Dalla Lana
School of Public Health

OHT Governance Oversight to Achieve Population Health Goals

“Deep Dive” Workshop for OHT Leaders

November 30, 2022

Institute of Health Policy, Management and Evaluation
UNIVERSITY OF TORONTO

ADVANCE Program

Accountability, Shared Leadership and Governance

Land Acknowledgement

ADVANCE Program Faculty

Mike Hindmarsh, Senior Leader with the Centre for Collaboration, Motivation and Innovation, is an established healthcare improvement consultant offering strategic planning, project direction, and technical assistance for implementing chronic disease programs in primary, specialty and ancillary care settings. His expertise includes quality improvement system redesign, training in patient self-management support, quality measurement techniques and practice coaching.

Paula Blackstien-Hirsch is a consulting facilitator and coach who focuses on Governance, Leadership and Quality Improvement across multiple sectors. She was core faculty for the Masters in Quality and Safety, University of Toronto for many years, is a member of the Sinai Health Board where she also Chairs the Board Quality Committee, and currently serves part-time as Quality Improvement Consultant with IHI, supporting 25 North American Sites focused on improving outcomes for Autism.

G. Ross Baker is a professor in the Institute of Health Policy, Management and Evaluation at the University of Toronto and was founding Program Lead in Quality Improvement and Patient Safety at IHPME. Ross had led a number of projects in Quality Improvement and Patient Safety and was Co-Lead for the IDEAS program (Improving and Driving Excellent Across Sectors). He currently chairs the Quality and Safety Committee for the UHN board.

Objectives for Today

- To provide leaders with a high level overview of the population health approach to improving patient/client outcomes;
- To explore an approach that translates strategic directions/priorities into specific, measurable population health aims, with associated outcome measures, to establish a foundation for effective and aligned involvement of Working Groups; and,
- To explore options/methods for leadership oversight of progress on achieving population health outcomes at various stages of initiative maturity.

Virtual Meeting Etiquette

- **Video** on (unless connection issues)
- Microphones **muted** unless speaking
- Scheduled feedback opportunities
- Disruptions & distractions happen

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OHT Integration and Leadership Support of Population Health Management

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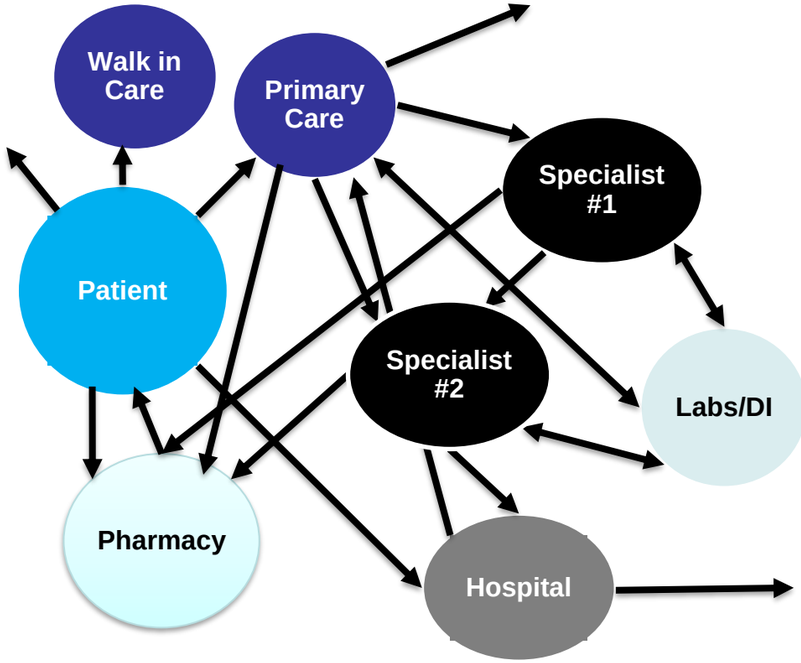
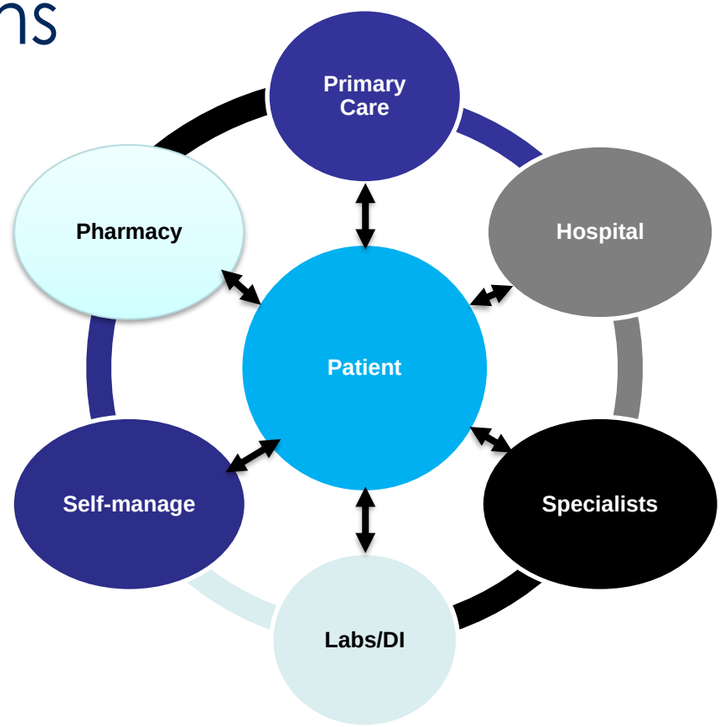
OHT Transformation: Introduction to Integrated, Accountable Local Care Systems





