

Queensland Clinical Senate

Connecting clinicians to improve care

Your integration – beyond fragmentation

3-4 November 2016

Meeting report

Royal on the Park, Brisbane

Queensland Clinical Senate, Meeting Report

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Presenters and panellists

- Martin Bowles PSM, Secretary of the Department of Health
- Adrian Carson, Chief Executive Officer, Institute for Urban Indigenous Health
- Dwayne Crombie, Managing Director, Private Health Insurance, Bupa Australia
- Lisa Davies-Jones, Chief Executive, North West Hospital and Health Service
- Anthony Elliott, Chief Operating Officer, Northern Queensland Primary Health Network
- Peter Gillies, Chief Executive, Darling Downs Hospital and Health Service
- Stuart Gordon, Chief Executive, Western Queensland Primary Health Network
- Kerrie Hayes, Executive Director Clinical Services, Sunshine Coast Hospital and Health Service
- Pattie Hudson, Chief Executive Officer, Central Queensland, Wide Bay and Sunshine Coast Primary Health Network
- Claire Jackson, Director, Centres for Primary Care Reform Research Excellence
- Shelley Kleinhans, A/Chief Executive, Brisbane North Primary Health Network
- Sue McKee, Chief Executive, West Moreton Hospital and Health Service
- Caroline Nicholson, Director, Mater UQ Centre for Primary Health Care Innovation
- Leeanne Schmidt, Metro South Refugee Health Service, Metro South Hospital and Health Service
- Ian Sturgess, Associate Medical Director, NHS Improvement, Greater London, United Kingdom
- Cherylee Treloar, Chief Executive, Footprints in Brisbane Inc.
- Mark Tucker-Evans, Chair, Health Consumers Queensland
- Andrea Vancia, Program Support Officer, Refugee Health, Brisbane South Primary Health Network
- Michael Walsh, Director-General, Queensland Health
- Luke Worth, Executive Director, Organisational Development, Strategy and Implementation, Metro North Hospital and Health Service
- Graham Wright, Gold Coast Primary Health Network

Chair's report



When the Senate first met to discuss integrated care in October 2015, primary health networks were still finding their feet. Integrated care was on the agenda but it was early days. Fast forward 12 months to the Senate's second integrated care meeting and we are operating in a very different and changing environment.

On the back of the Senate's first integrated care meeting, the Queensland Government announced its \$35 million integrated care innovation fund to invest in new initiatives to better integrate care and address fragmentation.

The Commonwealth Government's Health Care Homes initiative was announced in March 2016 and soon after, the Council of Australian Governments announced bilateral agreement on the need for coordinated care for people with complex and chronic disease.

In May 2016 the State Government's \$361 million Specialist Outpatient Strategy was launched to tackle waiting times and improve the patient journey.

At a local level, the state's primary health networks and hospital and health services have made huge strides towards shared governance structures and objectives, collaboratively improving care for patients with many successful integrated care programs underway.

In a vastly different landscape and with such momentum behind us we challenged Senate members and guests at our November 2016 integrated care meeting to have a conversation about how we can take integrated care to the next level in Queensland. What systematic changes are required to make sure integrated care is ingrained in everything we do? How can successful models be sustained and rolled out?

The Senate's recommendations focus on the need to reconsider the way services are funded so that we can more easily move from siloed to collaborative care, and providing the tools to robustly evaluate, share and roll out integrated care programs that are working. We must be careful not to layer innovation upon innovation without stopping to measure and share the initiatives that are making a difference. And we must have the courage to take risks at times – if we fail we will learn from those failures.

I am confident that integrated care is on the agenda to stay and that as health professionals we agree that for our system to be sustainable and move beyond fragmentation we must put the patient front and centre. I look forward to seeing what's ahead for our system and what this means for patients with chronic and complex conditions.

Dr David Rosengren
Chair, Queensland Clinical Senate

Actions to create a more integrated system

Collaboration around integrating care has delivered improved health outcomes in local sites throughout Queensland. To capitalise on this progress and realise system-wide change requires a culture and framework that supports implementation of proven innovations at scale.

