

Holistic Approaches to People-Centered Care

New Models for Service Delivery Built on Strong Primary Health Care

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Summary

- Challenges: why the need for a new service delivery model?
- Emerging and transformative models
 - People-Centered Integrated Health Care (PCIC)
- Findings from PCIC case work
 - 8 actions areas/tenets of PCIC models
 - Examples
- Implementation: the improvement model

Service Delivery: Missing Leg of UHC?

- Financial protection and service coverage: What is meant by service coverage – not just benefit entitlements – but received care
- Effective coverage: all receive the quality care they need (preventive, curative, promotive, rehabilitative and palliative) in a timely, appropriate and affordable manner
- Two challenges:
 1. Complex and increasing burden of NCDs
 2. Current design of health delivery

Worldwide Health Challenge

Non-Communicable Diseases (NCDs)

- The leading causes of death and disability have changed from communicable diseases in children to NCDs in adults.
- **38 million people die each year from NCDs** (mainly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes).



Source: WEF 2011, WB and IHME, 2013

- Over 14 million of these deaths occur between the ages of 30 and 70, of which 85% are in developing countries.
- If “undealt with,” NCDs represent a major threat to development, competitiveness and economic growth. By 2030, NCDs will cost US\$ 47 trillion, representing 75% of the global GDP in 2010.

Challenge: Health Service System Design and Processes

Care model

- Treatment orientation: emphasis on acute care and discrete interventions
- Facility-based; physical consultation; infectious disease orientation

Fragmentation

- Lack of integration of preventive, curative and palliative care
- Uncoordinated and often siloed providers

Hospital-centric structure (in many countries)

- Race to the top; bypassing of PHC

Distorted incentives

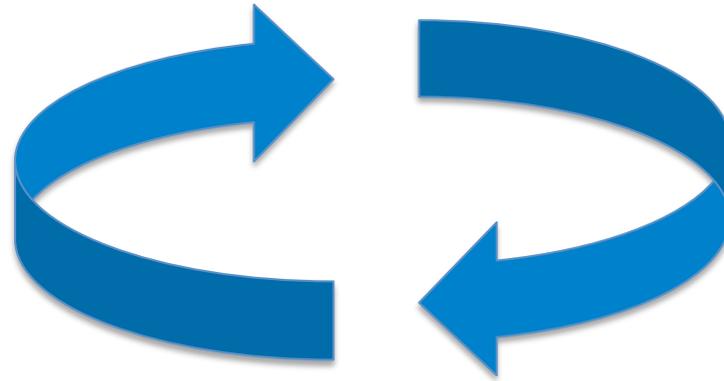
- Private sector: Provider-induced demand
- Public sector: Low level of effort

Weak focus on quality improvement

- Lack of data



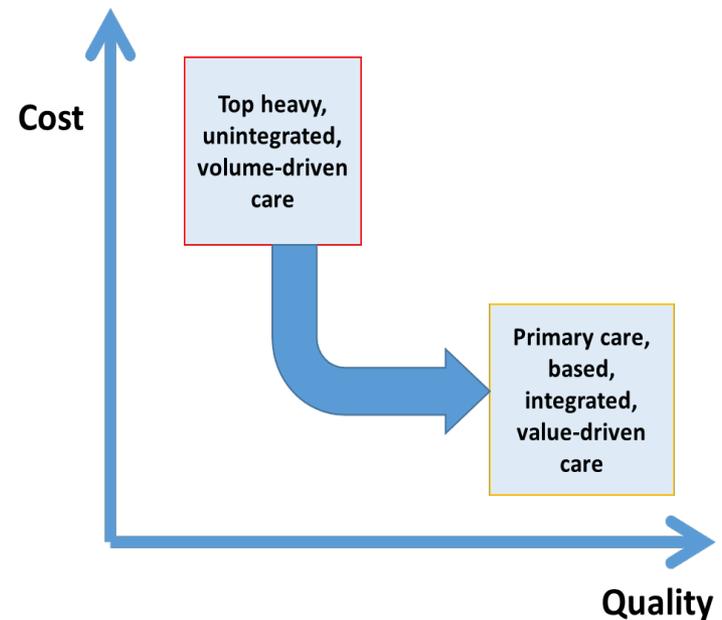
An Emerging and Transformative Service Delivery Model



Service Delivery with Better Value, More Balance and Increased Efficacy

An improved health system addressing 21st century challenges:

- Ensures continuity of care
- Anticipates health needs
- Bases care on evidence
- Effectively coordinates care
- Supports people to take responsibility for their own health
- Constantly identifies and reduces inefficiencies
- Shares knowledge and enables IT

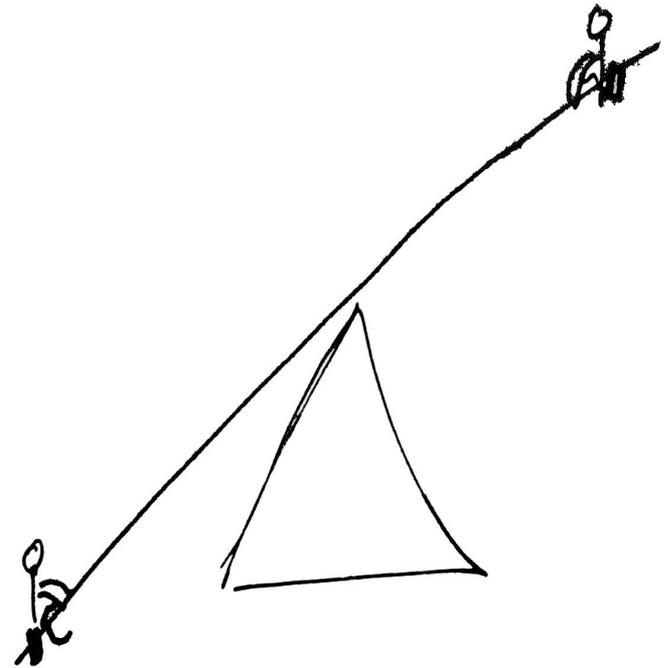


What Do We Mean by Value?

