Population Segmentation for Integrated Care

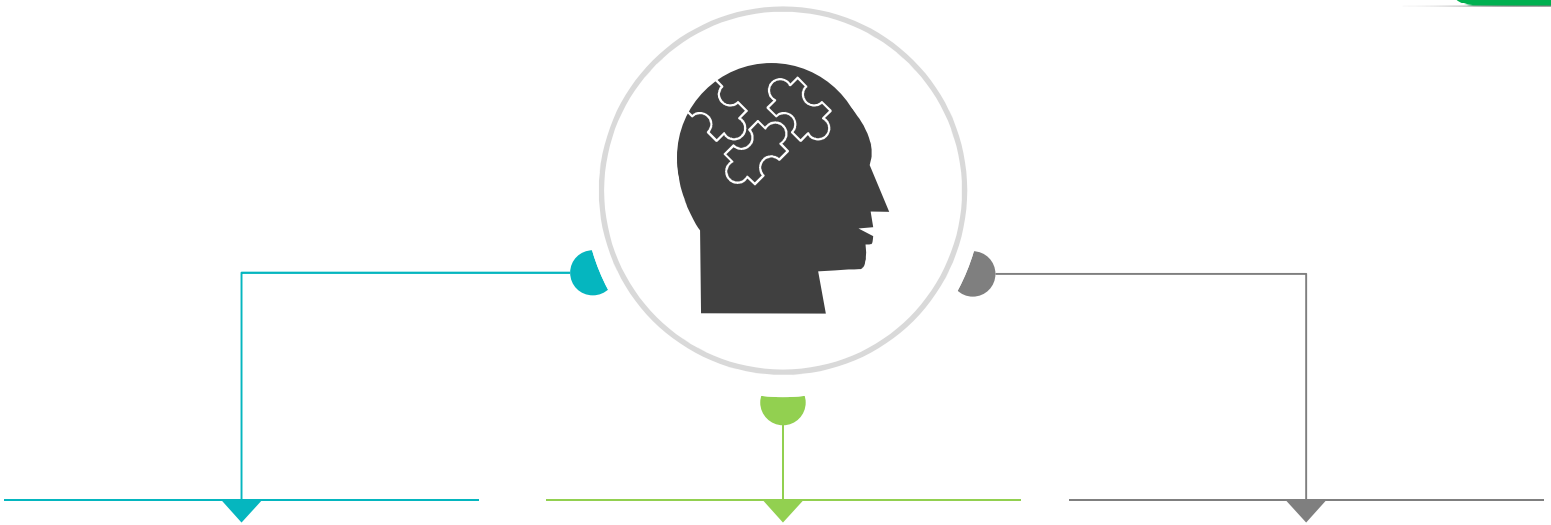
FOR HEALTHCARE LEADERS
HSJ

Discussion document

November 2014

McKinsey&Company

Welcome!



Are you involved in an integrated care programme today?

Will integrated care deliver its high hopes for quality and efficiency?

Do you think policymakers are doing enough to make it happen?

Why segment the population?

1. **Understand people's wants and needs holistically, rather than by setting – give parity to mental, physical & social care**
2. **Match care models to people's holistic needs rather than one-size-fits-all**
3. **Align incentives through capitation to get providers to work better together**
4. **Focus on outcomes that matter to people – and get providers to work to common goals in partnership**
5. **Provide an organising logic across all settings, providers, and commissioner to make integrated care happen!**

Traditionally, the health and care system has been organised around groups of professionals with similar skills

Mental Health Trusts

Acute Hospitals

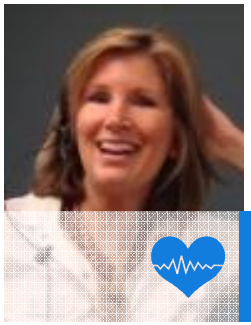
GP practices

Community Services and social care

Care homes

…rather than groups of people with similar needs

Different people, different needs – a few examples



- Quick, convenient and urgent access to routine care and preventative services
- Continuity for single episode of care

