A BLUEPRINT FOR INTEGRATED HEALTH CARE

MODELS IN SOUTH WESTERN SYDNEY

Australian Government

phn
SOUTH WESTERN SYDNEY

An Australian Government Initiative

Health
South Western Sydney
Local Health District

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INTRODUCTION

SOUTH WESTERN SYDNEY BLUEPRINT FOR INTEGRATED HEALTH CARE

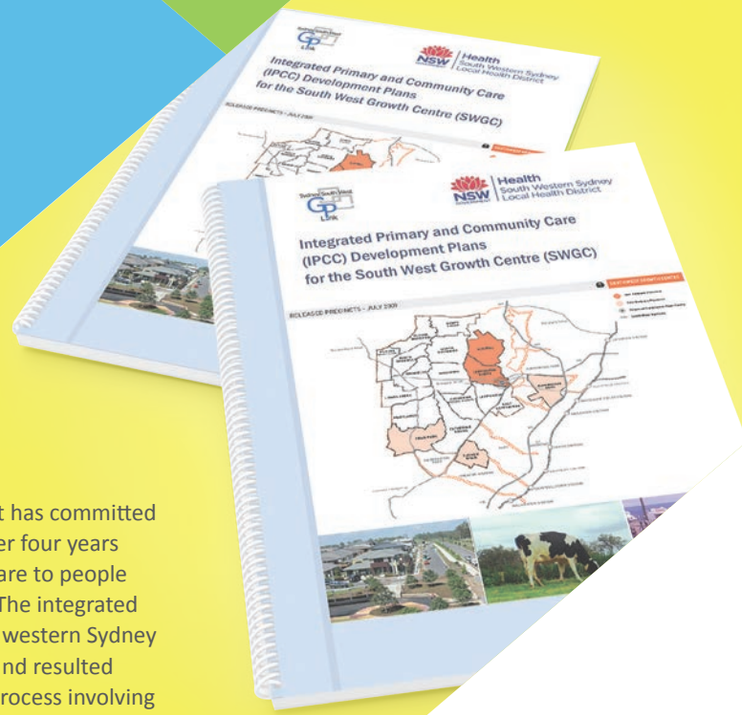
THE CASE FOR CHANGE

A unique opportunity exists for integrated health planning in south western Sydney to develop ground-up models of care that reflect international best practice, are at the leading edge of health policy directions and that meet the accelerating healthcare demands in south western Sydney driven from growing and ageing populations.

WATCH VIDEO

THE BURNING PLATFORM

Ref: NSW Health



The NSW Government has committed 120 million dollars over four years to provide seamless care to people in an integrated way. The integrated care strategy in south western Sydney commenced in 2010 and resulted from a collaborative process involving funders, planners, government and non-government agencies. A planning document resulted, informing plans for infrastructure and service improvements required to meet future population demand.

Foundational to the strategy is a partnership reflecting shared interests and goals between the South Western Sydney Medicare Local (SWSML) – as at 1 July 2015 called South Western Sydney Primary Health Network (SWSPHN) and the South Western Sydney Local Health District (SWSLHD).

Our region covers both rural and suburban communities across seven Local Government Areas from Bankstown to Wingecarribee and has a population of approximately 920,000 people. The vision is to provide a healthcare service that is patient focused, equitable and responsive to the changing and developing needs of the communities in south western Sydney. The region is among the most rapidly growing populations in NSW. It is also a vibrant, culturally diverse region with almost a third of its population speaking a language other than English at home.

KEY ISSUES LOCALLY

- POPULATION GROWTH
- LOCAL WORKFORCE SHORTAGES
- REGIONAL DIVERSITY AND GEOGRAPHIC SPREAD
- PUBLIC TRANSPORT IN RURAL AREAS
- RELIANCE OF SERVICES IN ADJOINING LGAS

THE OPPORTUNITY

In recognition of the unique opportunity arising from population growth, service reforms and the strength of the partnership between SWSPHN and SWSLHD, the prospect of developing organic integrated health care services reflective of evidence based best practice is present.

Growth in the region is predominantly planned around the development of a 17,000 hectare Greenfield site within the Camden and Liverpool Local Government Areas (LGAs) called the South West Growth Centre (SWGC). It is anticipated a population equivalent to the size of Canberra will settle in the region in the next 2 decades.

The development of an integrated primary care strategy in south western Sydney aligns with current primary health reform initiatives, linking primary health to other sectors, eHealth technologies to support care integration, workforce skilling on core competencies for multidisciplinary team care and providing the physical infrastructure for new models of primary health care delivery.

WHAT IS INTEGRATED CARE?

Integrated care provides seamless, effective and efficient care reflective of a person's continuing health needs. Done in partnership with the individual, their carers and family, coordination underpins improved access and experience throughout the person's health care journey, regardless of transitions across sectors.

Integrated Care meets a person's needs by providing seamless, effective and efficient care, organised for, by and with the person, from prevention through to end of life.

CARE IS PERSON CENTRED	CARE IS A SEAMLESS CONTINUUM	CARE IS EFFECTIVE	CARE IS EFFICIENT
Care is organised for, by and with the person by bringing care to the person's community or home rather than the person to the care.	Care is organised across spectrum of care ranging from social and preventative, to primary and acute, through to aged and end-of-life care	Care results in the outcomes that are desired by the patient and reflect achieved health status, recovery process and sustainability of health	Care makes efficient use of both financial and human resources

Ref: NSW Health

OUR VISION

The overarching blueprint for the south western Sydney Integrated Health vision encompasses many elements of change, conducive to a culture of innovation and collaboration.

