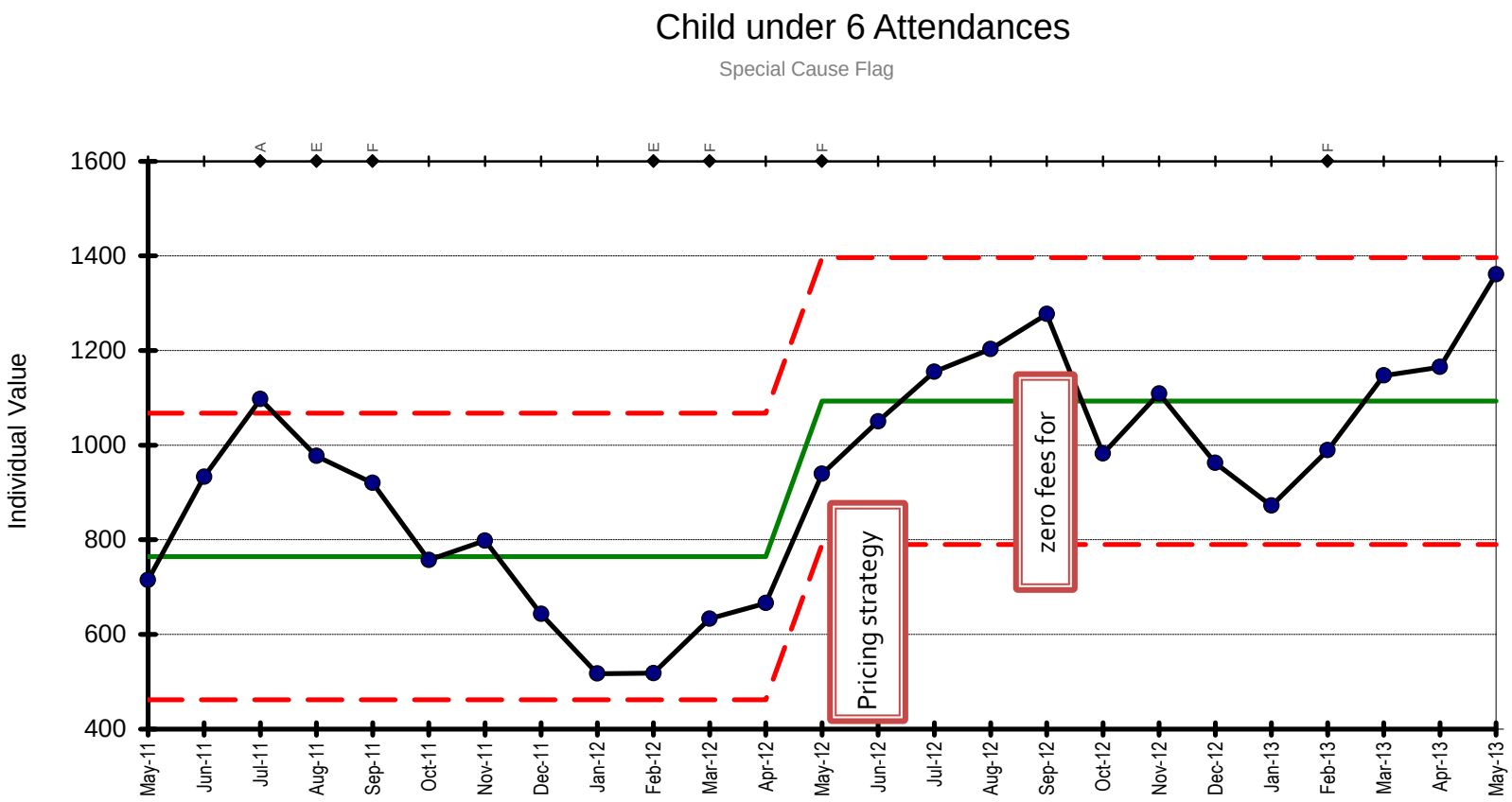
Focus on Patient Feedback



Looking for correlations



Monitoring the impact of our decisions



Outcome of Referrals to ED

Patients identifying Medical Centre @ Apollo as primary provider Presenting at North Shore ED Jan to Oct 2011				
	Total presentations	Referred by self	Referred by other GP	Referred by Apollo GP
Presenting to ED	1864	1262	227	375
		68%	12%	20%
Referred back to GP	1001	784	87	13
		78%	9%	1%

