



Health
Western Sydney
Local Health District



Laying the foundations

Integrated Care Demonstrator
MIDTERM REPORT MAY 2016

Contents

3	Foreword
4	A Word From...
6	Executive Summary
8	About Western Sydney Local Health District and Western Sydney Primary Health Network
10	Demography
12	Burden of Disease
14	Western Sydney Integrated Care Demonstrator
20	Outcomes
22	Consumer Input and Feedback
24	Key Challenges
26	Evaluation
27	Partnership, Governance and Transformation
29	Looking Forward
30	Abbreviations and Glossary

Foreword

We are pleased to present the Western Sydney Integrated Care Demonstrator Midterm Report highlighting our progress from March 2014 to May 2016.

Integrated care transforms how we deliver services to improve health outcomes for patients and aims to reduce costs deriving from inappropriate and fragmented care across hospital and primary care services.

Designing and delivering care that reorients resources around patients and builds partnerships across sectors including specialists, hospitals, community, and primary care is exciting while posing significant challenges.

This report outlines the complexity and learnings in undertaking such a transformative and innovative program of work.

At the core of the Western Sydney Integrated Care Demonstrator program is a strong and enduring partnership between Western Sydney Local Health District (WSLHD) and the Western Sydney Primary Health Network (WentWest) with a shared commitment towards system reform.

The Western Sydney Integrated Care Demonstrator, funded by NSW Health, is part of a broader body of work aimed at changing the way we deliver healthcare.

It aims to improve the care experience for patients, carers and families; advance the health of the population; achieve better use of health resources; and improve the work life of healthcare providers.

We believe the work of the Western Sydney Integrated Care Demonstrator is providing a robust foundation necessary for system reform.

As we continue to consolidate the learnings from this program of work, we build a stronger platform to adapt and develop services which better meet the needs of people in western Sydney and the NSW Health system.

We acknowledge the staff of WSLHD and the Western Sydney Primary Health Network who worked as a team, learning from each other in implementing integrated care. And we recognise the contribution of the many consumers, providers and stakeholders in planning and shaping this new model of care delivery.



Danny O'Connor



Walter Kmet

A handwritten signature in black ink, appearing to read 'Danny O'Connor'.

Danny O'Connor
Chief Executive Officer
Western Sydney Local Health District

A handwritten signature in black ink, appearing to read 'Walter Kmet'.

Walter Kmet
Chief Executive
Western Sydney Primary Health Network

A Word From...

NSW Health Minister

Jillian Skinner

Mrs Skinner described the NSW Government's focus on integrated care as a transformative step for healthcare in NSW.

"For many people, the health system is complex and hard to navigate.

"They can be referred to multiple healthcare professionals — across primary, specialist, hospital and community care — who may or may not have access to the same information to guide the best approach to care for them.

"Our integrated care strategy works in partnership with GPs, NGOs, private hospitals and others to support individuals to get seamless, joined-together-care they need in the right place at the right time.

"It's crazy to think we are putting some patients with conditions that can best be treated at home by a GP for example into a hospital bed, where their routine necessarily follows that of the busy hospital, rather than the relative calm and comfort of home.

"Not only does integrated care involving community based treatment ensure optimal care, it guarantees we make the most of every cent spent on the healthcare of the people of NSW."

Western Sydney Primary Health Network

Chair of the board

Professor Diana O'Halloran

"This report represents a significant milestone in our continuing partnership journey towards a single integrated health system.

"The Western Sydney Integrated Care Demonstrator has enabled the creative redesign of many existing programs and services, and the development of entirely new elements and tools.

"The progress made is exciting.

"But we know the journey is far from complete.

"Longer term, system wide policy change will be needed to ensure the sustainability of critical redesign initiatives such as integrated care."

**Western Sydney Local Health District
Chair of the board
Emeritus Professor Stephen Leeder**

"It is gratifying to read this report.

"While none of us can claim to have solid evidence about how best to provide care to people with serious and continuing illness, we know enough to establish experimental care arrangements.

"From what patients with these illnesses tell us, they seek continuity of care, a doctor or nurse who knows them and with whom they can make contact 24/7 and who has their record on tap.

"To meet this expectation we must bring together in a team all the professionals providing care.

"That means spanning traditional barriers between care in hospital and that in the community.

"We need to hear this message about continuity and its importance to patients.

"The projects reported here in western Sydney are experimenting with ways in which this continuity of care can be provided.

"A brave beginning has occurred due to goodwill of practitioners and patients in all points of healthcare.

"It is an exciting prospect.

"It will be vital to follow the projects to their conclusion so we can learn the way to assist patients with chronic problems and their home carers."



NSW Health Minister Jillian Skinner



Professor Diana O'Halloran



Emeritus Professor Stephen Leeder



Executive Summary

Delivering integrated care is one of three strategic directions in the NSW State Health Plan: Towards 2021.

The NSW Government has committed \$180 million over six years to implement innovative, locally led models of integrated care across the State to transform the NSW Health system.

Integrated care is the provision of seamless, effective and efficient care that responds to all of a person's health needs across physical, mental and social health in partnership with the individual, their carers and family.

In 2013 western Sydney was selected by the NSW Ministry of Health for an integrated care demonstrator.

Leveraging a shared commitment to system reform WSLHD and WentWest developed a joint proposal to strengthen and support the Patient-Centred Medical Home (PCMH) for the management of chronic conditions, building on previous integrated care approaches.

The submission was forged on evidence-based international models.

At the core of the program design is a shared responsibility to deliver the quadruple aim of: improving the health of patients; enhancing the patient experience; reducing healthcare costs and better supporting health professionals.

The brief was challenging. The WSLHD catchment is undergoing a population

growth with 846,000 people increasing to more than 1 million by 2020.

A diverse region, more than a third of the population was born overseas, and it is home to the largest urban Indigenous community in Australia.

Western Sydney encompasses some of the most socially disadvantaged areas in Australia and some of the sickest populations.

