Inner West Sydney

Healthy Homes and Neighbourhoods

Healthy Homes
and neighbourhoods

Posters and Oral presentations, Utrecht, Netherlands, 2018

An interagency collaboration for children, young people and their families

Auspiced by Sydney Local Health District

NSW GOVERNMENT Health
Sydney
Local Health District

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The Healthy Homes and Neighbourhoods Integrated Care Initiative

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Background and Aims

Healthy Homes and Neighbourhoods (HHAN) is a long-term, cross-agency integrated care initiative supporting vulnerable families with complex health and social care needs. It is intended to benefit adult family members through better management of their complex health and social conditions, resulting in improved health, independence and quality of life, and therefore improved safety, health and wellbeing of their children.

The success of the initiative will require multiple agencies working to make maximum use of available government and societal resources, with long-term sustained cross-agency care coordination, involving significant system redesign and commitment from partner organisations.

Justification of the program

1. Trans-generational disadvantage and trauma
2. Complexity of families
3. Interventions usually of a short duration
4. Barriers to cross-agency collaboration
5. Barriers to care being “wrapped around” the family
6. Lack of coordination
7. Needs of adult family members often not followed up

Methods

HHAN has nine key components, implemented over a period of years targeted at:

1. Identification of vulnerable families
2. Healthy Homes care coordination
3. Evidence-informed interventions
4. General Practice engagement, linkage and support
5. Family health improvement
6. Healthy Neighbourhoods place-based support
7. Interagency system change and planning
8. Monitoring of individual and family outcomes
9. Evaluation

Key Features

- Multiple core and non-core a**gencies working together over a sustained period of time** (i.e. 5 years) with families with complex health and social needs.
- **All the needs of families are in scope** for the intervention, including housing, employment, income support and legal advice.
- An **early intervention and public health approach** to breaking cycles of family disadvantage, poor health and psychological trauma.
- **A focus on efficiency** through the maximum use of, and leverage from, existing family, societal and government resources, including Medicare funded services.
- Use of **evidence-informed integrated care methods** by service partners, including family case conferencing, and ‘wrap-around’ care delivery.
- Encouraging families to have a **‘health home’** for all their health needs and supporting them to move from dependency to independence.
- **Supporting general practice** providers to care for families that are often seen to be ‘too difficult’.
- Development and implementation of **shared assessment tools and referral criteria.**
- Implementation of **family assessment and engagement tools** that can be used over the long-term to monitor the health and wellbeing of family members

Figure 2: Areas in scope for Healthy Homes and Neighbourhoods

Results

The evaluation framework for HHAN seeks to review the impact of the initiative at the micro-, meso- and macro- levels. Intended outcomes include:

- Establishment of a multi-agency HHAN network that fosters collaboration and communication with shared planning, commissioning and evaluation of initiatives
- Improved health, independence and quality of life for families
- Increased engagement
- Reduced need for intensive, crisis-oriented support and greater use of universal services
- Reduced impact of adult complex health conditions on the safety, health and wellbeing of children
- Sustainable models of care
- Skilled and well-supported general practice “health homes”
- Cultivation of leadership and empowerment for front-line clinicians
- Better returns on health investments via co-ordination of interventions

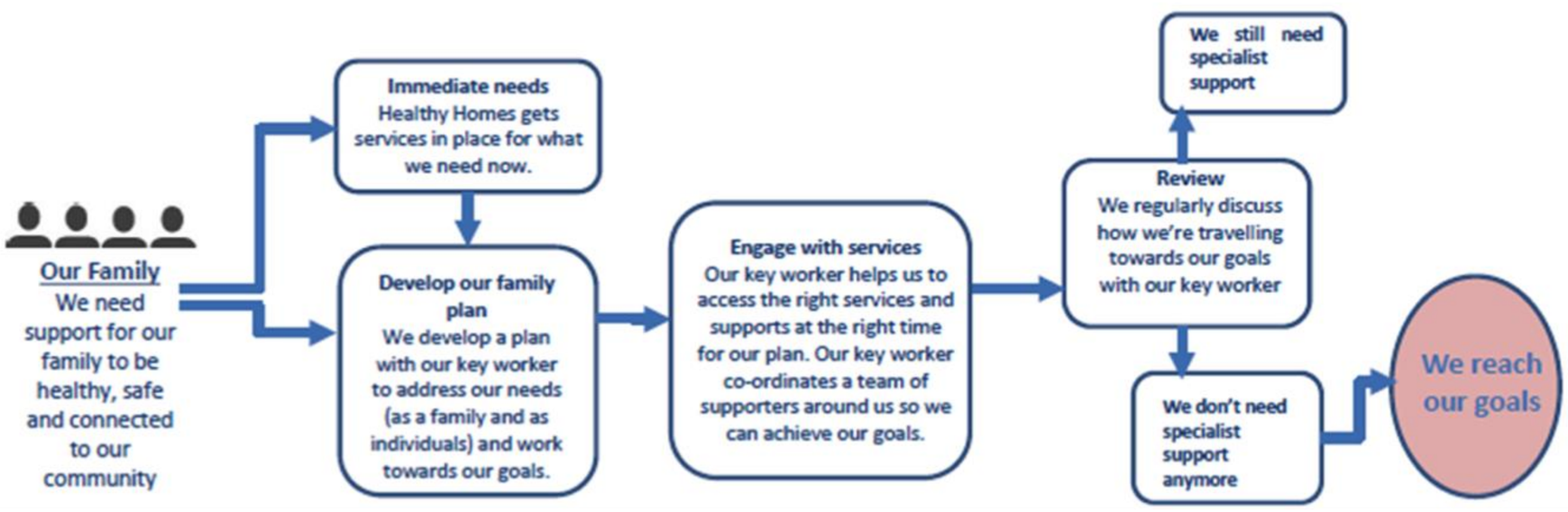

Figure 2: How Healthy Homes and Neighbourhoods provides care coordination

Geospatial Analysis of Family Stress in Sydney Local Health District (SLHD)

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Background

Disadvantage is a complex concept that incorporates a range of interrelated financial, social, cultural and political factors. As the number and diversity of indicators of disadvantage increase in specific geographic areas, disadvantage often becomes more entrenched and persists over time.

Spatial epidemiology is aimed at identifying patterns in the geographical distribution of health data and may detect irregularities such as spatial clusters of a disease or disadvantage.

This project took a spatial epidemiology approach to identifying the geographical distribution of the "most vulnerable" families with intergenerational cycles of disadvantage and trauma in Sydney LHD by:

- Identifying individual indicators of disadvantage and mapping them within SLHD
- Identifying clusters of disadvantage
- Analysing potential pockets or "hot spots" of extreme or complex disadvantage via layered analysis of individual indicators of disadvantage

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Methods

Data was collected at the Statistical Area (SA1) level from the multiple sources including the 2011 ABS census and a SLHD Maternal and Child Health Linked Dataset Collection.

Rates of key indicators were calculated for statistical areas within the Sydney Local Health District and mapped using ArcGIS software; cluster analysis on the distribution of relative rates of these indicators of disadvantage was done and analyses of hotspots carried out using the hotspot analysis tool in ArcGIS. A final score was calculated for individual statistical areas based on the frequency of its occurrence in a hotspot of disadvantage and these scores mapped for the district.

2011 ABS Census	SLHD Clinical Data (Midwives data)
1. High proportion of the population identifying as Aboriginal or Torres Strait Islander 2. Low rates of year 12 attainment 3. Low median weekly household income 4. High proportion of people reporting speaking English not well or not at all 5. High proportion of people requiring assistance with activities of daily living (disability) 6. High proportion of one-parent families 7. Large proportion of households with no access to a car 8. Large proportion of housing consisting of state housing 9. Large proportion of households with no internet access 10. High rates of unemployment 11. Low labour force participation rates	1. High rates of teen mothers 2. High rates of pregnant women without partners (sole mothers) 3. High rates of smoking during pregnancy 4. High rates pregnant women with a high antenatal Edinburgh depression score (≥10) 5. High rates of pregnant women reporting domestic violence (have either been hit or hurt by their partner, or report being frightened of their partner) 6. High rates of pregnant women reporting a history of child abuse 7. High rates of families known to Family and Community Services 8. High rates of pregnant women who have other children in out-of-home care 9. High rates of women who report consuming alcohol during pregnancy 10. High rates of LBW infants 11. High rates of pregnant women with delayed antenatal care (first visit at ≥20 weeks)

Table 1. Indicators included in the analysis

Results

A single map encompassing multiple indicators was produced, as well as maps describing the geographical distribution of individual indicators of disadvantage within Sydney Local Health District. This allowed for analysis of pockets of multi-layer disadvantage

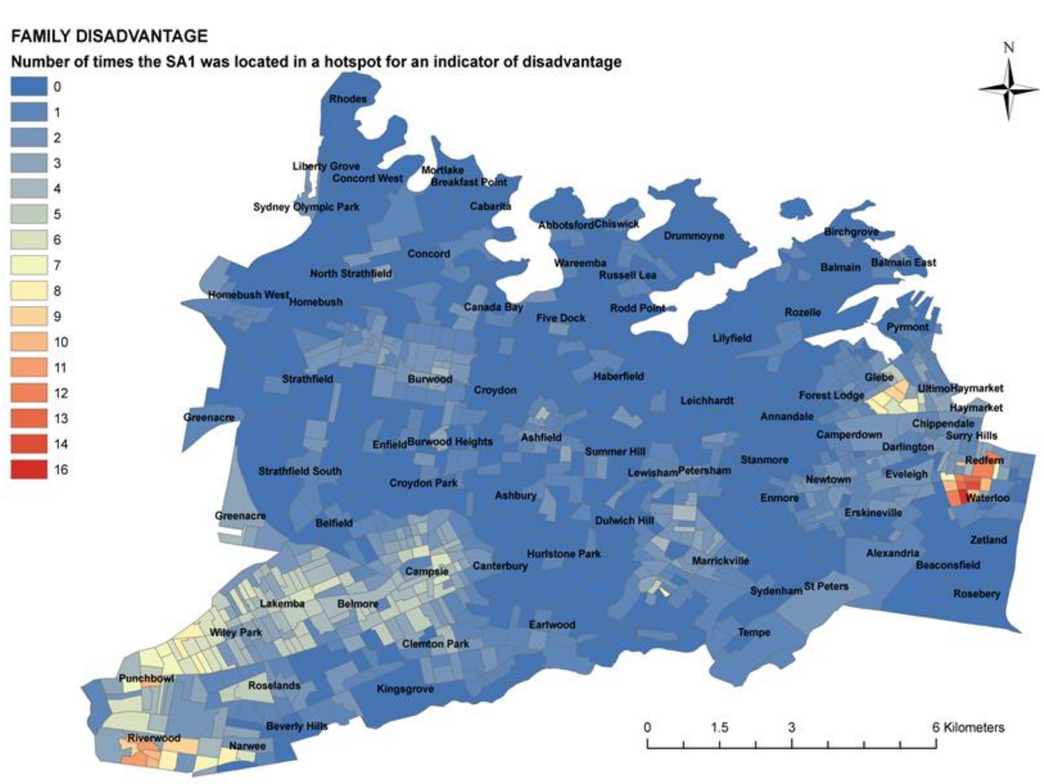

Figure 1: Number of times an indicator of family stress was located in a small statistical area (SA1)

