WESTERN HEALTH LINKS

Helping patients with complex and chronic conditions to stay at home.

Jason Plant, Program Director Western HealthLinks

A new approach by Western Health, with Silver Chain Group.

Silver Chain

Changing patterns of Melbourne's growth

Melbourne's population growth per decade

Western Health

1980s

+83k

Source: KPMG

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Changing patterns of Melbourne's growth

Melbourne's population growth per decade

Western Health

1990s

+73k

Source: KPMG

Changing patterns of Melbourne's growth

Melbourne's population growth per decade

Western Health

2000s

+138k

Source: KPMG

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Changing patterns of Melbourne's growth

Melbourne's population growth per decade

Western Health

2010s

+158k

Source: KPMG

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Changing patterns of Melbourne's growth

Melbourne's population growth per decade

Western Health

2020s

+182k

Source: KPMG

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Community of the west

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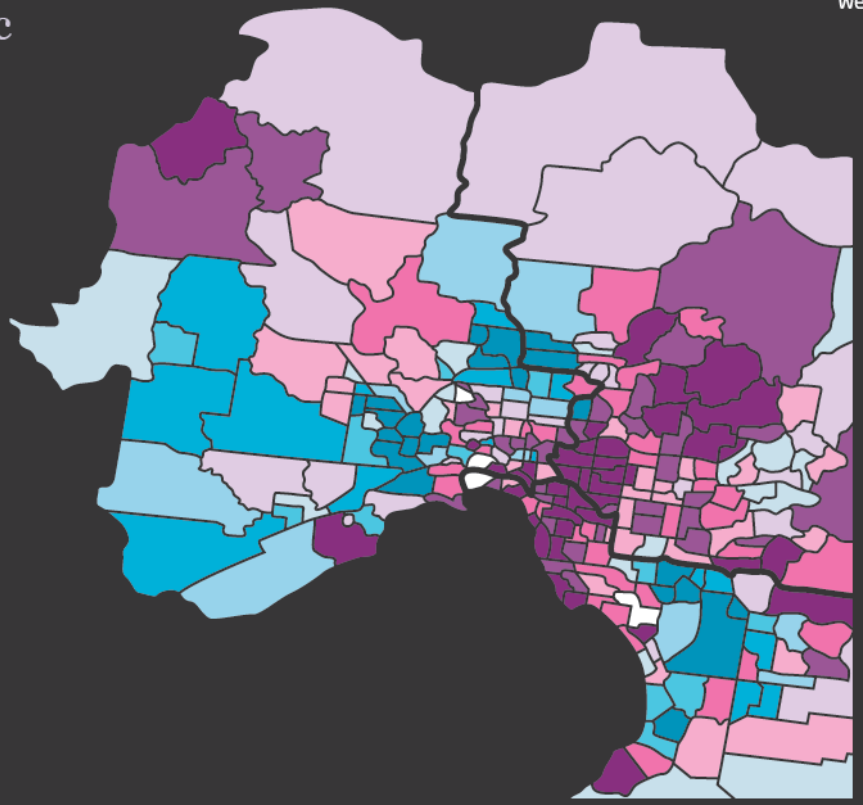
Percentile rank (Victoria)