There are high rates of diabetes and respiratory illness and people are more likely to die from cardiovascular disease than other Australians.

Over a year, the Western Sydney Integrated Care Demonstrator (WSICD) developed a comprehensive model of care for patients with congestive cardiac failure, coronary artery disease, chronic obstructive pulmonary disease and diabetes.

The model was improved and refined during implementation and includes:

- Joint governance with chief executives and senior clinicians from WSLHD and WentWest providing executive sponsorship and support
- Patient selection, enrolment and stratification
- Development of dynamic and effective shared care planning facilitated by use of LinkedEHR, an online care planning system within primary care designed specifically for this purpose



- Care facilitation by registered nurses who support general practice to identify, enrol and monitor patients
- A GP Support Line to access appropriate specialist advice with 240 calls received as at May 2016
- Rapid Access and Stabilisation Services (RASS) that provide streamlined access to specialists in the hospital setting and assist to return patients to their primary care team and the community as soon as possible
- Improvements in information technology allowing clinicians across the healthcare continuum to view a patient's care plan; and additional enhancements to improve patient identification and the flow of information
- HealthPathways, an existing online decision support tool for GPs and primary healthcare providers, has enabled care integration with access to developed integrated care protocols and referral information for RASS
- Capacity building, clinical leadership and training activities for the extended healthcare team
- Patient experience reporting with mechanisms for improving care based on feedback; and
- A process of ongoing evaluation incorporating local analysis and

performance monitoring; independent assessment by Western Sydney University; and a breakdown of hospital and Pharmaceutical Benefit Scheme activity by the Ministry of Health.

The model of care is operational and the demonstrator is entering a period of consolidation.

A total of 186 GPs have registered and the rate of patient enrolment in general practice is accelerating with 275 signed up and 450 forecasted by the end of July 2016.

The rate of patient enrolment (275) in general practice is accelerating, Rapid Access and Stabilisation Services have delivered more than 3000 occasions of service, and initial evaluation is showing reduced admission rates and/or reduced length of stay for patients accessing the service.

Feedback from patients and providers has been positive.

Time is needed to embed and support the changes that have been implemented and to monitor progress.

Into the future WSLHD and the Western Sydney Primary Health Network (WSPHN) will continue to work together to refine the elements of the WSICD and build on success. A strong partnership will assist to deliver better and more integrated care for people in western Sydney.



About Western Sydney Local Health District

WSLHD is responsible for providing and managing public healthcare in 120 suburbs comprising the five Local Government Areas (LGAs) of Blacktown, The Hills Shire, Holroyd, Parramatta and Auburn.

One of 15 Local Health Districts (LHDs) in the NSW Health system, the WSLHD catchment is one of the State's fastest growing with a rich tapestry of culture, people, traditions and beliefs.

Western Sydney's population of 846,000 will increase to more than 1 million by 2020.

WSLHD covers 780 square kilometres and employs 11,855 people across more than 100 sites including five hospitals and an extensive network of community health centres.

Westmead, Cumberland, Auburn, Blacktown and Mount Druitt hospitals as well as comprehensive community and population based services play a critical role in the provision of healthcare in Sydney's west.



Hospitals

- 1 Auburn Hospital
- 2 Blacktown Hospital
- 3 Mount Druitt Hospital
- 4 Cumberland Hospital
- 5 Westmead Hospital

* WentWest

Community Health Centres

- A Auburn Community Health Centre
- B Blacktown Community Health Centre
- C Doonside Community Health Centre
- D Merrylands Community Health Centre
- E Mount Druitt Community Health Centre
- F Parramatta Community Health Centre
- G The Hills Community Health Centre



About Western Sydney Primary Health Network

Since 2002 WentWest has been part of the western Sydney community, delivering support and education to primary care and working with key partners such as WSLHD on shared priority areas to improve the health outcomes for the region's residents.

From July 1 2015, WentWest took on the role of Western Sydney Primary Health Network.

Primary Health Networks are a Federal Government health initiative, established with the key objectives of increasing the

efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes and improving coordination of care to ensure patients receive the right care in the right place at the right time.

In its role as the Western Sydney Primary Health Network, WentWest focusses on addressing national and regional health priorities in consultation and partnership with local GPs, WSLHD, allied health professionals, consumers and community bodies and the broader health sector.





Demography

Western Sydney is a diverse community characterised by extreme wealth at one end of the spectrum and social disadvantage at the other bringing with it a range of complex health needs and social circumstances.

Currently experiencing a population growth, western Sydney is expected to increase from 846,000 people to more than 1 million by 2020.

More than a third (35 per cent) of residents was born overseas.

Of these 60,000 arrived in western Sydney between 2006 and 2011.

A total of 48 per cent of people speak a language other than English at home with the largest proportion from Auburn at 79.5 per cent.

People from Culturally and Linguistically Diverse (CALD) backgrounds may have a higher risk of developing some chronic diseases such as diabetes.

Additional considerations with CALD people may include language barriers, problems with health literacy, absence of family support, financial stress, low social status and a sense of disempowerment.

Western Sydney is home to the largest Aboriginal and Torres Strait Islander population with most living in low socioeconomic areas.

The 2011 Census indicates 11,500, or 1.4 per cent of the population self-identifies as being Aboriginal, with the majority (8,200) living in the Blacktown LGA. However it is believed the figure is closer to 13,000-15,000 as the community is transient and sensitive to completing the census.

A 55 per cent increase in people aged 70 years or over and a 50 per cent increase in people aged 85 years and over is forecast from 2016-2026.

There is a wide range of median weekly personal incomes, ranging from \$370 in south Parramatta up to \$740 for people in the northern parts of The Hills Shire, according to the 2011 Census.

Unemployment is a social problem and is associated with poor physical and mental health outcomes.

The health effects are linked to psychological consequences, financial problems and reduced life



opportunities, with outcomes worse in regions where unemployment is widespread.

In June 2013 the region had an overall unemployment rate of 6.5 per cent. The Australian average was 5.4 per cent.

