Guidelines for Developing

HealthOne NSW Services

Version 1.1

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NSW GOVERNMENT Health

HealthOne NSW

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1 Executive Summary

Increasing rates of chronic diseases, expanding costs in the health system and workforce shortages have led to funders to consider how to sustain more efficient health care systems. Since 2007, the Commonwealth Government has embarked upon an agenda of national health reforms. A key component of these reforms in primary care have been the establishment of Medicare Locals.

As a response to these emerging changes and challenges in the health sector NSW Health has been developing an integrated approach to primary and community health. Since 2006/07, the NSW Government has committed more than $45 million of capital funds to the development of HealthOne NSW services with a further $3.3 million per annum to support nursing, allied health and service integration positions within HealthOne NSW and other primary and community health services.

The HealthOne NSW program has four key features, five key objectives and four enablers. The four **key features** of HealthOne NSW services that distinguish them from other primary and community health services are:

1. Integrated care provided by general practice and community health services
2. Organised multidisciplinary team care
3. Care across a spectrum of needs from prevention to continuing care
4. Client and community involvement

The five **key objectives** of HealthOne NSW are to:

1. Prevent illness and reduce the risk and impact of disease and disability
2. Improve chronic disease management in the community
3. Reduce avoidable admissions (and unnecessary demand for hospital care)
4. Improve service access and health outcomes for disadvantaged and vulnerable groups
5. Build a sustainable model of health care delivery

The **four key enablers**

1. Service and capital planning
2. Information and communication technology
3. Governance and sustainability
4. Workforce development

There is no single model of integrated care that is suited to all settings; Local Health Districts should be guided by their community needs about the configuration that is best suited to each locality. To date three broad **service configurations** have been described for HealthOne NSW services:

1. Co-located services
2. Hub and spoke
3. Virtually integrated services

These are not mutually exclusive and some locations may use two configurations, for example hub and spoke and virtual, or co-located and hub and spoke.

2 Purpose of this document

The purpose of this document is to support the development of HealthOne NSW services. It has been informed by learning forums, previous workshops and case study interviews.

This document outlines the key objectives, features and enablers for developing HealthOne NSW services and is supported by case studies from existing services. This document has been developed around the five key objectives for HealthOne NSW services, to:

1. Prevent illness and reduce the risk and impact of disease and disability
2. Improve chronic disease management in the community
3. Reduce avoidable admissions (and unnecessary demand for hospital care)
4. Improve service access and health outcomes for disadvantaged and vulnerable groups
5. Build a sustainable model of health care delivery

By linking these objectives to developing services, integrated primary and community health will be strengthened across NSW. Lessons learnt are presented in the document as highlighted quotes from HealthOne NSW services and individual case studies are presented in boxed text.

3 Background

3.1 The policy context for primary health care in Australia

Since 2007, the Commonwealth Government has embarked upon an agenda of national health reforms. This includes the development of Australia's first National Primary Health Care Strategy: *Building a 21st Century Primary Health Care System* (the strategy). The strategy takes a broad view of primary health care, extending beyond the traditional Commonwealth focus on general practice. The five key building blocks for the strategy are:

1. *Regional integration* through the creation of Medicare Locals.
2. *Information and technology*, including the Personally Controlled Electronic Health Record.
3. A *skilled workforce* with additional funds for training health professionals and expanded access to the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme.
4. *Infrastructure,* with GP Super Clinics and the Primary Care Infrastructure funding.
5. *Financing and system performance* funding.

The strategy identifies four key priority areas for change:

1. *Improving access and reducing inequality* with a focus on after hours primary health care, access to primary health care for older Australians, mental health and an indigenous chronic disease package.
2. *Better management of chronic conditions* with a focus on diabetes care.
3. *Increasing the focus on prevention* with a new National Partnership Agreement (NPA), establishing Medicare Locals to conduct local planning and commissioning the Australian Health Survey.

4. *Improving quality, safety, performance and accountability* with a new performance and accountability framework, a new national performance agency and expanding the role of the Australian Commission of Safety and Quality in Health Care.

Under the National Health Reform Agreement the Commonwealth will develop a national strategic framework to set out agreed future policy directions and priority areas for GP and primary health care. This work will be informed by bilateral work on state-specific plans for GP and primary health care, with state-specific plans to be completed by July 2013[1].

3.1.1 Medicare Locals

A key component of the Commonwealth's National Health Reform process is the establishment of Medicare Locals (MLs). MLs will coordinate primary health care delivery and tackle local health care needs and service gaps through population based planning. They will also drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities. The roles and responsibilities of MLs are still emerging but it is anticipated they will be driven by evidence-based local population needs and based around the following 5 key objectives:

1. Identification of the health needs of local areas and development of locally focused and responsive services
2. Improving the patient journey through developing integrated and coordinated services
3. Provide support to clinicians and service providers to improve patient care
4. Facilitation of the implementation and successful performance of primary health care initiatives and programs
5. Be efficient and accountable with strong governance and effective management

In developing locally focused and responsive services MLs are required to have strong links to both General Practice and the community. There is a remit to establish a dialogue with consumers and some MLs have already established Community and Consumer Forums. The emergence of this model provides opportunities for the HealthOne NSW program, in particular those around developing integrated and coordinated services.

3.2 The policy context for primary and community health care in NSW

In 2007, NSW Health adopted the term 'Primary and Community Health' (PaCH) to describe the overlapping primary health care and community health sectors and services as a single integrated and cohesive structure[2]. Although the two sectors share many common features, and both are founded on the principles of primary health care, they have differing roles and organisational structures:

- Primary health care refers to universally accessible, generalist services (e.g. general practice, community/early childhood nursing services) that address the health needs of individuals, families and communities across the life cycle. Comprehensive primary health care includes early intervention and health promotion, treatment, rehabilitation and ongoing care. For most people, these services are the first point of contact with the health care system. Private practitioners provide the majority of primary health care services

- Community health refers to a range of community-based prevention, early intervention, assessment, treatment, health maintenance and continuing care services delivered by a variety of providers. Community health services predominantly operate from a social model of health whereby improvements in health and wellbeing are achieved by directing efforts towards addressing the social and environmental determinants of health. The NSW public health system provides the majority of community health services.

In 2011, the NSW Government published *NSW 2021: A plan to make NSW number one*. There is a focus on illness prevention, including a strong focus on mental health. The aim is to reduce the burden of chronic disease on the health system and keep our community active and healthy.

