Australian National University

Southern Cross UNIVERSITY
A new way to think

# POLICY OPTIONS

## Mapping service integration for primary healthcare patients

## Lessons from a regional GP Super Clinic

October, 2015

Susan A Nancarrow, Catharine Avila, Daniel Chamberlain, Robyn Keast, Joanne Bradbury, Frances Doran, Peter Hill, Kegan Barlow

## Policy context

In 2010, the first National Primary Health Care Strategy was prepared in response to challenges associated with the growing burden of chronic disease, an ageing population and health workforce pressures in Australia. General Practice (GP) Super Clinics were considered a key component of this strategy, to meet the growing demand for primary care integration by providing a 'one-stop shop' of health and medical services for consumers.

Current models of integration prioritise system and service drivers, but largely ignore the linking of the patient to the services. To redress this oversight, there has been a policy and programmatic push toward patient-centred service delivery models. This report provides an evidence base to inform and operationalise policy to better reflect patient perspectives on effective primary health care integration.

This study examines multi-level integration from the perspective of a regional GP Super Clinic. Grounded in a theoretical framework informed by the works of Valentijn and Keast, our longitudinal, mixed methods design incorporated expert interviews and a Social Network Analysis based on patient referral patterns. A Person Centred Integration Framework was developed from the synthesis of the different levels of data.

## Key findings

### Facilitators of integration at the micro level

> Co-location of allied health practitioners at the Super Clinic facilitated formal and informal communication through shared social spaces (tea rooms and corridors); shared records; by establishing trust and knowledge between diverse health care practitioners, convenience for patients; and ease of quality control from the perspective of the Super Clinic management.

> All co-located practitioners bulk-billed the Super Clinic patients, facilitating affordable health care and on-going communication between practitioners.

> Online systems supported integration through health practitioner referrals, including a 'drop-down' referral list which is searchable by specific clinicians, or profession type.

> Knowledge of the 'trade-off' between different attributes of potential referral sources, such as affordability of the service versus the quality of the reports received.

> Patients who saw more than one GP had access to larger referral networks.

- GPs who had worked in the practice for the longest time had the largest referral networks.
- Aboriginal patients received fewer referrals than the non-aboriginal population. This may be an artefact of sample size or reflect different care needs of the individuals in the small sample, but warrants further investigation.
- A risk to ongoing integration was the personal nature of the referral networks. If an individual GP leaves the practice, there is a danger to the Super Clinic of losing part of the referral network. This points to the need for forward planning and a level of redundancy in the system.
- Clinical integration was based on personal networks of referral relationships. Private providers functioned in isolation from the wider 'health system'. The individual fee-for-service funding model did not support system level involvement or team based care of patients by practitioners.

Patients valued

- Strong communication between the patient, the GP and the referring practitioner about the reasons for the referral, and ensuring that appropriate information transfer takes place.
- Consideration of their personal values and preferences in referral decisions; consideration of their preferences for accessibility, particularly in terms of the cost of the service.
- Access to a good 'quality' practitioner was prioritised over proximity.

### Facilitators of integration at the meso level

At the meso level, the Super Clinic relied on a series of ground up, *ad hoc* systems to serve and support integration. Chronic Disease Management plans combined with an entrepreneurial business model were an important driver of integration.

Several strategies were used to broker regional relationships between agencies/service providers, to enhance integration, including,

- Cross-board memberships between organisations which helped establish formal relationships and open-up referral pathways
- Student clinical placements, which relies on local infrastructure, a structured care model including supervision and formalised relationships between practitioners and other services
- Co-location of health care providers in other organisations. Examples included community pharmacists working in general practices, health practitioners performing screening in workplace environments
- Formalised referral documentation to simplify the pathway between practitioners and embed a common referral practice
- Physical proximity of providers was relatively unimportant to patients, however co-located practitioners received a higher proportion of referrals than off-site practitioners
- Formalised agreements with medical specialists who will bulk-bill local GP Super Clinic patients was evidence of professional integration.

### Facilitators of integration at the macro level

A model of primary health care integration at the micro level, the Super Clinic was poorly integrated at the macro level. The socio-political context of health service delivery locally meant that the local GP Super Clinic was not part of the system of integration promoted by regional stakeholders (the

Local Health District and the Primary Health Network). Similarly, the disinvestment from Super Clinics by the Commonwealth Government meant that, rather than being part of a network of practices, the Super Clinic is now largely autonomous. This raises the question of the role of the strategic and political contexts that aim to embed primary health care services within in the community.

# Policy options

The study provides policy decision makers with an evidence base to inform policy development, planning and implementation of integration,

- Findings re-enforce the success factors for patient-centredness, specifically: communication, clinical cooperation, service accessibility, and patient participation and involvement.
- The current policy drivers for integration focus on *service* and *systems* integration; however there is a need for mechanisms that better facilitate patient involvement and ownership of integration.
- Patients value practitioner intra-communication over practitioner co-location with a strong preference for shared health records. Opportunities for shared record keeping between practitioners need to be brokered at a policy level; alternatively, current technology means that it may be appropriate and possible for patients to be the owners and gatekeepers to their medical records.
- The fee-for-service context of the local GP Super Clinic reduces health care to a series of individual transactions rather than a truly integrated, team-based approach to health care delivery. This is antithetical to ongoing service relationships that put the patient at the centre of the process. Policy drivers reinforce the individual, fee-for-service models rather than truly integrated, team based care.
- Integration clearly is not a 'one-size-fits-all' approach. More dependent patients with complex needs are likely to have a greater need for integration. However, if the basic patient-centred principles of integration are embedded within health systems and policy, it should be possible to develop a bespoke approach to integration.

Rather than seek to fit the patient into the system, policy makers should draw from a set of models and associated processes to configure integrated service system that wrap the services around individual patients.

### The key implications for implementation and practice

- Embedding the centrality of the patient /provider relationship in practice requires the development of supporting and monitoring systems and processes.
- Opportunities and incentives are required to support the development of professional networks for information sharing, referral pathways and knowledge exchange, supported by complementary systems, processes and skill sets.
- At the macro level, integration analytical capacity must be developed by policy makers, managers and integrators to better understand the function and elements of the multiple levels in order to develop frameworks and processes to facilitate integration across, between and within these levels.
- Finally, the funding and commissioning of community-based health services need to be reconsidered to incentivise rather than hinder the delivery of person-centred care.

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.