Conrane IHS
International Health Solutions

3. Organisational Development

the keys to success in practice

- Effective Governance
- Stakeholder Engagement
- Strategy and Planning
- Service Design
- Whole System Transformation
- Informatics

Conrane IHS
International Health Solutions

Integrated care is seen as a key structural reform to drive transformational change in the NHS. In this occasional paper we provide a working definition in terms of the key components of an Integrated Care System.

This draws on the prescriptions of current guidance and frameworks plus the findings from concurrent evaluation of international best practice (including the Pioneer Accountable Care Organisations in the US). This highlights how the most successful innovators can transform quality of care whilst also reducing hospital utilisation and thereby containing costs.

Finally, in the main body of the document we list the key components of success and propose practical solutions to implementing each of these components.

1.1 Introduction The keys to success in practice

1. **A local needs analysis** which also shows the use of and expenditure on services at practice, locality and whole organisational levels and **opportunity analysis** highlighting where quality of care can be improved and use of resources made more effective, particularly through demand management
2. **Patient engagement** in the planning and delivery of care coordination based on co-production and individualised care plans
3. **A strategic plan and operational programme** showing the services to be prioritised and developed for a 5 year and initial 2-year time frame
4. **Services contracted direct by the ICS** under guidance on sub-contracting from the CCG
5. **An extended out of hospital network including advanced primary care also called the Primary Care Home**
6. **New models of care and service redesign**
7. **Sufficient and competent workforce capacity** which spans all the functions of care delivery and ICS governance
8. **An evidence-based performance framework** which functions both at the clinical interface to inform reflective practice and is aggregated to the overall ICS clinical governance process and upward performance report (such as to the CCG etc)
9. **Aligned Incentives payment systems** based on value and compensating alternative care when hospital utilisation is mitigated
10. **Meaningful informatics capacity** which inform all of the above processes the management of which is integral to the ICS and the clinical teams: The ICS requires its own internal informatics function and staffed trained to collate and interpret relevant data

1.2 Integrated Care Some learning from good practice

- Integrated Care (IC) is designed to provide financial incentives for providers to reduce inefficiencies in care delivery for a population under care;
- IC is aimed at reducing fragmentation and duplication in care by facilitating improved communication and coordination across providers and between patients and their doctors, thereby improving quality and controlling spending;
- IC at its best can sustain the workforce in primary and community care and develop into whole system transformation (sometimes also called advanced primary care);
- Structures can range 50,000 to over 100, 000 population;
- Most of them provide some form of comprehensive primary (and community care) plus sub-contract some hospital services on behalf of the major overall purchaser or health plan;
- A group of 'Pioneer ICSs' have been subject to systematic, formal evaluation of the US equivalent of the Department of Health. The findings from the first 3 years of this evaluation can offer important learning for the NHS

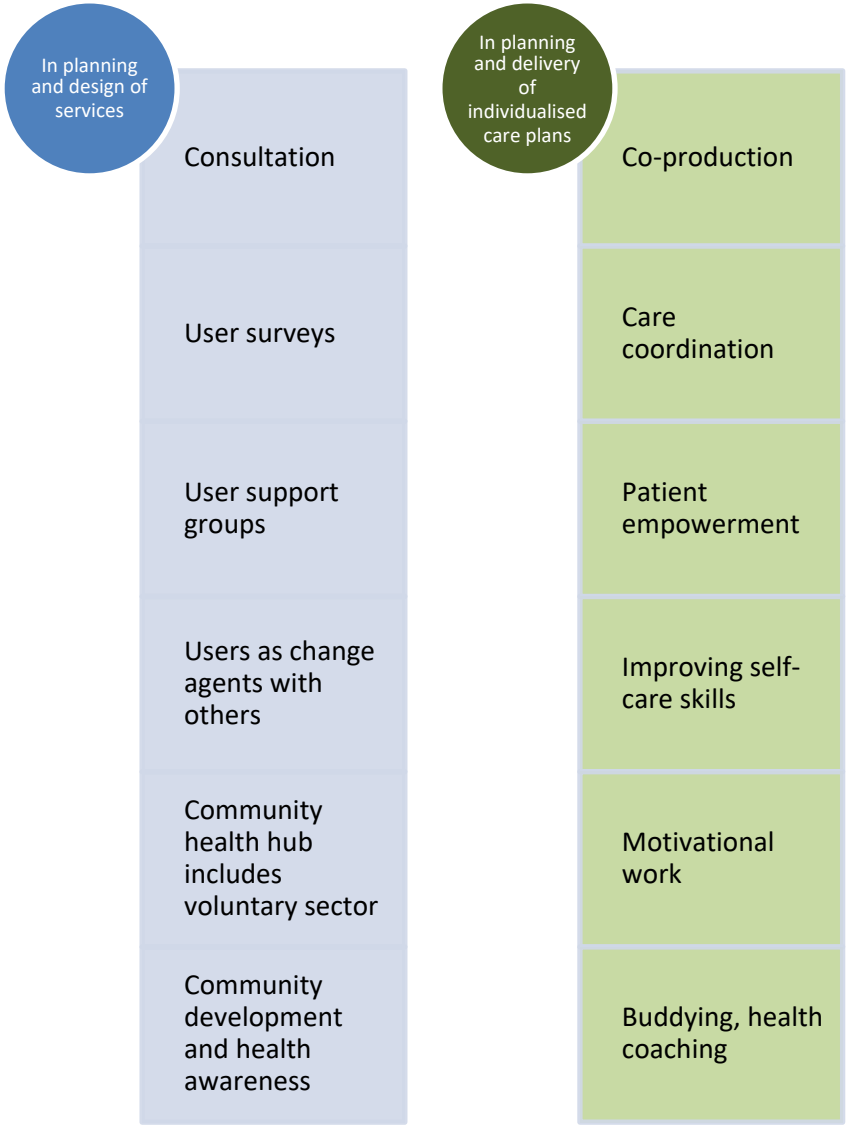
2. Founded on clinically-led governance

The most important success factor in the evaluation of international work to date is an effective governance structure. This comprises senior clinical staff from across the provider spectrum – with both primary and acute care clinicians on the same governance board. This body receives regular meaningful performance feedback and acts on this local evidence including the perspectives and experience of patients and carers. This requires a flow of meaningful data, organised to inform timely and effective decision-making (See slide 9.1).

