RISE

Rapid-Improvement Support and Exchange

Introduction to Day 2

OHT Forum

Toronto, ON, Canada

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Ontario Health Teams

- OHTs are a new way of organizing and delivering care that involves all health providers (including home and community care providers, primary-care providers, and hospitals, among others) working together in one coordinated team to achieve the quadruple aim of improving care experiences and health outcomes at manageable per capita costs, and with positive provider experiences
- As OHTs develop and mature, they will become clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined population
- OHTs may one day be seen to be as landmark a development in Ontario's health system as the introduction of universal coverage for hospital-based and physician-provided care
  - To make it landmark, we need to transition from pilot projects to ensuring that every step is a step towards full scale

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Rapid Learning and Improvement

- As part of the ministry's OHT Central Program of Supports, and inspired by the platforms that supported the development and maturation of accountable-care organizations in the U.S., RISE provides evidence-based support to OHTs, using a 'rapid learning and improvement' lens
- Rapid learning and improvement involves six steps (the first four of which will be stations through which population-focused groups rotate)
  - Identifying a problem (or goal) through an internal and external review
  - Designing a solution based on data and evidence generated locally and elsewhere
  - Implementing the plan (possibly in pilot and control settings)
  - Evaluating to identify what does and does not work
  - Adjusting, with continuous improvement based on what was learned from the evaluation (and from other OHTs' evaluations)
  - Disseminating the results to improve the coverage of effective solutions across the health system

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Year 1 Priority Populations (and Building Blocks)

- RISE supports rapid learning and improvement among OHTs both in
  - ‘Moving the needle’ on quadruple-aim metrics for their year 1 priority populations (as a key first step in laying the groundwork for moving the needle for their entire attributed population) – these are the population-focused groups that will rotate through the 4 stations
    - People at the end of life and/or needing palliative care
    - Older adults with greater needs, which OHTs variably defined as including ‘at risk,’ co-morbidities/chronic conditions, complexity, frailty, and high service users
    - People with chronic conditions, which OHTs variably defined as including congestive heart failure, chronic obstructive pulmonary disease, dementia, diabetes, and complex-care needs
    - People with mental health and addictions issues
  - Putting in place the eight OHT building blocks (e.g., digital health solutions such as e-consultations)

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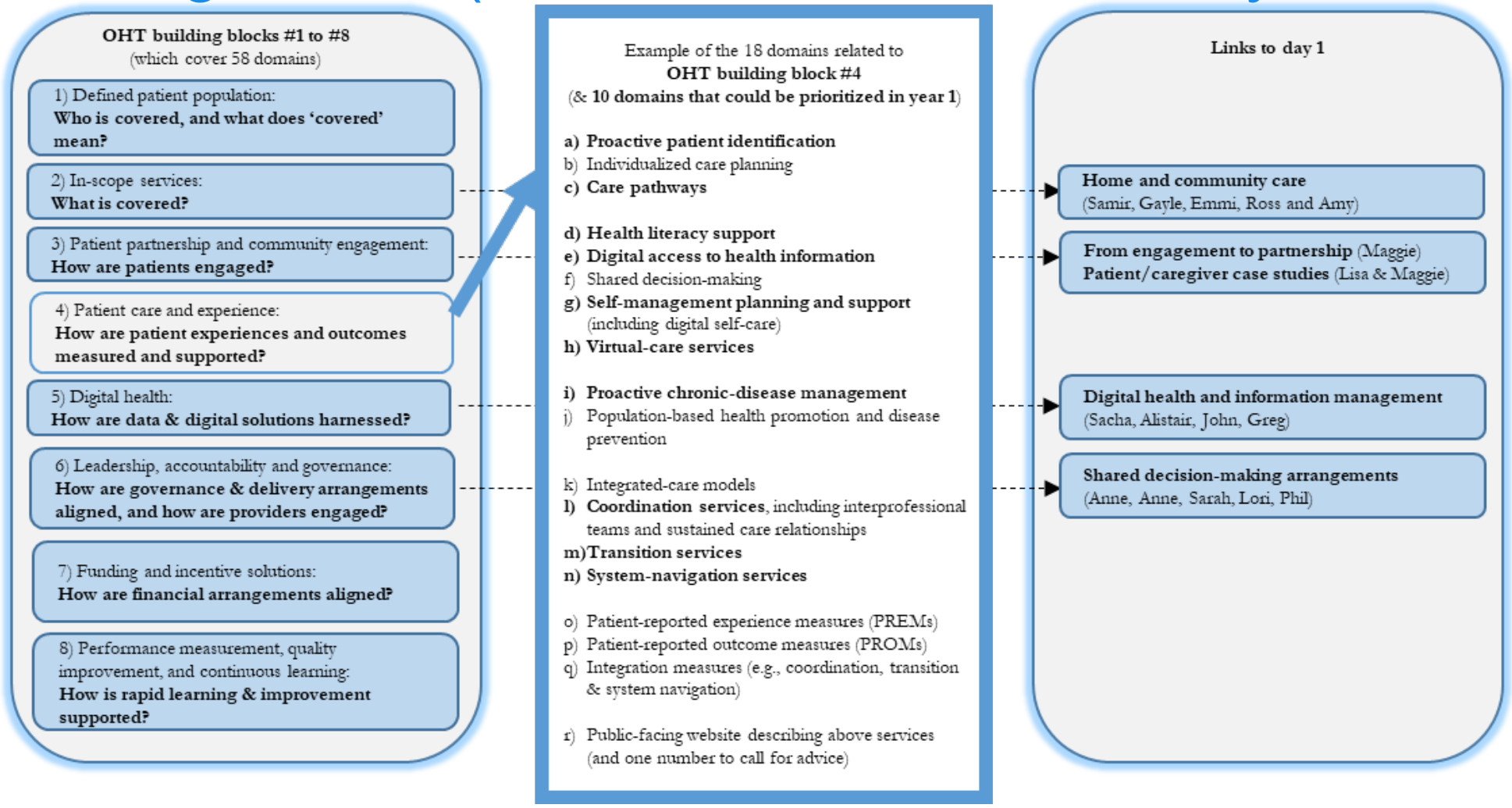
Building Blocks (& Related Domains & Day 1 Links)



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Objectives for Day 2

- Receive support to get started on using population-health management to 'move the needle' on quadruple-aim metrics for year 1 priority populations
- Connect with other teams focused on the same year 1 priority populations
- Connect with resource people who can support work on population-health management for year 1 priority populations

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Ontario Health Teams & Population Health Management

OHT Forum

February 20, 2020

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Population Health Management

- A central challenge for OHTs is to **integrate** & **manage** the continuum of health services for a **defined population** of patients
- OHT populations reflect prior care seeking & referral patterns (**attributed population**)
- For these defined populations, the **goals are to**:

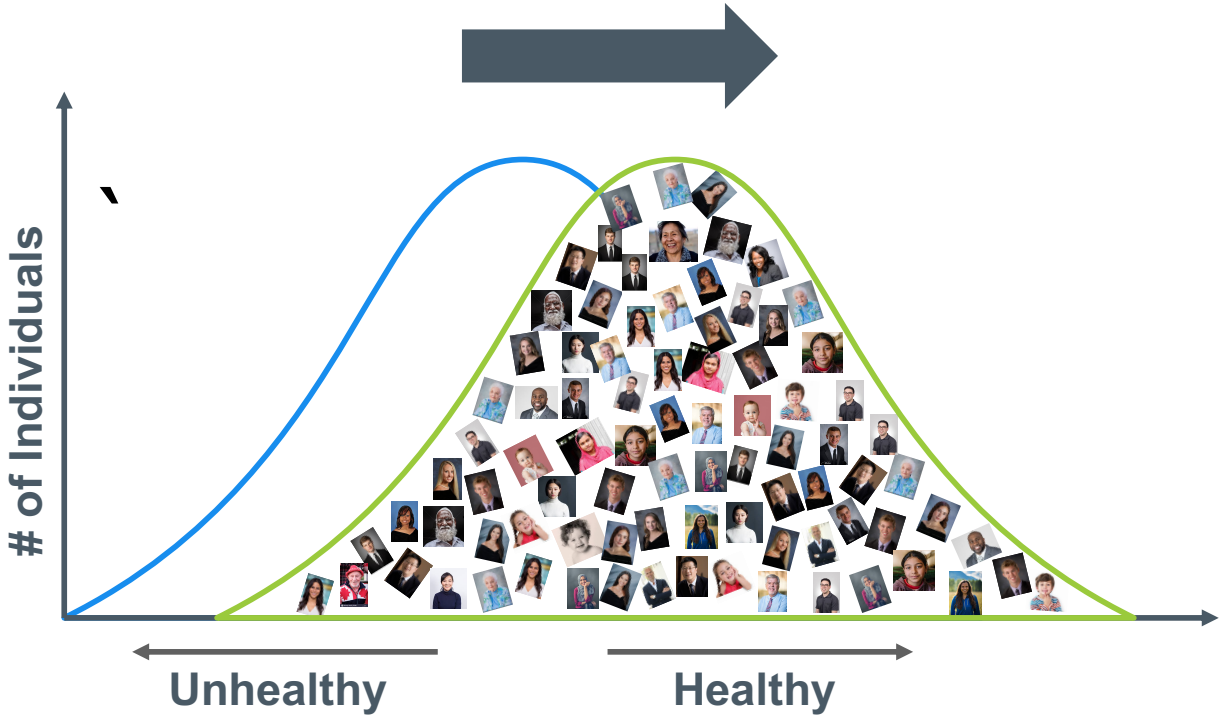
Population Health – A Definition

"The **health outcomes** of a **group** of individuals, including the **distribution** of such outcomes within a group."

Kindig & Stoddart. AJPH 2002;93(3):380-3

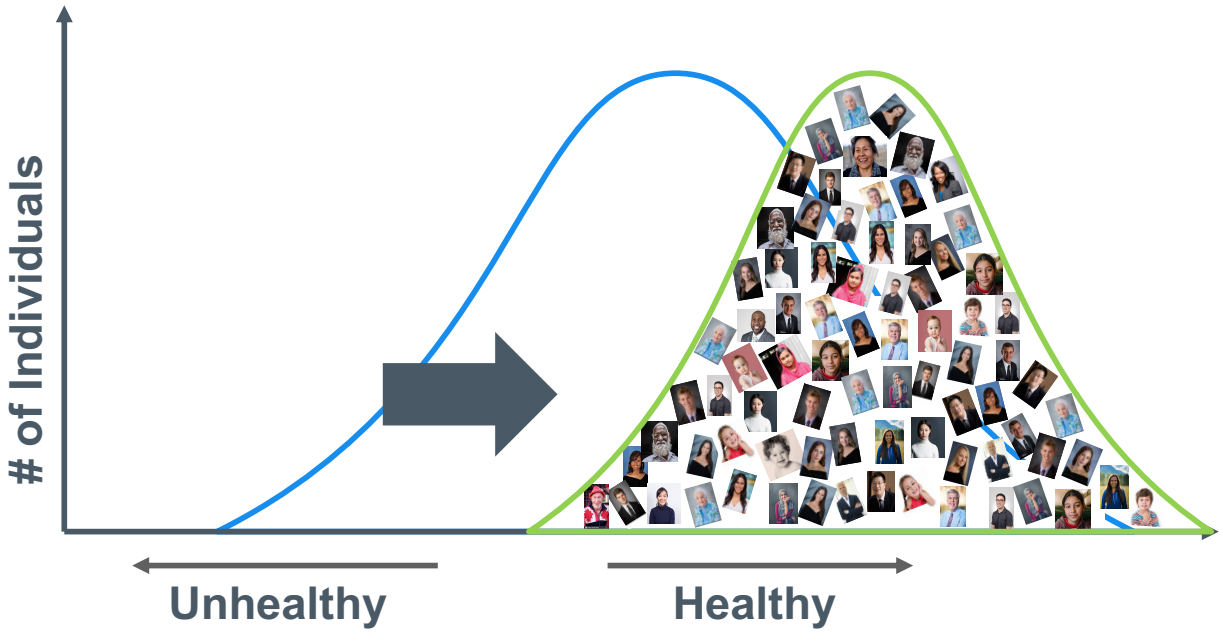
Population Health – A Definition

Population-wide approach
to **shift the curve**



Population Health – A Definition

Strategies to **squeeze the curve**
& **reduce inequities**



"LEAVE NO ONE BEHIND" & TACKLE THE "INVERSE CARE LAW"

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Determinants of Health in Populations

AREAS OF FOCUS FOR OHTS

WHAT MAKES PEOPLE SICK?		
11%	HEALTH CARE	Access to quality illness-related and preventive care, continuity of care, chronic care self-management
60%	SOCIAL CIRCUMSTANCES & HEALTH BEHAVIOURS	Income, early childhood development, disability, education, social exclusion, social safety net, gender, employment / working conditions, race, aboriginal status, safe and nutritious food, housing / homelessness, community belonging
22%	BIOLOGY	Biology, genetics
7%	ENVIRONMENT	Air &water quality, civic infrastructures

Adapted from: determinantsofhealth.org

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A Population Health Approach…

Identifies **systemic variations & patterns** in health & care

Focuses on the **conditions & factors** that are related & influence the health of populations

Develops services & policies to improve the health & well-being of populations

Implementation can be at the **individual or population** level

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Developing OHT Population Health Strategies at the Level of the Individual & Population

EXAMPLES:

POPULATION	INDIVIDUAL-LEVEL SERVICE	POPULATION-LEVEL POLICY/PROGRAM
PERSONS NEARING END-OF-LIFE	Palliative care programs	Educational campaigns on advance care planning & powers of attorney
FRAIL OLDER ADULTS	Programs of All-inclusive Care for the Elderly (PACE)	Age-friendly transportation options, built environment initiatives
PERSONS WITH DIABETES	Systematic screening & diagnosis, self-management support programs	Diet & physical activity promotion programs

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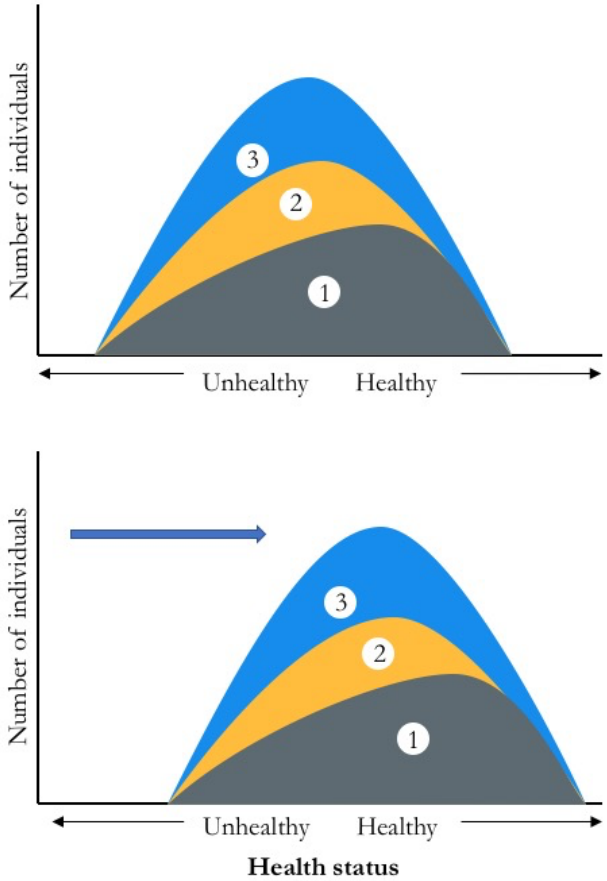
Role of Health Care in Producing Population Health:

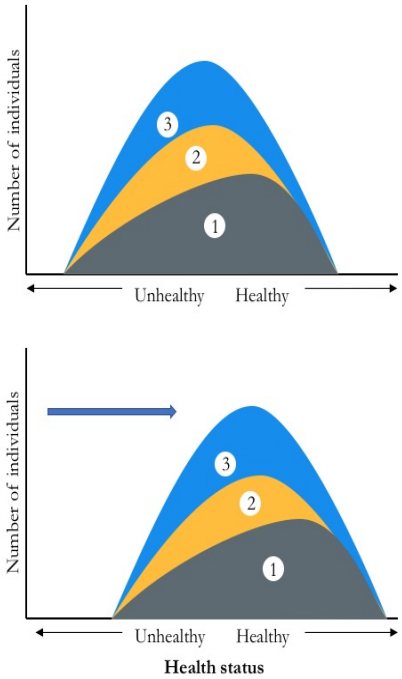
"Shifting the 3 curves"



