ribera salud grupo

From Hospital to Population Health Management

Tools for a better integration of primary care/social services/hospital with the community


THERE'S A HEALTHCARE TSUNAMI COMING!
WHAT'S THE PROBLEM?
AGEING POPULATION (20% OVER 65)
MED COSTS
10% GDP
20% COMPANY COSTS
IT'S A GLOBAL CHALLENGE
...BUT WE DO HAVE ANSWERS...
Scriberia


KEY IDEAS

HOSPITAL TRANSFORMATION

TRANSFORMATION = **PERMANENT GOAL**

1999

HOSPITAL CONTRACT

- System fragmentation
- Lack of previous experience in PPP models
- Lack of IT
- Capitated model
- Difficulty to implement new strategies

2003

HOSPITAL
+
PRIMARY CARE
+
MENTAL HEALTH
+
HOME CARE CONTRACT

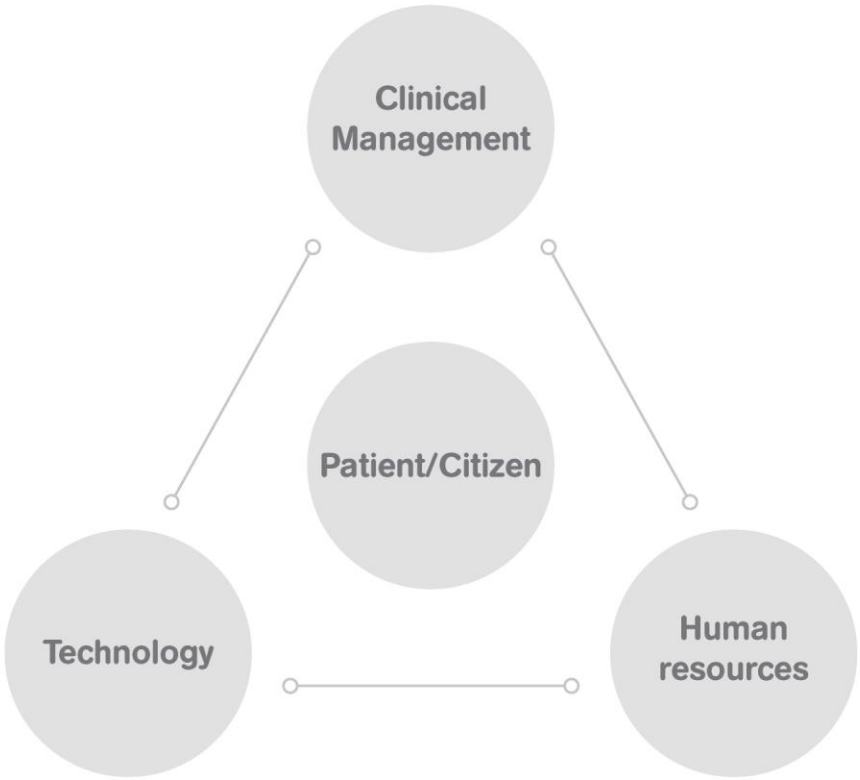
- Integration
- Cultural change in decision-makers
- Resistance to change
- Lack of experience in teamwork

TODAY

HEALTHCARE NETWORK

- Benchmarking
- Best practices
- Shared services
- Population health manegement
- Reduce clinical variability

TRIANGLE OF SUCCESS



THE MODEL COMBINES THE STRENGTHS OF:

- A citizen-centered clinical management strategy.
- Modern HR management.
- A cross-functional information system.
- “Ribera Salud triangle of success”.
- The citizens are at the heart of the Alzira model. These three elements are self-reinforcing in a continuous process of improvement.


TRANSFORMATION
AND INNOVATION

POPULATION HEALTH MANAGEMENT

WHAT IS BEST FOR THE CITIZENS?

