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Delivering tangible population-based outcomes via an alliance model: South West Primary Health Care Alliance Queensland

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Policy Issue

Health systems globally are faced with a shift in global demographics of ageing and increasing incidence of chronic conditions. Internationally, key health care reforms rely on improved integration of care to address fragmentation of services, moving to co-operation not competition; to enable better coordinated, more continuous care; and, shifting away from siloed and program-based funding towards new models of funding with more efficient use of resources.

These challenges require health systems to focus on better integrated care and organisational coordinated care across different settings at local or regional levels (Exley et al, 2024; George et al, 2023; Redgate et al, 2023; Gurung et al, 2022).

As international health care reforms look to promote ongoing collaboration and accountability to improve access to services and improving population health, little is known about which kinds of collaborations work, for whom, and in what contexts (Alderwick et al, 2021; Alderwick et al, 2022; Sanderson et al, 2018). Addressing governance challenges is key to such collaborations (Exley et al, 2024).

One such mechanism to embed ongoing service integration across primary secondary health care is that of alliance contracting or alliance governance.

This model, involving contractual and relational mechanisms, brings local stakeholders within a given geographical area

together to collectively address and govern health care design and delivery relevant to a specific shared problem (Akmal & Gauld, 2021; Keller et al, 202; Nicholson et al, 2018).

Alliancing supports independently governed services to work together to focus on shared problems, developing collaborative whole system approaches by developing commitment and trust between alliance partners (Redgate et al, 2023; Keller et al, 2021).

Such arrangements are called for in both the National Health Reform Agreement (Department of Health & Ageing, 2020) and Australian National Health Reform Agreement Mid-term Review (Huxtable, 2023) seeking commissioning arrangements that provide stronger incentives for local health organisations to co-ordinate care, pool funding and integrate health services.

The Mid-term Review specifically stated the need for 'commitment to greater alignment and collaboration between Primary Health Networks, Local Hospital Networks and Aboriginal Controlled Community Health Organisations' for 'a shared whole of Health System Agreement with the right architecture and governance' and 'a nationally consistent governance framework with formal governance structures, mechanisms, and roles and responsibilities that drive and enforce integration' (Huxtable, 2023). We report the successful implementation of this approach since 2022 in South West Queensland, Australia.

What does the evidence say?

Alliance contracting has been trialled successfully internationally (Gauld, 2017; George et al, 2023; Gurung et al, 2022; Cousins et al, 2020) using both formal (contracts) and informal (relational) governance mechanisms to address inherent tensions that come with cooperation and coordination (Solinas et al, 2022).

The three international and one Australian exemplar below demonstrate the evidence

involved in the approach – all different methodologies but within the same alliance governance contractual framework. Previous work has identified the ten elements, Figure 1 below, required for successful integrated primary/secondary health care governance across a regional setting (Nicholson et al, 2013; Nicholson, 2019). These 10 elements will be used to illustrate the strengths of the 4 case studies.