1. Patients seeking care from OHT partners
2. OHT population that is the focus of in-reach and out-reach approaches
3. Entire population of the community that would be affected by population-based approaches

Source: Washington AE et al. JAMA 2016 315(5); 459-460

Role of Health Care in Producing Population Health

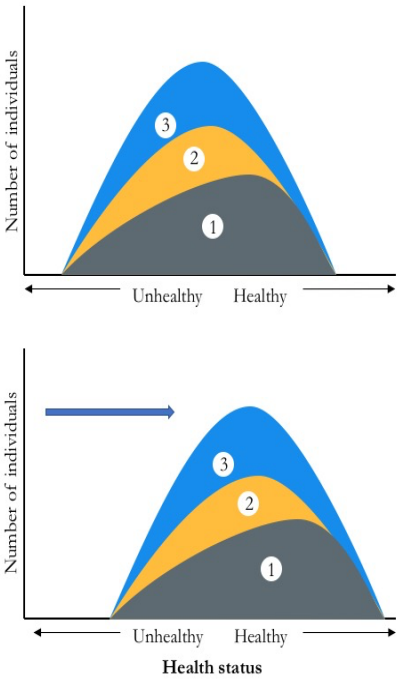


❶ 1st Curve – Care for Acute Health Problems

- Timely access to high-quality acute care services
- Oriented around care episodes (e.g. visits, hospitalizations)
- Reacts to individual patient needs, not populations
- Population health impact comes through users one-by-one (e.g. high-quality care for acute stroke)

"SUSTAIN THE GAINS"

Role of Health Care in Producing Population Health

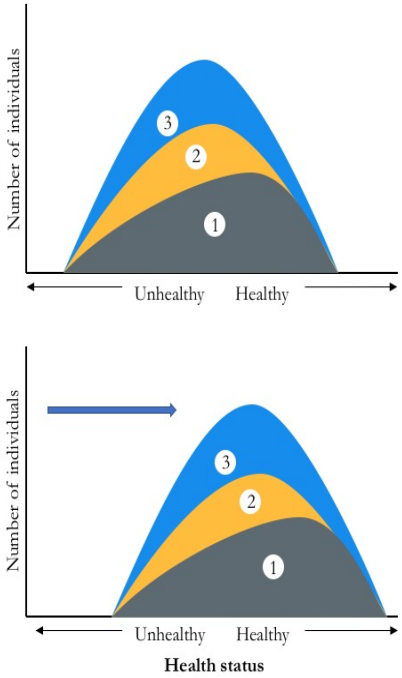


2 2nd Curve – Clinical Population Health Management

- Proactive management of chronic conditions & behavioural risks
- Population is segmented to identify persons with common needs
- Uses an equity lens & addresses barriers
- Interventions are individually focused & proactively applied
- Apply "good clinical care" consistently to everyone across population segments

"NEW FOCUS FOR OHTS"

Role of Health Care in Producing Population Health



❸ 3rd Curve – Population Policies & Interventions

- Focus is non-medical determinants of health
- Oriented longitudinally over the lifespan across large populations
- Health care community's role can be to provide, facilitate or advocate

"FUTURE FOCUS FOR OHTS
DEEPEN PARTNERSHIPS WITH LOCAL GOVT & COMMUNITY ORGS"

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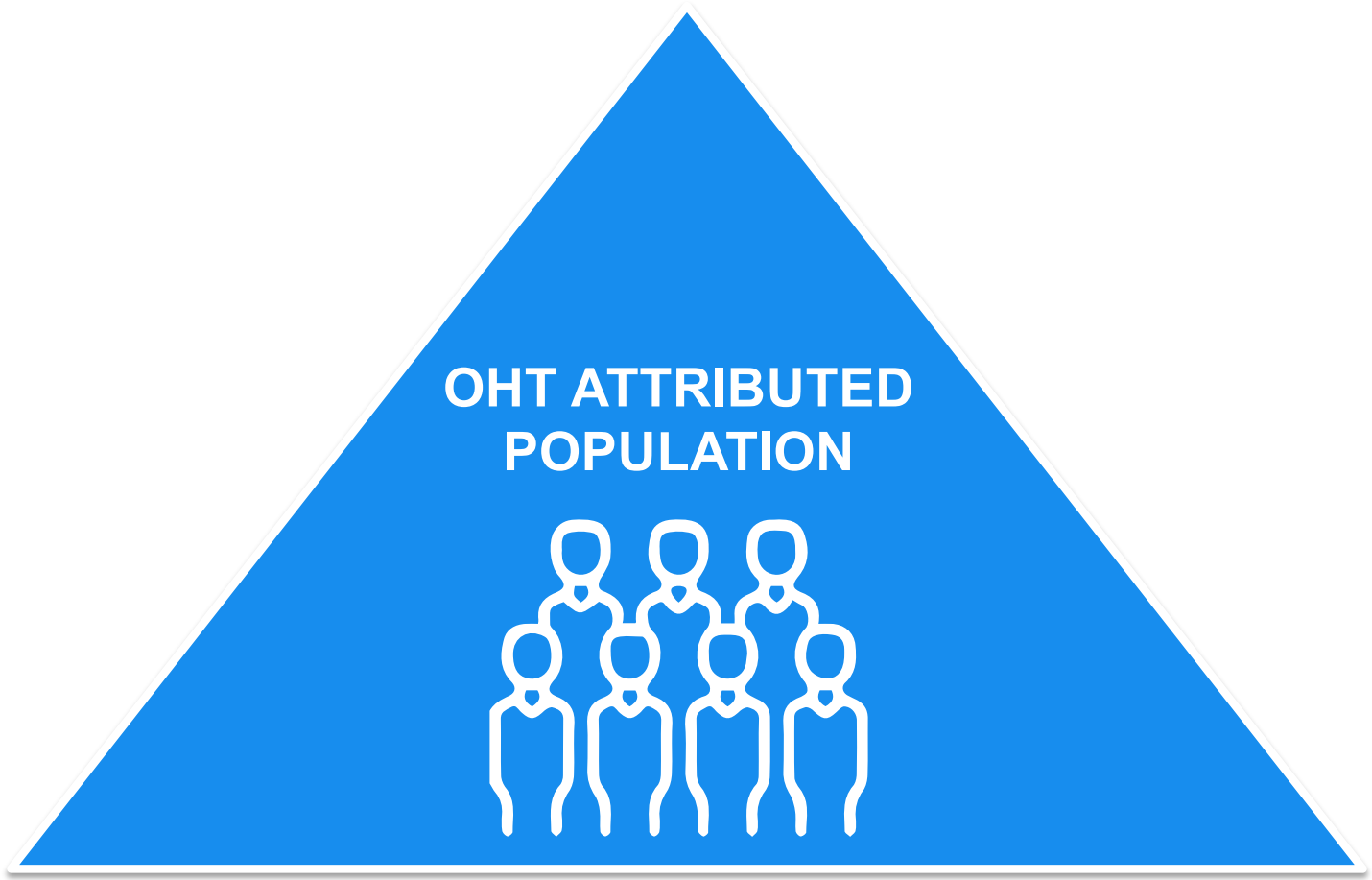
4 Steps of Population Health Management: the Second Curve

