Conrane IHS
International Health Solutions

4. Population Health Management

Opportunities and
how to realise them

- Overview
- Identifying the Population(s) at risk
- Bespoke Care Pathways
- Core Workforce roles
- Decision Support Tools

1. Overview

Core to the Integrated Care Systems (ICSs) are a focus on more pro-active care for people with chronic disease. In one large ICS footprint, an analysis of the population using the Johns Hopkins ACGs risk adjustment tool has highlighted the opportunities for proactive programmes with co-production as a core objective. 23% of the population could benefit from supportive self-care, They have differing levels of needs and thus support requirements from health and social care.

Core components of the service profiles are care coordination or defragmentation and aligning the interventions with the needs profiles of those sub-set of the population who can most benefit from. Nationally about 1 in 4 people have at least one long-term condition (1). This proportion increases with age, deprivation and some aspects of ethnicity (see page five for the MCP's position). This population is not homogenous and exhibits a range of needs from patients with a stable, early on-set condition (which can be managed within enhanced primary care) through to co-morbid patients with high complexity, and end of life care. Hence in order to align interventions to differential need:

- *The single condition management service* is aimed at patients with a single condition which due to degree of progression, instability and adherence challenges require levels of intervention and support which cannot be offered within enhanced primary care.

- *Care coordination* is aimed at two sub-sets of multi-morbid patients: (a) those with a degree of complexity but who can be transitioned to supportive self-care with an intensive but time-limited programme:

- Advanced Illness those with high degrees of complexity and major functional deficit which required a more protracted case management programme involving a multi-disciplinary team.

- Both services will be offered to nursing and residential home residents whose staff act as carers.

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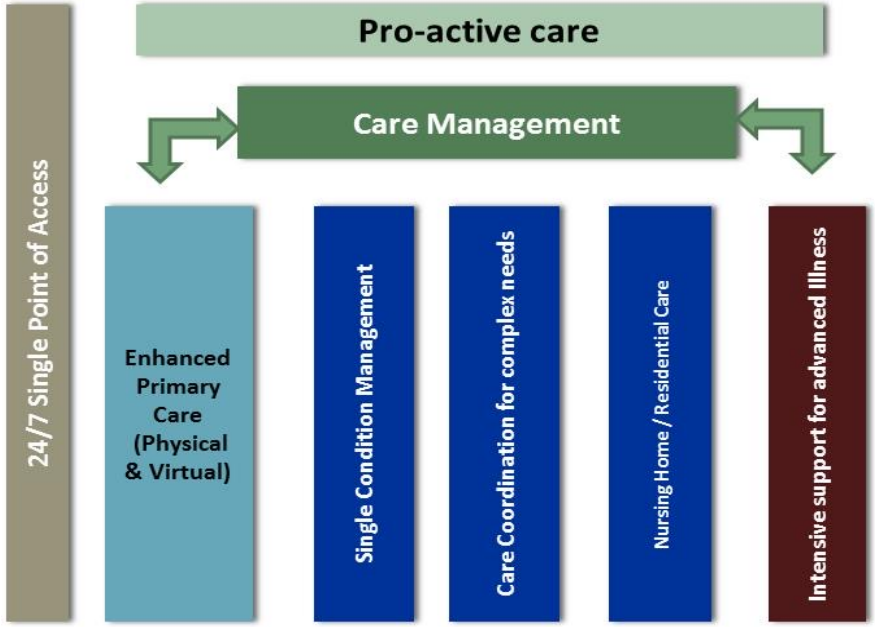
The services access initially via the 24/7 single point of access at which point referrals will be initially triaged. Patterns of need will be initially articulated using risk stratification and evidence-based referral guidelines and then confirmed and elaborated during detailed assessment at patient enrolment process. Interventions will be delivered by a key worker with multi-disciplinary team support for the most complex, through face to face contact and/or virtually using telephonic coaching and assistive technology.



Structure of the document from this point.