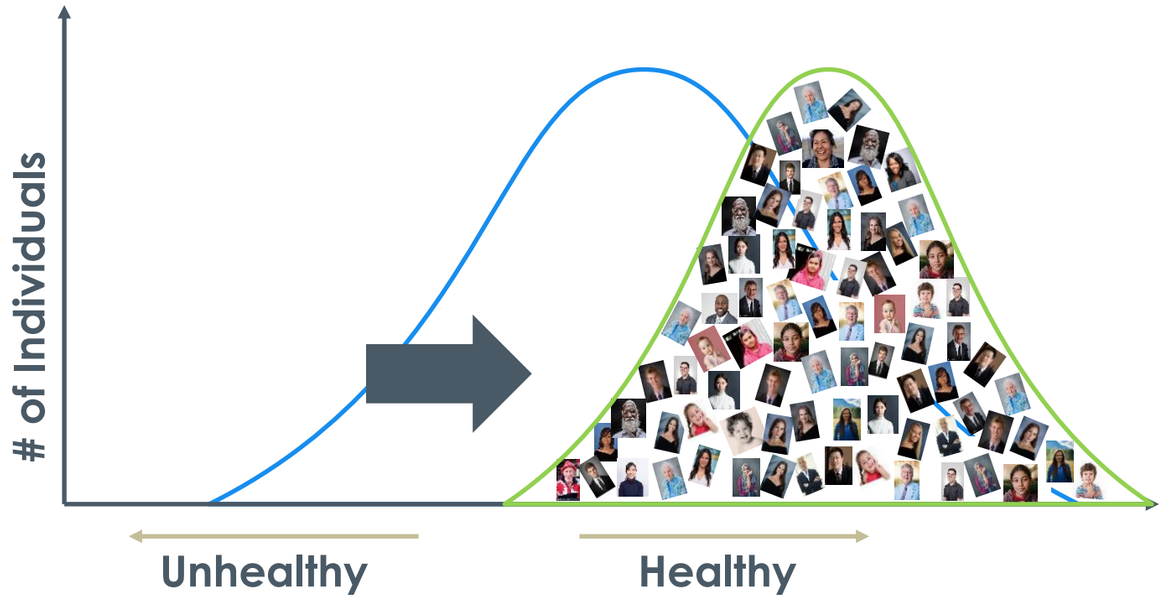
Population Health – the health outcomes of a group of individuals, including the distribution of such outcomes within the group and includes health outcomes, patterns of health determinants, and policies and interventions that link these two.

Kindig-Stoddard 2003

Population Health Management – Population health management refers to the process of improving health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models.

