ACI NSW Agency for Clinical Innovation

BUILDING PARTNERSHIPS
A framework for integrating care for older people with complex health needs.

Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs

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Aged and Community Services (NSW & ACT)

NSW Ambulance

Association of Relatives And Friends of the Mentally Ill

Clinical Excellence Commission

Carers NSW and the individual carers who donated their time

Central Coast LHD

Central Coast NSW ML

Council on the Ageing NSW and the individual consumers who donated their time

Eastern Sydney ML

Far West LHD

Far West ML

General Practice NSW

Hunter ML

Hunter New England LHD

Illawarra Shoalhaven LHD

Illawarra Shoalhaven ML

Inner West Sydney ML

Mid North Coast LHD

Murrumbidgee LHD

Murrumbidgee ML

NSW Ministry of Health Aboriginal Health Strategic Leadership Group

NSW Ministry of Health, Aged Care Unit

NSW Ministry of Health, Older People's Mental Health Policy Unit

Nepean Blue Mountains LHD

Nepean Blue Mountains ML

New England ML

North Coast ML

Northern Sydney ML

Northern Sydney LHD

Northern NSW LHD

South Eastern Sydney LHD

South Eastern Sydney ML

South Western Sydney LHD

South Western Sydney ML

Southern NSW LHD

Southern NSW ML

Sydney LHD

Sydney North Shore and Beaches ML

Western NSW LHD

Western NSW ML

Western Sydney LHD

Western Sydney ML

Foreword

People in New South Wales (NSW) are living longer and enjoying active and rewarding lives as valued members of our community. In 2010, there were 1.02 million people 65 years of age and over living in NSW. This is expected to double by 2050. However, for a growing number of older people, this will include living with complex health needs such as dementia and other chronic diseases. This will impact how we plan and design services to meet the needs of our local communities. Effective solutions will require the combined efforts of older people, their carers and families, and all those involved in delivering services for older people, to meet the challenges of a rapidly changing environment.

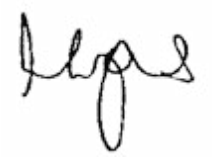
The ACI is the lead agency in NSW for promoting innovation, engaging clinicians and designing and implementing new models of care. The ACI builds models of care based on the needs of patients and which are underpinned by extensive research conducted in collaboration with leading researchers, universities and research institutions. In 2013, the ACI commenced work on *Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs* in response to the NSW Ageing Strategy.

This Framework aims to support local health districts and local partnerships of agencies to redesign and implement improved models of care for older people. This Framework introduces the vision for this work and the guiding principles underpinning the work to improve care for older people in NSW. The focus of this Framework is to support local decision making and community partnerships with older people, their carers and families, NSW Health services, Medicare Locals (or Primary Health Networks), General Practitioners, community and residential aged care service providers. The ACI is pleased to have the following peak groups endorse the principles of the *Building Partnerships Framework*: the Aged and Community Services NSW and ACT and General Practice NSW.

The Framework acknowledges that the My Aged Care and future health reforms will affect how services deliver care. However, the Framework principles are universal and should be applied regardless of future policy and funding environments.

This is a complex and constantly changing area with many barriers to creating integrated care. Local decision making and community partnerships will require boldness in working together towards a shared vision with multi-sector governance and leadership and involving older people, their carers and families, in every step of their journey.

On behalf of the ACI, I would like to thank Dr Terry Finnegan, Ms Viki Brummell (co-chairs of the Aged Health Network), Associate Professor Jacqui Close (former co-chair of the Aged Health Network) and the members of the Aged Health Executive for their dedication and expertise as the Steering Committee. Also, I thank the consumers, carers, managers and health professionals from across NSW who contributed their experiences and knowledge to the development of the Framework.



Dr Nigel Lyons
Chief Executive, Agency for Clinical Innovation

About the ACI

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- *Service redesign and evaluation* – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services.
- *Specialist advice on healthcare innovation* – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment.
- *Initiatives including Guidelines and Models of Care* – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system.
- *Implementation support* – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW.
- *Knowledge sharing* – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement.
- *Continuous capability building* – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

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Executive summary

Older people in NSW, and their carers and families, as partners in their care, have access to appropriate, high quality, evidence-based healthcare that is provided in a timely, equitable and coordinated manner and delivered safely as close to home as is possible.

Context and purpose of the Framework

The Agency for Clinical Innovation (ACI) under the auspices of the NSW Ministry of Health (MoH), has led the development of a framework for older people with complex health needs, their carers and families, to receive proactive, person-centred and evidence-based care, regardless of how or where they access it. An older person with complex health needs is defined as one whose underlying comorbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis. Although not age dependent, this definition mostly pertains to those over 75 years of age.

The Framework should be read in conjunction with the MoH Integrated Care Strategy. The Strategy seeks 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.

The Framework is designed to be flexible to respond to changes to the national aged care system under the Australian Government's 10-year *Living Longer Living Better* national aged care reform agenda and implementation of the My Aged Care Gateway, which encompasses a national intake, referral and assessment system governing access to all Commonwealth-subsidised aged care services.

The purpose of the Framework is to:

- Provide a comprehensive overview of key components, principles and next steps, as services look to integrate care for older people with complex needs, their carers and families through collaborative service design and delivery across sectors.
- Provide the platform to stimulate discussion at a regional level and promote collaboration among those involved in improving health outcomes for older people with complex needs, their carers and families.
- Provide consistency of practice across NSW that allows operational flexibility for innovation in local service work practices.

Target audience

The Framework is intended for executives and decision makers at the regional level and also those who provide services to the older person with complex health needs, their carer and family.

The Framework

The Framework provides a conceptual model to align behaviours and understanding of service providers. Elements of the Framework are interrelated and comprise key components, system design principles and next steps for Local Health Districts (LHDs) and additional stakeholders – Medicare Locals (MLs) (or Primary Health Networks [PHNs]), NSW Ambulance (Ambulance), Aboriginal health services, and residential and community aged care services – in integrating care for older people with complex needs, their carers and families. The Framework presents the following core components that together aim to strengthen existing services and relationships and address the systemic causes of current fragmentation of services.

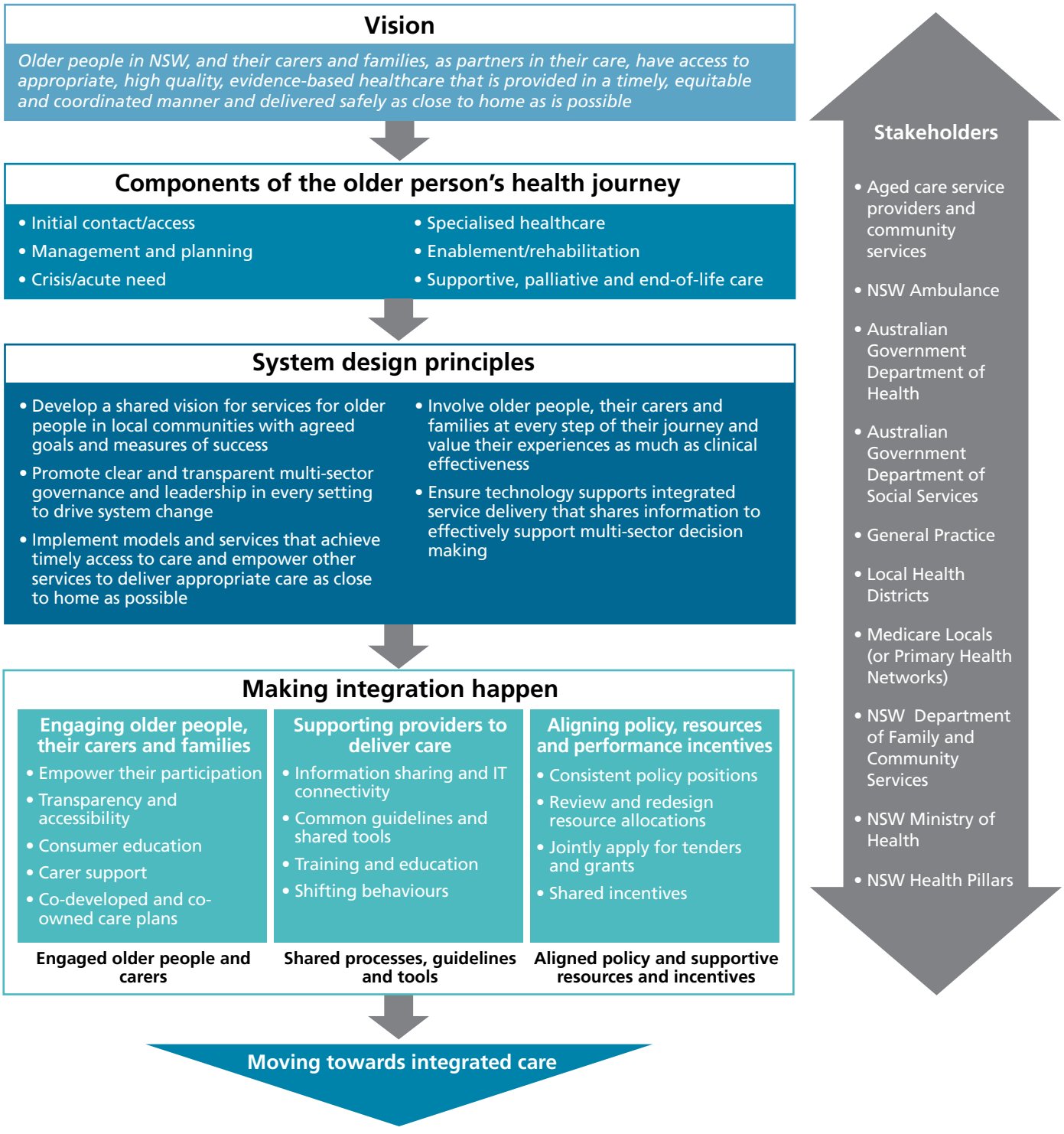
Components of the older person's health journey describes the alignment of stakeholders around consistent care components and considerations for person-centred care delivery in any setting, to address specific care needs of the older person with complex health needs.

System design principles describes the whole-of-system view to deliver integrated healthcare for older people with complex health needs, the overall system context and the system design principles on which the Framework is based. Core to these are a focus on shared governance, partnerships and relationships at the local level.

Making integration happen describes key enablers and actions to realise a system-wide vision of integrated healthcare for older people with complex health needs. It includes enablers such as: engaging older people, their carers and families; supporting health service providers to deliver care; and aligning policy, resources and performance incentives.

Moving towards integrated care describes the types of implementation-oriented activities that should be put in place at both the State and regional levels.

Figure 1. The Framework for Integrating Care for Older People with Complex Health Needs



Adapted from MacColl Institute for Healthcare Innovation 2012[1]

Section 1. Introduction

Life expectancy and the proportion of people living longer in NSW are increasing. A growing and significant amount of older people are living with complex health needs, such as dementia, which is expected to affect 1 in 10 Australians aged 75 years and over.

Older people, their carers and families, have multiple, disconnected and often duplicative interactions with the health system and longer lengths of stay in hospitals. The demand for home care and community support services outweighs supply, often resulting in unnecessary hospital admissions and excessive stress on carers. As the appropriate provision of services for this population cannot be met by one provider or sector, services must be coordinated through a shared plan with joint accountability.

Vision

Older people in NSW, and their carers and families, as partners in their care, have access to appropriate, high quality, evidence-based healthcare that is provided in a timely, equitable and coordinated manner and delivered safely as close to home as is possible.

Purpose

The purpose of the Framework is to:

- Provide a comprehensive overview of key components, principles and next steps, as services look to integrate care for older people with complex needs, their carers and families through collaborative service design and delivery across sectors.
- Provide the platform to stimulate discussion at a regional level and promote collaboration among those involved in improving health outcomes for older people with complex needs, their carers and families.
- Provide consistency of practice across NSW that allows operational flexibility for innovation in local service work practices.

For the purposes of this Framework, an older person with complex health needs is defined as one whose underlying comorbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis. Although not age dependent, this definition mostly pertains to those over 75 years of age.

The Framework acknowledges the diversity of older people in NSW. Similarly, the Framework supports the Carers (Recognition) Act 2010[i], which recognises carers of older people with complex health needs as partners in care, and considers their health and wellbeing. Providers must also consider the needs of older Aboriginal and Torres Strait Islander people, lesbian, gay, bisexual, transgender and intersex individuals and those from culturally and linguistically diverse backgrounds.

Older Aboriginal People

Aboriginal people are the first peoples of Australia, and have strong cultures and communities. More Aboriginal people live in NSW than in any other Australian State or Territory and improving Aboriginal health is a key focus for the NSW health system. Aboriginal people are an important group to consider in the Framework as the difference in life expectancy between Aboriginal people in NSW and the general population is estimated to be approximately seven to nine years. The greatest contributors to the higher mortality rates experienced by Aboriginal people are chronic disease, in particular cardiovascular disease, mental health, diabetes, cancers and injury.

The Framework complements the NSW Aboriginal Health Plan 2013–2023. The Plan recognises the importance of the NSW Aboriginal Health Partnership between the NSW Government and the Aboriginal Health and Medical Research Council (AH&MRC) at the State level, and the continued need for strong partnerships between NSW Local Health Districts (LHDs), Aboriginal Community Controlled Health Services (ACCHS) and other key stakeholders at the local level.[2]

Target audience

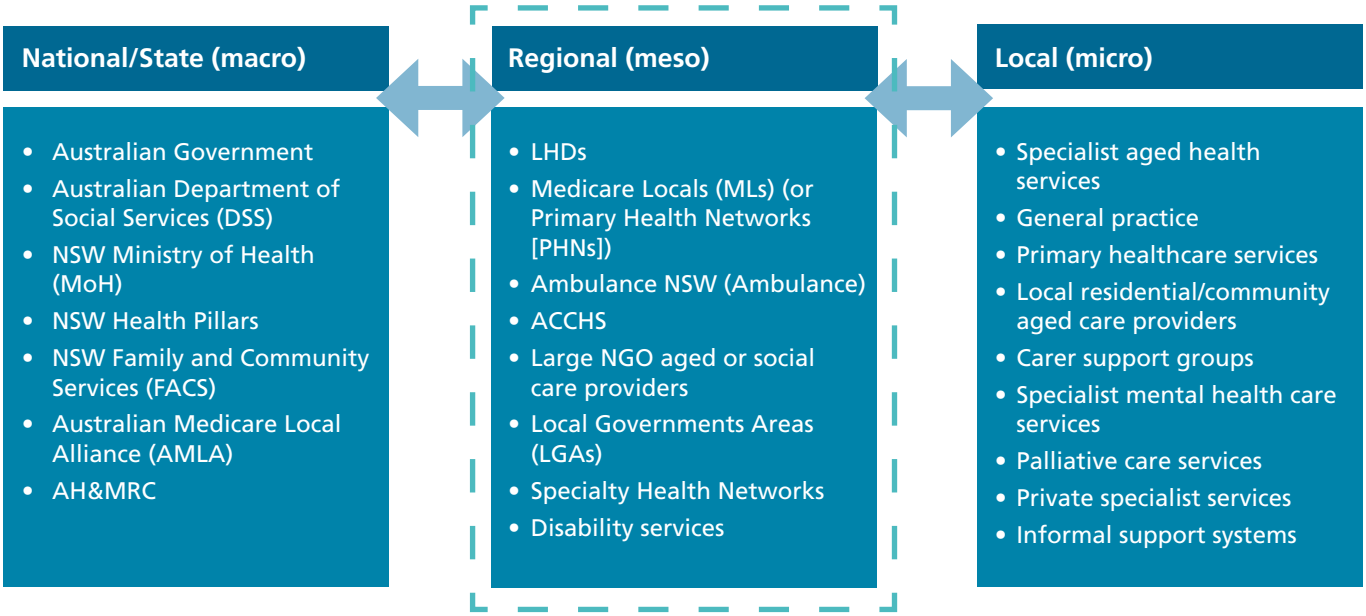
The focus of the Framework is to strengthen the regional (meso) level of the NSW aged healthcare system, to influence strategic level change at the National/State (macro) and local (micro) levels (Figure 2). The Framework is intended for executives and decision makers at the regional level and also those who provide services to older people with complex needs, their carers and families.

