HUNTER NEW ENGLAND

Integrated Care Alliance

Operational Plan

2019-2020

About this Document

This document is an Integrated Care Plan jointly owned by the Hunter New England Central Coast Primary Health Network (HNECC PHN) and Hunter New England Local Health District (HNELHD).

The initiatives it contains have already been agreed to by both organisations. They are set out here in one document.

This document has been endorsed by the Integrated Care Alliance Executive Team and the planned activities will commence in 2019-20.

Our Shared Vision

Healthy People and Healthy Communities – Now and Into the Future.

The Purpose of our Integrated Care Alliance

- To deliver innovative, locally relevant solutions that measurably improve the health outcomes of our communities.
- Cooperate, collaborate and communicate with our partners to meet agreed health needs.

Our Shared Values

- Collaboration/Cooperation
- Openness
- Respect
- Empowerment
- Innovation
- Accountability
- Integrity
- Recognition

What will Success Look like by 2022?

Patients, families and communities will:

- Easily find information about local health services and how to access them.
- Feel supported to understand and care for their own health, and stay well in their own communities.
- Have access to information that demonstrates high-quality, cost effective local health services.

Health professionals servicing the health needs of Hunter New England will:

- Easily access clear information that helps them to guide patients and families around our local health system (public, private, primary, secondary and tertiary care services).
- Know how to support patients and families to understand and care for their own health.

What we will do in 2019-20

Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will	Measures
Data Enablers	HNECC PHN Executive Manager Corporate Services, Lorin Livingston HNELHD Executive Director Finance and Corporate Services, Tony Gilbertson	HNECC PHN Information Management Information Technology Manager, Jason Rumianek Acting HNELHD Manager Health Analytics and Business Support, Sandy Bull	Implement NSW Health's Health Outcomes Patient Experience (HOPE) information technology platform in the hospital environment and conduct engagement and preparatory work in primary care. Use reports from the Patient Portal to measure our success in integrating care for patients. Pathology result of type HBA1c, when ordered internally by HNELHD, will automatically be provided to the General Practitioner. Participate in NSW Ministry for Health's Data Linkage Project and explore potential to trial the provision of regular feedback to GPs about their patients' hospital utilisation.	Renal Supportive Care and Osteoarthritis Chronic Care Program (Armidale) Patient Reported Measures (from 2020). # Patients registered in NSW Health Patient Portal. # results shared with General Practitioners.

What we will do in 2019-20

Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will	Measures
Integrated Care Enablers, including Community HealthPathways PatientInfo eReferral Service Directory Care Navigation MyNetCare	HNECC PHN Executive Manager Performance Integration & Communities, Heather Alexander HNECC PHN Executive Manager Primary Care Improvement, John Baillie HNELHD Executive Director Partnerships Innovation and Research, Jane Gray HNELHD Executive Director Information Technology, Chris Mitchell HNELHD Executive Director Clinical Governance, Melissa O'Brien	HNECC PHN HealthPathways Manager, Marika Mackenzie HNECC PHN Team Leader, Digital Health, Marilyn Reed HNELHD Manager Integrated Care, Karen Harrison HNELHD Quality Systems Manager, Karen Chronister	Complete implementation of eReferrals across the 240 primary care practices with Best Practice and Medical Director. Implement year 2 of the Integrated Care Enablers Service Level Agreement. Build the use of Integrated Care Enablers into contracts where appropriate, including registration of clients into NSW Patient Portal, use HealthPathways, smart eReferral etc.	80% of Best Practice and Medical Director General Practitioner practices using eReferrals. Increase % of eReferrals to John Hunter Hospital & John Hunter Children's Hospital to 50% as a total. All commissioned PHN services appropriate for General Practitioner referral are eReferral enabled. PHN Commissioned providers sign contracts agreeing to use of integrated care enablers.

What we will do in 2019-20				
Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will	Measures
First 2000 Days of Life	HNECC PHN Executive Manager Performance Integration and Communities, Heather Alexander HNELHD Executive Director – Children Young People and Families, Dr Paul Craven	HNECC PHN Integrated Care Manager, Bronwyn Penny HNELHD Children Young People and Families CPAIS Manager Matthew Frith	Implement paediatric community and outpatient redesign solutions developed in 2018/19. Including: (a) Collaborating with the PHN to develop an implementation plan for General Practitioners providing ongoing management of children with leaning and behavioural disorders. (b) Updating Health Pathways for children's services 0-5 years based on service mapping information and redesign solutions. Develop clinical priorities for service triage which are consistent and equitable across all 3 services. Develop, prioritise and implement additional First 2000 Days initiatives in light of the service mapping and gap analysis findings.	100% Health Pathways updated relating to 0-5yrs. Decrease in % of returned referrals to General Practitioners. Increase in # of patients with shared cared arrangements between Paediatrician and General Practitioners. >10% reduction in Failure to Attend specialist appointment.

