A “Triple Aim” case in a German region

The Kinzigtal philosophy and approach to care
Short introduction to the German system of healthcare
The population-based Integrated Care System „Gesundes Kinzigtal“: conditions, financial model, evaluation, trends

Helmut Hildebrandt – Chairman of the Board OptiMedis AG & CEO
Gesundes Kinzigtal Ltd

25. Februar 2016
Our fragmented healthcare systems are engineered for “repair” but not for “maintenance” and not at all for “prevention” and “innovation”.
Maria Roth from Zell a.H. is an 84 years old woman suffering from heart failure.

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.

I am afraid we have to move to a nursing home because of my wife’s bad health status.
Can’t we do better?
Innovating the health system to be more efficient and to produce health.
Hanna Held from Nordrach is also a 84 years old woman suffering from heart failure. Since the diagnosis six years ago she has been participating in the health care program „Strong Heart“ and she has a case manager at her GP practice.

In the last 4 years Hanna only went once to hospital because of an ophthalmic 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.
We improve health care in three dimensions:

- **Improve the health of the population**
- **Increasing health gain**
- **Enhance the patient care experience**
- **Reduce the per capita cost of care**

Based on the Triple Aim principles of Donald M. Berwick

Michael Porters View on Germany

Issues Facing the German System

- High and **rising costs**
- Overcapacity and low reimbursement levels leading to **excessive utilization of services**
  - High service utilization and costs are not producing better health outcomes
- Large variation in **quality** across providers
  - No systematic **measurement** of outcomes and costs
- **Hyper-fragmentation of services** across inpatient and outpatient care and **inadequate volume** of patients in a medical condition to achieve excellence
- **Lack of solidarity** between the public and private system
- Many **incremental reforms** with limited impact
  - Focus on containing costs, rather than improving value
The way the german system works for a patient

Everybody will be covered by a health insurance

› Working people (until income 49,500 € p.y.) must take a statutory (not-for-profit) health insurance, fee around 8% of income (+7,3 % paid by employer) people above this income may choose to have a private (for-profit) insurance (fee related to risk, usually smaller if young, but higher when getting older)

› Kids and non-working-spouses are free

› Pensioners ... same like working (but 7,3% paid by pension)

Most services are covered .. Hospital + GP + spec. +rehab + nursing + pharma + sick leave ... small copays
The way the german healthcare system works for the statutory health insurance (SHI)

Competition between ~100 SHIs around the fees for the members (small variations) but mostly gov.-fixed service packages + competition via selective contracting and „new“ service packages add-on to the gov.-fixed

The fees from the insured are forwarded to a central agency BVA that gives it back to the SHIs morbidity risk-, sex- and age-adjusted

Within the „normal“ system prices for services are for all SHI the same = bundled negotiations, but in the selective contracting SHI and providers act like normal companies on a market
Population Health in the Times of Global Financial Crisis: The Question

How to get a sustainable interest in investments in health and in delivering the best results?

How to get local health care providers motivated for health/public health?

... and how do we get this installed in a multi payer and multi provider system?
# Integrated Care in Germany = platform for population health management

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992-95</td>
<td>Discussion of Managed Care in the US / first projects / development of physician networks</td>
</tr>
<tr>
<td><strong>2000</strong></td>
<td><strong>German Health Care Reform Act</strong> – introducing Integrated Care as selective contracting between sickness funds and (groups of) HC providers</td>
</tr>
<tr>
<td>2004</td>
<td>New law allowing for start-up-financing of experiments like Kinzigtal (in effect until 2008)</td>
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<tr>
<td>2010</td>
<td>backlash ... imposing cost reduction effects within one year</td>
</tr>
<tr>
<td>2015</td>
<td>New Act (VSG): Reducing barriers to IC + “Innovation Fund” for experiments 300 M € every year</td>
</tr>
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</table>
Many years of experience with Gesundes Kinzigtal and the scientific evaluation shows that our integrated care model works.
Gesundes Kinzigtal: successful in the 10th year and still investing for further population health improvement

› Start: 2006 for a population of 33,000 insureds of AOK and LKK
› 58 % of all the GPs and specialists of the region have chosen partnership
› Surplus health care services, coaching and free preventive offers

› **Investing in health:** Central electronical data platform, around 20 prevention and care improvement programs, integrating sport and exercises
› 2015: Building a medical training & education center (3.5 million € investment)
The pillars of optimization and quality – Integrated health care programs in Gesundes Kinzigtal

Gesundes Kinzigtal

Primary prevention
- Health trainings / group activities
- Club sports
- Course offers (e.g. aqua fitness)

Health programs
- Heart failure
- Metabolic syndromes
- Back pain
- Psychic crises
- Depression
- Geriatric care
- etc.

