Scirocco Exchange

Capacity-building for integrated care

D5.1 Readiness of European Regions for Integrated Care

Annex D: Self-assessment process in Werra-Meißner-Kreis, Hesse, Germany

WP5 Maturity Assessment for Integrated Care

Co-funded by the Health Programme of the European Union

The SCIROCCO Exchange project is co-funded by the Health Programme of the European Union under Grant Agreement No.: 826676 (Chafea)

Document information

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- Gesunder Werra-Meißner-Kreis GmbH

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Delivery date - 31 January 2020

Dissemination level

I	Public

Statement of originality

This Report contains original unpublished work except where clearly indicated otherwise. Acknowledgement of previously published material and of the work of others has been made through appropriate citation, quotation or both.

Disclaimer

1 Introduction

The goal of Gesunder Werra-Meißner Kreis Ltd. (GWMK) is to reduce the projected increase of costs of health insurances by improving health literacy, care coordination and offering guidance in the German healthcare system. To achieve its goal, GWMK is building a "health network" with insurance members as well as healthcare professionals of all kinds.

A core project is the establishment of "health guides" ("Gesundheitslotsen"). For example, physician/pharmacy assistants, therapists, midwifes are trained and supported by GWMK to be low threshold points of contact for insurers. Health guides by means of motivational conversation and a special GWMK questionnaire nudge the insured to form their individual health target and to sign a target agreement. Moreover, health guides are provided an extensive map of (ideally) all prevention offers and health care services in the region by the GWMK back office. The health guides time to consult the insured is reimbursed by GWMK.

Another part of GWMK is the establishment and management of local sector-transcending treatment pathways with health professional network partners.

Third, GWMK is supporting its members contact to case management services e.g. by offering telemedicine services in conjunction with a partnering company.

Finally, GWMK offers self-management courses.

1.1 Characteristics of the healthcare system

Item	Description
Region	Country ("Land") = Germany State („Bundesland") = Hesse County („Landkreis") = **Werra-Meißner-Kreis**
Geographical scale of the region	Regional (State, province, territory)
Geographical size and dispersion of the region (km ^{2})	1,024.55 km^2 [1]
Population size of the region (thousands)	100,965 [2] (GWMK Target population ~21.000 based on health insurance contract)
Population density of region (inhabitants/km^2)	99/km^2 [2]
Life expectancy of the region (years)	Germany (born 2015): Male = 77,7y; Female = 82,7y [3 (born 2015, p.98)]
Fertility rate of the region (births/woman)	1,4 (year 2015) [3 (2019, p.98)]
Mortality rate of the region (deaths/1,000 people)	5,7 / 1000 people (574 /100.000 people) [3 (2013, p.190)]

Item	Description
Top three causes of death of the region	Ischaemic heart disease, acute myocardial infarction, malignant neoplasm of the bronchi and lungs [3] (2013, S.189)
Organisation and governance of healthcare services	Germany has a Bismarck type of healthcare system based on individual insurances, e.g. health insurance. Up to a certain income threshold, every person living in Germany must have (or is provided with) a statutory health insurance. However, people are free to choose their own provider (2019: 109), all of whom are in competition. People with higher income than a certain threshold, as well as civil servants, have to take private insurances; 10,7% of Germans are privately insured. Ambulatory physicians, who want to treat statutory insured people, need to be member of a "Kassenärztliche Vereinigung" (KV) (1 per state). Health insurances pay a lump-sum to the KV based on their members residence and comorbidities. The KV is then responsible to budget and manage ambulatory health care delivery. Hospitals are paid in two ways: building maintenance and long-term investment are paid by the state government. The running costs are paid directly by the health insurances to the hospital's management organisation.
Healthcare spending of the region (% of GDP)	Hesse: 28,3 billion € [4] (2017) / 279,1 billion € [5] (2017) =~10,1% WMK: BIP 2,4 billion €
Healthcare expenditure of the region (thousands)	Hesse: 28,3 billion € [4] (2017)
Distribution of spending in the region	No data. See description "Organisation and governance of healthcare services". The overall German budget structure makes it difficult to source reliable data.
Size of the workforce (thousands) and its distribution (%) in the region	• 36 pharmacies • 67 general practitioners' practices • 2 general hospitals • 7 specialist clinics (mainly orthopedic rehabilitations, historic cluster of five clinics in the town Bad Sooden-Allendorf) • 59 outpatient specialists practices (2 anesthesia, 6 ophthalmology, 1 surgery, 9 gynecology, 4 ear, nose and throat medicine, 2 skin-and venereal diseases, 22 inner medicine, 2 neurology, 9 orthopedics, 2 urology). • 66 dentist practices • 65 physiotherapists' practices • 17 fitness centers • 13 ergo therapist practices • 14 logopedic practices • 21 psychological psychotherapist practices • 7 children & adolescent psychotherapist practices

