Liverpool Health Challenges

30% of people in Liverpool live with one or more long term conditions
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Almost 26,000 older people have a long term illness that limits their day-to-day activities a lot.
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86% of people in Liverpool are not active enough to maintain good health
Liverpool Health Challenges

86% of people in Liverpool are not active enough to maintain good health.
Supported Self Care

- Promote healthy living and self care in Liverpool
- Consortium of Clinical Commissioning Group, Community Health, Council, Housing association, charities and industry
  - CCG: 500,000 patients, 95 GP practices
  - iMerseyside: 3 CCGs, 2 major hospitals
- 3 year programme with objectives for Telehealth, Telecare, Community Development and Healthy living
Hub based supported self-care

- Primary care pathway
- Clinically led hub
- Technology support
- Evolved a sophisticated on-boarding process
Patient cohort

![Image of a patient using a technology device]

**Figure 6: Risk-at-characteristics of intervention group**

<table>
<thead>
<tr>
<th></th>
<th>COPD</th>
<th>HF</th>
<th>Diabetes</th>
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Evidence for Impact

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<th>HF</th>
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<th>Deprv</th>
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<td></td>
<td>1808</td>
<td>66.3y</td>
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<td>0.46</td>
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<table>
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<th>n</th>
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<th>Adm</th>
<th>Δ Adm</th>
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<tr>
<td>TH</td>
<td>119</td>
<td>44.4%</td>
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</table>

Table 3 Results for 12 month admissions, R>30%, length on service > 6 months
Four audiences, 13 markets:

Survey of 25,555 patients
Survey of 2,659 healthcare professionals
> 300 qualitative interviews

Reduction in emergency admissions and secondary care cost for the top half of the pyramid.

Patients feel more in control.

The higher up the pyramid the more immediate the effect.

Patients who report more control are 6.5x more likely to report a decrease in healthcare utilisation than patients who do not.
International Research to Evidence Innovation

Four audiences, 13 markets:
Survey of 25,355 patients
Survey of 2,659 healthcare professionals
> 300 qualitative interviews

Evidence for Supported Self Care at Scale
A population approach to evaluating technology enabled support for long term condition management.

<table>
<thead>
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<th>Rank</th>
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<th>Access</th>
<th>Integration</th>
<th>Adoption</th>
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<td>57.9</td>
<td>50.7</td>
<td>38.4</td>
</tr>
</tbody>
</table>

13 market average 56.5  65.9  55.8  47.8

Future Health Index
Population Health

Philips defines population health management in this way:

“The organization of and accountability for the health and healthcare needs of defined groups of people utilizing proactive strategies and interventions that are coordinated, engaging, clinically meaningful, cost-effective, and safe.”
Population Health

Population stats and evidence

Quantified in scale and cost

Motiva, Flo, uMotif (HTS, PHS, PHM)

Multiple technologies and programmes

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NHS outcome frame work:
Increase patient and carer empowerment
Care as close to home as possible
Living well with LTC
Workforce quality and sustainability
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Business modelling

"The company needs to be more..."
Measuring success

- Knowledge, skills & confidence
- Patient activation
- Patient & carer experience
- Quality of life

- Utilisation of secondary care resources
- Unscheduled primary care contacts
- Medication optimisation

- Communication between care teams
- Care coordination
- Capacity
- Productivity
Clinically led Hub

Enabling technology

Defined patient cohorts

1. Joint care plans with a self-management component
2. Personal goal setting
3. Tailored protocols with: educational videos, quizzes, questionnaires/surveys
4. Vital signs monitoring with trend data for patients and the hub

Innovative / proactive service model

- Tailored protocols with: monitoring, advice and support, prompting / reminders with the aim of building skills and knowledge
- Basic tools to support population management
- Patient tools for symptom tracking
- Regular review calls
- Escalation management
- Advice and support

- Simple and clinically robust mobile and web health apps for patients
- Educational videos
- Symptom tracking
- Medication reminders
- Sign-posting and advice
- Electronic diary
- Basic tools to support population management
- Data reports for patients, carers, family and care teams

- Proven cognitive assessment tools
- Personal goal setting
- Tailored protocols with: educational videos, quizzes, questionnaires/surveys, medication reminders
- Vital signs monitoring with trend data for patients, carers and the hub
- Decision support tools for clinical triage
- Video calling
- Care coordination
- Sign-posting and navigation
- Health coaching visits
Summary

From disease management ... to patient (self-)management
empower the patient to have a role in their care management

From telehealth ... to city-wide Supported Self-Care at scale
Anticipate a unified, comprehensive approach to care across the system
Team decision making; effective communication & documentation across the care team, patient and carer
Plan for scale from the start, leveraging technology
Ensure the care team work at maximum efficiency

From single intervention ... to structured iteration
The programme will evolve - Step-on; Step-up; Step-down; Step-off
Apply event and data analytics to understand and evolve the programme

From supplier ... to co-design partner and joint stakeholder
Strong clinical and operational leadership
Share the success