



KØBENHAVNS KOMMUNE

FORTEGNELSE OVER ORIENTERINGMATERIALE til medlemmerne af Sundheds- og Omsorgsudvalget

Materiale omdelt til udvalget på mødet den 26. april 2012

- Embedsmandsdeltagelse den 26. april 2012
- Materiale vedrørende studieturen til USA herunder slides m.v.
- Kommende sager til Sundheds- og Omsorgsudvalget

Fremlagt i mødelokalet

- Bladet 'Ledsager' – april 2012 – udgivet af Gigtforeningen



Embedsmandsdeltagelse til det ordinære møde i Sundheds- og Omsorgsudvalget den 26. april 2012

Direktionen:

Administrerende direktør Lene Sillasen
Direktør Hanne Baastrup
Direktør Anne Mette Fugleholm

Center for Politik og Ledelse

Sekretariatschef Jesper Olsen
Udvalgssekretær Yvette Kovács

Punkt 2: 2. Behandling af Budget 2013

Økonomichef Carsten Riis og chefkonsulent Martin Dylewski

Punkt 3: Forventet regnskab 2012 pr. 31. marts 2012 – 1. kvartal

Økonomichef Carsten Riis, chefkonsulent Martin Dylewski og specialkonsulent Elsa Bjørnsen

Punkt 4: Bevillingsmæssige ændringer 2012

Økonomichef Carsten Riis, chefkonsulent Martin Dylewski og specialkonsulent Elsa Bjørnsen

Punkt 5: Årsrapport 2011

Strategi- og analysechef Thomas Karlsson og chefkonsulent Mie Nibsbjerg Holm

Punkt 6: Brugerundersøgelser på ældre- og sundhedsområdet 2011

Strategi- og analysechef Thomas Karlsson, ældrechef Margrethe Kusk Pedersen og chefkonsulent Kristian Lysholt Mathiasen

Punkt 7: Afprøvning af servicebeviser på madserviceområdet

Ældrechef Margrethe Kusk Pedersen og leder af kostsekretariatet Pernille Hansted

Punkt 8: Mad- og måltidspolitik

Ældrechef Margrethe Kusk Pedersen og leder af kostsekretariatet Pernille Hansted

Punkt 9: Hverdagsdemokrati på plejehjem

Ældrechef Margrethe Kusk Pedersen

Punkt 10: Orientering om Ældrekommissionens rapport

Ældrechef Margrethe Kusk Pedersen og konsulent Eva Algreen-Petersen

Punkt 11: Høring af Københavns Kommunes boligplan for borgere med handicap, sindslidelse og udsatte borgere

Leder af boligsekretariatet Per Christensen

Punkt 12: Høring af Københavns Kommunes restaurationsplan
Programleder Bjarne Rasmussen

Punkt 13: Redegørelse for inklusionsindsatsen
Programleder Bjarne Rasmussen

Punkt 14: Boligsociale helhedsplaner på Nørrebro
Programleder Bjarne Rasmussen

Punkt 15: Boligsociale helhedsplaner i Tingbjerg- Brønshøj/Husum
Programleder Bjarne Rasmussen

Punkt 16: Boligsociale helhedsplaner på Amager
Programleder Bjarne Rasmussen



25-04-2012

Sundheds- og Omsorgsudvalgets studietur til Silicon Valley

Som første opfølgning på studieturen til Silicon Valley vedlægges slide fra følgende fem oplæg under studieturen:

Bilag 1: Dr. Pompei, Clinical Professor, Medicine, Stanford University, E-mail: pompei@stanford.edu

Bilag 2: Karen E. Routt, direktør, Magnolia Prime, E-mail: karen@magnoliaprime.com

Bilag 3: Preben Brandenhoff, læge i Californien.
E-mail: transplant@brandenhoff.dk

Bilag 4: Hanwei Li, James H. Clark Center, Bio-X
E-mail: Lhanwei1@stanford.edu

Bilag 5: Steven DeMello, direktør CITRIS, U.C. Berkeley.
E-mail: sdemello@citris-uc.org

De resterende slides fra oplæg under studieturen forventes at kunne vedlægges i forbindelse med Sundheds- og Omsorgsudvalget møde den 24. maj 2012.

Det drejer sig om følgende oplæg:

Oplæg v. Dr. Laurence Baker, Professor of Health Research and Policy and CHP, Stanford University. E-mail: laurence.baker@stanford.edu

Oplæg v. Martin Frid-Nielsen, direktør for SoonR.
E-mail: martin@soonr.com

Yderligere drøftelser som opfølgning på studieturen kan ske i forbindelse med følgende møder:

Sundheds- og Omsorgsudvalgmødet den 24. maj 2012
"Opfølgning på Studietur til Silicon Valley"

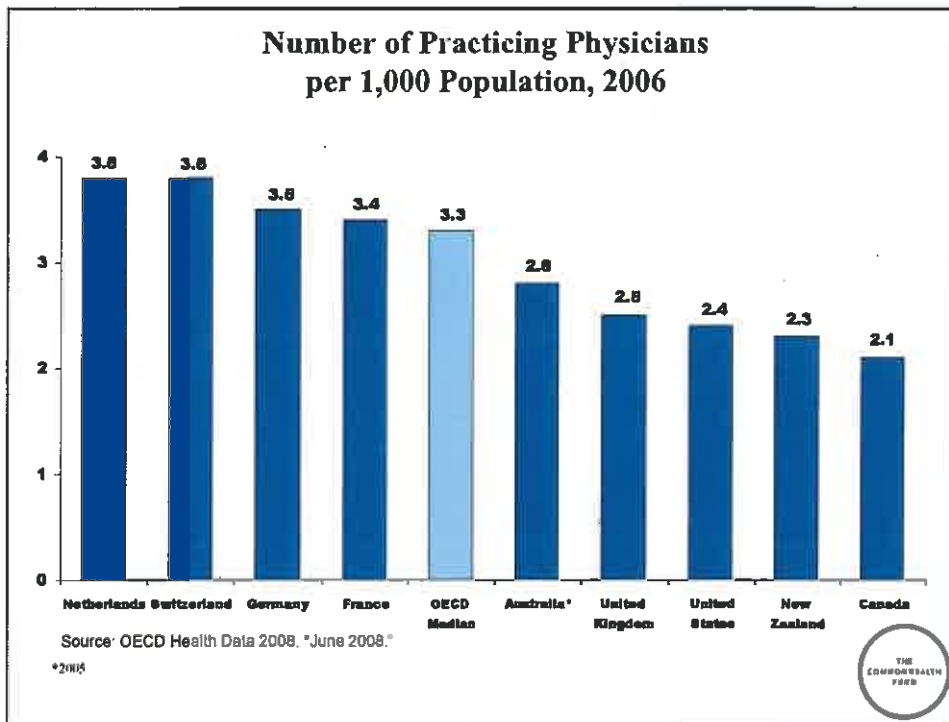
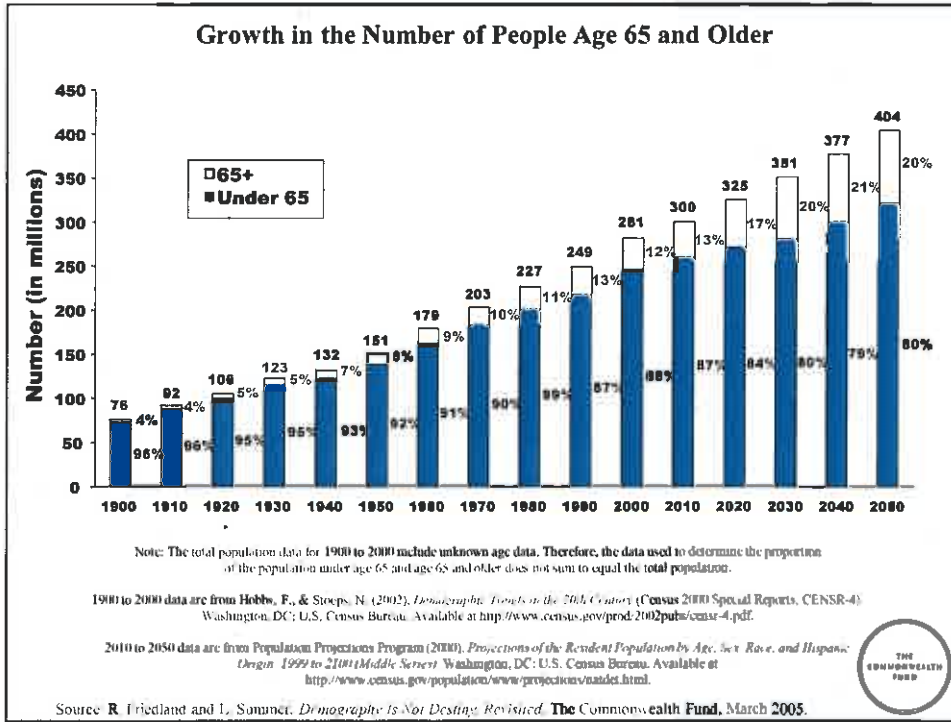
Sundheds- og Omsorgsudvalgmødet den 24. maj 2012
"Temadrøftelse om frivillighed og brobygning mellem forvaltningens tilbud og frivillige"

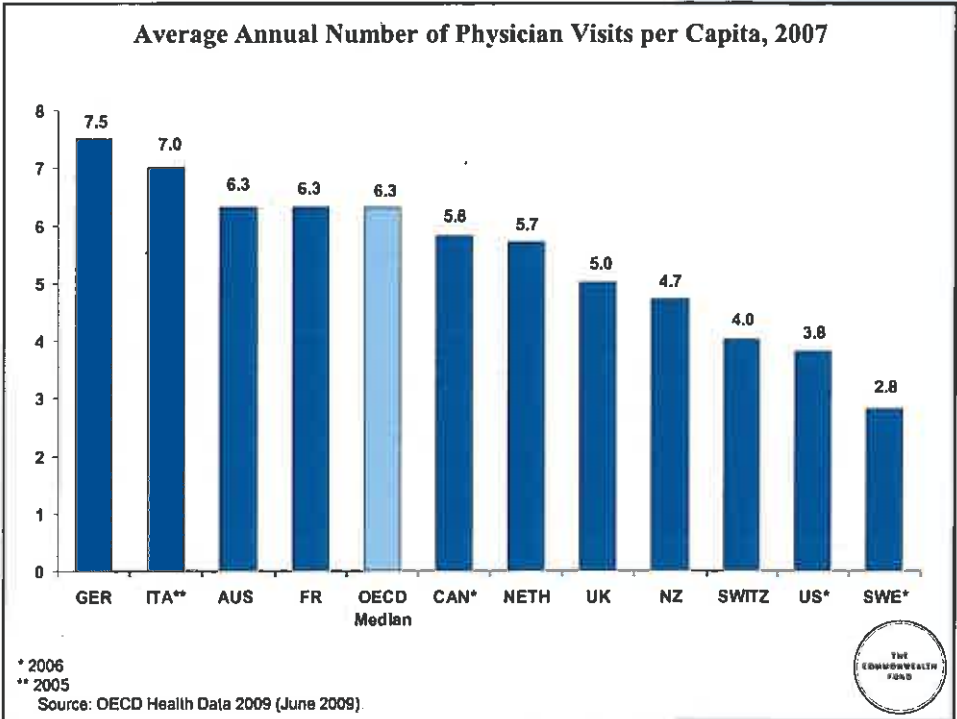
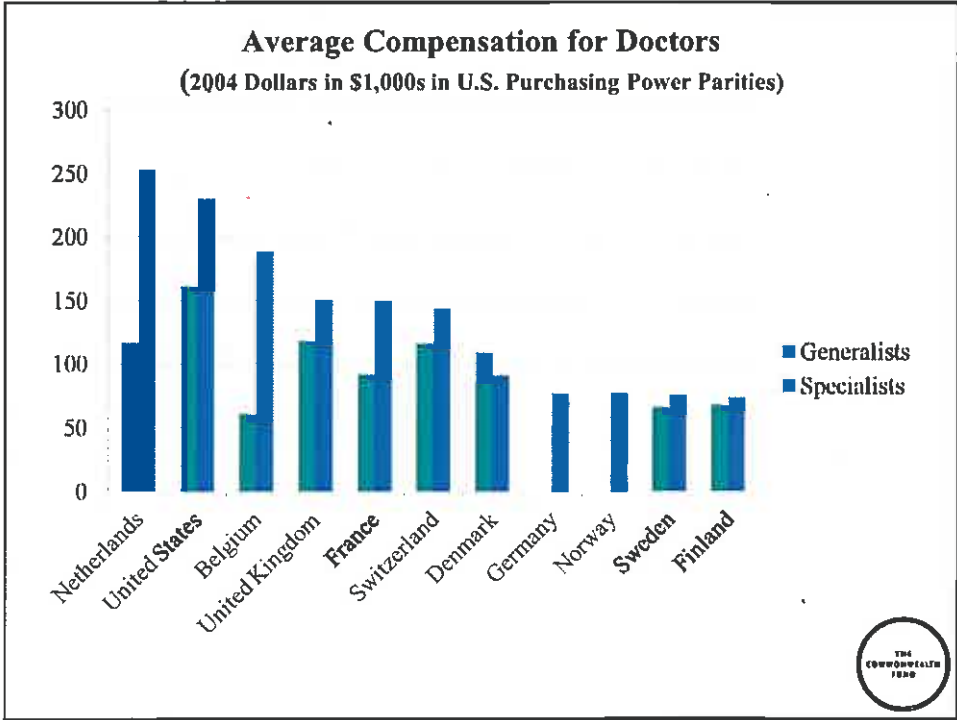
Sundheds- og Omsorgsudvalgets møde den 16. august 2012
"Temadrøftelse om forskning"

Sagsnr.
2011-107523

Dokumentnr.
2012-328220

Sagsbehandler
Pernille Holst





Length of Time with Regular Doctor or Place

Base: Adults with any chronic condition

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Has regular doctor or place of care	96	97	99	99	100	98	99	91
With regular doctor or place for five years or more*	58	64	75	79	79	61	73	49

* Base includes those with and without a regular doctor or place of care.

