

## WESTERN SYDNEY UNIVERSITY



# The Western Sydney Integrated Care Program Qualitative Evaluation

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*...before the Integrated Care Program Mum was constantly getting admitted into hospital... they would treat or fix one issue and then she'd come out of hospital and she had something else wrong...over the last six months I think she's been into hospital twice... her blood pressure and her sugar and everything are on track...and Mum's entire medical history was linked with both Blacktown and Westmead, through the GP. (Carer)*

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## Acronyms

ACRONYM	DESCRIPTION
AH	Allied Health
Best Practice	General Practice software
CALD	Culturally and Linguistically Diverse
Cerner	Electronic Health Record System for Hospitals
CCF	Congestive Cardiac Failure
CF	Care Facilitator
CNC	Clinical Nurse Consultant
COPD	Chronic Obstructive Pulmonary Disease
DNA	Did not attend
DoH	Department of Health
ED	Emergency Department
ENT	Ear Nose Throat
GP	General Practitioner
GPLN	General Practice Liaison Nurse
HCP	Health Care Provider
HealthOne	Integrated Care between General Practice and Community Health Care services
HN	Hospital Nurse
HS	Hospital Specialist
IT	Information Technology
KPI	Key Performance Indicator
LGA	Local Government Area
LHD	Local Health District
Linked-EHR	Linked Electronic Health Record
Medical Director	General Practice software
MG	Management Group
MoU	Memorandum of Understanding
My Aged Care	Australian Government Home Support Services
My Health Record	Patient medical data record
NGO	Non-Government Organisation
NSW MoH	New South Wales Ministry of Health
OT	Occupational Therapist
PACC	Post-Acute Community Care (hospital in the home)
PC	Patient/Carer
PCEHR	Personally Controlled Electronic Health Record
PCMH	Patient Centred Medical Home
PenCAT	Clinical Audit Tool
PHN	Primary Health Network
PIMS	Patient Information Management Services (for hospitals)
PN	Practice Nurse
PowerChart	Hospital software
QI	Quality Improvement
RASS	Rapid Access and Stabilisation Services
TopBar	Extracts data from General Practice IT Systems and transfers to Linked-EHR
WentWest	WSPHN
WSICP	Western Sydney Integrated Care Program
WSLHD	Western Sydney Local Health District
WSPHN	Western Sydney Primary Health Network (WentWest)
WSU	Western Sydney University

## Report Abstract

### Background

In 2014-17, the [Western Sydney Integrated Care Program](#) (WSICP) was implemented. It is a 'Demonstrator' partnership between the [Western Sydney Local Health District](#) and the Commonwealth's Primary Health Network in Western Sydney - [WentWest](#). Funded by the NSW Ministry of Health, it aims to integrate primary (community-based) and secondary (hospital-based) health care for patients with diabetes, cardiac failure and chronic obstructive pulmonary disease.

Several strategies were used to build local community capacity in managing these conditions, integrate care between service providers, and develop shared-care protocols.

Western Sydney University researchers here present a qualitative evaluation based on data from two interview rounds, conducted a year apart. These comprised 125 interviews with patients, carers, health care providers and WSICP management.

### Findings

By March 2017, after a slow start to the program, patients reported improved access to health services, including to [Rapid Access Clinics](#). 'Patient Hotline' phone access to known clinic staff was an alternative to Emergency Department (ED) attendance and, sometimes, to clinic presentation. Community-based care facilitators (usually nurses), assisting patients to follow shared-care plans, were a vital link between hospitals and general practitioners (GPs); following up patients in transition from hospital to home; and sharing information across sectors.

Interviewees valued holistic, team-based care provided by clinics, with their focus on giving patients knowledge and skill to better manage their illnesses. Shared patient-care plans and specialist action-plans improved communication and gave patients more confidence. Whereas relationships between GPs and hospital staff improved and disease-specific teamwork was demonstrated, inter-specialty collaboration did not improve as greatly.

Although GPs were, at times, difficult to engage , they reported improved access to hospital specialist advice through telephone support, and improvements in clinical care as a result of practice-based education where specialists helped GPs and vice versa. [Health Pathways](#) assisted with evidence-based care, though some GPs found the on-line platform challenging.

Information technology (IT) difficulties limited the use of shared records. Enrolment criteria were contentious. Many in need were excluded. Lack of transport and hospital parking were barriers, especially for the disabled. The fact of this being a short-term trial significantly impeded engagement with WSICP, staff recruitment and staff retention.

### Conclusions

We found achievement across all quadruple aims. **Patients** were better able to manage their health conditions, access hospital services and were highly satisfied with WSICP services. Improved **population health** is a likely longer term outcome, resulting from improved chronic disease management and a focus on preventive health care. Reduced **health care costs** were proposed as a consequence of reductions in ED attendance, admission rates, also through access to multiple providers in one hospital visit. **Health care providers** expressed satisfaction with team work, education, and strengthening of cross sectorial and interdisciplinary relationships.

## **Recommendations for extension of WSICP**

Reflecting on our research findings, we offer the following recommendations for the WSICP.

1. Ensure integrated care is seen as routine practice at all levels of the hospital and community through:
  - Policy and funding alignment;
  - Promotion of the success of the current program; and
  - Improved provision of information about WSICP internally and also to external stakeholders.
2. Continue a strong focus on patient education and empowerment, and include carers in these activities.
3. Seek long term commitment to continue and extend the WSICP including through:
  - Ongoing WSICP staff appointments especially to care facilitator roles;
  - Continuation of RASS clinics, and of patient and GP support lines;
  - Extension beyond the current three chronic diseases, and inclusion of those with co-morbidities such as mental illness;
  - Enrolment flexibility for those living in nearby areas who used WSLHD services and those in Aged Care Facilities; and
  - Engagement of allied health care providers especially to assist with mental health problems.
4. Improve cross disciplinary collaboration including through multidisciplinary clinics.
5. Continue outreach of hospital services into the community in collaboration with general practice.
6. Continue health care provider education across all disciplines and in all sectors as a core component of integrated care.
7. Provide cross-sectorial shared patient records and more responsive IT systems to provide real time access to shared information and alerts when information is entered.
8. Enhance parking and transport options to improve access to all hospital services.
9. Continue to support primary health care to deliver high quality care in the community and advocate for remuneration that rewards quality rather than through-put in general practice.
10. Ensure evaluation continues to inform development of integrated care in western Sydney.

# **Executive Overview**

## **Introduction**

The Western Sydney Integrated Care Program (WSICP) was funded by the NSW Government Ministry of Health as one of three integrated health service Demonstrator models to operate between 2014 and 2017. The program aimed to integrate care between local primary and secondary health care sectors for three chronic diseases - diabetes, cardiac failure and chronic obstructive pulmonary disease.

A range of strategies have been implemented:

- Care facilitators to assist in supporting and coordinating services for patients;
- Information technology (IT) initiatives to improve sharing of information;
- Shared care plans for better coordination of patient care;
- Specialist action plans at hospital discharge for enhanced care in the community;
- General Practitioner (GP) support line providing access to hospital services;
- Rapid access and stabilisation service (RASS) clinics to reduce unnecessary hospital admission/re-admission with a patient hotline for accessing these services;
- HealthPathways to assist GPs with referral and other health service information;
- Support payments for general practices to facilitate patient enrolment and care planning; and
- Promotion of Patient Centred Medical Home development.

This report documents a qualitative evaluation of the WSICP.

## **Methods**

We conducted individual, mostly face to face interviews in two rounds up to 12 months apart to gather information on implementation of WSICP over time. The semi-structured interview guide was developed in consultation with program managers and clinicians and piloted in the first 10 interviews. It was revised to ensure clarity and comprehensiveness of the interview questions and reviewed again prior to the second round of interviews. This ensured important questions arising from the first round could be included as well as questions around changes over time.

Research participants comprised patients enrolled in WSICP and their carers, management staff of the WSICP, clinical and allied healthcare providers employed by the Local Health District (LHD), and GPs and staff from general practices engaged in the WSICP. All interviews were audio-recorded and transcribed by an independent transcription service. We continued sampling until we reached our targeted total of participants stratified across the stakeholder groups. Participants in the first interview round were offered a second interview which most accepted. Some new patients and carers and staff from general practices were also recruited in the second round of interviews.

The initial 10 interview transcripts were coded independently by five members of the research team. The research team met to review the coding and agreed to continue analysis using a framework approach to consider how each WSICP strategy contributed to outcomes, including how the strategies were implemented and delivered, how they were utilised and their perceived value. Alongside this analysis the team agreed to undertake a thematic analysis to identify and describe meanings or “themes” in the data using an iterative approach in order to reach an overarching

understanding of the implementation of the program. Dr Trankle then conducted the remainder of the interviews and their coding, with ongoing discussion of the analysis in a series of research team meetings.

We received ethics approval from the WSU Human Research Ethics Committee and the WSLHD Human Research Ethics Committee.

## Results

We interviewed stakeholders including managers of the program, health care providers in hospital and community settings, and patients and carers. Fifty nine people participated in the first round of interviews conducted between March and September 2016, and 66 in our second interview round from late November 2016 to March 2017.

### Western Sydney Integrated Care Program (WSICP) Strategies

**Care facilitators** were described as assisting patients with following their shared care plans - providing information about health conditions and about navigating health services, including those beyond the program. For patients, they provided a key point of contact and source of advocacy as well as a familiar face in the hospital. They were seen as a vital link between hospitals and care in the community, following up patients in transition and providing information about patients to health care providers in each sector. This role was described as a key improvement delivered by WSICP, and their knowledge and skills were highly regarded by those we interviewed.

Lack of a clear job description and poor prior engagement with general practices were observed by interviewees to impact negatively on care facilitator functioning, especially in the early phase of WSICP. Care facilitator workload and the best employing organisation were raised as considerations for the future.

**Information Technology (IT) systems** were observed by most interviewees to be inadequate as evidenced by poor functionality of shared health records, lack of IT based communication between hospitals and the community, inadequate web based information provided concerning WSICP and suboptimal data management. Some commented on insufficient resourcing of IT services especially the shared electronic health record (Linked-EHR). IT support was also perceived as inadequate. Challenges were noted for less IT enabled general practices, the multiplicity of software systems in general practice was a barrier and concern was expressed that IT failings were impacting on GP engagement. In the hospital setting, shared care plans were often not accessible and interviewees expressed frustration with Cerner and the duplication of data entry required as well as its inability to link with GP systems. Interviewees strongly recommended one shared health record with real time access to shared information and alerts when information was entered. Training in use of these systems was also recommended. The import role of IT in data collection to enable evaluation of WSICP was observed.

**Shared patient care plans** were accessible to health care providers in the community and to patients and carers. They were valued by many GPs as improving efficiency and enhancing communication with allied health care providers, however some GPs were not using them and referral to allied health care providers still required email and manual upload of reports. GPs expressed concern about time taken to upload care plans and strongly recommended simplification of these processes. Care facilitators summarised care plans in hospital records as hospital staff could not access the care

plans themselves. GPs reported no feedback from hospitals on their plans. Patients and carers described care plans as promoting a stronger focus on patient needs.

**Specialist Action Plans** were described as providing guidance for more complex patient management and where treatment was changing frequently. They were observed by interviewees to be included in discharge letters that were printed off and provided to the patient and emailed to the GP. GPs valued the guidance these provided although they sometimes had to chase up this information. Hospital based interviewees valued the team based approach to development of these plans, although the formatting was observed to be time intensive. GPs and patients reported the plans as focused on patient needs and patients valued the reassurance and assistance in management. Many interviewees recommended sharing action plans via Linked-EHR. GPs asked for action plans to be easy to follow and hospital specialists were keen to hear how these plans were working for GPs.

The **GP support line** was intended to provide GPs access to advice in management of patients in the community and to arrange appointments at RASS clinics. Initially neither GPs nor hospital staff were aware of the service. Although this improved by the second interview round, use of the support line was still perceived to be suboptimal. GPs who had used the line found it useful as did care facilitators. The value of a specialist contact point was affirmed including in non-WSICP cases. Emergency department (ED) staff were also reported to be using the support line. Interviewees strongly recommended improved promotion of the support line.

**Rapid Access clinics** were intended to provide an alternative to ED for patients requiring urgent specialist review and **stabilisation clinics** provided post admission care. Initially most referrals to rapid access came from ED rather than GPs. By the second interview round, GPs reported rapid access for their patients, who were enthusiastic about the speed of access, avoidance of admission, information provided by familiar staff who attended to psychological as well as physical aspects of care, and the follow up at home. Hospital staff valued the ongoing, comprehensive, team based care and described intra hospital referral to rapid access which also linked patients with existing non-WSICP services and provided community outreach. At times the care was reported to extend beyond one specialty area.

For GPs rapid access assisted particularly with patients who had complex health problems or were financially disadvantaged and they described the benefits of this as an alternative to ED referral. However challenges were encountered with inconsistent referral approaches. The requirement for medical referral was a concern for some interviewees. Others suggested that rapid access may be seen by some patients as an easier alternative to attending their GP.

Post admission care in stabilisation clinics was valued as a means of preventing re-admission. Some interviewees recommended an extended clinical scope for RASS clinics.

**The patient hotline** was a strategy that evolved from RASS clinics to provide a means for patients to contact their hospital based care team in the clinics. This single point of extended hour contact with someone who knew them was highly valued by patients. Hospital staff also appreciated this new “connection” with patients and GPs observed that the information provided through the hotline assisted in patient self-care and provided reassurance for them.

**HealthPathways** was described by GPs who used it as a guide to best practice that was local and up to date, as well as a key means of improving their knowledge. It was noted to require an enormous amount of time to write and update. Reported use by GPs varied widely. HealthPathways was said to be used more by younger GPs although more experienced GPs also found it useful in accessing hospital services. Practice nurses and care facilitators reported using HealthPathways and sometimes prompting GPs with the information. Whilst some interviewees found it easy to access and navigate the site others described the time required to access information and the challenges in doing this during the consultation. Enhanced promotion and extension of this resource were commonly recommended.

**General Practice support payments** appeared to be variably understood by GPs we interviewed, but there was general consensus that this one off payment, whilst appreciated, did not adequately compensate for the time required to participate in WSICP and was not a driver for participation in WSICP. The needs for funding for patient follow up and for wider funding reform in primary health care were noted.

**The Patient Centred Medical Home (PCMH)** was described by interviewees as a Primary Health Network (PHN) strategy, however LHD stakeholders were supportive of the initiative, particularly its potential for reducing hospital care. Interviewees noted alignment with integrated health care and PCMH practices were said to be engaging better with WSICP. GPs, particularly those engaged in the initiative, valued the holistic, community-based team care. Some interviewees reported inadequate funding of this initiative and expressed concern about the limited, disease specific focus in WSICP compared to a whole of practice PCMH approach.

**Communication with other (Non-WSICP) services** and use of portals such as My Aged Care, were evident in later interviews with reports of new and growing linkages with other LHD services, private health care providers, community based allied health care, and other government and non-government agencies. These linkages, particularly in the area of diabetes, included services beyond the health sector. Patients valued the in-home care provided by some of these organisations. Health care providers described growing awareness of community services, however some communication difficulties were encountered. Improved sharing of information about these services and increased numbers of community- based positions were recommended.

### **Thematic Analysis**

Three overarching themes were identified in our thematic analysis. These related to the set-up of WSICP; challenges encountered; and the added value of the program.

#### ***Setting up of WSICP***

The first round of interviews highlighted the effort and time involved in setting up WSICP with lengthy delays related to LHD bureaucracy and delays in engaging GPs in the early phases. Understanding of policies and processes as well as provision of staff orientation appeared to improve over time. Concerns about restrictions on access to the program continued over time, with many who were perceived as likely to benefit, being excluded. Other barriers to integrated care described included limited English proficiency, financial barriers, people struggling with poor access to hospital clinics and inadequate parking. Addressing some of these barriers, RASS clinics were observed to tailor care to the individual. However, challenges were described in engaging patients

who did not appear to value an integrated approach or were not keen to receive care from many different health care providers.

Across all interviewee groups integrated care was understood as focussing on patient centred care that was integrated across hospital, specialist, GP and community settings. Informational continuity was often part of the description and the care facilitation role and team based approaches were also considered facets of integrated care. Good communications and upskilling of community health care providers were noted as key facilitators as was systems change within hospitals. There was some confusion between newly introduced WSICP strategies and pre-existing or related programs, however the need for all to work together for the benefit of the patient was seen as paramount.

### ***Challenges***

Challenges described by interviewees often related to differences between the cultures of general practice and hospital medicine. In general practice the fee for service remuneration model was observed to be a disincentive for team based care; however WSICP was seen to be changing this. Interviewees commented on siloed care provision with sharing of information even between hospitals, not routine practice, and a lack of regard in hospitals for care provided in the community. A divide between different speciality areas was also noted and this had not shifted greatly through WSICP. The failure of IT to assist in bridging these siloes caused frustration, as it impacted on communication, shared records, referral processes and collection of evaluation data. By the later interviews there was some evidence of successful sharing of health information across sectors aided by manual updating of the hospital records by care facilitators.

An initial challenge was the confusion about roles especially with new positions like care facilitators, but also for nursing, allied health and even hospital specialist roles in WSICP.

Less directly related to WSICP, but strongly emerging from our data was the substantial carer burden including 24 hour responsibility, grief associated with lifestyle limitations as well as their sadness in response to deterioration of their loved one. Improved carer support was strongly recommended.

The size and complexity of transforming health services to an integrated care model was often discussed and noted as compounded by the limited time and funding for WSICP; and the time needed to establish the program, to facilitate behaviour change and to see improvement in health outcomes. Concerns were expressed about losing good staff and if the program closed, losing all the gains made. Interviewees strongly advised long term commitment to realise the benefits of WSICP. Outcomes evident at this stage of WSICP were said to offer some promise for the future.

### ***Added Value of Integrated Care***

From early days the benefits of WSICP were valued by health care providers and by patients and carers. Services were described as more time efficient, and potentially more cost effective. Patients were supported to self-manage their care and assisted with holistic, patient centred care in the community by a multidisciplinary team who sometimes also engaged services beyond WSICP. This was seen to result in fewer hospitalisations. When hospital care was required, patients and GPs knew who to contact and patients valued the now familiar faces in this setting.

Team based approaches (particularly in RASS clinics) to patient upskilling and empowerment were reported to be changing key LHD indicators such as re-admission rates. Patients learned more about

their conditions and their management including lifestyle changes. Health care providers described enhanced collaboration with patients. Improved patient access to hospital services was highly valued with the patient hotline providing a good contact point and the care facilitator a familiar face in this setting.

Health care providers also described upskilling involving all members of the multi-disciplinary team. Hospital staff provided education for the GP team through case conferences, practice visits and evening workshops. GPs described learning from care facilitators and conferences and valued case based learning approaches. Hospital-based interviewees also described learning about general practice.

Growing collaboration and communication between hospitals and community based care providers was highlighted. GPs described easier access to hospital services and also reported improved communication from hospitals. Patients and carers noted alignment of care across the different care providers. Multidisciplinary team care was a strength of WSICP in hospital and community environments and valued by patients.

The WSICP was described as keeping people well and treating patients earlier in their illnesses. This was facilitated through RASS clinics and sometimes by hospital staff visiting patients in their homes. The benefits of this new focus on holistic, patient centred care were clearly identified.

Interviewees made a range of suggestions regarding ongoing rollout of WSICP. These included extending access beyond the current inclusion criteria and extension of WSICP activities seen to be working well, such as extension of case conferencing to other specialty areas and use of videoconferencing, and enhanced access to allied health care providers. One suggestion for addressing a perceived undersupply of some allied health services was group sessions. Other comments related to promotion of the program and enhanced learning across sites and over time. Improvements to communications and IT including more flexible responsive systems and shared patient records were an ongoing refrain. Additional space and co-location of integrated care services in the hospital were requested and improved access for patients to these services. More investment in general practice initiatives was recommended in both rounds of interviews and the need for wider systems change was also observed.

## Discussion

### Achievements

Our data provide evidence of achievement across all the quadruple aims. Interviewees reported enhancement of **patient experience** such that they were better able to self-manage their health conditions, navigate the health system, access hospital services and were highly satisfied with new services particularly care facilitators and RASS clinics. Improved **population health** was proposed by interviewees as a likely longer term outcome resulting from improved individual patient chronic disease outcomes and the strong focus on preventive health care. Reduction of **health care costs** was suggested by reported reductions amongst enrolled patients in ED attendance, admission and re-admission rates and possible reduced length of hospital stay, also time efficiencies through access to multiple providers in a single hospital visit. Improved work life of **health care providers** was evidenced in their satisfaction with a new focus on team work, capacity building through education, and strengthening of cross sectorial and interdisciplinary relationships.

## **Enablers**

Interviewees identified aspects of the WSICP working well which enabled many of the achievements described above. These included the strong partnership between WSLHD and the WSPHN; the focus across all strategies on patient centred care; relationships and team work between health care providers both within the hospital setting and between hospital and community based health care providers, as well as between patients and carers and health care providers; provision particularly through RASS clinics, of alternatives to ED presentation and hospital admission; the strong role of the care facilitators in supporting patients and in providing a crucial link between hospital and community based health care providers; all supported by a strong commitment to a common vision of integrated care.

## **Barriers**

Our research also highlighted challenges and barriers to the WSICP. Foremost amongst these in the early stages were delays encountered in setting up WSICP and a perception that it was not well promoted to health care providers and patients. This was compounded by the time-limited nature of the Demonstrator. Many interviewees referred to the investment of time and funding required for outcomes to be achieved from such a program and the impact on staff morale and retention when this was not recognised. Challenges with IT especially the hospital based Cerner system, and the failure of IT applications to save time or to greatly enhance integration of health care, were a strong and ongoing cause of concern. Barriers between hospital specialist disciplines appeared to be less impacted by WSICP than inter-professional and hospital/community barriers. Some GPs were reported to be less than ideally engaged with WSICP. Lack of access to WSICP for some patients excluded by inflexible eligibility requirements was a concern for many interviewees. Access to hospital services was noted to be reduced by lack of affordable parking options and distance from set down points to hospital services.

## **Conclusions**

In the short time it has been operating, WSICP has demonstrated achievement across all quadruple aims. A range of key strategies have been implemented and appear to be improving patient and health care provider experience and have strong potential for improving health outcomes and reducing costs. However, many challenges remain to be substantially addressed especially those related to IT. On the basis of our findings we would strongly recommend continuation and extension of these activities as described in the recommendations on page 7 of this report.

## **Introduction**

With populations aging, a growing prevalence of chronic disease and complex multimorbidity, higher expectations for quality of care, and a tight financial climate, there is an urgent need to deliver better care in more cost-effective ways (1). Integrated care has emerged as one solution to this problem (2, 3). Benefits are seen, in particular for service users and their families, when organisations and services work together, and where care is coordinated around the needs of people and populations (1, 4).

The New South Wales Ministry of Health (NSW MoH) has funded the Western Sydney Integrated Care Program (WSICP) as one of three integrated health service Demonstrator models (5, 6). Each will operate between 2014 and 2017 (5) and integrate care between local primary and secondary health care sectors. This report documents a qualitative evaluation of the WSICP.

### **The integrated care context**

Integrated care addresses fragmentation in patient services by reducing barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place (4, 7). Integrated health systems have been promoted as a means to improve access, quality and continuity of services, especially for people with complex needs and multiple morbidity (3). Integrated care is also considered important for improving the experience of care for patients (8) and for health care providers (9).

A key to service integration lies in building consensus and trust among different providers at the point of service delivery and, in the longer-term, persuading all engaged to consider the opportunities of locally-led service innovation based on a common understanding of integrated care (8, 10-13). Integrated care frameworks should also incorporate patient perspectives (14). The World Health Organisation (1) notes that a fundamental paradigm shift is required to put people and communities at the heart of the health care experience. Indeed, when patients and carers have been engaged as partners in co-designing an integrated health care system, care has been more effectively provided around patient/carer needs (15) and resulted in improved patient outcomes (16). Strong primary health care is also key to successful integration of health services with even stronger evidence supporting the role of primary health care in management of those with chronic conditions (17).

Integrated care has been implemented in many different forms in different health systems around the world (2, 4). In some cases the emphasis has been placed on integration by merging organisations. In others, priority has been given to supporting organisations to work more closely through networks and alliances. The scope of integrated care varies from initiatives that seek to cover the whole population to those that focus on particular groups within the population. Others, in common with WSICP, seek to manage high risk patients with complex and chronic conditions in collaboration with GPs to ultimately reduce presentations to the health service emergency department and strengthen capacity and capability of the workforce to improve delivery of health care in the community (18-20).

In Australia, there are more than a quarter of a million admissions to hospital annually for health problems that potentially could have been prevented (21). Most of these are chronic conditions.

There is a strong logic to integrate care that targets chronic diseases, which are also the leading cause of illness, disability and death in Australia (22).

## Western Sydney Integrated Care Program background and aims

Western Sydney has one of the sickest populations in Australia; over 57% of people have at least one major risk factor for chronic illness (23). Based on a strong prior relationship underpinned by a Memorandum of Understanding (24), and building on the current evidence for integrative health approaches (4, 25-27), the Western Sydney Local Health District (WSLHD) is working in partnership with the Western Sydney Primary Health Network (WSPHN) on the WSICP to develop and implement an innovative, system wide and sustainable service model for providing co-ordinated and integrated care services for managing chronic diseases in western Sydney. Its focus is on diabetes, congestive cardiac failure (CCF) and chronic obstructive pulmonary disease (COPD) (23). The WSICP was intended to support the quadruple aim of improving health of patients, enhancing patient experience, reducing costs of health care and better supporting health professionals (28).

Importantly, and differentiating the approach to integrated care in Western Sydney compared to the other Demonstrator sites, the goal of the WSICP was “to improve the management of chronic conditions in primary care and strengthen the Patient Centred Medical Home (PCMH).” The WSICP aimed to support and build capacity in primary care for better management of chronic conditions in the community, to establish better partnerships and integration between services providers, and develop new shared care protocols (28). Specific WSICP initiatives are identified in Table 1.

Table 1. WSICP initiatives

WSICP Initiative	Description
Care Facilitators	Employed by the LHD to liaise between patient, general practice, hospital and other services to assist in supporting and coordinating services for patients
Information Technology (IT)	Initiatives to improve sharing of information between hospital and community sectors
Shared Care Plans	Developed in general practices and shared with hospitals via a “Linked Electronic Health Record (EHR)”
Specialist Action Plans	Provided at hospital discharge and intended to inform patients and general practitioners about care in complex situations and where treatment is changing frequently
GP Support Line	Provides GPs with faster access to hospital specialists including referral to rapid access clinics as required
Rapid Access and Stabilisation Service (RASS) Clinics	Provided to reduce unnecessary hospital admission and re-admission and including Patient Hotlines to facilitate patient access to the clinics
HealthPathways	Support through a clinical editor to assist in developing and maintaining online access to referral and other health service information for GPs
Support Payments to General Practices	To facilitate patient enrolment and care planning
Promotion of Patient Centred Medical Home (PCMH)	Development by supporting general practices to lead multidisciplinary teams that provide comprehensive coordinated care
Communication between WSICP and non-WSICP Services	Connecting better between hospital and other government and non-government services for patient needs.

## **Research aims**

NSW MoH is evaluating the WSICP through collection and analysis of routine hospital data as well as survey data assessing engagement and satisfaction with the WSICP.

This evaluation complements the NSW MoH investigation by adding a qualitative component based on in-depth interviews in order to gain an understanding of how the program is working from the perspectives of the different stakeholders.

## **Reading this report**

This document reports the findings of our qualitative research. The methods section provides a detailed description of the research design including ethics approval, participant recruitment, development of the interview schedules and analytic approaches.

In results we report on our data analysis. This is divided into two sections, an initial analysis based on each of the WSICP strategies listed above and then a themed analysis looking across all strategies and stakeholder groups to gain a broader understanding of how the WSICP is working and what has been learned in the process. The more detailed analyses are included as separate appendices to the report.

In the discussion, we draw together findings of the research by reflecting on areas of achievement, facilitators and barriers to the WSICP. Based on our research, we present recommendations for the future which are also noted in the executive summary at the beginning of this report.

## **Methods**

### **Overview**

We conducted a qualitative evaluation (29-31) to explore the experience and satisfaction of participants with each of the WSICP strategies and processes. We conducted 125 individual interviews in two rounds up to 12 months apart to gather information on changes over time. In analysing our data we used a framework approach (32-34) to consider how each WSICP strategy contributed to outcomes, including how the strategies were implemented and delivered, how they were utilised and their perceived value. Alongside this analysis we also undertook a thematic analysis to identify and describe meanings or “themes” in the data using an iterative approach (35, 36). The two analyses provided different perspectives of the WSICP with one focussed specifically on the strategies implemented and the other seeking an overarching understanding of the implementation of the program.

### **The researchers**

The research team from Western Sydney University and University of Sydney are all experienced qualitative researchers. Dr Steven Trankle (ST) who led the evaluation was also very experienced in qualitative interviewing. The co-investigators from the WSLHD and the WSPHN brought content expertise in integrated care, especially in western Sydney, and valuable insight to the interpretation of data.

## **Ethics approval**

We received ethics approval from the following Human Research Ethics Committees:

- WSU Human Research Ethics Committee (H11334); and
- WSLHD Human Research Ethics Committee (4411).

This project also received approval from the WSLHD Scientific Advisory Committee.

## **Sampling and recruitment**

In consultation with the Integrated Care Evaluation Advisory Committee, we determined a sampling frame of key stakeholder groups who would provide important and varied perspectives on the WSICP. These comprised patients and carers enrolled in the WSICP, management staff of the WSICP, a range of clinical and allied healthcare providers from Westmead and Blacktown hospitals, and GPs and staff from participating general practices in western Sydney.

Patients and carers were recruited opportunistically when attending hospital appointments and by care facilitators. Hospital clinical staff were purposively sampled to include a range of healthcare providers working with the WSICP. Both these participant groups were informed about the study by WSICP program managers and clinical co-investigators at Blacktown and Westmead hospitals, and gave their consent for their contact details to be mailed to the researchers. They were then contacted directly by the research manager (ST) for completion of informed consent. Management staff volunteered to participate directly with the researchers. GPs and their nursing staff were recruited by the WSPHN staff, and were selected to provide a range of views of the program. After gaining their informed consent, their contact details were passed to ST who then arranged interviews directly. In all cases, prior to commencing interviews, a signed consent form was provided by the participant, either in person or mailed.

We continued sampling until our sample approximated the targeted total of 70 participants stratified across the stakeholder groups.

Participants were offered a second interview which most accepted. Participants signed a pre-consent form and provided their contact details again for a subsequent interview. Some new patients and carers and staff from general practices were also recruited in the second round of interviews. New participants were recruited by the same process as the first round.

## **Interviews (data collection)**

In consultation with the Integrated Care Evaluation Advisory Committee, and informed by the literature, we designed a semi – structured interview guide to collect participants' perspectives on the initiatives of the WSICP and their experiences of the program. The guide was refined in multiple meetings with program managers and clinicians. We piloted the guide in the first 10 interviews, after which interview transcripts were reviewed by the research team to ensure the clarity and comprehensiveness of the interview questions. The interview guide underwent some further revision throughout the data collection period, informed by the ongoing data analyses, with questions and prompts added to explore the emerging areas of interest in more depth. Before the second round of interviews commenced, the interview guide was refined again in consultation with the research team. This ensured important issues arising from the first round could be included as well as questions around changes over time.

Interviews in both rounds were conducted one-on-one by a single interviewer (ST), mostly face to face although some were conducted by telephone. All interviews were audio-recorded and transcribed by an independent transcription service. Transcripts were then checked for accuracy. Interviewees were offered the opportunity to review their transcript.

## Analyses

### Framework/matrix

We analysed data in both interview rounds according to a framework aligned to the individual WSICP initiatives. The framework method of qualitative analysis is a systematic and flexible approach to data analysis which supports a holistic, and comprehensive and descriptive overview of an extensive dataset. In a framework method, qualitative data is systematically organised into codes and categories within a matrix spreadsheet, the content of which is designed in advance to meet the objectives of the research, but which can be expanded according to emerging themes of interest (34).

We developed the framework matrix in consultation with the wider research team to capture specific aspects of interest related to each of the WSICP initiatives. We described how initiatives were implemented and used, the experiences around these, their perceived value, facilitators and barriers in achieving the desired program outcomes, and participant-identified suggestions for the future. We used N-Vivo 11 ® software to help organise our data coding.

The initial 10 interview transcripts were coded independently by five members of the research team. These researchers then met as a small group to discuss their coding and the framework. The framework was accepted unchanged. ST then conducted the remainder of the interviews and their coding, with ongoing discussion of the analysis in a series of research team meetings. Upon completion of coding, the full research team met to review the completed coding matrix and discuss and develop the analysis further. This provided the opportunity to discuss the positioning of individual categories and codes and ensure the framework was accurately inclusive of the data.

### Thematic

We conducted a concurrent thematic analysis to complement the framework specific coding. Thematic analysis allows patterns and meanings to be captured from qualitative datasets which are important to the understanding of the overall research question (35). Our thematic analysis was inductive and data-driven, allowing additional themes to enhance our understanding of the WSICP, and its outcomes to be described and interpreted without trying to fit them into the preconceived coding framework.

We explored the broader experiences of participants with health care including with the WSICP, and the health issues and needs of patients and carers of relevance to integrated health care. As with the framework analysis, five research team members coded 10 initial interviews to identify patterns within the transcripts after reading each transcript numerous times. The five researchers then met with the full research team where we discussed our analysis and agreed on core initial themes for further ongoing analysis. ST continued to code all transcripts, and convened with the wider research team after interviewing concluded to check and refine the emerging analysis. The second round of interview data was similarly handled and analysed, also using N-Vivo 11 ® software to aid organisation of data.

In order to further ensure the trustworthiness and credibility of the data, we provided the analyses to the Evaluation Advisory Committee of the WSICP at the end of each round for large group discussion.

## Results

### Introduction

Results of our data analysis are presented below. Detailed reports of the data analysis are provided in Appendices A and B of this report. Illustrative quotations are referenced to the stakeholder group and designated as round 1 or round 2 according to when the interview was conducted. Where there appeared to be a change in responses between the two rounds this is noted, otherwise the observations stand across both time frames.

### Participants

We undertook a total of 125 individual interviews, 59 in a first round of interviews and 66 in a second round. We began first round interviews in March 2016 and ended in late September 2016, and conducted second round interviews between late November 2016 and the end of March 2017. The recruitment period was extended in both rounds to maximise the exposure participants had to the WSICP and to access all stakeholder groups more comprehensively. We interviewed 12 patients enrolled in WSICP, with 8 patients participating in both the first and second round of interviews, and 11 carers. Twenty-eight LHD employed health care providers participated in the evaluation, including medical specialists, registrars, nurses, allied health care providers and WSICP care facilitators. The majority of these (71%) took part in both interview rounds. Twenty one GPs and GP Practice staff participated, with 38% of this group participating in both rounds. Additionally 10 members of the Evaluation Advisory Committee and of the Data Working Group (comprising a mix of managers and clinicians with advisory roles) were interviewed in one or both rounds.

Participants were spread across the three chronic disease areas and were from both Westmead and Blacktown hospital catchments. General practice participants were recruited from 14 different practices across western Sydney including, in the second round, practices that were not substantially involved in the Patient Centered Medical Home (PCMH) initiative.

Table2. Participants

Participant Group		First Round	Second Round
Patients/carers (PC)	<i>Patients</i>	11	9
	<i>Carers</i>	1	10
	<b>Total Patients /Carers</b>	<b>12</b>	<b>19</b>
Health care providers	<i>Hospital specialists and registrars (HS)</i>	12	8
	<i>Hospital Nursing staff (HN)</i>	7	6
	<i>Hospital Allied HCPs (AH)</i>	5	4
	<i>GPs</i>	7	12
	<i>GP Practice Nurses (PN)</i>	3	7
	<i>Care Facilitators (CFs)</i>	3	3
	<b>Total Health Care Providers</b>	<b>37</b>	<b>40</b>
Evaluation Advisory Committee (Titled “managers” in our results-MG)		10	7
<b>Total Participants</b>		<b>59</b>	<b>66</b>

## Integration Strategies

Our analysis explored each of the WSICP strategies listed above according to:

- implementation and delivery (developing, operationalising and implementing the strategy);
- use (how patient, carers and health care providers make use of the strategy);
- experience both positive and negative (what happens to the participant);
- satisfaction (affective response to experience);
- perceived value (judged usefulness to self and others); and
- suggestions.

For the purposes of this report we have considered positive experience, satisfaction and perceived value together as these often overlapped. Similarly negative experience was linked with suggestions.

### 1. Care facilitators

#### *Implementation and delivery*

The care facilitator role was not well defined at the outset and this caused concern including about who was responsible for patient follow up. Even by the second interview round the role was still being clarified.

*.... never given a guideline...never given a procedure... never given a policy... word of mouth ... WentWest saw one version compared to the LHD. (CF1 Round1)*

*...we need to clarify what their role is in regards to ... their patient load or whether they do ... more heavy duty end and some of the monitoring end is done differently. So we're really starting to model around that. (MG6 Round2)*

Employment of care facilitators by the LHD, whilst their work is predominantly in the community setting, was perceived (especially in the first interview round) to be a potential conflict. Some interviewees questioned “*...whether they should be rather more firmly based in the community health services, maybe in the PHN, practice based, rather than being very clearly employed by the LHD...*” (MG3 Round1).

#### *Use*

Care facilitators were seen to have an increasing role in WSICP over time and their key role was reported to be assisting patients to follow their shared care plan.

*... much more involvement now with the care facilitators than there was... (HN5 Round2)*

*... she got me onto the endocrinologist...I had diabetes for 16 years and at the beginning, I learnt all about it, and I saw endocrinologists...took the tablets, and lost a bit of weight... (PC3 Round1)*

Other care facilitator roles mentioned included patient recruitment to WSICP, education both about the health condition and about navigating health services, development of care plans and patient advocacy. Patients described them as first point of contact and “go to” for any concerns. Care facilitators were also said to provide a familiar face in the hospital setting.

*...she's actually linked them in with other services that I haven't been able to link into or haven't heard about. (PN4 Round2)*

*... the care plan that she has done they're very detailed... she seems to know what she's doing. (PN7 Round2)*

*... having an advocate, having an educator or someone with them, has a big impact on definitely service navigation and the understanding of their chronic disease. (CF3 Round2)*

*If I have a question – I just quickly jump on the phone with [CF] and she'll say, "Yep, no worries, I'll email the doctor," And if I have to get a referral to someone I wanted to check with [CF]...She goes, "Don't worry, I'll send it. I'll send it off to the doctor. Don't worry, I'll get it sorted," and it's done. (PC1 Round1)*

*... whenever we try and link up a new patient with the care program they [CF] also try... and meet the patient at the clinic. (GP4 Round2)*

Care facilitators were also seen as a source of information about patient care in the community for hospital staff and about patient admissions for general practice staff – a link between health care providers.

*... if I'm actually having problems with contacting the GP... with regards to the patients ... I usually refer it to the care facilitators... great at giving me the information... (HN6 Round1)*

*We've had a couple of patients admitted to hospital that we didn't know of... helped us to try and get in contact with them and make sure that we follow up with them... (PN4 Round2)*

*...care facilitator making that physical dynamic real time link between the care providers. (MG5 Round1)*

### ***Positive experience, satisfaction and value***

Interviewees across all participant groups were overwhelmingly positive about care facilitators, describing the value of their roles in patient and health care provider education, coordination of care, linking people to services including beyond WSICP, maintaining contact with patients and assisting them with appointments. Patients and carers particularly were appreciative of the assistance provided and the difference this made to accessing services with others also noting their expertise in this area.

*... had a patient who's a newly diagnosed CCF and [CF] is brilliant, I was sitting here listening to her educate the patient... learning from her, she really is very, very good. And the family were really pleased ... felt quite comfortable... knowing that she would also be a part of the team if they were in hospital or ... RASS clinic and I think it was very well done. (HS9 Round1)*

*...[CF] really good... I get a bit vague about making some of these appointments ...I'm not getting a letter from them so I get on to [CF]. (PC2 Round1)*

*... care facilitator was absolutely brilliant ... initially we had the one-on-one meeting with Mum present and then she would regularly be in touch... follow up any issues, anything that I can help you with... which I thought was fantastic (PC17 Round2)*

*The care facilitator is a living breathing health pathways. They know the things in behind the walls so they can match the requirements up really well. So I think from that point of view, totally brilliant. (MG5 Round1)*

From early on this role was seen as a key improvement delivered by WSICP. WSICP management described the importance of care facilitators in linking health services. GPs particularly valued the contribution to patient assessment, follow up and meeting ongoing care needs.

*... care facilitators work in directly with ...private care practices and the GPs is helping build stronger links between the hospital services and community services and primary care. (MG6 Round1)*

*... probably the biggest person that has become involved in our patient care that wasn't previously involved... big improvement, definitely. (GP6 Round1)*

*... having [CF] look at the patient's care plan and also them having done an assessment of the patient and that assessment being communicated to the GP, that has been particularly valuable... we've picked up extra issues that we weren't aware of...having someone to make sure that the patient is navigated through the health system. Someone the patient can call if there's an issue; that's been very valuable... (GP1 Round1)*

*...having that care co-ordinator has been the most useful thing for me so far... just getting an idea of what services there are... all of sorts of things from taxi vouchers to payments for incontinence pads... (GP2 Round1)*

Care facilitators also reflected on the value of their role especially their continuing and holistic care.

*...having the care facilitator or a support person or a go-to person is what they value the most because they know that person is consistent and was up-to-date with their care, and they can talk to us pretty much about any even social issues, mental health issues, emotional wellbeing, holistic kind of care that we provide. (CF3 Round2)*

### ***Negative experience and suggestions***

Much of the negative experience related to care facilitators concerned initial lack of information and support for the care facilitators. This resulted in some re-thinking of the role.

*Once [general practice] is ready and they've had a lot of support then we bring the care facilitator in. We're kind of taking the care facilitator in too early...So now what we're thinking is maybe splitting that role so that you've got the back end function supporting the GP and then once they're ready then bringing in the front end function which is about care coordination and patient focus stuff. (MG6 Round1)*

This change may address concerns expressed by care facilitators about being the “face” of WSICP.

*... you're the face of the program in general practice, so if ...anything's not working you're pretty much the one that cops it from general practice... disengage with you as well if the IT systems are not working or if you're taking too much of their time on a system that's not functioning... (CF3 Round1)*

In spite of the call for clearer role definition, it was also recognised that the care facilitator role needs to be sufficiently flexible to adapt to the general practice needs. A stronger role in home visiting was recommended by some.

*... care facilitator role needs to be more flexible because general practices are different... each scale and size and organisational level dictates a different need of the care facilitator. (MG5 Round1)*

*...if they're [CF] coming out to do a home visit... do they have a computer, do they have an iPad, how are they accessing their health information... (GP6 Round2)*

Occasionally GPs were perceived by care facilitators to undervalue their role although this appeared to be changing by the second interview round.

*... they [GP] used to think we're "just the nurses", but now I notice that's now changed and they feel the importance, of having us in there and trying to help them to navigate their patient for proper care and management. (CF4 Round2)*

Although one manager expressed uncertainty about whether the role should continue others, especially GPs, called for a continuing care facilitator role. The workload of the care facilitator also was noted to require consideration.

*... never quite sure whether they're there because they need to be a permanent and ongoing feature in the system or... a compensatory mechanism until we can end up with good care coordination in the community... (MG3 Round2)*

*Definitely having the care coordinator, that has got to be maintained, that's really important having that person here as the link between the hospital and you and the patient, and who has got to oversee everything, that's really vital. (GP6 Round1)*

*... needs to be some work around what is really an appropriate number of patients and how many hours... you feel you are drowning, because you're just going out to meet with patients at practices, you're doing assessments, you're doing telephone reviews, then phoning the GPs about what hospital to discharge, you're doing referrals and needing to make sure the GP stays on board and engaged you're sending faxes every day, writing, like all this takes time and when you have a huge amount of patient numbers, you're not really able to provide the proper care that these patients need. (CF3 Round2)*

## **2. Information Technology Systems**

### ***Implementation and delivery***

IT systems were observed by most of those we interviewed in both rounds to be inadequate. This was evidenced by poor functionality of shared health records, lack of IT based communication between hospital and community, little web based presence and inadequate data management. One management interviewee (MG6) described this as "*the most frustrating and complex area of the whole Demonstrator*".

*I would have thought that the step of communicating with the practices... to have been worked out from the beginning. It seems like it's not and that surprised me a little bit because that's the whole point of all this, is to share the information. (PN7 Round2)*

By the second round of interviews although IT initiatives like Linked-EHR were working better for many general practices, challenges were noted for less IT enabled practices and, in the hospital setting, the shared care plan was not accessible although Linked-EHR was visible. Whilst some reported time and resources committed to IT enablement, others commented that this was insufficient especially for systems like Linked-EHR.

*It's working a lot more efficiently with care plans... some practices it's still an issue...IT systems are so fragile that maybe they can't cope with another software... (CF3 Round2)*

*We can't access the shared care plans – [though] through the server we can actually link in with the EHR... (HN4 Round2)*

*In terms of the kind of investment that goes into developing IT systems more broadly, it's very, very tiny, and the Linked-EHR suffers from lack of investment generally... (MG3 Round2)*

In the hospital setting interviewees expressed frustration with Cerner (the LHD medical record system) and the duplication of data entry required as well as its inability to link with GP systems. An additional concern was the inconsistency between different clinics.

*... a lot of doubling up in terms of notes... we'll have paper files, the research paper files, we have the hospital electronic notes. There is a lot of overlap. (AH5 Round2)*

*... I'm just sending it out into the ether... just hoping that the person on the other side has actually read it and actually acknowledged it. (HS5 Round1)*

*...within our hospital systems, like all the clinics work really differently. The letters that go out to GPs, the templates are also different. (CF3 Round1)*

In general practices the time and training required for establishment of IT systems was noted. The variety of software systems in general practice and challenges in communication between these and hospital systems were reported to be barriers. At times lack of IT experience and skills in this setting were seen to be challenging and the substantial time and investment from WentWest was noted.

*It's just that it's not an easy set up. It requires a physical engagement... some degree of training of the end user. (MG5 Round1)*

*...different GP practices have got different computer programs, they don't marry up with the computer programs that we've got, so we can't see their information, they can't see our information... (HN2 Round1)*

*I'm assuming our system is linked up electronically, I don't know. We're just not very IT wise here. (PN2 Round2)*

*... spending a lot of time on it ... people from WentWest ...they can't keep up. (CF1 Round1)*

## **Use**

By the second round of interviews, difficulties with Cerner and the duplicative data entry had resulted in development of new databases that auto-populated letters and referrals in some clinics. Other later interviewees described upgrades to Cerner and access to notification of shared care plans through Cerner. However communication through Linked-EHR was not enabled.

*... entering the data in our clinics and our letters... then manually take that across into an Excel sheet, but there should be a way to automate that process. (HS6 Round1)*

*a big change...is that we have moved on to a separate database, that we are currently maintaining ourselves. We enter the data directly into our database in the clinic and use that data to export a letter from the database. (HS6 Round2)*

*... putting notes into Cerner, so every time they access a document... in the Cerner, if they see there's a previous Linked-EHR updated... (CF4 Round2)*

*... Cerner is now extracting that and creating the letter which we modify, but the letter then gets posted; it doesn't get sent via Linked-EHR ... (HS8 MG8 Round2)*

Although communications between general practice and hospitals improved by the second round of interviews, these were still described as sub-optimal. Shared care plans and action plans were more often described as uploaded, but there was no certainty that information was received in the other sector. Timely communication of discharge information remained a concern for GPs.

*I had uploaded a lot of information about the patient onto their eHealth record... but I don't think the hospital doctors were aware of that. I don't even know if they had access to the care plans ... (GP2 Round1)*

*... GPs still can't see the action plan...(HN2 Round2)*

*Occasionally, I get an electronic discharge if it's been uploaded onto a patient's electronic... record... but often that's not a routine thing. (GP2 Round2)*

The importance of IT support and training for use of initiatives such as Linked-EHR was highlighted repeatedly in our interviews.

