COORDINARE commenced operations as the South Eastern NSW Primary Health Network (PHN) in July 2015 and is one of 31 PHNs established across Australia. PHNs were established by the Department of Health on 1 July 2015 with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

COORDINARE is committed to working directly with GPs, other primary health care providers, secondary health care providers and hospitals to improve and better coordinate care across the local health system for patients requiring care from multiple providers or at risk of poor health outcome; and find innovative ways of building ‘one coordinated and sustainable health system’ which ensures better consumer experiences, improved health outcomes, and reduced costs.

The PHN region has approximately 600,000 residents and covers a large geographical area, from Helensburgh in the north down to the Victorian border, across the Cooma-Monaro region, Queanbeyan, Yass, Crookwell and Goulburn.

The Illawarra Shoalhaven Local Health District (ISLHD) is a NSW Health entity formed on 1 January 2011, in accordance with the National Health and Hospital Agreement. Local decision-making is at the forefront of how the organisation functions, led by a professional Health District Board and a Chief Executive.

ISLHD’s catchment area extends about 250km along the coastal strip from Helensburgh in the north to North Durras in the south, servicing a population of more than 390,000 residents.

ISLHD is one of the region’s largest employers with a workforce of more than 7,300 across nine hospital sites and community health services.

Introduction

Developing more integrated people centred care systems has the potential to generate significant benefits to the health and health care of all people, including improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction, improved efficiency of services, and reduced overall costs¹.

COORDINARE and ISLHD are committed to developing an integrated care strategy that will enable all people living across the region to access health services that are provided in a way that responds to their life circumstances, are coordinated across the continuum of care, and are safe, high quality, accessible, timely and efficient.

COORDINARE and ISLHD have a history of collaborating on shared priority areas such as immunisation, mental health and chronic disease management. This strategy constitutes a commitment to developing new ways of working together that will engender a cultural shift, and promote clinical leadership that brings health care providers closer together to work on a number of key areas.

¹ World Health Organisation Global Strategy on Integrated people centred health services 2016-2026, Executive Summary 2015.10.
Regional context

Increasing pressures on health and social systems internationally and across Australia means that all jurisdictions are seeking to make the delivery of health and social care more effective and efficient. Ageing populations, advances in science and technology, and increasing expectations among consumers and the public all contribute to growing health and social care costs. Although chronic and complex conditions are expected to account for 80% of the disease burden in Australia by 2020, services are becoming more specialised, segmented and siloed. The increase in chronic disease is particularly prominent in vulnerable populations, including Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities.

As in most large health services, across the Illawarra Shoalhaven, there is significant variation in health risks, status and outcomes between groups within the community. The health of Illawarra Shoalhaven residents is, on average, poorer than for other NSW residents, in terms of many indicators of current and expected future health status and system outcomes.

For example, residents are more likely than the average NSW resident to be:

- risk drinkers, overweight or obese
- experiencing psychological distress
- hospitalised for a condition that could have been prevented, had there been more effective earlier intervention
- hospitalised for attempted suicide

Compared to NSW as a whole, the risk of hospitalisation due to smoking and alcohol related conditions are not uniform across the district and are:

- high in Shoalhaven and Kiama Local Government Areas (LGA) for alcohol related conditions
- low in Kiama LGA for smoking related conditions
- the number of current smokers in Wollongong, Shoalhaven and Shellharbour is greater than the NSW average

Additionally, compared to the NSW average, the risk of being hospitalised for a high Body Mass Index (BMI) related condition are:

- higher in all Illawarra Shoalhaven LGAs except Kiama LGA (with the highest rates in Shellharbour LGA)
- lower in the Kiama LGA

The estimated number of people within the Illawarra Shoalhaven who suffer from co-morbidities is just over 89,000, which represents over 23% of our total population. Additionally people are more likely to have multiple chronic conditions as they age, and within the Illawarra Shoalhaven the fastest growing age brackets are for those between 65 to 84 and 85 and over. Growth in the number of people suffering from co-morbidities means that the health system within the Illawarra Shoalhaven must ensure it is coordinated in a manner that allows for the appropriate distribution of resources so that these people are receiving the right care in the right place at the right time.
What is integrated care?

Integrated care involves the provision of seamless, effective and efficient care that reflects the whole of a person’s health needs; from prevention through to end of life, across both physical and mental health, and in partnership with the individual, their carers and family. In practice it requires a greater focus on a person’s needs, better communication and connectivity between health care providers, and better access to general practice or an Aboriginal Medical Service (AMS).

