Improving integration of Care

A discussion paper for Medicare Locals

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THE UNIVERSITY OF NEW SOUTH WALES

Australian Medicare Local Alliance (AML Alliance) is a new national, government funded not- for-profit company. It has been set up to spearhead an organised system for primary health care across the country through a network of independent companies called Medicare Locals (MLs) - regional primary health care organisations which will play a key role in planning and coordinating primary health care services for their respective populations.

AML Alliance will have an interest and voice in Australia's primary health care policy setting and system. It will work with a variety of stakeholders including the general practice, health, aged and social care sectors to advance primary health care and promote improvement and excellence in the ML sector though evidence-based and innovative quality practice.

Lead by a skills-based board, AML Alliance will work with 62 MLs to:
- Make it easier for patients to navigate their local health system
- Provide more integrated care
- Ensure more responsive local General Practitioner (GP) and primary health care services that meet the needs and priorities of patients and communities
- Make primary health care work as an effective part of the overall health system.

AML Alliance's primary roles are to act as a lead change agent for Medicare Locals and to support Medicare Local performance.

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Introduction

This discussion paper has been developed by Australian Medicare Local Alliance (AML Alliance) in conjunction with University of New South Wales Research Centre for Primary Health Care and Equity.

This discussion paper is about integrating care. This is one of the major weaknesses of our current health care system, and one of the reasons Medicare Locals were established. It is also one of the places where primary health care can make a major difference.

Medicare Locals cannot solve the problem of fragmented care on their own. They cannot change national or state policy, and have little direct control over primary health care services. They must work with Local Health Districts and other services, who may have different priorities and approaches. So a collaborative approach is needed, with an emphasis on achieving 'good enough' integration that meets the needs of patients, communities and health professionals without being over-engineered.

Ahgren[1] refers to a 'patient Bermuda triangle' where patients drift in a sea of organisational, professional and cultural fragmentation. This paper identifies ways in which Medicare Locals can address these root causes of poorly integrated care, through tackling areas of fragmented care, creating infrastructure like secure messaging systems to support integration, building the capacity of services and providers and working closely with other health and related services.

In all of this, working with the patients and communities will be essential, so that health care can be designed around their needs rather than around organisational and professional boundaries.

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[1] Ahgren B (2010). 'Dissolving the patient Bermuda Triangle'. International Journal of Care Pathways, vol 14, no 4.

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What is this discussion paper about?

This purpose of this discussion paper is to help Medicare Locals and their partners identify what they can do to provide more integrated primary health care for their patients and communities.

Fragmented care is a problem for all advanced health systems. Ageing populations with an increasing burden of chronic conditions need consistent and well coordinated care. But services are becoming more specialised, often following sectoral and professional boundaries rather than the needs of patients and communities. Physical, mental, dental and social care services are poorly linked, leaving patients confused and providers frustrated.

Some common examples:

- community members and service providers cannot find the services they need;
- GPs do not know when patients are discharged from hospital;
- people with severe mental illness do not receive proper physical and dental care;
- people with multiple chronic conditions receive conflicting advice from different specialists and teams;
- families with multiple challenges receive uncoordinated assistance from health, education, community services and other sectors.
- public and private sector clinicians do not understand each others' priorities or ways of working.

Integration is firmly on the agenda of Medicare Locals. It was highlighted in the National Primary Health Care Strategy:

> Many patients, particularly those with complex needs, have either been left to navigate a complex system on their own or, even when supported by their GP, have been affected by gaps in information flows.
>
> A key challenge for primary health care reform is to better integrate and coordinate the range of organisations and service providers operating within primary health care, and to better link primary health care and other sectors.
>
> Continuity and coordination of care (will be) improved for those with chronic disease through better targeted chronic disease management programs linked to voluntary enrolment and local integration.
>
> National Primary Health Care Strategy (2010)[2]

Working with their Local Health Networks, Medicare Locals are expected to play a leading role in achieving more integrated primary health care. According to the government's Your Health website, Medicare Locals will:

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[2] Department of Health and Ageing (2010). Building a 21st Century Primary Health Care System. http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/report-primaryhealth#.T8q6ObBo1AU

> Make it easier for patients to access the services they need, by linking local GPs, nursing and other health professionals, hospitals and aged care, Aboriginal and Torres Strait Islander health organisations, and maintaining up to date local service directories.
>
> Work closely with Local Hospital Networks to make sure that primary health care services and hospitals work well together for their patients[3].

They will achieve some of this by implementing state/territory or national programs – for example the 48 hour follow up program for Aboriginal patients in NSW or Primary Care Partnerships in Victoria - but other local initiatives will also be needed.

The first four sections explore what integration of care is, evidence of benefit, how it can be improved and what helps or hinders this. Section 5 looks at opportunities for Medicare Locals, taking account of their role and place in the health system, section 6 how progress can be monitored and section 7 what this can contribute to the future of the health system. The appendices provide further information, references and useful websites and resources.

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[3] http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/medilocals-lp-1#.T8q6zrBo1AU, accessed 2/6/2012

What is integrated care?

A WHO report defines health services integration as:

the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money[4].

Integrated care is organised around the needs of those receiving it, and should be[5]:

- **comprehensive:** meeting all relevant health and social care needs;
- **coherent:** making sense to those providing and receiving care;
- **well coordinated**: convenient, avoiding duplication and wasting as little time as possible for all concerned;
- **patient or community centred:** taking account of the patient's or communities' perspective on their health and health care needs, and the reality of their lives[6].

Care is usually integrated by clinicians and clients within normal practice: as part of assessment, treatment, referral, review, education and self management support. Although this works in most cases, for an increasing number of occasions these informal arrangements are not enough. Patients fall into the gaps between services, receive inconsistent care and feel unsupported at the time they most need it.

