COORDINARE

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SOUTH EASTERN NSW
An Australian Government Initiative

NSW GOVERNMENT Health
Southern NSW
Local Health District

Southern New South Wales Integrated Care Strategy

CONTENTS

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EXECUTIVE SUMMARY

The Southern NSW Integrated Care Strategy outlines the commitment of COORDINARE, the South Eastern NSW Primary Health Network (PHN) and Southern NSW Local Health District (SNSWLHD) to work collaboratively to integrate healthcare for residents living in Southern NSW. Integrated care is a collaborative approach to strengthen person-centred health care delivery through the provision of coordinated, high quality care across the lifespan. Our vision is:

HEALTHY TOGETHER

Working with our community to support health and wellbeing across Southern NSW

This vision reflects the intent of both organisations to support and deliver person centred healthcare that is safe, effective and coordinated. The vision acknowledges the need to work with local communities to assist people in Southern NSW to lead healthy lives. COORDINARE and SNSWLHD are committed to working together to ensure safe, effective and sustainable delivery of health services.

Four **key health priority** areas have been identified in this strategy. The Strategy seeks to:

1. Improve **Aboriginal Health** – Integration of care across the region will improve the provision of connected, more culturally appropriate care for the Aboriginal community.
2. Improve care coordination for those living with **Chronic Conditions** – There is a significant opportunity to improve the coordination of care provided to people with chronic conditions, their experience with health care providers and their quality of life.
3. Implement the Regional **Mental Health, Drug & Alcohol and Suicide Prevention** Strategy – By working together we can reorient our regional mental health system to offer a stepped care approach to people with or at risk of mental illness.
4. Increase integration of **End of Life care** – Increased integration of care will improve outcomes for patients with palliative and end of life needs, and their families and carers, by providing greater support for dying at place of preference.

To facilitate ongoing improvements in the systematic and organisational arrangements between health care providers key **enablers** have been identified to underpin the strategy. Key enablers for the Southern NSW Integrated Care Strategy include consumer participation, data exchange, the engagement of general practitioner liaison officers, HealthPathways, integrated workforce planning and joint service commissioning.

The Southern NSW Integrated Care Strategy supports four broad **improvement objectives** for the regional area:

- Improve health outcomes for the population
- Improve the cost effectiveness of the health system
- Improve the experience for patients, families and carers
- Improve experience for service providers and clinicians.

The Strategy outlines the collaborative ways of working and is underpinned by a work plan. The work plan outlines the identified projects in the priority health areas and enablers, which will enhance the integration of care and improve outcomes for the residents in Southern NSW.

OUR ORGANISATIONS

COORDINARE - South Eastern NSW Primary Health Network (PHN)

COORDINARE is the Primary Health Network for South Eastern NSW, which includes the Illawarra Shoalhaven region. It is a not-for-profit public company, limited by guarantee, which was formed in July 2015, with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time. The organisation does this by putting consumers front and centre in all that we do; supporting general practice as the cornerstone of primary care; influencing the market through provider engagement and commissioning, partnering to integrate services and systems and building local networks and place-based leadership.

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

COORDINARE's two GP-led Clinical Councils and Community Advisory Committee advise the Board, ensuring there is community, consumer and clinical input and influence in the planning, prioritisation and evaluation of the strategy and performance. COORDINARE's governance structure embeds strong links between the Board, its Councils and Committee, enabling these to have a high degree of influence on the Board.

Southern NSW Local Health District

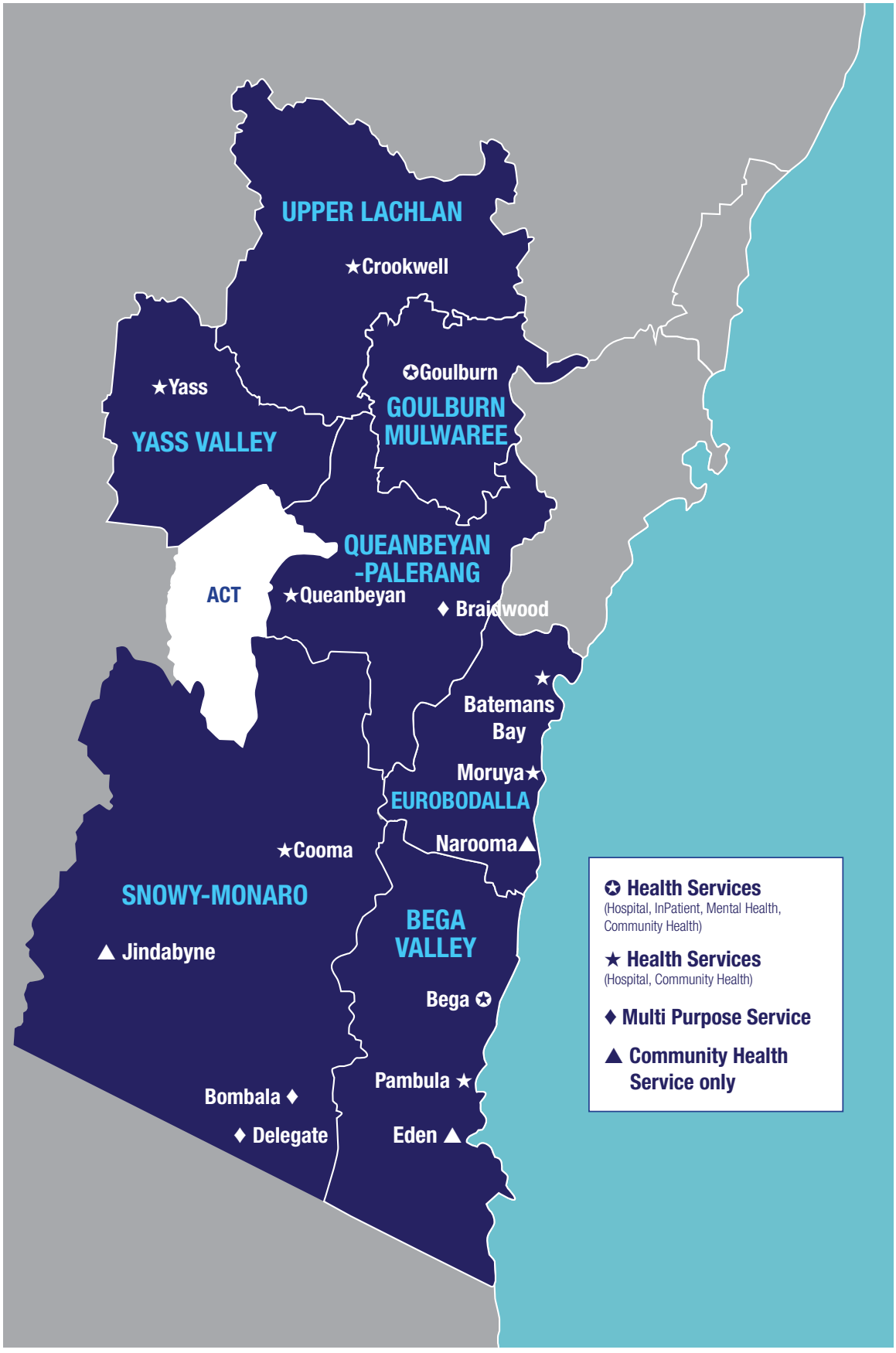
Southern NSW Local Health District (SNSWLHD) provides services across the southern region of NSW, from Batemans Bay, Bega, Bombala, Braidwood, Cooma, Crookwell, Delegate, Eden, Goulburn, Jindabyne, Moruya, Narooma, Pambula, Queanbeyan, and Yass.