The NSW Health Integrated Care Strategy is about transformation and innovation, not simply improvement, it is about change at the system level. It is not about the extension of existing programs but rather about sustainably doing things differently. This approach is also in line with Commonwealth policy direction towards improving care coordination for those most at risk of poor health outcomes.

NSW Health Integrated Care Strategy

The objectives of the NSW Health Integrated Care Strategy are 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 by:

- focusing on 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 to meet the needs of our smaller rural communities
- improving the flow of information between hospitals, specialists, community, general practice and AMS
- developing new ways of working across State government agencies and with Commonwealth funded programs to deliver better outcomes for identified communities
- providing greater access to out-of-hospital general practice or AMS care, to ensure patients receive care in the right place for them.

Achieving these objectives will be evidenced by:

- consumers reporting that they can more easily navigate the various parts of our health system
- an improved consumer experience, and better health outcomes
- reduced waiting times for consumers
- more consumers who can access their care through their usual General Practitioner (GP) or AMS and have other services in the community, with a reduction in avoidable hospitalisations and frequency of hospital admissions and emergency department attendance
- better sharing of clinical information and a resultant reduction in unnecessary duplication of diagnostic tests e.g. pathology and radiology tests.

Underpinning values and principles

While some early work has focused on promoting an integrated care approach across the region, there is a continued need to invest in developing stronger working relationships between consumers and health care staff. This requires a cultural shift that will see the Illawarra Shoalhaven Local Health District (ISLHD) and the primary care sector adopt a more collaborative and transparent approach to tackling local needs and developing service responses that are driven by the needs of the consumer and carers. This will involve developing a shared understanding and ownership of the problems as well as the solutions in an environment that is respectful, open and collaborative.

The development and adoption of a shared ‘culture of change’ by leaders across the health care system is necessary to further support and enhance innovation and integration that the strategy is seeking to achieve. This ‘culture of change’ must be underpinned by a comprehensive mix of learning and development opportunities that encourage innovative thinking that is centred on the patient. A strategy that encourages interaction and joint planning between individuals and teams in differing areas supports innovation and fosters an empowering environment. Taking initiatives to improve care provision within the wider context of sustainable system change is a key feature of patient centred care.

ISLHD and COORDINARE have a collaborative relationship that is founded on the common purpose of delivering improved health outcomes for the population of the Illawarra and Shoalhaven.

The proposed strategy aims to uphold common values and principles that seek to support care provided across a person’s lifespan:

- from prevention through to end of life, across both physical and mental health, and in partnership with the individual, their carers and family
- with a greater focus on a person’s needs, better communication and connectivity between health care providers in primary care, community and hospital settings
- providing better access to out of hospital health services closer to home.

This strategy does not represent the entirety of work being conducted by each respective organisation, rather its purpose is to detail an agreed approach and prioritise key initiatives between ISLHD and COORDINARE.

Both organisations share common elements in their vision to work towards improving the health of the community. However, the key to this strategy is identifying the focus points and priorities that will provide the impetus to achieving transformational change across the region.

<table>
<thead>
<tr>
<th>Shared vision</th>
<th>An integrated, person-centred health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISLHD</td>
<td>COORDINARE</td>
</tr>
<tr>
<td>Excellent services, quality partnerships, healthy communities</td>
<td>A coordinated regional health system which provides exceptional care, promotes healthy choices and supports resilient communities</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Shared purpose</th>
<th>Person-centred care, coordination across the health system, equitable access, and safe &amp; high quality health care</th>
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<tbody>
<tr>
<td>ISLHD</td>
<td>COORDINARE</td>
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<tr>
<td>Truly integrated care – right care, right place, right time</td>
<td>Supporting primary care in our region to be:</td>
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<tr>
<td></td>
<td>• Comprehensive</td>
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<td></td>
<td>• Person-centred</td>
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<td>• Population oriented</td>
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<td>• Coordinated across all parts of the health system</td>
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<td></td>
<td>• Accessible</td>
</tr>
<tr>
<td></td>
<td>• Safe and high quality</td>
</tr>
</tbody>
</table>

2. Schulman, C (2015), First Formative Evaluation of NSW Health 20014 Integrated Care Strategy, NSW Health pp7-8
3. Illawarra Shoalhaven Integrated Care Strategy 2017-2020
4. Illawarra Shoalhaven Integrated Care Strategy 2017-2020
Illawarra Shoalhaven Integrated Care Strategy

The following diagram provides a single page summary of the Illawarra Shoalhaven Integrated Care Strategy. It outlines the key components of the strategy and alignment with Commonwealth and State obligations.

