Integrated Health Care.
A population based approach in South Western Sydney
(Growing health neighbourhoods around people)

2nd World Congress on Integrated Care
Sydney, Australia, 2014
24 November

On behalf of the SWS Integrated Health Committee
Outline

• South Western Sydney (SWS)
• Governance Bodies
• Target Population and Region
• Needs Assessment
• The model of integrating care (Vision)
• The strategies for integration
• Applying our principles of Integrated Care
• The evaluation framework
Governance Bodies

- **Aug 2013**
  - Partnership Agreement
  - Between SWSLHD & SWSML

- **Oct 2013**
  - Integrated Health Committee
  - Fortnightly meeting

- **Mar 2014**
  - Wollondilly Health Alliance
  - Partnership between SWSLHD, SWSML & WSC

- **Oct 2014**
  - WHA Governing Body

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SWSLHD – South Western Sydney Local Health District  
SWSML – South Western Sydney Medicare Local  
WHA – Wollondilly Health Alliance
The Wollondilly Health Alliance

Our Aims
1. To improve the users experience
2. To improve the health of our people and population
3. To improve the cost effectiveness of our systems
(Acknowledgement/Ref: USA Institute for Healthcare Improvement IHI 2008/09)

Members:
Council, SWSLHD, SWSML, General Practice, Allied Health, Consumer, Carer, NGOs, Private Providers.
Comprehensive Needs Assessment (CNA)

- Initiated by the WHA in April 2014 and completed September 2014
- Three main characteristics of CNA
  - Statistical Analysis
    - Population characteristics, health profile and service utilisation
  - Community Consultations
    - Survey of residents, face to face/Teleconference consultations with residents and providers
    - 511 community, 105 providers, 35 organisations/services
  - Strategic Priorities Workshop
    - Expert Reference Group to set priorities
Other Integrated Health Care Models

• Manchester City Council (England) – “An integrated care blueprint for Manchester” 2013.

• Canterbury (New Zealand) – “The quest for integrated health and social care” 2013

• Basque (Spain) – “big plan” for system wide transformation. 2013.
• 17.2 people per square kilometer
• 46,295 in 2013.
• Population growth (80,000 by 2026 and 134,000 by 2036)
• Over 58% of working residents travel outside the area to work
• 51% complete Year 10, only 36% complete year 12
• Younger population with highest growth in aged
About Wollondilly Shire (health of population)

- Higher rates of GP and ED usage
- Lower rates of outpatient clinic usage
- Higher rates of hospitalisation for COPD, Coronary Care and obesity
- Slightly higher incidence and mortality rates for cancers
- 2\textsuperscript{nd} Highest rates of obesity in SWS
- Higher rates of death attributable to alcohol, smoking and obesity
About Wollondilly Shire (Services)

• No hospital/acute care centre (public or private)
• FTE GP : 2750 people
• Very limited access to specialists
• Only 3 RACF with provision of places < Govt benchmark
• 19 Allied Health Private Providers
• 10 Locally based NGOs.
• Government Service Providers
Key Issues & Key Challenges

Key issues

• Workforce shortage locally
• Poor public transport
• Reliance of services in adjoining LGAs
• Population size to sustain private health providers
• Local perceptions region is always a spoke never a hub in design and funding of health services

Key Challenge

• Model of health care that better meets current expectations and future significant population growth
The Model (Our Vision)

• The ‘patient centred medical home’

• Beyond this would be a ‘health neighborhood’

• Data is collected and analysed

• Technology and shared patient records facilitate more integrated and continuous care
The Model (Our Vision)

- Relationships within the health community and a network of social care to support health

- Consumers understand how to access care and are more involved in maintaining and managing their health

- Increased capacity to provide quality “right care, right place, right time”

- Increased access to care, 24 hours

- Changing the patient’s/community expectation on where care is delivered
Strategies of the Vision

• Process in identifying core strategies
  – CNA
  – WHA workshop
  – Application of agreed 7 Integrated Care Principles

• 19 strategies broken into 3 themes
  – Access issues and population growth forecasts
  – Models of service delivery
  – Workforce attraction and retention
Priorities for action

• The need for Health service planning aligned to Wollondilly Growth Management Strategy
• Improved connectedness between providers (point of care and sharing of information)
• Increased access to a range of health programs in the community that includes different models of care.
• Improved information and awareness about available health services
• Increase the availability of GPs, especially female GPs
• Improve the supply and access to medical specialists and diagnostic services.
• Enable Private sector services to be viable in small communities
Core Principles of Integrated Care

