RISE
Rapid-Improvement Support and Exchange

Building blocks

RISE brief 6 appendix (draft): Questions related to developing a population-health management plan (Last updated 12 Feb 2020)

Overview

On day 2 of the OHT Forum, you and other leaders or key members of an OHT working group focused on 'moving the needle' on quadruple-aim metrics for their OHT's year 1 priority populations will have the opportunity to further develop your OHT's population-health management plan in collaboration with:

1) other OHTs focused on the same population;
2) experts who are aware of the many assets and resources available in Ontario to support their efforts; and
3) experts who have experience with the four steps in population-health management and with facilitating groups.

The population-focused groups (i.e., the first two groups above) will cycle together through four stations, with one corresponding to each of four steps in population-health management:

1) segmenting your population into groups with shared needs (station 1);
2) co-designing care pathways and in-reach and out-reach services for each group (station 2);
3) implementing pathways/services in a way that reaches and is appropriate to each group (station 3); and
4) monitoring implementation and evaluating impact (station 4).

To enable all groups to move through all stations efficiently, the population-focused groups will be allocated to the following stations to start:

1) the group focused on people at the end of life and/or needing palliative care will start at station 1;
2) the group focused on older adults with greater needs will start at station 2;
3) the group focused on people with chronic conditions will start at station 3; and
4) the group focused on people with mental health and addictions issues will start at station 4.

The population-focused groups will then move through each successive station, with those leaving station 4 moving to station 1. We provide below a set of questions that will be used at each station. Note that the 'setting the context' questions will be addressed at your first allocated station, and the 'planning next steps' questions will be addressed at your last allocated station. We strongly recommend that you familiarize yourself with the questions and consider in advance how you would respond to them given the work your OHT has completed to date.

Setting the context [questions to be addressed at your first allocated station]

1) 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?
   a. will engage a meaningful proportion of your attributed population and meaningful number of your partners
   b. can be easily documented, spread to other populations, and later scaled to your entire attributed population
2) Are you open to refining your description of your year 1 priority population?
   a. to allow as many teams as possible with the 'same' year 1 priority population to work collaboratively towards 'moving the needle' on shared quadruple-aim metrics
   b. (if applicable) to minimize overlap among the four frequently selected year 1 priority populations:
      i. people with chronic conditions (e.g., congestive heart failure, chronic obstructive pulmonary disease, dementia, diabetes, and those with complex-care needs)
      ii. people with mental health and addictions issues
      iii. older adults with greater needs (e.g., 'at risk,' co-morbidities, complexity, frailty, high service users)
      iv. people at the end of life and/or needing palliative care
   c. (if applicable) to avoid conflicting concepts (e.g., palliative care is broader than end-of-life care and often doesn't include medical assistance in dying) and definitions that can create operational and equity challenges (e.g., defining groups based on an overall measure of high service use)

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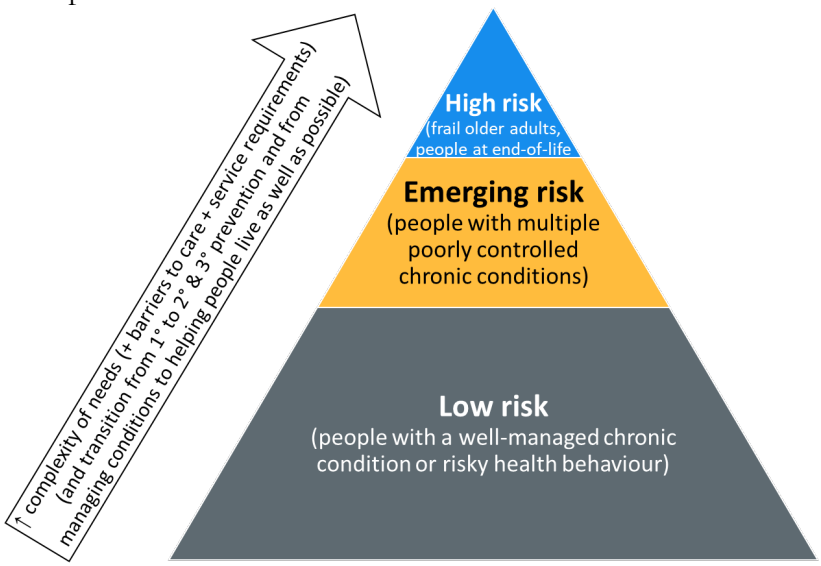
Step 1: Segmenting your population into groups with shared needs

3) What data-driven mechanisms will you use to divide the attributed population into clinical risk segments that specify groups at high, medium, and low risk based on the complexity of their ongoing health and social needs and their needs for care coordination and care management?
   a. demography (e.g., infants or persons of advanced age),
   b. prior morbidity and multimorbidity profiles obtained from administrative and/or electronic health record data, and
   c. prior service utilization



Note that a larger-scale version of this image is available in the accompanying RISE brief