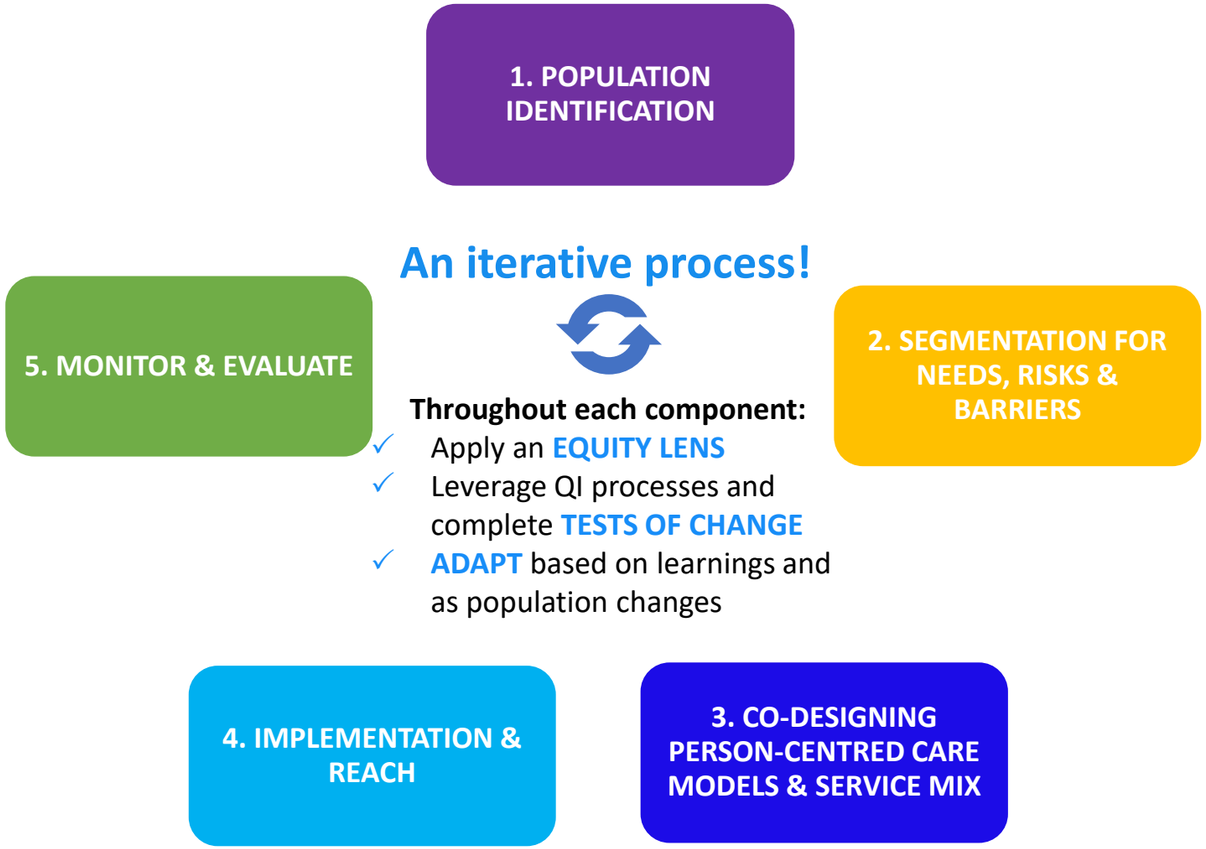
AHA Center for Healthcare Innovation

Strategies to **shift and squeeze the curve** & **reduce inequities**



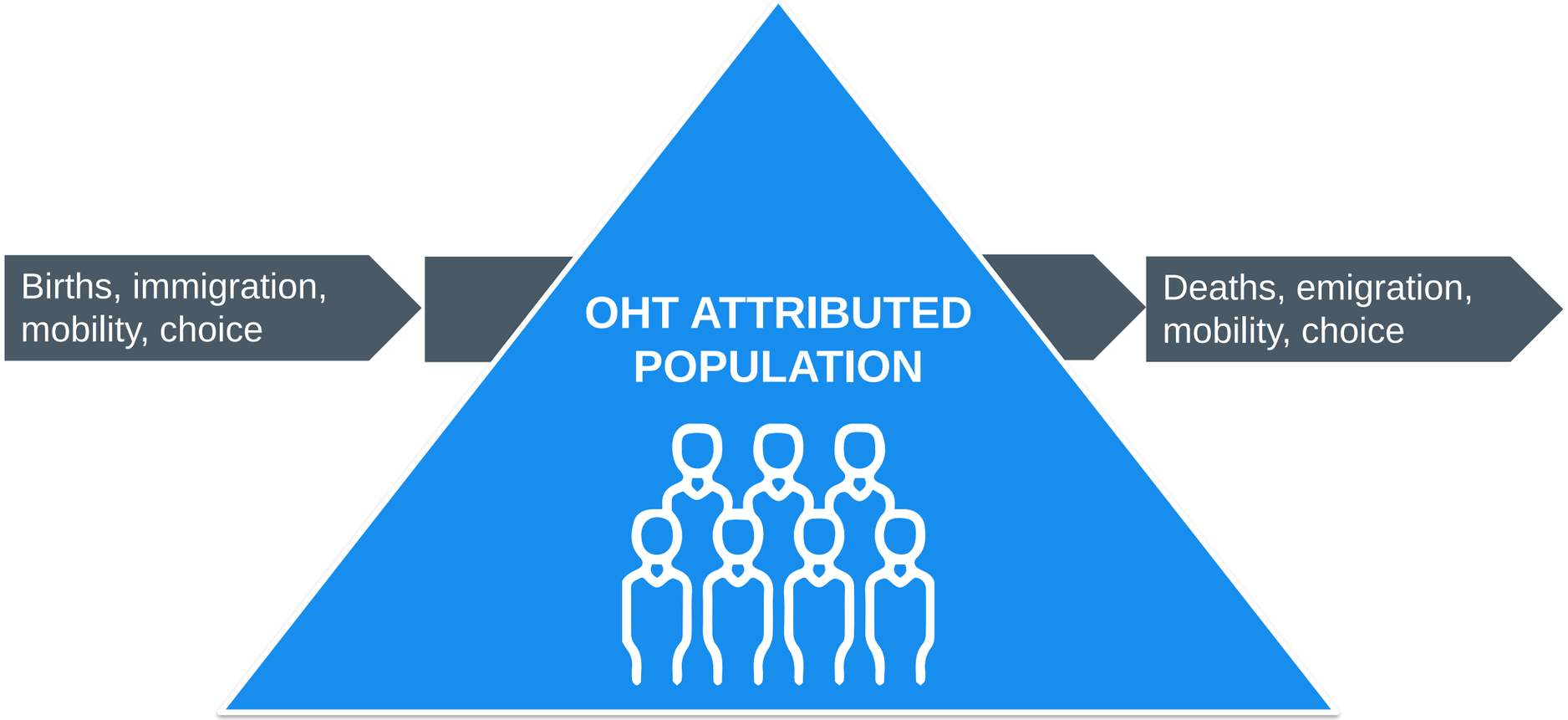
"LEAVE NO ONE BEHIND" & TACKLE THE "INVERSE CARE LAW"

Steps in population-health management



Source: Adapted from Population Health Alliance, 2012

Population Identification: OHTs & Their Attributed Populations

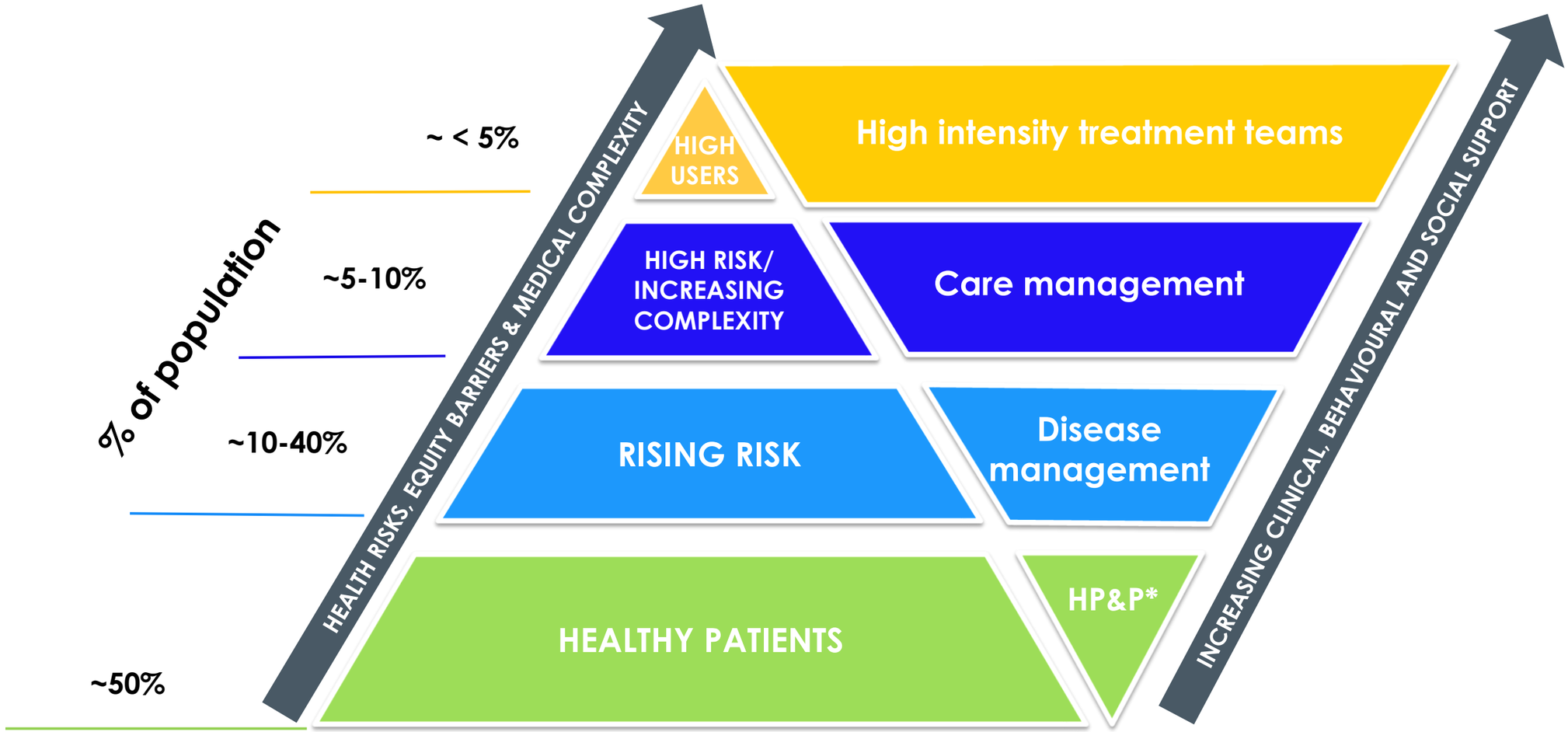


Keep the Full Population in Sight
Population is Continually Evolving

Segmentation for population-health management

- A process of **understanding** why the health of groups is not optimal
- Involves **using data and knowledge** to understand how systems, processes, medical care, and patient factors influence an outcome

