Western Sydney Integrated Care Program

Whole of Health Master Class

27th February 2015

Victoria Nesire

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Western Sydney
Local Health District

Western Sydney - Case for Change

- Population over 830,000 increasing to 1 million by 2020
- 17% of population are in the most disadvantaged SEIFA decile
- Diverse population – up to 65% overseas born in some areas
- Over 13,000 Aboriginal and Torres Strait Islander people
- 57.3% of population have 1 of 4 health risk factors
- 10– 20% higher evidence of diabetes & respiratory issues than the NSW average

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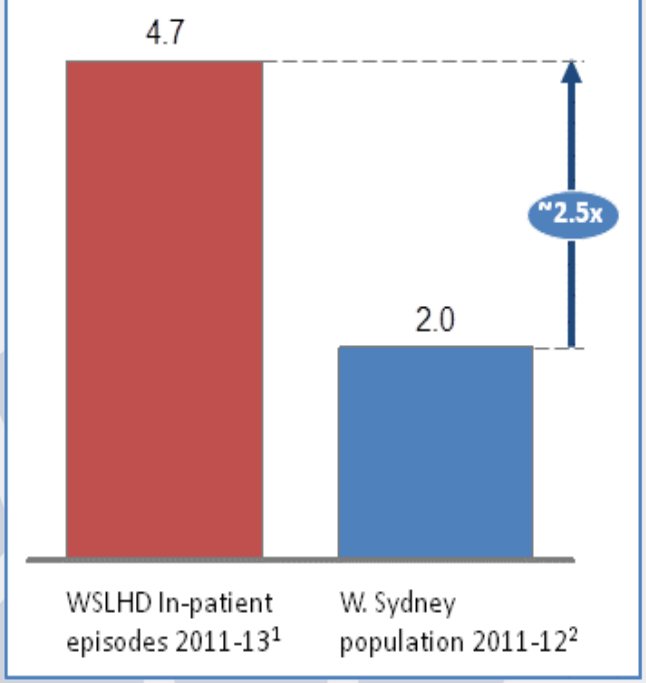
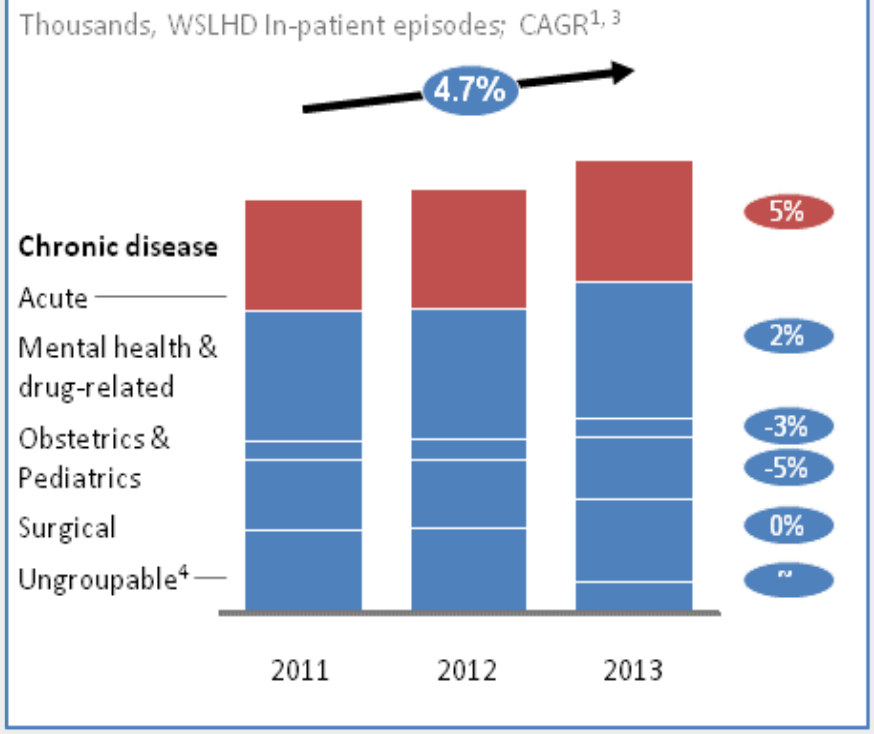
Chronic Disease is a significant driver of escalating healthcare activity and cost in Western Sydney