Source: Adapted from Population Health Alliance, 2012

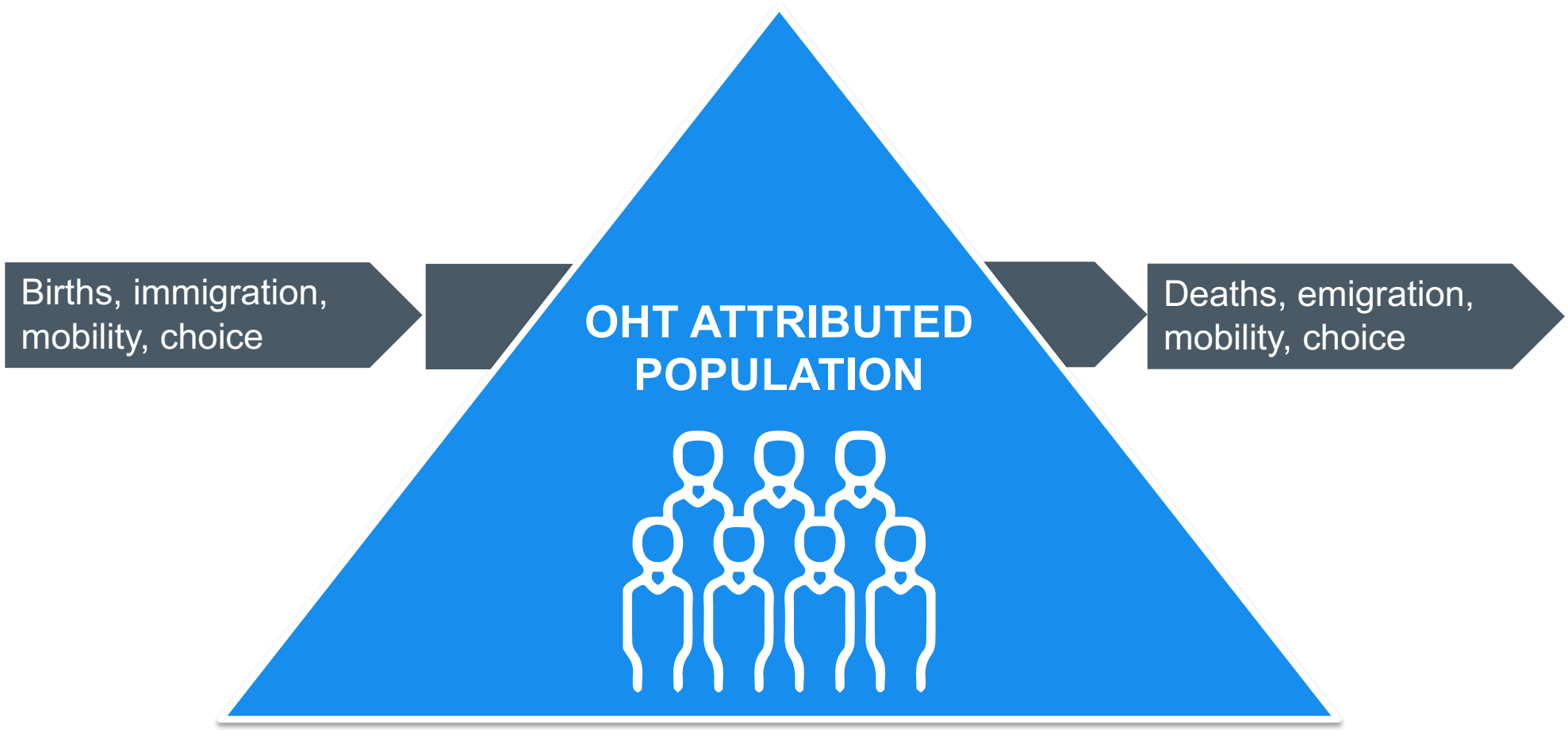
OHTs & Their Attributed Populations

Keep the Full Population in Sight



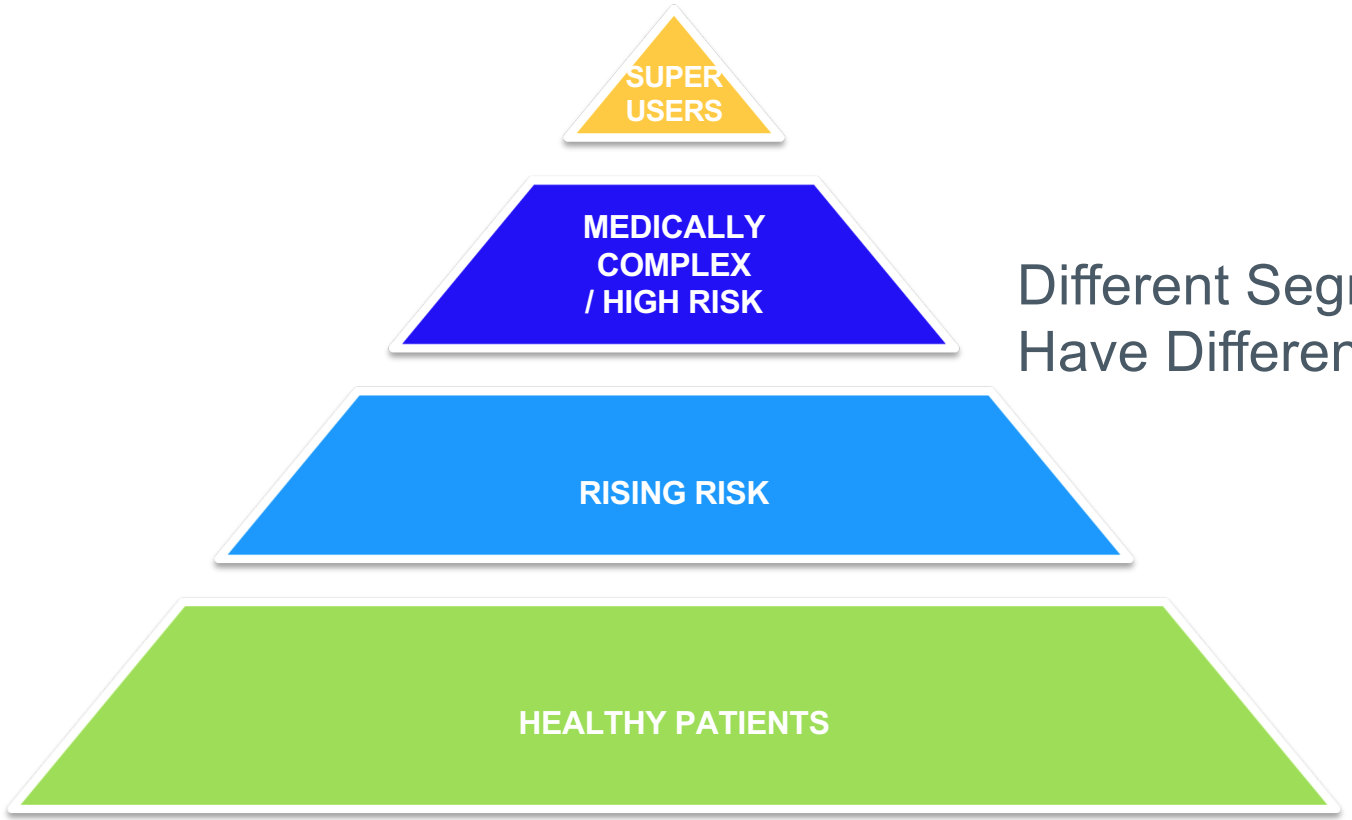
OHTs & Their Attributed Populations

Population is Continually Evolving



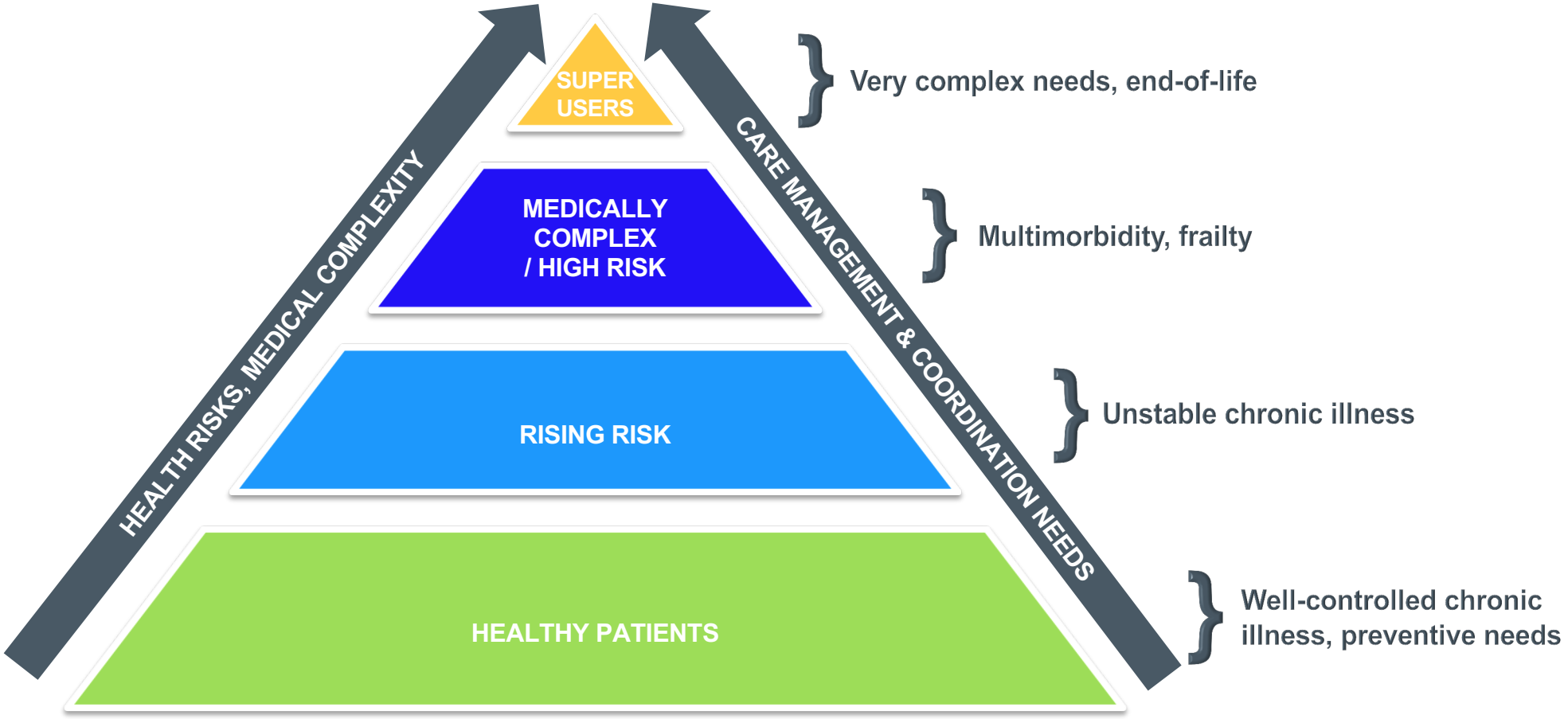
Step 1: Population Segmentation & Understanding Barriers to Care

