

Integrated Care Patient Journey

Whole of Health Program Master Class

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Collaboration. Innovation. Better Healthcare.

What is Integrated Care?

What is integrated care?

- ...provision of seamless, effective and efficient care that reflects the whole of a person's health needs;
 - From prevention to end-of-life,
 - > across physical and mental health,
 - in partnership with the individual, their carers and family.



What is Integrated Care?

- Who benefits from integrated care?
 - Integrated care is particularly important for people with complex and long term conditions,
 - > helping them manage their own health,
 - keeping them healthy, independent and out of hospital for as long as possible.



NSW Integrated Care Strategy

- \$180 million over six years to implement innovative, locally led models of integrated care across the State
 - Integrated Care Demonstrators Central Coast, Western Sydney and Western NSW
 - Planning and Innovation Fund The Innovators: All other LHDs/Specialty Networks funded for local, discrete integrated care initiatives – total 17 projects
 - <u>State-wide Enablers</u> including the eHealth systems (e.g. Healthenet), patient reported measures (PRMs) and risk stratification tools, and monitoring and evaluation.



Objectives of the NSW IC strategy

...to transform how we deliver care to improve health outcomes for patients and reduce costs deriving from inappropriate and fragmented care, across hospital and primary care services by:

- focusing 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.

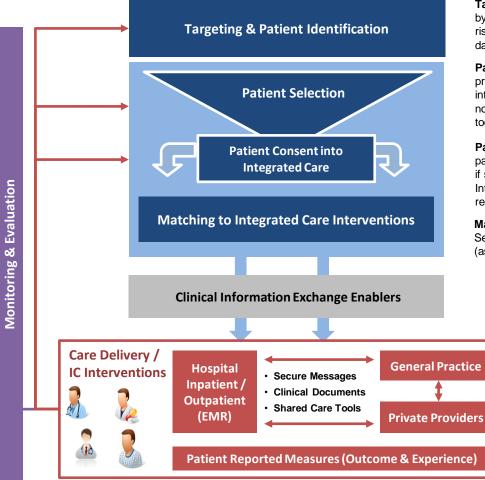


GOVERNANCE PARTICPANTS	GOVERNANCE STRUCTURE	KEY ACCOUNTABILITIES / DELIVERABLES
 Integrated Care Implementation Group Mary Foley, Secretary, Chair, MoH Elizabeth Koff, Dep Sec Strategy & Resources Susan Pearce, A/Dep Sec System Purchasing & Performance Nigel Lyons, CEO Agency for Clinical Innovation Zoran Bolevich, A/CEO eHealth NSW Carrie Schulman, Program Advisor Integrated Care Directors Brad Astill, MoH Sys Relationship Branch Ray Messom, MoH Health Sys Info & Performance Reporting Liz Junck, MoH Integrated Care Branch Alfa D'Mato, MoH ABF Task Force rep Chris Shipway, ACI Primary Care & Chronic Services Raj Verma, ACI Clinical Program Design & Implementation Michael Costello, eHealth Director of Strategy Integrated Care Program Managers Tiffany Spurway, System Relationship Branch Louise Fisher, Monitoring and Evaluation, HSIPR Errin Lilley, Risk Stratification, ACI Melissa Tinsley, Patient Reported Measures, ACI Linda Murray & Andrew Perkins, 	Integrated Care Implementation Group (ICIG) Integrated Care Directors Integrated Care Secretariat (ICB) Integrated Care Program Managers	 Integrated Care Steering Group Clear timely strategic / policy direction Secretariat (Integrated Care Branch) Linkage of governance from strategy to operations Secretariat to Integrated Care Implementation Group, Directors, and Program Managers Strategic/subject matter expertise in integrated care and complex system-wide implementation MoH System Relationship Branch Leads on performance management & coordinates supports to LHDs IC projects Management of communications across LHDs Facilitates knowledge transfer MoH Health Sys Info & Perform Rpting Design & delivery of monitoring and evaluation MoH Integrated Care Branch Alignment with policy agenda & external communications MoH ABF Task Force Coordination of funding analysis & advice ACI Primary Care & Chronic Services Facilitate alignment of Chronic Disease Management with Integrated Care initiatives ACI Clinical Program Design & Implement of Chronic Disease Management with Integrated Care initiatives

 Anne Mooney & Bayne McKissock, ICB

• Procurement, design, and delivery of priority IC e-enablers

Integrated Care Patient Journey Model



Key Elements & Enablers

Targeting & Patient Identification - Choose and quantify target cohort, informed by a local population health needs assessment. Identification of individual patients at risk of potentially preventable hospitalisations through searching of **electronic** databases using a standard set of risk predictors **(e.g. HARP Ontario or CARS)**.

