Better Health Together: integrating the integrated care programs in western Sydney

A shared program of the WSLHD and WSPHN Partnership Advisory Committee

WSLHD Integrated & Community Health Directorate

In cooperation with

WSPHN,

WSPHN region General Practitioners

and

Departments of Cardiology, Respiratory Medicine and Endocrinology

At Westmead and Blacktown Hospitals

Better Health Together

Western Sydney Integrated Chronic Care Program

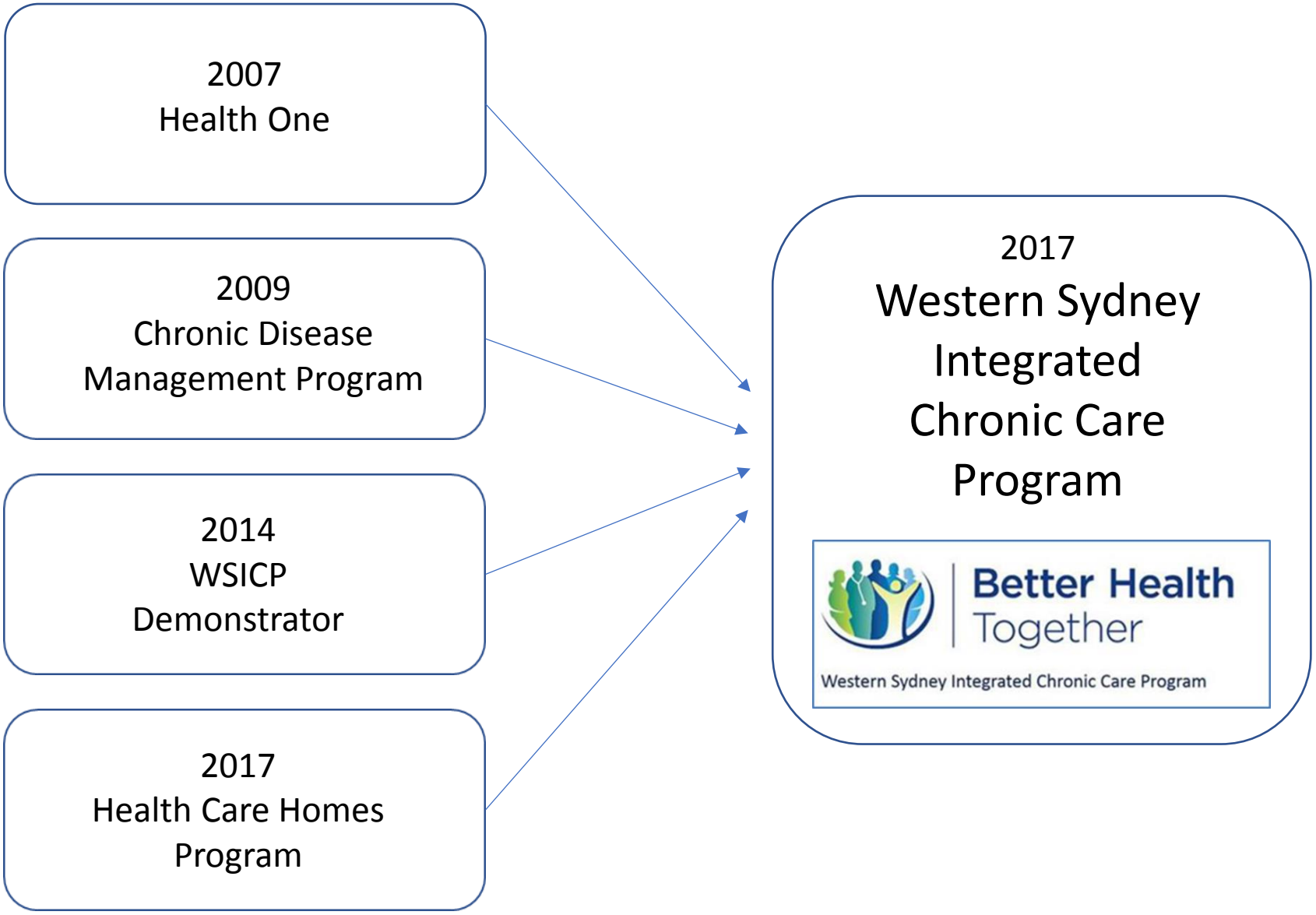
A long-term partnership approach to integrating care for western Sydney