PROVIDE BEST HEALTHCARE OUTCOMES

- QUALITY
- SATISFACTION
- SUSTAINABILITY

ALIGNMENT → **CULTURAL TRANSFORMATION**

INTEGRATION

- *Processes*
- *IT*
- *Stratification/*
- *Personalized care*

PAYMENT / BUDGET

- *Capitation*
- *Single Budget*
- *Health is financed*

GOALS / INCENTIVES

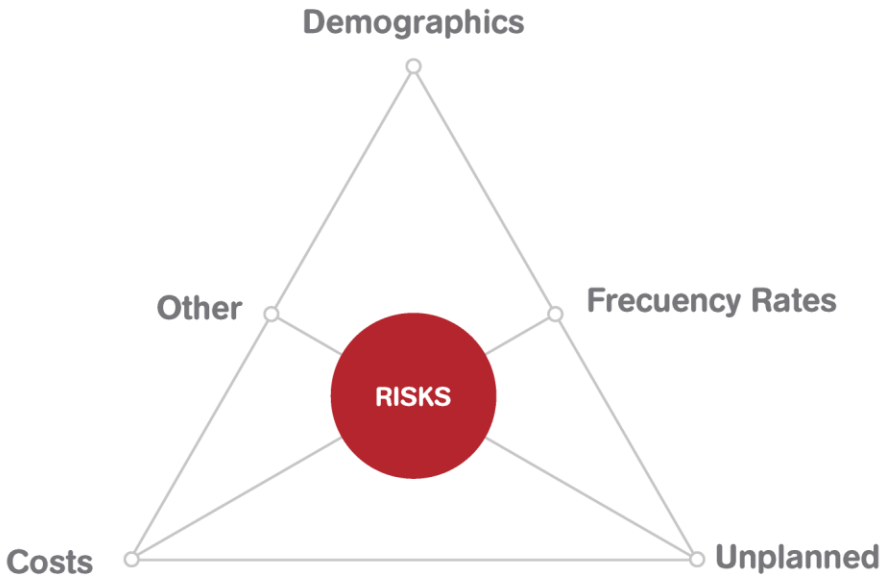
- *Shared goals*
- *Networking consolidation*

STAKEHOLDERS

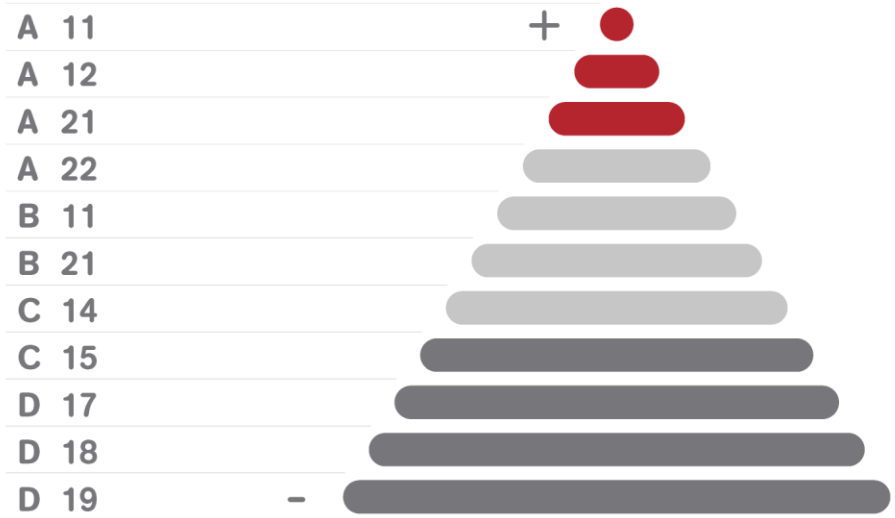
PAYERS – PROVIDERS – CITIZENS – POLICY MAKERS

TRANSFORMATION AND INNOVATION

Ribera Salud has been working on a clinical classification based on risk adjustment systems which allows us to build our own population pyramid and provides us with better information for more targeted care.



