Healthier Lancashire & South Cumbria

Population Health Management

LESSONS LEARNT AND IMPLICATIONS FOR FUTURE

Contents

- Context
- Learning from Neighbourhoods
- Optum on PHM road map
- So, what does this mean for us?

Acknowledgements

All ICP Leads, Clinical Leads, B.I leads
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Context

- 20 weeks population health management accelerator programme
- Population health management is a core capability of a mature ICS in the LTP Implementation framework
- One of the key domains for supporting Primary Care Networks
- Provides a methodology to enable learning across system, place and neighbourhood levels

- Dr. Naheed
- Dr. Khandavalli

Across the 20-week programme, we enabled 5 Neighbourhoods to implement interventions using PHM techniques

	Cohort(s) Selected	Intervention Developed	Metrics of Success
Blackpool	30-50 Residents of House's of Multiple Occupancy with a depression co-morbidity	Health coaching focusing on holistic assessment, counselling, peer support and sign-posting to support groups	Use PAMs as part of the patient assessment process to determine what is important to them. Other cohorts of patients identified and interventions planned
Skelmersdale	Respiratory (COPD)	COPD Review and Group Interventions	1 -2 sessions successfully delivered. Goal setting PAMs and tracking outcomes Reduced A&E attendances and admissions Number rescue packs issued Reduce GP visits
Chorley	Patients aged between 45-60 years Patients identified as being Moderately Frail (9 to 11 eFI deficits) Patients having 10 or more Primary Care appointments between 1st January 2018 – 31st December 2018	Care Co-ordinator Social Prescribing Approach Bespoke data capture system developed	Improved PAMS Better Outcomes, experience of care, health behaviours, reduced cost
Burnley	30-50 Over 65s with a moderate frailty score (5 or 6 on Rockwood)	Populate Dashboard as baseline F2F Health Coaching Assessment Range of interventions & activities developed Peer support groups commenced Stakeholder and community engagement conducted Developed template as DQ EMIS template	Improvement in frailty score – eFI / Rockwood Improvement of Patient Activation Measure in 6/12 review Impact of intervention on non elective spend in secondary care Role and importance of Primary Care, Community Services and Community Assets recognised
Barrow	Patients with Mental Health issues co-existing with Physical Health issues	Develop a quality improvement approach to focusing on patients with SMI who have not had an annual physical health check Develop an information leaflet for patients to outline why they ae having a follow up post review	Improvement in PHC against the Morecambe Bay baseline position (19.3%) Assess the impact of PHC on expenditure on SMI across the quintiles

"The clinicians got involved, dived in."

"Everyone having a sense of purpose and pace. While it hasn't been perfect, everyone has been very motivated to get this to work."

"I don't think we had brought the same section of people together previously, so doing things like bringing analysts and clinicians together has been helpful."

"The clinicians really engaged in the data sets… clinical engagement in data sets has been essential and fully embraced."

"The programme brought together people who have the same purpose, building a sense of camaraderie. Local teams are being activated."

"We need to focus on raising collective knowledge about what PHM is, and how different people play a part in this. Even people who might not see their role as part of this, like the receptionist, how can we help them understand their potential impact and why this matters?"

"We've only superficially scratched the service of what we could do in this space."

"Some of the Optum work has shown that when we come together, and have data learning sets, the connection really matters."