phn WESTERN SYDNEY

An Australian Government Initiative

NSW GOVERNMENT Health

Western Sydney Local Health District


2007
Health One
2009
Chronic Disease
Management Program
2014
WSICP
Demonstrator
2017
Health Care Homes
Program
2017
Western Sydney
Integrated
Chronic Care
Program
Better Health
Together
Western Sydney Integrated Chronic Care Program

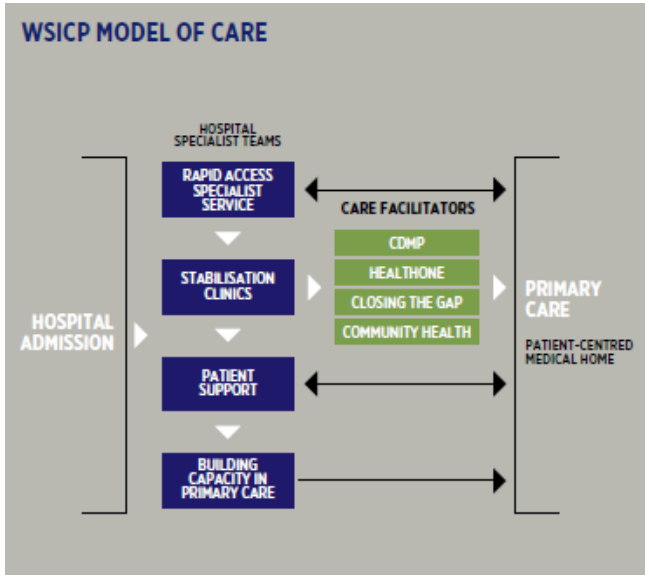
Health
Western Sydney
Local Health District