When is integration likely to break down?

Complex care needs: *people with multiple co-morbidities, older people with frail health*

Complex and critical treatments: *warfarin therapy*

Multiple providers and services, particularly if from different parts of the health and social care systems: *discharge, transfer, ongoing cancer care, chronic mental illness*

People are not well connected to the health system: *newly arrived refugees, Indigenous people*

People with limited resources to coordinate their own care,: *people with intellectual disabilities, with language or cultural barriers,*

Clinicians and services without the capacity to work effectively with other services: *some solo general practices.*

Lack of systems and structures to support integration: *unreliable referral systems, inconsistent eligibility criteria, no electronic records or secure messaging, explicit clinical governance systems*

Although integration is important, not all care needs to be highly integrated, and integrating care is not a panacea: as a WHO paper notes, *integration isn't a cure for inadequate resources*[7]. It can also have perverse results, as illustrated in Leutz pithy *Five Laws of Integration*[8]*.*

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[4] World Health Organisation (2008). Technical Brief 1, 2008. Integrated Health Services. What and Why? Making Health Systems Work. Available at: http://www.who.int/healthsystems/technical_brief_final.pdf (accessed 2/6/2012)

[5] See Appendix 1 for different levels for each of these qualities.

[6] Shaw S, Rosen R, Rumbold B (2011). What is integrated care? London, Nuffield Trust

> You can integrate all of the services for some of the people, some of the services for all of the people but you can't integrate all of the services for all of the people
>
> Integration costs before it pays
>
> Your integration is my fragmentation
>
> You can't integrate a square peg and a round hole
>
> The one who integrates calls the tune

The aim is perhaps 'good enough integration' which, like a 'good enough parent', achieves its aims even if it is not perfect. One way to approach this is through a stepped approach.

Figure 1 shows integration of care as a series of steps, corresponding roughly to levels in the Kaiser Permanente triangle (see below). The figure should be read from the bottom up. The bottom step this links between different providers or elements of care is largely informal and relies on unstructured collaboration. As care becomes more specialised and complex, more structured arrangements are needed. The aim is to organise care at the lowest level that is 'good enough' to meet a person's need.

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[7] WHO (2008) op. cit. p1.
[8] Leutz WN (1999). 'Five laws for integrating medical and social services: lessons from the United States and the United Kingdom'. Milbank Quarterly, vol 77, no 1, pp 77–110

Figure 1: a stepped approach to integrating care[9]

		Kaiser level	
Integrated care	All primary health care provided by a team under a single clinical management system. *Groups where consistency and continuity is essential: e.g. palliative care*	Kaiser level 3 Case management	Integration
Intensive case management	Care coordination with a case manager who has authority and responsibility to oversee care. May be supported by budget for patient's care. *Individual patients with complex care, where coordination is essential*	Kaiser level 3 Case management	Integration
Shared care	Structured care + patient registration + program governance, agreed roles for providers and services, shared systems for communication, information sharing, review. *Groups of patients requiring very consistent care from multiple providers over time*	Kaiser level 2 Care management	Coordination
Care coordination	Structured care + care coordinator who assists providers and patients to provide and access care as planned. *Individual patients and carers and their providers who need assistance with organising care*	Kaiser level 2 Care management	Coordination
Structured care	As below, + use of shared protocols and structured tools/pathways as required (GP Management plans, Team Care Arrangements). *Conditions requiring consistent care over time, transitions between services/providers*	Kaiser level 1 Supported self care	Linkage
'Normal' care	Care is Integrated through routine processes (assessment, care planning, referral, unstructured information exchange, informal patient education). *Episodic care and care largely from one provider.*	Kaiser level 1 Supported self care	Linkage

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[9] For a table summarising some ways of strengthening integration of care at each level, see Appendix 2.

Most health care is perfectly well managed through '**normal care',** using standard methods of assessment, treatment, referral and patient education. The range of care that can be managed in this way can be extended where clinicians are experienced, services well organised and there are good tools for coordinating care: for example single points for referral and standard eligibility requirements for services. Where this informal approach is not sufficient, care may need to be more **structured**, using shared pathways, protocols or other tools that are specific to a condition or treatment. These lower levels correspond to level 1 in the familiar Kaiser triangle of chronic care - 'supported self care'[10].

Where tighter integration is required, **care coordination** or **shared care** may be needed. These correspond to level 2 in the Kaiser triangle – 'care management'. Care coordination brings in a person who assists that GP (or other responsible clinician) to organise the services that are required, and make sure that the patient can access them. Individuals often only need care coordination for a limited time - for example during the acute phase of a condition. **Shared care** is for groups of people – for example those with diabetes - who need standardised and well coordinated care from different providers over a period of time. This involves agreed roles for the different providers, standard protocols and pathways, systems for sharing information and agreed outcomes. Shared care programs usually have a governance structure that monitors the program.

Finally there are some individuals and groups whose care is so finely balanced that it needs to be under the direct supervision of a single clinician (**intensive case management)** or clinical team (**integrated care).** Again, this may be a short or longer term arrangement. This corresponds to the top of the Kaiser triangle.

As care becomes more integrated, it requires tighter links between the service providers and organisations involved. This is summarised in the final column of Figure 1.

Linkage requires least changes to clinician and service routines, and improvements in linkage arrangements – for example secure messaging - have a potentially very wide application. **Coordination** requires providers to adopt a standard approach to coordinating care, usually for a specific condition or group of patients. This can be more challenging to implement. Full **integration** can be the most difficult to establish, and is usually reserved for exceptional circumstances: for example for AIDS sufferers in the early days of the HIV epidemic received their primary health care through specialised clinics. Now that the condition is more manageable, many are treated within mainstream primary health care.