Kaiser Risk Pyramid

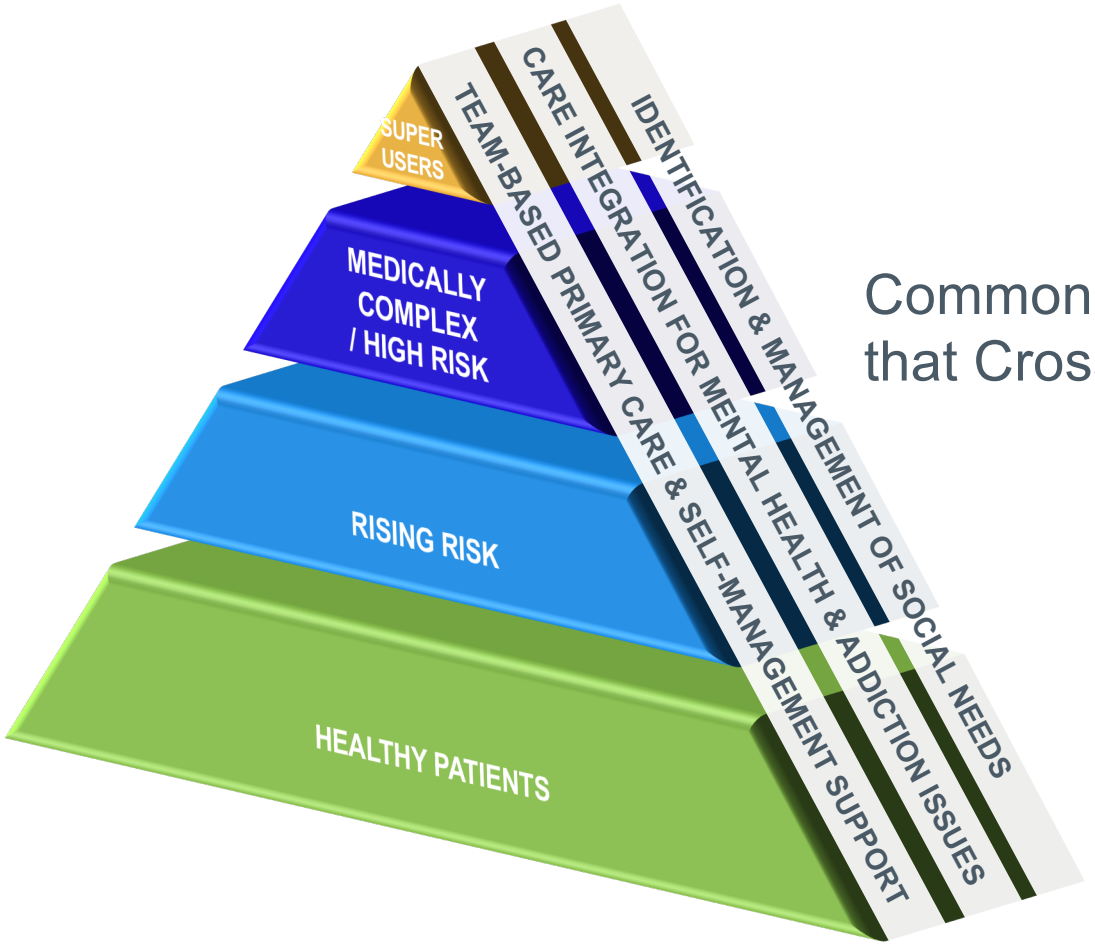


Different Segments Have Different Needs

Step 1: Population Segmentation & Understanding Barriers to Care



Step 1: Population Segmentation & Understanding Barriers to Care



Common Functions that Cross Segments

Adapted from: Amy Flaster, MD MBA, Center for Population Health, Partners Healthcare

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Step 1: Population Segmentation & Understanding Barriers to Care