3.3 Integrated primary and community health care: doing things differently

3.3.1 The challenges

Increasing rates of chronic diseases, expanding costs in the health system and workforce shortages have led to funders to consider how to sustain more efficient health care systems. Current challenges identified by the National Health and Hospital Reform Commission Report are[3]:

- the growing burden of chronic disease;
- avoidable hospital admissions;
- changes in treatment meaning that clients need greater and more complex care in the community; and
- increasing demand for clinical placements and training facilities for primary and community health care students and health professionals.

3.3.2 A NSW government response

As a response to these emerging challenges in the health sector NSW Health has been developing an integrated approach to primary and community health. Since 2006/07, the NSW Government has committed more than $45 million of capital funds to the development of HealthOne NSW services across NSW. A further $3.3 million per annum has been made available to LHDs each year to support nursing, allied health and service integration positions within HealthOne NSW and other primary and community health services.

4 HealthOne NSW

HealthOne NSW is an integrated primary and community health initiative that brings together GPs with community health and other health professionals in multidisciplinary teams. Bringing together these health professionals in a flexible manner is the strength of the model. While there is no fixed model for HealthOne NSW services, they are characterised by a motivation to bring health care professionals together to reduce the increasing burden of chronic disease and to focus on those people in the community who need a greater level of coordinated care. These goals can be achieved by a variety of methods and HealthOne NSW services are an ideal platform to bring together a mix of

public and private health services from state and commonwealth funded programs to non government run services.

We ask what are the problematic cycles that have developed and then we go ahead and work to break those cycles

4.1 Key objectives

The five objectives of HealthOne NSW are to:

1. Prevent illness and reduce the risk and impact of disease and disability
2. Improve chronic disease management in the community
3. Reduce avoidable admissions, and unnecessary demand for hospital care
4. Improve service access and health outcomes for disadvantaged and vulnerable groups
5. Build a sustainable model of health care delivery

These objectives are achieved by designing services with reference to the four key features of HealthOne NSW services: integrated, client focused, multidisciplinary team care across a spectrum of needs (pp.7-12). The process for developing these services is facilitated by focusing on the HealthOne NSW enablers: planning, governance, technology and workforce (pp.13-19).

Case study: HealthOne Auburn – improving access for vulnerable groups

The focus of HealthOne Auburn is the refugee community along with other vulnerable and at risk families in the area. Over 70% of the Auburn population speak a language other than English at home and one third of all refugees coming into NSW settle in the Auburn, Parramatta, Holroyd and Blacktown Local Government areas.

HealthOne Auburn has formed relationships with the Medicare Local, local GPs, the NSW Refugee Health Service, Transcultural Mental Health and Mental Health Services to progress the implementation of the HealthOne Auburn Model of Care.

4.2 Key features

The four key features of HealthOne NSW services that distinguish them from other primary and community health services are:

- Integrated care provided by general practice and community health services
- Organised multidisciplinary team care
- Care across a spectrum of needs from prevention to continuing care
- Client and community involvement

4.2.1 Integrated care

Fundamental to HealthOne NSW is the integration of general practice and community health services, along with other specialist, allied health and community services, in a way that is different from either a conventional general practice or community health service. The range of services provided by each HealthOne NSW service is configured to meet the needs of the local community as required, and will vary from site to site.

Sit down as a team and define the service model as early as possible

The integration of services may:

- increase equity of access to a comprehensive range of affordable primary and community health care services
- enable the client to be central to his or her own care planning and health management
- improve individual and population health outcomes
- reduce the fragmentation that often results where primary health services are funded and administered by different levels of government
- create efficiencies for service providers where resources and services are shared
- introduce more robust governance arrangements for the health and wellbeing of populations (and use of resources)
- create more professionally satisfying work environments for health professionals

In practical terms, integration for HealthOne NSW means that the planning, administration and provision of primary and community health care services is integrated. In establishing HealthOne NSW services, the process of transition from autonomous services, often provided at separate locations some distance from each other, to integrated services, can take time. Service partners may take a staged approach, starting with collaborative or coordinated arrangements. Successful integration is an ongoing adaptive process rather than a one-off initiative, it is organisational systems and processes, the work of teams and individuals that ultimately achieve the alignment and coordination associated with integration to deliver stepped changes for client and population benefit[4].

The integration of services can be achieved using one or a combination of any of the three HealthOne NSW service configuration models: services provided from one structure or location, services provided using a hub and spoke model or services that are virtually integrated.

Case Study: HealthOne Quirindi – a model of care coordination for those who need it

HealthOne Quirindi comprises a general practice co-located with community health and it is located within the same facility as Quirindi Community Hospital, with an integrated reception for all the services.

Under the HealthOne Quirindi model all clients are considered HealthOne NSW clients. There is no specialised intake process. According to need clients are allocated levels one to three. Level one clients are provided care for the presenting need. Level two clients undergo a more comprehensive assessment and may be seen by more than one health care professional. Level three clients require coordinated care from a range of health care services and/or professionals.

Using a client-centred approach to integrating care, all level 3 clients are invited to nominate a care coordinator. The HealthOne Quirindi team participates in monthly care coordination meetings for Level 3 clients. This team develops a care coordination plan. This plan is designed to reduce service duplication and the care coordinator ensures that team 'did what we said we would do'.

The *My Health Record* (red book) and the children's *Personal Health Record* (blue book) are used as communication tools for sharing health information with both the client and the treating health professional.

The strength of the partnership between the Local Health District, the general practitioner(s), the Medicare Local, local government and any other organisation involved in the establishment of a HealthOne NSW service is critical to the successful integration of services. Integration is achieved as

a result of careful planning by the participating organisations for the delivery of services, as well the practical, financial and administrative arrangements required.

Two different approaches have emerged for providing integrated care that is appropriate in the local setting. The first approach enrols, formally or informally, all clients seen by the GP as HealthOne NSW clients. This is often the working approach for HealthOne NSW services in smaller communities with a co-located primary and community health care team. Access to specialist services in these communities is through visiting services at the HealthOne NSW facility. At these services there is usually a formal process for identifying clients with a need for more coordinated, joined up care from the wider multidisciplinary team (MDT).

The second approach is where HealthOne NSW services identify vulnerable sub-populations within the community who require a more coordinated approach to care (e.g. child and family or chronic illness). At these services the integration team, led by a GP Liaison Nurse, works together to provide a more integrated care to clients. This is often the approach taken in larger, metropolitan centres. These larger centres may add a spoke site for serving smaller communities.

