inTouch – a holistic, person-centred and flexible approach to improve care and outcomes

OUR PLACE. OUR PEOPLE.

NSW GOVERNMENT Health
Western Sydney
Local Health District

UNSW SYDNEY

Acknowledgement of Country

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Image: Leilani Tallulah Knight (2021) U gonna listen now?, UNSW Arts Design and Architecture

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Study methods

Methods:

- Document analysis: n=38, 250 pages
- Key informant discussions: 10

Setting:

- WSLHD

Analysis:

- Thematic, deductive approach

***inTouch* pathways**:

1. COVID Care in the Community
2. Residential Aged Care Facility (RACF/RAFS)
3. Planned Care for Better Health (PCBH)

The *inTouch Program – session focus*

- The *inTouch* Program core elements and three pathways are presented to identify the key lessons to designing and implementing care pathways that are holistic, person-centred and flexible.

- The *inTouch* Program, designed and implemented by WSLHD across 2021-22, is a systems approach to reconceptualising service delivery that focuses on integrating systems components, platforms for service delivery and environments for improved care delivery.

Western Sydney Local Health District (WSLHD) context

NSW	WSLHD	Blacktown LGA	Cumberland LGA	Paramatta LGA	The Hills Shire LGA
Population 8,072,163	Population 1,052,990	Population 396,776	Population 235,439	Population 228,901	Population 191,876
3.6% Aboriginal (278,043 persons)	1.6% Aboriginal (16,531 persons)	3.1% Aboriginal (11,812 persons)	0.7% Aboriginal (1,516 persons)	0.9% Aboriginal (2,001 persons)	0.6% Aboriginal (1,207 persons)
31.0% born overseas (2,502,370 persons) Top 5 countries: India, China, Philippines, Republic of South Korea, Nepal	49.9% born overseas (499,241 persons) Top 5 countries: India, China, Philippines, Republic of South Korea, Nepal	46.8% born overseas (176,116 persons) Top 5 countries: India, Philippines, New Zealand, Fiji, China (excludes SARs and Taiwan)	57.3% born overseas (125,305) Top 5 countries: India, China (excludes SARs and Taiwan), Lebanon, Nepal, Afghanistan	55.1% born overseas (120,381 persons) Top 5 countries: India, China (excludes SARs and Taiwan), Republic of South Korea, Philippines, Hong Kong (SAR of China)	41.2% born overseas (77,439 persons) Top 5 countries: India, China (excludes SARs and Taiwan), England, Philippines, Republic of South Korea
28.2% speak a language other than English at home (2,276,350 persons)	54.3% speak a language other than English at home (538,565 persons) Top 5 languages: Mandarin, Arabic, Hindi, Cantonese, Punjabi	49.3% speak a language other than English at home (183,588 persons) Top 5 languages: Punjabi, Hindi, Tagalong, Arabic, Gujarati	71.0% speak a language other than English at home (153,498 persons) Top 5 languages: Arabic, Mandarin, Nepali, Cantonese, Tamil	58.9% speak a language other than English at home (127,099 persons) Top 5 languages: Mandarin, Cantonese, Korean, Hindi, Arabic	39.8% speak a language other than English at home (74,379 persons) Top 5 languages: Mandarin, Cantonese, Hindi, Korean, Arabic

Source: WSLHD Social and Health Atlas[5] *SAR=Special Administrative Region

The challenge: Western Sydney Local Health District (WSLHD)

- Western Sydney Local Health District (WSLHD) provides a vast and complex range of healthcare services including acute, community, mental health, drug health.
- WSLHD has the second largest population in NSW with 1,144,280 residents in 2021. More than 43 percent of the residents were born overseas and 45 percent speak a language other than English at home. WSLHD is home to the highest urban population of Aboriginal people in NSW.
- The District faces a growing burden of disease, increasing complex chronic conditions and rising demand for health services. Trends in the community profile include: childhood obesity, diabetes, rising mental health issues and conditions associated with aging.
- These combined demands place enormous pressure on WSLHD ability to deliver sustainable contemporary care.
- To address the challenges of high service demands and the detriments of hospitalisation, fundamental changes were required to the way patients with chronic conditions are cared for including alerting care options and processes so to be more responsive to the needs of patients and clinicians.

Background

- Globally, health systems are being transformed, with integrated care used as a guiding principle.
- Integrated care strengthens health services has long been viewed as a solution to fragmentation of care, increased complexity in delivery of care, and quality of care.
- However, integrated care is not a simple, one size fits all approach: care means different things to different people.
- What is required is achieving a more whole system approach to health service delivery, from simply treating healthcare conditions to addressing health and social care needs simultaneously.
- A gap in the integrated care field is that whilst multiple frameworks for integration exist, they tend to concentrate on targeted patients with defined chronic disease, rather than frameworks that foster the process of implementation for those with comorbidities or wider health and social care needs.
- The challenge remains for an integrated care process framework that can be adapted for different contexts, conditions and settings.

