

INTEGRATED CARE STRATEGY

2015



Health
South Eastern Sydney
Local Health District



South Eastern Sydney Local Health District

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The SESLHD Integrated Care Strategy was prepared by the Ambulatory & Primary Health Care and Improvement & Innovation Hub Directorates of the SESLHD in conjunction with key partners from within SESLHD and the South Eastern Sydney and Eastern Sydney Medicare Locals

STRATEGY AT A GLANCE

GOALS

TO CREATE AN AGILE **JOINED UP SYSTEM**



**BASED ON PATIENT
CENTRED CARE**



**AND A HEALTH INTELLIGENCE
STRUCTURE**

TO ENABLE **TARGETED ACTION** THROUGH **INNOVATIVE** MODELS THAT
DELIVER CARE PROACTIVELY.

SUPPORTED BY



CHANGE MANAGEMENT



AND ROBUST EVALUATION

THAT WILL ALLOW **TRANSFER** AND **SPREAD** OF SUCCESSFUL WAYS OF
WORKING.

STRATEGIES

Engage with people and communities through person centred planning and evaluation

Strategy 1: Spread **motivational interviewing and health coaching** techniques to support **collaborative care planning**, as adopted by SESLHD including general practice, by working with selected, motivated primary health care services.

Strategy 2: Test use of **patient activation, outcome and experience measures** and sharing of outcomes across all providers as a tool to improve quality of care.

Develop a Health Intelligence system

Strategy 3: Perform a **deep dive data analysis** on: processes, costs, health and community assets and socio-demographic factors to address priority areas and form hypotheses to stimulate new ways of working and the ability to measure impact.

Strategy 4: Develop localised **risk stratification** tools that complement state-based tools and apply these to our population's risk characteristics identified in the deep data dive.

Strategy 5: Work with IT and other partners to explore the feasibility of **population registers** for identified cohorts of people.

Use innovative models to target areas of need

Strategy 6: Test models of **anticipatory, multidisciplinary, person-centred care and planning** for selected cohorts of people.

Strategy 7: Work with IT partners to use information and communication technology (ICT) to provide **innovative eHealth** applications.

Strategy 8: Utilise and adapt work undertaken in the **use of mobile technologies** to improve care and enhance self-management for selected cohorts.

Utilise central support structures to evaluate, transfer and spread successful models

Strategy 9: Take an **organisation-wide approach** including the **Integrated Care Unit (IC Unit)**, the **Improvement and Innovation Hub (iiHub)**, **Program Management Office (PMO)**, and the **Strategy, Planning and Equity Unit** to: develop an integrated project management system for Integrated Care Projects; develop a robust framework for evaluation; develop leadership and workforce culture; assist in transfer and spread of successful models; guide the change management process. Work closely with key stakeholders and partners (including those above) to identify priorities to be tested through the Institute for Healthcare Improvement **Breakthrough Series Collaborative**.

CONTENTS

04

THE CASE FOR
INTEGRATED CARE

06

SESLHD FUTURE OF
INTEGRATED CARE

07

PRIORITY 1
ENGAGE WITH PEOPLE
AND COMMUNITIES

08

PRIORITY 2
HEALTH INTELLIGENCE
SYSTEM

09

PRIORITY 3
INNOVATIVE MODELS

10

CENTRAL SUPPORT
STRUCTURES

12

STRATEGIES

13

LOGIC MAP

14

ACTION PLAN
SNAPSHOT

15

CONTACT &
REFERENCES

16

REFLECTION
POINT
What does Integrated Care
mean to you?

THE CASE FOR INTEGRATED CARE

WHAT IS INTEGRATED CARE?

Integrated Care means different things to different people depending on an individual's frame of reference.

A **service user** (patient, consumer, carer or family) receiving Integrated Care will experience *"seamless, effective and efficient care in the right place and at the right time"*. Service users might be able to identify that they are experiencing Integrated Care via an improvement in their experience of care. For example; they are able to navigate easily through the system, feel supported through the process and that their needs and aspirations are responded to, and they are better able to self-manage their health in conjunction with their care providers. This should also lead to better health outcomes, leading people to stay healthier at home.

"the provision of seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health, in partnership with the individual, their carers and family. It means developing a system of care and support that is based around the needs of the individual, provides the right care in the right place at the right time, and makes sure dollars go to the most effective way of delivering healthcare for the people of NSW".

