Integrated care for community dwelling older Australians

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Abstract
Purpose – Integrated care is gaining popularity in Australian public policy as an acceptable means to address the needs of the unwell aged. The purpose of this paper is to investigate contemporary models of integrated care for community dwelling older persons in Australia and discuss how public policy has been interpreted at the service delivery level to improve the quality of care for the older person.

Design/methodology/approach – A scoping review was conducted for peer-reviewed and grey literature on integrated care for the older person in Australia. Publications from 2007 to present that described community-based enablement models were included.

Findings – Care co-ordination is popular in assisting the older person to bridge the gap between existing, disparate health and social care services. The role of primary care is respected but communication with the general practitioner and introduction of new roles into an existing system is challenging. Older persons value the role of the care co-ordinator and while robust model evaluation is rare, there is evidence of integrated care reducing emergency department presentations and stabilising quality of life of participants. Technology is an underutilised facilitator of integration in Australia. Innovative funding solutions and a long-term commitment to health system redesign is required for integrated care to extend beyond care co-ordination.

Originality/value – This scoping review summarises the contemporary evidence base for integrated care for the community dwelling older person in Australia and proposes the barriers and enablers for consideration of implementation of any such model within this health system.

Keywords Chronic care, Health and social care, Integrated care, Primary care, Aged care, Older person

Background
Integrated models of care are fundamental to Australia’s capacity to respond to the challenges emerging from an ageing population and rise in chronic disease (AIHW, 2014; NHHRC, 2009). Present methods of health and aged care delivery are unsustainable against this backdrop of demographic and epidemiological change (Tieman et al., 2007). The economic burden created from the needs of the unwell-aged demands a fiscally responsible approach for the alignment of health and aged care services while improving client outcomes. Fragmentation of care is the by-product of health and aged care systems under pressure (Amelung et al., 2017). Australia can boast universal access to medical, hospital and social care via a mix of public and private health service provision, yet disconnection between health and aged care services, difficulty with access and extended wait times are evident (Swierssen and Duckett, 2016; NHHRC, 2009; Strivens et al., 2016; Foster et al., 2017).

Cognitive and physical impairment, chronic disease and multi-morbidity demand timely, co-ordinated care to prevent complications that are costly to the health system and life-threatening for the older person (World Health Organization, 2015; De Carvalho et al., 2017). For many older persons, the need to access multiple medical specialists demands navigation of a complex and often disconnected web of health services (Strivens et al., 2016). Decrease in function associated with ill health and ageing requires access to the supports necessary to assist the older person to remain living at home. Defined by Leutz (1999, p. 77) as “[...] the search to connect the health care system (acute, primary medical, and skilled) with other human service systems (e.g. long-term care, education, vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency)”, integrated care brings these commonly fragmented services together for the provision of comprehensive,
quality care, to prevent avoidable hospitalisation and assist the older person to remain at home for longer. With its roots embedded in early models of primary health care, integrated care is a suitable means to mobilise and extend primary practice for a holistic, strengths-based approach to the delivery of health and social supports for the older person (Valentifin et al., 2013; Tieman et al., 2007; Davy et al., 2016).

Integrated care for the older person has an established history, internationally (deCarvalho et al., 2017; Philip et al., 2013; Wodchis et al., 2015). Evaluation of international models of integrated care suggests that the most effective community-based integrated strategies for the older person include a community extension to multidisciplinary sub-acute care, care co-ordination, shared data systems and primary–secondary care collaboration (deCarvalho et al., 2017; Philip et al., 2013; Wodchis et al., 2015). The Canadian Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) model is a programme of integrated care for the older person that creates a service delivery network through co-ordination of existing health and social services under a central organisation, resulting in client empowerment and improved satisfaction with care (Stewart et al., 2013). In New Zealand, the Te Whiringa Ora model of integrated care is a community-based multidisciplinary team with case management that places the client and their family at the centre of their health plan and broker health and social supports from partner providers (Wodchis et al., 2015). Te Whiringa Ora has shown improved access to care and a reduction in hospital admissions and length of stay (Wodchis et al., 2015).

