NHS England

LTC care for the future: Person Centred Co-ordinated Care

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Opening thought

The good physician treats the disease; the great physician treats the patient who has the disease.

William Osler - 1800s

Global challenges

Increasing demand

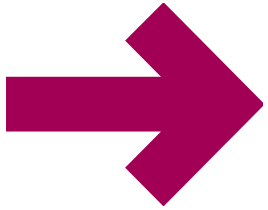
- Rise of chronic conditions and multi-morbidity: physical and mental
- Ageing population
- Increasing system wide expectations: access, treatment, cure not care

Supply pressures

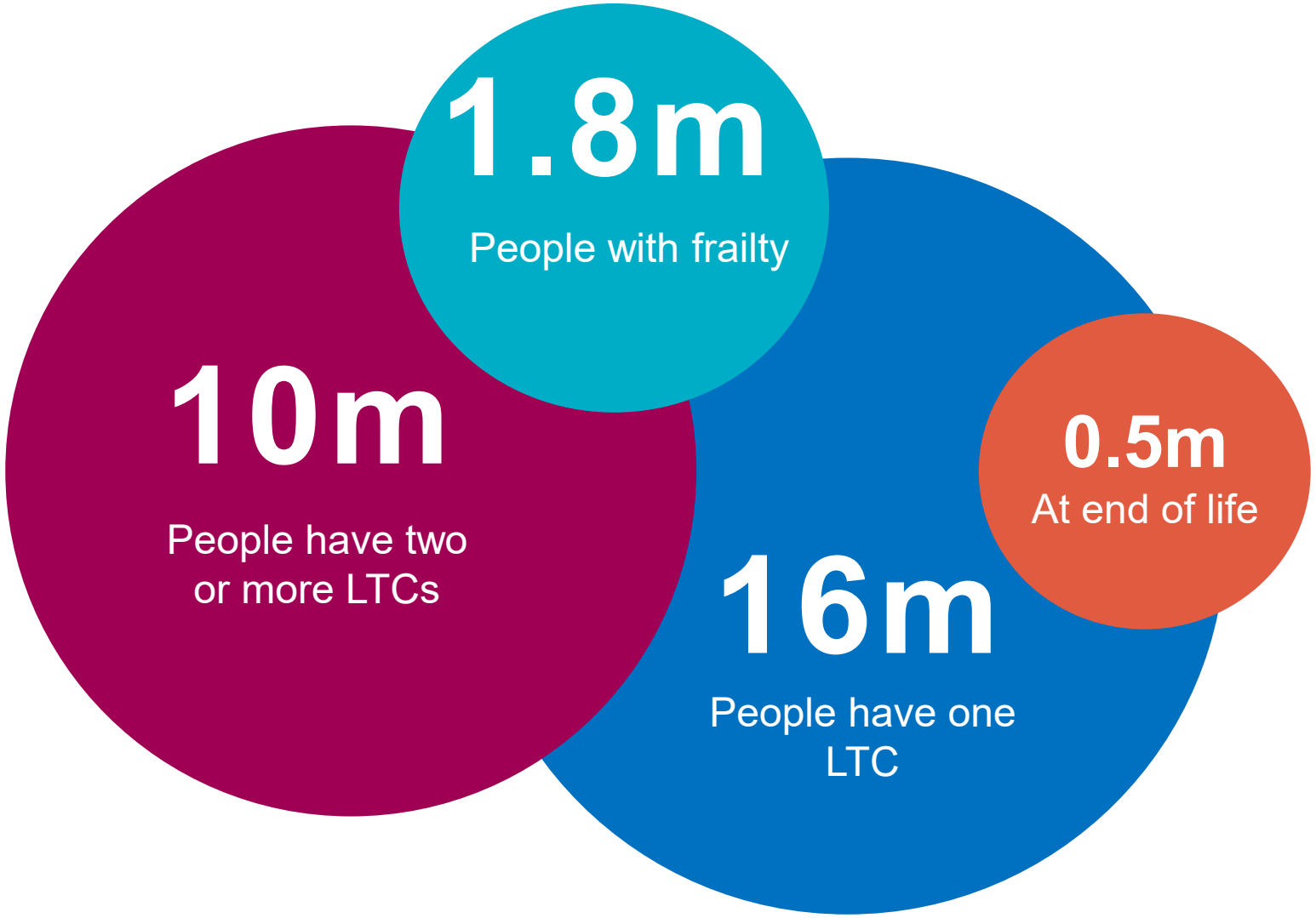
- Dependence on system
- Hospital and medic-centric care models
- Workforce – recruitment & retention, diversity and culture
- Fragmentation of care in health and to social care
- Crisis curve

Solution – Transforming what we buy and how we buy it:

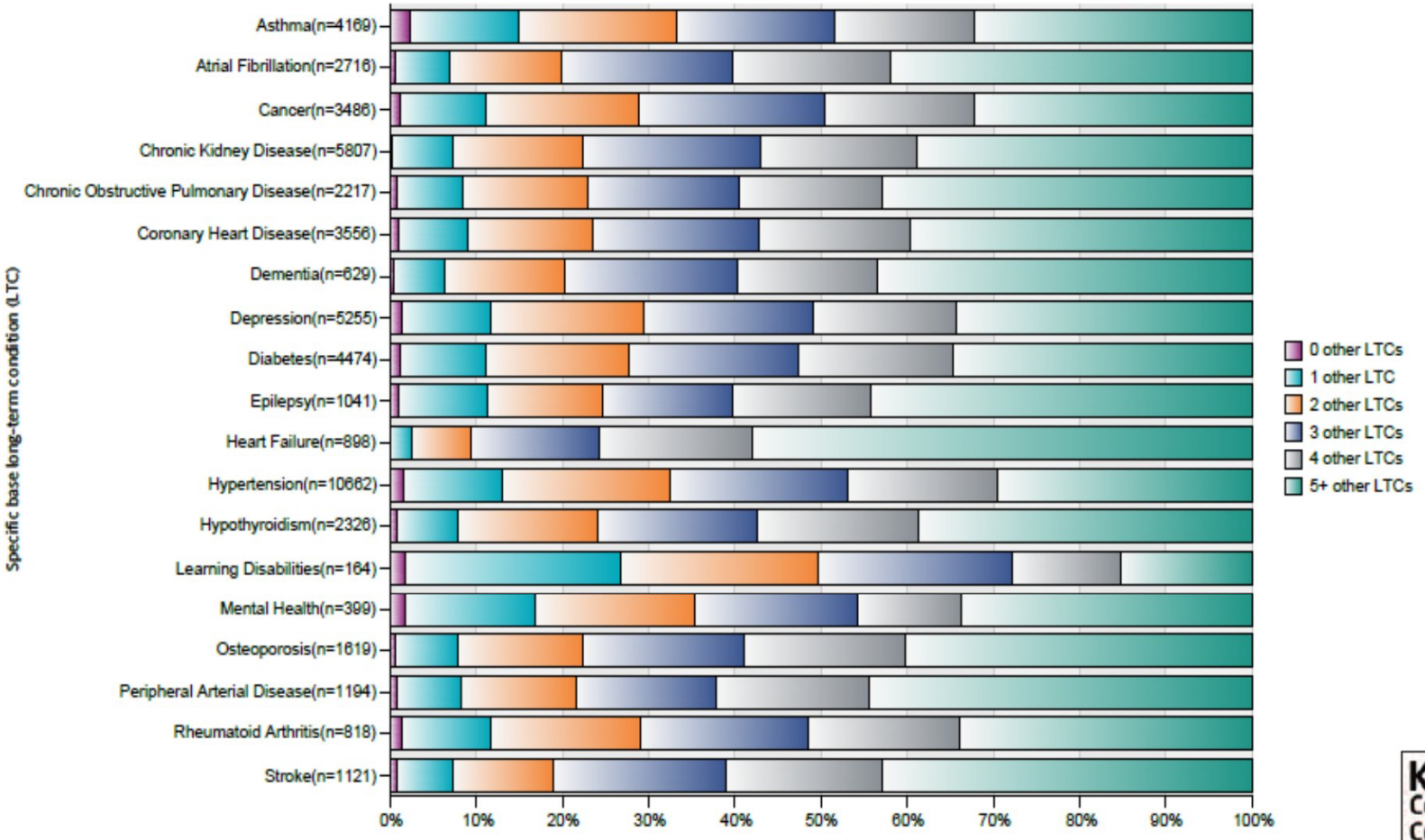
- Person centred co-ordinated care – whole person approach to improve outcomes and value



Long term conditions: some facts



Multi Morbidity is Common…….:



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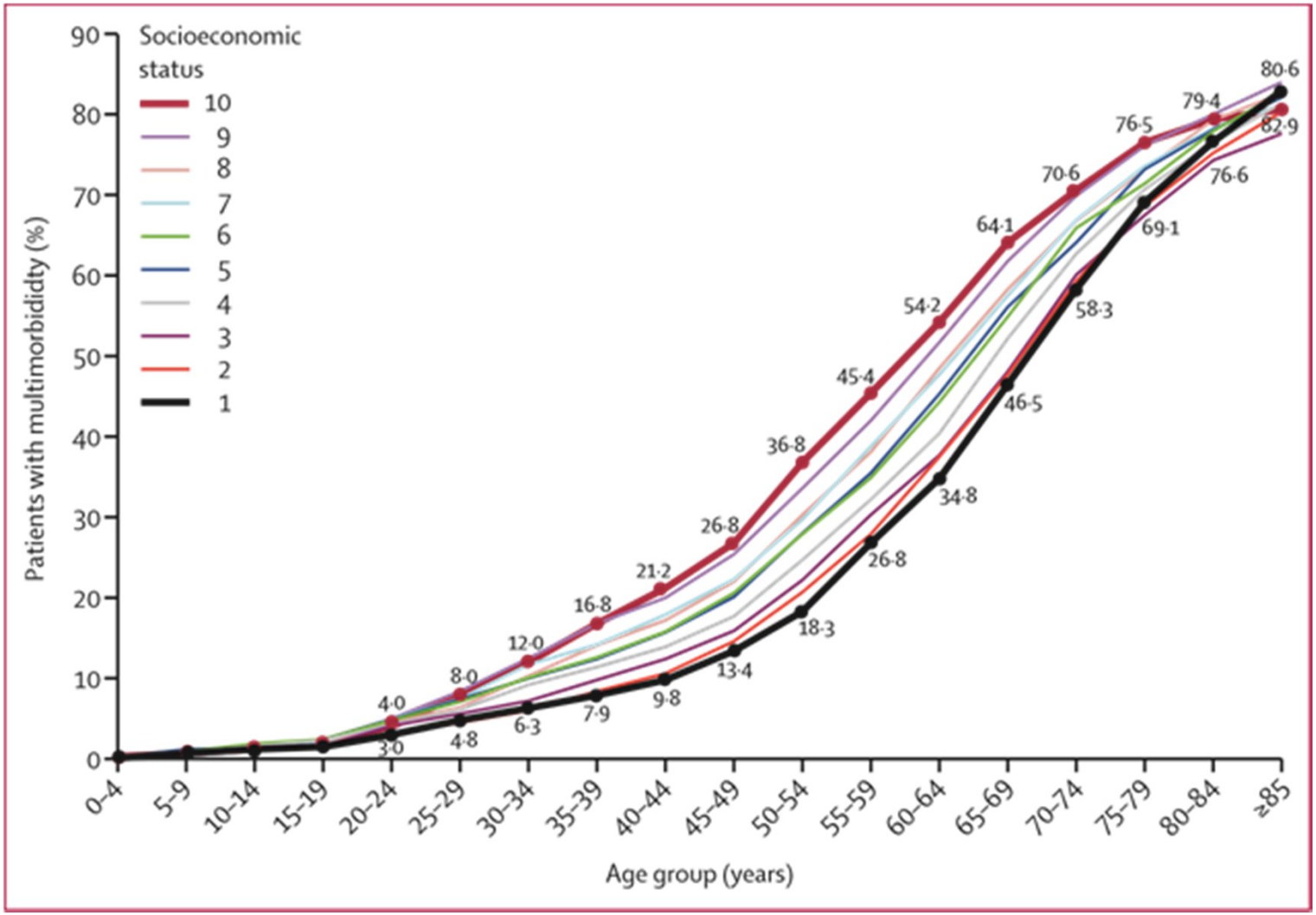
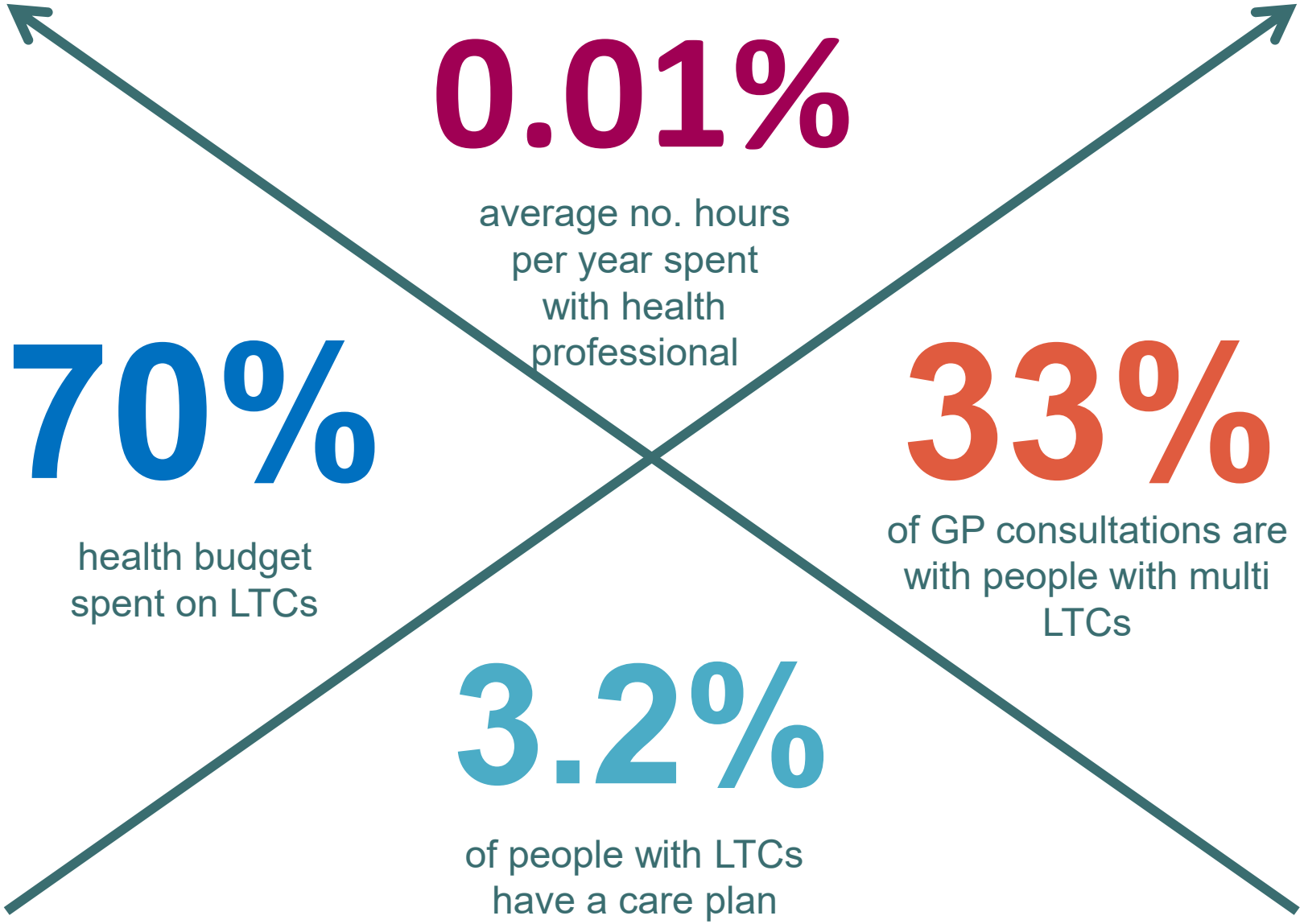
…..and an issue of ageing not age:

Prevalence of multimorbidity by age and socioeconomic status On socioeconomic status scale, 1=most affluent and 10=most deprived.

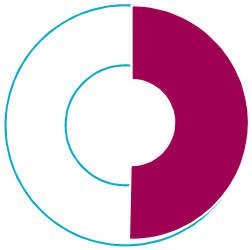


Source: Barnett K, Mercer SW, Norbury M, Watt G, Wyke S and Guthrie B (2012). Research paper. Epidemiology of multi-morbidity and implications for health care, research and medical education: a cross-sectional study The Lancet online

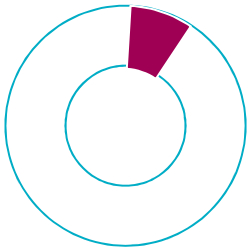
Long term conditions: some facts



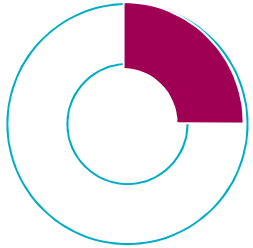
Impact on the system

50  50

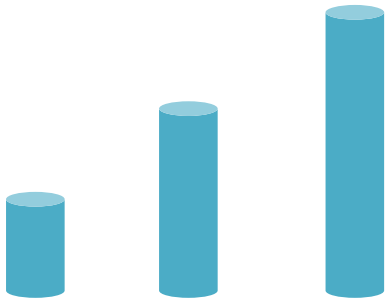
50% of total emergency beds days for over 75s

