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Rapid-Improvement Support and Exchange

Lunchtime Webinar: Population-health Management by OHTs

RISE Webinar

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RISE community members:

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Carolyn Gosse, RPH, ACPR, PharmD, Vice President of Integrated Care, St. Joseph's Health System, President, St. Joseph's Home Care and St. Joseph's Villa

McMaster University | HEALTH FORUM

The Ottawa Hospital RESEARCH INSTITUTE | L'Hôpital d'Ottawa INSTITUT DE RECHERCHE

Trillium Health Partners | INSTITUTE FOR BETTER HEALTH

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Today's Webinar

- Six lunchtime (12-1 pm) webinars focused on topics particularly relevant for teams invited to full application
  - Monday August 26 – Leadership infrastructure for OHTs
  - Tuesday September 3 – Population-health management by OHTs
    - Section 3: How will you transform care?
    - Appendix A: Home care
  - Monday September 9 – How OHTs can approach their work with an attributed population
  - Thursday September 19 – Topic to be confirmed
  - Monday September 23 – Topic to be confirmed
  - Tuesday October 1 – Topic to be confirmed
- A recording of today's webinar will be posted on the RISE website under 'Join events'

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Today's Webinar (2)

- Population-health management will require Ontario Health Teams (OHT) to complement:
  - A focus on individuals with a focus on populations
  - A reactive approach with a proactive approach
  - A condition or disease orientation with a person-centred orientation
- Observations based on experiences working in a high-performing in integrated health care delivery system. Meant to get you thinking about what's working well and what could be improved with your own approaches to managing health in your priority populations
- Please share your own observations or any questions in the chat box, and we'll return to them later in the webinar

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Today's Webinar (3)

- Designing your Population-health Management Approaches
  - Review key concepts for population health and population-health management
  - Approaching your attributed population
  - Proactively organizing and delivering care to the population
  - Population-health management: an example in action

- Learning with others:
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Population Health – A Definition

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

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

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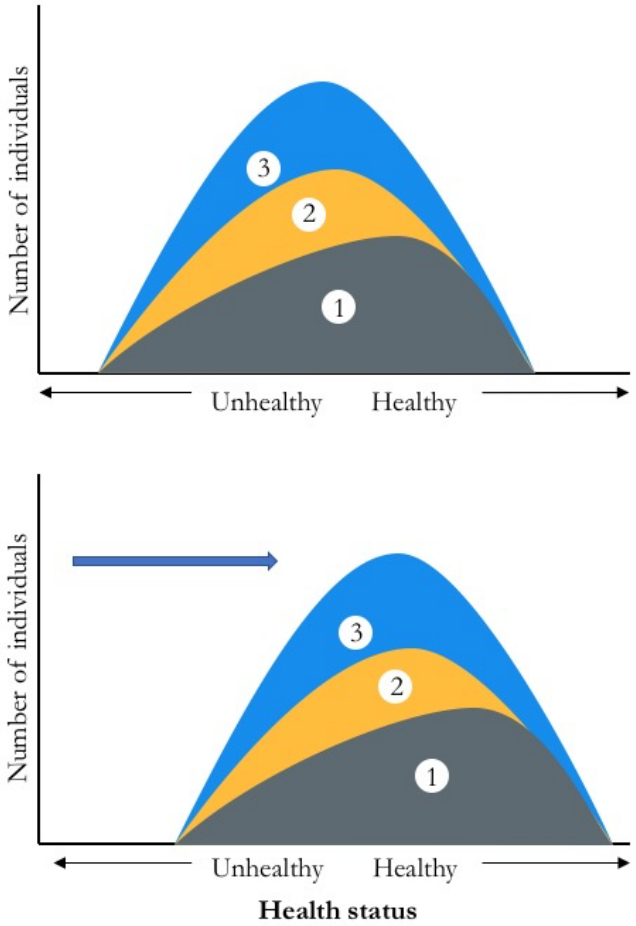
The Role of Health Care in Producing Population Health: "Shifting the 3 curves"



