INTEGRATED CARE STRATEGY

ACTION PLAN 2015-2018

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

OVERVIEW

This action plan describes the Key elements, Actions, Performance Indicators and Deliverables of the SESLHD Integrated Care Strategy. It also identifies the lead and support teams as well as timelines to implement the Strategy.

The action plan will be governed by the South Eastern Sydney Local Health District Integrated Care Steering Committee; chaired by the SESLHD Director Operations, Ambulatory & Primary Health Care and attended by:

- CEO's of Eastern Sydney Medicare Local and South Eastern Sydney Medicare Local
- Director Operations Prince of Wales/ Sydney, Sydney Eye Hospital, or nominee
- General Manager St George
- General Manager Sutherland Hospital
- General Manager War Memorial Hospital Waverley
- CEO Calvary Hospital Sydney
- Director SESLHD Mental Health Service
- Deputy Director Ambulatory & Primary Health Care
- SESLHD Director of Improvement and Innovation
- Representative from the SESLHD Program Management Office
- Deputy Manager Aboriginal Health
- Director Planning & Population Health
- Representatives from the SESLHD Integrated Care Unit
- Clinical Stream Directors or nurse managers
- Allied Health representative
- SESLHD Program Management Office representative
- Consumer representatives
- Connecting Care Managers from SCHN and SVHN

The responsibility of the committee is to provide high level strategic advice and direction in relation to planning and implementation of the action plan. The Committee will seek to enhance effective partnerships between services, clinicians and primary health care partners, and consumers to assist the effective implementation of the action plan.

Several of the deliverables will require ongoing refinement as part of the process of implementation including who is leading each action, and specific performance indicator measurements.

Feedback on the action plan is welcome, please contact:
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SESLHD Integrated Care Unit - (02) 9540 8181

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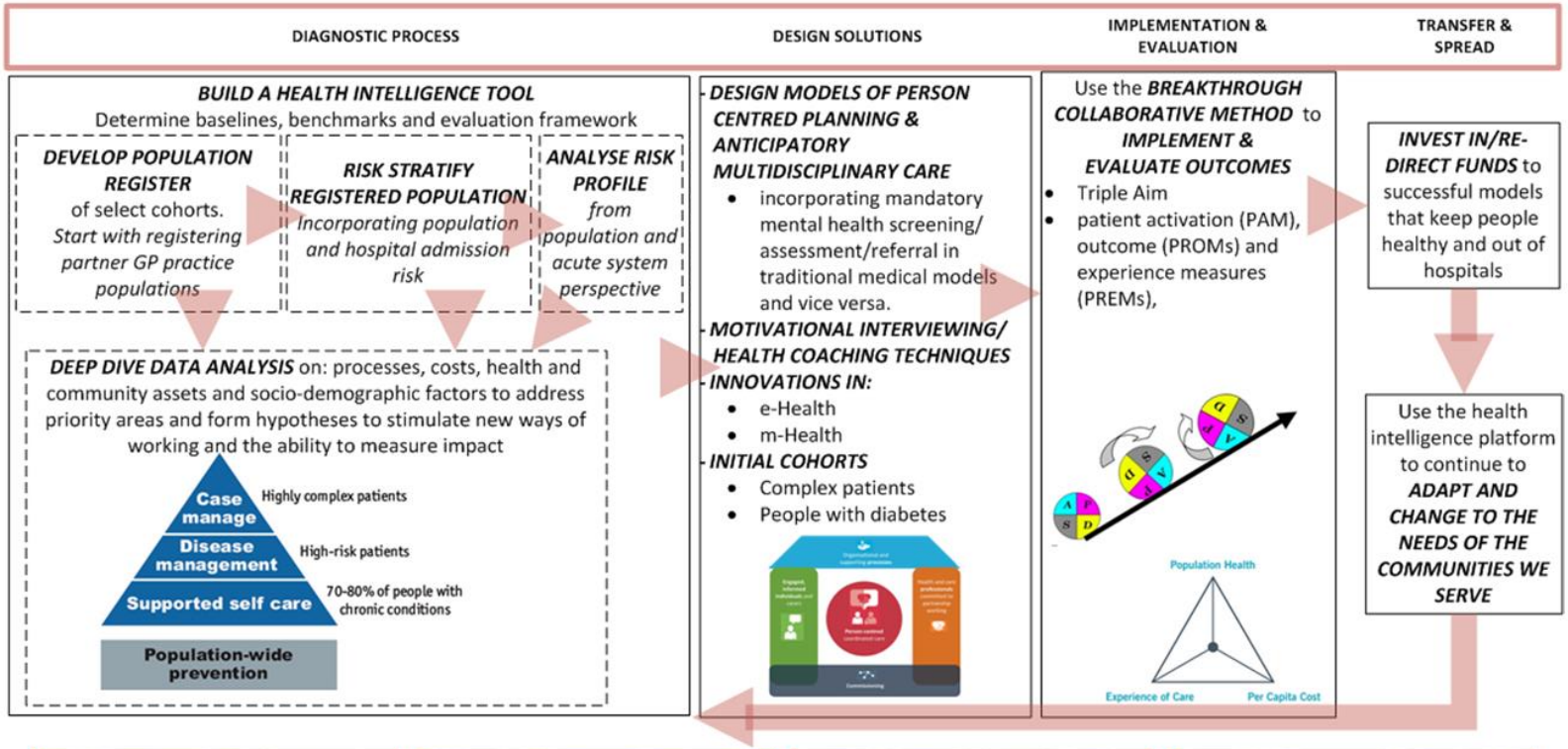