The Framework provides overarching principles to guide regional and local service planning and impetus for local decisions to be made.

It should be noted that not all stakeholders in the journey of the older person with complex health needs have been identified in this document. Each audience should consider all stakeholders relevant to their situation.

[i] *Carers Recognition Act 2010*

Figure 2. Health system levels



Context

The ACI under the auspices of the NSW Ministry of Health (MoH), has led the development of a framework for older people with complex health needs, their carers and families, to receive proactive, person-centred and evidence-based care, regardless of how or where they access it. The Framework aligns with the MoH Integrated Care Strategy to implement innovative, locally-led models of integrated care across the State.

The Framework forms part of the response to the NSW Government Ageing Strategy to develop integrated health service models that support older people with complex health needs.[3] This whole-of-government strategy identifies factors that influence an older person's health, including bio-psychosocial, housing, support services and transportation.

The Commonwealth, State and Territory Governments have agreed to a national reform of the health and aged care systems. The Australian Government's 10-year *Living Longer Living Better* national aged care reform aims to provide a fairer, more sustainable and national consistent aged care system that is responsive to the needs of an ageing population. Importantly, the consumer is at the centre of the reform process.

The Framework acknowledges that My Aged Care and future health reforms will affect delivery of care. However, the Framework principles are universal and can be applied regardless of future policy and funding environments.

These reforms bring opportunities that should be leveraged. They will:

- Drive improvements in the collaboration of health services. For example, the establishment of LHDs and Medicare Locals (MLs) (or Primary Health Networks [PHNs]) with shared geographic boundaries and the requirements for shared governance will facilitate shared planning and service models.
- Create drivers for better integration of care. For example, the introduction of activity-based funding for the hospital sector will lead to the consideration of the most efficient and effective service delivery models.
- Encourage the use of patient- and consumer-centred models of care. For example, the move to consumer-directed care in the community aged care sector and wider adoption of the philosophy of ageing-in-place.
- Provide information to support the evaluation of strategies and interventions which address the care of older people with complex health needs.
- The introduction of My Aged Care Gateway will encompass a national intake, referral and assessment system providing access to Commonwealth subsidised aged care services. This will ideally allow older people, their families and carers to be more easily connected the age care services they require.

Equally, the reforms present the following challenges:

- The delivery, funding and resourcing of services may change over time, meaning service models must be adaptable. For example, the administration of aged care assessments under My Aged Care is evolving and will impact on assessment responsibilities at a local level.

"If I am sick, I ring the GP (general practitioner) and am told it is a two week wait. So I get sicker and then it gets to 2am and I am really sick, breathless and alone at home so I call the ambulance to take me to ED where they keep me in for about two days doing tests and send me home with antibiotics. I would have just preferred to see the GP."

Female consumer, 84 years old

What is integrated care?

The NSW Health Integrated Care Strategy defines integrated care as "the provision of seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health in partnership with the individual, their carers and family. It means developing a system of care and support that is based around the needs of the individual, provides the right care at the right time and makes sure dollars go to the most effective way of delivering healthcare for the people of NSW".

The objectives of NSW Health's integrated care work program are to transform how care is delivered to improve health outcomes for patients and to reduce costs deriving from inappropriate and fragmented care, across hospital and primary care services by:

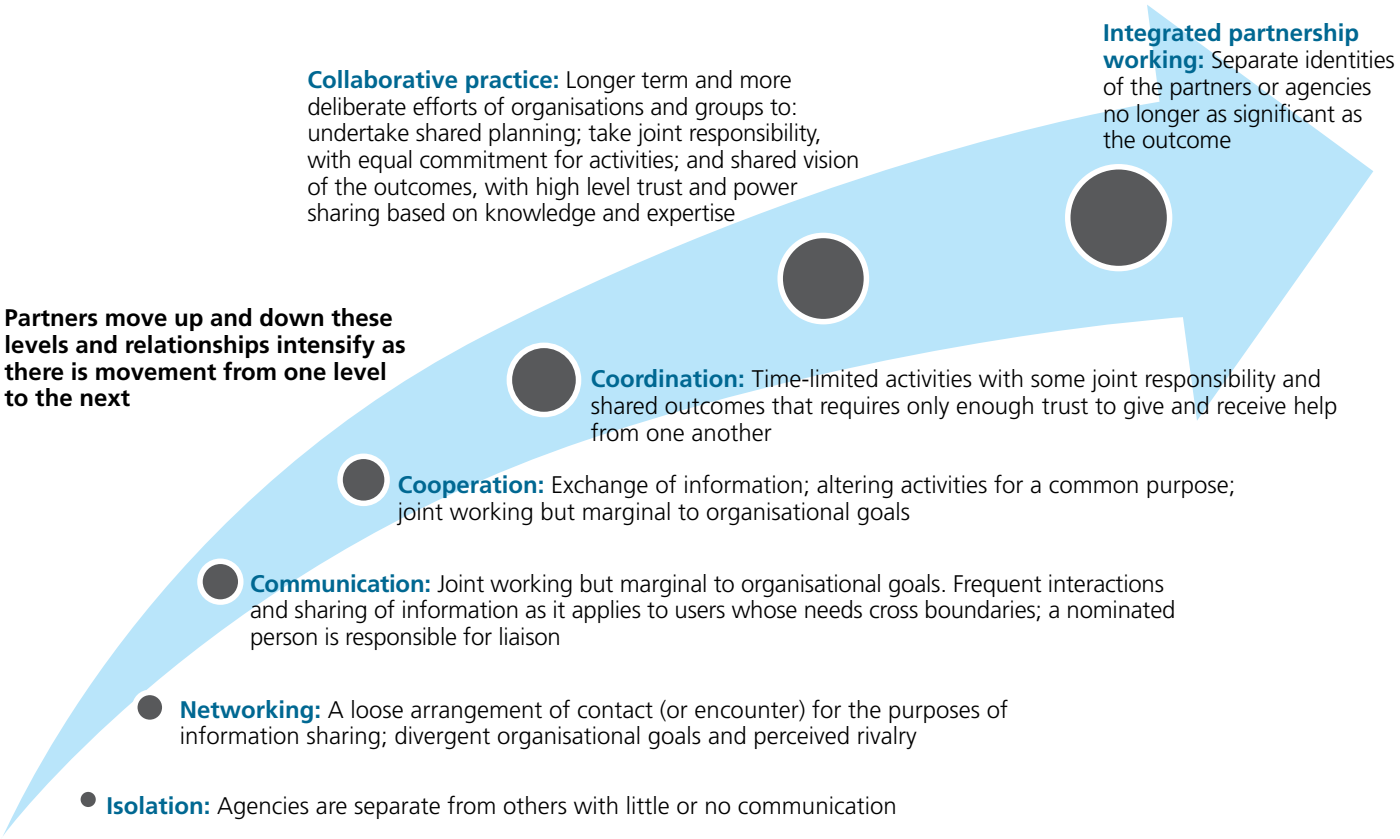
- focussing on organising care to meet the needs of targeted patients and their carers, rather than organising services around provider structures
- designing better connected models of healthcare to leverage available service providers to meet the needs of our smaller rural communities
- improving the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

Achieving these objectives will be evidenced by:

- patients reporting that they can more easily navigate their journey through the various parts of our health system
- an improved patient experience, and better health outcomes
- reduced waiting times for patients as they navigate the system
- more patients who can be cared for in the community receiving their care; there, 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 pathology and radiology tests.

Integrated care can be thought of as a progression of stages through which individuals and organisations move upwards (Figure 3). As relationships intensify, the individual or organisation move away from isolation towards integrated working partnerships.

Figure 3. Stages of integration[4]

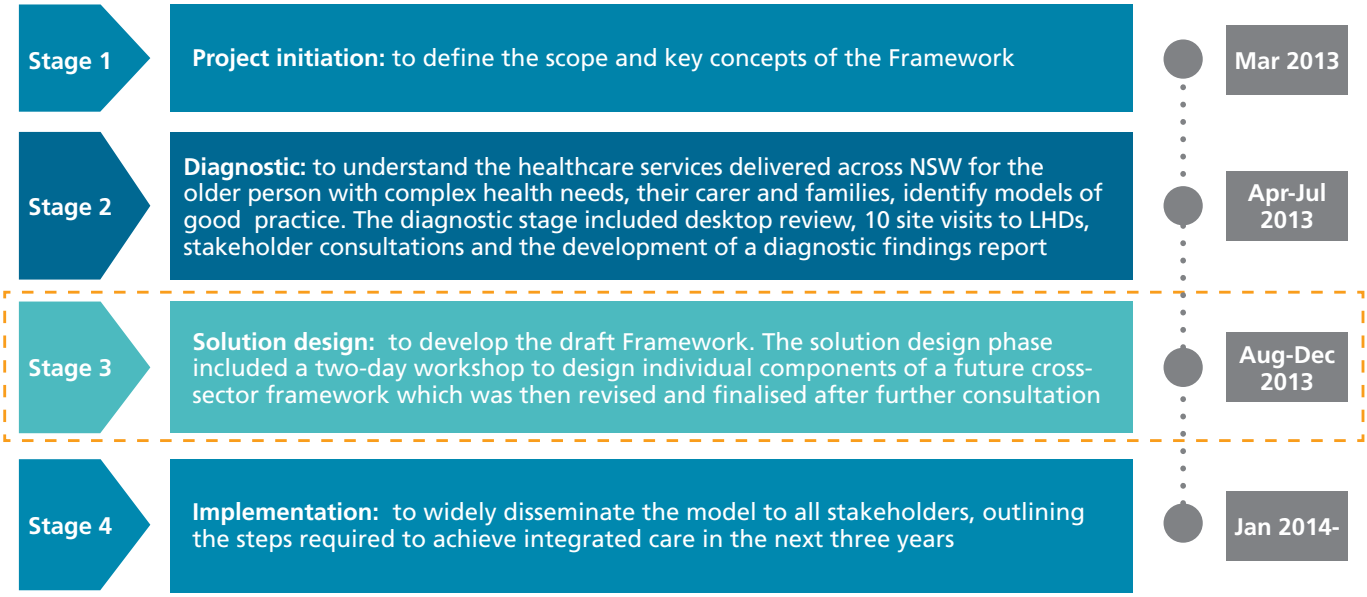


Adapted from VicHealth 2006[4]

Methodology

The Framework was developed following the NSW Health Redesign methodology (Figure 4. Developing the Framework). This Framework represents the outputs of the solution design stage.

Figure 4. Developing the Framework



1. Project initiation

The project initiation stage included defining the scope and definitions of the Framework.

2. Diagnostic

The diagnostic stage obtained a snapshot of the current landscape based on 10 site visits across rural, regional and metropolitan NSW Health services, literature and data reviews and further consultations with key stakeholders.

The purpose of the site visits was to understand the 'as-is state' of aged health services delivered across NSW; the care journey of the older person with complex health needs (and their carer and family) and the components that underpin the integration of care. The findings describe best-practice models of care, consistent themes and the enablers and barriers to integrated care for older people with complex health needs. Findings are presented in the Final Diagnostic Report, available at: *www.aci.health.nsw.gov.au/networks/aged-health/integrated-healthcare-of-the-older-person.*

3. Solution design

The solution design stage included a two-day workshop to inform the development of the Framework. In attendance were over 50 participants from LHDs, MLs (or PHNs), primary healthcare providers, NSW Ambulance (Ambulance), Aboriginal health services, aged care and community care services and consumer and carer representatives. The workshop aimed to verify findings and develop the Framework components.

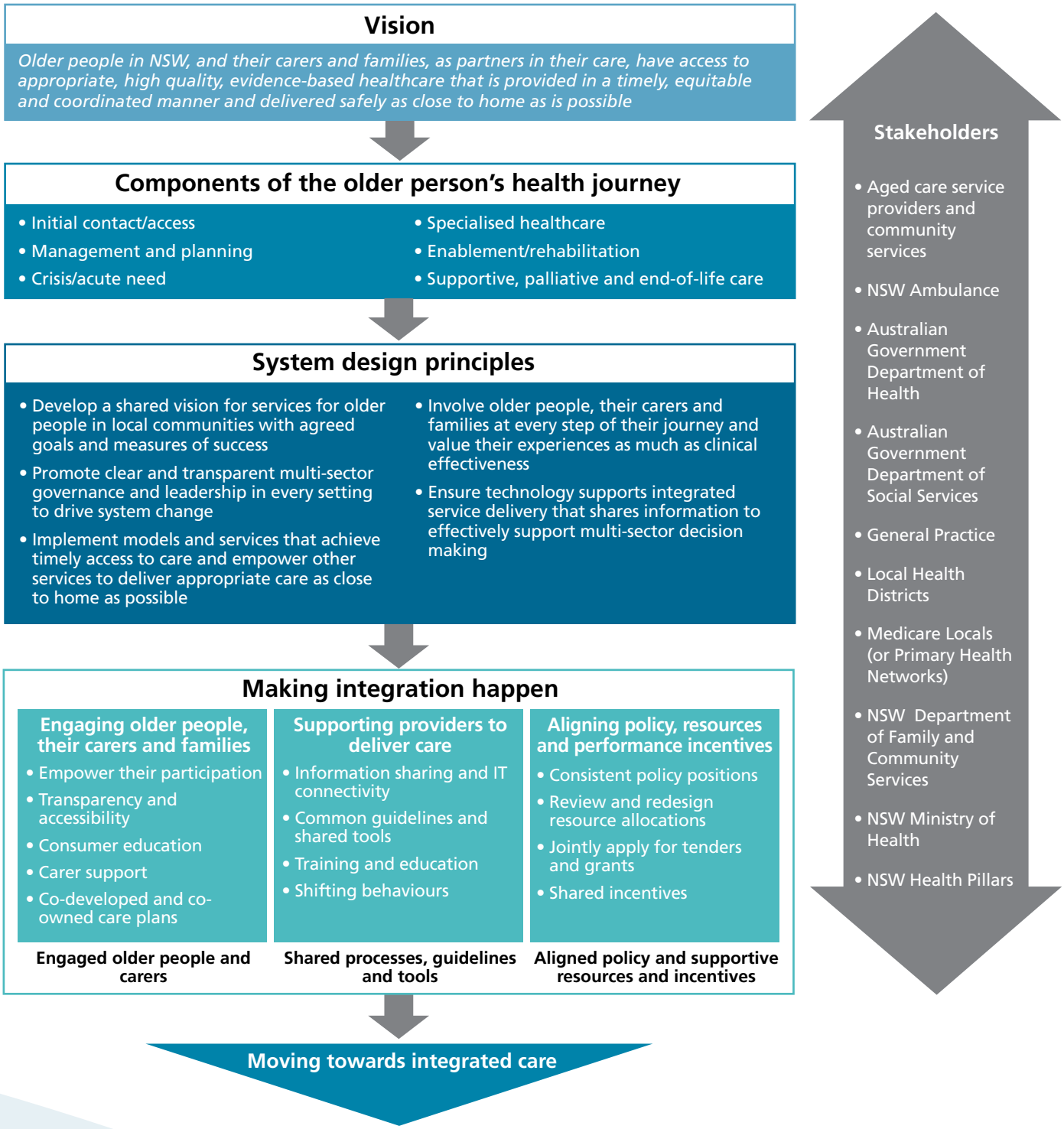
Outcomes of the workshop

- Developed and prioritised **system design principles**.
- Acknowledged current **barriers and enablers** to delivering integrated care.
- Detailed the **care needs** for an older person with complex health needs across settings.
- Identified the **quick wins and big ideas** that informed the development of the action plan for realising integrated care in the next three years.

