Disparity reduction strategy in Israel's Clalit Health Services

Overview

In response to widening health disparities across the country, Clalit Health Services – Israel's largest health fund – aimed to better meet the needs of its diverse population with the implementation of a health disparity reduction strategy across its organization. Capitalizing on an organization-wide electronic medical records system, Clalit developed a data-driven initiative to improve the performance of clinics where the widest health disparities were being observed. Using a composite health disparity score (QUIDS) of seven indicators measuring both performance and health outcomes, clinics were ranked by the level of disparity observed within their patient populations. Clinics from each district determined to have the highest inequality were then targeted for intervention. Through a top-down approach, district leaders were convened at a conference, provided with guidance on addressing observed disparities and assigned performance targets. District-level financial incentives were put in place to promote teamwork among clinics instead of individual competition. Through provider-led initiatives, local districts and clinics planned and implemented tailored interventions designed to reduce disparities. Interventions included strengthening leadership skills of clinic staff, extending clinic hours, providing more services in the community, improving cultural competencies, engaging community leaders and targeting outreach to at-risk patients. Regular feedback on performance facilitated continuous improvements and helped motivate clinics to achieve performance targets. Over a three-year intervention period, the difference on QUIDS scores between intervention and non-intervention clinics narrowed by 60%, with improvements seen on all indicators included in QUIDS. Clalit Health Services remains committed to the disparity reduction strategy and continues to monitor the initiative.

Problem definition

In 2012, Israel ranked highest among OECD countries for economic inequality, attributed in part to its diverse demographic profile comprising many different ethnic, immigrant and religious groups.[1] This inequality extends to other sectors, including health (Box 1). Israel has large differences in life expectancy, infant mortality and chronic disease relating to geographic area, minority status and education level. For example, the Arab population – the largest non-Jewish group in Israel – have an average life expectancy 3.2 years shorter than the Jewish population and are twice as likely to suffer from diabetes between the ages of 45–74 years[1].

Under national health insurance law, all Israeli citizens must join one of four government financed health funds. As government funding is provided on a capitation basis and health funds act as both the insurer and provider of services, health funds have a financial interest in supporting an enrollee's health. Clalit Health Services is the largest insurer with 4.2 million enrollees and provides coverage and services to over half of Israel's population, with an overrepresentation of vulnerable populations, including 70% of Israel's elderly.

Box 1

What problems did the initiative seek to address?

- Observed health inequalities in vulnerable populations.
- Higher costs linked to overrepresentation of vulnerable populations enrolled in Clalit Health Services.

Health services delivery transformations

Timeline of transformations

Despite having a long history of caring for vulnerable populations, decades of work to reduce health disparities within Clalit Health Services had been met with limited success. Government health insurance reforms in the 1990s of health insurance laws mandated universal health care access and uniformity in services provision, comparatively poor health outcomes persisted in vulnerable populations indicating that equal treatment alone was not enough. In 2008, recognizing this problem, Clalit launched the Disparity Reduction Strategy within their organization to address inequalities in health outcomes (Table 1). Using data already available from electronic medical records, a composite Quality Indicator Disparity Scale (QUIDS) was generated and 55 clinics reporting the greatest

Table 1
What were the key stages in Clalit Health Services' Disparity Reduction Strategy?

Stage		Description
1	Selection of quality indicators	Expert steering committee of Clalit health professionals examined 70 quality indicators currently collected by Clalit; each indicator was ranked by level of disparity between high and low socioeconomic populations determined through geocoding clinic locations; seven indicators were chosen.
2	Scoring of primary care clinics	Selected indicators were weighted by the steering committee for overall importance leading to the Quality Indicator Disparity Scale (QUIDS) measure based on seven indicators; clinics in each of Clalit Health Services' eight districts ranked using QUIDS.
3	Selection of target clinics	Clinics in each district with the highest level of disparity determined by QUIDS designated as target clinics for intervention; 55 clinics (approximately 10% of all clinics) selected.
4	Setting goals and incentives	Individual performance targets set for selected clinics; district-level financial incentives made available for individual targets achieved.
5	Planning of local interventions	Bottom-up planning approach applied to determine opportunities for performance improvement; clinic-specific interventions developed.
6	Continuous monitoring and evaluation	Ongoing assessment of improvements in each district in comparison to original QUIDS score.

health disparities were chosen for targeted intervention. Currently in the final stage, ongoing monitoring and evaluation of the QUIDS scores and clinics' progress continues to be carried out by Clalit Health Services to maintain and advance improvements already generated by the Strategy.