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

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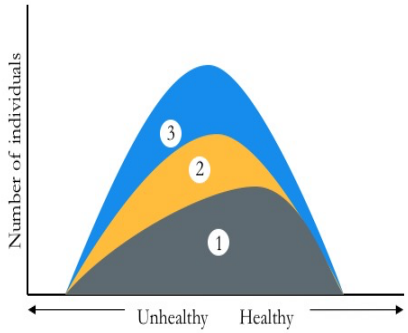
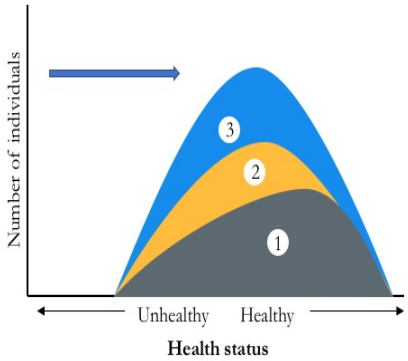
Shifting the 3 Curves of Population Health





❶ 1st Curve – Acute Care Needs

- Emphasis timely access to high-quality acute care services
- Oriented around care episodes (e.g., visits, hospitalizations)
- Focus is on individual patient needs, not on populations
- Population health impact comes through users one-by-one

❷ 2nd Curve – Population-health Management

- Emphasis is on chronic health problems & behavioral risk factors
- Oriented longitudinally on patient engagement and long-term mgmt
- Focus is on population segments with common needs
- Interventions are individually focused and proactively applied
- Uses an equity lens and addresses barriers
- Population health impact comes from applying good clinical care consistently across sub populations.

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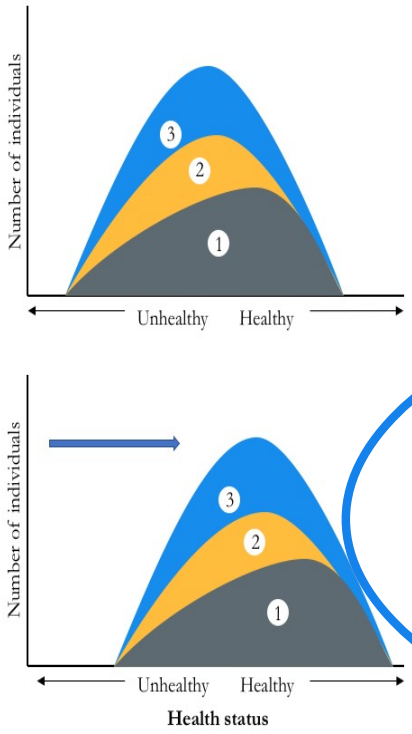
Shifting the 3 Curves of Population Health



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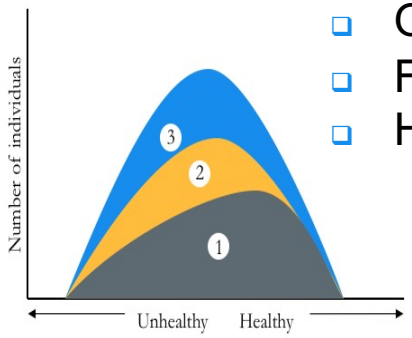
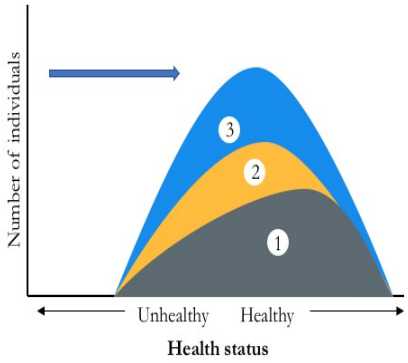
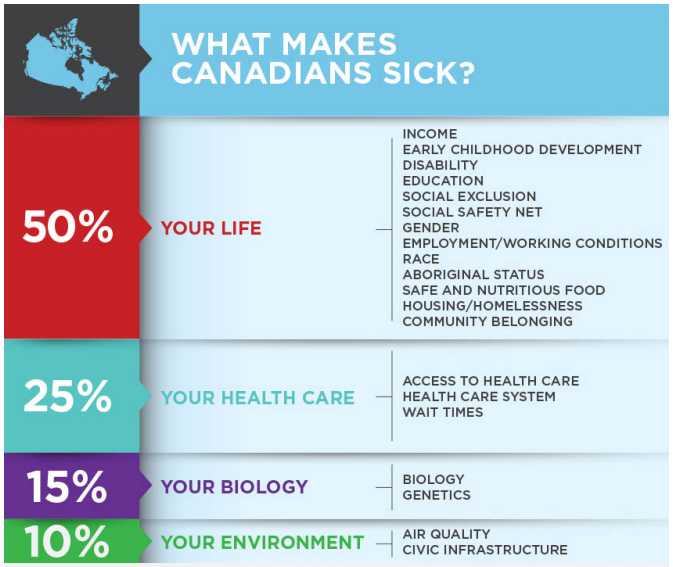
Shifting the 3 Curves of Population Health

