



Health  
Illawarra Shoalhaven  
Local Health District

# Illawarra Shoalhaven Integrated Care Strategy

2018-2020



Revised July 2018

This document has been developed collaboratively and jointly authored by:

Primary Health Network for South Eastern NSW (COORDINARE) and Illawarra Shoalhaven Local Health District (ISLHD)



COORDINARE is the Primary Health Network for South Eastern NSW, which includes the Illawarra Shoalhaven region. It is a not-for-profit public company, limited by guarantee, which was formed in 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.

The organisation has three members: University of Wollongong, Peoplecare and IRT, and is led by a skills-based Board which sets the strategic direction, oversees the implementation of strategic objectives and remains accountable for the organisation's performance.

COORDINARE's two GP-led Clinical Councils and Community Advisory Committee advise the Board, ensuring there is community, consumer and clinical input and influence in the planning, prioritisation and evaluation of our strategy and performance.

COORDINARE's governance structure embeds strong links between the Board, its Councils and Committee, enabling these to have a high degree of influence on the Board.



**Health**  
Illawarra Shoalhaven  
Local Health District

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.

Our 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 with an annual budget of more than \$770 million.

# 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 costs'<sup>1</sup>.

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.



<sup>1</sup> 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 patients 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, reflecting a range of more complex health and socioeconomic determinants.

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 self-harm.





Key health indicators include:

- 64% of people are classified as overweight or obese
- 23% of people have high cholesterol
- 32% of people have high blood pressure
- 11.8% of people have diabetes or high blood glucose levels
- 12.6% of people are current smokers
- by 2031 the population is expected to grow to 456,790 people

Over a quarter of the adult population of the Illawarra Shoalhaven suffer from multiple chronic conditions with people being more likely to have multiple chronic conditions as they age. With the fastest growing age brackets being those between 65 to 84, and 85 and over, in the Illawarra Shoalhaven, a significantly high growth is expected in the number of people suffering from co-morbidities. This 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<sup>2</sup> 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.

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:

- focussing 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.



<sup>2</sup> [NSW Integrated Care Strategy](#)

# 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.

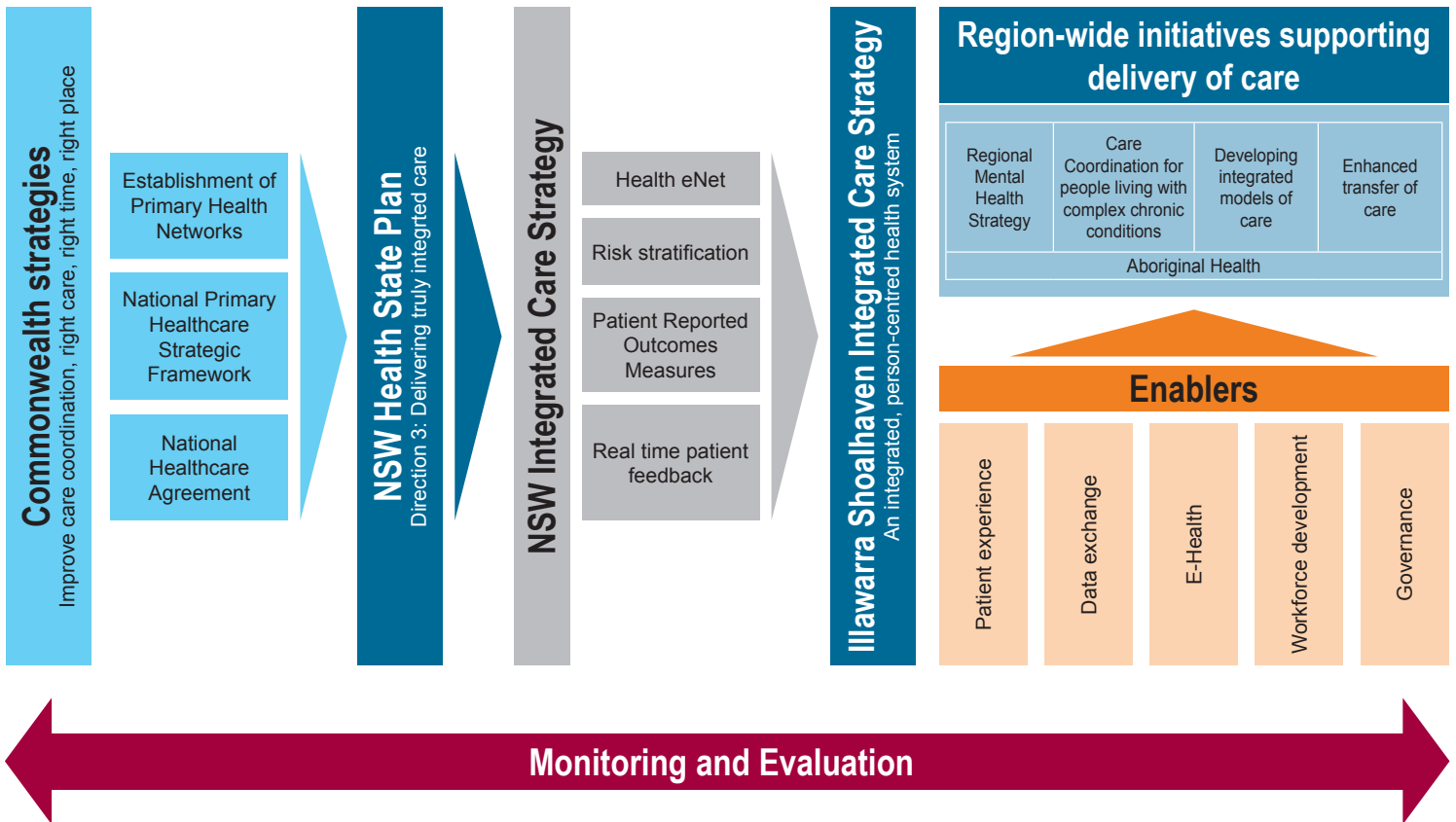
Both organisations share common elements in their vision to work towards improving the health of the community. However, the key to this strategy is identifying the focus points and priorities that will provide the impetus to achieving transformational change across the region.