*I do have access to Linked-EHR, and I have been shown how to use it. But I know some GPs have chosen not to use Linked-EHR because of IT issues. (HS7 Round2)*

In the absence of IT solutions, recourse to traditional communications such as letters, faxes and phone calls was described (and sometimes preferred) and email was used in place of shared records.

*... haven't got any e-referrals from any of the external practices. I mean, we think that GPs should be able to e-refer; they still can't e-refer to us at all. (HS1/MG7 Round1)*

*Well the letter that we write at the end of consultation is still posted... (HS4 Round2)*

*...some GPs and some cardiologists that have actually asked for email but only when their fax line is down, they still want the faxing. (HN4 Round2)*

*... to refer to an exercise physiologist...If I included that in the care plan it doesn't seem to be working. We've had to report the old way of printing out the care plan and fax a letter back saying that they agree to be part of the care plan. (GP2 Round2)*

### ***Positive experience satisfaction and value***

In spite of the challenges, WSICP was observed by some interviewees to be leading the way in terms of the work being done to overcome IT barriers to integrated care. The future potential for the IT initiatives being pioneered through WSICP was recognised.

*... online documentation has been pretty good...typing straight into notes...the way of the future rather than having a big set of medical notes; just for everything to be online and integrated care is a bit of a pioneer leading the way. (AH2 Round1)*

When solutions to the issue of multiple data entry in the hospital setting were found through development of local databases, the time saved was celebrated by those we interviewed.

*... built the [referral] forms ... I don't write notes anymore, I type it all into the computer... that's been a huge enabling factor; it's made me work quicker... (AH2 Round1)*

*... taken a lot of work out of my day, because I no longer have to ... enter that data again, to the database. It's also taken some work off of the administrative staff, because they don't have to copy, paste, and reformat a letter from Cerner. (HS6 Round2)*

In general practice the opportunity for monitoring and quality improvement, patient access to their own health information, and improved communication with hospital clinics and sometimes at discharge, were valued, though not fully operational by round two of our interviews.

*...the portal is quite easy to use, the Top Bar is quite useful... drawing out data from your Medical Director or the Best Practice Program to make sure you have got no care gaps - that's really good...Patients can also have access to the online portal, which is really good, so they can see what has been changed or what their medication list is... (GP6 Round1)*

*... the ability to send the information directly between primary care doctors and the hospital. for example, having easy access to the clinics...the ability to upload information about the patient quickly.(GP2 Round1)*

*I'm ... learning about patients being in hospital much sooner. And therefore I'm able to follow up those patients a lot sooner as well. (GP9 Round2)*

*...everything should be live and whenever we make a change, it should change instantaneously. (GP12 Round2)*

### ***Negative experience and suggestions***

Interviewees expressed frustration with IT applications (especially Cerner) and their failure to save time or improve processes including form filling, letter writing and sharing information through Linked-EHR. Compounding these difficulties was a perceived lack of understanding or response from LHD IT staff.

*... hard to not be frustrated with IT systems. We thought we'd go completely paperless... we tried to do that, so we worked with IT ...they advised us to use Power-note because it would then print out into a letter that the patient could take it home... we use it, it doesn't print out a proper letter. It's a letter that gets spread out across multiple pages. (HS1/MG7 Round1)*

*Cerner is still getting there ... It's clunky, it's clumsy... not organised around patients... (HS8/MG8 Round1)*

*... the IT folk don't understand what the clinicians want, and when we try to say to them we don't want that, we want this, they don't listen. (HS2/MG9 Round1)*

Concern was expressed that IT failings impacted negatively on GP engagement in important initiatives such as Shared Care Plans.

*... in general practices ... technology has been more of a challenge rather than making life easier ... it's not working at the hospital end yet and it's not working at the majority of the GP practices as well, so I'm not sure if the time and money we are spending in terms of Linked-EHR is really worth it ... feedback that I get from GPs, after two attempts they're like, "I don't want to do this. I don't even know if it's worth it." (CF3 Round1)*

A strong theme in our interviews was the call for one health record across general practice and hospital settings with real time access to shared information and alerts when information was entered. Some recommended strong action to achieve this and consideration of new systems or encrypted email to enable cross-sectorial communication.

*...somebody has to make some strong and dictator-like... decisions to get us doing that... with non-compulsory patient control e-health records it doesn't work. We need... everyone on the same system... (HS1/MG7 Round1)*

*The thing that would make a really big difference would be if we could look at their notes, and they could look at, maybe not everything... a shared electronic record. (GP7 Round2)*

*... find a system that would interface with Cerner so that Cerner doesn't have to do it all. It can become the repository of it but you have intermediary systems that are much more flexible and built for purpose and let the programs talk to each other. (HS8/MG8 Round1)*

*... In an ideal world, we would have a system where all the software programs can connect up and everything is live. (GP12 Round2)*

*... some kind of alert... so that everybody knows what's happening. (GP6 Round2)*

Another common request was for IT systems to be easier to use and for training to be provided.

*...improving the IT a little bit more just to make it a bit easier... as user friendly as possible; not everybody is as computer savvy as others. (GP6 Round2)*

*... we're now working on E-referrals and sending out the information through the IT systems, so we could do with some more training from that side of things. (HS5 Round1)*

The importance of IT in data collection to enable evaluation of WSICP was noted.

*Then we can evaluate the service in a very efficient manner. If everyone is on the same system... you can crunch the numbers easily. (HS6 Round2)*

### 3. Shared Patient Care Plans

#### **Implementation and delivery**

Shared patient care plans were intended to promote cross sectorial communication, however this was not fully achieved by our second round of interviews. General practices were responsible for uploading the shared care plan, with practice nurses often adapting the usual GP management plan to the WSICP template promoted on the HealthPathways website. Although care plans were accessible to allied health care providers in the community, hospital staff could not access them.

*...the notion that we have one document that is a shared care plan between us and GPs is not – hasn't reached reality yet. (HS8 MG8 Round2)*

*... we just do our normal care plan for the patient that gets uploaded onto Linked-EHR and in our practice it's ... the nurse who is uploading that information to Linked-EHR. (GP5 Round1)*

*... care plan through Linked-EHR can be shared with an allied health provider... at the moment it's not shared necessarily with the hospital clinician. (MG6 Round1)*

*So the hospital can't see it...All the care facilitators can see it, but the hospital specialist or hospital team can't see it. (CF3 Round1)*

#### **Use**

Care facilitators reported strong uptake in general practice although some GPs were not using them. Referral to allied health care providers required email and manual upload of reports.

*I think 90% of my patients have a Linked-EHR care plan ... (CF3 Round1)*

*The doctors here, if you said to them you can find so and so's care plan... in Linked-EHR, the first thing they'll say is "What's Linked-EHR?" (PN2 Round2)*

*...rather than uploading to a shared care plan, I just send my care plan electronically with the paperwork through the podiatrist. He will electronically send me back a report, and ... I then put that into my care plan for when do I do the next review... (GP7 Round1)*

Care facilitators were reported to be summarising care plans in hospital records however hospital staff could not access the care plans themselves and GPs reported no feedback on their plans.

*Care facilitators access yes. The hospital side, no, we might not be able to yet. (CF4 Round2)*

*I'm not entirely sure if they [specialists] are reading it or if they are making any comments... (GP4 Round2)*

*We can't access the shared care plans... [though] through the server we can actually link in with the EHR. (HN4 Round2)*

Patients and carers perceived the care plans as facilitating a stronger focus on patient needs.

*...all the focus is on the patient, now he does like direct the care plan. (PC18 Round2)*

### ***Positive experience satisfaction and value***

Shared care plans were valued including by GPs, as a key component of WSICP. They noted WentWest's assistance with set up and described resulting improvements in efficiency as well as the enhanced communication with allied health care providers. Practice nurses praised the template stating it was easier to use compared with GP management plans, the more commonly used care planning template for GPs prior to WSICP.

*...a linked in piece of the puzzle that I felt is probably the most critical bit for this program... (MG3 Round1)*

*WentWest helped us understand the care plans and how to review and upload and this has made a big difference to our practice's efficiency and patient care. (GP8 Round2)*

*I do really like the ability to use the care plans or to share the care plans with allied health professionals. (GP2 Round1)*

*I think Linked-EHR is great when it works. It's so much better than the medical software, the best practice care plans. I would much prefer to use Linked-EHR all the time. (PN3 Round2)*

Hospital staff described the information from the shared care plan that was added to hospital records by the care facilitators as helpful and by the second interview round, one carer reflected on the benefits of sharing health information.

*...I did read the notes of the care facilitator on Power Chart which is helpful in terms of summarising their care plan just so I know where the patient is... and where we can add to it. (HS6 Round1)*

*One particular program that the GP put us onto... they managed to link my Mum's entire medical history with both Blacktown and Westmead, through their GP. (PC17 Round2)*

### ***Negative experience and suggestions***

GPs expressed concern about the time taken to upload care plans and strongly recommended simplification of the processes for enabling shared care plans. They also requested care plans that would facilitate referrals to allied health care providers.

*...our nurses have been uploading them onto Linked-EHR and it takes ages. (GP6 Round2)*

*... not an easy set up. It requires a physical engagement, enrolment, usually taking WentWest's staff to do it. It requires some degree of training ... that would be the goal, to make that actual shared care plan a much easier device to implement and to operate. (MG5 Round1)*

*... more communication going on through the shared care plan... the ability to go directly to the allied health, referrals going straight through and everybody can work on the care plan together. (GP6 Round1)*

Hospital specialists struggled to access the plans and questioned the value of this strategy, whilst those in general practice recommended better engagement with hospital specialists.

*They [GP] say it's all there on the system, the patient tells us their doctor has made a care plan and we can't find it-makes you look a bit silly. (HS4 Round2)*

*But in proportion for the amount of effort that has gone in for generating the shared care plan to the usefulness, I think we could have spent our time doing other things. (HS2 MG9 Round2)*

*I don't know how much involvement the specialist has in the Linked-EHR, but their ability to access the shared care plan would be helpful. (PN4 Round2)*

One GP recommended a more patient centred approach in the shared care plans.

*... it should be more patient centred... for these care plans you are generally putting in what the GP thinks the goals are but we really should be getting more what the patient's goals are... (GP5 Round1)*

#### **4. Specialist Action Plans**

##### ***Implementation and delivery***

Specialist Action Plans were reported to be included in letters that were printed off and mailed or handed to the patient and emailed or faxed to the GP. GPs and practice nurses reported receiving a discharge summary containing the “action plan” rather than a stand-alone action plan and sometimes they had to chase this.

*... would write an action plan, but that's not functional at this stage. We write a letter and we send that to the patient and their GPs. It's mailed out to them, currently. (HS6 Round2)*

*...they send the discharge summary, always got follow up... see GP in two or three days, do this and then follow up with the specialist in six weeks. (GP9 Round2)*

*...we're just getting it paper wise, they're not coming through on the care plan, or the Linked-EHR, we have to constantly ring and ask them to fax it. (PN2 Round2)*

Action plans were intended to provide GP guidance for more complex patient management and in situations where treatment was changing frequently such as respiratory patients on corticosteroids. The action plan was said to provide a useful “line of communication”, though it was reported to require modification to include all relevant information and this was time intensive.

*... always write back a, management plan.... we haven't actually been doing this very well at this stage but hopefully this will improve – to provide a management or an action plan so GPs now know how to tackle the more difficult, complex cases. (HS10 Round1)*

*...every time I see a patient I have to do all of the assessment to then generate an action plan so, and then put that into a letter type format. So there is a lot of tweaking and a lot of, I think, extended writing... can take me a day and a half to do the paperwork, yet, within integrated care all I'm meant to do is send out an action plan. And I don't think that I can*

*honestly just send out things like, "Continue medications," or "This is reduced," without giving them the reasons why, giving them a set of obs. (HN5 Round1)*

### ***Use***

Hospital based interviewees described a team based approach to the specialist action plan. Both GPs and patients reported that the plan was focused on patient needs and useful for the GP.

*We all collaborate and put our few sentences in, and the specialist puts a letter together that goes back out to the GP, and out to the patient themselves. (AH6 Round2)*

*... it's got like four steps in it... and also things for the GP to do, and then they have got a patient plan... there were quite a few things on there that were sensible. (GP6 Round1)*

*... when you break down you've got to refer back to the action plan... two types of antibiotics. If it doesn't work, try this one. So the doctor also knows – actually she is the one that's got to give you the prescription for your medicine. (PC2 Round1)*

*We send a letter to the patient, addressed to the patient, in patient focused language. But that we send a cc to the GP and to the consultant. (HS2 MG9 Round2)*

Several hospital based interviewees commented on the importance of selecting the “right” patients, who have a good understanding of their illness.

*...not everyone is safe to have a specialist action plan... if the patient has severe COPD, a lot of comorbidities, a lot of heart problems. If they become short of breath, it could be anything ... it's dangerous in that situation to give them an action plan...I do encourage them to present straight to the GP or hospital. Some patients... young and well educated, motivated, only one single disease or two other, you know, minor medical issues but the dominating issue is COPD and... family support, I'm happy to give them action plans. (HS7 Round1)*

At times hospital staff commented on following up patients in the community. Practice nurses and care facilitators also reported following these patients actively in the community.

*I had a couple of patients were profoundly constipated so referred them back to their GP and suggested giving them something like lactulose which they did and I then followed them up on the phone to see whether or not there'd been any effect ... (HN5 Round1)*

*...that information flowing through to us when they've been admitted or discharged helped us get in contact with them and make sure that we follow up ... (PN4 Round2)*

*... GPs are saying they love the process, because the care facilitator then is taking on... responsibility for ... the action plan... (MG5 Round1)*

### ***Positive experience satisfaction and value***

Patients valued the reassurance and assistance the plan provided in their management. GPs also found the action plans helpful although at times GP staff reported that the actions prescribed were similar to those GPs had been recommending, that were not taken up previously by patients.

*...the letter they gave us when I brought [husband] home reassured me in that I was already doing the right things and helped me so much in planning for other things... (PC22 Round2)*

*... we can read through it, work out if anything needs to be done before the patient comes in ...helps with better coordination and management in terms of linking up with specialists as well. (GP4 Round2)*

*... they sent a bunch of recommendations for us...which the patient agreed... but we looked at his plan and we've done all and he never goes. (PN7 Round2)*

### **Negative experience and suggestions**

Many interviewees recommended sharing of action plans via Linked-EHR. GPs requested the action plan be simple and easy to understand and follow.

*...in the future, we are hoping that the action plan will actually go directly [electronically] to the GP, a consult, so they know what the plan is, from us. (HS6 Round2)*

*...Make it as basic as possible. Saying, are you short of breath, take your Ventolin. If you start to cough up green stuff, take this and make sure that that plan is given to the patient, is given to the GP as well so everyone knows what the plan is. (GP1 Round1)*

Hospital Specialists were keen to hear feedback on how these plans were working for GPs.

*We're filling it in and we print it out, fax it off ... but I don't get any feedback about it. I think it's a useful idea and I think it would be helpful for my GP colleagues but ... I'm not getting any feedback about it. (HS2/MG9 Round1)*

## **5. GP Support Line**

### **Implementation and delivery**

The intention of the GP support line (often referred to as “the GP hotline”) was summarised by one of our interviewees:

*So the idea is that there's a hotline phone that the GP can ring and get some advice... we get them into a Rapid Access Clinic... that's meant to prevent admission. (HS9 Round1)*

In the first interview round it was reported that although the support line was advertised on the HealthPathways website, neither GPs nor hospital staff were aware of it. There were problems with afterhours and calls at busy times. GPs were also unaware the support line was available for non-WSICP patients. In spite of some improvement by the second interview round, GP use was still suboptimal.

*... lack of awareness that they've [GPs] got that service that they actually can use. Not to say that we haven't had GPs ring up...but it's few and far between. (HN2 Round2)*

*...it's meant to work to 7 pm at night, the GP Hotline, so if it's not answered after 4 o'clock the phone's not diverted anywhere so they were going to fix that. (CF3 Round1)*

*... I've had to make three or four phone calls ...different registrars – they don't know what's going on. (GP1 Round1)*

*That has changed. The registrars now... they totally know what is going on... (GP5 Round2)*

### **Use**

Even in the second round of interviews there were many expressions of frustration at the underuse of the support line. Some hospital staff believed that GPs didn't "want to let go" of their patients and that patients on occasions went straight to the hospital when they were sick rather than seeing the GP who may have been able to call the support line. However GPs who had used the line found it useful in accessing RASS. GP registrars were reported to find it helpful and care facilitators were accessing the service. Staff from ED also used the support line on occasions.

*GP support line calls are improving. Not a huge amount, but definitely more than before. I'm getting calls from GPs...The [CFs] are calling me quite often as well... (HS7 Round2)*

At times calls concerned issues that were not aligned with the WSICP chronic diseases; however the value of a specialist contact point was affirmed even in these cases.

*...an average of maybe one call a week... more for general advice about... day-to-day sort of patients... not related to what this integrated person is about... (HS10 Round2)*

*... GP... had a question about someone with lack of thyroid... it's a really, really good idea, again, empowering the GP...building their skills... access to endocrinologist. (AH2 Round1)*

### **Positive experience, satisfaction and value**

GPs who used the support line reported it as helpful including in avoiding ED or sometimes even circumventing attendance at RASS. The easy access to specialist care and advice was greatly valued.

*Anything that bypasses emergency...access to the hospital facilities without going through emergency, is going to benefit everyone... I found it quite useful, getting some advice... sometimes we don't even need to send to the hospital, just talk to the specialist. (GP12 Round2)*

*It's actually great because, yeah, they have, like, Rapid Access and the doctor doesn't need to... look for a directory just to have an access in the hospital. (PN1 Round1)*

### **Negative experience and suggestions**

One interviewee vividly described challenges that others also encountered in using the support line.

*I had a GP who I encouraged to use the hotline... when they called the hotline it basically said this number doesn't exist. They had to choose another option... we called again so finally we were able to be put through... then they said, "You've rung the wrong department. This is not cardiology," and they gave a mobile number to ... ring the registrar ... the registrar said the Integrated Care Program is not live yet. (CF3 Round1)*

Another interviewee recommended more promotion of the support line and patients were suggested as a means of promoting this service to their GPs.

*I think there could have been a little bit more advertising and communication of who are the people at the end of the line. (CF1 Round1)*

*... we give them [patients] the information about the GP hotline, so when... their GP is... not sure of what to do, they say, "Don't forget we've got this hotline." (AH3 Round1)*

One interviewee described the importance of relationships in optimising use of the support line.

*I get half a dozen calls a week from GPs...trying to divert that to the hotline but it's hard to change, and it's because of the relationship. So the hotline would get hot if the relationship was built. (HS8 MG8 Round2)*

## 6. Rapid Access and Stabilisation Clinics (RASS)

### ***Implementation and delivery***

Rapid Access clinics were intended to provide an alternative to ED presentation for patients requiring urgent specialist review. Stabilisation clinics were for post admission care. Access to both types of clinics was not restricted to patients enrolled in the WSICP. In the early stages most of the referrals to the rapid access clinics were said to come from ED rather than GPs. Patients perceived this to be a "fast track service" offering thorough care. Hospital specialists also valued the opportunity for comprehensive team based care.

*Most of our patients are from ED... all these patients would otherwise be admitted or be in short stay, or just have a prolonged stay in emergency ... but the rapid access clinic provides them an option for early discharge. (HS6 Round1)*

*I haven't accepted a patient or have been referred a patient to the clinic from a GP as of yet. (HS10 Round1)*

*So they fast-tracked me and they took me straight up to the ward. I didn't have to go through the emergency care, wait there for about four or five hours...that's what happens with Rapid Access. (PC2 Round1)*

*... very thorough actually... didn't want me to go until I'd done everything... (PC11 Round1)*

*...having a nice multi-disciplinary clinic has been really good ... So we have a conversation together, pick up different aspects of the review. (HS3 Round1)*

By the second round of interviews GPs were also reporting rapid access for their patients although GPs found communication with RASS challenging and hospital staff described difficulties in following up patients. Hospital staff described integration of RASS with existing services and outreach from RASS into the community.

*I think it was good. The patient did get an appointment in a clinic within two weeks. (GP13 Round2)*

*... you try to ring the patient and they're not there, and you ring the patient again and they're not there, your KPI of two days is gone.(HS1/MG7 Round1)*

*... the GPs would ask, okay, if they haven't got a letter back from RASS clinic, the GPs will ask the patients and sometimes the patients cannot remember. (CF3 Round1)*

*... fully integrated into ... one heart failure service that has the existing heart failure services for in-patients, stabilised clinic patients, home visits, phone follow-up, and people from integrated care come into the rapid access service, for stabilisation and when they're finished there they're referred to the heart failure service for ongoing follow-up. (HN4 Round2)*

*... we do a lot of outreach visits to patients.. the aim of that clinic is to provide patient care at their home, because these patients are just too breathless to worry about coming in to a hospital. (HN3 Round2)*

### **Use**

GP use remained less than anticipated with this linked by some interviewees to problems communicating with RASS. Meanwhile ED was reported as getting better at referring appropriately to RASS. Intra-hospital pathways to RASS were described and some flexibility in the inclusion criteria.

*GP referrals are steady but nowhere near as much as we get from emergency departments or any other service of the hospital. (HS6 Round2)*

*I don't see a lot of GPs actively ringing the RASS service despite our promotion but... unfortunately... we've had a few bad experiences as well in ringing RASS. (CF3 Round2)*

*ED ... say, "well, actually you don't need to come to ED, just go to RASS". So, while we're not ... bypassing ED certainly making the route through easy and much faster. (HS1 MG7 Round2)*

*... people that we don't necessarily have enrolled in Integrated Care ... in our pulmonary rehab service and they get sick, we're then able to refer them to the rapid access clinic, and get them seen that way and that's been really efficient. (AH3 Round1)*

*... some patients probably aren't completely appropriate, but we see them anyway. (HS1 MG7 Round2)*

Patients reported on ease of access to RASS and the provision of information, though at times the communication was perceived to be within the health care team more than patient focussed.

*I just have to ring up, if he's having problems I just take him up to the heart failure clinic... Or ring up the cardiologist, and they just tell me to bring him in... (PC16 Round2)*

*...we had a nurse, and a doctor, to do with the pacemaker and, not that they tell you much, they talk – between themselves, but I kind of gathered everything was all right, and they improved the medication, but, they seem to let you know what's going on... (PC19 Round2)*

GPs described some good outcomes from referrals to RASS, although at times they reported using private specialists instead of RASS. GPs saw less benefit for the service in clinical areas where they had adequate expertise themselves.

*There's only one patient I can think of that I – try to avoid hospitalisation and referred to the cardiology... worked out really well ... other times we tend to use specialists...I can manage a lot of the respiratory patients. One patient would have probably needed some home oxygen and the specialist organised that...and we managed to treat her that way. (GP1 Round1)*

The stabilisation clinic was also reported to be operating as planned.

*...some of them come back, because we go from rapid access to stabilization. So if you've come direct and you need a bit more ongoing care, then you move to stabilization. There may be a couple of visits, then you're back to GP. (MG1 Round1)*

### ***Positive experience satisfaction and value***

Patients in both interview rounds enthusiastically described the benefits of the RASS clinics, often highlighting the information provided, their familiarity with the staff, speed of access, avoidance of admissions, attention to psychological as well as physical aspects of care and the follow up at home.

*... changed my life. Because before I wouldn't leave the house...Now I can go here, I can go there... Big change. (PC2 Round1)*

*They're brilliant... they explained what will happen, and how to deal with it. (PC14 Round2)*

*They're good, because I know the people that work there. They're very, very friendly. They make you feel...welcome as if they really want to help you. (PC12 Round1)*

*Before [HN] came along, I'd been into hospital two times in six weeks. (PC11 Round1)*

*...I've had experience of hours in the waiting room like everyone else, but I think your system bypassed that and I am checked over in no time at all in the hospital bed. (PC9 Round2)*

*...learnt how to control...if I'm having a anxiety attack... been so helpful... (PC11 Round1)*

*... I've had three visits from the nurses at home...I feel very happy about it. (PC8 Round1)*

Care facilitators described the benefits in terms of improved patient self-management and also found RASS accessible, expert and good at liaising with community based care. GPs also described the role that RASS had in care of patients particularly those who were complex or financially disadvantaged. They spoke of the benefits of having an alternative to ED. By the second round of interviews GPs and care facilitators were reporting good communication with RASS clinics.

*...clinic staff were fantastic. Always approachable, always gave patients an appointment, followed up really well, liaised with me really well to take back to the GP. (CF1 Round1)*

*He has had a very good experience dealing with ...the rapid access stabilisation clinic...good communication and extra - the patient felt much more supported ... not just out there sitting at home getting sick by themselves, that there are people who are actually going to be able to help them. (GP6 Round1)*

*The clinics have been useful... quick access for the patients to be seen ... not have to just go to ED... a step in between now and that's really important. (GP6 Round1)*

*...she's [PN] getting all the reports and feedback quite quickly and that's been really valuable so you know what's happening with the patients at all times. (GP6 Round2)*

Hospital staff noted the opportunity RASS provided for continuity of care and holistic team- based care that assisted in avoiding admissions. They also valued the ability to spend time with people and the flexibility to provide rapid care.

*... end up being a group of people that they see over and over again... because these are the sort of patients who often are in hospital a lot, we end up being the continuity. (HS9 Round1)*

*... see everyone else by coming to the same place and not then having to come again to the hospital, to see the dietician and go somewhere else to see the educator. (HS3 Round1)*

*... seeing a fall in our unnecessary admissions and ...we've been able to sort of pick them up before they've come into hospital in extreme need. (HS1/MG7 Round1)*

*... rapid access drop-in service has been of most value... to give a patient something right away, or to do it tomorrow, and not have to worry about appointments... (HS1 MG7 Round2)*

Post admission care in stabilisation clinics was also valued including as a means of preventing re-admission.

*... people don't have their follow up appointments made, or they didn't understand what was happening in hospital... does a powerful amount of good. (HS2 MG9 Round2)*

*... they can get follow-up very quickly once they discharge these patients from hospital and prevent them from coming back and being readmitted. (HS6 Round2)*

At times the team based care was reported to extend beyond one specialty area and through this integration of care across disciplines to be transforming health care.

*... see them with the cardiovascular team and the foot team ... improved outcome if we improve their blood sugar levels ...that's one of the examples of rapid access which can actually be quite transformative. (HS5 Round1)*

### ***Negative experience and suggestions***

Access to RASS was noted as a problem for some interviewees with inconsistency reported in referral processes in different hospitals and speciality areas. The requirement for medical referral was sometimes a barrier.

*... different between different hospitals and different clinics and again the information that goes back to the GP is not very consistent which is a bit of a barrier. (CF3 Round1)*

*...staff member from the community or the care facilitator sometimes rings us... then we have to chase to get a medical referral, so that's an issue. ... (HN4 Round1)*

Sometime ease of access was seen to be a problem and concern was expressed that RASS attendance was seen as an easier option for patients than attending their GP which may, therefore, impact on relationships between patients and GPs.

*... they get breathless, or they are sick for a couple of days – they don't go to their GP, because ...my GP is too busy, or they are just too breathless to make the trip...the easiest thing for them to do is call the ambulance. (HN3 Round2)*

Some interviewees recommended an extended clinical scope for RASS clinics.

*...if we could function as a mini clinic that is able to exclude acute coronary syndrome, then I think GPs would feel more comfortable sending the patients our way. (HS6 Round2)*

## 7. Patient Hotline

### ***Implementation and delivery***

The patient hotline was a strategy introduced by the respiratory clinic at Westmead prior to WSICP. Though this was not an originally planned strategy, it was implemented by all RASS clinics in order to provide a means for patients to contact their hospital based care team in the clinics. This single point of contact was available for extended hours and well promoted to patients.

*...we have one number that they call ... so you don't have to worry about what number to ring. (AH4 Round2)*

*... if anything happens to you, no matter what time of the day it is, give them a phone call. They pride themselves on a 100% pickup. (PC2 Round1)*

### ***Use***

Patients reported contact using the hotline whilst hospital staff noted the reassurance this provided patients and described how at times it was an alternative to clinic attendance.

*I'd rather be at home than in hospital and if I have any problems I can ring my doctor, my GP, and I can also ring the clinics at the hospital, I've got names and phone numbers that I can contact if I have any problems. (PC7 Round1)*

*...they use it. And they appreciate that help is available. It gives them a bit more confidence when we're making big changes to their treatment. (HS4 Round2)*

*...he used to come into rapid access once a week ...I thought that he used integrated care well, because whether he felt unwell, he would actually call. (HN3 Round1)*

### ***Positive experience satisfaction and value***

Patients were reported to value having one contact point, someone they knew, to talk with about their condition, especially at times when their GP was not available.

*... the clinic psych goes to see them, the dietitian sees them, there's three people, with three contact numbers ...there is one person that they can call to ask questions of – just general questions, instead of going, "Oh, who do I call?" (AH4 Round1)*

*... positive about that, to have a name and a face to call back on, so to speak. (HS6 Round2)*

*...the patient is really happy because he has the phone number of the rapid access clinic..., over the weekend, we are not working and sometimes he just called the clinic and then straight away went there. (GP3 Round1)*

Hospital staff commented on this new “connection” with patients sometimes describing it as a “safety net”. GPs noted the information provided as assisting in patient self-care and reassurance.

*... patient had a core line which was our integrated care CNC and she was able to come in, and prior to integrated care, we wouldn't have had that sort of connection. (HS1/MG7 Round1)*

*... I think it improves the patient's understanding of how to manage their condition, plus giving them extra education. (GP6 Round1)*

*... gives that patient extra reassurance, and autonomy as well, they know where they can go if something is wrong, not just here to the GP, but they also get that extra knowledge that there is a heart failure clinic ... somebody will see me... (GP6 Round1)*

### **Negative experience and suggestions**

At times the process was not clear to patients however the strong recommendation of those we interviewed was for continuation of this valued connection between patients and their health care providers in hospital.

*... I rang up the clinic, and they said, "Oh, well, you have to get a referral." Then the lady that looks after us, she said, "No, no, no, you don't need to do that. I just ring your GP - your heart specialist, and he said, "Whenever you need to come in, you just come into the heart failure clinic and you can be looked after there. (PC16 Round2)*

*I think we absolutely should do a nurse led patient hotline. So that we allow the patients when they are feeling off to call the nurses directly... They won't call the doctors, but to... have the nurses be able to essentially triage over the phone... (HS2 MG9 Round2)*

## **8. HealthPathways**

### **Implementation and delivery**

A care facilitator described HealthPathways as "...a streamlined process for every GP", "guideline how to treat or how to follow the procedures in the right way" (CF4 Round2). The enormous time required to write and update HealthPathways was described particularly by hospital specialists with one also commenting on their role in promotion.

*... part of what we need to do is to make sure that the information on the pathways is kept up to date ... when we talk to GPs ... we say, "Go to the HealthPathways. What we've told you is there". (HS8/MG8 Round1)*

### **Use**

The reported use of HealthPathways varied. Some GPs declared they found it effective and used it "all the time" whilst others said they hardly used it and didn't find it helpful. One GP described the challenge of accessing HealthPathways whilst they were consulting. Others noted the time required to explore all the information. Both practice nurses and care facilitators reported using HealthPathways and sometimes prompted GPs with the information.

*...when I do use it, it's extremely useful but it's just having that time to access it and just remember it's there...I've gone back and looked at it a few times after a patient's gone, but I should look at it while they were here. (GP9 Round2)*

*I utilise it predominantly to make sure that I'm on the right track... other times I will actually use HealthPathways, if I'm making a recommendation in management to the GPs. (CF3)*

HealthPathways was reported to be used more by younger GPs though the more experienced GPs also found it useful to access LHD services using the contact information on HealthPathways. GPs also described HealthPathways as a guide to best practice that was local and up to date.

*It's probably one of the main guidelines I use as well as therapeutic guidelines. (GP12 Round2)*

*It's up to date local information which is really important to me- not just stuff from somewhere overseas. (GP8 Round2)*

### ***Positive experience, satisfaction and value***

GPs who had accessed this information found it a useful guide in patient management and also a key means of improving their knowledge. Some interviewees experienced the site as easy to access and navigate and valued the information about local referral networks in both LHD and the community.

*... a good resource for GPs even in terms of trying to work a patient up or trying to determine what investigations or management would be appropriate... very helpful. (GP4 Round1)*

*...Improvement in my knowledge, especially through HealthPathways. (GP2 Round2)*

*... a great idea, I think there's a lot of good information there... I'm not that computer literate but I find it easy to navigate. (HN2 Round1)*

*...knowing which clinic to refer to and the most streamlined processes have been useful...having HealthPathways where each department will set down what they would like for a referral, I think it helps a lot. (GP2 Round2)*

*It's pretty good, especially it has the current referral... looking for an allied health in relation to podiatry and it has a good list of the community available podiatrists... (PN6 Round2)*

### ***Negative experience and suggestions***

Some interviewees commented that HealthPathways was probably easier for GPs who were "IT savvy" and one GP described their preference for hard copy rather than an IT platform. Simplification of the site was a reasonably common theme. Promotion of the resource and reminders to access HealthPathways were also recommended. One user noted the site was incomplete with some references to New Zealand remaining. Another highlighted the need to "keep it growing".

*...a bit clunky... need to look through things to be able to work out what's happening...I would much rather have seen a published version... a little bit inefficient. (GP1 Round1)*

*... some sort of a reminder... to use it more often. You don't sort of think about it, you don't use it. And when you don't use it you sort of become unfamiliar with that. (GP9 Round2)*

## 9. Support payments for GPs

### **Implementation and delivery**

GP support payments appeared to be variably understood in the general practice setting, although the general consensus was that this one off payment did not adequately compensate for the time required to participate in WSICP.

*I know the practice gets something but we do so much more work-identifying and enrolling patients, preparing care plans follow ups and things like that... (PN7 Round2)*

### **Use**

GPs acknowledged the part compensation this payment provided for the tasks involved in WSICP.

*it's allowed us to spend more time getting our systems up to scratch in terms of patient records and care plans and setting up reminders for follow-up. (GP14 Round2)*

### **Positive experience satisfaction and value**

Whilst GPs were appreciative of this payment, it was not seen to be a strong driver for engagement.

*I'm happy that they recognise the extra work... that some payment is needed. (GP6 Round2)*

*I think I received some payment... not a driving factor for enrolment for me. (GP2 Round1)*

### **Negative experience and suggestions**

Many interviewees commented that the payments were a “token” that did not compensate for the extra work GPs were undertaking particularly in development of shared care plans. Shared care plans were observed to be better remunerated through Medicare payments. Some saw the support payment as a stimulus for GPs to push patients to enrol in WSICP against their will.

*Is it adequate for us? Not from Doctor's point of view, we could do a GP management plan, which generates \$140 in how many minutes and what I'm trying to do is run off my integrated care program off the back of my GP management plans. (PN5 Round2)*

*... GPs sending patients... just want to enrol because it's incentivised... the patient goes, "No I don't want to be part of the program," and the GP's insisted "no you will". (CF2 Round1)*

Payment for ongoing follow up and change to funding models were recommended by interviewees.

*The one off is fine for getting things up and running but it's the ongoing and follow-up that takes time which we need to cover-perhaps something related to that could be arranged for those patients that need more work. (GP10 Round2)*

*... a one off payment...not a payment for overall care management or outcomes... we're just duplicating a faulty funding system by offering a one off payment. (MG6 Round1)*

## **10. Patient Centred Medical Home (PCMH)**

### ***Implementation and delivery***

The PCMH was described as a PHN strategy, promoted by WentWest. LHD stakeholders were supportive of the initiative, particularly its potential for reducing hospital based care. Interviewees noted alignment with integrated health care and PCMH practices were said to be engaging better with WSICP.

*...the LHD is aligned with the idea that the general practitioner is the patient's medical home and that's where the complete data should reside and that's where the care planning should primarily be done and that the role of the specialist and others, is to support the patient and the GP in the community. (MG3 Round2)*

*... quite a few practices are going to be working with the patient centred medical home model...most are the ones that have been working well with integrative care. (CF3 Round2)*

### ***Positive experience satisfaction and value***

GPs particularly those engaged in the initiative valued the holistic, community based team care.

*... a good idea... multidisciplinary approach... they see the nurse, they see other people before they see the doctor and it's based around holistic care for the patient. (GP4 Round1)*

### ***Negative experience and suggestions***

Some interviewees reported inadequate funding of this initiative and expressed concern about the limited, disease specific focus in WSICP compared to the whole of practice PCMH approach and recommended moving specialist services more into the community.

*There's not enough funding there. And it's too restricted to just a certain cohort of patients. So we are just pressing on with developing a PCMH-style practice, with the current funding model, and just figuring out how to best use what we have... (GP7 Round2)*

*... it's about managing the patient with what's available in the community... truly integrated care ... in the future to have the specialists out in the community, be it through technology like case conference and virtually through Skype or whatever. (MG2 Round1)*

## **11. Communication with other (Non-WSICP) Services**

### ***Implementation and delivery***

Interviewees recognised the need to work with other agencies and good relationships with external agencies and use of portals such as My Aged Care, were evident by the second round of interviews. These external linkages, particularly in the area of diabetes, included government departments and organisations well beyond the health sector.

*... good communication going between the community nurses and the heart failure service, so that's continuing...(HN4 Round2)*

*There's quite a lot of referrals we do in the community. And that's good. You really can hone in on what a patient needs, put them in the right direction. (CF2 Round 1)*

*... for home mods, equipment, any community services such as podiatry, or showering assistance, or nursing care, or anything, has to go through My Aged Care. (AH4 Round1)*

*...doing a bit of that work in diabetes, which is about urban design, transport, food supply and physical activity... (HS8 MG8 Round1)*

### ***Use***

Interviewees reported new and growing linkages with other health services such as community health; private health care providers including a radiology practice; a range of community based allied health care providers, and other government and non-government agencies. External referral was not universal with one interviewee describing internal LHD multidisciplinary services as easier to contact. GPs referred to expansion of their care teams to include pharmacists.

*...the main ones I talk to are community health, mainly OTs, Home Modification Service, My Aged Care, Meals on Wheels sometimes, and all of those community agencies, and I think, communication wise, they're very good... (AH4 Round1)*

*... I haven't been involved in a lot of the processes outside the hospital...we're getting such great links with our in-hospital connections, if I've got a problem, I tend to go to my in-hospital link, because it's easy... (AH3 Round1)*

### ***Positive experience satisfaction and value***

Patients valued the in-home care provided by many of the external agencies. Both hospital and general practice staff described a growing awareness of community based services. GPs also appreciated connections with services such as HealthOne.

*The hospital organised things like rails for the shower and front steps and connected us with home care to help me with cleaning—that happened really quickly and I feel [husband] is much safer now. (PC22 Round2)*

*...My doctor organised a community nurse who calls in regularly—because I can't get out easily with my COPD—she checks up on me and lets me know about transport and things like that—she always spends time with me. (PC2 Round2)*

*... having the time to spend... looking at community services and how the referral systems work has given me a better understanding of what's out there. (AH6 Round1)*

*... patients that have needed assistance from the HealthOne team as well, so the integrated care coordinators have been able to bring that in...so that's been really good. (GP6 Round2)*

### ***Negative experience and suggestions***

Some hospital staff described difficulties with communication with community based services with improved sharing of information and community-based positions recommended to address this.

*... while we've got good systems in place... they don't talk to each other and they don't have good forms of communication or referral in and out. (HS3 Round 1)*

*... positions that have a component which is working in a community hub, community practice or both, that needs to be built into the system at this stage... (MG3 Round1)*

## **Thematic overview**

Our thematic analysis describes three overarching themes. These relate to the set up and commencement of WSICP; challenges encountered; and the added value of the program. Findings in relation to these themes are described below.

### **Setting up the Western Sydney Integrated Care Program**

Both interview rounds highlighted a range of issues broadly related to the management of the program in these early stages; initiation and promotion of the program; understandings of integrated care; access to WSICP; and relationships with other unrelated programs and activities. These subthemes are described below.

#### ***Management of the Western Sydney Integrated Care Program***

Particularly in the first round of interviews but also in the second, the effort and time involved in setting up WSICP were described by both general practice and hospital staff. Hospital staff commented on the additional meetings and overtime required. GPs and practice nurses were particularly concerned with time taken to set up systems and recruit patients.

*...it was a long process getting those patients involved. It involved the whole practice, with reception staff, nursing staff, nurses and the GPs, and even also the care facilitator. (GP5 Round2)*

First round interviewees commented on lengthy delays related to LHD “bureaucracy” although by the second round of interviews this was no longer such a prominent refrain.

*... delays within the LHD because the LHD is a cumbersome beast and so positions need to be created... they needed to be signed off and then we needed to go through a financial process. There's a huge amount of bureaucracy... (MG2 Round1)*

Concerns were expressed about restrictions on funding for some initiatives and in particular a lack of funding for discretionary use by individual hospital departments. Some interviewees commented that Blacktown initiatives were less well funded than those at Westmead.

First round interviewees described policies and procedures as unclear and changing over time. Those interviewed in the second round continued to note a need for clarification of processes. Intended program outcomes were also said to be unclear, and changes in senior management were perceived to add to the confusion.

*...things are changing – so criteria, information and guidelines for the actual clinic are still starting to come out... everything's not so much finalised yet. (HN2 Round1)*

Interviewees were satisfied with plans for program evaluation and audit and these were noted as important in informing the current program as well as future iterations. Some aspects of WSICP were seen as challenging to measure, particularly those related to health care in the community such as impact of HealthPathways on patient outcomes.

*There's absolutely no evaluation of what is going on in the community, so what services are being used. Whether cross-sector supports are being brought into play, even allied health... (MG3 Round2)*

### ***Initiating and promoting the program***

The initial round of interviews highlighted uncertainty about policy and procedures from many engaged in the program, particularly general practices. Interviewees referred to incomplete design and inadequate communication. Some patients appeared uncertain as to whether the program had actually commenced.

*A lot of redesign work that is happening at the moment I think should have been done way before the Integrated Care Program was actually implemented... (CF3 Round1)*

A common comment concerned time taken to set up the program, develop new processes, recruit GP practices and patients. Referrals from general practice to hospital integrated care services such as the GP Support line and RASS clinics seemed slow, although this had improved somewhat by the second round of interviews.

*...time for the PHN to recruit enough GPs, such that the majority of patients that come to us can be sent back to an integrated GP. (MG1 Round1)*

By the second round of interviews, there appeared to be more promotion of the program to patients in the hospital and increasingly through general practice. Hospital staff engaged in WSICP identified suitable patients and advised GPs including in discharge letters. Reminders on GP records and support from the PHN were reported to assist in promoting the program. However some hospital staff appeared less aware of WSICP initiatives and this caused difficulties for GPs seeking to refer patients.

*... people seem to be a little bit more on board with it, when we sort of say to people, you're eligible for Integrated Care and the benefits ... they're more acceptable to it. (PN3 Round2)*

Orientation of new staff to the program, initially reported to be lacking, had improved by the second round of interviews.

*...new care facilitators coming on board have a different ...orientation to the way I was brought in, quite more substantial orientation than I received 12 months ago (CF2 Round2)*

### ***Access to WSICP***

Interviewees, particularly those in general practice, commented frequently on patient exclusion criteria such as those presenting with chest pain, with co-morbid cancer dominating care needs, mental illness as a primary diagnosis, those on dialysis, and those living marginally out of the geographical area or not actively engaged in the program.

*...patients with type 2 diabetes but they are on the dialysis - an exclusion criteria so they're not getting to the program but I thought these other patients who have got more complex medical problems, they should be probably better cared for during integrated care program. (GP13 Round2)*

Other interviewees believed the criteria were appropriate and prioritised access for those in most need, with one interviewee recommending exclusion of those not contactable after several attempts.

Particularly in the first round of interviews, but continuing into later interviews, concern was expressed about delays in enrolling patients due to lack of GP engagement in WSICP, especially in the Westmead area. Many suitable patients were observed to be missing out on integrated care, whilst others were referred to integrated care clinics from ED or at discharge rather than from the community.

*It would be nice to ... get more GP input from a community standpoint, but I don't know how long that's going to take. (HN2 Round2)*

*I've been really busy and the sad thing was, there were so many patients that would have been eligible for this. But just because it wasn't there in my mind I didn't think to recruit at that time. (GP Round2)*

Many barriers to integrated care were described. These included limited English proficiency; the illness itself making access to health care challenging and this exacerbated by poor accessibility of hospital clinics and long waits at GP practices. The integrated care clinics were said by some to provide tailored health care for the individual including access to interpreters.

*...people are more likely to refer them to our sort of stabilisation service because they can speak other languages ... It's harder for them to see their specialists in their community who can't get an interpreter necessarily. (HS1 Round1)*

The presence of financial barriers was a common theme with the low socio-economic status of many patients making purchase of medications and payment for medical services difficult. This was often seen as aligned with poorer education and unhealthy lifestyles. Medical care sometimes took second place to paid employment.

*...in Western Sydney it's probably the cost of medication and seeing specialists... Mostly general practice is bulk billed. They're able to see their GPs but it's - in an ideal world if we had a hospital clinic for every type of speciality it would help greatly. (GP12 Round2)*

Some interviewees reflected on patients who did not appear to value WSICP. Whilst difficulties with communication were said often to underlie this, some patients did not want to engage with a number of different health care providers.

*... having extra things to do or more people involved was actually a barrier. He wasn't interested in signing up because the last thing he wanted was more phone calls or more appointments. (GP6 Round2)*

Paucity of parking and the distance from parking to the hospital were frequently cited barriers to access. However some patients reported that disability permits, buses and assistance with transport from family alleviated these.

*I have to be dropped off at the door because there's no way in the world that I could walk from the carpark down to the hospital and I couldn't walk back there either. (PC7 Round1)*

### ***Understanding Integrated Care***

Across all interviewee groups, integrated care was understood as including a focus on patient centred care that was integrated across hospital, specialist, GP and community settings. Continuity of care, including informational continuity, was often part of the description and the care facilitation role and team based approaches were also considered facets of integrated care. Hospital staff noted the systems change required for integration of health care, often mentioning a focus on complex patients and benefits of avoiding hospital admission. The importance of providing adequate support for GPs to manage care in the community was also highlighted. For some health care providers their understanding of integrated care had grown with their involvement in WSICP.

*...a seamless process integrating care between the hospital, GP setting and the community  
...and having a multifaceted, multidisciplinary team approach to patient care. (CF2 Round1)*

*I didn't really know much about integrated care before the program was introduced to this practice... I've only learnt since our surgery's been put into the pilot. (PN3 Round1)*

Patients and carers used words like “one stop shop” to describe integrated care and often described the care continuum across hospital and community based care as a core feature of integrated care.

*In a nutshell I believe that's what the integrated carer system is about - integrating three different groups of people, which is hospital, GP, the patient carer... (PC17 Round2)*

### ***Unrelated programs and activities***

Often interviewees described programs that were unrelated to WSICP or pre-dated it, sometimes confusing these with WSICP strategies, other times noting the continuity between WSICP and these other programs and services.

*So many of the patients are shared anyway, you know, they sort of bounce back and forth from the normal heart failure program, integrated care, when they have deteriorations and ... we work as a team. (HN4 Round1)*

### ***Challenges***

Interviewees related many challenges to implementing integrated care approaches through WSICP. These included those related to organisations struggling to work together, issues related to roles and responsibilities of those working on WSICP, and the challenge provided by such major change within a limited time and funding frame.

### ***Inter-organisational challenges***

In both hospitals and general practices communication with the other sector was perceived to be challenging. GPs were said by hospital staff to be difficult to contact and to require immediate answers. Whilst GPs reported difficulty accessing busy hospital staff and also challenges with inconsistencies between different hospitals and services. Information technology, seen as a critical facilitator of integration on which much energy had been spent, was frequently criticised including in second round interviews.

*...still very basic at this stage... it's the connectivity, I'm not really happy with. (GP12 Round2)*

The IT shortfalls were observed to impact on communication across a range of functionalities including shared records, referral processes, checking receipt and entry of data. Incompatible slow

systems, inadequate investment of money and poor end user awareness were described as impacting also on data collection for evaluation of the program. However by the second round of interviews there were glimpses of the opportunities provided by integrated health records.