❸ 3rd Curve – Population-based Strategies & Interventions

- Emphasis is on non-medical determinants of health (housing, income, transportation, food insecurity etc.)
- Oriented longitudinally over the lifespan
- Focus is generally at population level (e.g., municipality)
- Health care institutions role can be to provide, facilitate or advocate







Infographic courtesy of Canadian Medical Association

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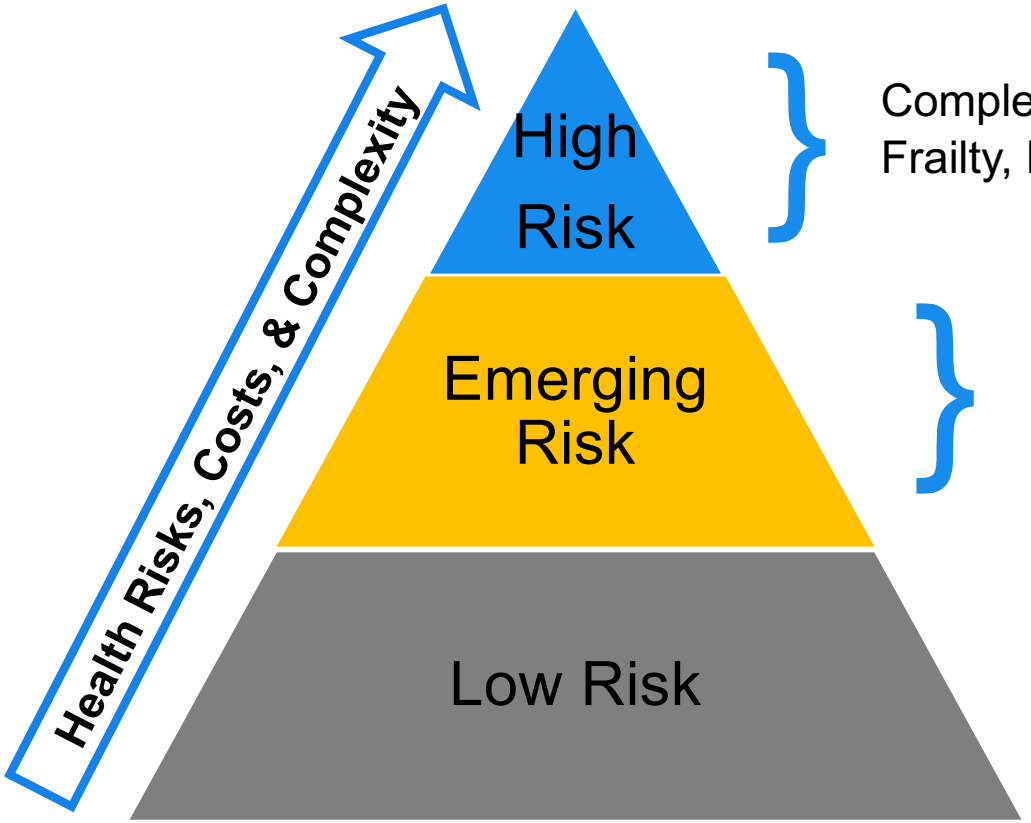
Selecting your Priority Populations: Different Groups, Different Ongoing Care Needs



