Integrated models or mayhem? Lessons learnt from three integrated primary health care entities in regional New South Wales

Jenny May, Rodney Cooper, Parker Magin and Anthony Critchley

Abstract

While "integration" may be a policy imperative at present, the reality of integrating services whilst managing the business of service delivery and best patient outcomes is both challenging and unfamiliar territory for most general practitioners. Recent policy changes in general practice have challenged traditional financial and governance models. This paper reviews three integrated general practice entities, all under the auspice of the University of Newcastle, for commonalities and concerns. A model was conceptualised and key factors identified and discussed. These factors included careful selection of partners, elucidation of the level of integration and the need for a lead champion to promote the changed environment. The financial and clinical governance systems needed to be clearly delineated, including the type and priority of service delivery intended. Integration is not a blanket solution but may be useful for patients with chronic and complex health problems. Being resource-intense, it may not be available or appropriate for all. The practical realities of workforce however, and the political and funding environment are likely to dictate how GP practices in the future embrace integration.

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What is known about the topic?

Integration in primary health care is of most value to patients with chronic and complex problems. The current policy environment is conducive to integrated models but funding remains fragmented.

What does this paper add?

A model for integrative activities is discussed with reference to the establishment of three different integrated general practice examples. Key establishment factors include clear definition of financial and clinical governance and mission within a community. Roles of health care professionals must also be clearly articulated with funding streams assured. Success will require a lead champion working from the front to promote and sustain a different way of working.

What are the policy implications for practitioners?

Current funding models in large part do not support the physical infrastructure and team work required to shift practitioners to larger "integrated" general practices. Scope of practice and indemnity need to be clearly defined to allow primary health care professionals to work to their potential both at individual and team-based levels. The policy shift towards integrated general practice or "GP Super Clinics" is occurring in the context of an overworked and ageing health care workforce.

PRIMARY HEALTH CARE integration is currently being viewed as a policy imperative, which has the potential to lower health care costs and lead to better patient satisfaction and outcomes.[1] Unlike more centralised overseas models, primary health care integration in Australia has largely grown around individual programs with funding from both state and Commonwealth governments.[1-3] While general practitioners are regarded as central to integrated primary health

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care programs, the reality of integrating services while managing the business of service delivery is both challenging and unfamiliar territory for most GPs. For example, one challenge for primary health care services contemplating integration is how to predicate involvement of consumers at the planning end of service provision as stakeholders in organisational structures, consumers of services and individuals with health needs. This paper outlines a model for framing a discussion of the challenges of integration from the perspective of service providers. Three evolving integrated general practice entities in regional New South Wales are presented as descriptive case studies. In considering the practical lessons learnt from these examples, the proposed model provides a framework for understanding and replicating different platforms for primary health care integration.

Integration in this context refers to a single system of service planning and/or provision put in place and managed together by partners (parent bodies) who nevertheless remain legally independent.[4] An integrated primary health care system might be said to demonstrate minimal fragmentation between providers and decreased autonomous action by people working within the system. There have been a number of international and local models of integrated services introduced in an attempt to improve the health of specific populations.[4-7] Research, however, suggests that integration is most needed and works best when it focuses on a specifiable group of people with complex needs and where the system is clear and readily understood by service users (and preferably designed with them as full partners).[4] However, there is also evidence that those with non-complex needs (the vast majority of people) will continue to be well served by their GP acting more or less independently of other services.[1] Thus, it is the degree of complexity of individual needs that should determine the requirement and context for integration of primary health care services.

In Australia there are a number of key drivers for integration, including the push for greater efficiency and cost savings.[1] Health professionals care for patients at an interface between Commonwealth fee-for-service arrangements, state government-funded health services, and private providers. Integration is seen as a crucial step to address gaps in primary health care delivery created by the different legislative and funding requirements across which health services operate (ie, three levels of government, and a mix between private and government payment systems). The need to focus on integrated service delivery is also being driven by Australia's ageing population and current shortage of health care professionals, especially in rural and regional areas.[8-10] This is accompanied by a quest for better health outcomes and a growing consumer awareness of health care options.[1]

In general practice there is increasing activity linking GPs with other health professionals.[2] The inclusion of practice nurses and allied health practitioners in uptake of care planning and team care arrangements are providing opportunities for GPs and other health professionals to consider linkages and service integration. The development of platforms for integration and the opportunity to pilot potential changes in roles and employment arrangements is the challenge for primary health care providers.

