SOUTH WESTERN SYDNEY
INTEGRATED CARE STRATEGY

JUNE 2016

NSW GOVERNMENT Health
South Western Sydney Local Health District

phn SOUTH WESTERN SYDNEY
An Australian Government Initiative

Background:

Operating under confirmed Terms of Reference and supported by a signed Statement of Intent, SWSLHD and SWSPHN established an Integrated Health Committee (IHC) to oversee improved integration of services and information between primary care services and the Local Health District. Under this stewardship, great progress has been made in developing local (south western Sydney - SWS) capacity to deliver integrated care initiatives. Recognising that it is now necessary to broaden the reach of this endeavour, this document reflects an effort by the IHC to produce a strategic framework to guide implementation of a holistic integrated care strategy across SWS.

Integrated Care, The Burning Platform:

Although the health system within SWS is performing well on key health indicators, healthcare needs to be better equipped to meet the needs of more people and older people accessing health services at a higher rate and expecting more comprehensive and expensive services than previous generations (MoH 2015). As a result, across the state and within SWS, the current health system needs reform to a more patient-centred integrated health system, connecting services across different healthcare providers with a greater emphasis on community-based services that better support people with long term conditions, ensuring long term financial viability. At the local level, this reform needs to align with a focus on reduced investment in expensive acute care beds to a reinvestment in integrated primary care models that bring services closer to where people live.

In addition, it is recognised the current Medicare Benefit Schedule (MBS) is not conducive to integrated care, especially under a chronic disease management model and the current MBS freeze in General Practice. Primary Care providers also struggle to maintain connectivity with the acute sector due to the increased burden and administration of managing a private business. The reform needs to align with care that can support the business unit of General Practice and ensuring the longitudinal relationship between a General Practitioner and their patients is enhanced.

Defining Integrated Care:

The NSW Ministry of Health defines integrated care as the provision of *"seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health, in partnership with the individual, their carers and family."* Definitions have been applied more broadly at the international level, described as the *"'smooth and continuous' transition between services … with co-operation and collaboration across services … and a 'seamless' journey for service users, as they receive health, support and social welfare services from a range of health and other professionals."*

In July 2015 the Commonwealth Department of Health developed a range of objectives and National KPI's for the 31 PHNs across Australia. The relevant National KPI used to drive integration is *"potentially preventable hospitalisations".* Underpinning this KPI was the objective that PHNs would *"engage with LHNs (or equivalent) to determine a shared approach and collaborate to enhance patient outcomes and reduce avoidable emergency department presentations and hospital admissions without duplicating efforts and initiatives"*

On 31 March 2016 the Commonwealth Primary Health Care Advisory Group (PHCAG) published its final report 'Better outcomes for people with Chronic and Complex Conditions". System integration and improvement was a key theme in the report. Among the 15 recommendations in the report was the need to *"Establish Health Care Homes (recommendation 2) and Restructure the payment system to support the new approach (recommendation 9)*

As these definitions and Government policy imply, integrated care takes on many different forms. In some circumstances, integration may focus on primary and secondary care, and in others it may involve health and social care. It may focus on real integration, in which organisations merge their services, and virtual integration, in which providers work together through networks and alliances. Integration may also entail bringing together responsibility for commissioning and provision. (BMJ 2011)

Commonly, the approach to integration involves the development of "New models of care which see the patient rather than the institution as the centre of service delivery and which aim to promote a more seamless patient journey across community, primary, and hospital sectors, greater use of primary and community care, and the shifting of care 'closer to home'". (IJIC 2011). Any new model of care also needs careful consideration related to business modelling in a General Practice and indeed the private Primary Care environment. Such considerations must include a funding model which enables private practice to implement any new care process.

Equally important, "evidence shows that integrated care not only can fix up fragmented health care but also effectively reduce hospitalization, emergency room, average length of stay and health expenditure, while improving the quality of life." (IJIC 2014). In addition, models of care that prevent patients from becoming frequent users of hospital/acute services must also be considered.

Core Elements of Integrated Care:

The BMJ (2011) has noted that integrated care is likely to deliver on its promise only if several ingredients are in place: team working that breaks down barriers between clinicians; aligned financial incentives that avoid overtreatment and support delivery of care in the most appropriate settings; responsibility for defined populations that enables relationships to develop over time; and partnerships between doctors and managers in leading improvement.

