



Population Based Risk Stratification and Intervention Management

Population Based Risk Stratification

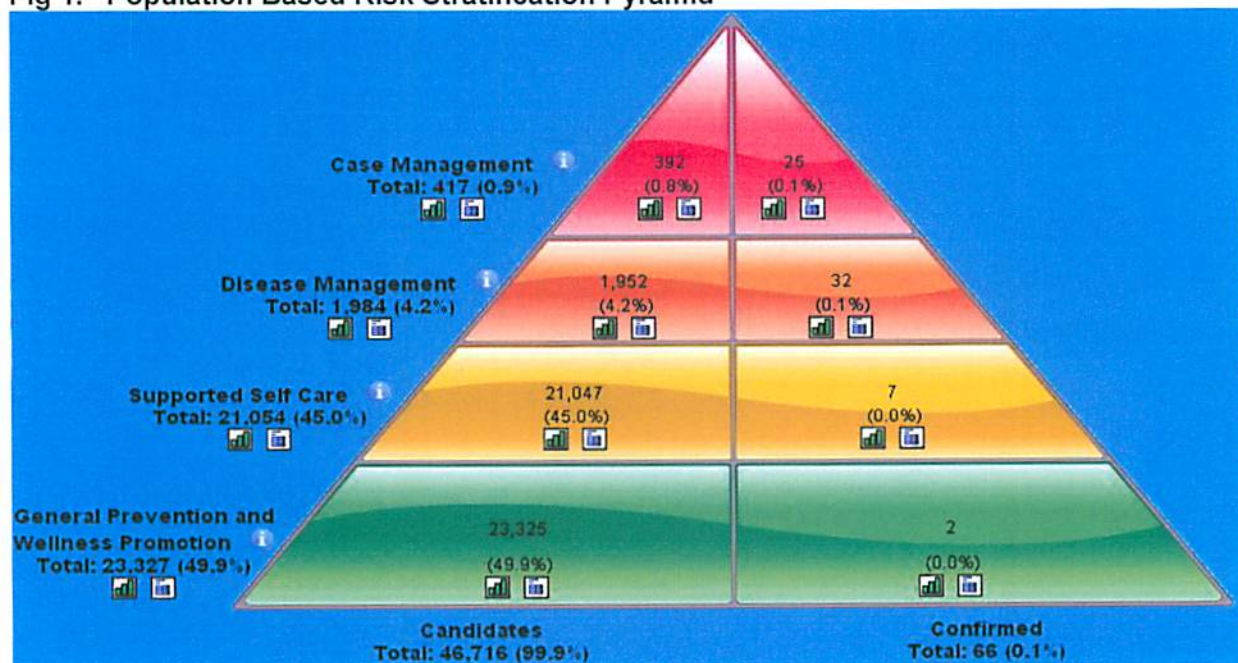
World Class Commissioning requires commissioners to undertake population based risk stratification. The intelligence formed through this exercise then leads to a requirement for the systematic referral of patients to a range of interventions.

CDRIntell is a powerful web-based, cross sector solution, which has been designed to assist PCTs, PBC Groups and General Practice meet these objectives through a comprehensive analysis, reporting and programme management solution.

The CDRIntell reporting solution will provide a comprehensive Dashboard so that General Practice, PBCs and the PCT will be fully supported in needs analysis, demand management and the operational delivery of “industrial scale” referral and interventions. CDRIntell uniquely enables the stratification of patients using several approaches and supports General Practice confirm which tier each patients should be managed at. Once patients have been assigned to a tier (see Fig 1 below), the application then supports the systematic referral of patients to a range of appropriate interventions.

For each intervention, inclusion and exclusion criteria are defined so that only relevant patients are identified for block referral.

Fig 1. Population Based Risk Stratification Pyramid



Key Benefits

- Promote and maintain patient health and wellness
- Promote and support patient self care
- Prevent patients from progressing from wellness to disease
- Encourage patients to attend programmes of self care
- Reduce health inequalities and maximise health promotion initiatives
- Systematic block referrals to a range of locally available interventions i.e. Medicines Management Reviews; Smoking Cessation; Expert Patient Programme, Exercise and Weight Loss interventions

Approaches to Risk Stratification

There is no need to be restrictive; CDRIntell supports any number of different approaches to the classification of patients.

- 1) The Kings Fund Combined Predictive Model
- 2) CVD Risk Stratification – those with established conditions and those at various levels of Primary Risk (aged 35-74).
- 3) Financial Based – the costs of individual's utilisation of healthcare resources are estimated. CDRIntell, using Primary Care data and Secondary Uses Services (SUS) data to derive the number and cost of:
 - Primary Care Consultations
 - Hospital A&E attendances
 - Hospital Outpatient, day-case and Inpatient events
- 4) For each Long Term Condition – CDRIntell classifies those patients by:
 - Those with an established LTC
 - Those likely to have a LTC and
 - Those 'at risk' of a LTC
- 5) A profile of what we do not know – It is acknowledged that we do not know everything about our patients and that patients may not come into contact with any NHS providers for months if not years. Where these patients have Long Term Conditions, this is a real problem and can result in acute and unscheduled care. A population profile based on the quantity of missing data, delivers an excellent way of identifying patients who require an intervention. For example: A patient with diabetes and COPD who has not seen the GP for over 9 months, or has not returned for their repeat medication, nor attended a diabetic outpatient appointment.

Interventions and Programme Management

There are many interventions that the NHS is currently pursuing to deliver major improvements in the quality of services and in the reduction of health inequalities. Practically all of these interventions may be organised and prioritised on a population based risk stratification and programme management basis.

The advantage of the organisation of these interventions on a programme management basis is that the **Need** can be established; the **Demand** for the service can be managed, that process and outcome measures are available to all.