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# RISE population-health management:

## co-designing care models for your segmented priority population

**March 18, 2021**


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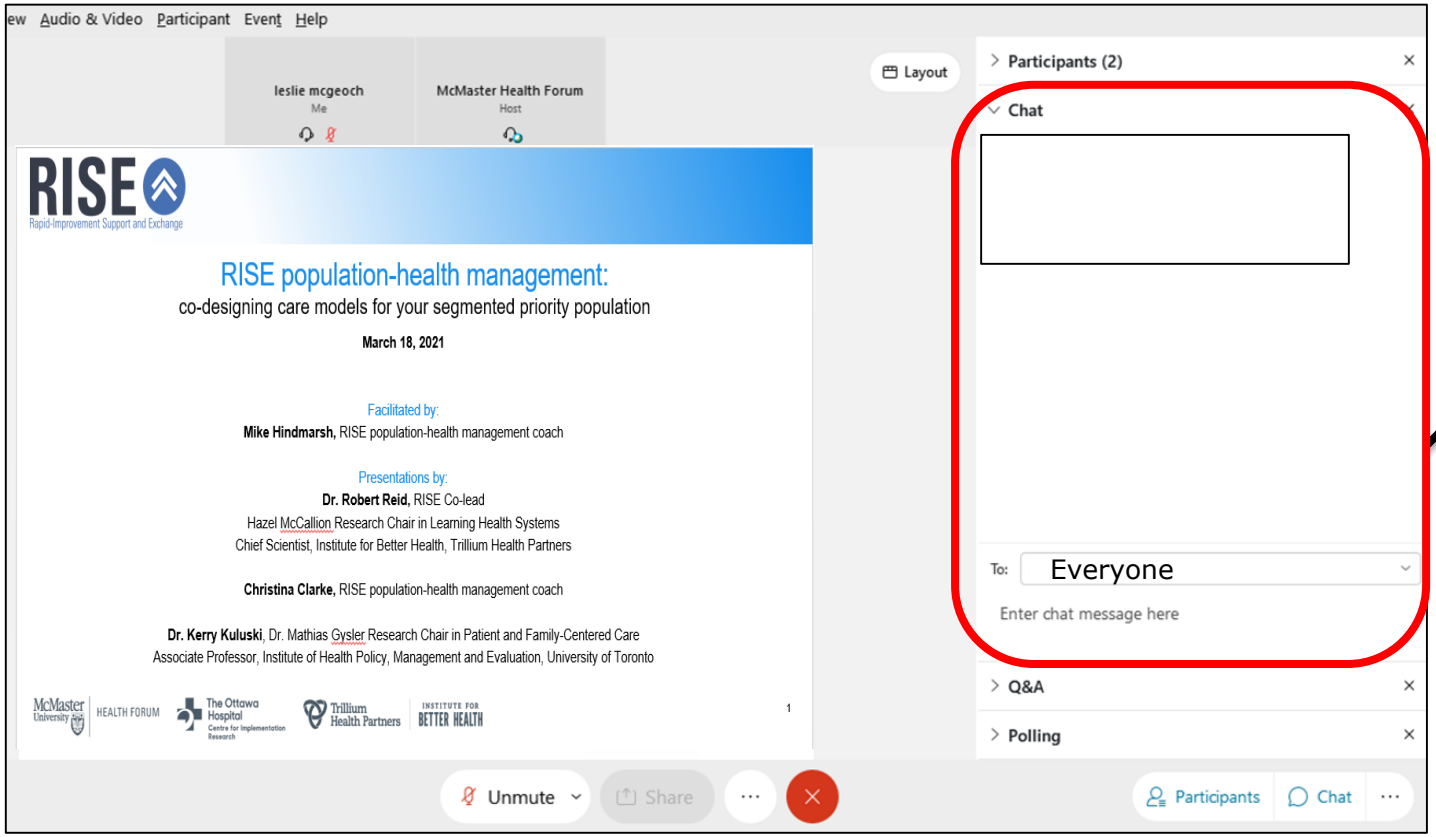
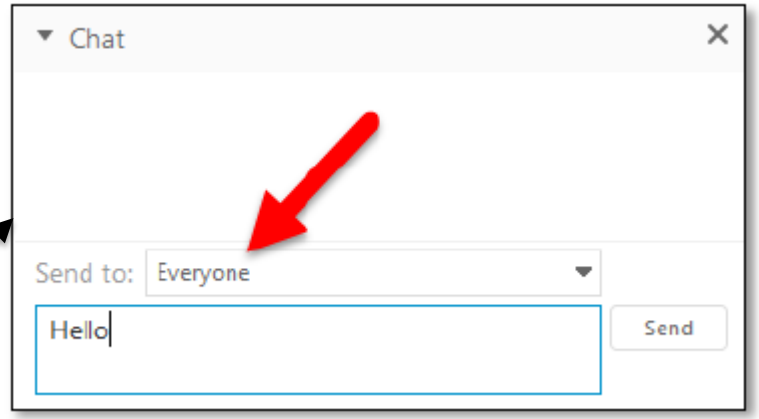
McMaster University | HEALTH FORUM
The Ottawa Hospital Centre for Implementation Research
Trillium Health Partners | INSTITUTE FOR BETTER HEALTH

# Welcome!

In the chat box, please select "everyone" tell us your name and your organization/OHT




You can also follow us on twitter @ OHTrise to learn about upcoming events and to post about population-health management!

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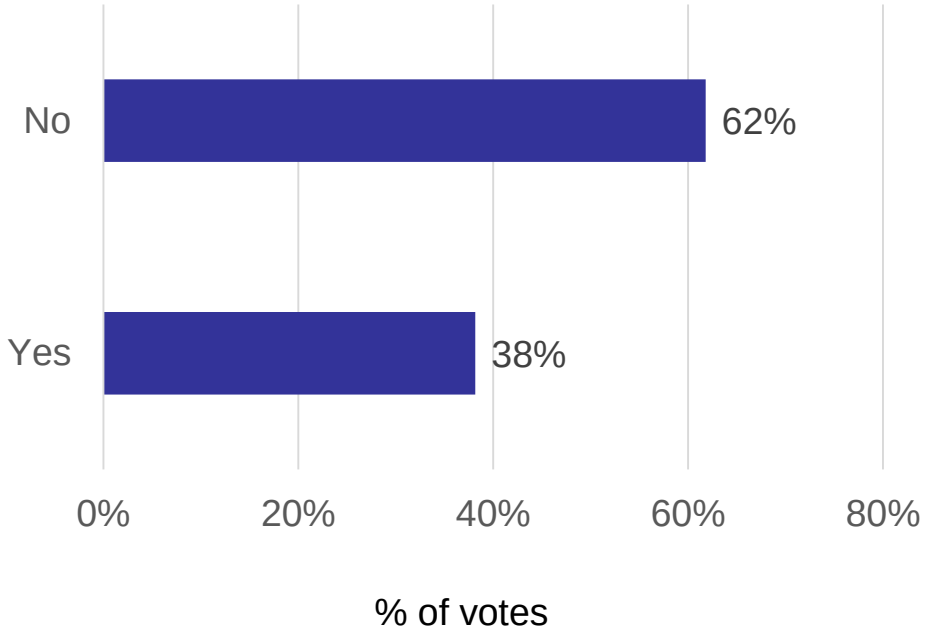
# Land acknowledgement