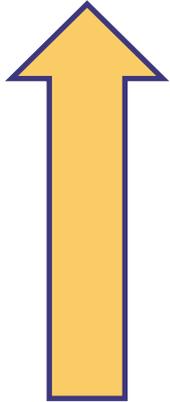
- Achieving the most health for the money spent
- Improving care experience and patient trust
 - Providing care that is effective, safe and reliable
- Improving the health of the population
 - Reaching out to communities and households with a focus on prevention, control and management of chronic diseases
 - Integrating care across provider levels

What Do We Mean by Rebalancing Service Delivery?

- Shifting away from acute care orientation, hospital-centric episodic care and fragmented delivery systems
- Shifting away from volume-based and FFS-based transactions
- Focus on changes in the entire delivery system (holistic approach), not just specific elements thereof

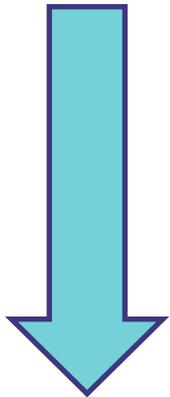


Goal: Better Health, Not More Treatment



More

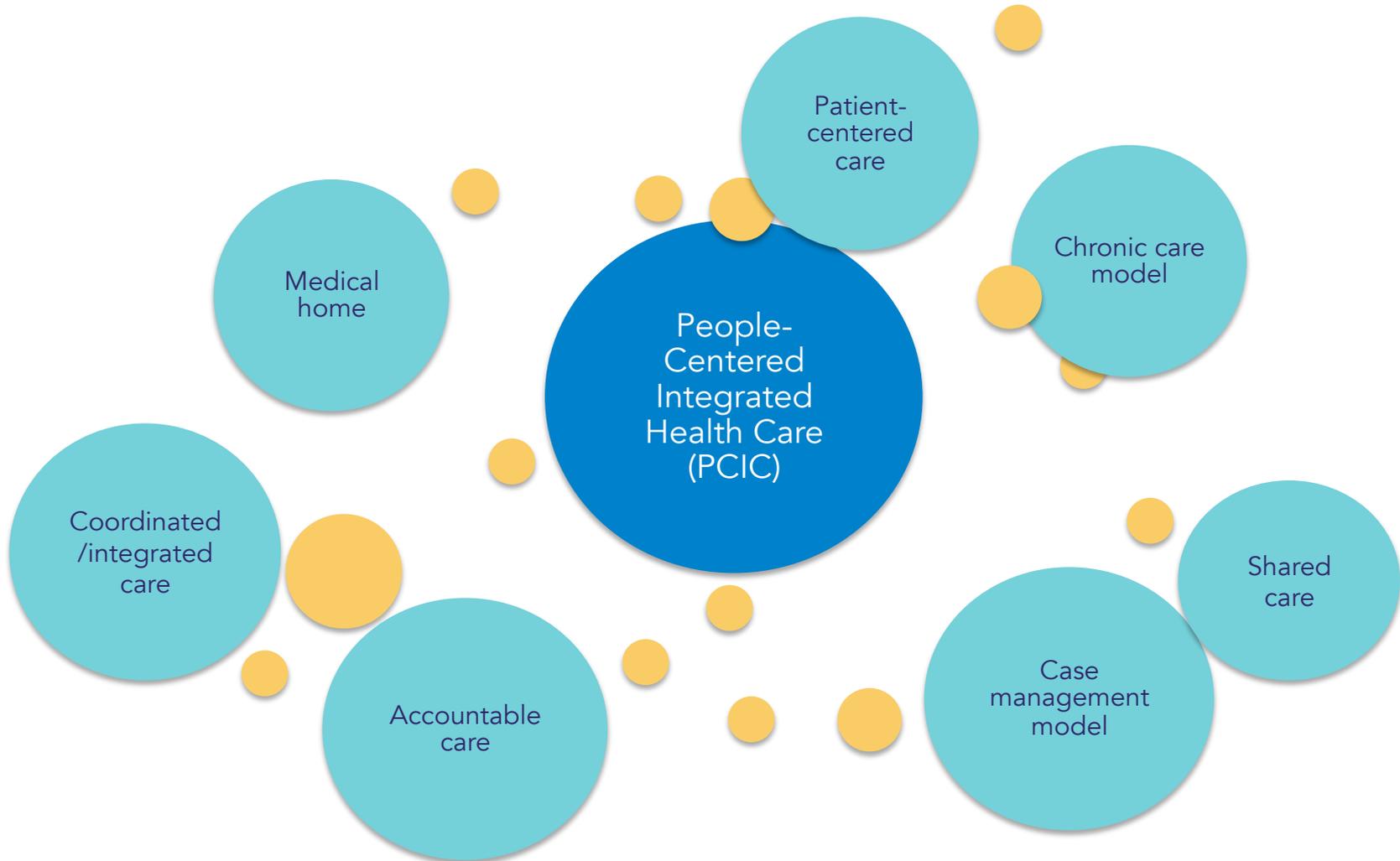
- Prevention and early detection of illness
- Outreach to and engagement with communities/families
- Correct diagnosis, appropriate (timely) treatment and follow-up
- Central role of primary care: cost-effective treatment location
- Emphasis on quality, costs and outcome measurements



Less

- “First-stop” hospital-based specialty care
- Hospital admissions, readmissions and extended stays
- Separation between inpatient, outpatient and rehabilitation care
- Separation between public health and health care
- Unnecessary care (e.g., prescriptions, tests)

