



NAPC | National Association
of Primary Care

ACHIEVING THE PROVISION OF INTEGRATED CARE

Exploring the development and successful
implementation internationally of new
models of integrated care

MSD have funded a medical writer for this document and have contributed to content.



Patient-Centered
Primary Care
COLLABORATIVE

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Foreword

There is nothing new about the international ambition to deliver integrated systems of care. Partnership working between health, social care and local government supports the focus on keeping people well and providing responsive, tailored care at times of illness. The aim of organising services around people, rather than people around services leads to a patient-centred and seamless approach.

However, International Care Systems sometimes still struggle to move from rhetoric to reality. It is now 10 years since publication of the NHS Next Stage Review, *High Quality Care For All* (Department of Health, 2008), which set out a detailed vision for healthcare development in the UK, with an emphasis on improving the integration of care.

As the National Health Service in the UK celebrates its 70th anniversary on July 5, 2018, it is a good time to look at what progress has been made internationally.

It is difficult to define exactly what is meant by integration of care, as the concept tends to reflect the perspectives of its various international architects.

The World Health Organization's definition refers to bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion as a means to improving access, quality, user satisfaction and efficiency (World Health Organization, 2016). But even this may now be considered incomplete, since influencing the wider determinants of health is becoming as important a goal as disease prevention.

The United Nations Global Compact's Action Platform *Health is Everyone's Business* (UN Global Compact, 2018) reinforces the need to create partnerships outside of traditional healthcare systems to support sustainable living in future, especially when it comes to the management of non-communicable diseases.

What is becoming clear for all international healthcare systems is that the transition from hospital-based care to care provided in the community and at home is vital to their sustainability. This can only be achieved through integrated approaches.

We hope that this publication enhances the debate, illuminates the issues and helps to describe ways in which integrated care can be achieved for the benefit of citizens, patients, populations, care delivery systems and the care providers who work within them.

We would like to thank all the people listed at the end of this document for their enthusiastic participation in our second international symposium and Merck, Sharp & Dohme Ltd (MSD) for their support in providing a medical writer and the funding for this document. The NAPC and MSD have both contributed and had editorial control on this report.

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On behalf of the National Association of Primary Care and International Faculty for Accountable Care.

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Executive Summary

The late Senator Edward (Ted) Kennedy is credited with saying that healthcare is a right, not a privilege. However international healthcare systems are consistently experiencing pressures to deliver the care that their citizens need.

‘The NHS stands on a burning platform...’, was the dire verdict delivered by Professor Sir Mike Richards, outgoing Chief Inspector of Hospitals for the UK Care Quality Commission, in March last year, following an alarming report into the state of acute hospitals in the National Health Service (National Health Executive, 2017).

He went on to say: ‘...the model of acute care that worked well when the NHS was established is no longer capable of delivering the care that today’s population needs.’

He could have been talking about any developed country in the Western world, where growing ageing populations, an increased prevalence of multiple chronic disease and rising expectations of what health care and technology can offer, combined with limited human and financial resources, have placed these systems under intolerable and unsustainable strain.

Integrated Care Systems, where health providers collaborate with other community stakeholders to prevent ill health, provide more comprehensive care closer to home, keep people out of hospital and reduce costs, is seen as the antidote to those problems.

This approach is now spreading around the world, taking many different forms from country to country. And impact reports to date suggest that it is on the road to achieving its ambitious aims.

We use the word ‘road’ advisedly because integrated care is not a quick fix that can solve problems overnight but a ‘journey’ that can take many years to accomplish – years that may (to push the metaphor a bit further) involve running into roadblocks, changing the route, getting lost, arguing with the satnav and falling out with the family.

This report of a two-day symposium attended by health experts from the UK, USA and Ireland, traces the development and impact of integrated care to date, homes in on some examples of successful practice and draws out the key lessons for later-adopters.

We identify factors likely to facilitate success – engaged leadership at all levels, real team working, a clear grasp of local population needs, underpinned by the appropriate tools and technology, continuous learning from experience, and community involvement, with people and patients seen as key partners.

On the flip side we consider barriers that could impede progress, such as pressure for quick wins, top-down controls impeding bottom-up evolution, outdated competitive behaviours and the eventual need – at least in England – to incorporate the new approach into contracts and legislation.

Mike Richards, quoted above, went on to say that ‘transformational change is possible, even in the most challenging of circumstances’.

We hope that this report will provide encouragement and support for those already involved in the transformational change that is integrated care and a motivational spur to those yet to take their first steps on the journey.

Background

This report summarises presentations and discussions at a two-day symposium on integrated care, attended by health experts from the UK, USA and Ireland, in Dublin, on April 30 and May 1, 2018.

It followed exactly a year after an initial symposium in Washington DC, which brought together health leaders from the UK and USA to share best practice and exchange ideas and experiences about what was then called accountable care.

The report of that meeting focused on explaining the shared principles of accountable care, describing their embodiment in the English Primary Care Home (PCH) and the American Patient-Centered Medical Home (PCMH) and outlining areas of consensus on the way forward (NAPC, 2017).

This current report is more concerned with what commissioners, providers and policymakers in the UK, USA and Ireland who are taking their first steps on the integrated care journey can learn from the experiences of early adopters worldwide.

