Our Report on Progress
November 2015
We are delighted to present this progress report of the Western NSW Integrated Care Strategy. The process of establishment and implementation has been both challenging and rewarding, and it is exciting to see that the hard work and dedication of all those who have been involved, has achieved positive change for our community. This includes the providers who have led development at the local demonstrator sites, the staff of our respective organisations, and our community who have embraced the new models of care and the opportunity to participate in care that is delivered in new and innovative ways; and for this we thank them.

The excitement of being announced as one of the three NSW demonstrator sites to trial large scale integrated care initiatives was just the beginning of the journey. This report details the challenges and highlights along the way, and our key achievements and learnings. These learnings have been invaluable and are strongly informing the roll out of our second wave of local demonstrator sites for which the selection process is currently underway. We hope these learnings will also assist other sites in developing their own innovative models of care.

To date, the most rewarding achievement for us has been successfully enabling new ways of working for general practice and other community providers, and being able to deliver integrated care for patients across primary and secondary services, and across multidisciplinary provider teams. Evidence of the satisfaction of patients is detailed in the case studies contained within this report.

We look forward to continuing our integrated care journey and achieving our Vision -

“To transform existing services into an integrated Western NSW system of care that is tailored to the needs of our rural and remote communities, and improves access to care and health outcomes, with particular focus on closing the Aboriginal health gap.”

Scott McLachlan  
Chief Executive Officer  
Western NSW LHD

Jamie Newman  
Chairperson  
Bila Muuji Aboriginal Health Services Incorporation  
Chief Executive Officer  
Orange Aboriginal Medical Service

Andrew Harvey  
Chief Executive  
Western PHN
List of abbreviations

<table>
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<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACHS</td>
<td>Aboriginal Corporation Health Service</td>
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<tr>
<td>ACI</td>
<td>Agency for Clinical Innovation</td>
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<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
</tr>
<tr>
<td>CLC</td>
<td>Clinical Leadership Committee</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HITH</td>
<td>Hospital in the Home</td>
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<td>HIU</td>
<td>Health Intelligence Unit</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>LHD</td>
<td>Local Health District</td>
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<tr>
<td>MHDA</td>
<td>Mental Health, Drug and Alcohol</td>
</tr>
<tr>
<td>ML</td>
<td>Medicare Local</td>
</tr>
<tr>
<td>MPS</td>
<td>Multi-Purpose Services</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>PCEHR</td>
<td>Personally Controlled Electronic Health Record (renamed My Health Record)</td>
</tr>
<tr>
<td>PFU</td>
<td>Patient Flow Unit</td>
</tr>
<tr>
<td>PHN</td>
<td>Primary Health Network</td>
</tr>
<tr>
<td>PRMs</td>
<td>Patient reported measures</td>
</tr>
<tr>
<td>SHP</td>
<td>NSW State Health Plan</td>
</tr>
<tr>
<td>SHSP</td>
<td>Western NSW LHD Strategic Health Service Plan</td>
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1. Introduction

One year after the NSW Integrated Care Demonstrator sites were launched in three Local Health Districts (LHDs) across the region, Western NSW is pleased to report on the progress that has been made in the Western NSW district.

This report represents one element of the evaluation of the Western NSW Integrated Care Strategy (the Strategy) and aims to serve as a report on progress to NSW Health, as well as a shared learning initiative, highlighting our key learnings which may assist other providers setting out on the integrated care journey.

1.1 Our key drivers for change - the burning platform

Two key differentiating characteristics of Western NSW are its rurality and remoteness, and the relatively high proportion of the population who are Aboriginal (11% - the highest of any LHD).

The selection of Western NSW as a NSW demonstrator site provided the opportunity for the LHD and our partners, the Medicare Locals (MLs) and Bila Muuji, to accelerate the scale, scope and pace of efforts that were already underway to progress innovative models of care to achieve seamless integration, greater patient focus, better application of eHealth technologies, and a sustainable multi-disciplinary workforce.

The Western NSW LHD’s Strategic Health Services Plan (SHSP) 2013 – 2016, developed in 2013, had highlighted areas that required joint action across primary, community and specialist services and therefore an integrated care approach to delivery.

This prompted the LHD and MLs to collectively identify new ways of working, and therefore when the Strategy was established, providers and patients were already committed to working together to develop progressive delivery models.

The key drivers of change for our region at the time of establishing the Strategy highlighted in our Health Needs Assessment (2013) were:

- The poor health outcomes experienced by the Aboriginal population
- The forecast growth in demand associated with population ageing and increasing prevalence of long term conditions
- The projected growth in medical and surgical hospitalisations from an already high admission rate
- Our service configuration of multiple small provider entities of primary, community and specialist outpatient health services, working in relative isolation

We also had a significant (but improving) financial deficit.

Together these factors necessitated the adoption of new ways of working to improve access and outcomes, and so make better use of the available workforce and funding.

1.2 Western NSW LHD

Western NSW LHD is the second most sparsely populated LHD in NSW. Out of the NSW LHDs it has the highest proportion of the population who are identify as being Aboriginal or Torres Strait Islander people, at 11% of the population. With a low rate of projected overall population growth, 8% to 2031, and a high growth in the proportion of the population aged 65 and over, there is a 33% projected growth in medical-surgical hospitalisations to 2030 if no change in Average Length of Stay or avoidable admissions to hospital occurs.
The population in Western NSW experience a high level of socioeconomic disadvantage with the average Socio-Economic Index for Areas lower in Western NSW than across NSW and across Australia. For each region within Western NSW, the level of disadvantage increases with the increasing distance from Sydney. The life expectancy at birth in Western NSW LHD is 76.5 years for males and 81.9 years for females. This is the lowest life expectancy out of the NSW LHDs.

The Western NSW population has high health care needs. The proportion of people with at least one of the four risk factors of smoking, harmful use of alcohol, physical inactivity or obesity is 59% in Western NSW, higher than the 54% across NSW. The health needs assessment undertaken in 2013 identified a number of interventions as being likely to provide the greatest outcome gains for population health:

- Smoking prevention and cessation
- Nutrition and physical activity interventions
- Diabetes prevention and management
- Well child care during the first 1,000 days of life
- Mental health - strengthening community care and support

1.3 Overarching requirements

Our Strategy is aligned with two key documents: the NSW State Health Plan and the NSW Health Integrated Care Strategy:

- ‘Delivering Truly Integrated Care’ as one of three key directions\(^1\) of the NSW State Health Plan (SHP). The SHP identifies integrated care as the key to delivering the right care in the right place at the right time
- The NSW Health Integrated Care Strategy focuses on driving integration at the local level that will transform the NSW health care system. The stated aim of integrated care is *‘developing a system of care and support that is based around the needs of the individual, provides the right care in the right place at the right time, and makes sure dollars go to the most effective way of delivering healthcare’*\(^2\). LHDs are charged with planning the new integrated care models, establishing better connections between health services and more creative partnerships with other health care providers.

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2. The WNSW Integrated Care Strategy

2.1 Vision, Priorities and Goals of our strategy

Our vision:

To transform existing services into an integrated Western NSW system of care that is tailored to the needs of our rural and remote communities, and improves access to care and health outcomes, with particular focus on closing the Aboriginal health gap.

The strategic priorities for Western NSW are shown below in Figure 1.

Figure 1: Strategic priorities of the Western NSW Integrated Care Strategy

<table>
<thead>
<tr>
<th>Develop a coherent system of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support high performing primary care</td>
</tr>
<tr>
<td>Close the Aboriginal health gap</td>
</tr>
<tr>
<td>Improve the patient experience</td>
</tr>
<tr>
<td>Live within our means</td>
</tr>
</tbody>
</table>

Western NSW is adopting the key performance indicators (KPIs) that have been developed for the state wide Integrated Care Strategy Monitoring and Evaluation, and supplementing these with additional local KPIs and clinical indicators. At the time of writing, these indicators were under review by NSW Health, however indicative KPIs are shown below in Figure 2.

Figure 2: KPIs for the Western NSW local demonstrator sites

**NSW Government determined KPIs**

- Number of patients participating in integrated care
- GPs and practices participating in integrated care
- Bed days for integrated care cohort
- Electronic discharge summaries to GPs for integrated care cohort
- Diagnostic tests for target cohort
- Patient reported measures
- Provider reported measures (to be defined)
- Program expenditure against budget
- ED attendances for integrated care cohort
- Hospital admissions for integrated care cohort
- Unplanned readmissions for enrolled cohort

**Western NSW determined KPIs**

- Health assessments completed for enrolled cohort
- Number of enrolled patients added to cdmNet
- Patient reported measure surveys completed
- Care navigator / coordinator assigned
- Signed up to Personally Controlled Electronic Health Record
2.2 The model

Figure 3 describes the program structure for the Strategy over the past 12 months.