Integrated care as a policy directive is not new to Australia (Nicholson et al., 2014). The Council for Australian Governments agreement for co-ordinated, patient-centred health care was released in 1995 (Australian Productivity Commission, 2017). More recently, the Australian Government's Living Longer, Living Better national aged care reform provided impetus for integrated health and social care solutions to deliver a fairer, more sustainable and consistent system for older Australians (NSW Agency for Clinical Innovation, 2014). However, translation of integrated care from a policy objective to the practice setting has proved challenging in Australia. The Australian Productivity Commission (2017) lists discordant funding objectives, incompatible information systems and poor professional linkages as obstacles to integration. The first round of Australian Coordinated Care Trials of the late 1990s experienced many of these barriers. Described as “ambitious” in design yet “disappointing” in capacity to show benefit to participants, the Australian Coordinated Care Trials were the first large-scale, national attempt at bridging the gap between various levels of health care via a care co-ordinator and fund pooling (Commonwealth Department of Health and Ageing, 2003a; Esterman and Ben-Tovim, 2002). However, brief project timeframes, rigid interventions and limitations in evaluation design compromised the capacity for the programme to produce or measure benefit to participants or the health system (Esterman and Ben-Tovim, 2002; Commonwealth Department of Health and Ageing, 2003b).

To clearly describe how the integrated care landscape for older persons in Australia has developed over the past decade, this scoping review explored innovative models of care for the community dwelling older person that translate public integrated care policy objectives to quality, service delivery at the community level. The aim of this scoping review was to identify and discuss contemporary Australian models of integrated care that target the needs of community dwelling older person. In alignment with current policy focus for integrated care, community-based enablement models were the focus of this scoping review.

Methodology
This literature review is scoping in design. A search for peer-reviewed articles was completed on the Cochrane, PubMed, Scopus and Informit databases. A search for grey literature was conducted on Australian State and Federal Government websites. Reference lists were reviewed to identify possible additional titles.
**Search terms**
The following keywords were searched: integrated/integrate/integration, co-coordinate/co-ordination/co-ordinator, multidisciplinary, elderly, older person, geriatric, frail, hospital avoidance and community. Keywords were searched as Boolean phrases and used to inform and explore MeSH terms. Results were limited to Australia, and to publications from 2007 to 2018.

**Inclusion and exclusion criteria**
To ensure consistency with Australian aged care and health policy that is considerate of the lower life expectancy for Aboriginal and Torres Strait Islander peoples, an older person was defined in this study as a non-Indigenous person aged 65 years and older and/or Aboriginal and Torres Strait Islander person over 50 years of age. Publications from 2007 were included in the review to capture all contemporary Australian models implemented within the past decade. Included models provided community-based care. Articles were excluded that investigated models of integrated care for older persons in residential care, which were hospital based or centred on palliation.

**Review strategy**
Peer-reviewed publications were screened for inclusion by title, abstract and full text. Two researchers independently reviewed search results at the stage of title review. One researcher reviewed the abstracts against inclusion and exclusion criteria. Any publications that were not clearly for inclusion or exclusion were reviewed by a second researcher.

**Synthesis/Analysis**
For this review, the level of integration macro, meso, micro (as defined in Table I) was used to delineate and describe the integrating features of the various models.

The methods of co-ordinating care, alignment of health and aged care services, and collaboration with primary care were examined. Data were extracted that described: outcome measures; economic viability; and barriers and enablers to implementation (Bardsley et al., 2013). As the focus of this scoping review was on the design features of the integrated models, the strength of study design was not evaluated.

**Results**
In total, 248 publications were identified through the described search strategy. The PRISMA flow diagram (Figure 1) outlines the process of refinement that resulted in 11 papers meeting eligibility criteria for review. Of the included papers, five were peer-reviewed publications and 6 were items within the grey literature (Table II).

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
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<tr>
<td>Macro</td>
<td>The level at which providers seek to deliver integrated care to the populations that they serve</td>
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<td>Meso</td>
<td>The level at which providers seek to deliver integrated care for a particular care group or populations with the same disease or conditions, through the redesign of care pathways and other approaches</td>
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<tr>
<td>Micro</td>
<td>The level at which providers seek to deliver integrated care for individual service users and their cares through care co-ordination, care planning or use of technology and other approaches</td>
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Source: Adapted from Curry and Ham (2010, p. 7)
Features of integration
Alignment of health and aged care services. Each of the models included in this review incorporated both health and aged care services in their approach to quality care for the older person. All but one model provided patient care initiated by a health service with strategies such as the Hospital Admission Risk Program’s (HARP) multidisciplinary team (Bird et al., 2007), HealthOne’s co-location of health services (McNab et al., 2013) and the nurse practitioner hospital in-reach role (Centre for Health Economics Research and Evaluation, 2017). A holistic approach to the needs of the older person was facilitated by engaging social supports and interventions from existing aged care services on an individual “as needs” basis supplementary to the direct health care provided from within the model. Alignment of health and social services in this way was universally considered the most efficient means of creating a comprehensive system of support for the individual that reoriented health care from preventable acute presentation through utilisation of community care, and assisted the older person to live at home for longer.