The Queensland Clinical Senate recommends:

- The Department of Health partner with hospital and health services (HHSs) and primary health networks (PHNs) to establish a centralised, integrating care innovation hub/unit, that will work with partners across hospital and primary/community care to:
 - Identify and support change champions
 - Invest in systems to assess health needs and collect health outcome data
 - Develop a framework to support clinicians to design, plan, implement, evaluate and disseminate proven innovations across Queensland
 - Create a central repository of innovations to ensure successes and failures are accessible to be shared and learned from.
- HHSs partner with PHNs to:
 - Continue to prioritise and report on joint governance and planning around shared vision, priorities and strategies across hospital and primary/community care
 - Commit to a joint plan to share local experiences and generate new ideas
 - Report annually on investment and outcomes from shared initiatives that deliver quality outcomes through improved integration of care.
- The Department of Health deliver funding reform that:
 - Incentivises HHSs to focus on the overall health of their population
 - Supports flexibility and innovation in service provision including alternatives to hospital-based healthcare.
- The Department of Health partner with the Commonwealth to deliver funding reform that facilitates joint funding or pooled budgets across HHSs and PHNs.

The Queensland Clinical Senate will continue to take a lead role in showcasing successful integration innovations.

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.'

Geoffrey Mitchell, Professor of General Practice

Why integrated care?

- Our population is ageing rapidly and with it will grow the number of people with chronic disease.
- 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.

What is already happening?

- PHNs were established on 1 July 2015.
- PHNs and HHSs in Queensland are working together to establish shared governance arrangements.
- Integrated care initiatives are underway around Queensland at a local level.
- The Queensland Clinical Senate's first integrated care meeting in October 2015 was a catalyst for the Queensland Government's \$35 million integrated care innovation fund announced in January 2016.
- In December 2015, the Primary Health Care Advisory Group released its report, 'Better outcomes for people with chronic and complex health conditions'.
- The Commonwealth Government announced the Health Care Homes initiative in March 2016.
- In April 2016, the Council of Australian Governments (COAG) announced bilateral agreement on the need for coordinated care for people with complex and chronic disease.
- In May 2016 the State Government's \$361 million Specialist Outpatient Strategy was launched.

Governance and engagement – supporting an integrated system

Michael Walsh, Director-General, Queensland Health

- Sustainability and innovation are two key principles in Queensland Health's vision– My Health, Queensland's future: Advancing health 2026.
- These principles and the directions outlined in the vision underpin the need for health care sectors, community organisations and primary health care providers at all levels to collaborate.
- The integrated care innovation fund invested \$35million into integrated care initiatives - eight have already been established.
- The overall goal must be from a patient perspective to increase capacity across the hospital system by reducing emergency department attendance, outpatient appointments, inpatient length of stay and readmissions.
- The department's role in delivering better integrated care is varied and far reaching and includes: working alongside HHSs and PHNs to ensure there is viable and productive partnerships; systemic thinking at all levels.
- A strong, collaborative workforce is essential in all sectors - support and encourage people to work collaboratively and reward collaboration.
- We must empower Queensland's primary care sector – legislation has been introduced to will make The Viewer available to GPs.
- Nurse navigators are helping patients navigate the public health system and between the public health system and the primary care system.
- New initiatives will help to improve the quality, safety and efficiency of our system.

Martin Bowles PSM, Secretary, Commonwealth Department of Health

- Health Care Homes were announced in 2016 – starting with 10 regions, 200 practices and 65,000 patients.
- Focus - looking at those models of care for chronic and complex patients and stratifying those patients and having them enrolled in a practice where they receive the care.
- Pooling Commonwealth and State funding around chronic and complex patients – coupled with Health Care Homes gives us a great opportunity to fundamentally shift things.
- A blended funding model will allow clinicians to do things differently without worrying about the payment mechanism.
- Early work indicates the need to continue with this initiative.
- Health care is not about short-term fiscal stimuli - it has to be about long-term thinking and stewardship.

'We need to start getting things up that fit within the strategic framework that we're working with and then I think we have a chance to make a big change. It will take some courage – courage to stand up to self-interest, courage to resist short-term gains to drive that longer-term positive outcome for both governments, industry and most particularly for consumers and patients.'