Hospital activity has been rising faster in Western Sydney than the population growth



Chronic disease is the fastest growing in-patient episode category



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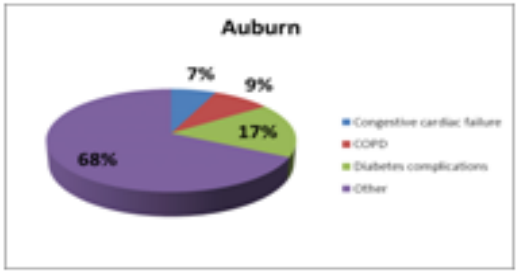
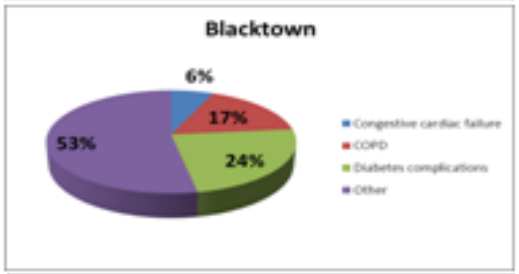
Case for Change

Integrated care aims to address the demands created by chronic disease

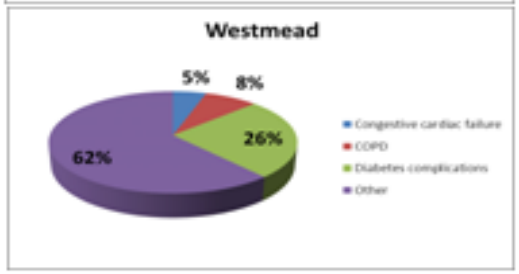
Preventable Admissions by Hospital 2013 / 2014



Auburn	13/14 Total	% of Total Episodes
Episodes	15097	
PPH	1806	11.96



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

Readmitted after 28 days:

- 25% Diabetes
- 25% COPD
- 15% of CCF

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NSW Health Investment in Integrated Care

$120M investment over 4 years

	Description	Goal	Indicative funding levels
Statewide enablers	Investment in enabling environment for integrated care at the State level: - information technology infrastructure - outcomes measurement - patient feedback - capacity building and evaluation.	Establish key **enablers of** integrated care benefiting all LHDs and stakeholders	$33M (27%)
Planning and Innovation Fund	Investment in integrated care initiatives to: - drive transformation - support strategic planning for integrated care at the local level - extension of successful integrated care Demonstrator approaches	**Support local planning**, collaboration and innovation initiatives	$36.6M (31%)
Integrated Care Demonstrators	Establish three LHD-led Integrated Care Demonstrators to: - support large-scale transformation of integrated local health systems - testing initiatives prior to extension across the State.	Develop **system-wide** integrated care approaches in three LHD's that are **transferrable and scaleable**	$50.4M (42%)

Demonstrators will involve partnerships with primary care organisations, NGOs and private providers

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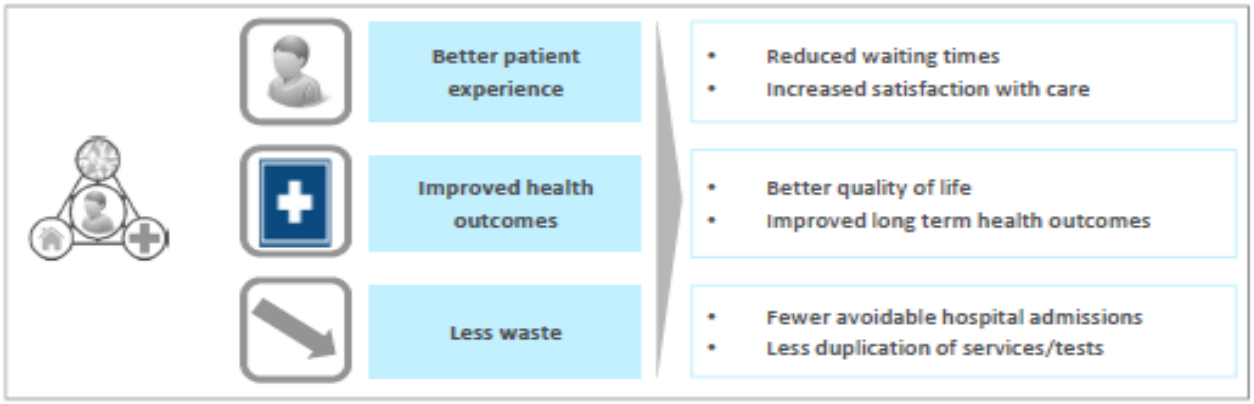
NSW Ministry of Health - Integrated Care

