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NSW GOVERNMENT

Integrated care maturity model – transforming health

Formative evaluation of the NSW Integrated Care Strategy

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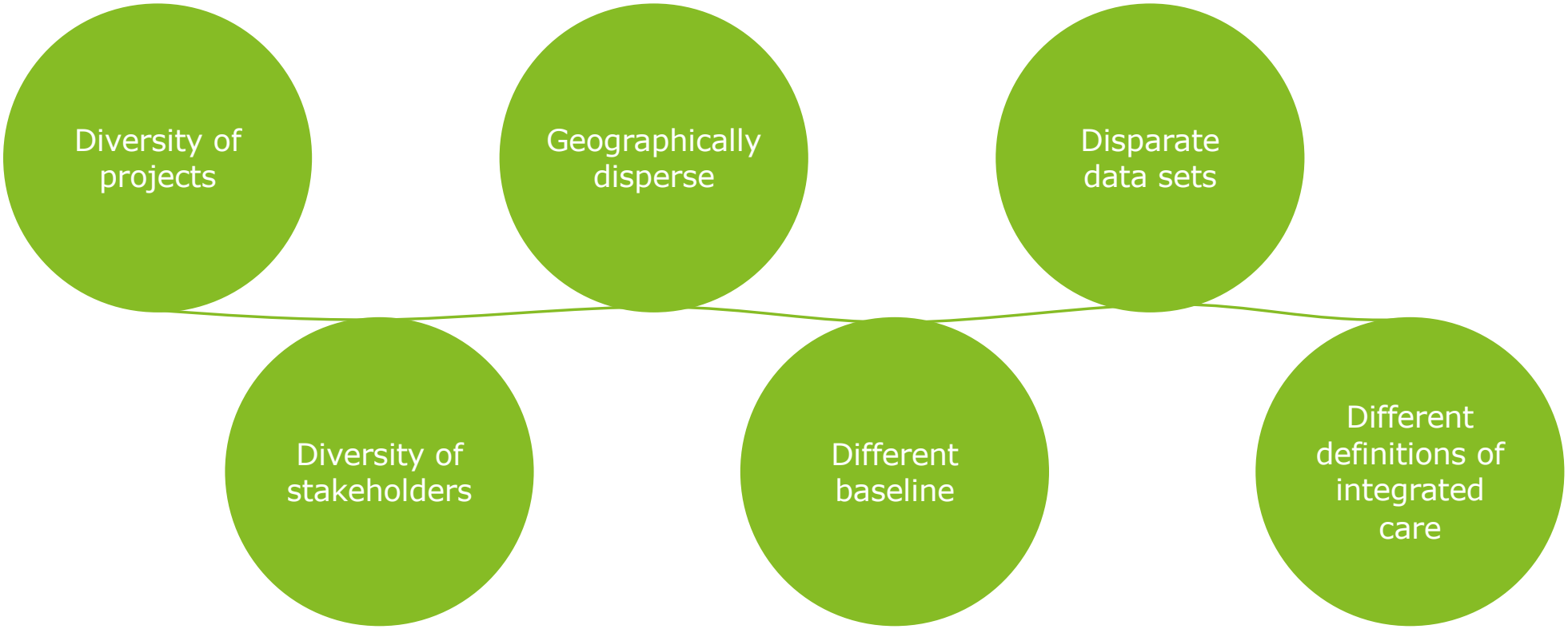
Introduction

- The NSW Ministry of Health committed funding over six years to implement innovative and locally-led models of care
- Designed to generate system change with flexibility for Local Health Districts/Specialty Health Networks to tailor and test based on local needs

$180m investment over six years

	Goal	Projects
Demonstrators	Develop and test system-wide approaches to integrated care that are transferable and scalable	3 Projects over 3 LHD/SHNs
Innovators	Implement innovative ideas at the local level that address a critical part of the delivery of integrated care	17 Projects over 15 LHD/SHNs
Statewide Enablers	Establish key enablers of integrated care benefiting all LHD/SHNs and stakeholders	Program management, monitoring and evaluation, risk stratification, patient reported measures and digital health

