Integration, co ordination & multidisciplinary care in Australia Growth by optimal governance arrangements

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29th April 2009
Outline for Today

- Introduction
- Findings
- Policy Implications
- Further research
- Questions
- Appendix
The Australian Primary Health Care Research Institute (APHCRI) funded this research into integrated governance in health care as part of its Stream 4 grant program.

Aim of research: To outline models of integrated governance described in the literature, describe the results of evaluation; and, describe barriers and enablers for achieving sustainable and effective models that can be applied to the Australian context.

Opportunity to
- Use a systematic review methodology to identify sustainable health delivery partnerships internationally
- Utilise a key informant interview methodology to identify information from the ‘grey’ literature and check evidence ‘fit’ within the Australian health care context
Findings

**INTEGRATED HEALTH CARE GOVERNANCE**

1. **GOVERNANCE OPTION i)**
   - Separate organisations merge into one single incorporated body which delivers all services on behalf of the original organisations.

2. **GOVERNANCE OPTION ii)**
   - 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.

3. **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.

**Findings**

- **e.g. Sunrise (NT), North Wyong (NSW).**

- **e.g. Advanced Community Care Association (SA).**

- **e.g. BSCHSI (Qld); Integrated Primary Mental Health Service (Vic).**
Over 50% of studies, supported by key informant interviews, identified the following enablers:

- Shared purpose, clear goals – clear & shared vision, leadership, commitment to outcomes, clear alignment
- Flexible partnership structures – model determined by local need
- Common clinical tools – appropriate clinical governance across the continuum
- Appropriate financing – patient focused approach linked with funding models and incentives
Over 50% of studies, supported by key informant interviews, identified the following barriers:

- Communication – lack of information, unclear expectations, ambiguous roles, duplication.
- Structural – inadequate resources, staff turnover, financial restrictions
- Cultural – lack of trust, eroded credibility, fear of change, unwilling to innovate
Emerging field with limited reported outcome-based research in this area.

Emerging local examples are identified demonstrated a link between strengthened integrated governance vehicles and improved local clinical /service outcomes.

There needs to be a clear separation between governance and operational management.

Careful measurement of process, impact and outcomes is often overlooked.
Brisbane South Collaboration for Health Service Integration (BSCHSI) – MHS, QH, DGP utilising the Service Integration Framework undertook:

- Integrated planning and service platform
- Common vision in relevant care areas
- Clear roles and responsibility for each organisation
- Equitable governance structure
- Connectivity focus
- Outcomes focus
Builds primary care capacity by uniting local general practices around a central ‘beacon’ practice

Supports and extends the capacity of local practices in:
- Areas of local population clinical need
- Undergraduate and postgraduate teaching
- Relevant local research
- Improved integration with local 1^0, 2^0 and other state-funded health care providers
Existing model:
- Removing focus of care away from GP
- Specialist centre holds onto patient

Beacon model:
- Increase capacity of GPs to manage these patients and reduce need for specialist 10/20 care
- Flow on effect of improving other general practices knowledge to manage refugee patients
Further Research

Inala Primary Care & Inala Chronic Disease Management

• CDMS team based approach to Diabetes management

Refugee Health Chronic Disease

• Multi-disciplinary team approach to management of CD in Refugee populations – focus on IPL, clinical model of care, communication using ICT, governance model and research.

GP Super Clinic for Redcliffe – ‘Moreton Bay Integrated Care Centre’ to provide 2 streams of care

• Acute care service
• CDMS team based approach to CDM
Challenges

© Policy makers have to reconsider commonwealth/state boundaries
  • Whose responsibility is it to educate the primary health career?
  • What is the incentive for the GP to participate and how engage?
    © Review remuneration for the “Clinical Fellow”/up-skilled GP, specialist and
      multi-disciplinary team
© Review “Business Rules” especially with respect to information
  systems and sharing of patients clinical information eg who owns the
  patients and the patient record?
© Navigating MBS to ensure sustainable and identifying need for new
  MBS item numbers
© Culture change - GP refer to another “GP”
© Long term sustainability and applicability to other
  chronic disease and settings
International experience

Polyclinics (UK) – no evaluation yet

- Development of polyclinic should only proceed where quality, access and cost benefit to local population is clear.
- Primary focus should be on developing new pathways, technologies and ways of working together.
- Co-location alone not sufficient to generate co-working
- Investment in CMx and strong clinical & managerial leadership required.
- Hub and spoke model more likely to achieve desired development of primary care services than major centralisation.
- Needs to be responsive to local need
- Requires rigorous evaluation

Other countries

- Lack of rigorous evaluation of polyclinics and contextual differences are important.
- Co-location not enough to guarantee integrated care.
Integrated Care Pilots (UK) - 16 sites launched 1st April 2009

- Identified need for improved integration between health and care services, to improve access to and quality of care within local communities
- Pilots to test and evaluate a range of models of integrated care
- Recognising one model will not work everywhere
- Requires bringing teams together, integrating the way staff work and creating new relationships between organisations
- National evaluation – impact on health outcomes, improved quality of care, service user satisfaction, effective relationship and systems.

Family Health Teams (Canada)
Questions?
