



EKIV Newsletter 2/2011

edited by
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in cooperation with *Gesundes Kinzigtal* Ltd.,
AOK BW and LKK BW

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Editorial

In 2010, the third survey of *Gesundes Kinzigtal's* partner providers was conducted. The first two surveys had taken place in 2008 and 2009. In contrast to the first two surveys, the third survey included a relatively high proportion of non-physicians such as physiotherapists or representatives of nursing homes or hospitals. For this reason, the results of the third survey promise new insights into the perspectives of the various provider groups that cooperate with *Gesundes Kinzigtal Integrated Care (GKIC)*. Therefore, in this edition of our newsletter – as well as in the next two editions – we report on some of the most interesting results of those three surveys. In this edition we concentrate on results which describe the perspective of *Gesundes Kinzigtal's* partner physicians on a basic element of GKIC: the shared decision-making between physicians and their patients in general and therapy goal agreements between physicians' and their patients in particular.

On pages 11-12 we present – as always in our newsletter – current data on *Gesundes Kinzigtal Integrated Care (GKIC)* including current numbers of enrolled assureds and the number of participants in GKIC's preventive programmes, and on page 13 we analyse GKIC's membership development in 2010 in greater detail.

As always, your questions on any of our newsletter topics – as well as any kind of feedback – are welcome. We look forward to answering your email (to info@ekiv.org or ekiv@medsoz.uni-freiburg.de) soon.

With best regards,

Achim Siegel & Ulrich Stoessel

Make *Gesundes Kinzigtal Integrated Care* your research topic!

Call for evaluation projects on *Gesundes Kinzigtal Integrated Care*

Since a couple of years *Gesundes Kinzigtal Integrated Care (GKIC)* is considered to be a 'flagship project' among Germany's integrated care approaches. Therefore GKIC seems to be an excellent subject of research into health services reforms and new forms of health services. The management company *Gesundes Kinzigtal Ltd.* and its contracting partners would like health services researchers to make GKIC a field of their research. If you are interested to include GKIC into your research project, just send an email either to us (ekiv@medsoz.uni-freiburg.de) or to Helmut Hildebrandt, CEO of *Gesundes Kinzigtal Ltd.* (h.hildebrandt@optimedis.de).

Evaluation of *Gesundes Kinzigtal Integrated Care* (GKIC):

Process evaluation of *Gesundes Kinzigtal Integrated Care* from providers' perspective: results of the providers' survey in 2008-10, part I

In edition 2/2009 of our newsletter we reported selected results of the first providers' survey¹, in edition 4/2009 results of the second survey in comparison with the first survey.² The first survey had taken place in summer 2008, the second one in summer 2009. In the meantime the data of the third survey (summer 2010) have been analysed. In today's edition of our newsletter we summarise selected results of this third survey: We report results which describe the providers' perspectives on shared decision-making (SDM) in general and on therapy goal agreements between providers and (some of) their patients in particular. Further results of the third survey (as well as on all three surveys in comparison) will be the subject of the next two editions.

Topics of the third survey (T3 survey)

The evaluation project "process evaluation from providers' perspective" is led and conducted by Dr. Matthias Nübling (GEBmbH – Gesellschaft für empirische Beratung, Denzlingen). The project follows the design of a trend study or a cohort study respectively. In 2008-10 one survey was conducted each year. After that the surveys will be conducted every second year, with the next survey taking place in 2012.

Contrary to the first two surveys, in the T3 survey two different questionnaire versions were employed: one version (version A) for all office-based physicians and psychotherapists who may be elected as 'physicians (or therapists) of trust' by enrolled patients, and another version B for all remaining health care providers such as, e.g., hospital-based physicians, office-based physiotherapists, or representatives of nursing homes and mobile nursing services. The shorter questionnaire version B contained questions on the following topics:

- motivation to become a partner provider of GKIC,
- possible concerns against becoming a partner provider,
- short evaluation of *Gesundes Kinzigtal* Ltd. administration office,
- short evaluation of both cooperating health insurers AOK BW and LKK BW as well as of the physicians' network MQNK,
- knowledge of GKIC's preventive and disease management programmes,
- short evaluation of these preventive and disease management programmes,
- evaluation of several other aspects of the GKIC project,
- overall satisfaction with GKIC so far,
- expectations and wishes for the future,
- proposals and notes on any other issue of interest.

