Overview of Value Based Health Systems, Integrated Care and Population Health

Discussion Document

DRAFT: NOT FOR DISTRIBUTION

UNIVERSITY OF TORONTO
Baycrest is fully affiliated with the University of Toronto
Baycrest

A shared understanding of key concepts and common definitions allow teams to plan, write and operate together.

Topics:

- Global Challenge
- NT OHT Year 1 and Planning for Maturity
- Value Based Health Care
  - Integrated Care
  - Outcomes (Quadruple Aim)
- Population Health Management
  - Population Segmentation
  - Risk Stratification
- Key Enabler: Advanced Analytics and Digital Health

Global market forces are creating significant demands for change and provide the context for developing the ‘next generation’ of (OHT) health care delivery.

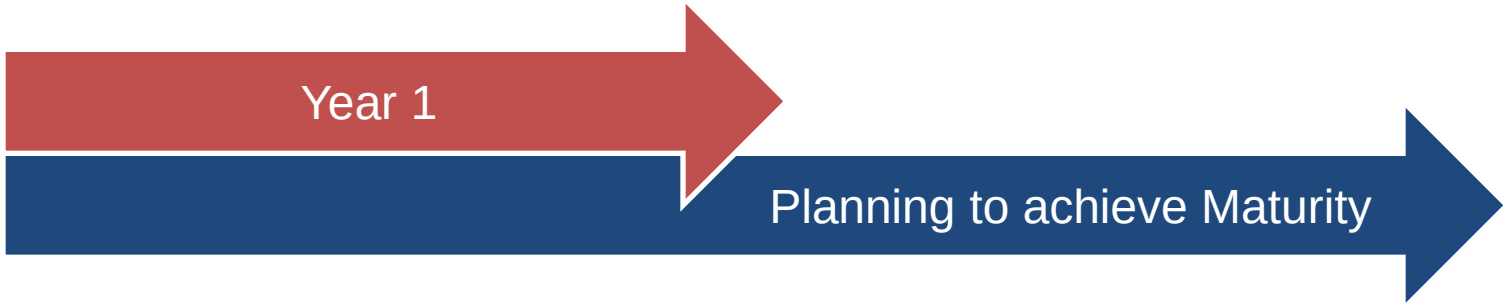
Consumer Expectations | Population Demographics | HHR Shortages | Data Management | New Technologies

System Focus	Individual Disease	Population Health
Reimbursement Models	Fee for Service	Value / Performance
Medical Information	Paper Based	Electronic Records
Data Analytics	Retrospective	Prospective, Big-Data
Provider Type	Physician	Inter-Professional Team
Location of Delivery	Hospital	Integrated / Virtual
Care Philosophy	Healthcare	Lifecare
Approach to Care	Illness Focus	Prevention

Adapted from: Baycrest Global Solutions

OHT planning teams will need to address both short term issues and develop a roadmap for longer term success. The path forward on each of these is different.