The model

- **Local demonstrator sites** - these were established in Cowra, Cobar, Molong, Wellington and Dubbo (explained further in Section 4) to demonstrate redesign of delivery models for general practice, primary and community health services local rural hospital / Multi-Purpose Services (where these existed), and specialist service support. Case studies from these sites are included in Section 4.

- **District wide initiatives** - these were developed in collaboration with the LHD, and MLs to support the delivery of district-wide innovative integrated care models (explained further in Section 5)

- **State-wide enablers** - we have worked closely with the NSW Government to develop and implement specific enablers that were intended to be consistently applied throughout the State (explained further in Section 6).
3. The Foundations for Establishment

3.1 Collaboration

A partnership approach and constructive collaboration across the district, primary care, secondary care and multidisciplinary providers has been paramount to the effective establishment and implementation of the Strategy at all levels of the program structure.

The Implementation Plan was developed in partnership by the LHD, the MLs and the Bila-Muuji group of Aboriginal Medical Services (AMSs), with these parties subsequently forming the establishment Governance Group. A key role of this group was to promote collaboration across the spectrum of health care services and providers, recognising that effective collaboration was essential to the successful development and implementation of new models of care and ways of working at the local demonstrator sites. This is described further in Section 3.2 below.

The development of a stakeholder management plan reinforced our commitment to engage and work closely with the wider community and district leaders in the change process, and to build commitment and ownership of the development and implementation process.

3.2 Governance arrangements

A Governance Group was established to provide strategic direction and oversight of the Strategy and the Implementation Plan. The responsibilities of the Governance Group are shown in Figure 4.

Figure 4: Responsibilities of the Governance Group

<table>
<thead>
<tr>
<th>Group responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing guidance on program approach and direction to ensure achievement of the agreed deliverables</td>
</tr>
<tr>
<td>Resource allocation to deliver on the program</td>
</tr>
<tr>
<td>Providing collective technical expertise to support and guide the program</td>
</tr>
<tr>
<td>Ensuring work is achieved within agreed timeframes</td>
</tr>
<tr>
<td>Facilitating engagement of key stakeholders</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote and provide relevant linkages for the program within their organisations and localities</td>
</tr>
<tr>
<td>Promote and champion the Western NSW Integrated Care Strategy within their own organisation and amongst their colleagues and communities</td>
</tr>
</tbody>
</table>

The disestablishment of the MLs and the recent formation of Primary Health Networks (PHNs) have necessitated a change in membership of the establishment Governance Group and therefore a refresh of the terms of reference for this group going forward.

The Governance Group has transitioned to become the Integrated Care Steering Group changing the focus of this group from having an oversight role to enabling consistent implementation of new models of care across local demonstrator sites. The functions of the Integrated Care Steering Group are to:

- Achieve the deliverables of the Strategy, ensuring implementation is aligned with the Strategy’s objectives and that the agreed model of care is implemented consistently across localities
- Provide consistent implementation guidance and direction to the project team
- Ensure work is achieved within agreed timeframes
- Monitor the projects risks
- Work closely with the Clinical Leadership Committee which has a key role in providing oversight and leadership to the demonstration sites
- Facilitate engagement of key stakeholders
3.3 Clinical Leadership Committee

The purpose of the Clinical Leadership Committee (CLC) was to play a leading role in the clinical governance of the Integrated Care Strategy.

It was intended that the CLC would work closely with clinical leaders, support the local demonstrator sites and provide expertise, advice and direction to the Governance Group on the development of patient centred, evidence based, sustainable and effective clinical services across the continuum of care. The key objectives of the CLC are shown in Figure 5.

**Figure 5: Key objectives of the Clinical Leadership Committee**

<table>
<thead>
<tr>
<th>Objective</th>
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<tbody>
<tr>
<td>Align the culture of primary and secondary health services across Western NSW with the values of transparency, comparison, learning and improvement</td>
</tr>
<tr>
<td>Articulate a clear and consistent vision at the ‘coal face’</td>
</tr>
<tr>
<td>Build trust between organisations as well as between clinicians and managers, and generate momentum by modelling new ways of working</td>
</tr>
<tr>
<td>Create a culture of learning from each other</td>
</tr>
<tr>
<td>Demonstrate, enable and communicate an integrated care vision for the district</td>
</tr>
</tbody>
</table>

The CLC took time to become established and has evolved from the establishment phase where medical clinical leaders were recruited with the objective of supporting the general practice based local demonstrator sites, into having a more multidisciplinary membership. The functions of the CLC are shown in Figure 6.

**Figure 6: The functions of the Clinical Leadership Committee**

<table>
<thead>
<tr>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide clinical leadership in the development and planning of integrated health services across the continuum of care</td>
</tr>
<tr>
<td>Build capacity to implement evidence-based practice changes more quickly by becoming key figures of change</td>
</tr>
<tr>
<td>Improve quality, through the endorsement and championing of agreed clinical standards, guidelines and protocols as developed by the Clinical Reference Groups and Clinical Streams, eg clinical pathways</td>
</tr>
<tr>
<td>Provide a vehicle to more rapidly assess and respond to changing service demands based on data provided by the Health Intelligence Unit</td>
</tr>
<tr>
<td>Provide recommendations to reduce unnecessary duplication of services and facilities, and consider options in relation to greater flexibility of facilities and equipment usage</td>
</tr>
<tr>
<td>Recommend options for more sustainable services through the sharing of workforce and funding resources and through a more proactive response to the implementation of appropriate new technology</td>
</tr>
<tr>
<td>Generate a shared understanding amongst clinicians of the important positive impacts integration can have in relation to patient outcomes</td>
</tr>
<tr>
<td>Endorse a culture of clinical performance reporting and review</td>
</tr>
<tr>
<td>Lead the way in modelling the changes recommended by the Committee</td>
</tr>
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</table>
The intention as the CLC matures and finalises an agreed work program, is that it will:

- Work closely with the District Clinical Streams and if required convene expert Clinical Reference Groups to support the work of local clinical leaders in establishing new models of care.
- Collaborate with the Clinical Excellence Commission and Agency for Clinical Innovation (ACI)

3.4 Health Intelligence Unit

The Health Intelligence Unit (HIU) was established as a shared resource for partners in the district, recognising that ‘health intelligence’ is an important input to developing evidence based approaches to prioritising outcomes, setting and monitoring key performance indicators (KPIs) and making decisions.

The collaborative governance arrangements and operational delivery has meant the HIU has taken time to become established and begin delivering its planned objectives. However, it is now operating as a virtual unit and is jointly owned by member organisations. These currently include Western PHN, Bila Muuji Regional Aboriginal Health Service, Western NSW LHD and Far West NSW LHD.

A team of data and information specialists from our member organisations is accountable to the HIU Governing Committee, through the Director of the HIU. The team specifically supports the Strategy by providing integrated information to help health providers (GPs, nurses, specialists, allied health) plan and evaluate the models of care implemented at the local demonstrator sites.

The HIU’s overall functions (some still in development) include:

1. Providing a one-stop-shop for accessing health and health care data:
   a. Drawing on all available sources of data
   b. Preparing meaningful reports that help people make the best decisions about health
   c. Providing better access to relevant evidence and research
   d. Liaising and consulting to ensure information needs are met
2. Offering expert advice and support on interpreting statistics and making best use of data and information
3. Advising on aspects of data collection and data management to improve the quality of source data
4. Collaborating with research institutes and academic units and support health-related research in the region
5. Collaborating with other closely aligned functions such as planning, health information management, quality improvement, and population health.

The HIU is now providing monthly data to local demonstrator sites and developing a template for annual
reporting. While baseline measures are available, future years will enable us to see whether there are changing trends that may be related to the implementation of integrated models of care.

3.5 Program management

The establishment of a robust program and project management framework (shown in Figure 7) was essential, given the size and complexity of the implementation work program.

The Integrated Care Program Manager with responsibility for overall project management reports through an Executive Sponsor to the collaborative Governance Group. The Integrated Care Program Manager works closely with key LHD, PHN staff, local demonstrator site teams, and a core project team to deliver on the overall implementation plan.

Over the past 12 months, the program structure has evolved responding to the changing resourcing requirements of the various local demonstrator sites. Significant resources have been invested in the establishment and ongoing support for the sites. This has included dedicated project management support for sites, and intensive LHD and ML support to enable the implementation planning and risk stratification process.