96  4

4% over 65s in care home with 14% total emergency admissions for over 65s

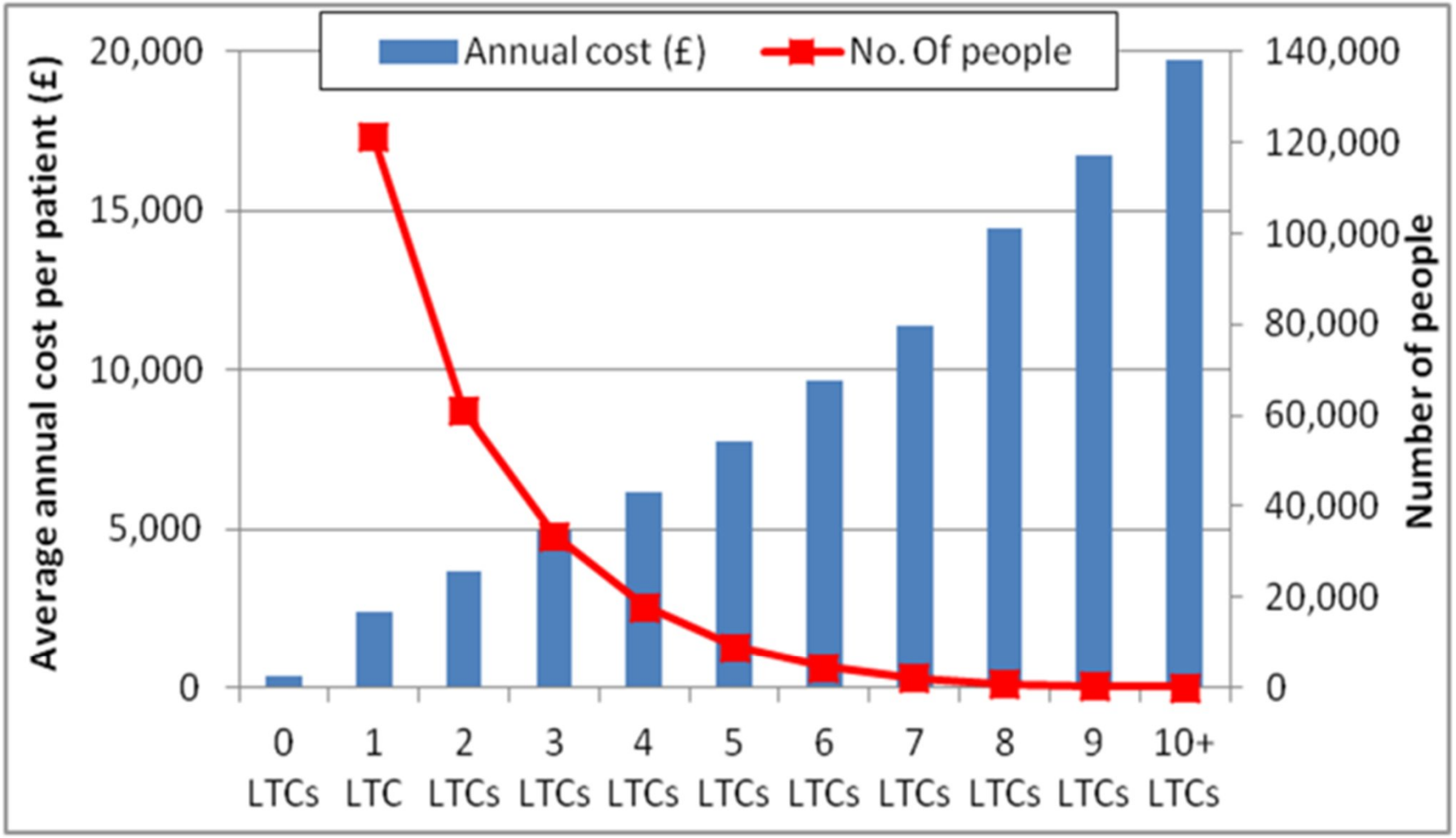
70  25

25% of hospital beds occupied by someone dying



Three-fold increase in cost of health care with frailty

The total health and social care cost is strongly related to multi morbidity:



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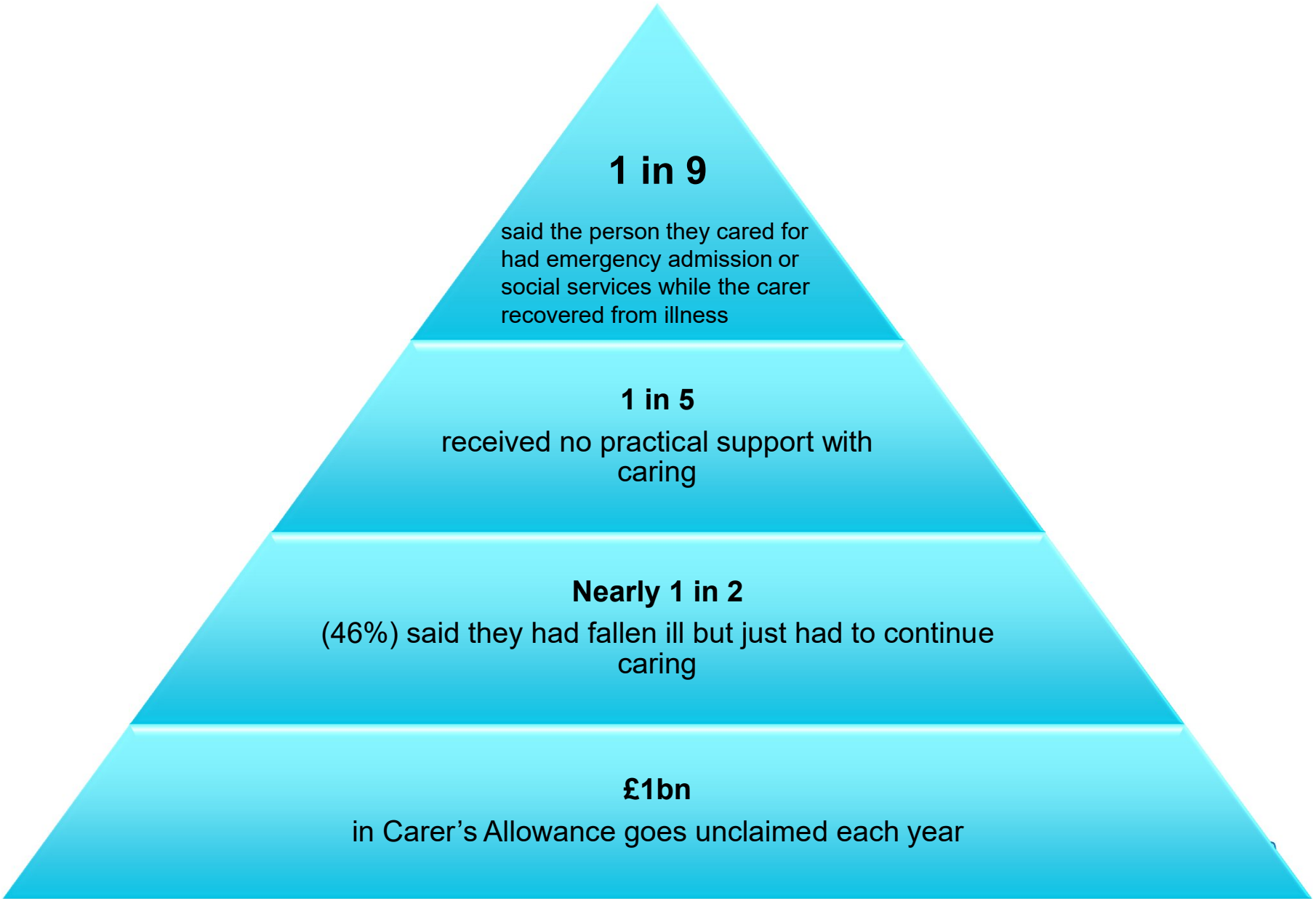
Impact on Carers



And…

- People living longer but not always well
- The larger the number of co-morbidities a patient has, the lower their quality of life
- Increasing evidence on over-treatment and harm
- Social isolation/loneliness a risk factor for mortality in over 75s and should be supported as a co-morbidity

Why does it matter to people with LTCs?

- Wellbeing is about more than just medically managing a condition
- It's about thriving not just surviving
- It's an ethical, social and financial issue
- Shared decision-making is key
- We need to take support people to self-care, feel in control
- No one knows more about their condition than the patient

Navigating health and care: Living independently with long term conditions, an ethnographic evaluation

- http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/navigating-health-and-care.aspx

Outcomes and benefits

- More activated patients have **8% lower** costs in the base year and **21% lower** costs in the following year than less activated patients
- Health coaching can yield a **63% cost saving** from reduced clinical time, giving a potential annual saving of £12,438 per FTE from a training cost of £400
- Coaching and care co-ordination has shown to **reduce emergency admissions by 24%**
- Improved medication adherence improves outcomes and yields efficiencies, for instance in 6000 adults in the UK with Cystic Fibrosis, could save more than **£100 million over 5-years**
- Between **20% and 30% of hospital admissions** in over 85's could be prevented by proactive case finding, frailty assessment, care planning and use of services outside of hospital (Mytton et al, 2012)

Goal:

Improve quality of life and experience of end of life care for people with Long Term Conditions and their carers through:

Person centred coordinated care

"My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes"

National Voices
People shaping health and social care

Long Term Conditions Year of Care Commissioning Programme

- Launched in 2010 by Department of Health (Sir John Oldham) commissioned and delivered by NHS England
- Patients receive care that is better managed, delivered seamlessly across different care settings and focused on patient needs **using different commissioning and funding approaches**
- Four year programme

Rationale:

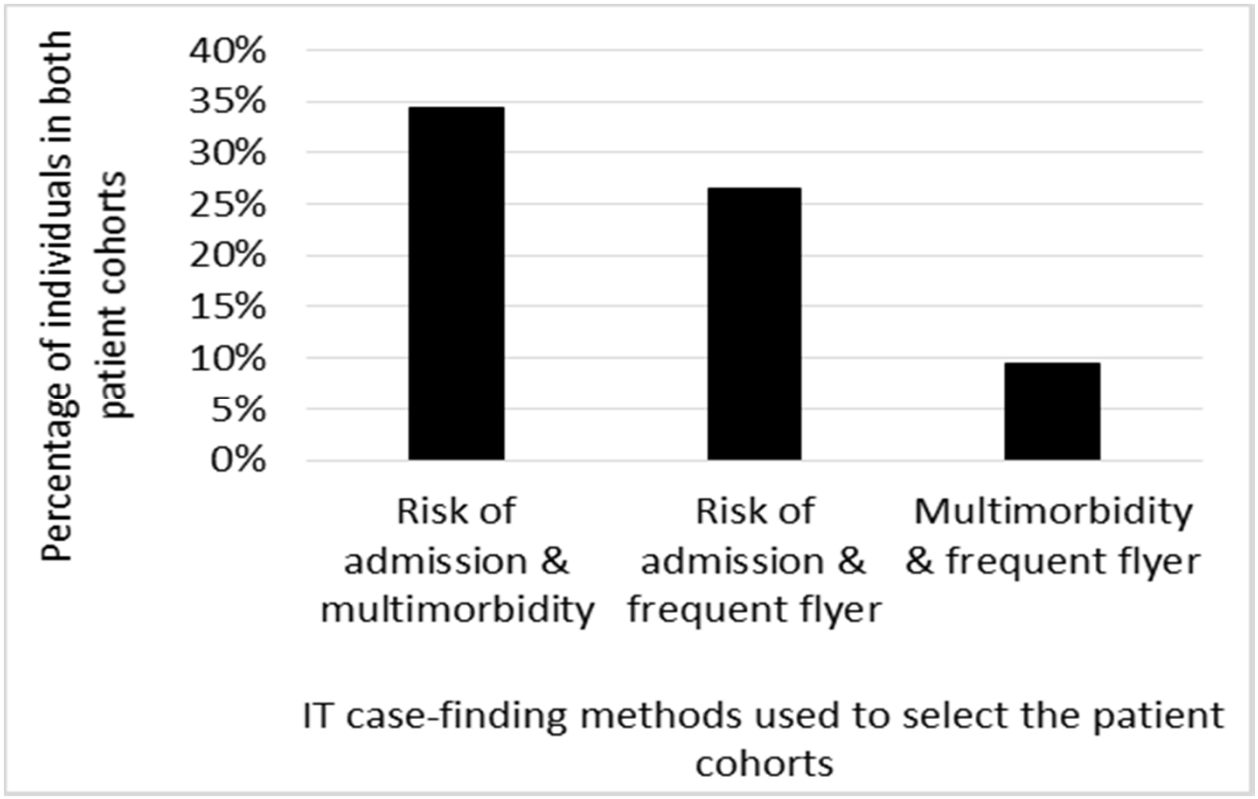
- **Multi morbidity is common**
- **Patients with multi morbidity have complex care needs and would benefit from personalised integrated care**
- **An integrated payment would encourage integration of services and cost efficiency**

Risk Profiling and population segmentation

- There are many techniques that can be used to segment a population.
- Different segmentation methods select different individuals
- The method used should match the outcomes required for the cohort to ensure applicability of any planned delivery model.
- IT-based segmentation should only be part of the selection: The Commonwealth fund paper ***"Segmenting populations to Tailor services, Improve Care, 2015"*** sets out the need to go beyond basic risk prediction to target care in most effectively and efficiently.
- Selected patients still need to be assessed for their care needs before a care plan is developed and services delivered.

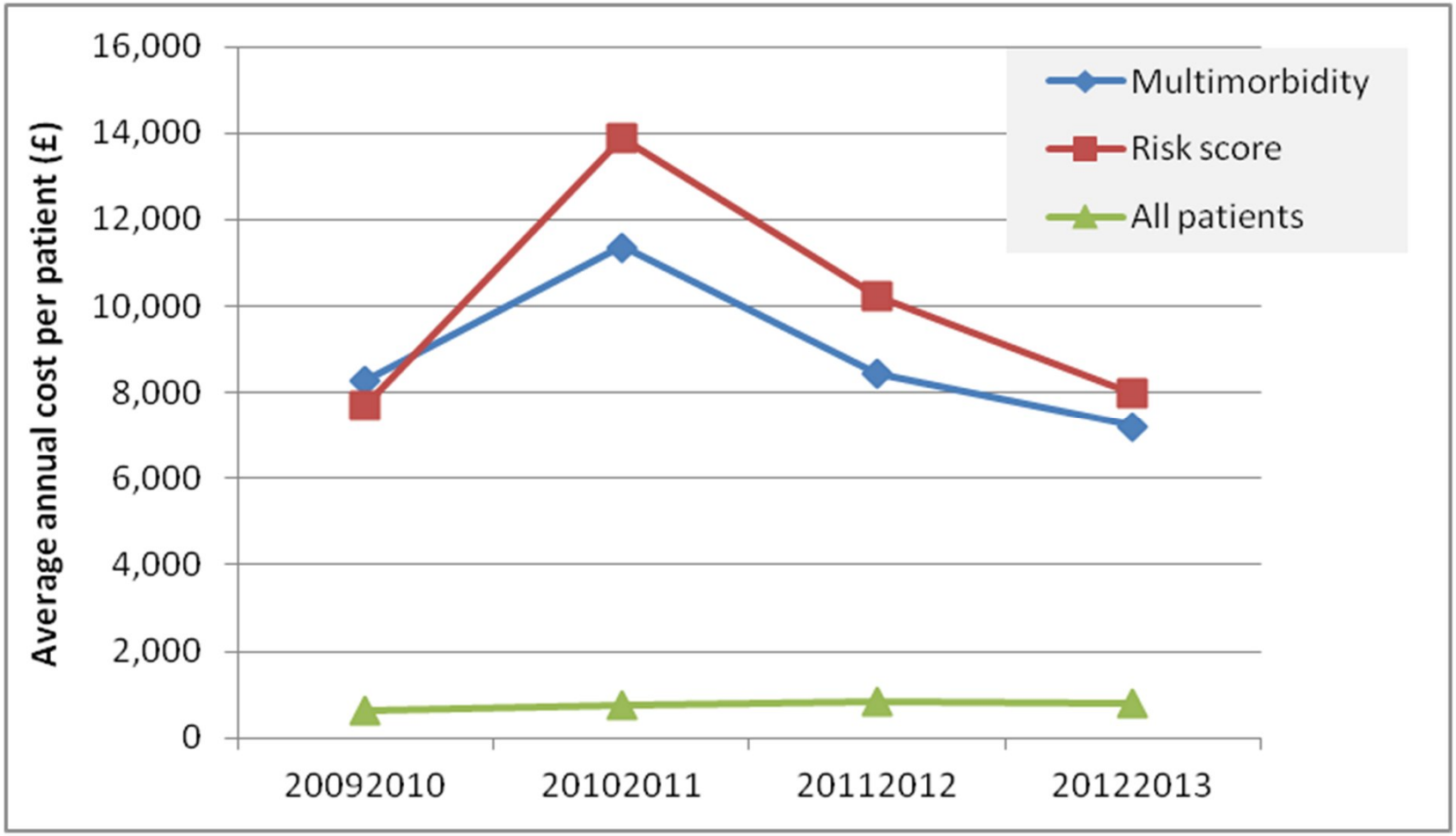
Risk Profiling and population segmentation

Overlap between patient cohorts selected using risk of admission, multimorbidity and frequent flyer IT case-finding methods



Change in risk profiling over time: The Crisis curve

People with complex health and care needs appear to demonstrate a ‘complex crisis curve’:



Multimorbidity appears to select a more stable patient cohort

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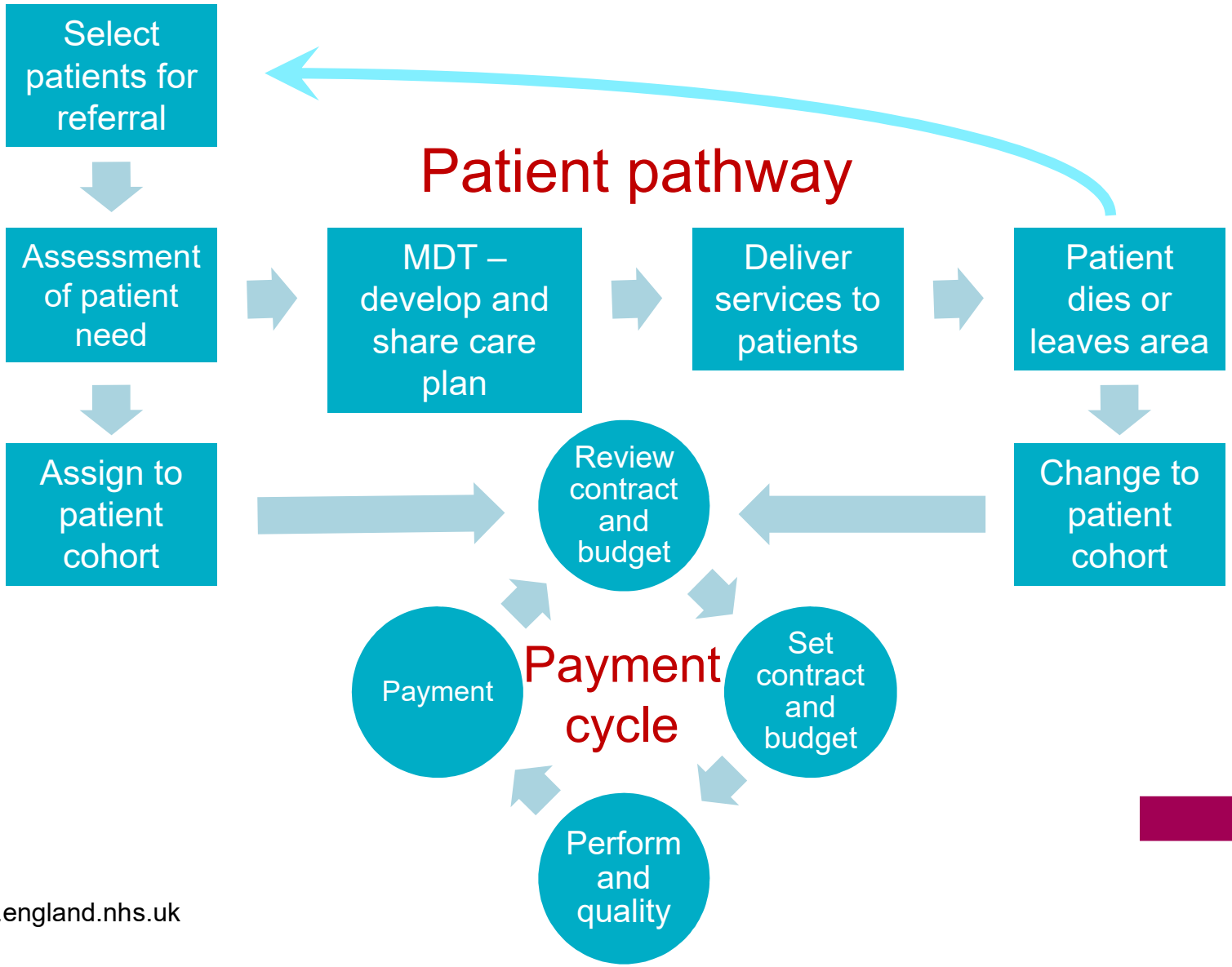
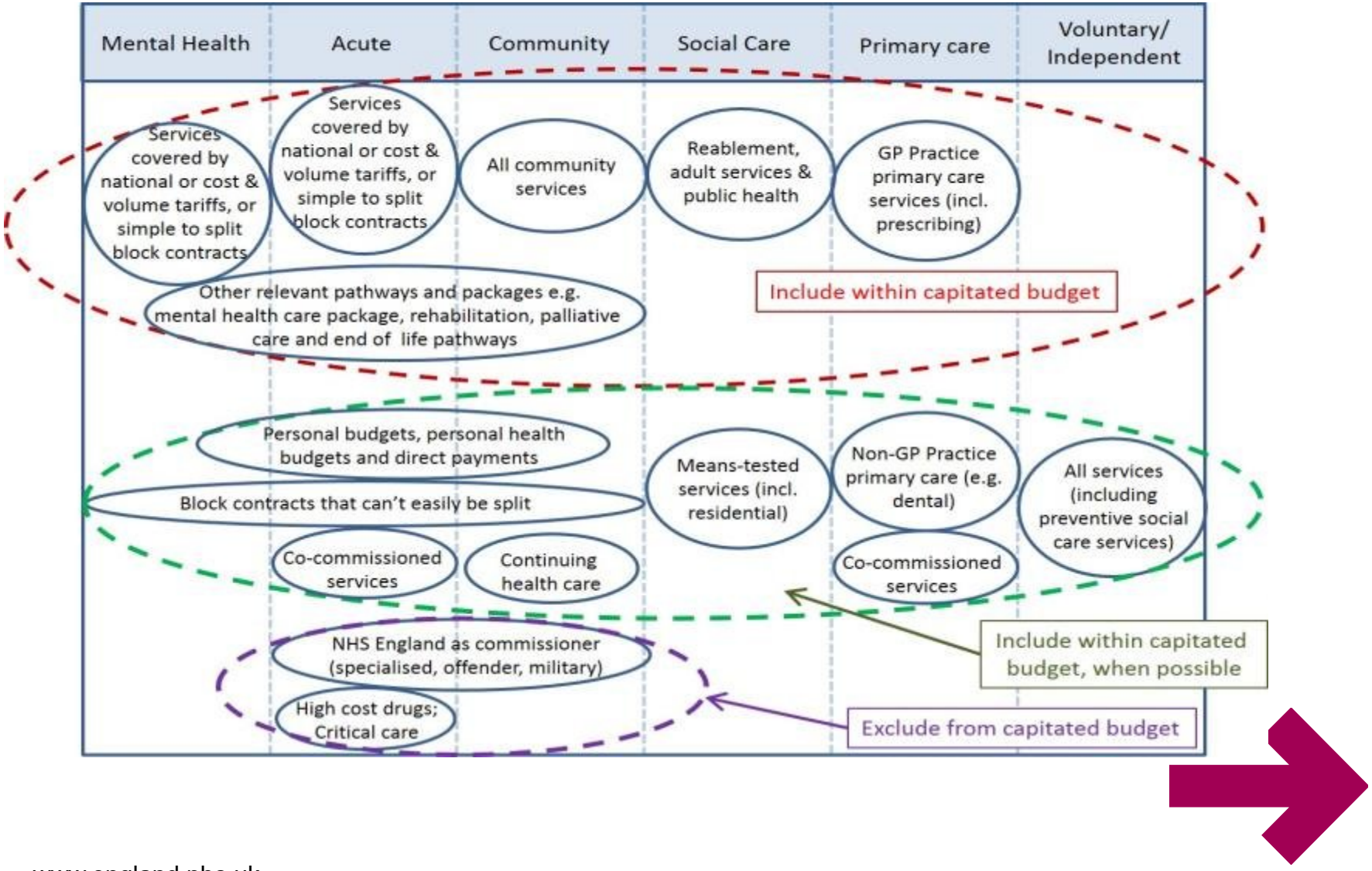
Patient selection: Generalised patient pathway and the payment cycle for complex care patients



Service selection: Year of Care Currency:

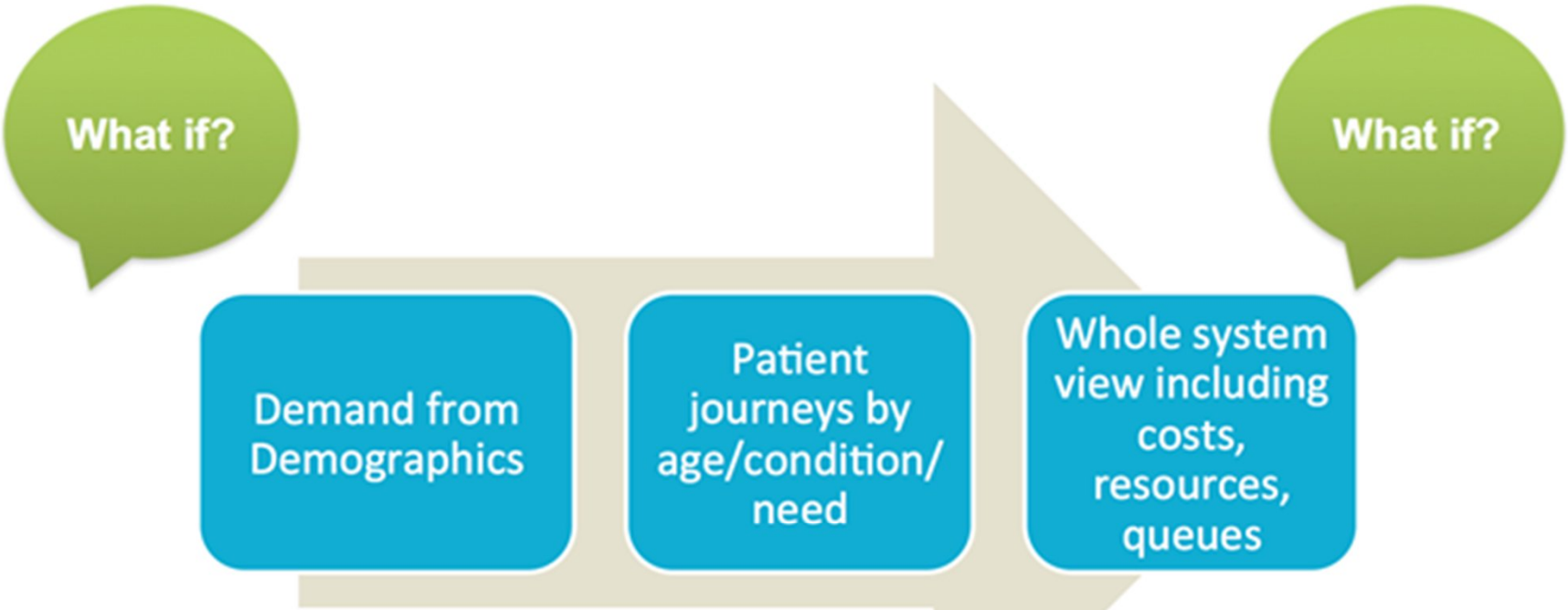


The Role of Simulation

Planning change: Why Use Simulation Modelling?