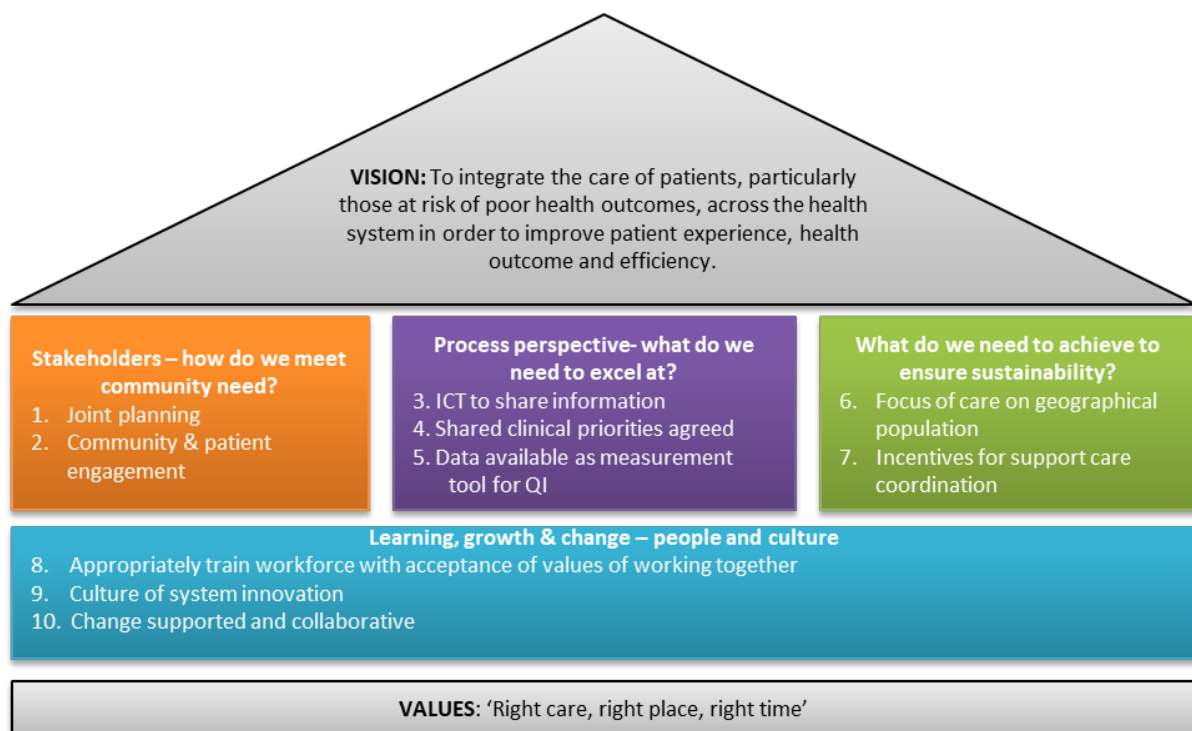


Figure 1: Key elements of alliance governance balanced scorecard (Nicholson, 2019).

Canterbury Health System, NZ

The Canterbury region of New Zealand began redesigning ways of working across health and social care in 2007 due to high levels of hospital admissions and increasingly non-sustainable financial costs (Timmins & Ham, 2013).

Canterbury District Health Board (DHB) had an alliance leadership team (ALT), membership of which was determined by the local DHB and Primary Health Organisation (PHO). Members included health professionals, others from hospital and primary care settings, and those with resources, such as the chief executives of the DHB and respective PHOs, as well as consumer representatives.

Each member signed a charter spelling out the rules of engagement and focus of the ALT, which then set local priorities and plans on how these would be met (Gullery, 2017; Gauld, 2014). Three key approaches attributed to Canterbury's success were, a clear vision of 'one system, one budget'; investment in staff through training, skills development and innovation; and an alliance model of service contracting and integrated working. (Scobie et al, 2022; Charles, 2017).

The Canterbury Health System alliance governance approach addressed all ten elements of governance redesign (Figure1): joint planning and priority setting; integrated information communication technologies (ICT), including development of web-based clinical pathways across the continuum and HealthOne an electronic Shared Care Record Viewer.

The ALT was clear about outcomes but flexible in how to reach these; service level alliance teams focused on shared clinical priorities; and the ALT and its member organisations were supported by flexible funding arrangements allowing pooling or shift of resources to support new configuration.

The focus was on the entire Canterbury population of ~510,000 with system-wide measures including patient experiences with the system; investment in integrated continued professional development via staff training and co-design workshops; and meaningful engagement with health professionals, community leaders, and patients.

There was also a sustained investment in providing staff and contractors with the skills needed to innovate (Timmins & Ham, 2013; Gauld, 2014; Cummings et al, 2021; Dolan et al, 2021).

Reported outcomes include the lowest ED attendance rate in Australasia at the time of measurement (178 per 1000 in 2017/18); and 27% fewer acute medical admissions in 2018/19 compared to the New Zealand average. In 2018/19, over 34,000 people who would previously have been treated in ED or acutely admitted to hospital, received their treatment and care in the community; and, with the implementation of its integrated falls prevention strategies 3291 fewer people with falls presented to ED, with 981 fewer than expected admissions for hip fractures saving about 30 hospital beds each year.

The reduction in hospital beds that followed the introduction of the model was approximately one ward reduction each year resulting in reduced expenditure of over NZ\$45M over 5 years for an annual investment of around NZ\$0.75 M (McGeoch et al, 2019;

Dolan et al, 2021). The Canterbury Clinical Network, an alliance of Canterbury health professionals, was disestablished in June 2024 and now hosted by Pegasus Health (Cassie, 2024).

