

INTEGRATED HEALTH MOVING TO THE FUTURE

FORUM REPORT



Report from the Integrated Health – Moving to the Future Forum

Held on Wednesday 5th April 2017 at Rosehill Gardens, Rosehill

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Executive Summary

The Western Sydney Local Health District hosted the Integrated Healthcare “*Moving to the Future*” Forum in April 2017. The purpose of the forum was to continue the discussions and practice of integrating care and to inspire and motivate clinicians, partners and consumers to take Integrated Care to the next level in western Sydney. The high calibre key note speakers set the bar high.

Sir John Oldham from the UK highlighted our key challenges – obesity and the chronic disease burden, noting that the most significant issue we face is that multiple morbidities are now the ‘norm’. Our current model of sub-specialist treatment ‘silos’ will not be sustainable for managing multiple conditions. The role of citizens in the management of their condition will become increasingly important, and they will need to be supported in this.

Professor Don Nutbeam highlighted the critical role of health literacy in consumers understanding their health condition, and supporting them to take responsibility to manage their health. It is anticipated that 60% of the general population have poor health literacy, and in western Sydney, these rates are likely to be poorer, with “cultural” literacy also a factor. Education, support and quality communication with consumers is required. “Teach back” is shown to be a successful method to ensure patients understand clinician’s advice. Communication between providers is also required.

Ultimately the goal of patient care is to provide seamless care, which requires many service providers operating together with a common goal that puts the patient at the centre of all that we do.

This approach has driven much of the innovation in Canterbury, New Zealand. Carolyn Gullery inspired with the alliancing approach that has been developed to integrate systems so that programs of work can be delivered in partnership, irrespective of agency ‘borders’ and funding silos.

The panel discussions and interactive Q&A, expertly facilitated by the effervescent MC Julie McCrossin, provided rich examples and opportunities of ways to move forward in western Sydney.

All stakeholders at the Forum indicated an importance and priority around the alliancing work. Ambulance NSW, the Primary Health Network, state agencies such as the Agency Clinical Innovation and Clinical Excellence Commission, non-Government organisations, were all keen to work together on key priorities. Consumers highlighted the imperative to be included in these conversations. Areas of priority reinforced at the Forum were early years (0-5 year olds), frail elderly and people with chronic conditions.

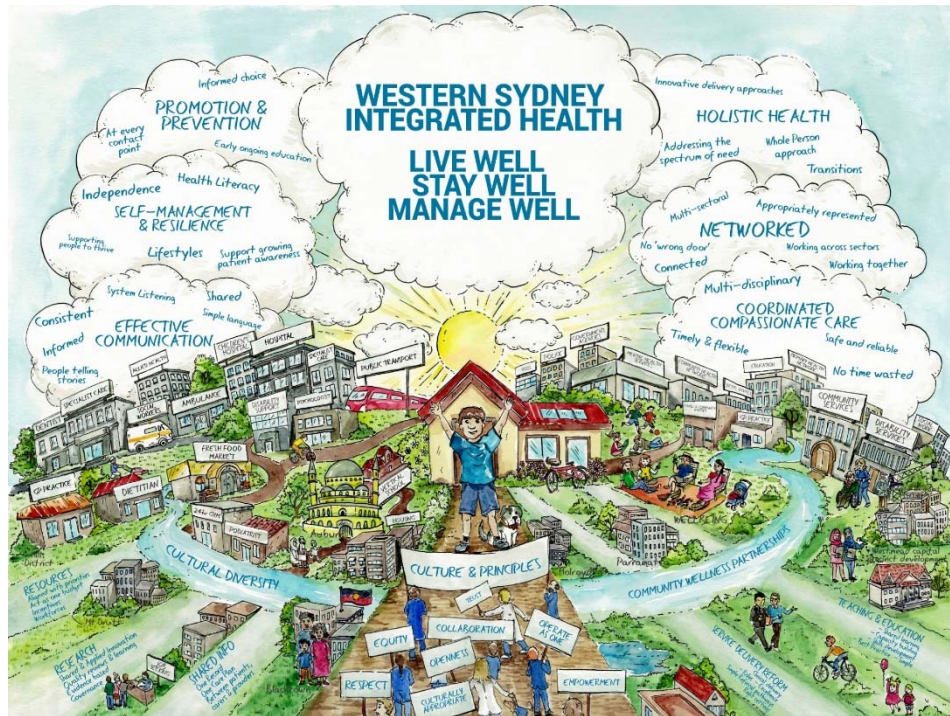
Western Sydney Integrated Health Partnership Framework

These agreed priority areas align well with the work currently underway in Western Sydney as part of the Western Sydney **Integrated Health Partnership Framework**. The Framework outlines how current and future partners will work together around five main priority areas – child, youth and family, chronic and complex conditions, mental health, Aboriginal health and older person health.

Five Steering Committees have been established for each priority area, to identify the agreed outcomes and oversight the activities to reach these goals. The committees report to the Western Sydney Partnership Advisory Council (WSLHD, WWPHN and SCHN). This forum provided another opportunity to expand on the work of the western Sydney Integrated Health Partnership Framework and to harness a broader range of stakeholders, including consumers, ACI, CEC, Ambulance and other partners to consolidate towards a multi-sector system alliance. Integrated and Community Health Directorate WSLHD will be an anchor point for the IHPF and ongoing discussions. Next steps are aimed at harnessing the motivation, inspiration and good will generated on the day.

We invite all partners to join with us to continue the journey of improving the health and wellbeing of people living in western Sydney.

***The path to integrating health is a journey.
It involves consumers and service providers in partnership***



Let's keep the conversation going in western Sydney to realise our vision

1. FORUM OVERVIEW

Forum details

The **Integrated Healthcare - Moving to the Future Forum** was held on Wednesday 5 April 2017. It was an all-day event, held at Rosehill Gardens, Sydney in the Grand Pavilion.

Organiser

The forum was hosted by the Integrated and Community Health Directorate of Western Sydney Local Health District (WSLHD), and sponsored by Western Sydney Primary Health Network (WSPHN), NSW Clinical Excellence Commission (CEC) and the Agency for Clinical Innovation (ACI).

Facilitator

The effervescent facilitator of the day was Julie McCrossin, the well-known Consultant Journalist and Broadcaster delivering a successful Q & A format



Welcome to Country

A warm welcome to country was delivered by Kerrie Kenton

Speakers

There were three keynote speakers on the day:

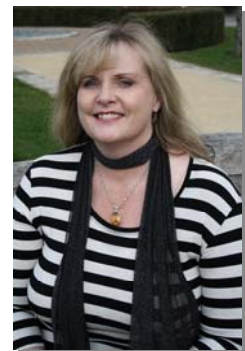


Sir John Oldham

Sir John is the National Clinical Lead for Quality and Productivity at the Department of Health in England and a member of the National Quality board for the National Health Service.

Carolyn Gullery

Carolyn is the General Manager, Planning & Funding, Canterbury District Health Board & West Coast District Health Board, in New Zealand



Professor Don Nutbeam

Don is Professor of Public Health at the University of Sydney, Senior Advisor at the Sax Institute and for Sydney Health Partners.

Partners / Sponsors

The three main partners and sponsors for the forum were the NSW Agency for Clinical Innovation, The Clinical Excellence Commission and the Primary Health Network, Western Sydney.



The audience of over 250 delegates comprised Western Sydney consumers, clinicians from primary and secondary care settings, ambulance NSW, health service executives and managers from WSLHD and other LHD's, academics, policy makers and representatives from partnership organisations, other government agencies, peer support networks and NGOs.

A key success factor of the day was the effective engagement of and representation from Consumers who spoke throughout the day across each of the Speakers topics.

The Vision

The vision was to provide a vibrant, engaging forum for actively discussing opportunities, innovation and potential initiatives to “move integrated healthcare into the future” in collaboration with consumers, clinicians, decision-makers and partners from a variety of health, social services and related settings.

Overarching themes

The themes of the forum were:

- How to achieve system change without breaking it
- Creating healthy communities – how do we create an environment which facilitates everyone to do their job
- Improving clinician-consumer alliances
- Triple/quadruple aims – achieving a balance
- System and policy solutions

Style / approach for the day

The delivery of the forum was intended to be interactive, dynamic and engaging with Julie McCrossin's question and answer (Q&A) approach to elicit key messages from a range of speakers, stakeholders and subject matter experts.

Live polling with “Slido” was used as a participant engagement strategy, along with livestreaming, supported by the Agency for Clinical Innovation (ACI).

2. BACKGROUND AND RATIONALE

Western Sydney Demographics

Western Sydney is the fastest growing community in Australia, with about 930,000 people set to approach 1 million by 2020. It has a diverse cultural mix with up to 65% of the population born overseas in some areas and 45% speaking a language other than English at home. There is a large number of refugee families and over 13,000 Aboriginal and Torres Strait Islander people living in the area. Western Sydney has the highest birth rate in Australia with about 14,800 babies born each year in the area with around 10,000 in public hospitals. There has been a 40% increase in residents aged over 65 since 2011/12.

Economically and socially, Western Sydney is an area of great disadvantage with 17% of the population in the most disadvantage SEIFA decile. This is also reflected in the unemployment levels and the high concentration of public and social housing in the area. As a group, Western Sydney residents have the lowest percentage of Australians participating in adequate physical activity and some of the highest levels of obesity in the country. Twelve percent of the population have high or very high level of psychological distress. Health literacy (and indeed general literacy) is extremely low. The prevalence of diabetes, cardiovascular and respiratory diseases is growing, resulting in an increasing burden on the health system.

Western Sydney Local Health District

Western Sydney Local Health District (LHD) manages 5 large public hospitals, a dozen community health facilities and numerous outpatient clinics across Western Sydney. Given the socio-economic disadvantage and extent of health needs, the WSLHD recognises and prioritises the importance of engaging with the community to improve the health and wellbeing of its residents.

“Burning Platform”

With this context of demographic and health-need in mind, the vision for the forum was to explore how health integration could move to the next level, engaging all health sectors in delivering services together to improve health outcomes and also improve the general health, wellbeing and health literacy of the Western Sydney community.

Danny O'Connor, Chief Executive of WSLHD, endorsed the forum via the following video message.

“We are committed to deliver integrated healthcare, wherever possible in partnership and in community-based models where the patient is at the centre of all that we do. Our western Sydney Partnership Advisory Council supports this with a shared governance around a tripartite partnership between WSPHN, WSLHD and SCHN delivering significant programs of work collaboratively. We have recently strengthened this shared governance with an Integrated Health Partnership Framework outlining new ways of working together in partnership to deliver improved outcomes for defined programs and services which speak to and promote our successes”.

3. PURPOSE AND OBJECTIVES

Purpose

The purpose of the forum was to engage health leaders, clinicians, partner agencies and consumers in, interactive, meaningful discussions to progress healthcare integration in western Sydney.

