INTEGRATED CARE COLLABORATIVE

2019/20 PROGRAMME

Capital & Coast District Health Board
Upoko ki te uru hauora

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1. Purpose

This document outlines the 2019/20 ICC Programme work plan.

The workplan remains fluid and adaptive as projects are scoped and delivered, and as the ICC ALT identifies new opportunities. Contents of this document will change over time in line with discussions of the ALT and its associated groups, as will the priorities and planned outcomes for the alliance.

The ICC Programme work plan should be utilised in conjunction with other ICC programme and project reference documents including:

- The ICC ALT Charter
- The ICC Programme Board Terms of Reference
- The ICC Programme Framework
- ICC Outcome Framework
- The ICC Steering Groups Terms of References
- ICC Programme Report template
- Capital & Coast DHB Project Management tools
- CCDHB System Level Measure Plan and related dashboards

2. Background

The Capital and Coast Health System Plan (HSP) 2030 outlines our strategy, or roadmap, to improve the performance of the region's healthcare system. Through the HSP CCDHB aims to improve health outcomes, prevent avoidable demand for healthcare, and improve the use of healthcare services.

The ICC Alliance Leadership Teams (ALT) is a key driver for integration and mechanism for delivering on the HSP.

CCDHB HSP Outcomes

Strengthened communities and families

Easy for people to manage their own health needs

Equal health outcomes for all communities

Long term conditions & complexity occur later in life and for shorter duration

Expert specialist services are available

The Integrated Care Collaborative (ICC) Programme and processes were established in 2012 following agreement between CCDHB sector leaders of the need to undertake a strategic, systems approach to improve services across the interface. This was an opportunity for clinicians, management and other key stakeholders to collaborate and develop integrated solutions to provide better services for the population and the health system. In 2013, the ICC was identified as the platform for CCDHB to implement it's alliancing process, and the ICC Leadership Group was instated as the CCDHB's ALT. The ICC Charter (attached as Appendix 1) outlines its purpose as:

> "Our purpose is to lead and guide our Alliance as it seeks to improve health outcomes for our populations, as outlined in the Agreement. We aim to provide increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a "best for patient, best for system" framework. These are aligned with the New Zealand Triple Aim."
>
> The ICC ALT Charter

The ICC ALT programme spans the whole of system. The programme has a focus on new settings of care for the delivery of urgent and planned care (Acute & Community Care), particular population groups across the life-course (Youth, Children, Older People) and enablers that underpin the integration of the health system (Health Pathways and Information Management). The programme also supports initiatives for specific priorities across the population (diabetes).

3. ICC Alliance Leadership Team Programme

At a programme organisation and governance level the following is an outline of 2019/20 developments:

2019/20 System Level Measure Plan Dashboard development	Quarter 1	Drafted
ICC Consumer Engagement guidelines	Quarter 1	Completed
ICC Outcome Monitoring Framework update	Quarter 2	Review
Revision of the ALT Programme Framework	Quarter 2	Review
Annual review of ALT Charter	Quarter 2	Review
Development of future programme of work	Quarter 4	
2020/21 System Level Measure Plan	Quarter 4	

On an on-going basis the ALT will be supported in its governance role and championing role with:

- Bi-monthly ICC ALT meetings;
- Bi-monthly monitoring and reporting of the overall ICC work programme
- Bi-monthly ICC Programme Board meetings
- Quarterly monitoring of progress against the outcomes framework & SLM dashboard
- Ongoing oversight of the delivery of the System Level Measure improvement initiatives as per the plan

3.1. ICC Equity Approach

The ICCALT Charter outlines the overall approach to Equity that continues to evolve and be strengthened. In 2019/20 the ICC Programme has committed to the following initiatives to strengthen its focus on improving equity:

- Each ICC agenda includes prompt questions for the Chair and Alliance members to create focus on the potential impact on equity to each agenda item
- All data utilised for development and monitoring of initiatives within the programme will be stratified for Māori, Pacific and non-Māori/Pacific.
- The project Charter template guides the approach to Equity and ensures Equity is a priority through-out ICC work developments. The ICCALT projects commit to delivering change and ensures that prior to a project being approved for initiation, this is a key consideration.

ICC steering groups, board and project teams are committed raise awareness of Equity, with the overall aim of defining an equitable action plan. The ICCALT supports an Equity lens across it programme of work.