The box below gives some examples of how Divisions or Medicare Locals have promoted integration of care at different levels. They illustrate how much this has been the bread and butter work of Divisions.

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[10] See Appendix 1(b) for the Kaiser triangle

Divisions/Medicare Locals integrating care: some examples

Normal and structured care

- *Aboriginal Health Workers in General Practice*: training Aboriginal Health Workers and supporting their employment in general practice, to enable more comprehensive and coordinated Aboriginal health care in those practices. (*New England DGP*)

- *Goldhealth network*. This secure network links general practices, specialists, hospitals and allied health professionals. A shared electronic health record is under development (*Goldfields DGP*)

- *Access to Allied Psychological Services Program.* Divisions and Medicare Locals act as fund holders and provide streamlined access to psychological services for GPs and their patients.

- *Mental health services in rural and remote areas program*. This provides culturally appropriate Primary Mental Health services for remote communities and outstations, including early intervention assessment, treatment, health education and promotion, as well as a pathway to secondary and/or specialist care. (*General Practice Network NT*)

Care coordination and shared care

- *Team Care Coordination*: Team Care Coordinators (community nurses) work with GPs to assess, plan and monitor their patient's health care and link them to community and allied health services. (*Metro North Brisbane Medicare Local*)

- *GP Plus Practice Nurse Initiative*: the Division trained and supported practice nurses to act as care coordinators for high needs patients in their practices, and arrange referrals to other services as required (*Adelaide North East Division of General Practice*).

- *GP Links*: Aboriginal health workers contact patients recently discharged from Royal Perth Hospital, assess their health needs, make an appointment with their regular GP and refer them to other services as needed. (*Canning Division of General Practice and Royal Perth Hospital*)

- *Diabetes Education and Management Program* provides comprehensive diabetes care to 60% of the estimated local population with diabetes. The program links general practice care with the Division diabetes, pre-diabetes or diabetes prevention programs, using a database to monitor progress (*Southern Highlands DGP*)

Integrated care

- *Headspace*: a number of Divisions and Medicare Locals are involved in this program, which provides integrated physical and mental health care for young people at risk of mental illness.

Source: Division and Medicare Local web sites

What is the evidence for benefit from integrated care?

Integrated care has been studied in many different contexts, and the evidence of benefit is mixed. Most evidence comes from programs addressing specific health issues (e.g. depression, COPD), or broad based trials of coordinated care across health services. There is less evidence from 'bottom up' developments within individual practices and services, or from other more local initiatives. We know more about the benefits to individual patients or the health system than to the communities' health or access to quality health care.

The following table, taken from a review in 2008, gives a summary of specific conditions for which integrated care approaches have been found to be beneficial.

Table 1: Effectiveness of integration[11] of care by issue

Condition	Care/case mgt	Disease mgt	Int. Care
Heart disease	✓	✓	✓
Asthma	✓	✓	
COPD		✓	✓
Diabetes			✓
Chronic (general)	✓	✓	✓
Mental health	✓		✓
Older people	✓	✓	✓
Palliative care			✓
Stroke			✓

Source: Scottish Government Social Research 2008[12]

Table 2 summarises the evidence from a 2005 report on different methods of integrating chronic disease care.

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[11] Note that it tables 3 and 4 'integrated care' is used as defined in the source reports, which may not be exactly the same as in the rest of this report.
[12] Johnston L, Lardner C and Jepson R. Overview of evidence relating to Shifting the balance of care: a contribution to the knowledge base. Scottish government Social Research, Edinburgh. Available at www.scotland.gov.uk/socialresearch. Accessed 2/6/2012

Table 2: Effectiveness of integration of care by methods

	Impact on patient experience	Impact on quality of care	Impact on clinical outcomes	Impact on resource use
Broad managed care programs	Improved satisfaction	Improved quality of care	Some improved outcomes	Some reduced costs
Integrated care[4]	From multi-disciplinary teams			Some reduced costs
Greater use of primary and community care				May reduce overall healthcare costs
Identifying those most at risk			Some improved outcomes	Reduced resource use
Case management for most vulnerable	Improved		Targeting people at high risk may improve clinical outcomes	
Evidence based care pathways		May improve processes of care		
Appropriate data collection and monitoring		Improved quality of care		Some improved outcomes
Learning and sharing amongst professionals		Some improved quality of care		
Involving patients in decision-making	Improved satisfaction and empowerment		No real changes	
Accessible structured information	Improved knowledge	Improved adherence to medication	No real changes when used alone	
Self management education	Improved self care and overall satisfaction	Improved quality of care	Some improved clinical outcomes	Reduced resource use and cost
Self-monitoring and referral systems		Improved quality of care	Improved clinical outcomes	

Adapted from Singh (2005)[13]

These very high level summaries[14] show widespread but not uniform benefit, and suggest that some issues and approaches are likely to be better bets than others. Note that much of this evidence comes from trials rather than routine care, and that what works in one setting may not work in another.

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[13] Singh D (2005a). Transforming Chronic Care: Evidence about improving care for people with long-term conditions. Birmingham: Health Services Management Centre. Available at: www.download.bham.ac.uk/hsmc/pdf/transforming_chronic_care.pdf (accessed on 2.6.2012).

Integration is more likely to be successful if it involves multiple rather than single strategies (e.g. training, improved systems, co-location of services). Improving systems to support integration of care is more likely to improve health outcomes, while improving relationships between providers is more likely to increase provider or patient satisfaction[15].

Broad based care coordination programs have a mixed history, reflected in a recent evaluation of sixteen regional Integrated Care Pilots in the UK[16], each addressing locally identified priorities. There was better use of processes such as care planning, and staff perceived that care had improved and would improve further. However most patients did not report any improvement and some feared losing continuity of care or having more 'professionalised' care. There were savings in planned admissions and outpatient attendances but not emergency admissions. Sites using case management had reductions in the overall cost of primary and secondary care.