We revisit the key principles of integrated care, trace its implementation to date and examine the available evidence of its impact on patients, providers and health systems. We look at the factors critical to success in establishing Integrated Care Systems as well as the challenges and risks involved.

Finally, we present two detailed case studies (one from each side of the Atlantic) that illustrate different approaches to developing integrated care and add flesh to the bones of the briefer experiential anecdotes scattered throughout the report.

The concept of 'accountable care' was originally invoked in the USA in 2006 during discussions of the Medicare Payment Advisory Commission and enshrined in legislation through the Affordable Care Act ('Obamacare') in 2010.

However, the terminology has become controversial in the UK because of fears that accountable care could bring health and care services under the control of private companies (King's Fund, 2018). For this reason, NHS England has renamed the Accountable Care Systems launched in 2017 as Integrated Care Systems (ICSs), although they remain 'accountable' for achieving improved outcomes for the populations they serve. In this report we mostly talk about 'integrated' care.

The Case for Integrated Care

Integrated care happens when health organisations work together to meet the needs of their local populations, sometimes in collaboration with other authorities and agencies (King's Fund, 2018). The most ambitious forms of integrated care seek to improve population health by tackling the causes of illness and the wider determinants of health.

The concept has emerged and developed in response to health challenges faced by developed countries worldwide: namely ageing populations, an increased prevalence of multiple chronic diseases and a variety of behavioural health issues (Greiner *et al*, 2017). The fact that these growing needs and demands have not been matched by increased resources, places health systems under

unsustainable strain. At the same time there is unacceptable variation in access, quality, cost and outcomes in the services provided to patients (McGough, 2018).

Integrated Care Systems have different names and take different forms from country to country but all share a value-based approach, focused on delivering the best possible outcomes at the lowest cost (McGough, 2018).

Integrated care differs from traditional care in the following ways:

- It is collaborative rather than competitive;
- It works across organisational and professional boundaries rather than in rigid 'silos';
- It is concerned with broad health outcomes rather than specific processes, procedures and services;
- It is flexible and evolutionary in nature, designed to respond to local needs and build on success;
- It is characterised by a 'bottom-up', provider-led approach rather than formal nationally-imposed structures;
- It is patient-centred and rooted in primary care.

Progress in Implementation

Integrated care approaches and systems are at various stages of development and implementation in many parts of the world. In this report we focus on developments to date in England, the US and Ireland, the key participants in this symposium, and briefly summarise progress in other countries.

England

In March 2017, NHS England articulated the bold aim: 'to use the next several years to make the biggest national move to integrated care of any major western country' (NHS England, 2017).

Two years earlier, 50 vanguards, covering more than five million people, had been selected to lead on the development of 'new care models' designed to join up local health services in different ways.

One model that has proved particularly popular is the Primary Care Home (PCH), developed by the National Association of Primary Care (NAPC) to unite care providers serving populations of 30,000-50,000 in focusing on local population needs and providing care close to patients' homes (NAPC, 2018). The PCH model has now been rolled out to 212 sites in England, covering 16 per cent of the population, and the programme is to achieve cover with 25 per cent of the population by the end of 2018/19.

In 2016, NHS organisations and local councils came together to form 44 Sustainability and Transformation Partnerships (STPs) covering the whole of England and set out their proposals to improve health and care for patients.

The big development in 2017 was to upgrade 10 of these STPs – based on the quality of their plans - to Integrated Care Systems (ICSs) that are taking the lead in planning and commissioning care for their populations.

In May 2018, NHS England and NHS Improvement announced a further four areas that would become ICSs as they had received a vote of confidence in strong local leadership, partnership working and ambitious plans to strengthen primary care and integrate services for the benefit of local communities. Successful ICSs will take more control of funding and performance, with less involvement by national bodies and regulators

The next step envisioned by NHS England was to establish more formal Accountable Care Organisations (ACOs), which would take responsibility for the health and care of defined populations, managing budgets under a contract with commissioners awarded after competitive procurement.

ACOs are under discussion in a few areas and NHS England is developing a new contract to be used by commissioners wishing to go down that route. But questions over the legality of ACOs under current legislation, and fears that they will open the door to privatisation of the NHS have delayed the contract. Current indications are that only two areas of England will use it when it becomes available (King's Fund, 2018).

Creative solution: 'Call and check visits' in Jersey

'Call and check visits' is an innovative project developed by Jersey Post in the UK Channel Island of Jersey, which involves postal workers checking on isolated frail elderly residents (Hindmarsh, 2017). In the course of a five-minute visit, postal workers deliver prescriptions, remind clients of upcoming medical appointments and ask about their health and social needs. Clients' concerns are then conveyed to health care providers or community support organisations. The project has not yet been formally evaluated, but after three years of operation, anecdotal feedback has been positive, with no complaints from customers, and all postal workers involved have expressed satisfaction with providing the service. Similar schemes are now being trialled in Finland, Iceland and Ireland.

The United States

The international accountable care movement has its roots in the USA, where reform began as early as 2003, starting with hospital quality reporting programmes and, later, value-based payment programmes. These efforts accelerated over the past decade through legislation such as the Affordable Care Act (ACA) of 2010 and the Medicare Access and CHIP Reauthorisation Act (MACRA) of 2015, which transformed care delivery, moving from fee-for-service towards value-based accountable systems.