Data collection: Harris Interactive, Inc.

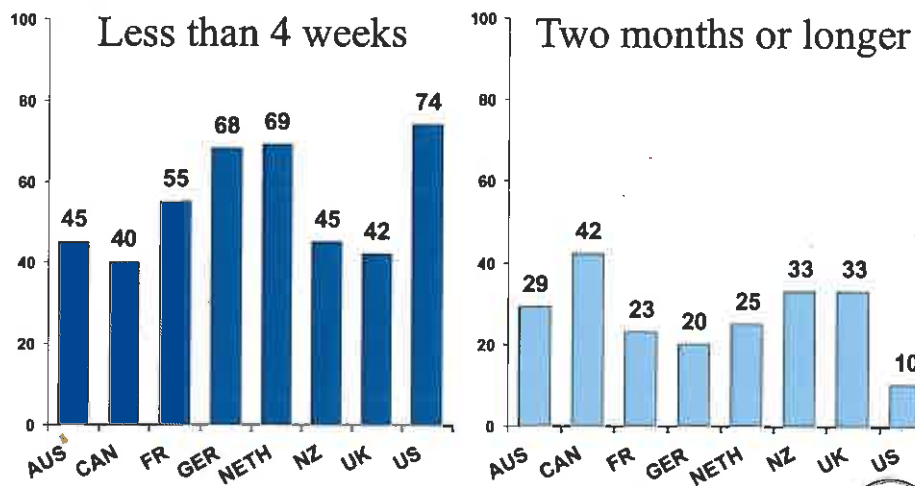
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.



Wait Time for Specialist Appointment

Base: Adults with any chronic condition who needed to see a specialist in past 2 years

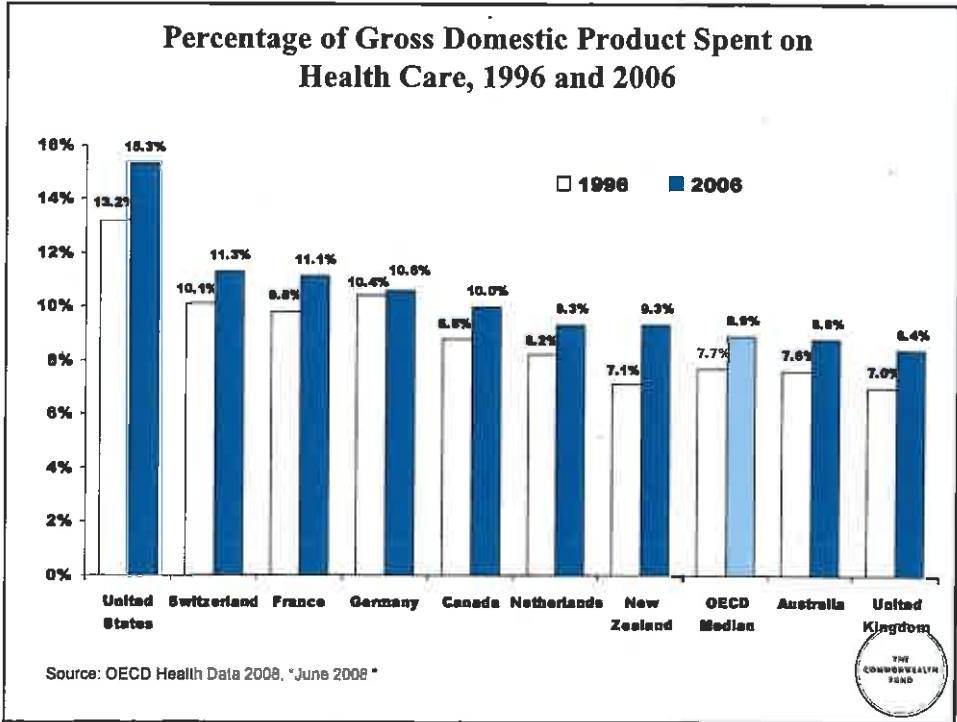
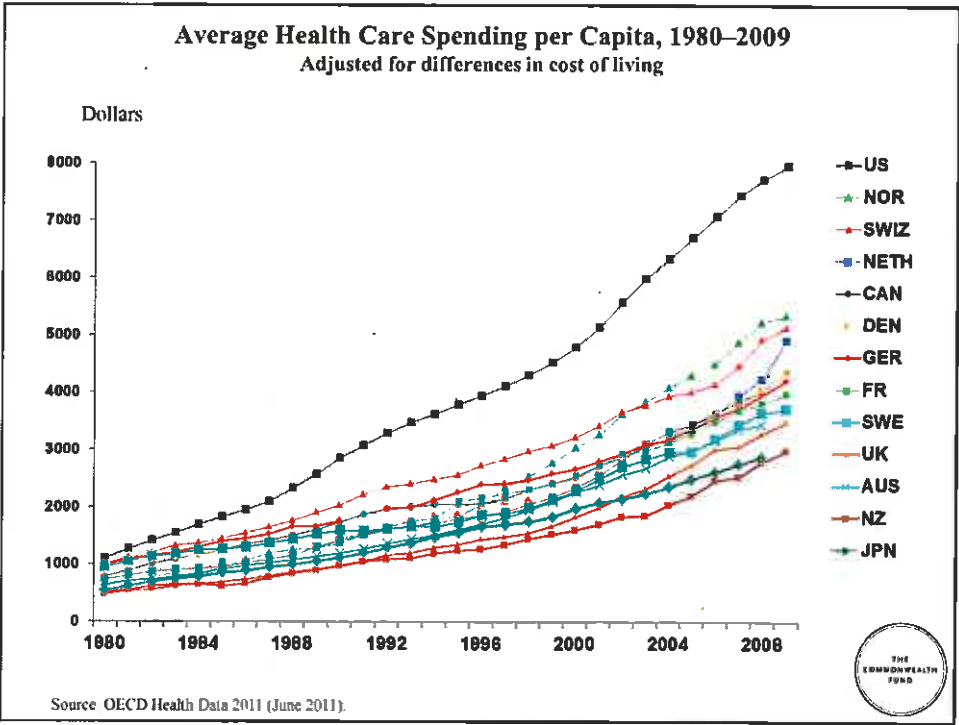
Percent

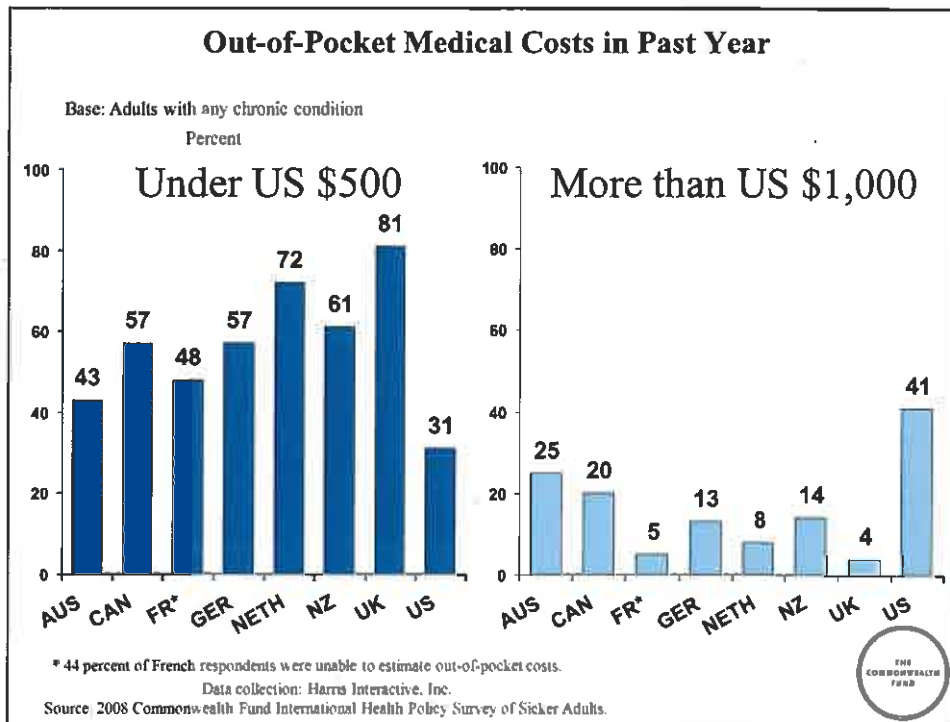
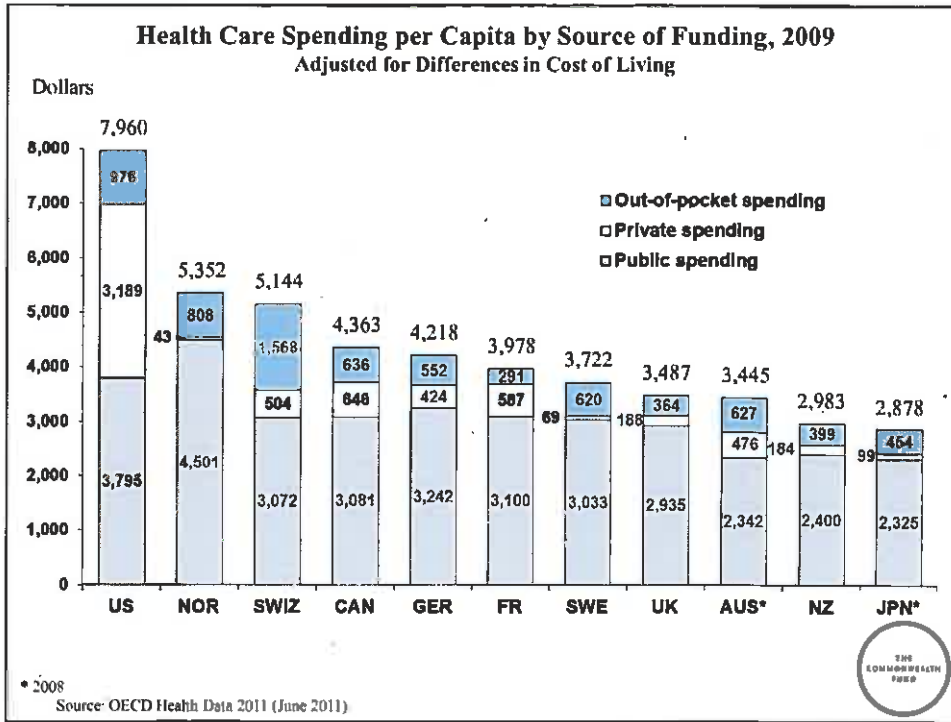


Data collection: Harris Interactive, Inc.