New Delivery Approach: Many Names

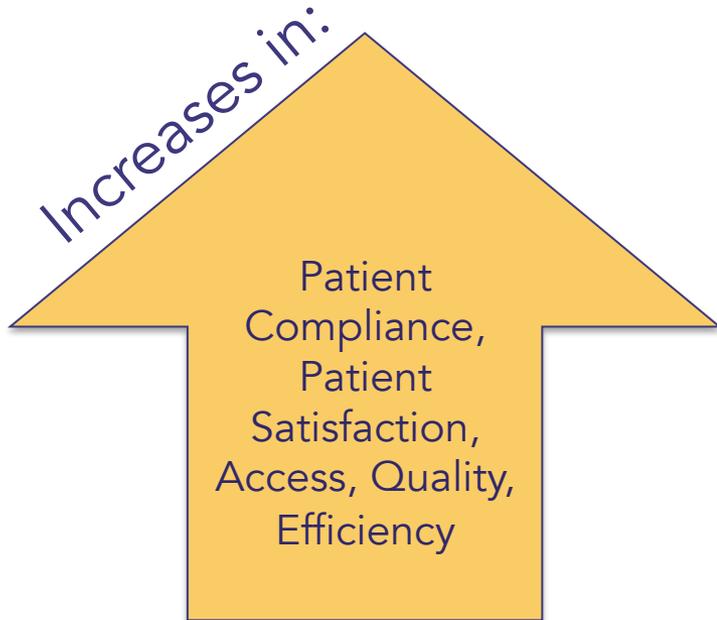


A Paradigm Shift? Toward a New Service Delivery Model

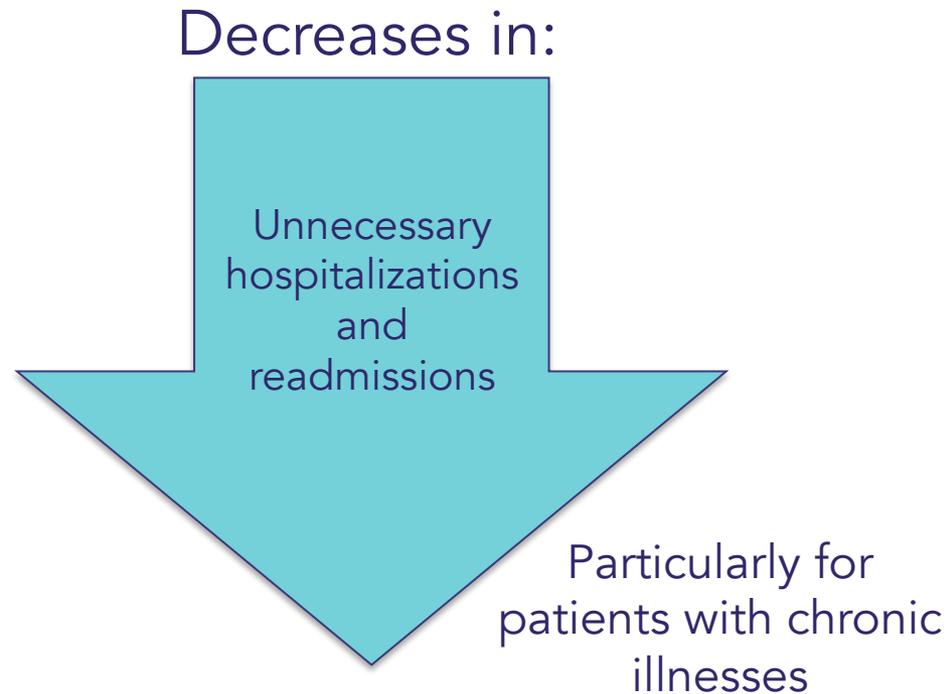
Conventional Care	People-Centered, Integrated Care
Focus on illness and cure	Focus on health needs, disease control and prevention
Patient-provider relationship limited to consultation	Patient-provider relationship is enduring and personal
Focus on episodic curative care/discrete interventions	Comprehensive, continuous and person-centered care; long-term chronic disease management
Responsibility limited to consultation advice	Responsibility for health care along the life cycle
Users are recipients of health/ medical interventions	People are partners in managing their health. Preferences/motivations are integrated into care planning.
Disjointed care: fragmented "stand-alone" facilities and programs	Integrated care delivery on professional, clinical and organizational levels; strong communication
Physician and hospital based	Team and network based
Incentives for volume-based care/ unnecessary care	Incentives for care management, population health, quality and efficiency

Adapted from WHO, 2008; Porter, 2010; Sanigest, 2010

Emerging Evidence From PCIC Approaches



Specific improvements in:
Follow-up care
Continuous care
Reduction in practice variations



World Bank Study: 22 Case Studies of PCIC-like Initiatives Across 11 Countries

Objective

Provide in depth analysis of PCIC initiatives in relevant high- and middle-income countries, with attention to emerging service models, including design features, enabling factors in financial, institutional and organizational environment, impacts and implementation arrangements and lessons.

Case Study Research Dimensions

Rationale

Why?

Design features

What?

Policy, finance and
institutional environment

Under what conditions?

Outcomes

How?

Implementation

Any effects?

Core Action Areas and Implementation Strategies in Support of PCIC

Core Action Areas	Implementation Strategies	JLN Country Examples (next session)
1: Primary health care is the first point of contact	<ul style="list-style-type: none"> Use empanelment to manage population health Stratify risks of empaneled population Strengthen and target gatekeeping Expand accessibility 	Ghana Turkey
2: Multidisciplinary Teams	<ul style="list-style-type: none"> Define team goals, composition, roles, culture, and leadership Form individualized care plans between care teams and patients 	US/VHA
3: Vertical integration, including new roles for hospitals	<ul style="list-style-type: none"> Redefine the roles of facilities, especially hospitals, within a vertically integrated network Establish provider-to-provider relationships through technical assistance and skill building Develop formalized facility networks 	Malaysia
4: Horizontal integration	<ul style="list-style-type: none"> Promote horizontal integration: service co-location Integrated care around the individual user can promote more patient-centered care 	Kenya

