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Conference Abstract

Is integration an add-on or a new way of working for health professionals in co-located medical practices?

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Abstract

Introduction: Characteristically health services within the community are not separated based on illness/condition but rather on profession for example, GP services, physiotherapy clinics. In the primary health sector government policy at federal and state levels has established integrated health services. Functional and operationalised integration does not spontaneously arise from co-locating health professionals. Despite primary health reforms there is no prescriptive method whereby services are integrated. For those health professionals working in a co-located primary health care environment how integrated is 'integrated'?

Practice and context: Our study examines integration at the point of service delivery, within co-located community medical practices in Australia: five different case study practices in areas of high population need. These are a purposeful mix of the state government model, Commonwealth government model (university linked Superclinic), a hybrid of state and Commonwealth model, and private for profit models.

Change implemented: These practices commenced delivering co-located health services with an underlying philosphy of service integration to better address patient health outcomes (between 3 and 10 years).

Objective of the change: We examine health professionals' experience of health service integration.

Targeted population: Health professionals in an integrated service delivery environment.

Stakeholders engaged: Health professionals in the case study clinics.

Timeline: These are practices offering a range of services for between 3 and 10 years. The questionnaire was completed over a 3 week period (July 2014) and focus groups were conducted from July – September 2014.

Theory/method: Our research method plan is a multiple case study (mixed methods design) of contemporary co-location service models. The case study approach incorporates close interaction with practitioners and deals with real management situations. Our data collection method was twofold; individual questionnaires designed for our research questions, and focus groups.

Highlights (innovation/impact/outcomes): This is timely research with the increasing emphasis on patient centred care and recognition that more than one discipline can contribute to patient wellbeing. Health professionals varied in their expectations of integration. There was variability across the models on different components of health professional experience. Integration was described as lacking direct leadership and overt expectations of health professionals. Some infrastructure supported integration at an operational level but integration regarding patient care was relatively informal. Co-location may be the only form of health professional interface.

Sustainability: Co-located services can be sustained without health professional integration because patients can continue to receive services but health professional retention and patient services can arguably be impacted by dealing with patients with multiple and chronic conditions on a longer term basis.

Transferability: Outcomes of this research can be transferred and adapted across co-located health services to improve levels of integration.

Conclusions: Integration as it impacts health professionals has been under-researched in co-located health services. The case study environments were not obstructive but were not making optimal use of co-located services.

Discussions: Co-location is a start towards integration but health professionals see greater potential in higher levels of integration.

Lessons learned: Health professionals favour integration and there are key factors that feature in their expectations of integrated health service delivery.

Keywords

primary health services; integration; case study; co-location; multi-disciplinary

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PowerPoint presentation

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