GOVERNANCE | LEADERSHIP | CULTURE | WORKFORCE

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SYSTEM & ORGANISATIONAL ELEMENTS

ABBREVIATIONS

ACI = Agency for Clinical Innovation (NSW Health)

APHC = Ambulatory & Primary Health Care Directorate (SESLHD)

ACHS = Australian Council on Healthcare Standards

BIEU = Business Intelligence & Efficiency Unit (SESLHD)

CGU = Clinical Governance Unit (SESLHD)

CPHCE = Centre for Primary Care and Equity (University of NSW)

ESML = Eastern Sydney Medicare Local

IC Unit = Integrated Care Unit (SESLHD)

iiHub = Improvement & Innovation Hub (SESLHD)

IMSD = Information Management Services Directorate (SESLHD)

HETI = Health Education & Training Institute (NSW Health)

PHN = Primary Health Network (formerly Medicare Local)

PMO = Program Management Office (SESLHD)

PPHE = Planning, Population Health and Equity Directorate (SESLHD)

SESLHD = South Eastern Sydney Local Health District

SESML = South Eastern Sydney Medicare Local

PHN = Primary Health Network

INTEGRATED CARE STRATEGY

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

Underpinned By:

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**.

PRIORITY 1: ENGAGE WITH PEOPLE AND COMMUNITIES

PERSONALISED CARE PLANNING & USE OF PATIENT ACTIVATION MEASURES

ACTION	RESPONSIBILITY

1. Spread motivational interviewing & health coaching techniques to support collaborative care planning by working with selected, motivated primary health care services.
• Develop a model to support a collaborative care planning process
• Train health providers in motivational interviewing/health coaching techniques
• Develop a strategy to educate providers and promote health coaching, of both new and existing services (Get Healthy and Connecting Care Health Coaching)
DEFINE
• Identify key teams requiring training
• Build on existing, ongoing programs of health coaching/motivational interviewing training and embed into everyday practice. Utilise PHN GP & Primary health care education sessions
DELIVERABLES
• Training plan
  ○ Motivational interviewing/health coaching
  ○ Education on services
PERFORMANCE INDICATORS
• Number/proportion of people receiving health coaching
• Number/proportion of people with a current care plan
• Number/proportion of staff & care teams trained in motivational interviewing/health coaching
• Improved staff skills and confidence in utilising motivational interviewing
	LEAD
	PHN
	SUPPORT
	PPHE, IC Unit, Clinical Streams and teams providing care to target cohorts, existing training programs for motivational interviewing/health coaching
	TIMEFRAME
	Training plan - Dec 2015
	Education & Training - ongoing