*“As we meet here today, we are in solidarity with Indigenous Peoples of Turtle Island and would like to begin by acknowledging that the land on which we gather is part of the Treaty Lands and Territory of the Mississaugas of the Credit, and before, the traditional territory of the Haudenosaunee, Huron and Wendat. We also acknowledge the many First Nations, Inuit, Métis and other global Indigenous Peoples who now call this area their home. We are grateful for the opportunity to be working on this land”.*

# Poll: Were you able to attend the RISE population-health management webinar in January on core concepts and population segmentation?




***62%*** *of participants indicated they were unable to attend the previous RISE webinar on population-health management webinar while* ***38%*** *were able to join January's webinar on population segmentation.*

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# Today's webinar

## Purpose

- share successful approaches to co-designing care models for your segmented priority populations
- help you understand the key changes needed to improve outcomes for priority populations
- cultivate shared learnings by hearing from peer OHTs on their application of population-health management

This session helps support OHTs in achieving the following OHT TPA milestones:

- Re-designing care for patients in your priority population(s)
- Helping every patient in your priority population(s) to experience coordinated transitions between providers

Hosts

**Leslie McGeoch,**
RISE Focal Point

**Steven Lott,**
RISE Communications Lead

Presenters

**Dr. Rob Reid,**
RISE Co-Lead

**Mike Hindmarsh,**
RISE PHM Coach

**Christina Clarke,**
RISE PHM Coach

**Dr. Kerry Kuluski,**
Dr. Mathias Gysler Research Chair

# It is a journey!

**Planning of OHT and development of OHT application**

- Understanding attributed population
- Segmenting attributed population into priority populations

OHT application approved!

Forming and establishing collaborative governance

Teams coming together to manage COVID

Restarting PHM work leveraging COVID learnings

Segmentation

COVID

today

Redesigning care models through co-design and testing changes

Adjust based on learnings

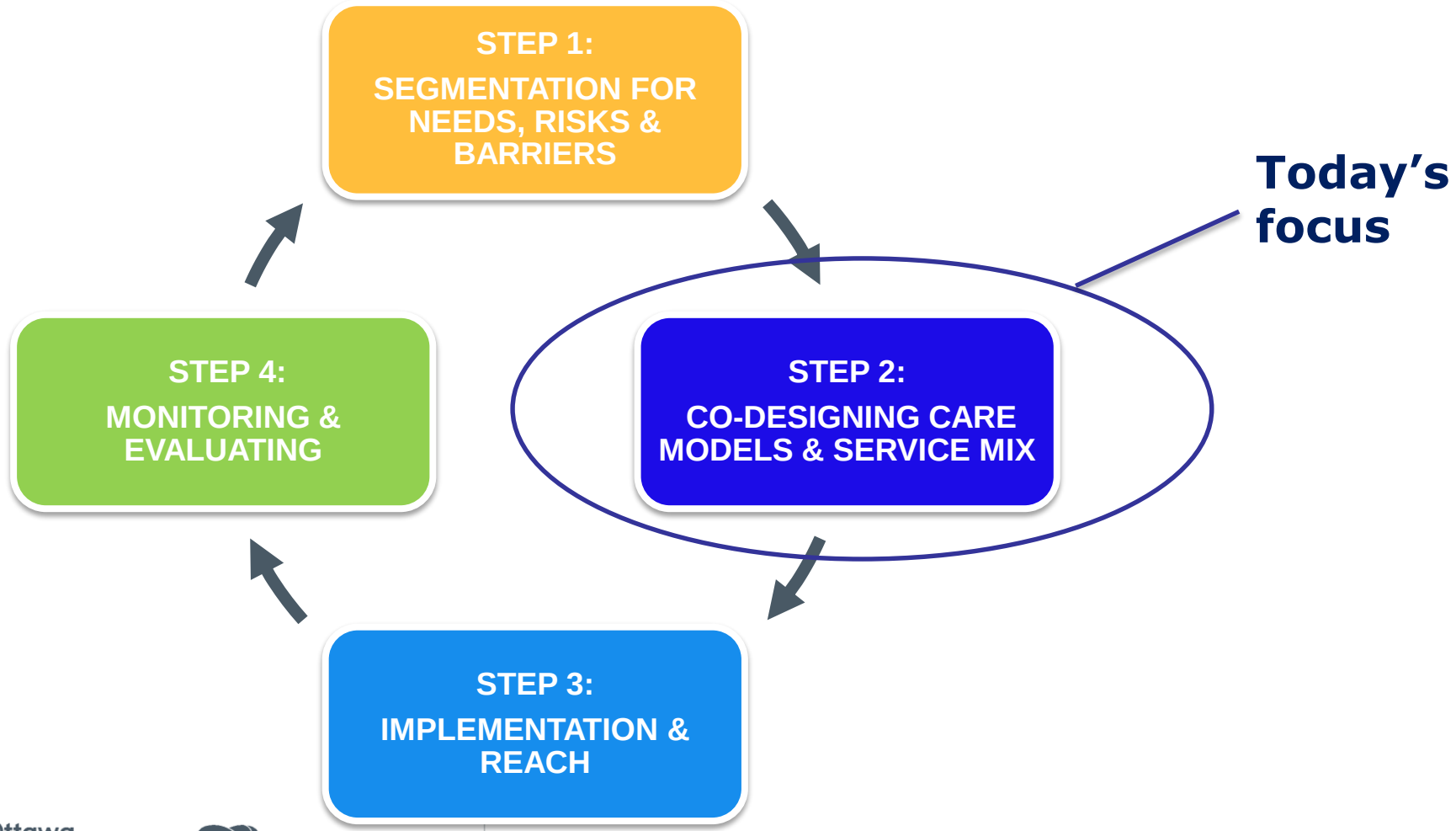
Test working with community and public organizations