Coordinated Care Organizations, Oregon, United States

In the state of Oregon (USA), the Oregon Health Authority (OHA) signed contracts with 16 organizations to serve as coordinated care organizations (CCOs) in 2012. These 5-year alliance contracts set new requirements for CCOs to improve care for Oregon Health Plan (OHP) members and hold down cost increases in Oregon's Medicaid program (Oregon Health Authority, 2022).

CCOs were local, with one budget that grew at a fixed rate for mental, physical and ultimately dental care. CCOs were accountable for health outcomes of the population they served, governed by a partnership among health care providers, community members, and stakeholders in the health systems that share financial responsibility and risk.

Key elements of the coordinated care model contract included implementing best practice to manage and coordinate care; having shared responsibility for health; measuring performance; payment for outcomes; clear and transparent information systems, and sustainable cost containment (Oregon Health Authority, 2022).

The CCO model addressed all ten integrated governance elements (Figure 1) in supporting

health governance with multiple stakeholders across the region. CCO's were accountable for setting local priorities and planning how these would be met; the OHA PointClickCare health IT platform shared information between users including CCOs, health plans, physical and behavioural health providers, hospitals, skilled nursing facilities, and Oregon Department of Human Services.

Oregon's Transformation Centre, a new office created with the OHA, was designed to support change leadership and dissemination. It convened statewide CCO learning collaboratives that provided peer-to-peer learning experiences, subject matter expert education, and quality improvement strategies, and was designed to serve as a hub for innovation.

The CCO model integrated financing and delivery systems for a broad scope of services; and accepted full financial risk in the form of a global budget. Population size covered ranged from 12,084 – 276,583 and CCOs measured quality of care as defined by 33 measures and were responsible for submission of Community Health Plans and Community Health Assessments (Oregon Health Authority, 2022).

To date CCOs have: delivered cost-effective services with a fixed annual cost growth rate of 3.4% versus 6.4% for non-CCOs; promoted comprehensive health investments by allowing for an expansion of the services Medicaid typically covered; improved access to primary

care; reduced emergency room visits and saved the state an estimated \$2.2 billion dollars in avoided health care costs whilst garnering community engagement and support (Tracy, 2018; Oregon Health Authority, 2018).

The Prevention Alliance, Stockport, United Kingdom

In 2015 Stockport Council (UK) faced an impending reduction in budget and having trialled the alliance contract commissioning model through the Stockport Mental Health Alliance in 2013 (Clark et al, 2015) had a desire to move to a more generic population-based approach led by need rather than specific support by group.

Prior to 2015 there were around 60 separate contracts and grants, and Council decided an alliance contract would better deliver on some of their strategic objectives. The Prevention Alliance (TPA), commissioned by Stockport Council as part of their wider preventative strategy, was established on 1st July 2015 with £4.5m over 3 years (Clark et al, 2015; Dixon, 2015).

The ongoing service is delivered through an alliance of organisations working with Stockport Council including Age UK Stockport, FLAG, Nacro, Stockport Age UK, Talk, Listen, Change (formerly Relate Greater Manchester South), Stockport Homes and Jigsaw Support (replaced Threshold from original set of providers).

Members agree to a values charter and are bound contractually to work together to achieve common outcomes.

The Alliance is led by an Alliance Leadership Team, including senior representatives from the six provider organisations and two Council commissioner representatives, working together driving forward innovation to achieve shared outcomes.

The Prevention Alliance approach addressed eight of the elements to support governance across the Stockport region. Stakeholders jointly developed an agreed vision, purpose and performance framework with a shared priority to reduce demand on high support services by first focusing on prevention for the local population of Stockport, approximately 280,000 people.

The Alliance contract shared risks across providers and success was judged against overall performance rather than the performance of individual organisations. A co-produced performance framework and reported outcomes monitored success, and flexibility and innovation were built in as an expectation of all.

Two of the 10 elements for success (Figure 1) underdeveloped by the Alliance were the lack of an ICT platform to share data, although there was some shared data about care pathways, processes and outcomes separately;

and while there was no formal joint professional development to support the value of joint working there was collective accountability and incentives to share learning. (The Prevention Alliance, 2021; Clark et al, 2015).

