HNE LHD | HNECC PHN Integrated Care Alliance

Operational Plan 2018-19

NSW GOVERNMENT Health
Hunter New England
Local Health District

phn
HUNTER NEW ENGLAND
AND CENTRAL COAST
An Australian Government Initiative

ABOUT THIS DOCUMENT

This document is an Integrated Care Plan jointly owned by the PHN and LHD.

The initiatives it contains have already been agreed to by both organisations.

They are now 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 the 2018-19 period.

Attachments to this document

1. Integrated Care Enablers Service Level Agreement (SLA)
2. Diabetes Alliance SLA
3. COPD SLA.

OUR SHARED VISION

Healthy People and Healthy Communities – Now and Into the Future

THE PURPOSE OF OUR 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:

- Be able to 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:

- Be able to 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 2018-19

TOPIC	PHN EXEC SPONSOR	PHN LEAD MANAGER	LHD EXEC SPONSOR
1. Data Enablers	Executive Manager Corporate Services	IMIT Manager	Executive Director Finance
2. Integrated Care Enablers	Executive Manager Performance, Integration and Communities	Manager HealthPathways	Executive Director Partnerships, Innovation and Research
	Executive Manager Primary Care Improvement	Team Leader Digital Health	Executive Director Information Technology
3. First 2000 Days of Life Service Integration	Executive Manager Performance, Integration and Communities	Manager Integrated Care	Executive Director Children Young People and Families/Networks and Streams
4. Drug and Alcohol Service Integration	Executive Manager Commissioning	Team Leader Alcohol and Other Drugs (AOD) and Aboriginal Mental Health	Executive Director Rural and Regional Health Services

LHD LEAD MANAGER	IN 2018-19 WE WILL
Manager Health Analytics and Business Support	Respond to the specific needs of other workstreams rather than have a specific "plan". More contact will be forthcoming as each workstream identifies their needs.
Manager Integrated Care and Partnerships	Implement the Integrated Care Enablers Service Level Agreement (SLA) (attachment 1), including: • Rapid eReferral Spread Strategy of 85 per cent of practices using Best Practice or Medical Director will exclusively be using eReferral • Implement 2018-19 HealthPathways Operational Plan, which includes the integration of Hospital Pathways. Implement electronic notification to GPs that their patient has been admitted to hospital or presented to an Emergency Department via secure messaging which is integrated with GP practice software.
Director Community Partnerships and Innovation	The First 2000 days (conception to commencing school) are acknowledged to be the most critical in how a child develops physically, emotionally and socially. Evidence shows that these first 2000 days affect a child's health and wellbeing for the rest of their lives. Multiple services are involved in supporting the development of children, including primary, secondary and tertiary mental and physical health services, education, child protection and Indigenous services. Currently these services are fragmented and poorly integrated. Improvements in outcomes in the first 2000 days will require close integration and collaboration between these services. A necessary first step to improved integration and collaboration is to identify all of the existing services involved with families in the first 2000 days. In 2018 we will map out the services (including their scope, function and priorities) and identify gaps. A shared and well-known priority area of concern is the service gap for access to general and community paediatric services across the Newcastle region, including both medical and allied health models. In 2018-19, we will also undertake a review of patients waiting for care across general and community paediatric services by using rigorous redesign methodology including the HNE Clinical Bundle and Outpatient Guiding and Service principals. Service mapping and gap analysis will align with NSW Ministry of Health Framework.
Director Drug and Alcohol Services	The PHN and LHD Alcohol and Other Drug (AOD) teams will work together on shared projects that address changes in regulations affecting the ability for primary care to prescribe opioids. Recent changes to regulations will enable primary care an opportunity broaden the scope of management. Capacity building in opioid prescribing for primary care will be enhanced over the period as a shared responsibility. Involvement in the AOD Network and collaboration in potential research funding will also occur in the 2018-19 period.

