Why we need integrated care? Experiences from implementation of integrated care in Germany and UK.

Andrew P. Smith BSc CPFA

Commercial Director,
OptiMedis COBIC UK Ltd

ŁOMŻA 20th September 2019

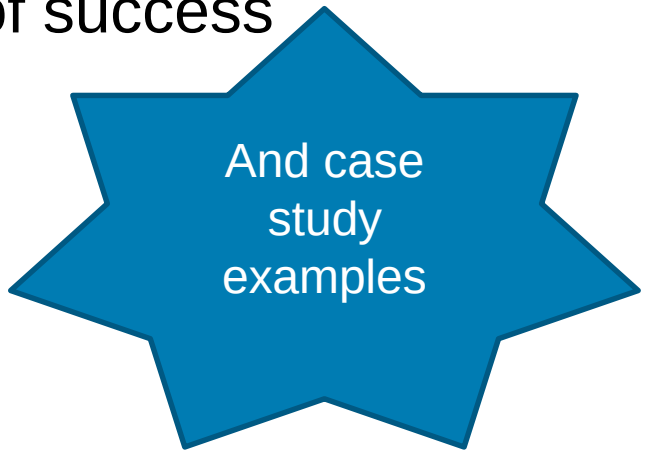
Contents

Introductions

What is Integration and why it is important (a brief history of the UK Journey)

How do we achieve it? Key elements of success

Lessons / Reflections



Introduction
OptiMedis COBIC UK Ltd

- Optimedis-COBIC is a joint venture between OptiMedis, world-leaders in the development of Accountable Care Systems, and COBIC, the UK pioneers of Outcomes Based Incentivized Contracting – developing outcomes frameworks and incentive models.
- Value Driven - established to support the NHS in UK and beyond to design & deliver population based integrated accountable care.
- Our approach is evidence based and built on public service values and principles.

We deliver the Quadruple Aim of Healthcare

- ✓1.4 years increased life expectancy for the 'managed' population compared to matched 'unmanaged' populations
- ✓system-wide cost savings of 7.5% per annum, and growing
- ✓improved quality & experience of care
- ✓improved staff recruitment and motivation

The Economist Case Study (2016). An integrated approach to value-based healthcare: Germany's Gesundes Kinzigtal, Economist (London) LINK

OECD (2016). Better Ways to Pay for Health Care. OECD Health Policy Studies. Paris: LINK

Case Study: Accountable Care in Practice: Global Perspectives. Duke University LINK

Contents

Introductions

What is Integration and why is it important (a brief history of the UK Journey)

How do we achieve it? Key Elements of Success

Lessons / Reflections

What is integration and why is it important?
Accident of History?

Our fragmented healthcare systems are engineered for “repair” but not for “maintenance” and not at all for “prevention” and “innovation”.

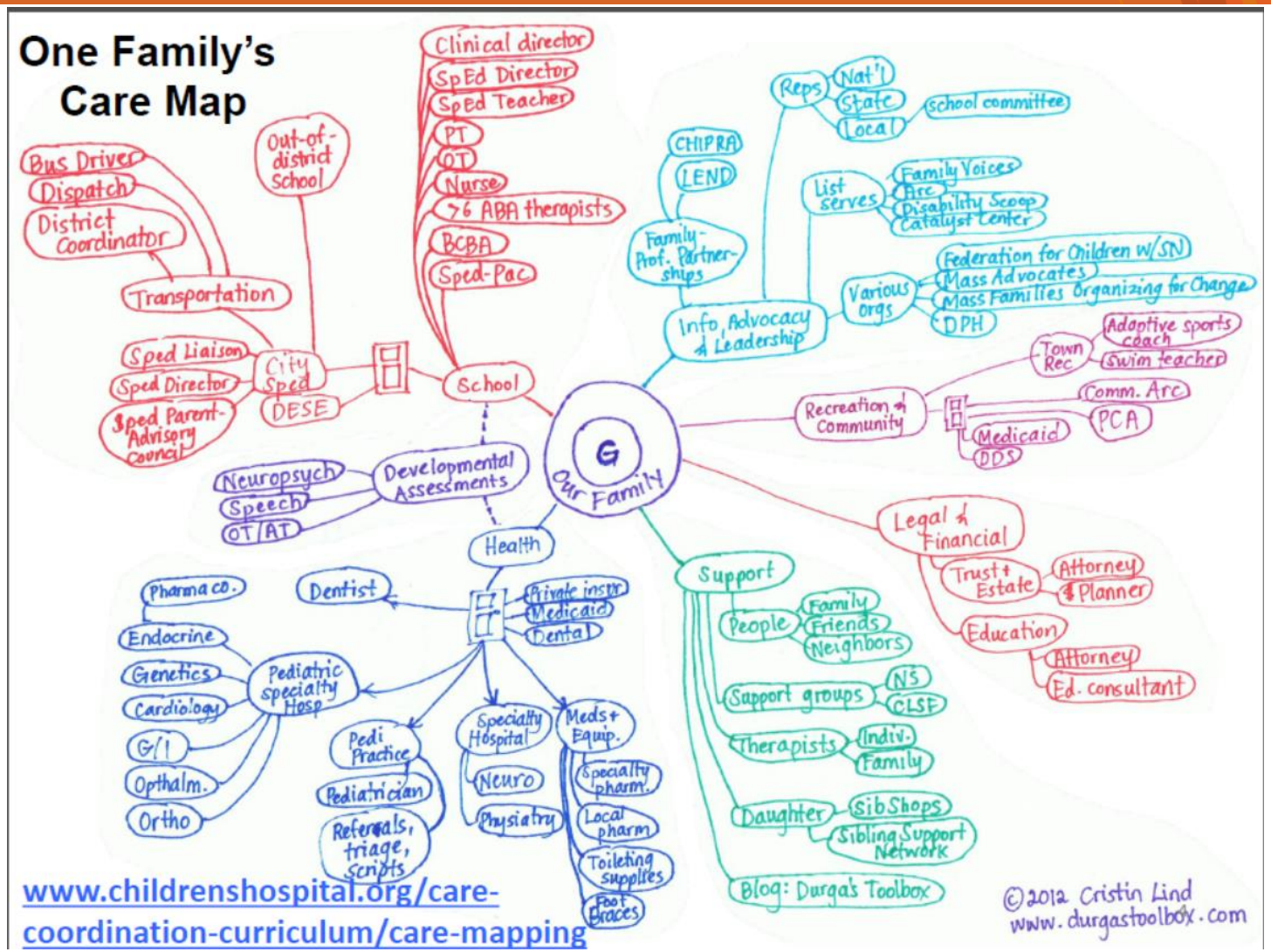
What is integration and why is it important?
Right now, who cares (overall)?

Meet Amy

6 months, 14 different microsystems, 21 visits

Professor Eugene C. Nelson, DSc, MPH, The Dartmouth Institute, USA

What is integration and why is it important?
The system works hard (in their own silos)

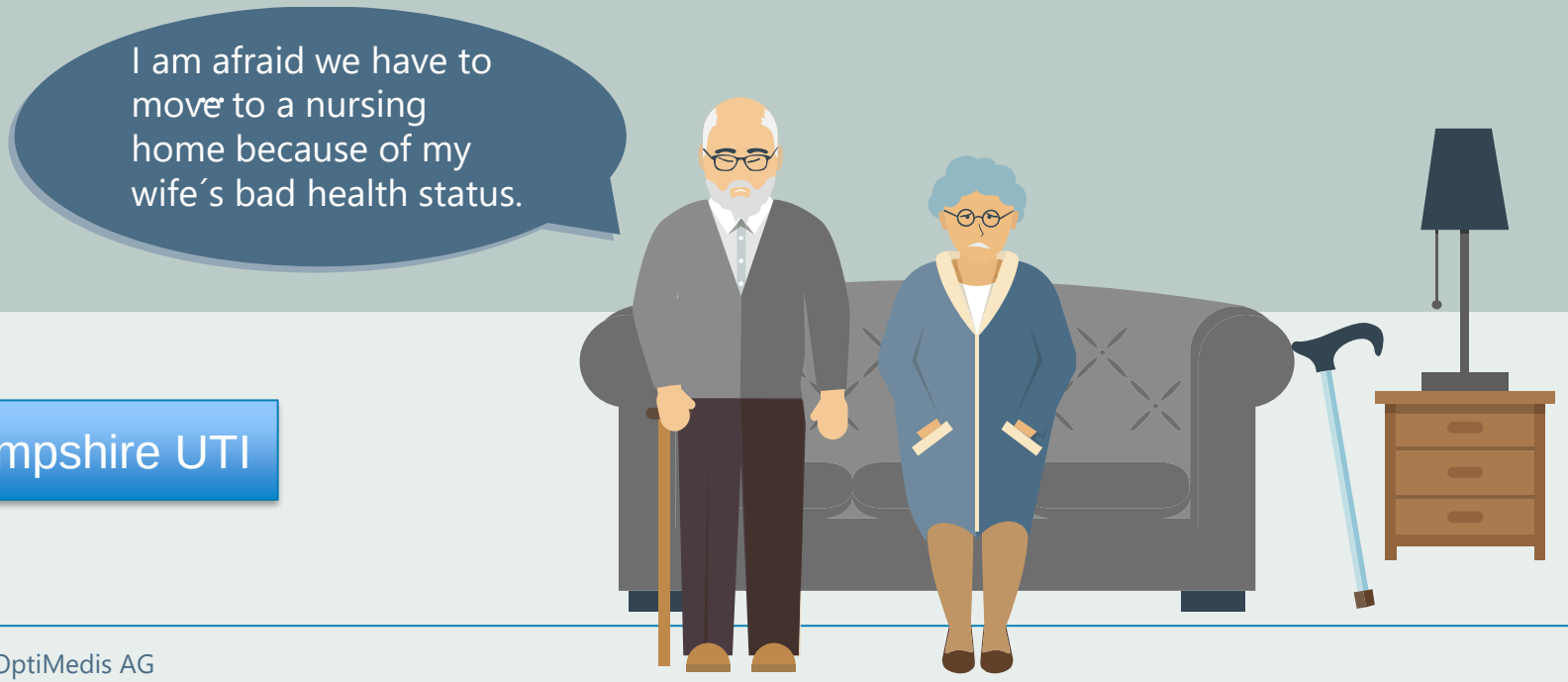


Richard Antonelli, MD, MS Medical Director of Integrated Care Boston Children's Hospital / Harvard Medical School Boston, USA

What is integration and why is it important?
The Impact on people and resources

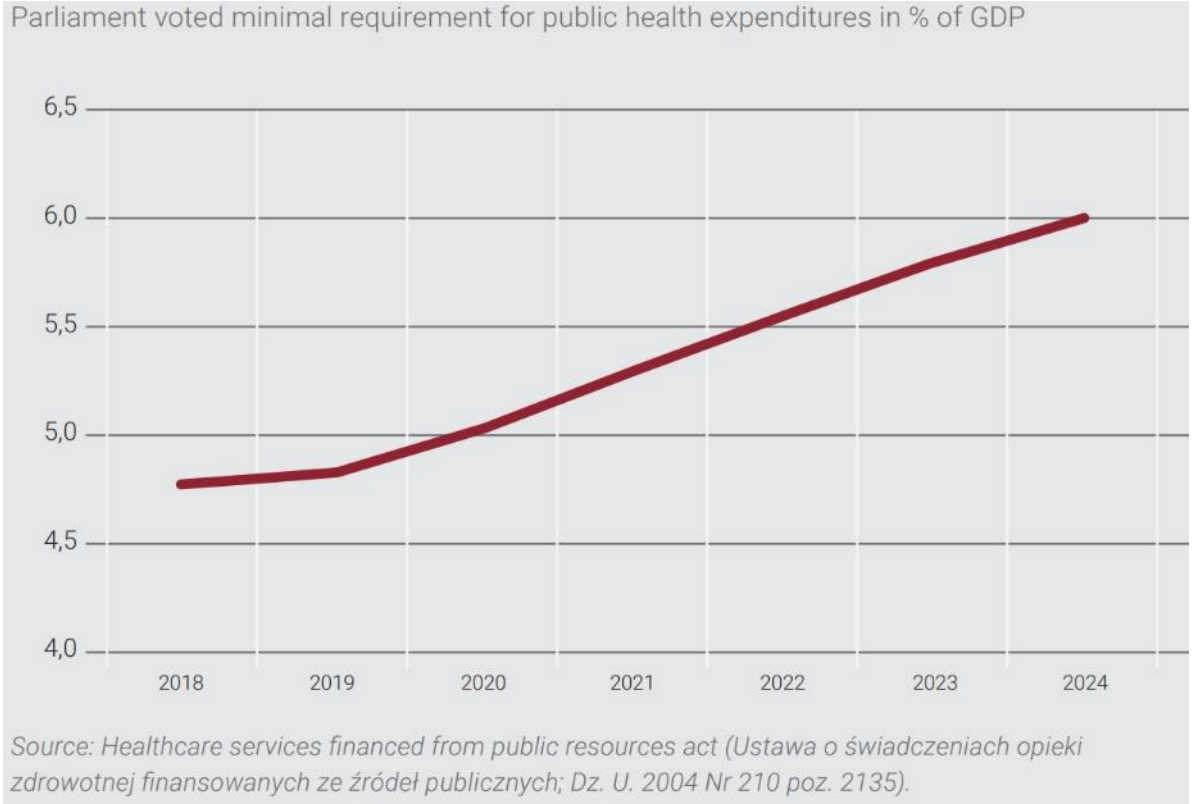
“Maria Roth” is a 84 years old woman suffering from heart failure. Since 2010 she was admitted to hospitals eight times because of inadequate monitoring and poor care coordination.

From 2010 to 2014 the total costs of care for Maria were 72,261 €, resulting in a loss for the insurance of -23,204 € or about -5,800 € per year.



Hampshire UTI

What is integration and why is it important?
Spending is increasing, but is the current model right?

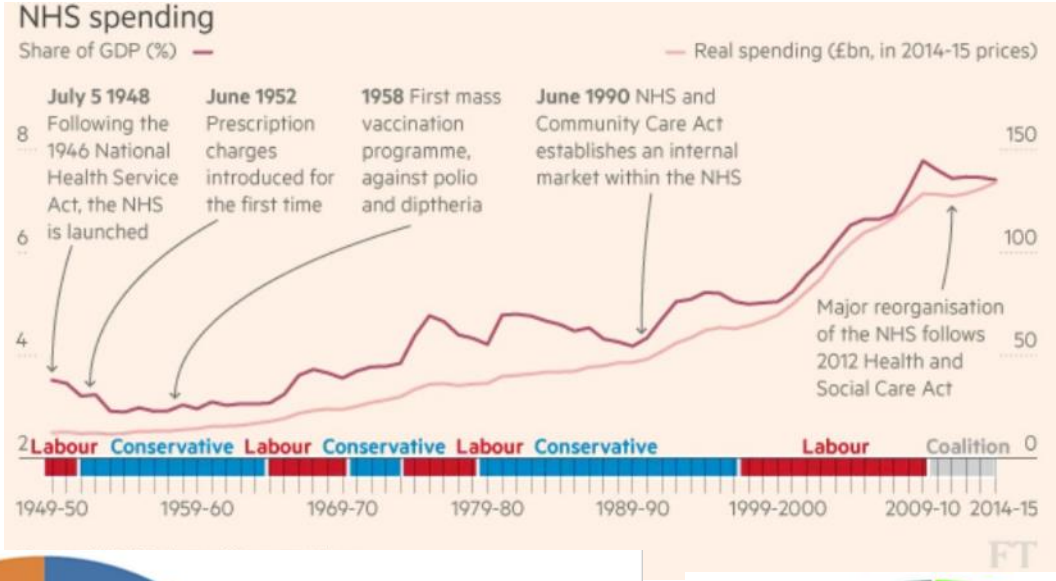


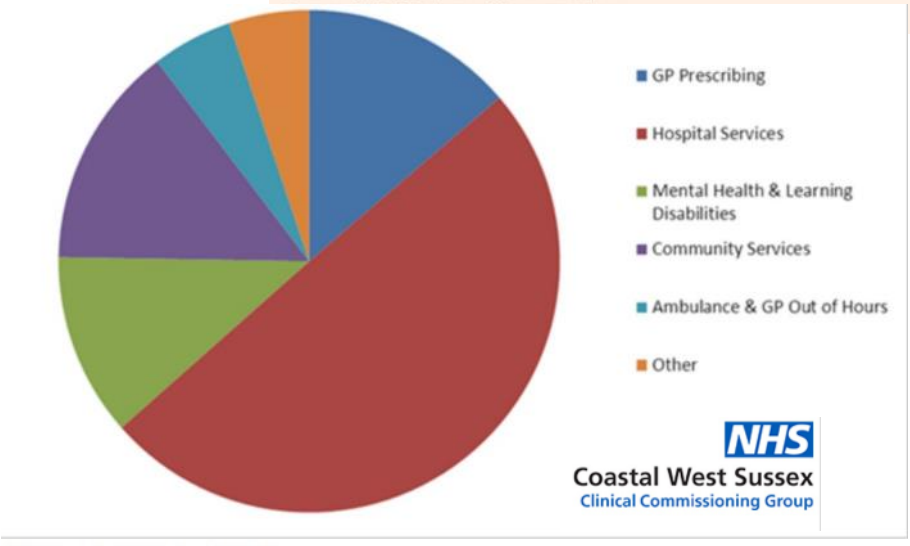
Source: Healthcare services financed from public resources act (Ustawa o świadczeniach opieki zdrowotnej finansowanych ze źródeł publicznych; Dz. U. 2004 Nr 210 poz. 2135).

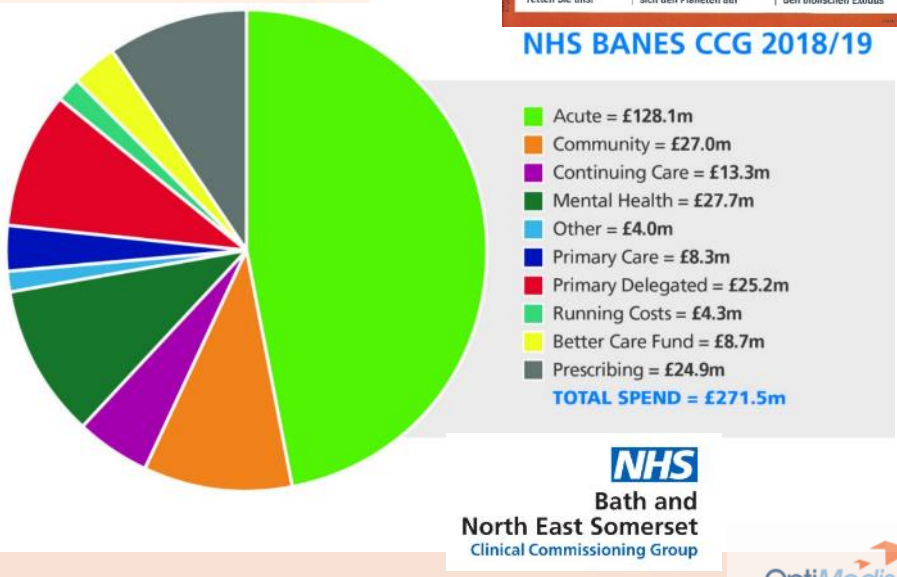
Where will the money go?

Innovating the health system to be more efficient and to produce health.

What is integration and why is it important?
Spending is increasing, but is the current model right?







Contents

Introductions

What is Integration and why it is important (a brief history of the UK Journey)

How do we achieve it? Key Elements of Success

Lessons / Reflections

The UK Journey to Integration

Policy, structural change & inviting more to the party…

2000

BBC Home

ON THIS DAY 1950 2005

Search ON THIS DAY by date 27 July

Front Page | Years | Themes | Witness

2000: Labour publishes plans to revolutionise NHS

The Labour Government has announced the most radical re-organisation of the NHS since it was founded in 1948.

Outlining the new 10-year plan to the House of Commons, Prime Minister Tony Blair said he wanted "to make the NHS once again the envy of the world".

