





Integrated Care in the ACT Region: *Conversations with Service Providers*

August 2023

Health Care Consumers' Association

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A catalogue record for this
book is available from the
National Library of Australia

Suggested citation:

Shivana Chandra and Sarah Spiller. August 2023. Integrated Care in the ACT
Region: conversations with service providers. Health Care Consumers Association.
Canberra.



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About HCCA

The **Health Care Consumers' Association (HCCA)** is a health promotion agency and the peak consumer advocacy organisation in the Canberra region. HCCA provides a voice for consumers on local health issues and provides opportunities for health care consumers to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- consumer representation and consumer and community consultations
- training in health rights and navigating the health system
- community forums and information sessions about health services; and
- research into consumer experience of human services.

HCCA is committed to **consumer-centred care** as a foundation principle in all its work and to promoting consumer-centred care across the health system, within government and across the ACT community. Consumer-centred care meets the physical, emotional, and psychological needs of consumers, and is responsive to someone's unique circumstances and goals.¹

This research is part of HCCA's Integrated Care Project, which is supported by the ACT Health Directorate.

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Acknowledgments

The Health Care Consumers' Association (HCCA) thanks all of the health professionals, community service providers, as well as the consumer advocates and researchers who shared their insights on and experiences in conversations for this project.

Our work is collaborative and benefits from the contribution of our staff and members. This research project and report has been enriched by the many conversations and support in provided in data collection, analysis and reviews of drafts.

HCCA also thanks the members of the HCCA Health Policy and Research Advisory Committee who provided valuable guidance and advice on this work. They are: Linda Trompf, Marion Reilly, Wendy Armstrong, Fiona Tito Wheatland, Indra Gajanayake, Emma Baldock and Shelley McInnis.

This work is part of a wider integrated care research project that is funded by the ACT Health Directorate.

Executive Summary

About this report

This report shares research findings on what integrated care means to providers who support people with chronic and complex conditions that are living in the ACT region.

HCCA acknowledges and includes the important role of unpaid carers, family members and supporters, and paid carers in supporting consumers to access the care they need¹.

This report explores:

- What integrated care means to health service providers, community service providers, consumer advocates, and researchers with specialist knowledge on integrated care.
- Factors that support or hinder the integration of health care, as well as how the service providers themselves support integration.
- Difficulties faced by their clients in accessing integrated care that meets their individual needs.

When asked what the ideal integrated care system would look like for them, participants consistently painted a picture of a system that:

1. Puts consumers at the forefront of their care. This means that services and service providers listen to the needs of the people and the communities they support. This also means that the expertise of consumers (and their carers and families) is acknowledged and listened to, and care is delivered in a partnership model.

“To me integrated care is a partnership model. Yes, I have (expertise) but families have expertise about their own needs with chronic disease. If every person with a chronic disease would just be allowed to manage themselves, some can’t, that’s fine, but given a lot more authority to judge for themselves.” (Participant U – health professional)

2. Takes a holistic approach to care and addresses the social determinants of health rather than focussing only on medical concerns. This includes using a trauma informed approach.

“Integrated care is care that recognises that a person is more than one disease, has multiple systems and recognises that all of those things interact. They have a whole wide care team and bringing the knowledge and the plan and the problems and issues of that care team, plus whatever social things they’re undergoing all together” (Participant T – health professional)

3. Supports continuity of care and provides smooth transitions between health care practitioners across public, private and community health services.

“It would look like one where people don't necessarily realise that they've moved from one provider to another because it would look like one where some needs have been anticipated because they're not unique, and people have proactively helped make things happen, whether that's about transport, whether that's about linking people up to things that are known, whether that's about actually better systems of transfer where we're not dumping people out of hospitals at 4:30 on a Friday. (Participant O - Consumer advocate)

4. Encourages communication between clinicians, consumers and their advocates. This would mean that consumers can relieve the burden of carrying their health information and having to repeat it multiple times, and professionals are able to accurately communicate with each other.

“To me, integration is about drawing together the communication in particular. It's very much that relational thing where you no longer have to be the consumer carrying information from place to place, reporting your history over and over again..., that it's very much all of the services that we already get, but them actually talking to each other instead of via the consumer.” (Participant A – research academic)

5. Gives consumers the information and the skills to be able to choose how and when they access health care. This includes the care they want, the provider they want to see, and how they want their information to be handled. This includes giving people access to information in a way that they understand and at the time they need it most.

“It's not necessarily about curing, it's about being able to live your life in a community if you want, with a family of your choice, with dignity, respect and having your human rights (met)” (Participant L – community service provider)

6. Provides effective resourcing and funding models that supports care effective, efficient and high-quality care. This means that there is consistency in the hours of service, as well as what service is offered and how it is provided.

This report draws on the five key elements identified from participant discussions that impact the delivery of integrated care for people with chronic and complex health conditions within the current system. Specifically, they identify that integrated care is reliant on:

Partnerships and collaboration

Integrated care is reliant on multidisciplinary care teams working together that includes and is not limited to a general practitioner, medical specialists, allied health, mental health specialists and health workers that support social determinants of health such as social workers, housing support providers, other community health and wellbeing providers and family and friend carers.

Communication

Participants were clear that integrated care is not possible without effective communication amongst members of care teams **and** between the care teams and the consumers and their families and carers. Current systems of communication such as processes of sharing information or referral pathways can often hinder the progress of integrated care.

Navigation, Access and Choice

Service providers often spoke of the difficulties they face in identifying what services and supports are available to support their clients' needs. They also spoke about the importance of allowing consumers to be able to choose the care they want for themselves, which includes improving the access consumers have to health care and support services.

Trust and Safety

Participants spoke of the trust that service providers needed to feel with each other to make multidisciplinary work happen. They also spoke of the importance of ensuring consumers feel safe engaging with health care services and that they are able to trust the health system. This was often raised through the concept of trauma informed care. Trauma informed care is essential when working with consumers to help consumers feel safe, understood and importantly be able to understand the challenges or hesitations consumers may have in trying to access healthcare.

Availability and the capacity of resources

Providing integrated care for people with chronic and complex conditions requires an investment of time from providers which is often limited due to workforce shortages, restrictions on the services that can be provided and/or limited funding to meet service demands.

The collaborative work done over the COVID-19 pandemic between the government and non-government, health and social services were excellent examples of integrated care and the learnings and experiences from this should be leveraged when setting up integrated care systems in the ACT region. The findings show the importance of cross sector collaboration to support the holistic needs of consumers to be able to manage their chronic and complex health needs.

During their interviews, participants were asked about the impacts that the COVID-19 pandemic had on their service provision. For many of the participants, the pandemic provided a unique opportunity to work in multidisciplinary teams that spanned across the public, private and community sectors. The urgency of the pandemic also provided these multidisciplinary teams the ability to rapidly and proactively adapt their services to meet the needs of the consumers they were supporting. As the state has moved out of the pandemic, participants were hopeful that the progress made on integrating care and collaborative work would continue.

Context

This work is the first element from a wider HCCA project, *Integrated Care: Consumer Perspectives in the ACT Region*. This project has been funded by the ACT Health Directorate.

The aims of this project are to

1. Gain an insight into what “integrated care” means to health care and community service providers who serve consumers with complex and chronic conditions in the Canberra region.
2. Identify opportunities to strengthen the provision of integrated care in the Canberra region for people with complex health circumstances and chronic conditions, including those who experience barriers to health service access.
3. Identify innovative ACT models of integrated healthcare and community service delivery, including those which were established in response to the COVID-19 pandemic to provide care and support for people with chronic and complex health needs.