For **service providers**, Integrated Care can mean: delivering front line services in conjunction with other service providers along agreed, shared care paths in agreed sequence or side by side in multidisciplinary clinic settings and across organisations, agencies, social and health services; addressing all aspects of the person's care plan; using an information and communication technology system that spans the whole health spectrum including primary care; learning new ways of working to ensure care is determined and provided in partnership with the individual, their carers and family; ensuring that care is not limited to medical or clinical treatment but engages and supports lifestyle and behavioural changes required to better self-manage and stay healthier in the community.

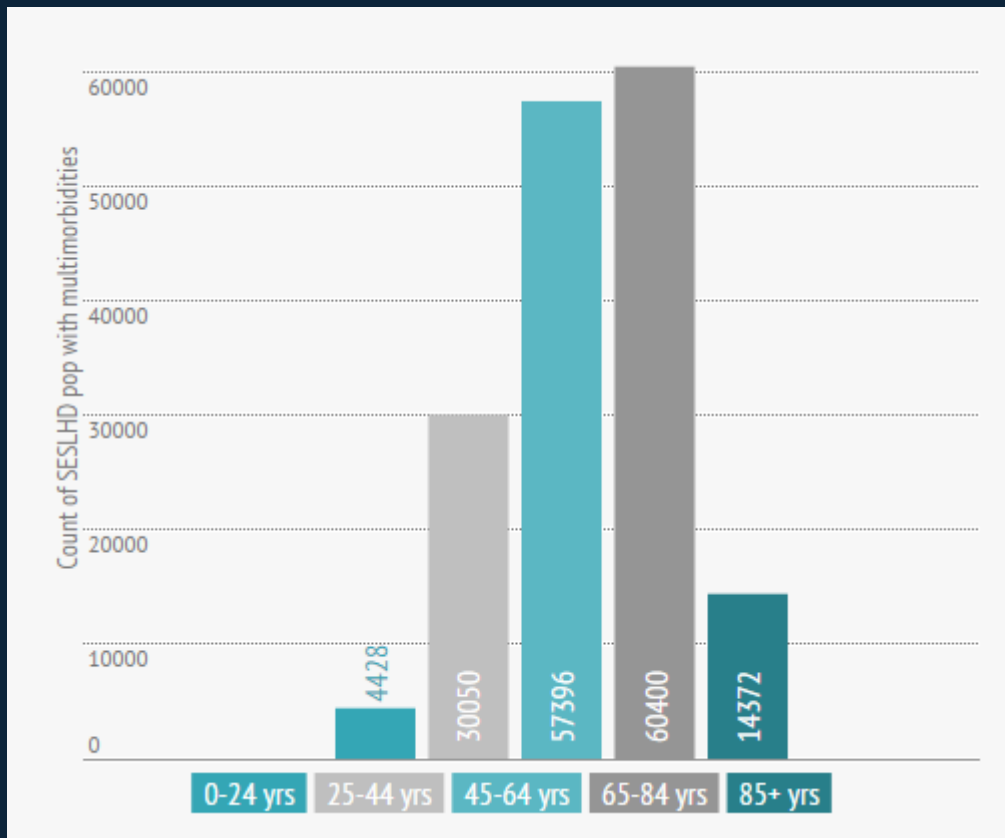


NSW Health Integrated Care Strategy

To the **health system**, Integrated Care means coordinating, or joining up services to enable care providers to deliver *"seamless, effective and efficient care"* to service users and families that is accessible from any touch point within the System be that primary or acute care or other human services. It means taking a population approach to planning and delivering services. The health system's enabling role is in providing the relevant tools, financing and overarching structure to enable people to receive Integrated Care. Most importantly, the health system needs to define which elements need to be "joined up" to provide a seamless journey for those receiving care and their carers regardless of where and how they access the System, and give service providers the platform and tools to provide it.

The Case for Integrated Care - SESLHD

SESLHD population with multi-morbidity



21%

Estimated Proportion of SESLHD resident population with multimorbidities



82%

Estimated Proportion of SESLHD residents aged 85 + with multimorbidities

SESLHD FUTURE OF INTEGRATED CARE

BUILDING THE HOUSE OF CARE

In order to transform current processes and delivery systems into a systemic and systematic approach to integrated care and develop a compelling local narrative about Integrated Care, we intend to localise the elements of the National Health Service (NHS) England House of Care modelⁱ (Figure 1). This model places person-centred and personalised care planning at the centre of the supporting components of integrated care. These components are:

- **Engaged, informed individuals and carers** – enabling individuals to self-manage and know how to access the services they need when and where they need them.
- **Organisational and clinical processes** – structured around the needs of people and carers using the best evidence available, co-designed with service users where possible.
- **Health and care professionals working in partnership** – listening, supporting, and collaborating for continuity of care.
- **Commissioning** – not simply procurement but a system improvement process, the outcomes of each cycle informing the next.