Implement and evaluate changes

Expansion to other populations

**Clinical and social support needs for improved population-health**

# Recall the 4 steps of Population Health Management






Source: Adapted from Population Health Alliance, 2012

# What the coaches heard from you

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

*What models are out there?* ***We don't want to reinvent the wheel.***

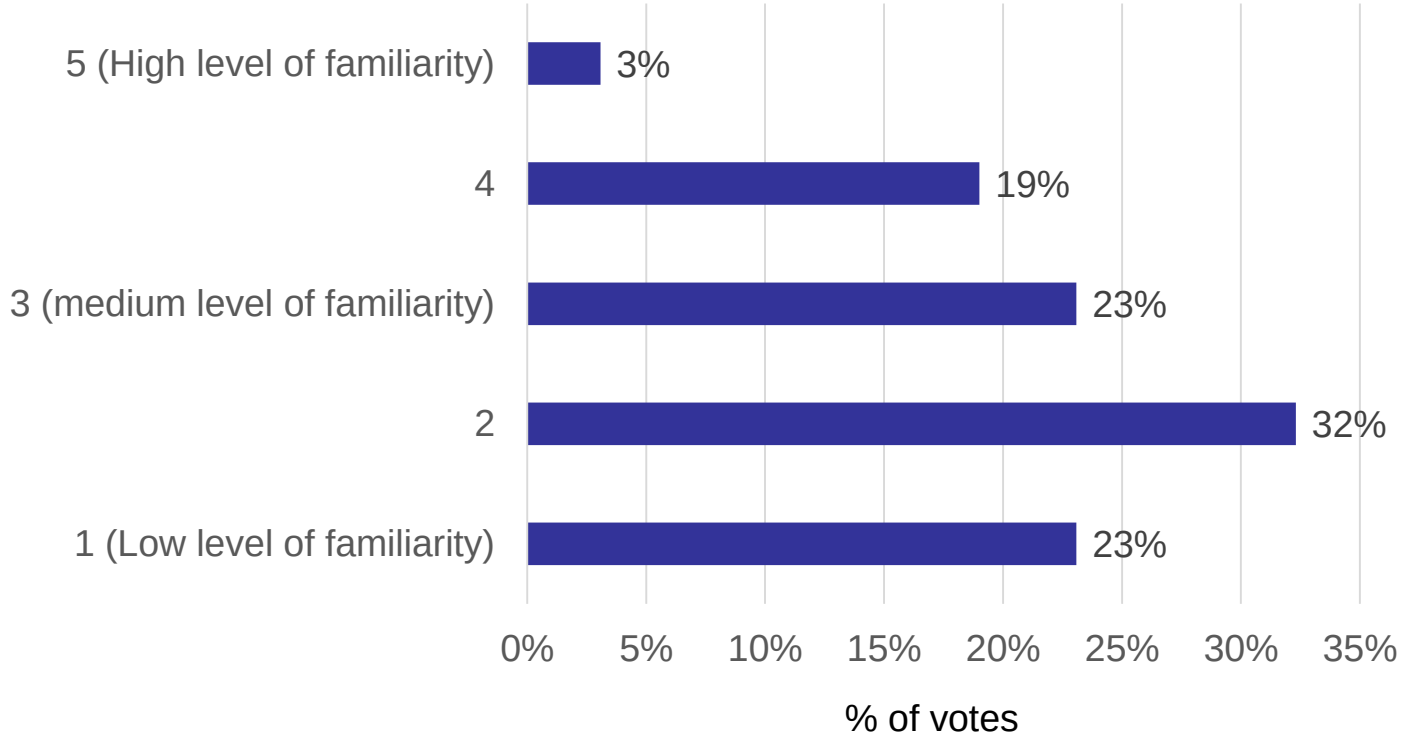
*What supports are there for applying an* ***equity lens*** *to reach vulnerable populations?*

*What are different* ***ideas for involving patients, families and caregivers*** *in co-design?*

*How do we translate existing models to* ***'on the ground' reality****?*

*How do we* ***balance provincial initiatives and local context****?*

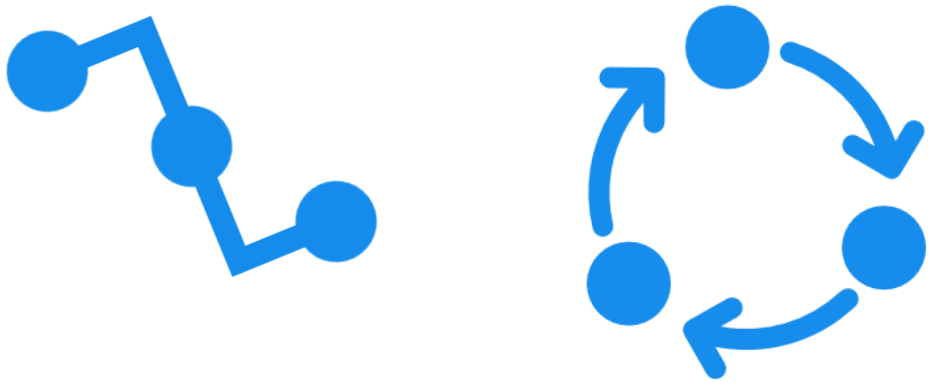
# Poll: Please rate your level of familiarity with co-designing care models for populations of patients. (1- being low level of familiarity and 5 being high)




***45%*** *of participants indicated they had a medium-high level of familiarity with co-designing care models while* ***55%*** *had a lower level of familiarity.*