Objectives

With the presence of three eminent guest speakers, the objectives of the forum were to:

- o Hear about best practice in integrated care from an international perspective
- o Discuss how these approaches and ideas can be applied to current practice
- o Identify key opportunities that could be taken forward in partnership to improve health integration to benefit the community, patients and clinicians across different settings.

Ideally, key learnings from the day will be threaded into the local context to further develop and build solid actions which can be implemented and tested in western Sydney primary and secondary environments.

Ultimately it is anticipated that the outcomes of these efforts will include:

- o Improving partnerships, community engagement
- o System and policy solutions
- o Supporting high-need populations
- o Creating healthy communities

4. PROGRAM

4.1 Opening welcome

The opening welcome was delivered by Prof Jeremy Chapman (WSLHD Board Member) on behalf of Danny O'Connor the Chief Executive from WSLHD, and Walter Kmet, Chief Executive from the Primary Health Network (PHN). The focus of their discussion was to identify common causes, shared narrative and the success factors that will drive innovation and integration of services in Western Sydney.



4.2 Program Overview

The three international guest speakers provided a total of 4 presentations, each with a focus area to inform the discussion about integrated care challenges and opportunities. Presentations included:

1. **Sir John Oldham**
How to achieve system change without breaking it
Triple/quadruple aims – achieving a balance
2. **Carolyn Gullery**
Creating healthy communities through alliancing
3. **Prof Don Nutbeam**
Improving clinician-consumer alliances

Participant Discussion

The presentations were followed by table discussions with structured questions to highlight patient experiences and opportunities for improvement; as well as identifying an extensive list of possible stakeholders and key partners for future engagement around health care integration (refer Appendix).

Panel Discussion - System and policy solutions

The final session was a lively, highly dynamic session with Julie McCrossin interviewing a range of clinicians, managers, consumers and partners. Some of the trigger questions she asked people included:

- Why is integrated healthcare important for the future of the people and health services of western Sydney?
- What will you do with the key messages and ideas you receive from the participants today?
- Given the constraints around resourcing, what is one solution you could take away and implement tomorrow?

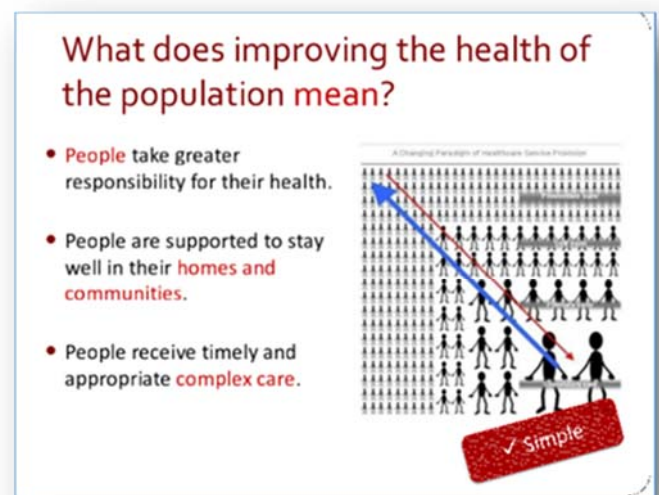
Conclusion

In closing the forum, it was clear that there was high enthusiasm and optimism about progress that could be driven in partnership across a number of key focus areas. It was intended that some of these opportunities would be prioritised on the day, utilising the opportunity to canvas the large cross-section of participants attending the forum. However, while enthusiastic discussion left insufficient time to do this, a clear outcome was the resounding endorsement to harness the positive energy of the day and to continue to progress work in this space.

5. KEY MESSAGES from the speakers

Sir John Oldham commenced the opening address with a stark picture of the 'tsunami of need' from an ageing population, and highlighted that the main challenge into the future will be the management of **multiple diseases**. This will be a particular challenge for our current health structures which tend to focus on single organs ("body parts") or conditions. Sir John's advice was that **specialist knowledge will need to be "pooled"** in future, not further siloed.

A critical success factor in managing multiple diseases will be how we focus on **keeping people well**, and **increasing the capacity of people to take responsibility for their health**. Citizens need to be supported to become meaningfully involved and motivated in their self-care as active participants of the care team. They need **the earliest possible access to treatment and intervention** when and where they need it.



**Delivering the right care, at the right time,
in the right place, by the right person.**

To support this, we need to create a **more health literate population in western Sydney**. Our health services and health facilities **need to be patient, consumer and family friendly**. Professor Nutbeam is

leading the way for this internationally and at a local level in WSLHD, with the creation of a world's first "Health Literacy Lab / Hub", a **laboratory for learning** about how to engage and work effectively with our diverse communities in western Sydney.

Additionally, the integration of services is critical to support citizens to stay well, and manage multiple diseases. Having **clarity about what it is that we want everyone to do to achieve integrated care** will be very important in achieving this goal.

Strong planning is required. Carolyn Gullery inspired many with the proven track record of achievements in integrating care in Canterbury, New Zealand. Her sage advice was to **establish an alliance, framework focused on a shared vision, and guided by a common way of working** with a common language. She also suggested identifying a key area of need in our local population – be that the frail elderly, the very young – and then ensuring that managers support the staff who will be required to work in new ways, bringing changes to practice to get on with the job of 'doing' things differently and collaboratively within a flattened, relational structure. Trust will be key for this initiative.

Carrie Marr from the Clinical Excellence Commission summarised an important outcome of the Forum. There is a real opportunity to start a **virtual alliance in western Sydney, inviting Commonwealth colleagues to start a conversation** and look at how that could help accelerate what and where WSLHD wants to progress in healthcare integration.



The appetite for change was palpable on the day, with health services, partners and consumers eager to continue these conversations and act to take integrated care to the next level.

6. ISSUES that would benefit from an Integrated Care approach

A number of issues were identified throughout the forum presentations, and these will need to be understood and addressed in order to bring about changes to the way we approach care integration.

Obesity

Sir John highlighted that in King Henry's time, the only people who were overweight were rich; now, the converse is true. And the western Sydney population is particularly affected.

Chronic disease burden

Not only is the huge weight of chronic disease mounting, there is an increase in the presence of multiple conditions. Alarming statistics from the UK, with similar patterns in Australia, show that the majority of people over 65 have 2 or more chronic diseases; and the majority of people over 75 have 3 or more chronic diseases. **More people have 2 diseases than have 1.**

System response to health need

To date, the system response to chronic disease has been to treat patients as single, isolated body parts. However, **disease specific pathways are a redundant strategy** for this particular future where multiple diseases are the norm. A single disease focus will now only work for 19% of the people we are trying to help.

To address this, patients need to be at the **centre of care**. And their healthcare needs to be **risk stratified**, so the demand for healthcare services within finite resources is better targeted, to ensure the right person gets the right care in the right time and place. **Partners need to be empowered** to deliver care where it is needed – e.g. ambulance, Residential Aged Care facilities (RACF), community-based health and social services and GP's. And **funding systems** need to start incentivising the right outcomes.

Good service and support networks are needed in the community, and then specifically for **culturally and linguistically diverse** populations, especially the temporary migrant community, who have even less connections and less entitlements and the indigenous population who already have significantly poorer health outcomes when compared with the broader population.

Consumers

In the UK experience, and presumably echoed in Australia, the voice of the consumer is clear: "I want you to treat the whole of me and I want you to act as one team".

Care needs to be delivered as **close to the patient's home** and community as possible, so that patients only go to Hospital when they need to.

Health literacy

And to support this, people need the information and skills **to make decisions about their health and apply them**.

Health literacy matters

- in a health care system where there is
 - need for more effective prevention,
 - commitment to patient centred care, and
 - greater than ever dependence on patient self-management of chronic conditions.
- There is a strong social gradient in the population, with lower levels of health literacy much more common among the socially and economically disadvantaged.
- Those with greatest need are generally least able to respond to the demands of the health care system
- **Business as usual will do nothing to address differential health outcomes from clinical care, and may exacerbate inequalities.**

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7. APPROACHES to Integrated Care

So what approaches should we be considering to start tackling these issues? The three speakers provided a number of ideas to guide this.

Evidence-based approaches

We need to be looking to the evidence to inform the approaches for how we manage people with multiple conditions. Sir John presented a summary of outcomes from the UK **integrated team approach**. This included improved health status, reduced weight, improved diet, people living independently in their own homes for longer, improved symptoms and behaviours, improved health status and mental well-being, and improved outcomes improved for lower cost.

Professor Nutbeam also presented on adopting and adapting interventions that work in health care settings. A review of outcomes by Sheridan et al in 2011¹ showed that **low health literacy can be improved through modification to communication and mixed-strategy interventions** – i.e. combining adapted communications with behavioural skills training. Simplified text and **teach-back** methods have

¹ Sheridan et al (2011), Interventions for individuals with low health literacy, a systematic review. Journal of Health Communication, 16.

been proven to be effective in **reducing the ‘literacy demand’** to access and use of services. A key challenge in health design is to make names of services more meaningful and easy to understand and follow – e.g. ‘ambulatory care’ is not well understood to represent outpatient care. We need to be clearer organisationally and across our health system in conveying messages to our consumers and communities.

Whole person care

Sir John presented an approach based on “whole person care” with clear expectations of what that would mean for a client:

- o I shape my own care around the **outcomes that matter** to me.
- o I and my community have a **real say in our local services**.
- o I understand more about my problems, **staying healthy**, and **what I can do for myself**.
- o **My experience of a service matters** to those who pay for it.
- o Everyone involved in my care knows **my goals** and **works together as one team**.
- o I receive **more care in my own home** and the community.
- o I own **my own health and care information** which is shared with my permission.
- o I have **one person acting for me** to make the system work.



This approach was then used to **orientate the system to meet those needs**, instead of the system driving what it thinks the client wants.

Consumer-focus

Related to a whole of person approach, is the need for a consumer-focus. The three speakers all emphasized the importance of this, and Sir John summarized it well:

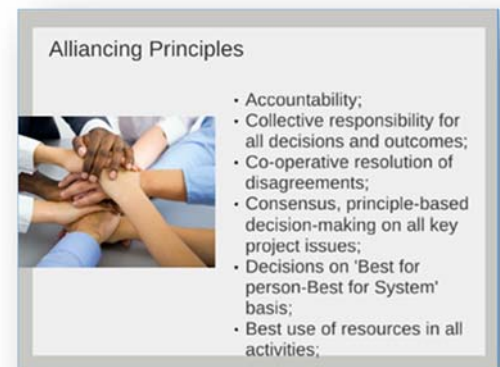
“Nothing we try in the name of integrated care will work if we are not doing it by, for and with the needs of our community - as citizens, as consumers of our health services, and other services and as patients in the healthcare system” - Sir John Oldham

And additionally, **we need to do things with patients who are not in front of us**. If we want to effectively reduce the chronic disease burden, we shouldn’t be waiting till people get sick and turn up at the door of the health system; we actually need to be planning and reaching out to them, and **involving them in their healthcare before they get sick**.

