Western Sydney Integrated Care Program

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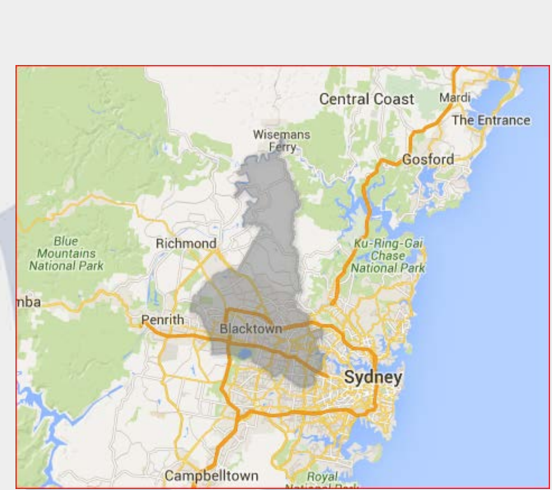
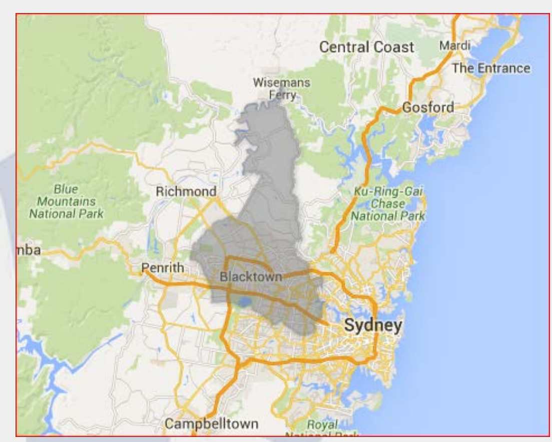
Western Sydney Integrated Care Program

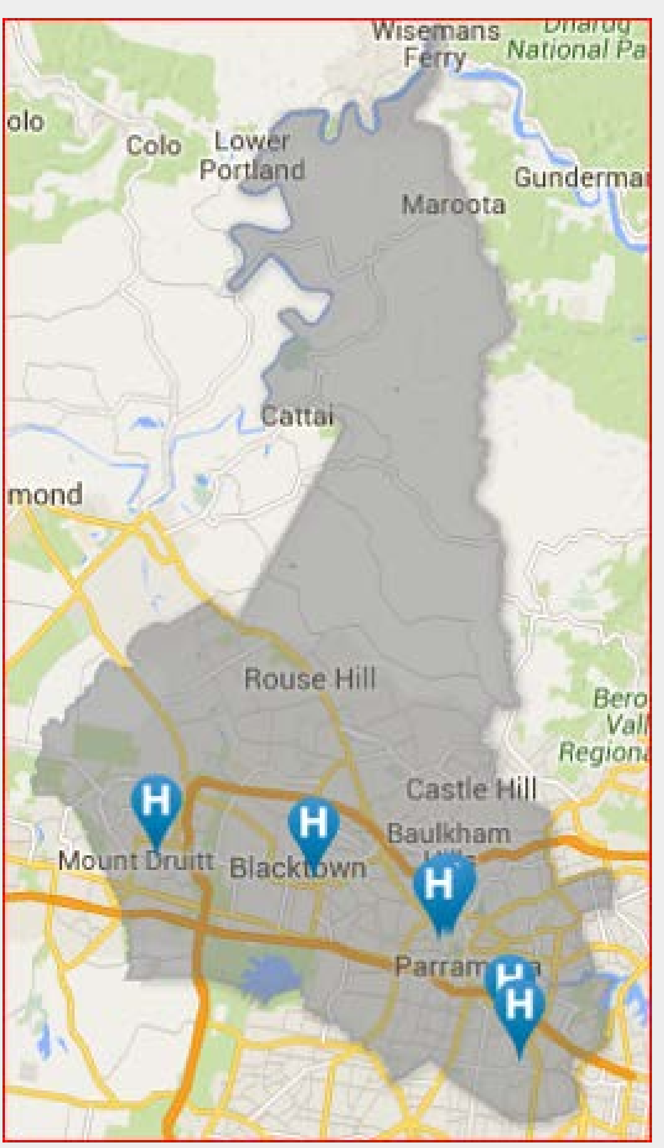
NSW Health Investment in Integrated Care

Establish three LHD-led Integrated Care Demonstrators to run over four years, aimed at supporting large-scale transformation of integrated local health systems and testing initiatives prior to extension across the State.