Conclusions

Addressing problems of entrenched disadvantage is a complex issue, however targeting particular locations and designing evidence-based place-based approaches has considerable potential to help improve outcomes for people experiencing multiple and inter-related forms of disadvantage.

Discussion

The analysis of indicators of family stress was a powerful tool for describing family needs to community and partner stakeholders. The analysis has been successful in generating interagency support for disadvantaged communities.

The analysis was only able to use family stress data collected from maternity and community health electronic records and the most recent census. The focus was on the experiences of mothers. The experiences of fathers was absent from the data.

Spatial latent class analysis will assist in determining if there are other groups with different characteristics.

Qualitative exploration of enablers and barriers to interagency collaboration from the perspectives of senior managers and executive staff including social network analysis

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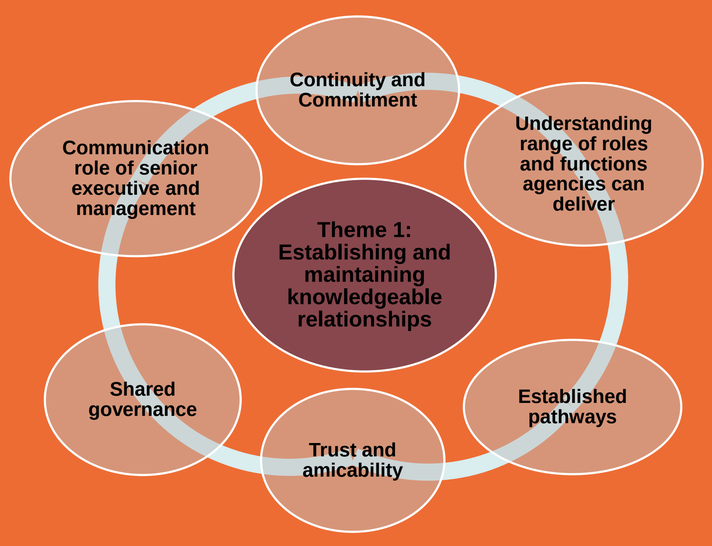
Background

The Sydney Local Health District (SLHD) integrated care initiative, Healthy Homes and Neighbourhoods (HHAN), is a comprehensive population based integrated care strategy to address the complex needs of vulnerable families based in Sydney, Australia. The spectrum of care required to optimise the health and social care outcomes for these families well exceeds the capacity of the public healthcare system alone. Needs such as housing, finance, and social supports often preclude these families from addressing physical and mental health issues[1]. As part of the evaluation of HHAN, this project seeks to understand the experiences of senior managers and executive staff with interagency collaboration from across the network.

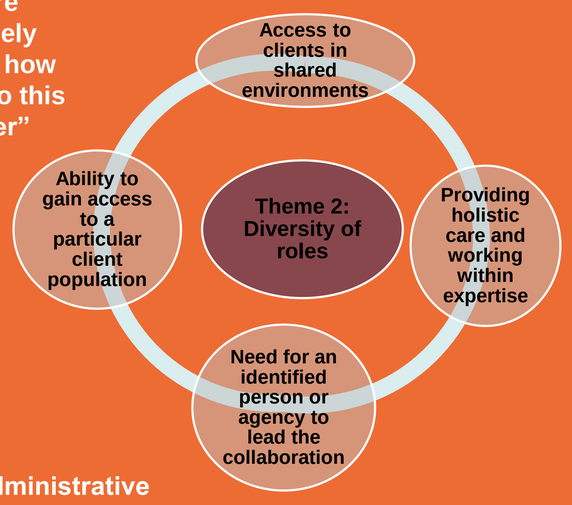


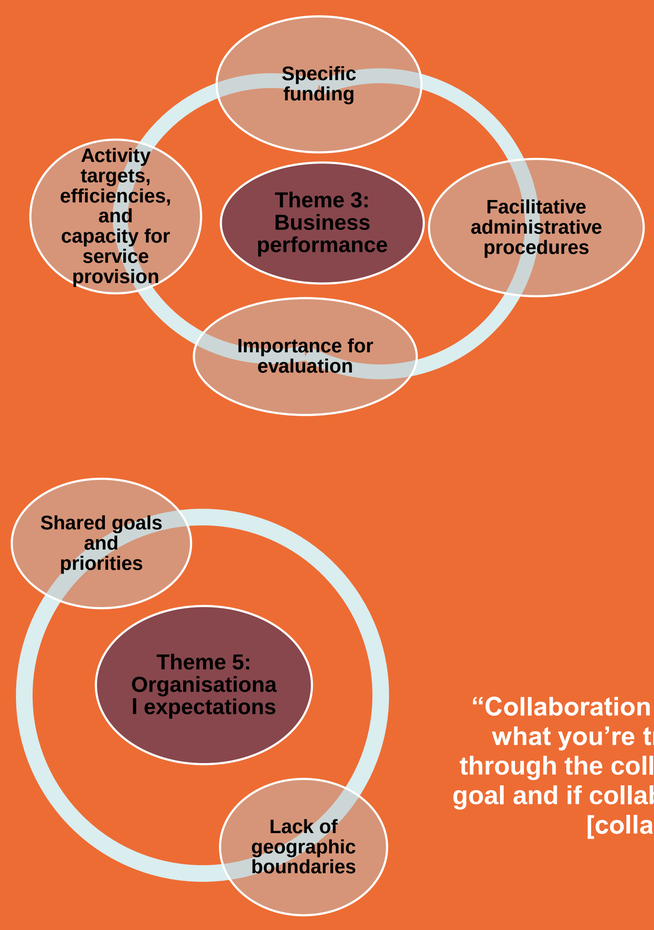
"The first step is to get the right policies in place and the right approach"

"One of the reasons why service partnerships start to dwindle, is when an evaluation is not clearly part of the process…It is not quite as easy as it seems, the evaluation"

"It is making a difference in the way that we're all thinking now. We are genuinely thinking how can we do this smarter"

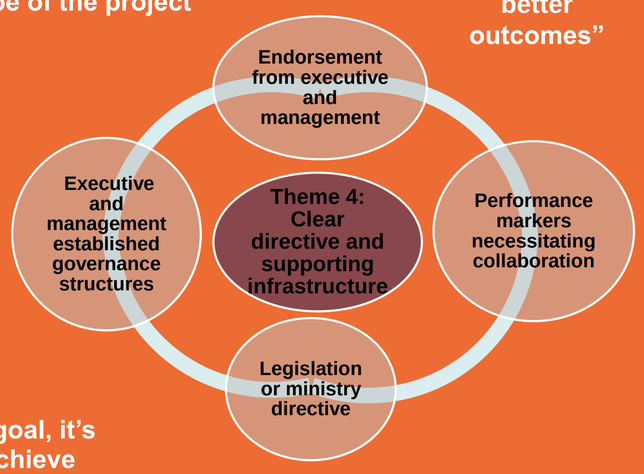
"You wouldn't choose to [collaborate] unless there was some value [to be added] … maybe bringing research skills or they may be bringing access to a particular population or cultural expertise or you know a myriad of things that we can't do alone"





"I think administrative process and, and administrative efficiency is incredibly important and matching the degree of paperwork to the scope of the project"

"It means more efficient, more effective collaboration. It means achieving better outcomes"



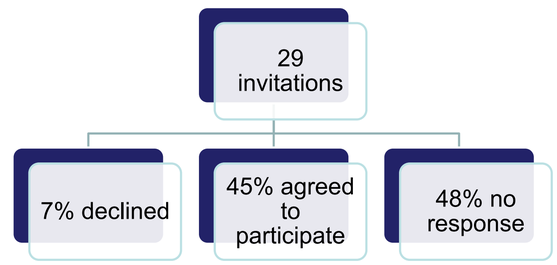
"Collaboration isn't the goal, it's what you're trying to achieve through the collaboration. Set the goal and if collaboration helps then [collaborate]"

Discussion

Thirteen semi-structured, qualitative interviews by a single interviewer occurred followed by a single-coder thematic analysis, in consultation with the research team.

The majority of participants expressed a continuum on which they viewed interagency collaborations to be able to occur, depending on what was trying to be achieved. Achieving efficient, knowledgeable referrals (with single client focus) between agencies, whether government or non-government, was the most basic and common type of collaboration being aspired to. Collaboration could also include working together on shared projects and strategic planning to advance population health initiatives.