In contrast, the Lungurra–Ngoora Aboriginal model of care described by LoGiudice et al. (2012) was focussed on the alignment of social supports to improve quality of life for the older person (amongst other population groups). In this community-led approach, pooled funding and centralised management of social supports facilitated patient-focussed aged care linkages as the primary objective of a holistic model that utilised social supports to facilitate improved client engagement with the health system.

Source: Moher et al. (2009)
<table>
<thead>
<tr>
<th>Author, date</th>
<th>Model features</th>
<th>Level of integration</th>
<th>Study purpose</th>
<th>Study design and sample size</th>
<th>Summary findings</th>
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<tbody>
<tr>
<td>Australian Government Department of Health and Ageing (2007)</td>
<td>Second round of co-ordinated care trials. Various designs. Coordinated Health Care Trial (CHC) focussed on community dwelling older persons and partnership between co-ordinator, GP and patient</td>
<td>Macro</td>
<td>To determine if co-ordinated care improved service delivery for patients and communities and identify features of success</td>
<td>Randomised controlled trial of 25 months duration. Total trial participants 1,108 in intervention group and 417 for control group</td>
<td>CHC: no significant change in health status of intervention group. No significant difference in quality of life between groups at 6 months. Care co-ordination model relatively expensive</td>
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<tr>
<td>Bentley et al. (2015)</td>
<td>Nurse Practitioner within a large GP practice. NP providing co-ordination and clinical care</td>
<td>Meso/ Micro</td>
<td>To describe the implementation and challenges for the development of a Nurse Practitioner (NP) role within primary practice</td>
<td>Multi-method evaluation with no comparison group. 2 NPs and 168 clients included in the study</td>
<td>Challenges to implementation included professional relationships, access to facilities. Client consultations provided via home visit. Multi-mobility a characteristic of 74% of trial participants at recruitment</td>
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<tr>
<td>Bernoth et al. (2016)</td>
<td>Community service workers trained to provide care aimed at functional decline and quality of life</td>
<td>Micro</td>
<td>Explore the experience of community support workers in the provision of a multidisciplinary service aimed at addressing functional decline</td>
<td>Qualitative evaluation. 7 individual client interviews and 12 support workers in focus group</td>
<td>Themes identified: functionality/independence; prevention; confidence; connection: the approach; the care plan; the role of the CSWs. Clients experienced improved quality of life</td>
</tr>
<tr>
<td>Bird et al. (2007)</td>
<td>HARP: geriatrician and multidisciplinary team for comprehensive assessment and care co-ordination plus budget for provision of support services and equipment</td>
<td>Micro</td>
<td>To discuss the format and outcomes of a programme designed to connect health and social services: hospital and health service utilisation; stakeholder satisfaction; economic viability; process of implementation</td>
<td>Quasi-experimental pre-post design with 231 persons in 85 persons in comparator group</td>
<td>Statistically significant reduction in Emergency Department presentations and bed days of the intervention group. Costs savings to the health service of $2m. Model of care complimentary to existing services</td>
</tr>
<tr>
<td>Cameron et al. (2013)</td>
<td>Multidisciplinary team providing care co-ordination and allied health intervention</td>
<td>Micro</td>
<td>Evaluate the effectiveness of an interdisciplinary frailty intervention</td>
<td>Randomised controlled trial, total of 216 older frail participants</td>
<td>Statistically significant between group frailty score at 12 months. Mobility remained stable in the intervention group but declined substantially in the control group</td>
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*Table II. Studies included in the review*
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<tr>
<th>Author, date</th>
<th>Model features</th>
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<th>Study purpose</th>
<th>Study design and sample size</th>
<th>Summary findings</th>
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<tr>
<td>Centre for Health Economics.......</td>
<td>Care co-ordinators who assist in the development and facilitation of a client’s care plan (GP Management Plan) by liaising with and linking client’s to existing services. Budget for home modifications.</td>
<td>Micro</td>
<td>To analyse change in referral pattern, expenditure allocation and effectiveness of a co-ordinated care programme</td>
<td>Pre-post design with no comparator group. Data available for 2,544 participants</td>
<td>Statistically significant reduction in ED presentations. TCC strongly associated with reduction in patient acuity.</td>
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<td>Davey et al. (2015)</td>
<td>Variety of Nurse Practitioner models of care working within a primary practice, solo practitioners or government based. Co-ordination and clinical service provision.</td>
<td>Meso/Micro</td>
