Introducing a system integrator to improve health outcomes: applying lessons from Gesundes Kinzigtal in Fareham and Gosport, Hampshire

1. Introduction

Over the last 12 months, the Hampshire Consortium have worked with local stakeholders and a 'system integrator' across Fareham & Gosport CCG to see whether the principles and lessons that have been successful in delivering all four dimensions of the quadruple aim in Gesundes Kinzigtal, Germany, can be adapted and implemented in the English NHS. See diagram below.

Gesundes Kinzigtal Quadruple Aim Delivery

Participants live **1.4 years longer** than non-participant actuarial matched controls

Improved staff satisfaction. Primary care vacancy rate reduced to zero.

7.3% reduction in health system costs compared to actuarial matched controls

98.8% of enrollees setting personal goals **recommend becoming a member** to family and friends.

2. What is a System Integrator?

A system integrator helps the local health and social care system (or a locality) to support citizens to better manage their own health and, when they need it, get the right care, in the right place at the right time. It does so by analysing data, facilitating conversations and service redesign, and co-ordinating and influencing the resources allocated to a population group, bringing together the different elements of care. There is also a collective sense of accountability for the population served.

Our Approach

The three main phases of our work

System Needs Analysis
- Needs analysis using local population data
- Identify key priority areas and opportunities for improving outcomes

Prototyping
- Governance & accountability
- Front-line Population Health Management
- Capacity & capability building

Delivery and Sharing Learning
- Working with key delivery partners
- Building the momentum for change

3. Population Health Management vs. Integrated Care?

Our definition of population health management:

The systems and processes required to achieve the greatest improvements in health and relief of suffering for a defined population from the resources available through,

i) The efficient and effective delivery of care in response to individuals presenting to and asking for help from the health and care system,

ii) Identification of individuals and offer of intervention to those currently not in receipt of interventions that evidence suggests are likely to improve their health and wellbeing, reduce the risk of future ill-health, and/or reduce costs to both the health system and the wider community,

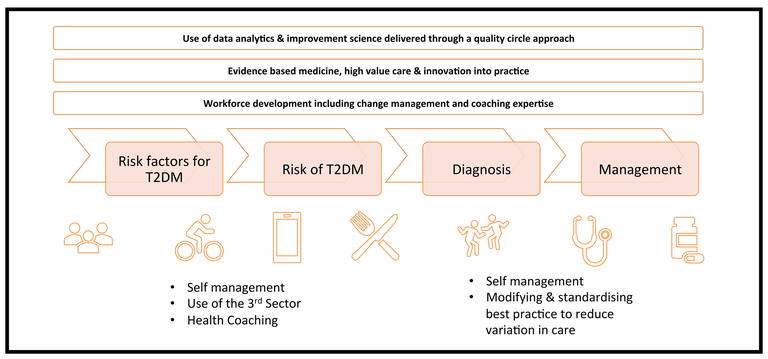
iii) Salutogenesis: i.e. provision of support for individuals and communities and the use of local assets to protect and promote health through:
- Promoting individual knowledge, behaviours and attitudes that promote health
- Supporting the development of strong social networks creating a health sustaining physical environment.

Source: Hicks NR, Groene O: OptiMedis-COBIC UK 2018

4. Prototyping – Frontline Population Health Management

We worked with a group of three GP practices, the community team and public health team in Fareham who service a population of 40,000. They wanted to start by exploring how they could use data analytics and improvement science to better design services for patients living with, or at risk of, type two diabetes mellitus.

Frontline Staff - What could we do?



The three phases - frontline population health management

Understanding the Current State	• Map current processes • Convene front-line clinicians • Use process map to prompt discussion
Data for Improvement	• Identify clinically relevant questions • Extract clinical data eg using Miquest query for whole practice population • Generate clinically relevant segments and address questions
Designing and Improving the Process	• Identify people whose care risks can be improved, addressing any current inequalities in care • Agree how to take action (co-design) • Act (plan-do-study-act) • Review

5. Results

i) Discussion led to the development of clinically relevant segmentation of the whole registered population,

ii) In each segment examples of actionable overuse, misuse and underuse of care were identified in specific patients together with opportunities for prevention,

iii) Plans to proactively tackle these issues are being developed.

6. Conclusions

- When supported by an integrator that convenes and facilitates data driven quality improvement conversations, groups of practices and their associated community and public health teams can take a population approach to their registered list and identify practical reactive, proactive and preventive actions to improve health.
- This demonstrates that practical front-line population health management can be achieved in the NHS, based on a population size of 40,000.

References

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