Alliance approach

In an alliancing model, the energy and resources that would otherwise be spent on competing with each other or duplicating efforts, are used instead to benefit the system and the consumer. **The alliance aims to wrap care and services around the patient, and the multi-disciplinary care team could come from anywhere** to support that.

An alliance approach establishes a **clear decision-making framework** that outlines the roles of each organisation, and how they will work in partnership to deliver coordinated care.



And this is often not about dictating STRUCTURAL change but instead is engineering BEHAVIOURAL change between the existing organisations. An alliance is a relationship-based contract, whereby you are contracting for behaviour around shared decision-making. And **relationships “trump” structures every time.**

This approach needs to have **leaders understanding and committed to driving change**, and **governance** which gives security when there are different funding streams, and different reporting lines.

A **high trust, low bureaucracy** environment is the goal, with **process mechanisms** to support accountability, quality, service development and innovation through shared resourcing and funding – the idea that the ‘right staff’, irrespective of the organisation by which they are employed are appropriately deployed as a shared resource to collaborative programs of work. Funding of course is moved about in the background but never a key factor in prohibiting the progression of collaborative work.

“An alliance approach is about having a shared vision, shared values, agreed outcomes and principles, transparent processes and information sharing” - Carolyn Gullery

The alliance also sets out to build a platform of programs.

In Canterbury, New Zealand, there are a range of programs that are delivered through an alliance approach, including Health Pathways, care coordination, Whole Restorative Home Support model, CREST, Acute Demand Management service, access to social services, electronic risk management system, and the shared health record. All of this supports the citizen and their general practice team to get the **right care in the right place at the right time.**

In Scotland, 300 leaders from every public agency across the whole of the country made a pledge to improve the lives of every child before the age of 5. These agencies included Fire, Police, Government, Health, Housing, Employment, Education and other services all committed to a common purpose, **pledged to improve together, not separately or in a duplicative way**, across their organisations.

Other examples include the creation of **‘virtual alliances’ and collective leadership**, bringing together an alliance of people around areas like **‘early years’, frail elders and long-term conditions.**

8. STRATEGIES to support Integration of Care

A person-centred, alliance approach needs to be underpinned by a range of strategies, with a number of those presented providing much inspiration.

Integrated health, integrated care and integrated systems

In order to deliver integrated health and integrated care, we need to start integrating the systems that will drive and support this work. **Service integration** includes the development of **effective alliances**, with clear objectives and transparent **drivers (societal and financial)**, **effective goals** that all healthcare providers are delivering, and supported by **effective information systems**.

*“We need to integrate all of the isolated efforts that we are currently contributing, into a greater **framework**” – Carolyn Gullery*

In Canterbury New Zealand, **service integration** is based on **trust** and a shared **vision**, and a system that is connected by relationships, IT, information flows, and is centred on the **patient**. The unifying metric is to **reduce the amount of time a person wastes waiting for the next step** in their journey to health. The system has been **enabled** and re-oriented to support **people taking greater responsibility for their own health and giving them the tools to do that**. And as a result, **a lot of things happen now in general practice that used to happen in a hospital**.

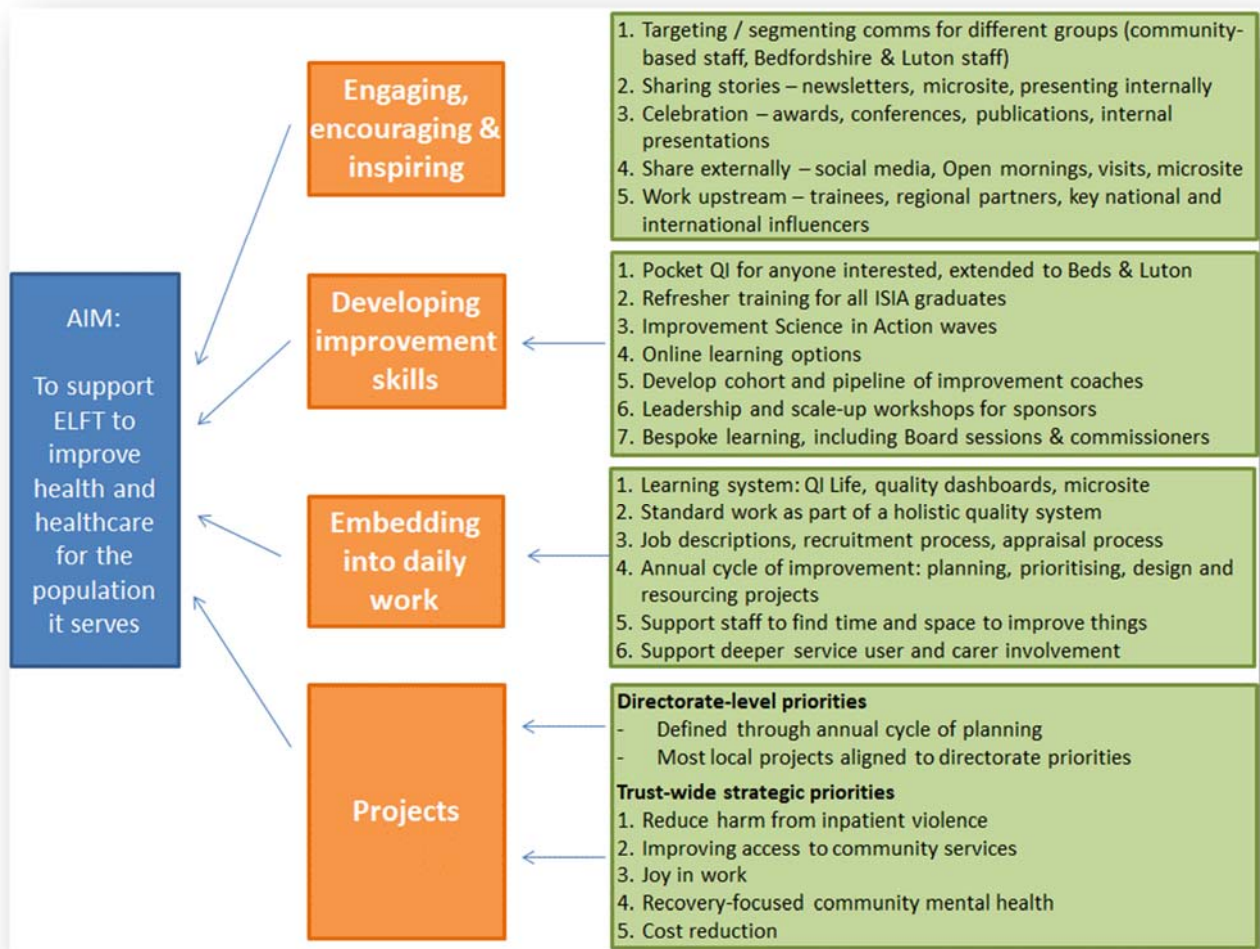
“Clients don’t get to a hospital at all unless what they need, needs a hospital” – Carolyn Gullery

In the UK, **integrated local care teams** have been established for populations of around 20,000-30,000. The purpose isn’t about recruiting new positions to coordinate care. Instead it’s about **harnessing existing employees and supporting and deploying them to work better together in a different way**. The range of service providers working collaboratively includes home care, community services, allied health professionals (physiotherapists and occupational therapists) and general practice. **Specialist expertise is accessed as and when necessary**. This is not about diluting the necessity of “specialism”, but it is about **pooling specialist expertise for the bespoke knowledge of individuals**, rather than keeping them in silos focused on body parts.

*The Integrated Care Team asks the client “**what matters to you?**”...
NOT “**what the matter with you is...**” – Sir John Oldham*

Service Improvement culture

The **culture of the teams** and the organisation needs to be embedded with a patient-centred approach, from the reception staff through to the whole team. This is **the quadruple aim** where staff are engaged positively in their role, and where **service improvement** is built into all aspects of the system. **Training people in quality improvement is a key strategy to deliver integrated care**. Sir John presented a framework for this (below) which embeds quality improvement in all areas of the service



Risk stratification

Systematic risk profiling of the population identifies those people in the community who are most at risk of going in and out of hospital. Using **risk stratification** enables services to then provide a targeted response – providing the **right care, in the right place, at the right time** to those most at risk. And the **consumer has a role to play** in saying to clinicians “I’m going to tell you what’s wrong with me, then you’re going to tell me what you’re going to give me”.

The process of risk stratification is a key strategy used by Care Facilitators in the Integrated & Community Health Directorate.

Co-management

The goal is **to maximise the number of people who can understand and co- manage their conditions**, through a systematic transfer of knowledge, and care planning.

Over the course of a year, a person with multiple chronic diseases, spends only a very small proportion of that time (3-4hrs/year) interfacing with health professionals. Yet most of our effort, energy and investment is on the health system.

Would it not make sense to invest in the patient and the 8000 hours they spend on their own self-managing?

Results of co-management

(ref: www.nesta.org.uk)

- Decreased A&E attendances
- Decreased hospital admissions
- Reduced length of stay
- Reduced consultations
- Reduced costs up to 20% (£4.4 billion in England)

In the UK and New Zealand, people are being supported to stay well and healthy in their own homes, through community-based models supporting patients at home. Within this same context, health literacy in itself, is beginning to emerge as a key determinant of health which must be improved in order for self-management to be both possible and effective.

9. ENABLERS of change

Along with the strategies noted above, the speakers also identified a range of enablers and programs which support and provide focus for the integration of care.

HealthPathways

In Canterbury NZ, the HealthPathways program underpins the whole healthcare system. As a decision-support tool, HealthPathways is not about disease-based pathways, clinical protocols, or business rules; it's a pragmatic system that **shows the clinician what resources are available right now to meet the needs of the person in front of you**. It is so pivotal to how care is delivered in Canterbury that they can change their whole health system over night by changing the HealthPathways, so everyone knows tomorrow "oh, we're doing things differently" – the capability to change entire models of care in a way that can be broadly communicated, understood and followed by clinicians, services and organisations.

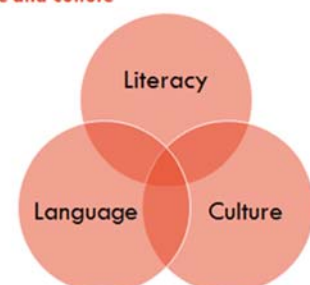
Health literacy

Professor Nutbeam challenged the audience with the question **"why won't our patients do as we tell them?"**

Statistically, the ABS estimates that about **60% of the general population** have **inadequate health literacy** skills. So patients may well **not understand what we are asking of them**. **Culture and language** are two really significant societal factors that can also influence a person's ability to obtain, understand and apply information to make good decisions about their health. Poor health literacy is also greatest among **older Australians**, for a whole range of reasons.

But this isn't the only barrier. The way in which we organise **the healthcare system often reduces peoples' ability to be able to find out things, understand them and apply them** in ways that benefit them. And this issue will increase as we move towards a **greater**

Reason 3: Understanding is mediated by language and culture - health literacy is inextricably linked with language and culture



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dependence on patient self-management, and on active patient engagement in health care, particularly in chronic conditions.

