Queensland Framework for Health Service Integration

2011
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The Queensland Framework for Health Service Integration

The Queensland Framework for Health Service Integration has been developed to enable improved coordination and integration of health services across providers and health sectors. The key enablers are grouped into local and statewide outcomes. Potential strategies and activities for achieving these outcomes are described in the key enablers as part of the Local Implementation Guide and Statewide Reform Guide. The diagram below provides an overview of the Framework enablers/elements.

The Framework has three components:

Section One – The Queensland Framework for Health Service Integration

This section provides a background overview, provides the policy context, sets out the aims, objectives, scope of the Framework and a description of the four key enablers of an ideal integrated health system. It also includes a broad overview of the Framework, the guiding principles and benefits to the health system, to hospital and primary care and to patients.

Section Two - The Local Key Enablers (Implementation Guide)

The local key enablers as part of an implementation guide supports the development of strategies and activities that can be implemented at a local level by Medicare Locals, Local Hospital Networks and service providers.

Section Three – The Statewide Key Enablers (Statewide Reform Guide)

The statewide key enablers as part of statewide reform guide supports the development of potential strategies and activities to be undertaken at a state level to support both local level Framework implementation and statewide system reform.
Section 1  

OVERVIEW  

Introduction  
Health care systems globally recognise the important role of the primary, secondary and tertiary interface as a key organisational feature of the health system. In order for the delivery of an affordable high quality, safe and equitable health care system into the future, changes to system level supports are required. In some countries, considerable attention has been given to this issue, through interdisciplinary education, the creation of hybrid workers (e.g. care coordinators, general practice liaison officers, boundary spanners, and knowledge brokers) to support transition periods and the facilitation of health-related partnerships designed to promote integrated service provision.

Workable solutions to the problems associated with transition require both vertical integration (e.g., clear pathways, smooth handovers between services and coordinated plans for forward movement) and horizontal integration (e.g., networks and partnerships between services, interdisciplinary teams and consumer engagement). The most successful strategies in terms of outcomes for consumers were those that involved a re-organisation of structures to strengthen relationships between organisations and the provision of tools to support coordination (e.g., shared templates, shared care plan and records) (Powell-Davies, 2006). Integrated organisational networks have become an important mechanism for building the capacity to systematically address complex community health needs, and delivering services (Provan et al., 2005). Creating new models of care which support continuity of service provision for the consumer is fundamental to supporting improved integration between the primary, secondary and tertiary sectors, preventing the need for acute care and facilitating the delivery of care in the most appropriate setting (Amos & Boughey, 2006; Jackson & Nicholson, in press; Jackson & O’Halloran, 2008; Naccarella et al., 2010).

Why a Queensland Framework for Health Service Integration?  
Given the number of patients accessing hospital services is increasing (Australian Institute of Health and Welfare AIHW, 2010; Swerissen & Taylor 2008) strategies to improve patient health outcomes and manage health service demand are needed. Models for linking GPs to hospitals, supporting care coordination across sectors, establishing team based approaches and improving integration and quality of patient care are emerging as cornerstone features of the health system. In Australia there is no consistent national strategy or framework to support health service integration activity across primary, secondary and tertiary sectors.

Investment in national and state research, development and coordination is required including the development of frameworks and competencies which support health service integration. This includes embedding policy within the health system to re-direct focus to supporting integration and continuity of care for patients through the utilisation of new and emerging workforce models, team based models of care, providing clinical leadership and strong governance and developing strategies to support connectivity and information flow between the various health sectors.

The Framework for health service integration provides potential strategies and activities for local partners to consider in shaping the direction of service integration in the region by building consistency, sharing resources and improving linkages between service providers. The Framework aims to support a more integrated and effective health care system, by providing an approach to reform that guides Medicare Local
Definitions of Health Service Integration

To assist understanding of this document, the following definition of health service integration used by the World Health Organisation (WHO) will be adopted.

