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Developing a Framework for Health Service Integration in Queensland

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Health Service Integration in Australia

Health service integration of health care is a priority identified by all levels of government and non-government sector in Australia. The focus of future health reform in Australia will include building Medicare Locals as key regional integration and coordination platforms together with Local Hospital Networks. The future health care system in Australia must be strategically positioned to provide greater access to health care, increase quality and safety and meet consumer driven expectations and demand. There is a need for policy and program development to incorporate service integration as a priority including the development of key performance indicators, which capture joint cross sector activity. This includes shifting focus within an integrated framework, which manages patients/consumers across a care continuum, including primary, secondary and tertiary settings.

Now more than ever, diverse sets of stakeholders and service providers from both public and private sectors will be required to work together in the provision of health and social services. Collaborative, integrated approaches, which incorporate coordinated planned strategies, will be required to meet the future health care needs of our communities. Incorporating integrated elements into cross sector planning will be critical to ensuring a comprehensive service focused on building capacity and linkages within local communities. This also includes a focus on the determinants of health to address the social, economic and environmental impacts. Under this approach, the focus will shift to the patient/consumer and their journey through the system. Service integration elements will need to be built around the individual to ensure a continuous, smooth transition between the various sectors.

A 'Framework for Health Service Integration'* has been developed in response to building a better integrated health system. The Framework, includes 12 core elements to support the development of a strengthened cross sector health care system. Each of these elements aims to guide, rather than direct activity. It acknowledges that to support integrated activity requires consideration of each of the elements, to generate opportunities to support integrated models of service delivery for local level innovation. In a rapidly changing environment, the Framework provides a guideline or reference tool for cross sector activity.

*Armstrong, K. (2010) Framework for Health Service Integration: Elements to support the development of strengthened primary care system in facilitating coordinated, cross sector services. Presentation at the GPQ Division Forum, October 15, 2010, Available at http://www.gpqld.com.au/page/Partnershipss/Collaborative_Research_Hub/ (*Note IP protected to Armstrong)

Challenges

Our current health system is fragmented and the coordinated care across services and sectors remains one of our greatest quality and safety challenges (Jackson & O'Halloran, 2008; Muenchenberger & Kendall, 2010). A lack of communication, connectivity and continuity of care between sectors presents significant challenges to our health system (Erlich et al., 2009; Jackson & O'Halloran, 2008). Providing a coordinated care system has been explored extensively in the research literature and according to Erlich et al., (2009) has led to confusion, has tended to contradict each other and have not provided sufficient guidance for practitioners.

Jackson & O'Halloran (2008) identified that the Australian Medicare system has supported general population access to health care that is well-funded by international standards, has health technologies which are available in most states and is supported by doctors and health clinicians which are regarded as some of the best trained in the world. The inefficiencies in the system have been attributed to the split Commonwealth-state funded responsibilities, an overburdened tertiary sector, a fragmented, under resourced primary care sector, an ageing population with multiple co-morbidities, an increase in chronic and complex disease, workforce shortages, increasing health care costs, advances in technology and changes in inter-professional service delivery models (Armstrong & Kendall, 2010; Humphries & Wakerman, 2008; Jackson & O'Halloran, 2008; NHHRC, 2009; Tran et al., 2008). These challenges are coupled with the uncertainty of how best to balance the funding of health services across the public and private sectors (Armstrong et al., 2007; Muenchenberger & Kendall, 2010).

The changes in disease demography associated with lifestyle related disease and the ageing population, renders current approaches increasingly unsustainable. In order for the delivery of an affordable high quality, safe and equitable health care system to be possible into the future, changes to system level supports will be required. Little is known about how to facilitate the integration of services and appropriately support people during their journey with chronic illness or injury. Thus, it is not surprising that transitions of care and system reform have been identified as the next major quality improvement challenges (Allen, Griffiths, & Lyne, 2004; Cotter et al., 2002; Jackson & Nicholson, In Press; Szwarcwald et al., 2010). In some countries, considerable attention has been given to this issue, through interdisciplinary education, the creation of hybrid workers (GP liaison officers, boundary spanners, bridges, knowledge brokers) to support transition periods, the gradual erosion of systemic and professional boundaries and the facilitation of health-related partnerships designed to promote integrated service provision.