At the same time the private sector has innovated with care delivery and payment models so that 'constant change has become the new normal for physicians, nurses, hospitals and other providers across the United States' (Greiner *et al*, 2017).

One particularly successful model, widely adopted by the federal government, state governments, Medicaid and private plans, is the Patient-Centered Medical Home (PCMH), a team-based model that coordinates treatment through primary care providers and aims to provide continuous care throughout a patient's lifetime to optimise health outcomes (AHRQ, 2017). Today nearly one in five primary care physicians practise in a PCMH (Greiner *et al*, 2017).

The PCMH continues to evolve, while other models of advanced primary care have come on stream. In April 2017, Family Medicine for America's Health (FMAHealth) and the Patient-Centered Primary Care Collaborative (PCPCC) set out seven 'shared principles of primary care' (PCPCC, 2017) that have since been signed onto by 260 organisations – a number that continues to climb.

The Accountable Care Organisations (ACOs) enshrined in the ACA bring together other providers beyond primary care in various different arrangements, all focused on achieving specific patient outcomes within a set budget.

As of April 2017, there were more than 900 ACOs, 59 per cent private, 30 per cent Medicare and 12 per cent Medicaid, collectively taking care of around 10 per cent of the US population (Greiner *et al*, 2017).

Chronic disease benefits: diabetes outcomes in Florida

US researchers found that transformation to PCMH status in Federally Qualified Health Centers in Florida appeared to improve the health of vulnerable patients with diabetes (Kinsell *et al*, 2017). Transformation to a PCMH was associated with 19 per cent greater odds of having well-controlled HbA1c values (a measure of blood glucose control) although it had no significant impact on blood pressure or body mass index.

Ireland

The Republic of Ireland, where some services are provided free but others subject to subsidised fees, is a latecomer to integrated care in terms of implementation. It is being introduced as a key provision of the Sláintecare Report of 2017, set up by the national parliament to devise a 10-year plan to address severe pressures on the health service, establish a universal single-tier service and re-orient the model of care towards primary and community services (Houses of the Oireachtas, 2017).

Under the new State policy, which has a clear focus on population health, the Health Service Executive has proposed that integrated care be delivered through a structure of nine Community Healthcare Organisations (CHOs) covering a broad range of services, including primary and social care, mental health, and health and wellbeing services.

The CHOs will be supported by 96 Community Healthcare Networks (CHNs), one for every large town/district, serving populations of around 50,000. These will be responsible, among other things, for:

- primary care service delivery, integration of specialist services and access to acute hospitals;
- encouraging patients and providers to work together to ensure that care is more comprehensive, coordinated and consistent;
- combining team work and information technology to improve care and the patient experience and reduce costs.

Introducing the plans at the symposium, Pat Healy, National Director of Community Strategy and Planning for Health Service Executive Ireland, said: 'For the first time in Ireland we have agreement that care has to shift from hospitals into the community. We have had a love affair with our hospitals but that is not sustainable with population growth. The existing system is broken and we need to reshape it.'

In recent years, several key stakeholders and leaders in Ireland have been working to establish a professional and political groundswell for improving primary care, as outlined in a key document published by Trinity College, Dublin (O'Dowd, 2017). They have also developed core principles, through the Tomorrow's Health Collaboration, for a new model of advanced primary care which is GP-led, comprehensive, coordinated, accessible and focused on quality and safety.

This work is consistent with the recommendations in the Sláintecare Report for expanding primary care services by building the capacity of the general practice team, shifting care from hospitals to the community and integrating services. According to the Trinity College report, Ireland already has many elements of a good primary care system in place, including well-trained and trusted GPs, who now need to build a team-based approach to population health by working in new partnerships with community and hospital providers.

Ireland is therefore well placed to develop its own GP-led, team-based population health management system, drawing on lessons from models established in the UK, USA, Denmark and New Zealand. The crucial first step is to develop a new GP contract that will equip general practice to lead the transition to integrated care.

Integrated care elsewhere

Integrated care is now a worldwide movement, although there are many different models, adapted to suit local circumstances.

Integrated care projects and initiatives have been introduced successfully in New Zealand, Australia, Canada and many parts of Europe and Scandinavia, while pilot programmes are under way in China and Singapore.

The Evidence to Date

Integrated care approaches and systems are designed to improve population health and the patient experience, relieve pressure on hospitals and reduce costs. What evidence is there that they are achieving these outcomes?

Primary care home benefits in the UK

In the UK, a report for NAPC based on early analysis of three PCH rapid test sites, covering a total population of more than 110,000 people, showed trends towards reductions in A&E attendances, emergency hospital admissions and GP referrals to hospitals, together with drops in average waiting time to see GPs and reduced stays in hospitals (PA Consulting, 2017).

For GP practices and other providers involved, the benefits seemed to include reduced prescribing costs and a rise in staff satisfaction and retention. But these are early days and the NAPC has concluded with caution that PCHs may have outperformed the wider system and may continue to do so but more time is needed to draw firm conclusions.

New care models and Integrated Care Systems

The findings in relation to the impact of the PCH are in keeping with NHS England data, showing that two of the 'new care models', primary and acute care systems (PACS) and multispecialty community

providers (MCPs) have seen lower growth in *per capita* emergency hospital admissions than the rest of England, while some models have reported absolute reductions and, in one case (Frimley Health and Care System), flat A&E attendances and falling emergency admissions and GP referrals (King's Fund, 2018).