History of *inTouch*

- *inTouch* was developed over a 17 year period.
- The initial catalyst was a need to develop a system of care outside of acute care, with a focus on chronic disease management and specific chronic conditions.
- The most recent iteration of the Program was developed in 2021, in response to the COVID Delta outbreak from existing WSLHD clinical capabilities.
- The enhanced pathway focused on a heightened health literacy approach that enabled patients to self-manage COVID symptoms and identify deterioration in their condition and the development of shared care pathways with specialist medical teams for high-risk patients with complex care needs such as renal and organ transplant, haematological malignancy, and human immunodeficiency virus infection.
- The *inTouch* Program continued to transform as the COVID-19 situation evolved, with the most recent iteration focused on providing care for people with complex medical conditions in the right environment. It takes into account the psychosocial care components.

Year	State - NSW Health	District - WSLHD
2006	HealthOne NSW	HealthOne Mount Druitt (HOMD)
2007		Promoting Integrated and Timely Care in the Community and Hospital (PITCCH)
2008		SWAHS Care Navigation Model
2008	Special Commission of Inquiry Acute Care Services in NSW Public Hospitals Final Report of the Overview Peter Garling	Chapter 3 Chronic complex and elderly recommendations
2010	NSW Health The Chronic Disease Management Program	Connecting Care in the Community Program
2014	Integrated Care Strategy – NSW Health	Western Sydney Integrated Care Demonstrator Program (WSICP)
2015		Chronic Disease Management Program Redesign Western Sydney Chronic Disease Management Program (WSCDMP)
2017	NSW Health - Reframing of the Chronic Disease Management Program	
2018	NSW Strategic Framework for Integrating Care	
2019	NSW Integrated Care Scaled Initiatives	
2020		WSLHD Integrated Chronic Care Program (ICCP)
2021	NSW Planned Care for Better Health	WSLHD Integrated Chronic Care Program (ICCP)* * ICCP adopted elements of PCBH but retained 6 key elements that are now the foundation of inTouch
2021-2023		**WSLHD *inTouch* Program**

Overview of *inTouch*

- *inTouch* provides community-based care to people who are at risk of unnecessary emergency department attendance or hospitalisation by connecting them to appropriate care in an easily accessible way.

- This care might be delivered in the community or acute settings by internal and external providers and agencies.

- The *inTouch* Program is facilitated through key advancements including:
    - improvements to digital health technology,
    - a reduction in the number of locations to access care,
    - connected care pathways,
    - development for health literacy and self-care capacity, and
    - increased clinician support to assist patient self-care.