ACTION	RESPONSIBILITY

2. Test use of patient activation, outcome, experience measures and sharing of outcomes across all providers as a tool to improve quality of care.
• Analytical review of PAM® project with SESML to determine feasibility of use and comparison to other tools
• Select and trial PAM, PROMs & PREMs and the process to administer. (Work alongside ACI state enabler and Innovation project)
DEFINE
• Select agreed measurement tools.
• Develop a system of administering & acting upon tools
• Build on/use learnings from:
  ○ State wide patient satisfaction survey
  ○ Patient Experience Trackers (PETs)
• Build on Planning & Innovation funded project use of PROMs & PREMs
DELIVERABLES
• Tools endorsed and shared
• A systematised process to administer and follow-up on measures (e.g. both during treatment as a clinical indicator and also as a program quality indicator)
• Develop and implement an education and training package
PERFORMANCE INDICATORS
• Utilisation rates of tools.
	LEAD
	IC Unit
	SUPPORT
	ACI, PHN, Innovation project team, teams providing care to target cohorts
	TIMEFRAME
	PAM review – Jun 2015
	PAM, PROMs & PREMs - Dec 15

PRIORITY 2: HEALTH INTELLIGENCE SYSTEM

"DEEP DIVE" DATA ANALYSIS, INCLUDING "ASSET" MAPPING, LOCALISED RISK STRATIFICATION, SHARED POPULATION REGISTERS

ACTION	RESPONSIBILITY

3. Work with IT and other partners to explore the feasibility of population registers for identified cohorts of people.
• Identify partner GP practices from PHN GP data cleansing projects to register and analyse their patient cohorts
• Develop agreement on:
  ○ Consent , shared ownership of information/data, analysis &collation, confidentiality and linking of data
DEFINE
• Expand & build on the ~160 practices with cleansed data through ESML and SESML projects (PHN)
• Utilise international expertise in informing and developing population registry as well as how to monitor the structure (Prof Andrew Morris – Scotland Chief Scientist, visit 2015/16)
DELIVERABLES
• Determine available options for population registers containing:
  ○ Aggregated data for defined areas
  ○ Individual level data
• Agreement on data consent , shared ownership of information/data, analysis and collation, confidentiality and linking of data
PERFORMANCE INDICATORS
• Number/proportion of linked GP partners
• Number/Proportion of population registered (LHD/LGA/suburb)
	LEAD
	PHN
	SUPPORT
	IMSD, GP partners, BIEU, IT partner/s, IC Unit, ACI, PPHE
	TIMEFRAME
	Jun 16

ACTION	RESPONSIBILITY

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
• Select risk stratification tool
• Develop agreement on:
  ○ Consent , shared ownership of information/data, analysis & collation, confidentiality and linking of data
• Administer tools to GP partner patient cohorts
DEFINE
• Work with key partners to identify a risk stratification tool that combines primary care and hospital data
• Agree on process of administering tool
• Risk stratify partner GP data for combined acute/primary risk
• Identify high risk service users within GP cohorts
• Develop agreed risk stratification reporting template
DELIVERABLES
• Localised risk stratification tool and template developed:
  ○ Aggregated to population level
  ○ Individualised to personal level
• Agreement on risk data consent and sharing
PERFORMANCE INDICATORS
• Number/Proportion of population screened for risk factors (LHD/LGA/suburb)
• Number/proportion of GP's using tool
	LEAD
	PHN
	SUPPORT
	IMSD, ACI, IC Unit, BIEU, PHN, GP partners, PPHE
	TIMEFRAME
	Jun 16

ACTION	RESPONSIBILITY
5. Perform a deep dive data analysis on processes, costs, health & community assets, socio-demographic factors to address priority areas to form a hypothesis that stimulates new ways of working as well as the ability to measure impact. • Map data/information sources in acute, primary care and population health • Identify gaps and holes in data • Identify data linking opportunities • Determine data linkage protocol • Build reporting template incorporating run charts on key data **DEFINE** Build a health intelligence platform/tool that can highlight areas of health needs in 'real time' determined by such factors as: • asset availability • socio-demographics • population health markers • aggregated risk for defined geographical areas (e.g. communities, neighbourhoods, GP cohort, suburb, hospital catchment, LHD population level) to identify 'hot spots' • patient level risk stratification to pick up 'at risk' individuals **DELIVERABLES** • Data dive analysis undertaken regularly • 'Real time' Health intelligence platform/reporting tool developed • Ensuring quality data **PERFORMANCE INDICATORS** • Regular analysis undertaken and utilised • Analysis findings used to inform planning • Quality of data	**LEAD** PPHE **SUPPORT** IMSD, BIEU, PHN, IC Unit, GP partners, Service providers, **TIMEFRAME** ongoing