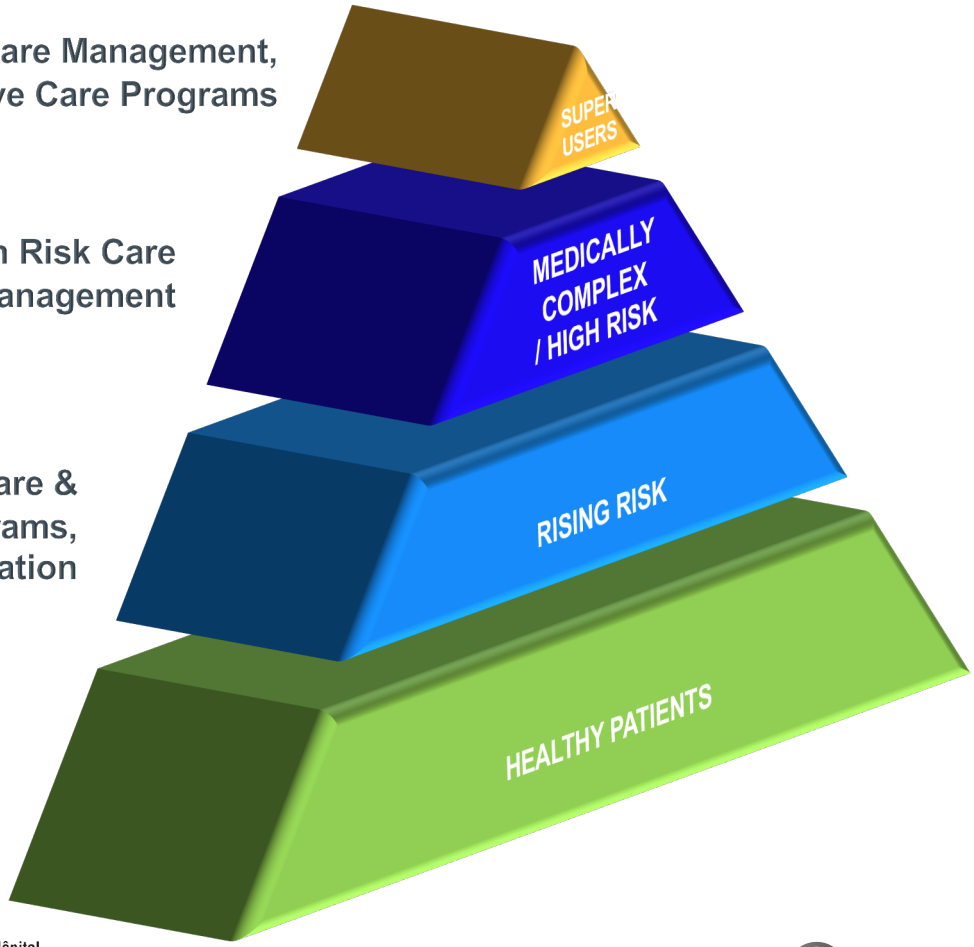
Health Programs & Interventions

High Risk Care Management, Palliative Care Programs

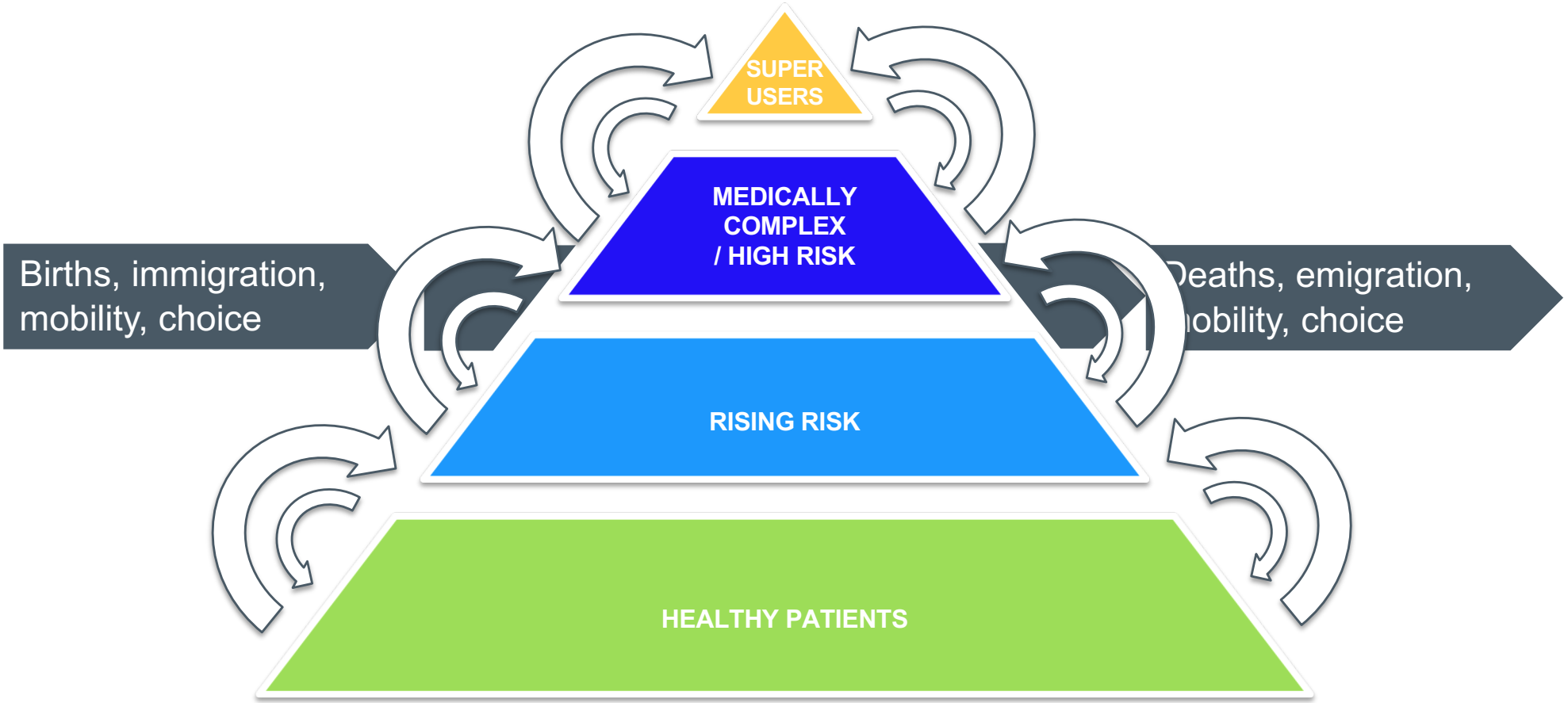
High Risk Care Management

Chronic Illness Care & Collaborative Care Programs, Care Coordination

Engagement, Screening & Counselling Navigation



Step 1: Population Segmentation & Understanding Barriers to Care



Population Segments are Continually Evolving

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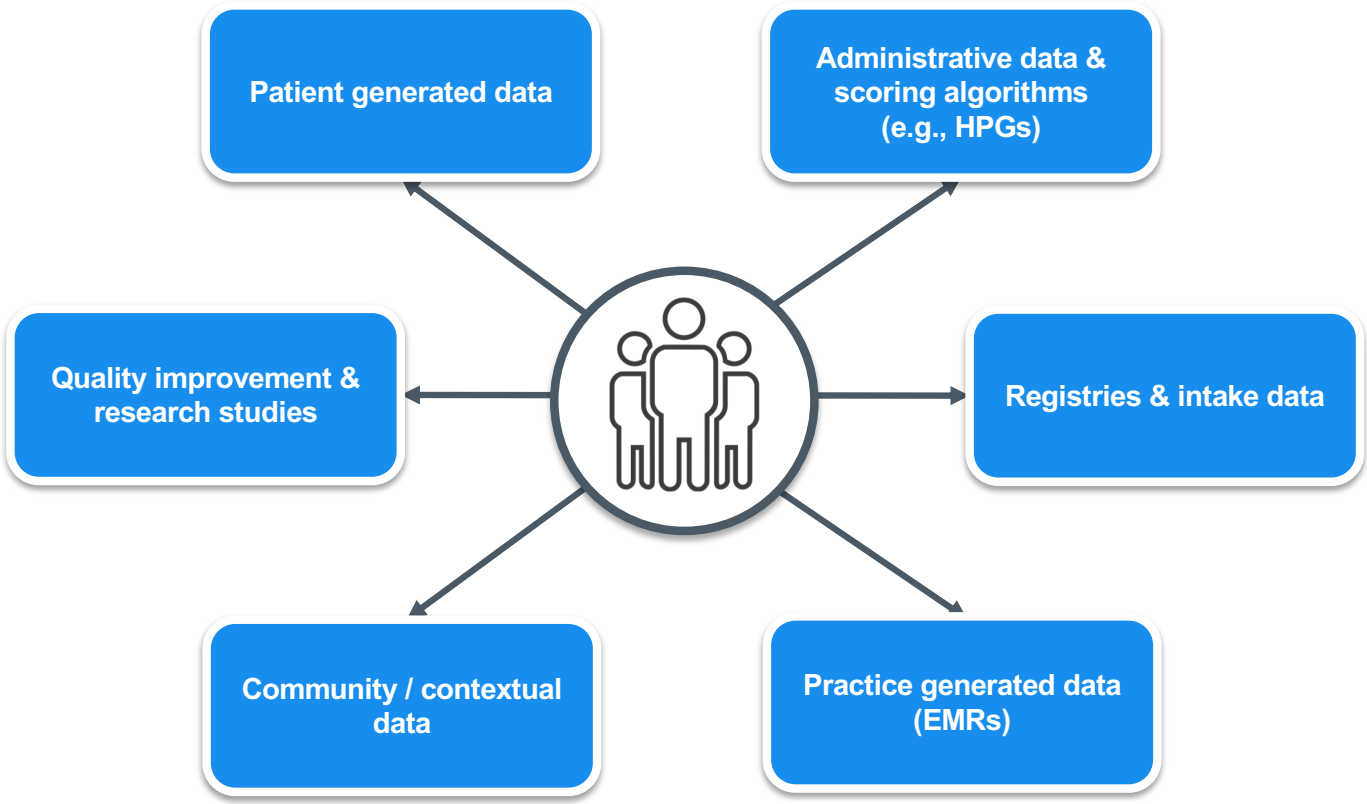
Step 1: Population Segmentation & Understanding Barriers to Care