Core Action Areas and Implementation Strategies in Support of PCIC

Core Action Areas	Implementation Strategies	JLN Country Examples (next session)
5: eHealth	<ul style="list-style-type: none"> Establish electronic health records systems (EHR) accessible to providers and patients Establish communication and care management Ensure interoperability of eHealth across facilities and services 	Malaysia
6: Integrated clinical pathways and dual referral systems	<ul style="list-style-type: none"> Craft integrated pathways to facilitate care integration and decision support for providers Promote dual referrals within integrated facility networks 	India
7: Measurement and feedback	<ul style="list-style-type: none"> Utilize standard performance measurement indicators Create continuous feedback loops linked to action plans to drive quality improvement 	Argentina India
8: Accreditation and certification	<ul style="list-style-type: none"> Develop accreditation criteria which are nationally and locally relevant Set targets for criteria and use to certify facilities 	Philippines

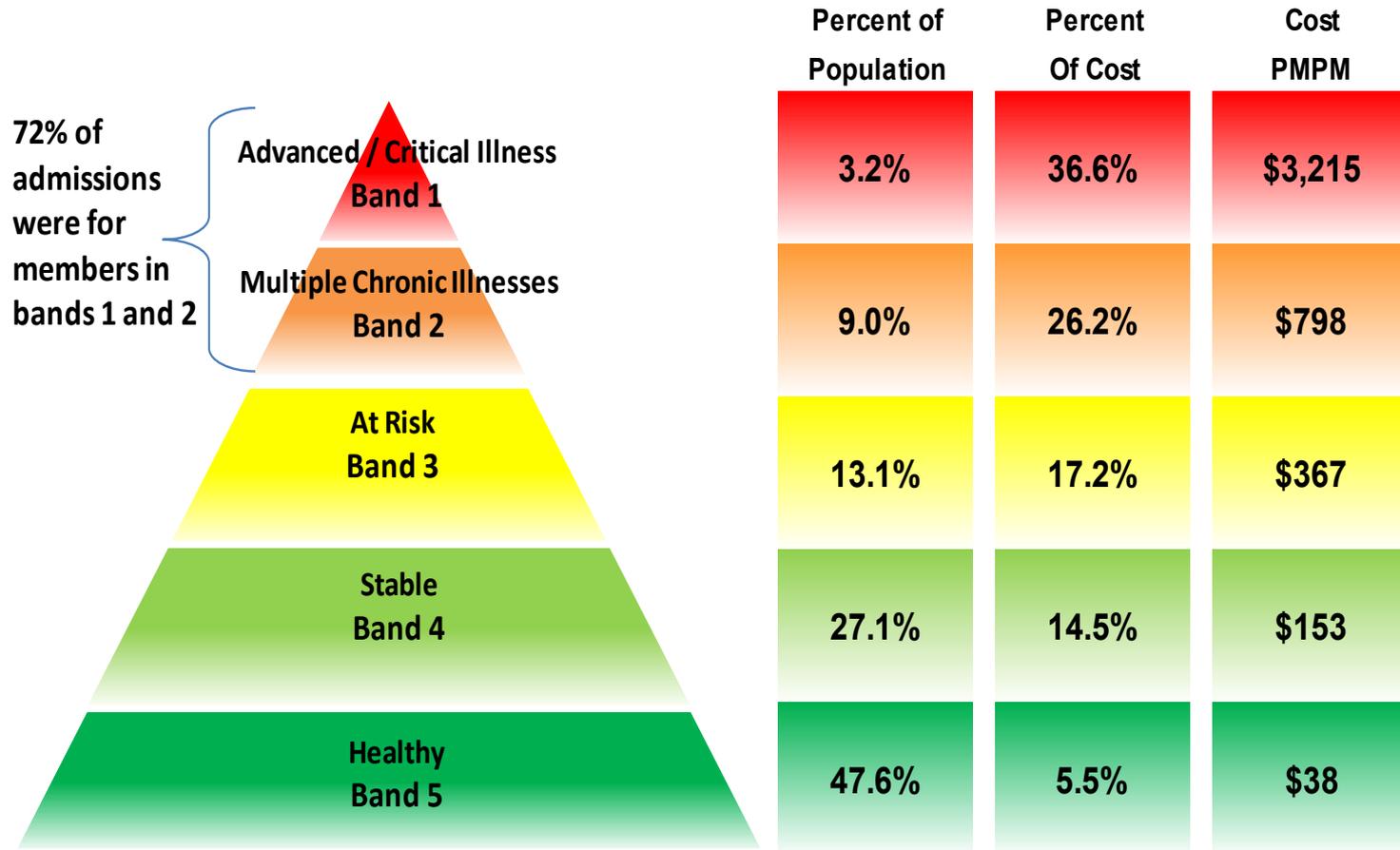
Examples of Action Areas/ Tenets from Case Studies

1. Primary Care as First Point of Contact

- Population empanelment
 - Turkey/Family Health
- Gatekeeping
 - China/Hangzhou: Explicit gatekeeping for patients with diabetes or hypertension
 - Several countries: Implicit gatekeeping: patients encouraged to first see primary care provider: hospital co-payment/fees reduced or waived
- Risk stratification
 - Germany: Risk status questionnaire upon enrollment
 - Maryland/USA Carefirst: Illness burden score based on 12 months of claims and diagnostic data: five bands

