

OPERATIONALISING WELLNESS

SYSTEMIC APPROACHES TO DRIVE TRANSFORMATION IN CARE DELIVERY, MEASURABLY IMPROVING OUTCOMES

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WHY ARE WE DOING THIS?

There is growing recognition of the urgent need to shift the health and social care system from reactivity to proactivity, from being focused on repair to driving prevention and pre-emptive action. To achieve this we recognise that public services will need to be more effectively integrated and personalised around the individual ‘customer’ rather than being organised around the provider and delivered in a siloed, fragmented way that does not meet the customer’s quality and experience needs.

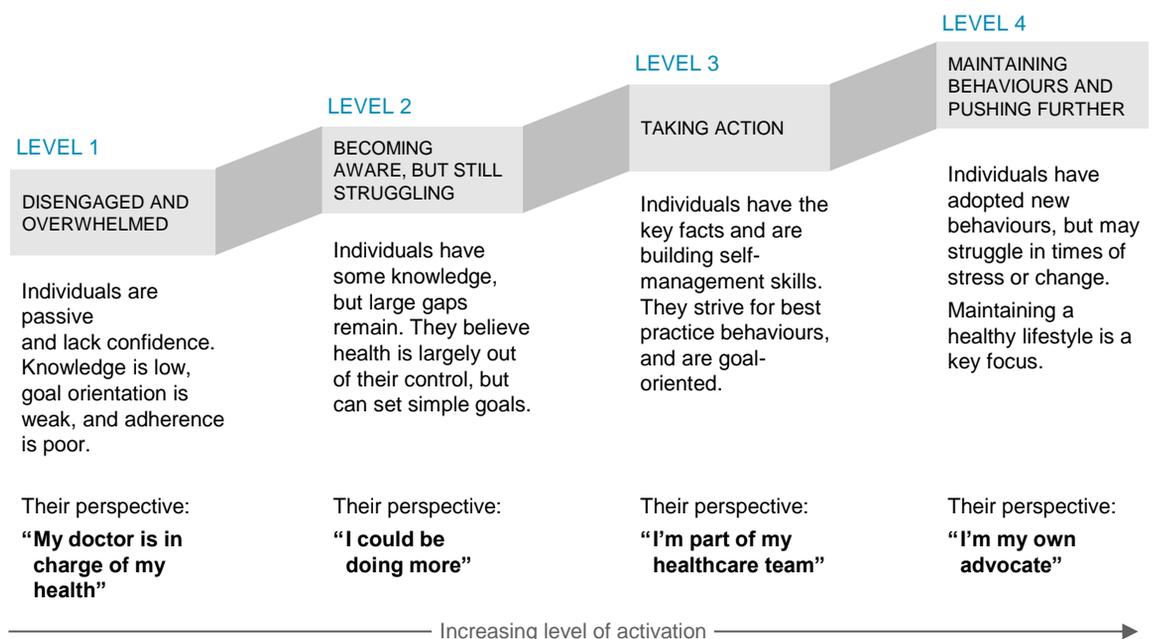
The first paper in this series “Measuring Wellness” describes the evidence and rationale of moving from a reactive “sickness and repair” service within health systems to one which is proactive and based on the person, population health and a salutogenic approach. It describes the implementation of change at an individual level towards full activation, also identifying preferred metrics to measure that change.

This paper builds on the first, looking at the pre-requisites of any systemic metric aimed at supporting these changes and also looking more specifically at the English health and social care systems and how these systems can be mobilised to help make this change in a manageable stepped fashion without the need for primary legislation.

MEASURING WELLNESS – AN OVERVIEW

Our “Measuring Wellness” paper highlighted the strong linkage between psychosocial wellness and physical health outcomes, as elucidated in Chida and Steptoe’s 2008 meta-analysis of 35 published studies. This concluded that positive psychosocial wellness was associated with reduced mortality in both healthy and diseased populations (including renal failure and HIV patients)¹. The paper also put forward a strong case for introducing patient activation for individuals in a stepped approach, building on the concept of Patient Activation Measure levels², as reproduced below. Patient activation is not only a better predictor of health outcomes than known socio-demographic factors such as ethnicity and age, but there is also a powerful economic case for driving improvements in patient activation. A recent US study³ showed that patients with the lowest levels of activation cost 8 – 21% more than patients with the highest activation level at equivalent health statuses and demographics.