Complex morbidity patterns
Frailty, End-of-life

Chronic illness (multiple, unstable, poorly controlled)

Healthy & prevention needs
Risky health behaviors
Well managed chronic illness

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Moving from Reactive to Proactive Care in OHTs

- Clinical Decision Supports
  - Common clinical practice guidelines & clinical pathways
  - Active use of prompts & reminders for patients & providers
- Clinical Information systems
  - Population registries & patient-centred trackers for care & outcomes
- System Redesign
  - New roles and new tools for care team members across OHT
  - Care coordination functions & use of high-risk care management
  - Mechanisms to identify and address barriers to care
- Self Management Support
  - Support to build motivation, skills, capabilities, and behavioral change
  - System navigation support

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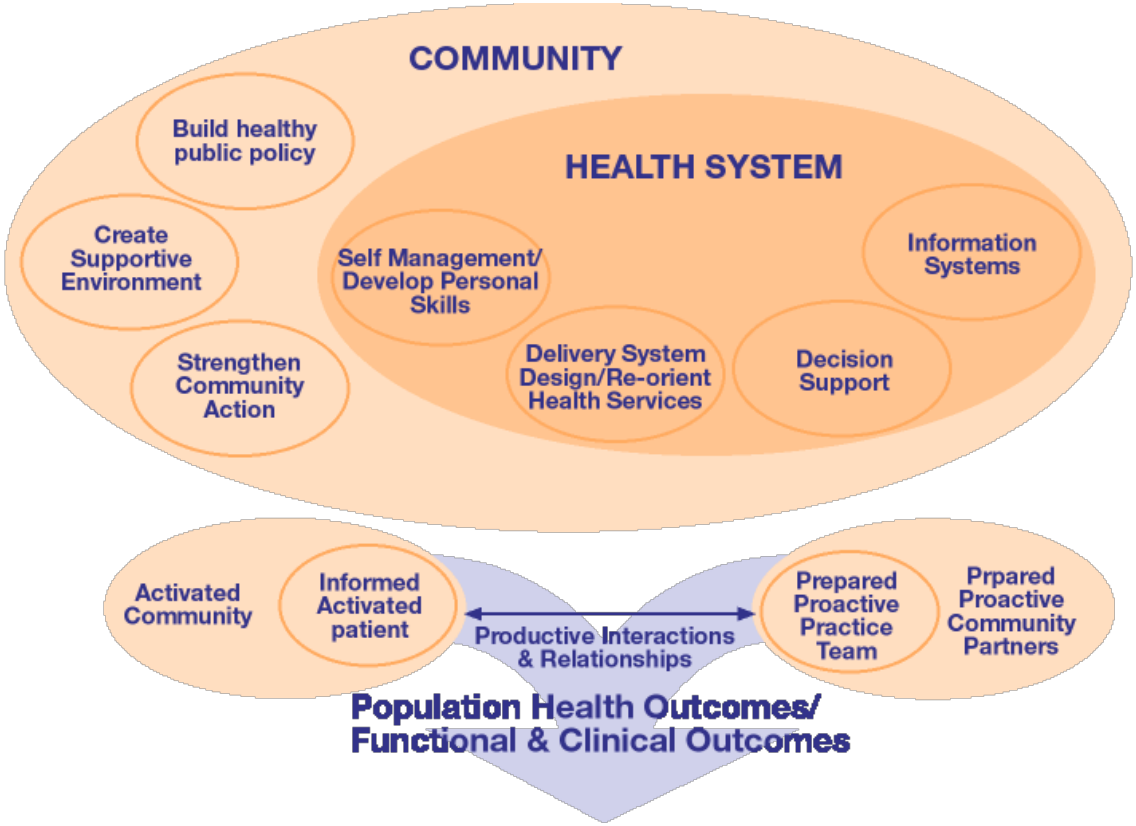
Expanded Chronic Care Model



Source: Barr VJ et al. Healthcare Q 2003:7(1):73-82.