Leutz[11] identified some consistent issues for integrating health care services. While Leutz[11-13] applied these "laws" to specific populations, they are helpful in conceptualising some of the broader issues that confront health care managers when establishing new platforms for integrated health service delivery. Leutz[11-13] concluded that some services can be integrated all of the time but one cannot integrate all of the services all of the time. Other laws include; "integration costs before it pays"; "your integration is my fragmentation"; "you can't integrate a square peg into a round hole"; and "the one who integrates calls the tune". These laws are highlighted in Box 1. Some of the practical consequences of these laws will be described in relation to the three case studies.

Describing the context

Recent integrated primary health care initiatives in Australia have been largely made operational

1 Leutz' laws of integration*

Leutz laws	Practical consequences
1.You can integrate some of the services all of the time but you can't integrate all of the services all of the time	Need to target integrated approach to people with complex needs as total integration may be inefficient
2. Integration costs before it pays	New services require resources including funds, training, systems and infrastructure
3.Your integration is my fragmentation	Changing focus of service delivery can create losses for services
4.You can't integrate a square peg into a round hole	Services that were previously free may not lend themselves to private fee for service arrangements
5.The one who integrates calls the tune	Decisions on the way in which services may be integrated will be made by the major providers

* Adapted from Integrated Care Network. Integrated working: a guide. 2004.[4]

through Divisions of General Practice, primary care networks (Victoria and NSW), community health services, Aboriginal community-controlled health services and university initiatives.[14] For example, provision of integrated primary health care is a strategic priority in the current NSW state health plan,[15] with NSW Health currently implementing 17 new integrated primary care (IPC) centres across the state.[16] Given that the funding requirements for establishing initial infrastructure are considerable, lead agencies are likely to be large funding bodies like the Commonwealth and state health departments. With the recent change in government "GP Super Clinics" are now very much on the agenda.[17]

The University of Newcastle's Faculty of Health, through the Discipline of General Practice and the University Department of Rural Health, has been a forerunner in supporting the development of both integrated primary health care and GP–hospital integrated services. Importantly, the university has supported local initiatives rather than direct new models of service delivery. The University of Newcastle has been involved in the estab-

2 Description of three integrated primary health care entities established in regional New South Wales

GP entity	Peel Health Care	Links to Health	Uni-Clinic Cessnock
Location	Tamworth, NSW. Regional rural town of 47 000	North Wyong, NSW. Outer urban, fast growing commuter belt projected 46 000	Cessnock, NSW. Semi-rural town of 50 000
Board structure	Not-for-profit company owned by the North West Slopes Division of General Practice	Not for profit company, auspiced by Division of General Practice	Corporate entity owned by the University of Newcastle
Employment arrangements	Doctors contracted on percentage. Practice nurses salaried. Allied health professionals either private or employed by Division	Doctors and nurses salaried	Doctors, nurses and allied health staff salaried
Billing	Private/70% bulk billing	Private/bulk billing	Bulk billing
Integration plan	Phase 2 expansion of premises with increase in private allied health sessions	Increasing collocated community health sessions	Phase 2 — further integration with community health services
Workforce numbers 2007	4 FTE GPs 1.5 FTE practice nurses 12 sessions allied health	2 FTE GPs 0.5 FTE nurse	5 FTE GPs 5 FTE nurses 1 FTE dietitian

FTE = full-time equivalent.