Data Sources



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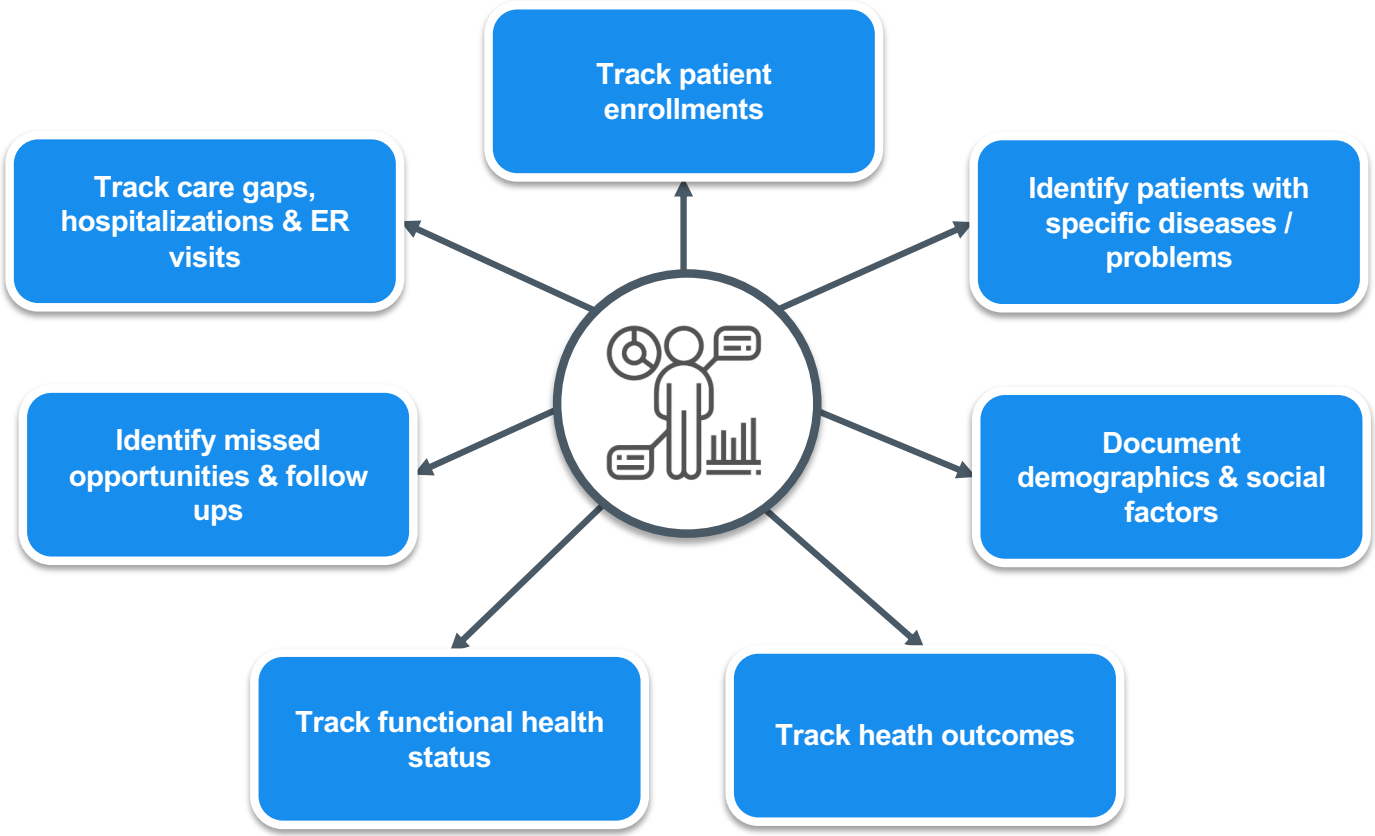
Step 1: Population Segmentation & Understanding Barriers to Care

Using the EMR to Document, Track, & Prompt



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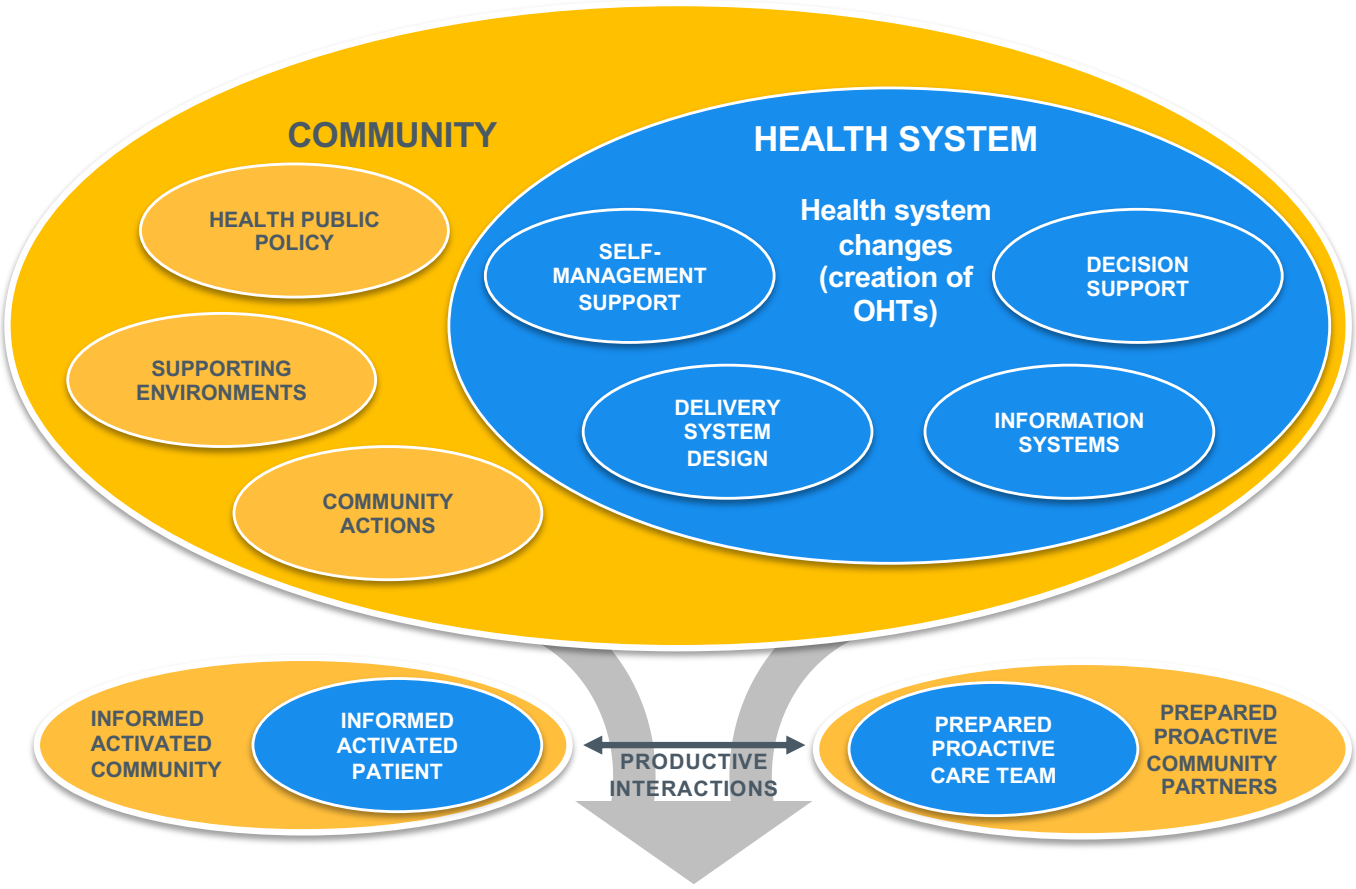
Step 2: Co-designing Care Pathways & Service-mix

Expanded Chronic Care Model for Population Health



Adapted from:
Barr VJ et al. Healthcare Q 2003:7(1):73-82.
Wagner EH et al. Milbank Quarterly 1996; 74(4): 511-44.