In 2013 (BMJ), a systematic review of international peer-reviewed articles and relevant websites on effective and sustainable integrated primary–secondary health governance models identified ten key elements that were important to support integrated care across the primary–secondary care continuum:

- Joint planning (including formal governance arrangements)
- Integrated information communication technologies (particularly, a shared electronic health record, and systems that link clinical and financial measures)
- Effective change management (shared vision, leadership, time and committed resources)
- The importance of shared clinical priorities
- The importance of integration at all levels of the continuum of care
- Aligning incentives to support the clinical integration strategy
- Providing care across organisations for a geographical population
- Use of data as a measurement tool across the continuum for quality improvement and redesign
- Professional development supporting joint working
- An identified need for consumer/patient engagement
- Adequate resources to support innovation

Critical to development of a comprehensive strategy of reform is an understanding of the levels of integration sought. For broadest reach, uptake and sustainability, it is understood that system reform will need to operate at the macro level (strategy, policy, contractual, financial and legal), meso level (inter-organisational and multi-disciplinary) and the micro level (joined up at the service level). (IJIC 2011) Similarly, it is essential to determine the appetite and capacity of all parties to the integration effort. This is determined by the commitment of parties to 'link-up' services under their control, focus on co-creation (genuine person-focused care which reinforces the longitudinal relationship with General Practice), align support functions and activities (eg. financial, management and information systems) and develop and maintenance a common frame of reference (i.e., shared mission, vision, values and culture). (IJIC 2013 Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care)

Current system characteristics	Integrated system characteristics
Organisational and individual visions - commissioner, funder and provider orientated	Visions shared across a place/cohort regardless of commissioners, funders and providers
Provider-centric	Patient-centric
Organisational leadership	Place-based leadership
Demand driven – universality	Need driven – more focused and targeted, segmentation
Siloed delivery/fragmented care	Integrated delivery/coordinated care
Sector-specific funding	Pooled funding
Activity focused and incentivised	Outcome focused and incentivised
Post-hoc care	Earlier intervention – keeping people well
Traditional approaches to the commissioner / funder divide	New partners/approaches – collaborative commissioning and delivery
Data retained on a sectoral basis	Data linked around the patient
Separate budgets	Pooled or bundled budgets

Integrated Care in NSW

In NSW, the Ministry of Health has signalled a long term focus on integrated care. Providing funding incentives to test 'demonstrator' pilots of integration and locally led 'innovators' (including WHA), the state is contributing to broader implementation of statewide 'enablers' for integrated care. To date, this includes:

- planned implementation of a fully linked-up electronic health record (HealtheNet), a web-based portal to enable summary patient information to be shared between care providers.
- Development of risk stratification tools to identify early intervention opportunities for people likely to need healthcare services frequently. This approach uses all available health utilisation data to identifying patients at risk of a hospital presentation or health deterioration, allowing the health system to direct 'Integrated Care Strategies' to those people most in need.
- Development of systems that allow patients to provide direct feedback on their care to drive improvement in services (Patient Reported Measures – PRMs).
- Redesign of the Chronic Disease Management Program to realign efforts in integration with known high risk patient cohorts, again directing available resources more efficiently.

The objectives of the strategy are to transform how care is delivered to improve health outcomes for patients and reduce costs deriving from inappropriate and fragmented care. In doing so, it is an attempt to develop a system that:

- organises care to meet the needs of targeted patients and their carers, rather than organising services around provider structures;
- designs better connected models of healthcare to leverage available service providers where this is needed;
- promotes and supports the longitudinal relationship between the patient their General Practitioner.
- improves the flow of information between all healthcare providers;
- develops new ways of working across State government agencies and with Commonwealth funded programs to deliver better outcomes for identified communities; and
- provides greater access to out-of-hospital community-based care, to ensure patients receive care in the right place for them.
- Designs and supports systems to prevent our community becoming frequent users of hospitals

As of March 2016, the Commonwealth Department of Health through the PHCAG in publishing its report Better Outcomes for People with Chronic and Complex Conditions" quickly followed up with a core strategy of a 21 million dollar additional investment in creating 'Health Care Homes' that will be responsible for the ongoing co-ordination, management and support of a patient's care.