Improved outcomes for 'high-performing primary care' in the USA

A systematic review of research published in 2016 on the impact of primary care practice transformation concludes that the Patient-Centered Medical Home (PCMH) has demonstrated improved outcomes in terms of quality, cost and utilisation, although not in all cases (Jabbarpour *et al* 2017).

The review, which looked beyond the PCMH model to cover other forms of 'high performing primary care', assessed a total of 45 reports from the peer-reviewed literature and additional government and state evaluations, and drew the following conclusions:

- Becoming or developing as a PCMH was associated with decreases in overall costs, particularly for mature PCMHs and those caring for patients with more complex medical conditions;
- Effects on care quality were mixed but, excluding one outlier, were either positively correlated with PCMH or showed no impact;
- All studies that examined the patient experience showed positive outcomes;
- The studies showed an increase in primary care provider use for PCMH-enrolled patients, but it is not clear whether this leads to a matching decrease in use of specialty services and emergency departments, or hospitalisations.

Earthquake as catalyst for change in New Zealand

The successful introduction of integrated care in Canterbury, New Zealand a decade ago has been a source of inspiration to other countries, not least because it was interrupted by a massively damaging earthquake in 2011 (King's Fund, 2017). Canterbury's proposed solution to the unsustainable demand for hospital care was a single, integrated health and social care system where services would work together around the needs of patients. The earthquake acted as a catalyst rather than a block to this transformation, with the health system primed to respond to the crisis and implement new initiatives more quickly. Compared with the rest of New Zealand, Canterbury now has lower acute medical admission rates, lower acute readmission rates, shorter lengths of stay, lower emergency department attendances and lower spending on emergency hospital care.

Medicare findings

Outcomes reported by Medicare ACOs, which account for 30 per cent of the total of 900, are mixed but increasingly positive each year, with those that are most mature, physician-led and smaller consistently reporting the best results (Greiner *et al*, 2017).

While quality improved consistently across ACOs in 2016, with 92 per cent meeting quality targets, costs savings were not consistently achieved, with only about a third achieving shared savings.

The fact that improvements in care designed to reduce emergency department visits and hospital admissions do not necessarily result in overall cost savings in the short term was exemplified by the experience of a multipayer PCMH programme piloted in Colorado, USA (Rosenthal *et al*, 2015). Although the programme led to sustained reductions in ED use, producing nearly \$5 million per year in savings, this did not translate into overall cost savings because of increased investment in other services.

The Comprehensive Primary Care Initiative

The most recent evidence on the impact of primary care transformation in the USA came in May 2018 from the final evaluation of the Comprehensive Primary Care (CPC) Initiative, a four-year intervention developed by the Centers for Medicare and Medicaid Services (CMS) to test whether multipayer support of 502 practices across the country would improve primary care delivery, improve care quality or reduce spending (Mathematica Policy Research, 2018).

The findings showed slight improvements for CPC practices when compared with matched comparison practices. These included:

- self-reported improved primary care delivery, such as care management for high-risk patients, enhanced access and improved coordination of aftercare transitions;
- 2% slower growth in ED visits and hospitalisations;
- slower growth in Medicare expenditures – although not enough to offset care management fees;
- no impact on physician or beneficiary experience, or practice performance on a limited set of Medicare claims-based quality measures.

However, two US organisations in particular have reported outstanding outcomes as a result of implementing integrated care.

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan has the largest and longest-running PCMH in the US, covering 1,709 designated practices across the State, involving 4,692 physicians, with more than 1.25 million members.

In 2017, by comparison with non-PCMH practices, PCMH practices achieved a:

- 19% lower rate of adult ER visits
- 25% lower rate of adult ambulatory care sensitive inpatient stays
- 23% lower rate of adult primary care sensitive ER visits
- 2% lower rate of pediatric primary care sensitive ER visits
- 15% lower rate of overall pediatric ER visits.

Costs savings achieved as a result of these quality improvements are estimated at \$427 million over the past six years (Blue Cross Blue Shield of Michigan, 2017).

CareFirst experience slows cost growth

CareFirst, the largest health care insurer in the Mid-Atlantic region, serving 3.2 million members in Maryland, Washington DC and Northern Virginia, launched the nation's largest PCMH programme of

its kind in 2011, with nearly nine out of 10 primary care providers participating in the programme (CareFirst BlueCross BlueShield, 2017).

CareFirst's Overall Medical Trend – a measure of annual total growth in health care costs – averaged just 3.4 per cent between 2013 and 2016, compared to an average of 7.5 per cent in the five years prior to the programme's inception. Factors contributing to the slowing of cost growth were a 15 per cent reduction in hospital inpatient admissions per thousand members, 13 per cent fewer emergency room visits and 6.2 per cent fewer days in hospital.

CareFirst members under the care of PCMH physicians compared well on key quality indicators with those under the care of non-PCMH physicians, with 10.5 per cent fewer hospital admissions per thousand members, 17.1 per cent fewer days in hospital, 34.7 per cent fewer hospital readmissions for all causes and 9.8 per cent lower cost per emergency room visit.

In 2016, the PCMH programme produced \$153 million in savings measured against the expected cost of care for CareFirst members, bring the total savings since 2011 to nearly \$1 billion.