- A service and system redesign
- Understanding the impact of changing service utilisation on:
  - Flow
  - Cost
  - Capacity/Resource
- No linked historic data
- Different impacts on organisations, costs and patients
- Different types of patients
- Testing new models of care prior to implementation
- Evidenced-based decision-making

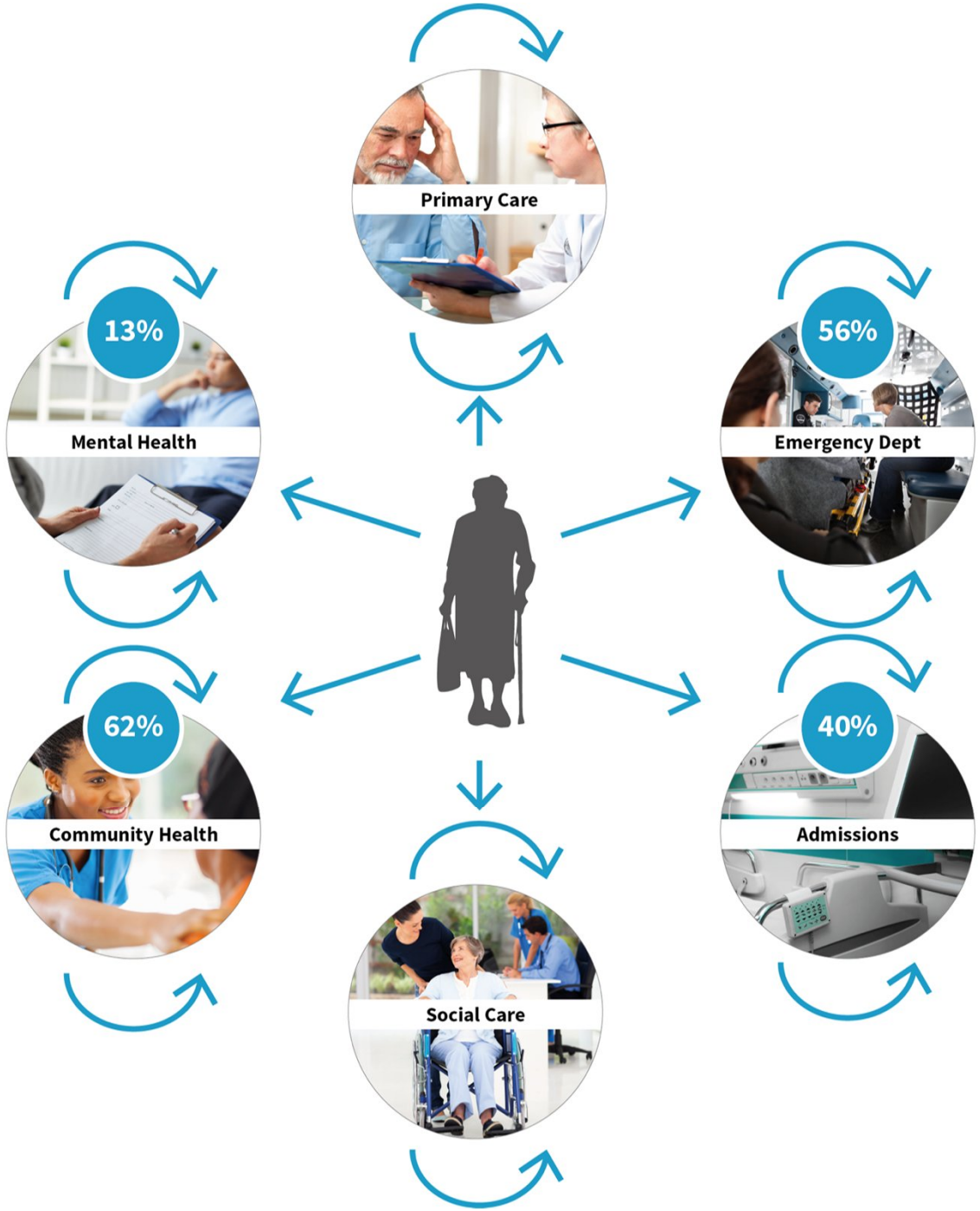
What is the impact of Person-Centred Care?



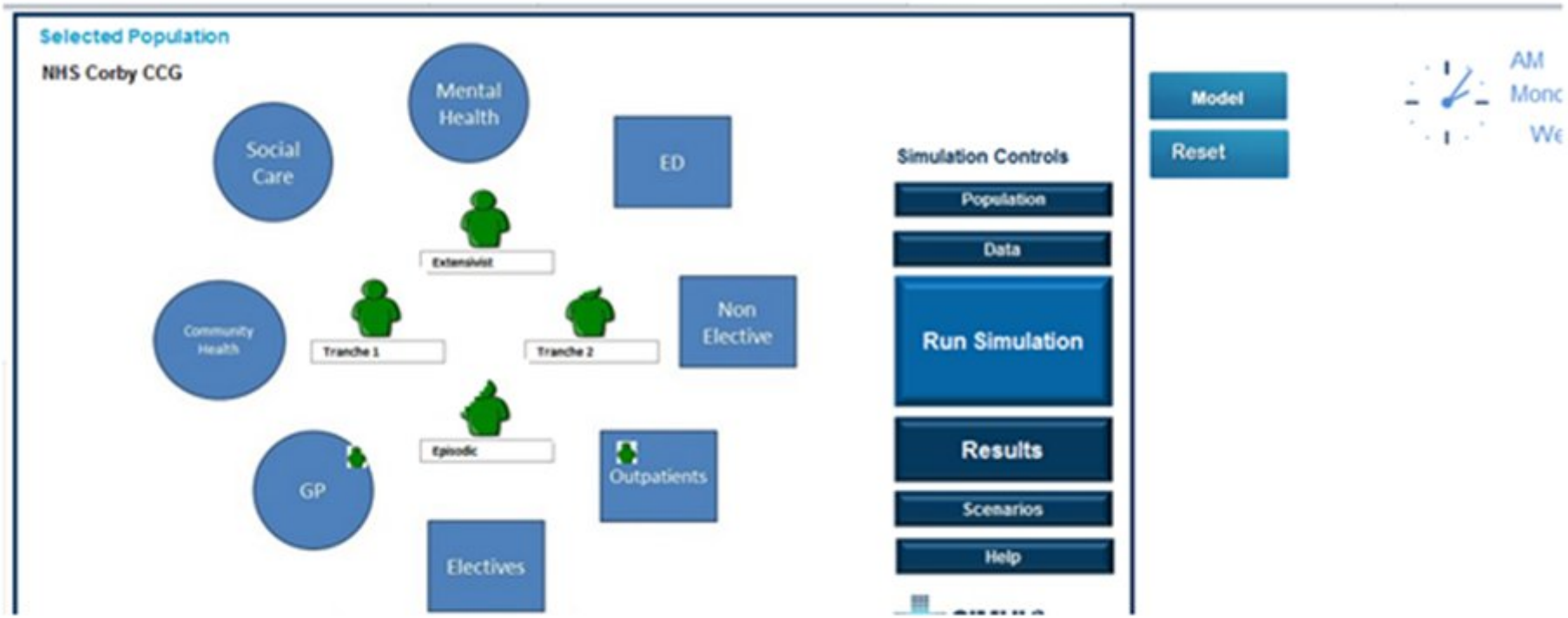
Can a model replicating good practice in one area help adoption in another?