4.2.2 Organised multidisciplinary team care

The second key feature of the HealthOne NSW service model of care is MDT care. An MDT involves a range of health professionals, from one or more organisations, working together to deliver comprehensive client care. The ideal MDT for the delivery of the HealthOne NSW model of care includes members from a clinical team and an administrative team.

CLINICAL TEAM

- General Practitioner(s)
- Practice Nurse(s)
- Community Nurse(s)
- Health educators (e.g. diabetes educators)
- Allied health professionals (e.g. physiotherapists, occupational therapists, dietitians, psychologists, social workers, podiatrists and Aboriginal health workers)
- Visiting health professionals, including specialists

Allied health professionals and medical specialists may be co-located in the service or be present as visiting health professionals. The visiting health professionals may be a mix of state funded community health and private professionals.

ADMINISTRATION TEAM

- Business Manager and/or Data Manager
- Receptionist
- Administration staff

As outlined clinical and administrative team members may come from the general practice and community health. Using a partnership approach to building the MDT members may also come from a wider set of partners, for example an Aboriginal Medical Service, Non-Government Organisations (NGOs) and other government services such as Family and Community Services (e.g. Housing, DADHC, DOCs).

Under the HealthOne NSW approach the MDT is linked together to provide integrated primary and community health care. This linking may be achieved by one role that does a mix of clinical and administrative work or by several roles (see the case study: HealthOne NSW – key roles for integration).

HealthOne NSW: shared MDT meetings

Shared integration meetings have seen real wins at many HealthOne NSW sites. Initially, the process of getting people together can be a hurdle to overcome. In circumstances where IT integration is patchy and the sharing of electronic health information is difficult these regular meetings are very important.

At HealthOne Molong the sharing of client health information happens verbally at these meetings. All of the team members from community health and General Practice have an opportunity to suggest clients for discussion to these meetings. For children there is a meeting every fortnight and for adults this sharing of information takes place in the hospital discharge planning discussion.

These meetings have made a difference and enabled the integration team to have a clearer understanding of who does what.

MDTs convey many benefits to both the clients and the health professionals working on the team. These include improved health outcomes and enhanced satisfaction for clients, and the more efficient use of resources and enhanced job satisfaction for team members.

To ensure optimum functioning of the team and effective client outcomes, the roles of the multidisciplinary team members in care planning and delivery must be clearly negotiated and defined This requires[5]:

- respect and trust between team members
- the best use of the skill mix within the team
- agreed clinical governance structures
- agreed systems and protocols for communication and interaction between team members

Case study: HealthOne Raymond Terrace – best practice MDT care through care pathways

HealthOne Raymond Terrace has not been built yet but the team at Hunter New England Local Health District have already commenced work on developing the HealthOne NSW model of integrated care.

The Clinical Integration Coordinator conducted a gap analysis for the service. Using the results of this work, a multidisciplinary working group came together and agreed on the criteria for prioritising service gaps, with Chronic Obstructive Pulmonary Disease (COPD) identified as the priority.

The Clinical Integration Coordinator reviewed the evidence and produced a draft pathway for the working group to develop further and approve. The outputs of this team influenced the local referral rules for COPD thus streamlining the care pathway for clients.

The working group also had to overcome the barrier of sharing the care pathway among the diverse group of health professionals. With the assistance of the New Zealand Canterbury Initiative the working group engaged Health Pathways to publish their COPD care pathway. The success of the project has now been spread to the entire Hunter New England Local Health District where Health Pathways goes live in March 2012.

The members of these MDTs may work in a single location or may provide care as a virtual team. Ideally the sharing of client health information would happen seamlessly across the boundaries of care and systems. The technological logistics of this is complex and may be currently beyond the scope of many teams.

4.2.3 Spectrum of care

The third key feature of the HealthOne NSW model of care across a spectrum of needs, these include:

- Primary prevention through health promotion and illness prevention
- Secondary prevention through early detection and intervention
- Continuing care for people with chronic and complex conditions, including tertriary prevention
- Multidisciplinary planned care for those who need it

In meeting these needs, the client must be clearly defined. HealthOne NSW clients are not a uniform population. There are no pre-defined criteria for HealthOne NSW services, these criteria must be decided so that local needs are met across the spectrum of needs. In smaller populations all clients may be HealthOne NSW clients and sub-populations are then identified as needing more joined up care. In larger metropolitan centres where service provision is meeting the needs of a larger number of people, HealthOne NSW may choose to use its integrated team to identify specific sub-populations for enrolment.

Case study: HealthOne Mt Druitt – clearly defining the client

HealthOne Mt Druitt operates under a model where general practice and community health are linked virtually without co-location. The coordination is led by a GP Liaison Nurse. The model at HealthOne Mt Druitt is focused on providing care to two distinct sub populations within the community: child and family and chronic and complex clients.

Identifying the chronic and complex stream is a more straight-forward process as these clients have clear indications for requiring additional care, for example a certain number of hospital presentations and a chronic condition.

The Child and Family clients who require additional care were more difficult to identify and the enrolment criteria were quite broad. A solution was provided with the implementation of the *NSW Health Maternal and Child Health Primary Health Care Policy* in the Supporting Families Early Package. Child and Family Health Nurses are now offering clients enrolment into the program whose level of care service response is determined as a level two or level three under this policy. Other staff who are not utilising the Supporting Families Early Package continue to refer to the broader criteria.

The range of services provided by each HealthOne NSW service will also vary from site to site and is planned and delivered in response to the needs of each community. The range of services reflects the spectrum described above, and can include immunisation, the provision of healthy lifestyle clinics and information sessions (smoking cessation, cardiac fitness), child and maternal health care, diabetes education, continence assessment, mental health care, cardiac rehabilitation, palliative care, drug and alcohol services and a number of dedicated Aboriginal health services.

Time and reflection has taught us we need to be more specific when identifying clients who require additional care

Several HealthOne NSW services also provide or co-ordinate access to other government and non-government health and human services to assist clients from culturally and linguistically diverse backgrounds, people from Aboriginal communities and others who require assistance to access health services and information. The range of HealthOne NSW service partners has previously included the Department of Community Services, the NSW Refugee Health Service, NSW Juvenile Justice, Aboriginal Health Services, Transcultural Mental Health Services, interpreter services and others.