"Our task is to provide both the money and the reform to make sure the health service and its founding principles live on and prosper into the 21st century," he explained.

Patient-centred service

Promising billions of pounds of extra investment, the 170-page blueprint contains wide-ranging changes to create a more patient-centred service.

Areas for improvement include:

- Waiting times to be reduced from 18 to six months by 2004 and to three months by 2008
- 7,000 extra beds over the next four years - the first increase for nearly 30 years

Waiting times are to be reduced to three months by 2008

In Context

Funding for the £40bn worth of NHS improvements was central to Chancellor Gordon Brown's 2002 budget.

He announced the first increase in direct taxation - national insurance - since he became chancellor five years before, to fund the reforms.

Spending on the NHS was to increase by 7.4% a year from 6.7% of GDP in 1997 to 9.4% by 2007/8.

The European average for health spending was 8% of GDP in 2002.

A survey of the health service in July 2005 found patients still had

2009

The National Archives

DH Department of Health

Integrated care pilots

In April 2009 the Department of Health launched a two-year pilot programme to test and evaluate a range of models of integrated care. The programme of integrated care pilots (ICP) is designed to explore different ways in which health and social care could be provided to help drive improvements in local health and well-being. ICP allows communities to take a fresh look at how to deliver such care, based solely around the needs of the local population. The aim is to look beyond traditional boundaries (e.g., between primary and secondary care) to explore new, integrated models.

2010

CO-OPERATION & COMPETITION PANEL
FOR NHS-FUNDED SERVICES

NHS

ABOUT THE CCP
- Our people
- Reference groups
- Clinical Reference Group
- Economics Reference Group
- Our sponsors
- Other relationships
- Working with the CCP

REFERRALS TO THE CCP

CASES

PUBLICATIONS

CCP NEWS

About the CCP

Introduction from the chair

Lord Carter of Coles

Choice, co-operation and competition in the NHS are important elements of the NHS reform programme, which puts patients at the heart of driving change in the NHS - directly through choice of service provider, and indirectly through influencing and shaping commissioning.

The benefits for patients and taxpayers of choice and competition include:

- Improving quality and safety in service provision
- Improving health and well being
- Improving standards of, and reduced inequalities in, access and outcomes
- Informed patients - with a 'voice and choice'
- Greater confidence in the NHS
- Better value for money.

The CCP helps support the delivery to patients and taxpayers of the benefits of competition by investigating and advising the Department of Health and Monitor on potential breaches of the Principles and Rules of Co-operation and Competition. The information on this website will, we hope, be a useful start for those interested in the role of the CCP.

What cases does the CCP undertake?

The CCP undertakes cases in four categories:

- Merger cases
- Conduct cases
- Procurement dispute appeals
- Advertising and misleading information dispute appeals.

We may also investigate non-case specific matters referred to us by either the Department of Health or by Monitor.

The UK Journey to Integration

A move from short term targets to long term change…

2013

FOR HEALTHCARE LEADERS
HSJ

ALASTAIR MCLELLAN
The Bedpan: Financially illiterate and morally wrong

SECTORS | TOPICS | HSJ LOCAL | COMMENT | HSJ KNOWLEDGE | EVENTS | JOBS

COMMENT

The NHS needs to think long term about contracts

By Nigel Edwards, Robert Breedon | 26 February 2013

2 Comments

The NHS needs to stop being short-termist and develop new ways for devising contracts, payment systems and procurement strategies, say Nigel Edwards and Robert Breedon

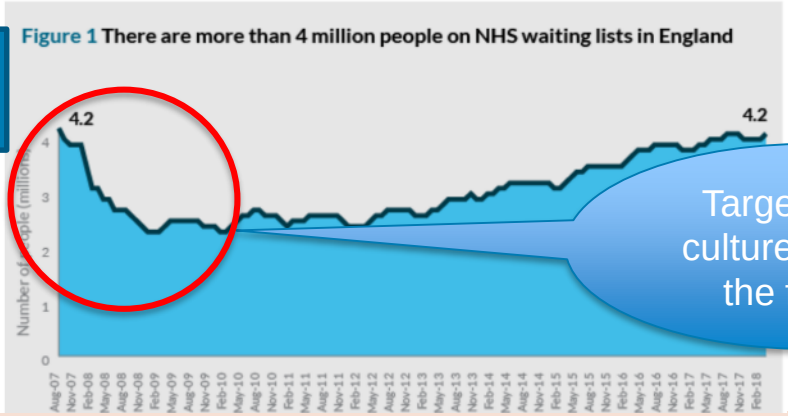
There are a number of important trends in the design of payment systems and contracting that suggest the need for some new approaches. The risk is that short-term contracts and fragmented payment models will hold back the creation of integrated care and methods such as prime contractor and

2015

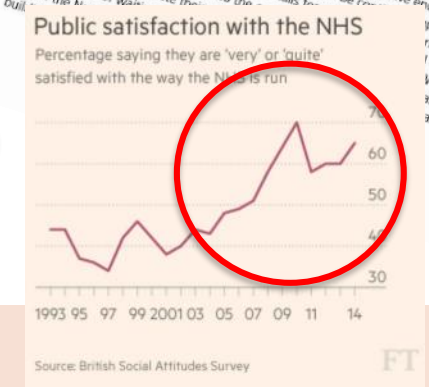
Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.
2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.
3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.
4. We are requiring the NHS to produce two separate but connected plans:
   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.
5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be [illegible] year financial outturn, and the winter period calls [illegible] standards in emergency care. It is also the [illegible] sustainable if they accelerate the [illegible] have the luxury of [illegible] early in the [illegible] built [illegible]

2018



Target driven culture, fanning the flames



The UK Journey to Integration
New models of integration emerge…

The NHS Five Year Forward View (2014/5)

- "Commissioners and providers across the NHS and local government need to work closely together – to improve the health and wellbeing of their local population and make best use of available funding.
- Services that are planned and provided by local government, including housing, leisure and transport as well as public health and social care, impact on the health and wellbeing of local people."

Integration and the NHS New Care Models

- **Multispeciality community providers** integrating the various strands of community services such as GPs, community nursing, mental health and social care, moving specialist care out of hospitals into the community
- **'Enhanced health in care homes'** offering older people better, joined up health, care and rehabilitation services.

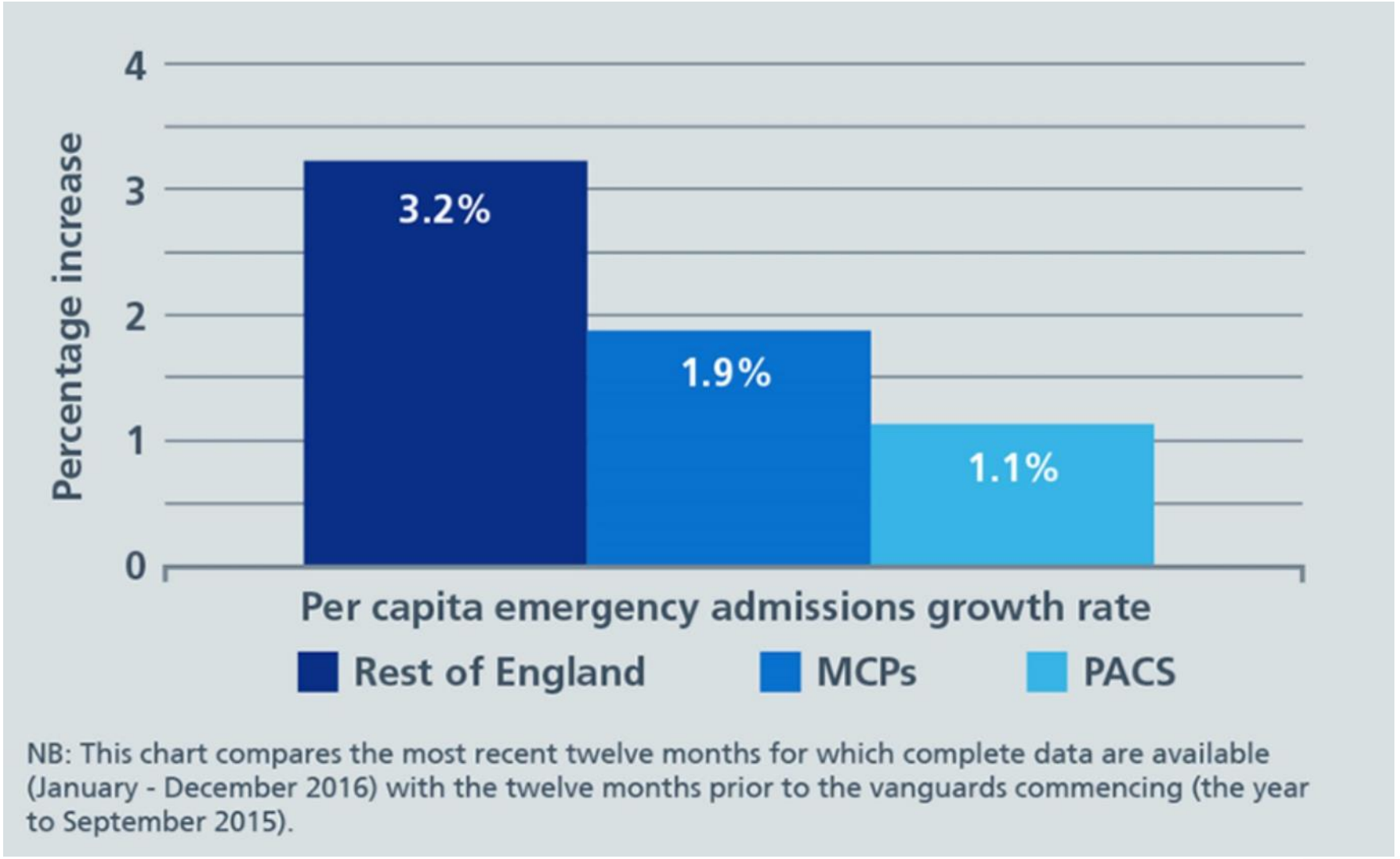
Integrated Care Partnerships (ICPs): a new type of integration

- Population-based care model based on the GP registered list.
- "A greater focus on prevention and integrated community-based care, and less reliance on hospital care."
  (Source: NHS England New Care Models)

Types of ICP:

- Primary and acute care organisations (PACS) can potentially include:
  - hospital (acute) services
  - community Services
  - mental health services
  - primary care services
  - social care services.
- Multi-speciality community providers include:
  - primary care services
  - community services
  - social care services
  - mental health services.

The UK Journey to Integration
There has been ‘top-down’ success



NB: This chart compares the most recent twelve months for which complete data are available (January - December 2016) with the twelve months prior to the vanguards commencing (the year to September 2015).

The German Journey to Integration
There has been ‘bottom-up’ success

“Hanna Held” is also an 84 yr old woman suffering from heart failure. Since the diagnosis six years ago she has been participating in the health care program „Strong Heart.“ She has a case manager at her GP practice. She gets supported in her self-management, her medication gets precisely adapted to her situation and she knows exactly to identify and act on signs of deterioration.

In the last 4 years Hanna only went once to hospital because of an opthalmic complication. Her total costs of care summed up to 14,281.8 €, resulting in a profit for the insurance of +2,613.6 € or about +650 € per year.

Contents

Introductions

What is Integration and why it is important (a brief history of the UK Journey)

How do we achieve it? Key Elements of Success

Lessons / Reflections

How do we achieve Integration?
Agree what we are trying to achieve

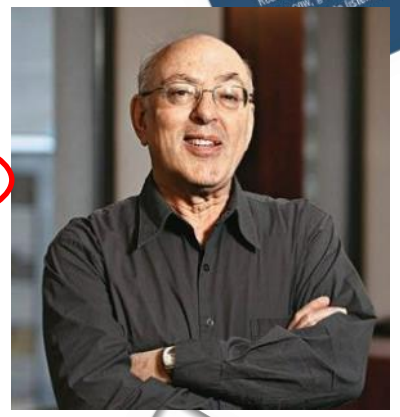
*"The fundamental principle of **value in healthcare** is first to **align** industry stakeholders around the **shared objective of improving health outcomes** delivered to patients for a given cost, and then to **give stakeholders the autonomy**, the right tools and the **accountability** to pursue the most rational ways of delivering value to patients. **This represents a different way of approaching the management and organisation of the healthcare sector."***

Source: Value in Health Care: Laying the Foundation for Health System Transformation
World Economic Forum 2017

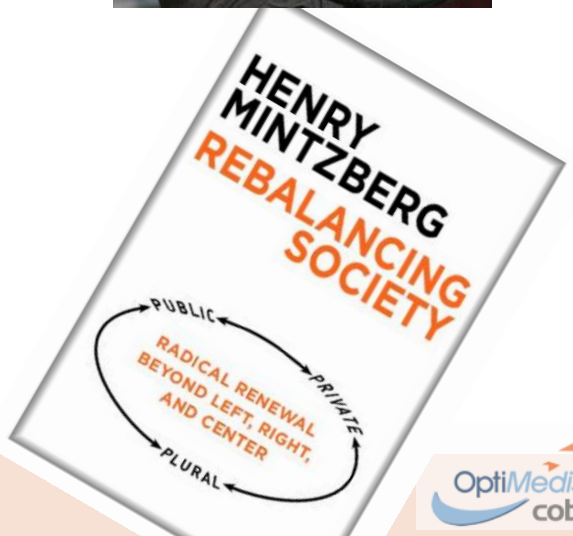
How do we achieve integration?
Identify Tasks and Coordinate those tasks

"Every organized human activity — from the making of pots to placing man on the moon — gives rise to two fundamental and opposing requirements:

1. the division of labour into various tasks to be performed,
2. the coordination of these tasks to accomplish the activity.



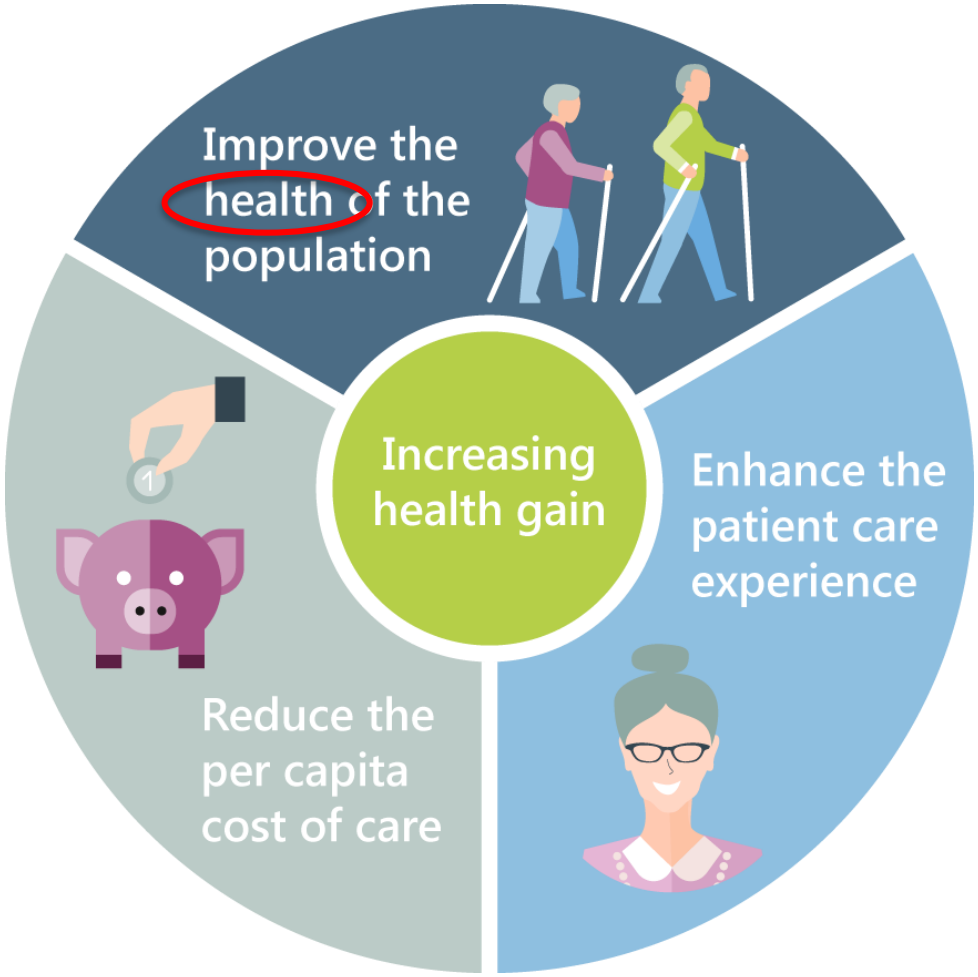
The structure of an organization can be defined simply as the sum total of the ways in which it divides labour into distinct tasks and then achieves coordination



Henry Mintzberg OC OQ FRSC

(Cleghorn Professor of Management Studies at the Desautels Faculty of Management of McGill University in Montreal, Quebec, Canada)

How do we achieve integration?
Simplify what we are trying to Achieve (The Triple Aim)



Berwick DM, Nolan TW & Whittington JW. The Triple Aim: Care, Health, And Cost. *Health Affairs 2008;* 27(3), 759–769.

How do we achieve integration?
The role of the integrator

Key components necessary to attain the Triple Aim:

- a clear (regionally defined) reference population
- total budget limit or assumption of financial responsibility for the population, (incentive alignment)
- the presence of a regional integrator to take responsibility for the three aims.

The role of a ***regional integrator***:

- assessing and managing population health
- redesigning health and care services – using outcomes
- achieving system integration at the macro level, and addressing local issues and
- establishing partnerships with individuals and families ("Activating Patients")
- implementing tailored solutions with the involvement of all stakeholders.

How do we achieve integration? have we asked our population what do they want? “Activated Patients”

“The results people care about most…including functional improvement and the ability to live normal, productive lives”

International Consortium for Health Outcome Measurement, 2013

How do we achieve integration? Putting the patient first - have we asked our population what it is that they want?

The National Voices Narrative for Integration

My goals / outcomes
All my needs as a person are assessed

Care Planning
I can decide the kind of support I need and how to receive it

Communication
I am listened to about what works for me, in my life

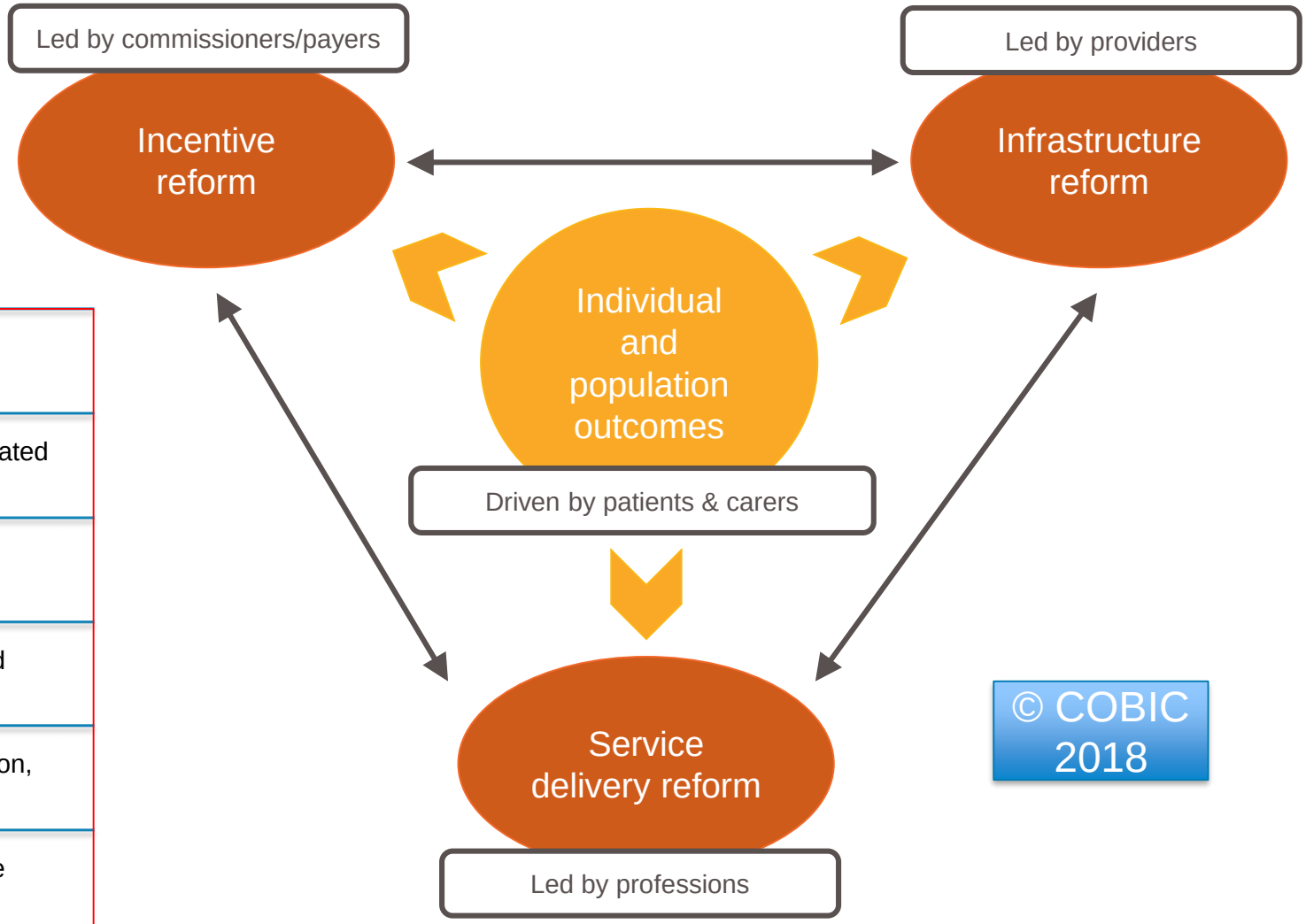
Person centred coordinated care
"I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me."