We strive for a health neighbourhood model in which services are designed to envelope their users, where data is collected and analysed, and technology and shared patient records facilitate more integrated and continuous care.

Our consumers contribute to the vision and planning, they understand how to access care and are more involved in maintaining and managing their health.

Our collaborators have relationships within the health community and are networked to coordinate care and support the journey to wellness. Through working together, the region collectively experiences increased capacity to provide the right quality care in the right place at the right time.

OUR AIMS

1. To improve the users experience
2. To improve the health of our people and population
3. To improve the effectiveness of our systems

IHI TRIPLE AIM

Ref: USA Institute for Healthcare Improvement IHI 2008/09

ENABLERS & STRATEGIES

Leadership, vision and partner investment

Broadening our partnerships and connections will foster support across boundaries to collaborate on common goals. Optimising strengths of our partners will enable improved utilisation of resources and skills throughout Primary Health Networks, not-for profit agencies and Government bodies and pillars to gain momentum in implementing our mission. A newly established directorate within Community Health, the Integration and Partnerships Directorate, is one strategy created to expand affiliations, co-create solutions and develop capabilities in modern methods for service procurement.

Strategic procurement and consortium contracting

Modernising the way entities collaborate to achieve common goals have seen new methods employed in the UK and New Zealand, such as alliance contracting. Efforts to improve governance structures between stakeholders are currently being explored in south western Sydney to enhance joint decision making and accountability. In addition, nuance methods to stimulate growth and capacity building such as strategic commissioning approaches with the non-government sector aim to improve linkages, capacity and health care access across the care continuum.

Outcomes Based Performance frameworks

Outcomes based measures will be employed against integrated care concepts to inform service effectiveness, reflect the patient experience and inform ongoing service planning. Outcomes based contracting is an emerging strategy globally and adds value to the provider/patient relationship through improved understanding of objectives between the customer and the service provider SWSLHD is currently exploring how to test this concept in a community setting with Not for Profit health care organisations.

Risk stratification

The foundational step of improving care for our community is understanding who our patients are and recognizing how and when they need access to health services. Stratifying population risk of disease is more important than ever in the current health care climate and platforms conducive to this are currently being explored for application in south western Sydney.

Information infrastructure

Innovation in information technology is a critical strategy for integrated care. Telehealth and decision support tools are some of the underpinning elements for improved access and care provision. The ability of systems however to send and receive real-time patient data add value for all stakeholders and are being explored as a priority. A shared IT platform between primary care and the local health district is our common goal.

Patient Centred Models of care

Models of care which are responsive and flexible to the consumers' needs and which extend beyond the intervention to monitor recovery and prevent deterioration are encouraged. Improvements in and standardisation of evidenced based models of care help providers to collectively and flexibly deliver care central to the consumer's needs. In addition, practitioners will be supported to conduct care planning and case conferencing to facilitate the patient journey.

INTEGRATED CARE PRINCIPLES IN SOUTH WESTERN SYDNEY

The seven core principles for integrated care in south western Sydney are used to guide the planning, implementation and evaluation of initiatives:

Principle 1: Access – Access relates to a range of conditions including, physical location and setting; facility type; service availability, service delivery modes and consideration of special needs groups/the needs of the local population.

Principle 2: Multidisciplinary team available for every person – Multidisciplinary teams working with each client/patient will vary according to individual needs but involve an array of providers with distinct roles who work together to remove distinctions between primary and secondary care.

Principle 3: Provision of Linked Up Healthcare – Linking organisations to share risk, funding and outcomes fosters shared objectives, skills and accountability.

Principle 4: Quality, excellence and innovation - Services promoted as integrated care initiatives should be of the highest clinical quality and evidence-based. Approaches that encourage interdisciplinary quality improvement, performance monitoring and values centred on the patient will be employed.

Principle 5: Fostering academic health sciences and evidence-based practice – Structures to develop the evidence base of our work with Universities and other stakeholders underpin key future workforce strategies. The University of Western Sydney and UNSW are current partners to initiatives.

Principle 6: Prevention and Early Intervention close to Home – Integrated care initiatives will foster coordinated models of care with a primary focus on prevention rather than treatment.

Principle 7: Accountability to the Community – Patient centred care is key to the integrated care strategy. Consumers will be engaged as essential cohorts in the planning, development, implementation, evaluation and ongoing feedback of services.

Our Measures of Success & Research & Evaluation
Our measures of success will reflect the values of consumers and clinicians. A change to patient experience and access will inform success of our ventures, as well as experience in the transfer of care for clinicians. Longitudinal population health improvements are desired and affiliations with the University of Western Sydney and UNSW will aid capacity in measuring change to indicators. Improved preventative health screening rates is a key public health outcome which will result from improved capacity of and coordination for front line care services. The sharing of data through improvements in technology will add value for users and providers and disease data repositories will inform our planning and service responses. Finally measures of system agility and efficiency are important to measure organisational growth and the responsiveness of the system to meet current and future demand.

NEEDS ASSESSMENT PARTNERSHIP

South Western Sydney Medicare Local formally engaged the South Western Sydney Local Health District (SWSLHD) Planning Unit in 2012 to contribute to the Medicare Local's Interim Needs Assessment process.