3. Active Service User Engagement

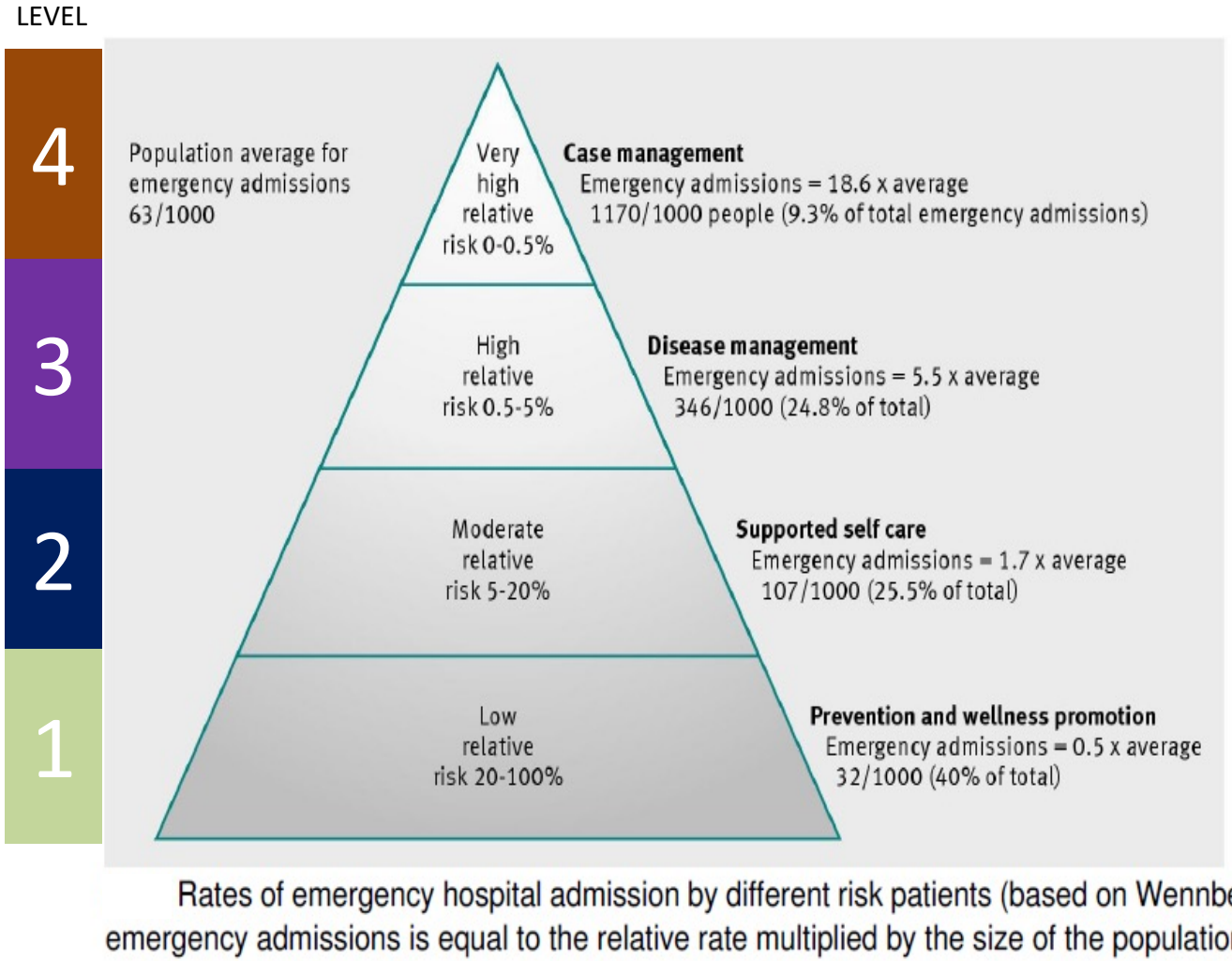
A major finding from the evaluation of ICSs internationally is the importance of active patient engagement. This is as important as the overall governance process described above. Patient engagement has two dimensions.

- To work with patients and their community to help plan, design and services and input to the governance process.
- To develop a genuine co-production model of care for people with long-term conditions, complex needs as well as those with mental health needs.



4. Local needs and opportunity analysis

A recent analysis in a large STP footprint showed over 20% of the population could benefit from more proactive care, resulting in significant opportunity to prevent hospital utilisation. 30% of this is *elective* hospital care.



Rates of emergency hospital admission by different risk patients (based on Wennberg et al 1996).[9] Percentage of all emergency admissions is equal to the relative rate multiplied by the size of the population group

Some models of care coordination are based on an assumption that interventions should focus on people at greatest risk of hospital admission – the top 0..5% to 2%. However, the epidemiologist Geoffrey Rose pointed out that most total admissions come from lower risk patients, Indeed in order to reduce emergency admissions by 10% by concentrating just on the 0.5% at highest risk of admission, more than the total number of admissions in this group would need to be avoided (107.5%). If the next group down were the focus of an intervention (the 4.5% of the population at high risk), 40% of their admissions would need to be avoided to produce an overall 10% reduction with the high risk group, An alternative approach is to target the intervention on a much larger group. This requires a local needs and opportunity analysis.

* Source: **Martin Roland et al: Reducing emergency admissions: are we on the right track?** ***BMJ*** 2012;345:e6017doi: 10.1136/bmj.e6017 (Published 18 September 2012)

5.1 Strategic and operational planning

The NHE E guidance calls for local strategic Plans (usually taken to mean up to five years ahead). The ICS will also have to consider its major programme of work during the first two years of operation. The plans will need to reflect

- a local needs assessment, the NHS Frameworks (see next slide);
- draw on best practice from the UK and :internationally;
- the views of the local clinical staff and the community;
- a workforce development plan as key enabler;
- willingness and readiness of local service providers to lead on innovation.