PRIORITY 3: INNOVATIVE MODELS

PROACTIVE, ANTICIPATORY, MULTIDISCIPLINARY, PERSON-CENTRED CARE AND PLANNING, IT BASED CARE LOGISITICS AND USE OF mHEALTH TECHNOLOGIES

ACTION	RESPONSIBILITY

6. Test models of anticipatory, multidisciplinary, person-centred care and care planning for selected cohorts.
• Define models of care to meet needs of high risk populations identified in the data dive
  ○ Complex older patients
  ○ Diabetes
• Use breakthrough collaborative series method to turn successful small scale tests of change into system wide changes
DEFINE
• Build on and enhance existing areas of integration delivering multidisciplinary, anticipatory and person centred care to complex, high risk patients in the primary care setting
• Identify gaps and areas requiring development of integrated models through analysis of risk stratification and deep dive data analysis
• Develop model around an agreed person centred plan that is shared and implemented by the patient with members of the multi-disciplinary team
DELIVERABLES
• Person centred Models of care established
• Business case for models
PERFORMANCE INDICATORS
• Number/proportion of teams delivering model/s care to selected cohorts
• Improved "patient reported" outcomes: e.g.:
  ○ PAM, PROM & PREM measures
• Decrease in unscheduled care
• Number/proportion of people with a care plan that is regularly reviewed
	LEAD
	IC Unit with GP clinical leads
	SUPPORT
	Service providers, iiHub, PHN, GP Partners, Director of Allied Health, Clinical Streams & Clinical Units involved with initial cohorts:
	- complex care, diabetes
	TIMEFRAME
	Dec 16

ACTION	RESPONSIBILITY

7. Work with IT partners to use information & communication technology (ICT) to provide innovative eHealth applications
• Identify solutions to bridge communication technology gaps across and within sectors for service providers and consumers (e.g. how to share person centred care plans and relevant information)
• Build on existing areas of eHealth integration (e.g. Specialist electronic consult – Renal portal)
• Identify areas to standardise the process for patients and carers utilising services to have access to their own health record (work with PCEHR & HealtheNet)
DEFINE
• Identify gaps in communication and look for innovative eHealth solutions that improve communication and decrease administrative burden for staff, patients and carers by:
  ○ E-referral auto populated electronic documents
  ○ Shared electronic record to support multidisciplinary person centred care with information available to service users and their families
  ○ Online decision support tools based on peer reviewed localised best practice
  ○ E-consulting with specialists
DELIVERABLES
• Defined IT solutions
PERFORMANCE INDICATORS
• Explore communication technology bridges
	LEAD
	IMSD
	SUPPORT
	NSW Health, IT partners, service users & carers, ACI, service providers (Clinical Streams, departments etc.), IC Unit, Director Allied Health
	TIMEFRAME
	2015-2018

ACTION	RESPONSIBILITY
8. Utilise and adapt work undertaken in the use of mobile technologies (mHealth) to improve care for local residents with long term conditions • Identify areas to develop mobile technology and use of apps to support self-management • Build on existing mHealth project work to refine a process of implementing mHealth technologies **DEFINE** • Build on existing work in developing apps to facilitate self-management (gestational diabetes, adolescent type 1 diabetes resilience) • Identify cohorts that would benefit from development of apps to support self-management • Improve communication & identify how to link information from mobile devices/apps back to the care team and health intelligence system • Identify ways of capturing activity & fund new ways of working that incorporate analysing "patient data" & phone consultations **DELIVERABLES** • A defined process of developing apps to support self-management • Proof of concept of apps as a tool to support self-management **PERFORMANCE INDICATORS** • Identify cohorts that would benefit from app use • Identify appropriate apps for self-management for identified cohort • Develop mHealth implementation process and plan	**LEAD** IC Unit **SUPPORT** PHN, IMSD, service users & carers, service providers. **TIMEFRAME** 2016

SYSTEM AND ORGANISATIONAL ELEMENTS

GOVERNANCE

ACTION	RESPONSIBILITY
• Determine clear lines of governance for Integrated Care **DEFINE** • Identify governing body and executive sponsorship **DELIVERABLES** • Governance structure developed • Governance structure endorsed	**LEAD** APHC **SUPPORT** SESLHD CE & Executive, SESLHD Key Directors/Managers, PHN **TIMEFRAME** 2015 – 2018