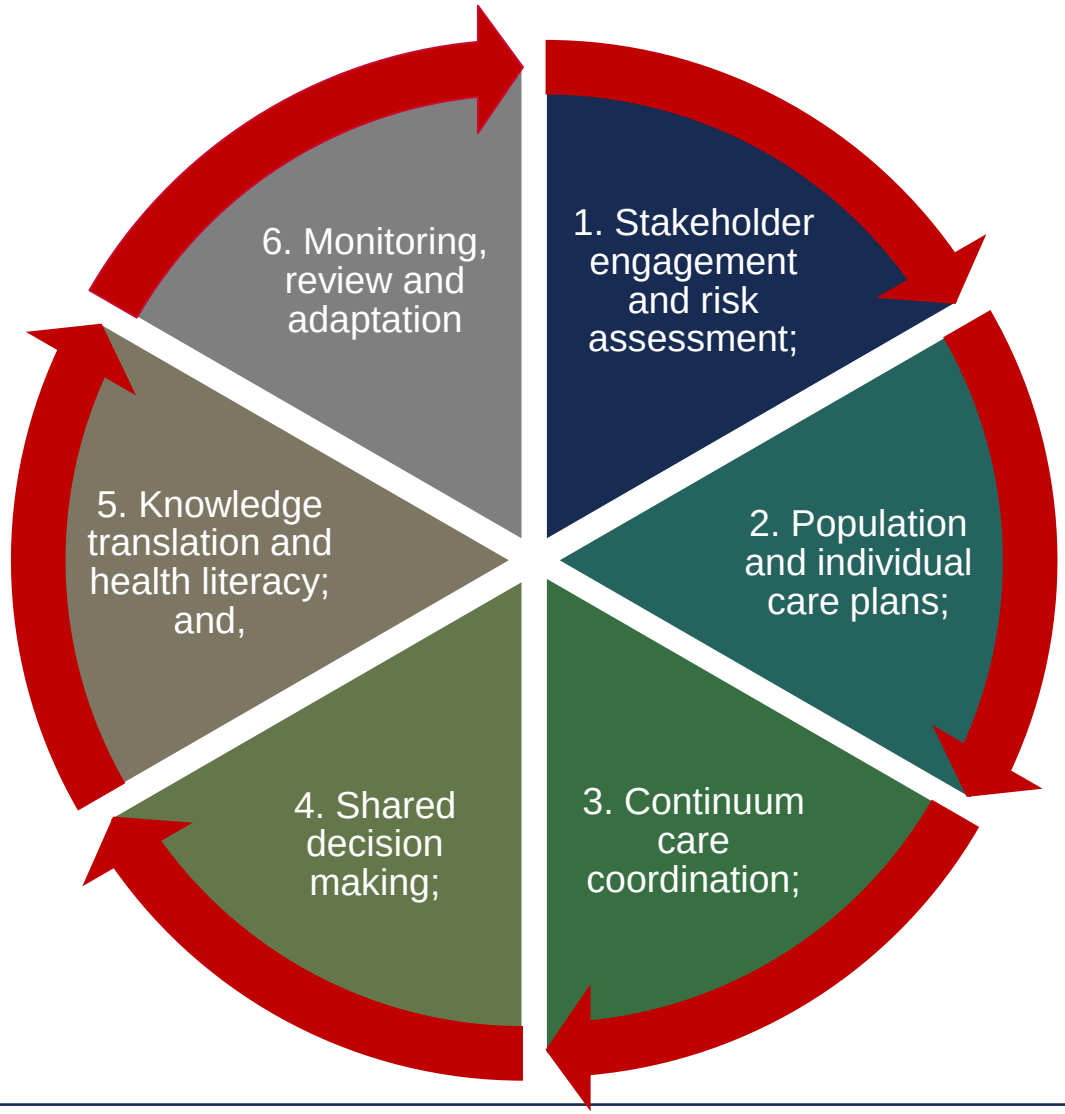
Features of *inTouch*

- WSLHD partnered with multiple internal and external healthcare providers to develop, deliver and modify several *inTouch* pathways, with flexibility to further develop pathways.

- External healthcare providers include NSW Ambulance, Western Sydney Primary Health Network, General Practitioners, 65 Aged Care providers, acute care specialty teams.

- The main feature of inTouch is that there is a dedicated central point of contact through a call service, 7 days per week. Features of the central point of access are as follows:
  - A dedicated phone number operating seven days per week, from 8 am to 8 pm
  - The phone line is responded to by a triage clinician
  - The triage clinician is supported with a procedure manual and clinical guidelines that inform responses to inquiries
  - The triage clinician is qualified to provide preliminary advice regarding care
  - Appointments can be organised within the District or appointments for follow up with GPs.

inTouch Program and care pathways core elements



inTouch Program and care pathways core elements

Elements	Descriptions
1. Stakeholder engagement and risk analysis	Identification and engagement of people who are at risk of hospitalisation
2. Population and individual care plans	Care plans developed to address population and individual health needs and risk factors
3. Continuum care coordination	Connecting patients to services across the continuum: acute, ambulatory, general practice and community health through navigation or referral to services
4. Shared decision making	Shared decision making between the patient, carer and all health care providers
5. Knowledge translation and health literacy	Bridge the knowledge gaps in health information and services to be able to make appropriate care decisions
6. Monitoring, review and adaptation	Identification of disease exacerbation, psychosocial issues and the need for initiation of early service provision