In questionnaire version A the first two of the above-mentioned questions were omitted because the overwhelming majority of office-based physicians and psychotherapists had already answered these questions in the T1 survey. Compared with version B, however, questionnaire version A contained some additional questions referring to special activities and responsibilities of a 'physician/therapist of trust', concerning the following topics:

- frequency of promoting patients to participate in GKIC preventive programmes,
- assessment of the programmes' popularity and attractiveness for patients,
- perceived functionality of (and barriers to implement) therapy goal agreements with patients,
- perceived functionality of (and barriers to implement) shared decision-making with patients.

¹ EKIV Newsletter 2/2009 (http://www.ekiv.org/pdf/EKIV-Newsletter_2-2009.pdf), p. 3-9 (in German).

² EKIV Newsletter 4/2009 (http://www.ekiv.org/de/pdf/EKIV-Newsletter_4-2009.pdf), p. 3-9 (in German).

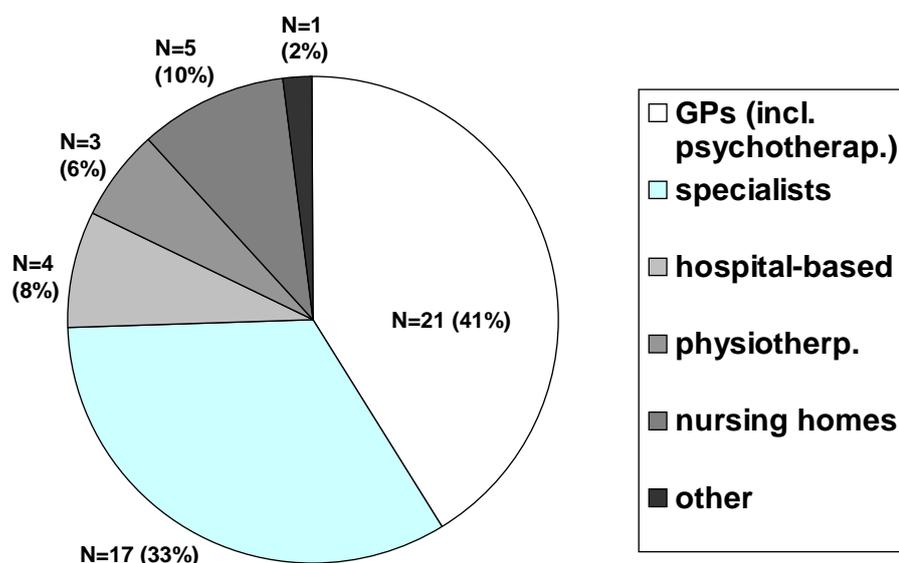
Provider participation in the T3 survey³

In June 2010, questionnaires were given to 85 providers, thereof 58 to (office-based) physicians and psychotherapists and 27 to other providers. In 2008 (T1 survey), questionnaires had been handed to 50 providers, and in 2009 to 59 providers. This testifies to the fact that since 2009 many new providers had decided to cooperate with GKIC and become a partner provider.

Out of 85 questionnaires 51 were sent back to the evaluating institute. This means a response of 60%. In the T1 survey the response had been considerably higher ($35/50 = 70\%$) whereas in the T2 survey the response had been slightly lower ($34/59 = 58\%$). 20 providers have taken part in all three surveys.

Out of 51 responders of the T3 survey, about 2/5 belong to the group of general practitioners and psychotherapists ($n=21$; 41%), 17 responders were specialists (33%). Among the remaining 13 participants were 4 hospital-based providers, 5 representatives of nursing homes, 3 physiotherapists, and 1 'other' participant (cf. fig. 1). Thus the response in the T3 survey was higher among office-based physicians including psychotherapists ($38/58 = 66\%$) than among the remaining providers ($13/27 = 48\%$).