Decision making including budgets
I am as involved in discussions and decisions about my care, support and treatment as I want to be

Information
I have the information, and support to use it, that I need to make decisions and choices about my care and support

Transitions
When I move between services or settings, there is a plan in place for what happens next

How do we achieve integration? Outcomes at the centre of system and all parts of system working towards them

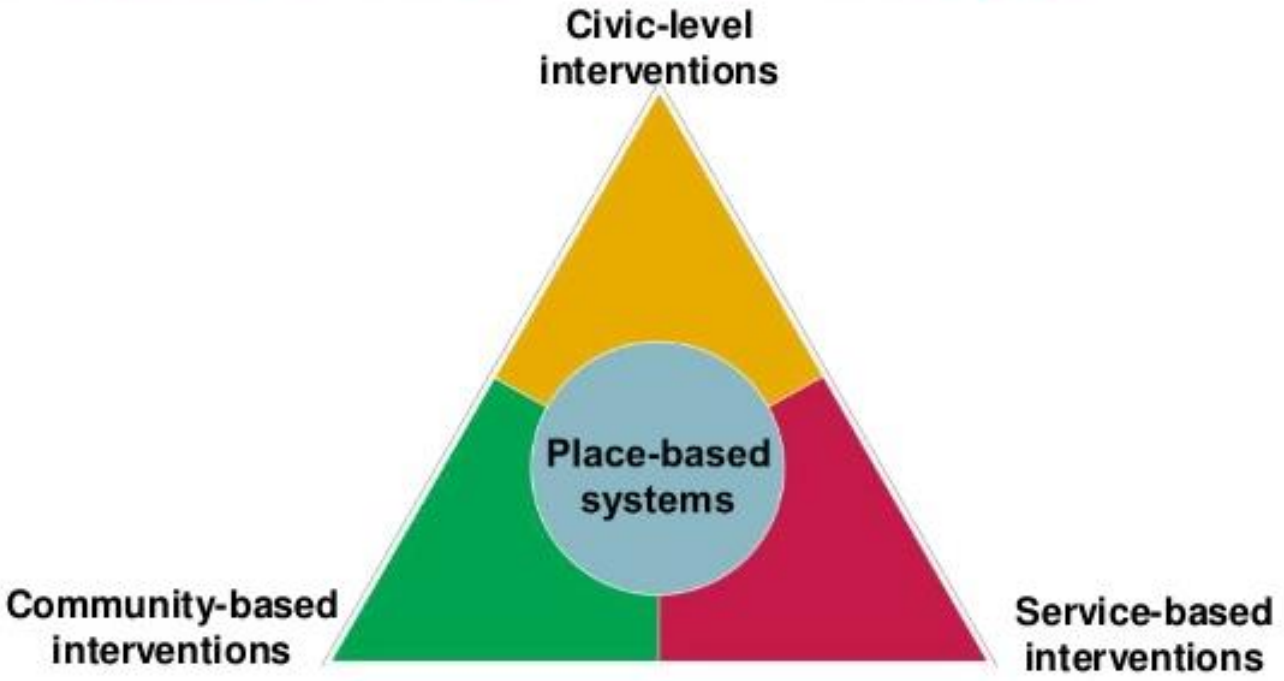


- Defined population and scope
- Desired outcomes and associated indicators
- Service model redesign (and willingness to change)
- Financial analysis and defined budget
- Agreed contract form & duration, describing incentives & risk
- Readied and prepared service providers

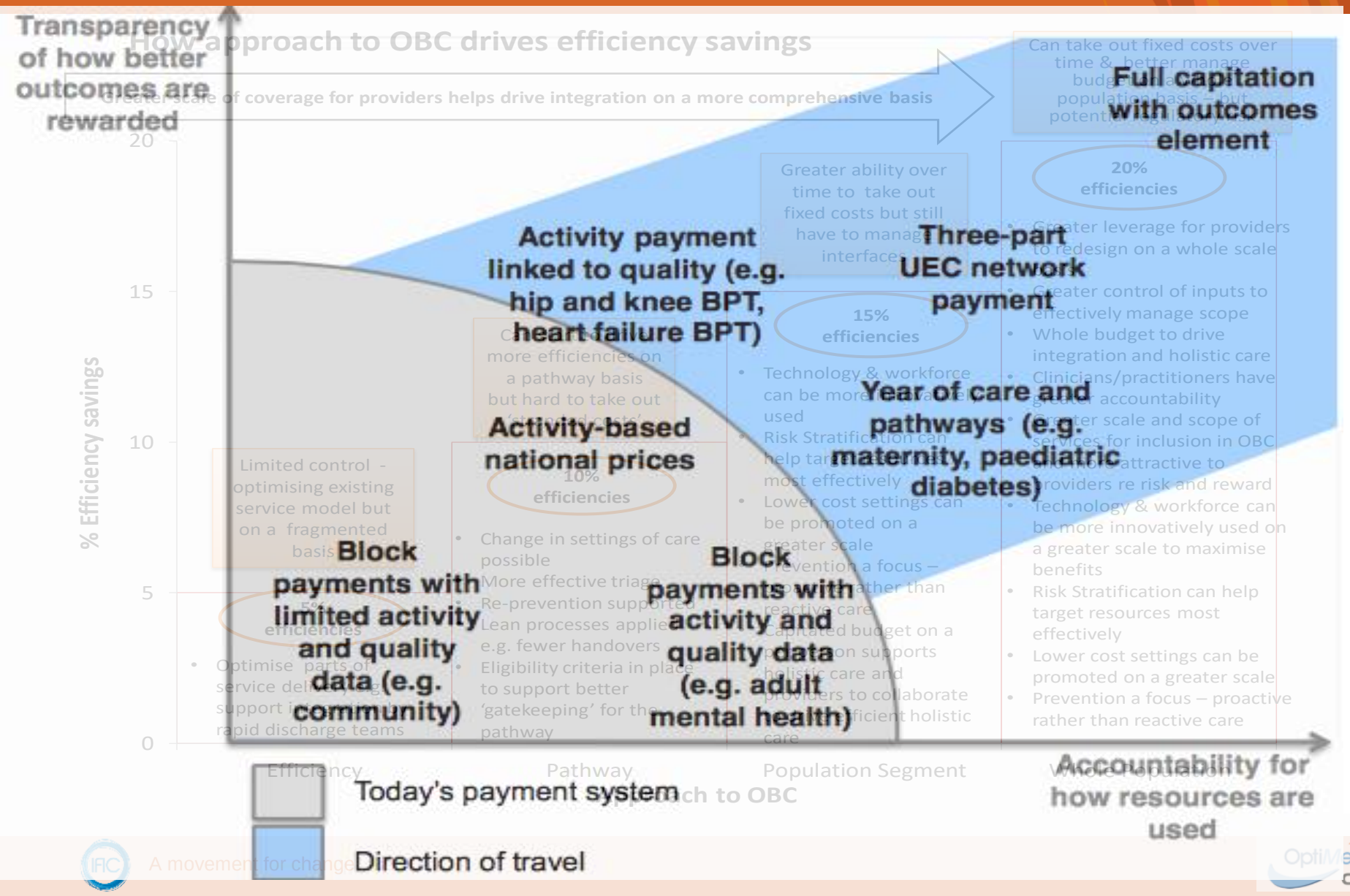
How do we achieve integration? All parts of system (not just health) working to achieve outcomes

Public Health England

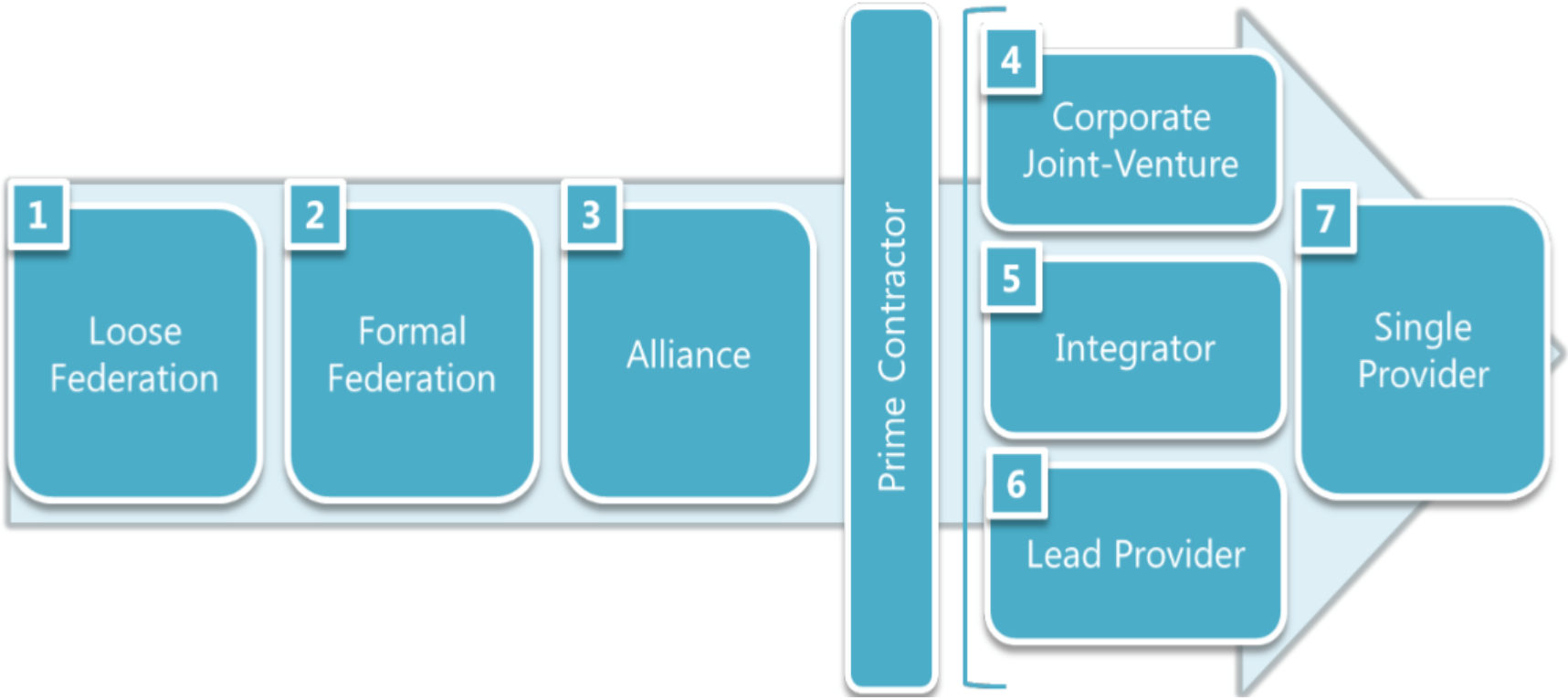
Population Intervention Triangle



How do we achieve Integration? Extend the scope and autonomy / ability to influence change

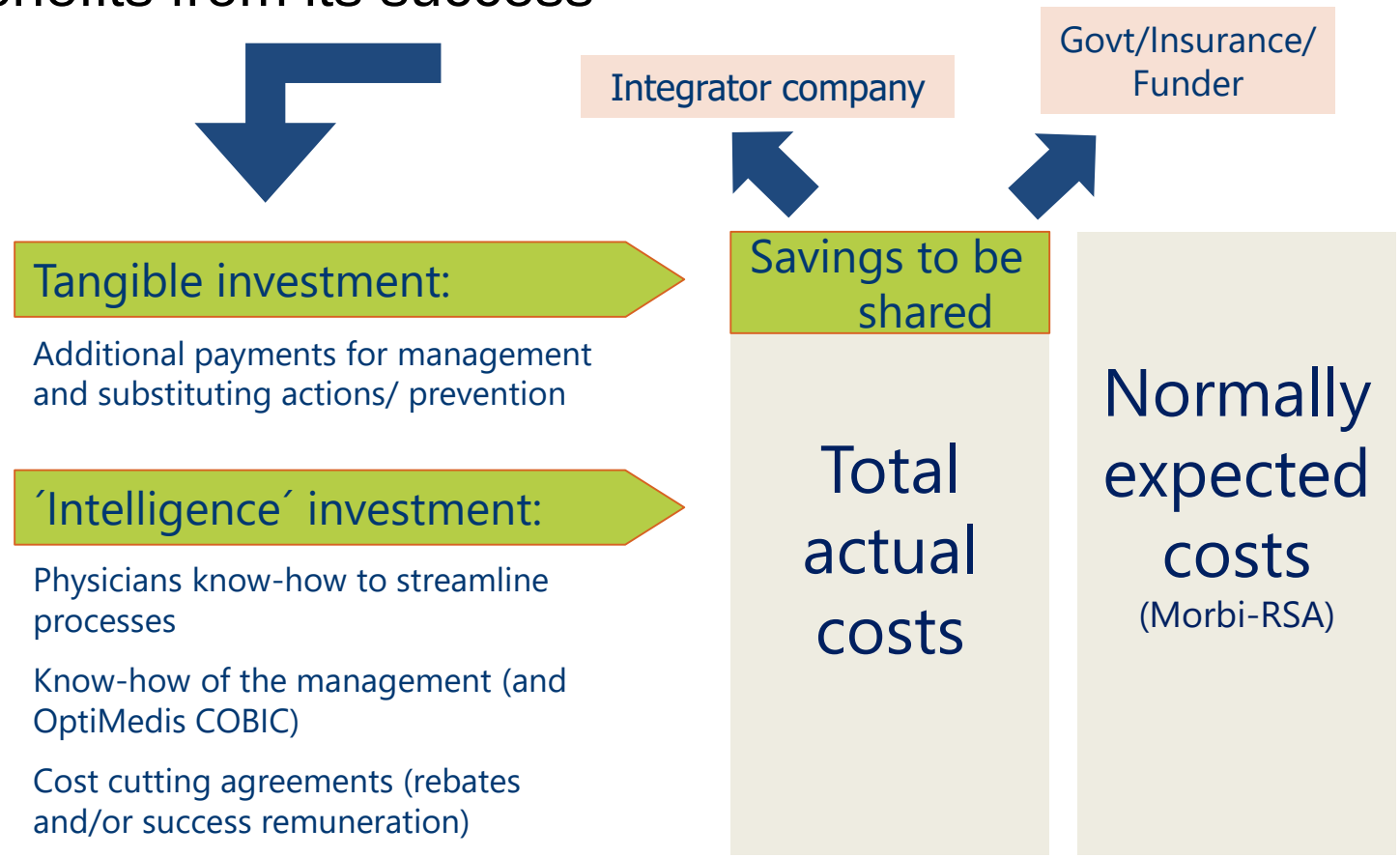


How do we achieve integration? By being transparent, agreeing roles, sharing risk / reward through contracts

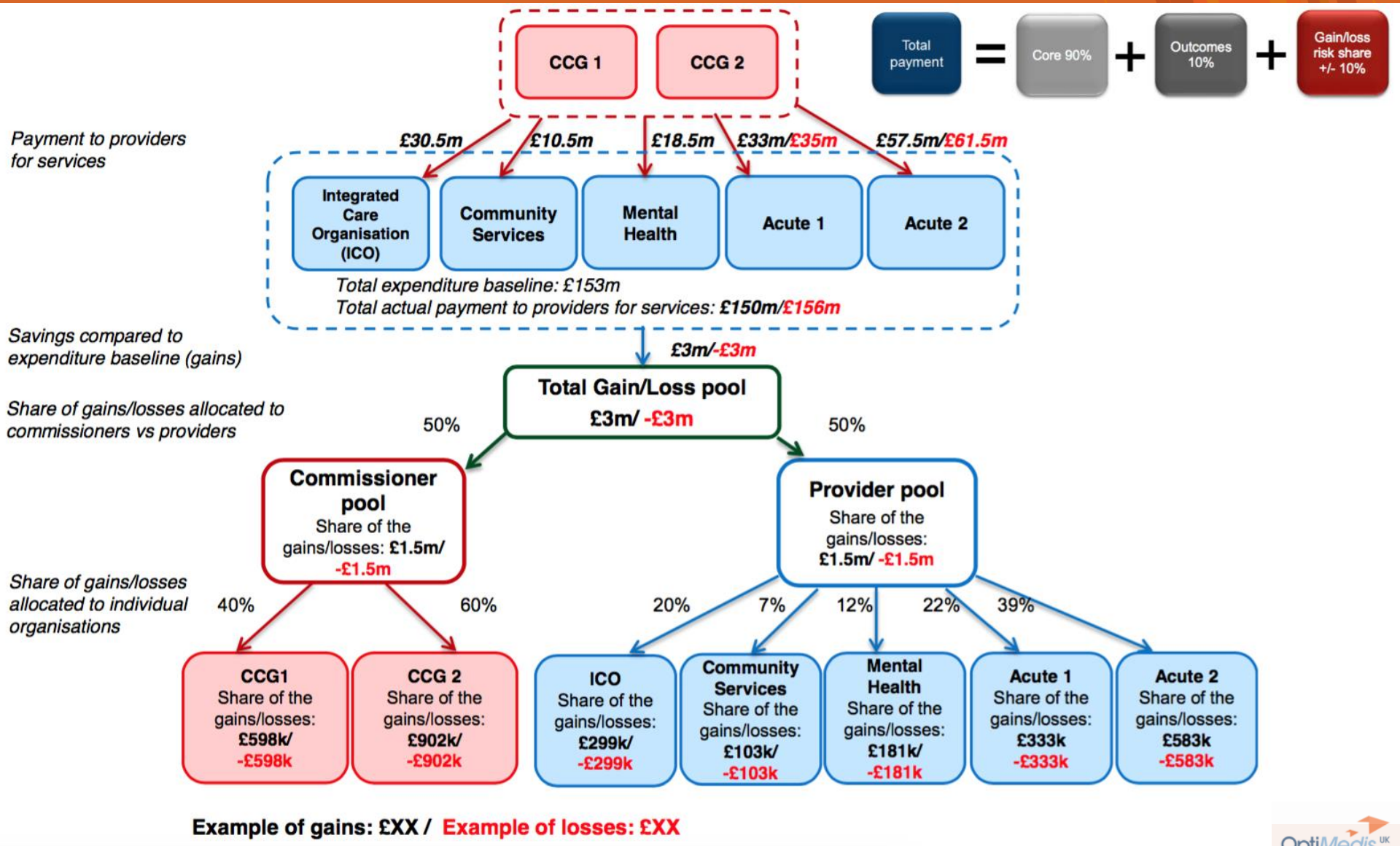


How do we achieve integration? Identifying and sharing the risk adjusted contributions of the partners