Case study: HealthOne NSW as a platform for health promotion in the community

HealthOne Coonamble is a platform for health promotion in the community. The core team bring together 'virtual teams' of health professionals to conduct health promotion activities in the community. Depending on the focus of the activity, these 'virtual teams' can include staff from primary care, community care, the local Aboriginal Medical Service and members of the local community.

HealthOne Coonamble applied for local council funding to run a health promotion activity. After conducting a health needs analysis HealthOne Coonamble was able to focus its attention on:

- building the community's capacity to prepare and eat healthy meals
- exercise programs, including a walk and talk group and a young women's exercise group
- a falls prevention program

As a result of the team building the profile of HealthOne Coonamble in the community, the local high school invited the team to present to the senior school on health issues for the *Crossroads* program.

4.2.4 Client and community involvement in HealthOne NSW services

The fourth key feature of the HealthOne NSW Model of Care is client and community involvement in care and planning for care. Best practice consumer participation recognises and engages with consumers as partners in healthcare and healthcare decision-making. This recognises that consumers have a role that is more than that of a recipient or subject of healthcare[6].

This translates into client-centred care at an individual level, client-clinician-carer involvement in planning care pathways or client journeys, and community involvement in planning for local health services to meet their needs.

In the development of HealthOne NSW services the client voice should be incorporated in the strategic development of services. This can occur through through representation on clinical governance committees and via the monitoring of the services[7]. The use of existing forums should also be considered as a means to gathering the views of community. At the LHD the Local Health Advisory Committee is an ideal avenue, as are the emerging Medicare Local Consumer and Community Forums.

Get out there and talk to the broad community – raise the profile of HealthOne NSW – so that the community knows who to come to when they need help with health promotion

In addition to community involvement in HealthOne NSW services, it is also important that services ensure that the care provided is client-centred. Research has identified three key elements of client-centred care that HealthOne NSW services should consider when planning for services[8]:

- communication with clients, including explanation of health issues and exploration of feelings, beliefs and expectations;

- partnerships with clients so that they have the autonomy within the client-clinician relationship to be involved in decision making;
- a focus beyond specific conditions, on health promotion and healthy lifestyles.

Case Study: HealthOne NSW – improving outcomes for individual clients

Joan* is a 40 year old partial quadriplegic who weighs 115kg and has a history of refusing to go to the hospital for necessary care. Any care required in hospital needs to be negotiated with Work Cover NSW. On admission Joan must be turned every hour and there had previously been conflict about whose role it was to provide this level of care. Prior to HealthOne NSW communication with the insurer was not initiated until after hospital admission, which often meant a delay to her necessary care and a longer hospital stay from resulting pressure sores.

Enrolment to the HealthOne NSW program has facilitated better care through a discussion with all stakeholders and an agreed management plan for who does what when. In partnership with Joan an agreed process was developed for an emerging need for hospitalisation. This has resulted in early intervention by the HealthOne NSW GP Liaison Nurse who is able to negotiate post admission care with the hospital, reducing the delay to appropriate care and ultimately resulting in a reduced length of stay. After 8 months, Joan has had 30% less hospitalisations. (*name and age have been changed)

4.3 Enablers

The enablers are the tools that Local Health Districts and their partners will need to build a successful service. There are four enablers for HealthOne NSW services:

1. Service and capital planning
2. Governance and sustainability
3. Information and communication technology
4. Workforce development

4.3.1 Service and Capital Planning

The level of planning required to establish a successful HealthOne NSW service is considerable and should not be underestimated.

Plan! Plan! Plan!

The HealthOne NSW Capital Planning Process Flowchart (Figure 2) sets out the process for the planning and development of a HealthOne NSW service. The first step should be the establishment of a planning working group. This group will develop a service plan and membership should consider representation from community members. As the project develops both the name and the composition of the working group may change according to the clinical and operational governance requirements. For example, the planning working group will need to be expanded into a Planning and Development Committee after a service plan is developed. Membership of each of these groups should be as broad as possible.

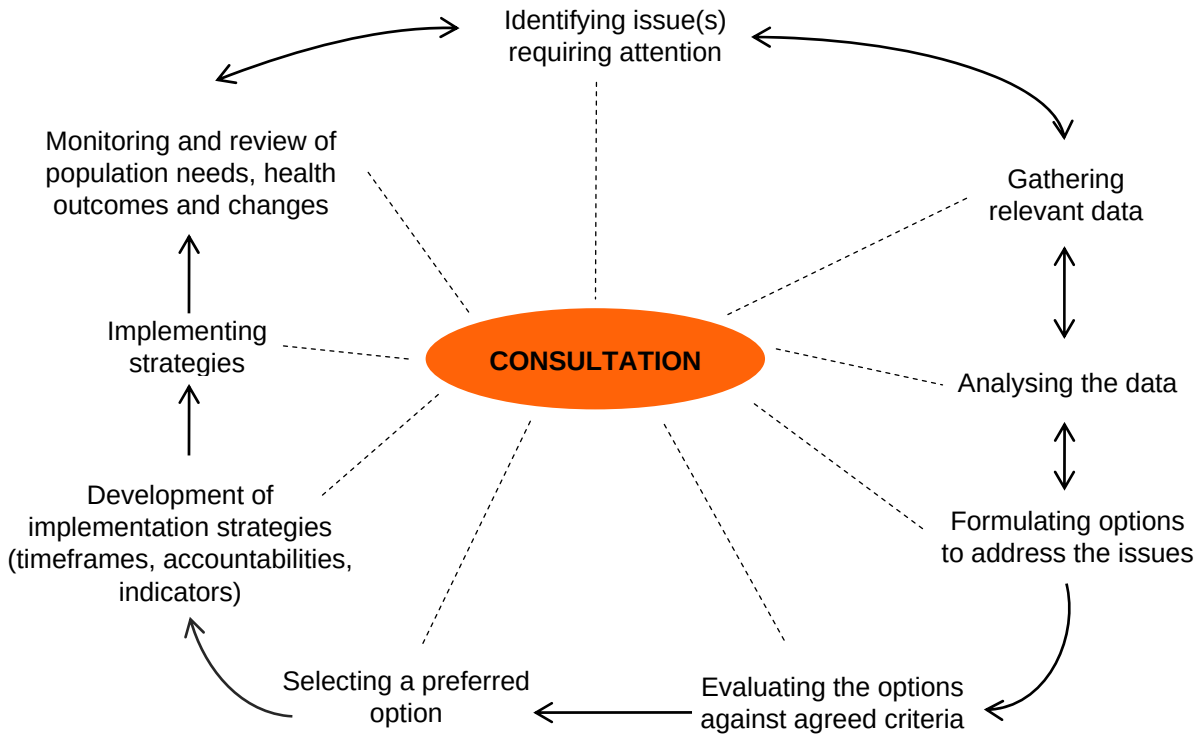
Service Planning

Service planning is an essential pre-requisite to developing a HealthOne NSW service. The service plan should provide background information about the local community, the services currently

available and demonstrate the need for the HealthOne NSW service. Any HealthOne NSW service plan developed must also align with the Local Health District Service Plan.