Fig. 1: T3 survey response – number (and proportion in %) according to profession⁴



Selected results of the T3 survey: perceived functionality of and implementation barriers to shared decision-making and therapy goal agreements with patients

In the following sections we focus on those two topics on which providers' had been questioned for the first time in the T3 survey, i.e. on the functionality of (and implementation barriers to) shared decision-making and therapy goal agreements with patients. This focus seems to be very interesting because of the following reasons:

³ These results have been excerpted from the following reports: Nübling M (2008): Integrierte Versorgung Gesundes Kinzigtal, Evaluationsmodul IV, Teilprojekt 2: Prozessevaluation aus Sicht der Leistungserbringer. Bericht zur ersten Befragung der Leistungserbringer (Projektbericht, unpubl. ms., in German); Nübling M (2009): Integrierte Versorgung Gesundes Kinzigtal, Evaluationsmodul IV, Teilprojekt 2: Prozessevaluation aus Sicht der Leistungserbringer. Bericht zur zweiten Befragung der Leistungserbringer 2009 (Projektbericht, unpubl. ms., in German); Nübling M (2010): Integrierte Versorgung Gesundes Kinzigtal, Evaluationsmodul IV, Teilprojekt 2: Prozessevaluation aus Sicht der Leistungserbringer. Bericht zur dritten Befragung der Leistungserbringer (Projektbericht, unpubl. ms., in German).

⁴ Nübling 2010, S. 11.

- (1) Irrespective of an extensive research on SDM in Germany, there are hardly any representative surveys on the acceptance of SDM principles among physicians in Germany. An exception is the 'health monitor' survey conducted in 2001-05 by the Bertelsmann foundation.⁵ According to this survey, key elements of an SDM approach encountered a rather mixed response among German physicians: In the 2003 survey, e.g., about half of the respondents indicated that informed patients „put strain on my work“, whereas only 25% responded this was not the case.⁶
- (2) In 2007 GKIC organised a training session for cooperating providers, focusing the theory and practice of SDM. In 2008 three follow-up training sessions on further aspects of patient-provider-communication took place. Thus, one should expect some openness for the idea of shared decision-making among GKIC's partner physicians.
- (3) Moreover, GKIC's partner GPs have consented to commit themselves to agreements on treatment goals with their risk patients so as to improve their therapy motivation and self-management capabilities. A ‚risk patient‘ is somebody with a chronic disease or with relevant risk factors – such as smoking or obesity – for a chronic disease. Out of 7.500 insurants who have enrolled into GKIC until now, 4.900 have been categorised as risk patients.⁷
- (4) Physicians' perceptions of barriers to SDM seem to be interesting because it has turned out in another GKIC evaluation study that patient participation (as perceived by patients) has decreased significantly more among GKIC patients than in a control group in 2007-09.⁸ Obviously, it is more difficult than expected earlier to significantly involve patients in medical treatment decisions. Therefore we should be interested to learn more about physicians' perceived barriers to implement SDM elements into their consultations with patients.

Functionality of and implementation barriers to shared decision-making (SDM) as perceived by GKIC's partner physicians

In the health care reforms of the preceding decade policy-makers regularly tried to promote the principle of ‚patient orientation‘ or ‚user orientation‘: Health services should become more responsive to patient needs not merely on a macro-structural level – by e.g. integrated care projects – but also on a micro level, i.e. in the context of doctor-patient-relationships. These relationships were to be more strongly based on partnership relations instead of expert authority.⁹

In the T3 survey, physicians' perceptions on SDM were enquired by four statements to which physicians had to respond either in the affirmative („fully applies“ or „rather applies“) or negatively („does rather not apply“ or „does not apply“). An additional possibility to respond to a statement was „I cannot judge“. Fig. 2 illustrates the mean values of the four statements in question. Using the first statement as an example, we briefly explain how mean values were calculated. The first statement was: „It is in principle sensible to have patients participate in medical treatment decisions“ (fig. 2, first column). Of 38 respondents, 5 did not judge this statement („cannot judge“). These 5 responses were not considered when the mean value was calculated. Out of the remaining 33 respondents, 24 „fully“ agreed whereas the remaining 9 „rather“ agreed with the statement. None of the respondents answered negatively. The high mean value of 91 results from the following calculation rule: a numerical value of 100 was attributed to the answer „fully applies“, a value of 67 was attributed to the answer „rather applies“ (and so on). Thus, a mean value of 91 results which means that the big majority of respondents agree more or less with the key idea of SDM.

⁵ Bertelsmann foundation: Shared Decision Making: Konzept, Voraussetzungen und politische Implikationen. Chartbook, p. 26/27. (http://www.bertelsmann-stiftung.de/cps/rde/xbcr/SID-6983A97E-D21EA41A/bst/SDM%20chartbook_final.pdf.)