WHAT WE WILL DO IN 2018-19

TOPIC	PHN EXEC SPONSOR	PHN LEAD MANAGER	LHD EXEC SPONSOR
5. Mental Health Service Integration	Executive Manager Commissioning	Team Leader Mental Health Manager Commissioned Services	Executive Director Mental Health
6. Palliative and End of Life Care Service Integration	Executive Manager Performance, Integration and Communities	Manager Integrated Care	Executive Director Children, Young People and Families/Networks Streams

LHD LEAD MANAGER	IN 2018-19 WE WILL
General Manager Mental Health	**Mental Health Line Redesign Project** HNE LHD will lead the diagnostics phase of the Mental Health Line Redesign project. The first phase of the project will look at three key focus areas: • Clarifying key customers and the primary purpose for each group of customers including a primary care • Information Technology and Telephony (IT&T) • People and Processes. Together we will ensure that GPs and other primary care customers of the Mental Health Line are considered as a key customer group and that primary care providers are consulted and contribute. **Transitional Care Packages** The PHN and LHD will co-commission transitional care mental health packages by working through the following steps: • Establishing Shared Governance • Establishing Shared Data, Analytics and System Measurement • Shared Needs Assessment and Service Design • Co-investment (specifically, how to co commission Transitional Care Packages) • Service Level Agreement between PHN, LHD and successful proponent • Shared Performance Monitoring, Management and Evaluation.
Palliative and End of Life Care Stream Leader	The Palliative and End of Life Care Integrated Alliance group will work in partnership to modify the Clinical Excellence Commission's (CECs) "Last Days of Life Toolkit" for use in Residential Aged Care Facilities (RACFs), and pilot the implementation of the modified documents in a select number of RACFs. To achieve this we will: • Identify and utilise existing networks available across the region that can support the use of consistent end of life planning tools in residential aged care settings, including but not limited to Aged Care Emergency service, the Aged Care Interagency network, Geriatricians, the RACF/Palliative Care Nursing interest group (k/a HAPCAN) and HNE LHD key staff and primary care providers • Engage with nursing staff and personal care staff working in Residential Aged Care facilities across the Hunter region, including those participating in HAPCAN, to ensure any modifications to the toolkit are fit for purpose and consider the workflows in facilities • Engage NSW Ambulance and the Palliative Care CNC (employed by NSW Ambulance) to consider the role NSW Ambulance's Authorised Care Plans have in caring for residents in the last days of life • Actively select, through an expression of interest process, a small number of RACFs willing to participate in a pilot implementation of the modified "Last Days of Life Toolkit". It would be preferred that RACFs selected to participate in the pilot will have access to a Nurse Practitioner to maximise the opportunity to embed the use of the toolkit in the workflows of the facility. This activity will also contribute to: • Enhancing patient information sheets and including them on HNE PatientInfo to allow easy access by consumers • Making available shared care planning resources for GPs to access on HNE HealthPathways to support decision making.

WHAT WE WILL DO IN 2018-19

TOPIC	PHN EXEC SPONSOR	PHN LEAD MANAGER	LHD EXEC SPONSOR
7. Urgent Care Workstream	Executive Manager Performance, Integration and Communities Executive Manager Commissioning	Integrated Care Officer Ambulance Liaison, Access and Demand Management Manager Commissioned Services	Executive Director Greater Metropolitan Health Services Executive Director Rural and Regional Health Services
8. Closing the Gap Initiative Integration	Executive Manager Commissioning	Manager Aboriginal Health Access	Executive Director Rural and Regional Health Services

LHD LEAD MANAGER	IN 2018-19 WE WILL
Service Manager Patient Flow Unit	This is the first opportunity for the Integrated Care Alliance to follow the steps in the PHN's co-commissioning model. For this workstream, "in scope" are services currently co-funded by the PHN and LHD (ie. those provided by General Practice After Hours and the Aged Care Emergency Service). This workstream will be responsible for equipping HNE LHD and HNECC PHN to co-commission urgent care services together in 2018-19. The first deliverable will be to commission after hour medical services (similar to those currently provided by GPAAH) by July 1, 2019. This involves working through the steps of co-commissioning as defined by the HNECC PHN, including: • Establishing Shared Governance • Establishing Shared Data, Analytics and System Measurement • Shared Needs Assessment and Service Design • Co-investment (specifically, how to co-commission ACE/GPAAH when current contracts end) • Service Level Agreement between PHN, LHD and successful proponent • Shared Performance Monitoring, Management and Evaluation. In conducting this work, the workstream will pay attention to the two priority areas from the Aged Care Planning meeting (held in Scone in February, 2018), which included: • Commence a service design project to develop a contemporary telephone support platform to support Aged Care Facilities facility • Develop an appropriate education model to support Aged Care teams manage the deteriorating resident.
Director Aboriginal Health Unit	The Aboriginal Workgroup seeks to explore the potential overlap and enhance integration between the Integrated Team Care (ITC) program, the HNE LHD Chronic Disease/Connecting Care for Aboriginal and Torres Strait Islander people and the Primary Allied Health Services (PAHS) programs to ensure equity of access for Aboriginal people. By reducing the potential overlap across these similar services and highlighting potential duplication of services, we will improve access to services and maximise opportunities for service provision.

