Integrated Care Matters

#ICMMatters
IFIC is a non-profit members’ network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice.

The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.
‘Integrated Care Matters’

Monthly Webinars

• User and carer perspectives

• Home and Away presentations

• Facilitated Discussion – add questions & reflections to chat box

• Knowledge Tree - Topic based resources developed for each session – send your resources to Marie: marie@hmcic.uk for uploading. A copy of this will be sent out to all registered following the Webinar today

• SIGs are in development and will be hosted on the IFIC Website, if not already done so, please sign up for IFIC membership – a community membership is free if you don’t want to join as a full member

• Up and coming Webinars

• Webinars are in collaboration with UWS, Alliance & HIS
Housekeeping

- Can all participants that are not presenting, please mute your microphone on the top bar:

- Can hosts & presenters please mute their microphone when not speaking

- When presenting, please use the arrow buttons at the bottom of the screen to move through your slides

- Add your questions, comment and reflections to the chat box
The Govan SHIP Project
(Social and Health Integration Partnership)

Vince McGarry,
Project Manager
Background

- The Govan SHIP Project covers the patients of the four GP Practices in Govan Health Centre in Glasgow. These are part of the ‘Deep End’ which is the group of 100 practices in Scotland serving the highest percentage of patients living in the 15% most deprived data zones in Scotland. They rank 24th, 29th, 36th and 80th respectively. (The last is a practice split over two locations and their rank changes to 11th when considering Govan patients only).

- The INVERSE CARE LAW (J Tudor Hart, 1971) is most apparent in areas of high deprivation where those who most need medical care are least likely to seek or receive it.

- Estimates of male and female life expectancy in Greater Govan are below the Glasgow average. The area has a high proportion of people claiming out of work benefits and young people not in education, employment or training, compared with the Glasgow average. The numbers of people limited by a disability is 20% higher than the Glasgow average.

- The prevalence of people with multi-morbidity is increasing and occurs 10-15 years earlier in deprived populations.
Project Aims / Objectives

• Person Centred approach – based on all health & social care needs, not criteria
• Shift demand in Primary Care
• Work to the top of the licence
• Develop anticipatory and preventative approaches
  – Reduce inappropriate use of Unscheduled Care, Avoid or delay hospital admission
• Provide improved support for chronic illness
• Evaluation
Key Components

• Aligned Social Workers
• Structured Multi-Disciplinary Team Meetings
• Additional time for GPs
  – Extended consultations
  – Polypharmacy reviews
  – Case Review
  – Outward facing / planning
Govan SHIP - MDT

**Patient / Client PERSON**

- General Practitioner (GP)
- District Nurse
- Mental Health
- Social Worker
- Health Visitor
- Links Worker (as appropriate)

As Required / Aspirational
- 3rd Sector
- Housing
- Carer Support
- Welfare
- Well being
- Social isolation

Hospital Sector
Approximately 39% of presentations per month are social work related.
Challenges

- The context of change
- Cultural Conflict
  - Universality vs. Criteria
  - Medicalisation vs. Enablement
- Organisational structures / boundaries
- Project Longevity
“Boundary maintenance and protectionism underly much of the tensions experienced here and elsewhere in integration projects and the members of the SHIP team are to be congratulated from moving from a position of negative, entrenched views and hostility towards a shared understanding and new learning.”
SO WHAT? - Outcomes

• Trends in the SHIP population indicating:
  – They were previously higher than average users of health services
  – Their level of demand was increasing over time
  – Their demand peaked over the period of intervention
  – Their demand levelled or declined after intervention

• Change is apparent ACROSS several services
  – A&E presentations, GP Demand, Outpatients, Emergency Admissions
    (less conclusive)
GP Demand

Govan SHIP Project GP Demand

1st 6 months SHIP Patients: 148 Patients
2nd 6 months non-SHIP patients: 90 Patients
7242 Patients

Demand Rate 100 interacting patients

Outpatients

Govan SHIP Project Outpatient Attendance Rate

- Rate per 100 patients attending
- 1st 6 mths SHIP patients

327 Patients
164 Patients
7408 Patients
Thank You
Enhanced Community Support
South Angus Locality model
March 2017

Dr Douglas Lowdon: South Angus Locality Geriatric Consultant and Clinical Lead.