Illawarra Shoalhaven Integrated Care Strategy - aligned with Commonwealth and NSW priorities

As both organisations seek to improve health outcomes, particularly for the most vulnerable, we will focus on how to work together towards ‘Closing the Gap’ on health issues for members of Aboriginal communities across the region. The Integrated Care Strategy will prioritise the Aboriginal population across all the areas of focus in the plan in order to achieve traction to redress the significant health disparities for Aboriginal residents. In chronic disease management this will involve increasing and improving care coordination. There will be further development and support of culturally appropriate and effective strategies to reduce suicide rates; and improvements made to ensure greater access to both specialists and urgent care.

In addition, collaborative approaches to strengthen the relationships with Aboriginal Community Controlled Health Organisations (ACCHO) will be developed. Options for enhancing genuine collaboration and partnerships with ACCHOs will be explored throughout 2017.

1. Regional Mental Health Strategy

The recent Commonwealth Review of Mental Health Services across Australia undertaken by the National Mental Health Commission highlighted many failures within the current system. Notably many were contributing to high suicide rates in some regions including the Illawarra Shoalhaven, and large numbers of people not being able to access the support they needed, at the time they needed it. Significant reforms have been recommended and are now in the process of being implemented.

A key first step is ensuring current resources are re-directed and invested in those services that are going to have the greatest impact towards improving the region’s mental health. This requires an initial investment in planning and service redesign, particularly in relation to the development of a stepped care model of service delivery for those living with mental illness.

The impact of mental health on the community has increased over the decades with the national survey of mental health in 2010 identifying that one in five Australians aged 18-65 are directly affected by mental ill-health. Nationally, the standardised death rate for deaths due to suicide has risen from 10.2 deaths per 100,000 people in 2006 to 12.6 suicide deaths per 100,000 people in 2015. Within the Illawarra Shoalhaven, hospitalisation rates for attempted suicide are higher than the NSW state average, and in 2015-16, over 1,100 people who presented to ISLHD Emergency Departments were found to be at risk of suicide or self-harm. Mental health services across the world and in the Illawarra Shoalhaven are seeking to reform the delivery of care introducing a recovery orientated health service. From the perspective of the individual with mental illness recovery focused care means gaining and retaining hope, understanding ones abilities and disabilities, engaging in an active life with personal autonomy and meaning. Central to this is that the lived experience and insights of people with mental health issues and their families are at the heart of the care decisions. This type of reform requires a cultural and attitudinal change and for health care staff to development meaningful partnerships with the individual, their carers and family and an extended network of support across a range of government, non-government and volunteer services.

A ‘Systems Approach to Suicide Prevention’ will be the first led joint initiative in mental health. The Illawarra Shoalhaven was recently chosen as one of four pilot sites within NSW to participate in the Lifespan program that has been developed by the Black Dog Institute. The funding will be provided with the aim to reduce suicides by at least 20% within a 3 year period. Strong collaboration is required between all health and social service providers as well as those with a lived experience to achieve this goal.

The collaboration around this critical issue will be enabled through HealthPathways, shared patient records, e-referrals and notably sharing data to identify patterns of vulnerability and service utilisation.
2. Redesign of the Chronic Disease Management Program

A significant component of the NSW Health Integrated Care initiative is building on the foundations of the Chronic Disease Management Program, Connecting Care in the Community. This program facilitates care coordination for people with complex chronic diseases, in collaboration with GPs. It actively promotes self-management and the building of a sound relationship between the consumer and their GP in order to improve the patient experience and reduce unnecessary admission into hospital.

The re-design and co-commissioning will extend the reach of the program and build on the key components that have witnessed success across the state. More significantly the changes will target people at an earlier stage in their illness in order to impact more positively on disease progression.

The proposed changes are described in Appendix 1. The elements that will be revised and implemented using common algorithms and screening tools include:

- targeting and patient identification
- patient selection and consent
- matching to integrated care interventions
- improving referral process into the program by GPs

The re-design and co-commissioning will be enabled through the systematic use of patient reported measures particularly in primary care settings as well as more stringent monitoring and evaluation of the outcomes of the (more clearly defined) care interventions.

Key steps actions:

- implementing the re-design of the Connecting Care in the Community Program to build on the strengths of the program and incorporate learnings to enable early intervention for an extended group of people
- align and coordinate chronic disease management initiatives within Illawarra Shoalhaven with the implementation of Health Care Home trials across Australia
- adopt a collaborative approach to address population health targets for childhood and adult obesity.