What we will do in 2019-20				
Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will	Measures
Mental Health Service Integration	HNECC PHN Executive Manager Commissioning, Catherine Turner HNELHD Executive Director Mental Health, Dr Marcia Fogarty	HNECC PHN Team Leader Mental Health, Leah Eddy HNELHD General Manager Mental Health, Leanne Johnson	**Improve Access to care** Develop Community Referral Health Pathways and e-Referrals directly to HNELHD Mental Health Services, the HNELHD Mental Health Contact Centre and the new HNECC-PHN-Access and Referral Service (eReferrals and alternative). Design and implement processes of referral between Mental Health Intake and Access and Referral Services. Be ready to implement a “Safe Haven” café should funding become available from NSW Health. Recommend priorities for future mental health investment using Dynamic Simulation modelling in partnership with Sax Institute and Lifespan partners. Evaluate success of Transitional Care Packages, and then move them to business as usual.	<5% Abandoned call rate for both contact lines. #eReferrals first line General Practitioner triage matches contact centre triage. % of eReferrals returned to General Practitioners. #warm transfers between PriMA and HNELHD contact centres. Business case prepared. Priorities are ready for procurement of services in early 2020. # of people seen by services # of people NOT re-admitted within 28 days.

What we will do in 2019-20				
Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will ……	Measures
Palliative + End of Life Care Service Integration	HNECC PHN Executive Manager Performance Integration and Communities, Heather Alexander HNELHD Executive Medical Director - Professor Trish Davidson	HNECC PHN Integrated Care Officer – Chronic Disease, Bronwyn Penny Director Palliative Care, Dr Rachel Hughes and HNELHD Palliative and End of Life Care Stream Leader, Dr Sharon Ryan	To determine the current "state of play" of end of life care for Residential Aged Care Facility (RACF) residents. This will occur in a 3 phased process. To document baseline rate of hospital use at end of life for RACF residents To attend a gap analysis within RACFs To determine the preferred setting where residents would like to receive their end of life care. To inform the implementation and evaluation of a proven model of "rounding" in palliative care. To position us to do a cost effectiveness analysis. Conduct Palliative Care Equipment Audit across Hunter and New England and develop strategy to address gaps and communicate with the community (e.g. PatientInfo).	PHN and LHD Service Level Agreement developed. Memorandum of Understanding with RACF sites developed. Audit completed. Strategy developed.

What we will do in 2019-20				
Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will ……	Measures
Urgent Care Access Integration	HNECC PHN Executive Manager Commissioning, Catherine Turner HNELHD Executive Director Greater Metropolitan Health Services, Karen Kelly	HNECC PHN Integrated Care Officer Ambulance, Access and Demand, Cat Eggert HNELHD Service Manager Patient Flow Unit, Jenny Carter	Optimise existing programs to ensure they meet patients' needs closer to home and minimise unnecessary presentations to hospital: • General Practice After Hours (GPAAH) Program • Aged Care Emergency (ACE) Program Explore other opportunities for better integration of care between our two organisations. Explore opportunities for registering frequent presenters to urgent care services into the Patient Flow Portal so we better understand their needs and service use and can explore better alternatives.	GPAAH Program Service Level Agreement in place ACE Program Service Level Agreement in place # patients registered in Patient Flow Portal