Those with the **greatest need** in our system are generally those **least able to respond** to the demands of the system that we create. People with lower levels of literacy are much less responsive to **traditional health communications** of all kinds. They're **much less likely to make use of available prevention services** – screening services, immunisation and so on. And people with lower levels of literacy are **less able to successfully self-manage chronic disease and engage in a partnership** with their clinician.

So we need to help people to **develop these skills**, and **create a system that respects them and enables them** to use these skills to make good decisions and become motivated about their health. It's not just the delivery of information that is needed to address this; **we need to have a dialogue**.

"This really matters in Western Sydney where we have an extraordinarily diverse population, and it's something we have to take account of in the ways in which we set up our system, and manage our communications and interactions with the community here" – Prof Don Nutbeam

Communication

Closely linked to this is improved **communication and education**. The more interactive and the more personalised the communications and messaging, the more likely it is that someone is going to be able to understand and act on what we are trying to communicate.

Where we can, we should try to create as many structured opportunities for people to develop their health literacy skills as possible. Through **modified communications** we can achieve much better medication use, more successful self-management of chronic conditions, reduced reported disease severity, reduced unplanned emergency department visits, and reduced hospital use.

Behavioural skills coaching is also important to get people to practice what it is that we want them to do. **"Teach-back"** is another valuable tool that enables a clinician to check that a patient has understood the information that has been given to them, by asking the patient to repeat back their understanding.

Communication also needs to drive a message to the community about **improving our health as we age**. We need to communicate that **with effective advertising campaigns that target issues at an earlier point**.

Health outcomes can be improved through better communication

- In clinical practice, there is broadly consistent evidence* that comprehension of health information among individuals with low health literacy can be improved through modifications to communication, and changes to the clinical environment
- These deliver improved health outcomes including
 - Improved medication use
 - Improved self-management of conditions
 - Reduced reported disease severity,
 - Reduced unplanned emergency department visits, and
 - Reduced hospital use

*Sheridan et al. (2011). Interventions for individuals with low health literacy: a systematic review. *Journal of Health Communication*, 16(s3): 30-54.

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Teach-back – four steps to improving patient understanding and successful adherence with medical advice.

1. **Clinicians must accept the burden of communication** - "I have covered a lot of information today and I want to make sure I did a good job of explaining this."



2. **The communication should focus on a specific behaviour** "Can you tell me when and how you will take this medicine?"
3. **The patient should be reassessed** and instructions should be explained again in a different manner as needed
4. **Clinicians should continue to explain** until both they and the patient agree that the information has been understood.

The University of Sydney

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Capacity building

An important integrated care strategy has been the **investment** – of time, money and staff - by the Local Health District **in chronic disease specialties** so they can deploy teams to **build capacity in primary care**. Education and decision-making support assists General Practitioners and primary healthcare workers to handle more complex cases. For example, investment in the Western Sydney Diabetes Initiative (WSDI) has resulted in a range of capacity-building strategies such as specialist case conferencing in GP practices to support the appropriate discharge of patients from the acute setting back into the care of their GP's who are supported by a number of mechanisms in the ongoing management of these patients.

Funding systems

An ongoing challenge for our health system is the current arrangement of **Commonwealth and State funding**, but the speakers all challenged us to consider ways to work around this. We also need to address **financial disincentives**, where current funding mechanisms for acute services (e.g. activity-based funding structures) may act as a barrier to change. If the financial incentive for the different organisations you are wanting to work with are pulling in different directions, then this will be an obstacle, irrespective of the goodwill to bring about change. In fact, the New Zealand experience is that **how** you fund health services actually has more impact on health service delivery than **how much** you fund.

In order to address these funding challenges, the focus should be on an **open and transparent process**, so it's clear what resources are available, and partners can **collectively make a decision** about where those resources need to go, with those funding mechanisms being as simple as possible.

Consideration is also needed around **what is being funded**. In New Zealand, the focus of funding allocation is on **outcomes**. It is then the responsibility of the **alliance** (the Canterbury Clinical Network), to decide **what it is they are actually going to deliver to meet those outcomes**, and this is determined by **both the clinician and the patient**. There are **different funding streams** for the hospital, the community, primary care and other services **but collectively they all have the same population to deal with**, so together they have determined how they can distribute those resources in a sensible, collective way that improves care for people and outcomes for the population.

Information systems

Sir John bemusedly pointed out that most of the people we are looking after think **we share their information**, and are surprised that we don't! The sharing of data would obviously reduce duplication of effort and gaps in information-sharing, as well as support outcome measurement and service improvement.

Sharing data also ends **information asymmetry** because everyone can see the same thing, everyone is on the same page, and everyone is working towards a shared goal. Shared data also enables quick response to changes in demand. In Canterbury, data drives system redesign and they can respond very quickly as data is updated.

Giving people information in order to be able to manage their disease is also really important. And we need to be cognisant of the "Facebook generation" who will have very different expectations of how the system provides them with information. We need to shape the interaction with **social media** in order to provide more responsive solutions to information sharing.

10. OUTCOMES – what to measure for Integrated Care

A key challenge that was presented by the speakers was the need to focus on outcomes, and how best to define these.

Outcomes and impacts

Carolyn Gullery provided an overview of what *could* be measured and then prompted consideration about what we *should* be measuring.

Outcomes: The key goal is a well and healthy population, so these are **long term gains and aims** - reducing smoking and obesity rates, reducing ED attendances, reducing the time that people spend in aged residential care, reducing the number of people admitted acutely to hospital. These goals don't happen overnight.

Impacts: e.g. increasing diabetes management, reducing hospitalisations of older people from a fall.

Outputs: There is huge diversity and volume of outputs across programs, as this often relates to the activities undertaken by services. For example, number of visits, education sessions, and group programs.

Quality: Getting more productive is actually about doing the right thing, so measures need to ensure the quality of service provision is being monitored and managed.

What should we measure? Given the above options, it is important that the right thing is measured. Carolyn Gullery's advice was to consider the following:

"Are we meeting the needs of the population as effectively as we can within the resources we have available?" – Carolyn Gullery

'More' is not always 'right'

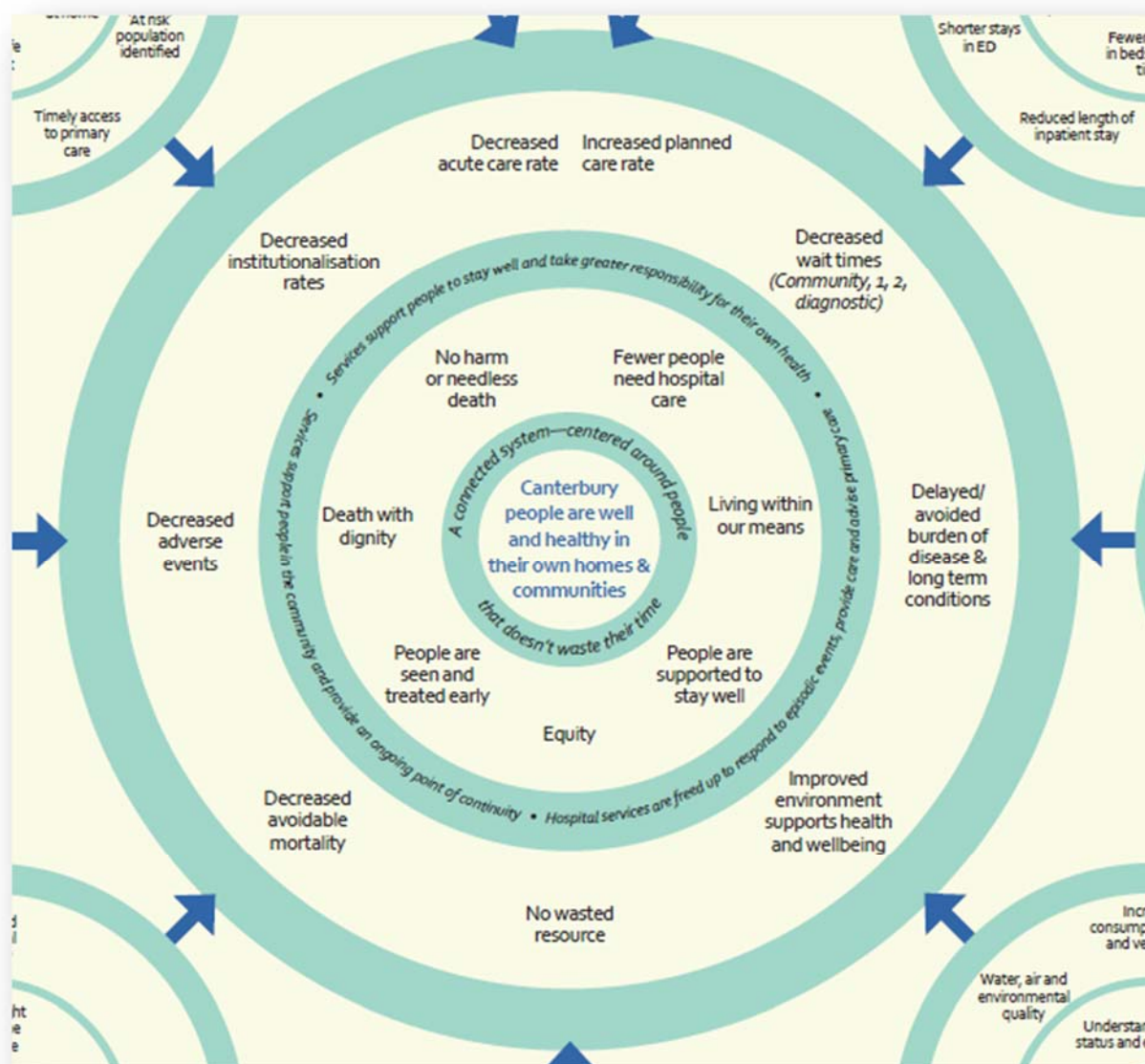
- Canterbury aims to provide the **right person** with the **right service** at the **right time** and in the **right place**.
- This does not necessarily mean delivering **more** outputs.
- All health interventions are a **balance** of **risk** and **benefit**

Shared outcomes framework

In Canterbury, a detailed Outcomes Framework² - refer to at link:

http://ccn.health.nz/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=3764&PortalId=18&TabId=1288 was developed which outlines key programs of work and how they are improving the patient experience. The Framework makes visible for people how their everyday activities are contributing to the outcomes for the system.

At the centre of the Framework is the **aim to keep people well and healthy in their own homes** and communities, delivered by a **connected system** centred around people, which aims not to waste their time. And this is underpinned by building services that **support people to look after themselves**, **designing services in a primary and community-based setting** with a single point of continuity and **releasing hospital-based services to support primary and community to deliver the right outcomes for people**.



