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NAPC PRIMARY CARE ZONE

at CONFED 19 CONFERENCE

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Population health: what is it in reality?

Dr Nav Chana MBE, National PCH Clinical Director, NAPC, and Sam Jones, CEO/President Centene UK

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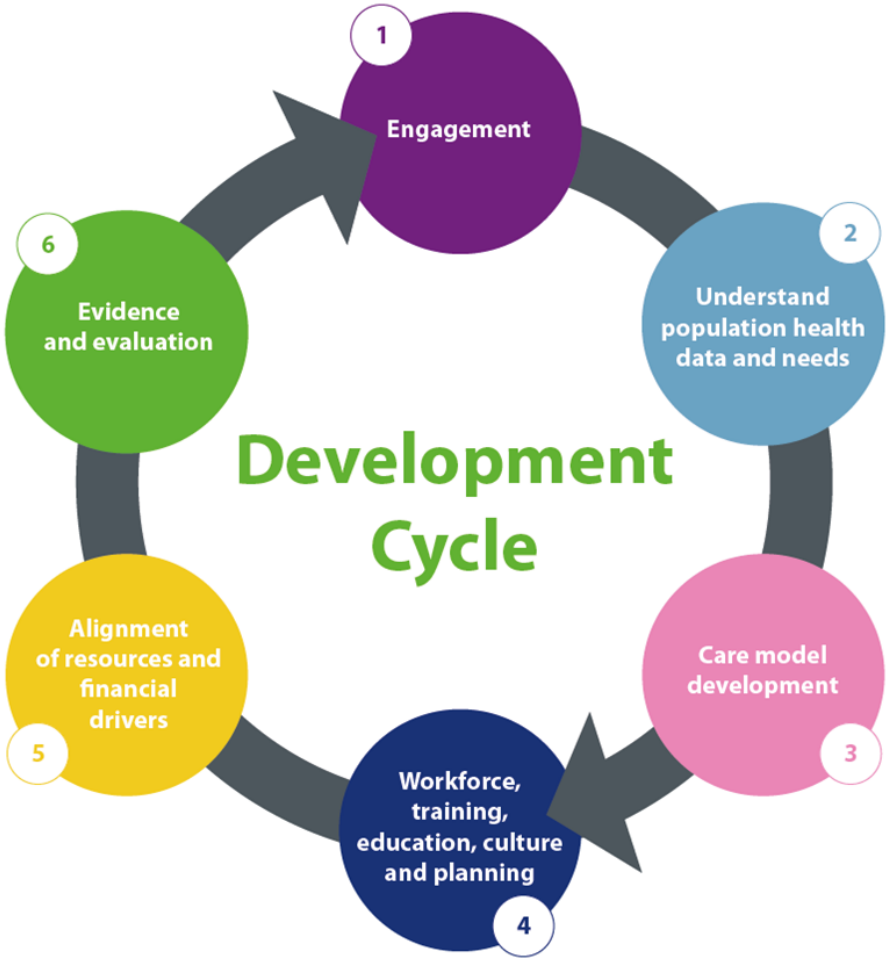
Primary care home has four key characteristics and six key enablers

1. an **integrated workforce**, with a strong focus on partnerships spanning primary, secondary and social care;
2. a combined focus on **personalisation of care** with improvements in **population health outcomes**;
3. aligned **clinical and financial drivers**
4. provision of care to a defined, registered population of between **30,000 and 50,000**.



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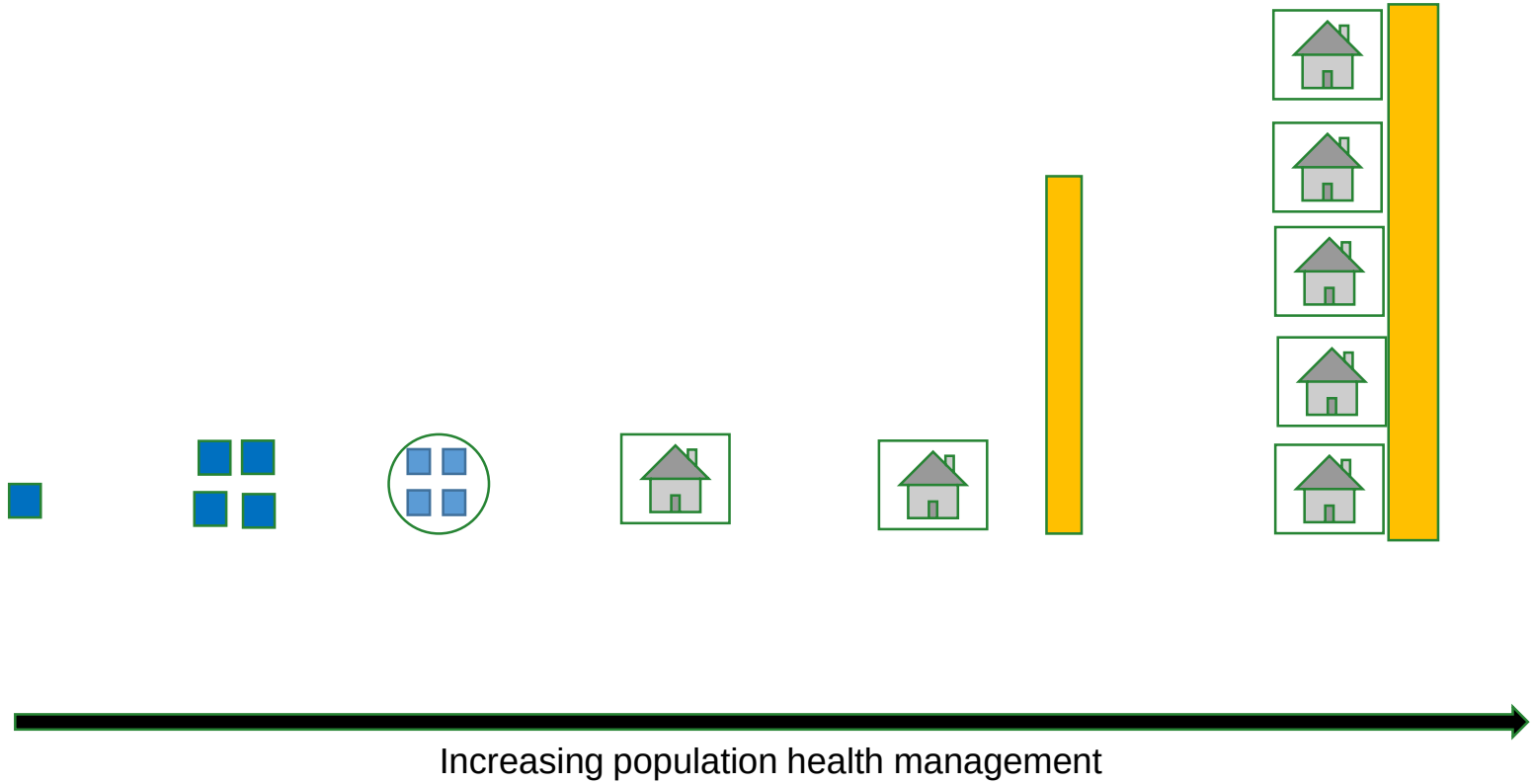
Primary care networks stages of maturity