phn
WESTERN SYDNEY

THE NEW FRONTIER OF HEALTHCARE

Western Sydney Integrated Care
Demonstrator 2014-2017

WSICP MODEL OF CARE



DANNY O'CONNOR
CHIEF EXECUTIVE
Western Sydney
Local Health District

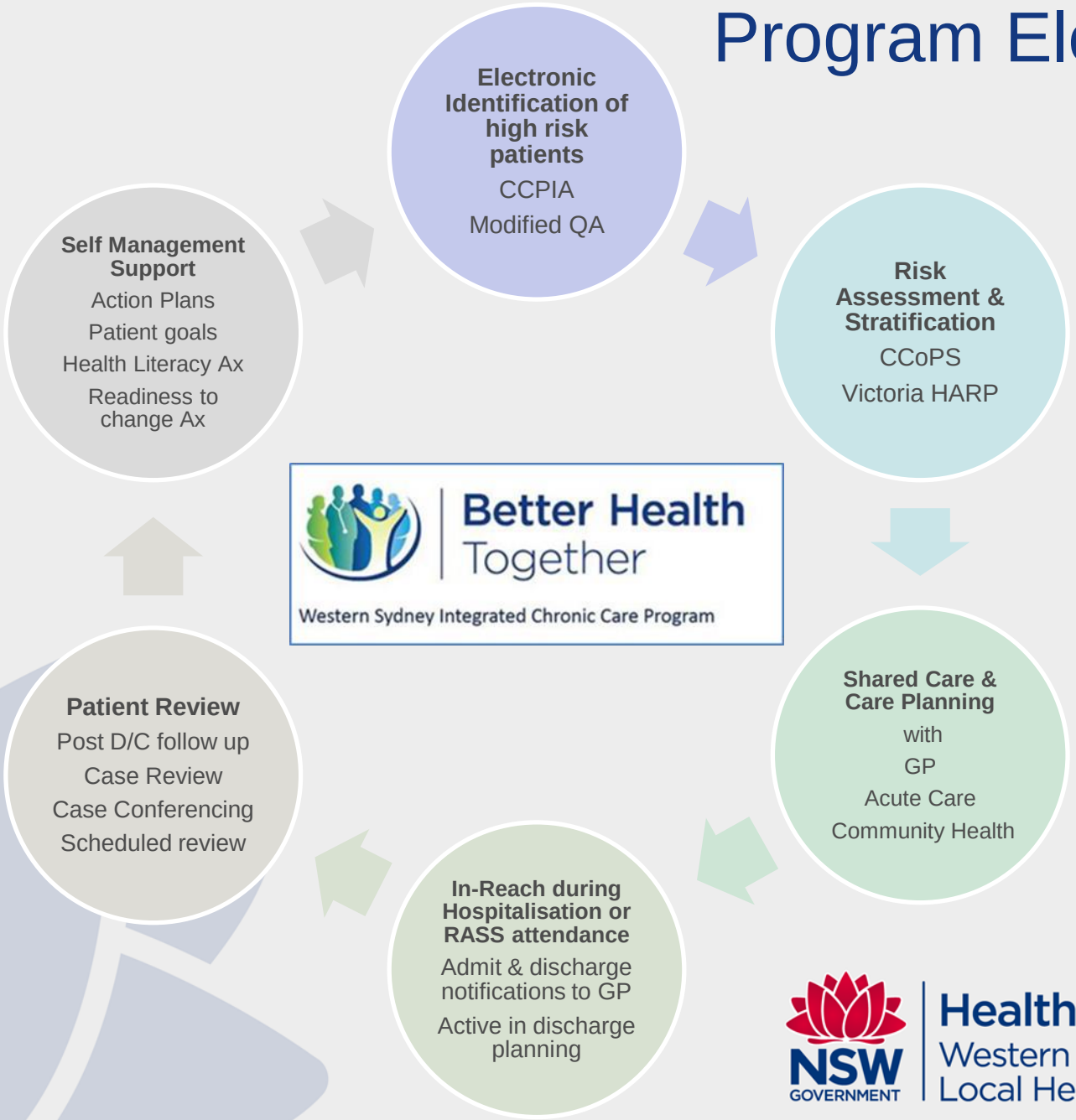
ADJUNCT ASSOCIATE PROFESSOR WALTER KMET
CHIEF EXECUTIVE OFFICER
Western Sydney
Primary Health Network

WESTERN SYDNEY INTEGRATED CARE DEMONSTRATOR 2014-2017

"IT IS VERY EXCITING TO BE PART OF A PROGRAM THAT BRIDGES THE GAPS FOR PEOPLE WITH CHRONIC CONDITIONS. I HAVE NURSED IN ACUTE CARE AND COMMUNITY HEALTH AND I COULD SEE THE GAPS — THE LACK OF COMMUNICATION BETWEEN THE TWO SECTORS. AS A CARE FACILITATOR I AM ABLE TO IDENTIFY THE BARRIERS TO ENSURE THE PATIENT IS GETTING THE RIGHT CARE AND I AM ABLE TO CONNECT THEM TO THE RIGHT PEOPLE TO ACCESS CARE SUCH AS AGENCIES LIKE CENTRELINK."