Central to the components of the House of Care is personalised care planning, whereby service providers and people living with long term conditions work together using a collaborative process of shared decision-making to agree on goals, identify support needs, develop and implement action plans and monitor progressⁱⁱ. This approach enables decisions about individualised care and, through analysis of aggregated information, provides guidance for the health system to allocate resources where there is a need, as identified by the service users themselves.



Figure 1: the NHS England House of Care model

PARTNERSHIPS

In SESLHD a Primary Health Care Partnership has been established to prioritise actions. Membership consists of:

- South Eastern Sydney Local Health District
- Both Medicare Locals within our region - South Eastern Sydney (SESML) and Eastern Sydney Medicare Local (ESML)
- Major Hospital Networks within SESLHD geographical borders - St Vincents and Sydney Children's Hospital (SCH)
- Centre for Primary Health Care & Equity, University of New South Wales (CPHCE).

Local Partnership priorities include:

- Creation of a Partnership Self Assessment tool
- Development of a Comprehensive Plan for Primary Care
- Providing a common language and framework to measure local integration
- Shared application of a local risk stratification tool
- Ensuring integration of IT systems from primary care, secondary care and tertiary services.

PRIORITY 1: ENGAGE WITH PEOPLE AND COMMUNITIES

PERSONALISED CARE PLANNING

Personalised care planning empowers individuals, promotes independence and helps people to be more involved in decisions about their care. It is about addressing an individual's full range of needs, taking into account their health, personal, family, social, economic, educational, mental health, cultural background and circumstancesⁱⁱ. Seventy percent of people with long term conditions say that their care has improved as a result of personalised care planning. The Year of Care Programmeⁱⁱ and subsequent work in the involved primary care services in the UK, demonstrated significant improvements in quality of care using this approach.

Personalised care planning requires a different model of professional-service user interaction built on a "strengths-based" approach and motivational interviewing techniques. SESLHD has already trained 350 staff in these techniques. We propose to spread this model into general practice by working with selected, motivated primary care services. This initiative is fully supported by our primary care partners (ESML and SESML). It requires strong clinical leadership and focussed change management in the primary care arena. A primary care clinical lead will be an integral component of this approach.

USE OF PATIENT ACTIVATION MEASURES

Service user engagement at all relevant touch points should be assessed and known. SESLHD has piloted the Patient Activation Measure® (PAM®)ⁱⁱⁱ assessment in local services (funded through an ACI project with regional partners). The PAM gauges the knowledge, skills and confidence essential to manage one's own health and healthcare. The PAM assessment segments consumers into one of four progressively higher activation levels. Each level addresses a broad array of self-care behaviours and offers deep insight into the characteristics that drive health activation. A PAM score should be shared across providers in the system. It can predict healthcare outcomes including medication adherence, Emergency Department utilisation and hospitalisation. One Patient Reported Outcome Measure (PROM) will be used in conjunction with Patient Reported Experience Measures (PREMs) as part of the evaluation of PROMs & PREMs. This project is one of the integrated care 'enablers', being developed by the NSW Ministry of Health^{iv}.



PRIORITY 2: HEALTH INTELLIGENCE SYSTEM

“DEEP DIVE” DATA ANALYSIS, INCLUDING “ASSET” MAPPING

Introduction of the House of Care model is reliant on the completion of a **deep dive data analysis** to map whole-of-system processes and costs. This will include in-depth review of imbalances across the system (e.g. queues; performance against targets etc.) and of high impact areas such as “patient flow”. NHS Tayside developed hypotheses and action plans to address priority areas with great results. It is the intention that SESLHD will utilise a similar approach.

Population level clinical and socio-demographic data is critical to inform service planning around specific priorities, risks and appropriate pathways of care. Whole-of-system analysis will involve accessing population-level clinical data sets via registries. An example is the NSW Clinical Cancer Registry (NSW Cancer Institute^v) which maintains records of people with cancer, their treatment, quality of care and outcomes. Where there are gaps in the necessary information, establishing other population-level clinical data registries will be required. Further work with partner organisations will be needed to fully scope these requirements.

Asset mapping is the process by which the health and social support capabilities of individuals, civic associations, and local institutions are inventoried^{vi}. It involves documenting the tangible and intangible resources of a community so that the population can be involved in personal health care plans and social support groups. The asset-based community development process involves the community in making an inventory of assets and capacity, building relationships, developing a vision of the future, and leveraging internal and external resources to support actions to achieve it.