MOSTLY HEALTHY ADULTS

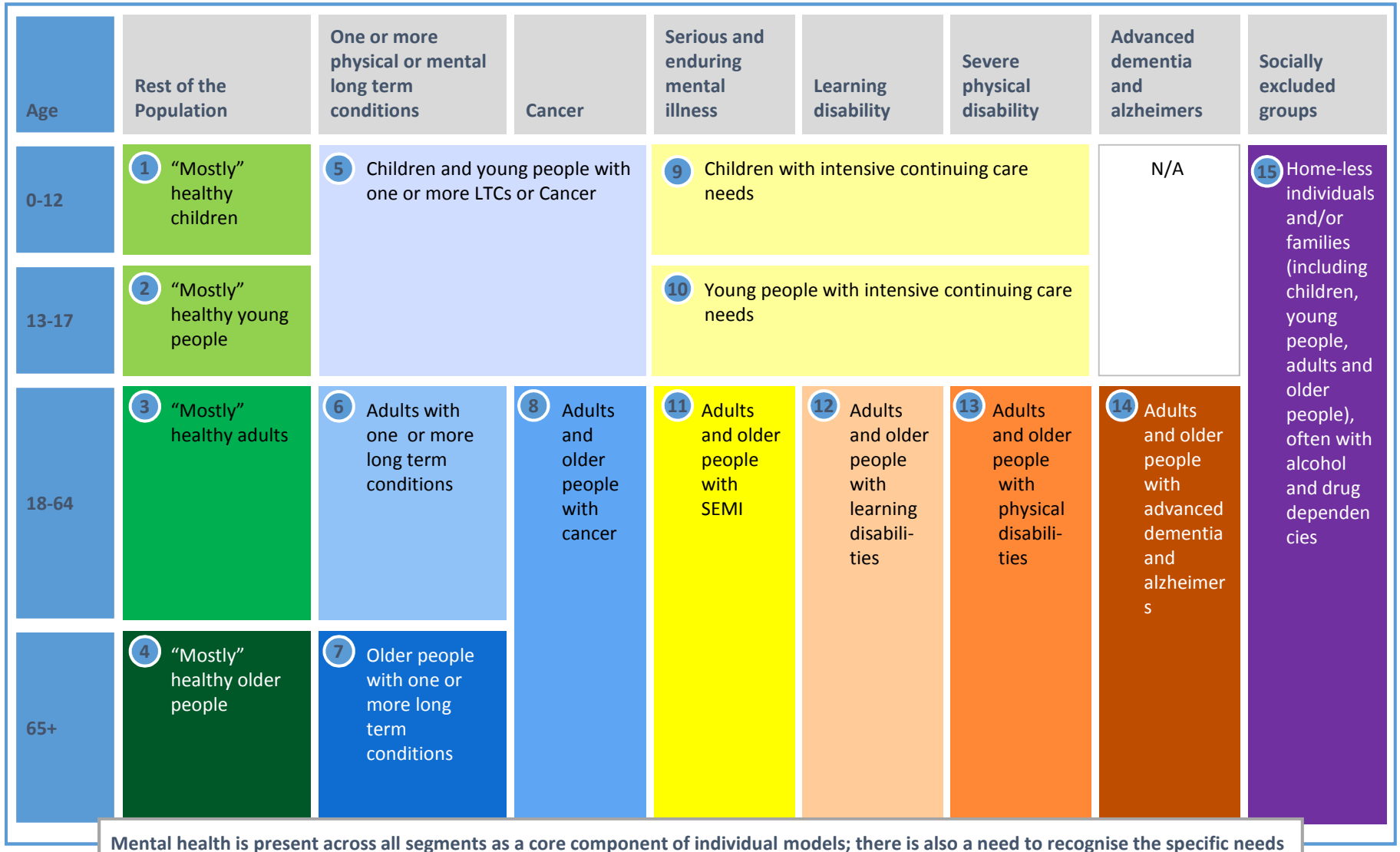
- Sustained continuity of care
- Close coordination of services
- Proactive care to prevent acute admissions

