The future of Australian General Practice: Lessons from USA health reforms

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Outline

• US Health system

• US Health Reforms: Affordable Care Act (Obama-Care)

• Patient Centred Medical Home

• What does success look like?

• Implications for Australian General Practice
EXHIBIT ES-1. OVERALL RANKING

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Notes: * includes ties. ** Expenditures shown in 2011 PPP (purchasing power parity). Australia data through 2010.


US Health System – It’s complicated!

- Health Cover
  - Employer
  - Uninsured
  - Medicare (65+)
  - Medicaid (poor)
  - Other (VA etc)
- Spend = $2.7 Trillion
  - Public
  - Private Insurance
  - Out-of-pocket
US Health Reforms - 2010

• The Patient Protection and Affordable Care Act (AKA: Obama-Care)
  • 2409 pages of reforms….

• Two Principal Objectives
  1: Coverage Expansion
    - Cover the uninsured
    - Regulate private markets
  2: Delivery System Reform
    - Pay for performance – quality/safety
    - Patient Centred Medical Homes
    - Health information technology (HIT)
    - Accountable Care Organisations

Patient Centred Medical Home
What is it?

Requires 2 changes:

1: General Practice organisation
   - staffing
   - workflows
   - population health focus

2: Payment

Results in:

1: Consumer focused care
   - better outcomes

2: Joy in practice

3: Better business model
   - value not volume

https://pcmh.ahrq.gov/page/defining-pcmh
Patient Centred Medical Home (PCMH) Principles:

- Accountability
- Comprehensive
- Continuity
- Team Care
- Self Management
- Patient Participation
- Access
- Health IT

'medical neighbourhood'

Education and Training

PCMH – how it works (simple)

1. Patients are enrolled with a practice
2. Practice meets PCMH accreditation standards
3. Monthly payment to practice for enrolled patients (capitation)
   - Fee For Service retained “Blended payment”

http://medicalhome.org.au/
PCMH (advanced)
It is a journey, not a fixed model of care

Traditional Methods of Managing Work Flow
Patient vignette 1: Betty

- 69 F bipolar disorder with psychotic features
  - Hypertension, valve replacement
  - Irritable bowel syndrome
  - No social supports, living in a caravan park with her cat
  - ED attendances every other week via ambulance
  - Healthcare card
  - No regular GP

How would your practice deal with this patient?
Case Studies: Background

- Health inequalities are pervasive, persistent and expensive
  - USA annual cost > $309 billion*

- The ACA enacted wide-ranging reforms affecting health disparities
  - Medicaid expansion
  - Service delivery reform (Patient Centered Medical Home)
  - Workforce reforms
  - Community investment
  - CMS/CMMI innovation funds

- Primary Care sector is under stress, struggling to adapt to complex demands

- Is better access enough?


Vulnerable populations

“those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability,” (AHRQ)
Research question

How have health care organisations extended upon the ‘medical home’ to proactively identify and address the needs of vulnerable populations?

OR

What capabilities and functions have been developed to achieve better health outcomes for vulnerable populations?

Methods

- Multiple Case Study design (N=4)
- Sample for maximal contextual variation
- Sites chosen based on expert consultation
- Inequality theory driven approach
- Case definition: Health care organisation that in addition to implementing a ‘medical home’ model of care, has had documented success in achieving the ‘triple aim’ for vulnerable populations
Analysis – Case Study Methods

- Triangulated data sources:
  - Interviews (N=62)
  - Site visit observations
  - Documents
    - (e.g. websites, literature, social media, organisational charts, job descriptions)
  - Artefacts (photos during site visits)

- Interviews independently transcribed
- Dual coding
- Source-checking
- Data analysis using Nvivo 10

Results

62 Interviews: 114 respondents

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The future of General Practice?
3rd space health care

Key findings:
1. Community development
2. Human resources
3. Technical assistance
4. Data & analytics
5. Financing & incentives

Third space health care - explained

- Primary care (PC) is drowning in complexity
  - Complex comorbidities including mental health and addictions
  - Administrative complexity and time pressures
  - Social determinants of health

- 3rd Space: Augmenting capabilities/functions – things PC rarely gets to:
  - Population needs assessment
  - Practice/workflow redesign
  - Panel/Case management
  - Expanded team/services
  - Community linkages
  - Data and analytics

  “We’re symbiotic with primary care”
  the ‘interstitial’ of health care

- Impact
  Technical & Allocative efficiency = Triple Aim
1. Community Development at multiple levels…