Item	Description
	• 35 Ambulatory care service • 27 nursing homes
Healthcare policies in the region	Werra-Meißner-Kreis key policies[7,8]: 1. Keep and attract general practitioners (a large proportion of general practitioners are over 60 years of age and are looking for younger colleagues to take over) 2. Secure the existence of the two hospitals in the region. In Germany, there is a debate to reduce the number of hospitals in general. Especially, the clinic in Witzenhausen could be subject to closure, which was discussed in the past. However, the hospitals are owned by the county and represent a major employer. 3. Attract and secure more caregivers for ambulatory and stationary care; the population is aging, and young people are unable to find jobs, so they move away. The older population stay in the area and, on average, live longer. Currently, most of the caregivers are relatives themselves rather than other professionals. However, intergenerationally, family structures are changing and it as assumed, more and more people will need professional care sooner.

1.2 Integrated care in Werra-Meißner-Kreis

The outcomes of maturity assessment showed that, in Germany, there is a lot of debate and awareness of integrated health and care. However, historically developed structures (especially different financing of ambulatory and hospital care) gives little incentive for a professional to move forward individually. Moreover, ambulatory general practitioners in Germany are historically very independent and feedback averse. Furthermore, the digital infrastructure in Germany is below an acceptable level due to the government subscribing to contracts that do not incentivise telecommunication companies to service the countryside efficiently. Low incentives for professionals to cooperate together, coupled with a weak digital infrastructure, proves that there is significant room for improvement in delivering integrated care. In conclusion, Gesunder Werra-Meißner-Kreis GmbH gives an approach within the existing fundamental structural of the German health care system, building an incentive framework for professionals and advancing the digital transformation of the region.

2 Self-assessment process in the county Werra-Meißner-Kreis

2.1 Identification process of the local stakeholders

The search for local stakeholders was divided in two parts. First, Gesunder Werra-Meißner-Kreis GmbH organised and supported an interdisciplinary quality circle of 12 regular members. Thus, it was decided to integrate the SCIROCCO Exchange assessment into the work of the interdisciplinary quality circle. Second, in a separate analysis, a number of important local stakeholder were identified: regional hospital management and physicians, health insurance manager of regional health insurance, lawyer (medical law), pharmacies, regional government health department, 'Kassenärztliche Vereinigung Hessen' = representative organisation for ambulatory GP's and specialists, representative of regional physician networks.

Table 1: List of stakeholders conducting individual assessments

Gesunder Werra-Meißner-Kreis	1x Branch Manager, 1x Health Care Manager
Health insurance	Team lead for care services of BKK Werra Meißner
Pharmacy	1x Pharmacist
Physicians	1x GP
Lawyer	1x Lawyer (medical law); involved in planning of a ambulatory specialist physician center in the region

