KEY MESSAGES

Integrating Care: Learning from first generation integrated primary health care centres

January 2017

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Policy context

Primary health care system reform has shifted its focus from GP Super Clinics to Health Care Homes. Each represents an ‘extended general practice model’ that aims to improve integration and quality of care, focuses on chronic disease management and prevention, supports coordination between and across services, increases access, and may promote workforce development. Useful lessons about the process and outcomes of integration can be learned from Aboriginal Community Controlled Health Services (ACCHS), which predate the GP Super Clinic model by nearly 40 years, and from newer models of co-located integrated primary health care offered by community-based refugee health services. Many of the quality innovations in primary health care which are now moving into broader general practice settings, from quality indicators to the ‘patient-centred medical home’, were pioneered in this sector. Distinctions between these broad-based primary care services for specific populations and more constrained integrated primary healthcare centres are likely to be artificial in terms of the primary care mandate to provide patient-centred whole person care.

Key messages

This project explored co-location in an ACCHS and in a refugee health centre, as a strategy for promoting service integration within multidisciplinary primary healthcare clinics, and identified developmental and operational characteristics that promote successful integration,

> Integration is both a process through which clinical and non-clinical staff coordinate tasks, and an outcome that recognises the patient in their unique context.

> Integration emerged organically in both case studies through commitment to the organisational ethos and a focus on patient-centred care, not through an objectified form of clinical integration which is often at the heart of efforts to seek or create integrated services.

> Physical co-location of services is an enabler, but not of itself a sufficient driver, of integration.

> It is important that clinicians strongly identify with their own team, but that the clinical boundaries between them are allowed to blur to foster understanding and communication.

> Informal communication and interactions are important in driving integration and may be facilitated by co-location.

> For patients, integration feels like belonging. This is reinforced by staff who are committed to a strong organisational ethos and the legitimate candidacy of patients.

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health.