International Experiences of Primary Health Care – linkages and lessons for Australia

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Context: National primary care trends / initiatives

- National PHC Strategy / PHC Framework.
- PHCAG, Medicare Review, Federation reform.
- RACGP: ‘Quality General Practice of the Future’.
- NSW Government: Integrated Care Program.
- Shared boundaries: LHNs and PHNs.
- Map of Medicine / Health Pathways.
- McKeon Review.
- ‘Co-creation’ between service delivery networks, innovators and researchers.
International trends

USA:
• Accountable Care Organisations, and
• Patient Centred Medical Home;

UK:
• Primary Care Commissioning,
• the NHS ‘5 year Forward View’

NZ:
• the expansion of PHOs
• Alliance contracting.
Accountable Care Organisations (ACOs)

• Emerged in the United States following the Affordable Care Act.

• Primarily involve hospitals and medical groups accepting responsibility for the cost and quality of care for a defined population.

• Usually a capitated budget under a contractual arrangement with a public or private insurer. They generally fall into three types:
  – organisations with integrated delivery systems offering a relatively large number of services.
  – smaller physician led medical groups offering a smaller number of services.
  – and a hybrid group led by a combination of hospitals, physicians, and health centres that offer an intermediate range of services.

• Long-established and better-known ACOs include Kaiser Permanente, Group Health Cooperative of Puget Sound, Geisinger, and Intermountain Healthcare.

http://www.bmj.com/content/bmj/350/bmj.h2005.full.pdf
Accountable Care Organisations (ACOs)

• The US now has about 750 ACOs serving an estimated 20 million people.

• The recent second year results on the Medicare Pioneer and Shared Savings ACOs show that they saved over $372m (£250m; €350m).

• Pioneer ACOs savings were significantly greater among those with higher baseline spending.

• Measures of quality and patient experience also improved.

• Need to allow time to build the relationships and payment systems that enable general practitioners and specialists to work together to improve care.

• Focus on high risk patients and IT powerful enablers.
The patient centered medical home (PCMH)

The core features

• Personal physician - each patient has an ongoing relationship with a personal physician who provides first contact, and continuous and comprehensive care. Physician directed medical practice – the personal physician leads a team of individuals who collectively provide care for the patient.

• Whole person orientation – the personal physician is responsible for meeting all the patient’s health care needs or for arranging care with other qualified professionals.

• Care is coordinated and integrated across all elements of the complex healthcare community - coordination is enabled by patient registration, information technology, and health information exchanges.

• Quality and safety - hallmarks of the patient centred medical home.

• Evidence-based medicine and clinical decision-support tools guide decision making - physicians in the practice accept accountability voluntary engagement in performance measurement and improvement.

• Enhanced access to care is available - open scheduling, expanded hours, e-access.

• Payment reform - recognizes the added value provided to patients.
The patient centered medical home (PCMH)

• Primary care services particularly those provided in general practice are the most financially and geographically accessible forms of healthcare.

• A Patient Centred Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults in a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient’s family.

• Described in US but NHHRC estimates 70% Australians have a ‘medical home’.
Overall benefits of having a medical home

• Improved health outcomes, at a lower cost with higher patient satisfaction.

• Improved continuity of care, preventive measures and reduced hospital admissions.

• Improved access to required services, including preventive screening and chronic disease management.

• Racial and ethnic disparities in access and quality are reduced or eliminated.
PCMH Cost savings

• A robust US study found there was a $10 reduction in total medical costs for every patient enrolled in a medical home each month.

• Additionally there was a:
  • 16% reduction in hospital admissions
  • $14 reduction in inpatient hospital costs - per patient/month
  • 29% reduction in emergency department use
Supporting studies – PCMH cost savings & benefits

- Grumbach and Grundy’s 2010 review of the evidence from prospective studies of PCMH interventions in the US revealed:

<table>
<thead>
<tr>
<th>Reduction in utilisation</th>
<th>Reduction in costs</th>
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<tr>
<td>32% drop in emergency department use</td>
<td>10.5% drop in inpatient specialist medical costs</td>
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<tr>
<td>36.3 drop in length in hospital stay</td>
<td>18.9% drop in ancillary costs</td>
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<tr>
<td>12.8% increase in chronic medication use</td>
<td>15% drop in outpatient specialty costs</td>
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Why adopt a ‘medical home’ approach in Australia?