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Designing your Strategies for Priority Populations

- Examine current state with respect to care gaps & coordination needs
- Adopt, adapt or co-develop care pathways with that cross OHT partners and extend longitudinally
- Develop a service mix (in-person and/or virtual) that includes:
  - In-reach services at the point of care (i.e., proactively offering evidence-based services anytime they are 'seen in' or 'touched by' the health system)
  - Out-reach services (i.e., proactively connecting with those who are not seeking care now and offering evidence-based services and removing barriers to accessing these services)
- Develop tracking, reporting, & reminding systems that facilitate ongoing care for attributed priority populations

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Example of Population-health Management

Improving Hypertension Control at Kaiser Permanente

- Improving blood pressure control for patients with hypertension selected as strategic priority in 2000s in California regions
- Rationale:
  - Hypertension is common; leading reason for visits & downstream costs
  - Hypertension is treatable with stepped therapy & patient engagement
  - Occurs alone as well as with other morbidities
  - BP control can reduce risks for poor outcomes (e.g, stroke) & mortality
  - Poor BP control was common

Source: Sim JJ et al, Can J Card 2014 Jaffe MG et al. J Clin Hyperten 2016. Jaffe MG et al. JAMA 2013.

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Example of Population-health Management

Improving Hypertension Control at Kaiser Permanente

Program Design

- **Clinical Decision Supports**
  - Systemwide evidence-based CPG with easy-to-use stepped therapy algorithm
  - Integration into all clinical pathways (e.g., patients with diabetes)
- **Clinical Information systems**
  - Hypertension registry; standardization of BP measurements
  - Access to info at individual & aggregate levels of BP use and CPG adherence.
  - Treat-to-target prompts & reminders; regular performance feedback (process & outcome)
- **System Redesign**
  - New roles for non-physician providers (med assistants, nurses, pharmacists)
  - Systematic use of telephone reminders, e-visits, mailed medications, etc
- **Self Management Support**
  - Initiatives to address health literacy & improvements in medication adherence
  - One-to-one teaching; peer group sessions, educational videos etc.

Source: Sim JJ et al, Can J Card 2014 Jaffe MG et al. J Clin Hyperten 2016. Jaffe MG et al. JAMA 2013.

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Example of Population-health Management

Improving Hypertension Control at Kaiser Permanente

- Population-health results (Northern California):
  - Improvement in hypertension control from 44% to 90% from 2000-2013
  - Over same interval
    - Reduction in heart attack incidence by 24%
    - Reduction in stroke mortality by 42%

Source: Jaffe MG et al. J Clin Hyperten 2016.

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Guiding Principles Can Also Help

- Focus on improving care experiences and health outcomes (i.e., the first two parts of the quadruple aim), and do so in ways that actively engage patients as partners in co-design processes and that respect the Patient Declaration of Values
- Draw on all relevant resources from participating OHT partners, not just those that have historically been part of the care circle, while being attentive to keeping per capita costs manageable (the third part of the quadruple aim)
- Be open to new and different roles among participating partners, without being bound by the way past contracts have been structured, but recognizing that change can be stressful and improving provider experiences is also a key goal (the fourth part of the quadruple aim)
- Identify the 'rules' (e.g., government legislation and organizational procedures) that need to be changed to get things right

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Guiding Principles Can Also Help (2)

- Build on what's already working well and leverage OHT partners' wealth of experience in designing care and support in ways that work well
- Push for more and better data to understand existing problems and their causes, and to monitor the implementation of new approaches
- Build on existing approaches that are evidence-based, look for evidence about possible new approaches, and help to build the evidence base when trying out new approaches that haven't yet been evaluated
- Undertake improvements to the care experiences and health outcomes of priority populations in ways that contribute to or draw on OHT building blocks and that make it easy to scale the approach to other populations in future

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Reminders About Related RISE Briefs

- RISE brief 6 about population-health management
- RISE brief 8 about data analytics
- RISE brief 9 about evidence sources
- Two-page summary about population-health management (linked to from each of the above RISE briefs)

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Observations? Questions?

Please remember that we're audio-recording the session (and we'll post the recording on the RISE website) and we can't answer policy questions

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

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