Challenges of evaluating the Integrated Care Strategy



Snapshot of the approach to the formative evaluation

Evaluation questions

- 13 questions
  - Acceptability
  - Adoption
  - Appropriateness
  - Cost
  - Fidelity
  - Sustainability
  - Interim outcomes

Primary data analysis

- Interviews
- Provider survey

Secondary data analysis

- Funding and activity data
- Roadmap data
- Patient reported measures data
- Data linkage reports
- Existing reports and documents

Maturity model

- Program and service innovation
- Patient centred care and empowerment
- Digital health and analytics
- Models of care
- Partnerships

Integrated care maturity model

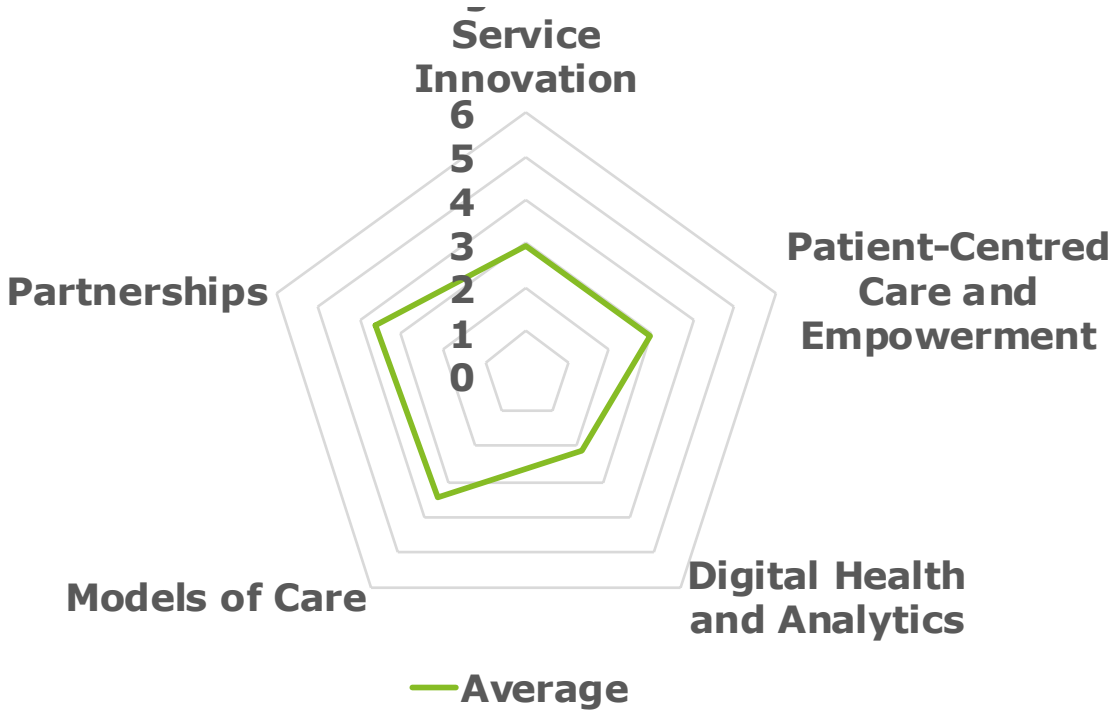
High

Low

Stage	Program and Service Innovation	Patient Centred Care and Empowerment	Digital Health and Analytics	Models of Care	Partnerships
6	• Innovation achieves sustained outcomes at a population health level	• Patient / carer needs frequently monitored and reflected in service delivery and policy-making	• Local health needs can be easily identified through predictive data analytics • Analysis can be used to target cohorts and develop systematic population level approaches to risk identification	• Model of care sits along side / is integrated with service models that operationalise service delivery and incorporate financial and / or non financial elements	• Whole of system integration (health, social services, education) • Cross sector co-commissioning
5	• Innovation is effectively scaled or transferred to another location or cohort	• Patients / carers actively self-manage care	• Solutions are scaled or transferred to other cohorts • Information sharing occurs across the system for all cohorts	• Primary and community care is used as a hub. Patients are provided with connected and coordinated care with provision of patient assessments and regular reviews	• Vision / strategy embedded in policies across care levels • Co-commissioning within health sector
4	• Innovation is financially sustainable • Evidence that the innovation can make a difference at a population health level	Clinician practices patient centred care evidenced by e.g. - Genuine partnerships with the patient, family and other care providers - Uses whole-patient information - Using PRMs and PROMs	• System wide information sharing enablers in place including - Unique patient identifier - Integration of systems - Shared care platform - Confidentiality and security policies	• Patients and clinician adopting model of care evidenced by - Appropriate and timely access to specialised care - Shared / joint care planning and management with the patient / carer	• Visible stakeholder engagement and support including executive, partners, clinicians and other staff across care levels • Active efforts to achieve integrated care across care levels