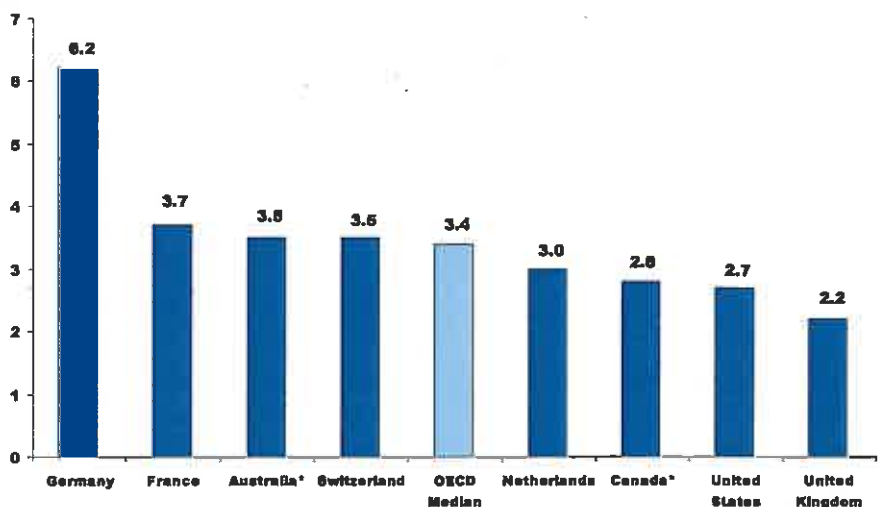
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults







Number of Acute Care Hospital Beds per 1,000 Population, 2006

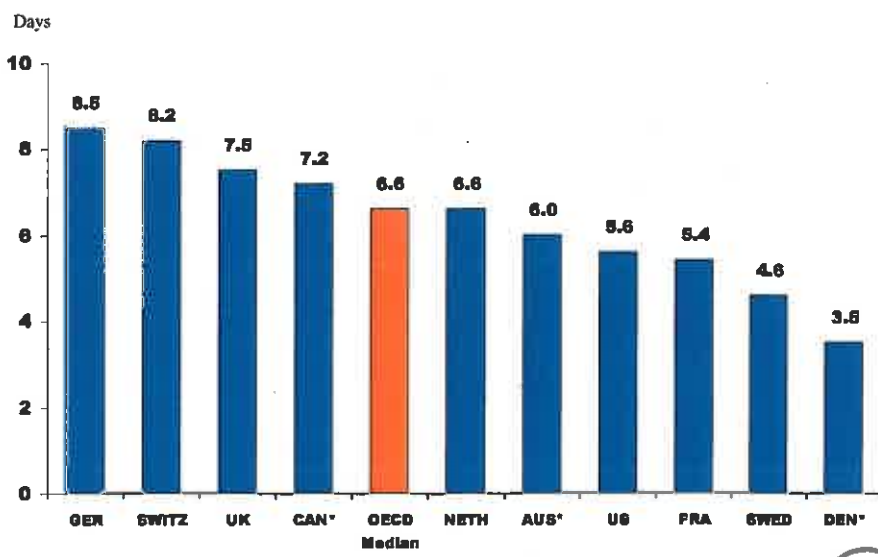


Source: OECD Health Data 2008 *June 2008*

*2005



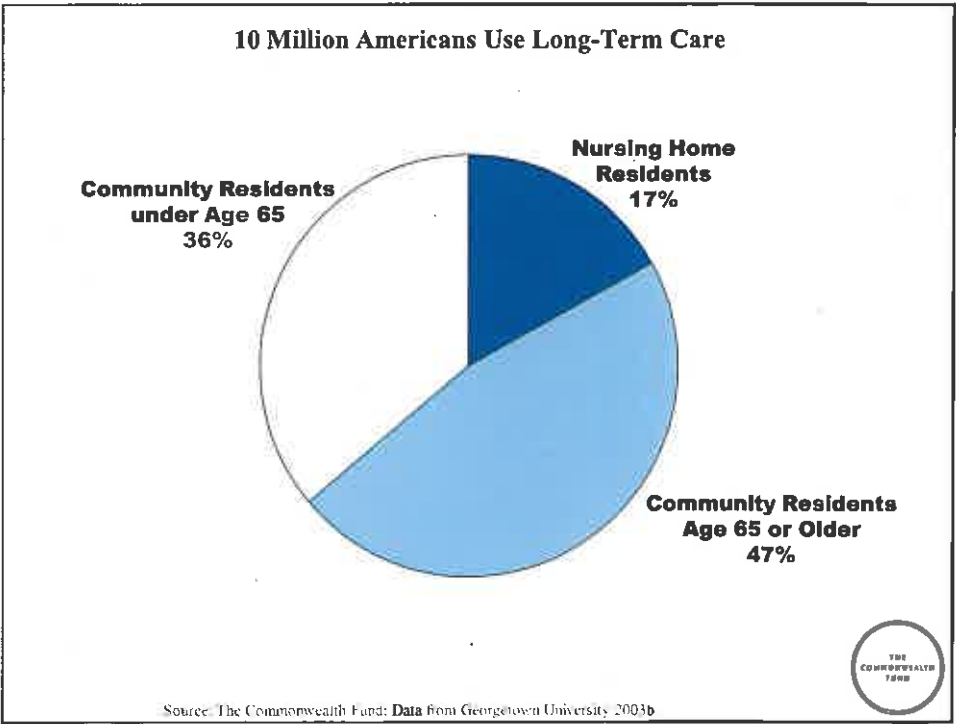
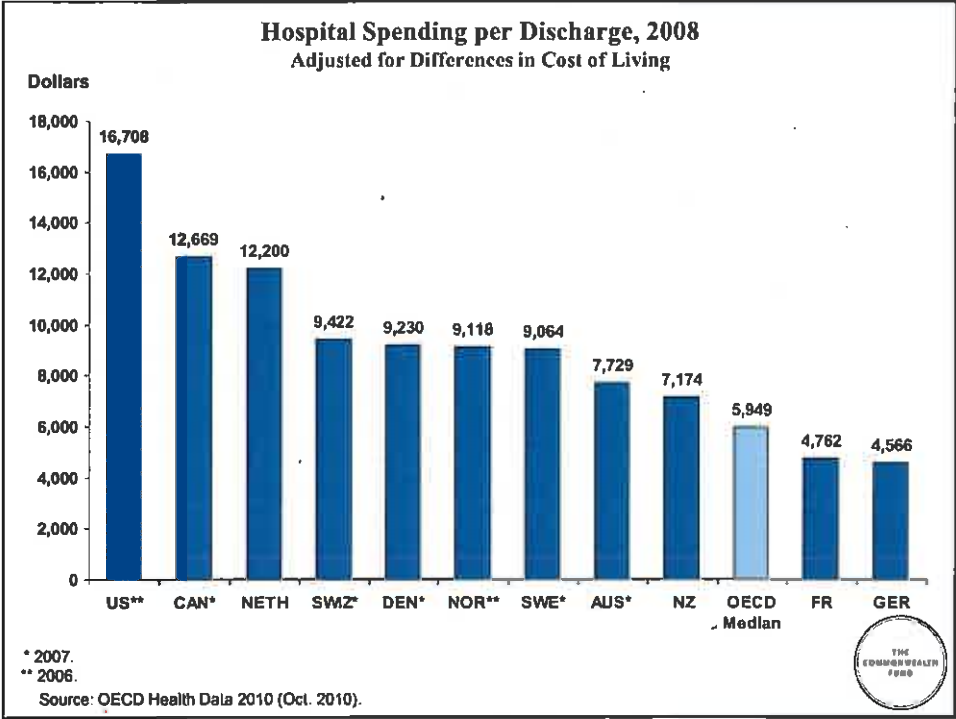
Average Length of Stay for Acute Care, 2006



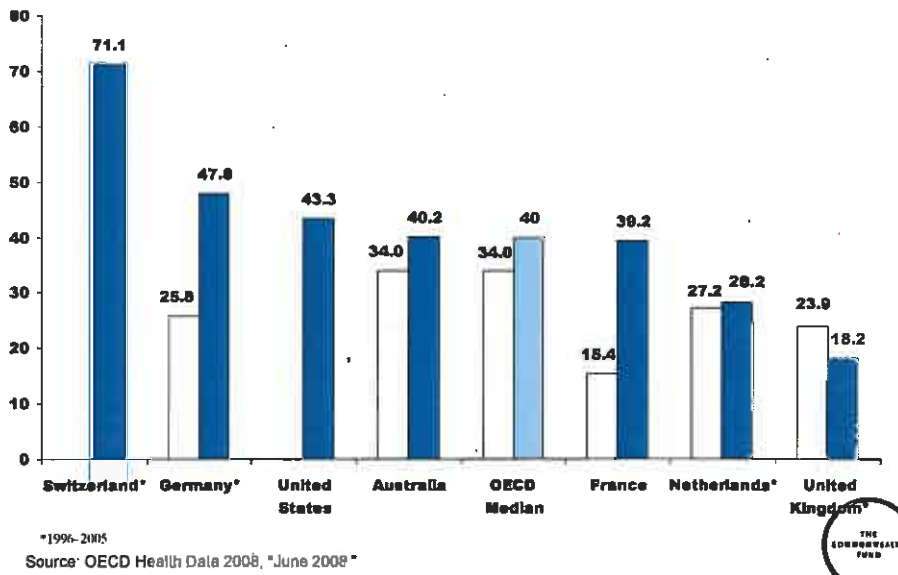
*2005

Data: OECD Health Data 2008 (June 2008).

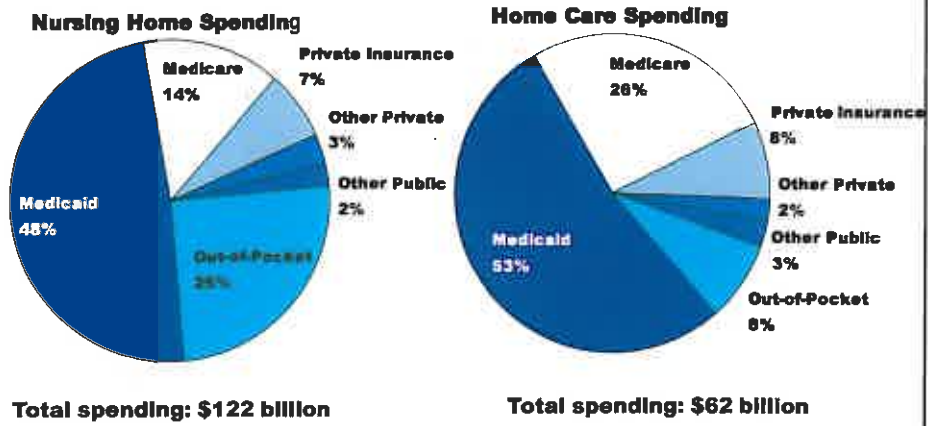




Number of Long-Term Care Beds in Nursing Homes per 1,000 Population Age 65 and Older, 1996–2006



National Nursing Home and Home Care Spending, by Payer, 2004

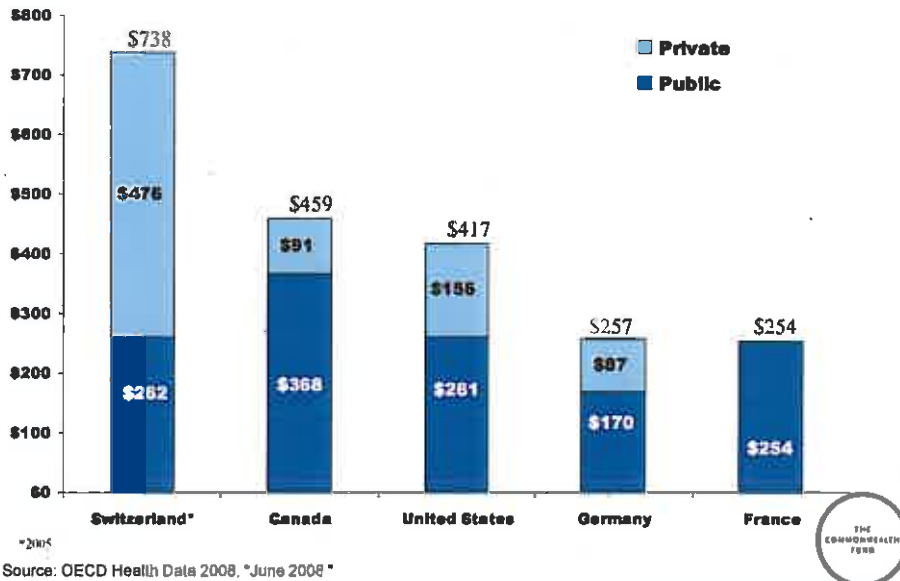


Note: Figure includes Medicaid spending on intermediate care facilities for the mentally retarded.

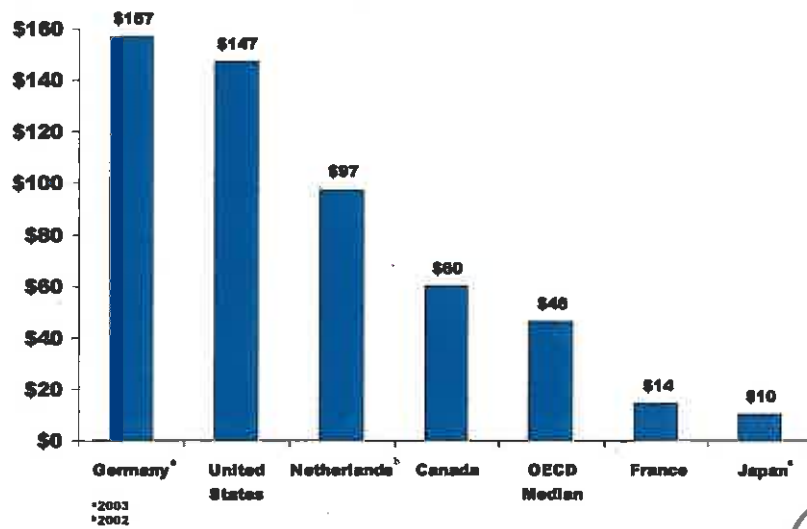
Source: Avalere Health analysis based on: Medicare, private and non-CMS public expenditures for free-standing nursing home and home health care reported by Centers for Medicare and Medicaid Services, National Health Expenditures by Type of Service and Source of Funds for 2004, and Medicaid Expenditures for Long-Term Care Services: 1992-2004 by Brian Burwell, Kate Sredl and Steve Eiken, www.hcbs.org.