In 2019 reported outcomes included 33% of the 560 people directed to TPA from public

services. This helped to relieve pressure on public resources, with 80% of people having made positive progress towards achieving their goals; 16% people connected to their community through social prescribing; 53% of people having maintained their goals independently; and 98% of people satisfied with how TPA worked with them (The Prevention Alliance, 2019).

South West Primary Health Care Alliance, Queensland, Australia

A South West Queensland all-of-community Health Forum held in March 2021 identified an unsustainable workforce across the region as a critical risk to service delivery, leading to the inception of the South West Primary Health Care Alliance, Queensland, (the Alliance) in 2022 as a means to integrate and optimise available workforce (Western Queensland Primary Health Network, 2024; Jackson, 2024).

Combining the actions of regional primary, community, and secondary care organisations were identified as key to addressing this threat. These included South West Hospital and Health Service, Western Queensland Primary Health Network, Health Workforce Queensland, CheckUp, private general practice, Royal Flying Doctor Service, Aboriginal Community Controlled Health Organisations (ACCHOs) including, Charleville

and Western Areas Aboriginal and Torres Strait Islanders Community Health Ltd (CWAATSICH), Goondir Health Services and Cunnamulla Aboriginal Corporation for Health (CACH).

An Alliance Leadership Team (ALT) formed that included senior representatives from hospital, primary and community care from organisations across South West Queensland.

Each member signed an alliance charter spelling out the rules of engagement and focus of the ALT, which then set local priorities and plans on how these would be met.

In addition, an Alliance Governance Framework (SWPHCA, 2024), with principles based on the 10 elements of health governance for integrated care (Nicholson et al, 2013) was formally adopted (Figure 2).



South West Queensland Primary Care Alliance Governance Framework

Vision

One integrated, high quality, and efficient system meeting the health care needs of South West Queensland communities.

Deliverables

1. An evidence-based 'whole of system' alliance governance approach for primary integrated care in South West Queensland
2. Accessible, well-integrated primary and secondary health care focussed on wellbeing
3. A sustainable, sufficient, and supported primary care workforce to deliver this care
4. A system responsive to patient needs and focussed on achieving the Quadruple Aim

Principles^a

- We will strive for equitable health outcomes across our population through accessible, culturally appropriate services;
- We will support whole of system planning based on commitment and collaboration, working together as equal partners;
- We will strive to address diverse perspectives co-operatively, and wherever possible achieve consensus decisions, conducting ourselves with honesty and integrity and developing a high degree of trust;
- We will adopt a patient-centred, 'whole of system' approach where optimal care is delivered in the most appropriate setting by the most appropriate provider;
- We will agree to formal administrative and resource sharing with clear roles and responsibilities, including formal and legal control mechanisms;
- We will support the best use of finite resources, including pooled funding, to achieve agreed health outcomes for our population;
- We will promote an environment of high quality, performance and accountability, supported by appropriate data sharing, in aligning incentives to meet organisational and Alliance goals; and
- We will support change leadership and clinically led service development to foster innovation and value-based care.

Figure 2: South West Primary Health Care Alliance governance framework deliverables and principles (WQPHN, 2024).

The Alliance model addressed some but not all the ten elements to support health governance. The ALT jointly agreed the alliance mission, vision, purpose and set local priorities and plans on how these would be met, and leadership was clear about what it was trying to achieve (outcomes/goals) but flexible about how to reach those goals.

The ALT developed a Workforce Implementation alliance team to address the shared priority of a sustainable workforce; its focus was the population of South West Queensland area - ~26,000 people across 319,000 square kilometres.

Patient and community engagement was required by partnering organisations; and

research supported the innovation spread and learning in the implementation of the model. At establishment there was a lack of an integrated ICT platform for data sharing and organisations separately reported and then combined key data.

Organisations used existing resources flexibly to support the work of the alliance with no funds pooling or joint risk sharing required; but set measurement of the alliance initiatives with strict KPIs to guide the work program and timely deliverables. No CPD was required in joint working across organisations.

At August 2024 37.5% of key performance indicators (KPIs) had been exceeded, 50% met and 12.5% partially met (Table 1).