Description of transformations

Selecting services. Clalit offers a comprehensive basic package of services. The addition of the Disparity Reduction Strategy has encouraged services to be tailored to the needs of vulnerable populations through locally designed and implemented interventions. Services where disparities were most pertinent, including performance of occult blood testing, influenza vaccination and mammography tests, are key areas of focus.

Designing care. Several tools have been developed to enable providers to identify at-risk patients and better respond to their needs. For example, at-risk patient lists are created at the clinic level so providers can target these patients for adapted care. At-risk patients are also proactively approached through outreach initiatives and encouraged to participate in preventive services.

Organizing providers. Clalit Health Services owns and operates a network of 1200 clinics, 14 hospitals (accounting for one third of all acute care beds in Israel) and a countrywide network of pharmacies, dental clinics, specialist centres and laboratories; 7500 physicians and 11,500 nurses are employed by the organization as part of its workforce. Clalit has a strong primary care network and every patient is overseen by a general practitioner who is fully accountable for their health. General practitioners work in large clinics within multidisciplinary teams comprised of nurses, allied health professionals and administrators. When patients enter secondary or tertiary care, discharge-planning nurses and real-time electronic medical records facilitate communication between providers to ensure continuity of care. The Disparity Reduction Strategy largely capitalized on the strong primary care network already in place within communities with adjustments made to the organization of providers based on individual clinic needs, such as extending clinic hours to increase access, increasing mobile community care and integrating translator services.

Managing services. Clalit Health Services is the largest insurance fund in Israel and operates as an entirely self-sufficient, integrated care organization. As such, it provides all care "under one roof" through a decentralized organizational model. A strong electronic medical records system enables predictive modelling and identification of at-risk patients and data is routinely collected on

70 general quality measurement indicators. With the necessary infrastructure already in place, the Disparity Reduction Strategy avoided the need for additional investments by using data already being collected to develop the QUIDS scale. Strengthening of managerial capacities at the local level for districts targeted for intervention by the Strategy has helped local leaders generate and maintain services delivery improvements.

Improving performance. While clinics continue to be assessed for overall quality performance, the addition of feedback on QUIDS scores has focused attention on reducing disparity rather than just generating overall improvements. To advance a culture of continuous learning and innovation, joint meetings between clinics and districts have allowed successful interventions implemented under the Strategy to be shared with peers. Additionally, many local interventions have delivered ad hoc trainings to strengthen providers' skills in areas such as leadership, management and cultural competencies, better enabling them to achieve new performance targets.

Engaging and empowering people, families and communities

By encouraging locally-designed interventions, the initiative has placed greater emphasis on engaging people and communities in health. Examples of local initiatives stimulated by the Disparity Reduction Strategy include outreach initiatives to encourage uptake of recommended preventive services, increased provision of care directly in communities through mobile care teams and partnerships with local community and religious leaders to deliver health promotion messages.

Health system enabling factors

The Disparity Reduction Strategy benefited from the existing organizational structure and culture of Clalit Health Services. Clalit's large self-sufficient care network

Table 2
How was the delivery of health services transformed through the initiative?