5.2 Developing the strategic and operational plans

Common themes in NHS-E AC0 Framework, NHS-E ICSs in Commissioning, STP/ICS performance priorities and success factors from US experience	ICS Frame-work	STP/ICS Priorities	ICSs and CCGs	Success factors
Understands health needs of its population and individuals with complex/special needs applying relevant informatics such as e actuarial analysis and predictive modelling systems which enables whole populations needs analysis and informs interventions	✓	**N/A**	✓	✓
Uses this data to inform detailed, tailored strategic and operational service plans and redesigns. These should focus on prevention, integrated care, personalised and individualised programmes and demand management: services designed to engage patients, improved skills and knowledge of self-care and address isolation. CO develops the supply chain required and evidence-based pathways	✓	N/A	✓	✓
Demand management should mitigate reduce pressure on and/or reduce avoidable/preventable: outpatient attendances, elective care, A and E visits, unplanned admissions, length of stay and delayed discharges as well as improve medicines management.	✓	✓	✓	✓
The ICS needs an effective governance structure drawn from all service sectors which takes decisions based on local evidence and meaningful performance data	N/A	✓	✓	✓
The ICS sub-contracts services on behalf of the main commissioners, according to local need and manages performance and cost. It may contract to incentivise its providers	N/A	N/A	✓	✓
The ICS improves quality within the scope of its direct service remit so it is more patient-centred, each patient with more complex needs has an individualised multi-disciplinary care plan and helps mitigate pressure on the local hospitals as a contribution to inpatient patient safety	✓	✓	✓	✓
The ICS will have flexibility to deploy and manage its budget whilst contributing to the CCGs overall cost-improvement programme	*N/A*	*N/A*	✓	✓
Programme priorities include mental health (incl. access to IAPT), care navigation for patients with long-term conditions and complex needs, and sustaining primary care to improve extended access	✓	✓	✓	✓

6.1 Services which can be provided by at Place level under sub-contact from the commissioner

The has listed a number of services and functions which could be provided at Place level.

- These services are integral to what is sometimes called *comprehensive* or *advanced primary care* or *the Primary Care Home. (See slide 3.2)*
- To achieve critical mass, extended services may be based at in a central 'integrated care hub'. (see slide 3.3)

6.2 Key Service Components of an ICS in Place

Primary care has proved to be one of the most successful, sustainable keystone of all high quality health and social care system. Integrated care designed for local population can build on this success across 4 dimensions. These are:

- (1) **Extended provision** which includes some devolved activity from the secondary sector including:
  - Outpatient activity, minor injuries and some minor procedures
  - Extending the GP function into a hospitalist role to optimize coordinated care for patients requiring a sub-acute admission and discharge of step-down and rehabilitation patients. These principles can also be extended to a comprehensive hospital at home service.

- (2) **Urgent Care** Holistic, pro-active care coordination should prevent some current urgent care demand. However when it does present the immediate response at primary care level should include:

  - Extension of the successful pilot which deploys paramedics drawn from the YAS teams, to go out to patients where an emergency visit is necessary. Not only does this relieve pressure on GPs, paramedics are skilled in pre-admission triage, and making initial falls assessments and referring patients to specialist falls services when required and not least accessing hospital care where genuinely needed.;

  - Out of hours primary care services;

  - Rapid response service for patients not needing acute hospital referral but some short-term medical and social support in the home – available 24/7

- (3) **Pro-active care** There are two major service components:

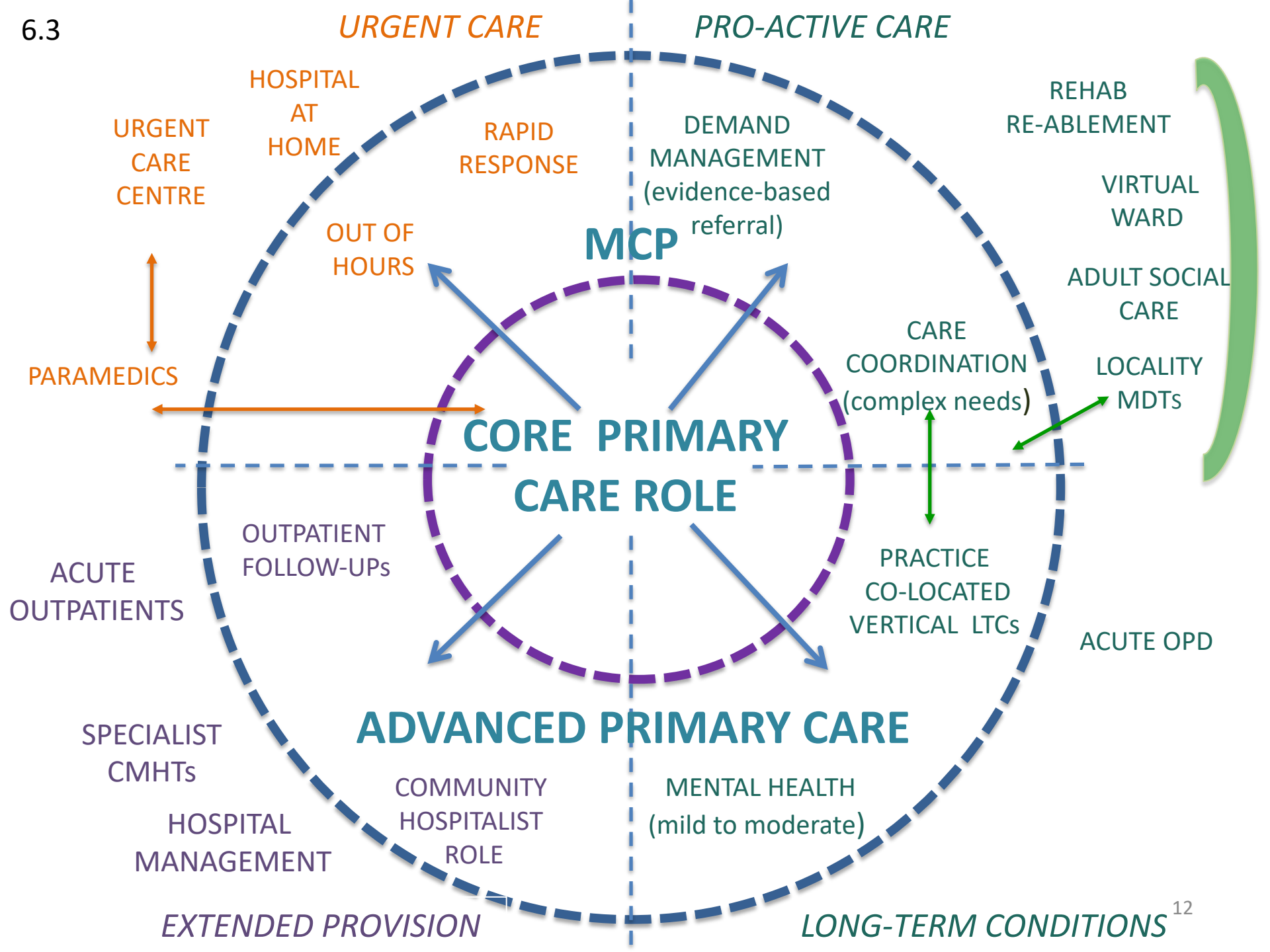
  - Demand or utilisation review which includes standardisation of evidence-based practice in referral to hospital, access to local GPs with special interest, and providing a first point of contact for urgent care services and to access local sub-acute hospital services (see appendix);