The integrator company (locally owned) (re) invests and benefits from its success



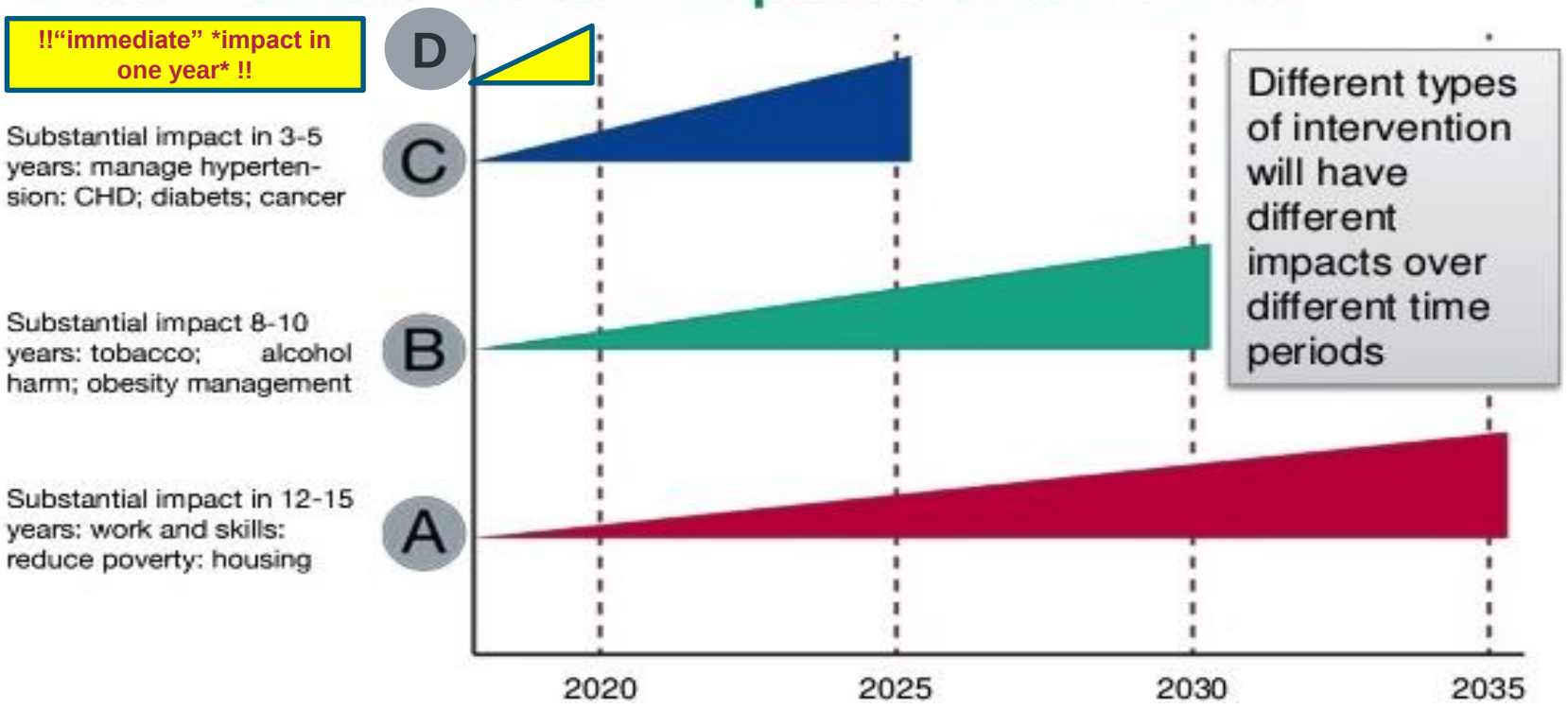
How do we achieve Integration? Sharing the risk and reward of all of the partners



How do we achieve integration – accept that some tasks are ‘easier/quicker’ some are more difficult / longer term

Public Health England

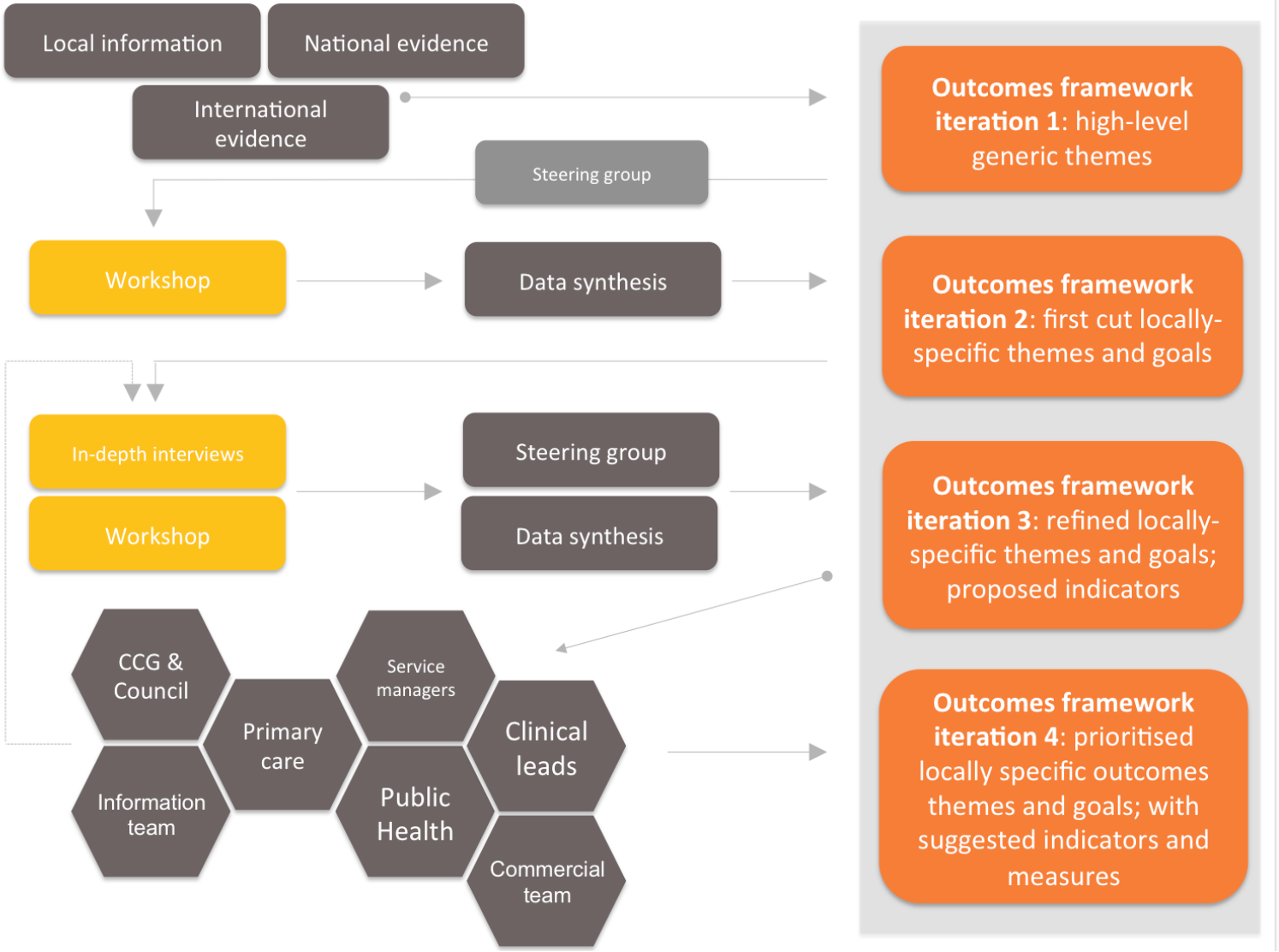
Interventions for impact over time



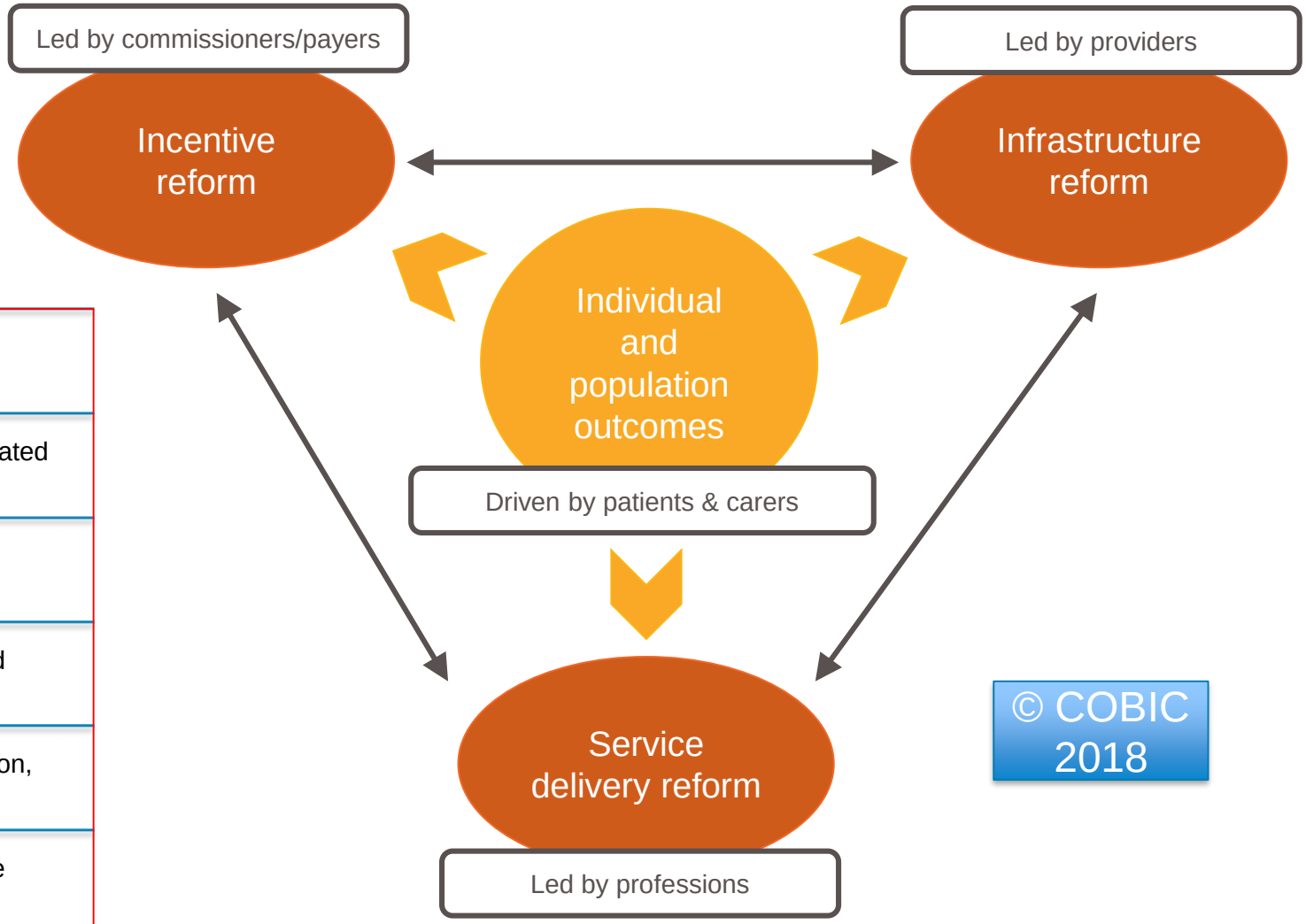
Using Outcomes: Case Study 1 Oxfordshire Mental Health

Using Outcomes to drive integration – Developing Outcomes with the system

Using Outcomes: Case Study 1 Oxfordshire Mental Health



Using Outcomes to drive integration – Key components to enable change



- Defined population and scope
- Desired outcomes and associated indicators
- Service model redesign (and willingness to change)
- Financial analysis and defined budget
- Agreed contract form & duration, describing incentives & risk
- Readied and prepared service providers

Using Outcomes to drive integration – Oxfordshire Mental Health Outcomes / Incentives

Outcome 1: people will live longer

Outcome 2: people will improve their level of functioning

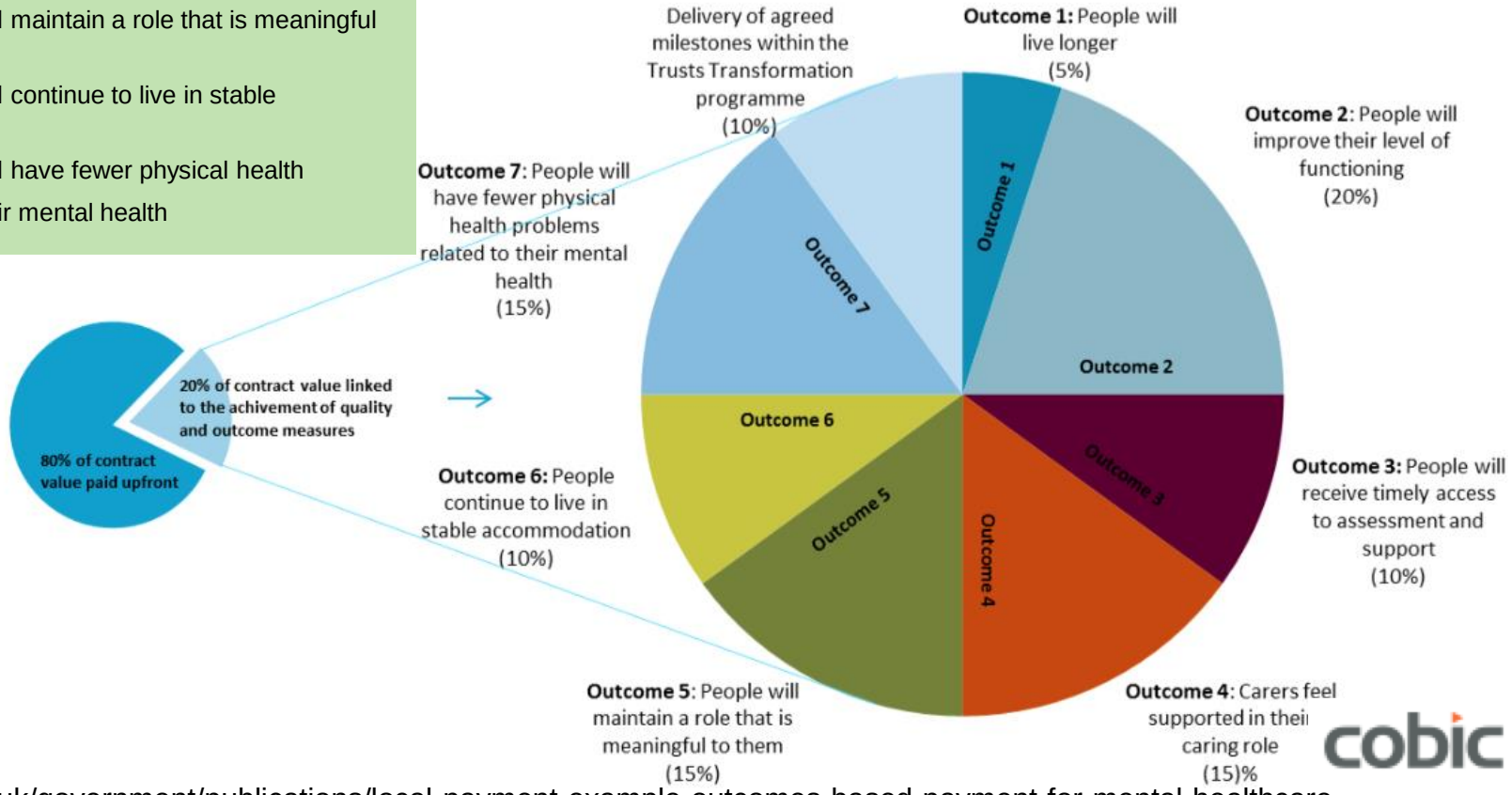
Outcome 3: people will receive timely access to assessment and support

Outcome 4: carers feel supported in their caring role

Outcome 5: people will maintain a role that is meaningful to them

Outcome 6: people will continue to live in stable accommodation

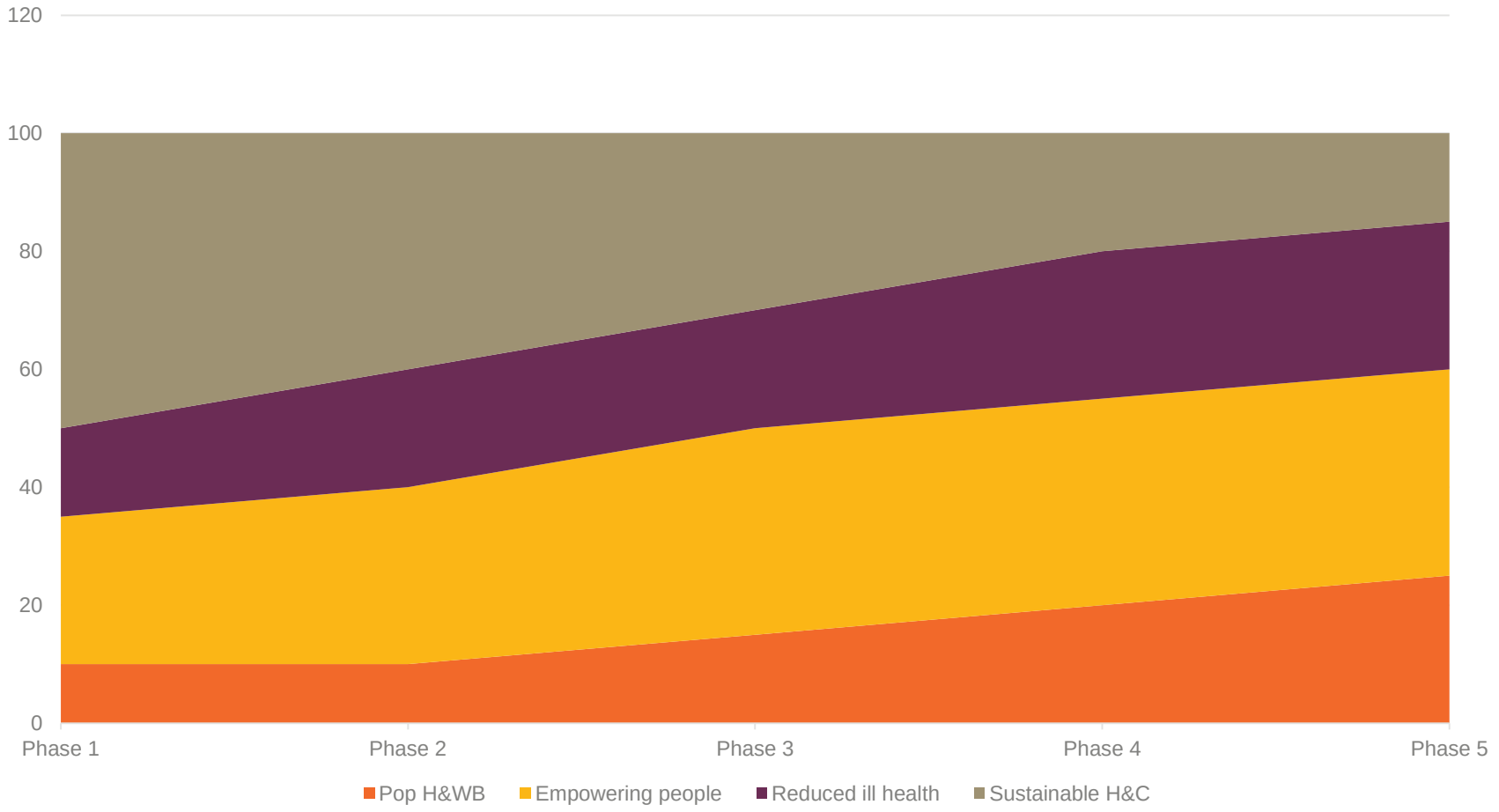
Outcome 7: people will have fewer physical health problems related to their mental health



www.gov.uk/government/publications/local-payment-example-outcomes-based-payment-for-mental-healthcare

Outcome	Outcome Description	Indicator	Outcome Points*	Indicator Points**
1	People will live longer	Mortality age of the MH adult population (reduction in excess of under 75 age mortality rate)*	5	5
2	People will improve their level of functioning	% aggregated improvement in score on validated recovery evaluation tool (e.g. Star Recovery Tool) amongst service users in clusters 4-17 at most recent cluster review*	20	7
		% of service users in clusters 4-17 under the care of OHFT with a reduction in intensity in HoNOS rating score at their most recent cluster review*		7
		% of service users who have been discharged from OHFT and are not readmitted to hospital at 28 days after discharge		6
		% of service users who have been discharged from OHFT and are not readmitted to hospital at 90 days after discharge		
3	People will receive timely access to assessment and support	Percentage of all referrals to adult mental health teams that are categorised as crisis/emergency where the patient (and carer where applicable) and the referring GP are contacted within 2 hours.	10	10
4	Carers feel supported in their caring role	% of identified carers who are, as a carer, satisfied with the care and support s/he receives as a carer	15	7.5
		% of identified carers who are satisfied with the care and support received by the person s/he cares for		7.5
5	People will maintain a role that is meaningful to them	50% of service users in paid employment, undertaking a structured education or training programme or undertaking structured voluntary activity	15	15
		with at least 33% of those, in paid employment		
6	People continue to live in stable accommodation	[x] % of service users living in stable accommodation	10	10
7	People will have fewer physical health problems related to their mental health	% of current service users in clusters 4-8 whose impact on the urgent care system will reduce	15	5
				5
		% of service users with BMI between 19 - 25		5
		% reduction in the prevalence of smoking amongst the service user population under the care of the contract		
Delivery of agreed milestones within the Trusts Transformation programme e.g. recovery college/SILS			10	10

Using Outcomes to drive integration – Outcomes priorities change over time



Using Outcomes to drive integration – Hampshire Children's Service

Case Study 2 – Hampshire Children's and Young People

Hampshire County Council

NHS
Fareham and Gosport
Clinical Commissioning Group

HAMPSHIRE PARENT CARER NETWORK

parentvoice

Barnardos

Special Education

NHS
West Hampshire
Clinical Commissioning Group

'Living well and living with meaning independently and throughout life'

Using Outcomes to drive integration – Hampshire Children's Service – Read more about it

Developing an Outcomes Framework for Children and Young People (CYP) in Hampshire

THE LANCET

Chloe Montague[1], Robert Pears[1], Andrew P. Smith[2] ,Nicholas Hicks[2], Eilidh Cunningham[3], Sallie Bacon[1], Nisreen Alwan[4].