Levels of Integration: Cross Sector, Vertical and Horizontal

However, workable solutions to the problems associated with cross-sectoral integration have been elusive or difficult to implement. A comprehensive systematic review (Powell Davies et al., 2006) of coordination strategies across multiple populations revealed nine approaches to coordination at the micro-level (individual service providers and individual with chronic conditions), meso-level (services and organizations) and macro-level (system). The approaches fell into two major categories, namely those focused on processes that facilitated coordination (e.g., communication processes, supports for service providers and supports for individuals with chronic conditions) and those focussed on structures for coordinating activities (e.g., shared information systems, referral proformas, care plans, support to make decisions and so forth). The most successful strategies in terms of outcomes for consumers were those that involved a re-organisation of structures to strengthen relationships between organisations and the provision of tools to support coordination (e.g., a shared care plan and records). In terms of structures, coordination is thought to be best facilitated by the

integration of services (Ehrlich et al., 2009). Integrated organisational networks have become an important mechanism for building the capacity to systematically address complex community health needs, and delivering services (Provan et al., 2005).

Although integration occurs at the level of systems and organisations, most evidence has acknowledged the importance of health professionals within those structures. Jackson and Nicholson (in press) proposed Service Integration Framework, provides guiding principles to support change management, in particular supporting the role of health practitioners around supporting service level integration. The roles aim to improve the patient experience and outcomes in providing a strategic, cross health service function focusing on systems change and improvements. Creating new models of care which support continuity of service provision for the client are fundamental to supporting improved transitions between the primary and secondary sectors, preventing the need for acute care and facilitating the delivery of care in the most appropriate setting (Amos, 2006; Jackson & Nicholson, in press; Jackson & O'Halloran, 2008; Naccarella et al., 2010a; Naccarella et al., 2010b).

The Integrated Approach

The recent release of the National Health and Hospitals Network report for Australia's Future Health System (DoHA, 2010), provides a pathway for supporting increased access and improved integration of service delivery through improved public hospital and primary health care services. The Local Hospital Network's and the network of primary health care organisations (PHCOs) (currently identified as Medicare Locals), will have a key focus on system level coordination and integration of service delivery (Council of Australian Governments COAG, Communique, 2010). Strengthening and increasing support in primary health care interface with the hospital sector is already a well established strategy used to improve efficiency, address inequality and access, reduce hospitalisations and mortality and improve health outcomes (Armstrong & Kendall, 2010; Muenchberger & Kendall, 2010; Powell Davies et al., 2006; Starfield & Shi 2007). The primary care GP-led and hospital sub-acute interface is a critical area for investigation in supporting enhanced system level supports in providing an integrated, coordinated and seamless service to the Australian people (Armstrong & Kendall, 2010; Naccarella et al., 2010).

Benefits of an Integrated Health System

Integrating elements of the healthcare system (Armstrong, 2010; Armstrong and Kendall, 2010; Harris et al., 2009; Nicholson et al., 2008; Naccarella et al., 2010a; Zwar et al., 2007) provides the opportunity to:

- Improve linkages between service providers and relevant agencies;
- enhance the quality, efficiency and responsiveness of care (transition to and from hospital, pathways between services, seamless care, equity of access, service gaps – health outcomes);
- increase the focus on addressing the burden of disease through strategies focused on prevention, early intervention, treatment and management across various health settings;
- improve the quality and safety of patient care (transfer of care – critical feedback loop – community to hospital and home again);
- ensure key systems are consistent, including standard treatment protocols, IM/IT systems;

- create the potential for economies of scale (workforce models);
- reduce the workload burden of health professionals through supporting a coordinated, integrated collaborative service delivery model (with team based models of care, defined and agreed roles) and;
- Ensuring a sustainable health system.