Western Sydney (WSLHD / WSPHN)

- 900,000 people
- 4 major Hospitals
- 1,100+ GPs (~320 practices)
- 1,300+ AHP
- 200+ Practice Nurses



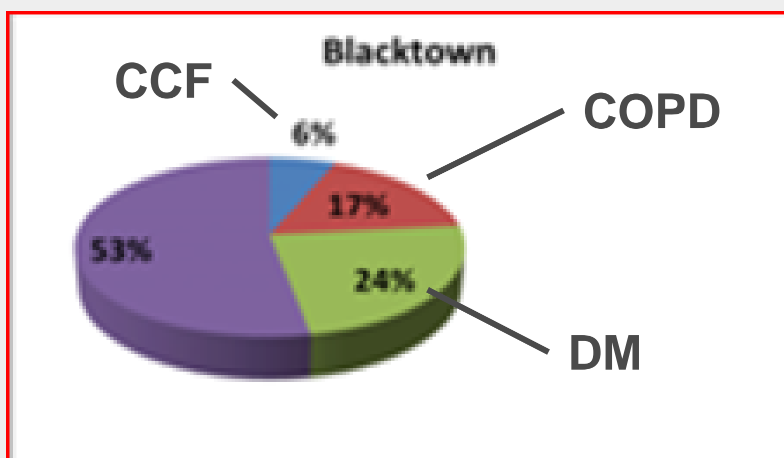
Western Sydney PHN

% with a long-term health condition 2013–14	42%
% overweight or obese 2011–12	60%
Deaths from potentially treatable conditions 2009-2011	~540 pa
% admitted to any hospital in the preceding 12 months 2013-14	9%
Potentially avoidable hospitalisation, chronic disease 2011-12	~9,800 pa

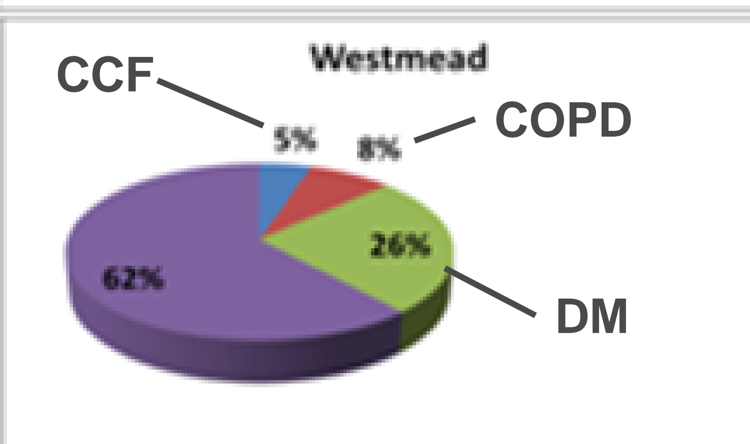
Western Sydney PHN (Access to Care)

Saw a medical specialist in the preceding 12 months 2013-14	35%
Saw an allied health professional or nurse 2011-12	16%
Adults referred to a medical specialist who felt they waited longer than acceptable to get an appointment in the preceding 12 months 2011-12	21%
Went to hospital emergency department for own health in the preceding 12 months 2013-14	10%

Chronic disease is a significant driver of escalating preventable admissions in Western Sydney