SNSWLHD's facilities provide a range of services including emergency, intensive care, medical and surgical services, acute, sub-acute and non-acute mental health services, and primary and community health services.

SNSWLHD's governance structures provide clinical and operational directive through local, District Executive and District Board input into the delivery of health services across the region. Service delivery is aligned to the priorities set by the NSW Ministry of Health and tailored to meet local community demand.

OUR COMMUNITIES

SNSWLHD is covered by the traditional lands of four Aboriginal nations – the Gundugurra, Ngunnawal, Ngarigo and Yuin Nations. The estimated population is 206,815 and the district spans 44,534 square kilometres over seven local government areas (LGAs): Bega Valley, Eurobodalla, Goulburn Mulwaree, Queanbeyan-Palerang, Snowy Monaro, Upper Lachlan and Yass Valley.



The District surrounds the Australian Capital Territory, with many Southern NSW community members accessing acute or specialist health care services in the ACT. A cross border agreement is in place between the NSW and ACT Government to ensure residents across the region can access the most appropriate care according to their health care needs.

COORDINARE and SNSWLHD work closely with Capital Health Network and ACT Health to coordinate service delivery and have a number of projects underway to strengthen the integration of care.

INTEGRATED CARE IN NEW SOUTH WALES

NSW Health has a long-standing commitment to progressing work across Integrated Care. Integrated Care is one of three strategic directions included in the NSW State Health Plan: Towards 2021[1]. The work completed to date includes the development of the NSW Integrated Care Strategy, which commenced in 2014 with $200 million committed over six years to implement innovative, locally led models of integration of care[2].

In Australia all governments have committed to a shared responsibility to integrate systems and services to improve health outcomes for Australians under the Commonwealth National Health Reform Agreement. In December 2017, a Bilateral Agreement was made between the Commonwealth and New South Wales to undertake coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services. The Agreement names data collection and analysis, system integration and care coordination, as critical underlying structures of joint coordination and reform. These priority areas are listed as relevant to NSW local needs and circumstances: palliative and end of life care, multidisciplinary team care, aged care, rural and remote health, and mental health.

Southern NSW Local Health District's mission is 'Delivering healthcare that matters', with the vision 'helping people lead healthy lives'. The aim is to ensure people across the diverse communities have timely access to the right health care in the right setting to maximise their health, wellbeing and independence. As a key action to support this mission, SNSWLHD has established a dedicated program area for integrated care and is currently undertaking a number of projects to improve the internal and external integration of services across the district. This has included the launch of the Community Health Central Intake Service in April 2018, and targeted partnership work with COORDINARE, ACT Health and Capital Health Network on the ACT and Southern NSW HealthPathways Project.

Integrated care is one of COORDINARE's six strategic priorities, stated as "Partnering to integrate services and systems". COORDINARE's aspiration is that patients and consumers in the region experience care which is seamless, timely and appropriate. To achieve this COORDINARE has built strategic alliances with health partners and developed joint plans for system improvement including the Regional Mental Health and Suicide Prevention plan. COORDINARE has jointly invested in integration enablers such as GP Liaison Officer roles, HealthPathways and digital health initiatives. COORDINARE is also trialling new models of integrated care and exploring co-commissioning approaches.

Integrated Care is a long-term vision for change across the healthcare sector that aims to deliver seamless care aligned to the needs of each community[3]. Work towards the integration of care is focussed on systems integration, in order to create efficiencies in service delivery and ultimately improve the experiences and outcomes for people, their families and carers.

THE STRATEGY

The Southern NSW Integrated Care Strategy will operate within the NSW Health and Commonwealth Primary Health Care Systems and where these services intersect with other health and social care services. The role of general practice and primary care is essential to lead and support the delivery of care associated with the strategy.

The aim of the strategy is for Integrated Care to support better care within a targeted service delivery model, providing care when it is needed. Integrated care is particularly important for vulnerable and at-risk populations, including older people, those with disability or mental health issues, people with complex health and social needs, culturally and linguistically diverse or Aboriginal and Torres Strait Islander backgrounds, or those experiencing domestic and family violence[4].

The joint Southern NSW Integrated Care Strategy builds on the already established Strategic Alliance between COORDINARE and SNSWLHD, and provides a platform to ensure ongoing focus on priority population initiatives. The Strategy:

- articulates a clear vision for integrated care in Southern NSW across the next three years
- outlines principles, enablers and expected outcomes for achieving the vision, monitoring and evaluation
- strengthens collaboration with key stakeholders, including people, families and carers, general practitioners, health and social care providers, and other government agencies
- aligns projects, programs of work and opportunities to enhance client experience through integration within a consolidated work plan to ensure transparency and visibility of initiatives underway.

1 NSW Health, 2014
2 NSW Ministry of Health, 2016
3 World Health Organisation, 2016
4 Sansosi, Grootemaat, Seraji, Blanchart, & Snoek, 2015

VISION AND PRINCIPLES

The vision for the Southern NSW Integrated Care Strategy, ***Healthy Together: Working with our community to support health and wellbeing across Southern NSW***, reflects the commitment of COORDINARE and Southern NSW Local Health District to work collaboratively to ensure safe, effective and sustainable delivery of health services that are designed to meet the needs of the local community.

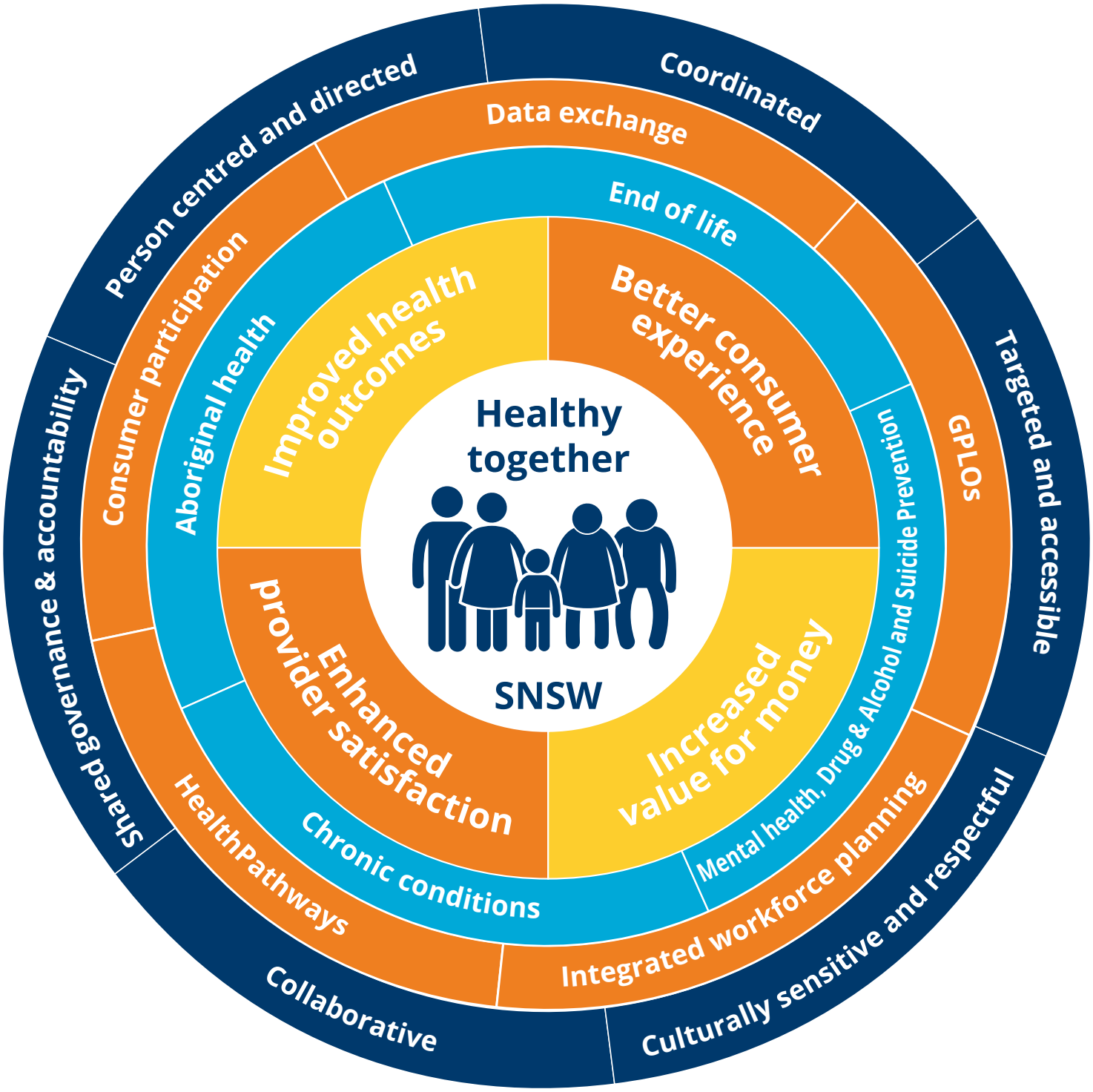
The vision is underpinned by six **principles**, guiding the shared approach to integrated care and the delivery of care.