CLINICAL CLASIFICATION



LEVEL OF RISK

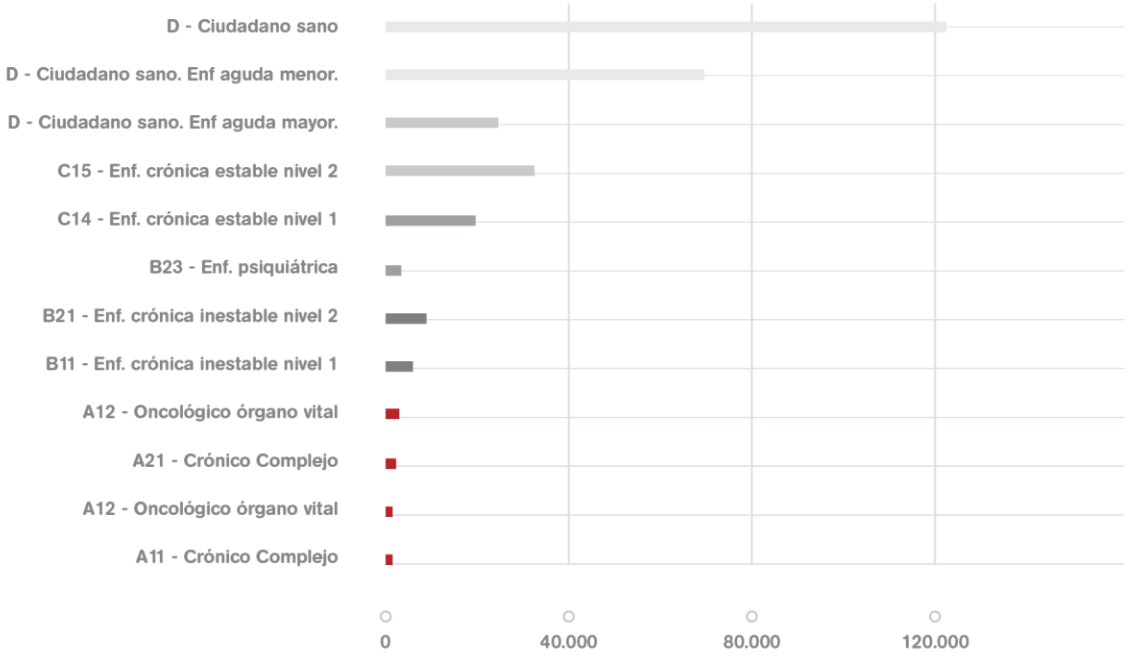
MORE PROACTIVE AND TARGETED CARE

RIBERA SALUD POPULATION PYRAMID

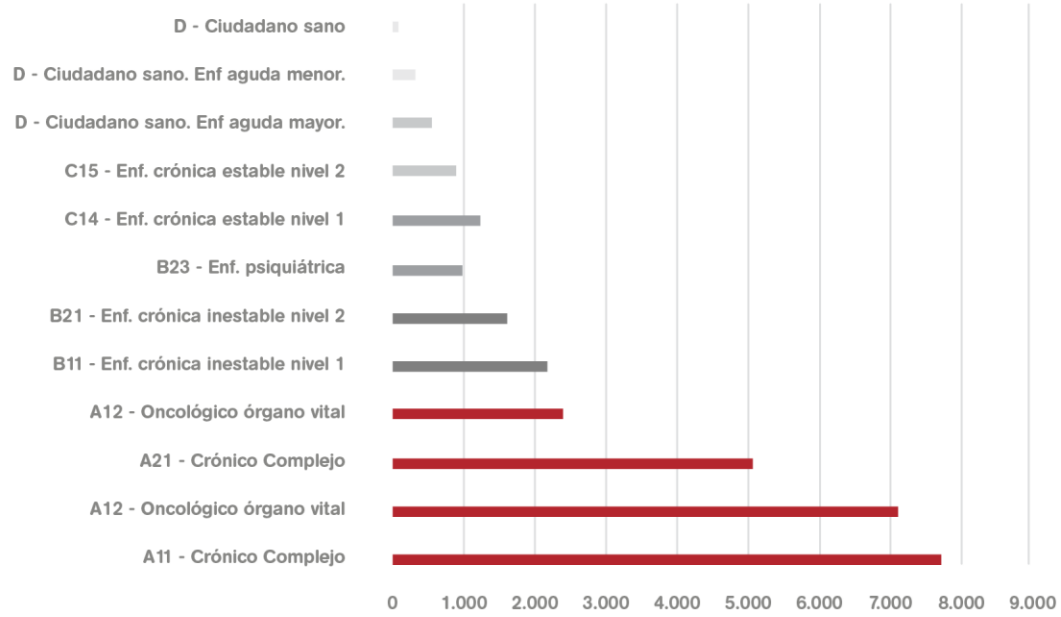
	DEMOGRAPHIC			UTILIZATION LEVEL			UNPLANNED INPATIENT			COST		
RSG	PATIENTS	%PATIENT	AGE	INPATIENT	EMERGENCY	OUTPATIENT	>0	%RSG	IP DAYS	COST	RUB	FRAILTY
A11	2.569	0,5%	77	1,38	1,52	10,1	1.784	69,4%	13,6	9.498	4,6	19,9%
A12	3.788	0,7%	66	0,91	1,26	13,3	1.650	43,6%	13,6	7.077	4,1	8,3%
A21	3.945	0,7%	74	0,79	1,13	8,1	1.896	48,1%	10,4	5.915	4,3	15,5%
A22	9.380	1,7%	66	0,25	0,72	7,9	1.200	12,8%	6,3	2.190	3,5	2,3%
B11	13.759	2,5%	69	0,32	0,77	6,0	2.956	21,5%	7,9	2.600	3,6	8,8%
B21	19.979	3,6%	61	0,19	0,72	5,8	2.523	12,6%	6,5	1.747	3,4	17,8%
B23	2.703	0,5%	42	0,10	0,64	6,1	203	7,5%	9,7	1.051	3,1	1,0%
C14	36.677	6,7%	50	0,09	0,62	4,8	1.997	5,4%	4,8	1.041	3,0	0,8%
C15	59.052	10,7%	49	0,05	0,53	3,5	1.746	3,0%	3,6	746	2,7	0,2%
D17	59.519	10,8%	35	0,03	0,75	2,0	1.375	2,3%	3,1	591	2,5	0,2%
D18	145.683	26,5%	34	0,01	0,33	1,3	715	0,5%	1,9	273	1,7	0,0%
D18	193.592	35,2%	40	0,00	0,00	0,0	0	0,0%	0,0	0	0,0	0,0%
TOTAL	550.646	100%	42,1	0,05	0,35	2,0	18.046	3,3%	7,3	592	1,6	1,1%