Integrated service delivery is “the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.” (Technical Brief 1, Integrated Health Services, What and Why? WHO, 2008)

Policy Context

All levels of government in Australia and Queensland have an increasing focus on improving the coordination and integration of services through improved service quality, effectiveness, equity of access and efficiency. This focus is delivered in the context of limited resources, disjointed systems, duplication of services and increasing demand on services due to increased burden of disease.

The Framework promotes the achievement of policy goals and improved health outcomes by supporting the actions of Australian and Queensland government commitment to improving health outcomes for people through a better-coordinated service system. The Framework provides a foundation for achieving goals and provides a platform for guiding all partners consistently.

The Framework sits with the Current State and National Policy environment, including:

- Alignment with the service delivery reforms at a state and national level focused on health system integration;
- Consistency with the objectives for MLs and LHHNs, as outlined in the ML strategic objectives and the LHHN protocols;
- Alignment with the Queensland Health Strategic Plan 2007-2012 and the National Primary Care Strategy (2008) and the core values of the Queensland Divisions Network focus on ‘building an integrated health system’;
- Advocacy for a patient centred focus;
- Implementing an outcome focused approach;
- Supporting reduction in duplication of services; and
- Providing activities and strategies focused on integration of services across sectors.

Foundations of the Framework

The Framework builds on international models of health service integration drawing on knowledge and lessons from the United Kingdom (National Health Service; Primary Care Trusts), Germany (Statutory Health Insurance Physicians (KVB)), and New Zealand (Primary Health Care Organisations). A review of the evidence base, policy implications for practice, key consensus documents and expert opinion was gathered to inform the development of the Framework. This Framework builds on the collective knowledge, which has emerged around informing the health service integration key enablers and possible implementation strategies and activities.
**Framework Aim**

The Framework aims to maximise accountability, information sharing, and integration of care and delivery of systems based change to ensure the people of Queensland receive 'the right care, in the right place'.

**Key Objective of the Framework**

The key objective of the Framework is to support a safe, high quality Australian health system through improved integration and coordination of health care for the people of Queensland.

**Principles**

The guiding principles aim to provide a shared mandate to enable effective cross sector integration of care for Queensland people. The principles established under the auspice of the Clinical Senate in Queensland will be adopted as the overarching principles to guide broader integration practices (see [http://www.health.qld.gov.au/qldclinicalsenate/default.asp](http://www.health.qld.gov.au/qldclinicalsenate/default.asp)). The principles outlined below relate to more targeted principles health service integration planning, development and provision. These include:

1. The integrated health system will support consumer advocacy and ownership of health care through a focus on the continuity of care and journey of the person through the system. This will require an integrated, coordinated, collaborative service delivery model.
2. An integrated and coordinated service system will increase capacity of the health workforce to increase access and equity of care.
3. Advocacy, clinical leadership and change management will support best practice models and increase the capacity of the workforce to deliver safe, effective, efficient and quality care.
4. A comprehensive health system has cross sector organisations and services working in coordinated partnerships to benefit communities.
5. Integrated governance models will provide leadership and expanded range of integrated services across sectors.

**Key Enablers of the Framework**

The Framework seeks to create greater efficiency through integration that reflects local health care needs through the delivery of health networks of primary, secondary and tertiary providers. The Framework has been designed to facilitate integration and coordination of care, which is underpinned by four local key enablers:

- Clinical leadership and governance
- Service re-design (connectivity and information flow)
- Organisational and workforce development
- Outcomes based incentives

Supported by two statewide key enablers:

- Policy and strategy
- Systems development

**Scope of the Framework**
It is acknowledged that there will be significant differences in the applicability of the Framework between rural and remote regions, and provincial and metropolitan areas of Queensland. Whilst the Framework has potential for transferability, workforce demands and scope of practice will be limited in some places in Queensland.

It is recommended that each of the key enablers of the Framework be considered when implementing health service integration strategies and activity. The Framework is neither exhaustive, nor is it prescriptive, but instead a guide for developing mechanisms, structure and approaches to drive comprehensive and integrated health services.