Primary care networks stages of maturity

Population health management is a proactive approach to managing the health and well-being of a population.
It incorporates the total care needs, costs and outcomes of the population.

It involves segmenting the population into groups of people with similar needs to enable targeted interventions for both those population cohorts and the individual citizens within.

BUT!

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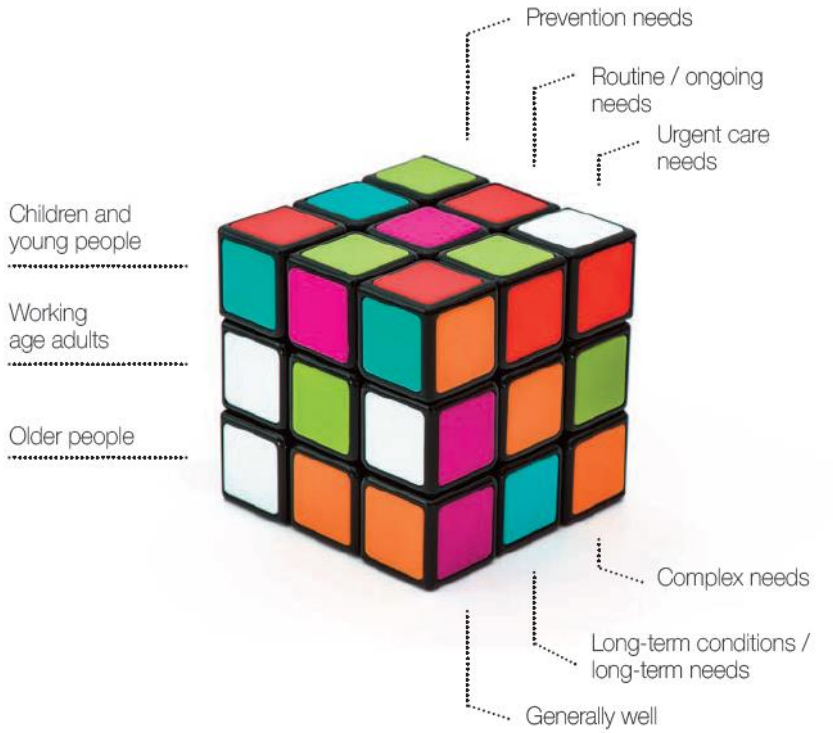
Our perspective: PCH based on population health management approach

	Generally well / good wellbeing	Long-term conditions / social needs	Complexity of LTC(s) / social needs and / or disability
Children and young people			
Working age adults			
Older people			



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Examples

PRIMARY CARE HOME NAPC ®

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PCH List Size: 36, 890	Generally well 27439 (74%)		Long term conditions / Long term needs 5,935 (16%)		Complexity of LTC(s) and/or disability 3516 (10%)
	Low risk	High risk	Low risk	High risk	All
Children and Young People (11,942) (0- 25)	**9685**	**1515**	**397**	**288**	**57**
Working Age Adults (22,129) (26- 65)	**7395**	**8394**	**748**	**3652**	**1940**
Older People (2,819) (66 and over)	**203**	**247**	**85**	**765**	**1519**

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	Generally well		Long term conditions / Long term needs		Complexity of LTC(s) and/or disability
	Low risk	High risk	Low risk	High risk	High risk
Children and Young People (0- 25)		**Child only risk factors** ▪ Prematurity ▪ Low birth weight ▪ Looked after children ▪ Child in need/child protection ▪ ? Free school meals ▪ Plus all risk factors below	**Single LTC** ▪ Respiratory condition ▪ Cardiovascular condition ▪ Musculoskeletal condition ▪ Renal condition ▪ Cancer ▪ Gastrointestinal condition ▪ Diabetes ▪ Learning disability ▪ Mental Health condition ▪ Dermatological condition	2 + LTC Or 1 LTC plus risk factors	▪ Two or more LTCs in different body systems ▪ Progressive or metastatic malignancy ▪ Progressive condition with expected reduced life expectancy (exclude those with remission for more than 5 years) ▪ Continuous reliance on technology for at least 6 months ▪ Plus complexities as below
Working Age Adults (26- 65)		**Risk factors (child and adult)** ▪ Smoker (14yrs +) ▪ BMI >30 ▪ BP > 150/90 ▪ Physical inactivity ▪ Drug misuse ▪ Alcohol >14 units ▪ Pre-Diabetes ▪ Gestational diabetes ▪ Tired all the time ▪ Armed Forces veteran ▪ Social isolation ▪ Temporary accommodation ▪ Homeless ▪ Low income ▪ Stress Problem situation relating to social and personal history ▪ Bereaved in last year ▪ Carer at home ▪ Frequent attender to primary care			**1+ LTC with** ▪ Palliative Care need ▪ Dementia ▪ Nursing Home ▪ Residential Home ▪ Immuno suppressed ▪ Housebound ▪ Reduced Mobility ▪ Sensory impairment
(66 and over) Older People					