  - Care coordination of complex needs patients within a 'co-production model', including managing referrals to community matrons and the local multidisciplinary team according to patient need in turn informed by risk stratification (see appendix);

- (4) **Long-term condition management** A "co-production" model using evidence-based care pathways for the management of single conditions such as diabetes, COPD, CHF and asthma needs to be delivered at primary care level with access both in the practice and the patient's homes. This extends to services for patients with mild-to moderate mental health problems. Empowering primary care in mild to moderate mental health is facilitated by the co location of specialist community services, a model already in place in HRW.

Advanced primary care is a natural extension of the core general practice role as shown in the next diagram.

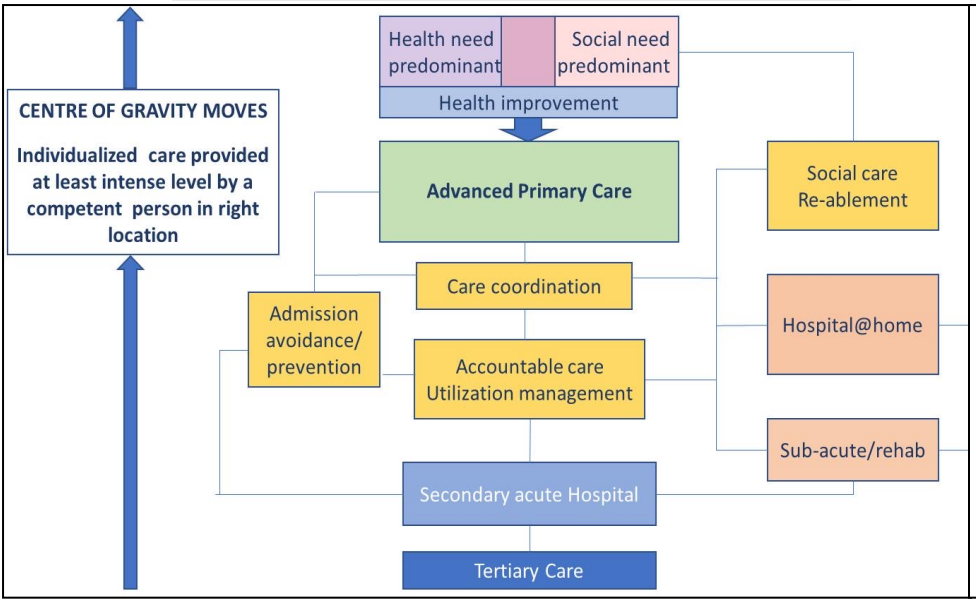
6.3


URGENT CARE
PRO-ACTIVE CARE
HOSPITAL AT HOME
URGENT CARE CENTRE
RAPID RESPONSE
DEMAND MANAGEMENT (evidence-based referral)
REHAB RE-ABLEMENT
VIRTUAL WARD
ADULT SOCIAL CARE
LOCALITY MDTs
OUT OF HOURS
MCP
PARAMEDICS
CARE COORDINATION (complex needs)
CORE PRIMARY CARE ROLE
OUTPATIENT FOLLOW-UPs
ACUTE OUTPATIENTS
PRACTICE CO-LOCATED VERTICAL LTCs
ACUTE OPD
ADVANCED PRIMARY CARE
SPECIALIST CMHTs
COMMUNITY HOSPITALIST ROLE
MENTAL HEALTH (mild to moderate)
HOSPITAL MANAGEMENT
EXTENDED PROVISION
LONG-TERM CONDITIONS

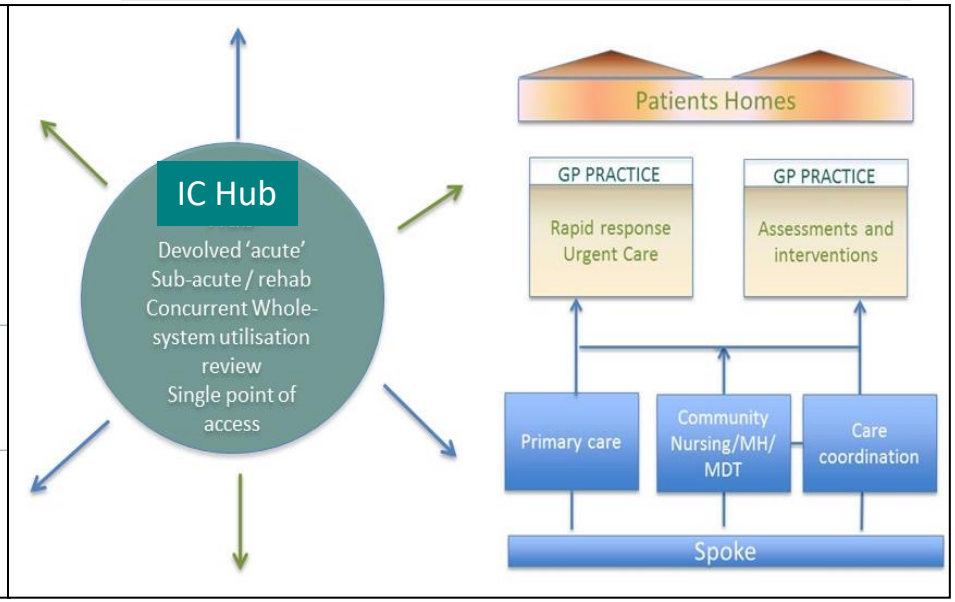
6.4 Integrated care at Place level: a hub and spoke model

Integrated Care Organisations (ICSs) comprise providers reconfigured as 'Integrated delivery systems' with a strong base in extended primary care and with clear accountability for quality and costs across the continuum of patient care. Incentives are aligned and performance is monitored on the ;triple-aims' framework. Through care coordination, ICSs can reduce utilization of acute care services by improving health outcomes in clinical networks offering pro-active and out of hospital care. Working with Vanguards in the NHS we have developed a working model for organising and supporting Integrated care at locality level. This has quantified the needs which are currently often met by acute care but which can be viably addressed in an IC network. This applies to both rural areas, and cities with distinct neighbourhoods and communities. At the same time there are issues of critical mass, staffing viability as well as facilities and informatics requirements.

