PRO.M.I.S.
Programma Mattone Internazionale Salute

CONFERENCE

"Integrated services: organizational healthcare models in the framework of chronic diseases".

ACT@Scale: Advancing Care Coordination and Telehealth at Scale

26-27 March 2018
Turin, C.so Regina Margherita, 174

Dr. Cristina Bescos
Philips

Ministero della Salute
Regione del Veneto
Regione del Veneto ULSS4 Veneto Orientale

Since 1914 delivering game-changing innovations

1915
Arga-lamp

1925
Metalix- X-ray tube

1926
Pentode

1931
Philora sodium lamp

1939
Philishave rotary shaver

1948
First live TV broadcast in NL

1963
Compact Cassette

1979
Compact Disc

1980
Compact fluorescent lamp

1996
Ultra-High-Performance (UHP) lamp

1998
3D rotational X-ray

1999
Flat-panel X-ray detector

2004
Ambilight TV

2007
Brilliance iCT

2010
Lifeline AutoAlert

2011
HeartNavigator

2011
AirFloss

2012
Hue

2013
AlluraClarity

2014
IntelliVue CL Respiration Pod

2017
Lumify

Four profound trends are shaping the future of health technology

Global resource constraints

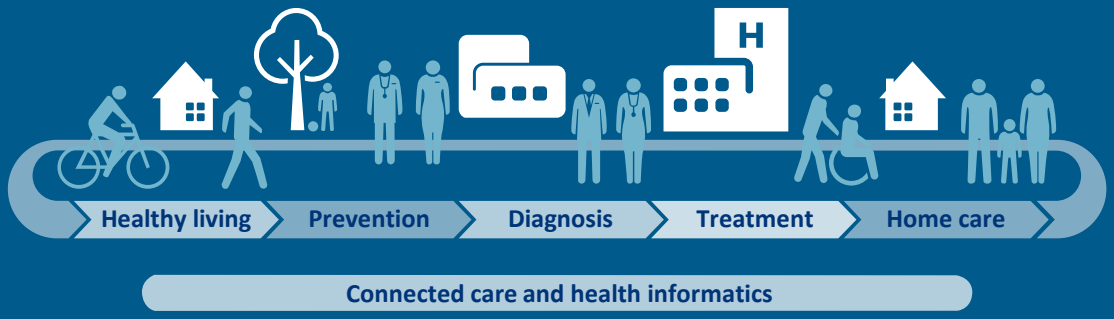
Aging populations and the rise of chronic illnesses

Increasing consumer engagement

Digitization

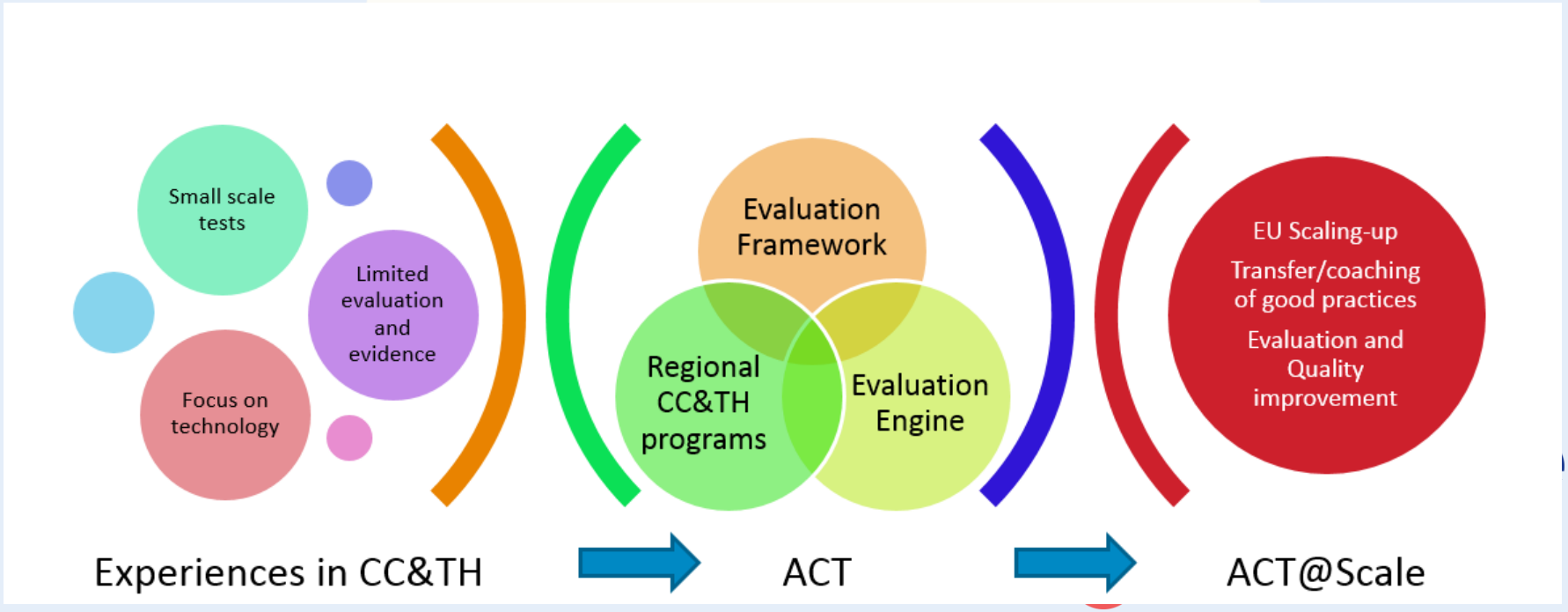
Ready to take on the healthcare challenge