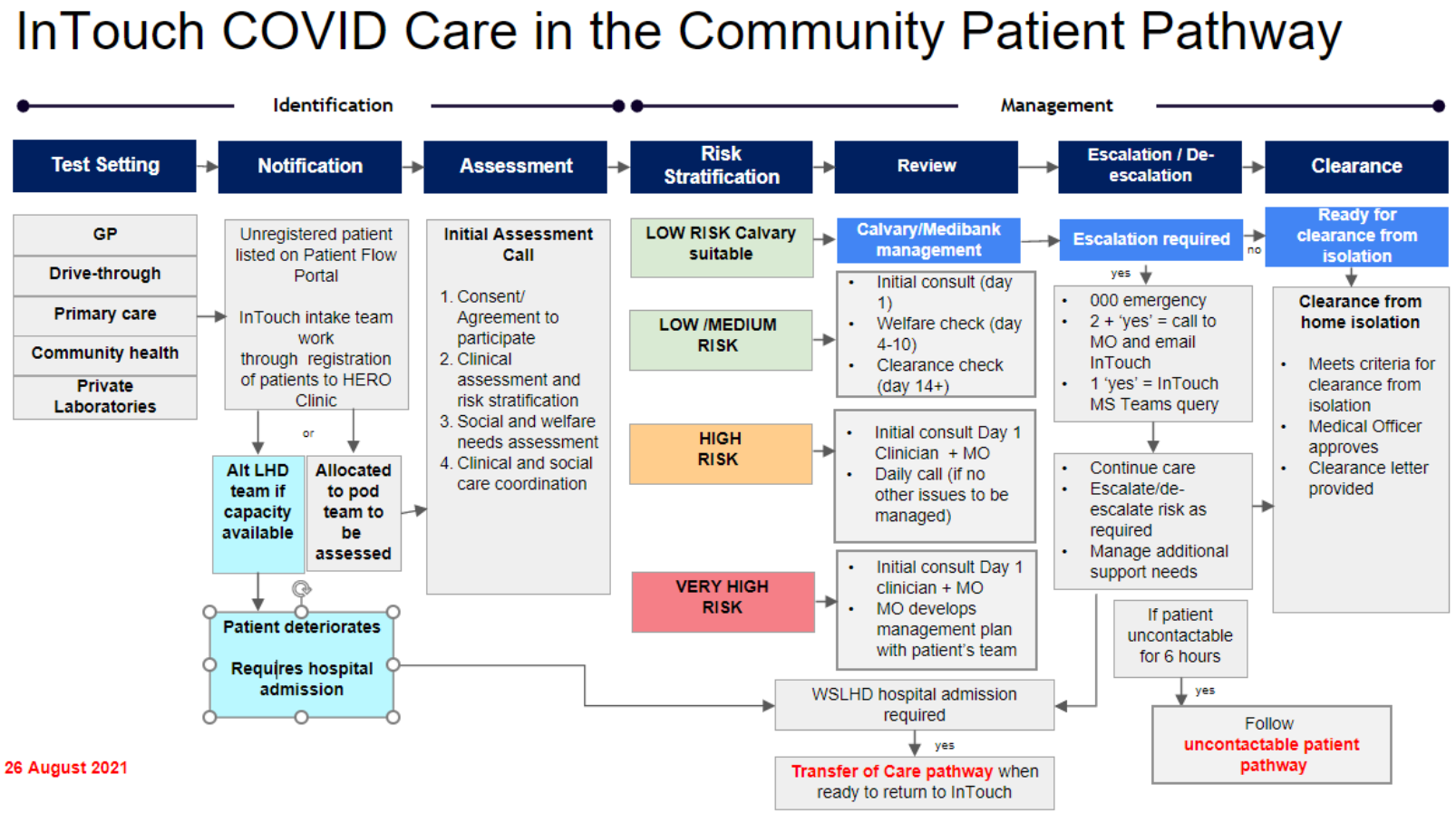
Overview of three care pathways using *inTouch*

	COVID Care	RACF/RACS	PCBH
Purpose/ aim	Care for COVID-19 positive patients who do not need face to face clinical care or intervention Provides early identification and intervention to COVID-19 positive patients who are deteriorating	Improve aged care residents' health and wellbeing through person-centred, flexible, timely care	Facilitate and strengthen care for patients who have been identified of being at risk of unplanned hospitalisation within 12 months
Implementation strategy (how)	Adaptive: continual experimentation and scaling up of what works; useful in unpredictable environments in which new technologies or business models drive changing offerings and patterns of demand – Pandemic Pivot	Visionary: use of imagination to create a game-changing product, service, or business model, followed by persistence in the creation and development of a market; useful when a firm can have a significant influence over the environment rather than merely adapting to it	Classical: clear phases of analysis, planning, and execution; useful in predictable and stable contexts
Who with	WSLHD Speciality teams NSW Ambulance NSW Health COVID response	Aged care providers (n = 65) NSW Ambulance WSLHD Speciality teams Primary Care through WSPHN	Primary health network (PHN) WSLHD Speciality Teams Justice health
Data sources	WSLHD NSW Ambulance NSW Health	WSLHD NSW Ambulance	NSW Health • Integrated Care Outcomes Database (ICOD) • Patient Flow portal WSLHD • WSLHD activity & hospital utilisation data sets • NSW Health Integrated Care Outcomes Database
Evaluation/ monitoring	NSW Ambulance & WSLHD COVID Monitoring Framework WSLHD *inTouch* COVID Clinical Governance Framework	NSW Health Urgent Care Service Evaluation Framework NSW Ambulance & WSLHD RACF Monitoring Framework Analysis of WSLHD activity & hospital utilisation data sets	NSW Health Integrated care Monitoring & Evaluation Framework