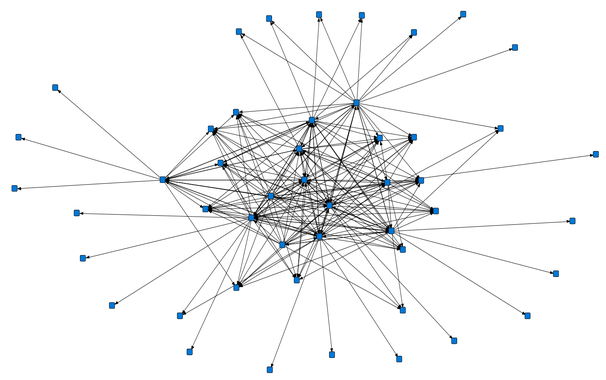
Reviewing enablers and barriers, it became apparent that whether something was being characterised as an enabler or as a barrier was dependent on how the idea was being framed. Therefore, the five themes of enablers which emerged from the data have been presented above, noting responses were often framed from the opposite perspective, in that the negative may be a barrier to collaboration. While features of a grounded theory approach were used, strict adherence to the methodology did not take place nor did complete saturation of themes.



Recruitment took place by purposive sampling. Agencies which HHAN considers partners or potential partners were identified and an appropriate informant from within each agency was selected. An agency for the purpose of this project could be within a broader organisation.

Interviews and social network analysis data collection took place between October 2017 and February 2018.

Social Network Analysis



Sociogram of the collaborative community network. Dots represent individual agencies or services and lines represent the presence of a referral, information sharing or "other" collaborative relationship.

Social network analysis is a method that can be used to identify and map inter-organisational relationships[6]. Interviewees were asked to complete an online survey in which they nominated other community agencies and organisations with which they collaborated by receiving referrals from, sending referrals to, sharing information about clients, and "working together in other ways." Respondents could also nominate other agencies not listed in the survey. Forty-five agencies were nominated as being part of the collaborative community network. There was a central cluster of 19 agencies that worked together most closely. The most interaction in this cluster was between two health agencies.

Current and Future Analysis

Two key pieces of work helped to guide analysis. One is "The Collective Impact Model" by Kania and Kramer[2]. There was notable alignment between the Collective Impact Model and the data collected in interview. Whether this study provides supporting evidence to the work by Kania and Kramer or if it is a reflection of familiarity of their work is not clear, with the model being spontaneously referred to in only one of the interviews. The second is "Working together: intersectoral action for health" by Harris, Wise et al[3], their work is widely known and influential within the HHAN network.

The second phase of analysis will involve a comprehensive literature review to compare these themes to other established models.

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Integrated Care Across Health District Boundaries

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Healthy Homes and neighbourhoods

NSW GOVERNMENT Health Sydney Local Health District

Background

The Healthy Homes and Neighbourhoods (HHAN) Program provides long term care coordination to families with complex health and social needs in the Sydney Local Health District (SLHD). Referral during the antenatal period is the preferred pathway, which ensures complex families have support for themselves and their child, commencing prior to birth. Previous geospatial mapping has identified the Riverwood area as a "hot spot" of family disadvantage, so the program aims to engage families residing in this area.

Actions and Aims

HHAN identifies and engages with vulnerable women and their families living within SLHD, but attending "out of area" health services.

Engagement with health and social care providers across health district boundaries is essential as HHAN aims to ensure vulnerable women and their families are not "falling through the cracks".

Through attendance at SLHD perinatal psychosocial case discussion meetings (SAFE START), it was noted that pregnant women with psychosocial vulnerabilities living in Riverwood or surrounding SLHD suburbs were not attending SLHD hospitals for antenatal care or birthing.

A HHAN Care Coordinator established communication with two hospitals in adjoining health districts to discover patterns of attendance for pregnant women residing outside their respective Local Health District boundaries. Further research into cross-boundary hospital attendance will be undertaken. Local Government has recognised gaps in public transport connection to in-area hospitals.

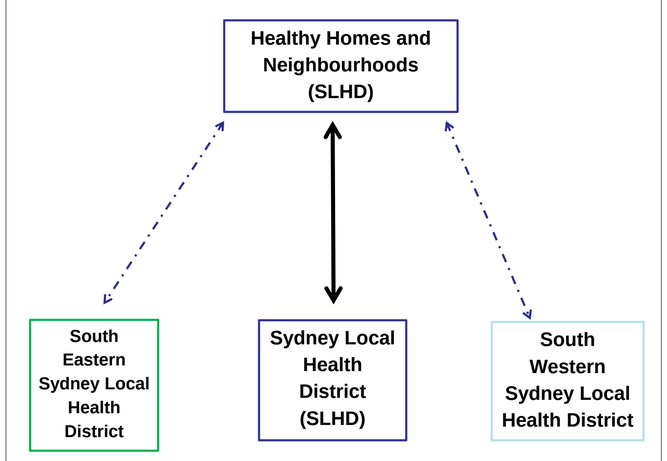
Initial cross district communication acknowledged the identified gap in SLHD antenatal care attendance for these women, with recognition of cross boundary health service utilisation for antenatal care. HHAN attendance at adjacent Health District SAFE START meetings commenced in July 2017 and has resulted in referrals of vulnerable families into the HHAN Care Coordination program.

Discussion

Inter-Health District Care Coordination is a developing area with Australian public health systems. This Sydney-based, high-risk, antenatal pathway demonstrates to health care providers and their consumers that flexible support is possible across health district boundaries. An integral component of the success of the HHAN program has been the development of trusting relationships between HHAN Care Coordinators, health and NGO service providers, and their clients. Liaison with adjacent Health Districts is enhancing communication and planning across health district borders.

Collaboration between health service providers is one step towards providing timely, integrated and supportive care for vulnerable families.

Table 1: HHAN Alternate Pathways



Integrating Care for Children Young People and Their Families SIG - Service Policy and System Approaches

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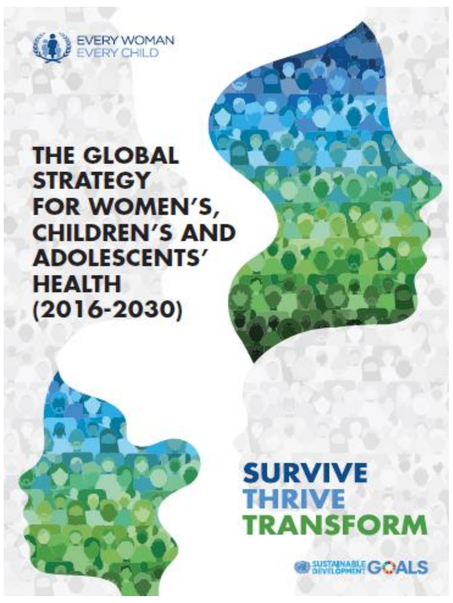
Aim

To discuss service, policy and system approaches for promoting and protecting the health, development and wellbeing of children, young people and their families.

Background

We have called for the establishment of a special interest group for “Integrating Care for Children Young People and their Families. Children are our future to support the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030).

We need a world “ in which every woman, child and adolescent realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies”.



Integrated People-Centered Health Services Framework

The United Nations Convention on the Rights of Children and the Sustainable Development Goals (SDGs) provide our global platform. Building on the SDG goal of achieving universal health coverage, WHO developed a global strategy and framework for people centered and integrated health services, recommending that countries consciously consider the perspectives of individuals, families, and communities, and respond to their preferences and needs.

For health services to become more integrated and people-centred they need to:

- empower and engage people and communities
- Strengthen governance and accountability
- reorient the model of care
- coordinate services within and across sectors
- create an enabling environment.

References

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3. WHO, Nurturing care for early childhood development: A framework for linking Survive and Thrive to Transform health and human potential. 2018, World Health Organization: Geneva.

A Nurturing Care Framework

The integration of system-wide policies and services is the foundation for promoting and protecting the health, development and wellbeing of children, young people and their families.

The proverb “it takes a village to raise a child” provides the underlying ethos whereby all members of society work together to raise healthy and resilient children and young people. Building on the “Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)” a draft “Nurturing Care Framework” is under development by WHO.

That draft Framework contains five guiding principles:

- The child’s right to survive and thrive (Child Rights principal)
- Leave no child behind (equity principal)
- Family-centred care
- A whole-of-society approach
- Whole-of-government action.

Based on an analysis of effective programmes the Framework proposes five action areas that “create universally enabling environments and include a focus on communities, families and children in greatest need … accompanied by strong monitoring systems and accountability mechanisms.” The five proposed action areas are:

- Provide leadership, create societal awareness and invest
- Value that families and communities are at the heart of Nurturing Care
- Create enabling environments through policies, information and services
- Monitor progress in implementation, results and impact
- Strengthen local evidence and innovate to support scale up.

A Position Paper

We propose that these two WHO frameworks be used to develop a framework for integrated service, policy and system approaches for promoting and protecting the health, development and wellbeing of children, young people and their families. Such a framework could form the basis of a position paper and guide the work plan of the newly established Special Interest Group “Integrated Care for Children Young People and their Families”.

Realist Research Design and Evaluation for Integrated Care SIG

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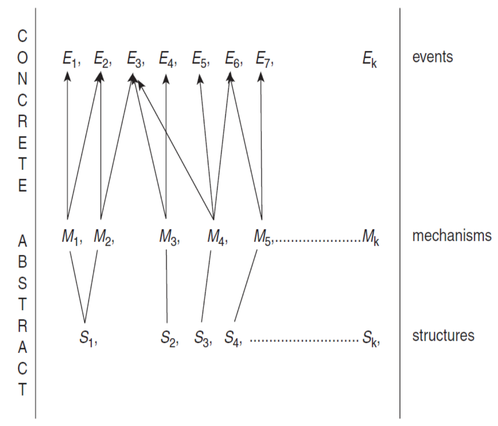
Background

Realist philosophy and methodology is progressively being explicitly used in the field of integrated care to research. The purpose is to study the extant context, structure and mechanisms at play, and to design and evaluation interventions. Philosophic realism is the view that entities exist independently of our perception or our theories about them. While the realist philosophy underpins much of modern health and social science, it is only recently that this philosophical approach has been popularised within main stream health and social science literature.

Realist research methodology is increasingly being described in research areas that are relevant to the study of integrated care, namely, organisational management, information science, social epidemiology, economics, and health services evaluation. Importantly realist approaches are increasingly being used in mixed method research designs and to elucidate the processes at play in experimental and quasi-experimental studies.