The findings of this report will be relevant to anyone that delivers health or community services to people with chronic or complex conditions and individuals and organisations wanting to design and implement integrated services.

The second element of this project will be focused on eliciting the perspectives of consumers with chronic and complex conditions on what integration of care means to them, and how health and community services can support them to manage their health and wellbeing more effectively.

We will use what we learn from both parts of the project to advocate for consumer-focused integrated care.

Introduction

The goal of more integrated health care has been sought for several decades in the ACT as can be seen through the many health related policies and frameworks. Across Australia and internationally, better integration of health services serves to improve consumer experience of care, provide high quality care for the increasing number of people with long-term health conditions, and overcome fragmentation between services and parts of the health and social services system. The increasing proportion of people in our community with long-term health conditions has increased the urgency to develop ways of achieving integrated care for people with chronic and complex health needs.

What is integrated care?

Despite the interest in integrated care, there is currently no agreed definition of what integrated care is, and no consistent approach to its implementation. This is partly due to the different perspectives and purposes of the stakeholders involved in designing, funding, regulating, and providing services within health care systems².

Because the overarching aim of the project is to elicit consumer experiences of integrated care, HCCA uses the consumer-led definition of integrated care established by the National Voices UK³ and recognised by the World Health Organisation⁴:

“My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes.”

Care can be integrated within the health care system and between health and community or social service systems⁵. The latter aspect is essential to enabling better health and wellbeing for people with complex and chronic condition health conditions.

This report:

1. identifies what integrated care means to services and providers that support people with chronic and complex conditions in the ACT region.
2. highlights the experiences of not only health care professionals, but also community services who support individuals in managing their chronic and complex conditions and consumer advocates.
3. documents what integrated care looks like on a practical level, and
4. identifies the enablers and barriers to achieving the integration of care.

What are chronic and complex conditions?

To achieve an integrated system of care that meets the needs of people with chronic and complex conditions, it is important to understand what chronic and complex conditions are. We define chronic conditions as long-term and persistent, often leading to a gradual deterioration of health and loss of independence⁶.

Chronic conditions:

- have complex and multiple causes
- usually have a gradual onset, although they can have sudden onset and acute stages
- occur across the lifecycle, although they become more prevalent in older age
- can compromise quality of life and create limitations and disability
- are long-term and persistent, and often lead to gradual deterioration of health and loss of independence
- individuals may have one or more chronic conditions
- are the most common and leading cause of premature mortality in Australia⁷.

In the 2021 census, 49.6% of all adults living in the ACT reported having at least one chronic condition, such as arthritis, asthma, cancer, dementia, lung conditions, heart disease, diabetes, kidney disease, mental health conditions, or stroke⁸. These may be combined with disability, with 5% of the ACT population recorded as needing some assistance with a core activity⁹.

People with complex health needs may also experience other social needs, including needs related to problematic drug or alcohol use, social isolation, inadequate or insecure housing, family or domestic violence and cultural, circumstantial or intergenerational disadvantage¹⁰.

Existing health and social service systems are frequently unable to meet the complex needs of people in these circumstances. Standard models of health care can further isolate and discourage people with complex health needs who are already socially isolated and may experience significant barriers to accessing health and social services¹¹.

In this project complex needs (or complexity) are defined as a combination of health needs that can include diagnosis, treatment and rehabilitation. An individual's circumstances may also include social support needs for example for access to affordable, secure and safe housing, or assistance to live independently¹².

Method

This was a qualitative scoping study using semi-structured interviews to elicit the perspectives of service providers in the ACT region.

Participant recruitment

Participants in this project were recruited using convenience sampling¹³. HCCA staff leveraged working relationships to identify and contact potential participants. We invited health professionals and services, community services, and a small number of respected and well-connected consumer advocates with extensive experience in policy design related to chronic conditions to participate in the research to ensure a diverse voice was heard within this project.

Data collection and analysis

Data for this project was collected via 25 semi-structured interviews with service providers between May-August 2022. The interviews were conducted either online or face-to-face and were audio recorded with the consent of all participants.

The interviews:

- asked participants to define what integrated care meant to them and what it would look like for their organisations or practice
- included questions on the types of services offered and factors that support or challenge the provider's ability to provide integrated care
- explored provider experiences of providing care and/or services to people with complex or chronic conditions over the COVID-19 pandemic.

The interviews were transcribed using an external transcription service. NVivo software was used to analyse the transcripts and identify key themes. Thematic analysis was conducted using pre-determined themes based on the aims of the project. These were factors that promote or hinder integrated care, what integrated care means and looks like and, the impacts of COVID-19 on care provision.

Limitations

This is a qualitative scoping study of service provider experiences around integrated care. The findings were drawn from 25 interviews. While a variety of providers participated, in consideration of the number of services that are available in the ACT and the number of service providers, these findings should not be read as representative of the views of all providers within the ACT region. However, there was strong consistency in the issues and concerns among participants and data saturation was achieved. For the context of this project data saturation is defined as the point at which themes and comments in interviews were consistently replicated¹⁴.

Findings

After identifying what the ideal integrated health care system looks like, we asked participants what makes integrated care happen.

Participants identified five key elements that allow for care to be integrated:

1. Partnerships and collaboration
2. Communication
3. Navigation, access and choice
4. Trust and safety
5. Access and capacity of resources

The sections below discuss these elements in greater detail and highlight the ways in which integrated care is affected.

1. Partnerships and Collaboration

People with chronic and complex conditions are often in contact with multiple providers and services in both the public and private sectors. Participants discussed that an effective integrated care system for people with chronic and complex conditions includes the development of multidisciplinary care teams to help manage and support a person's health and wellbeing needs.

Participants identified that care teams often include the treating physicians, general practitioners (GPs), medical specialists, allied health staff, staff from community organisations who may be supporting a person with their non-medical needs, and most importantly the consumer and their carer/s. Participants spoke of these care teams as 'wrap-around supports' that support people to identify their care needs and supporting them to connect with the services they need, whether it be health care, mental health support, social services, community-based services, or for-purpose organisations.

A multidisciplinary care team however is reliant on building partnerships with the care team and effective collaboration.

For the participants, these partnerships and collaborative relationships were not only between the care providers but also between the care providers and the consumers and their families and carer/s.

Participants acknowledged that the consumer is the person who is responsible for the daily management of their health and wellbeing and is them who knows their specific situation and needs the best. Therefore, it is critical that the care team also respect the knowledge and insight a person brings to their own health and healthcare needs.

"But being willing to work with consumers, no matter how difficult you think they are, is really the key to all of this stuff. It's the fancy language called relational continuity: developing a good relationship with people and acknowledging the challenges and finding ways to work with people." (Participant A – research academic)

All participants spoke of the need for collaboration and what it takes to make it happen. Participants emphasised the need to work with other providers who have a shared sense of purpose and goals.

Both community service providers and health professionals spoke of the importance of building trusting relationships with their colleagues. Every provider we spoke to said that collaboration relies on experience and interpersonal skills to promote their services or learn about relevant referral pathways.

“...most organisations tend to work collaboratively together as long as you have built those relationships. And that is the biggest investment there is putting your trust in another organisation”
(Participant J – community service provider)

These discussions highlighted the heavy reliance on informal relationships to make integrated care happen. One community provider spoke of their reliance on personal relationships to push for and secure housing for their clients. One health professional spoke of relying on personal relationships to help patients get access to specialists and referrals where they don't ordinarily have access.

