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25th July 2016

Integrated Care, PCMH, Digital Platforms and a Time for Change

The Western Sydney Experience
Integrated Care, PCMH, Digital Platforms and a Time for Change

- The Western Sydney context
- The model and approach to Integrated Care
- Implementation progress
- 10 lessons learned!
The Western Sydney Context
One of our challenges

SOURCE: Thomas Astell-Burt, School of Science and Health, University of Western Sydney
Western Sydney is a health issues ‘Hotspot’

- 57.3% of population have at least 1 of 4 health risk factors smoking, obesity, inactivity and alcohol abuse
- 10 – 20% higher evidence of diabetes and respiratory issues than the NSW average
- Local estimates put 50% of the population in 3 of the 5 LGA’s at high risk of diabetes
- Chronic disease is driving escalating activity and expenditure
- Reliance on fee for service in primary care is becoming progressively misaligned with achieving better health outcomes
Escalating hospital activity in Western Sydney has been driven by chronic diseases.

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

Chronic disease is the fastest growing in-patient episode category.


1 2013 annualised; 2 June 30, 2011 to June 30, 2012; 3 Each DRG classified into one of five categories by GP
4 Ungroupable DRGs are those that have not yet been classified - mostly from Nov, Dec 2013 episodes that were not yet coded or were still in progress.
High bulk billing and MBS expenditure

WSPHN highest percentage of bulk billed attendances in NSW

WSPHN second highest MBS expenditure per attendance in NSW
In Australia, appropriate care for chronic diseases is only provided ~50% of the time.

% of clinical encounters

<table>
<thead>
<tr>
<th>Condition</th>
<th>Appropriate care not provided</th>
<th>Appropriate care provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic heart failure</td>
<td>24%</td>
<td>76%</td>
</tr>
<tr>
<td>COPD</td>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>Depression</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>Asthma</td>
<td>62%</td>
<td>38%</td>
</tr>
<tr>
<td>Obesity</td>
<td>76%</td>
<td>24%</td>
</tr>
</tbody>
</table>

Source: CareTrack: assessing the appropriateness of health care delivery in Australia (MJA 2012)
How we currently fund primary care

International funding compositions in primary care
% based on approximate estimations

Note: Both Canada (in some provinces) and New Zealand are in the process of extending hybrid models of health care funding
The model and approach to Integrated Care

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.

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

Walter Kmet
Chief Executive
Western Sydney Primary Health Network
Integrated Care at two levels

1. NSW Health Western Sydney Integrated Care Demonstrator

2. Core business as the Primary Health Network

Strategic Plan 2016 - 2019

VISION: Healthier communities, empowered individuals, sustainable primary health care workforce and system
MISSION: Working in partnership to lead better system integration and coordination, strengthening equity and empowerment for Western Sydney communities and the people who care for them.


Consumer Centric Shared Values
Patient’s care and families engaged in improving their health outcomes.

Strategy Development and Innovation
Understanding regional and community needs.

General Practice and Primary Care Development
Improving integrated care and coordination with consumers.

Strengthening Partnerships and Developing Workforce
Improving integration and coordination of patient care in partnership with consumers.

System Enabling and Scalable Infrastructure
Expanding out of traditional evidence-based clinical pathways (Healthways).

Organisational Excellence
Fostering the ongoing performance, development and diversity of our people.

EVALUATION
Partnership for Education, Evaluation and Research

OUTCOMES
Patient Experience of Care
- Satisfied and effective care
- Patient and family needs met

Quality and Population Health
- Improved health outcomes
- Reduction in health inequalities
- Improvement in individual behavioural and physical health

Sustainable Cost
- Efficiency and effectiveness of services
- Reduced cost of care
- Evaluation of commissions

Provider Satisfaction
- Increased clinical and staff satisfaction
- Evidence of leadership and teamwork
- Quality improvement culture

HEALTH PRIORITIES
The building blocks of a successful integrated care system

Understand Needs
- Very high risk
- High risk
- Moderate risk
- Low risk
- Very low risk

Organise Delivery
- Protocols
- Care plans
- Care coordination and delivery
- Performance review

Support with Enablers
- Payment
- Governance
- Information
- Leadership
- Support

“Quadruple Aim”
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.
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
A vision for the Patient Centred Health Care Home in the Australian context