OHT Long Term Goal: Integrating Care for Full Attributed Population

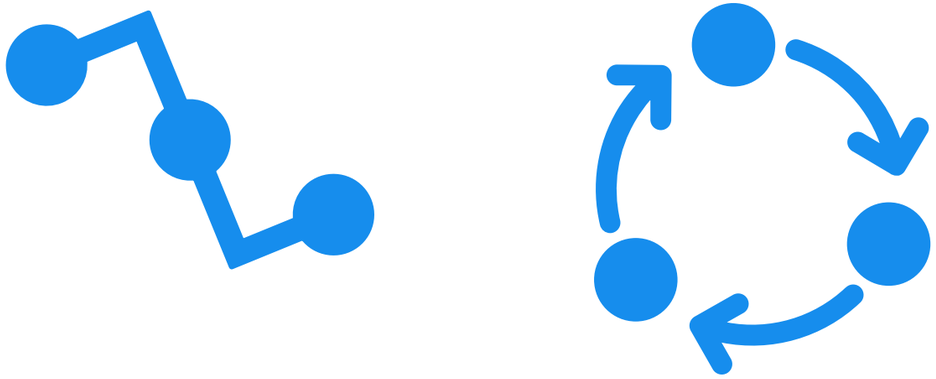


* Health promotion and prevention

Co-designing Care Models

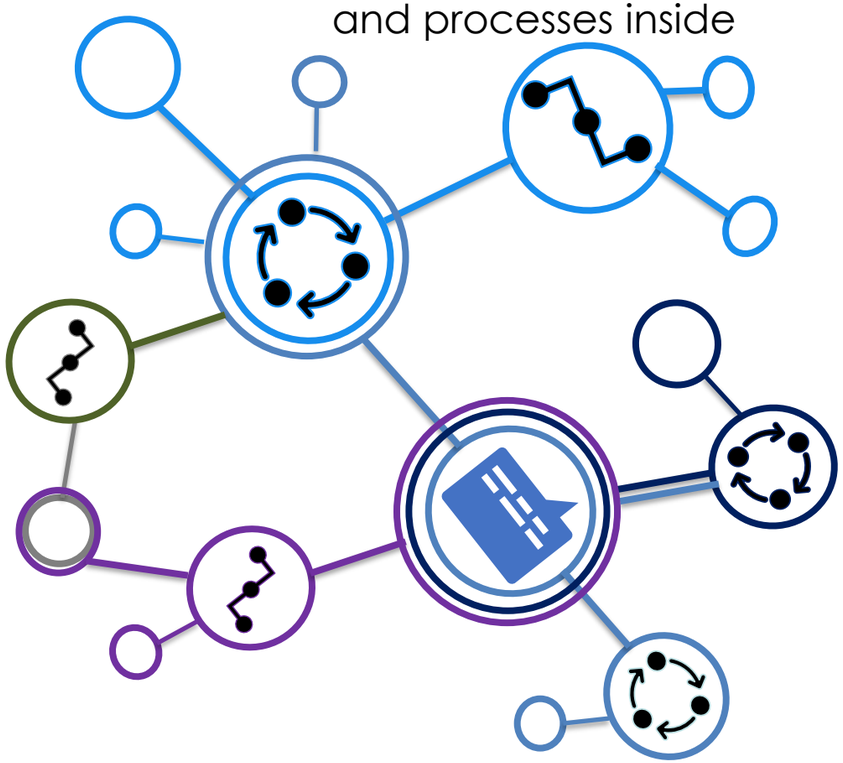
Care pathways

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



How might we understand current state?

- **SCENARIO 1: Change can be accomplished within existing system structure**
  - *Do we know of all the services currently available in our communities and if they are being utilized in the best way?*
- **SCENARIO 2: Change requires redesign of existing system**
  - *Could an existing program meet the needs identified through scale up, expansion to new population groups or other adjustments to the model?*
- **SCENARIO 3: Change requires building a new system to improve care**
  - *If "no" to scenario 1 and 2 then move onto scenario 3, but only if we know there aren't existing services that can be leveraged first.*

Co-designing Care Models

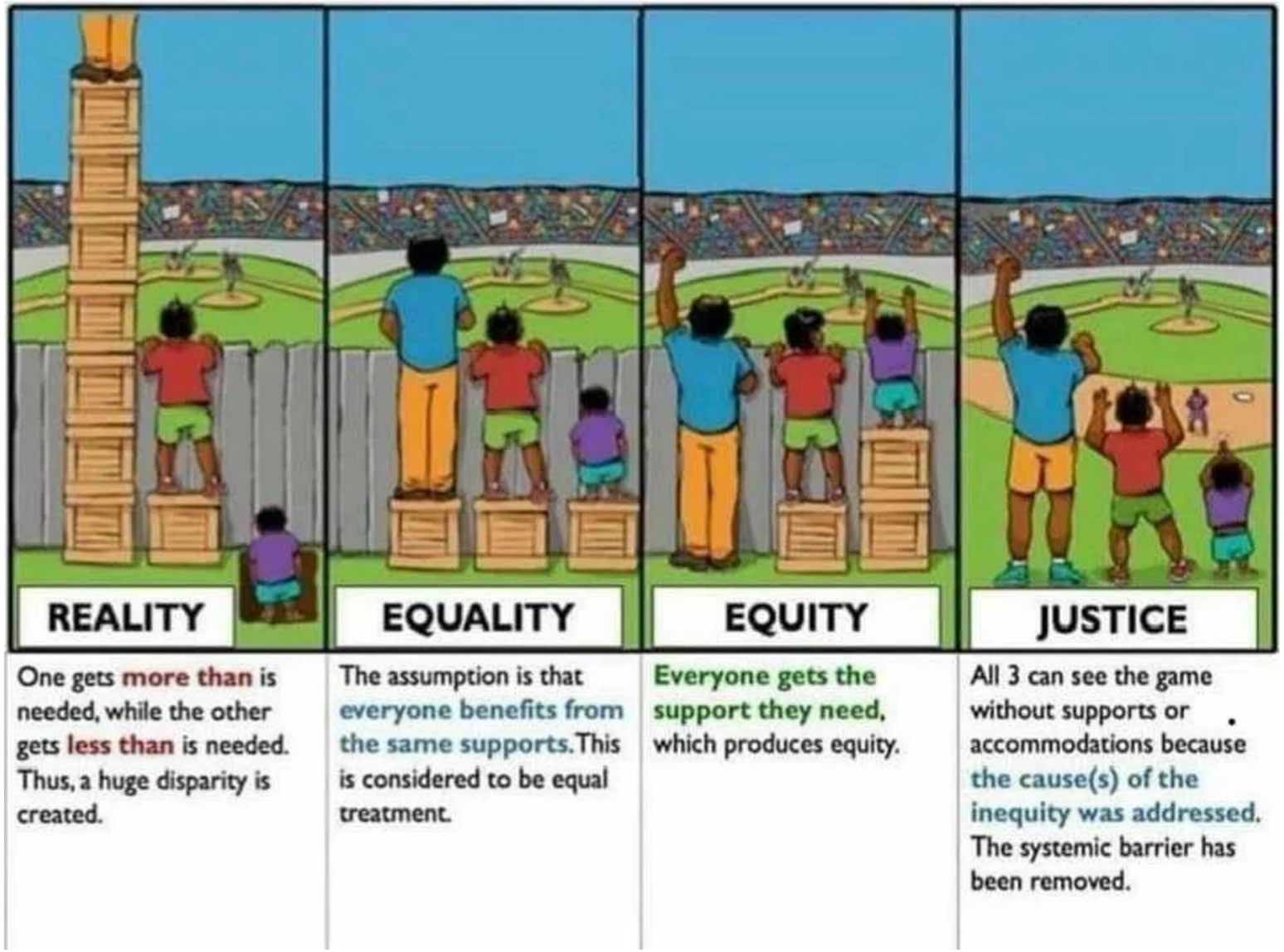
Co-designing Care Model & Service Mix: System Redesign Concepts to Build the Infrastructure for an Integrated System of Care