2.2 Self-assessment survey

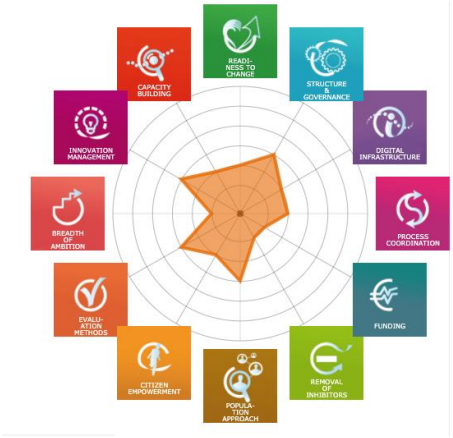
First, in the beginning of October 2019, invitation emails to participate in the maturity assessment process were issued, including the link to the online self-assessment tool and a date for a local workshop at the end of November 2019. However, this approach was only partially successful due to a lack of interest and/or time constraints. Another reason was also the lack of instructions on how to complete the survey, hence 2-page instructions (translated into German) were provided. As a result, the consensus-building workshop was postponed to the end of January 2020. Six people filled the online questionnaire prior to the workshop. Other stakeholders were offered the opportunity to complete the assessment survey on the day of the workshop.

2.2.1 Outcomes of self-assessment survey

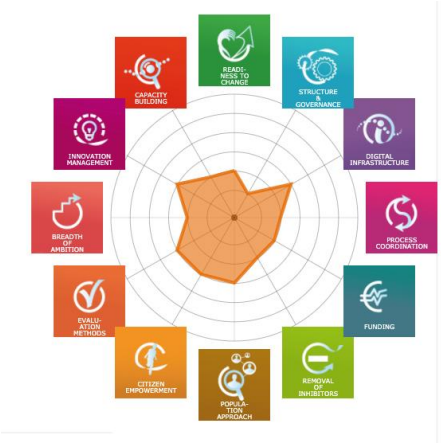
6 stakeholders filled in the survey and 5 of them successfully shared their assessments and provided justifications (features) of their ratings. The following spider diagrams reflect the diversity of the stakeholders' perceptions on the maturity of the GWMK for integrated care.

Figure 1- Outcomes of the individual self-assessments

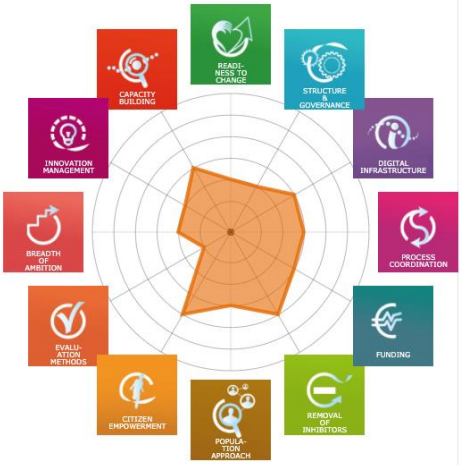
1. Branch Manager, GMWK



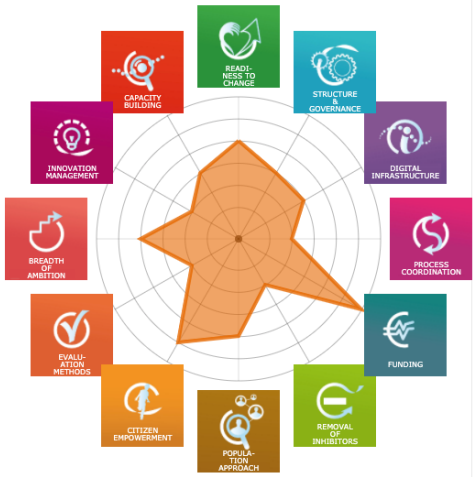
2. Healthcare Manager, GMWK



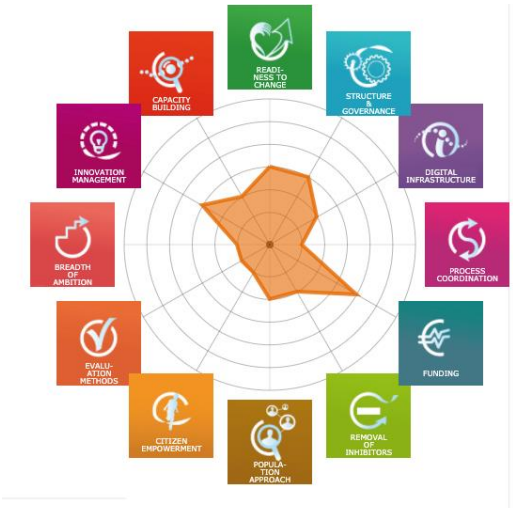
3. Team lead for care services of BKK Werra Meißner



4. Pharmacists



5. Manager of Health Insurance



2.3 Stakeholder workshop

The stakeholder workshop was organised on 24 January 2020 and 13 stakeholders made a commitment to participating in the workshop. In the end, 9 stakeholders participated at the meeting (Table 2).