[1]Hampshire County Council, [2]COBIC, [3]PPL Consulting, [4]University of Southampton.

https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)32889-7.pdf

Conclusions

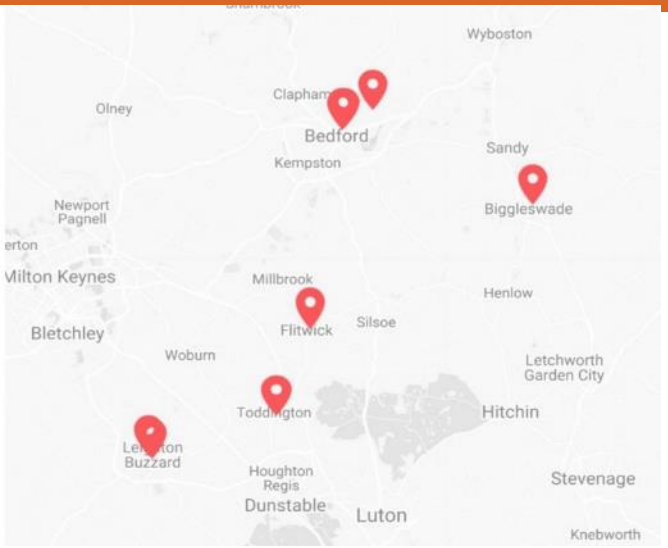
Our ambition is that the framework will become embedded within Hampshire County Council and the National Health Service, supporting both service improvement and integration efforts. This will encourage organisations to work together to address complex issues that are influenced by wider health determinants. A consideration of local drivers and barriers will ensure that any similar framework can be meaningfully adopted elsewhere.

References

1. Hampshire County Council. *Hampshire Small Area Population Forecasts (SAPF) 2017 based*. http://documents.hants.gov.uk/population/HampshireFS17.pdf

Case Study 3 – Bedfordshire MSK

Using Outcomes and shared savings to drive integration
The Circle MSK Service (Bedfordshire)



Circle

Inherited Problems to resolve:

MSK conditions represented rising cost - driven by demographic growth

MSK services were traditionally uncoordinated and inefficient, producing:

- Poor patient experience (referred to wrong service - patients ping-ponged round system)
- Poor value for money
- Health inequality
- Long waiting times (2nd Care Capacity)
- Clinical Outcomes were hard to measure
- More conservative treatments were needed in the community (outdated, 'Hospital Centric approach')

What Circle has learned from its Bedford contract

By Will Smith | 7 October 2015

FOR HEALTHCARE LEADERS HSJ

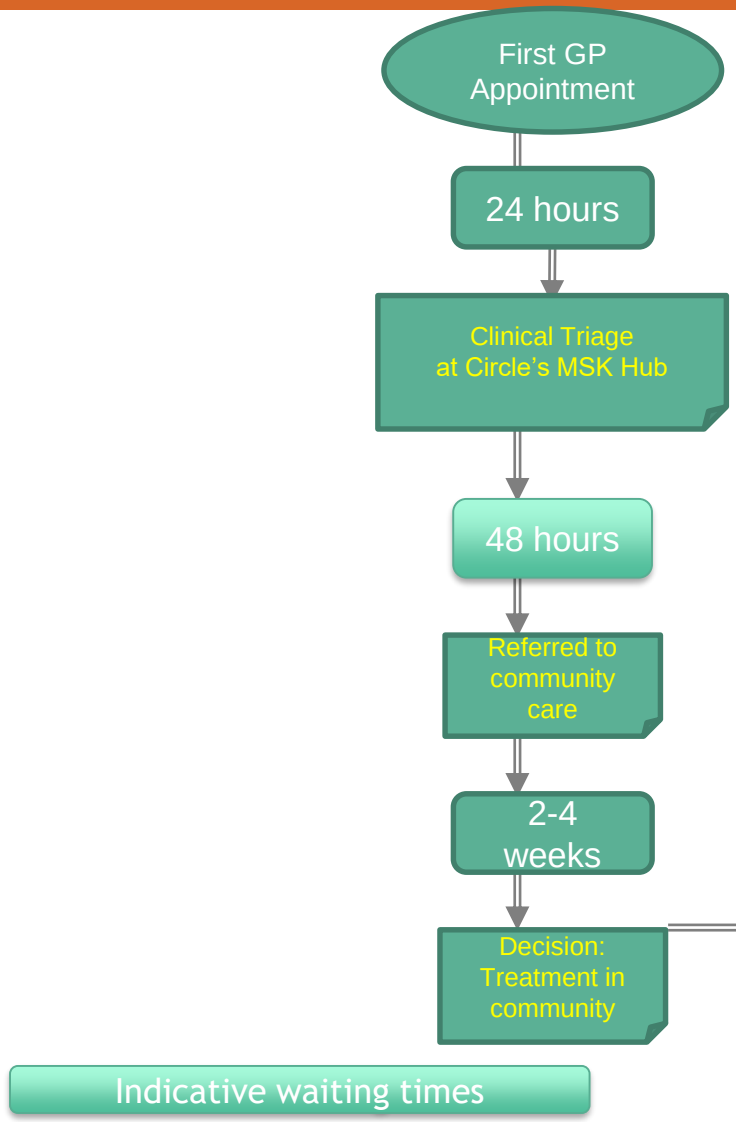
6 Comments

The first year of Circle's contract in Bedford - the country's first whole population MSK care contract - provides a useful prescription: policy clarity on referrals, data sharing and registration are all essential, writes Will Smith

Last year, Circle started a contract in Bedfordshire managing musculoskeletal care.

'We believe we are starting to show the real benefits of integration'

The Circle MSK Service (Bedfordshire)
Enhanced role for clinical triage and community physios



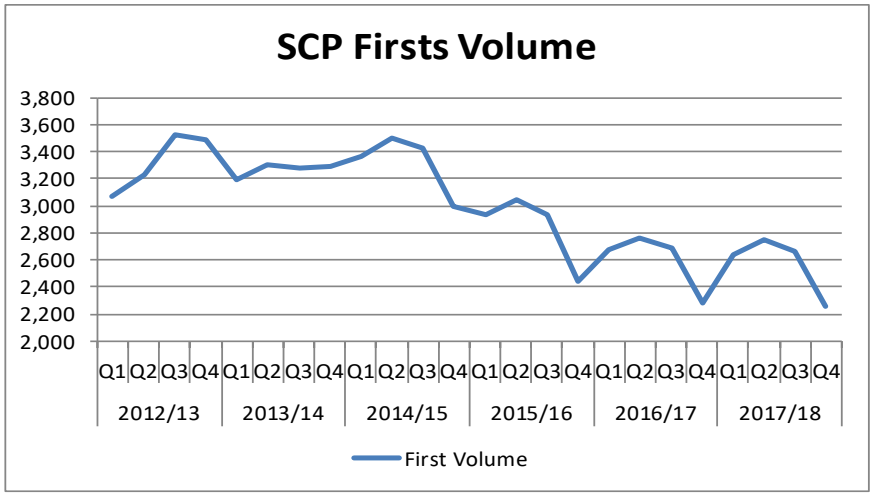
- ☑ Right clinician first time round
- ☑ No need to go back to GP
- ☑ Waiting times and outcomes monitored
- ☑ Less inappropriate treatment – more care in community

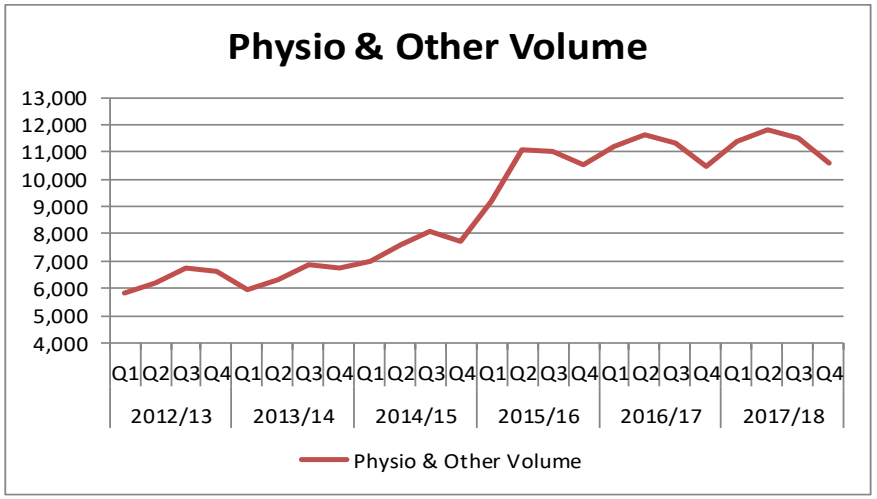
'To ensure delivery of high quality MSK care and experience to patients and improve outcomes within available resources'

Total waiting time: 2-8 weeks (including diagnostics as appropriate)
Patient experience: Excellent

Circle

The Circle MSK Service (Bedfordshire)
Enhanced role for clinical triage and community physios





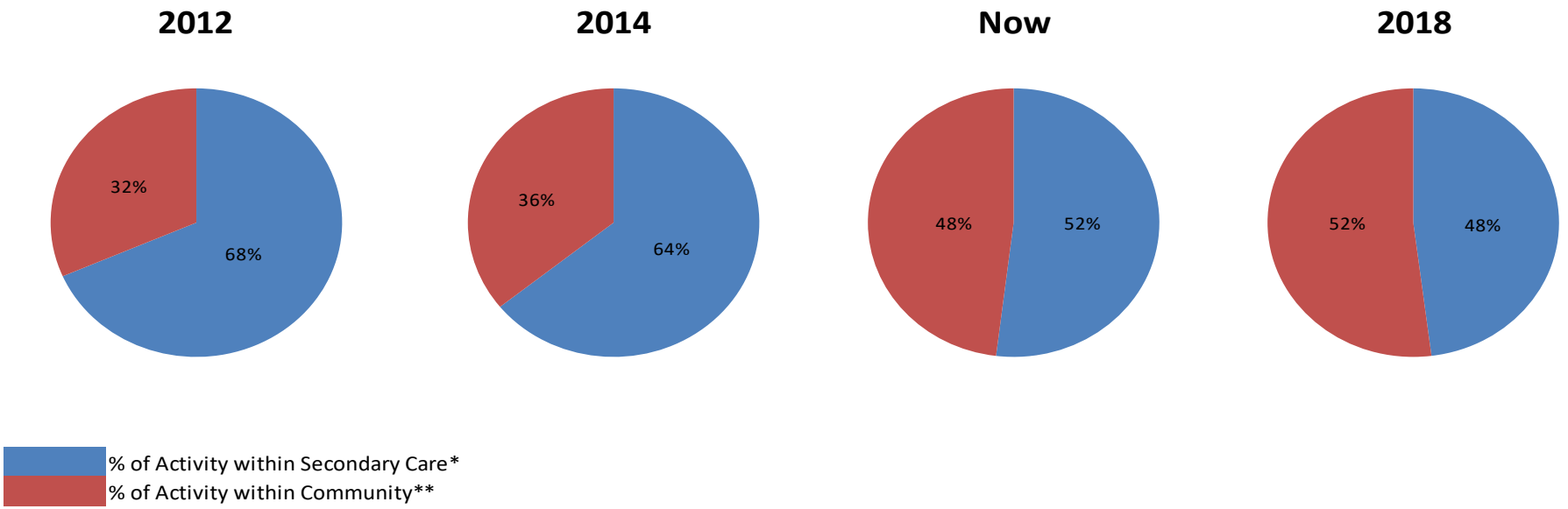
Commentary

Total SCP firsts has decreased by 10% since the start of the contract and is expected to decrease by a further 26% by the end of 2017/18
Average monthly SCP firsts is currently 1016 and expected to decrease to 753 by 2017/18 compared to 1099 prior to the start of the contract.

Average monthly Firsts is currently 1016 This is compares to 1099 prior to the start of the contract. This is expected to reduce to 859 by 2017/18

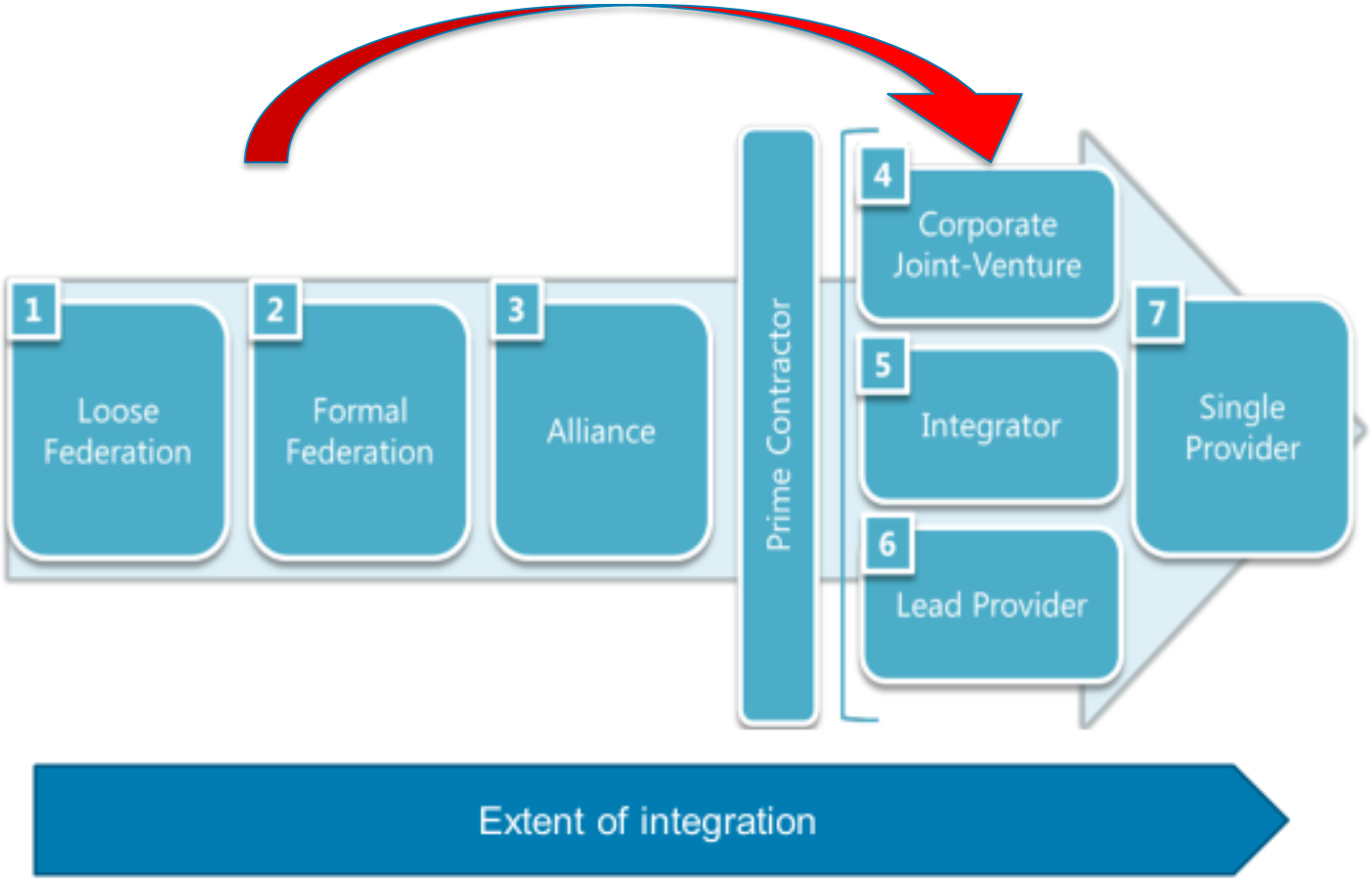
Physio and Other is defined as Community Physio, Other Secondary, DA Physio, Podiatry and Community Work Up.