Patient Selection – Selection of individual patients at risk of potentially preventable hospitalisations whose health outcomes could be modified with integrated care interventions based on additional screening for predictive factors not available electronically (e.g. cognitive, social) using a standardised screening tool. (e.g. Western Victoria HARP).

Patient Consent - Based on patient selection process a decision is made if patient risk level indicates potential benefit from Integrated Care interventions and if so Patient Consent is undertaken for intake and data sharing for the range of Integrated Care interventions including for example: care coordination, patient reported measures, and shared care.

Matching to Integrated Care Interventions – Also as part of Patient Selection the patient is matched to appropriate Integrated Care interventions (as well as usual care referrals),e.g.

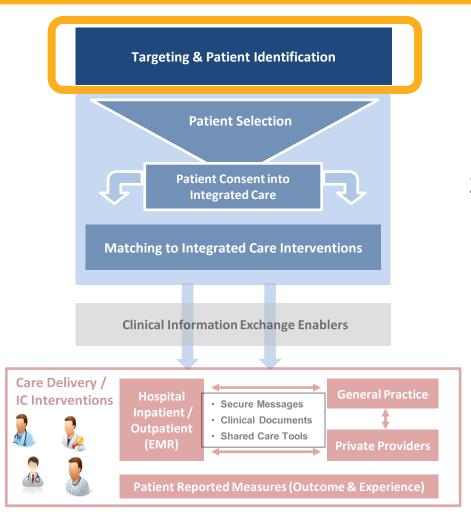
- Care navigation
- Care coordination
- Care management
- Health coaching
- Shared care planning & systematic assessments

Clinical Information Exchange Enablers, including systems interfaces, secure messages and clinical repositories to facilitate exchange of patient clinical information between care providers (point to share).

Patient Reported Measures – processes and tools to enable definition of patient outcomes and shared decision making as part of care planning.

Monitoring & Evaluation - state-wide data collections, and reporting that enables experiential learning for providers and evaluation of system performance.

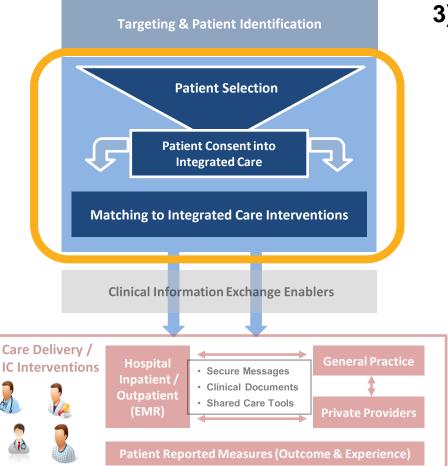
Patient targeting and identification



- Targeting choose and quantify the cohort of patients at risk of poorer health outcomes (e.g. PPHs) that are considered a priority for targeting with different or additional interventions.
- 2) Identification identify individuals within the target cohort. This is achieved through manual or automated searching of routinely collected clinical and demographic data held in electronic databases using a standardised set of risk predictors.

In NSW Health 'risk stratification' is: a systematic process to target, identify and select patients who are at risk of poorer health outcomes, and who are expected to benefit most from a particular intervention or suite of interventions.

Patient selection & consent

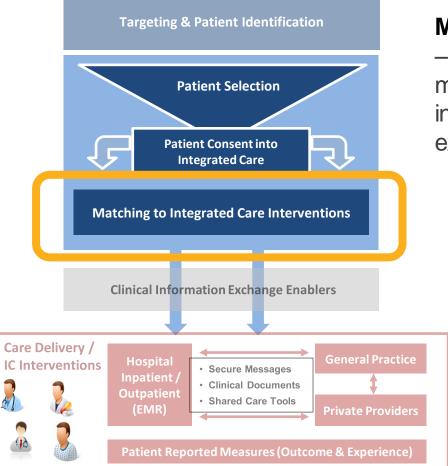


3) Selection – use a selection tool to undertake further assessment of each identified patient's modifiable risk, and match their needs to the most appropriate integrated care interventions. This can be administered via telephone or faceto-face, and generally requires information not held in the electronic medical records (eMRs).

Patient Consent - Based on patient selection process a decision is made if patient risk level indicates potential benefit from Integrated Care interventions and if so Patient Consent is undertaken for intake and data sharing for the range of Integrated Care interventions including for example: care coordination, patient reported measures, and shared care.

Patient selection is key to linking people identified at the highest risk of health deterioration to the most appropriate evidence-based integrated care strategies.