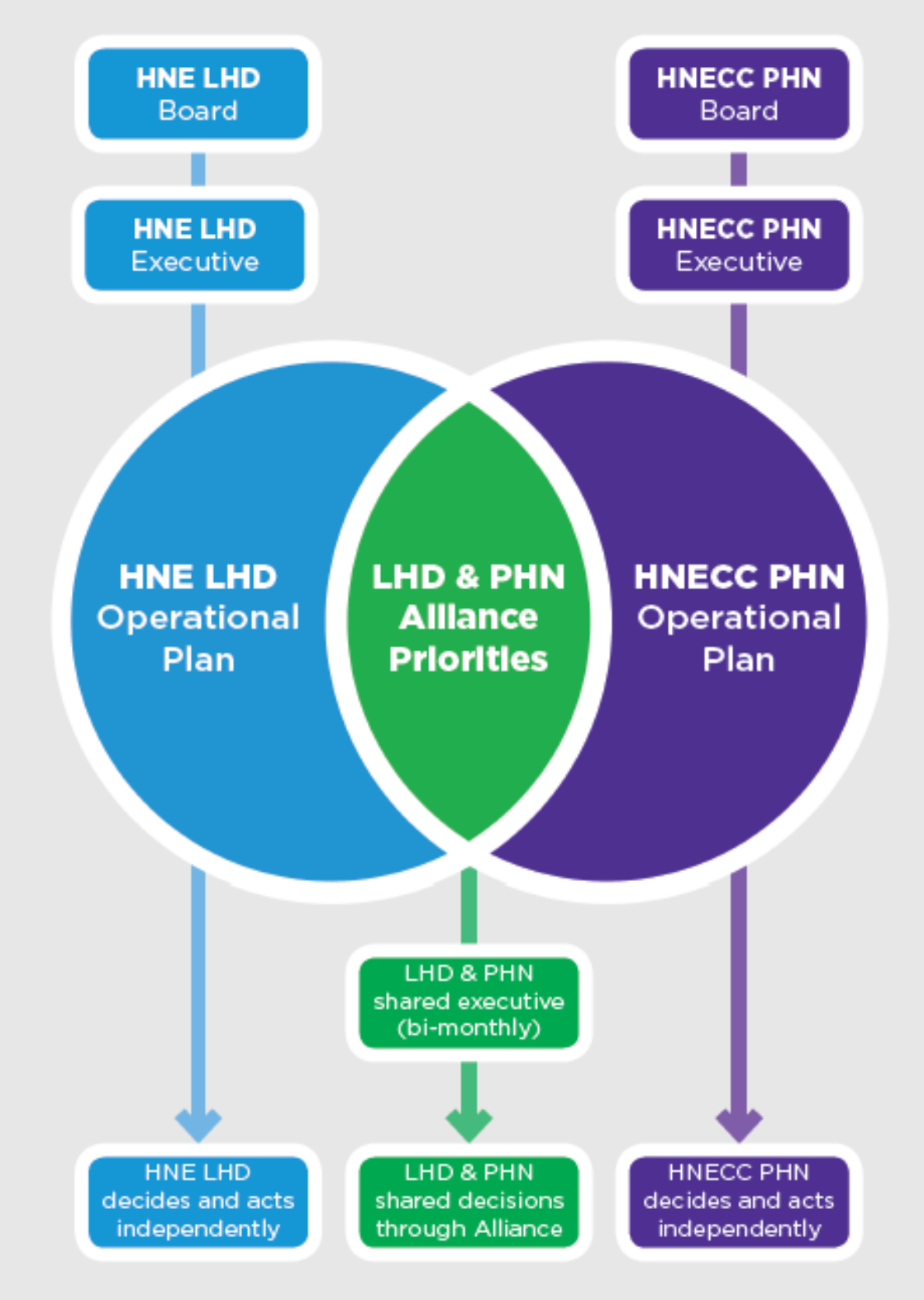
What we will do in 2019-20				
Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will ……	Measures
Closing the Gap Initiative Service Integration	HNECC PHN Executive Manager Performance Integration and Communities, Heather Alexander HNELHD Executive Director Rural and Regional Health Services, Susan Heyman	HNECC PHN Manager Aboriginal Health, John Manton HNELHD Director Aboriginal Health Unit, Tony Martin	Executive Sponsors and senior managers to host workshop in August to agree on priorities to work on together in Alliance. The group will explore specific work around • Smoking cessation • Cancer screening	Reduced rates of smoking. Increased rates of cancer screening.