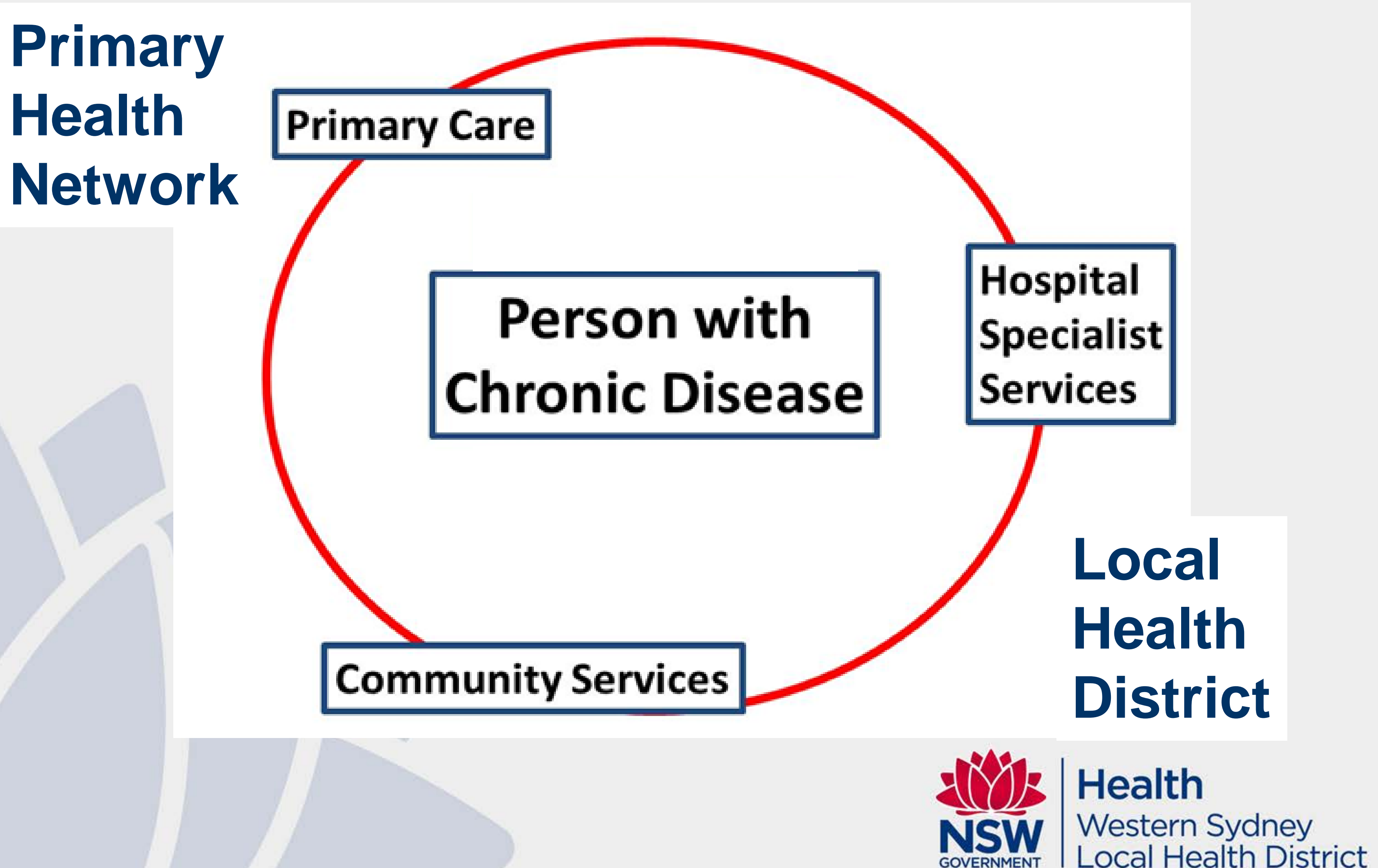


Blacktown	13/14 Total	% of Total Episodes
Episodes	27386	
PPH	4079	14.89



Westmead	13/14 Total	% of Total Episodes
Episodes	87013	
PPH	7727	8.88

Western Sydney Integrated Care Program



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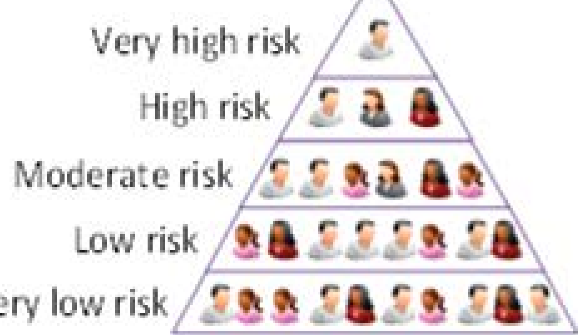
Overview of Holistic Integrated Care Model

Triple Aims (Quadruple)

Aspirations:
- Improve people's experience of care
- Improve health of population
- Improve cost effectiveness

+ Improve healthcare provider experience and satisfaction

2 Patient register and risk stratification



3 Care interventions delivered by a multi-disciplinary team

1. Self-management
2. Care planning and MDT
3. Care navigation
4. Case management
5. ...

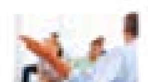
4 Key enablers

Patient engagement

Funding and incentives

Information technology and communications

Governance and quality improvement


Clinical engagement and redesign

WSICP Model of Care

For a cohort of patients:

- **identified at either GP and Hospital**
- **by Clinical Criteria (Cardiac, COPD, DM)**
- **with Participating GP/General Practice**