Some community providers also spoke of the divide between the health care and social and community sectors. For these participants, the divides were focussed on the lack of understanding about what community services or support workers do, which made clinical services and professionals more hesitant to collaborate or share information to support a client.

“I guess more generally there is a feeling that I don't think clinicians understand what support workers are and what they do and how they could actually be useful to them. And so you kind of end up getting left out of everything.” (Participant K – community service provider)

In recognising these barriers to collaboration, community providers also described some of the measures they took to help reduce and manage the concerns of medical practitioners. Some of these measures included assuring the physician that they were there to help the client and not to criticise the clinician and advising clients to inform their doctors when making an appointment that they would be joined by a support worker and to book a longer appointment time.

While both health providers and community service providers discussed the importance of multidisciplinary teams to support integrated care, these same providers often rely on personal relationships to make collaborative work happen.

Participants differed on their perspectives around formalising the processes around collaborative work. While some felt that formalising the relationships would detract from the openness and flexibility of the collaborative process, others felt that a reliance on personal relationships is not sustainable or replicable across the system for everyone. As one participant suggested:

“That's where I think that if people are more open to ... relinquishing a little bit of control and coming to the table understanding that

everyone has something to give in that space and has specialties in that space, I think that's what makes integrated care... You have to have open and honest conversations and have ways of working that allows people to move forward..." (participant S – health professional)

To achieve effective collaboration and interdisciplinary work, time needs to be taken to understand the knowledge and skills of each specialty and organisation and build trust in each other's capacity to achieve a shared goal of integrated care.

2. Communication to support transitions of care

While providers spoke of the need to have multidisciplinary teams working together to support consumers to manage their health and wellbeing, they also spoke of the need to improve transitions for consumers moving between health care consultations, settings and providers. **Participants spoke about transition of care as an area where greater integration was most needed to avoid poor health outcomes for consumers.**

Transitions of care can happen across different types of care (e.g. GP to allied health), across different sites and levels (e.g. discharge from the hospital back to the GP), between care providers at the same setting (e.g. care handover from one physician to another at the hospital)¹⁵.

"It's those transition points from different types of acute care so, paediatric to adult. Its transition from hospital back to general practice and community. And I think that's where the challenge of integrating care and connecting care really become obvious. And there's any number of factors at play there. It's about communication between providers; it's about systems failing; it's about a paucity of information to direct consumers about what they can effectively do to self-care and self-manage." (Participant Q – consumer advocate)

Transition of care within the health system is a systemwide issue that has significant impacts on the consumer and the wider health system¹⁶. Transition is critically impacted by communication breakdown between the public and the private health system, which leads to:

- delays in the receiving appropriate treatment or supports
- duplication of diagnostic testing
- unnecessary hospital re-admissions
- increased costs to the consumer and the health system from inefficiencies

Providers acknowledged that this period is challenging for them as they were often unaware of the transitional supports and services consumers need based on their wider life circumstances. They identified that this often occurred from either the reluctance of consumers to share this information or from providers not asking those questions.

Participants described the transition period as a critical time where appropriate and adequate support could often make the difference between the recovery or the decline of a person's health. **Participants highlighted that communication is a key element of care that enables providers to share adequate and relevant information with other providers and the consumer and their carer to support the care of an individual during these transition periods.**

Participants were very clear that being able to share information about a person's care and treatment between the care team was an integral part of communication systems that enabled integrated care. Whilst participants acknowledged the need for effective communication and appropriate sharing of information across care providers, they also discussed the many challenges to sharing information.

"There's a big kind of dearth in terms of who can access what information and so it kind of filters through in a way that's quite unhelpful to being an integrated approach." (Participant D – community service provider)

The key challenge they identified by community providers was the difficulty in getting information from clinical staff due to concerns around privacy and confidentiality. One participant also spoke of the reluctance of mental health professionals to share information with other clinicians. While protection of privacy is important, it presents barriers to integrated care. This is an issue that needs to be explored further to enable workable solutions to be identified.

Participants also discussed issues around the quantity and the quality of information being shared. Both health professionals and community service providers spoke of issues with the amount of information being shared following patient visits or included in referrals. For example, on discharge from the hospital, there may not be enough information for a GP to support appropriate care, or the lack of effective mechanisms that allow notifications and communication between the hospital and the GP to support timely follow up and continuity of care. Timeliness and the quality of communication is critical to being able to adequately support a person.

"I think the main thing is really the quality and timeliness of communication. The perspective from a lot of GPs is they might refer someone into a specialist service. They provide a bunch of information on that referral. What they get back is very little, or the referral will get rejected, and there's no information there. There's no way for them to follow that up or ring someone and say, "Can we actually have a conversation about this?" (Participant W – health professional)

These issues not only delay care for the consumer, but it also places the responsibility on the consumer to provide the information or to advocate for themselves.

Information supports continuity of care. As discussed earlier, information supports timely and quality care as patients transition through treatment settings or treatment teams. For example, for GPs it is important to understand why a referral may have

been rejected so they can refer their patient on to a more appropriate specialist. Alternatively, following a hospital visit, a detailed discharge summary can help the GP support the long-term care of the patient by providing an understanding of what has led to an admission and preventing re-admissions.

Variation in referral systems were also identified as a challenge for health and community services providers. Whilst some participants reported they had formal ways of receiving referrals, others had more informal systems or a combination of both. This variation meant some referrals may be missing information or are made to an inappropriate service or provider.

Sharing information with the care team removed the need to go back and forth between providers to get the correct information and consumers were able to receive the appropriate care in a timelier manner. This also reduced the burden on the consumer of carrying information and repeating their story with each provider.

Participants discussed that the burden placed on consumers to carry their health story creates a variety of challenges. Having to repeat their story across multiple providers may lead consumers to hesitate to seek additional support. Re-telling may cause additional trauma. Relying on consumers to relay complex medical information may mean the information they relate is not be accurate or complete, which may lead to additional unintended harm. For example, one health professional spoke about elderly patients incorrectly remembering and relaying their medication dosage, which can have unintended negative consequences.

“If we need letters of support and what not for NDIS applications, we can't get (specialists) to send them to us, they've often got to go to the persons' GP. Then (the clients) have to go to the GP and go and get it. So, the person is going to multiple appointments and then having to bring it back to us anyway, because we are the ones helping them and finalising the paperwork” (Participant N – community service provider)

Participants spoke of mechanisms to support good communication, such as case conferencing to bring together multidisciplinary teams to collaborate and plan. Barriers to effective communication included members of the care team working different hours, different patient loads, lack of time, or no crossover in shift times. Some participants spoke of the difficulty of sharing an adequate amount of information because of the time it takes, which took away time from seeing their other clients.

Participants acknowledged that addressing the issues around sharing information are complex, and that measures can and should be taken to prevent information from being shared inappropriately. Some of the measures discussed included:

- limiting what is shared and who it is shared with in consultation with the consumer
- ensuring that the appropriate consent is obtained for the relevant and appropriate information

- adapting existing systems to allow greater transfer of information without adding to the workload of providers.

Open and effective communication for participants also means a willingness to come together to discuss their practice, seek and share advice, and discuss how existing practices are working and how they can be improved.

Achieving effective integration of care relies on improving communication that supports the continuity of care for consumers across different care settings and practitioners and life stages.

3. Navigation, Access and Choice

The goal of integrating health care is to support a health system that is person-centred. To effectively engage with the health system, consumers must first know what is available to them, then have the skills and knowledge to make an informed choice about their care and finally know how to access it.

Navigation

Participants told us that navigating programmes and specialist services is challenging for providers as well as consumers. Participants identified that the specialisation within services creates silos in practice and knowledge. This makes it more difficult to know what each service is providing and who is eligible, making it time consuming to work through the referral process.