Index of Relative Socio-economic Disadvantage

Western Health



Source: Australian Bureau of Statistics

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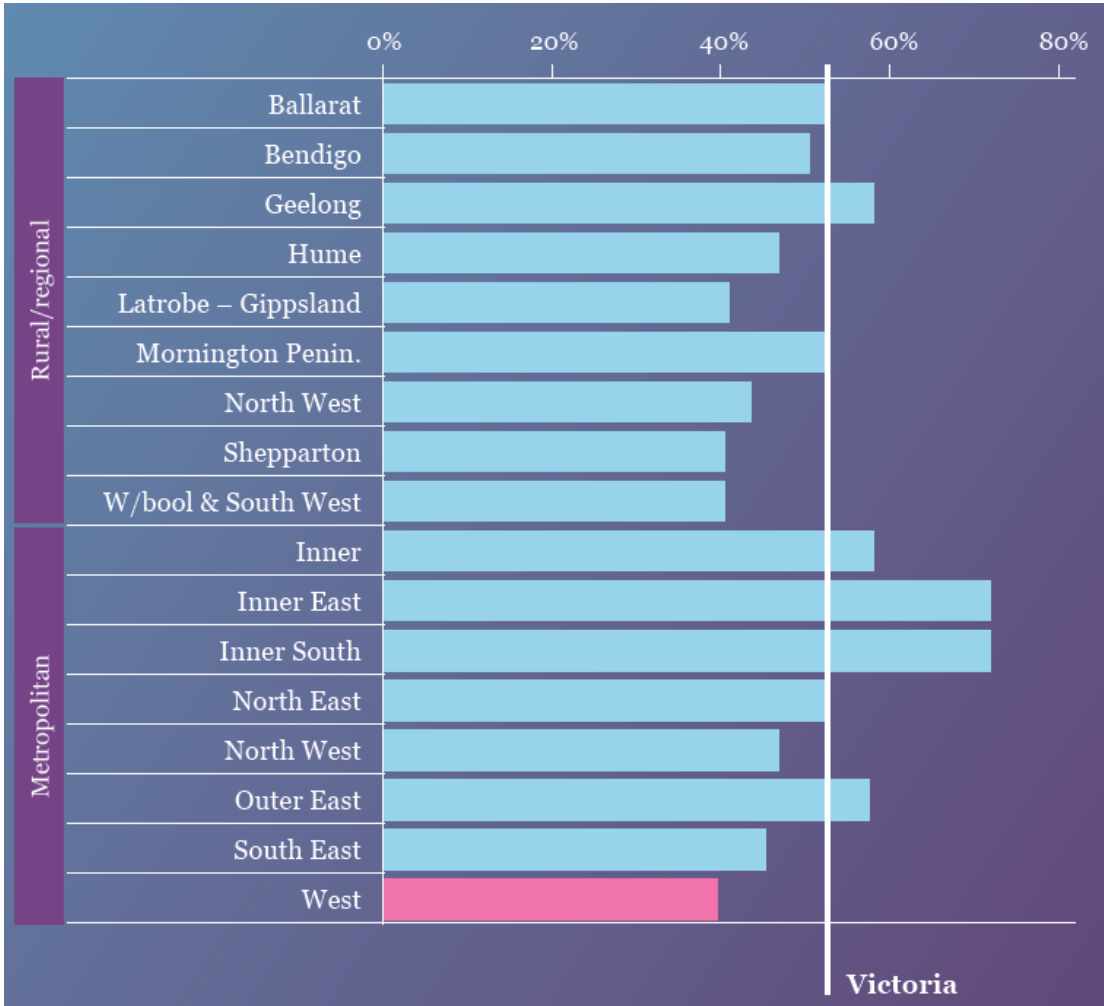

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Limitations of healthcare provision in the West

Percentage of taxpayers with private health insurance (2013/14)

Source: Australian Tax Office

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Developing the Western Health strategy

Western Health

AIM 1:
Growing & improving the delivery of safe, high quality care

AIM 2:
Connecting the care provided to our community

AIM 3:
Communicating with our patients, our partners & each other with transparency & purpose

