

# Taking a Population Health Management Approach to the Referral of Meddygfa Glan Cynon Patients With an Electronic Frailty Index to the Community Health and Wellbeing Team

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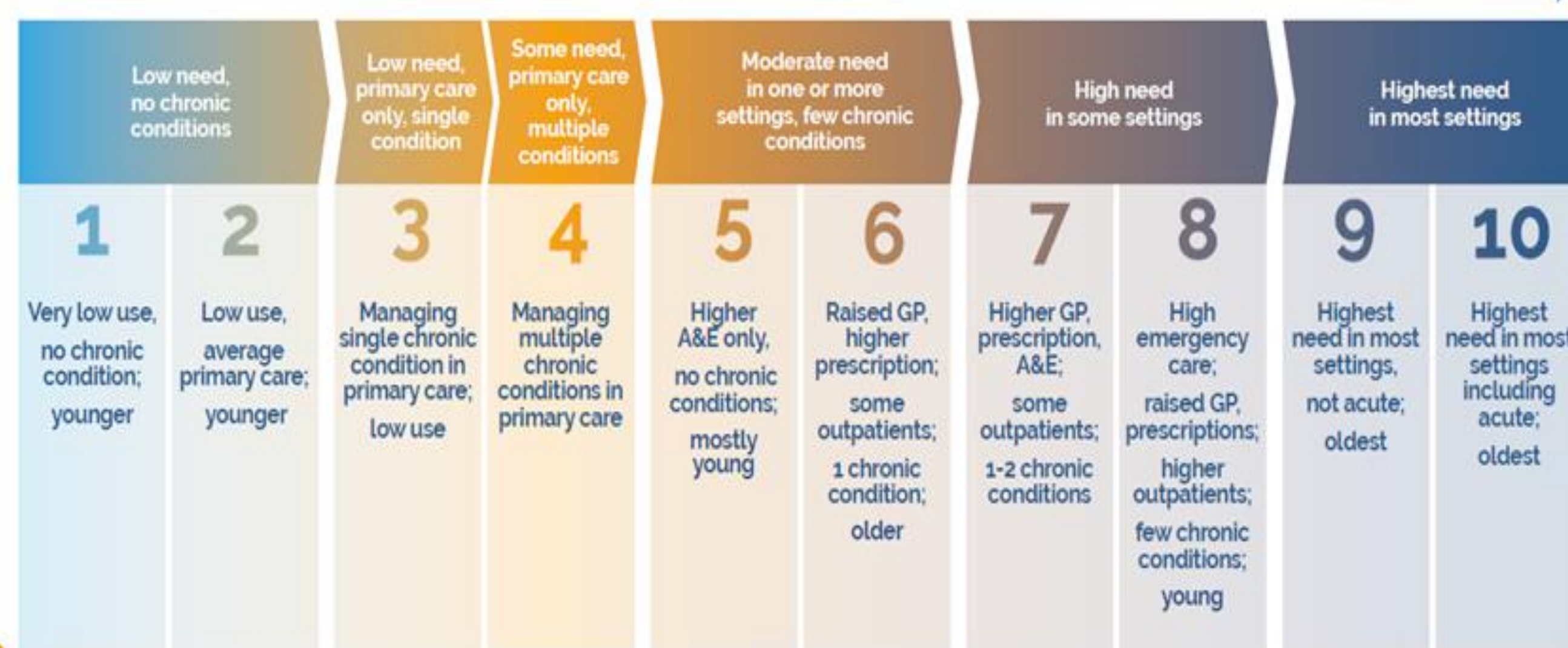
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## Background

- Frailty is associated with adverse health outcomes for individuals and increased healthcare costs<sup>1</sup>. The winter months can impact frailty; older adults with frailty have a lower capacity to cope with seasonal variations<sup>2</sup>.
- Population Health Management (PHM) helps us better understand both the needs of patient populations and use of health care resources and therefore tailor services to improve population health.
- Welsh Government recognises that achieving quality-of-life outcomes for older people and people living with frailty demands a shift towards a PHM and 'place based' approach<sup>3</sup>.
- The Community Health and Wellbeing Team (CHWT) are a multi-disciplinary team that work together to meet individual patient needs.

## Population segments in CTMUHB

Increasing health care utilisation and comorbidities



Population Segmentation (PS) groups together individuals with similar health care need; this can help us identify specific groups of patients to target for preventative care.

## Aims

- Lessen burden of frailty felt by patients by improving opportunities for preventative care closer to home.
- Test feasibility and acceptability of using current PS data to inform the referral of patients living with frailty to the CHWT.
- Understand the impact on system pressures in this cohort within Primary Care as a result of this project.

## Methodology

- A PHM approach was used, whereby PS and clinical data were used to identify and prioritise patients by estimated need.
- Inclusion criteria for the project included patients being in segment 4 or 7, living in identified areas of deprivation and having certain health conditions.
- Eligible patients from Meddygfa Glan Cynon Surgery were triaged by the GP lead of the CHWT and care discussed through a 'What Matters' based conversation; patients were referred to the CHWT and other services as appropriate.

## Results



316 patients identified



83 patients contacted



21 patients referred

- 15 to CHWT
- 2 to first contact physio
- 4 to other services

- A higher proportion of patients with severe frailty and multiple chronic conditions were referred to an intervention.
- Of the 9 patients who had a follow-up patient centred assessment method (PCAM) score, 8 of the patients had improved scores for health and wellbeing, social environment and service coordination.
- Partners' saw the use of a PHM approach and the resulting intervention as a proactive project that had a positive impact on patients and staff.

*'It is definitely picking up the people who haven't contacted health services, or at least about their, I guess the social need... But yeah it is, hopefully a good group to be trying to catch'*

*'I know we saw a few people who would not have accessed services otherwise than being contacted it opened a whole area for quite a lot of the team members to get involved with some people'*

## Strengths & Limitations

- The PHM approach targeted services to those with estimated higher need in a proactive and preventative way; supporting patients that may not have otherwise been identified.
- Due to challenges within the system only a proportion of identified patients were contacted; findings may not be reflective of all patients identified.
- A small number of patients were referred to and seen by the CHWT; difficult to deduce impact on system and winter pressures.

## Recommendations

CHWT and PHM Unit to scope the use of PS data to aid wider service delivery and prioritisation of caseload.

## Contact us

Contact [CTM.PHMunit@wales.nhs.uk](mailto:CTM.PHMunit@wales.nhs.uk) or visit the PHM Unit webpage for more information.