Southern Parramatta and south-west Blacktown have 11 per cent unemployment, more than twice the Australian average.

Subsequently these two regions have the highest rates of total concession card holders with more than a quarter of the population in each of these regions holding a Centrelink concession card.

Nutritious food is fundamental to good health and disease prevention.

There are significant health risks associated with poor nutrition, including the increased risk of chronic diseases such as heart disease, type 2 diabetes and some cancers.

Poor nutrition contributes to chronic disease risk factors such as high blood pressure, high cholesterol and obesity.

In parts of Blacktown adults on average consume fruit at a rate lower than the Australian average.

The southern part of WSLHD has the highest obesity rates in the region with south-west Blacktown and Auburn having the worst with more than 20 per cent of the population being obese.





Burden of Disease

Western Sydney has one of the sickest populations in Australia.

A total of 57.3 per cent of people have one of four health risk factors.

There is a 10-20 per cent higher incidence of diabetes and respiratory issues than the NSW average, coupled with challenging demographics.

Of the population, 17 per cent is in the most disadvantaged decile of Socio-Economic Indexes for Areas (SEIFA).

Western Sydney is a diabetes hotspot with an estimated quarter of the population likely to be affected by diabetes or pre-diabetes.

There is a threefold difference in diabetes prevalence between the communities

of the Blacktown LGA and the affluent suburb of Mosman, according to researchers at Western Sydney University.

In heart failure, western Sydney is witnessing increasing presentations with a mean length of stay of about 10 days per patient.

Cardiovascular disease deaths are significantly above Australian averages in aged-adjusted comparisons.

In Blacktown's south west the rate of 51.5 deaths per 100,000 is almost twice the Australian average of 27.9 per 100,000.

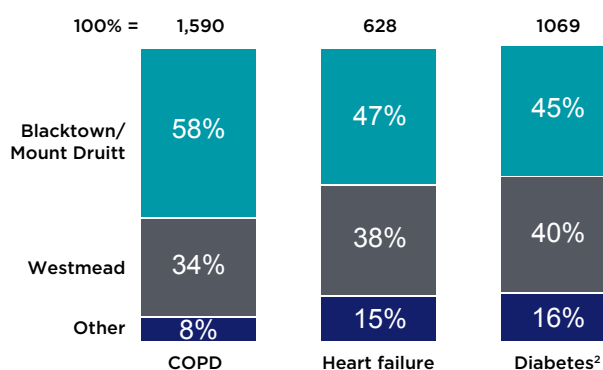
Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death worldwide and by 2020 it is estimated that it will be the third.





2013 WSLHD select chronic disease admissions

Number of inpatient episodes¹



1. Based on DRG associated with inpatient admission, excluding ungroupable DRGs mostly from Nov, Dec 2013 episodes that were not yet coded.

2. Excludes hemodialysis.

SOURCE: Western Sydney LHD Inpatient data 01/01/2013-19/12/2013

Most frequently managed chronic problems in general practice (per BEACH 2013-14 report)

Chronic Problems	% of total chronic problems	Rate per 100 encounters
Hypertension	15.3	8.6
Diabetes	7.4	4.3
Ischaemic heart disease	2.0	1.1
COPD	1.7	1.0
Heart failure	1.1	0.6

It is associated with a high level of disability and cost including potentially preventable hospital admissions.

The principal risk factor for COPD is smoking, with the amount and the length of time smoking increasing probability.

Blacktown's south west has the highest number of deaths from COPD with a rate 66 per cent higher than the Australian average of 7.8 per 100,000.

We can improve care for patients with chronic disease.

Only 40 per cent of western Sydney patients with diabetes have a care plan or team care arrangement and 45 per cent of diabetes patients have a glycated haemoglobin level (HbA1c) greater than 7 per cent, indicating diabetes.

A significant driver of escalating healthcare activity and costs is due to chronic disease.

Driven by chronic disease, hospital activity has been escalating faster in western Sydney than population growth with 4.7 per cent compound annual growth rate (CAGR) compared to 2 per cent CAGR in 2011-2013.

Western Sydney Integrated Care Demonstrator

Integrated Care

Integrated care is the provision of seamless, effective and efficient care that responds to all of a person's health needs across physical, mental and social health in partnership with the individual, their carers and family.

Western Sydney clinicians have articulated a need for improved collaboration, accountability, prevention and patient-centred care that manages patients more in the community than in acute settings.

Patients in western Sydney consistently rate their experience below the State average identifying potential to improve health literacy, self-care and capacity to navigate services to receive the right care at the right time in the right place.

The Demonstrator

The NSW Government committed \$180 million over four years to implement innovative locally-led models of integrated care across the State to transform the health system through integration with services connected across providers and focused on individual patient needs.

In 2013 western Sydney was selected by the NSW Ministry of Health for an integrated care demonstrator.

WSLHD and WentWest, the Western Sydney Primary Health Network, developed a new model of care to meet the needs of the diverse and fast growing western Sydney population.

The partnership focusses on supporting patients with congestive cardiac failure, coronary artery disease, chronic obstructive pulmonary disease and diabetes.

The Western Sydney Integrated Care Demonstrator is designed to:

- Improve the health of patients
- Enhance the patient experience
- Reduce healthcare costs; and
- Better support health professionals.

Specific objectives of the WSICD are to:

- Engage patients from the cohort into a Patient-Centred Medical Home (PCMH)* and actively involve them in the management of their care
- Build capacity and expertise in primary care in the management of the specific chronic diseases
- Create care pathways and shared care plans between primary, community and hospital providers for continuity of care; and
- Utilise community based care facilitators to assist in care planning, navigation, transitional care between services, and patient education and self-management.

*A Model for Australian General Practice: The Australian Person-Centred Medical Home

A sustainable and scalable funding model to improve care for people with chronic and complex care needs. How can we make it happen? Discussion paper | November 2015

Source: Ernst & Young, Australia.



While the initial focus is on the management of chronic conditions, the initiative will in time be scalable and transferable to a broader array of patients.