At Philips, we take a holistic view of people's health journeys, starting with healthy living and prevention, precision diagnosis and personalized treatment, through to care in the home – where the cycle to healthy living begins again.



ACT@Scale

Start	**March 2016**
Duration	**36 months**
Project Budget	**3.5 MEuros (60% funded)**
Consortium	**lead by Philips Healthcare (Germany)**



ACT@Scale Objectives

- Demonstrate how the benefits of CC & TH can be successfully deployed at scale in real world healthcare settings
- From small pilots to routine practice
  - Healthcare regions are investigating how best to incorporate CC & TH services into care delivery, and how to scale up and incorporate to standard practice.
- Reaching large scale
  - Scaling-up encompasses making the services sustainable, providing them to entire populations, and engaging patients and practitioners.
- Transfer knowledge among key EU decision makers
  - Develop, test, consolidate CC & TH **best practices** that can be exchanged and leveraged by healthcare regions to expedite deployment of services at scale.
  - Promote **European thought leadership** at EU policy level and showing payers, practitioners and providers how patient care can be improved under restricted budgets.

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ACT@Scale Aims

- Aim: scaling-up integrated care programs
  - Structured methodology (PDSA) for assessment, benchmarking and exchange of good practices of scaling-up
  - Transferability of good practices for scaling-up

- Topics:
  - **Stakeholder and change management**.
    - Achieve support and commitment
  - **Service selection**.
    - Appropriate level of distribution of health and care resources by dynamic needs of patients and populations
  - **Financial models and sustainability**.
    - Deliver at least equal quality of care at lower cost / better resources utilization
  - **Citizen empowerment**.
    - Total engagement of users / citizens to make the strategy self-sustaining
  - **Evidence**.
    - Collecting and measuring experience, status, progress and success of scaling-up

Programs

Basque Country:

Multimorbid Integration

Cluster: Multimorbid

Description:
Multimorbid Population Integrated Intervention Program

Target group:
Complex multimorbid patients

CHF Telemonitoring

Cluster: Cardiac

Description:
Telemonitoring services for Congestive Heart Failure

Target group:
Heart failure patients

Catalonia:

Nursing homes

Cluster: Independant living

Description:
Healthcare support programmes for nursing homes

Target group:
Elderly living in institutionalised homes

Chronic Care

Cluster: Chronic

Description:
The Chronic Patient Program – Badalona Serveis Assistencialis

Target group:
Complex chronic and frail patients

Complex case Management

Cluster: Chronic

Description:
Support for complex case management AISBE

Target group:
Complex patients that require linking tertiary care with the community

Physical activity

Cluster: Chronic

Description:
Services for promoting healthy lifestyles: physical activity - AISBE