- **Person centred and directed** – People are empowered to self-manage their health and are actively involved in care and treatment decisions. Regular consumer feedback about their experiences of care is used to monitor and guide service improvements.
- **Coordinated** – Members of integrated care teams work together in complimentary roles with a focus on cooperation to deliver and plan care including transitions across care settings. There is effective sharing of data to enable shared decision making.
- **Targeted and accessible** – Integrated care is targeted to priority health areas and populations in Southern NSW that have the most to benefit from improved care coordination. Accessible services are readily available, with a no-wrong-door entry point, ensuing that people can access the right service regardless of how they enter a service.
- **Shared governance and accountability** – The Strategic Alliance provides overall governance of the Integrated Care Strategy, an executed Memorandum of Understanding states the agreement of the two organisations to work together, and the objectives of integrated care are mutually beneficial. At a program and service level appropriate reporting and governance mechanisms are in place to ensure safety and quality.
- **Collaborative** – Within healthcare, collaboration involves care professionals working together in complimentary roles, with a focus on cooperation, shared responsibility and shared decision making. Collaboration occurs with the client at the centre, and is built on a framework of trust and respect.
- **Culturally sensitive and respectful** – The Integrated Care Strategy reflects the understanding that for Aboriginal people, the social, emotional and cultural health of the community is critical to the wellbeing of the individual. Members of the care team are required to undertake cultural sensitivity training to ensure services are delivered safely and in a respectful and culturally sensitive manner.

THE STRATEGY ON A PAGE

HEALTHY TOGETHER

Working with our community to support health and wellbeing across Southern NSW



SHARED HEALTH PRIORITIES

Improving the integration of care will mean people, their families and carers access the right type of care, provided by the right person, at the right time and in the right place. Work undertaken as part of the strategy will assist local service providers and clinicians to more effectively collaborate within health care settings and out into the community.

There are identified groups in the community who have the most to gain from services working better together: **Aboriginal people, people with chronic conditions, people with mental illness and people who are at the end of their life.**

The Southern NSW Integrated Care Strategy articulates key projects underway and projects planned that involve targeted engagement and partnership work across primary and secondary care. Projects align to the four health priority areas, with the many projects including focus across more than one priority area.

The Southern NSW Integrated Care Strategy projects are time limited, outcome driven and involve sub-committees who will report back to the Integrated Care Strategy working group. Detailed work plans are included at the end of the Strategy.

1. ABORIGINAL HEALTH

COORDINARE and SNSWLHD acknowledge the significant unfair health disparities between Aboriginal and Non-Aboriginal people. The Aboriginal community comprises approximately 4.2% of the local population (around 8,700 people). Aboriginal people tend to underuse primary care services[5], and have higher modifiable risk factors. As a result, Aboriginal residents present more frequently to hospital, and have shorter life expectancies.

COORDINARE and the SNSWLHD will work together with Aboriginal Community Controlled Healthcare Organisations, and other primary care providers across the region to improve the provision of connected, more culturally appropriate care for the Aboriginal community.

WHAT DOES THE DATA TELL US?

- Approximately 2600 or 30% of Aboriginal residents in the LHD live in the Eurobodalla LGA, 2100 or 24% in Queanbeyan-Palerang, 1500 or 17% in Goulburn Mulwaree, 1300 or 15% in Bega Valley.
- The **Aboriginal population is young:** 61% of the population or more than 5000 are aged 0-29 years, compared to 32% of the non-Aboriginal population.
- SNSW Aboriginal children's immunisation rates are currently at or close to target. In the quarter to June 2018 higher than non-Aboriginal children for the 1, 2 and 5 year age groups with rates of 95%, 94% and 97% respectively[6].
- Aboriginal people have **shorter life expectancies.** Only 8% of the population or around 720 people are aged over 60 years, compared to 30% of the non-Aboriginal population.
- Rates of **potentially preventable hospitalisation** in the Aboriginal population are 2.5 times higher than in the non-Aboriginal population.
- **Chronic conditions** are responsible for 70% of the health gap between Aboriginal and non-Aboriginal Australians.
- Rates of **smoking during pregnancy** in Aboriginal mothers are 3.7 times higher than non-Aboriginal mothers.
- The most common causes of hospitalisation in 2016/17 included:
  - Dialysis (7 times higher than the rate for non-Aboriginal people)
  - Mental disorders (2.7 times higher)
  - Maternal, neonatal and congenital (1.6 times higher).

5 Australian Institute of Health and Welfare 2014. Access to primary health care relative to need for Indigenous Australians. Cat. No/
6 Australian Immunisation Register, Southern NSW, June 2018

WHAT HAVE CONSUMERS TOLD US?

- Aboriginal and Torres Strait Islander people experience racism when accessing mainstream health services.
- Medical staff need to be more culturally appropriate and respectful in their dealings with Aboriginal and Torres Strait Islanders[7].
- Medical staff could help people more if they were educated on Closing the Gap prescriptions and the range of services available to Aboriginal and Torres Strait Islanders[7].
- The Aunty Jean's program (for Aboriginal and Torres Strait Islander peoples with chronic and complex care needs) is highly valued as it provides a holistic approach to well-being[7].
- Aboriginal Health Workers are greatly valued due to their close connection with Aboriginal and Torres Strait Islander people and their ability to keep a watchful eye on people's well-being and know when additional or modified care is required. In addition, their ability to transport people to and from services further assures continuity of quality care[7].

WHAT HAVE HEALTH PROFESSIONALS TOLD US?

- Aboriginal Community Controlled Health Organisations (ACCHOs), and Aboriginal Health Workers within State and Primary Care settings provide holistic care to their consumers and value the ability to determine their own priorities, in consultation with their communities.
- General practices and other mainstream services want to provide culturally-sensitive and respectful services to Aboriginal people and look for support to do so.
- There is a need to improve communication and transfer of care when Aboriginal patients are transferred from tertiary facilities back to their home community.