<td>To assess the extent that Nurse Practitioner models of care improve access to care for elderly clients, facilitate growth in the NP workforce and are economically viable and sustainable</td>
<td>Multi-method evaluation with no comparator group. No sample size provided</td>
<td>Model managers and NPs viewed the initiatives to be effective. Improved access to primary health care for older people. 30% of overall models did not continue because they were not financially viable. Clients satisfied with care provided by the NP. Increase in client numbers and use of community services. Up-skilling of staff. Funding gaps identified. Agency partnerships formed. Complicated funding arrangements hindered the project. The need for services to relinquish or share roles challenging.</td>
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<tr>
<td>LoGiudice et al. (2012)</td>
<td>Fully integrated model with joint funding arrangement and common objectives created between health and social services. Care co-ordination.</td>
<td>Meso</td>
<td>To describe the development and implementation of a model of health and social care in a remote Aboriginal community.</td>
<td>Multi-methods study with no comparator group. 25 stakeholders interviewed. 22 programme participants</td>
<td>Increase in client numbers and use of community services. Up-skilling of staff. Funding gaps identified. Agency partnerships formed. Complicated funding arrangements hindered the project. The need for services to relinquish or share roles challenging.</td>
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<tr>
<td>Masso et al. (2015)</td>
<td>Various models. Three models targeted community dwelling older persons at risk of functional decline. Care co-ordination to link health and social supports.</td>
<td>Meso</td>
<td>To evaluate the success in achieving the following: establish referral pathway; Improve access; reduce hospital admissions and length of stay; skilled and flexible aged care sector</td>
<td>Summative multi-method evaluation with no comparison group. Total of 2,734 programme participants. 69 stakeholder interviews</td>
<td>Objectives met: improve access to complex health care services for aged care recipients; diversify the aged care sector to include more complex community and residential health care services for aged care recipients; establishment of effective referral pathways between aged care and health care service providers.</td>
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<td>McNab et al. (2013)</td>
<td>Model centred on the role of the GP liaison nurse. Nurse assists client through the continuum of care by creating a care plan and arranging required services and facilitating communication between existing organisations</td>
<td>Meso</td>
<td>To evaluate the success of a programme designed to align primary health and community services: Hospital and health service utilisation, stakeholder satisfaction, economic viability, process of implementation</td>
<td>Multi-method evaluation with no comparison group</td>
<td>Reduction in ED presentations for the chronic aged and complex group. Clients felt supported experienced improvement in quality of life. Increase in referrals to allied health and decrease in referrals for nursing. GP satisfaction with the programme</td>
</tr>
<tr>
<td>McNamara et al. (2017)</td>
<td>Not applicable</td>
<td>na</td>
<td>Examine health care provider (HCP) experience of approaches to multi-morbidity management for community dwelling older persons</td>
<td>Qualitative study. Semi-structured interviews with 26 HCPs</td>
<td>Themes identified: incorporation of shared decision making and patient preferences; evidence base; patient prognosis; clinical feasibility of treatment plans; optimising therapies and health management plans; co-ordination of care system wide gaps in implementing a co-ordinated approach to the care of the older person with multi-morbidity</td>
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Collaboration with primary care. Each model of care included in this review incorporated primary care into their design with service delivery performed where primary care interfaced with either acute or secondary care provision. A general practitioner (GP) and care co-ordinator partnership was formed in many of these models with case conferencing utilised to facilitate joint decision making (Australian Government Department of Health and Ageing, 2007; Bentley et al., 2015; Centre for Health Economics Research and Evaluation, 2017; Davey et al., 2015; Masso et al., 2015; McNab et al., 2013; McNamara et al., 2017). The co-location of nurse practitioners within the GP practice produced a depth of integration with primary care not seen in other models; co-location was reported to enable timely case discussion and collaboration on joint care plans. The establishment of the GP liaison role in HealthOne was a targeted and beneficial means of increasing communication with primary care across the care continuum. Unique to the GP liaison role was the capacity to facilitate case conferencing with the primary care physician to inform inpatient care and assist with discharge planning (Bentley et al., 2015; Davey et al., 2015; McNab et al., 2013). Self-management, specialised aged care assessment and frailty interventions were utilised across several models to complement existing primary care services.