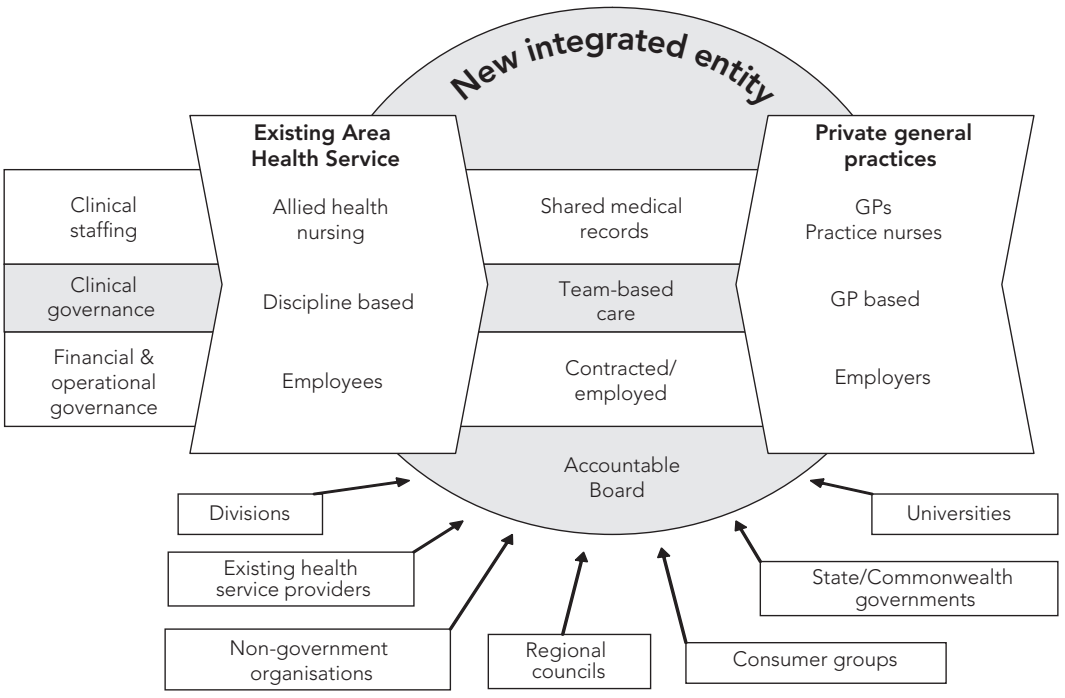
lishment of three regional NSW general practice entities, representing three very different platforms for primary health care integration. These units, Peel Health Care (Tamworth), Links to Health (North Wyong), and the Cessnock Uni-Clinic are detailed in Box 2. Each of these entities is located in an area of workforce shortage and services communities with high levels of social disadvantage, reduced access to health care services, relatively high unemployment and a lack of adequate transport infrastructure. All three entities have had extensive consumer input at a Board level and, while structured differently, have encountered common barriers to planning for integrating services. Consequently each entity has developed specific local solutions.

Landscape for the potential integrator

In describing these new GP entities, practical lessons can be drawn, which may inform the establishment of other potential integrated practices. To highlight the lessons learned, the model depicted in Box 3 is put forward to help the potential integrator identify some of the essential relationships which need to be considered when establishing and delivering an integrated general practice service. Integrated entities have the potential to create a "new space" with staffing, and clinical and organisational governance that is different from both state health services and traditional general practices. The potential benefits of integrated primary health care is the greater mix of skills and expertise brought together from existing services (state health and general practice) in a common space to provide "team care". For example, all three entities discussed in this paper are "housing" allied health professionals, including some seconded area health staff, with GPs and practice nurses.

Clinical governance and professional indemnity which are the responsibility of the GP within the "cottage tradition" of general practice would necessarily need to be altered to encompass individual responsibilities for clinical care and also

3 Proposed model of integrated general practice



team care within the new practice entity as highlighted in Box 3.