Special Themes
- Incentive program
- Quality indicators
- „World of health”
- Health management
- etc.

Committed network

OptiMedis AG
The voice of the participants in GK programs – Patients Advisory Committee

› Every second year the enrollees of Gesundes Kinzigtal select their representatives in a meeting of members

› This Patients Advisory Committee represents the voice of the enrollees of Gesundes Kinzigtal

› Actually the Patients Advisory Committee consists of five elected members and one ombudsman
Various public festivities and exhibitions to be visible and present in the community
... and working closely together with municipalities, local authorities, regional sport clubs and others

2007: Fest der Gesundheit, Haslach
2010: Fest der Gesundheit, Gengenbach
2011: Transparente Mensch, Haslach
2012: Fest der Gesundheit, Haslach, „Begehbare Darm“, Haslach
2013: Kinderfest, Haslach
2014: Schwimmbad-Jubiläum, Haslach
2014: Spendenaktion zugunsten der gesundheitsfördernden Arbeit der Vereine im Kinzigtal
New developments in Kinzigtal

Creating a Training Academy for the health care professions
www.gesundheitsakademie-kinzigtal.de

Building a „World of Health“ with a medical physical exercise centre
www.gesundheitswelt-kinzigtal.de

Developing a „Healthy Companies Network“
www.gesunde-betriebe.net

Plan: Employing young doctors to secure care
A new business model: Shared Health Savings Contracts / Shared Health Benefits Contracts

In “Shared Health Savings Contracts” we generate an economical benefit for purchasers for a defined population through wise investments, prevention and optimized care.

An even better expression would be “Shared Health Benefits Contracts”, because we share the surplus benefit for the either sickness funds or national health systems.
Health gain sharing: the risk adjusted contribution margins of the partnering health insurances

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

Tangible investment:
- Additional payments for management and substituting actions/ prevention

Intelligence investment:
- Physicians know-how to streamline processes
- Know-how of the management (and OptiMedis AG)
- Cost cutting agreements (rebates and/or success remuneration)

Integrator company

Savings to be shared

Total actual costs

Health insurance

Normally expected costs
(risk adjusted with Morbi-RSA algorithm)
Different methods of evaluation of results are used

All insurees with residence in the Kinzigtal region

Program participants vs. risk adjusted non-program participants

Enrolled insurants vs. risk adjusted non-enrolled insurants

Patients of cooperating physicians vs. patients of non-cooperating physicians (attribution via number of contacts > 50%)

Real development versus predictions
Gesundes Kinzigtal produces value in three Dimensions:

1. Improve the health of the population
   - Participants die 1.4 years later (78.9 vs 77.5 control)

2. Increase health gain

3. Enhance the patient care experience
   - 98.9% of enrollees who set an objective agreement with their physician would recommend becoming a member to their friends or relatives

5.5 Mio € surplus improvement for the two sickness funds in the Kinzigtal region in 2013 against 75 Mio € norm costs
It even produces **value in three further dimensions:**

**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 + vice versa).

**Community building and securing health care for the region:** Local municipalities are calling on Gesundes Kinzigtal to secure the supply of health care and the staff for physician and nursing practices.

**Healthy workforce:** Companies are calling on Gesundes Kinzigtal to get support for health promotion management and activities around health at the workplace.
Triple Aim Results: Medical outcomes

45% less fractures after program participation „Strong Muscles – Solid Bones“ (n= 438) for patients with osteoporosis

1,5 years longer survival for GK-enrollees, less potential years of life lost (trend V2 Statistisches Bundesamt)

Triple Aim Results: Patient Reported Outcomes

“I live healthier now“ – Answering in a positive way is correlated with the intensity of involvement, cooperation and shared-decision making

All respondents (2012):

... Respondents being “chronically ill”:

... R being “GK-program participants”:

... R who as well stated that “they had defined goals with GP”:

Triple Aim Results: Margin improvement for the two sickness funds in the Kinzigtal region 2013 – 5.5 Mio €

Development of Morbi-RSA allocations, actual healthcare costs, margin improvement and number of insured of AOK und LKK in the Kinzigtal region
Monitoring system for the physicians health services cockpit focused on the Triple Aim

<table>
<thead>
<tr>
<th>Outcome perspective:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcome: What impact has my doctor’s practice on health outcomes?</td>
</tr>
<tr>
<td>Economical Outcome: What impact has my doctor’s practice on financial outcomes?</td>
</tr>
<tr>
<td>Patient Experience: What impact has my doctor’s practice on the improvement of the individual experience of care?</td>
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</tbody>
</table>

Internal Processes

How can we provide optimal care processes?

