Queensland
Clinical Senate

Connecting clinicians to improve care

Your integration is my fragmentation – building relationships

15-16 October 2015

Meeting report

Pullman Brisbane

Queensland Government

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Meeting facilitator – Stephen McKernan QSO

Summary

Almost half of all Queenslanders aged 65 and over have a chronic disease, and one in five have two or more. With a rapidly ageing population this number will rise and with that the burden of disease on our health system and in our communities. Now is the time for health systems around the world to take action so that we are better prepared to cope with this increased demand.

Globally and locally, health systems are looking to integrated care as the answer. How can acute and primary care work together and with consumers to prevent avoidable diseases and make the healthcare experience better for patients who are living with chronic disease? The Queensland Clinical Senate brought together more than 140 senior clinicians from across the state to start this important discussion.

A commitment to a joint strategy on integrated care is the critical first step in achieving change. Listening to conversations around the tables and watching consumers, clinicians, chief executives and board chairs from acute and primary health interact and talk constructively about the future of our health system gave me the greatest degree of confidence that the meeting was indeed a valuable exercise.

This forum gave us the opportunity to learn from local, interstate and international initiatives. We also heard directly from consumers about how it feels to receive care in a fragmented system and what an integrated health system would look like to them.

The conversation about integrated health care needs to start with consumers … and it needs to end with consumers.

Delegates agreed on the importance of seamless integration in allowing a sustainable health system and that shared governance between HHSs, private and NGO providers and PHNs was essential. There are clearly variable levels of progress around the state regarding shared governance models and identifying this served as a reality check on where we are at in terms of integrated care.

Integrated care will again be on the senate's agenda next year to revisit the outcomes of this meeting and to focus on the finer details of what we, as clinicians and administrators, need to do to deliver on improved patient experiences and outcomes. In the meantime, healthcare leaders and consumers are challenged to continue this discussion and their work towards shared governance models and integrated care initiatives.

We will continue to encourage the Department of Health to support initiatives for integration, particularly around information sharing and the development of flexible funding models that support chronic disease management in the community and hospital avoidance initiatives.

I am encouraged by the active and productive discussions at this meeting that we are on the right path to indeed keeping integrated care high on the healthcare agenda and making the experience for our patients a more positive one.

Dr David Rosengren

Chair, Queensland Clinical Senate

Actions to create a more integrated system

Successful integration of care requires a serious commitment from - and strong partnerships with - all stakeholders. Queensland has a unique situation where Hospital and Health Service (HHS)/Primary Health Network (PHN) structural change has removed some of the historical structural barriers to integration. Acknowledging the varying levels of maturity of Queensland PHNs and relationships with relevant HHS, private and NGO partners, the Queensland Clinical Senate (QCS) challenges:

Consumer and community organisations to:

- Partner with PHNs and HHSs to enable better integrated care, including participation in governance arrangements
- Assist in the development of strategies to enable effective consumer and community participation in their own care and in co-designing integrated models of care.

Primary Health Networks and Hospital and Health Services to:

- Work together to identify and commit to a shared vision and single strategy for patient focused integrated care based on what is best for the patient and the health system
- Formalise collaborative governance arrangements (horizontal and vertical), accountabilities and metrics for defining monitoring and evaluating success
- Develop and implement consumer-focused integrated models of care that deliver safe high-quality care across the continuum of care
- Support and resource clinician champions to lead the change, including the provision of dedicated non-clinical time to progress initiatives and build cross sectoral relationships
- Create opportunities for shared learning between acute and primary care sectors.

The Department of Health to:

- Support sharing of information between hospitals and primary care by enabling access to whole of system data including as a priority, primary care and private specialist access to *The Viewer* and then a single electronic health record in the longer term
- Provide stimulus funding to support:
  - Statewide spread of existing evidence-based models of integrated care proven to be effective in delivering efficiencies and improved health outcomes for patients
  - The development, implementation and evaluation of new innovative models of care that address service fragmentation.
- Develop flexible HHS funding methodologies and/or financial incentives that will better support consumer-focused integrated care and encourage collaborative working across acute and primary care sectors.
- Ensure its commitment to improving integration is reflected in HHS Service Agreements.

