

## Innovations in Primary Care in Israel



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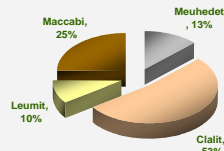
### About Israel

- Size: 20,700 square kilometers
- Population: 7 Million; 20% minorities
- Elderly: 9.9% aged 65+
- Life expectancy at birth male/female: 77.4 / 81.6
- Infant mortality: 4.5% per 1,000 births
- Average no. of physician visits per year: 8.4
- Average length of stay (general hospitals): 4.2 days
- National expenditure on health
  - % of GDP: 7.8%; 2,069 \$ PPP



## Provision of Health Care Services

- Four competing not-for-profit sick funds; guaranteed freedom of choice



- Ministry of Health owns half the hospital beds; responsible for psychiatric care, preventive care and long term care

## Primary Health Care in Israel

- All residents insured in a sick fund of their choice
- NHI law defines the overall budget and a uniform basket of services sick funds provide
- Prospective payments to sick funds using an age adjusted capitation formula
- Nationwide network of clinics and independent physician's offices; high access in rural areas
- PCPs are salaried or have a contract (prospective, per listed patient); no fee for service
- The PCP has a central role; over 90% of population have a regular PCP
- The PCP – physician of first contact and gatekeeper; direct access only to common used specialties

## Innovative Strategies to Improve Quality of Care

1. Changes in structure
2. Performance measurement
3. Changes in processes of care
4. Training of primary care physicians

## 1. Redesigning Primary Care Services in Maccabi Healthcare Services\*

- Objective: to improve quality of care.
- Tool for improvement: a structural change
- Traditionally, primary care services provided by a solo practitioner
- Redesign:
  - treatment is provided by a physician-nurse dyad
  - responsible for proactive prevention, life style counseling, treatment and regular follow up of patients.
- Since 2007 the model is implemented in 50 clinics.

\*Source: Wilf-Miron R, Kokia E and Gross R. "Redesigning primary care services in Maccabi". Health Policy Monitor, September 2007. <http://www.hpm.org/survey/is/a10/3>

## Main Features of Program

- Care is provided by a multi-disciplinary team
- Physicians have a defined community of members
- The encounter is used for comprehensive management of patients' health
- One-stop-shopping for preventive care
- Care is "patient-centered"

Based on the "chronic care model", Bodenheimer et al. 2002

## Incentives

- **Physicians:**
  - opportunity to improve patients' health
  - Opportunity to improve performance in internal quality measures
  - Teamwork will provide the physicians with more time for the clinical tasks (→job satisfaction)
  - Physicians receive funding for a trained nurse
- **Sick fund:**
  - Improve quality of care, equality among population groups and cost-efficiency

## 2. National Primary Care Quality Measurement System\*

- System-wide voluntary cooperative effort to improve quality of primary care.
- Tool - measurement of medical indicators and feedback to the sick funds
- Based on the HEDIS indicators (50 to date)
- Uniform methodology to construct the measures based on data from Electronic Medical Records

\*Source: Porath A., Rabinowitz G, Raskin Segal A (2008). Quality Indicators for Community Health Care in Israel Public Report 2005-2007. State of Israel Ministry of Health, Health Council, The National Institute for Health Policy and Health Services Research.

## Main Features of the Program

- Endorsed by the Ministry of Health (2004); annual reports published to the public and available on the web
  - Reports present national trends by age group and SES (planned to present by geographic region)
  - Sick funds receive confidential report showing their score compared to the average
- Since 2007 sick funds reimbursed for participation
- Sick funds initiate programs to improve quality (e.g. monitoring, training, patient education)
- Improvement in many measures over time

## Medical Conditions (2007 results)

- **Asthma** (78% preventive medications)
- **Breast cancer screening (60% among 50-74)**
- **Screening for colorectal cancer** (22% tested for fecal occult blood)
- **Flu vaccine** (59% among 65+)
- **Pneumococcal vaccine** (36% among 65+)
- **Diabetes** (49% Hga1c<7; 61% LDL<100 mg/dl; 73% BMI documented; 67% BP< 130/80)
- **Cardio vascular diseases** (76% cholesterol level tested; 68% beta blockers prescribed after angiography of bypass)
- **Children's health** (42% BMI documented; 66% of babies hemoglobin values documented )