The partnership was an innovative move among Medicare Locals and Local Health Districts at the time, and was the beginning of a fruitful partnership which has undertaken many projects for the betterment of south western Sydney. These projects include:

- Developing an interim population health needs assessment involving extensive consultation of over 900 people, providers and services, rigorous data analysis and the development of a plan to improve the health of the region. The interim needs assessment in south western Sydney was seen as an example of better practice among the Medicare Local Network.
- Developing a comprehensive needs assessment which built on these findings and specifically engaged consumers and service providers within our targeted vulnerable communities. This included Aboriginal communities, culturally and linguistically diverse communities, young people, aged people and people living with severe and persistent mental illness and their carers.
- Building up an extensive data supplement for the region.
- Development of 'White Papers' on key health issues for south western Sydney communities
- Developing a needs assessment to inform the direction of the Partners In Recovery Program- a service for people living with severe and persistent mental illness and their carers. The team consulted directly with people living with severe and persistent mental illness via Day to Day living programs and undertook an innovative patient profile of 103 people who were engaged with NGOs. This patient profile built a repository of information about the health and social needs of a group for which there is a paucity of data
- Collaboration on the Innovative Models Promoting Access-to-Care Transformation (IMPACT) study

The partnership has had a number of benefits for both organisations. From the Medicare Local's perspective, the expertise afforded by the senior planners has proven invaluable. The District also relied on extensive experience and expertise in the primary care sector provided by SWSML, as a platform for an integrated approach to planning for the future. The population needs assessment and the SWSLHD Strategic Priorities in Health Care Delivery 2021 report were developed in broad strategic alignment. This allowed for shared community and provider consultation processes, enhancing efficiencies. In addition, sharing responsibility for the outcomes of the needs assessment has led to greater engagement and collaboration between primary and secondary care providers at the coal-face of healthcare in south western Sydney. This teamwork and partnership have led to the development of truly integrative strategies that rely on the sectors synergies in the best interest of patient-centred care.

For more information, visit www.swsphn.com.au or contact Amy Prince at amy.prince@swsphn.com.au

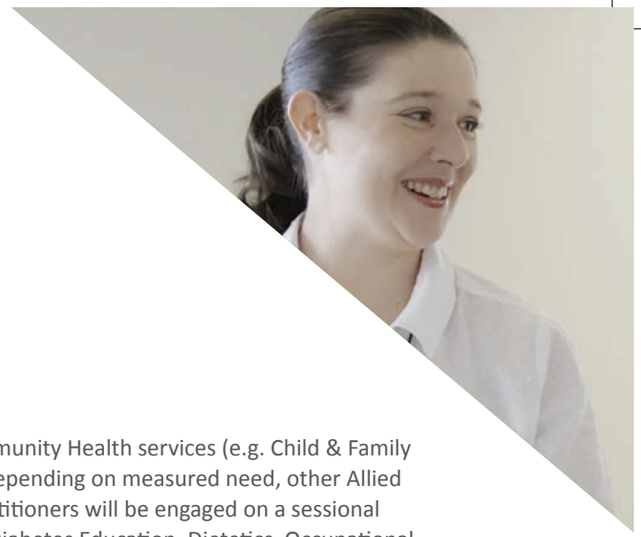
PROJECT FOCUS

ORAN PARK FAMILY HEALTH

THE INITIATIVE

The Oran Park Family Health (OPFH) project is the inaugural Integrated Primary Care Centre (IPCC) planned for the south western Sydney growth corridor.

WATCH VIDEO



Construction of Stage One of Oran Park Family Health (OPFH) is now complete, in a 642m2 street-frontage leasehold site within the Oran Park Town Podium retail precinct.

The facility includes eight (8) GP consult rooms, a three (3)-bed treatment room, four (4) Allied Health consult rooms, four (4) Specialist suites, plus space for Medical Imaging, Pathology collection and Physiotherapy. Shared spaces include a meeting/ training room, hot-desk work stations plus a common waiting area, reception, practice manager's office and staff amenities. Co-located in a tenancy next door, with shared egress to the waiting area, is a retail pharmacy.

The purpose of OPFH is to provide multidisciplinary evidence-based care that is patient-centred and team-based, whilst respecting autonomy and choice. From the patients' perspective, integrated care at OPFH will mean:

- A single point of entry to all relevant care.
- Consistency in the quality of service delivery irrespective of the provider.
- Continuity of care and handover between services.
- A single point of billing for services delivered.

In a visionary partnership, SWSLHD, SWSML and UWS School of Medicine agree that the future health needs of the growth corridor will be best met through progressive investment in evidence-based primary and ambulatory care, not more hospital beds. Establishment of an integrated primary care centre (IPCC) network is a key deliverable for this vision.

THE STRATEGY

Creating an IPCC represents a three (3) stage hierarchical development of services.

1 **Stage One**, services focus on General Practice-led, team-based primary care. The initial priority is to engage GPs, supported by Practice Nursing, Diagnostic Services (Pathology collection, Medical Imaging), key Allied Health Practitioners (e.g. Physiotherapy) and select Community Health services (e.g. Child & Family Nursing). Depending on measured need, other Allied Health Practitioners will be engaged on a sessional basis (e.g. Diabetes Education, Dietetics, Occupational Therapy, Podiatry, Psychology, and Speech Pathology).

2 **Stage Two** becomes viable once the service population exceeds 4,000 registered patients. The priority for additional services includes attracting visiting Medical Specialists on a sessional basis, with the aim to draw on a broader catchment area.

3 **Stage Three** becomes viable once the service population exceeds 18,000 registered patients. With a focus on a much wider catchment area, this represents a significantly larger, more diverse facility. Whilst incorporating those services matured through stages one and two, it may also include resident medical specialist suites, day surgery, ambulatory care clinics (possibilities may include chemotherapy and renal dialysis), dentistry plus advanced diagnostics.

