NSW HEALTH

Strategic Framework for Integrating Care

NSW GOVERNMENT

A message from the Minister

Our communities, regions and families are constantly changing and evolving. So it's only natural that our health services need to keep pace to ensure we continue delivering the essential care that our community deserves.

From public and private hospitals, GPs, specialists – it can sometimes be a system that is difficult to navigate.

That is why we need to make the most of available technology and innovation to help people get the health care they need, when they need it the most.

The NSW Health Strategic Framework for Integrating Care sets out how we can all work together in partnership with other health and social services to respond to the community's needs.

As Minister, I am committed to providing our front line health staff with the tools they need to ensure that mums, dads, children and the elderly – regardless of location – receive the best possible health care.

Over the last seven years, there has been extensive work by NSW Health to establish health networks that are flexible, sustainable and able to respond to a patient's needs.

This Framework builds on that early work and will set out how we will all step into the future and continue to deliver comprehensive and world-class health services for our communities.

The Hon. Brad Hazzard MP
Minister for Health
Minister for Medical Research

Foreword

The integration of care across settings and providers is an aspiration of all health services. Integration provides enhanced quality and safety of care and better patient experiences.

Systems integration is critical for shifting the paradigm from volume to value care. By improving integration within NSW Health, and with our partner organisations, we can deliver better value for the system and better outcomes for patients.

The Strategic Framework for Integrating Care supports this shift by setting a long term vision for high quality, seamless care within the health system and at our points of connection with social care. The evidence is clear that putting people's outcomes and experience at the centre of our decision-making supports safe, high-quality and high-value care.

Enablers and building blocks in the Framework provide guidance on how to improve partnerships, pathways, models of care, funding arrangements and performance monitoring to align with this value-based approach. They complement NSW Health's increasingly mature approach to digital health and data analytics, which is enabling us to better measure health outcomes and embed evidence-based practice.

Through systems integration, we are coordinating and aligning different systems to deliver more connected care and better value for people receiving care in NSW. The Framework provides the foundation for this process. It supports NSW Health and our partners to be more efficient and effective, by working together to ensure people are receiving the care they require and by reducing duplication.

The goal of this work is to design a system around the needs of people to make sure that the care they receive is of the highest quality and seamlessly connected. We look forward to working together with NSW Health staff, services and our partners to implement this Framework across NSW and to realise this ambition.

Elizabeth Koff
NSW Secretary for Health

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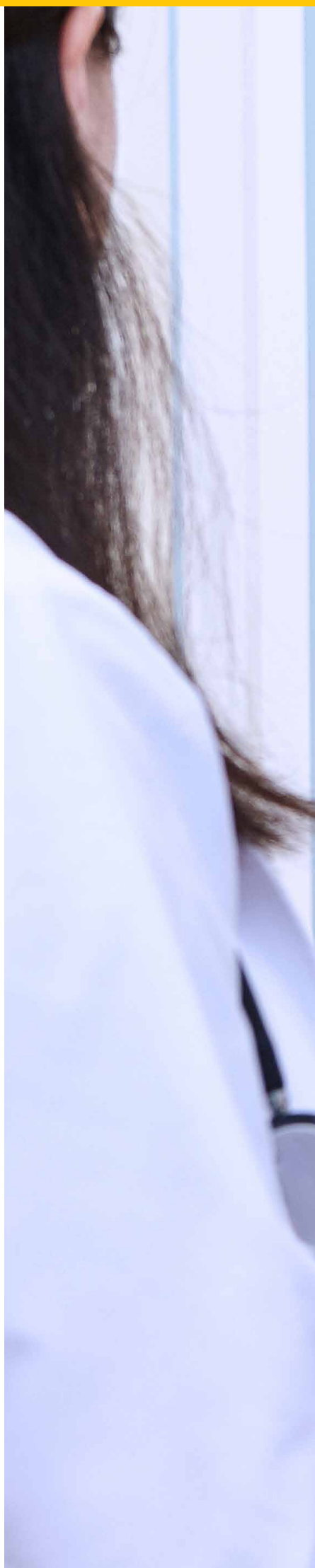

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“I felt very at ease and included in the diagnosis and treatment. Everything was explained fully and I was given options – which I liked. ”

Adult who participated in an integrated care program

Included throughout this Framework are statements from people who have participated in integrated models of care as patients or carers. Their experiences reflect the changes that take place when care and services are organised around the needs of the person.

Background

1.1 Why a Strategic Framework for Integrating Care?

The Strategic Framework for Integrating Care supports better outcomes for individuals, families, health professionals, community health workers, and the broader health system.

These outcomes include:

- People, families and carers experiencing better coordination of care across different settings.
- Improved health and wellbeing of the population, with greater health literacy and self-care.
- A more value-based health system with reduced duplication in investment and services and more effective use of resources.
- Greater job satisfaction for service providers, clinicians and other staff, with improved experiences of providing care.

The Framework sets an overarching vision for how NSW Health approaches integration of care. It is aligned with NSW Health's move toward value-based healthcare that aims to improve health outcomes, the experiences of receiving and providing care, and the effectiveness of care by placing people at the centre of our decision making.

The Framework describes a system-wide approach to integration that encompasses population health, acute, non-acute and community services. It will support and guide health services in moving towards closer systems integration. It brings together different approaches under one umbrella and through enablers that support the delivery of care that is closely coordinated and integrated.

Systems integration creates greater efficiencies in service delivery leading to improved outcomes and experiences for people, their families and carers as they interact with the health system. It supports better care outcomes for all people through care that is targeted to their needs.

1.2 What is integration of care?

Integration of care is an approach that aims to deliver seamless care within the health system and its interface with social care.

It places people at the centre of care, providing comprehensive wrap around support for individuals with complex needs and enabling individuals to access care when and where they need it.

A more integrated health care system is easy to use, navigate and access. It is responsive to the specific health needs of local communities, providing them with more choice and greater opportunities to actively engage with the health system.

For service providers and clinicians, integrating care supports them to collaborate more effectively across health and with social care.

Integrating care is vital to improving outcomes for vulnerable and at-risk populations and people with complex health and social needs. This may include older people, children and young people, people living with disability, people living with a mental illness, Aboriginal people, people from a culturally and linguistically diverse background, and people who have experienced or are experiencing domestic and family violence.

1.3 Integrating care in NSW – What are we building on?

The NSW Government has made substantial progress to deliver care that is more integrated. The integration of care is one of three strategic directions outlined in the NSW State Health Plan: Towards 2021.

NSW Health has a long-standing commitment to integrating care, with multiple drivers and targeted actions that have been tailored to strengthen areas of high demand within the health system.

Integrating care continues to be a priority for health and social care services in NSW, particularly as settings continue to shift focus to person centred models of care that are coordinated across different care settings.

NSW's current approach to integrating care builds on a long history. A substantial investment in integration was made with the introduction of HealthOne NSW in 2006, which initially focused on facility-based integration with primary care through information sharing, care coordination and co-location. The operational HealthOne sites provide multidisciplinary care for people close to where they live.