Realist Methodology

Realist researchers seek to explain the underlying "cause" or mechanism(s) that generate observed phenomenon or events. The realist understanding of how the world is (ontology) includes the notion of a hidden or "real" domain where mechanisms generate forces that result in the phenomena which we observe.



Source: Sayer 2010

Realists also view the world as consisting of strata or layers of reality which may interact with other layers to produce new mechanism. This approach is proving useful for studying and developing theory about complex health and social care systems, and then designing and evaluating possible interventions.

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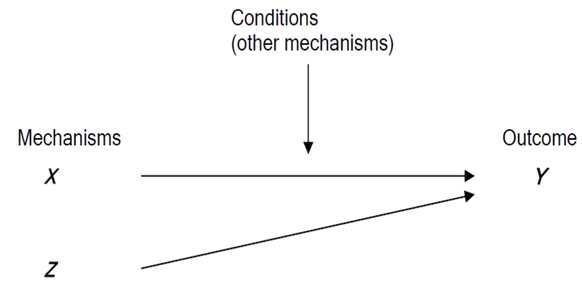
	Research Element	Research Focus
HISTORY	CONTEXT	*Macro social organisation* Values, tradition, forms of social and economic organization and power relations. For example, legally sanctioned forms of ownership, control, distribution; interlocking directorships, state intervention, as they are implicated in the sector below.
	SETTING	*Intermediate social organisation* Work: industrial, military and state bureaucracies; labour markets; hospitals; social work agencies, domestic labour; penal and mental institutions. Non-work: Social organisation of leisure activities, sports and social clubs; religious and spiritual organisations
	SITUATED ACTIVITY	*Social activity* Face-t-face activity involving symbolic communication by skilled, intentional participants implicated in the above contexts and settings. Focus on emergent meanings, understandings and definitions of the situation as these affect and are affected by contexts and settings (above) and subjective dispositions of individuals (below)
	SELF	*Self-identify and individuals social experience* As these are influenced by the above sectors and as they interact with the unique psychobiography of the individual Focus on the life-career

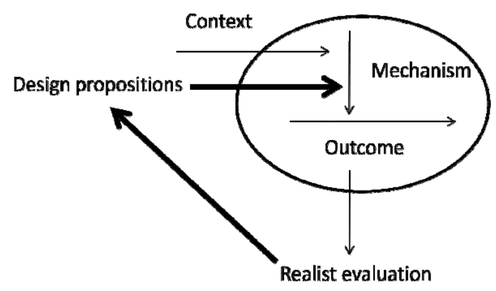
Source: Layder 1993

Realist Causal Propositions



Source: Danermark et al 2002

Realist Design Propositions



Source: Keller et al 2010

A Special Interest Group

Realist research methodology offers the integrated care community a set of approaches that can be applied to explaining problems that integrated care is trying to address (i.e. complex causal pathways to health care within complex settings – institutional and community). The mixed method methodology seeks to answer the questions how and why things are, and what will work for whom in what circumstances. The abstract abductive form of reasoning used by realists, also known as *inference to the best explanation,* is well known to medical disciplines who use this to analyse differential diagnoses. The focus on structures and mechanisms also assist integrated care researchers to postulate "hidden" entities that may be critically important to why some approaches work and others don't.

Over the last number of years a number of realist studies have been presented at the International Foundation of Integrated Care conferences including: realist studies of context and mechanisms; realist design of integrated care interventions; realist synthesis of literature; and realist evaluations of integrated-care interventions. The methodologies, and the dialectical debates, are complex, and therefore, deserving of special consideration within the Integrated Care community.

The establishment of a Realist Integrated Care SIG will support evaluators and researchers to use realist methods in integrated care and other complex evaluations. Because realist evaluation was initially developed using smaller-scale programs, methods need to be modified for large scale programs, while remaining consistent with underlying methodological principles. The Realist Integrated Care SIG will provide a forum to discuss the value of and the dilemmas involved in using realist methods for large and complex integrated care programs.

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Healthy Homes and Neighbourhoods Integrated Care Program

John Eastwood
Erin Miller

18th International Conference on Integrated Care, Utrecht

May 2018

Health Sydney Local Health District

Healthy Homes and neighbourhoods

Why IC for vulnerable families?

- Families with trans-generational disadvantage and psychological trauma
- Complexity of family needs – health and social complexity
- Poor engagement by families with services
- Poor engagement by services with families
- Interventions usually of short duration
- Barriers to cross-agency collaboration
- Needs of adult family members often not addressed

Health Sydney Local Health District

Healthy Homes and neighbourhoods

Core Partners

- SLHD (Community Health, Mental Health, Drug Health, Chronic Disease)
- Family & Community Services (Housing, Child Protection)
- CESPHN
- Education
- Sydney Children's Hospital Network
- Tresillian
- SDN Children's Services – Brighter Futures
- The Infants' Home Ashfield – Child and Family Services
- Barnardos – Family Referral Service
- The Benevolent Society – Child and Family Services
- Jannawi Family Centre

Health Sydney Local Health District

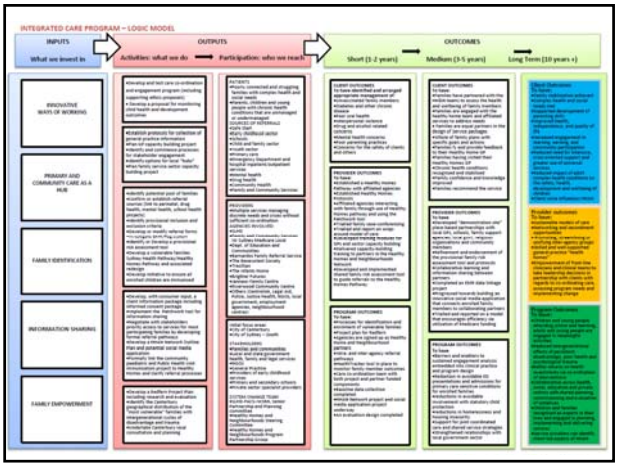
Healthy Homes and neighbourhoods

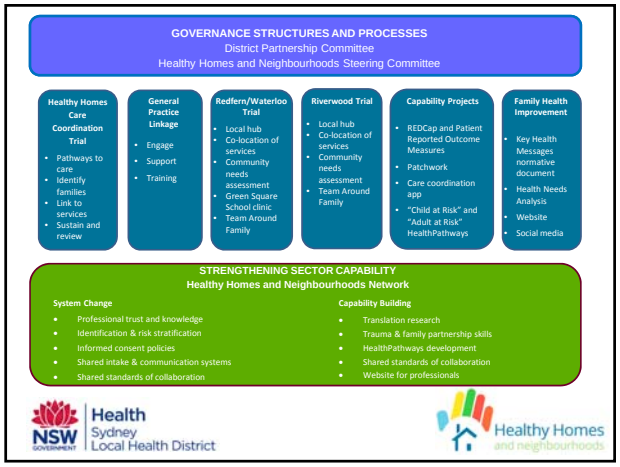
Core Components

1. Risk Stratification
2. Care Coordination
3. Evidence informed capacity building
4. General Practice engagement and support
5. Family Health Improvement
6. Place-based hubs
7. System Change
8. Outcome monitoring
9. Complex evaluation

Health Sydney Local Health District

Healthy Homes and neighbourhoods





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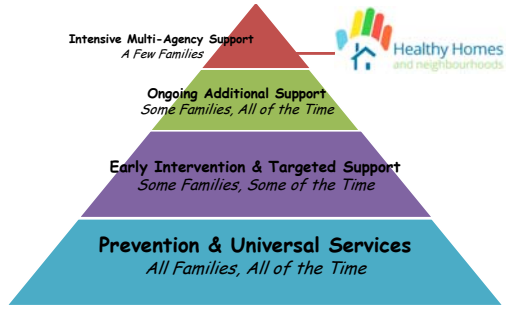
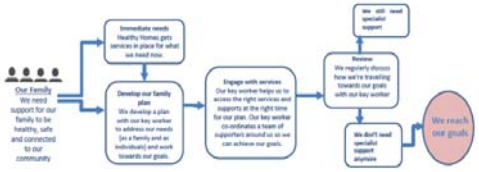
Risk Stratification



Healthy Homes and neighbourhoods

Family-Centered Care Coordination



- Wrap-around model
- Family Group Conferencing
- Family Partnership
- Shared-care planning

- Clinical review
- Patient reported outcomes
- HealthPathways

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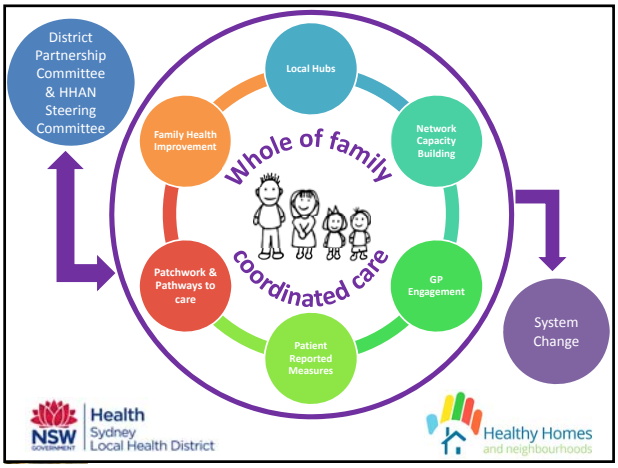
Healthy Homes and neighbourhoods



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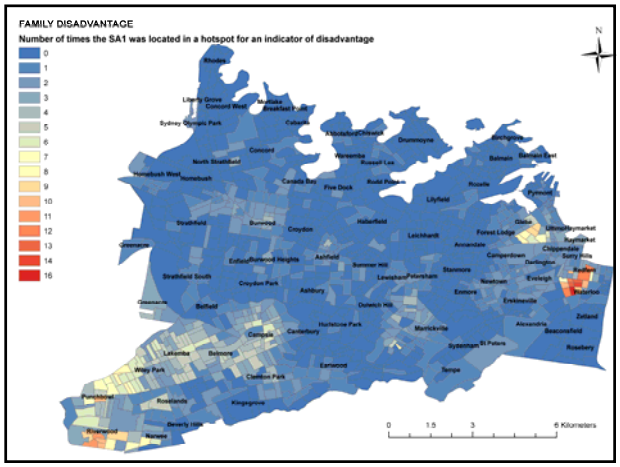

