
CONFERENCE ABSTRACT**Practice Population Profiling – Using PMS data for patient and practice benefit**4th World Congress on Integrated Care, Wellington, NZ, 23-25 Nov 2016Paul Abernethy¹, Diane Taylor¹, Hywel Lloyd², Chris Churcher²

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Identifying and planning the care for people with existing and emerging long term conditions is a significant challenge in primary care.

Historically an uncoordinated disparate range of options have been implemented ranging from personalised care plans, to disease specific education and intervention programmes, on top of routine general practice care.

The Chronic Care Model (CCM) first proposed in 2001 outlined the importance of an integrated systematisation of long term conditions (LTC) management. Wagner described the role information technology should play in understanding a practice's population and triggering transformational change in the way practices approach LTC. The adoption of the CCM at a practice level has been slow.

Having the tools to understand primary care system data and re-orientating services has proved elusive. Practice teams are increasingly wanting to reflect on, compare, contrast and track the overall outcomes for groups of at-risk patients.

Te Awakairangi Health Network (TeAHN) is a primary health organisation (PHO) based in the Hutt Valley, serving a population of around 120,000 through 21 practices. Within this population there is a growing proportion of people with existing or emerging long term conditions. TeAHN has established a partnership with BPAC Clinical Solutions and has been using their Best Practice Intelligence and decision support technology across the Network.

In 2015, TeAHN approached BPAC seeking a tool that would enable TeAHN to create a practice population profile, drawing on the data held within the PMS to stratify enrolled patients at practice level.

The resulting tool has demonstrated what can be achieved through the collaboration of an innovative health network and skilled technology partner. The Practice Population Profile tool is now available across the Network. It gives TeAHN and the practices a set of views of their population that can be customised to the individual practice and used to develop, implement and monitor new interventions.

The tool is deployed through a web interface, and uses a series of indicators to build a profile of the practice's population. It demonstrates the number of people with a high number of risk indicators through to those with emerging risks. This enables a funding model to be created and managed. The tool provides clarity at: Micro level - activities that promote integration among individual practitioners working at the practice;

- Meso level - interorganisational working between PHO, community organisations and secondary care;
- Macro level – for alternative funding models, and organisational policy and strategy.

This partnership has provided the Network and its practices with a significant advance in both the models of care and the ability to understand and instigate change for at-risk populations. While similar tools have been developed before, this one is unique in terms of its integration into a suite of decision support tools that allows clinical teams to drill down on individual quality indicators from within their Practice Management System. This provides current, patient, practitioner and practice level data in a form that enables teams to monitor the outcomes of their plans and interventions.

Keywords: practice population perspective; innovation; empowering clinical decision making