Before	After
Selecting services	
Comprehensive package of services defined by the government; needs of vulnerable populations not adequately met by generic provision of services.	Comprehensive package of services continues to be offered, but with adaptations to better target vulnerable populations; services with wide pre-existing disparities prioritized for intervention, such as occult blood testing.
Designing care	
Patients follow generic care planning for each patient.	At-risk patient lists developed to enable targeted care and proactive outreach to vulnerable groups.
Organizing providers	
Providers organized in large practices to pool skills and resources; general practitioners oversee all care for patients, supported by other providers as necessary; electronic medical records connect all Clalit providers; strong focus on team-working.	Small adaptations made at the local level to improve access to providers for vulnerable groups; examples include extending clinic hours, increasing mobile community care and integrating translator services.
Managing services	
Clalit organization entirely self-sufficient owning its own network of facilities; decentralized organizational model in place; strong electronic medical records system across organization collects data on 70 quality indicators.	QUIDS developed from existing data collection system to track progress towards disparity reduction performance targets; local managerial capacities strengthened to support services delivery improvements.
Improving performance	
Continuous monitoring and generic feedback on quality indicators motivated overall quality improvement, but failed to close disparity gaps.	Specialized feedback on progress towards QUIDS disparity reduction targets provided; successful local disparity reduction strategies shared through meetings; ad hoc trainings offered to strengthen providers' skills.

allows the organization almost complete control over establishing the conditions necessary for change. Conditions are set in a top-down manner within a decentralized organizational structure. Clear reporting requirements and accountability measures are in place at each organizational level. Clalit's senior management set organizational goals and provide oversight for district and sub-district managers who are responsible for planning, implementing and monitoring improvements on defined quality measures. District and sub-district managers hold general practitioners accountable for patients' health. As patients tend to remain with the same general practitioner, this establishes a clear link between providers and overall health outcomes for local populations, making providers highly accountable for performance. Additionally, providers have a deep-rooted sense of responsibility towards their patients' health created through a cradle-to-grave relationship.

While no disincentives for poor performance are applied, strong accountability lines create managerial pressure through inherent competition mechanisms to motivate general performance improvements. Financial incentives were put in place to support achievement of the Strategy's goals. Unlike pay-for-performance, which rewards individual providers, incentives are applied at the district level to foster team-work and collaboration between clinics in each district. This supports peer-learning between clinics by positioning them as partners working towards common goals instead of competitors. A centrally-appointed steering committee further assists the shared learning process through coordinating peer-learning activities and disseminating best practices among local clinics.

Strong information systems throughout Clalit ensure that reporting on services delivery is immediate and reliable. Regular feedback and assessment on QUIDS rankings helps motivate performance improvements. Clalit's electronic medical records system was a crucial element for enabling the initiative to take place as it provided data from which QUIDS – the driving factor behind the Strategy – was constructed. The electronic medical records system continues to be updated and new applications developed to further support quality improvements.

Outcomes

The initiative went beyond encouraging general improvements in health outcomes to more specifically motivate reductions in disparity. Furthermore, the Strategy directly targeted those health conditions known to most inequitably affect Clalit's enrolled population.

Table 3
How has the health system supported transformations in health services delivery?

System enablers	Example
Accountability	• Senior management for Clalit Health Services responsible for setting performance goals and providing organizational oversight. • District managers responsible for care delivery and oversight for providers in their local districts. • General practitioners care for patients from cradle-to-grave and, consequently, are highly accountable for local population health outcomes.
Incentives	• District-level financial incentives applied if clinics meet disparity reduction goals. • No disincentives for poor performance; managerial pressure and basic principles of competition encourage improvements where needed.
Competencies	• Culture of continuous learning within Clalit. • Central steering committee for Clalit facilitates peer-learning and dissemination of successful interventions for disparity reduction.
Information	• Comprehensive electronic medical records system collects data on extensive range of indicators, providing necessary information and allowing ongoing performance monitoring and evaluation.
Innovation	• New technologies researched to support performance improvements.

Early findings report positive results as a result of the Disparity Reduction Strategy (Box 2).

Box 2

What were the main outcomes of the initiative?