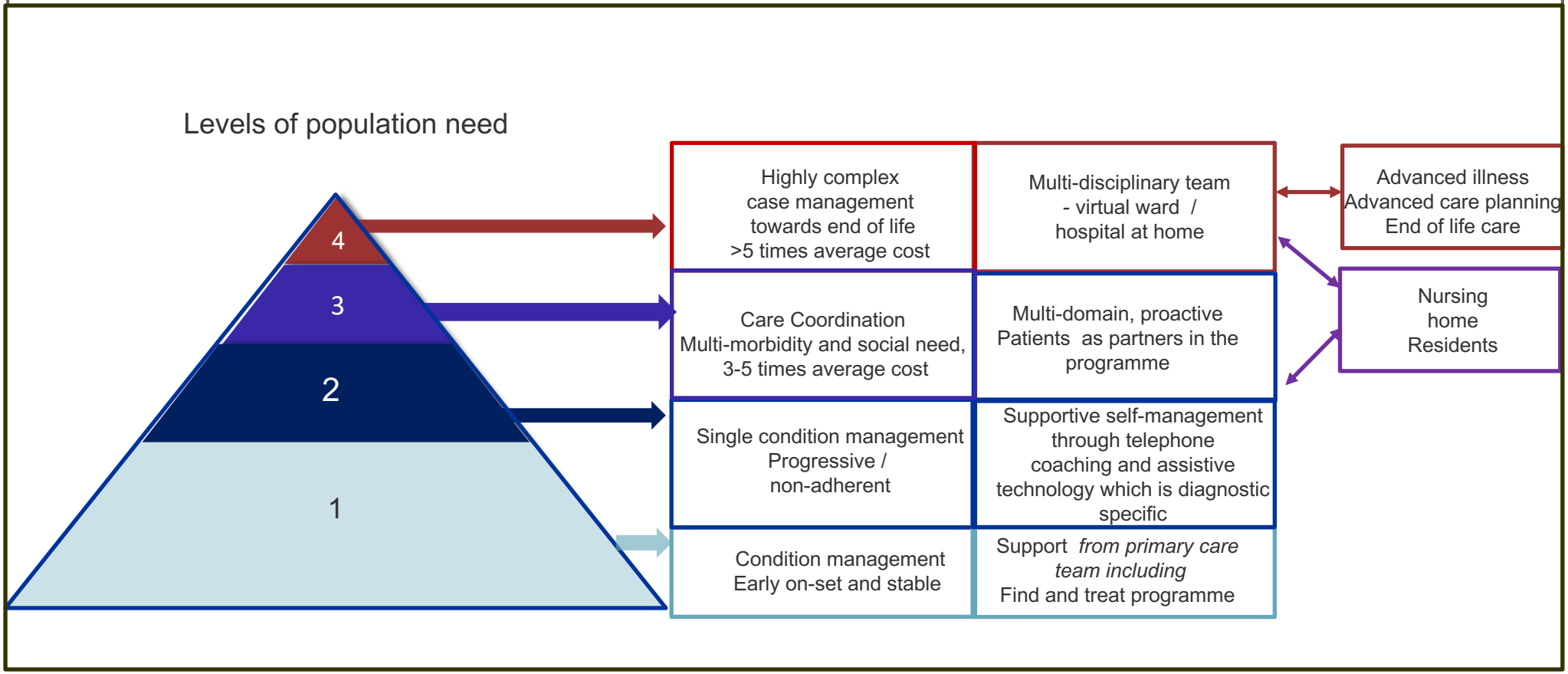
In section 2 of this document we set out the expected population sub-sets to be offered condition management and complex case management. 4 levels of need are identified.

Section 3 covers patient identification and enrolment,, process descriptions and management pathways *for levels 2, 3 and 4 patients* and expected, patient engagement periods with the services and on-going referral.

Section 4 sets out the key workforce roles and decision-support tool requirements

2. 1 Populations subsets who can benefit from more proactive care

The schematic represents the sub-sets of need within the population with at least one long-term condition:
(described in narrative on the next page)



These subsets represent more of a continuum than precisely differentiated, homogenous groupings. In terms of prevalence, the proportion of patients in the population with one or more long-term conditions varies with a local health economy's age profile, ethnicity, deprivation and ultimately case-mix

2.2 Populations subsets needing condition and case management

Description of the sub-sets of need within the population with at least one long-term condition.

Level 1 condition management patients (managed by enhanced primary care) Targeting low risk populations Early diagnosis of a single long-term condition which may need daily medication or life-style management such as diet. Patients will be capable of self-management and adherence and thus require only intermittent monitoring by the primary care team delivered by periodic review (depending on the diagnosis). Includes a 'find and treat' programme for pre-diagnosis patients at risk.

Level 2 condition management patients Targeting moderate risk populations, focused on managing 'climber' population to maintain health status and/or prevent exacerbation. These patients will have a predominant single life-threatening but manageable long-term condition such as: diabetes, COPD, CHF, IHD, and sometimes alongside this less serious conditions such as blood pressure. They will be on a treatment programme which requires specific significant clinical management such as daily medication, and monitoring such as weight, blood pressure, blood sugars etc. These patients will require regular support contact to remain adherent to treatment programmes.