<b>Shared vision</b>	
An integrated, person-centred health system	
<b>ISLHD</b>	<b>COORDINARE</b>
Excellent services, quality partnerships, healthy communities	A coordinated regional health system which provided exceptional care, promotes healthy choices and supports resilient communities
<b>Shared purpose</b>	
Person-centred care, coordination across the health system, equitable access, and safe & high quality health care	
<b>ISLHD</b>	<b>COORDINARE</b>
<ul style="list-style-type: none"> <li>• Excellence in models of care, health programs and health services</li> <li>• An engaged and high performing workforce for the future</li> <li>• Innovation, agility and learning for continuous improvement</li> <li>• Efficient, effective, sustainable financial operations</li> </ul>	Supporting primary care in our region to be: <ul style="list-style-type: none"> <li>• comprehensive</li> <li>• person-centred</li> <li>• population oriented</li> <li>• coordinated across all parts of the health system</li> <li>• accessible</li> <li>• safe and high quality</li> </ul>

# 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





## Region wide priority initiatives

With a focus on delivering integrated care and on ensuring sustainable gains across the whole region, the following projects and improvement initiatives have been identified as priorities. Each initiative has specific goals addressing agreed areas of concern. More importantly all initiatives centre on the needs of patients, their families and carers, as their main objective.

The five key priority areas are:

1. implementation of Regional Mental Health Strategy and Suicide Prevention Plan
2. care coordination for people with chronic and complex health conditions
3. developing integrated models of care
4. enhanced transfer of care
5. improved Aboriginal Health

### Regional Mental Health and Suicide Prevention Plan

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 10.6 suicide deaths per 100,000 people in 2007 to 11.7 deaths per 100,000 people in 2016. Within the Illawarra Shoalhaven, hospitalisation rates for intentional self-harm are higher than the NSW state average, and in 2016, 1,045 people presented to ISLHD Emergency Departments with self-harm or risk of suicide.

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' is the first lead joint initiative in Mental Health. The Illawarra Shoalhaven was chosen in 2017 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 has been 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 other key action will be the implementation of the Joint Regional Mental Health and Suicide Prevention Plan that is informed by and builds on the success of the respective ISLHD, Southern NSW LHD and COORDINARE plans.

