NORTHERN NSW INTEGRATED CARE

Northern NSW Integrated Care Collaborative

Final Report

Prepared by
Improvement Foundation (Australia) Ltd
PO Box 3645
Rundle Mall SA 5000
www.improve.org.au

Contents

Executive Summary

In 2015, Northern New South Wales Local Health District (LHD) received funding under the NSW Health's Integrated Care Strategy and partnered with North Coast Primary Health Network (PHN) to implement an Integrated Care Program. As part of this program, the LHD and the PHN undertook an Integrated Care Collaborative (ICC) between September 2015 and June 2016. The objective of the ICC was to encourage and support participating health services across North Coast New South Wales to deliver rapid, measurable, systematic and sustainable improvements in the care they collectively provided to patients.

The ICC focused on improving health outcomes and preventing avoidable hospital admissions for people with complex, long term conditions, with the following aims:

- That 200 or more patients with complex care needs were managed by an Integrated Care Team
- That at the nine-month mark there was a 20% improvement in patients' Quality of Life
- That at the nine-month mark there was a 20% improvement in clinicians' perceived connectedness of the system.

Hospital and community based clinicians from the LHD and clinicians and staff from fifteen primary health care services participated in a series of learning workshops, interspersed with activity periods. During the activity periods, participants applied the workshop learnings to identify and test change ideas for making improvements in their organisations. The tests of change were defined and refined using the Model for Improvement (MfI) framework, which enables change ideas to be developed at a local level. The impact of the changes was assessed by analysing the regular data submissions made by participants on the suite of improvement measures established for the program.

Learning Workshop Series

Three learning workshops were held over the course of the ICC. The first learning workshop focused on the concept of integrated care; the ICC aims, measures and change principles and discussions on ways to integrate care to benefit patients. More than 200 participants attended both workshops and 120 completed evaluations. Of those 120, 60% of attendees rated the information provided and the opportunity to network as excellent.

The second learning workshop included a review of progress; an expert speaker who presented on best practice in integrated care; presentations from participants on innovative changes they'd trialled and two consumers who shared their experiences of their health care journeys. More than 140 participants attended the workshop. Evaluations were received from 87 attendees and of those, 56% rated the information provided as excellent and 61% rated the opportunity to network as excellent.

In the final learning workshop NSW Health presented on the eHealth strategy; a facilitated panel discussion was held with local experts discussing how to improve patient self-management; more exemplars presented their innovative collaborations and participants were asked to provide feedback on the successes of the ICC and what improvements could be made. Evaluations were

received from 60 of the 120 participants and 45% of them rated the information provided as excellent and 64% rated the opportunity to network as excellent.

Activity Periods

During the activity periods, participants were asked to complete and submit MfI cycles to an online web portal on a monthly basis. A total of 266 MfI cycles were submitted by forty eight participants from twenty one organisations over the eight month period**.** The majority of MFI cycles, 189 (71% of the total), were submitted by the participating primary health care services with the remaining 77 (29%) submitted by hospital and community based clinicians and staff. Most of the MfI cycles related to the building of relationships between health care providers working in different areas of the health care sector.

Data Analysis

Data from the LHD and the primary health care services, patients and clinicians was collected in order to track progress towards meeting the ICC aims (as listed above) and to assess the impact of changes undertaken at the individual, service or regional level. Data received from the primary health care services indicated that a total of 205 patients were enrolled in the ICC, exceeding the aim of 200. Improvements were observed in the proportion of patients with current care plans, from 44% to 66%. The proportion of patients with Advance Care Directives increased from 6% to 22% and at the conclusion of the ICC, almost 17% had Shared Health Summaries uploaded to the My Health Record.

Significant technical and system issues prevented the LHD from accessing data relating to a number of measures, however data were collected relating to admission and discharge notifications. In April 2016, the LHD began a trial of an Admission and Discharge Notification service in which GPs were alerted when their patient(s) had an unexpected admission to an LHD facility, and this service provided notification rates of between 22% and 48% between April and June 2016. The timeliness of discharge summaries provided to GPs improved from 80% to 100%, however the number of completed discharge summaries for enrolled patients on a monthly basis varied substantially over the course of the ICC, from 46.5% to 68.6%. A small number (4) of discharge summaries were uploaded to the My Health Record in December 2015 but a low number of patient registrations in the My Health Record and system issues regarding data automation prevented further uploads.

Technical issues prevented the collection of baseline data from the enrolled patients, however data was collected from 82 patients over the duration of the ICC regarding their experience of integrated care and how their health status impacted on their ability to carry out daily activities. A large majority agreed that their care was well coordinated (91%); that they and their carers were actively involved in decision making on their care and treatment (90%) and that they were well supported to understand and manage their conditions (94%). 65% of patients stated that health status allowed them to carry out daily activities always or usually, 26% stated about half the time and 9% stated seldom.

Data from clinicians regarding their perceived connectedness of the system was collected at baseline only. In addition, only a small number of clinicians (29) responded. Almost half of the respondents believed that team members communicated well and almost half disagreed. 24%

agreed that communication is received in a timely way with 24% disagreeing and 31% were undecided. 66% of respondents did not agree that they experience well connected health services and 3% strongly disagreed, while 14% agreed and 17% were undecided. 38% believed that the system is becoming more patient centred but 31% disagreed and 31% were undecided.

Successes and Challenges

Some of the successes of the ICC include strong Executive Team support by the LHD and the PHN which strengthened participant engagement, recruitment and participation; a notable increase in relationships between providers from the acute, community or primary care sectors and improvements in communication between the participating services, such as the successful trial of an Admissions and Discharge Notification Service in which GPs were alerted when their patient(s) had an unexpected admission to an LHD facility.

A number of challenges were also observed. These included a belief that the duration of the ICC was of insufficient length for successful outcomes to occur; that confusion as to who were members of each patient's care team delayed integration; that technical and system issues delayed/precluded the submission of certain data from the LHD and that the ICP and PHN support teams lacked experience to provide effective support to participants.

Lessons Learned

Lessons learned from the challenges and from ICC sponsors and participants have informed a number of recommendations for future ICC initiatives. These include extending the duration to 12 months to enable time for participants to successfully trial and implement changes; simplifying the ICC measures and the collection and submission processes; enhancing strategies for engaging and recruiting participants; and supporting patient involvement in identification of their care teams via activities such as patient journey mapping.

Background

The New South Wales Government committed significant funding under the Integrated Care Strategy 2014-2017 to implement new and innovative locally led models of integrated care across the State. The funding aimed to help achieve a more integrated health system with services connected across many different providers and focused on individual patient needs, with locally led integration initiatives being central to the strategy.

Northern New South Wales Local Health District (LHD) received funding under the Integrated Care Strategy and partnered with North Coast Primary Health Network (PHN) to implement an Integrated Care Program. The LHD and the PHN committed a number of resources to this program, including several advisory groups, a number of 'care navigators' at the Lismore Base and Tweed Hospitals to drive redesign, and a full time Program Manager. In addition, the LHD and the PHN elected to undertake an Integrated Care Collaborative (ICC), based on the APCC's Integrated Care Wave held in Townsville in 2014-2015.

Improvement Foundation (IF) was contracted by the LHD to support the ICC by providing specialist advice, access to existing Collaborative methodology infrastructure, and ongoing support for the duration of the Collaborative program, which commenced in September 2015 and concluded in June 2016.

The objective of the ICC was to encourage and support participating health services across North Coast New South Wales to deliver rapid, measurable, systematic and sustainable improvements in the care they collectively provided to patients. This was to be achieved through the sound understanding and effective application of quality improvement methods and skills.

The ICC focused on improving health outcomes and preventing avoidable hospital admissions for people with complex, long term conditions, with the following aims:

- That 200 or more patients with complex care needs were managed by an Integrated Care Team
- That at the nine-month mark there was a 20% improvement in patients' Quality of Life
- That at the nine-month mark there was a 20% improvement in clinicians' perceived connectedness of the system.