Operational and financial governance, while previously the domain of the employer, whether GP or health service, would need to encompass all professionals working in the integrated entity. With the establishment of a separate or independent Board structure, organisations with an interest in the integrated practice can therefore become major stakeholders. For example, Divisions, local councils, consumer groups, health providers and academic institutions may well combine their expertise with state and Commonwealth health structures to develop new local Board structures.[2] It is evident from the literature[3,18,19] and applied experience that primary health care integration must be localised to draw on the unique patterns of local health service delivery, historical relationships and localised health demographics. The visual framework illustrated in Box 3 is uniquely influenced by the local mix of workforce issues, funding streams and individual community needs.

Operational issues for consideration — lessons learnt

Governance structure

Careful selection of business partners

Choosing partners is a complex process and Leutz's first law suggests that this should be targeted with the integration goal in mind.[11] While this makes perfect sense from a theoretical perspective, the realities of the service context may dictate very different choices. For example, each entity chose partners based on who was keen to be involved and who could bring resources and needed expertise to the table. By selecting local members from state and Commonwealth governments, GPs, state health services, Divisions of General Practice, consumer groups, local councils and the University of Newcastle, each entity was able to incorporate key decision makers from across the major providers of health service delivery and planning in their respective regions. The involvement of key stakeholders ensured that the chosen model received implicit endorsement from CEOs/general managers (decision makers within each organisation) and that it was managed within their portfolio or through immediate delegation. It also meant that when each model was formalised, financial and staffing resources could be immediately allocated to operational needs. Early active engagement of community members provided direct links to likely consumers as well as key advice around needs and access issues for identified target groups. For instance, momentum from consumer and carer representatives supported by other partners was used to improve public transport access to one of the locations.

Develop a clear understanding of what is intended

A clear vision and mission statement is imperative. An explicit description of the intended service and its intended recipients was discussed and developed with all stakeholders by each of the three entities. Leutz[11] in his third law alludes to the potential negative impact on other services when their vision is altered. Existing services must keep this in mind when framing their involvement in a new integrated entity. Access and equity are important issues, but in a situation of finite health workforce, decisions must be made based on reality and any service limitations need to be stated upfront. For example, in the planning stage of Peel Health Care, some community members expressed their hope that it would work as a bulk-billing emergency clinic with extended hours. While this was not possible in the initial funded set up, the new practice nevertheless agreed to bulk bill all card holders and commence after-hours targeted clinics. Provision of longer hours remains a vision but depends on recruitment of more health staff and other financial considerations.

Identify an Integration Manager or local champion

Central to the success of an integrated service is a leader or champion with a "can-do" attitude, who constantly champions the model, and who has dedicated time to manage stakeholder relationships. Unless the boundary issues are constantly

negotiated, stakeholders are likely to retreat into existing modes or "silos" of practice. Each entity dedicated considerable time and resources in assisting a champion to sell the integration concept. For example, Peel Health Care dedicated half-time funding to a program manager whose job it was to "sell" the model to GPs, other health professionals and to the local community.

Define the level of integration required

Not all organisations/services need to be fully integrated. Leutz[13] defined three strategies for organisations/services to work together: (1) linkage — no holistic view of user needs. Rather, actions and decisions are arrived at independently and without coordination and information sharing occurs when required; (2) coordination — there is a shared view of user needs with coordinated action and decision making; (3) full integration — fragmentation between service providers and autonomous action are minimised while work practices become transparent.

Integration appears to work best for patients with more complex health care needs. There is evidence that patient outcomes can be improved where three providers are involved in their care.[20] Chronic problems requiring long-term treatment and monitoring and communication between different providers are likely to provide the greatest benefit with collocated service provisions. For patients the "one-stop-shop" concept where they might access a doctor and possible allied health services, like podiatry, in one visit is very appealing. The reliance on fee-for-service funding however, has limited the capacity to involve private allied health professionals as many who have chronic and complex health problems are also financially disadvantaged.

For other services a Memorandum of Understanding (MOU) or Service Level Agreement may be all that is necessary to ensure timely access to a service. The development of a formal process like an MOU between organisations, funding bodies and key stakeholders is often valuable to lock in commitments and make contributions explicit. Alternatively, Service Level Agreements may be preferred because they are often easier to garner and better understood by clinicians.