*Another frustration is the whole integration of health records; that's been hopeless. I suppose, the other frustration is that they said we could get e-referrals. We haven't got any e-referrals from any of the external practices...GPs should be able to e-refer. (HS1 Round1)*

*...I would say 70% better... I think 90% of my patients have a Linked-EHR care plan which is great... (CF3 Round2)*

Interviewees commented on the culture of siloed care provision, with sharing even between hospitals not routine and a lack of regard for care provided in the community. GPs acknowledged that they were part of this problem with the fee for service model a disincentive to team based care. One hospital based care provider wondered if GP reluctance to access hospital expertise was related to concern they may be revealing lack of knowledge to the person answering the GP support line.

*...this disinclination on the LHD staff to recognise community health or other services, are of any relevance to this whole exercise (MG3 Round2)*

*I think our culture needs to change a bit. I think general practice has been a bit of a silo, and I really like working with allied health people...I really enjoy the team approach to patient care. (GP7 Round1)*

*GP practices being businesses sometimes it's just quicker for them to see 15 patients in 15 minutes, rather than put in all this work to have case conferencing and working together. (CF3 Round2)*

*I don't know whether GP's think if they ring in and ask for advice or support we wonder what are they doing? .... if that's the reason they're not using the service, which is silly because, yes, they're GP's but they're not going to be experts in cardiology, or respiratory, or endocrine... (HN2 Round2)*

Beyond the divide between hospital and community, divide between different speciality areas within the LHD was also noted to be a barrier to integrated care and WSICP was not perceived to have changed this substantially.

*... still uneasiness between the teams, in terms of integrated care working, I think we need to do a lot more teambuilding...very much viewed as an us and them approach. (CF2 Round2)*

### ***Challenges with roles and responsibilities***

In the first round of interviews there appeared to be confusion about roles especially with new positions like care facilitators, but also for nursing, allied health and even hospital specialist roles. One care facilitator described being "crash test dummies". By the second round of interviews those we interviewed were becoming clearer about their roles.

*...it's a bit more defined what we're doing now. I think it's a combination of consulting and actually co-coordinating or case managing. (CF3 Round2)*

Additionally, at times expectations appeared to exceed the position descriptions. This was particularly the case for care facilitators who struggled to engage GPs in the program. The additional administrative burden WSICP imposed on hospital staff was also described as challenging.

### ***Carer burden and support needs***

Carers vividly described their round the clock responsibility and the grief and loss associated with their lifestyle limitations as well as the sadness of witnessing their loved one deteriorate. They highlighted their needs for good information and for support in their roles including in one instance family counselling.

*... no real interactions since [husband] had the defibrillator, because that was major, really, really ...overwhelming ... even now it ... remains a bit of a mystery to us, scares the life out of us. But, I don't think there's been much follow up from the program. (PC13 Round2)*

*... if there's any carer forums so the professionals – they won't fix your problem, but that's not what I'm expecting, but they will probably tell things that I'm not aware of, how to deal with different situations... (PC17 Round2)*

The services provided by WSICP were observed to need tailoring to the individual with one interviewee describing case conferences, perceived by many to be helpful, as inappropriate.

*...our GP asked us if a professor could come from the hospital to have a look at [NAME] ... he just completely upset the program. I was very angry actually, because I thought well we're doing good... if I can keep [NAME's] readings under 10, I think we're having quite a good day. (PC22 Round2)*

### ***Scale of the undertaking in the timeframe provided***

The size and complexity of transformation to an integrated care model was often discussed and this challenge was noted to be compounded by the limited time and funding for WSICP. Interviewees described the time required to establish the program, and the challenge of changing engrained behaviours related both to health care providers and to patients.

*You're rebuilding, changing, you're realigning the way we're doing business. We're trying to turn the Titanic around a little bit and we're slowly doing that. (MG6 Round1)*

*...we have to allow the time to get this message out to the GPs, allow time for changing behaviour... we're not even a year into this and I think we're trying to change a system that's been in place for a very, very long time. (HS3 Round1)*

*... their lived experience is "I get sick, I come to hospital, I get admitted ..." (HS2 MG9 Round1)*

Concerns were often expressed about the risk on closure of WSICP, of losing gains made. The need for long term commitment to see outcomes, especially for chronic diseases, was a strong theme and comment was made that the outcomes evident at this stage offered some promise for the future. Concerns about short term funding were often linked to comments about losing good staff and a history of similar short term projects in NSW. However by the second round of interviews there was some reassurance about ongoing albeit reduced funding.

*I'm worried that the funding stops and all of this is a waste of time. I don't think you can see results in two years, I don't know that you can even see results in five years, but I think it needs long-term investment in an initiative like this that focuses on outpatients and keeping patients well in the community. (AH6 Round1)*

*...chronic disease, in its very nature, is not something that changes quickly or that you see an impact quickly... the fact that we're actually seeing something so soon does suggest that this is going to be beneficial in the longer run. But it needs time. (HS3 Round1)*

*... obviously people are worried about what's going to happen after that, a lot of turnover of staff– then you have to start again and retrain people. (HS3 Round2)*

*... so many different programs come out from the Ministry of Health and then it just fades and dies... initially that may have also led to some of the resistance internally... (HN5 Round2)*

### **Added Value of Integrated Care**

In spite of comments about time needed for change, many interviewees described changes as a result of WSICP. These included enhanced capacity of patients and health care providers, changes in behaviour, finding value in integrated care and suggestions for the future.

#### ***Building capacity***

WSICP was described as building understanding, knowledge and capacity of patients and carers and health care providers.

##### **Patients and carers**

In our early interviews, there were many examples of patient upskilling and empowerment, and of enhanced health care provider collaboration with patients as they learned more about their condition, its management and better ways to navigate health systems. This focus on education was thought by some to be changing key LHD indicators such as re-admission rates.

*...a patient who used to come in once every month, now haven't seen him for a few months in the hospital because he's been managed through integrated care service ...He gets a management plan. He's able to empower himself, he's learned what to look for... how to manage his weight, how to manage his salt intake, what to do with his diuretics... he knows what to do now... and whenever something goes wrong he'll see the GP. (HS10 Round1)*

*...we've slightly decreased the readmission rate... they're weighing themselves regularly, they're watching their fluid restriction, they're taking their medication... (HN2 Round1)*

Care facilitators and allied health care providers especially, spoke about empowering patients to ask questions in order to get the required information. Engagement of patients in decisions about their management was described as a shift away from a medical model to a patient centred model of care. Patients also described taking control of their health care and enthusiastically described provision of information by WSICP staff and through their own efforts.

*... it helps because I can ask some questions...they are open ... (PC18 Round2)*

*... in a hospital setting... what happens with the patient is decided by the medical staff, and the doctors, whereas this is more about the patients ... they have a hand in deciding what's*

*happening to them... having them as the focus of the care. So it's a shift away ... from the medical model. (AH4 Round1)*

*... I make my own decisions on my health, taking those kind of medicines. So I'm aware of what I'm doing. Because I don't want to be hospitalised. (PC2 Round1)*

*They're brilliant, they explained what will happen, and how to deal with it. (PC14 Round 2)*

*I've done all the, like research online by myself, so, I think, I've learnt a bit. (PC15 Round2)*

This empowerment was observed to extend beyond medical care to lifestyle choices.

*... take matters into their own hands a little bit more in terms of choosing better foods, or ... exercising... going to help impact their health definitely... they understand why they're doing it a little bit more, it's not just do this, do that, now there is a reason behind it. (GP6 Round1)*

Team based care was described as assisting in patient education with different health care providers having different roles and expertise.

*I've been saying the same thing to the patient and achieving nothing, but when the team comes, [patient] goes, okay, listens, this is the message, and just does it but it's actually good having someone else with the authority, reinforcing it... (GP14 Round2)*

*... dieticians and educators are some of the key players in enabling patients, because they often have the advice for day-to-day practical matters. (HS4 Round1)*

*[Care Facilitator] is brilliant... listening to her educate the patient on his newly diagnosed disease and learning from her... (PN3 Round1)*

Health care providers and patients described improved ability to access services and navigate the health system as a result of WSICP. The patient hotline was seen to be a way into the system and frequently the care facilitator was mentioned as assisting in health care navigation as well as being a familiar face in the hospital setting. Although some patients preferred to retain their GP as the first point of contact, WSICP provided alternative contacts when the GP was not available.

*...feeling like they've got a central point of contact and that they're not lost in a sea of people ... they know where to go to get the help that they require. (AH3 Round1)*

*Now I know who to call and when to if I need them... (PC7 Round 1)*

*... they appreciate that that there is a care facilitator as well with a bit of a one stop kind of shop if they have got questions or problems, help them navigate the system. (GP6 Round2)*

*...if you're away and something goes wrong, they know who to call... (GP6 Round1)*

### Health care providers

Health care providers also described upskilling through WSICP. Hospital staff provided education across the three disease areas for the GP team including practice nurses. This was also a strategy for enhancing referrals to WSICP. While earlier interviewees, particularly practice nurses, did not report a lot of education, by the second round practice nurses and GPs were reporting a variety of

approaches including case conferences, practice visits, evening workshops, learning from care facilitators and conferences. GPs particularly valued case based learning approaches. One hospital specialist described challenges engaging GPs in teaching sessions.

*... it actually is better if we have the patient and talk about particular patients because that's actually means I learn a lot but yes it is part of the skilling up process. (GP5 Round1)*

*We get some general practice nurses and some other practice managers...in terms of educating GPs...they just won't turn up, and I put on free meals for them, it's been in different venues... (HS2 MG9 Round2)*

Teaching sessions were provided for community based allied health care providers. Hospital interviewees also described learning about general practice.

*...going out to GP practices and doing some teaching has been incredibly eye-opening, I've got a much better understanding of what it is my GP colleagues want and need. (HS2 MG9 Round1)*

By the second round of interviews there were many comments about improvement in knowledge and skills resulting from the educational initiatives including impacts on patient empowerment.

*...treatments from the GPs have increased. They're more confident to changing medication... patients seem to like it ... prefer to come to their GP than go to a specialist. (PN3 Round2)*

*...our nurse is more educated and knowledgeable about diabetes... [this] is also then transferring to our patients in helping them self-manage. (GP5 Round2)*

In the hospital setting also, education was being provided with multidisciplinary team members learning from each other, teams from one disease area learning from those in other areas, as well as presentations focussed on the integrated care program.

*So it has really been educational for various different health professions... OT and dietetics and so on, so everyone showing their piece of the pie. (AH5 Round1)*

*... emphasis on education... has been really huge, really valuable, really steep learning curve... learnt more in the last three or four months than I have for a very long time. (AH4 Round 1)*

### ***Changes in practice***

Engagement in WSICP was reported to have changed practices of health care providers and patients.

#### **Improved communication between hospital and community services**

Interviewees highlighted growing collaboration and communication between hospitals and community based care providers including GPs. This was emerging in the first round of interviews and more positively stated in the next interview round, though with room for improvement noted.

*We do seem a little bit disjointed, I've had GP feedback but not from the GPs, it's come via a third, fourth, fifth person... (HN5 Round1)*

*... more GPs contacting the service ... referring their patients to our care. There are more doctors being talked to by the care facilitators in regards to ... services... (HN6 Round2)*

*I've worked on getting quite a good communication going between the community nurses and the heart failure service... GP wise sometimes we get something, a lot of the times we don't; we're sending them everything and hearing nothing back. (HN4 Round2)*

GPs attributed the increased communication to easier access to hospital services and staff and this was thought by hospital specialists to decrease GP referrals to the emergency department.

*There's more communication with the rapid access clinic... It was very hard for us, previously to try and talk to someone and get them admitted but now it's a lot easier. (GP12 Round2)*

*Historically, if GPs were unsure of these patients, they would just say, "Go to emergency," but if they have something to fall back on... building a bridge between primary care and the specialists... (HS6 Round1)*

Interviewees also reported improved and timelier communication from hospitals, particularly by the second interview round, when the key role of the care facilitators in improving this communication was well described. Patients and carers also observed this improved communication.

*The doctors from the hospital are more into calling us for more information, I think, there's no hesitancy to ring us if they need help. (GP8 Round2)*

*... I call the GP from the clinic and say, "I have your patient here. We're going to do this." So it's not just a letter. (HS1 MG7 Round1)*

*...the patient that's in the Integrated Care Program, they go to hospital, I get notified, which is excellent. It would be good if I had that with all my patients. (GP2 Round2)*

*If one of my patients go into hospital, I get a call from the care [facilitator], and they ... talk to the patient ...and when they go home, also they call... (GP11 Round2)*

*...more contact with [GP] from the hospital because of it [WSICP]. (PC9 Round1)*

Several interviewees commented on the value of face to face contact in building relationships and improving communication. This was described as facilitated through visits to GPs by hospital staff and also visits by practice nurses to the hospitals.

*...we have multiple talks with the GPs and even visiting practices ... it's opened up those links as well... (HS11 Round1)*

*I might call some of the GPs and have a chat to them about the patient... I find it difficult, no recognising of faces – doesn't appear to be much of a relationship... (HN2 Round1)*

*...recently we had little visits from practice managers. They came in to just review Integrated Care Clinic to see what went on... they could relay that back to the GPs. (HS4 Round2)*

Patients and carers reported alignment across the health care team and the second round of interviews also highlighted the growing linkages with other programs.

*We are on the same track. The psychologists, the doctors, the care plan clarified – hopefully you get to understand drugs, how to manage correctly, so they are good. (PC18 Round2)*

*We are working with HealthOne and General Practice Liaison Nurses, so that we know if we have a common patient we can try and work together to communicate with each. (CF4 Round2)*

#### **Improved communication and collaboration within hospitals**

Some improved cross disciplinary collaboration was described in the first interview round, although the need for improvement was clearly noted with distance between the different specialty areas of the hospital described as a barrier even into the second round of interviews. By the second round there were more descriptions of collaboration within and between hospitals with intra-hospital referral to RASS clinics a key facilitator and benefit of WSICP.

*I know we're all trying to work to the same thing...but I think, the three chosen areas... I don't think we're talking that well together. (HN1 Round1)*

*... respiratory is so isolated from where cardiology and diabetes are. So we're up on Level 5, while they are on the ground floor and they might have interaction ... (HN3 Round2)*

*... patients that require, for example, endocrine and cardiac input, we will try and put them into our combined clinics on a Friday. (HS1 MG7 Round2)*

*it's given them more access to each other. We were working in siloes before almost didn't know the other was there. (HN4 Round2)*

*Also we're now aware of the groups in Blacktown as well, so I think that there definitely has been improvement in that. (HS1 from Westmead, Round1)*

*...being able to access the rapid access clinics for diabetes and cardiology has been really useful...I'll see a patient... their sugars are a bit all over the place... before I wouldn't have known what to do that but now I know I can call diabetes rapid access. (HS2 MG9 Round1)*

#### **Multidisciplinary team care**

The opportunity provided by WSICP for multidisciplinary team care was highlighted in both hospital and the community environments. Patients also commented on this changed approach.

*...my Thursday morning foot service, there is also the infection disease department... the actual surgeon is there, and quite a lot of foot doctors as well – podiatrists – we're engaged with them a lot more than we were, which is fantastic. (HS5 Round2)*

*...with the case conference and I think it is a good thing, because we can see everyone's input on it and we can work together as a team to better manage this patient. (CF4 Round2)*

*Well I never had all this dieticians and things like that but now all of a sudden everybody's getting involved. (PC10 Round1)*

*We see dieticians down there and there's someone there from the chemist, like to help you with your medication... there's always someone ringing me up or coming out. (PC19 Round2)*

Focus on earlier treatment and preventive health care

WSICP was described as promoting preventive health care, aiming to keep people well and to treat patients earlier in their illnesses. The benefits of this approach were clearly described with earlier diagnosis sometimes described as dramatically altering patient outcomes.

*...we're picking up changes a bit earlier and keeping on them, so I think it does help them to self-manage a bit better. (HN4 Round2)*

*...before the Integrated Care Program Mum was constantly either getting admitted into hospital... they would treat or fix one issue and then she'd come out of hospital and she had something else wrong...over the last six months I think she's been into hospital twice... her blood pressure and her sugar and everything on track. (PC1 Round1)*

*... two patients which we didn't even think were going to be an issue, ended up going for emergency by-pass...prevented a heart attack and definitely prevented them dying. (HN2 Round2)*

This early treatment was supported by access to hospital services through RASS and sometimes facilitated by hospital staff visiting patients in their homes.

*This provides a service where we see these patients very early on within most of the patients nowadays we're seeing within 48 hours. (HS6 Round1)*

*doing home visits...they're quite frail, they're very breathless, they're often carting around oxygen tanks... really hesitant with respiratory conditions that come to the hospital environment, because they might pick up a bug... and land up in hospital. (AH6 Round2)*

Community based approaches to preventive health included those that were patient specific and some related to wider systems and planning issues.

*... doing a lot more preventative things and keeping in touch with the patient, it does improve their compliance with treatment and hopefully keep them out of hospital... (GP12 Round2)*

*urban design, transport, food supply and physical activity, and then identifying people at risk of, say, chronic disease as an example and then working with primary care ... to keep them healthy. (HS8 MG7 Round1)*

#### Patient centred holistic care

WSICP approaches were clearly identified both by health care providers, and by patients and carers, as putting the focus on the patient and doing what was important for them. The difference between this approach and standard care was highlighted.

*...they really feel a bit special... like, hey, this is the first time that I really have been looked after, in a way that they can understand, in a way that they really seem to appreciate and can engage with. (AH6 Round2)*

*Oh, yes, I believe it has, I find that the people are more forthcoming and at least you can stay and talk to them and you'll get an answer. (PC7 Round1)*

*[I] might see that them not being able to get a shower is really very important, but they may not. So, therefore, I don't work on that. I work on other stuff. Making a cup of tea, walking to bingo, or whatever... what they want to achieve. (AH4 Round1)*

*... in a large hospital, with 50 patients to manage, there was no luxury - to do good care was a luxury... logically difficult...the Integrated Care Program is so amazing... because of the patient focus, everything we do is so mindful, that it is all about our patients. (HS7 Round2)*

*... an opportunity to look at the patient as a whole and treat them a bit more holistically, instead of just addressing their one problem at a time when they come in... (GP12 Round2)*

Attention to the whole person and all the patient needs within WSICP was seen as another benefit of the program.

*...not only have their symptoms addressed by the doctor but...issues with food addressed... issues with anxiety or depression or manual tasks with the OT and the psychologist. (AH6 Round1)*

*...can package the service into a one hour, two hour period, rather than, say, an admission or have a patient come back three times to see different parties. (HS4 Round1)*

*... someone come out to me weekly... talk psychologically...I find going out of the house traumatic and I don't care if you come here but I don't want to come to you. (PC8 Round2)*

### **Valuing WSICP**

From the early days of WSICP, benefits of the program were recognised with resulting improvements valued by health care providers and by patients and carers.

*I think even in this short space of time, I feel like we've improved some of those things... can see a tangible improvement... you feel that that investment is rewarding. (HS3 Round1)*

*...even though it's early stages, I think it will have a significant positive impact in the future... it's a good idea. (GP4 Round1)*

*With the health service, the best thing I've ever actually come across. (PC1 Round1)*

Improved service provision as a result of WSICP was described in general practice and hospital settings. Access to services was described as more timely and efficient including through the ability to see multiple care providers in one visit. One GP expressed surprise at how quickly efficiencies were realised through use of care plans.

*... able to treat the underlying condition more effectively, we're able to address complications and then hopefully improve their quality of life. Definitely I think that's money and time well spent... it's a good program that is actually going to be effective. (GP6 Round1)*

*...patients are in emergency departments for less time... seeing their own specialists much sooner. They have a firm follow-up plan, compared to the time where there wasn't a rapid access clinic. (HS6 Round2)*

*...when I was on the program... being sent through to be put in a ward and being X-rayed and being attended to in very quick time - very good care. (PC9 Round1)*

*Initially I thought it was going to create a lot more problems, like take a lot more time. If anything it's actually made it work a lot more efficiently. And care plans are now up to date... being followed up properly - I'm definitely seeing that it's helping and I'm getting results. (GP9 Round2)*

Some interviewees noted the impact of WSICP on cost effectiveness as well as patient outcomes. The opportunity to avoid hospital admission was described by patients also.

*...if we can look after patients in the home setting, or in the general practice setting, limiting their admission time ... it will certainly be cheaper. (GP8 Round2)*

*...ED avoidance or getting them to get out of ED quickly so ... they can be at home and ... come and see us the next day in the hospital...I think the value of the service cannot be underestimated in preventing admissions and improving patient outcomes. (HS11 Round1)*

*...saw that phlegm that came out which was pretty yellow, and I told her that I'd already been on these tablets. Anyhow, she called the doctor in that works with her, and the doctor prescribed me these other tablets, which I got. And they fixed me up within a week. I didn't have to go to the hospital. (PC11 Round1)*

Interviewees highlighted the importance of patient comfort with people they knew and could contact easily and the impact on their on their ability to self-manage.

*...that makes people feel comfortable when they see a face and they know they'll see that face somewhere else and that person's able to control their health, control their appointments, their exposure to emergency departments or try to limit that. (PN3 Round1)*

*...of particular value have been giving that patient the ability to have contact people in the program.....the heart failure nurses that are really contactable, that gives that patient extra... reassurance, and autonomy. (GP6 Round1)*

The shift of care into the community was a more prominent theme in the second round of interviews as were comments about the value of WSICP in linking with other services.

*... to say that the care and the management of patients with chronic and complex illness is based in general practice is a massive shift in attitude and understanding and to a lesser extent, behaviour. (MG3 Round2)*

*...to bridge that barrier from between the hospital and the GP, and to move the burden of care for some of these chronic diseases back to the GP, and it's trying to create a connection that is easier to navigate. I can see how all of those things are happening. (HS3 Round2)*

*... more services for the patients and having someone to help streamline that process has been really valuable as well. We've had patients that have needed the assistance from the HealthOne team as well, so that the integrated care coordinators have been able to bring that in...so it's all ... streamlined in kind of one place. (GP6 Round2)*

### ***Suggestions from interviewees***

Interviewees made a range of suggestions regarding ongoing rollout of WSICP. Many of these concerned extending the program beyond the current inclusion criteria such as extending to aged care facilities or to those with mental health problems. Provision of access to dental services was also mentioned.

*Why can't we go to the nursing homes and try and educate the nursing staff? (HN3 Round1)*

*... something similar for mental health... like a link-up with a hospital or a psychologist or a psychiatrist, who would be able to review the patient on as needs basis... (GP4 Round2)*

Many interviewees suggested extension of WSICP activities seen to be working well. This included extension of case conferencing to cardiology and COPD and videoconferencing these. Others requested particular allied health care providers such as exercise physiologists, community diabetic educators, psychologists, and more physiotherapy for COPD patients. One way proposed to address the undersupply of some allied health services was group sessions. GPs and patients and carers also noted the potential of such groups to provide support.

*...they all get seen by the three doctors; there's only one dietitian. Something I have been thinking about is doing a group. (AH2 Round1)*

*...group sessions where you can also talk to other people who are in similar situations. (PC17 Round2)*

Other comments related to improving promotion of the program and enhancing learning across the sites and over time.

*... not a lot of advertisement regarding the program, what we can do. I think you need a full project manager to help with communication, newsletters, you know, establishing who we are. (CF2 Round2)*

*... networking a little bit more just to see how we're all doing, how we're all going, that we can, sort of, trouble shoot as well, what works for us might not work for Blacktown... (HN1 Round1)*

*...we all meet up, and we look at all the data... maybe once every couple of months, just the medical team, and the nursing team, and the allied health get together and maybe have a discussion as to how we could try collaborate and improve the system. (HN3 Round2)*

One patient had not experienced the home based care described by health care providers and requested this be considered for the future. Use of other community services for patient support was another suggestion.

*...travelling it's quite difficult for us, so I would – my suggestion is if ever, this would be occasionally, just making an appointment or just visiting the patient at home. (PC18 Round2)*

*...tapping into that particular service with Blacktown Council... maybe a cab charge voucher that facilitates them getting to their appointment on time. (HN6 Round1)*

Improvements to communications and IT including more flexible responsive systems and shared patient records were an ongoing refrain as was improved staffing of IT.

*...just send out emails, we could just send out text messages to landlines. (HN5 Round 1)*

*... you put a summary in shared care plan then you have seen them again... added all the diagnoses... put that back in a new shared health summary ... can't reimport that into the care plan. (GP6 Round2)*

*... if we could look at their notes, and they could look at, maybe not everything... If we had a shared electronic record. (GP7 Round2)*

*We needed to employ some IT people in integrated care not defer to the LHD IT. (HN5 Round2)*

Recommendations for co-location of hospital based services have been noted above. Additionally room and resources more generally were requested by others.

*... we still don't have a definite room or a clinic to base Integrated Care on. (HN6 Round1)*

*It's not going to be a quick fix problem with low budget... I think investment in resources in terms of health professionals, location and equipment and administrative support is needed. (HS11 Round1)*

For patients and carers access to services needed more attention.

*... they need more closer parking for people, like, invalid people... (PC7 Round1)*

More investment in general practice initiatives was proposed in both rounds of interviews. Additionally the need for alternative funding models and wider systems change in primary health care was also observed.

*... more investment in general practice... we probably don't have the manpower or the staffing or the funding to employ someone to be able to track these patients and recall them... (GP3 Round1)*

*Despite the small volume of incentives that we've managed to bring in with this program, the system is still geared to reward high throughput, but not high value. (MG3 Round2)*

*I think having the community recognize the value of having one practice providing most of their care... community education would be really useful. (GP7 Round1)*

## **Discussion**

In this discussion section we provide an overview of the key achievements of the WSICP, describe key enablers and barriers and, finally, we offer some concluding remarks and recommendations for the WSICP into the future.

### **Key Achievements**

The quadruple aim of enhancing patient experience, improving population health, reducing costs and improving the work life of health care providers underpins delivery of health care in western Sydney including through the WSICP (28). Using the quadruple aim as a framework, it is clear from our qualitative research that WSICP has made much progress across each of these areas in management of patients with diabetes, COPD and CCF. Growing patient and general practice enrolment and engagement with WSICP highlights the strengthening integration of primary and secondary health sectors, and is strongly supported through care facilitator involvement. These outcomes have been achieved in a relatively short time and promise greater change in the longer term with continuation of the WSICP. Other evaluation approaches will of course be required to provide definitive evidence of some of the outcomes described by our interviewees. We note the following key achievements:

**Enhanced patient experience** which was evidenced in our interviews by:

- Empowerment of patients and enhanced ability to manage their health condition and to navigate the health system;
- Improved care in the community and easier access to hospital services when required; and
- High levels of satisfaction with new services particularly care facilitators and RASS clinics.

**Improved population health** was suggested in our interviews as a likely outcome in the longer term as a result of individual patient outcomes in terms of their chronic diseases and, at times, related acute conditions. There is a strong focus on preventative health initiatives and earlier interventions likely to reduce morbidity and mortality.

**Reducing costs** in the future was suggested by reported:

- Reductions in ED attendance amongst those with chronic conditions;
- Reductions in admission and re-admission of enrolled patients and some suggestion of reduced length of stay in hospital for those admitted; and
- Time and therefore cost efficiencies through access to multiple providers during a single visit.

**Improving work life of health care providers and their satisfaction** was well evidenced across all health provider stakeholder groups with a new focus on team work, building capacity through education and strengthening of cross-sectorial and, in some cases, interdisciplinary relationships. All of these were highly valued.

## **Enablers**

Throughout our evaluation interviewees identified aspects of the WSICP working well and enabling many of the achievements described above. Some of those key aspects of the WSICP are noted below.

### ***Partnership between the WSLHD and the WSPHN***

Integration of care between primary and secondary health sectors in western Sydney is underpinned by the partnership formalised in an MoU between the Local Health District and Primary Health Network (24). The mutual respect, trust, and common vision as well as previous shared activities, have provided a strong basis for the development and implementation of the WSICP.

### ***Patient Centredness***

Interviewees across all stakeholder groups and particularly patients and their carers described patients as the focus of care. They were included in conversations and supported through education and encouraged to contribute to decisions about their care. They described this collaboration and empowerment as improving their skills in managing their illness and their ability to navigate the health system. These changes were confirmed by many health care providers.

### ***Building relationships***

Even at this early stage of WSICP, relationships between health care providers within the hospital and between hospital based and community based health care providers were perceived to be strengthening. Early collaborations across hospital disciplines were reported. Visits by hospital specialists and nurses to general practices, enhanced access for GPs to hospital specialists through the GP support line and more timely communication between the sectors were all said to assist in integrating health care. Team based approaches to care were reported both in hospital and community settings.

Relationships between health care providers and patients and their carers were also considered an important facilitator of WSICP. Many interviewees commented on the value of patient relationships with care facilitators and staff in RASS clinics, in increasing confidence to access hospital care.

### ***Alternatives to ED and admission***

RASS clinics offered an alternative to ED presentation for complex patients requiring ongoing care, and a means of following up care for those recently discharged. They were reported to be reducing admission and re-admission rates. Patients and carers valued the holistic care, access to a range of health care providers and the strong focus on education in the clinics. Contact through patient hotlines often provided an alternative to presentation at the hospital, and home visits by hospital staff were also reported to assist in keeping care based in the community.

### ***Care facilitator role***

Interviewees from all stakeholder groups valued the contribution of care facilitators. They not only supported patients to follow their care plans including through education and assisting with health care navigation, but also provided a crucial communication link between general practice, other community services and the hospital. Care facilitators were seen by some as the “embodiment” of health care integration.

### ***Shared understanding of integrated care***

A shared understanding of integrated care was apparent among the different interviewees. Certainly health care providers appeared to have a strong commitment to a vision of integrated health care which aligned with the WSICP model. Patients and carers also described what integrated care meant to them reflecting on many of the WSICP initiatives.

### **Barriers**

Throughout the evaluation, Interviewees also reflected on challenges and barriers to the WSICP. Whilst some of these were being addressed by the second round of interviews, others persisted and hampered the effectiveness of the WSICP.

#### ***Delays and bureaucracy in setting up WSICP***

Initially the WSICP faced difficulties overcoming institutional inertia. The planning and establishment processes including set up of governance and financial systems were reported to have delayed implementation. Clarifying roles such as care facilitator roles and also those of other key hospital staff, and engaging appropriate staff members, further delayed implementation. Yet conversely at times, these processes were rushed with inadequate job descriptions and orientation perceived to be a major challenge for care facilitators in the early phases of the WSICP.

#### ***Time limited nature of Demonstrator***

The delays above were widely reported to be compounded by the time limited nature of the WSICP. Many interviewees expressed concern over the time it would take to see outcomes from the program and suggested that the program would conclude just as these were being achieved. They noted the time required to change attitudes and behaviours of clinicians and patients as well as the time to see changes in chronic conditions. The impact of time limited programs such as WSICP was perceived to be compromised from the outset and this was reported as negatively affecting staff engagement and retention.

#### ***WSICP not well promoted***

Many interviewees commented on poor promotion of the WSICP. Especially in the first round of interviews, patients were unaware the program had started. Delays in enrolling GPs were frustrating hospital staff who were seeing patients who could benefit from the program, however were not eligible for all WSICP services as their GPs had not enrolled them.

#### ***Information Technology***

Interviewees expressed frustration with IT applications, especially the hospital based Cerner database and the failure of these to save time or improve processes including form filling, letter writing and sharing information through Linked-EHR. Compounding this was a perceived lack of understanding or response from LHD IT staff. In the general practice setting, duplication of data entry was also a concern and less IT enabled practices struggled with the introduction of new applications. Support from the PHN was required and multiple software programs made this work time consuming. Many interviewees expressed disappointment that the vision of “one shared health record” across hospital and community settings appeared as distant by the end of our evaluation, as it had been prior to WSICP.

### ***Attitudinal barriers***

Although progress was reported in breaking down barriers between hospital and community based services, barriers between specialist disciplines were less impacted by the WSICP and some GPs were also reported to be resistant to the team based care promoted by the WSICP. Interdisciplinary siloes were suggested as a barrier to holistic care and failure to co-locate services inhibited attempts to address these siloes. Some GPs were reported to be only financially motivated in recruiting patients, and failing to engage with key elements of the WSICP such as shared care plans and care facilitators. There was a perception that their patients, although enrolled, were not receiving the full benefits of the WSICP.

### ***Access to services***

Lack of access to the WSICP for certain types of patients who were perceived as likely to benefit from the program, was a concern for many of our interviewees. This included concerns about enrolment criteria and discharge rulings for patients who could not be readily contacted.

Although access issues related to hospital services pre-date the WSICP, the aim of the WSICP to provide “access” to integrated health care requires some mention of the strongly voiced concerns about access expressed by many of the patients and carers we interviewed. Notable concerns included parking availability and cost as well as distances from parking to hospital services.

## **Recommendations**

Collaboration across health care sectors has enabled WSICP to provide care that meets patient and health care provider needs and appears likely to improve health outcomes and cost efficiencies. Our interviews have provided a rich understanding of the successes and the challenges of the WSICP as well as insights and suggestions informing future health service reform. Reflecting on our research findings, we are able to offer the following recommendations for the WSICP in order to consolidate gains already achieved and address areas for further attention.

1. Embed integrated care as routine practice at all levels of the hospital, in the community and with key stakeholders through:
  - Policy alignment;
  - Promotion of the vision of integrated care and the success of the current program to all stakeholders;
  - Provision of information about integrated care including through specified contact people at both the PHN and the LHD as well as through resources such as flow charts outlining the processes related to the WSICP; and
  - Face to face visits from GP teams to hospital staff to GPs.
2. Continue the focus on patient education and empowerment which includes carers and, as appropriate, families in these activities and improve support for carers such as facilitating support groups and information sessions.
3. Seek long term commitment of all stakeholders including funders, policy makers, managers and practitioners, and also patients and carers to continue and extend the WSICP including through:
  - Ongoing WSICP staff appointments including, and critically, to care facilitator roles;
  - Continuation of RASS clinics and related communication through support lines;

- Extension of the program beyond the current three chronic diseases and inclusion of those with co-morbidities such as mental illness;
  - Consider enrolment flexibility for those living in nearby areas using local services and those in Aged Care Facilities; and
  - Engage more allied health care providers especially those who can assist with mental health problems associated with chronic diseases.
4. Improve cross disciplinary collaboration, including through multidisciplinary clinics and better co-location of hospital services, and more space and resourcing in hospitals for integrated care approaches.
  5. Continue and enhance provision of community based care by hospital staff in close liaison with GPs and others providing services in the community.
  6. Continue health care provider education across all disciplines and in all sectors as a core component of integrated care.
  7. Provide seamless shared patient records and more responsive IT systems to provide real time access to shared information and alerts when information is entered. This should include dedicated WSICP IT support and orientation and training of staff in hospitals and the community.
  8. Enhance parking and transport options to address the needs of those with physical disabilities related to their chronic illnesses in accessing hospital services.
  9. Ensure primary health care continues to be supported to deliver high quality care in the community, including advocacy for remuneration that rewards quality rather than through put in general practice.
  10. Ensure evaluation continues to inform development of integrated care in western Sydney through ongoing support for data collection and analysis, including qualitative and process evaluations, as well as research concerning health outcomes and health service utilisation and costs across primary and secondary/tertiary health care sectors.

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## **Appendix A.**

### **Matrix coding of specific WSICP initiatives with illustrative quotations**

The following analysis of the interview data is organised in a matrix specifically addressing each of the key WSICP strategies: Care Facilitators, IT Systems, Shared Care Plans, Specialist Action Plans, GP Support-line, Rapid Access and Stabilisation Service Clinics including Patient Hotline, HealthPathways Website, Support Payments for GPs, Patient Centred Medical Home development, and communication with Non-WSICP services.

As agreed in our research plan, each of these strategies is described according to implementation/delivery, use, experience (positive/negative), satisfaction, perceived value, and suggestions. Implementation/delivery is process oriented and considered as “Developing, operationalising and implementing strategies”. Use is conceptualised as “How patient, carers and health care providers make use of the strategy”. Experience (positive or negative) is regarded as “What happens to the participant.” Satisfaction is the “Affective response to experience”. Perceived value is regarded as “Judged usefulness to self and others”.

#### **Participant Key:**

MG (Management Group); HS (Hospital Specialist); HN (Hospital Nurse); AH (Allied Health); GP (General Practitioner); PN (Practice Nurse); CF (Care Facilitator); PC (Patient/Carer).

\*Black font indicates first round interview (noted as Round1)

\*Blue font indicates second interview of first round participant (noted as Round 2).

\*Purple font indicates new second round participant (noted as Round 2).

## Care facilitator

<b>Implementation / delivery</b> <ul style="list-style-type: none"> <li><i>Employment by LHD with role in the community sector may be challenging but is being achieved</i></li> <li><i>Unclear roles but developing with program</i></li> <li><i>Uncertainty of future CF role</i></li> <li><i>No guidelines or procedures for CF</i></li> <li><i>Inconsistent instructions</i></li> </ul>	<p>* you could look at the placement of the coordinators and the role of the coordinators, whether they should be rather more firmly based in the community health services, maybe in the PHN, practice based, rather than being very clearly employed by the LHD, what difference that makes to their attitude, loyalties and behaviours. (MG3 Round 1)</p> <p>*I think the care facilitators really are these days more community based than hospital based (MG3 Round 2)</p> <p>* it is a fairly new role as well and we're pretty much the guinea pigs at the moment. (CF3 Round 1)</p> <p>*we need to clarify what their role is in regards to how many patients are their patient load or whether they do need to do more heavy duty end and some of the monitoring end is done differently. So we're really starting to model around that (MG6 Round 2)</p> <p>* The care facilitators who are integrally involved in helping us with this hadn't really worked out their roles either. So I think that's taken a while for each group in this to work out what your role is (GP5 Round 1)</p> <p>*care facilitators are kind of stuck in the middle, one is never quite sure whether they're there because they need to be a permanent and ongoing feature in the system or whether they're there as a compensatory mechanism until we can end up with good care coordination in the community working between general practice and community health (MG3 Round 2)</p> <p>* we were just sent out as crash test dummies to try and figure out what was the best way to engage GPs and patients into the program. (CF1 Round 1)</p> <p>* we were never given a guideline, we were never given a procedure, we were never given a policy. We were just given word of mouth of what they wanted from us and it differed. And because it was a partnership WentWest saw one version compared to the LHD. (CF1 Round 1)</p>
<b>Use</b> <ul style="list-style-type: none"> <li><i>follow up post discharge and notify hospital</i></li> <li><i>proactively arrange hospital appointments and reminds patients</i></li> <li><i>Others providing CF role? duplication</i></li> <li><i>Providing contact with GP</i></li> <li><i>Provides useful information for HCPs and PCs and advocacy</i></li> </ul>	<p>* ...they follow up with the patients we see when we discharge them, and they let us know what's happening with them and remind patients to come and see us, so they're good value. Yeah, we work quite closely with care facilitators... (HN4 Round 1)</p> <p>* she got me onto the endocrinologist, because I had diabetes for 16 years and at the beginning, I learnt all about it, and I saw endocrinologists, and just sort of took the tablets, and lost a bit of weight (PC3 Round 1)</p> <p>* She just rang the other week and then I actually forgot about - to get back to her, and then she just rang again and said, "Tomorrow you're going to the clinic, I'll see you there." I said, "Yeah, sweet." (PC4 Round 1)</p> <p>* I think [CF] is an additional help for me and also for the patients as a reminder system to them. (PN6 Round 2)</p> <p>it took a long while because in some ways we're still trying to find our roles, for example, well, who does the follow-up on the patients? (AH4 Round 1)</p> <p>* ... I was looking to contact them [CF] for them to try and coordinate these appointments, but I just thought it was easier for me to directly contact the endocrinologist and say, look, we already have a clinic which is running tandem, would you mind seeing them? (AH5 Round 1)</p> <p>* ... if I'm actually having problems with contacting the GP for getting information with regards to the patients ... I usually refer it to the care facilitators. They're actually great at giving me the information required. (HN6 Round 1)</p>

<ul style="list-style-type: none"> <li>• <i>Patient education</i></li> <li>• <i>Develop patient care plan</i></li> <li>• <i>Link between HCPs</i></li> <li>• <i>More engagement with CFs</i></li> </ul>	<p>* ...really good in communicating with us. We've had a couple of patients admitted to hospital that we didn't know of... it just kind of helped us to try and get in contact with them and make sure that we follow up with them after that acute episode (PN4 Round 2)</p> <p>* a lot of GPs tell me that, there's a big gap in terms of when patients are being discharged from hospital and they don't get an appropriate discharge summary or they're given to the wrong patient, or they're not even aware that their patients have gone into hospital before our service came on board. (CF3 Round 2)</p> <p>* ... I'll often have questions and they may not be related to the integrated care but at least she might say to me no you need to go here, there or whatever. So I'm using her as a resource for everything, actually. (PN2 Round 1)</p> <p>* If I have a question – I just quickly jump on the phone with [CF] and she'll say, "Yep, no worries, I'll email the doctor," And if I have to get a referral to someone I wanted to check with [CF] if there's any information about it. She goes, "Don't worry, I'll send it. I'll send it off to the doctor. Don't worry, I'll get it sorted," and it's done (PC1 Round 1)</p> <p>*I think I've only got to make a phone call and they're just onto what I need. (PC8 Round 1)</p> <p>*I think if I couldn't get over there – which is difficult to get over there anyway – I probably ring up [CF], 'cause I don't want to bother [HN] every five minutes, so [CF] is the one that comes to help me. (PC11 Round 1)</p> <p>* Often some of the patients don't know what services they can get or what help they can get. Sometimes just having an advocate, having an educator or someone with them, has a big impact on definitely service navigation and the understanding of their chronic disease. (CF3 Round 2)</p> <p>*I was ringing her a lot, I was really frustrated at different times and I rang her and said what do I do [CF], you know, I'm after this, I'm after that, keep pushing it, ask for it (PC19 Round 2)</p> <p>* the previous care facilitator was trying to help them quit smoking and discussed options and different management techniques ... They have been very helpful... (GP4 Round 2)</p> <p>* Care facilitators, like when we see people in clinic we contact them and they go out and talk to the GP how to best manage, come up with a plan and tell them about the services and then work with them so that the patient can be well-managed. (AH1 Round 1)</p> <p>*I'm looking at the care plan that she has done they're very detailed. She has been talking to me about how she sets up – there's some patients she reviews monthly, some patients she reviews every two weeks, so she's – keeping up with – she seems to know what she's doing (PN7 Round 2)</p> <p>* the care facilitator making that physical dynamic real time link between the care providers. (MG5 Round 1)</p> <p>* ... and whenever we try and link up a new patient with the care program they also try, if appropriate, try and meet the patient at the clinic (GP4 Round 2)</p> <p>*she's actually linked them in with other services that I haven't been able to link into or haven't heard about (PN4 Round 2)</p> <p>*... much, much more involvement now with the care facilitators than there was beforehand. (HNS Round 2)</p>
<b>Experience (positive)</b> <ul style="list-style-type: none"> <li>• <i>Educating patients</i></li> <li>• <i>Educating HCPs</i></li> </ul>	<p>* today, I had a patient who's a newly diagnosed CCF and [CF] is brilliant, I was sitting here listening to her educate the patient on his newly diagnosed disease and learning from her, she really is very, very good. And the family were really pleased and I could sense that they felt quite comfortable with her knowing that she would also be a part of the team if they were in hospital or sent down to</p>

<ul style="list-style-type: none"> <li>• <i>Coordinating care</i></li> <li>• <i>Understanding HealthPathways</i></li> <li>• <i>Maintains contact with patients and carers</i></li> <li>• <i>Organises appointments</i></li> </ul>	<p>the RASS clinic and I think it was very well done. (HS9 Round 1)</p> <p>* She helps me a lot and I've learnt lots from her... (PN1 Round 1)</p> <p>*I've had some good experience with the care facilitators. We've had a case conference this year with a patient who required a lot of input and a lot of work between various groups, and she co-ordinated everything; she was fantastic. (HN2 Round 2)</p> <p>* The care facilitator is a living breathing HealthPathways. They know the things in behind the walls so they can match the requirements up really well. So I think from that point of view, totally brilliant. (MG5 Round 1)</p> <p>* She would regularly keep – initially we had the one-on-one meeting with Mum present and then she would regularly be in touch with whatever, just follow up any issues, anything that I can help you with, you know, which I thought was fantastic (PC17 Round 2)</p> <p>* she has helped me so much. She's got me letters from the diabetic place and she sends me every little pamphlet she finds, and she rings me up to see how I'm going all the time. (PC10 Round 1)</p> <p>* I speak to [CF] maybe once a month; she'll ring and check in, which is awesome. (PC1 Round 1)</p> <p>* in the hands of the care facilitators ... seeing more services and more timely services for their patients for the care plans. MG5 Round 1)</p>
<b>Experience (negative)</b> <ul style="list-style-type: none"> <li>• <i>Infrequent contact from CF</i></li> <li>• <i>CF is "face" of the program for GPs and experiences their frustration</i></li> <li>• <i>CF unsupported</i></li> <li>• <i>Role of CF not respected/valued</i></li> </ul>	<p>*I guess it's nearly six months since I first made contact with [CF]. I guess there was a period there where there was – I hadn't heard from her for a while. Whether she was busy or on leave, or had too many patients, I don't know. (PC3 Round 1)</p> <p>* being the care facilitator, you're the face of the program in general practice, so if ...anything's not working you're pretty much the one that cops it from general practice, 'cause they say, 'oh, we were told this was going to happen and that's going to happen', so they obviously tend to disengage with you as well if the IT systems are not working or if you're taking too much of their time on a system that's not functioning ... (CF3 Round 1)</p> <p>* never had any backing. When we come across a problem we used to have to self-solve our issues ...no backing. (CF1 Round 1)</p> <p>*We've got a GP that just thinks I'm some admin officer, doesn't want any communicating from the care facilitator at all.(CF2 Round 1)</p> <p>*one GP that I tended to contact, and he is just dismissive, and there's another GP on the program that doesn't want any input from the care facilitators either, just admission and discharge notification (CF2 Round 2)</p> <p>*Before we used to be a nurse – they [GP] used to think we're just the nurses, but now I notice that's changed and they feel the importance, of having us in there and trying to help them to navigate their patient for proper care and management. (CF4 Round 2)</p>
<b>Satisfaction</b> <ul style="list-style-type: none"> <li>• <i>Professional and good at the job</i></li> <li>• <i>HCPs learning from CF who provides information</i></li> <li>• <i>Reminds and guides</i></li> </ul>	<p>* Well, she was fairly magic for me..., and she was certainly interested in my progress, and I think she wasn't aware of everything that had happened to me, and it was always just very professional. (PC9 Round 1)</p> <p>* I think they're great at their job. Yeah, yeah, they're good (HN4 Round 1)</p> <p>* ...she's good at her job and she knows her stuff and I have learnt (PN3 Round 1)</p> <p>* She's great. She's fantastic. I mean I constantly ring her and ask her and she guides me; she's fantastic. (PN2 Round 1)</p> <p>* Yeah and remind me, yeah, because sometimes - I'm not good with memory and I mixed up the days. Very good. (PC5 Round 1)</p> <p>*She's very good. Anything that I want, she says to give her a ring, and she makes appointments for me (PC11 Round 1)</p>