Planning for Maturity



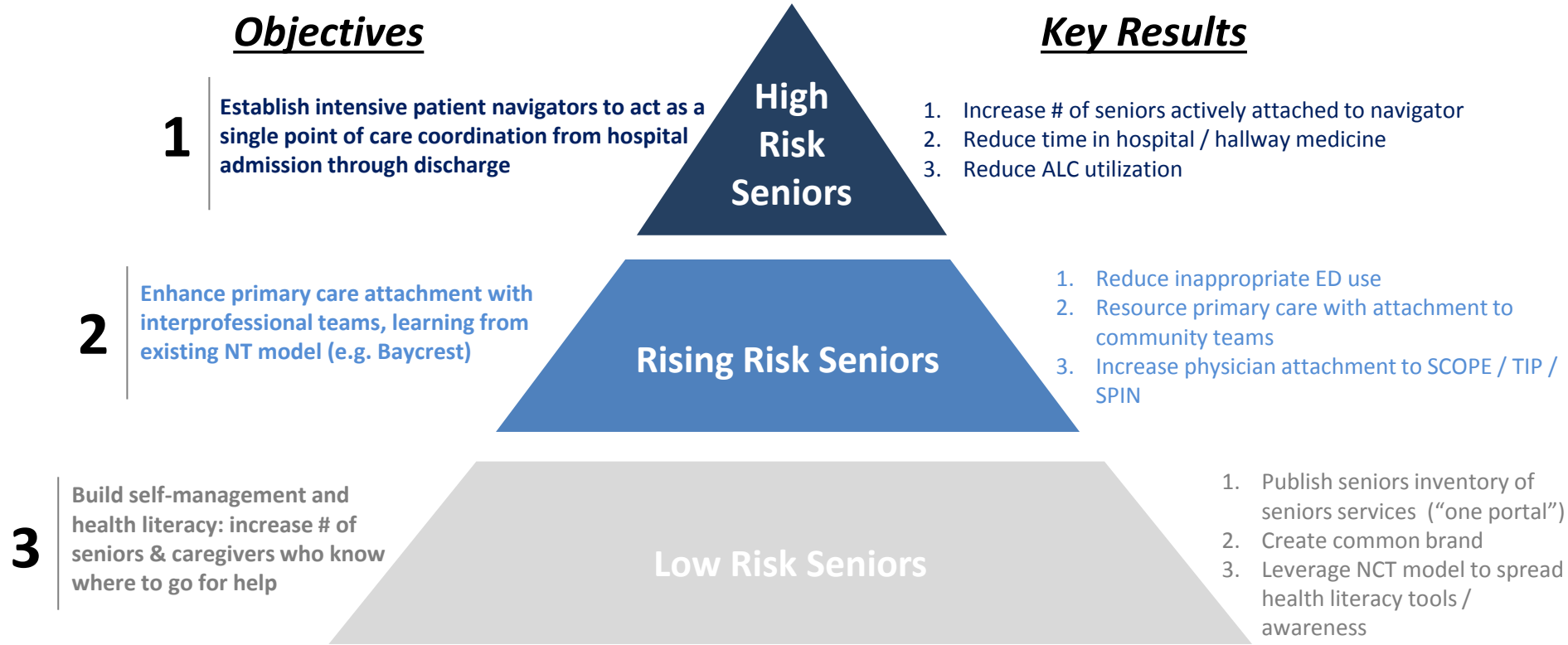
What **general structures** should we adopt / adapt?
How should we determine our **priority activities and timelines, beyond the Y1 priorities**?
How are we **resourcing** these streams?

**Slide from TCLHIN for North Toronto ELT Planning Table*

The North Toronto OHT Executive Leadership Team have developed a draft Year 1 focus with Objectives and Key Results

Guiding Principles / Key Considerations

- Focus our collective efforts on **frail seniors**
- Build on what we already **have established and working**
- **Simplify** programming / access and create **spread and scale**



**Slide from North Toronto ELT Planning Table*

Value-Based Health Care is a recurring theme in health care funding reform.

- “Value is defined as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes”.

  Michael Porter (October 2013). The Strategy That Will Fix Healthcare. Harvard Business Review, p. 4

- Value-Based Health Care is composed of two of the four aims in the quadruple aim:

  1. Better Health Outcomes
  2. Better Value and Efficiency.

Note: Value-Based Health Care appears in questions 2.4, 4.1, Appendix A and Appendix B

The IHI Quadruple Aim provides 4 key elements for Ontario Health Teams to consider.

Ontario Health Teams: Guidance for Health Care Providers and Organizations. http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf page 26.

Value-Based Health Care experts tell us that we have been measuring the wrong things. PROMS and PREMS are what matter to patients.

