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Conference Abstract

Building regional change at scale and pace: Integration lessons from the NSW Chronic Disease Management Program

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Abstract

Introduction: Over the last four years NSW has developed at scale and pace local disease management services following implementation of the Chronic Disease Management Program (CDMP-Connecting Care). Connecting Care has worked to engage and empower people to be actively involved in their health care. This has resulted in a streamlined patient journey with improved care coordination, self-management and coaching for people with long term conditions in the community.

Practice and Context: A team of committed managers implemented the CDMP - Connecting Care Model across NSW. Person-centred care is increasingly seen as a key indicator of quality and essential to improving healthcare systems and consumers are a key part of the model. In order to improve experiences and outcomes for patients and carers, staff charted a course between the acute, community and primary health care interface by embedding referral lines, recognising care pathways and GP care in the home.

Description of Change Implemented: The first steps were to seek engagement and integration between health services and to deliver better health outcomes by streamlining the patient journey, providing greater care coordination and access to coaching for people with long term conditions in their home setting. Empowering consumers to play an active role in decisions about their care is central to the provision of person-centred care. This would lead to improved self-management and is a key goal of the ACI Chronic Care Network.

Improvement realized: A central organising entity prioritised primary care engagement across intersection points within the acute care system. This led to the creation of patient navigation hubs for registered patients with long term conditions. Care partnerships, improved technology, outbound call centre protocols and integrated service delivery have meant patients have been more rapidly returned to the community after unplanned hospital admissions.

Targeted population: Connecting Care targeted people in NSW with chronic disease i.e. Diabetes, Congestive Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary

Disease and Hypertension who were aged 16 years and over and who were at high to very high risk of hospitalisation and who may benefit from care coordination and self-management support.

Stakeholders Engaged: At a local level engagement has consisted of Local Health Districts Medicare Locals (MLs) in collaboration with General Practice (GP), Aboriginal Medical Services (AMS), Non-Government Organisations (NGOs), private health care professionals, and private health insurers.

Timeline: Connecting Care has been implemented across NSW since 2010.

Theory/Methods used: As people often have more than one chronic disease and require different levels of care and access the Kaiser Permanente triangle has been used to inform navigation to a range of services as their disease progresses and changes. Local Health Districts and Specialty Health Networks have been recurrently funded to deliver Connecting Care to eligible people in their community. The aim is to enrol at least 59,000 people into the program by 2014-15.

Innovation, Impacts and Outcomes: Results for the program have been measured locally and with the assistance of a state wide evaluation consortium led by the George Institute for Global Health. Case Study based processes and local evaluation reveal a reduction in admissions (66%), bed days (63%) and 2.1 day average length of stay. Patient feedback has shown many have been engaged with disease management services for the first time and appreciate the coaching, locally based interventions and stronger links with their General Practitioners.

Sustainability, Transferability: Connecting Care staff were able to chart a course between the acute, community and primary health care interface in NSW; preparing for a regional House of Care locally that had patient and carer centred care, recognition of the importance of the GP led medical home, embedded referral lines, known care pathways and greatly improved outcomes.

Conclusions: A central organising entity was created with the Connecting Care program that prioritised primary care engagement and created patient navigation hubs for a registered group of patients with long term conditions.

Discussions and Lessons Learnt: Care partnerships, improved technology, outbound call centre protocols and integrated service delivery are the building blocks of a sustainable system change. Other programs are now using this model to implement fracture prevention services and widen the targeted diseases scope.

Keywords

regional; scale; connecting care; co-ordination

PowerPoint presentation

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