Care co-ordination. Service linkage and liaison were familiar strategies across all models of care, most often facilitated by a care co-ordinator who established an individualised care plan for the client and referred to external services to facilitate plan activities. The title of this co-ordinating position differed: general practice liaison nurse (McNab et al., 2013); care facilitator Bird et al. (2007); and service co-ordinator (Australian Government Department of Health and Ageing, 2007); however, the key duties of this position were described similarly between models to include client advocate, educator, co-ordinator and counsellor. A nurse filled the co-ordination role in many models (McNab et al., 2013; Bentley et al., 2015; Centre for Health Economics Research and Evaluation, 2017; Davey et al., 2015; Masso et al., 2015). HARP (Bird et al., 2007) employed multidisciplinary care facilitators of a variety of health professions who could refer to each other for specialist intervention.

The role of the co-ordinator was valued by stakeholders and participants as an essential component to integration:

And then the GP Liaison Nurses, their role, coming on board [was] instrumental in getting all this going. If they weren’t there, this wouldn’t have moved along. So, a very, very fundamental glue, if you will, between how community health does its business, and linking into general practice […] We perhaps hadn’t quite appreciated when you start out with these things that these were sort of the linchpins of the model in terms of how do you bring disparate parties together to keep them, to keep them working together. (Policy Maker, McNab et al., 2013, p. 61)

Programme outcomes

Client-level outcomes. Neither of the randomised controlled trials included in this study produced a significant statistical difference in emergency department (ED) presentations or quality of life between groups at the completion of the study period (Australian Government Department of Health and Ageing, 2007; Cameron et al., 2013). However, HARP, Brisbane North Team Care and HealthOne, each attributed improved access to timely health and social supports to a decrease in the number of ED presentations for intervention participants (Bird et al., 2007; Centre for Health Economics Research and Evaluation, 2017; McNab et al., 2013). The HARP described by Bird et al. (2007) also credited a decrease in acute hospital usage to an improved understanding of appropriate health service utilisation amongst participants.

An increase in quality of life for integrated care participants was identified in two model evaluations with participants of HealthOne and Bernoth’s Participatory Care Model
reporting a decrease in health anxiety linked to the direct support provided by their GP liaison/community support worker (McNab et al., 2013; Bernoth et al., 2016). Qualitative findings highlight positive outcomes related to physical and psychological health:

I’m not so stress […] So yeah…they’ve done like a lot for me like if I didn’t have the help I wouldn’t have the grass done and the walker […]. (Mrs K. in McNab et al., 2013, p. 43)

And:

One particular client had [a] severe condition that limited his ability to walk or manage his personal hygiene […] he had not walked for many months and was unable to access his toilet or shower, and his mental state was very low […] however the project has enabled him to partake in valued activities such as fishing. (Allied Health Professional, LoGiudice et al., 2012)

**Cost effectiveness.** The Coordinated Care Trials, HARP and Nurse Practitioner models included economic evaluation, with mixed results (Australian Government Department of Health and Ageing, 2007; Bird et al., 2007; Davey et al., 2015). The HARP claimed a $2m saving to the health service achieved through a reduction in ED presentations and hospital admissions amongst HARP participants following the intervention, with success attributed to linkage to and use of community health and social services in place of reliance on acute hospital care (Bird et al., 2007). The National Evaluation of Nurse Practitioners reported that 30 per cent of models included in their evaluation did not continue as restricted revenue streams impacted negatively on financially viability (Davey et al., 2015). The National Evaluation of Coordinated Care Trials reported that inpatient costs for the intervention group were lower than the control in the late stages of the trial but that care co-ordination was determined to be “relatively expensive” (Australian Government Department of Health and Ageing, 2007).