The Circle MSK Service (Bedfordshire)
case mix changed – because relationships changed

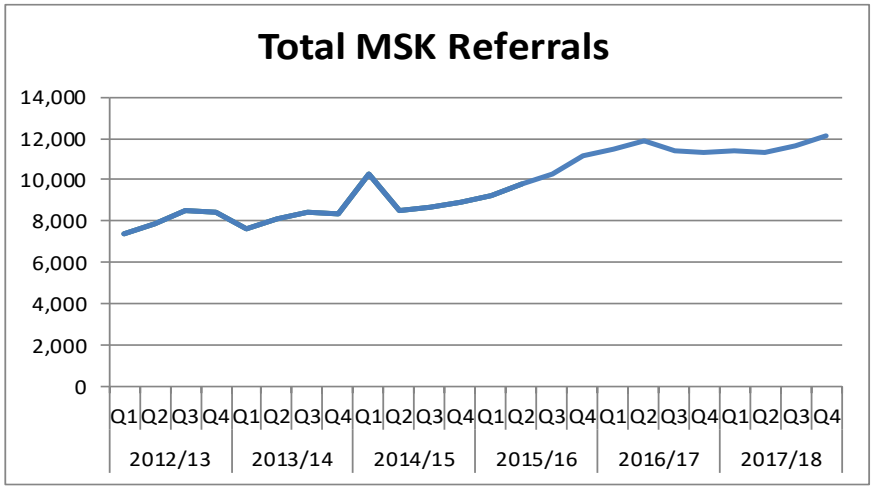


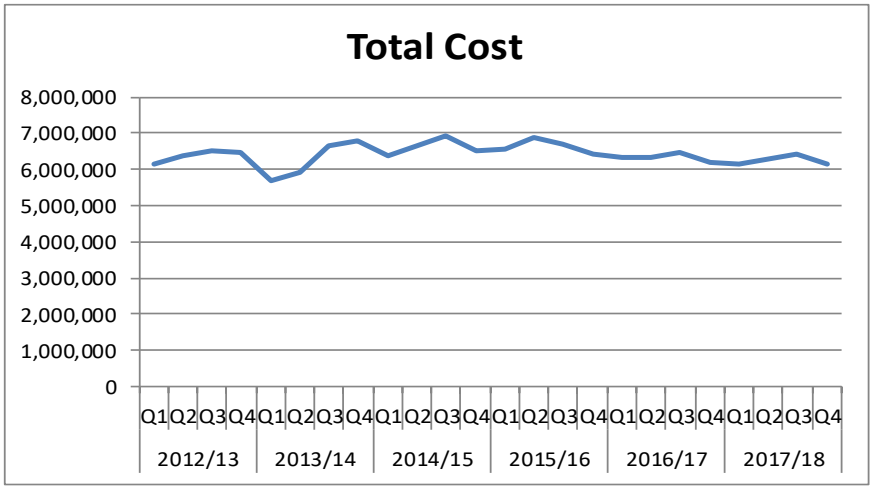
There has been a clear shift in activity from activity taken place in Secondary Care to Community settings. It is expected that this trend will continue in to 2016 and beyond.

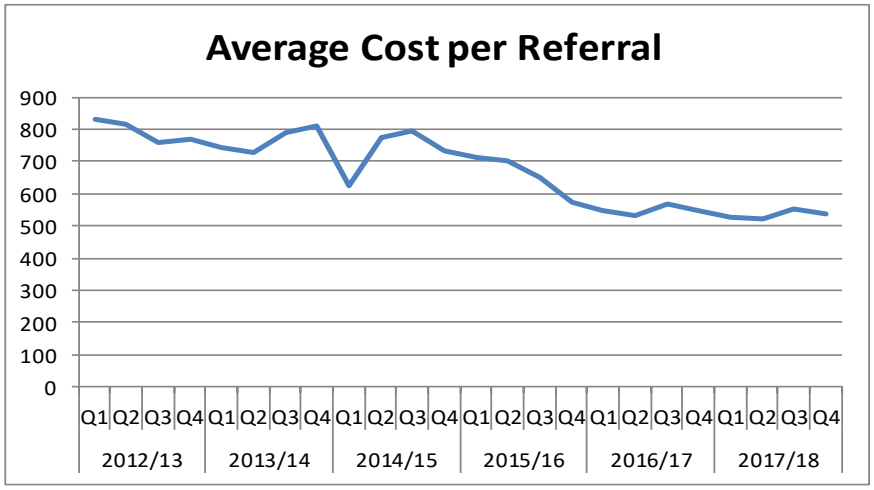
*Cost of Firsts, Follow Ups, Daycase and Inpatient procedures
**Cost of Community Physio, DA Physio, Other Secondary, Podiatry and Community Work Up


1
Loose Federation
2
Formal Federation
3
Alliance
Prime Contractor
4
Corporate Joint-Venture
5
Integrator
6
Lead Provider
7
Single Provider
Extent of integration

The Circle MSK Service (Bedfordshire)
Activity increased – total cost reduced







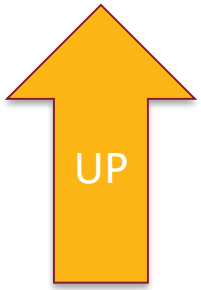
Commentary

Total MSK Referrals have increased by 25% since 2012
Total MSK Referrals are expected to increase by 64% by the end of 2017/18
This represents a compound increase of 8% per year.

Total MSK cost has increased by 12% since the start 2012/13 contract year.
Total MSK cost is expected to decrease by 11% from now to the end of 2017/18 contract year.

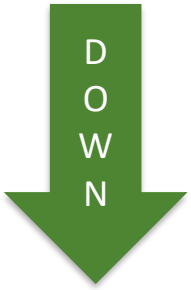
This results in a decrease in average cost of referral from £833 at the start of 2012, to £536 at the end of 2017/18.
This represents a decrease of 36%

The Circle MSK Service (Bedfordshire)
12-18 months – change happening – incl role of patient



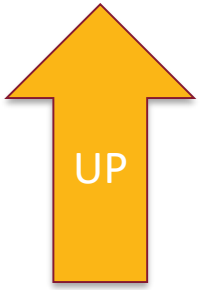
Shared Decision Making

35% of patients having a dedicated discussion choose alternatives to surgery



Referrals to hospital care

24% reduction in referrals to hospital-based care



Patient Outcomes

Tracked across whole pathway
7,700 measures collected
84% positive health gain (from 70% in 1yr.)

Community-based care

From 32% of total spend in 2012 to 48% now.
On track for 52% by 2018

average cost per referral reduced from
£833
to
£536

Data from Bedfordshire MSK, courtesy of Circle, Jan 2016

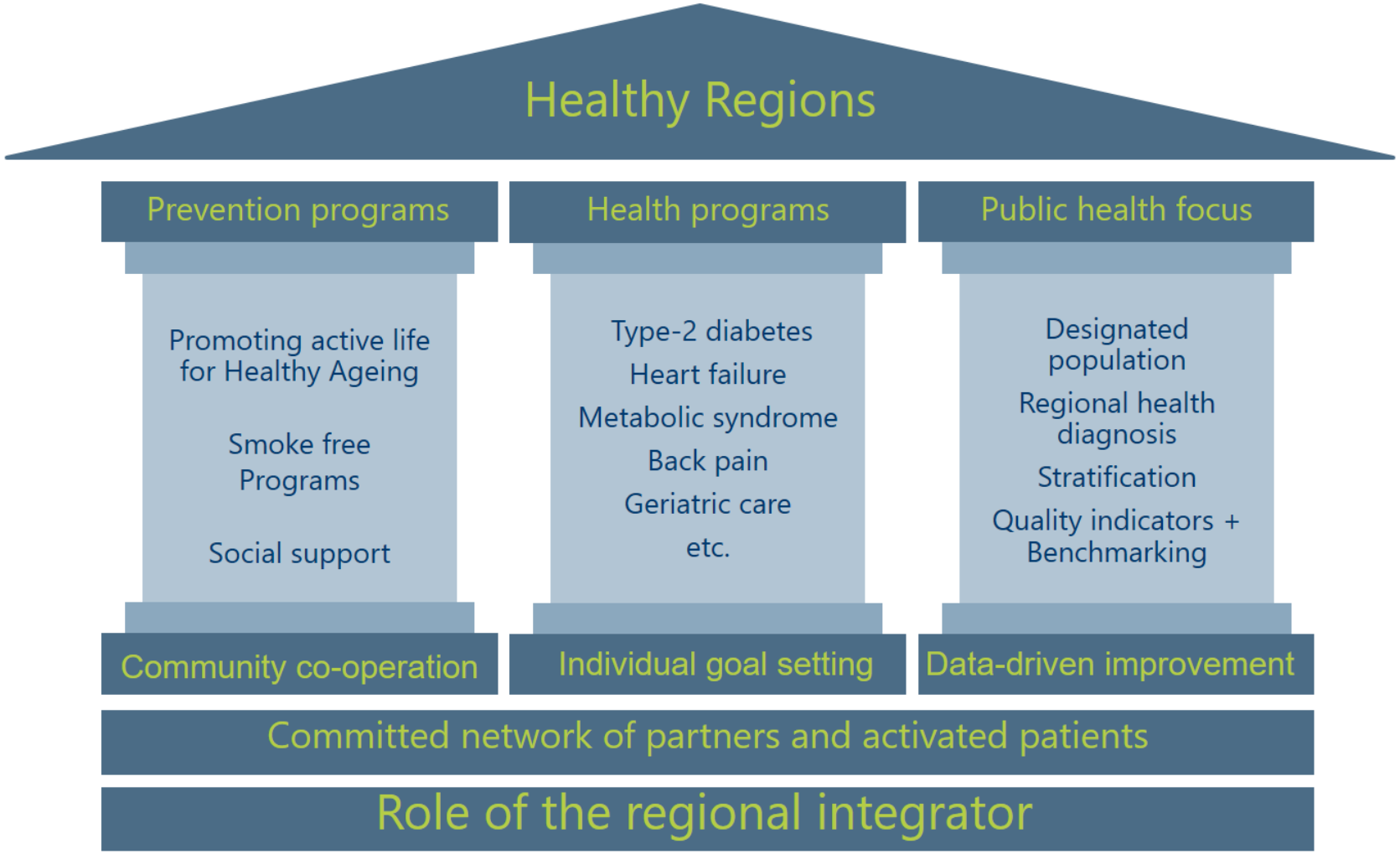
Case Study 4 – Kinzigtal, Germany

Gesundes Kinzigtal (Germany)
More than 10 years later, success still flourishes!

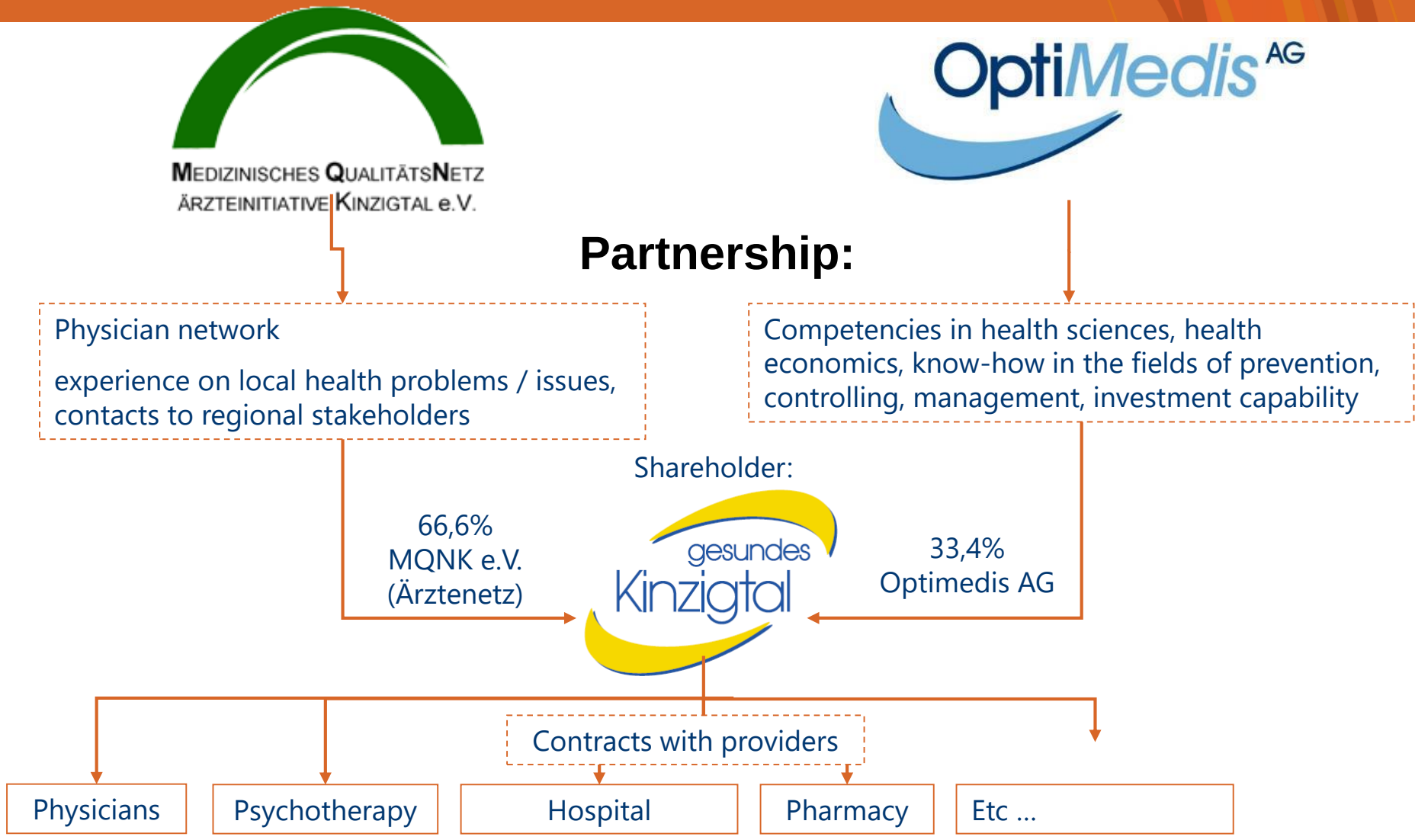
- 2006 Identified Population of 33,000 (insurance funded)
- 58% of all GPs and specialists of the region have joined partnership
- Investment in health care services, coaching, free preventative offers
- Central data platform, 20+ prevention and care improvement programs, integrating sport and exercises

- 2015: Built a medical training & education center (3.5 million € investment)
- 2016: Unlimited contract with AOK

Gesundes Kinzigtal (Germany) The programme for prevention of illness, promotion of health and continual improvement



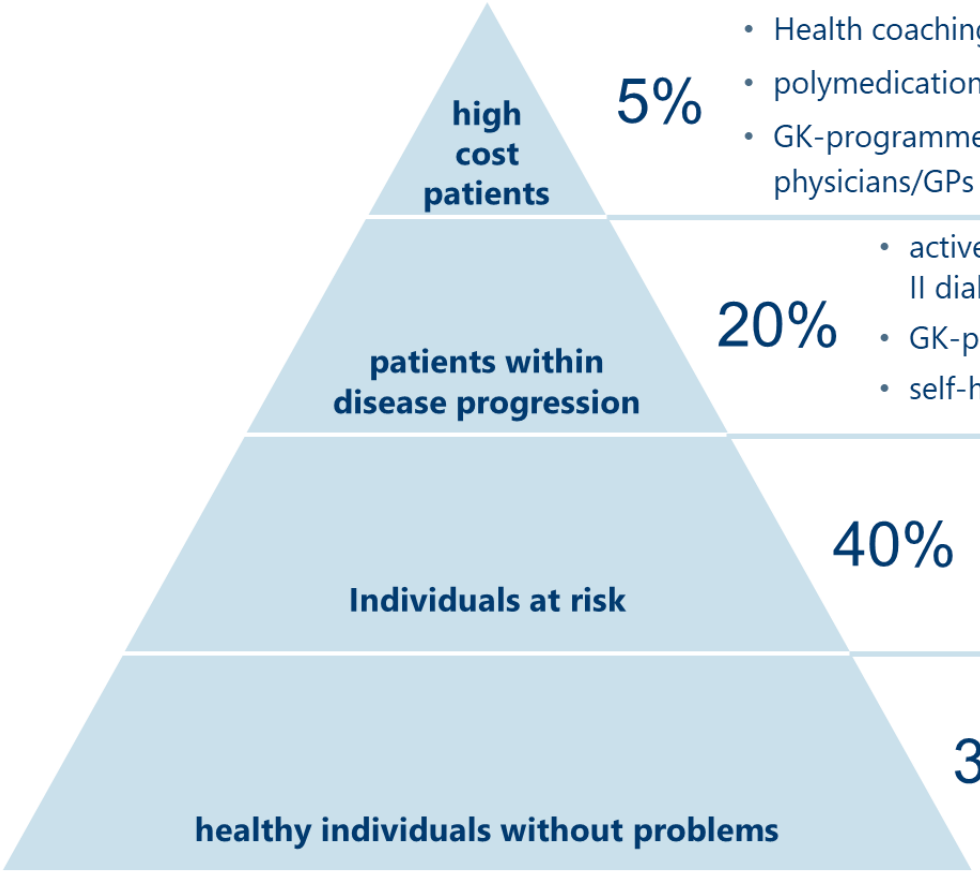
Gesundes Kinzigtal (Germany)
The Model and ownership structure



Gesundes Kinzigtal (Germany) prevention and health promotions that have been developed so far

- **Strong heart (programme targeting heart failure)**
- **Healthy weight (for metabolic syndrome, including diabetes)**
- **Good prospects (care services for children)**
- **In balance (blood pressure)**
- **Strong muscles – solid bones (osteoporosis)**
- **Staying mobile (treating early stage rheumatism)**
- **Strong support - healthy back (chronic back pain)**
- **Better mood (depression)**
- **Good counselling (help, advice and support in critical times)**
- **Psycho Acute (acute psychological issues)**
- **Disease management programmes**
- **Smoke-free Kinzigtal (including pre-surgery smoking cessation)**
- **Social support (to reduce stress where patients are in critical situations)**
- **Liberating sounds (in tune with music) and,**
- **New: a self-management training programme (based on the Stanford Chronic Disease Self-Management Programme).**

Generic and specific interventions related to the management of diabetes mellitus II (T2DM)



5%

- Health coaching (by case managers)
- polymedication – medication counsils
- GK-programme: „physicians plus care" (interaction between physicians/GPs and nursing homes)

20%

- active support of the disease management programme type I and II diabetes
- GK-programme: „psychotherapy acute"
- self-help + self management training for chronic ill patients

40%

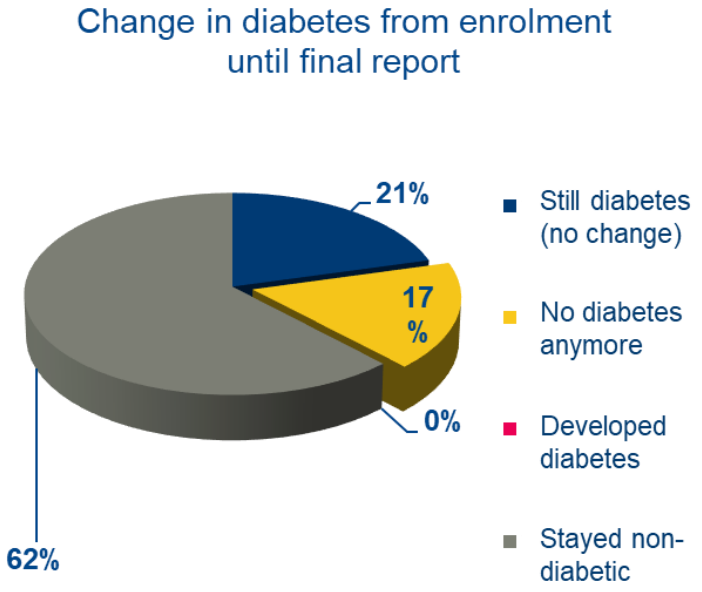
- GK-programme „healthy weight"
- GK programme: „my blood pressure under control"
- target/objective agreement with GPs
- cooperations with several sport clubs

35%

- education / training offerings (Health Literacy)
- health fairs + events
- support of the insurance companies' preventive interventions

Generic and specific interventions related to the management of diabetes mellitus II (T2DM) – initial results

- Positiv: none of the 156 participants developed a diabetes
- 62% stayed non-diabetic
- 38% had a defined diabetes at the beginning (but only 21% at the last examination)
- For four out of ten participants the progression was stopped and even turned around (HbA1c < 5,7%)



Excerpt from: Integrated Diabetes Care in Germany: Triple aim in GK
(Caroline Lang, Elisa A.M. Kern, Timo Schulte, Helmut Hildebrandt)^^

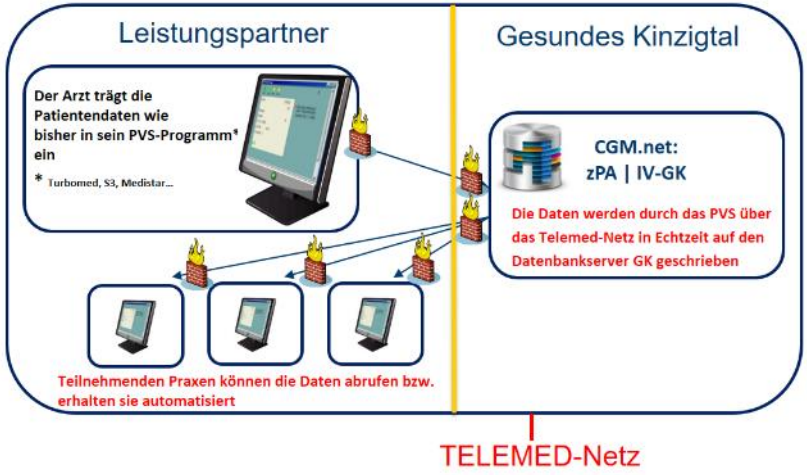
Gesundes Kinzigtal (Germany) important ingredient – shared are record and transparency of information

Now: Every physician can see in his own Computer-system, what was recorded by other physicians (the medications, the goals + lab results).