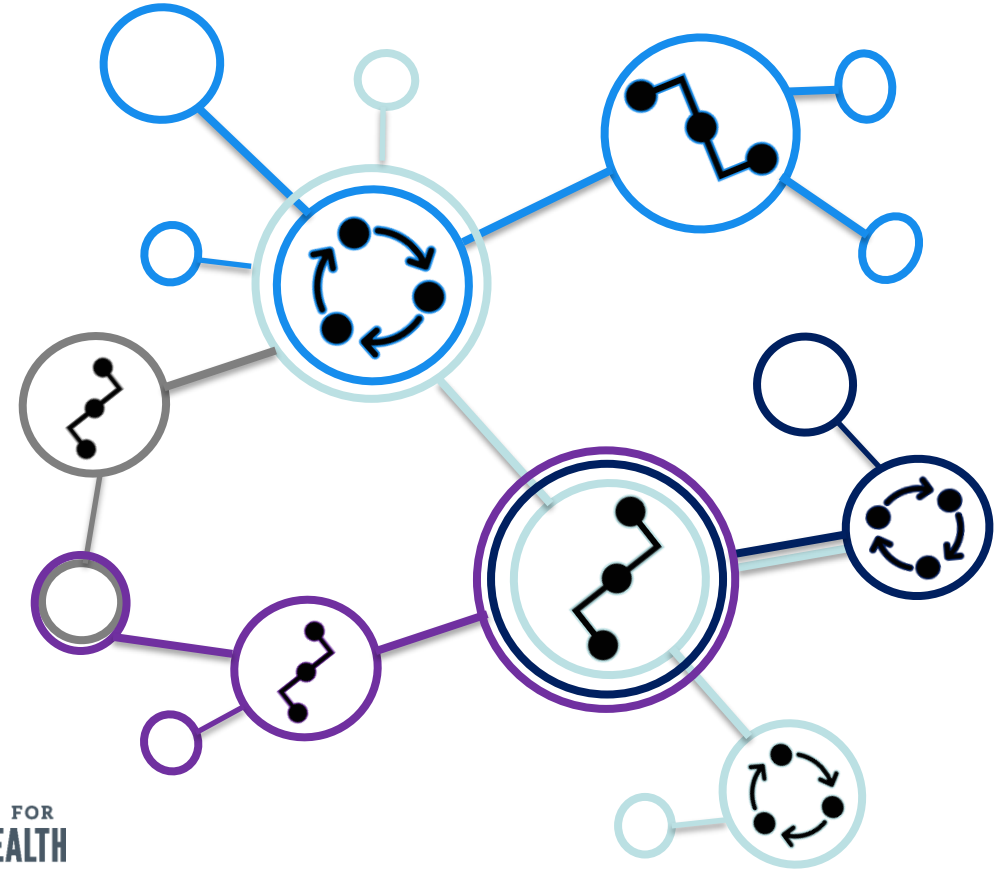
# Care pathways

Care Pathways refer to **steps** **taken to deliver a care process**



# Care models

Care Models are **systems of care** with multiple pathways and processes inside



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# What co-design looks like?

Mike Hindmarsh, RISE PHM Coach


| Beginning with initial population segment(s) of priority population | Expanding co-design to new segment(s) | Changing care for whole priority population |
|---|---|---|
| • **Scenario 1:** Change **requires building a new system** to improve care<br>• **Scenario 2:** Change can be accomplished **within existing system structure**<br>• **Scenario 3:** Change requires **redesign of existing system** | • Action Teams/Work Groups **develop interim measures** to see if changes are an improvement<br>• Testing ensures no failures when moving to implementation.<br>• **Membership of team may change** as Care Model co-design evolves. | • Individual changes **ready for implementation.**<br>• No failures when implementing. Membership of team may change to members with implementation expertise | • system **monitoring and evaluating** with **continuous quality improvement** lens.<br>• This functionality built into OHT infrastructure. |

***Continuous testing of changes until system is impacting population health as planned***

**ALL** redesign needs apply an equity lens

# Step 2: Co-designing Care Model & Service Mix: System Redesign Concepts to be Considered

- **Delivery System Redesign**
- **Clinical Decision Supports**
- **Information Technology Support**
- **Self-management Support**
- **Community Resources**

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# Delivery System Redesign

- Cross-organization coordination of care
  - Effective transitions
  - Stepped Care protocols
  - Integrated Case Management functionality
  - System navigation at all touchpoints
  - Regular assessment of disease severity
  - Medication reconciliation
- Proactive In-reach & out-reach functionalities
  - Emphasis on Equity and Access
- Planned Care versus Reactive Care
- Recall functionality and Regular Follow-up
- Culturally sensitive at all patient touchpoints

## Co-design questions to consider:

**What parts of existing systems need redesigning?**

**What new systems need to be developed?**

**ALL** redesign needs to be informed by socioeconomic factors

# Clinical Decision Supports

- **Evidence-based guidelines** embedded in care
- **Specialty care–primary care-home care agreements**
- **Clinical case management agreem**ents
- **Social factors** to consider when creating patient care plans
- **Care model education** for all circle of care members
- **Patient and caregiver education** about care models and guidelines

## Co-design questions to consider:

How does the OHT stay current with emerging evidence and care trends?

How does the OHT communicate changes in care models as new evidence emerges?

How do changes in the Circle of Care get communicated?

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# Information Technology Support

- **Segment** patient subpopulations for proactive care (registries)
- Facilitate individual patient **care planning across OHT partners**
- Provide **reminders** for providers and patients
- **Patient portals** to access care information
- **System alerts** for critical changes in patient status
- **Monitor** performance of team and system

## Co-design Questions to Consider:

What needs to be built inside the OHT versus what is being built provincially?

What interim "throw away" systems are needed to bridge the gap in the above question?

What data are good enough for improvement?

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# Self-management Support (SMS)

- **Emphasize the patient's central role** at every point of contact
- **Use effective SMS strategies** that include goal-setting, action planning, problem-solving, motivational interviewing and follow up.
- Redesign care interactions to provide **support patient self-management**
- Ensure patient receives some level of self-management support during any contact in the OHT system.

