SESLHD Integrated Care Strategy

Evaluation and Monitoring Framework
Integrated Care Strategy

Goal:

• To create an agile joined up system based on patient centred care and a health intelligence structure to enable targeted action through innovative models that deliver care proactively.

• The achievement of this goal is supported by change management and robust evaluation that will allow transfer and spread of successful ways of working.

Priority populations

• People with diabetes

• Older people with complex needs.
Aspiration:
By localising the elements of the HoC model, SESLHD & partners will transform current processes & delivery systems into a systemic & systematic approach to integrated care & develop a compelling local narrative about integrated care.
IC Strategy priorities

1. Engage with people and communities through person centred planning and evaluation
2. Use innovative models to target areas of need
3. Develop a health intelligence system
4. Utilise central support structures to evaluate, transfer and spread successful models
<table>
<thead>
<tr>
<th>Priority area</th>
<th>Priority actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engage with people &amp; communities through person centred planning &amp; evaluation</td>
<td>Develop better models for care coordination &amp; collaborative, personalised care planning.</td>
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<tr>
<td>2. Use innovative models to target areas of need</td>
<td>Test implementation of community-based multidisciplinary teams in selected practice networks.</td>
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<tr>
<td>3. Develop a health intelligence system</td>
<td>Develop localised LHD-wide mechanisms for risk stratification, taking into account social factors such as isolation &amp; community support.</td>
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<td>Rapidly develop more sophisticated analytics capacity &amp; decision support mechanisms.</td>
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<td>4. Utilise central support structures to evaluate, transfer &amp; spread successful models</td>
<td>Rapidly develop mechanisms for enhanced clinical leadership in primary care &amp; in relevant specialist services.</td>
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<tr>
<td>All 4 priority areas</td>
<td>Work with CESPHN to develop “GP Clusters/Networks” - to be the localised implementation mechanism.</td>
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IC Evaluation & Monitoring Framework

Purpose

• To provide a blueprint for the ongoing monitoring and evaluation of the Integrated Care Strategy.

• As a stand alone resource for those intending to evaluate all or some components of the Integrated Care Strategy or other integrated care projects.
IC Evaluation & Monitoring Framework Aims

Was the SESLHD IC Strategy:

• Appropriate for the SESLHD context
• Effective within and across the SESLHD and partner agencies
• Efficient in the reduction of avoidable costs and re-allocation of resources
• Sustainable (including scalable and replicable)
Rainbow model of integrated care
Priority 1: Engage with people and communities

Strategy 1: Spread motivational and health coaching techniques to support collaborative care planning
- Identify teams requiring training for health coaching and motivational interviewing
- Develop training plan to educate providers & promote HC & MI
- Train health providers in HC/MI
- Select PAM, PROMs & PREMs for trial
- Develop system for administering and using tools
- Review PAM to assess feasibility of use & comparison with other tools
- Develop model to support collaborative care planning process
- Work with ACI State Enabler and Innovation Project to learn from experience with state wide Patient Satisfaction and PETs

Strategy 2: Test use of Patient Activation, Outcome and Experience Measures
- Number/proportion staff & care teams trained in HC/MI
- Number/proportion people receiving health coaching
- Improved staff skills & confidence in using MI
- PRMs tools endorsed and shared
- Systematic process for administering and following up on PRMs in place

Outputs
- Model for collaborative planning process in place
- Number/proportion people with current care plan
- Education strategy for new and existing services in place
- PRMs tools are used routinely at practice level as a clinical indicator
- Number/proportion of practices using PRMs as program quality indicator

Outcomes
- Shared data informs planning and care
- Staff are confident in using motivational interviewing within a strengths based approach to providing care
- Care planning identifies an individual's full range of needs
- Individuals are more involved in decisions about their care
- PRMs tools are used to support personalised collaborative care planning and delivery for patients
- PRMs are used routinely at program level as a quality indicator

Context:
Outer organisational: Policy environment promoting measurement of PHC impacts, processes and outcomes,
Inner organisational: Stakeholder buy-in, Leadership,
Mapping of current IC project evaluations against the IC strategy evaluation questions

<table>
<thead>
<tr>
<th>IC evaluation</th>
<th>PRISM</th>
<th>PAM</th>
<th>Health Failure</th>
<th>Skin Cancer &amp; Wounds clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Effective</td>
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<td></td>
<td></td>
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<tr>
<td>Efficient</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Impact</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Sustainable</td>
<td>X</td>
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Where up to

- TRGS submitted
- Finalisation of the IC evaluation plan
- Dissemination
- Implementation (staged approach, dependent on resources)