From Silos to Systems

Prepared for Region Midtjylland

October 25th 2018

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Advisory Board

From Silos to Systems

The best practices are the ones that work for you.℠

research technology consulting

Section 1

What do we ***really*** mean by Population Health and Integrated Care?

The Tower of Babel

Care transformation
Alignment of care
Multidisciplinary care delivery
Seamless care
Coordinated care
Service integration
Triple aim
Joined-up care
Managed care
Person-centred care
Integrated care
Cross-sectoral teamwork
Shared care
Population health management
Interdisciplinary care
Accountable care
Continuum of services
Virtual integration
Care coordination
Value-based care
Transmural care
Multifaceted approach
Comprehensive care
Whole-system approach
Right care, right place, right time

Source: Advisory Board interviews and analysis.

A Working Definition for Care Transformation towards Population Health.

What is yours?!

> The attempt to **encourage stakeholders** to **work together** in a **person-centred** approach to **effectively treat** in the **lowest-cost appropriate setting** and to **reduce the need for treatment** in a **population**.

Source: Advisory Board interviews and analysis.

A Flexible Framework

Each Term Suggests Multiple Approaches

Elements of Working Definition of Integrated Care

Source: Advisory Board interviews and analysis.

Section 2

What does the end state look like?

What can we learn from successful Population Health models?

No Single Model for Success

Successful Care Managers Vary in Size and Type

Areas of Variability Between High-Performing Care Management Enterprises

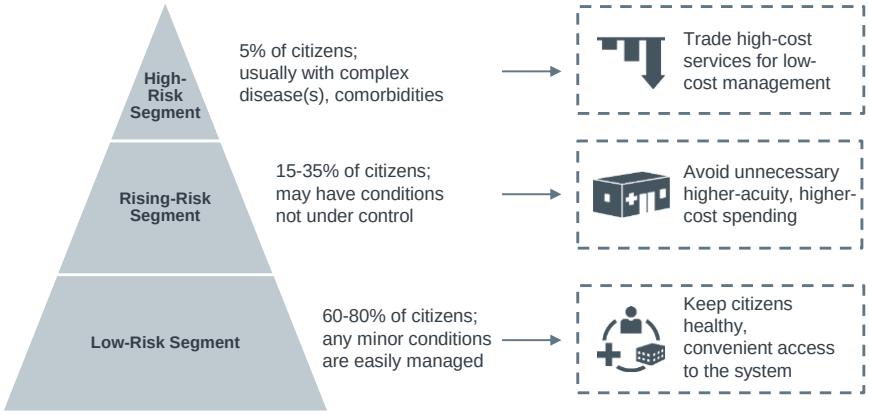
Size		Range from single hospital site to provincial or state health systems
Location		Located throughout the world
History		Risk management experience ranges from a few years to over 50 years
Market Type		Across all health system payment models
Organisational Structure		Doctor-based and health system-based enterprises (often including social care)
Medical-Staff Alignment		Range of doctor compensation models
EPR		With and without a common electronic patient record across enterprise

Source: Advisory Board interviews and analysis.

Beyond High-Risk

Best Population Health Managers Target Three Populations

Managing Three Types of Demand



Source: Advisory Board interviews and analysis.

Organisational Models Set Early Adopters Apart

Common Approach to Care Integration

1. Develop Care Management Processes

Operational Practices

- Stratifying patient/citizen populations
- Scaling specific services to manage patients/citizens at different risk levels
- Redeploying staff for care management roles
- Coordinating providers across continuum

2. Create Organisational Structure

Management Strategies

- Setting shared objectives with local partners
- Acquiring organisations to build the continuum of care
- Crafting contracts to align independent entities on shared outcomes
- Building a shared-risk network

Research in Brief: The Population Health Enterprise

Forthcoming Global Forum publication on care management strategies and tactics. Available Q1, 2015.

Source: Advisory Board interviews and analysis.

