
CONFERENCE ABSTRACT

Experiencing integration in Australian primary health care: a pilot study

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Introduction: Integrated care means different things to different people. We often find the terms 'integration' and 'integrated care' used interchangeably. However, Kodner and Spreeuwenberg (2002) suggest 'integration' refers to structures and processes, while 'integrated care' refers more to patient experiences and the outcomes of such processes. Contributing further to its complexity, integration occurs between different levels of the health system: vertical integration, such as between acute and primary care organisations; and horizontal integration such as between general practitioners (GPs) and allied health professionals. Given there is no recognised common model of integrated care, a conceptual framework is needed to better understand integrated care and guide empirical research (Nolte and Pitchforth, 2014, Valentijn et al., 2013, Kodner and Spreeuwenberg, 2002).

A starting point for understanding how integration operates as a process is the seminal work by Fulop et al (2005), which recognises the importance of process and cultural changes in addition to structures and governance. They identify six dimensions needed for effective integration. Factors such as the structure of the organisation (organisational integration); non-clinical and back office processes (functional integration); organisation level clinical services (service integration); clinical team level care pathways (clinical integration); as well as the role of shared values (normative integration); and, the coherence of policies across organisational levels (systemic integration).

Recognising the central role primary care plays in integration, Valentijn et al. (2013, 2015a, 2015b) have developed a conceptual framework that can be used to aid an understanding of integrated care from a primary care perspective. They developed a taxonomy through expert consensus, which combines the functions of primary care with the dimensions of integrated care. The taxonomy consists of 21 key characteristics identified as necessary for achieving integrated care in a primary care setting. However, the authors acknowledge that the development of the model did not include the perspectives of health consumers and its utility in practice required further investigation.

The purpose of this project was to examine the perspectives of consumers and providers on integrated care within an Australian primary health care setting: what each expects of integrated care and what each experiences. A key focus was whether frameworks developed

from a professional perspective, such as those created by Fulop et al (2005) and Valentijn et al (2015b), could provide an effective means to explore people's experiences.

Methods: This pilot study focused on one large urban integrated primary health care centre. Nineteen consumers with chronic illness and 10 practice staff, including GPs, allied health professionals and practice support staff were interviewed. The semi-structured protocols explored their perspectives on, and understanding of, integrated primary health care. Transcripts were thematically analysed, using a combination of deductive coding against the Fulop et al (2005) dimensions and Valentijn et al descriptors (2015b) and inductive coding of experiences that did not fit within the framework.

Results: Consumers' comments that could be coded to the Fulop et al (2005) dimensions and Valentijn et al (2015b) descriptors were primarily about clinical and functional integration, particularly their experiences of continuity of providers, the usefulness of the shared information systems and the helpfulness of front desk staff. Health professionals had a strong focus on clinical level integration, but also talked about integration at the service (i.e., interprofessional) and organisational levels, as well as functional and normative integration. Practice support staff focused on normative and functional integration.

Across all groups, discussion of normative integration was primarily in terms of a collective attitude. There was very little discussion of system level integration. A common feature of the way participants from all groups described their expectations and experiences of integrated primary health care was a "one stop shop," reflecting the perceived benefits of the co-located model on which the health centre operated.

Discussion: Overall there was evidence of the more "practical" elements of integrated care such as information flows as well as evidence of the development of a shared culture, noticeable to the consumers as well as staff. Rather than a focus on more business-like concepts such as coherence of policies and management, integration was described in terms of the way people interacted with one another and the ease of navigating healthcare.

The findings of this study suggest the frameworks are useful for capturing the way people in service provision, especially health professionals, describe integration, but less useful for consumers, who speak of their experiences of integration as part of a broader experience of quality primary health care. However, this pilot was limited to a small number of consumers and providers in one clinic. The findings will inform a larger, comparative study of Australian integrated primary health care models.

Conclusion: Primary health care integration using a co-location model can improve the care experience both for consumers and providers. Existing frameworks for integration have been heavily influenced by the provider and organisational perspectives. The current study provides evidence that work is still needed on the key concepts of quality integrated primary health care from the consumer perspective. A potential area of focus may be the intersection of integrated primary health care with dimensions of consumer experiences of health care more broadly.

Parkinson; Experiencing integration in Australian primary health care: a pilot study.

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