The evaluators drew a number of conclusions:

- Large scale integration is more complex than most participants anticipated. Some of the problems lay outside the scope of the program (e.g. government policies).
- Several programs were over-ambitious. It was easy to get lost in developing the mechanics of integration and lose the perspective of clinicians and patients.
- Large scale coordination programs can improve quality of care over time if they are well managed and well led. However they tend to be driven by the perceptions of service providers rather than patients, whose needs might sometimes have been better met in other ways.
- Case management approaches can lead to reductions in secondary care costs.

Thus integrating care is a useful strategy for improving the quality of care in some circumstances but not all. It is a complex undertaking that requires strong leadership, careful planning, time and resources, and is likely to pay off in the longer rather than the shorter term. Ongoing monitoring and evaluation can help fine tune programs to make sure they work as intended.

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[14] For further details and supporting evidence, see the original reviews.

[15] Powell Davies PG, Williams AM, Larsen K, Perkins D, Roland M, Harris MF (2008). 'Coordinating primary health care: an analysis of the outcomes of a systematic review'. Medical Journal of Australia, vol 188, no 8, S65–S68.

[16] RAND Europe, Ernst & Young LLP (2012). National Evaluation of the Department of Health's Integrated Care Pilots. http://www.rand.org/randeurope/research/projects/integrated-care-pilots.html accessed 2/6/12

Improving integration

'Every system is perfectly designed to get the results it gets'[17]. This means that better integration is likely to mean significant changes to systems and services. Fulop (2006) has identified a number of areas within which changes can be made to improve integration of care (figure 2).

Figure 2: domains for integration after Fulop (2006)[18].

Systemic integration *(consistent privacy policies, pooled funding arrangements)*		
Functional integration *(shared records, service directories, single point of contact for referrals)*	Organisational integration *(e.g. joint ventures, liaison officers, service networks)*	Service integration *(multi-disciplinary teams, 'one stop shops')*
	Integrated care to the patient/ services to the community	
	Clinical integration *(shared care programs, use of clinical pathways)*	
Normative integration *(multi-disciplinary training and education)*		

Organisational integration involves bringing organisations together to support more integrated care. This might include collaboration agreements with Local Health Networks, joint working groups for service planning or community consultation, and in some case joint accreditation or employment of staff. Liaison officers can be employed as 'boundary spanners' between organisations, and the Medicare Local can support networks of otherwise independent service providers working on a particular issue – for example refugee health.

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[17] Dr Paul Betelan, quoted at http://dartmed.dartmouth.edu/summer06/html/what_system_03.php, accessed 1st April 2012

[18] Strictly, Fulop treats these as areas in which *integration* can be pursued. However there may other strategies – for example capacity building – which can be undertaken in each of these areas in order to achieve the prime target of integrated care to the patient/services to the community.

Functional integration builds systems that support better integration of care. This might include shared records or communication systems; service directories; sharing population profiles for planning with other organisations, or having a single front desk and appointment system for an integrated primary health care service.

Service integration brings clinicians and services together within a shared organisational structure. These might involve an integrated primary health care service with doctors, nurses and allied health providers; co-locating services which remain separate but collaborate closely (primary medical care and addiction services), or supporting multi-disciplinary teams.

As with other aspects of integration, personal relationships and trust are essential, along with appropriate functional systems to support integrated care.

Clinical integration coordinates care through clinical systems: for example using shared guidelines and protocols or shared care programs.

Normative integration creates values and expectations that support integrated care. This can be highlighted in the Medicare Local vision and through its partnerships and promoted by organisational and clinician leaders. It can be strengthened by, for example multi-disciplinary and cross sector education programs, or through awards and other recognition for achievements in integration.

Systemic integration is creating coherent policies and operational rules that support integration. Medicare Locals and Local Health Districts can work together to streamline local policy and procedures and remove barriers to integration.

Integration of care to the patient or services to the community is the goal. This may not require action across all domains: an improved communication system or single point of access may be enough, leaving service providers and patients to do the rest themselves. Of course it is also possible to improve other domains and have no impact on patient care.

A Medicare Local may be active in each of these domains. This will involve a wide range of stakeholders, who may have different ideas and frameworks that guide their thinking about integration. Some of the better known of are summarised in the following table.

Table 3: Concepts and models for integrating care

	Model	Use
Patient/provider	Bio-psycho-social model of health care	Highlights the range of needs to be considered in integrated care (may also include spiritual needs)
	Shared decision making	Provides framework for involving patients in decisions about their care
	Health literacy	Identifies patients' capacity for contributing to managing and coordinating their care
	Self management support	Identifies ways of supporting patients' contribution to managing and maintaining their health
Health care team	Multi-disciplinary care	Considers the ways in which providers can work together and the structures needed to support this
Managing care	Joint/shared care planning, assessment and review	Describes ways in which different clinicians and patients can collaborate in planning and monitoring a patient's care needs
	Shared care	Involves a framework of shared roles, guidelines, pathways and outcomes to coordinate evidence based care for people with a specific condition.
	Care coordination	A system of supporting patient and providers to ensure that he/she receives the care agreed in a care plan relating to a specific condition (e.g. a Team Care Arrangement).
	Case management	A system of coordinating all the care for individuals involving assessment, planning, linking monitoring and advocacy (not condition-specific).
	Care management	A system of coordinated health care for the **population** that is not disease-specific and involves care planning and coordination.
Service/practice	Health Care Home	American concept of a service that provides comprehensive, coordinated and continuing care over time to a specific group of patients.
	Integrated primary health care service	Primary health care service involving at least GPs, nurses and allied health staff working as a health care team. This includes many Aboriginal community controlled health services, community health centres with GPs, GP Superclinics, HealthOne NSW and GP Plus in South Australia as well as some private developments.
Chronic care	Kaiser triangle	Diagram relating different types of care coordination to different levels of health and health care need.
	Disease management	A program of continuous, coordinated and comprehensive health care for people with a specific condition.
	Chronic care model	A model of how the different elements in chronic disease care come together through an informed activated patient and a proactive activated team and a proactive prepared practice team.
	Extended chronic care model	As above, but includes the role of the community.