An Integrated care system



Hub and spoke model 30-100k population



- Sustainable extended 'primary care home'
- Extended out of hospital network
- Concurrent utilisation review
- Payment by value and aligned incentives
- Performance monitoring using triple-aims

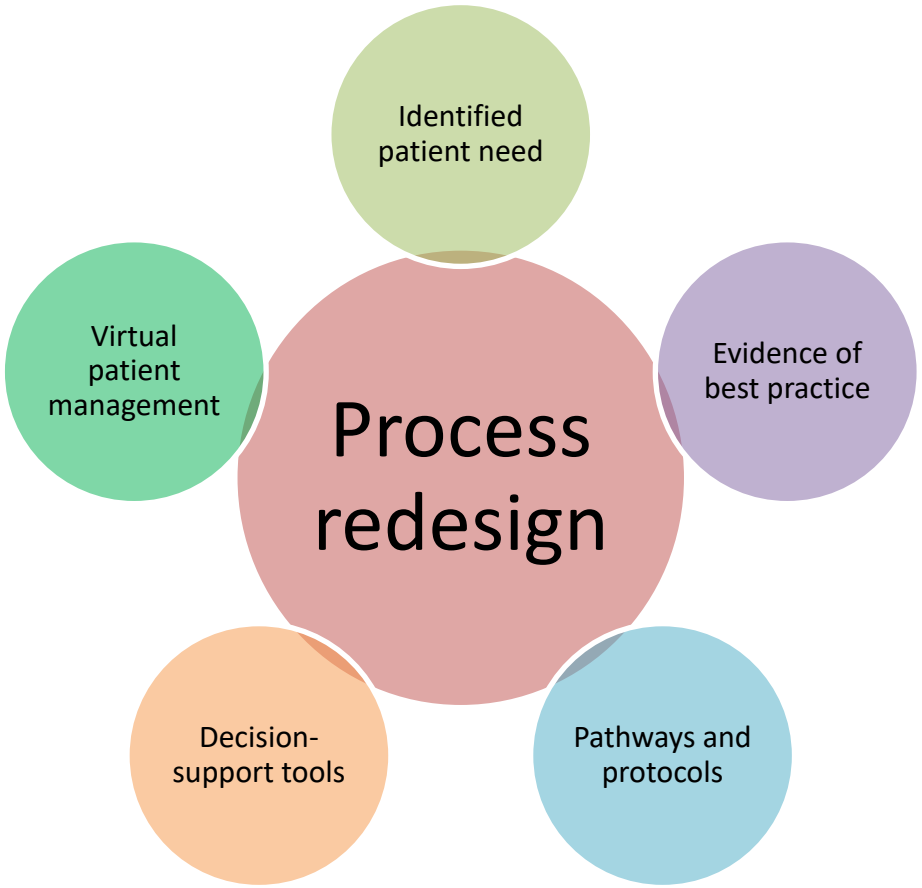
- Individualized care
- Evidence-based protocols
- Locality integrated
- Manages demand
- Practices in clinical networks
- Practices retain local identity and access

SEE ALSO http://conrane.com/wp-content/uploads/Conrane-IHS-STP-guidance.pdf

7.1 Transformation requires new and redesigned care processes

Redesigns at the point of patient care are the essential building blocks of whole system transformation . ICSs will have the opportunity to innovate new care processes and pathways . New processes will include the extension of virtual patient management both at primary care level and at the interface between primary and secondary care. Extending pro-active care to support hospital demand management requires learning from best practice and evidence to create new pathways.

An example of this type of pathway for care coordination of complex needs patients using a co-production model is set out in the next slide.



7.2. Pathway for care coordination of complex needs (level 3) patients – a co production model of care

Multi-domain assessment in the home setting

Agree programme objectives with patient, carers, home staff

Draft multi-domain care plan and agree with GP

Involve MDT if required

Coordinate further staff input as required

(e.g. SW, MH, Re-ablement)

Initiate self-planning and motivational work

Develop joint contingency plan with patient

Agree phased implementation and milestones with patient and carers (home staff)

Connect patient to community resources as required

Transition patient to telephonic management, deploy assistive technology and monitor

Discharge once agreed with patient that care plan fully implemented and stable for 4 weeks

3 monthly outcomes monitoring via patient contact and reports on KPIs

Stage of care led by

Clinical care coordinator (registered)