Agree on the type of model required

Given the variety and "cottage industry" nature of general practice, the development of alternate interdependent frameworks within general practice will be likely uneven. Some health professionals have inherent capacity to consult and collaborate while managing their professional boundaries, while others need to work within existing frameworks until team members can trust each other. All three entities developed a completely new clinical unit, which was an advantage for patients and stakeholders as expectations and mission could be established anew.

Integrated practice models have included employed GPs supporting employed nurses and health professionals, employed GPs liaising with health service staff and GPs contracted to the practice entity and linking with private and employed allied health staff. This last model is the likely format for the new GP Super Clinics being proposed by the Commonwealth government.[17] In defining the service the following questions need to be asked: Will the service entity provide discrete general practice services targeting marginal groups? Will it provide for overflow from emergency departments? Is the brief to integrate services related to a particular service (eg, sexual health)?

Determine the financial governance

In planning a new health care entity, there is a need to explicitly acknowledge the potential income streams and proposed financial model. The financial risk that will accrue to individual stakeholders needs to be clearly articulated while policies for charging for clinical activity need to be clear and comprehensive. An informed understanding of the funding sources and line management as well as operational issues around pay, conditions, and relief arrangements need to be clear to all stakeholders. Available and motivated staff comprises a scarce human resource which needs to be looked after.

The entity's capacity to raise funds and stockpile cash reserves for equipment renewal or expansion will also need clarity. Billing practices utilising employed practitioners need to be understood by the practitioners with budgets and remuneration targets discussed and monitored. For example, Peel Health Care pays GPs a percentage of their fee-for-service billings and is exploring ways of creating incentives for participation in team-based care activities to improve uptake. Disbursement of blended payments is negotiated taking into account where the service is provided and by which practitioner. Time to break even and budget limitations should be affirmed by all financially contributing and underwriting stakeholders.

Issues around clinical and financial governance

Because all three entities were developed in areas of workforce shortage, each has had to be wary of the problem of taking staff from existing stakeholders or other health care providers in the region. One approach has been to try to attract individuals interested in different ways of working and explore the type of systematic support they require. At the Cessnock Uni-Clinic for instance, nurses and allied health professionals work within GP-led teams. This allows a closer working relationship than in some other areas of nursing, with more of a focus on preventative health care and treatment of chronic and complex conditions.

Peel Health Care has also encouraged practice nurses to be involved in primary acute care as well as more traditional roles. Protocols for supporting allied health involvement in the practice have necessarily been developed with emphasis on team contribution and medical record expectations. Links to Health on the other hand, has encouraged collocated Area Health Service community nurses to explore closer collaboration with GPs and allied health professionals. Collocated non-government agencies involved have also sought clear guidelines about their roles and responsibilities within the Links to Health integrated practice. The crucial questions which must be asked in order to define the roles and responsibilities within a new practice entity are: Who is entitled to do what? What form will the multidisciplinary team structure take (ie, GP as team leader or GP as part of team)? What are the priorities if there are not enough team members?[21]

Developing new team practice environments can be professionally threatening. Professionals need to be very clear about existing frameworks and protocols around their operation.[22,23] For example, the scope of nursing practice should be clearly enunciated and practice nurses should be supported individually to identify their roles and competencies. Up-skilling should be offered in line with practice needs and individual interests. This articulation of roles needs to be reflected in practice systems. Practice nurses taking clinical responsibility, for example, might be authorised to write in medical records and follow up and maintain chronic disease records and recall systems.

As highlighted in Box 3, access to shared electronic records is a major issue where individual practitioners have different requirements for clinical notes, statistical records to keep as evidence of activity, and demographic or management information needed for billing and funding. In all three entities electronic records were used. In the case of Peel Health Care, visiting specialists, and private allied health personnel were also able to use electronic medical records and have printed off information to use for their own statistical purposes with informed consent elicited from patients. The use of the electronic record can be further refined by organising differing levels of access to clinical or other information. In this way sensitive information elicited and required by one health professional is not freely accessible by others in the workplace. Demographic and important clinical information such as allergies, medications, treatment and management plans can be shared and contributed to by all health professionals involved in the care of the patient.