Table 1: South West Primary Health Care Alliance Workforce Implementation Strategy outcomes

Objective	Strategies	KPI	Outcome	KPI result
Shared Workforce Data and Health Intelligence				
The recruitment & retention of permanent ongoing practice workforce.	Identify current established & vacant positions at baseline & 12 months	Permanent primary care workforce numbers stable at 12 months	At 12-month primary care workforce stabilised from an unsustainable position 12 months previous.	Met
Identify current geographical access to services through activity funding.	Benchmark using population primary care activity and billing data in the last 12 months.	<ul style="list-style-type: none"> - Identify proportion of the population without access to MBS - Identify proportion attending the practice at least 3 times in past 2 years 	<ul style="list-style-type: none"> - ~25% do not access to the MBS. - Of those who access the MBS ~30% attended the practice at least 3 times in 2 years 	Met
To map continuity of provider.	Analyse continuity of care provider on all hospital and general practice contact	>80% all hospital contact has record of continuity of care (CoC) provider	All hospital contacts with recorded CoC provide: <ul style="list-style-type: none"> - Apr-23 61.5% - Apr-24 81.5%. 	Met
Partnerships Enabling Capability and Transformation				
Remote ongoing workforce support for vulnerable practices using digital enablers in SW Qld	Support implementation of Qld Virtual Integrated Practice Program	<ul style="list-style-type: none"> - 15% practices using VIPP support at 18 months 	<ul style="list-style-type: none"> - 30% practices using VIPP - 100% patients satisfied/highly satisfied - 99% reported improved access to a GP 	Exceeded
	Support uptake of eConsultant model of care available to support all practices	<ul style="list-style-type: none"> - 25% all practices using eConsultant at 18 months. 	<ul style="list-style-type: none"> - 30% practices using eConsultant: - Mean time for specialist response to GP request for advice 0.54 days - 87% of patients avoided a face-to-face outpatient appointment 	Exceeded

		- Provider satisfaction	- GPs (n=3) rated the service as excellent for patient management	
A population health data informed redesign to provide appropriate primary care continuity of care to SW rural communities.	Describe potential model(s) and develop a prioritisation framework to assess strengths and weaknesses of models.	Primary Care Pilot in operation at 12 months in one remote community	Workforce agreed and hosted locally for 4 remote communities.	Exceeded
		Consider implementation options for medical workforce	Primary Care Access Integrated Model presented and endorsed by Alliance Leadership Group.	Met
	Optimise access to outreach Allied Health Professionals (AHPs) across the SW	Access to AHP across Primary Care Pilot Model implementation areas: - 5% increase in professional support - 10% increase in telehealth	Data from one organisation, not all, presented. Key issue is collection of consistent data across organisations.	Partially met

What is the quality of the evidence available?

Few comprehensive evaluations of the alliancing contracting model demonstrating outcomes in the health literature exist currently - those available are commonly

reports presenting general findings (Cumming, 2021). This paper seeks to report those most successful based across similar reporting framework.

What does this mean for policymakers?

The Alliance governance framework represents a worthy vehicle to support the NHRA Review's call for a nationally consistent, better integrated health care platform for Australian communities.

It creates the opportunity for binding 'whole of system population-based health care delivery in areas which require an all-service focus to achieve impact without the need for independent organisations to surrender control or structural change.

The governance structure is a critical enabler, allowing both a shared vision and all-service commitment for local care improvement, preservation of individual organisational autonomy, and equal input into the shaping and delivery of the desired outcomes.

The model allows development of a true population health systems perspective, including pooling of data and budgets; place-

based leadership drawing on skills from different agencies and sectors based on shared vision and strategy; goal setting based on analysis of local need and evidence-based interventions; effective community engagement; and incentives to encourage joint working.

It is hoped that this paper will encourage policymakers, coalface clinicians and managers, and health consumers to understand the opportunities offered by this model, and to look to their own communities for adoption. The NHRA Review rightfully identifies both the failures of, and urgency for, improved integration in optimally delivering \$60 billion annually in Commonwealth / state administered health spend. Alliance governance is a proven model able to deliver the needed change, and well worthy of consideration as the new Agreement commences in 2025.

Closing remarks

Implementing an alliance governance framework defines how partners collaborate, communicate, co-commission and co-ordinate mutually agreed goals and outputs. The principles which sit behind and enable this include trust and commitment among the

partners, flexibility, and valuing each partner's organisational reality. Opportunities currently exist to support increased uptake of the model but require local and national commitment, leadership and policy support to progress.

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