WHAT ARE OUR OBJECTIVES?

Together we will address identified health issues for the local Aboriginal communities to help close the gap, with particular focus on:

- improving and maintaining the rates of childhood immunisation, and
- increasing access to, and participation in, chronic condition programs
- strengthen the cultural competency of health professionals in the Southern region.

WHAT WILL WE DO TOGETHER?

- **1.1 Integrated Team Care program communication and support:** Improve coordination of services and identify service gaps by strengthening the relationship between all agencies.
- **1.2 HealthPathways localised for Aboriginal services:** Develop localised pathways and consumer resources for Aboriginal Health services and programs.
- **1.3 Increase access to specialist services for Aboriginal clients:** To introduce clinical specialty services, prioritising access for Aboriginal clients in Southern NSW.

7 COORDINARE commissioned Self-Managed Care Consumer and Carer Consultations November 2017

2. CHRONIC CONDITIONS

Chronic conditions last for many years and require ongoing management by the person in line with their condition and current health needs. Often chronic conditions require support from multiple health care workers, with monitoring and support provided in partnership between the person and their health care team.

The greatest burden of disease on the community is from chronic conditions. Care is provided across a continuum, with the level of support identified according to the phase of the condition and the needs of the individual person. A large proportion of the burden of chronic conditions can be prevented through lifestyle choices early in life. Active identification and early intervention can reduce the impact of chronic conditions on the person, community and health system.

There is a significant opportunity for COORDINARE and SNSWLHD to improve the care provided to people with chronic conditions, their experience with health care providers and their quality of life.

WHAT DOES THE DATA TELL US?

- SENSW has higher than NSW and Australian average figures for prevalence of chronic obstructive pulmonary disease, asthma and arthritis. Respiratory and asthma prevalence is higher in SNSW than in Illawarra Shoalhaven. Service providers in SNSW have reported diabetes and musculoskeletal disease as the two biggest contributors to the chronic condition burden amongst patients.
- 27% of the population in SNSW is estimated to have more than one chronic condition adding to the complexity of their health needs.
- LGAs of Eurobodalla, Goulburn Mulwaree have the highest prevalence of most chronic conditions in SNSW.
- Significantly high rates of opioid prescription for the region, in particular the South Coast NSW is placed in the 2nd highest Australian decile for opioid prescription rates.
- The prevalence of asthma and diabetes within the Aboriginal population is particularly high compared to the non-Aboriginal population. Within potentially preventable hospitalisations, rates for Aboriginal people are 2.6 times higher for 'chronic' category of conditions than for non-Aboriginal people most commonly due to diabetes complications and COPD
- Chronic conditions account for 70% of the health gaps between Aboriginal and non-Aboriginal people.

WHAT HAVE CONSUMERS TOLD US?

- Educate consumers and carers on their condition and warning signs that indicate the need to seek further attention. [7,11]
- Validate and acknowledge the valuable role of the carer in managing chronic conditions – identify strategies that carers can practice to improve their ability to deliver and sustain caring related responsibilities[7].
- Where appropriate, appoint the GP as the central point for coordination[7].
- Provide clear instructions around medication[7,11].
- There is difficulty accessing treatments due to limited service availability, long waiting times and cost barriers, which leads to further deterioration in both mental and physical wellbeing[12].
- There is a lack of awareness of wellness programs and inadequate local opportunities to be physically active, improve diet and manage weight[12].

WHAT HAVE HEALTH PROFESSIONALS TOLD US?

- Lack of coordination between providers in the health system impacts on efficient service delivery and improved health outcomes[12].
- A lack of service providers to support interdisciplinary team care[12].
- Many consumers are unable or unwilling to pay out of pocket cost for services that are available[12].
- Collaborative relationships between medical and allied health providers assist with providing comprehensive care to people with complex chronic conditions such as chronic pain[13].

11 TRG Research Report: Patient centred care to reduce unplanned readmission within 28 days. Dot Hughes, Uta Conway, David Schmidt. SNSWLHD, December 2017.
12 COORDINARE Health priority: Chronic conditions
13 Southern Clinical Council, August 2018 Meeting Minutes

WHAT ARE OUR OBJECTIVES?

- Improve care coordination for people with chronic conditions with the GP as the lead health professional.
- Consult and involve consumers in planning and developing services and redesign activities.
- Explore opportunities to strengthen the focus on prevention, education and early intervention programs to improve the management and reduce the impact of chronic conditions.

WHAT WILL WE DO TOGETHER?

- **2.1 Outreach pain management education and services**: Increase access to specialist pain management services as well as build capacity of LHD and primary care clinicians in best practice pain management.
- **2.2 Goulburn Redesign Project – Integrated Model of Community Care:** Design models of care with consumers of local health services. Implement an integrated model of care which responds to the need of individuals through coordinated care delivery.
- **2.3 Integrated care for people with chronic and complex conditions (ICPCC):** Develop a risk stratification matrix to identify high risk consumers requiring shared care plans. Align the care coordination of ICPCC complex consumers with GP shared care planning.

3. MENTAL HEALTH, DRUG & ALCOHOL AND SUICIDE PREVENTION

Mental health has been agreed at Chief Executive level as one of two joint priorities across the broader South Eastern NSW region. That means COORDINARE, Southern NSW LHD and the Illawarra-Shoalhaven LHD have committed to work together to improve mental health services and supports right across the region.

A key premise for the work is that a regional mental health system should offer stepped care to all people in the region. A stepped care approach is a staged system of options that match to an individual's needs, ranging from the least to the most intensive. The multiple levels of a stepped care approach do not operate in silos or as directional steps, but instead offer a spectrum of service and support options. In essence, a stepped care approach allows an individual to access the right service to meet their needs at the right time, to maintain their wellness, or to support their recovery back to wellness, as required. This need is reflected in the Regional Mental Health and Suicide Prevention Plan developed in Southern NSW in 2018.

WHAT DOES THE DATA TELL US?

- SENSW has a higher than national average of persons suffering from some form of long term mental or behaviour problem (13.69 per 100 persons) with rates particularly high in Bega Valley, Eurobodalla and Goulburn Mulwaree LGAs.
- In 2016-17 Southern NSW had the 3rd highest rates of self-harm hospitalisation in all of NSW, reported as 227.1 hospitalisations per 100,000 population. Identified hot spots are Eurobodalla, Bega Valley and Goulburn Mulwaree LGAs.
- The 2015 suicide rate for SNSW was the 3rd highest amongst all LHD regions in NSW.
- SNSW has a higher than NSW average level of alcohol and undetermined substance use at 33.9% (Southern NSW) vs 29.8% (NSW average).
- Nearly 3,000 ED presentations to hospitals are for Mental Health and Drug & Alcohol problems (2.5% of all ED presentations). Most common presenting problems were suicidal ideation and mental health problems (each 16%), anxiety (9%), behavioural disturbance (8%), depression and self-harm (6%). 11% were Aboriginal people (up to 21% at Moruya hospital).

WHAT HAVE CONSUMERS TOLD US?

- The consumer and carer voice must be in all aspects of service delivery
- The principle of recovery must underpin all services
- Mental health plans should be a holistic approach to well-being rather than focus primarily on medication. GPs should suggest non-medical interventions such as exercise, diet and social activities[7].
- A key issue underpinning access to required levels of care is a person's ability or that of others to advocate on their behalf[7].
- Expand opportunities for social connections[7].
- Experiences of stigma impact a consumer's willingness to trust and access services in a timely fashion[7].