Health Care Homes

The Commonwealth Government’s policy statement in March 2016 regarding support for pre implementation of ‘Health Care Homes’ which will be further developed over a two-year period. This is the most significant reform in primary care since the introduction of Medicare. Health Care Homes promote greater coordination between Primary Health Care Networks (PHNs) and Local Hospital Networks (LHNs) in the planning and procurement of health services for their local communities, including:

- coordination of all the medical, allied health and out-of-hospital services required as part of a patient’s tailored care plan
- Health Care Homes will be delivered by GP practices or Aboriginal Medical Services. Patients will be able to enrol with the practice of their choice
- new payment structures to encourage flexible and innovative care delivery moving away from fee for service
- improved use of digital health measures to improve patient access and efficiency
- stronger data collection, measurement and evaluation tools including opportunities for benchmarking
- processes to empower patients and their families to be partners in their own care and take greater responsibility for the management of their conditions.
3. Developing improved models of integrated care with an initial focus on Shoalhaven

The Shoalhaven has long been identified as an area of significant under-resourcing, high levels of social disadvantage and limited diversity in health service delivery. Community demand for improved access to affordable health care in the Shoalhaven is strong. Contributing factors are the increasing proportion of older people living in this part of the region, areas of rurality, as well as the large number of tourists that visit the area during the summer months.

Given these indicators, there is agreement to prioritise the Shoalhaven as the area for commencing the rollout of integrated care initiatives. Stronger collaboration between local GPs and specialists, including visiting specialty services, residential aged care providers and urgent care providers is expected to lessen the need for emergency responses to people experiencing exacerbations of their illnesses after hours.

Seeking to understand the issues behind the demand for emergency care across business and after hour’s periods creates an opportunity for local GPs and the Emergency Department at Shoalhaven Hospital to collaborate to develop improved models of integrated care that will reduce the demand for hospital services.

A current example that will be expanded across the area is ‘Geriatrician in the Practice’ Project where specialists and GPs in the Shoalhaven are working collaboratively to increase the skill of GPs in undertaking dementia assessments, thus seeking to reduce the demand for ongoing specialist appointments.

Additionally, resources allocated to the CHRISP (Centre for Health Research Illawarra Shoalhaven Population) initiative will be deployed to comprehensively analyse available data and information to formulate a reliable and accepted picture of the current health service utilisation patterns in the Shoalhaven. This will assist to generate agreed strategies and evaluation measures.

4. Enhanced access to specialist non-admitted outpatient services

The strategy aims to improve timely access by GPs to specialist advice and review, as well as capacity and speed of access to outpatient clinics. It is widely recognised that ‘rapid access’ to specialist care can significantly improve outcomes for patients by de-escalating the clinical progression of a disease and improving self-management of long-standing conditions.

A critical enabler of enhanced access to specialist care is timely, transparent and secure communication between all health care providers involved in the management of an individual’s patient care. Specifically ISLHD and COORDINARE will collaborate to:

- improve the timeliness and quality of discharge summaries from inpatient settings as well as the quality and comprehensiveness of letters from outpatient clinics
- expand the use of secure messaging between GPs and specialists to minimise duplication of diagnostic testing and medication errors.

There are already a number of strategies in place to assist to significantly improve the current state of play:

- Health Pathways
- secure messaging
- ease-e-referrals (Diabetes)

Additional investment can be made in the following areas:

- My Health Record (extended rollout in 2017)
- Extend e-referrals across the region
- Shared clinical education and training sessions between GPs and specialists

Numerous studies have demonstrated that the enhancement of communication between GPs and specialists can be achieved by increasing the number of opportunities for joint meetings to discuss issues of common concern and develop their clinical skills together. Increasing GP’s expertise can often reduce the need to refer to a specialist in the first place. It is also important for specialists to increase their understanding of GPs capability and capacity.

5. Aboriginal health

The Integrated Care Strategy will prioritise the Aboriginal population across all the areas of focus in the plan in order to achieve traction to redress the significant health disparities for Aboriginal residents. In addition, collaborative approaches to strengthen the relationships with Aboriginal Community Controlled Health Organisations (ACCHO) will also be developed. Options for enhancing genuine collaboration and partnerships with ACCHOs will be explored throughout 2017.
Population health priorities

The delivery of health services are also influenced by national and state policies regarding health priorities. PHNs are to deliver outcomes against the following national health priorities:

• increase Cancer Screening rates for bowel, breast and cervical cancer
• increase Childhood Immunisation rates
• improve Mental Health treatment rates; and
• reduce potentially preventable hospitalisations (PPH)

ISLHD is also required to meet the challenges of the NSW State Health Plan to:

• deliver truly integrated care
• keep people healthy
• provide world-class clinical care

These priorities provide the context for the Integrated Care Strategy and also provide the impetus for ensuring prevention and early intervention initiatives are aligned and engaged with the strategy. Along with the joint planning and data exchange there are opportunities to identify the population health interventions that will impact most significantly to achieve improved health.