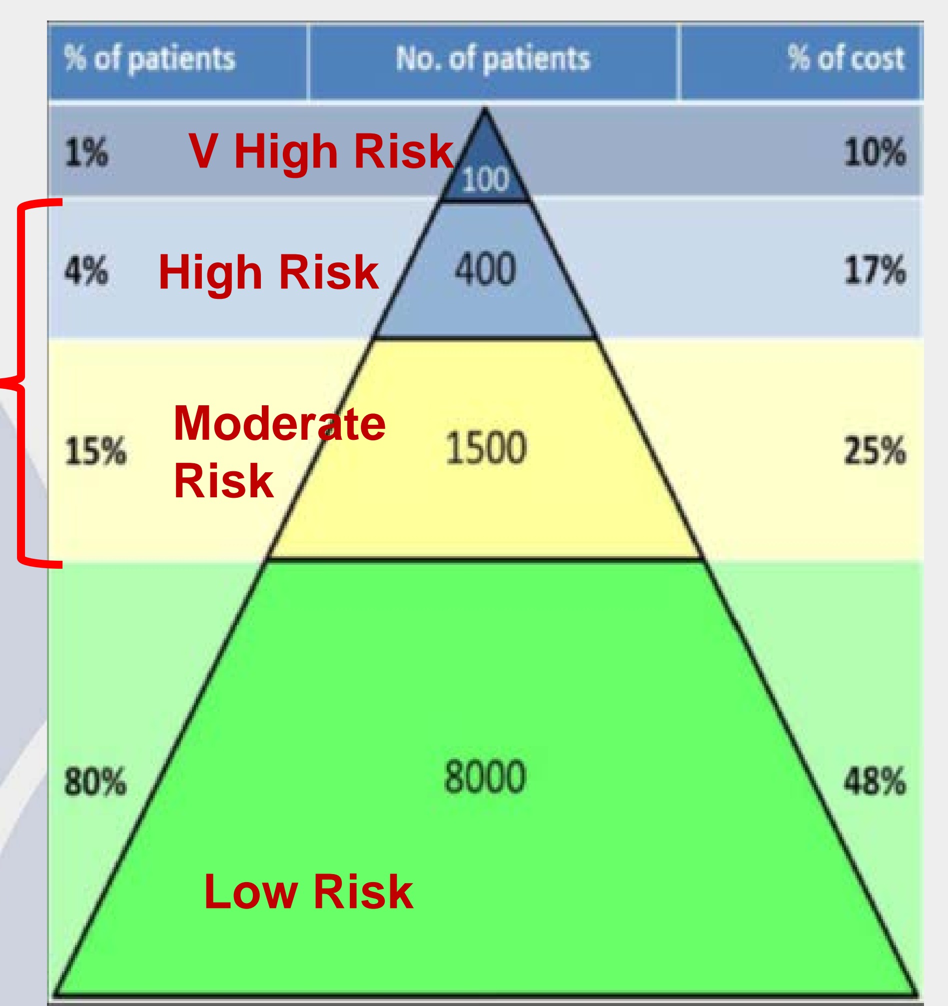
There will be an array of:

- **Services**
- **Systems**
- **Support**

Available to the patients and their treating teams:

- **to optimise their management in the community**
- **to reduce their need for hospital admission**
- **To improve communication and data sharing**

Registration and Risk Stratification



WSICP Registrants

3000 Subjects

COPD

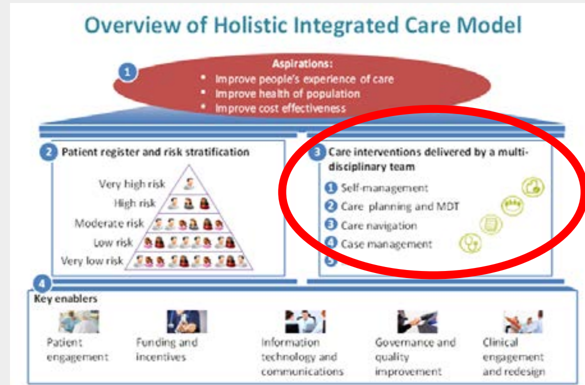
CCF/Chest pain

T2DM
- HbA1c > 8
  OR
- Unstable diabetes requiring insulin
  OR
- Recent or current hospital admission related to diabetes, diabetic complications, high risk foot