**Vision**

**Desired future state**
Equity and Quality

**For patients:**
- Improved self-care, health outcomes and access to care

**For General Practices:**
- Multidisciplinary group of clinicians, practicing at the top of their license
- Multi-modal interaction: face-to-face and non face-to-face
- Care supported by navigation and coordination

**For Primary Health Networks:**
- Effective and efficient primary healthcare delivery

**For health ecosystem:**
- Integrated healthcare system, continuous patient journey
Defining the Medical Home

The medical home is an *approach* to primary care that is:

- **Person-Centered**: Supports patients and families in managing decisions and care plans.
- **Comprehensive**: Whole-person care provided by a team.
- **Coordinated**: Care is organized across the ‘medical neighborhood’.
- **Accessible**: Care is delivered with short waiting times, 24/7 access and extended in-person hours.
- **Committed to Quality and Safety**: Maximizes use of health IT, decision support and other tools.

Source: www.ahrq.gov
## Patient Centered Medical Home

<table>
<thead>
<tr>
<th>Today’s Care</th>
<th>Medical Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are registered in our medical home</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet health needs, with or without visits.</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests and consultations, and follow-up after ED and hospital</td>
</tr>
<tr>
<td>Clinic operations centre on meeting the doctors needs</td>
<td>An interdisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>

The Patient Medical Home (PCMH) concept advocates enhanced access to comprehensive, person-centred, coordinated, evidence-based, interdisciplinary care.

**Source:** Adapted with permission from F. Daniel Duffy, MD, MACP, Senior Associate Dean for Academics, University of Oklahoma School of Community Medicine.
Building Blocks for High-Performing Primary Care *

- Adoption of an evidence based approach to achieving good quality primary care for the community
- Engaging and investing in leadership at all levels – especially GP Leaders
- Linking the model to:
  - What we do and can do more of
  - What changes are needed and how we can make them
  - A platform for integrated care
- Promoting networks of practices
- Sustaining the effort

*Willard & Bodenheimer 2012*
# 4. Team Based Care

| General Practitioner team leaders are FRACGP qualified, experienced clinicians with all necessary team leader skills and attributes and appropriately delegates tasks to other members of the primary care team | The practice recruits and retains qualified and skilled team members and supports their development as clinicians, team members and educators | The practice continues to assess the skills needed to meet the practice population’s needs, assesses skills gaps and supports team members to acquire the additional skills required | Clinical support staff perform key clinical service roles that match their abilities and credentials and work to maximise practice scope and capability | Medical students and Registrars perform key clinical service roles that match their abilities and credentials | GPs and clinical support staff consistently work in the same team | Workflows for clinical teams have been documented, are utilised to standardise workflows and are evaluated and modified on a regular basis |

Make required behaviours visible and explicit
Implementation and progress
Partnership Practices

- Practice support & quality improvement
- GP data via clinical audit tool
- eHealth enabled
- Allied health providers consulted
- WSLHD partnership

Diabetes Strategy

- ‘Visiting’ endocrinologist and diabetic educator
- HealthPathways
- Skilling GP teams and building ‘cluster’ of care providers
- Prevention initiatives

Integrated Care

Mid 2014

Patient Centred Medical Home

- NSW Health Integrated Care Strategy
  - From partnership to operational model of integration of care across primary, secondary and tertiary settings
  - Initial focus on chronic disease

- Implementation of PCMH principles across 15 practices
  - Structured learning sets – international masterclasses
  - Investing in teams to support GPs.
  - Integrating GPs into hospital structures
  - LinkedEHR
Driving Integrated Care

Nature of work | WSPHN Support | Practice Focus
--- | --- | ---
Transactional | • Helpdesk • ASC | Business as usual
Practice and Business Optimisation | • Helpdesk • PPC • Chronic Disease Nurse • Care Facilitator | Quality Improvement Focus
Transformation | • Helpdesk • Chronic Disease Nurse • Care Facilitator • Business and Change Coach | Integrated Care

Low
Resourcing and Change

66%

22%

12%

High

Resourcing and Change

CLASSIC ADOPTION CURVE

EARLY MAJORITY LATE MAJORITY

EARLY ADOPTERS

INNOVATORS

2.0% 13.5% 34% 34% 19%
eHealth Enablers

- An electronic data extraction tool to assist providers monitor and manage patient care
- A dynamic shared electronic care plan to support provider integration and efficient contribution to patient care
- Localised pathways for patient assessment, management and referral
- Telstra Care Plan Connect is a highly personalised and comprehensive patient self-management application populated by the patient’s LinkedEHR shared care plan
- A client management system that is used for activity planning, data capture and reporting and funding arrangements including automated invoicing
- Building B2B capability to support commissioning
Example, dynamic shared care plan

Health Summary

Care Plan

Clinical Metrics
# Care Facilitators Dashboard

The Care Facilitators Dashboard is a tool designed to manage and monitor the care plans for patients in the Health Western Sydney Local Health District. It provides a comprehensive view of each patient's care plan, including details such as date of birth (D.O.B.), age, last updated date, patient category, and options to change the category.