To deliver on patient expectations, OPFH will incorporate a range of evidence-based strategies shown to enable integrated care. These include:

- Linked information and communications technology (ICT) systems for all staff, sub-tenants and contractors.
- Building on the requisite interoperable ICT platform, a cross-enterprise document sharing (XDS) system will support safe, real-time sharing of electronic clinical information between the providers' range of software applications.
- A common corporate and clinical governance framework for all services onsite.
- An active commitment to the provision of culturally appropriate services.
- Models of care that:
  - Engage GPs in health assessments and care coordination.
  - Provide access to a range of co-located Allied Health Practitioners
  - Support linkages for providers with the broader role of publicly-funded Community Health, including specialised teams (e.g. Mental Health, Drugs & Alcohol; Oral Health; Child, Family & Youth Health Services etc); plus population-based and networking activities with other relevant government agencies and social welfare services.

THE MODELS OF CARE

The service needs of OPFH's catchment will be largely driven by resident population growth, and associated trends over time in socio-economic and epidemiological characteristics. Whilst the most relevant model of care will depend on the clear assessment of each patient's need, the OPFH model will systemically implement the following key elements:

- Centralised patient registration.
- Lifestyle risk screening and stratification.
- Consent to use de-identified, aggregated data for the purposes of research, teaching and quality improvement.
- Coordination of scheduled clinics for planned follow-up care e.g. minor procedures.
- Access to preventative health care initiatives (e.g. antenatal shared care program in partnership with Campbelltown Hospital; childhood immunisation services; Child and Family Health nursing services.
- Annual health check reminders for key population groups.
- Care coordination and chronic disease management.
- After hours GP care.
- Access to consultant Medical Specialists.
- A commitment to quality clinical teaching, training and research.

For further details contact Lauren Hickson, Director of Integration & Partnerships, SWSLHD.
Email lauren.hickson@sswahs.nsw.gov.au or visit http://swslhd.nsw.gov.au

PROJECT FOCUS

WOLLONDILLY HEALTH ALLIANCE

A POPULATION BASED APPROACH TO INTEGRATED HEALTH CARE

Wollondilly Health Alliance

Growing Health Neighbourhoods around people

WATCH VIDEO

BACKGROUND

The SWSML and the SWSLHD have responsibility for identifying the population health needs of the communities within south western Sydney and developing plans and managing health services to meet those needs.

As part of this role, in 2013 the SWSML developed a Population Health Needs Assessment of south western Sydney. This needs assessment provides an overview of the demographic and health characteristics of the communities which reside in the region, the health services available and their capacity to meet the health care needs of communities. It identifies priorities for locally-focused service development and actions that will be taken to improve the health of local communities.

Wollondilly is one of seven LGAs that comprise the SWSLHD. Through the regional needs assessment process, the access of residents living in the Wollondilly Shire to health services has been identified as an issue requiring further investigation. Among the most important health issues in Wollondilly is the relative undersupply of healthcare providers and related support services, with poor access to scarce providers exacerbated for small, scattered and isolated rural communities.

In March 2014, the Wollondilly Shire Council (WSC), SWSML and SWSLHD agreed to establish the Wollondilly Health Alliance to further investigate the health needs of the Wollondilly community and improve access to health care in Wollondilly. The Alliance also includes representatives of local consumers, carers, GPs, allied health providers and non-government organisations.

The purpose of the WHA is

- To improve users experience of care in Wollondilly
- To improve the health of the Wollondilly population
- To improve the cost effectiveness of our systems (Acknowledgement/Ref: USA Institute for Healthcare Improvement IHI 2008/09)

The proposed measures of success include

- Community trust
- Population health planning - not segmenting out disease management programs
- Linked data mining
- Shared access to health records/health information
- No wrong door
- Enhanced health promotion and supported self care
- Use of care coordinators and care navigators
- Strengthening multi-disciplinary health and social care teams
- Working towards responsive provider networks available 24/7
- Committed to responding to patient experience and outcomes (Ref Goodwin July 2014)

Critical to the success of the WHA is a governance arrangement the enables the WHA to guide the development of integrated health care from a population health perspective, whilst ensuring the three main partners in this venture can contribute to the decision making activities. A governance model was implemented – figure 1

AUG 2013	• PARTNERSHIP AGREEMENT • BETWEEN SWSLHD & SWSML
OCT 2013	• INTEGRATED HEALTH COMMITEE • FORTNIGHTLY MEETING
MAR 2013	• WOLLONDILLY HEALTH ALLIANCE • PARTNERSHIP BETWEEN SWSLHD, SWSML & WSC
OCT 2014	• PARTNERSHIP AGREEMENT • BETWEEN SWSLHD & SWSML

Fig. 1

WHAT HAS BEEN ACHIEVED TO DATE?