PEOPLE WITH LONG TERM PHYSICAL CONDITIONS

- Outreach/outbound care
- Close coordination of services
- Access to specialist care

PEOPLE WITH SEVERE AND ENDURING MENTAL ILLNESS

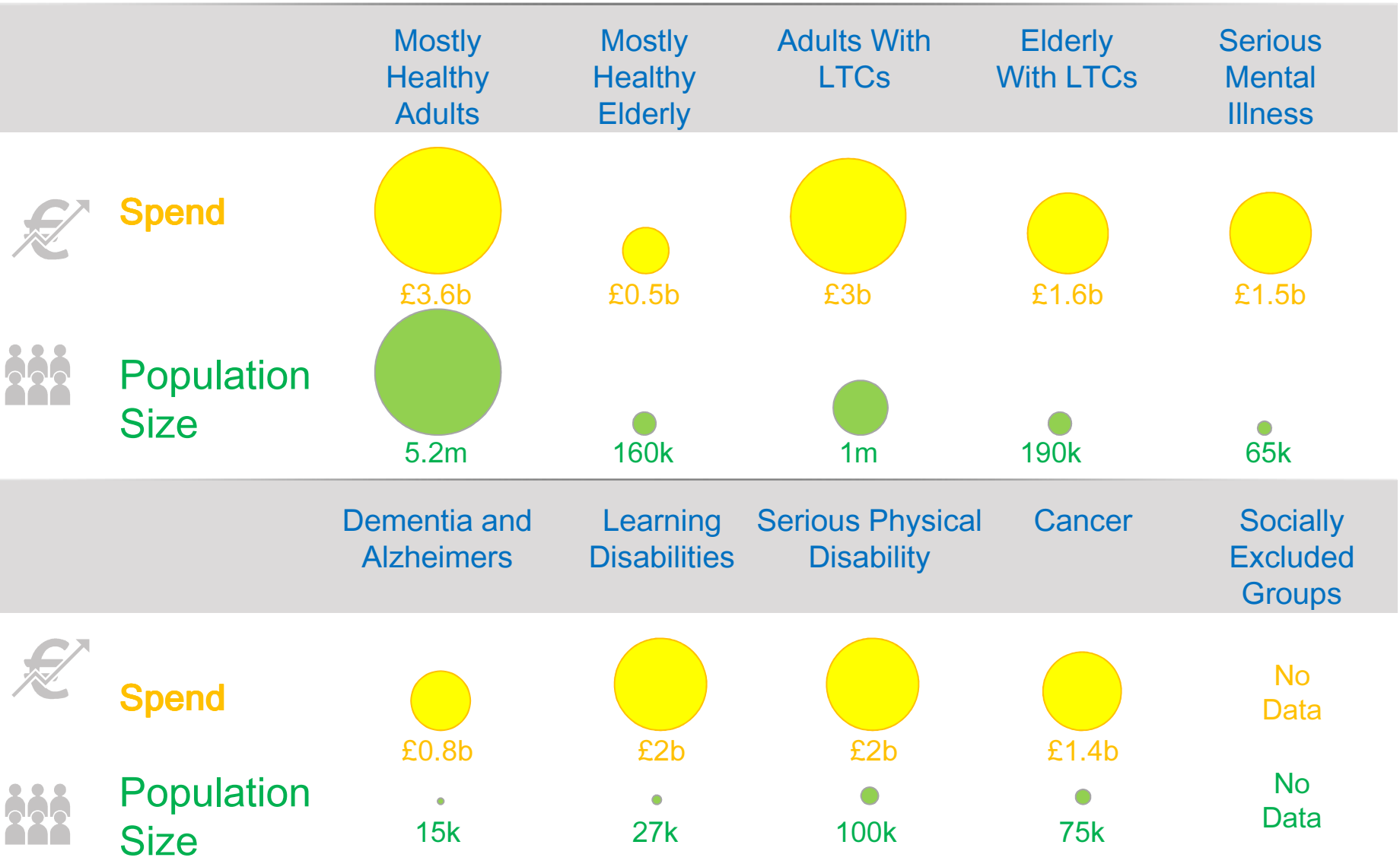
Segmentation from London Health Commission