Structure:

<table>
<thead>
<tr>
<th>Learning and Innovation</th>
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</thead>
<tbody>
<tr>
<td>In which field can we make improvements? Is there a solid base for success in the future?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who ist the target group and (how) do we reach it? What morbidity do the patients of my doctor’s practice have?</td>
</tr>
</tbody>
</table>
Monitoring system for the physicians health services cockpit focused on the Triple Aim

<table>
<thead>
<tr>
<th>Qualitätsindikatoren und relevante Kennzahlen</th>
<th>Ihre Praxis (Praxis 12)</th>
<th>Ø-LP-Hausärzte</th>
<th>Ø-NLP-Hausärzte</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deckungbeitrag pro Patient</td>
<td>179,47</td>
<td>24,38</td>
<td>-68,53</td>
</tr>
<tr>
<td>Morbi-RSA Zuweisungen pro Patient</td>
<td>927,02</td>
<td>835,22</td>
<td>777,65</td>
</tr>
<tr>
<td>Morbi-RSA Gesamtkosten pro Patient</td>
<td>747,54</td>
<td>810,84</td>
<td>846,17</td>
</tr>
<tr>
<td>Gesamtkosten pro Patient</td>
<td>774,08</td>
<td>823,58</td>
<td>871,45</td>
</tr>
<tr>
<td>Arzt-Kosten pro Patient</td>
<td>234,13</td>
<td>195,00</td>
<td>167,85</td>
</tr>
<tr>
<td>Krankengeld-Kosten pro Patient</td>
<td>25,15</td>
<td>44,07</td>
<td>34,11</td>
</tr>
<tr>
<td>Krankenhaus-Kosten pro Patient</td>
<td>177,33</td>
<td>255,45</td>
<td>310,90</td>
</tr>
<tr>
<td>Reha/Kur-Kosten pro Patient</td>
<td>0</td>
<td>13,96</td>
<td>17,43</td>
</tr>
<tr>
<td>Arzneimittel-Kosten (brutto) pro Patient</td>
<td>228,77</td>
<td>191,85</td>
<td>195,05</td>
</tr>
<tr>
<td>Kosten sonstiger Leistungen pro Patient</td>
<td>108,70</td>
<td>123,25</td>
<td>146,10</td>
</tr>
<tr>
<td>Anteil Osteoporose-Patienten mit Fraktur</td>
<td>11,5%</td>
<td>12,3%</td>
<td>14,6%</td>
</tr>
</tbody>
</table>

2. Prozess – Worin müssen wir hervorragend sein?

<table>
<thead>
<tr>
<th>Verbesserung der Diagnosequalität</th>
<th>Anteil n.n.bez. Diagnosen</th>
<th>24,5%</th>
<th>23,3%</th>
<th>26,3%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anteil Verdachtsdiagnosen</td>
<td>0,7%</td>
<td>1,5%</td>
<td>1,9%</td>
</tr>
<tr>
<td>2.2 Kennzahlen zum Inanspruchnahmeverhalten</td>
<td>Patienten &gt;= 35 J. KV-Check-Up Quote</td>
<td>10,0%</td>
<td>8,6%</td>
<td>8,2%</td>
</tr>
<tr>
<td></td>
<td>Erwerbsfähige Patienten mit AU %</td>
<td>35,2%</td>
<td>41,0%</td>
<td>42,7%</td>
</tr>
<tr>
<td></td>
<td>Ø-Dauer AU pro Erwerbsfähiger (in Tagen)</td>
<td>4,30</td>
<td>5,69</td>
<td>5,94</td>
</tr>
<tr>
<td></td>
<td>Anteil Patienten mit KH-Aufenthalt</td>
<td>4,2%</td>
<td>6,3%</td>
<td>7,2%</td>
</tr>
<tr>
<td></td>
<td>KH-Fälle pro 1.000 Patienten</td>
<td>42,40</td>
<td>74,52</td>
<td>86,65</td>
</tr>
</tbody>
</table>

2.3 Verbesserung Arzneimittel-Management

<table>
<thead>
<tr>
<th>Generikaquote</th>
<th>Patienten &gt;= 65 J. mit pot. inad. Med. (%)</th>
<th>91,4%</th>
<th>85,6%</th>
<th>83,6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anteil HI-Patienten mit leit. Arzneimittel</td>
<td>30,0%</td>
<td>35,5%</td>
<td>68,6%</td>
<td></td>
</tr>
</tbody>
</table>
Important but expensive: **Central medical record + ICT-integration**

Now: Every physician sees in his own Computer-system what the other physicians did with the patient ... the medications, the goals + lab results.

Huge investment of time and of money  (around 1.4 Mio € .... including the analytical Data-WareHouse even around 4 Mio €)

First requirement: Trust between providers and joint experiences in working groups etc.

