

# Six elements of integrated primary healthcare

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## Background

Integrated care has the potential to deliver efficiencies and improvements in patient experiences and health outcomes. Efforts towards integrated care, especially at the primary and community health levels, have increasingly been under focus, both nationally and internationally. In Australia, regional integration is a priority, and integration of care is a task for meso-level organisations such as Primary Health Networks (PHNs).

## Objectives

This paper seeks to provide a list of elements and questions for consideration by organisations working across primary healthcare settings, looking to enact and improve the delivery of integrated care.

## Discussion

Six elements that consistently emerged during the development of a series of rapid reviews on integrated primary healthcare in Australia are presented in this paper. The elements identified are context, governance and leadership, infrastructure, financing, engagement, and communication. They offer a starting point for reflection in the planning and practices of organisations in their drive for continuous improvements in integrated care.

## Integration and the National Primary Health Care Strategic Framework

The main aim of Australia's National Primary Health Care Strategic Framework is to better integrate healthcare.<sup>1</sup> In order to improve efficiencies in primary healthcare delivery, sustainability and return on investment, and provide coordinated, patient-centred care, there is a need for integration across organisations and sectors in the health system. The health system incorporates multiple levels:

*micro, meso and macro levels ... refer to the patient interaction level, the health care organization and community level, and the policy level, respectively.<sup>2</sup>*

Meso-level integration, the focus of this paper, thus rests on the ability of organisations and the professionals within them to establish coherent models at funding, administrative, organisational, service delivery and clinical levels.<sup>3</sup>

There is much debate over the terminology associated with integrated care. Throughout this paper, integrated care refers to 'an organising principle for care delivery with the aim of achieving improved patient care through better coordination of services';<sup>4</sup> integration refers to the 'processes, methods and tools'<sup>4</sup> facilitating integrated care. At a meso or healthcare organisation and community level, integration structures are on a continuum from formal mergers through to informal connections created

by organisations with shared values.<sup>5</sup> Examples of meso-level organisations include Primary Health Networks (PHNs; previously Medicare Locals), Aboriginal community controlled health services (ACCHSs) and Victorian Primary Care Partnerships.<sup>6</sup> Additional dimensions of integration at the meso level, relevant to this paper, relate to professional, organisational, functional and normative integration (Table 1). Further, organisations can be involved in vertical integration between different levels of the health system (eg secondary care in hospitals and primary healthcare in the community) or horizontal integration (eg links among providers within a sector or region), which is the focus of this paper.<sup>7-9</sup>

This paper draws attention to elements underpinning integrated care and questions for reflection by organisations operating at the meso level of primary healthcare. The elements were sourced from a series of rapid reviews.<sup>6,10-15</sup> Australian 'grey' and peer-reviewed literature, published between 2003 and 2013, was explored. Electronic bibliographic databases (eg PubMed with the PHC Search Filter), grey literature sources (eg Google Scholar), government websites (eg Department of Health) and relevant organisation websites (eg National Aboriginal Community Controlled Health Organisation [NACCHO]) were searched for keywords related to integrated primary healthcare. This informed a set of pragmatic literature reviews<sup>16,17</sup> addressing issues across

macro, meso and micro levels, and as applied to specific populations (ie patients with musculoskeletal or mental health conditions). The consistent themes emerging from thematic analysis<sup>18</sup> of the material included in this series represent six commonly described elements of integration.

### Elements of integration

#### Context: Do you understand your local context within the broader system?

Health systems are complex and dynamic, influenced by political, economic and social factors.<sup>19</sup> Actions that support integrated care in one region will not necessarily do so in another; organisations' settings and surroundings influence their processes and practices. In planning integration, it is necessary to reflect upon the community, geographical factors, historical context, leadership, assets and institutions. Understanding context relies on needs assessments and sound methods for collection, analysis, interpretation and use of data. The more nuanced and detailed the data are across a variety of sector perspectives, the greater the ability to inform the delivery of more integrated approaches, monitor progress and address quality improvement. For example, the SA–NT Datalink collaboration

offers a resource to support this, providing access to context-specific, de-identified information held by government agencies and other organisations to inform policy and service development.<sup>20</sup>

#### Governance and leadership: Do you know who is making the big decisions for your organisation?

While understanding context through reliable linked data is useful, it is also important for organisations to consider who their key decision makers and leaders are. That is, they should identify individuals and groups who account for the distribution of power and, in particular, those who will drive integrated care. Leadership is crucial for creating a vision, followership and journey that can result in normative integration. Engagement at the governance level, whether within the organisation or across sectors, is vital for guiding actions, for regulation, and for enabling formal relationships that allow management of deliverables, risks and processes, and offer sustainability.

Organisational integration can occur via network-like governance mechanisms.<sup>8</sup> As an example, the main objective of aligning primary healthcare organisations with Local Hospital Network (LHN; also termed Local Health Network, Local Health Area, Area Health Service and Local

Health District, depending on jurisdiction)<sup>1</sup> boundaries is to encourage improved engagement between the sectors. However, geographical alignment alone is not enough; actions such as shared board membership, activities and workforce are essential. In 2012–13, there were 90 joint staff appointments between primary healthcare organisations and LHNs, and more than 1400 joint planning initiatives,<sup>21</sup> many of which pertained to integration (eg referral pathways, hospital avoidance programs, discharge planning).

#### Infrastructure: Do you have the right combination of resources in an appropriate environment?

Once the needs and key actors responsible for integrated care delivery are identified, assessment of sufficient infrastructure can be considered. The Australian Government recognises efficient use of infrastructure (ie physical, virtual and human resources) as a building block for effective primary healthcare.<sup>22</sup> This includes facilities, equipment and co-location where possible, providing shared space.<sup>23</sup> For example, GP Super Clinics are intended to facilitate multidisciplinary teams to train and practice together, enabling models of care for specific population groups. This approach highlights the importance of an adequate workforce with the right mix of skills and capacity to address communities' needs in a complementary fashion.