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

Testing is Critical

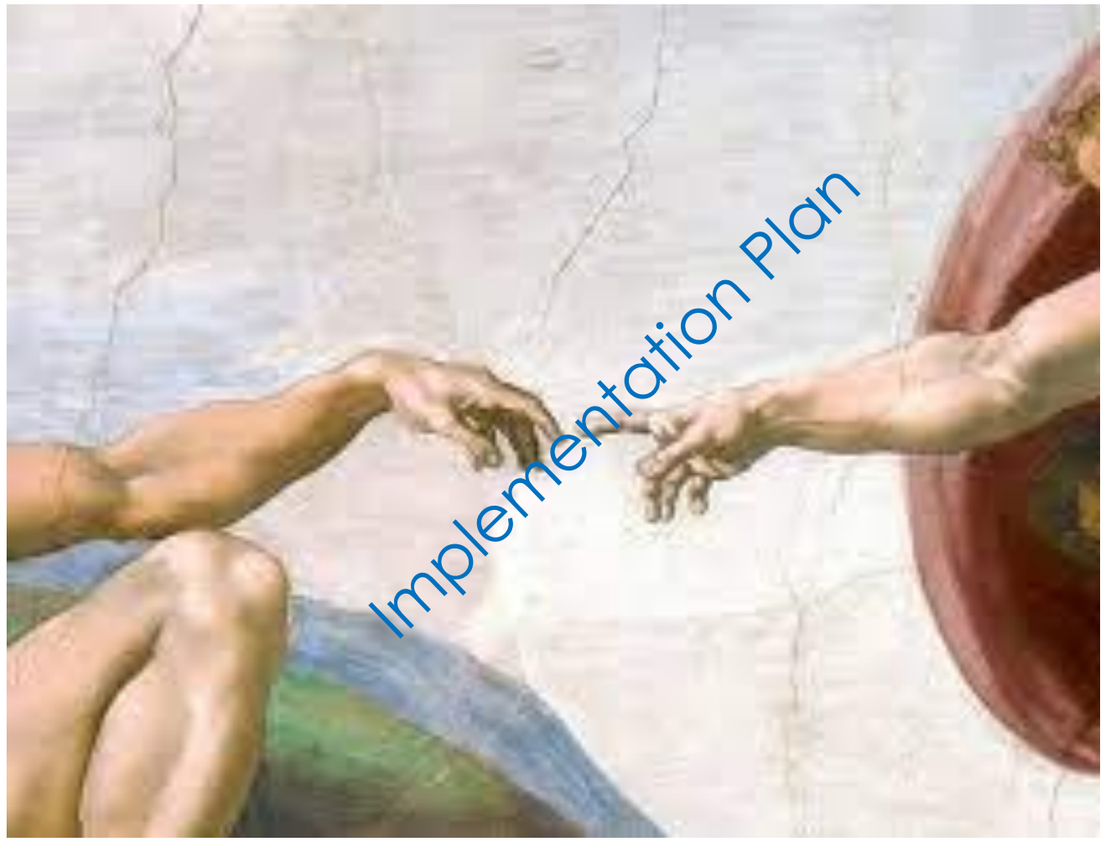
Uses of Equity Data

1. **Informing clinical care delivery**
   - ✓ Language/interpretation; cultural sensitivity; income supports
2. **Quality Improvement**–
   - ✓ Analyze/profile who is being served
3. **Care model planning and design**–
   - ✓ Illuminate gaps in service specific to certain population segments
4. **Evaluation/Research**
   - ✓ Confirm whether interventions are reducing disparities



Implementation & Reach

- ✓ Jumping to implementation before testing is common
- ✓ Do not want failures when implementing
- ✓ Must test during co-design
- ✓ Must also test reach model
- ✓ Develop sustainability plans to avoid returning to old ways



Monitoring & Evaluation

- Revise logic model/driver diagram based on your initial work
- Choose outcomes that **clinically and care process relevant**, **easily extractable** and are measurable as **part of routine care model**
- Perform on-going monitoring and evaluation at an **individual-level** and **system-level**

Some Leadership Questions for Reflection

- What is the balance between leadership and management to accelerate the integration of services to deliver PHM?
- Are your working groups “charged” to do Population Health Management?
- Do your Boards and Collaborative Councils understand Population Health Management?
- How do you manage directives/developments that may “distract” from the PHM imperative?

BREAKOUT SESSION

- *Breakout will focus on how you support a priority population working group that is struggling to make progress.*

- Setup:
  - The Mental Health and Substance Use Working Group cannot reach consensus on where and when to start screening for anxiety and depression: primary care is too busy, acute care is swamped, and long-term care/home care are willing but only touch a small portion of the sub-population.
  - As a Leadership Council, how can you assist the Working Group lead(s) and the Executive Lead (backbone support) to move forward?

