INTEGRATED CARE FRAMEWORK
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Adelaide PHN Integrated Care Framework
Version 1  October 2019
WHY IS ADELAIDE PHN FOCUSING ON INTEGRATED CARE?

Adelaide PHN has described what integrated care means for our organisation and what role we play in the integrated care space. We hope this will support conversations and actions first internally and then externally with our commissioned service providers, partners and stakeholders in facilitating:

A connected quality health system where health providers work together to improve people’s experiences of the health system and their health outcomes.

WHO BENEFITS FROM INTEGRATED CARE?

Integrated care can benefit anyone with health needs but is particularly important for people with complex and long-term conditions, helping them to manage their own health, keeping them healthy, independent and out of hospital for as long as possible. This includes people with chronic conditions, frail elderly people, people with disability and those at the end of life.

Adelaide PHN applies the integrated care principles across all our priority areas and programs, including but not limited to:

- Mental health;
- Aboriginal health;
- Aged care;
- Health workforce;
- Digital health;
- Population health;
- Alcohol and other drugs;
- Disability;
- Palliative care;
- Children and youth;
- Cultural and linguistically diverse communities.
EXPLORING ADELAIDE PHN’S INTEGRATED CARE MODEL

Adelaide PHN’s integrated care model (see diagram 1) describes several dimensions of integration that work together to achieve integrated, person-centred care. Integration activities will align with one or more of these dimensions. Whether engaging, partnering, designing or monitoring activities, these dimensions can assist in providing a lens to focus discussions around integration.

PERSON CENTRED CARE

Person centred care is the active engagement of people as partners in their care to improve their overall wellbeing, and not focusing solely on individual conditions.

INTEGRATION TYPES

Types of integration, or the ‘what’ of integration, centre around common health care activities. More than one type can be applicable to an integration activity.

- **Clinical integration** describes how care is coordinated around an individual person’s needs through clinician-to-clinician interactions. Examples include team care arrangements and pathways of care.

- **Professional integration** represents the respect and understanding of each profession’s contribution to the care of people in identified communities and the existence and promotion of partnerships and shared learnings between professionals.

- **Service integration** describes how service providers and organisations partner to deliver seamless care services to meet the needs of an individual and/or communities. Examples include consortia, collectives, provider networks, or contracts/agreements between separate service providers.

- **Administrative integration** refers to the platforms and processes that support sharing of clinical information and data. Examples include My Health Record, MasterCare Plus, ReferralNet, cdmNET, Pen CS CAT4.

INTEGRATION MECHANISMS

Mechanisms of integration describe ‘how’ the integration is enabled. Adelaide PHN utilises both partnering and commissioning to enable integration and may use them together.

- **Commissioning for outcomes & integration** refers to how Adelaide PHN provides an enabling platform for integrated care, such as through the use of formal commissioning mechanisms and processes including contracts, MoUs and partnership agreements.

- **Partnering for outcomes & integration** refers to the extent to which different partners in care develop and share an ethos of mutual values, or a commitment to coordinating work which enables trust and collaboration in delivering health care.

INTENSITY OF INTEGRATION

The intensity of integration allows us to quantify ‘how much’ integration is taking place - from small-scale transfer of information, through to fully integrated activities involving shared resources. This can include concurrent elements at several levels.

LEVEL OF INTEGRATION

Integration can occur in many places in the health system continuum. This can be at individual clinician level, service provider, local area, sector, or whole of system integration.
Types of integration: the ‘what’

Types of integration, the ‘what’, centre around common healthcare activities. More than one type can be applicable to an integration activity.

Mechanisms of integration | the ‘how’

Mechanisms of integration describe ‘how’ the integration is enabled. Adelaide PHN utilises both partnering and commissioning to enable integration and may use them together.

Intensity of integration | the ‘how much’

The intensity of integration allows us to quantify ‘how much’ integration is taking place – from small-scale transfer of information, through to fully integrated activities involving shared resources. This can include concurrent elements at several levels.

Level of integration | the ‘where’

Integration can occur in many places in the health system continuum. This can be at individual clinician level, all the way through to a whole of system integration.
WHEN TO USE THE FRAMEWORK

It is an expectation that this Framework will be used as a key guiding document for staff and the organisation when working to achieve better person centred care. This includes, but is not limited to, consideration of other Adelaide PHN Frameworks for example:

- The Department of Health PHN Program Performance and Quality Framework;
- The Adelaide PHN Service and Clinical Governance Framework;
- The Adelaide PHN Quality Framework;
- The Adelaide PHN Health Promotion Framework.

As part of the Integrated Steering Groups (ISGs) structure and process, the ISGs play a key role in translating strategic directions into operational planning to ensure a coordinated and integrated approach to what we do. Project groups are established as required to work on the operational activities of a project (i.e. deliverables of a project including design, implementation, monitoring and reporting, communication and marketing and project specific engagement).

THE INTEGRATION PROCESS IN ADELAIDE PHN

Table 1 includes key prompts that can be used to determine when and how integration should be considered when undertaking design, implementation, monitoring and reporting, communication and marketing and project specific engagement. This is a process which is partnership based and requires engagement and discussion with key stakeholders.

