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Integrated Care

A tonic for good health

Gil Carter, Partner, Cogility

Health professionals want nothing more than for patients to get the care they need, when they need it and where they need it. In reality this is not always easy (or possible). Referral pathways can be dotted with twists, turns, roadblocks and dead-ends and public funding is provided from a variety of sources, but accessing it can often be through a complex eligibility process in some cases.

Care providers are facing constant cost pressures, whether as part of a public health environment that has many needs to meet or as a small business operator in primary care working to deliver good care. Accessing and sharing patient clinical information can be fraught with inefficiency as a result of inconsistent information exchange, legislative impediments (particularly from acute care to primary care), and the limited value of sharing episodic information.

An integrated care approach links the healthcare functions across a region, joining up primary, community, allied, aged and acute care. Integrated care uses coordinated teams to provide holistic care to patients with chronic or complex needs. It allows for more efficient care management across the range of settings that a patient visits, and creates a **patient-centric** view of the care continuum.

Public and private health providers have advocated strongly that there is a need for a more integrated approach to healthcare, and international experiences in environments such as Canterbury[1] in New Zealand have shown that good results can be delivered through such an integrated approach.

Governments in Australia are now investing into integrated care programmes with initiatives that are well beyond limited short-term pilots. For example, NSW Health is operating a $120M program[2] over three years to investigate and deliver integrated care in a range of settings across the state.

In QLD, a promising collaboration program[3] commenced in 2013 between the Gold Coast Medicare Local (now PHN) and Gold Coast HHS. This program looks at rapid risk stratification and intervention if patient condition deteriorates, and manages a patient cohort at higher risk of hospitalisation. With the good results from this initiative paving the way, the QLD government announced[4] a substantial $35M innovation investment fund to further develop programmes in integrated care over a four year period.

In both cases, the funding committed is more than a simple pilot and lasts for long enough to allow good results and learnings to be gathered. The onus is now on those trial programmes to tackle the tricky issues, develop viable models, show good results and make the review for continued funding and broader coverage an easy decision for government make.

The areas where the programmes will need to focus include:

- Inclusion of the right health provider types to deliver the care needed. Integrated care needs collaboration between primary and acute, state and federal, public and private.
- Using the best information sharing and management platform. The Commonwealth government's MyHR program is continuing to build capability for managing health information across many care settings, and can play a role in supporting information transfer.
- Selecting and managing a patient cohort that will receive strong benefit from participating in an integrated care program.

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Another challenge for funders is that results from localised trial programmes can be very dependent on the skill of the participants and the local patient demographics. When scaling up a programme of integrated care, a 'one size fits all' model is unlikely to be adopted successfully across the health sector. Instead, the programmes should seek to capture the repeatable elements that are complex to manage in each programme, and allow for local customisation of delivery model.

The types of repeatable platform elements that an integrated care programme could commoditise might include:

- Policy and legislative enablers. Once the agreements and mechanisms for clinical safety, information sharing, privacy/security and technical backplane have been developed, bake these into a target operating model for integrated care.
- Clinical pathways or care pathways. Chronic conditions such as diabetes, kidney disease and cardiac disease can have a well-considered suite of patient journeys built to work effectively across an integrated care environment. Having these as a library that can be picked up and used widely will make delivering good results faster and more repeatable.
- Agreements between providers: public acute care and PHN's, public and private. The structures that exist in the health sector are consistent, but integrated care trials seek to join these organisations in a novel way. A standardised set of agreements can make the setup process much easier.
- Benefits and outcomes measures and models. The effectiveness of integrated care can be seen in many places, such as the reduction in unplanned hospital presentations, but the overall benefits can be hard to quantify. The benefit of the integrated care trials is being able to develop a robust series of benefits metrics, and then to be able to judge the success of the program objectively.

If these elements (and others of a similar theme) can be developed into a repeatable implementation model, the challenge for funding integrated care becomes much simpler. A centrally-defined system almost invariably loses relevance when it arrives into a local domain. An integrated care program that can come with a strong underlying ecosystem of supporting material, but deliberately require that local programs take ownership of local implementation is more likely to be adopted successfully.

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This approach of being 80% standardised and 20% localised would allow region-based programmes to focus on the local issues that will make their own implementations successful. The activity would be in areas such as:

- Selecting the right patient cohort. The 'frequent flyers' of chronic disease are clear candidates.
- Involving the most effective care providers. The local environment for care delivery varies enormously: rural or remote vs metro areas, indigenous or non-english speaking, disease prevalence. Being able to link up with the right services is key.
- Getting involvement from clinical champions, business advocates and consumers. Health projects are highly influenced by the personalities of the lead participants, and a solid platform for the systems will make it much easier to attract the best participants. A model that is already biased toward success becomes even more favourable if the best people are running it.

Integrated care is an area of significant promise in healthcare. The domain has moved successfully from small scale trials to longer term pilot programs funded over a number of years. This is a vital phase, and will allow the models to be refined and commoditised for widespread permanent adoption.

If the areas of common concern can be captured and well managed in this pilot phase, the benefits of integrated care can be easily recognised by funders and widely adopted by health organisations. At the end, the patients managing chronic disease across Australia will benefit from better coordinated care, and enjoy improved quality of life.

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References

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Gil Carter is a partner and principal consultant with boutique consulting firm, Cogility. He is recognised throughout Australia as an expert in the eHealth domain. He has played a key role in a number of projects at the forefront of the design for digital health and hospital services. Gil combines creativity and innovative design thinking with his technical qualifications and has strong skills in major sector reform, program design and delivery. He has spent over twenty years in sectors such as health, education, mining, finance and human service delivery programs.

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