LOCALISED RISK STRATIFICATION

The **risk stratification** key enabler project, led by the Agency for Clinical Innovation (ACI), will enable state-wide development of risk stratification tools for use with people with chronic and complex care needs. This work will build on risk stratification frameworks such as the Kaiser Permanente chronic disease “risk pyramid”. SESLHD will develop complementary local risk stratification tools based on our population’s risk characteristics identified in the deep data dive. The identification of a person’s health risk category is the first step towards planning, developing and implementing a personalised care plan by the care team including the person, their carer and family. The plan may address a need for more robust or more intensive care coordination or, for better collaboration with community and social care resources.

SHARED POPULATION REGISTERS

Shared **population registers** based in primary care for people with multiple co-morbidities are an essential tool for sharing individual-level health information. This tool can also be used for preventive services (e.g. COPD spirometry screening, smoking cessation, chronic kidney disease screening) for the practice based population. Information collected about persons at risk of deteriorating health conditions, or newly diagnosed diabetes or kidney disease, can then be linked to appropriate care pathways (e.g. using Map of Medicine). Sharing this level of information on a population basis will deliver information to health service providers and planners at state and local level to enable a range of health interventions.

PRIORITY 3: INNOVATIVE MODELS

PROACTIVE, ANTICIPATORY, MULTIDISCIPLINARY, PERSON-CENTRED CARE AND PLANNING

Anticipatory care for people with complex medical and social conditions involves both identification and proactive intervention to reduce hospitalisation. One component is multidisciplinary conferencing. This approach produced statistically significant reductions in unplanned hospitalisations for a cohort of people with multiple morbidities (Scottish Government)^{vii}. It demonstrates the potential for providing better care for individuals and carers as well as better value in providing targeted health and social care services. The planning process also allows the opportunity to screen for behavioural or psychological conditions that need to be addressed in order to better enable self-management and health behaviour change. It is of particular benefit in managing end-of-life care and involves training a wide range of community care providers – practice and community nurses, pharmacists, non-government organisations, local councils and general practitioners. This will require strong clinical leadership and focussed change management in both the primary and secondary care arenas. Clinical leads will be an integral component of this approach.

IT BASED CARE LOGISTICS

Over the last five years, the Chronic Disease Management Program in Alberta Canada^{viii} has created tools for clinicians and providers in the Calgary and Edmonton Regions that have enabled them to capture, manage and provide

access to condition-specific information to support primary care delivery to people with chronic diseases. IT based care logistics involved building and implementing a Province-wide Client Profile Viewer and Population Dashboard with an IT partner (Orion Health) in order to improve the quality of care for Albertans with chronic conditions. If information flows smoothly across the multidisciplinary care team, the health providers, service user and carers gain access to important health information for improved self-care.

USE OF mHEALTH TECHNOLOGIES

mHealth is an abbreviation for mobile health – the practice of medicine and public health supported by mobile devices. The term is most commonly used in reference to using mobile communication devices, such as mobile phones, tablet computers and personal digital assistants (PDAs), to provide health services, information and support. The mHealth field has emerged as a sub-segment of eHealth. We will work with our IT innovation partners CSC and Orion Health to use information and communication technology (ICT) to provide innovative mHealth applications.

The SES LHD Innovations in Integrated Care Grant Program (\$3 million per annum 2013 – 2015) includes an initiative to develop an app for improved gestational diabetes management. We will build on this work to develop apps and other mHealth technologies for people with long term conditions. We will utilise and adapt work undertaken in Bradford UK on the use of mobile technologies to improve care for people with long term conditions^{ix}.

CENTRAL SUPPORT STRUCTURES

ORGANISATION WIDE

APPROACH

SESLHD will take an organisation wide approach, led by a coalition between the Integrated Care Unit, the Improvement and Innovation Hub (iiHub), Program Management Office (PMO) and the Planning, Population Health and Equity Unit to: develop an integrated project management system for Integrated Care Projects; develop a robust framework for evaluation; develop leadership and workforce culture; assist in transfer and spread of successful models; guide the change management process.

We will work closely with key stakeholders and partners (including those above) to identify priorities to be tested through the Institute for Healthcare Improvement Breakthrough Series Collaborative.

INTEGRATED CARE UNIT

The Integrated Care Unit will lead and facilitate the development and implementation of the Integrated Care Strategy. The Directorate aims to provide improved outcomes through better system efficiency for people with complex problems that cut across multiple services, providers and settings. The Integrated Care Unit will continue its role of enabling movement towards a whole of system model including tailoring solutions for vulnerable populations – Aboriginal groups, CALD groups, people with cognitive disorders, mental health issues and addictions. Measuring effectiveness involves a range of service level indicators, activity and

readmission rates for hospitals, specialty groups and particular population groups (people affected by chronic disease, mental ill-health, and Aboriginal people).