The Alzira Model

Control Incentives Enforced by Valencia

Budget Controls

- Hospital ownership retained
- Set fee per inhabitant

Quality Protection

- Outcomes targets in contract
- Free patient choice
- Profit capped at 7.5%

Access Protection

- Universal, free care stipulation
- 80% out of network reimbursement

20-25%

Consistently lower expenditures than comparable publicly managed institutions

91%

Patient satisfaction rate

Case in Brief: The Alzira Model

- Spain's national health system grants private companies ability to manage public health care assets in Valencia
- Private company, Ribera Salud, assumes responsibility for health of Valencia region's population of 250,000 based on capitated annual payment for each citizen
- Renegotiated contract to include primary care after first endeavour failed. Now operating several sites of care

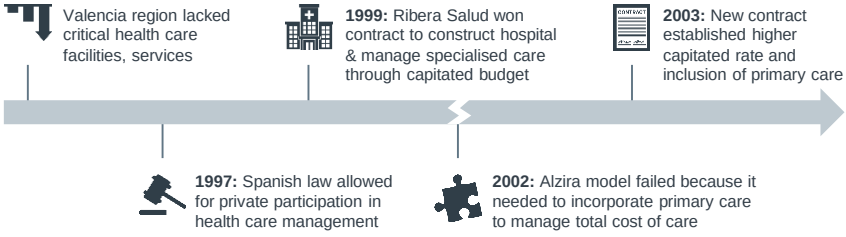
1) Accountable Care Organisation

Source: McClellan, Mark, "Accountable Care Around the World," *Health Affairs*, Sept. 2014, 33:9, 1507-1515; "Spanish health district tests a new public-private mix", *WHO*, http://www.who.int/bulletin/volumes/87/12/09-031209/en/; Advisory Board interviews and analysis.

Missing Partner Up-ended Business Model

Critical Partners Needed to Assume Population Health Risk

Timeline of Alzira Model
Alzira, Spain



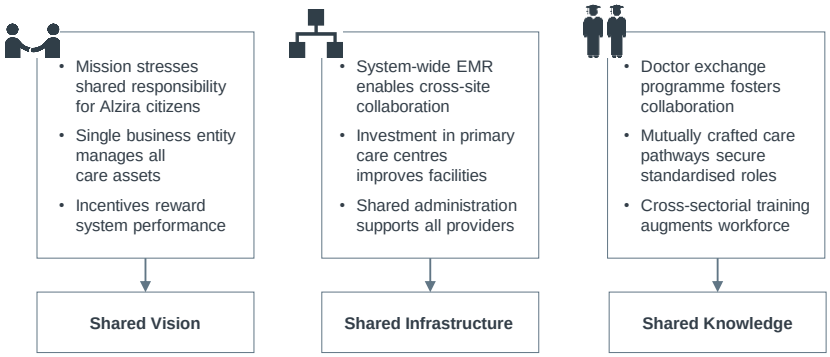
> "Before primary care was integrated with the hospital, our model struggled. We were responsible for the health of the population but could not do that without full integration of primary and hospital care. Now that primary care, home care, and hospital care are integrated, we can fully manage our population's health."
>
> *Alberto de Rosa Torner, CEO, Ribera Salud*

Sources: Carlos T. Serrano, "Alzira model: Hospital de la Ribera, Valencia, Spain," EUREGIO III; Advisory Board interviews and analysis.

Cross-Sectorial Collaboration Key to Success

Care Management Grounded in Primary Care with Acute Care Support

Key Investments in Primary-Secondary Partnership



Sources: Advisory Board interviews and analysis.

Immersion Creates Mutual Understanding

Two-Way GP-Specialist Exchange at Ribera Salud

The Alzira Approach to Primary-Acute Care Collaboration

Two-Way Provider Immersion

- GPs spend a week in hospital, specialists take GP's place in primary care clinics
- Post-immersion feedback loop to assess success of integration and knowledge exchange

Consistent Commitment

- Specialists dedicate time to GP consultations in primary care clinics
- Support development of cross-continuum pathway on weekly basis

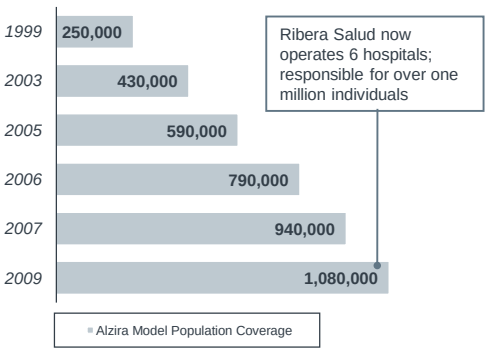
- Uses a systematic approach to facilitate cross-sector collaboration, by immersing GPs in acute setting and specialists in primary care. GPs regain voice in hospital through post immersion survey
- Understanding between provider groups linked to improved emergency care utilisation

Source: Advisory Board interviews and analysis.

