

POLICY OPTIONS

Emerging models of integrated primary health care centres: How they optimise access and integration and what influences this

October 2015

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Policy context

Well-functioning primary health care (PHC) systems are associated with improved health outcomes, better integration and coordination, and more effective management of chronic disease.

Improving access and better chronic disease management are key policy priorities. Since 1999 there has been a number of Federal funding incentives designed to support better chronic care and teamwork. Australian and State governments have invested in strengthening the coordination and integration between multidisciplinary PHC providers, albeit within existing PHC structural and funding arrangements.

There is some evidence that integrated primary health care centres (IPHCCs) can improve access and integration. Recent Australian examples include GP Super Clinics (GPSCs), HealthOne Services/Centres in New South Wales, and GP Plus Centres in South Australia. Other long standing models include Community Health Centres in Victoria and Aboriginal Community Controlled Health Services. Little is known about factors influencing how Australian IPHCCs are organised and operate, how they address access and integration for people with chronic conditions and what influences this.

The aim of this case study of six co-located multidisciplinary IPHCCs was to investigate their approaches to optimising access and integration and the influence of context and organisational factors for people with chronic conditions. Aspects of access included the availability of services and accommodation of community needs, the approachability of services, their acceptability and affordability and the range of multidisciplinary services within the centres. Aspects of integration included arrangements at three levels: between co-located organisations, amongst differing health professions and at the clinical care level; and the supporting systems.

The sample included three GPSCs, a HealthOne NSW Centre, a Community Health Centre and a multidisciplinary general practice. Centres were located in urban and rural locations in NSW and Victoria. Data was collected during on-site visits via interviews with managers, clinicians and administrative staff, non-participant observations, document analysis and a survey.

Key findings

IPHCCs were providing an expanded range of multidisciplinary health services involving allied health professionals and in some cases medical specialist services for people with chronic conditions. Access approaches reflected the size and scope of the business. All centres made attempts to increase the availability of services, their affordability and the degree to which they accommodated patient needs. However few had explicit arrangements to enhance the service acceptability for hard to reach or vulnerable populations, such as people with complex health conditions including mental illness, drug and alcohol problems, complex co-morbidities. Other areas of variability included the availability of after-hours GP services and the provision of outreach services (e.g. home/RACF visits).

Centres were in early stages of developing integration approaches. Co-location afforded opportunities for informal communication and information sharing, but more formal approaches to achieving integration varied. With few exceptions the level of organisational integration could best be described as a loose affiliation of independent organisations, where co-location was the uniting feature. Clinical integration between GPs and allied health had not advanced much beyond traditional referrals. More formal approaches for multidisciplinary planning and/or reviews of patients common to all groups was less developed. Integration was more advanced in larger organisations and where funds had been dedicated to improve integration. The HealthOne model was a good example of how additional funding could generate higher levels of integration across most dimensions.

Arrangements varied for sharing clinical information due to the differing systems, clinician and organisational requirements. There was no clear indication about the best arrangements.

IPHCCs have developed incrementally, with specific developments reflecting opportunities afforded by the model; ownership imperatives (for-profit and not-for-profit) and context (history, relationships, and the need to find a niche in order to maintain financial viability).

The IPHCC model, ownership and size were strong drivers of access and integration.

- > GPSCs had more co-located medical specialist services and greater availability of after-hours services. State health models had a stronger population orientation and focus on the acceptability of their services for 'at risk' groups. Professional and clinical integration arrangements were more formalised than in other models and organisational integration was characterised by more structured approaches (e.g. joint structures to work together; most co-located services were part of a single entity).
- > The for-profit owned centres substantially differed from the not-for-profit centres. They had less complex governance arrangements, management structures and scope of co-located services and few formal integration arrangements. In contrast, the other centres involved a complex mix of private and public/non-government sector relationships characterised by different organisational cultures and ways of working.
- > Small centres lacked the infrastructure and capacity of medium and larger centres. Larger centres were more likely to have a greater range of services and provide after-hours services, than smaller centres which also had few formal integration arrangements. This suggests that there is an optimum size for enhancing access and integration.

A broader PHC focus and population health orientation followed engagement of local health networks (LHNs), through public/private partnerships and co-location of allied health and medical specialist services.

Policy options

Australian/State/Territory governments

- > Alternative payment mechanisms that fund multidisciplinary IPHCC care on a capitation/patient-registration basis. This in part could encourage IPHCCs to provide dedicated accessible services for 'at risk'/marginalised populations with chronic and complex conditions.
- > Consider blended payment models to provide opportunities to improve multidisciplinary clinical and professional integration between general practice (GPs/Practice Nurses) and other co-located services.
- > Provide incentives for PHNs and IPHCCs to work with LHNs to improve access and integration arrangements for common patient groups with chronic conditions.
- > Develop and embed access and integration indicators into routinely collected data that enable IPHCCs to monitor their performance.

PHNs /LHNs

- > Support continued development of public/private partnership models of new IPHCCs to enhance a population and equity focus.
- > Support IPHCCs to implement collaborative approaches to chronic care planning, care provision and patient reviews between GPs, Practice Nurses and other co-located health professionals.
- > Develop and/or strengthen relationships with existing IPHCCs to improve access to well-coordinated multidisciplinary care for common patient groups with chronic conditions.
- > Support IPHCCs to develop formal integration arrangements between the range of co-located services and to strengthen interprofessional relationships.
- > Foster multidisciplinary and intersectoral continuing professional development activities focused on chronic disease management and the contribution of differing health professions.

Professional associations

- > Develop guidelines and other resources on approaches and strategies to enhance interprofessional and clinical integration, especially for patients with chronic conditions.
- > Provide members with multidisciplinary networking opportunities and continuing professional development activities.