An integrated approach will strengthen cross sector links by fostering collaboration, shared planning and joint activity. This will require the ability to collectively address and respond to areas of unmet need. This includes service-re-design and the development of models of service provision underpinned by a commitment to collaborative activity between all stakeholders.

Framework for Health Service Integration in Queensland

The Framework for Health Service Integration provides a comprehensive integrated response to strategy and systems development in working towards a shared vision for supporting improved health outcomes for the people of Queensland. The core elements identified as part of the state-wide Framework are centred around; integrated governance models; collaboration and partnership development; population health and service planning (service re-design); infrastructure support; workforce utilisation (informing models of service provision); engagement model (clinician, community & consumer); communication and connectivity; education and training; funding models and sustainability; innovation; performance measures and; leadership and change management.

Framework Overarching Key Factors

To address the core elements required to support a comprehensive integrated health system, three overarching key factors of policy development, joint accountability and coordination of planning and shared networks is required. These factors will need to be addressed in supporting the core systems elements.

Policy Development

The release of the National Health and Hospitals Network report for Australia's Future Health System (2010), provides a pathway for supporting increased access and improved integration of service delivery through improved public hospital and primary health care services. The Local Hospital Network's (LHNs) and the network of primary health care organisations (PHCOs) (currently identified as Medicare Locals [MLs]), will have a key focus on system level coordination and integration of service delivery (Council of Australian Governments COAG, Communique, 2010). Strengthening and increasing support in primary health care interface with the hospital sector is already a well established strategy used to improve efficiency, address inequality and access, reduce hospitalisations and mortality and improve health outcomes (Armstrong and Kendall, 2010; Muenchberger & Kendall, 2010; Powell Davies et al., 2006; Starfield & Shi 2007).

The primary care GP-led and hospital sub-acute interface is a critical area for investigation in supporting enhanced system level supports in providing an integrated, coordinated and seamless service to the Australian people (Armstrong & Kendall, 2010; Naccarella et al., 2010). Human and financial resources for policy and program development will need to be allocated to service integration efforts. Investment in policy development to guide integration activity will be required as a key milestone for the public and private sector. Investment in national and state research, development and coordination is required including the development of frameworks and competencies. This includes embedding policy within the health system to re-direct focus to supporting integration and continuity of care for patients through the utilisation of new and emerging models of service provision.

There are currently a range of policy drivers for improving the engagement of primary care with the secondary and tertiary hospital sector in Queensland. The current evidence identifies the broader policy context which plays a significant role in providing:

- consistent government policies;
- human resourcing;
- supportive frameworks and funding models that encourage collaboration

(Canadian Health Research Foundation, Teamwork in Healthcare, 2006; Kendall et al., 2009; Tieman et al., 2007; Zwar et al., 2006).

GP 'liaison' models of systems integration provide an emerging key strategy in reforming primary health care through expanding the skill-mix and workforce demand management strategies (Kendall et al., in press; Naccarella et al., 2010ab; Patterson et al., 2007).

Joint Accountability

Currently in Australia, there is no mechanism to address accountability of health service integration across sectors. There are no consistent policies or frameworks, which enable public and private sector participation to address improved service provision or health outcomes. The primary, secondary and tertiary sectors operate in silos, a reflection of the current funding models in Australia. The development of Frameworks focused on cross sector joint accountability enables the better use of resources, builds on the collective expertise, supports collaborative approaches, clinical leadership and re-directs focus to broader health system enablers. The development of joint Frameworks will influence policy development and health renewal through integrating the various elements of the health system to support improved continuity of care and health outcomes for the people of Australia. Joint accountability and service integration will be future priorities for Medicare Locals and Local Hospital Networks and integrated planning Frameworks will be required to help guide local service provision.

State-wide Coordination and Planning

The Framework can enable the achievement of improved quality and efficiency of care by streamlining healthcare delivery and facilitating clinicians, community sector and hospitals working together across traditional boundaries. Statewide support and coordination will be required to achieve the desired outcomes. This includes the establishment of a shared network, which supports shared learning's, resources and knowledge translation.