Section 2.
The Framework

This section describes the Framework structure, key elements of successful integration and necessary components of integrated care for the older person with complex health needs, their carers and families.

Figure 5. The Framework for Integrating Care for Older People with Complex Health Needs



Adapted from MacColl Institute for Healthcare Innovation 2012[1]

The Framework structure

The Framework provides a conceptual model to align behaviours and understanding of service providers. Elements of the Framework are interrelated and comprise key components, system design principles and next steps for LHDs and the broader stakeholders (MLs [or PHNs], Ambulance, Aboriginal health services, and residential and community aged care services) in integrating care for older people with complex needs, their carers and families.

Road map

Components of the older person's health journey

This section provides an overview of the health journey for older people with complex health needs, their carers and families, recognising the different levels and types of care required throughout. It is a starting point to align thinking and consider the resources needed at different points in time.

Components of the health journey include:

- initial contact/access
- management and planning
- crisis/acute care
- specialised healthcare
- recovery/rehabilitation
- palliative and end-of-life (EOL) care.

System design principles

This section describes the whole-of-system context for delivering integrated healthcare for older people with complex health needs, and the core system design principles on which the Framework is based.

Making integration happen

This section describes key enablers and actions to realise a system-wide vision of integrated healthcare for older people with complex health needs. It includes enablers such as: engaging older people, their carers and families; supporting health service providers to deliver care; and aligning policy, resources and performance incentives.

Moving towards integrated care

The successful integration of care begins by bringing providers together to align their vision and goals. The Framework acknowledges the numerous components that influence integration. It also provides a platform to stimulate open discussion at a local level and to promote collaborative actions towards integration among those who have a role to play. This section describes the key activities for the State (macro) and Regional (meso) levels.

State (macro) level

1. Developing a communication and dissemination plan
2. Undertaking a utilisation and economic analysis
3. Considering implementation support requirements
4. Supporting service mapping and gap analysis
5. Developing an evaluation framework and supporting key performance indicators (KPIs)

Regional (meso) level

1. Establishing a dedicated multi-sector aged health governance structure to drive integrated care
2. Aligning stakeholders to a regional shared vision of integrated care
3. Undertaking a joint gap analysis/needs assessment and service planning
4. Developing shared processes, tools and guidelines to support regional implementation
5. Implementing the vision

Section 3. Components of the older person's health journey

This section provides an overview of the health journey for older people with complex health needs, their carers and families, recognising the different levels and types of care required throughout. It is a starting point to align thinking and consider the resources needed at different points in time.

Older people with complex health needs, their carers and families, require different levels and types of care throughout their journey, which include episodes of increasing and decreasing clinical and bio-psychosocial stability. Their care does not follow a linear progression that is based on singular diagnosis pathways or that fits within health service structures. Instead, it is undulating in nature, characterised by periods of crisis/acute care, recovery and progressive physical and/or psychological frailty and an extended palliative or EOL period. This is described and compared with other trajectories of disease in Figure 6.

Care of the older person is currently provided across three specific sectors (acute, primary and community) with separate funding and management structures. Care is often provided in parallel by different healthcare professionals and services with little coordination or association. Consequently, there is significant duplication across settings as little information is transferred between providers and each episode is not connected to previous or future episodes of care. Duplication of care often adds to fragmentation of services and increases pressure on the healthcare system.

In general, the point of access to care is defined by the consumer rather than the service provider. Older people access care in different ways for specific reasons, such as cost, location, familiarity and perceived acuity, or by default, due to inability to access their preferred care provider.

In an integrated person-centred approach to care, the setting in which care for the older person takes place should be principally determined by what care is needed and how this meets the need of the person at any point in time.

Services may improve the use of current resources by determining:

- Which providers are best placed to provide specific aspects of care.
- Where care should occur (e.g. community-based clinics, home).
- How services can be better connected to enhance clinical decision making and inform future episodes of care.
- Potential ways to manage or direct referrals and enquiries.

The health journey for older people with complex health needs has six components of care (Figure 7). These components, together with care planning and care coordination, are necessary across the older person's health journey.

Figure 6. Three key trajectories at end-of-life[5]

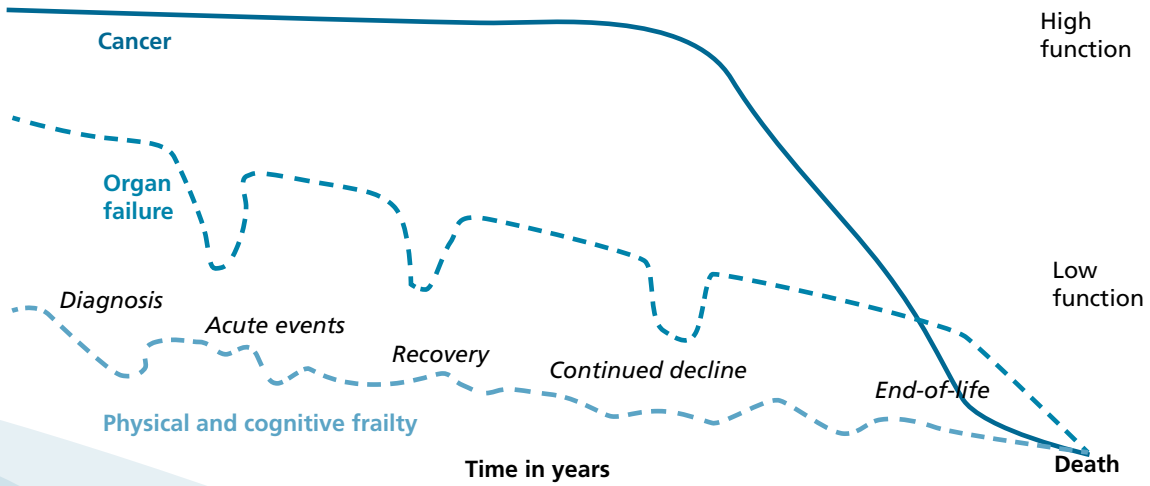


Figure 7. Components of the older person's health journey

Best practice across all components

The delivery of care across all components of the older person's health journey requires best practice, including care plans and care coordination.

Care plans

Care plans are a best-practice mechanism for clear and consistent communication among the older person, their carer and providers, about their situation, treatment regimen and key health goals. While provider assessments may differ, their plans for services and monitoring of the older person should be part of a comprehensive shared care plan. The owner of the care plan should ultimately be the older person and their carer with ongoing, two-way communication between providers, the older person and their carer. However, it should also fall with the most appropriate service provider to keep this plan updated.

The ability to share care plans among service providers is currently limited. However, steps can be taken in the short term to move towards a more consistent approach, through the use of:

- an agreed template for multidisciplinary input
- a mechanism to update and transfer that information with the older person and their carer
- communication protocols by providers around the care plan.

Care coordination

Care coordination is a best-practice approach to provide effective health management for people with multiple and often chronic morbidities who require timely and consistent care and self-management support.

In the context of care for older people with complex health needs, care coordination encompasses aspects of care delivery, including:

- multidisciplinary team meetings
- chronic disease management
- bio-psychosocial assessment and the provision of required care
- referral practices
- data collection
- development of common protocols
- information provision and shared care plan
- individual clinical treatments.

In designating the role of care coordinator, several factors should be considered, including the service provider with the most appropriate resources and capacity, and the degree of complexity of the health conditions of the older person.

The key actions of care coordination apply to all parts of the older person's journey and include:

- initiating links via continuous communication among the care team, the older person and their carer
- continuously reviewing and updating the care plan, facilitating case conferencing and supporting robust transfer of care
- cross-sector delivery of integrated care across the components of the older person's health journey.

These models recognise General Practitioners (GPs) as the main medical care providers who provide strong support for the care of older people with complex health needs. The older person's GP is usually in the best position to act as the care coordinator (or medical home), as they have in-depth knowledge and close relationships with the older person, their carer and family. The concept of the medical home, which acts as the hub of care, coordinated by the primary care provider in conjunction with the multidisciplinary team and specialist input, is described in Appendix E.

Initial contact/access

Initial contact/access describes the point, provider or care setting in which an older person with complex needs or their carer seeks health or social care support.

The purpose of initial contact/access is to:

- triage need through an initial bio-psychosocial assessment
- address the immediate need of the older person and stabilise presenting problem
- identify immediate next steps to connect the older person and their carer to a more comprehensive assessment and care planning program
- initiate immediate links with initial support/service providers.

Several considerations must be addressed to enable the older person and their carer to better navigate the system.

- Does the older person have a regular GP? If not, ensure this is facilitated.
- Focus on support and empowerment to manage issues and seek appropriate follow-on care.
- Increase awareness of access and entry points through publicity and promotion.
- Consider their social context, for example, culture, community and geographic complexity.

Triage and assess → Address immediate care needed → Refer/connect → Initiate immediate links

Suggestions for optimising initial access

- Referral hotline.[ii]
- Coordinate access and entry to Commonwealth-subsidised aged care services through the national My Aged Care Gateway
- Service directories.
- Standardised bio-psychosocial assessment.
- Linking local providers.
- Communication/education tools based on local area services.
- Information sharing across providers and the older person and carer (e.g. PCEHR).

ii The My Aged Care Gateway encompasses a national intake, referral and assessment system governing access to all Commonwealth-subsidised aged care services

Management and planning

Management and planning describes the initiation, development and continuous review of care plans. Evidence suggests that those with a structured management and treatment plan have greater success in self-management and appropriate and timely access to healthcare services.

The purpose of management and planning is to:

- undertake a comprehensive geriatric assessment, including comorbidities
- manage disease- and treatment-related symptoms and side effects, including comorbidities
- co-develop a care plan that addresses the bio-psychosocial needs of the older person and their carer (short, medium and long term) including prevention, management and escalation
- initiate links with the care team to be involved in their care plan including providing or coordinating appropriate initial support
- continuously review and update the care plan based on disease progression, changes to the plan or medication and level of services accessed.

Several considerations must be addressed for older people to have access to coordinated care and a co-developed care plan.

- Care plans should be developed with the older person and their carer. The older person and their carer should understand the plan for ongoing care and their roles in the process.
- The care team should be empowered and enabled to provide the required care. Joint conversations and case conferencing should be undertaken where possible.
- A goal-orientated care plan should be jointly owned and accessible by the older person, carer and care team.
- Older people should have access to a comprehensive assessment and care plan from any point in the healthcare system.

Comprehensive assessment | Treatment and symptom management | Co-development of care plan | Refer/connect/ coordinate | Review

Suggestions for optimising management and planning

- Start with the needs of the older person and carer and include health and bio-psychosocial needs.
- Improved engagement between specialist aged health services and general practices.
- Standardised care planning tool shared across providers.
- Team care arrangements and case conferencing.
- Ensure the social supports needs of the patient are also addressed by the plan e.g. community organisations..

Crisis/acute care

Crisis/acute care is predominantly unplanned in nature, which denotes the need for an immediate response.

The purpose of crisis/acute care is to provide access to:

- immediate 24 hour/7 day-a-week (24/7) specialised triage or assessment of an older person and their carer situation
- appropriate:
  - carer assistance
  - assessment of risks
  - treatment of the immediate issue
  - management advice for the next 24 hours
  - referrals for further care
- facilitation of transfer to acute care service.

Several considerations must be addressed for older people to have timely access to care and for services to be responsive in an unplanned situation.

- Timely access to diagnostics and expert aged health advice for accurate clinical decision making, allowing for immediate commencement of a treatment plan.
- Use of hospital alternatives closer to home.
- Treatment actions and intensity should consider the wishes of the older person and their carer in relation to use of resources and comfort.
- Timely access to appropriate acute care interventions and specialist service consultations as identified (e.g. respiratory, geriatrics, cardiology, mental health, palliative care, care of the confused hospitalised older person, orthogeriatrics, pain protocols).
- Older people presenting with acute needs and no current care plan should be appropriately referred for comprehensive assessment and management.

24/7 access → Specialised triage and assessment → Treat/assist/risk assess → Follow-up or transfer

Suggestions for optimising crisis/acute care

- Training and skill development that supports rapid and appropriate response/resources for this population.
- Emergency department (ED) bypass strategies utilised where appropriate (e.g. Medical Assessment Unit [MAU], Aged Care Emergency [ACE]).
- Clinical handover (i.e. care plans, care coordination, access to clinical information).
- Information technology (IT) systems that allow access or sharing of information (e.g. PCEHR - essential in rural settings).
- Partnerships and coaching relationships between providers (e.g. aged health specialists and on-the-ground clinicians).
- Use of Telehealth for rural access to specialists.

Specialised aged healthcare

Specialised aged healthcare services describe the provision of services by specialist aged health and Specialist Mental Health Services for Older People (SMHSOP). These services focus on issues that are unable to be addressed by organ-specific or disease-specific disciplines or other providers. Their end goal is to maximise independence through optimising physical, psychological and cognitive function.

Older people with complex health needs transition to specialised aged healthcare services from other services that cannot meet these specific needs.

Specialist aged health may include:

- geriatricians
- specialist aged health nurses
- allied health professionals with expertise in aged health issues.

SMHSOP may include:

- old age psychiatrists, nurses and allied health professionals
- behavioural consultants with expertise in mental health issues affecting older people as well as behaviour assessment and management.

The specialised aged healthcare team support other services through direct care and capacity building to recognise and manage older people with increasingly complex care and support needs.

The purpose of specialised aged healthcare is to provide aged health specialist services for:

- assessment
- diagnosis
- treatment
- self-management/primary care management advice
- care plan input/oversight
- capacity building within other services.

Several considerations must be addressed for older people to have timely access to appropriate specialised aged healthcare and continuity of care in the community.