IMPROVEMENT AND INNOVATION HUB

The SESLHD Improvement and Innovation Hub (iiHub)^x has been created to work in partnership with the newly created Program Management Office (PMO) and existing district Directorates to support the transformation agenda outlined in the SESLHD Roadmap to Excellence.

The iiHub, in its role of building and enabling capacity and capability for improvement and innovation across the system, has identified four primary areas of action (Figure 2): culture, data and measurement, education and learning, and deployment. The iiHub will have a key role in supporting project development and application of the Breakthrough Series Collaborative model^{xi}.

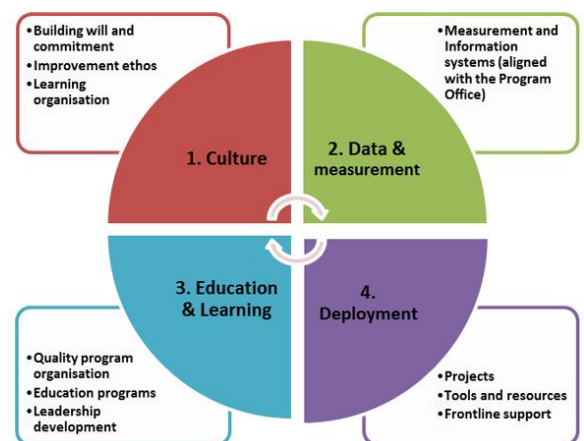


Figure 2: iiHub key action areas

PROGRAM MANAGEMENT OFFICE

- Incorporating the Business Intelligence and Efficiency Unit (BIEU)

The emphasis of the Program Management Office (PMO) ^{xii} is to deliver tangible improvements to the outcomes of projects across the Local Health District.

The PMO's focus is on building better business processes, project management, analytics forecasting and independent reporting that will aid transforming to whole-of-system integrated healthcare.



Figure 3: Key factors incorporated into the development of the SESLHD PMO

PLANNING, POPULATION HEALTH AND EQUITY UNIT

- Incorporating the Strategy, Planning and Epidemiology Unit

The Strategy, Planning and Epidemiology Unit:

- provides advice and information to assist in identifying the community's health needs and health status
- provides population health intelligence to services and partners
- leads and facilitates population based clinical services planning to inform models of care and service developments that align with current and future community needs.

The Planning, Population Health and Equity Directorate provides leadership and coordinated support to programs and services to effectively plan and engage communities to identify and respond to their health needs and preferences; promotes equity through identifying indicators of population and clinical unwarranted variation and undertaking health intelligence; and delivers targeted programs to vulnerable groups to improve the community's health, wellbeing and resilience.

The Strategy, Planning & Epidemiology Unit will collaborate with the iiHub and the PMO to support implementation of the Integrated Care Strategy across the District.

IHI Model for Improvement & Breakthrough Series Collaborative

The Breakthrough Series Collaborative enables change to be transferred and scaled up quickly. After topic experts are recruited to the 'faculty' and key care teams are enrolled, a series of learning sets and active periods of small scale tests of change take place. Teams have the chance to trial and measure change during action periods and then come back together to share learnings of success so they can be replicated in other sites to rapidly scale successful change.



STRATEGIES

ENGAGE WITH PEOPLE AND COMMUNITIES

Strategy 1: Spread **motivational interviewing** and **health coaching** techniques to support **collaborative care planning**, as adopted by SESLHD including general practice, by working with selected, motivated primary health care services.

Strategy 2: Test use of **patient activation**, **outcome and experience measures** and sharing of outcomes across all providers as a tool to improve quality of care.

INNOVATIVE MODELS

Strategy 6: Test models of **anticipatory, multidisciplinary, person-centred care and planning** for selected patient cohorts.

Strategy 7: Work with IT partners to use information and communication technology (ICT) to provide **innovative eHealth** applications.

Strategy 8: Utilise and adapt work undertaken in the **use of mobile technologies** to improve care and enhance self-management for selected cohorts.

HEALTH INTELLIGENCE SYSTEM

Strategy 3: Perform a **deep dive data analysis** on: processes, costs, health and community assets and socio-demographic factors to address priority areas and form hypotheses to stimulate new ways of working and the ability to measure impact.

Strategy 4: Develop localised **risk stratification** tools that complement state-based tools and apply these to our population risk characteristics identified in the deep data dive.