Health service providers, PHNs, the Department of Health and Health Consumers Queensland are challenged to report back on progress around shared governance models and implementation of integrated care models.

This will be showcased through a formal report in the lead up to the QCS meeting on integrated care in October 2016.

What is integrated care?

'Integrated care is an aspiration – it's aspiring to deliver seamless care of any service required by a person across primary, secondary and tertiary care. Usually it relates to people who have chronic and complex conditions and the complete management of those conditions requires the input of many health practitioners.'

Professor of General Practice, Geoffrey Mitchell

The facts

- 4.6 million people live in Queensland
- 14 per cent are aged over 65
- Almost half have a chronic disease
- 20 per cent have two or more chronic diseases
- nearly 40 per cent aged over 45, have two or more chronic diseases
- chronic diseases are the leading cause of death in Queensland[1] and are the leading cause of illness, disability and death in Australia[2].

Why integrated care?

- Our population is ageing rapidly and with it will grow the number of people with chronic diseases.
- The population aged 65 years and over rises from 2.2 million in 1997 to about 4.0 million in 2021 and between 6.0 million and 6.3 million in 2051.[3]
- Substantial increases in the number of people aged 85 years or more also rises from 216,000 in 1997 to around 440,000 in 2021, and reaching between 1.1 and 1.2 million in 2051.[3]
- There is an urgent need for the health system to be ready for this increased burden of disease.
- Improved integration between primary and acute care is internationally accepted as being key to a sustainable health system.
- Currently, care for people with chronic disease is fragmented – acute care (State funded) and primary care (Commonwealth funded) work in isolation and patient care is not coordinated.
- Integrated care ensures the needs of consumers are placed at the centre, resulting in improved patient satisfaction and better health outcomes.

1. The Health of Queenslanders 2014: The Fifth Report of the Chief Health Officer
2. Australian Institute of Health and Welfare www.aihw.gov.au
3. Australian Bureau of Statistics www.abs.gov.au

Consumer perspectives

Health consumer, Janelle Colquhoun

'I want to be central to my own health issues. Most people tend to forget that I am the one you need to discuss things with.' Janelle Colquhoun.

- Health consumers want to be treated as health literate.
- It's about trusting me, respecting me and asking for my input and listening to me.
- I like to be consulted – I like to be part of the dialogue.
- Make me the centre of the patient care. That's what I really think is one of the big problems with poor integrated care.
- You don't know who the patient is and what their experience or background is – I talk around the world at conferences, so often I have more up-to-date information than some of my doctors.
- Respect my input - that's what I, as a patient, would like and what I think could help to improve the health system.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-colquhoun.pdf

Health consumers Sharon White and her son, Tyler

'About 5 months ago I got a phone call that no parent ever wants – Tyler had been hit by a car. It brought us into a whole new world … it was all very overwhelming and incredibly stressful.' Sharon White.

- Managing the situation after Tyler's accident was very difficult – trying to get information wasn't easy
- As the mother of a patient, my message is that families need to be treated as a whole and listened to - that makes the experience far less traumatic.
- One patient's accident/illness can affect the entire family, so work with the family as opposed to just with the patient.
- IUIH Connect aims to give Aboriginal and Torres Strait Islander patients continuity of care from the hospital to the home. http://www.iuih.org.au

The national perspective

Primary Healthcare Advisory Group, Professor Claire Jackson

- The Primary Health Care Advisory Group initiative was announced by the Commonwealth Government in April 2015.
- Priorities include:
    - Better care for people with chronic and complex health conditions, including mental illness
    - Innovative care and funding models
    - Greater connection between primary health care and hospital care.
- Why primary healthcare? Chronic disease is common, it's expensive, risk factors such as obesity are exponentially increasing, and settings for chronic care are not appropriate.
- Discussion paper highlighted four key themes for primary health:
    - Effective and appropriate patient care
        - Health care homes
        - Care coordination and team-based care
        - Patient participation and patient pathways
    - Increased use of technology
        - Electronic health records
        - Home-based self-testing and monitoring
        - Phone and video consultations
    - How do we know we are achieving good outcomes?
        - Continuous quality improvement
        - How can we address deviations from clinical best practice
    - Payment models – OECD countries moving away from pure fee for service.
        - Consider health payment mechanisms.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-jackson.pdf

'We need leadership across all parts of the health system if we are to start to connect all of the fragmented and disconnected parts that we see.'
Martin Bowles PSM
Secretary of the Commonwealth Department of Health

Integrated care in action

Learnings and perspective from New Zealand

Stephen McKernan QSO, EY, Partner Oceania

'Integrated care is about leadership, vision, combined planning, building capacity and use of data and information.'