Table 2: List of stakeholders participating in the consensus-building workshop

Self-employed	1x Nutritionist
Pharmacy	1x Pharmacist
Fitness studio	1x CEO
Medical supply store (Sanitätshaus)	1x Manager Care Management
Health insurance	(BKK Werra Meißner): 1x Team lead (care services: Remedies and aids) (online survey)
Therapy	1x Physiotherapist + Osteopathist
Association for mental health / Psychiatry	1x CEO
Physicians	1x GP + Internist (online survey), 1x GP + chairman regional physician network
Care	1x Care Consultant

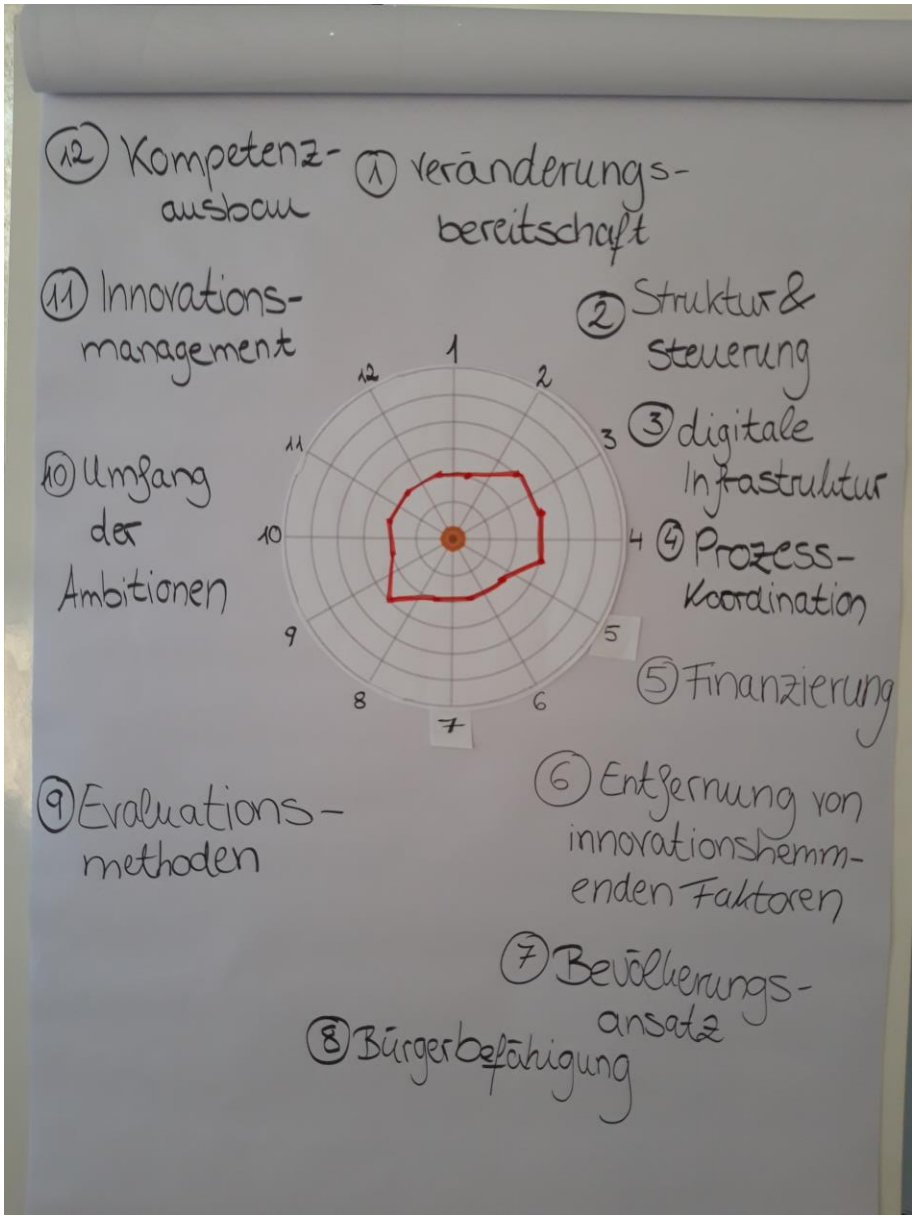
As mentioned in section 2.2 above, there was a mixture of responses; some assessments were done online previously and some stakeholders provided their individual assessments on paper on the day of the workshop (Table 3).