inTouch Pathway 1 - COVID Community Care in the Community

- The first *inTouch* pathway – *inTouch* COVID Community Care - was developed January 2021 in response to the COVID-19 Delta outbreak.
- The aim is to ensure patients are supported to self-isolate safely.
- The focus of this pathway is to ensure those who test positive to COVID-19 in the community are supported to self-isolate safely; this includes the support required for early detection of deterioration in their physical, mental, and social health aspects.
- This pathway helps to reduce unnecessary emergency department and hospital admissions by identifying and rectifying deterioration early in COVID-19 positive patients, and to support these patients to feel comfortable to manage their care where applicable at home.
- The *inTouch* Program is able to match additional support for patients where required. This includes clinical care that can be provided by Hospital in the Home (HITH) services, mental health support or support for social welfare related needs.

inTouch Pathway 1 - COVID Community Care in the Community



inTouch Pathway 1 - COVID Community Care in the Community

- Over the life of the program from 24/03/2020 to 30/09/23 47,587 patients have received care.
    - 16,485 were cared for by WSLHD from 24/03/2020 to 31/07/23.
    - A further 31,767 were cared for by Calvary/Medibank under contract with WSLHD using the *inTouch* model of care from September 2021 to 31 January 2023.
- During the peak of the pandemic in 2021 WSLHD *inTouch* admission rates were 4.6% compared to 25% for New South Wales and death rates were 0.04% compared to 1.4% for NSW.

inTouch Pathway 2 - Residential Aged Care (RACS/RACF)

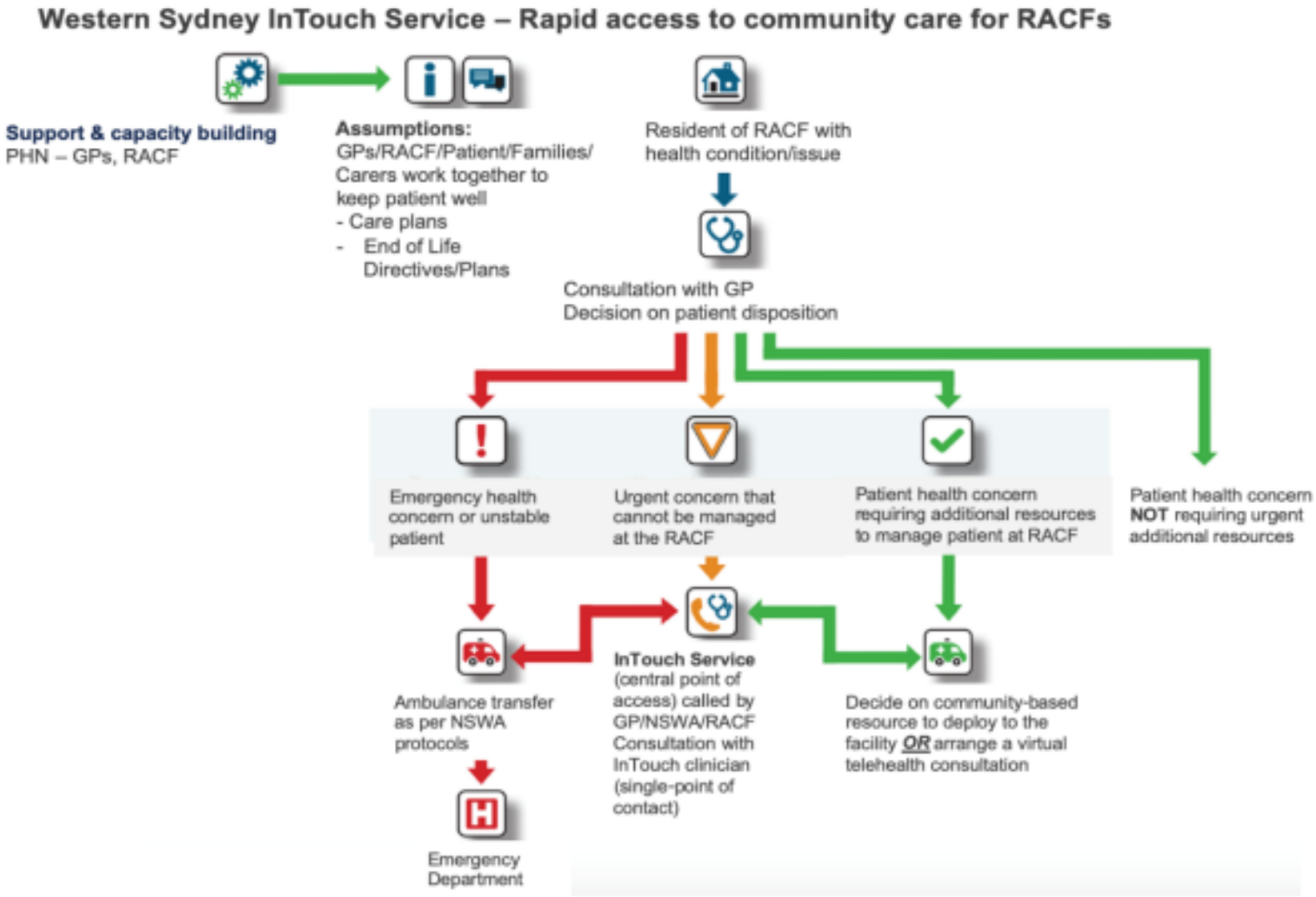
- The Western Sydney Local Health District (WSLHD) *inTouch* Residential Aged Care Service (RACS) was established in April 2022.