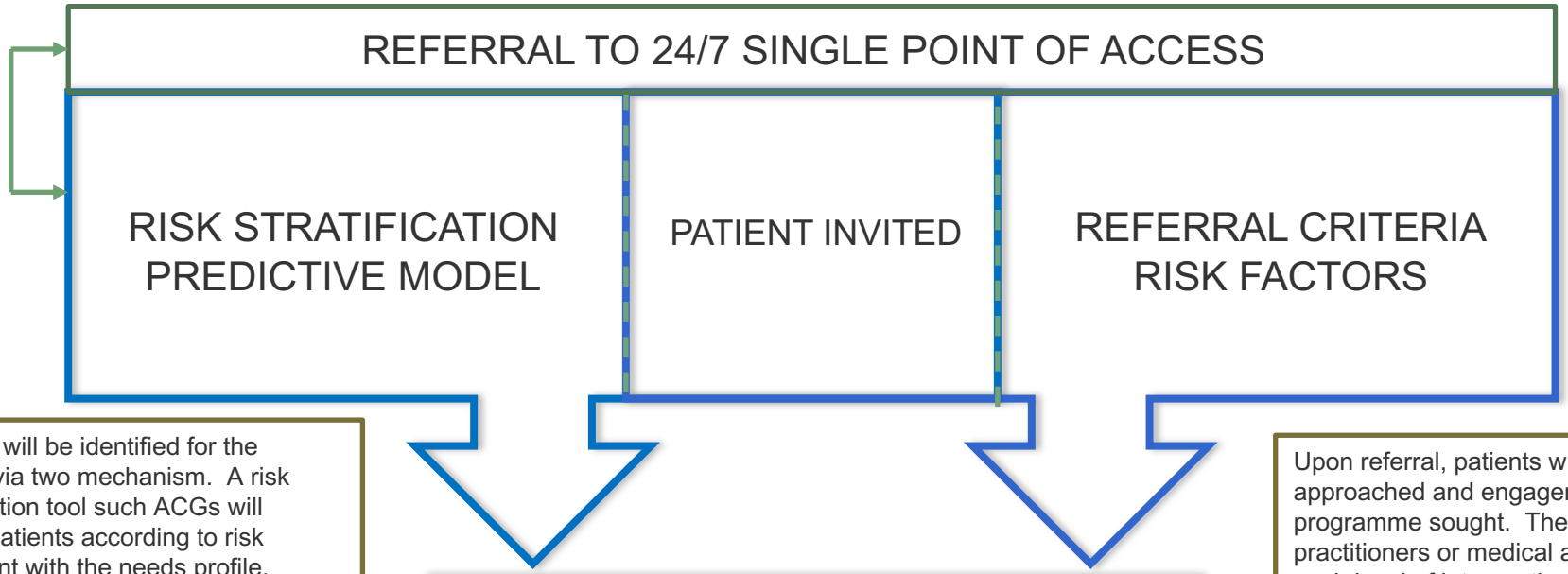
Level 3 patients represent 90% of multi-morbid patients (range of 3-7% of the total population) often with associated social and functional needs but not only less complex than level 4 (below) they can benefit from a time-limited intervention. They will be typically be consuming between 2 and 5 times the average per capita cost, be at high risk of future admission, and have been in receipt of care from multiple practitioners in the previous 12 months. They will have high potential for self-management and motivation to engage with services more pro-actively. Initially engaged and assessed face to face, once care plans are in place, they may be transitioned to self-care with primary care team support or transfer to virtual management and coaching alongside level 2 patients.

Level 4 highest-risk patients represent around 10% of multi-morbid, complex needs patients (typically 0.5% of the total population), with progressive disease profiles, and very significant cognitive and functional deficits; often house-bound. They typically consume > 5 times the average health care costs(secondary and primary care) and have experienced two or more unscheduled hospital admissions in the previous year. They have limited potential for self-management upon assessment, require the input of a multi-disciplinary team and need regular contact with services over a relatively protractive period. Some level 4 patients transition to advanced illness defined as being in last 12 months of life. The intervention then focuses on the development of an advanced care plan and explicit end-of life goal setting, as well as symptom management.

Advanced illness : Targeting individuals identified as being in last 12 months of life. Focused on development of anticipatory care plan and explicit goal setting, as well as symptom management.

For residents of nursing / residential home offered bespoke care management services: Targeting nursing home and residential care population (e.g. frail elderly, young people with physical disabilities), MCP care managers and nurses working in collaboration with the partners to provide care coordination and case management to all patients living in care homes. Nursing home case managers allocated to set care homes in order to respond early, provide preventative oversight, monitor changes, and communicate with treating GP. Supports early identification of an exacerbation of an illness allowing for early and proactive treatment. Includes step-up programmes to match exacerbating cases to the right clinical resource and settings (e.g. capacity planning intermediate care resources).