1. The Wollondilly Health Needs Assessment was completed in Sept 2014. Some 500 residents, 105 Service Providers representing 35 organisations were involved in this process.
2. The key issues identified include
   a. The relative shortage of GPs across the Shire
   b. In addition to the shortage of GPs, the most commonly identified gaps in the service system include medical specialists, allied health practitioners, mental health services, services for children and young people, diagnostic services and preventative health services.
   c. The population is not large enough nor sufficiently concentrated to support much in the way of private / commercial services (medical specialists, allied health diagnostic services).
   d. As in most parts of NSW, resources for community health, home care and social support programs are limited and so are focused on areas of greatest need.
   e. Long travel distances within Wollondilly and from Wollondilly to health services in Campbelltown, Camden, Bowral and further afield have implications both for residents and service providers.
   f. Travel distances are exacerbated by the poor public transport available in the Shire
   g. Wollondilly residents use a wide range of hospitals, with greatest use of Campbelltown and Bowral Hospitals and a variety of private hospitals.
   h. A need has been identified for health prevention and promotion programs in Wollondilly to tackle issues such as high levels of overweight and obesity, smoking and drug use, particularly among young people.
3. 17 Strategic priorities were identified through a local steering group to identify proposed actions to address the needs identified above – October 2014
4. In November 2014 the WHA was accepted into the World Congress on Integrated Care to outline its population health approach to integrated care. The report was extremely well received
5. In December 2014 the WHA submitted to the NSW Ministry of Health for Innovation and Planning funds that would tackle Integrated Care in south western Sydney
6. In March 2014 the WHA was advised of its

successful submission for funding given the innovation it proposed related to this population health approach to integrated health care

7. As at May 2014 the WHA has agreed to progress with a first round of initiatives that address the local needs of the community. These include
   - **a.** Expansion of health promotion services using the existing "Dilly Wanderer" run by the local council
   - **b.** Development of a WHA website to commence a local health information hub that aims to link service providers and enable social media opportunities to share information
   - **c.** Development of tele-monitoring for the local community which will help individuals manage their own health by having portable devices that can monitor some of their health problems with results immediately connected with health providers
   - **d.** Plans to commence tele-health consultations which will improve access to specialists services to conduct medical interventions for consumers using on line technology in collaboration with General Practitioners
8. More initiatives are planned as the WHA continues to action the 17 Strategic Priorities for the region.

For more information, visit www.wollondilly.nsw.gov.au

The following words best describe our vision to improve the health for the residents of the Wollondilly Shire.

- A ‘patient centred medical home’
- Beyond this would be a ‘health neighbourhood’
- Data is collected and analysed with all providers
- Technology and shared patient records facilitate more integrated and continuous care – connected community
- Relationships within the health community and a network of social care to support health
- Consumers understand how to access care and are more involved in maintaining and managing their health
- Increased capacity to provide quality “right care, right place, right time”
- Increased access to care, 24 hours
- Changing the patient’s/community expectation on where care is delivered

PROJECT FOCUS

GENERAL PRACTITIONERS AND EMERGENCY DEPARTMENT PHYSICIANS LEARNING TOGETHER

Seamless care requires both acute care physicians and General Practitioners to understand each others business and share clinical knowledge and learnings.

A significant relationship that requires fostering and ongoing improved collaboration is the one between General Practice and the Emergency Department staff. By improving this relationship and by sharing clinical knowledge between these providers we envisage an improved patient journey for our community.

In 2014 SWSML and SWSLHD commenced a GP/ED project aimed at General Practitioners attending professional development seminars in Emergency Departments. Lead Emergency Physicians were to provide education to GPs on topics that were most relevant to both Emergency Department staff and General Practitioners. Aside from the educational component of this initiative the additional objective was to enable our GPs to be orientated to the Emergency Department and personnel working in them. The ultimate aim being a shared understanding of each others business, placing a face to a name, and suggesting system improvements for the benefits of the community.

Four hospitals have been engaged in the process. These include Bowral and District, Campbelltown, Liverpool and Fairfield Hospitals. Commencing in mid 2014, to date seven educational sessions have been completed. Educational topics have included:

- Chest pain (when and where to send your patient)
- Disasters in Emergency (what you don't want to misdiagnose
- An Approach to the breathless patient
- Update on Venous Thromboembolism

Some 39 General Practitioners across SWS have attended these sessions. Each session is formally evaluated using the Royal Australian College of General Practitioners evaluation process. Over 90% of the responses indicated all the learning objectives were met. Most importantly 100% of attendees strongly recommended this continue as a means for GPs and ED staff to communicate. As one response articulated – reflecting the overwhelmingly positive response to this initiative

"Excellent presentation that every GP in the region should attend"

As our acute care staff and GPs are more exposed to this form or learning, we are expecting more suggestions on how to improve the actual "system" of care. as people become more familiar with each others business.

For more information, visit www.swsphn.com.au or contact Allison Tran at allison.tran@swsphn.com.au

PROJECT FOCUS

SOUTH WESTERN SYDNEY HEALTH PATHWAYS PROGRAM

HealthPathways
SOUTH WESTERN SYDNEY


Changing the way
we practise
WATCH VIDEO

In the context of health care, a pathway describes the journey for patients as they move through the health system. The experience for patients can sometimes appear disjointed when care is shared between the primary and acute sector.

Care pathways are tools used to systematically plan and follow up a patient's care[1] and are helpful to standardise health care processes.

International research has shown that implementing clinical pathways reduces the variability in clinical practice, improves quality of care, optimises the use of resources and improves patient outcomes.

In partnership with the south western Sydney Medical Local, south western Sydney Local Health District has engaged Streamliners NZ to introduce HealthPathways as a means to improving consistency of care for local residents. We are now amongst a collaborative of 22 regions across Australia and New Zealand applying the HealthPathways tool. Collectively, already in excess of 800 current, evidence-based care pathways have been developed. With an agreement to openly share intellectual property, information and resources, this stimulates the rapid localisation and adoption of relevant care pathways.

HealthPathways is an online portal which provides evidence based information on the assessment and management of health conditions together with referral details for local specialists and services across both public and private sectors. The tool is designed to be used during a consultation, with the average cited time to search and extract information to be 54 seconds.