Sustained Partnership Drives Business Success

System Exceeds Government Targets and Expands

Population Covered Under Ribera Salud Group[1]



Alzira Performance Compared to Peers in Valencia on Major Metrics

34%
Fewer 3-day readmissions

54%
Lower emergency wait times

26%
Higher patient satisfaction

1) In Spain across Valencia region and Madrid: Hospital Universitario de La Ribera, Hospital de Torrevieja, Hospital de Denia, Hospital de Manises, Hospital de Vinalopó, Hospital de Torrejón.

Sources: NHS European Office, "The search for low-cost integrated healthcare," 2011, http://www.riberasalud.com/ftp/biblio/1403201310251220 11%20NHS%20bibliografia.pdf ; Advisory Board interviews and analysis.

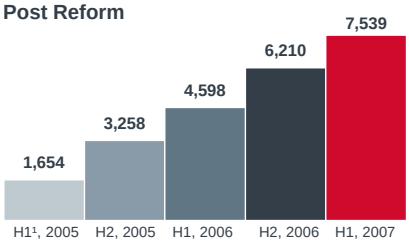
Encouraging Experimentation

Setting Aside Money for Piloting Integrated Care Programs

Reform Type in Brief

- Pool of money set aside to incentivise payers and providers to experiment with integrated care initiatives
- Germany, New Zealand, UK, United States, and the European Union have introduced innovative incentive pools for integrated care

Number of Integrated Care Contracts Post Reform



Example: Statutory Health Insurance Modernisation Act 2004

- German legislation from 2004-2008 with one element requiring sickness funds to set aside 1% of their budget to support establishment of integrated care contracts, initiations, and experiments
- Most contracts link two providers, but more complex contracts to manage population exist

[1] Half a year

Source: Blum, K, "Care Coordination Gaining Momentum in Germany," 2007, *http://hpm.org/en/Surveys/Bertelsmann_Stiftung_-_Germany/09/Care_coordination_gaining_momentum_in_Germany.html*; Advisory Board interviews and analysis.

Fragmented Care in Germany Hinders Integration

Causes and Effects of Care Fragmentation in Germany

Strict Payer Regulation
Payers compete for patients but cannot deliver, own or restrict care

Private Provider Competition
Providers negotiate with insurance companies, competing for health care dollars

Free Patient Choice
Patients have free choice among providers, without gatekeeping

German Health Care

- Unrestricted health care access for patients
- Fee-for-service environment encourages over-use of care
- Limited means to reduce care access or control use by payers

"[Germany's] historically strict division of health services is connected to a reimbursement system without incentives for outcome-oriented health care or prevention so that quality- and value-based incentives have been virtually non-existent"

Helmut Hildebrandt, CEO, OptiMedis AG

Sources: Helmut Hildebrandt et al., "Gesundes Kinzigtal Integrated Care: improving population health by a shared health gain approach and a shared savings contract," 2010, *International Journal of Integrated Care*, vol. 10; Advisory Board interviews and analysis.

A Private Approach to Population Health

Case in Brief: Gesundes Kinzigtal

- Health management system caring for ~31,000 residents in rural Southern Germany
- Private management company and GP provider partnership set up risk-based contracts with two sickness funds, becoming contractually accountable for their respective population
- Doctor network (2/3 share) and management company (1/3 share) share gains if successful

Key Participants in Population Health Contract

1 Medical Staff

- Multispecialty doctor network based in the Kinzigtal region
- Provides clinical and regional expertise

2 Management Company

- Management company with background in sociology and health economics
- Provides contractual and management expertise

Continuum Partners Contracted for Wraparound Services

GPs | Pharmacy | Social Care | Hospitals | Nursing Care

Source: Helmut Hildebrandt (2014). "Generating economic impact and common welfare by clinical wisdom, targeted prevention and data analysis – the case of Kinzigtal in Germany" at the *King's Fund Integrated Care Summit*.