Table 3: Individual assessments grouped by profession

Assessment	Profession	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
1 Workshop, 1 online	Pharmacyists (2)	2 & 3	0 & 0	1 & 2	1 & 1	1 & 5	1 & 1	1 & 3	2 & 4	0 & 1	1 & 3	0 & 1	0 & 2
2 Workshop, 1 online	General practitioner (2)	2 & 2	2 & 2	1 & 2	1 & 3	1 & 1	1 & 1	0 & 2	1 & 4	1 & 1	0 & 0	0 & 2	1 & 2
Workshop	Physiotherapist	3	2	1	1	1	0	0	3	0	1	1	1
Workshop	Nutritionist	1	2	1	4	1	1	2	1	2	1	1	0
Workshop	Manager Psychiatry	2	2	1	1	1	0	0	1	0	0	0	0
Workshop & online	Manager Health insurance	2	2	2	2	3	1	1	3	1	2	1	2
Workshop	Manager (old age) Care	1	1	0	1	1	1	1	1	1	1	0	1
Workshop	Manager fitness studio	2	1	1	1	1	1	/	1	/	1	1	/
Online	Health Care Manager (GWMK)	1	0	2	1	1	1	2	2	2	1	2	1
Online	Health Care (Branch Manager) (GWMK)	1	2	1	1	0	0	2	1	2	0	2	1

2.3.1 Negotiation and consensus building

The participants started the workshop by filling out the assessment and taking notes on a separate sheet. After everyone filled out the questionnaire, the results were collected by a show of hands and summarised on paper. These outcomes were then inputted into the SCIROCCO Exchange online self-assessment tool.



In general, the health insurance manager gave the highest maturity scorings while the manager for ambulatory psychiatric patients gave the overall lowest scores for the two dimensions that had the highest variances; Q4 – Process Coordination and Q8 – Citizen Empowerment. However, in the end, they did not heavily influence the overall groups' consensus score.

During the workshop,the physician leading a regional physician network became the informal discussion lead. Since she is very involved in the building of integrated health care processes for her practice, she offered a lot of insight and brought some arguments that other participants could elaborate on.

2.3.2 Final consensus

The spider diagram and the Table below illustrates the outcomes of the final consensus on the maturity for integrated care in Gesunder Werra-Meißner-Kreis GmbH.