Expected benefits

- Improved patient experience of the health system
- Reduced waiting times for patients as they navigate the system
- Improved health outcomes for patients and better quality of life
- Reduced avoidable or unnecessary hospitalisations
- Less duplication of tests through better sharing of information
- Better use of health resources



+ Improve healthcare provider experience and satisfaction

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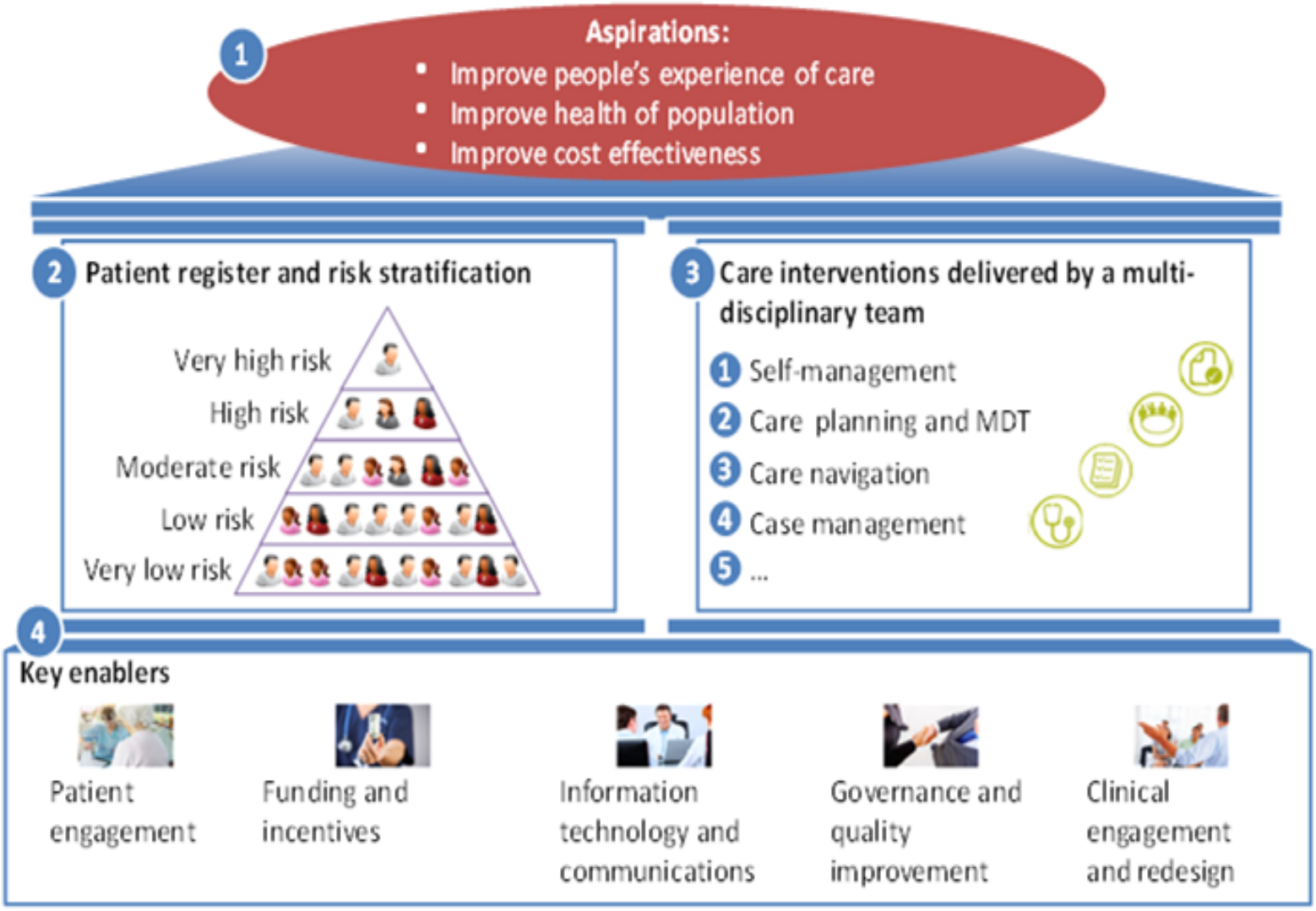
Overview of Holistic Integrated Care Model