## Co-design Questions to Consider:

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# Community Resources

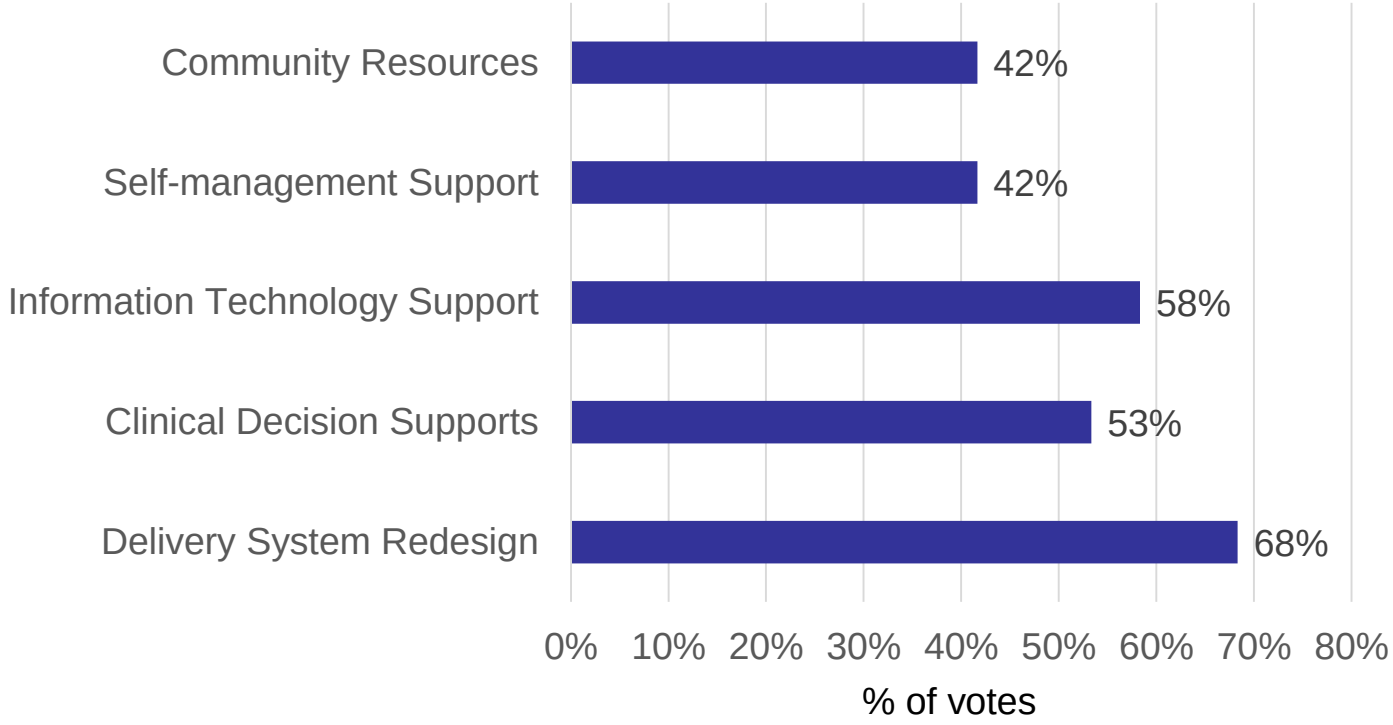
- **Encourage/incentivize patients to participate** in effective programs.
- **Form partnerships with community organizations** to support or develop programs
- **Develop universal referral processes** across social support organizations
- **Coordinated communication** regarding social factors impacting patient lives

## Co-design Questions to Consider:

What are the high leverage community partners?

How can equity and access to resources be guaranteed for those experiencing poverty and/or trauma?

# Poll: Which of the co-design concepts do you need help with?
## (check all that apply)




*The majority of participates indicated they need help with co-design concepts for* ***delivery system delivery design (68%), information technology supports (58%)*** *and* ***clinical decision supports (53%).***

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# Example: applying redesign and co-design to frail seniors (CHS 4-6)

**Christina Clarke,** RISE Population-health management coach

# CLINICAL FRAILTY SCALE

**1 VERY FIT** — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

**2 FIT** — People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.

**3 MANAGING WELL** — People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

**4 LIVING WITH VERY MILD FRAILTY** — Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.

**5 LIVING WITH MILD FRAILTY** — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

**6 LIVING WITH MODERATE FRAILTY** — People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7 LIVING WITH SEVERE FRAILTY** — **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

**8 LIVING WITH VERY SEVERE FRAILTY** — Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

**9 TERMINALLY ILL** — Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

## SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY



Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

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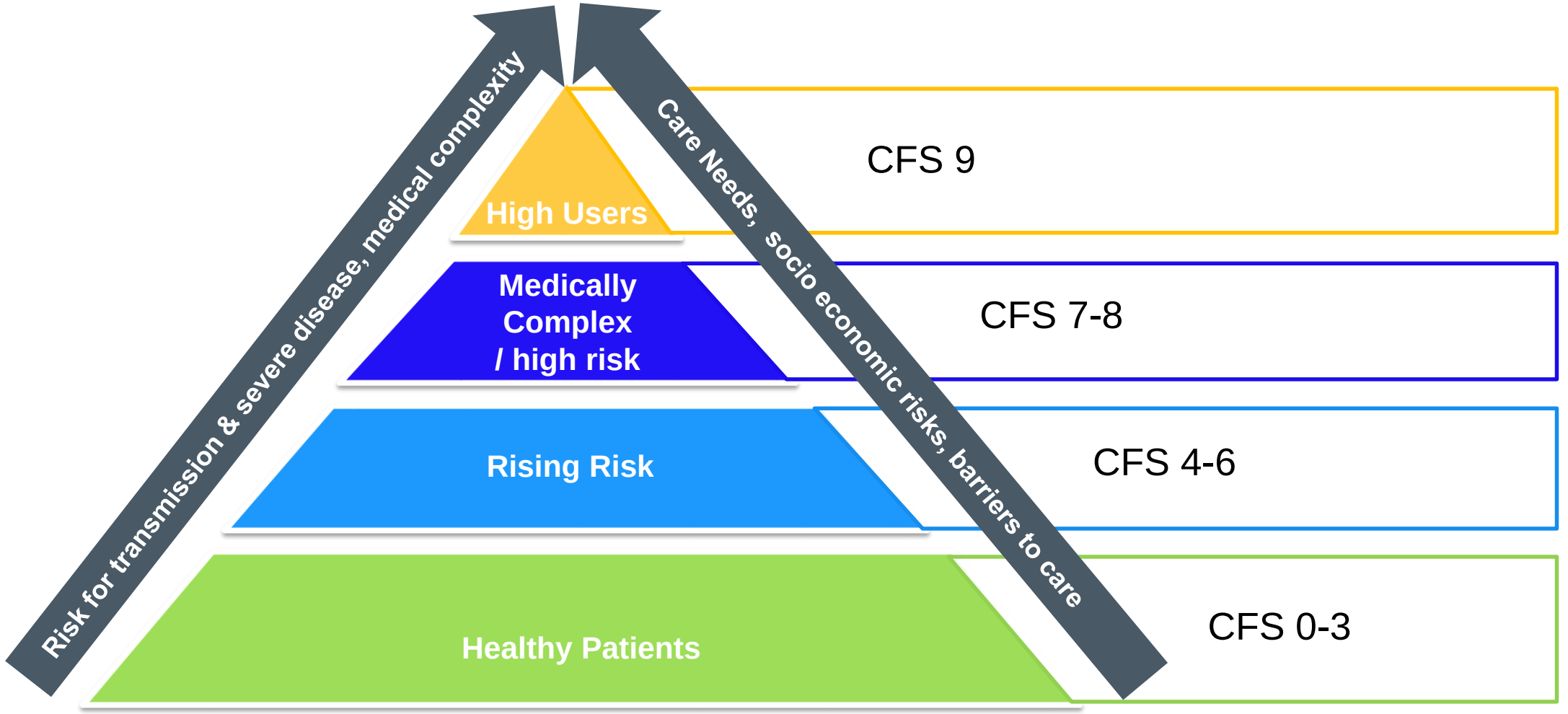
# Using the clinical frailty scale (CFS) to segment the older adult population (>65)