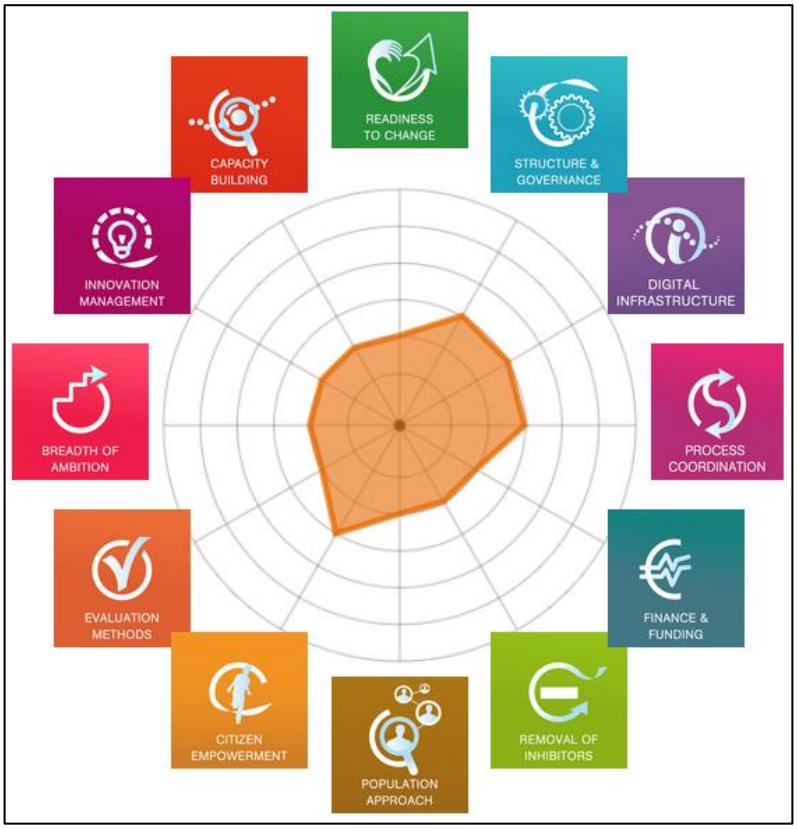


Figure 2: Final spider diagram

Dimension	Scoring	Justifications & Reflections
Readiness to Change	1	Lots of professionals see the need to change, however, there is a lack of political will to fundamentally change the existing structures. Ideas and vision on integrated care are present, but requirements necessary for the implementation of change are unclear, and an overarching concept is missing.
Structure & Governance	2	Health care professionals are interested in working across the professions and disciplines; however, the existing structure does not support this collaborative working. Structure and governance should be put in the hands of physicians. Two physician networks in region are working internally and are not willing to structurally open up to outside professions
Digital Infrastructure	2	Broadband internet connection in Werra-Meißner-Kreis is only in deployment. County and local cities should support broadband installation. There exists a standardised hard- or software to connect ambulatory and stationary care as well as other parts in one closed information system.
Process Coordination	2	Individual professions possess good guidelines, however, there is no standardisation of guidelines between professions.

Dimension	Scoring	Justifications & Reflections
Funding	1	There is a lack of dedicated funding for integrated care; and mostly only for the pilot projects.
Removal of inhibitors	1	Cultural change needs to happen to redefine health as more than the ability to earn money for physicians; holistic patient centered care with a focus on prevention is needed. Lack of political support, dedicated funding and weak digital infrastructure are perceived as major inhibitors.
Population Approach	1	Risk groups exist in theoretical concepts; they are not used to develop professions' overarching regional care concepts.
Citizen Empowerment	2	Age-based demographic problems: unwillingness to deal with the internet where most of health information can be accessed (e.g. Dr. Google, health portals, gesundheitsinformationen.de). People are very subjective of what constitutes a healthy lifestyle. Health insurances offer online courses for empowerment. Finally, there is no structured and easy access to health data.
Evaluation Methods	1	This dimension was not discussed as individual assessments were quite consistent.
Breadth of Ambition	1	This dimension was not discussed as individual assessments were quite consistent.
Innovation Management	1	This dimension was not discussed as individual assessments were quite consistent.
Capacity Building	1	Capacity building is not incentivised (money for time); professionals are on their own to develop themselves.

3 Analysis of the outcomes

In general, the outcomes of the maturity assessment process reflect the actual situation in the region. However, dimension Q3 – Digital infrastructure scored quite high compared to the reality. There is no integrated digital platform allowing the flow of information between different professions and health care areas.

There are no results which would be particularly surprising. Surprising was rather the discussions held during the meeting. For example, discussion between physicians and the pharmacists; urging the pharmacists to take more action regarding medication management and the prevention of over-medication. This discussion was surprising, as the average German assumes that these professions work very close together already. On the other hand, this is a case were physicians seeking support could use digital services for the management of medication if it existed rather than relying on the human resources which are often very limited.