Hospital and community based clinicians from the LHD and clinicians and staff from fifteen primary health care services participated in an orientation session and a series of learning workshops, interspersed with activity periods. During the activity periods, participants applied the workshop learnings to make improvements in their organisations. Improvement required teams to carry out tests of change and measure their impacts. The tests of change were defined and refined using the Model for Improvement (MfI) framework, which enables change ideas to be developed at a local level. The impact of the changes was assessed by analysing the regular data submissions made by participants on the suite of improvement measures established for the program.

Recruitment and Participation

Primary Health Care Services

Recruitment of primary health care services was undertaken by the PHN. A total of 19 primary health care services were initially recruited to the ICC, however 4 of these withdrew their participation. Two general practices withdrew within the first two months of the Collaborative, citing an excessive workload as the reason, and the other two withdrew after the first learning workshop, citing an inability to commit resources to the Collaborative.

The following 15 primary health care services completed the ICC:

Service Type	**Location**
Alstonville Clinic	Alstonville, Richmond Valley
Bullinah Aboriginal Health Service	Ballina, Richmond Valley
Grant Street Clinic	Ballina, Richmond Valley
Bangalow Medical Centre	Bangalow, Tweed Valley
Bulgarr Ngaru Aboriginal Medical Corporation, Richmond Valley	Casino, Richmond Valley
Goonellabah Medical Centre	Goonellabah, Richmond Valley
McKid Medical	Kyogle, Richmond Valley
Lennox Head Medical Centre	Lennox Head, Richmond Valley
Aboriginal Medical Service	Lismore, Richmond Valley
King Street Medical Centre	Murwillumbah, Tweed Valley
Mullumbimby Comprehensive Medical Centre	Mullumbimby, Tweed Valley
Central Pottsville Medical Centre	Pottsville, Tweed Valley
Cornerstone Medical Centre	Tweed Heads, Tweed Valley
Healthwise Medical Centre	Tweed Heads, Tweed Valley
Tweed Health for Everyone Superclinic	Tweed Heads, Tweed Valley

Local Health District Services

Recruitment of hospital and community based clinicians from the LHD was undertaken by the Integrated Care Program (ICP) team as the executive management of the LHD were keen to recruit as many clinicians as possible. Whilst more than 80 clinicians from seven hospital sites and a number of community health centres participated, participants' involvement varied greatly according to their area of work/service and level of access to the Collaborative infrastructure. For example, a number of community nurses attended all three learning workshops, however they did not undertake data or Model for Improvement submissions as they were not provided with access to qiConnect, IF's online web portal.

The seven participating hospitals were as follows:

Hospital	**Region**
Ballina District Hospital	Richmond Valley
Byron District Hospital	Tweed Valley
Casino & District Memorial Hospital	Richmond Valley
Lismore Base Hospital	Richmond Valley
Mullumbimby Hospital	Tweed Valley
Murwillumbah District Hospital	Tweed Valley
The Tweed Hospital	Tweed Valley

Learning Workshops

Learning workshops are designed to provide participants with evidence-based information, the opportunity to share knowledge and experiences with peers, and to build on knowledge gained from previous workshops. Due to the distinct geographic regions serviced by the two participating major hospitals, it was decided to run each of the three learning workshops in 2 regions, thus a total of 6 workshops were held.

Learning workshops 1 were held in November 2015. The content included discussions on the concept of integrated care; the ICC aims, measures and change principles and measuring for improvement. Two ideas factories were held for participants to explore:

- What can be done to build an integrated care team around patients enrolled in the ICC, and
- What can be done better together to look after patients in the participating services / practices.

More than 200 participants attended both workshops and evaluations were received from 106 individuals. 60% of attendees rated the information provided and the opportunity to network as excellent.

Learning workshops 2 were held in February 2016. After a review of progress to date, an expert speaker from the NSW Agency for Clinical Innovation presented on current best practice in integrated care. A number of exemplars from both the primary and acute care sector shared innovative changes they'd made during table top presentations and 2 consumers shared their health care journeys with attendees during the penultimate session. The final session provided teams with time to plan their next steps.

More than 140 participants attended both workshops. Evaluations were received from 87 attendees and of those, 56% rated the information provided as excellent and 61% rated the opportunity to network as excellent.

More than 120 people attended the final learning workshops, which were held in May 2016. The workshops commenced with a presentation on the NSW eHealth strategy by speakers from eHealth NSW. Following this, a facilitated panel discussion with local experts discussed improving patient self-management, with particular reference to health literacy, shared decision making, lifestyle modification and patient advocacy. Prior to a networking dinner, more exemplars presented their innovative collaborations via a table top session. During the dinner, participants were asked to discuss and share answers to the following questions:

- What's worked well in the NNSWICC and what can be improved?
- What 2-3 integrated care strategies will you continue with/implement after this workshop?

Evaluations were received from 60 participants, 45% of whom rated the information provided as excellent and 64% of whom rated the opportunity to network as excellent.

Participants who attended all 3 workshops rated the networking opportunities, the table top presentations and the consumer interviews most highly.

Activity Periods

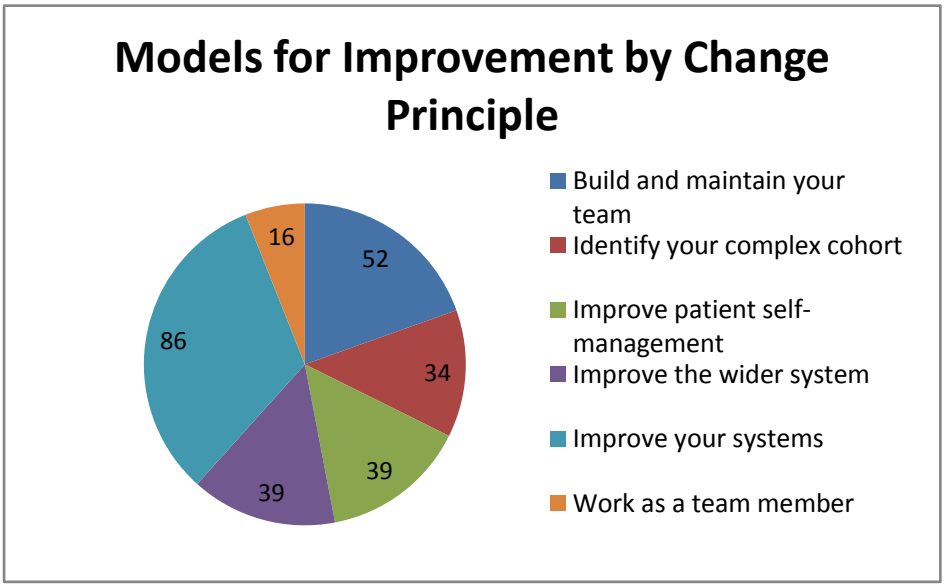
During activity periods, participants apply what they have learned from exemplars and expert speakers at the learning workshops. Ideas for improvement are tested and reviewed using the MfI and success is tracked through monthly submission of data relating to the suite of improvement measures selected for the ICC. Use of the MfI is aligned to Change Principles that guide participants through the Collaborative intervention. Change Principles are selected by an expert group with the aim of distilling the key changes that are likely to lead to innovations in a topic area into a structure that can be used by health services to make changes at a local level. The ICC change principles were:

- Build and maintain your team
- Identify your complex cohort
- Improve your own systems
- Work as a team member
- Improve patient self-management
- Improve the wider system

Model for Improvement Submissions

A total of 266 MfI cycles were submitted during the course of the ICC. Analysis of the proportion of MfI cycles submitted by Change Principle indicates that the majority of changes tested related to the Foundation and early Change Principles (see Figure 1). The largest number, 86 (32% of the total), were submitted under Change Principle 2: Improve your systems, and 52 (19% of the total) were submitted under the Foundation Change Principle: Build and maintain your team. The smallest number, 16 (6% of the total), were submitted under Change Principle 3: Work as a team member.