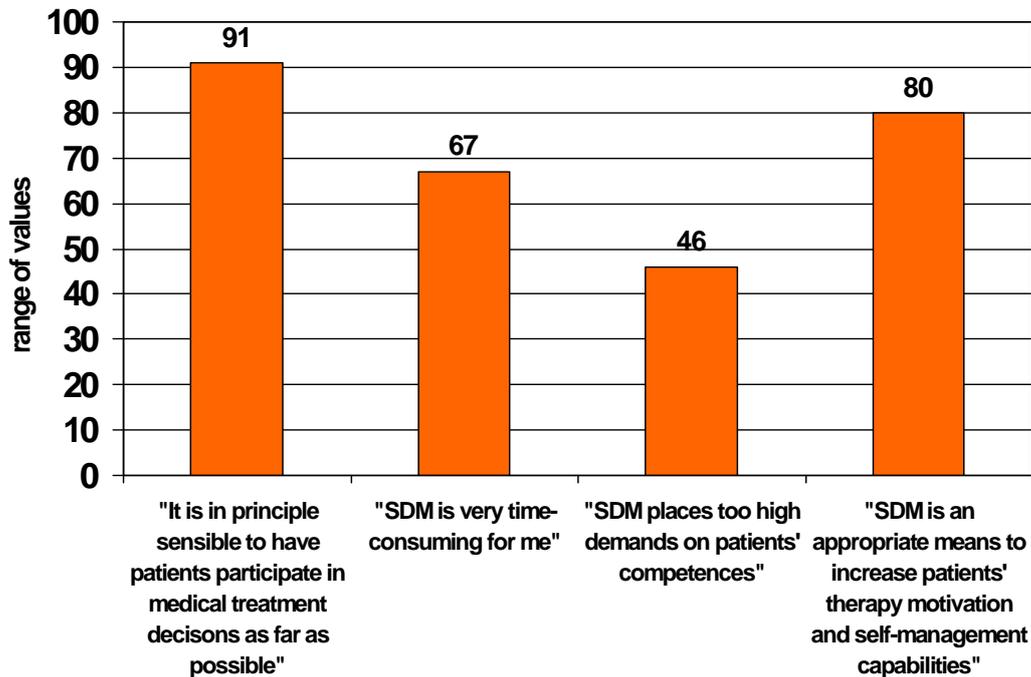
⁶ Ibid., p. 27.

⁷ Cf. our current data on GKIC on p. 13.

⁸ Cf. EKIV Newsletter 1/2011, p. 4-7 (http://www.ekiv.org/pdf/EKIV-Newsletter_2011-1_English-version.pdf).

⁹ Cf. the reports of the German ‚Advisory Council on the Assessment of Developments in the Health Care System‘ 2000/2001 and 2003 (summaries in English can be downloaded from <http://www.svr-gesundheit.de/Startseite/Startseite.htm>).

Fig. 2: Functionality of (and implementation barriers to) SDM, as perceived by physicians (range of values: 100 „fully applies“, 67 „rather applies“, 33 „does rather not apply“, 0 „does not apply“)



The next two statements illustrated in fig. 2 focus possible barriers to implement SDM (second and third column in fig. 2). With respect to both statements, 9 respondents abstained from a valid answer. 21 out of 29 respondents indicated that SDM was „very time-consuming“ – however, 8 respondents contradicted this statement (“does not apply”/“does rather not apply”). Thus, a mean of value of 67 resulted. Only 13 out of 29 respondents thought that SDM placed too high demands on patients’ competences, with 16 respondents explicitly contradicting (mean value: 46). The optimistic statement that “SDM is an appropriate means to increase patients’ therapy motivation and self-management capabilities”, was explicitly agreed to by an overwhelming majority of 29 respondents; only one respondent contradicted while the remaining 8 respondents abstained.