In 2009, the Chronic Disease Management Program introduced a community-based, integrated model of care, providing coordinated services to manage the health of people with diabetes, congestive heart failure, coronary heart disease, chronic obstructive pulmonary disease, and hypertension. The program was evaluated in 2014, and the lessons learned led to a redesign of the program overall, and increased alignment with the NSW Integrated Care Strategy.

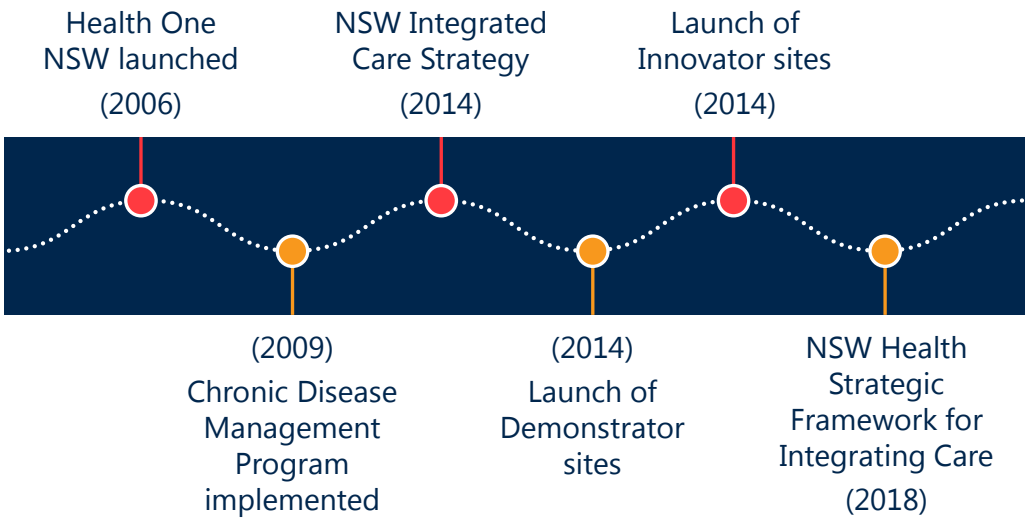
In 2014, the NSW Government introduced the NSW Integrated Care Strategy (ICS), providing funding of over $180 million to enable LHDs, SHNs and PHNs to develop specific, innovative solutions to address the needs of their local communities.

These were guided by the five focus areas of:

- empowering patients and carers
- identifying and selecting patients
- fostering innovative ways of coordinating care
- prioritising primary and community care
- sharing patient information electronically.

The ICS addressed 17 functional components, including: risk stratification, using patient reported measures, supporting and promoting self-management, and establishing roles focused on organising person-centred care.

FIGURE 1. Key funding investments



The achievements made by sites under the Strategy include:

- establishing governance and partnerships across health, primary, and social care settings
- implementing integrated models of care
- developing eHealth technologies and solutions.

A monitoring and evaluation framework was established to guide evaluation of the Strategy. Work has now commenced to embed these innovations into business as usual.

In the current service context, major system reforms are occurring at both Commonwealth and State levels, including: the National Disability Insurance Scheme, Aged Care reform, Health Care Homes, and reform of Out Of Home Care. These reforms require our systems to be adaptive and well connected, particularly between acute, primary care, and social services. They will provide greater opportunities for health and social care systems to place people at the centre of care, providing them with increased choice, and better connecting care within and across the various systems.

The NSW Government and NSW Health have developed a leadership culture, increasing partnerships and engagement in the community to achieve better outcomes for at-risk populations and the growing number of people living with chronic or complex health needs.

Greater data linkage and the use of new technologies have seen improvements in the sharing of information and shared care planning. Through the Bilateral Agreement and initiatives such as My Health Record, NSW Health and the Commonwealth have developed shared governance and improved connections. This has supported improved patient health outcomes, delivered efficiencies and reduced avoidable demand for health services.

1.4 How will the Framework operate?

The Framework has been informed by extensive engagement and consultation with stakeholders across the health and social care setting, by findings from a review of published, unpublished and peer-reviewed literature. It also builds on the experience gained from over ten years of integration processes across NSW health care services.

This Framework applies broadly across the NSW health system and across the intersections between health and social care - including the public sector, private organisations, not-for-profit organisations, and other government agencies. General practice and primary care will play an integral supporting role in the delivery of the Framework.

It applies to all the settings in which health care is provided, and across all health services, including: mental health, disability, chronic disease, Aboriginal and Torres Strait Islander health, children and young people, domestic violence, and palliative care. It will also apply to the intersections with social care services such as: housing, child protection, community, ageing, disability and home care, employment, and justice services.

The Framework builds on the key lessons from the ICS and measurable outcomes delivered under the ICS. It continues NSW's record of being at the forefront of implementing integrated models of care in Australia.

"The more support you've got, the less you feel alone. You see [your child's care coordinator] waiting for you: they've contacted emergency; emergency already knows their needs."

Parent of a child who received integrated care coordination

2 Strategic framework

2.1 Overview

About this Framework

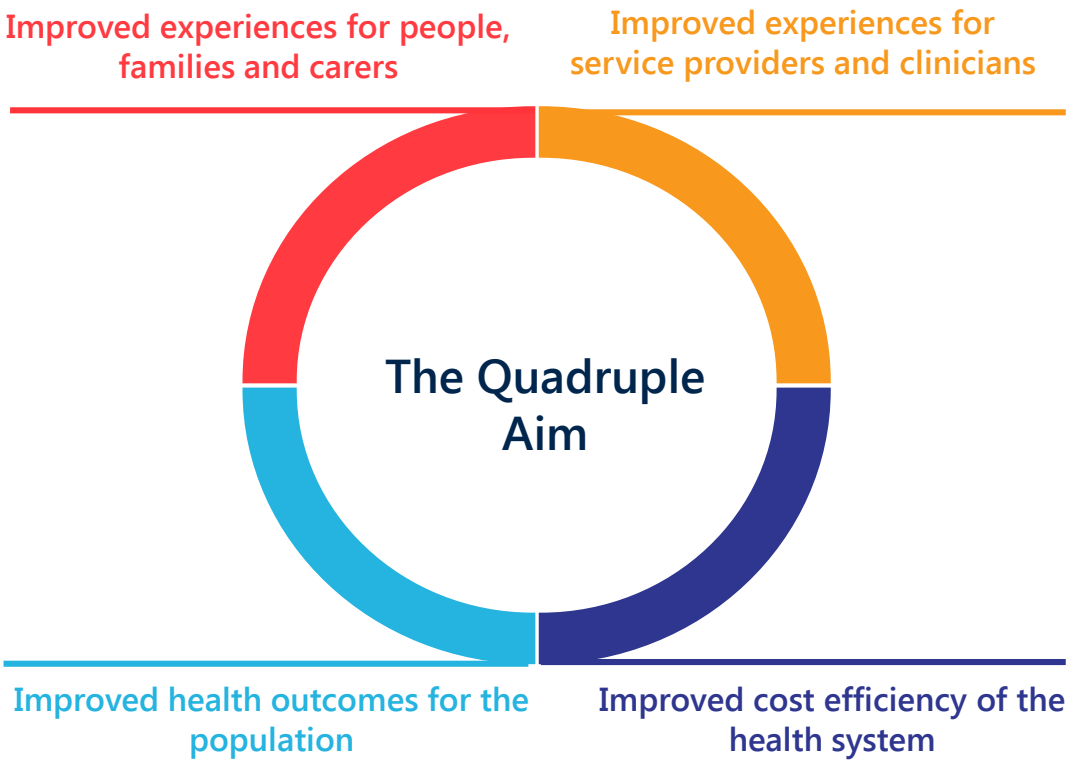
This Framework:

- Articulates a clear vision for integrating care in NSW for all people, from birth, to end of life, across the health and social care setting, for the next five to ten years and beyond.
- Outlines six principles, nine enablers, and a series of expected outcomes for achieving the vision and developing a consistency of understanding and approach, supported by guiding questions to assess its success.
- Speaks to a broad range of stakeholders and system participants, including: individuals, families and carers, primary health care providers, health and social care providers, private insurers and providers, LHDs and SHNs, PHNs, peak health and social care bodies, NSW Health Pillars, the NSW Ministry of Health, and other government agencies.