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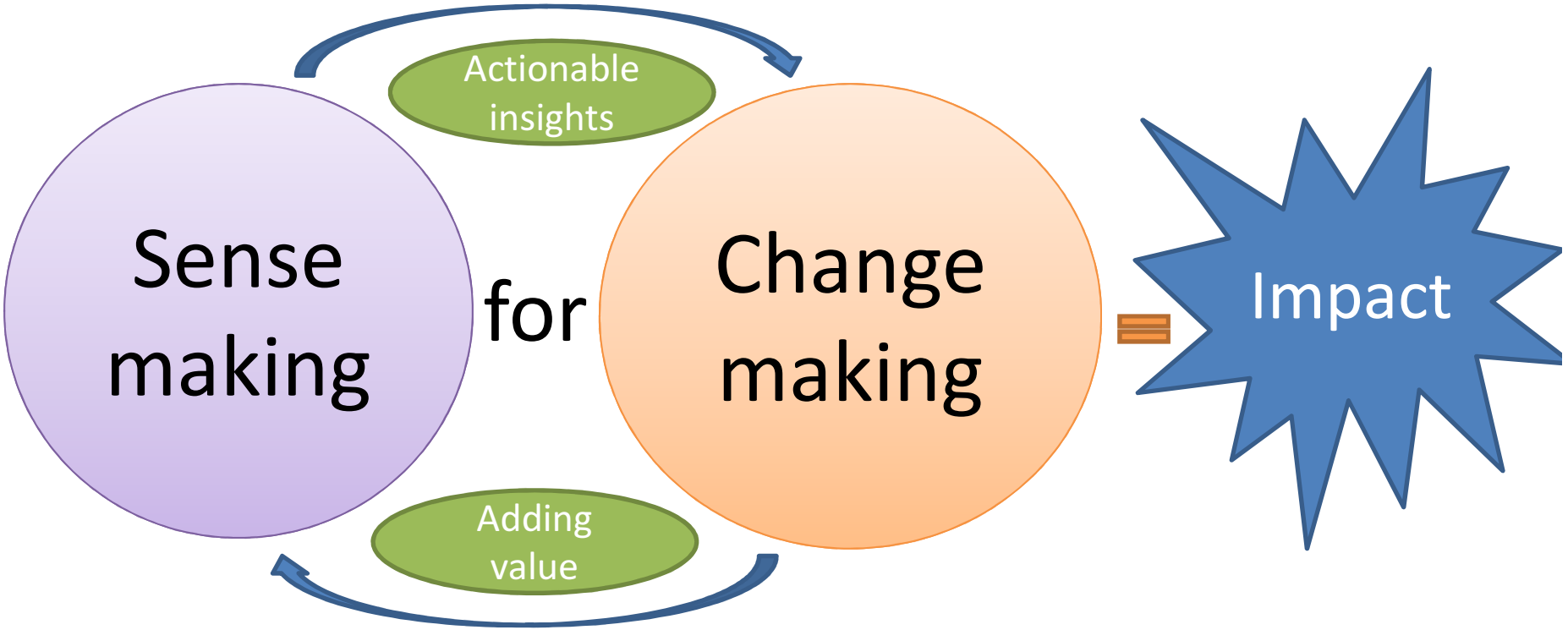
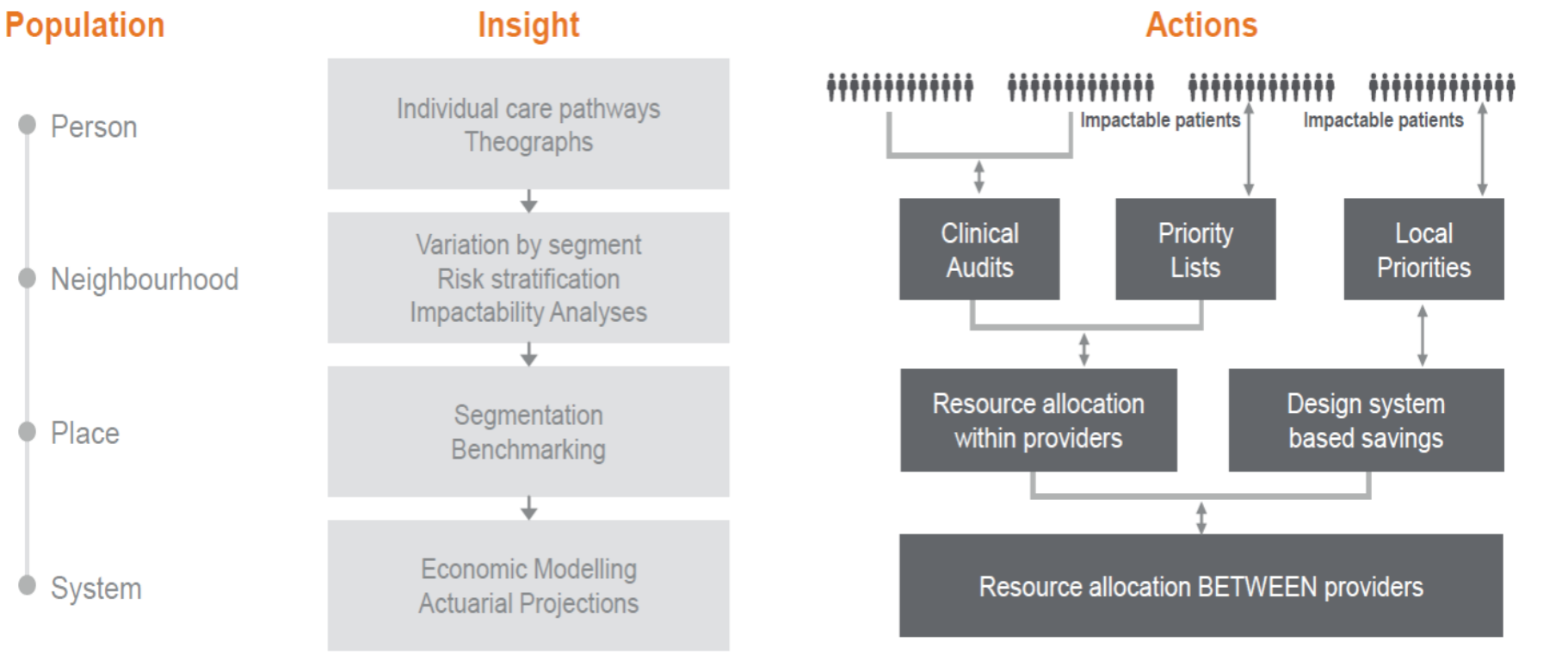


