Western Sydney Integrated Care Program

N Wah Cheung

Clinical Advisor, Western Sydney Integrated Care Program
Director, Dept of Diabetes & Endocrinology, Westmead Hospital
Clinical Professor, University of Sydney
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
<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with a long-term health condition 2013–14</td>
<td>42%</td>
</tr>
<tr>
<td>% overweight or obese 2011–12</td>
<td>60%</td>
</tr>
<tr>
<td>Deaths from potentially treatable conditions 2009-2011</td>
<td>~540 pa</td>
</tr>
<tr>
<td>% admitted to any hospital in the preceding 12 months 2013-14</td>
<td>9%</td>
</tr>
<tr>
<td>Potentially avoidable hospitalisation, chronic disease 2011-12</td>
<td>~9,800 pa</td>
</tr>
</tbody>
</table>
## Western Sydney PHN (Access to Care)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saw a medical specialist in the preceding 12 months 2013-14</td>
<td>35%</td>
</tr>
<tr>
<td>Saw an allied health professional or nurse 2011-12</td>
<td>16%</td>
</tr>
<tr>
<td>Adults referred to a medical specialist who felt they waited longer than acceptable to get an appointment in the preceding 12 months 2011-12</td>
<td>21%</td>
</tr>
<tr>
<td>Went to hospital emergency department for own health in the preceding 12 months 2013-14</td>
<td>10%</td>
</tr>
</tbody>
</table>
Chronic disease is a significant driver of escalating preventable admissions in Western Sydney.
Western Sydney Integrated Care Program

Primary Health Network

Person with Chronic Disease

Primary Care

Hospital Specialist Services

Community Services

Local Health District
Overview of Holistic Integrated Care Model

**Triple Aims (Quadruple)**

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

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
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

3000 Subjects
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

INTEGRATED HOSPITAL SPECIALIST TEAMS

RAPID ACCESS AND STABILISATION SERVICE

GP SUPPORT LINE

BUILDING CAPACITY IN PRIMARY CARE

HOSPITAL ADMISSION

ED

PRIMARY CARE
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
Western Sydney Integrated Care Program

Shared Care Plan

GP Plan
Clinical Information
Metrics

Hospital Action Plan

Dynamic Shared Care Plan
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.

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.
Western Sydney Integrated Care Demonstration Project
Bridging the Gap between Hospital and Primary Care

INTEGRATED HOSPITAL SPECIALIST TEAMS

RAPID ACCESS AND STABILISATION SERVICE

GP SUPPORT LINE

BUILDING CAPACITY IN PRIMARY CARE

IT Connectivity

CONNECTING CARE
CLOSING THE GAP
COMMUNITY HEALTH
HEALTHONE

HOSPITAL ADMISSION
PRIMARY CARE
### WSICP RAPID ACCESS & STABILISATION

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

<table>
<thead>
<tr>
<th>WSICP Registrants</th>
<th>3000 Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td></td>
</tr>
<tr>
<td>CCF/Chest pain</td>
<td>+ clinical criteria</td>
</tr>
<tr>
<td>T2DM</td>
<td></td>
</tr>
<tr>
<td>Current/Past/Potential admission to hospital</td>
<td></td>
</tr>
<tr>
<td>GP in WSICP</td>
<td></td>
</tr>
</tbody>
</table>
Western Sydney Integrated Care Program

Primary Health Network

- Primary Care
- Person with Chronic Disease
- Community Services
- Hospital Specialist Services

Local Health District
Western Sydney Integrated Care Program

Primary Health Network

IT Link Communication

Shared Care Plan

Person with Chronic Disease

Care Facilitators

Community Services

Hospital Specialist Services

Local Health District
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