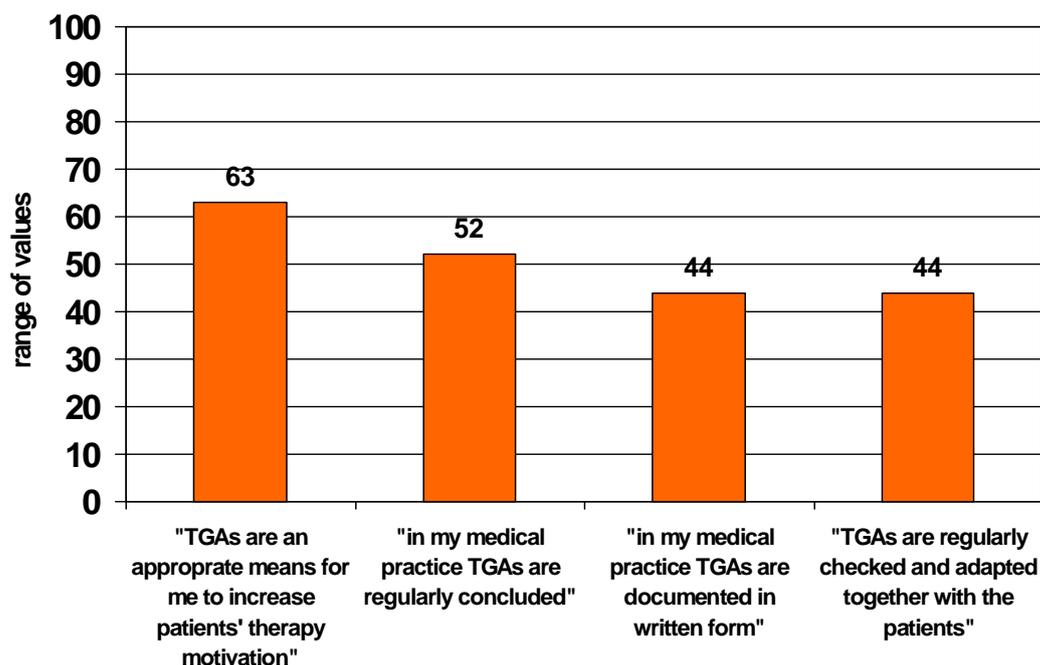
To sum up: Obviously, most physicians cooperating with GKIC agree that SDM is basically a good idea. However, the majority of respondents indicate that SDM is very time-consuming for them, and a considerable minority thinks that SDM places too high demands on patients’ competences.

The relevance of treatment goal agreements with patients from physicians’ point of view

Treatment goal agreements (TGAs) between physicians and their patients are considered an important element of SDM. As to the relevance of TGAs, the responding physicians (and psychotherapists) had to give their opinion to seven statements, either in the affirmative („fully applies“ or „applies“) or negating the statement („does not apply“ or “does rather not apply“). The respondents’ answers to these seven statements are summarised in form of mean values in fig. 3a and 3b. (Respondents who did not judge were disregarded when calculating mean values.)

The first statement illustrated in fig. 3a reads: „TGAs are an appropriate means for me to increase patients’ therapy motivation“. Only 25 out of 38 respondents gave valid answers, 13 abstained. (These 13 respondents were not considered when the resulting mean value of 63 was calculated.) A mean value of 63 means, then, that the dominating answer to the statement in question is represented by “rather applies”.

Fig. 3a: The relevance of treatment goal agreements (TGAs) as perceived by physicians, I (values: 100 „fully applies“, 67 „rather applies“, 33 „does rather not apply“, 0 „does not apply“)