Enablers

The integrated care strategies above are reliant on key enablers to ensure that the approach is sustainable and systemic. It is proposed that there is a shared investment in the following foundations.

Patient experience

Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) will enable all services across the health system to monitor their quality, effectiveness and timeliness through regular patient feedback.

Plans to work in partnership with the Agency for Clinical Innovation (ACI) in using these tools in both primary and secondary care are underway. This work will have input from both ISLHD’s Co-Design Council and COORDINARE’s Community Advisory Committee.

These new electronically enabled tools seek to put patient’s concerns and issues up front so the health practitioner and the consumer can partner more equally in the care planning.

There will also be the opportunity to develop greater collaboration between consumers and health professionals in the development of ‘Health Care Homes’ through general practice, as part of the Commonwealth’s primary care reforms.

eHealth

Navigating the complicated multiplicity of systems required in order to refer patients can be frustrating and often results in poor quality information being exchanged.

Significant gains have been made in a small number of services within ISLHD to accept e-referrals through secure messaging. Extending the use of secure messaging between primary care and secondary care will assist in improving the timely flow of information between GPs and specialists. It is proposed to extend the use of secure messaging from the initial work in the Eas-e referral project.

The development of an ISLHD ICT Integrated Care Strategy that aligns with the work being rolled out by the Ministry of Health will facilitate the up-take of electronic options for the transfer of information. In addition this will support developments in:

• eMeds – allowing for electronic pharmaceutical orders and improving the quality of medication lists for discharge summaries and medicines reconciliation
• shared care tool/s
• eMR (rollout through ISLHD)

The ability to share patient records, particularly of those living with chronic conditions is key to ensuring seamless, timely and appropriate service delivery for patients. The Commonwealth’s plans to promote greater uptake of My Health Record with the introduction of an ‘opt out’ system in 2017 creates more opportunities for shared records to be utilised, particularly in General Practice, Emergency Departments and Residential Aged Care Facilities.

The use of real-time secure messaging as well as timely transfer of care summaries and e-referrals can also support the sharing of care in the absence of a single patient record.

Data exchange

In order to ensure the joint plans and strategies developed are targeted appropriately and effectively implemented, there is a need to ensure there is a commitment to data exchange and shared intelligence. Creating forums to explore data, enables joint identification of areas for improvement and garners shared ownership of problems and strategies to address them.

The decision by ISLHD to establish a health research and evaluation centre of ‘excellence’ through the establishment of CHRISP (Centre for Health Research Illawarra Shoalhaven Population) will promote more informed future planning and resource allocation, and will also incorporate primary health data. Further data sharing and analysis can be formalised through agreed protocols.
Establishment phase

In the Establishment phase it will be necessary to ensure that all relevant stakeholder’s interests are represented, and that all these stakeholders are involved in the decision making process. The following diagram represents the proposed governance for the establishment phase.

- Integrated Care Strategy
  - Joint Board meetings
  - Strategic Alliance Executive Committee
    - Board
    - Strategic Executive
  - Strategic Alliance Operational Group
    - Board
    - Clinical Council
    - Community Advisory Committee

The Strategic Alliance Executive Committee will initially meet once every month, and will be the overarching committee responsible for decision making, strategic direction and leadership. The group will consist of the following members:
- COORDINARE Chief Executive Officer, Board sponsor and Executive Team
- ISLHD Chief Executive, Board sponsor and relevant Executive Staff

The Strategic Alliance Operational Group will be responsible for progressing, monitoring outcomes and advising on all aspects of the strategy, and will consist of representatives from the Strategic Alliance as well as relevant clinical and operational staff from the respective organisations.

Implementation phase

The governance structure of the implementation phase will be determined through the program establishment phase, and will recommend a long term governance structure for developing integrated care across both organisations.

Communication strategy

A detailed communication plan and reporting framework will be developed to assist in rolling out the plan.

Evaluation and monitoring

An evaluation and monitoring plan will be developed.

Shared governance

Strengthening governance and accountability involves improving policy and planning dialogue and evaluation between local people, decision makers and service providers.