Redfern/Waterloo Place Based Component

- Co-location at **RedLink**
- Engaging directly with community and local services
- HHAN staff presence at community events
- Identifying community needs
- Providing care coordination from RedLink site

- Project with Green Square School
- Evaluation of RedLink

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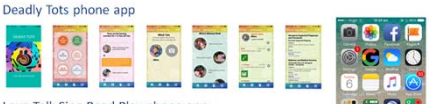
Riverwood Place Based Component

- Consultation and assessment of needs with service providers
- Community consultation
- Co-located at Riverwood Community Centre
- Piloting care coordination / wrap around in primary schools
- Capacity building and facilitate change in understanding, identification and engagement
- Community development focus e.g. Picnic in the Park, outreach playgroups, interagency work

Healthy Homes and neighbourhoods

Self-care and Family Health Education

- Deadly Tots phone app



- Love Talk Sing Read Play phone app

- Love Talk Sing Read Play mobilised website

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Family and Practitioner Knowledge and Skills

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Community Literacy

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Healthy Homes and neighbourhoods

Social Media

Health Sydney Local Health District

Healthy Homes and neighbourhoods

Challenge: Evaluating a complex intervention

- Limitations of quantitative evaluation
- Realist: analysis of the Contexts, Mechanisms and Outcomes underlying the program

"What works for whom in what circumstances, in what respects, how and why?"

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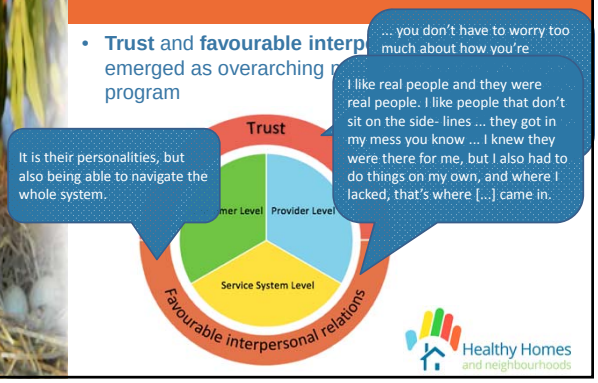
Healthy Homes and neighbourhoods

Results

- **Trust** and **favourable interp** emerged as overarching m program



Healthy Homes and neighbourhoods

Realist Evaluation

CONTEXT	MECHANISMS	OUTCOME
• Clients distrustful of services • Feelings of hopelessness • Let down by services in the past • Competing priorities • Domestic violence • Intergenerational trauma or disadvantage • Overwhelming physical and social co-morbidities • Isolation • Powerless to articulate concerns to professionals • Health care is expensive and not a priority • Poor health knowledge • Mental health issues • Responsibilities as a carer	• Persistence of care coordinators • Empowerment • Meeting clients on their own terms • Trust and respect • Whole of family • Strengthened referral processes • Flexibility of service delivery • No power base • Favourable interpersonal relations • Belief in the idea and commitment to collaboration	• Clients engaging in care • Clients empowered and setting long term goals • Clients linked to General Practice • Clients have more perspective on their situation • Clients have increased knowledge of health norms • Referrals and consults with other services occurring faster • Increased trust between service providers • Knowledge transfer between service providers

Challenge: Relationships and trust

- Do not underestimate the time and effort it takes to build relationships and trust with stakeholders and the community – plan for this in timeline; difficult to measure in real-time
- A local 'hub' can assist in developing trust, partnerships and knowledge transfer

"…And I guess it also takes time, you can't just expect people to trust you overnight, and trust you with everything…" – Client

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Challenge: Keeping it local

- Find a hub
- Tap into existing networks – enhance this instead of re-inventing the wheel
- Allow model of care coordination to emerge over time to meet needs of the population and to inform enabler projects

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Challenge: Preparing and supporting staff

- IC is a change to professional practice:
  - Our own staff
  - Their interactions with staff from other services and organisations
  - Expect "push back" and support your staff to manage this
- Complexity of clients who have encountered system failure over many generations
- Vicarious trauma

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Healthy Homes and neighbourhoods

Adding value

- Whole of government and NGO
- Whole of family/kin
- Increased access to services for our most vulnerable patients
- Earlier engagement with antenatal care
- Maintaining the family unit/avoiding child removal
- Families have a team of support
- Cross-sector capacity building e.g. trauma informed care; child protection; child development
- Professional trust and willingness to share power
- Contribution to research nationally and internationally

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Healthy Homes and neighbourhoods

Elizabeth & Baby Lizzy

NSW Health Sydney Local Health District

Healthy Homes and neighbourhoods

Care coordination for vulnerable families in the Sydney Local Health District: what works for whom, in what circumstances, and why?

18th International Conference on Integrated Care, Utrecht
May 2018

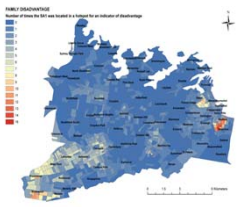
Suzannah Dewhurst[1,2]
Sally Hansen[1]
Elaine Tennant[1,2]
Erin Miller[1]
John Eastwood[1,2,3,4,5]
Kristy Allworth[1]

Health NSW Sydney Local Health District

Healthy Homes and neighbourhoods

Background: Healthy Homes and Neighbourhoods Integrated Care Program

- Long term care coordination for vulnerable families with complex health and social care needs, who are disconnected from key services and require multi-agency support to have these needs met.
- Aims to keep clients and their families safe, and connected to society.
- District wide (Central/Inner West Sydney) with foci in two identified "hotspots" of disadvantage.



Care coordination

- Care coordinators operate through home-visit and place-based settings
- Clinicians work at client, provider, and service levels
- Link clients to appropriate services, whilst communicating horizontally with services, working to break down health silos

Aims / Objectives

- Realist evaluation of HHAN Program
- "What works for whom and why?"
- Analysis of the contexts, mechanisms and outcomes underlying the implementation of the care coordination component of the program

Methods

- Semi-structured interviews: 15 HHAN clients, 5 HHAN care coordinators, 1 program manager, 16 stakeholders
- As research progressed, theories were refined, and the interview questions revised.
- Context-mechanism-outcome configurations were discussed with the research team

Participant characteristics

- Clients: all female caregivers, 7 from the Redfern area, 8 from the wider SLHD
- All HHAN care coordinators were interviewed
- Stakeholders: professionals involved with HHAN through shared clientele, or the steering committee.
  - 9 from Redfern area
  - 7 from the wider SLHD

Results

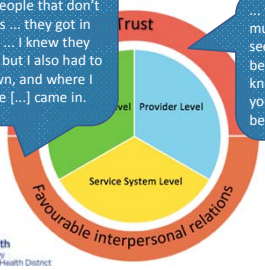
- Two overarching mechanisms identified for effective care coordination
- Six key modes of intervention identified, divided at a consumer, provider, and service system level
- Context, mechanism and outcome relationships identified within each mode of intervention

Results: Overarching mechanisms

- **Trust** and **favourable interpersonal relations** erarching mechanisms for the entire

I like real people and they were real people. I like people that don't sit on the side- lines ... they got in my mess you know ... I knew they were there for me, but I also had to do things on my own, and where I lacked, that's where [...] came in.

... you don't have to worry too much about how you're seeming to them, you can just be yourself, be honest, and you know they will be honest with you and try and help you in the best way they can.



Results: Consumer level

- **Whole of family approach**

C: Distrust with health services, vulnerability

M: Rapport building wi members

O: Client feels supported in community, acceptance and acknowledgement of HHAN

If you look at their list, you can connect most of them up. HHAN is not just helping one household, they are helping an entire community because there are the cousins, the aunties and uncles ... it's creating this standardised trust.

Results: Provider level

- **Accessibilit**

C: Distrust with he vulnerability, inf syste

M: Approachable, available, many modes of communication

O: gagement

I mean I just didn't want to see anybody, but she did call, she did text, she did messages, emails and came around to see me, ask how I was doing ... by coming to my home and saying hi, how is everybody, everyone chilled out a bit.

They don't come to our families with an authoritative attitude, they're relaxed, they speak in a normal conversation, not 'I'm above you', which is important for our families.

Results: Provider level

- **Accompaniment –** intensive "hand-holding"

C: Distrust with health services, vulnerability; Program flexibility, care coordination/case management

M: Bit by bit I'm getting my life back together ... but I am finding the thought of her not being with us difficult, because I'm becoming reliant on her.

O: Client independence; Client reliance, risk of case management model emerging

She's given me some guidance, I'm familiar with where I should go now and what needs to happen ... I'm comfortable doing so.

Results: Provider level

- **Clinician autonomy**

C: ...you have an understanding with a about what you're trying to achieve you in and give you information abo things ... Healthy Homes is a more r where they want everything to be b working well, instead of just looking of things.

M: Clients divulge some incredibly personal and quite disturbing histories at times ... and I think that's a real challenge within this job. It's that there isn't a client who isn't challenging, so there's not down time. We can't fix our clients, and I think that's a different way of thinking compared to nursing or medicine ... with HHAN, you don't leave.

O: Client independence, service engagement; Risk of burnout, service delivery dependent on experience of clinician

Results: Provider level

- Service navigation

She gives you the information and says would you like me to advocate for you or can you manage? ... I guess she uses resources she has, but it's h

It has given me opportunities to do things I didn't think I was going to do ... now I have my learners license ... I am pregnant and having another child, I'm going to have a home nurse come out and check up on the baby.

M

O

Wrap around care for clients, ability to self-navigate services, improved outlook, actively planning for future

Results: Service System level

- oration

It's been about the relationships across the table ... that willingness to form relationships and respect for other services I think is what pushes this project along.

ystem, complexity of HHAN, ent vulnerability

Referral pathways, recognition of collaboration & motivation informal & formal communicat decision making

There's definite recognition, acknowledgement. At least verbally. That hasn't always translated into systems practice change.

