Building an Integrated Health System: Translating Evidence into Practice

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FRAMEWORK FOR SERVICE INTEGRATION

- Elements to support the development of strengthened primary care system in facilitating coordinated, cross sector services.
Shaped around the health needs of individual patients, their families and communities;
Focus on prevention of disease and injury and the maintenance of health, not simply the treatment of illness;
Support integrated approach to the promotion of healthy lifestyles, prevention of illness and injury, and diagnosis and treatment of illness across the care continuum and;
Provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

(COAG, 2008a: A–3)
Patient (consumer) navigating through the system – key focus
Social determinants – foundation for integrating elements of the system (aim to increase access and equity)
Whole of system approach –
  ◦ Macro (systems, human rights, economic, employment – *QH*)
  ◦ Meso (community, built environment, public policy – *Divisions*)
  ◦ Micro (interpersonal level, neighbourhood, crime and safety, financial security, health behaviours, social integration and support – *GP Practice, Community & Human Services: SD*)
  ◦ Individual (health outcomes, wellbeing – Person self managing)

Baum, 2006 & 2010; Gudes et al., 2010; Muenchenberger & Kendall, 2010; NHHRC, 2009; Powell Davies, 2006; Schulz & Northbridge, 2004; Starfield & Shi, 2007; WHO, 1997
Health Service Integration

- Vertical integration – how levels of the system work together
- Horizontal integration – how to work across sectors
- Need to focus on **structures and systems** (shared information systems, referral proformas) and **processes** to facilitate coordination to address continuity – link, bridge and connect

Ehrlich et al., 2009; Naccarella et al., 2010a; Powell Davies et al., 2006; Zwar et al., 2006 & 2007
INTEGRATION FRAMEWORK
12 Key Elements – PHC in Australia

- Integrated Governance Models
- Collaboration and Partnering
- Population Health & Service Planning
- Infrastructure Development
- Workforce Utilisation – Models of Care
- Integration Across Sectors
- Engagement Model – Strategies (clinician, consumer & community)
INTEGRATION FRAMEWORK
12 Key Elements

- Training and Education
- Funding Models and Sustainability (New organisations need time and stability to build capability, trust, culture and systems to be sustainable, McDonald et al., 2006)
- Innovation – R & D, Knowledge Sharing, EBP
- Performance Measures – KPIs (Performance Framework – accountability, UK System)
- Change Management – leadership, advocacy, education, behavioural and cultural change
Integrated Governance Models

KEY

→ Collaboration and funding

Collaboration, not funding

GOVERNANCE OPTION i)

Separate organisations merge into one single incorporated body which delivers all services on behalf of the original organisations.

Integrated Governance Models

GOVERNANCE OPTION ii)

KEY

→ Collaboration and funding

Collaboration, not funding

Where organisations have a common business overlap, funds and control in that specific area move to a separate incorporated structure which delivers services to the specified population.

APHCRI – Powell Davies, 2006; Nicholson & Jackson, 2008
Integrated Governance Models

GOVERNANCE OPTION iii)

Organisations formally commit to a common governance arrangement where there is business overlap across a geographical area, but otherwise maintain separate and independent governance and funding.

KEY

→ Collaboration and funding

Collaboration, not funding

Governance, Management & Leadership

- Governance structures within the PHCO Clearly defined – LAYERS Board → Community
- Management structure and processes should be clearly documented.
- Clinical governance – involved decision making, care pathways, clinician led (GPLO clinical decision making, integration projects – interface)
- Level and nature of community involvement needs to be identified and agreed – Community Panels (RHealth, NWQPHC – Mount Isa)

(APHCRI, 2006; Armstrong, 2010; Jackson, 2008, 2010, McDonald et al., 2006; Wakeman et al., 2006)
Collaboration & Partnerships

- Critical – to facilitate coordination to address continuity

- Linkages – All critical linkages at different levels are identified and documented (who does what? Roles)

- Identify champions – leaders from the service, community and government should be identified and actively engaged in the support and operation of the PHCO

- Maximise integrated activity and coherence within the region – to ensure efficient and effective co-ordination with external agencies and programs and services relevant to patient care

(APHCRI, 2006; Wakerman et al., 2006)
Use of data and evidence to inform health planning is limited and lack of prediction methodologies (Auditor General Report, QH 2009) – Healthy Community Model – LBHC (PBI) aim to develop a model of collaborative health planning – Researchers (urban planning & human services) developed an on-line prediction tool within the region using GIS (Gudes et al., 2010)

Model of Collaborative Planning – need to strengthen PHCO, capacity building (broad membership, joint indicators – integration, Communities of Practice CoP…..Healthy Cities Approach, GPGC)

Gather evidence – Mapping, use of data, service re-design (NW Region + Lower Gulf – Re-orient Outreach Model of Care)

Lessons from Rural Primary Health Services Program (RPHS) DoHA

Check out www.rch.org.au/aedi/
Infrastructure Development

- PHC infrastructure is key to improving access and equity, enhancing quality and increasing efficiency
- Areas for investment based on a notion of optimal size and scope of practice:
  - Physical space
  - HR Support
  - Education and Training
  - Clinics and new, emerging models of care (GP Connections – GPLO model – Specialists doing clinics in general practice, Inala CDM model, Askew et al., 2010, CPHC – wellbeing centres – Cape York, Lower Gulf)
  - Systems – to support eHealth and connectivity across service providers (maintenance and sustainability) TGPN, GPGC, HRX investment in eHealth systems within general practice (GPAC; 2010; Narcarella et al., 2006; 2010)
Workforce Utilisation – Organisational Models

- Organisational structures are more effective in changing local service delivery where they control the funds for PHC through some form of **commissioning or contracting** (McDonald et al., 2006 Systematic Review of comprehensive PHC models).