Integrating care aims to achieve the quadruple aim of improved experiences for individuals, families and carers, improved experiences for service providers and clinicians, improved health outcomes for the population and improved cost efficiency of the health system (Figure 2).

FIGURE 2. The Quadruple Aim

NSW Health's vision for a value-based health care system is centred on the quadruple aim and underpins the Framework.



How to use the Framework

There are seven elements to the Framework: the vision, purpose, outcomes, principles, enablers and building blocks, stakeholder contributions and measures of success. Each element builds off the previous element to provide a logical flow for how stakeholders should engage with the Framework. The Framework is intended as a practical document to support the delivery of care that is integrated and to embed the integration of care as business as usual. Stakeholders using this Framework should work through each individual element, understand each element's purpose and importance, and consider what actions they need to undertake to support the integration of care in NSW.

Table 1 outlines each element and provides a description.

TABLE 1. The elements of the Framework

ELEMENT	DESCRIPTION
VISION	The vision describes the future state of the health system and its interface with social care following successful implementation of the Framework. It is designed to inspire all stakeholders to take action to deliver care that is integrated.
PURPOSE	The purpose outlines the intention of the Framework. It is designed to guide the implementation of the Framework.
OUTCOMES	The outcomes set out the intended changes and impact of the Framework compared to the quadruple aim of improved experiences for people, families and carers, improved experiences for service providers and clinicians, improved health outcomes for the population and improved cost efficiency of the health care system.
PRINCIPLES	The six key principles underpin the Framework's delivery. They support achievement of the Framework's vision and will remain integral to integration of care over time.
ENABLERS AND BUILDING BLOCKS	The enablers are the components that drive the integration of care. The desired future state describes the intended change and impact of that enabler. The building blocks are practical actions that can be undertaken to lead to the enablers. While some services across NSW are at different stages of their level of integration, the building blocks are some options that service providers can consider to address local issues as they arise. They do not represent an exhaustive checklist, but are valuable considerations that can lead to improvements to the integration of care. The state-wide supports are NSW Health initiatives and resources available to different parts of the health and social care systems to assist with the integration of care.
STAKEHOLDER CONTRIBUTIONS	The stakeholder contributions outline how stakeholders in health and social care settings can contribute to the success of the integration of care.
ASSESSING THE SUCCESS OF THE FRAMEWORK	The assessing the success of the Framework section outlines how our State will measure the success of the Framework against each element of the quadruple aim.

2.2 The Framework at a glance

The Framework at a glance illustrates the key elements of the Framework and how they relate to each other.

VISION: Integrating care – organised by, with, and for people, families and carers.

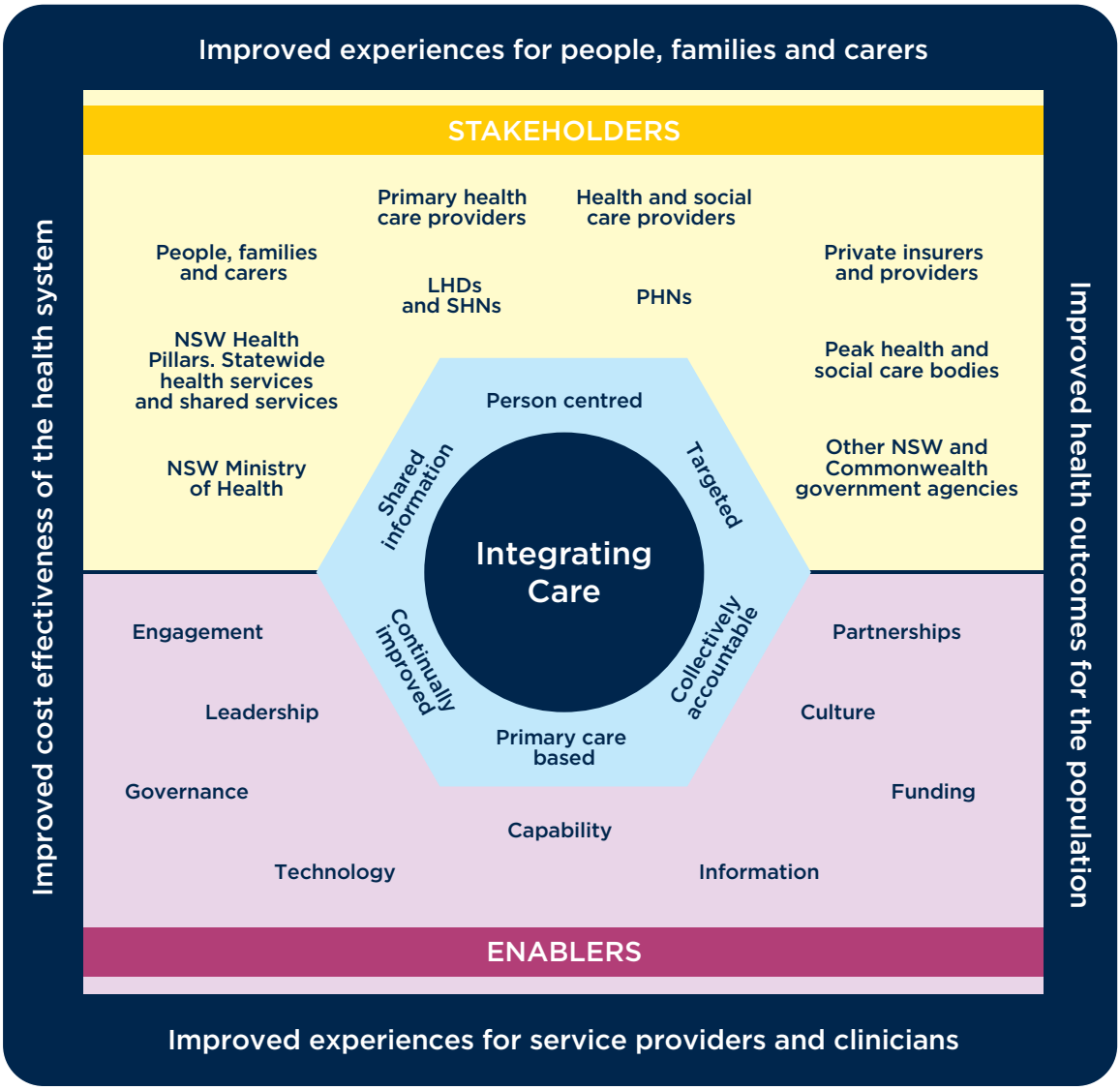
PURPOSE: To ensure a consistent understanding and approach to integrating care across the health system and its interface with social care in NSW.