Diagram 1: Levels of patient engagement in the Patient Activation Measure



Source, Insignia Health

“Measuring Wellness” identified the WEMWBS (Warwick-Edinburgh Mental Well-being Scale)⁴ as the most appropriate single scale with which to measure wellness. It is operationally feasible within the present landscape in England, captures the essential parameters of a supra-sectoral metric and drives health and social care providers to cooperate and work collegiately and congruently.

Aligning care provider teams and other stakeholders across health systems with an agreed common measurement approach will facilitate collaboration around innovation in service delivery and achieve value for the populations they serve. For example, innovative services focused on the mental health needs of young people could be delivered in schools with both education and mental health providers working collaboratively to drive for measurable improvement in wellness, activating youth to engage and take action to achieve personal wellness. Utilising metrics which assess salutogenic approaches will ensure that both mental and physical wellbeing are core to any intervention, actively encouraging the parity of esteem around mental health which has proven so elusive to attain.

This paper develops these themes and describes changes required in the NHS in England to match the stepped approach.

WHAT ARE THE PRE-REQUISITES OF A WELLNESS METRIC?

There is a set of core principles a wellness metric should follow in order to support the shift from a reactive to a proactive health and care system. The principles are largely independent of the parameters which govern the health and care system (e.g. unified government funder/ employer/ insurer). The metric should:

- Move away from a disease focus to a whole person focus – from “medicine by body part” to a person-focused system that unifies physical and mental health and incorporates non-biomedical and social parameters
- Shift from activity counting (e.g. number of operations or medical consultations) to more holistic assessments and outcomes – in essence, salutogenesis
- Move away from “sickness and repair” concepts to ones that encourage aspects of risk reduction and in some cases the prevention of ill health
- Address the years of lost or diminished life, not merely encourage longevity. The metric should seek to add life to years and reduce the years of misery associated with debility and multi-morbidity
- Have relevance to the individual. The recipient of care should be able to drive towards the outcomes they most value, rather than remain a passive recipient of activity prioritised by others. In this way, the metric should encourage and drive the four levels of patient activation outlined above
- Be constructed within a common thematic. Unified metrics will require different sectors (e.g. primary care, hospital care, social care, mental health care, education, etc.) to work together in order to achieve common goals
- Be incentivised through payments that are linked to the achievement of outcomes. It should reward participating sectors equally and in proportion to the extent common goals established with or by the individual are achieved

Measuring wellness can be used to galvanise appropriate and congruent activity across the whole health and social care system. Diverse actors can be incentivised to align around wellness and be held to account for its improvement. These actors could include all sectors within healthcare and social care and also potentially others from the broader care system, including education, justice, crime prevention and local government.

Health and care systems are complex adaptive systems and require the careful, specific and bespoke introduction of new metrics, often via a graduated methodology to diminish the likelihood of disengagement and unsustainability. Their introduction will likely be opposed if they affect existing activity based metrics and there needs to be a clear understanding of the roles of Payers and Providers of care and the behaviours they are likely to exhibit as a result. All these considerations need to be factored into the introduction process.

MOVING TOWARDS IMPLEMENTATION

In order to progress patients along the Patient Activation Levels described in Diagram 1, broader changes will need to occur across the whole health and care system. We need to move from the “sickness and repair”, hospital dominated, transactional, disconnected and provider-centric care system of today to one which is integrated, personalised, patient-centric and focused on prevention, wellness and population health.

Supportive infrastructure such as technology, payment systems and contractual levers will be required to effect this transformation and increase patient engagement. Examples of these are outlined in Diagram 2 and described below.