- All 55 target clinics showed improvements on QUIDS post intervention; target clinics accelerated improvements by 3.25 times the rate observed pre-intervention, while improvements for non-target clinics remained relatively constant.[2]
- Inequality gaps between target clinics and non-target clinics narrowed by approximately 60% within three years of implementing the Strategy.
- Greatest improvements were seen in performance-based quality indicators (performance of blood tests, influenza vaccination and mammography tests); outcome-based indicators (diabetes, blood pressure and lipid control and infant anaemia) were more modest, but still exceeded those seen in non-target clinics.
- Incident acute myocardial infarction rates among low-socioeconomic groups at Clalit declined at twice the rate of those in high-socioeconomic groups, significantly reducing previous disparities.[3]

Change management

Key actors

Top-down leadership at the senior management level within Clalit Health Services drove the initial development and implementation of the Disparity Reduction Strategy by establishing the necessary conditions and priorities for performance improvements. Top-down leadership was, however, coupled with a bottom-up approach and district leaders were empowered to implement tailored interventions at the local level, with primary care providers acting as the main implementers of change (Box 3). The commitment of primary care providers to improvement was largely driven by a sense of accountability for population health deriving from cradle-to-grave relationships with their patients. Primary care providers showed dedication to improving patient health and flexibility in their willingness to adapt practices to better meet patients' needs.

Box 3

Who were the key actors for the initiative and what were their defining roles?

- **Senior management**. Set the conditions for change through a top-down approach; established performance indicators to measure performance; provided feedback on performance to district management and awarded performance incentives; led monitoring and evaluation of the initiative.
- **District management**. Devised local solutions to achieve goals set by senior management; provided oversight for the initiative at the local level.
- **Primary care providers**. Key implementers of change at the ground-level; modified practices to realize changes proposed by district management; provided targeted interventions to vulnerable populations; worked in teams to achieve performance targets.

Initiating change

Economic drivers coupled with a long held organizational commitment to caring for vulnerable populations helped build momentum for change at the senior management level. Districts were informed of the strategy via a conference held in 2008, which served as a venue to initiate the planning process, issue guidance on evidence-based approaches for disparity reduction and present successful examples of peer-led interventions. Districts were issued a report on their current QUIDS rankings along with two-year targets. Each district initiated an internal planning process together with sub-district and clinic-level management to create locally tailored interventions for each targeted clinic within their district.

Implementation

Team-building and strengthening local leadership were key themes of interventions devised by districts. For example, clinical management teams participated in leadership skill-building workshops, multidisciplinary team meetings were incorporated into clinics' routines and individual staff members at clinics were assigned as champions to lead improvements on specified target indicators. Regular feedback to providers and district managers on QUIDS ensures continuous performance improvement and a sustained focus on disparity reduction.

Moving forward

Data indicates disparity reduction trends within target clinics for selected indicators. However, as little is currently known about the mechanisms through which these improvements were achieved, a comprehensive programme evaluation is currently underway to provide insight into how improvements were accomplished and explain why only moderate success was achieved for some indicators. Meanwhile, the initiative will continue to be monitored and supported as part of Clalit Health Services' commitment to disparity reduction.

Highlights

- Universally-applied quality improvement initiatives may not directly benefit vulnerable populations; focused disparity-reduction targets helped drive quality improvements for those most in need.
- Top-down leadership from senior management within Clalit Health Services was essential for creating the conditions needed for change.
- Locally-designed initiatives provided tailored solutions for achieving targets set by senior management.
- Capitalizing on pre-existing strengths and resources minimized the need for costly investments.
- Data-driven performance measures were the backbone for the initiative, providing evidence of the need for intervention, allowing monitoring of performance, incentivizing performance improvements and enabling evaluation.
- Regular feedback and monitoring fostered a culture of continuous learning and evidence-based performance improvement.

1 Organization for Economic Cooperation and Development (OECD). (2012). "Executive summary, assessment and recommendations". In *OECD reviews of health care quality: Israel.*

2 Balicer, R.D., Cohen, A.D., Goldfracht, M., Greenberg-Dotan, S., Jacobson, O., Jana, L., Lieberman, N., Regev-Rosenberg, S., & Shadmi, E. (2011). Reducing health disparities: Strategy planning and implementation in Israel's largest health care organization. *Health Services Research, 46* (4), 1281-1298. doi: 10.1111/j.1475-6773.2011.01247.x

3 Reges O., Leibowitz M., Hoshen M., Rabi Y., Gluzman I., Cohen CJ., & Balicer, R.D. (2014). Reduction in myocardial infarction incidence: focus on socioeconomic disparities. *Int J Cardiol, 174* (3), 773-4. doi: 10.1016/j.ijcard.2014.04.073