AIM 4:
Being socially responsible & using resources sustainably

AIM 5:
Valuing & empowering our people

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Guido

Western HealthLinks

Robert

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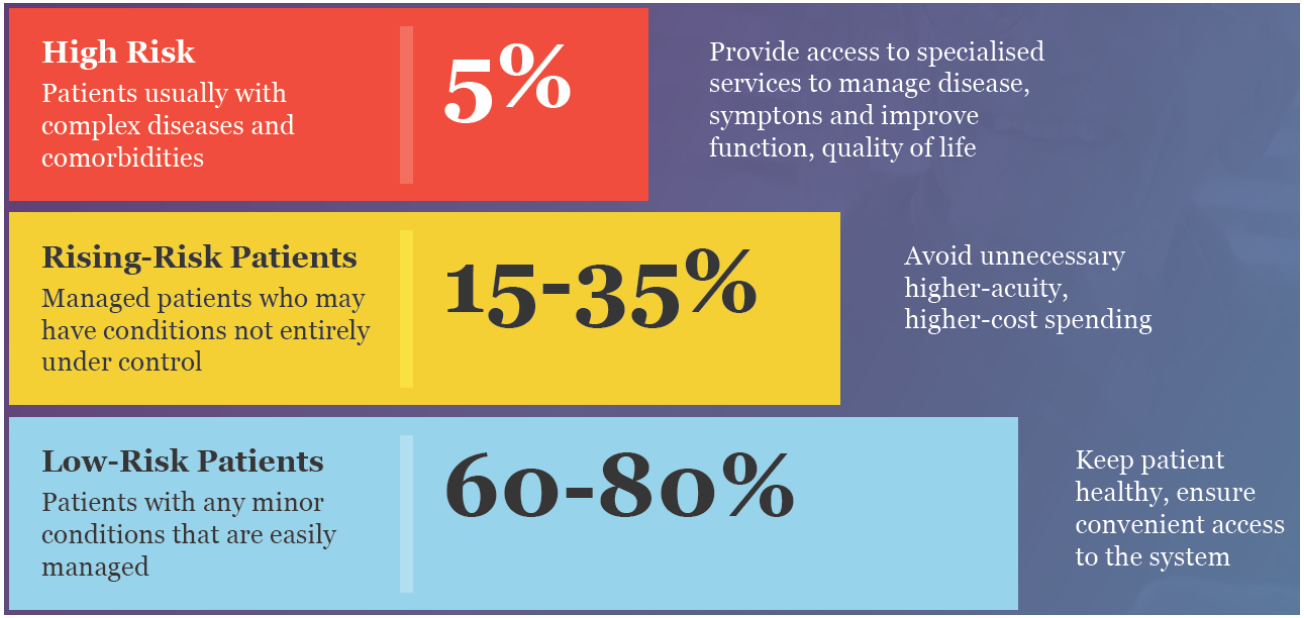
10 Key Success Factors to Quality Care Integration

1. Identification System
2. Advanced Discharge Program
3. Post Discharge Support Program
4. Expert 'Hospital Like' Clinical Care in the Home
5. Care Coordination/ Care Navigation
6. Integrate with GP's and Primary Care
7. Post Discharge Pharmacy Review
8. E-Health
9. Advanced Care Planning
10. Multicomponent, integrated and collaborative strategies

* Based on extensive literature review

Consultation



The Advisory Board Company

Silver Chain

Western Health

Benchmarking

The Health Roundtable

Silver Chain

Western Health

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Current Model and Gaps

Western Health

- Patient Identification
- Internal Hospital Navigation
- Risk Stratification
- Collaborative Care Planning
- Transition to a Care Navigation Service

Gaps in current model of care

Care Navigation	Medical & Nursing Care
Care Facilitation	Telehealth
24/7 Phone Support	Allied Health
Psychosocial Support	Priority Response Service
GP Care	Clinical Portal

HealthLinks

GP & Primary Care

Our collaborator

Silver Chain Group

Western Health

- Silver Chain Group – not-for-profit - run large in-home health and care services around Australia and employ more than 3,500 staff
- Work with hospitals and health services to strengthen the interface between hospital and community based care
- Enabling hospitals to focus on high-end, complex acute care with patients returning to the community as soon as safe and practicable
- They employ doctors, nurses, allied health professionals and support staff
- Proven experience delivering acute care in home settings on the scale required by Western Health

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Western Health

Silver Chain Group

24/7 Phone Support	Patient Information Systems (Clinical Portal)
Priority Response (PRA)	Telehealth
External Care Navigation	GP Care

Western Health Community, Ambulatory and Sub-acute Services

Internal Care Coordination (ICCT)	Home Services	Allied Health
Rapid Discharge Support Service (RDSS)	Psychosocial Support	Clinical Nursing Care
Sub-acute Services and Specialist Clinics	Pharmacy / Medication Support	Medical Support

Western Health Acute Services

Acute Inpatient Care

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Model of Care

Patient Identification

- Initial Inpatient engagement
- Confirm patient contact details
- Inform treating unit of admission
- Communication with SCG Navigator

GP Engagement

- Current GP/Community Care Plans

Collaborative Care Planning & Risk Stratification

- GP
- Treating Unit
- ICCT
- SCG Navigator
- AH

Clinical Information and Care Transfer

- Collaborative Care Plan transitioned to GP and SCG Navigator
- e-Referral for post discharge care requirements sent to SCG

Post Discharge Services

- SCG Contact within 24 hours of discharge
- Collaboration with patient's GP
- 24/7 Phone Access
- Rapid Clinical Response (PRA)
- Clinical Portal

Post Discharge Care

- Medical
- Nursing
- AH
- Psychosocial support
- Pharmacy Review
- Education
- Home Support

Connection maintained with Health Service (if required)