The right planning and governance mechanisms will also contribute to ensuring that new service development, such as the commissioning work of COORDINARE, is appropriately targeted and designed to meet local needs. Increasingly, work in this area will provide opportunities to drive integration by incentivising and contracting for collaboration, new models of care, improved care pathways and capacity building that will facilitate the delivery of integrated care.

The involvement, support and participation of the clinical workforce is a principal requirement for integrated care. Strong clinical sponsorship and leadership, as well as the ability to identify and communicate potential opportunities across both COORDINARE and ISLHD is integral to developing an integrated health system.

Leadership is required across both ISLHD and COORDINARE at a clinical level, and an environment where a willingness and desire to build and maintain working relationships based on mutual trust and respect across the health system will help to ensure that integrated care is adopted as core clinical business practice. Clinical leadership is a key enabler in ensuring that work is done in a multidisciplinary manner, which is a major factor required in building and sustaining an integrated health system.

Similarly, effective change management is required to support changes to care delivery models. ISLHD and COORDINARE must be engaged at the clinical level to support substantive cultural change required to establish integrated care models, assist the integration of primary and secondary care, and support the uptake of reforms to policies, practice, training and professional development.

A critical success factor is shared governance and robust executive sponsorship across both organisations. It is also pivotal that the governance structure allows for all stakeholders involved to be incorporated into the decision making process.

For the purpose of the Integrated Care Strategy, it is proposed that the governance structure be divided into two phases in order to effectively address the needs of the program (the establishment and the implementation phase). The governance structure will allow for reporting to be escalated through the strategic alliance, as well as maintaining consistency with each organisation’s reporting lines.
## Regional Mental Health Strategy

The recent Australian review of mental health services highlighted too many people are missing out on accessing services despite significant expenditure; outcomes remain poor, and are not monitored well. The Illawarra Shoalhaven also has one of the highest suicide rates in NSW. There is an opportunity to work together to redress these issues.

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Milestones/targets/work in progress</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Implement the ‘Systems Approach to Suicide Prevention’ as promoted by the Black Dog Institute and the Centre for Research Excellence in Suicide Prevention</td>
<td>Joint project with the Illawarra Shoalhaven Suicide Prevention Collaborative funded by ISLHD and COORDINARE, and Black Dog Institute through the Paul Ramsay Foundation. (Lifespan Integrated Suicide Prevention project) COORDINARE employer of positions</td>
<td>Reduction of suicides by 20%</td>
<td>As per Suicide Prevention Plan currently in development</td>
</tr>
<tr>
<td>1.2 Deliver coordinated and complimentary mental health service plans that offer a range of services and supports across the continuum of care, that are flexible and responsive to individual need.</td>
<td>ISLHD Mental Health</td>
<td>Reduction in suicide attempts by 30%</td>
<td>(Within a 3-year period to 2020)</td>
</tr>
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</table>

## Redesign of the Chronic Disease Management Program

Care coordination for people with complex chronic diseases, in collaboration with GPs, is the cornerstone of improvement in health outcomes. Promoting self-management and building a sound relationship between the consumer and their GP in order to improve their experience can assist to reduce unnecessary admission into hospital. The re-design will extend the reach of the program and will build on the key components that have witnessed success across the state. More significantly the changes will target people at an earlier stage in their illness in order to impact more positively on disease progression.

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Milestones/targets/work in progress</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Redesign the CDM program towards Integrated Care.</td>
<td>ISLHD</td>
<td>Meet the Ministry of Health targets for Integrated Care</td>
<td>June 2017</td>
</tr>
<tr>
<td>2.2 Health Care Home</td>
<td>COORDINARE</td>
<td>Four different innovations developed and trialled in at least eight practices across SE NSW. Coordinate Chronic Disease Management initiatives with HCH trial within Illawarra Shoalhaven</td>
<td>June 2018</td>
</tr>
<tr>
<td>2.3 Obesity Management</td>
<td>ISLHD</td>
<td>ISLHD and COORDINARE collaborate to address targets for childhood and adult obesity</td>
<td>Commence February 2017</td>
</tr>
</tbody>
</table>
### 3. Developing integrated models of care (initial focus on Shoalhaven)

Development of viable models of integrated care that reduce the number of potentially preventable hospitalisations, particularly in the Shoalhaven.