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.

## Care coordination for people living with chronic and complex health conditions

The NSW Integrated Care Strategy is one of three strategic directions identified in the NSW State Health Plan: Towards 2021. To support this strategy, ISLHD and COORDINARE are collaborating to deliver a patient centred model of care that facilitates patient activation and self-management, in partnership with GPs, to promote the development of patient centred medical homes and enhance care integration across the health continuum. ISLHD and COORDINARE will partner to deliver the “Connecting Care in the Community” service to June 2020.

Originally, the program focussed on five chronic diseases namely Cardiac Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Hypertension and Diabetes. However, the program has continued to evolve and has now been extended to include people experiencing a wider range of longer term health conditions and complex health needs. The program’s key objectives remain unchanged and focus on the provision of care coordination, care navigation and health coaching to people with ongoing health issues in close partnership with General Practice.

The identification of patients into the program will be informed by risk stratification tools in both ISLHD and General Practice. There will also be a greater focus on quantitative and qualitative measures to identify the effectiveness of the program on elements such as:

- Quality of life
- Patient activation and self-management
- Provider activation and confidence
- Impact on health service utilisation

It is anticipated that the partnership approach between ISLHD and COORDINARE to deliver the Connecting Care in the Community Service will enable an accelerated implementation of the program objectives and result in greater diffusion of the benefits of care coordination to people with chronic and complex health needs.

ISLHD and COORDINARE have tested the concept of co-commissioning through the tender process to secure a new provider to deliver the Connecting Care service post June 2018. ISLHD and COORDINARE are committed to ensuring the process of entering into a joint tender is comprehensively documented in order to assist other LHDs and PHNs into the future.

## Developing integrated models of care

Community demand for improved access to affordable health care across the region is strong. COORDINARE and ISLHD are committed to developing integrated service delivery models that share care across the health system, with priority given to end of life care, mental health services and care of older people.

### End of Life Care

COORDINARE and ISLHD invested significant resources in identifying ways of improving the way palliative and end of life care is being delivered locally. The case for change is strong, it aligns well with Commonwealth and State direction and is well supported by regional data.

Consultation with General Practitioners (GPs) and other stakeholders for HealthPathways identified concerns in the way services work together in the provision of palliative care, including:

- increasing pressure on resources and workload for specialist care teams
- difficulties in providing viable and sustainable palliative care within a general practice
- lack of capacity and resources required for GPs to be able to effectively handle this type of care, which includes the provision of appropriate MBS items
- need for continued palliative care education and active involvement in palliative care for GPs
- access to support services (including after hours care)
- clear and documented referral processes and communication channels between GPs, specialists and patients, and their families and carers.

Initial achievements made as a direct result of this consultation include:

- stronger working relationships with both LHDs and Palliative Care Specialist Services and a commitment to work in partnership
- palliative care pathways developed, documented and implemented as part of the HealthPathways program
- GP education at a cluster level
- tailored online education modules for GPs and other health professionals

An integrated palliative and end of life care model has been developed. This model of care aims to build on the strengths of care delivery in the region through outlining best practice care and services as a patient experiences their palliative and end of life care. It provides key principles, clarity on the way palliative and end of life care is delivered in the Illawarra Shoalhaven NSW, and defines care arrangements for three levels of patient complexity at different stages of care. The focus now is on implementing this model of care across the region.

## Mental Health

A key theme in all consultations undertaken by the Local Health District and COORDINARE in relation to mental health has been concern about the fragmentation of service delivery in the area. Services and workforce are under pressure, limited communication between services, poorly defined transition arrangements and sometimes patchy local service availability all contribute to a system which is very hard for consumers and service providers to navigate. It can also seriously compromise outcomes for consumers.

Possibly the most concerning problem in this respect is that consumers report that service arrangements and communication protocols are not routinely in place in all parts of the region to ensure that consumers experience a smooth transition to care in the community through primary or specialist community mental health care upon discharge from hospital or inpatient care. This increases chances of readmission, and raises risk of suicide.

