Patient Centered Managed Services
International Digital Health and Care Congress

Ageing Well:
Using technology to support people as they age

King’s Fund Breakfast Workshop
Thursday 11 September 2014

Speakers:
Martin Clark, European Director, Patient Centered Managed Services, Medtronic Hospital Solutions
Amrin Singh, European Business Strategy Manager, Patient Centered Managed Services, Medtronic Hospital Solutions
Breakfast seminar agenda

Ageing well: using technology to support people as they age

**Question 1**
*What prevents people from ageing well?*

**Question 2**
*How can technology support people as they age?*
Key opinion leader quotes
There is an urgent need for radical reform of the health system

70% of the NHS England’s £110bn budget consumed by 15.4 million people with 1+ long-term condition

People with multiple long-term conditions often fall through the gaps as their secondary [hospital] care is highly specialised and their GP care highly generalised, with little continuum between the two

Martin McShane, Clinical Lead for LTC NHS England

A healthy patient costs the NHS about £288 a year, those with one long-term condition cost an estimated £783. Those with two cost £1,521 and those with three cost £2,559

Professor Andrew Street, Health Economist York University

The NHS and social care have been slow to rise to the twin challenges of an ageing population and increased prevalence of long-term conditions like diabetes. Urgent need to transform how GPs treat people with these conditions, and to support people themselves to take more control over their health

Professor Chris Ham, Chief Executive of the King’s Fund Health
Frail and elderly patients have significant challenges managing their own health

### Typical patient profile

- **Heart Failure**
- **COPD**
- **Diabetes**

#### Patient Characteristics
- Significant comorbidities
- Limited cognitive ability
- Social isolation

#### System Characteristics
- Disconnected treatment points
- Multiple care takers
- Resource limited
Navigating through the care continuum provides a snapshot of the problem

**Patient Journey through Care Continuum**

- **Patient Identification**
- **Patient Action**
- **Therapy Delivery**
- **Patient Management**

**Health System Pain Points**

- Limited Prevention
- Avoidable A&E attendance
- Access
- Delay in discharge
- Poor coordination, productivity, and access to transitional care
- Unplanned admissions from A&E
- Elective access
- High waitlist
- Lab efficiency
- High # of re-admissions (30 day)

**System-wide pain points:**

- Data coordination / communication
- Lack of incentive alignment
- Others

**Person/Patient**

- Self-diagnose. Limited Prevention

**A&E**

- Avoidable A&E attendance

**Primary Care (GP)**

- Access

**Specialist (outpatient)**

- Elective access

**Specialist (inpatient)**

- Unplanned admissions from A&E

**Community care**

- Delay in discharge

**Home**

- Lack of patient compliance to care plan
Question 2

How can technology support people as they age?
Medtronic will need to expand from our traditional position to create more value for the health system.
Cardiocom, the leading provider of telehealth, was acquired by Medtronic last year.

Cardiocom® manages over 60,000 patients at the US Department of Veteran Affairs

Patient vitals and symptom data are collected and analyzed remotely

Clinicians receive the right information, for the right patient at the right time
COPD proof of concept case study

**Headline System and Patient Outcomes**

- **24% reduction in GP appointments**
- **97% patient satisfaction**
- **62% of patients more confident to self-manage trigger symptoms**
- **94% service compliance**
**Patient journey vision: Anticipatory managed care programme**

1. **Admission & Care Delivery**
   - Patient
   - ED
   - Specialist
   - Multiple comorbidity patient
   - Vital signs checked, recorded and transmitted
   - Transferred to specialty unit
   - Notification sent to care coordinator
   - Therapy delivery
   - Care coordinator manages case

2. **Discharge Preparation**
   - Risk Score given
   - High risk score indicates need for monitored intervention
   - Care coordinator provides in-person training, materials, and follow-up arrangements

3. **Post-acute Management**
   - Home
   - Patient
   - Remote monitor, telephonic intervention, in-person follow-up [Food delivery, appointment preparation, rehab training]
   - Care coordinator continues to manage case
   - Remote monitoring
   - Delivery
   - Med compliance
   - Follow-up

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**Key Processes**

- **Medication Reconciliation**
- **Nutrition / Hydration**
- **Training / Education**
- **Appointments / Transportation**
Open floor debate

How can technology support people as they age?
Ageing Well:
“Using technology to support people as they age”

Thursday 11 September | 8:15 – 9:00am
Maynard theatre (lower ground floor)

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