Breakdown of silos, recognition & collaboration by service partners, utilise appropriate services, **foundations for integration**

Systems remaining siloed

Conclusions / Lessons learned

- Trust and favourable interpersonal relations should be recognised as major mechanisms across all facets of program delivery.
- Whole of family care, accessibility and service navigation are vital design elements for the delivery of care coordination for vulnerable families.
- A flexible program model permitted the emergence of a case management model, or an intensive care coordination model.
- Flexible program design and clinician autonomy create positive client outcomes, however highly skilled clinicians must be employed for effective implementation.
- Service collaboration is necessary for the breakdown of silos, however there remains a resistance to collaboration that is impeding the integration of services as part of this program.

Limitations

- Interviews were undertaken between December 2015-September 2017, during which time the program was still developing
- The study may be subject to participant bias, as clients who agreed to be interviewed may have strong views for or against HHAN
- The exact CMO configuration for each mode of intervention was difficult to define

Future research

- Exploration of quantitative data to further assess the impact on health and social outcomes.
- Ongoing mixed-methods evaluation of the program will continue to assess medium to long-term client and family outcomes.

References

- Todd, K. (2015). *Geospatial Analysis of Disadvantage in Sydney Local Health District (SLHD)*. Community Paediatrics. Sydney Local Health District. Croydon NSW.

Affiliations

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NSW GOVERNMENT Health Sydney Local Health District

Healthy Homes and neighbourhoods

A qualitative study into the health, social needs and barriers to service access for families residing in a suburb of Sydney with high rates of disadvantage

Deslyn Raymond
Erin Miller
Sally Hansen
Suzanne Gleeson
Marilyn Wise
John Eastwood

18th International Conference on Integrated Care, Utrecht
May 2018

Health Sydney Local Health District

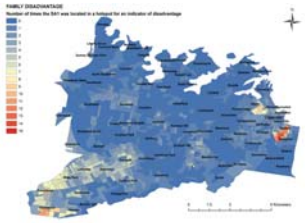
Healthy Homes and neighbourhoods

Aims

- Through consultation with service providers and community members:
  - Identify barriers and enablers to service access and engagement
  - Inform the delivery of targeted health, education and social services
  - Engage consumers and partners in a place based initiative

Background and Context

- What is Healthy Homes and Neighbourhoods (HHAN)?
- Spatial epidemiology – identify "hot spots" of extreme family disadvantage
- Place-based centres of focus in those suburbs



Methods – Service Provider Consultation

- Interviews were undertaken in 2015 - 2016 to identify opinions and viewpoints of key organisations re: access and engagement with services
- Preliminary results - 15 groups analysed
  - → Developed shared vision and goals
  - → Multi-agency working group formed
  - → Commenced planning for research with the community

Methods – Community Forum

Held in 2017 to investigate barriers and enablers to accessing health and social care

- **Recruitment** – multilevel community engagement
- **Instrument** - small group facilitated discussion to gauge five dimensions of accessibility:
  1. approachability
  2. availability
  3. accommodation
  4. affordability
  5. appropriateness
- **Analysis**

Community Forum

47 participants attended

37 demographic surveys completed: cultural background, highest level of education, age, dwelling type

Results – Service Provider and Community Consultation: Extrinsic Factors

Service Providers – Extrinsic Factors	Community Consultation – Extrinsic Factors
• Inconsistent service delivery boundaries in both government and non-government sectors • Clients are referred to differing Local Health District services and are falling between the cracks • Lack of outreach service models • Service models deal with crises or most severe cases and short term work • Episodic care with reluctance to get involved with complex families • Health services difficult and not readily engaged by residents - barriers of cost, waiting times and location • Lack of prioritisation of vulnerable families to access scarce community resources • Need for preventive programs to address health literacy	• Families need to go out of area to seek care for major medical problems • Residents unaware of many free public services Difficulties accessing public services via public transport • Lack of local women's health services • Lack of outreach health services • No female doctors • Cost concerns • Lack of after hours medical centres/ pharmacies Services not applicable to children's age or needs Lack of interpreters in Health Services, children often translating for adults • Need employment support for all

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Results – Service Provider and Community Consultation: Intrinsic Factors

Service Providers – Intrinsic Factors	Community Consultation – Intrinsic Factors
• Attitudes and beliefs - feeling stigmatised by the 'expected' attitudes of health staff leading to avoidance of these services • General attitudes and beliefs - historic mistrust of services, intergenerational beliefs • Low health literacy Residents' historical interactions with services – negative experiences with agencies, including involvement with Child Protection services and Police, with fears of child removal	Nil raised

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Discussion

- Intrinsic factors were not ascribed by the community, possibly due to fears of disclosure within a large group setting
- Both intrinsic (social determinants) and extrinsic (systemic) factors were identified only by service providers
- This study reiterates that Riverwood families face multiple barriers to care

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Discussion

- The findings highlight the need for continued community engagement
- Multi-agency place-based models of care in Riverwood
- Next phase - in-depth exploration via focus group with group who could not access the forum (language, culture)

NSW Health Sydney Local Health District | Healthy Homes and neighbourhoods

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NSW Health Sydney Local Health District | Healthy Homes and neighbourhoods

An exploration of models of care to meet the needs of families requiring health and social care in Sydney

Kristy Allworth
Erin Miller

18th International Conference on Integrated Care, Utrecht
May 2018

Health Sydney Local Health District

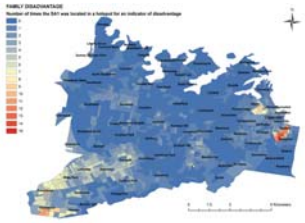
Healthy Homes and neighbourhoods

Method

- Semi-structured interviews with HHAN care coordinators
- Electronic medical records were reviewed to explore case history, activity and outputs of care coordinators

Background and Context

- What is Healthy Homes and Neighbourhoods (HHAN)?
- Spatial epidemiology – identify "hot spots" of extreme family disadvantage
- Place-based centres of focus in those suburbs



"Care Coordination"

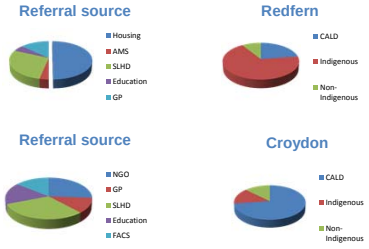
The act of organising patient care activities between two or more agencies or services that include the patient (family) to assist in facilitating the appropriate delivery of health and social care.

The organisation includes the gathering of services and other resources that are required to deliver all identified care needs and managed by communication across all involved in such care

Aims

- Understand HHAN model of care coordination
- Describe the outputs and essential components for success

Demographics



HHAN Model of Care Coordination

Healthy Homes and Neighbourhoods	REDFERN (PBI) Place based	CROYDON (CBC) Centre based
Intake and referral	Self referral External	External
Reach identified vulnerable family	Drop-in Home Visit	Home /other locale visit
Family Assessment	Joint assessment Care Plan	Assessment Care Plan
Care Coordination	Co-located services	Identify service supports
Evaluate family plan	Family plan review	Family plan review

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Healthy Homes and neighbourhoods

Assessing Need and Coordinating Support

Needs Assessment	Hierarchy of Needs	Community Service
Unemployment Incomplete schooling Social isolation Criminal justice		Justice Health partnership Primary Health-GP
Lack of parenting role models Adverse childhood experience		NGO-Intensive family support Paediatrics Child and Family nursing
Domestic violence Mental health Substance abuse Bullying		Education DV Liaison Officers Psychiatric and psychological services
Food insecurity Housing insecurity Financial difficulties		Discounted food EAPA vouchers Community services Housing NSW

Source: https://www.powerofpositivity.com/maslows-hierarchy-needs-meet/

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Healthy Homes and neighbourhoods

HHAN Care Coordination

The HHAN model of care is based on the following practice principles:

- Culturally safe practice
- Trauma informed care
- Whole of family care
- Strengths based care
- Coordinated and integrated service plan
- Continuity of care
- Persistent accompaniment
- Social justice

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Care Coordination Activities

Activities of Care Coordination	Redfern (PBI) N= 13 families	Croydon (CBC) N=13 families
Assessment	13	13
Service referral		
Paediatric assessment	6	6
Legal service	6	1
Health	10	10
Housing	9	5
Financial	5	5
Mental health	9	8
Family violence	2	2
Education	4	7
Team around family (care-coordination meetings)	7	8
Service provision		
Transport	9	8
Goods	8	2
Incidental counselling/coaching	13	13

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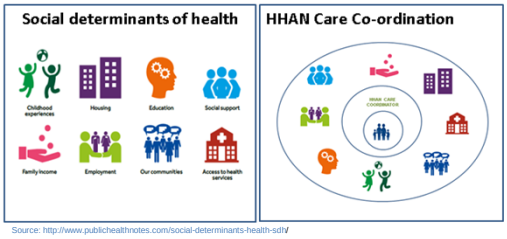
HHAN Care Coordination



Source: http://www.publichealthnotes.com/social-determinants-health-sdh/

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Healthy Homes and neighbourhoods

Failure to attend prior to HHAN

Appointments	Son 1	Son 2	Son 3	Son 4
FTA – Profession 1	1	1	1	1
FTA – Profession 2	1	1	1	2
FTA – Profession 3	1	1	1	1
FTA – Profession 4	4	1		

Health Sydney Local Health District

Healthy Homes and neighbourhoods

Inter-professional collaborative practice

Croydon (CBC)

- Developing relationships with other service providers – trust and time
- Non-flexible service models
- Assertive outreach
- Referrals from other services
- Slow persistence to help families identify needs if not immediately apparent

Redfern (PBI)

- Distributive leadership
- Flexible team approach
- Meet immediate needs of families - needs identified and assistance sought by families (self referring)