What helps or hinders?

Greater integration will only occur if managers, service providers, patients and carers believe that the benefits outweigh the costs. This includes altruistic benefits, but personal and professional costs also need to be considered. This perception may change over time as people experience new ways of working.

Table 4 summarises some of the typical benefits and costs for the different groups.

Table 4. Typical costs and benefits of integrating care

	Typical benefits	Typical costs
Providers	Better patient outcomes Greater professional satisfaction Greater income/better use of resources Improved quality of life Professional standing	Costs of adopting/following new practices Loss of autonomy or power Reduced income Working in unfamiliar ways or with people they do not trust
Managers	Better community outcomes Greater efficiency Greater professional satisfaction Meeting external targets	Difficulty in implementing change Extra costs of improved systems Addressing provider resistance Engaging the community
Patients and carers	More comprehensive care Better health and quality of life More convenient /cheaper services Greater satisfaction Better support for self management	Loss of familiar routines of care Loss of personal continuity of care Concern about confidentiality

Costs and benefits tend to fall unevenly across the groups, especially those with different roles (providers and managers) or at different levels in the organisation (team leaders and front line staff). All parties need to be involved in service re-design to find ways of making new arrangements a winner for all.

Integration is particularly difficult when the impetus comes from only one of the parties involved. This was one of the major barriers in the NSW ABHI Primary Health Care Integration Program, which funded Divisions to improve integration of care but gave their partner Area Health Services no funding. It was also difficult to get a flow through from high level collaboration to changed patterns of care[19], as the following table shows.

Commitment within the Division	All
Partnership with the Area Health Service and other organisations	Nearly all
Practical ways of working together on specific integration tasks	Most
New service arrangements, models of care, systems integrating care	Some
Changes in patterns of patient care.	Few

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[19] Powell Davies PG, McDonald J, Christl B, (2010). Evaluation of the NSW Australian Better Health Initiative Primary Care Integration Program. Sydney, UNSW Centre for Primary Health Care and Equity

Integration is generally helped by the commitment of health service staff to providing good health care, and evidence of patient or community benefit can be a powerful motivator[20]. Many enjoy being involved in projects, and clinical leaders can become champions for change. Better systems for supporting integration - single referral points, secure messaging – make it easier and more rewarding. Finally there are strong expectations that Medicare Locals and Local Health Networks will collaborate.

Co-location – putting different teams under one roof – can help. However it is no guarantee of integrated care: while corridor conversations can be helpful, teamwork and proper systems (especially shared records) are also needed. Contrariwise, teams can achieve well integrated care across different sites providing that systems and supports are in place. While it can be useful to be part of the same organisation, the focus has shifted in recent years towards virtual integration through networks of services, linked by shared protocols and information systems.

Some barriers are frequently under-estimated.

- **Power**. Integration often means working with people of higher or lower status. This can be uncomfortable, and lead to unwelcome compromises.
- **Tunnel vision**. People often find it difficult to understand the world of other services or providers.
- **Autonomy**. Professional culture emphasises the exercise of clinical judgement. Sharing care can seem to undermine this.
- **Time.** Clinicians may find planning and change management distractions from their main task of service provision, and, for those in the private sector, from their source of income.
- **Frequent changes** in health systems can mak**e se**rvice providers sceptical.
- Different **drivers** (economic and other) - between service providers and managers, public and private sectors and Medicare Locals and Local Health Networks.
- **Scaleability.** New patterns of care will only reach the population at large when they are adopted by the majority of providers.

In addition, the balance of costs and benefits is likely to be less favourable and integration more difficult where:

- issues of privacy, intellectual property or clinical responsibility are unclear;
- relationships are weak or hostile;
- there is an oversupply of services (and hence potential competition for work);
- there is a culture of focusing on the interests of providers rather than of patients or communities;
- the groups have a limited understanding of each others' worlds, or of patient or community needs.

What are the opportunities for Medicare Locals?

Medicare Locals work within state and national policies which they cannot change, and seek to influence the behaviour of clinicians and services over which they have little direct control. Their role will often be one of persuasion and facilitation rather than direct control.

Divisions of General Practice showed that much can be achieved in this way: for example some established networks of health service networks, developed new models of care for people with chronic conditions and improved practice capacity for coordinating care. The challenge was often to get innovations taken up on the wide scale needed for population level impact.

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[20] Note however that clinicians may be more focused on benefits for their patients, and planners/managers on the overall benefit to the community

Problems can be identified in several ways: through data on service utilisation (e.g. high rates ambulatory sensitive conditions) or outcomes data (high death rates from heart failure); or through reviewing areas where problems often arise (aged care, transfers between hospital and primary care, chronic disease care, and primary care in nursing homes). Patients, community and partner organisations may also identify problems, especially if the Medicare Local has an open approach to feedback.

They can improve integration of care directly, by tackling specific areas of fragmented care, or more indirectly by improving infrastructure, enhancing services' and providers' capacity and working closely with partner organisations. Opportunities will arise across the areas of Medicare Local's work:

- building the Medicare Local organisation and its partnerships;
- strengthening networks of services/providers and the systems needed to support integration of care;
- needs assessments and planning;
- building the capacity of providers and organisations; and
- direct program and service development.

