Strategic priority:
Partnering to integrate services and systems

What do we mean?

Integrated care involves the provision of seamless, effective and efficient care that reflects a person's health and social care needs. Integrated care is most important for people with multiple chronic and complex conditions.

The concept of integrated care runs from prevention through to end of life care, across both physical and mental health, and includes partnering with the individual, their carers and family. In practice, it requires a greater focus on a person's needs,better communication and connectivity between health care providers, and better access to health services closer to home such as general practice or Aboriginal Medical Services (AMS). Collaboration between service providers is key as no one provider can deliver integrated care.

Why is this a priority?

Chronic and complex conditions, which are best managed through integrated care, are expected to account for 80% of the disease burden in Australia by 2020. At the same time, services are becoming more specialised, segmented and siloed. The increase in chronic conditions is particularly prominent in vulnerable populations, including Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities, reflecting a range of more complex health and socioeconomic determinants.

Ageing populations with a greater prevalence of chronic conditions, advances in science and technology, and increasing consumer expectations are all contributing to growing health and social care costs. With increasing pressures on health and social systems, jurisdictions are seeking to make the delivery of health and social care more effective and efficient. Integrated care offers a way of containing cost pressures while providing a better experience for consumers.

What does the evidence say?

A recent analysis of successful integrated care initiatives identified the following key characteristics:

- bottom up innovation driven by local needs
- a single point of entry for consumers
- holistic care assessments
- comprehensive care planning
- care coordination
- well connected provider networks

The Productivity Commission has stated that "the International and Australian experiences with integrated care indicate that if properly implemented, it leads to gains in health outcomes for patients, improvements in the patients experience of care, reductions in costs, and improved job satisfaction for clinicians. Since hospitalisation is the single and most distressing part of the health system, effective management of people's conditions in the primary care system is a key element of integration."

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What have our stakeholders told us?

Consumers and service providers have regularly stated that there is poor coordination of care and lack of associated affordable and timely services to refer to.

In response to questions about their experience of chronic disease management, our consumer panel reported:

- more than 80% were somewhat or very satisfied with the care they received, however 62% had difficulty accessing treatment. This was due to services or facilities not being available in their local area (32%) and long waiting times (28%), while others said the care was not affordable (12%) or they were not aware of what was available (8%).
- more than 70% of respondents were unaware of wellness programs available

Health service providers, including GPs, have reported difficulties in gaining access to other services for their patients, such as specialist services. Causes of these difficulties are varied and include unclear referral processes, long waiting lists, out of pocket cost or in some cases a lack of appropriate services. GPs also report a lack of timely communication around patient care that has taken place in other services or acute settings.

Our system partners, the Illawarra Shoalhaven and Southern NSW Local Health Districts, and ACT Health, have made commitments to working in stronger partnership with us. These partnerships aim to ensure greater service and system integration between primary and acute care, reflecting our shared belief that effective management of people's health condition within a primary care setting is a key component of service integration.

What is our approach?

Our aspiration for this strategic priority is that patients and consumers experience care which is seamless, timely and appropriate in our region.

To achieve this, we will:

- build strong strategic alliances with partners and **develop joint plans for system improvement,** such as the Illawarra Shoalhaven Integrated Care Strategy and the Regional Mental Health and Suicide Prevention Plan
- identify **agreed priorities for action** with Local Health Districts, with **shared investment in the key enablers** that ensure initiatives are systematic and sustainable
- jointly establish **GP Liaison** roles (or equivalent) with Local Health Districts
- ensure **clinical pathways** are agreed and clearly documented through HealthPathways in Illawarra Shoalhaven and Southern NSW/ACT
- implement **system improvements** designed to optimise pathways for patients and coordinate their care
- increase use of **digital health initiatives,** including support for the roll out of My Health Record
- increase the use of **secure messaging** to streamline the flow of relevant patient information across the health provider community
- collaborate in trialling **new models of integrated care,** such as the Illawarra Shoalhaven Geriatrician in the Practice Program and the Chronic Pain management in southern NSW
- investigate the development of **health care neighbourhoods,** initially trialling the approach in a small number of clusters