FOR PEOPLE, FAMILIES AND CARERS
People are actively involved in their own care and can navigate health services in NSW.

FOR SERVICE PROVIDERS AND CLINICIANS
Health services in NSW work together to provide high quality, safe care and continuously improve.

FOR POPULATION HEALTH
The health of the population improves as a result of integration of care.

FOR THE HEALTH SYSTEM
The NSW Health system is more effective and provides better value care for people in NSW.



How will we assess the Framework's success?

Are we achieving the purpose? Are the outcomes being reached?
Are the principles guiding activity across the system?
Are stakeholders using the enablers to implement and support the integration of care?
Do stakeholders understand how they contribute to integrating care, and are they actively contributing to it?

2.3 Vision

The proposed shared vision for integrating care in NSW is:

Integrating care –organised by, with, and for people, families and carers

The vision for the Framework centres upon the role of people, families and carers. It ensures that care is provided to all people in all settings. Integration of care can be tailored to the specific requirements of vulnerable populations, helping to improve their health, wellbeing, and their overall experience of care.

This vision:

- Will be shared by all within the health setting and will apply to the interfaces with social care settings.
- Ensures the right care is provided, in the right place, and at the right time.
- Supports the provision of health and associated social care that meets the needs of all people, families and carers, in a timely, accessible, coordinated, and supportive manner.

How integration of care is managed, delivered and directed may vary based on the needs of the person.

2.4 Purpose

The purpose of the Framework is:

To ensure a consistent understanding and approach to integrating care across the health system and its interface with social care in NSW

2.5 Outcomes

The successful delivery of the vision will provide positive expected outcomes for people, service providers and clinicians within the health system and in their interactions with social care systems. The expected long term outcomes are outlined in Table 2.

The vision and expected outcomes provide a clear direction for how the NSW Health Strategic Framework for Integrating Care should be delivered. The next section outlines the principles that underpin its delivery.

TABLE 2. Outcomes of integrating care in NSW across the quadruple aim

People, families and their carers

- I am effectively involved in my care planning, can better manage my own health, and feel empowered to participate in making decisions.
- I know how to navigate health and social care services and can access the information I need.
- I am provided with care that addresses my needs and improves my health and wellbeing outcomes.
- I participate in the co-design of services within the health system and its interface with social care.
- I have a positive experience when receiving care:
  - I know where and how to find information.
  - I don't have to wait too long.
  - I don't need to re-tell my story.
  - My test results are available when my doctor needs them.
  - I don't have to go to hospital or into a facility unless I need to.
  - The care I receive is welcoming and considers my personal context and culture.

Service providers and clinicians

- I can access all relevant information about the person so that I can provide high quality continuity of care.
- I know what other services are available to meet people's needs, and can easily work in partnership with other service providers to ensure that all of these needs are met, based on my professional judgement.
- I work in an efficient and effective system that supports me to provide high quality care to people, families and carers and as a result I have high job satisfaction.
- I receive the support I need to develop my skills, capability and confidence to provide care for people in a way that is integrated.
- I collaborate and communicate effectively with other service providers and clinicians to plan and deliver the best possible care for the person.

Health of the population

- There is a transition to proactive and preventive care at the population level.
- Service providers collect and share data across the health and social care setting to understand ongoing trends.
- Care for people with long-term conditions is improved.
- Care addresses the social determinants of health.
- The health of the population improves as a result of integration of care.

Cost efficiency of the health system

- The system is efficient and integrating care results in greater value and better use of limited resources.
- IT systems and processes are integrated across the health system and its interface with social care.
- Health care services in NSW connect with social care and provide positive outcomes and experiences for people.

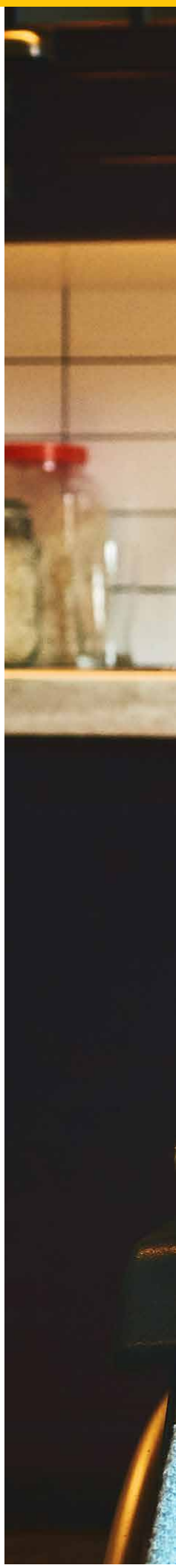
2.6 Principles

Six principles underpin the NSW Health Strategic Framework for Integrating Care. These are outlined in Figure 3.

A health care system that embodies these principles will support the achievement of the quadruple aim and provide the basis for high quality integration of care. These principles set clear expectations for what people, families, and carers, should experience when they receive care that is integrated. They provide service providers and clinicians with guidance on how they could approach integrating care. Embedding and normalising these principles throughout the entire system will result in improved health outcomes and better value health care.

TABLE 3. The principles of the NSW Health Strategic Framework for Integrating Care

PRINCIPLE	WHAT IT MEANS FOR INTEGRATING CARE
PERSON CENTRED	Care planning and delivery places the person at the centre of the process and actively involves people, their families and carers through shared decision making. Individuals are empowered to direct their care journey according to their needs and aspirations, supported by clear information about the services they need and timely access to those services. Their needs are met regardless of the point at which contact is made with the system.
PRIMARY CARE BASED	Care is coordinated through primary health care providers where appropriate to the person's needs.
TARGETED	Resources which support the integration of care are targeted where they are most needed. There is equity in access to and delivery of care.
CONTINUALLY IMPROVED	Care operates in a flexible environment, where innovation and integration are supported. There is a focus on learning from experiences and continuous improvement.
COLLECTIVELY ACCOUNTABLE	All service providers and clinicians share responsibility for the person's wellbeing when integrating care. Integrating care is multidisciplinary and interdisciplinary. Service providers, clinicians and other system participants act with trust and confidence, and there is mutual benefit.
SHARED INFORMATION	Information flows with people regardless of which service they seek. Robust information sharing processes are in place to support rapid communication between sectors, organisations, teams and clinicians, including a single record gathered from a shared assessment. Planning and monitoring systems are in place.



2.7 Enablers and building blocks

Building on the principles, nine enablers have been identified that are required to implement and support the integration of care in NSW.

The nine enablers are:

1 Engagement

2 Partnerships

3 Leadership

4 Culture

5 Governance

6 Funding

7 Capability

8 Technology

9 Information

The following pages outline the future desired state and the building blocks, that will continue to be developed over time, for each of the nine enablers.