Designed by clinicians for clinicians, HealthPathways uses a structured, efficient and systematic method to house crucial information for health professionals. The development and localisation of each pathway involves the collaboration of the primary and acute care sectors to determine the most appropriate clinical and referral content and opportunities for greater service coordination.

HealthPathways aims to improve the coordination of patient care between primary and acute care settings, enhancing communication to develop a stronger health network and ensuring that patients receive the right care at the right time in the right place within south western Sydney. The facilitation of workgroups to inform clinical priorities, refine the clinical pathways and consider service improvements are improving relationships for clinicians across the region.

The HealthPathways program officially launched in south western Sydney in February 2015 with the live portal site available from July 2015.

For further details visit
http://sws.healthpathways.org.au
or contact HealthPathways@sswahs.nsw.gov.au

1. De Luc K. Developing care pathways - the handbook. Oxford: Radcliffe Medical Press Ltd, 2001.

Networking

Workgroup Discussions

Stakeholder Consultations

Communication & Information Sharing

PATHWAY DEVELOPMENT PROCESS

Improved Patient Outcomes

Clinical management

Access to timely care

Satisfaction & experience

PROJECT FOCUS

IMPACT

The Innovative Models Promoting Access-to-Care Transformation (IMPACT) study is an international research project with six sites across Australia and Canada.

In NSW the research is delivered by a partnership between the University of NSW, south western Sydney Local Health District (SWSLHD) and south western Sydney Medicare Local (SWSML)/ Primary Health Network (PHN). The aim of the study is to evaluate models for improving primary healthcare access for vulnerable populations.

The study is delivered via a Local Innovation Partnership; a group of policy makers, senior health managers, healthcare providers including GPs, and community members working together to determine opportunities to improve healthcare access for vulnerable populations.

The IMPACT study in south western Sydney is designed to complement and build on activities conducted by SWSLHD and SWSML/PHN, form stronger relationships among key stakeholders, further inform local planning and be part of a wider knowledge network.

The study has employed a number of processes and initiatives including an extensive analysis of qualitative and quantitative data and development of access case studies; consultation through deliberative forums on perceived barriers to access to primary health care for local vulnerable populations and appropriate strategies to address them; and formulation of an intervention and research question. Through all these processes, the study has actively engaged with 16 key stakeholders from the health sector and with a number representatives from non-government organisations.

As a result of the activities undertaken to date, the following intervention has been proposed for south western Sydney:

Target group: Vulnerable populations with chronic disease (may include: low socioeconomic groups, Aboriginal community, culturally and linguistically diverse communities, and refugee and humanitarian entrants).

Intervention: Encouraging and coaching patient use of e/m/tele health tools by primary care providers (GPs, nurses, allied health professionals and pharmacists) to improve self-management of chronic disease.

The next steps of the project involve an in-depth realist literature review which aims to synthesise existing scientific knowledge about the effectiveness of the intervention and its scalability. The review will occur at all six IMPACT sites in Australia and Canada. In the meantime, a communication strategy involving newsletter and email correspondence has been employed to support ongoing engagement of key stakeholders in the IMPACT study.

South western Sydney is characterised by its diversity. The IMPACT study presents an exciting opportunity to make a real and lasting difference to the healthcare of our unique population. A third of our population were born overseas and more than a third of NSW humanitarian entrants have settled in our region. South western Sydney is also home to 13,070 Aboriginal and Torres Strait Islander people, representing around 1.6% of our total population, and up to 3.2% of the total population in the Campbelltown region.14 of the 20 most disadvantaged suburbs in metropolitan Sydney are located within our catchment area. In addition, the rate of chronic diseases, such as diabetes is well above state average in some local government areas in south western Sydney.

It is envisaged that the IMPACT study will improve knowledge and understanding of underlying risk factors for chronic disease, self- management and health care navigation within targeted vulnerable populations. Broadly, it is expected that the proposed intervention will gradually reduce chronic disease morbidity/ mortality and hospital admissions, improve quality of life and experience of health care for vulnerable communities.

For more information, visit www.swsphn.com.au or contact Amy Prince at amy.prince@swsphn.com.au

PROJECT FOCUS

TOWARDS SEAMLESS CANCER CARE

FOSTERING THE INTEGRATION OF CANCER SERVICES AND GENERAL PRACTICE THROUGH IMPROVED COMMUNICATION

DEFINING THE PROBLEM

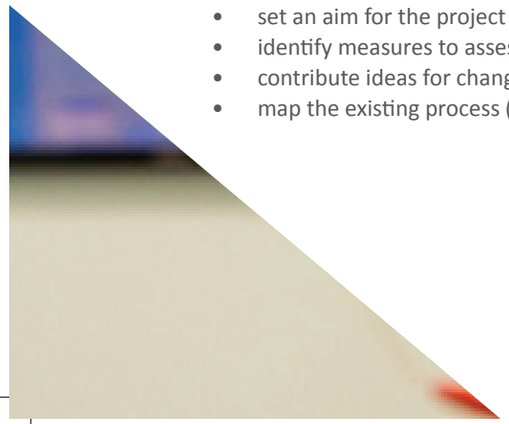
Letters from oncologists were taking up to three months to reach family doctors. This was discovered through a qualitative research project using semi-structured interviews with 22 local GPs and quantified by a survey. GPs said delays were wasting time and affecting their care of cancer patients.