<p><i>patients</i></p> <ul style="list-style-type: none"> <li>• <i>Provides contact for hospital with GP</i></li> <li>• <i>Input to care planning and coordinating appointments valued</i></li> <li>• <i>Close relationship and contact with HCPs and patients</i></li> </ul>	<p>* ... coming to the practice, so if we have got a patient we want her to follow-up with, or she has been telling us who she has followed up with ...that's been really good for structuring for planning the care as well (GP6 Round 1)</p> <p>*our care facilitator, he's excellent, and we've been told about his care plans, he's then documenting in the patient's notes, they're great, he'll ring me and tell me, "I've seen so and so," and he writes in the notes, and that's actually quite useful (PN2 Round 2)</p> <p>*It's very good... if I have problems with a patient, especially with organising their appointments, they actually help me with regards to facilitating that (HN6 Round 2)</p> <p>* ...without her input I dare say I'd be struggling. And she has her assistant, she phones you every second week to see how you're going. Are you doing this and what's happening with you. (PC2 Round 1)</p> <p>*She is always checking in with us-how things are going, anything else we need-we know she's there if we need her (PC15 Round 2)</p> <p>* ...there's one care facilitator, she's fantastic. She's a very close relationship. We actually email each other all the time, we talk about patients. When a patient comes and she's available to be here, she will be here to support the patient. And she'll refer. She has great... working relationships with GPs. So that's fantastic (HS7 Round 1)</p> <p>*We had one, she was great, she's left, and I have a new one that I haven't actually made much contact with. And, certainly when we had , she was very helpful (GP14 Round 2)</p> <p>*There are some really good care facilitators. They're amazing. The patients like them, patients know them, they know patients really well. They communicate with me with any concern the patients have or anything that's important for us to be aware of. (HS7 Round 2)</p>
<p><b>Perceived value</b></p> <ul style="list-style-type: none"> <li>• <i>Follow up of patients post discharge and communication with hospital valued</i></li> <li>• <i>CFs are a big improvement in care delivery</i></li> <li>• <i>Consistency and familiarity important for patient/ carers</i></li> <li>• <i>Holistic focus of CFs</i></li> <li>• <i>Face to face contact useful</i></li> <li>• <i>Patient assessment and input to care planning</i></li> </ul>	<p>* they're a good link because they follow up with the patients we see when we discharge them, and they let us know what's happening with them and remind patients to come and see us, so they're good value. Yeah, we work quite closely with care facilitators and keep in touch. (HN4 Round 1)</p> <p>*I've got faxes - they turned up in emergency or in the various hospitals. And that part has been extremely helpful. (GP9 Round 2)</p> <p>* The care facilitators are superb, they, I think, are the lynchpins of it all (AH4 Round 1)</p> <p>* the care facilitator, that's been probably the biggest person that has become involved in our patient care that wasn't previously involved in the care, so yeah, so having that person on board has been a big improvement, definitely (GP6 Round 2)</p> <p>*the care facilitator is able to come out to the community and meet the patients; I think that's quite good. I think the role of the care facilitator is actually quite vital and important (GP4 Round 2)</p> <p>* it is very helpful because I think the patient does feel that they have consistency and that makes people feel comfortable when they see a face and they know they'll see that face somewhere else (PN3 Round 1)</p> <p>* having the care facilitator or a support person or a go-to person is what they value the most because they know that person is consistent and was up-to-date with their care, and they can talk to us pretty much about any even social issues, mental health issues, emotional wellbeing, holistic kind of care that we provide (CF3 Round 2)</p> <p>* I think having the care coordinator look at the patient's care plan and also them having done an assessment of the patient and that assessment being communicated to the GP, that has been particularly valuable. So we've picked up extra things, extra issues that we</p>

<ul style="list-style-type: none"> <li>• <i>High expertise of CFs</i></li> <li>• <i>Assists HCPs in navigation through health and other services</i></li> <li>• <i>Linking hospitals and community based services</i></li> <li>• <i>Links hospital, GP and patient</i></li> <li>• <i>Assist in clinical follow up of patients and provides information</i></li> </ul>	<p>weren't aware of. The other thing is just having someone to make sure that the patient is navigated through the health system. Someone the patient can call if there's an issue; that's been very valuable for the patients. (GP1 Round 1)</p> <p>* I'm really, really, really confident and encouraged in terms of the work that the care facilitators do and how – they're just competent, they're a high calibre of nurse that we have. (MG2 Round 1)</p> <p>* care facilitators are kind of stuck in the middle, one is never quite sure whether they're there because they need to be a permanent and ongoing feature in the system or whether they're there as a compensatory mechanism until we can end up with good care coordination in the community working between general practice and community health (MG3 Round 2)</p> <p>* having that care co-ordinator has been the most useful thing for me so far, so I'm just getting an idea of what services there are... all of sorts of things from taxi vouchers to payments for incontinence pads, all that sort of stuff (GP2 Round 1)</p> <p>*that central care facilitator who knows what is going on and that they know how the hospital works and they know what's available and they know where the services are and things (GP6 Round 2)</p> <p>* Definitely having the care coordinator, that has got to be maintained, that's really important having that person here as the link between the hospital and you and the patient, and who has got to oversee everything, that's really vital (GP6 Round 1)</p> <p>* I think having the care facilitators work in directly with the private care practices and the GPs is helping build stronger links between the hospital services and community services and primary care. (MG6 Round 1)</p> <p>* Oh, [CFs] really good, because sometimes I get a bit vague about making some of these appointments ...I'm not getting a letter from them so I get on to [CF]. And [CF] is pretty good. (PC2 Round 1)</p> <p>* Yeah, my sugar was really high; really, really high, yeah. Now I'm trying to get it down and [CF] is ringing me up all the time checking up, which – you know what? It does help. It does help. (PC10 Round 1)</p> <p>* That's good. She rings me every now and again and asks me what's happening and everything else, and if I've got a problem or that, she intervenes. (PC12 Round 1)</p> <p>*Very good. Yeah. They've told me things that I've had no idea that existed. (PC12 Round 1)</p>
<b>Suggestions</b> <ul style="list-style-type: none"> <li>• <i>Maintain the CF role</i></li> <li>• <i>Flexibility in CF role</i></li> <li>• <i>Clear policies and procedures</i></li> <li>• <i>Ensure practices are prepared before introducing CF</i></li> <li>• <i>More home care</i></li> <li>• <i>CFs could provide greater assistance with</i></li> </ul>	<p>* Definitely having the care coordinator, that has got to be maintained, that's really important having that person here as the link between the hospital and you and the patient, and who has got to oversee everything, that's really vital (GP6 Round 1)</p> <p>* the care facilitator role needs to be more flexible than we've designed it because the practices, the general practices are different across the whole spectrum and so each scale and size and organisational level of practice dictates a different need of the care facilitator. (MG5 Round 1)</p> <p>* There's no policy, in procedures in place, so you're really opening up nurses to a lot of litigation should something come - go wrong in the field. So those things need to be addressed (CF2 Round 1)</p> <p>* ... doing a lot more work in the primary care GP practice ...so that they're integrated care ready ...Once they're ready and they've had a lot of support then we bring the care facilitator in. We're kind of taking the care facilitator in too early...So now what we're thinking is maybe splitting that role so that you've got the back end function supporting the GP and then once they're ready then bringing in the front end function which is about care coordination and patient focus stuff. (MG6 Round 1)</p>

<p><i>community based care options</i></p> <ul style="list-style-type: none"> <li>• Review CF workload</li> </ul>	<p>*Community care and that, they keep you in your own place. I think there should be more of that out there so that people know. I think it should be, I don't know, but I had no idea that you could stay in your own place and they would look after you. (PC12 Round 1)</p> <p>*if they're [CF] coming out to do a home visit or something, that would be something they could be checking, do they have a computer, do they have an iPad, how are they accessing their health information - have they ever accessed it, that kind of thing (GP6 Round 2)</p> <p>*I've just recently done a HealthPathways on the NDIS, so I feel that that's something that the care facilitator should be really up on, and community transport options. I had a COPD patient who I had to work out all this myself – complicated. Maybe if they had a checklist of - discuss transport options and give transport options if these are trouble for a patient. (GP5 Round 2)</p> <p>*there needs to be some work around what is really an appropriate number of patients and how many hours up to – 200 or something patients already, you feel you're drowning, because you're just going out to meet with patients at practices, you're doing assessments, you're doing telephone reviews, then phoning the GPs about what hospital to discharge, you're doing referrals and needing to make sure the GP stays on board and engaged you're sending faxes every day, writing, all this takes time and when you have a huge amount of patient numbers, you're not really able to provide the proper care that these patients need. (CF3 Round 2)</p> <p>*if they're [CF] coming out to do a home visit or something, that would be something they could be checking, do they have a computer, do they have an iPad, how are they accessing their health information - have they ever accessed it, that kind of thing (GP6 Round 2)</p>
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## IT systems

<p><b>Implementation / delivery</b></p> <ul style="list-style-type: none"> <li>• Hospital to GP communications was not prioritised at inception</li> <li>• Poor web presence</li> <li>• Poor capacity for data collection and QI</li> <li>• System unable to accept clinical metrics</li> </ul> <p><b>GP Issues</b></p>	<p>*I would have thought that the step of communicating with the practices to have been worked out from the beginning. It seems like it's not and that surprised me a little bit because that's the whole point of all this, is to share the information (PN7 Round 2)</p> <p>*the most frustrating and complex area of the whole demonstrator. It would probably be one of our biggest learnings. Some of the key functionality that was meant to be in phase one...our existing E-referral, that's still not up and functioning (MG6 Round 2)</p> <p>*at the beginning there was a lot of resources devoted towards the IT aspects of integrated care, but I just feel like it takes a long time to make any change. (HS3 Round 2)</p> <p>* I'm not convinced that we have good just general web information presence on our information systems...Patients still can't find clinics... these days everybody looks to the web and the internet to find information. (HS1/MG7 Round 1)</p> <p>* Data collection is crucial for this program to work and to demonstrate that it's working and I think the data collection and input into the program has been quite flawed (HS11 Round 1)</p> <p>*we were trying to establish putting everything electronically to be able to easily pull data but we're not able to do that. So, we're trying to keep our own audit... (HS3 Round 2)</p> <p>*clinical metrics can't be uploaded into Linked-EHR (CF2 Round 2)</p> <p>*they're spending a lot of time on it ...spending with the people from WentWest...and then they're onto PenCat ...they can't keep</p>
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<ul style="list-style-type: none"> <li>• <i>GP time required</i></li> <li>• <i>Under resourced</i></li> <li>• <i>Flawed IT threatens GP engagement</i></li> <li>• <i>Delayed delivery</i></li> <li>• <i>Challenges with GP software including multiple systems</i></li> <li>• <i>End user training required</i></li> </ul>	<p>up. (CF1 Round 1)</p> <p>*In terms of the kind of investment that goes into developing IT systems more broadly, it's very, very tiny, and the Linked-EHR suffers from lack of investment generally (MG3 Round 2)</p> <p>*... the doctors don't understand what it is either. It's worse when Top Bar is not working ...like they'll say, "Well what is this integrated care?" (PN2 Round 1)</p> <p>*I'm assuming our system is linked up electronically, I don't know. We're just not very IT wise here (PN2 Round 2)</p> <p>*... I went to develop care plans and the error message came up. So there was one message and then we got through and then we tried to develop another one and then we got so far into the care planning and a different error message... very reliant on the way they code their Best Practice and Medical Director and if the identifier is not correct from Medicare you'll come up with an error.(CF1 Round 1)</p> <p>*Oh, my gosh. From then until now, oh my goodness. The top bar was up and down. And recently, it was down (PN1 Round 2)</p> <p>*...IT systems are so fragile that maybe they can't cope with another software with Linked EHR (CF3 Round 2)</p> <p>* It's just that it's not an easy set up. It requires a physical engagement, enrolment, usually taking WentWest's staff to do it. It requires some degree of training of the end user.(MG5 Round 1)</p>
<p><b>Hospital issues</b></p> <ul style="list-style-type: none"> <li>• <i>Outdated systems</i></li> <li>• <i>Different templates within the hospital</i></li> <li>• <i>Hospital doctors not aware or accessing information uploaded by GP</i></li> <li>• <i>Time expenditure in using</i></li> </ul>	<p>*...CERNER it's a bit outdated...it's never actually tried to be updated to be a bit more functional on the GP side (HS5 Round 1)</p> <p>* ... we're being forced to use Cerner because that's the one that New South Wales Health and others have adopted. What I use for case conferencing... is Genie, which is just like the GP software. HS8/MG8 Round 1)</p> <p>*...within our hospital systems, like all the clinics work really differently. Like heart failure clinic is so different to diabetes clinic or COPD clinic. The letters that go out to GPs, the templates are also different. (CF3 Round 1)</p> <p>*OTs or the physios that may have been in with the patient, the ability to be able to actually access their notes on line because at the moment OTs and physios try and use electronic records and that's a big issue (AH4 Round 2)</p> <p>*I had uploaded a lot of information about the patient onto their eHealth record or eHealth system but I don't think the hospital doctors were aware of that. I don't even know if they had access to the care plans as such..., so I think there's still problems with accessing the same information about a patient(GP2 Round 1)</p> <p>*We can't access the shared care plans – through the server we can actually link in with the EHR (HN4 Round 2)</p> <p>* A few of the doctors are able to do it [access EHR] and they've been doing it. If they don't find anything on it they usually ask us anyway. But apart from that there are always doctors there who don't know how to access it to be honest (CF4 Round 2)</p> <p>* after seeing a patient, we have to write, put in data, put in a report and it takes a lot of time to actually enter the data into it and they would have to generate another specialist letter to the GP. All that takes time. (HS7 Round 1)</p>
<p><b>Connectability Issues</b></p> <ul style="list-style-type: none"> <li>• <i>Different systems – incompatibility also</i></li> </ul>	<p>* some of the allied health don't have the same computer programs if we're having to fax instead of being able to shoot things off. (PN9 Round 1)</p>

<p><i>duplicates work</i></p> <ul style="list-style-type: none"> <li>• <i>Difficulty uploading care plans</i></li> <li>• <i>Challenges linking between hospital and community</i></li> <li>• <i>Delays in implementation of connectable systems</i></li> <li>• <i>No e-health</i></li> <li>• <i>Possibility of linking with private specialists</i></li> </ul>	<p>*Well the letter that we write at the end of consultation is still posted - we rely a bit on snail mail (HS4 Round 2)</p> <p>*I'm ringing a GPs rooms to say, "Can you please send me the current medications," there are some GP practices that you actually have to write a letter requesting it formally (HN5 Round 2)</p> <p>*it's [Linked EHR] still not compatible with all the systems. I think it's only compatible with best practice and medical director software (GP5 Round 2)</p> <p>*... we use the care plan per patient and Best Practice software that we use. And the integrated care program is using a different template so they are basically creating two different care plans (GP13 Round 2)</p> <p>*I think at the start of this, we really thought that integrating the e-health systems would happen. But one of the biggest frustrations is that that has not happened, and I suppose though, maybe it's because it was a more complex beast than we potentially (HS1/MG7 Round 1)</p> <p>*like most of them [GPs] are not even able to upload shared care plans because the system's not even working yet. So the hospital can't see it. (CF3 Round 1)</p> <p>*The connections between the GP and here are still not manageable because the electronic component isn't up and running (HN4 Round 2)</p> <p>* ...different GP practices have got different computer programs, they don't marry up with the computer programs that we've got, so we can't see their information, they can't see our information...(HN2 Round 1)</p> <p>*It can still happen in what we do here and the technology and techniques that we've got, certainly the shared care plan, that technology's available for viewing in private places, in private specialists MG5 Round 1)</p>
<p><b>Use</b></p> <ul style="list-style-type: none"> <li>• <i>Duplication of data entry</i></li> <li>• <i>Unclear whether other clinicians reading transmitted data</i></li> <li>• <i>New referral forms built</i></li> <li>• <i>Uncertainty regarding documentation in hospital database</i></li> <li>• <i>Encrypted communication required for referrals</i></li> <li>• <i>Time required for use of Linked EHR</i></li> <li>• <i>Some GPs prefer non-electronic communication</i></li> </ul>	<p>* we are entering the data in our clinics and our letters, and then I'm having to use that information and then manually take that across into an Excel sheet, but there should be a way to automate that process. We shouldn't have to doubly enter data.(HS6 Round 1)</p> <p>*We do a lot of doubling up in terms of notes and that sort of thing. So we'll have paper files, the research paper files, we have the hospital electronic notes. There is a lot of overlap (AH5 Round 2)</p> <p>*... I'm just sending it out into the ether... just hoping that the person on the other side has actually read it and actually acknowledged it.(HS5 Round 1)</p> <p>* We're able to send and upload new care plans and that part of it's working well. What's happening with information coming back is what we need to work out. Not sure if we are getting it always (PN7 Round 2)</p> <p>* so one of the doctors at Westmead has built the forms for – a dietitian form and an educator form and an endocrinologist form, so we've got – I don't write notes anymore, I type it all into the computer.(AH2 Round 1)</p> <p>*All I know at the moment regarding IT is that, purely the documentation services, that there is something there on Power-Chart ...a particular integrated care section to use.(HS10 Round 1)</p> <p>*we're documenting now in Cerner what's going on, and Cerner is now extracting that and creating the letter which we modify, but the letter then gets posted; it doesn't get sent via Linked-EHR or anything else, as far as I know (HS8/MG8 Round 2)</p>

<ul style="list-style-type: none"> <li><i>CFs entering EHR data into hospital systems</i></li> <li><i>Some use of electronic discharge letters</i></li> <li><i>Fax still preferred method of communication</i></li> </ul>	<p>*It's improving as more people have yet to take on encrypted communication... I just send my care plan electronically with the paperwork through the podiatrist. He will electronically send me back a report (GP7 Round 1)</p> <p>*I do have access to Linked-EHR, and I have been shown how to use it. But I know some GPs have chosen not to use Linked-EHR because of IT issues. (HS7 Round 2)</p> <p>*At this stage we're putting notes into Cerner, so every time they access a document patient in the Cerner, if they see there's a previous Linked-EHR updated, that's how we've been doing it. (CF4 Round 2)</p> <p>*Occasionally, I get an electronic discharge if it's been uploaded onto a patient's electronic, like, My Health Record. Then we'll be notified, but often that's not a routine thing. It seems to be a routine thing in the children's hospital actually, but not at adult hospital. (GP2 Round 2)</p> <p>*there are some GPs and some cardiologists that have actually asked for email but only when their fax line is down, they still want the faxing (HN4 Round 2)</p>
<b>Experience (positive)</b>	*
<b>Experience (negative)</b> <ul style="list-style-type: none"> <li><i>Database unable to produce required information</i></li> <li><i>No audit facility for Database</i></li> <li><i>Clinician needs not accommodated</i></li> <li><i>Delays in responding to requests persist</i></li> </ul>	<p>* it's hard to not be frustrated with IT systems. We thought we'd go completely paperless with our – just our basic clinic records and we tried to do that, so we worked with IT initially we wanted to use more a database form, but they advised us to use Power-note because it would then print out into a letter that the patient could take it home... we use it, it doesn't print out a proper letter. It's a letter that gets spread out across multiple pages. It's horrendous. (HS1/MG7 Round 1)</p> <p>*My other sense is that the IT folk don't understand what the clinicians want, and when we try to say to them we don't want that, we want this, they don't listen. (HS2/MG9 Round 1)</p> <p>*the ability to audit the data; we still haven't been – we've logged multiple jobs, and this has been over a six to eight month period and none of those have come back. So, unable to audit our own data, unable to write our letters as planned. (HS1/MG7 Round 1)</p> <p>*Ohhh Westmead IT is just horrendous. It's just getting anything done, we've got a job still in from July last year, we just keep following up on it. Yeah, yeah, we'll get to it, we'll get to it. July last year, really? (HN2 Round 1)</p> <p>*just frustration because it was paid to work and it doesn't and its coming and its coming and it's still happening (HN4 Round 2)</p>
<b>Satisfaction</b> <ul style="list-style-type: none"> <li><i>Letter formatting improved</i></li> <li><i>Unable to receive e-referrals</i></li> <li><i>Electronic notes vs hand written notes</i></li> <li><i>Practice staff prefer Linked EHR</i></li> <li><i>Improved IT assists prompt</i></li> </ul>	<p>* the care plan at the bottom of the letter, like the letter and the format I think is better than what I was sending them before, so that has certainly improved that sort of integration (HN4 Round 1)</p> <p>* it's taken a lot of work out of my day, because I no longer have to come back from the clinic and enter that data again, to the database. It's also taken some work off of the administrative staff, because they don't have to copy, paste, and reformat a letter from Cerner (HS6 Round 2)</p> <p>* the other frustration is that they said we could get e-referrals. We haven't got any e-referrals from any of the external practices. I mean, we think that GPs should be able to e-refer; they still can't e-refer to us at all.(HS1/MG7 Round 1)</p> <p>*so one of the doctors at Westmead has built the forms for – a dietitian form and an educator form and an endocrinologist form, so ... I don't write notes anymore, I type it all into the computer. So I feel like that's been a huge enabling factor; it's made me</p>

<p><i>communication and follow up care</i></p>	<p>work quicker... (AH2 Round 1)</p> <p>*So we use PowerChart and we write all of entries electronically, which can be turned into a letterhead. It is good in that ... instant accessibility is important and if it's online you can reproduce it, print it. (HS4 Round 1)</p> <p>*when it works it's so much better than the medical software. I would much prefer to use Linked EHR all the time. (PN3 Round 2)</p> <p>*I'm seeing changes or I'm learning about patients being in hospital much sooner. And therefore I'm able to follow up those patients a lot sooner as well. So within a day or two of them being discharged I'm getting to see them now. (GP9 Round 2)</p> <p>*In the past, I mean patients, weeks after they've been discharged, missed the time that they wanted repeat tests done. Or the patient might even forget to bring their letter with them. And sometimes they won't even tell you they've been in hospital. (GP9 Round 2)</p>
<p><b>Perceived value</b></p> <ul style="list-style-type: none"> <li>• <i>Hospitals sharing care plans across disciplines</i></li> <li>• <i>Too much effort required from GPs (not worth it)</i></li> <li>• <i>On line documentation good</i></li> <li>• <i>Good when fixed</i></li> <li>• <i>Top Bar helpful in checking for care gaps</i></li> <li>• <i>Patient access to online portal</i></li> <li>• <i>When information can be shared efficiently and securely</i></li> </ul>	<p>*... power chart...there is a separate section and that auto populates their plans into our care. So, if the patient is being seen by them [endocrine or respiratory], I'll automatically know what their plan is from their perspective. (HS6 Round 1)</p> <p>*technology has been more of a challenge rather than making life easier 'cause it's not working at the hospital end yet and it's not working at the majority of the GP practices as well, so I'm not sure if the time and money we are spending in terms of linked EHR is really worth it because the majority of the feedback that I get from GPs, after two attempts they're like, "I don't want to do this. I don't even know if it's worth it." (CF3 Round 1)</p> <p>*... online documentation has been pretty good...typing straight into notes...the way of the future rather than having a big set of medical notes; just for everything to be online and integrated care is a bit of a pioneer leading the way. (AH2 Round 1)</p> <p>* I feel once that's fixed it's probably going to be a good idea, and every time we see a patient we update their plans and our recommendations (AH2 Round 1)</p> <p>*I know a lot of money has been put into PenCAT, which is great. I think it has a lot of potential but I know it takes a while. So, they're still working on that. (GP5 Round 2)</p> <p>* the portal is quite easy to use, the Top Bar is quite useful in terms of how it's sort of drawing out data from your Medical Director or the Best Practice Program to make sure you have got no care gaps - that's really good. (GP6 Round 1)</p> <p>*Patients can have access to the online portal, which is really good, so they can see what has been changed or what their medication list is...They are also able to then access the clinics, the heart failure clinic... (GP6 Round 1)</p> <p>*there is the ability to send the information directly between primary care doctors and the hospital in a timely way. Like, for the clinics, for example, having easy access to the clinics and then having the ability to upload information about the patient quickly. (GP2 Round 1)</p> <p>*it's still very basic at this stage. I think it's still - the connectivity, I'm not really happy with. I mean, ideally everything should be live and whenever we make a change, it should change instantaneously. (GP12 Round 2)</p> <p>*I think they're still concerned about security with email. (HN2 Round 2)</p>
<p><b>Suggestions</b></p> <ul style="list-style-type: none"> <li>• <i>Consider effective systems</i></li> </ul>	<p>*we can do that with Genie and it does everything that Cerner is meant to do. Cerner is still getting there ...It's clunky, it's clumsy. The way it's organised, it's not organised around patients (HS8/MG8 Round 1)</p>

<p><i>already available and in use</i></p> <ul style="list-style-type: none"> <li>• <i>Strong decision making needed to deliver appropriate IT</i></li> <li>• <i>"Compulsory" patient controlled e-health</i></li> <li>• <i>Single system needed</i></li> <li>• <i>Training needed and user friendly software</i></li> <li>• <i>Change or change use of Cerner</i></li> <li>• <i>Develop systems "before" program implementation</i></li> <li>• <i>Start with paper based system and translate to IT based</i></li> <li>• <i>Use of encrypted email</i></li> <li>• <i>General practices flagged when changes made to patient records</i></li> <li>• <i>Improved data collection for evaluation</i></li> </ul>	<p>*I don't know how much involvement the specialist has in the Linked-EHR, but their ability to access the shared care plan would be helpful (PN4 Round 2)</p> <p>*somebody has to make some strong and dictator like – some strong decisions to get us doing that. I mean, with non-compulsory patient control e-health records it doesn't work. We even need to be – everyone on the same system or we can't manage billions of different systems. It just doesn't work. (HS1/MG7 Round 1)</p> <p>*The thing that would make a really big difference would be if we could look at their notes, and they could look at, maybe not everything, but if I could actually look and see what's happened. If we had a shared electronic record. (GP7 Round 2)</p> <p>*If the hospital was doing something they'd just send me a discharge letter and then I have to manually change the medications. In an ideal world, we would have a system where all the software programs can connect up and everything is live (GP12 Round 2)</p> <p>*so we're now working on E-referrals and sending out the information through the IT systems, so we could do with some more training from that side of things (HS5 Round 1)</p> <p>*improving the IT a little bit more just to make it a bit easier to make the online care plan and things linked EHR and just getting at least as easy as possible, you know, as user friendly as possible; not everybody is as computer savvy as others (GP6 Round 2)</p> <p>* working on the software, to make it as easy to use as possible and having a way for the hospital to also access that would be really use useful (GP2 Round 2)</p> <p>*Or find a system that would interface with Cerner so that Cerner doesn't have to do it all. It can become the repository of it but you have intermediary systems that are much more flexible and built for purpose and let the programs talk to each other. Don't force the providers to use the clunky Cerner thing... (HS8/MG8 Round 1)</p> <p>*if we were starting again we should just develop our systems on paper, and this is with the experience in Christchurch as well – develop the systems on paper, make the systems work on paper and then get the IT to enable it, don't do the IT first.(HS2/MG9 Round 1)</p> <p>* ... have everyone on an encrypted email and not have to be scanning thousands of paper documents... (GP7 Round 1)</p> <p>* I flag it as ED that comes back to us, to say that an entry has been made by ED Westmead or Blacktown...like flagged in the patient's notes here that the patient was in hospital on this date (PN3 Round 2)</p> <p>* make sure if there is some kind of alert... so that everybody knows what's happening. (GP6 Round 2)</p> <p>*Then we can evaluate the service in a very efficient manner. If everyone is on the same system and I think evaluating the system, you can crunch the numbers easily, compared to when everyone was using different databases and different sort of outcome (HS6 Round 2)</p>
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## Shared Patient Care Plans

<p><b>Implementation / delivery</b></p> <ul style="list-style-type: none"> <li>• <i>GPs usual care plan - different to proposed by</i></li> </ul>	<p>*the notion that we have one document that is a shared care plan between us and GPs is not – hasn't reached the reality yet (HS8/MG8 Round 2)</p> <p>*what my nurses are complaining, that we use the care plan per patient and Best Practice software that we use. And the</p>
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<p><i>WSICP</i></p> <ul style="list-style-type: none"> <li>• <i>Nurses upload GP plan to Linked-EHR</i></li> <li>• <i>HealthPathways as a means of providing GPs with the Shared Care plan protocol</i></li> <li>• <i>Hospital staff cannot see Care Plans</i></li> <li>• <i>Incorrect information in care plans</i></li> <li>• <i>Care plan set up from first hospital visit</i></li> <li>• <i>Delays in GP enrolment impact on value of care plans</i></li> <li>• <i>Lack of GP understanding of functionality of Care Plan</i></li> <li>• <i>GPs not alerted when changes made to plans</i></li> <li>• <i>Some carers note their information is well connected and shared</i></li> <li>• <i>Patient focused and directed</i></li> <li>• <i>Importance of payment for development of the plan</i></li> </ul>	<p>integrated care program is using a different template so they are basically creating two different care plans (<b>GP13 Round 2</b>)</p> <p>*Basically we just do our normal care plan for the patient that gets uploaded onto Linked-EHR and in our practice it's going to be the nurse who is uploading that information to Linked-EHR. (<b>GP5 Round 1</b>)</p> <p>*what I've also done in HealthPathways is I've organised this shared care plan protocol ...So each time one of these integrated care patients comes in there's a set thing, set protocol for how to. (<b>GP5 Round 1</b>)</p> <p>*most of them are not even able to upload shared care plans because the system's not even working yet. So the hospital can't see it...All the care facilitators can see it, but the hospital specialist or hospital team can't see it. (<b>CF3 Round 1</b>)</p> <p>*We can't access the shared care plans through – integrated care's supposedly got – through the server we can actually link in with the EHR (<b>HN4 Round 2</b>)</p> <p>*once the IT has finished, that they're building, we'll be able to, every time we see a patient, update the care plan and what my recommendations are and what my plan is, which I think will be a good thing that is promoting communication amongst the team(<b>AH2 Round 1</b>)</p> <p>* when we see someone for the first time, we're setting up a shared care plan and when we have case conferences, and then we feed that information back to all the relevant parties involved. (<b>AH3 Round 1</b>)</p> <p>*I think we're still struggling at the level of GPs understanding what a care plan is...what a care plan entails for ongoing management of these patients. ... that care plan through Linked-EHR can be shared with an allied health provider, a podiatrist or someone else but at the moment it's not shared necessarily with the hospital clinician. (<b>MG6 Round 1</b>)</p> <p>* it doesn't tell me who has added stuff to it, but I don't think anything has changed at this stage, but - actually maybe - yeah, I don't know if something has been changed or not (<b>GP6 Round 2</b>)</p> <p>*One particular program that the GP put us onto, the fact that they managed to link my Mum's entire medical history with both Blacktown and Westmead, through their GP (<b>PC17 Round 2</b>)</p> <p>*all the focus on the patient, now he does like direct the care plan. (<b>PC18 Round 2</b>)</p> <p>*often the WentWest chronic disease management nurse preparing the care plan...the GP is not even wanting to log on and connect to the EHR and see the care plan because they know someone's done it and that they'll get the money out of the care plan. (<b>CF3 Round 2</b>)</p>
<p><b>Use</b></p> <ul style="list-style-type: none"> <li>• <i>Limited use by HS</i></li> <li>• <i>GPs not aware</i></li> <li>• <i>Good uptake</i></li> </ul>	<p>*so I've done care plans a lot with patients prior to this and I have seen what it looks like on the Linked-EHR so I know what it looks like, I haven't actually done a care plan on Linked-EHR but I can understand what it is. (<b>HS9 Round 1</b>)</p> <p>*Some people would argue in primary care there's good shared care planning happening between primary care and allied health providers...I don't believe it's happening yet with the hospital facilities...they all should be part of the one team. (<b>MG6 Round 1</b>)</p> <p>* The doctors here, if you said to them you can find so and so's care plan, or whatever in Linked-EHR, the first thing they'll say, "Is</p>

<ul style="list-style-type: none"> <li>• Not linking with hospitals</li> <li>• Not being updated with action plan information</li> <li>• Uncertain if the information is accessible or used</li> <li>• Enhances team care</li> <li>• Summarises current status</li> <li>• Not useful for referrals</li> </ul>	<p>what's Linked-EHR?" (PN2 Round2)</p> <p>*It's working a lot more efficiently with care plans. I think, 90% of my patients have a Linked-EHR care plan ... (CF3 Round2)</p> <p>*Care facilitators access yes. The hospital side, no, we might not be able to yet. (CF4 Round 2)</p> <p>*We haven't had any shared care plans that we've had to look at. (HN2 Round 2)</p> <p>*I haven't seen much back or being added to the care plans as yet (GP6 Round2)</p> <p>*I'm not entirely sure if they [specialists] are reading it or if they are making any comments because our nurse usually uploads the care plans once the patient is linked up with the Integrated Care Program, but I haven't seen any comments. (GP4 Round 2)</p> <p>*the hospital clinicians still send an action plan to the GP but often GPs don't really update the care plan with the action plan, because that's how it's meant to happen. (CF3 Round 2)</p> <p>*our care facilitator, he's excellent, he's then documenting in the patient's notes, he'll ring me and tell me, "I've seen so and so," and he writes in the notes, and that's actually quite useful, but the doctors don't actually look at them (PN2 Round 2)</p> <p>*that was supposed to be one of the cornerstones of how we communicated amongst ourselves and with the GP, but the reason we're not utilising it is because it actually doesn't go anywhere and people don't look at it and so we need to know if that's up and running, so that we can start using it (HS3 Round 1)</p> <p>*For us that's only read only, so the GP is the one that alters that; we can see it, but currently not working in Cerner and can't actually see the patients that are enrolled (HN4 Round 2)</p> <p>*We haven't had a lot, we've had a couple of patients that we've had multidisciplinary approaches with, with the endocrine, not so much with respiratory here. So we've had combined care plans for those patients, they seem to work okay. (HN2 Round 1)</p> <p>*I did read the notes of the care facilitator on Power-Chart, which is helpful in terms of summarising their current care plan, and so I know where the patient is in terms of their care plan and where we can add to it (HS6 Round 1)</p> <p>*rather than unloading to a shared care plan, I just send my care plan electronically with the paperwork through the podiatrist. He will electronically send me back a report ... then I put that into my care plan for when do I do the next review... (GP7 Round 1)</p>
<b>Experience (positive)</b> <ul style="list-style-type: none"> <li>• PHN assists general practices with care plans</li> <li>• Sharing with allied health</li> </ul>	<p>* WentWest helped us understand the care plans and how to review and upload and this has made a big difference to our practice's efficiency and patient care (GP8 Round 2 )</p> <p>* I do really like the ability to use the care plans or to share the care plans with allied health professionals.(GP2 Round 1)</p>
<b>Experience (negative)</b> <ul style="list-style-type: none"> <li>• Much time uploading</li> <li>• Practice staff not notified of care plan changes</li> <li>• GPs unfamiliar with Linked-EHR</li> </ul>	<p>*our nurses have been uploading them onto Linked-EHR and it takes ages - quite a long time for that process (GP6 Round 2)</p> <p>They [GP] say it's all there on the system, the patient tells us their doctor has made a care plan and we can't find it-makes you look a bit silly (HS4 Round 2)</p> <p>* Resistant, I don't know whether that's probably the correct word to use. It's probably more apprehensive about it. They [GPs] don't like the change and new ways, especially using Linked-EHR. Linked-EHR is like a barrier to it, because it's just time consuming, and the time that they don't have (PN3 Round2)</p>
<b>Satisfaction</b>	<p>*Yeah, it's easy to use as well. (PN1 Round 1)</p>

<ul style="list-style-type: none"> <li><i>Ease of use</i></li> <li><i>Effective communication of current status</i></li> </ul>	<p>*I think that was easy...is helpful so I know where the patient is in terms of their care plan and where we can add to it (HS6 Round 1)</p>
<b>Perceived value</b> <ul style="list-style-type: none"> <li><i>Access to shared care plan central to WSICP effectiveness</i></li> <li><i>GPs value as tool for team care</i></li> <li><i>Concerns about volume and value of information</i></li> <li><i>Sharing across hospital disciplines useful</i></li> <li><i>Increased work may not be worth effort</i></li> <li><i>Provides useful information for P/Cs</i></li> </ul>	<p>*a linked in piece of the puzzle that I felt is probably the most critical bit for this program (MG3 Round 1)</p> <p>*They're going to be a really good resource for the GP, for the allied health, for the specialist, because it's going to be up on Linked-EHR, everybody's going to be able to access it (GP5 Round 1)</p> <p>*I do really like the ability to use the care plans or to share the care plans with allied health professionals. I think having that is really useful. (GP2 Round 1)</p> <p>* I worry that I'm going to be overwhelmed by the amount of stuff that we could access from general practice but I don't want to access a pile of stuff, I just want the useful stuff (HS2/MG9 Round 1)</p> <p>* if they've [patients] been seen in Cardiology Rapid Access or Diabetes Rapid Access, then I see that on the Shared Care Plan, and that's useful. But in proportion for the amount of effort that has gone in for generating the Shared Care Plan to the usefulness, I think we could have spent our time doing other things. (HS2/MG9 Round 2)</p> <p>* I think it's a good idea. It's - because they know what's going on. (PC12 Round 1)</p>
<b>Suggestions</b> <ul style="list-style-type: none"> <li><i>Use of shared care plan to facilitate communication</i></li> <li><i>More use by hospital specialists</i></li> <li><i>Greater patient centredness</i></li> <li><i>Training and set up required</i></li> <li><i>Streamline process of updating and uploading</i></li> <li><i>Practice staff need to be notified of changes being made</i></li> </ul>	<p>* ... more communication going on through the shared care plan... referrals going straight through and everybody can work on the care plan together. (GP6 Round 1)</p> <p>* I don't know how much involvement the specialist has in the Linked-EHR, but their ability to access the shared care plan would be helpful (PN4 Round 2)</p> <p>* it should be more patient centred. That's actually one of the things from the US, when you put in the goals for these patients – for these care plans you are generally putting in what the GP thinks the goals are but we really should be getting more what the patient's goals are... (GP5 Round 1)</p> <p>*It's just that it's not an easy set up. It requires a physical engagement, enrolment, usually taking WentWest's staff to do it. It requires some degree of training of the end user... if we had to tweak anything else in the end at the time that would be the goal, to make that actual shared care plan a much easier device to implement and to operate. (MG5 Round 1)</p> <p>It is a very complicated way now, how the nurse and the care facilitator are doing that [updating and uploading], there's some time, maybe half an hour, or something like that (GP11 Round 2)</p> <p>* we uploaded them but I did it for the doctors [GPs] and they can view the results – the care plan online. They still need more education though, the doctors (PN6 Round 2)</p> <p>* I'm not sure if there is an alert system or something like that so that everybody knows what's happening with changes (GP6 Round 2)</p>

## Specialist Action Plans

<b>Implementation / delivery</b> <ul style="list-style-type: none"> <li>• <i>Plans more succinct</i></li> <li>• <i>Limited implementation and isn't sent electronically</i></li> <li>• <i>GP unable to access Action Plan in power chart</i></li> <li>• <i>Cannot access Action plan through Linked-EHR</i></li> <li>• <i>Discharge summary contains recommended actions</i></li> <li>• <i>Source of communication especially in rapidly changing clinical situation or complex cases</i></li> <li>• <i>A source of patient information</i></li> <li>• <i>Format not as well suited to some clinical situations where assessment findings need to be included</i></li> <li>• <i>Labour intensive</i></li> </ul>	<p>* They were getting letters from me before, now they're getting it in a more succinct way, and hopefully those that are already on board can look back and see the updated plans. (HN4 Round 1)</p> <p>* I'm hearing that it's not well implemented yet. it's.... printed and given to the patient and emailed to the practice (MG5 Round 1)</p> <p>* So, the issue with that at the moment, it still can't be sent electronically. (MG6 Round 1)</p> <p>* so the letter back to the doctors is still by paper mail...we can't ensure that they're on the common system. (HS1/MG7 Round 2)</p> <p>* we would write an action plan, but that's not functional at this stage. We write a letter and send that to the patient and their GPs. It's mailed out to them, currently. That's really the way that we communicate with patients and their GPs. (HS6 Round 2)</p> <p>* what next will happen with that database, it will export the letter, but it also will automatically put a patient summary into the action plan on Cerner, and that's what in the future the GP will be able to see straight away (HN2 Round 2)</p> <p>* we can put it on to our power chart... So the GP does not have access to add to that or change that. So it's fine for within the hospital but because the major person we're communicating with is the GP, we haven't been utilising it. ... The main information is in the letter that you're posting to the GP.(HS3 Round 1)</p> <p>* we're just getting it paper wise, they're not coming through on the care plan, or the Linked-EHR, we have to constantly ring and ask them to fax it. (PN2 Round 2)</p> <p>* Some of them, I do get electronic health patient summary ...Sometimes I don't get anything. (GP13 Round 2)</p> <p>* they send the discharge summary, always got follow up and, you know, see GP in two or three days, do this and then follow up with the specialist in six weeks (GP9 Round 2)</p> <p>* Through the program we always write back a, management plan. So it's not just about, how you're going, and medication. I think, we haven't actually been doing this very well at this stage but hopefully this will improve – to provide a management or an action plan so GPs now know how to tackle the more difficult, complex cases. (HS10 Round 1)</p> <p>* there is a line of communication open there, but the main one really is the setting in respiratory and the steroid patients which swing up and down like a yo-yo, and we don't know what they're doing in terms of their full dosing and their potential outcomes so that has been a line of communication that's been working quite effectively. (HS5 Round 1)</p> <p>* I got a patient's copy from the hospital with an explanation of what's happened. (PC9 Round 2)</p> <p>* every time I see a patient I have to do all of the assessment to then generate an action plan so, and then put that into a letter type format. So there is a lot of tweaking and a lot of, I think, extended writing in the cardiology format, when I see might four patients in a day, it can take me a day and a half to do the paperwork, yet, within integrated care all I'm meant to do is send out an action plan. And I don't think that I can honestly just send out things like, "Continue medications," or "This is reduced," without giving them the reasons why, giving them a set of obs. (HN5 Round 1)</p>
<b>Use</b> <ul style="list-style-type: none"> <li>• <i>All hospital team provide</i></li> </ul>	<p>* We all collaborate and put our few sentences in, and the specialist puts a letter together that goes back out to the GP, and out to the patient themselves (AH6 Round 2)</p>

<p><i>information</i></p> <ul style="list-style-type: none"> <li>• Standard instructions that are reinforced with patient</li> <li>• Clinician and patient plans in patient focused language</li> <li>• Patient follows instructions but needs to see GP for prescriptions</li> <li>• HNs following up</li> <li>• GPs use to follow up</li> <li>• No feedback as not seeing patients</li> <li>• Offer selectively to patients who have good understanding</li> <li>• Unsure of clinician preference over discharge letter</li> <li>• GPs prefer summarised information</li> <li>• May not be appropriate or safe in complex patients</li> </ul>	<p>*ours is more general, like if this happens, seek medical help sort of stuff; it's a standard thing they get given anyway, so we just reinforce that when we meet them and say, "go and see your GP about this," or whatever. (HN4 Round 1)</p> <p>*so the patients that I have sent in they have come with a letter that has got a cardiology action plan, it's got like four steps in it, like that's good, and also things for the GP to do, and then they have got a patient plan... there were quite a few things on there that were sensible. (GP6 Round 1)</p> <p>* Sometimes I've typed them out for the patient, or I've done all their medications out for them. Now, with the action plan, we can type it in and just print it off, and at least then they've got it for the GP as well. (HN2 Round 2)</p> <p>* they give you an emergency plan. Like if I can't breathe, we'll start off on Prednisone and antibiotics and then you're supposed to go to the doctors. Well, I just take the Prednisone. I know myself if it's going to be a hospital visit or a couple of days in bed (PC8 Round 2)</p> <p>* I actually handwrite on a piece of a paper the instructions to the patient and give it to them, but whatever I handwrite and I write down the medical recommendations and the action plan so the GP and the cardiologist get both of them (HN5 Round 2)</p> <p>* normally in the clinic, doctors print out the paper and bring it to the patients and for a GP too (AH1 Round 2)</p> <p>* From the Breathlessness Clinic we do it a bit differently. We send a letter to the patient, addressed to the patient, in patient focused language. But that we send a cc to the GP and to the consultant. (HS2/MG9 Round 2)</p> <p>* because the patient is the most important thing to us, we write the letter to the patient, and we put it in to layman's terms, so the patient understands what's happening (MG6 Round 2)</p> <p>* And when you break down you've got to refer back to the action plan. They normally put in there two types of medicine, two types of antibiotics. If it doesn't work, try this one. So the doctor also knows – actually she is the one that at the end of the day that's got to give you the prescription for your medicine. (PC2 Round 1)</p> <p>* I had a couple of patients who were profoundly constipated so referred them back to their GP and suggested giving them something like lactulose which they did and I then followed them up on the phone to see whether or not there'd been any effect from the treatment... (HN5 Round 1)</p> <p>* that information flowing through to us when they've been admitted or discharged helped us get in contact with them and make sure that we follow up with them after that acute episode. (PN4 Round 2)</p> <p>* We're filling it in and we print it out, fax it off ... but I don't get any feedback about it. I think it's a useful idea and I think it would be helpful for my GP colleagues but ... I'm not getting any feedback about it. (HS2/MG9 Round 1)</p> <p>* ... you just have to make sure that you give it to the right patients who have a good understanding of their disease process and can identify when they're becoming unwell. Because, you don't want them to be abusing antibiotics and steroids. (HN3 Round 1)</p> <p>* We should be testing well, did they [GP] actually look at it, was it useful, quality information and did it in any way inform practice, is it something they'd like to be receiving into the future and then there's the thing around well, how is it different to a discharge letter. (MG6 Round 1)</p> <p>* the letter is more comprehensive, so the action plan will only be a couple of lines. (HN2 Round 2)</p>
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	<p>* One guy [GP] goes, I chuck everything away except the first page because that's where you're putting all the information (HN5 Round 2)</p> <p>* not everyone is safe to have a specialist - - - COPD action plan. For instance, if the patient has severe COPD, a lot of comorbidities, a lot of heart problems. If they become short of breath, it could be anything, including COPD. So it's dangerous in that situation to give them an action plan. ...So those kind of patients, I encourage them to present straight to the GP or hospital. Some patients who are, young and well educated, motivated, only one single disease or two other, you know, minor medical issues but the dominating issue is COPD and they've got family support, I'm happy to give them action plans. (HS7 Round 1)</p>
<b>Experience (positive)</b> <ul style="list-style-type: none"> <li>• <i>Carer reassurance</i></li> </ul>	<p>*I found the letter they gave us when I brought [husband] home reassured me in that I was already doing the right things and helped me so much in planning for other things that could help him (PC22 Round 2)</p>
<b>Experience (negative)</b> <ul style="list-style-type: none"> <li>• <i>Accurate action plan takes time to write</i></li> </ul>	<p>* it can take me a day and a half to do the paperwork, yet, within integrated care all I'm meant to do is send out an action plan. I don't think that I can honestly just send out things like, "Continue medications," or "This is reduced," without giving them the reasons why, giving a set of ob's that they're hypotensive. So the action plan embedded in the assessment does cause me grief (HN5 Round 1)</p>
<b>Satisfaction</b> <ul style="list-style-type: none"> <li>• <i>CF helps implement</i></li> <li>• <i>Improved patient care when patients part of the process</i></li> <li>• <i>Summaries high quality and prompt</i></li> </ul>	<p>* this is where the GPs are saying they love the process, because the care facilitator then is taking on, as we expected them to, some degree of responsibility for ensuring that the action plan has got the right and adequate lines and resources (MG5 Round 1)</p> <p>* certainly improved their care and they've been very happy with the discussion had and time to understand it. (HS11 Round 1)</p> <p>*We try to hand it out to the patient, taking it to the GP and they quite like that (HS5 Round 2)</p> <p>*the discharge summaries have been coming out really promptly and really good summaries – good communication from the hospital about that (GP5 Round 2)</p>
<b>Perceived value</b> <ul style="list-style-type: none"> <li>• <i>See what others are doing</i></li> <li>• <i>Assists patient management and coordination</i></li> <li>• <i>Assists patients if they act on recommendations</i></li> <li>• <i>More effective than letters</i></li> <li>• <i>Seeing evidence of use of the plans</i></li> </ul>	<p>* At least we can see now a bit better what other people are doing, so I think that's good. I think that's a positive thing. (HS1/MG7 Round 1)</p> <p>* It's actually very thorough...it actually highlights them of some other stuff that wasn't seen by the GPs, or the other specialist, and she actually gives a very simplified version of exercises that they need to do which actually helps patients in the long run. (HN6 Round 1)</p> <p>*if patients are discharged from hospital we can read through it, work out if anything needs to be done before the patient comes in so that can save a little bit of time, and it helps with better coordination and management in terms of linking up with specialists as well. (GP4 Round 2)</p> <p>* they sent a bunch of recommendations for us– I think they were wanting a dietician, wanting a physio, a whole bunch of things, which the patient agreed – said that he wanted, but we looked at his plan and we've done all and he never goes. (PN7 Round 2)</p> <p>* I feel once it's done it'll be effective, because at the moment the doctors are just writing the standard letters. (AH2 Round 1)</p> <p>*there's a couple whom we've provided with, say, COPD action plans and they've sort of come back and they've used their action plan. We've got one in particular who's really quite, you know, confident with his action plan and knows when to use it and</p>