Target group:
Frail elderly patients

Frail older adults

Cluster: Independant living

Description:
Integrated care for subacute and frail older adults PSPV

Target group:
Frail elderly patients

Northern Netherlands:

Asthma / COPD

Cluster: Respiratory

Description:
Asthma / COPD Telehealth service

Target group:
Patients suffering from asthma and / or COPD

Embrace

Cluster: Independant Living

Description:
Embrace – Connecting health and community services

Target group:
Patients suffering from asthma and / or COPD

Effective Cardio

Cluster: Cardiac

Description:
Heart failure program

Target group:
Complex heart failure patients

Gesundes Kinzigtal:

Cluster: Pop Health

Description:
Gesundes Kinzigtal

Target group:
Citizens of region

Cluster: PhysicalActivity

Description:
World of Fitness

Target group:
Chronic patients

Northern Ireland:

COPD Telemonitoring

Cluster: Respiratory

Description:
COPD Telemonitoring Services

Target group:
People with COPD

Diabetes Telemonitoring

Cluster: Diabetes

Description:
Diabetes Telemonitoring Services

Target group:
People with diabetes

Weight Management Telemonitoring

Cluster: Pregnancy

Description:
Weight Management Telemonitoring Services

Target group:
Woman with BMI over 39

South Denmark:

Telepsychiatry

Cluster: Mental Health

Description:
Center for Telepsychiatry

Target group:
Citizens eligible for telepsychiatric treatment

Cluster: Cancer

Description:
VC for Relatives

Target group:
Cancer patients and relatives

Scotland:

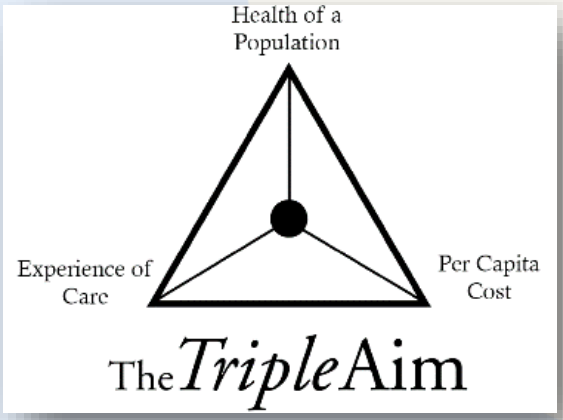
Cluster: Diabetes

Description:
My Diabetes My WAy

Target group:
Diabetes patients

Hypothesis

- Care coordination and telehealth can contribute to meet the “Triple Aim” goal in health systems
  - Improving the user’s experience
  - Improving population health
  - Better resource utilization



Quadruple aim

+4 Improved care team experience

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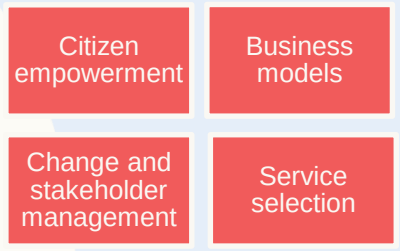
Evaluation Framework: Donabedian model

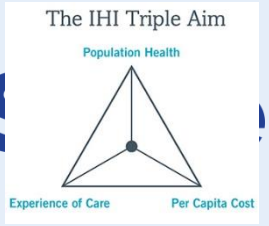
- Conceptual model for examining health services and evaluating quality of health care.
- Quality of care information drawn from 3 categories:

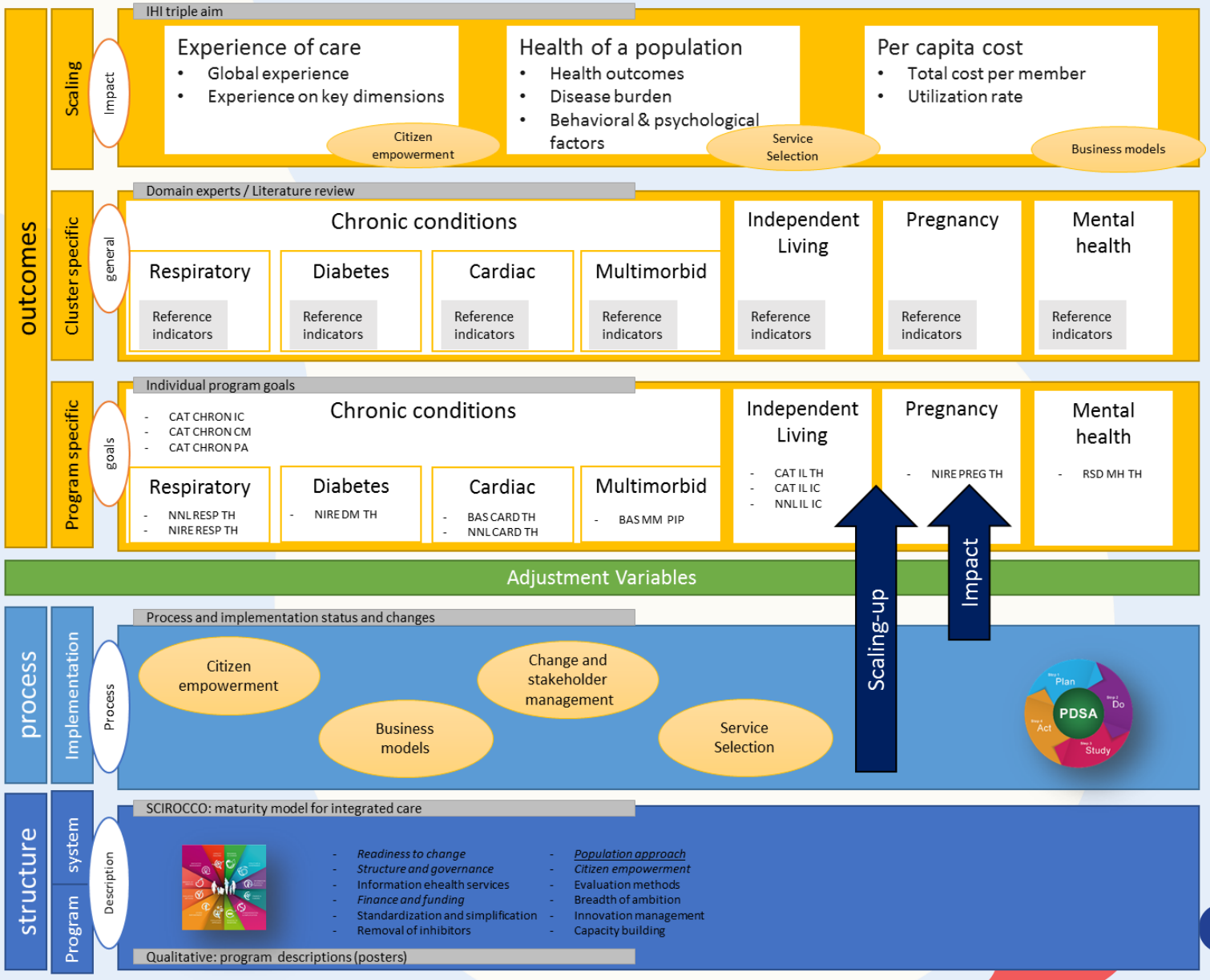
  - **Process** → drivers
    - Culture and professional cooperation



  - **Structure** → context of the program / health system
    - Resources, organization, …

  - **Outcomes** → IHI triple aim
    - Competence development, goal achievement




outcomes
Scaling
Impact
IHI triple aim
Experience of care
Global experience
Experience on key dimensions
Citizen empowerment
Health of a population
Health outcomes
Disease burden
Behavioral & psychological factors
Service Selection
Per capita cost
Total cost per member
Utilization rate
Business models
Cluster specific
general
Domain experts / Literature review
Chronic conditions
Respiratory
Diabetes
Cardiac
Multimorbid
Reference indicators
Independent Living
Pregnancy
Mental health
Program specific
goals
Individual program goals
CAT CHRON IC
CAT CHRON CM
CAT CHRON PA
NNL RESP TH
NIRE RESP TH
NIRE DM TH
BAS CARD TH
NNL CARD TH
BAS MM PIP
CAT IL TH
CAT IL IC
NNL IL IC
NIRE PREG TH
RSD MH TH
Adjustment Variables
Scaling-up
Impact
process
Implementation
Process
Process and implementation status and changes
Citizen empowerment
Business models
Change and stakeholder management
Service Selection
PDSA
Plan
Do
Study
Act
structure
system
Program
Description
SCIROCCO: maturity model for integrated care
Readiness to change
Structure and governance
Information ehealth services
Finance and funding
Standardization and simplification
Removal of inhibitors
Population approach
Citizen empowerment
Evaluation methods
Breadth of ambition
Innovation management
Capacity building
Qualitative: program descriptions (posters)