• **Principle 1: Access** – Tele health initiatives that enable specialists providers to link up

• **Principle 2: Multidisciplinary team available for every person** – Increasing the availability of local allied health services by using the Dilly Wanderer as a means of community information

• **Principle 3: Provision of Linked Up Healthcare** - WHA as the governing body auspicing health reform in Wollondilly and guiding the direction and application of funds in the region

• **Principle 4: Quality, excellence and innovation** - KPIs of the WHA as a means to evaluate outcomes of this group and initiative
Core Principles of Integrated Care

- **Principle 5: Fostering academic health sciences and evidence-based practice** - Developing the evidence base of our work with Universities and other stakeholders

- **Principle 6: Prevention and Early Intervention close to Home** - Explore development of an interactive social media and web facilitated Healthy Wollondilly Community to enhance preventative health, health promotion and healthy lifestyles

- **Principle 7: Accountability to the Community** Engage the consumer as an essential member of the team through a robust communications plan that includes consumers involved in the planning, development, implementation, evaluation and ongoing feedback
## Indicative Evaluation Framework

<table>
<thead>
<tr>
<th>PHC strategic framework</th>
<th>Inputs / Mechanisms to promote integration</th>
<th>Impact</th>
<th>Outcomes</th>
<th>IHC Strategic Plan</th>
<th>NSW Health Integrated Care</th>
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</thead>
<tbody>
<tr>
<td>A. Consumer-focused integrated PHC system</td>
<td>e.g. Clinical handover, Health information exchange, PCEHR &amp; navigation aids</td>
<td>Patient-centred care services</td>
<td>Patient &amp; provider satisfaction, Patient activation</td>
<td>Identify communities who require integrated health care and respond to their needs</td>
<td>Leadership &amp; vision, Investment, Funding models, Purchasing &amp; Contracts, Performance frameworks, Change management, Risk stratification, Capacity building, Information infrastructure, Telehealth, Decision support, System design</td>
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<td></td>
<td>e.g. eHealth, e.g. Access (5A’s)</td>
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<td>B. Improve access &amp; reduce inequity</td>
<td>Telehealth, mHealth, PCEHR and navigation aids</td>
<td>Community-centred services</td>
<td>Health navigation literacy, Equitable distribution of services w.r.t. population</td>
<td>Right care at right time by right people at right place</td>
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<td>C. Health promotion, prevention, screening &amp; early intervention</td>
<td>Evidence-based self-management protocols, Information systems &amp; online/digital resources, PCEHR &amp; decision aids</td>
<td>SNAPW compliance, Health literacy</td>
<td>Global health outcomes, Disease specific indicators, Risk factors control, Health literacy</td>
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<td>D. Quality, safety, performance &amp; accountability</td>
<td>Clinician-management partnerships, Data quality assessment, Data, clinical and corporate governance</td>
<td>Effective governance structures and protocols</td>
<td>Informatics Capability Maturity, Data fit for purpose, Learning organization</td>
<td>Supported by well-structured collaboration, teaching and research</td>
<td>Models of care</td>
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<td>Methodology</td>
<td>Self-assessed &amp; observed maturity of Integration Capacity and Informatics Capability; Team Climate Inventory; Observation/Interviews/surveys of patient, carer &amp; provider; Data extraction, quality assessment, analysis, dissemination</td>
<td>Acceptable levels of: Team Climate Integration capacity, Informatics capability, Patient, carer &amp; provider satisfaction</td>
<td>Indicators of Cost-efficiencies, Integrated care, Evidence-based care, Control of Risk factors, Health outcomes</td>
<td>Evaluation framework and plan</td>
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Measures of Success

Our Markers of success will include

(Goodwin July 2014)

- Community trust
- Population health planning - not segmenting out disease management programs
- Linked data mining
- Shared access to health records/health information
- No wrong door
- Enhanced health promotion and supported self care
- Use of care coordinators and care navigators
- Strengthening multi-disciplinary health and social care teams
- Working towards responsive provider networks available 24/7
- Committed to responding to patient experience and outcomes
Conclusion

• A long journey with a Heterogeneous community
• System wide population approach to integrated care that includes health and social care.

Growing health neighbourhoods around people