TRANSFORMATION AND INNOVATION

NUMBER OF PATIENTS

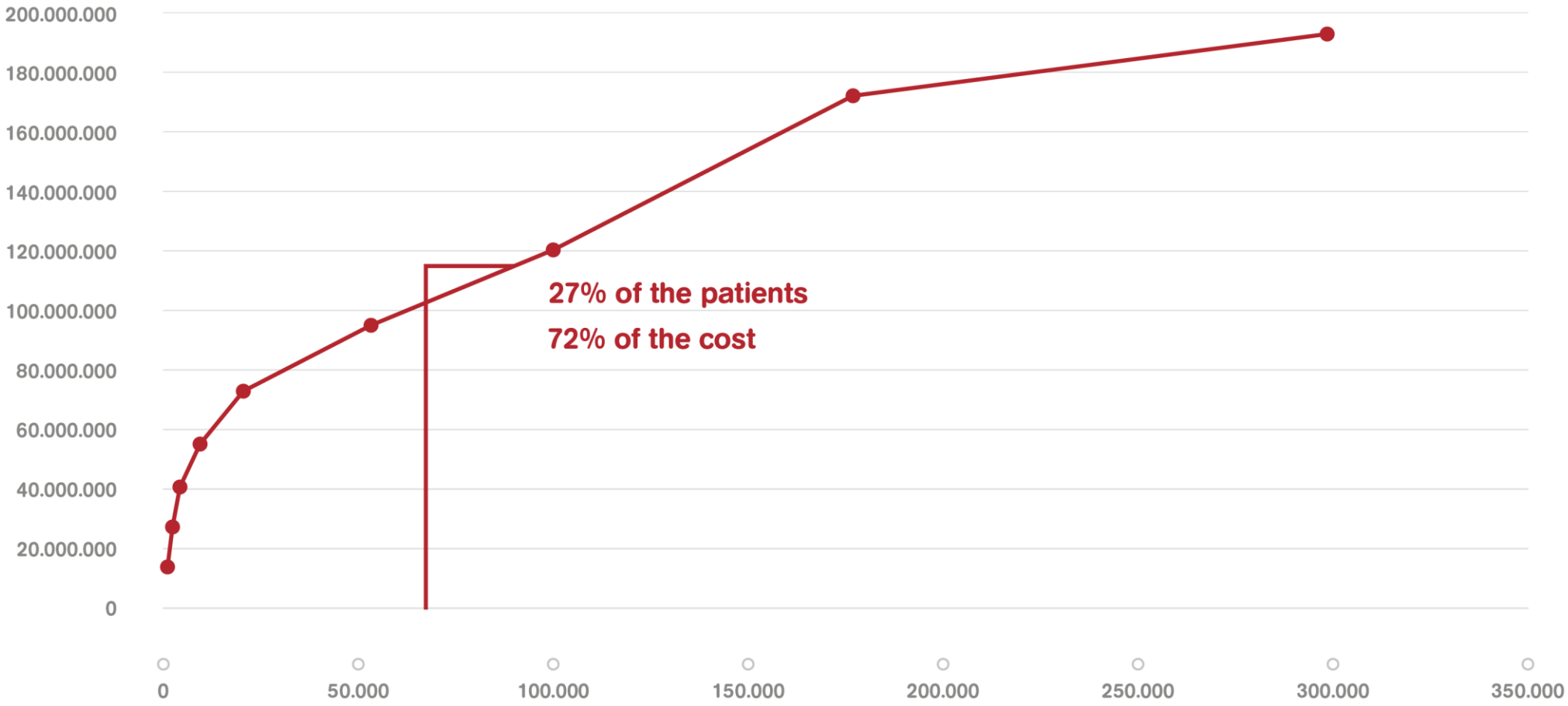


AVERAGE COST PER PATIENT



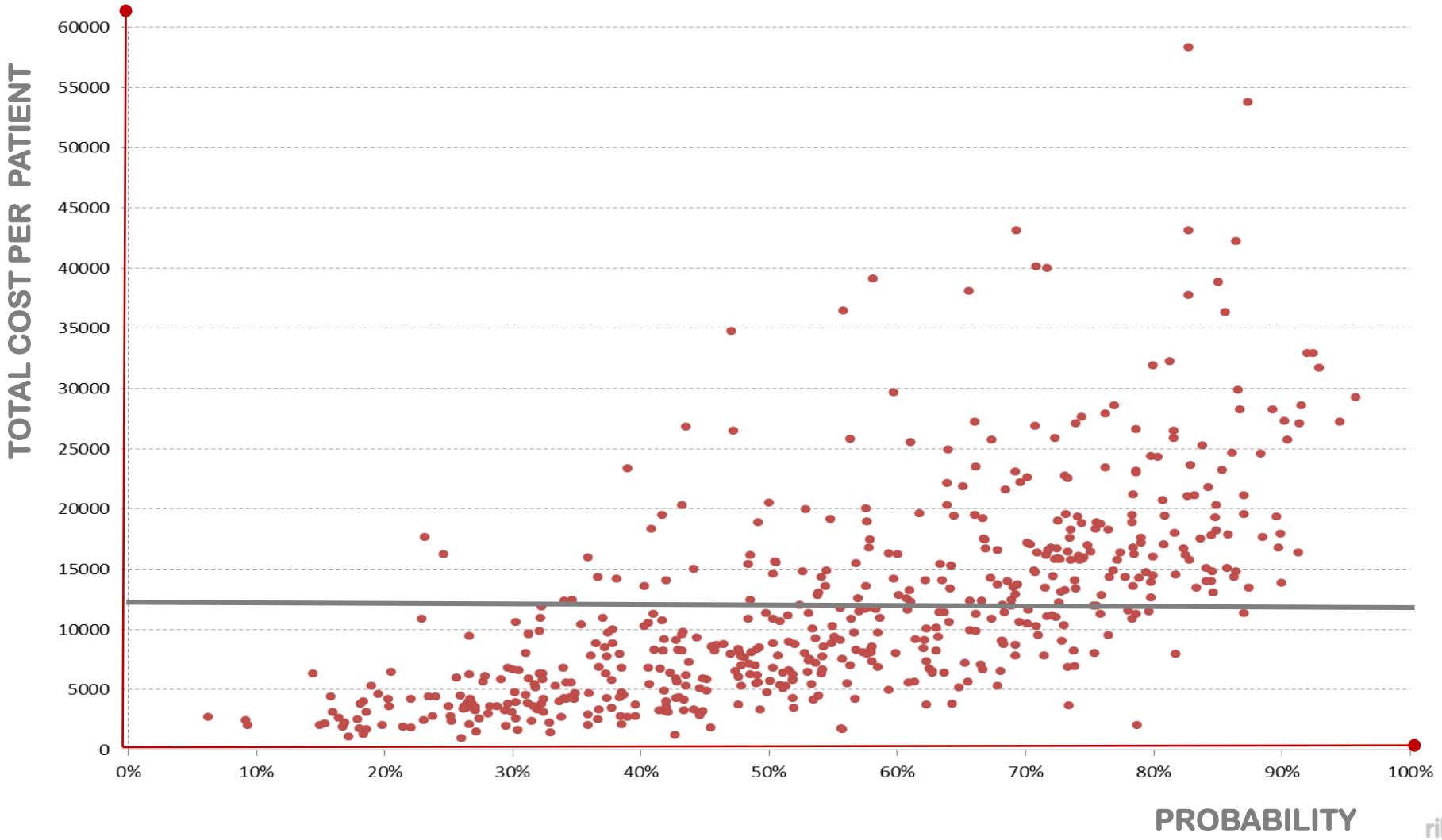
TRANSFORMATION AND INNOVATION

POPULATION AND COST DISPERSION



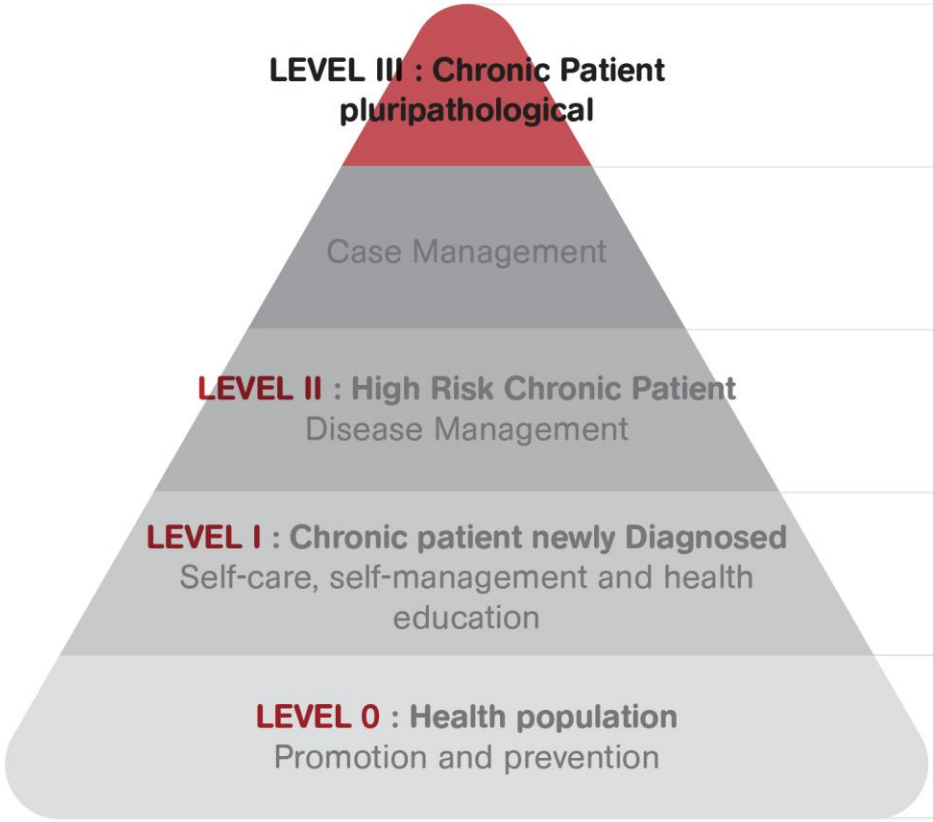
MORE PROACTIVE AND TARGETED CARE

COST PER PATIENT



TRANSFORMATION AND INNOVATION

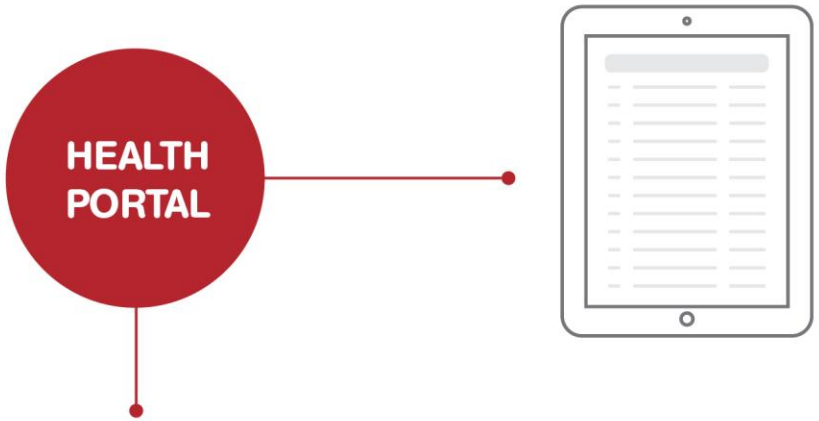
PYRAMID OF RISK