Participants identified the importance of having a good GP as part of the team. For many consumers with chronic and complex health conditions, the General Practitioner (GP) plays a central role in providing the links to services and continuity of care across different specialists, providers and life stages.

“The GP is somebody that actually knows the patient, and I've had good GPs over the years and I know what a good GP can do to help coordinate care...” (Participant P – consumer advocate)

However, participants also acknowledged that having the GP as the main coordinator of care is not feasible. GPs will not always know all the services and supports that are available to a person. They also acknowledged the burden placed on the GP to coordinate and integrate complex care while managing ever-increasing workloads and the inadequacy of funding to support these roles.

“I think integration means somebody at a local level absolutely needs to be responsible, and we can't add it onto clinicians' roles, and in fact, it's a terrible waste of money because why pay a clinician to do that when that money is far better spent with them just looking after clinical care?” (Participant O – consumer advocate)

Health professionals and consumer advocates discussed the challenges of providing the level of integration and the continuity of care that is needed by consumers living with chronic and complex health conditions:

- They acknowledged that health professionals don't always know what a person needs or what supports are available to them in the community.
- Supporting consumers and providing care as they move across different health and social services.

"they're [GPs] those clinicians that really see the whole patient and not just the heart condition or the appendix that's infected and they talk a lot about services to support the family and the GP clinic holding all the puzzle pieces together. But the GPs also talk about the difficulties, how to get those services onboard, the phone calls, the emails, getting the clinicians in the hospital to give them access to a discharge summary that makes sense" (Participant U – health professional)

Participants shared potential ways to address some of these challenges. This included employing specialist navigators who know the variety of services available and can bridge the knowledge gap for both consumers and service providers.

"I think part of creating a health-literate health service and the responsibility of services is providing people with the information they need in a way that people understand at the time that they need it that's not just about you managing your care and your self-management, that's also about, "this is the range of services that's around that can help you now." There needs to be someone who has that responsibility. I don't think it's fair to expect that to be a newly diagnosed consumer who's never ... needed to know that. There are some people who, once they're given that information, can take control of that and can self-manage. But there's other people, who for a range of reasons will never be able to do that. Plus we're expecting people to do that when they're at their sickest." (Participant O – consumer advocate)

For some participants this is in the form of peer navigators who can support consumers and link them to services. Peer navigators have the lived experience of facing similar barriers to accessing services. This lived experience can be invaluable in supporting a person to identify and access the supports they need.

"I think that having a peer navigator to help you, particularly if you're marginalised and disempowered for whatever reasons, significant minority, stress etcetera, having somebody to hold your hand, care coordinator, whatever you want to call it, is the mechanism that makes that integrated care achievable." (Participant F – community service provider)

Health professionals spoke of the work being done by the GP Liaison Units in ACT public hospitals to facilitate communication and navigation between hospitals and GPs.

For some participants, the enhancement of existing resources, such as HealthPathways, would allow for greater awareness of the range to other services

that are available and how to access them.

“I think there’s infrastructure and systems and people that could be put in place in enhanced primary health care hubs, general practices on steroids if you like. That would be a combination of systems. So, for example, health pathways. Health pathways... could have non-health, non-medical referral options in there to various community-based services and support. There could be a consumer facing portal from the health pathways platform where consumers could go there and look around themselves at what options are available.”

(Participant Q – consumer advocate)

While many participants discussed how the use of navigators within the health system could help bridge some of the knowledge gaps, others also viewed the additional process as an extra step within their workflow.

“You still have to connect everyone into the connector and that takes so much time.” (Participant T – health professional)

Participants generally viewed navigators as an important innovation that supports integrated care while recognising the possibility that such a service or role could further complicate care pathways. They emphasised the need for good communication about the benefits of navigation services to all providers.

Access and choice

Participants identified that integration of care was affected by:

1. The number of appropriate services and practitioners available in the area where they live.
2. How accessible the available services are i.e wait times.

Health professionals, community service providers and consumers all identified that some consumers were unable to access care that is appropriate and sensitive to their needs, or in some instances the type of care they need is not available at all.

“Regional areas are often smaller in population and, as such, smaller in services or different ranges of accessibility or pathways into services. That can stem from just not having the service available in smaller towns, or smaller regional areas, not having something that’s appropriate, culturally, for people or not having a variation of services. Where somebody may not want to access one service for a certain reason it’s really difficult to have two or three other options whereas Canberra really does have that.” (Participant M – community service provider)

“A third of patients in the Canberra Hospital actually come from rural non-ACT settings, and I don’t think there’s as much understanding of the doctors in the Canberra Hospital of the context into which they’re discharging their patients, and that they might assume that there’s just a GP, surgeon just down the end of the street. Well, they might

be in a town 100 kilometres away and the amount of service you can get from that is considerably less. And that then leads to unnecessary readmissions to the acute care sector, a whole range of things, which could be avoided if there was better liaison between the acute care clinicians or acute care system and the primary care providers, who can do a lot more if you empower them.” (Participant O – consumer representative)

One health professional also spoke of the lengthy waitlists for health services in the public system, and that referring patients into private services was often a faster way for their patients to get treatment and care, even if it added a financial burden for their patients.

Participants identified that the more difficult and time-consuming managing health care becomes for consumers, the harder it becomes to engage them in managing their health and wellbeing.

“This is the thing: particularly for people who are experiencing really complex problems, we really have to make healthcare as easy as possible, and it doesn't matter how many times you nag people about the importance of their health, etcetera. If you're telling them that in order to look after their physical health, they have to have three monthly fasting blood tests where they have to go somewhere unfamiliar that is in addition to their regular appointments, they're not going to do it.” (Participant A – research academic)

Participants identified that for many consumers, good integrated care would mean that consumers would be able to access multiple services at one site or close to each other. For others, accessibility is more about services feeling like a safe space.

Integrating care is about supporting care providers AND consumers and their families and carers to navigate everything that is available to them. It is also about supporting consumers to have access to and the opportunity to choose the care they need when and how they need it. This means increasing the number of services available to consumers and to have the ability to choose the most appropriate service for them and how they want to access it.

4. Trust and Safety

An interesting finding from this project was the importance of trauma informed care as an essential component of integrated care. Participants discussed the need for health services to understand and better support consumers using a trauma-informed approach.

The current healthcare system often doesn't recognise and address the trauma that impacts a person's health and wellbeing.

“There's all these behavioural things that I don't even know what to call them in a gentle, kind way, because the health system doesn't know how to do that at the moment. So, the behaviours of whether it's mental health, whether it's really escalating and getting either

aggressive, or loud, or distressed I suppose in health care spaces. Drug and alcohol, dependency issues or drug seeking behaviours. And then it all comes under the same umbrella I think that the health system isn't equipped to deal with people with these complex needs, and they're basically shunned, or they're just kicked out of the health system because they don't turn up to appointments, or they don't behave in the right way or whatever. And then their health really declines." (Participant V- health professional)

Participants highlighted the importance of staff understanding trauma and how to provide trauma informed care when engaging with people with chronic and complex conditions to allow stigmatised and disengaged consumers to feel safe within the care environment and seek support where they otherwise wouldn't.

Many of the participants in this project identified that providing support and care in a trauma informed way, allowed consumers to build trust and relationships with healthcare and support providers and encourages long term engagement in the health system.

5. Availability and capacity of resources

Participants spoke of the availability and capacity of resources as part of wider systemic issues that affect the success of integrated care. They discussed the impacts of workforce, funding and technology to providing integrated care.