The dimension of Digital Infrastructure was a focal point of the discussion. It was agreed that this dimension is very much linked to other dimensions such as Q2 – Structure and Governance, Q4 – Process Coordination, Q6 Removal of Inhibitors as well as dimension Q8 – Citizen Empowerment. This lack of functional infrastructure is borne in decisions of previous

German governments who signed contracts with telecommunication providers that do not compel those provider to cover the countryside (rural areas). Based on capitalistic thinking, the digital infrastructure is strongest where most people can buy stuff online, i.e. the cities, and not where distances need to be bridged, i.e. for telemedicine in rural areas. This leads to a situation where it is not feasible for physicians to offer innovative applications for the management of patient appointments, due to too few people adopting the service. Moreover, there does not exist a single communication system where all regional health care providers could communicate with each other.

The workshop identified four dimensions with the highest score of 2. For GWMK the dimension Q8 - Citizen Empowerment is perceived as a strength, however further work is needed to increase the maturity of this dimension.

The dimension of Digital Infrastructure is the main problem and weakness of integrated health care in the region. Patients do not have their health and care information readily available, nor van be easily accessible by other health and social care professionals. In fact, data gets deleted after 7 years, when even health insurances anonymise personal data and the treating physician does not save the data individually. Moreover, neither a communication platform for patients with professionals, nor between professionals exists. Finally, even if there were digital solutions, people could not use them (i.e. running apps) since between population centres the internet connection is not strong enough to support the needs of modern health care apps (i.e. everything more than text). However, since the improvement of the internet connection is out of scope for health care professionals, we propose to focus attention on the other dimensions.

Modern Process Coordination fundamentally builds upon a reliable digital infrastructure. Now inter disciplinary working and coordination is mostly reduced to referrals. The extent of the coordination is determined by the individual health care providers. The interdisciplinary quality circle that GWMK is supporting is a first step to remedy this issue. However, there is great potential for improvement.

Finally, low citizen empowerment is also strongly connected to the lack of digital infrastructure. Access to personal health information is obstructed and good sources of health information generally unknown. For example, the German government took steps to build a repository of health information (www.gesundheitsinformationen.de) that is supposed to give all German citizens the opportunity to find scientifically researched answers to the most pressing health care needs and illnesses. However, the institute that provides the repository (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (IQWIG) does not get funding to disseminate their services to the wider German population. The IQWIG was happy to receive a request from GWMK asking for flyer/information material in order to help with the advertisement for their services. Now GWMK is in negotiation to get a technical access to the repository in order to integrate the information in the daily business and keep it automatically up to date.

As a priority, GWMK is interested to strengthen the aspects of process coordination and citizen empowerment as well as improving the digital infrastructure.

Some specific factors may have influenced the outcomes of the maturity assessment process, in particular geographical ones. The county Werra-Meißner-Kreis is divided by a mountain ("Meißner"). The northern half and southern half were independent counties till 1974. This still creates an anecdotal rift between the populations who argue who lives on the front or back of the mountain. In practice, this division is incorporated by the two existing physician networks, one north, one south of the Meißner, which do not cooperate on a broad scale.

4. Key messages

First, we observed that stakeholders in our region do not favour online questionnaires. The fundamental question needs to be asked: "Should we, just because we can?" In this sense, the digitalisation and insistence on the online use of the SCIROCCO Exchange Tool was perceived as a barrier in the maturity assessment process. Offering a face-to-face meeting (workshop) helped to motivate the selected stakeholders to fill in the assessment. As a result, we would like to recommend also using the SCIROCCO Exchange Maturity Model in a paper-based format, where more appropriate.