Professional Development

- Clinical Director and Urgent Care Leader
  - 12 non-clinical hours per week
- Mentoring for all general registrants
  - Paid time for mentors
- Peer group meetings
- Collegial morning tea
  - 30 mins no bookings
- CME & CNE (generous paid leave for employees)

Some of the team

The Experience of an Apollo GP

Dr Khalid Hikmat Associate GP

GP practice at Apollo

- A&M facility <-> *transfers* <-> GP facility
- Other facilities within the building
- Extended hours
- Systems and guidelines
- Continuity of care
- Collegial support / Easy to deal with uncertainty…

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GP practice at Apollo

- Clinical Director
- Training practice
- Easy to cover holidays and leave
- Management
- Difficulty to predict workload
- Continuity of care

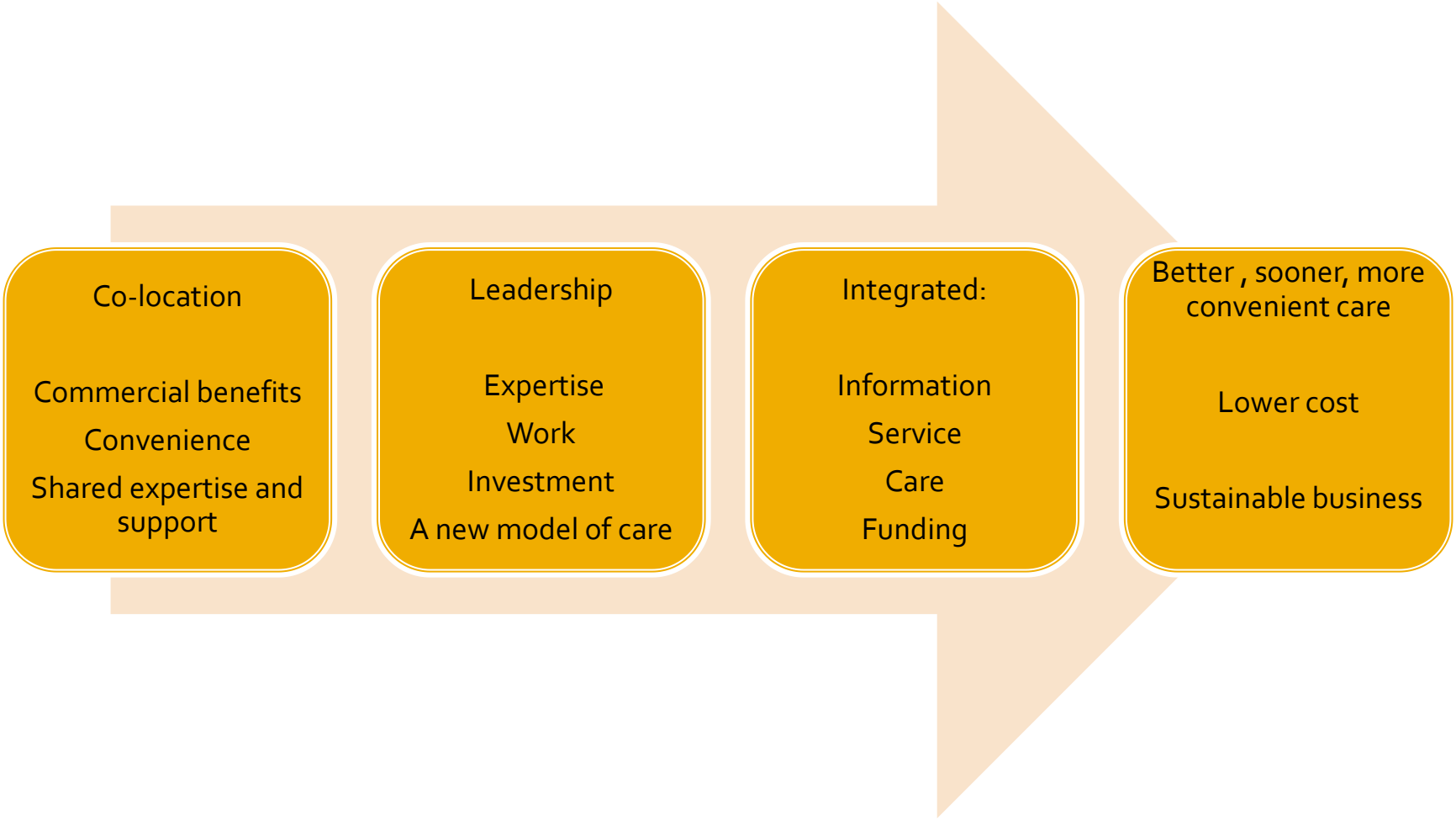
Are we there yet? Attaining and funding integration that is '*more than the sum of it's parts*'?