Figure 7: Program management structure for Western NSW Integrated Care Strategy
4. Local demonstrator sites

The local demonstrator sites within Western NSW are performing a proof of concept role. The sites test the concepts to ensure they are feasible for real-world implementation. In this way the local demonstrator sites are trialling different prototypes of the integrated care model in the field to establish operational viability, identify and resolve technical issues, and share learnings to enable rapid and effective roll out and provide feedback for decision making processes to inform overall direction.

The first wave of local demonstrator sites in Western NSW LHD are located in Cobar, Dubbo, Wellington, Molong and Cowra as shown from top to bottom in Figure 8.

While local demonstrator sites have targeted differing population groups, all have undertaken a consistent approach to establishment that differs from standard practice in a number of ways:

- Patients are identified through risk stratification
- Eligible and willing patients are enrolled at the local demonstrator site to have their care delivered under the local integrated care model
  - Enrolment includes patients providing consent for their health information to be shared across the multidisciplinary provider team, and for it to be collected and analysed. Any published information however, is anonymised and presented in aggregated form
- Once enrolled, an assessment is completed for each patient. This includes consideration of both the health and social needs of the individual
- A care plan is developed in conjunction with the patient, to direct the care provided
- Care is provided by a GP-led multidisciplinary team
  - This involves multi-disciplinary case conferencing
  - Shared care planning for each patient facilitated by an electronic shared care platform.
4.1 Cowra

Table 1: Key characteristics of Cowra local demonstrator site

<table>
<thead>
<tr>
<th>Local population</th>
<th>12,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with Aboriginal or Torres Strait Islander background</td>
<td>6.5%</td>
</tr>
<tr>
<td>Children aged 0 to 14</td>
<td>9.8%</td>
</tr>
<tr>
<td>People aged over 70</td>
<td>15.8%</td>
</tr>
<tr>
<td>Lead practice</td>
<td>Kendal St Medical Care</td>
</tr>
<tr>
<td>Started accepting enrolments in</td>
<td>April 2015</td>
</tr>
<tr>
<td><strong>Key Statistics as at September 2015</strong></td>
<td></td>
</tr>
<tr>
<td>Cumulative number of patients enrolled</td>
<td>83</td>
</tr>
<tr>
<td>Number of patients withdrawn or passed away</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total number of patients enrolled</strong></td>
<td>79</td>
</tr>
<tr>
<td>Number of Health Assessments completed</td>
<td>31</td>
</tr>
<tr>
<td>Number of Care Plans developed</td>
<td>54</td>
</tr>
<tr>
<td>Number of Case Conferences conducted</td>
<td>28</td>
</tr>
</tbody>
</table>

Cowra selected two focus areas: Better management of elderly patients with multiple complex and chronic disease; and people with enduring mental health, drug and alcohol (MHDA) issues.

**Key Points:**
- Clinical leadership has been provided by clinicians at the Kendal Street Medical Service who have joined with the Western NSW LHD, MHDA, Local Council and Health Council to form the Local Leadership Group
- Consumer representatives have worked together with clinicians to help co-design local models of care
- The population identified with complex and chronic disease is not always unique to the population identified with MHDA issues and there was considerable cross over between the groups
- Considerable stakeholder consultation was undertaken in Cowra to engage the large number of fragmented services and providers
- The proposed project implementation was ambitious. Multiple cohorts necessitated the development of new models of care and enrolment processes required more resource than was initially anticipated. More detailed planning up front and time spent on resource allocation would have been beneficial in supporting the workload that eventuated.
Case Study 1 - Integrated Care in Cowra

Debbie Hall is 44-years-old and lives in Cowra with her husband and son.

When she’s not spending time with her family, Debbie enjoys going to the movies, listening to music and scrapbooking. However, recent mental and physical health issues have affected her quality of life.

What are some of the health issues you have experienced in the last five years?

I have suffered on and off from depression for many years.

I had to undergo a hysterectomy and have suffered from complications including menopausal symptoms and chronic pain. I also suffer from tendonitis.

All of these health issues have really affected my day-to-day life and I am keen to receive more holistic care.

What are some of the challenges you face when trying to manage your health?

I've needed to travel to receive treatment from different specialists out of Cowra which can be challenging with transport and accommodation.

It would be great if I could receive all my treatment under one roof. It would also be great to have all health providers on the same page so I can receive more holistic care.

What has your experience been like as an Integrated Care patient?

Not long after I joined Integrated Care, I noticed an improvement in my overall health.

Having a proper pain management plan allows me to get on top of my pain sooner, which means I can function better and reduce the need to go to hospital.

It has also improved my mental health because I feel like I am in more control of my health.

How has Integrated Care improved your health and way of life?

I have been able to manage my pain much better which means that I can do a lot more around the house.

I also find that I am able to spend more quality time with my family, especially my son, which is great.

What are you looking forward to in the next five years?

I’m looking forward to continuing to improve my pain management, which will allow me to be more physically active and improve my overall health.
Case Study 2 - Integrated Care in Cowra

Norma Thrupp lives with her husband in Woodstock approximately 15 minutes out of Cowra.

A retired nurse and welfare worker, Norma’s health has begun to deteriorate and her mobility has suffered which has had a big impact on her independence.

What are some of the health issues you have experienced in the last five years?

I suffer from diabetes and hypertension. My weight has also worsened my arthritis and I suffer from chronic wounds.

My health issues have affected my ability to do the things I enjoy such as gardening, and contributing to community development projects.

What are some of the challenges you face when trying to manage your health?

The most frustrating thing about my health is my reduced mobility and the lack of independence I have.

I find it difficult to do basic tasks around the house and rely on my husband to do a lot of the things that I used to do.

It’s also hard to be on the receiving end of care after spending so many years caring for other people.

What has your experience been like as an Integrated Care patient?

It has been great. I have been on a bit of an emotional rollercoaster with my health; however Integrated Care has helped me come out of my shell and encouraged me to actively engage in the management of my health.

How has Integrated Care improved your health and way of life?

I can get some of my care delivered to my door which is very helpful. It has also helped me coordinate my appointments and medication and avoid duplication and confusion.

Integrated Care is like you are on a conveyor belt and everything happens in the right order and when it should, which I think is great.

What are you looking forward to in the next five years?

I don’t expect my health will get dramatically better but I think Integrated Care will hopefully delay me getting much worse.

Family is very important to me and I am looking forward to seeing my granddaughter finish university.
4.2 Cobar

<table>
<thead>
<tr>
<th>Target population</th>
<th>People aged over 70 years (or over 45 years if Aboriginal) with diagnosed chronic disease and associated complex health and care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>GP led multidisciplinary team based care for older people with chronic disease and associated complex care needs</td>
</tr>
<tr>
<td>Enablers</td>
<td>Care Navigation/Coordination, including social care coordination, shared care planning and multidisciplinary case conferencing.</td>
</tr>
</tbody>
</table>

**Table 2: Key characteristics of Cobar local demonstrator site**

<table>
<thead>
<tr>
<th>Local population</th>
<th>4,900</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with Aboriginal or Torres Strait Islander background</td>
<td>12.8%</td>
</tr>
<tr>
<td>Children aged 0 to 14</td>
<td>22.4%</td>
</tr>
<tr>
<td>People aged over 65</td>
<td>12.0%</td>
</tr>
<tr>
<td>Lead practice</td>
<td>Cobar Primary Health Care Centre</td>
</tr>
<tr>
<td>Started accepting enrolments in</td>
<td>November 2014</td>
</tr>
</tbody>
</table>

**Key Statistics as at September 2015**

| Cumulative number of patients enrolled | 95                                                                 |
| Number of patients withdrawn or passed away | 11                                                               |

**Total number of patients enrolled**

| 84                                                                 |
| Number of Health Assessments completed | 82                                                                |
| Number of Care Plans developed | 82                                                                 |
| Number of Case Conferences conducted | 48                                                                 |

Initial project plans for the local demonstrator site at Cobar described the development of a fully integrated GP-led multidisciplinary model of care to prevent unnecessary hospitalisations. This included strategies to improve patient participation and health literacy, address workforce issues, increase the ability of service to support people and their carers at home and enable sharing of clinical information between Cobar Primary Health Care Centre (PHCC), the Lillian Brady aged care facility and the Cobar Hospital Emergency Department.

**Key points:**

- The establishment of the Cobar local demonstrator site has been supported by strong GP leadership and a high level of engagement from representatives across the range of health care providers.
- The patients from the cohort who were identified as being highly complex benefited from a high level of involvement of support from the social sector.

**Key Learning**

- Incorporate a step-down approach into the design of care navigation services. The more complex the cohort, the more important the relationship with the social sector.