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Collaborative methodology

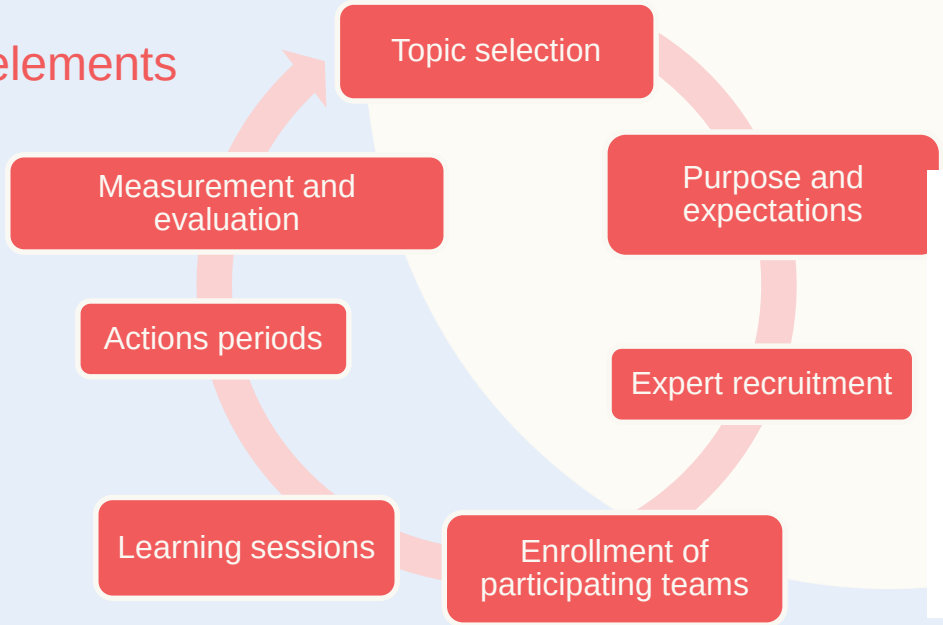
The collaborative approach requires groups to come together periodically to learn change ideas and quality methods, and to exchange their experiences with making changes.