WHAT HAVE HEALTH PROFESSIONALS TOLD US?

- Coordination and planning is essential especially when consumers are transitioning between services[14].
- Opportunities for better partnerships, alliances and networks between services and across sector boundaries must be taken up[14].
- The system must have treatment options and self-management solutions available for people to access wherever they live in SNSW[14].

14 COORDINARE Health Priority: Mental health and suicide prevention

WHAT ARE OUR OBJECTIVES?

- Progress key actions associated with the Regional Mental Health and Suicide Prevention Plan.
- Targeted focus on improvement in coordination of care and support for consumers at risk of suicide.

WHAT WILL WE DO TOGETHER?

- **3.1 Regional Mental Health and Suicide Prevention Plan:** Multiple objectives to achieve better access, integrated care, better outcomes and improved workforce confidence, networks and satisfaction.
- **3.2 Suicide Prevention Collaborative:** Establish and maintain a multi-agency collaborative approach to reduce suicide attempts and deaths, utilising the Lifespan approach.
- **3.3 Drug and Alcohol Redesign Project:** To improve the quality, efficiency and integration of SNSWLHD D&A services.

4. END OF LIFE CARE

End of life refers to the period of time when a person is living with an advanced, progressive, life limiting illness. While estimating the time when someone will die is difficult, the focus is on better care for those people whose increasing disability and illness will lead to their death sometime within the next year.

Many people are at risk of falling through gaps when end of life care is fragmented and underutilised. This is especially the case for Aboriginal people, people of culturally diverse backgrounds, those under 65 years of age, those with a non-cancer diagnosis, and those living alone or with dementia[15].

As the population in Southern NSW continues to age, specialist palliative care services will experience challenges in meeting growing demand. Primary care plays an increasingly important role in addressing this demand. More consistent involvement of primary care practitioners in palliative and end of life care also has significant benefits to consumers and the community, including increased ability for people to die out of hospital (in line with most people's preference). This reflects the inclusion of end of life care as a priority area for SNSWLHD and COORDINARE.

WHAT DOES THE DATA TELL US?

- Around 1,700 SNSW residents die each year, with approximately 41% dying in hospital. This figure does not include figures from ACT private hospitals, so the percentage is likely to be higher.
- The proportion of deaths coded as Palliative Care type increased from 36% in 2014 to 47% in 2016.
- The provision of community-based specialist palliative care support delivered by SNSWLHD has increased from 9,051 client consultations in 2015-16 to 10,672 in 2017-18.
- In is anticipated that demand for end of life care will increase with nearly 7% of the population in SNSW (16,420 people) aged 75 years and over and projected to grow by 53% between 2016 and 2026, with the highest number and proportion located on the South Coast.

WHAT HAVE CONSUMERS TOLD US?

- To involve them and their families early in end of life care discussions, ideally with their GP's involvement.
- The need to respect each person's preferences around their death, to take into account cultural differences, and to respond to needs as they change over time.
- They would like more support for families and carers with care coordination and as they deal with bereavement.

WHAT HAVE HEALTH PROFESSIONALS TOLD US?

- There is a strong sense of community in some local areas which supports personalised and tailored care.
- There is variation in care delivery, often dependent on levels of engagement of patient's GP.
- There are resourcing and service gaps, including workforce capacity limitations, lack of available after-hours nursing support in many parts of the region, limited access to counselling and bereavement support, and minimal use of case conferencing to support coordination.
- There is inconsistent uptake of advance care directives and NSW Ambulance palliative care plans.
- The significant burden on family members into supporting their loved one's care at home; difficulty attracting GPs and other clinicians to positions in rural areas; and barriers to access medical care in in rural areas.
- Structural barriers to information sharing and coordination across providers and time required to build sustainable care models and relationships across providers.

15 NSW Agency for Clinical Innovation Report to Inform Model for Palliative and End of Life care Service Provision, 2014.

WHAT ARE OUR OBJECTIVES?

- Enhanced communication and coordination across care providers.
- Access to timely specialist support and advice.
- Increase understanding of palliative approach and capabilities among care providers, including GPs.
- Increase the number of end of life care plans and advanced care directives.

WHAT WILL WE DO TOGETHER?

- **4.1 Palliative and end of life model of care:** Implement the proposed model of care that seeks to improve communication and coordination, access to services, increase understanding and capabilities of palliative care providers, increase advance care planning.

ENABLERS

Enablers play a key part in facilitating improvements in the systematic and organisational arrangements between health care providers. They will support and underpin the work that will occur as a result of this strategy.

Key enablers for the Southern NSW Integrated Care Strategy include:

A. CONSUMER PARTICIPATION

The Joint Strategic Alliance (between COORDINARE and the LHDs in Illawarra Shoalhaven and Southern NSW) has identified an imperative to further develop meaningful consumer engagement and participation in the planning, delivery and outcomes of the health care system. A working group has been established to define what is in and out of scope for each organisation in order to develop a shared activity plan that will be included in this Integrated Care Strategy.

The ACI has developed Patient Reported Measures (PRMs) as part of the NSW Health Integrated Care Strategy to support patients and clinicians, and to add value to their interactions. PRMs aims to 'enable patients to provide direct, timely feedback about their health-related outcomes and experiences to drive improvement and integration of health care across NSW'. Continued participation in this shared platform will be critical to achieve person centred care in SNSW.

B. DATA EXCHANGE

SNSWLHD and COORDINARE are working with NSW Health to pilot systems that will enhance communication to improve patient care, but also to review population health level data and patient journeys to inform service planning and delivery.

Both organisations are also working to ensure meaningful use of MyHealthRecord by healthcare providers to ensure safe and effective care for people across primary, secondary and tertiary health services.

C. GENERAL PRACTITIONER LIAISON OFFICERS

COORDINARE and SNSWLHD jointly employ four GPLOs who work one day a week in each of the four LHD cluster areas. The objectives of the GPLO program are:

- Improve healthcare providers' awareness of available services across primary and secondary care settings.
- Establish and enhance communication between medical practitioners across hospital and primary care.
- Identify system-based challenges impacting on access to and quality of care provided across the region.
- Identify opportunities for incremental and transformational changes to improve system functionality to support health professionals in the coordination of care across the health care continuum.

A GPLO district-wide evaluation, District project plan and individual GPLO Cluster project plans have been developed and are detailed in the GPLO Evaluation Framework.

As evidenced in this document, GPLOs are already playing an enabling role in many integrated care projects. It is also important to note GPLOs have contributed to a number of Leading Better Value Care (LBVC) initiatives by representing primary care and ensuring appropriate communication is considered and duplication avoided.

D. HealthPathways

ACT and SNSW HealthPathways is a four-way partnership between ACT Health, Capital Health Network, SNSWLHD and COORDINARE. The HealthPathways platform is evidence informed and provides information on how to assess, manage and refer patients in a timely manner to relevant local services. The project is now at a level of maturity where success cannot simply be defined by the number of localised pathways but now includes identification of system redesign, service changes and better integrated care for both health professionals and patients.

E. INTEGRATED WORKFORCE PLANNING

SNSWLHD and COORDINARE have recognised opportunities to strengthen the alignment between the workforce across secondary and primary care settings. A number of opportunities will be explored to enhance the coordination of service delivery, and to formalise links between the clinical and support workforce. This includes:

- Shared education, research and professional development
- Promoting an agreed, shared understanding of what Integrated Care is, and how this applies to the regional context
- Investment in shared appointment, including the General Practitioner Liaison Officers
- Exploring and developing models of care to support SNSWLHD staff to provide on-site support in primary care settings
- Coordinated future workforce planning to include considerations for joint appointments across agencies, and targeted recruitment and retention strategies

F. CO-COMMISSIONING

SNSWLHD and COORDINARE have recently signed a Memorandum of Understanding but as yet have not entered into any co-commissioning arrangements. Future opportunities to pool funds in order to deliver innovative and efficient models of care to meet the specific needs of the region should be explored.