Long-Term Institutional Care Spending per Capita, 2006 Adjusted for Differences in Cost of Living

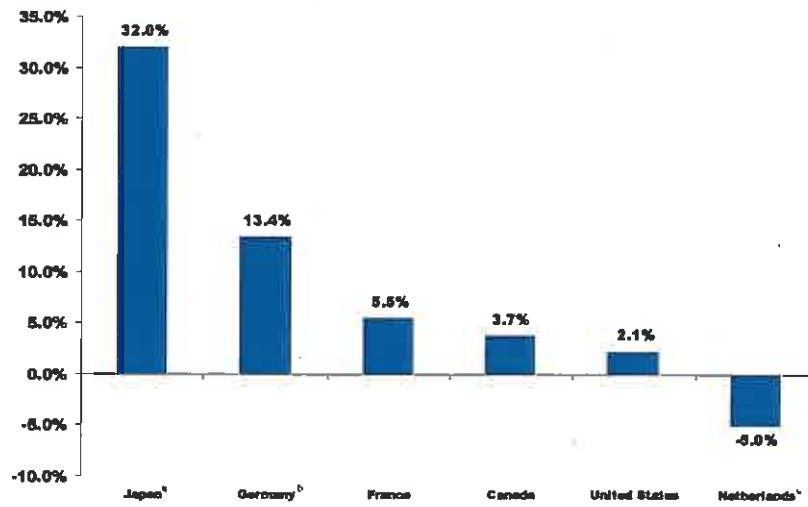


Home Health Care Spending per Capita in 2004 Adjusted for Differences in Cost of Living



Source: The Commonwealth Fund, calculated from OECD Health Data 2006

Average Annual Growth Rate of Home Health Care Spending per Capita, 1994-2004

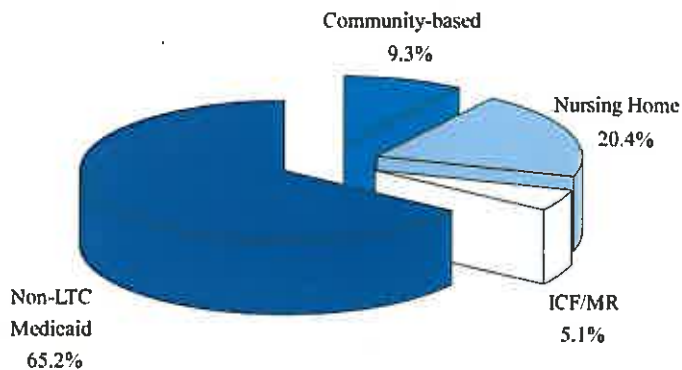


^a1995-2003 ^b1994-2003 ^c1994-2002

Source: The Commonwealth Fund, calculated from OECD Health Data 2006.



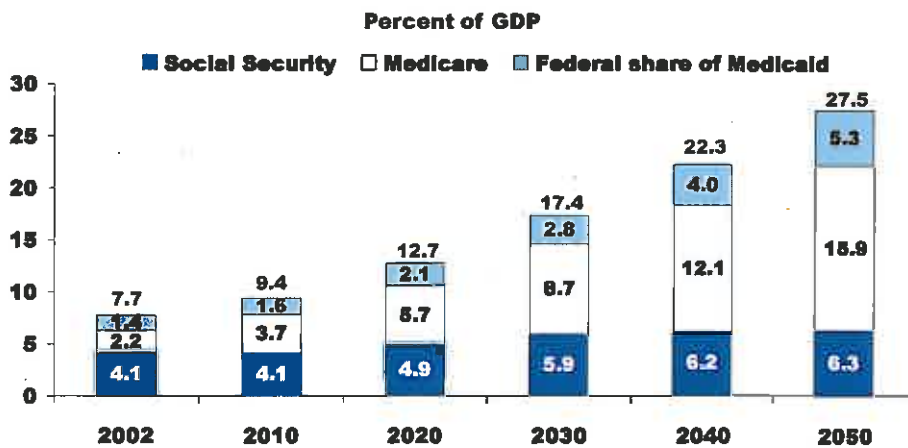
Thirty-five Percent of Medicaid Spending Goes to Long-Term Care



Note: ICF/MR = intermediate care facilities for the mentally retarded
 Source: MEDSTAT HCBS



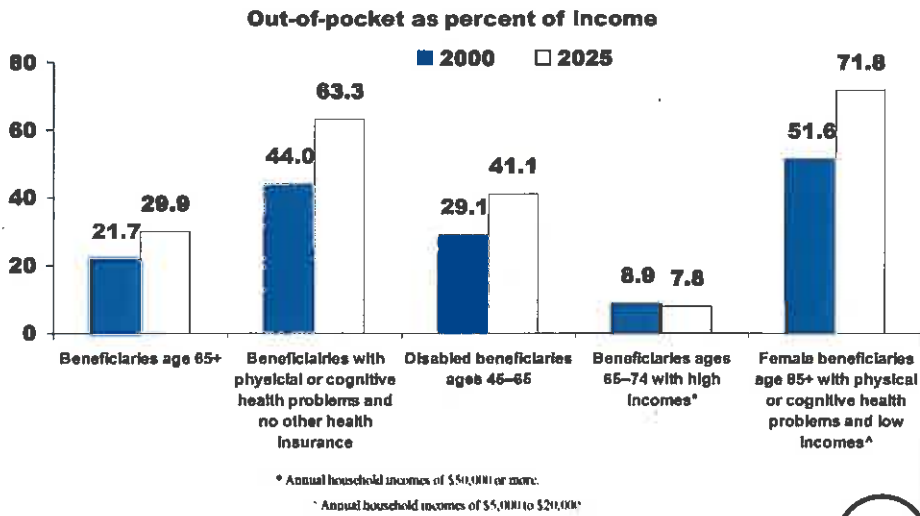
Projections of Federal Expenditures as a Percentage of GDP



Source: Congressional Budget Office (2003). *The Long-Term Budget Outlook (Supplemental Tables)*. Available at <http://www.cbo.gov/showdoc.cfm?id=4916&sequence=0> as reported in R. Friedland and L. Summer. *Demography Is Not Destiny, Revisited*. The Commonwealth Fund, March 2005.



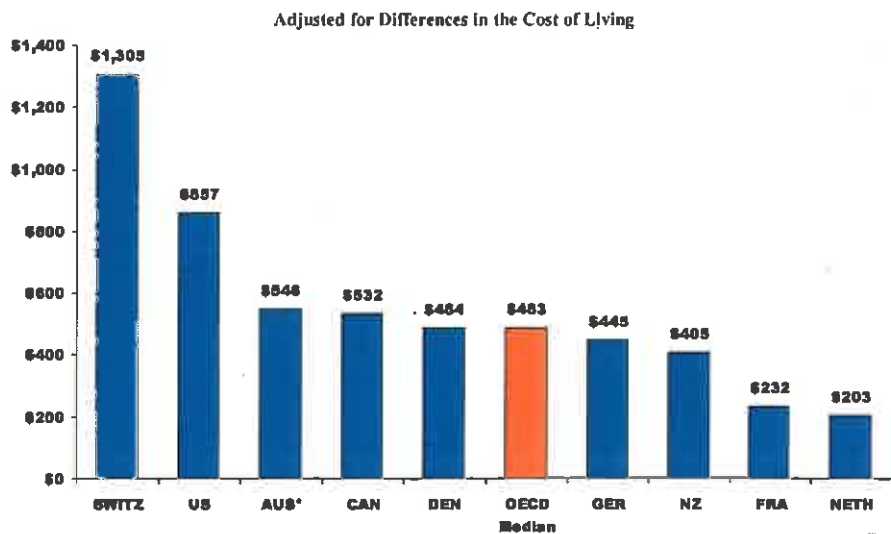
Projected Out-of-Pocket Spending As a Share of Income Among Groups of Medicare Beneficiaries, 2000 and 2025



Source: S. Maxwell, M. Moon, and M. Segal. *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*. The Commonwealth Fund, January 2001 as reported in R. Friedland and L. Summer. *Demography Is Not Destiny, Revised*. The Commonwealth Fund, March 2005.



Out-of-Pocket Health Care Spending per Capita, 2006



*2005
 Data: OECD Health Data 2008 (June 2008).



Overall Ranking

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00



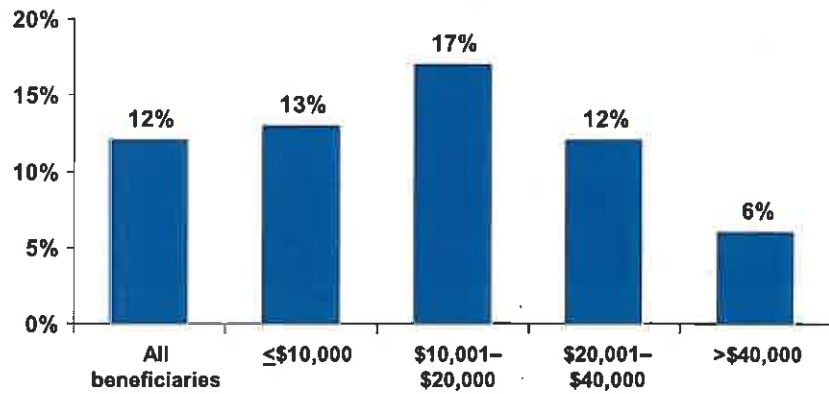
	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	1	7	6	3	5	2	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	2	1	1	3	6
Patient-Centered Care	1	5	3	4	1	2	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	6	1	3	4	5
Efficiency	1	6	5	3	4	2	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	1	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,637*	\$2,454	\$2,992	\$7,290

Note: * Estimate. Expenditures shown in \$US PPP (purchasing power parity).
 Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).



Medicare Beneficiaries Without Supplemental Coverage, 2002

Percentage by annual household income

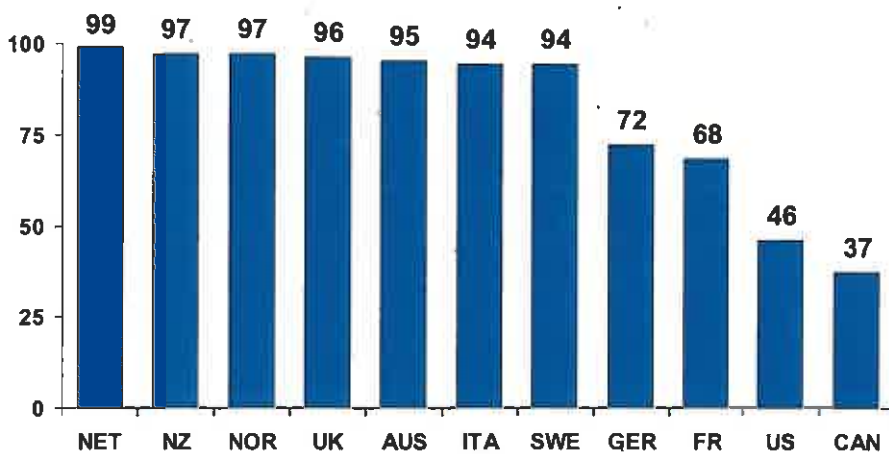


Source: E. Fishman, S. Tamang, and D. Shea, Medicare Out-of-Pocket Costs: Can Private Savings Incentives Solve the Problem?, The Commonwealth Fund, March 2008



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Doctors Use Electronic Patient Medical Records*

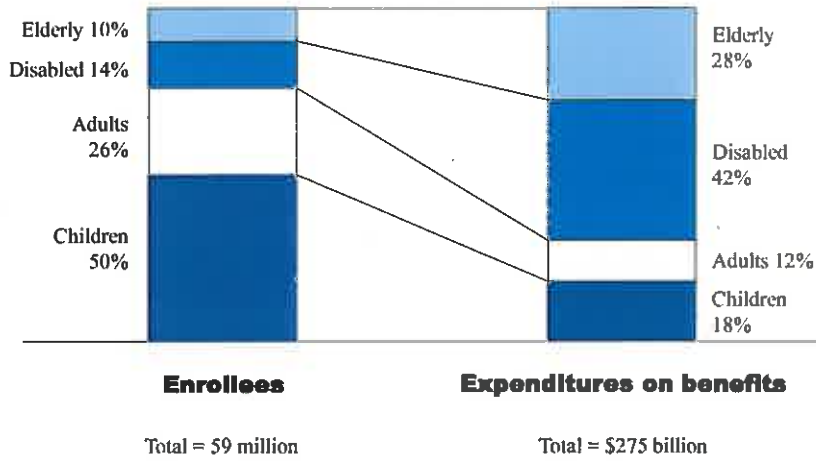


* Not including billing systems.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians



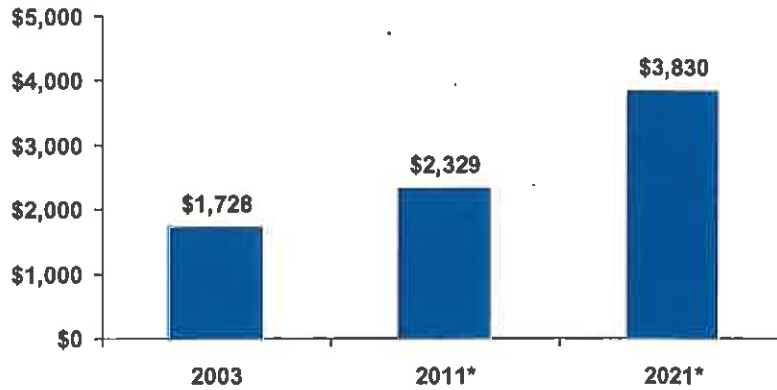
Medicaid Enrollees and Expenditures by Enrollment Group, 2005



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data



Average Annual Supplemental Medigap Plan F Premium for Medicare Beneficiaries Age 65 and Up



* Projected costs assume an annual 5.1% inflation rate

Source: E. Fishman, S. Tamang, and D. Shea, Medicare Out-of-Pocket Costs: Can Private Savings Incentives Solve the Problem?, The Commonwealth Fund, March 2008



Bilag 2, Magnolia




MAGNOLIA PRIME
"Letting Them Hear Your Voice..."