Creative solution: IT workshops in Devon (UK)

Beacon Medical Group, one of the original Rapid Test Sites for the Primary Care Home concept in the UK, is working with patient groups and local partners to promote empowerment and self-help through computer literacy. With the help of local social housing provider Plymouth Community Homes they have developed short animations to promote online services and are planning further initiatives to encourage the use of online tools to access help. The Group is also working with a local bank to train people to use the internet to view their own records and manage appointments.

Critical Success Factors

The symposium identified a number of factors that are critical to the success of Integrated Care Systems, based on research evidence and their own experience. These are:

Engaged leadership

This was the first building block identified by Thomas Bodenheimer in his influential 2014 paper, *The 10 Building Blocks of High-performing Primary Care* (Bodenheimer *et al*, 2014). High-performing practices, he said, have leaders fully engaged in the process of change at all levels of the organisation, creating measurable goals and objectives for their teams to work towards. Practices may also engage patients in leadership roles, calling on them as experts in the healthcare experience to identify priorities for improvement.

Engaged and consistent leadership is also required from the policymakers and strategists, who need to maintain a long-term vision about the promise of integrated care in the face of obstacles, disappointments, setbacks and slow pace of development.

A recent paper on leadership of population healthcare drew the following distinctions between institutional and population healthcare (Gray *et al*, 2017):

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Institutional healthcare	Population healthcare
Focus on service provided to patients	Focus on health status of whole population
Competitive	Collaborative
Quality and safety, whatever the cost	Invest in value-based outcomes
Winning	Win-win
Give patients minimal information	Offer people access to all information
Clinicians responsible for effectiveness, quality and safety	Clinicians responsible for effectiveness, quality, safety AND stewardship of resources

Creative solution: virtual cancer coaching in Canada

NexJ Health, a Canadian provider of cloud-based population health management solutions, has launched an app to help cancer patients manage their condition remotely (Ottawa Regional Cancer Foundation, 2018). The app, now available free of charge for clients of the Ottawa Regional Cancer Foundation, allows them to access a care plan guiding them through their cancer journey and work with a cancer coach remotely for ongoing support.

Effective team working

This is Bodenheimer's fourth building block for high-performing primary care (Bodenheimer *et al*, 2014). Building teams that add capacity is a good way to 'share the care' but large teams may work against a positive patient experience. Bodenheimer favours smaller 'teamlets', made up of stable pairings of clinicians and clinical assistants, supported by larger teams including nurses, social workers, pharmacists and behaviourists.

The PCH approach emphasises the importance of developing multidisciplinary teams that are focused on collaboration across organisations rather than competition. NHS research has demonstrated that effective team working (Borrill *et al*, 2000):

- reduced hospitalisation and costs;
- increased effectiveness, innovation and wellbeing of team members;
- reduced patient mortality, error rates, turnover and sickness absence;
- increased staff engagement.

The hallmarks of an effective team are (West, 2004):

- clear objectives;
- close working between team members to achieve those objectives;
- regular meetings to discuss effectiveness and the need for improvement.

Teams with these characteristics produce potentially better outcomes in terms of risk of errors, job satisfaction and staff retention than those that are less well developed.

Interestingly, research suggests that it is better not to work in a team at all than to work in an ineffective or 'pseudo' team (West, 2012). Job satisfaction is measurably lower in those not working in a team at all than in 'real' teams but lower still in pseudo-teams. The risk of errors, stress and injury are higher in non-teams than in real teams much higher in pseudo teams, and the same is true of harassment and violence, and intention to quit jobs.

Understanding local population needs

Population health management is a proactive approach to managing the health and wellbeing of a given population, which is a defining characteristic of integrated care. It involves segmenting the population into groups of people with similar characteristics to allow for targeted interventions that will improve specified health outcomes for the whole population as well as the individuals within it (Gray, 2016).

Territorial boundaries should not be allowed to impede progress towards these outcomes. 'The important conversation is not who provides, for example, the immunisation', said Mark Davies, NAPC Regional Primary Care Home Lead, 'but how you reduce the prevalence of the relevant condition – and that leads all the other conversations.'

Integrated care models need clear and measurable performance standards aligned with their outcomes (McGough, 2018). But this is not as simple as selecting an off-the-shelf suite of indicators because commissioners need to assess which outcomes meet their local priorities, how much of the contract income should be attached to them and their respective weighting/levels and benchmarking to reflect the desired strategy and behaviours.

Effective population health management depends on sophisticated analytical tools, which in turn depend on joined up digital technology and fully electronic patient records.

Continuous learning

Participants in the symposium agreed that integrated care organisations needed to start small, adapt to local circumstances, learn from their experiences and build from success.

'Transformation works best with a series of small experiments over a long period of time', said NAPC President Dr James Kingsland. 'Nothing succeeds like success, so a strong organisational memory is vital in developing new ways of working.'

'The best way to start is to identify early adopters and support them to demonstrate the changes they have made, with the intention to scale up', said Dr Paul Grundy, Global Medical Director of HealthTeamWorks (USA).

'We should never be done with it – never stop innovating and looking for continuous improvement', said Kristi Bohling-DaMetz, Chief Strategy Officer of HealthTeamWorks. 'Long term commitment is vital in view of shifting agendas, and iterative success is vital.'

