Community-Oriented Integrated Care

Evaluating the care of patients with long term conditions

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Key messages

- Traditional approaches to evaluating care for patients with long term conditions are based on disease oriented processes of care that are easily measurable.
- Models of care delivery should be designed around outcomes that matter to allow the impact of primary care to be fully realised.
- Further research is needed to develop metrics for evaluating care for patients with long term conditions more truly representing person derived outcomes encompassing the dimensions of health and well-being.

Why this matters to me

New models of care based on the people that matter most, namely patients, families, carers and communities, are essential for designing 21st century health care. To do this, there has to be a greater understanding of how people define the value of health care and how this should be fundamental to care design.

ABSTRACT

Approaches to evaluating the care of patients with long-term conditions first need to be framed around defining outcomes that ‘matter to people’, rather than those that are focused on disease and easily measurable. Secondly, approaches to evaluating such care should be organised with the ability to ‘deliver what matters to people’ – such models of care must allow for the opportunity to maximise the impact of primary care. Finally, any approach to

evaluation must also ‘enable the delivery of what matters to people’, including approaches to promote self-care, well-being and interprofessional workforce development organised around educational networks.

Keywords: chronic disease; health promotion; patient outcome assessment; primary health care

Introduction

This paper outlines an alternative approach to evaluating the care of patients with long-term conditions and is based on discussions with primary care experts at a recent round table event in London in the summer of 2014. The fundamental tenet outlined in this paper is that any approach to evaluating long-term condition care must start with identifying outcomes that matter to patients, families, carers or

indeed the communities in which patients live. Such patient- and population-centric outcomes could be used as the basis for evaluating the quality and redesign of services. This is entirely consistent with the ambition of the London Health Commission.¹ We describe enablers to care delivery that maximise the potential of primary care, which if adopted at scale,

could lead to significant improvements in outcomes that matter to patients.

Measuring what matters

Current government policy has made clear its intention to shift the focus of accountability away from process-oriented targets and towards health-outcomes-driven measures.² In doing so, it is seeking to sweep away the state infrastructure built up over the last two decades. Primary care trusts and strategic health authorities have been abolished and replaced by lean, outwardly facing, clinically engaged and health-outcomes-focused clinical commissioning groups.

Such process-focused outcomes and performance-managed approaches have been criticised for diverting focus and distorting activity away from clinical care and ‘patient’ related clinical outcomes.^{3–5} Alongside this, previous attempts at aligning resources, activity and outcomes have had little impact on health inequalities for local populations, as amply evidenced by three decades of research in this area.^{6–8} In essence, a continued focus on disease process outcomes leads to professionally centric behaviours and arguably an ‘over managed’ care sector. In addition, traditional approaches to measuring quality and outcomes distil and simplify complex and contextualised phenomena missing out hidden and co-dependent phenomena. There is a need to consider an alternate research approach in developing outcomes for primary care.⁹

We would suggest that this continued failure to focus on outcomes that patients want as well as persistent health inequalities requires a refocusing of our approach towards patient-defined and population-based health outcomes. This should be particularly true for general practice, a part of the healthcare system traditionally imbuing the values of population-based care.¹⁰

What does matter to people?

People value personalisation

Snowden *et al*¹¹ define ‘value’ in a healthcare system as ‘a quality based on a person’s principles or standards, one’s judgment about what is valuable and important in life, and what a person deems important.’ Such personalisation of health care is still in its infancy; however, we are seeing greater use of personalisation in influencing healthcare providers through processes such as the GP Patient Survey (GPPS); patient-related experience and outcome measures (PREMs and PROMs)

and commissioning for quality and innovations (CQUINs).

People value opportunities to improve their sense of well-being

The aim of population health policy as defined by Kindig *et al*¹² is ‘to improve the health of individuals and populations by investments in the determinants of health through policies and interventions that influence these determinants.’ Booske *et al*¹³ suggest that health care as a determinant of outcomes accounts for about 20% of the potential for improvement. More importantly, modifiable lifestyle behaviours influence outcomes to the tune of 30%, with environmental and economic factors making up the difference. The potential to make a fundamental difference to patient and population outcomes through engaging with supporting the development of well-being approaches is therefore significant. There is an urgent need to build incentives for providers to engage with the well-being agenda through the use of tools such as the Warwick–Edinburgh Mental Well-being Scale and other such patient-defined wellness measures that can be used to help guide healthcare interventions.¹⁴

People value trusted relationships with their healthcare practitioner

Allison *et al* describe in their paper, also in this issue, that people want trusted patient–physician relationships. This is as true in the urban UK as it is in rural USA.¹⁵

Delivering what matters

We suggest that the building blocks of a system that can systematically provide personal care, opportunities for well-being and trusted relationships are emerging. These include a focus on strong primary care as part of an integrated accountable care organisation.