East Merton…

Acute response

Integrated nursing

Mental health (CYP and older age)

Specialist advice (including radiology)

Care navigation and health coaching

Medicines Management

MSK and OT

Benefits, employment and housing advice

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Newport Pagnell Primary Care Home

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Focus areas September 2018	Generally well		Long term conditions / Long term needs		Complexity of LTC(s) and/or disability	
	Low risk	High risk	Low risk	High risk	Low risk	High risk
Children and Young People (11-17)		• Mental Health • Emotional social challenges • Social exclusion, sexting, FB bullying and other struggles/ risks	• Mental Health • Drug and alcohol • Gender identity Issues • Social health needs, • substance misuse, • Depression & low mood 35 • Young carers. 1x5yrs, 1x17yrs		Severe/ Complex Mental Illness • Psychosis 7 • Self harm 3 • Suicidal ideation/suicide attempts 15 • antidepressants/ antipsychotic/hypnotic medication 54 (Identified in the last year)	

Adults (19- 75)		• Pre diabetes 428	**Mental Health**
			• Anxiety
			• Depression
			• Phobias
			• OCD
			• Panic disorder
			Total 799 (Identified in the last 2 years)
			
			LTC
			• Diabetes 986 /Vascular 1,107 (LTC)
			• COPD
			• LTC/Smoker/Unplanned admission (Bev's project) 64 patients in the last 6 months, 11 outstanding
					Severe Frailty (under 75) 4
					
					Mental health
					• Psychosis/bi-polar/ schizophrenia 129
					• PTSD 16
					• Complex mental health needs
					
					Complexity
					• Community matron caseload rag rated:
					  • Red = 20
					  • Amber = 307
					  • Green = 5517
					  • Total 542
					• Adult carers 377
					• Dementia 215
					• Heart Failure End of life 4
					• Severe frailty over96	

Older People 76 and over						

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Holistic suite of interventions	Generally well/ good wellbeing	Long term condition(s) / social needs	Complexity of LTC(s)/ social needs and/or disability
Children and young people	• SMILE course • Working with local Youth Clubs	• 'Talk for Sport' • COMPASS Milton Keynes Young Peoples drug and alcohol service. Children's drop in sessions during the summer holidays • Providing volunteering opportunities with the elderly	• Working with Hannah Pugliese, CCG commissioner for children's mental health on metrics & CAHMS
Working age adults	• Developing primary care navigators and social prescribing • Why Weight?	• Health & Nutrition clinics • Primary Care Plus • Joint Multiple LTC clinics • Improving Access to Psychological Therapies (IAPT) project	• Primary Care Plus including antipsychotic injections in house
Older people	• Referral to Brooklands to support wellness including • Working with Lovat Fields, retirement village to support a better quality of	• Focus on end of life care for diagnoses other than Cancer – Heart Failure • Falls prevention • DN diabetes/Vascular care project • Keep active for respiratory patients	• Community Matron – a holistic model • District Nursing Care • Working with MKUH – reducing admissions from nursing/residential homes • Working with MK Council provision of