Simulating the Concept and Reality

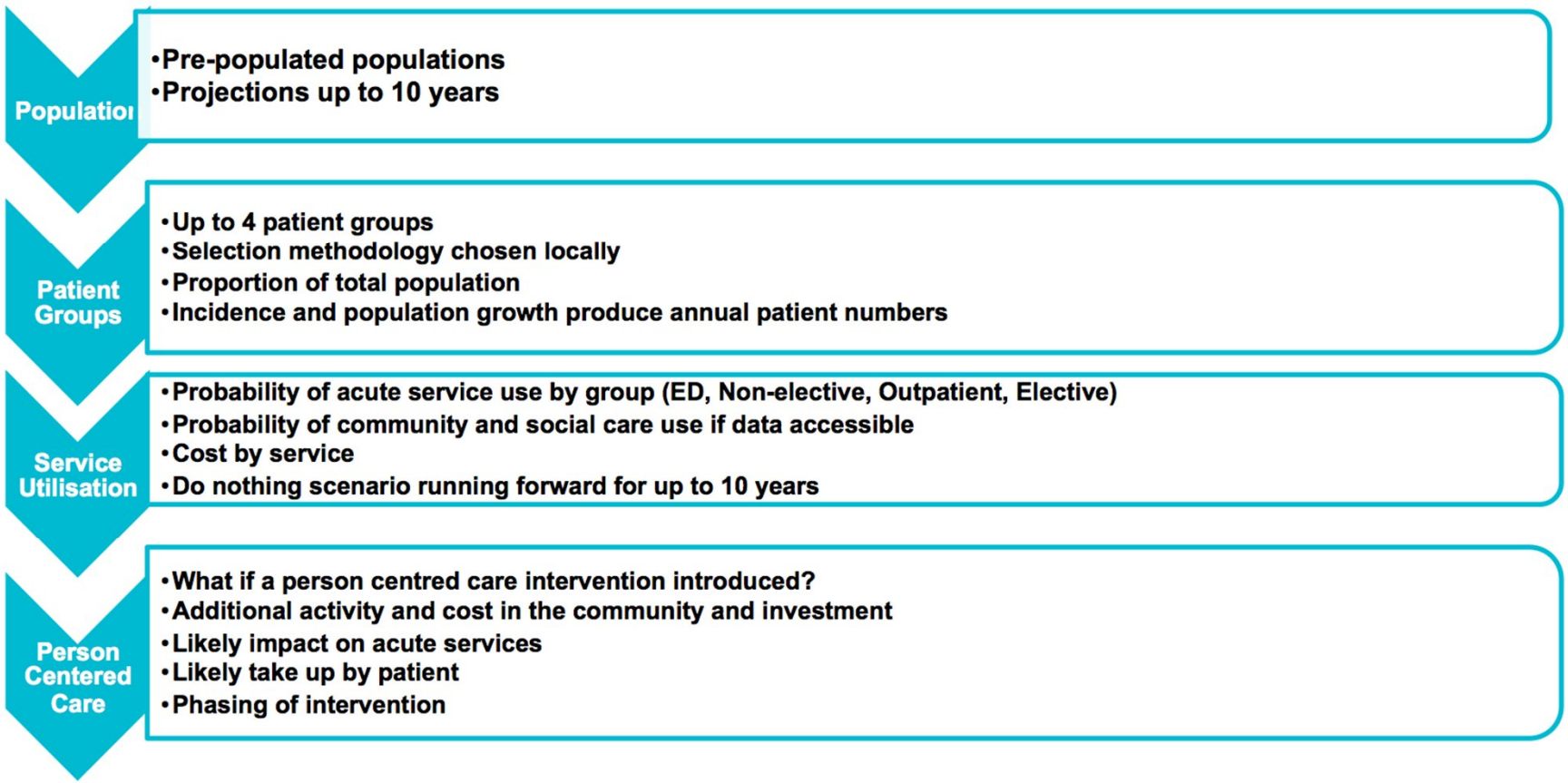
Segmenting Patients



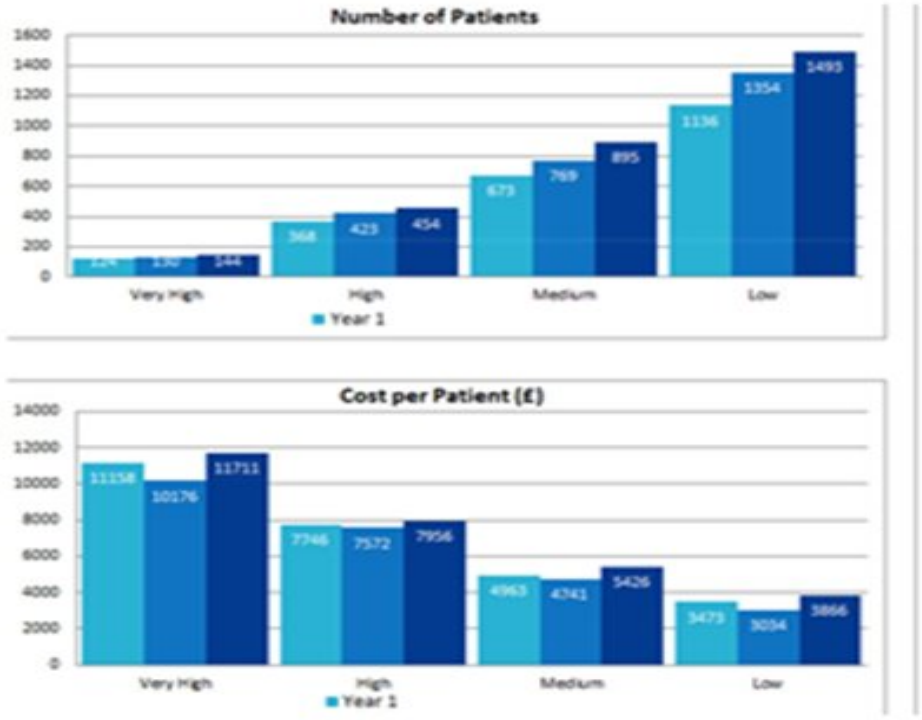
How the Simulation Works



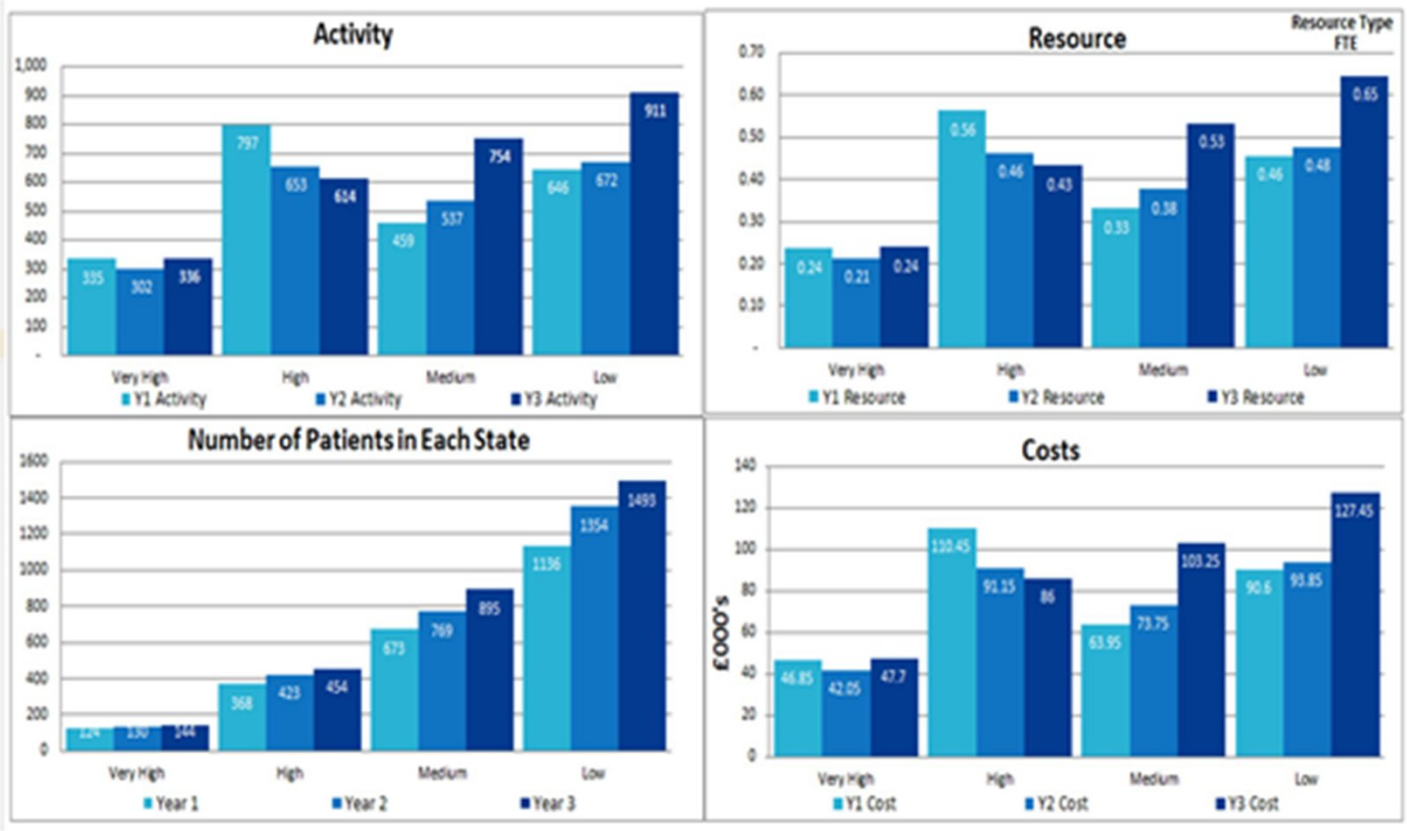
The Logic


Populatio
•Pre-populated populations
•Projections up to 10 years
Patient Groups
•Up to 4 patient groups
•Selection methodology chosen locally
•Proportion of total population
•Incidence and population growth produce annual patient numbers
Service Utilisation
•Probability of acute service use by group (ED, Non-elective, Outpatient, Elective)
•Probability of community and social care use if data accessible
•Cost by service
•Do nothing scenario running forward for up to 10 years
Person Centered Care
•What if a person centred care intervention introduced?
•Additional activity and cost in the community and investment
•Likely impact on acute services
•Likely take up by patient
•Phasing of intervention

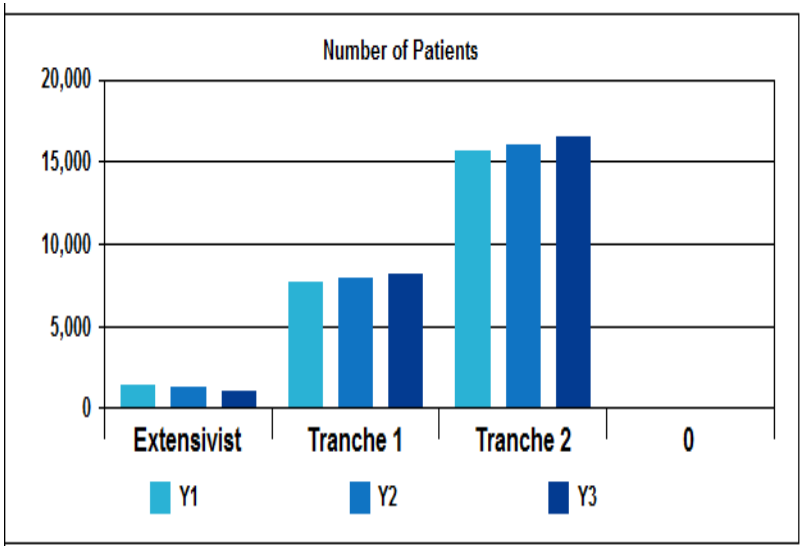
Results from a Simulation: What is the Cost of a Patient Each Year?