Framework Core Elements

These 12 core elements identified include:

- Integrated Governance Models
- Collaboration and Partnership
- Population Health & Service Planning (Service Re-Design)
- Infrastructure Development
- Workforce Utilisation – Shaping Models of Service Provision
- Engagement Models – Strategies (clinician, community & consumer)
- Communication & Connectivity
- Education & Training

- Funding Models and Sustainability
- Innovation – Research and Development, Knowledge Sharing, Evidence Based Practice
- Performance Measures
- Leadership & Change Management – advocacy, education, behavioural and cultural change

Integrated Governance Models

Greater alignment between primary, secondary and tertiary care is required to increase the capacity of the health workforce to deliver an expanded range of services in Queensland communities. There is a need for integrated governance models (Jackson et al., 2008) to improve the integration between the public and private sectors in supporting state and Commonwealth funding and policy around new models of service delivery. The governance model should be underpinned by collaborative, integrated, partnership approach, which brings together key stakeholders across public and private sectors. This includes shared performance management frameworks which clearly articulate governance mechanisms in relation to clinical governance, corporate governance and engagement of consumers and communities as part of the governance framework.

Strategies will be required to ensure broad representation and facilitation of cross membership to reflect local district needs. Integrated governance functions will need to be clearly identified including roles and responsibilities of the various committees established as part of the governance process and accountability. This also includes building on existing collaborative partnerships and structures such as clinical networks and the Queensland based Partnership Councils (PC) established through the Connecting Health Care in Communities (CHIC) initiative.

Strengthening integrated governance models has the capacity to influence local clinical and service outcomes (Jackson, et al., 2008). Public and private sector integration will require maximising the use of scarce resources, given the increasing health care demand. This includes collaborative efforts supported by integrated governance mechanisms. Forming effective relationships which have the capacity to set priorities and strategic goals will be critical to the delivery of integrated health care systems. Working effectively across artificial divides will require a focus on aligning organisational strategies and capability and ensuring joint accountability. Appropriate governance structures will be required to achieve these goals, which allow representation and decision-making from key stakeholders (including communities themselves), which carry responsibility for funding and accountability across local collaborative partnerships.

Collaboration and Partnership

Partnership development and cross-sectoral and inter-organisational arrangements represent a shift away from models based on individualism towards those focused on integration and collaboration (Kendall et al., 2009). According to Sunderland et al., (2009) community partnerships for health have become a relatively enduring strategy for addressing complex health issues in local communities and bringing about health-related social change in Australia and internationally (Wandersman et al. 2005). Collaborative partnerships have the capacity to function as a valuable medium to bring together a diverse range of skills and resources to address complex community-based health issues in a more efficient and effective manner (VicHealth 2003; Wandersman et al. 2005).

Collaborative partnerships (people and organisations from multiple sectors working together in common purpose) are a prominent strategy for community health improvement. Collaborative arrangements based on partnership development are critical to cross sector

integration of health services. Building on existing partnerships, structures and support mechanisms will be required, as well as establishing new collaborative arrangements (governance mechanisms) to support the interface between ML and LHNs.

Population Health & Service Planning (Service Re-Design)

The field of collaborative health planning faces significant challenges created by the narrow focus of the available information, the absence of a framework to organise that information and the lack of systems to make information accessible and guide decision-making (Gudes et al., 2010). There is a lack of localised, collaborative and evidence-driven health related decision-making.

There needs to be a strategic approach to service planning to identify gaps in services and to meet the workforce needs in the future. There needs to be clear and active planning processes to support connectivity across sectors and data management systems. There is a lack of available information and data to inform collaborative health planning and lack of systems to guide decision-making. There is a need for comprehensive information management frameworks to guide planning, but also allow the exploration of local setting-based determinants of health (Gudes et al., 2010).

Future health planning will require agencies across public and private sectors to share information and data to inform planning. The priority will need to be focused on ensuring the *'right care is being provide in the right place'*. This includes providing responsive care based on health need. Currently there are no cross sector systems or strategies in place, which provide support to enable the use of data to inform health planning. Providing an integrated approach to health planning including integrated governance models and collaborative partnership approaches will be fundamental to supporting an integrated health system for MLs and LHNs in the future.