	<p>knows when it's not working (HS9 Round 1)</p> <p>* like the Action Plan, it just gives you information – when you're feeling good, what do you do when you're not so good, and when you're really bad – ring up the ambulance. (PC11 Round 1)</p>
<b>Suggestions</b> <ul style="list-style-type: none"> <li>• <i>Clear instructions</i></li> <li>• <i>Ensure shared with patients and with GPs</i></li> <li>• <i>Electronic delivery</i></li> </ul>	<p>*Make it as basic as possible. Saying, are you short of breath, take your Ventolin. If you start to cough up green stuff, take this and make sure that that plan is given to the patient, is given to the GP as well so everyone knows what the plan is. (GP1 Round 1)</p> <p>*in the future, we are hoping that the action plan will actually go directly [electronically] to the GP, a consult, so they know what the plan is, from us. (HS6 Round 2)</p>
<b>GP Support Line (hotline)</b>	
<b>Implementation / delivery</b> <ul style="list-style-type: none"> <li>• <i>Aspirational</i></li> <li>• <i>Not well promoted</i></li> <li>• <i>GPs not aware they could use for non-enrolled patients</i></li> <li>• <i>Poor hospital staff orientation and awareness but some hospital staff are promoting</i></li> <li>• <i>Not answered/diverted to correct person</i></li> <li>• <i>Work load for registrars</i></li> </ul>	<p>*So the idea is that there's hotline phone that the GP can ring and get some advice from me and then we get them into a Rapid Access Clinic so, you know, I talk to the GP. I say, "Okay, you've started them on their action plan. Great. I'll see them in Rapid Access Clinic tomorrow." And it's another measure that's meant to prevent admission (HS9 Round 1)</p> <p>* It has been used on occasions by some GPs who stumble across it on health pathway - on the WentWest website – other than that it's not been openly advertised to GPs (HS5 Round 1)</p> <p>*we hadn't realised initially that we could ring up - patients who were not involved in integrated care, we could still ring the GP support line. (GP5 Round 2)</p> <p>*... lack of awareness that they've [GPs] got that service that they actually can use. Not to say that we haven't had GPs ring up...but it's few and far between (HN2 Round 2)</p> <p>*Now we have a GP support line and the numbers are all on the HealthPathways website (HS6 Round 2)</p> <p>*The problems that I've had is the registrars that don't know what's going on. I've had to make three or four phone calls ...different registrars – they don't know what's going on. (GP1 Round 1)</p> <p>* respiratory CNC and myself did a talk to community nurses, so when they feel that there's someone that's sick enough out there they are also calling us and I'm automatically telling them they need to get onto the GP to call the GP support line. (HN5 Round 1)</p> <p>*two GPs in particular...they're either being fobbed or no one is available or they're answered or the person who's answering doesn't really know what it's all about. So at this stage we've got a lot of glitches (MG3 Round 1)</p> <p>* That has changed. The registrar's now when I ring up, they totally know what is going on and it's a bit more streamlined. Yep, it's a better process. (GP5 Round 2)</p> <p>*it's meant to work to 7 pm at night, the GP Hotline, so if it's not answered after 4 o'clock the phone's not diverted anywhere so they were going to fix that. (CF3 Round 1)</p> <p>* ... last month where a GP had rung at 5.30 or 6 o'clock and that's when ED rings the advanced trainee to offload the ED patients. So he was on the phone sorting out five or six consults, could hear the messages coming through. As soon as he got off the phone ...he rang the GP back immediately (HN2 Round 1)</p>

<b>Use</b> <ul style="list-style-type: none"> <li><i>Underutilised but some GP registrars are using more often</i></li> <li><i>Use improving and CFs utilising</i></li> <li><i>Fast admission to RASS</i></li> <li><i>Some GPs time poor or reluctant to collaborate</i></li> <li><i>ED using more than GP</i></li> <li><i>Inappropriate use – not for designated illness</i></li> <li><i>Value in empowering GPs</i></li> <li><i>A good source of advice</i></li> <li><i>direct communication with specialist/ registrar is sometimes used instead</i></li> </ul>	<p>*we've had very little uptake from GPs at this point. (HN4 Round 1)</p> <p>*It's hopeless. I think that the GP Hotline is not used because the patients that just don't go to their GP when they get sick. They come straight to the hospital. So the GP doesn't have an opportunity to intervene. (HS2/MG9 Round 2)</p> <p>*the trainees who take the call, they've been seeing very few heart failure calls. (HN4 Round 2)</p> <p>*we've been a bit disappointed by the hotline. We'd like to be able to have that utilised but don't feel that it's being utilised as much. (HS1/MG7 Round 2)</p> <p>*we've had good feedback, especially with the amount of patients that I book with regards to the referral and coming from the GP... it's actually picked up (HN6 Round 2)</p> <p>*I haven't - not this year - actually my registrars, they use that a lot. And they find it really useful. (GP9 Round 2)</p> <p>*GP support line calls are improving. Not a huge amount, but definitely more than before. I'm getting calls from GPs...The community nurses [CFs] are calling me quite often as well... (HS7 Round 2)</p> <p>*the only time I ever used it was like, I just rang up and asked to get someone in and that happened, but haven't had to actually to go through anyone - discuss the patient with anyone (GP14 Round 2)</p> <p>I think just they're very busy, they're not familiar with it, until they've tried it they don't realise how helpful it is, and sometimes they don't want to let go. The GPs can be very precious with their patients sometimes as well (HN4 Round 2)</p> <p>*they have been utilised by ED ringing up, but that's – it was meant to be a GP hotline (HS1/MG7 Round 1)</p> <p>*it takes time for a GP to understand how to use it, because some of the calls have not been appropriate. (MG1 Round 1)</p> <p>*they do get calls about other cardiac problems, which of course they deal with, but they don't meet integrated care criteria. So they don't actually come through the RASS clinic. It has to be chronic illness heart failure. (HN4 Round 2)</p> <p>*I get an average of maybe one call a week, maybe two...unfortunately those calls are more for general advice about things to help run their day-to-day sort of patients, for example questions about the medications... not related to what this integrated person is about (HS10 Round 2)</p> <p>* ...a GP just found the number and had a question about someone with lack of thyroid. And I can see how it's a really, really good idea, again, empowering the GP...building their skills and again giving access to endocrinologist. (AH2 Round 1)</p> <p>*...I found it quite useful, getting some advice. And sometimes we don't even need to send to the hospital, just talk to the specialist, and get some advice and then if they do need to go in there - they might just see the doctor at the clinic and then come back the next day for review (GP12 Round 2)</p> <p>* ... because of the work we've been doing with case conferencing I get half a dozen calls a week from GPs and so does my registrar. We're trying to divert that to the hotline but it's hard to change (HS8/MG8 Round 1)</p>
<b>Experience (positive)</b> <ul style="list-style-type: none"> <li><i>Limited experience of working well</i></li> </ul>	<p>*from what I've seen, it works quite well from the experiences that I've heard. (HS11 Round 1)</p> <p>*I think GP hotlines are working well... The GPs that have called in have gotten good responses. (CF2 Round 1).</p>
<b>Experience (negative)</b>	<p>*feedback has been the frustration with the times when the GP support line hasn't worked properly. It's not been answered or it's</p>

<ul style="list-style-type: none"> <li><i>GP support line not answered/ operational</i></li> <li><i>Hospital staff not orientated</i></li> <li><i>GPs perceive differences in activities between hospitals</i></li> </ul>	<p>been answered by someone who doesn't understand the program (<b>MG5 Round 1</b>)</p> <p>*I had a GP who I encouraged to use the hotline when their patient was unwell and when they called the hotline it basically said this number doesn't exist [laughs]. They had to choose another option, like we called again so finally we were able to be put through to a department and then they said, "You've rung the wrong department. This is not cardiology," and they gave a mobile number to the GP to ring the registrar that was working for that day. When the registrar answered the phone, the registrar said the Integrated Care Program is not live yet. (<b>CF3 Round 1</b>)</p> <p>*I was ringing up about an ischemic heart disease patient and because I rang to Blacktown they weren't set up to manage that there, they said Westmead's team is but Blacktown's wasn't, so they just advised to send the patient to the ED rather than use Rapid access which is fair enough. But it seems like there was still some differences between what the two hospitals were doing (<b>GP6 Round 2</b>)</p>
<b>Satisfaction</b> <ul style="list-style-type: none"> <li><i>helpful responses</i></li> <li><i>Good advice</i></li> <li><i>Also unsatisfactory responses</i></li> </ul>	<p>*I've rung it a few times...everybody that I have spoken to so far have all been cardiology and one was really good. ... they have all been quite helpful and good to speak to (<b>GP6 Round 1</b>)</p> <p>* The GP support line. I haven't used it more than once but it was good (<b>GP13 Round 2</b>)</p> <p>* So I've used that GP support line. I've found that quite helpful ... (<b>GP5 Round 2</b>)</p> <p>*That's been great, so I've used the cardiology and the respiratory and the endocrinology team for advice and that's been good. (<b>GP2 Round 2</b>)</p> <p>* ...the person who had the original pager had given it to someone else at the hospital, the doctor wasn't very impressed with that, because, that was the first time she used it...it's a lot of running around and chasing up and she couldn't get hold of anyone (<b>PN2 Round 2</b>)</p>
<b>Perceived value</b> <ul style="list-style-type: none"> <li><i>Helpful in avoiding hospital admission</i></li> <li><i>Source of information – consultation especially for new GP registrars</i></li> <li><i>Can provide pathway into hospital services e.g. RASS</i></li> <li><i>Direct access an advantage</i></li> <li><i>Link to Rapid Access</i></li> </ul>	<p>*if there is any change of the patient you don't have to send them into the emergency, you can call the hotline, talk to the team, they can see the patient on the same day or the second day. (<b>GP3 Round 1</b>)</p> <p>*the link it provides to GPs, the GP support line, is another way of preventing admissions. Historically, if GPs were unsure of these patients, they would just say, "Go to emergency," but if they have something to fall back on, again, that's helping out the community in terms of building a bridge between primary care and the specialists. (<b>AH5 Round 1</b>)</p> <p>* Anything that bypasses emergency and is subacute that can be treated with access to the hospital facilities without going through emergency, is going to benefit everyone. Yeah, so I found it quite useful, getting some advice. And sometimes we don't even need to send to the hospital, just talk to the specialist (<b>GP12 Round 2</b>)</p> <p>*I've seen so many new registrars being trained for GP practice and they don't know how to do things right – and they're not all that sure about how to manage the patient, so these GP support lines have been very valuable support for them with those kind of patients. (<b>CF4 Round 2</b>)</p> <p>*... in the past the only access us GPs had to the specialist, if the person didn't have a private specialist, was to ring the registrar on call and they always didn't have time to have a bit of a chat with you about the slightly more complex management of diabetes through medication... whereas now that GP support line is a really good access point for the GPs to get some information... without having to send the patient to ...hospital (<b>GP5 Round 1</b>)</p>

	<p>*It's actually great because, yeah, they have, like, Rapid Access and the doctor doesn't need to, you know, look for a directory just to have an access in the hospital. (PN1 Round 1)</p>
<b>Suggestions</b> <ul style="list-style-type: none"> <li>• <i>Poorly promoted</i></li> <li>• <i>Promote widely to GPs early on</i></li> <li>• <i>Use patients to promote to GPs</i></li> <li>• <i>Extension to other disease areas</i></li> <li>• <i>GPs need to be aware of the types of services that can be accessed</i></li> <li>• <i>Hotline access contingent upon relationships</i></li> </ul>	<p>* I think there could have been a little bit more advertising and communication of who are the people at the end of the line. (CF1 Round 1)</p> <p>* the first thing they should have done was try and get as many GPs as they could on board. (HN3 Round 1)</p> <p>*We had one incident where it wasn't manned and somebody at Westmead actually said the lines not operational. So I think there needs to be awareness that the program is up and running (CF2 Round 1)</p> <p>* our patients that we have enrolled in Integrated Care, we give them the information about the GP hotline, so when they're going to the GP and their GP is struggling or not sure of what to do, they say, "Don't forget we've got this hotline." (AH3 Round 1)</p> <p>* So with this rapid access line, because my referral was not for ENT or orthopaedic, it was for diabetes. So it worked, but if it was for ENT, eye or orthopaedic, will it work, that's my question to you? (GP13 Round 2)</p> <p>*Maybe a bit more aware that the GP, so they know who to call for what kind of thing (GP6 Round 2)</p> <p>*I get half a dozen calls a week from GPs and so does my registrar. We're trying to divert that to the hotline but it's hard to change, and it's because of the relationship. So the hotline would get hot if the relationship was built (HS8/MG8 Round 2)</p> <p>* if the patients are being risk stratified within 48 hours, I think that's a very good thing, and it's really a safer approach in terms of managing ischemic heart disease. So I guess that's the relationship we have with emergency. I would like to see in future a similar relationship built with the general practices. I mean, we only get maybe one or two calls a week from the GPs around this area, and I guess that's something to improve on. (AH5 Round 1)</p>

## Rapid Access and Stabilisation Service (RASS) Hospital Clinics

<b>Implementation / delivery</b> <ul style="list-style-type: none"> <li>• <i>Communication challenges make KPIs difficult to achieve</i></li> <li>• <i>Utilised mostly by ED in some specialties</i></li> <li>• <i>Poor GP engagement</i></li> <li>• <i>Fast track patients</i></li> <li>• <i>Multidisciplinary clinic</i></li> <li>• <i>Thorough</i></li> <li>• <i>RASS is integrated with existing heart failure services</i></li> </ul>	<p>* we don't have e-referrals, so you get a fax that turns up on a fax machine the day after the patient's visit, and then you try to ring the patient and they're not there, and you ring the patient again and they're not there, your KPI of two days is gone. (HS1/MG7 Round 1)</p> <p>* when the patients go and see the GPs, the GPs would ask, okay, if they haven't got a letter back from RASS clinic, the GPs will ask the patients and sometimes the patients cannot remember (CF3 Round 1)</p> <p>* Most of our patients are from ED, and so I guess it helps out emergency in that all these patients ... would otherwise be admitted or be in short stay, or just have a prolonged stay in emergency before they have a discharge destination, or a plan, but the rapid access clinic provides them an option for early discharge (HS6 Round 1)</p> <p>* I haven't accepted a patient or have been referred a patient to the clinic from a GP as of yet. (HS10 Round 1)</p> <p>* So they fast-tracked me and they took me straight up to the ward. I didn't have to go through the emergency care, wait there for about four or five hours, none of that. So they go, that's what happens with Rapid Access. (PC2 Round 1)</p> <p>* When I go there's pretty much— as far as the heart clinic goes, I'm pretty much straight in. Not sort of sitting there or waiting around for hours and hours (PC4 Round 2)</p>
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<ul style="list-style-type: none"> <li>• Provides outreach</li> </ul>	<p>*there's still room to improve but it's become much more a rapid access service. So, either from the GP or from emergency – I think that's running a lot better, and the processes of getting them in are running a lot better (HS3 Round 2)</p> <p>*I think it was good. The patient did get an appointment in a clinic within two weeks. (GP13 Round 2)</p> <p>*having a nice multi-disciplinary clinic has been really good, because one of the challenges with diabetes is that it's not just the doctor bit, you have to have the diet, you have to have the education. .. So we have a conversation together, pick up different aspects of the review. (HS3 Round 1)</p> <p>*she's [HN] very thorough actually. She didn't want me to go until I'd done everything, she was – they looked after me well, to tell you the truth. (PC11 Round 1)</p> <p>* it is fully integrated into a heart failure service –it's one heart failure service that has the existing heart failure services for inpatients, stabilised clinic patients, home visits, phone follow-up, and people from integrated care come into the rapid access service, for stabilisation and when they're finished there they're referred to the heart failure service for ongoing follow-up (HN4 Round 2)</p> <p>*part of our clinic is a breathlessness clinic where we do a lot of outreach visits to patients. The aim of that clinic is to provide patient care at their home, because these patients are just too breathless to worry about coming in to a hospital (HN3 Round 2)</p>
<b>Use</b> <ul style="list-style-type: none"> <li>• Lack of GP referrals to some RASS clinics</li> <li>• RASS as a source of information and individualised care</li> <li>• Use by ED</li> <li>• Some GPs use specialists</li> <li>• GP use depends on their clinical capacity</li> <li>• Fast track admission from RASS</li> <li>• RASS used not only for enrolled GP patients</li> <li>• One stop shop</li> <li>• Inappropriate referrals from ED without medical check back</li> <li>• RASS does not exclude</li> </ul>	<p>* we're not getting a lot of referrals from GPs at this point (HN4 Round 1)</p> <p>*GP referrals are steady but nowhere near as much as we get from emergency departments or any other service of the hospital.(HS6 Round 2)</p> <p>*I don't see a lot of GPs actively ringing the RASS service despite our promotion but, I think, sometimes, unfortunately on the negative side, sometimes we've had a few bad experiences as well in ringing RASS (CF3 Round 2)</p> <p>*I think the service is being utilised more and more. But I'd say maybe 50/50 in terms of hospital referrals and GP (HS4 Round 2)</p> <p>* they said "here's all these programs and numbers, and brochures, and things, and you can do them if you want", but I wasn't really interested because I'm busy anyway (PC3 Round 1)</p> <p>*we had a nurse, and a doctor, to do with the pacemaker and, not that they tell you much, they talk – between themselves, but I kind of gathered everything was all right, and they improved the medication, but, they seem to let you know what's going on (PC19 Round 2)</p> <p>*they're organising something for me to do some like exercise up there in their facility under supervision and stuff. That was a bit of a suggestion because I'm just a bit concerned if I try to do something at home and I have an incident that I'm stuffed (PC4 Round 2)</p> <p>* I think, at this stage the main thing it is being used for is if someone comes straight through to ED and has a problem with diabetes, and that essentially is the main reason why they're actually here then to do something to temporise the situation, and then to send them to be seen in the next clinic (HS5 Round 1)</p> <p>* I'm getting referrals from ED, unfortunately they've all been inappropriate so it's been initiated by the nurse in ED who is not discussing it with the medical staff because all of them have been admitted. (HN5 Round 1)</p>

<p><i>patients</i></p> <ul style="list-style-type: none"> <li>• Internal hospital use of RASS</li> <li>• Transition from Rapid access to stabilisation</li> <li>• Locating RASS at relevant clinical departments</li> <li>• Patients able to access as required</li> </ul>	<p>* ED is getting good and quick and say, well, actually you don't need to come to ED, just go to RASS. So, while we're not actually completely bypassing ED certainly making the route through easy and much faster (HS1/MG7 Round 2)</p> <p>* There's only one patient I can think of that I – try to avoid hospitalisation and referred to the cardiology ... that worked out really well for them, but other times we tend to use specialists. (GP1 Round 1)</p> <p>*I still think a lot of community heart failure patients have their own cardiologist they [GPs] prefer to send them to the cardiologists rather than send them to us (HS6 Round 2)</p> <p>* respiratory is a bit of a waste of time, 'cause I can manage a lot of the respiratory patients. One patient would have probably needed some home oxygen and the specialist organised that. I've got one of my patients that was an acute heart failure patient that I got someone to see her quickly and we managed to treat her that way. (GP1 Round 1)</p> <p>* I've had the one specific example of a patient who was unwell of my own who I sent down and they were assessed in the rapid access clinic and in fact they were deteriorating so they had a facilitated admission which was very effective for that patient's healthcare at the time. (MG5 Round 1)</p> <p>* I was willy-nilly at first, because that's the way I was before, through the revolving door - it's a one stop shop. (PC2 Round 1)</p> <p>*I think the large majority are appropriate, but there are some patients probably aren't completely appropriate, but we see them anyway (HS1/MG7 Round 2)</p> <p>*I also find the people that we don't necessarily have enrolled in Integrated Care ... we have them in our pulmonary rehab service and they get sick, we're then able to refer them to the rapid access clinic, and get them seen that way and that's been really efficient. (AH3 Round 1)</p> <p>*some of them come back, because we go from rapid access to stabilization. So if you've come direct and you need a bit more ongoing care, then you move to stabilization. There may be a couple of visits, then you're back to GP. (MG1 Round 1)</p> <p>* we've elected to have integrated clinics on level seven in the respiratory area... so we have all the resources, and everything here (HS11 Round 1)</p> <p>*I think that is the best thing because I retain CO2 and sometimes I'd sit there and I'd think, if I could just get my blood gases checked and if they're low, terrific, if they're high, I can do something about it before it gets worse and I feel like this clinic thing is really good for me. (PC8 Round 1)</p> <p>* I just have to ring up, if he's having problems I just take him up to the heart failure clinic and that's it. Or ring up the cardiologist, and they just tell me to bring him in, or just take him to the hospital. (PC16 Round 2)</p>
<p><b>Experience (positive)</b></p> <ul style="list-style-type: none"> <li>• Comprehensive care</li> <li>• Friendly and supportive</li> <li>• Assist in self-management</li> <li>• Time efficient</li> <li>• Special (individualised)</li> </ul>	<p>* Wonderful, they have been really wonderful. When I do go into the clinics for an appointment it's a friendly atmosphere, they do all they have to do to check everything with me and then they explain all the things that I either should be doing or could be doing (PC7 Round 1)</p> <p>*there was a particularly little Welsh nurse, and she was fabulous. I felt as if I was getting support. (PC22 Round 2)</p> <p>*he talks very highly of the program ... now after having COPD for a very long time and panic attacks for a very long time, he was referred to that program and he has been helped by that (AH5 Round 1)</p>

<p><i>treatment</i></p> <ul style="list-style-type: none"> <li>• <i>Good communication and support</i></li> </ul>	<ul style="list-style-type: none"> <li>* it's been amazing; she's never had to wait and I was really concerned about having to wait that particular time in the waiting room setting – I'd come straight from school that day, so yes, I always thought that hospital was just fantastic. (PC1 Round 1)</li> <li>*A comment from the one patient that I sent down to the rapid access was it was magic, it was gold, treated like special rather than waiting in emergency for hours and hours feeling unwell, here I was being seen by people who met me at the door with a wheelchair and took me places to assess me and then decided I was unwell and then admitted me directly onto the ward. So they felt like they were royalty as far as the process was concerned (MG5 Round 1)</li> <li>* you've got to put the big tick for Rapid Access. The doctor, [CF], the whole three of them, really, they are all linked together. So without one of them not being there I dare say it could be very, very dark. (PC2 Round 1)</li> <li>* He has had a very good experience dealing with the heart failure clinic, like the rapid access stabilisation clinic, so having that good communication and extra - the patient felt much more supported (GP6 Round 1)</li> </ul>
<p><b>Experience (negative)</b></p> <ul style="list-style-type: none"> <li>• <i>Inconsistent information to GP</i></li> <li>• <i>Risk that patients bypass GP</i></li> </ul>	<ul style="list-style-type: none"> <li>*it's different between different hospitals and different clinics and again the information that goes back to the GP is not very consistent amongst the clinics, which is a bit of a barrier (CF3 Round 1)</li> <li>* I've had a patient call me and she's a joint respiratory cardiology and she goes, "Oh, I knew that if I called one but it didn't matter which one I called because I knew you'd make an appointment and arrange to see me." And I've gone, "Well, did you see your GP?" "No, there's no point" (HN5 Round 2)</li> <li>*our patients as soon as they get breathless, or they are sick for a couple of days – they don't go to their GP, because ...my GP is too busy, or they are just too breathless to make the trip...the easiest thing for them to do is call the ambulance. (HN3 Round 2)</li> </ul>
<p><b>Satisfaction</b></p> <ul style="list-style-type: none"> <li>• <i>Life changing</i></li> <li>• <i>Avoid admission</i></li> <li>• <i>Approachable and helpful</i></li> <li>• <i>Continuity with and familiarity with a team and with GP</i></li> <li>• <i>Good patient communication and support</i></li> <li>• <i>Rapid access to specialist services can improve clinical outcomes</i></li> <li>• <i>Patients seeing benefit including with home follow up</i></li> </ul>	<ul style="list-style-type: none"> <li>*Well, it's changed my life. Because before I wouldn't go – I wouldn't leave the house. Now I can. I can go here, I can go there. Yeah. Big change. (PC2 Round 1)</li> <li>* there have been some that we've able to send home and just follow-up in a week's time, so I think they're working well. (HN4 Round 1)</li> <li>* clinic staff were fantastic. Always approachable, always gave patients an appointment, followed up really well, liaised with me really well to take back to the GP. (CF1 Round 1)</li> <li>* And you can ask them anything and they will answer you with a straight answer. I don't know, they just help you a lot. (PC12 Round 1)</li> <li>*They're brilliant, I mean, they explained what will happen, and how to deal with it (PC14 Round 2)</li> <li>* They're good, because I know the people that work there. They're very, very friendly. They make you feel, well I know I shouldn't say this, but they make you feel welcome as if they really want to help you. (PC12 Round 1)</li> <li>* I think from most of them we've had quite positive feedback in that we end up being a group of people that they see over and over again. So it's the same people, yeah. And, you know, again because these are the sort of patients who often are in hospital a lot, we end up being the continuity. (HS9 Round 1)</li> <li>* she [HN] understands me very well. I can tell her anything. She understands. (PC12 Round 1)</li> <li>* He has had a very good experience dealing with ...the rapid access stabilisation clinic, so having that good communication and</li> </ul>

<ul style="list-style-type: none"> <li>• Multidisciplinary management</li> <li>• Shared interdisciplinary perspectives</li> <li>• Patients appreciate RASS care</li> </ul>	<p>extra - the patient felt much more supported, so that's been really good... not just out there sitting at home getting sick by themselves, that there are people who are actually going to be able to help them. (GP6 Round 1)</p> <p>* they're continually ringing to see how I am. No. I don't think I can do much better. (PC14 Round 2)</p> <p>* I've only been twice [to RASS] and each time – and I've had three visits from the nurses at home and I could not fault one thing. I feel very happy about it. (PC8 Round 1)</p> <p>*They've got the community nurses that come around and check me out once a month. They're very good. They just reassure me that I'm doing the right thing. (PC2 Round 2)</p> <p>* it's helped me a lot in terms of getting them access aside from a hospital admission, to urgent care and, especially with diabetes, that's all they need sometimes and then they can really turn around quite quickly. (HS3 Round 1)</p> <p>* they've been able to see everyone else by coming to the same place and not then having to next week come again to the hospital, to see the dietician and go somewhere else to see the educator (HS3 Round 1)</p> <p>* the multidisciplinary team that we've created for the breathlessness clinic has been really useful and it's really interesting because we've got OTs, the dietician, a physiotherapist, a nurse and a psychologist on that team....having the opportunity to talk to other clinicians that are not doctors about COPD and get their perspective about how we might better manage these patients has been just gold. (HS2/MG9 Round 1)</p> <p>*I've had a couple of emails [from patients] that have been very positive; thank you emails afterwards. That's been really good (HN2 Round 2)</p> <p>*they all love our clinic and they don't want to leave at the end because they get very intense care (HS3 Round 2)</p>
<b>Perceived value</b> <ul style="list-style-type: none"> <li>• Prevent admissions</li> <li>• Quick access to specialist care</li> <li>• Early intervention</li> <li>• Good liaison with GPs</li> <li>• Multidisciplinary care</li> <li>• Cross disciplinary care</li> <li>• Good care for complex patients</li> <li>• Access to specialists in public system for those without private (e.g. low SES)</li> <li>• Provision of patient</li> </ul>	<p>* is of value because it has prevented some admissions to hospital. (HS4 Round 1)</p> <p>*Before [HN] came along, I'd been into hospital two times in six weeks. (PC11 Round 1)</p> <p>* but those three patients that I've had a walk in visit with would have probably turned up to ED otherwise, and we've been able to – between the GP and follow up with GP and then coming back to see us very quickly, probably have prevented their admission. (HN2 Round 1)</p> <p>*what the patients really appreciate is that there is that step before having to be admitted to hospital, so if they feel that they're getting unwell; one, they're a priority patient in the practice so they know that they can ring up and we'll see them that day; two, that they do have access to a specialist reasonably quickly (PN3 Round 1)</p> <p>* there's no such thing as waiting time with them. They are all – you go to your doctor, or I get onto a hotline to them, so they want you in there ASAP because they don't want you to go to hospital. (PC2 Round 1)</p> <p>* to have a rapid access drop-in service has been of most value. Just to have an ability to be able to give a patient something right away, or to do it tomorrow, and not have to worry about appointments and things (HS1/MG7 Round 2)</p> <p>*I've had experience of hours in the waiting room like everyone else, but I think your system bypassed that and I am checked over in no time at all in the hospital bed (PC9 Round 2)</p> <p>* Where can you go with 48 hours and see a consultant for free? I was just saying earlier, there's nowhere. (HN2 Round 2)</p>

<p><i>education</i></p> <ul style="list-style-type: none"> <li>• <i>Patients see benefits of improved health</i></li> <li>• <i>Encourages self-management</i></li> <li>• <i>Improved post admission care</i></li> <li>• <i>Ability to see outreach patients</i></li> </ul>	<p>* we're seeing a fall in our unnecessary admissions and ...we've been able to sort of pick them up before they've come into hospital in extreme need. (HS1/MG7 Round 1)</p> <p>* the Rapid Access Clinics, have been able to get people through the door quickly and facilitate that approach and recommendations are made by the clinic conveyed to me by letter (GP1 Round 1)</p> <p>* very good at getting communication flowing, she's [PN] getting all the reports and feedback quite quickly and that's been really valuable so you know what's happening with the patients at all times (GP6 Round 2)</p> <p>*they would see the diet educators and doctors all at once – so you can package the service into a one hour, two hour period, rather than, say, an admission or have a patient come back three times to see different parties (HS4 Round 1).</p> <p>* see them with the cardiovascular team and the foot team down there, because they think that the diabetes may in some way be attributing to their foot ulcer and their foot wounds and that there could be an improved outcome if we improve their blood sugar levels ...that's one of the examples of rapid access which can actually be quite transformative. (HS5 Round 1)</p> <p>* It's very good for the complicated patients. (GP3 Round 1)</p> <p>* if you're under the care of a specialist, you tend to refer them to – or you're going to call a specialist rather than call the RASS Clinic to look at them. For those that haven't got a specialist, it's an advantage. (GP1 Round 1)</p> <p>* the clinic has been good, especially for patients who are not financially well off (GP4 Round 2)</p> <p>* Like people have been connected to the rapid access clinic who have never seen a respiratory specialist for years because of a lower socioeconomic, now they've had a chance to see a specialist...Medications have been changed. Their lifestyle has improved. (CF1 Round 1)</p> <p>* she's become more amenable to psychological intervention after figuring out that it was more about breathlessness related anxiety intervention rather than anything else (AH5 Round 1)</p> <p>* I've learnt how to control – if I'm having a panic attack. If I'm having a anxiety attack, which has been – they've been so helpful up there. And, just the general breathing part of it. (PC11 Round 1)</p> <p>*They show me the exact things I should be doing. Like, I didn't exercise properly. They've showed me how to exercise properly. They talked me into going into the rehab for my lungs...They're very good. (PC12 Round 1)</p> <p>* it has been really useful to encourage self-management amongst patients (CF3 Round 1)</p> <p>* I think that more intense connection initially, will lead to regular service and help them self-manage a bit better. (HN4 Round 2)</p> <p>* We find out that people don't have their follow up appointments made, or they didn't understand what was happening in hospital. We check their inhaler technique. I think that does a powerful amount of good. (HS2/MG9 Round 2)</p> <p>* A different way of looking at heart failure. I think we cover everything as far as education goes, as far as follow-up goes, as far as support goes (HN2 Round 2)</p> <p>*What do we call it – I'm trying to think off the top of my head – it's been a long day, but Outreach, that's what it is, so Integrated Care Outreach Program which I think is good because we get to see patients and we wouldn't normally see around that area. (AH2 Round 1)</p>
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<ul style="list-style-type: none"> <li>• <i>Time efficient to see multiple providers in one visit</i></li> <li>• <i>Faster hospital discharge</i></li> <li>• <i>Benefits of time</i></li> <li>• <i>Having time to spend with patients-time to work better</i></li> <li>• <i>Time to educate patients</i></li> </ul>	<p>*The clinics have been useful, just having that quick access for the patients to be seen is really important, because the general practice setting and not have to just go to ED, I think actually there is a step in between now and that's really important (GP6 Round 1)</p> <p>*I really believe in the rapid access and stabilisation clinic you really see the value of patients coming in, getting reviewed by the specialist care treatment team and then they go back out in the community (CF2 Round 1)</p> <p>* the heart failure service is quite valuable ...because they can get follow-up very quickly once they discharge these patients from hospital and prevent them from coming back and being readmitted. (HS6 Round 2)</p> <p>* you need a long time not just to cover their COPD but the osteoporosis and heart failure and reflux, and other things that could be heading towards it and do questionnaires and link them into rehab exercise programs. So I think they have been able to dedicate the time that these chronic, complex patients need which probably cannot possibly be met in primary care or even in specialist care because of the time involved and the general frailty and complex nature of the patient (HS11 Round 1)</p> <p>*Because they spend an hour with us. Spend the time to explain everything and we understand so much better about what it was and action plan and how to prevent getting sicker and prevent coming back into hospital. (HS11 Round 1)</p> <p>* we're trying to spend a lot of time with them to try and increase their understanding and really make them understand the importance of self-management and trying to, keep in touch with us in the initial period after hospitalisation to try to prevent them from coming into emergency. (HS6 Round 1)</p>
<b>Suggestions</b> <ul style="list-style-type: none"> <li>• <i>Referrals without GP approval</i></li> <li>• <i>Focus on prevention</i></li> <li>• <i>Collect long term patient data</i></li> <li>• <i>Expand clinical criteria</i></li> </ul>	<p>* it's set up so that the GP makes the referral, so if a nursing staff member from the community or the care facilitator sometimes rings us... then we have to chase to get a medical referral, so that's an issue... (HN4 Round 1)</p> <p>*management is really more a long-term thing and we may not see the results of this until maybe five years or something... So it would be very interesting to keep a track of these patients to look at long-term. (HS6 Round 1)</p> <p>*I think it would be good to expand it a bit, it would be probably good to look – well, we're doing heart failure but to link in a hypertension clinic. (HN2 Round 1)</p> <p>* if we could function as a mini clinic that is able to exclude acute coronary syndrome, then I think GPs would feel more comfortable sending the patients our way (HS6 Round 2)</p> <p>* they're looking at an arrhythmia part to the clinic as well which may possibly be one day a week, and that will be good as well (HN2 Round 2)</p>
<b>Patient Hotline</b>	<p><b>Implementation / delivery</b></p> <ul style="list-style-type: none"> <li>• <i>A means for direct patient contact reassurance and autonomy</i></li> <li>• <i>A central clinic number</i></li> </ul> <p>* the patient hotline at the moment has enabled them to contact us directly, so maybe there's no need for a care facilitator (HS1/MG7 Round 1)</p> <p>* we'll give them the phone number of an educator, we say, please call us if you have any concerns, call us anyway in a week's time so we can help with insulin doses or with what you're doing (HS5 Round 2)</p> <p>*She always said we could ring them up at any time. They made sure of that. (PC22 Round 2)</p>

<ul style="list-style-type: none"> <li>• May provide a bypass for CFs</li> <li>• Phone always answered</li> </ul>	<p>* we are now actually planning this year to start up a hotline where we provide probably a 12-hour service to our patients, so that when they are breathless, they don't know what to do, they have someone that they can call (HN3 Round 2)</p> <p>* we have one number that they call when they opt to – whether it be OT, physio, et cetera, and that works – so you don't have to worry about what number to ring because seriously it's hard enough knowing who to ring from my point of view, let alone their point of view (AH4 Round 2)</p> <p>*But their number one rule is that if anything happens to you, no matter what time of the day it is, give them a phone call. They pride themselves on a 100% pickup. (PC2 Round 1)</p>
<b>Use</b> <ul style="list-style-type: none"> <li>• Patients call as early intervention</li> <li>• Ring clinic to avoid clinic attendance and hospital admission</li> <li>• Patients call or drop in when serious concern</li> </ul>	<p>*And if they do notice that their symptoms deteriorate, they often have the number for the CNCs at the RASS clinics, so they will call the nurse practitioners or the CNCs to say this is what's been happening. I can see my weight has gone up by this, so they're taking a bit of early intervention rather than sitting at home and waiting for symptoms to get worse and come into hospital. (CF3 Round 1)</p> <p>* I've got a direct line straight to Rapid Access. There was a couple of times I've been up there ...if it's serious and I feel that the medicine is not working. (PC2 Round 1)</p> <p>* he used to come into... rapid access once a week or once every fortnight...I thought that he used integrated care well, because whether he felt unwell, he would actually call (HN3 Round 1)</p> <p>* Like, I can ring up whenever I want, the thing is if I need anything – which I don't go and ring up any old time, it's only when there's something really wrong with me, that I give her a ring. (PC11 Round 1)</p> <p>* So we give them their numbers, we give them two phone numbers, mobile numbers of the educators who are here five days a week and they then can actually call me to inform me or send me an email about themselves and I get back to them in real time (HS5 Round 1)</p> <p>* it's more an interaction with our nurse specialist... basically it's a hotline for them to call the nurses if they experience any problems, and to get input from them. (HN6 Round 1)</p> <p>*I've had patients that I see in my normal clinic that have also been coming in to - been using the integrated care services, and they like having that in between. They feel like it's a level of safety in that they can come and talk to as well. (HS1/MG7 Round 2)</p> <p>*they carry a mobile between them and I just ring them anytime I need them (PC4 Round 2)</p> <p>*they use it. And they appreciate that help is available. It gives them a bit more confidence when we're making big changes to their treatment (HS4 Round 2)</p> <p>*I'd rather be at home than in hospital and if I have any problems I can ring my doctor, my GP, and I can also ring the clinics at the hospital, I've got names and phone numbers that I can contact if I have any problems. (PC7 Round 1)</p>
<b>Experience (positive)</b> <ul style="list-style-type: none"> <li>• Improve patient understanding of their condition and who to</li> </ul>	<p>* I certainly see patients ring up on the hotline...our feedback from them has been that they are happier with their understanding of their condition and who they need to talk to. (HS1/MG7 Round 1)</p>

<i>contact</i>	
<b>Experience (negative)</b>	*
<b>Satisfaction</b>	<p>*... patients ring up on the hotline, so I think they feel that that's better, and our sort of bits and pieces feedback from them has been that they are happier with their understanding of their condition and who they need to talk to. (HS1/MG7 Round 1)</p> <p>* they have been positive about that, to have a name and a face to call back on, so to speak. (HS6 Round 2)</p> <p>*the patient is really happy because he has the phone number of the rapid clinic – access clinic and he, over the weekend, we are not working and sometimes he just called the clinic and then straight away went there. Patient is really happy. (GP3 Round 1)</p> <p>*we get phone calls from people that we have discharged you know for a long time because they're worried about their conditions. I think especially the carers are happy. Because they don't have to worry about going to GP (AH1 Round 2)</p>
<b>Perceived value</b>	<p>* be a designated person, point of contact. So, at the moment, if I go and see them, and the clinic psych goes to see them, the dietician sees them, there's three people, with three contact numbers ...there is one person that they can call to ask questions of – just general questions, instead of going, "Oh, who do I call?" (AH4 Round 1)</p> <p>* a patient we saw a few weeks ago, is not getting better and the GP is not happy and so the patient rung and we said, come in right now. So, we were able to attend that today, and that patient had a core line which was our integrated care CNC and she was able to come in, and prior to integrated care, we wouldn't have had that sort of connection (HS1/MG7 Round 1)</p> <p>* giving that patient the ability to have contact people in the program... that gives that patient extra... reassurance, and autonomy as well, they know where they can go if something is wrong, not just here to the GP, but they also get that extra knowledge that there is a heart failure clinic ... somebody will see me; (GP6 Round 1)</p> <p>*it's like a safety net...if anything were to go wrong ... they may present to hospital for something minor that could have been sorted out as an outpatient (HS6 Round 2)</p> <p>*if anything untoward happens, I know that I can get a hold of her straight away, and she can then say, "Get yourself up here," and I just put him in the car straight up to the heart failure clinic. (PC16 Round 2)</p> <p>*Well, now I can just ring up and say I need to come in. I come in and I take my blood gas and see what my oxygen levels are ...Once they wouldn't let me go home because my oxygen was so low and the next time I was terrific. (PC8 Round 1)</p> <p>*I feel not so scared or not so – I have to wait and think will I go to hospital, won't I, will I, do I ring the ambulance, what do I do. I can just ring the girls up and say I don't feel very well and they'll say come in and I can see them without hospital. (PC8 Round 1)</p> <p>*So it seems to have changed because she got access to everything. And then if she is not too happy, she just phones Rapid Access and tells them that I'm on my way up. But I think it has changed it big time, mate, I can tell you it has stopped me from going to hospital, that's what I'm getting at. I no longer go to hospital, I don't want to go to hospital. (PC2 Round 1)</p> <p>... I think it improves the patient's understanding of how to manage their condition, plus giving them extra education. (GP6 Round 1)</p>
<b>Suggestions</b>	<p>*he was having problems with his breathing and food retention. And I rang up the clinic, and they said, "Oh, well, you have to get a referral." Then the lady that looks after us, she said, "No, no, no, you don't need to do that. I just ring your GP - your heart</p>

<p><i>process</i></p>	<p>specialist, and he said, "Whenever you need to come in, you just come into the heart failure clinic and you can be looked after there" (PC16 Round 2)</p> <p>* I think we absolutely should do a nurse led patient hotline. So that we allow the patients when they are feeling off to call the nurses directly. They won't call the doctors, but to call nurses directly and have the nurses be able to essentially triage over the phone (HS2/MG9 Round2)</p>
<h3>HealthPathways Website</h3>	
<p><b>Implementation / delivery</b></p> <ul style="list-style-type: none"> <li>• Continually updated part of the program delivery</li> <li>• Need for linked online forms</li> <li>• Easy process for GPs to follow correct treatment guidelines</li> <li>• Time required to write pathways</li> <li>• Maybe too much information</li> </ul>	<p>* they're actually in the process of updating the diabetes pathways, we see it as our - part of what we need to do is to make sure that the information on the pathways is kept up to date and all the programs we've talked about there is information, and when we talk to GPs and we do case conferencing we say, "Go to the HealthPathways. What we've told you is there" (HS8/MG8 Round 1)</p> <p>* our online forms aren't quite there yet, but the idea is eventually we'll be able to type our forms in and, again, put it onto that program.(AH2 Round 1)</p> <p>* It's actually a streamlined process for every GP in their LHD and they're following in your guideline how to treat or how to follow the procedures in the right way. (CF4 Round 2)</p> <p>*I spend a lot of time writing stuff for it and updating it and reviewing it, and I'm aware that other people have spent a much greater amount of time writing for it and updating it and reviewing it (HS2/MG9 Round 1)</p> <p>*Lots of information But when there's so much information, sometimes there's information overload and people get lost. (HS7 Round 1)</p>
<p><b>Use</b></p> <ul style="list-style-type: none"> <li>• Use increasing but still underutilised</li> <li>• Challenge of using in the consultation</li> <li>• Helpful information for GPs but takes time to explore</li> <li>• Potential for CF role in promoting</li> <li>• Used by practice staff and CFs</li> <li>• Used more by</li> </ul>	<p>*Yeah, yeah, I'm starting to use that more these days. I've put the little brochure on my wall where I keep my resources (GP6 Round 1)</p> <p>*It is effective, and I use it all the time. (GP8 Round 2)</p> <p>*I've hardly used it to be honest with you...I didn't think it was – from my view I didn't particularly find it very useful. (GP1 Round 1)</p> <p>*well, HealthPathways is sort of gaining force or traction but it isn't getting used as much as we'd hoped but I think.(GP5 Round 1)</p> <p>*when I do use it, it's extremely useful but it's just having that time to access it and just remember it's there...I've gone back and looked at it a few times after a patient's gone, but I should look at it while they were here. (GP9 Round 2)</p> <p>*it's a matter of them getting used to it and by taking the time out to explore the website and to know what's on there, and for them again, it's just another thing that adds onto their time... (CF3 Round 2)</p> <p>*it's still a work in progress, I do give that information to all my GPs the first time I meet with them and I constantly encourage them to use that, but I think it's every now and then that I've come across a GP who is using it in their day-to-day practice (CF3 Round 2)</p> <p>*I've used it once or twice, it is good. (GP13 Round 2)</p> <p>* I may initiate looking at it to save time or to try and be efficient or to follow some of the things I could do, but a GP would always see – would follow-up a patient at the time. (PN3 Round 1)</p>

<p><i>younger GPs</i></p> <ul style="list-style-type: none"> <li>• <i>Used for referral pathways into LHD</i></li> <li>• <i>Used for clinical updates and therapeutic guidelines</i></li> <li>• <i>A resource that patients can also use</i></li> </ul>	<p>*I tend to have it open as a quick reference for the patients here (PN4 Round 2)      * I utilise it predominantly to make sure that I'm on the right track... other times I will actually use HealthPathways, if I'm making a recommendation in management to the GPs (CF3 Round 1)      *I think that it is being used a lot by the GP registrars and the younger people ...For established GPs I think occasionally they look it up for how to refer people into the LHD, and that is useful for them... (HS8/MG8 Round 1)      * I make use of it clinically and... occasionally reading through looking for things.... really valuable (MG5 Round 1)      *HealthPathways is very valuable. It's probably one of the main guidelines I use as well as therapeutic guidelines. Yeah, it's good in that it's got pretty much everything we need (GP12 Round 2)      *, I think even for patients, we've been giving them a website and they can have a look at the problems and they can look how to do things...There's a lot of resources for patients as well. (CF4 Round 2)</p>
<p><b>Experience (positive)</b></p> <ul style="list-style-type: none"> <li>• <i>Helpful when dealing with complexity</i></li> </ul>	<p>*as a GP I find it's a valuable tool (MG5 Round 1))      * I had a patient with a range of difficult issues and it gets quite complex working out a path of action. The HealthPathways website was a great help. It covered topics that were relevant and helped me get his meds right. (GP12 Round 2)</p>
<p><b>Experience (negative)</b></p> <ul style="list-style-type: none"> <li>• <i>Difficult to navigate</i></li> </ul>	<p>*Again, I know that it exists, and I've tried to look it up myself and there's a few links and it's not the most clear website, so it takes a bit of digging to find the right thing.(HS4 Round 1)</p>
<p><b>Satisfaction</b></p> <ul style="list-style-type: none"> <li>• <i>Information is updated</i></li> </ul>	<p>*as a GP, I love it. (MG5 Round 1)      * It was changed a lot. So, a lot of information is now – has been uploaded and it's really helpful. (PN1 Round 2)      *It's up to date local information which is really important to me- not just stuff from somewhere overseas (GP8 Round 2)</p>
<p><b>Perceived value</b></p> <ul style="list-style-type: none"> <li>• <i>Better if simple</i></li> <li>• <i>Internet access a barrier for some</i></li> <li>• <i>Not fully localised to Australia but more local information is becoming available</i></li> <li>• <i>Valuable for patient diagnosis and management</i></li> <li>• <i>Helps GPs develop knowledge</i></li> <li>• <i>Hospital staff endorse</i></li> </ul>	<p>* from my view I didn't particularly find it very useful. HealthPathways, what I'd find more useful is someone's list. Something simple. (GP1 Round 1)      * like some GPs who are IT savvy would use it a lot more than others, whereas some would say it's just too complex. I just want to know the answer rather than get into a computer website and reading through it. (CF3 Round 1)      * I think it's a bit clunky. I think you need to look through things to be able to work out what's happening. But I would much rather have seen a published... rather than having to navigate a whole step plus process. I think it's a little bit inefficient. (GP1 Round 1)      *... it's not complete yet...some of the references are still in New Zealand (PN1 Round 1)      *I've been using that more often myself since starting with integrated care so that's been really good. I've got my sticker on my monitor so I'm able to log in and get all the access to that, and that's been really helpful, especially for the ones that have been localised already, so diabetes pathway for example, that's been really helpful. Yeah, that has been good actually; that's a very good resource. (GP6 Round 2)      *It's been quite useful ... a good resource for GPs even in terms of trying to work a patient up or trying to determine what investigations or management would be appropriate. I have found that very helpful. (GP4 Round 1)      * I'm actually finding it helpful, like the diabetes pathway and things like that is quite useful. I'm starting to use that much more, so I'm finding that that is beneficial as well for supporting GPs. (GP6 Round 1)</p>