CareFirst, Maryland, USA

Illness Pyramid – Under 65 Population

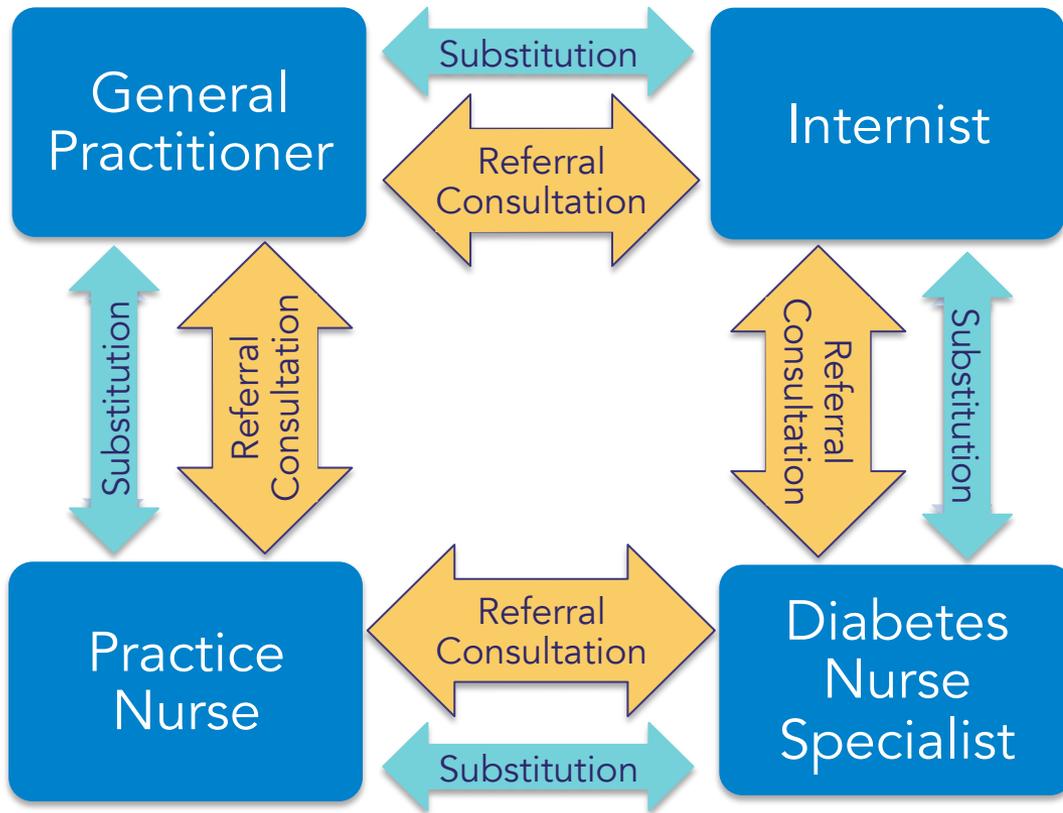


Source: CareFirst HealthCare Analytics – Commercial, Under 65 Population – 2013

2. Functioning Multidisciplinary Teams

Netherlands: Care substitution for diabetics among multidisciplinary team involving hospital-based specialists and primary care physicians and nurses

Netherlands and others: Individual care plans for the chronically ill



3. Vertical Integration, Including New Roles for Hospitals

- Xi County, Henan, China
 - Hospitals responsible for improving the capacity of primary care providers
 - Rotation of specialists
 - “green” channel referrals
 - PHC-hospital contracts: specified patient flow pathways under NCD management
- Hangzhou, China
 - Formation of “joint centers” staffed by hospital specialists and primary care professionals to manage patients with diabetes and hypertension
- Fosen, Norway
 - Virtual network between primary care centers and hospitals: daily teleconference meetings and joint teleconsultations

4. Horizontal Integration

- Fosen, Norway
 - Co-located public health units, primary care and urgent care in single facility
- PACE Program, USA
 - Comprehensive set of health and social services for elderly with multiple chronic conditions

Major Services Provided by PACE Centers

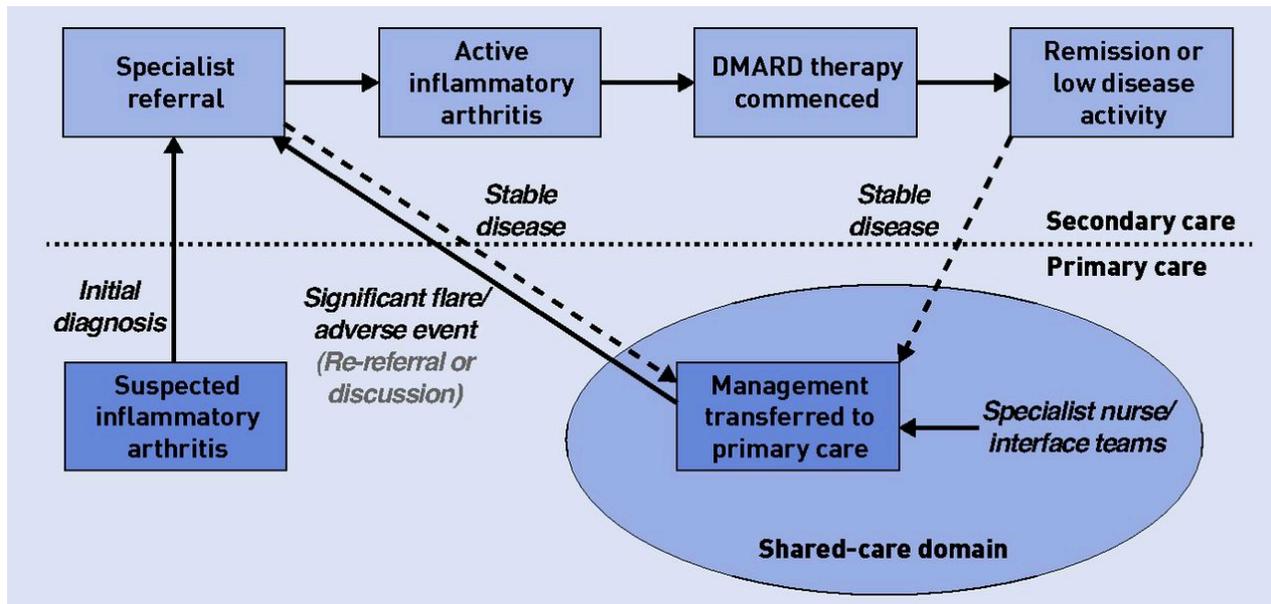


5. eHealth

- Several countries: Electronic medical records
- PACE, USA: Patient portals for self management
- Turkey: Central physician appointment system
- China: Messaging APPs
- Norway: telemedicine and video conferencing between PHC and hospitals
- China: mobile eHealth workstations for use in remote areas (check-ups, diabetes management, ECG monitoring, pulse oximetry testing,

6: Integrated Clinical Pathways and Dual Referral Systems

- Canterbury, NZ:
 - 570 integrated pathways to manage patient flows between hospitals and PHC
 - Scope of responsibility of different providers
 - Guidelines for post-discharge care