Martin Bowles PSM, Secretary, Commonwealth Department of Health

Dr Ian Sturgess, Associate Medical Director, NHS Improvement, Greater London, UK

Frailty and de-conditioning, risks and opportunities

- Our present approach to frailty is fundamentally flawed - we are increasing the rate of deconditioning in frail older people – we must change this approach.
- Fragmentation in the system increases deconditioning and deconditioning to a large extent is avoidable. Gaps in care processes increase the risk of deconditioning - waiting is not a passive process - it causes harm.
- Long-term care facilities for frail older people would be unaffordable in the medium to long term (The WHO Kyoto conference in 2013).
- Frailty is a well-recognised syndrome - it isn't always a natural consequence of ageing but its rate of decline can be accelerated by inappropriate process and systems in our health and social care systems.
- Our systems are inherently ageist – we make assumptions that because you're getting old and frail you will decline. There is a small element of truth in that but much of what we do accelerates that decline.
- Deconditioning can start to happen within the first 24 hours of an acute admission - establish a mechanism for early identification of people with frailty.
- As soon as a patient starts to decondition the risk of them having a long length of stay markedly increases.
- Most (over 80%) of admitted older patients with frailty have 'non catastrophic illness'. The 'catastrophes' occur due to the waiting in the system.
- We must deal with the purpose of admission assertively in the first few hours or it will become more severe and they will have deconditioned. We must: put in place a multi-disciplinary response that initiates comprehensive geriatric assessment within the first hour; ensure there is a very early mobilisation plan – don't enforce a reduction in habitual activity; and set up a rapid response system for frail older people in urgent care settings.
- We have to focus on frailty and recognise that our current approaches internationally for frailty are not fit for purpose.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-sturgess.pdf>

Stephen McKernan, QSO

What's changed?

- One of the key changes in society is people's willingness and desire for a different model of health care delivery – very much consumer led.
- One of the key themes and priorities is to understand the changing patterns of consumer behaviour and how these can be incorporated into models of care.
- Consumers are much more savvy and demanding around health information and technology and there is a willingness to use technology in a way that hasn't occurred previously.
- A keenness to demand from providers a more seamless and integrative patient experience.
- Sustainability – one of the challenges we have is layering additional programs and investments on top of an already busy system.
- One of the critical issues is how you use the data and information available to you to drive and support that change.
- As we look to building integrated care models there is a risk of 'initiative-itis' as opposed to looking to build the core foundation and enablers to support a high performing health system.

Panel Discussion

- As a consumer we want the same level of care no matter where we live.
- The divide between Commonwealth and State is changing – we are working together with a commitment to the management of the national healthcare system.
- If Health Care Homes is successful it will change both the clinical models of care and the way services are funded.



- Chief Executive Officers (CEOs) of PHNs in Queensland have a collaborative and work as a 'one state voice' in this area.

- Great initiatives are underway around the state and PHNs have been encouraged by Government to continue those.
- PHN CEOs are working closely with Brisbane North PHN, which has been chosen as a Health Care Home pilot site, to share lessons learned around best practice.
- The nature of the workforce is changing dramatically in hospitals, aged care, primary care – the way we worked five years ago has changed to the way we work today and we don't know what it will look like in five years.
- Projections for 2030 show a surplus of doctors but a shortage of nurses - we haven't addressed the nursing problem the same way we addressed the shortage of doctors. Nursing statistics show that there are more nurses out of the workforce than in the workforce.
- Two-thirds of people in aged residential care have dementia - a lot of the support they need can be done by a wide range of people and that may not necessarily be a nurse.
- Bupa has placed 25 GPs in 25 aged care facilities and that has dropped the rate of hospitalisations by more than half - quick intervention can change the course.
- The 10 year gap for indigenous communities is serious – a lot of the Commonwealth work in Indigenous care is getting traction but a lot of the communities don't have the basic needs.
- The Commonwealth is bringing together five agencies to try something different around closing the gap.
- Our biggest challenge is working out how to embed successful integrated care initiatives and change our fundamental system to make them sustainable.
- Education for the system and the community is key to a program such as the frailty project.
- Social isolation, which is a major cause of de-conditioning, is a community consequence and something the community can do something about.
- Priorities in quality care across the board include: appropriateness of care and variation in care: continued digitisation of health information; and changes in funding and governance at a local level.

Adrian Carson, Chief Executive, Institute for Urban Indigenous (IUIH)

- Thirty-eight per cent of Queensland's Indigenous population lives in southeast Queensland and make up 1.2% of the total southeast Queensland population, yet they experience 2.2% of the disease and injury burden.
- Southeast Queensland's Indigenous population is expected to double by 2031.
- The 'gap' between Indigenous and non-Indigenous people in southeast Queensland is estimated to be at least 10 years.
- The IUIH was established in 2009 to integrate planning, development and delivery of comprehensive primary health care services to Aboriginal and Torres Strait Islander populations across southeast Queensland.
- The IUIH understood the complex and fragmented nature of the health system – we need to make it easier for our people to access fully integrated/ comprehensive care.
- We need to integrate the system (data and ITC, planning, investment, delivery) at the regional level in order to ensure integrated care at a local level.
- There must be a strong focus on integrating a fragmented health system and disparate funding programs (Indigenous specific and mainstream) to support a coherent regional strategy, which spans the care continuum and life course.



Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-carson.pdf>

‘Rather than giving our people a compass to navigate their way across this fragmented health system in southeast Queensland we wanted to ensure that there was a strategy, which brought all the disparate strands of funding and programs into a coherent strategy, to ensure it was easy for Aboriginal and Torres Strait Islander people to access the care they needed in a manner that addressed their cultural needs as well.’

Adrian Carson, Chief Executive, Institute for Urban Indigenous Health

Dwayne Crombie, Managing Director, Private Health Insurance, Bupa Australia

- Around 50 per cent of Australians have private health insurance and if the whole health system doesn't work that affects members.
- If primary care and early intervention are not done well the result is more avoidable admissions both in public and private systems.
- Integrated care offers a way of using resources more wisely and getting better value - health insurers have a huge interest in supporting that cause.
- Private health insurers are operating in a new world in which there is much greater interest in:
 - how to engage members in their health and wellbeing – what can insurers do in terms of informational support?
 - how to help members get through the health system in terms of what their choices might be – what out of pockets they might face, is something being recommended to them a good idea?
 - collaboration - health insurers understand the need to collaborate and that this requires shared strategic goals and relationship management. Health insurers understand the need to change adult human behaviour around chronic disease and unless the consumer is at the centre it's not going to work.
- Health insurers want to be involved in integrated care and want to have a longer-term view of the health system – health insurers are not in this for a short term.

'Integrated care is not the end in itself – what we are striving for is a system that gives us safer and better outcomes, a system in which you have great customer experience and where fundamentally your need determines your ability to access care and support, not your ability to pay.'

Dwayne Crombie, Managing Director, Bupa

Central Queensland, Wide Bay and Sunshine Coast Primary Health Network

Pattie Hudson, Chief Executive Officer

- The PHN and the three associated HHSs (Central Queensland, Wide Bay and Sunshine Coast) are working together to support a more integrated system that is patient and population focused.
- The aim is to improve the integration between primary and secondary care through appropriate training of workforce, development of shared clinical priorities and clinical referral pathways from primary care to hospital services.
- Partnering with universities enables outcome focused, monitored and evaluated programs/work.

- Integration must become an integral part of our core business – we must have the courage to change and disrupt the status quo every now and then - think globally and act locally.
- We must share stories to encourage a shared purpose.
- Lessons learned: working together is critical; make time for a coordinated approach; have joint visions and goals; identify joint priorities and joint leadership.
- Opportunities: co-planning, co-designing and co-investing to make sure our combined dollar gets the best outcome for our patients; sharing of information to make informed investment; and joint workforce training and education for improved health outcomes.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-hudson.pdf>

Brisbane North Primary Health Network and Metro North Hospital and Health Service

Shelley Kleinhans, A/Chief Executive, Brisbane North PHN
Luke Worth, Executive Director, Organisational Development, Strategy and Implementation, Metro North HHS

- The Memorandum of Understanding between Brisbane North PHN and Metro North HHS is now called a protocol and is based largely on the 10 key elements for integrated governance.
- A joint needs assessment for the region is underway.
- Shared clinical priorities are a priority and health pathways are underway.
- PHN and HHS community engagement groups are being combined into one for the Brisbane North region.
- Governance structures for the two organisations are being adjusted:
 - Mandate to bring boards together twice a year
 - The formation of a protocol governance group including both CEOs and senior executives to look at vision, set priorities and solving emerging issues
 - Protocol operational group that includes operational leads.
- Where are we heading? Proposing to bring the two organisations together as a joint venture/alliance - The North Brisbane and Moreton Bay Health Alliance – sharing governance and staff.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-kleinhans.pdf>

Western Queensland Primary Health Network (WQPHN)

Stuart Gordon, Chief Executive

- We are creating an environment for collaboration across the HHSs and PHN – as health providers we will at some point in time be interacting with the same patients
- Reaching a consensus on the key areas for collaboration – identify high areas of mutual interest founded in evidence.
- We sort to leverage from the unique foundational elements of the WQPHN formed by the three HHSs.