  - *Assign a facilitator and a recorder (15-20 min for discussion)*

Poll – Given your experience to date, would you…?
(choose one)

1. Stay the course
2. Reboot and start again differently
3. Pause, take stock and modify your approach
4. Accelerate existing work
5. Not sure

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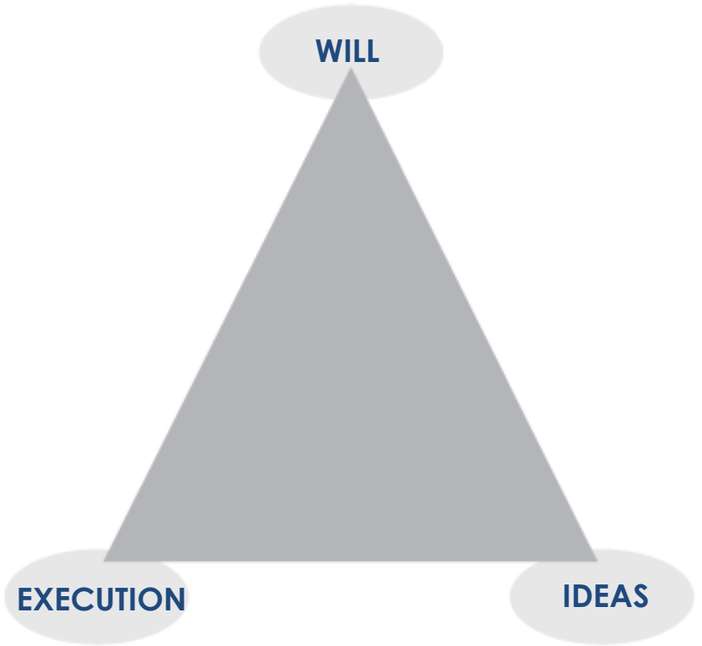
WILL, IDEAS, & EXECUTION:

Translating Goals to Measurable Aims, Outcomes and Aligned Initiatives



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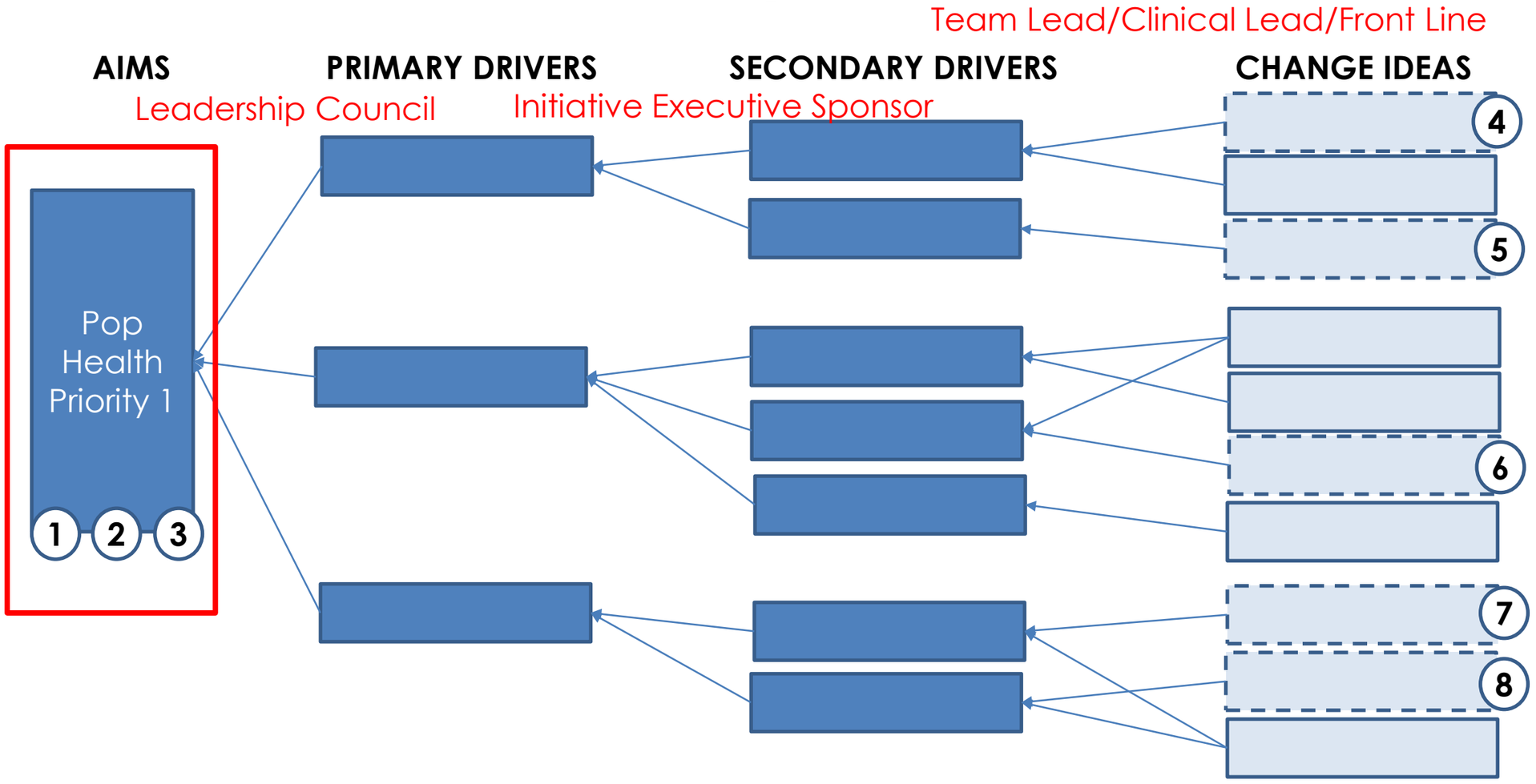
Relevance of the Framework to OHTs

- **WILL:**
  - At all levels, but especially senior leaders
  - Make new ways of working attractive, status quo uncomfortable

- **IDEAS:**
  - Redesign of care delivery
  - How work gets done, how relationships are built, how patients/family & providers are engaged

- **EXECUTION:**
  - Need a portfolio of aligned initiatives to achieve system-level results
  - Leadership oversight is critical to success

Driver Diagrams: a tool for strategic alignment of aims, measures and activity



Measures

Outcomes

1.
2.
3.

Process

4.
5.
6.
7.
8.