<p><i>the information provided</i></p> <ul style="list-style-type: none"> <li>• <i>Streamlines referral processes</i></li> </ul>	<p>*I use HealthPathways all the time...I think there's a huge role for HealthPathways for everyone, junior and senior. Just so that you know what's out and available, and for clinical care, making decisions (GP7 Round 2)</p> <p>*Quite good, it's helped, it is so helpful for some information we can gather (GP11 Round 2)</p> <p>* Improvement in my knowledge, especially through things like HealthPathways. So, not directly, but indirectly. I think that's been a big one. (GP2 Round 2)</p> <p>*It's a great website. Lots of information. (HS7 Round 1)</p> <p>*I think it's a great idea, I think there's a lot of good information there, and I think it's easy to navigate. I'm not that computer literate but I find it easy to navigate. (HN2 Round 1)</p> <p>*knowing which clinic to refer to and the most streamlined processes for those clinics have been useful...having HealthPathways where each department will set down what they would like for a referral, I think it helps a lot (GP2 Round 2)</p> <p>*It's pretty good; especially it has the current referral. Let's say I'm looking for an allied health in relation to podiatry it has a good list of the community available podiatrists... (PN6 Round 2)</p>
<p><b>Suggestions</b></p> <ul style="list-style-type: none"> <li>• <i>Localising</i></li> <li>• <i>Promotion</i></li> <li>• <i>Better if simplified</i></li> <li>• <i>A reminder to use it</i></li> <li>• <i>Should be expanded</i></li> </ul>	<p>* So there are really good HealthPathways for cardiology and now respiratory, but they need to be better integrated into the conversations between specialists and GPs. (HS8/MG8 Round 1)</p> <p>* we just need to get it localised as much as possible (GP2 Round 1)</p> <p>* I don't think enough GPs really know about it (GP2 Round 1)</p> <p>* what I'd find more useful is someone's list. Something simple. (GP1 Round 1)</p> <p>*maybe we need to have some sort of a reminder or something to use it more often. You don't sort of think about it, you don't use it. And when you don't use it you sort of become unfamiliar with that. (GP9 Round 2)</p> <p>*That's been really good. We'll want it to keep on growing, just to cover as much as possible. (GP2 Round 2)</p>
<h3>Support payments for GPs</h3>	
<p><b>Implementation / delivery</b></p> <ul style="list-style-type: none"> <li>• <i>One off payment</i></li> <li>• <i>Little disbursement to date</i></li> <li>• <i>GPs unclear of the nature of the payment</i></li> <li>• <i>Some compensation for the time required of a GP and practice staff</i></li> <li>• <i>Still not rewarding quality practice</i></li> </ul>	<p>*the payment is very small and it's a facility for change really, to say, if you invest a bit of time in this care plan we'll give you some money. And that's not sustainable, it's a one-off payment (MG2 Round 1)</p> <p>*There's very little that's been paid out so far. I think at the moment we've paid out something like \$5000 which is a pretty small amount across the practices. (MG5 Round 1)</p> <p>...someone said it's a one-off sign-on payment to the patient and I think that - from what I can vaguely remember I think it would be fine, whatever the amount, but there is that extra time you need for that patient. (GP6 Round 1)</p> <p>* I don't think it relates very well to how much time gets put in. (GP5 Round 2)</p> <p>*I know the practice gets something but we do so much more work-identifying and enrolling patients, preparing care plans follow ups and things like that (PN7 Round 2)</p> <p>*There is a fair bit of work setting everything up for integrated care and it sort of covers that but it doesn't cover all the other ongoing work (GP13 Round 2)</p>

	*it's still a one off payment. That's not a payment for overall care management or outcomes. So in some ways we're just duplicating a faulty funding system by offering a one off payment. (MG6 Round 1)
<b>Use</b> <ul style="list-style-type: none"><li>• <i>Conversation starter</i></li><li>• <i>Funds staff time for practice efficiencies</i></li></ul>	*it's prompted and it's driven some conversations. MG2 Round 1) *it's allowed us to spend more time getting our systems up to scratch in terms of patient records and care plans and setting up reminders for follow-up (GP14 Round 2)
<b>Experience (positive)</b> <ul style="list-style-type: none"><li>• <i>Spending more time with patients</i></li></ul>	*we have always tried to provide holistic care for our patients and much of what we do is bulk billed so having that payment has allowed the practice to keep me more in the integrated care role and following up patients which I enjoy (PN5 Round 2)
<b>Experience (negative)</b> <ul style="list-style-type: none"><li>• <i>GPs financially motivated</i></li></ul>	* we've had multiple GPs sending patients and they know the criteria, but they just want to enrol because it's incentivised. I've had a patient ring the GP and the patient goes, "No I don't want to be part of the program," and the GPs insisted "no you will". (CF2 Round 1)
<b>Satisfaction</b>	*I'm happy that they recognise the extra work this generates and that some payment is needed (GP6 Round 2)
<b>Perceived value</b> <ul style="list-style-type: none"><li>• <i>Does not cover work involved</i></li><li>• <i>Using other Medicare payments to cover costs</i></li><li>• <i>Not much of an incentive (token)</i></li><li>• <i>Helpful to cover additional time</i></li><li>• <i>Not a driving factor for some GPs</i></li><li>• <i>Creates greater collaboration between practice staff</i></li></ul>	*if you just sit down and see how much work is involved, it's not enough to do it. And if I've got to take time - my extra staff to start calling patients, that's extra. (GP1 Round 1) * I don't think sometimes that's good enough for GPs, they would like more or would expect more for their time (CF3 Round 2) *it's \$75 twice a year ...so I thought, ok let's set it up ...Now...I'm going to have to go through and check on these care plans every time, and if the doctors do the same thing, I'm not so sure now (PN7 Round 2) *Is it adequate for us? Not from Doctor's point of view, we could do a GP management plan, which generates \$140 in how many minutes and what I'm trying to do is run off my integrated care program off the back of my GP management plans (PN5 Round 2) * They're a token, they're something but they're not sufficient to really be an incentive. They're a recognition of the work involved but not an adequate recompense in the sense. (MG3 Round 1) *I'm not really sure they're much of an incentive. They're not much. I think it's like \$100, \$150 per patient, per integrated care patient per year ...A bit of a token. (GP5 Round 1) * Well look, anything would help, particularly if our nurses, in the future, will be spending time doing it, and updating patients' care plans and reviewing them. (GP12 Round 2) *I think it's an adequate payment, yeah. (GP14 Round 2) *quite often I do the Linked-EHR care plan after the patient's gone and – not necessarily on the same day. So that's still taking some time. So you kind of need to compensate the practice for that. But I do think the payments are adequate (PN4 Round 2) *I get paid for work done, so yeah, I think that's important (GP2 Round 2) * I received some payment, the practice will be given some portion of that for the patients I enrol. Yeah, I mean trying to, sort of, be a payment but – yeah. It's not a driving - that payment is really not a driving factor for enrolment for me (GP2 Round 1) * ...incentives for the GPs they can then sit down with the practising nurse and then they can read through the Linked-EHR ... It's

	an incentive for the doctors putting extra time for their patients (CF4 Round 2)
Suggestions	* The one off is fine for getting things up and running but it's the ongoing and follow-up that takes time which we need to cover-perhaps something related to that could be arranged for those patients that need more work (GP10 Round 2)
<b>Patient Centred Medical Home (PCMH)</b>	
Implementation / delivery	<ul style="list-style-type: none"> <li>• <i>PHN initiative</i></li> <li>• <i>Alignment of LHD and PHN</i></li> <li>• <i>Registrar teaching re PCMH</i></li> <li>• <i>Awareness building</i></li> <li>• <i>Similarity with Integrated care will assist PCMH transition</i></li> <li>• <i>Funding seen as a barrier</i></li> </ul> <p>* The LHD's involvement in that is much more peripheral...it is being completely driven by the PHN. (MG3 Round 1)    *the LHD is aligned with the idea that the general practitioner is the patient's medical home and that's where the complete data should reside and that's where the care planning should primarily be done and that the role of the specialist and others, is to support the patient and the GP in the community (MG3 Round 2)    * it fits with the whole concept of having everybody that cares for a patient all on the same page...for a subset of my patients, it definitely aligns well with the PCMH models where having a care plan which is viewable by everyone is great... (GP2 Round 2)    * I'm a registrar so we did get a bit of teaching through WentWest about that and had a few discussions with some other colleagues about the patient centred medical home. (GP4 Round 1)    *And they hear health care home and they hear the things in the media, and stuff like that. So it's not new anymore. People have heard of it. (HN4 Round 2)    * The doctors are already aware of integrated care/patients at a medical home, so you incorporate very similar themes. It's helped bring people on board quicker because they're already aware of what it's all about. (GP5 Round 2)    *.. quite a few practices...are going to be working with the patient centred medical home model...most of the practices that are transitioning are the ones that have been working well with integrative care (CF3 Round 2)    * We have been thinking about heading that way in terms of the patient centred medical home. What has the Integrated Care program done to facilitate that? I guess in a way it has helped us with that thinking or with that mentality of looking at patients in a more holistic kind of approach (GP4 Round 2)    * this practice is really working towards that so we have kind of got that team based approach (GP6 Round 2)    * I was enrolling patients and empanelling them for different doctors. That's been a good move from the Integrated Care Program, which is helped with PCMH model overall as well (GP2 Round 2)    * There's not enough funding there. And it's too restricted to just a certain cohort of patients. So we are just pressing on with developing a PCMH-style practice, with the current funding model, and just figuring out how to best use what we have, so that we can fund that style of care. (GP7 Round 2)</p>
Use	*
Experience (positive)	*
Experience (negative)	*
Satisfaction	*
Perceived value	* I liked the idea, yeah, but I'm not sure yet until we get everything in place that it has been achieved, but yes, it certainly is an

<ul style="list-style-type: none"> <li>• <i>Aspirational</i></li> <li>• <i>PCMH sign of innovation</i></li> <li>• <i>Multidisciplinary</i></li> <li>• <i>Holistic care</i></li> <li>• <i>Patientcare in the community and hospital avoidance</i></li> <li>• <i>Reduces risk of adverse events related to multiple independent providers</i></li> </ul>	<p>excellent goal, yeah. (HN4 Round 1)</p> <p>*I think the patient centred medical home ... was a significant influence on the demonstrator and us getting the demonstrator ... already ahead of the game moving towards the patient centred medical home (MG6 Round 2)</p> <p>*a good idea because in a sense that's also somewhat kind of like a multidisciplinary approach, that they see the nurse, they see other people before they see the doctor and it's everything kind of based around, holistic care for the patient. (GP4 Round 1)</p> <p>* it really helps to optimise the patient care and share the care around allied health and the team members, and it helps for the patients to understand that they have got a team around them and not just one individual provider (GP6 Round 2)</p> <p>* the concept is about providing as much care as you can for the patient and the community. So it's not about the home, it's about the community, how you'll use the community to manage the patient so that they don't need to go to hospital. (MG2 Round 1)</p> <p>* I think one of the really big challenges in general practice is people going into multiple practitioners and having lots of things done and I think having a service where patients get their health care and we remove that risk of drug interactions, of different treatments ... (MG5 Round 1)</p>
<p><b>Suggestions</b></p> <ul style="list-style-type: none"> <li>• <i>Integrate hospital specialists with community</i></li> <li>• <i>Funding essential</i></li> </ul>	<p>* it's about managing the patient with what's available in the community. But with truly integrated care then, yes, there is a role somewhere in the future to have the specialists out in the community, be it through technology like case conference and virtually through Skype or whatever. (MG2 Round 1)</p> <p>... it just needs to be properly funded so people can put the proper resources into it. (MG5 Round1)</p> <p>* you can see that same attitude coming through with the health care home stuff from the Commonwealth. They're talking about shifting from volume to value, but really what they've done is to offer greater flexibility in utilising exactly the same number of dollars, which is hardly a big incentive (MG3 Round 2)</p>

## Communication with other (Non-WSICP) Services

<p><b>Implementation / delivery</b></p> <ul style="list-style-type: none"> <li>• <i>Accessing existing contacts and networks</i></li> <li>• <i>Linking into external services including non-health services</i></li> <li>• <i>Limited integration and co-location with community sector</i></li> </ul>	<p>*Outside, community nursing, I worked hard when I first took on this role so we had a good foot in the door with them as well so integrated care could link in with that, and they are aware of integrated care...(HN4 Round 1)</p> <p>* getting quite a good communication going between the community nurses and the heart failure service, so that's continuing... (HN4 Round 2)</p> <p>*so now all referrals to My Aged Care, so, for home mods, equipment, any community services such as podiatry, or showering assistance, or nursing care, or anything, has to go through My Aged Care (AH4 Round 1)</p> <p>* Now that we've got My Aged Care, if they're over 65 it's a different form to refer (CF3 Round 1)</p> <p>* we've linked up GPs with their optometrists and we're actually standardising the referral from a GP to a preferred optometrist and then getting information from the optometrist back to the GP and anyone identified with diabetic eye disease goes to the secondary centre and can get rapidly triaged into the hospital (HS8/MG8 Round1)</p> <p>*doing a bit of that work in diabetes, it's about urban design, transport, food supply and physical activity (HS8/MG8 Round 1)</p>
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<p><b>Use</b></p> <ul style="list-style-type: none"> <li>• <i>Growing relationships with private providers</i></li> <li>• <i>Building multidisciplinary expertise in general practices</i></li> <li>• <i>Connections with other Government and NGO organisations</i></li> <li>• <i>WSICP facilitates awareness of non-WSICP providers</i></li> <li>• <i>Referrals are still mostly internal</i></li> </ul>	<p>*we've got linked in with a private heart scan at Merrylands which has got a really good scanner for coronary CT angiograms. ... we have a really good relationship there as well (HN2 Round 1)</p> <p>*... I've been in contact with community dieticians that I haven't been in contact with before and I think that will have benefits in both of my roles. (AH6 Round 1)</p> <p>*In terms of the other community OTs that you are referring to, or trying to get that information from, I find that allied health are pretty good. You – like, if I call they may get back to you later in the day (AH4 Round 1)</p> <p>* generally it would be the community OTs or the PACC OTs or the OTs that work with the home mod service that's really good it just takes a phone call if you're not sure what to do and that's all really quite easy (AH4 Round 2)</p> <p>*We're starting to use a pharmacist in our practice... would be so helpful ... because the pharmacists have so much knowledge that they could be helping us with and saving us problems and preventing medical issues occurring (GP5 Round 1)</p> <p>* I think not just verbal but written down....My Aged Care. They leave a folder there, all the PACC service leave a folder... and you can look up their care support person, or whatever, and then you can ring them (AH4 Round 1)</p> <p>*Some of the Community Services – we do interact with things like PACC Services and sort of all those existing ones that we've been involved with, but sometimes patients already have some links to community services where we can just let them know that the patient's going back (HS1/MG7 Round 1)</p> <p>* the main ones I talk to are community health, mainly OTs, Home Modification Service, My Aged Care, Meals on Wheels sometimes, and all of those community agencies, and I think, communication wise, they're very good, but if you actually go through the central system, like My Aged Care is still breaking down a tad. (AH4 Round 1)</p> <p>* Other people at the Mt Druitt Community Health, not with integrated care, but the child family nurse, and they get back you by phone and in writing usually, which is really good, so you get the verbal and you can talk to them in person as well (GP6 Round 2)</p> <p>* we do use Connecting Care is another one (AH1 Round 2)</p> <p>*I have come to know more health care providers through the program. Prior to the program I never bothered to know the community nurses as much. I do refer to them, but won't have taken an extra interest in them. (HN3 Round 1)</p> <p>* I've communicated a lot with the podiatrists, because I've been searching some of the really good ones (PN6 Round 2)</p> <p>*fair comment to say is that I haven't been involved in a lot of the processes outside the hospital, and, I think, because we're getting such great links with our in-hospital connections, if I've got a problem, I tend to go to my in-hospital link, because it's easy... (AH3 Round 1)</p>
<p><b>Experience (positive)</b></p> <ul style="list-style-type: none"> <li>• <i>Allied health services accessed for home modifications</i></li> </ul>	<p>*The hospital organised things like rails for the shower and front steps and connected us with home care to help me with cleaning—that happened really quickly and I feel [husband] is much safer now. (PC22 Round 2)</p> <p>*My doctor organised a community nurse who calls in regularly—because I can't get out easily with my COPD—she checks up on me and lets me know about things I can do and who to contact for transport and things like that—she always spends time with me (PC2 Round 2)</p> <p>*we've had patients that have needed assistance from the Health One team as well, so the integrated care coordinators have</p>

	been able to bring that in and get that liaising as well, so it's all kind of streamlined in kind of one place, so that's been really good (GP6 Round 2)
<b>Experience (negative)</b> <ul style="list-style-type: none"> <li>• <i>Greater community integration needed</i></li> <li>• <i>Feedback from external providers can be slow</i></li> <li>• <i>Communication not well connected across all providers</i></li> </ul>	<p>*You would have positions that have a component which is working in a community hub, community practice or both, that needs to be built into the system at this stage and absolutely isn't (MG3 Round 1)</p> <p>*I'm aware of things like PACC, and My Aged Care and various places... but in terms of getting feedback from them and knowing what's happened to my patients between when I last saw them and when I next saw them, I don't tend to get a good sense of that, I just feel like the communication is pretty messy (AH6 Round 1)</p> <p>*Other allied health that are in the community, always a little bit more tricky, but when you are kind of waiting for that letter to come back to find out what's happened or things are a bit slow (CF2 Round 2)</p> <p>*We send all the information through with a referral... doesn't seem to be getting to the home mods service. ..it just lengthens the process of – before the person can get the rails... (AH4 Round 1)</p> <p>*the problem is that while we've got good systems in place, so primary healthcare, the specialist healthcare, a lot of patient and community systems, they don't talk to each other and they don't have good forms of communication or referral in and out. (HS3 Round 1)</p>
<b>Satisfaction</b> <ul style="list-style-type: none"> <li>• <i>Collaboration with other hospitals</i></li> </ul>	<p>* I try to have some connection with Concord as well. But it's good to collaborate with each place see what we're doing, get ideas from each other (HS7 Round 1)</p>
<b>Perceived value</b> <ul style="list-style-type: none"> <li>• <i>Engagement with community benefits WSICP roles</i></li> <li>• <i>Time to build awareness of other services</i></li> <li>• <i>Some services do not have capacity</i></li> </ul>	<p>*Yeah, look, I've been in contact with community dieticians that I haven't been in contact with before and I think that will have benefits in both of my roles [dietician and educator]. (AH6 Round 1)</p> <p>*we deal with Heartscan at Merrylands and they're fantastic , and there's an agreement there with Medicare so the patient doesn't pay (HN2 Round 2)</p> <p>*Just having the time to spend on making some phone calls, talking to some dieticians in private practice in the area, looking at community services and how the referral systems work has given me a better understanding of what's out there (AH6 Round 1)</p> <p>*I'm more aware they're out there. That's probably the thing I'm aware what the services that are available out there for the patients with different things (PN2 Round 1)</p> <p>* NDIS is a mess, a big mess, and, it's that – I suppose it's just been rolled out so it will get better but there's a huge time delay with people being able to be assessed (CF2 Round 2)</p>
<b>Suggestions</b> <ul style="list-style-type: none"> <li>• <i>Prevent fragmented care</i></li> <li>• <i>Share information</i></li> </ul>	<p>*we've decided to give our patients the little card that says they come to us, and if they come to a different practice, could you please send a copy of any results, or a copy of your medical notes, so we can follow on their care. I don't know if that will work or not, but it's that fragmentation you need to address (GP7 Round 2)</p> <p>* just in terms of whether it's in the community or whether its, home mods or whatever , or someone working in one of the respiratory clinics it would be good if we could all get the same information (AH4 Round 2)</p>

## Appendix B.

### WSICP Thematic Analysis with illustrative quotations

The following analysis of the interview data is structured within three main categories of: Set Up/Operationalising; Challenges; and Value Add. The key themes corresponding to these categories are provided in the table below. In the analysis, each of these key themes is further elaborated by subthemes which are then described and illustrated by selected quotes.

Set /Up Operationalising	Challenges	Value Add
Managing WSICP	Interorganisational Challenges	Building Capacity , Education and Upskilling
Promotion and initiation	Challenges with Roles and Responsibilities	Changes in Practice
Access to WSICP	Scale of the Undertaking	Valuing WSICP
Understanding Integrated Care		Suggestions
Unrelated Activities/Programs/Processes		

All participants' voices have been presented in the analysis. Colour coding is provided to identify the stakeholder group and type of participant within the group. The following key provides relevant colour codes and the participant acronyms.

#### Participant Key:

MG (Management Group); HS (Hospital Specialist); HN (Hospital Nurse); AH (Allied health); GP (General Practitioner); PN (Practice Nurse); CF (Care Facilitator); PC (Patient/Carer).

\*Black font indicates first round interview (noted as Round 1)

\*Blue font indicates second round interview of first participant (noted as Round 2).

\*Purple font indicates new second round participant (noted as Round 2)

## Set up / Operationalising

### *Management of WSICP*

<b>Effort</b> <ul style="list-style-type: none"> <li>• <i>WSICP has created extra work in General practices and hospitals</i></li> <li>• <i>Time taken in development of program including for meetings and afterhours</i></li> </ul>	<p>* in terms of the online care plan, it's created extra work for us (GP1 Round 1)</p> <p>* Had lots of meetings and a lot of doctors still aren't that keen because of the work involved but we're getting there (GP5 Round 1)</p> <p>*It's more busy I guess but I'm still adjusting in working around things and I can still do my other jobs (PN1 Round 1)</p> <p>*we have had a lot of input for it and not seen many patients actually enrol, so there has been a lot of time and money spent on introducing this for our practice...it's also been very difficult for us nurses, to be honest, putting it into place at a systems level because the admin it's so all over the place at the moment (PN3 Round 1)</p> <p>*it was a long process getting those patients involved. It involved the whole practice, with reception staff, nursing staff, nurses and the GPs, and even also the care facilitator. (GP5 Round 2)</p> <p>*The engagement enrolment strategy is tedious and consuming of efforts and time and – hard to know how much that has really helped the general practice. (MG4 Round 2)</p> <p>*It is affecting the workflow because we have not got the time to sit down and physically go through all that information... we're reviewing these plans normally anyway for the patient but we've got to do it in two places at once and time doesn't allow that. (PN5 Round 2)</p> <p>*It is hard for – let's say we've got 12 patients booked in, because the consults I do I can see three or four patients, but the doctors might want me to see all the patients and it's just not possible (AH2 Round 1)</p> <p>* I'm working on it three days a week and there's an enormous amount of work to do (MG5 Round 1).</p> <p>* that's been quite stressful because they don't give you additional – it's a set up approach. They have given us money to start, but before that, it's a lot of hours put in of our own time and private time too to get this up and running (HS11 Round 1)</p> <p>* I've attended so many meetings about this whole program over the time (HS1 Round 1)</p>
<b>Bureaucratic delays</b> <ul style="list-style-type: none"> <li>• <i>Lengthy bureaucratic process as part of large organisations</i></li> </ul>	<p>*I mean, we took about six/seven months to plan and then there were delays within the LHD because the LHD is a cumbersome beast and so positions need to be created, they needed to be created, they needed to be signed off and then we needed to go through a financial process. There's a huge amount of bureaucracy which is a massive bugbear coming from an NGO environment where it was a big organisation but nowhere near as bureaucratic (MG2 Round 1).</p> <p>*hospital processes have held up the Integrated Care Program a lot, which I think has been frustrating, but that has slowed things down a lot even though integrated care was quite committed the hospital wasn't yet, really together (HS1 Round 1)</p> <p>* anything you put a job in for, if it's anything that writing a [IT] program – I don't know how to write a program so maybe there's quite a bit involved, but it just seems to take so long to get anything done (HN2 Round 1)</p>

<b>Funding allocation</b> <ul style="list-style-type: none"> <li><i>Requests for more discretion in allocation of funding</i></li> <li><i>Unequal funding distribution across sites</i></li> </ul>	<p>* I don't manage the financial end of anything, I don't have much understanding of it but for departments to have more scope at grassroots level to decide where money is better spent, I think, is better than having people way up in higher levels of management deciding where money is spent - - - and a little bit more scope to say, okay, "Well, thank you very much for the funding but we don't actually want it right here, we want it over here, and we don't want it for two years, we want it for a bit longer because two years isn't enough [laughs] to get it off the ground (AH6 Round 1).</p> <p>* Respiratory were saying maybe we could come out and show you how to do spirometry. So and I think actually respiratory said that there's not enough money to do that and it's an expensive thing but anyway. So if more money can go into that, that would be good. (GP5 Round 1)</p> <p>*we don't have a dietician with us, it's a really important part of the program, but funding is a limitation. One of the podiatrists is funded through Integrated Care – one and a half. (HS5 Round 2)</p> <p>* Certainly the money that was given to Blacktown Hospital is half of what was given to Westmead Integrated Care (HS11 Round 1)</p>
<b>Policies, procedures, management unclear/ changing</b> <ul style="list-style-type: none"> <li><i>Hospital staff unsure of referral procedures</i></li> <li><i>GPs unsure of referral</i></li> <li><i>No set guidelines or criteria - leading to changes along the way</i></li> <li><i>Guidelines still not clear by Round 2</i></li> <li><i>Program outcomes unclear</i></li> <li><i>Instability of senior staff engagement impacts program direction</i></li> </ul>	<p>* I received an email saying, "When you see a patient on the ward that needs outpatient dietetic services and has diabetes, if they've got a green referral card they can go through integrated care, if they don't have a green referral care card they go through the usual channels". And I said to my colleagues, "I haven't seen one of these green referral cards. Has anyone seen a green referral card?" and they've just gone, "I don't know, I haven't come across it" (AH6 Round 1).</p> <p>*I was ringing up about an ischemic heart disease patient and Blacktown weren't set up to manage that there, they said Westmead's team is but Blacktown's wasn't, so they just advised to send the patient into the ED rather than use Rapid Access which is fair enough. But it seems like there was still some differences between what the two hospitals do (GP6 Round 2)</p> <p>*things are changing – so criteria, information and guidelines for the actual clinic are still starting to come out, so everything's not set in stone, everything's not so much finalised yet. So there's still areas that are changing, so I suppose you're adapting as you go along (HN2 Round 1)</p> <p>*a discharge guideline has been put out in terms of discharging patients off the program, and that's been a little contentious; I think practices are unaware or they may not be following the process correctly, but there's been some dispute over the process and what needs to be done. So that needs clarification (CF2 Round 2)</p> <p>*a very big issue – is that no one is clear on what the outcomes of the program should be, or what we should be showing to show it works. From the top down nobody thinks of a clear idea and what benefit we should be showing or where we should be aiming this at to show a benefit by February 2017 (HS11 Round 1)</p> <p>*there's been a bit of a lack in continuity with the senior management, and there have been a few people who have come and gone, so I'm engaging with some people who are extremely good, but now they've left, I don't know where this actually leaves us (HS5 Round1)</p>
<b>Evaluation and Quality improvement</b> <ul style="list-style-type: none"> <li><i>Active research and evaluation</i></li> </ul>	<p>* Pretty good, actually, because you get to see what each speciality is doing and how many patients we've actually enrolled into the program, whether we will get more GPs and things like that, looking at data to see if we're actually making a</p>

<p><i>across the WSICP</i></p> <ul style="list-style-type: none"> <li>• <i>Particular areas identified for evaluation e.g. no shows and discharge to GP</i></li> <li>• <i>Evaluation considered central in providing care and needs to be embedded in systems improvement processes</i></li> <li>• <i>Concerns re narrow focus on integration and lack of access to some data</i></li> <li>• <i>Learning from evaluation leads to ongoing program development</i></li> </ul>	<p>difference (HN3 Round 1).</p> <p>*they've done it about three or four times now - where they go in and they do a bit of a quality audit to work out what's actually happening behind that referral and whether they're adhering to the program elements (MG6 Round 2)</p> <p>*I'd like to say, yes, I think, it has been worth it, but I can't answer scientifically until I have that data...and I've been working to accrue that (HS5 Round 1)</p> <p>*I did institute a survey of GPs about what their educational needs are around COPD and then it went broader to diabetes and cardiology, and that's been really revealing. And I need to start to implement what the GPs told me their educational needs were but I don't know how to do it. (HS2/MG9 Round 1)</p> <p>*identifying the reasons for no shows could be useful. We often feel it's a shame when people don't come here, because we offer such a good service – they're missing out. (HS4 Round 1)</p> <p>*one of the purposes is to try and see whether we're able to – we haven't evaluated yet, but I suspect that we're discharging many more people back to the GP than probably what was happening in the past, so, that's some of the stuff we're trying to look at, so that we have some objective information as well (HS3 Round 2)</p> <p>*We have got stats on it - they're substantial, in cost savings and I can't remember the amount of days, in-hospital days saved. (HN2 Round 1)</p> <p>*There's absolutely no evaluation of what is going on in the community, so what services are being used. Whether cross-sector supports are being brought into play, even allied health, it's just a non-event. There's an undue focus at the RASS end, and a complete neglect of community end; I think that needs to be fixed (MG3 Round 2)</p> <p>*They've been collecting data for a while, we really questioned the type of data that they're actually obtaining...around 30 face-to-face encounters with patients over the month yet very few are captured because they're just looking at the integrated care, they're not looking at all of our productivity (HN5 Round 1)</p> <p>*I don't know. I mean, how do you audit the pathway? I mean, we hope the GPs use it, but there's no way for us to know if they're using it or whether the use of it has improved the health of patients (HS11 Round 1)</p> <p>* It needs to be thought of as part of our regular care, not as research-- it's not research. I mean, it's monitoring which is crucial, because, I mean, we do things like M&amp;N meetings and they're relatively all systematic and we need systematic ways (HS1 Round 1).</p> <p>* Oh, evaluating this program, taking the good things from it, understanding where it's not delivering us any benefits and modifying it over time I think is the only way to go. You can't go back to square one and start again, we've got people engaged, we've got processes running, we've got to take the bits that work. That's what pilots are all about (MG4 Round 1).</p> <p>*We're getting - actually we are documenting and evaluating as we go along and publishing.(HS8/MG8 Round 1)</p>
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<i>Promotion/ Initiation</i>	
<b>Initiation and set up</b> <ul style="list-style-type: none"> <li>• Partnership and linking different organisational cultures was foundational to WSICP</li> <li>• Program implemented before design/resources ready to go</li> <li>• WSICP not effectively communicated to GPs</li> <li>• PHN supports GP implementation</li> <li>• Patient unsure of program status</li> <li>• Referrals increasing</li> </ul>	<p>*Initially we were a partnership, so - trying to bring two cultures together WentWest and the LHD. So there was some work to be done to bring – so that partnership had existed for a long time. The demonstrator was the first real opportunity to put that to test in terms of “let’s get something off the ground as a joint – as a partnership and let’s work on it and let’s build it, let’s implement it”. So we brought two teams together from different cultures and that team had to become quite cohesive and work well together actually. That was a very early kind of challenge that required some attention (MG2 Round 1).</p> <p>* A lot of redesign work that is happening at the moment I think should have been done way before the Integrated Care Program was actually implemented or done because I don’t think GPs like change all the time (CF3 Round 1),</p> <p>*I would have thought that the step of communicating with the practices, to have been worked out from the beginning. It seems like it’s not and that surprised me a bit because that’s the whole point of this, to share the information (PN7 Round 2)</p> <p>*they just told me, “Go and do this integrated care program.” And I mean [CF] and [CF] come out and talk to me, but at the moment because it’s still not up and running because we can’t give out care plans or anything like that we’re not really doing anything (PN2 Round 1)</p> <p>*real understanding, and it’s very variable from one GP to the next, I don’t think the GPs fully understand the integrated care program or what it is or what they’re actually getting their patients to sign up for and I think they have different ideas. I think there is a real communication gap (HS8/MG7 Round 1)</p> <p>*it’s lack of awareness in our area. Yeah, lack of awareness that they’ve got that service that they actually can use. Not to say that we haven’t had GP’s ring up, we have, but it’s few and far between (HN2 Round 2)</p> <p>*[...] from WentWest has been good too, she’ll come out or answer phones, send emails, she’s very good with communication in that sense of coming out. The support’s been great from them (PN3 Round 1)</p> <p>*because the program’s really started and they haven’t actually done anything with it. Well, funny enough, I mentioned it to [CF], she just rang me an hour ago, because I’ve got an appointment at the cardiac clinic tomorrow morning – glad she rang because I forgot about it. Maybe that’s a sign it’s working [laughs] (PC4 Round 1)</p> <p>*to start with what was the actual number of patients - we didn’t really have much of a referral basis to start with, but as I’ve gone along, there’s been more and more referrals coming through (HS5 Round 1)</p> <p>*There are more GPs referring their patients to our care. A lot more patients are being referred to our service (HN6 Round 2)</p>
<b>Marketing and providing information</b> <ul style="list-style-type: none"> <li>• Challenges in promoting the program particularly to GPs and patients and also time taken in the hospital setting to promote</li> </ul>	<p>*That’s going to get the message out about the value of the service by that sort of stuff, but that takes time (HN4 Round 1)</p> <p>*I think if you ask anybody in the cardiology department, they would know about the initiative now, and we’ve got a huge department as you know (HS1 Round 1)</p> <p>* The Breathlessness Clinic [laughs]. Yeah. I don’t think there’s that much available from my understanding. I’m only here for a short time but certainly – my three patients, certainly have said that primary rehab is really the – the main thing they’ve</p>

<ul style="list-style-type: none"> <li>• Hospital staff promoting WSICP to GPs and Patients including those who may not have enrolled GP</li> <li>• GPs rely on their staff and PHN for program knowledge and help</li> <li>• Uptake improving in response to promotion</li> <li>• Patients also learning of WSICP from GP and enrolling in program</li> <li>• Limited promotion to Emergency and other staff also unaware of program</li> </ul>	<p>received in a very long time, and the GP, they don't even know about it (AH5 Round 1).</p> <p>* we had such a pool of heart failure patients and I'm trying to speak to everyone and talk to them about ICP. Now, that doesn't always happen so, if I've got a long list of people to see I may not have that time to go through ICP with them so some of them are being missed and sometimes other staff are not as motivated to talk about ICP with them (HN5 Round 1)</p> <p>* getting the word out there that it's a new program, getting people to understand the program, understand the referral criteria, and actually receiving those referrals has been quite challenging (AH3 Round 1).</p> <p>*I have personally done a lot of talks to the Blacktown area GPs. A lunch time session - talking to them, introducing the Integrated Care Program (HS7 Round 2)</p> <p>*we always write a letter back to the actual GP, even if they're not referred by the GP, just to say that we've seen your patient and we're here, and at least we think that in their mind it helps them to actually be aware of us (HS5 Round 1)</p> <p>* we do mention it to some patients. But we are a bit hesitant about that, because we don't want to set up a scenario where they might go to another GP for that reason (HS5 Round 2)</p> <p>*we've done a lot of things to improve enrolment. We write a one liner at the end of every letter saying that they're suitable for integrated care and the GP support hotline and the details are on the HealthPathways, so, that's one form of advertising, and then we flag the patient and that list is given to Wentwest so that they can look at which GPs are involved with those patients and target those Practices for recruitment.(HS3 Round 2)</p> <p>*the nurse within my practice is certainly helpful, if I lack time, then I can pass on the communication barriers for me, I'm lucky that I have a nurse. There is also a WentWest facilitator that comes to help us and educate me, or inform me of what I should know about this program. (GP8 Round 2)</p> <p>*It's starting to pick up now so we're starting to gain more patients, and I think that's just through advertising the actual role and trying to get the information out there (HN2 Round 1)</p> <p>*[HN] at the clinic told me about it. She said, "Interested in going on it?" I said, "Yes." Plus, I thought it would be good – I've been there a couple of times when I was in and out of ambos and hospitals (PC4 Round 1)</p> <p>*they [GP] put Mum onto the integrated care system. Prior to that we weren't aware of such facilities available for patients, really (PC17 Round 2)</p> <p>* it comes up on their record that this patient would be suitable for the integrated care program. I just have to give them a two minute talk, explain what the situation is. And everyone I've spoken to has agreed to now be part of it (GP9 Round 2)</p> <p>*Certainly I promoted it quite heavily within the department in respiratory medicine, so I think we're doing quite a bit and don't really know if we will continue to do so in terms of advertising the program. But emergency is another area where I think more engagement from them would be good (HS11 Round 1)</p> <p>*I still feel that doctors in the hospital aren't as well aware of the program requirements...that was probably one of the reasons where we did have difficulty getting in touch with one of the doctors at the clinic... I'm not too sure whether the other doctors in the hospital are as well educated about clinic access and things (GP4 Round 2)</p>
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<b>Orientation</b> <ul style="list-style-type: none"> <li><i>Workshops focus on referral</i></li> <li><i>GPs need assistance to use PenCAT effectively</i></li> <li><i>Limited information for staff at recruitment stage</i></li> <li><i>Compared to initial CFs, new CFs receive full orientation and mentoring</i></li> </ul>	<p>* I think for Westmead I'd have to say the collaboration is very good because we've started doing some workshops on how to refer patients to the integrated care pathway (CF2 round 1)</p> <p>* we weren't quite sure how to use PenCAT I think in fact it wasn't even working properly on our system and on our data (GP5 Round 1)</p> <p>* There was minimal information, so when I applied for the job, I was just trying to research what Integrated Care was. I found that quite difficult. There was minimal information on the website, as in the health website, New South Wales Health (HN2 Round 1)</p> <p>* new care facilitators coming on board have a different route to orientation to the way I was brought in, quite more substantial orientation than I received 12 months ago (CF2 Round 2)</p> <p>* I had a full orientation – had to go to different community services...followed that up with another care facilitator who actually mentored me through the process of how to do things – we had a schedule orientation for more than a month for the program (CF4 round 2)</p>
<b>Time required</b> <ul style="list-style-type: none"> <li><i>Takes time to set up program and streamline practices</i></li> <li><i>Takes time to recruit GP practices</i></li> <li><i>Hospital staff note quality of work due to WSICP but also that it is time consuming</i></li> </ul>	<p>* I think that there's been a lot of people that have also individually felt that they've spent a lot of time (HS1 Round 1)</p> <p>* because it was a new system, where we were having to do everything electronically and there was a lot of glitches in streamlining it and, you know, things like that we didn't have the letters up and running yet. So that was a time – that was ending up costing us a lot more time and a barrier in terms of how many people we could see (HS3 round 1).</p> <p>* It just takes time, I think. And, so, it takes time for the PHN to recruit enough GPs, such that the majority of patients that come to us can be sent back to an integrated GP. We don't have enough of them out there to send back to (MG1 Round 1)</p> <p>* we're trying to do some really good work and some really important work and I'm really proud of the work we're doing but it all takes time (HS2/MG9 Round 1)</p>
<b>Access to WSICP</b>	
<b>Eligibility</b> <ul style="list-style-type: none"> <li><i>Mental illness excludes</i></li> <li><i>Cancer excludes</i></li> <li><i>Only CCF included not chest pain</i></li> <li><i>Dialysis excludes</i></li> <li><i>Out of area excludes</i></li> <li><i>Wider inclusionary criteria allows greater access</i></li> <li><i>Patients discharged from program if inactive status</i></li> </ul>	<p>* if there's just a depression or anxiety or something as part of it then that's fine that they can be included but I think if they're developing – say if they're in mild stages of dementia but they're not that bad I think they're excluded (GP5 Round 1)</p> <p>* patient has diabetes but is diagnosed with cancer then they can't really be involved in integrated programs (PN1 Round 2)</p> <p>* I've got patients who have diabetes and a heart problem as well but the patient was not inclusion, because the patient had non-Hodgkin's lymphoma (GP13 Round 2)</p> <p>* if the GP is seeing a patient with chest pain, more often than not, they would send to the emergency department (HS6 Round 2)</p> <p>* patients with type 2 diabetes but they are on the dialysis - an exclusion criteria so they're not getting to the program but I thought these other patients who have got more complex medical problems, they should be probably better cared for during integrated care program (GP13 Round 2)</p>

	<ul style="list-style-type: none"> <li>* Oh, one of the GPs who's actually been involved with the project, has got a patient who lives outside the area and therefore can't be registered. Is that acting bonkers or what? So I'm taking the straightjackets off (MG4 Round 1)</li> <li>* It's quite helpful that there is a clinical metrics inclusion criterion as well. The majority of our patients who would benefit from the program are able to get in in that sense (GP4 Round 2)</li> <li>* we had some issues with patients we had enrolled that were then unenrolled from the program, because they weren't active in the program, which I think is a shame because those patients still would have benefitted from being in the program even though they may not necessarily been very active (GP2 Round 2)</li> <li>* If you send through a patient, and the patient is uncontactable after four or five times, there's only so much that the care facilitator can do. That person needs to be off the program, it's a waste of resources (CF2 Round 2)</li> </ul>
<b>Delayed GP enrolment</b> <ul style="list-style-type: none"> <li>• <i>Concerns of not effectively engaging with GPs</i></li> <li>• <i>Perception re selection of GPs for the program as a problem</i></li> <li>• <i>Patients missing out due to slow GP enrolment</i></li> <li>• <i>GPs too busy and forget to enrol patients, or cannot spend enough time</i></li> <li>• <i>Most referrals from Inpatients</i></li> <li>• <i>Enrolment not consistent across LHD</i></li> <li>• <i>Enrolling GPs still taking time</i></li> <li>• <i>Patients receive some IC services even if GP not enrolled</i></li> </ul>	<ul style="list-style-type: none"> <li>*I don't know if we've heard enough from the GPs to get them involved because certainly they're not signing up to the program now. I feel like we might not have done our homework correctly is my concern (HS1 Round 1)</li> <li>*it's more from the GPs engaging in the service. We've got a hotline we use. That's accessible from the GP's service through a mobile number that's on the website. I've only had less than five phone calls in the last six months through that hot line. So GPs are not engaging...the barrier is the uptake of the service by GPs at the moment (HS10 Round 1)</li> <li>*a lot of my patients are potential candidates for ICP but the practices are not engaged (HN5 Round 2)</li> <li>* we got 30 something patients in the program at the moment, but the doctor is not really focusing on Integrated Care and letting me know that these patients are eligible for it; a bit slack (PN2 Round 2)</li> <li>*They've got a selective criteria training for GP so maybe if we open it up to all the GPs maybe they will get used to it (AH1 Round 1)</li> <li>* There are people in the hospital setting who would be recruited but they don't have a regular GP or a GP that is involved in the program. So they're not being brought into the program, even though they're eligible. (MG3 Round 1)</li> <li>*I've been really busy and the sad thing was, there were so many patients that were coming through that would have been eligible for this. But just because it wasn't there in my mind I didn't think to recruit at that time. (GP9 Round 2)</li> <li>*I think they [GPs] just need more time with their patients really. Some of them are just rushing. (PN6 Round 2)</li> <li>*it's not having enough GPs at the start that have been enrolled in the actual program, so we were getting many of our referrals from inpatients (HS5 Round 1)</li> <li>*the phone is just not ringing and there is just – in my opinion, not enough GPs enrolled in this area. There's been some work to try and enrol GPs and there's a lot more GPs enrolled in Blacktown (HS2 MG9 Round 1)</li> <li>*It would be nice to think that we could get more GP input from a community standpoint, but I don't know how long that's going to take. I think it will happen but I just think it's going to be really long and slow. (HN2 Round 2)</li> <li>*In terms of enrolling patients it hasn't improved. Even if we don't enrol them in to integrated care, if they have a diagnosis of COPD we still see them (HN3 Round 2)</li> </ul>
<b>Patient language and other</b>	* There was one lady who was very claustrophobic and so she didn't want to go in the lift so this was – she was from

<p><b>difficulties</b></p> <ul style="list-style-type: none"> <li>• Need for individual strategies to address barriers</li> <li>• Challenges where English a second language</li> <li>• Preference for health care providers who speak their primary language</li> <li>• Too ill to attend hospital</li> <li>• Clinic difficult to find</li> <li>• Dietary (and SES) challenges for patients</li> <li>• Patient difficulty with appointment <i>and waiting times</i></li> <li>• Mail contact is inefficient</li> <li>• Patients too busy to attend</li> <li>• Financial concerns of patients <i>including losing their job</i></li> <li>• Patients not using IT</li> <li>• Some patients need greater home support</li> </ul>	<p>Breathlessness Clinic, which is another aspect of the program, but – yeah, so in the end we solved that problem by organising to see her down in pulmonary rehab that she could get to without going in the lift. (HS9 Round 1)</p> <p>*there's a bit of a delay with interpreters. Yes, we can get phone interpreters, but it is a lot better to have a physical interpreter in the consult room and you might wait longer depending on the language if it's very obscure (HN2 Round 2)</p> <p>* Some people would say that if anything, it's an opposite barrier because then we – people are more likely to refer them to our sort of stabilisation service because they can speak other languages. They'll go back to the regular specialist because specialists can't speak that language. It's harder for them to see their specialists in their community who can't get an interpreter necessarily, so then they get sent to us (HS1 Round 1)</p> <p>*it turned out because he'd spoken to us with an interpreter and he trusted us with the interpreter – he had no idea what we said and went back to his GP for more advice, and the advice was very contrary to the advice we had given him, so a difficult situation (HS5 Round 1)</p> <p>* So I often do have conflict with patients who really want their family to interpret and we're not allowed to go down that path (AH3 Round 1)</p> <p>*the majority of our patients are Filipino, so they prefer Filipino allied worker because they understood them more and they can speak in their first language, if they go to a dietician or a diabetes educator that is not Filipino, they can – language barrier can be a problem (PN1 Round 1)</p> <p>*Some of them I know feel that they're too sick to come, some of them it's too much effort to get back to the hospital, some of them forget, some of them misplace the timing and interpreters – ugh. (HS2 MG9 round 1)</p> <p>* most of them, not everyone can find the clinic even for new services, everyone gets told to go to the university clinic and to come down here for a few things – and if they have a wheelchair then that's another hurdle (AH1 Round 1)</p> <p>*...food and eating healthy... I think a lot of it's poor education as well, financial, like being from a lower SES background, not having the money to necessarily buy the things that – like fresh fruit and vegetables. (AH2 Round 1)</p> <p>*we've changed to walk-in appointments to try and get them in with the 24-48 hour, even five day...A couple of times people have been discharged at 2.00 or 3.00 and been told to turn up the next morning and they haven't...they're probably still in bed (HN2 Round 1)</p> <p>*I ask for a script he goes, no I want you to come up, you know, when he thinks it's time for me to come and get checked [COPD]. I feel he knows my anxiety about and that. His practice is so busy, I'm not sitting there for three hours, I can't. I get too worked up over it. (PC8 Round 2)</p> <p>*I have problems with the constant mailing, now that; one, the cost has gone up; two, it's not an everyday service; and a lot of our patients we found were not attending because they weren't getting their mail in sufficient time (HN5 Round 1)</p> <p>*I had a business going at the time, that's obviously gone now because of everything, but I just felt really crook at work, so I arranged to go and just drop in at lunchtime. Because it was my own business, I was a one-man band, so customer service morning and afternoon and everything.(PC4 Round 1)</p>
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	<p>*some people are really busy, they work Monday to Friday, and the GP is closed on the weekend so they can't come and see GPs. (CF4 Round 2)</p> <p>*Well, I'm on ten medications a day, or ten doses a day, something like that. It's a lot. I take three for emphysema and three for diabetes and one for the reflux and one for blood pressure, so that's ten. The costs of scripts are adding up a bit. (PC3 Round 2)</p> <p>*in Western Sydney it's probably the cost of medication and seeing specialists and things like that. Mostly general practice is bulk billed. They're able to see their GPs but it's - in an ideal world if we had a hospital clinic for every type of speciality it would help greatly. (GP12 Round 2)</p> <p>*I've had a couple under threat of being retrenched because of their leave that they're having to take to go and see doctors and to come to our clinic appointments (HN5 Round 2)</p> <p>*Mainly having patients that don't have any Internet or computers and things like that. There are still patients that aren't using technology very much so they're not going to be able to access the patient portal side of the care plan or anything like that (GP6 Round 1)</p> <p>* ...and he's alone... so organising meals on wheels is needed because he's not able to cook. And organising services like home care. (GP13 Round 2)</p>
<b>Patients refusing/ not valuing WSICP</b>	<ul style="list-style-type: none"> <li>• <i>Patients not prioritising health care and difficulty promoting to younger patients</i></li> <li>• <i>Difficulty getting to the hospital</i></li> <li>• <i>Difficulties communicating with the hospital</i></li> <li>• <i>Patients happy with current level of care</i></li> <li>• <i>Poor patient motivation</i></li> <li>• <i>Patients fear loss of independence from too much involvement</i></li> </ul> <p>* I think one of the challenges is probably trying to explain to patients and get them to, I guess, agree to being part of the integrated care program just in terms of the location that we're in sometimes with a bit of noncompliance and lack of, I guess, health awareness. So some patients may not necessarily be that keen. The ones that I've had so far have been okay (CF1 Round 1)</p> <p>*they feel like they're well, so they don't need that kind of support or prevention to further disease or complications, they're not acting – yeah, they don't care about their health (PN1 Round 2)</p> <p>*patients who are older patients have time to talk to us, and they have time to listen, and they might be the patients who are going to the hospital as well - we can enrol, then they get more benefit, but I feel that younger people, it's very difficult to enrol - promote them to service (GP11 Round 2)</p> <p>* Patients don't – aren't communicated to about the necessity of attending them. They don't see it as a priority and they find with Westmead hospital hopeless to get to anyway, but they don't see the priority of it and they don't see the communication, and I think the other thing is that they find it difficult to communicate back with us (HS1 round 1)</p> <p>*More than half of them said, oh, this is not needed, what is this for, what you are doing is okay, we don't want another person involved (GP10 round 2)</p> <p>*she had all the education in the world, she saw every member of the team numerous times, which is probably actually more than what we normally would do for a patient. I feel like for her it was just her motivation; she wasn't motivated to make the changes (AH2 Round 1)</p> <p>*there's a few patients who are just, like, "I don't want to have to go and attend anything, I don't want to have to – I just, no, I</p>