- Major problems in the New Zealand health system in 2000 included poor care coordination, very high out-of-pocket costs, and very stubborn inequalities.
- Response was the development of new legislative framework, district health boards and primary health organisations.
- Key to this was a strengthened emphasis around population health, enrolment and alignment with core primary care provider.
- Six years later, integrated care levels varied greatly across the country.
- The Ministry developed an alliancing approach to accelerate integration and primary care progress – districts working and planning together in the interests of population. This became a powerful tool to support the next stage of integrated care.
- A range of initiatives were introduced all with a strong focus on locality planning – 'neighbourhood hub'. Examples included:
    - Risk stratification for population groups
    - Disease management and acute demand initiatives
    - Multidisciplinary team with involvement from clinical pharmacists, specialist nurses, allied health professionals and care coordinators/navigators.
    - Different model of care for general practice.
- Achievements across all four areas of performance: people, culture change, infrastructure/services and performance improvements.
- One of the major achievements was acute growth remaining at or around demographic growth for a decade.
- Among a range of learnings were:
    - Integration needs to be driven locally, not centrally, with local leadership to reflect the local circumstances. The system could, however, support the spread of innovation.
    - Focus on health inequalities – needs to be embedded in the legislation and core accountability documents.
    - Organisations need to be accountable for population health outcome using a pragmatic selection of performance targets.
    - Engage with clinicians and work with the willing.
    - Constrain hospital growth – fundamental to allow reinvestment in other areas.

Learnings from Canterbury, New Zealand

David Meates, Chief Executive, Canterbury and West Coast District Health Boards

'People are the fundamental reason we exist as health systems.'

- Canterbury's health system was fragmented and disjointed.
- If nothing changed a new tertiary hospital would have to be built along with 20 per cent more general practice and more residential care beds.
- Change started with a shared vision of a connected system centred on people - right care, right place, right time, delivered by the right person.
- Three simple goals underpinned the vision:
    - Support people to take greater responsibility for their own health care
    - People stay well in their own homes and communities
    - People receive timely and appropriate complex care.
- It was also underpinned by a new way of working - one health system, one budget.
- Using information to plan and drive improvement. Everything is based on what's best for the patient and what's best for the system.
- Leadership development program - clinicians enabled to do the right thing in the right way.
- Investing in sustainable innovation processes – clinical leads and engineers working together across the divide between primary and secondary care.
- HealthPathways are an agreed way of working across the system – 98 per cent of Canterbury general practices now use HealthPathways every day.
- Shifting from referrals to an electronic request management system.
- Consumer involvement in co-designing health services.
- 'Opt off' technology across the system connects hospitals, GPs, community pharmacies and home-based care providers with relevant patient information.
- Managing 70 per cent of the health system with 'real-time' information.

Key learnings:

- Patient time is the key metric of performance.
- Language connects and aligns people to create purpose and identify.
- Patient and staff stories encourage continuous innovation.
- Integrated networks trump organisational hierarchy for empowering and enabling change.
- Share a problem to empower and entrust people to deliver the solution.
- Shared experiences enhance engagement and learning application.

What does this mean for people?