- Rapid Access to Consultative expertise
- Rapid Specialist Clinic Access
- Planned Patient Admission

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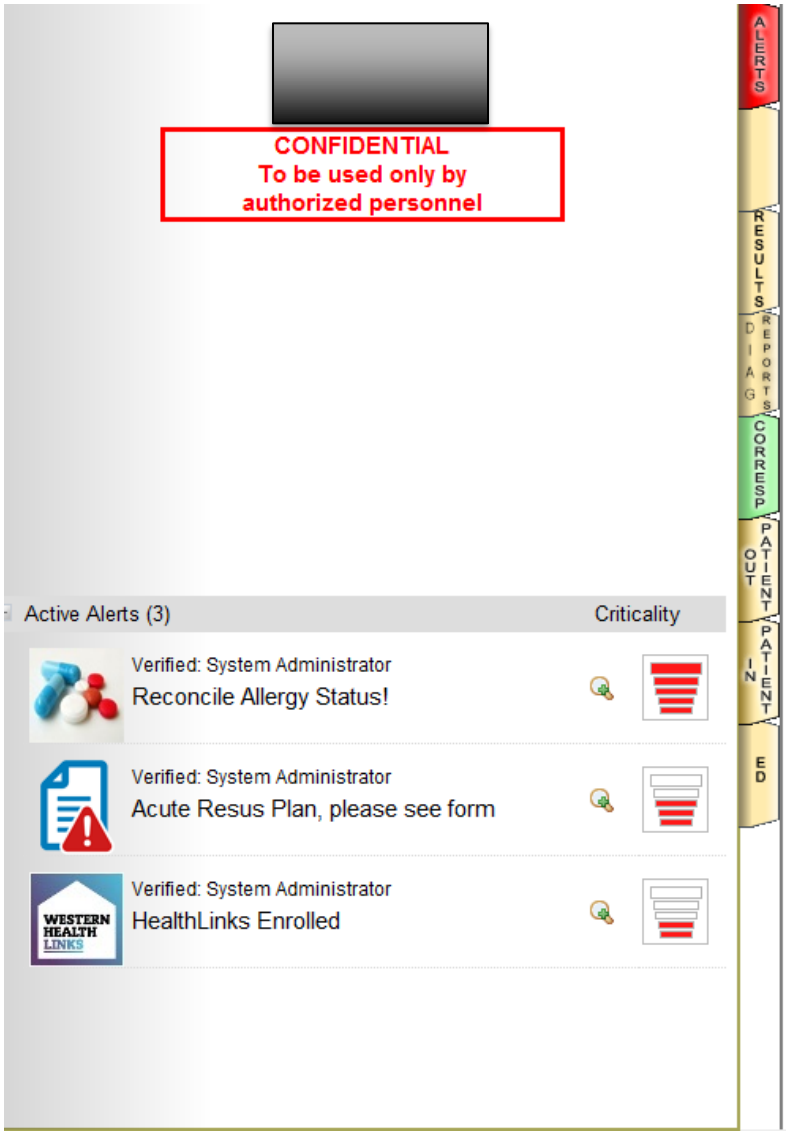
CONFIDENTIAL
To be used only by authorized personnel
ALERTS
RESULTS
DIAG REPORTS
CORRESP
OUT PATIENT
IN PATIENT
ED
Active Alerts (3)
Criticality
Verified: System Administrator
Reconcile Allergy Status!
Verified: System Administrator
Acute Resus Plan, please see form
Verified: System Administrator
HealthLinks Enrolled

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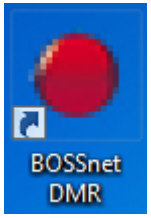
Automatic Identification System –