**Patient and provider satisfaction.** Patient satisfaction was reported in the evaluation of three models (Bernoth et al., 2016; McNab et al., 2013; Davey et al., 2015) and stakeholder satisfaction in four evaluations (LoGiudice et al., 2012; Bernoth et al., 2016; McNab et al., 2013; Davey et al., 2015). Overall, findings from both groups were positive with the role of the care co-ordinators valued by both groups.

Care co-ordinators appreciated the benefits of applying a holistic patient-centred approach to care:

[…] I think we’ve become closer to our clients. They feel that we really care about how they are actually doing. (Community Support Worker in Bernoth et al., 2016, p. 433)

GPs were impressed with the capacity to have a pathway to access hospital-based information and valued the trust built with the care co-ordinator.

Clients felt supported, connected and listened to. Client’s felt relief in having a central point of contact for their needs:

If I could have [Mrs S.’s GP] and the team down here [GPLN and Mount Druitt Community Health staff], I wouldn’t need anybody else [laughter]. There you go, that’s how, I am absolutely rapt in them. And if the government, and if that goes back to the government, if the government ever stops it, look out, I’ll be on your door step [laughter]. (Mrs S. in HealthOne Mt Druitt in McNab et al., 2013, p. 42)

**Barriers and enablers to implementation**

The process of implementation was discussed in many of the publications. Alignment of disparate services was discussed as a challenge:

The major impediment to improving connections between aged care and health care was the silos within which individual providers work […] These silos differ in so many ways – different goals, different philosophies of care, different sources of funding and different operational requirements. (Masso et al., 2015, p. 73)
And:

Working with the GP who has a slightly different way of working. Get a shared understanding of what each other does, and how those roles can complement each other, and that’s not an easy thing as you’re coming from very different places. And, you know, it’s just a lot of hard work to actually work that through to get that shared understanding. (Policy Maker in McNab et al., 2013, p. 67)

Introduction of a new model of care within and across existing services was often met with a reluctance to change, particularly for those models integrating at the meso level. The Lungurra–Ngoora programme in remote Western Australia (LoGiudice et al., 2012) sought to develop partnerships for integration through a strong shared governance framework. A steering committee and local action group involved in all aspects of model of care development could not overcome the uncomfortable experience of organisational change and related relinquishment of roles.

Conversely, evaluation of HealthOne (McNab et al., 2013) concluded that commitment of key partners and dedication to a changed way of working were essential to model implementation and sustainability. The inclusion of primary care in the early stages of model development was an enabling feature of HealthOne and the CHC. While the establishment of trust and respectful relationships took time, these models were situated to benefit all parties and common values were established:

[…] we determined at the outset that there were certain parameters within which we wanted this model to develop, and the absolute fundamentals [were] that it had to be a partnership between general practice and community health […] (Policy Maker in McNab et al., 2013)

Discussion

The aim of this scoping review was to identify and discuss contemporary Australian models of integrated care for community dwelling older persons implemented within the past decade. Although the documented evidence of integrated models of care designed specifically for this client group within Australia was scarce, the 11 publications included in this review provide insight into the interpretation of public integrated care policy to improve care provision for the older person; each model unique to their community yet distinguished by their use of care co-ordination and collaboration with primary care.

The World Health Organization (2015) clearly outlines that comprehensive care for the older persons’ demands connection of health and social care. The combination of improved access to health services, the smoothing of transitions within health care and the co-ordination of aged care supports in the home have shown internationally to improve the quality of life of the older person, reduce acute hospital utilisation and keep the older person living at home for longer (Wodchis et al., 2015; Curry and Ham, 2010; Goodwin et al., 2014; Sendall et al., 2016). In Australia, the disparate funding arrangements of health and aged care services (acute and secondary care funded by the State, and primary care and aged care funded by the Commonwealth) remain influential in shaping methods of integration with minimal evidence to suggest that integration of health and social services beyond care co-ordination is possible. Many of the models of care included in this review utilise Commonwealth-funded services to impact State-funded hospital outcomes. This is discussed, not to discredit goals of improved quality of life and independent living, but to illustrate why silos of care continue and why the design of integrated models at the macro level are avoided.