Findings:

- average delay of 19 days (range 3-104)
- GPs thought a week was timely

We convened an expert reference group of GPs, GP practice staff, oncologists and cancer service staff which met for one day to:

- set an aim for the project
- identify measures to assess progress
- contribute ideas for change.
- map the existing process (see process map below)



LANGLEY AND NOLAN'S MODEL FOR IMPROVEMENT:

The three improvement questions

1 What are we trying to achieve?

Seven days from dictation to reading of letter

2 How will we know the change is an improvement?

Measure days from dictation to posting letter

3 What ideas do we think will make a difference?

- Increase same day dictation
- Trial automated transcription
- Trial outsourcing transcription
- Reduce steps in process

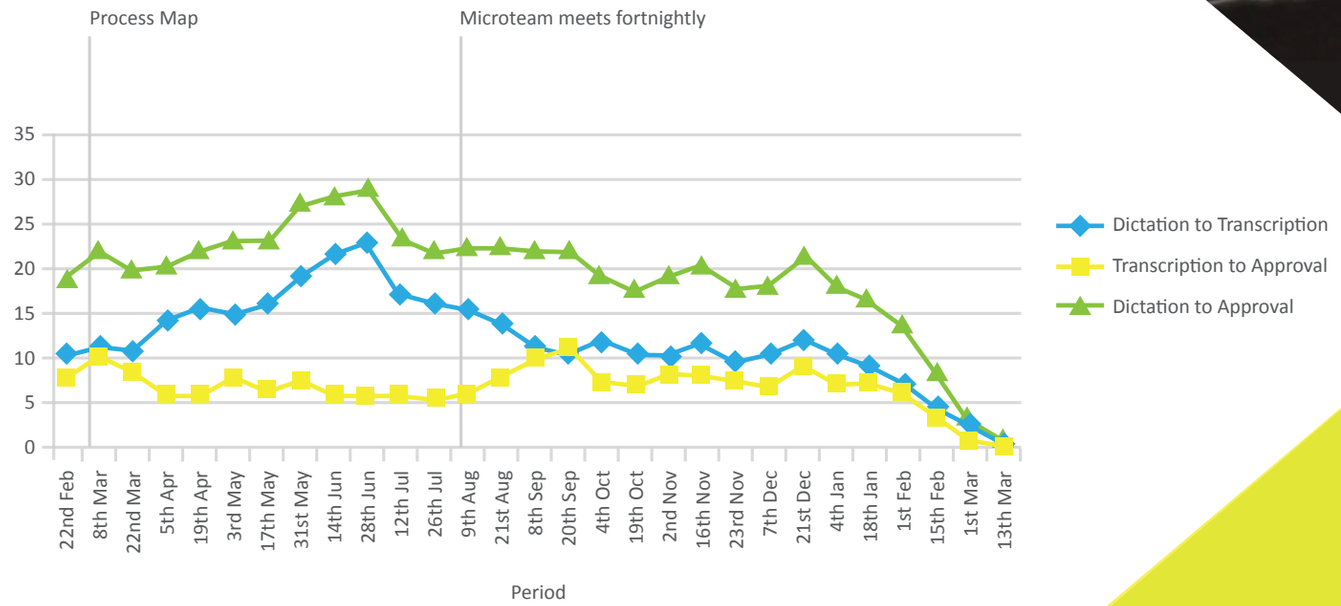
THE INTERVENTION

A micro-team led by the Fairfield GP Unit with cancer services staff met fortnightly to carry out rapid improvement cycles. Each meeting re-examined the process map and designed changes to save time and simplify it.

CHANGES

A key improvement involved testing time and cost of the four existing transcription methods with a standard letter. Outsourcing transcription was cheaper, faster and freed staff for other work. It was adopted as the main strategy. Numerous Plan/Do/Study/Act cycles were used to test simplifications of the process. Later in the project digital transmission of letters was explored to save time and money on postage.


DRAGON
LEARN
DICTATE END CLINIC.
CRASHES
IN BETWEEN
QUEUE
PALL CARE
TRANSCRIBE TO MOSAIC
PART
LETTER
ORGANISE FAST
CENTRAL SPOT
SORT
COPIES
SPECIALIST PENDING LIST
TRANSCRIPTION REPORT
STAFF?


Process Map
Microteam meets fortnightly
35
30
25
20
15
10
5
0
22nd Feb
8th Mar
22nd Mar
5th Apr
19th Apr
3rd May
17th May
31st May
14th Jun
28th Jun
12th Jul
26th Jul
9th Aug
21st Aug
8th Sep
20th Sep
4th Oct
19th Oct
2nd Nov
16th Nov
23rd Nov
7th Dec
21st Dec
4th Jan
18th Jan
1st Feb
15th Feb
1st Mar
13th Mar
Period
Dictation to Transcription
Transcription to Approval
Dictation to Approval

LESSONS LEARNED

Rigorous qualitative research identified letter delay as a real and strategic problem.

Process mapping promoted buy in from all involved parties. The complexity of the process map convinced stakeholders that change was required. Referring to the map helped identify change ideas to test.
Rapid improvement cycles developed relationships between project team members and enabled testing of changes prior to wider implementation.

The partnership between Cancer Services, the Medicare Local (now the Primary Health Network), the Ingham Institute and the SWSLHD Fairfield GP Unit has facilitated the success of the integration projects.

FOR THE FUTURE

Electronic transmission of letters is the way of the future to save time, free up staff and save money.

Having achieved timely production of letters the case for electronic transmission has become more convincing. The building blocks of secure messaging systems, GP and specialist IT systems are in place. We are keen to use cancer services to pioneer improved integration of general practice with hospital services through electronic communication.