Medical assistant – see next 2 pages

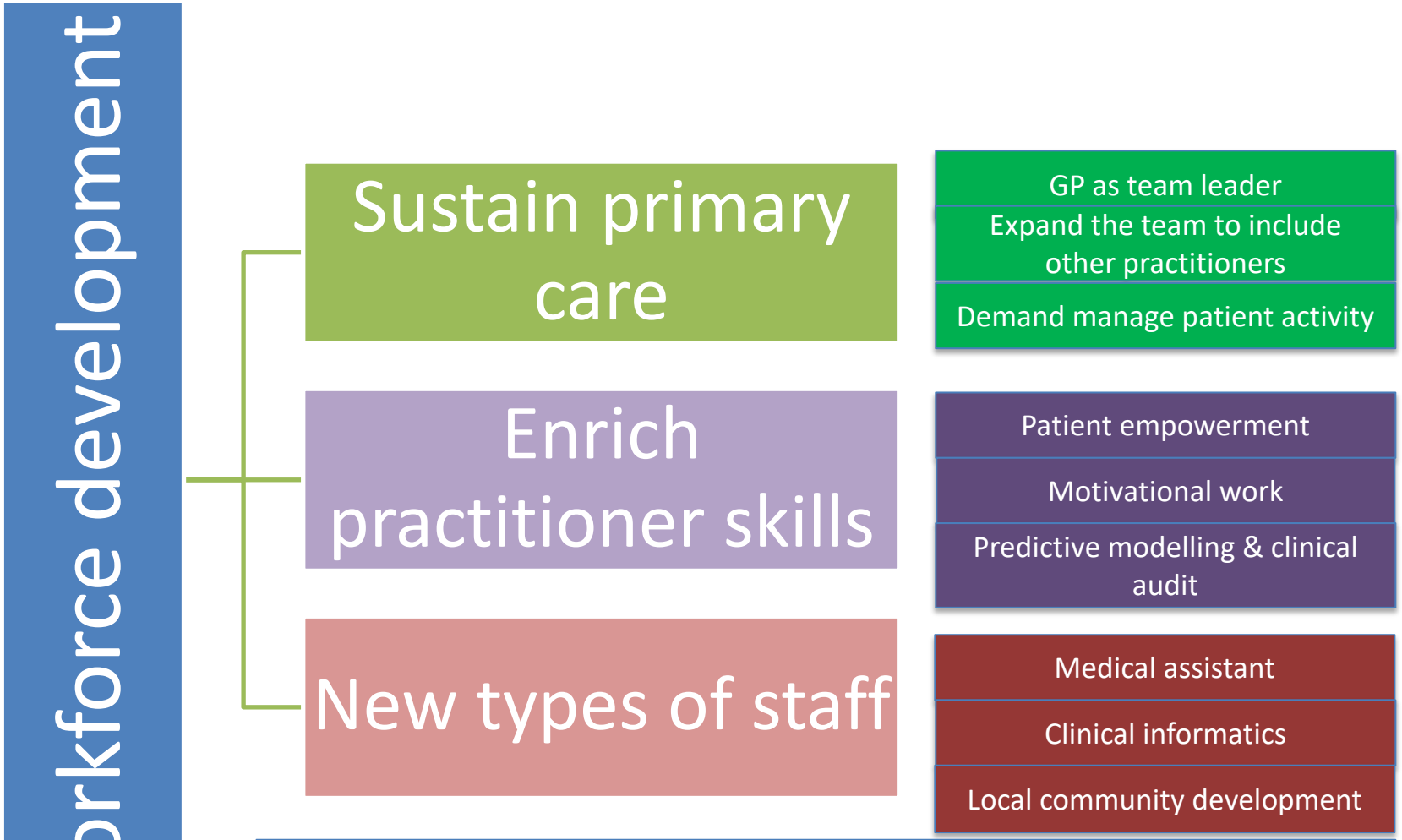
TRANSITIONING TO SELF-MANAGEMENT

In the red phase, (weeks 1 – 4) patients are identified and assessed with the GP fully involved. They are engaged in a partnership approach via face-to-face assessment.

In the amber phase, (weeks 5-8) the patient and practitioner sets the objectives and the joint holistic care plan and patient education programme is developed. Multi-disciplinary team input is involved as required. The plan is then set into train.

In the green phase (weeks 9-13) the patient has become largely self-managing, supported where necessary by mainstream primary and social care and/or community resources Measureable clinical and utilisation parameters are under control and the patient can b discharged into with periodic monitoring.

8.1 Workforce development in primary care -a key enabler



Workforce capacity is a key enabler within ICSs. Bringing pro-active care closer to home will not simply require more capacity, but new types of staff with new skill sets. There are significant opportunities to better manage demand at primary care level to enrich to role of the GP as a clinical team leader and clinician. Two examples of innovative roles are set out in the next slide.

8.2 Core workforce roles – indicative job contents

The New Registered practitioner

- Risk adjustment and stratification modelling
- Assessment and care planning
- Patient self-management coaching; education and counselling;
- Medication management (minimum);
- Motivational interviewing and managing people telephonically,
- Health coaching and monitoring
- Working in multi-disciplinary environment;
- Care transition planning; contingency/disease trajectory planning
- Management of patient pathways
- Coordination of additional health, social and 3rd sector l services.
- Clinical supervision of medical assistants
- Coordinates with staff and Nursing Homes on patient management
- Participate in clinical audit and outcomes reporting
- Disease management modules
- Non-medical prescribing
- Clinical audit

Practitioners should abide by the NMC Code of Conduct, and it clearly states that they "put the interests of people using or needing nursing services first' and the Coalition for Collaborative Care NHS England 2015"

Independently assessed as competent in above
Grade as Agenda for Change grade 7

Medical assistant job content

Position Summary

The medical assistant is responsible for a variety of case management duties working ***under the direction of the registered staff***. The medical assistant is responsible for utilizing Nursing Process to ensure that quality care is provided to adult patients with chronic conditions and complex needs.

