Health
Western NSW
Local Health District

To our valued GPs,

The Integrated chronic and complex care service in Western NSW LHD is transforming to Integrated Care - Planned Care for Better Health (PCBH) under a state wide initiative.

Why the change?

PCBH is one of the premier's priority in improving outpatient and community based care and a key enabler in identifying people at risk of hospitalisation in the next 12 months. PCBH builds on the existing connecting care model to better coordinate care for patients with chronic complex health and social needs by assessing their holistic care needs and linking them with support services to reduce the risk of unnecessary hospital presentations, provide a better experience of care and improve patient outcomes. PCBH delivers a broader, more preventative focus shifting from acute episodic care to concentrate on support that is integrated and centred on the patient's goals and care needs.

What will be different under Integrated Care – PBCH?

PCBH moves away from a disease-specific focus, and considers shared health determinants, risk factors and multi-morbidities across a broader range of chronic conditions. It takes into consideration a person's socioeconomic status, indigeneity, age and their number of ED presentations and hospital admissions in the last 4 years to calculate their risk of hospitalisation (ROH).

Suitably identified patients will be identified through a state wide ROH algorithm developed by NSW Health, be over the age of 16 and have had a recent ED presentation or hospitalisation. Every patient that presents to a public hospital is automatically given a ROH score which represents a meaningful predictor of hospitalisation in the next 12 months. Suitable patients are enrolled in the PCBH program and are managed by a care coordinator from our health service. They will deliver a mandated Ministry of Health care assessment both across the acute and community care sectors. This will help understand the complexity of the patient and inform the most appropriate intervention required when transferring and managing care. Once enrolled in PCBH, patients will remain on the program for a minimum of 12 weeks to ensure interventions are appropriate, and that patients and carers are connected to the most appropriate health and social care services and linked back into primary care.

Delivering a multidisciplinary team care approach aims to provide the most comprehensive shared care possible, at the right time and in the right place for each patient. Increasing care in the community, improving a patient's experience of care by offering choice and empowering people to better understand and manage their health is key to preventing unnecessary ED presentations and hospitalisations.

How will this affect GPs?

The importance of having a GP involved in all aspects of the patient's care continues to be recognised. We aim to connect all patients to a treating GP within 2 weeks of enrolment. PCBH strives to assist GPs to manage complex patients who require greater time and resources than can be provided in the General Practice setting. There will be regular communication by the care coordinator to the GP, including enrolment and progress reports, person centred care plans, supported GP visits (care coordinator attends with patient if required) and requests for case conferencing.

Community referrals from GPs and other providers will still be received, screened and processed through Central Intake.

For further information or questions, please contact
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Regional Intake for Integrated Care: 1800 931 975

Western NSW INTEGRATED CARE