Ontario Health Teams & Population Health Management: a Recap from the OHT Forum

RISE OHT Webinar
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Welcome!

Why does population health management matter to OHTs?

- OHT model shifts from *reactively* providing care to the people who walk through the doors of our health system To
- **Proactive** health promotion, prevention, treatment and care for a whole population
Acknowledgements and Caveats

- RISE provides evidence-based support to OHTs, using a ‘rapid learning and improvement’ lens, as part of the ministry’s OHT Central Program of Supports

- 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
Connection to Building Blocks

OHT building blocks #1 to #8
(which cover 58 domains)

1) Defined patient population:
   Who is covered, and what does 'covered' mean?

2) In-scope services:
   What is covered?

3) Patient partnership and community engagement:
   How are patients engaged?

4) Patient care and experience:
   How are patient experiences and outcomes measured and supported?

5) Digital health:
   How are data & digital solutions harnessed?

6) Leadership, accountability and governance:
   How are governance & delivery arrangements aligned, and how are providers engaged?

7) Funding and incentive solutions:
   How are financial arrangements aligned?

8) Performance measurement, quality improvement, and continuous learning:
   How is rapid learning & improvement supported?

Links to day 2

Population-health management for year 1 priority populations
(Rob, Andrew, facilitators, resource people)
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:
  - Improve population health
  - Improve care experiences
  - Achieve care efficiencies
  - Improve provider satisfaction
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 strategies to **shift and squeeze the curve** to improve overall population health and reduce inequities

“LEAVE NO ONE BEHIND” & TACKLE THE “INVERSE CARE LAW”
Determinants of Health in Populations

<table>
<thead>
<tr>
<th>AREAS OF FOCUS FOR OHTS</th>
<th>WHAT MAKES PEOPLE SICK?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH CARE</td>
<td>Access to quality illness-related and preventive care, continuity of care, chronic care self-management</td>
</tr>
<tr>
<td>SOCIAL CIRCUMSTANCES &amp; HEALTH BEHAVIOURS</td>
<td>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</td>
</tr>
<tr>
<td>BIOLOGY</td>
<td>Biology, genetics</td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td>Air &amp; water quality, civic infrastructures</td>
</tr>
</tbody>
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Adapted from: determinatsofhealth.org
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
Developing OHT Population Health Strategies at the Level of the Individual & Population

**EXAMPLES:**

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>INDIVIDUAL-LEVEL SERVICE</th>
<th>POPULATION-LEVEL POLICY/PROGRAM</th>
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<tbody>
<tr>
<td>PERSONS NEARING END-OF-LIFE</td>
<td>Palliative care programs</td>
<td>Educational campaigns on advance care planning &amp; powers of attorney</td>
</tr>
<tr>
<td>FRAIL OLDER ADULTS</td>
<td>Programs of All-inclusive Care for the Elderly (PACE)</td>
<td>Age-friendly transportation options, built environment initiatives</td>
</tr>
<tr>
<td>PERSONS WITH DIABETES</td>
<td>Systematic screening &amp; diagnosis, self-management support programs</td>
<td>Diet &amp; physical activity promotion programs</td>
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</tbody>
</table>
Role of Health Care in Producing Population Health: “Shifting the 3 curves”

Source: Washington AE et al. JAMA 2016 315(5); 459-460
Role of Health Care in Producing Population Health

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

2️⃣ 2\textsuperscript{nd} 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

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”
4 Steps of Population Health Management: the Second Curve

1. SEGMENTATION & UNDERSTANDING BARRIERS TO CARE

2. CO-DESIGNING CARE PATHWAYS & SERVICE MIX

3. IMPLEMENTATION & REACH

4. MONITORING & EVALUATING

Source: Adapted from Population Health Alliance, 2012
OHTs & Their Attributed Populations
Population is Continually Evolving

Births, immigration, mobility, choice

Deaths, emigration, mobility, choice
Step 1: Population Segmentation & Understanding Barriers to Care

Kaiser Risk Pyramid

Different Segments Have Different Needs
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
- Healthy Patients
Step 1: Population Segmentation & Understanding Barriers to Care

Population Segments are Continually Evolving

Births, immigration, mobility, choice

Deaths, emigration, mobility, choice

Super Users

Medically Complex / High Risk

Rising Risk

Healthy Patients
Step 1: Population Segmentation & Understanding Barriers to Care

Data Sources

- Patient generated data
- Administrative data & scoring algorithms (e.g., HPGs)
- Quality improvement & research studies
- Registries & intake data
- Community / contextual data
- Practice generated data (EMRs)
Step 1: Population Segmentation & Understanding Barriers to Care

Using the EMR to Document, Track, & Prompt

- Track patient enrollments
- Track care gaps, hospitalizations & ER visits
- Identify missed opportunities & follow ups
- Identify patients with specific diseases / problems
- Document demographics & social factors
- Track functional health status
- Track health outcomes
Step 2: Co-designing Care Pathways & Service-mix

Expanded Chronic Care Model for Population Health

Adapted from:
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
Some of What We Heard at OHT Forum

Step 1. Segmenting population into groups with shared needs

- Variable experience in working at the population level
- Common challenges:
  - Where to start with palliative care?
  - Focus on single vs across chronic conditions?
  - How to integrate physical, mental and social issues?
- Need help with access to data (deidentified and identifiable), both quantitative and qualitative
- Need help with interventions to address social needs

*NB: Upcoming RISE brief on population health management*
Some of What We Heard at OHT Forum

Step 2. Co-designing care pathways and in-reach/out-reach services

- Variability in capacity for and experience with patient partnership to co-design
- Balance provincial initiatives and local context
- Complementing representation with meaningful co-design ‘on the ground’
- Keep focus on equity and patient voices
- Add self-management supports
Some of What We Heard at OHT Forum

Step 3. Implementing pathways/services in a way that reaches and is appropriate to groups

- Not everyone is at the point of implementation
- Common barriers relate to data sharing and physician engagement
Some of What We Heard at OHT Forum

Step 4. Monitoring implementation and evaluating impact

- Need coordination to share data, logic models, performance metrics, outcome measures/performance metrics, and evaluation tools
- Common commitment to ‘moving the needle,’ especially with patient and provider experiences

NB: Upcoming RISE session on logic models
Summary

- 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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Andrew Pinto (andrew.pinto@utoronto.ca)

English: www.OHTrise.org | Français: www.ESOrise.org
Join RISE for upcoming webinars

- Four webinars about resources to support population-health management – one for each year 1 priority population – have been scheduled
  - People who would benefit from a palliative approach to care:
    Webinar on Tuesday 17 March from 12-1 pm
  - People with mental health and addictions issues:
    Webinar on Tuesday 24 March from 12-1 pm
  - People with chronic conditions:
    Webinar on Monday 30 March from 12-1 pm
  - Older adults with greater needs
    Webinar on Tuesday 31 March from 12-1 pm
More webinars to join & new resources coming soon

- **OHT Central Program of Supports**: Tuesday 7 April from 12-1 pm
- **Primary-care physician engagement**: Tuesday 14 April from 12-1 pm
- **Data sharing within existing rules**: Tuesday 21 April from 12-1 pm
- **Insights for provincial health-system partners** about balancing provincial guidance and local contextualization and transitioning to high-value data collection: Tuesday 28 April from 12-1 pm

- Prepare or update RISE briefs about population-health management, four priority populations, and building blocks (e.g., overall; data-analytics platform; population segmentation), and key patient partner, health-system partner and research partner resources (e.g., OHT Central Program of Supports; OH’s Quality Business Unit)
Thank you!

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