Newly Enrolled Patients

Health Links Newly Enrolled List | Load Shared Consult List | Shared Consults

Bed	URN	Patient Name	Arrival ▲	DOB	Sex	Consultant	Diagnosis	New	Unseen	Sign
Ward F 3B (Footscray) (2 patients)										
R12-29-F3B			25/01/2017	8/11/1926	F	Sydenham, MR Daniel	Left intertrochanteric NOF#. IMN 28/1.			
R12-30-F3B			28/01/2017	14/8/1935	F	McKie, DR Claire	Left knee pain			
Ward F Coronary Car										
R08-15-FCCU			31/01/2017	5/4/1939	F	Krawczyszyn, DR Mark	chest pain			
Ward F Emerg - Obse										
R02-06-FEOU			31/01/2017	23/1/1936	F	Kelly, MS Anne Marie	Infectious disease, unspecified			
Ward S 2A (Sunshine										
R10-36-S2A			23/12/2016	24/5/1932	F	Johannesen, DR Mark	Chronic back pain			
R12-41-S2A			1/02/2017	8/2/1929	M	Joseph, DR Shikandini	tendency to fall			
Ward S 3E (Sunshine										
R08-08-S3E			31/01/2017	17/9/1928	M	Bashir, DR Rashid	pneumonia			
R06-06-S3E			1/02/2017	1/4/1931	M	Bashir, DR Rashid	PNEUMONIA, LOBAR			
Ward S 3F (Sunshine										
R14-25-S3F			29/01/2017	24/11/1937	M	Rodrigues, DR Mathew	Haemoptysis ?bronchiectasis ?malignancy			
R21-32-S3F			31/01/2017	17/3/1926	M	Meagher, DR Damien	generalised weakness			
Ward S Intensive Ca										
08-SICU			31/01/2017	31/3/1932	F	Bui, MR Hai Thanh	team A : ? perf diverticulitis ?? pyelopnephritis			

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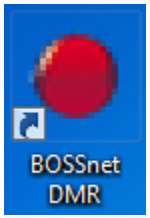
Western Health

Automatic Identification System –

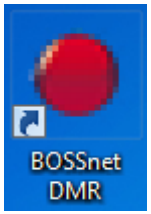


Readmitting Patients

Health Links Already Enrolled List | Load Shared Consult List | Shared Consults

Bed	URN	Patient Name	Arrival	DOB	Sex	Consultant	Diagnosis	New	Unseen	Sign
Ward F 2 East (Footscray) (1 patient)										
R11-17-F2E			30/01/2017	8/1/1934	F	Tramontana, DR Adrian	Splenic infarct			
Ward F 2B (Footscray										
R07-39-F2B			31/01/2017	20/2/1955	M	Ng, DR Su-Lin	HYPERGLYCAEMIA			
Ward F 2C (Footscray										
R11-23-F2C			29/01/2017	28/7/1950	M	Vinay, DR Amirthan	FEVER FI ,PRE SACRAL ABSCESS, BIL KNEE PAIN, PROSTATE \T\ RECTAL CA, PANCYTOP SPLENOMEGALY			
Ward F 3 East (Footsc										
R03-06-F3E			31/01/2017	17/5/1936	F	Jacobs, MR Rodney	blocked peg tube, await new tube phx - partial bowel removal, Breast Ca, Hysterectomy			
Ward F 3B (Footscray										
R05-08-F3B			5/01/2017	25/5/1925	M	Long, DR Claire	# R) NOF			
R07-14-F3B			19/01/2017	30/8/1929	M	Long, DR Claire	SEPSIS \T\ AKI			
R04-06-F3B			23/01/2017	13/12/1952	M	Long, DR Claire	gout			
R12-30-F3B			31/01/2017	14/8/1935	F	Long, DR Claire	JOINT PAIN			

