Regional approaches to integration

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APAC
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Regional approaches to integration

1. Context of our approach
2. Defining our objectives
3. Establishing foundations
4. The NSW/WSIC Program
Primary Care Organisation

AGPT
Established in 2002 to provide the Australian General Practice Training (AGPT) program across Greater Western Sydney.

medicare local
In July 2011, WentWest became one of the first Medicare Locals, building on the capability of the organisation as a former Division of General Practice.

www.wentwest.com.au
Strategic Plan 2013-2017

Vision: Healthier communities, empowered individuals, sustainable primary health care workforce.

Mission: Leading integrated primary health care towards better health, equity and empowerment for our greater Western Sydney communities and the health professionals who care for them.

Health Priorities:
- Chronic Disease
- Aboriginal Health
- Mental Health
- Child and Family
- Population Health
- Aged Care

Who we are:
WentWest is unique in Australia, being both a Regional Training Provider (RTP) and a Medicare Local (ML).

Established in 2002 to provide the Australian General Practice Training (AGPT) program across Greater Western Sydney, WentWest began providing Division of General Practice services to more than 200 general practices in the LGAs of Auburn, Blacktown, Holroyd and Parramatta in 2006.

In July 2011, WentWest became one of the first Medicare Locals. Since then, we have continued to grow in partnership with the Western Sydney community and its diverse stakeholders.

Governance:
WentWest is a member-based not-for-profit company limited by guarantee governed by a Board of Directors. WentWest provides final formal avenues for engagement with GP and Allied Health Leaders.

WentWest work is supported by contracts with the Commonwealth Department of Health and Ageing (DoHA), General Practice Education and Training (GPET), Western Sydney Local Health District (WSLHD) and a range of other organisations.

We value our partnership with many organisations including the AMSWS, WSLHD and the Universities of Sydney and Western Sydney.

WentWest’s Values:
- Creativity - challenge convention
- Leadership - inspire action
- Equity - actively overcome barriers
- Excellence - be the best we can be
- Respect - understand others

Key Result Areas:

1. Knowing our community
   - population health needs assessment and planning
   - consumer engagement and consultation
   - Local Community Partnerships

2. Workforce quality, capacity and performance
   - GP and Allied Health services support and development
   - retention and expansion of human resources
   - continuous quality improvement capabilities

3. Integrated and coordinated care
   - health and human service partnerships (eg: HealthOne)
   - system innovation, models of care (eg: HealthPathways)
   - defining and investing in system enablers (eg: eHealth)

4. Teaching, education and research
   - integration of education and research into health service planning and delivery
   - vertical integration of education, training and research
   - eLearning and extended skills development
   - partnerships for research and evaluation

5. Organisational excellence and sustainability
   - developing our people based on a values driven culture
   - demonstrating system gains and improved health outcomes
   - maintaining and improving our Quality Systems
   - commercial sustainability
   - strong corporate and clinical governance

WentWest:
- Supports the provision of person-centred, integrated, coordinated care, reflecting Medical Home Principles
- Strengthens quality, scope, connectedness and capability in general practice and primary health care
- Promotes innovation, integration and continuous improvement to increase quality, safety and equity in all health care
- Enhances health literacy and self care capabilities for individuals, families and communities
- Leads the design of locally-responsive and equitable services by working with local communities and building on what already exists
- Works across sectors to influence the socio-economic determinants of health
- Integrates teaching and research into health service planning, delivery and evaluation

We pay our respects to the traditional custodians of this land, including their elders past and present and extend that respect to all Aboriginal people.
Levels of Healthcare Integration

**Micro Level** – service level with individual and practice focus

**Meso Level** – collaboration at regional and population level

**Macro Level** – system impact through jurisdictional policy and funding

Do we need scale and pace?
The role of Medicare Locals

- Improving the patient journey through developing integrated and coordinated services
- Support to clinicians and service providers to improve patient care
- Identification of the health needs of local areas and development of locally-focused and responsive services
- Facilitation of the implementation and successful performance of primary health care initiatives and programs
- Be efficient and accountable with strong governance and effective management.
PHNs and Integration

- build and sustain strong and locally relevant PHC sectors that are integrated with other health and related sectors to maximise system productivity and improve health outcomes for patients

- clinical system integrators:
  - Clinical Councils and Community Advisory Committees
  - champion clinical care pathways
  - reduce system fragmentation and duplication
  - shared indictors with LHNs
  - joint population health needs assessment and planning
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Defining an outcome from integration

At its heart, it can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs

(Lloyd & Wait 2005)
A regional vision for integration

An integrated health and human services system in Western Sydney that is as much as possible owned by the community and its services providers, not for the exclusive use of one entity
Innovation is required!

Care, which imposes the patient’s perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless

(Lloyd & Wait 2005)

The structure of service delivery should be a function what we need now not the default of what has always been there
5 laws of integrated care

Law 1: You can’t integrate all of the services for all of the people
Who you should target for integrated care? What intervention is the most effective to use.

Law 2: Integration costs before it pays
Costs are unavoidable, but savings are not assured. There is an element of risk.

Law 3: Your integration is my fragmentation
The process of integrated care requires strong leadership and skilful handling to broker the partnerships required to make it work.

Law 4: You can't integrate a square peg into a round hole
All integrated care is local and no one model can be effectively prescribed. It must be built from the bottom up, driven by local ownership, within a system that rewards this.