We would like to address other issues identified in our earlier project including improved access to cancer services for GPs and increased role for GPs in cancer survivor care.

Joint projects between the Local Hospital District, the Primary Health Network and facilitated by academic departments such as the Fairfield GP Unit are a good model for increasing integration.

For further details contact Dr Andrew Knight
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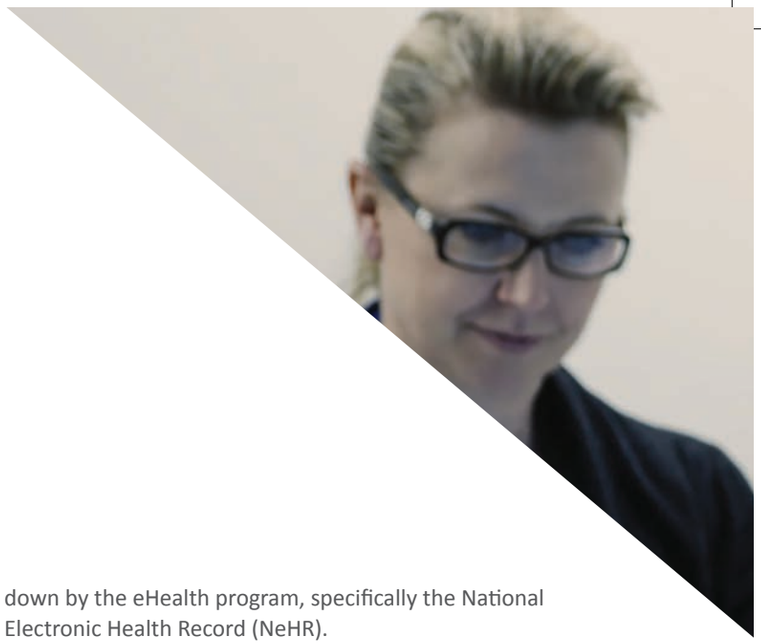
PROJECT FOCUS

IM/IT

FOSTERING THE INTEGRATION OF CANCER SERVICES AND GENERAL PRACTICE THROUGH IMPROVED COMMUNICATION

WATCH VIDEO



The eHealth system within Australia is "the electronic management of health information to deliver safe, more efficient, better quality healthcare." (Department of Health or DoH)

The above definition addresses the need to integrate the fragmented state of the healthcare system of Australia. This is evident whenever a patient tries to use multiple services such as GPs, allied health professionals and specialists.

eHealth provides new ways of managing health information making healthcare more accessible regardless of where in Australia you live or travel. South Western Sydney Medicare Local (SWSML) started to roll out the eHealth Change & Adoption program in the latter half of 2012. The initial step was an information campaign regarding what the Personally Controlled Electronic Health Record (PCEHR) is and what its benefits are for both the health providers and consumers, and how to participate in the eHealth program. Participation rate was good with nearly all accredited practices within the SWSML's catchment signing up – about 150 practices, nearly half of all practices in the area. Additional reports indicates that a small number of practices have applied for the program on their own with SWSML assistance. There are currently 68 general practices in SWSML area that receive discharge summaries via GP Communications, around 350 send and receive medical reports through secure messaging delivery (SMD).
We have also engaged the community by providing information sessions, setting up stalls and booths in various community events, and mass mail out of eHealth information in the south western Sydney region. In June 2014, approximately 65,000 persons from our area have registered for an eHealth record. As of this writing, eHealth-ready practices are still registering patients.

We currently have an initiative to help practices organise their electronic clinical data by encouraging the use of the PENCS Clinical Auditing Tool. This initiative helps the practice meet their accreditation requirements, qualify them for the e-Practice Incentive Program, and get them ready to contribute to their patients' electronic health record. Currently, we have 180 general practices enrolled using the tool.

We have also started on GPs about HealtheNet, the eHealth NSW program to improve information sharing between hospitals, community health, GPs, other private providers and consumers - closing the loop between primary, community and acute patient care. HealtheNet integrates with the infrastructure laid down by the eHealth program, specifically the National Electronic Health Record (NeHR).
An eHealth record consolidates a patient's key health information, allowing them and their healthcare providers to easily view and manage their health information. This can make getting the right treatment faster, safer and easier.

Having an electronic health record means patients will not have to repeat their medical history every time they see a new doctor, even if that doctor is in a different state or territory. If their doctor is participating in the eHealth system they will be able to access the patient's medical history via the eHealth record and simply confirm it with the patient, rather than asking a series of questions over and over.

A patient can keep their own notes in their eHealth record to better track their progress and response to treatments and medications, or to keep track of alternative therapies or remedies they may be taking. The convenience of having an eHealth Record means they will not have to remember every medication, dosage, test or health-related incident, or when a child was immunised.

The patient can nominate a trusted person, such as a family member or carer, to view or manage information on their behalf. This could be particularly important for those with chronic conditions or who need high levels of healthcare and support from others.

While eHealth does not propose to solve all of the problems of Australia's healthcare system, it is a step in the right direction. A massive undertaking, the new Primary Health Network organisation needs to embed the eHealth idea in everything it does. From there we can work together with the health providers, from GPs to specialists, into a more efficient future of serving the consumers of healthcare services.

For more information, visit www.swsphn.com.au or Contact Michael Blancia at Michael.Blancia@swsphn.com.au

Australian Government

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SOUTH WESTERN
SYDNEY

An Australian Government Initiative

Health
South Western Sydney
Local Health District