The use of care navigators to assist patients and their carers access health and support services has been effective, however they quickly reached capacity. In planning the delivery of care navigation services, the level of resources needs to be considered, as does a step down approach.
Case Study 3 - Integrated Care in Cobar
71-year-old Cobar resident, Margaret Jenkinson, enrolled in Integrated Care in January 2015.

A full time carer for her husband, Ian, who has dementia, Mrs Jenkinson has recently had her own health issues and found it challenging to keep both of them well and out of hospital.

What are some of the health issues you and Ian have experienced in the last five years?

I was diagnosed with breast cancer in 2011 and had an operation. While I am not completely out of the woods, I am feeling better.

A few years ago Ian was diagnosed with dementia so I spend most of my time looking after him. I like to play golf, knit, and bake but I'm finding it harder to find the time now.

Ian's health is slowly deteriorating and he recently had a cataract removed. I've also had chest infections and a few colds - nothing too bad but it makes caring for Ian a bit harder.

What are some of the challenges you face when trying to manage Ian's dementia?

Due to dementia, Ian had his licence revoked so I have to drive him everywhere we go. We would like to stay independent in our own home but we don't have enough support.

Neither of us have family in Cobar so we don't have any additional support which is hard.

What has your experience been like as an Integrated Care patient so far?

It's been very good. The Integrated Care team has arranged home care for us. We can also now access community transport to get to our health appointments. They also regularly check in on us, remind me about appointments and help me keep track of medications.

How has Integrated Care improved your health and way of life?

While it hasn't directly affected my health it's made it much easier for me to care for Ian. Things like transport and arranging appointments has been really excellent.

What are you looking forward to in the next five years?

I'm looking forward to me being cleared of my cancer which is in the next 2 years, getting healthier and losing a bit of weight. I'm also hoping we can get Ian into good care which he needs.
Case Study 4 - Integrated Care in Cobar

When Dorothy Blacker retired she spent most her time volunteering at several different charities until leg problems restricted her movements.

Now 89 years old, Dorothy lives alone at home and spends her time attending CWA meetings and working on craft projects such as cross stitching and knitting berets for soldiers.

What are some of the health issues you have experienced in the last five years?

I am in remission for breast cancer at the moment. I have also previously had a knee reconstruction but now my leg has fused which makes it very difficult to get around.

I've also had a few falls and earlier this year I was hospitalised with an infection for almost three months.

What are some of the challenges you face when trying to manage your health?

I find it frustrating that I can't do some of the simple things like washing and housework.

My daughter doesn't live in Cobar and I usually rely on taxis for transport to get to and from my appointments.

What has your experience been like as an Integrated Care patient?

I signed on to Integrated Care in March this year and I would be completely lost without all the services they have put in place for me.

The Integrated Care navigator has worked with my daughter and together, they have organised everything for me. I now go to occupational therapy appointments; I have a new chair; an adjustable bed; and my bathroom will be renovated. All these things have helped me get around on my own much better.

How has Integrated Care improved your health and way of life?

It has helped me access the services I need. I am able to maintain a social life, visit friends, have lunches and attend CWA meetings. It also helped me stay healthy at home and keep out of hospital.

What are you looking forward to in the next five years?

I'm looking forward to turning 100 and getting a letter from the Queen, or King William.
Case Study 5 - Integrated Care in Cobar

Until recently, 93-year-old Norman Bargwanna lived alone in a unit in Cobar. Now residing in an aged care facility, Norman struggles with the general effects of old age such as bad eyesight and hearing, decreased mobility and arthritis. In October 2014, Norman signed on to Cobar’s Integrated Care Strategy.

What are some of the challenges you face with your health conditions?

I used to play bowls regularly until it became too hard to bend down. I also used to read a lot but macular degeneration in my eyes made it too difficult, so most of the time I watch television.

I am having trouble with my balance and have had a few falls lately. My worsening eye sight and arthritis means I cannot move around much and I require assistance to do a lot of things around the home.

Simple things like preparing a meal or doing the washing has become quite difficult for me.

I sometimes get my neighbour to collect prescriptions for me, otherwise I get a cab to the chemist and walk home.

What has your experience been like as an Integrated Care patient so far?

A lot has changed for me. For one thing I am still alive!

The Integrated Care team helped me get appropriate furniture including a more comfortable chair.

They took away my old bed and arranged for a new electronic bed that helps me retain some independence.

Even just the little things like getting a shoe horn to help put my shoes on has made a difference.

I also now have access to a personal carer and get assistance with domestic duties.

How has Integrated Care improved your health and way of life?

Integrated Care has definitely improved my quality of life. I feel more secure and it gave me a bit more time in my own home, which I am grateful for.

What are you looking forward to?

I’m looking forward to attending my sister’s 80th birthday next week!
Case Study 6 - Integrated Care in Cobar

Genie McMullen is a registered nurse and has been living in Cobar with her husband and four children for more than eight years. Three months ago Genie became the Project Lead for Integrated Care in Cobar. Prior to this, Genie was the Nurse Manager at Cobar Hospital and was involved in the early implementation of Integrated Care.

What is your role in Integrated Care?

As Project Lead, I oversee the implementation of Integrated Care across the different health care providers in Cobar.

I was the Nurse Manager at the hospital for three years and was involved with the early stages of development of Integrated Care in Cobar, so was aware of many of the innovative changes that were being trialled.

The move from acute care, where I’ve worked for 20 years, to primary care has been a steep learning curve but Integrated Care is one of the most exciting developments in the health care space and I am very proud to be a part of it.

What are some of the challenges that the Cobar community faces?

The greatest challenge that living in Cobar presents is isolation. We’re 300km from Woolies!

It’s very challenging to recruit health care providers and access allied health services, but it also makes for a very resilient staff and community, where people become very solutions focussed.

For many years there was no physio in the town. Services that other regional and urban communities take for granted, such as women’s health nurse, mental health worker, speech therapist, and occupational therapist are visiting services, drive in, drive out or fly in, fly out.

How do you think Integrated Care is helping to address those issues?

Integrated Care has been instrumental in bringing service providers to the table in Cobar - we now have a ‘Community Services Forum’ that meets bi-monthly.

It was quite surprising just how many organisations have outreach services to Cobar which were not widely known.

We are helping each other to address issues and find local solutions. The forum has also helped us bring new ideas to the table. It’s a really positive forum.

What do you like most about your role?

The best thing about my role is that I’m now able to explore ideas on how to improve the delivery of health care in a community that my children call home.

I’ve enjoyed being part of a change process for something that can and will make a real difference in people’s lives.

What do you think Integrated Care can achieve five years from now?

I think Integrated Care has the potential to make a real difference to the way people utilise health services and help people better manage their own health needs.
Case Study 7 - Integrated Care in Cobar

Two years ago, Kelly Leonard moved to Cobar from Dubbo with her husband and three children. Last year, Kelly joined the Integrated Care team in Cobar as the Social and Community Coordinator. Kelly’s community role has given her great insight into some of the social and practical challenges faced by elderly patients in Cobar struggling with chronic and complex diseases.

What is your role in Integrated Care?

My role is to support the Care Navigators, patients and GPs to help coordinate and locate social and community services in Cobar and the region. Things like referrals to Home Care for domestic assistance, Meals on Wheels or taxi vouchers.

I also support carers by organising things like counselling, planned respite, or Carers Allowance through Centrelink.

I also do the initial patient enrolment and follow patients up with a phone call or when they visit the Cobar Community Health Care Centre.

About three months after they have joined Integrated Care, I check in to see how they are going and if they need any more assistance or need help.

What are some of the challenges that the Cobar community faces?

Cobar is isolated and many residents are unaware of what services are available locally and what services come from other areas like Dubbo.

Many elderly residents rely on taxis or friends and family to get them around.

How do you think Integrated Care is helping to address those issues?

Integrated Care has addressed some of the social issues by streamlining information about services and getting organisations to work together more.

We hold bi-monthly meetings with health and community service providers and invite guest speakers from Dubbo and surrounding areas to talk about how we can improve and promote our services for the people of Cobar.

What do you like most about your role?

I enjoy working with the variety of people in the community. I like that Integrated Care is patient-centred and that each care plan is different, depending on the person’s individual needs.

What do you think Integrated Care can achieve five years from now?