Service planning always takes longer than what you think. Set clear deadlines and follow up and support colleagues to get things done on time

Figure 1 The Planning Process



Source: Figure 2, NSW Health Guide for the Development of Area Healthcare Services Plans, 2005

Future proof your planning process to make sure you can meet service needs

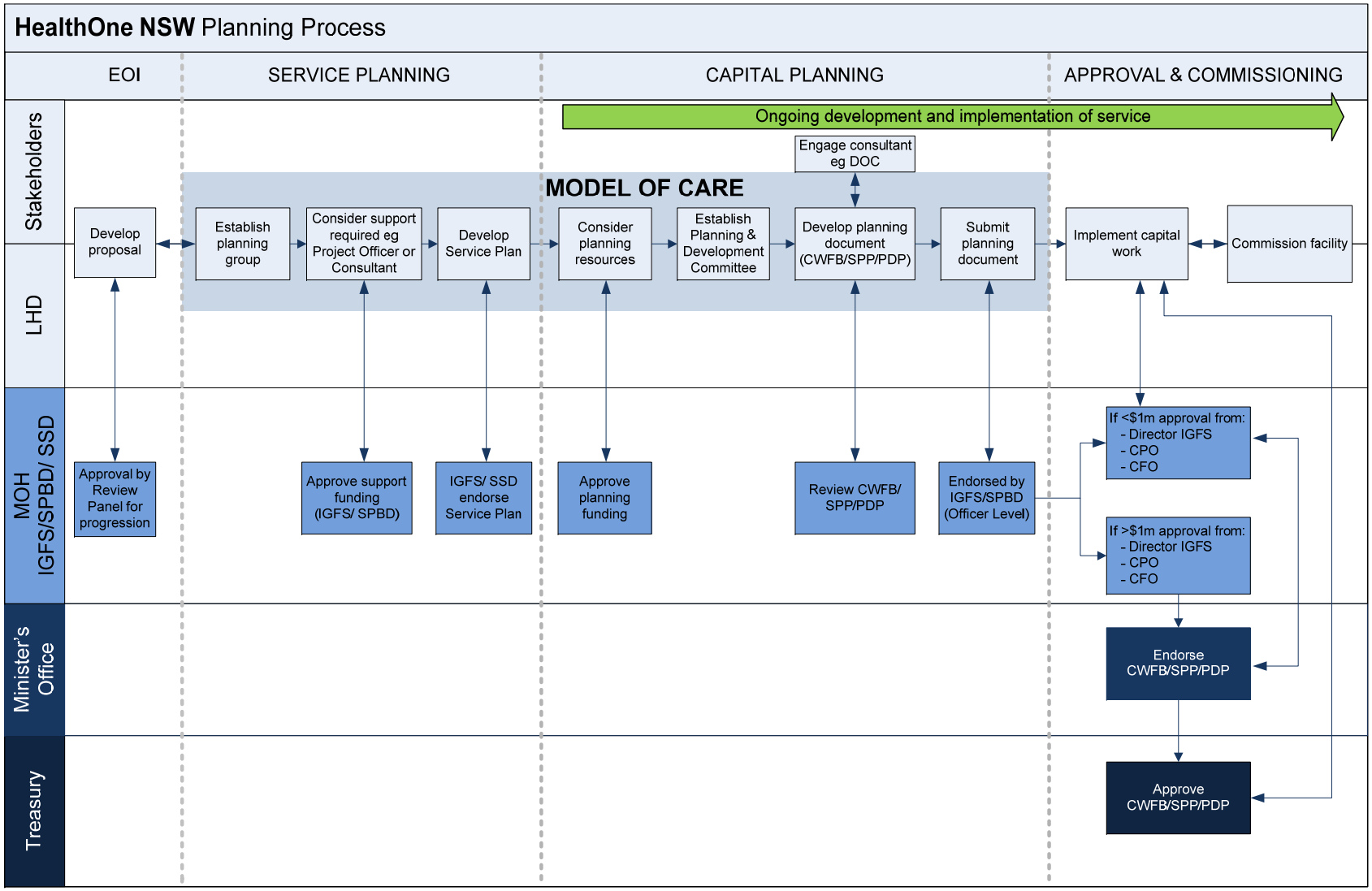
The NSW Health *Guide for the Development of Area Healthcare Services Plans* outlines the process for developing a Local Health District service plan and the importance of linking individual service plans to the direction of the LHD. Consultation with key stakeholders is typically critical to the success of local service planning[9].

The *Service Planning Handbook for Rural Health Planners*, available from the NSW Department of Health's intranet site, provides useful information about service planning. This document outlines planning for NSW Health services; a generic outline of approaches to adopt; a description of the process for service planning; description of contents expected in a service plan with suggestions on the scope of detail; and a list of planning resources to assist planners.

Capital Planning

The procurement portal on the NSW Health website provides information for Local Health Districts and other government and non-government organisations involved in the planning and delivery of health care facilities in NSW. NSW Health service planners can draw on a number of resources such as guidelines, templates and process maps for projects. These documents can be found at: http://www.health.nsw.gov.au/assets/process_update.asp.

Figure 2 HealthOne NSW Capital Planning Flowchart



The NSW Treasury has produced the *NSW Government Guidelines for Economic Appraisals* which also provides guidance for the preparation of Financial Impact Statements. It can be found at www.treasury.nsw.gov.au.

The Australasian Health Facility Guidelines are also recommended for use in NSW Health capital developments. They can be found at: http://www.healthfacilityguidelines.com.au/default.aspx.

The RACGP Standards for general practices will also be useful for those services who wish to co-locate general practice. They can be found at: http://www.racgp.org.au/standards.