**Who benefits?**  
The Framework has been developed for health care service providers, planners, service managers, those organisations who interact with the health care system, program designers and policy makers. Benefits of using the Framework will include better communication between providers and information flow, improved capacity to support clinical leadership and governance mechanisms, improved workforce and organisational development including skills and training opportunities and a reform focus on outcomes based incentives associated with improved integration and coordination of health services. Ultimately the goal is for the system level enablers to flow through to improved health outcomes for the people of Queensland.

Collaborative approaches will be required and much of the work is in change management and encouraging a cultural shift from individual service providers and organisations to working as part of a network. resources, it can make
The Framework Enablers

Statewide Enablers
- Systems Development
- Policy and Strategy

Local Level Enablers
- Clinical Leadership and Governance
- Service Re-Design (connectivity and information flow)
- Organisational & Workforce Development
- Outcomes Based Incentives
Section Two

Local Key Enablers (Implementation Guide)

How to use?

A directory of local key enablers appears on the following pages. This directory can be used by MLs, LHHNs and service providers to either implement key enablers of the Framework within their own service, or to facilitate broader regional implementation with other local service providers.

Key Drivers and Context

To address the key enablers required to support a comprehensive integrated health system, four key enabling outcomes of:

- clinical leadership and governance,
- service re-design,
- organizational and workforce development and
- outcomes based incentives is required.

DIRECTORY

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<tr>
<th>ENABLER: CLINICAL LEADERSHIP AND GOVERNANCE</th>
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<tr>
<td>STRATEGIES</td>
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<td>Support the development of clinical leadership</td>
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<td>Develop clinician engagement strategies</td>
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<td>ACTIVITIES</td>
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<td>• Support the development of clinical leaders in building understanding of local clinicians.</td>
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<td>• Provide resources and marketing material for ‘change champions’ to act as role models for new ways of working.</td>
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<td>• Develop policy and position statements, which reflect the policy development of integrated health services within the locality.</td>
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<td>• Support the emergences of natural leaders through enabling representation to inform and advise on the delivery of care for local people.</td>
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<td>• Provide clinical leadership for quality improvement and change cycles.</td>
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<td>• Ensure clinician engagement needs are aligned with management objectives and based on the foundations of service delivery needs of local communities.</td>
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<td>• Seek input from clinical leaders into strategic and health service planning.</td>
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<td>Implement a change management approach</td>
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<td>• Seek input from clinical leaders to develop clear and measurable outcomes to joint service planning across sectors.</td>
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<td>• Identify incentives and motives that drive clinician participation and engagement.</td>
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<td>• Work collaboratively to support cultural and behavioural change to shift the mindset from working as individual clinicians and practices to working with the broader health care sector.</td>
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<td>• Support development of plans around change issues including:</td>
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<td>- cultural issues</td>
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<td>- infrastructure needs</td>
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<td>- IT support</td>
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<td>- Information management</td>
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<td>Implement strong governance and accountability</td>
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<tr>
<td>• Identify clear accountability and lines of authority for decision-making.</td>
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<td>• Identify levels of governance including membership and reporting.</td>
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<td>• Partners should develop detailed terms, conditions and expectations of providers.</td>
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<td>• Principles of partnership should be developed and clearly outline the foundations for operating.</td>
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| Define the role and function of providers at each level | • Executive governing partners should develop a clear understanding of the roles and responsibilities of providers in supporting joint health service integration activity.  
• Partners should work collaboratively to identify and develop local priority areas.  
• Roles and functions of each provider need to be clearly defined and communicated to all partners (providing transparency in decision-making). |
| Support the development of linkages and local capacity | • Develop or build upon existing local resource directory and referral pathway tools to ensure service providers have a thorough knowledge of other services.  
• Develop strategies to ensure service providers understand, respect and value other services.  
• Provide support to service providers working together.  
• Encourage service providers to collaborate to address priority areas within the region.  
• Provide mentoring of local health teams.  
• Foster joint training opportunities to enhance collaboration between service providers.  
• Advocate for services based on identified community need. |
| Promote consumer and community engagement in all levels of cross sector activity | • Embed consumer input and approaches into governance and quality mechanisms (e.g. complaints processes).  
• Incorporate patient advocates and strategies for engagements with consumers.  
• Incorporate the need for consumer experience, equity (of access), efficiency (financial performance) and population and individual health outcomes.  
• Actively participate in the monitoring and performance of MLs and LHHNs standards through the National Health Performance Authority.  
• Develop information tools that create transparency across providers (e.g. shared databases)  
• Develop risk stratification to manage change process and interface with partners.  
• Develop tools to support providers delivering cross sector services (e.g. case management). |
consultation into policy documentation.
- Identify and engage with consumer and carer groups.