Figure 1: Total number of Models for Improvement cycles submitted in the Northern NSW Integrated Care Collaborative



The majority of MfI cycles, 189 (71% of the total), were submitted by clinicians and staff from the fifteen participating primary health care services. The remaining 77 (29% of the total) were submitted by hospital and community based clinicians from the LHD. The highest number of MfI cycles was submitted by Alstonville Clinic (25) with staff and clinicians from the LHD submitting 24 MFI cycles.

The most common, and often the most successful, MfI cycles submitted related to the building of relationships between health care providers working in different areas of the health care sector. This improvement occured though activities such as multidisciplinary meetings and the streamlining of processes and/or documents, including referral pathways. A more detailed analysis of MfI cycles may be found in a separate report.

Results

As mentioned earlier, the ICC aims were:

- That 200 or more patients with complex care needs were managed by an Integrated Care Team
- That at the nine-month mark there was a 20% improvement in patients' Quality of Life
- That at the nine-month mark there was a 20% improvement in clinicians' perceived connectedness of the system.

Progress towards meeting the aims, as well as the impact of the changes undertaken at the service level, was assessed by analysing the regular data submissions provided by participants on the suite of improvement measures established for the program. Measures for the ICC were selected by an Expert Reference Panel. An Expert Reference Panel consists of subject-matter experts (including those with research expertise) and application experts who have applied practical improvements in integrated care.

Data was submitted by the LHD and the primary health care services as well as patients and clinicians. Separate measures were established for the primary health care services and the LHD and specific measures were created for patients and clinicians. The following sections discuss the data that were submitted and the improvements that were observed.

Primary Health Care Service and Local Health District Measures

The selected measures were as follows:

Primary Care Health Services

- Number of patients enrolled on the complex care needs register
- Percentage of enrolled patients for whom a GP Management Plan (GPMP) and/or Team Care Arrangement (TCA) has been created or reviewed within the previous 6 months
- Percentage of enrolled patients with an Advance Care Directive in place
- Percentage of complex care needs register patients with a Shared Health Summary (SHS) uploaded (to the PCEHR/My Health Record) updated within the previous 6 months

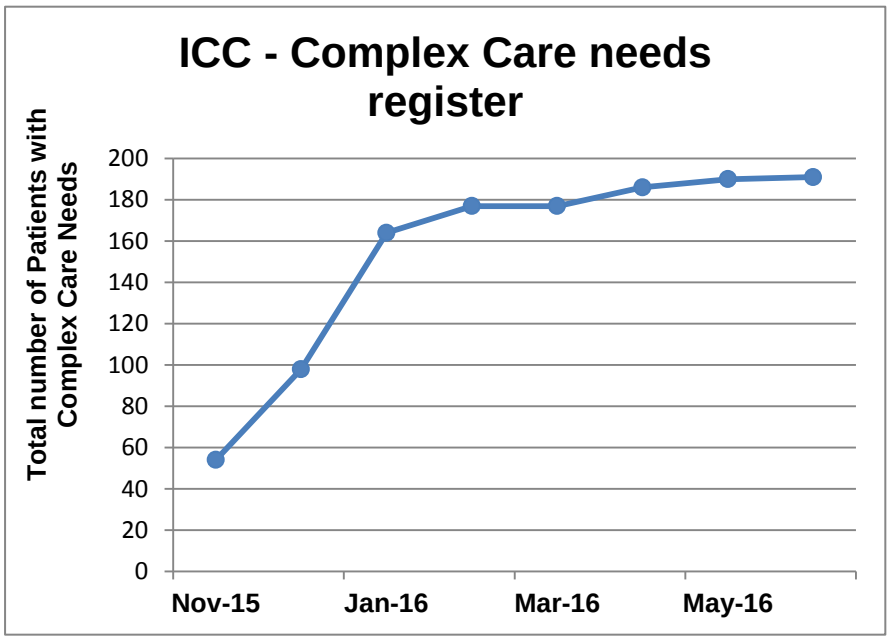
Local Health District

- Percentage of enrolled patients who present at the Emergency Department in the previous month
- Average number of the Emergency Department presentations per total number of enrolled patients presenting to the Emergency Department in the previous month
- Percentage of enrolled patients who have an unplanned admission to hospital in the previous month

- Average number of occupied bed days for unplanned admissions for admitted enrolled patients in the previous month
- Percentage of enrolled patients who have unplanned re-admissions to hospital in the previous month
- Percentage of admissions of enrolled patients in which the GP is notified at the time of their admission to hospital
- Percentage of discharges of enrolled patients in which a discharge summary sent to their usual GP within 48 hours post-discharge
- Percentage of enrolled patients with a Discharge Summary uploaded (to the PCEHR/My Health Record)
- Average number of Shared Health Summary views for enrolled patients

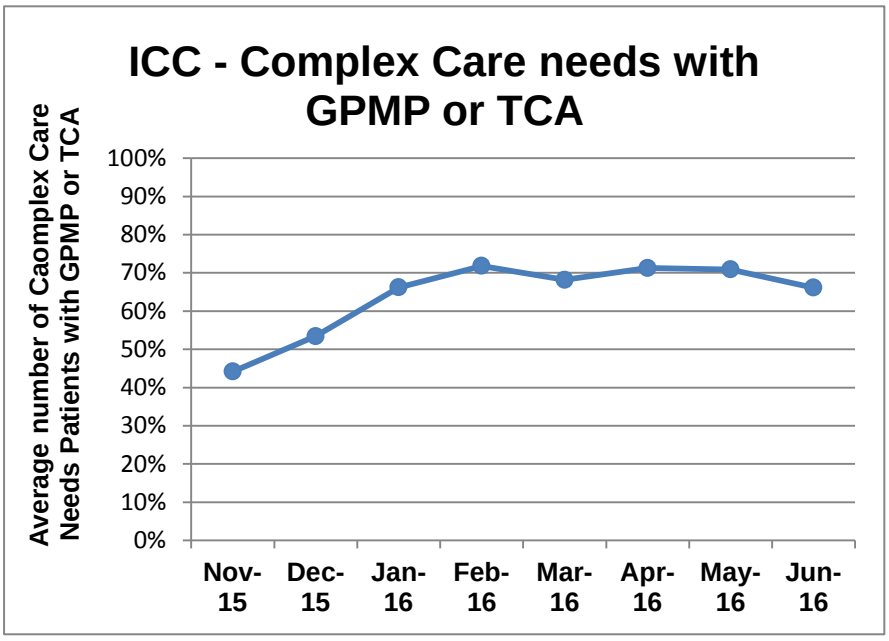
Primary Health Care Service Data

Figure 1: Number of patients enrolled on the complex care needs register



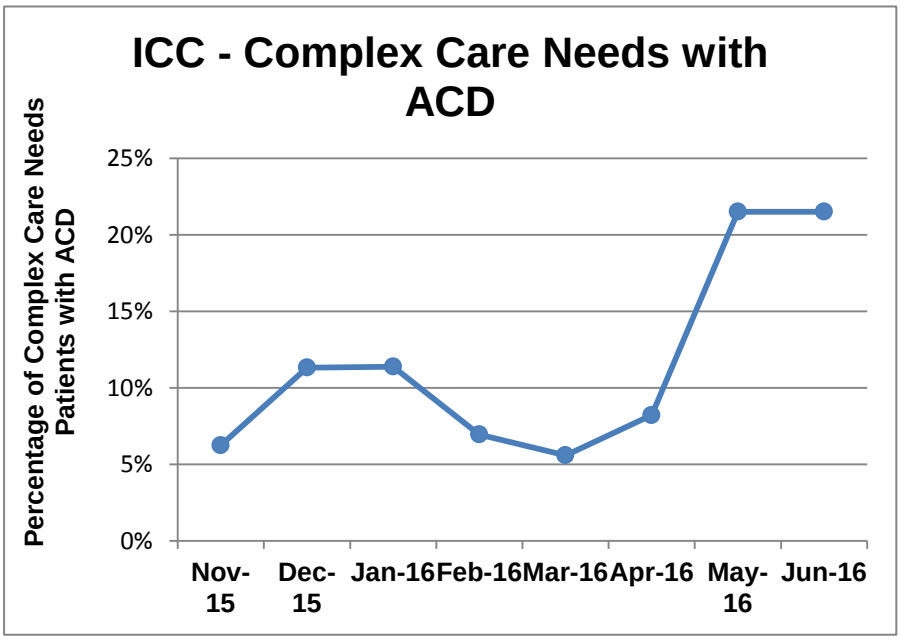
A total of 205 patients were registered over the duration of the ICC, however two primary health care services did not submit data for this measure and 11 patients either withdrew from participation and/or died. At the conclusion of the ICC, there was a total of 191 registered patients.