Current/Past/Potential admission to hospital

GP in WSICP

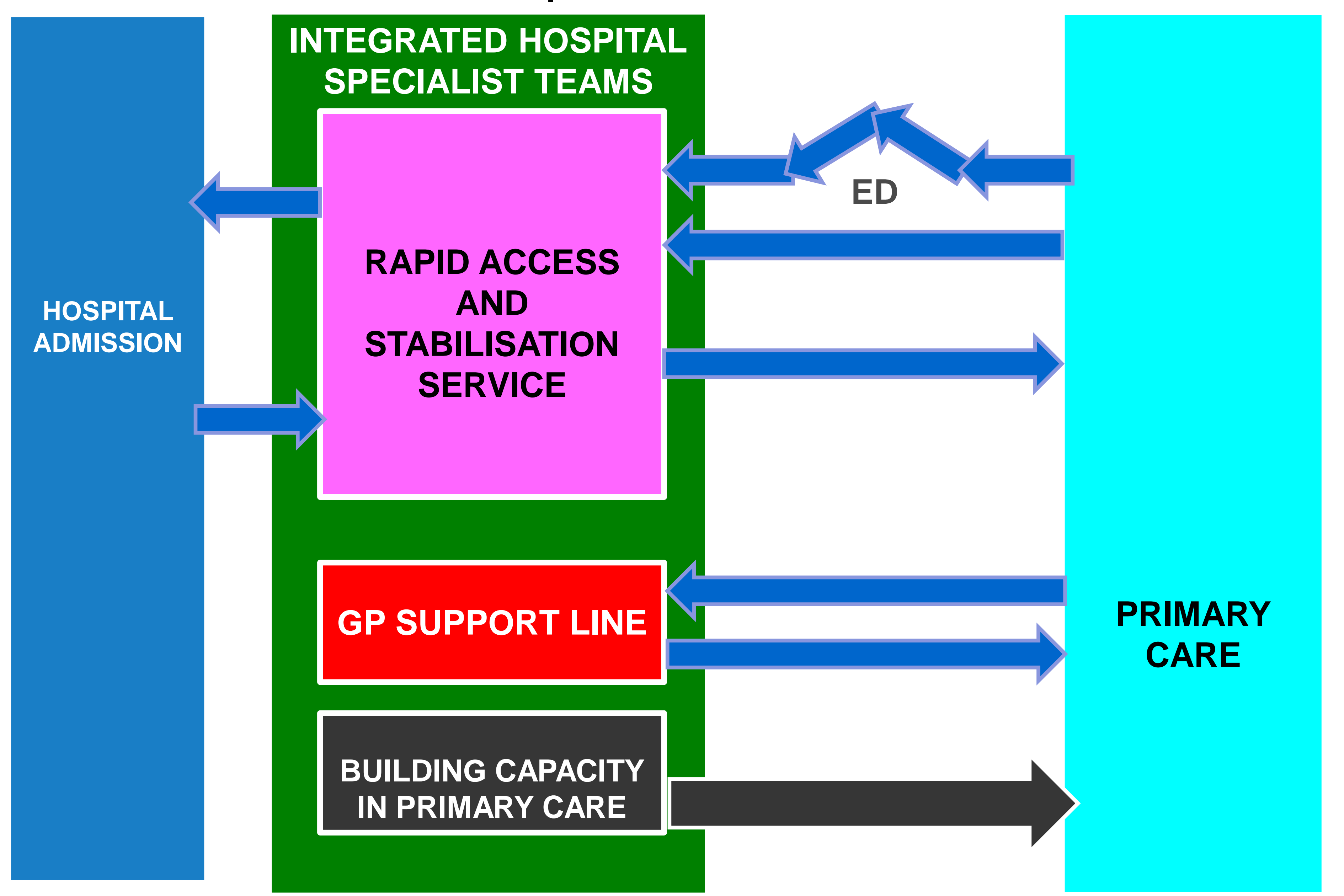
Care Interventions Multidisciplinary Team



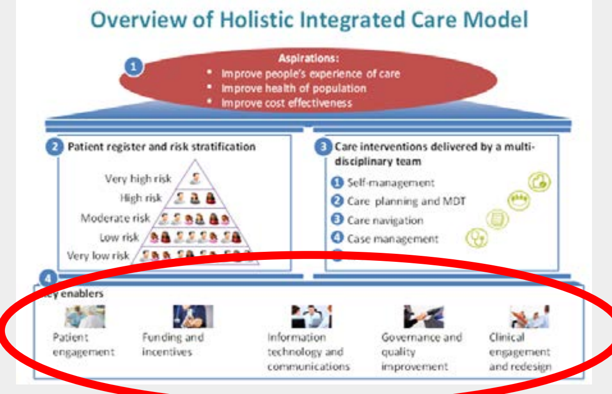
- Care Facilitators
- Specialist services focused on Integrated Care
- GP Support Line
- Training of primary care teams including case conferencing
- Better trained and supported primary care teams
- Links with other community services

Western Sydney Integrated Care Demonstration Project

Specialist Services



Enablers



- E-Health strategy: Shared Care Plan
- Action Plan
  E-Referral
  E-Specialist Letters
- Healthpathways: shared protocols, targets
- Links with other community services
- Shared governance
- Consumer engagement
- Quality audits
- GP incentive funding

Shared Care Plan

GP Plan
Clinical Information
Metrics

Hospital Action Plan

Dynamic Shared Care Plan

Shared Clinical Pathways: HealthPathways

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- Western Sydney **Integrated Care** Program (WSICP)
- **Integrated Care**
- WSICP - Frequently Asked Questions
- HealthPathways Teams - Who's Who
- Rapid Access and Stabilisation (RAS) Service
- Diabetes Shared **Care** Plan Protocol
- COPD Shared **Care** Plan Protocol
- CCF / IHD Shared **Care** Plan Protocol
- Comprehensive Medical Assessment (CMA) for RACFs
- Home Occupational Therapy Assessment

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Diabetes Shared Care Plan Protocol

Indicates specific advice about Aboriginal and Torres Strait Islander people.