Automatic Identification System



Health Links Newly Enrolled List | Load Shared Consult List | Shared Consults

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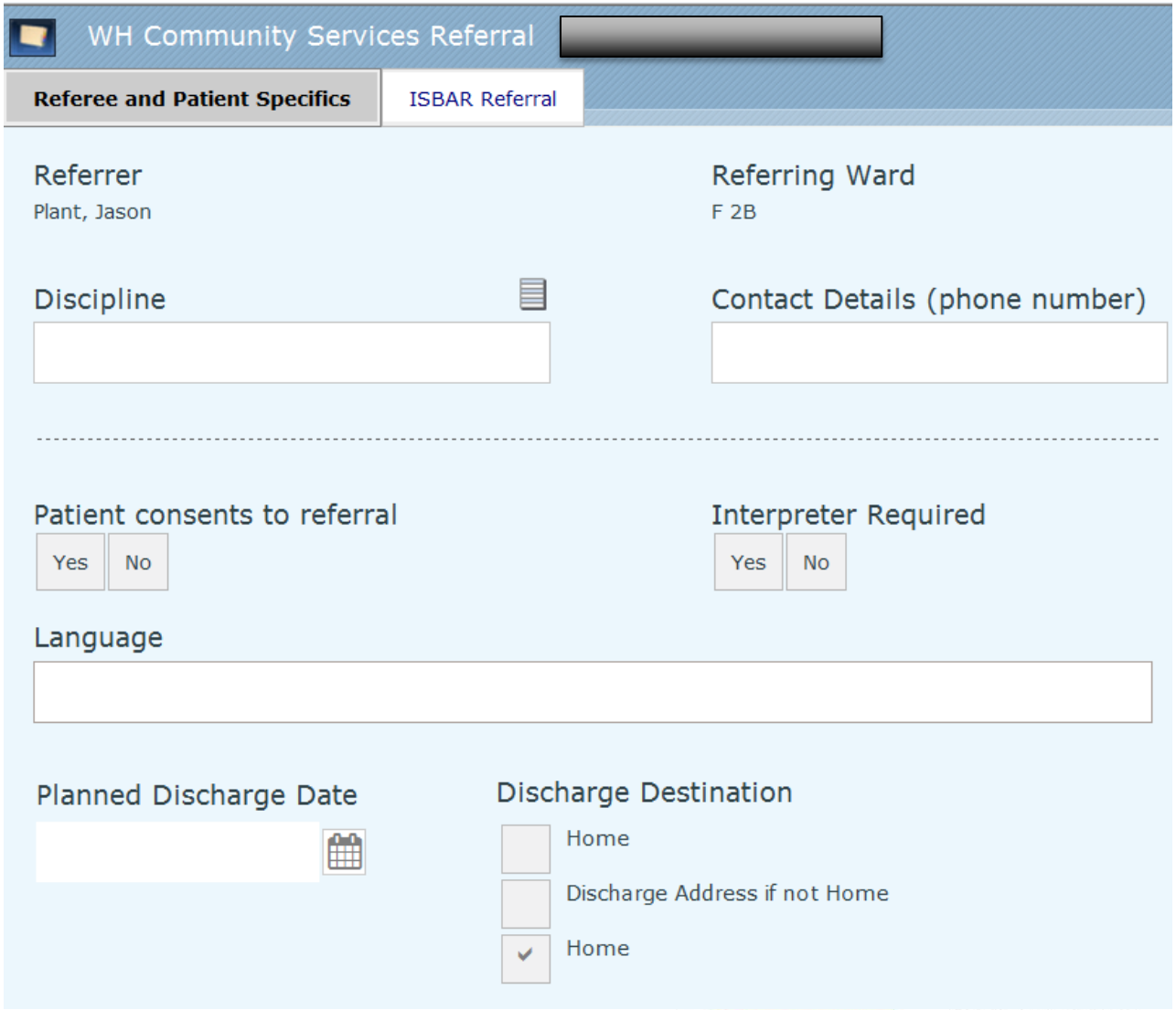
E-Referral



Debility, Psychosocial Screening Questions

Debility, Psychosocial Risk Score		
Question	Available Score	**Patient Score**
1. Does the patient experience difficulty walking (e.g., unable to walk 5 metres in 5 seconds), or had a slip, trip or fall in the past 6 months?	1	
2. Does the patient have memory problems or confusion?	1	
3. Is the patient being treated for anxiety, depression or other mental illness?	1	
4. Will the patient experience any homelessness for the month after they leave the hospital?	1	
5. Does the patient have inadequate food available in their home?	1	
6. Does the patient have inadequate heating and cooling in their home?	1	
7. Will the patient experience difficulty caring for themselves or have inadequate carer support for the 30 days after they leave hospital?	1	
8. Does the patient or carer believe the patient might unexpectedly return back to a hospital bed in the 30 days after they leave the hospital?	1	
9. Do you (Navigator) believe the patient might unexpectedly return back to an inpatient bed in the 30 days after the patient leaves the hospital?	1	
Total Debility, Psychosocial Risk Score		

Governance

Project	Clinical	Performance	Research & Evaluation
• Steering Committee (Monthly) • Operational Committee/PMO (Fortnightly) • Working Group (Weekly) • Working Group Teleconference (Daily)	Western Health & Silver Chain Group Clinical Governance Frameworks	• Patient experience • Increased days out of hospital • 30 day readmission rate • ED presentation rate • Health system activity • Cost	• Western Health & DHHS/CSIRO • Video interview series • Co-design

Leon

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The future

Challenge our health service to move outside the existing frameworks