Figure 2: Proportion of enrolled patients for whom a GP Management Plan (GPMP) and/or Team Care Arrangement (TCA) has been created or reviewed within the previous 6 months



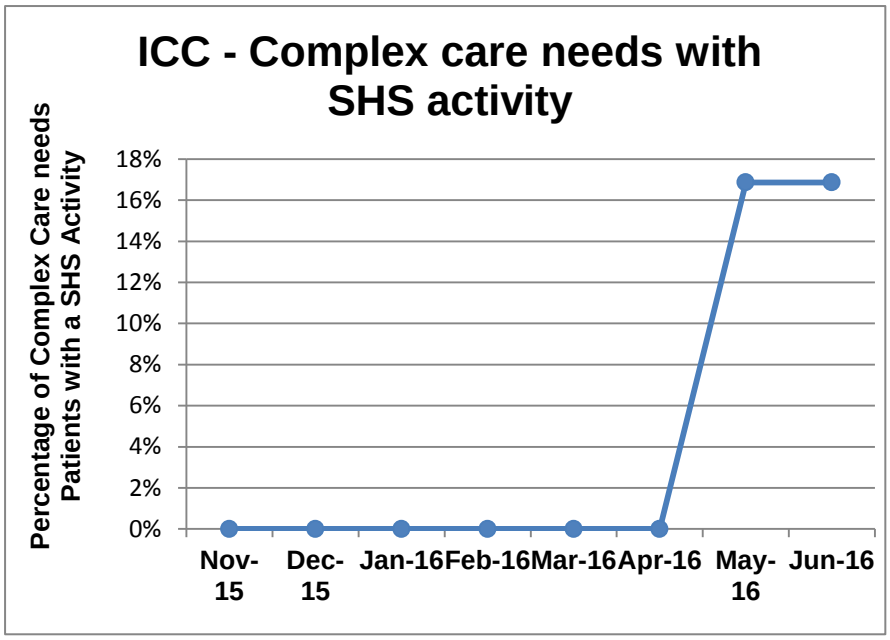
The proportion of ICC patients with GPMPs and/or TCAs increased over the course of the ICC, from 44% to 66%, however this was offset by an increase in the denominator. Small decreases were observed in March and June due to a decrease in the proportion of primary health care services who submitted data for this measure.

Figure 3: Proportion of enrolled patients with an Advance Care Directive in place



The proportion of ICC patients with Advance Care Directives (ACDs) increased from 6% to 22% over the 8 month period of the ICC. The increase in May was due to a concerted effort by two general practices to ensure as many of their ICC patients as possible had an ACD. The dips in February, March and April were due to lack of data submissions.

Figure 4: Proportion of complex care needs register patients with a Shared Health Summary (SHS) uploaded (to the PCEHR/My Health Record) updated within the previous 6 months



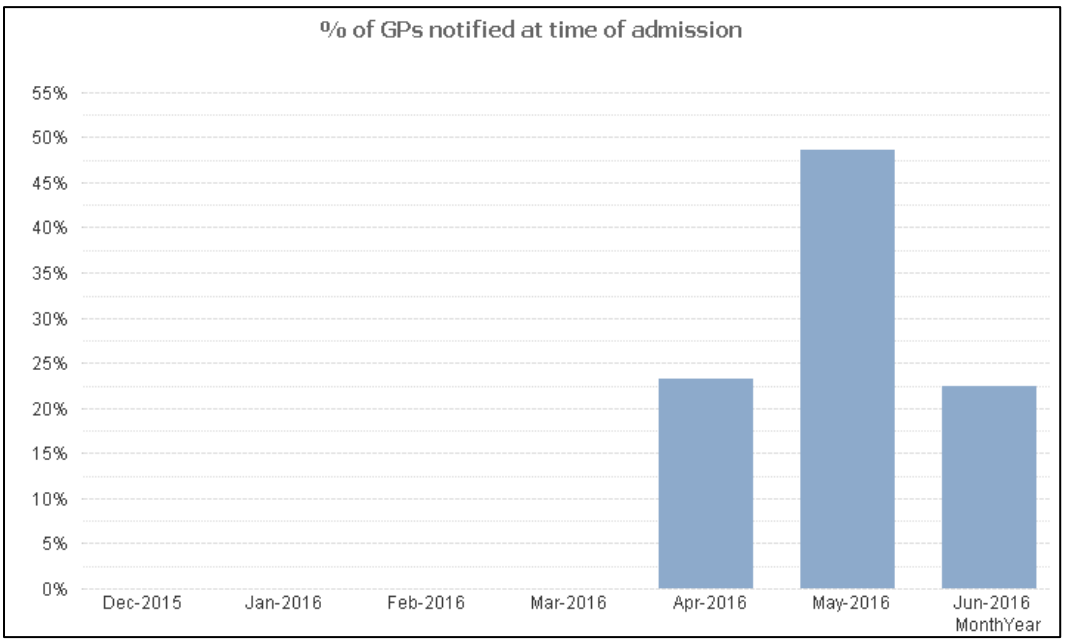
Little improvement was seen in the uploading of Shared Health Summaries (SHS) to the My Health Record until May when four general practices markedly increased the proportion of ICC patients with SHS activity. At the conclusion of the ICC, almost 17% of patients had a SHS uploaded.

Local Health District Data

Significant technical and system issues were barriers to the LHD from accessing and uploading data relating to a number of measures, consequently this section can only discuss the three measures for which data was available.

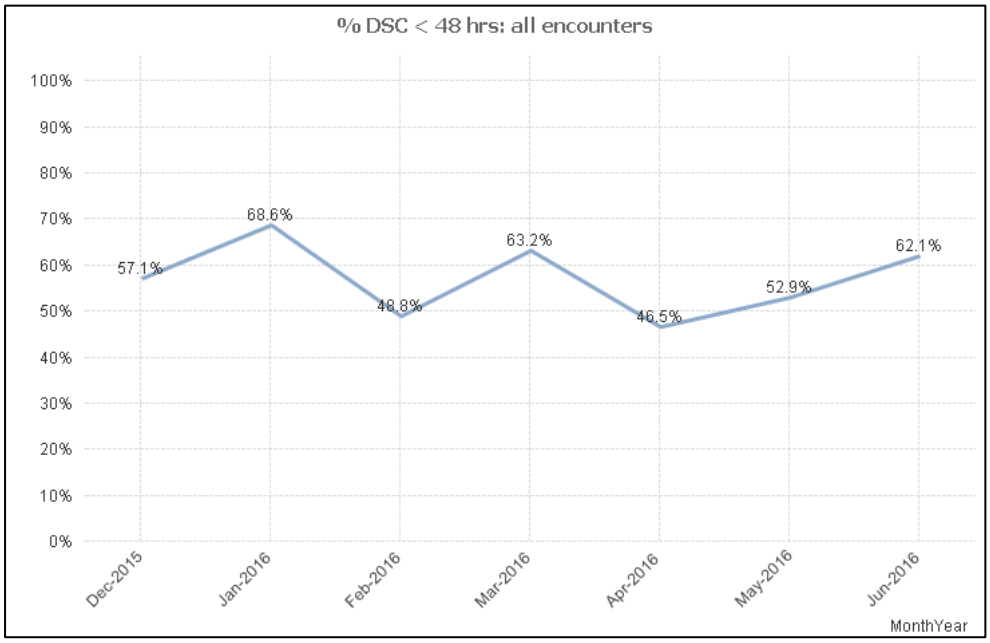
In April 2016, NNSWLHD began a trial of an Admission and Discharge Notification service (ADNs) in which GPs were alerted when their patient(s) had an unexpected admission to an LHD facility. The following three graphs relate to this service.