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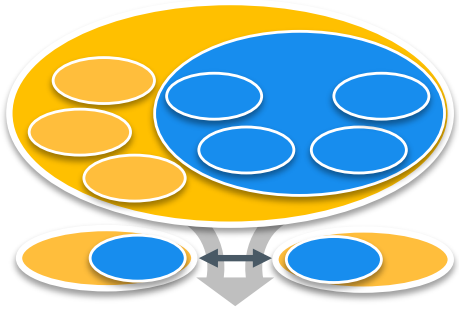
Step 2: Co-designing Care Pathways & Service-mix



- **Delivery System Redesign**
  - **New roles** & **new tools** across OHT
  - **In reach** and **outreach** functionalities (often virtual)
  - **Care coordination** functions & use of **care management**
  - Mechanisms to identify & address **barriers to care**
- **Clinical Decision Supports**
  - Agreed upon **clinical pathways** & **practice guidelines**
  - Active use of **prompts** & **reminders** for providers & patients
- **Clinical Information Systems**
  - Population **registries** & patient-centred **trackers** for care & outcomes
- **Patient Self-Management Support**
  - Interventions to build **motivation**, **skills**, **capabilities** for **behaviour change**

Step 3: Implementation & Reach

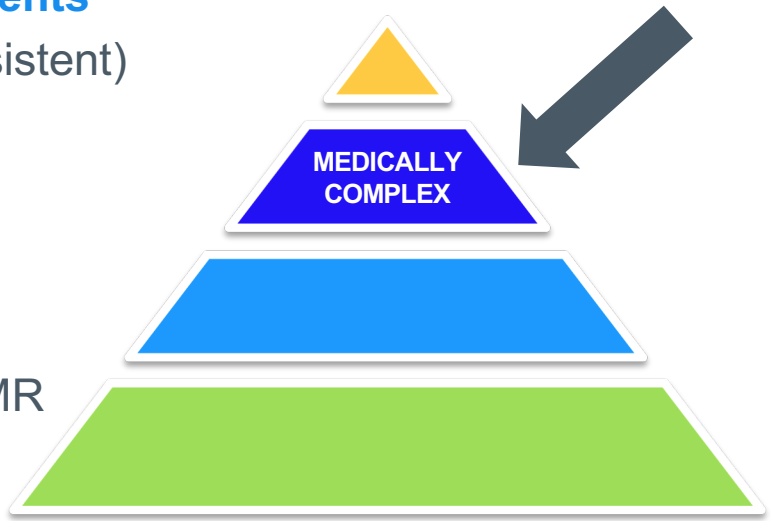
- Develop an initial program logic model, that connects inputs, activities and short-term and long-term outcomes
- Pilot test new care pathways, tools and approaches with a small number of patients, over a short period of time
  - Focus on implementation, getting quick feedback from patients and providers
- Increase reach gradually, keeping track of what proportion of a priority population the new pathway, tool or approach is reaching, over what period of time

Step 4: Monitoring & Evaluation

- Revise program logic model based on your initial work
- Include ongoing monitoring and evaluation, including both the number of patients who are served and the impact, at an individual-level and system-level
- Choose outcomes that are clinically relevant, measurable as part of routine care, and can be extracted easily from EHRs
- Feed findings back to OHT leadership, and share with others who are serving the same priority population

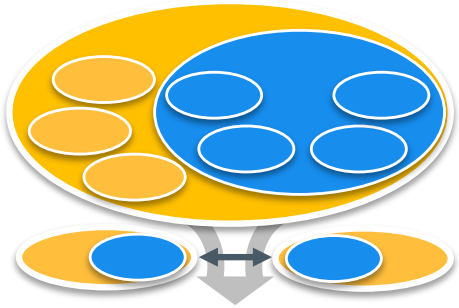
Example: High-risk Case Management Program at Partners Healthcare

- **High-risk care management program** embedded within primary care
- Focuses on **chronically ill**, **medically complex patients**
  - ✓ Multiple chronic illnesses (some severe and persistent)
  - ✓ Mental health or substance abuse complicating medical conditions
  - ✓ SES factors complicating medical management
- Predictive risk score used to **segment & identify population**, **supplemented by social risks** from EMR
- **Enrollment confirmed** by primary care clinicians



Source: Amy Flaster, MD MBA, Center for Population Health, Partners Healthcare

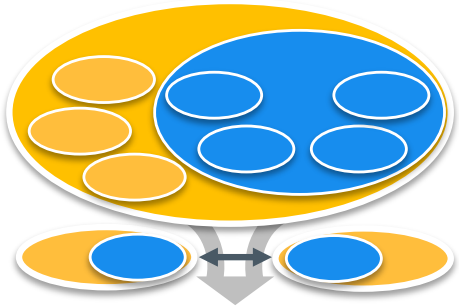
Example: High-risk Case Management Program at Partners Healthcare



- **Delivery System Redesign**
  - Care manager with roster, embedded in primary care
  - Use of home visits, tele-monitoring, virtual care, post-acute integration
- **Clinical Decision Supports**
  - Structured care plans, goals of care conversations, case reviews
  - Ongoing support & training for teams & staff
- **Clinical Information Systems**
  - Registries & care coordination tools
  - Real-time notifications of admissions & discharges
- **Patient Self-Management Support**
  - Health coaching & shared-decision making tools

Source: Amy Flaster, MD MBA, Center for Population Health, Partners Healthcare

Example: High-risk Case Management Program at Partners Healthcare



- **Care Manager** has panel of patients with target panel size
  - Medical complexity – RN Lead
  - Psychosocial complexity – social worker lead
  - Community/social complexity – community health worker lead
- **Responsible for…**
  - Patient assessment (risks, gaps)
  - Care plans and systematic case reviews
  - Care coordination, communication, transition planning
  - Goals of care conversations, self-management support
- Supported by **community resource specialist**, **pharmacist**

Source: Amy Flaster, MD MBA, Center for Population Health, Partners Healthcare

Anticipate your challenges…

- Population health thinking is **new** & **challenging** for most people.
- Operating in a **resource constrained environment**. Will need to shift efficiently shift care among partners among partners.
- **Selecting** & **transitioning** populations is **key, but tricky**.
- Building **better data** & **analytic capacity** for planning & care. But avoid paralysis.
- Holding each other **accountable** in the application of **care pathways**.
- Focusing on **clinical population health strategies first**, followed by broader population-based strategies.

Questions?

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English: **www.OHTrise.org** | Français: **www.ESOrise.org**

Learning Stations & Population-Focused Groups

- Learning stations will each have a facilitator, several population-health management resource people, and a support staff
  1) Segmenting your population into groups with shared needs
  2) Co-designing care pathways and in-reach and out-reach services for each group
  3) Implementing pathways/services in a way that reaches and is appropriate to each group
  4) Monitoring implementation and evaluating impact
- Population-focused groups will cycle through the four learning stations along with their population-focused resource people
  1) Group for people at the end of life and/or needing palliative care starts at station 1
  2) Group focused on older adults with greater needs start at station 2
  3) Group focused on people with chronic conditions starts at station 3
  4) Group focused on people with mental health and addictions issues starts at station 4 (and then moves to station 1 in the next rotation)

Learning Station Configuration

- As you enter the room corresponding to each station
  - Facilitator and flip charts will be at the ‘front’ of the room
  - Population-health management resource people will be sitting on the left
  - OHT members should sit in front of the facilitator and flip charts
  - Population-focused resource people accompanying OHT members should sit on the right
  - Observers should sit at the ‘back’ of the room
  - Support staff will be by the door at the back of the room (and will be taking notes)

Available RISE Resources

- Hard copies of two documents (that you've already been sent electronically) will be available at your first station
  - Questions related to developing a population-health management plan
    - 'Setting the context' questions will be addressed at your first allocated station
    - 'Planning next steps' questions will be addressed at your last allocated station
  - List of facilitators and resource people
- You've also been sent electronically
  - Updated RISE brief on population-health management
  - Four RISE briefs on year 1 priority populations (the one you're focused on and the three others just for additional background)
  - RISE brief on OHT building blocks (for additional background)
- All of these draft resources are now available on the RISE website (and final versions will be posted in both English and French within a few weeks)

Available Resources (2)

- RISE prepares both its own resources (like RISE briefs) that can support rapid learning and improvement, as well as provides a structured 'way in' to resources prepared by other partners and by the ministry
- RISE is supported by a grant from the Ontario Ministry of Health
- The opinions, results, and conclusions – both those conveyed in our resources and at events like this one – are those of RISE and are independent of the ministry
- No endorsement by the ministry is intended or should be inferred

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Consolidation Opportunity

- After rotating through the four learning stations (with 45 minutes at each), you'll have a chance to re-group for another 45 minutes with other members of your OHT
  - Discuss synergies in approaches to and next steps for population-health management across your priority populations
  - Identify at least three actions that you can now take
- Remember the first question
  - Are you approaching your efforts to 'move the needle' on quadruple-aim metrics for your year 1 priority population in a way that lays the groundwork to become a designated OHT in future?
    - Will engage a meaningful proportion of your attributed population and meaningful number of your partners
    - Can be easily documented, spread to other populations, and later scaled to your entire attributed population
- Please raise your hand if you'd like speak to any resource people (population-health management resource people or population-focused resource people) or have any questions (and a RISE staff person will come over to find out what you need)