LEADERSHIP

ACTION	RESPONSIBILITY
• Develop a leadership program for Integrated Care with key partners **DEFINE** • Work with NSW Health pillar institutions on developing a suitable leadership program **DELIVERABLES** • Leadership program implemented and reviewed	**LEAD** iiHub **SUPPORT** HETI, ACI, IC Unit **TIMEFRAME** 2015-18

CULTURE

ACTION	RESPONSIBILITY
• Build narrative on the Integrated Care Strategy at all levels of the system • Engage with clinicians and managers to enhance the culture of an integrated approach built around people's needs **DEFINE** • Build on existing culture development programs (Change Day; Bright Spots; Big Conversation; You said, we heard) • Continue to develop training & education on person centred care planning based on motivational interviewing and health coaching • Engage key clinicians in designing ground up integrated care models/solutions **DELIVERABLES** • Shared understanding of Integrated Care as a key component of health care delivery	**LEAD** iiHub **SUPPORT** IC project teams, Workforce, People & Culture, HR, PHN, IC Unit **TIMEFRAME** 2015-18

SYSTEM AND ORGANISATIONAL ELEMENTS

WORKFORCE

ACTION	RESPONSIBILITY

• Using the deep data dive & needs assets analysis, determine workforce capacity to deliver integrated care
DEFINE
• By knowing capability and capacity to deliver integrated care we can determine:
  ○ where training may be required to design extended scopes of practice to fill skills gaps
  ○ where we need to commission services +/- partners
  ○ the design of new roles to bridge care gaps
DELIVERABLES
• Explore the use of community based integrated care teams
• Existing staff look to enhance and further engage in Integrated Care
	LEAD
	IC Unit
	SUPPORT
	iiHub, Workforce, Clinical Streams, People & Culture, HR, PHN, IC Unit, service providers **TIMEFRAME**
	2015-18

FINANCIAL & CONTRACTUAL MECHANISMS

ACTION	RESPONSIBILITY
• Determine new models of mixed provision of care and contracting (private, public, NGO) • Design business models that utilise funding from NGO's, private sector, MBS etc. • Development of business case with key partners (build on PwC work) **DEFINE** • By analysing needs & gaps we can work with other providers to ensure continuity of care is provided around the needs of our people • Build on lessons learned from HealthOne Sutherland on mixed service provision • Develop a commissioning framework that helps determine the level of contract required to deliver integrated care with other service providers e.g. SLA, MOU **DELIVERABLES** • Commissioning framework developed • Business models to realise external funding opportunities explored • Clear process for disinvesting to invest in primary health care developed	**LEAD** SESLHD CE, DET **SUPPORT** PPHE, PMO (incl BIEU), key Directors, managers from LHD, PHN, NGO's, consultants etc. **TIMEFRAME** 2015-18

SYSTEM AND ORGANISATIONAL ELEMENTS

INCENTIVES TO DELIVER INTEGRATED CARE

ACTION	RESPONSIBILITY

• Address ABF disincentive
• Explore & develop incentives to deliver integrated care
DEFINE
• Negotiations and planning with the Ministry of Health to determine how to avoid the disincentive of ABF & reinvesting ABF into community/primary care based activity
• Explore different incentives to participate in new models:
  ○ Financial
  ○ Non-financial: e.g. better ways of working improved staff; better outcomes for service users
DELIVERABLES
• Develop an ABF funding discussion paper to describe the disincentives in moving activity to primary care and address those disincentives
• Explore financial incentive for better integrated care
	LEAD
	Director Primary Care and SESLHD CE
	SUPPORT
	DET, PMO, NSW MoH, Networking Health, PHN
	TIMEFRAME
	2015-18

INFORMATION AND IT

ACTION	RESPONSIBILITY
• Identify key ICT stakeholders, internally & externally, to map existing IT architecture and explore how repositories may be pulled together • Liaise with Healthshare NSW on HealtheNet/PCEHR development **DEFINE** • IMSD team are already exploring these actions as outlined in their strategic plan • Determine linking data plan & process of pulling data allowing for privacy, confidentiality etc. **DELIVERABLES** • Develop map of ICT capacity to link systems • Opportunities of data linkages identified and specific data linkage projects identified	**LEAD** IMSD **SUPPORT** IT partners, NSW MoH, IC unit **TIMEFRAME** 2015-18

