Integrated Care - Bringing it all Together

Central Coast Integrated Care Program

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- General Manager
  - Responsible for:-
- 4 privately owned practices – 1 Principal GP
- 33 GPs
- 40+ Admin staff including 4 Practice Managers
- 20+ Nursing staff – including 1 Nurse Manager
- Senior Finance / IT Manager; Finance Manager; Operations Manager; HR Manager; Executive Assistant; Administrative Assistant
- Specialists 10+, Allied Health 15+, Pathology 3 + other tenants such as pharmacy, physio & X-ray.

Overview

- CC 1 of 3 demonstrator locations chosen by Dept. Health
- Our practice chosen as demonstrator site by CCLHD due to its size & patient demographic
- Collaboration with CCLHD (PwC also involved at beginning)
- Appointment (from EOI tendering process) of Care Collaboration provider (single point of access) to undertake the project.
- Principles:
  - Patient centered
  - To focus on the 'vulnerable aged' (over 65yrs) in the Wyong region.
  - Emphasis on the importance of the General Practice as being the 'health care home' for patients.
  - GP driven

Consultation Process

- Included
  - LHD
  - General Practice
  - Aged Care Facilities
  - Local Council

- Common Themes
  - Need for better care coordination across sectors
  - Hospital prevention measures that include an urgent response
  - Coordinated discharge from hospital

Issues Identified

- Different funding streams do not necessarily support whole system thinking
- How services operate within their own business models
- Interactions between different services and care providers have not always been positive > leading to dis-integration

Feedback from GPs

- *"they (health) don't want to know what we have to say"*
- *"I refer to the nursing service & I never hear back until patient comes back to see me 10 weeks after discharge"*
- *"just give me a phone call to let me know what's happened. I don't hear anything even if there's been a significant event"*
- *"they (health) discharge patient with 2 days' worth of meds & instruction to see me to get referrals but don't understand how General Practice operates"*

Feedback from LHD

- *"we receive health summaries from the GP & they haven't cleaned up their meds in years"*
- *"a phone call is fine but they (GPs) never answer & a call with me doesn't help the rest of the team if I'm about to end my shift"*

Goals

- 10 year vision to transform care
- To make it easier for organisations to communicate meaningful information at the appropriate time
- Promote to all clinicians the importance of the other care providers in treating their patients
- Undertaking work to promote lifetime relationships between GPs & their patients
- To value the information GPs can provide to others who are caring for their patients
- Reducing avoidable hospital admissions & delivering care in the most appropriate setting.

Top 9 Variables That Predict the Risk of an Unplanned Admission

- Age
- Number of chronic conditions
- Had a previous hospital admission in the last year
- Prolonged GP visit in past year
- Smoking
- Diabetes test in past year
- Number of meds prescribed in past year
- Health assessment in past year *
- Disadvantage *
- * **determined through population-wide analysis rather than patient-level sample.**