- People have shorter waits for care
- People get to stay home and self-manage in their own home and communities
- Acute hospital care is not increasing

- Portion of 65+ attending emergency departments is dropping
- If they do go to hospital they are not staying as long and are less likely to come back
- Those who do go to aged residential care stay less time
- Hospital capacity freed up to do more elective surgery.

https://prezi.com/txnir2dxxors/integrated-care/

New South Wales integrated care strategy

Scott McLachlan, Chief Executive Western NSW Local Health District

- Western NSW LHD is described as a deprived, vulnerable region.
- Eleven per cent of the district's 280,000 population is Aboriginal.
- 600 people visit emergency daily and three-quarters of those could be cared for in alternative settings.
- Several deaths per day from preventable conditions.
- One of the highest rates of smoking and is the most obese region in the country.
- Western NSW took a lead for the rural districts in a state-wide integration care strategy.
- Five local demonstrator sites delivering targeted innovative models of integrated care to determine what would work. Work to date has included:
    - development of GP-led multidisciplinary models of care to manage high risk patients and those with chronic and complex illnesses (including diabetes, CVD, COPD, mental illness)
    - risk stratification using agreed clinical markers to identify those patients who would benefit most from integrating their care
    - implementing integrated models of care, tailored to the local needs of the population, with a focus on engaging all relevant care providers within a locality
    - recruited care navigators, based in primary care, to support and manage patients enrolled in the local strategies
    - 640 patients enrolled across the five sites
    - implemented the electronic shared care planning tool cdmNet for sharing of clinical information between relevant care providers
    - collection of patient reported measures to evaluate the impact of integration on their experience/health.
- Central to all of this is the design of a Health Intelligence Unit as a central point for coordinating, preparing and presenting statistical and related information to support integrated health care planning, delivery and evaluation.

- Challenges have included readiness and capacity to change; public/private business models and funding; lack of financial incentives to integrate care; engagement of private providers; reluctance to change practice; and leaders' committed to and capable of managing the organisational change process.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-mclachlan.pdf

Gold Coast integrated care

Professor Martin Connor, Executive Director, Centre for Health Innovation

'Fundamentally this is about relationships – how can we build trust.'

- Taking an evidence-based approach at scale and systematically for a defined population.
- Using a model designed to bring about population-based management based on proactive, shared care.
- Model is holistic and patient-centred, not disease-centred, focused on patients at risk of hospital admission.
- General practice is the foundation: as the main co-ordinator and advocate of care but in shared governance with hospital specialists.
- Our job is to support GPs to offer the best care for the patient. If we can't do that we fail.
- Working with 14 general practices and 100 GPs in network, plus allied health providers.
- Five functions in new model: specialist service delivery, 24-hour contact centre, system navigation, education and training, IT and support.
- Two principal risks – hospitalisation and poor outcomes as a result of disease.
- Disease registers – seven in design: diabetes, chronic kidney disease, respiratory, chronic heart disease, end of life, frailty and residential aged care facilities.
- Three categories for disease-level risk stratification:
    - Subspecialist review and holistic assessment
    - Shared Care + GCIC input
    - GP care only.
- Using Extensia for shared-care record - accessible by patient, care providers.
- Information integration is the lifeblood of the new system: risk stratification and condition management using combined GP and hospital data.
- By January, intending to install in network practices a new web application with four functions:
        - disease registers
        - patients admitted, in hospital or discharged
        - surgical waiting list

    - outpatient waiting list.
- Now ‘live’ with a new approach to person-centred care for 136,000 people
- Using risk-based analytics and a joint design between primary care physicians and specialists, we are developing a quality based pro-active healthcare system.
- The technical elements of the system represent significant challenges, the real change is coming through a change in culture: joint governance, higher trust and problem-solving conversations between clinical leaders.
- Recruiting and activating patients into the new system.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-connor.pdf

Queensland Snapshot

'The introduction of primary health networks can reshape health care in this country…I think it is one of the most pivotal pieces of infrastructure we will have in this country.'
Martin Bowles PSM
Secretary of the Commonwealth Department of Health

Primary Health Networks (PHNs) were established on 1 July 2015, replacing Medicare Locals throughout the country. Queensland has seven PHNs. Representatives from three PHNs and one HHS presented a progress snapshot of integration in their region. Strong themes included:

- Establishing governance arrangements and protocols to support planning and prioritisation
- Do not reinvent the wheel – transfer and implement what is already working
- Benefit of General Practice Liaison Officer roles to better support some of the integrated initiatives in a tangible way with an emphasis on data and information
- Determine common priorities and commit resourcing
- Getting below the surface to identity the real needs
- Access and support for education across the system and the role new technologies can play in that.