Qualifications upon entry

Current NVQ 2/3 certification
Previous experience as primary care HCA preferred

Essential Functions of the Job

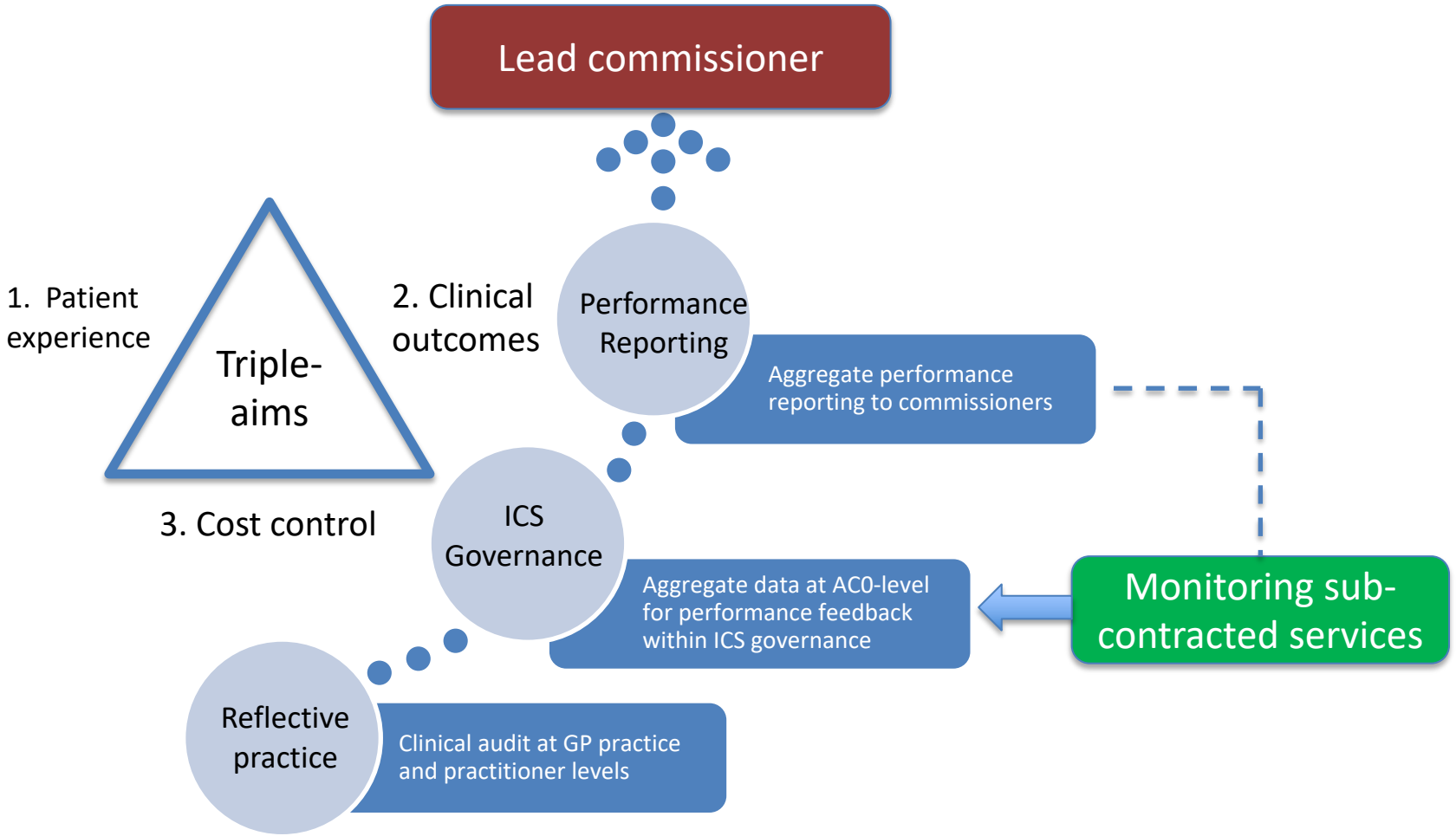
- Manage Referrals
- Provide health teaching, advocacy, counselling
- Engage with and managing patients on the telephone or in the home
- Monitor and coordinate chronic disease management and supports patient monitoring procedures
- Maintains a register of 3rd sector services
- Document virtual visits
- Records and collates outcomes KPIs

Knowledge and skills

- Understands clinical parameters of specific conditions
- Engagement and motivational skills;
- Risk adjustment and stratification modelling
- Understands and can present clinical audit data
- Understanding the various referring agencies;
- Risk management including understanding boundaries
- Working in multi-disciplinary environment

Independently assessed as competent in above: Agenda for Change grade

9.1 Reflective practice and performance feed-back

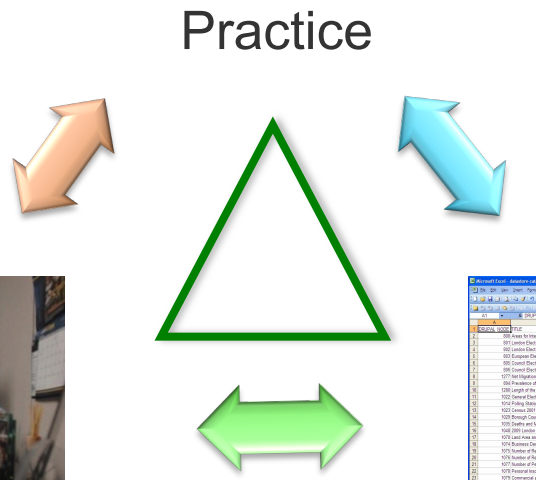


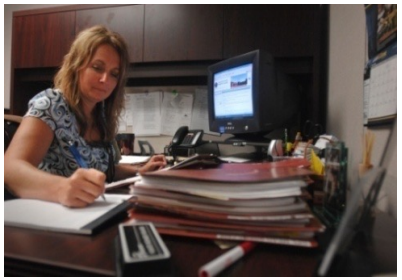
Concurrent performance monitoring which builds from reflective practice is common to all healthcare organisations internationally achieving the aims envisaged for ICSs. This indicates that such processes are not merely desirable or preferable, but *rather essential to deliver triple-aims outcomes, particularly cost control*.

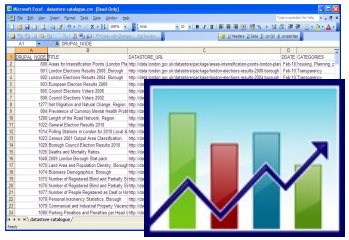
9.2 Concurrent Outcomes and Reflective Practice

1) **The practitioners** are more likely to generate good outcomes if they see this data regularly and concurrently. Also the resultant positive feed-back is highly motivational.

2) **Commissioners/payors** have evidence to inform business cases. *This avoids decision-making after the event or 'in the dark'.*







3) **Internal and external performance reporting** will have access to a baseline and enough real case data to demonstrate impact.

TO DELIVER ON OUTCOMES, *THE CULTURE AND RESOURCES TO MEASURE THEM* REQUIRED IN PRIMARY AND COMMUNITY CARE WITH THE TEAMS (AS IN SPECIALIST ACUTE CARE)

9.3. Evidence-based performance framework requires data

- Meaningful indicators
  - *Triples aims* of (1) quality, (2) patient experience and (3) preventable/avoidable utilisation and cost control
- External reporting requirements agreed with commissioners and contracted services
- Regular review at ICS governance level
- Data which is available and/or economic to collect

10. Aligned incentives and payment for value

- Case-mix adjusted to reflect equity at practice and locality levels
- Based on population needs not volume of activity
- Money needs to move with service delivery to incentivise new practice and out of hospital care
- Patient-specific budgets. A case-mix adjusted costing and revenue approach needs to be patient specific to enable sensitive patient-specific budgets for those with complex and medium-term care needs.

