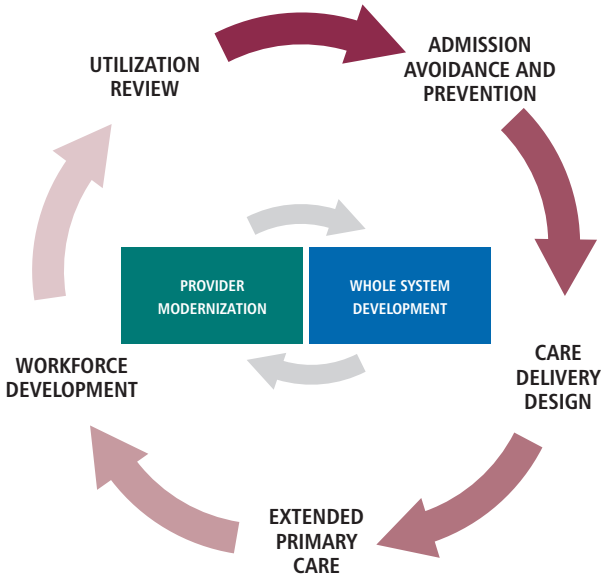
Conrane–IHS
International Health Solutions

"We need a comprehensive, integrated approach to service delivery so that clients receive a continuum of preventive and curative services according to their needs: across different levels of the health and social care system. We need to fight fragmentation."

Best-practice Solutions in Integrated Care

Conrane International Health Solutions is a group of senior health and social care system development consultants. Our multi-disciplinary team of over 20 experts has been at the forefront of innovation in integrated care for over 15 years. We offer a bespoke portfolio of technologies and organizational development solutions informed by international and domestic best practice and evidence. These are tuned to meeting the major challenges facing health and social care development with a focus on:



- Whole systems approaches to managing growing demand for unscheduled hospital services by redesigning local care networks to offer more clinically-appropriate and cost-effective alternatives;
- Clinical utilization review across local hospital networks better to align acute and community hospitals services to measured levels of need in the population;
- Supporting the design and development of:Multispecialty Community Providers (MCPs); Primary and Acute Care Systems (PACS); including the small hospital of the 21st century.
- Developing evidence-based, holistic and pro-active care coordination;
- Workforce development including staff role redesign and quality-driven productivity in acute, community, and primary care to enhance quality, cost control and meet supply challenges;
- Thought leadership informed by international best practice through our networks to integrated care systems across the OECD;
- International health system reform and redesign informed by 15 years experience in 12 countries on four continents with the World Bank, UK DfID and the healthcare governing authorities in Australia, New Zealand, Hong Kong and the Gulf states.

FIG 1 AUDIT OF LOCAL SERVICE NETWORKS AT CCG-LEVEL IN RELATION TO INTEGRATED CARE

Most local health economies have some components of an integrated care network already commissioned and in place. However, some services will need to be redesigned and there is a foreseeable requirement to commission new programmes and decommission poorly performing interventions. In order to assess the degree of completeness and performance of the current service networks, a qualitative and quantitative audit process is required against a comprehensive framework for integrated care. This process is informed by bespoke templates to be completed by the health economies and supplemented by interviews with key stakeholders as required. The output is in three parts as in the diagram.

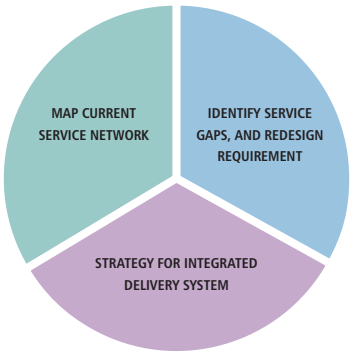


FIG 1

FIG 2 PRIMARY CARE HUBS

A current project is working with a GP Federation, one of the Prime Minister's Challenge Fund pilots, developing advanced primary care to support patient focused, locally-accessible alternatives to current hospital-based treatment. Informed by international experience of the Medical Home and accountable care organisations, general practice will extend along a integrated continuum into pro-active long-term condition and demand management, extended urgent care and interventions on the acute pathway best provided at practice-level; key components of an MCP.