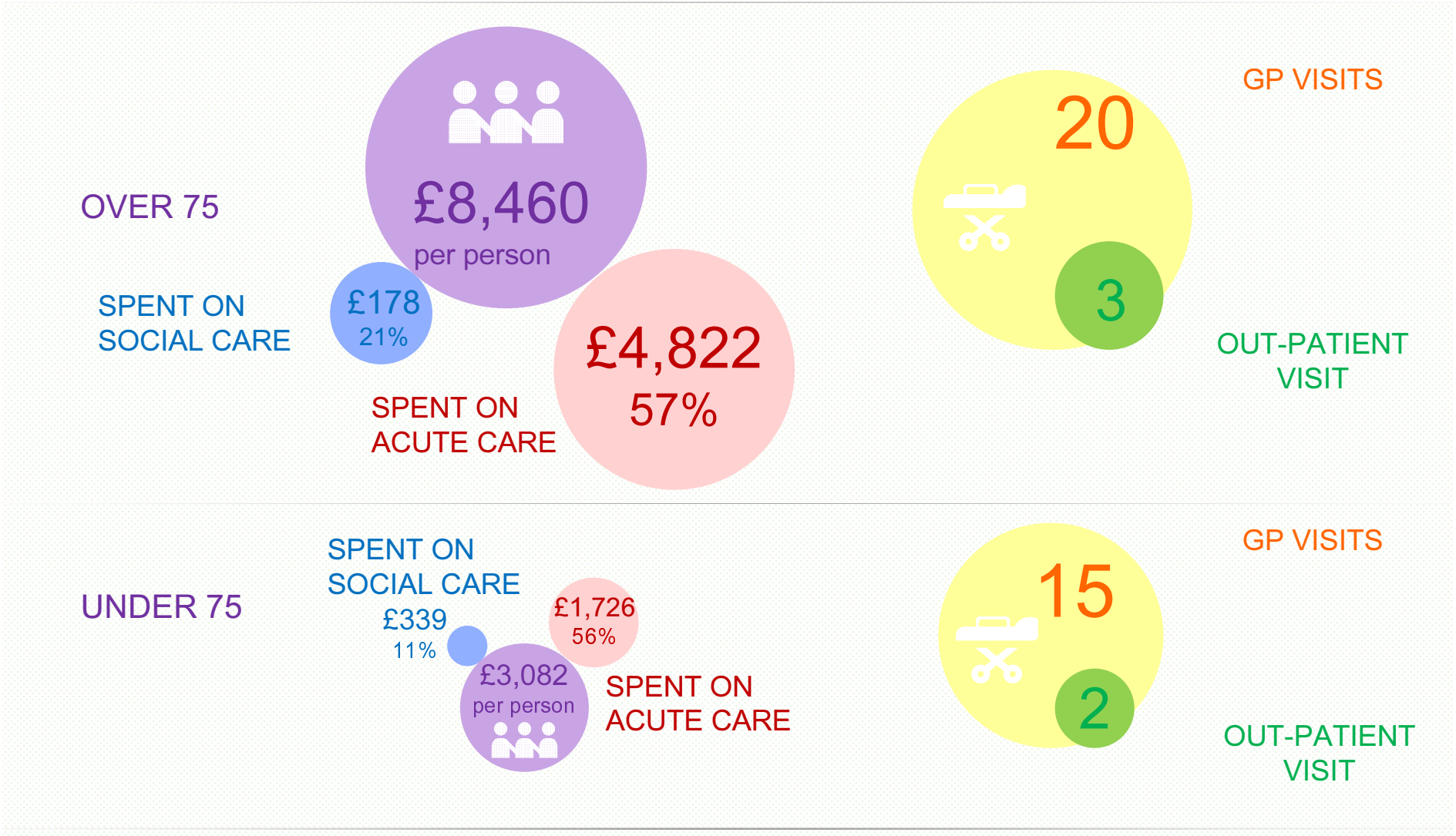
Mental health is present across all segments as a core component of individual models; there is also a need to recognise the specific needs of London's pregnant women in various segments who present late and have co-morbid conditions.