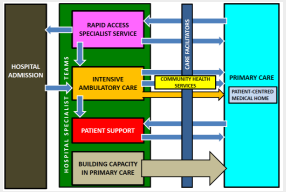
Model of Care

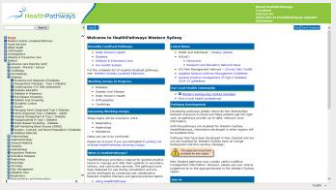
Identified Integrated Care patient cohort (initial)

- 3 eligible conditions
  - Diabetes
  - Congestive Cardiac Failure + Coronary Artery Disease
  - Chronic Obstructive Pulmonary Disease
- Patient cohorts (identified, enrolled and registered)
  - General Practice
  - Hospital
- Cohort identification and risk estimation tools
  - Interim tools being developed for stratifying GP and Hospital cohorts
  - NSW Health tool

Optimal access to healthcare services

1. General Practice Patient Centred Medical Home (PCMH)
2. Shared Care Plan and Care Protocols
3. Care Facilitator
4. Integrated Hospital Specialist Teams
5. Community based services





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Hospital Cohort

"This year's re-admissions"

Type 2 diabetes
COPD
CCF/Chest pain

Admission to hospital

- (Potentially preventable)
- Potential admission to hospital
- GP in WSICP

Can be largely managed in primary care

Equally Sourced

Primary Care Cohort

"Next year's admissions"

Type 2 diabetes
COPD
CCF/Chest pain

Past admission to hospital

- (Potentially preventable)
- Other risk factors for admission
- Out of range parameters
- GP in WSICP

Can be largely managed in primary care

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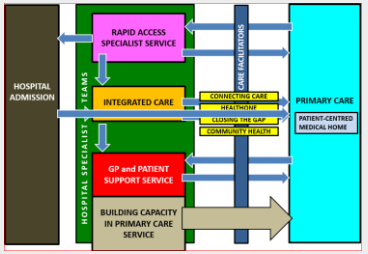
Western Sydney Integrated Care Program

Every Integrated Care patient will have:

- Integrated Care General Practice
  - Level 1 - Patient Centred Medical Home
  - Level 2 and 3 – limited aspects of PCMH
- Nominated GP
  - Consent to participate and share clinical information
- Shared Care Plan
- Hospitalisation Risk Score
- Care Facilitator to assist with:
  - Care planning, coordination and navigation
  - Patient self-management
- Access to the suite of WSICP interventions, including Specialist and community based services



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Role of Care Facilitators

- Responsible for facilitating the care path for patient ("the glue that sticks the patient and their care team together")
- Care monitoring, navigation, coordination and case management
- Supports the GP team, Specialist team and Community team
- Monitor their patients' Care Plans, Clinical Parameters, Referrals and Transfers of Care

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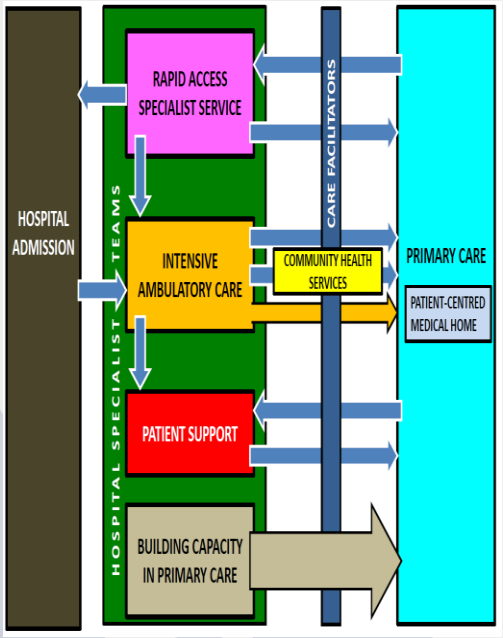
Integrated Hospital Specialist Teams



- Rapid Access and Stabilisation Service
- GP Support Services
- Capacity Building in Primary Care Services

All service providers access and contribute to Shared Care Plan (with assistance of Care Facilitator)