Community involvement

Given the collaborative nature of integrated care and the need to ensure broad local support, people, patients and communities need to be treated as key partners in the venture. It is also helpful to be aware of and engaged with local democratic systems.

When the PCMH movement started in the USA, one of the requirements was that each medical home had to have an advisory panel of patients.

The NHS *Five Year Forward View* sets out a commitment to create new relationships with communities and citizens, rethinking the boundaries between health professionals and patients, carers and the voluntary sector, and involving them much more effectively in decisions about health and care services (NHS England, 2014).

It can be particularly instructive to involve patient groups in discussions about outcomes. 'It is dangerous to be prescriptive about outcomes without patient input', said Mark Davies, who was working on some clinical outcomes for people with diabetes but found, to his surprise, that the outcome people were most interested in was confidence in managing their condition.

Creative solution: behavioural health integration in Kansas City

The Clay Platte Family Medicine Clinic was the first in Kansas City, Missouri, to be recognised as a Patient Centered Medical Home (PCMH). The practice, which serves 28,000 patients, has fully risk stratified its empanelled population and now bases decisions on patient needs. As part of this approach, steps are under way to move towards an integrated behavioural health model, with a team of care managers employed to support the needs of at-risk patients, who are given real-time access to behavioural health workers during clinic visits.

Challenges and Risks

These are the flip side of the critical success factors. They include:

Short-termism

Symposium participants agreed that integrated care is a 'journey' and that providers, commissioners and policymakers need to be in it for the long haul, allowing sufficient time for the new models to evolve, become established and deliver results.

'The key learning is that this takes time', said Dr Paul Grundy. 'Ministers want to see results in six months, but they are implementing moving parts that need seasoning. Kaiser said at the start that it would be a 20-year journey. The practices doing best in the US are still only about a third of the way there.'

Top-down approaches

The consensus among participants was that a 'bottom-up' approach is best, with the impetus coming from local providers and communities, meeting local needs and reflecting local realities, rather than having prefabricated structures and templates imposed from above.

There is a risk that regulators could undermine moves to system working if they resort to top-down performance management to address performance challenges rather than relying on ICSs to take the lead (King's Fund, 2018).

Competitive behaviours

The key to effective integration is collaboration across organisational and professional boundaries, which means moving away from the siloed mindsets, competitive behaviours and territorial instincts that have characterised the UK system, at least, for many years.

'We need to have collaborative conversations around care pathways', said Kristi Bohling-DaMetz, 'not just about how patients move but how we share the information. It's not about taking patients from you but making sure you see the right patients.'

According to Chris Ham, Chief Executive of The King's Fund (King's Fund, 2018): 'The biggest risk to integrated care is organisational protectionism rather than privatisation, linked to a history of competitive behaviours and sometimes poor relationships between the leaders who need to collaborate to make a reality of integrated care.'

Statutory changes and payment systems

This is most relevant to England, where new models of care have been allowed to evolve without accompanying reform of provider contracts and institutions. But the seismic changes happening in primary care will inevitably have knock-on effect on secondary care, which will eventually need to be reflected in legislation. Work will also be needed to align the different statutory, regulatory and payment systems of health and local government.

To quote Chris Ham again (King's Fund, 2018): 'Changes in legislation will be needed to align current developments with the statutory framework. There is no prospect of this happening in the short term because the government lacks a working majority and because Brexit is dominating the parliamentary timetable.'

'For the foreseeable future, the NHS and its partners will have to find ways of making progress through workarounds, hoping that the political will can be found before too long to bring the law into line with the priority being given to integrated care.'

Case Study 1: Dorset Integrated Care System (UK)

The largely rural county of Dorset in South West England was one of the first wave of 10 emergent Integrated Care Systems (ICSs), selected by NHS England in 2017 on the basis of the maturity of their Sustainability and Transformation Plans (STPs). In 2016, all areas of England had been tasked with producing these plans, designed to close gaps in care and quality, outcomes and efficiency.

Dorset, which had the advantage of being served by a single Clinical Commissioning Group (CCG), had already taken a lead on reviewing its clinical services to address these issues over the preceding three years, and so had a head start.

'Our drivers were around workforce, finance, sustainability, quality and access,' says GP Karen Kirkham, who, as ICS clinical lead, provides strategic direction for the whole county. 'Over an 18-

month period we involved clinicians in designing a care model that would shift us from providing disjointed care in professional and organisational silos to fully integrated care, serving the county's needs across acute and community settings, physical and mental health.'

The ICS comprises three acute hospitals, a single community and mental health trust, one ambulance trust, the CCG, three local authorities and 86 GP practices divided into 13 geographical 'localities', which cover a total population of 800,000.

In late 2017, the ICS started working with the National Association of Primary Care (NAPC) to encourage the localities to work as Primary Care Homes (PCHs), smaller collaborative units serving populations of 35-50,000. By mid-2019, all 13 localities are expected to have established PCHs – up to 30 for the County as a whole.

One early result of improved collaboration is a network of integrated 'frailty hubs' combining health and social care services for elderly people with complex needs, who are known to be heavy users of hospital services. 'We used to just send them into hospital because we couldn't join up the care,' explains Dr Kirkham, 'but now we identify patients proactively, make care plans, share records and can set packages of care in motion with a single 'phone call.'