- Timely access to specialist aged health assessment and advice to provide immediate commencement of a treatment plan and to review current care plan based on new needs identified (e.g. changes in physical/psychosocial/cognitive decline).
- Direct links and discussion with the manager of the current primary care plan (e.g. GP or care coordinator) and follow-up service linkages.
- Bio-psychosocial aspects of care should be considered by all care providers.
- Treatment actions and intensity should consider the wishes of the older person and their carer in relation to the use of resources and comfort (EOL care/ guardianship).
- Care delivery will include specialised carer support (e.g. counselling, respite, coping strategies and education).

Specialist assessment and diagnostics | Diagnosis and treatment | Care plan and self-management advice | Team/shared care pathway | Specialised carer support

Suggestions for optimising specialised aged healthcare

- Multidisciplinary input from care providers with appropriate capabilities.
- GP, specialised aged health, and other relevant service providers working together to optimise outcomes and continuity of care. Across settings and over time.
- Transparency of acute service availability/access (e.g. crisis response or ED bypass models).
- Reduce barriers to access (e.g. community-based clinics or response services).
- Access to specialised aged health care support / consultation by GP and other services as required, especially in rural / remote areas (e.g. case conferencing or Telehealth).
- Maximising the older person's ability to maintain capacity and independence based on ongoing awareness of their cognitive and psychological status.
- Grouping of specialised services with primary healthcare services.

Enablement/ rehabilitation

Enablement/rehabilitation looks to support the older person as close to home as possible.

The purpose of enablement/rehabilitation is to:

- identify the functional goals of older people that will support their achievement of optimal function (e.g. activities of daily living [ADL] goals)
- bring together a multidisciplinary team to support the older person to achieve their rehabilitation goals
- educate and support older people and their carers to participate in this process, and support to actively maintain their optimal level of function
- measure and evaluate their progress towards individual goals
- prevent deconditioning, avoidable frailty, ongoing psychological impairment and social exclusion of older people.

Several considerations must be addressed to support the enablement and rehabilitation of the older person with complex health needs.

- Rehabilitation should be accessible for those who wish to recover, maintain or improve their functional ability. Failure to offer this support has significant ramifications for the older person, their carer and family and may lead to hospital readmission.
- Timely access to appropriate rehabilitation is imperative to avoid further functional and psychological decline. Rehabilitation care is best provided where intensity and specificity can be achieved through access to appropriate equipment, care providers and the older person's context/ natural environment. Where required, access to mental health and/or psychological support should be provided.
- The enablement philosophy of care has proven to be effective from the point of admission and throughout care delivery. Enablement actively seeks to enhance older people's function and self-management ability.
- Social participation and continued ADL are relevant goals for the older person and can make significant difference to their physical and psychological health.
- The ACI Rehabilitation Model Of Care provides further information about the principles for rehabilitation and enablement.

Early identification | Joint goal setting | Support intensity of therapy | Measure and review | Community-based support

Suggestions for optimising enablement and rehabilitation

- Care coordination across a multidisciplinary team that extends to services at home.
- Shared care plan across disciplines and across service providers.
- Co-location of services/providers to encourage information sharing (e.g. electronic medical records [EMRs], case conferencing, standardised assessment tools).
- Defined end point (e.g. goal reached or supported care).
- Enablement/rehabilitation stage occurs at the crisis/acute component.

Palliative and end of life care

The term 'palliative care' describes designated specialist services provided by an interdisciplinary team of specialist palliative care professionals whose substantive work is with people approaching the end of life (EOL).

The term 'end of life care' describes care provided to people approaching the end of life by all health professionals regardless of where they work in the health and aged care systems. EOL care is an integral component of aged care services, medical and surgical care, management of chronic and complex illness, intensive care, accidence and emergency care and paediatrics amongst others. All health professionals should be competent to provide care to people who are approaching the end of their life or dying.

It is important to recognise that the trajectory for ageing with declining psychological and physical function can be lengthy and difficult to predict. Having discussions about goals of care with people who may be in their last year of their life can be difficult for everyone and often very hard for clinicians to initiate. Having these discussions and planning for care into the future can have a positive impact on the quality of care provided and overall quality of life for the patient, carer or family member.

Palliative & End of Life Care
A Blueprint for Improvement

Palliative and End of Life Care – A Blueprint for Improvement is an online resource developed by the ACI Palliative Care Network. It is a flexible guide for health services to meet the needs of people approaching and reaching the end of life, their families and carers. It emphasises the need for an integrated approach to care whereby relationships between specialist palliative care provider and care providers across all care settings are fostered. The Blueprint aims to guide services and Local Health Districts in constructing their own, localised models of care structured around 10 Essential Components.

10 Essential Components

1. Informing community expectations and perceptions on death and dying
2. Discussions about palliative and end of life care and planning for future goals and needs
3. Access to care providers across all settings who are skilled and competent in caring for people requiring palliative and end of life care
4. There is early recognition that a person may be approaching the end of life (i.e. last year of life)
5. Care is based on the assessed needs of the patient, carer and family
6. Seamless transitions across all care settings
7. Access to specialist palliative care when needs are complex
8. Quality care during the last days of life
9. Supporting people through loss and grief
10. Quality care is supported through access to reliable, timely clinical information and data

Components of the older person's journey within a Local Health District

To achieve greater integration of services within LHDs, current services for older people with complex health needs, their carers and families, must share a transparent, common vision. Services will need to be highly collaborative with clear coordination of the older person's care. Some LHDs have already invested in a strategic approach to management across their services and have demonstrated improved delivery of better care outcomes, service efficiency and experiences of the older person, carer and family (Figure 8).

The diagnostic and solution design stages of the Framework identified that an absence of one or more of these strategic aged health service delivery components may result in or contribute to:

- inappropriate acute admissions
- delayed assessment and treatment
- exacerbation of disease, symptoms and rapid deterioration
- increased infection risk
- increased behavioural management issues
- longer lengths of stay
- exacerbated functional decline
- higher level of care or support required on discharge
- readmissions due to discharges without support
- increased morbidity in the community
- inappropriate community management or support
- increased pressure on carers and families
- inappropriate RACF admissions.

Further details on the specific models that contribute to this approach are in the diagnostic report at: *http://www.aci.health.nsw.gov.au/networks/aged-health.*

Figure 8. Strategic aged health service delivery cycle

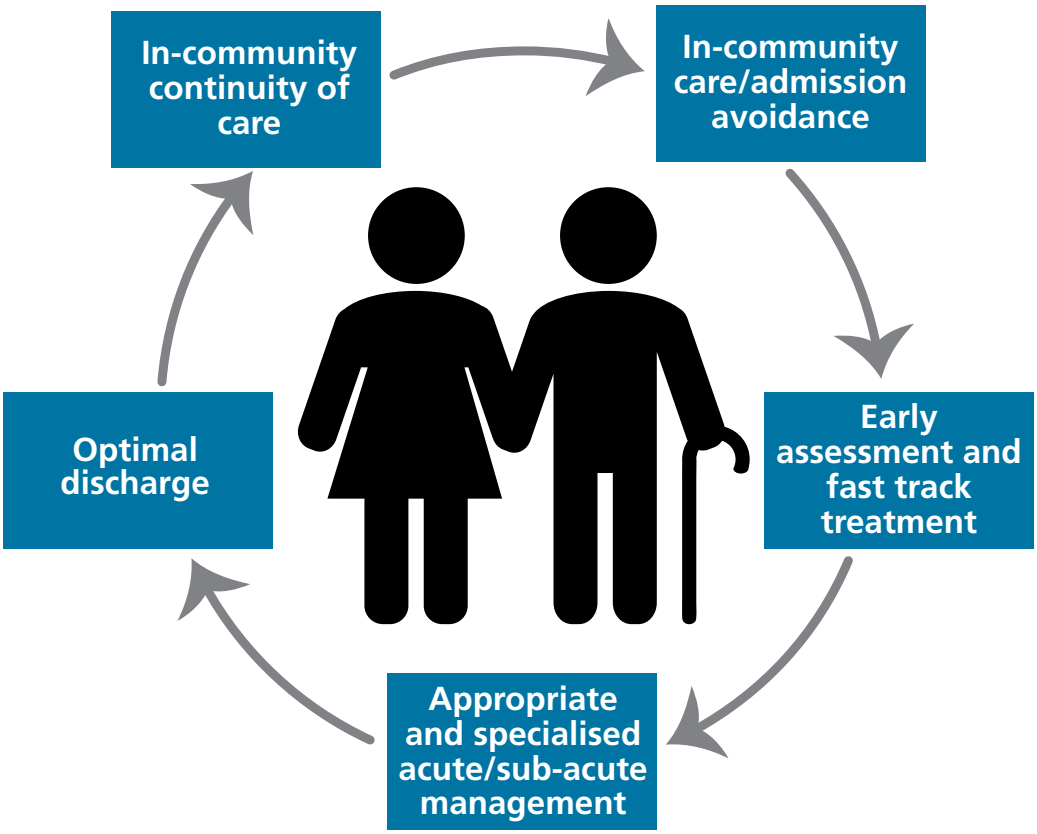


Table 1. Strategic aged health service delivery components

	In-community care/admission avoidance	Early assessment and fast-track treatment
Purpose	In-community care/admission avoidance. To provide assessment and care in the community (as possible) through: • redistribution of resources • delegation/enablement of community-based care providers to address common reasons for ED attendance.	Involves the 'front-loading' of specialist aged health resources in ED or MAUs to ensure the right care is initiated at the start of the care journey through a specialised aged health team. The purposes are to: • avoid further deterioration of older person with complex health needs on presentation to ED • support immediate initiation of a clinical care plan.
Benefits	Person-centred care delivered closer to home. Improved patient experience and continuity of care in community. Reduced cost of care episode. Reduced use of diagnostics and assessment resources.	Immediately directs care to the right place/provider in a timely manner, resulting in: • reduced deterioration of older people waiting for appropriate care • reduced length of stay (LoS) (due to improved efficiency in care, reduced deterioration and need for rehabilitation) • improved experience for the older person and their carer with potentially reduced behavioural issues. Resourcing reflects person-centred care need. Targeted use of diagnostics and assessment resources.
Examples	Single point triage referral for care need (e.g. aged health hotlines, Aged Care Services in Emergency Teams [ASETs] and Aged to Aged Related Care Services [AARCS] in ED). Acute care/crisis response teams or alternative providers (e.g. Ambulance Extended Care Paramedics [ECPs], after-hours GPs, nurse practitioners) for assessment and treatment at residence. Management plans jointly developed by general practice and RACFs. Community-based resources (e.g. diagnostics, Hospital in the Home [HITH], residential support, community nursing, geriatrician support). Planned admission pathways via ED bypass models (e.g. specialist assessment by SMHSOP). Early intervention rehabilitation or restorative care programs in the community (similar to Transitional Aged Care Program [TACP] models).	ED bypass or fast-track models for older people with complex health needs (e.g. ED bypass plans could be added to care plans as a response to escalating need). Specialist support on assessment and decision making at the start of the patient journey (e.g. ASET, ED teams, aged specific MAUs). Appropriate environment for assessment and management (e.g. dedicated ED areas, aged specific MAUs, dementia or delirium support). Fast-track diagnostics that consider management of the older person with complex health needs (e.g. mobile diagnostics, access and proximity).

Appropriate and specialised acute/ sub-acute care management	Optimal transfer of care processes	In-community continuity of care
To specifically and proactively address the unique care needs of older people with complex health needs to: • reduce complications or environments that trigger physical and/or psychological functional decline • return the older person to optimal function as soon as possible.	Begin optimal transfer of care processes on admission to provide timely progression of: • communication to the older person, their carer and family about discharge destination and what to expect • assessments, care packages or home modifications • contact and continuity of care with primary healthcare providers, care coordinators and community and residential aged care providers • guardianship or other administrative issues.	Continuity of care that reaches into the community and links with primary care providers and community-based support services is imperative for older people with complex health needs to re-establish themselves at home after an acute-care episode. There are three core aspects: 1. Updates to care plan and medication are discussed with the older person and carer and communicated to the nominated general practice/care coordinator. 2. Bio-psychosocial needs are identified and supported. 3. Follow-up appointments and deterioration action plans are in place.
Directs care to the right place/provider in a timely way. Reduces the need for behaviour management responses. Reduces avoidable deterioration and medical complications due to specialised knowledge and protocols. Efficiently and effectively returns older people to optimal function. Educates and builds the capacity of hospital staff to appropriately manage health needs and behaviours.	Early access to rehabilitation during admission. Reduced LoS due to delays in access to services or resolution of administrative issues. Optimised support for return home or entry into residential care. Carers and family have reduced anxiety and increased knowledge to care for the older person. Early understanding of service availability. Improved ability for an older person to return home with support if they wish Reduced unnecessary RACF admissions.	Reduced unplanned and avoidable readmissions. Reduced unsupported morbidity in the community. Improved capacity of the older person and their carer to confidently manage at home, reducing the need for higher-level care. Improved communication among care providers. Improved experience of the older person with complex health needs and their carer.
Aged health wards/beds/teams that work to provide: • an aged appropriate environment • enablement philosophy of care (proactive management and mobilisation) • specialised team care • cognitive/functional impairment friendly services. Shared specialist care/in-reach models for older people with multiple specialist needs (e.g. orthogeriatric care models, geriatrician/ other specialty parallel management). SMHSOP units and community teams. Dementia/delirium Clinical Nurse Consultant (CNC) or champions onwards.	Functional goal setting based on discharge destination and activities of daily living (ADL) goals. Pro-active planning for: • capacity and capability assessments • rehabilitation or restorative care • modifications to home environments • transition to RACFs • respite care options for carers • guardianship or other administrative issues. Initiation of early discussion with the older person's nominated primary health care provider or care coordinator and identification or establishment of a care plan for the older person to extend into the community. Development of an action plan for deterioration post discharge. This may include a number for business-hours services, after-hours support or ED bypass pathways.	Access to sub-acute (i.e. palliative, geriatric evaluation and management [GEM], rehabilitation or psychogeriatric) support as appropriate. Chronic Disease Management Plan (CDMP) aims to support people with chronic disease to better manage their condition, improve their health, wellbeing and quality of life, prevent complications, and reduce their need for hospitalisation. Access to restorative, personal care or aged care packages as appropriate (e.g. TACP, ComPacks, Home and Community Care [HACC]). Co-designed management plans with general practice and primary healthcare teams. In-community management action plans for any escalation or decline in condition (e.g. drop in clinics, mental health support, after-hours GP care, acute response teams and ECPs). Links with aged care and community service providers as part of the extended care team. Capacity building of carers, including education, ongoing communication and respite care. ED bypass models for admissions agreed by admitting specialist (or GP).

Section 4.
System design principles

This section describes the whole-of-system context for delivering integrated healthcare for older people with complex health needs, and the core system design principles on which the Framework is based.

Systems design thinking considers how the relationship among system components contributes to successes and failures of the whole system. This shifts the focus away from the individual components and instead places importance on their interactions and relationship within the larger system.[7] This creates an effective basis from which to define roles, prioritise funding and work together to improve the overall system. This systems-thinking approach has been used internationally by healthcare systems that have successfully integrated care services.[8,9]

The Framework provides steps to reorient the current system toward person-centred care by aligning the system components to the same care goals.