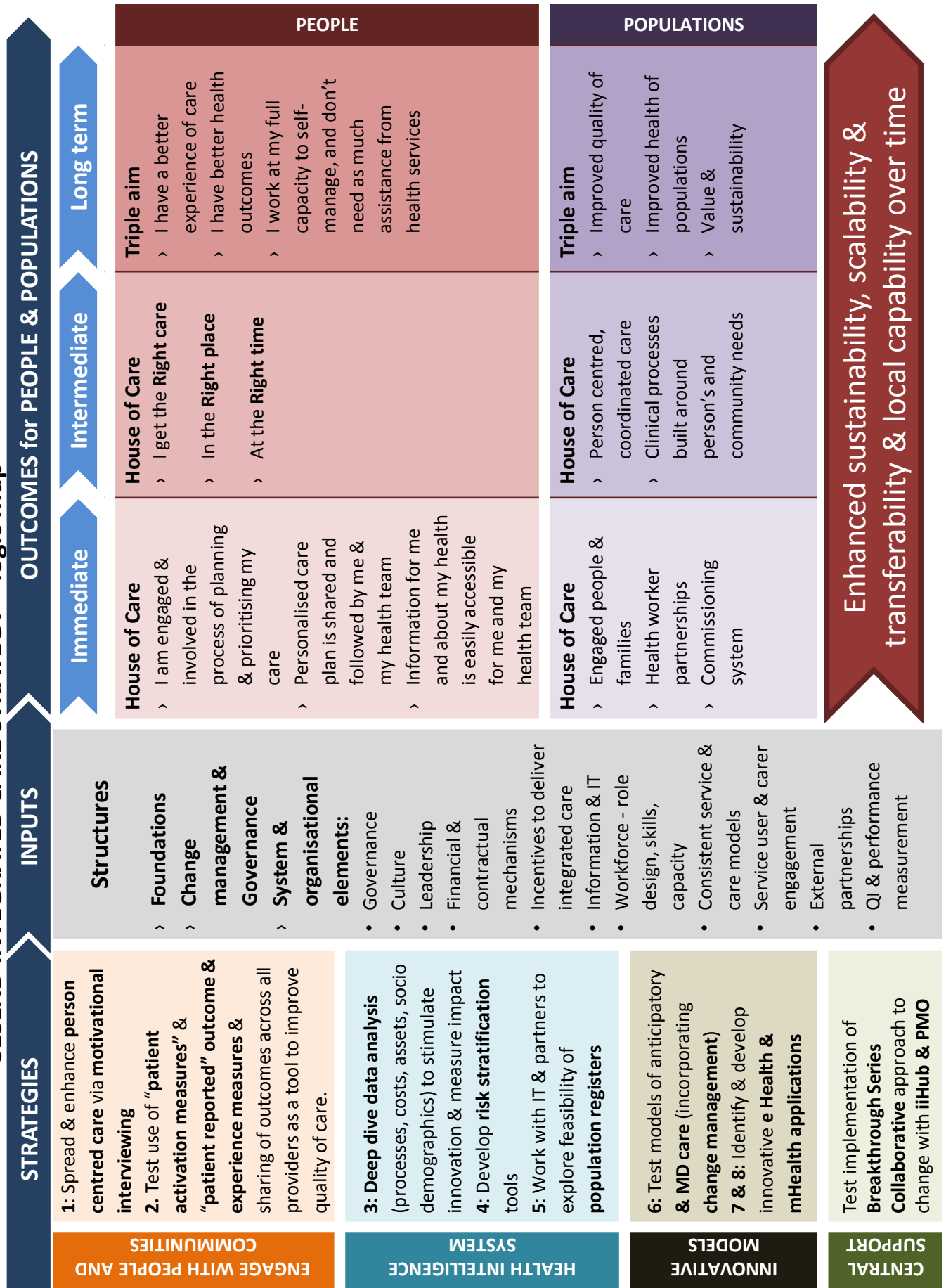
Strategy 5: Work with IT and other partners to explore the feasibility of **population registers** for identified cohorts of people.