Key features of the Health Care Home are:

- **Voluntary patient enrolment** with a practice or health care provider to provide a clinical 'home-base' for the coordination, management and ongoing support for their care.
- **Patients, families and their carers as partners in their care** where patients are activated to maximise their knowledge, skills and confidence to manage their health, aided by technology and with the support of a health care team.
- **Patients have enhanced access** to care provided by their Health Care Home in-hours, which may include support by telephone, email or videoconferencing and effective access to after-hours advice or care.
- **Patients nominate a preferred clinician** who is aware of their problems, priorities and wishes, and is responsible for their care coordination.
- **Flexible service delivery and team based care** that supports integrated patient care across the continuum of the health system through shared information and care planning.
- **A commitment to care which is of high quality and is safe.** Care planning and clinical decisions are guided by evidence-based patient health care pathways, appropriate to the patient's needs.
- **Data collection and sharing** by patients and their health care teams to measure patient health outcomes and improve performance.

Many patients will recognise features of the Health Care Home in their existing general practices.

Integrated Care in SWS

At the macro level, SWSLHD and SWSPHN have established an Integrated Health Committee, supported by a Statement of Intent, to oversee improved integration of services and information between primary care services and the Local Health District. To achieve this, criteria have been developed to enable determination of shared integration priorities between the two entities. As a result, a range of integration initiatives have emerged with the support of this collaboration, targeting meso and micro level programs that are consistent with state and regional priorities.

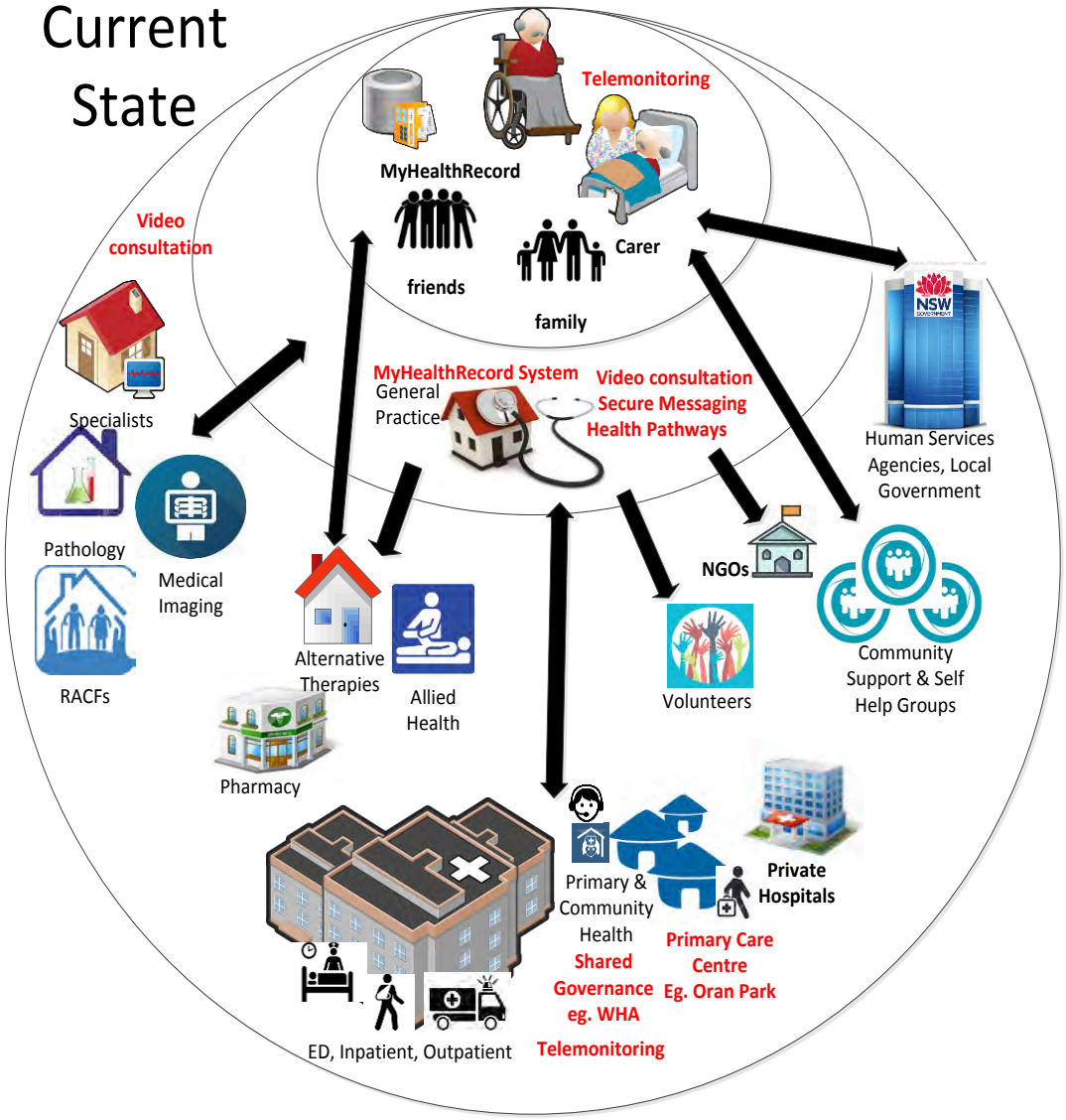
To date, the key areas of work have focus on seven agreed principles of integration: access; multidisciplinary team available for every person; provision of linked-up healthcare; quality, excellence and innovation; fostering academic health sciences and evidence-based practice; prevention and early intervention close to home; and accountability to the community. Key achievements made through this program of work include:

- building ehealth capability between General Practice and acute care through SWS Health Pathways, secure messaging (75% reach), cancer transcription and communication
- shared planning resources and function between the two entities (eg. T2DM)
- development of an integrated primary care model to operate out of a new urban greenfield site (Oran Park)
- development of a population-based virtual integration hub, operating under an alliance model, in a semi-rural site (Wollondilly)

The committee also acknowledges there are numerous other activities being conducted in the primary care sector that currently achieve various levels of integrated care.. These include but are not limited to Ante Natal Shared Care and Ambulatory Care Services conducted in collaboration between acute and primary sectors.

While impressive, this program of work has served as a test ground for success and now needs to expand in reach and ambition. The parties agree that a framework is necessary to steer a regional approach that is to grow and include the social care sector, a localised risk stratification methodology, assimilation of the Chronic Disease Management Program into this paradigm, development of a cluster-based At-Risk Model for those vulnerable to hospital attendance, an understanding of locally relevant patient reported measures of care, the building of medical neighbourhoods across SWS, design of a shared IT solution for implementation across primary, secondary and acute care in SWS and development of research capacity to understand and share the outcomes that can be achieved.

Current State



Our Vision

We strive for a health neighbourhood model in which services are designed to envelope their users, where data is collected and analysed, and technology and shared real-time patient information is available to health care providers to facilitate more integrated and continuous care.

Our consumers contribute to the vision and planning, they understand how to access care and are more involved in maintaining and managing their health.

Our collaborators have relationships within the health community and are networked to coordinate care and support the journey to wellness. Through working together, the region collectively experiences increased capacity to provide the right quality care in the right place at the right time.

A Framework for Action

To meet this vision, we will target our efforts at all levels of integration:

At the macro level by developing whole of population systems that re integrated vertically (linking health providers) and horizontally (across sectors e.g. social care, education, housing);

At the meso level by integrating care for specific groups of patients and populations (e.g. chronic care, mental health) across settings vertically and horizontally; and

At the micro level by coordinating clinical and service delivery for individual patients and carers and supporting clinicians in their work environment to implement change.