Health Sydney Local Health District | Healthy Homes and neighbourhoods

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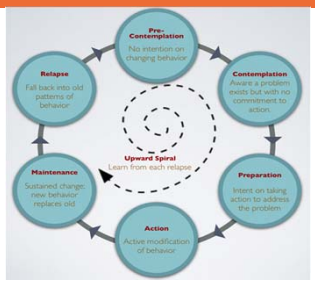
Integrating Health and Social Care Special Interest Group Kick Off
24 May 2018
7:30am – 9:00am
Room 14

Health Sydney Local Health District | Healthy Homes and neighbourhoods

Stages of Change



Source: http://socialworktech.com/2012/01/09/stages-of-change-prochaska-diclemente/

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- **Public** Health Notes 2018, Social determinants of health, Public Health Notes, viewed 25 March 2018 < http://www.publichealthnotes.com/social-determinants-health-sdh>
- Social Work Tech 2017, The stages of change (Prochaska and Diclemente), Social Work Tech, viewed 1 May 2018 http://socialworktech.com/2012/01/09/stages-of-change-prochaska-diclemente/

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Integrated Care is a Relationship Business

HHAN care coordinators must engage in *'symphonic thinking… the ability of composers and conductors, whose jobs involve coralling a diverse group of notes, instruments and performers producing a unified and pleasing sound….Symphony...is the ability to put together the pieces. It is the capacity to synthesize rather than to analyze; to see relationships between seemingly unrelated fields; to detect broad patterns rather than to deliver specific answers; and to invent something new by combining elements nobody else thought to pair.'*

— Dan Pink, A Whole New Mind (2005)

Health Sydney Local Health District | Healthy Homes and neighbourhoods

Developing new pathways to health and social care for vulnerable clients in targeted primary schools

18th International Conference on Integrated Care, Utrecht
May 2018

Deslyn Raymond
Erin Miller
Dan Sprange
Robert Borg
Elaine Tennant
John Eastwood

Health Sydney Local Health District
Healthy Homes and neighbourhoods

Establishment of pathway

Consultation project with service providers and community – many intrinsic and extrinsic barriers to accessing health and social care

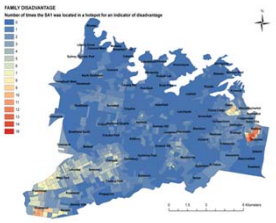
A preferred pathway was piloted in late 2015:

- Riverwood Public School
- Hannans Road Public School
- Each school was offered a prioritised referral of one family with complex needs impacting on the children

Health Sydney Local Health District
Healthy Homes and neighbourhoods

Healthy Homes and Neighbourhoods Integrated Care Initiative (HHAN)

- Vulnerable families with complex health and social care needs
- Targeted integration with Riverwood Primary schools, develop pathways to multi-agency support



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Defining vulnerability in target group according to schools

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Healthy Homes and neighbourhoods

Practice change – what did services tell us?

- Service provider interviews in 2015-2016 explored the views of key organisations relating to access and engagement difficulties with health and social services
- Findings indicated numerous extrinsic and intrinsic barriers for families to access the health and social care sector

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Healthy Homes and neighbourhoods

Intervention offered – key elements

- Experienced Health Senior Social Worker
- Long term care coordination
- Dedicated worker - families can be told this worker will work with them on ongoing
- Regular ongoing communication with schools
- Whole of family 'in scope'
- Fast track outreach Paediatric assessment and review

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Healthy Homes and neighbourhoods

Intervention offered – key elements continued

- Intensity of contact, as required, subject to goals
- Flexible contact – home or where client is comfortable
- Whole of school needs – health education, health promotion and development

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Healthy Homes and neighbourhoods

Evaluation – the families

- Independent qualitative evaluation of the role of the care coordinator
- In-depth semi-structured interviews were audio-recorded and transcribed
- Families from school pathway interviewed had complex needs and faced multiple barriers to care, both intrinsic and extrinsic

Health NSW Sydney Local Health District

Healthy Homes and neighbourhoods

What has worked well – schools' perspective

8 families referred -- 25 individuals

- Wrap around model
- Expertise, diligence and long term relationship provided by the service
- Multi-nodal – excellent access to experts in the field
- Strong and open lines of communication and follow through
- Confidence and trust

Health NSW Sydney Local Health District

Healthy Homes and neighbourhoods

Sample families' results – what works

Key elements from client interviews:

- better engagement with services
- increased trust in health services
- empowerment
- improved outlook and planning for the future

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Healthy Homes and neighbourhoods

What has worked well – schools' perspective

Investment of time in engagement is not wasted, a long term view is taken and stays involved even when things get tough

Can rely on, allowing school to focus on their expertise

Service will not suddenly stop due to funding, small eligibility barriers or other priorities

Each case has progressed to the point of significant and positive change

Significant positive change has occurred to the family and wellbeing circumstances of the children referred

Healthy Homes and neighbourhoods

Families' perspectives re: schools pathways

The Principal referred, and she's worked with other families and stuff like that

She's there when you need her; very reliable, she addresses situations like she wants to hear what your thoughts, she wants to know what's going on in your….you know,

I'm in a drain now and I don't know how to explain it, and I know I can just talk to her and she's there helping me

She's the first one, to help me coordinate, like this. Normally I just do it all on my own and she come at the right time, sort of pushing me like cause I'm like, just take my time or I'll avoid what I have to do

Open connection with the school, I like that, I want to know what is going on

Healthy Homes and neighbourhoods

Areas for improvement – schools

'Some complex cases have a way of being unresolved, long term and improving just enough to avoid the life changing interventions which are required'

'Hard to see outcomes and progress as quickly as schools want'

'Complex human factors present barriers at times, but this comes with this type of case load'

Healthy Homes and neighbourhoods

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Healthy Homes and neighbourhoods

Lessons learned

- Difficulty to quantify and show results
- Cost effectiveness - outcomes require 3-5 years
- Need time and commitment to build trust and relationship with school and families
- Goals and priorities between agencies can clash
- Outreach to the schools enhances partnership, information exchange and collaboration

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Healthy Homes and neighbourhoods

Future Directions

- Opportunities for partnership at whole of school and community level
- Participation in Learning Support Meetings to offer consultation more broadly to schools
- Applicability and replicability of model in other communities
- Showcase success and promotion to education and social sector

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Healthy Homes and neighbourhoods

Integrated Health and Social Care

Promoting health and wellbeing using whole of system approaches

Models of Integrated Care

- Individually focussed models of integrated care
- Group and disease-specific models
- Population-based models

Overview

- Models of Integrated Care
- Individual Focused
- Group Focused
- Population-based
- Social Support and Care
- Healthy Homes and Neighbourhoods

Individual Models

- Individual coordination of care for high risk patients with multiple conditions and their carers
- Aim to facilitated the appropriate delivery of health care services and overcome fragmentation between services
- Extends beyond one episode of care and embraces the life-course.

Models of Integrated Care

Case-management

To ensure coordination of a patient's care through the assignment of a case manager. The primary tasks of a case manager are to:

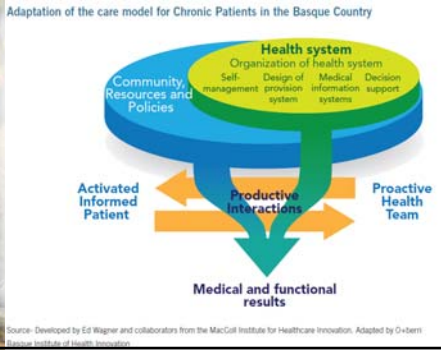
1. assess the patient's and carer's needs,
2. develop tailored care plan,
3. organize and adjust care processes accordingly,
4. monitor quality of care and
5. maintain contact with the patient and carer

Individual Care Plans

The aim is to deliver more personalized and targeted care by creating shared care plans that map care processes:

1. clearly articulate the role of each provider and patients in the care process
2. hold retrospective and prospective information about the care for a particular patient
3. Document agreed outcomes.

Chronic Care Model

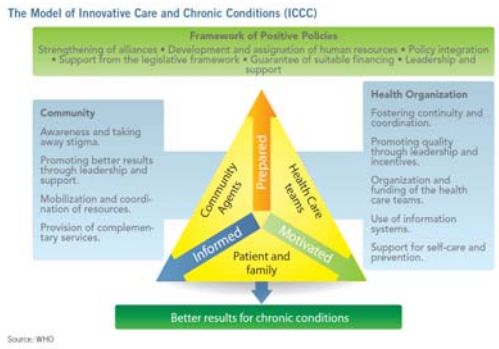


Patient-centred medical home

Some times referred to as primary care medical home. It is a physician-directed group practice that can provide care which is:

1. accessible,
2. continuous,
3. comprehensive
4. coordinated
5. delivered in the context of family and community

Innovative Care and Chronic Conditions

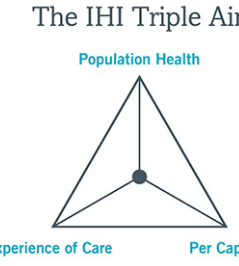


Group and Disease Models

Chronic Care Model best known. Six Domains:

1. community
2. health system
3. self-management support
4. delivery system design
5. decision support
6. clinical information systems.

