Creating the conditions for a more integrated health care system

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Our ‘Hundred-Foot (20 year) Journey …’

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The Journey … Part 1

- Integrated clinical MOC (1996-2001) \(^1,2,3,4,5\) : integrated pathway design and implementation in maternity share-care, postnatal, diabetes, respiratory, neonatal, ED, eye care
- Integrated IT (1999 - 2006) \(^7,8\) : electronically-generated discharge summaries (MEHRS) and e-referrals from general practices direct into OPD
- Inter-professional training across the continuum (1996 – 2006) \(^5,9,17\)
- National Integration Conferences (2001- ) : now bienniel and with both international presenters and audience (Brisbane March 2016)
- 16 State-wide Integration Workshops (2003 -5): bringing together DHS, DGPs, Community Health, indigenous service teams, consumers, relevant others to strategically plan
- Brisbane South Centre for Health Service Integration (2003-7) \(^10,11\).
- Service Integration Framework (2006) \(^12\)
The Journey … Part 2

• Primary Care Amplification Model (2006) \(^{11,13,14,16}\) described the ‘beacon’ practice (an ethos to support and extend the capacity of all primary care in the area, acting as mustering point to better integrate locally-relevant service delivery between general practice, specialist services and other state-funded care)

• Complex diabetes services (2007-) \(^{15,17,18,19,22}\) established across Brisbane South to substitute for OPD in hard-to-reach populations. Equivalent quality with improved access and reduced cost

• Hospital avoidance (2010-15) \(^{9,23,25}\) substituted community models based on integrated service delivery reduce hospital attendance and admission for those with complex, chronic disease

• Centres of Research Excellence x 2

• PCMH and opportunities for improved integration \(^{20}\)

• Co-creation methodology (2015) \(^{21,24}\): researchers and end-users designing and implementing together

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WHAT DID WE LEARN about making integration happen?

• It’s hard – really hard – and lengthy and time-consuming, but it works!

• Service Integration Framework essential

• Our clinical worlds are frantic, over-stretched, risk-averse and change-weary, so very hard to engage – that’s the reality…

• Our cultures are still strongly silo-ed and must move to an ‘all-of-system’, patient-centred, outcomes focus to be future-ready
How do we make integrated health services happen?

- **Vision … People … Leadership….Culture**
  - Setting common objectives / principles of engagement
  - Clear vision: what do you want to achieve? How can you do better working together? What are the gaps in care to plug / opportunities for improved care?
  - What would need to change? – process, resources, people?
  - Effective locally-relevant planning and clear roles and responsibilities important
  - Constantly reflecting back to what makes good care accessible to the patient / community within a given budget
  - Realising it is key to health system survival for all of us – it is OUR problem / OUR solution
Enablers

- Right structure enabling the right culture

- No such thing as ‘failure’, rather ‘learning opportunity’, with regular measurement and review

- It’s about people and engagement and process re-design, then about evaluating impact, fine-tuning, celebrating success and building momentum….

- Strong and engaged clinician and executive leadership essential

- The tools are there – make them work for you ….
References


5. McKernon M, **Jackson** C. ‘Is it time to include the practice nurse in integrated primary health care?’ *Australian Family Physician*, Vol 30, No 6, June 2001, p610-615.


The Future is not a result of choices among alternative paths offered by the present, but a place that is created - first in the mind and will, next in activity.

The future is not some place we are going to, but one we are creating. The paths are not to be found, but made, and the activity of making them, changes both the maker and the destination.

John Schaar, futurist