A key management requirement for Integrated Care patients is to have an up-to-date, dynamic shared care plan to direct best practice ongoing care.

This protocol provides the basis for the elements of a Care Plan that refer to managing a patient's diabetes.

Every consultation

1. Assess compliance with diet and exercise. Offer lifestyle modification programs.
2. Assess diabetes control:
   - Discuss self-monitoring of blood glucose and review blood sugar levels (BSLs)
   - Optimise glycaemic control.
   - Ask about hypoglycaemic symptoms. See also Diabetes NSW – Hypoglycaemia.
3. Review medications, assess compliance, and adjust medication if needed (after reviewing blood sugar levels).
   - Discuss oral hypoglycaemic agents (OHA) and consider insulin. Do not delay if optimal management not being achieved with maximal oral therapy and lifestyle changes.
   - Review diabetogenic medications.
   - Consider the use of a statin and/or an ACE inhibitor as per the guidelines.
4. Check smoking status and encourage smoking cessation if relevant.
5. Calculate body mass index (BMI) and interpret the result.
6. Measure waist circumference.

Every 3 months

If indications of poor control consider measuring HbA1c.

Every 6 months (depending on clinical condition)

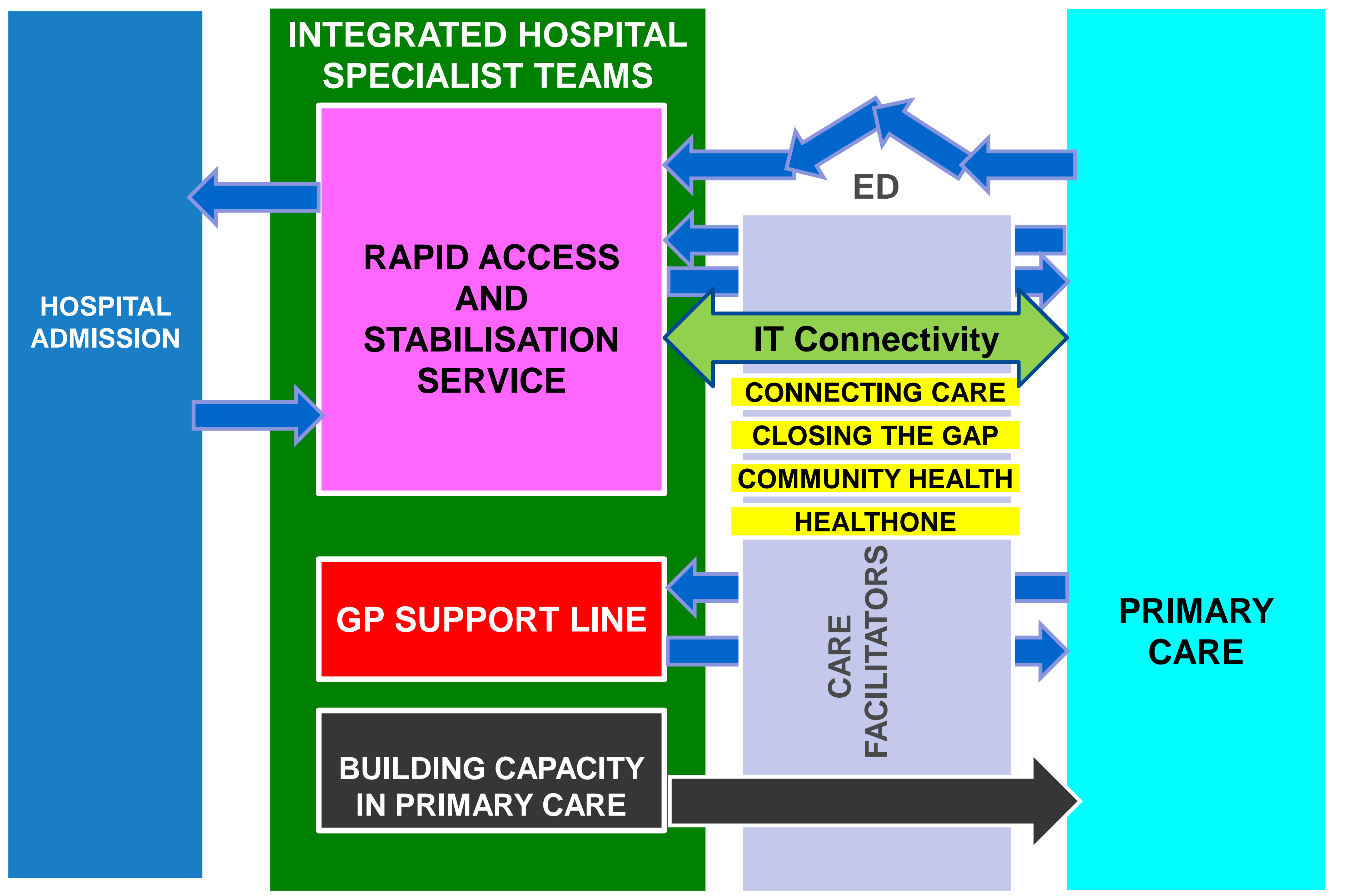
1. Measure HbA1c.
2. Measure blood pressure.