Figure 5: Admissions of enrolled patients in which the GP is notified at the time of their admission to hospital



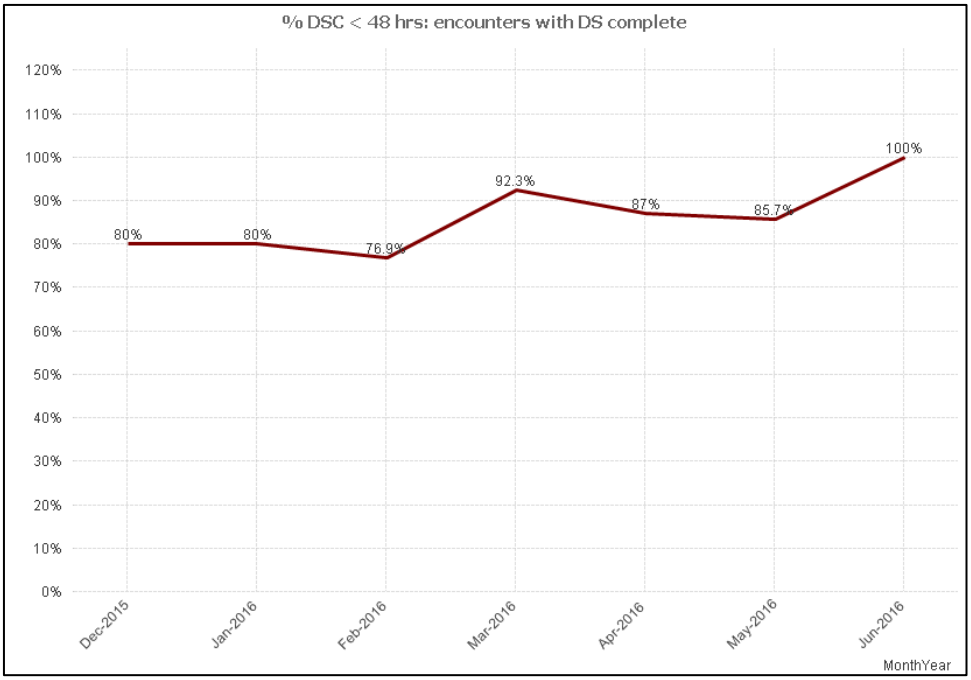
Data for Figure 5 is based on the sum of all admission and discharge notifications, divided by two (one admission and one discharge is assumed per encounter) and divided by all discharges per month. Please note that Admission and Discharge logs do not show the message type so there is no way to determine whether the ADNs are admission notifications, discharge notifications or an equal split.

Figure 6: Discharges of enrolled patients in which a discharge summary was completed within 48 hours post-discharge



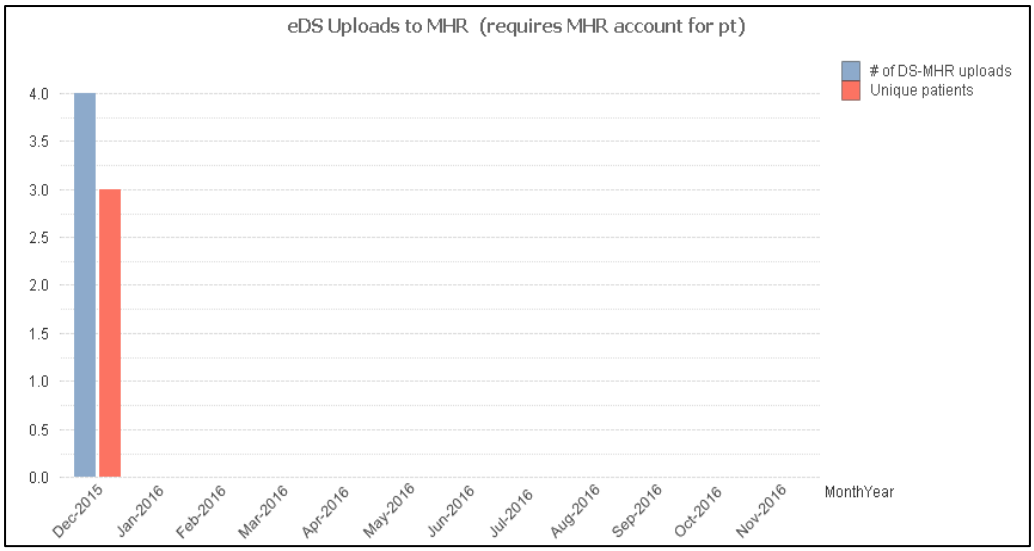
Data for this graph were sourced from monthly reports on the numbers of completed discharge summaries. The variation is due to differing proportions of discharge summaries that were completed each month.

Figure 7: Discharges of enrolled patients in which a completed discharge summary was sent to their usual GP within 48 hours post-discharge



Please note that discharge summaries are sent to the GP nominated by the patient on admission, so the term “usual” cannot be verified.

Figure 8: Percentage of enrolled patients with a Discharge Summary uploaded (to the PCEHR/My Health Record)



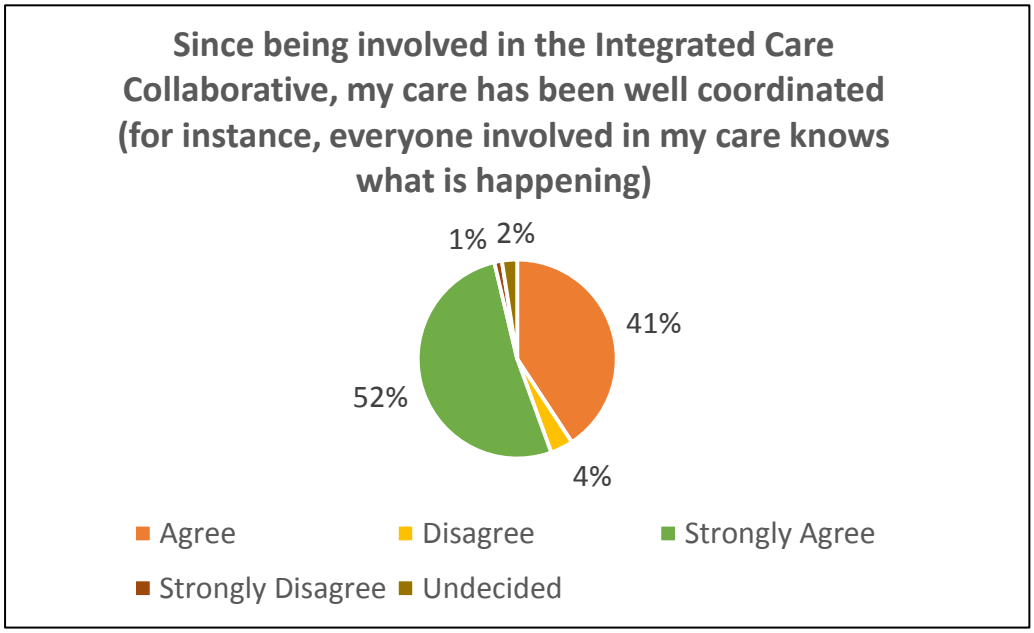
The December 2015 data for this measure was collected manually as there was no infrastructure in place to automate data collection. There were no discharge summary uploads between January and June 2016 due to patients either not having a My Health Record and/or declining to allow the upload of a discharge summary, as well as the infrastructure issue.

Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)

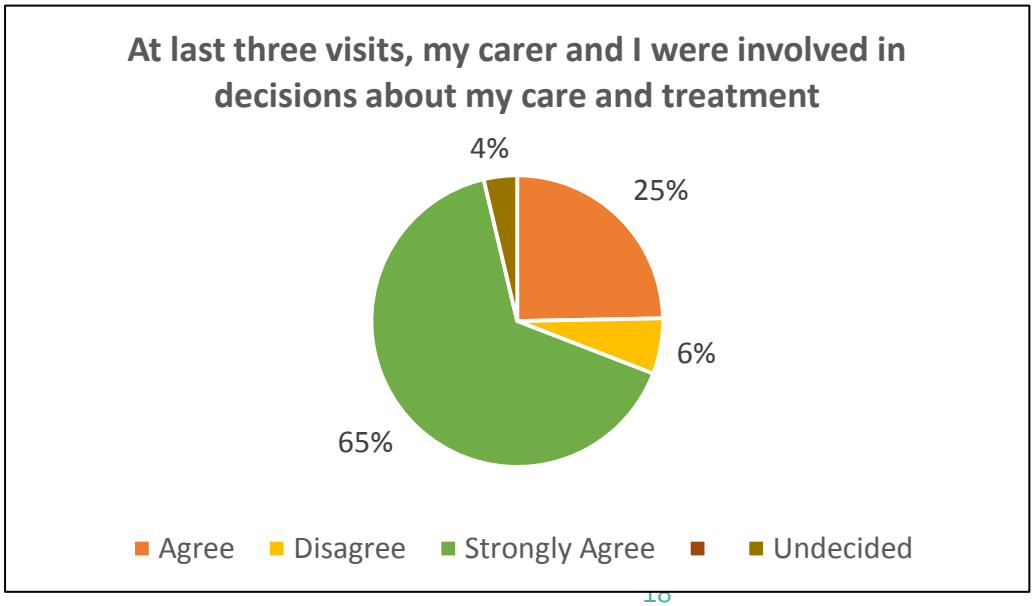
The second ICC aim: "That at the nine-month mark there was a 20% improvement in patients' Quality of Life" was measured via a survey to ascertain improvement from the patient perspective. Patients were asked three questions relating to experience and one relating to outcome and the responses were measured using Likert scales. It was hoped that patients would complete the survey at the beginning and at the conclusion of the ICC, however technical issues prevented this from occurring.

The following summarises the responses received from eighty two patients from nine participating primary health care services. Four of these services are located in the Tweed Valley and five in the Richmond Valley. The responses were received at different times during the course of the ICC.