Incentives Build Compelling Business Model

Attractive Offering Prevents Out-of-network Care Provision

Incentives Gesundes Kinzigtal Provides to Create a Network

For Insurance Company

Incentives:

- Shared savings contract rewards reduced utilisation
- Comprehensive care management services for patients at no additional cost

For Providers

Incentives:

- Insurance pays for additional service provision
- Doctors able to provide better care quality

For Patients/Citizens

Incentives:

- Rewards for preventative care participation
- Extended primary care office hours; express access to services

…and for Gesundes Kinzigtal

- If they are able to save the insurance company money they can share in those savings
- To date, they have not paid out any savings bonuses, opting instead to reinvest money

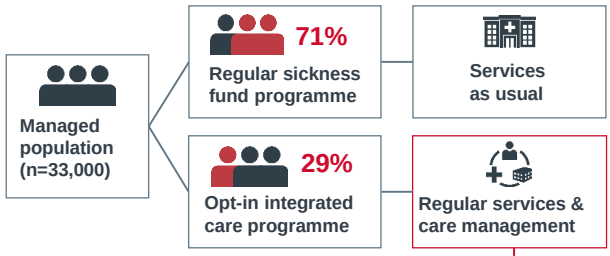
Source: Advisory Board interviews and analysis.

Optional Care Management for Insurees

Enrollment Process

1. Gesundes assumes responsibility for full insuree cohort
2. GK encourages insurees to opt-into integrated care
3. Opt-in patients benefit from additional services free of charge

Patient/Citizen Enrollment and Care Management Pathway



Primary care anchor
'Doctor of trust' with mobility and availability beyond regular office hours

Patient activation
Encouragement through goal-setting agreements and wellness incentives

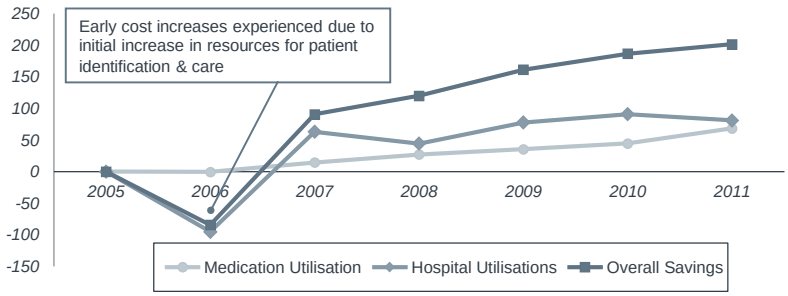
Independent treatment plans
Creation of ITP in collaboration with patients/citizens if risk identified through check-up

Shared EMR
Information collection to enable sharing, predictive modelling, and cost analyses

Source: Helmut Hildebrandt et al., "Gesundes Kinzigtal Integrated Care: improving population health by a shared health gain approach and a shared savings contract," 2010, *International Journal of Integrated Care*, vol. 10; Advisory Board interviews and analysis.

Model Demonstrating Concrete Outcomes

Savings per Insured Compared to Control Group (in €)



Tangible Benefits Seen Over Time

1.4
Life expectancy years gained

~380%
Increased patient/citizen[1] participation

€4.56M
Savings for insurance company[2]

~50%
Sickness fund drop-out rate reduction

1) Since programme launch (2005-2014)
2) AOK & LKK: German sickness fund

Source: Helmut Hildebrandt (2014). "Generating economic impact and common welfare by clinical wisdom, targeted prevention and data analysis – the case of Kinzigtal in Germany" at the *King's Fund Integrated Care Summit*; Helmut Hildebrandt et al., "Gesundes Kinzigtal Integrated Care: improving population health by a shared health gain approach and a shared savings contract," 2010, *International Journal of Integrated Care*, vol. 10; Advisory Board interviews and analysis.

A Daunting Mission

Population Health Management Developed as Survival Strategy

Four Elements of Montefiore's System and Success

- Service delivery adapted to a highly-deprived population
- Formal alignment with clinical staff on managing financial risk
- Dedicated arm created for crafting and administering risk based contracts
- Focus expanded to improving patient/citizen environment

Case in Brief: Montefiore Health System

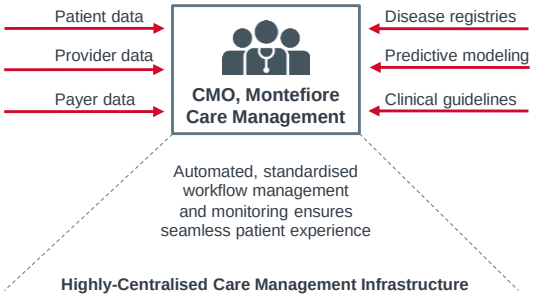
- 2,200-bed multi-provider health system in urban Bronx neighbourhood in New York City
- Serves one of the poorest and most densely populated areas in the United States, with a 31% poverty rate; one-quarter of adult population uninsured before the ACA[1]
- Montefiore's care management company, CMO[2], oversees value-based arrangements covering 300,000 individuals; care management enterprise supported by 800 employees

1) Affordable Care Act, 2011 U.S. health care reform legislation that expanded insurance coverage among Americans
2) CMO, Montefiore Care Management

Source: Advisory Board interviews and analysis.