Workforce

The number of services available to consumers is significantly affected by workforce availability. Both healthcare professionals and community service providers spoke of workforce shortages affecting the service availability. Many participants spoke of the lack of appropriately skilled staff in the ACT region as a significant barrier to providing integrated care. These workforce issues make it difficult to provide the care and support consumers need and add to the demand on services. In particular, providers spoke of the shortage of GPs, mental health professionals and social workers in the region to effectively meet the demand.

A Needs Assessment undertaken by the Capital Health Network (CHN) in 2021¹⁷ and the 2022 *Health of the Nation: General Practitioners Report*¹⁸ highlighted the significant impact of workforce shortages on care provision. Some of the issues identified included:

- increased wait times for health services
- increased costs of accessing care as practitioners move to private practice for higher remuneration.

Additionally, the CHN needs assessment identified that workforce improvements should prioritise health provider skills in:

- providing care that is trauma informed and culturally appropriate

- providing appropriate referrals and supporting these pathways
- delivering care using digital tools.

Funding

Participants talked about two funding issues that affects their ability to provide integrated care:

- funding to provide services that support consumers with chronic and complex conditions
- funding to support collaboration with other professionals to provide integrated care.

Funding through Commonwealth, State and Territory bodies has created complexities in how providers are funded for the work they do. Participants highlighted that existing funding schemes do not support integrated care.

Participants discussed the importance of planning for and including funding that allowed for collaboration when designing integrated care programs. Integrating care takes time, and for many services and providers this is time that is taken away from other clients. They also highlighted that most integrated practices, such as case conferencing more pressure to a workforce already under significant pressure to meet the level of demand.

“We hear this a lot from GPs, if we want to get them to do more case conferencing and having team-based sessions where they're reviewing a patient. One, they don't actually get paid for that, but two, that means that's time out of actually seeing patients. When you've got a huge waitlist, how do you balance that?” (Participant W – health professional)

Participants from the community sector identified that many of the programs they offer are under-funded or un-funded whilst the demand for their programs continues to grow. For example, one community service provider spoke of the challenges of trying to reduce the cost of therapies for clients who aren't eligible for bulk billed therapies through Enhanced Primary Care Plans (EPCs).

Participants within the community sector noted a hesitancy amongst other services to be completely open to sharing the work they are doing as the commissioning process turns collaborators into competitors for funding.

“...we are funded through ACT Health's x subsector, and they're going through a commissioning phase where they're going to redesign all of the services that are in ACT, and then they're going to go through a procurement phase, which means that we could potentially be competing for funding from people who have previously been our partners. And so that is a new development, but we can already sense that people are starting to hold back a little bit which is completely understandable. But that has been a bit of a challenge right now, where we go, where do we stop partnering, or

do we stop partnering, what do we do? But everyone's a bit more closed off." (Participant J – community service provider)

For community services, funding dictates the services an organisation can provide and how many people they can support. For health professionals, funding dictates the capacity they have to incorporate systems to support the integration of health care, such as the time and infrastructure to participate in multidisciplinary case conferences.

Embracing technology

Participants were clear that technology is critical for effective integrated care. Telehealth or virtual health were identified as the most common technological approach. During the COVID-19 pandemic, providers saw that telehealth contributed to an increase in the services provided to customers with chronic and complex diseases. For consumers, this also meant greater opportunity to access the care they need and eliminating the barrier of travel.

Some participants emphasised the importance of finding a balance between virtual and face-to-face health care. They told us that face-to-face appointments are essential for building trust and rapport to enable them to provide the most effective care and support. They also identified that there needs to be flexibility to determine the best setting or format to provide the best care.

"And in terms of telehealth, really varies by clinician, but it's a large percentage that say that trauma informed work is not practical and is not ethically sustainable on an online platform. So generally speaking, the clinicians will come from a point of view which is trauma informed care requires a certain number of weekly engagements to start off with. If you're going to go down that path it needs to be face-to-face for the majority of that. And a very understandable concern about what happens when x, y, and z happens, and you're working with that person remotely." (Participant F – community service provider)

Participants also discussed using technology to facilitate information sharing between providers, and between providers and consumers. One example that participants spoke of frequently was the My Digital Health Record (MyDHR) initiative, which aims to improve communication and the flow of health information between ACT Health Services and consumers. While many welcomed the initiative, they also pointed out that the MyDHR would require external providers (such GPs and private clinics) to implement a new communication system in addition to their current ones, increasing the time and resources needed to manage information. For some health professionals, the MyDHR provides an opportunity to increase communication between hospitals and GPs, however, the systems hadn't yet been put into place and would take time and investment from all health practitioners to allow the system to work.

6. Provider perceptions of consumer barriers to accessing healthcare

During the interviews, participants were asked what they saw as the biggest barriers to accessing health care for consumers with chronic and complex conditions. The lack of appropriate housing, cost, transportation and navigating services were the most prominent barriers identified. One participant identified that trying to manage chronic and complex health conditions also increased the likelihood of a person facing barriers that stem from poor health.

“It is often a health issue that would lead a person to becoming homeless. And that might stem from the death of a spouse that was helping them manage their health. But it is often something like that, a chronic illness or early onset dementia that worsens after a spouse dies, that leads an older person to become homeless when they may not have been in their life previously.” (Participant I – community service provider)

Health needs and social complexity are closely intertwined in the lives of people living with chronic and complex conditions and have a cause-and-effect role.

Housing

Participants identified that the biggest issue faced by their clients with chronic and complex conditions related to a dire lack of adequate and appropriate housing in the ACT and region.

Having access to safe and appropriate housing allows consumers to then be able to access the other supports they require. Community service providers in particular discussed that no housing, or unsafe housing, creates high levels of stress and anxiety within consumers.

“I think the majority of clients that we see in that space, their housing is really subpar, so they’re constantly dealing with high levels of stress and anxiety and being really very hypervigilant around their safety, so to try and get them to an appointment at the hospital, which is important for the function of their long-term whatever, they won’t make it. And it doesn’t matter if we book a cab, it doesn’t matter if we try and get all these things in place” (Participant H – community service provider)

Access to safe and stable housing plays a crucial role in being able to access healthcare. When consumers are dealing with issues around securing a place to sleep for the night, or ensuring their belongings are safe or even ensuring their own safety in the places they live, they are less likely to engage in the health system to manage their health.

Safe and secure housing means consumers are then able to turn their attention and resources to managing their health.

Navigating the health system

Health professionals, consumer advocates and community providers identified the complexity of the health system and the challenges of navigating the system as the second biggest challenge faced by consumers.

Navigating the system includes knowing where to go, understanding how to get the support they need, understanding the language of the health system, and ultimately being able to access the care they need.

“it’s the difficulty people have navigating the Aged Care system. And the NDIS system. And any other supports that are available to them in the community. And the challenge there seems to be an assumption on behalf of some services or most services that people are really digitally literate. They can use gateways. They can use online portals. They can use their phone. That they have a phone or an iPad. And some of those things; they’re big assumptions.”

(Participant Q – consumer advocate)

Access to the health system is more than just knowing where to go and what care or support to ask for. For some consumers access to health care is limited by the location and distance they need to travel to access the different health services they need.

Financial barriers

Participants also discussed the cost of accessing healthcare as an additional barrier. For many consumers, the costs of accessing healthcare is further compounded by misunderstandings of how Medicare or the public health system works. For consumers who don’t have access to Medicare, the financial barriers are increased as they are forced to go through the more expensive private health care system.