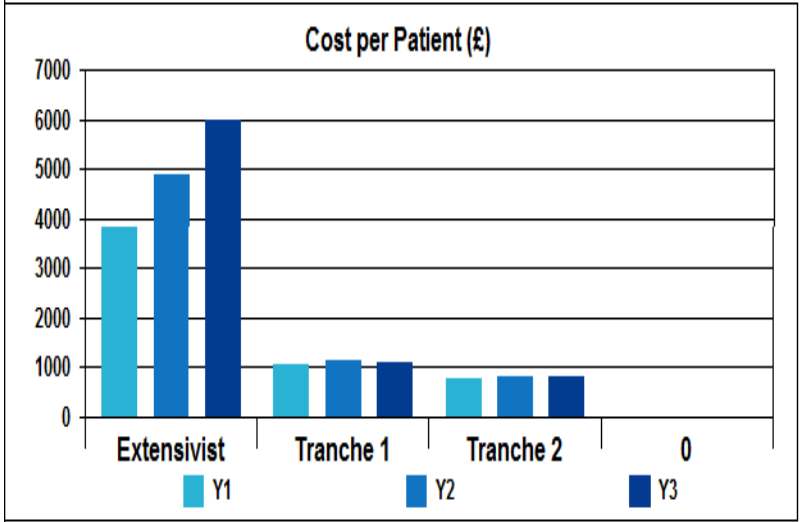


How do Patients Typically use Services, What is the Cost and what Resource is Needed?:



Example: Baseline results





Proposed new model of care

Person Centred Care Navigator intervention:

- well being support worker
- activating patient, connecting with other services and co-ordinating care
- 12 visits a year
- £18 per visit
- Patient take up 50%
- Phased over time
- Reduces A&E and admissions by 25%

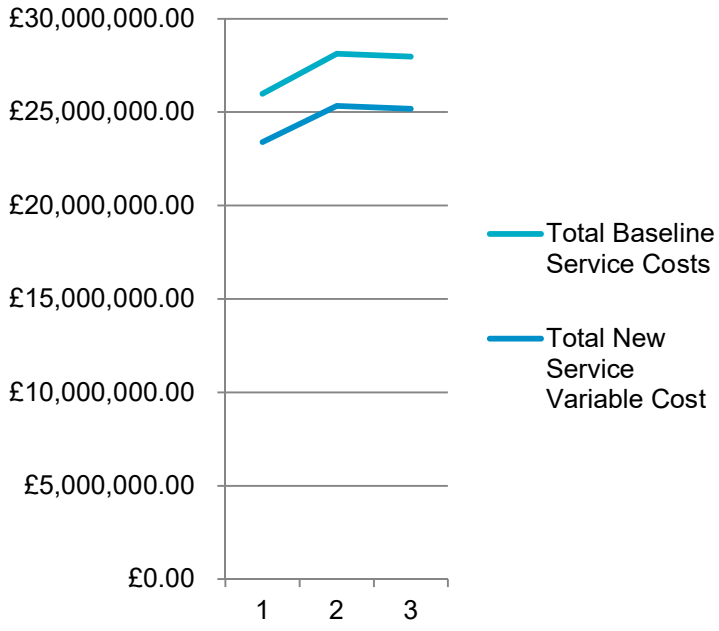
Person-Centred Care Scenario Results

- Applied to all groups – results show that the new intervention costs more than baseline
- Applied to all patients in the highest acuity group and a proportion of patients in other groups, a saving can be made.

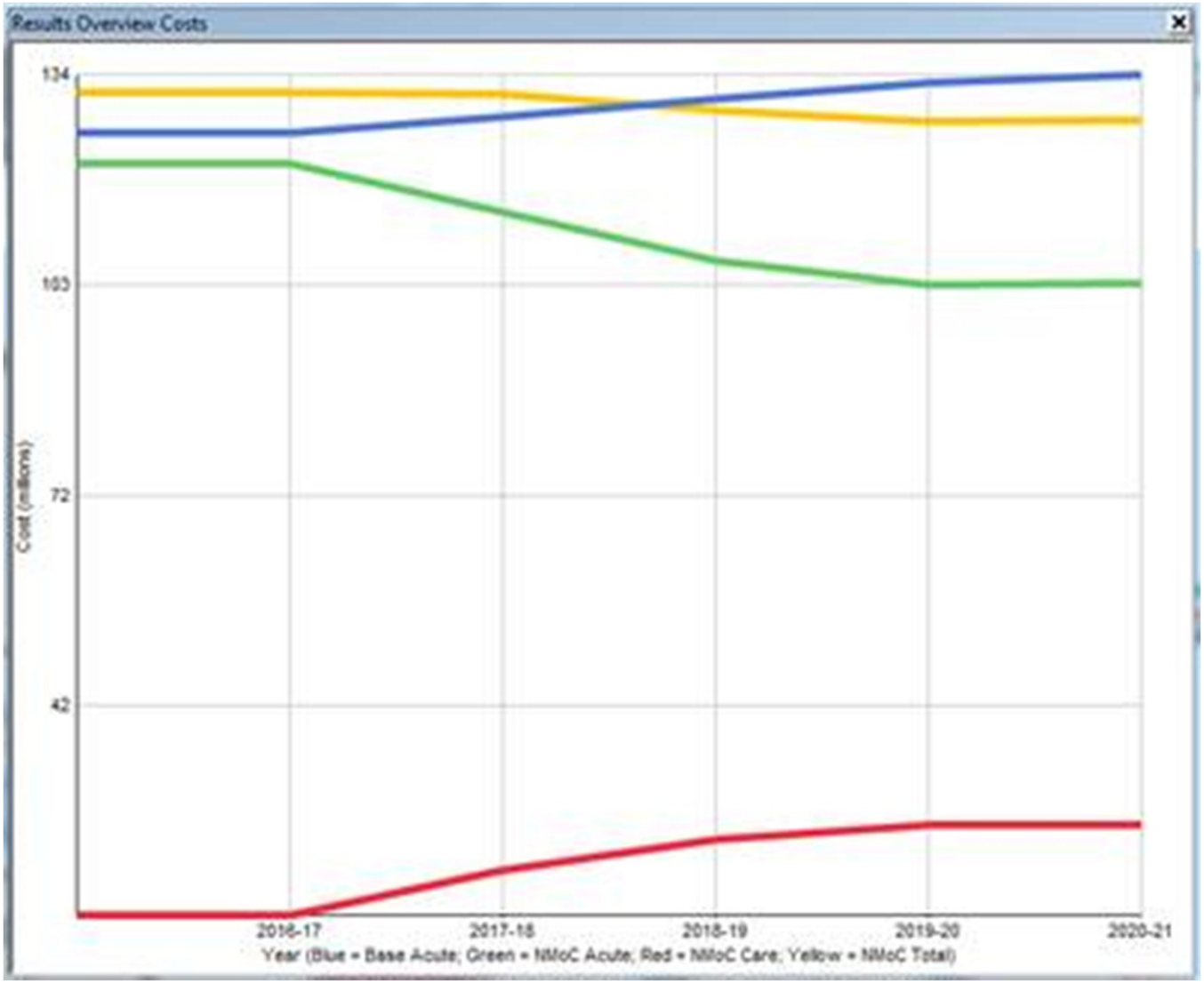
Baseline Results			
Baseline Service Costs	**Y1**	**Y2**	**Y3**
Number of Patients treated Baseline Services	24793	25289	25637
Cost Per Patient for these services	£1,048.33	£1,112.41	£1,091.21
Total Baseline Service Costs	£25,991,277.00	£28,131,816.00	£27,975,350.00

Scenario Results			
Baseline Service Costs	**Y1**	**Y2**	**Y3**
New Service Costs			
Number of Patients Treated New Services	24793	25289	25637
Cost Per Patients for these services	£943.72	£1,001.51	£982.37
Total New Service Variable Cost	£23,397,606.00	£25,327,154.00	£25,185,053.00
Total Scenario Costs			
Total Scenario Costs	£23,397,606.00	£25,327,154.00	£25,185,053.00

Return on Investment	**Y1**	**Y2**	**Y3**
ROI for Scenario	£2,593,671.00	£5,398,333.00	£8,188,630.00
Average Savings per Patient	£104.61	£110.90	£108.84



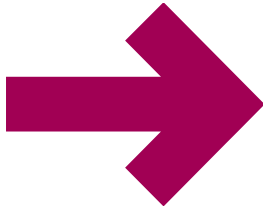
Population level analysis



http://www.simul8healthcare.com/nhse

Using Simulation Results to:

- Discuss with stakeholders across organizational boundaries
- Agree a capitated budget for each patient type
- Test the impact of a new model of person-centered care to:
  - Understand the RoI
  - Understand financial and resource impact for each provider



Lesson Learned

Impact of person centred care

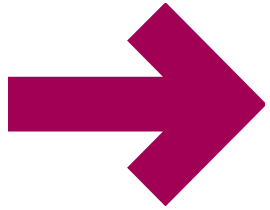
- Cost of high acuity patients can be impacted with a new model of care
- Financial benefits of lower acuity interventions may not be realised for a year or two as they are prevented from becoming more acute
- Some patients may choose not to access a service

Can a simulation support adoption of a new model of care?

- One location changed a disease-based improvement strategy to a person-centred strategy after using the model.

Simulation Benefits

- ✓ Test before implement (no harm to patients)
- ✓ Dissemination of practice and sharing of models of care
- ✓ Supports decisions where no historical data
- ✓ Helps to formulate exact models of care and predict impacts



For further information

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