Dr Alison Clement: General Practitioner Monifieth Health Centre and Clinical Director Angus IJB
Angus Localities:
- 4 localities
- population 110,000
Angus Localities – South Angus

South Angus:
- 2 localities: South East and Southwest
- Total population 55,000
- 7 GP Practices
- 2 deprivation areas
Comprehensive geriatric assessment (CGA)

Multidimensional, MDT diagnostic process to determine the medical, psychological and functional needs of frail person in order to develop coordinated and integrated plan for treatment and long-term follow up.

Reduces morbidity, mortality, hospital stay and (by increasing independence) the need for 24-hour care

Conroy et al. Age and ageing Jan 2014
Enhanced Community Support
Phase I – December 2013 South West Locality

Unscheduled care funding from Scottish Government.

Aim of project:

1. Early, co-ordinated intervention of frail older people in their own home by members of an MDT, based in General Practice NOT hospitals, aimed at delivering a joined up care that would enable patient to live as independently in community as possible.

2. Reduce crisis situation, but if arise to support management at home is possible and safe.

This is not hospital at home. This is co-ordinated care to prevent need for hospital at home.
Enhanced Community Support
Winter project 2013-2014

What do we do?
- Frail patients identified by community staff, OOH, community alarm, paramedics, and are reviewed by GP to ensure medical plan.

- Care co-ordinated same day by senior community nurse and comprehensive assessment delivered.

- MDT General Practice based support available:
  Pharmacist, physiotherapist, occupational therapist, pharmacy technician, Locality MFE Consultant, Old age psychiatry/ community mental health team, social work Home Care Assessor, Carers agencies, voluntary agency …

- Patients discussed real-time via various communications forms including email, face to face and also weekly MDT meeting in GP Practice..

- MDT anticipatory care plan created and documented, if appropriate
Nine Principles of Enhanced Community Support:

1. General practitioners and community nurses will use clinical judgment to identify frail community-dwelling older people requiring comprehensive community-based MDT/multi-agency assessment (Enhanced Community Support) and specialist support.

2. General practitioners have additional capacity to deliver “Specialist Generalist” role to undertake comprehensive medical review.

3. Occupational therapists, pharmacy, pharmacy technicians, physiotherapists, and community nurses are also provided additional capacity to support ECS.

4. The overall care of these patients is co-ordinated by a single named primary care clinician, usually district nurse.

5. These patients should have timely access (within 24 hours) to the full multidisciplinary team in the community, including physiotherapy, occupational therapy and pharmacy.

6. These teams are aligned to respective GP Practices. Many of the team are based in the Practice building.

7. Level III medication review and assessment of medication compliance should be undertaken, if appropriate.

8. Weekly multidisciplinary meetings attended by the locality MFE team and the practice based multidisciplinary team.

9. All these patients should be considered for an anticipatory care plan, including a CPR decision.
Enhanced Community Support
Activity numbers – population coverage 40,000

Figure 1: ECS activity numbers 2nd December 2013 to 30th March 2014.

Dr Ellie Hothersall, Consultant in Public Health Medicine, NHS Tayside
Public Health evaluation June 2014
Impact of Enhanced Community Support Phase I

Stephen Halcrow Principal Information Analyst

Monthly Occupied Bed Days Before and After ECS for Patients Registered to a Practice in South West Angus

- Monthly Occupied Bed Days
- ECS Regression Line
- Non ECS Regression Line
Impact of Enhanced Community Support Phase I

Stephen Halcrow Principal Information Analyst

Monthly Occupied Bed Days Before and After ECS for Patients Registered to a Practice in South West Angus

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Impact Enhanced Community Support (ECS Phase I) has on care home placements from hospital.

