NNSW Integrated Care Program- Status Report June 2016

Items	Strategies	Outcomes to date
Integrated Care Governance Structure	• Establish governing structure to support integrated care initiatives • Partnership / stakeholders	- Steering Committee established - Implementation working group operational - Partnerships established
Integrated Care Program Management & Executive Sponsor	• Establish management support structure to progress integrated care initiatives • Strategic Planning	- Appointment of Integrated Care Program Manager - Executive Sponsorship established and maintained - Strategic Planning workshop held April 2016
Integrated Care Workshop Launch	• Conduct Workshop Launch with stakeholders in May 2015 • Ensure clinician and consumer involvement	- Workshop Launched in May 2015 - MOH, ACI and key partnership Executive in attendance - Clinician and consumer involvement at workshop
Engagement with clinicians and stakeholders	• Conduct Integrated Care Roadshows – presentation at key partnership governance and clinician lead councils/ meetings	- Roadshows conducted at Tweed /Richmond Networks - Presented at key Clinical Council, CEAG - GPs engaged through newsletters and face to face meetings

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E-Health solutions	• Explore e-health solutions	- E-health working collaboratively with Northern Integrated Care team
	• Admission / Discharge notifications	- Admission / Discharge notifications piloted
	• Shared Care Plan (Orion)	- Shared Care Plan (Orion) under development as proof of concept
	• Discharge Planning summaries	- Discharge Planning summaries created at site level
	• ACI PREMS and PROMs	- ACI PREMS and PROMs incorporated into Integrated care collaborative
Improved communication between GP, AMS and NNSWLHD clinicians	• Appoint a designed project officer to progress initiatives • Information Technology initiatives identified – admission and discharge notifications (ADT's). • Improved transfer of discharge summaries	- Project Officer appointed - Pilot of ADTs now flagging Integrated Care patients in the EMR system – 200 patients / GP ? o Tracking ADT process and addressing 'teething' issue as they arise. - This is a state-wide initiative and supported by E health. - Structure developed for reporting on Discharge summaries
Source a shared care planning tool.	• Explore suitable shared care planning options o Orion selected as the appropriate tool for a pilot to shared care planning. o Stakeholder engagement required for piloting of Orion Shared care planning o Need to engage with medical specialists and private providers	- Northern Integrated Care selected to pilot Orion Proof of Concept o EHealth funding imitative as a state –wide trial o Governance structure established o Gained stakeholder engagement – GP, LHD staff. o Appointing designated Project Officer

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	• Orion Pilot needs to resourced	○ MOH funding Orion Project Officer - Proof of concept planning commenced – rollout planned for September 2017 till September 2017.
Integrated Care Collaborative – A model of care	• Explored options to develop an integrated care-model of care • Concept of GP Integrated Care Collaborative endorsed by partnership executives • Improvement Foundation contracted to conduct GP Integrated Care Collaborative • Identify location to implement GP Integrated Care Collaborative.	- Integrated Care Collaborative commenced in October 2015 - Collaborative commenced at Tweed /Byron and Richmond Networks. - GP Practices engaged (16) - >98 LHD Clinicians participated - Collaborative Learning workshops held. (3 x 2) - ACI, MOH & Ehealth attended collaborative workshops - Evaluation data now being collated - Plan to implement collaborative in Clarence Valley in Feb 2017.
Evaluation	• Develop evaluation plan • Appoint agency to conduct evaluation • Strategies of engage and consult with clinicians and stakeholders developed	- Deloitte Access Economics appointed - Evaluation baseline collected - Tools utilized to consult with Clinicians / stakeholders; survey, face to face meeting, data analysis
Explore patient journeys as patients transition from acute to primary care	• Care Navigators appointed – TTH, LBH, Mental Health	- Patient journeys mapped - Service gaps and opportunities for improvement identified - Awareness of 'integration' - Mental Health Care Navigator contract extended in recognition of opportunities to improve service

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		integration between mental health and local GP practices

Community Nursing Review	• Establish steering Committee
	  ○ Engage Consultant
	  ○ Consult with clinicians
		- Community Nursing Review completed
		- Developing implementation plan

Review of Chronic Disease Management Program (CDMP)	• Establish Steering Committee
	  ○ Establish TOR
	  ○ Consult with clinicians
		- Chronic Disease Management (CDM) Program Review completed
		- Implementation plan developed
		- CDM staff work practices redesigned to support service integration with primary care

Review of Chronic Care Aboriginal People (CCAP)	• Establish Steering Committee
	  ○ Establish TOR
	  ○ Appoint consultant
	  ○ Consult with clinicians and partner organisations
		- Chronic Care Aboriginal People (CCAP) redesign commenced
		- Consultant appointed
		- Consultation with local Elders and Aboriginal communities

Joint NSW Ambulance and NNSWLHD initiatives to	• Explore opportunities to implement Paramedic Connect at Urbenville MPS ○ Option to utilise skill set of NSW Ambulance in the Tweed area	- Planning commenced for the implementation of Paramedic Connect at Urbenville MPS
Comply with MOH governance reporting requirements	• Development Logics and Roadmaps in consultation with partners ○ Structure developed to meet reporting	- Logics and Roadmaps reports completed. - Budget reports and acquittals meet MOH time lines

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	requirements for MOH ○ Budget reporting processes in place	- Initiatives involves working in partnership with local stakeholders
Exploring Integrated Care opportunities in aged care	• ACI funded 2 additional local integrated care initiatives in Tweed & Grafton. $200k each ○ Local initiatives focused on aged care ○ Initiatives involves working in partnership with local stakeholder	- ACI funded specific initiatives. ($200k) - Local Governance and support structured established - Project Officer appointed - Stakeholders engaged - ACI providing clinical advice and upskilling of Project Officer
Support structure for chronic care patients	• Identify service gaps in relation to providing chronic care support to patients • Identify workforce skill set and capacity • Allocated resources to support chronic care patients in GP Practices • Ensure culture of patient centre care.	- New chronic Care Registered Nurse posts identified for Tweed, Richmond & Clarence - Recruitment commenced for Chronic Care Nurses - Post to work across acute & community health and support GP Practices - Culture of patient centre care central to new post work flow / practices
Monitoring Framework governance structure	• Develop Integrated Care Monitoring Framework • Framework reflects ability to utilise existing NNSW & GP data bases • Consultation process underway • Establish regular reporting time frame	- Integrated Care Monitoring Framework completed and consultation underway
Workforce capacity to reflect philosophy of integrated care	• NNSWLHD Workforce redesign initiatives required ○ Identified key services area for redesign: community nursing, HITH, Chronic Disease Management and Aboriginal Chronic	- NNSWLHD Workforce redesign initiatives commenced

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	Disease Service. ○ Identify knowledge and skills gaps in partnership agencies • Develop education and training programs to address skills gap	- Joint training needs identified between AMs, GP Practices and NNSWLHD clinicians ○ Patient Self-Managed care – Health Coaching ○ Joint training to be conducted between June and November 2016
Further Integrated Care Opportunities	• Explore options to embed integration across the LHD Health Service Networks • Identify clinical areas that would benefit from improve integration with stakeholders and local GP's. • Service redesign needs to reflect culture of patient centre care	- ACI funding two initiatives ○ Preparedness for Surgery at Tweed / Byron and End of Life Care at Richmond ○ KPI attached to $200k funding