System design principles

The following principles define a shared vision for integrating care for older people with complex health needs, their carers and families.

- Develop a shared vision for services for older people in local communities with agreed goals and measures of success.
- Promote clear and transparent multi-sector governance and leadership in every setting to drive system change.
- Implement models and services that achieve timely access to care and empower other services to deliver appropriate care as close to home as possible.
- Involve older people, their carers and families at every step of their journey and value their experiences as much as clinical effectiveness.
- Ensure technology supports integrated service delivery that shares information to effectively support multi-sector decision making.

The system design principles underpin the vision of the 'future system'. Their purpose is to help local level services, jointly, to:

- target efforts, reduce unnecessary duplication and improve outcomes
- identify a path of coordinated action among diverse stakeholders
- consider unique contextual factors, such as the needs of the population, strategic priorities and availability of resources
- improve consistency and sustainability through flexible standardisation.

Stakeholders at all health system levels in NSW should assess their services against the design principles. In this way, service providers can use the system design principles as a platform for defining a shared vision, to guide improvements through aligned decision making and priority setting.

Section 5.
Making integration happen

This section describes key enablers and actions to realise a system-wide vision of integrated healthcare for older people with complex health needs. It includes enablers such as: engaging older people, their carers and families; supporting health service providers to deliver care; and aligning policy, resources and performance incentives.

Engage older people, their carers and families

Engaging older people, their carers and families, is a crucial part of delivering 'person-centred care'. Older people have a right to choose, participate in and make decisions about their care. Furthermore, their care experience should be valued as much as the clinical effectiveness achieved by care delivery. An integrated model of care needs to include the older person, their carer and family as key members of the care team and empower the older person to be engaged and actively participate in their care.

Engaging older people (and their carers) in their care begins with information from service providers about how to access care and what options are available. Care providers can more effectively communicate this information through training on interpersonal/communication skills and education on person-centred care. Older people and their carers also require support to improve their ability to understand information about their care (health literacy) and service options in order to actively participate in decision making.

The voice of older person and their carer in making decisions about their care and the consideration of their values is as important as the outcomes of care delivery. The integrated care model needs to support older people in accessing services and information both for and beyond their immediate care.

Assessments of the older person with complex health needs should consider the holistic needs of the person (e.g. a bio-psychosocial assessment), which involves the input of carers and family. A shared care plan should be developed, providing agreed key interventions and goals so that all care providers understand their roles and responsibilities. Having a care coordinator for older people with complex health needs is also encouraged. This role can be played by any stakeholder involved in care delivery, depending on who has the most suitable skill set and supporting resources. Shared care plans in cancer care are examples of how this can work effectively, and also support rural and regional residents to access specialist care without needing to travel.

Making it happen

- ✔ Empower the older person, their carer and family to be key members of the care team and ensure they are included in all decision-making processes.
- ✔ Support and educate the older person, their carer and family to make informed decisions (e.g. increase understanding in accessing care, understanding who the key contacts are, supporting their improvement in health literacy, having an emergency action plan).
- ✔ Train and educate service providers about the specific needs of the older person with complex health needs (e.g. hearing difficulties, difficulty accessing information online, more time may be required for consultations).
- ✔ Ensure accessible and transparent information about care services at the local level, and ensure it follows the care journey, not the service structure.
- ✔ All service providers and the older person, their carer and family to co-develop and co-own care plans.

Support providers to deliver care

Transitioning to a future model of integrated care requires support for providers through communication and information sharing, shared processes and guidelines and education and training. Deterring current behaviours and enabling collaboration are also essential.

Information sharing

Timely and effective communication among care providers are crucial to build a working relationship and improve quality of care. The integrated care model should look to support timely communication and case-conferencing methods across care settings, underpinned by best practice, communication guidelines and standards. Solutions such as Telehealth and electronic medical records (EMRs) can enable exchange of information but should not be solely relied on as the only means of communication. Importantly, the use of electronic referrals, discharge summaries and medical records needs to be consistent among service providers.

Streamlined processes and guidelines

An enabler of integrated care is timely, effective transfer of information across settings facilitated by shared guidelines and standards. Tools to streamline work processes may include: consistent templates for sharing information (e.g. referrals, discharge); a co-created shared care plan with stakeholder roles and responsibilities; standards for ways of working in an integrated system; and one shared directory of care providers.

Interprofessional training and education

Higher education is currently delivered in professional silos with little multidisciplinary interaction. Shifting this behaviour toward an integrated model requires interprofessional education and interdisciplinary work placements. They are a good opportunity to build greater understanding of other professionals' roles and capabilities and can be included in the curriculum of higher education and continuing professional development programs. There should also be a clear career progression pathway for those with an interest in aged healthcare designed to strengthen and build this workforce. For example, all staff should be educated on management of dementia and delirium.

Shifting behaviours and attitudes

Mechanisms to support integrated care, such as shared information systems, processes and guidelines, should be complemented by efforts to shift current behaviours and attitudes at all levels. Leadership must exhibit model behaviours aligned to the vision in order for care providers to follow suit. Stakeholders must also be engaged in the new vision and understand the necessity for change. Current ways of working in professional silos have led to ingrained interprofessional bias which needs to be addressed to work effectively. Co-location of teams or services is a way to propagate collaborative behaviours as are team case conferences and interdisciplinary training.

Making it happen

- ✔ Model the behaviour reflecting the vision for integrated care by leadership in every sector so as to set an example for care providers.
- ✔ Develop communication guidelines and standards on the minimum requirements for information sharing and communication so it is as effective and timely as possible for all.
- ✔ Ensure consistent use of technology solutions such as Telehealth and electronic medical records through training and education for all stakeholders.
- ✔ Develop tools for sharing information about referrals, discharge and care planning.
- ✔ Develop clear career progression pathways for those who are interested in aged healthcare.
- ✔ Implement cross-sector training and opportunities to work collaboratively within an integrated model; educate on professional roles and responsibilities and communicating with older people with complex health needs, their carers and families.

Alignment of resources, policy and performance incentives

Resources, policy, funding and performance incentives are major considerations and can be significant enablers of or barriers to achieving integrated care. Historically, continuity of services has been negatively affected by the complexity and fragmentation of Australian healthcare funding models and differing performance targets and policy positions. Seemingly simple tasks, such as shared recruitment of staff by MLs (or PHNs) and LHDs, are proving difficult due to differing industrial awards across providers for similarly skilled staff. There is currently no consensus view on what funding and incentive models work best for integrating care but it is widely acknowledged that one size does not fit all. Part of working within the current funding constraints is to consider examples of innovative practice in NSW where LHDs have worked together with MLs (or PHNs) and other services to provide integrated care to older people with complex health needs in a sustainable way and how this can be applied locally. Examples of different funding models are available in Appendix D.

While funding can assist in enabling integrated care, it is not the sole driver of behaviour change. It is, however, important that incentives are aligned to the change in behaviour that is required. Efforts to shift behaviour also need to extend beyond policy and funding mechanisms and consider other incentives such as a shared vision, a strong case for change and an engaged stakeholder group.

Making it happen

✔ Establish a dedicated multi-sector aged health governance structure to lead and drive integrated care and review:

- current policies across organisations that potentially conflict (e.g. recruitment and industrial entitlements) and may require consideration in implementation
- current performance or reporting requirements that potentially disincentivise the desired collaborative or proactive behaviours
- current funding and how it may be more efficiently resourced in line with the system design principles (e.g. pooled funding, joint recruitment, delegation of service to a new setting) and service mapping/gap analysis activities
- new funding for specific aged health and social care initiatives and where that funding is best directed in line with the joint vision and system design principles.

✔ Jointly review potential tenders and grants from NSW Health and Federal departments to understand what a joint response might be, who will lead and what support can be provided across agencies.

✔ Ensure decision makers are accountable and there is a direct transparent approval process (e.g. as part of the terms of reference, define the delegation/escalation of decisions across all parties).

Section 6.
Moving towards integrated care

Next steps: State (macro) level

The following activities are required at the State (macro) level to enable stakeholders at the regional (meso) and local (micro) levels to work together around a consistent framework for the provision of integrated care for older people with complex health needs, their carers and families. These include:

1. Developing a communication and dissemination plan

It is important for all healthcare providers in NSW to have an agreed conceptual framework for the delivery of integrated care for older people with complex health needs, their carers and families. To support this, a communication plan should be developed to provide awareness of the Framework among stakeholders and clarity on the required steps.

2. Undertaking a utilisation and economic analysis

Changes to existing practice will require time, resources and reinvestment and/or reallocation of funds. The ACI, in conjunction with the required stakeholders, will develop a 'business as usual' analysis, identifying the resource used and the costs of continuing current practice. Due to a lack of robust non-acute data, the analysis will focus on the utilisation of acute resources. This will help guide where changes are required at a state level and inform service providers of the benefits of change and the potential for the development of shared investment and reallocation of resources. Supplementing this will be population profiles and analyses and State level analysis of Medicare Benefits Schedule (MBS) funded services utilisation.

3. Considering implementation support requirements

To support shared working and implementation, consistent tools and resources will need to be developed. These could include:

- governance terms of reference
- stakeholder engagement/management strategies
- change management tools
- enablers and Framework components (e.g. best-practice care plan, terms of reference, role definitions, governance, communications standards)
- KPIs relevant to performance improvement/ performance management
- defined workforce standards and required skill mix to support the Framework.

4. Supporting service mapping and gap analysis

At a statewide level, a service mapping exercise is required to better understand the current service delivery landscape, where there are duplications and gaps and best-practice examples of integrated care. The findings of these activities can be disseminated widely to allow local service providers to undertake a joint needs assessment and service planning.

5. Developing an evaluation framework and supporting KPIs

As with any project, an exploratory exercise to determine the most effective way to measure progress will be necessary to ensure objectives are being met. This should include KPIs built into performance frameworks at all levels. The KPIs will need to incorporate person-centred outcome indicators, such as older person experience, as well as traditional impact and process indicators.

Additionally, it is good practice to have fair and transparent ways of incentivising integrated care for all participants involved.

Next steps: Regional (meso) level

Achieving integrated care is not expected to be immediate or easy. If used to its potential, this Framework provides the platform to stimulate open discussion at a regional level and to promote collaborative action towards integration among those who have a role to play. Section 7 provides greater detail on what is required at a regional level to implement the Framework in LHDs, MLs (or PHNs), Ambulance, Aboriginal health services, and aged care and community providers.

1. Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care

Dedicated multi-sector aged health governance is necessary to provide leadership to all stakeholders and drive the agenda of integrated care. This group should include representation from all stakeholder groups; have a clear terms of reference to define participant roles and responsibilities; facilitate regional leadership; and set standards by which they will deliver care.

2. Aligning stakeholders to a regional shared vision and purpose of integrated care

In order to create a better, more efficient and cost effective system, care delivery needs to be aligned to a shared vision with practical implications considered. The first task of a dedicated multi-sector aged health governance group will be to agree on a shared vision and purpose for integrated care. The vision describes the ideal state of care for older people with complex health needs, their carers and families, and how the services work together to achieve this. The vision also provides the opportunity for services to become person-centred rather than provider-centred and to bridge the gaps in communication that cause care delivery duplications and other inefficiencies to occur.

3. Undertaking a joint gap analysis/needs assessment and service planning

With NSW Health Executive level endorsement, stakeholders have the opportunity to work with a common framework to examine their current services and approaches and undertake a collaborative gap analysis. LHDs, MLs (or PHNs), local governments, regional human services agencies and Non-Government Organisations (NGOs) are already encouraged to undertake a needs assessment and evaluation of aged healthcare services as part of their operational remit. Undertaking a collaborative gap analysis will provide a starting point to achieve consistent practice and implement good practice where gaps exist.

A key consideration for LHDs and MLs (or PHNs) will be how they can potentially partner with other organisations to undertake a regional and joint needs assessment. For example, some LHDs and MLs (or PHNs) have jointly recruited population health planning officers to work across organisations. It was reported that access to data by both parties has proven to be mutually beneficial.

4. Developing shared processes, tools and guidelines to support regional implementation

Timely and consistent communication among service providers are important to inform decision making. Shared processes, guidelines and tools for working together will support service providers in a model of integrated care and may include:

- co-developed minimum requirements for information outlined in shared communication guidelines
- shared care plan, shared IT systems or consistent use of existing technology
- a regionally relevant terms of reference
- a single directory for care providers.

5. Implementing the vision

Working relationships need to be built and nurtured at every level (e.g. governance and service delivery). Additionally, all relevant stakeholders who provide care should be engaged so they can work together effectively. For this reason, participants are encouraged to establish or actively participate in their regional aged healthcare networks to develop and facilitate working relationships, identify key issues and prioritise areas of need across services. For example, service providers developing relationships with RACF staff has led to significant benefits to older people in their care, the staff and system.

Figure 9. Local implementation planning

The following activities should occur at the local (micro) level within a consistent framework to provide integrated care for older people with complex health needs, their carers and families.

Initiation and engagement (short term)	Progress and execution (medium term)	Evaluation and refinement (long term)
Shared vision and governance • **Establish** dedicated multi-sector aged health governance. • **Jointly develop** a shared vision for integrated aged health and aged care with local stakeholders. **Joint assessment and planning** • **Undertake** a service mapping and gap analysis exercise to understand current service delivery. • **Evaluate** current services to understand where there is good practice and widely disseminate findings. • **Assess** local needs and plan services through the multi-sector aged health governance to meet these needs. • **Design** how the regional aged health care system will look in an integrated model of care. • **Define** provider roles, responsibilities and needs for the system to operate effectively. • **Agree** on a plan for achieving integrated aged healthcare. **Shared processes, guidelines and tools** • **Co-develop and agree** on cross-sector guidelines for transfer of information that encourages stakeholders to develop cross-sector working relationships. • **Identify** enablers, tools and resources to achieve integrated care across settings.	**Progress** • **Continue** multi-sector aged health care governance to facilitate leadership and drive the agenda. **Appropriately incentivised service providers** • **Optimise** current and future funding arrangements by examining what resources are needed to deliver the most appropriate services as close to home as possible. • **Develop** KPIs that reflect and align to the shared vision and build into performance frameworks. • **Identify** measures that can be incentivised for service providers. **Shifting existing behaviours** • **Develop and deliver** interdisciplinary training to up-skill providers on working collaboratively. **Empowering older people** • **Empower the older person, their carer and family by:** – involving them in all decision-making (e.g. care planning) activities – educating them about available services – encouraging the use of individualised shared care plans across providers.	**Apply** • **Develop** policy positions and solutions to align to the shared vision of integrated care. **Evaluate** • **Ongoing evaluation and monitoring** of integrated processes leading to continuous performance improvement. • **Continual refinement and adaptation** of models and services to meet changing population health needs. **Ideal state** • **National and state-wide policy** that reflects and supports the importance of integrated care. • **Care designed around the holistic needs of the older person:** – provided as close to home as possible – the experience of the older person, their carer and family is considered as much as clinical effectiveness – timely access to the right care in the right place. • **A skilled and growing workforce** of service providers with expertise in providing aged healthcare. • **Engaged older people,** their carers and families. • **Full adoption of eHealth solutions** and compatibility of information sharing systems.

