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CONFERENCE ABSTRACT

Population Health Management in Ribera Salud

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Due to the ageing population and the increase of chronic diseases, new models of health care delivery are unavoidable. The rising cost of health care represents perhaps the most significant threat to long-term economic security.

Ribera Salud has developed a Population Health Management (PHM) program that is based on:

A population stratification model based on different tools such as ACG or CRG, to identify the level of risk of every citizen

The creation and monitoring of personalized care plans, including prevention and health promotion. A complete assessment is done to every citizen and as a result a personalized care plan is created and all the interventions needed to accomplish the plan are scheduled. All this process is supported by a tool "TruCare".

The empowerment of the patients to self-manage their pathology by providing a variety of technologies (health portal to communicate directly with the doctor, to share health information, etc) and collaborative care models.

An organizational transformation within the primary care centers to adopt this new manner of working.

The measurements of outcomes.

The main aim of this program is to improve clinical and financial outcomes.

The whole population within the health departments managed by Ribera Salud (550.000 citizens) is the targeted population. All the professionals are PHM stakeholders.

In 2012 Ribera Salud started working with a Chronic Plan focusing on high risk level patients. Since then, continual improvements have been developed and, in November 2016 we started a pilot phase with the implementation of the PHM program and the software "TruCare" with the aim of covering the whole population.

Highlights:

A reduction in hospital admissions and emergencies

An improvement in the citizens` satisfaction

Awareness of the importance of a healthy lifestyle

PHM has been identified as a critical tactic for developing sustainable healthcare models as, through it, health organizations can improve the health status of their population by providing each person with the care they need in a proactive manner.

This program can be transferred to any organization, mostly to those with integrated care between primary care and hospitals. It can also be transferred to those that just manage primary care but which have a good coordination with other levels of care.

Conclusions: PHM is an effective model to improve population health. Engagement of patients and health professionals is essential in this model. Technology provides tools to make things different, more accessible and effective, BUT we must use it in the right way and never forget about the humanism in the relationship between patients and doctors and nurses.

Although PHM was identified many years ago as a critical tactic for developing sustainable healthcare models, very few healthcare organizations have successfully implemented an effective program to manage patient populations. The barriers must be overcome.

Lessons learned:

Leadership is critical.

Population must be correctly stratified to obtain good results.

Care must always be patient centered.

Empowerment of the patient from the beginning, actively participating in the development of their care plan

Providing continual feedback to professionals

Community participation

Keywords: population; prediction; personalisation; prevention; participation