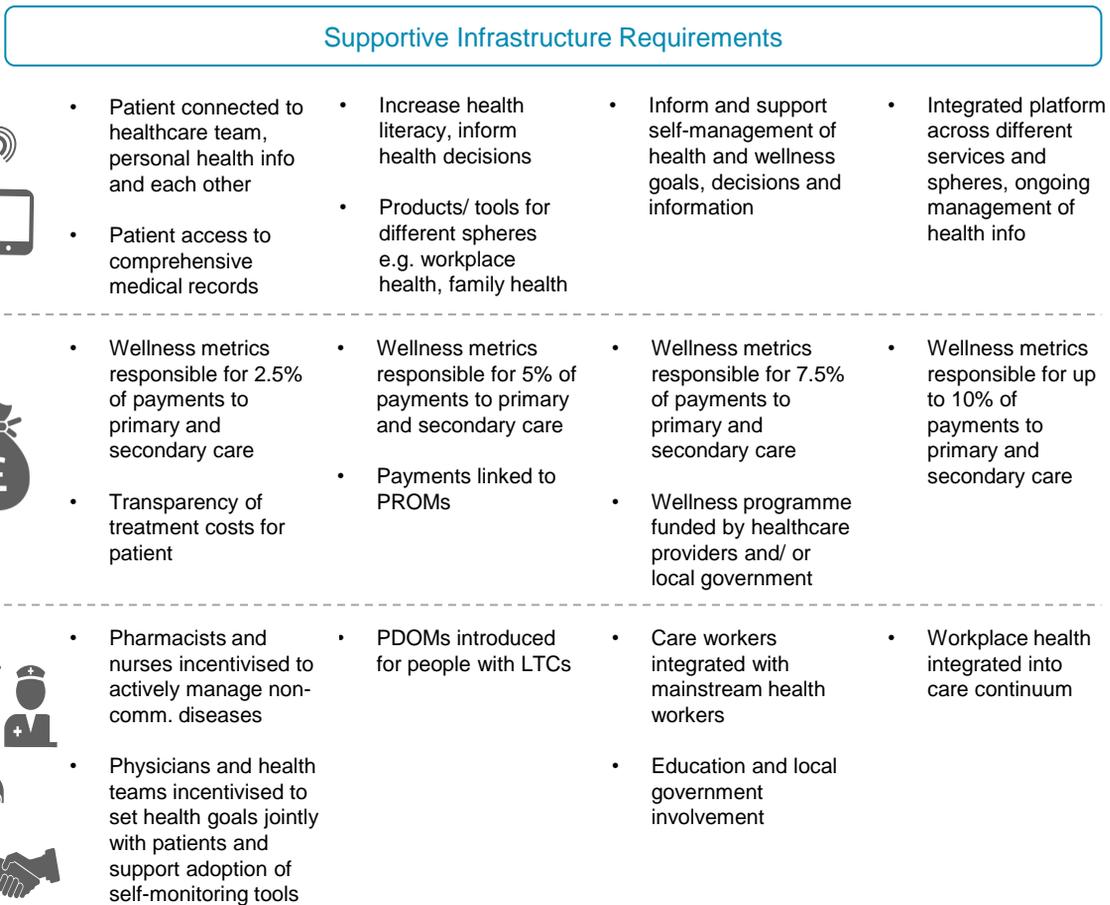
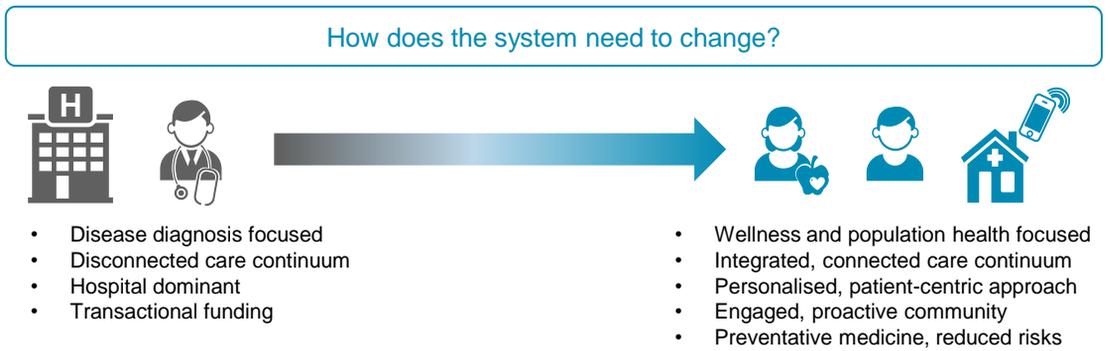
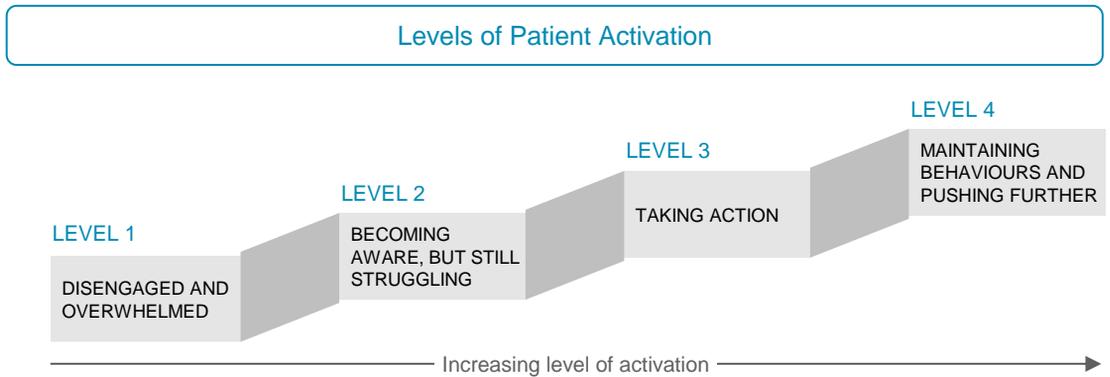
Increasing patient engagement from Level 1 (“Disengaged and overwhelmed”) to Level 2 (“Becoming aware, but still struggling”):