LEVEL OF RISK	COMMUNICATION	PROFESSIONAL IN CHARGE
LEVEL III : Chronic Patient pluripathological	High Complexity. Care at home.	Case management nurses Basic Area - Care Center Programmed telephone follow
Case Management	Face to Face at care Center	UBA Nurses
LEVEL II : High Risk Chronic Patient Disease Management	Face to Face at care Center	UBA Nurses
LEVEL I : Chronic patient newly Diagnosed Self-care, self-management and health education	Health portal/ Phone	UBA Nurses / Care Center
LEVEL 0 : Health population Promotion and prevention	Health Portal	Care Center

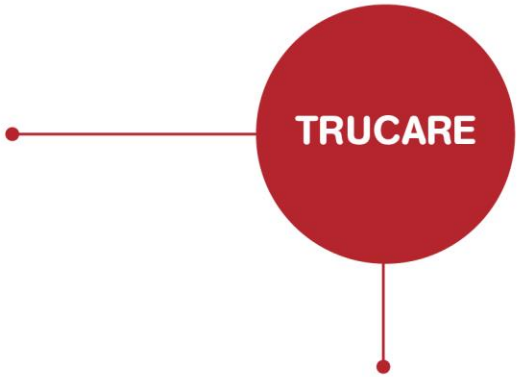
TRANSFORMATION AND INNOVATION

TOOLS



TruCare is a Managed Care Tool.
It will:

- Assign pre-defined care plans (IAPs) to patients / citizens based on the " screening " of risk criteria
- Action Plan