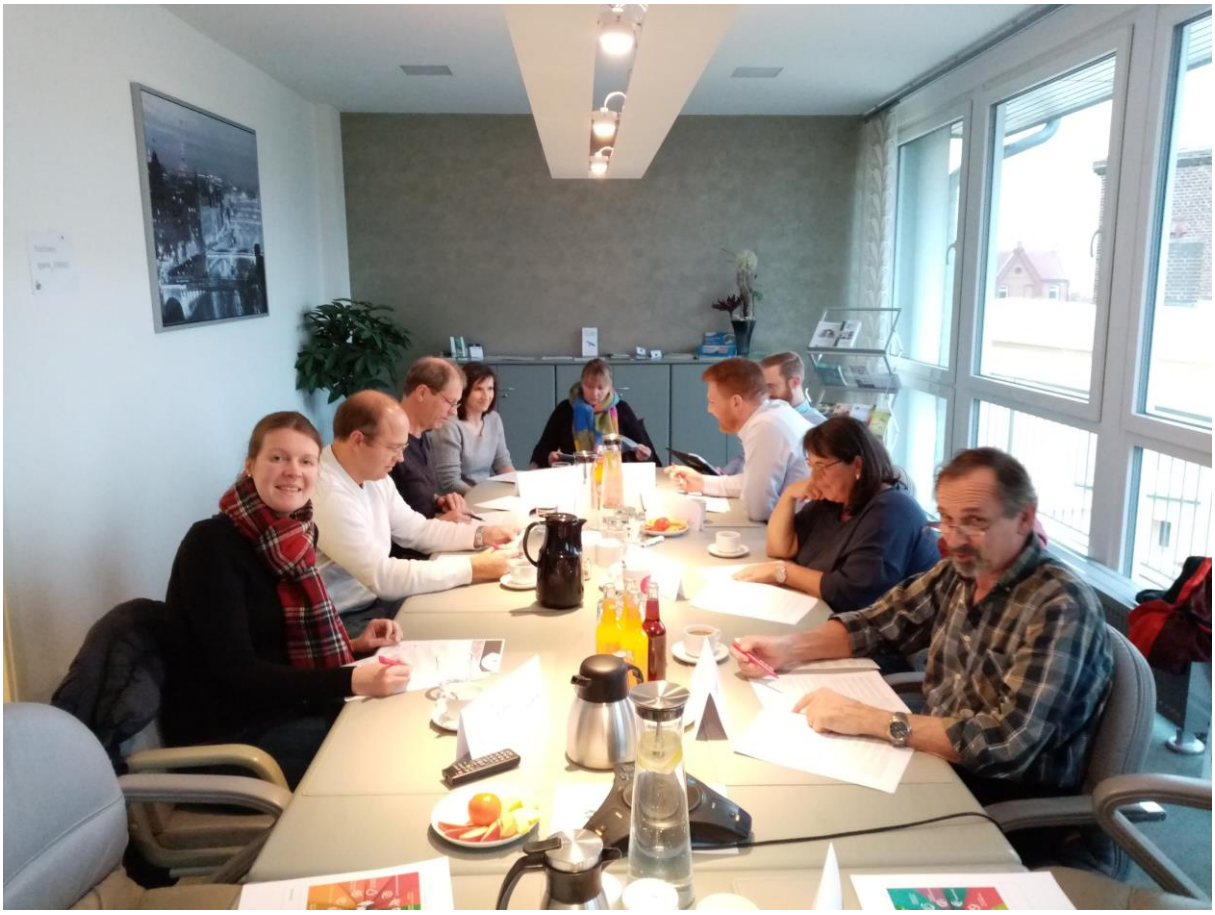
Secondly, stakeholders were often confused from which perspective they should provide the scoring e.g. if it is from a personal, professional or regional view. This needs to be emphasised more strongly in the SCIROCCO Exchange assessment methodology.

Finally, the online assessment is not easy to use, especially when there is a language barrier. This is particularly the case for healthcare professionals. To overcome this, a leaflet with instructions on how to use the SCIROCCO Exchange online self-assessment tool was created.

5. Conclusions and next steps

The assessment demonstrated that GWMK is at a low maturity level regarding the implementation of integrated care. While the overall rating is plausible and has face validity amongst participants, the majority of items are phrased in fairly generic terms and difficult to answer by healthcare professionals working on very concrete activities. In terms of next steps, we will contemplate specific improvement actions in line with our GWMK portfolio of actions in order to achieve the current maturity level.

Annex 1 Self-Assessment Workshop in Werra-Meißner-Kreis – Agenda



Agenda

24.01.2020 15:00-18:30 (left over time for interdisciplinary quality circle)

Planned time: 2,5h (Assumed time: 3h)

15 min: Welcome & Introduction

30min: Project description and individual survey

10min: Break

70min: Negotiation and consensus building

10min: Break

15min: Conclusion

Real time: 3,5h due to prolonged discussions in the negotiation and consensus building phase