	<p>don't want to be told what to do with my health care," and they're just really not interested, I don't know why, maybe they just want their GP to do it (PN3 Round 1)</p> <p>*some patients just – they just don't want to see so many people. Yeah. Normally those people are medically noncompliant. So I think it's not the program problem, it's just their personal perspective (GP3 Round 1)</p> <p>*Some patients have really been anxious about getting into Integrated Care, they see it as another level of loss of control, and it's really hard to actually convince them, no, this will be better for you, rather than, no, there's someone else saying what they can't do (GP14 Round 2)</p> <p>*I get told by my patients a lot the fact of having extra things to do or more people involved was actually a barrier. He wasn't interested in signing up because the last thing he wanted was more phone calls or more appointments (GP6 round 2)</p> <p>*out of that diabetes thing [case conference], they actually had a couple of patients not come back to the practice because they didn't like what they heard from those specialists.(PN2 Round 2)</p>
<b>Transport and parking</b>	<p>* Yeah, they miss their rehab sessions, they miss therapy appointments, they ring and say, look, I drove around for an hour and couldn't get a car park, that's why I didn't come to my appointment today. So I think that's quite disappointing (AH5 Round 1)</p> <p>* The hospital parking is atrocious at Blacktown, yeah. I have to be dropped off at the door because there's no way in the world that I could walk from the carpark down to the hospital and I couldn't walk back there either. I think, I honestly do believe that they need more closer parking for people, like, invalid people (PC7 Round 1)</p> <p>*with the wheelchair, my sister drops me right out the front door and I don't move until she comes.(PC8 Round 2)</p> <p>*a lot of them don't have much family support. So they're somewhat isolated, then they have to book patient transport, which is often a bus. And some of them are worried, because they're on diuretics, that they don't have enough toilet stops on the way to the appointment. A lot of them don't drive, a lot of them can't walk very far [with COPD] (AH5 Round 2)</p> <p>*It's a nightmare at Westmead. You've got to pay for your bloody thing, and you've got to wait to get in there. It's so big, that place. So many people going in there, and the distance from the main door to the ward, you need a bloody vehicle to get down there (PC2 Round 2)</p> <p>*I've now got a critical mobility parking spot, so I can park fairly close now in a designated spot. (PC14 Round 2)</p> <p>* Transport I find is quite a big one. If they can't - I guess some patients can be linked to community transport but some don't meet eligibility criteria, so they can't be and they have to catch a taxi to go to their medical appointments if they don't have any family or relatives, so transport can have an impact that they don't turn up (CF3 round 1)</p> <p>*we found out, that we could get a bus up to the hospital, and that saves me worrying about parking (PC22 Round 2)</p>
<b>Understanding Integrated Care</b>	
<b>Good understanding of integrated care</b>	*It's improving the care continuum with the patient. It's got different elements; it's about patient-centered care; it's about integrating all the care providers plus that patient into their own clinical care plan. It's about systems as well, so the systems

<ul style="list-style-type: none"> <li>• Patient centredness that includes carer and family</li> <li>• Coordinated and continuous care</li> <li>• Systems to support including informational continuity</li> <li>• Multidisciplinary team based care</li> <li>• Bridging gap between primary care/ community and hospital care</li> <li>• Communication between health care providers important from patient perspective</li> <li>• Prevent hospitalisation</li> <li>• Linking all services including in hospital and into community and beyond health</li> <li>• Building GP capacity</li> <li>• Mainly for complicated patients/ "frequent flyers"</li> </ul>	<p>around to enable that interaction to occur; we need to work together and I think that's being integrated (HS1 Round 1)</p> <p>*In a nutshell I believe that's what the integrated carer system is about - integrating three different groups of people, which is hospital, GP, the patient carer or a different family member (PC17 Round 2)</p> <p>*Like a one stop shop (PC3 round 1)</p> <p>*somebody communicating with all the various specialities that take care of a patient. So, there's one person kind of overlooking it all and making sure everything is working well together (PN7 Round 2)</p> <p>*it means coordinated care. That's the way that I like to see it. And coordinated from the perspective of the medical services, allied health and taking into account what the patient's goals and objectives are (GP1 Round 1)</p> <p>*main benefit for the patient is that there's continuity. Their healthcare plans are uploaded so other health professionals who are involved in their care can have an idea of what's going on with what other people are doing (GP12 Round 2)</p> <p>*To me integrated care is between your doctor, hospitals, your specialists and whoever else is involved in the medical (PC7 Round 1)</p> <p>*Care that's shared between people in looking after patients, so we all know what's happening and if you think a patient needs extra care in an extra area – or extra support, it's easy to get in and get referred to those people (GP14 Round 2)</p> <p>*encompasses all the people involved in that patient's care, so multi-disciplinary team to care, as well as being coordinated, so making sure there is good communication involved, and also involve the patient; so the patient is actually involved in their care as well. (GP6 Round 1)</p> <p>*it's communication with the doctor, particularly, for doctor to referral - and they interconnect. They interconnect - it's not complicated, it's simplicity. (PC18 Round 2)</p> <p>*But, integrated care needs to be more general, it should be an approach, not necessarily a specific model (MG2 Round 1)</p> <p>* its a team based approach where people are working in those various settings understanding their role. So there's not a transfer of care. It's more a contribution of a shared care approach between a hospital setting, a community setting and then even in a broader sense working with councils and transport and other sectors to keep people healthy (HS8/MG7 Round 1)</p> <p>*Shared-care, basically. So, we're looking at a group of people to look after the one patient. (PN5 Round 2)</p> <p>*I think this is a seamless process integrating care between the hospital, GP setting and the community. I think that's what it's about for me and having a multifaceted, multidisciplinary team approach to patient care. So that's what integrated care is for me. (CF2 Round 1)</p> <p>*My understanding it's where they – together they talk to each other to ensure that she's getting the right care for all of her issues. Not just focussing on one element (PC1 Round 1)</p> <p>*it's integrated care between general practice and the tertiary hospital system and trying to integrate the care of the patients across that system with, I think, an end goal of trying to – and have skills in primary care and it has care delivered in primary care but the end, end goal of trying to prevent hospitalisations (HS2/MG9 Round 1)</p> <p>*GP and the health facilitator that is involved in the program, specialist if needed, to allow more care and support services to</p>
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	<p>be given to the patient to help keep them at home, if possible, and with care in the community, and avoid, or prevent them from being admitted to the hospital as much as possible. (GP8 Round 2)</p> <p>*broadly, for me integrated care is actually looking at improving the coordination in the patient journey – and it's not just through the hospital but through their whole health (HN5 round 1)</p> <p>*We want to empower the GP and we don't want patients to – we want them to look after themselves of course, and to work on themselves. But through the GP (HS10 round 1)</p> <p>*It's mainly for the complicated patients, so we can get everyone involved and everyone will know the patient's situation, if there is any change. Yeah and also we know about who is involved in the patient care so we will know who we should talk to if there is an issue (GP3 Round 1)</p> <p>*they're looking to target the group of higher flyers in emergency departments who are not being well managed and link them in so that they can improve the comprehensive care (GP7 Round 1)</p>
<b>Limited understanding of WSICP</b> <ul style="list-style-type: none"> <li>• <i>Varying understanding noted</i></li> <li>• <i>For some, focus is on preventing ED attendances or on sharing information</i></li> <li>• <i>Some describe lack of understanding prior to WSICP</i></li> <li>• <i>GPs perceived to lack understanding of the program</i></li> <li>• <i>Patients describe getting additional assistance</i></li> <li>• <i>Patients may be unaware they are receiving integrated care</i></li> </ul>	<p>*Understanding of some of the concepts are quite varied and very difficult to sometimes get people to engage (HS1 Round 1)</p> <p>*Integrated care meaning that we're actually looking after the patients in the community so that we're, sort of, like, preventing over-population in [laughs] emergency, I guess, overcrowding (PN1 Round 1)</p> <p>*Well, as far as I can see, it's that they share all your information. That's all. (PC12 round 1)</p> <p>* this has been a real thing in the practice because no one seems to understand what it was. My understanding is now that if we have patients with those chronic illnesses like the diabetes and hypo and stuff like that, if they're not well and they need rapid access we can contact the specialist at the hospital (PN2 round 1)</p> <p>* to be honest I didn't really know much about integrated care before the program was introduced to this practice, didn't really know anything about it, so I've only learnt since our surgery's been put into the pilot (PN3 round 1)</p> <p>* I didn't know what integrated care was until it was explained to me. (HS10 Round 1)</p> <p>*They get people from outside to try and help you – people that know what they're doing to help you out, try and help your condition and try and help you work out and get over what you've got. Things like that (PC10 Round 1)</p> <p>* I don't know how much the patients know that they're actually in Integrated Care. They just think it's business as usual, that's how it always ought to happen (HS8/MG8 Round 2)</p>
<b>Differences in models across WSICP sites</b> <ul style="list-style-type: none"> <li>• <i>Discipline specific differences in templates seen to be inefficient by some and positive adaptation by others</i></li> <li>• <i>Differences in use across hospitals and in services offered</i></li> </ul>	<p>* I think within our hospital systems, like all the clinics work really differently. Like heart failure clinic is so different to diabetes clinic or COPD clinic. The letters that go out to GPs, the templates are also different. Like, some would have more information, some would have less and again, that's a barrier because it doesn't reflect that our side of the work is really efficient or consistent. It's such a mixed approach and Westmead is so different to Blacktown as well (CF3 Round 1)</p> <p>*Because they've all got their set minds and set agendas on how the model works (CF1 Round 1)</p> <p>*there's a number of planks that we're trying to institute in Respiratory as our version of integrated care which is a little bit different to some of the things that the other subspecialty disciplines are doing. (HS2 MG9 Round 1)</p> <p>*at Blacktown it's set up quite differently; for example, at Westmead we almost use it as a post-discharge clinic so we'll see</p>

	<p>patients that aren't necessarily suited in the program, but whereas at Blacktown they like to recruit the GPs first and then we see patients through the GP (AH2 Round 1)</p> <p>*I was ringing up about an ischemic heart disease patient and Blacktown they weren't set up to manage that there, they said Westmead's team is but Blacktown's wasn't, so they advised to send the patient into the ED rather than use the Rapid access which is fair enough - seems like there was still some differences between what the two hospitals were doing (GP6 Round 2)</p>
<i>Unrelated Programs/ activities</i>	
<b>Specific non-WSICP programs</b>	<p>*We've had one service, which you've probably heard about, with an endocrinologist coming out and working directly with GPs and chronic patients and building capability in not just the general practitioner but the practice team. That is a model that we would like to build here as well on other fronts, but you've got to have a specialist who is able to do it and has an understanding of the need and how to approach it (MG3 Round 1)</p> <p>*the Spirometry Roadshow I think is helpful. We've only been to a few general practices and really that hasn't come from integrated care, that's come from a variety of drug reps saying to us, "Can you come out to this GP practice and give us a talk? (HS2/MG9 Round 1)</p> <p>*the breathlessness clinic is a hybridised model from the UK. All of the rest of it is a lot of what Western Sydney wanted me to do. (HS2/MG9 Round 1)</p> <p>*I've been involved with the rehab unit, on the program and also on the maintenance side of it since 2014, been going to Blacktown Hospital (PC9 Round 1)</p> <p>*The integration of the chronic care management program and the demonstrator has occurred, which we love them both. So those programs are now the one program; the demonstrator being a bit of a subset of it...and we've retained the enablers parts, particular to the demonstrator (MG6 Round 2)</p>
<b>Relationship with WSICP</b>	<p>* So many of the patients are shared anyway, you know, they sort of bounce back and forth from the normal heart failure program, integrated care, when they have deteriorations and so for, so, yeah, we work as a team (HN4 Round 1)</p> <p>*we've set up an Acute Exacerbation COPD Clinic, more a stabilisation than rapid access clinic, where we see people following their hospitalisation, about two weeks after, to try and get them into pulmonary rehab or try and make sure that they're getting better, and make sure that what was planned on their discharge summary has actually happened (HS2/MG9 Round 2)</p> <p>*I also find the people that we don't necessarily have enrolled in Integrated Care or aren't yet identified as needing integrated care, that if we have them in our pulmonary rehab service and they get sick, we're then able to refer them to the rapid access clinic, and get them seen that way and that's been really efficient (AH3 Round 1)</p> <p>*I'm not sure if it's from integrated care or not, but home visits I think are done by [CNC] who is not part of integrated care, but I think that perhaps that service, I don't think its mainstream (HS10 Round 2)</p> <p>*That was the heart failure clinic, but this is the cardiac rehab unit where you do physical exercises and treadmills, coffee</p>

<ul style="list-style-type: none"> <li><i>Programs designed to prevent illness expand upon WSICP</i></li> </ul>	<p>grinder, under supervision and the maintenance programs are voluntary (PC9 Round 2)</p> <p>*we're running two parallel initiatives; one is the Western Sydney Diabetes Initiative and the other one is the demonstrator program and it's of no surprise that there are elements that are in both those programs that overlap and reinforce each other. But actually harmonising and maximising the way they work together has been a bit of a challenge (HS8 MG7 Round 1)</p> <p>*there's also the case conferencing as part of the – what's going on at Blacktown as kind of an almost separately funded process, which is focusing on case conferencing rather than the integrated care project, whereas at Westmead, we're trying to do it as part of the integrated care project. I think that's where some of the difficulties are coming (HS3 Round 2)</p> <p>*we've got linked in with a private heart scan at Merrylands which has got a really good scanner for coronary CT angiograms. (HN2 Round 1)</p> <p>*I don't know if this is part of the Integrated Care Program for a pharmacist to come to my home and see how my medications were being stored and double checking how I was using them and that sort of thing. (PC3 Round 2)</p> <p>*We know in our patch, like Mount Druitt, they live in food deserts, so the food environment is not good and the affordability of fresh vegetables is not, and then they don't know what to do with them if they got them. So that's why we're working on urban design, food supply, identifying people at risk and getting them into lifestyle coaching programs like the Get Healthy phone line and there's a diabetes Get Healthy phone line (HS8/MG7 Round 1)</p> <p>*The foot clinic, we have. And that's another good thing too. Foot clinic's started, fully fledged foot clinic. (AH1 Round 2)</p>
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## Challenges

### Inter-organisational challenges

<b>Inconsistent processes, procedures and policy across PHN/ LHD</b> <ul style="list-style-type: none"> <li><i>GPs need to adapt to different processes cross LHD</i></li> <li><i>Challenges of meeting GP needs in context of hospital workload</i></li> </ul>	<p>* trying to link in with the three, sort of, sites, so the WentWest, the Blacktown and ourselves, trying to link in a little bit better so we can all see what's going - because I don't think there's a wrong or a right way to do this, but it would be good if we were all, kind of, doing it the same way, especially for the GPs as well, they're out there going, oh well, Blacktown does it this way, so I've got to do this, Westmead will do it this way, so I've got to do it this way (HN1 Round 1)</p> <p>*the registrar during the day might be on the phone to emergency sorting the patients, so there has to be some understanding as to the workload that the tertiary institution takes on, we have to be mindful, too, if the GP has got a patient in their practice and they need to find out something about some information or anything, we need to have a reasonable time frame where that phone needs to be answered, so I think there's some problems and some tweaking with that (HN2 Round 2)</p>
<b>IT systems</b> <ul style="list-style-type: none"> <li><i>Electronic communications is not working</i></li> </ul>	<p>*the software, it's clunky for everyone. It's a third party system for us. It's a third party system for the hospital. It's not conducive for daily use. I'm not sure what could be done about that, unless we're all on the same platform (GP2 Round 2)</p> <p>*there's been an enormous amount of work that's gone on to link the GP IT system to the hospital IT system and I</p>

<ul style="list-style-type: none"> <li>• Poor Connectability of hospital with community</li> <li>• Poor integration of health records but some carers note sharing of their medical information</li> <li>• Unsure if communication by providers has been received</li> <li>• Relying on mailed paper communications</li> <li>• Changes made in Linked-EHR are not flagged</li> <li>• Poor IT affects data collection and evaluation</li> <li>• Problems with numerous individual IT programs within the hospital system and General practices</li> <li>• IT issues impacting on data collection and program evaluation</li> <li>• Limited spending on IT</li> <li>• Using IT can be time consuming</li> <li>• IT improving but not all GPs have IT capacity</li> <li>• GPs not aware of Linked-EHR</li> <li>• PHN assists GPs with IT</li> </ul>	<p>understand that that's difficult, and it still hasn't happened (HS2/MG9 Round 1)</p> <p>*the care plan is uploaded to Top Bar and that. At the moment our Top Bar not working. So still working on all of that, so even care plans haven't been uploaded at this stage.(PN2 Round 1)</p> <p>*it's still very basic at this stage. I think it's still the connectivity, I'm not really happy with. Ideally everything should be live and whenever we make a change, it should change instantaneously. (GP12 Round 2)</p> <p>*Another frustration is the whole integration of health records; that's been hopeless. I suppose, the other frustration is that they said we could get e-referrals. We haven't got any e-referrals from any of the external practices. I mean, we think that GP's should be able to e-refer; they still can't e-refer to us at all (HS1 Round 1)</p> <p>*... they managed to link my Mum's entire medical history with both Blacktown and Westmead, through the GP. So in emergency situations the facilities of those places have full access at the touch of a button rather than me having to explain everything or try to remember all the details, or remember all her medications. (PC17 Round 2)</p> <p>*encrypted electronic communication's a big barrier, because a lot of people don't use encrypted email, and we would love to just have everyone on an encrypted email and not have to be scanning thousands of paper documents in every week... (GP7 Round 1)</p> <p>*for me to know that what I've sent has been read and acknowledged, and that's important because I'm just sending it out into the ether, not knowing what the heck is going on and just hoping that the person on the other side has actually read it and actually acknowledged it (HS5 Round 1)</p> <p>* the letter back to the doctors is still by paper mail, and we can't ensure they're on the common system. (HS5 Round 2)</p> <p>* she [CF] started making changes on Linked-EHR which I can see, but I just don't get notification of it – she told me she'd made a change in a page of Linked-EHR file, and that that was the only reason I knew about. She said to look out for it, so once I went in I saw it (PN3 Round 2)</p> <p>*one of the major things is eHealth and the fact that we don't have it, and different GP practices have got different computer programs, they don't marry up with the computer programs that we've got (HN2 Round 1)</p> <p>*some of the allied health don't have the same computer programs if we're having to fax ... (PN3 Round 1)</p> <p>* I think they need to be aware that the data collection is flawed and that's how the data that's collected, especially PIMS is how the program is going to be judged. So ensuring that works well and data collection is critical and I think it needs to be urgently reviewed (HS11 Round 1)</p> <p>* trying to put everything electronically was to be able to easily pull data but we're not able to do that. So, we're trying to just keep our own audit, trying to look at comparisons – at the start of the clinic versus the end of the clinic for patient outcome, and looking at referral sources and also looking at discharge destinations (HS3 Round 2)</p> <p>*there was a huge investment going in, that's only huge in terms of limited PHN resources. In terms of the kind of investment that goes into developing IT systems more broadly, it's very, very tiny, and the Linked-EHR suffers from lack of investment generally (MG3 Round 2)</p>
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	<p>*our nurses have been uploading them [care plans] onto Linked-EHR and it takes ages. It takes quite a long time for that process (GP5 round 2)</p> <p>*we do drag a lot of information out of PenCAT. But because everything is not put on the computer it's double the entry, and this is where we're finding the major issues-we're not fully computerised, is another matter (PN5 Round 2)</p> <p>*I would say 70% better. It's working a lot more efficiently with care plans, I think, 90% of my patients have a Linked-EHR care plan which is great but for some practices it's still an issue –whose IT systems are so fragile that they can't cope with another software with Linked-EHR (CF3 Round 2)</p> <p>*the doctors here, if you said to them you can find so and so's care plan, or whatever in Linked-EHR, the first thing they'll say, "Is what's Linked-EHR"? (PN2 Round 2)</p> <p>*we haven't had many problems. I usually call the technicians from WentWest if there's any problem in the Linked-EHR if we're going to upload, it has been okay lately (PN6 Round 2)</p>
<b>Siloing and non- collaboration</b> <ul style="list-style-type: none"> <li>• Hospitals don't integrate well with community health care</li> <li>• Difficulties referring between hospitals</li> <li>• Interdisciplinary collaboration lacking</li> <li>• Different paths to common goals</li> <li>• Culture change needed in General practices</li> <li>• Poor relationships between GPs and Hospitals</li> <li>• Historical difficulties between hospital and GPs</li> <li>• A feeling that GPs may not consult through fear of being seen as unskilled</li> <li>• GPs not respecting CFs</li> <li>• GPs lack time for hospital specialists</li> </ul>	<p>* What goes on here in the hospital is fairly insular and we don't necessarily – I've explored, through integrated care, community dietetics, what's out there in the community, which I've never really had the chance or the inclination or the push and shove to do in my inpatient role. (AH6 Round 1)</p> <p>* I wonder about the optimal distribution of roles between the various care coordination functions and, in particular, this disinclination on the LHD staff to recognise community health or other services, are of any relevance to this whole exercise (MG3 Round 2)</p> <p>* Westmead Hospital IC has a blood pressure monitoring system and I had a guy that I felt would benefit from that and I discovered that I can't electronically refer to Westmead. In that sense the two hospitals don't speak (HN5 Round 2)</p> <p>*I suppose also about us all sort of being more on one page, as opposed to I fix the foot and you fix the knee and someone else fix the heart... I suppose there's more siloed care that we've been increasingly delivering over the years (HS1 Round 1)</p> <p>*I think there's still uneasiness between the teams, in terms of integrated care working, I think we need to do a lot more teambuilding exercises there. I think it's still very much viewed as an us and them approach. (CF2 Round 2)</p> <p>* I mean, in terms of chronic disease I still don't think we've truly embraced the multidisciplinary approach. I still think that we've got the departments together but they're still very much three different departments (MG2 Round 1)</p> <p>*I think our culture needs to change a bit. I think general practice has been a bit of a silo, and I really like working with allied health people, it has a lot of podiatrists and physios and we communicate back and forth, so I really enjoy the team approach to patient care. (GP7 Round 1)</p> <p>* its them [GPs] that's not coming back to us. I think it's really time for GPs to get their act together. If they want to benefit in this then they need to start making use of it and being more proactive in getting in touch with us (HN4 Round 2)</p> <p>*GP practices being businesses sometimes it's just quicker for them to see 15 patients in 5 minutes or 15 minutes, rather than put in all this work to have case conferencing and working together (CF3 round 2)</p> <p>* Westmead Hospital and GP's haven't always had a good relationship, so there's been a breakdown or a barrier there</p>

	<p>with starting the service from the word go (HN2 Round 2)</p> <p>*I don't know whether GP's think if they ring and ask for advice or support we wonder what they're doing? Did they get their medical degree where? I don't know, if they think that and that's why they're not using the service, which is silly because, yes, they're GP's but they're not going to be experts in cardiology, or respiratory, or endocrine (HN2 Round 2)</p> <p>*I went up to a GP late last year, sent him all the information, he went to the appointment, kind of fobbed me off. He literally spoke over me and said send me information, no consent. (CF2 Round 2)</p> <p>*I recently made a call to a GP - a GP told the reception that he didn't have time to talk to me. I have sometimes left messages for GPs to call me, but most of the time they don't call me back. (HS7 Round 2)</p>
<b>Challenges with roles and responsibilities</b>	
<b>Unclear roles</b> <ul style="list-style-type: none"> <li>• <i>No role definition or clarity of role expectations for CFs</i></li> <li>• <i>CF role developing and clarity improving</i></li> <li>• <i>Lack of role clarity influences care hospital staff can provide</i></li> <li>• <i>GP staff unsure of their role in the program</i></li> <li>• <i>Staff adapting their roles</i></li> </ul>	<p>*But, again, it is a fairly new role as well and we're pretty much the guinea pigs at the moment. Trialling. So, yeah. I guess at the moment we don't really have clear definitions of what is expected or what is part of this role and what's not. (CF3 Round 1)</p> <p>*Well, that's the problem. Because I think we were just sent out as crash test dummies to try and figure out what was the best way to engage GPs and patients into the program. You'd have to find a way to get an in to where they saw your role within the program. How did you complement their practice? Did they want you there at all? Were we taking up their time that they could be seeing patients? (CF1 Round 1)</p> <p>*the boundaries between care facilitators and our team has been a bit shady in the beginning and that's been a cause of problems because there could be boundaries that are unclear and there can be conflict and confusion. Certainly our nurses not being allowed to call patients after they've been seen in clinic and I think that's a problem because the patient knows the nurse but then they're going back to the GP and home. We understand that it needs a process, so I think that's been a problem that's been highlighted to me. (HS11 Round 1)</p> <p>*it's a bit more defined what we're doing now. I think it's a combination of consulting and actually co-coordinating or case managing (CF3 Round 2)</p> <p>* it's not entirely clear what I'm actually supposed to be doing, particularly with the inpatients because, you know, most of them are under the care of a respiratory physician so I don't really want to come along and tell them, "You should change their puffers." (HS9 Round 1)</p> <p>*you're employing me in this job but you've really hindered me because I can't actually do anything here (HN5 Round 2)</p> <p>*as a dietitian I'm not sure if I'm supposed to get in contact with the facilitators. I think, again, that's what it all comes down to; it's such a new program no one's quite sure of the role. (AH2 Round 1)</p> <p>*I'm a bit confused because I'm not really quite sure what my role is in the integrated care program. (PN2 Round 1)</p> <p>*There has been no defined role. I basically see my role as bringing the funding across to support other patients and support the program at [named] Hospital, and I've obviously delegated [HS] to run it with the help of the CNC and the</p>

	clinical medical officer, but providing close advice and support for [HS], but a clear role for me in the program has not been defined and I think every department has been managing it in its own way (HS11 Round 1)
<b>Difference in employer/ responsibilities</b> <ul style="list-style-type: none"> <li>• <i>Responsibilities not matching role expectation of CFs</i></li> <li>• <i>Hospital staff regard work load expectations as unrealistic</i></li> <li>• <i>Admin not seen as clinical responsibility</i></li> </ul>	<p>* when the principal GP has said I don't want to participate. It's up to and the clinical lead here to go out, have a meeting, discuss with them what's the problem and then cut ties or offer the GPs some support. (CF2 Round 1)</p> <p>* the care facilitators were all about being in the practice with the GP, helping the GP identify the patients, doing risk stratification of their patient population and then helping the GP with their care planning and all that. I'm calling that the back-end. They're also meant to be doing the front end which is working with the GP and the patient to help coordinate the patient journey (MG6 Round 1)</p> <p>*for certain practices it depends on the GP and it depends on the practice and how much they're willing to use us (CF3 Round 2)</p> <p>* I know that the expectation is that we see 16 patients in our clinic session, I'm sorry, but I'm never going to see 16 patients within that timeframe...there's this disparity, what is ideal and what's achievable (HN5 Round 1)</p> <p>*the admin people don't understand the real life of a clinician, and keep wanting me and my staff to do extra admin crap, and I will not do it - that's driving me nuts (HS2/MG9 Round 2)</p>
<b>Carer burden</b> <ul style="list-style-type: none"> <li>• <i>Caring is a fulltime job</i></li> <li>• <i>Confusion</i></li> <li>• <i>Need for information from program to help carers manage better</i></li> <li>• <i>Use of WSICP can assist with costs of care</i></li> <li>• <i>Grief and loss</i></li> <li>• <i>Watching loved one deteriorate</i></li> <li>• <i>Giving up work</i></li> <li>• <i>Support from other carers</i></li> </ul>	<p>*I am the one who looking after him, for the medicine, for the food, for the – everything. Even I'm working, I have to prepare that in the morning. And then I have to get - give that to the carer. Every time, an hour, every hour I call in the house...24 hour must be having somebody looking on him. (PC21 Round 2)</p> <p>*Full-time. You know previously it was just a lot of hard work, I mean, and come home [from work] and you'd get all the stuff prepared before you go but now you know she's 89 and I need to be there fulltime. (PC17 Round 2)</p> <p>* I thought the actual insulin was to be – doled out - like it would help. I thought well this pill they need to give us 25 in the morning and 40 at night. It's not like that. With the readings you've got to adjust it. And there's nothing that tells you how much to adjust (PC22 Round 2)</p> <p>*Well its rather hard being his carer, just after any information when he's sick or that, it's just hard to find information. I'm just totally confused, don't ask anybody anything because they won't tell you (PC19 Round 2)</p> <p>*We got discharged, we got nothing. Lucky enough he has gone through it all before and I knew that I had to restrict his fluid intake, and watch his weight and all that, because they didn't have much to give you when you left (PC19 Round 2)</p> <p>*there's been no real interactions since [husband] had the defibrillator, because that was major, really, really major, and really, really overwhelming, to be honest. We'd certainly heard of people with pacemakers and so on, and even now it is still something that remains a bit of a mystery to us, scares the life out of us. But, I don't think there's been much follow up from the program that way (PC13 Round 2)</p> <p>*this worries me with some specialists, not all of them charge through Medicare. Privately some of them charge of the expenses, we are only pensioners (PC18 Round 2)</p> <p>*another area of cost, his medication. You know, some months – depending how many Webster Packs, so it depends</p>

	<p>how often they draw your prescriptions down and how many, one month he could pay \$50.00, and another month it might come down a bit or it might go up more (PC19 Round 2)</p> <p>*the problem has been mostly for both of us, psychological, one for [husband] really understanding still how, where and why, and mine, yeah, grieving and changing lifestyle, I suppose, in a man who is still trying to be the man that he was, but can't be. (PC13 Round 2)</p> <p>* The problem is, he's doing, not the same like before. It's like I have a baby now [after stroke]. (PC21 Round 2)</p> <p>*in 2013 I gave up full-time work purely because of me being single and with the type of work I was doing, I was travelling a lot interstate. And my concern was she was quite okay being alone at home, but you do sit back and think what if they call us or what if family does (PC17 Round 2)</p> <p>*so suddenly you've lost your social support group in a sense, and now we've even lost our lifestyle to a degree. (PC13 Round 2)</p> <p>*look, I spend a lot of time at home and that frustrates me, because when you're confined to just your home all the time it's like what's my life come to? (PC17 Round 2)</p> <p>*it's good to everyday talking to carers because we also are with this problem. We try to look after our patient but at the same time sometimes we overlook ourselves (PC18 Round 2)</p> <p>*I don't know what support is out there for a carer because I've never looked, I've just put my head down and done what I've had to do (PC16 Round 2)</p>
<b>Carer Supports</b> <ul style="list-style-type: none"> <li>• <i>Family support</i></li> <li>• <i>Helping carers understand what to do</i></li> <li>• <i>Suggestions</i></li> </ul>	<p>*my son helping me. I feel I have somebody can help me when I go out to work. (PC21 Round 2)</p> <p>*No other family care for her except me (PC15 Round 2)</p> <p>*our GP asked us if a professor could come from the hospital to have a look at Bob. At the practice. And truly he just completely upset the program. I was very angry actually, because I thought well we're doing good. I've got the opinion that if I can keep [husband's] readings under 10 I think we're having quite a good day. (PC22 Round 2)</p> <p>*You'd go cross-eyed looking at all the bloomin' wee-tiny writing on goods, to see how much sugar is in things. I'm 70 next month and don't see too well (PC22 Round 2)</p> <p>*the only problem I have at the moment is the dental. I know the Medicare has cut off everything so that is now our problem (PC18 Round 2)</p> <p>*perhaps with the patient's consent, a family counselling information session may be made available if they are receptive (PC13 Round 2)</p> <p>* Communication, maybe groups, I don't know whether there's carers groups out there or, I don't know. Just someone to talk to sometimes. (PC19 Round 2)</p> <p>*I would definitely like to get involved with is if there's any carer forums so the professionals – they won't fix your problem, but that's not what I'm expecting, but they will probably tell things that I'm not aware of, how to deal with different situations, whether the forums have group sessions where you can also talk to other people who are in similar</p>

	situations. (PC17 Round 2)
<b>Scale of the undertaking</b>	
<b>Size and complexity of program</b> <ul style="list-style-type: none"> <li>• <i>A change at systems level</i></li> <li>• <i>Unexpected complexity</i></li> <li>• <i>A large administrative burden enrolling into program</i></li> </ul>	<p>*You're rebuilding, changing, you're realigning the way we're doing business. We're trying to turn the Titanic around a little bit and we're slowly doing that. (MG6 Round 1)</p> <p>*At the start of this, we really thought that integrating the health – the e-health systems would happen. But one of the biggest frustrations is that that has not happened, and I suppose though, maybe it's because it was a more complex beast than we potentially contemplated. (HS1 Round 1)</p> <p>*my mind boggles at the bureaucratic overhead that we have created, which may be necessary for a test environment, but it sure had better now be for broader implementation. I mean, it's frankly bonkers that we have got to go to such huge lengths to get practices enrolled and get GPs enrolled and get patients enrolled (MG4 Round 2)</p>
<b>Program and funding time limited</b> <ul style="list-style-type: none"> <li>• <i>Not enough time to see results</i></li> <li>• <i>Cost benefit is a longer term outcome</i></li> <li>• <i>Closing as awareness is building</i></li> <li>• <i>Difficult keeping staff</i></li> <li>• <i>Staff invested in success of program feel responsible</i></li> <li>• <i>Uncertainty around future beyond pilot</i></li> <li>• <i>Concern about WSICP enduring affects staff commitment</i></li> <li>• <i>Limited ongoing funding has been secured</i></li> </ul>	<p>*I'm worried that the funding stops and all of this is a waste of time. I don't think you can see results in two years, I don't know that you can even see results in five years, but I think it needs long-term investment in an initiative like this that focuses on outpatients and keeping patients well in the community (AH6 Round 1)</p> <p>*The key thing is whether that investment is continued, because it takes a long time for things to get going, as you know, and this was really recently considered as a true four year project, but really it's only just getting started. (MG1 Round 1)</p> <p>*the cost benefit in terms of the patient getting better care, avoiding hospital, getting them out of hospital quicker and getting them out of emergency quicker. But I think these things take time and the time frame is quite limited of this program (HS11 Round 1)</p> <p>*it will be good to actually know that there will be some, sort of, long term plan for this. Because it is hard to hold onto good people when there's a time restriction there. We're having a high turnover of our educators - it's very hard (HS5 Round 1 and 2)</p> <p>*it's going into mid next year [2017], that makes it very difficult people are worried about what's going to happen after that, a lot of turnover of staff– then you have to start again and retrain people and fill jobs (HS3 Round 2)</p> <p>*We know we're in this for a change that has to happen and be sustained and if you set it up as a demonstrator what happens when the money runs out, what happens to all the people that you've brought on and are starting to catch on and how can you employ people and give them a 12 month contract and expect them to have their heart in the system? So I think that the system is flawed because it is a project (HS8/MG7 Round 1)</p> <p>*I've seen so many different programs come out from the Ministry of Health and then it just fades and dies. And I think initially that may have also led to some of the resistance internally, with inside the hospital because doctors get a bit jaded (HN5 Round 2)</p> <p>*There is continued funding available, it may not be of exactly the same quantum and there may also be some new investments available (MG3 Round 2)</p>

<p><b>Time needed to establish program</b></p> <ul style="list-style-type: none"> <li>• Embedding program in system</li> <li>• Program developing over time</li> <li>• Working through difficulties</li> <li>• Expectations of worthwhile outcomes including new ways of working</li> </ul>	<p>*the program's still very, very new, everyone, like I said, it's a very new program, we're trying to figure out the referral pathways and where everyone sits within it (AH2 Round 1)</p> <p>*we're at a point that we've got a reasonable way; happier now than I was six months ago in terms of how much we've delivered. I think we've finally got our team and our models of care in place when we're at that point where we're testing them and seeing whether they work, and there's a number of frustrations there that haven't been worked through yet (HS1 Round 1)</p> <p>*I don't see a lot of GPs actively ringing the RASS service despite our promotion, sometimes, unfortunately on the negative side, we've had a few bad experiences as well in ringing RASS like no one answered the phone call despite leaving voice messages, no-ones contact them back. It's improving ... (CF3 Round 2)</p> <p>*we had so many problems with our computers we could not upload it and actually get patients in. For about a year they [WentWest] were working on our computers trying to make it work and it wasn't until either December or January this year [2017] that finally the links are now working and we can upload the metrics and get patients on (PN7 Round 2)</p> <p>*if the GP hotline doesn't ring then I'm not going to be able to do anything, and I knew that setting up the breathlessness clinic was just going to take time and, again, it's going to be a slow burn.(HS2/MG9 Round 1)</p> <p>* It's just unfortunately a lot of these really good ideas take a lot longer than expected but that doesn't mean that it's not going to be worthwhile in the end. It's just taking us longer to get there. (GP5 Round 1)</p> <p>*This is certainly a very good step, it's one year down the track in terms of the interview now - we're still definitely in the infancy of it. (HS10 Round 2)</p> <p>*I don't think we can go back to old ways of doing things– it's just like we've still got training wheels on (MG6 Round 1)</p>
<p><b>Challenges and time required for behaviour change</b></p> <ul style="list-style-type: none"> <li>• Time required to build awareness and embed new GP behaviours</li> <li>• New hospital based approaches require culture change</li> <li>• Some GP attitudes a barrier to engagement</li> <li>• Education of patients in accessing services more effectively</li> <li>• Noticeable changes in how people think about providing care needs to translate in practices</li> </ul>	<p>* we have to allow the time to get this message out to the GPs, allow time for changing behaviour. Which takes time. I think, we're not even a year into this and I think we're trying to change a system that's been in place for a very, very long time. (HS3 Round 1)</p> <p>*the other problem I think is the GPs fall-back position of, they're unwell, they go to ED. (HN5 Round 2)</p> <p>*they have some confidence in us, they probably feel more comfortable referring more patients to us. I think we are changing the GPs practice behaviour, in a way (HS7 Round 2)</p> <p>* I think it takes time for a GP to understand how to use it, because some of the calls have not been appropriate. (MG1 Round 1)</p> <p>*We've got some doctors, particularly the young ones, who, yep, we can do that, but there are doctors who've been around quite a while and are a little bit resistant to big changes, have really struggled and one doctor hasn't come to any of the sessions that have been put on to learn about patient integrated care at all, he's just completely uninterested (PN3 Round 1)</p> <p>*within the patient population, their lived experience is "I get sick, I come to hospital, I get admitted so I must need to be in hospital", and there's all this sort of sick role, you can't change that for the current group of patients. You have to wait</p>

	<p>for them to shuffle off the mortal coil essentially and re-educate a whole new group of patients, and that's just going to take time (HS2 MG9 Round 1)</p> <p>*We're seeing a change in people's thinking. I think it's more embedded in people's thinking. I don't know that it's embedded in practice yet. But I'm not surprised. These things take time (MG6 Round 2)</p>
<b>Time required for chronic disease outcomes</b> <ul style="list-style-type: none"> <li>• <i>Already seeing an early impact to chronic conditions</i></li> <li>• <i>Challenges in dealing with comorbidity</i></li> </ul>	<p>*we're focusing on chronic disease, so chronic disease, in its very nature, is not something that changes quickly or that you see an impact quickly and so I think the fact that we're actually seeing something so soon does suggest that this is going to be beneficial in the longer run. But it needs time. It really does (HS3 Round 1)</p> <p>* I think that it's very early days but, we're starting to show some improvement in primary outcome measures which is the breathlessness management (AH4 Round 2)</p> <p>*COPD patients have a lot of emotional issues. So focussing on that, is really important, to reduce admissions to hospital ...when people get breathless the first thing they want to do is call ambulance, so teaching them how to manage their breathlessness and their COPD at home; is so important. (HN3 Round 2)</p>
<b>Value Add</b>	
<b>Building Capacity/ Education/ Upskilling</b>	
<b>Patient upskilling</b> <b>Advocacy and patient empowerment</b> <ul style="list-style-type: none"> <li>• <i>Patients are making their own decisions</i></li> <li>• <i>Information empowers patients and provides choices</i></li> <li>• <i>Patients better able to identify their care providers</i></li> <li>• <i>Carers prepare before meeting doctor</i></li> <li>• <i>HCPs collaborate to support patients in working on gaps in their care</i></li> <li>• <i>Educating patients builds awareness and understanding and they feel supported by CFS</i></li> </ul>	<p>*So yeah, I make my own decisions on my health, taking those kind of medicines. So I'm aware of what I'm doing. Because I don't want to be hospitalised (PC2 Round 1)</p> <p>*If I'm not feeling good or whatever I'll just go and do it. I don't need a committee to get something done. I'll just go and get it done (PC4 Round 2)</p> <p>*They're a bit more proactive in coming in. I'm seeing more patients, which is good, and not just because they're unwell, it's because they need something checked as part of diabetes, like blood care and stuff like that (PN3 Round 2)</p> <p>*– he suddenly reached the point where he actually wanted to make a difference, wanted to make a change and so the RASS clinic was perfect. He was so determined. (GP5 Round 2)</p> <p>* He's able to empower himself, he's learned what to look for, in particular heart failure, how to manage his weight, how to manage his salt intake. What to do with his diuretics. At a ground level he knows what to do now, and so he does that and whenever something goes wrong he'll see the GP. (HS10 Round 1)</p> <p>*It's very easy to forget what you want to ask when you actually get to see the doctor so I tend to write it down. I like to take my book with me with the readings and say, "Why do you think that happened there?" And try to get answers. (PC22 Round 2)</p>

	<p>* we're trying to identify where there might be gaps in care or where things might be falling down, and then really ... supporting the patients to work on those gaps themselves ... So getting them to go to their specialist and say, "Look, I know you've look at this but I'm really concerned about this, can we have a discussion about it?" (AH3 Round 1)</p> <p>*One of the main barriers is patients knowing who their specialist is, and you say to them, "Okay, we need to write down all of your health team," "Oh, I see someone who's my cardiologist, I just can't remember his name." But, I think, as we're giving the patients more and more training ... we're assisting them in keeping their own records more effectively, so that they're able to name those people. (AH3 Round 1)</p> <p>* through the time and education spent on them they are able to take matters into their own hands a little bit more in terms of choosing better foods, or maybe for their exercising, or they're doing those lifestyle changes that is going to help impact their health definitely, because they feel like they understand why they're doing it a little bit more, it's not just do this, do that, now there is a reason behind it(GP6 Round 1)</p> <p>*after the last case conference I had a few patients who came back to follow up with me and they felt a lot, I guess empowered was the word, with the information they had. And also other resources that they can access at home when they had instead of, just running off to the doctor (PN4 Round 2)</p> <p>*sometimes patients tell me when I have been to the GP with them for my first visit, the GP has explained in a lot more in detail about their condition, rather than when then patient goes alone so I think sometimes just having an advocate, having an educator or having someone with them, it has a big impact on definitely service navigation and the understanding of their chronic disease (CF3 Round 2)</p>
<b>Collaboration in decision making</b> <ul style="list-style-type: none"> <li>• <i>Patients and GPs work together</i></li> <li>• <i>Change from medical model of care engages patients in decisions</i></li> <li>• <i>Patients are proactive in their treatment</i></li> <li>• <i>Doctors check understanding with patients</i></li> </ul>	<p>*they leave it up to me, they don't come across with the decision to what I should do, so, ultimately, if we make me feel better I've got to listen to them and put it into practice. (PC14 Round 2)</p> <p>* So I still had some of that left, so I said to the GP, "Oh, look, I'm thinking – I'm just about out of the one called duo and what if I go back on the metformin and see how I go and I'll just keep measuring my sugars and see how we go?" And he said, "Yeah, that's a good idea." (PC3 Round 1)</p> <p>* I think that if you're working in a hospital setting... what happens with the patient is decided by the medical staff, and the doctors, whereas this is more about the patients here, and they have a hand in deciding what's happening to them, or with them, and it's more having them as the focus of the care. So it's a shift away a little bit from the medical model... (AH4 Round 1)</p> <p>*it empowers them, because they actually have a say now in how they are treated. They show keenness in motivating themselves to get well, they actually get much more from the program than just waiting for something to happen to them (HN6 Round 1)</p> <p>*being a patient, you've got to communicate properly with them, you know? If you're unaware of what they're saying, ask them to explain it in layman's terms. I've learnt that now. I've learned not to just accept (PC2 Round 2)</p> <p>*when I'm in hospital. They come up and ask you "is there any questions or do you understand this"? (PC12 Round 1)</p>