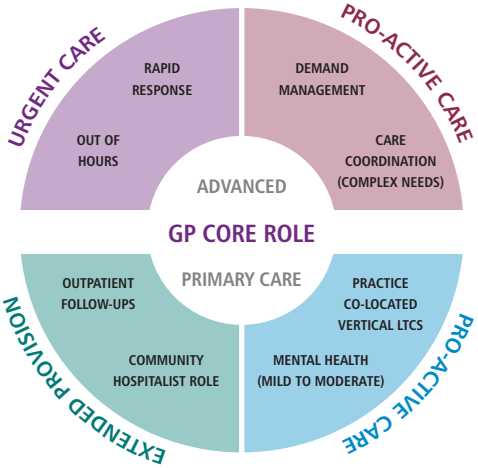


FIG 2

FIG 3 EVIDENCE-BASED CARE COORDINATION

5% of the population typically account for 50% of health and social care costs. Yet due to poor design many programmes lack compelling outcomes data. To address this, our model, perfected over 15-years, is co-located with primary care and complies with two types of evidence in clinical innovation; (i) excellent outcomes on the triple-aims framework which we have replicated with different practitioners, in different localities; (ii) randomized control trials in the US showing significant returns on investment . This evidence informs our care coordination training, expert mentorship, clinical audit systems and applied risk stratification: all designed with Imperial College and international 'best of class' . Not only are these key components of effective practice enriching the role of current community matrons, and widening the patient population they can serve beyond the narrow group or '0.5% at the top of the needs profile'.

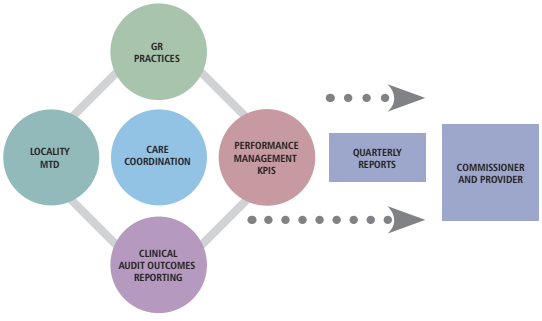


FIG 3

FIG 4 CLINICAL UTILISATION REVIEW

Our consultants have pioneered the application of proprietary care guidelines to understanding in detail the opportunities of clinical utilisation review to aligning acute care to measured acute population need at local level. This typically shows that 25% of current unscheduled admissions and up to 60% of patients in hospital for 5 days or more no longer in need of acute care. Our implementation programmes address this in terms of improvements at hospital level and wider system redesign. There are already benefits in admission avoidance, timely discharge, and reducing readmissions.
The dimensions of clinical utilisation review are:

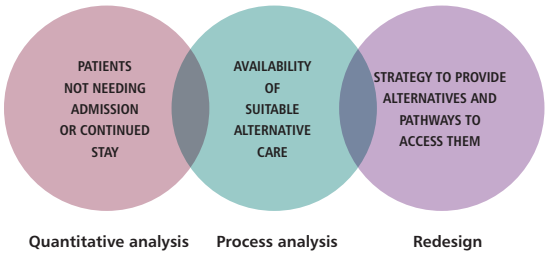


FIG 4

FIG 5 TO INFORM THE COMMISSIONING OF PRIMARY CARE

iRIS supports case-mix adjusted capitation, performance benchmarking, and needs-based planning. To ensure equity and clinically acceptability to GPs, CCGs need an approach which reflects differing population needs at practice level. iRIS can differentiate 'which practices have patients sicker than others'. This in turn alleviates any concerns of 'conflict of interest'

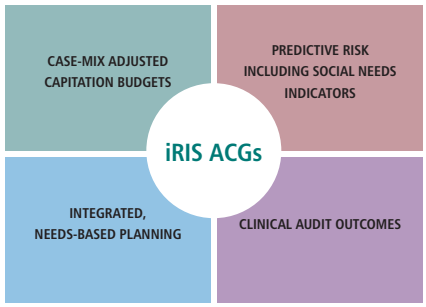


FIG 5

FIG 6 SYSTEM ENABLERS

Whole system transformation requires congruent commissioning and reformed payments systems. Our team therefore includes senior commissioning and financial modeling experts who have been at the leading-edge of change over the last five years. Meanwhile providers and staff require organizational development. In addition to staff training and mentorship, our HR strategy team are redefining workforce planning at home and abroad. In acute providers, community services and primary care we are aligning staff with business activity and strategic change, supply and labour market constraints and not least financial frameworks.

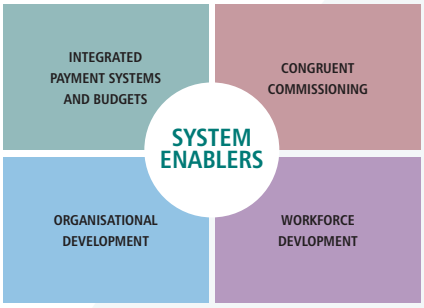


FIG 6

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