SOURCE: NWL WSIC, SLIC, LHC

Example – segmentation of adults in London



Example – people with physical long-term conditions



Example – ChenMed in the US focuses on people with multiple long-term conditions who are over the age of 65

ChenMed
A Family of Companies

Focused on people with multiple LTCs over age of 65

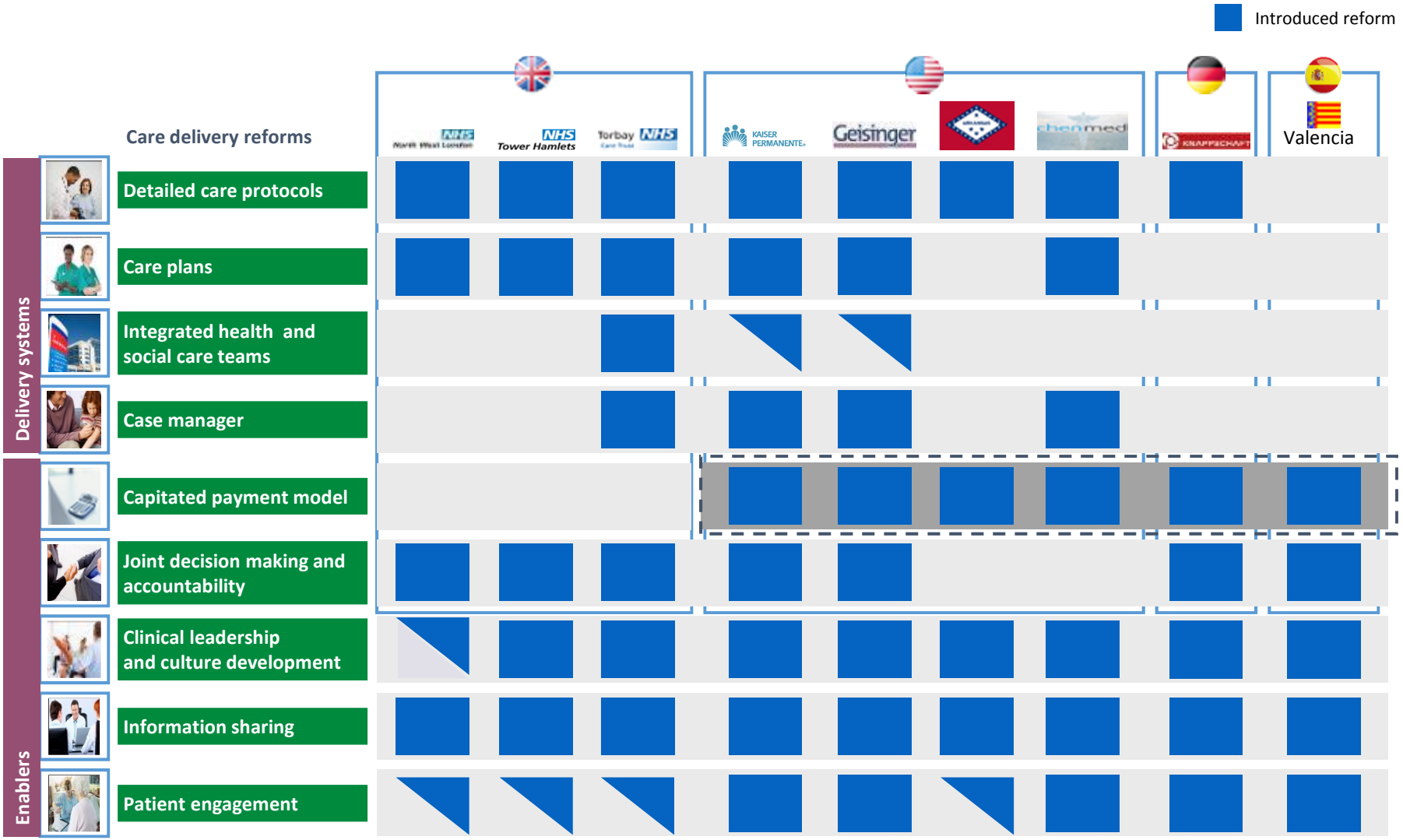
- >85% GP continuity
- Long appointments
- Multidisciplinary teams