Matching to interventions



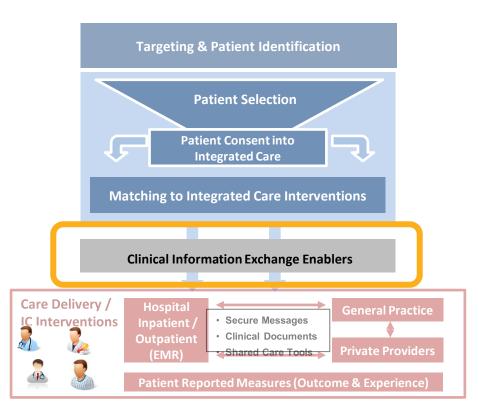
Matching to Integrated Care Interventions

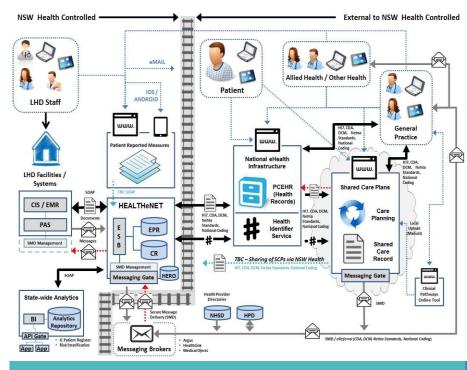
- Also as part of Patient Selection the patient is matched to appropriate Integrated Care interventions (as well as usual care referrals), for example:

- Care navigation
- Care coordination
- Care management
- Health coaching
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Clinical information exchange enablers

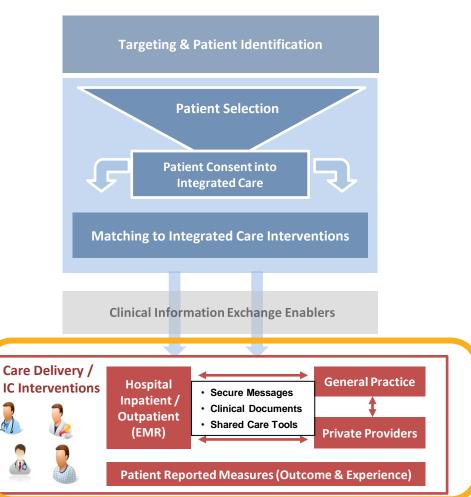
Clinical Information Exchange Enablers, including systems interfaces, secure messages and clinical repositories to facilitate exchange of patient clinical information between care providers (point to share).





It's a complex landscape...

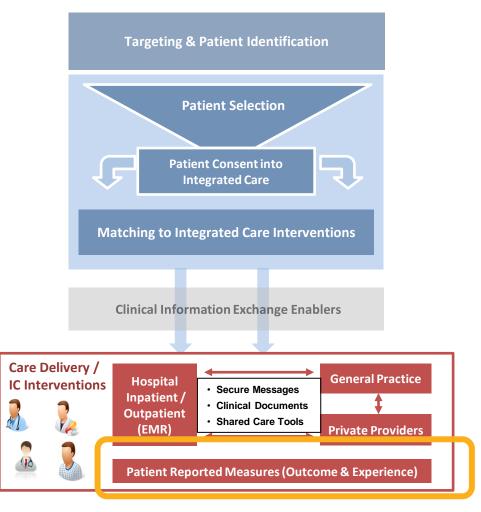
Care delivery



Usual Care

- Integrated Care Interventions
- Patient Reported Measures
 - Outcome measures
 - Experience measures

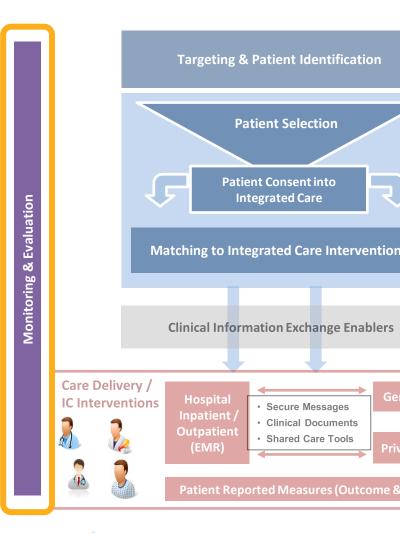
Patient Reported Measures



Processes and tools to enable definition of patient outcomes and shared decision making as part of care planning.

Monitoring and evaluation

State-wide data collections, and reporting that enables experiential learning for providers and evaluation of system performance





More information

Risk stratification

- 'Patient identification and selection handbook' (by 30 Oct)
- Literature reviews and useful links
- www.aci.health.nsw.gov.au/resources/integratedcare/aci/integrated-care/risk-stratification-program

Patient Reported Measures

- Literature review, resources and program information
- http://www.aci.health.nsw.gov.au/resources/integratedcare/aci/integrated-care/patient-reported-measures