The online version of the Framework links to a searchable database of LHD-level activities that support integrating care.

Enablers and building blocks

ENGAGEMENT

Engagement supports empowering people, families and their carers to influence their health care journey and to meet individual and community needs and aspirations.

What will this look like in the future?

- People are engaged and participate in the design and planning of health care that is integrated with social care and meets individual and community needs.
- Through improved health literacy, people can and are supported to, participate in shared decision making and are empowered to access information and self-manage their health and social care.
- Health services make it easy for people to find the services they need and to navigate the system.
- People understand the importance of information sharing and are confident that agencies, service providers and other system participants will use their personal information in their best interests and respect their privacy and confidentiality.
- Health service performance monitoring processes include measures of engagement with people. The experiences and outcomes of people using health services are collected and used as a tool to guide service planning.
- Priority populations are identified and supported, and preventive and proactive care is provided to these cohorts.

What are the building blocks?

- Services develop and strengthen shared decision-making practices.
- Services support individual health literacy, provide information in a way that meets the needs of people, carers and families, and provide wayfinding.
- People, families, and carers are engaged in co-design activities when designing services or interventions that integrate care.
- Services provide multidisciplinary and multiagency care functions that align with the needs of the person as business as usual.
- Health service processes and systems embed patient reported outcome measures (PROMs) and experience measures (PREMs) to inform patient care and service improvement.

"Being able to learn about my physical health – about diet and exercise – has made a big difference to my life, it has provided me with a sense of wellbeing and social connection and... I feel more purpose in my life."

Adult living with mental illness who participated in a healthy lifestyle group

PARTNERSHIPS

Effective working partnerships and relationships across the health system and its interface with social care promote clear roles, accountability, trust, shared decision-making and information sharing between partners.

What will this look like in the future?

- Agencies, service providers, clinicians and other system participants develop and maintain partnerships within and across services that are proactive, and focused on the needs of the person.
- Partnerships are based on reciprocity and a shared accountability for the wellbeing of the person, in order to close service gaps and eliminate silos.
- Relationships within and across agencies, service providers and other participants are founded on information sharing, collaboration and service provision that best meets a person's needs.
- Partnerships facilitate the sharing and/or pooling of funding and resources to support innovative service models.
- Relationships are trusting and support effective inter-professional collaboration.

"I appreciate [the program's] efforts finding the right home for us. Now I can breathe clean air and exercise so I can get ready for my surgery."

Participant in chronic disease program who needed support with housing

What are the building blocks?

- Services work in partnership with other health services, non-government organisations and other government agencies.
- Partnerships are based on clear goals, and there is a shared understanding of and commitment to these goals among partners.
- Each partner understands the lines of communication, roles, responsibilities and expectations of partners, and is involved in setting priorities for collaborative action.
- Partnerships are formalised with executive level support to drive integrated care at the local level, and further investment in developing relationships with key partners at all levels.
- Some staff have roles that cross the traditional boundaries that exist between agencies in the partnership.
- There is a participatory decision making system that is accountable, responsive and inclusive.
- Agencies standardise common processes.
- Service partners provide regular opportunities for contact between staff to share information and best practice.
- Partners can demonstrate the outcomes of their collective work and establish processes for celebrating collective achievements.
- Partnerships are continually reviewed and changed as required.

LEADERSHIP

Strong clinical and executive leadership and management are crucial enablers of the integration of care. Leaders are important role models of the mindsets and behaviours that support the successful integration of care. Empowering local teams to be leaders on the ground also supports more effective integration of care.

What will this look like in the future?

- Leaders embody and drive the shift towards a person centred and integrating care culture.
- Senior leaders possess the qualities that facilitate strong alliances and collaboration within a healthcare setting and its interactions with social care.
- Local leaders are empowered as champions to help deliver and lead care that is integrated
- Senior and local leaders effectively manage change through the use of a common language and by supporting and informing staff throughout the change process.
- Senior and local leaders establish frequent communication and share lessons learned.
- Processes and workflows are streamlined, integrated, and support a seamless care journey.
- There is an alignment between clinical, operational, strategic and financial leaders.

What are the building blocks?

- Leadership development programs and structures embed integration of care.
- Health organisations and services mentor staff early in their careers into leadership across the health and social care setting.
- Health organisations and services develop systems to support leaders to reflect on lessons learned in integrating care.
- Health services empower local teams to work, collaborate and make decisions, and establish frequent communication across all levels.
- Health organisations and services develop 'Communities of practice' to encourage collaboration to solve existing system issues relating to integrating care.

"The doctors and specialists were very easy to talk to and listened to my questions and answered in a manner that I could understand."

Adult who participated in an integrated care program

CULTURE

Integrating care requires a shift in thinking to create a health service culture that is centred on the needs of the person, is proactive rather than reactive, operates as one integrated system, and increases multidisciplinary and multi-system care.

What will this look like in the future?

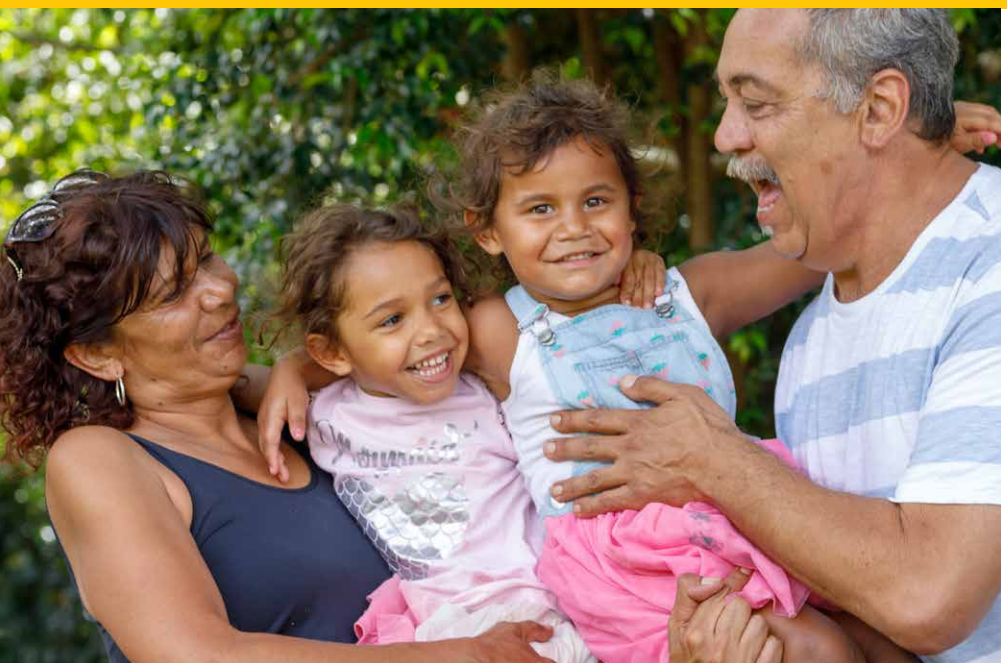
- Clinicians, service providers, and other system participants have an understanding of, and commitment to, working within a culture dedicated to the integration of care through a person centred approach.
- Clinicians, service providers, and other system participants share information, collaborate and display positive inter-professional attitudes and interact with trust and confidence.
- Teams delivering care operate within common protocols, systems and standards.
- Services actively promote and protect people's health and wellbeing.
- There is a quality improvement culture across the public and private health sectors.
- There is a shift from a discharge of care orientation to a transfer of care orientation.