Appropriate infrastructure to encourage meaningful use of virtual resources may also support communication and sharing across teams.<sup>24</sup> For example, collaborative practice is enhanced by shared electronic health records. eHealth offers opportunities for information governance, an important aspect of functional integration that enables improved referral processes with e-transfer systems designed to promote care coordination.<sup>24</sup> For example, the Grampians Rural Health Alliance Clever Health project provided innovative delivery of primary healthcare services to the region, using a broadband videoconference network. It has connected more than 40 facilities including hospital-based services,

**Table 1. At a glance: Dimensions and descriptions of integrated care<sup>9</sup>**

| Dimension                  | Description  |
|----------------------------|--|
| Professional integration   | Inter-professional partnerships based on shared competencies, roles, responsibilities and accountability to deliver a comprehensive continuum of care to a defined population  |
| Organisational integration | Inter-organisational relationships (eg contracting, strategic alliances, knowledge networks, mergers), including common governance mechanisms, to deliver comprehensive services to a defined population   |
| Functional integration     | Key support functions and activities (ie financial, management and information systems) structured around the primary process of service delivery to coordinate and support accountability and decision-making between organisations and professionals in order to add overall value to the system |
| Normative integration      | The development and maintenance of a common frame of reference (ie shared mission, vision, values and culture) between organisations, professional groups and individuals  |

bush nursing and community health centres.<sup>25</sup>

### Financing: How do you fit into existing funding arrangements?

Investment in infrastructure is one element of integrated care; however, the financial structure and arrangement of health delivery often affects the ability and willingness of organisations and individual providers to integrate services. Funding differences between levels of government and forms of remuneration create ongoing difficulties in many primary healthcare programs. Improving integration must recognise and address risk-sharing and administrative and funding splits between organisations.<sup>26</sup>

Organisations grapple with using various streams of funding in an effective and efficient manner. It is important to consider how functional integration might be affected if partners have mixed funding types. Further, in some cases, if collaboration is a challenge, engagement may need to be incentivised. For example, Medicare payments for Team Care Arrangements encourage medical practitioners to coordinate arrangements in which three or more providers, offering different services, collaborate to provide ongoing chronic disease management.<sup>27</sup>

### Engagement: Who is on your team?

Integrated care innately requires team arrangements. Engagement relates to connecting organisations, consumers/patients, providers/practitioners, and communities. It reflects knowledge exchange, building trust, demonstrating respect and involving stakeholders as early as possible in shaping services.

Maintaining engagement requires clear definitions of expectations<sup>28</sup> and acknowledgment that this process will require significant time, effort and resources. Partners in integrated care will have varied priorities, processes and cultures; these must be addressed, and mutual understanding and agreement about goals and roles established.<sup>28</sup>

Through partnerships, organisations can combine their attributes, skills and contacts to achieve a common purpose with mutual benefit, relating to Fulop's<sup>5</sup> notions of service integration and clinical integration. An evidence-based partnerships analysis tool may help organisations gain a clearer understanding of the range and purposes of collaborations, reflect on existing partnerships and focus on strengthening new joint projects.<sup>29</sup> Locally developed tools or those adapted from other settings can include enablers such as models of care (ie HealthPathways), and have shown promising results for integrated care on implementation in primary healthcare settings.<sup>30,31</sup>

### Communication: How do you keep in touch?

For organisations to unite, it is essential that lines of communication remain strong. Open, frequent and respectful communication is the cornerstone of effective integrated care.<sup>32</sup> It is not enough to just engage stakeholders; their involvement must be maintained through ongoing, transparent communication. This may occur through direct, face-to-face or virtual verbal connections, written channels, or networking through electronic health records.<sup>33</sup>

Formal communication strategies (eg meetings, seminars) allow stakeholders to meet and discuss population or patient needs and plans to address them;<sup>11</sup> there is also support for the value of informal exchanges and 'corridor conversations', one of the perceived benefits of co-location.<sup>19</sup> As indicated by the aforementioned Grampians model, communication can be particularly important for integrating providers that are large distances apart.<sup>25</sup>

### Discussion

Integration between organisations and across sectors in Australia is challenging. There are systemic challenges around funding and delivery models compounded by diverse geographies, cultures and short

political cycles. While there has been much theoretical support for integration, practical methods of enacting and evaluating integrated care are limited. This is problematic for the sustainability of innovative approaches because funding cycles depend on tangible, real-world impacts on healthcare improvement. The science and methodology for measuring integrated care is evolving and this is a key issue that organisations must address. It must also be noted that integrated care, while a current government priority, is not always the best practice. In some regions, and for some patients, practices are perfectly adequate for the community's needs and the shift to integrated care would undermine already effective systems. The idea of the elements presented in this paper is that organisations reflect on which are the most relevant and practicable for them to address in their local context. For example, the role of professional integration will be considerable given the function of the newly formed, general practitioner-led, Clinical Councils and Community Advisory Committees established by PHNs. Effective relationships will rely on engagement and communication with interdisciplinary partnerships based on shared governance, competencies, roles, and accountability.

This paper presents some of the key elements of integration, including examples or resources relevant to an Australian context. It provides ideas for new (eg PHNs) and well-established primary healthcare organisations to consider as they work towards integrated care. Reflection on the aforementioned questions may be valuable in the early planning stages, but integration is not the destination; these elements must be revisited, taking into account lessons and changing context along the way. Mechanisms and resources need to be in place to ensure these elements are embedded in the practice of organisations to encourage an integrated health system and support the needs of Australian communities.

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