3. 1 Patient identification, and enrollment



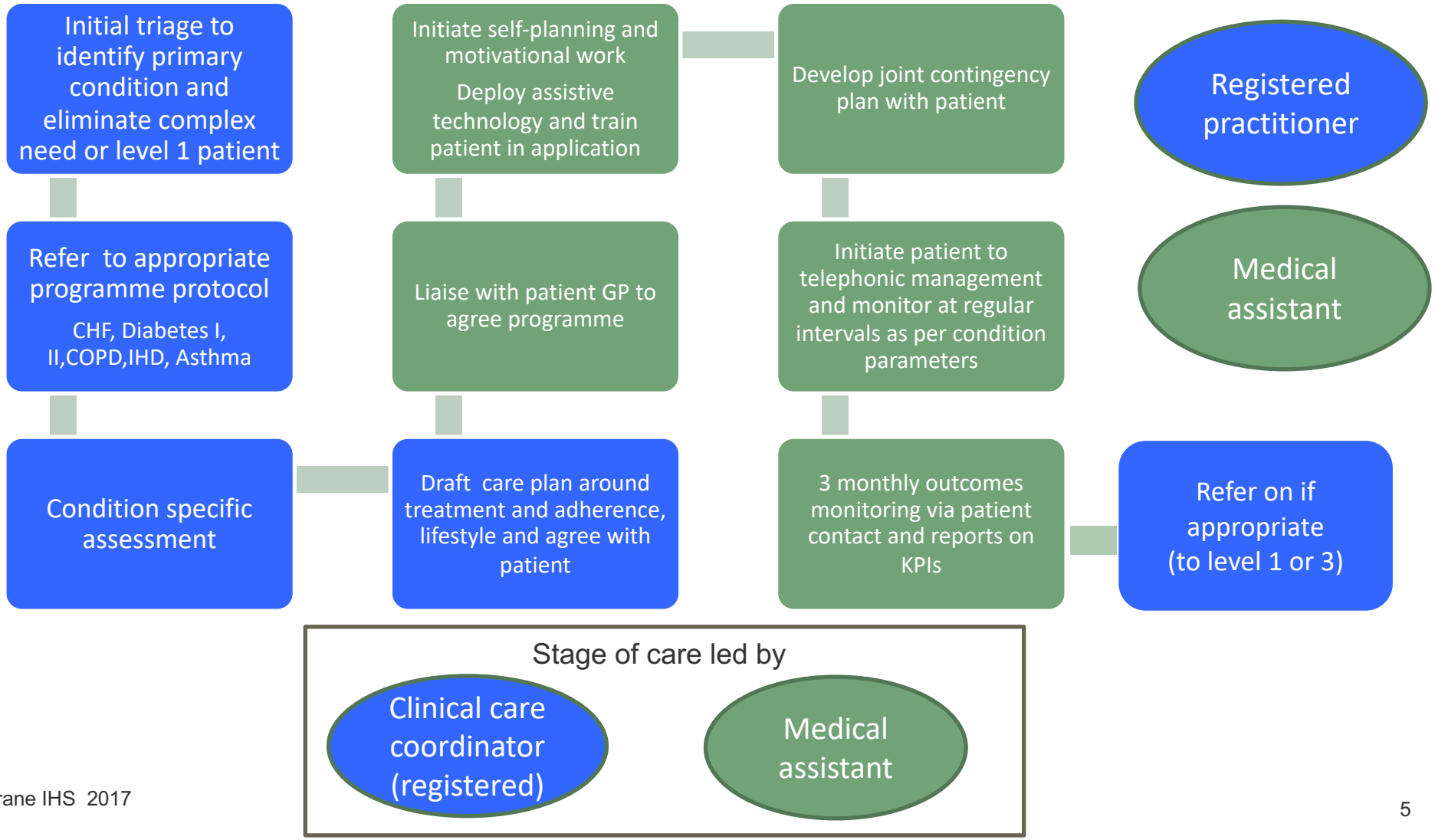
Patients will be identified for the service via two mechanism. A risk stratification tool such ACGs will stratify patients according to risk consistent with the needs profile. There are two categories – multi-morbidity and single-diagnosis patients. Each category will be further divided by degree case-mix and level of intervention expected. The service will also accept direct referrals according to the agreed criteria. Rights of referral will be accorded to the patients and carers, GPs and practice staff, associated health services such as district nursing, and the multi-disciplinary team. Referrals will be coordinated via the 24/7 single point of access (SPA. The 24/7 SPA will manage the risk stratification process and liaise direct with the GP's and advise of patients who are risk but have not yet been referred,

Upon referral, patients will be approached and engagement in the programme sought. The lead practitioners or medical assistants at each level of intervention will initially contact patients on behalf of the GP. Where required the GP will write directly to the patient. Only patients initially agreeing to participate will be invited to the next assessment stage.

Targets for patient participation rate participation rates will be:
Level 4 – 90%
Level 3 – 90%
Level 2 – 60%

Each patient will be assessed according the operational policy of each level of intervention. At that point the final decision to enter the patient into the programme is made.

3. 1. Management pathway for level 2 patients (detailed pathway is condition specific)



3. 2 Management pathway for level 3 patients (detailed pathway is patient specific)

Multi-domain assessment in the home setting

Agree programme objectives with patient, carers, home staff

Draft multi-domain care plan and agree with GP

Involve MDT if required

Coordinate further staff input as required

(e.g. SW, MH, Re-ablement)

Initiate self-planning and motivational work

Develop joint contingency plan with patient

Agree phased implementation and milestones with patient and carers (home staff)

Connect patient to community resources as required

Transition patient to telephonic management, deploy assistive technology and monitor

Discharge once agreed with patient that care plan fully implemented and stable for 4 weeks

3 monthly outcomes monitoring via patient contact and reports on KPIs

Stage of care led by

Clinical care coordinator (registered)