What are the building blocks?

- The vision for integrating care is used to develop a common sense of purpose and motivation to change working practices and instil trust.
- Health organisations and services use the Strategic Framework to build greater understanding within the workforce about integration of care principles and the value of integrating care, embedding integration as business as usual.
- Change management methodologies are developed, implemented and refined to support the transition to integrating care.
- Services improve voluntary participation rates in activities related to integrating care e.g. reporting against voluntary quality frameworks.
- Services celebrate and reward good practice in the delivery of care that is integrated.
- Influential professionals and leaders discuss integrating care at relevant and visible forums and platforms.
- Clinicians are provided with the opportunities to build relationships with their peers across agencies.

"Attending the appointments has made me realise that I need to make my health a priority. I'm feeling very positive. Although I have smoked for many years, I feel that now is the time to give it up."

Adult who participated in an integrated care program



"I am thankful for what the program offers. It is helping me build confidence with dealing with my ongoing medical issues."

Adult who participated in an integrated care program

GOVERNANCE

Governance supports effective decision making and clear accountabilities when integrating care. Effective governance structures are especially important to support partnerships within and between health care organisations and their interface with social care organisations.

What will this look like in the future?

- Governance structures are transparent and involve people and communities in decision making.
- Governance structures and policies formalise cross-sector and multi-agency/organisation partnerships and define clear roles and accountabilities.
- There are processes in place that enable planning, governance and co-commissioning to be coordinated across different service providers and sectors.
- Governance structures are supported by the right people with regards to seniority and expertise, and there is clarity of roles to effectively support the integration of care across the health and social care setting.
- There are measureable key performance indicators and accountabilities across the health setting and its interface with social care.
- There is clear support through legislative recommendations.
- Processes and workflows are streamlined, integrated, and support a seamless care journey.
- There is local engagement in co-design.

What are the building blocks?

- Health organisations and services develop governance structures with strong horizontal collaborations between partners and strong vertical collaborations between executives and senior clinicians.
- Health organisations and services use shared governance arrangements where appropriate, in particular where heath interfaces with social care.
- Health organisations and services develop measureable key performance indicators which are outcomes-based across health and its interface with social care.
- The public provision of comparable information on health system performance increases accountability and reporting on integrating care.
- The health system develops a single set of state-wide guidelines that outlines agreed standards for service coordination practice.

FUNDING

Funding mechanisms influence system wide implementation of integration of care initiatives. Incentives can influence the behaviour of system participants including service providers and clinicians. Additionally, ongoing incentives which are built into the system (rather than temporary incentives) play a critical role in promoting and supporting the integration of care.

What will this look like in the future?

- Services, activities and projects that support the integration of care are funded as business as usual.
- Funding models and incentives are person-centred, outcomes-based, and strengthen care coordination, care navigation and interfaces between the health and social care systems.
- Funding supports continuing quality improvement in ongoing integration.
- A culture of co-commissioning is established through joint commissioning projects. Service commissioning and contracts include arrangements and/or specifications to integrate care for target population groups, regions and/or care requirements.
- Funding and incentives are directed towards the delivery of care that is integrated align with the commercial requirements of service providers and other system participants.
- Incentives encourage service providers and other participants to deliver innovative and alternate models of care that is integrated.
- Funds follow the person and are allocated as required to address their needs.

What are the building blocks?

- Investment in integrating care is shifted from project-focused programs to operational business as usual and outcomes-based budgets.
- The health system employs incentives to encourage providers to use integrated medical records and information systems that are accessible to providers and people, families and carers.
- The health system uses funding to stimulate immediate and long-term improvements in performance in integrating care, and to remove financial barriers.
- Existing fee-for-service payments are changed to more flexible funding models, and there is clarity on available funding mechanisms.
- The health system reinvests savings achieved through the integration of care into direct patient care.
- Services invest in prevention and early intervention activities, and non-admitted activity is captured routinely.
- A co-commissioning framework guides joint service planning and purchasing for NSW LHDs and PHNs.
- Services support local authorities and the community-managed sector, and develop a reward mechanism for achievement of KPIs and outcomes at the local level.

"My stress level has gone down. I couldn't get everything in order but now I get to appointments."

Adult who participated in an integrated chronic disease program

CAPABILITY

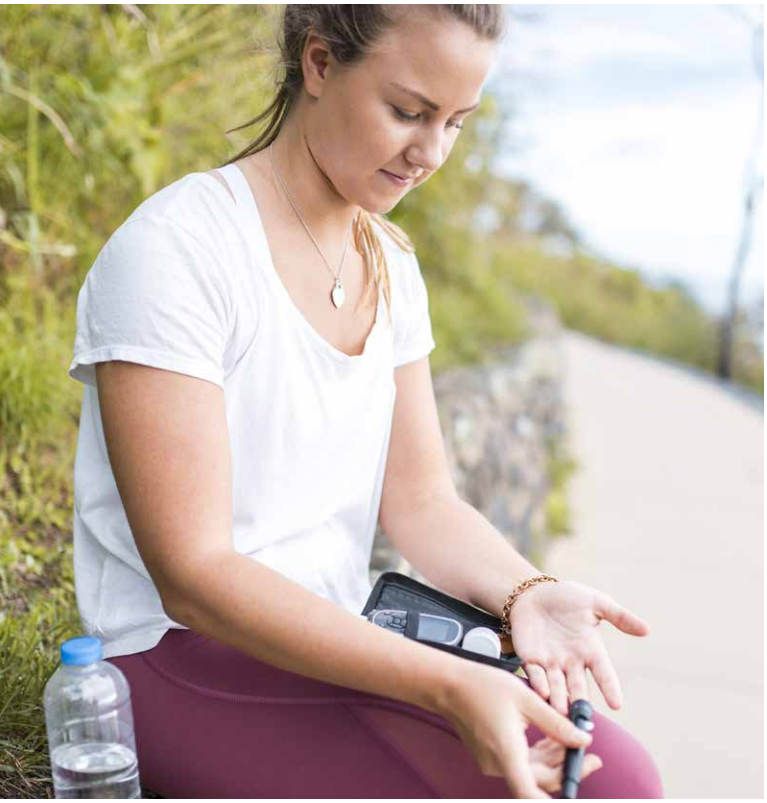
Capability recognises that staff require a specific skillset to deliver care that is integrated. Different capabilities are required across all aspects of the integration of care from program design and management, through to the delivery of health and social care and the measurement of outcomes associated with the integration of care.

What will this look like in the future?

- People in the workforce are provided with training and learning opportunities to enable them to deliver care that is integrated. Training is inter-professional and inter-organisational to ensure everyone has the capability to connect people and providers in the system, and provided with mentoring across agency boundaries.
- Performance management mechanisms are in place to ensure that training is targeted and that care that is integrated is effectively delivered.
- Recruitment strategies hire people with the right skills, capabilities and values to deliver care that is integrated.