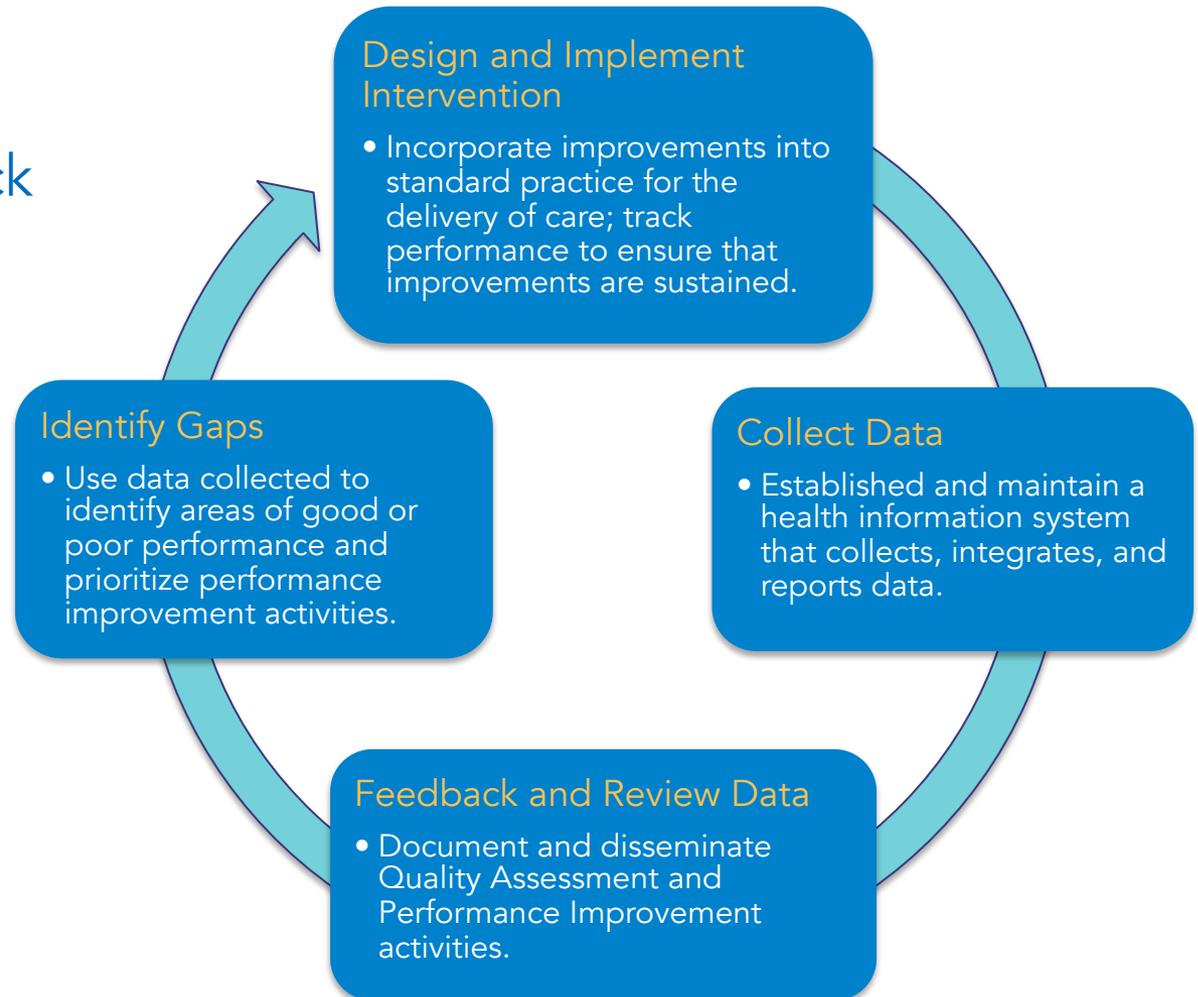


7: Measurement and Feedback

PACE Program, USA:

- Continuous feedback loops
- Data-driven quality assessment and performance improvement program