Stimulates rapid improvement

Disseminate good ideas

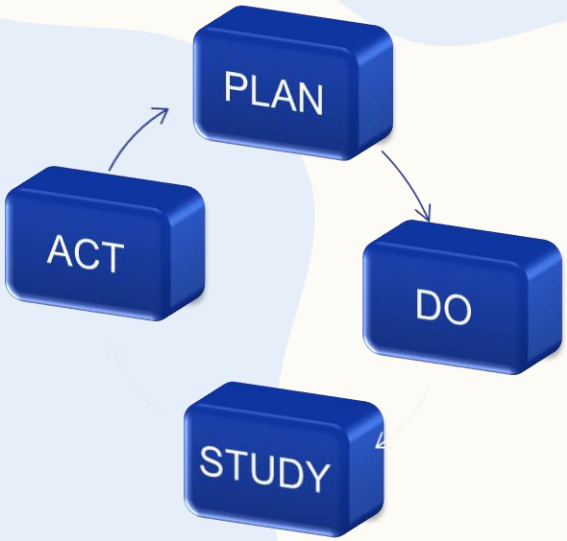
Boost learning skills

Key elements

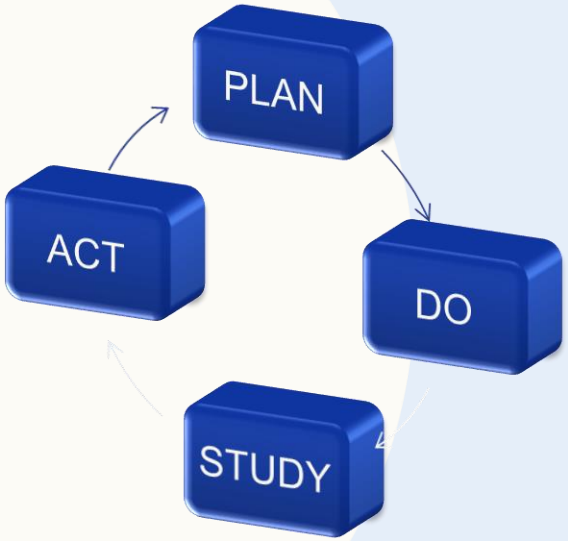


Collaborative methodology

1st PDSA cycle



2nd PDSA cycle



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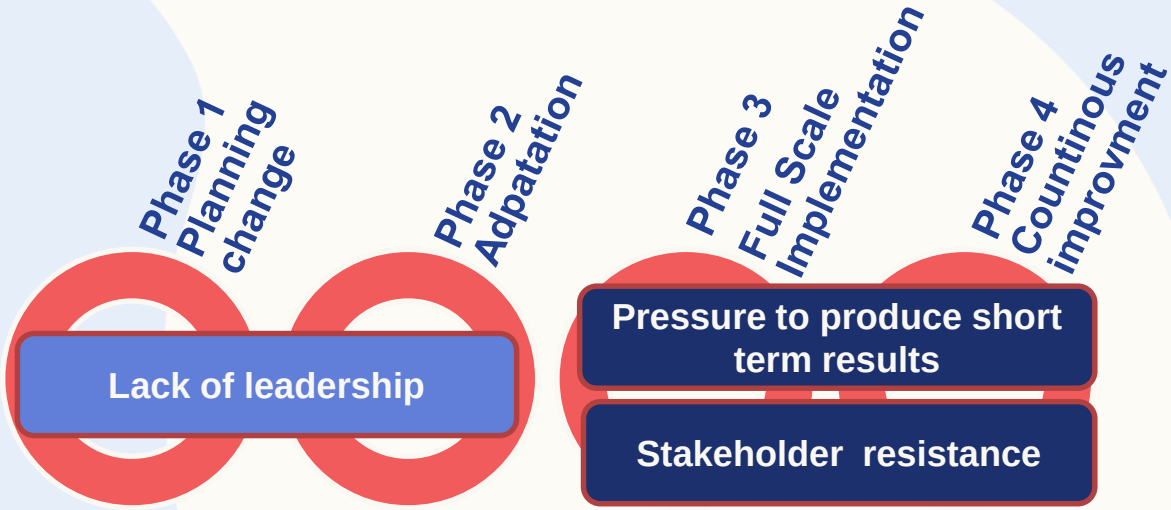
Change Management - Barriers



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Stakeholders management at baseline

- Most of the programmes declared having a strategy to identify stakeholders, but in many cases they don't have a detailed plan to identify and prioritize them
- Usually no commitment nor risk assessment are performed
- Most of them have an action plan oriented to maintain and increase stakeholders commitment
- The process itself it's not assessed

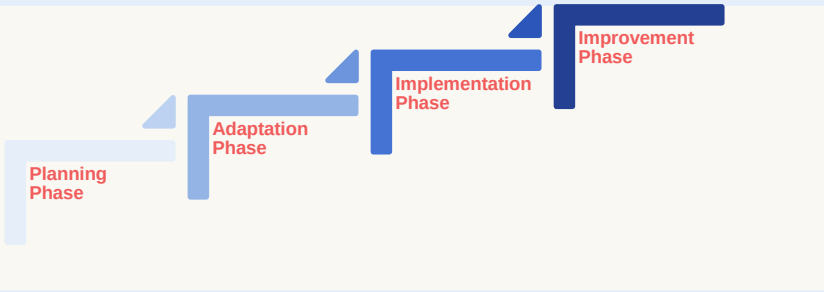
IMPROVEMENT AREAS	OBJECTIVES	INTERVENTIONS	PROCESS INDICATORS (EIP-AHA B3)
LACK OF EVIDENCE	-Create awareness success	Collect methodologies to measure stakeholder involvement	- Identification and selection stakeholders' implementation plan - Plan to maintain and increase stakeholders commitment - Change Management's methodology applied
LACK OF ENGAGEMENT	-Engage all stakeholders	-Define, validate, share and execute an implemental planning -Multidisciplinary team representing all stakeholders and organizations	- Involve stakeholders depending the implementation phase - Periodic assessments Stakeholders process
LACK OF SPECIFIC SERVICES AT NEW SITES	-Scaling existing services to new sites	-Implementation strategy -Improve the program phase	- Change management elements addressing - Step in the following integrated areas (depending phase developed)
INSUFFICIENT COORDINATION HEALTH CARE LEVELS	-Increase awareness among professionals -Discuss cooperation health care levels	-Develop and implement coaching modules in different care levels	- Involve stakeholders depending the implementation phase - Periodic assessments Stakeholders process
POOR IMPLEMENTATION TM SERVICES	-Assess effectiveness TM programs	-Define and apply evaluation framework	- Involve stakeholders depending the implementation phase - Periodic assessments Stakeholders process