MONITORING AND EVALUATION

Monitoring and evaluation will be separated into two tiers:

1. Strategy wide governance and evaluation
2. Project governance and evaluation

STRATEGY-WIDE EVALUATION:

Monitoring and evaluation of the strategy will align with the NSW Integrated Care Maturity Model which was developed as part of the state-wide Integrated Care Formative Evaluation. The model reviews maturity across five dimensions of integrated care:

1. Program and Service Innovation
2. Patient Centred Care and Empowerment
3. Digital Health and Analytics
4. Models of Care, and
5. Partnerships

The maturity model provides a framework for ongoing evaluation of the Strategy, as well as an opportunity to review the effectiveness of individual projects to ensure the ongoing focus on integration across care settings and across a person's lifespan.

The maturity model will be used as a reference and measurement point to ensure that the features of the strategy, enabling work and targeted projects lead to system-wide improvements in integration across primary and secondary care. An annual target has been set to achieve staged increase in the maturity domains, monitored through the Integrated Care Strategic Working group and reported to the Strategic Alliance Committee as a component of the annual report.

MATURITY MODEL EVALUATION

Evaluation Area	Goal	Objective	Measure/KPI
Maturity Model	To develop and maintain maturity of the Southern NSW Integrated Care Strategy to ensure a consolidated approach to Integrated Care across settings	Achieve an annual maturity model index score increase of 1 stage within targeted domains	Stage of Maturity Model – by domain and aggregated

ANALYTICAL FRAMEWORK - MATURITY

INTEGRATED CARE MATURITY MODEL

HIGH

Stage	Program and Service Innovation	Patient centred Care and Empowerment	Digital Health and Analytics	Models of Care	Partnerships
6	• Innovation achieves sustained outcomes at a population health level	• Patient / Carer needs frequently monitored and reflected in service delivery and policy-making	• Local Health needs can be easily identified through predictive data analytics • Analysis can be used to target cohorts and develop systematic population level approaches to risk identification	• Model of care sits along side / is integrated with service models that operationalise service delivery and incorporate financial and / or non financial elements	• Whole of system integration (health, social services, education) • Cross sector co-commissioning
5	• Innovation is effectively scaled or transferred to another location or cohort	• Patient / Carer actively self-manage care	• Solutions are scaled or transferred to other cohorts • Information sharing occurs across the system for all cohorts	• Primary and community care is used as a hub. Patients are provided with connected and coordinated care with provision of patient assessments and regular reviews	• Vision / strategy embedded in policies across care levels • Co-commissioning within health sector
4	• Innovation is financially sustainable • Evidence that the innovation can make a difference at a population health level	• Clinician practices patient centred care evidenced by e.g. - Genuine partnerships with the patient, family and other care providers - Uses whole-patient information - Using PRMs and PROMs	• System wide information sharing enablers in place including - Unique patient identifier - Integration of systems - Shared care platform - Confidentiality and security policies	• Patients and clinician adopting model of care evidence by - Appropriate and timely access to specialised care - Shared / joint care planning and management with the patient / carer	• Visible stakeholder engagement and support including executive, partners, clinicians and other staff across care levels • Active efforts to achieve integrated care across care levels
3	• Sufficient evidence that the innovation is making a difference to the health or service outcomes • Feedback loop in place for the ongoing quality improvement	• Patient / Carer empowerment to engage, question and discuss through - Pro-active engagement and support in care planning - Increased health literacy - Increased access to information	• Patient information - Is available to clinicians across care settings - Is monitored and analysed • Insights used to develop new approaches to risk identification and interventions	• Implementation of a system of standardised assessments, regular patient reviews, uploading of relevant clinical metrics	• Wider consultation of vision and strategy between care levels (e.g. primary and secondary)
2	• Innovation project structures and processes active • Monitoring, evaluation and reporting undertaken to demonstrate that innovation can make a difference to the health or service outcomes	• Implementation of interventions and on going processes and systems to embed patient centred care approach and build patient / carer access to information, health literacy and capacity to self manage	• A pilot / local solution for targeted cohort is developed to share information • Patient data for targeted cohort is prepared for sharing through the solution	• Patients identified, contacted, enrolled and connected to care plan custodian	• Vision and strategy shared and discussed with key stakeholders within the same level of care (e.g. primary) • Enlisted stakeholder support within the same level of care
1	• Innovation project plan developed and structures and policies in place • Innovation project plan is practical, feasible and acceptable • Project manager and team appointed	• Identification of gaps and barriers to patient centred care and patient self-management • Identification of gaps and barriers in clinician confidence and skills to engage patients • Defined interventions to address gaps and barriers	• Patients are identified / risk stratified • An electronic trackable cohort list is established	• Identification of a model that sits across the continuum of care • Establishment of roles focused on patient centred care • Capacity / capability building • Stakeholder / partner consultation and buy in	• A compelling and clear shared vision / strategy created • Change Management Plan developed
0	• Innovation idea generated • Application submitted • Funding received for implementation	• Limited patient centred approach to care • Low level of patient empowerment including health literacy and capacity to self manage	• Limited to no information sharing • Isolated and multiple medical record systems • Limited capacity to perform analytics as data is not holistic	• Low levels of care coordination and integration across service providers	• Low levels of acknowledgment for the need of integrated care • Limited understanding of the meaning of integrated care • Siloed care efforts and patient / carer as[illegible] integrator

LOW

STRATEGY-WIDE OUTCOMES:

Patient Reported Measures - The inclusion of patient reported measures will also provide a baseline and improvement measure over time within most project areas. Patient Reported Experience Measures (PREMs) and Patient Reported Outcome measures (PROMs). Provider experience will also be a key point of measurement and monitoring, as well as understanding of integrated care. Targeted measures will be developed assigned to each project area and reported on through the consolidated strategy-wide evaluation.

GOVERNANCE

An Integrated Care Working Group was agreed by the Strategic Alliance to develop the Southern NSW Integrated Care Strategy. The nominated Working Group members are Executive and Managers of COORDINARE and SNSWLHD who have responsibility for integrated care and/or identified priority health areas.

The Integrated Care Working Group will be maintained to monitor and report the progress of individual projects as well as achievements against the maturity model domains and report findings to the Strategic Alliance. The Working Group will also undertake a six-monthly assessment of its performance as per the Terms of Reference and will provide this to the Strategic Alliance.

A Memorandum of Understanding has been executed between SNSWLHD and COORDINARE effective until 30 June 2020. The MoU specifies the two organisations will work collaboratively to address common health priorities and engage in and support each other's programs, projects and committees. The MoU specifies that separate Project Agreements are to be developed and executed for individual programs, activities or initiatives and will include reporting and governance arrangements.

REPORTING

Six monthly Strategy reports will be submitted and tabled at the Strategic Alliance Group meetings as well as at the Joint COORDINARE and SNSWLHD Board meeting.