Dr Andre George Associate GP

Stepping stones to integration

- Co-location ***is not*** Integration – just a pre-requisite
- **Integration** implies:
  - Internal: Shared best practice within each health provider/service
  - External: Collaboration + synergy between heath providers
  - Vertical: Primary to secondary care challenges – Private or Public
- Clinical governance and Information sharing are key drivers
- Challenge is creating synergy and value between health providers so that the 'IFHC is greater than sum the parts' ***and to fund it!***
- Some low hanging fruit for integration - e.g. clinical necessity (fractures, warfarin) and funder driven opportunism (ACC)

The journey to integration



But Everything has a Co$t

SIZE ENABLES….

- Range of services & operating hours
- Range of expertise and special interests
- Professional support and development
- Investment in Clinical Governance/QI
- Investment in management & administration expertise
- Development of systems, procedures and guidelines
- A drive for consistency in practice

BUT

- Extended operating hours and services are expensive
- Clinical governance and professional development is also expensive
- Communication with everyone is complex
- The physical size of the facility creates difficulties for patients
  - The number of people in the waiting room
  - The distance to the consulting rooms

AND

- Individual practitioner styles maybe constrained

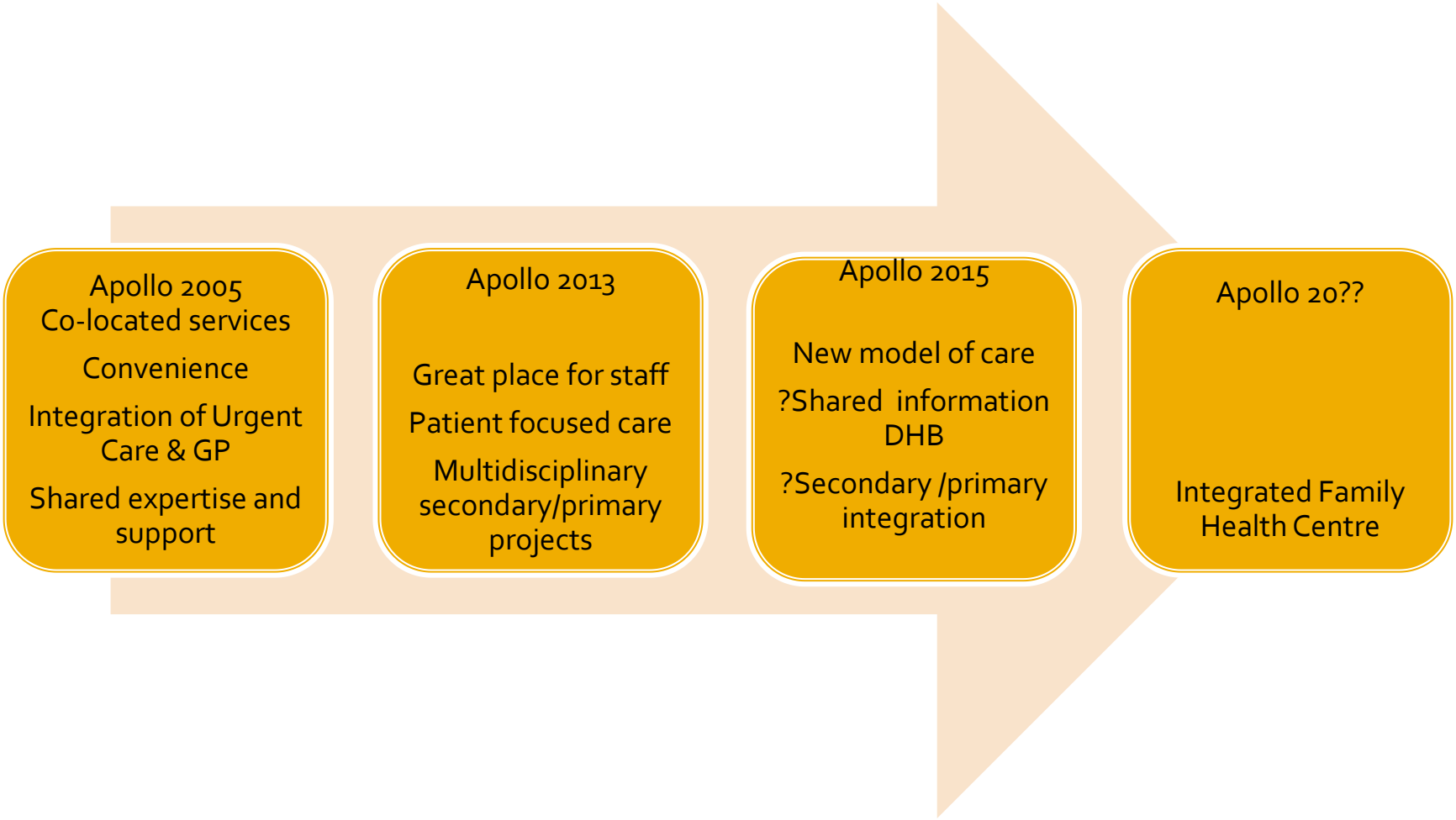
And there are limitations

- Access to on-site specialty services is heavily dependent on patient payment or ACC
- Shared information is limited to:
  - Test Safe- Lab results and some pharmacy
  - Private radiology within a specific local provider