A Unified Approach to Care Management

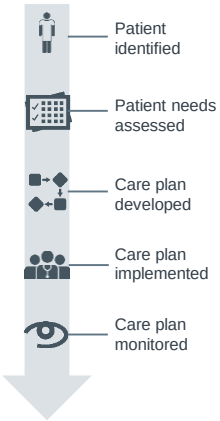
CMO[1] "Air Traffic Control" Activities



Highly-Centralised Care Management Infrastructure

- Disease management
- Patient /Citizen education
- Care coordination across settings
- Complex care management programmes
- Intensive case management
- Community partnerships

Patient Experience Across the Continuum



1) CMO, Montefiore Care Management

Source: Advisory Board interviews and analysis.

Incorporating Non-clinical Factors

Comprehensive Discharge Planning Extends Beyond Clinical Continuum

Montefiore Housing at Risk Patient/Citizen Identification

Housing at Risk Patient Criteria

- Previously identified by housing or social service provider as at-risk
- "Home" address that is a hospital, clinic, or shelter
- Address that says "homeless," or "undomiciled"
- Previously seen by a GP who specialises in homeless care

Source: Advisory Board interviews and analysis.

Addressing the Foundation of Health

Montefiore's Community Health Initiatives

Homeless Care GP

- Works with street homeless population in the community
- Specialises in care for this population
- Flags citizens they care for and is notified if one presents to the hospital

Respite Housing Organisation

- Montefiore contracts with organisation for a set number of beds annually
- Will provide housing for medically stable, homeless citizens post-discharge
- Housing organisation works to determine citizen's long-term solution to lack of housing

Other Community Organisations

- Legal aid organisations
- Transportation organisations
- Financial services organisations

"Graduating" a High-Risk Patient

Prior to getting him into our Housing at Risk programme, one of our patients had 16 admissions. Since we put him in that programme, he has been to the emergency room once, has now received his green card, he has Medicaid, and should be moving into a transitional program next month. There is a significant savings to the institution through a reduction in readmissions.

Director, CMO, Montefiore Care Management

Source: Advisory Board interviews and analysis.

Impressive Results with Full-Risk Management

Early Investments Facilitate Success in an "Impossible" Environment

Dramatic Decline in Acute Demand

25% Decline in admission rate per 1,000 people over three years

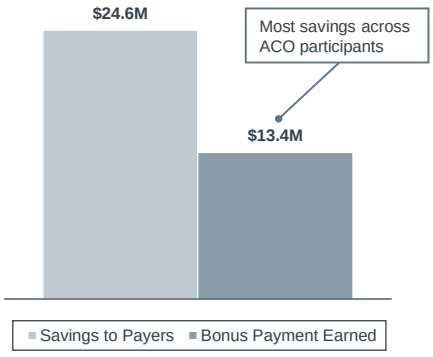
62% Reduction in average length of stay over 16 years

Beating the Odds in Financial Management

2.5% Margin maintained since 2009

7% Reduction in 2013 spending

Montefiore 2013 ACO[1] Pioneer Program Savings in USD



1) Accountable Care Organisation

Source: Evans, M "CMS posts long-awaited Pioneer ACO quality and financial results," *Modern Healthcare*, http://www.modernhealthcare.com/article/20141008/NEWS/310089921/cms-posts-long-awaited-pioneer-aco-quality-and-financial-results; Advisory Board interviews and analysis.

Section 3

The Blueprint for our Journey towards population Health

The Key Priorities we need to consider and ideas from other systems that would help us take action!