Clarification of individual responsibility for handover of clinical information,[20] and arrange-

ments for after-hours care must be commensurate with skills and competencies being sought, and fully supported. Trust requires shared experience and is a goal rather than a policy. Ways of promoting this include shared training opportunities, patient review, and practice projects, thus modelling the potential complementary skill mix. Skill sets are then enhanced when clinicians feel supported to use them.[24] Accreditation and an individual practitioner's adherence to professional best practice is both crucial to other team members and to the patients. Research evidence of enhanced patient outcomes with wider scope of practice for nurses and pharmacists is encouraging in view of this team approach.[24]

The current GP environment of rebates tied to doctor time, vicarious liability of the GP for other practice staff and the lack of systems that promote responsibility by practice staff has meant that articulation of differing roles often occurs within an environment of fear and uncertainty. The issues of competency in individual disciplines and clinical management and governance remain problematic. In all three integrated practice entities, distinctions have been drawn between clinical management and financial or operational management. Systems of clinical accountability must be developed that acknowledge the individual's responsibility for competent and safe clinical practice but also for the need to collaborate and respect others.[24]

Evaluate the outcomes

In developing integrated practice entities, priority must be given to what outcomes will deem the project successful. In the early phase it is likely that Leutz's second law will come into play where integration will cost before it pays.[9] Significant capital infrastructure costs as well as time costs needed to redefine ways of delivering services will be required. The short and long-term benefits of integration, however, are still being established with most evaluations to-date focussed on process indicators of service delivery or patient and practitioner satisfaction rather than cost effectiveness or comparisons of access and equity. Evaluation templates are in development but will need to reflect local priorities and visions.

Discussion

New platforms for integration are currently being developed across Australia and are seen as a crucial step to address gaps in primary health care delivery.[1,2] Integrated service delivery is also being driven by external factors such as Australia's ageing population and current shortage of health care professionals, especially in rural and regional areas. While integration is not a blanket solution, it may be most useful for patients with chronic or complex health problems.

Multidisciplinary team-based care requires new, focused clinical and financial governance structures and may not be appropriate for all practices. The pointers discussed in this paper provide a useful starting point for organisations as they grapple with this "new space" and its differing responsibilities and employment options.

Operators of these new entities will require clear articulation of purpose as well as informed and motivated health professionals willing to look at new and collaborative working styles.

The key factors common to all three described entities included clear start-up goals and different arrangements for financial and clinical governance. The current political reality of primary health care in Australia is that integrated models cannot be provided for all Australians and funding arrangements are therefore likely to be a mix of fee-for-service and block payments for allied health involvement. The current environment is problematic as the patients most likely to benefit from integrated chronic and complex care may not have good access to current allied health professionals who are private providers. The availability of team care arrangements is a start but much more will need to be done. The involvement of consumers in the process of setting up and maintaining integrated practices is crucial. Furthermore, the capacity of individual towns and facilities is likely to vary widely, hence the need for greater understanding of the premises upon which these changes are based.

Box 3 provides a visual depiction of the changed structure and issues likely to become operational realities. Given workforce shortages, the access of individual patients to teams of health professionals and the way these teams interplay is likely to remain highly variable in the short to mid term.

Conclusion

With GP Super Clinics and State Health Integrated Primary Health Care Centres part of the new health landscape there will be a transition from existing models to integrated entities for many health professionals. Taking account of the lessons learnt from the establishment of integrated practices may help new players avoid potential pitfalls. Financial and practical realities of workforce and the political environment are likely to dictate how GP practices in the future embrace integration. For maximum impact, evaluation should be focused on clinical and patient outcomes as well as achievement of financial viability and patient acceptability.

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Competing interests

The authors declare that they have no competing interests.

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