WORK PLANS – HEALTH PRIORITY AREAS

1. ABORIGINAL HEALTH

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
1.1 Integrated Team Care program communication and support.	**COORDINARE** AMS, SNSWLHD, Grand Pacific Health.	To improve coordination of services and identify service gaps by strengthening the relationship between all agencies.	Regular joint meetings of ITC providers, AMS, LHD and COORDINARE commencing in 2019.	Regular joint meetings. Evidence of one collaborative initiative that improves coordination of care.	Regular joint meetings. Evidence of an additional collaborative initiative that improves coordination of care or addresses an identified service gap.
1.2 HealthPathways localised for Aboriginal services.	**COORDINARE** SNSWLHD, ACT Health, ACT PHN, Aboriginal and Torres Strait Islander consumers.	Improve quantity and quality of localised pathways for Aboriginal Health services and programs.	Pathways for Integrated Team Care (ITC) program, Closing the Gap, Health Assessments developed. Aboriginal and Torres Strait Islander consumer HealthPathways reference group to be established. Aboriginal and Torres Strait Islander health priorities factored into pathway prioritisation and review process.	Aboriginal and Torres Strait Islander consumer HealthPathways reference group develops prioritised culturally appropriate consumer resources. Aboriginal and Torres Strait Islander health professionals included during pathway development as SMEs (subject matter experts) piloted for conditions with high prevalence in indigenous population.	Aboriginal and Torres Strait Islander health professionals included during pathway development as SMEs becomes business as usual for conditions with high prevalence in indigenous population.
1.3 Increase access to specialist services for Aboriginal clients.	**SNSWLHD, NSW Rural Doctors Network,** COORDINARE.	To introduce clinical specialty services, prioritising access for Aboriginal clients in Southern NSW.	Introduction of ophthalmology surgical service Joint service development discussions and service agreement between agencies.	Identified additional service developed.	Identified additional service reviewed.

2. CHRONIC CONDITIONS

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
2.1 Outreach pain management education and services.	**Collaboration:** ACI, SNSWLHD, COORDINARE, St Vincent's Pain Service	Increase access to specialist pain management services. Build capacity of LHD and primary care clinicians in best practice pain management.	Increase and broaden the geographic spread of referrals to St Vincent's Outreach Telehealth Pain Clinic. Provide 3 St Vincent's Outreach Pain Education events per annum for LHD and primary care clinicians.	Increase and broaden the geographic spread of referrals to St Vincent's Outreach Telehealth Pain Clinic. Undertake opioid deprescribing capacity building initiatives.	TBD following review of service access, ED presentation and opioid prescribing data.
2.2 Goulburn Redesign Project – Integrated Model of Community Care.	**SNSWLHD,** GPLO, COORDINARE, NSW Ambulance, GP Practice, Consumers	Design models of care with consumers of local health services. Implement an integrated model of care which responds to the need.	Project Steering Committee with representation from consumers, LHD, COORDINARE/ and Ambulance established. Consultation with consumers and representatives from all agencies to ensure input into each stage of the project. Diagnostics finalisation – Nov 2018. Solution design – Dec 2018.	Solution Implementation Jan – Nov 2019. Solution Evaluation – Dec 2019. Consumer Focus Groups and feedback through solution review and evaluation – throughout 2019-20.	Commencement of diagnostic across secondary sites with solution implementation.
2.3 Integrated care for people with chronic and complex conditions (ICPCC).	**SNSWLHD,** GPLO	To develop a risk stratification matrix to identify high risk consumers requiring shared care plans. To align the care coordination of ICPCC complex consumers with GP shared care planning.	Review of Integrated Care multidisciplinary meetings and risk stratification process to improve the identification of high-risk consumers requiring additional care coordination – Nov 2018. Introduction of client risk stratification tool into the patient flow portal for LHD patients – March 2019. Commencement of Clinical Nurse Specialist Goulburn & Bega to develop risk matrix – Jan 2019.Interviews with general practitioners to identify shared care planning opportunities and procedure to follow – Oct 2018 – March 2019.	Trial of extended risk stratification tool for highly complex consumers - 2019- Jan 2020 Development of shared care plan template for use by GP and LHD for consumers with chronic and complex conditions .	TBD.

3. MENTAL HEALTH, DRUG & ALCOHOL AND SUICIDE PREVENTION

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
3.1 Regional Mental Health and Suicide Prevention Plan.	**COORDINARE,** SNSWLHD, ISLHD	Better access – services matched to need and more equitably distributed through better resource use. Integrated care – consumers should receive holistic, joined up services and experience smooth transitions. Better outcomes for consumers – care should be available to address mental health issues early and reduce the overall impact of illness. Improved workforce confidence, networks and satisfaction – through respectful team work, better communication and timely support.	Plan endorsed by all three partner organisations – December 2018. Implementation plan developed – March 2019. Psychosocial support.	Joint implementation. Example drought funding and psychosocial supports. Commitment joint Governance to support the implementation plan strategies.	Mid-term review– December 2020, which includes the implementation strategies through co design. Ongoing commitment joint Governance to support the implementation plan strategies. Final evaluation report – December 2022.
3.2 Suicide Prevention Collaborative	**COORDINARE,** SNSWLHD, GPLO, Education, Police, LGA, Aboriginal Controlled Health Organisation, Service Providers, Consumers, Carers, Peer Workers	Establish and maintain a multi-agency collaborative approach to reduce suicide attempts and deaths, utilising system based approach.	Coordinated activity in suicide reduction strategies, outlined in the 5th Plan approach, with regular reporting every 6 months. Annual review of Terms of Reference to ensure ongoing cross sector commitment – April 2019. Aftercare service to support people who have attempted suicide, embedded and meeting contracted targets. Completion of a final review of the aftercare model, using a comparative analysis of other models, with recommendations to be put forth. Postvention plans to be developed, localised and reviewed ongoing.	Building ongoing relationships and community awareness of the approach. Ongoing commitment to joint Governance to support the approach. Raising the profile of the approach through collaborative community forums. Postvention plans to be developed, localised and reviewed ongoing.	Ongoing commitment to joint Governance to support the approach. Stakeholder assessment of the collaboration, using EBP tools. Results of assessment can be used to complete a formal evaluation the approach. Postvention plans to be developed, localised and reviewed ongoing.
3.3 Drug and Alcohol Redesign Project	**SNSWLHD**, COORDINARE, Consumers, ACI	To improve the quality, efficiency and integration of SNSWLHD D&A services by December 2019.	Project team formed July 2018. Project plan developed and endorsed by steering committee – Sep 2018. Diagnostic of current model of care – Nov 2018. Solution design - Nov/Dec 2018. Implementation – Jan – Dec 2019. Evaluation Dec 2019. Endorsement and implementation of the solutions from redesign.	Partner in a joint implementation strategy, identifying model of care for LHD and Primary Care supports. Continue to work in collaboration to support areas of need, co design models that will support people along the care continuum. Build workforce capability in primary care.	Increase Opioid Treatment Program prescribers in the GP community. Joint evaluation of the redesign solutions. Seek collaborative feedback from consumers, clients and service providers on the service models in place. Develop a joint DA Regional Plan.

4. END OF LIFE

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
4.1 Palliative and end of life model of care	**COORDINARE,** SNSWLHD, service providers, consumers	Implement the proposed model of care that seeks to ensure: • Stronger communication and coordination across care providers • Access to timely specialist support and advice • Increase understanding of palliative approach and capabilities among care providers, including GPs • Increase the number of end of life care plans and advanced care directives	Explore and expand use of communication and information sharing platforms/ approaches (e.g. case conferencing, secure messaging, and patient held records) to support coordination between providers. Coordinate promotion and uptake of advance care directives.	Implement agreed information sharing approaches. Ongoing promotion and uptake of advance care directives.	Monitor and review agreed information sharing approaches. Ongoing promotion and uptake of advance care directives.