Be practical when planning – think of simple things like storage, computer ports, phone lines

4.3.2 Governance and sustainability

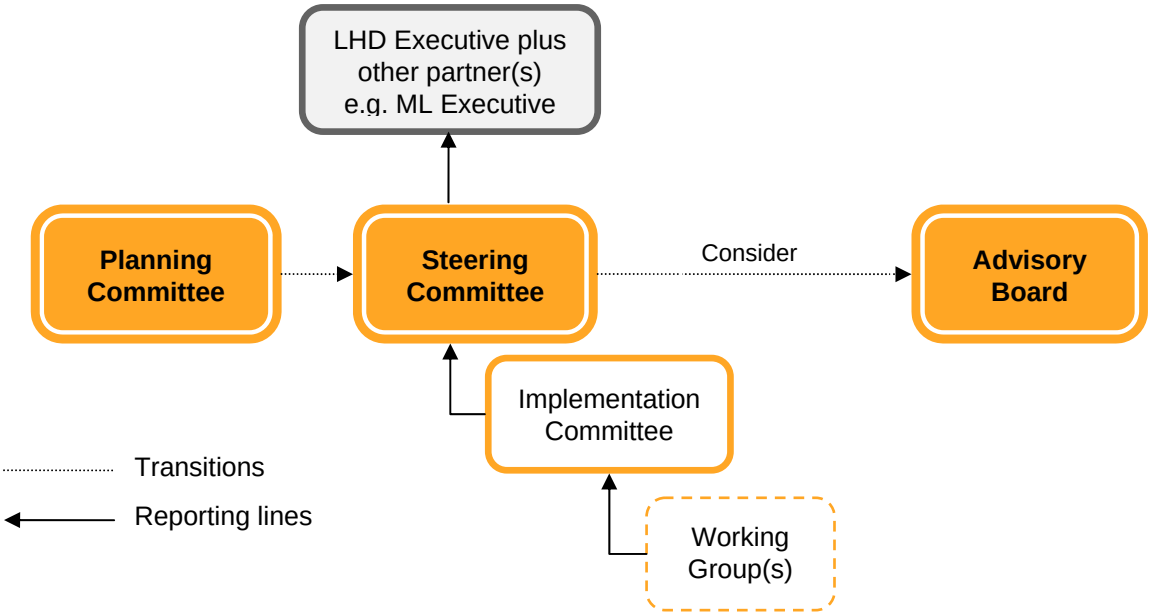
Governance

The establishment of new integrated care services in diverse settings across NSW represents an innovative approach to providing primary and community health care for the community. HealthOne NSW services involve a range of participants and stakeholders that varies from site to site and can include the NSW Ministry of Health, Local Health Districts, General Practitioners, Medicare Locals, Local Government Authorities, non-government organisations and other service providers. These participants come together through a governance structure that should begin to be established early in the service planning process and continue to be developed as the service itself is developed.

The best way to persuade people to be involved is to demonstrate clear benefits for clients

Good governance processes must include a consideration of both the clinical and the operational governance. Services must establish suitable governance arrangements which meet individual and collective needs and comply with relevant legislation.

Figure 3 HealthOne NSW: good governance structures



In the context of the HealthOne NSW services clinical governance refers to the structures and processes for decision-making on client care and treatment, including the keeping of records. It relates to specific clinical decisions relating to aspects of quality care, safety and client needs. Clinical governance integrates clinical decision-making in a management and organisational framework and requires clinicians and administrators to take joint responsibility for the quality of clinical care delivered by the organisation. This is normally subsidiary to corporate governance and is best delegated to those with professional expertise and clinical responsibility.

Partnering with the Medicare Local has been crucial – it facilitates a greater involvement with so many community stakeholders, as well as general practice

Operational (corporate) governance refers to the arrangements, structures and processes for decision-making in relation to corporate and organisational issues and the roles and responsibilities of the participants in relation to the financial, contractual and business arrangements for the service.

More information on the establishment of suitable, workable corporate governance arrangements for HealthOne NSW services can be found in the *Guidelines for Developing Governance Arrangements for HealthOne® NSW Services*. The recommended approach and resources in the document have been informed by the experiences of existing HealthOne NSW services with multiple configurations.

Case study: HealthOne NSW in Western Sydney – one approach to good governance

Western Sydney Local Health District (WSLHD) has four operational HealthOne NSW sites and several more in various stages of development. It currently has a Steering Committee and an Implementation Committee for each of its operational HealthOne NSW services.

As the ultimate decision-making authority the Steering Committee requires high level representation. There is a need for broad representation to ensure buy-in by the greatest number of people. There is currently a Steering Committee for each service and as the services become embedded WSLHD and Western Sydney Medicare Local (WSML) want to ensure that there is no duplication. The Executives of both organisations are currently considering how to meet the overarching governance needs of the HealthOne NSW services; one consideration is a single Steering Committee for HealthOne NSW across Western Sydney.

There is an Implementation Group for each HealthOne NSW service and this is the group that works on matters relating to service delivery e.g. setting up services, developing clinics and developing promotional material. Its membership is comprised of a subset of the Steering Committee plus additional clinical and administrative staff. This group drives the day to day work of the services and may set up time-limited Working Groups (e.g. capital and fit out working group, diabetes working group).

As the services change the governance structure may also need to change, co-opting new members when new partners are added.

Sustainability

Integration is not the cure for inadequate resources[10]. In the face of limited resources, planning for integrated care requires a consideration of the recurrent costs to the service in the future. The service design must be sustainable, it must balance rising cost pressures against limited resources. Financial sustainability, while the most obvious consideration, is not the only consideration. There are many dimensions to sustainability. In a general sense, they can be grouped into the following six domains[11]:

- Financial - availability of general funds, specific funds and incentives
- Political - taking into account local, state and national political contexts

- Institutional - relationships between and within institutions
- Economic - affected by interactions between funding models and models of care, staff time and workload issues
- Client - dependent on expectations, experience and out of pocket costs for client
- Workforce - staffing profile, skills and staff motivation

4.3.3 Information sharing and communications

The capacity of clinicians across HealthOne NSW services to exchange client information and to have information systems that provide data to support a multidisciplinary team environment is critical to the effective operation of a HealthOne NSW service. Information sharing can be achieved in person, in a paper file and through electronic means.

Significant barriers exist for the electronic sharing of health information when working across different services and locations. This is an area where incremental gains are more likely from a stepped approach to sharing health information across services and locations.