These are discussed below, and related back to the domains of integration on P.14.

Developing the ML organisation and its partnerships
This contributes particularly to normative and systemic domains

The Medicare Local can keep integration on the agenda by being inclusive, working within an explicit primary health care framework, and making integration a focus of all its partnerships. It can encourage member organisations and the community to use the Medicare Local as a forum for resolving integration problems, even where they are not a direct Medicare Local priority. It can adopt a 'whole of health service' perspective it its dealings with Local Health Networks and the local community.

Strengthening the networks and systems needed to support integration of care
This contributes particularly to organisational, functional and clinical domains.

The Medicare Local can make its policies and protocols more consistent with those of Local Health Networks. It can establish networks of service providers working in areas like refugee health, Aboriginal health or within a common geographical area. It can create the infrastructure to support integrated service provision: service information for providers and community (including eligibility criteria, costs and hours of operation), simplified referral processes, a single point of referral for all community based services, and systems for secure communication and sharing records. It can use boundary spanners and inreach to link organisations: liaison staff, primary health care triage staff in the Emergency Department, or community based teams for hospital discharge planning.

Needs assessment and planning
This contributes particularly to service and clinical domains.

These provide opportunities to identify and address service gaps and problems of fragmentation, particularly if conducted jointly with other organisations and focused on the needs of people rather than single conditions.

Building capacity of providers and organisations
This contributes particularly to functional and clinical domains.

The Medicare Local can help create the capacity for integrated care within practices/services and between them. This might include supporting liaison roles for practice nurses, shared information systems and agreed protocols for sharing care. Medicare Locals will have a particular opportunity to extend this to private allied health providers.

Direct program and service development

This presents opportunities for addressing all domains

The Medicare Local can create examples of well integrated care, within existing services and in any new services it develops or commissions. Medicare Locals and Local Health Networks may be able to work together to implement national and state integrated care initiatives.

Are we making progress?

There are many ways of monitoring progress in integrating care. Three broad approaches are suggested here.

One is to evaluate integration projects separately, ideally moving from formative evaluation (is this developing as we wanted?) through summative evaluation (is this achieving our goals?) to ongoing monitoring of key outcomes. Typical outcome measures for such evaluations include the following.

> **Uptake**: what proportion of clinicians and services are using the initiative?
> **Reach**: what proportion/ distribution of eligible people are benefitting?
> **Equity** – is it reaching those most in need?
> **Satisfaction**: do patients and clinicians prefer the new arrangements?
> **Cost and cost effectiveness**: is it worth it?
> **Efficiency**: does it make better use of resources?
> **Quality of care**: improved? For whom?
> **Service utilisation**: changed? More appropriate?
> **Health outcomes**: improved?
> **Sustainability**: is the funding/support available to maintain the new care arrangements over time?

Specific outcome measures may also be relevant for different areas of health care.

Another is to monitor overall progress in supporting integrated care, using a modified Donabedian framework.

- **Context:** do we know what systems and programs are in place? Have we identified the problem areas?
- **Inputs**: do we have the right partnerships, information systems in place?
- **Processes:** do needs assessments and planning focus on integration? Are we working with the right stakeholders?
- **Outputs:** what new systems have we built? Capacity developed? Programs implemented?
- **Impacts:** how well do services collaborate? What proportion of service providers and patients are receiving relevant models of care?
- **Outcomes:** what are the improvements in glycaemic control, reductions in unplanned hospital admissions?

Finally, it is also possible to monitor progress in each of the domains described on P14.

Organisational integration
- Is integration a specific priority for the Medicare Local?
- Do the Medicare Local and its partners understand each other's circumstances and approach to health care?
- Is integration of care part of the work plan with members and with the Local Health District?
- Does the Medicare Local conduct its community consultation and planning and service development jointly with the Local Health District?
- Are there arrangements for joint clinical governance?

Normative integration

- Do all working parties, training programs and community consultations involve a full mix of services, community groups, professions and sectors?
- Are there identified clinician and consumer leaders for key areas of integration of care?

Systemic integration
- How does the Medicare Local learn of problems that service providers and people experience with integration of care?
- Do the Medicare Local and Local Health District have consistent policies and protocols to support integration of care?

Functional integration
- Are there systems to support referrals, including up to date service directories, standard referral forms for Local Health District services and a single access point for referrals?
- Can primary health care services messaging securely to other services within the Medicare Local district?

Service integration
- What is the Medicare Local doing to support co-location of services?
- What is the Medicare Local doing to support multi-disciplinary team work within and between services? Is it improving?
- What networks of service providers (e.g. for refugee health) does the Medicare Local support, and what proportion of relevant service providers take part?
- Are services developed or commissioned by the Medicare Local fully integrated, internally and with other services?

Clinical integration
- Have priority areas for integration been agreed within the Medicare Local and with the Local Health District?
- Do major transitions of care occur smoothly (e.g. between hospital and community, residential aged care and emergency departments, rehabilitation programs and follow up care)?
- Can primary health care providers to be involved in the care of their patients when in hospital or with a specialist service?
- Are there structured shared care arrangements for chronic and other conditions which need this level of support? What is known of their reach and effectiveness?

Integrated care
- What proportion of people receives well integrated care for high priority issues (e.g. complete cycles of diabetes care)?
- Has this increased?
- Is this equitably distributed?
- What is the impact on health outcomes, satisfaction, and service use?