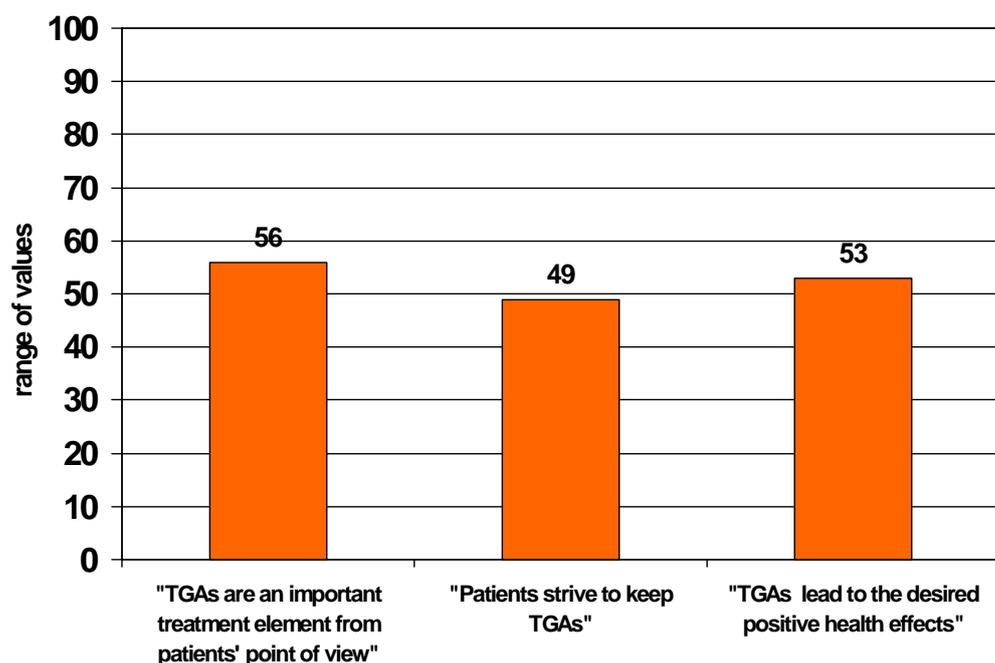


If we consider the mean value (63) only, the result seems quite positive. Two things, however, should be kept in mind: Out of 25 respondents who really judged the statement in question, 8 (i.e. 32%) explicitly declined the statement ("does not apply" or "does rather not apply"). Moreover, the number of physicians who did not judge the statement (n=13) seems rather high. This means that altogether slightly less than half of all respondents (n=17) are convinced that TGAs are an appropriate means to increase patients' therapy motivation.

The three remaining statements illustrated in fig. 3a, however, received a higher proportion of valid answers: Only 8 respondents did not judge these three statements. Nevertheless the results seem to be mixed. 16 respondents regularly conclude TGAs with their patients („applies“ or „fully applies“) so that a mean value of 52 results, and 13 respondents indicated that in their medical practice TGAs were documented in written form (mean value: 44). The same mean value results with respect to whether TGAs are regularly checked and adapted together with the patients, with 14 respondents giving an explicitly positive answer ("applies" or "fully applies").

The results documented in fig. 3b, too, reflect rather mixed results. When judging the statement "TGAs are an important treatment element from patients' point of view" (first column in fig. 3b), 13 respondents abstained. Out of the remaining 25 respondents 14 answered in the affirmative and 11 negated the statement so that a mean value of 56 resulted. Slightly more reserved were the respondents with respect to the statement "Patients strive to keep TGAs" (second column in fig. 3b): 11 respondents answered in the affirmative, 12 negated and 15 did not judge the statement (mean value: 49). A similar tendency may be seen with respect to the statement „TGAs lead to the desired positive health effects“ in patients (third column in fig. 3b): 11 physicians responded in the affirmative, 11 negated the statement, and 16 respondents abstained (mean value: 53).

Fig. 3b: The relevance of treatment goal agreements (TGAs) as perceived by physicians, II (values: 100 „fully applies“, 67 „rather applies“, 33 „does rather not apply“, 0 „does not apply“)



With respect to TGAs we might interpret our results as follows. A considerable proportion of respondents abstained from judging substantial statements on TGAs. If we interpret this as an abstention because respondents (presumably) lack any substantial experience with TGAs in clinical practice, then the results mean that slightly less than half of all respondents are convinced that TGAs are feasible in clinical practice and lead to the desired results.

Summary and preliminary conclusion

The third survey of GKIC's partner providers contained – for the first time – questions on the relevance of shared decision-making (SDM) and treatment goal agreements (TGAs) with patients. It turned out that a majority of (office-based) physicians and psychotherapists agree with the key ideas of SDM. This positive attitude is certainly an important – if not *the crucial* – precondition for an effective implementation of SDM strategies in clinical practice. The majority of physicians hold however that SDM is very time-consuming – this is the most commonly mentioned barrier to implementing SDM strategies. Fewer physicians mention a lack of competence in patients as an additional barrier.

As to these barriers, our results confirm – in rough terms – the results of other (mainly international) studies: According to a systematic review on barriers and facilitators of SDM from clinicians' point of view¹⁰ in which 38 (mostly qualitative) studies were analysed, the heightened expenditure of consultation time was by far the most common barrier. In this context it is of utmost interest whether this point of view – that SDM is inherently very time-consuming – is confirmed by the latest research. Until now it is, however, far from certain that SDM implies a higher expenditure of consultation time than 'normal care'¹¹: According to one study, consultation time increased in the SDM

¹⁰ Légaré F, Ratté S, Grave K & Graham ID (2008): Barriers and facilitators to implementing shared decision-making in clinical practice: Update of a systematic review of health professionals' perceptions. In: Patient Education and Counseling 73: 526-535.