The Western Sydney Integrated Care Demonstrator incorporates the following strategies, service delivery models and initiatives:

- Patient cohort: Patient selection, enrolment and stratification
- Integrated care team: Implementing the PCMH
- Care facilitation
- Dynamic shared care plans
- Rapid access to specialist care
- Building IT integration between hospitals and primary care
- Targeted investment in primary care to support timely creation, maintenance and display of health summaries, care plans and clinical metrics
- Systems to build capacity so primary care health professionals can better manage patients with chronic disease
- Joint governance between the LHD and the PHN
- Patient experience reporting; and
- Ongoing evaluation of implementation and program outcomes.

Patient Cohort

The demonstrator has developed a model of care which can be expanded to other chronic diseases and health conditions.

The initial focus is on patients with one or more of the four chronic conditions:

1. Congestive cardiac failure
2. Coronary artery disease
3. Chronic obstructive pulmonary disease; and
4. Diabetes.

Patients with one or more of these conditions are risk stratified and those at greater risk are included in the WSICD cohort.

For these patients, the WSICD is focussing on integrating the care provided by primary care teams with the care provided by community and specialist teams.





Patient-Centred Medical Home

The Patient-Centred Medical Home (PCMH) supports people with chronic and complex care needs.

The PCMH model emphasises a patient having an ongoing relationship with a GP who leads a multidisciplinary practice team; and primary care that is comprehensive, coordinated and accessible, with a focus on safety and quality.

The PCMH coordinates the care delivered by all members of a person's care team which may include hospital inpatient care.

It ensures each patient experiences integrated healthcare.

The PCMH has been demonstrated internationally to be effective, efficient and welcomed by patients and providers.

Integrated Care Team

For the selected patients the WSICD provides an integrated care environment consisting of the primary care team, care facilitator, specialist team and community based healthcare providers.

Patients within the cohort are enrolled through primary care, community or hospital specialist teams depending on the point of first contact and are registered in a central database.

Patients are managed and monitored in accordance with their care plans by their GP who is supported by other members of the primary care team and community based care facilitators.

The care plans are shared with the patient and all healthcare providers and maintained by the healthcare team using LinkedEHR, an online care planning system.

LinkedEHR is a centralised data repository receiving content from GP clinical management systems and the national Personally Controlled Electronic Health Record (PCEHR).

The primary care goals are to maintain good health and prevent acute or chronic deterioration of the patient's condition.

The patient's health status and care plans are regularly reviewed by the primary care team.



Care Facilitator Role

Care facilitators are registered nurses who provide a level of care coordination to the enrolled patient.

Located in community and primary care they support GPs and assist clinicians to identify, enrol, manage and monitor patients using integrated care enablers such as HealthPathways and LinkedEHR.

Care facilitators ensure patients have regular reviews based on preventative and continuing care needs including medication assessments, vaccinations, smoking cessation, annual spirometry and nutritional screening.

In conjunction with the patient's GP and specialists, care facilitators provide referrals to health coaching, self-management strategies, community and other specialist services including occupational therapy, physiotherapy, dietetics, community exercise programs, comprehensive pulmonary rehabilitation, the Integrated Chronic Care Program (formerly Connecting Care) and community nursing.

Capacity Building

One of the overarching principles of the WSICD is to support and develop the PCMH approach to improve the management of chronic illness in the community.

Creation of the GP Support Line, access to specialist services and case conferencing are all underpinned by extensive training across professions.

GP Support Line

The GP Support Line is a telephone service to provide an avenue for general practitioners to contact the relevant specialist hospital service. GPs are referred to the appropriate specialty and hospital, Westmead or Blacktown.

Probable outcomes are:

1. Specialist advice to the GP to assist in the management of the patient. It may include instructions to call back on another day if there has been no improvement in the patient's condition
2. Instructions for the patient to attend the Rapid Access and Stabilisation Services which aim to provide a review within 24 hours of notification; or
3. Admission to hospital via ED.

Specialist Teams Providing Rapid Access and Stabilisation Services (RASS)

RASS are specialty services that have been established at Westmead, Blacktown and Mount Druitt hospitals to reduce:

- Waiting times for patients as they navigate the system
- Unnecessary hospital admissions
- Avoidable presentations to emergency departments
- Readmission rates; and
- Provide a less complex and more appropriate patient journey.



They are regulated by clinical care protocols and agreed referral pathways which are detailed online for GPs and primary healthcare providers in the HealthPathways program.

The Rapid Access Clinic provides fast evaluation of an acute deterioration of a patient's chronic condition.

The assessment may result in avoiding a hospital admission or expediting admission.

GPs directly contact the relevant integrated care specialty clinician via the GP Support Line bypassing unnecessary management delays or Emergency Department (ED) presentations.

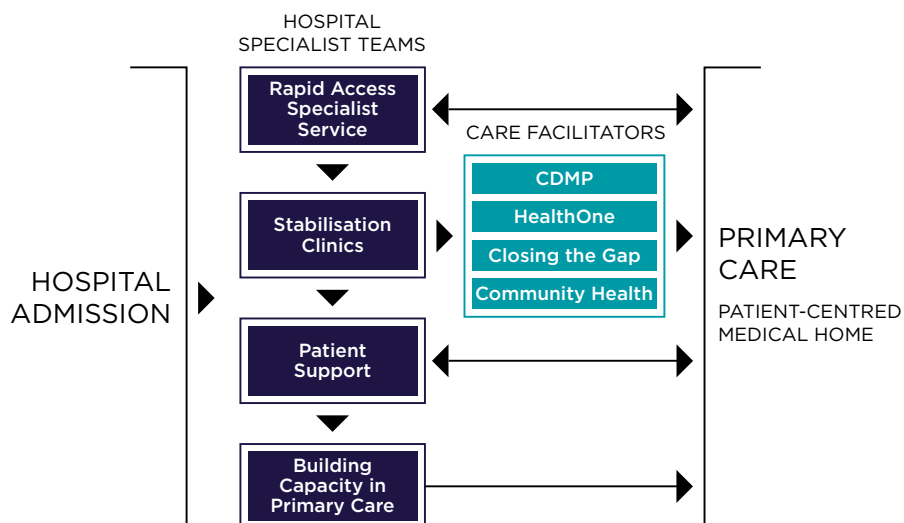
For patients who are seen in ED, the Rapid Access Clinic provides a third option other than admission or discharge.