Medical assistant

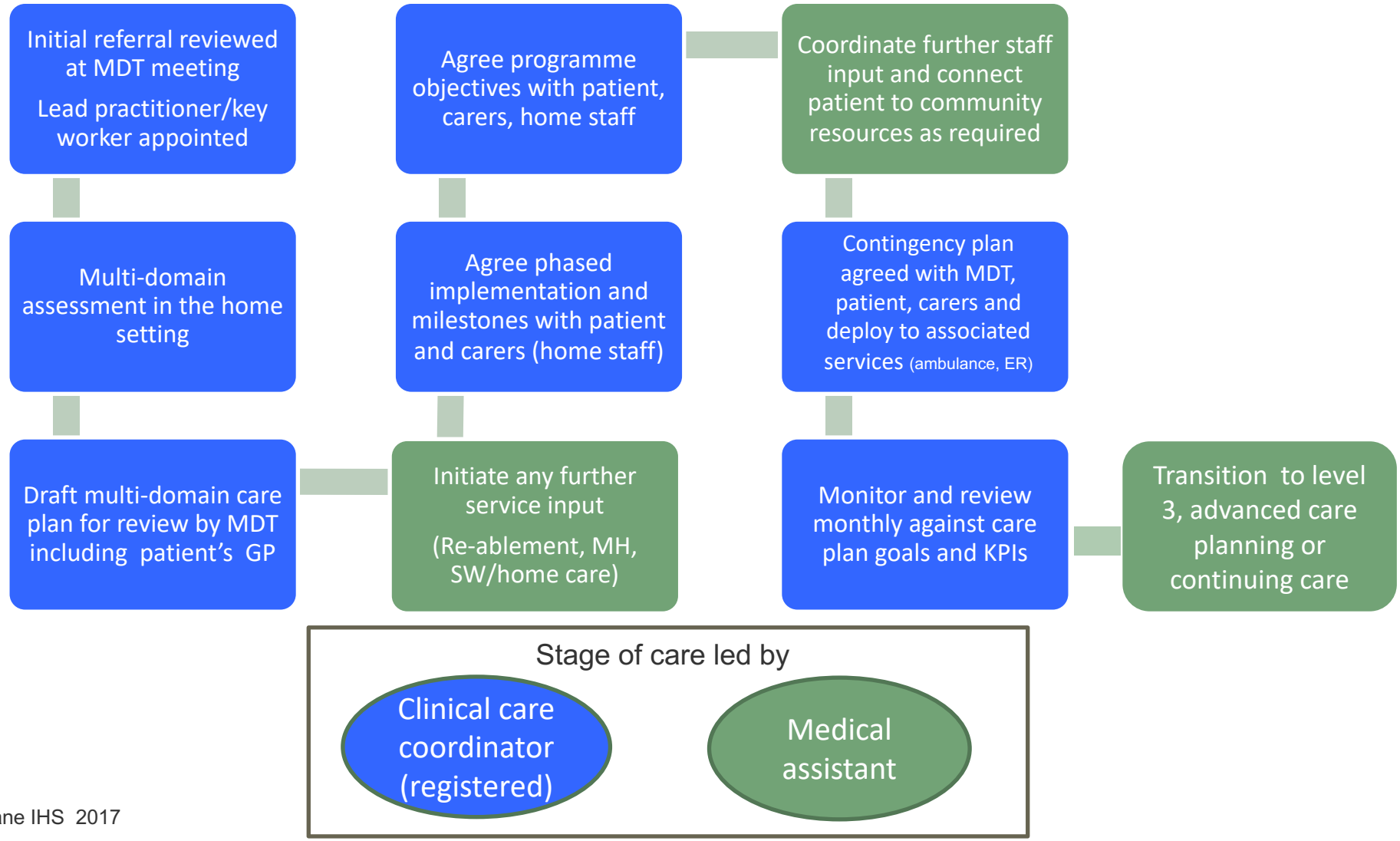
TRANSITIONING TO SELF-MANAGEMENT

In the red phase, (weeks 1 – 4) patients are identified and assessed with the GP fully involved. They are engaged in a partnership approach via face-to-face assessment.

In the amber phase, (weeks 5-8) the patient and practitioner sets the objectives and the joint holistic care plan and patient education programme is developed. Multi-disciplinary team input is involved as required. The plan is then set into train.

In the green phase (weeks 9-13) the patient has become largely self-managing, supported where necessary by mainstream primary and social care and/or community resources Measureable clinical and utilisation parameters are under control and the patient can be discharged into with periodic monitoring.