Infrastructure Development

There is a need to invest in primary care models in relation to the relocation of hospital service models to primary care (Nicholson, Jackson & Doust, 2008). The transfer of care from acute and secondary care to primary care to support care in the *'right place and the right time'* including the community where people live, provides demand management strategies for taking pressure off the hospital system. However, there is a need to support the physical and human resource infrastructure in primary care to achieve this goal. This also includes practice management and integrated electronic health systems and space for undertaking patient education and inter-professional education and training (Naccarella et al., 2010a,b).

Workforce Utilisation – Shaping Models of Service Provision

Australia is facing a workforce crisis with shortages in medical, nursing and allied health disciplines. Demand for primary health care systems is expected to increase due to an ageing population with multiple co-morbidities, an increase in chronic and complex disease, workforce shortages, increasing health care costs, advances in technology and changes in inter-professional service delivery models (Armstrong & Kendall, 2010; Humphries & Wakerman, 2008; NHHRC, 2009; Tran et al., 2008). These challenges are coupled with the uncertainty of how best to balance the funding of health services across the public and private sectors (Armstrong et al., 2007; Muenchenberger & Kendall, 2010).

There is strong support and recognition that we must invest in multidisciplinary team based models using collaborative partnership approaches which support integration and coordination of health services (Hills et al., 2007; NHHRC, 2009; Mitchell, 2008; Naccarella et al., 2010a; Pinnock et al.,

2009; Tieman et al., 2010; Yates et al., 2007; Quinlan & Robertson, 2010; Zwar et al., 2006). It is now widely recognised that no single profession can meet the primary care needs of Australian communities, and through expanding the skill-mix provides the opportunity to enhance the quality, efficiency and responsiveness of care. Integrating elements of the health system creates the potential for economies of scale. In Australia, a spectrum of new models of care has emerged to address these challenges (Naccarella et al., 2010a).

Strengthening and increasing support in primary health care is already a well established strategy used to improve efficiency, address inequality and access, reduce hospitalisations and mortality and improve health outcomes. Primary health care systems around the world are trying to re-orientate themselves to a primary health care model which supports collaboration, coordinate and integrated approaches in supporting multidisciplinary teams (Hills et al., 2007; Kendall et al., 2009; Tieman et al., 2007). The need to re-shift focus to have the person as the central focus in navigating the health system and the need for integrated teams of health professionals is key to progressing workforce development and reform in Australia (Humphries & Wakerman, 2008; NHHRC, 2009; National Primary Health Care Strategy, Department of Health and Ageing, 2009; Tran et al., 2008).

There is a need for more research in defining the roles of team members, how best to support information and communication transfer across teams and the various models, which support coordinated care for teams. Addressing barriers, particularly around funding models and change management around leadership cultural norms and behaviour change to support a team led approach versus a silo-orientated model are required. There is a need to create opportunities for health professionals to engage in critical reflection and dialogue with other health professionals and, ensuring that clinical champions who advocate for team based approaches are supported. Integrating team based approaches into education, training and professional development and in the contextual frameworks to support multidisciplinary team based approaches are required (Naccarella et al., 2010a&b; Zwar et al., 2006 & 2007).

Supporting the individual in the context of their lived environment as apposed to episodic care across the disease trajectory and care continuum are critical elements in supporting a coordinated, integrated primary health care model. This includes integration across the primary, secondary and tertiary interface. A team of health professionals working together with the individual, family and carers to provide a tailored package for the client/patient is a key priority. This also includes planning and monitoring the determinants of health and working in partnership across sectors (Muenchenberger & Kendall, 2010).

Engagement Model – Strategies (clinician, community & consumer)

Clinical Engagement

It is now broadly accepted that clinical engagement is essential to deliver a quality health care system. However, strong support from clinicians alone will be insufficient to bring about the efficient, high quality health system we aspire towards. This will only occur if clinical support is aligned with management objectives and based on the foundations of service delivery needs of local communities (North West Strategic Health Authority, 2007).