Our activities will address the drivers of integration identified by the NSW Ministry of Health:

- **Information and other infrastructure** – IT & e-health, administrative support and capital infrastructure
- **Collaboration framework & workforce** – flexible workforce, new ways of working, motivated providers
- **Patient focus** – personalised and patient centred, close to the community
- **Outcomes monitoring and feedback** – track and feedback on care outcomes, patient experience, quality, efficiency and cost
- **Funding models & incentives** – supporting collaboration of providers in integrated care delivery
- **Prevention focus** – screening the population, early intervention, health education for patients and providers
- **Connect health & social care** – linking health, social, aged and family support particularly for vulnerable populations
- **Clinical practice** – innovative practices for better integrated care e.g. clinical pathways
- **Governance, provider links & commissioning** – governance structures across providers with joint decision making, demonstrating leadership and building commissioning capacity
- **Care coordination** – methods to provide seamless care e.g. central entry point, care navigation and care planning

SWS Core Principles for Integrated Care

1. **Improving access to services**
2. **Delivering multidisciplinary care**
3. **Providing linked-up care**
4. **Focus on clinical quality, excellence & innovation**
5. **Fostering evidence development**
6. **Coordinating prevention & early intervention closer to home**
7. **Remaining accountable to our community**

Consistent with NSW Ministry of Health core areas of focus, we will establish systems of work, tools and strategies that build **patient/carer empowerment,** foster **innovative ways of working**, utilise **primary and community care as a hub**, facilitate **patient identification and selection** based on identified needs and **share real-time patient information** amongst health care providers who need it.

Our strategic approach builds on a three pronged aim adapted from the widely adopted USA Institute for Healthcare Improvement *Triple Aim*:

- To improve the users **experience**
- To improve the **health** of our people and population
- To improve the **effectiveness** of our systems.

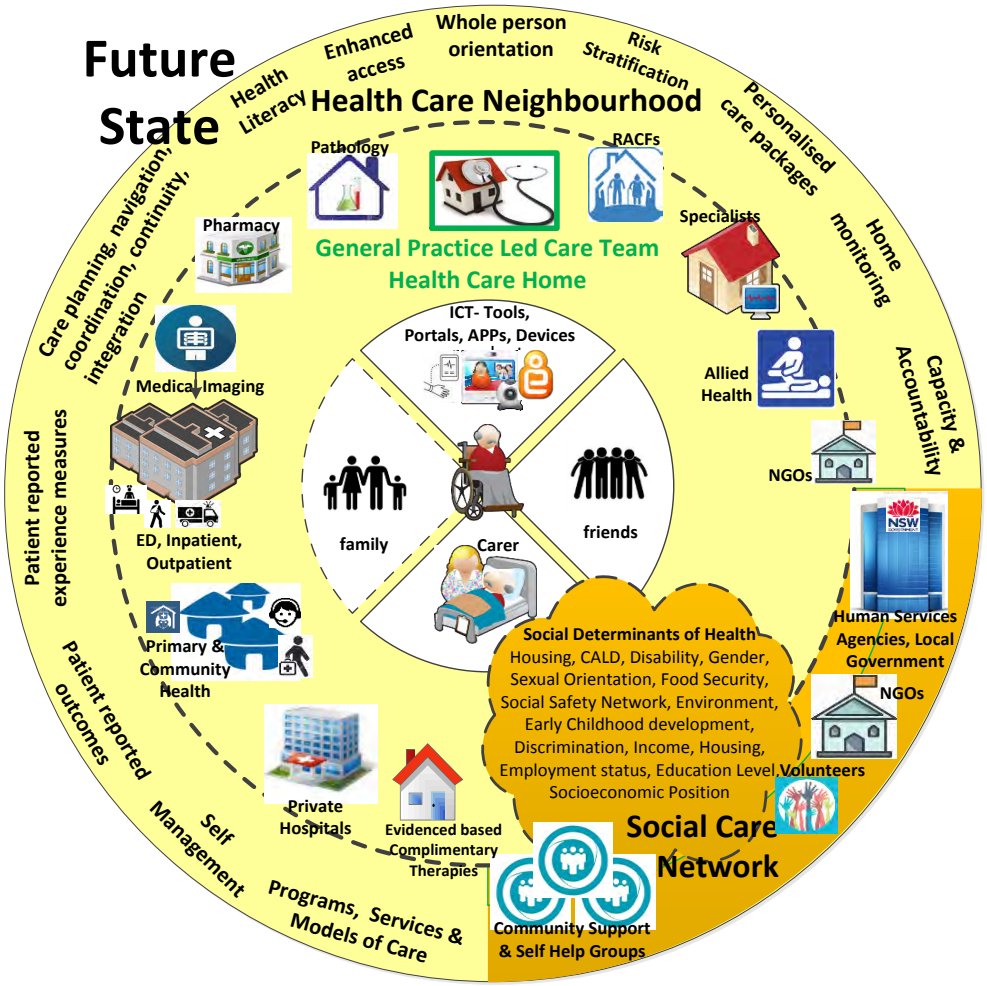
In South Western Sydney, this is expanded to include a fourth aim:

- To improve the **work life** of healthcare providers (Bodenheimer et al 2014)

To ensure we have a holistic approach to integration we will assess our initiatives against these components and recalibrate our efforts to meet any gaps. Our vision for integrated care sees primary care as a hub of coordination, networking patients to a range of health and social support services that take account of the social environment in which they have lived, the social determinants of health.

Key Definitions	
Risk Stratification	A systematic process to target, identify an select patients who are at risk of poorer health outcomes, and who are expected to benefit most from a particular intervention or suite of interventions. Involves 3 stages to target, identify and select high risk patients for early and tailored intervention. (MoH 2015)
Telehealth	Defined as the 'use of telecommunication techniques for the purpose of providing telemedicine, medical education and health education over a distance' (Commonwealth Department of Health 2015). This represents the broadest possible definition of technology-enabled health support systems.
Telemedicine	Defined as the 'use of advanced telecommunication technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers'. (Commonwealth Department of Health 2015) This can include such interventions as video-linked case conferencing between health professionals and use of telemonitoring systems.
Telemonitoring	In the SWS context, a definition by Pare, Jaana & Sicotte (2007) is proposed: "telemonitoring (is) an automated process for the transmission of data on a patient's health status from home to the respective health care setting". This can include linking this information through a third party health care setting (eg. telemonitoring provider).
Health Care Home	Essentially a persons General Practice where care is delivered and coordinated in the primary care setting. Data, clinical records and team based care is clearly integrated across all continuums of care
Health Care Neighbourhood	A grouping of Health Care Homes where the health of a population cohort is supported by all service providers and where these service providers are appropriately linked to ensure seamless service delivery

Achievements So Far	*Opportunities for Development to 2021*
Establishment of a governance structure to oversee development of integrated care initiatives between primary, secondary and acute health services across SWS (SWS Integrated Health Committee).	• Expanded membership to include social care sector and alliance contracting • Testing new models of funding for integration of services (eg. Alliance contracting)
Introduction of SWS Health Pathways; providing access to localised clinical referral pathways for a host of diagnoses and clinical issues whilst helping to standardise care.	• Continue expansion and promotion of the program • Development of a patient portal to support self-management
Establishment of SWSs first integrated primary care centre at Oran Park (Oran Park Family Health), bringing together Primary & Community Health, General Practice, Pathology, Allied Health and visiting Specialists.	• Introduction of medical imaging, day surgery, ambulatory care clinics, dentistry & advanced diagnostics • Linked information and communications technology for all staff and sub-tenants, applied and tested in other medical neighbourhoods across SWS
Implementation of a health alliance for Wollondilly involving SWSLHD, SWSPHN, Wollondilly Shire Council and local non-government organisation partners. Built on a comprehensive needs assessment, the project has received MoH funding to develop a virtual health hub for this population, including a focus on health promotion and telehealth interventions for those at risk of poor health.	• Development of a linked-up, technology-enabled Wollondilly Medical Neighbourhood • Demonstrable increase in access to care for residents of Wollondilly and subsequent reduction in demand for acute care services • Creating a 'healthy town'
Completed an assessment of information & communication technology connectivity amongst General Practice in SWS, confirming that 85% have access to secure messaging, more than 1 in 3 are enabled to utilise the Personally Controlled Electronic Health Record (PCEHR).	• Increased utilisation of secure messaging across SWS • Increased utilisation of the MyHealth Record by practices and consumers across SWS • Increased electronic access to discharge summaries, patient medications, medical imaging results, pathology results and case management plans for all clinicians involved with individual patients
Completed a review of the District Chronic Disease Management Program (CDMP), realigning the model to deliver an integrated model of care coordination that is built on patient risks and appropriate levels of intervention (risk stratification).	• Implement and sustain this revised model of care, consistent with the goals of the integrated care strategy • Further develop health system capacity to risk stratify patient cohorts according to need • Developing innovative models of care for patients identified as being 'at-risk'