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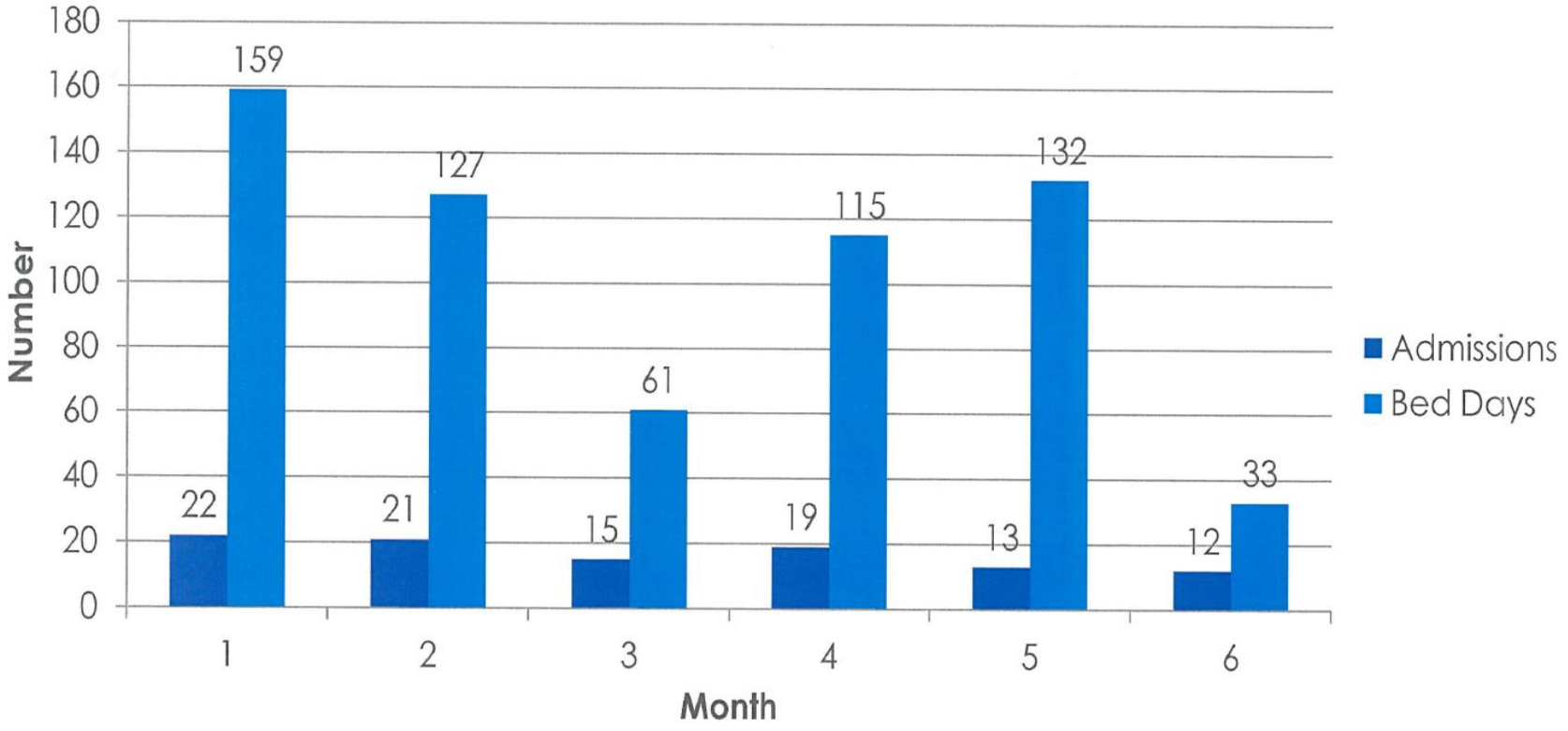
Risk Stratification Model

- The RSM used by PwC predicts the risk of an unplanned admission with **79%** accuracy for people aged 65+ in a GP setting
- **60%** of all unplanned admissions are predicted by focusing on patients in the top **20%** risk band

Unplanned Admissions and Bed Days by Month (Toukley)



NSW GOVERNMENT Health
Central Coast
Local Health District

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Patient Journey

Sonya - Aged 81 yrs – Married to Harry

- Type 2 Diabetes
- Peripheral Oedema
- UTI
- Urinary Incontinence
- Arthritis
- Gout

Live in 3 bed home with 2 adult children (redundant)

Husband / wife felt “forgotten” in the system.

Sonia was anxious due to above conditions – not wanting to go out (for last 1.5yrs)> more strain on Harry (who is very independent).

Adult children able to assist but have own issues (failed marriage, redundancy etc)

Sonia felt embarrassed that children had to clean up her mess & help with showering.

Strain on the relationship with the children. Felt like a "burden".

High usage of pads and liners – additional financial strain (on a pension).

What was organised:-
ACAT assessment; home care package arranged; increased incontinence funding; community support; carers allowance; pelvic floor exercises; budgeting.

Sonia felt like ‘tide’ was turning with additional support & extra services.

Found courage to get out of the house & go shopping.

Unfortunately Harry died not long after this (unexpected).

Sonia reverted back – all efforts came undone for approximately 2 mths.

Started to come out of the grieving period & wants to get her life back on track again. Support services & interventions recommenced.

She has learnt to become independent again & the family has pulled together to be stronger.

THANK YOU

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