3	• Sufficient evidence that the innovation is making a difference to the health or service outcomes • Feedback loop in place for ongoing quality improvement	• Patient / carer empowered to engage, question and discuss through - Pro-active engagement and support in care planning - Increased health literacy - Increased access to information	• Patient information - Is available to clinicians across care settings - Is monitored and analysed • Insights used to develop new approaches to risk identification and interventions	• Implementation of a system of standardised assessments, regular patient reviews, uploading of relevant clinical metrics	• Wider consultation of vision and strategy between care levels (e.g. primary and secondary)
2	• Innovation project structures and processes active • Monitoring, evaluation and reporting undertaken to demonstrate that innovation can make a difference to the health or service outcomes	• Implementation of interventions and on going processes and systems to embed patient centred care approach and build patient / carer access to information, health literacy and capacity to self manage	• A pilot / local solution for targeted cohort is developed to share information • Patient data for targeted cohort is prepared for sharing through the solution	• Patients identified, contacted, enrolled and connected to care plan custodian	• Vision and strategy shared and discussed with key stakeholders within the same level of care (e.g. primary) • Enlisted stakeholder support within the same level of care
1	• Innovation project plan developed and structures and policies in place • Innovation project plan is practical, feasible and acceptable • Project manager and team appointed	• Identification of gaps and barriers to patient centred care and patient self-management • Identification of gaps and barriers in clinician confidence and skills to engage patients • Defined interventions to address gaps and barriers	• Patients are identified / risk stratified • An electronic trackable cohort list is established	• Identification of a model that sits across the continuum of care • Establishment of roles focused on patient centred care • Capacity / capability building • Stakeholder / partner consultation and buy in	• A compelling and clear shared vision / strategy created • Change Management Plan developed
0	• Innovation idea generated • Application submitted • Funding received for implementation	• Limited patient centred approach to care • Low level of patient empowerment including health literacy and capacity to self manage	• Limited to no information sharing • Isolated and multiple medical record systems • Limited capacity to perform analytics as data is not holistic	• Low levels of care coordination and integration across service providers	• Low levels of acknowledgement for the need for integrated care • Limited understanding of the meaning of integrated care • Siloed care efforts and patient / carer as the integrator

What can the maturity model tell us?

