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Integrated Healthcare Homes & Neighbourhoods: governance, clinical, managerial & evaluation matters

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BACKGROUND

Persisting systems gaps and fragmented care within and between primary and secondary healthcare teams are key national and international issues. For patients, this fragmentation is compounded by poor communication. Continuity and coordination of patient-centred care requires effective communication, coordination, teamwork, and judicious use of eHealth tools within a medical home and across the health neighbourhood. This Integrated Healthcare Homes and Neighbourhood (IHH&N) program is a response.

CONCEPTUAL FRAMEWORK

General practice is the logical Healthcare Home and hub of the Healthcare Neighbourhood to coordinate information exchange seamlessly across primary, secondary, acute, aged and social care. Multidimensional integration of data/information, clinical & managerial workflow, and professional practice with a person-centred and transparent team, underpinned by the Chronic Care Model, is essential. The Healthcare Neighbourhood is defined as the primary and ambulatory care services in a locality that relates largely to a hospital-based secondary care service provider. It is a logical denominator to assess the effectiveness of integration interventions. Its size may vary based on geography and/or population requirements.

AIM

To describe an Australian case study to (1) demonstrate the data, clinical, managerial and inter-professional integration required, and (2) highlight the governance, clinical, managerial and evaluation challenges.

SETTING AND CONTEXT

A network of general practice- and hospital-based services in SW Sydney established by the UNSW/SWSLHD Academic General Practice Unit to support its health services research and development (R&D) program. METHODS

A mixed methods case study using data collected from review of protocol documents and publications, staff and patient interviews, participant observation, and EHR data quality assessment. A self-assessment of Informatics Capability Maturity (ICM) describes how the organisation collects, manages and shares information, manages technologies and change, governs data quality and use, and uses “business intelligence” to plan and monitor care.

KEY FINDING & LESSONS

Primary and secondary care clinicians fail to share data beyond traditional referral letters and discharge summaries. Quality, privacy and security standards are reported governance issues.

Tools to collect/extract, assess and manage the quality of data are often inconsistent. Validation must be transparent within a data and clinical governance framework.

The pseudonym-based linkage is highly accurate; similar and sound-alike ethnic names were a common problem. Patients journeys were tracked through primary and secondary care services reliably.

Serious data quality deficiencies persist in primary care and hospital systems. Feedback through structured data quality reports (SDQR) can improve quality. Ontological data management methods being validated..

The T2DM case finding algorithm was accurate and improved with increasing sample size and number of attributes used. We identified large cohorts of T2DM patients with data from general practices, Diabetes Clinic and local hospital.

Issues: Australian and international collaborators highlighted common issues plus: interoperability, proprietary software and transparency; business model and sustainability; multiple ethical perspectives; and cognitive load on patients and clinicians from managing multimorbidity.

CONCLUSION & RECOMMENDATIONS

IHH&N and integrated care requires integrated health data and systems. In addition to local customisations, there are governance, clinical, managerial and evaluation matters to address.