¹¹ Cf. Simon D & Härter M (2010): Patientenorientierung bei medizinischen Entscheidungen im Krankenhaus. In: Hoefert H-W & Härter M (Hrsg.): Patientenorientierung im Krankenhaus. Göttingen usw.: Hogrefe: 229-244.

intervention group.¹² According to some other studies, however, it did not.¹³ Thus it is far from certain that there is an inherent tendency in SDM interventions to increase consultation time.

For *Gesundes Kinzigtal Integrated Care* (GKIC), treatment goal agreements (TGAs) between physicians and their so-called risk patients embody the idea of SDM in clinical practice. Thus we were interested how many physicians (and psychotherapists) indicated to have employed TGAs in their own medical practice. Here we got mixed results: The majority of responding clinicians agree with the idea that TGAs are “an appropriate means to increase patients’ therapy motivation”. However, a considerable minority contradicts this statement. Furthermore, a relatively high proportion of respondents abstain from judging this statement. Thus, 17 out of 38 respondents explicitly affirm that TGAs are an appropriate means to increase patients’ therapy motivation. Consequentially, not more than 16 physicians respond that they regularly conclude TGAs with patients, and only 14 respondents indicate that TGAs are regularly checked and adapted together with the concerned patients. We should however keep in mind that the tendency to give an affirmative answer is more pronounced in general practitioners and psychotherapists compared with specialists. This might indicate that patients’ ‘doctors of trust’ – i. e. their primary contact persons in the professional health sector – practise TGAs to a higher degree than the above-mentioned mean values indicate (due to the fact that the ‘doctors of trust’ are mostly GPs and not specialists).¹⁴

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¹² Cf. Whelan T, Sawka C, Lewine M, Gafni A, Reyno L, Whyllan A et al. (2003): Helping patients make informed choices: A randomized trial of a decision aid for adjuvant chemotherapy in lymph node-negative breast cancer. In: *Journal of the National Cancer Institute* 95 (3): 581-587.

¹³ Cf. Loh A, Simon D, Wills C, Kriston L, Niebling W & Härter M (2006): The effects of a shared decision making intervention in primary care of depression: A cluster-randomized controlled trial. In: *Patient Education and Counseling* 67: 324-332, as well as Hamann J, Langer B, Wikler V, Busch R, Cohen R, Leucht S & Kissling W (2006): Shared decision making for in-patients with schizophrenia. In: *Acta Psychiatrica Scandinavica* 114: 265-273.

¹⁴ If we consider only the answers of GPs and psychotherapists (instead of all physicians including specialists), the following mean values would result in fig. 3a and 3b: (1) regularly concluded TGAs with patients: 56 (instead of 52); (2) TGAs documented in written form: 53 (instead of 44); (3) TGAs regularly checked and adapted together with patients: 49 (instead of 44).

Current data on *Gesundes Kinzigtal Integrated Care* (as of August 9, 2011)

Number of actively enrolled insurants	7.612 *
- thereof AOK BW insurants	7.184*
- thereof LKK BW insurants	428*

* Enrolled members who have deceased, changed residence to outside the Kinzigtal region or resigned because of other reasons (AOK: n=711, LKK: n=35) are not considered in this list.

Number of patients with higher morbidity risk	4.927
- thereof AOK BW insurants	4.607
- thereof LKK BW insurants	322

GKIC preventive programmes and extended national disease management programmes (DMPs)	no. of participants
AGil (Active health promotion in the elderly)	511
Smoking cessation programme ("Rauchfreies Kinzigtal")	163
Prevention/treatment of congestive heart failure (CHF)	73
Lifestyle intervention for patients with metabolic syndrome	159
Prevention of osteoporosis and osteoporotic fractures	633
Early intervention by psychotherapists in cases of acute personal crises	229
Electronic health card („Gesundheitspass“)	761
Specific medical care for the elderly in nursing homes	90
Social service (case management by social workers according to physicians' recommendation)	122
Diet counselling by AOK BW	64
Specific fall prophylaxis for the elderly	93
Sponsored membership in sports clubs	139
Individually blistered drug packages („Medifalter“)	104
„Better tuned“ – a programme for people with depression	20
Ophthalmological check-up for children (amblyopia, U10 + U11)	427
Lecture series on health issues (no. of participants since 2009:)	1.948
DMP diabetes mellitus type II	898
DMP coronary heart disease	294
DMP breast cancer	15
DMP asthma	115
DMP COPD	170