- Transport from home for all patients

- Onsite pharmacy means patients leave with their medication

- 35% reduction in hospital admissions
- Review every admission

Global moves towards capitated payment models



SOURCE: McKinsey analysis

Three characteristics of capitation

Predictable

- As a defined component of the payments is **paid up front**, providers get the **stability to plan** and implement changes

Accountable

- As a single provider or provider group is **accountable for the holistic needs** of a person, there is less chance of them **falling in the gaps** between providers

Risk transfer

- As providers take on **greater risk** (depending on actual care utilisation) they have **incentives to invest in preventative care** and treat in the lowest cost settings

Swings and roundabouts

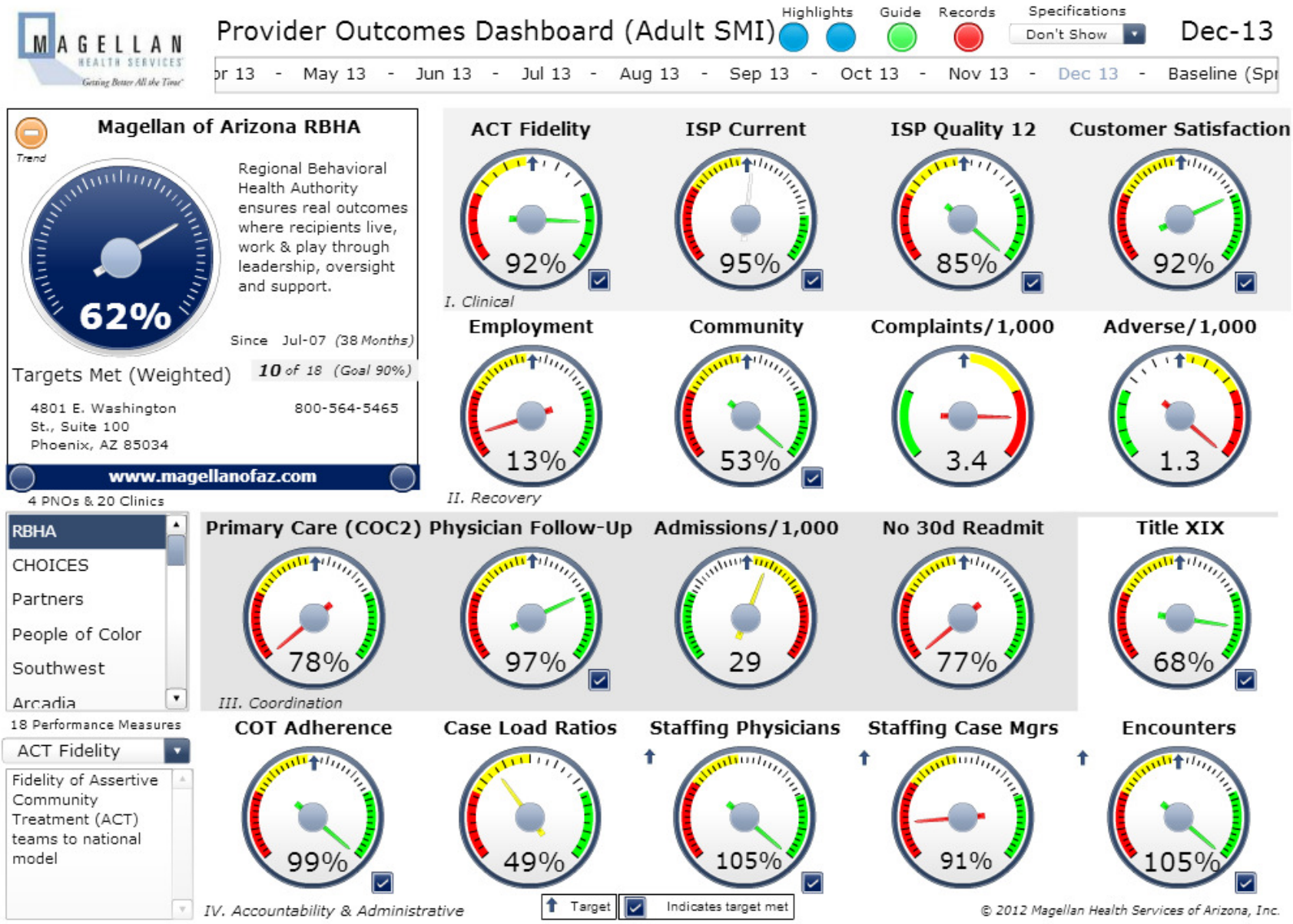
Advantages

1. Can promote **primary prevention** as the incentive is to keep people healthy
2. Promotes **secondary prevention** as that reduces costs without reducing revenue
3. Promotes **allocative efficiency** by enabling providers to **judge the best intervention holistically** for an individual or for the population
4. Promotes **productive efficiency** by incentivising care to take place in the lowest cost setting and hence promotes investment in **care coordination**
5. Promotes **technical efficiency** by ensuring each setting in itself is **most efficient** so that providers can maximise surplus
6. Providers are incentivised to **reduce factor costs** to maximise surplus
