
CONFERENCE ABSTRACT

Data driven population health management: first steps to an integrated approach in Leuven Cares (Zorgzaam Leuven)

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Gijs Van Pottelbergh¹²³, Marie Van de Putte¹²³⁴

1: Zorgzaam Leuven, Belgium

2: Integreo.be, Brussels, Belgium

3: KU Leuven, ACHG, Leuven, Belgium

4: Vlaams Apothekers Netwerk, Flanders, Belgium

In 2018 we started the Leuven Cares project in the city of Leuven. The aim of this project is to develop, implement and evaluate the necessary changes to enable integrated care.

We installed a proactive approach to manage the health and wellbeing of the population of Leuven, to move away from the provision of reactive, demand-led care.

All inhabitants of Leuven are targeted, 102000 people. All relevant healthcare organizations participate in the project, which is financially supported by the federal government and by 60 local organizations.

We use a data driven population health management approach based on 4 building blocks:

1. Know your population health's needs: obtaining data from the population for constant re-evaluation of the interventions at as many levels as possible. Define clearly for every action the type and subgroup of patients.

2. Engage with your population: collaboration in integrated neighborhood teams at a local level of 5000 to 10000 inhabitants. Map clearly local level interventions (5000 to 10000 inhabitants) versus meso level (100000 inhabitants) using natural existing networks, functional collaborations and structures.

3. Manage your population: different interventions or different types of patients starting with the correct stratification. Every intervention and intermediate evaluation is based as much as possible on data, existing or collected data.

4. Provide support from an integration management team: a so called integrator structure as a backoffice to permanently catalyze the transition towards population based integrated care.

Our results (September 2022):

-50%-60 % of primary caregivers participated in at least one Leuven Cares action.

-for the various Leuven Cares actions, a total of 6500 patients were included on an individual basis and stratified within the 'Leuven cares stratification map'.

-the stakeholder consortium consists of more than 73 partners and is still augmenting. This consortium consists of partners representing health care organizations, social welfare

organizations, academic partners, local health insurance partners and other broadly oriented local partners.

-the “integrator” function was constructed as a complex conceptual entity inside the global governance arrangement. It consists in total of more than 40 individuals and a small coordination team of 3 FTE functions.

Lessons learned and next steps: At a micro level, a key facilitator for a population health management approach is to install integrated neighborhood teams of primary care professionals, to manage the population. At the meso level, create a strong integrator function with a diversity of liaison arms in the different partner organizations. The integrator needs support of a central backoffice team with visionary leadership and management skills to facilitate a population-oriented approach.

The effects on the entire population of this project and the various subactions of this project will be studied in the coming years. The ongoing process shows good participation of professional caregivers and their organizations, a need for leadership, a collaborative attitude, a data- and evidence-based approach and a strong local integrator supporting the transition towards integrated care. In a next step, we want to measure the long-term impact of this project on relevant quintuple aim parameters.