It is the care of people with severe mental illness where both primary care and specialist services must play an important and complementary role to meet both physical and mental health needs. Consultations with consumers have indicated people want to be connected early in their treatment to the service that best meets their particular needs and not be sent from place to place until this happens. They expect their GPs to be supported by and in touch with specialist services at times their needs elevate. They expect step down services after acute episodes to be supported by clear communication. They want their service providers to know about other non-health services which might meet their needs. Finally they want their mental health to be treated like physical health – with a focus on providing support before health deteriorates and a crisis occurs.

## Care of older people

A current example of integrated care that will be expanded across the area is the '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.

There is also growing momentum to improve the quality of care frail older people receive across the system. We know that frail patients are vulnerable to sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication. This can cause them to remain in acute settings for longer. However, evidence tells us that by keeping our most vulnerable patients in hospital longer than clinically necessary, we are unintentionally causing them harm.

The literature states that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs in people over 80 years of age! Of course this impacts their reconditioning, which is a disastrous outcome for our older patients. We also know that if an older person with complex co-morbidities is admitted to hospital, on average, they potentially have around 1000 days of life remaining and almost half of people aged 85 will die within a year of hospital admission.

Locally, over 75 year olds make up 9% of the Illawarra Shoalhaven population, but this age group accounts for 16% of ED presentations, 60% of falls and 43% of medication issues.

Taking all of this into account, reconsidering how the health system treats our frail and elderly patients is crucial, the Fit for Frailty Project is a priority initiative for the region.

Additionally, resources allocated to the CHRISP (Centre for Health Research Illawarra Shoalhaven) 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 across the region. This will assist to generate agreed strategies and evaluation measures.

## Enhanced transfer of care

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.

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

- HealthPathways
- Secure messaging
- My Health Record (opt out implementation 2018)
- 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. To this end a number of General Practice Liaison Officers will be employed to facilitate more of this communication at both a strategic and operational level across both organisations and with general practices. 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.

## 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. The Aboriginal Health Partnership Agreement 2017 – 2020 with ISLHD, COORDINARE, the University of Wollongong and the Aboriginal Community Controlled Health Organisations (ACCHO) will help drive the direction of the work to be implemented. The focus of this work will be on improving the transfer of care processes for Aboriginal people and developing culturally appropriate health literacy initiatives that contribute to improved care coordination for Aboriginal people living with chronic and complex conditions, mental health and drug and alcohol and maternity care.



## 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

Both organisations have patient experience and consumer participation in care as a key priority in their strategies. Both agree this work needs to be embedded in clinical practice. Additionally the Australian Council on Healthcare Standards (ACHS) Standard two: Partnering with Consumers is now a core requirement of accreditation of health services.

There is agreement that in all integrated projects where we work together patient experience will be measured with an appropriate tool.

### E-health

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

HealthPathways Illawarra Shoalhaven continues to be a key component of the strategy to enhance the integration of care across the health continuum in the Illawarra Shoalhaven region. The web based platform has been widely accepted by GPs and ISLHD clinicians and is the key source point for current local medical management of a wide range of conditions. The program has made significant progress and has highlighted opportunities to exploit future prospects for service integration.

Significant gains have been made in a 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. Work has commenced to extend the use of secure messaging across the region for a larger number of specialities. 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:

- E-Meds – allowing for electronic pharmaceutical orders and improving the quality of medication lists for discharge summaries and medicines reconciliation
- Shared care tool/s

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 strategy to increase utilisation of My Health Record with the introduction of an 'opt out' system in 2018 is creating more opportunities for shared records to be utilised, particularly in General Practice, Emergency Departments, Pharmacy 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

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

The focus will be on utilising the data capability of CHRISP to highlight focus areas for Integrated Care Delivery enhancements.

### Workforce development

Effective change management and workforce development is required to support changes to care delivery models. ISLHD and COORDINARE must be engaged at the clinical level to support substantive cultural change and workforce development 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.