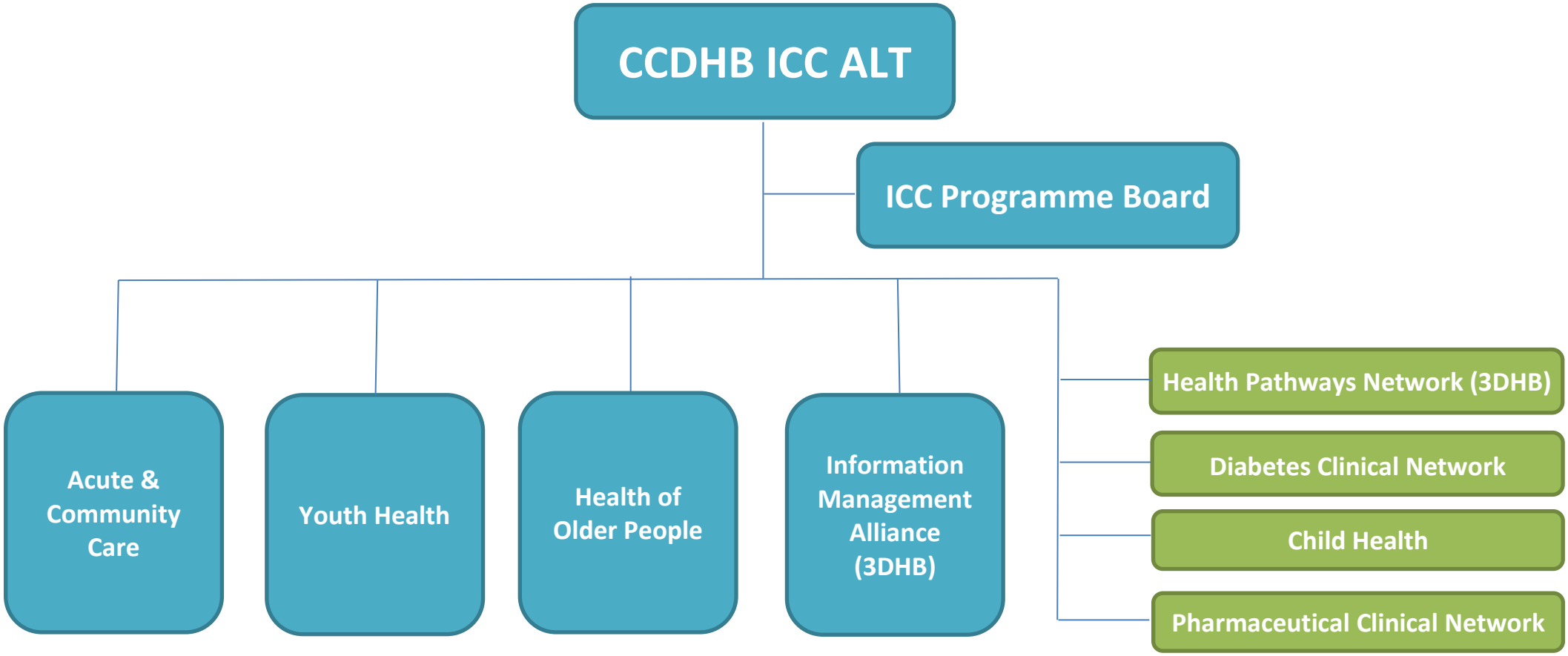
3.2. Communications Approach

Communication outside of stakeholder environment is through online platforms that is accessible to public, internal and external audiences. The ICCALT work programme has a broad audience including International integrated care colleagues, National District Health Board staff and stakeholders, local primary care organisations and all health professionals. There will be ongoing opportunities for ad hoc communications and engagement strategies through presentations to various forums, project related information releases and participation in wider DHB system discussions.

In 2019/20 the programme will strengthen its active communication and making its work visible for interested parties. A table breakdown of platforms and target audiences:

Platform	Audience	Content	Link with
ICC ALT Website	External and Internal • Primary Care Organisations • General practice teams • NGOs • Service providers • Internal Staff • Government • Clinical Services	• Presentations and models of care • Reports and evaluations • Clinical leads • Structure and membership • Charter • Partners • External • Work stream	➢ System Level Measure ➢ Health System Plan ➢ CCDHB ICC Share point
CCDHB ICC Share point	• All Internal staff	• ICCALT programme • Project milestones, success and achievements • Current upcoming meeting and events	➢ ICCALT website ➢ ICCALT Share point
ICC ALT Share point	• Visible to all internal • Page entry for project teams – full access by request	• Work streams • Reference documents and papers • Meet material • Project governance documents • Planning documents	➢ Project owned and operated

4. ICC ALT Programme Development Groups



4.1. Acute and Community Care Steering Group

The Acute & Community Care ICC Steering Group will support the further strengthening of care being provided in the community for the CCDHB population. The Group will focus on strengthening community based care with Health Care Homes as a core service that will be linked to other services in order to provide effective and efficient acute care. The Group work programme will evolve as opportunities for improved patient care arise.