Future State
Health Literacy
Enhanced access
Whole person orientation
Risk Stratification
Personalised care packages
Home monitoring
Capacity & Accountability
Care planning, navigation, coordination, continuity, integration
Patient reported experience measures
Patient reported outcomes
Self Management
Programs, Services & Models of Care
Health Care Neighbourhood
General Practice Led Care Team
Health Care Home
Pathology
RACFs
Specialists
Pharmacy
Medical Imaging
ED, Inpatient, Outpatient
Primary & Community Health
Private Hospitals
Evidenced based Complimentary Therapies
Community Support & Self Help Groups
Allied Health
NGOs
Human Services Agencies, Local Government
NGOs
Volunteers
ICT- Tools, Portals, APPs, Devices
family
friends
Carer
Social Determinants of Health
Housing, CALD, Disability, Gender, Sexual Orientation, Food Security, Social Safety Network, Environment, Early Childhood development, Discrimination, Income, Housing, Employment status, Education Level, Socioeconomic Position
Social Care Network

Appendix 1 - SWSICC Strategic Roadmap

	Year 1	Year 3	Year 5	Program Outcomes
For people who use our services	• Patients determined to be '**at-risk**' are enrolled in local programs, including but not limited to: WHA **telemonitoring** program; and **CDM** risk stratified models of care • Patients are provided with links to **HealthPathways** relevant to their care needs • Patients have access to reliable patient information & resources to support self-care & health literacy • Clear patient consent protocols are in place to support program registration • Patients have care plans that identify health literacy needs • **Patient Reported Measure** tool is available to patients in south western Sydney • There is improved utilisation of the **Get Healthy health coaching** program by south western Sydney residents	• There are an increased number of patients utilising health prevention and primary care services • There is increased participation in care planning by patients & carers • There is increased utilisation of **self-management/care options** • Patients with chronic & complex conditions report reductions in ED presentations & hospitalisations	• Patients with chronic & complex conditions report an improved patient experience & reduction in ED presentations & hospitalisations • Improved QALYs and FIMS • Increase in self-management • Increase in health literacy	Measured changes in: - $/QALYs - FIMS - health literacy - Tracking pt journeys - care plan compliance - Pt Communications Measured changes in: - ED presentations - Potentially preventable hospitalisations.
For people who deliver our services	• CQI program designed and established with practices • improved knowledge of services & referral mechanisms and access • Providers routinely access **HealthPathways** • identified minimum data set/s • **data sharing** agreements in place • shared patient records • Reduced clinical error & adverse incidents			GP surveys Measured changes in: - Referral patterns - ED triage profiles - ALOS of potentially preventable hospitalisations. - Mean clinical & metabolic indicators Compliance with data sharing agreements Implementation of: - Shared pt record - Shared care planning tool
	• identified programs for risk stratified patient enrolment • centralised intake • personalised **care packages** available • **risk stratification** and enrolment programs available • care coordination payment schedules available • **GPs lead team-based care plans**	• Reducing low-complexity presentations to ambulatory clinics • Reducing duplicate diagnostic investigations Reducing demand for ED presentations • Measurable changes in mean clinical & metabolic indicators • adoption of **shared care planning tool**	• Significant reduction in potentially preventable hospitalisations • Significant changes in mean clinical & metabolic indicators	

For systems we use to deliver care	• identified minimum data set • data sharing agreements in place • shared patient record developed • **PRM Tool** selected and implemented • **navigation tools** for patient and providers implemented • Robust & **secure communication channels** established across providers • Alliance partners actively promote agreed health initiatives • **HIE** established • evaluation framework commissioned with research unit	• shared patient record implemented • Patient data routinely linked & tracked across sectors: - Longitudinal monitoring - Recalls & reviews - Audits & benchmarking - Outcome linkages • Integrated Primary Care Centre (**OPFH**) operational	Agreements Implementation of: - Interoperable ICT platform - PRM tool - HIE
	• **shared care planning tool** developed • timely & accurate transitions of care systems developed	• timely & accurate transitions of care systems implemented • shared care planning tool implemented	

Definitions: CDM – Chronic Disease Management, QUALY - quality adjusted life year, FIMS - functional independence measure, CQI - continuous quality improvement, PRM - patient reported measure, HIE - health information exchange, ALOS – average length of stay

