Integrated Care

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Part One

Sourced from Ministry of Health Integrated Care Branch
Various drivers are placing increasing pressure on our health system

- Growing and ageing population
- Increased number of people living with long term conditions
- Improvements in technology
- Increasing number of people living with long term conditions
- Productivity targets
- Increasing specialisation in medicine and nursing
- Rising consumer expectations
- Societal changes
Our current system is siloed and geared to episodic care, focusing on patient outcomes by exception.

“Systems designed to treat occasional episodes of care for normally healthy people are being used to deliver care for people who have complex and long term conditions.

The result is that they are passed from silo to silo without the system having the ability to co-ordinate different providers”

S Dorrell, NHS Health Service Journal, 2011
The health system is not sustainable or fit for purpose

Health system is siloed and designed around episodes of care

Growing pressures on health system

Broad range of health system inefficiencies

To achieve a sustainable health system that supports the people of NSW requires a significant shift
Integrated care is central to building a sustainable health system

Today

- Fragmented (often)
- Episodic (largely)
- Inefficient (in parts)
- Unsustainable

Tomorrow

Integrated

Sustainable system of integrated care
What is integrated care?

Integrated Care meets a person’s needs by providing seamless, effective and efficient care, organised for, by and with the person, from prevention through to end of life.

- **Care is person centred**: Care is organised for, by and with the person by bringing care to the person’s community or home rather than the person to the care.

- **Care is a seamless continuum**: Care is organised across spectrum of care ranging from social and preventative, to primary and acute, through to aged and end-of-life care.

- **Care is effective**: Care results in the outcomes that are desired by the patient and reflect achieved health status, recovery process and sustainability of health.

- **Care is efficient**: Care makes efficient use of both financial and human resources.

Value-based healthcare

NSW Agency for Clinical Innovation
Integrated care is everyone’s business

Integrated care is everyone’s business. Multiple health providers need to connect around a person’s needs to provide seamless care and help navigate a complex system – this requires tackling cultural, funding, workforce and information barriers.
What have we done?

NSW already has a number of programs which aim to integrate care in some way

- HealthOne NSW creates a stronger primary health care system by bringing Commonwealth-funded general practice and state-funded primary and community health care services together
- Since 2006/07, NSW has committed $46 million to the capital development of HealthOne services. A further $5 million per annum is available to LHDs to support nursing, allied health and service integration positions within HealthOne NSW
- The NSW Chronic Disease Management Program (Connecting Care in the Community)'s mission is to deliver more effective health management for people with chronic diseases at high risk of unplanned hospital or Emergency Department presentation
- The Program to enrolled 43,000 people over four years to present a new model of joined and shared care across the NSW. This program delivers integrated, patient focussed, whole person approach when addressing patient clinical and non clinical functional deficits.
- Hospital in the Home services
- Com Packs
- Transitional Aged Care program
- GRACE
- Aged Care Assessment Teams etc.

More programs …
### Integrated care strategy for NSW focuses on three different inter-related tranches

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<thead>
<tr>
<th>Description</th>
<th>Goal</th>
<th>Indicative funding levels</th>
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<tbody>
<tr>
<td>Investment in enabling environment infrastructure for integrated care at the State level, focused on information, outcomes measurement and patient feedback, capacity building and evaluation of the integrated care program as a whole.</td>
<td>Establish key enablers of integrated care benefiting all LHDs and stakeholders</td>
<td>~25-30%</td>
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<td>Investment in individual integrated care initiatives to drive transformation, alongside supporting strategic planning for integrated care at the local level, and extension of successful integrated care approaches from the Demonstrator LHDs.</td>
<td>Support local planning, collaboration and innovation initiatives</td>
<td>~25-35%</td>
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<td>Establish three LHD-led Integrated Care Demonstrators to run over four years, aimed at supporting large-scale transformation of integrated local health systems and testing initiatives prior to extension across the State.</td>
<td>Develop system-wide integrated care approaches in three LHDs that are transferrable and scaleable</td>
<td>~40-45%</td>
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Strong relationships need to be developed with primary care organisations, NGOs and private providers.
How do the 3 strategy investment tranches fit together?