## Shared governance

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

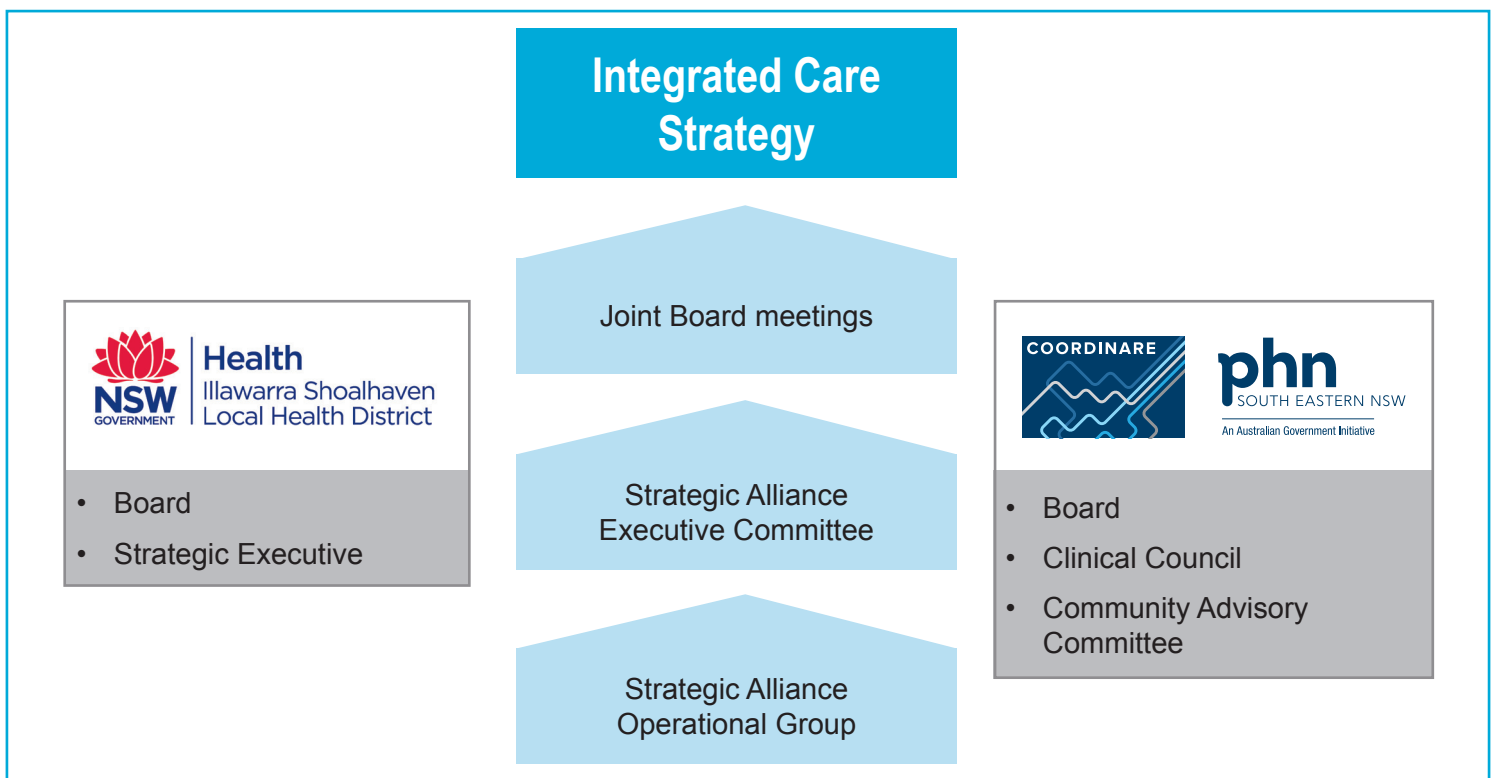
The right planning and governance mechanisms will also contribute to ensuring that new service development, such as the commissioning work of COORDINARE, is appropriately targeted and designed to meet local needs. Increasingly, work in this area will provide opportunities to drive integration by incentivising 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.

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 the governance structure is as follows. The governance structure allows for reporting to be escalated through the strategic alliance, as well as maintaining consistency with each organisation's reporting lines.



The Board members of each organisation will meet annually to confirm the continuation of the relationship, confirm the strategy and key priority areas and receive reports on progress to meeting the agreed objectives.

The Strategic Alliance meets every second month, and is the overarching committee responsible for decision making, strategic direction and leadership. The group consists 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 is responsible for progressing, monitoring outcomes and advising on all aspects of the strategy, and consists of representatives from the Strategic Alliance as well as relevant clinical and operational staff from the respective organisations.