CENTRAL SUPPORT SYSTEM

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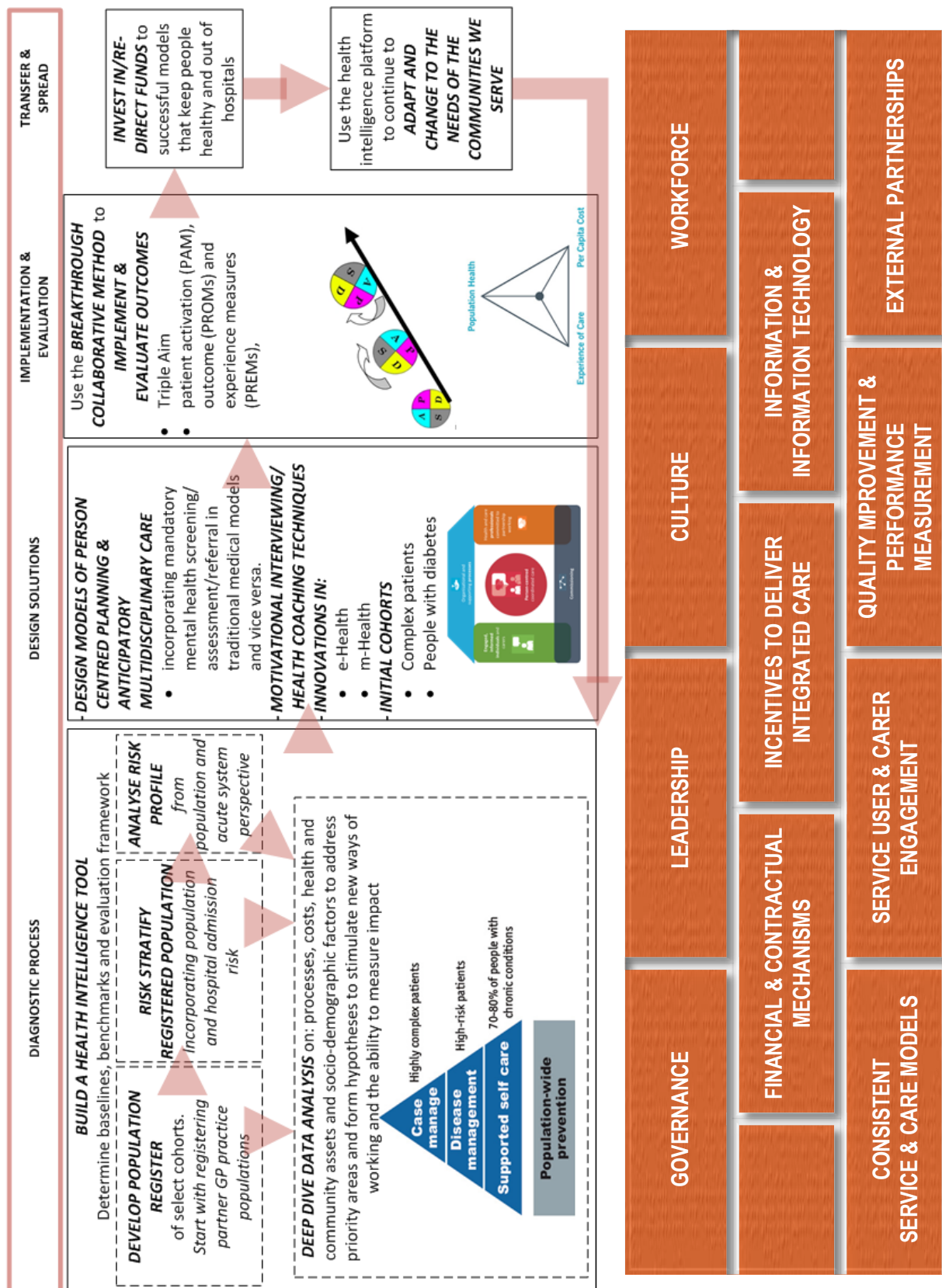
an **organisation-wide approach**, including the Integrated Care Unit, the **Improvement and Innovation Hub (iiHub)**, **Program Management Office (PMO)**, and the **Strategy, Planning and Equity Unit** to: develop an integrated project management system for Integrated Care Projects; develop a robust framework for evaluation; develop leadership and workforce culture; assist in transfer and spread of successful models; guide the change management process. Working closely with key stakeholders and partners (including those above) to identify priorities to be tested through the Institute for Healthcare Improvement **Breakthrough Series Collaborative**.

SESLHD INTEGRATED CARE STRATEGY – logic map



Enhanced sustainability, scalability & transferability & local capability over time

SESLHD INTEGRATED CARE STRATEGY – Action plan on a page



SYSTEM & ORGANISATIONAL ELEMENTS

A more detailed action plan has been developed,
for a copy please **CONTACT.**

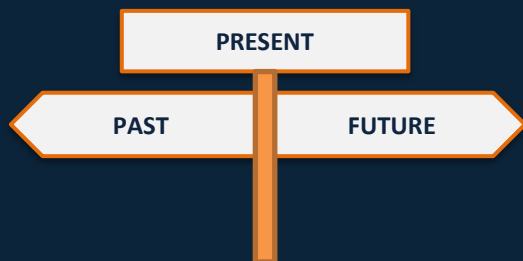
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REFLECTION POINT

What does Integrated Care mean to you?