Stabilisation Clinics serve two main functions. They:

1. Provide brief and immediate access to further review by specialist services and short-term management post the Rapid Access Clinic.
2. Offer a mechanism for early review of patients following hospital discharge.

The aim is to transition these patients from the hospital environment back to their primary care team and the community setting as quickly as possible.

Western Sydney Integrated Care Demonstrator – Model of Care





Demonstrator in Practice

Yash, 65, of Indian descent has high blood pressure.

He was diagnosed with type 2 diabetes five years ago and is lax in checking his blood sugar levels or seeing his GP.

He has been admitted to hospital twice with complications.

Western Sydney GP Dr Phan runs a busy practice with four GPs.

He struggles to manage people with chronic conditions because their appointments run over making it difficult to see other patients.

Hearing of the integrated care demonstrator from a fellow GP, Dr Phan contacts the Western Sydney PHN support team.

With his practice already eHealth enabled, Dr Phan joined the program and trained on LinkedEHR and HealthPathways.

On his next visit to Dr Phan, Yash is introduced to the integrated care program and a shared care plan is prepared for him in LinkedEHR.

He meets care facilitator Jenny who refines his plan and they identify services to help him achieve his goals.

Dr Phan refers Yash to a foot specialist and other allied health services using LinkedEHR.

The following week Jenny arranges Yash

to undergo a behaviour-based checklist to ascertain the barriers and challenges to his care and to help self-manage his blood sugar.

A few weeks later Yash becomes breathless and dizzy and is assessed by his GP.

Dr Phan uses the GP Support Line to discuss Yash's case with an integrated care cardiologist and they agree to refer Yash to the RASS clinic where he can see a specialist without going to the ED.

After treatment to control his heart failure, the specialist messages Dr Phan about any changes in Yash's management.

Mary, the clinical nurse coordinator, sends the updated action plan to Dr Phan and arranges Yash to be seen by his GP.

At that review, Dr Phan updates Yash's LinkedEHR record, revises his medication and arranges his practice team and Jenny the care facilitator to revise the shared care plan and set up regular reviews at Dr Phan's surgery.

With the online HealthPathways decision-support tool, Dr Phan can obtain best practice, evidenced-based information about managing people in his care.

Dr Phan is also supported by specialists through a GP Support Line, case conferencing and the Rapid Access and Stabilisation Services at the local hospitals.

Outcomes

Despite several challenges implementing the Western Sydney Integrated Care Demonstrator, some of the work taking place is breaking new ground in integrated care in Australia.

There were significant outcomes by midterm including training 186 GPs who continue to recruit patients.

A total of 275 patients signed up to the WSICD. Of these 244 patients were through general practice. The rate of enrolment is accelerating rapidly now elements of the model are in place with more than 450 people forecast to be registered by the end of July 2016.

Rapid Access and Stabilisation Services have delivered more than 3000 occasions of service across Westmead and Blacktown hospitals. The RASS clinics accept enrolled patients as well as those not registered.

Initial evaluation of RASS shows many patients avoid hospital admission by utilising these services. Therefore length of stay is shorter for inpatients referred to RASS.

A total of 87 patients were referred in the first four weeks of the cardiology Rapid Access and Stabilisation pilot in 2015.

Of these 81 per cent were from ED and 18 per cent from cardiology early discharge rounds.

During the same period there were 69 admissions under a cardiologist for chest pain, compared to an average 101 per month.

In the initial six month pilot there were 540 bookings for cardiology RASS.

The average length of stay was 1.2 days shorter for inpatients referred for stabilisation compared to those who were not.

Successful joint governance of the WSICD between WLSHD and the Western Sydney PHN has enabled the demonstrator to succeed, address challenges and initiate an overarching integrated health framework.

There has been positive feedback from patients and providers (Page 22).

Much needed improvements in IT functionality delivered visible, comprehensive and current information between care providers.

Now there is capacity for hospital clinicians to view the shared care plan in Cerner.

A care facilitators' dashboard is available in LinkedEHR.

An automatically generated GP report is available when enrolled patients present at the hospital.

LinkedEHR has been provided free to GPs and allied health professionals and access has been extended to the hospitals.

The hospital specialist teams, the GP, the care facilitator and allied health in the community can get access to the LinkedEHR shared care plan.

The electronic medical record system in outpatients will be made available



so specialists can write action plans for the patient that will be sent to the GP electronically.

GPs are equipped with an eReferral system which has been built into LinkedEHR. By October 2016 GPs will be able to send a specific eReferral to the hospital via HealtheNet in support of an appointment in one of the appropriate clinics.

Western Sydney has successfully incorporated Connecting Care (now the Integrated Chronic Care Management Program) under a single governance and enrolment structure.

Capacity Building and Clinical Leadership Activities

Supporting the western Sydney journey towards implementing integrated care was a WSICD-initiated tailored Clinical Leadership Academy conducted by McKinsey, Kaiser Permanente, Hurley Group and the NHS England.

The objectives included sharing of best practice ideas with clinicians. There were 81 participants at the event conducted in November 2015.

Health sector partnering workshops to discuss diabetes, respiratory and heart failure models of care took place in March and June 2014.

WentWest held three GP and nurse education evenings to provide further information about the WSICD in April 2015.

A number of education sessions for diabetes, respiratory and heart failure have been conducted with approximately 113 practice nurse participants.

Heart failure education will be ongoing as will training of care facilitators employed by the LHD.

Specialists provided in-service training for community nurses in COPD management.