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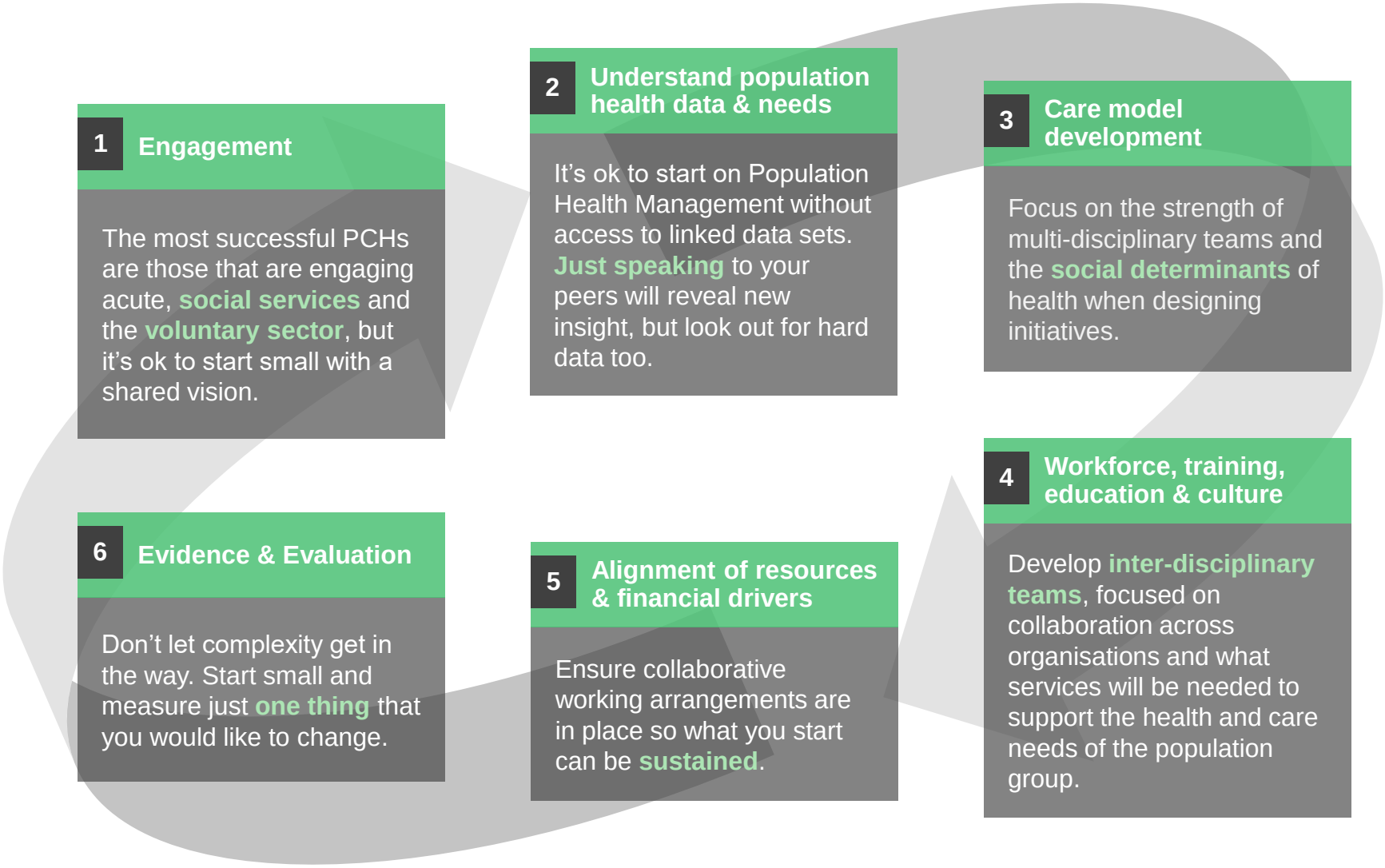
Emerging themes from mature Primary Care Homes



1 Engagement

The most successful PCHs are those that are engaging acute, **social services** and the **voluntary sector**, but it's ok to start small with a shared vision.

2 Understand population health data & needs

It's ok to start on Population Health Management without access to linked data sets. **Just speaking** to your peers will reveal new insight, but look out for hard data too.

3 Care model development

Focus on the strength of multi-disciplinary teams and the **social determinants** of health when designing initiatives.

4 Workforce, training, education & culture

Develop **inter-disciplinary teams**, focused on collaboration across organisations and what services will be needed to support the health and care needs of the population group.

5 Alignment of resources & financial drivers

Ensure collaborative working arrangements are in place so what you start can be **sustained**.

6 Evidence & Evaluation

Don't let complexity get in the way. Start small and measure just **one thing** that you would like to change.

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What are Primary Care Home sites doing?

Analysis of **263** Initiatives

Collaboration

60%

of initiatives are engaging other local partners and **19%** are already working with agencies beyond the health system to address wider determinants of health.

Health Needs

24%

of initiatives are addressing mental health issues. Other common areas of focus include care of the elderly, LTCs, Wellness, Diabetes and MSK.

Care Models

38%

of initiatives include multidisciplinary case management. Other common interventions include social prescribing, specialist co-location, home care, early detection and health promotion.

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How are Primary Care Home sites performing?

Analysis of PCHs covering **10%** of Primary Care

Workforce

8%

more clinical non-GP staff compared to the national average. PCH sites employ proportionally fewer GPs and fewer non-clinical staff compared to the national average.

Population

2%

more people are very happy with their GP practice in PCH sites compared to the national average.

System

3%

lower A&E admission rate in PCH sites compared to the national average and a **9% lower A&E admission** rate when controlled for age. Also the growth in A&E admission is **33% lower in PCH sites.**

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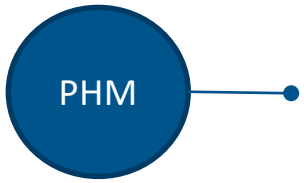
Supporting & enabling integration

Population Health: What Is It In Reality?

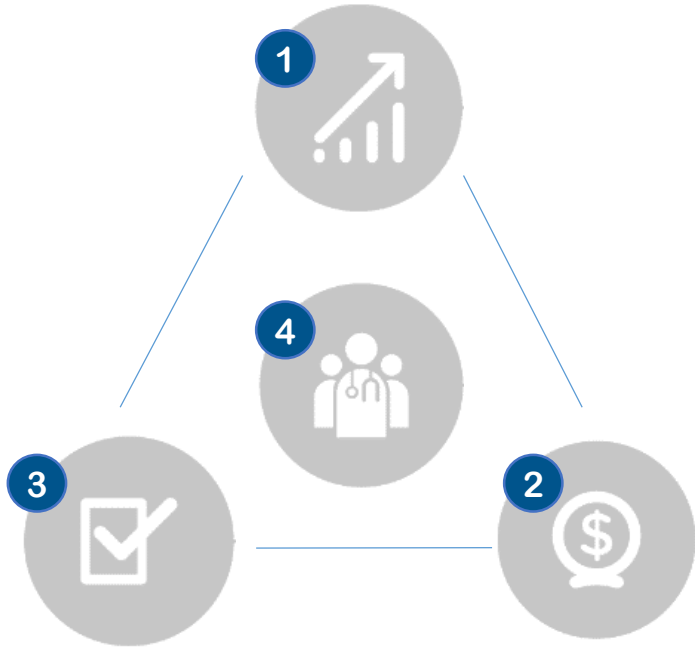
Confed19

Our Perspective: Definition of Population Health Management



The efficient and constant management over time the health needs of the population, through care coordination, disease management, preventive detection and proactive action