Western Queensland PHN - Kristine Battye

- Covers a geographical area of 954,210sq km with a population of 68,000
- The Western Queensland PHN is an initiative of North West, Central West and South West hospital and health services.
- The PHN is a start up in its early stages – board being established and currently recruiting CEO.
- Three regional coordinators will be point of contact between PHN, community and service providers.
- Establishing three clinical councils to advise Board, and building on HHS Community Advisory Networks to support community engagement.
- Main opportunities at present:
    - Collaborative planning with HHS and other players
    - Pool planning resources with HHSs
    - Leverage off (and add to) community engagement resources and processes with HHSs.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-battye.pdf

Brisbane North PHN - Jeff Cheverton

'Our work is all about relationships – trying to develop relationships, collaboratives and working groups where there are high levels of trust.'

- Covering a geographical area of 4100sq km with a population of over 900,000.
- Aligned with Metro North HHS and work according to a jointly developed protocol based on 10 principles described by Nicholson et al (2013).
- Strong connections between HHS and PHN - Boards have met twice a year for past four years, monthly meetings between executives.
- Annual PHN and HHS joint forum to showcase initiatives to community.
- PHN acts as lead commissioning agency for Community Health Support Program (aged care) and Partners in Recovery Program (mental health).
- HHS funding for General Practice Liaison Officers flows through to PHN.
- Team Care Coordination has demonstrated a 26 per cent reduction in inpatient usage for complex, chronic disease patients.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-cheverton.pdf

Cairns and Hinterland HHS and Northern Queensland PHN – Robin Moore

'NQPHN's aim is to evaluate, map, plan and commission primary healthcare services to achieve better health outcomes for the community of north Queensland.'

- Fourth largest PHN in Australia, covering 511,000 sq km. Includes four hospital and health services - Torres and Cape, Cairns and Hinterland, Townsville and Mackay.
- CHHHS region has a high level of disadvantage, a higher indigenous population – 11% compared with 3.7% for Queensland, and an ageing population.
- Establishing a governance structure across CHHHS and PHN to improve connectivity and communication between acute and primary care
- Working together to improve management of frequent presenters and avoidable admissions
- Engaging with GPs about after hours care
- Development of a North Queensland Health Alliance Leadership Team.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-moore.pdf

Mackay HHS – Clare Douglas

'This is a real opportunity to improve the health outcomes of our community by working together.'

- Mackay HHS led the successful bid for the Northern Queensland PHN.
- The HHS is now working in parallel with the PHN in the planning process to ensure there is strategy alignment and synergies.

- The HHS went live with HealthPathways in June 2015 and now has 112 pathways to assist GPs and other community healthcare providers access assessment and referral information about the HHS.
- A General Practice Liaison Officer is improving two-way communication between HHS and GPs in the region.

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-douglas.pdf

'The new PHN structures in Queensland present a unique opportunity to integrate our hospital and health services with primary care.'
Cameron Dick, Health Minister

Panel (L to R): David Meates, Scott McLachlan, Martin Connor, Robin Moore, Clare Douglas, Jeff Cheverton and Kristine Battye.

Panel discussions highlighted a number of key issues for clinicians.

- My Health Record important for integrated care - need the infrastructure in place to manage the information base and privacy/access issues.
- A national unique identifier for patients is available through My Health Record but more work needs to be done to transition to this from the current system.
- Models of care for integration will be different for each location depending on the problem being addressed.
- Models of care have to be clinician-led and based on evidence. The current challenge is that models of care are being designed in an environment where there is some evidence and some opinion (not based on evidence).
- The Primary Health Care Advisory Group is researching models of care.
- Integration should only be looked at if it's going to arrive at a benefit for the patient –better health outcome, experience, less problematic engagement with the health system for the patient.
- If there are real solutions that see movement of resources and accountabilities we want to try them … managing the system without any change is unsustainable.
- The change to an integrated system is a whole new way of working for existing professionals – a new paradigm. Coordination of care as opposed to care delivery is a profoundly different way of working.
- Health professionals need to be supported to transition to the new way of working, and new graduates need to be trained in this new way of working.
- Gold Coast Integrated Care Program is currently working with its School of Medicine to include its integrated care coordination centre and network general practices in the rotation for General Practice trainees so they gain exposure to the new information systems and new approaches.
- Primary care needs to be recognised as the fundamental point of continuity in a system – if a system doesn't have its head around that it will never allow primary care to do what needs to be done.
- You will know when your healthcare system is truly integrated by asking the people who are using it - their experience will tell you if it's integrated.