ED nurses have been educated in the WSICD model; and chronic disease management nurses employed by WSPHN are expediting initial care plan development in LinkedEHR in enrolled practices.





Consumer Input and Feedback

Consumers bring a wealth of knowledge and experience to the design of the demonstrator program. They also expect the health system to work as one around their need which integrated care has to address.

The WSLHD Consumer Advisory Council has been operating since June 2015.

Additionally, an Integrated Care Consumer Advisory Working Group was set up in August 2015.

The group is responsible for delivering agreed engagement activities and ensures consumers are fully involved in the planning, delivery and evaluation of the demonstrator.

They have provided extensive feedback on the model of care, communications and patient monitoring apps under development.

Consumers are represented on key governance groups including the Integrated Chronic Care Management Program Steering Committee and Integrated Care Research and Data Group.

The Western Sydney Integrated Care Demonstrator seeks to provide seamless and best practice care for people along the continuum of their healthcare needs in primary care, community, and specialist settings.

As we progress it is important to listen to the very people for which this program was designed, the patients of western Sydney.

"I was referred to the integrated care program by my GP. I found it really beneficial and very helpful. It offered me a different level of care than just visiting the doctor. I was attending regular exercise classes and learnt a lot about correct breathing, which was really important for my emphysema. The nursing staff gave me a lot of advice about my condition, exercises to help me breathe and things to do to better manage. I wouldn't have got that from just going to the doctor. It definitely made me feel like I was getting a lot more information and advice."

Declan Hampsey, patient, 67, Lalor Park

"I have been having treatment for diabetes for months, dealing with my head doctor, two nurses and a social worker. Often in the healthcare system, you feel like you have so many different people saying different things to you. Integrated care works because everyone is on the same page. All the health professionals talk to each other and they're all working together to give you the best care possible. I feel like I've been getting quality care because everyone is across my case. I don't have to keep explaining it to different people, everything is integrated. It's given me confidence in the system and taken a lot of the fear away. You know everyone is working together. For a patient, that level and type of care is very comforting."

Gail Smith, patient, 61, Seven Hills



"Working as a care facilitator is extremely rewarding. You are not only enabling better and timely access to healthcare services for clients, you are an educator, an advocate, a leader and an innovator. The role of a care facilitator is full of challenges but what I most enjoy is having the ability to empower clients and their carers to make informed choices. Our goal is always to prevent deterioration and improve a client's quality of life."

Heena Puri, care facilitator

"I have several patients who are part of the integrated care program. As a GP we look at the medical side of things. We prescribe the drugs and treat the condition. The integrated care facilitator looks at a patient's health more globally. They have the time to look into what a patient really needs beyond just medical assistance. They have the time to investigate their social situation, their lifestyle and they can refer them to social workers, exercise programs, rehabilitation, things that as a GP, I might not be aware of. It does make my job easier because you know you have someone there who is looking at the patient holistically. The feedback from my patients has been really positive. They like having someone calling them up and checking in on them. It's giving them that next level of care. They've got another person looking after them."

Dr Con Paleolopos, GP, Alpha Medical Centre

"I've been working as an integrated care registrar for about four months and I've already seen the benefits of the integrated care model. We are helping to reduce the length of stay for patients and we're seeing patients a lot quicker. In the past, someone with chest pain might visit their GP. They would then be referred to a cardiologist and they could be waiting weeks or months to be seen. Now, in most cases, we're seeing patients within two days. It just gives patients that peace of mind. This model allows us to speak to patients about risk factors like smoking and diabetes, while it's fresh in their minds. We find the patients receive the advice a lot better. The model has allowed me to work with different cardiologists and build relationships. You can talk about patients, bounce ideas off each other and it really helps us as health professionals to understand those different areas of healthcare."

Dr Mohammad Eshan Khan, integrated care registrar, Westmead Hospital

Key Challenges

System Change

Demonstrator funding has enabled investment in system level changes necessary to move towards a PCMH approach however there are still significant barriers.

As we move forward there needs to be an ongoing commitment to:

- Invest in large-scale change readiness/ GP-LHD business transformation supports
- Develop tools and financial models to incentivise local providers to make the shift; and
- Consider shared savings approaches that break down ineffective funding silos.

Developing models of care that work across acute and primary services is extremely complex and time consuming.

Significant inter-professional learning and trust-building needs to occur before planning can commence.

This means successful programs will have a lag time between funding and delivering at scale.

In western Sydney, the strong partnership between WSLHD and Western Sydney PHN has made this process easier.

Influencing GPs, who are private practitioners running small businesses, and who have a wide variation in capacity and engagement with the public health system, is especially convoluted.

The WSICD has been a strong role model and advocate for change. Ongoing investment in change management across the continuum of care is necessary to maintain momentum. It needs to extend to training staff, implementing new systems and embedding behaviours which may take several years to become the norm.



Information Technology

Providing access to the shared care repository LinkedEHR across primary and acute care has produced a range of legal, privacy and procurement challenges.

Stringent security requirements and adherence to national and NSW Clinical Data Architecture Standards further add to the complexity.

As one of the first LHDs to implement such a system in Australia, negotiating the hurdles involved has at times been both frustrating and rewarding.

The opportunity to implement a fully functional shared care planning process is enormous.

However the entire project has taken nearly three times longer than initially envisioned.

Implementation raised and will continue to raise issues with eHealth NSW due to competing demands. Solutions need to be designed and tested which puts ongoing pressure on eHealth NSW outside of their existing workloads.

HealthPathways, an existing online decision support tool containing the integrated care protocols and referral pathways for GPs and primary healthcare providers has promoted, supported and enabled care integration.

An analysis of utilisation rates indicates the RASS has remained in the top 10 viewed management and referral pathways from February to May 2016.

General Practice Engagement

WentWest has leveraged off its strong pace of engagement with general practice in western Sydney.

A small amount of funding is provided to general practice to free up the capacity needed to enrol in the WSICD, however this is not sustainable long term.

Fee for service payments in general practice do little to assist the development of a PCMH where patients with chronic and complex conditions are appropriately managed in the community.