CONSISTENT SERVICE AND CARE MODELS

ACTION	RESPONSIBILITY
• Sustain & spread successful models as indicated previously through the Breakthrough Collaborative method **DEFINE** • Transitioning of successful projects into sustained programs will require clear guidance on objectives & outcomes & how funding will transition from expensive hospital based care to the primary setting • Utilise the SESLHD service rationalisation framework to guide investment/disinvestment **DELIVERABLES** • Undertake the Breakthrough Collaborative method • Embed and sustain identified new models of care	**LEAD** iiHub **SUPPORT** PPH, PMO, PHN, IC Unit, CGU **TIMEFRAME** 2015-18

SYSTEM AND ORGANISATIONAL ELEMENTS

SERVICE USER AND CARER ENGAGEMENT

(for the Integrated Care Strategy)

ACTION	RESPONSIBILITY

• Service user co-design of a new model incorporating electronically captured person centred care plans & priorities.
  ○ Engage with existing mechanisms (consumer councils)
DEFINE
• The new models are based around motivational interviewing/health coaching that lead to a person centred shared care plan that will:
  ○ Guide individual personalised care
  ○ Guide care providers and the health system as to what larger communities are asking for through aggregation of priorities identified in individual care plans
• IT infrastructure that will capture and share this information
DELIVERABLES
• Establish mechanism for ongoing engagement of consumers and carers that is consistent with local consumer plan
• Establish formal training for consumers
	LEAD
	IC Unit
	
	SUPPORT
	Service users & carers, SESLHD Community Participation Committee & PHN Consumer Councils, Clinical Streams, Carers NSW, Health Consumers NSW, DPPHE
	
	TIMEFRAME
	2015-18

QUALITY IMPROVEMENT & PERFORMANCE

ACTION	RESPONSIBILITY
• Link with existing Quality improvement (QI) framework & linking with ACHS standards **DEFINE** • Ensure that existing QI & performance measurement mechanisms are utilised & linked to avoid duplication of reporting **DELIVERABLES** • Agreed QI and performance reporting structure • ACHS requirements met	**LEAD** CGU **SUPPORT** Existing Quality managers, PHN, ACHS **TIMEFRAME** 2015-18

EXTERNAL PARTNERSHIPS

ACTION	RESPONSIBILITY
• Mapping, assessment & review of existing partnerships • Identify new/missing partner organisations **DEFINE** • Determine partnerships, contractual elements & obligations to deliver integrated care • Build on HealthOne examples to establish a framework for partnership agreements **DELIVERABLES** • Partnership framework updated in light of development of PHN	**LEAD** Primary Health Care Partnership Committee (Chair) **SUPPORT** BIEU, Key Executive & Directors, HealthOne **TIMEFRAME** 2015-18

EVALUATION PLANNING

DEVELOP AN EVALUATION FRAMEWORK FOR THE INTEGRATED CARE STRATEGY

ACTION	RESPONSIBILITY

• Design & implement an evaluation plan with key partners, that meaningfully reports to integrated governance on agreed, shared, cross sector key indicators and deliverables for the Integrated Care Strategy
DEFINE
• The evaluation plan will inform the governing bodies on:
  ○ progress on implementation of the Strategy
  ○ outcomes for:
  ▪ service users and carers
  ▪ service providers and the health system
DELIVERABLES
• Academic partnership/s
• Evaluation undertaken. Framework and plan developed
• A community of scholars, panel of integrators, group of regional leaders and service users to analyse and respond to ongoing evaluation
	LEAD
	IC Unit
	SUPPORT
	PHN, DPPHE, SESLHD-CPCE Research Hub
	TIMEFRAME
	Dec 2015