eydraft.healthpathways.org.au/index.htm

Western Sydney Integrated Chronic Care Program

Western Sydney Integrated Care Demonstration Project

Bridging the Gap between Hospital and Primary Care



WSICP RAPID ACCESS & STABILISATION

People with COPD / CCF / Chest pain / T2DM but not Registered

WSICP Registrants

COPD
CCF/Chest pain + clinical criteria
T2DM

Current/Past/Potential admission to hospital
GP in WSICP

3000 Subjects

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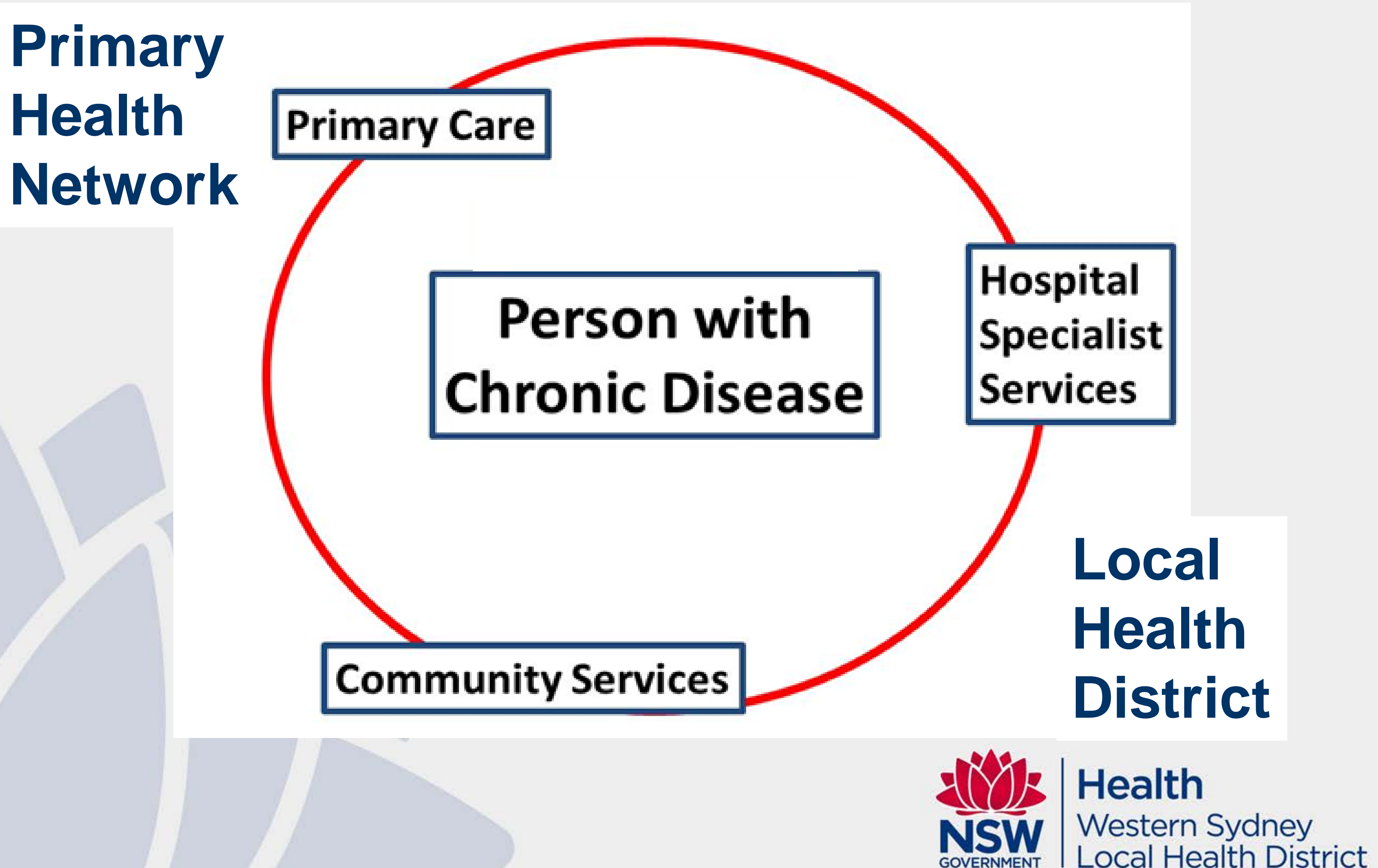

