RISE
Rapid-Improvement Support and Exchange

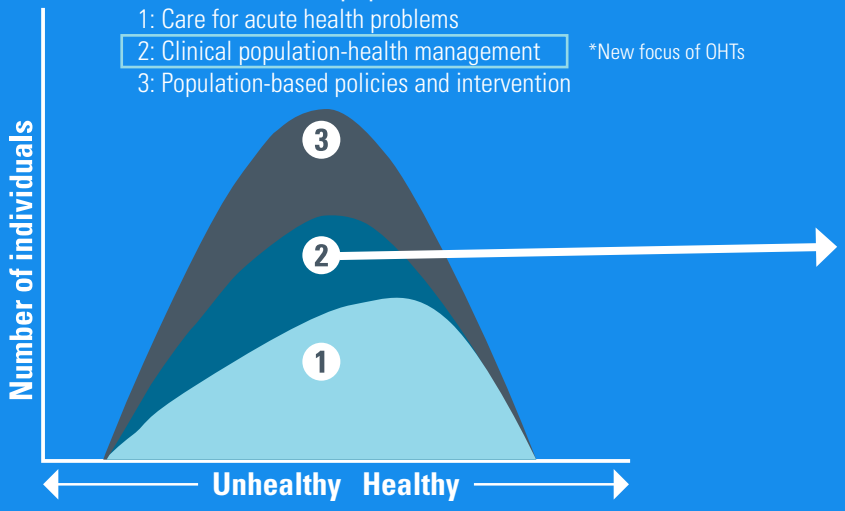
Population-health management
Snapshot of the webinar from 21 January, 2021

Click here to access the webinar recording

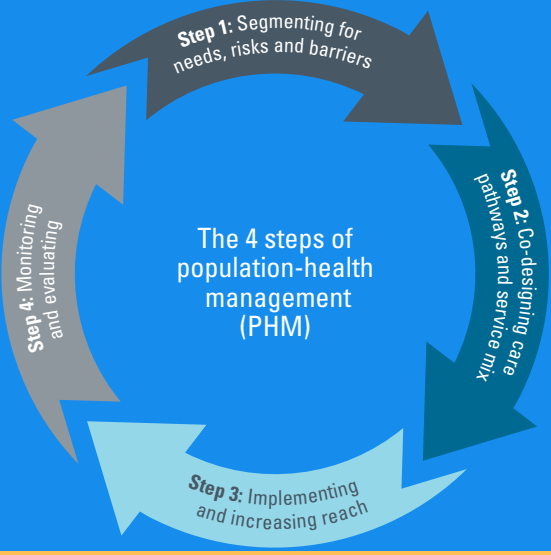
Core concept and principles

* Click here to read RISE brief #6: Population-health management

The "3 curves" of population health
1: Care for acute health problems
2: Clinical population-health management *New focus of OHTs
3: Population-based policies and intervention



Washington AE, Coye MJ, Boulware LE. Academic health systems' third curve: Population-health improvement. JAMA 2016; 315(5): 459-460.



RISE's population-health management supports for Ontario Health Teams

To support Ontario Health Teams (OHTs) to understand, plan and implement a population-health management (PHM) approach with their priority population(s), RISE is offering three types of supports.

1

Webinars

- **What:** foundational PHM concepts and principles
- **Who:** open to all
- **When:** monthly (1hr)

2

Coaching sessions

- **What:** One-on-one PHM coaching
- **Who:** OHT admin leads/ priority population working groups lead
- **When:** bi-weekly (1hr or as decided with coach)

3

Virtual collaborative meetings

- **What:** facilitated discussion by priority population to share learnings and solve problems with other OHTs and coaches
- **Who:** OHT admin leads/ priority population working groups lead
- **When:** monthly (1.5hrs)

+

Online PHM collaborative discussions

- **What:** by priority population, share learnings and solve problems together as a group
- **Who:** OHT admin leads/ priority population working groups lead
- **When:** on-going/anytime
- **Where:** OHT collaboratives website

Coaches


Christina Clarke


Christina Southey


Connie Davis


Lorri Zagar

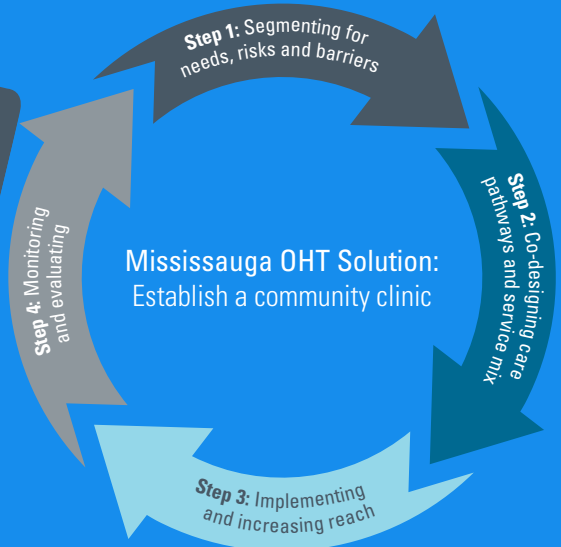

Mike Hindmarsh

Example of a population-health management approach: Mississauga OHT cough and flu clinic

Challenge

Physicians face barriers in providing in-person assessement/ treatment for patients with COVID-19 symptoms (e.g. PPE supplies, staffing, IPAC)

Patients seeking testing at assessment centres had lack of continuity of care between alternative sites and regular providers



1. Prioritized those experiencing symptoms of COVID-19 needing in-person care but unable to see their own provider
2. Developed cough and flu clinic with five OHT partners , led by primary care
3. Partners provided clinic space, managed setup and operations, and recruited community primary care physicians to staff it
4. Developed key performance indicators that measured clinic use, the overall effectiveness of the clinic and were easily extractable from EMRs (e.g. volumes, % swabbed, % positivity)

Next steps:

Based on learnings to date, iterate the 4 steps of PHM - Use data (including postal code analysis) to relook at population segmentation and target outreach to address emerging "hot spots"