Integrated IT is a real barrier – but people will do the best with what they have

The NSW Ministry of Health has published a set of documents outlining HealthOne NSW service responsibilities for privacy, consent and the sharing of information. The Privacy Guidance for Local Health Districts and its supporting documents lay a foundation for developing good practice around the sharing of a person's health information. The Commonwealth Government has policy responsibility for a national Personally Controlled Electronic Health Record (PCeHR). HealthOne NSW services which implement the privacy guidance should be well placed to take advantage of the PCeHR, due for implementation from 1 July 2012.

NSW Health acknowledges that there is more work to be done in this area.

Case study: HealthOne Northern Sydney – the virtual integration of care

A feature of HealthOne Northern Sydney is the virtual integration of community health and general practice via secure messaging of clinical information. General practices collaborating with HealthOne Northern Sydney are now able to receive admission and discharge status messages and full hospital discharge summaries via secure messaging.

The sharing of health information at HealthOne Northern Sydney has been a staged project. Testing is now underway to allow electronic GP referrals into GP Shared Care services such as Acute/Post Acute Care. Plans for the next stage are in place to include other community health discharge summaries in the collection of services that can securely and electronically transmit information back to general practice.

4.3.4 HealthOne NSW Workforce

The Productivity Commission report on Australia's health workforce identified workforce shortages across a number of health professions, particularly in rural and remote areas. The report acknowledged that developing technology, growing community expectations and the ageing population will increase demand on the health workforce. Strategies identified to address this problem include increased efficiency and effectiveness of the available workforce and the development of new models of care[12].

Thought needs to be given to change fatigue in a constantly changing environment, especially when staff work in a recently restructured service

It is also necessary to consider the way in which the team is organised. The delineation of roles, task delegation (which professional completes which task) and task substitution (where a person from one professional background performs a task traditionally performed by another type of health professional) to maximise the use of the various skills of the team in order to provide effective and efficient care[13].

A current example of task delegation and substitution can be found in general practice, with the increasing emphasis on the role of practice nurses supported by the Practice Nurse Incentive Program. This allows more efficient use of the skills of the practice nurse and general practitioner. Similarly, there have been recent changes to the MBS to allow greater use of the allied health workforce. However, there are constraints to which tasks can and cannot be delegated and substituted within the general practice component of a HealthOne NSW service.

Case study: HealthOne NSW – key roles for integration

HealthOne NSW services take different approaches to the key roles for integrating primary and community health care. In HealthOne NSW sites that service larger populations and/or are multi-site facilities the roles are often split between two functions, as below:

Integration Coordinator	GP Liaison Nurse
▪ non-clinical, operational role ▪ focuses on the – operational planning, – governance, and – management of the service	▪ clinical role ▪ focuses on identifying clients requiring care coordination and linking GPs and other health care professionals ▪ require a good knowledge of the services offered within the community ▪ as clinical change manager this role will need to use the governance structure within the organisation to effect change

For those HealthOne NSW services working to smaller populations the functions of an Integration Coordinator and GP Liaison Nurse is often a single Clinical Integration Coordinator role. This role can be split so it is performed by more than one person.

Clinical Integration Coordinator
▪ the full mix of clinical and operational work outlined above ▪ the driving force for integrating care ▪ strongly embedded in the clinical operation of the service

There are various other ways to split the clinical and non-clinical aspects of integration. Irrespective of how the roles are delineated the goal is to bring together primary and community health care professionals to provide an integrated service.

The success of these strategies to implement new ways of working is dependent on professional respect, understanding of each others roles and building trust within the team. Supporting workforce changes with sound clinical governance, planning, team meetings and team activities can help foster understanding and respect.

Don’t duplicate! Link with other services to lighten the load of the entire system

Many General Practice and Community Health services carry full clinical loads and often experience workforce shortages, creating challenges in implementing the necessary service changes. Careful consideration needs to be given to these when developing and implementing a HealthOne NSW service. Once functioning fully, the HealthOne NSW model aims to maximise use of the current primary and community health care workforce and also attract new staff by offering professionally satisfying work environments.

4.4 Service configurations

There is no single model of integrated care that is suited to all settings; local needs should guide decisions about the models of care best suited to each LHD. To date three broad service configurations have been identified for HealthOne NSW services. These are not mutually exclusive and some locations may use two configurations, for example hub and spoke and virtual, or co-located and hub and spoke. Effective operational (corporate) and clinical governance structures and communication strategies will be essential to promote and support integration under each of the service models.

Each service configuration is characterised by a set of service elements. These are the basic requirements for consideration when planning for and designing for HealthOne NSW service (Figure 4).

We started with one scenario and as we lived and breathed it, we realised the model needed to be improved. We are constantly learning and adapting.

4.4.1 Service elements

For all HealthOne NSW services, the goal is to create a system that delivers integrated, client focused, multidisciplinary team care across a spectrum of needs. To implement this type of care there are a set of service elements: two are compulsory for all HealthOne NSW services, the remainder are elements that services are urged to consider when designing and developing their configuration. The two compulsory service elements are:

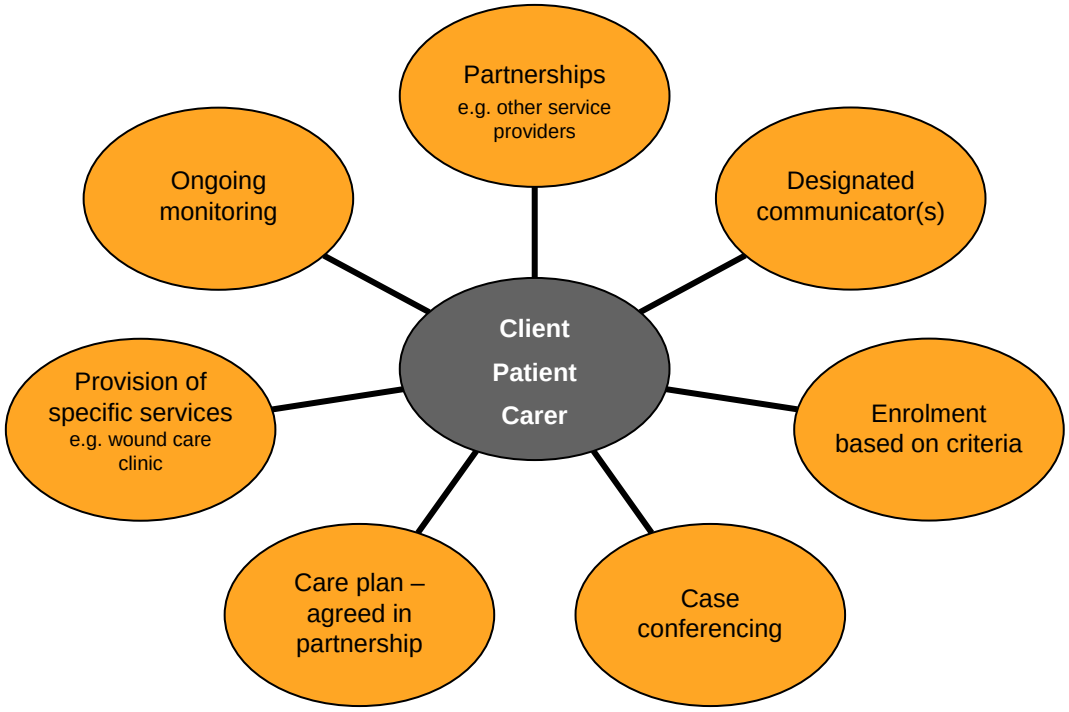
- **Partnerships**: at a minimum, HealthOne NSW services should have strong links between General Practice and community health.
- **Designated communicator(s)**: are important for the operational and clinical aspects of a service. Clients who require a higher level of care co-ordination should also have a single contact point. These designated communicators can be within a single role or split across several roles.