“A lot of our asylum seekers don’t have Medicare, so they have a ‘ACT Access Card’. People without Medicare cannot even access a normal mainstream GP, because there’s no ability to bulk bill or go off and have a blood test. They have to have it done through ACT Health, thank goodness they do have the access card, because that gives them access to healthcare.” (Participant E – community service provider)

The cost of seeing a health practitioner is not the only financial barrier faced by consumers. Consumers also face the cost of travelling to and from appointments at multiple locations, sometimes in another town or city. Other financial barriers to health care include the cost of pathology tests or imaging, medication, accessing allied health or community health supports, or having the relevant technologies to access or to manage their health and wellbeing.

Trust, stigma and previous experiences

Some participants identified that if a consumer has had poor experiences with the health care system, they may be less willing to seek support for their health again. This barrier can stem from stigma, or fear of stigma, for issues such as homelessness and alcohol or other drug use.

“I think our health settings look at what’s wrong with this patient rather than what has happened to this patient. And that’s where I see the shift needs to be, so that they feel that they’re not judged in going there, and then they’ll feel safe to go back.” (Participant H – community service provider)

Participants identified that negative experiences with healthcare can also stem from a lack of understanding of trauma as well as clinicians’ lack of understanding of their patients. The attitude of health professional makes a difference to the experience of care for consumers. One participant talked about how it’s critical for doctors to collaborate with consumers to plan and manage treatment based on what they can and cannot accomplish, instead of prescribing a care plan that they can’t or won’t adhere to.

Barriers may also arise if there is a lack of health care appropriate for the cultural and gender diversity of consumers.

The discussion around the common barriers to accessing health care clearly highlights the impact that social determinants of health have on individuals, particularly the impact of adequate housing. When attempting to improve the integration of health care for people with chronic and complex health and life circumstances, the health system needs to account for the accessibility, availability and the integration of social services and supports.

7. Impacts of COVID-19 on care provision

Each participant was asked about their experience providing services during the COVID-19 pandemic. Participants consistently spoke about the value of collaborations during the pandemic, additional COVID funding, the demand on services, and innovations around the use of technology.

Collaborations

Service providers identified that one of the key changes to service provision during the pandemic was the success of cross sector collaborations. Providers attributed this success to the urgency of the situation, which led to an increased willingness to work together to find the best outcome for consumers.

A key example of the excellent work done during the pandemic was the collaborative work done by ACT Health and non-government services in the quarantine hubs at Condamine Court, Ainslie Village and Ragusa. The hubs involved the ACT Health Directorate, YWCA Canberra, Canberra Alliance for Harm Minimisation, ACT Shelter, CatholicCare, St Vincent DePaul Society, Northside Community Services and Health Care Consumers’ Association. The model of care provided at the quarantine hubs, with some trial and error, provides a strong example of what integrated care could look like.

A multidisciplinary team was put together to provide an effective quarantine model with the appropriate integrated supports. The team included: qualified social

workers, community nurses, peer support workers, and specialist community sector case managers from NGO's that individuals would likely be familiar with. The services provided by the team included:

- Providing food and material aids
- Entertainment options activities for children and adults
- Friendly check-ins
- Wellbeing and mental health support
- Coordinating with existing and additional support services
- Referrals to drug, alcohol, and other medical support
- Referrals and support for financial counselling
- Peer support for drug, alcohol, and other issue
- Disability support/referrals and assistance in applying for NDIS
- Referral to health supports
- Support for housing exit pathways.

This collaboration was made possible through open and regular communication amongst providers. There was a willingness to explore what was and was not working, how issues could be managed, and processes and practices improved.

Many participants noted that due to the urgency of the pandemic, there was a greater willingness to take risks to trial new systems, and a greater willingness and openness to learn and work through challenges.

Service demands

While providers talked of the successes, they also talked about the strain that the pandemic put on services and staff. Participants observed not only an increase in the demand for services, but also a change in the services consumers needed. This may have been physical health supports, mental health supports, support finding employment, or other financial supports as people were unable to work during the extended lockdowns.

Many participants, talked about the significant increase in working hours and staff burnout over this period.

COVID-19 Funding

Many participants discussed the changes to funding that happened during the pandemic.

During the pandemic, service providers were not required to return any funding they did not use for services that weren't able to be delivered. For many community service providers this provided funding to change their service delivery to an online format. For one organisation, the money they retained was used to fund staff to teach elderly clients how to use technology so they could access online services. For other providers, the funding was used to provide additional supports they would not normally have been able to provide.

However, providers noted that now COVID-19 funding has been withdrawn, services are increasingly having to cut back on the new services as they can no longer afford to run them. Many participants reported that their clients have really benefited from the changes and would like the new services to continue.

Innovations around technology

Participants discussed how COVID-19 pushed providers to innovate and use technology more effectively. Participants discussed an increase in telehealth appointments as well as investigating uses of technology that allow doctors to assess and examine patients remotely through nurse-operated technology or patient-operated technology.

Participants spoke of the unexpected benefits of the increased use of telehealth on their clients, such as allowing patients to involve family members in appointments when this previously may not have been done. Online appointments also reduced the need for consumers to travel to a physical appointment and reduced undue stress and expense from travel. Whilst telehealth allowed patients to access care remotely, not all care can be managed remotely. For example, people still needed physical appointments to manage wound care.

Participants also discussed the challenges of increased use of technological tools in health care. The increased use of technology requires higher levels of digital literacy, access to reliable internet service, and cost to enable access to technology for both consumers and practitioners. This potentially reduces equity and inclusion in access to appropriate and high quality health care for disadvantaged groups.

Learnings from the pandemic

Providers spoke about the innovations to service delivery during the pandemic they would like to see continuing to support integrated care. These included:

- a greater willingness across services to take risks and come together to resolve issues
- openness of communication across services
- increased use of technologies to support the service and care delivery
- reviews of existing funding models to support services and providers to provide integrated care and encourage collaboration.

These findings support those of a case study conducted by the ACT Government *Commissioning for Social ImpACT on the Ragusa COVID-19 Quarantine Support Hub*¹⁹.

The case study highlights the need for collaboration between government and non-government health and non-medical sectors to support the delivery a high-quality quarantine service. The case study also reflected the importance of the development of multidisciplinary intake and assessment forms and discharge summaries. These forms that allowed the case management team to identify the needs of each person in quarantine and provide them with the appropriate support. The case study also

identified the need for an integrated data sharing system to support effective communication.

Examples of Integrated Care

Integrated care in the ACT region

This report also hopes to showcase some excellent examples of integrated care being provided in the ACT region identified by the organisations and clinicians that participated in this project. This is not an exhaustive list of the integrated care work being done in the ACT region.

Junction Youth Health Service

Run by Anglicare, the Junction Youth Health Service provides primary health care and support services to young people aged 12 to 25. The health service works as a multidisciplinary team of GPs, nurses, nurse practitioners, youth workers, and psychotherapists to provide full primary health care services, mental health, drug and alcohol assessments, and reproductive and sexual health. Youth workers also support young people with their non-medical needs for example, support with Centrelink applications, housing, advocacy, support with job applications. They also provide outreach supports such as organising transport to and from health care appointments or accessing services like Centrelink or ACT Housing.

For more information: <https://www.anglicare.com.au/services/youth-family/health/>

GP Liaison Unit (GPLU) at Canberra Health Services

The GPLU has been designed to support partnership and communication between the hospital and general practitioners within the ACT region. The service provides a point of contact at the hospital for GPs, practice staff and other primary health providers for matters related to their patients, hospital services, referral processes and general advice.