The Strategic Alliance Operations Group reports to the Executive Committee and meets monthly to ensure the implementation of the plan. The group consists of the following members:

- COORDINARE Executive Team
- ISLHD Executive Director Integrated Care Mental Health Planning Information and Performance, Director Ambulatory and Primary Health Care and Stream Leader Integrated Chronic Disease Management.

## Evaluation

Each of the initiatives / programs developed in response to the strategy will develop evaluation process based on the desired outcomes of the initiative or programs of work. Some will be detailed and mapped over many years for example the work of the Suicide Prevention Collaborative. Others will be less complex and may not necessarily require formative evaluation. In addition to consideration of measuring the effectiveness of each initiative it will also be important to evaluate the partnership and its effectiveness overall.

In 2017 the MOH commissioned a formative evaluation of the Integrated Care Strategy. That evaluation used a maturity model developed to provide a consistent analytic model to map projects and models across five criteria; program and service innovation, patient-centred care and empowerment, digital health and analytics, models of care and partnerships. The model has been designed to provide ongoing assessment and measurement.

It is proposed that each year the partnership undertake an assessment of the total program of works using this model and also, where applicable, apply the model to individual programs.

The maturity model assesses projects across five domains of integrated care:

1. program and service innovation
2. patient centred care and empowerment
3. digital health and analytics
4. models of care
5. partnerships

Projects are evaluated according to which stage of maturity they fall under across each of the five dimensions. A copy of the framework is available in the Appendix.