**Presentation to the City of Copenhagen
Health and Care Committee and
Administration**

Presented by Karen E. Rouit, Founder & CEO, Magnolia Prime

Wednesday, April 11, 2012



**Blame It on the
Parents!**

- ✦ Lifelong public sector careers.
- ✦ Active retirees in their 60's, 70's and 80's.
- ✦ Role models in work and life.

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My Background

- * Stanford University MBA and University of Michigan BA (Applied Mathematics)
- * Subject matter expert: aging, the elderly, health care
- * Former Chief of Staff to the Mayor of Cambridge, Mass.
- * Partial client list includes University of California San Francisco, Sarnoff (Stanford Research Institute), Medical University of South Carolina and ABHOW



Agenda

- * Health Care and Home Care in the United States
- * Use of Technology by the Elderly
- * Magnolia Prime Demonstration
- * Building Blocks in Silicon Valley
- * Q&A

Health Care and Reform

- * All provisions implemented by 2014. Coverage of young adults and prescription relief for seniors already in place.
- * Giving an additional 40 million individuals access to health care.
- * More attention to preventive care and disease management.
- * Financial Attention: Avoid rehospitalizations
- * Providers more accountable for outcomes: bonuses, penalties.
- * Pilots for increased use of technology and more care in the home. (\$10 billion: Office of the Natl. Coordinator for Health I/T)

Home Care: The Facts

- * Largely funded by CMS, or Medicare, which is part of the U.S. Department of Health and Human Services
- * \$17.1 million in annual revenues
- * 121 million annual home visits to 3.5 million annual patients
- * 69% of patients are 65+ years old or over
- * Prescription required by physician for each 60-day period.
- * Flat fee payment - based on patient's diagnosis.
- * Health Care reform is introducing bonuses and penalties based on outcomes.

Medicare Reports on ALL Agencies

Quality Measure	Survey Period: Agency	Star Rating	National Average
Medicare-covered Services: Home Care Services: Yes Personal Therapy Services: Yes Occupational Therapy Services: Yes Speech Pathology Services: Yes Medical Social Services: Yes Home Health Aide Services: Yes			
Personnel Requirements and Staffing: The type of staff in the full range of working conditions is appropriate for the agency's services. The number of patients is not greater than the staff can handle.	54%	43%	63%
Personnel Education and Training: The number of patients who get a full course of training is not less than 80%.	43%	62%	61%
Personnel Performance: The number of patients who get a full course of training is not less than 80%.	48%	48%	63%
Personnel Satisfaction: The number of patients who get a full course of training is not less than 80%.	43%	66%	63%
Lower Requirements and Barriers: Percentage of patients who had to be admitted to the hospital.	54%	31%	29%
Percentage of patients who had to be admitted to the hospital. Percentage of patients who had to be admitted to the hospital. Percentage of patients who had to be admitted to the hospital.	42%	25%	24%
Percentage of patients who had to be admitted to the hospital. Percentage of patients who had to be admitted to the hospital. Percentage of patients who had to be admitted to the hospital.	2%	1%	1%

Source: www.medicare.gov/therapies

Home Care: Shifts and Opportunities

- † Market trends
 - † 70 million baby boomers will have different expectations of care.
 - † More care provided in the home, plus shortage of skilled clinicians.
 - † Home care differentiation based on better service and reputation
 - † Be attractive to providers who want to avoid upcoming penalties due to patient re-hospitalization (pay-for-performance)
 - † Partnering to create "Accountable Care Organizations" and continuum of care.

Use of Technology by the Elderly

2011 Home Care Tech Report Survey
 Only 38% use telehealth (n=177)
 Some/Significant benefit 81% (n=54)
 Somewhat/Very satisfied w/ tech (n=54)

2011 Linkage Tech Survey (65-100 yo)
 Of those > 85 yo:
 35% own PCs (n=1727)
 26% have Internet (n=1680)

Stepping Stone Pathways
 Drivers to consumer adoption by seniors providing care to the elderly: 1. *difficulting prospective/perceived care*; 2. *supporting seniors' information/design needs*; 3. *Having an integrated solution that can be fine-tuning based on needs.*

Sources: "Home Care Technology Report 2011 Technology Utilization Survey," Magnolia Press. "Technology Survey Age 65 to 100," Aflac, Laura M., Nov 2011. <http://www.aflac.com/healthcare/stepping-stone/healthcaretechnology/homecarecaretech.html>

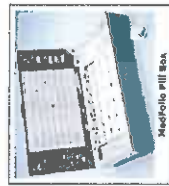
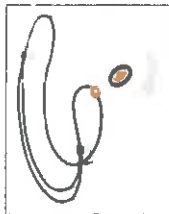
The Big Study!

Barriers and Drivers of Health/IT Use for the Elderly, Chronically Ill, and Underserved
 1. Computer process benefit 2. Convenience 3. Data entry not be cumbersome 4. Fits into daily routine 5. Delivered on technology used every day 6. Easy and frequent interactions through clinician

- + Reviewed 563 studies to identify those that focused on at least one of the populations of interest.
- + Included 129 articles.
- + Systems that provided only one or a subset were less consistently effective.

Source: "Barriers and drivers of Health Information Technology Use for the Elderly, Chronically Ill, and Underserved," James et al. Agency for Healthcare Research and Quality (AHRQ), Nov 2008. Report No. 08-0091

Home Care in the National Health Care Setting



My Company: Magnolia Prime



- Magnolia Prime provides a *communications services platform* to home health care agencies, managed care organizations senior services/housing and disease management companies under a Software-as-a-Service business model.
- The platform *automatically* places *personalized telephone calls* to *assess* a patient's current status, *confirm* information through two-way voice messaging, *notify* safety-net contacts when a message is not delivered, and *improve* compliance with the care regimen, all in their *first language*.

Demonstration

Value Add

- * Positive impact to the bottom line
- * Leverage costly staff to handle clinical tasks.
- * Redirect or eliminate equipment expenses.
- * Benefit to elderly and family caregivers.
- * Elderly benefit because it fits into their daily routine using familiar equipment.
- * Family appreciate additional contact and follow up.
- * Language specific.
- * Customizable to the organization.

Case Study: Jewish Home Lifecare



Who?	Why?	Results	Impact
<ul style="list-style-type: none"> • \$100M senior services and housing organization. • Has two home health agencies serving (Manhattan and Bronx). 	<ul style="list-style-type: none"> • Medicare tracks patient's perception of how well agency communicates with them. • Impacts referrals today, possibly payment in future. 	<ul style="list-style-type: none"> • Improved communication of services being received: <i>increase from 77% to 89%.</i> • Nurse informs me of when arriving at home (always or usually): <i>increase from 50% to 63%.</i> 	<ul style="list-style-type: none"> • <i>Anticipate improved patient satisfaction scores from required quarterly survey.</i> • <i>Successful pilot converted into on-going client.</i>

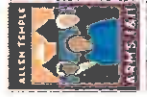
Case Study: Meals on Wheels-S.F.



Who?	Why?	Results	Impact
<ul style="list-style-type: none"> • Deliver meals to 1.6K clients/day; 20K/mo. • Operate on \$6M budget. 	<ul style="list-style-type: none"> • Holiday delivery schedule causes client confusion. • Confusion on part of client. • Inefficient use of social worker time. 	<ul style="list-style-type: none"> • Demonstrated value to staff. • 4.3-5.0 rating by clients (5.0 = very helpful). 	<ul style="list-style-type: none"> • <i>\$19K (est.) in organizational savings.</i> • <i>>1K (est.) hours of social worker time reallocated for higher value tasks.</i>

Testimonials about Magnolia Prime

- ✦ "Magnolia Prime reminds me that I'm not here alone. I know someone is thinking about me, someone cares. I look forward to the call. Plus, sometimes I lie down in front of the tv after dinner and don't wake up until midnight. I am supposed to take my medicine 30 minutes before going to bed, but have missed my evening medicine a lot. A call each night from Magnolia Prime really helps me with that." *Dulcie J., 88-year-old woman who lives with her cat, Baby Writer Show*
- ✦ We send Magnolia Prime phone notifications when our Service Coordinator has arranged a health or education program. Attendance has doubled since we started using Magnolia Prime!" *Lewis Sellars, Administrator, Allen Temple Arms Senior Housing, Oakland CA*
- ✦ "New Device-Free Telehealth System Emerges, Combines Internet with Telephone" *Tim Rowan, Publisher and Editor, Home Care Technology Report*



Case Study: Allen Temple Arms

Who?	Why?	Results	Impact
<ul style="list-style-type: none"> • Senior apartments. • Low income, subsidized by the Federal government. 	<ul style="list-style-type: none"> • Avoid isolation, depression, etc. • Promote independent living as long as possible. • Going "green." 	<ul style="list-style-type: none"> • Eliminated photocopying and distribution of paper fliers to 180 apartments. • Paper announcements replaced with timely and efficient phone notification. 	<ul style="list-style-type: none"> • Staff redeployed to more value-added tasks. • Dramatic doubling of attendance at events sponsored by the residence.

The On-going Challenge: Funding

- ✦ Silicon Valley Bank/Angel Resource Institute's "Halo Report: 2011 Angel Group Year in Review."
- ✦ Median size of angel/angel group rounds was \$700 million in 2011, up from \$600 million in 2010.
- ✦ In 2011, 58% of investments were in health care and Internet.
- ✦ Alternative Approaches
- ✦ Strategic partners or customers
- ✦ Customers pre-pay

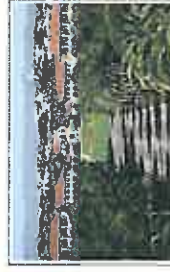
Lessons Learned



- ✦ Build a solid team that complements my skills and experience: they drank the "Kool Aid"

facebook

- ✦ There is only one Facebook.
- ✦ Leverage your networks.
- ✦ Stanford University, Silicon Valley, past jobs, friends.
- ✦ Anyone who will listen.



Recap

- ♦ Changing health care policies have created turmoil, but future hope, for the U.S. to reduce costs and improve patient care.
- ♦ Consumer awareness is now catching up with knowledge of technology options, but opportunity still exists in the marketplace.
- ♦ Access to adequate funding for growth (after proof-of-concept) often limits entrepreneurial growth.
- ♦ Magnolia Prime is ready to partner with Denmark government, research, universities and corporations.



MAGNOLIA PRIME
"Letting Them Hear Your Voice..."

Thank you!

Karen Roult

650.331.0756

karen@magnoliaprime.com

US Healthcare Seen Through the Eyes of a Danish
Physician
Presented to the City of Copenhagen - The Health and
Care Committee

- San Francisco, 11. april 2012.
- Preben Brandenhoff, M.D.
Associate Clinical Professor, UCSF(vol.)
- Thoracic Transplant Consultants, Inc.

- Disclosures: None, except for a consistent propensity for
speaking the inconvenient truth.

Preben Brandenhoff, M.D.

- 1977 MD, cum laude, University of Copenhagen
- 1988 Board Certified General Surgery (DK)
- 1993 Board Certified Thoracic Surgery (DK)
- 1999 US Medical Licensing Exam, 1, 2 & 3
- 2002 Licensed as a Physician and Surgeon, OH
- 2003 Licensed as a Physician and Surgeon, CA
- 2004 UNOS Certified Transplant Surgeon

Preben Brandenhoff, M.D.
Work History – DK – 24 Years

1977-1986 University of Copenhagen Hospitals,
County and City of Copenhagen

1986-1988 Roskilde County Hospital

1988-2000 University of Copenhagen Hospitals,
Rigshospitalet.

2002-2003 Privathospitalet Hamlet, Frederiksberg.

Preben Brandenhoff, M.D.
Work History – US – 11 Years

- 2000-2002 The Cleveland Clinic Foundation, OH
- 2004-2012 University of California San Francisco Medical Center, California Pacific Medical Center, California Transplant Donor Network, Thoracic Transplant Consultants Inc.

How Do Physicians Spend Their Time?



How Do Physicians Spend Their Time?

- In Denmark hospital based physicians spend 25% of their time on administration.
- In the US physicians(no distinction) spend 8% of their time on administration.