### ENABLER: SERVICE RE-DESIGN
*(CONNECTIVITY AND INFORMATION FLOW)*

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>ACTIVITIES</th>
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| Undertake joint population health and service planning | • Assist in partnership development and service planning in order to direct patients to the most appropriate care setting.  
• Undertake joint health planning with Medicare Local, Local Hospital Network and other key stakeholders to identify local priority areas.  
• Develop local working groups based on priority areas (including after hours services)  
• Work collaboratively to enhance continuity of patient care in local priority areas.  
• Contribute to service planning and implementation of integrated shared care models.  
• Identify barriers to access to general practitioners and other primary care providers.  
• Identify responsiveness of services including quality of the services and patient experience.  
• Identify targeted health outcome measures and track over time and across settings.  
• Identify level of community readiness through involvement in identification of health needs and planning of services. |
| Develop and advocate for team based models of care | • Provide support to service providers working together.  
• Define the roles of team members.  
• Outline how best the team members can support information and communication transfer across teams and the various models.  
• Identify and address barriers to support a team-led approach.  
• Identify pro-active management strategies of disease to avoid unnecessary hospitalisation.  
• Identify and link with key health professionals |
from different agencies and settings to coordinate health care needs of patient.

| Support flexible models of service provision | • Work with executive level partnerships, GPs, consultants, allied health, local health workers, liaison officers and other stakeholders to support care pathway and service redesign taking account of state and national priorities while responding to local need.  
• Build capacity of workforce to take on new tasks and roles (e.g. after hours care, health promotion, case management, telehealth).  
• Develop case studies promoting local innovation and workforce models of service provision.  
• Utilise flexible service models to target hard to reach populations and address unmet service gaps.  
• Evaluate alternative workforce models to capture key learning’s to inform future models. |
| Investigate and invest in shared information management systems | • Build or link IT systems capacity, processes and governance of cross sector organisations to ensure the flow of information.  
• Develop and integrate strategies to support the flow of information and data across health care boundaries to enable clinicians to share the treatment and management of patients.  
• Build on the functions to support information flow including: development of agreed data sets, sharing of care plans, measuring the delivery of care and monitoring performance and health outcomes at patient level, practice level and population level.  
• Development of shared and agreed data sets that enable patient-level aggregated data that can be analysed.  
• Establish monitoring and surveillance of health system performance. This also includes training in data collection and analysis.  
• Development of disease registers where multiple parties can view patient information.  
• Develop risk stratification through population segmentation, which enables patient needs to be identified, based on their relative risk. A suite of intervention options should then be developed and available to patients based on individual needs. |
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<th>Establish shared referral pathways and protocols</th>
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| • Develop agreement on shared clinical pathways and protocols.  
  • Implement risk stratification to care plans based on risk and need. This enables the health team to coordinate the delivery of care from a range of service providers across settings.  
  • Facilitate integration of care pathways across providers and agencies.  
  • Build on existing entry points to the health system to expand on models for improving information flow between various agencies and sectors.  
  • Respond to the demand for clinical information and exchange by focusing on improving the timeliness, quality and safety of information transfer.  
  • Identify protocols for the most complex patients and when the multi-disciplinary team provide case conferencing.  |