Section 7.
Regional level implementation

This section outlines the considerations for the following stakeholder groups implementing the Framework:

- LHDs
- MLs (or PHNs)
- Ambulance
- Aged care and community service providers

Implementation by Local Health Districts

The infrastructure and expertise of LHDs and specialist staff in the delivery of health services to older people with complex needs, their carers and families, is critical to the success of integrating care.

With the introduction of person-centred and integrated care approaches, LHDs will need to rethink their historical service structures and reorient their infrastructure, workforce and support services towards supporting the delivery of care closer to home and in local communities.

1. Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care

Within the LHD

A key first step will be to establish an interdisciplinary aged health network to facilitate systemic leadership and to drive the agenda of integrated care within the LHD. This network should be multidisciplinary and include representation from all stakeholder groups and have the authority to make decisions. The network should:

- develop a clear terms of reference to define participant roles and responsibilities and set the standards by which they will deliver care
- develop a vision for aged healthcare within the LHD
- develop meeting schedules, governance arrangements, and locally-relevant terms of reference which align to the vision and system design principles
- facilitate systemic leadership at all levels including modelling the behaviours required to support integration.

With other stakeholders

Dedicated multi-sector aged health governance is necessary to provide leadership to all stakeholders and drive the agenda of integrated care. This group should include representation from all stakeholder groups; have a clear terms of reference to define participant roles and responsibilities; facilitate regional leadership; and set standards by which they will deliver care.

This group should:

- develop a clear terms of reference to define participant roles and responsibilities and set the standards by which they will deliver care
- develop a vision for aged healthcare within the LHD
- develop meeting schedules, governance arrangements, and a locally-relevant terms of reference which align to the vision and system design principles
- identify enablers, tools and resources needed to achieve integrated care across different settings
- facilitate systemic leadership at all levels (across sectors) to support integration.

2. Aligning stakeholders to a regional shared vision and purpose of integrated care

In order to create a better, more efficient and cost effective system, care delivery needs to be aligned to a shared vision with practical implications considered. The vision describes the ideal state of care for older people with complex health needs, their carers and families, and how the services work together to achieve this. The vision also provides the opportunity for services to become person-centred rather than provider-centred and to bridge the gaps in communication that cause care delivery duplications and other inefficiencies to occur.

The first task of a dedicated multi-sector aged health governance group will be to agree on a shared vision and purpose for integrated care. In the LHD context this would require a shared vision for the aged health and aged care service as well as a jointly developed shared multi-sector vision for integrated aged health and aged care with all local stakeholders.

3. Undertaking a joint gap analysis/needs assessment and service planning

Person-centred service design starts with the older person, their carer and family and what their care needs are. It also identifies system inefficiencies that are currently accepted as 'normal practice'.

Within the LHD

LHDs should consider the following when assessing gaps in current service delivery and service planning and designing future models of care:

- Compile service mapping and gap analysis information from all stakeholders to understand the existing service delivery landscape and if duplications and/or gaps exist.
- Undertake an evaluation of current services to identify good practice; widely disseminate these findings.
- Review current funding and how it may be more efficiently resourced in-line with system design principles (e.g. pooled funding, joint recruitment, delegation of service to a new setting) and service mapping/gap analysis activities.

With other stakeholders

This document provides the opportunity to work with a common framework to examine current services and approaches and undertake a gap analysis. Undertaking a gap analysis will provide services with a starting point to achieve consistent practice and implement good practice where gaps exist.

LHDs are required to undertake strategic planning for their region – to guide strategic direction and inform resource allocation. Other organisations also undertake a similar review of local population health needs and service distributions (e.g. ML [or PHN] needs assessment based on population health assessments and gap analysis).

A key consideration for LHDs and MLs (or PHNs) will be how they can potentially partner with other organisations to undertake a regional and joint needs assessment. For example, some LHDs and MLs (or PHNs) have jointly recruited population health planning officers to work across organisations. It was reported that access to data by both parties has proven to be mutually beneficial.

Immediate opportunities include:

- Compiling service mapping and gap analysis information from all stakeholders to understand the existing service delivery landscape and if duplications and/or gaps exist.
- Undertaking an evaluation of current services to identify good practice; widely disseminate these findings.
- Reviewing current funding and how it may be more efficiently resourced in-line with system design principles (e.g. pooled funding, joint recruitment, delegation of service to a new setting) and service mapping/gap analysis activities.
- Reviewing new funding for specific aged health and social care initiatives and where that funding is best directed in line with the joint vision and system design principles.
- Jointly reviewing potential tenders and grants from NSW Health and Federal departments to understand what a joint response might be, who will lead and what support can be provided across agencies.
- Partnering to address specific areas of need identified through joint initiatives.

4. Developing shared processes, tools and guidelines to support regional implementation

Working across services, sectors and providers requires standardisation of processes and protocols, minimum information sharing requirements and terminology.

Effective communication among service providers is important, and processes, standards and feedback loops will be imperative for integration. As providers' training and perspectives vary, it may be necessary to flag potential conflicting frames of reference by identifying a common language and developing a shared set of processes for working together. The minimum requirements for information need to be outlined in co-developed, shared communication guidelines. Health Pathways is an example of providers collaboratively exploring solutions to address local health needs.

Other tools to consider include a shared care plan, shared IT systems or consistent use of existing technology, a locally relevant terms of reference and a single directory for care providers. Existing tools and templates that support integration have been developed and can be adapted for local use. Examples include care plans, multidisciplinary assessment forms, eHealth forms, yellow envelopes (RACF) and Advance Care Directives (ACDs).

The benefits of having standardised processes and tools:

- Ability to establish a minimum level of care, information transfer requirements and the existence of ACD.
- Reduced administration and management reporting and assisting with the high volume of transfers between residential care, ED, acute care and sub-acute care.
- Identify opportunities for systemic tools and processes including access to ACD, dementia assessments, Aged Care Assessment Team (ACAT) assessment results and carer status.

5. Implementing the vision

Working relationships need to be built and nurtured at every level (e.g. governance and service delivery). Additionally, all relevant stakeholders who provide care should be engaged (e.g. RACFs, NGOs, Ambulance, Aboriginal health services) so they can work together effectively. For this reason, participants are encouraged to establish or actively participate in their local aged healthcare networks to develop and facilitate working relationships, identify key issues and prioritise areas of need across services. For example, ED staff developing relationships with RACF staff has led to significant benefits to the system, the staff and older people in their care.

As with any project, an exploratory exercise to determine the most effective way to measure progress will be necessary to ensure objectives are being met. This should include person-centred outcome indicators, such as older person experience, in addition to traditional impact, process, system and utilisation indicators.

Key considerations for implementing the vision include the following:

i. Training and education

Multidisciplinary cross-sector training and education are important for developing relationships, facilitating collaboration and understanding service providers' roles.

Coordinating local multidisciplinary secondment opportunities would help put such learning into practice. Resourcing and capacity are often considered limitations for metropolitan and rural and remote sites in providing education and training. Understanding the current and future workforce, identifying individuals interested in working in aged healthcare, creating a clear career progress plan and providing speciality training, will allow for improved provision of services, mentoring and successful future workforce planning.

ii. Resourcing

One of the key ingredients to service design is resourcing. There is an opportunity to align with the strategic vision of an integrated person-centred model of care, through alternative resourcing or better utilisation of wider healthcare services such as primary care and community services.

Thinking differently about resourcing allows services to distribute resources where they can have the most impact. For example, the implementation of residential aged care liaisons and specialised aged care staff in ED has led to more appropriate care being arranged in the older person's home, limiting unnecessary admissions.

The benefit of front-loading specialised resources to the component of the older person's care journey has benefits to care outcomes and service performance metrics. Likewise, there are alternatives to current staffing structures that would better use non-medical and generalist staff.

iii. Infrastructure

Currently, service providers are geographically distributed by funding stream. For example, private providers are located near commercial centres and LHD aged health services are positioned on the periphery of the hospital campus – that is they are neither facility nor community-based. Similarly, the type of service provided is often funded by MBS and LHDs.

Co-location of services can facilitate integration by allowing regular face-to-face community and shared care activities to occur. Both help to build effective working relationships among stakeholders and decrease division among service providers.

Ease-of-access is an important benefit of co-location for the older person with complex health needs. The solution design stage of this project identified community based 'one stop shops' with a full range of aged health specialist services (allied health and nursing), salaried GP oversight and specialist input. Services such as these could be directed to areas where service delivery requires improvement and where specific groups may benefit.

Recognising that co-location is not always appropriate or possible, the virtual integration of information sharing systems and records is encouraged as a minimum requirement to facilitate integrated care.

Providing supportive physical environments for older people with complex health needs and their carers in acute care (including ED bypass), is proven to reduce resource intensity and offer a more effective person-centred care service. Design features, such as natural light, courtyards and simulated home environments are

reported to improve the experience and behaviour of older people at risk of becoming distressed or exhibiting difficult behaviours.

Simple design features, such as well-located diagnostic services, influence the wellbeing of the older person and staffing resources required to support the transfer of these patients to and from these services. Similarly, secure units for older people with behavioural and psychological symptoms of dementia (BPSD) reduce the use of physical and pharmacological restraints and the need for additional staffing.

iv. Technology/information flow

A major barrier to communication among providers and care settings is incomplete patient information. For example, patient files are often part electronic and part hard-copy, making them difficult to connect.

While it is acknowledged that the limitations of information and communications technology (ICT) structures are a significant barrier, there are potential steps to improve short-, medium- and long-term progress towards shared-information systems, including:

- encouraging system, software and behaviour uptake
- defining minimum data and information required by different parties to be effective in their role
- enabling two-way electronic communication between care providers.

Importantly, community-based care teams need to work efficiently. Current systems require duplicative data entry and offer limited access to information. Mobile devices that link and upload patient data entered into LHD systems should be accessible and able to be edited immediately, as inability to do so limits the number of people that can be supported per community-based resource and results in significant cost and efficiency implications. Secure messaging ability for community care, RACFs and LHDs would greatly enhance communication regarding common patients (e.g. Argus).

The use of Telehealth to connect care providers is progressing. Telehealth is the delivery of health-related services via information and communication technologies such as video conferencing. Examples of Telehealth services include:

- specialist consultation
- health monitoring
- residential aged care GP support
- emergency assessment/support.

Telehealth

What is it? Telehealth is the delivery of health-related services via information and communication technologies such as video conferencing.

How it works: A metropolitan hospital will establish an arrangement with a regional or rural facility to provide health services via information and communication technologies. The two facilities will determine a funding arrangement for providing the services. For example, a geriatrician from a metropolitan hospital provides dementia Telehealth services to a regional ML (or PHN) which has a Registered Nurse (RN) to help facilitate the assessment. The State funds the Telehealth equipment, the ML (or PHN) funds the RN, and the metropolitan facility receives MBS funding from the federal government for each patient that is assessed.

Resourcing: These models are delivered across community, primary and acute care and are facilitated by a mix of clinical and non-clinical staff including RNs, geriatricians, Clinical Nurse Consultants (CNCs) and administrative coordinators.

Success factors:

- Strong governance arrangements between Telehealth facilities.
- Procedures and guidelines to support the Telehealth service model.
- IT frameworks that support Telehealth.

Examples in use: Consultative Geriatric Service (Concord-WNSWLHD), Telehealth Dementia Clinic (Hornsby-Armidale), Telehealth service (Wagga Wagga), Residential Aged Care Support (Nepean).

Opportunities for Medicare Locals (or Primary Health Networks)

The objectives of MLs (or PHNs) are to:

- improve the care journey through integrated and coordinated services
- provide support to clinicians and service providers to improve care
- identify the health needs of the local area and develop responsive services
- implement primary healthcare initiatives
- establish strong governance and effective management.

In practice, MLs (or PHNs) are well positioned to look broadly across the components of care needs experienced by an older person, their carer and family to: understand how current services in local areas meets care demand; identify opportunities to better integrate and coordinate services among primary healthcare providers, LHDs and other care providers; and, develop locally tailored primary healthcare services that fit local catchment needs and priorities in aged health.

MLs (or PHNs) are already implementing key activities and programs that support this Framework, including:

- comprehensive needs assessment
- after-hours program
- eHealth implementation
- Health Pathways.

"Health Pathways is really just about having open dialogue about processes and overcoming the barriers you identify jointly. One solution we came up with was as simple as buying a $200 colour printer to cut out three steps in a process."

An example of engagement of MLs (or PHNs) in aged care programs is the Metro North Brisbane ML (below), who have demonstrated the role MLs (or PHNs) can have in the future by employing home-care services in their region.

Metro North Brisbane Medicare Local case study

What is it? The Metro North Brisbane Medicare Local currently delivers Home and Community Care (HACC) services across the Metro North region through a Consortium of 10 contracted service providers.

How it works: The ML is the lead agency and is responsible for the procurement, coordination, management and reporting of service delivery.

In May 2013, the ML used this Consortium model to successfully transition 3,500 HACC clients from the Hospital and Health Services (HHS) to community partners in six weeks with only five complaints.

The Consortium delivery model of commissioning services from a range of providers enables much greater capacity to meet clients' specific needs such as culturally and linguistically diverse (CALD) and homelessness. The model aims to: strengthen links, integration and coordination amongst the various providers of HACC-funded services in the region; enable the identification of areas for improvement and the opportunity to work together to increase and improve service provision.

Success factors: Consortium members are diverse in size, skills and experience, have strong connections with their local communities and a track record of delivering consumer-focused community care. They were selected on their willingness and capacity to collaborate, their consumer-centred philosophy and their ability to respond to client needs.

1. Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care

Part of the MLs' (or PHNs') roles within the Framework is to enable primary healthcare providers to think systemically about care provision and educate them about provider roles and responsibilities.

Current arrangements and communication between specialist and primary healthcare is ad-hoc and often reported to be problematic. International research suggests that 70% of patient-related adverse events were caused by a lack of basic communication and collaboration among health professionals.[10]

Dedicated multi-sector aged health governance is necessary to provide leadership to all stakeholders and drive the agenda of integrated care. This group should include representation from all stakeholder groups; have the authority to make decisions; facilitate local leadership; and set standards by which they will deliver care.

This group should:

- develop a clear terms of reference to define participant roles and responsibilities and set the standards by which they will deliver care
- develop a vision for aged healthcare within the LHD
- develop meeting schedules, governance arrangements, and a locally-relevant terms of reference which align to the vision and system design principles
- identify enablers, tools and resources needed to achieve integrated care across different settings
- facilitate systemic leadership at all levels (across sectors) to support integration.

2. Aligning stakeholders to a regional shared vision and purpose of integrated care

In order to create a better, more efficient and cost effective system, care delivery needs to be aligned to a shared vision with practical implications considered. The vision describes the ideal state of care for older people with complex health needs, their carers and families, and how the services work together to achieve this. The vision also provides the opportunity for services to become person-centred rather than provider-centred and to bridge the gaps in communication that cause care delivery duplications and other inefficiencies to occur.