What are the building blocks?

- The health system maps capabilities against the person's journey through the health setting and its interface with social care to understand the key capabilities required to deliver care that is integrated.
- Health organisations and services operate local and regional integrating care forums to transfer and scale up care integration, and stakeholder engagement in a changing environment.
- The health system further develops the capability to measure patient outcomes and experience, case-based learning opportunities, and cross-sector (health and social care sectors) training programs.
- Services promote reflective practice, clinical reasoning and evidence-based practice in a context of integrating care.
- Health care providers are provided opportunities to engage in redesign, project management and change management activities in the context of integrating care.



"I felt like I'm not alone, like I still have power."

Participant in a program for families with complex needs

TECHNOLOGY

Technology supports and facilitates the integration of care. Technology provides important architecture to support many of the activities critical to integrating care such as information sharing. This includes systems, which are critical to embedding the integration of care into business as usual.

What will this look like in the future?

- Service providers, clinicians and other system participants can view complete and up-to-date Electronic Health Records (eHR) and e-referrals that span public, private, and not-for-profit providers, and non-government organisations.
- Information and communications technology is well integrated and operates seamlessly across health and social care systems and across providers.
- There is continued investment in information and communications technology infrastructure to increase quality and accessibility to consumer data across multiple platforms.
- People have access to their eHR and electronic shared care plan to support them as partners in their own health care.
- There is an increased use of technologies that allow more seamless and accessible care to be delivered. This may involve remote monitoring, delivery by a single provider or multidisciplinary team or case conferencing between providers.
- Platforms are secure, and information practices address the privacy and confidentiality concerns of consumers and providers.

What are the building blocks?

- The use and quality of eHR and MyHR to support integrating care are maximised.
- The health system explores opportunities for common technology and system platforms and shared investment across health and social care.
- Systems are developed which will support access to real-time information as required.
- The health system increases investment in telehealth and other telecommunications infrastructure (and associated clinical protocols and guidelines) to support integrating care.
- Services incentivise clinicians to invest and engage in the meaningful use of health IT, promote the use of eHR, and progress other e-enablement solutions.
- Services, clinicians and other health workers understand the problems that need to be addressed to deliver care that is integrated and applying technology as a solution.
- Services use a change management approach to incorporate technological innovations into integrated service delivery.
- Services ensure that staff develop the capability to use technology to complement their existing skills and capacity to deliver care that is integrated, and are supported to identify new models of care that would be enabled by technology.

"It prevents a lot of phone calls back and forth... it's been easy... having that reassurance and having that contact. Also, we could be 6 to 8 weeks in between visits so every little thing that comes up is on record because we put it into the app, which loads into her medical files so we know that [my child's] team knows what's going on."

Parent speaking about an app for children with complex care needs

INFORMATION

Information plays an important role in ensuring the seamless provision of care is provided in the most effective manner. The sharing of information between service providers and clinicians facilitates seamless care for consumers. Accurate and effective information analytics ensures integrated care is targeted to the people who will benefit most and supports the continuous improvement of the system.

What will this look like in the future?

- Data linkage and analysis drives decision-making and risk stratification.
- Robust information sharing processes are in place to support rapid communication between sectors and organisations and within teams, including a single record gathered from shared assessment.
- The planning of individual care, service development and quality improvement is supported by data linkage and analytics.
- Data supports regular, robust and comprehensive monitoring and evaluation of performance and assesses the degree to which care is integrated.
- Information on patient needs and costs of care are used to ensure there is a focus on shifting limited resources to the areas of most need and areas which offer the best value.

What are the building blocks?

- Services strengthen processes for effective and efficient data collection and linkage in relation to integrating care.
- Services employ patient monitoring including retrospective, comparative and predictive analysis, patient reported measures collection and analysis, and provider surveys.
- Data-driven decision making is encouraged and access to shared care databases is enabled. Services use decision-making models based on whole-of-system stratification to manage individuals who required a higher intensity of care and to better identify those with chronic/long-term conditions.
- The health system builds the capacity of system leaders to use data effectively to support integration approaches.
- The health system reviews and aligns legislation with integration of care principles to support information sharing.
- Decision-makers receive access to health economics expertise to build business cases and access funding mechanisms that enable integrated care.

"Asthma education session [for parents of children who are frequent presenters at hospital was] incredibly useful in terms of learning about what asthma is, being pro-active. I feel much more under control with his asthma now and am able to keep him out of hospital when he got a cold because [we followed the] advice."

Parent who participated in an education and care coordination program

2.8 Stakeholder contributions

The success of the integration of care relies on the efforts of all stakeholders in health and social care settings. Figure 4 outlines how each stakeholder can contribute to the success of the integration of care.

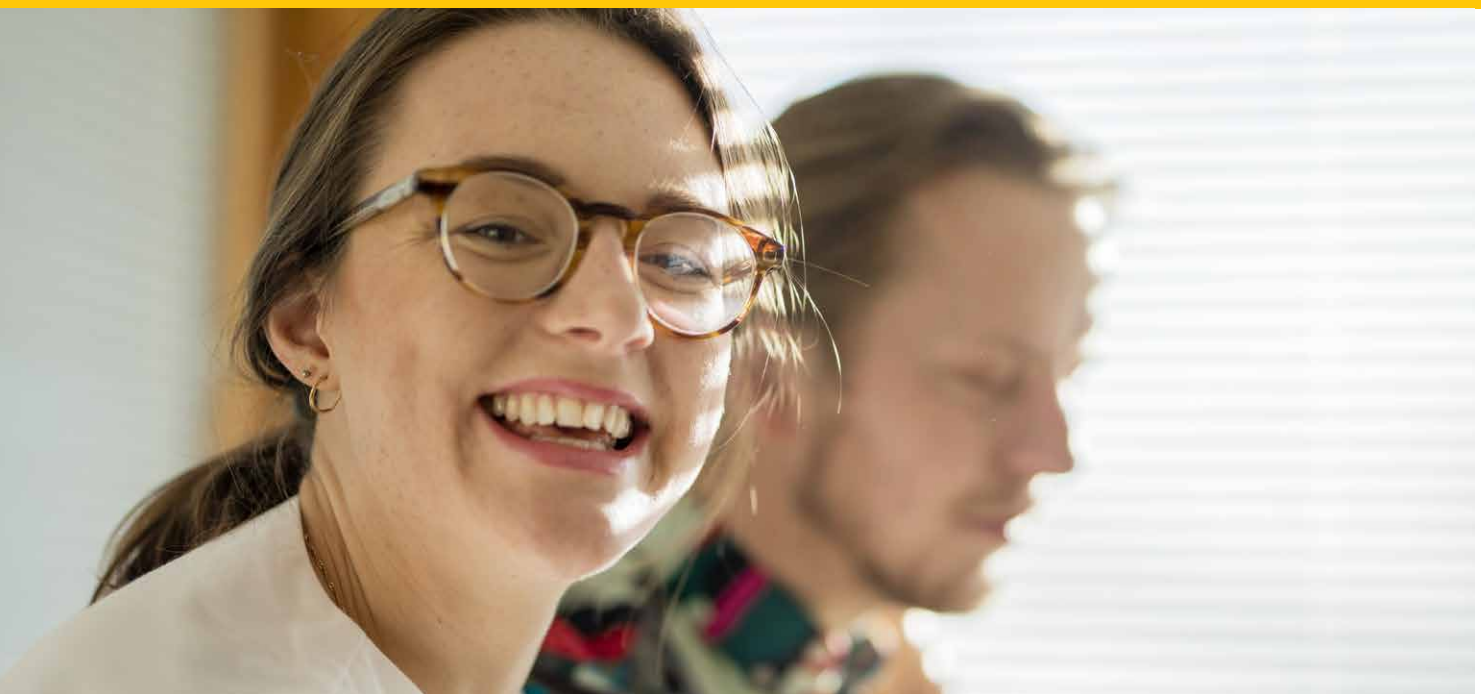
FIGURE 4. What integrating care means for each stakeholder in the health system and its interface with social care