- Promotes the essential role that general practice plays in providing evidence-based quality primary care from NPHCS.
- Builds on and formalizes the relationship most Australians have with their general practice, ACCHS or rural MPS.
- Fits neatly with the RACGP “Quality General Practice of the Future’.
- Accelerates benefits of:
  - Improved health outcomes for individual patients (effective management of chronic diseases, routine preventive screening, coordinated quality care).
  - Reduction of overall health expenditure with greater community care responsibility.
  - Current reform initiatives.
  - Builds on and links PCEHR roles and responsibilities.
  - Identifies A/H care and continuity of care responsibilities.
UK: Primary Care Commissioning

Key findings:

1. **CCG members have mixed views on primary care co-commissioning**
   On 1 April 2015, the majority of CCGs took on fully delegated or joint responsibility for commissioning primary care with NHS England. New responsibilities include designing incentive payments and performance-managing GP practice contracts. Although most governing body members felt positive about co-commissioning (81%), a majority of GPs and practice managers without a formal CCG role felt ‘negative’ (26%) or ‘neutral’ (43%). Many may be waiting to see how the policy is implemented before forming a view.

2. **Most GPs do not support performance management by CCGs**
   The majority of GPs accepted that their CCG has a role in supporting primary care development, particularly in influencing GPs’ prescribing patterns (which 83% support) and encouraging collaboration with neighbouring GPs and others (77%). However, few GPs supported their CCG’s use of performance management tools such as targets (25%) and sanctions (13%) to achieve these ends.
3. **Clinical engagement in CCGs is declining, but, is higher than under PBC**

2013 – 2015: the proportion of GPs highly engaged with their CCG declined from 19% to 11%; those who felt they could influence their CCG’s work declined from 47% to 34%.

However, overall GP engagement remains higher than estimates under Practice-based Commissioning (PBC).*

The survey identified a number of possible reasons for declining engagement: the majority of CCG leaders felt they lacked the time or training to fulfil their role; CCG managers were seen to be more influential in commissioning decisions than GPs on the governing body; referral and prescribing patterns had reportedly changed since the establishment of the CCG, but only 21% of GPs felt the quality of care had improved.

4. **There are some positive signs for the future**

The majority of CCG leaders planned to continue in their role for the foreseeable future, and a fifth of GPs and practice managers not currently in leadership positions were interested in getting involved.
UK: Primary Care Commissioning (Cont.)

- **Maintain positive clinician-to-clinician relationships**: in implementing co-commissioning, CCGs must make full use of their links with members to influence practices and avoid alienating members when performance-managing GP practice contracts – a CCG role that few respondents support.

- **Avoid a perception of CCGs as manager-led organisations**: clinical engagement is declining and CCG managers are already seen as more influential than GPs. To be successful in co-commissioning, CCGs must forge strong partnerships between members and managers that maximise the clinical voice, while ensuring they manage the conflicts of interest that arise as GPs Commission primary care.

- **Focus on improving quality in primary care**: few GPs feel CCGs have improved the quality of care locally. However, co-commissioning gives CCGs an opportunity to make positive changes that are visible to GPs in their day-to-day practice. This will be vital to maintaining GP engagement and driving much-needed change in primary care.
**Sustain clinical leadership**: as CCGs implement the Five Year Forward View, they will have to compete with emerging provider organisations for GP leaders’ time. Some GPs were keen to get more involved in CCG work and this enthusiasm needs to be harnessed. Practice managers appear to be an under-utilised resource, with the potential to play a more defined role in supporting the work of CCGs, as well as in the development of new delivery models.
NHS ‘Five Year Forward View’ Oct 2014

• Radical upgrade in prevention and public health
• Patient’s gain greater control over their own health
• Multispecialty Community provider
• Integrated Primary and acute care systems (ACOs)
• Redesign urgent and emergency care
• Meaningful local flexibility
NZ: Alliance Contracting

- From mid 2013, New Zealand moved to implement a governance model across the entire country, aimed at integration.

- required an alliance between each DHB and corresponding PHOs (followed investment in nine pilots).

- The alliance concept derives from the construction industry, where independent companies collaborate, rather than compete, to ensure that large, complex projects are delivered on time and within budget.
Building a culture of co-creation in research

What should governance for integrated care look like? New Zealand’s alliances provide some pointers

Multidisciplinary leadership teams and flexible approaches are helping streamline New Zealand’s health care system

While the search continues for governance arrangements that support health system and service integration, developments in New Zealand provide useful new insights. New Zealand presently has 26 distinct health boards (DHBs) planning and funding regional hospital and other services, and around 50 primary health organizations (PHOs) that plan and fund elements of general practice and primary care for enrolled patients. These two sets of arrangements have functioned largely separately from one another, despite DHBs funding PHOs and both having common populations.

New Zealand’s policymakers and health care providers have concluded that it is no longer acceptable nor sustainable to operate a health system with parallel structures that lack coordination or a governance model that supports this.