Investment of time and money, but a key requirement for continui of care and timely data analytics.

Starting point: Trust between providers and joint experiences in working groups etc.

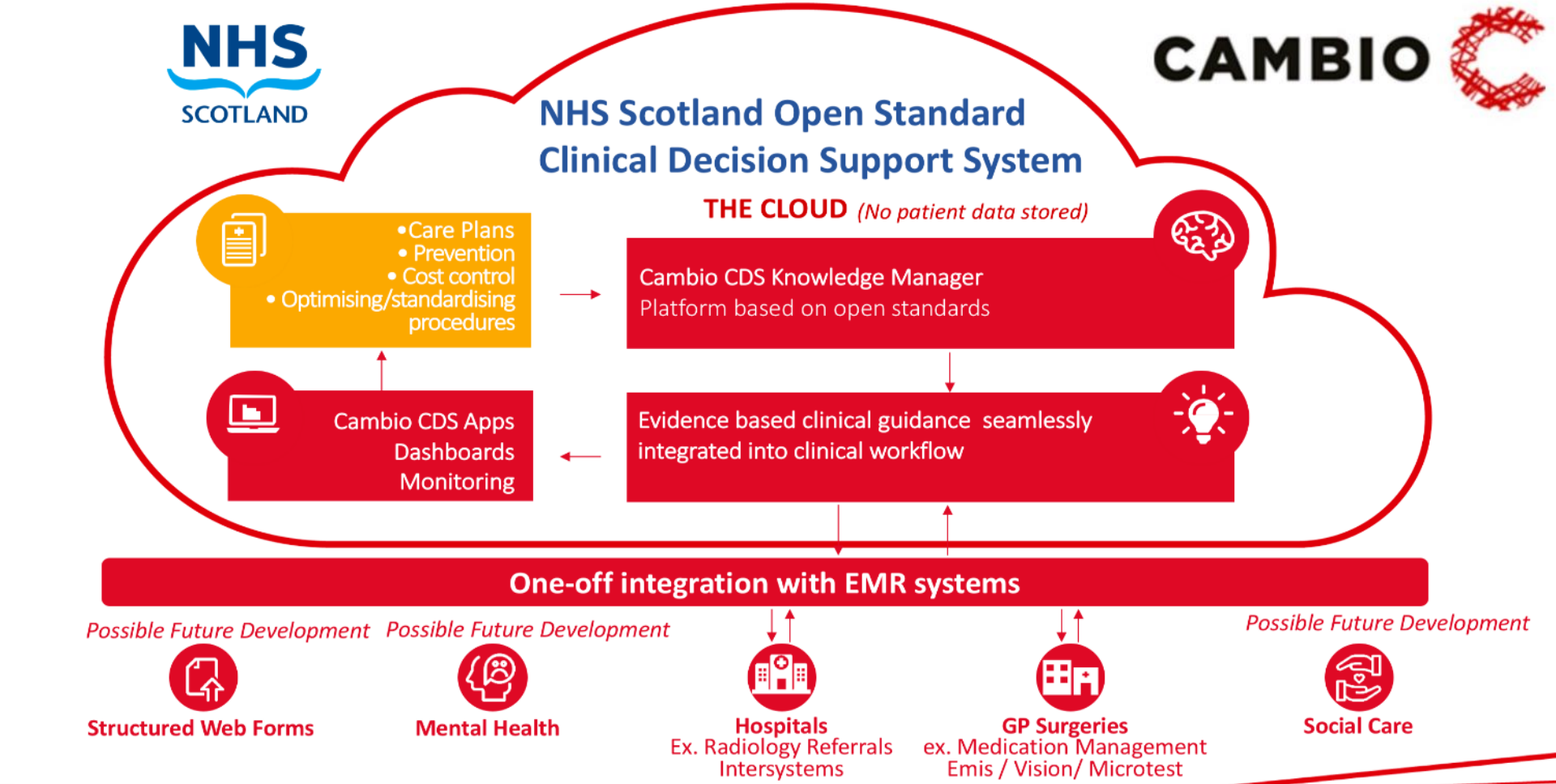
Keep it simple and smart …



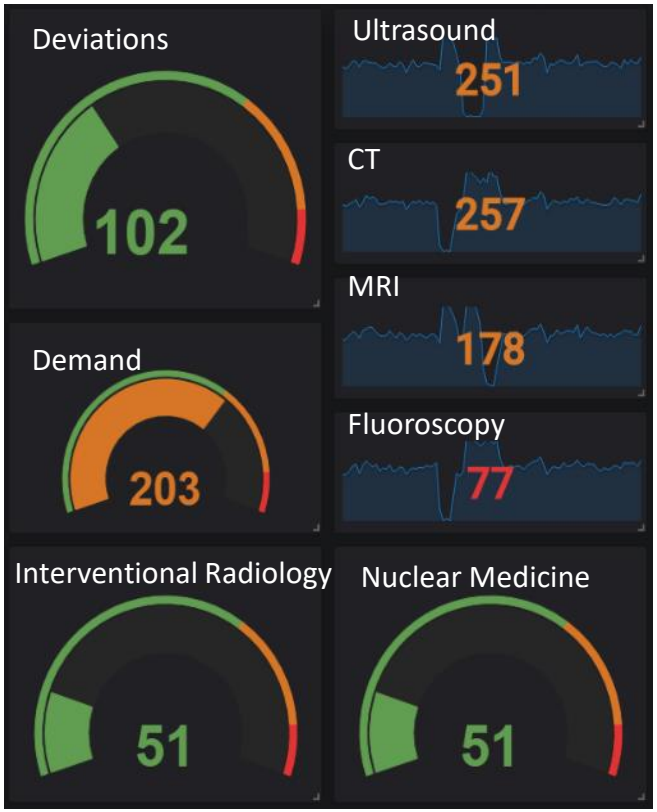
When doctors share visit notes with patients: a study of patient and doctor perceptions of documentation errors, safety opportunities and the patient–doctor relationship

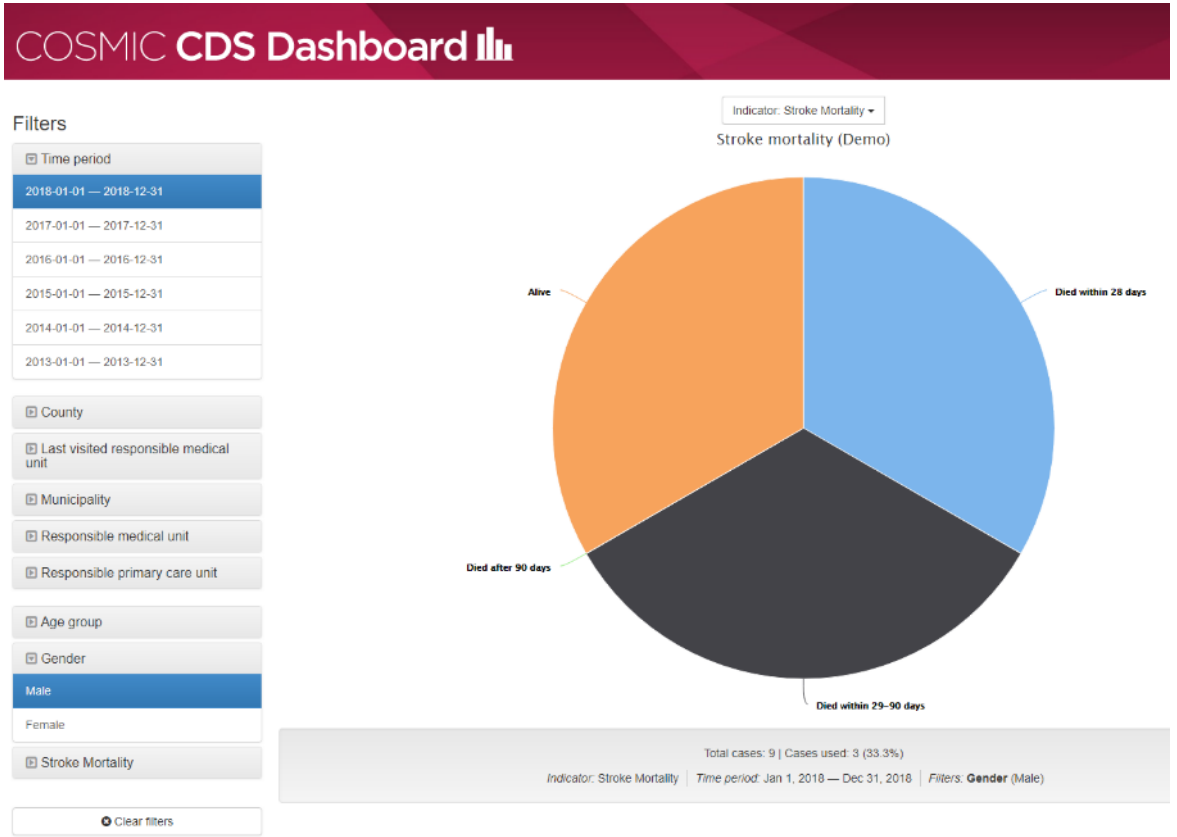
Sigall K Bell,[1] Roanne Mejilla,[1] Melissa Anselmo,[1] Jonathan D Darer,[2] Joann G Elmore,[3] Suzanne Leveille,[1,4] Long Ngo,[1] James D Ralston,[5] Tom Delbanco,[1] Jan Walker[1]

Shared Care Record
Clinical Decision Support (NHS Scotland)



Clinical Decision Support (NHS Scotland)
Supporting and Monitoring Compliance against best practice





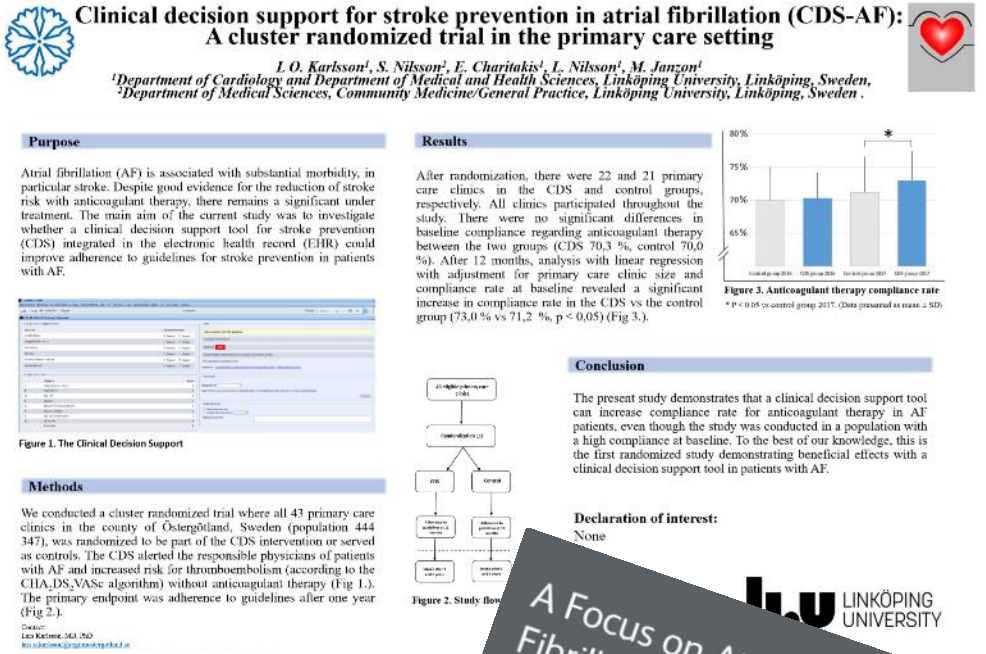
Clinical Decision Support (NHS Scotland)
Cost vs Value (example, stroke (AF))

NHS Scotland Atrial Fibrillation Study.
(50% Compliance)

”If you go from actual 50 % compliance to 70 %, you prevent 20 x 33,5 = 670 strokes!

The economic calculations for NHS costs (using your £ 43,000) will give savings of £ 28,8 millions, and non-NHS cost savings of (using your £ 23,000) £ 15,4 millions, altogether £ 44,2 millions of savings for first year stroke treatment costs.”

Prof Magnus Janzon, Head of Cardiology
Lindoping University Hospitals.



Clinical decision support for stroke prevention in atrial fibrillation (CDS-AF): A cluster randomized trial in the primary care setting

L O. Karlsson[1], S. Nilsson[2], E. Charitakis[1], L. Nilsson[1], M. Janzon[1]
[1]Department of Cardiology and Department of Medical and Health Sciences, Linköping University, Linköping, Sweden,
[2]Department of Medical Sciences, Community Medicine/General Practice, Linköping University, Linköping, Sweden .

Purpose

Atrial fibrillation (AF) is associated with substantial morbidity, in particular stroke. Despite good evidence for the reduction of stroke risk with anticoagulant therapy, there remains a significant under treatment. The main aim of the current study was to investigate whether a clinical decision support tool for stroke prevention (CDS) integrated in the electronic health record (EHR) could improve adherence to guidelines for stroke prevention in patients with AF.

Figure 1. The Clinical Decision Support

Methods

We conducted a cluster randomized trial where all 43 primary care clinics in the county of Östergötland, Sweden (population 444 347), was randomized to be part of the CDS intervention or served as controls. The CDS alerted the responsible physicians of patients with AF and increased risk for thromboembolism (according to the CHA_2DS_2VASc algorithm) without anticoagulant therapy (Fig 1.). The primary endpoint was adherence to guidelines after one year (Fig 2.).

Results

After randomization, there were 22 and 21 primary care clinics in the CDS and control groups, respectively. All clinics participated throughout the study. There were no significant differences in baseline compliance regarding anticoagulant therapy between the two groups (CDS 70,3 %, control 70,0 %). After 12 months, analysis with linear regression with adjustment for primary care clinic size and compliance rate at baseline revealed a significant increase in compliance rate in the CDS vs the control group (73,0 % vs 71,2 %, p < 0,05) (Fig 3.).

Figure 3. Anticoagulant therapy compliance rate

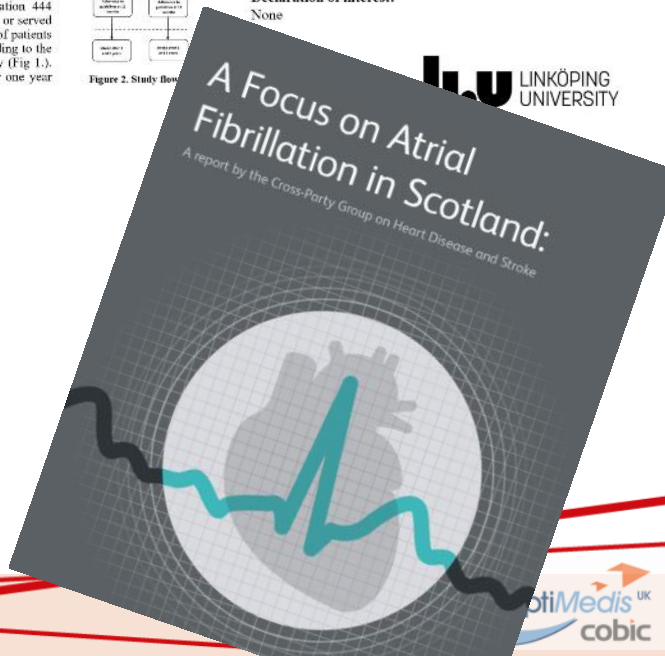
Figure 2. Study flow

Conclusion

The present study demonstrates that a clinical decision support tool can increase compliance rate for anticoagulant therapy in AF patients, even though the study was conducted in a population with a high compliance at baseline. To the best of our knowledge, this is the first randomized study demonstrating beneficial effects with a clinical decision support tool in patients with AF.

Declaration of interest:
None

LINKÖPING UNIVERSITY



Clinicians Cockpit (Germany)
Comparing and Assessing performance

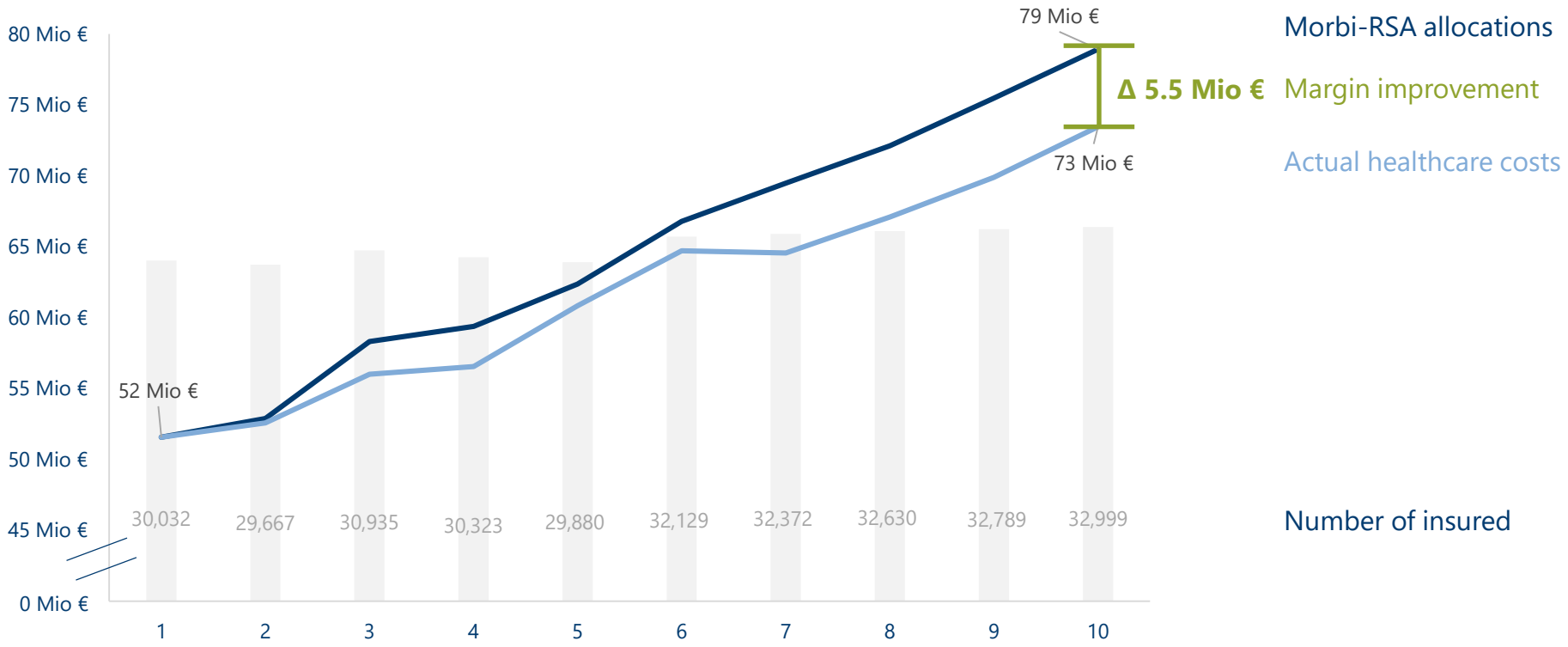
Quality indicators and key figures		Your Practice	Ø-LP-GP's (n=17)	Ø-NLP-GP's (n=22)	Min/ Max GP (n=39)
3. Outcomes: Which impacts have interventions on medical and financial outcomes and patient satisfaction?					
3.1 Economical outcomes	Allocation (Morbi-RSA) per patient	845,45 →	765,33	687,81	937,79
	- Total costs per patient	841,81	764,78	677,81	251,72
	= Contribution margin per patient	3,64	0,55	10,00	326,69
3.2 Health outcomes	Hospital cases per 1.000 patients (risk-adj.)	82,91	87,42	98,55	42,35
	Decedents % (risk-adj. mortality)	0,51%	0,57%	0,60%	0,00%
	Patients with osteoporosis & fracture %	3,64%	8,49%	12,98%	0,00%
3.3 Patient satisfaction	Impression of practice very good - exc. %	66,7%	61,0%	79,9%*	83,3%
Weisse Liste / GeKiM 2012/13	Med. treatment very good - exc. %	52,8%	53,0%	75,1%*	79,2%
*Ø-NLP here = Ø-Germany	Recommendation likely - certain %	85,2%	84,6%	88,1%*	95,6%
2. Process - Where do we have to be excellent?					
2.1 Diagnostic quality	Unspecified diagnoses %	20,4%	20,1%	24,1%	12,5%
	Suspected diagnoses %	1,6%	1,3%	1,6%	0,6%
2.2 Utilization	Patients >= 35 with health-check-up %	7,5%	7,8%	7,1%	17,1%
	Patients incapable of working %	39,0%	41,7%	43,8%	33,8%
	Length of incapacity for work	5,52	5,93	6,37	3,87
2.3 Improvement of Medication	Generic quota	93,0% →	88,6%	87,2%	93,0%
	Pat. with heart-fail. & guideline prescr. %	79,9%	75,4%	72,9%	100,0%
	Patients >= 65 with pot. inad. med. (PRISCUS)	14,3%	13,2%	12,5%	4,2%
	Patients >=65 with inad. prescr. (FORTA D) %	4,0%	4,8%	4,3%	0,6%
1. Structure - What ist the target population? Where can we improve structure elements to generate better outcomes?					
1.1 Patient stucture					
1.1.1 Age, gender, etc.	Ø-Number of patients	509,0	485,3	338,9	931,0
	Ø-Age	57,1	54,6	52,5	53,5
	Female %	56,8%	56,5%	55,8%	65,2%
	Patients capable of work %	55,2%	58,5%	60,5%	72,7%
	Patients dependent on care %	6,7%	7,7%	7,0%	13,0%
1.1.2 Morbidity	Ø-Charlson-comorbidity-score	1,85 →	1,26	1,14	1,99
	Regional GP-risk-score (Morbi-RSA)	1,16 →	1,05	0,94	1,29
1.1.3 Enrollment	IC-participants %	88,8%	61,1%	10,2%	88,8%
	DMP-participants %	67,4%	53,9%	32,0%	81,9%
1.2 Learning & innovation	Participation in quality circles (Ø = 1,0)	1,3	1,0	-	2,1