Care co-ordination is widely considered to be an essential component in quality patient outcomes and is an appealing approach to integration in Australia, as it is internationally, as there is no need to address the structure of existing services, conflicting funding objectives can be avoided and there is little requirement to manage behavioural symptoms of change (Amelung et al., 2017; Goodwin et al., 2014; Suter et al., 2009;
Curry and Ham, 2010). For these reasons, care co-ordination remains popular as the driver of integration in Australia. However, care co-ordination on its own, particularly when based on a linkage model, does little to address the underlying reasons for service fragmentation (Goodwin, 2013). Care co-ordination provides the most vulnerable clients with an improved experience of the health system by bridging gaps and navigating complexities of the care continuum, but the gaps and complexity remain. As such, a disconnect between integrated care as a policy directive and the governmental structures required to embed integrated care into the Australian health and social care landscape is evident. Short-term project funding creates reliance on care co-ordination and avoidance of the complexities of service alignment, but results indicate that care co-ordination is expensive (particularly when undertaken by a nurse practitioner) and does not have a reliable revenue stream in the Australian health system to promote model sustainability (Masso et al., 2015; Davey et al., 2015; Australian Productivity Commission, 2017).

Primary care is valued as an essential element of integrated care for the older person yet engaging well in this space remains challenging. The GP, specifically, is vital to sustainable health outcomes for the older person (Amelung et al., 2017; Mitchell et al., 2015). The expressed difficulty in aligning integrated care interventions to the values of the GP appears at odds with this. A reluctance to participate in patient-focused care is discussed by the Australian Productivity Commission (2017) as a barrier to integration, an obstacle that while not unique to Australia contrasts with health care models of those western countries that place value on the patient’s role as a co-contributor in their care (Australian Productivity Commission, 2017; Swierssen and Duckett, 2016; Topol, 2015). Engagement of the GP in early stages of model development and a commitment to relationship building, while difficult, are beneficial to implementation and programme acceptability.

Integrated, patient-focused care is the right care, at the right place, at the right time. The first round of coordinated care trials emphasised the need to understand usual care as a pre-cursor to system redesign (Commonwealth Department of Health and Ageing, 2003c). A strength of many international models of integrated care is their capacity to respond to unique community needs, with family inclusion and community-led care evidence of this in practice within the Te Whiringa Ora model. Consistent with this New Zealand-based approach, community consultation is particularly important for strategies implemented for Aboriginal and Torres Strait Islander communities within Australia, as this approach fosters key community partnerships, can ensure cultural safety of the intervention and assists in broadening integration beyond a biomedical model to include spiritual and community well-being and the social determinants of health (Amelung et al., 2017; Davy et al., 2016; Smith et al., 2011). A one-size-fits-all approach to service delivery is rarely successful between and within communities. Triage, prioritisation and flexible service design were suggestions of the first round of Coordinated Care Trials, considered to be components of successful programming (Commonwealth Department of Health and Ageing, 2003c).

Electronic patient records, teleconferencing and other means of technological application are considered central to contemporary integration, to improve timely communication, avoid duplication of assessment and to improve access to care (Suter et al., 2009). The geographical spread of Australia’s population is motivation for technological innovation to facilitate integration but activities focussed on this were not described or explored by any of the models of care included in this review. The lack of focus on information management within integrated care models is not unique to Australia (Goodwin et al., 2014).

**Limitations**

This study was limited by the reporting mechanisms employed by the evaluations and the subsequent difficulty in drawing conclusive statements about those interventions that were the most successful. The summative nature of the Better Healthcare Connections, Second
Conclusion
The Australian health system is becoming increasingly interested in the concept of integrated care to facilitate sustainable, quality outcomes for an ageing population. Care co-ordination remains the most popular and acceptable means of supporting older persons with complex needs to manage the complexity of the current health system. Care co-ordination must align with primary care and support the work of the GP for the greatest success. Although popular, reliance on supernumerary models of care linkage does not address the underlying cause of fragmentation within the Australian health system and lacks the capacity to work with patients preventatively. Little evidence exists of the effectiveness of strategies that pursue integration through service redesign and the use of technological mechanisms for communication and service delivery is underutilised or unexplored. Historical barriers to integrated care permeate contemporary approaches and compromise the capacity for depth of integration to be achieved. With solid cross-sectoral partnerships and innovative funding arrangements future models of integrated care could push beyond care co-ordination for sustainable quality service provision that addresses the challenges of accessing the right care, at the right time, for older persons with complex needs.

References


Further reading

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