- There is little information from DHB on performance such as the ED presentation outcome data (the example above was a one off)
- Multi-disciplinary GP and Specialist case reviews or care planning is limited and has to be funded *by the practice*

In Summary

Mary Baldwin

Apollo's journey



Apollo Medical in 2013

- Provides an excellent primary care service
- Is a professionally rich and supportive environment for all staff
- We are working on profitability but the current model of care and funding models constrain profitability
- We are working towards integration: representation on several joint projects – Palliative Care, Paediatric pathways and more in the pipeline

But the road to integration is uphill

- There is no funding for the provision of Urgent Care Services and the extended hours of operation
- The high cost of service provision, for extended hours and urgent care, is reflected in comparatively high patient co-payments and decrease in profitability
- There are no DHB provided services within the centre
- IT sharing and clinical support tools are limited
- Access to services within the centre is dependent upon the patient's ability to pay
- Funding for clinical governance, quality improvement, and professional development is dependent upon financial investment by the business

What needs to happen?

- The model of care has to be substantively different to produce a profitable sustainable business
- The funding model has to take into account the services provided and the resulting patient outcomes
- Goals, targets, and measures, have to be agreed
- There has to be an investment in:
  - Leadership
  - Expertise
  - Professional development
  - Shared information systems
  - Processes for shared care- multi-dip meetings etc,
- There has to be financial incentives for integrated services

Thank you