Clinical engagement of leaders will be critical to developing the visions and policy planning to support the implementation of future health services. Clear and measurable outcomes to joint service planning across sectors will be required, based on clinician expertise and grounded in the needs of individuals and the communities they service. This includes building on existing structures within state government and primary care and community sectors.

Strategic objectives will need to align with future LHNs and MLs to ensure they can be achieved. It is essential that these structures build on the work of clinicians already positively engaged in health reform, but also reaches those clinicians who are presently not involved. Understanding incentives and motives that drive their participation will be key to encouraging their support (North West Strategic Health Authority, 2007).

Community and Consumer Engagement

Input from community and consumers will be critical to supporting an integrated health system. This has been supported by the Council of Australian Governments (COAG, 2010) that the health system should “be shaped around the health needs of individual patients, their families and community”. Community and consumer engagement will be critical to supporting an integrated health system.

Queensland Health and local primary care and community organisations have a number of community and consumer mechanisms and engagement processes. These are used to inform policy, planning around priorities and needs (Queensland Health, Health Reform Consultation Paper 5, 2010). At a Ministerial level, Health Consumers Queensland (HCQ) has been established as a Consumer Advisory Committee and Secretariat supported by the Office of the Director-General. It has been established to contribute to the continued development and reform of health systems and services in Queensland, by providing the information and advice from a consumer (patient) perspective and by supporting and promoting consumer engagement and advocacy. HCQ provides a mechanism to strengthen the consumer perspective in health services policy, systems and service reform and improvement.

At a local level numerous ways of engaging consumers has emerged in Queensland, in an effort to align services to meet the needs of local people and communities. Continued effort will be required, and formalised strategies to engage and link with governance arrangements and partnerships between LHNs and MLs in the future. This includes clear and measurable outcomes to ensure that the community and consumer engagement does not become a token exercise.

Communication and Connectivity

Our current health system is fragmented and the coordinated care across services and sectors remains one of our greatest quality and safety challenges, particularly for older Australians and those with chronic disease (Jackson & O'Halloran, 2008; Muenchenberger & Kendall, 2010). A lack of communication, connectivity and continuity of care between sectors presents significant challenges to our health system (Erlich et al., 2009; Jackson & O'Halloran, 2008). Currently multiple strategies are being developed across all areas within health from consumer focused to integrated health systems. Modern communication technologies have changed how consumers, health professionals and agencies interact and collaborate, (O'Grady et al., 2009), giving power to people to create, communicate and share knowledge. As new initiatives develop, new models of service delivery and consumer interactions also develop. Clear goals around strategies to support integration and coordination of care across sectors are required including better information and communication technologies, management systems, decision support systems and protocols for supporting the transition of care across sectors.

Building on existing entry points to the health system and expanding on models for improving information flow between primary care, community and hospitals are required. This includes improving the timeliness, quality and safety of information transfer. The demand for clinical information and exchange between individual health care practitioners, organisations and

government health departments has increased significantly. Systems e-Health interoperability is a national priority and will continue to drive improvements toward electronic inter connectivity to deliver better health outcomes in a more cost-effective way in the future (NEHTA, 2010). Ongoing focus on communication and connectivity between primary, secondary and tertiary sectors will be required in the future as a key enabler to integrating the health system.

Training and Education

To address the need for coordination, it is critical to improve the health workforce expertise and capacity (Ehrlich et al., 2009; Naccarella et al., 2010a; Wolff & Boulton, 2005; Zwar et al., 2006 & 2007). Facilitating changes required to support team based care and skill-mix will require considerable education, attitude change, leadership and collaboration (Naccarella et al., 2010a; Kendall et al., in press). According to Sibbald et al., (2004) such changes can be achieved by enhancing the role of some professionals, substituting one type of worker for another, delegating tasks both vertical and horizontal or through innovation (i.e. the creation of new roles or new workers). According to Zwar et al., (2007) supporting training of primary care staff in a multidisciplinary team approach (for the management of chronic disease), with clear role delineation and financial incentives to support nurse-led models of care was required.