7. Promotes **innovation** and incentivises providers to **change the productivity frontier** as they have flexibility to invest
8. **Downside risk** scenarios imply providers are **prompted into action**

Disadvantages

1. Providers may
   - **a) restrict access** to services
   - b) explicitly or implicitly **reduce quality** of services (e.g., cheap vs. best), or
   - c) may attempt to **cherry pick patients**
2. Could result in **shifting of costs to other settings,** if not all services in scope
3. May not incentivise investment **in primary prevention**, if contracts **are too short**
4. **Providers** may **not successfully manage risk** leading to potential financial distress
5. Risks resources being **sub-optimally allocated into provider surplus**, if not enough clarity on real costs
6. Providers **may not invest** in improving **productivity in the** long run, if contracts are too short
7. Risks **providers abusing monopoly situations** e.g., reduced patient choice,
8. Depending on setup risks creating **pure sub-contractors**, with in-sufficient clinical credibility or experience

Example – outcomes for people with SEMI from Magellan



Source: http://www.magellanofaz.com/programs/outcomes-dashboard.aspx

5 big enablers for integrated care

Reimbursement & incentives

- Significant (30%+)
- At scale (30%+)
- Sustained (3-5 years)
- Align risk and reward across system

Governance

- Bind in decision making about significant flows of money
- Allow holding to account for delivery

Information

- Functions
  - Patient access records
  - Clinical decision making
  - Peer pressure
  - Payment
- Overcome information governance

