Integrated Care

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System Performance Support
NSW Ministry of Health
STRATEGIC CONTEXT

State Health Plan: Designing and delivering a 21st century health system

Our Contribution to the 30 NSW Priorities

Critical priorities:
1. Patient Safety First
2. Leading Better Value Care
3. Systems Integration
4. Strengthening Governance and Accountability
5. Digital Health and Data Analytics

NSW Health Strategic Priorities FY2017-18

1. Keep People Healthy
2. Provide World-Class Clinical Care Where Patient Safety is First
3. Integrate Systems to Deliver Truly Connected Care
4. Develop and Support Our People and Culture
5. Support and Harness Health and Medical Research and Innovation
6. Enable eHealth, Health Information and Data Analytics
7. Deliver Future Focused Infrastructure and Strategic Commissioning
8. Build Financial Sustainability and Robust Governance
NSW INTEGRATED CARE STRATEGY (2014)

Objectives of the Integrated Care Strategy
To transform how we deliver care to improve health outcomes for patients and reduce costs deriving from inappropriate and fragmented care, across hospital and primary care services:

- Organising care to meet the needs of targeted patients and their carers, rather than organising services around provider structures
- Designing better-connected models of healthcare to leverage available service providers
- Improving the flow of information between hospitals, specialists, community and primary care healthcare providers
- Developing new ways of working across State government agencies and with Commonwealth funded programs to deliver better outcomes for identified communities, and
- Providing greater access to out-of-hospital community-based care, to ensure patients receive care in the right place for them

Achieving these objectives will be evidenced by:

- An improved patient experience, health outcomes and quality of life
- A more sustainable, affordable health system
- Reduced waiting times for patients as they navigate the system
- Greater access to community based care
- Fewer Emergency Department presentations, and reduced avoidable hospitalisations
- Reduction in duplicate testing through better sharing of information

Functional Components of Integrated Care
- Empowering patients and carers
- Identifying and selecting patients
- Fostering innovative ways of coordinating care
- Making primary and community care a hub
- Sharing patient information electronically
INNOVATIVE LOCAL INITIATIVES

RASS (Rapid Access & Stabilisation Services), Western Sydney LHD
- Located at 3 hospitals - 50% of attendees seen within 2 days of referral
- Teams comprise diabetes, COPD, congestive cardiac failure and ischaemic heart disease

Multilevel Specialist Care, South Eastern Sydney LHD
- A bulk-billed GP integrated skin cancer clinic – led by GPs with supervision and support from specialists
- Jointly funded by SESLHD, private dermatology provider Ramsey, the Central and Eastern Sydney PHN, and Macquarie University

Healthy Homes and Neighbourhoods, Sydney LHD
- A cross-agency care coordination network. Care coordination is aimed at the whole family using: a family medical home (general practice), family case conferencing, wrap-around multi-agency support, targeted parenting programs, information sharing and long-term health and wellbeing monitoring of family members.
Continuous Improvement approach

• Quarterly Roadmap Reporting

• Formative Evaluation

• Patient Flow Portal
Common facilitators:

- strong local leadership, clear strategic vision, clinical sponsorship and commitment by the LHD/SHN and partner organisations to supplement the NSW Ministry of Health funding

Common system barriers:

- payment and regulatory barriers, technology constraints, lack of a workforce trained in effective collaboration, and cultural differences across care settings

Integrated Care Maturity Model
MOVING FORWARD

- Structured Purchasing model
- Agreed definitions of Integrated Care activities
- Harmonisation of initiatives and integrated care approach expansion
- State-Wide Risk Stratification
- E- enablers
Rapid Review: Integrated Care Interventions

**Health Coaching**

**Working definition:** A patient-centred approach to goal-setting, active learning and self-management that guides, empowers and motivates an individual to change their behaviour (Modified from Wolever).

**Core components:**

- Patient directed goal setting,
- Self-discovery/active learning,
- Motivational interviewing and support.

However, the exact mix of components may be tailored according to risk and condition.

**Care Navigation**

**Working definition:** Facilitating access to services for the care of a patient, their carers and family for a defined episode of care. The aims are to improve the timeliness and appropriateness of care and reduce barriers to access to care and loss to follow up.

**Core components:**

- Providing information about treatment or referral options, advocacy or brokering of access, shared decision making
- Identification of barriers can include poor health literacy, language or culture, cost, distance and complexity of care pathways
- Patient support to address these barriers (including home visits, interpreters, transport, child care),
- Monitoring use of services and follow up.

**Care Coordination**

**Working definition:** Deliberate person-centred organisation of patient care activities between providers to facilitate self-management, appropriate care, health outcomes and greater efficiency.

**Core components:**

- Individual level: Identification (single entry), assessment, self-management support, education (including coaching), care plan and review, medication review.
- System level: facilitated information exchange, shared accountability, guidelines/standards.
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[LHD NAME] – INTEGRATED CARE APPROACH

**ENABLERS** incl program management, technology

**Population 1**
People with Chronic Conditions

**Population 2**

**Population 3**

**Population 4**

**Target Population**

**Program Name**
- ICPCC - People with Chronic Conditions who are at risk of hospitalisation
- e.g. HCH or other PHC version
- e.g. Innovator / Demonstrator cohort with Chronic Condition(s)
- e.g. Vulnerable Children & Families
- e.g. People likely to be in the last year of life
- e.g. People with Mental Health issues

**Patient Identification & Selection**
- Patient Identification: CCPIA
- Patient Identification: e.g. QAdmission
- Patient Identification: OTHER
- Patient Identification: OTHER
- Patient Identification: OTHER
- Patient Identification: OTHER
- Patient Identification: OTHER

**Patient Selection**
- Patient Selection: CCoPS
- Patient Selection: e.g. HARP (Vic)
- Patient Selection: OTHER
- Patient Selection: OTHER
- Patient Selection: OTHER
- Patient Selection: OTHER
- Patient Selection: OTHER

**Interventions**
- Health Coaching
- Care Navigation
- Care Coordination
- GP Care
- Medications Review
- Telemonitoring
- Dental Care
- [planned] Hospital Admission

**Match to Intervention**
- Design and implement innovative new model of care / suite of interventions
- e.g.
  - Advanced Care Plan
  - Ambulance Care Plan
  - Care Coordination
  - GP Care
  - Respite Care
  - [planned] Hospital Admission

**Capturing Activity**
Tier 2 Clinic Type (HERO ID) / other activity capture

**Enablers**
- e.g. Innovator / Demonstrator cohort with Chronic Condition(s)
- ICPCC - People with Chronic Conditions who are at risk of hospitalisation
RISK STRATIFICATION APPROACH

<table>
<thead>
<tr>
<th>PERSON</th>
<th>HOME</th>
<th>MEDICAL HOME</th>
<th>MEDICAL NEIGHBOURHOOD</th>
<th>HOSPITALS</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>GP</td>
<td>Specialists</td>
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<tr>
<td>Family Carers</td>
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<td>General Practice</td>
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<td>RACF</td>
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<td>Pharmacy</td>
<td>Social Care</td>
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<td>Self-management tools</td>
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<td>Practice Nurse</td>
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<td>Community Mental Health Services</td>
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<td>Allied and community health</td>
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<tr>
<td>Dental Services</td>
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</tbody>
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Patient Identification: CSIRO
Patient Selection: HARP (Vic)