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Appendix 1: resources and further reading

Web sites

The Kings Fund (www.kingsfund.org.uk) and the Nuffield Trust (www.nuffieldtrust.org.uk) have extensive UK resources and discussion on integrated care, including case studies. While these need to be translated to Australian conditions, the thinking and the evidence summaries are very useful

The Australian Resource Centre for Healthcare Innovations (www.archi.net.au) has Australian material, including pathways for a number of different conditions. State health websites often have state specific pathways and integrated care programs and resources: for example in NSW the Agency for Clinical Innovation (http://www.aci.health.nsw.gov.au) and in Victoria the Department of Health (http://www.health.vic.gov.au/divisions/wica/integrated.htm)

The International Journal of Integrated Care (www.inic.org) has published articles on integrated care for more than ten years. It is worth browsing its back list of articles for particular topics.

Books, reports and articles
Policy

Department of Health and Ageing (2010). Building a 21st Century Primary Health Care System. Canberra, 2010. http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/report-primaryhealth#.T8q6ObBo1AU, accessed 2/6/2012

This is the foundation document for the current primary health care reforms in Australia. It has a strong emphasis on integration.

Concepts of integration

Kodner, DL & Spreeuwenberg, C (2002): Integrated care: meaning, logic, applications, and implications – a discussion paper. International Journal of Integrated Care, Vol. 2, 14. Nov. 2002

One of the foundation papers for the current integrated care movement. Well worth re-visiting.

Singh D, Ham C. Improving care for people with long term conditions: a review of UK and international frameworks. Health Services Management Centre, Birmingham. Available at http://www.improvingchroniccare.org/downloads/review_of_international_frameworks__chris_hamm.pdf. Accessed 2/6/2012

An excellent compendium of models for prevention and management of chronic conditions from different countries, with a strong emphasis on integration.

Experience and ways ahead

Curry N, Ham C (2010). Clinical and service integration. The Kings Fund, London. Available at http://www.kingsfund.org.uk/publications/clinical_and_service.html, accessed 2.6.2012

An excellent overview of integration, drawing on examples from a range of countries.

Goodwin N and Smith J. The Evidence Base for Integrated Care (presentation). Available from the Kings Fund at

http://www.kingsfund.org.uk/applications/site_search/?term=fulop&searchreferer_id=2&submit.x=28&submit.y=17, accessed 2/6/2012

A very accessible brief summary of integration of care, from a presentation to a Kings Fund seminar

Johnston L, Lardner C and Jepson R: Shifting the Balance of care: an overview of evidence relating to Shifting the balance of care: a Contribution to the knowledge base. Scottish Government Social Research 2008. Available at www.scotland.gov.uk/socialresearch. Accessed 2/6/2012

A review of the evidence for the benefit of changing models of care: their focus (e.g. to more integrated care), location (e.g. to hospital to community), staff roles (and responsibilities (e.g. focus on self management). A very broad and interesting approach

Ramsay A, Fulop N (2008). The Evidence Base for Integrated Care. London: Department of Health. Available at:
www.dhcarenetworks.org.uk/_library/Resources/ICN/ICN_advice/The_evidence_base_for_integrated_care.pdf (accessed on 2/6/2012).

A useful overview of integration of care

Shaw S, Rosen R, Rumbold B (2011). What is integrated care? London, Nuffield Trust. Available at www.hsmc.bham.ac.uk/news/pdfs/Altogether_Now_Report.pdf (accessed on 3 November 2010).

Two accessible and well digested summary of integrated care, the evidence for it, and its implications.

Fulop N, Mowlem A, Edwards N. Building integrated care: Lessons from the UK and elsewhere. London, NHS Confederation, available at
http://www.nhsconfed.org/Publications/Documents/Building%20integrated%20care.pdf

A good summary of lessons on integrated care from a number of systems, with a particular focus on the hospital-primary health care interface.

Milbank Memorial Fund (2010). Evolving models of Behavioral Health Integration in Primary Care. Available at http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf, accessed 2/6/2012

An excellent overview of models of integration relating to linking mental health and primary health care.

Strandberg-Larsen M, Krasnik A. Measurement of integrated healthcare delivery: a systematic review of methods and future research directions. International Journal of Integrated Care – Vol. 8, 4 February 2009

A useful article on evaluating integrated care, with extensive references

Appendix 2: Some additional frameworks and models for integrated care

This appendix describes some other frameworks relating to integration of care which may be useful.

(a) Qualities of integrated care

Integrated care should be comprehensive, coherent, coordinated and patient centred. The following table suggests some different levels for each of these qualities. Their relative importance will vary: for example it might be particularly important that diabetes care is comprehensive, that care for older sicker people be well coordinated, and that long term mental health care be very patient centred.

Figure 3: Qualities of integrated care

Level	Comprehensive	Coherent	Coordinated	Patient centred
High	Covers all physical and psycho-social needs (e.g. including physical and dental care for people with mental health problems) Care for presenting problems in context of related problems (e.g. co-morbidities) and psycho-social needs, including prevention and treatment	Dedicated education program supported by all providers Standardised patient education resources across providers Patient information consistent across providers	Case management Care coordination Multi-disciplinary team care Agreed protocols, pathways and shared records Single clinician with responsibility for coordinating/managing care Normal referral and informal communication and information sharing	Health literacy and capacity for self management systematically reviewed and developed Patient/carer concerns addressed Education and information adjusted to patient and carer understanding
Low	Care for presenting problem			

(b) Types of integration

Some authors distinguish different types of integration, based on the context in which it occurs, the relationship between the organizations involved and the methods used. This table summarises some of the different types of integration that have been described.