With its focus on meeting previously unmet needs, the new ways of working are more likely to ease pressures on a fragmented system than reduce overall costs. But significant benefits already observed include:

- a huge increase in staff satisfaction and morale, with community teams actually *asking* to work across weekends to improve care, and GP recruitment easing in previously hard-to-recruit areas;
- greatly improved GP access, with most people able to make appointments on seven days a week;
- increased patient satisfaction as measured by surveys;
- early signs of reductions in emergency admissions and lengths of stay in hospital.

'This collaborative working is the beginning of a journey for all of us,' says Dr Kirkham. 'We are starting to reap the benefits for patients, clinicians and other staff and for the next few years we need to hold our nerve, keep believing we are doing the right things and adapt and improve our services as we go. But it is a long-term aim, not a quick fix.'

Case study 2: The Ochsner Health Network (USA)

The Ochsner Health Network (OHN), which brings together nearly more than 2,500 providers, 300 physician groups and 33 hospitals to treat more than two million patients per year, is the largest 'super' Clinically Integrated Network in the Greater Gulf South region of the USA (Ochsner Health Network, 2018)

The Network was set up just three years ago to collaborate and share knowledge, resources, processes and technology with a view to delivering better care and improved access at lower overall cost for the entire population of the state of Louisiana.

The task of realising this mission through better coverage solutions and a patient-centred care model called for significant planning and alignment across a wide range of partner environments. Supported by transformation experts from IBM Watson Health (IBMWH), OHN and each of its partners created strategic governance structures to support a new alignment model with a focus on collaboration and value.

The Network also implemented the IBMWH Enterprise Performance Management Tool as a shared source of measurement for key outcomes. In one year, 10 clinical and claims data sources were integrated into a common healthcare data model, generating performance measurement and population health insights for more than 500,000 patients.

These efforts have already produced improved outcomes for OHN's patients as well as generating overall costs savings and value-based income for its physicians.

For example, screening compliance rates for breast cancer for eligible populations have risen by 10 per cent and now exceed the National Committee for Quality Assurance's 90th percentile for commercial and Medicare populations.

In November last year, the Network announced results for 2016, which included a reduction in the expected cost of healthcare by more than \$5.5 million (Ochsner Health System, 2017).

'OHN is driving a notable agenda of collaboration between physicians, health plans and patients and we are experiencing a high level of physician engagement with the OHN quality programs', reports Patrick Torcson MD, Vice President and Chief Integration Officer at St Tammany Parish Hospital in Covington, Louisiana.

'The results so far are significant progress towards delivering on the Triple Aim of better care for our patients, better health for the citizens of Louisiana and lower costs to the healthcare system', states his testimonial on the OHN website.

References

Agency for Healthcare Research and Quality. (2017). *Transforming the organization and delivery of primary care*. Available at <https://www.pcmh.ahrq.gov>

Blue Cross Blue Shield of Michigan and Blue Care Network. (2017) *Media Fact Sheet 2017: Patient-Centered Medical Home*. Available at: <http://www.valuepartnerships.com/wp-content/uploads/2017/10/2017-PCMH-Media-Fact-Sheet.pdf>

Bodenheimer T, Ghorob, A, Willard-Grace R, Grumbach K. (2014). *The 10 Building Blocks of High-Performing Primary Care*. *Ann Fam Med*, vol 12, no 2, 166-171.

Borrill C, West M, Dawson J. (2000). *Team working and effectiveness in health care: findings from the Health Care Team Effectiveness Project*. Aston Centre for Health Service Organisation Research. Available at: <http://www.affinaod.com/wp-content/uploads/2015/01/Team-Working-and-Effectiveness-in-Healthcare.pdf>

CareFirst BlueCross Blueshield. (2017) *Patient-Centered Medical Home 2016 Program Performance Report*. Available at: <https://individual.carefirst.com/carefirst-resources/pdf/2016-pcmh-program-performance-report.pdf>

Department of Health. (2008). *High Quality Care For All: NHS Next Stage Review Final Report*. The Stationery Office.

Gray, M. (2016). *Population Healthcare: a new clinical responsibility*. *Journal of the Royal Society of Medicine*, vol 109 (12), 437-438.

Gray M, Chana N, Kanani N. (2017) *Leadership of population healthcare*. *Journal of Royal Society of Medicine*, vol 119, issue 10, 400-403.

Greiner A, Grundy P, Kingsland J, Chana N. (2017). *Leveraging primary care to derive value: a collaboration across the pond*. Patient-Centered Primary Care Collaborative. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20171219.582714/full/>

Hindmarsh, M. *Postal Service "Call & Check Visits" for Isolated, Frail Elderly in the Community*. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2017. Available at: <http://www.ihl.org/resources/Pages/Publications/Call-and-Check-Visits-Frail-Elderly-Innovation-Case-Study.aspx>

Houses of the Oireachtas. (2017). *Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report*. Dublin: Houses of the Oireachtas.

Jabbarpour Y, DeMarchis E, Bazemore A, Grundy P. (2017). *The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization*. Available at: https://www.pcpc.org/sites/default/files/resources/pcmh_evidence_report_08-1-17%20FINAL.pdf

King's Fund. (2017). *Developing accountable care systems: Lessons from Canterbury, New Zealand*. Available at: https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pdf

King's Fund. (2018). *Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England*. Available at: <https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems>

Kinsell HS, Hall AG, Harman JS, Tewary S, Brickman A. (2017). *Impacts of Initial Transformation to a Patient-Centered Medical Home on Diabetes Outcomes in Federally Qualified Health Centers in Florida*. J Prim Care Community Health. Oct; 8(4):192-197.