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<th>Develop standardised care packages</th>
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| • Ensure IT systems, processes and governance are in place to support delivery of care packages (based on disease profile and health needs of local community).  
  • Develop standard treatment protocols.  
  • Develop proactive management of illness through the development of care packages based on avoidable hospitalisation of identified disease incidence, prevalence and mortality rates.  |

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<th>Develop standardised communication channels</th>
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| • Support eHealth systems interoperability including NEHTA strategic priority 2 including: improved continuity and coordination of care through clinical information transfer; enable safer medication management and; enable improved access to and use of diagnostic information (point of care).  
  • Link e-communication with Queensland Health implementation of Electronic Medical Record (EMR), Enterprise Discharge Summary  |
(EDS), e-referrals, GPQs iHealth Care Directory and e-prescribing at a national level.

- Improve lines of communication between all providers, with particular attention given to the interface between primary, secondary and tertiary care, after hours providers, mental health and social care providers.
- Develop sustainable systems for timely and appropriate exchange of patient information between Medicare Local, Local Hospital Networks and primary care service providers.
- Utilise the Continuity of Care Planning (CCP) Framework for Queensland to support continuity of care around referral, discharge planning between general practitioners and hospitals.
- Where possible increase shared electronic patient information.
- Assist in the development of sustainable systems to enhance communication and transition of information of patient care between primary and tertiary sectors prior to admission and following discharge from hospital.
- Expand the suite of communication tools available for cross sector use including directories, guidelines, care pathways, referral templates, discharge summaries.
- Enable a culture of change through communication, motivation and marketing.

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**ENABLER: ORGANISATIONAL AND WORKFORCE DEVELOPMENT**

**STRATEGIES**

Support the development of cross sector (primary, secondary and tertiary health sectors, and community sector) structures