![Bar Chart: Patients going from South Angus MFE beds to care home placement](chart.png)
Enhanced Community Support
Phase II – February 2015

- Role out to neighbouring Angus South Easy locality
- Integrated change Fund resource top “pump prime”
- ECS model with coverage of 7 General Practices and population 55,000
Enhanced Community Support South Angus - outcomes
Enhanced Community Support staff satisfaction survey outcomes

May 2016:

q5. Team has adequate time and resources to achieve objectives

q14. This MDT team works well together

q18. The ECS MDT meets the needs of patients, clients and carers in South Angus

q32. Morale on the MDT Team is high
Impact Enhanced Community Support (ECS Phase I) has on care home placements from hospital.

Patients being discharged from South Angus MFE hospital to a new care home place:

- Monifieth/Carnoustie Locality
- Arbroath Locality
- Total

<table>
<thead>
<tr>
<th>Period</th>
<th>Monifieth/Carnoustie</th>
<th>Arbroath</th>
<th>Total</th>
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<tbody>
<tr>
<td>Jan-Dec 2013</td>
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<td></td>
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<tr>
<td>Jan-Dec 2014</td>
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<td>Jan-Dec 2015</td>
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<tr>
<td>Jan-Dec 2016</td>
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Impact of Enhanced Community Support Phase I

Stephen Halcrow Principal Information Analyst

Monthly Occupied Bed Days Before and After ECS for Patients Registered to a Practice in South West Angus

- Monthly Occupied Bed Days
- ECS Regression Line
- Non ECS Regression Line
Financial impact of Enhanced Community Support

Stephen Halcrow Principal Information Analyst

Monthly Occupied Bed Days Before and After ECS Registered in an South East Angus

- Monthly Occupied Bed Days
- ECS Regression Line
- Non ECS Regression Line

Graph showing the comparison of monthly occupied bed days before and after ECS registration in South East Angus.
Impact of Enhanced Community Support Rates of hospital bed day use using HEAT T12.

Stephen Halcrow Principal Information Analyst

Annual HEAT 75+ Emergency Bed Day Rates per 1,000 Pop for 75+ as at March 2016
Financial impact of Enhanced Community Support

Stephen Halcrow Principal Information Analyst

**ECS Phase I:**

Between Jan 14 and Nov 16 there have been approximately 1,700 potential bed days saved, which at a unit cost of £230 per day, adds up to around £400,000.

**ECS Phase II:**

Between Feb 15 and Nov 16 there have been approximately 3,000 potential bed days saved, which at a unit cost of £230 per day, adds up to around £700,000.
Impact of Enhanced Community Support on local hospital bed day use in South Angus.

Impact of Enhanced Community Support on South Angus Hospital bed use
December 2013 to December 2016
Enhanced Community Support
Phase II – February 2015

- Role out to neighbouring Angus South Easy locality
- Integrated change Fund resource top “pump prime”
- ECS model with coverage of 7 General Practices and population 55,000
- Service Transition with closure of 12 community hospital beds releasing permanent funding and workforce alignment to enable model to be self sufficient.
Enhanced Community Support
Phase III – Nov 2016

- Role out to North East Locality
- Integrated change Fund resource from South Locality to “pump prime” ECS in North East Locality
- ECS model with coverage of 12 General Practices and population 84,000
Services available to Older People...

Enhanced Community Support...

Supporting people to stay at home!

With me at the middle!

Prevention of admission services
LOCAL DISCIPLINARY TEAMS

DR. HARRY POPE, GP & IFIC FELLOW, AUSTRALIA

• Healthcare in Australia
• Delivery of primary care teams at Primary Health Care Limited
• Examples of local teams within Primary Health Care Limited
• Care Study – Fairfield Medical Centre
  o Location and demographics
  o Team structure
• Next steps
HEALTHCARE IN AUSTRALIA

- The healthcare system in Australia operates in a complex funding and regulatory environment.
- Through the ‘Medicare’ system funded by the federal government, all Australians are eligible for hospital and primary care services.
- For hospital services, patients may elect to instead be treated at private hospitals if they are covered by their private health insurance policy.
- For primary care services, patients may see their private General Practitioner (GP) who receives a fee-for-service payment from Medicare.
- It is up to the practice to either bill at the government’s rate (“bulk-bill”) or ask for additional money through a co-payment from the patient.
Primary Health Care Limited (Primary) was established in 1985 with the opening of Warringah Mall 24 Hour Medical Centre by Dr Edmund Bateman in Brookvale.