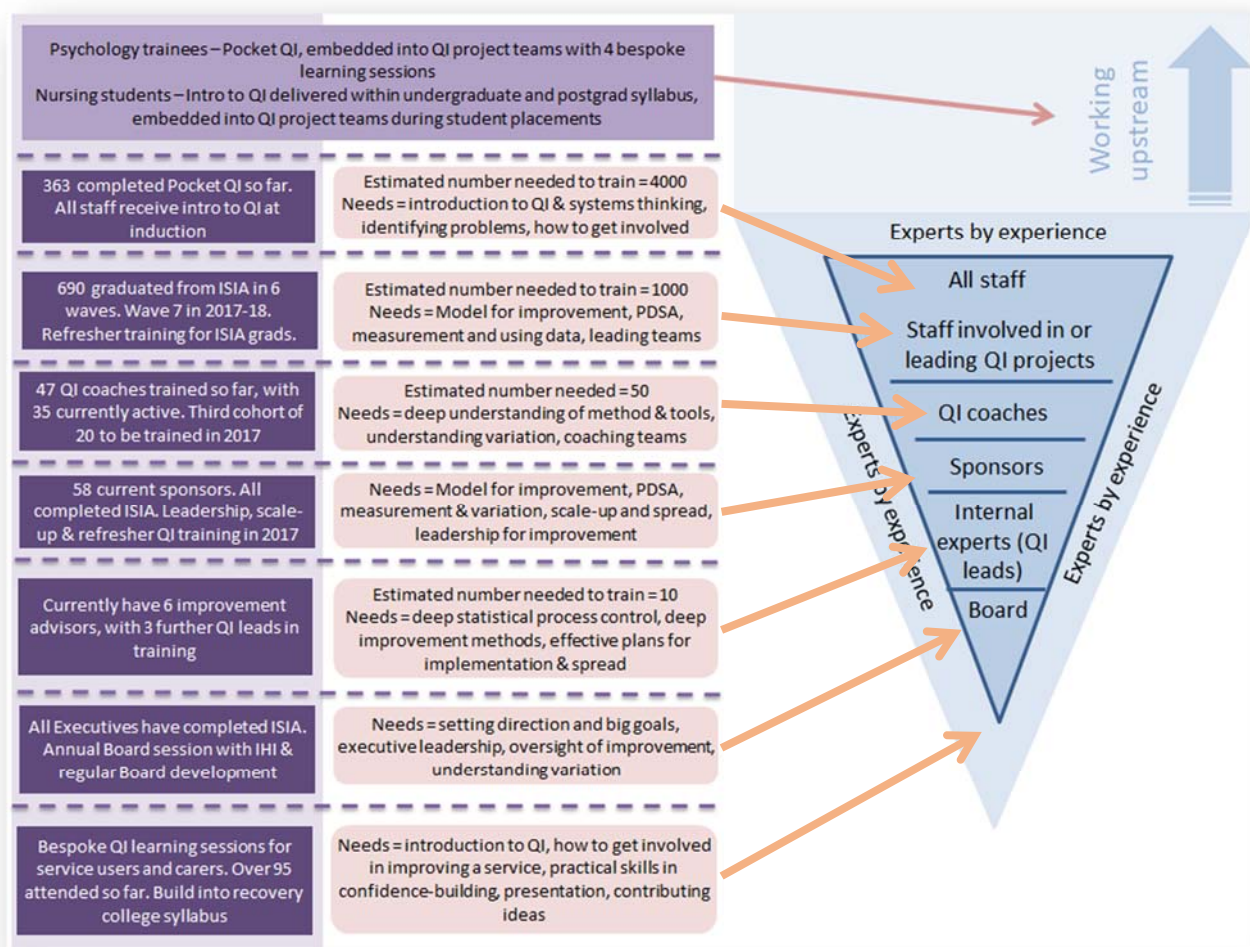
Triple aim/“quality trinity”

Sir John presented on the Triple Aim which is to **improve patient care outcomes, improve patient (and staff) experience and maximise resources.**

Quality improvement became a key focus to support these 3 outcome areas. The assumption was that in doing more of the right things, and less of the wrong things, then improved outcomes could result for patient care, patient experience and system expenditure. Some of the strategies included:

- o Quality goals were built into the annual business plan
- o Management systems were designed around a focus on quality and service improvement
- o Training in quality improvement was provided for all staff, including the Board
- o Quality groups were set up with a clear focus and committed resources
- o Started things and stopped doing other things

A quality improvement framework ensured these strategies were system-wide, supported all staff across the organisation including members of the Board, and were embedded in processes.



11. PROGRAMS OF WORK / INITIATIVES – examples from Overseas

A range of innovative programs and models of care were presented by the speakers, providing inspiration for exploring new and evidence-based programs for integration of care.

Falls prevention program.

In Canterbury, New Zealand, the **community-based falls prevention** program recognises when someone might be at risk of a fall and “triggers” a falls champion to step in and assist. As a result, over the last 4 years, **the program saved 1,862 ED attendances and 553 fractured hips, and 211 people less died**, post 188 days.

People who had a fractured hip received faster care, got to surgery more quickly, received **the right rehabilitation**, and there was a **decline in the death rate**. And there were **32,000 less beddays used**. The cost of the program is \$650,000 a year, with a saving estimated at **\$8million per annum in avoided orthopaedic surgery**. Additionally **the flow on effects** include people not coming to ED, not ending up in hospital and not ending up in residential aged care.

Ambulance

When data was reviewed in Canterbury, it revealed that Ambulances often bring people that don't actually need to be in hospital. So the model was changed to give **Ambulance direct access to general practice and direct access to the acute admission avoidance program, which resulted in reduced ED presentations** over time. The number of people calling ambulances hasn't reduced. But 30% of those calls result in the patient staying at home.

A similar profile of Ambulance use has been identified in Sydney, where **40% of the Ambulance case load is low acuity** and often can be better managed through either the GP or various other primary care providers. At the moment, **those patients are brought to ED**. But there is an opportunity to better utilise the **Extended Care Paramedics** who are helping patients to stay at home (e.g. catheter care, oral antibiotics, suturing) or directing them to the GP.

Another opportunity to improve care at home options involves the use of **Ambulance authorised care plans** and **authorised palliative care plans**. However, these are separate to other plans that the GP or specialist may have completed, and it is recognised that **inter-connectivity** is required to improve sharing of GP shared care plans.

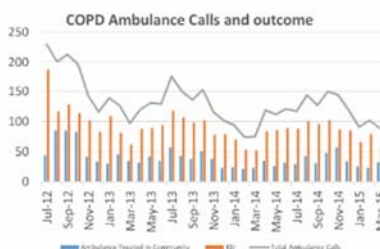
Canterbury NZ Example - Ambulance protocols for Chronic Obstructive Pulmonary Disease (COPD)

A model was introduced which **empowered Ambulance to trigger a response that is right for that person in their own home**. This involved a range of protocols to support decision-making as well as purchasing mobile phones to improve communication. For example, protocols enabled Ambulance to assess oxygen saturation levels on the basis of what was 'usual' for the patient, thereby avoiding an 'automatic' transfer to ED for levels that may be low, but within the usual range for that patient.

“These strategies to empower Ambulance decision-making in the patient's home resulted in fewer admissions, fewer ambulance arrivals, and a significant decrease in Hospital beddays because people are actually being looked after in their own home” – Carolyn Gullery

Integrated Respiratory Services – COPD

- Integrated response focusing on community management
- Around one third of 111 calls for respiratory issues are now diverted to community care
- Growth in admissions has been reduced
- Large reductions in bed days



Advance care planning.

In Canterbury, advanced care plans are done in a **general practice setting**, and then become part of the **shared integrated health record**. If a person then presents to a **pharmacy, general practice, hospital, NGO provider or Ambulance**, their wishes are clear and available. The shared integrated health record is the repository for all care plans – shared care plans, acute care plans and advance care plans. By centralising this information, any service provider can be confident that the care plan they are viewing is **the right plan**, that it is **up to date**, and that **it is what the person really wants**.

UK examples:

Plymouth integrated care approach

This model was developed in response to the growing burden of chronic disease in a local community, and it was identified that a coordinated response across a range of providers was needed. This integrated approach meant that **staff from various agencies** - hospital, general practice, community services, education, leisure facilities, and private companies - **could work outside their usual boundaries to start to change the lifestyles of the inhabitants of Plymouth through an integrated approach**.

Background to Plymouth Thrive (4-4-54)



- **Poor diet, lack of exercise, tobacco use and excess alcohol consumption are risk factors for coronary heart disease, stroke, cancers and respiratory problems which together contribute to 54% of deaths in Plymouth**
- **Changing these four behaviours would help prevent four diseases and reduce the number of deaths due to chronic diseases**

Principia integrated care approach

Another example of the power of combined effort was in Principia with the amalgamation of all the general practices into one, looking after around 100,000 people. This meant there was sufficient demand to recruit staff for both generalist and special interest roles – e.g. urology, gynaecology or dermatology. **This enabled some sub-specialist care to be drawn out of the hospital system and be provided in the primary care setting, closer to the patient.**

Other UK examples

- In Bradford, a home-based program was developed **teaching people how to manage their own blood pressure** and track it better. The program trial resulted in **210 fewer strokes**.
- In Ashford, a **combined musculo-skeletal service was developed with Physiotherapists undertaking assessments**. This resulted in a 30% reduction in those patients needing to go to hospital.
- In Slough, an approach was developed to **case manage the top 1%** to reduce ED presentations and admissions, using an **integrated approach in case management**. Sir John's prompt was that there are 10,000 people in western Sydney in that top 1%, and we need to know who they are in order to better manage them.

12. BRINGING IT ALL TOGETHER

Key themes from the Western Sydney Integrated Health Forum Panel:

Consumers/Citizens

A key theme for the forum was **engagement with consumers/citizens**. A range of strategies are needed at various points in the system.

We need to **expand who we engage with** – not just the clients in front of us, but also **the ones who are not linked to the system**. Currently we see only those “in front of us” and we wait until they become ill, rather than aiming resources at early intervention to prevent or ameliorate conditions.

Risk stratification will assist in identifying the risk factors (which are determinants of health) and then ensuring resources are allocated to those in need. **Public health campaigns** are also needed, providing key messages to the community about improving and maintaining our health.

In order to improve access to health services and health information, we need to **improve health literacy and ‘cultural’ literacy, by engaging in a dialogue** that is based on an *understanding* of cultural norms, not assumptions. Health care is not just about the delivery of information, it's about gaining understanding. Utilising best practice techniques in communicating with patients (e.g. **teach back**) is essential. For the younger 0-5 year population, it's more about **‘developmental literacy’** (interaction between the environment and the developing brain of the child). A key priority that will improve long-term health outcomes will be investment in the 0-5year olds at the bottom of the socioeconomic gradient.

The key success factor in all of these strategies is **engagement with clients**, and changing the focus from **what we want to give patients to what they need**, and seeking their input and feedback.