Reverse Engineering System Success

Criteria for Study Assessment

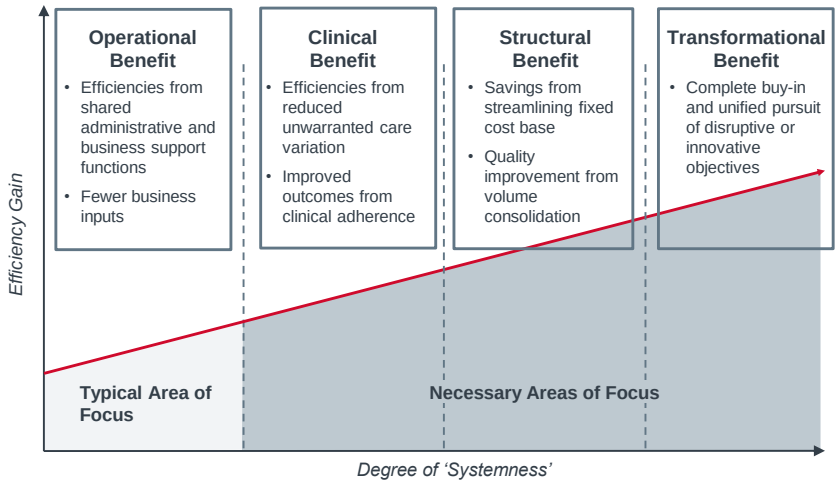
Size	Minimum two health care entities collaborating
Location	From any health system globally
History	Improved clinical and financial performance five years post-assembly
Market Type	Feasible across all health system payment models
Organisation Structure	More than one leadership group to manage
Work Component	Successfully completed service reconfiguration
EHR[1]	With or without a common electronic patient record across enterprise

1) Electronic health record.

Source: Advisory Board interviews and analysis.

Distinct and Staged Benefits of Working as System

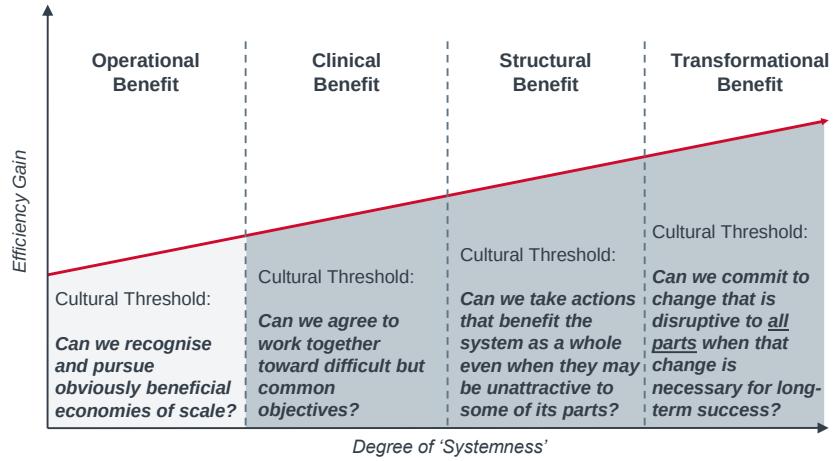
Systemness as Both Journey and Outcome



Source: Advisory Board interviews and analysis.

Cultural Thresholds Drive Collective Action

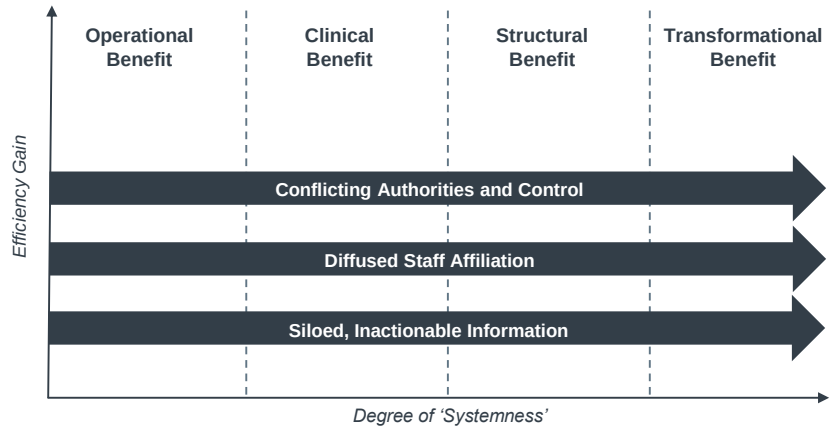
Build Trust and Political Capital Along the Journey



Source: Advisory Board interviews and analysis.

Most Persistent Barriers to System Development

No-Regret Focus Areas Regardless of System Ambition



Source: Advisory Board interviews and analysis.

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Lessons for Enabling System Development

1

Establish an Empowered Governance Structure

Define Decision-Making Authority

2

Create System Citizens

Develop a Comprehensive Communication Strategy

Uncover Doctor Allies

Ensure Citizen Engagement

3

Establish the Fully-Informed Health System

Craft Common Performance Metrics

Use System Data to Drive Action

Source: Advisory Board interviews and analysis.