WHAT WE WILL DO IN 2018-19

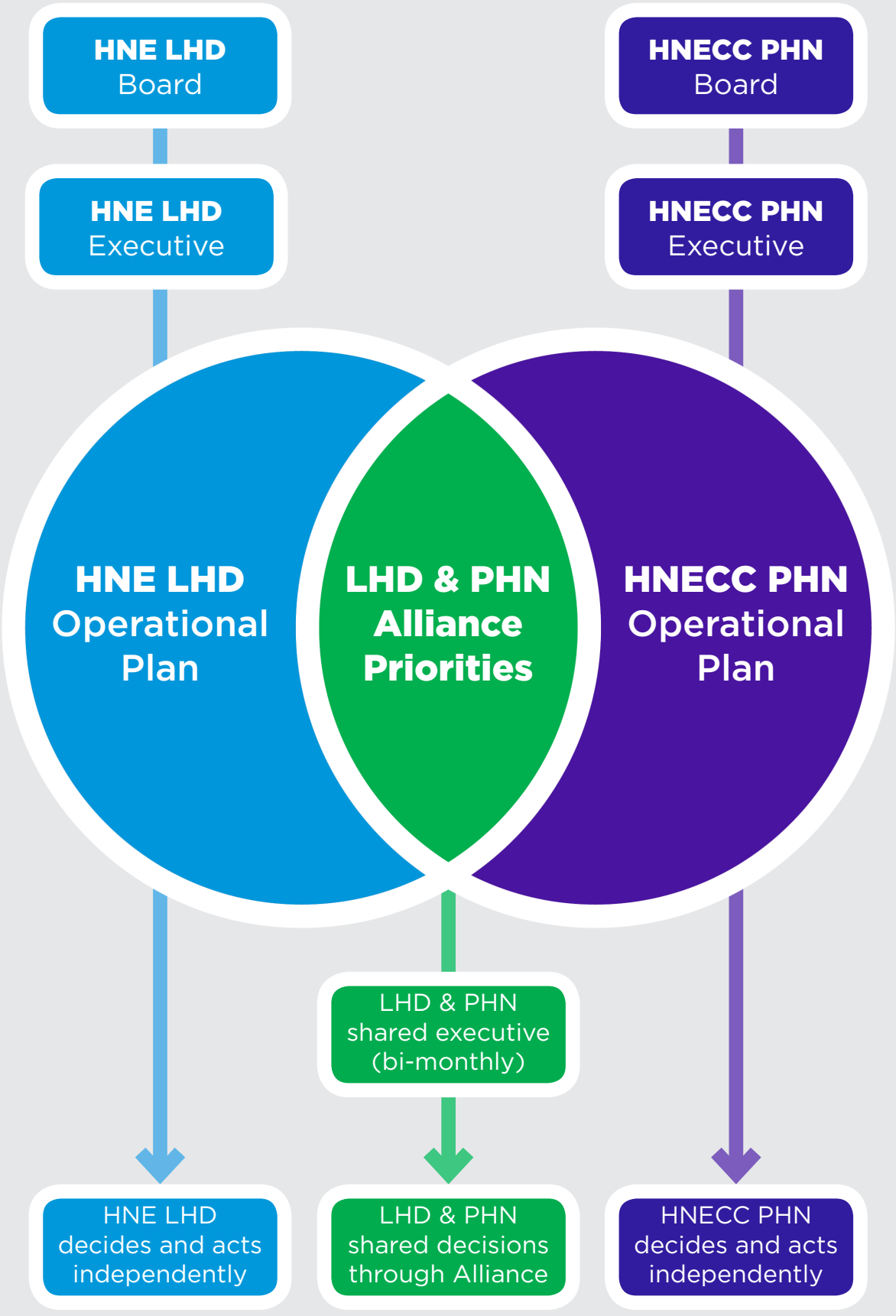
TOPIC	PHN EXEC SPONSOR	PHN LEAD MANAGER	LHD EXEC SPONSOR
9. Chronic Disease Service Integration	Executive Manager Performance, Integration and Communities	Integrated Care Officer Chronic Disease Management (Hunter)	Executive Director Greater Metropolitan Executive Director Rural and Regional Health Services
10. GP VMO Workforce Planning Place Based Approach	Executive Manager Primary Care Improvement	Team Leader Workforce and Continuous Professional Development (CPD)	Executive Director Rural and Regional Health Services Executive Director Workforce Executive Director Partnerships, Innovation and Research
11. Participate in NSW Regional Health Partners Centre for Innovation in Regional Health	Executive Manager Performance, Integration and Communities	Manager Health Planning, Research and Evaluation	Executive Director Partnerships, Innovation and Research