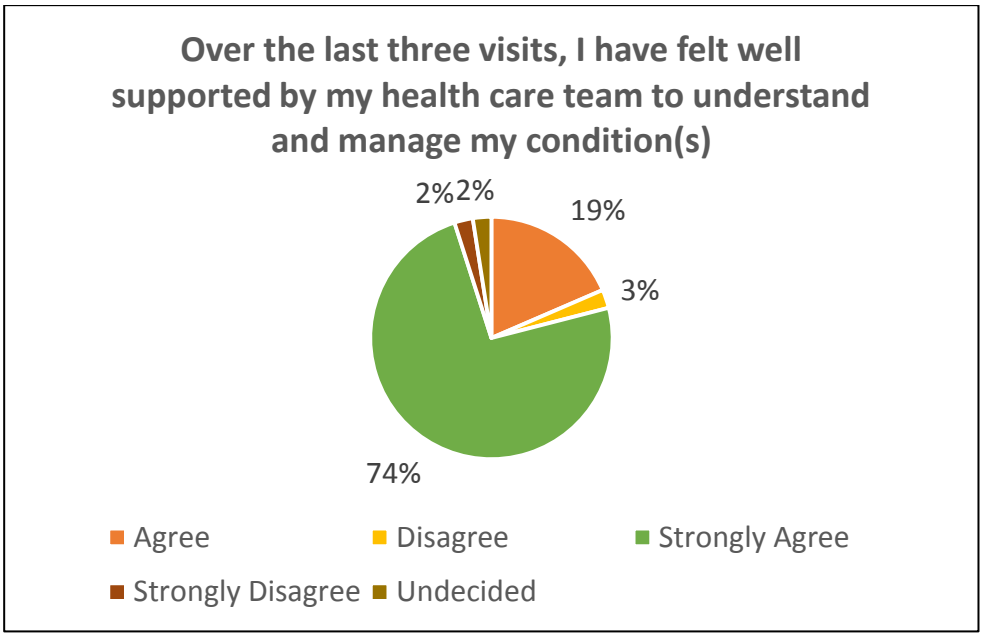
Q.1 Experience Measure



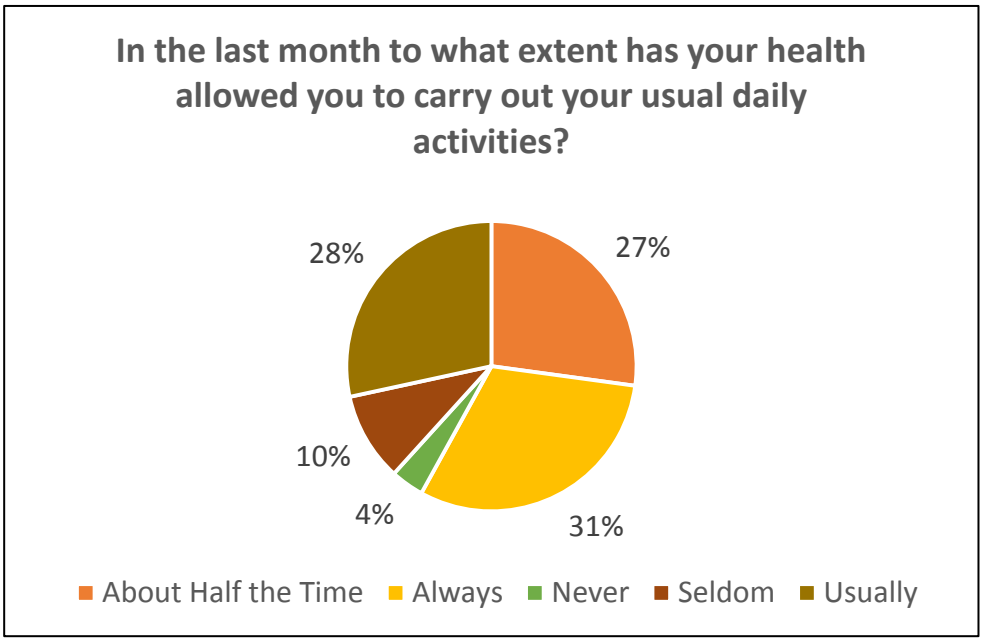
Q.2 Experience Measure



Q.3 Experience Measure



Q.4 Outcome Measure

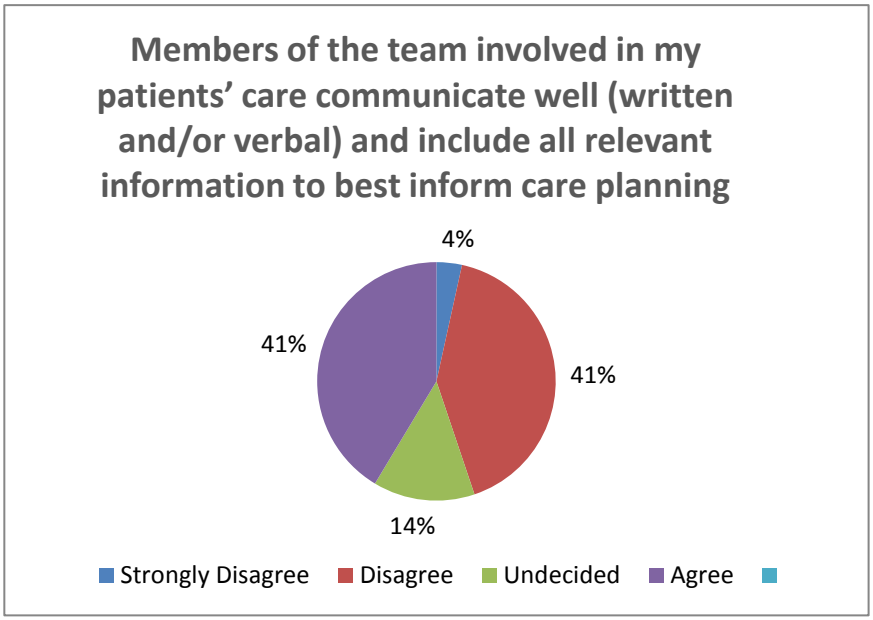


Clinician Reported Measures

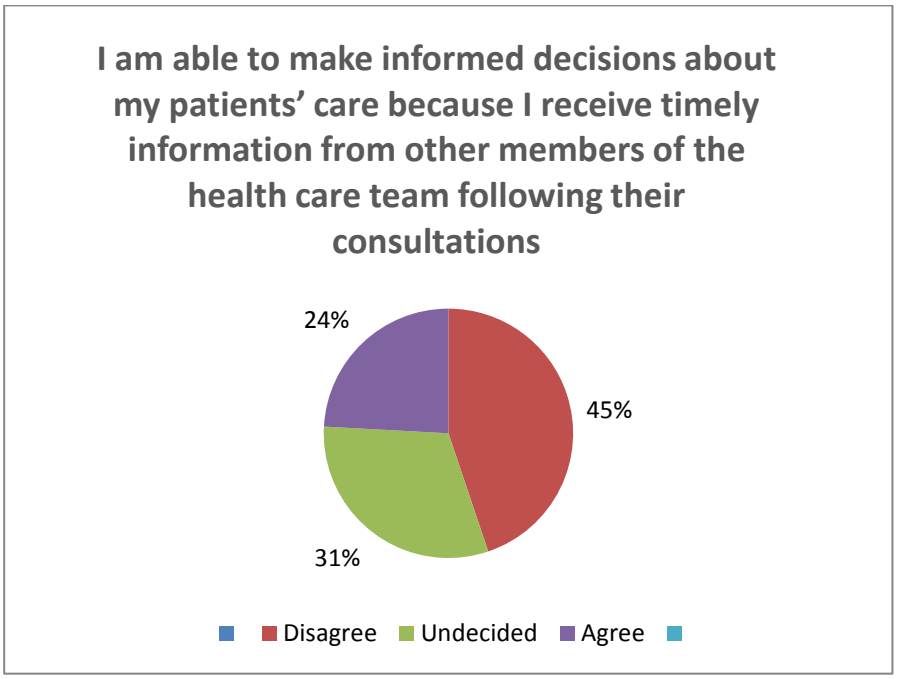
The final ICC aim: “That at the nine-month mark there was a 20% improvement in clinicians’ perceived connectedness of the system” was to be measured via an online survey at the beginning and at the end of the ICC however clinicians provided responses at the start only, thus the responses below are baseline data. The majority of the twenty nine clinicians who completed the survey work in the LHD.

No completion data is available.

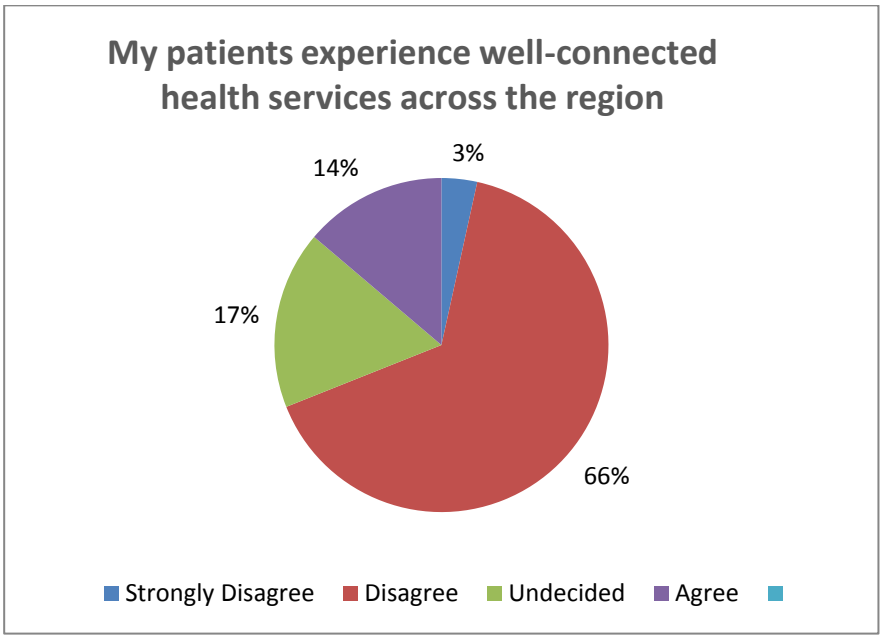
Q.1



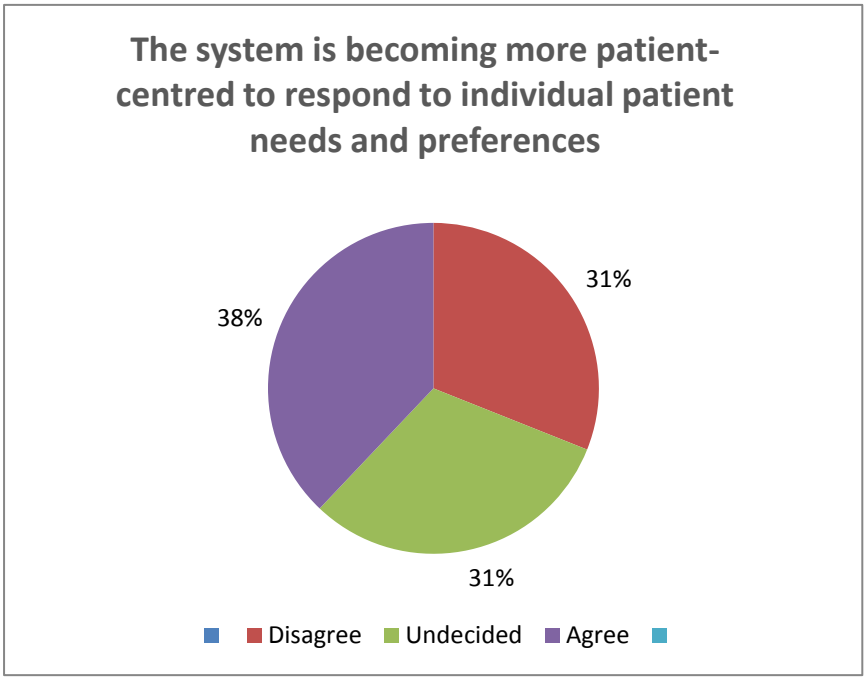
Q.2



Q.3


My patients experience well-connected health services across the region
3%
14%
17%
66%
Strongly Disagree
Disagree
Undecided
Agree

Q.4


The system is becoming more patient-centred to respond to individual patient needs and preferences
31%
38%
31%
Disagree
Undecided
Agree

Successes

The ICC may be considered successful in a number of ways.

The consistent and ongoing Executive Team support from the LHD and the PHN enabled the inclusion of a large number of participants, from the acute care sector in particular, and the ongoing engagement of most of those participants in the learning workshops and in undertaking changes at a local level. Many participants from the acute care sector had never felt empowered to trial changes within their service/area of work and participation in the ICC enabled this for the first time. This led to a high level of enthusiasm and innovation from clinicians and staff.