Keep it simple and smart ... No second system but deep integration into the work flow
OptiMedis: Our function as regional integrator

• We develop and manage regional multi-professional healthcare-networks in which physicians, hospitals, physiotherapists, pharmacies, sport clubs, schools and enterprises are engaged together.

• We improve the level of health and create significant health benefits for whole regions applying scientifically proven interventions and activating patients towards prevention.

• We analyze health care data and perform independent, data-based real-life health care research and make the results available for the integrated provision of health care services.
Is Kinzigtal so special that we cannot do the same in other regions?
No
Different contexts, different problems, but similar solutions

• From rural to urban
  Solutions such as patient engagement, strengthening the role of GPs, implementing shared information systems are equally (or even more) relevant in an urban context with a disadvantaged population.

• Additional focus on inequalities and the social determinants of health
  Based on 40 years of research on the social determinants of health, the origins of inequality and strategies to reduce them are well established (WHO Closing the gap in a generation, 2008).

• Role of the regional integrator
  Additional stakeholders (e.g. more social service involvement and representation of target groups such as migrants), but the same approach to intervention planning, performance feedback, and shared savings.
Possible as well in insurance based systems as in countries with national health systems

In “Shared Health Savings Contracts” we generate an economical benefit for purchasers for a defined population through wise investments, prevention and optimized care.

An even better expression would be “Shared Health Benefits Contracts”, because we share the surplus benefit for the either sickness funds or national health systems.
By Reinhard Busse and Juliane Stahl

Integrated Care Experiences And Outcomes In Germany, The Netherlands, And England

ABSTRACT Care for people with chronic conditions is an issue of increasing importance in industrialized countries. This article reviews three recent efforts at care coordination that have been evaluated in systematic reviews. The first is Germany’s Gesundes Kinzigtal, a population-based approach that organizes care across health service sectors and indications in a targeted region. The second is a program in the Netherlands that bundles payments for patients with certain chronic conditions. The third is England’s integrated care experience, which take a variety of approaches to care integration for a range of target populations. Results have been mixed. Some intermediate clinical outcomes, process indicators, and indicators of provider satisfaction improved; patient experience improved in some cases and was unchanged or worse in others. Across the English pilots, emergency hospital admissions and readmissions were lower in the intervention groups. Therefore, our second conclusion is that the German integrated care program, which targeted roughly 50 percent of the population in a well-defined area regardless of people’s age or health status, deserves to be more closely studied by researchers and policy makers in the United States as they search for solutions to help accountable care organizations overcome the weaknesses of fragmentation, find appropriate financial incentives, and meet the needs of people with chronic conditions.
Our Partners in Germany and Europe

In Switzerland several regions and health insurances are interested in cooperation with OptiMedis.
OptiMedis Nederland: working on adapting best practices to NL

VWS/NZa feedback
Apollo network
NPHF project group

Bottlenecks & solutions

Facilitation

Expansion & improvement

Acceptance

Input & support

(Model) Contracts and cases

Vital Vechtdal

other Triple Aim regions

Nijkerk & Nieuwegein

VEROZ

DE FRIESLAND ZORGVERZEKERaar

OptiMedis AG
### Success factors of our regional integrated care model

<table>
<thead>
<tr>
<th>Regional care company as “integrator” + partly ownership through local providers</th>
<th>Investment for the first three years (until earnings are big enough for ROI)</th>
<th>Going / thinking beyond healthcare + entrepreneurial health sciences spirit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional quality between providers, professions, management and patients</td>
<td>Comprehensive implementation of technology: ICT &amp; data-driven management approach</td>
<td>“Coopetition” = cooperation and competition through transparency and benchmarking</td>
</tr>
<tr>
<td>Balanced payment system oriented towards achieving the Triple Aim</td>
<td>Innovative culture and friendly interactions “open source” mindset</td>
<td>10 years contract with sickness fund to refinance investment</td>
</tr>
</tbody>
</table>
Our „take-home-message“

A clever long lasting contract, oriented towards „Integrated Chronic Care“ and „Triple Aim“ with the possibility to (re)invest and to analize the claims data, guarantees success.

„But: there is no free lunch“: Regional integrated care for a whole population and the re-integration of Public Health, health promotion and traditional health care management needs a lot of invest and courage...

... but out of the health sciences there is so much input to be taken and the work delivers such an amount of pride, excitement and generates real value for the whole society ... so it is really worthwhile.
More information

Our regional integrated care model as infographic: www.optimedis.com
Let’s get in contact

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We keep you up to date with our OptiMedium: www.optimedis.com/newsletter
Better health of populations, better experience of care, lower costs + earning a share of the benefit produced

Integration of

› health care and social care
› clinical wisdom and scientific competence
› targeted prevention + mobile innovation
› electronic data exchange
› analysis of Big Data for improvement
› community organizing & health promotion