SESLHD Integrated Care Strategy - Action Plan 2015-2018

SESLHD Integrated Care Strategy 2015-2018		2015			2016				2017				2018	
		Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun
Integrated Care Strategies														
1 - Engage with people and communities through person centred planning and evaluation														
1.1	**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**													
a	Develop a model to support a collaborative care planning process													
b	Train health providers in motivational interviewing/health coaching techniques to													
c	Develop a strategy to educate and promote health coaching of both new and existing services (Get Healthy and Connecting Care Health Coaching)													
1.2	**Test use of patient activation, outcome and experience measures and sharing of outcomes across all providers as a tool to improve quality of care**													
a	Analytical review of PAM project with SESML to determine feasibility of use and comparison to other tools													
b	Select and trial PAM, PROMs & PREMs and process to administer													
2 - Develop a Health Intelligence system.														
2.1	**Work with IT and other partners to explore the feasibility of population registers for identified cohorts of people.**													
a	Identify partner GP practices from PHN GP data cleansing projects to register and analyse pt cohorts.													
b	Develop agreement on: Consent , shared ownership of information/data, analysis and collation, confidentiality and linking of data													
2.2	**Develop localised risk stratification tools that compliment state-based tools and apply these to our population's risk characteristics identified in the deep data dive**													
a	Select risk stratification tool													
b	Develop agreement on: consent , shared ownership of information/data, analysis and collation, confidentiality, linking of data													
c	Administer tools to GP partner pt cohorts													
2.3	**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.**													
a	Map data/information sources in acute and primary care and population health													
b	Identify gaps and or holes in data													
c	Identify data linking opportunities													
d	Determine data linkage protocol													
e	Build reporting template incorporating run charts on key data													

SESLHD Integrated Care Strategy - Action Plan 2015-2018

SESLHD Integrated Care Strategy 2015-2018		2015			2016				2017				2018	
		Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun
Integrated Care Strategies														
3 - Use innovative models to target areas of need														
3.1	**Test models of anticipatory, multidisciplinary, person-centred care and care planning for selected cohorts.**													
a	Define models of care to meet needs of high risk populations identified in the data dive: complex patients, diabetes													
b	Use breakthrough collaborative series method to turn successful small scale tests of change into system wide changes													
3.2	**Work with IT partners to use information and communication technology (ICT) to provide innovative eHealth applications**													
a	Identify solutions to bridge information communication technology gaps across and within sectors for service providers and consumers (e.g. how to share person centred care plans and relevant information)													
b	Build on existing areas of eHealth integration (e.g. Specialist electronic consult – Renal portal)													
c	Identify areas to standardise the process for people and carers utilising services to have access to their own health record (work with PCEHR and HealtheNet)													
3.3	**Utilise and adapt work undertaken in the use of mobile technologies to improve care for local residents with long term conditions**													
a	Identify areas to develop mobile technology and use of apps to support self-management													
b	Build on existing mHealth project work to refine a process on implementing mHealth technologies													

System and Organisational Elements														
4 - Governance														
a	Determine clear lines of governance for Integrated Care													
5 - Leadership														
a	Develop a leadership program for Integrated Care with key partners													
6 - Culture														
a	Build narrative at all levels of the system on the integrated care strategy													
b	Engage with people and communities to enhance the culture of integrated working around peoples needs													
7 - Workforce														
a	Determine capacity to deliver integrated care													
b	Determine capability to deliver integrated care													

SESLHD Integrated Care Strategy - Action Plan 2015-2018

SESLHD Integrated Care Strategy 2015-2018		2015			2016				2017				2018	
		Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun
System and Organisational Elements														
8 - Financial & contractual mechanisms														
a	Determine new models of mixed provision of care and contracting (private, public, NGO)													
b	Design business models that utilise funding from NGO's, private sector, MBS etc.													
c	Development of business case with key partners (build on PwC work)													
9 - Incentives to deliver integrated care														
a	Address ABF disincentive													
b	Explore and develop incentives to deliver integrated care													
10 - Information and IT														
a	Identify key ICT stakeholders, internally and externally, to map existing IT architecture and how repositories may be pulled together													
b	Liaise with Healthshare NSW on HealtheNet/PCEHR development													
11 - Consistent service and care models														
a	Sustain and spread successful models, as indicated previously, through the Breakthrough Collaborative method													
12 - Service user and carer engagement														
a	Service user co-design of a new model incorporating electronically captured person centred care plans and priorities.													
b	Engage with existing mechanisms (consumer councils)													
c	Investigate formal training for consumers													
13 - Quality Improvement and safety														
a	Link with existing QI framework and linking with ACHS standards													
14 - External partnerships														
a	Mapping, assessment and review of existing partnerships													
b	Identify new/missing partner organisations													

15 - Evaluation Planning														
a	Establish academic partnership/s													
b	Design and implement an evaluation plan for the Integrated Care Strategy (dependent on deep data dive)													
c	A community of scholars, panel of integrators and group of regional leaders to guide planning and be responsive to initial and ongoing evaluation.													

Health
South Eastern Sydney
Local Health District