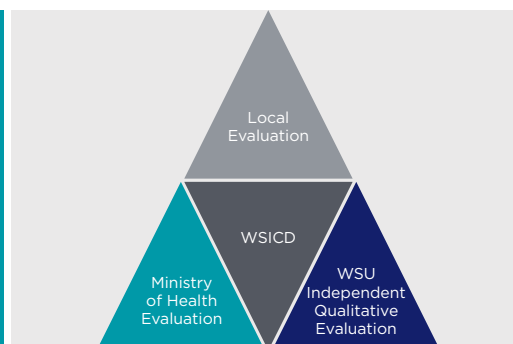
Looking forward a model has been developed with GPs to explore funding arrangements that would better align with the PCMH approaches, for example a multimodal system comprising payments based on fee-for-service (FFS); patient complexity; performance; and capability and capacity building.

The payment system would improve the financial sustainability of general practice.

Shifting away from FFS payments towards block funding would assist providers by delivering a more consistent funding stream that reflects the complexity of care provided.

Policy levers and funding supports from the Commonwealth need to be realigned to enable general practice staff the time and flexibility to engage in patient identification and selection, training, inter-professional learning and capacity building in general.

The Western Sydney Integrated Care Demonstrator is progressively being measured and analysed by internal and external agencies with results informing implementation for growth and success



Evaluation

Evaluation of the WSICD is multipronged. The results and findings from each component will be collated over the course of the project to inform future implementation.

Local analysis and performance is measured against aims and objectives, and key performance indicators agreed with the NSW Ministry of Health.

The demonstrator will assess the impact on length of stay and presentation frequency, and monitor condition-specific clinical metrics through the GP care planning software (LinkedEHR).

In addition, Western Sydney University (WSU) is undertaking an independent qualitative local evaluation.

WSU's first round of stakeholder interviews and analysis with the research team is scheduled for June 2016.

Preliminary findings will be reported in July 2016.

A WSICD patient registry is submitted quarterly to the Ministry of Health (MoH). The MoH link data on hospital activity and use of the Pharmaceutical Benefit Scheme (PBS) for WSICD participants and provide comparisons with a non-enrolled cohort.

A survey assessing communication, knowledge and workload with healthcare providers is also being conducted by the MoH every six months.

The first report showed a good understanding of the WSICD across providers and support for the model of care.

NSW Health's Agency for Clinical Innovation has commenced its patient reported data collection. Feedback is being collected from patients at the GP practice level and delivered in real time allowing the information to be used in the consultation and included in the dynamic shared care plan.

Partnership, Governance & Transformation

WSLHD has strong connections with WSPHN and the Sydney Children's Hospital Network (SCHN).

These relationships have been further strengthened through the Health Partnership Advisory Council comprising the three organisations.

The result is a robust collaborative approach to programs, priorities and initiatives with the combined effort improving care integration for the residents of western Sydney.

Strong governance has been one of the key success factors for the WSICD, the hallmark of which is collaboration between executives and senior clinicians.

Clinical leadership has been a catalyst for guiding and disseminating a shared focus and interest in integrated care initiatives, and importantly, establishing the fundamental linkage to social and behavioural change.

WSLHD has developed strong alliances while working to address key health determinants including the NSW Department of Premier and Cabinet, Department of Family and Community Services, Juvenile Justice, NSW Department of Education, and the NSW Police Force as part of the services delivery reform with a strong focus on vulnerable families.

The WSICD's shared governance structure between WSLHD and the WSPHN reports through an Executive Steering Committee and the Integrated Chronic Care Management Program Advisory Committee (ICCMPC).

The WSICD is an innovative model trialling shared governance between WSLHD and the WSPHN, including service design, priority setting, funding and performance monitoring.

This is reflected in the collaborative change management program of works undertaken.

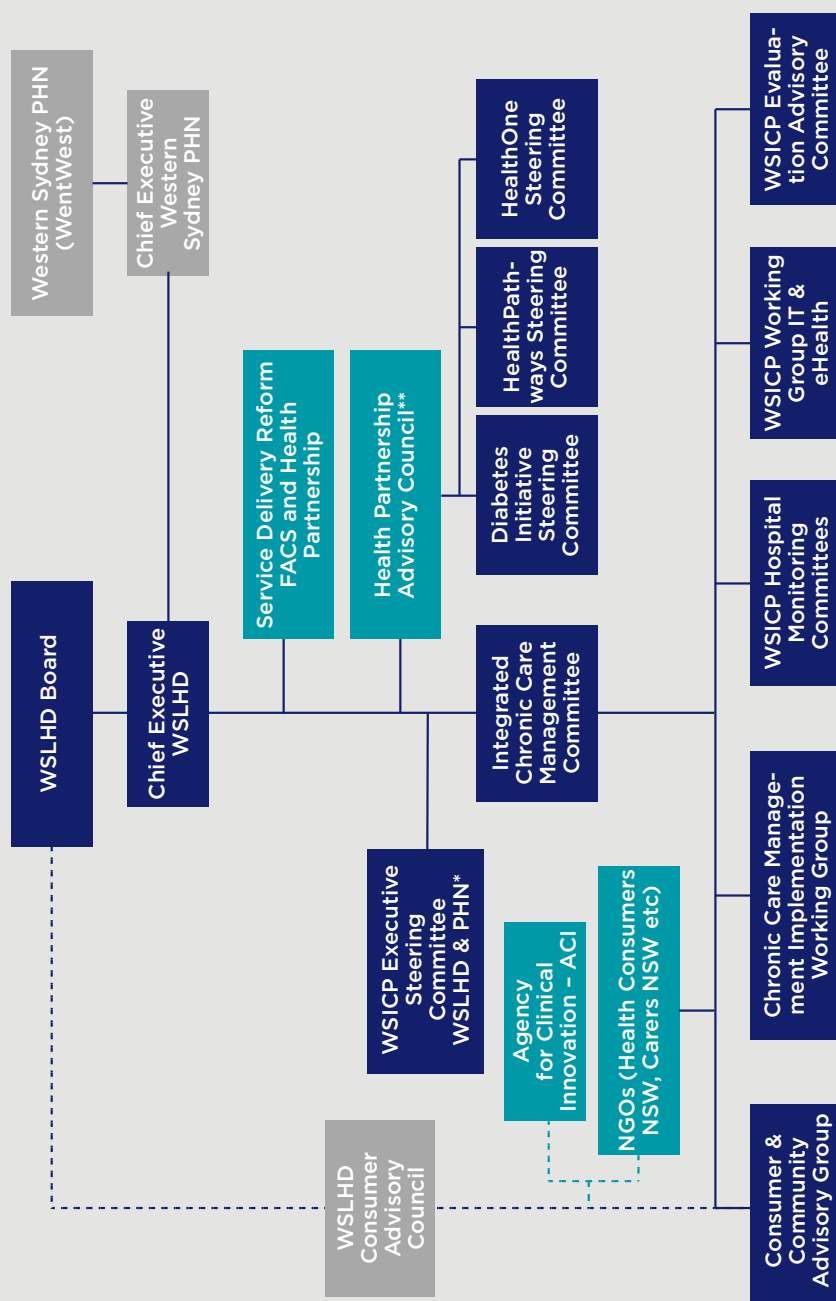
Two large change management forums and smaller working groups engaged external and internal stakeholders advancing a collective, shared vision for integrated care in western Sydney.