Remember that integration is participatory and partnership based - it is done ‘with’ and not ‘to’.

Integration starts with a key goal to be achieved.

**TABLE 1**

*Key prompts to determine when and how integration should be considered*

<table>
<thead>
<tr>
<th>GOALS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why do you want to integrate?</strong></td>
<td>What are you seeking to address?</td>
</tr>
<tr>
<td><strong>Will integration assist with/fix that problem?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How can you tell? Is integration the ‘best’ solution?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Is it person-centred?</strong></td>
<td>Will people benefit from the activity being integrated?</td>
</tr>
<tr>
<td><strong>Who do you need to integrate with?</strong></td>
<td>Why would they want to integrate with you?</td>
</tr>
<tr>
<td><strong>Do they see this as a shared possibility?</strong></td>
<td>Is your problem a problem for them?</td>
</tr>
<tr>
<td></td>
<td>How would you know this? Do you have any evidence?</td>
</tr>
<tr>
<td></td>
<td>Need to identify a mutual problem – note that this problem may look different for each of you</td>
</tr>
<tr>
<td></td>
<td>This forms a part of the stakeholder identification and analysis</td>
</tr>
</tbody>
</table>
What resources do you and your integration partners have for integration? Doesn’t have to be financial! What systems, processes, motivation, people, connections do partners have to use for integration? Examples include newsletters, databases, venues, specialised knowledge, and patient groups.

What will Adelaide PHN contribute to support integration in this activity?

Who will be involved from each party? What do they ‘bring to the table’?

What are everyone’s roles and responsibilities in relation to integration? Set out roles and responsibilities for the integration. Make sure all parties agree!

How will leaders be used to champion and manage the integration?

Where is the integration happening? Clinicians – individuals

Service providers – organisations, practices

Local area – geographically similar

Sector – shared interest, e.g. aged care

System – population level

Who will be partnering in the integration?

Communication – e.g. sharing of information on an as-needs basis (written, electronic)

Collaboration – e.g. occasional face to face discussions; working together to improve patient care as required

Cooperation – planned, pro-active transfer of information (written, electronic) with regular face to face discussions; some shared operating platforms; Working to together to plan patient care

Integrated – shared vision, shared systems, pooled funding

Which types of integration are you considering? Clinical

Professional

Service

Administrative

Which mechanisms of integration are you considering? Commissioning for outcomes & integration

Partnering for outcomes & integration

How much integration is required?
HOW TO MEASURE INTEGRATION

As there are many dimensions of integration, measurement and monitoring of integration can be challenging. Table 2 provides some examples of methods to measure integration.

### TABLE 2
Methods to measure and monitor integration

<table>
<thead>
<tr>
<th>TYPE</th>
<th>LEVEL</th>
<th>MECHANISM</th>
<th>INTENSITY</th>
<th>METHOD</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical integration</td>
<td>Clinicians</td>
<td>Partnering for outcomes and integration</td>
<td>Communication</td>
<td>Audit of practice software</td>
<td># of TCAs # of referral to/from AHP</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>Providers</td>
<td>Commissioning for outcomes and integration</td>
<td>Collaboration</td>
<td>RACGP Standards for Patient Centred Medical Home</td>
<td># of formal agreements # case conferences</td>
</tr>
<tr>
<td>Service integration</td>
<td>Local</td>
<td>Partnering for outcomes and integration</td>
<td>Communication</td>
<td>Existence of collaborative practice networks</td>
<td># of networks # of participants including return rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sector</td>
<td>Commissioning for outcomes and integration</td>
<td>Communication</td>
<td>Qualitative reporting in PMHCS provider reports Providers staff questionnaire</td>
<td># of partnerships with other PMHCS providers to facilitate cross referrals # of cross-referrals between PMHCS providers</td>
</tr>
<tr>
<td></td>
<td>System</td>
<td>Commissioning for outcomes and integration</td>
<td>Collaboration</td>
<td>MH Schedule reporting – Indicator Regional Integration</td>
<td># of formalised partnerships with other regional service providers to support integrated regional planning and service delivery</td>
</tr>
<tr>
<td></td>
<td>Professionals</td>
<td>Partnering for outcomes and integration</td>
<td>Communication</td>
<td>Evaluation of multi- or cross-disciplinary professional development</td>
<td># of participants rating the event highly in domains pertaining to multidisciplinary practice</td>
</tr>
</tbody>
</table>

### REFERENCES

1. Integrated Care Models: An Overview, World Health Organization Regional Office for Europe, October 2016
2. The Project Integrate Framework, Calciolari, S., Gonzalez, L., Goodwin N., Stein V., September 2016
4. Adelaide PHN Clinical Councils, 2019
5. Adelaide PHN Consumer Advisory Councils, 2019
We acknowledge the Kaurna peoples who are the Traditional Custodians of the Adelaide Region. We pay tribute to their physical and spiritual connection to land, waters and community, enduring now as it has been throughout time. We pay respect to them, their culture and to Elders past and present.