Multimorbid Integration

	IMPLEMENTATION PROGRESS	
	2016*	2017**
Process INDICATORS		
Stakeholder management	Planning Phase	Adaptation Phase
Organisational models	Developing Implementation Phase	Implementation Phase
Workforce development	Developing Adaptation Phase	Adaptation Phase
Stratification tools	Developing Implementation Phase	Implementation Phase
Integrated care pathways	Developing Implementation Phase	Implementation Phase
Financing and incentives	Developing Implementation Phase	Implementation Phase

*PM survey results

** DO Phase Analysis



- ✓ A multidisciplinary team where all sectors and organizations were represented has been created
- ✓ An integrated sustainable pathway has been developed and validated
- ✓ A training programs to improve healthcare professional's knowledge in integrated care pathway and stratification methods has been analyzed
- ✓ An assessment framework and collaboration agreement regarding the indicators to assess cost-effectiveness and sustainability has been developed

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Act Phase

To refine changes and to determine future plans

Adopt

The desired change is achieved.

Once improvement is affirmed, determine when the successful change can be reproduced on a larger scale

Adapt

Revise the change process.

Return to Plan, Do, Study, Act.

Repeat the test using a different method or by gathering different pre and post data

Abandon

The change exacerbated the old problem or created a new harmful problem.

Return to the Plan phase.

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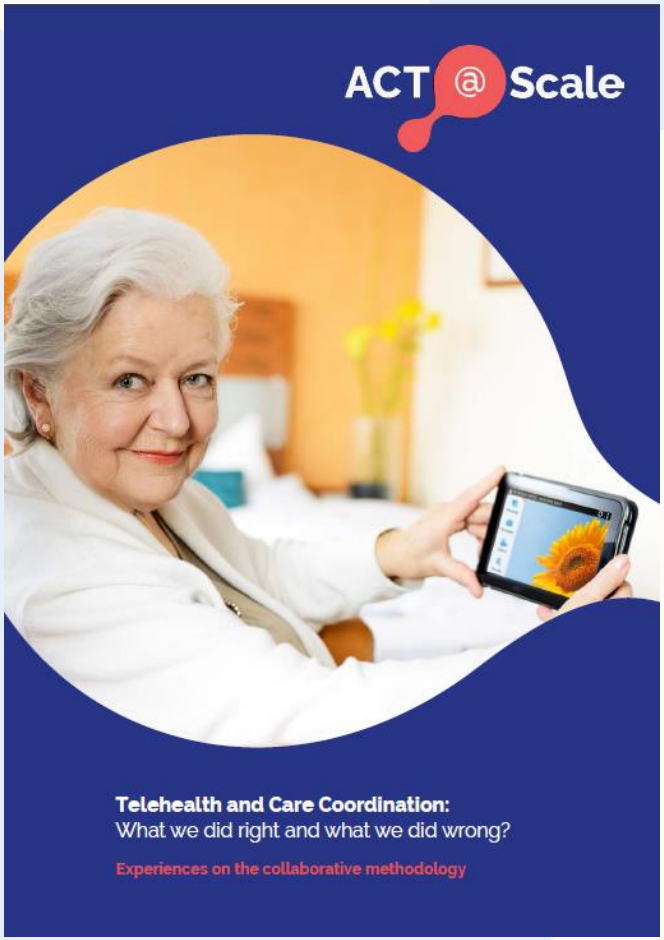
WHINN Event (Oct 2017)



In the Basque Country, the collaborative team working in the scaling-up of the integrated care for multimorbid patients was composed of stakeholders of distinct levels (macro, meso and micro), with varied roles and representatives of all organizations where the intervention was expected to be implemented. In particular, the Health- care Directorate represented the policy makers of Osakidetza (macro), whereas Medical and Nursing directors provided meso-level managers' opinion. Primary care (GPs, GP practice nurses) and secondary care (internists, hospital nurses) professionals represented front line staff's views.