Population Health Management: Achieving the Quadruple Aim



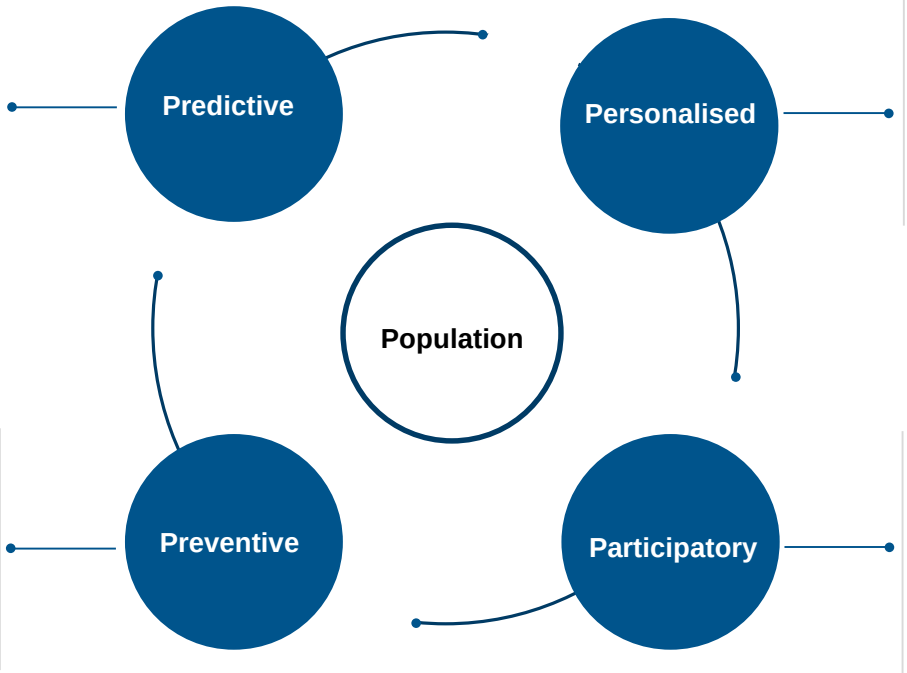
The Main Goals of the Quadruple Aim

1. **Better Outcomes**: improvement of health population outcomes
2. **Reducing Cost**: achieve the goals through efficiency and lower costs per capita
3. **Patient Satisfaction**: the quality improvement should be transmitted to the patients to increase their perception and experience
4. **Professional Commitment**: professionals commitment is the key to achieve the 3 previous goals

Actionable Population Health Management

Predictive 5Ps model

Development of a predictive model of the risk associated with each patient based on different risk adjustment systems



Each citizen has a health plan adapted to their needs, general condition and chronic diseases

The program includes interventions for disease prevention and health promotion

Each citizen is directly involved in their care plans

Population Health Management Supports the Alignment of Resources and Financial Drivers

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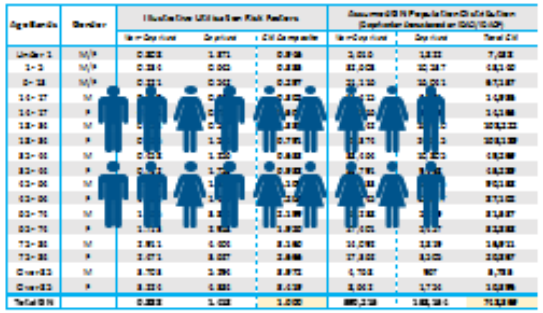
Understanding population risk to manage system



Age Bands	Gender	Illustrative IP Admits/1000 (Medical)			Illustrative IP Admits/1000 (Surgical)		
		Non-Deprived	Deprived	GN Composite	Non-Deprived	Deprived	GN Composite
Under 1	M/F	56.3	95.6	65.9	22.5	38.1	26.3
1 - 5	M/F	16.3	45.0	23.3	6.5	17.9	9.3
6 - 13	M/F	15.4	37.8	20.7	6.1	15.1	8.3
14 - 17	M	13.2	46.6	21.1	5.3	18.6	8.4
14 - 17	F	29.4	54.7	35.4	11.7	21.8	14.1
18 - 34	M	17.6	39.5	23.0	7.0	15.8	9.2
18 - 34	F	38.7	107.0	55.1	15.4	42.7	22.0
35 - 44	M	31.9	87.5	44.1	12.7	34.9	17.6
35 - 44	F	50.3	122.0	65.4	20.1	48.7	26.1
45 - 64	M	73.6	93.1	77.1	29.3	37.1	30.7
45 - 64	F	80.5	99.6	83.9	32.1	39.7	33.4
65 - 74	M	130.0	268.7	153.3	51.8	107.2	61.1
65 - 74	F	119.4	206.2	133.8	47.6	82.2	53.4
75 - 84	M	202.9	306.9	220.2	80.9	122.4	87.8
75 - 84	F	172.3	252.8	185.8	68.7	100.8	74.1
Over 85	M	258.1	369.0	276.8	102.9	147.2	110.4
Over 85	F	224.7	305.6	238.3	89.6	121.9	95.1
Total GN		61.9	98.8	69.7	24.7	39.4	27.8

Understand Total Individual Risk Factor (TIRF) to inform aggregate analysis. This considers demographic, socioeconomic, and health information.