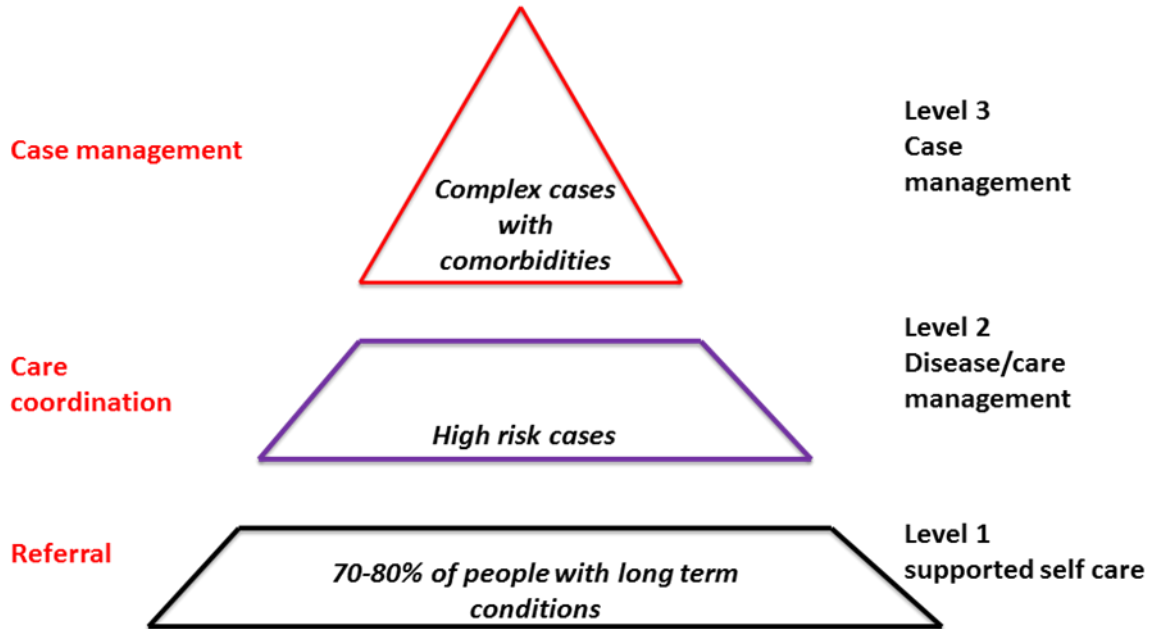|	
Sequential	Care is transferred from one provider/service to another for the next stage of care. The task is to ensure a smooth transition for patient/ carers and providers. Strategies: easy communication systems, structured information, targets for notification on time. *Discharge planning*
Simultaneous	Several providers give care in the same period. The task is to make care consistent and well coordinated. Strategies : agreed roles, protocols and care pathways, care planning, case management, multi-disciplinary team care *GPs, specialist and allied health providing ongoing diabetes care.*
Horizontal	Integration within a single level of care (e.g. within primary health care). This often involves simultaneous coordination between different providers. Strategies: as for simultaneous above. note need to avoid gaps or overlap in care *Practice and community nurses coordinating their work on wound care*
Vertical	Integration across different levels of care (e.g. hospital and primary health care). This often involves sequential coordination and cross sectoral boundaries. Strategies: as for sequential above. Note need to manage differences in drivers and in perspectives on health care. *Between specialist geriatric services and general practice*
Intersectoral	Integration with non-health services: for example with schools or local government. Strategies: requires a clear understanding of the priorities, culture, language and capacity of each sector. *Medicare Locals and councils working together on a community plan*
Virtual	Providers remain part of separate organisations, services or teams, and collaborate through ongoing partnerships or networks. Strategies: good communication systems, clear roles and responsibilities, personal relationships and trust. *Networks of services providing services to newly arrived refugees.*
Real	Providers work as part of a single organisation, service or team. Coordination of care is managed within the organisation. Strategies: strong organisational and systems and teamwork. *Services working from more than one base: e.g. non-collocated integrated primary health care services*

(c) Strengthening integration using the stepped approach

This table summarises some ways of improving integration of care at each of the steps of integration of care in Figure 1. The list is not exhaustive. Note that the table goes top to bottom, where Figure 1 reads bottom to top

Step	Can be strengthened by
Normal care	• Developing more integrated and comprehensive primary health care services • Supporting continuity of care within the 'medical home' • Providing up to date health service directories • Having structured forms for referral to secondary services • Providing a central point for referrals • Improving teamwork within the practice/service • Providing patient centred care and supporting self management • Systems for service review, including analysis of clinical information and patient feedback to practice/service
Structured care	• Developing agreed pathways, protocols, decision supports for structuring care across services and providers • Enhancing protocols for single medical conditions to take account of multi-morbidity and psycho-social factors • Monitoring patterns of referral/service use, including reach, with an eye to reach and equity
Coordinated care	• Ensuring clear roles for care coordinators and their responsibilities in relation to clinicians • Developing explicit criteria for patient eligibility for care coordination • Having agreed structures for patient care and care coordination plans • Discretionary budgets to supplement individual patient care
Shared care	• Developing explicit criteria for patient eligibility • Including a significant role for patients, assisted through self management support • Governance structure for program that includes all main stakeholders
Intensive case management	• Case manager has overall authority and responsibility for primary health care management • Patient centred budget, allowing choice of services and providers • Effective care coordination arrangements with any other service providers who may be needed
Integrated care	• Team/service has overall authority and responsibility for all patient care • Single budget, allowing use of best available models of care • Sufficient capacity in the team/service for the full range of clinical tasks

(d) Kaiser Permanante Pyramid of Care

Kaiser Permanente Pyramid of Care – patients with long term conditions

Case management — red triangle: *Complex cases with comorbidities* — Level 3 Case management

Care coordination — purple trapezoid: *High risk cases* — Level 2 Disease/care management

Referral — black trapezoid: *70-80% of people with long term conditions* — Level 1 supported self care

(e) Extended chronic care model

This builds on the original chronic care model from Wagner and others to include the role of health promotion and community context as well as health system organization in improving chronic disease care.

The Expanded Chronic Care Model: Integrating Population Health Promotion

Created by Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts and Darlene Ravensdale (2002)
Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001) "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.