Basque Country

Multimorbid Integration

Cluster: Chronic - Multimorbid
Target group: Complex multimorbid patients

This multimorbid program has been developed by a multidisciplinary team formed by primary healthcare professionals, specialists, and managers with expertise in the design and development of new pathways to care for older people with complex health and social care needs. These people are at high risk of hospital or care home admission.

This is achieved through Information and Communication Technology (ICT) enabled health and social care service coordination, monitoring, care involvement, and patient self-management. ICT-based platforms have the potential to improve treatment compliance; enhance self-management, and increase patient and healthcare professionals understanding. The program is designed to improve clinical outcomes and enable people to lead more fulfilled lives. The program aims to provide multimorbid patients with integrated care facilitated by distinct ICT solutions. The program is in place in 4 Integrate Care Organizations (ICOs).

Current coverage: 4944 patients

Aim to scale to: 18.000 patients

Topic
Purpose
Experts
Team
Learning
Action periods
Evaluation

Lessons learned

Tip 3:

'Be effective in running the collaborative meetings'.

The collaborative meetings have to be chaired by experts in improvement methods and group dynamics to ensure motivation of the participants and the best use of their knowledge and time.

Transfer to another setting:

- You need someone that is capable of leading a good group discussion and make the interaction in the multidisciplinary teams proactive, creative, constructive.
- A facilitator will need to create space for critical feedback; it should be an expert in the methodology being applied as well as in group dynamics.
- This person will need to have adequate time to prepare for the meetings, and in the meeting offer points of discussion, create the right atmosphere and bring together and summarise what has been said at the meetings.

"Use facilitators to organize and lead effective collaborative meetings."

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8 tips for for implementing collaborative methodology

Tip 3:
‘Be effective in running the collaborative meetings’.

Lessons learned
The collaborative meetings have to be chaired by experts in improvement methods and group dynamics to ensure motivation of the participants and the best use of their knowledge and time.

“Use facilitators to organize and lead effective collaborative meetings.”

Multimorbid Integration

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ACT@Scale Consortium

- Philips Healthcare Germany (coordinator), Germany
- Osakidetza – Basque Country Health System, Spain
- KRONIKGUNE – Research Centre on Chronicity, Spain
- University Medical Center Groningen, the Netherlands
- Region of Southern Denmark, Denmark
- Agency for Health Quality and Assessment of Catalonia (AQuAS), Spain
- Centre for Connected Health and Social Care, Northern Ireland, Ireland
- Philips Electronics (Netherlands), the Netherlands
- Aristotle University of Thessaloniki, Greece
- City University London, School of Health Sciences, UK
- Universitätsklinikum Würzburg, Germany
- University of Hull, UK
- The Consorci Institut D'Investigacions Biomediques August Pi i Sunyer (IDIBAPS), Spain
- University of Dundee, Scotland, UK
- Gesundes Kinzigtal, Germany
- Optimedis, Germany

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Engage with us: Collaborating partners

Engagement as observer	Engagement as evaluation site
• Access to programme results and participation in project meetings • Learn from the others' good practice and experiences • Provide opportunities for collaboration leading to efficiently (re-) design and validate innovative care services and expand the services to larger population - with the same level of investment • Enlarge your visibility at international level • Enable local industry to see a larger market, beyond the "local border" • Engage political/industrial support	in addition, • Access to the ACT evaluation engine and fully participate in the evaluation process and best practice selection • Get evidence and benchmarking of your solution under the review of the key international experts • Combine evidence with all the evaluation sites

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THANKS FOR YOUR ATTENTION

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Integrated Services

Integrated services