Clinical leadership

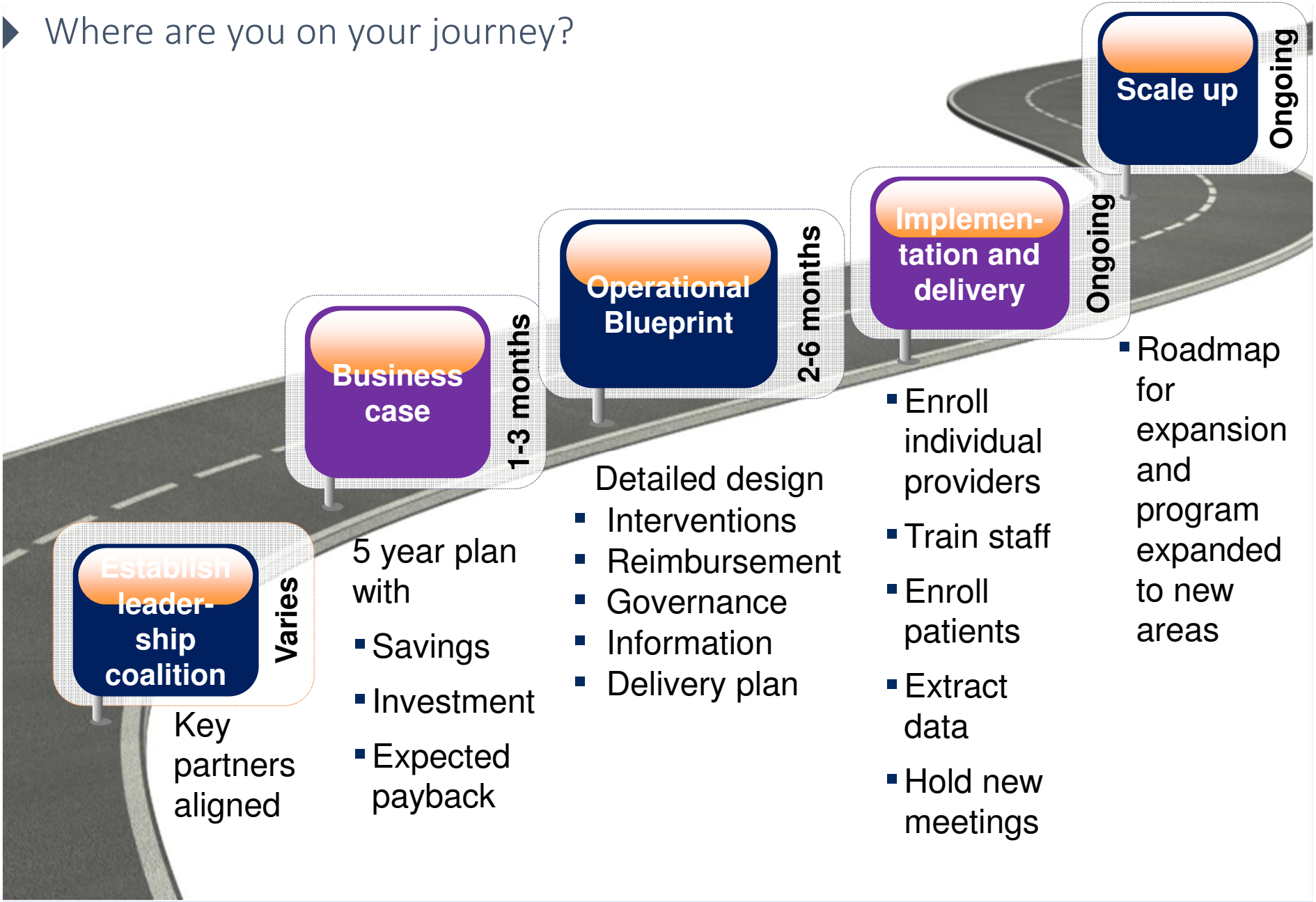
- Role model behaviour
- Deliver consistently
- Hold peers to account
- Work within team

Patient engagement

- Empower patients with informed choice
- Make use of behavioural economics

SOURCE: McKinsey & Company

Where are you on your journey?



SOURCE: McKinsey & Company