- **Central investment in enablers**
  - Provide state-wide enablers
    - Provide the foundations for integrating care

- **Demonstration in 3 locations**
  - Develop and test system-wide integrated care approaches (Demonstrators)
    - Share learnings
    - Support the implementation of successful approaches
    - Provide the foundations for integrating care

- **Statewide implementation and roll out**
  - Support other local ideas and roll out of successful initiatives through the Planning and Innovation Fund

Integrate care as the norm in NSW
Investment in integrated care is a substantial part of the wider policy and strategy development.

Full strategy and integrated care policy framework development over ten years

Investment in integrated care is the starting point of the wider integrated care strategy and policy framework development.

$120M investment in integrated care

Year 1

Year 10

Time
Experience highlights 10 building blocks which need to be part of a holistic approach to integrated care

<table>
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<th>Driver of integration</th>
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<tr>
<td>Information and other infrastructure</td>
<td>Design, develop and roll-out infrastructure required by providers to be able to deliver integrated care, including supporting IT &amp; e-health as well as administration and other infrastructure</td>
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<tr>
<td>Collaboration framework &amp; workforce</td>
<td>Develop methods &amp; plans that non-financially motivate providers to collaborate and provide integrated care and allow for flexible workforce (e.g., update workforce models/roles, devise shared targets/KPIs)</td>
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<tr>
<td>Patient focus</td>
<td>Provide care in a personalised and patient centred way (e.g., enable patients to take responsibility for their own care, support shared decision making, build convenient care, close to the community)</td>
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<td>Outcomes monitoring &amp; feedback</td>
<td>Routinely track and feedback on care outcomes, including patient experience, patient outcomes, quality of care, efficiency and cost</td>
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<tr>
<td>Funding models &amp; incentives</td>
<td>Develop financing models and incentives to support the collaboration of different providers and the delivery of care in an integrated way (e.g., create new funding models, link incentives to outcomes)</td>
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<tr>
<td>Prevention focus</td>
<td>Screen population, manage people at high risk, provide care proactively to prevent worsening of health status and provide health education both to consumers and providers</td>
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<tr>
<td>Connect health &amp; social care</td>
<td>Design includes a social component, linking different care types (health, social, aged, family support), organise care proactive for vulnerable populations, reflect wider determinants</td>
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<tr>
<td>Clinical practice</td>
<td>Develop innovative practices to provide better, more integrated care (e.g., clinical pathways &amp; protocols, strategically expand/relocate services)</td>
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<tr>
<td>Governance, provider links &amp; commissioning</td>
<td>Design high level links and governance structures across providers to allow for integrated care (e.g., joint decision making, communication models, enhance leadership and build commissioning capabilities)</td>
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<tr>
<td>Care coordination</td>
<td>Build care coordination methods to provide care in a seamless way across different providers/types of care (e.g., central entry point, care navigation and care planning, discharge management)</td>
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Achieving integrated care at a systems level requires a focus on all of these drivers
Part Two
What are partnerships like?

- Opportunistic
- Reliant on personalities and relationships
- Evolving and often Messy

- Egs: Osteoporosis Prevention; Chronic Disease Program; Health Ones; RACF/ED Partnerships
Lessons from 7 Studies

- No single model best supports integrated care.

- Integrated care is a process that must be led, managed and nurtured over time.
Making Partnerships Work

- Making Integrated Care Happen at Scale and Pace
- 16 Lessons from Experience
Working Together

- Shared Narrative
- Persuasive Vision
- Shared Leadership and Governance
Time and Space

- To build trust
- At all levels of the system
- Clinical leaders are central to this
Prioritise

- Identify services and user groups where the potential benefits are the greatest
Bottom up and top down
Flexible resourcing

- Pool resources
- Innovate in contracting and commissioning
- Be realistic about cost
- Osteoporotic Refracture, Chronic Disease Management Program
Empower users

- To make informed health decisions (coaching, advanced care planning)
- To purchase
- To control their health decisions (shared decision making tools)
Share information about users

- Integrated care is often underpinned by commitment to sharing information
- Appropriate governance
- Not overzealous interpretation of the rules
- Secure messaging (Argus), Health Pathways, PCEHR
Lessons from 7 Studies

- No single model best supports integrated care.

- Integrated care is a process that must be led, managed and nurtured over time.
Leutz’s 5 Laws of Integrated Care

1. You can’t integrated all of the services for all of the people
2. Integration costs before it pays
3. Your integration is my fragmentation
4. You can’t integrate a square peg in a round hole
5. The one who integrates calls the tune
How are you integrating with similar programs, populations and systems?
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