Develop a composite (segment/cohort) view of risk factors: Understanding individual risk factors enables to understand wider risk by segment and/or cohorts

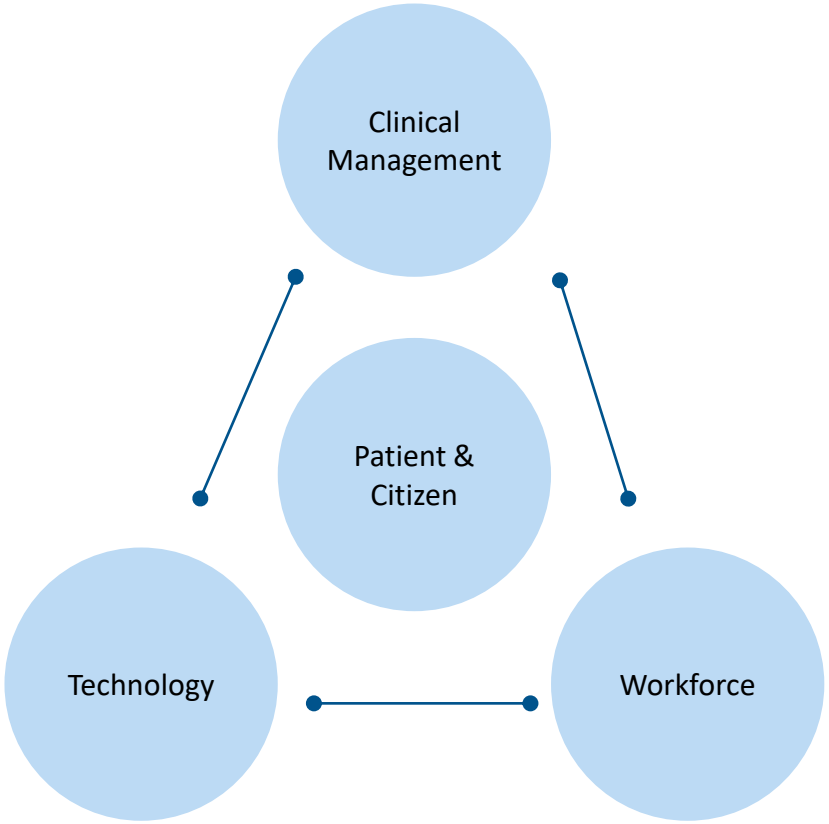
Use risk factors to project future utilisation: An understanding of risk factors provides ability to forecast/project expected utilisation. From this it is possible to monitor performance to identify variation in performance

Actionable Population Health Management

Learning from International Experience

Supporting & enabling integration

Ribera Salud: Triangle of Success



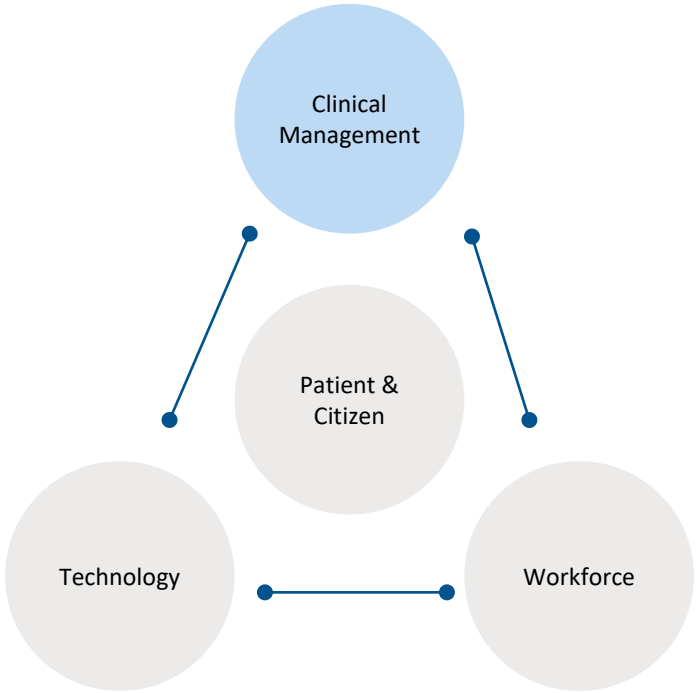
The Model Combines the Strengths of:

- A citizen-centred clinical management strategy
- Modern workforce management
- A cross functional information system
- The Citizens are at the heart of the model

These elements are self-reinforcing in a continuous process of improvement

Actionable Population Health Management

Learning from International Experience



Clinical Management

- Proactive population health management, personalised care and patient / carer engagement
- Health and wellbeing as the ultimate goal. Healthcare promotion, education and prevention
- Better coordinated care
- Reduced clinical variation

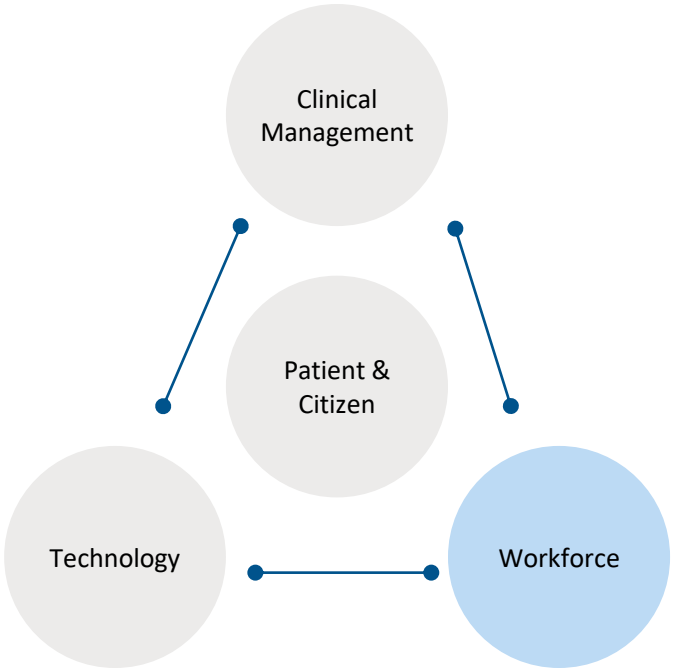
PHM allows for the appropriate utilisation of scarce resources across the system