## Type of Measures

- Morbidity indicators (prevalence of diabetes, hypertension)
- Prevention indicators (screening, vaccinations)
- Performance indicators (medication to diabetics, beta blockers; measuring BP, BMI)
- Outcome indicators (achieving a recommended control value e.g. Hga1c <7 ; BP <140/90)
- Documentation indicators (vital information is recorded e.g.BMI)

### 3. Proactive Program in Clalit Health Services for Managing Clinical Quality\*

- Objective: To improve Clalit's national quality indicators
- Tool for improvement: changes in process of care - proactive case management; patient centered care
- The change ("Yozma" Program):
  - Proactive identification of target group by clinic staff
  - Invitation of patients for special consultation to improve control of chronic conditions prevention
- Since 2008 implemented in 50% of clinics

\*Source: Goldfracht et al. "Proactive Program for Managing Clinical Quality". Health Policy Monitor, April 2009.

### Background: Organization of Primary Care in Clalit

- Provided mainly in multidisciplinary community clinics (8 districts; 400 clinics);
- Physicians have defined patient list (average size: 1,500); 90% work at a clinic with a nurse
- Guidelines issued for preventive medicine and management of chronic conditions
- Electronic medical record for all patients
- 72 quality indicators monitored internally by Clalit
- Periodic computerized reports on performance by clinic, physician and patient

## Main Features of Program

- Each participating clinic selected a group of quality indicators for active intervention; received a list of patients with low scores
- Clinic proactively invited patients for lengthy consultation by nurse and physician
  - Check up by nurse to complete preventive procedures (vaccinations, BP measurement)
  - Physician checked for cardiovascular risk factors  
Patient referred to relevant tests
  - Patient received recommendations to improve control and management of chronic disease
  - Follow up visit scheduled with doctor and/or nurse

## Incentives

- **Sick fund:** improvement in national quality indicators; cost containment
- **Clinic:** strategy for improving performance & gaining appreciation of district management
- **Physicians & nurses:** professional satisfaction from improving clinical care; positive feedback from patients

## Outcomes of Yozma Program (Internal Evaluation)

- Pilot conducted with 10 clinics (medium/low scores in quality indicators); Matched control clinics (size, SES, age, % chronics, staff characteristics; quality scores)
- After 6 months- improvement in indicators (e.g. patient satisfaction, mammography); high staff satisfaction; lower workload; cost containment
- Rapid dissemination: within a year voluntarily adopted by 50% of Clalit clinics

## 4. Training Primary Care Staff to Address Mental Distress \*

- Objective: improve ability to diagnose and treat depression and anxiety
- Tool for improvement: training of primary care staff (knowledge, attitudes, skills)
- Training program:
  - Dissemination of guidelines for identifying and treating common mental health problems (depression; anxiety)
  - Compulsory training of primary care teams as part of Clalit's CME programs
- 90% of teams attended training seminars

\*Source: Goldfracht et al. "Treating Mental Distress by Primary Care Staff\*\*" Health Policy Monitor, October 2006.

## Main Features of Program

- Developing guidelines by a multi-disciplinary team and disseminating them at clinic staff meetings
- Developing tools for identifying mental distress
- Internal marketing: one-day conference; in-service one day "train the trainer" seminar for district representatives
- Compulsory in-service one-day seminars for primary care teams at district level
- Three follow up seminars ("mood ruler"; prescribing medication and increasing patient compliance; staff's emotional difficulties in treating mental distress)

## Incentives

- **Sick fund:** improved care and cost containment
- **Primary care team:** professional satisfaction; reduce workload (related to untreated condition); obligatory seminars and monitoring

## **Outcomes of Training Program (Internal Evaluation)**

- 90% satisfied with training seminars
- Before/after measurements indicated increase in knowledge & perceived skills; decrease in perceived barriers
- 15% increase in number of patients using anti-depressants; 15% rise in DDD for prescribed anti-depressants

## **Reflection on Innovations to Improve Quality of Primary Care**

- Structural features: managed care system; strong primary care; highly developed IT
- National health policy: sick funds compete over patients and operate within tight budgetary constraints
- Growing realization among sick fund management that appropriate high quality primary care contributes to cost containment
- Consequently, sick funds initiate innovations to improve quality of primary care: changes in structure, process of care, and training of staff

**Thank You!**