Why Can US Physicians Spend More Time With Their Patients?

- They use "physician extenders":
- Nurse Practitioners
- Physician Assistants
- Medical Assistants
- Administrative Assistants(formerly "secretaries")
- Medical Students

How Can DK Physicians Spend More Time With "Their" Patients?

- Start thinking out of the box (innovatively!)
- Eliminate professional barriers maintained by professional organizations in the interest of misguided union politics.
- Look at and learn from the US model.

"Factoids" on US Healthcare

- Total annual spending on healthcare:
- \$2,3 trillion! – Or 15.7% of GDP
- Anyone knows how much 2,3 trillion dollars is?
- And the answer is: 12000 milliarder kroner!!
- Or the same as the rest of the western world combined spends on healthcare.

"Factoids" on US Healthcare

- 30% or close to \$700 billion of the total annual healthcare spending is considered "wasted".
- "Wasted" in this context means spent on unnecessary tests, practicing "defensive" medicine, fraud/abuse, preventable conditions and avoidable care.

"Factoids" on US Healthcare

- The 10 largest private health insurance companies in the US spend 29% of their revenue on administration.
- The 2 largest government = tax payer funded health insurance/ -care agencies in the US, Medicare and Veterans Administration spend 3% of their revenue on administration.

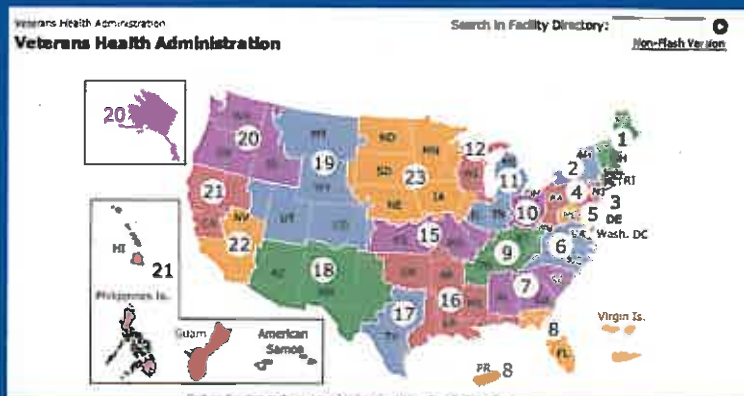
Medicare

Medicare is a national social insurance program, administered by the U.S. federal government, that guarantees access to health insurance for Americans ages 65 and older and younger people with disabilities as well as people with end stage renal disease. As a social insurance program, Medicare spreads the financial risk associated with illness across society to protect everyone, and thus has a somewhat different social role from private insurers, which must manage their risk portfolio to guarantee their own solvency.

Medicare

In 2010, Medicare provided health insurance to 48 million Americans—40 million people age 65 and older and eight million younger people with disabilities. Medicare serves a large population of old, sick, and low-income people, many of whom would be unable to afford health care otherwise.

On average, Medicare covers about half (48 percent) of health care costs for enrollees. Medicare enrollees must cover the rest of the cost. These out-of-pocket costs vary depending on the amount of health care a Medicare enrollee needs. They might include uncovered services—such as long-term, dental, hearing, and vision care—and supplemental insurance



Veterans Health Administration

Government run health care system consisting of 21 integrated service networks.

"Factoids" on US Healthcare

- Approximately 30 million US persons are without health insurance at any given time.
- Approximately 12 million undocumented immigrants obtain their healthcare from emergency rooms and government/community funded free clinics.

"Factoids on US Healthcare

- Only 2 countries in the world allow commercial advertising for prescription drugs.
- You guessed it:
- USA , and more surprisingly:
- New Zealand

"Factoids" on US Healthcare and Seniors
A few definitions

- End-of-life issues: Advance Directives when admitted to hospital or long term nursing care.
DNR orders: Do Not Resuscitate!
- Use of Bio Ethicists

US Healthcare and Seniors
A few more definitions

- Retirement community: can be likened in many cases to a high end, i.e. expensive, "village" of seniors capable of caring for themselves in most aspects of their daily life.
- Assisted living housing: as above but with more assistance (beskyttet bolig)
- Nursing home: 24/7 assistance (plejehjem)

"Factoids" US Healthcare and Senior Citizens

- 5% of the elderly live in a nursing home at any given time.
- About 30% of overall health care resources are spent in the last year of life.

"Factoids" US Healthcare and Senior Citizens

20 – 30% of those medical expenses have had no meaningful influence in terms of survival and quality of life

18 – 20% of Americans spend their last days in an ICU to the tune of \$10,000 a day or more.

Are US Physicians "Better" Than Their Danish Colleagues?

- The simple answer is: Yes (and no!)

Are US Physicians "Better" Than Their Danish Colleagues?

- Yes, because:
- Medical students receive better training.
- Residents and fellows receive better training, more hours, more patients, more exposure.
- While in training the doctors focus more on direct patient care, while non-patient related jobs are handled by other staff.

Are US Physicians "Better" Than Their Danish Colleagues?

- No because:
- They spend so much time in a highly competitive world and away from "the real world" that they tend to lose the human aspect and to develop as human beings.

Are US Physicians "Better" Than Their Danish Colleagues?

- The simple answer is: Yes (and no!) and yes again??

Are US Physicians "Better" Than Their Danish Colleagues?

- Yes, because:
- Postgraduate training is more focused with less redundancy. (Residency, fellowship)
- All states require 3 medical licensing exams.
- A medical license has to be renewed every 2 years and CME is a prerequisite for renewal.

What Is CME?

- Continuing Medical Education
- In California the requirement is 25 hours of accredited CME per year before the biannual license renewal.
- Special requirements: End-of life CME

Other "Quality Assurance" Requirements

- Board Certification = Speciallæge anerkendelse.
- Can only be obtained after a successfully completed residency/fellowship and after passing a written and an oral exam.
- Recertification after 10 years.

More "policing"

- Federal authorities, CMS, DOJ
- State Medical Boards
- Hospital Medical Staff Bylaws

NOTIFICATION OF ACCUSATIONS/PETITIONS TO REVOKE
PROBATION/AMENDED ACCUSATIONS FILED:

1. On March 23, 2011 a second amended accusation was filed against the license of ROBERT MICHAEL BITER, M.D. (A 77870) with an address of record in Encinitas, CA.
2. On March 20, 2012 an accusation was filed against the license of PETER JOHN COTSIRILOS, M.D. (G 66322) with an address of record in El Dorado Hills, CA.
3. On March 23, 2011 an accusation was filed against the license of ALLEN A. FUJIMOTO, M.D. (G 7287) with an address of record in San Lorenzo, CA.
4. On March 23, 2012 an accusation was filed against the license of GREGORY FUNG, M.D. (G 41709) with an address of record in San Francisco, CA.
5. On March 23, 2012 an accusation was filed against the license of LAWRENCE H. HANSEN, M.D. (G 7513) with an address of record in Los Alamitos, CA.

And the list goes on and on.....

Thank you!

Bilag 4, Bio-X



Bio-X
Stanford University



What is Bio-X?

Unique pioneering initiative on evolving multidisciplinary biosciences to accelerate scientific discovery and innovation, and to understand entire organ systems in all their complexity



Encompasses numerous programs including seed grants, fellowships, travel awards, workshops/courses/seminars, and corporate affiliate program



A respected "brand" for life science programs around the world that facilitates collaborations among 500+ faculty, representing 5 Stanford schools and 60+ departments



Training platform for all types of researchers: clinicians, engineers, computational scientists, physicists





James H. Clark Center Bio-X Hub in the heart of Silicon Valley



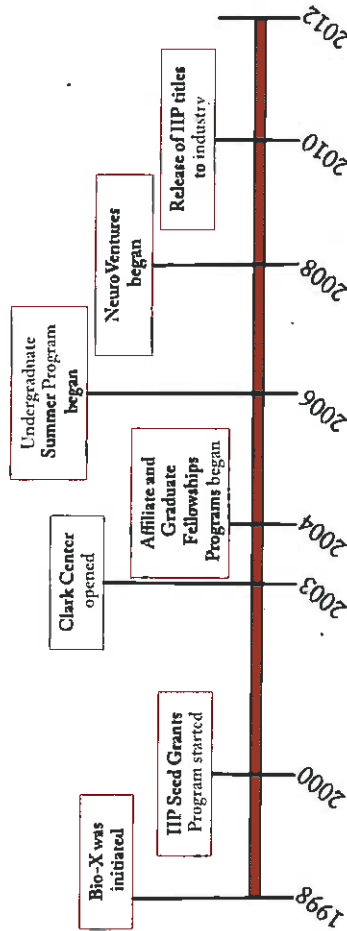
Location, Location,
Location!!!



3 Pods – 3 Stories High – Open Lab Space
44 Faculty from 23 different departments

Nexus Restaurant, Peet's Coffee and Tea
Clark Auditorium, 8 Conference Rooms, 4 Seminar Rooms

Bio-X Timeline





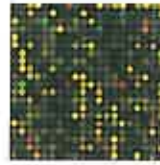
Bio-X Shared Resources

Clark Center

- Biodisigo Collaboratory and Teaching Areas
- Oprogenetics Innovation Lab
- Small Animal Imaging Facility
- Machine Shops
- Motion Laboratory
- Seminar Rooms, Auditorium
- Shared Visualization Room
- Special Projects Rooms
- Supercomputers
- Ultra-low Vibration Laser Laboratories

Stanford University

- Bioinformatics Resource
- Cell Sciences Imaging Facility
- Electron Microscopy Core Facility
- Mass Spectrometry Laboratory
- Microarray Core Facility
- Nuclear Magnetic Resonance Facility
- Product Realization Lab
- Stanford Shared FACS Facility
- Stanford Synchrotron Radiation Lab
- Stanford Tissue Bank
- Transgenic Animal Facility





Seed Grants for Success Interdisciplinary Initiatives Program (IIP)



- Seed funding for interdisciplinary projects every 2 years since 2000
- **Criteria for projects: innovative, high-risk, high-reward, collaborative**
- Competitive: only ~20% of proposals are funded; avg of 20-25 awards per round, \$150K per award
- So far, 114 different projects have been awarded from 5 rounds
- Created 450+ team across the 5 different Stanford schools and dozens of departments
- Currently in our 6th round of IIPs, with ~120 proposals received
- Industry interest: Releasing of titles of IIP proposals (with permission of faculty) to ID interdisciplinary projects of interest
- Bio-X/Sanofi Discovery Awards and Bio-X/NIJ Translational Innovation Partnership Awards Program (TIPP) initiated



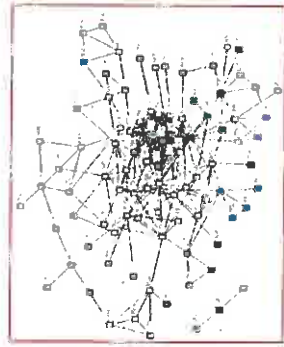
IIP Seed Grants 360° Success

Measured by:

- Increased Collaborations
- Increased Funding to Stanford
- Publications and Patents



Bio-X Seed Grants: Increase in Collaborations



'95-'97
Before Bio-X IIPs



'05-'07
After Bio-X IIPs



Seed Grants: Return on Investment

Between 2000-2008, 4 rounds of IIP
\$12M invested into the IIPs →
\$160M+ in external support to Stanford University
TENfold+ return on investment

Patents filed (30+)
Publications in top journals
Training foundation for future scientists



Stanford University Office of Technology Licensing

- **FY 2010-2011:**
 - 500+ new invention disclosures
 - 101 new licenses
 - 8 start-up companies



Seed Grants Success Stories



Computational Analysis of Tumor Morphology to Build Prognostic Models and Discover Biological Networks in Breast Cancer (2010) – Daphne Koller, Matt Van de Rijn



An Integrated Approach To Cardiac Repair: Predictive Computational Models, Engineered Biomaterials, and Stem Cells (2008) – Sarah Heilshorn, Ellen Kuhl, Chris Zarins



Development and Applications of Real-Time fMRI Technology (2008) – Scan Maekey, Gary Glover, Ian Gotlib, Allan Reiss, Brian Knutson



Inventing a microscope to measure sarcomere lengths in humans (2006) – Scott Delp, Terry Sanger, Mark Schmitzer, Stephen Smith



Artificial Cornea (2002) – Christopher Ta, Juan Noolandi, Alan Smith, Robert Waymouth, Phil Huie



Fellowships



- *Goal:* to train graduate students pursuing interdisciplinary projects – investing in future of human health
- Self-nominated application
- Students encouraged to work with multiple mentors
- 12-17 students awarded per year for 3-yr fellowships
- To date, 108 PhD students & 6 postdocs have been funded
- Currently in the middle of our 9th call of proposals, and have received ~90 applications
- Fellows also supported by Affymetrix, Amgen, Genentech, Medtronic, Pfizer, and various donors



Bio-X Fellowships Success Stories



David Myung (2008) (Christopher Ia)

- 3 patents
- 6 first-author publications
- Biomimedica startup - \$2.4M VC funding



Viviana Gradinaru (2010) (Karl Deisseroth)

- Sammy Kuo Prize for best neuroscience research paper
- Nature, Cell, and Science publications
- 2 patents



Gaurav Krishnamurthy (2011) (C. Miller/E. Kuhl)

- Medtronic Fellow
- 2 patents
- At least 6 different publications



Bio-X Fellows: Where are they now?