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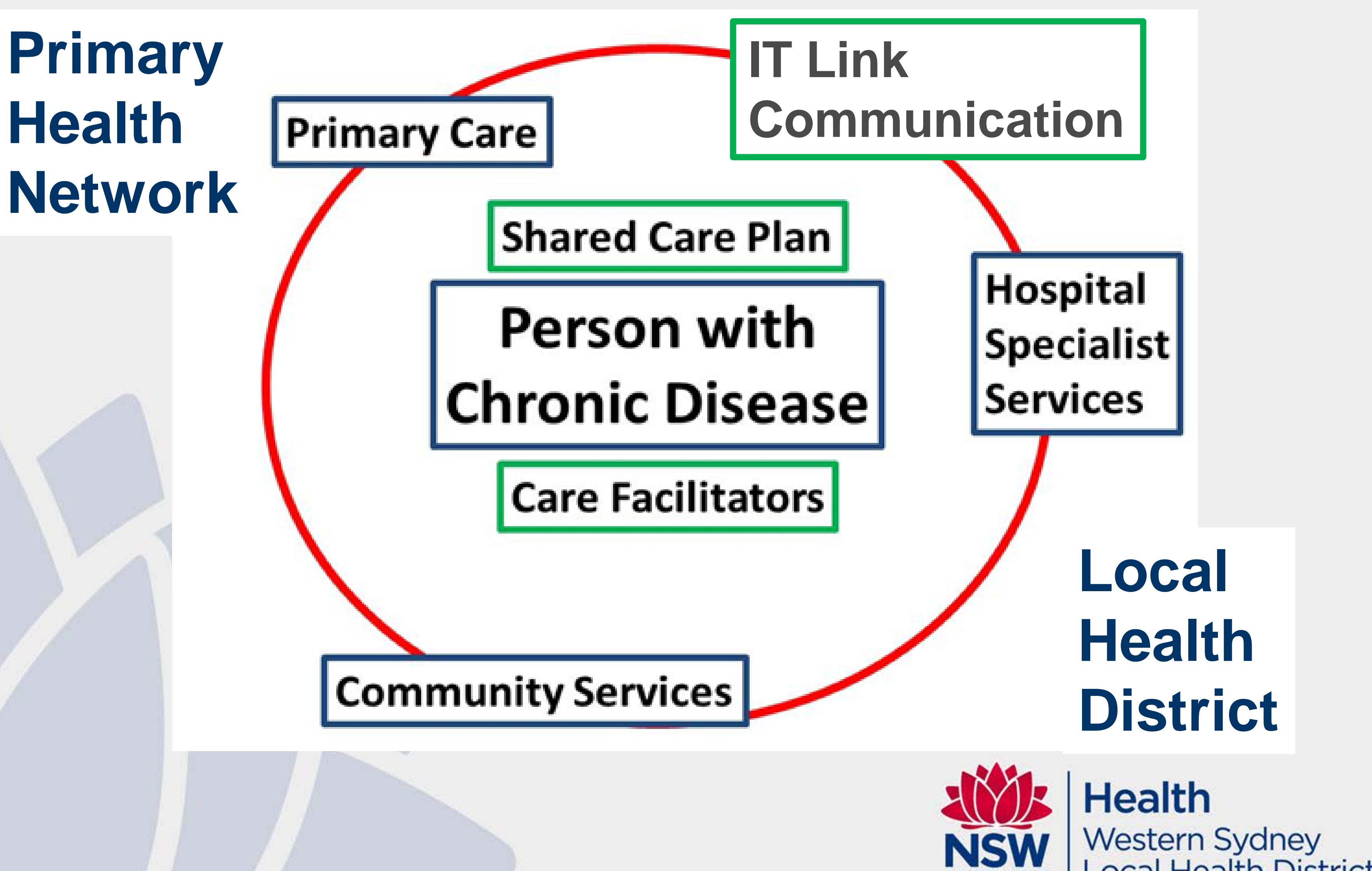

Current Status

- 67/320 General Practices participating
- 938 subjects enrolled
- 864 (92%) Linked eHR Shared Care Plan uploaded
- 2591 referrals to Rapid Access & Stabilisation
- 8939 occasions of service in RAS (Diabetes 3106)
- 50% seen within 2 days, 83% within 5 days
- 406 calls to GP Support Line

Next Steps

- Evaluation - Health services utilisation
  - Clinical outcomes
  - Quality of care
  - Consumer satisfaction
  - Consumer care experience
  - Service Provider satisfaction

- Wider Implementation

- Extend model to other chronic diseases

INTEGRATED CARE