- Frame engagement within a strategic construct and leverage from clinical leadership available through general practice – good general practice is crucial to comprehensive health care.
- Developed a protocol supported by an independent process - fundamental in that is the language around integration.
- Bi annual meeting of representatives of the four organisation’s board members.
- The protocol helped to orientate the four organisations toward a contemporary approach and started a process of partnership and transparency, which can support greater strategic intent and leadership.
- There is a huge case for change in the region – burden of disease, remoteness, workforce and market, general practice.
- What is important in the process – relationship within a strategic construct; realistic expectations; independent facilitation to start engagement across jurisdictions; protocol helpful in informing the five-year plan.
- What is important going forward: developing a shared narrative, meaningful clinical and consumer engagement, shared health intelligence, understand commissioning, adopt a ‘think regional, act local’ approach, identify ‘exemplar’ opportunities.
- Early outcomes: co-design of the WQPHN strategic plan, significant leadership and willingness to collaborate, joint consortia approach WQPHN Mental Health and Suicide Prevention and Alcohol and Drug Treatment Services Regional Plan.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-gordon.pdf>

Panel discussion

- How can we make integration work? A shared sense of what is important; make integration part of core business; commitment at policy level that integration is paramount; inspire change; relationships; start with shared health intelligence and getting an accurate picture of the problems; don’t presume that everything is broken; bring consumers to the table and start to plan with them.
- We’ve got to get away from the funding and think about the consumer - go straight to the consumer and find out how they want to be supported.
- Build the capacity of people to understand how the health system works and that they have a right to expect the best care, while also ensuring people are empowered to take control of their health.
- We need a more strategic approach to communications so consumers know what’s available.
- Health literacy is an important part of health prevention – how do we equip consumers to make well-informed decisions?
- Resources need to be dedicated to community engagement to ensure that community engagement happens everyday.
- Key driver or reporting metric to facilitate change to shift the right care to the right place: Choosing Wisely; customer episode and net promoter score; measuring the patient experience and health literacy; evidence-based models of care; the community voting with their feet.

Implementation showcase

The Lower Gulf – a case for change

Lisa Davies-Jones, Chief Executive, North West Hospital and Health Service

- North West HHS is working in partnership with Western Queensland PHN and Gidgee Healing, the region's key Indigenous health organisation.
- Agreement that change in the service delivery approach is required in the Lower Gulf to improve health outcomes of people living in the region.
- A jointly developed primary health care strategy has been endorsed with strong focus on partnership working with Aboriginal and Torres Strait Islander people participating in decision-making, preventative care, culturally safe services and developing the Aboriginal workforce.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-davies-jones.pdf>

Mental Health

Cherylee Treloar, Chief Executive, Footprints

- Mental Health Demonstration Project to test a new integrated social housing, health and psycho-social person-centric service delivery model to assist social housing tenants with mental illness or related complex needs to sustain their tenancies.
- Provided effective individualised, integrated case coordination and management plans developed through collaboration of two government departments (Public Works & Housing, Queensland Health) and non-government organisation (Footprints).
- Interim evaluation by University of Queensland's Institute for Social Science Research has indicated that shared-care planning using cloud application one of the key successes of the project to date.
- 98% of participants sustained housing (2% relocated to alternative housing) and 100% no eviction to homelessness.

Presentation: https://www.health.qld.gov.au/_data/assets/pdf_file/0028/632863/qcs-pp-1611-treloar.pdf

The frail and elderly

Pattie Hudson, Chief Executive Officer, Central Queensland, Wide Bay and Sunshine Coast Primary Health Network

Kerrie Hayes, Executive Director of Clinical Services, Sunshine Coast Hospital and Health Service

- CEDRIC Project - A high number of patients being transferred to the emergency departments (EDs) from residential aged care facilities on the Sunshine Coast.
- Worked collaboratively with the ED, University of the Sunshine Coast (USC) and residential aged care to put nurse practitioner in aged care and a geriatric team in the ED.
- SPOT ON Project to reduce transfers of low acuity patients by Queensland Ambulance Service (QAS) to ED when patients can be treated within general practice or primary care

- Collaboration between QAS, SCHHS, PHN, GPs and USC.
- Preliminary outcomes: significant increase in QAS patient transfers to GP; reduction in QAS transports of Cat 5 to ED; patients rated experience positive; more cost effective for low acuity patients.