MLs (or PHNs) have multiple stakeholders within their circle of influence. For this reason, it is important that MLs (or PHNs) become a champion for integrated aged healthcare by modelling and promoting the shared vision for integrated aged healthcare and reflecting the importance of this in their strategic priorities.

3. Undertaking a joint gap analysis/needs assessment and service planning

Within the ML (or PHN)

MLs (or PHNs) are required to undertake a local comprehensive needs assessment to guide strategic direction and inform resource allocation. The needs assessment will have a three-year time horizon with provision for annual review, in relation to ML (or PHN) priorities and activities. The objective of the local needs assessment is for MLs (or PHNs) to work with community, consumers, GPs and health professionals to:

- assess the health status of the population and identify the key health issues for the region, including the causes of ill health, level of risk and burden of disease
- consider evidence on interventions to address the health issues effectively and identify opportunities for change
- identify the population groups or localities most affected and the social determinants at play and/or health inequities present.

With other stakeholders

MLs (or PHNs) receive funding to deliver specific programs (e.g. after-hours primary care services, eHealth support) as well as flexible funding to meet locally identified needs or areas of priority based on their health needs assessment. Collaboration would benefit from exploring how joint investment could promote better integration of service delivery for the older person with complex health needs.

Opportunities for MLs (or PHNs) to undertake this local needs assessment jointly with LHDs and other service providers include:

- Leveraging, sharing or co-developing local needs analyses with LHDs and aged care and community service providers.
- Identifying core strategic priorities that are best driven within primary healthcare and supported by MLs (or PHNs).

- Representing the views and needs of primary care providers while identifying systemic solutions.
- Service mapping of current services and subsequent gap analysis.
- Service directory support comprising geographical information on services and programs.
- Defining and delineating roles and responsibilities of primary healthcare professionals in delivering care across sectors to the older person with complex health needs, their carer and family.

4. Developing shared processes, tools and guidelines to support regional implementation

Working across services, sectors and providers requires standardisation of processes and protocols, minimum information sharing requirements and terminology.

Effective communication among service providers is important, and processes, standards and feedback loops will be imperative for integration. As providers' training and perspectives vary, it may be necessary to flag potential conflicting frames of reference by identifying a common language and developing a shared set of processes for working together. The minimum requirements for information need to be outlined in co-developed, shared communication guidelines. Health Pathways is an example of providers collaboratively exploring solutions to address local health needs.

Other tools to consider include a shared care plan, shared IT systems or consistent use of existing technology, a locally relevant terms of reference and a single directory for care providers. Existing tools and templates that support integration have been developed and can be adapted for local use. Examples include care plans, multidisciplinary assessment forms, eHealth forms, yellow envelopes (RACF) and ACD.

The benefits of having standardised processes and tools:

- Ability to establish a minimum level of care, information transfer requirements and the existence of ACD.
- Reduced administration and management reporting and assist with the high volume of transfers between residential care, ED, acute care and sub-acute care.
- Identify opportunities for systemic tools and processes including access to ACD, dementia assessments, ACAT assessment results and carer status.

Some MLs (or PHNs) have already established joint governance programs with LHDs and other providers that may be leveraged to support local implementation. In this way, MLs (or PHNs) are encouraged to enhance their own networks in order to progress forward more rapidly.

5. Implementing the vision

Working relationships need to be built and nurtured at every level (e.g. governance and service delivery). Additionally, all relevant stakeholders who provide care should be engaged (e.g. RACFs, NGOs, Ambulance, Aboriginal health services) so they can work together effectively. For this reason, participants are encouraged to establish or actively participate in their local aged healthcare networks to develop and facilitate working relationships, identify key issues and prioritise areas of need across services.

Due to its accessibility, older people with complex health needs will initially access primary healthcare in the early stages of their care journey. As a result, their experiences are highly dependent on how proactive their primary healthcare provider is in:

- undertaking a holistic assessment of their bio-psychosocial and healthcare needs
- devising a care plan with structured follow-up and monitoring
- linking with other services and providers.

MLs (or PHNs) will have a specific role in ensuring providers have the required tools to be successful and that standards of care are upheld across providers, thus avoiding unnecessary morbidity and mortality caused by communication breakdowns.

At a system level, MLs (or PHNs) will have a role in encouraging the right care is delivered at the right time in the right setting and as close to home as possible by:

- ensuring that care coordination is appropriately delegated and resourced to best use skills of all health professionals
- coordinating relationships among stakeholders to support collaboration.

"There is significant value in a comprehensive GP assessment and care plan after acute admission in at-risk groups such as older people with complex needs – the problem is there is currently no consistent process or incentive."

Key considerations for implementing the vision:

- **Shared care** - MLs (or PHNs) can play a key role in formalising shared care arrangements between LHDs and primary care.
- **Care coordination** - MLs (or PHNs) have a key role in supporting better care coordination among primary healthcare, LHDs and other service providers. Care coordination is a best-practice approach to provide effective health management for people with multiple and often chronic morbidities who require timely and consistent care and self-management support. It includes multiple aspects of care delivery including multidisciplinary team meetings, management of chronic disease, provision of required care, referral, data collection, common protocols, information provision and treatment.
- **Access** - The care experience of older people with complex health needs, their carers and families, is greatly influenced by where, how and when they initially seek healthcare and can be informed by accessibility, health needs and health literacy.
- **eHealth** - MLs (or PHNs) have a responsibility to encourage the use of eHealth (and the PCEHR) within general practice, allied health, aged care and pharmacy. Despite current challenges facing eHealth, over time, it will enable the sharing of information across care boundaries.
- **Communication to the community** - MLs (or PHNs) have a key role in communicating service information and treatment options to older people, their carers and families. This includes location, opening hours, cost, available rebates and specific programs. Ultimately, this information should be accessible at one point of contact, such as a hotline number, website, or flagging specific 'aged friendly' primary healthcare practices where the appropriate care is facilitated.

Other integrated care considerations for MLs (or PHNs) include:

- **Shared resourcing** - In order to coordinate working relationships among sectors delivering care for the older person with complex health needs, MLs (or PHNs) may wish to allocate specific resources to this role (e.g. an Integration Manager) to provide oversight and project management for local initiatives.
- **Development of a national information resource** (e.g. My Aged Care website) that provides older people, their carers and families, with information about services and conditions.
- **Training and education** for primary healthcare providers on collaboration.
- **Governance** for local service delivery against care standards outlined in this Framework.
- **Knowledge** and dissemination of best practice and/or case studies.
- **Supporting local tenders and funding** applications to help providers meet care standards outlined in this Framework.
- **Encouraging the use of technology** and Telehealth to support care.
- **Commissioning of services** where gaps in primary healthcare services or service inefficiencies exist (potentially on behalf of LHDs).
- **Shared performance reporting** through governance.

Opportunities for aged care providers and community services

Aged care providers include RACFs and other community aged care providers. There are over 800 such aged care organisations in NSW.

RACFs are a special-purpose facility providing accommodation and other types of support, including assistance with day-to-day living, intense forms of care and assistance for independent living to frail and aged services.

Community aged care providers deliver services designed for older people to support them living and staying healthy in the community for as long as possible (e.g. HACC services). These are providers whose services may not focus specifically on older people and includes a number of NGOs who have significant expertise and resources to offer.

Aged care service providers and community services have an important role in realising the vision to deliver care as close to home as possible and to connect older people and carers with bio-psychosocial supports and tangible support such as respite options. The multi-morbid nature of older people with complex health needs means that no single organisation can address all aspects of health and social care.

Relationships among aged care service providers, community services and health providers are mixed, with some having strong, effective relationships and others having little interaction. Inclusion of these groups in multi-sector aged health governance will enable discussion across the spectrum of aged services, and identify potential areas of collaboration.

Aged care service providers and community services can support implementation by:

- Engaging local primary healthcare providers in the vision of integrated care for older people with complex health needs.
- Sharing current data on the care of older people with complex health needs. This information is not readily accessible by LHDs and provides important insights.
- Mapping regionally-funded aged care services and how these apply to service demand projections.
- Sharing or co-developing strategic plans for local aged care services and how they interact with aged health specialist services and primary healthcare providers.
- Identifying core strategic priorities that are best driven within aged care services.
- Representing the views and needs of aged care service providers while identifying systemic solutions.
- Working with large NGOs and insurer groups on models of care to identify the best use of resources in the region to benefit the rapid progression of delivery models.

Other opportunities include:

- Co-funding arrangements between LHDs and RACFs to expand initiatives.
- Increase staff numbers and hours of operation.
- Develop a palliative care outreach program.
- More community nurses and Nurse Practitioners providing services in RACFs.

Table 3. Silver Chain case study

What is it? Silver Chain is a not-for-profit organisation based in Western Australia that provides Hospital in the Home (HITH) services to non-emergency hospital level care in metro Perth. This allows services to be delivered to older people in the home who would otherwise need to visit or stay in hospital. Services can include acute, post-acute, community and primary care services.

How it works: Hospital in the Home is a 24/7 hospital substitution program. Older people will receive quality and responsive acute care at home for which they would otherwise require a hospital admission or extended hospital stay by virtue of a medical condition and necessary treatment. Referrals can be through a public hospital/ED, GP, specialist or RACF.

Resourcing:

The health team consists of:

- Allied Health Professionals
- Enrolled Nurses (ENs)
- RNs
- Case Coordinators
- CNCs
- CNC Managers
- Nurse Practitioners
- Medical Practitioners.

Success factors:

- No cost to the referrer or older person – it is part of the Home Hospital and the Friend in Need Emergency Scheme, a WA Government initiative.
- Older person treated at home and avoids the stress of being transferred to hospital.
- The older person's usual GP may be involved in care.
- Supports early discharge from acute setting.
- Older person is able to access allied health services on assessed need.
- Reduced ED presentation, admission to hospital and less pressed on hospital beds.

Aged care service providers have noted the difficulty in having GPs attend residences to clinically review older people with complex health needs. Consequently, there is often rapid deterioration and/or unnecessary transfer to ED. This is a significant cost to the system and increases stress on the older person, their carer and family.

For this reason, hospitals in NSW have implemented various clinical response programs for emergency assessment at residences of older people and RACFs. These programs are hospital outreach services that deliver care to older people who are acute enough to warrant a same day review. Hospital staff work in collaboration with GPs and RACF staff to provide education on prevention, management and triage of acuity and offer resources to support older people remaining in place, where possible.

Benefits of such programs include:

- reduced stress on the older person, their carer and family as transfer to ED is not required
- reduced ambulance transfers, ED presentations, hospital admissions and use of diagnostics
- better continuity of care and opportunities to provide care as close to home as possible
- cross-sector skills transfer and up-skilling of RACF staff.

One example is the Better Health Care Connections: Aged Care Multidisciplinary Care Coordination and Advisory Service Program (the Program) – a new program under the Living Longer Living Better reform. The Program will provide $9.969 million over five years to support older Australians with complex health needs through:

- increased access to multidisciplinary teams of health professional to coordinate care and treatment
- an innovative pilot of GP consultations via video conferencing to RACFs.

Opportunities for NSW Ambulance

The NSW Ambulance (Ambulance) has a historical role in the health system of responding to emergencies. However, increasingly its role has been in responding to non-emergency requests for services. Ambulance data shows that 27% of call outs in 2011/2012 were for non-emergencies.[iii] Many of these call-outs are to older persons living alone who require clinical support after hours.

Given this increase in the use of ambulance services for this purpose and the broader health system aim to reduce ED presentations, the NSW Ambulance acted to implement a number of initiatives to improve the services to this group of non-emergency callouts by tailoring the make-up of their workforce. In this way, Ambulance have significant experience in allocating roles, redesigning services, processes and ICT systems for the needs of older people already.

NSW Ambulance currently provides a number of initiatives to reduce transfer to ED by managing older people at or close to home with programs such as:

Extended Care Paramedics (ECPs) - ECPs are dispatched to emergency calls to undertake specific assessment and care management. Their scope of practice is guided by predetermined care pathways.

Authorised Care Program (ACP) - One aspect of this program is an end-of-life pathway document (care plan) led by NSW Ambulance to provide ambulance services with a predetermined care pathway for the palliative patient or those with life limiting chronic health issues.

Critical Emergency Response Services (CERS) - A hospital facility with a limited ED workforce to meet their demand is able to draw on local ambulance resources to provide assistance with emergencies in the ED, this can be very effective in rural facilities.

Paramedic Connect - In low ambulance activity areas, paramedics complement community health services by undertaking activities such as dressings, monitoring medications at home post-discharge, applying compression stockings, health promotion and ED support.

> *"Our Extended Care Paramedics have really embraced the opportunity to think more laterally about the care of older people for whom they are called out to. They feel well supported by having a direct line to an on-call geriatrician at Nepean."*

These models have been specifically implemented to complement or address system failures that were exponentially increasing ED presentations and care costs. Specifically each model has required training and education of paramedics in new skills and roles. There are some practical steps in delineating clinical scope of practice and encouraging roles that are very different to core paramedic roles.

Older people (in the case of the ECPs) were extremely positive with feedback with their overall encounters with these services.

Currently, these models are being delivered in pockets across NSW but have the potential to be rolled out state-wide and adapted or selectively implemented where local needs exist.

Ambulance has a pivotal role in the NSW aged health and social care system as it is an intermediary or touch-point between all providers involved in this system (e.g. hospital, primary care, RACFs, carers). Similarly it is a 24hr service that delivers assessments support

[iii] *Ambulance Year in Review 2011/12*
http://www.ambulance.nsw.gov.au/Media/docs/Year%20in%20Review%2011%2012-f0937949-c33e-4990-9887-ec166c5931a7-0.pdf

or treatment at home and in the case of ECPs have appropriate skills to triage care need of an older person specifically.

Currently, relationships between Ambulance are at an LHD or state-wide level with limited interaction with MLs, primary care or aged care service providers specifically. The inclusion of this group in regional multi-sector aged health governance will enable discussion around crisis and acute response, planned transfers and logistics of in community care.

Specifically NSW Ambulance can support implementation by:

- Engaging NSW Ambulance in the vision of integrated care for older people with complex health needs.
- Sharing current data and information on call-outs and older people with complex needs in their care. This data and information is not readily accessible by LHDs and provides important information on the service utilisation of this population.
- Sharing or co-developing strategic plans for local aged care services and identifying best use of resources.
- Identifying core strategic priorities that are best driven by Ambulance.
- Representing the views and needs of Ambulance services whilst also identifying systemic solutions.

Table 4: Extended Care Paramedics case study

What is it? ECP is a program delivered by NSW Ambulance that increases the clinical role of a small group of selected paramedics in:

- patient assessment
- recognition and management of minor illness and minor injury presentations
- provision of definitive care
- referral to community-based health services for a range of presentations.

How it works: ECPs are dispatched to emergency calls to undertake specific assessment and care management. Their scope of practice is guided by predetermined care pathways that are in addition to Ambulance standard care protocols.