WSLHD CARE FACILITATOR NATASHA MAUNSELL

Program Elements



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WSICCP Program Services

Referral Support

Make referrals on behalf of clinicians

Follow up on services

Patient advocacy with providers

Single Point of Access

Intake and processing of new referrals

Risk Assessment & allocation to the right intervention or team ICCP team

Stanford SMP

6 week skills development workshop to make better health & lifestyle choices

Care Facilitation with Enrolled Practices

Risk Assessment

Care Planning

In reach into acute & community care

Self Management Support

Care Facilitators with Non Enrolled Practices

Risk Assessment

Care Planning

In reach into acute & community care

Self Management Support

WSICCP Specialist Services

RASS Clinics

GP Support Line

Case Conferences

GP Capacity Building

Telephonic Health Coaching

Coaching patients in health behaviours & risks to achieve national standards

Aboriginal Chronic Care

Post Discharge Follow UP

Care Facilitation for High Risk Patients

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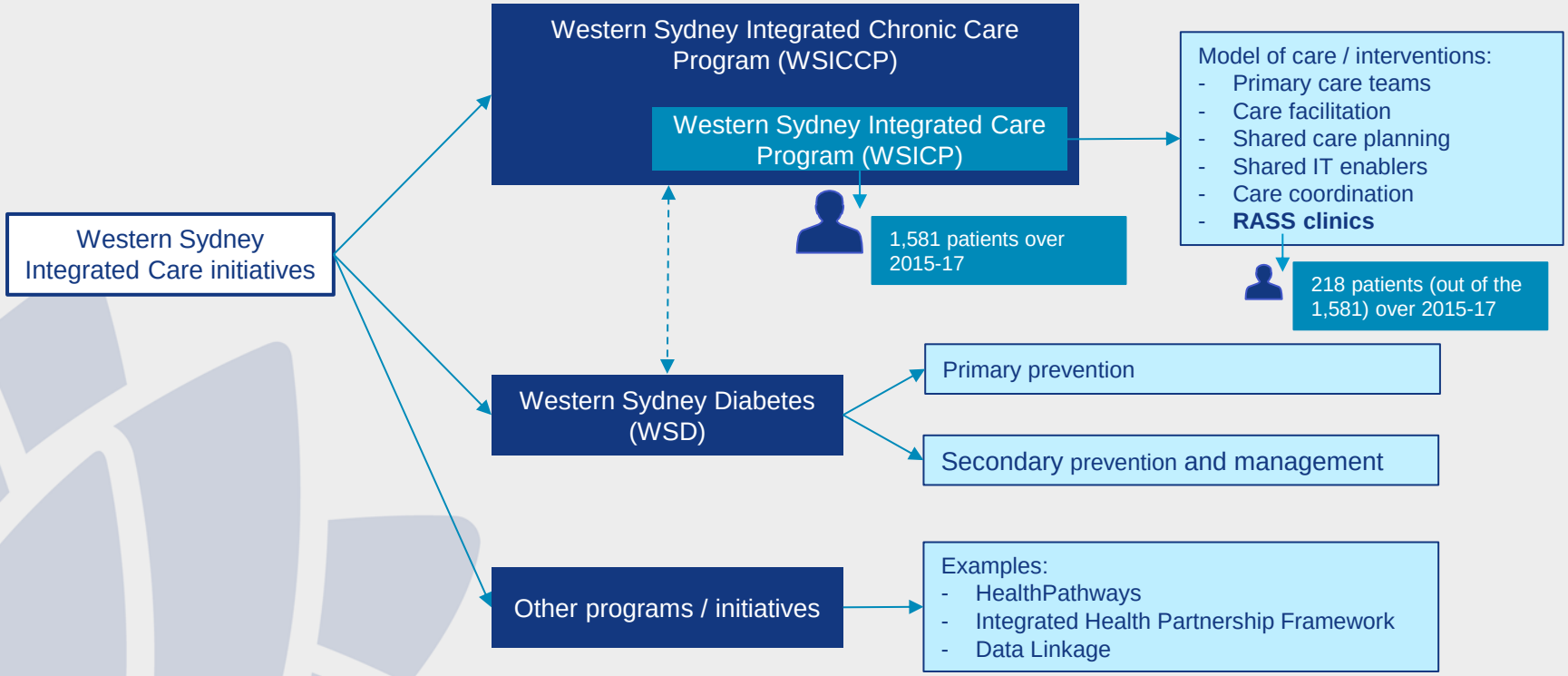
Overview of Western Sydney's Integrated Care initiatives

Two of the key chronic care initiatives in WSLHD, in partnership with WentWest PHN, are:

1. The Western Sydney Integrated Care Program (WSICP) (a subset of the broader Western Sydney Integrated Chronic Care Program (WSICCP))
2. The Western Sydney Diabetes (WSD) initiative

For the purpose of this preliminary analysis the work has focused on the WSICP and WSD only.