Naccarella et al., (2010b) has also identified the need for exploring training of the medical and allied health workforce at the undergraduate level to embed inter-professional education and learning initiatives into curricula and clinical practice placements. The postgraduate medical training model in Australia has been identified as a significant barrier to interdisciplinary practice in primary health care setting (Naccarella et al., (2010a). The current evidence base around inter-professional education and learning to support multidisciplinary team based models of care is lacking and research and evaluation according to Naccarella et al. (2010a) is need to enable students to 'learn together and hence work together in multidisciplinary team based primary health care' (p12). Promising undergraduate clinical placement emersion programs in Australian rural settings and in overseas poverty stricken disadvantaged countries have begun to contribute to a deeper understanding of the coordination of care and team based practice in primary health care for undergraduate medical and allied health students.

Providing inter-professional learning and education is required in up-skilling the existing workforce. Competency based training and education in primary care settings is required including broadening generalist training to medical, allied health and nursing, as well as training in broader skills including e-Health, business and human resources management. There is a need identified to establish incentives and systems that support generalism across primary care (Harris & Harris, 2006) including developing models of sustainable multidisciplinary practice, which are responsive to community need.

To improve patient health outcomes, and build capacity within primary care and community sector, there is also a need to support adequate training of primary care providers to increase the quality of care and efficiency and effectiveness of care. There is recognition that no single profession can meet the primary care needs of Australian communities. Regional primary health care organisations (Medicare Locals) will play a key role in facilitating and supporting multidisciplinary teamwork through supporting:

- information management systems
- decision support systems
- disease registers
- coordinating shared care networks
- facilitating coordinated care teams
- establishing links between specialists and programs
- coordinating liaison officer support roles

- supporting practices to access funding for teamwork under the Medicare Item numbers
- supporting the collaborative methodology and tools (Naccarella et al., 2010a).

Funding Models and Sustainability

The Australian health system is complex and considerable time and effort is invested in trying to integrate the various elements of the system. The Commonwealth's Medicare system is restrictive, complex, can overlap between initiatives and is counter-productive to developing integrated, collaborative care. It is a dominant GP fee-for-service payment system with few incentives for practitioners to provide coordinated services across health and social services. The system has many regulations, is a burdensome administrative system and does not reward quality care.

To adopt an integrated person-centred approach to the coordination of care needed to assist individuals to successfully manage their health, there is a need for a system wide shift to explore alternative funding models. This shift is central to the reform debate in advocating for better integration of care for consumers. This places the person as the central focus in navigating the health system. There is a need for new funding models, systems and integrated teams of health professionals in order to avoid service gaps and duplication and to achieve coordinated patient care. This includes a funding mix which supports: patient enrolment for complex conditions; a model that enables multidisciplinary care; practice nurse and allied health incentives in supporting team based care; increasing PIP payments (especially for rural/remote practices); remuneration for training and ongoing education; block funding to support practices including administration and infrastructure and; support for cross learning and integrated networks.

Naccarella et al., (2010a: p16) proposes an alternative typology of incentive approaches or systems that enable and support teamwork in primary health care. The authors propose that this model should focus on building capacity as a way of using available incentive approaches for policy making which seek to influence and develop the capacity of individuals (micro), organisations (meso) and systems (macro) to engage and support team work. The payment based incentives include: capitation payments based on patient enrolment; team-based bonuses; sharing of income/profits and employment contracts with practices.

Nicholson, Jackson and Doust, (2008) in the GPAC workforce capacity report identified potential funding models based on a variety of models including fee-for-service, care packaging, team based clinical service delivery and fund pooling between key stakeholders based on mutually agreed outcomes. Regional health organisations such as Divisions of General Practice (future Medicare Locals) have a potential role to play in supporting funding for new and emerging models of care. This includes brokerage models, cluster service provision, sub-contracting services through medical practices or groups of medical practices and 'sharing' of an allied health or nursing position with another funded organisation. These regional approaches are recognised models of service delivery supported by the Department of Health and Ageing through the Rural Primary Health Services (RPHS) program (2009) and have the potential to be expanded to support new and emerging mix of funding models.