Priorities and principles for progressing further work in healthcare integration have been identified.

An Integrated Health Framework, representative of the three-way alliance, is being progressed and overseen by the Health Partnership Advisory Council to value-add to an integrated investment of resources.

The significance of the framework will be seen in strengthened shared governance, operationalised steering groups and collaborative action in the continued pursuit of healthcare integration.

Western Sydney Integrated Care Committees, Governance and Partnerships



* WSLHD Executive Steering Committee:

Chief executive WSLHD
Chief executive WSPHN (WentWest)
Business manager WentWest
WSLHD clinical director Medicine and Cancer Services
WSLHD director Integrated Health

**Health Partnership Advisory Council:

1. Western Sydney PHN (WentWest)
2. Western Sydney Local Health District
3. Sydney Children's Hospitals Network

Service Delivery Reform

- Department of Premier and Cabinet
- Department of Family and Community Services
- NSW Health
- Juvenile Justice
- NSW Department of Education

Looking Forward

Integrated Care is a high priority for WSLHD and the WSPHN.

Together we are building an overarching integrated healthcare framework partnering with the Sydney Children's Hospital Network, social care agencies including the NSW Department of Family and Community Services, NSW Department of Education, consumer organisations and the NSW Police Force.

WSLHD is moving towards a healthcare business that utilises its hospital services more appropriately, increasing its focus on keeping people healthy and well, and enabling high performance through workforce and technology improvements.

It has commenced a process of strategic realignment, creating an Integrated and Community Health Directorate which sits at the executive table in the leadership structure and includes Community, Multicultural and Aboriginal health.

Services and programs have been aligned to better meet the needs of patients, an integrated health framework and strategic directions of the LHD.

These programs include the new Integrated Chronic Care Management Program (previously Connecting Care); HealthOne; HealthPathways; the Diabetes Initiative; along with several IT enablers.

The demonstrator journey has just begun.

Strong foundations for an integrated care platform have been built on the achievements to date.

Time is needed to consolidate system changes. The next phase will involve:

- Further work to support the PCMH in western Sydney
- Refining the role of the care facilitator to determine how to better support coordination of care for patients
- Consolidating and monitoring services to ensure closer links with primary care
- Lobbying and advocating for system changes — funding models, IT and sharing of data to support integrated care for patients
- A comprehensive communications campaign to market the WSICD including branding, targeted information, and a media program will promote integrated care to stakeholders.

By continuing to work together with the WSPHN and other external partners we will maintain the delivery of highly functional, integrated care to the people of western Sydney.

Abbreviations and Glossary

CALD	Culturally and Linguistically Diverse
Care facilitators	Care facilitators are registered nurses who provide a level of care coordination to the enrolled patient cohort
CAGR	Compound Annual Growth Rate
Cerner	Cerner Corporation is a supplier of health information technology solutions, services, devices and hardware
CDMP	Chronic Disease Management Program
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
FACS	Department of Family and Community Services
FFS	Fee-for-service
HbA1c	Glycated haemoglobin. By testing the level of glycated haemoglobin clinicians are able to get an overall picture of average blood sugar levels over a period of weeks/months. For people with diabetes the higher the HbA1c, the greater the risk of developing diabetes related complications
Health Partnership Advisory Council	Western Sydney Primary Health Network (WentWest), Western Sydney Local Health District, Sydney Children's Hospitals Network
HealthPathways	HealthPathways is an online health information portal for GPs to be used within patient consultations. It supports better linkages between GPs and specialist services
ICCMPC	Integrated Chronic Care Management Program Advisory Committee
IT	Information Technology
LinkedEHR	An online care planning system designed to manage patients with a chronic disease and a team of health professionals involved in their care
LGAs	Local Government Areas
LHD	Local Health District
MoH	Ministry of Health
NGOs	Non-government organisations
PBS	Pharmaceutical Benefit Scheme
PCEHR	Patient-controlled electronic health record
PCMH	Patient-Centred Medical Home
PHN	Primary Health Network
RASS	Rapid Access and Stabilisation Services provide rapid evaluation of an acute deterioration of a patient's chronic condition with the aim to intervene early to prevent an admission or expedite admission to hospital if required
SEIFA	Socio-Economic Indexes For Areas
SCHN	Sydney Children's Hospital Network
WentWest	Western Sydney Primary Health Network
WSPN	Western Sydney Primary Health Network
WSICD	Western Sydney Integrated Care Demonstrator
WISCP	Western Sydney Integrated Care Program
WSLHD	Western Sydney Local Health District



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