Law 5: The one who integrates calls the tune
Effective integrated care networks need skilled managers to broker a common path between partners that have competing interests.

(King’s Fund 2011)
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Leading a regional PCO integration approach at many levels

Local Community Partnerships
- Needs assessment
- Cross sector coordination
- Responding to diversity

Programs and Projects
- Aligning and targeting resources
- GP & AHP capacity building
- Innovative solutions

Regional leadership
- Health planning
- Enabling investments
- Structuring consumer engagement

Building a “bottom up” approach supported by regional leadership and a strong evidence base
Working in Partnership
Find common cause with partners and be prepared to share sovereignty

(Kings Fund 2013)
The main elements in the Western Sydney Diabetes Prevention and Management Initiative Strategy and Plan

- Prevention addressing the social determinants
- More screening and lifestyle coaching
- Enhanced management by GPs and community allied health
- Specialised consultation and enhanced hospital care

INTEGRATED MULTI-SECTOR PARTNERSHIP APPROACH
Supporting service providers

There is a need for general practice to adapt rapidly so that it operates at a scale that can provide a platform for integrated care

(Kings Fund 2011)

Finding ways to build leadership amongst primary health care providers and working with early adopters
The Patient Centred Medical Home (PCMH) concept advocates enhanced access to comprehensive, coordinated, evidence-based, interdisciplinary care.

<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>

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

- Development funding for PCMH concepts in WentWest Region
- Defined roles with training and skills checks to reinforce best practice.
- Trained and engaged leadership at all levels
- A collective vision for integrated care that is shared across sectors, professions and most importantly the consumer and the local community

*Willard & Bodenheimer 2012
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Western Sydney
Integrated Care Program

Demonstrator Project
Overview of Holistic Integrated Care Model

Aspirations:
- Improve people’s experience of care
- Improve health of population
- Improve cost effectiveness

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
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
WSICP interventions

**GP**
To function with elements of Patient Centered Medical Home
Monitoring and management of current health problems
Preventative health requirements

**Community**
Incorporates allied health providers, community health resources, Connecting Care services, private Specialist services

**Hospital**
Rapid Access to Specialty Services
Integrated Ambulatory Care Service
Patient and GP Support Services
Capacity Building in Primary Care
All can access and contribute to Shared Care Plan (with assistance of Care Facilitator)

All can access and contribute to Shared Care Plan (with assistance of Care Facilitator)
WSICP model of care

Identified and registered cohort of Chronic Disease patients
Diabetes, CCF and COPD (initially)

For each patient
Identified General Practice – (functioning with elements of a PCMH)
Care Facilitator - working with patient’s care providers to ensure:
- timely access to appropriate care
- continuity of care
- completeness of care, and
- clear communication among care team and with patient of changes in care

Shared Care Plan - dynamic web based
Optimal access to healthcare services in primary care, community and hospital specialist practice
Western Sydney Integrated Care Demonstrator Project
Bridging the Gap between Hospital and Primary Care

HOSPITAL ADMISSION

HOSPITAL SPECIALIST TEAMS

PATIENT SUPPORT

BUILDING CAPACITY IN PRIMARY CARE

RAPID ACCESS SPECIALIST SERVICE

INTENSIVE AMBULATORY CARE

COMMUNITY HEALTH SERVICES

PATIENT-CENTRED MEDICAL HOME

CARE FACILITATORS

PRIMARY CARE
WSICP enablers

**Patient identification and registration**
- Cohort selection and maintenance in GP and Hospitals
- Central registration and tracking

**Funding and incentives**
- Care Facilitators
- Hospital based services
- GP based services

**Clinical engagement**
- GP engagement options
- Hospital Specialist Service development
- Community Health services options

**Information Technology**
- Interconnectivity - Health-e-Net
- Shared Care Plan - LinkedEHR
- Care Protocols - HealthPathways

**Governance and Quality Improvement**
- Director of Integrated Care
- Integrated Care Office
- Measurement and Evaluation

www.wentwest.com.au
### eHealth enablers

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
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<tbody>
<tr>
<td><img src="image1.png" alt="Static Medical Record System" /></td>
<td>A shared electronic static medical record to support provider integration and contribution to patient care</td>
</tr>
<tr>
<td><img src="image2.png" alt="Data Extraction Tool" /></td>
<td>An electronic data extraction tool to assist providers monitor and manage patient care</td>
</tr>
<tr>
<td><img src="image3.png" alt="Dynamic EHR System" /></td>
<td>A dynamic shared electronic care plan to support provider integration and efficient contribution to patient care</td>
</tr>
<tr>
<td><img src="image4.png" alt="Pathways System" /></td>
<td>Localised pathways for patient assessment, management and referral</td>
</tr>
<tr>
<td><img src="image5.png" alt="Client Management System" /></td>
<td>A client management system that is used for activity planning, data capture and reporting and funding arrangements including automated invoicing</td>
</tr>
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Critical success factors

- Shared vision and principles of operation
- Building on existing relationships, some formal
- Leadership and investment in developing a case for change and a model(s)
- Defining where existing silos/organisations and “pitch in” and add value roles and responsibilities
- Allocating resources including systems and money
- Small deliberate decisions on an ongoing basis
- Ability to handle risk
- A commitment to ongoing evaluation