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Source: Advisory Board interviews and analysis.

Striking the Balance

Powers Must Be Allocated Wisely

Balancing Central and Local Authority

System-Level Governance

Potential Drawbacks:

- Lack of local perspective
- Difficult implementation
- Reduced staff engagement

What is the right balance of central and local control?

Facility-Level Governance

Potential Drawbacks:

- Unjustified variation
- Conflicting efforts
- Redundancy

A Balance of Power

"There's a tendency to build more bureaucracy and become very, very process-oriented, which then creates less opportunity to be agile and respond to the perhaps unique needs…of each different facility."

Florence Spyrow, Senior VP, Genesis Health System, US

Source: Barr P, "Making a System Work," Modern Healthcare, June 2, 2012, http://www.modernhealthcare.com/article/20120602/MAGAZINE/306029972; Advisory Board interviews and analysis.

Critical to Clarify Decision Authority, Not Hierarchy

Empower Right Partner to Make Best Decisions

Delegating Authority Based on Proximity to Patient / Citizen

Closer to system

Closer to patient/citizen

Non-Negotiables and Operational Strategy
What are our system objectives?

'Upwards' Discussion with Payers
What is the relationship between our care delivery and our reimbursement from the payer?

Service Planning
What is our product and asset portfolio?

Incentives
How do we incentivise cooperation across various partners?

Workforce Planning
Who comprises our clinical workforce?

Frontline Engagement
How can we engage staff in achieving system goals?

Care Delivery
How should this citizen be treated?

Source: Advisory Board interviews and analysis.

Distinction Most Important for Certain Core Powers

Strategic Decisions Set System's Direction

System at the Helm of Core Powers

System: Planning Power

Local: Operational Power

Set overall strategy and objectives for system	Business Strategy	Manage utilisation for locally delivered services
Establish service distribution across system	Service Portfolio	Deliver high-quality, low cost services
Identify opportunities for new construction, repurposing, closures	Facility Planning	Maintain facility, request upgrades
Create model for doctor partnerships throughout the system	Doctor Playbook	Manage credentialing, monitor local quality, make individual hiring decisions

Source: Advisory Board interviews and analysis.

From Silos to Systems

Lessons for Fostering Stakeholder Engagement

1

Establish an Empowered Governance Structure

Define Decision-Making Authority

2

Create System Citizens

Develop a Comprehensive Communication Strategy

Uncover Doctor Allies

Ensure Citizen Engagement

3

Establish the Fully-Informed Health System

Craft Common Performance Metrics

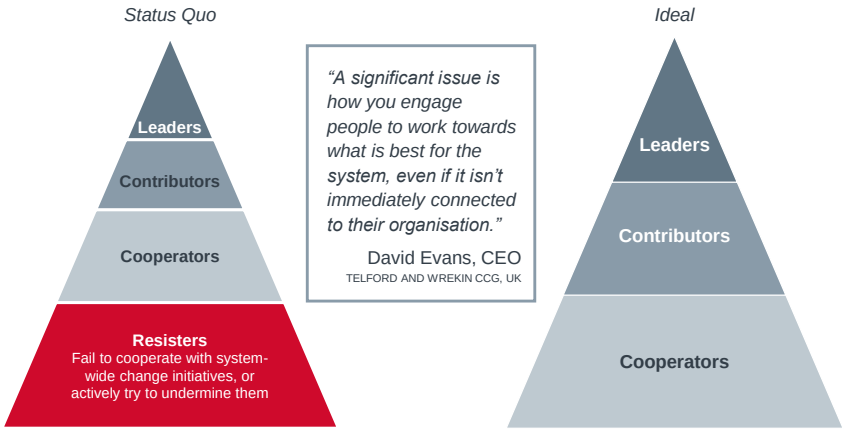
Use System Data to Drive Action

Source: Advisory Board interviews and analysis.

Too Few Individuals Act as System Citizens

Disproportionate Amount of System Resisters

Stakeholder Roles in System Change Initiatives



Source: Advisory Board interviews and analysis.