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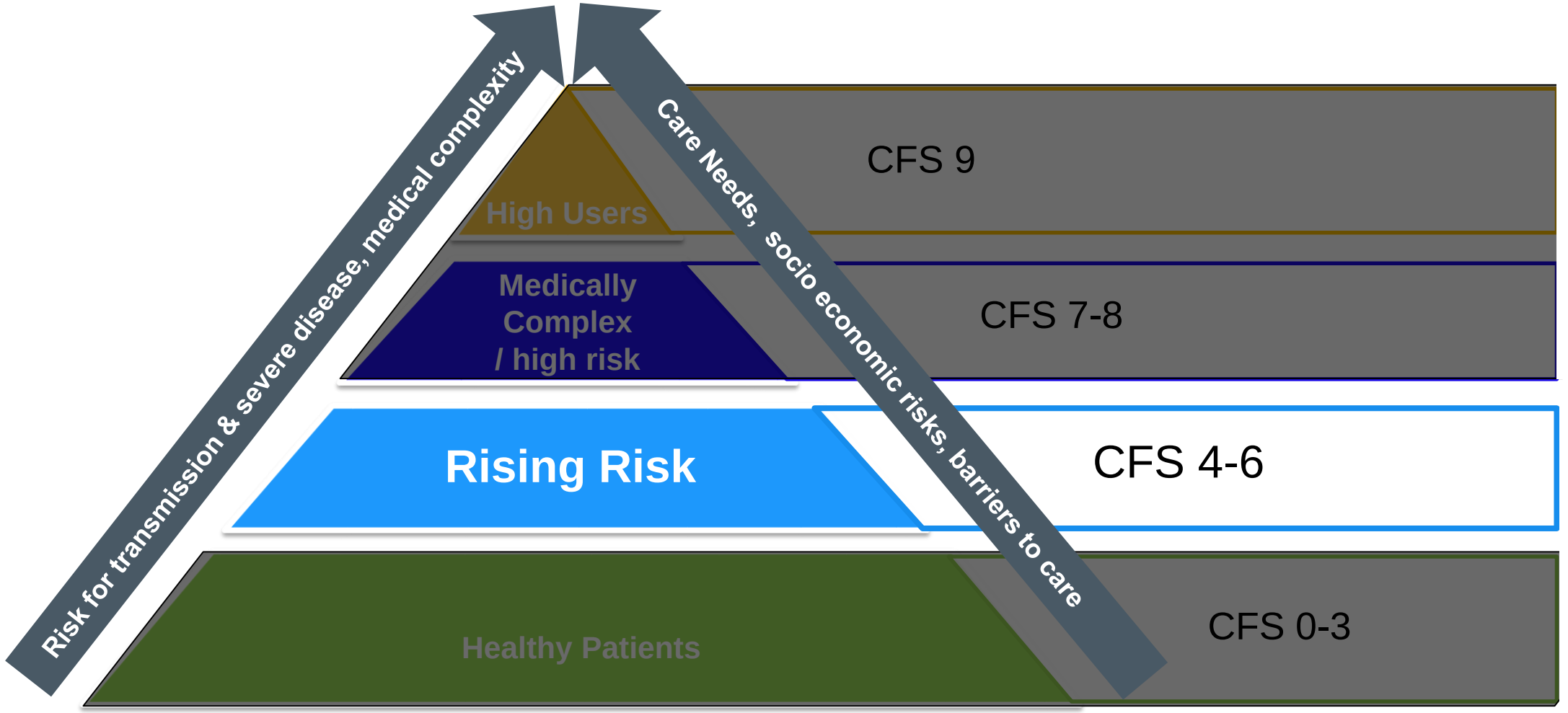
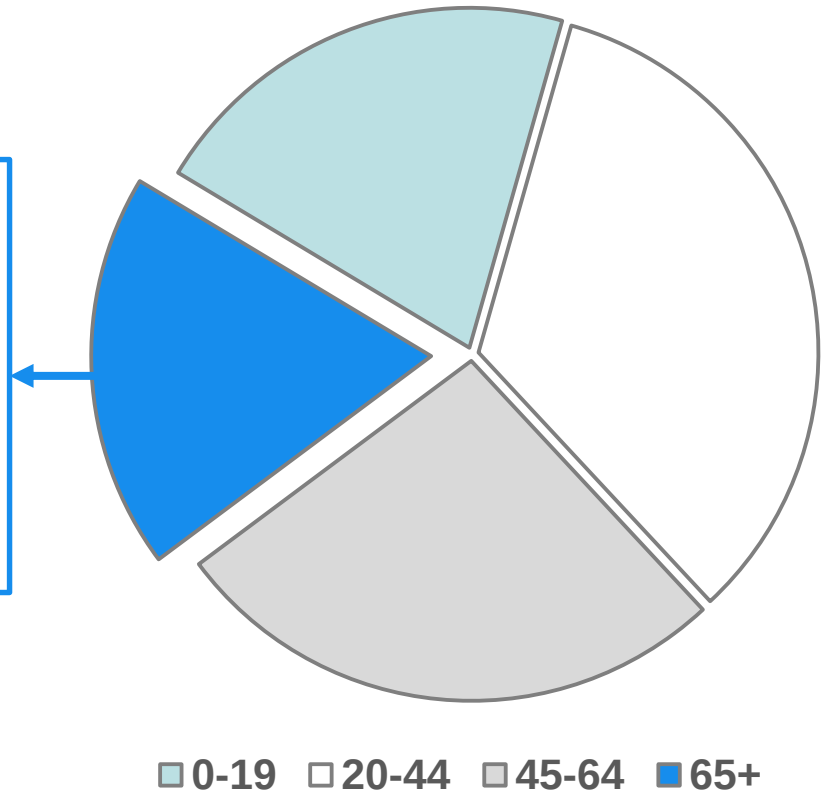
# Starting with one segment to characterizing needs, risks, barriers



# Characterize needs in this population segment

## Attributed population by age group

- Who in our population CFS 4-6?
- What is their health status?
- What is their experience of care?
- Utilization?