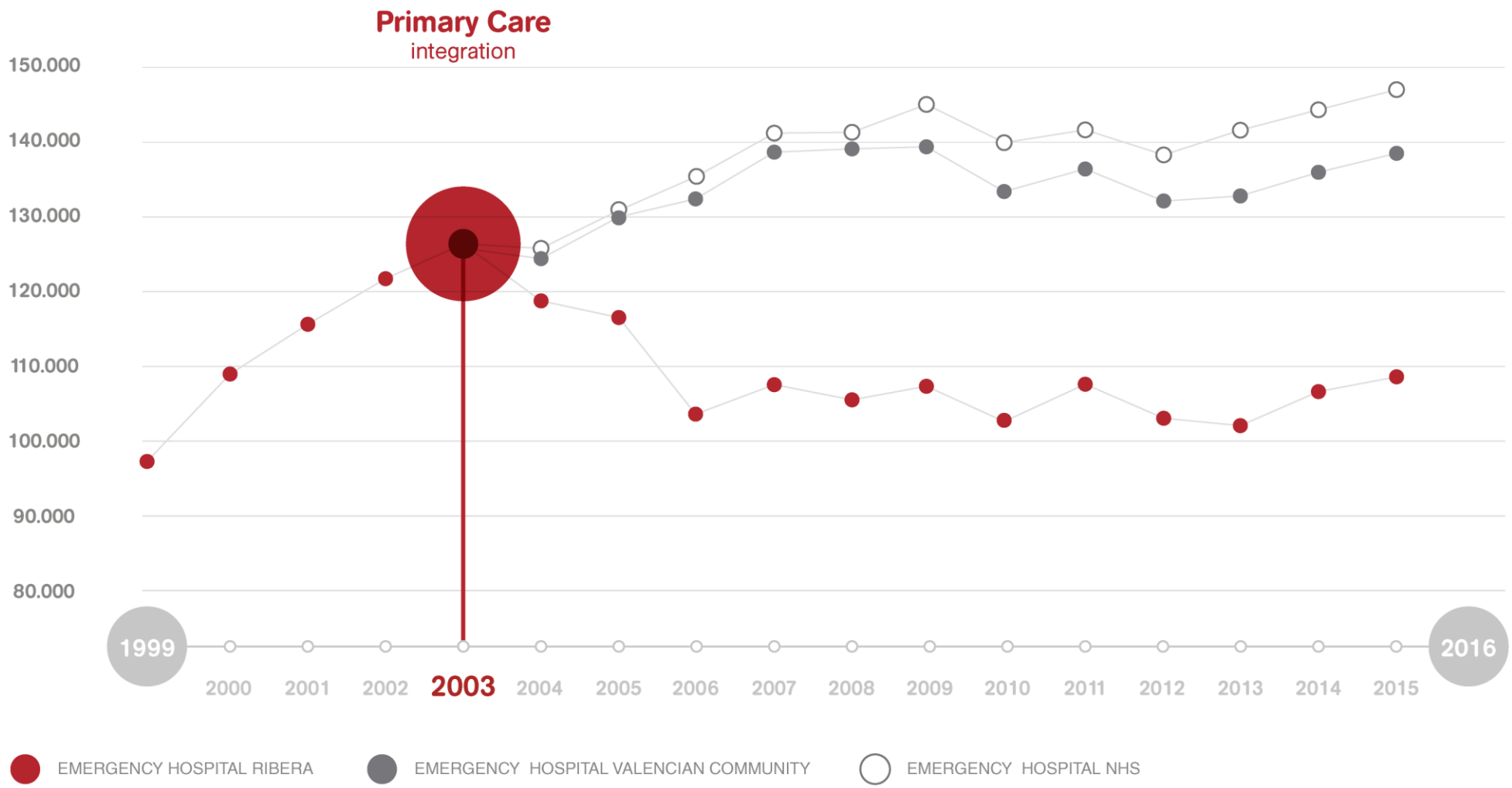


Health Portal will be the main means of communication for the level 0 of the population and a big part of population in level I.