For more information: <https://www.canberrahealthservices.act.gov.au/health-professionals/information-for-general-practitioners-gps>

Pre- and Post- surgery rehabilitation at Arthritis ACT

Arthritis ACT in collaboration with the rheumatology unit at the Canberra Hospital and orthopaedic surgeons within the ACT, provide pre- and post-surgery rehabilitation services for adults who have had joint replacements or who need long-term care and support for chronic pain. This includes services like hydrotherapy, physiotherapy, support group sessions and even art therapy to support the mental health needs for people suffering with chronic pain.

For more information: <https://www.arthritisact.org.au/>

YWCA Canberra Mura Lanyon Youth and Community Centre (MLYCC)

The MLYCC is run by the YWCA Canberra with funding from the ACT Government Community Services Directorate and provides support to young people and adults in the Tuggeranong region. The centre is home to:

- Teen clinic where young people can speak to nurses about a range of medical and non-medical issues in a non-judgemental and confidential environment for free.
- Youth engagement services.
- Warm connections counselling for families with young children and young people up to 15 years.
- Network coordination that supports people to get connected with services and supports in their area.
- Lanyon food hub and emergency relief.
- Care Financial Services.
- CatholicCare Next Step.

For more information: <https://ywca-canberra.org.au/community-services/mura-lanyon-community-centre/>

Directions Health Mobile Primary Care Outreach Clinic (PAT)

PAT is a collaboration between Directions Health, the Capital Health Network, John James Foundation and the ACT Health Directorate. The PAT van provides a mobile primary care clinic to allow people access to healthcare in locations that are easily accessible to them.

The PAT van provides a multidisciplinary health service that incorporates GPs, nurses, mental health practitioners and an alcohol and other drug practitioner to provide multidisciplinary medical and non-medical supports.

For more information: <https://directionshealth.com/chat-to-pat/>

Newborn and Parent Support Services (NAPSS)

Canberra Health Services' NAPSS support parents of high-risk newborns and infants who need neonatal intensive care or special care nursery support in the newborn period.

The nurses in this service work with the clinical care coordinator, neonatologist, paediatrician, speech pathologist, nutritionists, social workers and other members of the allied health team to provide ongoing nursing and medical care once a baby is discharged from hospital. The nurses work with the parents to identify their child's care needs and determine the frequency and location of the visits, whether it be in the home, hospital or a community clinic.

For more information: <https://www.canberrahealthservices.act.gov.au/services-and-clinics/services/newborn-and-parent-support-service>

Reach, Teach, Treat, Thrive (RTTT) at Hepatitis ACT

Hepatitis ACT have partnered with Interchange Health Co-Op to host a GP/GP registrar at their pop up clinic. The service provides a walk-in service for individuals to come in and see a GP to test for Hepatitis C (HCV) infections and provide further liver health support. The clinic supports people with

- HCV blood tests

- Treatment for HCV infections
- Referrals to specialist clinics if required
- Education, information and support for the treatment plan
- All other regular GP services e.g. blood tests, mental health plans, vaccinations & referrals to Interchange Health Service for ongoing treatment.

For more information: <https://hepatitisact.com.au/what-we-by-do/>

Meridian's HIV Positive Services

Meridian provides support and advocates for people living with and impacted by HIV in the ACT. They offer access to quality support services, including peer support, case management and counselling. Meridian also promotes social inclusion, organises safe and accessible events, and work to eliminate stigma and discrimination of HIV-positive people. They also engage in community advocacy, addressing policy issues and ensuring the needs of people living with HIV are met.

For more information: https://www.meridianact.org.au/support_and_advocacy

Head to Health Canberra

Head to Health is a locally run multidisciplinary mental health initiative that is available to people in the ACT. The centre provides free at point of care telephone or face-to-face support for individuals to understand the needs of the people accessing the service and aims to connect them with the most appropriate resources and services. The multidisciplinary team includes psychologists, mental health assistants, nurses, occupational therapists and social workers with input from psychiatrists. The program is partially funded by the national Head to Health program as well as Capital Health Network.

For more information: <https://canberraheadtohealth.com.au/>

National and International Examples of Integrated Care

We also reviewed activities in other jurisdictions that deliver integrated care. This is not an exhaustive list, it focusses on examples that participants in this project raised and those that have appeared in literature as exemplars.

The Shed – Western Sydney

Based in Mt Druitt, Western Sydney, The Shed is a suicide prevention centre that supports disadvantaged men²⁰. The program was established in 2004 as a partnership between Western Sydney University, Men's Health Information and Resource Centre (MHIRC) and the Holy Family Church at Mt Druitt. The Shed supports men who are at risk of serious stress and suicide that stems from cumulative stress from disadvantage and/or difficult life events. The staff help to connect the men and their families with the services they need, for example: housing, employment, financial issues and separation from children.

Complex Chronic Disease Team (CCDT) – Queensland

The Complex Chronic Disease Team (CCDT) – Queensland is a service that provides coordinated and integrated care for adults with chronic and complex health conditions. The CCDT offers a “Complex Needs Service” that focuses on health consumers with complex physical, psychological, and social factors impacting their wellbeing. The team of medical, nursing and allied health professionals conducts comprehensive assessments and develops individualised care plans to address the diverse needs of clients. The team also provides specialised services such as general physician and geriatrician consultations, cardiac rehabilitation for recent cardiac events, and pulmonary rehabilitation for clients with pulmonary diagnoses. Referrals can be made through the Community and Oral Health Central Referral Unit, ensuring access to these vital services at no cost to consumers.

For more information: <https://metronorth.health.qld.gov.au/community/healthcare-services/ccdt>

Partners in Recovery Program

The Partners in Recovery Program, was an initiative of the Australian government to provide a free service that helps people with severe and persistent mental illness and complex needs to better connect with services and support²¹. The program was available to people who had no existing service coordination arrangements in place with a goal to:

- Better support people with severe and persistent mental illness with complex needs, and their carers and families;
- Facilitate better coordination of clinical and non-clinical services to deliver ‘wrap around’ support to meet the full range of an individual’s needs;
- Improve referral pathways and strengthen partnerships with existing services;
- Further embed a community based recovery model of support and service delivery throughout the mental health and related sectors; and
- Adopt a ‘no wrong door’ approach to service access and referral.

While this program was defunded in 2019, evaluation of the program showed positive outcomes for the consumers in the trial as well as benefits for the health system²². This program has informed the new Commonwealth Psychosocial Program that began in 2021.

Finnish Asthma Care Program

Between 1994 and 2004, a National Asthma Programme was set up in Finland. The goal of the program was to reduce the burden caused by asthma on individuals and society by improving asthma care and prevent an increase in costs associated with diagnosis, treatment and management.

The programme had a multidisciplinary approach, involving general practitioners, nurses, specialists, pharmacists and asthma coordinators to improve the diagnosis, treatment and management of asthma. The program showed early success with a reduction in the number of asthma-related hospitalisations and reduced hospitalisations and asthma-related²³.

Where to from here?

This projects findings clearly demonstrate care integration is occurring in the ACT and its surrounding regions.

These findings show that organisations, whether they are community organisations, general practices, or hospitals, can be successful at integrating health care to support clients with complex needs and chronic conditions. However, it is frequently difficult to integrate treatment across providers and organisations because of systemic barriers.

The findings of this report are consistent with the Productivity Commission's Reform case study on care for chronic health conditions which also highlighted the need to²⁴:

- build collaborative relationships
- improve communication
- support consumers to manage their health conditions
- support the health care workforce to provide better care and outcomes for the consumer and to
- explore innovative ways to manage funding in the health system.