3. 3 management pathway for level 4 patients (detailed pathway is condition specific)



3. 4 Service engagement periods and on-going referral

Patient profile	Expected period of engagement	Referral to on-going care
Level 4	Up to *12* months Review every 3 months	If patient improves significantly refer to level 3. If no progression, refer to continuing care or initiate advanced care planning
Level 3	Average of 12 weeks Maximum 6 months 3 monthly monitoring	Refer on to health coaching or primary care team including DNs. *If significant deterioration* refer to level 4 service
Level 2	Remain engaged medium-term 3 monthly review	If adherence declines and complexity ensues refer to level 3 service If progression halted and adherence improves refer to level 1
PATIENT ENGAGEMENT IS HOME-BASED INCLUDING RESIDENTIAL HOMES (where staff are carers)		

The *core* workforce will comprise registered practitioners and medial assistants all assessed as competent in their respective roles to manage the client groups. These staff will work to evidence-based care pathways and practice manuals which along with the competence frameworks will be agreed with/accredited by the MCP. Other specialist roles will provide sessional input to the team overall. (see section 4)

Patients with long-term conditions can both improve (the principle intention of the service), remain stable (the minimum aim) or further progress. They thus move up and down the needs profile triangle. They should therefore be subject to regular review with a view to referring to more appropriate care as required. The primary aim should be to move patients down the continuum on care to a less intensive intervention. To illustrate this, Level 1 and 2 patients who remain stable may remain in the service for the medium term; if level 2 patients improve they can managed at level 1 within primary care Patients with multi-morbidity at level 4 who may improve will benefit from a level 3 intervention to progress to greater self-management. Others who make no progression and or decline should be referred on to a continuing care service or advanced care planning if in the last 12 months of life.

Specific services offered to residents of nursing and residential care homes: Targeting nursing home and residential care population (e.g. frail elderly, young people with physical disabilities), Specific MCP practitioners allocated to particular homes, working in collaboration with the partners to provide care coordination and case management to all residents. Nursing home case managers allocated to set care homes. Also supports admission avoidance by early identification of an exacerbation of an illness allowing for early and proactive treatment by MCP staff and strengthening the resilience of home-staff in clinical management capacity of less severe cases without need for referral. Includes step-up programmes to match patients to the right clinical resource and settings.

4. 1 Core workforce roles – indicative job contents

Complex Care coordinator – Registered practitioner

- Risk adjustment and stratification modelling
- Assessment and care planning
- Patient self-management coaching; education and counselling;
- Medication management (minimum);
- Motivational interviewing and managing people telephonically,
- Health coaching and monitoring
- Working in multi-disciplinary environment;
- Care transition planning; contingency/disease trajectory planning
- Management of patient pathways
- Coordination of additional health, social and 3rd sector l services.
- Clinical supervision of medical assistants
- Coordinates with staff and Nursing Homes on patient management
- Participate in clinical audit and outcomes reporting
- Disease management modules
- Non-medical prescribing

Practitioners should abide by the NMC Code of Conduct, and it clearly states that they "put the interests of people using or needing nursing services first' and the Coalition for Collaborative Care NHS England 2015"

Independently assessed as competent in above
Grade as Agenda for Change grade 7

Example of a medical assistant job content

Position Summary

The medical assistant is responsible for a variety of case management duties working ***under the direction of the registered staff***. The medical assistant is responsible for utilizing Nursing Process to ensure that quality care is provided to adult patients with chronic conditions and complex needs.

Qualifications upon entry

Current NVQ 2/3 certification
Previous experience as primary care HCA preferred

Essential Functions of the Job

- Customer service
- Manage Referrals
- Manage Recall Lists
- Provide health teaching, advocacy, counselling and assistance to a group or population of patients defined as at High Risk for Admission or Re-Admission and support what is in best interest of patient or group
- Engage with and managing patients on the telephone or in the home
- Monitor and coordinate chronic disease management and supports patient monitoring procedures
- Maintains a register of 3rd sector services
- Document virtual visits
- Records and collates outcomes KPIs

Knowledge and skills

- Understands clinical parameters of specific conditions
- Engagement and motivational skills;
- Risk adjustment and stratification modelling
- Understanding the various referring agencies;
- Risk management including understanding boundaries re practitioners
- Working in multi-disciplinary environment

Independently assessed as competent in above: Agenda for Change grade 4

All staff will work to the agreed patient flow processes and pathways for each level of care and the associated practice manuals and patient documentation. These will be agreed with / accredited by the MCP. The competence frameworks for staff which complement these documents will be agreed with / accredited by the MCP.

4. 3 Decision support tools Risk stratification requirement and referral criteria

Risk stratification specification

- Predictive power - Predictive power is measured as C-statistic (relative reliability of the forecast), Predictive models that achieve in excess of 0.7
- are a minimum standard.
- All risk groups identified (delivers intelligence of level 3/4, very-high risk patients, level 2, and level 1 other patients with long-term conditions who are at moderate and low risk),
- Comprehensive data set for all patients by GP practice
- Shows current population case mix
- Shows current and predictive costs per patient
- Reports show patients by chronic condition and allows sub-setting by diagnosis
- Supports comparative case-mix analysis by GP practice
- Predictive of future resource usage including likelihood of hospitalisations
- Allows clinical staff to sort patients on relevant criteria
- Allows users to input intervention programme markers
- Is updated regularly – minimum of 3 monthly
- Supports outcomes measurement
- Exports data into standard applications software

Referral criteria Level 2 patients

Level 2 patients (the presence of 2 or more criteria on same patient may indicate need for entrance into condition management):