I think Integrated Care will make a big difference in Cobar. It will streamline health services and empower people to take control of their forever-changing health needs.
4.3 Molong

<table>
<thead>
<tr>
<th>Target population</th>
<th>People aged over 16 years with diagnosed chronic disease and associated complex health and care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>GP led multidisciplinary team based care for people with chronic disease and associated complex care needs</td>
</tr>
<tr>
<td>Enablers</td>
<td>Care Navigation/coordination, shared electronic medical record, multidisciplinary care conferencing</td>
</tr>
</tbody>
</table>

### Table 3: Key characteristics of Molong local demonstrator site

<table>
<thead>
<tr>
<th>Local population</th>
<th>2,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with Aboriginal or Torres Strait Islander background</td>
<td>3.3%</td>
</tr>
<tr>
<td>Children aged 0 to 14</td>
<td>23.4%</td>
</tr>
<tr>
<td>People aged over 65</td>
<td>13.6%</td>
</tr>
<tr>
<td>Lead practice</td>
<td>Molong HealthOne General Practice</td>
</tr>
<tr>
<td>Started accepting enrolments in</td>
<td>November 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Statistics as at September 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative number of patients enrolled</td>
</tr>
<tr>
<td>Number of patients withdrawn or passed away</td>
</tr>
<tr>
<td><strong>Total number of patients enrolled</strong></td>
</tr>
<tr>
<td>Number of Health Assessments completed</td>
</tr>
<tr>
<td>Number of Care Plans developed</td>
</tr>
<tr>
<td>Number of Case Conferences conducted</td>
</tr>
</tbody>
</table>

The Molong local demonstrator site built on the Molong HealthOne General Practice with the objective of providing a fully integrated GP-led multidisciplinary care model.

**Key points:**

- A key objective for the site was to develop a shared medical record that could be accessed by members of the multi-disciplinary team, to increase the involvement of all health professionals in patient management and the effective use of referral pathways.
- Due to the colocation of providers in Molong, the majority of providers already shared a single electronic health record for each patient. This has made the establishment of a standardised electronic shared care platform difficult.
- There is still opportunity for existing nursing resources to be better aligned to support the model of care.

**Key Learning**

Align and leverage roles of existing staff to support the new model of care being implemented.
### 4.4 Wellington

<table>
<thead>
<tr>
<th><strong>Target population</strong></th>
<th>Indigenous people aged between 15 and 50 years with a diagnosed chronic condition and/or associated complex health care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model</strong></td>
<td>GP led multidisciplinary team based care for chronic disease and associated complex care needs</td>
</tr>
<tr>
<td><strong>Enablers</strong></td>
<td>Care Navigation, shared care planning and multidisciplinary case conferencing</td>
</tr>
</tbody>
</table>

**Table 4: Key characteristics of Wellington local demonstrator site**

<table>
<thead>
<tr>
<th>Local population</th>
<th>8,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with Aboriginal or Torres Strait Islander background</td>
<td>23%</td>
</tr>
<tr>
<td>Children aged 0 to 14</td>
<td>21%</td>
</tr>
<tr>
<td>People aged over 65</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Lead practice</strong></td>
<td>Wellington Aboriginal Corporation Health Service (WACHS)</td>
</tr>
<tr>
<td><strong>Started accepting enrolments in</strong></td>
<td>February 2015</td>
</tr>
<tr>
<td><strong>Key Statistics as at September 2015</strong></td>
<td></td>
</tr>
<tr>
<td>Cumulative number of patients enrolled</td>
<td>65</td>
</tr>
<tr>
<td>Number of patients withdrawn or passed away</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total number of patients enrolled</strong></td>
<td>63</td>
</tr>
<tr>
<td>Number of Health Assessments completed</td>
<td>33</td>
</tr>
<tr>
<td>Number of Care Plans developed</td>
<td>39</td>
</tr>
<tr>
<td>Number of Case Conferences conducted</td>
<td>4</td>
</tr>
</tbody>
</table>

The main aim of WACHS local demonstrator site is improving the outcomes of Aboriginal patients with chronic and complex conditions, with a core focus of Integrated Care in Wellington to help close the Aboriginal health gap.

**Key points:**

- The implementation plan for this site focused on integrated care funded roles and strategies to increase health literacy and participation. Patient-Centred models adopted have enabled local aboriginal patients to assume more ownership to their health care, with this project continually supporting them in their journey.
- Internal and external relationships have become stronger with the assistance of this project. Greater connection, through the sharing of information, has led to a more enhanced and engaging partnership with all stakeholders. Strong local clinical leadership and the facilitation of more case conferencing will only see this aspect develop more into the future.
- The eHealth platform has been embraced within the project with over 100 client’s signing up to the My Health Record (PCEHR). This will only serve to enhance further sharing of health information across all spectrums within the local community.
4.5 Dubbo Aboriginal Diabetes

<table>
<thead>
<tr>
<th>Target population</th>
<th>Aboriginal people in Dubbo with Type 2 Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>GP led multidisciplinary team based care for Aboriginal people in Dubbo with Type 2 Diabetes</td>
</tr>
<tr>
<td>Enablers</td>
<td>Shared Care Planning, Care Navigation/Coordination, multi-disciplinary case conferencing</td>
</tr>
</tbody>
</table>

Table 5: Key characteristics of Dubbo Aboriginal Diabetes local demonstrator site

<table>
<thead>
<tr>
<th>Local population</th>
<th>40,500 (5,000 Aboriginal and/or Torres Strait Islander)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead practice</td>
<td>Dubbo Aboriginal Medical Service</td>
</tr>
<tr>
<td>Started accepting enrolments in</td>
<td>June 2015</td>
</tr>
</tbody>
</table>

Key Statistics as at October 2015

| Cumulative number of patients enrolled | 47 |
| Number of patients withdrawn or passed away | 1 |
| Total number of patients enrolled | 46 |
| Number of Health Assessments completed | 47 |
| Number of Care Plans developed | 47 |
| Number of Case Conferences conducted | 4 |

To improve understanding of the barriers to improved health for Aboriginal people two pieces of research were commissioned: one to one to understand the perspectives of local care providers; and the other to understand the lived experience of Aboriginal people with diabetes in Dubbo.

Key points:

- Enabling pieces of work undertaken by the local demonstrator site included:
  - Audit and update of National Diabetes Support Service register
  - Review of existing referral processes and pathways
  - Use of Aboriginal Health Worker Network to improve support offered to Aboriginal patients with diabetes
  - Implementation of a Support Group for Aboriginal people with diabetes which also incorporates patient education, health checks, and engagement with health professionals

- It has become evident that effective implementation requires: strong clinical leadership; sufficient nursing and support staff to assist with the additional workload (during and post implementation); nursing staff with a strong understanding of chronic disease; and clinical information systems that are compatible with LHD enablers, including cdmNet.

- Practices may be vulnerable to staffing changes which impacts on sustainability and implementation

- Evaluation of health outcomes is difficult when not supported by existing practice software

- To roll out the coordinated care model at any of the remaining practices, a funding model is required.
4.6 Local demonstrator site learnings

Significant learnings have emerged from First Wave local demonstrator sites especially around a site’s readiness to develop and progress implementation of new integrated models of care in a locality.

These learnings have strongly informed our planning for 2nd wave sites including:

**Entry criteria**

We have refined the minimum requirements for practices to participate as a local demonstrator site:

- Local clinical leaders will be committed to innovative service redesign
- Commitment to development and implementation of initiatives that align with the key directions of the Strategy and on improved health outcomes for patients
- Co-operative working relationships with the Western NSW PHN and LHD
- Co-operative working relationships with other locality providers
- Evidence of participation in primary and community care innovation (eg, Australian Primary Care Collaborative Program)
- Initiatives will have a significant impact in a prioritised service/population health need area
- Learnings will be transferrable
- Commitment to participation in a reporting and performance framework that will include monitoring and reporting against agreed KPIs and performance targets
- Active engagement in whole of practice quality framework development, and health outcome KPIs

- Support for the shift of service from secondary to primary care (especially for chronic disease management)
- Development and implementation of initiatives will enhance the role of multi-disciplinary teams through workforce support, development and innovation
- Commitment to effective use of eHealth, including shared health records through use of the My Health Record (i.e. upload of patient Shared Health Summaries), provide linkable patient data to an agreed data repository, and the use of telehealth
- Provide anonymised practice patient data to the secure Quality Improvement portal as it relates to KPIs and risk stratification, for the purpose of analysis and feedback to the practice
- Willingness to participate in shared learning fora and to share performance information including clinical information across sites.
Transferability

We consider that a key objective of our role as a demonstrator site is to support development of models of care that are easily and rapidly transferable to other sites and localities.