Industry

- Intel
- McKinsey & Comp
- BCG
- Goldman Sachs
- Amgen
- Abbott
- Yahoo!
- Oracle
- Medtronic
- Start-ups (DNAxexus, Biomimetica)

Academia

- Professorship
- Medical School
- Residency
- Postdoc
- Research Associate
- Government
- Business School
- Biodesign

And more!



Summer Undergraduate Fellowship Program



- Started in 2006
- 10 weeks full-time research in Bio-X laboratory with stipend of \$5600
- Weekly lunch seminar with participating faculty
- Poster presentation of results at the end of the summer
- Exponential growth of interest in the program: # of fellowships awarded per year has increased from 1 ~ 5 ~ 11 ~ 32 ~ 34 ~ 46
- *Results:* 1st author publications, Best Poster awards, Dean's award, conference presentations, and more
- Currently reviewing our 7th call for proposals, and have received ~90 applications



Bio-X has already built a unique platform for innovation and collaboration across disciplines.

Can we use this platform to tackle big problems with big future payoffs?

Bio-X Ventures



What is Bio-X Ventures?

- ✧ Invention, development and dissemination of new technology and science; not a core facility
- ✧ Exceptional projects with unusual potential to change the way academic science is done
- ✧ Larger scale enterprises needing rapid development and innovation beyond scope of any one department, school or discipline
- ✧ Incubate under Bio-X umbrella, then disseminate when mature



Introducing Bio-X Neuro Ventures



Novel inventions and collaborations with unusual promise for unlocking the secrets of brain and behavior

Endorsed by President Hennessy
Launched with initial gift from
Rosenberg Foundation + Matching
University Funding

Director: William T. Newsome, Professor
of Neurobiology, SOM

First round of proposals (~30)
received in Nov 2011 - 5 projects
awarded, each up to \$500K



Corporate Forum Affiliate Program



Become a Bio-X affiliate!

- Portal between industry and Stanford's interdisciplinary biosciences research community
- Establishes deeper connection through specific collaborations, networking and recruiting
- Development of breakthrough technologies & leading-edge discoveries through collaborations
- So many ways to get involved!
 - Membership, sponsored research, gift
 - Seed Grants, Fellowships, In-Kind



*What can Bio-X do for
you as an affiliate?*

- Facilitate interactions between faculty & industry
 - Customized technical summits, round-table meetings ★
 - Networking
 - Invitations to Symposia and Seminars
 - Faculty Liaison
 - Visiting Scholar Program
- Intellectual Property and liaison to Stanford OTL
- Stanford Center of Professional Development
- Newsletter

*Bio-X holds numerous symposia on
an annual basis*

- 2 IIP Seed Grant Symposia
- Annual Symposium
- Kids' Day
- Fellows Symposium
- Undergraduate Symposium
- Individual Technical Summits



Contact Information

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Bio-X Corporate Forum Liaison

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Heideh Fattaey, Ph.D.

Executive Director of Bio-X Programs and Operations


650-725-7882

hfattaey@stanford.edu



Agenda

- 2:00 pm Welcome and Introductions
- 2:15 pm Overview of CITRIS and the Health Care Initiative
- 3:00 pm Break
- 3:15 pm Q&A/Discussion
- 3:45 pm Closing Remarks and Next Steps
- 4:00 pm Adjourn




Introduction to CITRIS

Health Care Strategy

Discussion and Next Steps

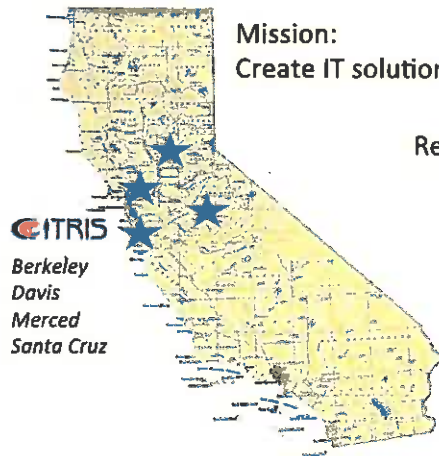
3



Introduction to CITRIS

4

CITRIS: An Institute of Science & Innovation



Mission:
Create IT solutions for pressing social problems

- Research Focus:**
- Energy
 - Health Care
 - Intelligent Infrastructure
 - New Media

The Goal: New Technologies and Businesses

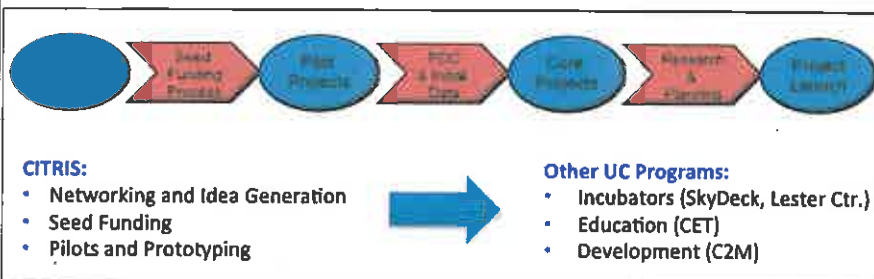


CITRIS was created to “shorten the pipeline” between world-class laboratory research and the societal impact of technology through its rapid transfer to established companies, and the creation of start-ups and whole industries.

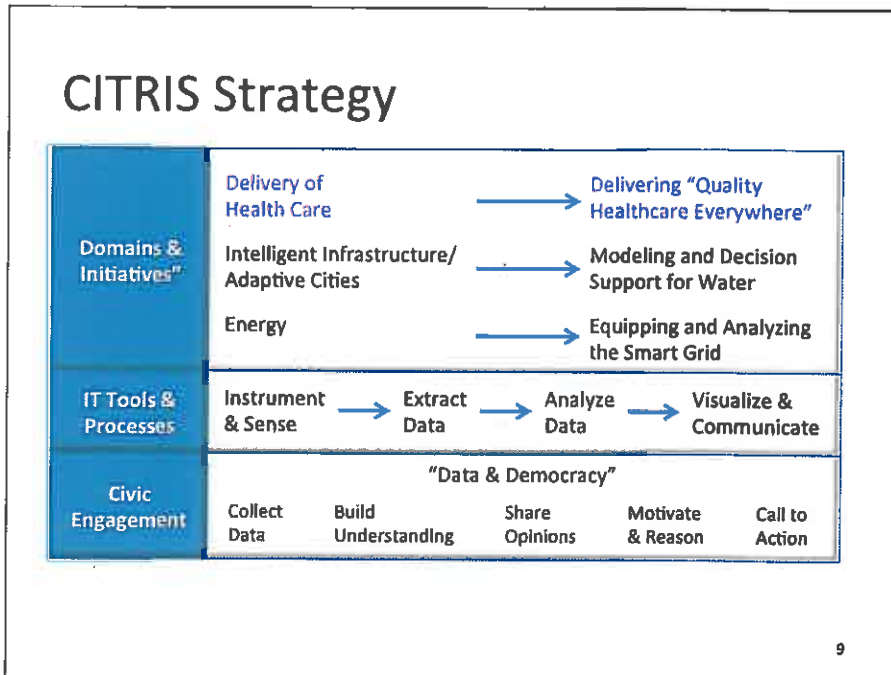
The CITRIS Solution: Invention Resources

- CITRIS is bringing together world-class facilities, equipment and staff to support researchers in early invention:
 - Nanofabrication
 - Precision Manufacturing
 - Device Design and Development
- These collective resources support earlier, more professional design, prototyping and development of new technology

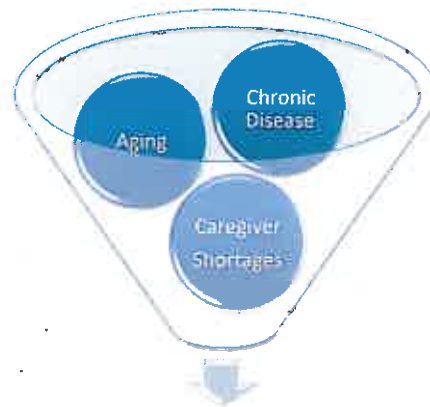
Collaboration to “Shorten the Pipeline”



CITRIS collaborates with other UC programs for business development and incubation to “shorten the pipeline” from idea to social impact

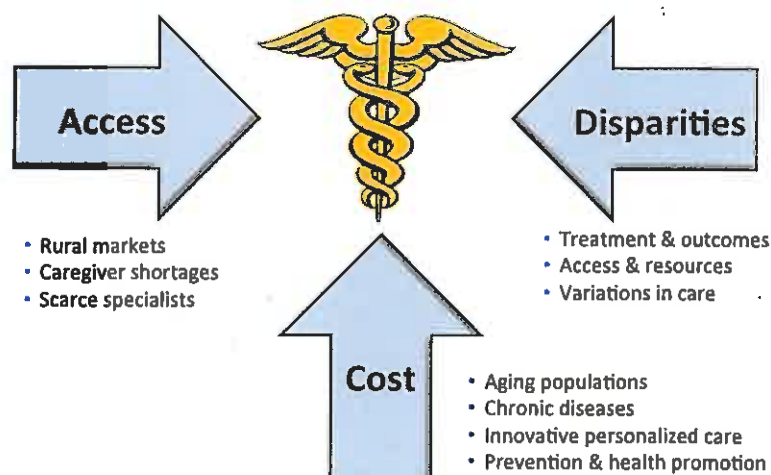


The "Perfect Storm"



**Increasing demand for care
with no viable means of supply**

Compelling Health Care Needs



We don't need improvement ...

...We need transformation

What Does Transformation Look Like?

Now	Future
Treat individuals	Treat groups
Treat in institutions	Treat in the home and community
Focus on "professional" caregivers	Involve family, friends, other informal caregivers, and patients
Accept fragmentation	Drive integration
Use technology to support current process	Use technology to disrupt current process

Metrics of Transformation

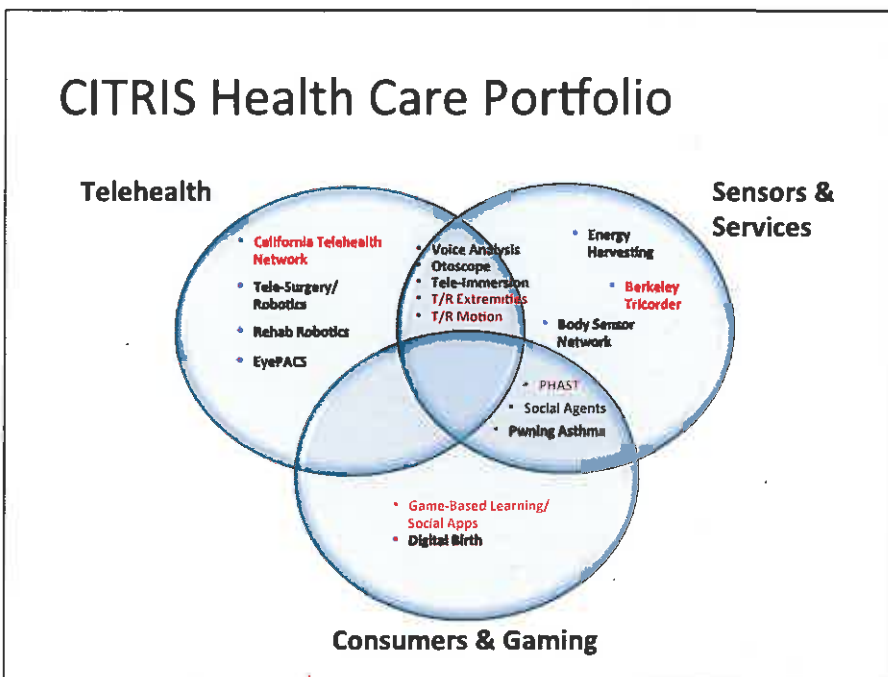
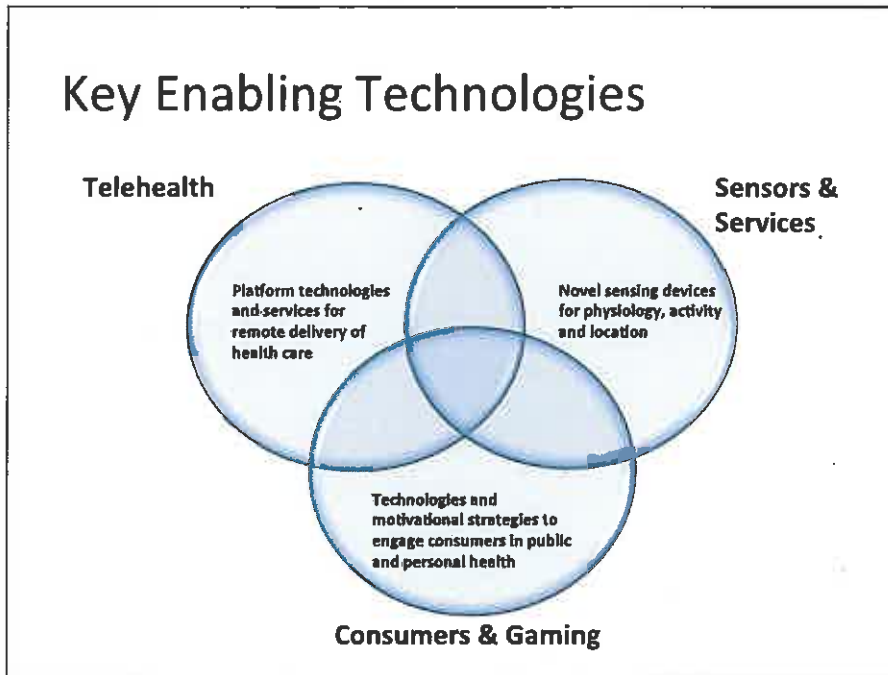


The CITRIS Health Care Initiative

Delivering “Quality Healthcare Everywhere”
for Californians



Improving access and reducing disparities by
creating a statewide, trusted “medical-grade” network.