Technology: A number of technologies need to be introduced and adopted, including those that connect patients to their healthcare team, personal health information and each other. Patients should be given access to a comprehensive set of their medical records. Data from mobile devices and apps should be linked to official medical records to track progress and outcomes of activation

Payment systems: Patients should be informed of the cost of the treatment and investigation options available to them (the more granular the better) so that there is greater awareness of value amongst system stakeholders. Primary and secondary care organisations need to be incentivised to focus on population health through a payment system which is dependent on wellness metrics (for example, population WEMWBS scores) for up to, perhaps, 2.5% of payments initially

Contractual levers: Physicians should be incentivised to work in provider teams that establish health goals jointly with patients and encourage patients to track progress against their goals by accessing and recording in their medical records

Diagram 2: Operationalising Wellness



(with appropriate audit trail). Physicians and health teams should be incentivised to support patient adoption of self-management tools and devices (e.g. step meters) in order to increase patient activation. Pharmacists, nurses and other professionals should be made responsible for the active management of non-communicable diseases, thereby improving access and achieving whole person care. Physicians should manage the complexity of multi-morbidity and work collaboratively with the team to support and encourage individual activation and goal attainment

Moving from Level 2 (“Becoming aware, but still struggling”) to Level 3 (“Taking Action”):

Technology: Technologies are required that increase health literacy and inform health decisions. Patients should be equipped with tools that allow them to engage with their health across different spheres of their lives, for example workplace health and family health

Payment systems: Wellness metrics should be made responsible for up to, perhaps, 5% of payments to primary and secondary care organisations. Payments should be linked to patient reported outcome measures (PROMs) to incentivise improvements in patient experience

Contractual levers: Patient determined outcome measures (PDOMs) should be introduced for people with long-term conditions (LTCs) to encourage adherence to treatment plans, set personalised treatment goals and encourage the reduction of risk factors

Moving from Level 3 (“Taking Action”) to Level 4 (“Maintaining behaviours and pushing further”):

Technology: There is a need to harness the increasingly available technologies that inform and support self-management of health and wellness goals, decisions and information, including the tracking of individual goals and outcomes

Payment systems: Wellness metrics should be made responsible for up to, perhaps, 7.5% of payments to primary and secondary care organisations. Wellness programmes could be funded by healthcare providers in some systems and local governments in others

Contractual levers: Care workers should be integrated with mainstream health workers. Education and local government should be involved in wellness programmes

Consolidating Level 4 (“Maintaining behaviours and pushing further”):

Technology: Patients should be equipped with an integrated platform that reaches across the whole range of health and social services to enable ongoing

management of their health information and incentivise the perpetuation of new behaviours

Payment systems: Wellness metrics should be made responsible for up to, perhaps, 10% of payments to primary and secondary care organisations

Contractual levers: Workplace health should be integrated into the broader care continuum

