


Leadership in a Capitated Environment

The use of information to support change and dependability

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OBJECTIVE

- Commit to the developmental pathway for the information environment which most effectively and efficiently supports achievement of the outcomes sought


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TO WHAT END?

- Health Gain
- **Reduce Inequalities**
- Trust and Security
- Increased Participation

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THE FUNDAMENTAL PROBLEM


Highly cost-effective interventions
for common uncomplicated long-term conditions
are not happening dependably

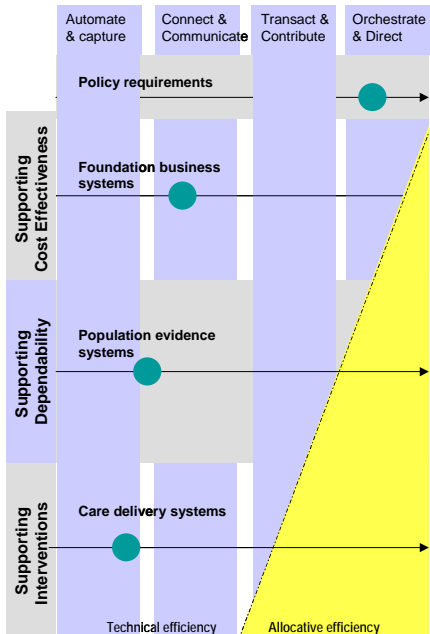
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 **THE RISKS**

- Capitated allocation of public funds presents a fantastic opportunity to do the right thing.
- However, it increases the risks on all parties.


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 **THE JOURNEY**




The diagram illustrates the 'Journey' of health systems through four stages: Automate & capture, Connect & Communicate, Transact & Contribute, and Orchestrate & Direct. It is structured into three horizontal layers of supporting systems: Supporting Interventions (Care delivery systems), Supporting Dependability (Population evidence systems), and Supporting Cost Effectiveness (Foundation business systems). A grey bar at the top represents Policy requirements. A yellow triangle at the bottom indicates the transition from Technical efficiency to Allocative efficiency.

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A CAPABILITY FRAME


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Individual Whanau Community

POPULATION HEALTH


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POPULATION HEALTH

- Identify relevant subpopulations for targeted proactive interventions.
- Understand the changes in health risk patterns and outcomes for subpopulations from the targeted interventions.
- Support performance improvement efforts in different domains.
- Sophisticated ability to identify population health need and be able to use this to target and structure funding and performance approaches.

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POPULATION HEALTH ↔ **TARGETING CARE TO INDIVIDUALS**

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Summarised data to track and plan care for people with long-term conditions and monitoring their progress over time.

Information systems that support the calculation of overall risk (as determined by multiple rather than single risk factors) and then support the appropriate interventions to be delivered.

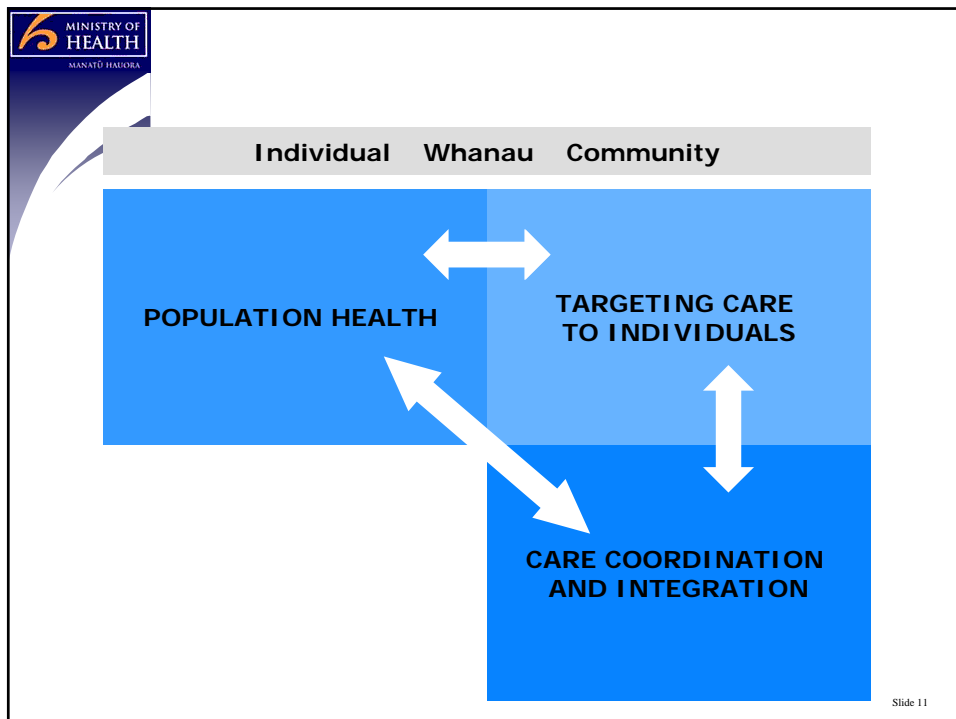
Embed evidence-based guidelines into daily clinical practice. Guidelines integrated through timely reminders, feedback, standing orders and other methods that increase their visibility at the time that clinical decisions are made.