SERVICE USER/CARER

- Are you confident in managing your care?
- Are you involved in the planning of your care?
- Do you have a care plan that you and your care team follow?
- Do you have access to all of the information you need?
- Do you set goals with your care team?
- Do you know who to contact if you have questions?
- Do you know everyone involved in your care and what they do?
- What matters to you? What needs to change? What are your ideas?

SERVICE PROVIDER

- Do you have a clear idea or vision of what integrated care is?
- Can you see where your service fits on the spectrum from fragmentation to integration?
- How do you respond to people's changing needs and aspirations?
- Do you measure and act upon any patient reported activation, outcome and experience measures?
- How are your care plans and relevant information shared with other multidisciplinary teams including primary care?
- Are there extra skills you could develop or could you work in a different way to develop a more integrated model?
- Are there areas of your practice that could be expanded to better accommodate the needs of people using your service?
- How do you prioritise goals with people seeking your service?
- What other providers would you like to partner, link or connect with?
- What parts of the system need to join up better to provide seamless care transitions and flow of information to you and from you?
- Do you have the right relationships with the right people to support care paths/models?
- What matters to you? What needs to change? What are your ideas?





What does Integrated Care mean to you?

SYSTEM MANAGER/EXECUTIVE

- Do you have a clear idea or vision of what integrated care is?
- What other organisations do you need to partner or connect with to allow seamless transfer of care and information?
- How can you deliver a proactive collaborative service in the community/primary care setting?
- What are service users and service providers telling you?
- How do you collect and respond to service users and service providers needs to optimise and align service provision?
- Is your leadership team trained and ready for integration?
- Are you prepared to do things differently?
- Where does your organisation sit on the integration spectrum?
- Are you providing the resources and leadership to develop Integrated Care?
- Which units in your organisation are integrated and which units need the most attention?
- Are you scaling up successful models of integration to the rest of your organisation?
- Do you share goals with other organisations providing services for the same people?
- How can you remove disincentives and put enablers in place for providers to deliver Integrated Care?
- What are your barriers and enablers of Integrated Care?
- What matters to you? What needs to change? What are your ideas?

The SESLHD Integrated Care Strategy – Action Plan has been developed

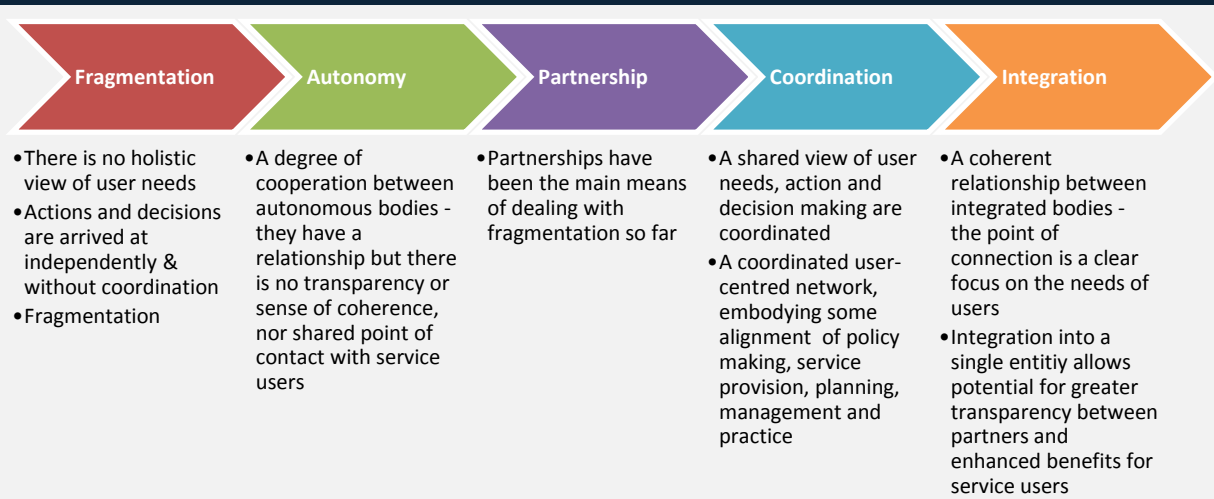
For a copy to see where your ideas may align please contact

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