Primary is a leading healthcare company in Australia and has been providing quality, affordable and accessible healthcare to the people of Australia for more than 30 years.

Primary has 3 major divisions:

1. **Pathology**: With 15 million patient cases per year, 1:3 Australian pathology tests are conducted at a Primary laboratory.

2. **Imaging**: Currently over 150 imaging centres with 2.2 million scans per year.

3. **Medical Centre**: 72 medical centres in most states and territories with over 8 million consults per year.
Primary Medical Centres places a focus on affordable, accessible and quality healthcare:

- **Affordable**
  - Bulk-billed consultations to all Medicare patients.

- **Accessible**
  - Co-located services under one roof (including for most centres GPs, treatment rooms, dentists, specialists, imaging, pathology and pharmacy).
  - Open extended hours 365 days a year.
  - Walk in medical centres with some appointments for chronically ill patients and allied health and specialist visits.

- **Quality**
  - Strong governance through established clinical councils, dedicated in house accredited training institute.
  - Commitment to the use of data to drive behaviour.
Team structure

- Co-location facilitates a number of interactions within the medical centre.

- At most centres, there are three leaders:
  1. **Practice Manager**: responsible for the centre’s operational matters.
  2. **Lead Doctor**: oversees the GPs and any clinical issues.
  3. **Treatment Room Leader**: practice nurse responsible for the management of the treatment room.

- Regular **meetings** facilitate discussions on operational and clinical improvement:
  - The Practice Manager meets monthly with centre staff to improve centre processes.
  - The clinical team meets fortnightly for clinical education, often presented from allied health providers or other local providers including specialists from hospitals, aged care providers etc.
LEVELS OF INTEGRATION – PRIMARY (CONT)

Systems

- The care team (GP, Allied Health, Clinical Care Coordinator and specialists) are interconnected through the use of the same clinical software.

- **Pathology results** are instantly communicated through an electronic download integrated with the clinical software.

- Patient records are securely shared online with the hospital system and other enabled providers through *My Health Record*. This is currently an opt-in shared health record platform run by the federal government that allows all medical providers access to a central health record.
EXAMPLE OF A PRIMARY MEDICAL CENTRE
WARRINGAH MEDICAL & DENTAL CENTRE
WARRINGAH MEDICAL & DENTAL CENTRE
Open every day, 6:00 – 20:00 (7:00 – 20:00 weekends)

CORE TEAM
– 26 GPs
– Clinical Care Coordinator

SUPPORTING TEAM
– Treatment Room Nurses
– Pathology Collection
– Diagnostic Imaging (X-Ray, Ultrasound, OPG, MRI, CT Scan)
– Practice Manager, 2IC & Receptionists

SPECIALISTS
– 4 Dentists
– Rehabilitation Specialist
– 3 General/Consultant Physicians
– Skin Cancer Clinician
– 2 General Surgeons
– 3 Gynaecologists
– 2 Plastic Surgeons
– Orthopaedic Surgeon
– Cardiologist
– Neurologist
– 2 Gastroenterologists
– Eye Centre (incl. 5 Ophthalmologists)
– Day Surgery Suites

ALLIED HEALTH
- 3 Physiotherapists
- 3 Psychologists
- Podiatrist
MY CENTRE – FAIRFIELD MEDICAL CENTRE
**FAIRFIELD MEDICAL & DENTAL CENTRE**

Open every day, 7:00 – 22:00 (8:00 – 22:00 weekends)