To achieve this, local demonstrator sites need to commit to working towards a consistent model of care. Therefore, we intend to require 2nd wave sites to explore the following core dimensions:

- Physical and virtual integration to provide a critical mass of the local workforce
- GP clinical leadership of the multi-disciplinary team
- Risk stratification of the local population to identify the user groups and services where the potential benefits from integrated care are greatest
- Standardised ways of working (eg, coordinated care for risk groups; shared care planning)
- New workforce roles, including development of higher skills within scopes of practice, and delegation of clinical functions within the team
- Locality planning to meet prioritised local needs and service gaps, and the required future capacity
- IT connectivity and sharing of patient information
- Structures and processes that support:
  - appropriate skills-based clinical and corporate governance;
  - engagement of clinical and community stakeholders; and
  - performance accountability
- Transparent performance reporting of an agreed KPI set, and support for evaluation.

Change management

A key learning from the 1st wave site development was the intensive support and resource required to support an agreed and consistent establishment and implementation process and subsequently models of care. Therefore we intend to establish a change team to work with 2nd wave local demonstrator sites. This team will move from site to site to support the establishment phase.

The change team will have experience in integrated care delivery and provide guidance in key areas such as:

- The development of Local Leadership Groups. For example: how they should be structured, the terms of reference and sample agendas
- Preparation of local health needs assessment and developing a profile to identify priority cohorts
- Mapping processes within the health care system such as care pathways, current journey vs future journey
- Identifying resources and workforce roles
- Risk stratification and data cleaning.
5. District-wide initiatives

District wide initiatives were established to support the delivery of innovative integrated models of care across the district. They were also intended to actively support local demonstrator sites to deliver their locally developed models of care.

These initiatives included:
- A commissioning framework
- Integrated care pathways
- Enhanced ambulatory care and hospital in the home service delivery
- Enhanced health promotion planning
- Mental health, drug and alcohol services
- Workforce planning.

5.1 Commissioning framework

Commissioning is envisaged as a dynamic process, enabling multiple stakeholders in Western NSW to work collaboratively to plan, design and invest in services and systems that are catalysts for improved patient access and population outcomes, and improved service performance. The Western NSW LHD commissioning cycle is shown in Table 6.

With the disestablishment of the MLs, progress on the development of the district-wide commissioning framework was delayed to enable consideration of a collaborative approach following establishment of the Western NSW PHN.

While there is yet to be formal work on developing the district-wide commissioning framework to be used across Western NSW LHD, it was intended that a commissioning approach was to be used in the local demonstrator site model.

Table 6: The commissioning cycle applied in Western NSW

<table>
<thead>
<tr>
<th>Stage</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Planning</td>
<td>1. Assess needs through the - use of the existing Western - NSW health needs - assessment, and - development of locality profiles 2. Review current service provision to inform service responses to priority health needs 3. Decide and agree priorities through participatory and collaborative process, based on information from previous steps, risk stratification, defined criteria for evaluating and prioritising investment (and disinvestment), current and future demand, and resource and financial modelling</td>
</tr>
<tr>
<td>Outcome focused procurement</td>
<td>4. Specify and agree quality and outcomes ensuring that there is a clear ‘line of sight’ between commissioned patient outcomes and strategic population outcomes 5. Collaboratively design services and pathways that logically support outcomes-based delivery, including clinical and key practitioner leadership 6. Contract with providers and shape the supply structure using appropriate funding models, price(s), volume(s) and quality/outcomes dimensions</td>
</tr>
<tr>
<td>Monitor and manage demand, supply and performance</td>
<td>7. Manage demand and ensure appropriate, equitable access to care, particularly for vulnerable populations 8. Ensure clinical engagement and leadership in monitoring and overall decision-making to foster a high level of clinical integrity and accountability 9. Manage quality and evaluate performance and outcomes utilising transparent decision-making criteria and protocols. Clinical integrity will be maintained through the use of a clinical lens</td>
</tr>
</tbody>
</table>
5.2 Integrated care pathways

Integrated care pathways define how structured care, referral and discharge can best be managed for higher risk patients across the service continuum. The pathway describes the ideal route patients should take as they move through the health system. Integrated care pathways are resources that provide guidance on the assessment and management of clinical conditions and administrative information on accessing diagnostics, specialist opinion, specialist treatment services and other supports.

The CLC has the responsibility for developing and implementing the integrated care pathways across the district and specifically to support local demonstrator sites.

It was intended that the CLC would use information from the local demonstrator sites to identify priority areas for pathway development, and once the pathways were developed and implemented, the CLC would utilise review and feedback mechanisms to monitor the impact of the care pathways and assess whether performance improvement had occurred.

To date, there has been little buy-in to the care pathways process and little progress has been made in their development. There is a need to clearly demonstrate the value of pathways and their potential to reduce unwarranted variation in practice. With wide-ranging practice models in place and a voluntary uptake approach, there will need to be collective effort in achieving buy-in to the development and implementation process for the pathways to have a measurable impact. To overcome this, multiple initiatives have been put in place including:

- The Governance Group has decided four priority areas for the CLC to focus on
  - High risk diabetes
  - Congestive Heart Failure
  - Depression
  - Cellulitis
- Interest in the use of integrated care pathways will be generated through the LHD Clinical Streams which include primary care representation and other fora
- Discussions with ACI, other PHNs and LHDs who have successfully implemented integrated care pathways to identify potential clinicians who could be utilised to encourage, challenge, and debate rationale for the use of pathways.

5.3 Enhanced Ambulatory Care and hospital in the home service delivery

Having a chronic illness increases the likelihood of potentially preventable hospitalisation and increase the level of hospital utilisation including emergency department presentations for an individual and as a result, improving the coordination of care delivery for chronically ill patients with multiple care providers was an early priority of the strategy. A focus on Emergency Department flows and models to divert non-urgent presentation to ambulatory or community services was taken. Shared-care models of ambulatory care utilising existing acute and community nursing workforce in rural communities was implemented in sites, with support for this initial work and subsequent HITH planning enabled by an Integrated Care project role resource.

HITH services provide acute, sub-acute and post-acute care to patients residing in their homes, with the objective of improving patient comfort and reducing risks such as falls and infections associated with hospital admission. Implementing HITH in more rural services also assists hospitals to manage their hospital beds more efficiently and effectively. Daily HITH care may be delivered in the home or clinic or residential aged care facility. The intention for Western NSW LHD was to take a strategic
approach to developing and implementing HITH or hospital substitution models of care that are appropriate for rural and remote settings.

Alternate options for care include shared-care between acute and community workforce, rostering to allow patients to be admitted to HITH on weekends and piloting HITH type services in several facilities of differing sizes, to test how HITH can be provided in District, Rural, Remote and Multi-Purpose Services (MPS). To date, activity planning activity has included two demonstrator sites (Cowra and Cobar) and two non-demonstrator sites.

- Cowra (District site) - active planning with anticipated HITH commencement December 2015
- Cobar (Remote site) - active planning with anticipated HITH commencement December 2015
- Peak Hill (MPS) - pre-planning commenced
- Canowindra (Rural site) - pre-planning commenced

Sites are required to identify key integrated care deliverables and linkages and to report on their progress quarterly.

Ambulatory care includes any non-inpatient care that takes place as a day attendance at a health care facility. Prior to the Strategy, Dubbo, Orange and Bathurst already had large established Ambulatory Care Units which included HITH service offerings. Both ambulatory and HITH services are considered to be substitutes for step-down from hospital care and reflect patient preferences for being treated in the community where possible. The aim of increasing utilisation of these out-of-hospital services is to increase the beds and resources available to treat patients who are more critically ill in hospital.

Target levels have been set for HITH admitted activity and for avoidable admissions for targeted conditions. Results for each HITH sites are shown in Table 7.

Bathurst and Orange have performed well against both targets and Dubbo is doing particularly well against the avoidable admission target. Parkes HITH service only recently commenced in September 2014 and therefore a lag is expected before improvements are seen. Whilst there has been a decrease on the overall percentage of avoidable admissions from previous years (not shown in table 7), Parkes has yet to reach target but to date is performing well against the HITH target.

<table>
<thead>
<tr>
<th>Site</th>
<th>Overnight admissions to HITH June 2015 Results</th>
<th>Avoidable hospital admissions for targeted conditions (people aged over 16) April 2015 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Result</td>
</tr>
<tr>
<td>Bathurst</td>
<td>4.9%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Dubbo</td>
<td>1.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Orange</td>
<td>1.1%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Parkes</td>
<td>2.3%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>
Case Study 9 - Ambulatory Care

In a small rural town Edith utilised a new Ambulatory Care Service instead of being frequently hospitalised.

After a series of illnesses within two years including heart problems requiring a pacemaker and a “burst bowel” and hernia following a colonoscopy Edith is receiving regular chemotherapy at a larger town for bone cancer.