Individuals Prioritise Selves Over Systems

Self-Sacrifice Rarely Rewarded

Disparity Between Personal and System Priorities

Stakeholder Group	Personal Needs	System Needs
Policymakers	• Meet constituent needs • Align policy with party ideology	• Make policies that support incentives across providers and reward system change
Clinicians	• Maintain freedom to practice medicine autonomously • Ability to maintain or grow income	• Uphold evidence-based practices set forth by system • Serve as department change leaders
Frontline Staff	• Attend to influx of patients • Avoid burnout	• Manage on-the-ground change during system-wide initiatives
Patients	• Receive the best care possible • Clear ways to access system	• Appropriately access care and utilise system resources
Community	• Ensure health services are accessible when needed	• Advocate for system change to the public and media

Source: Advisory Board interviews and analysis.

Doctors Require Targeted Engagement Efforts

Strategies to Engage Doctors in System Change

Traditional	*Innovative*
'Systemise' Clinical Leaders *Give facility medical officers system-wide oversight and power*	**Grant Decision-Making Status** *Allow doctors to help choose solutions to system-level issues*
Offer Financial Incentives *Align payment structures to promote adherence to system change*	**Exchange System Benefits** *Provide doctors with clinical support in return for system buy-in*

Source: Advisory Board interviews and analysis.

Patients Are Inherently System Citizens

Patients Span Fragmented Health Care Continuum

Primary Care	**Secondary Care**	**Tertiary Care**	**Post-Acute Care**	**At-Home Care**
GPs[1]	Specialists	Surgeons	Geriatricians	Home Care Aides
RNs[2]	Internists	Specialists	PTs[3]	Social Workers
Patients/ Citizens	Patients/ Citizens	Patients/ Citizens	Patients/ Citizens	Patients/ Citizens

> "The patients and citizens only see one health system. They don't care about our divisions of labour. They just want their problem solved."
>
> *CEO, UK Foundation Trust*

1) General practitioners.
2) Registered nurses.
3) Physical therapists.

Source: Advisory Board interviews and analysis.

From Silos to Systems

Lessons for Utilising System Data

1

Establish an Empowered Governance Structure

Define Decision-Making Authority

2

Create System Citizens

Develop a Comprehensive Communication Strategy

Uncover Doctor Allies

Ensure Citizen Engagement

3

Establish the Fully-Informed Health System

Craft Common Performance Metrics

Use System Data to Drive Action

Source: Advisory Board interviews and analysis.

Isolated Information Hinders System Progress

Standardised Metrics and Actionable Data the Gold Standard

Shortcomings of a Typical System's Information Sharing

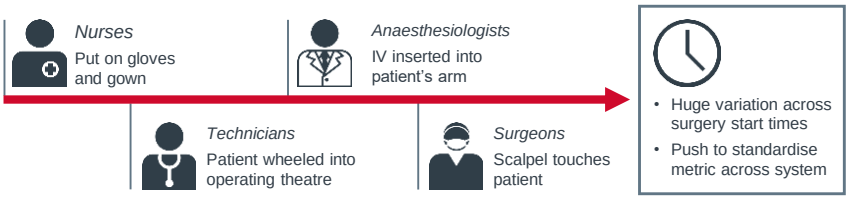
Problem		*Solution*
Siloed Data Rarely Stitched Together Despite identifying as a system, entities still track and measure data independently from the network as a whole	→	**Craft Common Performance Metrics** Standardise definitions, metrics, reporting methods, and data visibility across the entire system
System Data Alone Not a Panacea Just because data is accessible does not make it meaningful or actionable	→	**Drive Action from System Data** Utilise on-the-ground teams or technological solutions to make sense of raw data trends

Source: Advisory Board interviews and analysis.

Variation in Surgery Length Depicts Larger Issue

Make Sure Definitions are *Exactly the Same* Across System

Discrepancies in Operating Theatre Start Times



Case in Brief: Cabrini Health

- 832-bed private, non-profit health system in Victoria, Australia
- Attempted to standardise time in theatre for surgeries by auditing average length of certain procedures and approaching doctors with above average operating times
- Found that different clinicians began surgery clock at different times; sought to define exactly when procedures begin and end to minimise discrepancies in operating times

Source: Advisory Board interviews and analysis.

From Silos to Systems – What Now?!

Breakout Focus Areas:

Discussion One:

- How do we understand population health and integrated care?
- How do we understand it in an intersectorial perspective?
- Do we agree on definition/clarification of concept?

Discussion Two:

- How will we work with population health and integrated care in our common plan with vision, targets, focus areas and principles for collaboration?
- What specific trial operations can we test? What is the next step? What barriers are there? How can we overcome them?

Source: Advisory Board interviews and analysis.

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