Applying the evidence

Professor Claire Jackson, Director, Centres for Primary Care Reform Research Excellence, University of Queensland

- Centre for Primary Health Care Innovation funded by the Mater Health Services and University of Queensland to promote care integration from 1994.
- Remit to innovate models of care linking community and hospitals; evaluate models and publish widely; training and professional development in better integrated care.
- Wide success in various integration projects in the short-term but they all faced longer-term sustainability challenges.
- Service Integration Framework developed to identify the key pillars in sustainable service integration (clinical model of care, inter professional and inter organisational development/training, ICT supporting information transfer, and integrated governance) with appropriate change management as the core foundation.
- Four critical elements to make integrated care happen: Shared vision, right people/right champions, leadership in all settings, and culture (our problem together/our solution).

https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-jackson-2.pdf

Caroline Nicholson, Director, Mater UQ Centre for Primary Health Care Innovation

- A systematic literature review of successful primary/secondary care integration programs identified 10 elements that were key for success and sustainability.
- The 10 elements were developed into a balanced scorecard tool to support the development of integrated governance between meso-level and organisations – PHNs and HHSs. The tool is divided into four categories: stakeholders, process, sustainability, and people and culture.
- The vision is for a system approach – essential for patients with complex co-morbidities.
- A strategy map containing the 10 elements was developed as a practical tool for PHNs and HHSs to inform their working together in developing integrated care locally. It was tested with two HHS and PHN Boards for relevance.
- Evidence says that if you address each of the 10 elements you will have a much higher success rate of your program being sustainable into the future.

  https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1510-nicholson.pdf

Actions to create the conditions for change

Delegates identified actions to create the conditions for a more integrated system using a framework of the 10 governance elements identified by Nicholson et al. 2013.[1]

Themes common across small group discussions included:

- Including/encouraging consumer and community participation at all levels of planning and service development.
- Developing strong collaborative partnerships that include primary care, acute care, community services and consumers.
- Working together to identify and commit to a shared vision and single strategy for patient focused integrated care based on what is best for the patient and the health system.
- Formalising collaborative governance arrangements (horizontal and vertical), e.g. joint board meetings, joint executive steering committees, joint membership on clinician leadership groups, agreeing joint outcomes.
- Identifying accountabilities and metrics for defining monitoring and evaluating success.
- Strong clinician and executive leadership - identifying champions for change and providing dedicated non-clinical time to support clinician leadership. General Practice Liaison Officers were identified as important change agents.
- Developing integrated models of care and service delivery that cross the continuum of care and traditional sector boundaries.
- Providing stimulus funding to identify and spread the implementation of current projects/programs that are effective and have cross-jurisdictional application AND develop new ideas and models.
- Consider alliancing to support new models of service delivery.
- Develop a shared/agreed vision for ICT integration that will enable 'whole of system' information sharing. In the interim, enable access to the Queensland Health Viewer for those working in general practice.
- Communicate a message of commitment by healthcare leaders to integration and support of the change process (e.g. media release/ communique/local launches for specific integration activities).
- Use early wins and visible/tangible service delivery changes to demonstrate the benefits of change and maintain motivation.
- Create opportunities for shared learning between acute and primary care sectors, for example, joint education forums, multidisciplinary team-based training across the continuum of care, 'clinician exchanges' across settings.

[1] Nicholson C, Jackson C, Marley J. 2013. A governance model for integrated primary/secondary care for the health-reforming first world – results of a systematic review. BMC Health Services Research 13:528

- Using data to evaluate the effectiveness (outcomes and economic) of initiatives using measures that are relevant to all partners and can be changed as required (e.g. patient time, patient and staff satisfaction).
- Use of holistic (not disease based) risk stratification tools for patient populations.
- Identify health and social providers within ‘communities of care’/population groups who will need to partner to deliver care to population groups.
- Sectors working together to provide community awareness sessions.