Provide timely reminders for providers and patients e.g. recall reports, listing patients due for visits and which tests or procedures they need to undergo.

Patient-specific education reports that help patients self-manage their conditions.

TARGETING CARE TO INDIVIDUALS

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Share information between patients and providers to coordinate care.

Integrate specialist expertise and primary care.

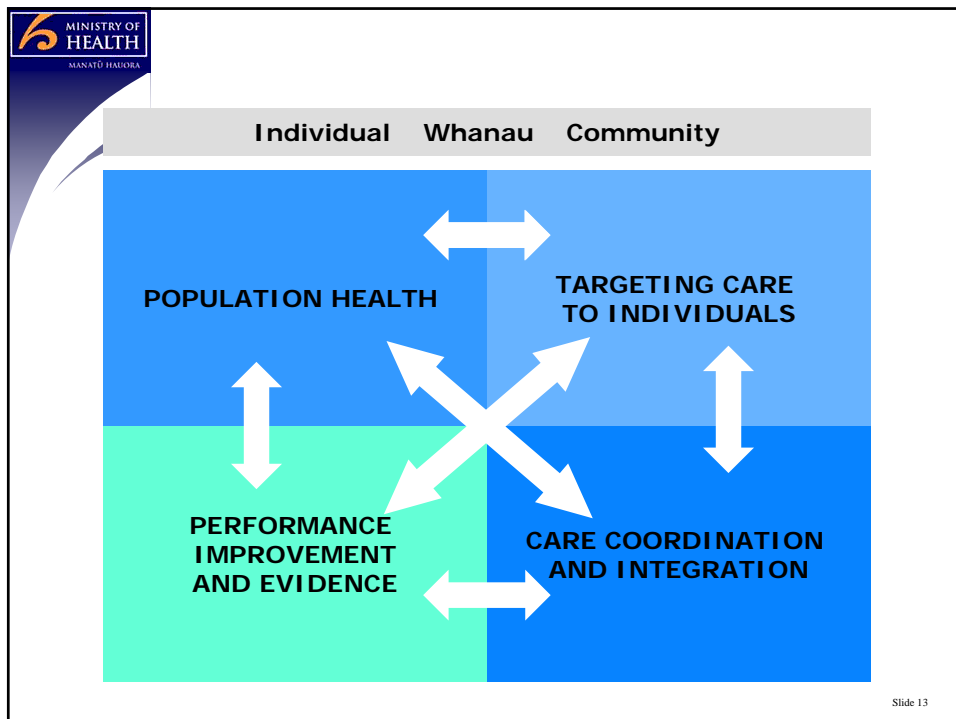
Defined communication protocols and formats to improve communication between health and social care professionals to facilitate a more seamless and integrated care process.


Multi-dimensional assessment plans requiring a multi-disciplinary assessment of needs for health and social care. This can reduce the number of assessments that a patient undergoes and provides coordinated information to support care.

Support collaboration by allowing teams to compare results in treating specific conditions over time.

CARE COORDINATION AND INTEGRATION

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**PERFORMANCE
IMPROVEMENT
AND EVIDENCE**

Provide self-review, organisational and system performance tools.

Evidence bases to support planning and service configuration at all layers of the health system.

Coordinated data sources to examine the distribution and nature of co-morbidity. Ascertainment of baseline risks on co-morbidity.

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POPULATION HEALTH	TARGETING CARE TO INDIVIDUALS
PERFORMANCE IMPROVEMENT AND EVIDENCE	CARE COORDINATION AND INTEGRATION

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