Population Health Management – Actions from Person to System and from System to Person



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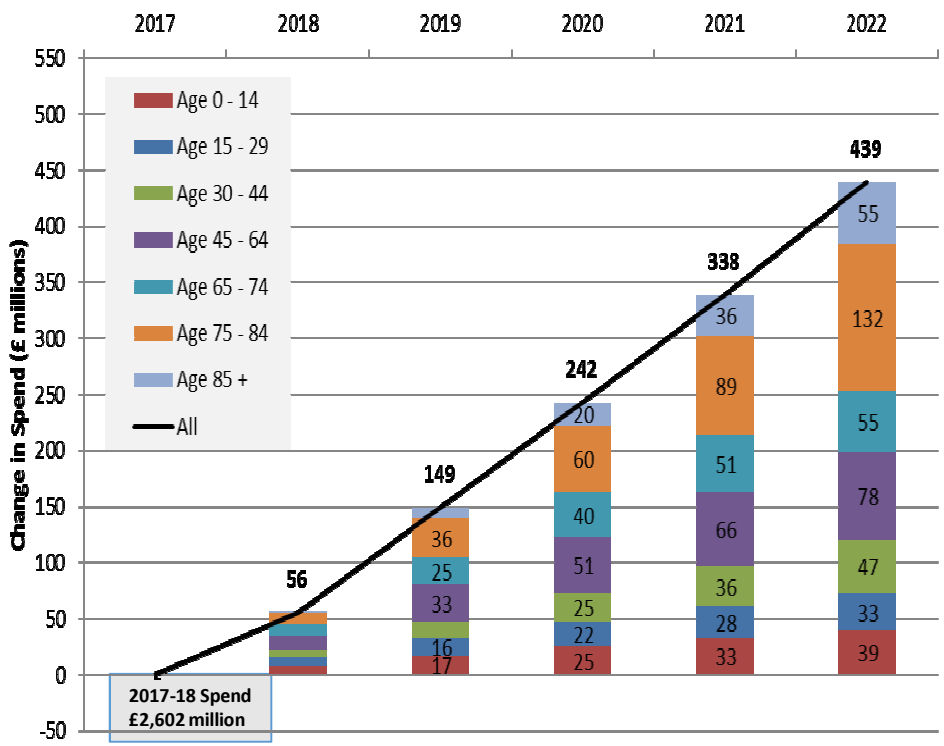
Unmitigated spend projection by segment

By zooming in on the projected **change** in annual spend compared to 2017/18, population segments can be prioritised for action



Observations

- Health system spend is forecast to increase by £439 million over the next 5 years
- Most significantly in the 75+ (frailty / end of life), but also 45-74 (multi-morbidity)

The results relate to NHS operational years. “2017” is shorthand for 2017-18.