PACE Continual Feedback Loop



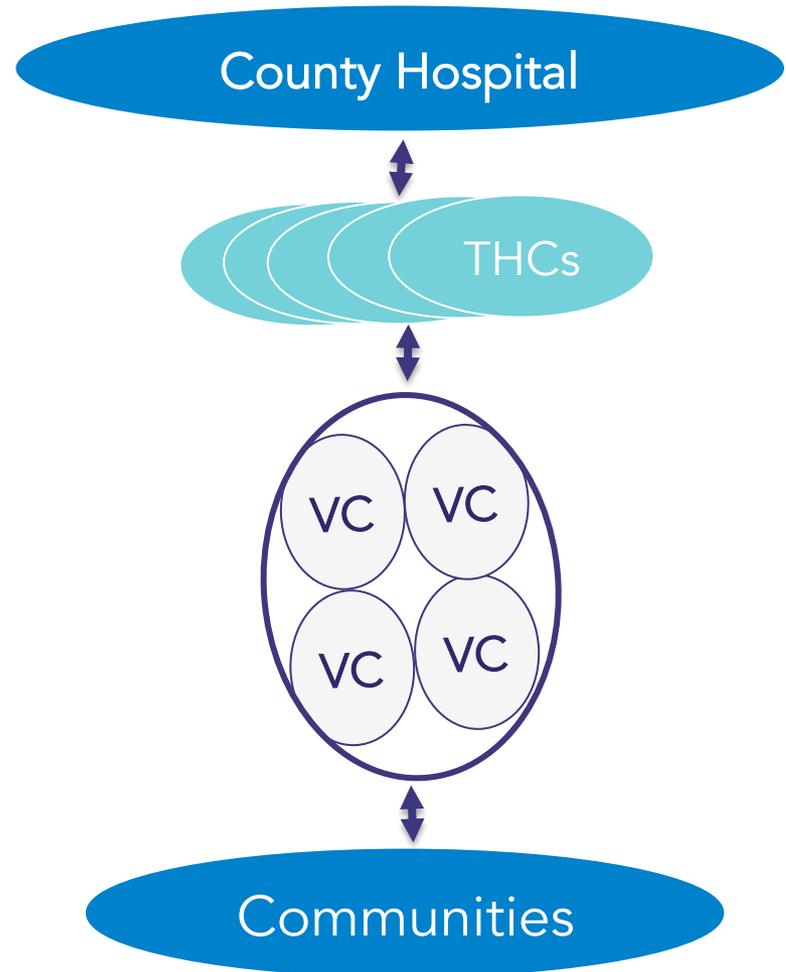
8: Accreditation and Certification

NCQA Patient Centered Medical Home Certification Guidelines

Standards	Elements	Possible Points
Patient-Centered Access	Patient-Centered Appointment Access	4.5
	24/7 Access to Clinical Advice	3.5
	Electronic Access	2
Team-Based Care	Continuity	3
	Medical Home Responsibilities	2.5
	Culturally and Linguistically Appropriate Services	2.5
	The Practice Team	4
Population Health Management	Patient Information	3
	Clinical Data	4
	Comprehensive Health Assessment	4
	Use Data for Population Management	5
	Implement Evidence-Based Decision Support	4
Care Management and Support	Identify Patients for Care Management	4
	Care Planning and Self-Care Support	4
	Medication Management	4
	Use Electronic Prescribing	3
	Support Self-Care and Shared Decision Making	5
Care Coordination and Care Transitions	Test Tracking and Follow-Up	6
	Referral Tracking and Follow-Up	6
	Coordinate Care Transitions	6
Performance Measurement and Quality Improvement	Measure Clinical Quality Performance	3
	Measure Resource Use and Care Coordination	3
	Measure Patient/Family Experience	4
	Implement Continuous Quality Improvement	4
	Demonstrate Continuous Quality Improvement	3
	Report Performance	3
Overall Total		100

Implementation Guidelines: the Improvement Model

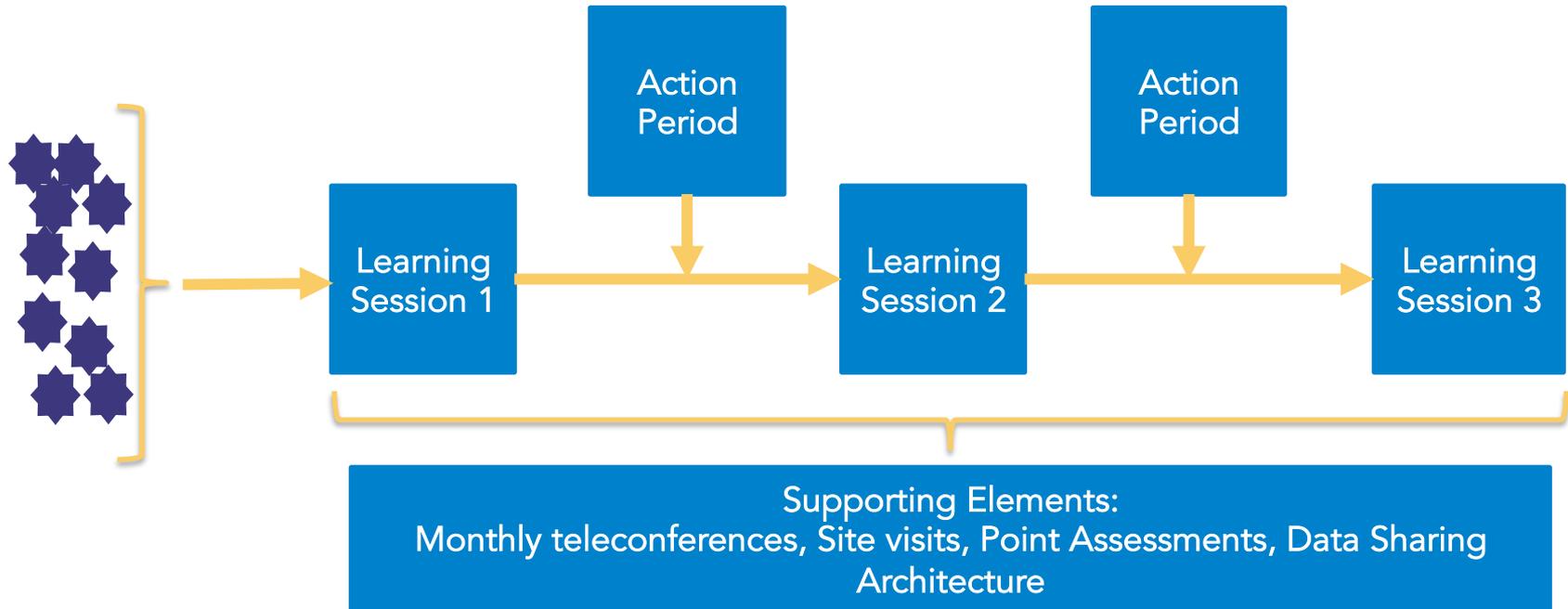
- Select a unit of demonstration that can scale. The size of the demonstration activity must be sufficiently large that it can be replicated sequentially in 3-5 years.
- Bring facilities into the demonstration in waves within the region, municipality, county or province.



Implementation Guidelines: the Improvement Model

- Use a collaborative managed learning system to implement specific reforms at a facility level.
 - Build a system for continuous learning.
- Ensure information feedback mechanisms to front-line clinics and health centers are in place.
- Build a system that measures performance on a variety of key indicators at least monthly as the rate of measurement often correlates with the rate of change.
- Develop the capability to implement health system reforms particularly at the lowest levels of the system.

Transformation Learning Collaborative (TLC) Design



- ◆ Facility level teams. Such a team will be composed of 3-5 people including the operational manager, clinical leaders and data managers from the participating facilities (hospitals, primary care centers, community workers).