Integrated Care Radar – Statewide average



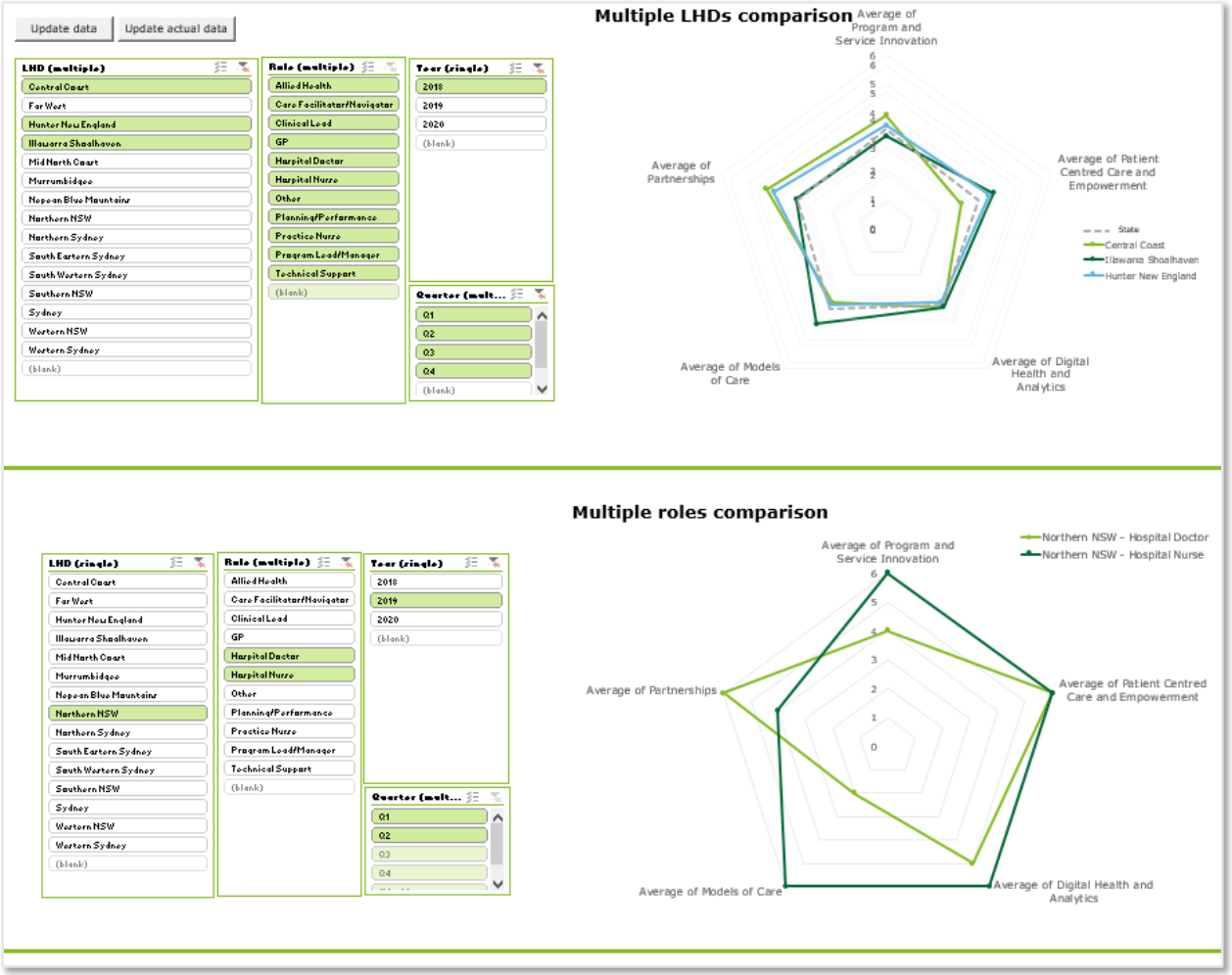
Contribution to system wide transformation in health

"What works" based on the evaluation findings

Facilitators to successful implementation

- Strong local leadership
- Clear strategic vision
- Clinical sponsorship
- Partnerships
- Change management

Interactive maturity model



The dashboard provides comparisons of:

- Maturity across LHD/SHNs
- Maturity against Statewide average
- Maturity over time
- Perspectives by stakeholder/role

Thank you and questions

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