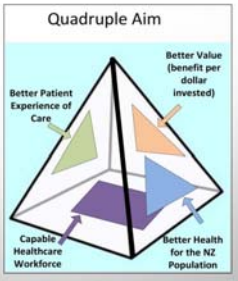
Triple Aim



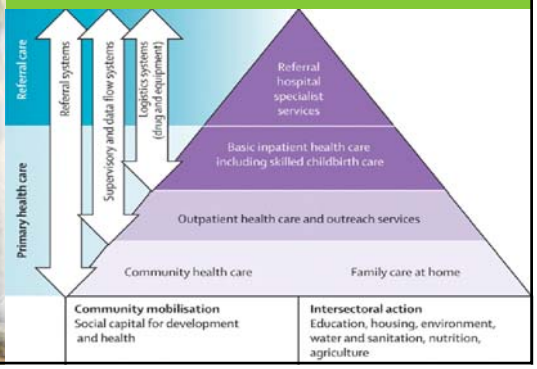
Quadruple Aim (NZ)

THE COMPONENTS OF OUR 'COLLABORATIVE QUADRUPLE AIM'

- ✓ BETTER PATIENT EXPERIENCE OF CARE
- ✓ BETTER HEALTH FOR THE NZ POPULATION
- ✓ BETTER VALUE
- ✓ A CAPABLE HEALTHCARE WORKFORCE



Alama Ata Declaration 1978



Population-Based

- Kaiser Permanente
- Primary Health Care
- Health Promotion
- Population Health

Healthy Homes and neighbourhoods

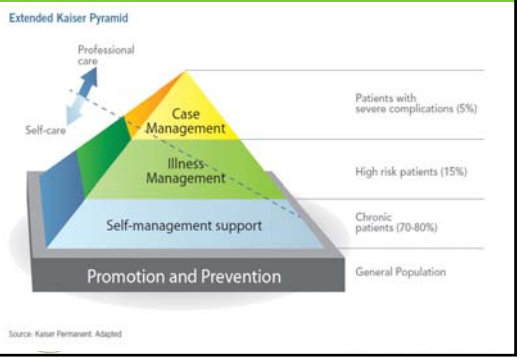
Ottawa Charter

Enable
Mediate
Advocate

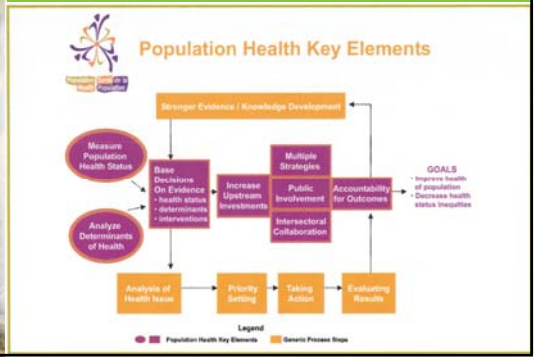
Strengthen Community Action
Develop Personal Skills
Create Supportive Environment
Reorient Health Services
Build Healthy Public Policy

Healthy Homes and neighbourhoods

Kaiser Pyramid (Population Stratification)



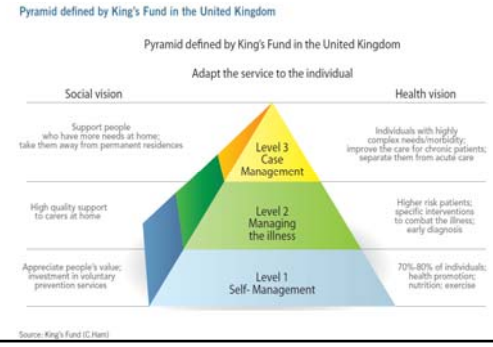
Population Health Canada 2001



The Rainbow Model

Healthy Homes and neighbourhoods

KP Pyramid Health and Social



Rainbow Model of Integrated Care

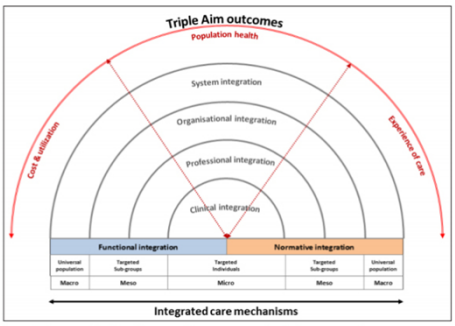


Figure 1: The revised RMIC, value-based integrated care. Source: Valentijn (p. 160, 2015).

Inter-sectoral Health and Social Action

Healthy Homes and neighbourhoods

What is the Social Dimension

Healthy Homes and neighbourhoods

Possible Domains of Social Action

- Social Determinants of Health
- Social Exclusion and Inclusion
- Social Capital and Cohesion
- Social Isolation and Support
- Social Care and Services

Healthy Homes and neighbourhoods

SDOH Definition

"The circumstances in which people are born, grow up, live, work and age, and the systems in place to deal with illness, which are all shaped by wider societal factors"

- *WHO Commission on Social Determinants of Health, 2008*

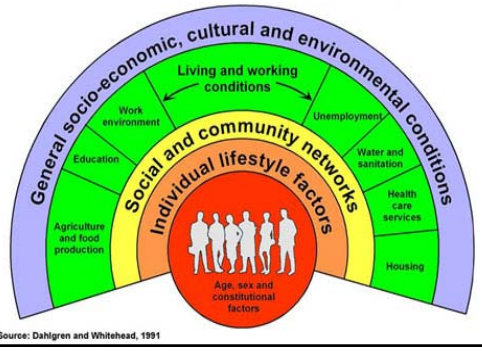
Healthy Homes and neighbourhoods

Key social determinants (Marmot & Wilkinson)

1. Socioeconomic status
2. Stress
3. Early life
4. Social isolation or exclusion from wider community
5. Nature of work
6. Unemployment: or risk of unemployment
7. Social support: from family or friends
8. Addiction: to drugs, alcohol, tobacco
9. Availability of good food
10. Transportation system that encourages physical activity

Healthy Homes and neighbourhoods

Determinants of health



Source: Dahlgren and Whitehead, 1991

Additional 5 determinants (second edition, 2006)

11. Racial/ethnic inequalities
12. Ageing
13. Impact of neighbourhood features on health
14. Housing
15. Sexual behaviour/sexual health

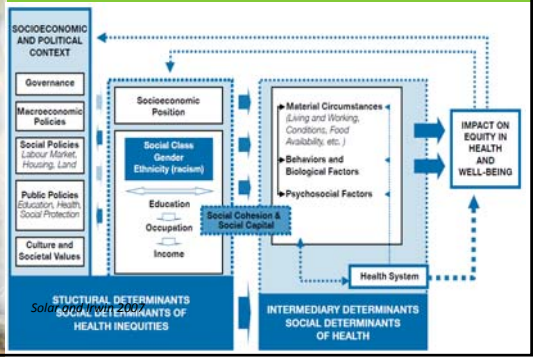
Healthy Homes and neighbourhoods

Key social determinants of health

- Marmot & Wilkinson: 'Social determinants of health – the solid facts' (WHO, 2003)
- 10 key social determinants of health plus policy implications for each
- Second edition published 2006: additional 5 determinants

Healthy Homes and neighbourhoods

Social Determinants



Solar (WHO 2007)

Social Isolation

Capioppo and Hawkley (2003) note that:

"social isolation is a potent but little understood risk factor for morbidity and mortality" with negative consequences "most profound among the elderly, the poor and minorities".

Social Capital

- Bonding social capital refers to resources that can be accessed within social groups whose members are alike in terms of their social identify.
- The term "bridging capital" is used to describe the process whereby resources are accessed by individuals and groups through their connections that cross class, race, cultural and other boundaries of social identity.

Social Exclusion

"social exclusion is not only about material poverty and lack of material resources, but also about the processes by which some individuals and groups become marginalised in society" (Millar, 2007).

While there is an overlap with the concept of social isolation, it is used here primarily in relation to access to resources.

Stress Theory

Social Inclusion

"Social inclusion is a process which ensures that those at risk of poverty and social exclusion gain the opportunities and resources necessary to participate fully in economic, social, political and cultural life and to enjoy a standard of living that is considered normal in the society in which they live.

It ensures that they have greater participation in decision making which affects their lives and access to their fundamental rights"(Commission of the European Communities, 2003, p. 9).

Social Services

- Tenancy Lawyers
- Income support office
- Home-help
- Peer support workers
- Respite care
- Counselling services

Integrating Health and Social Care SIG
Establishing a Special Interest Group

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International Foundation for Integrated Care
A movement for change

Contact email:
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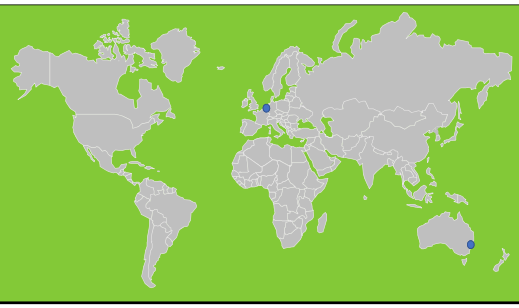
Global Participants



Why establish a SIG for Health and Social Care?

There is:
- lack of a standardised local, national and/or global definition of integrated care as it applies to social determinants of health, social policy and social services
- increasing recognition of the importance of the social dimension of integrated care
- paucity of suitable policies, strategies and frameworks to support social dimensions of integrated care

The Health and Social Care Special Interest Groups (CYFSIG) aims to bring together interested parties to:
- advocate for an integrated approach to care as social dimensions of health and wellbeing
- provide collegial leadership in this area locally, nationally and globally
- create enabling environments to deliver integrated care by aligning policy, information and services
- strengthen the evidence-based for integrated health and social care
- build capacity to translate such evidence into practice

Initial Focus

- Establish a global network of interested parties
- Define the dimensions of integrated health and social care
- Develop position paper
- Develop a framework for integrated service, policy and system approaches for integrated care as it applies to social determinants of health, social policy and social services
- Collaborate on research and grant proposals
- Develop and promote appropriate outcome and evaluation measures, building an evaluation framework
- Share knowledge, successes, lessons-learnt, and current models of care
- Establish a community website

Process of establishing the HASC-SIG

- Develop processes with the guidance of IFIC
- Select a lead, deputy lead and core group
- Promote the SIG to interested parties via IFIC and core group networks
- Run an initial workshop at the 2018 IFIC International Conference on Integrated Care
- Confirm members and Terms of Reference for HASC-SIG
- Develop a framework for integrated service, policy and system approaches for integrated care as it applies to social determinants of health, social policy and social services
- Write a position paper and develop a work plan for the SIG
- Convene annual face-to-face meetings at IFIC International Conferences on Integrated Care

Expected Outcomes

- A forum for like-minded professionals from across organisational, sectorial and geographical boundaries to come together to promote the agenda for a social dimension to integrated care
- Collaborative research and joint publications
- Shared platform of lessons learnt and successful case studies, projects, programs of work, models of care, frameworks, tools and resources
- Pooled data and resources to facilitate comparative work

Healthy Homes
and neighbourhoods

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