WORK PLANS – ENABLERS

A. CONSUMER PARTICIPATION

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
A.1 Consumer engagement and participation	**COORDINARE,** SNSWLHD, ISLHD, Consumers.	Develop meaningful consumer engagement and participation.	Project/s to be identified and developed early 2019.	TBD.	TBD.
A.2 Patient Reported Measures	**ACI,** SNSWLHD, COORDINARE	Ensure patient feedback is received to improve patient and program experience and outcomes.	Inclusion of PRMs in key integrated care and LBVC programs including proof of concept test sites to be established in selected general practices.	Increased sector capacity to engage with shared PRM data. Expansion of participating practices with shared learnings across primary and secondary care settings- specifically targeting patients involved in integrated care and LBVC programs.	PRM data contributes to health care decisions across whole of health for patients involved in integrated care and LBVC programs.

B. DATA EXCHANGE

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
B.1 Admission and Discharge Notification	**eHealth,** SNSWLHD, GPLO,	To provide notifications to general practitioners of patient admission, discharges and ED presentations.	Project team established with eHealth lead – Aug 2018. GP ADT Notifications solution architecture design – Oct 2018. Stakeholder consultations – Oct – Dec 2018.	Expanded scope of admission and discharge notification to all hospital streams/areas. System design trial.	Introduction of admission/ discharge notification system for community health services.
B.2 Data linkage pilot project	**NSW Health,** SNSWLHD, ISLHD, COORDINARE, GPLOs, General practices	Inform the design of NSW Health systems to improve the quality and experience of care. Inform local patient journey and population health decisions.	Recruitment of 5 General Practices by September 2018. Data Extract completed end 2018. Data review leads to the development of evidence informed quality improvement initiatives.	TBD.	TBD.
B.3 My Health Record (MyHR) Meaningful use	**COORDINARE**, SNSWLHD, GPLOs	Improve integration and coordination of care and reduce potential for adverse medication interactions through effective use of the My Health Record.	100% Awareness of MyHR in general practice and pharmacy. Net increase of number of general practice / pharmacy providers with conformant software registered to access MyHR (85% goal). 5% increase in Shared Health Summary and dispense record uploads. 5% increase in general practice / pharmacy providers viewing records authored by another. Increase in the number of discharge summaries uploaded to MyHR. Increase in hospital providers viewing records authored by another.	100% Awareness of MyHR in general practice and pharmacy. Net increase of number of general practice / pharmacy providers with conformant software registered to access MyHR (90% goal). 5% increase in Shared Health Summary and dispense record uploads. 5% increase in general practice / pharmacy providers viewing records authored by another. Increase in the number of discharge summaries uploaded to MyHR. Increase in hospital providers viewing records authored by another.	100% Awareness of MyHR in general practice and pharmacy. Net increase of number of general practice / pharmacy providers with conformant software registered to access MyHR (95% goal). 5% increase in Shared Health Summary and dispense record uploads. 5% increase in general practice / pharmacy providers viewing records authored by another. Increase in the number of discharge summaries uploaded to MyHR. Increase in hospital providers viewing records authored by another.
B.4 Innovation Project - RACF Functional Summary	**Lead GP, COORDINARE,** GP practices, RACFs, SNSWLHD	Functional summary completed for RACF clients in Broulee & Moruya.	MHR installed & operational at RACFs.	Functional summary completed 3 monthly for RACF clients and uploaded to MHR. LHD staff view MHR summaries at ED presentation. Project evaluation completed. Project learnings inform improved RACF communication project initiation in additional locations.	Evaluation of additional RACF communication projects.

C. GPLOs

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
C1. GPLO District Wide Work Plan – Awareness of service	**COORDINARE, SNSWLHD**	Improve healthcare providers' awareness of available services across primary and secondary care settings.	Improved awareness of service and providers (GP survey). Service directories regularly updated and available across sites/care settings.	Improved provider awareness of services (GP survey). Local hospital services directories available on HealthPathways. Orientation and information package videos for LHD and Primary Care staff.	Improved LHD staff awareness of community health and primary care services (LHD survey). Increase in HP page views of hospital directories Improved provider awareness of services (GP survey)
C2. GPLO District Wide Work Plan – Improved communication	**COORDINARE, SNSWLHD**	Establish and enhance communication between medical practitioners across hospital and primary care.	Direct communication with ED project to reduce inappropriate ED presentations and streamline ED admissions/ hospital presentations Improve knowledge, understanding and use of the TEC service Improve discharge summary delivery rate to GPs Contact list and contact systems established that are successful and readily available	Improved quality of information at transfer of care to GP after hospital admission Improved TECs referrals and management Secure messaging trial Maintenance of contact lists and systems	Secure messaging implementation
C3. GPLO District Wide Work Plan – System improvements	**COORDINARE, SNSWLHD**	Identify system-based challenges impacting on access to and quality of care provided across the region.	Improved paediatric referral process (district wide) Reduction of inappropriate MH referrals (Goulburn)	Participation in implementation of the Admission, Discharge and Notification project Improved outpatient referral process (SERH) Development and implementation of GP Hospital access policy and procedure	Extension of GPLO identified projects
C4. GPLO District Wide Work Plan – Improved coordination of care	**COORDINARE, SNSWLHD**	Identify opportunities for incremental and transformational changes to improve system functionality to support health professionals in the coordination of care across the health care continuum.	Participation in LBVC projects with specific focus on transition and coordination of care back into a primary care setting	Ongoing participation in tranche 1 and 2 LBVC initiatives Project commenced with residential aged care, General Practice and LHD to reduce unnecessary hospital presentations from aged care facilities Involvement in the Goulburn Redesign project (supporting frequent service users)	Extension of GPLO identified projects Trial commenced for shared care planning between community health and GP shared care plan Involvement in district wide roll out of Goulburn Redesign project (supporting frequent service users)

D. HEALTHPATHWAYS

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
D.1 ACT and SNSW HealthPathways Program	**Partnership:** ACT Health, Capital Health Network, SNSWLHD, COORDINARE	Support health professionals to deliver the right care, in the right place, at the right time. Expand the discharge pathways project. Increase HP usage. HealthPathways identifies and contributes to redesign.	400+ localised pathways achieved, pathway reviews underway. Additional outward facing discharge pathway identified for development. Increased use of HP. HP mobile site launched.	400+ localised pathways achieved, pathway reviews underway. Additional outward facing discharge pathway developed. Increased use of HP. One redesign initiative commenced Continued localised pathway development and review. Outward facing discharge pathway demonstrating improved patient outcome and experience.	Continued localised pathway development and review. Increased use of HP. Additional redesign initiative completed.

E. INTEGRATED WORKFORCE PLANNING

Project	Participation & Lead agency	Objectives	Milestones FY18/19	Milestones FY19/20	Milestones FY20/21
E.1 Formalised links with tertiary education providers in South Eastern NSW	**University of Canberra,** SNSWLHD, COORDINARE,	To develop a plan to enhance student placement experience across Southern NSW and support the delivery of innovative models of care.	Introductory meetings with University of Canberra, Australian National University, SNSWLHD and COORDINARE. Key opportunity paper to be presented to COORDINARE / SNSWLHD.	Development of shared/ funded staff roles to support student led clinics, education and support for health professionals. Pilot area of work for student placement, staff education and student-led clinic models to be trialled.	Innovative student-led models of care supported through formalised service agreement.

FOR MORE INFORMATION:

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