Project	Purpose	Scope	Benefit measures
Community Health Network Development	To develop the DHB Community Health Network implementation plan.	• Understand current community setting of care • Develop community settings models of care • Service mapping • Identification of resource requirements	➢ Establishment of 1-2 CHNs ➢ Increased linkages between community providers ➢ Increase links to Hospital services
Health Care Home	To implement the HCH model in local GP practices.	• Continue to support practices beyond Year 3 • Continue to develop Tranche 2 & 3 • Develop Skill Sharing • Implementation of Community Services Integration • Progress the evaluation of the programme	➢ Reduced ED presentation; acute admissions; readmissions ➢ Improved Time to third next available appointment & other access measures ➢ Improvement in measures related to service, quality and impact ➢ Expansion of MDTMs ➢ Service Integration ➢ 80%
Community Acute Response (Kapiti only)	To support the Kapiti population with local acute demand services	• Expand on the acute community packages of care delivered by primary care • Offer funded packages for earlier discharge from MAPU • Work with WFA to support ambulance re-direction • Review impact of new service after 6mo of implementation	➢ Reduction in ambulance transports from Kapiti ➢ Reduce the growth of demand in ED. ➢ Increase ED/MAPU dischargers ➢ Reduce travel time for patients ➢ Increase breadth of service delivery in primary care
Primary Options for Ambulatory and Acute Care (POAC)	To enable primary care to deliver enhanced care in the community	• Deliver increased range and volume of primary care packages of care	➢ Increased packages of care delivered in the community ➢ Reduction in ED presentations
Winter/Influenza Working Group	To support system wide planning for 2020 winter influenza	• System wide overview of winter season and influenza monitoring • Inform whole of system approach and response to increased demand on services • Increase volumes of vaccinations for vulnerable populations	➢ Local and National Influenza Immunisation rates for patients and workforce ➢ POC testing in hospital and community ➢ Regional Outbreak monitoring ➢ ILL rates in PHO
E-referrals	To identify preferred e-referral solution for CCDHB	• Finalise procurement process for a preferred e-referral solution • Complete business case for preferred vendor	➢ Implement Phase 1-2 of the preferred e-referral solution ➢ Reduced referral rejection rate

		• Implementation plan for solution	
Tele Health	Improve the patient quality and experience of care through the use of telehealth services	• Telehealth service mapping & hardware needs assessment • Develop implementation plan with the application of the prioritisation framework	➢ Increased telehealth outpatient services ➢ Reduction in travel for people who receive telehealth services ➢ Telehealth may act as an enabler to some patients in simplifying care and for others improve access for those whom access may be challenging ➢ Reduce travel between locations for Healthcare professionals

4.2. Youth ICC Steering Group

The Youth ICC Steering Group will focus on establishing more integrated models of care for the youth population of CCDHB. The Group will focus on improving the youth experience and utilisation of youth appropriate services as outlined in the project summary below. The Steering Group will also be responsible for the development, implementation and monitoring of the youth related aspects of the CCDHB System Level Measure Implementation plan.

Project	Purpose	Scope	Benefit measures
Sex and Gender Diverse Youth	To support SIP in progressing and implementing responsive services for sex and gender diverse youth	• Develop and oversee a long term strategy to support improvements in services for Gender Diverse young people which supports international best practice	➢ Improved access to services that support gender diverse youth ➢ Improved health outcomes for gender diverse youth
Integrated Youth Services in Porirua	To develop a model of care for an integrated youth service in Porirua	• Develop a model of care in co-design with youth to integrate health services in Porirua • Identify service requirements and develop related business case • Support youth to implement the agreed service in Porirua	➢ Establishment of Porirua based integrated youth service ➢ Increase engagement of the youth of Porirua in health
Comprehensive School based Services	TBC – subject to MOH budget	•	➢
Youth SLM	To implement the SLM 2019/20 interventions and monitor outcomes	• Implement the actions part of the 2019/20 plan	➢ Increased testing for Chlamydia in youth ➢ Increase in youth enrolment in primary care ➢ Improved utilisation of primary health services by youth

4.3. ICC Health Of Older People Steering Group

The Health of Older People steering group will be the reference group for a number of older people related initiatives and projects. A number of these projects have been with Acute & Community Care and will now sit under ICC Health of Older People.