As mentioned previously, the strengthening of relationships was observed throughout the ICC. An example of this was the establishment of a series of meetings between staff and clinicians from The Tweed Hospital, one of the participating primary health care services and a support staff member from the PHN. These meetings were designed to encourage the formation of a multi-service, multidisciplinary team; to collectively identify communication gaps and to support enhanced information sharing related to patient care. One outcome of this collaboration involved the creation of a medication profile for all ICC inpatients prior to discharge from hospital in order to improve patient safety.

A number of successful initiatives centred on enhancing communication to support these growing relationships. Some examples of this include:

- A GP survey on the format and utility of the information in the discharge summaries and amendments made accordingly. Following this, a successful trial of an Admissions and Discharge Notification Service commenced, in which GPs were alerted when their patient(s) had an unexpected admission to an LHD facility.
- The provision of GPs' mobile phone numbers to the local community health service to enable community nurses to contact GPs during home visits to discuss the need for an appointment with the GP and/or strategies for hospital avoidance.
- The ICP and PHN support teams created a dedicated ICC newsletter to keep all participants informed of upcoming events, to provide feedback on progress and to share the learnings and successes with all stakeholders and any interested parties.

Executive and support staff from the PHN and the LHD, as well as a number of ICC participants, were asked to comment on the best thing about the ICC and the answers were as follows:

- GPs and LHD working together
- People were engaged
- The table top presenters
- A&E contact with primary health care services
- Leadership coming from the PHN and LHD working strongly together
- Consumer presenters at the second learning workshop

- The cultural change of working together
- Collaboration between organisations
- Better success where there was more than one patient with the same diagnosis.

Challenges

There were a number of challenges that impacted on the overall success of the ICC.

Firstly, the online orientation session was considered unsuccessful. It was felt that the online method of delivery was inappropriate as a mechanism to engage and inform participants of their requirements for participating in the ICC. Feedback received on the ICC included the following: “The Orientation Webinars were poor quality and did not build confidence in IF capabilities, or enthusiasm of staff.”

The duration of participant involvement was considered to be too short for successful outcomes to occur. It takes time for individuals and teams to understand the Collaborative method and to apply this learning at a local or service level. In addition, most participants from the LHD were completely unfamiliar with the Collaborative method and did not feel they had adequate information at the start of the ICC. This was compounded by the lack of education and training at the learning workshops, in particular training in the Model for Improvement.

There was confusion regarding team formation following the first learning workshop. Many participants believed that the ‘team’ members were those with whom they were seated. This delayed effective integration and collaboration as these teams did not always share care for the enrolled patients.

There were a number of technical and system issues that delayed the submission of data for some of the measures from the LHD. The ICP team worked hard to address these issues at both a local and a state based level, however the solution to some of these issues was unresolvable in the timeframe. Technical issues also delayed the collection and submission of patient outcome and experience data and the data were received at the conclusion of the ICC only. This precludes analysing the data to ascertain improvements in either patient experience or outcome as no baseline data were received. Feedback provided by members of the support teams also indicated that the questions were inappropriate for specific cohorts, e.g. Aboriginal and Torres Strait Islander peoples, and that the responses were not used to guide clinical management.

Whilst there were no technical issues with the collection of clinician data, only a small number of individuals responded to the clinician survey, and data was received at the start of the ICC only, making it difficult to ascertain any improvement.

The provision of local support to participants is a cornerstone of the Collaborative method. The majority of the ICP and the PHN support staff were unfamiliar with the Collaborative method and some of the PHN support staff were employed after the ICC commenced. This reduced the capacity of both teams to guide participants for the duration of the ICC and to provide individualised education and support.

Lessons Learned and Recommendations

As discussed in 'Successes', executive support from the PHN and the LHD was instrumental in engaging and supporting participants throughout the ICC and is to be commended. The sharing of ideas via the table top presentations was well received as it showcased integration in action, gave participants ideas to trial and provided motivation for the activity periods. Engagement of consumers at the second workshop was also considered to be very valuable.

An ICC evaluation meeting was held in July 2016 with executives from the PHN and the LHD, one of the Wave Chairs, one of NCPHN's GP advisors, ICC participants, representatives from the ICP and the PHN support teams and representatives from IF. The following list of recommendations has been collated from the meeting minutes and feedback received from other stakeholders.

1. Future ICC Waves to be 12 months duration to enable participants to understand the Collaborative method; to have adequate time for primary health care services to recruit patients; to ensure sufficient time for participants to trial changes before implementing them and for the support teams to have sufficient data to analyse trends and identify successes and exemplars.
2. Participant recruitment requires the creation of messages highlighting the need for change, supporting why involvement is positive and these messages should be used consistently. Involvement from a GP in message creation is important, e.g. the use of a testimonial from a GP who participated in the ICC. There is a need to develop some marketing resources on what integrated care is; the Collaborative method; the workshop content and focus; the expectations of participating and how participants will be supported by teams from the LHD and the PHN. In addition, an online information session should be provided to interested parties.
3. Local engagement meetings should be held in the region in which the Wave will be held in order to understand local needs and priorities; as a method of engagement and to generate interest in participating.
4. Over-recruiting would be a good way to reduce the impact of withdrawals.
5. Future ICC Waves should have four face-to-face workshops including the Orientation. Training in the Model for Improvement should be included in the curriculum.
6. Patient selection criteria should be reviewed to consider which patients would benefit most from being enrolled. It was suggested that patients who present at A&E may be a more appropriate cohort than those at risk of hospitalisation.
7. The patient consent process needs to be reviewed and the process of enrolment made easier. It was suggested that it would be preferable to avoid the consent and enrolment if possible.
8. To ensure appropriate team formation, patients who are enrolled in the future ICC Waves should be consulted as to who they believe their care team is.
9. To support team formation and collaboration, an activity such as the mapping of individual patient journeys should be considered.
10. The PROMs and PREMs questions need to be reviewed to ensure they are culturally appropriate and reflect the health literacy status of the cohort. Collection of the data should be paper based and should be used to inform clinical management.

11. Clinicians need to be supported to respond to the measures survey. Time may be allocated at the first and last workshops to encourage survey completion.
12. The roles and responsibilities of the teams from the LHD, PHN and IF needs to be scoped and clarified to reduce duplication. It was noted that collaboration between the teams ensures successful workshops.
13. Data collection and submission processes need to be reviewed to ensure that they are easy. The ICC measures should only include data that are collectable from the LHD and from the primary care sector.
14. In the primary care sector, teams need participants to be actively involved in the activity periods as well as at the learning workshops, particularly GPs, and a contingency plan for the absence of team members when on leave should be created.
15. Participants require active assistance from the support teams in order to maintain and encourage ongoing activity and momentum. To ensure successful delivery of support, ICP and PHN teams require education in the Collaborative method and an education event(s) should be included in program plans.

Glossary of Terms

Term/Acronym	Meaning
A&E	Accident and Emergency
ADNs	Admission and Discharge Notification service
ACD	Advance Care Directive
Change Principle(s)	A pathway that Collaborative participants can follow to guide improvements in a topic area
Collaborative	A specific method of quality improvement used to distribute and adapt existing knowledge to multiple groups to achieve a common aim
ED	Emergency Department
GP	General Practitioner
GPMP	GP Management Plan
ICC	Integrated Care Collaborative
ICP	Integrated Care Program
IF	Improvement Foundation
LHD	Northern NSW Local Health District
MfI	Model for Improvement
PHN	North Coast PHN
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
Primary health care services	Includes general practices and Aboriginal Medical/Health Services
SHS	Shared Health Summary
TCA	Team Care Arrangement
Wave	One iteration of a Collaborative
Wave Chair	A clinician who provides clinical oversight of the Collaborative and supports participants