- Provides the opportunity and flexibility to develop:
  - range and mix of services
  - multi-disciplinary team approaches and
  - community-oriented models

- AIM to meet:
  - local population health needs (Pop health & service planning)
  - appropriate and responsive (quality, safety & access)
  - held accountable (integrated performance frameworks)
Service Delivery Models

- Discrete services
- Integrated services
- Comprehensive PHC services
- Outreach services
- Virtual outreach services

- Cluster service provision
- Subcontracting services
- “sharing” positions
- Brokerage

Integrated Primary Health Care Models

(DoHA - RPHS, 2009; Humphries & Wakeman et al., 2008)
Workforce Utilisation – Models of Care

- Two main types of emerging workforce models:
  - New categories of health workers – GPLO, care coordinators, health navigators
  - Redeploy existing workers in primary care or in new roles as part of multidisciplinary team.

- Most models include **clinical** and **practice capacity building** roles; the exception being allied health provider roles in Australia where the focus is on the clinical role of (predominantly) private practice professionals.

(McDonald et al., 2006; Narcarella et al., 2010)
Workforce Utilisation – Models of Care

• Team based care – improves quality and safety of care, reduce workload burden of health professionals – coordinated, integrated, collaborative service delivery model – Economies of Scale

• Shared care and collaborative models, nurse led clinics in general practice, upskilling existing workforce, quality care initiatives (NPCC), Chronic Care Models (Wagner, 1996)

• Clarity around roles

• Better understanding – health workforce can complement each other

• In practice barriers: medico-legal issues, business models, funding and sustainability, infrastructure, lack of incentives, risk to innovation (Harris et al., 2009; Narcarella et al., 2010; Zwar et al., 2007)
### Models of Care: Settings

<table>
<thead>
<tr>
<th>RESEARCH SETTING</th>
<th>EMERGING WORKFORCE</th>
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<tbody>
<tr>
<td>• CDM</td>
<td>• Nurse practitioners</td>
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<tr>
<td>• Family practice teams</td>
<td>• GPLO</td>
</tr>
<tr>
<td>• Cancer care</td>
<td>• GPs wit special interests</td>
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<tr>
<td>• Heart Failure</td>
<td>• Shared care</td>
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<tr>
<td>• Ageing</td>
<td>• ‘Guided Care’ Nurses</td>
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<tr>
<td>• Rehabilitation – stroke &amp; brain injury</td>
<td>• Physician assistants</td>
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<tr>
<td>• Child &amp; youth with special needs</td>
<td>• Care coordinators</td>
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<tr>
<td>• Childhood obesity</td>
<td>• Facilitator/liaison type roles</td>
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<tr>
<td>• Hospital in the home</td>
<td>• Case management</td>
</tr>
<tr>
<td>• Respiratory services</td>
<td>• Transition care</td>
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<tr>
<td>• Hospital re-admission</td>
<td>• Self management</td>
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- Care giver support
- Health Navigators
Health Service Integration

- Integrating elements of the healthcare system provides opportunity to:
  - enhance the quality, efficiency and responsiveness of care (transition to and from hospital, pathways between services, seamless care, equity of access, service gaps – health outcomes)
  - improve the quality and safety of patient care (transfer of care – critical feedback loop – community to hospital and home again)
  - Key systems are consistent, including standard treatment protocols, IM/It Systems
  - creates the potential for economies of scale (GPLO workforce)
  - reduce the workload burden of health professionals through supporting a coordinated, integrated collaborative service delivery model (team based models of care, defining roles)

Armstrong and Kendall, 2010; Harris et al., 2009; Naccarella et al., 2010a; Zwar et al., 2007
PHCO – LHN will play a key role in facilitating their role in supporting primary-secondary interface through supporting:
- information management systems
- decision support systems
- disease registers
- coordinating shared care networks
- facilitating coordinated care teams (CoP)
- establishing links between specialists and programs
- coordinating liaison officer support roles
- supporting collaborative methodology and tools (Naccarella et al., 2010a).
Health Service Integration – Performance Measures

- Both PHCO and LHN accountable –
- KPIs:
  - Continuity – Information Transfer (referral/discharge, minimum data sets)
  - Quality, Safety & Access (timeliness, quality of information transfer, access to services)
  - Governance and Partnership (e.g. clinical governance, community/consumer engagement models, partnership agreements)
Engagement Model

- Fundamental to ownership. Recommend developing engagement strategies early
- Clinical
- Community
- Consumer
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Thank You

- Collaborative Research Hub Briefing Series 2

- Check out:
  - [http://www.manchesterknowledge.com/home](http://www.manchesterknowledge.com/home)