LHD LEAD MANAGER	IN 2018-19 WE WILL

Manager Clinical Networks	• **Heart Failure** – build Primary Care Teams' capacity for early detection, management and monitoring and improve referral pathways/rapid access to specialist advice for Primary Care Teams
	• **Diabetes** – implement Integrated Model of Care as per Service Level Agreement (SLA) (attachment 2) and develop new SLA which takes into account High Risk Foot initiatives
	• **COPD** - implement Integrated Model of Care as per COPD Service Level Agreement (attachment 3)
	• **Osteoporotic Refracture** – implement strategy to refer patients with refracture for Primary Care follow up and ongoing management. This will include aligning acute care service to the new approach and training some special interest GPs
	• **Osteoarthritis Chronic Care Program** – implement strategy to support Primary Care Teams to optimise management of patients before referral for surgery.
	• **Health Care Homes (HCH)** - HNECC PHN will lead the implementation of the Health Care Homes program. Together we will:
	  • Ensure HCH enrolled patients are identified if they attend a HNE LHD facility
	  • Encourage the use and access of My Health Record for HCH enrolled patients and health care providers
	  • Ensure there is no duplication in services delivery of Care Coordination and Management between HNE LHD and Health Care Home practices.

Director Medical Services Rural and Regional Health Services	In considering workforce priorities, the workgroup will work together to: • Obtain data from Rural Doctors Network (RDN) related to the GP VMO Workforce in the towns in the rural towns (including a sub set related to procedural VMOs) • Risk stratify the towns and develop an associated "Heat Map" • Consider and develop local (placed based) strategies to mitigate the risk to at risk communities.
Director Research and Research Translation	The Integrated Care Alliance Executive is a forum for the HNE LHD and HNECC PHN to discuss strategic research priorities and how they can work together to progress these through the NSW Regional Health Partners CIRH, of which they are both members.

RELATIONSHIP OF THIS PLAN TO THE HNE LHD AND HNECC PHN OPERATIONAL PLANS



MEMBERS OF THE INTEGRATED CARE ALLIANCE

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 - HNE LHD
6. Executive Director, Greater Metropolitan Health Services - HNE LHD
7. Executive Director, Rural and Regional Health Services - HNE LHD
8. Executive Director, Mental Health Services - HNE LHD
9. Executive Director, Children Young People and Families - HNE LHD
10. Executive Director, Partnerships Innovation and Research - HNE LHD
11. Other HNE LHD Executive Directors, as required.

Secretariat
Executive Assistant to the Chief Executive, with support from:

- Manager, Integrated Care - HNE LHD
- Network Manager - HNE LHD
- Manager, Integrated Care - HNECC PHN.

HOW WILL WE WORK TOGETHER?

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

Some may choose to seek advice from a “workstream” comprising experts on the topic. Many workstreams are already established (eg. mental health, drug and alcohol).

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

All Executive Sponsors will also use our integrated care enablers, such as HealthPathways, Hospital Pathways, PatientInfo, eReferral.

Information for the public about our Integrated Care Alliance will be hosted on the **Research and Innovation Portal** and be linked from the HNE LHD and HNECC PHN websites.