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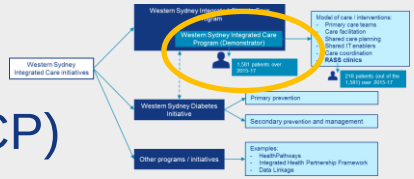
Western Sydney Integrated Chronic Care Program (WSICCP)

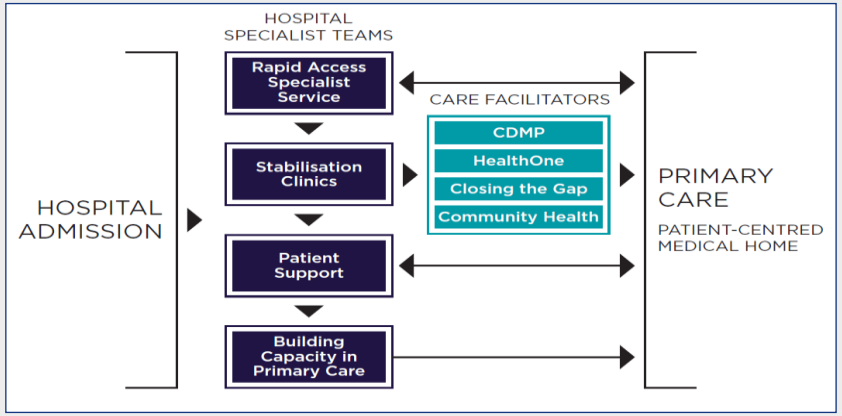


A key initiative in WSLHD, in partnership with WentWest PHN, is the **Western Sydney Integrated Chronic Care Program (WSICCP)** – otherwise known as the Demonstrator. A lot of work has been done to understand the activity and impact of the WSICCP.

The WSICCP aims for integration at a number of different levels

- *transforming service delivery to be orientated around the persons needs*
- *integration of care in general practice may reduce secondary care costs*
- *Benefit for the heaviest users of healthcare - patients with chronic conditions who require more continuity of care*

The model of care has been collaboratively developed with consumers, health staff and members of the community.



Preliminary evaluations indicate

- trends of better care navigation and decreased acute service utilisation by using the Rapid Access and Stabilisation Services (RASS) services
- data suggests people are being enrolled and referred to services in the community earlier in their condition trajectory, possibly delaying use of acute care services.

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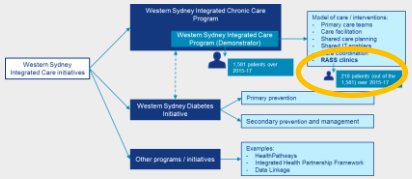

Early results (calculated over 2 years for RASS clinics)

RASS clinics show decreases in hospital admissions and Emergency Department attendances for clinic attendees when comparing service utilisation for these patients for equal periods of time before and after attending the clinic. This converts to significant cost savings for the management of these patients.

Results from the RoI analysis for all 4,897 RASS clinic attendees - June 2015 and September 2017

Source	Before	After	Result
Reduction in unplanned hospitalisations	*8,344*	*5,487*	*(34%)*
Length Of Stay Unplanned Hospitalisations (Days)	*43,468*	*32,716*	*(25%)*
Unplanned Readmissions	*1,429*	*1,898*	*33%*
Potentially Preventable Hospitalisations	*3,219*	*2,044*	*(37%)*
Hospitalisation Cost (NWAU)	**11,603**	**7,182**	**(38%)**
ED Presentations	*9,978*	*6,760*	*(32%)*
Length Of Stay ED (Days)	*3,382*	*2,485*	*(27%)*
Ambulance Arrival	*4,309*	*3,300*	*(23%)*
ED Cost (NWAU)	**1,987**	**1,326**	**(33%)**

Participation Jun 2015 - Sep 2017:

- The RASS clinicians provided consultations for 4,897 patients with Chronic Conditions.
  - ➢ 218 ICP enrolled patients
  - ➢ 4,678 ICP non-enrolled patients
- The RASS clinicians performed 17,077 occasions of service

Capacity in system (NWAU*):

- Hospitalisation $21.6M
- ED: $3.3M

Source: Western Sydney Integrated Care Status Summary. Preliminary WSLHD analysis: Pankaj Gaur, Michael Crampton, Linda Soars, 30 October 2017.
** National Efficient Price taken as $4,883*