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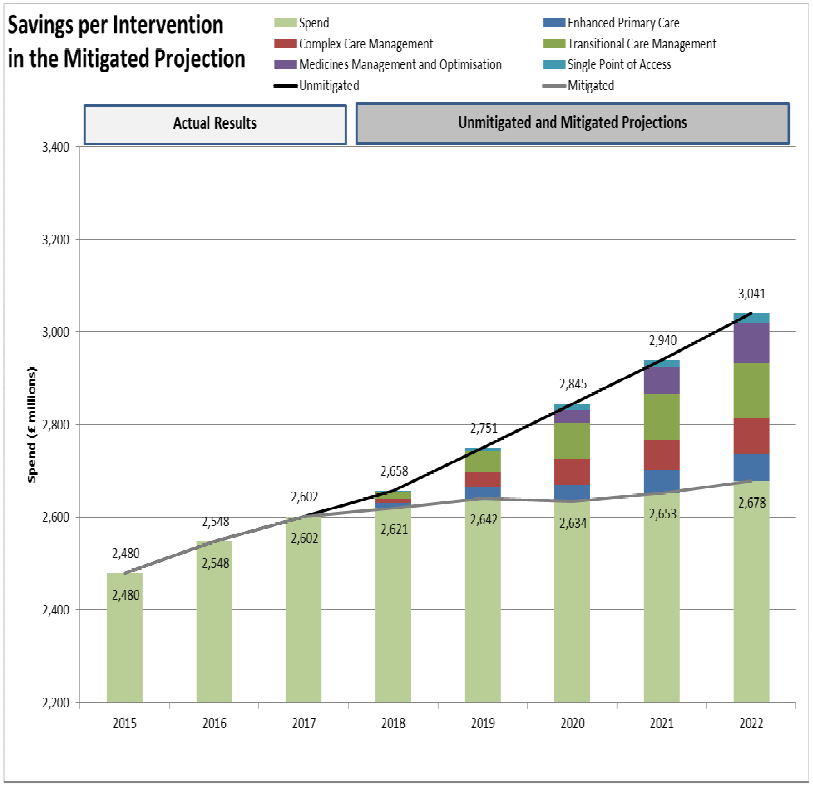
Modelling the Impact of Interventions

The projections of unmitigated demand are the baseline for testing the impact of new interventions. The modelling approach allows the impacts to be quantified in relation to population segments.



Mitigated Projection - Population Segment View

- With the PHM approach, the interventions are designed around clearly defined population segments and the impacts are quantified at this level.
- Resource allocation and operational plans can be formulated in terms of population segments.
- The chart shows indicative savings due to each intervention and the resulting "mitigated projection".

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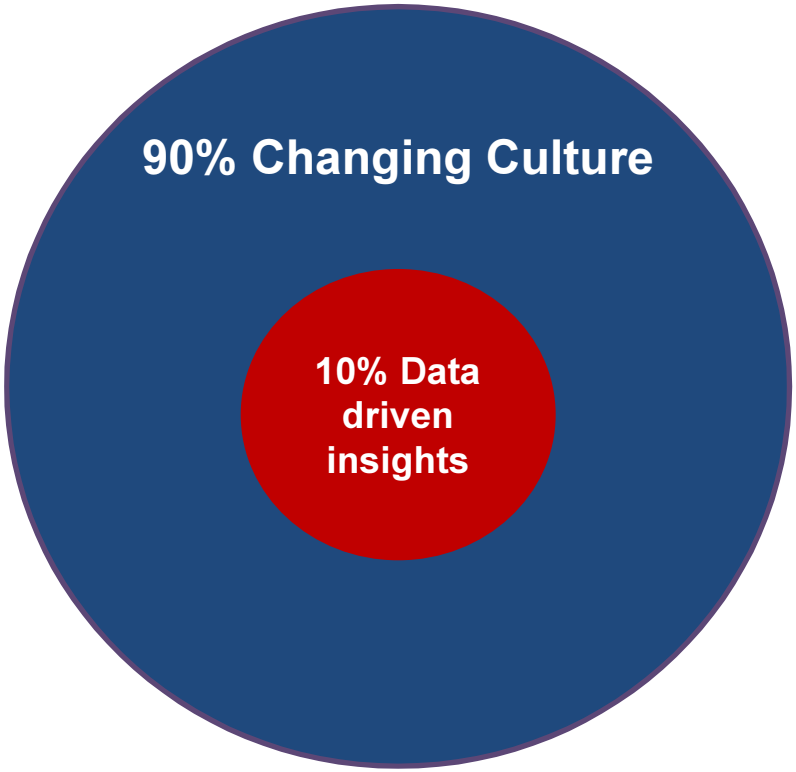
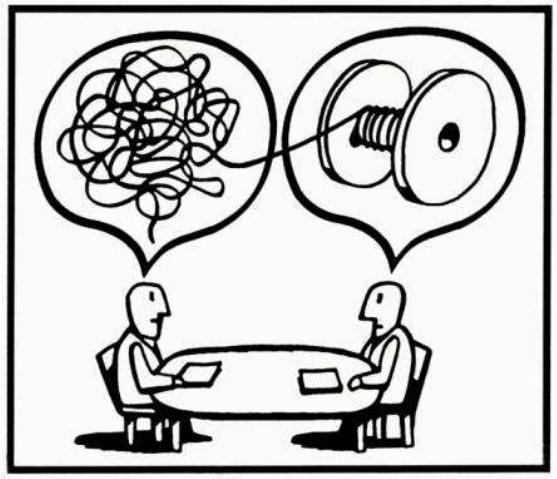
What it really means!