Appendix 2- SWSICC Project Roadmap

Current	Year 1	Year 3	Year 5	Desired outcome	Lead
Oran Park Family Health (OPFH)	• Operational ▪ Pathology ▪ Physio, Psychology, Podiatry, Dietician ▪ Specialists ▪ centralised reception, billing • Medical Imaging commissioned & fitout complete, operational (18months) • centralised patient registration and informed consent system • ICT Connectivity between Cerner & Best Practice • Evaluation plan, developed, approved and implemented, incorporation Patient Reported Measures • Implemented a shared strategy for: ▪ marketing ▪ community engagement ▪ continuing education	• Established ▪ research, teaching and quality improvement program ▪ clinical student placement program ▪ hospital avoidance program ▪ After-Hours services • Stage 3 scoped, designed, approved and in development	• Stage 3 operational	Measured changes in: - $/QALYs - FIMS - health literacy - Tracking patient journeys - care plan compliance - patient Communications Measured changes in: - ED presentations - Potentially preventable hospitalisations. Implementation of: - Interoperable ICT platform - PRM tool - HIE Compliance with data sharing agreements	SWSLHD
Wollondilly Health Alliance	• Sustainability plan is developed, approved and implemented • Diabetes Project implemented • Evaluation plan, developed, approved and implemented, incorporation Patient Reported Measures • Tele-monitoring final report • Data extract reports	•	•	Compliance with Alliance Agreements Compliance with data sharing agreements Measured changes in: - $/QALYs - FIMS - health literacy - Tracking patient journeys - care plan compliance - patient Communications Measured changes in: - Referral patterns - ED triage profiles - ALOS of potentially preventable hospitalisations.	SWSLHD

				- Mean clinical & metabolic indicators Implementation of: Implementation of: - Shared care planning tool - PRM tool Measured changes in: - $/QALYs - FIMS - health literacy - Tracking patient journeys - care plan compliance - patient Communications	
Health Pathways	• A further 120 Pathways developed • Evaluation plan, developed, approved and implemented, • 1st draft Sustainability plan developed	• Consumer portal scoped, designed, approved and implemented, incorporates Patient Reported Measures • Sustainability plan is approved and implemented	•	Measured changes in: - Referral patterns - ED triage profiles Measured changes in: - health literacy - Tracking patient journeys - care plan compliance - patient Communications	SWSLHD
Risk Stratification	• Level 1 Health coaching plan developed, approved and implemented across SWS • Design, approval and implementation of At Risk Model & Program for SWS. Pilot Wollondilly & OPFH • Evaluation plan, developed, approved and implemented, incorporation Patient Reported Measures	•	•	Measured changes in: - $/QALYs - FIMS - health literacy - Tracking patient journeys - care plan compliance - patient Communications Measured changes in: - Referral patterns - ED triage profiles - ALOS of potentially preventable hospitalisations. - Mean clinical & metabolic indicators Implementation of: - Shared care planning tool	SWSLHD

Potential	Year 1	Year 3	Year 5		
GP/Specialist Communications Stage 2	• Additional 2 clinical streams adopting Cancer Stage 1 methodology	•	•		SWSPHN
GP/Acute ICT Platform, HIE & shared care planning tool	• Platform between GP scoped, designed, approved and proof of concept development – • Rapid Micro adoption for Wollondilly and Oran Park	•	•		
Antenatal Shared Care	• Scoped, project plan developed and commenced	•	•		
Diabetes Care Plan	• Scoped, project plan developed and commenced	•	•		

Appendix 3 - SWSICC Strategy Communication Roadmap

Activity	Jul – Sep 2016	Oct – Dec 2016	Jan – Mar 2017
Awareness campaign	• Design and develop a campaign to raise awareness of SWSICC strategy/challenges being addressed and initiatives underway. • Opportune presentations at meetings eg Clinical Stream meetings. • Leverage existing facility newsletters and intranet sites	• Implement	• Evaluated
Web Page/Site	• Scope, design & implement, key areas: ▪ The vision /strategy/challenges being addressed ▪ The projects and progress ▪ Outcomes for staff and consumers ▪ How to become involved/provide input?	• Implement	• Evaluated