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Conference Abstract Oral presentation

Serving citizens, patients and communities in South Eastern Sydney – making the system balance

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Abstract

Introduction: Current evidence about our health system has described a fragmentation of the care system – with siloed clinical and information systems and difficulties for anyone trying to navigate the system. At a key clinicians workshop in our region in 2013, it was recognised that community expectations of the level of care may not be realistic or affordable and that health literacy levels can be low, especially for vulnerable populations most in need of more integrated care. Reported barriers stated that there were different organisational cultures in different parts of the health system and a lack of clarity about respective roles and responsibilities with patient care across the system.

Practice and Context: Chronic Disease Management has been offered in the region with agreed chronic care frameworks for functional service integration – referral points, electronic directories and change management training for clinician use in the region. System wide collaboration between primary care partners in the Medicare Locals and General Practice has widened to include private allied health staff based in primary care.

Description of Change Implemented: Connecting Care within South Eastern Sydney emphasised patient centred care, optimising region wide system improvements in effective chronic care coordination, timely access to advice and referral and measurable performance gains that reduced costs in the acute sector.

Improvement realized: Evaluation of changes from the implementation of the Connecting Care program across South Eastern Sydney (population 850,000 people) has produced:

1.District-wide and coordinated regional management and enrolment for patients with a range of long term conditions using an electronic coordination centre and shared care plans.

2.Practice improvements for navigation and clinical alerts and care integration across the system

These changes resulted in efficiency savings in 2013-14 for patients enrolled in the program. Local Connecting Care evaluation has seen sustained improvements in reductions of Average Length of Stay (ALOS) - 2.1 days per admission saved, and a reduction pre and post a 90 day enrolment indicator with 66% less admissions and 62% less bed days used for the cohort. Estimated savings roughly calculated on acute bed costs for 1678 patients showed just over 3500 bed days saved producing an efficiency saving of just under 3 million dollars for the District or a cost saving of $1788 per patient.

Targeted population: Connecting Care targets people with chronic disease aged 16 years and over who are at high to very high risk of hospitalisation and who may benefit from care coordination and self-management support. The target chronic diseases are Diabetes, Congestive Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Hypertension.

Stakeholders Engaged: Consumers have been engaged to prioritise and implement behaviour change strategies with their chronic and long term conditions focusing on cardiac, respiratory and diabetes health problems that may be present with co-morbidities that increase their risk of care complexity and the need for unplanned hospital admission. Health care professionals have worked across the acute, community and primary care sector to deliver a more integrated and holistic journey.

Timeline: Connecting Care has been implemented in South Eastern Sydney since 2010 and registered nearly 8,000 patients.

Theory/Methods used: Planning across the health and social care system in the South Eastern Sydney NSW region for effectiveness and quality patient care has used the Wagner Model, the Kaiser Permanente triage system and principles of the Regional House of Care. Clinicians have attempted to understand the existing patient flow within the system and analysed the areas in need of realignment and redesign.

Innovation, Impacts and Outcomes: Benefits from the greater focus with the Connecting Care program on service improvement and shared patient centred care planning has resulted in greater patient satisfaction and lower costs in the acute service sector. Graph 1 shows the potentially avoidable hospitalisations in the region reducing from this focus on more coordinated and integrated chronic care in our region of NSW from 2001 and again in 2010.

Graph 1: Potentially preventable admissions across the region 2001-2013

Sustainability, Transferrability: Creation of an integrated contact centre that built on successful models of aged care and chronic disease management provided timely screening of eligible patients from electronic data sources (iPM, Cerner records, CHIME), phone triage and assessment and recommended interventions in an appropriate care setting. Reduction of variation and clinical decision support paths from agreed protocols and care pathways provided by a range of phone based clinicians provide interventions from medical, nursing and allied health staff.

Conclusions: Existing clinician networks in primary care have a voice in service development with Connecting Care and an active role in care planning across the system using innovations in technology, greater sharing of electronic health records and pooled resources. The changes have resulted in system efficiencies and demonstrated savings for the acute care sector with more patients able to be seen.

Discussions and Lessons Learnt: General Practitioners are able to refer patients for services, decision support and specialist in reach support from acute care services using the Connecting Care coordinated phone based access and referral centre. Primary care based clinics for rehabilitation, education and support hubs have been increased to provide coordinated care for patients and carers, assist in hospital avoidance and produce a planned transition for patients to their usual residence with supportive domestic and personal care.

Keywords

efficiency; hospital avoidance; navigation; affordable

PowerPoint presentation

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