Emergency alternatives

Shelley Kleinhans, A/Chief Executive, Brisbane North Primary Health Network

- Community education campaign to improve awareness of after hours care options, to help people make informed and appropriate choices when accessing services, reduce burden of inappropriate ED presentations.
- Parents with children under 15 and young people aged 20-29 identified as two key target audiences most likely to make change.
- Campaign involved bus stop, shopping centre, social media and newspaper advertising, fridge magnets and posters for GP clinics.
- Twenty-three per cent of people who saw the campaign used alternative services as a direct result.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-kleinhans-2.pdf>

An Integrated Refugee Health Model of Care

Leeanne Schmidt, Metro South Refugee Health Service, Metro South Hospital and Health Service

Andrea Vancia, Brisbane South Primary Health Network

- 400% increase in new refugee arrivals in the Logan region with no extra resources for Metro South Refugee Health Service.
- Metro South Refugee Health Service and Brisbane South PHN working together to build capacity in general practice, provide settlement agency staff education, and planning for an integrated sustainable refugee health nurse pathway.
- Timely response achieved as a result of the underlying strong partnerships in refugee health in southeast Queensland.
- Will result in stronger and sustainable partnerships and integration of services across the refugee health sector.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-vancia.pdf>

My Health Record Participation Trial

Anthony Elliott, Chief Operating Officer, Northern Queensland Primary Health network

- To support the 'opt out' model to ensure people understood what they were making a decision about.
- Extensive engagement with healthcare providers, consumers and stakeholder groups.
- 1.9% opt out rate; 700,000 people in region with My Health Record.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-moore.pdf>

Integrated care from a GP perspective

Graham Wright, Gold Coast Primary Health Network

- Can improved integration of care between general practice and hospital care improve care for patients with chronic and complex needs and be cost effective?
- Targeting patients with diabetes, cardiac, renal and chronic respiratory disease with a raised risk of hospitalisation in the next 12 months.
- Chronic disease registers established for these groups.
- A shared care record system was created, accessible by patient, care team and hospital (if patient admitted acutely).
- 1500 patients enrolled by September 2016, 15 GP practices and 112 GPs taking part.
- 10,500 GP –patient contacts uploaded to the shared care record.
- Integrated care program running outpatient clinics for patients identified as needing additional support.
- Servers installed in GP practices providing real time information on patients and chronic disease registers to the GPs.
- Research study to be published in 2018.

Presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1611-wright.pdf>



Appendix 1: Barriers and opportunities to integration

Senior leaders from Queensland HHSs and PHNs shared learnings and discussed barriers and opportunities to integration in a pre-meeting workshop.

Key messages included:

Barriers	All of State Solution
1. Fixed historic Commonwealth/State funding separation	Blurring boards to jointly focus on local population priorities
2. Multiple local funding streams creating duplication, confusion and fragmentation (e.g. rural funding, ATSI funding, special grants etc.)	Population based integrated Commonwealth and State approach to commissioning rather than procurement e.g. partners in recovery program
3. Change management and leadership across sectors	Implement state-wide demonstrated strategies supporting change e.g. GPLOs, joint Board meetings, local joint clinician groups, shared agreed vision, annual action plans, networks that span across sectors/groups, leadership – top down and bottom up
4. Variation in integration approaches and outcomes across the State geography	Consistent expectations, commitment and support for articulated deliverables at State level Shared narrative across sectors
5. Sharing of accurate clinical information in a timely, consistent manner	Systems for and business rules for sharing information e.g. secure messaging, MyHR?
6. Continuing historical culture	Shared vision for new models of care with funding reform and community engagement to deliver care in new ways and settings
7. Data and needs driven change	Needs assessment -> data and priorities -> Local clinician, manager innovation -> effective initiatives
8. Social determinates of health not prominent in health planning for most vulnerable	High disadvantaged groups require all of government approach (housing, transport, education, police)

Appendix 2: Critical elements to creating the conditions to implement proven innovations Queensland wide

Delegates participated in small group work to identify the critical elements that were needed to support system wide change and tangible actions to support change.