- Accountable communities of care - at optimal scale
  - Deeper contextual understanding of patient needs
  - Participatory governance/leadership of the 3rd space
  - Regional autonomy

- Service redesign to address identified needs:
  - Co-location & behavioural/mental health integration
  - Linkage and leverage of community resources
  - Working ‘beyond the walls’ – outreach case management

- Strategic investment in vulnerable communities:
  - Employment of peers and community workers
  - Rebuilding community for marginalised persons

2. Strategic human resource management

- Intentionality about integration
  - Behavioural interviewing to hire ‘change ready’ staff
  - Onboarding, cultural alignment and emotional intelligence
  - Time, space & expectation to innovate - “build it while flying it”

- Success driven by professional and personal relationship building: ‘Teamness’ and ‘Therapeutic alliances’

“Integration is really where everything starts… relationship and being integrated because without that we can’t do anything.”
3. Technical assistance

- Integrating provider-centred innovations in care
  - Case management and community resource linkage
  - Service redesign – PCMH, EHR, team workflow
  - Quality improvement – rapid PDSA

- Learning Organisation
  - Innovation grants
  - Collaboratives
  - Innovation platform

“You have to start where the provider is at”

“We’re teaching them to fish”

4. Data and analytics for vulnerable populations

- Innovative use of existing data
  - All claims, all payer, pharmacy databases
  - Post 9/11 hospital admission data feeds (federal mandate)

- Data is a foundational stone of the 3rd space
  - Needs assessment
  - Quality improvement
  - Population management

- Predictive analytics
  - ‘Impactable’ patients
  - Health mapping (GIS)

“We want numbers for learning, not used for manipulation to hit a target.”
5. Finance and Incentives

• **Four Organisations – Four funding models**

  • Integrated Health System/Multi-payer enables a population approach
  
  • Medicaid only - less effective ‘high utilizer’ or ‘hotspotting’ approaches
  
  • Increased social spending,
    o on linkage - not direct delivery of social services
  
  • Freedom from fee for service is integral to case management success
  
  • Provider incentives are predominantly non-financial

Provider experiences

• Greatly improved satisfaction in practice – **Quadruple aim**
  
  o Reductions in waste, fragmentation, duplication
  
  o Innovations for vulnerable applied across entire panel (all payers)
  
  o Practitioners want case management for entire panel, not just for some payers/narrow eligibility criteria
  
  o Positive gearing of patient interactions
  
  o Better patient outcomes

  “it has truly rejuvenated me in terms of practice”

  “patients that have been failures are no longer failures”
Vulnerable patient experiences

• Transformational care through empowerment & activation
  o Knowledge, skills and confidence to control all issues
  o Learning how to trust again – trauma informed care
  o Relationships crucial to success
  o High satisfaction

“When you have someone that you can talk to and answer all of your questions, then I have no problems.”

Patient vignette 1: Betty

1: (PHN) Identified through linked data

2: Case management support
   Enroll her in PCMH
   Advocacy with GP
   Link to social services
   Build community supports
   On-call support

3: PCMH – multidisciplinary plan
   Clinical pharmacist
   Psychologist
   Dietician
   GP – wellness plan – self Mx

4: Medical Neighborhood
   Pharmacist (linked through EHR)
   Housing
   Day activities – knitting group

Investment return 3:1
Barriers to health equity

- Commonly recognised barriers:
  - Information sharing
  - Politics and policy
  - Service limits – social determinants
  - Data/EHR limits
  - Workforce

- Emerging barriers:
  - Carve outs (e.g., behavioural health) = cost shifts & fragmentation
  - Aggressive corporate hospital takeovers of primary care

Conclusion: How the ‘Quadruple Aim’ for vulnerable populations is being achieved

- Building accountable communities of care around primary care - based on relationships and community activation

- Maintaining a primary care focus and equipping primary care teams for the tasks of the 21st century health care
  - Teams – right skills, roles and personalities
  - Data – to learn and to manage populations
  - Technical assistance

- Customer focus and the capability to address issues through empowerment, problem solving and advocacy
**Australian General Practice – Future Gazing**

1: Australian PCMH Standards

2: Patient Enrolment

3: Finance reform - value

4: Population Health role of PHNs
   - technical assistance to GP practices
   - workflow & PCMH accreditation & CQI
   - Case management of customers
   - Collaboratives – Innovation platform
   - Data linkage and analytics
   - Community resource/service linkage

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Affordable, quality health care. For everyone.

For further information: Paul.Burgess@nt.gov.au