- The service provides a single encounter of care for ‘primary care type’ low acuity conditions such as falls and wound care of aged care residents to prevent Emergency Department (ED) presentations and increase a resident’s options of care setting.

- The service provides a front door for General Practitioners, RACF clinicians, NSW Ambulance, Paramedics, and the Virtual Clinical Care Centre (VCCC) to access out-of-hospital care for aged care residents in a timely way in the comfort of their own homes.

- *InTouch* partnered with WSLHD Specialty Services, NSW Ambulance, 65 local RACFs and General Practitioners to design and deliver the service.

inTouch Pathway 2 - Residential Aged Care (RACS/RACF)



inTouch Pathway 2 - Residential Aged Care (RACS/RACF)

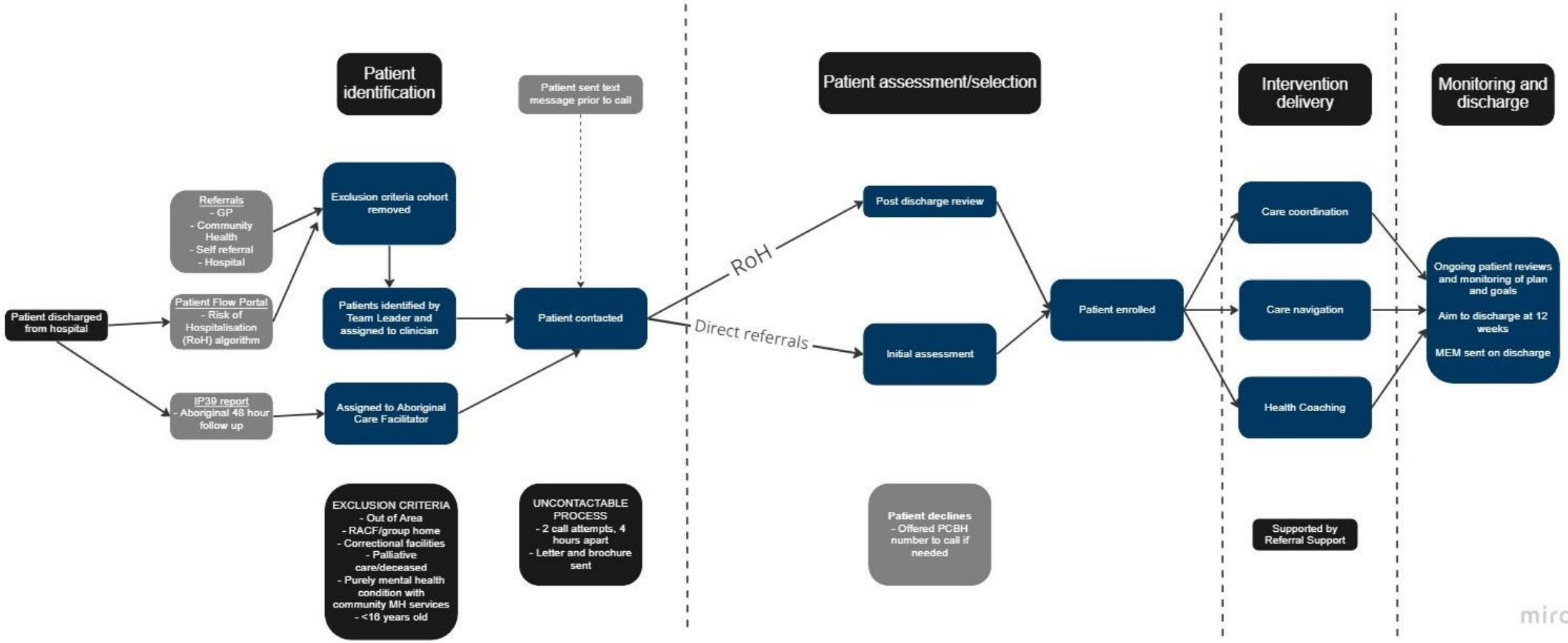
Over the life of the program from 24/03/2020 to 30/09/23 *inTouch RACS* has received 5,127 referrals and has avoided 1965 (38%) transfers of Aged Care Facility residents to WSLHD Emergency Departments.