# Analytical framework - maturity model

## Integrated care maturity model

	Stage	Program and Service Innovation	Patient centred Care and Empowerment	Digital Health and Analytics	Models of Care	Partnerships
HIGH	6	<ul style="list-style-type: none"> <li>Innovation achieves sustained outcomes at a population health level</li> </ul>	<ul style="list-style-type: none"> <li>Patient / Carer needs frequently monitored and reflected in service delivery and policy-making</li> </ul>	<ul style="list-style-type: none"> <li>Local Health needs can be easily identified through predictive data analytics</li> <li>Analysis can be used to target cohorts and develop systematic population level approaches to risk identification</li> </ul>	<ul style="list-style-type: none"> <li>Model of care sits along side / is integrated with service models that operationalise service delivery and incorporate financial and / or non financial elements</li> </ul>	<ul style="list-style-type: none"> <li>Whole of system integration (health, social services, education)</li> <li>Cross sector co-commissioning</li> </ul>
	5	<ul style="list-style-type: none"> <li>Innovation is effectively scaled or transferred to another location or cohort</li> </ul>	<ul style="list-style-type: none"> <li>Patient / Carer actively self-manage care</li> </ul>	<ul style="list-style-type: none"> <li>Solutions are scaled or transferred to other cohorts</li> <li>Information sharing occurs across the system for all cohorts</li> </ul>	<ul style="list-style-type: none"> <li>Primary and community care is used as a hub. Patients are provided with connected and coordinated care with provision of patient assessments and regular reviews</li> </ul>	<ul style="list-style-type: none"> <li>Vision / strategy embedded in policies across care levels</li> <li>Co-commissioning within health sector</li> </ul>
	4	<ul style="list-style-type: none"> <li>Innovation is financially sustainable</li> <li>Evidence that the innovation can make a difference at a population health level</li> </ul>	<ul style="list-style-type: none"> <li>Clinician practices patient centred care evidenced by e.g.                             <ul style="list-style-type: none"> <li>Genuine partnerships with the patient, family and other care providers</li> <li>Uses whole-patient information</li> <li>Using PRMs and PROMs</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>System wide information sharing enablers in place including                             <ul style="list-style-type: none"> <li>Unique patient identifier</li> <li>Integration of systems</li> <li>Shared care platform</li> <li>Confidentiality and security policies</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Patients and clinician adopting model of care evidence by                             <ul style="list-style-type: none"> <li>Appropriate and timely access to specialised care</li> <li>Shared / joint care planning and management with the patient / carer</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Visible stakeholder engagement and support including executive, partners, clinicians and other staff across care levels</li> <li>Active efforts to achieve integrated care across care levels</li> </ul>
	3	<ul style="list-style-type: none"> <li>Sufficient evidence that the innovation is making a difference to the health or service outcomes</li> <li>Feedback loop in place for the ongoing quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>Patient / Carer empowerment to engage, question and discuss through                             <ul style="list-style-type: none"> <li>Pro-active engagement and support in care planning</li> <li>Increased health literacy</li> <li>Increased access to information</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Patient information                             <ul style="list-style-type: none"> <li>Is available to clinicians across care settings</li> <li>Is monitored and analysed</li> </ul> </li> <li>Insights used to develop new approaches to risk identification and interventions</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of a system of standardised assessments, regular patient reviews, uploading of relevant clinical metrics</li> </ul>	<ul style="list-style-type: none"> <li>Wider consultation of vision and strategy between care levels (e.g. primary and secondary)</li> </ul>
	2	<ul style="list-style-type: none"> <li>Innovation project structures and processes active</li> <li>Monitoring, evaluation and reporting undertaken to demonstrate that innovation can make a difference to the health or service outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of interventions and on going processes and systems to embed patient centred care approach and build patient / carer access to information, health literacy and capacity to self manage</li> </ul>	<ul style="list-style-type: none"> <li>A pilot / local solution for targeted cohort is developed to share information</li> <li>Patient data for targeted cohort is prepared for sharing through the solution</li> </ul>	<ul style="list-style-type: none"> <li>Patients identified, contacted, enrolled and connected to care plan custodian</li> </ul>	<ul style="list-style-type: none"> <li>Vision and strategy shared and discussed with key stakeholders within the same level of care (e.g. primary)</li> <li>Enlisted stakeholder support within the same level of care</li> </ul>
	1	<ul style="list-style-type: none"> <li>Innovation project plan developed and structures and policies in place</li> <li>Innovation project plan is practical, feasible and acceptable</li> <li>Project manager and team appointed</li> </ul>	<ul style="list-style-type: none"> <li>Identification of gaps and barriers to patient centred care and patient self-management</li> <li>Identification of gaps and barriers in clinician confidence and skills to engage patients</li> <li>Defined interventions to address gaps and barriers</li> </ul>	<ul style="list-style-type: none"> <li>Patients are identified / risk stratified</li> <li>An electronic trackable cohort list is established</li> </ul>	<ul style="list-style-type: none"> <li>Identification of a model that sits across the continuum of care</li> <li>Establishment of roles focused on patient centred care</li> <li>Capacity / capability building</li> <li>Stakeholder / partner consultation and buy in</li> </ul>	<ul style="list-style-type: none"> <li>A compelling and clear shared vision / strategy created</li> <li>Change Management Plan developed</li> </ul>
	0	<ul style="list-style-type: none"> <li>Innovation idea generated</li> <li>Application submitted</li> <li>Funding received for implementation</li> </ul>	<ul style="list-style-type: none"> <li>Limited patient centred approach to care</li> <li>Low level of patient empowerment including health literacy and capacity to self manage</li> </ul>	<ul style="list-style-type: none"> <li>Limited to no information sharing</li> <li>Isolated and multiple medical record systems</li> <li>Limited capacity to perform analytics as data is not holistic</li> </ul>	<ul style="list-style-type: none"> <li>Low levels of care coordination and integration across service providers</li> </ul>	<ul style="list-style-type: none"> <li>Low levels of acknowledgment for the need of integrated care</li> <li>Limited understanding of the meaning of integrated care</li> <li>Siloed care efforts and patient / carer as the integrator</li> </ul>
LOW						

© 2017 Deloitte Touche Tohmatsu. All rights reserved





**Health**  
Illawarra Shoalhaven  
Local Health District

**FOR MORE INFORMATION:**

**COORDINARE – South Eastern NSW**

Phone: 1300 069 002

Website: [www.coordinare.org.au](http://www.coordinare.org.au)

Email: [info@coordinare.org.au](mailto:info@coordinare.org.au)

**Illawarra Shoalhaven Local Health District**

Phone: (02) 4221 6899

Website: [www.islhd.health.nsw.gov.au](http://www.islhd.health.nsw.gov.au)

Email: [ISLHD-trim@health.nsw.gov.au](mailto:ISLHD-trim@health.nsw.gov.au)