During one admission the Ambulatory Care nurse (Nurse J) suggests that she use the new Ambulatory Clinic to have the fluids – the nurse would meet her there and connect her up to the fluids and she could go home afterwards. “It was Nurse J’s idea to use the Ambulatory Clinic”. This was assisted when the larger site inserted a more permanent PICC line. Edith was relieved – at times the local doctors in the surgery were unable to access a vein after multiple attempts – one doctor tried eight times and then handed over to another who tried three times. “My local nurse (Nurse J) looked after the PICC line – at the larger site they asked me “Who did this dressing? - it is a great job”.

“At the Ambulatory Clinic I sit on the verandah in a chair for three hours and they bring me a cup of tea and sandwiches – I don’t have to go into hospital anymore and I just ring up now when I think I need fluids. The nurse always organises it and I don’t have to stay in the hospital anymore for days. I don’t know why but I felt so much better when I had the fluids and was able to go home afterwards. I’m generally feeling better now and getting out and about - it’s been about five weeks now since I needed to go to the clinic”.

“The care is always very good - not only the nurses but the other staff as well”. The nurse always organises Edith to go to the Clinic and makes sure everything is organised and follows up afterwards. Edith has another family member who is unwell and feels the care is always very respectful.

Often she feels unwell, not wanting to eat or drink properly and has no energy. The local doctor always sees her straight away and she never has to wait in the surgery. The local doctor always told Edith to go to the hospital where she could have an intravenous drip inserted and stay for a few days. The local doctor said “The only thing I can do is put you in hospital”. Edith can’t remember how many times this happened but it was frequent. Edith didn’t like being hospitalised - “I don’t like going to hospital - I saw so much of it with my husband - it went on for five years and it wasn’t for me”.

What is working well?
The care delivered provides:
- Easy Access to Care
- Respect for patient needs
- Coordination of Care
- Emotional support
- Physical comfort.

What could be improved?
Although the service is supported by local health professionals, it is not fully promoted.
The service is underutilised.
Case Study 10 - Ambulatory Care

Mary lives on a farm. Her doctor wanted to admit her for 2-3 days with an infected leg however the beds were all occupied. She attended the Ambulatory Clinic for 2 days

Mary lives outside of a small rural town on a farm. Her lower leg had been leaking for several days. “I knew I had an infection and went straight to the medical surgery - the doctor wanted me admitted for 2 to 3 days”. The beds were all full at the hospital. Mary was self caring and the only thing that was required was IV antibiotics. Mary’s daughter was staying with her at the time and was able to help Mary, so the doctor agreed to utilise the Ambulatory Clinic at the hospital. Staff at the Ambulatory Clinic put a cannula in the elbow section of her arm and commenced treatment leaving the cannula in, so that they did not need to find a new vein the next day. Mary is on warfarin and when having blood tests, staff often have trouble finding a vein. Mary always found the nursing staff were “very good” and personally known to her over the years. When Mary was having her treatment, one or two nursing staff from the ward would also check on her at times.

“It suited me to go home and come back each day because my daughter was staying with me and I could rest with my leg up”. On the third day I went to the doctor’s rooms - I think he asked me to go and see him. He did the antibiotic treatment that day and told me to come back to the surgery after that. He used a special angina patch each day to help find the vein and injected the antibiotics himself for the last 2 days.

Mary noticed that it was busy everywhere. The doctor was very busy in the rooms - the doctors waiting room was always full and the doctor did a morning and evening round at the hospital. The nurses at the hospital always looked busy as well.

Mary would definitely use the Ambulatory service again even though she lives out of town and even if her daughter was not staying with her “As long as it doesn’t affect the beds - there are so few beds left now - quite a few people are saying the same thing - that’s my concern - what worries me is that we used to have a Women’s Ward and aged care sections - now there’s just exercise equipment in the Women’s Ward where those beds used to be.

What could be improved?

There is currently a perception in the community that ambulatory service might be replacing hospital beds rather than giving people more options to have care in their community.

Community perception about benefits of ambulatory and prevention programs (gym equipment) to keep people well and at home.

What is working well?

The care delivered provides:
- Access to appropriate service
- Meets patient needs
- Care is provided by respectful staff with the involvement of family
5.4 Health Promotion Planning

We believe there is a significant opportunity to improve the current and future health of the population of Western NSW LHD by changing modifiable risk factors. In 2013 it was estimated that of the Western NSW population aged 18 and over, 22% were smokers and 21% were classified as obese.

Local demonstrator sites have made progress in health promotion planning by analysing and identifying the existing prevention activities and models operating in and available to the community, determining the financial and workforce resources available and identifying opportunities for new interventions. Although new health promotion activities have not been instigated, these activities will support the broader Strategy and models of care being implemented at various local demonstrator sites.

To further progress the opportunity in this area, we are undertaking planning to develop a district wide health promotion planning framework to support integrated care strategies. We are expecting a preliminary report in November 2015 for engagement with other key stakeholders to determine next steps.

5.5 Mental health, drug and alcohol services

There is now a growing body of evidence that indicates the significant impact mental ill-health can have on physical illness and disease, as well as the poor physical health that many consumers of mental health services suffer. Such evidence confirms the importance of bringing mental health and physical health care together to provide holistic care for people with mental illness and/or other chronic and complex illnesses. This needs to involve the establishment or strengthening of collaborative partnerships between primary and secondary care providers and the development of improved integrated models of service delivery. (Physical Health Care of Mental Health Consumers Guidelines, Department of Health NSW 2009)

A review of the mental health, drug and alcohol (MHDA) services being accessed by the population in Western NSW LHD was completed in June 2014. The aim of the review was to better understand the changes required to further improve outcomes for people using these services and ensure the most effective and efficient use of services.

Following the review, the MHDA Service Transformation Project was initiated in order to progress service change, in line with the underlying principles from the mental health review and key policy directions:

- Contemporary model of care
  - Better align services with demography and need
  - Ensure an equitable spread of services
  - Least restrictive care / closest to home / recovery focus
  - Increasing community services & residential care, with a focus on multidisciplinary input, peer support and integrated models of care
  - Decreasing inpatient care
- Better address needs of Aboriginal people & people in rural and remote areas
- Ensure a cohesive and integrated system of care
- Use funding to the best effect for the health of the population

The key elements of the future MHDA service model to be progressed include:
1) Building effective community services
2) Equitable spread of services
3) Investing in community services and then adjust inpatient services

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3 Having a body mass index of over 30
Integrated care is a key focus of the future service model to achieve seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health, in partnership with the individual, their carers and family.

Over the next 2 years and beyond, the MHDA service will be working in a planned and staged way to move to the future service model. The Integrated Care Strategy will incorporate specific initiatives supporting implementation of a model of care focused on integrated care and partnerships; is the least restrictive, provided as close as possible to home and with a recovery focus. It will involve significant change over time to ensure a multidisciplinary approach, an equitable spread of services, based on demography and need and working to better address the needs of Aboriginal people & people in rural and remote areas.

5.6 Workforce planning

We have supported workforce development and planning in the local demonstrator sites and more generally across the LHD to enable integrated models of care. The new models of care have required a flexible workforce, changing roles, skill mix and competencies to support:

- Enhanced community and home-based care
- Person-centred delivery developed from community, consumer and carer need perspective
- Models of care based around eHealth and telehealth applications
- General practitioner led teams across all health professions
- Leadership

A review of the workforce supporting the new models of care was undertaken in June 2015, it:

- Describes how the model has been operationalised in different settings
- Extracts the core workforce requirements for the model
- Develops some consistent language around integrated care positions
- Identifies variances across the sites and where/why specific differences might be applicable
- Provides the groundwork for development of a flexible workforce framework to guide the implementation of the model in new locales and service areas

Figure 9 describes the current workforce configuration supporting the integrated model of care in Western NSW.
A workforce planning tool is being developed to assist in the implementation of the Strategy. It will:

- Accurately describe the key integrated care functions across the “care journey” for a client
- Capture the range of people that could or should be involved with each function, or along each stage of the care journey
- Identify capability and qualifications required to complete each function to the required standard, and identify who might have this capability

### 5.7 Patient flow unit

Western NSW is the second most sparsely populated LHD in NSW, with just over 1 person per sq km (271,000 people; 250,000 sq. km). This presents significant challenges to the delivery of specialist clinical and support services, and explains why Western NSW LHD operates facilities in more than 40 geographical locations.

The distances between the different facilities within the LHD means that patients frequently require supported transport to maximise the utilisation of available beds and to access an appropriate level of service. The LHD spends in excess of $26 million in transporting patients and specialists throughout the district. In response, the LHD’s Patient Flow Unit (PFU) commenced operation in 2006, and remains unique within NSW Health.