Incentivise collaboration

What	Who
For key /shared priorities (pooled funding for acute care, primary care, community care services working together etc.) – existing funding and ‘change funding’ to enable movement from the old way of doing things to the new. Ensure ‘incentive’ leavers are aligned.	Commonwealth Department of Health – Queensland
Use the culture of healthy competition to encourage action and the achievement of the desired health outcomes.	HHSs and PHNs
Legislative reform where necessary.	Commonwealth Department of Health – Queensland
Distribute funds into primary care rather than having community health services based within hospitals. Incentivise HHSs to make savings by supporting primary care to provide the services.	Commonwealth Department of Health – Queensland
Longer term funding and support for NGOs.	Commonwealth Department of Health – Queensland

Strong leadership (at all levels across the health system, top down and bottom up)

What	Who
Encourage involvement from all leaders from stakeholder groups.	All organisations
Establish a leadership and innovation framework to encourage leadership amongst the workforce.	HHSs and PHNs
Set policy direction and expectations.	Department of Health – Queensland

Genuine engagement with all stakeholders (non/clinical; grass roots to executive)

What	Who
Strong consumer engagement (to understand the community’s needs).	All organisations
Promote health literacy (to enable community driven change).	All organisations
Harness the ideas and energy of the younger workforce.	All organisations
Enable HHSs to have more direct relationships with general practice.	Department of Health – Queensland

Communication strategy

What	Who
Use existing networks and forums where appropriate.	All organisations
Strategy - targeted but widespread communication across organisations - use existing infrastructure (e.g. local government and other departments) using a variety of mediums (forums, Twitter, Wikipedia, LinkedIn, chat rooms).	
Transparent public reporting.	All organisations

Dissemination and translation of implementation(s) into practice

What	Who
Central repository of evidence based innovations and champions for change that are accessible to, and content is contributed by all health sectors. System must be resourced (human/financial/infrastructure).	Department of Health – Queensland
Need to support local and system innovation (local innovation is a lever for system change).	HHSs and PHNs
Mechanism/framework to support consistent innovation (and implementation) at a system level with support for local innovation - need local adaption of innovation to respond to local needs.	Department of Health – Queensland
Process for innovation implementation to ensure it becomes embedded in practice (implementation science methodology) including resources and tools.	HHSs and PHNs
Establish an integrating care innovation centre within the Department of Health – role is the central point of contact and ‘conduit’ for information, coordinate system activity, support central repository of innovations and change champions, ensure learnings are captured and implemented from failed projects.	Department of Health – Queensland
Use an implementation science approach.	All organisations
Hold an annual ‘Innovation Day’ to both showcase innovation and generate new ideas. Fund the winner to promote healthy competition.	HHSs with PHNs
Acknowledge the role all organisations play in integrating care and improving health outcomes for patients and families.	All organisations

Innovation evaluation

What	Who
Transparent consistent evaluation methodology to give people confidence that a robust system was applied and outcomes reflect the objective.	Department of Health – Queensland
Cost benefit analysis / opportunity cost analysis to support options analysis where several approaches might achieve a specific outcome.	
Outcome metrics that include patient centric and provider centric measures of experiences and outcomes.	
Scalability evaluation completed for rural/regional/urban	

relevance. Might include core components relevant to all to achieve system outcomes with components for local customisation.	
Sharing/communication of innovation failures – what didn't work and why?	
Have systems in place to collect the data needed to measure and evaluate the outcome.	
Partner with academia – use university partners.	
Establish frameworks for project development and evaluation.	Department of Health – Queensland
Sharing data and protocols (national, state, local) – formalise through MOUs and service level agreements.	
All innovation evaluations include an assessment of scalability.	
Evaluations completed by external party to exclude bias.	

Change management

What	Who
Culture that embraces change and continuous learning (including a learning approach to failure, sharing of information and collaboration is 'normal' behaviour, including the responsibility of training providers role in embedded a change culture in trainees).	All organisations
Governance and accountabilities clearly defined.	All organisations
Fund the resources required to support change management - ensuring the resource is directed to what it was intended for.	All organisations
Accountability for KPIs – written into role descriptions and performance appraisals.	HHSs and PHNs
Enable scope of practice and remove barriers where they exist.	HHSs and PHNs
Dedicated time for leaders and champions to do the work.	HHSs and PHNs
Consistent expectations and commitment.	All organisations

Joint planning and synchronisation of planning across the region(s)

What	Who
Access to local and statewide data/information to support the identification of shared priorities and outcome evaluation.	HHSs and PHNs
Blurring board boundaries to jointly focus on local population priorities.	HHSs and PHNs
PHNs and HHSs co-commission.	HHSs and PHNs
Involvement of sectors beyond health (e.g. transport, housing).	All organisations
"Health supply chain" mapping to identify opportunities and partners.	HHSs and PHNs
Sharing data and protocols (national, state, local) – formalise through MOUs and service level agreements.	HHSs and PHNs
Agreed vision, goals and targets.	HHSs and PHNs
Consumer involvement in all stages of design and planning.	All organisations

Appendix 3: Hospital and Health Board Forum Feedback – 8 December 2016

Members of Queensland's Hospital and Health Boards participated in a brief discussion about governance of the Integrated Care agenda within their health services. Boards were asked to consider 2 specific questions – this an overview of the key themes from those discussions.