Patient enrolment for complex conditions and a funding model that enables multidisciplinary care, and remuneration for training and ongoing education requires consideration. Block funding to support practices including administration and infrastructure and performance and quality frameworks, which provide targets for measuring quality primary care, provide potential strategies for consideration in reforming financial incentives in primary care and general practice as key enablers to supporting integrated health system. There is also a need for future planning and lobbying around reforming the Medicare system directed toward priority health issues including:

chronic and complex care; indigenous health and; mental health, as well as incentives for after hour's care and training and education.

There is a lack of incentives and rewards in primary care and general practice, which is impacting on the sustainability and viability in supporting integrated, coordinated care across health care settings. There is a need for a better system of remuneration for quality in general practice care, which does not compromise access to care for marginalised, disadvantaged groups, especially those in rural and remote parts of Queensland. Performance and quality frameworks, which provide targets for measuring quality primary medical care (Sutton & McLean, 2006), provide potential strategies for consideration in reforming financial incentives in general practice and primary care in supporting the adoption of integrated health system.

Innovation – Research and Development, Knowledge Sharing, Evidence Based Practice

Investment in national and state research, development and coordination will be required including the development of frameworks and competencies in practice. This includes embedding policy within the health system to re-direct focus to supporting integration and continuity of care for patients through the utilisation of new and emerging workforce models. There is a lack of available evidenced based models to build a case for support for investment in primary care. This includes financial and business modelling and the need to support financial incentives for preventative health care. Further research is required into the key drivers of change and more rigours evidence to support the proposed models of care (Nicholson, Jackson & Doust, 2008). Knowledge translation and exchange can provide greater accountability and evidence-based practice in health planning, policy-making and service delivery (Tetroe et al. 2008).

However, there is significant evidence to confirm that the passive dissemination of information, the time delay between knowledge creation and innovation and its uptake in practice is generally ineffective as a way of altering practice or policy. New ways of supporting the adopting of research into practice is required (Armstrong & Kendall, 2010). The transformation of evidence is dependent on the presence of key agents of change, the accumulation of collective knowledge of the evidence, the development of critical mass and the full engagement of the clinical and community sectors to drive local activity (Baum 2007; Dobbins et al. 2009). There is a need for future planning to support the translation of evidence into policy and practice through communication of key outcomes and advocating for research and development into new and emerging models of service provision.

Providing integrated, coordinated care for the consumers are priorities for future services and emerging models of service provision. Providing efficient, effective care linked across services will be required to support innovation. Each of the core integration elements identified in the Framework will need to be addressed in order to progress new ideas and build existing capacity. Expanding and trialling a variety of funding models will be required to support best practice. It will be important that new models of service provision be evaluated including measuring health outcomes and cost effectiveness. This also includes sharing key learning's, advocating for new and emerging effective models of service provision and ensuring best practice policy outcomes are embedded across state and Commonwealth jurisdictions.

Performance Measures

There is a need to ensure that shared indicators are developed across the primary and secondary care sectors. Joint ownership and mechanisms for ensuring integration performance measures are developed will be critical to continuity of patient care. Performance measures should be embedded

within quality improvement cycles with standardised recommended indicators used as a guide to direct local service provisions activity.

Leadership and Change Management – advocacy, education, behavioural and cultural change

There is a need for consistent leadership at a strategic level to address barriers and support integration policy levers in reform. This includes developing a clear mandate, key messages and united voice, particularly in an era of uncertainty and changing environment. Providing appropriate change management to develop and support a new direction going forward (Nicholson, Jackson & Doust, 2008) is fundamental to service delivery reform in Queensland. There is a lack of conceptual clarity about workforce models and a need for clear leadership and cultural change in supporting integration needs in the future. Overcoming professional boundaries, clinician autonomy and traditional boundaries will require cultural change and education. Having local clinical leadership and change ‘champions’ to drive the process will be fundamental to encouraging and aligning improved effort and supporting the change process during the implementation of the reform agenda.

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