<p><b>Learning about the condition and self-management</b></p> <ul style="list-style-type: none"> <li>• <i>Providing health care that has a strong educational focus</i></li> <li>• <i>Case conferencing improves self-management for diabetes and reinforces the message</i></li> <li>• <i>Patients learn about their illness and how to manage but not all carers receive information they need</i></li> <li>• <i>Some carers and patients self-educate</i></li> <li>• <i>Action Plan has step by step instructions for patient</i></li> <li>• <i>Key role of allied health and CFs in patient education including in the home</i></li> <li>• <i>Education and self-management reduces re-admission rates</i></li> <li>• <i>Prevention and follow-up keeps patients out of hospital</i></li> <li>• <i>Improvements in patient health and satisfaction noticed at primary care practices and the hospital</i></li> <li>• <i>Patients keep log books to actively self-monitor</i></li> <li>• <i>Educational leaflets and brochures, and websites and telephone services also help patients self-manage their illness</i></li> </ul>	<p>*They're brilliant, they explained what will happen, and how to deal with it (PC14 Round 2)</p> <p>* There's patients have attended diabetic for educating, education sessions while in the program also respiratory type of education. Yeah. I must say it has improved. (GP1 Round 1)</p> <p>*Oh that [case conference] was extremely valuable, highly valuable for everyone. I think every patient that came through there were very good suggestions - and all of them were taken on board. And all the patients who were involved in that have better outcomes (GP9 Round 2)</p> <p>*the diabetes case conference, that's helped patients self-manage and I've definitely seen that a number of times for the patients on the integrated care program.... (GP5 Round 2)</p> <p>*I've been saying the same thing to the patient and achieving nothing, but when the team comes, the [patient] goes, okay, listens, this is the message, and just does it but it's actually good having someone else with the authority, reinforcing it, I think, makes a lot of difference (GP14 Round 2)</p> <p>* I've learnt a lot more about my heart problem and I have issues, what, with the lung and very bad infection of the lung and that and that took about nine months to get over, but, yes, I have learnt a lot from it. (PC7 Round 1)</p> <p>* some patients have gone to the COPD clinic and they've taught them or they've gone through their medication use and what medications do and how to actually administer them properly, so that's been helpful for managing their own condition.(HS9 Round 1)</p> <p>*We're going over everything; you know weight, fluid intakes. Keep an eye on the weight (PC4 Round 2)</p> <p>* was rather hard being his carer...to find out information. "Oh who are you? I'm his carer". Even now, we've been in Westmead, Blacktown and Mount Druitt in the last couple of months, and I walk away shaking my head. (PC19 Round 2)</p> <p>*I've done all the, like research online by myself, so, I think, I've learnt a bit through there (PC15 round 2)</p> <p>*my father calls me Dr Google. I said, "Yeah, well it's my body." But I'm not stupid to believe everything I read. (PC8 Round 2)</p> <p>* we give them an action plan which is when I get these particular symptoms this is what I do. I start taking more of my puffer and if that doesn't work then we've got Step 2 which I start taking this prednisone and/or antibiotics and I go and see my GP. And for some patients they really get it and they do it. (HS2 MG9 Round 1)</p> <p>*the dieticians and educators are some of the key players in enabling patients, because they often have the advice for day-to-day practical matters (HS4 Round 1)</p> <p>*I had a patient who's a newly diagnosed CCF and [CF] is brilliant, I was sitting here listening to her educate the patient on his newly diagnosed disease, she really is very, very good. The family were really pleased and I could sense that they felt quite comfortable with her knowing that she would also be a part of the team if they were in hospital or sent down to the RASS clinic and I think it was very well done. (PN3 Round 1)</p> <p>*most of them do feel more confident at the end of the program, in managing their breathlessness, and less anxious about being breathless (AH5 Round 2)</p>
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	<p>* when it's their home environment, they're far more open, to what education you're providing, and they can think in their own environment about how what you're saying applies to their meal preparation, their shopping. (AH6 Round 2)</p> <p>*we've slightly decreased the readmission rate, so I suppose that's something, as in they're weighing themselves regularly, they're watching their fluid restriction, they're taking their medication. Maybe we've got some people to stop smoking (HN2 Round 1)</p> <p>*we're doing a lot more preventative things and keeping in touch with the patient, it does improve their compliance with treatment and keeps them out of hospital. It has benefited the patients and a lot of them are keen to continue (GP12 Round 2)</p> <p>*we've seen improvements directly through HbA1c improvements and day-to-day glucose readings. So, yeah, they've been some very clear improvements and patients have engaged well (HS4 Round 2)</p> <p>*when they have eventually come to hospital they'll tell us, "But look I've been watching my weight," and this and that. So they flag the things that have been flagged and they keep their own log books and they come back in, provide the log books. I think they certainly have learned, how to, watch for deterioration, what to do if - and we've developed patient's plans with them and it's certainly given them that sense of ownership about their own health (HS10 Round 1)</p> <p>*it definitely improves, because my patients have a really good education from the clinic. They are very happy. (GP3 Round 1)</p> <p>*the patient does see a specialist as well but the heart failure CNC has been able to kind of give them some other education about their condition as well as monitoring and any other suggestions that may be able to assist the patient in that sense (GP4 Round 1)</p> <p>*there's a lot of educational leaflets and brochures and education provided in terms of the disease, puffers and smoking cessation, and so forth (HS11 Round 1)</p> <p>*They have a Better Health website, which is good; we can give them the resources available, can easily print out what's available, and then hand it over to them. Even the GPs can easily do that as well. It's, basically, a source of library for everybody else out there in the community (CF4 Round 2)</p> <p>*How to control – if I'm having a panic attack. If I'm having an anxiety attack, which has been – they've been so helpful up there. And, just the general breathing part of it. (PC11 Round 1)</p>
<b>Navigating the health system</b> <ul style="list-style-type: none"> <li>• <i>Patient hotline gives patient a central point of call</i></li> <li>• <i>Patients can contact CFs but not all have easy access</i></li> <li>• <i>Some patients prefer to go through GP</i></li> <li>• <i>System provides familiarity to patients</i></li> </ul>	<p>* I certainly see patients ring up on the hotline, so I think that's - they feel that that's better, and our sort of bits and pieces feedback from them has been that they are happier with their understanding of their condition and who they need to talk to. (HS1 Round 1)</p> <p>* I think, the patients are, like I said earlier, feeling like they've got a central point of contact and that they're not lost in a sea of people that are trying to help them that are not connected and they don't know where to go, and, I think, they're feeling like they know where to go to get the help that they require. (AH3 Round 1)</p> <p>* I think they appreciate that that there is a care facilitator as well with a bit of a one stop kind of shop if they have got</p>

<ul style="list-style-type: none"> <li><i>Patients also followed by clerical staff- impacts DNA rate</i></li> <li><i>Patients and carers know who to call and when to call-awareness of services</i></li> <li><i>WSICP has prompted HCPs to think about patient navigation but some patients are still highly dependent on their GP</i></li> </ul>	<p>questions or problems, help them navigate the system (GP6 Round 2)</p> <p>* Sometimes they're not sure whether to call – we've given them online and mobile numbers but some of them ... have to rely on a landline and they might be not have access ...Also not having IT knowledge (CF4 Round 2)</p> <p>* they still don't see us at the point of contact, they would much rather do their GP and then get the GP to call us, which works well as well (CF2 Round 2)</p> <p>* ... a familiar face to the patients that come and see quite frequently in the hospital setting (HS10 Round 1)</p> <p>*they get a number to call, they can just pick up the phone and ring the nurse or pick up the phone and ring the doctor and that's kind of all they need. They've got so many other things going on, so the fact that they can navigate that or go to the GP, get the GP to call us, I think that is a big plus, the navigation aspect (HS11 Round 1)</p> <p>*I think it's made things a bit easier for them... because we've got a clerical person, they've been able to follow them up...that's had a huge impact on the do not attend rate (HN2 Round 1)</p> <p>*I think it's made things a bit easier for them... because we've got a clerical person, they've been able to follow them up...that's had a huge impact on the do not attend rate (HN2 Round 1)</p> <p>*Now I know who to call and when to if I need them (PC7 Round 1)</p> <p>* Good to know that, there's things out there that I can get on to if I need to find out anything more, which makes it easier for me (PC16 Round 2)</p> <p>*I've said to a number of patients, if you start to put on more than two kilos, if you're not able to do the same sort of activities as you were, if you're getting more short of breath, call your GP, try and get an appointment." They go, "He only works two days a week." "Okay, you call us and we'll arrange a clinic appointment." But I'm always going to stress that they need to call their GP first because they're the primary person responsible for their care (HN5 Round 1)</p> <p>* ...if you're away and something goes wrong, they know who to call apart from us. (GP6 Round 1)</p> <p>* And, so, integrated care has helped me think about the patient's navigation through the system and how all the little bits link up together.(MG1 round 1)</p> <p>* the patient is very dependent on the GP, or the practice nurse on making phone calls, so they come to me and then hopefully I'll know where and who to call (GP8 round 2)</p>
<h3>Training and Education of practitioners</h3>	
<b>GPs and practice staff</b> <ul style="list-style-type: none"> <li><i>Hospital specialists from the WSICP are visiting general practices and providing education in the program's three areas of chronic illness</i></li> <li><i>A multidisciplinary approach to</i></li> </ul>	<p>* Because we're looking more at the practice nurses and that sort of thing and there is education going on for them in the three disciplines, diabetes and respiratory, we've already done that, and we start ours in the middle of June, so they'll get four sessions on heart failure.(HN4 Round 1)</p> <p>* respiratory were saying maybe we could come out and show you how to do spirometry and I think that is part of a similar thing but I have tried to encourage them that it actually is better if we have the patient and talk about particular patients because that's actually means I learn a lot but yes it is part of the skilling up process (GP5 Round 1)</p>

<p><i>education</i></p> <ul style="list-style-type: none"> <li>• GPs prefer case based approach</li> <li>• Education increases general practice awareness which may increase referral</li> <li>• Hospital specialists learn about general practice needs</li> <li>• Hospital allied health providing education in the community and building relationships</li> <li>• Hospital admissions are reduced</li> <li>• Need for education about integrated care</li> <li>• General practice staff learning and building skills- satisfaction</li> <li>• Case conferencing builds GP confidence and relationships</li> <li>• New practice skills translate to patient self-management</li> <li>• Education workshops are not always taken up well by GPs</li> </ul>	<p>*three times last year an endocrinologist came to my rooms at three different locations seeing my diabetic patients, they brought their diabetic educator, and we lined up my poorly controlled diabetics to see them with us. (GP8 Round 2)</p> <p>* the conferencing we have done has mainly been with or without the patient present, and then with the care facilitator and with the public community nurse, with our pharmacist, the dietitian and allied health professionals (GP6 Round 2)</p> <p>*My work in diabetes, which is also aligned with the Integrated Health Demonstrator Project, is about building the capacity of general practice to better manage diabetes and the way that we have been doing that is with a series of interventions that one of those is case conferencing (HS8 MG7 Round 1)</p> <p>*we're coming out to extending –but also explaining and educating and that also, maybe in some sense, could actually end in referrals (HS5 Round 1)</p> <p>* going out to GP practices and doing some teaching has been incredibly eye-opening, I've got a much better understanding of what it is my GP colleagues want and need. (HS2 MG9 Round 1)</p> <p>*Based on that feedback that I got from dieticians within the community, and also our OT and psychologist got from those relevant disciplines in the community, we decided to run an education evening for allied health in the community, just to share what we're doing, and what messages we think are worthwhile reinforcing in the patient group, so that was a really good opportunity to network outside of the hospital (AH6 Round 2)</p> <p>*Conferences have been really good. They've been good in terms of formulating the plan and avoiding unnecessary referrals (GP2 Round 2)</p> <p>*education as far as GPs, yes, there has been some education done but it probably needs to be a lot better from WentWest sort of process, because I don't think the GPs actually know that it's there half the time (HN2 Round 1)</p> <p>*I am learning from sitting down with [CF] [laugh], she's been - seriously she's awesome, I really like her she's good at her job and she knows her stuff and I have learnt and I'm also coming from a paediatric background so all this adult stuff is pretty good for me, so I'm learning a lot (PN3 Round 1)</p> <p>* I think understanding of the management of the patient has improved, so I think overall it's starting to improve education as well of managing the patient (GP6 Round 1)</p> <p>*It's been fantastic [case conferencing]. The treatments from the GPs have increased. They're more confident to changing medication and up medications. And the patients seem to like it as well because they prefer to come to their GP than go to a specialist (PN3 Round 2)</p> <p>*they upskill GPs. I still feel anxious about starting people on insulin but I am able to do that now, whereas before I wouldn't have felt comfortable doing that. (GP5 Round 2)</p> <p>* our nurse has been educated in diabetes, it really improves her knowledge. She's meeting up with patients. The fact that she is more educated and knowledgeable about diabetes is also then transferring to our patients in helping them self-manage as well (GP5 Round 2)</p> <p>* we go out to GP practices, but we've also put on a couple of education nights for GPs which have been pretty</p>
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	underwhelming, to be honest. We get less than 10 GPs, for our education night. We get some general practice nurses and some other practice managers and things, but in terms of educating GPs that's been a monumental waste of my time. Because they just won't turn up, and I put on free meals for them, it's been in different venues (HS2 MG9 Round 2)
<b>Hospital and specialist</b> <ul style="list-style-type: none"><li>• <i>Clinical and integrated care educational initiatives in the hospital</i></li><li>• <i>Learning and teaching are reciprocal</i></li><li>• <i>Working with others facilitates learning</i></li><li>• <i>Adapting theoretical knowledge practically</i></li><li>• <i>Learning to manage comorbidity</i></li></ul>	<p>* We've had guest lectures on COPD and other sort of Breathlessness Clinics, we've had library education, we've had in-house education from registrars about COPD in terms of what they look at and FEV1 and all those sort of things that some health psychologists aren't so up with. So it has really been educational for various different health professions, different perspectives, so OT and dietetics and so on, so everyone showing their piece of the pie (AH5 Round 1)</p> <p>* There are a number of seminars, more so planning meetings and to speak about the intention of the integrated care program. (HS5 Round 1)</p> <p>* for our own training purposes, and we speak on a regular basis to those in the other teams such as cardiology and also respiratory, so that's great stuff (HS4 Round 1)</p> <p>* I've been attending the meetings every six weeks, we have these operational meetings and I get to learn about, the integrated care how its developing and all of the challenges and how we are working towards, mitigating those challenges (HS6 Round 2)</p> <p>* I work with an amazing team. And we always do education to try and make sure that each member can teach the other member of the team something new about – from their speciality. And I had an amazing consultant, and CNC's that mentor me (HN3 Round 2)</p> <p>* I think, the emphasis on education for those sorts of areas has been really huge, really valuable, really steep learning curve, but, yeah, I've probably learnt more in the last three or four months than I have for a very long time. So, just that gain of knowledge from working so closely with them. (AH4 Round 1)</p> <p>* I'm actually more au fait with how to manage foot wounds, the influence of off-loading, the kind of shoes they have to wear, the important of blood pressure control. And we've also moved into the area of anxiety and psychology and mood, because that's really important (HS5 Round 2)</p>
<b>Changes in Practice</b>	
<b>Collaboration/ communication between community and hospital</b> <ul style="list-style-type: none"><li>• <i>Cooperation between Primary and Tertiary sectors to integrate care</i></li><li>• <i>Hospital connects with external providers</i></li><li>• <i>Hospital staff connecting better with GPs – and learning of their needs</i></li></ul>	<p>* Well, the most positive factor, I think, is the spirit of cooperation between primary care and hospital care. And, so, those who are involved in integrated care, whether they come from primary care or from the hospital end, have been very enthusiastic and keen to have integration of care. (MG1 Round 1)</p> <p>* We have a contact with external imaging services that are able to accommodate, the level of investigations we require, in terms of the volume.(HS6 Round 2)</p> <p>* As a result of the program, there are - for my service there has actually been better communications between some of the GPs and us, and I'm finding I'm getting more responses, or we're getting more responses from the cardiologists. We've had a more formal letter going out with the care plan on it to all cardiologists that meets their needs, so they're</p>

<ul style="list-style-type: none"> <li>• GPs use WSICP rather than sending to ED</li> <li>• Hospital allied health now better connected with community allied</li> <li>• Feedback from GP to hospital is not always direct or frequent though possibly changing in second round</li> <li>• Some GPs better informed when patients are admitted</li> <li>• More immediate communication from hospital to GP</li> <li>• Hospital Follow up post discharge useful</li> <li>• Care facilitator is pivotal in hospital and General practice communication and in connecting strongly with community services</li> <li>• GP staff more aware of services</li> <li>• Referral to specialists easier</li> <li>• Limited number of patients in WSICP in early days</li> <li>• Education at general practices establishes stronger links with hospital</li> <li>• Practice managers visit hospital for education</li> <li>• Patients and carers note greater collaboration between GP and hospital and improved feedback</li> <li>• Carers receive feedback</li> </ul>	<p>more aware of what we do.(HS9 Round 1)</p> <p>Historically, if GPs were unsure of these patients, they would just say, "Go to emergency," but if they have something to fall back on, again, that's helping out the community in terms of building a bridge between primary care and the specialists, respiratory and cardiology and endocrinology.(HS6 Round 1)</p> <p>* Yeah, look, I've been in contact with community dieticians that I haven't been in contact with before and I think that will have benefits in both of my roles.(AH6 Round 1)</p> <p>* I feel like I can now have the capacity more to contact GPs and write them letters and say, well I'm happy to keep seeing the patient here, however could be beneficial for them to see the private dietitian (AH2 Round 1)</p> <p>*my role is to arrange some long-term follow up - actually involves liaising with their GP to organise for them to see their GP on a regular basis for a long-term review (HS5 Round 1)</p> <p>*The doctors from the hospital are more into calling us for more information, I think, there's no hesitancy to ring us if they need help (GP8 Round 2)</p> <p>*We do seem a little bit disjointed, I've had GP feedback but not from the GP's, it's come via a third, fourth, fifth person and it would be much better that if there was an issue that they discussed it with me. (HN5 Round 1)</p> <p>*We see there are actually more GPs contacting the service with regards to referring their patients to our care. There are more doctors being talked to by the care facilitators in regards to how the services are being done (HN6 Round 2)</p> <p>* I've worked on getting quite a good communication going between the community nurses and the heart failure service, so that's continuing. GP wise sometimes we get something, a lot of the times we don't; we're sending them everything and hearing nothing back (HN4 Round 2)</p> <p>* the feedback or the communication has been much better. I'm seeing changes or I'm learning about patients being in hospital much sooner. And therefore I'm able to follow up those patients a lot sooner as well. (GP9 Round 2)</p> <p>*the patient that's in the Integrated Care Program, they go to hospital, I get notified, which is excellent. It would be good if I had that with all my patients. (GP2 Round 2)</p> <p>* The only thing we are kept out of the loop lately is when our patients are admitted to hospital (PN3 Round 2)</p> <p>*From a GP point of view I still feel that maybe the doctors in the hospital aren't as well aware of the program requirements (GP4 Round 2)</p> <p>*the relationships between general practice and the specialists are greatly improved and therefore I think you are able to actually manage more disease better and earlier in general practice (HS8 MG8 Round 2)</p> <p>*while I might call some of the GPs and have a chat to them about the patient if they're quite a difficult patient or quite complicated, I still haven't met that GP. There's a professional relationship but it would be nice to know who you're talking to (HN2 Round 1)</p> <p>* ... I call the GP from the clinic and say, "I have your patient here. We're going to do this." So it's not just a letter. (HS1 MG7 Round 1)</p>
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	<p>*I feel that the discharge summaries have been coming out really promptly and really good summaries – good communication from the hospital about that (GP5 Round 2)</p> <p>*the main person it changed with is the care facilitator. I think that is the person who is having the most contacts with us still face-to-face or on the phone or anything like that. (GP6 Round 1)</p> <p>*I think it's easier to refer to the specialist than before (GP3 Round 1)</p> <p>* There is a shift in the thinking with the hospital - between the hospital and the GP. There's more communication with the rapid access clinic and things like that. It was very hard for us, previously to try and talk to someone and get them admitted but now it's a lot easier. (GP12 Round 2)</p> <p>*I only have a few patients who are linked up with the integrated care program. So, for example, that heart failure CNC, I got correspondence back on her I think within a week or so (GP4 Round 1)</p> <p>* we have multiple talks with the GPs and even visiting practices to talk to GPs about education; it's opened up those links as well and we can't forget also communicating with the patient because obviously they have a point of contact, but the feedback has been very positive for patients, to have a point of contact (HS11 Round 1)</p> <p>* linking the specialists in with the GPs that are looking after their patients as well, so it's definitely helping the communication side of things, and it's definitely helping with access which is a really big part of improving the care of the patient. (GP6 Round 1)</p> <p>*recently we had little visits from practice managers. They came in to review Integrated Care Clinic to see what went on, so that they could better understand what happens with us and they could relay that back to the GPs (HS4 Round 2)</p> <p>*I think there maybe more contact with Dr [GP] from the hospital because of it [WSICP] (PC9 Round 1)</p> <p>*We are on the same track. The psychologists, the doctors, the care plan clarified – hopefully you get to understand drugs, how to manage correctly, so they are good. It's also, like an assurance for me that I'm doing it right. As a carer (PC18 Round 2)</p>
<b>Collaboration/ communication in the hospital</b> <ul style="list-style-type: none"> <li>• <i>Greater collaboration and communication across disciplines to attend to patient comorbidities</i></li> <li>• <i>Collaboration includes multidisciplinary team care</i></li> <li>• <i>Cross hospital collaboration improved</i></li> <li>• <i>Rapid access clinics facilitate within hospital collaboration</i></li> <li>• <i>Collaboration is not always equal</i></li> </ul>	<p>*it's given them more access to each other. We were working in siloes before almost didn't know the other was there (HN4 Round 2)</p> <p>* So many of the patients are shared anyway, you know, they sort of bounce back and forth from the normal heart failure program, integrated care, when they have deteriorations and so for, so, yeah, we work as a team.(HS9 Round 1)</p> <p>* we try and link them on the Friday morning if they're there seeing their cardiology, then, yeah, we get them sent to us, and the same with respiratory, there's been a couple of referrals recently from them into our clinic. (HN1 Round 1)</p> <p>*with patients that require, for example, endocrine and cardiac input, we will try and put them into our combined clinics on a Friday (HS1 MG7 Round 2)</p> <p>*my Thursday morning foot service, there is also the infection disease department because they're also vascular, so the actual surgeon is there, and quite a lot of foot doctors as well – podiatrists – we're engaged with them a lot more than we were, which is fantastic (HS5 Round 2)</p>

<p><i>across disciplines sometimes due to location</i></p> <ul style="list-style-type: none"> <li>• <i>CFs relationship with management more effective</i></li> </ul>	<ul style="list-style-type: none"> <li>* I know we're all trying to work to the same thing, and there's care coordinators out there trying to recruit the GPs. But, I think, the three chosen areas, as it were, I don't think we're talking that well together (<b>HN1 Round 1</b>)</li> <li>* Diabetes and cardiology want to work together to see patients with comorbidities so that's great. (<b>MG2 Round 1</b>)</li> <li>* Also we're now aware of the groups in Blacktown as well, so I think that there definitely has been improvement in that (<b>HS1 Round 1</b>)</li> <li>* the CNC nurse and doctor work well together, they're connected, and by involving emergency and respiratory even at Mt Druitt emergency to give some talks because we get admissions from there to Blacktown Hospital, and also they're getting better with other specialities, with cardiology and diabetes working together with them and having joint meetings with them (<b>HS11 Round 1</b>)</li> <li>*we meet once a week following clinic when we go through every patient and who has been involved and what the outcomes were and what to do next. So for the whole 8-week period, they get reviewed each week. (<b>AH4 Round 2</b>)</li> <li>*being able to access the rapid access clinics for diabetes and cardiology has been really useful because I'll see a patient and I'll go, actually their sugars are a bit all over the place and I'm a bit worried. And before I wouldn't have known what to do that but now I know I can pick up the phone and call diabetes rapid access (<b>HS2 MG9 Round 1</b>)</li> <li>*the collaboration needs to improve, certainly in this program there's closer collaboration between respiratory and cardiology, very little with endocrine and I think that's something that we have to work on but I'm not really sure how to be honest because they're quite spread away. (<b>HN5 Round 1</b>)</li> <li>*we've had a couple of patients that we've had multidisciplinary approaches with, with the endocrine, not so much with respiratory here...We have a multidisciplinary day every Friday morning if required (<b>HN2 Round 1</b>)</li> <li>*the problem is in respiratory where it is so isolated from where cardiology and diabetes are. So we're up on Level 5, while they are on the ground floor...they might have interaction with each other, compared to respiratory (<b>HN3 Round 2</b>)</li> <li>*the team has become more collaborative, within our own management team we're all working together this year so they are best to understand our frustrations and try and translate that into solutions for us, that's changed (<b>CF2 Round 2</b>)</li> </ul>
<p><b>Team based care</b></p> <ul style="list-style-type: none"> <li>• <i>Multidisciplinary team includes allied health</i></li> <li>• <i>Linking GP and Hospital for complex patients</i></li> <li>• <i>Linking to private specialists</i></li> <li>• <i>Team based care addresses patient needs and includes home visits</i></li> <li>• <i>Case conferencing facilitates team work</i></li> </ul>	<ul style="list-style-type: none"> <li>* I guess, there's another thing I've noticed, is there's – when you're endocrine, then you've got your chronic heart failure and then the COPD, the respiratory team, and I find that, yes, we are integrated care (<b>HN3 Round 1</b>)</li> <li>*meeting with all the – other specialties like cardiac and respiratory, it's really good. You can see then what they're doing together, like we work together (<b>AH1 Round 1</b>)</li> <li>* we're lucky that we have got such a good team environment here, so our allied health are onsite and easy to communicate with, you can do joint consults, you can team up which makes the communicating side of things a lot easier... it really helps to optimise the patient care and share the care around (<b>GP6 Round 2</b>)</li> <li>* here at the moment we have a dietitian and an educator – we have our clinicians and the registrar as well who also works with us (<b>HS5 Round 1</b>)</li> <li>* In terms of Allied health, I would say – it has increased, I mean I go to different case conferences and different practices</li> </ul>

<ul style="list-style-type: none"> <li><i>Increased GP capacity to do more on site helps carers</i></li> </ul>	<p>where the patient's reviewed with the exercise physiologist and we're all around the one table and we talk about different patients (CF3 Round 2)</p> <p>*the multidisciplinary team we've created for the breathlessness clinic has been really useful and it's really interesting because we've got OTs, the dietician, a physiotherapist, a nurse and a psychologist on that team (HS2 MG9 Round 1)</p> <p>*we work alongside allied health, often sharing the room and doing something and they're doing something, we're all working together rather than the educator being separate to me (HS4 Round 1)</p> <p>* they've been able to employ the dietician and educators and I guess before those patients wouldn't be touched, but now we are getting through more and more people. (AH2 Round 1)</p> <p>*I never had all this dieticians and things like that but now all of a sudden everybody's getting involved (PC10 Round 1)</p> <p>* The OT goes in and enters their home environment to try and see if they can improve and make life easier and happier for them. And then if we think they have problems with their level of anxiety or depression, then we refer them to our clinical psychologist (HN3 Round 2)</p> <p>*We see dieticians down there and there's someone there from the chemist, like to help you with your medication... since he's come home there's always someone ringing me up or coming out (PC19 round 2)</p> <p>* with the case conference and I think it is a good thing, because we can see everyone's input on it and we can work together as a team to better manage this patient (CF4 Round 2)</p>
<p><b>Keeping people well - focus on preventative health (and seeing patients earlier)</b></p> <ul style="list-style-type: none"> <li><i>Organisational direction to prevent illness</i></li> <li><i>Patients no longer need multiple hospital visits</i></li> <li><i>Some patients visited at home when they cannot attend hospital</i></li> <li><i>Patients seen early in disease trajectory</i></li> <li><i>Short term interventions improve patient outcomes</i></li> <li><i>Rapid access and stabilisation is preventing complications and admissions</i></li> <li><i>Early intervention allows a focus on self-management</i></li> </ul>	<p>* so, at an organisational level, we're looking at how we better manage health in Western Sydney and how we keep people well as opposed to how we treat people that are sick. (MG2 Round 1)</p> <p>* before the Integrated Care Program Mum was constantly either getting admitted into hospital, like I said before, so they would treat or fix one issue and then she'd come out of hospital and she had something else wrong... The medication was constantly being changed, whereas now the Integrated Care Program over the last six months I think she's been into hospital twice... she goes for two months with her blood pressure and her sugar and everything on track. (PC1 Round 1)</p> <p>*they're feeling a little bit sick. They cannot attend the appointment because they are feeling unwell, in which case we're just coordinating it with the CNC, who is more than happy to do home visits (HN6 Round 2)</p> <p>* we're going out and doing home visits, it's also that they're quite frail, they're very breathless, they're often carting around oxygen tanks, so a lot of people are really hesitant with respiratory conditions that come to the hospital environment, because they might pick up a bug and get sick and land up in hospital (AH6 Round 2)</p> <p>* This provides a service where we see these patients very early on within most of the patients nowadays we're seeing within 48 hours. (HS6 Round 1)</p> <p>*we picked up in a week there was two patients which we didn't even think were going to be an issue, ended up going for emergency by-pass. So, definitely prevented a heart attack and definitely prevented them dying (HN2 Round 2)</p> <p>* huge research that shows diet and exercise is better than anything else. So I guess our educators here, it has –</p>

<ul style="list-style-type: none"> <li><i>Regular monitoring is noted positively by patients and prevents hospital admission</i></li> <li><i>Keeping people well extends beyond the medical to the social domain</i></li> </ul>	<p>hopefully you'd think in the community it's made a difference and will prevent admissions, will delay complications of onset of diabetes (AH2 Round 1)</p> <p>*we're picking up changes earlier and keeping on them, it does help them to self-manage a bit better. (HN4 Round 2)</p> <p>*For me just ongoing monitoring is the main thing. ...all of it's been positive in the way of the care I've gotten once something's happened. (PC4 Round 1)</p> <p>*we're doing a lot more preventative things and keeping in touch with the patient, it does improve their compliance with treatment and hopefully keep them out of hospital (GP12 Round 2)</p> <p>* urban design, transport, food supply and physical activity, and then identifying people at risk of, say, chronic disease as an example and then working with primary care as they interface with the health system to keep them healthy and keep them well (HS8 MG7 Round 1)</p>
<b>Patient centredness</b> <ul style="list-style-type: none"> <li><i>Patients receive better communication</i></li> <li><i>Patient care individualised</i></li> <li><i>One-on-one care</i></li> <li><i>Patients know they are the focus</i></li> <li><i>Doing what is important to the patient</i></li> <li><i>Patients feel heard</i></li> <li><i>WSICP changes how care can be provided in the hospital</i></li> </ul>	<p>* Oh, yes, I believe it has, I find that the people are more forthcoming and at least you can stay and talk to them and you'll get an answer.(PC7 Round 1)</p> <p>* they really feel a bit special, a little bit like, hey, this is the first time that I really have been looked after, in a way that they can understand, in a way that they really seem to appreciate and can engage with (AH6 Round 2)</p> <p>* we were all giving him information, but, I think, he was quite empowered, because he knew we were all there doing the different things, but he was still the centre of what was happening (AH2 Round 1)</p> <p>* might see that them not being able to get a shower is really very important, but they may not. So, therefore, I don't work on that. I work on other stuff. Making a cup of tea, walking to bingo, or whatever, it has – into the garden. Sitting in the garden, whatever it is, so it is becoming more focused on that. So what they want to achieve (AH4 Round 1)</p> <p>*The cardio, when stuff has happened, he fits me in ahead of schedule on things, so everyone's been good. They actually get it done. They know I'm not a hypochondriac, so if I say something is wrong they listen (PC4 Round 1)</p> <p>*when you were working in a large hospital, with 50 patients to manage, there was no luxury - to do good care was a luxury. It was, logically, difficult. But the Integrated Care Program is so amazing that we have - because of the patient focus, everything we do is so mindful, that it is all about our patients (HS7 Round 2)</p>
<b>Holistic Care</b> <ul style="list-style-type: none"> <li><i>Addressing complexity</i></li> <li><i>Comorbidity especially psychological needs addressed through multidisciplinary patient centred care including in the home</i></li> <li><i>Time efficiency for those with multiple needs</i></li> </ul>	<p>* some of the more complicated patients... have received more intensive care. (GP1 Round 1)</p> <p>* From a psychology perspective, it's a big difference, because psychology is not often included in a lot of medical conditions whereas a lot of people with medical conditions have pre-morbid anxiety and depression and it's a big cycle. I think treating one helps the other.(AH5 Round 1)</p> <p>* the fact that they can get a lot of different services rolled into one will be attractive for patients that they can not only have their symptoms addressed by the doctor but they can have their issues with food addressed and they can have their issues with anxiety or depression or manual tasks with the OT and the psychologist.(AH6 Round 1)</p> <p>*someone rang me yesterday and said they're going to come out and offer me support. And then they're going to have someone come out to me weekly. And I think he said talk psychologically. Because I find going out of the house</p>

	<p>traumatic and I don't care if you come here but I don't want to come to you (PC8 Round 2)</p> <p>* he [GP] has a nurse come in to do his blood tests on one and a half days a week. Then he has a podiatrist come in once a month (PC3 Round 2)</p> <p>*if they were accessed by our service they would see that the diet educators and doctors all at once – so you can package the service into a one hour, two hour period, rather than, say, an admission or have a patient come back three times to see different parties (HS4 Round 1)</p>
<p><b>Valuing of WSICP</b></p> <p>Participants from all stakeholder groups valued the WSICP and considered it worthwhile. They spoke about many areas:</p> <ul style="list-style-type: none"> <li>• Patient self-management</li> <li>• Moving care into the community and improving relationships between GPs and Hospital</li> <li>• Change observed even in short space of time</li> <li>• Longer term benefit</li> <li>• Connecting disjointed care for chronic conditions</li> <li>• Patients and carers valuing</li> <li>• Rapid access to care</li> <li>• Improved patient quality of life</li> <li>• Patient confidence improves</li> <li>• Health care providers able to provide better service</li> <li>• Linking up HCPs to provide better care</li> <li>• Continuity and familiarity with care providers especially CFs</li> <li>• Improved patient access to providers</li> <li>• Holistic care</li> </ul>	<p>* Look, if we can help these patients manage their health better and try to get them out into the community and get them to see a GP, and manage their health, I feel like, yes, it is worth it.(HN3 Round 1)</p> <p>* I'm seeing a lot more improvements, in terms of the patient's ability to self-manage their condition and making sure they go to their GP before it becomes worse(CF3 Round 2)</p> <p>* it's actually a really huge step forward for the LHD and the hospital system to say that the care and the management of patients with chronic and complex illness is based in general practice. That is a massive shift in attitude and understanding and to a lesser extent, behaviour. I do think that's been achieved to varying degrees certainly, and still a long way to go in terms of the attitude of many specialists. (MG3 Round 2)</p> <p>* the health system where it used to be centralised, now it's more decentralised, more for the patient's better care, and trying to help them out in the community and manage them in community, rather than send – bring them down to the base and doing things, which is going to cost extra for the government anyway. (CF4 Round 2)</p> <p>*if we can look after patients in the home setting, or in the general practice, limiting their admission time ... it will certainly be cheaper (GP8 Round 2)</p> <p>* the relationships between general practice and the specialists are greatly improved and therefore I think you are able to actually manage more disease better and earlier in general practice and if we keep doing this, we're going to bend the curve a little bit (HS8 MG8 Round 2)</p> <p>*trying to bridge that barrier from between the hospital and the GP, and to move the burden of care for some of these chronic diseases back to the GP, and it's trying to create a connection that is easier to navigate. I can see how all of those things are happening (HS3 Round 2)</p> <p>* I'm familiar with a lot of the challenges and difficulties and I think even in this short space of time, I feel like we've improved some of those things. And you can – when you know, sometimes if you can see a tangible improvement... it makes you feel that that investment is rewarding.(HS3 Round 1)</p> <p>* the fact that we're coming into a pretty hopeless situation where they're at rock bottom, and we seem to be improving their quality of life measures, and improving their management of their chronic disease, what I've seen from the small amount of data we've got so far just seems to be quite incredible (AH6 Round 2)</p> <p>* even though it's early stages, I think it will have a significant positive impact in the future. Yeah. I think it's a good idea</p>

<ul style="list-style-type: none"> <li>• <i>Joining up services beyond WSICP</i></li> <li>• <i>Investment worthwhile</i></li> <li>• <i>Time effective for GPs</i></li> <li>• <i>Good return on investment with HCPs providing better service</i></li> <li>• <i>Reduced admissions</i></li> <li>• <i>Increased patient and provider awareness</i></li> </ul> <p><i>Beneficial systems level changes were noted already, as seen above, and were expected to continue and grow.</i></p>	<p><b>(GP4 Round 1)</b></p> <p>* I can already see that the benefits of this service will be really fantastic, and the thing that I feel we're doing really well is targeting those people with chronic health needs who often had disjointed care and gaps in their care. So, yeah, I found it fantastic. <b>(AH3 Round 1)</b></p> <p>*the results that we're starting to see and the effects so that it has a – makes an impact, so I think it is worth the sum of money and it got a more core service for the patients <b>(AH4 Round 2)</b></p> <p>* With the health service, the best thing I've ever actually come across. <b>(PC1 Round 1)</b></p> <p>*when they talk, they are actually keen on attending the Integrated Care Program, because they have actually seen improvements. <b>(HN6 Round 1)</b></p> <p>*They [patients] really like the idea that the specialist and the GP are in the room together at the GP's practice and they tell us often that they find it difficult to get into the hospital because in most places you've got a big wait list and it's very inconvenient and it's really difficult for them. But the very fact that we're out there seeing them with their GP or they know that we're building the GP's capacity is seen in a really positive light <b>(HS8 MG7 Round 1)</b></p> <p>*I was just one of the patients in a block of patients that were waiting to be looked after, but when I was on the program, there was an indication that I was just being sent through to be put in a ward and being X-rayed and being attended to in very quick time - very good care <b>(PC9 Round 1)</b></p> <p>*we've been able to get people into pulmonary rehab within a month of hospitalisation and there's good evidence that that prevents rehospitalisation. So that's been really nice, that's worked really well. <b>(HS2 MG9 Round 1)</b></p> <p>*we can get these patients in, we get them seen reasonably quickly and from the point of view of the community they're seeing an actual consultant in a couple of days. Now where can that happen in any other service? <b>(HN2 Round 1)</b></p> <p>* we do improve the work for the hospital in that, you know, patients are in emergency departments for less time and they are seeing their own specialists much sooner. They have a firm follow-up plan, compared to the time where there wasn't a rapid access clinic <b>(HS6 Round 2)</b></p> <p>* that makes people feel comfortable when they see a face and they know they'll see that face somewhere else and that person's able to control their health, control their appointments, their exposure to emergency departments or try to limit that, it really did make them feel comfortable and the care facilitator role, I think, is excellent <b>(PN3 Round 1)</b></p> <p>*things that have been of particular value have been giving that patient the ability to have contact people in the program.....the heart failure nurses that are really contactable, that gives that patient extra... reassurance, and autonomy <b>(GP6 Round 1)</b></p> <p>* it gives us an opportunity to look at the patient as a whole and treat them a bit more holistically, instead of just addressing their one problem at a time when they come in, which we often do in general practice. <b>(GP12 Round 2)</b></p> <p>*The organising of more services for the patients and having someone to help streamline that process has been really valuable as well. We've had patients that have needed the assistance from the Health One team as well, so that the</p>
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	<p>integrated care coordinators have been able to bring that in ..so it's all ... streamlined in kind of one place (GP6 Round 2)</p> <p>*I think it's – philosophy is very good. I think if it works it works. If it works it will make a huge difference and it's certainly worth the investment I think (HS10 Round 1)</p> <p>* Initially I thought it was going to create a lot more problems, like take a lot more time. If anything it's actually made it work a lot more efficiently. And care plans are now up to date. Care plans are being followed up properly - I'm definitely seeing that it's helping and I'm getting results (GP9 Round 2)</p> <p>*we're more able to treat the underlying condition more effectively; we're able to address complications and then hopefully improve their quality of life. Definitely I think that's money and time well spent. I think it's a good program that is actually going to be effective (GP6 Round 1)</p> <p>*ED avoidance or getting them to get out of ED quickly so they don't need to stay in hospital for long; they can be at home and they can be linked up to come and see us the next day in the hospital. So these are all benefits that have come about. I think the value of the service cannot be underestimated in preventing admissions and improving patient outcomes.(HS11 Round 1)</p> <p>*a patient who used to come in once every month, now haven't seen him for a few months in the hospital because he's been managed through integrated care service (HS7 Round 1)</p> <p>*when I went in there she took all the usual things that they take...your weight and all that... she saw that phlegm that came out which was pretty yellow, and I told her that I'd already been on these tablets. Anyhow, she called the doctor in that works with her, and the doctor prescribed me these other tablets, which I got. And they fixed me up within a week. I didn't have to go to the hospital (PC11 Round 1)</p> <p>* it has improved because it's not only the case of his diabetic condition but the general outgoing life, especially for the aged, for our age, it helps because I can ask some questions and the care plan giver - it's open, so you're not put away or whatever, so they are open to, like I would like to explain this and then they do, and it is helpful. (PC18 Round 2)</p> <p>*raising awareness and having a team to deal with that and to educate emergency nurses, doctors, look at how these patients are managed in hospital; all of those things have really come about as a result of the program.(HS11 Round 1)</p>
<p><i>Suggestions for the future incl new GP models e.g. capitation</i></p> <ul style="list-style-type: none"> <li>• <i>Include nursing homes in Integrated care</i></li> <li>• <i>Increase networking across hospitals</i></li> <li>• <i>Enhanced role for allied health professionals in follow up of high risk patients</i></li> </ul>	<p>* Why can't we go to the nursing homes and try and educate the nursing staff? If somebody is short of breath, rather than sending them into the hospital, they actually have qualified personnel there that can try and manage these things. But they just made that as one of the exclusion criteria.(HN3 Round 1)</p> <p>* I think, we just probably need to - that networking a little bit more just to see how we're all doing, how we're all going, that we can, sort of, trouble shoot as well, what works for us might not work for Blacktown, but vice versa, so it would just be good(HN1 Round 1)</p> <p>*all three specialities should be at the same place. Maybe, we do get these executive board meetings where we all meet up, and we look at all the data. But maybe once every couple of months, just the medical team, and the nursing team, and the allied health get together and maybe have a discussion as to how we could try collaborate and improve the</p>

<ul style="list-style-type: none"> <li>• Vision of expanding the model to other areas of chronic illness including psychiatry</li> <li>• Review GP payment models</li> <li>• Training in IT</li> <li>• Review communication processes between hospitals and GPs</li> <li>• Explore options for client education groups</li> <li>• Expand cardiac services in the WSICP</li> <li>• Greater general practice staffing support</li> <li>• Improved IT support including easier to use</li> <li>• Changes to care plans need to be flagged</li> <li>• Ongoing investment in integrated care</li> <li>• Access to outreach for patients/carers</li> <li>• Greater engagement with non-medical community services</li> <li>• Expand case conferencing to other disciplines</li> <li>• Develop electronic capacity for case conferencing</li> <li>• Enhance community valuing of continuity of primary care and awareness</li> <li>• Review exclusionary criteria</li> </ul>	<p>system (HN3 Round 2)</p> <p>* I've heard a number of other clinicians say, maybe we should do an integrated care model, you know, maybe we should utilise those things in this problem, so, I think that's been interesting hearing people say we should apply similar things to other health conditions, or ways managing conditions, so, that's exciting to me. I think that, yeah, it will work for that as well. (HS1 MG7 Round 2)</p> <p>* You know one thing I'd like to add. If we could have an exercise physiologist, that would be good.(AH1 Round 1)</p> <p>* if there was a community educator – diabetes educator that would be great. I think so that all the community nurses would upskill their skill as well as connect with the GP (AH1 round 1)</p> <p>*people are very anxious and very depressed, and that for them is a major problem, and until you can break that barrier – so the other frustration is that we don't have our own team down there. I have an educator with me, I don't have a dietitian, and I don't have psychologists. (HS5 Round 2)</p> <p>* what else would be helpful would be if there was something similar for mental health where there was, like a link-up with a hospital or a psychologist or a psychiatrist, who would be able to review the patient on as needs basis, but having that would be accessible for the patients as well as (GP4 Round 2)</p> <p>*our patients, the patients who are in the Integrated Care Program need more facilities, like more physiotherapy for COPD patients, they are acute and chronically sick, but only five visits they can see with the therapist (GP11 Round 2)</p> <p>*a clinical psychologist, I really think there's a role for them - I've done my statistics as well and in my clinic I would say about 50% of my patients suffer from some form of mental illness, whether it's mild or severe.(HS7 Round 2)</p> <p>* They're looking at capitation funding plus pay for performance, whilst you're leaving a fee for service in place for the more episodic and acute ones. There's no way they will - the political end of the spectrum will move that far, that fast. But they may well have to move that far in the longer term. Despite the small volume of incentives that we've managed to bring in with this program, the system is still geared to reward high throughput, but not high value. (MG3 Round 2)</p> <p>*the concept [PCMH] is good however I'm not too sure how things will work in terms of – the funding is a big issue for that and in terms of how things would work in relation to Medicare. (GP4 Round 1)</p> <p>*[Health Care Homes involve] bundled payments with tiny amounts of money, and only for your sickest patients. We worked out we would be far, far, far worse off. (GP7 Round 2)</p> <p>*we're now working on E-referrals and sending out the information through the IT systems, so we could do with some more training from that side of things (HS5 Round 1)</p> <p>*would be good if we could e-refer but that isn't happening I need to fax information through (GP11 Round 2)</p> <p>*we should have actually like a pathways, like a flow chart of where we can actually say where to start or where to end or where to stop. (CF4 Round 2)</p> <p>* I feel a quick phone call is more useful for your GP than the long letter, and it's persuaded me that maybe I should do a quick phone call more often...shorter, sharper communication with the GPs might be helpful, and also just understanding</p>
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that we come from a completely different place (HS2 MG9 Round 1)

\*what I would love to do is have a program whereby we could just send out emails, we could just send out text messages to landlines (HN5 Round 1)

\*If letters were dictated and transcribed quickly then that could work. I'd probably spend an extra 10 minutes with each patient writing a letter myself. I don't mind when we have time, but on a busy day it slows things down. (HS4 Round 1)

\* we might have 12 patients booked in, they all get seen by the three doctors; there's only one dietitian. Something I have been thinking about is doing a group (AH2 Round 1)

\*Something to consider in the future - in like a group setting because I think that it may be helpful for patients to see that, for example, their diabetes or COPD or whatever it is, that it's not just them, that there are other people like them. (GP4 Round 1)

\*I would say more awareness for patients – so it can be like some health education to them, I don't know how we can go about it though. There are forums and all, but the patient's participation might be a little bit low (GP10 Round 2)

Education of the patient and of the community as a whole, and more exercise facilities (GP8 Round 2)

\*it would be good to expand it a bit, it would be probably good to look – well, we're doing chest pain and heart failure but to link in a hypertension clinic (HN2 Round 1)

\*if the GP's unsure whether this is an acute coronary syndrome or not, then we have no choice but to refer them to the emergency department, to exclude that. I think what would make a huge difference, if we were to have the resources, then if we could function as a mini clinic that is able to exclude acute coronary syndrome, then I think GPs would feel more comfortable sending the patients our way (HS6 Round 2)

\* I think it needs a little bit more investment in general practice... we probably don't have the manpower or the staffing or the funding to employ someone to be able to track these patients and recall them in, get them in... (GP3 Round 1)

\* you put a summary in shared care plan then you have seen them again and you have added all the diagnoses and you have put that back in a new shared health summary, but then you can't reimport that into the care plan (GP6 Round 2)

\*find a system that would interface with Cerner so that Cerner doesn't have to do it all. It can become the repository of it but you have intermediary systems that are much more flexible and built for purpose and let the programs talk to each other. (HS8 MG7 Round 1)

\*We needed to employ some IT people in integrated care not defer to the LHD IT. (HN5 Round 2)

\*if the IT was working it would make it much easier for everyone to not have any paper based communication. (HN4 Round 2)

\* more allied health follow-up, so however it would be funded, allied health could take on more of a role as well, not just in sessions that they are being provided through a GP managed care plan to use a team care arrangement, but if there is some other diversion or funding so that they can then put those high risk patients on a follow-up list or make sure that they are being phone followed-up (GP6 Round 1)

\*The thing that would make a really big difference would be if we could look at their notes, and they could look, maybe not everything, but if I could actually look and see what's happened. If we had a shared electronic record. (GP7 Round 2)

\* my suggestion is if ever, this would be occasionally, just making an appointment or just visiting the patient at home (PC18 Round 2)

\* we still don't have a definite room or a clinic to base integrated care on. (HN6 Round 1)

\* So I think a significant degree of investment in time and resources are needed to tackle that problem. It's not going to be a quick fix problem with low budget, so yes, I think investment in resources in terms of health professionals, location and equipment and administrative support is needed (HS11 Round 1)

\* tapping into that particular service with Blacktown Council. Or, in other cases, maybe a cab charge voucher that facilitates them getting to their appointment on time (HN6 Round 1)

\* \*diabetes do case conferencing, but how practical it would be from a cardiology point of view and how beneficial, but something where all the parties involved could get together would be good, that sort of thing, yeah (HN4 Round 1)

\*I keep saying to her, I think you should do the case conferences for COPD as well. (GP5 Round 2)

\*the practice can manage those cases without the specialist coming out. The [GP] would say that once that relationship is established, more of that can be done by video conference (MG3 Round 2)

\*I think having the community recognize the value of having one practice providing most of their care, coordinating it, would be, on top community education would be really useful (GP7 Round 1)

\*There's not a lot of advertisement regarding the program, what we can do. I think you need a full project manager to help with communication, newsletters, you know, establishing who we are (CF2 Round 2)

\*Well I would say that for diabetes, there should not be any exclusion criteria. Because people who have got complex medical problems, they need the integrated care more. (GP13 Round 2)