Project	Purpose	Scope	Benefit measures
Advanced Care Planning (3DHB)	Operate within the 3 Alliance Charters and deliver the regional framework	• Deliver eACP • Develop eACP Māori and PGC ACP mode	➢ Increase in ACP conversations and plans completed ➢ Reduced interventions at end of life ➢ Improved patient experience at end of life
Palliative Care	To implement Living Well, Dying Well 3DHB strategy in order to support clients and their whanau during their palliative journey to live well and die well	• Implement a new model of palliative care in line with the Living Well, Dying Well Strategy • Develop key elements of the model including: Integrated Palliative Care; Acute palliative demand; workforce; specialist services; and NGO and voluntary services	➢ Palliative care planned around patients, their families and personal supports ➢ Supports patients' care in their place of choice and seamless transitions between settings of care ➢ Enables timely services in response to need ➢ Addresses equity for Maori and other vulnerable groups
Falls Clinical Network (3DHB)	To lead the development and strategies to reduce incidence and severity of injury of falls across the 3DHB region	• Implement the Fragility Fracture Protocol in practices • Activate pro-active screening in practices	➢ Increase in proactive falls screening ➢ Increase fragility fractures protocol ➢ Increase in access to strength & balance programmes ➢ Reduced NOF rates
Community Health of Older People Initiative (CHOPI)	To implement a community base older people service linked	• Finalise the service delivery model and employment of service resource • Implement proactive and acute service elements in two community health networks	➢ Reduction in ED presentations for older people ➢ Reduction in polypharmacy ➢ Reduced ALOS
Older people Model of Care	Further develop existing MOC work	• Re scope and refine existing MOC	➢ To define when outcomes are scoped.

4.4. Information Management Alliance

The Information Management Alliance (IMA) aims facilitate the safe and efficient sharing of health information where this will help achieve the triple aim (improve patient experience/safety, improve population health and equity, make better use of resources), and is consistent with the Health Information Privacy Code. This 3DHB Steering Group leads technology based solutions to improve the integration of the DHB's health systems.

Project	Purpose	Scope	Benefit measures
Shared Electronic Health Record - Hospital Access	To complete the transition of the shared electronic health record to the Indici platform	• Finalise transition of Medtech cloud hosted practices to the indici platform	➢ Improved quality of care for people accessing hospital services ➢ People not having to tell their stories multiple times
Patient Portal	To support (in tandem with the Health Care Home initiative) the increase uptake and use of the patient portal	• Promote the ongoing increase in portal activations • Support the extension of services available via the portal • To identify portal activation across different ethnicity groups	➢ Empowering patients with access to their health information ➢ Creating practice and patient efficiencies in care delivery ➢ Understand/prevent the development of a digital divide
Primary Care Access to Concerto	To increase access to patients hospital record for primary care and other community providers	• Complete roll-out of primary care practice access to concerto • Develop plan for further providers to access concerto and progress roll-out accordingly	➢ Improved quality of care for people accessing community based health services ➢ People not having to tell their stories multiple times ➢ Increase the range of providers (eg. Community pharmacy) access to Concerto
Shared Care Planning	To implement the Indici e-shared care planning tool	• Workflow processes outlined and tested with selected Health Care Homes • Roll-out plan developed and implemented across the DHB	➢ Patients with complex health needs have a proactive care plan ➢ Providers and support services involved in a patients care are able to work smartly together ➢ Improved long term conditions management
e-Advance Care Plans	To develop and implement a e-Advance Care Plan	• Phase 1 – scanned ACPs are made available on the Indici shared electronic record • Finalise user requirements of eACP • Environment scan of potential tool and/or development in accordance to local requirements	➢ Increased number of ACPs completed. Patients and support services are able to easily document, retrieve and utilise a patients ACP ➢ Increase number of people are supported in line with their ACP plan

4.5. Integrated Care Networks

The ALT ICC Networks have a focus on monitoring the implementation of new developments and leading ongoing quality improvement for identified focus areas of the alliance.

Each Network develops an annual plan of activity to drive the ongoing quality improvement and the following is a summary:

Network	Purpose	Scope	Benefit measures
3DHealth Pathways Governance Group (3DHB)	To develop, publish and monitor the clinical pathways across the 3DHB sub region	• Localise 100 pathways per year • Revision and updating of current pathways • Implement the Streamliners style manual • Implement the prioritisation	➢ Increase page users and page views ➢ 100 pathway localisations per year ➢ Increase utilisation of Pathways ➢ Increase quality of care of patients
Child Health Network	*TBC - To implement the SLM 2019/20 interventions and monitor outcomes*		
Diabetes Clinical Network	To provide advice on diabetes care and management and initiate quality improvements projects as required	• Plan for the evolution of the Diabetes Care Improvement Plan across CCDHB • To support primary care and the hospital services to strengthen their service delivery for people with diabetes • To support self-management	➢ Increased quality of care with skills sharing across primary and secondary care ➢ Improved HbA1c levels – improvement project focusing on young Maori and Pacific people ➢ Increased renal screening coverage and maintenance of rate of people with microalbuminuria not on ACE inhibitors.
Pharmaceutical Clinical Network	Provide clinical leadership, advice and recommendations on Pharmacist services and Pharmaceutical utilisation	• Advice on Community Pharmacy investment to deliver maximum value for the population. • Clinical Governance and direction to the Pharmacy facilitators • Provide advice and clinical leadership about improving the use of medications	• Investment plan for Community Pharmacies • Deliver work plan for PHO Pharmacy facilitators