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# Development of a framework for integrated primary/secondary health care governance in Australia

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## Introduction

- Background
- Research questions
- Literature review
- Proposed method
- Publications
- Timelines





## Definitions

- 'Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive PHC includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.' (APHCRI)
- Secondary care is medical care provided by a specialist or facility upon referral by a primary care physician.
- 'Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination.' (Nuffield Trust)
- 'Integrated governance is **a collation of systems, processes and behaviours** … which … **lead, direct and control functions in order to achieve … objectives, safety and quality of service** and in which they relate to patients and carers, the wider community and partner organisations.' (Peskett, 2009)





## Background

Integrated care is concerned with improving patient care through better coordination

For the goals of health reform to be realised **Medicare Locals** and **Health and Hospital Services** (HHSs) (previously Local Health and Hospital Networks) must work together to achieve co-ordinated and integrated primary healthcare services. There is however a paucity of research evidence around successful strategies to deliver this objective.

What does this research add?

This study will describe elements of a 'best practice' governance model which allows optimal linkage between Medicare Local and Hospital and Health Services activity informed by integrated clinical care model for chronic and complex diabetes patients.

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## So what?

- There is an identified need for more robust and high-quality evidence to inform decisions about how to develop integrated care. There is no single model of integrated care that is suited to all contexts, settings and circumstances. **Researchers and policy-makers need to work together with practitioners to develop, evaluate and implement effective approaches**. (Nuffield Trust June 2011)


'Would you tell me, please, which way I ought to go from here?'
`That depends a good deal on where you want to get to,' said the Cat.
`I don't much care where--' said Alice.
`Then it doesn't matter which way you go,' said the Cat.
`--so long as I get SOMEWHERE,' Alice added as an explanation.
`Oh, you're sure to do that,' said the Cat, `if you only walk long enough.'

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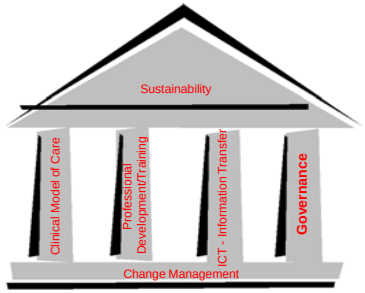
## Why governance in integrated care?




Jackson CL & Nicholson C. 2008. 'Making integrated health care delivery happen – a framework for success' Asia Pacific Journal of Health Management 3(2): 19-24

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Documented characteristics for primary health care systems

| Characteristic | National Primary Care Strategy (Australia) | Primary Health Care Strategy[1] (New Zealand) | Medical Home[2] (USA) | RCGP[3] (England) |
|---|---|---|---|---|
| **Clinical care:** | | | | |
| Population health based focus | Voluntary patient enrolment | Enrolled populations | | Enrolled populations |
| Identifies and aims to reduces health inequalities | ✓ | ✓ | | ✓ |
| Delivers uniformly accessible, patient-centred, continuity of care | Better access to primary health care services<br>There are key issues in relation to relocation of hospital service models | Offer access to comprehensive services to improve, maintain and restore people's health | Enhanced access is available through systems e.g. open scheduling, expanded hours and new options for communication | Provide access including urgent care.<br>Major after hours problems<br>Responsiveness |
| Clinical care well-integrated, and coordinated with secondary care | Explicit statements on integration of primary /secondary services to improve co-ordination, continuity, collaboration | Co-ordinate care across service areas<br>Low level coordination and integration to date | Care is co-ordinated and/or integrated across all elements of health care<br>Personal physician<br>Whole person orientation | Practices collaborating and working together |
| Must have a primary care workforce appropriate to local conditions and need | GP led most appropriate and accessible blend of multidisciplinary team care | Develop the primary health care workforce | Physician directed medical practice – the physician leads a team of individuals who collectively provide care | GP-led, integrated and expanded multidisciplinary teams |
| Provides high quality, safe, evidence-based care | Integrated quality and safety tools | Continuously improve quality using good information | Quality and safety – hallmarks of the medical home | Culture of quality and safety of care |
| **Education and training:** | | | | |
| Appropriately resourced and vertically- integrated professional development and training | Commitment of training and education | Limited commitment to training and education | | Culture of education, teaching and training |
| **ICT:** | | | | |
| Has Information Communication Technology (ICT) systems that integrate information effectively across the health care system | Improved ICT to support continuity of care | *Not present* | | ICT infrastructure to support care |
| **Governance:** | | | | |
| Has an appropriate governance model with local engagement, responsibility and appropriate decision making capacity, accepting of and managing diversity & complexity locally | Meso-level primary care organisations to facilitate:<br>- Local engagement: patient and community participation; provider representation<br>- Linkage between micro and macro sectors of the system<br>n=61 (July 2012) | Meso-level primary health care organisations who have shared governance with clinicians, community and Maori groups.<br>There is limited ability to accept responsibility for complex decision making<br>n=32 (2011) | | Meso-level Primary Care Trusts are transitioning to smaller GP Consortia led and championed by clinicians locally<br>n=152 (2010) |
| Uses a funding model which encourages maximal management of complex disease in the community, an outcomes focus, and health promotion / disease prevention | Non-fee-for-service physician payment (capitation)<br>Right funding signals and incentives across the system to maintain care within the community<br>Variety of funding models to fit local circumstance and priorities | Mixed funding model with government funding applied by variation of capitation.<br>Patients pay fee for service<br>Some limited quality and performance payments | Payment reform – recognising the added value provided to patients who have a patient-centred medical home | Commissioning, resource management and co-ordination of care |