SOME FIGURES

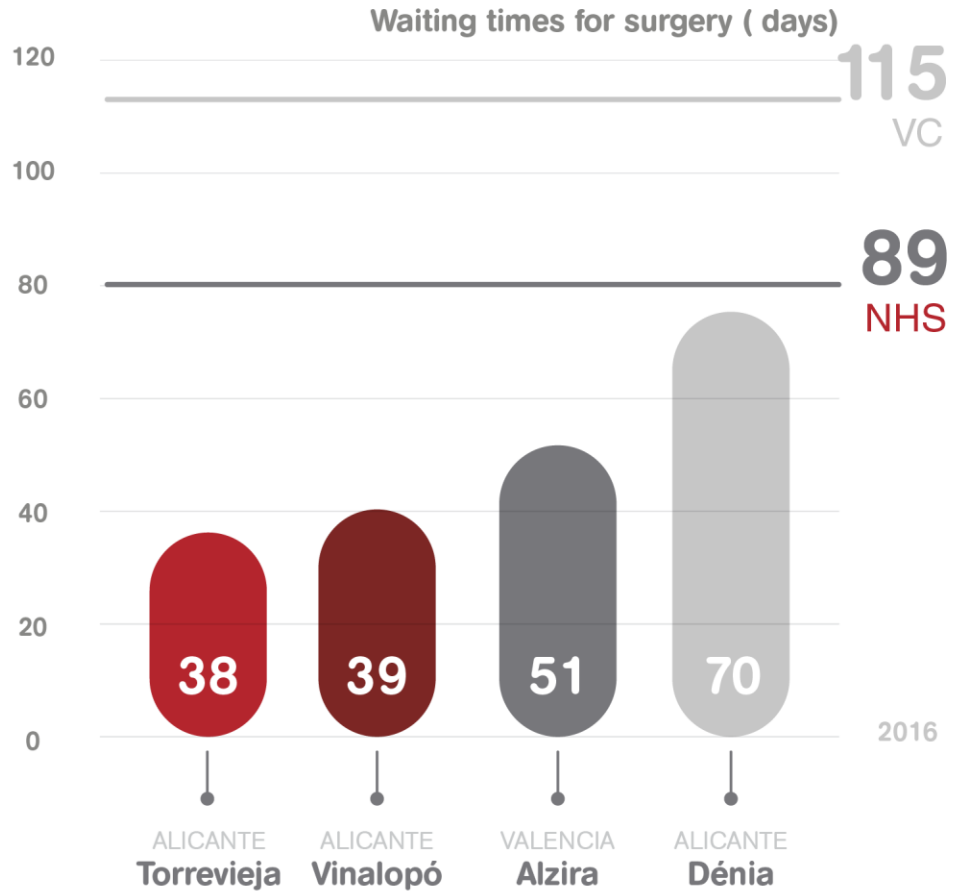
SOME FIGURES

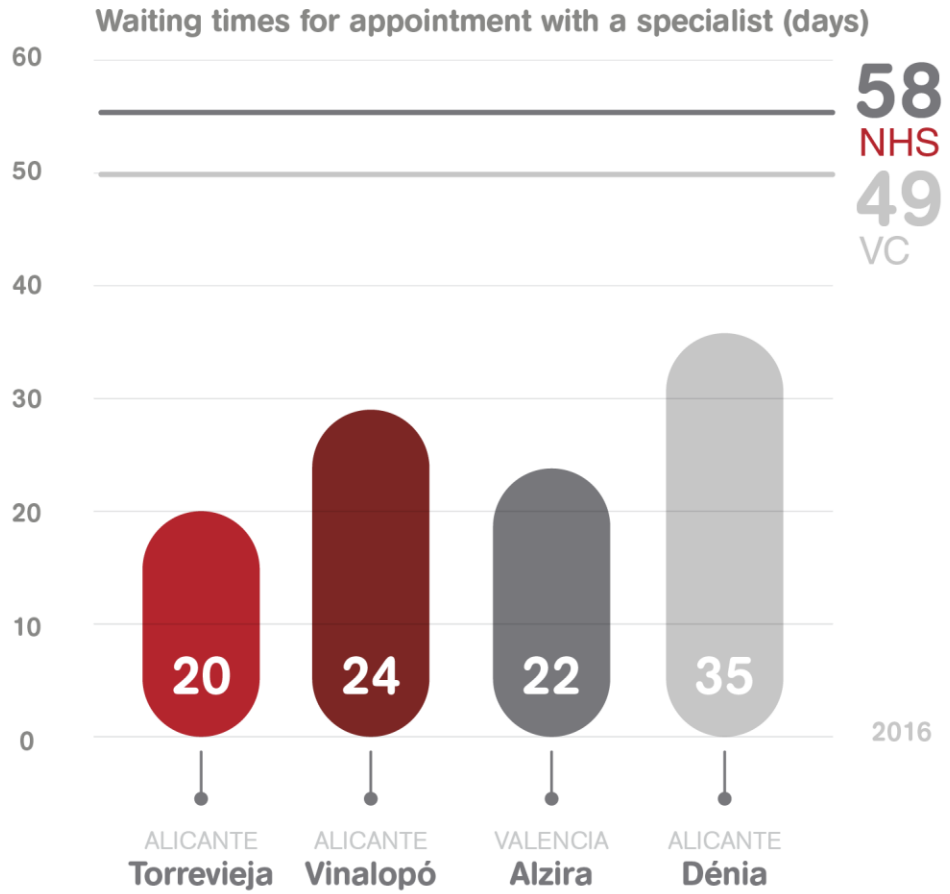
EMERGENCY EVOLUTION



SOME FIGURES

WAITING LIST RESULTS





SOME FIGURES

INDICATORS

INDICATORS 2016	RIBERA SALUD	VALENCIAN COMMUNITY
Diabetes Type II Control	59,70 %	50,15 %
Outpatient surgery substitution rate	78,48 %	64,98 %
Rate of Low - risk section	3,53 %	7,76 %
Hip fractures operated within 48 hours	90,02 %	57,04 %

SOME FIGURES

BROOKINGS INSTITUTION “Spain: Global Accountable Care in Action”

Reinventing Chronic Care Management for the Elderly

MEASURE	BEFORE	AFTER	VARIATION
First outpatient visits	5.688	5.190	8,76 %
Ongoing outpatient visits	15.700	16.122	2,69 %
Hospital emergencies	6.752	5.680	-15,88 %
Hospital admissions	2.933	2.123	-27,62 %
Hospital re-admissions	266	197	-25,94 %

CONCLUSIONS

CONCLUSIONS

REFORMS

Which is easier, healthcare reform or climbing Everest?

THANK YOU