Population-based Integrated Care
The OptiMedis Model

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Meet Amy

Microsystems Today

6 months, 14 different Microsystems, 21 visits

OptiMedis AG

Prof Eugene Nelson, Dartmouth Institute
Richard Antonelli, MD, MS Medical Director of Integrated Care Boston Children’s Hospital / Harvard Medical School Boston, USA vom 26 October 2016 in Wellington, Neuseeland
A major limitation of current service delivery is that it focuses too much on individuals, and to little on the determinants of health. Our approach focuses on population health management, addressing both major chronic diseases groups as well as patients at-risk in the community.

Components of the OptiMedis model:
• Framework contract, incentivize value, not volume
• Data analytics: potential analyses, patient segmentation tools, risk modeling
• Digital transformation: needs-oriented, piloted, embedded
• Creating an innovation space and focusing on system outcomes
Regional Healthcare Networks drive Health Care

Our sole mission is to improve health outcomes for citizens, their families and their communities and better value for those that pay for care.

We are managing a group of regional Integrated Care Delivery Systems/Accountable Care Organisations located in rural and urban parts of Germany, the UK, the Netherlands and Belgium.

Together with regional physician networks, we are building an integrated healthcare structure in which doctors, therapists, hospitals, pharmacies and many other partners work in association and overcome past constraints.

The integrator function is complemented by its research and performance management institute that evaluates these regional delivery systems.
Shared savings contract: incentive to invest in long-term health gain

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)

**Total actual costs**

**Savings to be shared**

**Normally expected costs**
(Morbi-RSA)

**Health insurance**

**Integrator company**
Our intervention logic focuses on the Triple Aim

Outcome perspective:

Health Outcome: What impact has my doctor’s practice on health outcomes?

Economical Outcome: What impact has my doctor’s practice on financial outcomes?

Patient Experience: What impact has my doctor’s practice on the individual experience of care?

Internal Processes

How can we provide optimal care processes?

Generic vs specific interventions

Structure:

Learning and Innovation
In which field can we make improvements? Is there a solid base for success in the future?

Patient Characteristics
Who is the target group and (how) do we reach it? What morbidity do the patients of my doctor’s practice have?

Berwick D. The Triple Aim: Care, Health, and Costs. Health Affairs 2008
Taking responsibility for the whole population: The chronically ill, the frail are in our focus but as well all the others

- The intervention is **directly** related to the **enrolled** integrated care participants.

- **Indirectly**, all insureds of the participating purchasers benefit from doctors' training, health promotion, prevention and BGM interventions.

- Participation is free of charge & voluntary

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**Direct interventions**

- Target Agreements + Risk Screening
- add. care provision programs, comparable to Disease Management Programs
- Joined electr. Patient Record
- Personalized advice
- Case Management
- Functional Training / Rehab-Sport
- Relaxation/Balancing
- Benchmarking + Feedback-Reports by means of GKV-standard data to physicians
- Campaigns to reduce / critically evaluate prescription of antibiotics
- Self-management-trainings
- Trainings, classes
- Healthy Company network

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**Indirect interventions**
INVEST Billstedt/Horn

Population based integrated care in a deprived urban community (high % migrant background, language barriers, low health literacy)

13 years difference in observed age at death between city boroughs

Higher secondary care utilization
Germany’s first Health Kiosk in Billstedt

98.9% of GK members who agreed to define health goals, would recommend GK membership and more than 50% of those state “we live healthier now”.

From 2007 to 2017 totaling € 47.0 Mill. in cost savings margin (net € 15.3 mill.,) for the participating health insurance funds.

Positive confirmation of provider satisfaction by external scientific evaluation + Four vacant local GP practices successfully staffed + 15 % increase in income for partnering physicians per case.

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Scaling up the OptiMedis Model: lessons learnt

Possible to reach the Quadruple Aim, but importance of advanced data analytics to support system transformation.

Start up investment needed, then sustainable business model based on shared savings contract.

Regional integrated care network becomes a test-space for a wide range of digital & health innovations and public health interventions.