In order to deliver equity of resource allocation, cost control and align incentives, ICSs need new payment systems. These reward success but are also aligned to local population need which can vary significantly at GP practice and locality levels. To support this, and other key functions, the ICS requires informatics which link need, to cost to service utilisation from the individual patient to GP practice, locality and ICS-wide levels. This is described in the next section.

11.1 Informatics functions in the planning and delivery of Integrated Care - the critical success factors

- To allocate resources with in the ICS based on locally-measured clinical need patterns including varying case-mix at practice-level
- Providing meaningful performance data for practitioners
- Highlights local opportunity for whole population management including highlighting (at ICS/locality and practice levels) the cohorts of patients, by needs profiles which make up 50% of admissions to hospital
- Supports resource planning within the ICS to reflect local opportunities and variations in need
- Supports evidence-based care coordination of multi-morbid patients
- Supports reflective practice and triple-aims outcome reporting

For example Johns Hopkins Health Care in Baltimore provides a Pioneer ICS which provides for Baltimore and wider Maryland residents plus the employees of Johns Hopkins Healthcare Facilities. It is an example of how informatics can support successful Integrated care and deploys the ACG system.

11.2 The benefits to be gained from applying informatics in Integrated care

Specific to Primary Care within an Integrated Care System

- **Equitable resource allocation to practices** within an ICS
- **Comparative management of practice budgets**
- **Resource management at practice level**

Across the ICS

- **Whole population management** – opportunity analysis in terms of current utilisation patterns and costs
- **Detailed needs analysis from individual person to aggregate at practice or locality levels**
- **Supporting specific evidence-based interventions** – to identify patients for care coordination etc.
- **Outcomes reporting and clinical audit**

Conrane IHS
International Health Solutions

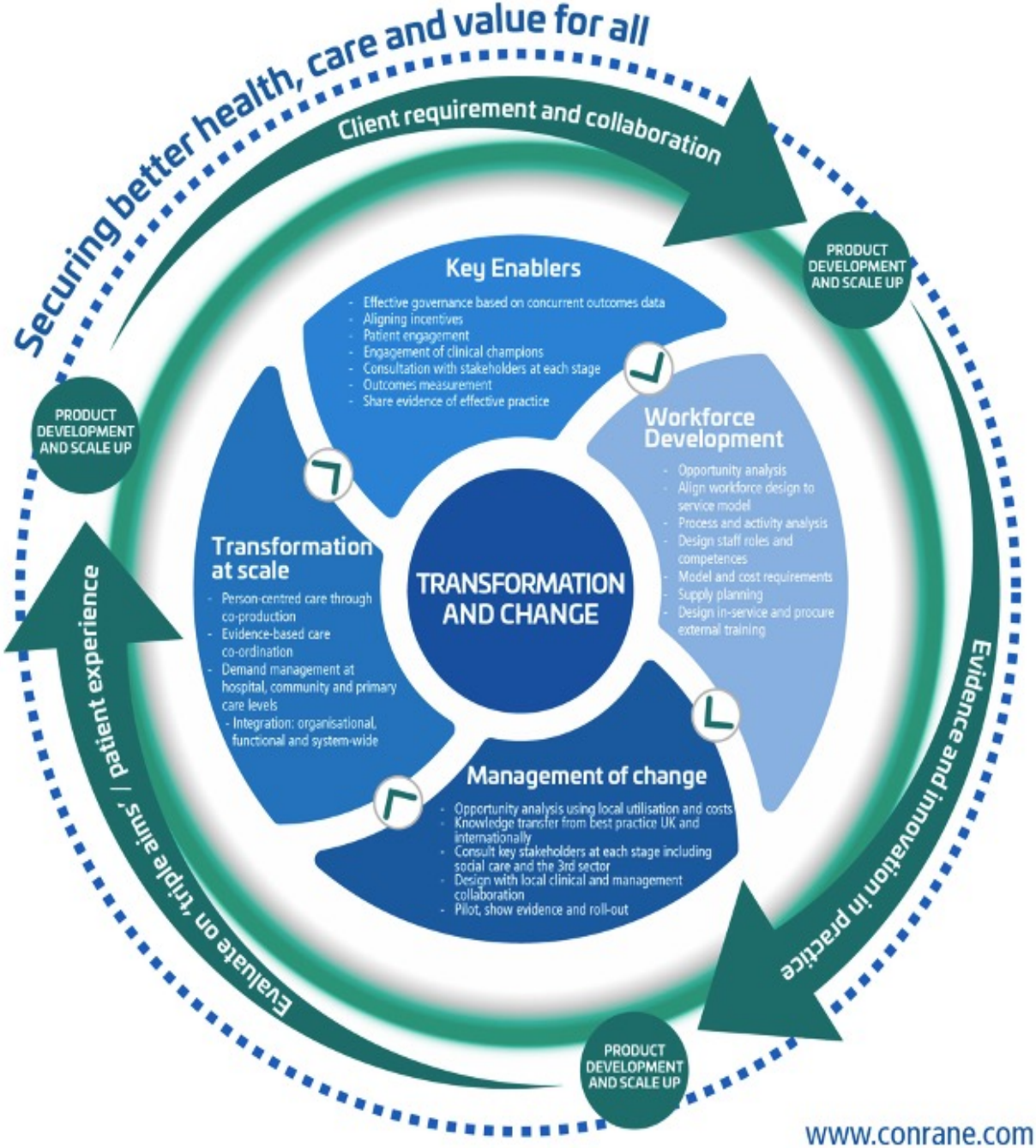
TRANSFORMATION AND CHANGE

Our knowledge and experience demonstrates that the pursuit of improved quality and patient experience in health reform will deliver whole system value for money.

We bring together skills, experience and products that support innovative and workable solutions to 21st century healthcare challenges.

These include:

- Integrated Care at ICS and Place-levels
- Acute utilisation review and demand management
- Innovative business cases including Vanguards and other Integrated Care Hubs
- Whole system redesign
- Long-term Conditions – Care coordination, case management and Guided Care
- Population health management using the Johns Hopkins Adjusted Clinical Groups Tool
- Risk adjusted resource allocation and management
- Workforce planning in acute, community and primary care
- Workforce and process re-design
- International healthcare system reform working with the World Bank and other major donor organisations



Contact **David Cochrane**
Phone: **07970739656**
Email: **info@conrane.com**

www.conrane.com