Actionable Population Health Management

Learning from International Experience

Supporting & enabling integration

Ribera Salud: Triangle of Success



Workforce

- Supporting culture change
- Talent attraction, promotion and retention
- Professional career development plans

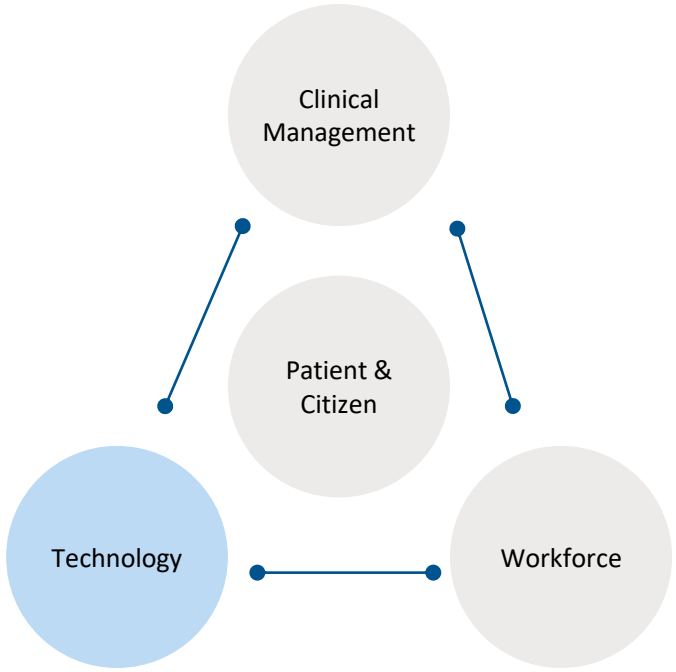
Ensuring the highest levels of staff satisfaction

Actionable Population Health Management

Learning from International Experience

Supporting & enabling integration

Ribera Salud: Triangle of Success



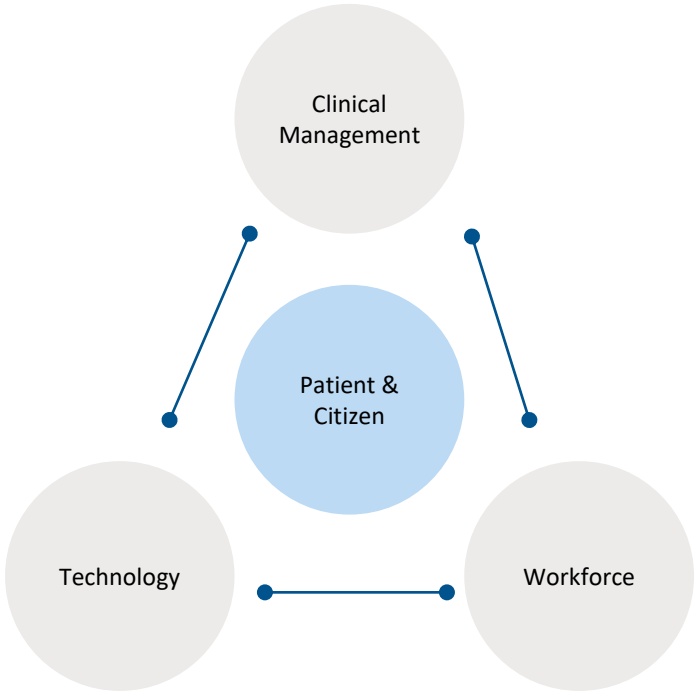
Technology

- Improving Care Coordination
- Increasing Patient Access to Care
- Enhancing Patient Engagement in Care
- Proactive and Preventive Focus versus Reactive

Technology is an enabler to facilitate change and depends on strong clinical management and an empowered workforce to be successful

Actionable Population Health Management

Learning from International Experience



Patient / Citizen

- Right care at the right time
- A focus on prevention and health education
- Encouraging self care
- High levels of patient satisfaction and confidence

Patients are active participants in the management of their healthcare

Using Technology to Support Actionable Population Health Management

Patient portal

Patients are able to access their care plan via a patient portal. It also enables them to interact with health care professionals digitally

Jim is able to access results of appointments, upload information and contact is care team if he has any concerns or issues

Risk Stratification and Segmentation

Frequent, comprehensive stratification of the population identifies patients who could benefit from coordinated care

Jim has multiple long term conditions including heart failure and diabetes. He is identified as high risk.

Assessment and Care Plan

Dedicated multi-disciplinary care management team performs personalised assessment with patient

Jim is invited to meet with the care management team to explore goals and ways to manage his condition

TruCare

The outcome of the assessment results in a personalised care plan which is uploaded and shared electronically

Jim is able to access a copy of his care plan via the portal

Care management

Primary care

Hospital teams

Care plan delivery

Care management teams share the care plan and work to the same care plan with designated tasks. Patients remain part of care management until goals achieved

Jim attends appointments with relevant professionals as agreed in care plan. Continues to have regular meetings with care coordinator

PCNs and the Delivery of Actionable Population Health Management: Supporting System Integration