<table>
<thead>
<tr>
<th>CORE TEAM</th>
<th>ALLIED HEALTH</th>
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<tr>
<td>– 13 GPs</td>
<td>– Physiotherapist</td>
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<tr>
<td>– 2 Clinical Care Coordinators</td>
<td>– Psychologist</td>
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<td></td>
<td>– Dietitian</td>
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<td>– Podiatrist</td>
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<td>– Optometrist</td>
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<td></td>
<td>– Diabetes Educator</td>
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<tr>
<td>SUPPORTING TEAM</td>
<td>SPECIALISTS</td>
</tr>
<tr>
<td>– Treatment Room Nurses</td>
<td>– Cardiologist</td>
</tr>
<tr>
<td>– Pharmacy</td>
<td>– Endocrinologist</td>
</tr>
<tr>
<td>– Pathology Collection</td>
<td>– General Surgeon</td>
</tr>
<tr>
<td>– Diagnostic Imaging (Adjacent to centre: X-Ray, Ultrasound, OPG, MRI, CT Scan, Mammogram)</td>
<td>– Gynaecologist</td>
</tr>
<tr>
<td>– Practice Manager &amp; Receptionists</td>
<td>– Gastroenterologist</td>
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<tr>
<td></td>
<td>– Haematologist</td>
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# CLINICAL CARE COORDINATOR INVOLVEMENT

Our Clinical Care Coordinators are essential in chronic disease management and team care coordination.

<table>
<thead>
<tr>
<th>Key responsibilities</th>
<th>How</th>
<th>Outcomes</th>
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| **Chronic disease management, team care coordination and preventative health screening** | Collaboration with GPs and other health care practitioners including Allied Health and specialists | • Streamlined workflows  
• Greater collaboration between clinical and non-clinical support teams in order to provide a holistic health care approach  
• Positive engagement with GPs, patients and health care providers  
• Promotion and delivery of a robust and compliant chronic disease management program  
• Measurement of clinical outcomes |
| **Health behaviour change** | Embedding health behaviour change principles into the planning and delivery of care by performing age and diagnosis specific health assessments designed to empower and increase patient ownership of their health | • More preventative screening tools are being used to better identify patients with chronic conditions |
| **Improving patient care and engagement** | Increased participation of the nurse in chronic condition prevention and management, team care co-ordination and other related programs | • Evidence of growth in the number of health assessments, GP management plans, team care arrangements and reviews including medication reviews in compliance with the Medicare recommended schedule and regulations |
| **Other business development initiatives** | Involvement in the set up of clinics at the medical centre including chronic care management, occupational health etc. | • Diversification of tasks for clinical and non-clinical support teams to provide variety of work and engagement |
EXAMPLES OF STREAMLINED WORKFLOWS

Diabetes care plan workflow

Referral pathway
**NEXT STEPS**

1. Determine other chronic care pathways and streamlined workflows.
2. Identify patients for chronic care pathways.
3. Roll out diabetes clinic to other Primary Health Care Limited medical centres (already in progress).
4. Further software data analysis for disease specific conditions with additional search fields for last review, biometric assessment, etc. (e.g. diabetes – cycle of care).
5. Patients or carers self identify on hearing of the programs
6. Other Health Care Professionals including specialists referring into the pathways.
7. Comparison study on patient outcomes.
8. Patient and Clinician satisfaction surveys.
Locality Interdisciplinary Teams
Knowledge Tree

Marie@hmcic.uk
Next Webinar Dates for Your Diary

• Community Centred Palliative Care                                April 19th
• Building community connections and resilience – the importance of context and culture   May 16th

Volunteer presenters for future webinars welcome

Contact: anne.hendry@lanarkshire.scot.nhs.uk
Enhanced Community Support in

https://vimeo.com/194360349
Stay connected and grow our Integrated Care Matters Learning Community

- **Join us at:**
- Tweet #ICMatters
- **Blogs** – share your thoughts and experience
- **Knowledge Tree:** Add your resources and grow our tree. Send resources to Marie at: marie@hmcic.uk
- Involve your colleagues in future webinars

- Visit the WHO portal [http://integratedcare4people.org/](http://integratedcare4people.org/)