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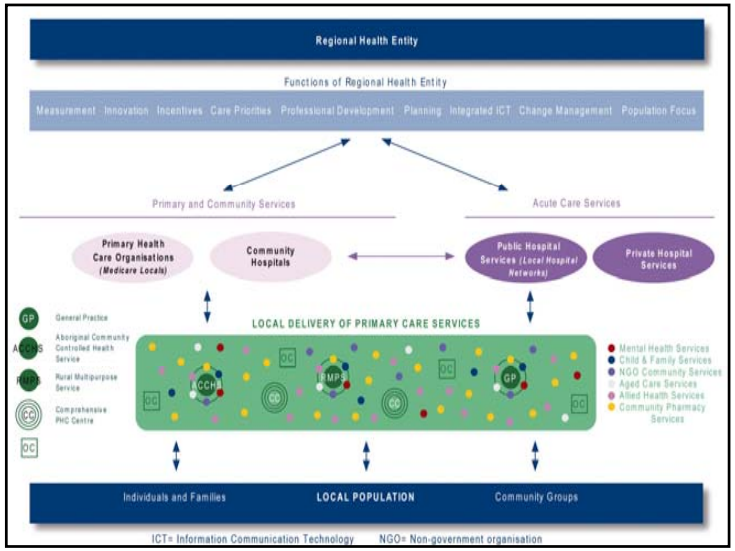

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## Research questions

Aim: To describe the elements of health care system capable of supporting integrated primary/secondary health care governance

***Question1: Are there additional functions to those previously described for a regional governance framework?***

*Question 2: How it is demonstrated these functions are supported?*

*Question 3: What is the link between this model and the effectiveness of integrated care delivery for Australian adults with chronic and complex diabetes?*

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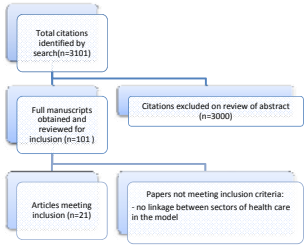
## Literature review

- Electronic databases: PubMed, Medline, CINAHL, Cochrane Library, Informit Health Collection, PHC RIS, Canadian Health Services Research Foundation, European Foundation for Primary Care, European Forum for Primary Care, Europa Sinapse
- Search strategy
- Duplicates removed. Results filtered and formatted

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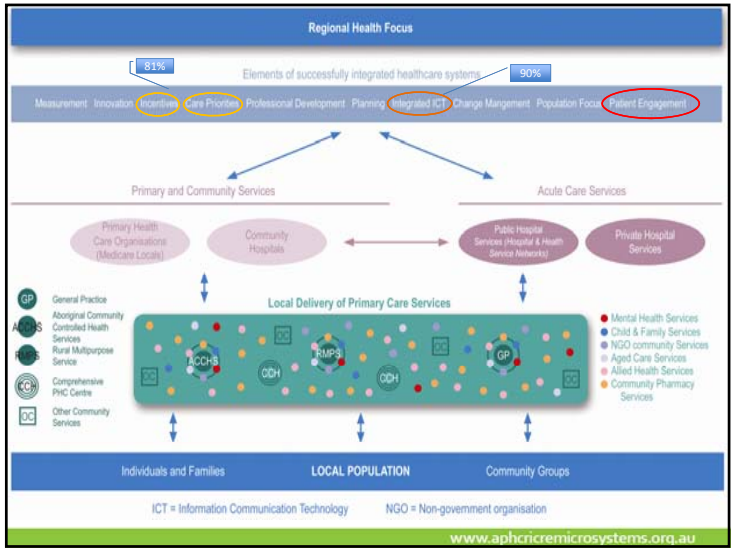
Peer reviewed published literature