- Diagnosis of diabetes, I, II, CHF, Asthma, COPD etc with progression
- Medication adherence problems
- Disease parameters not controlled
- Recent and severe exacerbation of LTC
- Hospitalizations in past 12 months (especially if for the above diagnosis)
- A and E visits in past 12 months (especially if for same diagnosis)

Referral criteria Level 3 and 4 patients

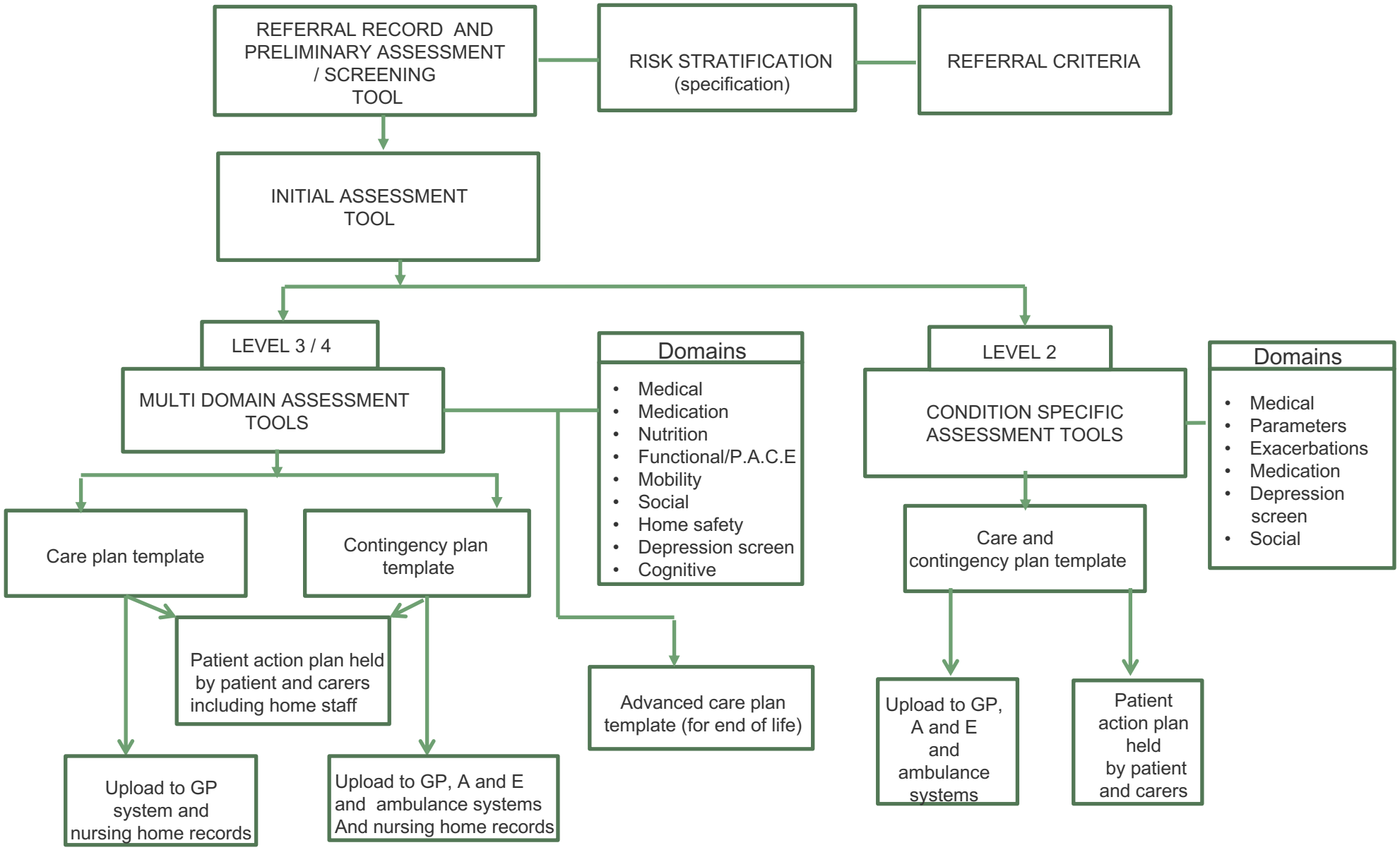
Level 3 patients High Risk Profiles (the presence of 3 or more criteria on same patient may indicate need for entrance into case management

- As above plus
- Four or more active chronic diagnosis
- Four or more medications prescribed on a chronic basis; more than six months
- Recent and severe exacerbation of LTC and/or two falls in the previous two months
- Biochemical or anthropometric evidence of malnutrition
- Adherence problems
- Significant impairment in one or more major activities of daily living (bathing, toileting, dressing, etc.)
- Significant impairment in one or more of the instrumental activities of daily living (preparing meals, shopping, basic housekeeping, transportation, etc., particularly in absence of a support system)
- Lives alone with no viable carer
- Recently bereaved, particularly if life partner
- 75 Years of age or older (an additional risk factor)