What we will do in 2019-20

Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will	Measures
Chronic Disease Service Integration	HNECC PHN Executive Manager Performance Integration and Communities Heather Alexander HNELHD Executive Director Rural and Regional Health Susan Heyman	HNECC PHN Integrated Care Manager Bronwyn Penny Chronic Disease Network Manager Jane Kerr	Implement year 2 of the **Chronic Obstructive Pulmonary Disorder** Service Level Agreement. Implement year 2 of the **BEEM-HF Study Service Level Agreement** (based on agreement to implement the NSW Translational Research Grant). Implement year 3 of the **Diabetes Service Level Agreement** **PLUS** work in partnership to clearly define the roles of primary, community and acute health professionals in relation to the management of foot health, in both community based and high risk Podiatry. This will be included in future Diabetes Service Level Agreement **PLUS** Extend current **Diabetes Model of Care Service Level Agreement Addendum** by 12 months (i.e. extend nurse led model of care project by 12 months).	COPD includes clinic #; patient #; practice #l; referral to Pulmonary Rehabilitation; Pulmonary Rehabilitation commencement and completion measures. Congestive Heart Failure measures include control practice # and intervention practice # and educational event participation. HRFS Multidisciplinary Team referrals (iPMS), High Risk Foot Service referrals (CHIME), High Risk foot care referrals (primary care). Diabetes includes patient #; practice 3; # GP participated; Tertiary service waiting list #; GP quality improvement process and clinical measures; patient activation measures; % of practices captured in local registry and education attendance measures. # patients registered in Patient Flow Portal.

What we will do in 2019-20				
Work Stream	Executive Sponsors	Lead Managers	In 2019/2020 we will	Measures
Place-Based Community Consultation	HNECC PHN Executive Manager Performance Integration and Communities Heather Alexander HNELHD Executive Director Rural and Regional Health Services Susan Heyman	HNECC PHN Amy Clyde-Smith HNELHD Rural and Regional Health Services Graeme Kershaw	Rural Community Consultation - Consult communities in Glen Innes and Tenterfield about health needs, in partnership with NSW Rural Doctors' Network. Continue to jointly contribute to Department of Premier and Cabinet partnership.	5% increase in engagement scores from people in the Glen Innes and Tenterfield communities, measured using PeopleBank.
Alliance Communication and Ways of Working	HNECC PHN Executive Manager Performance Integration & Communities Heather Alexander HNELHD Executive Director Partnerships, Innovation and Research Jane Gray	HNECC PHN Communication Manager Scott White HNELHD Manager Integrated Care, Karen Harrison	Refresh the story of our Integrated Care Alliance with • Vision and principles • Narrative about governance and how we work • Case studies showing results Develop an orientation package for Conduct Alliance Orientation for LHD and PHN staff working within the Alliance.	1. Story available on PHN and LHD websites. 2. Standard PowerPoint presentation. 3. Brief video stories to illustrate outcomes. 4. Orientation Package re Alliance for new recruits to LHD and PHN. 5. All Executive Sponsors/ senior leaders complete orientation.

Relationship of this Plan to the HNELHD and HNECC PHN Operational Plans



Members of the Integrated Care Alliance Executive Team

1. Chief Executive - HNECC PHN
2. Executive Manager, Commissioning - HNECC PHN
3. Executive Manager, Primary Care Improvement - HNECC PHN
4. Executive Manager, Performance, Integration and Communities - HNECC PHN
5. Chief Executive - HNELHD
6. Executive Director, Greater Metropolitan Health Services - HNELHD
7. Executive Director, Rural and Regional Health Services - HNELHD
8. Executive Director, Mental Health Services - HNELHD
9. Executive Director, Children Young People and Families - HNELHD
10. Executive Medical Director – HNELHD
11. Executive Director, Partnerships Innovation and Research - HNELHD

Other HNELHD Executive Directors will attend as required (including HNECC PHN Executive Manager Corporate Services, HNELHD Executive Director Finance and Corporate Services, HNELHD Executive Director Clinical Governance, HNELHD Executive Director Information Technology).

Secretariat

Executive Assistant to the Chief Executive HNECC PHN, with support from:

Executive Director, Partnerships Innovation and Research, HNELHD
Executive Manager Performance Integration and Communities Manager, Integrated Care – HNECC PHN.

How we work together

Each “pair” of Executive Sponsors is jointly accountable for leading implementation and reporting regularly to the Chief Executives and the Integrated Care Alliance Executive.

Each Executive Sponsor nominates a senior manager in their service to support the work, and these people also work in partnership as a pair.

Each pair of Executive Sponsors can choose to establish a “workstream” comprising experts on the topic if this will help them accomplish the work outlined in the annual operational plan.

They may also seek advice from the Clinical Councils and Community Advisory Committees of both organisations.

All Executive Sponsors actively promote the use of our integrated care enablers, such as Community HealthPathways, Hospital HealthPathways, PatientInfo, eReferral and MyNetCare.

Information for the public about our Integrated Care Alliance is hosted on the HNELHD Research and Innovation Portal and be linked from the HNELHD and HNECC PHN websites.