Q: How will we (the Board) know when we are delivering excellent integrated care to our community?

- Good integrated care can mean different things to different people. Work with and engage stakeholders - patients, consumers, carers, families, NGOs, the community, clinicians - from all professions and sectors to understand what it means to them and incorporate that into consumer engagement strategies.
- Recognise the diversity of populations and ensure engagement is appropriate to groups.
- Care is delivered in the right place at the right time by the right provider, with the consumer being supported to access care when it cannot be provided locally.
- Patients and stakeholders can easily identify/navigate pathways for care across the system.
- We will know the 3-5% of complex disease patients at risk of hospitalisation and we will be able to predict who they are using predictive algorithm based on integrated clinical data.
- Improvement in agreed baseline statistics, which might include:
 - Consumer/patient community in care experience and health outcomes (all - not just a selected few)
 - Readmission rates to hospitals per capita of patients with complex and chronic disease
 - Avoidable hospital admission rates per capita
 - Admission rates (including ED presentation rates of lower triage categories and admissions from residential aged care facilities) per capita
 - Access time to services - including wait times for surgery
 - Population health measures: reduction in obesity/overweight, smoking rates etc
 - Burden of chronic disease - quality of life indicators – life expectancy
 - Drug reaction rates
 - Take-up of telehealth and Myhealth record
 - Discharge planning compliance levels

- Patient reported outcome measures
- Discharge against medical advice rates.
- Strong effective partnerships with stakeholder organisations, e.g., HHSs, PHN's, Community Care, local/state/federal government:
 - Joint planning
 - Shared clinical priorities
 - Shared information
 - Evidence that healthcare provider/s is/are connected across service boundaries: co-designed and evidence-based care processes; agreed integrated care pathways with PHN/HHSs to ensure care is delivered in the right setting by the right provider and visible service delivery models
 - Staff from across sectors know each other and value working together
 - Service duplication is removed (improve value), and
 - 360 degree questionnaires.

Q: How will we (the Board) measure and report activities and performance around integrated care?

- Indicators should measure performance and drive/inform service improvement and be relevant to all partner organisations.
- Reflect the patient journey across health sectors with a focus on the points where care transitions from one service/provider to another.
- Reflect key stakeholder perspectives by including them as partners in designing measures: patients, consumers, carers, clinicians etc.
- Measurement might focus on:
 - Experience of care and health outcomes. For example:
 - Patient/consumer/carer/family experience surveys. All patients, immediately after or during care, to provide a more realistic gauge of patient satisfaction and prompt feedback to clinicians and managers to address issues, and
 - Staff/clinician experience.
 - Quality and safety of care. For example:
 - Unplanned readmission rates within 28 days of separation
 - Unplanned and emergency re-presentations to ED within 48 hours
 - Readmission rates for care sensitive conditions
 - Potentially avoidable admissions/hospitalisations
 - Electronic discharge summaries provided and received within agreed timeframe (24 hours), and

- Adverse events rates.
- Service access -
 - Indicators relating to the avoidable use of acute care services / hospital admissions
 - Waiting times for elective surgery and ED care
 - Referral rejection rates.
- Population health measures -
 - Improvement in smoking, obesity/overweight, other chronic diseases and immunisation rates
 - Improvement in closing the gap indicators.
- Effectiveness of integration processes (e.g. information sharing, shared decision making, coordination of care) -
 - Discharge summary provided and received within agreed timeframe (24 hours)
 - Rates of patients presenting to hospital with lower level triage categories
 - Test/investigation duplication rates
 - Joint PHN and HHS meetings
 - Sharing of information/data through MyHealth record, health plans, The Viewer etc.
 - QAS hospital avoidance pathway compliance
- Feedback on progress to stakeholders (people, organisations and the broader health system) -
 - Transparent monthly performance report, which demonstrates progress/improvement and benchmarks against peers
 - Timely reporting
 - Key reports from front line staff to gauge validity of data and clinicians involvement in reporting.