Services are also urged to consider the following service elements:

- **Enrolment based on criteria**: this enables a clear identification of the client. At a minimum, services without a formal enrolment process should have a system for ensuring clients consent to the sharing of their health information.
- **Provision of specific services**: examples of specific services include clinics in wound care, foot care, maternal and child health and immunisations. Additionally HealthOne NSW can be a platform for health promotion activities such as healthy eating and smoking cessation.
- **Case conferences**: case conferencing provides an opportunity to improve the management of clients with complex needs.

- **Care plan**: any care plan should be agreed in partnership with the client and their multidisciplinary team.
- **Ongoing monitoring**: at a minimum those clients who have a care plan will require ongoing monitoring.

Figure 4 HealthOne NSW: Typical service elements



Source: modified from HealthOne Mt Druitt Key Service Pathway Elements

The biggest achievement is that all clinicians recognise the importance of the GP. Before HealthOne NSW that wasn't happening.

4.4.2 Co-located services

Co-location involves general practice, community health and other services physically located together or in close proximity to each other, often in the same building. Although co-location does not necessarily lead to integration, the proximity of service providers enhances opportunities for informal and formal communication, collaboration and the coordination of care for clients.

Co-located services need to plan for the levels of service integration required for client groups who include people with relatively simple needs through to those with complex conditions who require the involvement of multiple health professionals.

A truly great result of co-location is informal communication across the health professional boundaries, just talking in the tea-room and corridors makes a difference

Co-location is not always not always feasible or desirable, particularly in metropolitan areas where existing primary and community health care services may be dispersed over a large geographical area. Hub and spoke and/or virtual models may be more appropriate for some locations.

Case study: HealthOne Blayney – integrated care for small populations through co-location

At HealthOne Blayney the general practice is co-located with community health in a single building with a shared reception. More than 20 visiting services operate from HealthOne Blayney. The local hospital is also located in the same building but with a separate entrance. All clients who attend the service consent through a single process and they are all provided with integrated, holistic care. Prior to HealthOne Blayney clients had to register with each service and services were quite separate with duplication in many areas.

The Clinical Integration Coordinator is the first point of contact for staff in the wider team and is responsible for ensuring services are coordinated. Every two months the HealthOne Blayney team come together to discuss clients who require additional coordination of their care.

4.4.3 Hub and spoke

In a hub and spoke model, one site acts as a central base for activity and plays a support and coordination role to the spokes or satellite services. Providers in the satellite services may also provide services to the hub. Effective corporate and clinical governance structures and communication strategies are essential to supporting integration between the hub and its spokes.

Case study: HealthOne Mt Druitt and HealthOne Willmot – a hub and spoke model

HealthOne Mt Druitt is a hub located in a purpose-built extension to the Mt Druitt Community Health Centre. The integration of services is, in part, virtual and achieved by the collaboration of GPs, Community Health and other service providers. The HealthOne Mt Druitt hub operates several joint clinics and outreach clinics at the spoke site of HealthOne Willmot.

Willmot is located on the periphery of Mt Druitt and the service was established after extensive community and stakeholder consultation. There were previously trust and safety issues at the site and problems with transport.

Based on the needs assessment, HealthOne Willmot provides services for 2 part-days per week. HealthOne Willmot provides an information and referral service, and:

- Child and Family Health Clinic
- Women's Health Clinic, and
- Mature Age Person's Clinic

HealthOne Willmot aims to provide a foot care clinic through an additional visiting services via a partnership with the local aged care facility. The team is also looking at linking the service with the outreach bus for conducting Health Checks.

4.4.4 Virtually integrated services

In the virtual model, a number of separately located providers function as a team through electronic and other forms of communication. Members of a virtual HealthOne NSW may rarely meet face to face. Integration may occur through formalised networks based on explicit governance arrangements and is often unpinned by service level agreements or contracts.

The virtual HealthOne NSW service model may be more appropriate for the coordination of services to clients whose care requires the involvement of fewer health professionals. While the provision of fully integrated services is possible in a virtual model, significant planning is required to ensure governance structures and communication technologies support clinical care and workforce requirements. Relationships that are linked by shared goals is a key feature of models that successfully integrate using a virtual approach.

It may be possible to establish either a co-located service or a hub and spoke model that support elements of virtual integration. This is particularly evident where services bring a team together to work around integration care for a specific client. This team may work virtually for a period of time until the client's care needs are met. This can be an ongoing feature of services as the team works to meet client's needs.

5 Supporting documentation

Privacy guidance for HealthOne NSW services:
http://www.health.nsw.gov.au/initiatives/healthoneNSW/privacy.asp

Guidelines for Developing Governance Arrangements for HealthOne® NSW Services:
http://www.health.nsw.gov.au/pubs/2011/healthone_guidelines.html

Strategic Procurement & Business Development: Templates and Process of Facility Planning
http://www.health.nsw.gov.au/assets/process_update.asp

NSW Government Guidelines for Economic Appraisals: www.treasury.nsw.gov.au.

Australasian Health Facility Guidelines: http://www.healthfacilityguidelines.com.au/default.aspx.

RACGP Standards for general practices: http://www.racgp.org.au/standards.

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