Alliancing approach

In order to improve the integration of care for consumers and citizens, organisational and system change is required. A key shift that was identified was the need to **treat the ‘whole’ person** instead of a specific part of the person (as represented by the sub-specialisation “silos” in the health system).

There is an opportunity to “bridge” these silos and multiple programs of work, by identifying a **collective goal (the patient!)** and building **effective alliances and drivers** (societal and financial), managed within a **collaborative cross-sector framework**. This will require the **realignment of business** drivers and processes across our organisations, and all stakeholders need to be aligned to a **shared vision** as well as a **common way of working and a common language**.

This can be achieved with the establishment of a **virtual alliance** and collective leadership. Under this arrangement, each partner pledges commitment to a **common purpose** to improve together, not separately across their organisations.

It was identified during the Forum that there is opportunity for a virtual alliance to be established in western Sydney, where there could be a focus on 3 key areas – for example **early years, frail elderly and chronic long term conditions**. Such an alliance could be initiated with an invitation to Commonwealth colleagues to join a conversation about what this alliance could look like and how it could accelerate the directions being pursued by western Sydney. Carolyn Gullery's advice was that for change to occur, there is a need to identify and start with something pragmatic – such as the priority groups mentioned – and then the leaders of the system must support this and provide the necessary authority/permission to progress these focussed initiatives.

Model of care development and new ways of working

There was much discussion from the Panel about new ways of working, and embracing **evidence-based models of care**, as demonstrated by the presenters. There was great interest in programs that enhanced **community-based primary care**, in order to provide patients with care in the most appropriate setting. One opportunity is to provide greater investment in hospital teams deployed to the community, to build capacity in primary care, particularly around chronic disease. This model is currently operating with the **Western Sydney Diabetes Initiative**, providing case conferencing support to General Practice to support the management of diabetes in primary care.

Ambulance NSW was identified as an under-utilised and sometimes 'forgotten' stakeholder in these community-based care discussions. They highlighted some relevant statistics:

- 10% of their workload is time critical, immediately life-threatening
- 50% urgent but not immediately life-threatening requiring transport to an ED
- 40% of caseload is actually low acuity and suitable for management by general practice or other primary care providers.

Improved IT connectivity with ambulance and partners could enable referral of this 40% caseload to primary care providers, instead of ED. Additionally, Ambulance are developing a 'Hospital-In-The-Home (HITH)-hybrid' service, providing a range of clinical services such as changing catheters, suturing, oral antibiotics etc. **This important initiative provided by Extended Care Paramedics is supporting patients to stay at home, instead of being transferred to primary or tertiary care.**

Enablers – communication and connectivity

In spite of the promising work being undertaken by Ambulance NSW, a rate-limiting step for them is the **lack of IT connectivity**. Ambulance have authorised care plans (including palliative care plans) which are developed by GP's/Specialists and stored in the Ambulance medical record systems - eMR. Unfortunately, authorised care plans cannot be accessed by ambulance officers on the road because they don't have internet access, with the result that officers rely on the patient having a hard-copy of their care plan.

Communication across disciplines and agencies is pivotal to the success of any efforts made to improve the integration of care. The representatives participating in the panel discussion all highlighted the importance of this. Dialogue, seeking understanding, reaching out, working together with trust and goodwill, were all acknowledged as critical to the success of developing truly integrated models of care.

13. EVALUATION

The Forum was considered a resounding success by all who attended and confirmed by the evaluations (conducted via *Slido* technology, as well as in a follow-up post-forum survey). The keynote speakers inspired with approaches and programs that have achieved positive outcomes overseas, and their advice was that these initiatives could be readily harnessed and actioned here in Western Sydney where there is a growing level of understanding, goodwill and motivation.

- **Evaluations – Survey Monkey results**

There were 42 responses with almost universal satisfaction with the Forum, content, speakers and format.

Sir John Oldham was the most popular speaker, although all were resoundingly applauded.

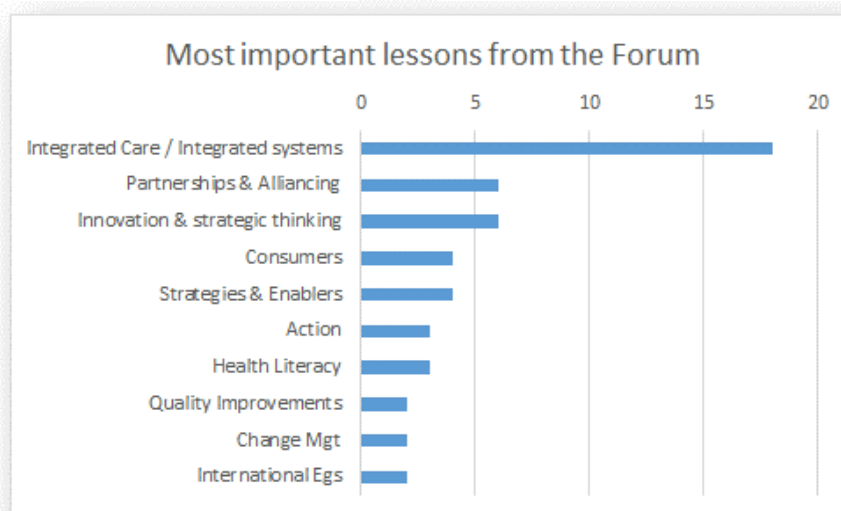
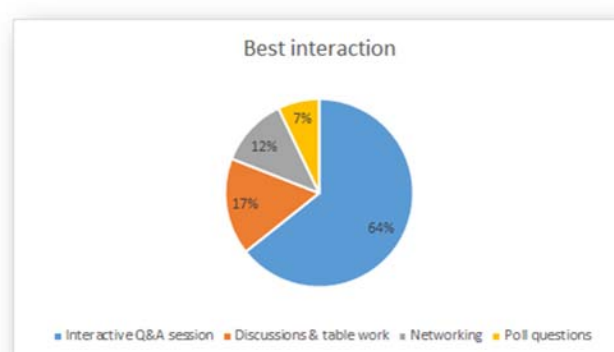
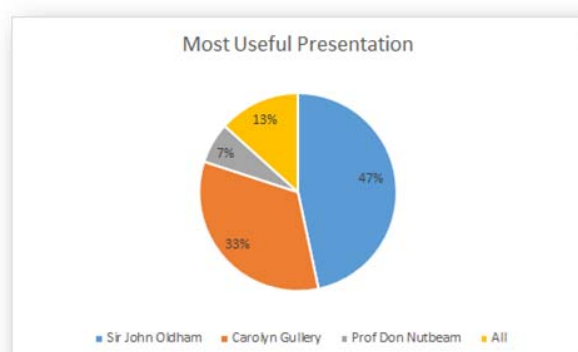
The most important lessons from the Forum related to the integration of systems and integration of care, followed by partnerships and alliancing, and innovation and strategic thinking.

The interactive Q&A session was considered the most popular of the interactive formats on the day.

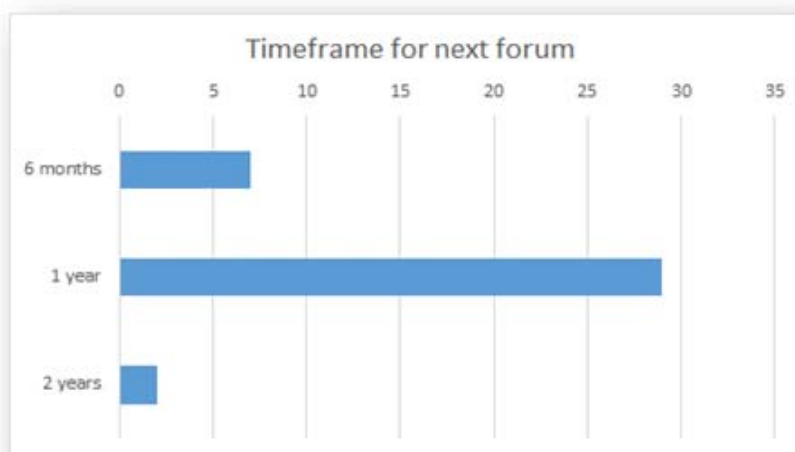
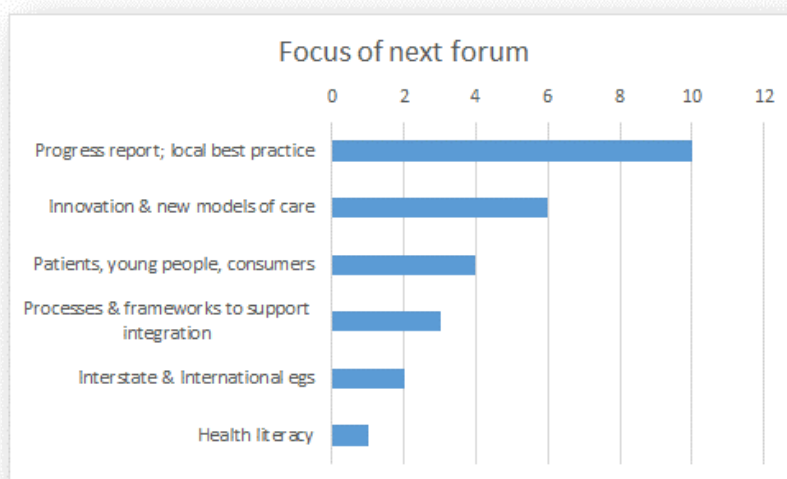
There was considerable support for an annual forum, with the most popular focus for the next forum being progress to date, lessons learned and local examples of best practice. Refer to Appendix 6 for more detailed survey results.

Survey Monkey results

There were 42 responses received. The survey questions are indicated in the heading of the graphs (below), with the results provided either as raw data (count of responses) or as a percentage.



Most important lesson		%	Sample comments
Integrated Care / Integrated systems	18	36%	"All areas need to work together if we truly want to be integrated and each part of the team is important for patient care and best client outcome, egos need to be left behind and silos need to fall".
Partnerships & Alliances	6	12%	"Developing alliances and ensuring all relevant stakeholders are present in the room when holding important discussions regarding community/population health".
Innovation & strategic thinking	6	12%	"WSLHD is ready to make big gains if we take this to scale with WSPHN, GPs as active partners and SCHN all in a concerted effort on this".
Consumers	4	8%	"Consumers are an untapped resource"
Strategies & Enablers	4	8%	"Cede power and gain influence"
Action	3	6%	"Just do it!"
Quality Improvements	2	4%	"Quality improvements through collaborative work can lead to transformational change and impressive results".
Change Management	2	4%	"Change is possible when you have leaders and sponsors who have a vision and dedicated change managers who can enact that vision".
International Examples	2	4%	"If the South Island NZ can do it so can western Sydney"



14. RECOMMENDATIONS AND NEXT STEPS

The energy in the room at Forum was palpable, and there was a clear message from workshop participants that **ongoing conversations are needed about the future potential of integrated care**. With attendees covering a broad range of public and private health services and other sectors, along with consumers, these conversations can readily be progressed within the context of a partnership approach.