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Adrian McCourt, Optum

Achievements and Reflections

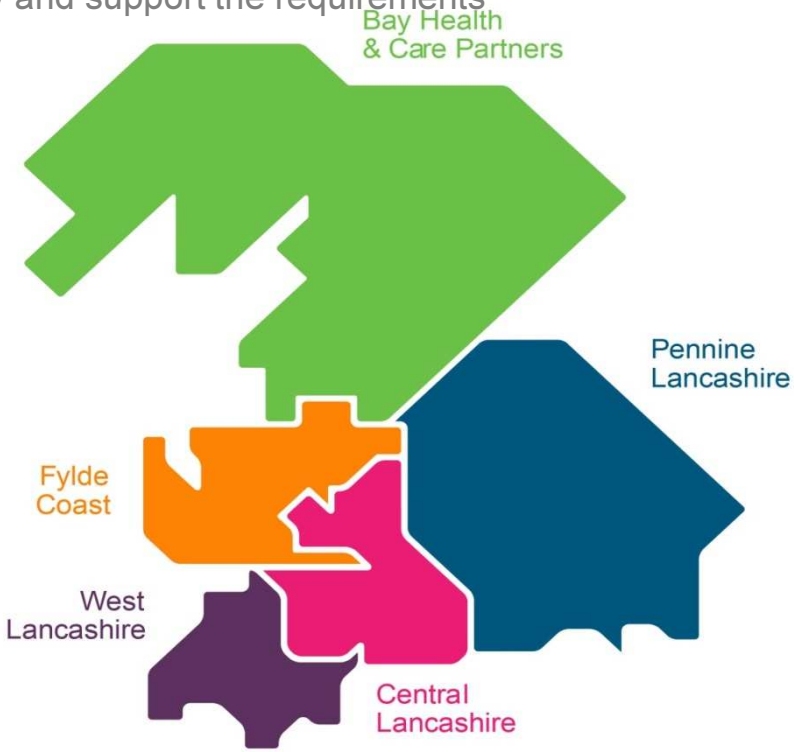
Achievements of the programme

- IG solution implemented to allow creation of linked patient level data set. Longer term plan developed to support ongoing data linking and addition of further complimentary data sets.
- Neighbourhood patient level analytics produced for all 5 participating PCNs. BI and Analytic methods and materials transferred to BI Action Learning Set group. Longer term analytics plan developed.
- All 5 neighbourhoods implemented patient level interventions and delivered actual change to patient pathways in 20 weeks. Scale and sustain plan for neighbourhoods detailed in Roadmap.
- Local leads, who will act as point of contact for future analytics support, identified. Future requirements and resourcing outlined in local analytics and IG plan.
- Unmitigated system level model produced and method for completion of mitigated model transferred to financial leads.