Centene ICS Framework

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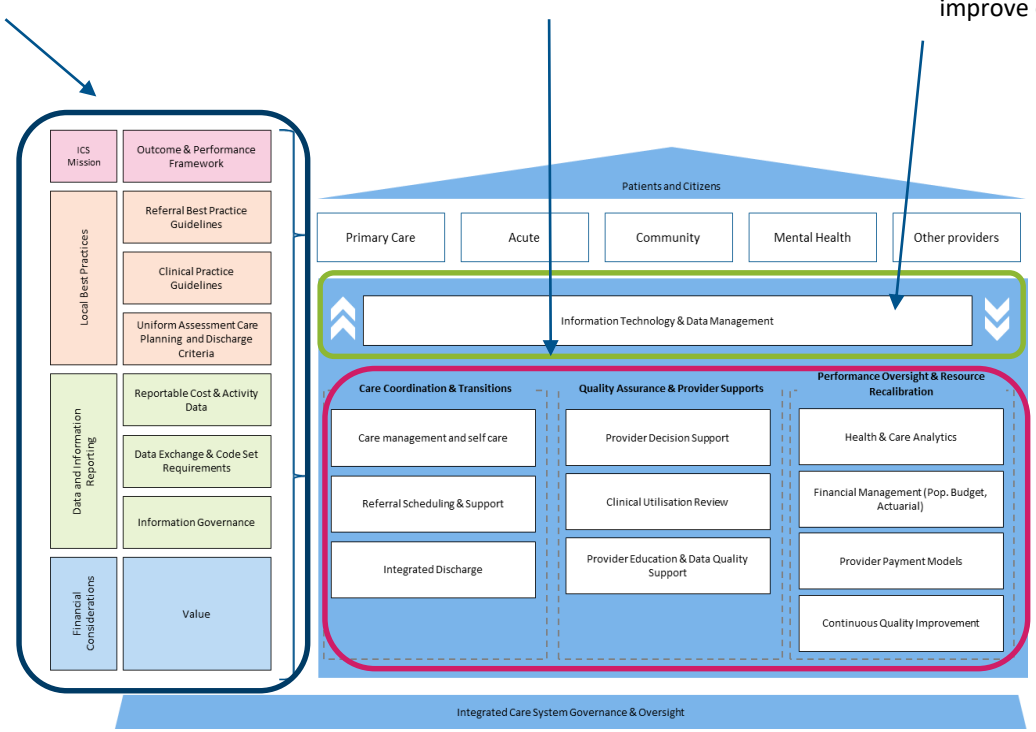
Supporting & enabling integration

Enablers
- Shared outcomes for system and population
- Agreed guidelines
- Shared data and information including cost and activity

Functions
- Ongoing support functions ensure services are able to apply enablers effectively improving population outcomes

Technology
- Used to enhance application of integration functions and embed enablers
- Improve access and improve outcomes



Developing Primary Care Networks to Deliver Population Health

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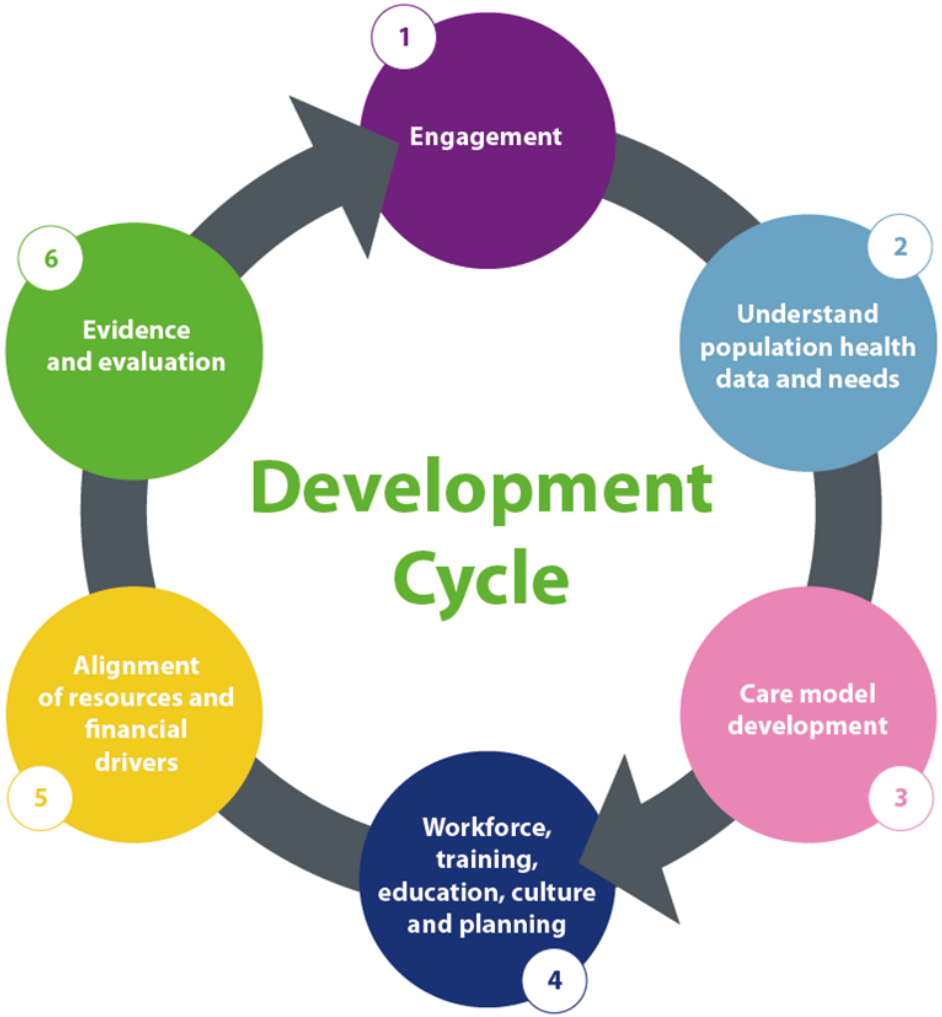

The Ribera Approach

https://www.youtube.com/watch?v=vGnZiCgkdo4&app

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