The Strategy provided the opportunity to further enhance support for delivery of improved patient care at the right place and right time through enhancements to the PFU, given the potential to significantly reduce travel for patients and improve the coordination of services throughout the region. In particular, the PFU is intended to enhance specialist support for remote areas.
A key development has been the trial placement of a Medical officer in the PFU. This trial has been successful in achieving its intended objectives, including:

- Securing all LHD clinicians to use the PFU for all inter-facility transfers and to work with these medical officers to ensure service satisfaction
- Acting as a support to GPs for patients where clinical concern is evident
- Escalating delays for tertiary referrals
- Eliminating tertiary referral where services are available within the LHD
- Eliminating the admissions for transfer sake
- Reviewing transport Level B patients to guarantee ambulance preferred method of transport
- Assisting with the development of brief for introduction of cardiac and mental health services
- Reviewing diagnostics transport requests to ensure that timeframes for procedures are appropriate to the clinical need of the patient
- Investigating the use of Telehealth for inpatients required to attend fracture clinics at Dubbo and Orange
- Monitoring estimated dates of discharge for LHD facilities and liaising with clinicians to support discharge
- Providing ongoing education to the Nurse Coordinators PFU
- Acting as a clinical resource for small sites where clinically deteriorating patients are identified and a GP is unavailable.

We consider there is further opportunity for PFU developments to support local demonstrator sites. This could include:

- Promoting consistency across sites and increasing regional capability
- Supporting care navigators at local sites by taking away administrative work such as booking coordination.

Work is continuing on future planning and could incorporate 3 core components:

- Expanding hours and capability
- Telehealth
- Links with remote areas work.
6. Enablers

The NSW Ministry of Health identified enablers that would benefit all demonstrator sites across the state. It was intended that the state development of these resources would reduce the level of duplication and resources required, and enable a more consistent approach to process implementation across the state in the future. The areas originally identified for state-wide development included:

- eHealth
- Risk stratification
- Patient reported measures (PRMs) including real time patient feedback

Development of these enablers has been variable at the state level, and therefore we have progressed local development in line with state objectives.

6.1 eHealth

The use of eHealth and other emerging digital health technologies are recognised as key mechanisms to enable the sharing of patient records between different service providers. The increased availability of complete patient information has the potential to improve patient care, improve the effectiveness and efficiency of service delivery and assist in the tracking of health care performance.

The roadmap for the delivery of eHealth across NSW was made available in 2014 for delivery over the following three years.

The implementation of HealtheNet and the provision of electronic health records and secure messaging ability were identified as being essential for the delivery of functional elements required for improving patient management. However uncertainty around the NSW Health eHealth implementation timeframe for both software and hardware requirements required us to progress development activity.

The key eHealth elements required for the establishment of local demonstrator sites have included:

- the use of PCEHR to share health records (i.e. upload of patient Shared Health Summaries)
- an industry standard clinical data audit tool (PENCat) to enable sharing of anonymised data through
  - being able to provide linkable patient data to an agreed data repository
  - use of telehealth
  - providing anonymised practice patient data to a secure Quality Improvement portal for the purposes of KPI monitoring and reporting, risk stratification, providing analysis and feedback to the practice
- a shared care platform is a key enabler. We reviewed three tools before selecting cdmNet as our preferred option for a 12 month period. Varying results have been achieved in implementation across the local demonstrator sites:
  - The tool has worked well in Cowra with smooth integration achieved across existing software and workflow at the medical centre and multidisciplinary providers
  - In Molong an existing shared single electronic health record was already in use at the HealthOne site. Therefore the new shared care platform was not seen to be beneficial.
  - The local demonstrator site in Wellington was unable to implement cdmNet as it does not integrate with their existing practice management system.

We intend to retain cdmNet where it is working well, however we will also offer an alternative option for second wave demonstrator sites.
Intensive integrated care program resources have been required to support the identification, development and implementation of the necessary tools. The Integrated Care Strategy covers the costs for:

- The annual licencing for PEN Cat
- The data cleansing tool fees
- The Quality Improvement Portal
- PHN staff to assist with extraction, cleansing, reporting and analysis of the data

### 6.2 Risk stratification

The ability to stratify patients by risk, thereby identifying who in the population is most likely to benefit from targeted interventions, is an important aspect of maximising the benefits gained from the local demonstrator sites.

In Western NSW we have developed simple risk stratification tools informed by international evidence and tools utilised in New Zealand chronic care programs. These have enabled us to segment local demonstrator site populations into the very high and high risk categories as shown in Figure 10, and enabled different care models and care plans to be developed for the identified populations dependant level and type of health care need.

![Figure 10: Population stratified by risk and their associated intervention model](image)

Specifically we have applied risk stratification tools to identify:

- those in rural communities who are at a high risk of poorly controlled chronic illnesses and/or high utilisation of secondary and tertiary services over primary care, and hence most benefit from a formally integrated model of care
- those within their communities with mental health issues who have a history of resistance to service intervention for whatever reason.

We have identified and successfully implemented a process to combine hospital and general practice data to improve the accuracy of the patient risk assessment.
A key requirement for successful risk stratification is ‘clean’ practice level data. Data extraction and cleansing has been a complex component of the establishment process for the local demonstrator sites. This has required intensive support resource from the Integrated Care Strategy including the use of ML practice support staff and dedicated project managers for each local demonstrator site.

6.3 PRMs including real-time patient feedback

The Strategy aims to achieve improvements in patient experience, health outcomes and quality of life. Tracking PRMs and using real-time patient feedback provides insight into the patient experience and improves the provider’s understanding of areas where their service can be improved, or even highlight actions having unintended consequences.

Since May 2015 PRMs have been collected in Western NSW using a tool developed in conjunction with ACI. To date, 132 patients enrolled in the integrated care program have completed their baseline survey. They will complete follow-up surveys annually and the results will inform program evaluation. In the meantime, the responses of each patient are being provided back to their primary care provider to be used in discussions about their care.

Western NSW is also participating in the piloting of electronic tools for collection and real time feedback of PRMs being led by ACI.
7. Conclusion

The establishment of the Strategy and in particular, the development of new models of care at five local demonstrator sites across Western NSW LHD, has at times been challenging, but it is something we are all proud of. We believe that our community and the providers in Western NSW are seeing and experiencing the benefits of an integrated model of care.

As shown in this report each local demonstrator site has faced its own challenges and all are continually assessing and adjusting the features of their delivery models to best meet the needs of their population. Establishing the 1st wave sites reinforced the importance of both provider readiness and their commitment to developing and implementing innovative integrated models of care. The importance of identifying and supporting local clinical leaders who are committed to innovative service design cannot be emphasised enough.

The intensity of resources required to support local planning and action has been considerable and in some areas, underestimated at the outset. Key learnings for us has been the need for early engagement with providers; clear criteria for participation being agreed between ourselves and new local demonstrator sites; and a collaborative planning process with clinical leaders to ensure realistic goals are set within available resources.

The successful establishment of the HIU is an exciting step, not just for integrated care, but for broader health care planning. Having a single point of contact across the district and providers to collectively access, analyse, and interpret health care data is key to being able to use health information intelligently. The shared responsibility and governance commitment of each participating organisation is a testament to the importance of the work.

We consider that the learnings outlined in this report are transferable to other contexts, with appropriate tailoring to local environments. An example of this is the work we have undertaken in developing and implementing a risk stratification tool at the local demonstrator sites. Similar work has been undertaken by other health care organisations and it would be valuable to share the experiences and learnings coming out of this process. We welcome further opportunities to share learnings across districts.

Next steps

Given the evolving nature of a demonstrator site, progress against the original Strategy has been variable across the range of activity as outlined in this report. Therefore in June 2015, we engaged Ernst & Young (EY) to undertake an independent review of progress against the plan to inform our decision making process with regard to confirming priorities for 2015/16, and the subsequent development of the 2015/16 work program. The review identified a number of key areas of focus for 2015/16 including:

- Progressing HIU functionality and capability to support performance improvement
- Ensuring a consistent integrated model of care that delivers change and health outcomes
- Implementing effective IT enablers that support making the right thing to do the easy thing to do
- Developing business and remuneration modelling that supports general practice decision making to participate in integrated care
- Enabling rapid and effective transferability of the integrated care model across district and State.

We have incorporated these findings into our 2015/16 work programme and are well down the track of planning for, and implementing the second year of the Strategy. We are now gearing up for the establishment of the 2nd wave local demonstrator sites. These will have the advantage of the learnings from the 1st wave local demonstrator sites and will also create their own learnings that can be transferred within and beyond the Western NSW region. We look forward to continuing to provide the opportunity for our community to participate in integrated care delivery, and to continue to grow relationships with health professionals and service providers across Western NSW.