California Telehealth Network



The Challenge

Provide high-quality statewide access to a wide array of telemedicine services.

The Innovation

A statewide, "medical grade" virtual private network for telemedicine.

The Results

Point-to-point access between over 800 hospitals, clinics and other providers.

Bringing high quality telemedicine services and support to over 800 hospitals, clinics and other providers in California

- A novel infrastructure that creates a statewide network of providers for telehealth and telemedicine applications
- Combines high-quality services and an affordable rate structure to create true access
- Provides a research "test bed" for the development and deployment of new services

Network launch is planned for 2010

19

Berkeley "Tricorder"



The Challenge

Provide powerful remote sensing in a small, light, wearable form

The Innovation

A multi-function sensor with wireless connectivity and multi-day data storage capacity

The Results

Fully functional, and unobtrusive monitoring for cardiac and other at-risk patient groups

Remote monitoring of multiple health functions in an unobtrusive, wearable wireless device

- Combines accelerometer, ECG, stethoscope, myography and other functions
- Bluetooth radio with connectivity to PC and telephone
- 2 GB data storage capacity – two days of continuous monitoring

Versions currently in use for clinical testing

20

Tele-Rehabilitation



The Challenge

Monitor and measure upper body movement during remote physical therapy

The Innovation

Tele-Immersion technology that observes and measures exact patient movement

The Results

Therapists can more accurately deliver, monitor and measure PT performance remotely

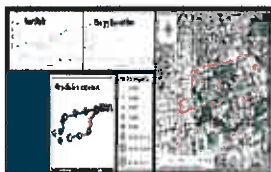
Remote monitoring and measurement of physical therapy for improved treatment and expanded capacity

- Therapist and patient communicate and interact in a tele-immersive environment
- Sensors track upper body movement during therapy
- Sensor data is transformed into precise measurements of movement, to evaluate therapy execution and progress

Initial experiments completed, and new development underway

21

PHAST Public Health Assisting Smart Technologies



The Challenge

Promote awareness of personal activity spaces and how they impact health.

The Innovation

Utilize wearable sensors to track activity, energy expenditure and environmental conditions.

The Results

New personal health tools for asthma and obesity management.

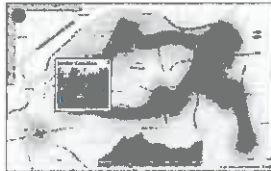
Using pervasive computing and sensor technology for personal and environmental monitoring to better manage disease

- Monitoring of spatial activity patterns for infectious disease transmission
- Development and testing of an energy expenditure algorithm for obesity management
- Integrated sensor system for the study and management of asthma

Currently refining and validating the sensor system for future studies.

22

Dengue Torpedo



The Challenge

Develop a low-cost, high accuracy system of identifying hazard areas.

The Innovation

Create a crowdsourced cell phone game that allows citizens to identify hotspots.

The Results

Increased levels of reporting and citizen participation.

Using mobile phones and gaming tactics to engage citizens in reporting public health risks

- Uses cell phones with GPS and camera capability to identify potential "hotspots"
- Aggregates and visualizes data into an area-wide "heat map" for identification of risk areas
- Integrates game play and rewards into the structure of the application, encouraging participation

Currently refining prototype and negotiating for test area and population.

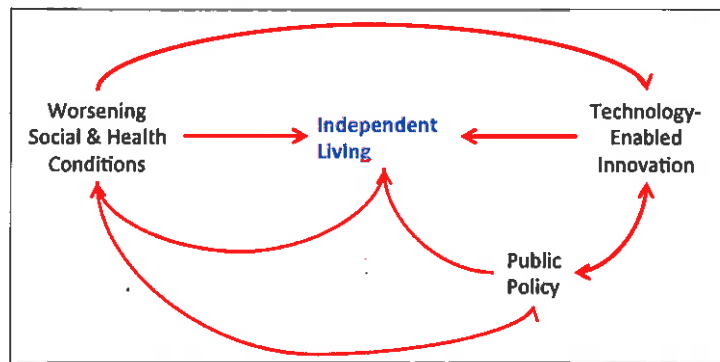
23

Technology-Based Innovation for Independent Living

- Explore value-driven service innovation in health care by examining applications that can advance the goal of "one year longer at home"
- Compare and contrast the experience of stakeholders in four different geographic and political environments:
 - Scandinavia
 - United Kingdom
 - United States
 - Japan
- Focus on models of successful innovation in public and private markets

Why Independent Living?

Independent living solutions are being driven primarily by worsening social and health conditions, technology-enabled innovation, and public policy



Early Comparative Findings

- Despite general interest in technology, there has been little mainstreaming
 - Exceptions: social alarms in UK, Scandinavia
 - Primary reason cited: lack of clinical evidence
- There have been major pilots in each market, but trouble transitioning from demonstration to widespread uptake
 - Most successful dissemination accomplished by government agencies
- Collectively, these markets include widely different funding and purchasing systems
 - Public and private, integrated and freestanding, near-monopoly and open market

Early Comparative Findings

- The markets also represent very different levels of activity and interest in the public policy dimension(s) of independent living
 - Significant public policy activity in all but the US
 - Locus of policy and decision-making varies by level in other markets (local/regional/national)
- The markets represent very different approaches to integration of technology
 - Telecare: UK and Scandinavia (social alarms)
 - Domestic robots and smart home: Japan
 - Clinical telehealth: US

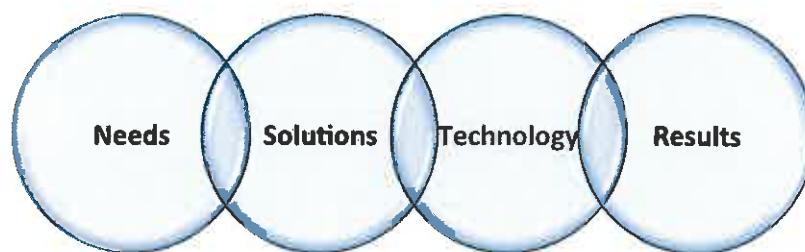
“In Vita”

- Individualized Technology-Aided Assistance System in Heart Failure for Patients and Clinicians
- A partnership of Aalborg University, The Cleveland Clinic, and CITRIS
- Objectives:
 - Identify most appropriate patient characteristics, technologies and care models to reduce CHF readmissions
 - Develop international guidelines for management of CHF with new technologies

In Vita Work Streams

1. Stratification of HF Patients
2. Home Telehealth for the Future HF Patient
3. Design and Evaluation of HF Decision Support
4. New Techniques for Monitoring HF Patients
5. Innovation of Care Models
6. Economic Evaluation and Business Models
7. Dissemination and Network Activities

CITRIS Health Care Strategy



- Access
- Disparities
- Cost

- Data
- Services
- Platforms
- Engagement
- Teams

- Telemedicine
- Sensors & Services
- Consumers & Gaming

- Greater access
- More effective services
- Better results
- Lower cost



Steven DeMello

Director of Health Care

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Discussion and Next Steps

Opinion Space



The Challenge
 Model and visualize opinions within a community, including participant status

The Innovation
 Application that measures both content and status, and provides engaging visualization.

The Result
 Improved participation and understanding of community opinion.

Using visualization and social networking to engage and evaluate public discussion of policy issues

- Software application evaluates answers to choice and open-ended topical questions to create a model of the discussion community
- The model is then visualized in a way that illustrates both the relative opinions of participants and the perception of them by the community
- Currently applied by the Department of State

Actively developing new tools and applications.

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Opinion Space

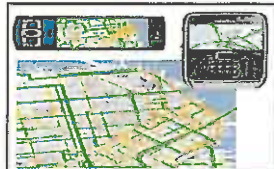


Users rate vote both their agreement with and level of insight of the opinion – then see their response plotted against the entire community of readers and writers.

They can also join the discussion directly...

34

Traffic and Public Health



Challenge
Create a real-time forecasting model for air and noise pollution for personal and public use.

Innovation
Integrate crowdsourced traffic with other data sets for real-time forecasting.

Impact
Increased level of safety and awareness for citizens and public health officials.

Using crowdsourcing and analytics to generate real-time air and noise pollution data for local areas

- Using a well-established crowdsourcing model for real-time traffic estimates
- Merging air quality and noise data with traffic to develop forecasting algorithms
- Planning to deliver data to both the public (for personal use) and government (for public health use)

Currently working on data assembly and algorithm development.

35

“Pwning” Asthma Triggers



Objectives:

- What health care and climate data are “gameable” on mobile platforms?
- Which mobile game designs can motivate underserved communities to increase engagement in their health care ?
- How can games provide a sustained learning effect that promotes active, participatory citizenship?

Project Team:

- Social App Lab at CITRIS
- Greg Niemeyer, UC Berkeley Department of Art Practice
- James Holston, UC Berkeley, Department of Anthropology
- Inez Fung, Berkeley Institute of the Environment, UC Berkeley
- Qing Hua Guo, School of Engineering, UC Merced

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Til Sundheds- og Omsorgsudvalget

26-04-2012

Kommende sager omdelt på mødet den 26. april 2012

Oversigten er omdelt på mødet den 26. april 2012.
Der tages forbehold for ændringer.

Sagsnr.
2011-64497191

Dokumentnr.
2011-906920

Sagsbehandler
Tanja Vilhof

Sundheds- og Omsorgsudvalgets møde den 24. maj 2012

1. Temadrøftelse om frivillighed og brobygning mellem forvaltningens tilbud og frivillige
2. Høring vedrørende Administrationsplanprojektet
3. Forslag til ændrede kriterier af tilskud efter § 79
4. Udmøntning af 2 mio. kr. på forebyggelsesområdet
5. Godkendelse af anlægsregnskaber
6. Status for anlægsprojekter, driftsprojekter og hensigtserklæringer
7. Retningslinjer for udpegning af afdelingsbestyrelser for plejecentrene og botilbud efter almenboligloven (fællesindstilling mellem SOF og SUF)
8. Orientering om nødkald
9. Status for Øget sundhed for børn 2011 og udmøntning for 2013-2015
10. Aftale mellem København Kommune og Frederiksberg Kommune om kræftrehabilitering
11. Etablering af tværsektoriel udredningsenhed
12. Hjertestartere – opfølgning på høring
13. Høring vedrørende revision af hospitals- og psykiatriplan 2020 (fællesindstilling mellem SOF og SUF)
14. Rapport fra Sundheds- og Omsorgsudvalgets studietur til Silicon Valley, Californien, USA herunder opfølgning.

Sundheds- og Omsorgsudvalgets møde d. 14. juni 2012

1. Budget 2013 – ønsker
2. Budget 2013 – takster
3. Genberegning af priser på baggrund af regnskab 2011
4. Brugerundersøgelser på ældre- og sundhedsområdet 2011 – retur fra høring
5. Kvartalsrapport – 1. kvartal 2012
6. Måltal for færdigbehandlede på hospitalerne
7. Tilsynsredegørelse for 2011
8. Sundhed i nærmiljøet
9. Evaluering af ny visitations- og styringsmodel for hjemmeplejen – besøgsblokke

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10. Status og fremtid for aktivitetstilbud
11. Medlemsforslag om effektivisering vedrørende hjælpemidler til børn (fællesindstilling mellem SOF, BUF og SUF)
12. Orientering om beretning 2011 om magtanvendelse og andre indgreb i voksnes medbestemmelsesret

Sundheds- og Omsorgsudvalgets møde d. 16. august 2012

1. Temadrøftelse om forskning
2. Temadrøftelse vedr. barrierer for at flytte i plejebolig
3. Revision af de 17 principper for ny- og ombygninger af plejeboliger
4. Revision af årsregnskab 2011 - Direktionsnotat
5. Forventet regnskab 2012 – halvårsregnskab pr. 30. juni 2012
6. Bevillingsmæssige ændringer 2012
7. Status for fremdrift for fællesstrategi for udsatte og syge borgere i BIF, SUF og SOF
8. Høring om grundbudget 2013 – Kejd
9. Status på Københavns Kommunes veteranpolitik