| Author | Country | Year | Population focus | Shared clinical priorities | Planning | Measurement (Maturity tool) | Innovation | Change management | Professional development | Integrated ICT | Incentives | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Baker et al | USA | 2008 | | ✓ | | ✓ | | | ✓ | ✓ | ✓ | |
| Conner et al | UK | 2010 | ✓ | ✓ | ✓ | | | | ✓ | ✓ | | Patient engagement |
| Cumming | NZ | 2011 | | | ✓ | | | | | | ✓ | |
| Donaldson et al | Aust. | 2010 | | ✓ | | | | | | ✓ | ✓ | |
| Featherstone et al | UK | 2013 | | | | | | | | ✓ | | |
| Franchetti et al | USA | 2009 | | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | |
| Hutchinson et al | Canada | 2009 | Pr enrolment with PHC | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | |
| Jackson et al | Aust. | 2007 | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Jackson et al | Aust. | 2008 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Jackson et al | Aust. | 2008 | ✓ | ✓ | | | | ✓ | ✓ | ✓ | ✓ | |
| Jackson et al | Aust. | 2008 | ✓ | ✓ | ✓ | | | | | ✓ | ✓ | |
| Jackson et al | Aust. | 2010 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Overfield et al | | 2010 | ✓ | ✓ | | | | ✓ | | ✓ | ✓ | |
| Paina et al | USA | 2008 | ✓ | ✓ | | ✓ | ✓ | | | ✓ | ✓ | Patient engagement |
| Pinkett | UK | 2009 | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Powell-Davies | Aust. | 2008 | | ✓ | ✓ | | | | ✓ | ✓ | ✓ | |
| Rittenhouse et al | USA | 2009 | | | | ✓ | | | | | ✓ | |
| Smyth | Canada | 2009 | | ✓ | ✓ | ✓ | | | | ✓ | | |
| Sullivan et al | Canada | 2005 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | |
| Sutter et al | Canada | 2009 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | |
| Wedel et al | Canada | 2007 | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | |

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## Grey literature

- Grey literature was identified from works know by the researcher, from reference lists and web searches of government departments and policy organisations
- Synthesis of the data comprised of progressive readings of the documents, and the identification, categorisation and comparison of recurrent themes is currently underway

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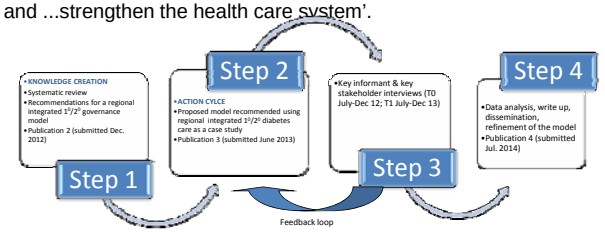
## Research plan

- Using a *knowledge translation/implementation science* approach the research will be 'a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more efficient health services and ...strengthen the health care system'.

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## Methodology

1. Derive knowledge; generate tools
2. Apply knowledge: Identify, review and select knowledge, that is to mirror the essential elements of the described governance model in the development and delivery of integrated services for patients with the most chronic and complex diabetes in Brisbane
3. Key informant interviews
   - Data collected over two time periods (July-Dec 2012; July-Dec 2013)
   - Based on the themes related to the elements of the integrated governance model
   - Interviews will be semi-structured, taped and transcribed to allow for thematic analysis
4. Evaluate outcome and sustainability

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## Outcomes

- Identify functions promote $1^0/2^0$ integration.
- Methods of measuring functions are determined
- Learn from those integrating what the barriers and enablers are
- Apply the framework to the development of a complex diabetes service

### Significance of this:

'We need to move beyond arguing for integration to making it happen, whilst exploring the barriers'. (*NHS Future Forum, 2011)*

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## Timelines

| Research Question | Method | Jan-Jun 12 | Jul-Dec 12 | Jan-Jun 13 | Jul-Dec 13 | Jan-Jun 14 | Jul-Dec 14 |
|---|---|---|---|---|---|---|---|
| What functions support a regional approach to integrated $1^{o}/2^{o}$ health service delivery? | Lit. review | | | | | | |
| | LNR ethics submitted | | Jul-12 | | | | |
| | Publication 2 submitted | | Dec-12 | | | | |
| For each function what are the policies, structures and procedures that contribute to sustainable clinical and organisational governance across the continuum? | Document review | | Jul-12 | | | | |
| | Publication 3 submitted | | | Jun-13 | | | |
| How is the framework supported by the complex diabetes service developed in Brisbane? | Qualitative interviews with key stakeholders Document review | | $T_0$ Jul-Dec-12 | | $T_1$ Jul-Dec-13 | | |
| | Data analysis, refinement of the model & write up. | | | | | | |
| | Publication 4 submitted | | | | | | Jul-14 |

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- **Nicholson C**, Jackson CL, Marley JE & Wells R. (2012). The Australian Experiment: How Primary Health Care Organizations Supported the Evolution of a Primary Health Care System. *J Am Board Fam Med*; 25(Suppl1):S18-S26.
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## Questions

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