This report identifies that collaboration and communication between health practitioners, community services, private practice and the consumer and carer is a key component of providing integrated care but is often the most challenging to address. The importance of collaborating and communicating with consumers and their families/carers is also a key component of the National Safety and Quality Health Service Standards²⁵, which states that 'patients are partners in their own care to the extent that they choose (p. 14)'.

An interesting finding from this report has been the reliance on personal relationships to support collaboration and integration of health care. The participants in this report have acknowledged that a reliance on personal relationships is unsustainable, however being able to trust partners in care is important.

Participants spoke of the systemic issues that created barriers to integrated care, include workforce shortages and skills and the lack of adequate funding. Adequate and appropriate funding plays a critical role in making integrated care happen. This finding was also highlighted in an evaluation of the Health Care Homes program²⁶, which found that to enable successful integrated care initiatives, we need to consider:

- collaborative work takes time. This includes time taken to build rapport and trust and learning how to talk to professionals, the community and the consumer and carer.
- adequate time and funding must be allocated to supporting the set-up process for initiatives to work. This includes funding for the equipment or software and for training staff in delivering care, learning to work with collaborators and consumers.

- making change takes time. Initiatives need to make a case for change, have strategies that can be used and adapted as challenges arise and ensure there are champions for change in every team.

Participants identified that the pandemic gave them an opportunity to access more flexible funding, allowing community organisations to change their models and scope of service to provide their clients with additional supports to help them manage their health and wellbeing and cope with pandemic related changes. This makes a case for exploring a more widespread use of flexible funding agreements in the ACT. Not only is flexible funding a recommendation made by the Productivity Commission²⁷, it has also shown success in allowing for the implementation of models of integrated care in Victoria as part of the HealthLinks: Chronic Care Program²⁸.

While there is consistency in the discussion around what makes integrated care happen and the key enablers and barriers to integration, we must begin to consider how to overcome the barriers and create a program of change that is sustainable.

HCCA advises implementing the recommendations included in the national and state reports mentioned above to find methods to incorporate integrated care into routine practice throughout the ACT health system. HCCA also strongly recommends using the momentum developed during the COVID-19 lockdowns and leveraging the collaborative relationships that were developed to adopt the ways of practice and models of care that allowed the success of initiatives like the multidisciplinary approach to COVID in the ACT social housing units.

Achieving integrated care is a complex and complicated journey. However, it has the potential to significantly improve the access and quality of care provided to people with chronic conditions and complex health needs. Integrated care benefits the health system through costs savings from a potential reduction in the use of emergency and urgent care services as well as a streamlining of services through improved communication, more efficient referral mechanisms, and greater collaboration across the health system.

References

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- ¹ *Carers Recognition Act* (2021). ACT. s8
- ² Goodwin, N. (2016) 'Understanding Integrated Care', *International Journal of Integrated Care*, 16(4). Available at: <https://doi.org/10.5334/ijic.2530>.
- World Health Organization Regional Office for Europe (2016) *Integrated care models: an overview Working document*. Available at: <http://www.euro.who.int/pubrequest>.
- ³ National Voices UK and Think Local Act Personal (2013) *A Narrative for Person-Centred Coordinated Care*. Available at: www.nationalvoices.org.uk@NVTweetingwww.thinklocalactpersonal.org.uk@TLAP1
- ⁴ World Health Organization Regional Office for Europe (2016) *Integrated care models: an overview Working document*. Available at: <http://www.euro.who.int/pubrequest>.
- ⁵ Valentijn, P.P. et al. (2013) 'Understanding integrated care: A comprehensive conceptual framework based on the integrative functions of primary care', *International Journal of Integrated Care*, 13(JANUARY-MARCH 2). Available at: <https://doi.org/10.5334/IJIC.886>.
- ⁶ Australian Health Ministers' Advisory Council (2017) *National Strategic Framework for Chronic Conditions*. Canberra.
- ⁷ See note 6.
- ⁸ Australian Bureau of Statistics (2018) *National Health Survey: First Results 2017-18*.
- ⁹ Australian Bureau of Statistics (2021) *Core activity need for assistance (ASSNP)*. Available at: <https://www.abs.gov.au/census/guide-census-data/census-dictionary/2021/variables-topic/disability-and-carers/core-activity-need-assistance-assnp>.
- ¹⁰ Hamilton, M. (2010) 'People with Complex Needs and the Criminal Justice System', *Current Issues in Criminal Justice*, 22(2).
- Baldry, E. et al. (2015) *A predictable and preventable path: IAMHDCCD Report*.
- ¹¹ Hamilton, M. (2010) 'People with Complex Needs and the Criminal Justice System', *Current Issues in Criminal Justice*, 22(2).
- ¹² Shearer, D.H., Steel, K.M. and Calas-Proolingheur, L. (2004) *Mental Health Glossary*.
- ¹³ **Convenience sampling** is a method of collecting samples by taking samples that are conveniently located around a location or Internet service.

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- ¹⁴ Saunders, B. *et al.* (2018) 'Saturation in qualitative research: exploring its conceptualization and operationalization', *Qual Quant*, 52, pp. 1893–1907. Available at: <https://doi.org/10.1007/s11135-017-0574-8>.
- ¹⁵ Australian Commission on Safety and Quality in Health Care (ACSQHC) (2021) *National Safety and Quality Health Service Standards*. 2nd ed. Sydney.
- ¹⁶ [ACT Primary Health Network's Baseline Needs Assessment \(2021\)](#)
- ¹⁷ Capital Health Network (ACT PHN) (2021) *2021-2024 Needs Assessment*.
- ¹⁸ The Royal Australian College of General Practitioners (2022) *General Practice: Health of the Nation 2022*.
- ¹⁹ ACT Government Commissioning for Social ImpACT (2022) *Case Study: Ragusa (COVID-19 Quarantine Support Hub)*. Available at: <https://www.communityservices.act.gov.au/commissioning/commissioning-case-studies#ragusa>
- ²⁰ Macdonald, John. and Welsh, Ricky. (2012) *The Shed in Mt Druitt: addressing the social determinants of male health and illness*. [Men's Health Information and Resource Centre, University of Western Sydney].
- ²¹ Trankle, S.A. and Reath, J. (2019) 'Partners in Recovery: An early phase evaluation of an Australian mental health initiative using program logic and thematic analysis', *BMC Health Services Research*, 19(1). Available at: <https://doi.org/10.1186/s12913-019-4360-2>.
- ²² Waks, S. *et al.* (2017) 'Outcomes identified and prioritised by consumers of Partners in Recovery: A consumer-led study', *BMC Psychiatry*, 17(1). Available at: <https://doi.org/10.1186/s12888-017-1498-5>.
- ²³ Haahtela, T. *et al.* (2006) 'A 10 year asthma programme in Finland: major change for the better', *Thorax*, 61(8), p. 663. Available at: <https://doi.org/10.1136/THX.2005.055699>.
- ²⁴ Australian Productivity Commission (2021b) *Innovations in care for chronic health conditions: Productivity Reform Case Study*. Canberra.
- ²⁵ See note 15.
- ²⁶ Pearse, J. *et al.* (2022) *Evaluation of the Health Care Homes trial: Final evaluation report*. Available at: www.healthpolicy.com.au.
- ²⁷ Australian Productivity Commission (2021a) *Implementing innovation across the health system, Information Paper*. Canberra.
- ²⁸ Victoria. Department of Health (2022) *Healthlinks Chronic Care Evaluation Summary Report*. Werribee.