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Milestones/targets/work in progress</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Implementation of Integrated Care Innovator Project – Geriatrician in the Practice</td>
<td>ISLHD</td>
<td>Increased access to geriatric specialist services</td>
<td>June 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improving skill base of General Practice staff re dementia assessment</td>
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<td></td>
<td></td>
<td>Viable business models developed for provision of specialist services within GP practice that can be replicated for other specialities</td>
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<td></td>
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<td>Increase the number of people receiving initial dementia assessment and reduce number of assessment reviews</td>
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<tr>
<td>3.2 Increased options for residents to access urgent care support in and out of hours in the Shoalhaven</td>
<td>COORDINARE</td>
<td>Priority issues agreed</td>
<td>December 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication plan developed for residents in collaboration with ED, primary care, AMS and Child and Family Services to articulate options for local residents</td>
<td>February 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strategies to address priorities developed and implemented</td>
<td>April 2017</td>
</tr>
<tr>
<td>3.3 Infrastructure plan for delivery of Integrated Primary and Community Health Services</td>
<td>ISLHD</td>
<td>Service delivery principles defined and agreed promoting enhanced collaboration between primary care and ISLHD Ambulatory Care services to avoid duplication and maximise service delivery</td>
<td>December 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capital delivery and asset plan drafted</td>
<td>April 2018</td>
</tr>
<tr>
<td>3.4 Utilising data capability of CHRISP to highlight focus areas for integrated care delivery enhancements</td>
<td>ISLHD</td>
<td>Commission reports of the CHRISP team focussing on elements that enable integrated care</td>
<td>Commence February 2017</td>
</tr>
</tbody>
</table>

### 4. Enhanced access to specialist non-admitted outpatient services

Improve timely access by GPs to specialist advice and review, as well as capacity and speed of access to outpatient clinics. It is widely recognised that ‘rapid access’ to specialist care can significantly improve outcomes for patients by de-escalating the clinical progression of a disease and improving self-management of long-standing conditions.

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Milestones/targets/work in progress</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Improved two way communications and discharge information to GPs</td>
<td>ISLHD</td>
<td>eMedication and iPharmacy reconciliation on discharge</td>
<td>Progress defined by June 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase in timeliness, number and percentage of completed discharge summaries sent compared to previous year and acknowledged by GP (baseline December 2016)</td>
<td>June 2017</td>
</tr>
<tr>
<td>4.2 Improved two way communications and discharge processes for mental health consumers from acute care into the community and back.</td>
<td>ISLHD</td>
<td>HealthPathways developed for discharge from mental health services to community</td>
<td>June 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seven day community follow up target achieved for those who have been discharged acute to community follow-up</td>
<td>January 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Electronic discharge summaries to GPs, % of discharges sent within 24 hours</td>
<td>June 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved General Practice satisfaction with discharge processes</td>
<td>GP baseline survey June 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GP satisfaction improvement December 2017 and June 2018</td>
<td></td>
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</tbody>
</table>
### 5. Aboriginal health

The health of Aboriginal people is a key priority for both ISLHD and COORDINARE and action will be taken to implement collaborative approaches to redress the disparity of health outcomes for Aboriginal people.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>ISLHD</td>
<td>Develop an Aboriginal Health Partnership plan</td>
<td>Plan delivered December 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reference Group established</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scope of plan agreed</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>COORDINARE</td>
<td>Deliver coordinated and complimentary mental health service plans that offer a range of services and supports across the continuum of care for Aboriginal and Torres Strait Islanders that are flexible and responsive to individual needs</td>
<td>Ongoing to June 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ISLHD participation in COORDINARE’s Regional Mental Health and Suicide Prevention Strategy</td>
<td>September 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COORDINARE to implement 1st year of Mental Health and Suicide Prevention Commissioning Plan that will contribute to addressing some of the mental health needs of the Aboriginal and Torres Strait Islander communities</td>
<td></td>
</tr>
</tbody>
</table>

### Enablers

The integrated care strategies above are reliant on key enablers to ensure that the approach is sustainable and systemic. It is proposed that there is a shared investment in these foundations.

### E1. Patient experience

<table>
<thead>
<tr>
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<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>COORDINARE</td>
<td>Pilot use of PROMs &amp; PREMs in General Practice</td>
<td>No of GPs utilising PROMs and PREMs with ACI June 2017</td>
</tr>
<tr>
<td>b.</td>
<td>ISLHD</td>
<td>Improvement in patient experiences within ISLHD</td>
<td>Increased percentage of people reporting hospital experience as ‘good’ or ‘very good’ with BHI (baseline December 2016) August / September 2017</td>
</tr>
<tr>
<td>c.</td>
<td>ISLHD</td>
<td>Consumer and Carer Co-design Committee</td>
<td>Substantial progress made on prioritised Access and Flow issues identified by consumers through work of Health Co Design Council June 2017 and 2nd yearly reviews</td>
</tr>
</tbody>
</table>

### E2. eHealth

The Integrated Care Strategy has its foundations built on effective and secure communication between health practitioners working across the care continuum. The promulgation of eHealth processes to expedite this communication is critical. The following strategies highlight the key eHealth components of strategic priorities listed above.