Lessons from the neighbourhoods

The following lessons have been derived from the case study and support the requirements identified for longer term sustaining and scaling

- Support systems to make progress by starting where they are and developing key elements of their infrastructure
- Identify dedicated, protected resource at all levels of the system and ensure this contains the right expertise
- Commit significant up front effort to ensure IG requirements and linked data sets are in place
- Support teams to make progress without the data being perfect and should start with what they have
- Facilitate Action Learning Sets with specifically skilled resource
- Enable MDTs to draw their own conclusions from linked data set insights. Then coach them to apply PHM approach based on these conclusions



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Embed and Sustain 2-4 Months

Neighbourhoods
- Continue with ALS support with the inclusion of BI (to ensure PHM approach perpetuates) to embed learning and approach
- Define tangible benefits against quintuple aim
- Develop a replicable process and approach to roll out

Data and analytics
- Embed PHM approach within analyst team through additional ALSs
- Re run neighbourhood data and provide insights as to the PHM patients cohorts with the largest opportunities
- Develop next level PHM capability within system BI resource, inc. predictive modelling
- Support the development of a business case for a pop health analytics system hub

Actuarial Models
- Develop ICP actuarial models (mitigated and unmitigated), and ICS model in order to understand patient and financial flows and business case for PHM investment

PCNs
- Support the development of the L&SC PCN offer- ensuring PHM approach; confirming how the many support offers align

Leadership
- Develop, with LSC colleagues, a L&SC Pop Health Management plan with clear articulation of priorities and responsibilities at System, place, PCN and person levels
- Develop consistent view of **what** PHM means for ICP exec teams and **how** it will be applied to achieving existing strategic imperatives- single control total, PCNs etc.

Promote and Scale 6-12 Months

Neighbourhoods
- Scale to all PCNs : Minimum support and data pack; accelerator cohort additional support through ALS

Data and analytics
- Coaching/ ALS for dedicated PHM system BI resource
- Development of at scale pop health analytics capability

Finance and incentives
- Using Actuarial modelling and linked data set to understand impact and then to align incentives to behaviour and system value

Leadership
- System PHM capability development plan, linked with Lancaster Uni and Edge Hill

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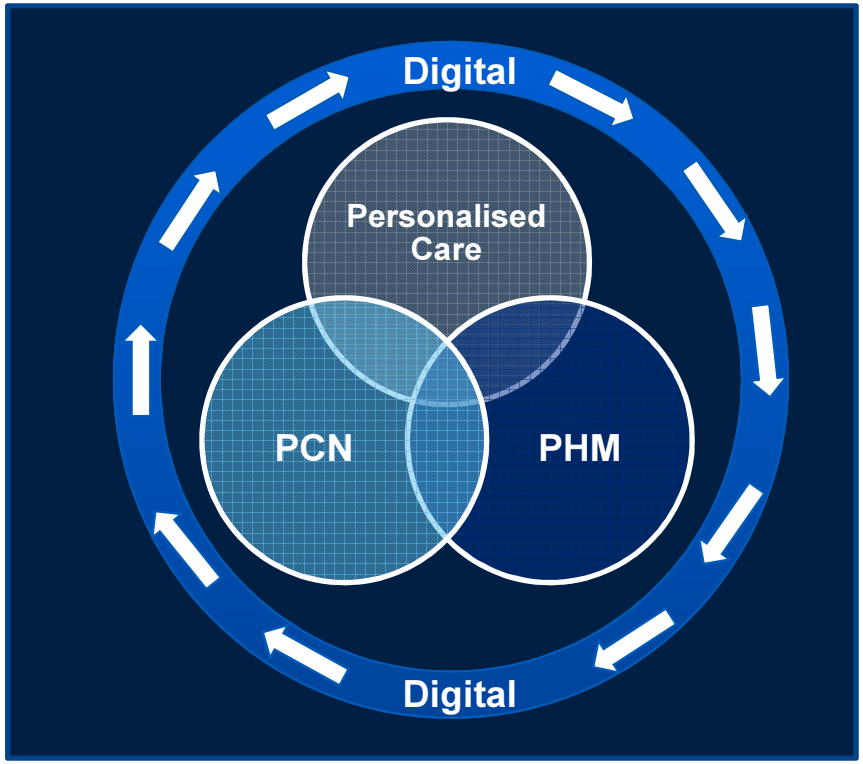
So, what does this mean?

We need Board support to work differently to improve health and care at scale

1. We need to strengthen our capability on analytics and insight generation, including I.G B.I, CSU, LA, Universities, AHSN (In progress)
2. Embed PHM as a core component for primary care development (In progress)
3. Wider Provider sector engagement to connect with PCNs (needs developing)
4. Resources prioritised/identified to support Neighbourhood development (To be agreed)
5. Adopt Population Health Management as a methodology to implement ICS Priorities (To be agreed)

What's next – improving health and care at scale



- Roll out to the other 36 Primary Care Networks
- Action Learning Sets
- D3P
- Pop Health Management Institute
- Offer of Support to Wave 2 sites – architecture
- Alignment to LHCRE

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Population Health

Working in partnership with our communities to help local people live longer, healthier lives.
People are at the heart of everything we do.