- The *inTouch* Residential Aged Care Service has delivered access savings to the Health Care System.
- The access saving includes:
    - 11% in readmission savings based on the usual readmission rate within 28 days for this group of patients.
    - 2% in Emergency Department representation savings based on the usual representation rate within 48 hours for this group of patients.
- NSW Ambulance and NSW Patient Transport Service savings include:
    - 2,692 hours or 70 full-time working weeks have been saved in Paramedic time based on an average of 101 minutes of case cycle time.
    - 1,562 return trips to RACFs by NSW Health Patient Transport Service.

inTouch Pathway 3 – Planned Care for Better Health (PCBH)

- The *inTouch* Planned Care for Better Health (PCBH) pathway aims to facilitate and strengthen care for patients who have been identified of being at risk of unplanned hospitalisation in the next 12 months.
- The *inTouch* PCBH service has been operational since the July 2022 and was developed using the *inTouch* elements in response to the NSW Health NSW Integrated Care Scaled Initiatives.
- In addition to a patient's hospitalisation and medical history, their demographic and socioeconomic factors are also considered. Risk of Hospital (RoH) algorithm is used to identify/select appropriate patients and tailor patient centered interventions.
- Many of these patients will have complex and chronic needs. Inclusion criteria for this pathway includes patients with; any chronic conditions related to diabetes, asthma, renal, COPD/respiratory, cardiac; palliative but services not set up; Oncology, in respite but not palliative; and, Mental Health/Dialysis/Gynaecology/Oncology if they also have any chronic conditions as above.
- The PCBH pathway aims to improve the patient's experience of care and keep patients healthier over the long term to ultimately prevent ED presentations and potentially preventable hospitalisations.
- Patients are enrolled into a 12-week program in which they are assigned an intervention – care navigation, care coordination and/or health coaching.

inTouch Pathway 3 – Planned Care for Better Health (PCBH)



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inTouch Pathway 3 – Planned Care for Better Health (PCBH)

PCBH Care Facilitators provide care to people who are at risk of hospitalisation .

They are partners in multidisciplinary shared care with General Practice & Speciality Teams who deliver the medical care whilst care facilitators do health coaching, coordinate care and navigate access to services.

From July 1, 2022 to June 30, 2023 the number of referrals to PCBH is 8,097

Under the remit of health coaching, care coordination and care navigation PCBH From July 1, 2022 to June 30, 2023 has delivered care according to the different needs of these 8,097 patients:

Post Hospital Discharge Follow Up Calls

- Calls to ensure people understand post hospital care such as medication management , any further tests needed and follow up with GP
  - 5053 calls to Non Aboriginal people who are at high-risk of hospitalisation
  - 840 calls by an Aboriginal Health Practitioner to Aboriginal people with chronic conditions

Case Conferencing https://westernsydneydiabetes.com.au/framework-for-change/enhanced-management/joint-gp-and-specialist-case-conferencing/

- 58 Diabetes Type 2 case conferences with Speciality Teams and General Practitioner (April – June 2023)

Transfer of Care and Self Management Support

- 1994 episodes of supportive post discharge transfer of care to General Practitioner and self management support to people with Atrial Fibrillation

Care Navigation

- 316 people referred to the inTouch referral support team to access services e.g., My Aged Care

Health Coaching (COACH Program) http://www.thecoachprogram.com/

- 136 people referred to the COACH program team for lifestyle risk factor modification

Examples of plans and outcomes – RACS/RACF pathway

Patient	Plan of care	Outcome
• 92 year old • Fractured wrist • Removed plaster • Dementia • Multiple co-morbidities • Nursing home resident	• Care to be provided in nursing home. • Wrist splint required. • Advice provided as to which one to purchase and where to purchase. • Follow up in 6 weeks with ortho as outpatient.	• Services organised for care navigation from *inTouch* RACF pathway: • GP discussion with *inTouch* MO / updates of care and plan • Avoided ED and waiting time • Avoiding multiple ambulance calls and ED presentations • Able to stay in familiar environment reducing anxiety and fear • Family able to be updated and regularly • Excellent team work with inTouch RNs and MOs working together / excellent clinical handover used between the shifts
• 88 year old • Iron infusion • Multiple co-morbidities • Nursing home resident • Wheelchair bound	• Iron infusion to be administered to within the facility • HITH to administer iron infusion • GP involved with primary care to monitor and ongoing iron infusion in facility as required.	• HITH organised to administer iron infusion • GP discussion with *inTouch* MO / updates of care and plan • GP now aware of Health pathways and HITH • Avoided ED and waiting time • Ambulance cancelled as not required • Able to stay in familiar environment reducing anxiety

inTouch: keys to success

To enable success, changes are necessary at multiple levels:

- Support at all levels including executive, managers and staff
- Relationships with internal partners, external agencies etc
- Resources
  - Access to appropriate information sources
  - Access to quality and safety experts including clinical education teams, health departments, other parts of the healthcare system
- Medical/clinical buy in (medical governance)

inTouch: keys to success

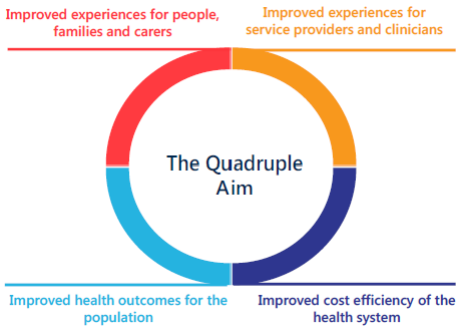

Image source: NSW Health, 2018

- Patient-centric, integrated care requires the addressing of health and social care needs simultaneously.
- What is required is an integrated care process framework that can be adapted for different contexts, conditions and settings.
- *inTouch* is a mechanism to ensure appropriate and quality patient care is delivered in the right environment.
- This innovative program allows the reconfiguration of services by facilitating cooperation and coproduction between internal and external healthcare providers across social care services, primary care, aged care, community care and hospitals.

Supporting resources

- Effective partnerships , strategic , commercial , operational, clinical
- Mobile Diagnostics – X-ray
- Digital Case Conferencing – health professionals, staff, patients and their family
- Service monitoring: safety and quality indicators, "Plan, Do, Study, Act" (PDSA) cycles
- Enhanced training and education packages competency focused
- Technology –
    - GoShare patient health information platform
    - HealthPathways
    - MDS
    - Microsoft products (e.g. Teams)
- Project management approach to implementation

Consumer Feedback

Listened and gave time.

Everything. Made me feel valued & mattered.

Listened, acted, and followed up. Boosted my morale when I needed it most. I can't thank the team enough.

All in all, not a bad experience this time.

You do well in all aspects. Thank you.

Very happy with the care

I am the main carer of my mother. The nurse who phoned was well versed with my mother's situation which was refreshing. She was supportive and caring, gave me advice on what to do next with my mum should her condition not improve.
She asked if we touched bases with the GP since discharge and we discussed the outcome of GP consultation.
All in all was a very productive conversation with a caring person who seemed genuinely concerned with my mother's health outcome.

You did well in everything from explanation to answering my questions.

All of it really helped me.

Patient experience data identified that patient experience ratings consistently scored above the 85% in the areas of staff introductions, communication with them and across the care team, involvement in care and help to understand their condition and how to manage it

The care and concern for my well-being was paramount.

Excellent to help patients and get them the right care they need.

The amount of information given is so much better than what I would have expected from the internet.

Everything worked well staff friendly professional and always willing to help with any problem or inquiry.

Clinician Feedback

- The RACF clinician experience data identified that clinician experience rating consistently scored above the 85% benchmark in the areas of communication, information sharing and a shared approach to care planning across teams.

- *“There was a follow up call from inTouch that provided clear direction on what actions have been taken and which service will be in touch with site to support site”.*

- *“inTouch always do follow ups and calling us with an update.”*

Recognition – *inTouch* awards and nominations

Internal

- 2022 WSLHD Quality Awards: CE Award https://www.wslhd.health.nsw.gov.au/Quality-Patient-Safety/WSLHD-Quality-Awards-in-Healthcare/2022-wslhd-quality-awards (Winner)

- 2023 WSLHD Quality Awards: Transforming Patient Experience Award https://thepulse.org.au/2023/09/14/winners-list-announcing-the-champions-of-the-best-of-the-west-quality-awards-2023/ (Winner)

External

- 2023 Finalists NSW Health Awards https://www.health.nsw.gov.au/awards/2023awards/Pages/default.aspx (Finalist)

- 2023 Finalists NSW Premiers Awards: Highest quality healthcare Award https://premiersawards.nsw.gov.au/finalists/2023-finalists award notification date is 14/11/23

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