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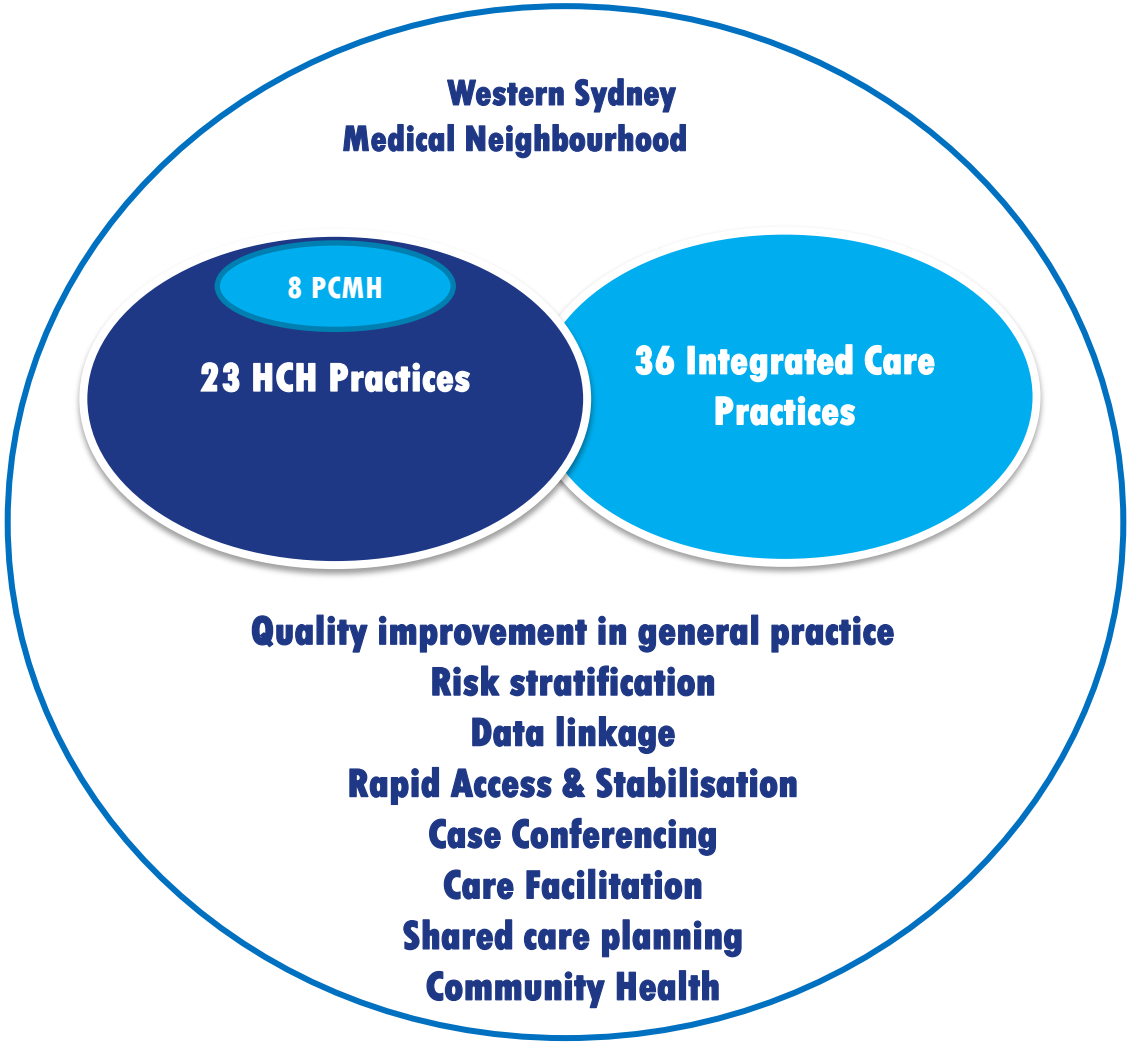
Body of aligned activities



Western Sydney Diabetes

Pharmacists in general practice

HealthE

Go Share Health

Next Steps

- need shared accountability and flexible funding options
- a greater focus on quality of health outcomes using information, data sharing and data linkage
- data analysis using control group - cohort being developed with NSW Ministry of Health
- Questions?

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