In response, from mid 2013, New Zealand has moved to implement a governance model across the entire country aimed at integration by requiring an alliance between each DHB and corresponding PHOs. This followed a two-year pilot. The alliance concept derives from the construction industry, where independent companies collaborate, not because there is a need, but because they are often working together on the same project.

Some of the pilots suggest, provide considerable promise. For example, alliances have helped drive important initiatives that provide better support for complex patients in primary care settings by enabling general practitioners to work together with hospital specialists and other providers.

While early days, there is some evidence of reductions in emergency department admissions and of more services traditionally provided in hospital settings now being delivered in the community, such as specialist outpatient consultations.

Older people, their carers, and emergency response services that might help to ensure a hospital stay. Importantly, those involved in the alliances believe it is a model that helps steer health system and service design in an important new direction.

Some important factors underpin the alliances. Members should:

- have the clinical leadership from across the health system, with influence and respect among colleagues;
- have a clear strategy of how to use the alliance table, so decisions can be implemented, and
- have a mandate for action and who is responsible for the leadership role, and who is responsible for the leadership role, and who is responsible for the leadership role.

Most important, no single stakeholder will be able to make decisions without the influence of all others. This is being explored by the rapid funding arrangements, whereby the PHO can use existing ring-fenced allocations in new ways devised by the alliance. The ESS is expected to contribute to this pool which will grow as the health system evolves.

How alliance performance will be measured is an important question that the government is taking seriously. An ongoing evaluation is necessary.

Building a Culture of Co-Creation in Research
NZ: Alliance Contracting

• Important factors underpin the Alliances.

• Members should be clinical leaders from across the health system, with influence and respect among colleagues;

• have capacity to bring resources to the alliance table so decisions can be implemented; and

• very importantly, cast aside sectoral interests, work to assist one another, and take a whole-of-system approach to planning and decision making based on what is best for the patient and health system.
Alliance Contracting - early results

- Reduced ED admissions.
- Avoidable hospitalisations.
- Improved primary care support for complex patients in primary care settings.
- Improved Older People’s health.
- Out-patients services in the community.
- Rural health.
- Pharmaceuticals.
NZ: PHOs

- Primary health organisations (PHOs) are funded by district health boards (DHBs) to ensure the provision of essential primary health care services, mostly through general practices, to those people who are enrolled with the PHO.

- Currently there are 32 PHOs that vary widely in size and structure, although all are not-for-profit organisations. A PHO provides primary health services either directly or through its provider members. These services are designed to improve and maintain the health of the enrolled PHO population, as well as having responsibility for ensuring that services are provided in the community to restore people’s health when they are unwell. The aim is to ensure GP services are better linked with other health services to ensure a seamless continuum of care.

- Some PHOs have recently amalgamated but still report separately, which is why 36 PHOs are shown in the How is my PHO performing? information.
How is My PHO performing?

2016/15 Quarter Four (April to June) Results

Increased Immunisation
Using Technical Advisory Services (TAS) Data

Better Help for Smokers to Quit
Using Technical Advisory Services (TAS) Data

More Heart and Diabetes Checks
Using Technical Advisory Services (TAS) Data

More information on the health targets can be found on www.health.govt.nz/healthtargets

New Zealand Government

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Pre-Conference Conference Workshop

Monday 14th March 2016

Transforming Primary Care at practice level – creating and evaluating a ‘Medical Home’

Facilitators - Prof J. Nwando Olayiwola & Prof Kevin Grumbach (tbc), University of California, San Francisco, Dept of Family and Community Medicine, San Francisco, USA

Prices: $250 for Conference Delegates or $450 to only attend the workshop

Abstract Submission Closing 15 September 2015

The conference planning committee invites clinicians, researchers, consumers, policy makers and health care organisations to submit abstracts for presentations or posters that reflect the conference themes. Submissions close on 15th September 2015

Conference Themes
Primary Care in Transition, Primary/Secondary Health Care Integration, Quality and Capacity Development, E-Health, Measurement, End-Users as Partners, Change Management, Innovation, Incentives, Improving the Health Care Value Proposition

Click here for more information on Abstract Submission
Click here to submit your abstract

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Prof J. Nwando Olayiwola
University of California, San Francisco, Dept of Family and Community Medicine, San Francisco, USA

Ms Shelley Frost
Chair GPNZ

Dr Robin Osborn
The Commonwealth Fund, New York, USA

Prof Trish Greenhalgh
Professor of Primary Care Health Sciences, Nuffield Department of Primary Care Health Sciences, UK

Dr Paul Grundy
Patient-Centred Primary Care Collaborative, USA

Prof Kevin Grumbach
University of California, San Francisco, Dept of Family and Community Medicine, San Francisco, USA

Dr Rachael Addicott
The Kings Fund, London, UK

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Canterbury & West Coast District Health Boards, NZ

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