## What data do we have?

- Prevalence estimates from literature (e.g., 16% of adults aged 65-74 were frail; 29% of adults aged 75-84 were frail; 52% of adults aged 85 or older were frail) (1).
- ED admissions, fall related ED visits, etc.
- RAI, homecare use, other

## What data do we have that we need to share?

- Homecare – primary care – Hospital – Specialty - community

## What data do we need to begin collecting?

- Begin case finding and documenting frailty status for adults 65+
- Patient experience / what matters index
- Caregiver distress
- Socioeconomic factors

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# Example: applying redesign and co-design to frail seniors (CHS 4-6)

## Who are our rising risk seniors (CFS 4-6)?

**Concept(s) leveraged: Information Technology Support + Community Resources**

- Data not currently available so need to co-design case finding process
- Test and iterate new processes on small scale (one provider) and plan for spread/scale up

## Characterize patient needs

**Concept(s) leveraged: Community Resources + Self-management Supports**

- Create a registry of patients in segment to understand needs in a sub-set of segment
- Use quality tools to understand care gaps (e.g., fishbone diagram, FMEA) and prioritize solutions (e.g., NGT, Pareto Analysis)

## Design care models/programs/pathways

**Concept(s) leveraged: Delivery system redesign + Community Resources, Self-management Supports**

- Co-design/re-design care pathways with patients, caregivers, primary care, specialty care, home and community to meet needs of patients
- Test and iterate new models/pathways

## Monitor care and outcomes

**Concept(s) leveraged: Information Technology Support + Community Resources + Clinical Decision Supports**

- Link/share population health data (primary-hospital-home community) to learn, monitor care quality, and population health outcomes
- Monitor quadruple aim metrics

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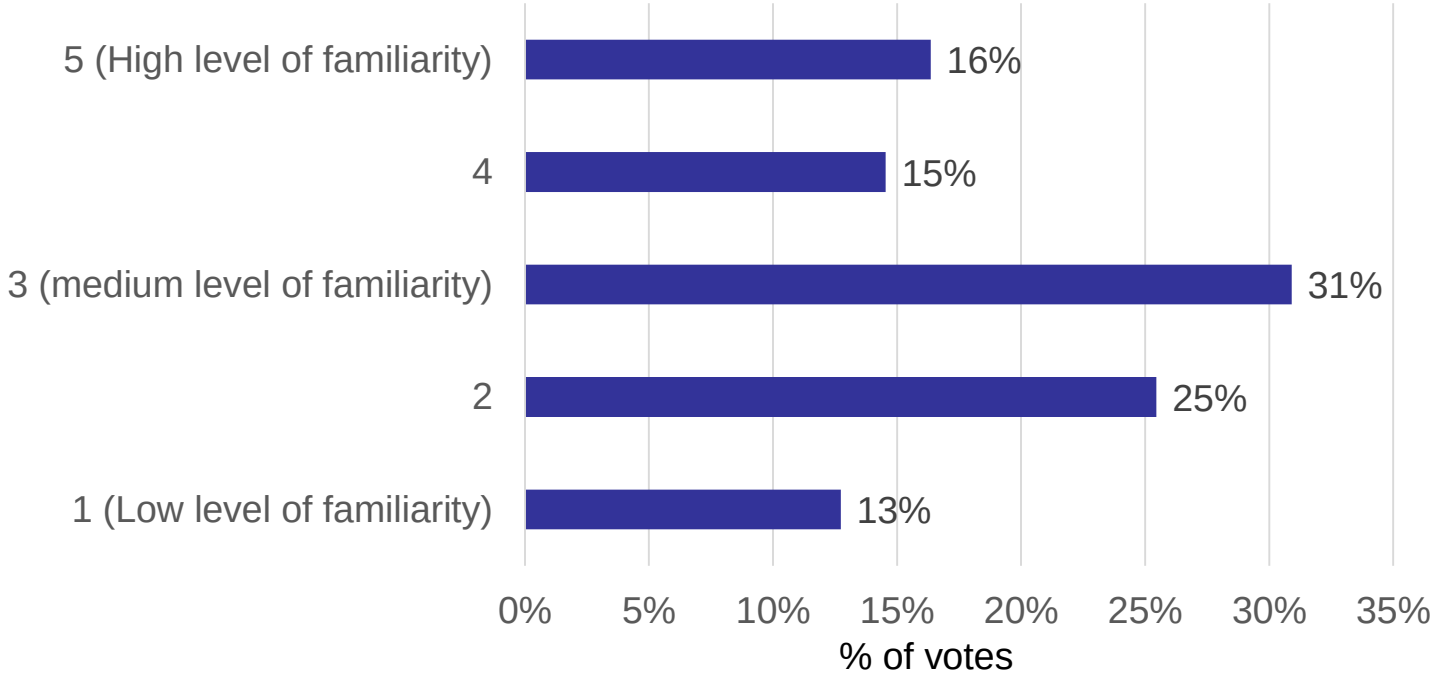
# Matching care models/programs to segment need

| CFS | Services/programs | Goal |
|---|---|---|
| **CFS 0-3** | • **Proactive** case finding and documentation of frailty status in primary care<br>• **Self-management support** and programs that support healthy aging (e.g., vaccination, social, diet/nutrition, promote activity, optimize medication)<br>• Screen for **social determinants of health**<br>• Follow-up after ED visits | **Support older adults in healthy aging** |
| **CFS 4-6** | • **Proactive** case finding and documentation of frailty status in primary care<br>• Additional assessment, **care planning, and care coordination** for those screening CFS 4-6<br>• **Team based care supports**<br>• **Support for caregivers** | **Slow and reverse frailty progress, support older adults in healthy aging** |
| **CFS 7-8** | • **Home care and care planning** (interRAI)<br>• **Comprehensive** geriatric assessment and care planning<br>• **Assess for palliative** | **Coordinated, supportive care for older adults with higher needs.** |
| **CFS 9** | • **End of life care**<br>• **Caregiver supports** | **Comprehensive physical, psychosocial and spiritual care for patients and families** |

# Poll: How familiar are you with ways to co-design care models with patients and caregivers?

## (1 being low level of familiarity and 5 being high)




***62%*** *of participants indicated they had a medium-high level of familiarity with co-designing care models with patients and caregivers while* ***38%*** *had a lower level of familiarity.*

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# Co-designing Care: Including the Patient Experience

Dr. Kerry Kuluski, Dr. Mathias Gysler Research Chair in Patient and Family-Centered Care

- Opportunity to build and strengthen relationships among your OHT partners and communities (including underrepresented populations)
- Explore care models and tailored approaches to care for your specific OHT populations
- **Virtual World Café** session with interactive break-out sessions
  - Explore key questions
  - Identify core components of care delivery models, barriers and facilitators to implementation

This article illustrates how to use co-design through world café methods including with patients, care partners and care providers.
https://pubmed.ncbi.nlm.nih.gov/32602628/

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# Co-designing Care: Including the Patient Experience

- For each priority population – develop 2-3 “vignettes” to reflect a range of characteristics/needs
- Use these vignettes as a communication tool to spark conversation among your partners (care providers, patient and caregiver partners, volunteers, organizational leaders)
- Develop optimal care packages/service design
- Work with your community partners to determine optimal ways to include underrepresented populations / have dedicated sessions for BIPOC

This article provides an example of segmenting data from homecare data and using vignettes to develop care plans with care providers.
https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2524.2012.01064.x

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# Co-designing Care: Key considerations

## Enlisting and Preparing Patients

E.g., expectations set and reviewed between staff and patient partners; barriers to engagement known and addressed; experienced patient partners paired with new patient partners.