The primary care home

Starfield *et al* considered the characteristics and impact of a primary care home (PCH) on population health and, in particular, dealing with health inequalities with specific reference to international models described in the literature.¹⁶ They characterised PCHs as providing ‘accessibility for first contact care for each new problem or health need, long-term person-focused care (“longitudinality”), comprehensiveness of

care, and coordination of care in instances in which patients do have to go elsewhere'. Their findings demonstrated that PCHs were associated with better health outcomes, lower costs and reductions in health inequalities. Rosenthal also demonstrated that PCHs improved patient outcomes and reduced costs, as well as improving quality of care, reducing medical errors and leading to greater satisfaction.¹⁷

The concept of the PCH describes a system (without clarifying the architecture) based on the characteristics described above. This approach allows for the local development of different forms of networks. It also incorporates other models described in the literature, for example federated practices and poly-systems.¹⁸ The PCH concept respects localism, the historical evolution of services, the existing level of integration among healthcare providers in a geographic area, and the level of sophistication of primary care commissioners in developing and specifying the shape of services.

An example of the development of the PCH concept is seen in a programme in Warrington, funded by the Prime Minister's Challenge.¹⁹ Here, each PCH is centred around three to six practice lists. These act as a hub for all primary care, district nurse (and other community provision), mental health and social care services. Practices in a PCH will be encouraged to share services (e.g. phlebotomy or cardiac investigations). It is anticipated that PCHs will also be better placed to tackle health inequalities through providing improved access to primary care, reducing variations in the quality of care, and through their greater size have the opportunity to tackle issues specific to the local population.

General practice in the UK is at the heart of a community-based healthcare service well placed to deliver better population-related outcomes, and reduce the significant disparities in health outcomes. Indeed, general practice as a core element of a PCH holds significant potential for reducing health inequalities, continuing to improve outcomes for the whole population, and at a lower cost than secondary care services. However, it is also recognised that PCHs have limited ability to save resources and reinvest as a means of improving services and care. It is more likely that a partnership with secondary care (in the context of an accountable care organisation) will do so.

Accountable care organisations

There is increasing recognition that current payment mechanisms for healthcare services are simplistic, promoting overutilisation of services rather than more effective coordination and integration of care. It is also recognised that wide commissioner and provider separation has not yielded the level of ben-

efits expected,²⁰ while integration alone may not achieve what is needed.^{21,22} It has therefore been suggested that a combination of reform of payment mechanisms, integrated care and sharing of risk is more likely to yield benefits. These issues have led to widespread interest in the development of accountable care organisations (ACOs), which have emerged in the USA following the Affordable Care Act.

ACOs are provider organisations caring for a defined population according to a capitated budget.²³ The make-up of an ACO varies, but tends to involve partnerships across multiple sites. Primary care is a strong focus of all successful ACOs. There are numerous payment mechanisms for ACOs and these are associated with varying levels of risk and focus on outcomes.^{24,25}

Notwithstanding the evidence on ACOs, we would argue that approaches leaning towards accountable care are important in the context of delivering population health outcomes. International consensus on the approach to accountable care has highlighted five key steps: namely, defining a population (a strength of list-based general practice in the UK), developing population outcomes, creating appropriate metrics – with aligned incentives – and leading to coordinated delivery across providers.

Enabling the delivery of what matters

Identifying what matters, and defining how it is delivered is predicated on ensuring that there are key resources that work with shifting our health (and social care) system in achieving these goals. Included are information systems, community assets, and a workforce capable of taking on the challenges we face as a society. We wish to highlight specifically the opportunities afforded by developing an asset-based approach to community development and community education provider networks.

Asset-based community development

Kretzman and McKnight proposed the development of an approach to community development that emphasised building the capacity and capability of local communities to enhance their strengths and resources, tackle the issues that mattered to them, and use existing resources and expertise to achieve improvements locally.²⁶ In short, put local communities and their members in the 'driving seat'. This contrasted with the rather more traditional approach of identifying the deficits and needs of local communities, then planning an 'intervention' to resolve these

needs. The benefits of asset-based community development are that it results in local issues being dealt with by local people, usually at a much lower cost than externally imposed national and regional programmes, and is likely to make for sustainable change. The types of assets that come into play include people, organisations, lands and buildings.

London has a rich and variegated heritage of community-development programmes with the expertise to empower local communities residing within the third and voluntary sector. There is an urgent need for health and social care to work with the voluntary and third sector to empower local communities to tackle the challenges of social and health determinants that result in poor outcomes. This is also a key ambition within the bold targets set out by London's Health Commission.

Education provider networks

The greater pressures on clinical workloads, the drive for integrated working and improving population-based outcomes require an approach to supporting the health and social care workforce that encourages more local and responsive workforce planning and development, greater involvement and ownership of workforce development by local communities and employers, and provision of education and training driven by local providers of higher education.

The three London and Kent, Surrey and Sussex Local Education and Training Boards (LETBs) are in the process of developing community-based educational provider networks (CEPNs) to encourage local and employer-led workforce development strategies.²⁷ Educational networks have started linking population needs with workforce plans, taking ownership for educational provision (especially for those groups most in need of primary and community placements – for example, student nurses) and encouraging organisations unused to working together to collaborate around education and training. Educational networks also offer the opportunity to support the development of local clinicians in leadership skills, quality improvement techniques and behaviour change techniques.