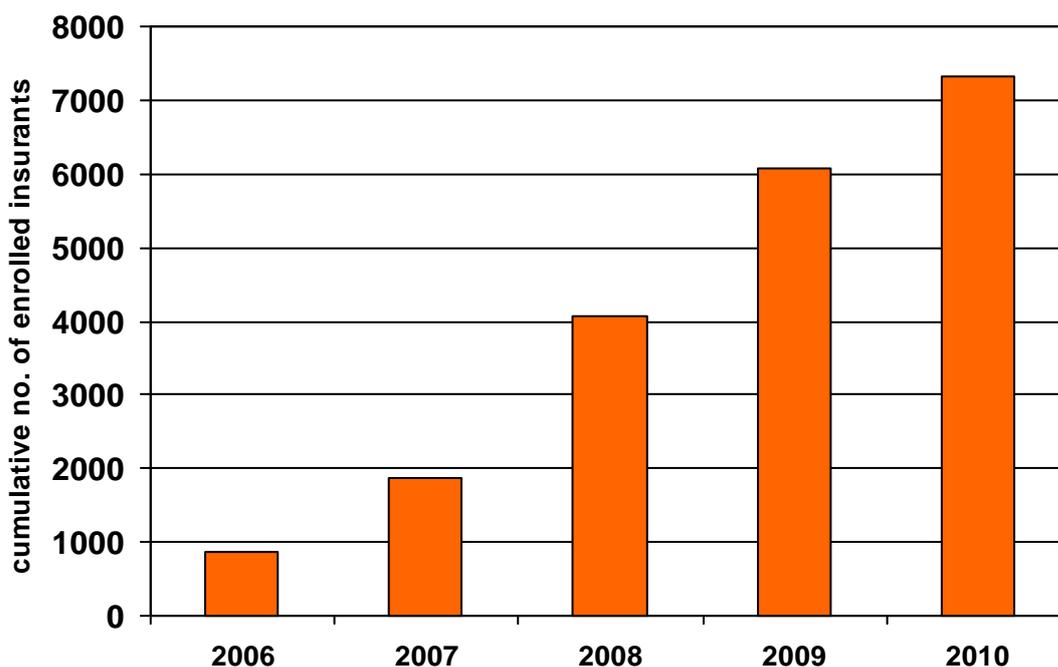
(continued on the following page)

Physicians and other providers contracting with GKIC	82
- family physicians	22
- specialists	22
- pediatricians	5
- psychotherapists	4
- hospitals	6
- physiotherapists	7
- nursing homes	11
- outpatient nursing services	4
- social-therapeutic services	1
Other partners cooperating with GKIC	46
- pharmacies	16
- sports clubs	24
- fitness centres	6

Development of *Gesundes Kinzigtal Integrated Care's* Membership in 2010

In 2010, too, the number of GKIC members (insurants who have enrolled into GKIC) has increased, as is illustrated by fig. 4: On December 31, 2009, 6.064 GKIC insurants had enrolled into GKIC. One year later – at the end of 2010 – 7.311 people were members of GKIC. This means an increase by 1247 people or 20.6%. Although the pace of growth has decreased a little – compared to the two preceding years 2009 and 2008 –, the management company *Gesundes Kinzigtal Ltd.* and its contracting partners may be glad about a continued two-digit growth.

Fig. 4: Number of GKIC members (cumulative number of enrolled insurants¹⁵) according to year



The year 2010 brought about a slight shift as to the socio-demographic structure of GKIC's membership: In 2010, young people and men enrolled more frequently into GKIC than before. Thus, the proportion of members whose age does not exceed 19 years has increased from 28.6% (December 31, 2009) to 33.3% at the end of 2010. Similarly, the proportion of men rose from 45.6% (December 31, 2009) to 46.1% at the end of 2010.

More information on organisational features and the development of GKIC can be found in GKIC's annual report 2010. The report can be downloaded from the following address:

http://gesund-es-kinzigtal.de/images/stories/Bilder/Download/gk_jahresbericht_2010_web.pdf.

¹⁵ The numbers of enrolled GKIC members which are presented in fig. 1 are „net numbers“, i.e. members who have deceased over the course of the year or changed residence to outside of the Kinzigtal region or resigned membership because of other reasons are not considered here.