Level 4 patients As above plus

- Major impairment in one or more major activities of daily living (bathing, toileting, dressing, etc.)
- Major impairment in one or more of the instrumental activities of daily living (preparing meals, shopping, basic housekeeping, transportation, etc., particularly in absence of a support system)
- Currently housebound
- 85 years or older (an additional risk factor)

4. 2 Decision support tools



Conrane IHS
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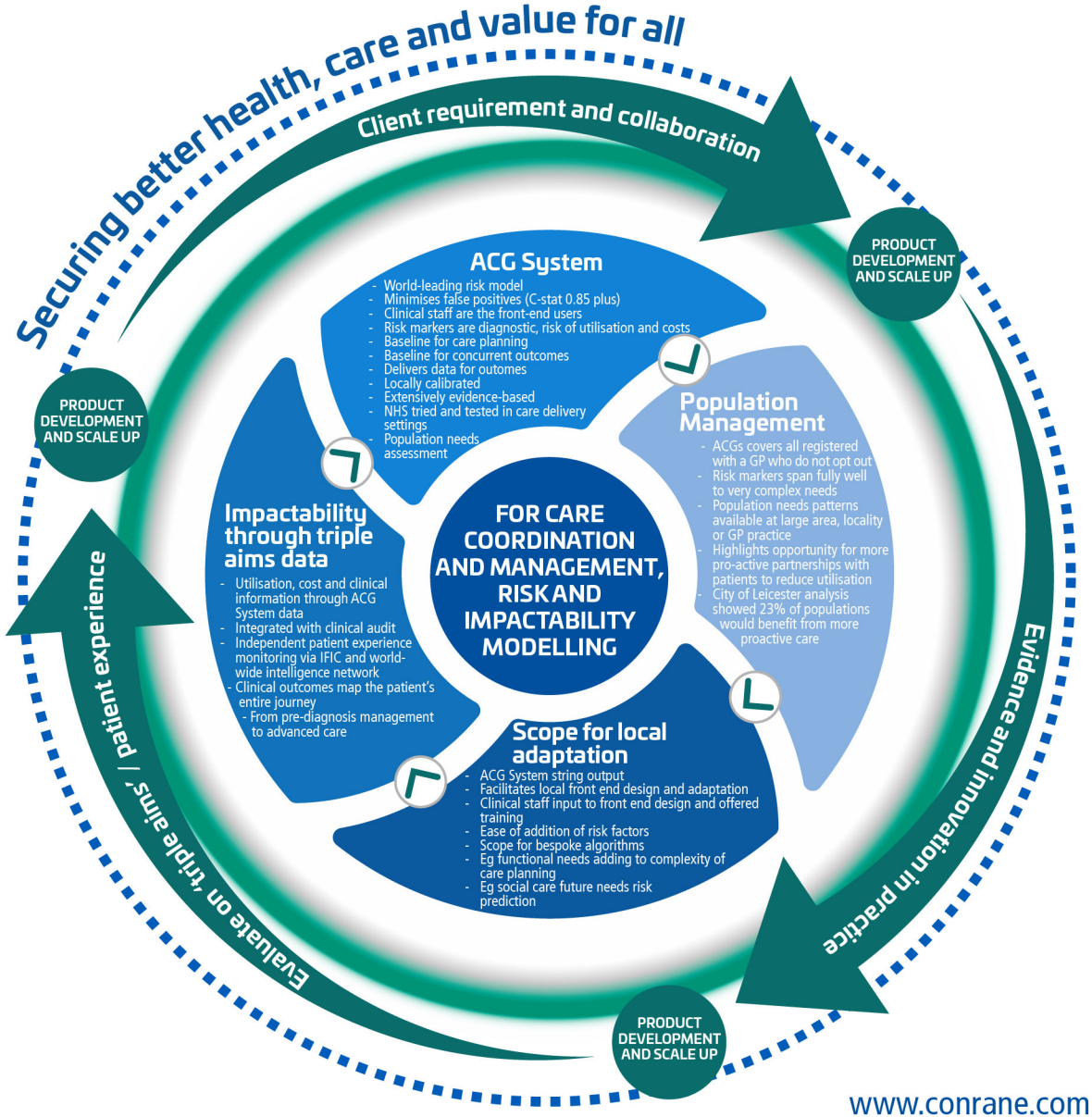
INFORMATICS, ANALYTICS AND DIGITAL TOOLS

Our knowledge and experience demonstrates that the pursuit of improved quality and patient experience in health reform will deliver whole system value for money.

We bring together skills, experience and products that support innovative and workable solutions to 21st century healthcare challenges.

These include:

- Integrated Care at ICS and Place-levels
- Acute utilisation review and demand management
- Innovative business cases including Vanguards and other Integrated Care Hubs
- Whole system redesign
- Long-term Conditions – Care coordination, case management and Guided Care
- Population health management using the Johns Hopkins Adjusted Clinical Groups Tool
- Risk adjusted resource allocation and management
- Workforce planning in acute, community and primary care
- Workforce and process re-design
- International healthcare system reform working with the World Bank and other major donor organisations



www.conrane.com

Contact David Cochrane
Phone: 07970739656
Email: info@conrane.com