<table>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>COORDINARE</td>
<td>HealthPathways</td>
<td>Population registered with My Health Record increased (%), (currently 15% Sept 2016) Reporting 6 monthly</td>
</tr>
<tr>
<td>b.</td>
<td>ISLHD</td>
<td>Digital Telehealth Plan for Illawarra Shoalhaven</td>
<td>Number of health pathways localised Ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. of GP Education events that link to HealthPathways</td>
<td>Number of new and regular users of the site Regular Quarterly updates</td>
</tr>
<tr>
<td>c.</td>
<td>ISLHD</td>
<td>Increased access for patients to telehealth &amp; tele-home care</td>
<td>Digital Telehealth Plan for Illawarra Shoalhaven December 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e-referral tenders developed</td>
<td>e-referrals introduced District wide for all outpatient services and surgery January 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utilisation benchmarked and tracked</td>
<td>Utilisation benchmarked and tracked Commencing July 2017</td>
</tr>
<tr>
<td>d.</td>
<td>COORDINARE</td>
<td>Increase utilisation of My Health Record</td>
<td>Population registered with My Health Record increased (%), (currently 15% Sept 2016) Reporting 6 monthly</td>
</tr>
</tbody>
</table>
E3. Data exchange
The data exchange seeks to value add to data each organisation currently collects by providing further insight and measurement to for example, the forecasting of hospital bed requirements or the mapping of patient health service utilisation across inpatient and primary care.

<table>
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<th>Timeline</th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Data Sharing</td>
<td>COORDINARE Establishment of process and protocols for data sharing and analysis</td>
<td>February 2017</td>
</tr>
</tbody>
</table>

E4. Population health priorities

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Development of joint action on shared population health priorities (obesity, physical activity, cancer screening, immunisation, preventable hospitalisations)</td>
<td>ISLHD Joint actions identified and outcomes agreed</td>
<td>January 2017</td>
</tr>
</tbody>
</table>

Measurement and evaluation data shared for joint planning and publications | July 2017 |

E 5. Shared governance

<table>
<thead>
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<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Strategic Alliance is a mechanism for joint governance</td>
<td>COORDINARE Strategic Alliance meetings attended and actions implemented</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Strategic Alliance Operational Committee to facilitate actions from Strategic Alliance</td>
<td>Meet monthly or as required</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Joint ISLHD and COORDINARE Board meetings</td>
<td>COORDINARE ISLHD and COORDINARE Board meetings occur annually</td>
<td>August each year</td>
</tr>
</tbody>
</table>

Appendix 1

Integrated care patient journey model and enabling elements

Key elements and enablers

Targeting and Patient Identification - Targeted cohort informed by a local population health needs assessment. Identification of individual patients at risk of potential preventable hospitalisations through searching of electronic databases using a standard set of risk predictors (e.g. HARP Ontario or CARS).

Patient selection - Selection of individual patients at risk of potentially preventable hospitalisations whose health outcomes could be modified with integrated care interventions based on additional screening for predictive factors not available electronically (e.g. cognitive, social) using a standardised screening tool (e.g. Western Victoria HARP).

Patient consent - Based on patient selection process a decision is made if patient risk level indicates potential benefit from Integrated Care interventions and if so Patient Consent is undertaken for intake and data sharing for the range of Integrated Care interventions including for example: care coordination, patient reported measures, and shared care.

Matching to integrated care interventions - Also as part of Patient Selection the patient is matched to appropriate Integrated Care interventions (as well as usual care referrals), e.g.
  - care navigation
  - care coordination
  - care management
  - health coaching
  - shared care planning and systematic assessments

Clinical information exchange enablers, including system interfaces, secure messages, clinical repositories and collaboration tools to facilitate exchange of patient clinical information between care providers (point to point, point to share).

Patient reported measures - Processes and tools to enable definition of patient outcomes and shared decision making as part of care planning.

Monitoring and evaluation - State-wide data collections, data warehouses and reporting that enables experiential learning for providers and evaluation of system performance.
FOR MORE INFORMATION:

COORDINARE – South Eastern NSW
Phone: 1300 069 002
Website: www.coordinare.org.au
Email: info@coordinare.org.au

Illawarra Shoalhaven Local Health District
Phone: (02) 4221 6899
Website: www.islhd.health.nsw.gov.au
Email: ISLHD-trim@health.nsw.gov.au