Starting with Population Health Priority Aims

Typical Aim:
We aim to improve outcomes for individuals with COPD.

SMART AIM
- How much?
- By when?
- As measured by?
- (for whom?)

Revised Aim *(High Level Aims are generally multi-year):*
By March 31, 2025, we will have:
- decreased hospitalizations for individuals with COPD by 20%; and,
- decreased significant respiratory illness for those at-risk for COPD by 30%.

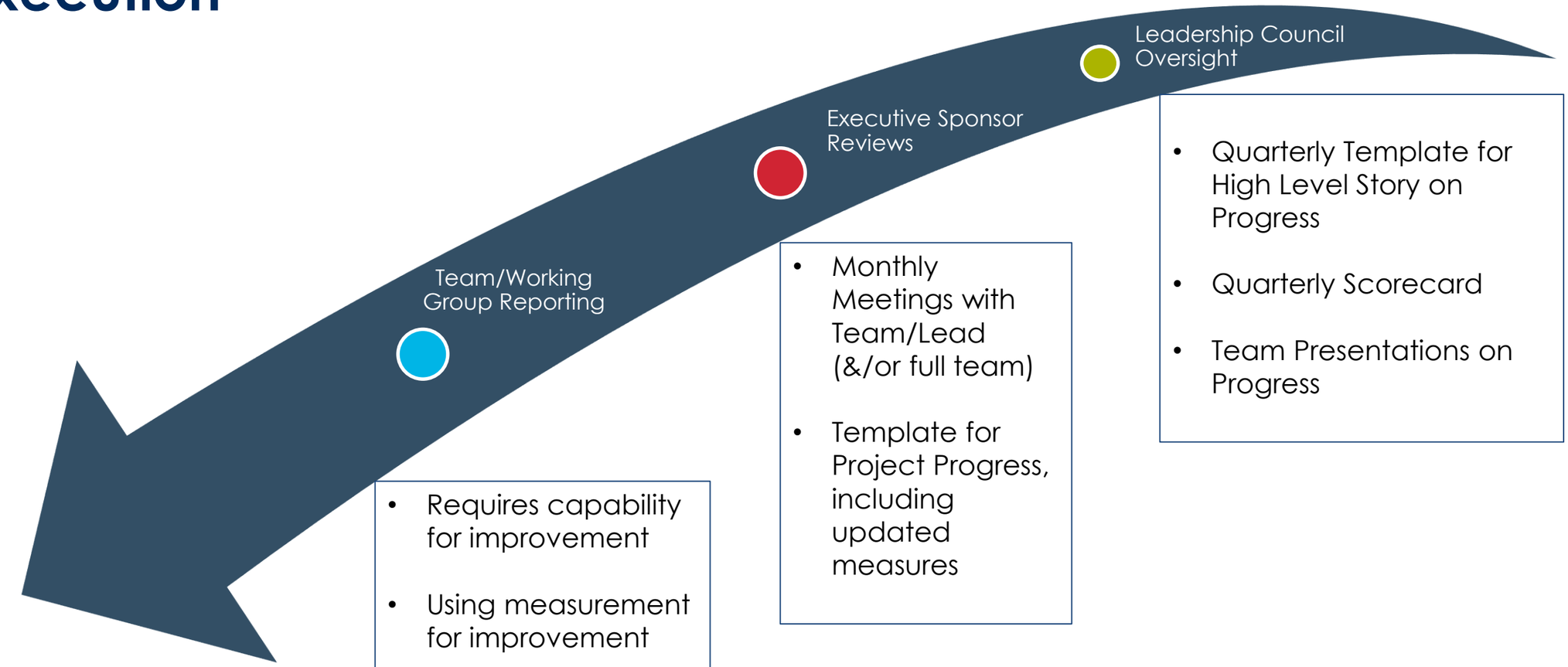
Agreement on Targets for Outcome Measures is part of the Leadership role

- Based on:
  - Organization's own experience
  - Other organizations in the top 10th percentile, top 25th percentile
  - Best in class
  - Theoretical best (e.g. "0 defects")
  - "Half life" – 50% increases/decreases over a few years
  - Benchmarks

- 3-5 Year "Stretch" Targets vs Annual "Inspirational" Targets

- Balance between an inspirational "stretch goal" and ensuring teams are not demoralized by a target that is not within reach

Ensure enabling infrastructure & process to guide successful execution



- Quarterly Template for High Level Story on Progress
- Quarterly Scorecard
- Team Presentations on Progress

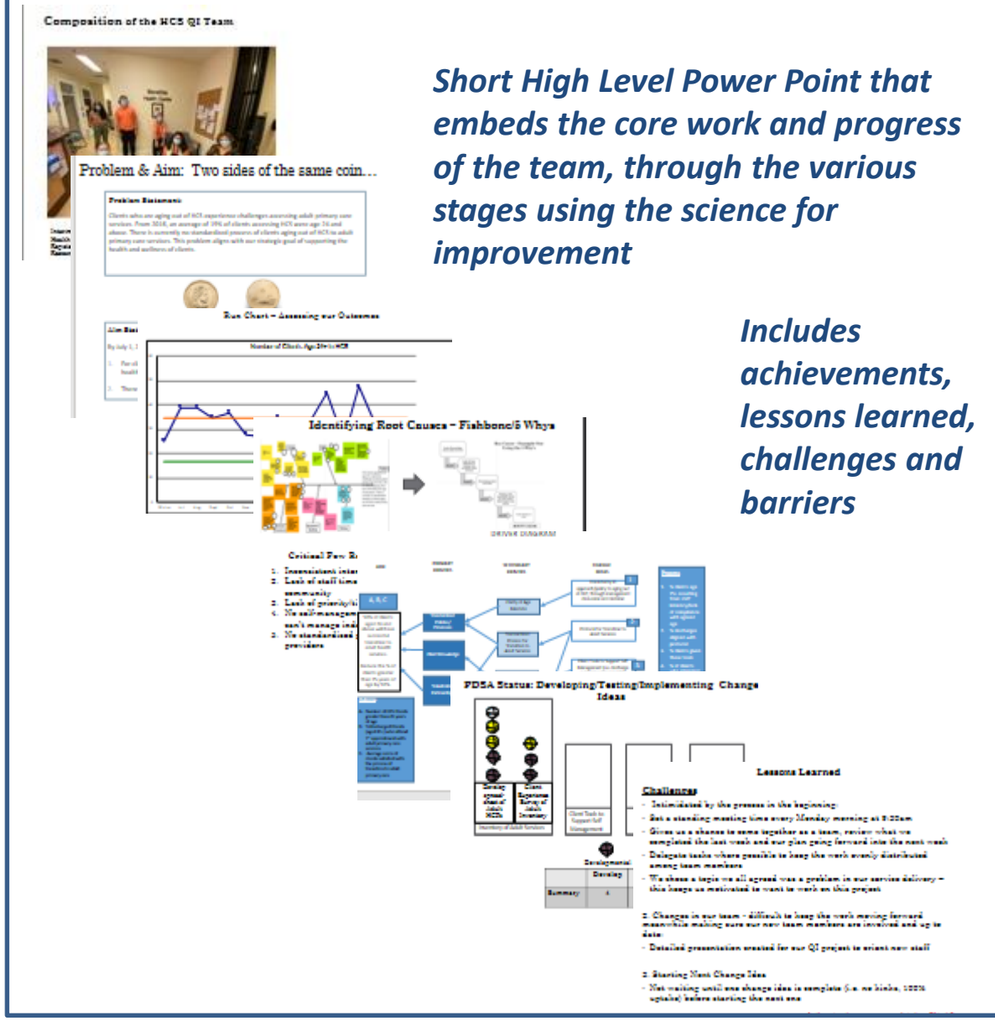
- Monthly Meetings with Team/Lead (&/or full team)
- Template for Project Progress, including updated measures