**ACTIVITIES**

- Establish governance structures to support cross agency activity - establish local cross-agency networks/partnerships.
- Establish clinical governance across the network of agencies to support implementation of agreed integrated model(s) of care, ensure quality and standards, and information sharing.
- Establish or enhance structures to support local service providers to support the Framework implementation (e.g. steering committee, partnership council, working groups etc.)
| **Support and participate in strategic development across sectors** | **• Work collaboratively on mutual education activities to improve understanding of each sector's contribution to care.**  
**• Support the development and monitoring of integrated service delivery.**  
**• Develop clear governance structures to provide transparency and accountability to partners and the community.**  
**• Develop processes and evaluation mechanisms to monitor performance.**  
**• Establish structures to support the coordination of services across providers.**  
**• Undertake joint strategic planning across agencies and community.**  
**• Develop shared purpose, clear goals across agencies and communities.**  
**• Develop strategic health action plans (with identified priority areas) as a joint planning tool.**  
**• Assist in the development of systems to improve partnerships between Medicare Locals, Local Hospital Networks, general practitioners and primary care service providers to implement models of shared care to direct patients to the most appropriate setting.**  
**• Ensure the organisational culture supports a network approach to working together to understand the various cultural make up of the various partners.**  
**• Build the capacity of informal leaders and champions within the network.**  
**• Manage and communicate the changes to wider stakeholders.**  
**• Ensure consistent branding, marketing and promotion of key outcomes to communities and stakeholders.**  
**• Increase focus on addressing the burden of disease through strategies focused on prevention, early intervention, treatment and management of disease across various health settings.**  
**• Improve communication between health service districts (through Local Hospital Network) and primary care services (through Medicare Local) to support collaborative** |
| Build education and training opportunities | - Identify opportunities to enhance the knowledge and skills of clinicians from primary, secondary and tertiary sectors.  
- Develop a health education strategy with educational needs and priorities determined at the local level.  
- Ensure educational activity targets gaps in knowledge to ensure it is meaningful and useful.  
- Develop preventative health approaches through education and training.  
- Support development of educational tools and resources.  
- Support the development of training in the use of tools and resources.  
- Provide training to primary care providers on the use of directories, minimum data sets and quality referral.  
- Facilitate and enable the education of primary health care teams, GPs, hospital residents, registrars and consultants working with and through other stakeholders as required.  
- Ensure service providers have access to quality research, initiatives and training to support quality health service provision.  
- Actively participate in undergraduate level placements. |
| Build capacity and capability of the workforce | - Support the development of clinical and practice capacity building strategies.  
- Build on workforce expertise and understanding of primary care and hospital cultures and context.  
- Support attendance of service providers at key meetings, workshops and forums.  
- Coordinate interdisciplinary training and/or peer support activities.  
- Expand and create new roles and workers (hybrid workforce) using experience from international evidence (e.g. health navigators, knowledge brokers, 'guided care' nurses). |
| Role definition | • Provide competency based training and education to broaden generalist training to medical, nursing, allied health as well as eHealth, business and human resource management.  
• Provide workshops with team members to recognise the benefits of working together and to promote accountability as a collective responsibility. |
| Increase service provider knowledge on access and scope of practice of other providers | • Define and document critical health service integration roles.  
• Identify how roles are linked and operate across the region (map roles across the region).  
• Consult and refine the various roles and how they relate.  
• Support the development of clearly defined roles for clinicians involved in case management, telehealth, health promotion and prevention.  
• Facilitate discussions to encourage decision-making agreement across local service providers in the allocation of critical roles to the most appropriate service.  
• Develop position descriptions for critical health service integration roles.  
• Identify what the incentives are for teamwork.  
• Develop effective mechanisms to resolve conflict. |
| Increase service provider knowledge on access and scope of practice of other providers | • Develop or enhance a local resource directory.  
• Develop local marketing material in electronic and hard copy to promote access to local services.  
• Hold and build on ‘meet and greet’ functions.  
• Develop a knowledge translation strategy.  
• Establish or broker liaison/coordination positions to coordinate activity (service providers may be able to pool funds and share the position).  
• Target strategies at wider audience including emergency services, schools, prisons, Centrelink, churches, employment agencies, accommodation services, Home and Community Care, police, etc.  
• Identify opportunities for co-location of service providers, intern placements. |
| Support research opportunities and innovation | • Develop a research and development (R & D) strategy.  
• Identify linkages to research agencies/university expertise  
• Link research to local health planning and identification of priority areas.  
• Explore new and emerging models of care using evidence based best practice (including evaluation).  
• Enable the implementation of change that is both grounded and innovative.  
• Build research and innovation capacity through workforce support and joint research fellowship opportunities. |

| ENABLER: OUTCOMES BASED INCENTIVES |  |

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<th>STRATEGIES</th>
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| Promote cross-sector relationships | • Develop care packaging funding models.  
• Consider fund pooling between key stakeholders based on mutually agreed outcomes.  
• Investigate joint service provision models including brokerage models, cluster service provision, sub-contracting services through medical practices or groups of medical practices and ‘sharing’ of allied health or nursing positions.  
• Development of joint indicators for performance and accountability framework.  
• Establish performance management strategy based on inputs, processes and outputs, which lead to desired outcomes.  
• Development of joint disease registry and measurement of service delivery, population health and individual health outcomes. |

| Explore funding based incentive mix | • Explore funding options for patient enrolment for complex conditions based on capitation payments.  
• Explore model that enables multidisciplinary care including team-based bonuses.  
• Investigate practice nurse and allied health |
| Identify performance and practice incentives for multidisciplinary team based care | ● Identify and establish incentives and systems that support generalism across sectors including developing models of sustainable multidisciplinary practice, which are responsive to community need.  
● Develop model that enables multidisciplinary care.  
● Identify what the incentives are to promote team based care.  
● Identify what the extent is for regulatory mechanisms which support/value/reward teamwork?  
● Define workforce roles and competency standards. |
| --- | --- |
| Develop evaluation, monitoring and surveillance strategy to measure outcomes. | ● Ensure accountability by promoting transparency through making performance measures of Medicare Locals and Local Hospital Network publicly available.  
● Develop an integrated data platform.  
● Use evidence based approaches to funding and planning by MLs, LHHNs and health providers to focus improvement effort of quality outcomes measures.  
● Develop tracking and surveillance systems.  
● Use comparative measurement, evaluation and data analysis to track performance. |
- Use evidence based metrics and methodologies to evaluate outcome measures.
- Evaluate and monitor service outcomes and activities.
- Identify service gaps and under-utilised services.
Section Three