Hospital generated Action Plan to inform Care Plan

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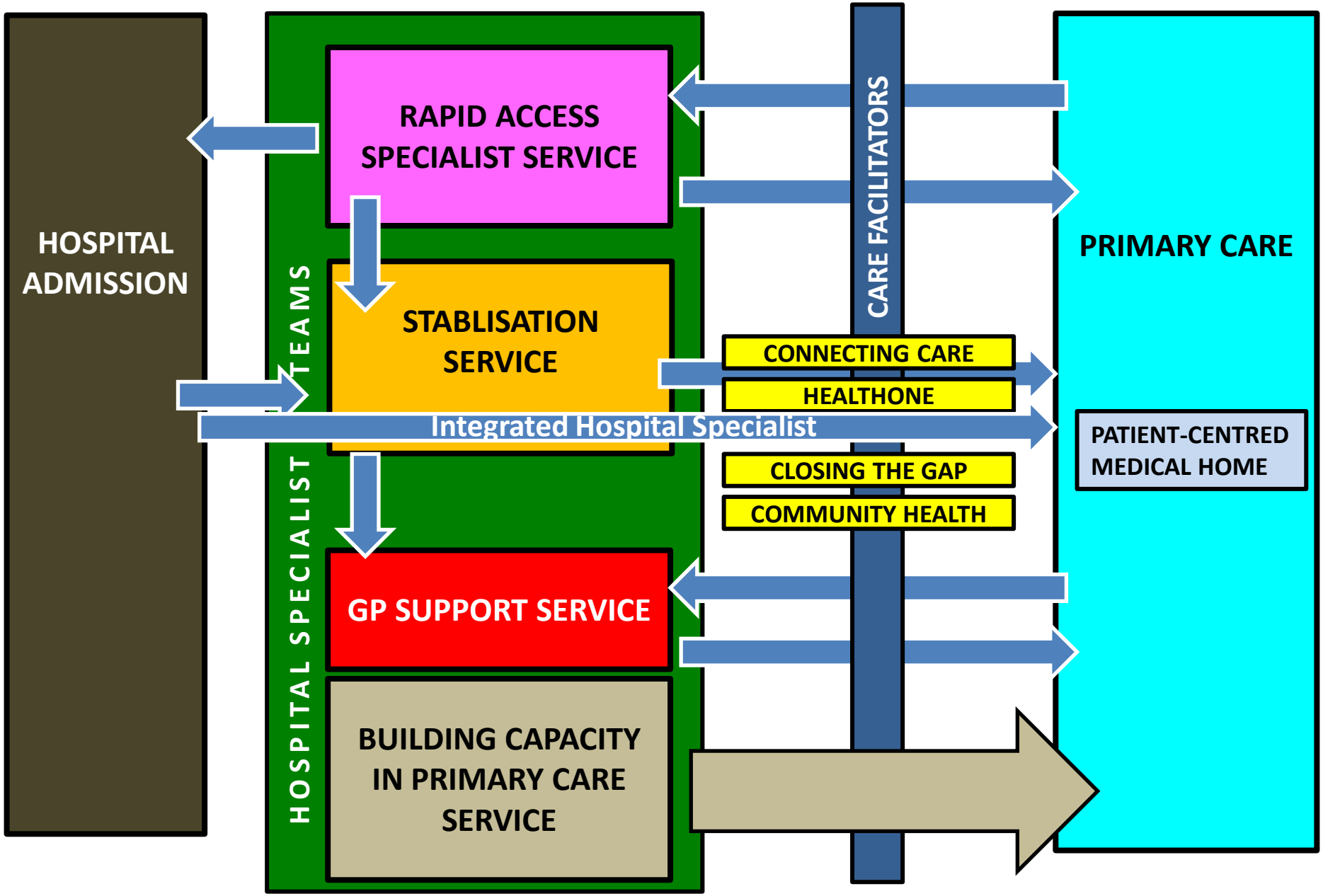
HOSPITAL ADMISSION
HOSPITAL SPECIALIST TEAMS
RAPID ACCESS SPECIALIST SERVICE
STABLISATION SERVICE
GP SUPPORT SERVICE
BUILDING CAPACITY IN PRIMARY CARE SERVICE
CARE FACILITATORS
CONNECTING CARE
HEALTHONE
Integrated Hospital Specialist
CLOSING THE GAP
COMMUNITY HEALTH
PRIMARY CARE
PATIENT-CENTRED MEDICAL HOME

Questions