Primary Care Networks

Personalised Care

Population Health Management

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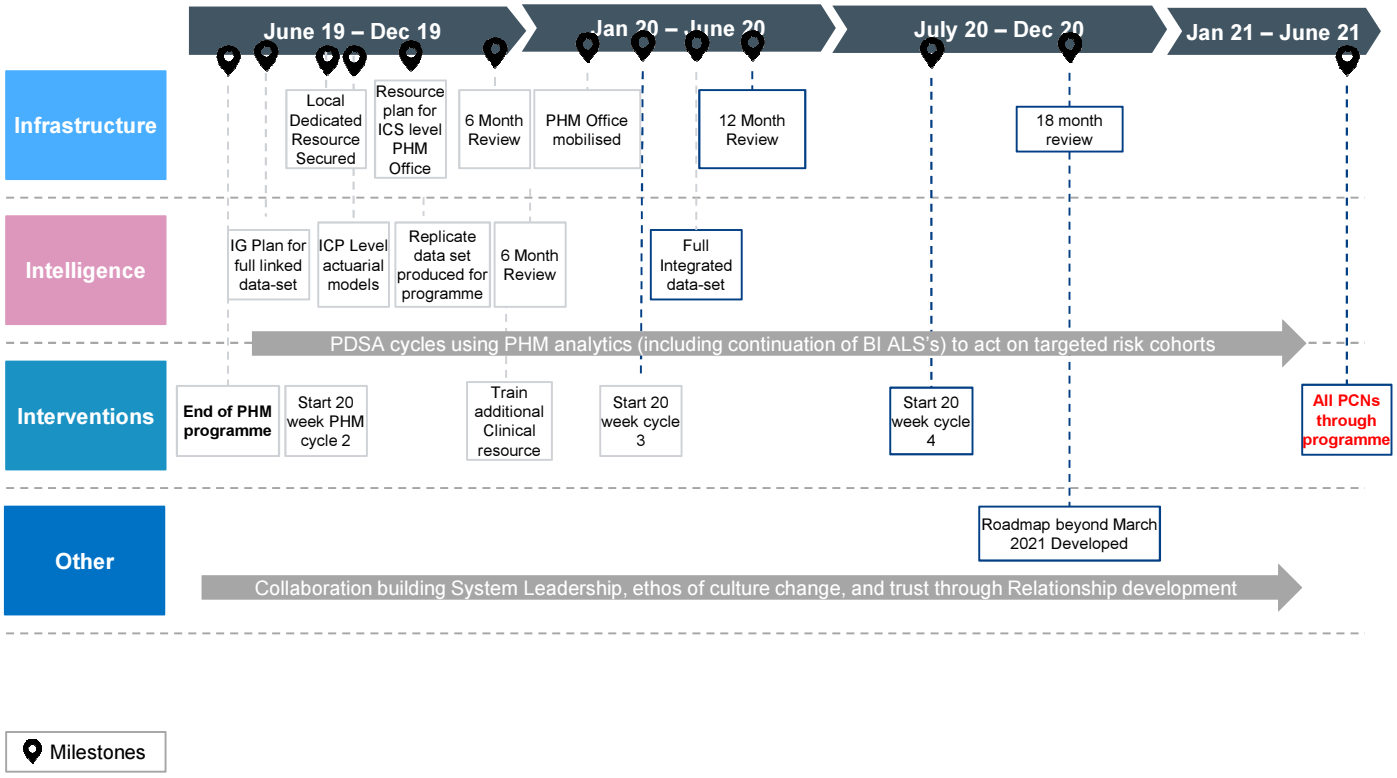
Next Steps

- Continuing with supporting 5 neighbourhoods and developing mitigated scenarios
- Sustainable IG arrangements
- Support PCN development
- Ongoing support to ICPs
- Strengthening system wide PHM Capability

Our Initial roadmap identifies key steps to enable us to further strengthen our PHM capabilities (Needs to be agreed across the system)

We have set out key milestones agreed as a result of the programme



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