### Care Plans

<table>
<thead>
<tr>
<th>Name</th>
<th>D.O.B</th>
<th>Age</th>
<th>Last Updated</th>
<th>Patient Category</th>
<th>Change Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25/11/2001</td>
<td>14</td>
<td>23/07/2015 15:12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13/01/1948</td>
<td>87</td>
<td>08/11/2015 16:07</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22/07/1950</td>
<td>57</td>
<td>31/07/2015 10:30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13/09/1991</td>
<td>34</td>
<td>02/10/2015 11:27</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23/03/1998</td>
<td>19</td>
<td>10/06/2015 11:38</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15/08/1981</td>
<td>34</td>
<td>08/09/2015 17:01</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12/11/1983</td>
<td>52</td>
<td>16/07/2016 10:56</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>28/08/1996</td>
<td>20</td>
<td>19/08/2015 12:48</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20/07/1984</td>
<td>51</td>
<td>23/07/2015 15:21</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23/07/1992</td>
<td>55</td>
<td>24/02/2015 15:55</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13/02/1992</td>
<td>23</td>
<td>24/02/2015 14:10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The dashboard also includes a feature to change the patient's category, with options such as Frail or Health Awareness. The screenshot shows a successful change password notification, indicating that the user's password has been updated successfully.
Shared Clinical Pathways: HealthPathways

COPD Shared Care Plan Protocol

Caution: this pathway is in development

A key management requirement for Integrated Care patients is to practice ongoing care,
This protocol provides the basis for the elements of a Care Plan

Every consultation

1. Assess severity (mild, moderate, or severe). Ask about:
   - Symptoms
   - Breathlessness, using MMRC dyspnoea scale
2. Check smoking status and encourage smoking cessation

Every 6 months (depending on clinical condition)

1. Review:
   - medications
   - inhaler technique (SN2 says: I used this link)
2. Measure blood pressure.
3. Perform spirometry.
4. Assess nutritional status by measuring BMI
   - If underweight, provide simple advice on more frequent but smaller high calorie meals, simple measures for food fortification e.g., additional use of milk powder.
   - If overweight, advise weight reduction measures.
   - Consider referral to dietitian
5. Monitor exercise
6. Assess for complications

Every year

1. Assess and manage associated conditions.
2. Assess need for oxygen therapy.
3. Educate about symptoms recognition and exacerbation management:
   - Create or review COPD action plan. If the patient does not already have one formulate using the Australian Lung Foundation
   - Consider providing supply of prednisone and/or antibiotics (prednisolone 50 mg for 5 days with or without amoxicillin/doxycycline)
4. Advise immunization:
   - offer annual influenza immunisation, and
   - pneumococcal immunisations. 5 five years apart.
5. Assess barriers to good care in Aboriginal and Torres Strait Islander peoples. Register with Closing the Gap and consider referral to specific ATSI services:
   - Aboriginal Outreach Worker
   - Aboriginal Medical Service
6. Prepare or review:
   - GP Management Plan or Review (721/732) or Team Care Arrangement or Review (723/732)
   - Home medicines review (300). See also Medication Management Referrals.
   - Fitness to drive
   - Advance Care Planning
Main findings

1. The HealthPathways approach has strong support within the three partner organisations by both clinicians and senior management.

2. It has further improved collaboration and relationships between the three organisations and is seen as an important driver supporting the achievement of a number of their key objectives including improved service integration and referrals.

3. The current process for developing HealthPathways is strong and incorporates a number of successfully trialled innovations.

4. Greatly enhanced uptake and engagement of HealthPathways by GPs is critical to future success.

5. Encouragingly, after quite slow uptake during the first two to three years, there are indications that utilisation by primary care has recently more than doubled.