Mathematica Policy Research. (2018). *Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report*. Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

McGough R. (2018). *Face value: how a value-based approach to healthcare could be a game changer for the NHS*. Hill Dickinson. Available at: <https://www.hilldickinson.com/insights/articles/face-value-how-value-based-approach-healthcare-could-be-game-changer-nhs>

National Association of Primary Care. (2017). *Providing accountable care: comparing the delivery of Primary Care in the UK and USA through Accountable Care Systems and Organisations*. London: NAPC.

National Association of Primary Care. (2018). *About Primary Care Home*. Available at: <https://napc.co.uk/primary-care-home/>

National Health Executive. (2017). *Patient Safety*. Available at: <http://www.nationalhealthexecutive.com/Health-Care-News/cqc-nhs-stands-on-burning-platform-as-trusts-struggle-to-meet-demands>

NHS England. (2014). *Five Year Forward View*. London: NHS England.

NHS England. (2017). *Next steps on the NHS Five Year Forward View*. London: NHS England.

NHS England and NHS Improvement. (2018). *Refreshing NHS plans for 2018/19*. London: NHS England and NHS Improvement.

Ochsner Health Network. (2018). <https://www.ochsner.org/ochsner-health-network/>

Ochsner Health System. (2017). Available at: <https://news.ochsner.org/news-releases/ochsner-accountable-care-network-announces-over-5.5-million-in-savings/>

O'Dowd. (2017). *A Future Together: Building a Better GP and Primary Care Service*. Available at: <https://www.hse.ie/eng/services/publications/primary/a-future-together.pdf>

Ottawa Regional Cancer Foundation. (2018) *Virtual Cancer Coaching – There's an App for That*. Available at: <http://www.ottawacancer.ca/wp-content/uploads/2018/05/NexJ-Press-Release-05-15-18.pdf>

PA Consulting. (2017). *Does the Primary Care Home make a difference?* London: PA Consulting.

Patient-Centered Primary Care Collaborative. (2017). *Shared Principles of Primary Care*. Available at: https://www.pcpcc.org/sites/default/files/Shared_Principles.pdf

Rosenthal MB, Alidina S, Friedberg MW, Schneider MD, Singer SJ, Eastman D, Li Z. (2015). *A Difference-in-Difference: Analysis of Changes in Quality, utilization, and Cost Following the Colorado Multi-Payer Patient-Centered Medical Home Pilot*. Journal of General Internal Medicine. Available at: <https://link.springer.com/article/10.1007%2Fs11606-015-3521-1>.

United Nations Global Compact. (2018). *Action Platform: Health is Everyone's Business*. Available at: <https://www.unglobalcompact.org/take-action/action-platforms/health>

West, MA. (2004). *Effective Teamwork: Practical lessons from organizational research*. Oxford: Blackwell/British Psychological Society.

West MA, Lyubovnikova J. (2012). *Real Teams or Pseudo Teams? The Changing Landscape Needs a Better Map*. Industrial and Organizational Psychology, 5 (2012), 25-55.

World Health Organization. (2016). *Integrated care models: an overview*. Copenhagen: WHO Regional Office for Europe.

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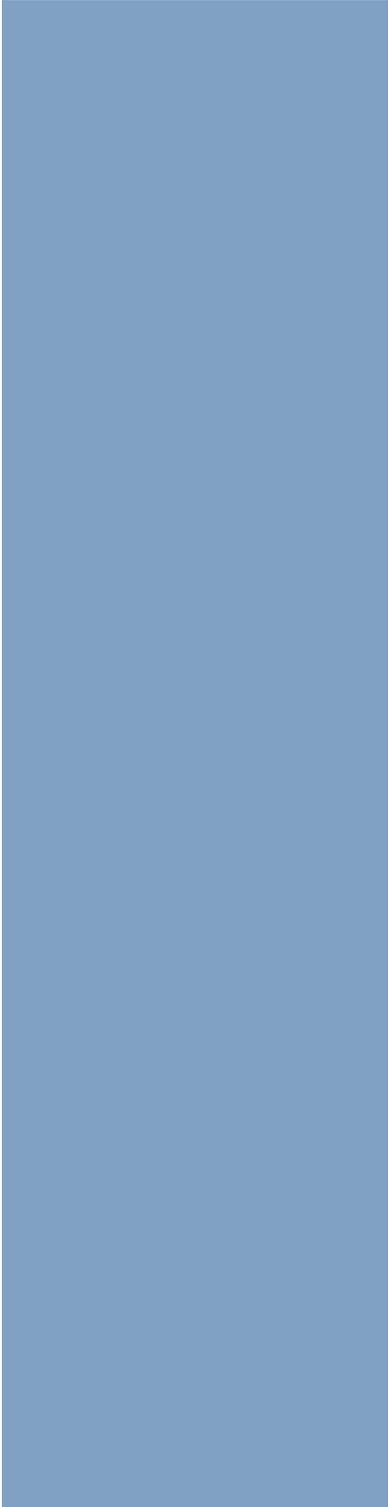
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