Appendix 1: Actions to create the conditions for a more integrated system

A commitment to a joint strategy on integrated care is the critical first step in achieving change. Progress to implement joint governance arrangements varies greatly across Queensland - some organisations are newly formed and others have transitioned quickly from Medicare local structures and are further along the process.

Summary from group work
Most commonly discussed elements:

- Joint planning (to formalise joint governance arrangements)
- Access to whole of system data to create burning platform for change and inform decision making
- Change Management – building relationships, partnerships, identifying champions for change and providing dedicated non-clinical time to support clinical leadership.

Joint planning

- Progress governance arrangements across a number of jurisdictions, acknowledging some organisations are newly formed.
- Formalising governance arrangements to support the identification of local needs, common goals, priorities, planning/timeframes and responsibilities through:
    - Memoranda of understanding between PHN and each HHS in the boundary catchment which includes overarching key performance indicators
    - Joint board meetings and executive steering committee meetings (co-developed agenda with alternating PHN/HHS chair responsibility, venue etc). Regular attendance by PHN Chair/CEO demonstrates commitment and assists to translate talk into action.
    - Joint membership on lead clinician group
    - Joint strategic plan
- Map services and complete a provider stocktake

Integrated information and communication technologies

- Access to whole of system data (HHS, PHN, private facilitates) to enable the creation of a burning platform to forecast what the future looks like if nothing changes and inform combined decision making regarding priorities, investment patterns, the focus of new models of care and options available to change workforce roles and patterns:
    - GP access to the QH Viewer
    - Access to GP data/information to HHS
    - Enabling interoperability between existing clinical systems

- Single shared electronic health record.

- Shared/agreed vision for ICT integration.
- ICT initiatives need to be clinician led and tested - focused on clinical risk.
- Strong HHS and PHN relationships required as a foundation for ICT integration.

Effective Change Management

- Shared leadership and strong partnerships – community, clinicians and executives from PHN and HHSs (building relationship capital where it might be missing)
- Create the burning platform for change
- Vision statements aligned.
- Message of commitment to integration (media release/pubic statement. Local launch for integration initiatives).
- Resources to support change – including non-clinical time to support clinical leadership.
- Identify champions and early adaptors – General Practice Liaison Officer seen as crucial agent for change and interface between acute and primary care sectors.
- Effective communication strategies (community and clinician consultation)
- Early wins

Shared Clinical Priorities

- Agreed clinician-led priorities and decision making through data analysis.
- Collaborative development of multidisciplinary standardised pathways of care that cross the continuum of care – essential for population risk stratification process.
- Produce and communicate genuine shared care plans (and escalation plans).
- HealthPathways.
- Examine the nurse navigator role in terms of setting and professional background.

Aligning incentives to support integration

- Consumer focus (to unify and incentivise).
- Better consumer outcomes and consumer satisfaction.
- Better staff satisfaction – GP and HHS.
- Funding (including applications for joint funding for services rather than submissions in competition with each other).
- Workforce.
- Alliancing to support/consider new models.
- Incentives – to enable 'blue sky' thinking.

Geographical population focus

- Holistic (not disease based) risk stratification of patient population.
- Identify high-risk patients and 'communities of care' that are geographically clear.
- Identify health and social providers to partner to deliver care to population groups.

Data as a measurement tool

- Risk stratification tools.
- Data to evaluate effectiveness (outcomes and economic).
- Patient time, and patient and staff satisfaction.
- Measures must be relevant to all and able to change as required.

Professional development supporting joint working

- Joint education forums
- Multidisciplinary team-based training across continuum of care.
- Common access point to training and education tools/facilitates.
- Compulsory training, e.g. leadership training.
- Identify opportunities for clinician 'exchange' across settings.

Consumer/patient engagement

- Ensuring consumer/community participation at all governance levels.
- Awareness education and identification of consumer and community champions.
- Opt in models to involve consumers and community.

Innovation

- Adequate resourcing to develop, implement, monitor/evaluate effectiveness and maintain the adoption of innovative models of care into standard practice.
- Mechanisms to recognise and promote innovative models of care (e.g. allied health generalists, community care facilitators, GPs in acute care settings).
- Identify and spread the implementation of current projects/programs that are effective and have cross-jurisdictional application.