6. Although a solid foundation has been established, it will be important over the next 18 months to demonstrate to senior management and clinicians clear tangible outcomes.
Western Sydney Integrated Care Solution Architecture
GP Practice Engagement

- eHealth enabled / Pen Licences: 186 Practices
- Pat Cat ‘Active’: 120 Installed
- Integrated Care Contracts: 61 Signed
- LinkedEHR Registered: 218 GP, 158 AHP, 45 Nurse, Total 421
- PCMH Engaged: 30 IC Practices, 8 PCMH Transformation
- Health Pathways: 2,960 Unique and returning users YTD, 244 pathways live
10 lessons learned
“Family General Practice”

Principle GP: Senior GP
13 GPs ≈ 6FTEs
3 Practice Nurses

What prompted you towards the implementation of the PCMH Model?
• Patient Registration
• Shared Partnership
• Using Data to improve
• Working within a team
• Being more in touch with the sentiments of our patients

Main barriers:
• Staff resistance to change
• Lack of financial incentive to change;

“Doctors resist three things: a threat to their integrity, a threat to their income, and a threat to their independence. When you start asking doctors to question what they do, and ask them to change, you tick all of those boxes”.

What would you do differently if commencing this PCMH journey now?
“I would be much clearer and learn much more about leadership and change management before embarking on any of it. Leadership is paramount and change management is crucial. I would learn more about enabling my team in working out tasks to achieve goals. But I would start with a clear vision and strategy to achieve that vision”
Lessons learned WSPHN and General Practice

- **eHealth enabler and derailer?**
  - eHealth platform critical but strategic choices needed
  - Rapid market fragmentation threatens integration
  - Interoperability critical

- **Leadership (and management) are a challenge**
  - GPs generally not trained in leadership or change management
  - Need to foster fundamental business skills

- **Data is king...and often lacking**
  - Only minority of practices truly data informed and driven
  - Begins with fundamental discipline of data recording

- **Workflow trumps better patient care**
  - Changes to workflow are resisted...any change has to work first time
  - Ensure thorough trialling before implementation

- **Fee for service is not supportive of complex patient care**
  - Current care plan items do not reward practice for time to create a ‘quality’ care plan
  - FSF frustrates effective team based care and use of most appropriate staff
Lessons learned Western Sydney IC Demonstrator

| Challenge of PCMH implementation | - Business transformation is complex and practices often lack the skills and resources to do this
|                                | - Focus of WSICD is to broaden and deepen support |
| Refining bridging roles         | - Bridging roles critical
|                                | - Role clarity for care facilitators fundamental and evolving |
| Ongoing service integration     | - Key role of HealthPathways in this
|                                | - Significant service and culture change required |
| Advocacy for change             | - Changes to funding model critical for success
|                                | - Data sharing and IT integration requires championing |
| Communication as a key enabler  | - Building awareness at scale has been challenging
|                                | - Effective communications campaign and targeting critical |
Thank You
As the Western Sydney Primary Health Network, WentWest is focused on addressing both regional and national health challenges. Together with health professionals, partners from both the health and hospital sector, consumers and the broader community, WentWest seeks to identify gaps and commission solutions for better health outcomes.
Supporting activities and projects

- Business and Clinical Leadership Program co-commissioned with Capital Health, ACT PHN
- Grants for UNE Medical Assisting Course
- Expanded case conferencing
- Clinical pharmacist in general practice commissioned pilot and UTS evaluation
- ED HbA1c testing and outbound GP and patient follow up
- GASP practice nurse asthma project in partnership with Asthma NSW
- Education curriculum aligned to Integrated Care
- Aligning flexible, stepped care mental health model to PCMH
- Data linkage pilot with NSW Health and WSLHD
Western Sydney Diabetes Prevention and Management Initiative Case Conferencing

Summary of suggested management (n=710)
- No change: 75%
- Decrease in medication: 13%
- Increase/change in management: 12%

HbA1c reduced by 0.87% (95% CI -1.31, -0.44) (Highly clinically significant)

Decrease referrals to Diabetes Centre

710 patients, 124 GPs and 35 practices

Average pre 8.92%  Average post 8.05%
Need to better integrate mental health into primary care via PCMH model

Consultative Model

• Psychiatrist/psychologist/social worker (behavioral /mental health expert) sees patients in consultation in behavioral health setting

Co-located Model

• Behavioral/mental health expert sees patients in primary care setting

PCMH Team Based Care Model

• Behavioral/mental health expert provides caseload consultation about primary care patients; works closely with primary care team