Identified priorities such as young children, and the frail elderly were suggested as a potential focus for a shared program of work. This proposal aligns with work currently underway in Western Sydney with the recent development of the **Integrated Health Partnership Framework**. The Framework outlines how current and future partners can work together around a common priority group, with Steering Committees currently being established for each priority area, to oversight a work plan and deliver outcomes. As a result of the Forum there is an opportunity to expand the scope of this Framework approach to harness a broader range of stakeholders, including our consumers and communities, ACI, CEC, Ambulance and much broader working toward a multi-sector system alliance.

Additionally, work is progressing to establish a **Health Literacy Hub and Lab in Western Sydney**, under the stewardship of Professor Don Nutbeam. This new initiative will identify evidence-based approaches to health literacy and 'test' these in various programs of activities at the clinical interface across the LHD and broader community of western Sydney. The intent is to implement evidence based strategies resulting in translation of research to practice aimed at improving the health literacy of our population.

The Integrated and Community Health Directorate welcomes ongoing dialogue with all interested stakeholders

APPENDIX I

Program Outline

Forum Title: Western Sydney Integrated Healthcare – moving to the future Date: Wednesday 5 April 2017 Venue: Rosehill Gardens Time: 8.30 am – 4.30 pm Rationale and purpose: To engage health leaders and clinicians in interactive discussions to identify what is required to move healthcare integration to the next level in western Sydney.	
8.30 – 9.00 am	Registration and breakfast/coffee
Morning session – setting the scene	
9.00 – 9.05 am	MC – Julie McCrossin
9.05 – 9.10 am	Welcome to Country – Kerry Kenton
9.12 – 9.18 am	- Opening address – Prof Jeremy Chapman (WSLHD, and on behalf of Danny O'Connor, CE of WSLHD) and Walter Kmet (CE of PHN) - Common causes, shared narrative and what success factors will drive innovation and integration of services in Western Sydney
Focus 1 – How to achieve system change without breaking it	
9.18 – 9.21 am	- MC – explains structure of session: 1. International speaker 2. Break-out groups 3. Report back to whole room and feedback from international speaker MC introduces Sir John Oldham
9.21 – 9.51 am	Sir John Oldham – speaking from international perspective
9.51 – 9.53 am	MC to provide focus and purpose of breakouts, split of tables into breakout groups and facilitators for each group
9.53 – 10.13 am	Breakout groups (identify facilitators/leads)
10.13 – 10.30 am	Report back (2 mins per group) comment at end from Sir John Oldham
10.30 – 10.50 am	Morning tea
Focus 2 – Creating healthy communities	
10.50 – 10.53 am	- MC – explains structure of session: 1. International speaker 2. Break-out groups 3. Report back to whole room and feedback from international speaker MC introduces Carolyn Gullery)
10.53 – 11.23 am	Carolyn Gullery (Canterbury NZ) International perspective
11.23 – 11.25 am	MC to provide focus and purpose of breakouts, split of tables into breakout groups and facilitators for each group
11.25 – 11.45 am	Breakout groups (identify facilitators/leads)
11.45 am – 12.07 pm	Report back (2 mins per group) comment at end from Carolyn Gullery
12.10 – 12.50 pm	Lunch
Focus 3 – Improving clinician-consumer alliances	
12.50 – 12.53 pm	- MC – explains structure of session: 1. International speaker 2. Break-out groups 3. Report back to whole room and feedback from international speaker MC introduces Prof Don Nutbeam

12.53 – 1.23 pm	Prof Don Nutbeam (University of Sydney) Consumer and engaging with health
1.23 – 1.25 pm	MC to provide focus and purpose of breakouts, split of tables into breakout groups and facilitators for each group
1.25 – 1.45 pm	Breakout groups (identify facilitators/leads)
1.45 – 2.07 pm	Report back (2 mins per group) comment at end from Professor Don Nutbeam
Focus 4 – Triple/quadruple aims – achieving a balance	
2.07 – 2.10 pm	- MC – explains structure of session: 1. International speaker 2. Break-out groups 3. Report back to whole room and feedback from international speaker MC introduces Sir John Oldham
2.10 – 2.40 pm	Sir John Oldham International perspective
2.40 – 2.42 pm	MC to provide focus and purpose of breakouts, split of tables into breakout groups and facilitators for each group
2.42 – 3.02 pm	Breakout groups (identify facilitators/leads)
3.02 – 3.24 pm	Report back (2 mins per group) comment at end from Sir John Oldham
3.24 – 3.45 pm	Afternoon tea
Theme – System and policy solutions – PANEL DISCUSSION	
3.45 – 3.50 pm	MC – introduce panel – explain focus of panel to consider systemic responses. How can we learn from international successes in integrating care across communities for patients
3.50 – 4.20 pm	- Panel: 1. Sir John Oldham 2. Walter Kmet (WS PHN) 3. Nigel Lyons (Dep Sec Strategy & Resources NSW Health) 4. Carrie Marr (CE CEC) 5. Professor Don Nutbeam 6. Caroline Gullery
4.20 – 4.25 pm	Close – thank you gifts to speakers

There is also available a **video** of the four speaker presentations, which can be found on the Western Sydney **Better Health Together** website:

<https://www.betterhealthtogether.com.au/news-and-events/first-integrated-healthcare-forum-a-great-success-7-apr-2017>

A transcript of these presentations as well as the slide deck will also be available.

References from the presentations can be accessed (where available) from the slide deck.

APPENDIX II

Speaker Profiles

Sir John Oldham

Sir John Oldham is the **National Clinical Lead for Quality and Productivity at the Department of Health in England and a member of the National Quality board for the National Health Service**, setting the strategic direction for quality and safety. His specialty is the reconciliation of two difficult priorities. We need to make healthcare more efficient, and that requires a strong managerial strategy. At the same time, physicians need a high level of autonomy to exercise their special genius. How can these needs — for overarching strategy and employee autonomy — be reconciled? Sir John's insights are especially valuable for healthcare but also for any field that struggles to balance these two values. Sir John has a long history of leadership in quality and management in healthcare. He collaborated in 1997 with Don Berwick, CEO of the Institute of Healthcare Improvement, to redesign surgery systems in the U.S. On his return to the UK, he was a pioneer of the Collaborative method, founding the National Primary Care Development Team in 2000. The Primary Care Collaborative was the largest improvement program in the world, covering 32 million patients in 40 months and delivering 72% improvement in access to GPs and substantial reductions in mortality to patients with CHD. He also created the concept of the award winning Healthy Communities Collaborative with residents of deprived areas as the improvement team members. He was invited by the Australian Government to design and train a team to operate a Primary Care collaborative across the whole of Australia, and similarly Saskatchewan and Alberta in Canada.

Professor Don Nutbeam

Professor Nutbeam returned to Sydney in February 2016 following a six-year term of office as Vice-Chancellor (President) of the University of Southampton, UK. He recently completed a six month appointment as the Interim Executive Director of Sydney Health Partners, an Advanced Health Research and Translation Centre. He now shares his time as a **Professor of Public Health at the University of Sydney**, and a **Senior Advisor at the Sax Institute**, an independent, not-for-profit organisation dedicated to knowledge transfer for better public policy, and as a **Senior Advisor of Sydney Health Partners**. His career has spanned positions in universities, government, health services and an independent health research institute. Prior to his appointment as a Vice-Chancellor he was Academic Provost (2006-09) and Pro-Vice-Chancellor (Health Sciences) at the University of Sydney from 2003. In this latter position, he was Head of the College of Health Sciences, comprising the Faculties of Medicine, Health Sciences, Dentistry, Nursing and Pharmacy. From 2000–2003 he was Head of Public Health in the UK Department of Health, responsible for leading policy development on a range of complex and large-scale public health challenges, for the development of the public health workforce across the whole of England, and public health research and information strategies. He has substantial international experience in both developing and developed countries, working as an advisor and consultant on public health issues for the World Health Organisation over a 30 year period, and as consultant and team leader in health system capacity development projects for the World Bank. He is a social scientist with research interests in the social and behavioural determinants of health, and in the development and evaluation of public health interventions. His early work examined the development of health related behaviour during adolescence. During the 1990s, he made a significant contribution to public policy development in Australia. This included leadership of a project to rewrite Australia's National Health Goals and Targets, and major contributions to national reviews of programs to tackle diabetes

Carolyn Gullery

General Manager, Planning & Funding, Canterbury District Health Board & West Coast District Health Board

Carolyn has almost 30 years of experience in health, in both the public sector and private sector roles. In the public sector she has had senior roles in the Southern Regional Health Authority, Health Funding Authority and now works for the Canterbury District Health Board as General Manager of Planning,

Funding and Decision Support. Her focus has always been on developing new models that support an integrated health system response, organised around the needs of the person and the population, in a way that ultimately reduces demand on the whole system. Tested under extreme conditions in the Canterbury earthquakes, Carolyn believes that an integrated, connected system is more effective and more resilient. Carolyn was a director of New Zealand's drug governing body, Pharmacy, for two years, Chief Executive of New Zealand's largest primary health organisation for four years, and has also worked as a consultant within the health sector in Australia and New Zealand. Carolyn is sought after internationally as a keynote speaker on how to make an integrated health system work and is currently advising health systems in UK and Australia on system integration, funding models, alliancing and the use of data to drive change in health care delivery.

Workshop Discussions

There were **2 workshop discussions** based around the tables participants were seated at (approximately 8 people per table).

The first focused on **solutions to poor patient experiences**. Participants were asked to consider a patient experience of the health system (preferably harnessing the 'lived experience' of consumers in the room) and to then identify possible solutions which could improve the patient experience. A summary of the table notes is provided in the table below.

The second workshop discussion asked participants to identify a range of **participants who should be consulted in future discussions** around Integrated Care. The 'sticky notes' exercise for this is also captured in a summary table in the table below (*noting potential errors in roles and details may be present due to the informal nature of the exercise*).

The final session for the day was an **interactive panel discussion** / Q&A facilitated by MC Julie McCrossin, interviewing key people about their areas of interest and expertise with the following trigger questions:

- o *Why is integrated healthcare important for the future of the people and health services of western Sydney?*
- o *What is one thing that could make a difference tomorrow?*
- o *What will you do with the key messages and ideas you receive from the participants today?*
- o *What will you do when you return to your workplace?*
- o *How can managers make a difference within limited resources?*

The panellists included:

- o Dr Michael Crampton (2016 GP of the year, GP lead, WentWest)
- o Josefin Charles (Care Facilitator, WSLHD)
- o Professor Michael Fascher (local GP, Clinical Lead for Thrive at Five in Doonside).
- o Claire Walker (Primary Community Care Coordinator with NSW Ambulance)
- o Dr Ting Ming (TM) – Head of Endocrinology Blacktown Hospital
- o Dr Keng Seang Lim (local GP, 2015 GP of the year, WentWest board member)
- o Carrie Marr (NSW Clinical Excellence Commission)
- o Kittu Randhawa (The Indian (Sub-Continent) Crisis & Support Agency)
- o Carolyn Gullery (General Manager, Planning & Funding, Canterbury District Health Board & West Coast District Health Board, New Zealand).