- Requires capability for improvement
- Using measurement for improvement
- Ideally meeting regularly to progress the work

QI Resource from Backbone **Learning/ Problem Solving Culture**

Leadership Council Templates for Oversight

Useful earlier on when outcomes have not been impacted;
Also useful for Leadership Council spotlight presentations



Short High Level Power Point that embeds the core work and progress of the team, through the various stages using the science for improvement

Includes achievements, lessons learned, challenges and barriers

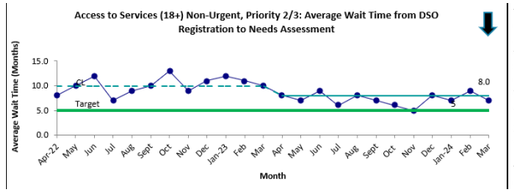
Useful and meaningful further along in the maturity of the OHT

SCORECARD

Colour –coded Dashboard – Quarterly Results with Baseline & Annual Target

Key Performance Indicators	Jan	Feb	March	Q1 Goal	Q1 Actual
Grow monthly Web 20% from 10,000 to 12,000	12,335	12,693	10,860	36,000	35,890
Increase organic traffic from 38% to 50% of overall traffic	41%	42%	47%	50%	43%
Maintain average time on page > 2minutes	1:48	1:51	1:50	2:00	1:50
Maintain bounce rate <60%	54%	53%	55%	10	54%
Increase Web lead conversion 20% from 1.8% to 2.16%	2.13%	2.16%	2.19%	2.16%	2.16%
Grow monthly inbound leads by 20% from 208 to 260	262	274	237	780	777
Grow monthly software evaluation downloads by 20% from 50 to 60	58	61	60	180	179
Consistently execute to the content marketing plan	✓	✓	✓		✓

Graph with Monthly Data Over Time and Accompanying Narrative



The average wait time for all clients from date of registration to date that DSO refers out to community service agencies was 10.0 months for the baseline 2022/23 fiscal year and decreased to 8.0 months over the past fiscal year. Although the decrease represented a statistically significant change, it has not been sustained for the past couple of months, and while moving in the right direction, it is not yet at the target level of performance. The key underlying factor in reducing the average wait time has been the removal of a bottleneck allowing for Needs Assessments to be conducted in a more timely way.

An EDI analysis demonstrates that there is no difference in performance levels for clients who are _____ & _____ .

The DSO team will continue to work on eliminating some of the other bottlenecks identified through the process mapping and timing analyses conducted.

Some Leadership Questions for Consideration

- Across our population health priorities, how many initiatives do we have capacity to support at a given time if we are going to achieve the annual targets we've established?
- What process was used to develop the Driver Diagram?
- What process was used to establish the multi-year and annual targets? Are they sufficiently aspirational? Are they too aspirational?
- Are we on track to achieve our aims? If not why not?
  - Do we have the appropriate resources and knowledge/skill allocated?
  - Are there barriers that are outside your span of control?
  - Is there an issue with provider engagement?
- How confident are you that we can achieve our annual target? Our multi-year target?
- What have we learned that we can apply to other priorities?
- How many patients do you have involved? How are you involving them?

BREAKOUT SESSION

- *Breakout will focus on a template that is more relevant to an Executive Sponsor review, but will highlight some important knowledge/considerations for all leaders.*

- Setup:
  - You receive a one page summary of Working Group progress a week before a scheduled meeting with the Working Group Leads, and as you review it, you write down some key thoughts and questions you will want to ask during your meeting with them in a few days
  - Review the one page summary and use the accompanying list of questions to guide you through your review

  - *Assign a facilitator and a recorder (25-30 min for review)*

Poll – Reflect on the practices discussed, and indicate those you currently have in place

- Population Health Working Groups each have an Executive Sponsor
- Population Health Working Groups include front line staff and managers
- Our population health Aims include “How much?, By when?, As measured by?”
- We have a process in place for reviewing progress on our aims at multiple levels on a regular basis (working group, executive sponsor, Leadership Council)
- We have nurtured a culture of problem solving and continuous improvement that encourages Working Groups to share successes and failures
- We have standardized templates for reviewing progress and results on outcome measures for our population health goals

Next Session – February 1st

Action Period (Dec 1st – Jan 20th) – Will be a Coaching Session based completely on submission of templates from the Action Period

Complete one or more templates (to be emailed to your key contact):

1. In terms of planning for future priority population aims, delineate what you would expect a Working Group to present to the Leadership Council in order for you to understand their rationale for selecting the priority population to focus on and to be comfortable with their approach to the work ahead.
2. Complete a Driver Diagram Template, including outcome measures to enable the Leadership Council to visualize and understand the alignment between all current OHT Priority Population activity and measurement.
3. Identify your current process(es) for overseeing progress on your Population Health Aims and the central resources (internal and external to the OHT) being used to support the work; indicate how you might change this infrastructure and process to better support the work in the future, based on the discussion today.

Will reach out to all OHTs within the next week to ensure we have sufficient involvement/action/commitment upon which to design an engaging coaching session. The greater your involvement in Application, the more you will benefit as an OHT.

Thank you!