## Ensuring Leadership Support and Strategic Focus

E.g., core value, distributed leadership model, addressing power dynamics and understanding why they need to shift, dedicated resources for patient engagement including with underrepresented communities, engagement linked to longer term strategy

## Engaging Staff to Involve Patients

E.g., Education and training provided for staff on how to engage inclusively; staff can articulate purpose of why they are engaging with patient partners; taking the time to build relationships and trust.



Source: Engagement Capable Environments Framework, Baker & Denis (2006)

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# Co-designing care models themes from questions and answers

**How do you combine physical and social frailty** (ability to afford medications etc.)**?**

- It's important to take into consideration all aspects of a person's physical and social context that may affect health and well-being.
- Specific to frailty, there are many different tools and approaches for carrying out frailty assessment and care in community. And, there are many additional assessments that care teams may decide to include as part of standard care processes that aim to understand needs and support needs based care planning and delivery.
- A good resource for OHTs seeking to assess frailty is the Healthcare Excellence Canada's (HEC) Advancing Frailty Care in the Community Collaborative. A number of primary care sites in Ontario are participating in this effort to improve frailty care finding, assessment, and care.

**How does the patient-co-design approach differ from QI approach in which patients are on the QI team?**

- They are not different approaches as within QI, care processes need to be co-designed and tested. The language of "co-design" emphasizes the importance of involving many perspectives including patients, families, caregivers, providers and community both in QI and in the design of care models.

**How do we encourage patients/caregivers who are hesitant to engage in the co-design process?**

- It is helpful to meet with patients/caregivers in advance and to understand from them what is necessary to create an environment where they feel safe to explore the challenges they are encountering. This includes understanding what barriers they may face to engage (e.g. the language used) and what formats work best for them.

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# Upcoming events

## Webinars:

- **HSPN OHT Improvement Measures from Health Administrative Data (March 23rd, noon-1:10pm):** Where are OHTs Starting From? (https://hspn.ca/evaluation/oht/)
- **RISE PHM core concepts webinar #3 (May 6th, noon-1pm):** topic to be determined based on today's discussion and feedback received from OHTs (https://www.mcmasterforum.org/rise/join-events)

## Cohort 1 activities:

- **Virtual collaborative session #2** (week of April 5th):
  - Cohort 1 working group leads to complete survey for preferred date
  - **What will it help me do?** it will help you to think about how to build care models which meet the needs of all segments of your priority population.
  - Registration: please contact Leslie McGeoch (Leslie.McGeoch@thp.ca) or your coach

- **Online collaborative discussion space** (available anytime):
  1. Visit the OHT Collaboratives platform and click the "Sign Up" button.
  2. Join the collaborative of your choice (or join all 3!) by clicking on the "Join Group" button:
     - Older Adults and Chronic Diseases Collaborative
     - Mental Health and Addictions Collaborative
     - Palliative Care Collaborative

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# Population-health management (PHM) resources

**A detailed article of today's example on co-designing care models**

- Frailty screen and case finding for complex conditions

**RISE supports:**

- Resources by priority population
- **January** webinar, deck and one page summary including an overview of the RISE PHM resource for OHTs
- **Additional webinars on PHM:** Spring 2020 and Fall 2019
- **For PHM feedback and questions**, please also connect with your coach or Leslie McGeoch (Leslie.McGeoch@thp.ca)

**Segmentation and evaluation supports**

- HSPN (including additional PHM resources)

**Supports by priority population**

- **Older adults with greater needs**
  - Provincial Geriatrics Leadership Ontario (PGLO):
- **Palliative approach to care**
  - Ontario Palliative Care Network (OPCN) including the Palliative Care Health Services Delivery Framework
- **Mental health and addictions**
  - Centre for Mental Health and Addictions Provincial System Support Program: including the Ontario structured psychotherapy program

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# Resources for OHTs when engaging patients and caregivers

- **The Ontario Caregiver Association** create a healthcare provider resource center including a section dedicated to co-design
- **The Change Foundation created** an inventory of co-design resources
- **The Centre for Excellence on Partnerships with Patients and the Public** developed a competency framework for collaborative practice and patient partnership in health and social services and an Evaluation Tool-Kit
- **The Indigenous Primary Health Care Council (IPHCC)** developed a toolkit to support safer health system environments for Indigenous people in Ontario
- **RISE briefs** with many additional resources by priority population are listed under building block #3
  - RB 15 on population-health management (PHM) for people with chronic conditions
  - RB16 on PHM for people with mental health and addictions issues
  - RB17 on PHM for older adults with greater needs
  - RB18 on PHM for people who could benefit from a palliative approach to care
- Assessing Organizational Readiness for Patient Engagement (BC VOICES Network)
- **HSPN** created a Practice Guide for Understanding and Partnering with Patients and Care Partners
- **McMaster** created Public and Patient Engagement Evaluation Tools which consist of 3 questionnaires (participant level, project level, and organization level)

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# Additional resources shared in the chat box!

**Equity engagement**

- The CCO created framework for equity engagement. You can find the document here: https://www.ccohealth.ca/en/what-we-do/person-centred-care/equity-engagement.

**Older Adults and chronic disease**

- Additional support for using the CFS for segmentation can be found at https://rgps.on.ca/wp-content/uploads/2021/03/2021-OHT-Fact-Sheet-Segmenting-the-population-vMar-1.pdf
- Frailty estimates by census division are available at https://rgps.on.ca/resources/frailty-estimates-by-census-division-and-ontario-health-region/
- Training to use the frailty tool available at https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale/cfs-guidance.html

**Palliative Care**

- For teams that have identified palliative care as a focus, the OPCN has developed a model of care that can be leveraged to integrate palliative care into your service delivery planning: https://www.ontariopalliativecarenetwork.ca/resources/health-services-delivery-framework
  - It also includes a patient pathway: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/2021-01/OPCNPatientPathwayFigure1.pdf

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# THANK YOU!