Mapping the next chapter of integrated care: The value of genuine stakeholder engagement

Victorian Department of Health
Integrated Chronic Disease Management Forum
15th September, 2014
The Challenge:
Potentially Preventable Hospitalisations (PPHs) in the BML region

- 21% more chronic PPHs than its peer group
- Diabetes is responsible for nearly 50% of all PPH bed days
- 17,000 admissions & 94,000 bed days annually
- 72% of PPH bed days due to chronic conditions
- $87 million is spent annually on chronic PPH bed days in our region alone
The Challenge:
Multimorbidity is the new norm

Number of chronic diseases by age-group (Adapted from Barnett et al, 2012)
The Challenge: Multimorbidity and lower SES populations

Prevalence of multimorbidity by age and socioeconomic status (Adapted from Barnett et al, 2012)
The Challenge:
Multimorbidity and lower SES populations

Prevalence of multimorbidity by age and socioeconomic status (Adapted from Barnett et al, 2012)
The Challenge:
Health system implications of multimorbidity

- Higher risk of hospitalisation for all causes
- Greater risk of post-op complications
- Longer than average hospital stays
- More specialist and unplanned GP appointments
- More tests and investigations
- Higher overall healthcare costs
- Polypharmacy and greater risk of drug interactions
The Challenge:
Multimorbidity leads to poorer patient outcomes

- Increased mortality
- Increased burden of disease
- Reduced quality of life
- Increased psychological distress
- Reduced functional ability
Who is Responsible?

Who is Accountable?
Integrated Care:

“Integrated care is essential to meet the needs of the ageing population, to transform the way that care is provided for people living with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives”

(Goodwin and Smith, 2011)
Principles of successful integrated care strategies:

• There is no single model of integrated care
• Integrated care is a process that must be led, managed and nurtured over time
• Collaborative design is essential
• Integrated care must be designed around the patient and their needs, not diseases
• Target the people who are likely to benefit the most.
Enablers to achieving integrated care:

- A shared commitment to change and support for innovation
- A clear vision for the future
- Investment in education and training.
- Alignment of funding and resources.
- Collaborative culture that emphasises team work and the delivery of patient-centred care.
The Partnership

“to collaboratively develop a pilot proposal for an innovative model of care that will improve the experience and outcomes of care for people with complex chronic conditions in the Bayside region.”
Stakeholder Engagement:

• Commitment to genuine stakeholder engagement.
• Consultations included:
  ❖ Consumers
  ❖ General practice: GPs, practice nurses and managers
  ❖ Community health: Clinicians and managers
  ❖ Public and private hospitals: physicians, nurses, allied health and managers from inpatients and outpatients
  ❖ Private allied health
  ❖ Community services: RDNS, councils etc.
  ❖ RACGP
  ❖ Government: state and federal
The Model Development Group:

• Skills-based advisory group
• Included local clinical, operational and consumer expertise on primary care
• Responsible for collaboratively exploring and designing the new model of care
• Aim was to deliver a recommended service model design to form the basis of the pilot funding proposal.
## Model Development Group membership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Lauren Barker</td>
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<td>Felice Borghmans</td>
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<td>Prof. Don Campbell</td>
<td>Monash Health</td>
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<td>Tere Dawson</td>
<td>Health Issues Centre (Consumer organisation)</td>
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<td>Dr. Ian Chenoweth</td>
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<td>Dr. Gary Yip</td>
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![Logos](image-url)
Collaborative Design Process:

• Three workshops held over five weeks
• Independent facilitator
• Pre-reading material
• Small working groups between workshops
• Feedback and input from stakeholders outside the MDG
Key Outcomes:

• Development of a new model of care – an Integrated Complex Care Service (ICCS) - that enjoys in-principle support from a broad range of stakeholders

• A business case and proposal for a proof-of-concept pilot to be submitted for consideration

• Unity of purpose between stakeholders to provide the foundation for successful implementation of the ICCS proof-of-concept pilot
The ICCS will provide enrolled patients with ongoing case management and care coordination and rapid access to a specific chronic disease management clinic. The ICCS will have a formalised links with General Practitioners. Communication and information sharing will be supported by an electronic health platform.

The service will build the capacity of affiliated General Practices to proactively manage people with chronic disease. It will aim to foster knowledge and skills transfer between GPs and general physicians at the ICCS clinic.

**ICCS principles**

- Target those who have the potential to benefit most
- Develop the model around the patient and their experience
- Person-centred rather than disease-focused
- Continuous care, not episodic
- Shared information

**ICCS target group**

- One or more chronic conditions
- Polypharmacy
- More than three health professionals involved
- Low socioeconomic status
- Low health literacy
- Limited social support or ability to self-manage
The ICCS patient journey

Detection and referral
Fact-finding triage
Needs assessment
Ongoing monitoring
Initial care & support
Case conference
The ICCS provider environment

Core ICCS team
- GP and Case Manager partnership
- Tailored supports for all ICCS patients
- Formally affiliated GP clinics
- Shared eHealth platform for provider collaboration

ICCS Clinic
- Specialised service for patients with complex clinical issues
- Involves specialist general physicians, general practitioners, nurses and pharmacists
- Responsive to urgent needs
- Strong links with affiliated GP clinics
- Professional education for local service providers

Local health service system
- Local service provision supported and enabled by the core ICCS team and clinic
- Involved according to individual patient needs
- Optimises existing service system expertise and programs
Key messages:

• Innovative and acceptable solutions can be designed when the key stakeholders are the designers.

• Relationships are critical to effective design as well as implementation.

• Primary care solutions must be based in primary care.