Additional Lessons from Implementation

- Change must be comprehensive (not siloed)
 - How can health care contribute to population health?
- Need for paradigm shift to raise value and quality
 - Understand the system drivers of low value
 - Craft a vision of change
- Learn from elsewhere, but adapt to local context
- No one model or approach
 - Different contexts suggest different approaches
- Journey takes time; is not linear (or ever complete)
- Experimentation with evaluation (learning)

Thanks

Name and Location for 22 Commissioned Case Studies

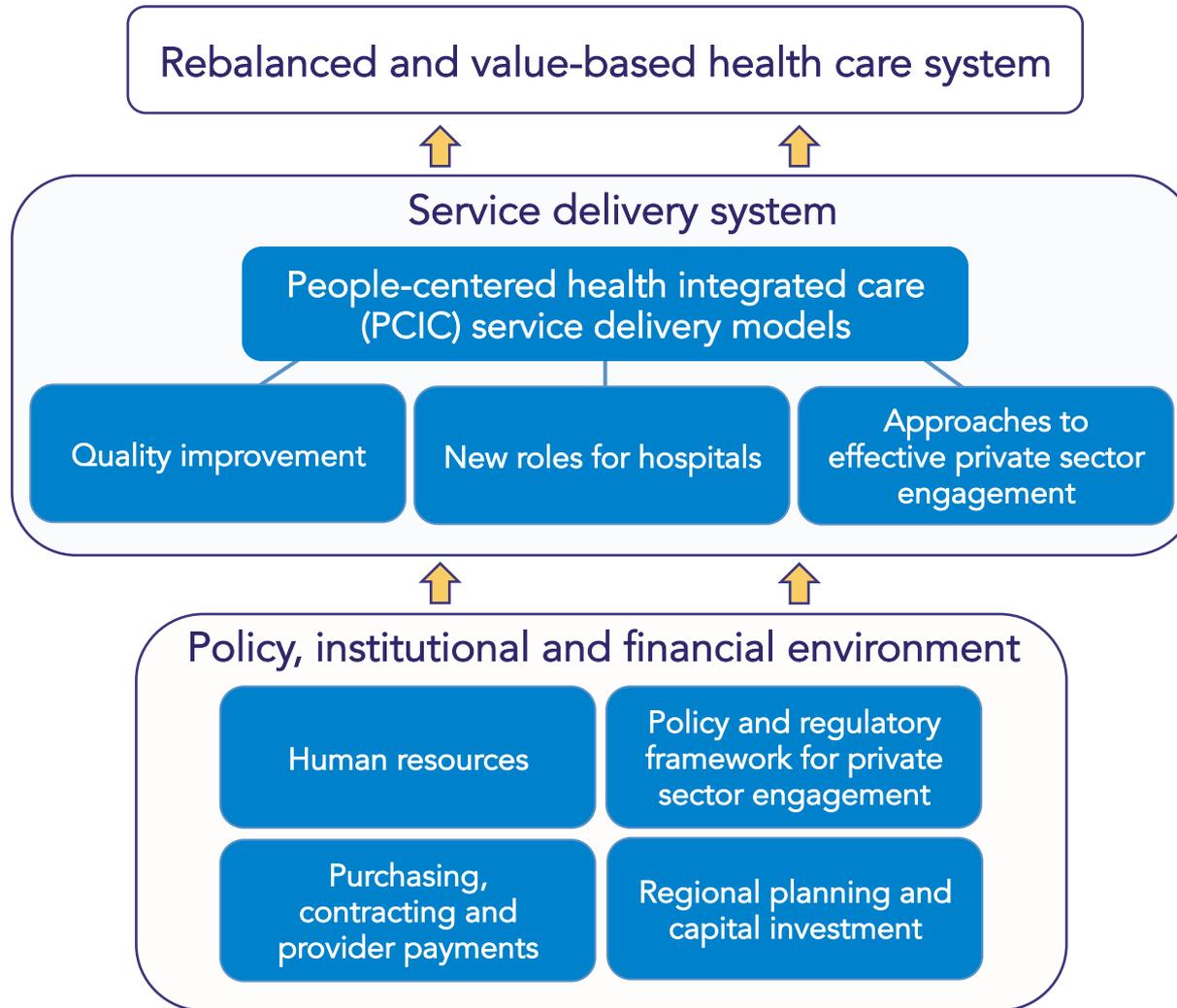
Case Studies	Location
Chinese Case Studies	
Beijing Chaoyang Hospital Alliance (CHA), Four cases	Beijing
Peking University-Renmin Hospital Integrated Delivery System (PKU IDS)	Beijing
Strengthening the Capacity of Primary Health Care (SCPHC) Twelfth Five year (TFY)	Anhui, Feixi
Health Care Alliance (HCA)	Zhejiang, Hangzhou
Family Doctor System (FDS)	Qinghai, Huangzhong
Shanghai Ruijin-Luwan Hospital Groups (RLG)	Shanghai
Integrated Care (IC)	Shanghai
Great Health (GH)	Henan, Xi
Jiangsu Zhenjiang Kangfu Hospital Groups (ZKG)	Jiangsu, Zhenjiang
International Case Studies	
Health Services Plan (HSP)	New Zealand, Canterbury
The integrated effort for people living with chronic diseases (SIKS)	Denmark
District Medical Center (DMC)	Norway, Fosen
James Cook University Hospital (JCUH) – Ambulatory Emergency Care (AEC)	England
Gesundes Kinzigtal (GK)	Germany, Kinzigtal
CareFirst Patient Centered Medical Home	United States, Maryland
Maastricht Diabetes Care (DTC)	Netherlands
Local Health Unit (ULS)	Portugal
Regional Health Systems (RHS)	Singapore
Health Transition Plan (HTP)	Turkey
Program for All-Inclusive Care for the Elderly (PACE)	United States
Veteran Health Administration – Patient-Aligned Care Teams (PACT)	United States

People Centered Integrated Health Care (PCIC) Basics

- Integration across provider levels
- Team-based accountability for population health
- IT and knowledge enabled primary care
- Emphasis on quality improvement
- Patient engagement and self management
- New role(s) for hospitals

Analytic framework

Components/
Pillars



Cross cutting analyses: diagnosis, fiscal analysis