APPENDIX III

Patient experience and solutions – summary of table discussions

<i>Diagnostics (Patient Stories)</i>	<i>Solutions</i>
• Poor experience with patient discharge unit. • Long wait for ambulance and stressful. • Communication of the patient's medical record between hospitals. • No coordination of care and discharge plan.	• Rehabilitation at home. • Integration for transport. • Ongoing communication (to patient). • Better coordination of care. • Discharge plan. • Hospital closer to home/family.
• Patient had to travel to hospital. • General practitioner referred patient to ED due to comorbidities.	• Electronic shared records. • Consumer focused care. • Involvement of consumers in their care plan. • Consumer feedback regarding system functioning. • Bring hospital expertise to general practice. • Patient empowerment. • Clinical judgement not just protocol.
• Child denied access to appropriate services due to parents low health literacy. • Lack of trust for health professionals. • Human rights issues. • Education engagement.	• Equitable access to a multidisciplinary team. • No assumptions, holistic approach to health. • Parents involved in management plan.
• 2020.	• Training and education for diversity and change. • Reduce costs of healthcare for patients. • Co-design between consumers and healthcare workers. • Online appointment scheduler and SMS. • Patient centred and compassionate care. • Improved discharge planning processes.
	• Raise awareness about how the health system works. • Better data collection and sharing. • Diversity and equity strategies. • Better collaboration between health services. • Work force reflecting the local population. • One point of contact for the health journey.
Acute Ankle Sprain – young person.	• Shared communication between multidisciplinary team. • Access multidisciplinary team. • Patient centred.
Palliative/ End of life care. • Poor health literacy. • CALD population. • Admitted 5 times to ED 12/12 of life.	• Diagnose with an interpreter. • Psychosocial support. • Advanced care planning. • In home assessment for support. • One point of contact for care support team.
NZ plan.	• Family involvement. • Allied health services in surgery. • Pharmacy integration. • Teach back methodology.

By 2020 ('No wrong door')	• eHealth to support and inform consumers.
• Chronic Pain. • Fragmented Care. • Non-holistic approach. • Family offering solutions rather than the health system. • Repetitive process.	• Case conferencing with all health care workers. • eHealth. • More holistic person centred care. • Less fragmented.
• Integrated between public and private.	• Whole of person approach • Integrated complementary, coordination, communication. • Team approach.
Not Specialist services.	• Community Hub/ Wellness Centre.
eHealth in 2020	• Shared access to understand compliance clinical. • Real time sharing. • Care co-ordination.
• Medication. • Notes. • My Health Record	
eHealth 2020	• A nationally integrated healthcare information system. • Fully integrated primary, secondary, community and tertiary health services.
Chronic and complex client.	• Care support involvement of family. • My Aged care. • Support at home for all the family. • Timely communication between health providers. • Remote monitoring.
• Elderly. • Carer of children. • Cardiomyopathy. • Osteoporosis. • Out of area GP.	
Newly diagnosed acute admissions, multiple comorbidities.	• Whole person centred care. • One senior clinical lead for person's care. • MDT model. • Family management. • Coaching. • Warm care transition at discharge. • Timely information exchange. • Increased time at home and decrease hospital stays/ admissions. • Better data collection and experience measures.
• Multiple doctors. • Conflicting advice. • Lack of family involvement.	

APPENDIX IV

Suggested Future participants

Key individual, roles and groups who were identified by Forum participants to be included in future Forums.

Politicians – State and local MPs.

Public Sector Agencies – including Housing NSW, Human Services, Department of Education, NSW Treasury, Premiers and Cabinet, Family and Community Services, Police, Ambulance, Planning and Environment, National Disability Insurance Agency, NSW Services for the Treatment and Rehabilitation of Torture and Trauma Survivors, Australian Aged Care Quality Agency, NSW Refugee Health service, Justice Health, Agency for Clinical Innovation (ACI), Clinical Excellence Commission (CEC).

Other Agencies – Royal Australasian College of General Practice (RACGP), Australian Medical Association (AMA), Medical Board of Australia, medical colleges, the aged care sector, Assessment services (Aged care assessment team, regional assessment), Research Institutes including Australian Bureau of Statistics (ABS), Australian Institute of Health & Welfare (AIHW), Active & Health NSW, Health Share NSW, Australian Aged Care Quality Agency

Peak Bodies, non-Government organisations and special interest groups - The National Aboriginal Community Controlled Health Organisation, Hepatitis NSW, Diabetes NSW, National Diabetes Service Scheme, Disability Services Australia, Australian Aphasia Association, Heart foundation, Asthma Foundation, Red Cross, Beyond Blue, Community Migrant Resource Centre, Auburn Diversity Services, Families 4 Families, Australian Breastfeeding Association, Interpreter services, Volunteer coordinators

Research – Links to Universities, National Health and Medical Research Centre, Aboriginal Health and Medical research council of NSW, University of Sydney Brain and Mind Centre, Academic roles across the Local Health District,

e-Health / IT services - eHealth NSW, My Health Record, Australian Digital Health Agency, Australian eHealth Research Centre, Head of IT WSLHD, software providers.

WSLHD - community health services, Councils in the WSLHD, Chief Executive and Executive Directors of WSLHD, General Managers of the Hospitals in WSLHD, Chief Executive Sydney Children's Hospital Network (Westmead), Senior Clinical Heads both Hospital Specialists and General Practitioners, Care coordinators

Private businesses – Experts in funding models, PwC Australia, Supermarket chains, transport services.

APPENDIX V - Poster Presentation – Western Sydney Integrated Care Program



Governance is through and Executive Steering Committee with Chief Executives of WSLHD and Primary Health Network and the Western Sydney Integrated Chronic Care Steering Committee. **Heads:** Dennis O'Connor, Walter Kline, Victoria Reine, (Dr Michael Frampton, (Dr Michael Watson) and the Western Sydney Health Partnership **Senior Executives:** Judith Taylor, (Dr John and Rosanna Bellwood
Linda.Sears@health.nsw.gov.au or 0400518777



Contact:

BETTER HEALTH TOGETHER



BACKGROUND

Collaborative Partnership with WSLHD and Western Sydney PHN that has implemented the Western Sydney Integrated Care Program a demonstration site for integrated care solutions in Western Sydney, NSW, Australia.

This program is a key part of local service delivery reform

Better West: Strategic Priorities - Healthy People

- Diabetes Initiative
- Good Start to Life
- Integrated Health

Integrated Health Partnership Framework created 2016-2017

- Aboriginal Health
- Child & Family
- Chronic & Complex
- Older Person Health
- Mental Health

Realigning our community based services began March 2017

Building on the foundations for change

- Consolidating the Integrated Chronic Care Program
- Incorporating with Health Care Home Trial
- Improved links with Whole of Hospital and Whole of System program
- Collaborating with SCHN and ACl to deliver the Transition Care program

GP Practice Distribution 2017

60 General Practices are currently registered with 207 General Practitioners involved in the program. With 52% of GP Practice enrolments from Blacktown LGA, 25% from Parramatta LGA and 17% from Hills LGA



25% of consumers Thought their care could have been provided by a GP instead of hospital emergency department (2012-13)

OBJECTIVES

Guiding Principles

- Quadruple Aim
- Primary Care management
- Secondary Care support and capacity building
- LHD wide implementation
- Enablers and Interventions
- Evaluation

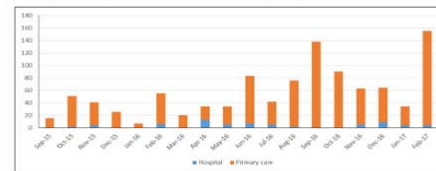
14% consumers saw 3+ health professionals for same condition in the preceding 12 months (2012-13)

78% consumers - had a preferred GP in the preceding 12 months 2013-14

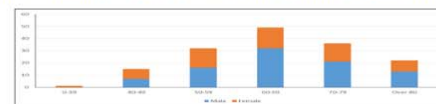


BASELINE MEASURES (2015-2017)

Integrated Care Enrolled Patient, from Sep 2015 to February 2017



Integrated Care Patients Enrolled by Gender and Age Group, from June 2015 to February 2017



RESULTS

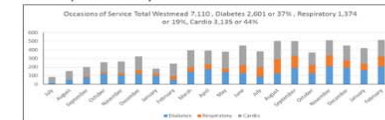
Enrolments, Care Planning and Clinical Metrics – February 17

ENROLMENT		Feb 17	Total	Target
Number enrolled in CHOC (eMHR) as IC patient		154	1093	3000
Number enrolled in LinkedEHR (shared care plan) as IC patient		104	956	
			(87%)	
Number LinkedEHR Care Plans created for IC patients		97	939	70%
			(98%)	
CARE PLANNING AND CLINICAL METRICS		Jan 17	Total	Target
(Aims to be completed within one month of enrolment)				
Number enrolled in LEHR as IC patient		45	864	
No of IC patients with LinkedEHR care plan completed within 1 month of their enrolment		41	800	70%
		(91%)	(87%)	
No of IC patients with clinical metrics recorded within one month of their enrolment		39	753	80%
		(87%)	(87%)	

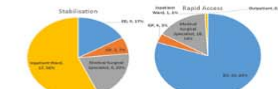
RESULTS

Over the last 18 months the Western Sydney Integrated Care Demonstrator developed a comprehensive model of care for patients with congestive cardiac failure, coronary artery disease, chronic obstructive pulmonary disease and diabetes.

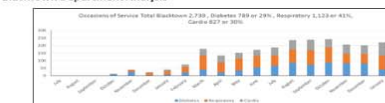
Westmead Department Analysis



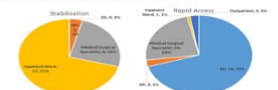
Referral Source for RASS services – Westmead



Blacktown Department Analysis



Referral Source for RASS services – Blacktown



GP Support Line: 1300 972 915
DIRECT ACCESS TO INTEGRATED CARE SPECIALISTS
Diabetes | Congestive Heart Failure | Coronary Artery Disease | COPD

LEARNINGS TO DATE

- Importance of clinicians involvement in developing the model
- Shared governance with chief executives from WSLHD and Primary Health Network and senior clinicians has strengthened support.
- Risk stratification and use of a dynamic shared care planning tool (LinkedEHR) important tool.
- Patient experience reporting has improved care based on feedback.

NEXT STEPS 2017/18

- Phase 2 planning** - GP Data linkage with LHD and GP records (pilot with Ministry of Health)
- Sustainability option** - Activity based funding and MBS items as a source of funding
- Continued integration** within and between Hospital Departments, community and capacity building and integration with General Practice
- New primary care enablers**
 - Health Care Home – GP plus and capitation fee
 - Digital Health framework – eReferral, improved shared care planning, HealthNet
 - Go Share (Real Time Health) patient education videos - messages via email and text