4) What mechanisms will you use to identify important barriers to care, such as poverty, homelessness and unstable housing, language or cultural barriers, lack of social supports, poor health literacy, family violence, food insecurity, occupational status, and transportation challenges?
5) How will you prioritize groups where the greatest impacts on the quadruple aim can likely be achieved in an equitable way (e.g., will you focus initially on one, two and/or all three levels in the population risk pyramid)?
6) What scalable mechanisms (including data platforms) will you use to track patients dynamically?
   a. to identify patients, assess their complexity and needs (and barriers to care), and stratify them into groups
   b. to identify and reach patients who are eligible for specific care pathways and in-reach and out-reach services

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Step 2: Co-designing care pathways and in-reach and out-reach services for each group

7) How will you engage patients, families and caregivers in co-designing three types of care?
   a. care pathways (for patients with a particular need for care), which means making decisions about what bundle of services will be proactively offered to which patients (e.g., people living with diabetes or frail older adults)
   b. in-reach services (for patients when they are seen by any OHT partner), which means making decisions about what types of services will be offered (to promote health, prevent disease and help people live well with their conditions) and how these services will be offered proactively, opportunistically and in a coordinated way
   c. out-reach services (for patients not seeking care now), which means making similar decisions about what types of services will be offered proactively, and making decisions about how and when they will be contacted, how and when services will be offered proactively, and how to approach removing barriers to care
8) How will you make decisions about pathways and services in ways that are sensitive to five factors?
   a. the best available research evidence (including about cost-effectiveness), quality standards, and other inputs
   b. the complexity and needs of different groups (e.g., a frail older adult may have health goals that would not be well served by the aggressive management of each of their chronic conditions)
   c. the barriers to care that each group may face (e.g., lack of stable housing, reliable transportation, and money to pay for non-covered services)
   d. the 'in-scope services' provided by current OHT partners (and any opportunities to expand these partners over time to those offering complementary services that are also needed for groups)
   e. the 'spreadability' to other populations and scalability to the entire attributed population

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Step 3: Implementing pathways and services in a way that reaches and is appropriate to each group

9) How will you use the six components of the 'Chronic Care Model' to make decisions about when, where, by whom and how pathways and services will be implemented (keeping in mind the five factors in question 7)?
   a. self-management support (i.e., empowering and preparing patients to manage their health and healthcare)
   b. delivery-system design (i.e., organizing programs and services to assure the proactive, culturally sensitive delivery of effective, efficient clinical care and self-management support by care teams)
   c. clinical information systems (i.e., organizing patient and population data to facilitate more efficient care through, for example, an electronic health record that provides reminders for providers and patients, and monitors the performance of care teams, OHT partners, and the local health system in which they work)
   d. decision support (i.e., promoting clinical care that is consistent with scientific evidence and patient preferences through, for example, embedding quality standards and related patient decision aids into daily clinical practice, and supporting their implementation through continuing professional development)
   e. health-system changes (i.e., creating a culture, organization and mechanisms that promote safe, high-quality care, which can include visibly supporting comprehensive system change that moves beyond 'silos' for home and community care, primary care, specialty care, rehabilitation care, long-term care, and public health)
   f. community resources (i.e., mobilizing community resources to meet the needs of patients even though these resources are not formally part of the local health system)
10) How will you use the three components of the 'Behaviour Change Wheel' to support the types of behaviour changes among patients and providers that are needed to implement pathways and services (again keeping in mind the five factors in question 7)?
   a. sources of behaviour, namely capability, motivation and opportunity to engage in the behaviour
   b. strategies to change behaviour, such as education, modelling, persuasion, training and enablement (i.e., increasing means or reducing barriers to increase capability or opportunity)
   c. policies to support strategies, such as guidelines, communications/marketing, and services (e.g., navigation)
11) How will you support the types of collaborative governance and leadership among OHT partners that are needed to support the transformation to a population-health management approach across your entire attributed population?

Step 4: Monitoring implementation and evaluating impact

12) Will you use a framework, logic model or other tool to describe how pathways/services are anticipated to affect metrics related to implementation and impacts?
13) What scalable mechanisms will you use to monitor patients, services and performance?
    a. to identify changes in patients' complexity and needs (and barriers to care) and re-stratify them as needed
    b. to examine whether the right pathways and services reached the right patients (i.e., underuse and overuse)
    c. to measure the performance of care teams, OHT partners and the local health system
14) Are you open to working with other OHTs that share a year 1 priority population and with the OHT Central Program of Supports to identify a manageable number of metrics to be used in evaluating what pathways/services and implementation approaches do and do not work in terms of achieving impacts on the quadruple aim (i.e., optimizing care experiences and health outcomes while keeping per capita costs manageable and provider experiences positive)?

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Planning next steps [questions to be addressed at your last allocated station]

15) Would you be interested in continuing to work with other OHTs that share a year 1 priority population and with the OHT Central Program of Supports as part of a 'learning and improvement' collaborative and, if so, what would make the collaborative most useful to you?
16) What coaching and other supports could the OHT Central Program of Supports provide to help you '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?

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