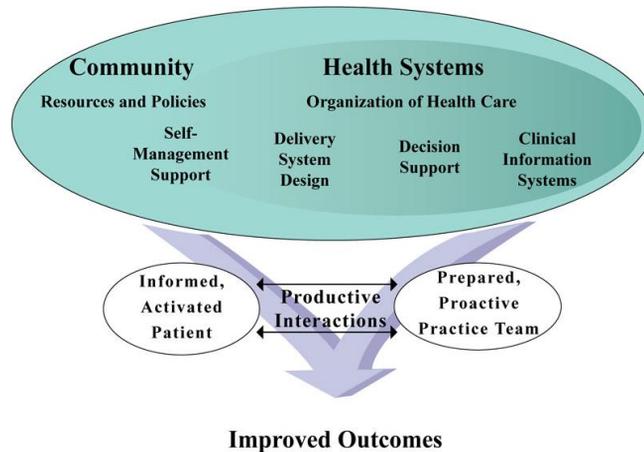
Our vision for a holistic health and social care system is one where the achievement of wellness outcomes will be responsible for as much as 10% of all payments for both Primary Care and Hospital Care. They will be an important system driver, aiding in the achievement of sustainability and self care, and widely accepted as an integral part of healthcare. Workplace health will be part of the integrated mosaic of interventions which will encourage and sustain individual activation. Education and local government will also be part of the new broader system of health and social care, enlisted by the most appropriate actor within the healthcare continuum depending on local factors.

Supra-sectoral wellness metrics will become the method of choice to assess performance of local health economies and commissioners as well as to allow local government the opportunity to critically appraise the connectivity of health systems with their populations. Care workers will become indistinguishable from mainstream health workers as the non-health determinants of wellbeing are recognised as both relevant and essential. Social isolation will also lessen as dependence on wellness metrics increases. Wellness improvement schemes will be funded directly by healthcare providers in some healthcare systems, or by local government in others. Whatever the incumbent system, links between care and health will increase to the extent that the interface will become largely indistinguishable.

The vision described above is one where integration is key, both across the health and social care system and also with others in the broader care system, including education, justice, crime prevention and local government. Patients are informed and actively engaged, cultivating strong links with their proactive and well-equipped health care team. This insistence on whole system integration and the productive interactions between informed, activated patients and their prepared, proactive practice teams has also been emphasised elsewhere, most notably in The Chronic Care Model⁵.

The Chronic Care Model (CCM), outlines six factors that are necessary to obtain improved care outcomes: community resources and policies, health care system, patient self-management, decision support, delivery system design and clinical information systems. According to a recent World Health Organisation (WHO) publication⁶ on mental health and other chronic diseases, studies⁷ suggest that “redesigning care using the CCM leads to improved patient care and better health outcomes”.

Diagram 3: The Chronic Care Model



Source, Improving Chronic Illness Care. Image developed by the MacColl Institute

WHAT ARE THE IMMEDIATE NEXT STEPS TO IMPLEMENT THE WELLNESS METRICS?

There are a number of steps that could be taken quickly to implement these important metrics.

An efficient way to capture WEMWBS data would be to incorporate WEMWBS into the existing patient questionnaires: this would provide measurement within the primary and secondary care systems. It also lends itself to digital capture over the internet including by mobile devices, although of course there will be an important segment of the population without access to the internet whose input would need to be captured through “low-tech” methods. The system currently used in the travel industry, *tripadvisor*, is easily accessed and an equivalent system could be used as an ongoing, real-time measure of patient activation and experience of health systems. The data thus captured could be collected initially on a cheap and rudimentary system which could then be developed as experience demands.

As outlined in the first paper of this series, the capture of WEMWBS data could also be complemented by the Emergency Bed Day usage per 1,000 65+ population metric to assess the effectiveness of elderly care provision across commissioning areas. The data for this analysis is already routinely captured by the NHS.

In parallel with the capture of current baseline data, appropriate incentives will need to be developed to encourage providers to focus on wellness. These incentives will need to be applied across the whole system. For example, Commissioning for Quality and Innovation (CQUIN) mechanisms could be used to link payments for acute and mental health trusts to supra-sectoral wellness metrics. Personal Medical Services (PMS) contracting could be used to introduce wellness metrics for both General Practice and Community Pharmacy. Similar types of mechanisms can be utilised to assess and drive performance in clinical

commissioning groups (CCGs) , the Pioneer programme and the Better Care Fund. This would be best achieved on a step basis as discussed above.

The key next step is to identify a significant population (for example a major city) to pilot the wellness metrics and rapidly develop this approach by learning through doing.

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