Robert S. Kaplan and David P. Norton, "Using the Balanced Scorecard as a Strategic Management System," Harvard Business Review (January-February 1996): 76.

Pimperl A., Schulte T., Daxer C., Roth M. & Hildebrandt H. (2013). „Balanced Scorecard-Ansatz: Case Study Gesundes Kinzigtal". Monitor Versorgungsforschung 6, Nr. 1 (2013), 26-30

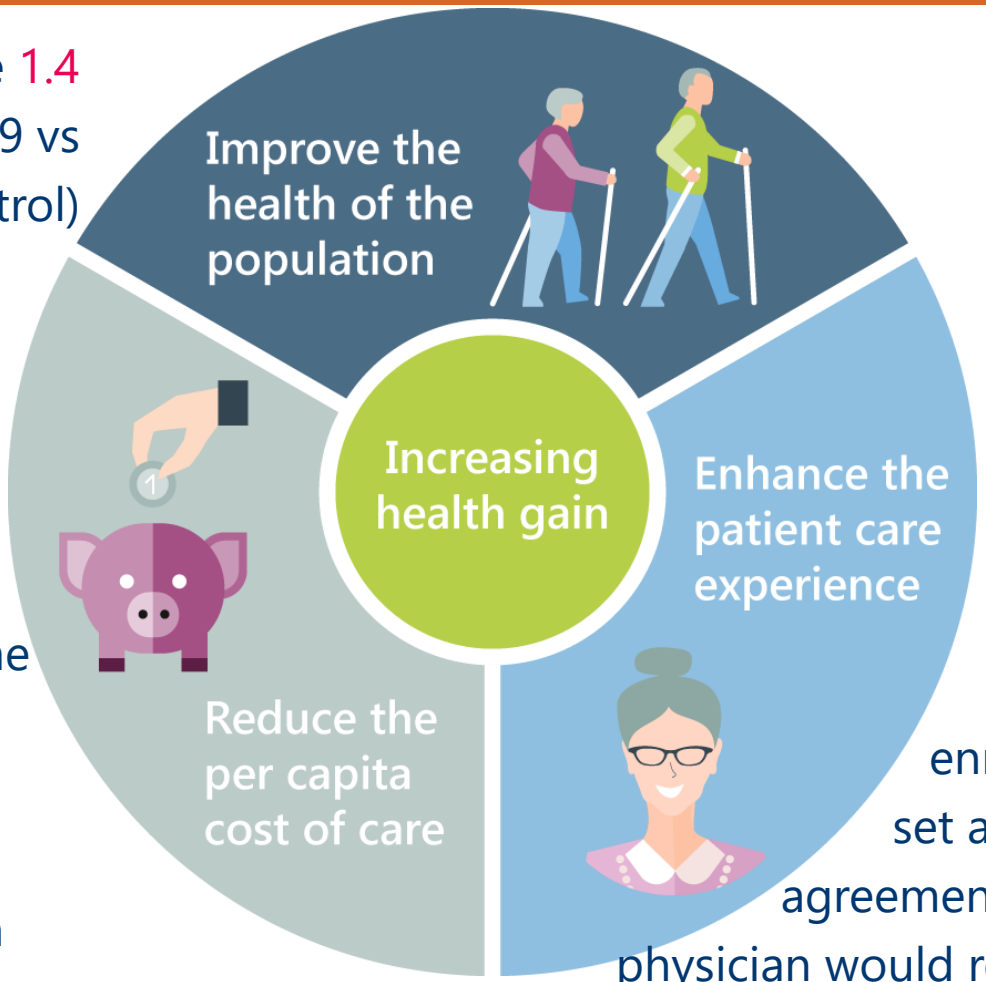
OptiMedis in Kingzigtal
Delivers Results for the payors!

Development of Morbi-RSA allocations, actual healthcare costs, margin improvement and number of insured of AOK und LKK in the Kinzigtal region



OptiMedis in Kingzigtal
Delivers Results for everyone (measured vs Triple Aim)

Participants die 1.4 years later (78.9 vs 77.5 control)



And quality of life and professional satisfaction of providers: 15 % increase in income for partnering physicians per case + higher satisfaction through better cooperation (with other providers and patients + viceversa).

€5,5m surplus improvement for the two sickness funds in the Kinzigtal region in 2013 against €75m norm costs

98.9 % of enrollees who set an objective agreement with their physician would recommend becoming a member to their friends or relatives

OptiMedis in Kingzigtal
The impact is visible and tangible



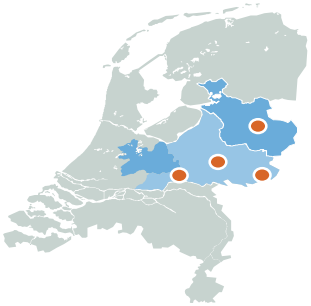




Healthy workforce: Companies are calling on Gesundes Kinzigtal to get support for health promotion management and activities around health at the workplace.

ent advisory board

OptiMedis in Germany
And throughout Europe



Interest of partners in Kanton Bern and from the Swiss health authorities

A movement for change

OptiMedis model beyond Germany
What would be needed to create similar projects abroad?

- Investment funding for at least the first three years
- National health services or social health insurance organisations – willing to share the savings long-term
- Relative cost savings can be calculated in a robust and reproducible manner
- Professionally managed organization to act as regional integrator, with comprehensive know-how in health data analytics, public health, ICT implementation …

And

- … interested local providers to embrace the opportunity

Contents

Success factors of the regional integrated care model

Regional care company as “integrator” + partly ownership through local providers

Investment for the first three years (until earnings are big enough for ROI)

Going / thinking beyond healthcare + entrepreneurial health sciences spirit

Emotional quality between providers, professions, management and patients

Outcomes used as a model of describing services for the population

Collaborative Working (coordinated)

Comprehensive implementation of technology: ICT & data-driven management approach

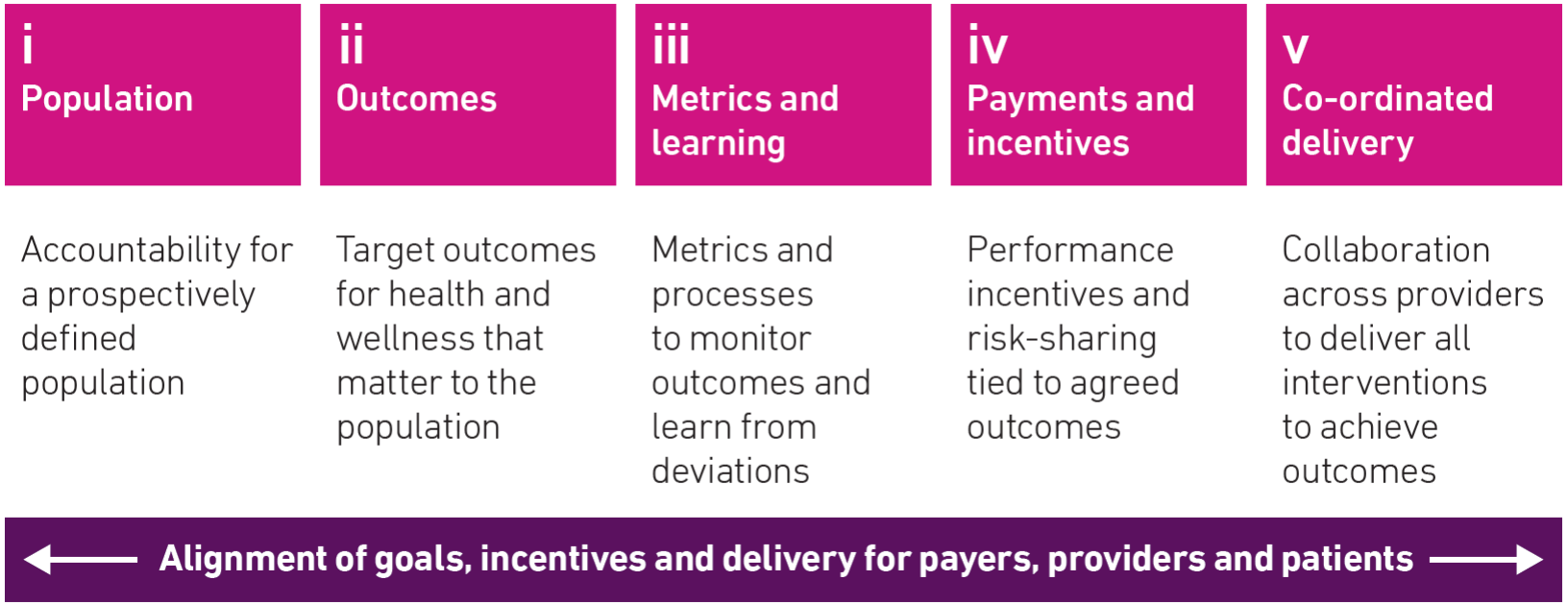
“Coopetition” = cooperation and competition through transparency and benchmarking

Balanced payment system oriented towards achieving the Triple Aim

Innovative culture and friendly interactions “open source” mindset

10 years contract with sickness fund to refinance investment

What is needed for successful Integration: the McClellan Model



Accountable Care - "A system in which a group of providers are held jointly accountable for achieving a set of outcomes for a prospectively defined population over a period of time and for an agreed cost."

McClellan M et al. Accountable Care Around The World: A Framework To Guide Reform Strategies. Health Affairs, 33, no.9 (2014):1507-1515

	i Population	ii Outcomes	iii Metrics and learning	iv Payments and incentives	v Co-ordinated delivery
5	**Intersections accounted for** (ie, co-morbidities)	Outcomes that **matter to people**; prioritized based on **individual goals**	Aggregated longitudinal data made **public** in cross-provider **consistent** format	**Full capitation** with guard rails on quality; differential payments for outcomes	Clinical and data **integration of provider network**; patients **co-design** care
4	**At-risk** individuals identified, using all available sources	Focus on **prevention** and **wellness**; goals adjusted based on patient **risk** level	Results shared with people in **usable** form; monitoring **built into** clinical work flow	Upside and **downside** shared savings; strong professional competition	Patients **empowered** to self-care; **care plan** and **managed transitions**
3	**Registry** of population **integrated** with EHR	**Comparable** with other providers and aligned with global **best practice**	**Real-time** and **summary** learning; results **shared** with payer and clinicians	**Upside-only** shared savings and risk for whole health; bonuses to staff	**Clinicians empowered** to adjust interventions to improve outcomes
2	**Defined** population (eg, morbidity, age, geography, payer)	Incorporation of **patient experience** into targets	**Leading clinical indicators** with **evidence link** to outcomes	**Bundled payments** with quality controls for episodes of care	Multi-disciplinary **meetings**; all team members used to **maximum potential**
1	**Holistic view** of existing funding and providers	**Basic clinical outcomes** decided at local level	**Admin-based** measures; **limited** transparency; summary evaluation only	**Pay-for-performance** bonuses **on top of** fee-for-service or block payments	**Basic electronic data-sharing** across providers
0	No identified population	No target outcomes	No metrics nor learning	Payments for activity only	Uncoordinated provision of elements of care

McClellan M et al. Accountable Care Around The World: A Framework To Guide Reform Strategies. Health Affairs, 33, no.9 (2014):1507-1515

Refresher – what we need for successful integration

1. **The policy driver / the will / the ambition**
2. **An identified population to manage**
3. **Outcomes that describe the needs / wants of the population**
4. **A group of providers that are ready, willing and able**
5. **An Integrator!**
6. **A budget and incentive programme**
7. **A means of paying that benefits the system**
8. **A contract to hold it all together (over a number of years)**
9. **Framework for managing / monitoring performance (shared care record)**
10. **Culture change! (and patience)**

1. You need…Strong leadership

Behaving as one group and choosing not to be constrained by organisational governance and bureaucracy etc.

Modelling integrated relationships strong leadership in practice

Working culture across organisational boundaries, creative, innovative, taking risks together

Interest in each others' KPIs e.g. shared few (AA avoidance, reduced care home admissions or domiciliary care packages, increased reablement access)

Independent support to facilitate **culture change management** engaging front line staff

National Voices '**I statements**' underpin the process

Long term vision – there are no quick fixes and the challenge is sustaining the change when individual leaders leave

Courtesy of Professor Paul Corrigan

2. You need… joint working with people and communities

Citizens, service users, patients the same individuals are called different things and treated very differently. MUST have a **common language for people**

Too many have become used to having to **tell their story many times** and being treated as body parts rather than people

People usually treated kindly but as deficits with **little attention paid to the different cultural and experiential assets** that they have

Too often the crucial asset of their **independence is squandered**

Too often **voluntary organisations are ignored**

Communities are **not seen as a repository of assets** that can co-produce outcomes

Courtesy of Professor Paul Corrigan

3. You need… committed and empowered frontline staff

The only way to change people's experience is by **engaging front line practice**

Strong leadership – really making sure people really understand where we are going and behave in a way to show people the journey not telling people

Working with GPs to change the way they have worked for many years.

Investment – Visiting surgeries to explain how we want to change practice for the benefits of service users, how the system may work differently

Inter-professional practice – moving beyond fragmented working, use of one shared care plan (now called an Iplan) building on the concept of I statements

Health and social care managers at all levels in the teams **working in partnership** has been a significant enabler

Shared access to training and development opportunities – **joint learning** sessions

Staff engaged and feeling confident to be creative and continue to develop ideas, support to implement change, share good practice and encourage others to do so

Courtesy of Professor Paul Corrigan

4. You need…operational managers that work across boundaries

Co-location and i**ntegrated management structure** for all integrated teams

Joint learning – being reflective/reflexive

Well designed team meetings to encompass of both health and social care agenda

Encourage/empower people to be confident to articulate challenges and difficulties, in a solution focussed way. On balance notice and celebrate successes

Understand health and social care business, culture, priorities, duties etc. as much as possible, but model that its OK not to know everything and that learning will evolve and develop

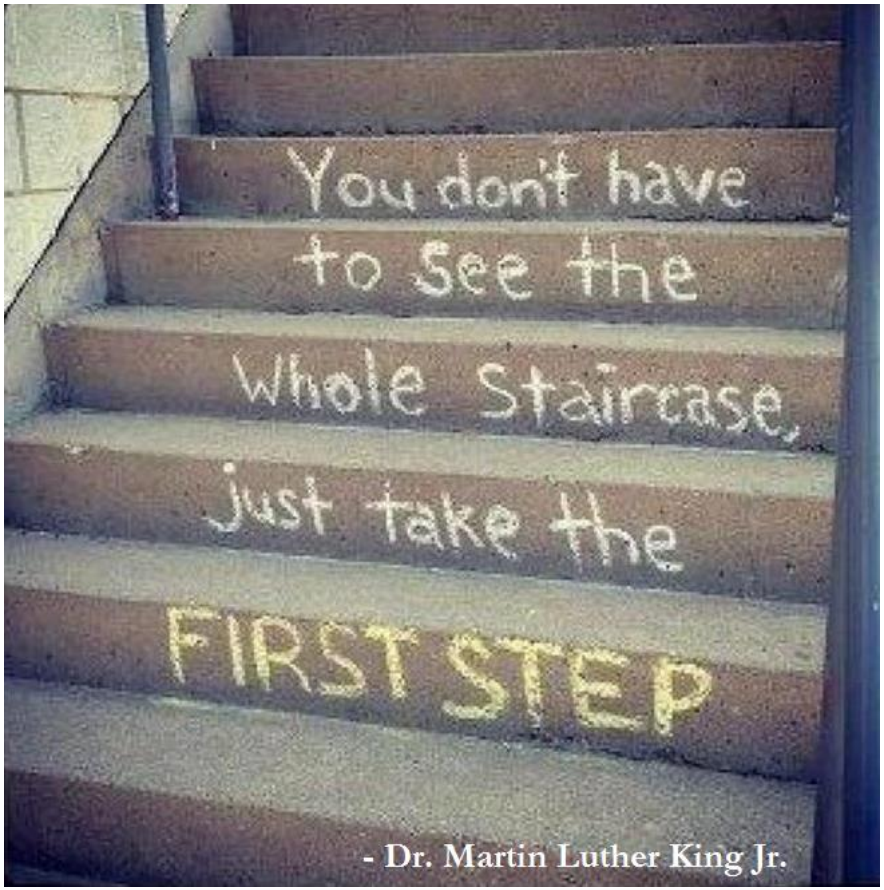
Take time to **understand the individuals**, use annual appraisal to develop a wider perspective of learning

Build confidence in the staff to be able to approach either the health or social care manager to ask core questions about service users

Use case studies which were led by staff to **showcase innovative integrated practice** to help share with the rest of the team and spread the word/demonstrate the value

Courtesy of Professor Paul Corrigan

5. You need…


You don't have
to see the
whole staircase,
just take the
FIRST STEP
- Dr. Martin Luther King Jr.

Dziękuję Ci
Lets stay in Contact

Andrew P. Smith
Commercial Director
Andrew.smith@cobic.co.uk
Mobile: + 44 7815 114779

OptiMedis COBIC UK Ltd
Oxford and London UK, Europe

See our latest news https://optimedis-cobic.co.uk/news

www.optimedis-cobic.co.uk