Clinical roles include:

- replacement of catheters in emergency situations
- provision of initial wound assessment and care (dressings/sutures)
- replacement of percutaneous endoscopic gastrostomy (PEG) tubes
- provision of falls screening and assessment for referral purposes
- provision of aged care screening and assessment for referral purposes
- commencement of pharmacotherapy administration
- education and clinical practice for ECPs is undertaken at the Nepean Clinical School and Nepean Hospital. Specific training and telephone support by geriatricians is provided to these paramedics in relation to clinical management, dementia and delirium, pharmacy – effectiveness and adversity in the elderly.

Resourcing: ECPs are experienced paramedics that undergo specialised training. They operate out of a small single response vehicles. The ECP program has been internally and externally evaluated. The cost effectiveness is realised through:

- salary of a single paramedic response rather than a double crew
- vehicle savings (ECP vehicles are less expensive to set up and lease and have lower ongoing running costs)
- higher non-transport rate: an ECP average non-transport rate of 50% compared to SC 14%, and a regional ECP non-transport rate is 54%
- reduced average case cycle time (CCT) which is 60 minutes (10–20 minutes less than average non-ECP vehicle) due to non-transport.

Success factors:

- Support of a senior aged health decision-maker such as a geriatrician.
- Paramedics with specialised clinical skills with a rigorous clinical governance framework in place.
- Strong relationship with RACFs including educating them on the model.
- Strong communication links with ED regarding those that require admission and opportunities to bypass ED.

Where this service been implemented:

- The dedicated ECP modules are located in Illawarra, across Sydney, Central Coast and Hunter.
- There are also ECPs working as part of a double crew are located across the state at Murwillumbah, Port Macquarie, Tweed Heads, Leeton, Cootamundra, Armidale, Shoalhaven, Wagga Wagga and other metropolitan locations.

Appendix A:
Glossary of terms and abbreviations

Abbreviation	Description
AARCS	Aged to Aged Related Care Services
ACAT	Aged Care Assessment Team
ACCHS	Aboriginal Community Controlled Health Services
ACD	Advanced Care Directive
ACE	Aged Care Emergency
ACI	Agency for Clinical Innovation, NSW
ACP	Advance Care Planning
ADL	activities of daily living
AH&MRC	Aboriginal Health and Medical Research Council
AHLO	Aboriginal Hospital Liaison Officer
AMA	Australian Medical Association
AMS	Aboriginal Medical Services
ASET	Aged Care Services Emergency Teams
BPSD	behavioural and psychological symtpoms
CACPs	Community Aged Care Packages
CALD	culturally and linguistically diverse
CCT	case cycle time
CDMP	Chronic Disease Management Plan
CERS	Critical Emergency Response Services
CNC	Clinical Nurse Consultant
DoH	Department of Health
DSS	Department of Social Services
ECP	Extended Care Paramedics
ED	emergency department
EMR	electronic medical record
EN	Enrolled Nurse
EOL	end-of-life

Abbreviation	Description
FACS	Department of Family and Community Services
GEM	Geriatric Evaluation and Management
GP	General Practitioner: the collective term used for doctors/physicians who are the main prescriber of medicines
HACC	Home and Community Care
HHS	Hospital and Health Services
HITH	Hospital In The Home
ICT	information and communications technology
LoS	length of stay
KPI	key performance indicator
LGA	Local Government Areas
LHD	Local Health District
LHN	Local Health Network
MAU	Medical Assessment Unit
MBS	Medicare Benefits Schedule
ML (or PHN)	Medicare Local (or Primary Health Network)
NGO	Non-Government Organisation
NHPA	National Health Performance Authority
NHRA	National Health Reform Agreement
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PEG	percutaneous endoscopic gastrostomy
RACF	Residential Aged Care Facility
SMHSOP	Specialist Mental Health Services for Older People
TACP	Transitional Aged Care Program

Appendix B: Participants in aged health and social care

This lists key participants and is by no means a list of every provider involved in their care.

Participants	Description
Older person with complex health needs	For the purposes of this Framework, an older person with complex health needs is one whose underlying comorbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis.
Carers	A carer is someone who provides personal care, support and assistance to a person with a chronic condition, terminal illness, disability, drug or alcohol dependency or who is frail. A carer may be a family member, partner or friend, and there may be multiple carers supporting an individual. Carers are often relied upon to provide significant levels of unpaid care, which can have a negative effect on their own mental and physical health, financial status and ability to participate in employment and community life. This effect is not always visible, as caring often happens in the home, and can reach a crisis point before carers will seek help. It is critical that the important role of carers and families is recognised and supported for this population.
Local Health District (LHD)	LHDs are regional (meso) level organisations responsible for providing health services in a wide range of settings. Eight LHDs and one LHN cover the greater Sydney metropolitan region and seven cover rural and regional NSW.
Medicare Local (ML) (or Primary Health Network [PHN])	MLs (or PHNs) are regional (meso) level primary healthcare organisations funded by the Australian Government. MLs (or PHNs) have five specific strategic objectives:[11] • improving the patient journey through developing integrated and coordinated services • providing support to clinicians and service providers to improve patient care • identifying the health needs of their local areas and development of locally focused and responsive services • facilitating the implementation of primary healthcare initiatives and programs • being efficient and accountable with strong governance and effective management.
Aboriginal health services	The vision for Aboriginal health services is health equity for Aboriginal people, with strong, respected Aboriginal communities in NSW, whose families and individuals enjoy good health and wellbeing. This recognises importance of partnerships between the NSW Government and the AH&MRC at the State level, and the continued need for strong partnerships between NSW LHDs and ACCHSs at the local level. ACCHSs are incorporated Aboriginal organisations, initiated by and based in, a local Aboriginal community that delivers a holistic and culturally-appropriate health service to the community that controls it. AHLOs provide a liaison service to Aboriginal and Torres Strait Islander patients admitted to hospital.
Community services	Community services are those that provide support and services to the older person, their carer and family, outside of those addressing their immediate health needs. These are providers whose services may not focus specifically on older people and includes a number of NGOs who have significant expertise and resources to offer. Community services have an important role in realising the vision to deliver care as close to home as possible and to connect older people and carers with bio-psychosocial supports and tangible support such as respite options.

Participants	Description
Primary healthcare providers	Primary healthcare providers include GPs, nurses, allied health professionals and pharmacists. Groups of networked or co-located primary healthcare providers are often referred to as 'general practice'. AMSs are also an example of a grouping of primary health and social care providers, together addressing the specific health and cultural needs of Aboriginal and Torres Strait Islander people.
Residential and community aged care providers (RACFs)	This includes both RACFs and other community-based aged care providers. There are over 800 such aged care organisations in NSW funded by the Australian Government. RACFs are a special-purpose facility providing accommodation and other types of support, including assistance with day-to-day living, intense forms of care and assistance for independent living to frail and aged. Community aged care providers provide services designed for older people to support their living and staying healthy in the community for as long as possible.
NSW Ambulance (Ambulance)	Ambulance provides a core role in responding to emergencies as well as providing care in non-emergency requests. Ambulance provides a number of initiatives to reduce patient transfers to EDs by managing older people at home and providing health promotion and prophylactic management of conditions.
Specialised aged healthcare services	Specialised aged healthcare services describe the provision of services by specialist aged health and SMHSOP. These services address issues that are unable to be addressed by organ-specific or disease-specific disciplines or other providers. The end goal is to maximise independence through optimising physical, psychological and cognitive function.
Diagnostic services	Diagnostic services are provided by private providers in the community or as part of a healthcare facility. Access to diagnostics is via a GP or specialist referral. Services delivered in the community attract some MBS rebates, and those delivered in a hospital are funded by the LHD.

Appendix C:
Broader governance stakeholders

The local system of care delivery for older people with complex needs does not exist in isolation of the broader policy and governance arrangements for aged health and social care. There are various levels of governance and policy that must be recognised and considered in the implementation of this Framework.

Broader governance stakeholders in the system of aged health and social care

Who	Description	Roles and responsibilities
Department of Health (DoH)	DoH provides all funding and policy responsibility for primary care. Their aim to achieve better health for all Australians is through: • strengthening evidence-based policy advice • improving program management • research • regulation • partnerships with other government agencies, consumers and stakeholders.	National policy makers. Funders of: • MLs (or PHNs) • MBS • PBS • Specific initiatives (e.g. Telehealth, eHealth). Performance monitoring.
Department of Social Services (DSS)	DSS vision is a strong and fair society for all Australians achieved through supporting our Minister by collaboratively developing and implementing excellent social policy. DSS is responsible for the delivery of quality, affordable and accessible aged care and carer support services for older people, including through subsidies and grants, industry assistance, training and regulation of the aged care sector.	National social service policy makers. Funders of: • ACATs • CACPs • RACFs • HACC services to be replaced by Commonwealth Home Support Program from 1 July 2015 • My Aged Care Gateway. Performance monitoring.
NSW Ministry of Health (MoH)	MoH has a core role in advising the Minister on policy, legislation and governance arrangements and stimulating system-wide initiatives that improve quality and efficiency, negotiating service agreements with LHDs, specialty networks, Pillars and HealthShare, monitoring against agreements and securing resources needed to deliver on policies.	NSW Health policy makers. Funders of LHDs, specialty networks, Pillars and HealthShare. Performance monitoring and management. Commissioners of services.
Local Health Districts (LHDs)	LHDs are regional (meso) level organisations responsible for providing health services in a wide range of settings. Eight LHDs and one LHN cover the greater Sydney metropolitan region and seven cover rural and regional NSW.	LHDs have responsibility and accountability for managing all aspects of hospital and health service delivery for their local district.

Who	Description	Roles and responsibilities
NSW Health Pillars	ACI is the lead agency in NSW for promoting innovation, engaging clinicians and designing and implementing new models of care.	ACI builds models of care based on the needs of patients and which are underpinned by extensive research conducted in collaboration with leading researchers, universities and research institutions.
	Health Education and Training Institute (HETI) supports and promotes coordinated education and training across NSW Health.	HETI ensures that world-class education and training resources are available to support the full range of roles across the public health system, including patient care, administration and support services.
	Clinical Excellence Commission (CEC) was established to promote and support improved clinical care, safety and quality across NSW.	CEC has a central role in the responsibility for quality and safety in the NSW health system.
	Bureau of Health Information (BHI) seeks to achieve excellence in the provision of relevant and impartial information for the people of NSW about their public health system.	BHI works to inform, evaluate and advise on efforts to improve patient care and is the leading source of information on the performance of the NSW public health system.
Medicare Local (ML) (or Primary Health Network [PHN])	MLs (or PHNs) are regional (meso) level primary healthcare organisations. MLs (or PHNs) have five specific strategic objectives: 1. Improving the patient journey through developing integrated and coordinated services. 2. Providing support to clinicians and service providers to improve patient care. 3. Identifying the health needs of their local areas and development of locally focused and responsive services. 4. Facilitating the implementation of primary healthcare initiatives and programs. 5. Being efficient and accountable with strong governance and effective management.	MLs (or PHNs) are tasked with: • population needs analysis and service mapping for primary healthcare services • planning and supporting the effective local delivery of coordinated and integrated primary healthcare services • enabling and supporting the implementation of a range of community-based national programs and aspects of NHRA (e.g. eHealth, Telehealth).
Aged and Community Services Australia (ACSA) and Leading Age Services Australia (LASA)	ACSA is the national peak body representing not-for-profit and faith-based providers of residential and community care, and housing and support for people with a disability and their carers. LASA represents all industry participants for age services across Australia. They are committed to improving standards, equality and efficiency for the aged services industry and advocate for the health, community and accommodation needs for older Australians, working with government and other stakeholders to advance the interests of all aged service providers.	ACSA has a key role advocating for the industry to ensure Australia has a sustainable system able to deliver quality services and care for our ageing population. LASA plays a leadership role in shaping the strategic direction and vision for the care and wellbeing of older Australians for the benefit and betterment of older persons in Australia.

Who	Description	Roles and responsibilities
Australian Medical Association (AMA)	The AMA is an independent organisation which represents more than 27,000 doctors and is the peak body representing registered medical practitioners and medical students of Australia. The AMA promotes and protects the professional interests of doctors and healthcare needs of patients and communities.	Working with governments to maintain and increase provision of medical care to Australians. Tracking and reporting government performance on health policy, financing, services and programs. Providing policy position statements to the government. Providing informed expert medical commentary. Developing and promoting health policies and responding to issues in the health debate.
Professional associations and groups	The Royal Australian College of General Practitioners (RACGP) Australian and New Zealand Society for Geriatric Medicine (ANZSGM) Faculty of Psychiatry of Old Age (FPOA) Royal Australian and New Zealand College of Psychiatrists (RANZCP) Royal Australasian College of Physicians (RACP) Psychogeriatric Nurses' Association Australia (PGNA) Australian Practice Nurses Association (APNA) Allied Health Associations	Maintain professional standards. Lobby and advocate on issues that influence their membership. Provide education and training resources.
Mental Health Commission of NSW	To prepare a strategic plan of mental health services in NSW.	Monitor its implementation and provide oversight of and advocacy for mental healthcare.

Appendix D: King's Fund top 16 needs to make integrated care happen

The following are the King's Fund's top 16 needs to make integrated care happen at scale and pace.

1. Find common cause with partners and be prepared to share sovereignty.
2. Develop a shared narrative to explain why integrated care matters.
3. Develop a persuasive vision to describe what integrated care will achieve.
4. Establish shared leadership.
5. Create time and space to develop understanding and new ways of working.
6. Identify services and user groups where benefits from integrated care are the greatest.
7. Build integrated care from the bottom up as well as the top down.
8. Pool resources to enable commissioners and integrated teams to use resources flexibly.
9. Recognise that there is no 'best way' of integrating care.
10. Support and empower users to take more control over their health and wellbeing.
11. Share information about users with the support of appropriate information governance.
12. Use the workforce effectively and be open to innovations in skill mix and staff substitution.
13. Innovate in the use of contracting and payment mechanisms and use of the independent sector.
14. Set specific objectives and measure and evaluate progress towards these objectives.
15. Be realistic about the costs of integrated care.
16. Act on all these lessons together as part of a coherent strategy.

Appendix E: Person-centred medical home

The concept of a medical home or having a regular provider within a healthcare team is increasingly recognised to improve population health planning and strengthen integration, coordination and continuity of care for patients.[1,2]

The person-centred medical home includes a patient-chosen clinician to be responsible for a patient's ongoing and comprehensive, whole-person medical care. This clinician is usually a GP. In a medical home, patients, their families and carers have a continuing relationship with a particular GP; this partnership is supported by a practice team, and other clinical services in the medical neighbourhood. The medical home coordinates the care delivered by all members of a person's care team, which may sometimes include hospital inpatient care. The medical home ensures that each person experiences integrated (joined-up) healthcare.[3]

Under this approach, a GP Inreach program is facilitated in the hospital setting. Thus, the medical home is always informed and consulted at admission, able to access progress during admission (e.g. virtually) and informed and consulted at discharge. This approach builds on a shared care approach where care isn't handed over; therefore, many of the problems inherent in clinical handover fall away.

It is the role of the hospital staff to communicate with a patient's medical home. LHDs and other service providers should consider how they work with MLs (or PHNs) to develop a process for identifying a medical home for patients who do not have a coordinating clinician (e.g. GP), particularly for patients with complex needs.

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