Our early experience suggests that workforce development and education and training initiatives are a powerful driver for building networks. Furthermore, the networks – aligned around a defined geography – can develop workforce initiatives that are configured around the outcomes that matter to a population. Such approaches can, therefore, enable the workforce to be truly responsive to the needs of a population.

Conclusion

This paper has set out that the key first steps in evaluating the care of patients with long-term conditions should be to define outcomes that matter to people in terms of the personalisation of care, improving their sense of well-being and developing trusted relationships with healthcare practitioners. These can only be delivered if care is organised to deliver these outcomes and we have described the potential for primary care to be fully utilised to do so through models such as the PCH and the ACO. Whatever the model of care delivery applied, we wish to state the importance of asset-based approaches to community development and educational provider networks as important enablers that could allow outcomes that matter to people to be delivered. We assert that approaches to the evaluation of long-term condition care should be directed at measuring what matters, delivering what matters and enabling the delivery of what matters.

CONFLICTS OF INTEREST

None.

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REFERENCES

- 1 London Health Commission (2014) Summary of Call for Evidence. www.londonhealthcommission.org.uk/summary-call-evidence-published/
- 2 Department of Health (2012) *The Health and Social Care Act*. London: HMSO.
- 3 Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. www.midstaffspublicinquiry.com/report
- 4 Dixon A, Khachatryan A, Wallace A, Peckham S, Boyce T and Gillam S (2011) *Impact of Quality and Outcomes Framework on Health Inequalities*. London: The King's Fund.
- 5 Goodwin N, Dixon A, Poole T and Raleigh V (2011) *Improving the Quality of Care in General Practice*. London: The King's Fund.
- 6 Black D, Morris J, Smith C and Townsend P (1980) *Inequalities in Health: report of a Research Working Group*. London: Department of Health and Social Security.
- 7 Acheson D (1998) *Inequalities in health: report on inequalities in health did give priority for steps to be tackled*. *BMJ* 317(7173):1659.

- 8 Marmot MG, Allen J, Goldblatt P *et al* (2010) *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*.
- 9 Thomas P (2014) Understanding context in healthcare research and development. *London Journal of Primary Care* 6:103–5.
- 10 Thorlby R (2013) *Reclaiming a Population Health Perspective*. London: The Nuffield Trust. www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130425_reclaiminga-population-health-perspective.pdf (accessed 06/01/14).
- 11 Snowdon A, Schnarr K, Hussein A and Alessi C (2012) *Measuring What Matters: the cost vs. values of health care*. Ivey International Centre for Health Innovation.
- 12 Kindig DA, Asada Y and Booske B (2008) A population health framework for setting national and state health goals. *JAMA* 299(17):2081–3.
- 13 Booske B, Athens J, Kindig D, Park H and Remington P (2010) *County Health Rankings Working Paper: different perspectives for assigning weights to determinants of health*. University of Wisconsin, Population Health Institute.
- 14 Ellison C, Reynolds C and Alessi C (2014) *Measuring Wellness*.
- 15 Allison C, Zittleman L, Ringel M *et al* (2014) Translating the medical home into patient-centred language. *London Journal of Primary Care* 6: .
- 16 Starfield B, Shi L and Macinko J (2005) Contribution of primary care to health systems and health. *Milbank Quarterly* 83:457–502.
- 17 Rosenthal TC (2008) The medical home: growing evidence to support a new approach to primary care. *The Journal of the American Board of Family Medicine* 21: 427–40.
- 18 Lakhani MK, Baker M and Field S (2007) *The Future Direction of General Practice: a roadmap*. London: Royal College of General Practitioners.
- 19 McKay C (2014) *Primary Care Home Project 2014*. www.warringtonccg.nhs.uk/Downloads/Public%20Information/GB%2014%20May%202014/031%2014%20Primary%20Care%20Home%20Report.pdf
- 20 Clover B (2013, 12 July) Hospital chiefs give thumbs down to purchaser-provider split. *London Government Chronicle*.
- 21 Soljak M, Cecil E, Gunn L *et al* (2013) *North West London Integrated Care Pilot Evaluation: Report on Work Programme 3 – Quality of care and health outcomes*. London: Nuffield Trust.
- 22 Bardsley M, Blunt I and Roberts A (2013) *North West London Integrated Care Pilot Evaluation: Report on Work Programme 2 – Impact on service use and cost*. London: Nuffield Trust.
- 23 Light D and Dixon M (2004) Making the NHS more like Kaiser Permanente. *BMJ* 328(7442):763.
- 24 Fisher ES, McClellan MB, Bertko J *et al* (2009) Fostering accountable health care: moving forward in Medicare. *Health Affairs* 28:w219–31.
- 25 McClellan M, Kent J, Beales SJ *et al* (2014) Accountable care around the world: a framework to guide reform strategies. *Health Affairs* 33:1507–15.
- 26 Kretzmann JP, McKnight J and Neighborhood Innovations Network (1993) *Building Communities From the Inside Out*. Center for Urban Affairs and Policy Research, Neighborhood Innovations Network.
- 27 Ahluwalia S, Tavabie A, Spicer J and Chana N (2013) Community-based education providers network: an opportunity to unleash the potential for innovation in primary care education. *Education for Primary Care* 24: 394.

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