Statewide Key Enablers (Statewide Implementation Guide)

A directory of statewide key enablers appears on the following pages. This directory can be used by Medicare Locals, Local Hospital Networks and service providers to either implement key enablers of the Framework within their own service, or to facilitate broader regional implementation with other local service providers.

Statewide Key Drivers and Context

To address the statewide key enablers required to support a comprehensive integrated health system, two overarching statewide key enablers of policy and strategy and systems level development are required. These factors will be addressed in supporting the four local key enablers to health service integration in Queensland.

DIRECTORY

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<th>ENABLER: POLICY AND STRATEGY</th>
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<td><strong>STRATEGIES</strong></td>
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<tr>
<td>Supportive policy for</td>
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<td>sustainable health services</td>
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| **Collaborate to ensure commonwealth and state relations are streamlined** | • Develop streamlined policy to enable cross-sector networks to develop and implement sustainable cross sector models appropriate to community need.  
• Ensure partner bodies have clear understanding of requirements.  
• Assist in refining indicators for the local settings.  
• Support e-Health capacity development between general practice, primary care and hospitals.  
• Support development of streamlined data management processes. |
| **Develop policy to support rural and remote considerations for mainstream services** | • Advocate for unique settings based approach for rural and remote communities.  
• Develop policy to ensure program and service delivery protects and promotes the health needs of people living in rural and remote communities.  
• Ensure essential health care is made universally accessible to individuals and families in rural and remote communities in the spirit of self-reliance and self-determination. |
| **Support planning and engagement** | • Work with all stakeholders in an advisory capacity to ensure that cross sector integrated services are appropriate to local needs and in line with state and national priorities (planning and engagement).  
• Ensure representation of professionals at executive level partnerships, networks and other relevant groups to enable clinical involvement in commissioning decisions.  
• Provide integrated health leadership and representation to inform and advise on the delivery of care for Queensland people.  
• Incorporate and enhance service provision with a consumer and carer focus.  
• Increase opportunities for feedback from consumers and carers on policy and service developments. |
| Support continuity of care planning | • Seek opportunities within emerging health care planning to improve continuity of care and patient journey.  
• Support development of effective continuity of care planning activities through web based repository of tools.  
• Link Framework implementation to the Queensland Continuity of Care (COC) Framework.  
• Develop or enhance a clear set of recommendations to funders and service providers in relation to effective shared-care models.  
• Investigate the effectiveness and efficiency of co-located services. |
| ENABLER: SYSTEMS DEVELOPMENT |  |
| STRATEGIES | ACTIVITIES |
| Provide support for cross sector coordination to facilitate inter-sectoral coordination of primary health care activities | • Ensure structures and systems in place to support cross sector statewide coordination.  
• Ensure state level stakeholders proactively influence policy and project development through efficient communication mechanisms.  
• Increase knowledge and awareness of integration activity.  
• Support state level mechanisms for consumer input (e.g. engagement with Health Consumers Queensland).  
• Support development of educational tools and resources. |
| Support for development of statewide network | • Support development of statewide network to enable cross sector learning, sharing of resources, knowledge translation and reporting.  
• State level partners have formal collaborative arrangements in place.  
• Develop knowledge sharing strategy to ensure stakeholders are involved in decision-making and informed of latest developments.  
• Work collaboratively with local networks to ensure there are sufficient resources to meet local demand. |
| Support provided to regions to improve linkages across health | • Provide state level support, leadership and coordination to implement the Framework. |
| sectors | • Develop strategies for broad sector stakeholders participation in the implementation of the Framework.  
• Support workforce development and coordination of new roles and emerging models of care.  
• Support the development of local participation in policy development. |
References


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