STAKEHOLDER	WHAT INTEGRATING CARE MEANS FOR THEM
PEOPLE, FAMILIES AND CARERS	People, families and carers are actively involved in their own health management and make informed decisions.
PRIMARY HEALTH CARE PROVIDERS	Health and social care providers work in partnerships together, share information and transition people smoothly across from one provider to another. This includes public, not for profit and for-profit providers.
HEALTH AND SOCIAL CARE PROVIDERS	Health and social care providers work in partnerships together, share information and transition people smoothly across from one provider to another. This includes public, not for profit and forprofit providers.
PRIVATE HEALTH INSURERS	Private insurers support integrating care initiatives such as chronic disease management, and explore new opportunities in primary health care in collaboration with public health.
LHDs AND SHNs	Local Health Districts (LHDs) and Specialty Health Networks (SHNs) work in partnerships together and with PHNs, share information, and co-commission.
PHNs	Primary Health Networks (PHNs) work closely in partnerships with LHDs and SHNs, and primary health care providers, to integrate care at all levels.
PEAK HEALTH AND SOCIAL CARE BODIES	Peak health and social care bodies advocate for integration of care at a high level across stakeholder groups and care settings.
NSW HEALTH PILLARS, STATEWIDE HEALTH SERVICES AND SHARED SERVICES	NSW Health Pillars, state-wide health services and shared services invest in information and data analytics, and contribute to the systems, protocols and processes which support care integration.
NSW MINISTRY OF HEALTH	The NSW Ministry of Health generates, disseminates and implements policy which is aligned with, and facilitates, integration of care. The Ministry also drives system management and monitoring.
OTHER NSW AND COMMONWEALTH AGENCIES	Other NSW and Commonwealth government agencies work alongside the NSW Ministry of Health, and peak health and social care bodies to coordinate and share resources which support the integration of care.

2.9 Implementing the Framework

The Ministry of Health will work with NSW Health stakeholders to identify mechanisms and initiatives to integrate care, in line with the vision, purpose, principles and enablers of the Framework. The Ministry of Health will develop an implementation plan that will include mechanisms to share success stories and key learnings throughout the health system and its interface with social care.

The implementation plan will provide real life and interactive examples of how LHDs and SHNs are using the building blocks and enablers within the Framework as a practical tool used to self-assess the integration of care.



2.10 Assessing the success of the Framework

It is recognised that the needs of people, families, carers, and the health and social care setting will change over time. The NSW Health Strategic Framework for Integrating Care is not intended to be a static document, and therefore the principles, enablers, expected outcomes and measures of success may change. The Framework will be reviewed annually and updated by the peak NSW governance group to ensure that the direction remains appropriate.

High-level questions to assess how we will know if we have succeeded in delivering the Framework are listed in Table 4. Each question should be considered along each element of the quadruple aim. The Integrated Care Implementation Group will use more detailed questions to assess the Framework's success.

TABLE 4. How do we know if we have succeeded in delivering the Framework?

FRAMEWORK ELEMENT	GUIDING QUESTION
PURPOSE	Are we achieving the purpose?
OUTCOMES	Are the outcomes being reached?
PRINCIPLES	Are the principles guiding activity across the system?
ENABLERS AND BUILDING BLOCKS	Are stakeholders using the enablers to implement and support the integration of care?
STAKEHOLDER CONTRIBUTIONS	Do stakeholders understand how they contribute to integrating care, and are they actively contributing to it?

With an ageing population and a growing number of people living with chronic or complex health conditions, people's needs are changing across the health system and its interface with social care.

The integration of care is fundamental to the delivery of services that improve experiences for people, families, and carers, for service providers and clinicians, health outcomes for the population, and cost efficiency of the health system. Services should aim to provide seamless, effective and efficient care that reflects the whole of a person's health needs, from prevention through to end of life, across both physical and mental health, and in partnership with people, their carers and families. This Strategic Framework makes clear that all parts of the health system and its interface with social care in NSW will play an important part in integrating care for people.

Glossary

ITEM	DESCRIPTION
BETTER VALUE CARE	An approach that increases value to patients, the community and the health system using the resources that are available
EHR	Electronic Health Record
FACS	Family and Community Services
INTEGRATING CARE	The conduct of activities and reform targeted towards the provision of seamless, effective and efficient care that responds to all of a person's health and social care needs, across physical and mental health, in partnership with the person, their carers and family. Integrating care involves developing a system which provides the right care in the right place at the right time, and ensures the delivery of healthcare is cost-effective[1]
INTEGRATION OF CARE / INTEGRATED CARE	As for 'integrating care' above
LHD	Local Health District
MYHR	My Health Record
PERSON CENTRED CARE	Care that focuses on the views of individuals, carers, and families as participants in the health system. Person centred care considers the needs of people, rather than individual diseases. It respects social preferences and encourages choice in decision making[2]
PERSON	Consumers and patients
PHN	Primary Health Network
PRIMARY CARE PROVIDERS	Primary care providers deliver services at the first layer of health care. Primary care providers include a range of health professionals such as: general practitioners; nurses (including general practice nurses, community nurses and nurse practitioners) allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers
SHN	Specialty Health Network
SOCIAL CARE	The provision of supports and services to enable vulnerable people and families to participate in social and economic life and build stronger communities. This includes, but is not limited to, housing, child protection, community, ageing, disability and home care, employment and justice services
SYSTEMS INTEGRATION	Bringing together disparate systems either physically or functionally to act as a coordinated whole, including information technology, funding and organisational systems, that promote the delivery of coordinated or integrated care, centred around people's needs
VALUE	NSW Health defines value through the quadruple aim, which is a framework for the delivery of high value care. The quadruple aim is: improved experiences for people, families and carers; improved experiences for service providers and clinicians; improved health outcomes for the population; and improved cost efficiency of the health system[3]
ICS	NSW Integrated Care Strategy

1 Adapted from NSW Health (2014), *Integrated Care: Info Summary*, NSW Health, accessed at www.health.nsw.gov.au/integratedcare/Documents/integrated-care-info-summary.pdf

2 World Health Organization Framework on integrated, people-centred health services, 2016.

3 Bodenheimer T and Sinsky C (2014), 'From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider', Annals of Family Medicine, 12(6), p. 573-576.