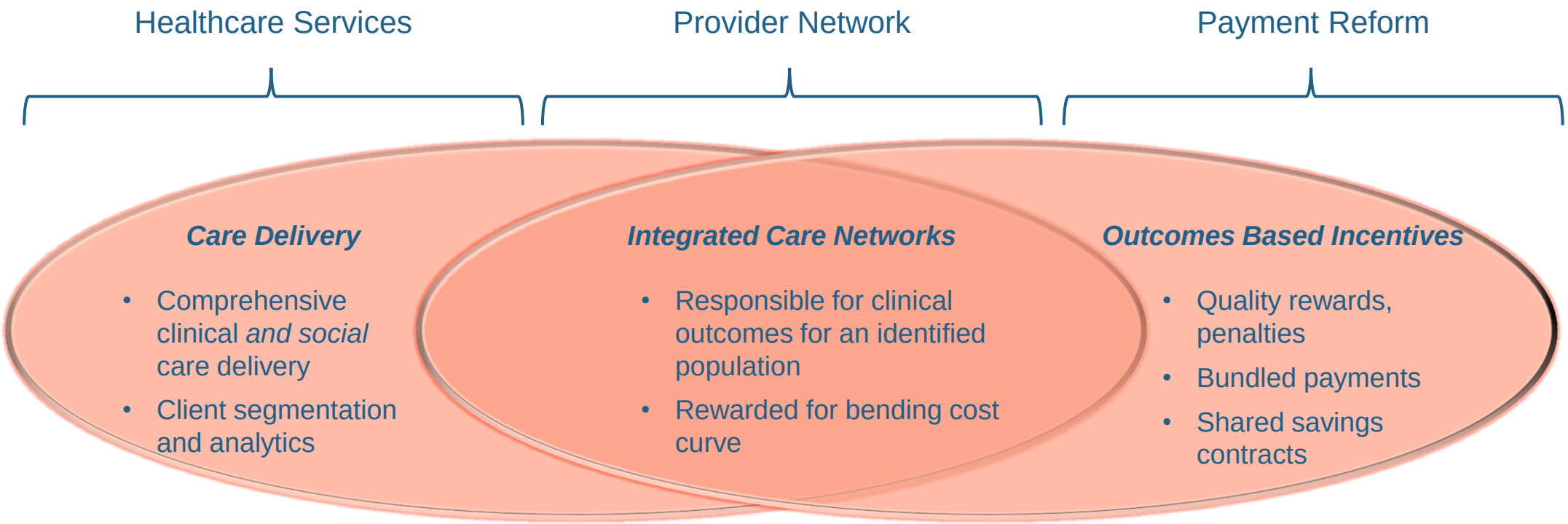
- "…the great majority of health care providers fail to track either outcomes or costs by medical condition for individual patients. For example, although many institutions have "back pain centers," few can tell you about their patients' outcomes (such as their time to return to work) or the actual resources used in treating those patients over the full care cycle." (Porter, 2013).

- PROMS (Patient Reported Outcome Measures) - PROMs are measurement instruments that patients complete to provide information on aspects of their health status that are relevant to their quality of life, including symptoms, functionality and physical, mental and social health.

- PREMS (Patient Reported Experience Measures) - provide the patient's view on the delivery of services (e.g., communication with staff, cleanliness, timeliness).

https://www.cihi.ca/en/patient-reported-outcome-measures-proms

Integrated care networks are created when payment reforms support the development of healthcare services that manage segmented populations.



Sustainable clinical service planning needs to shift from the optimization of existing funding formulas to creating greater value for our communities and improving the health of our populations.

Adapted from The Health Care Advisory Board

Successful population health managers segment a population into groups with shared needs to support both planning and operations.

- Creating subgroups of individuals from a larger, attributed population is called ‘population segments’. These segments can be built around risk levels, social factors, age or type of health conditions but must be designed to provide utility to the team. Segmentation prevents a team from ‘trying to boil the ocean’.

Why segment a population?

- By segmenting into different groups with similar needs and wants, service planning can be taken more holistically rather than being based on the traditional organization of health care providers.
- Enables the development of customized care models to best match the specific needs of the segment. The healthcare system cannot afford to provide a single care model for an entire attributed population.
- To support the measurement of outcomes that matter to clients and patients.
- To provide an organizing framework across a large number of network organizations and staff so that priorities can be identified and care can be better integrated.

Depending on the needs and stage of development of the population health manager, segmentation can occur at different levels.

In 2011, the King's Fund Report suggested a three-tier model:

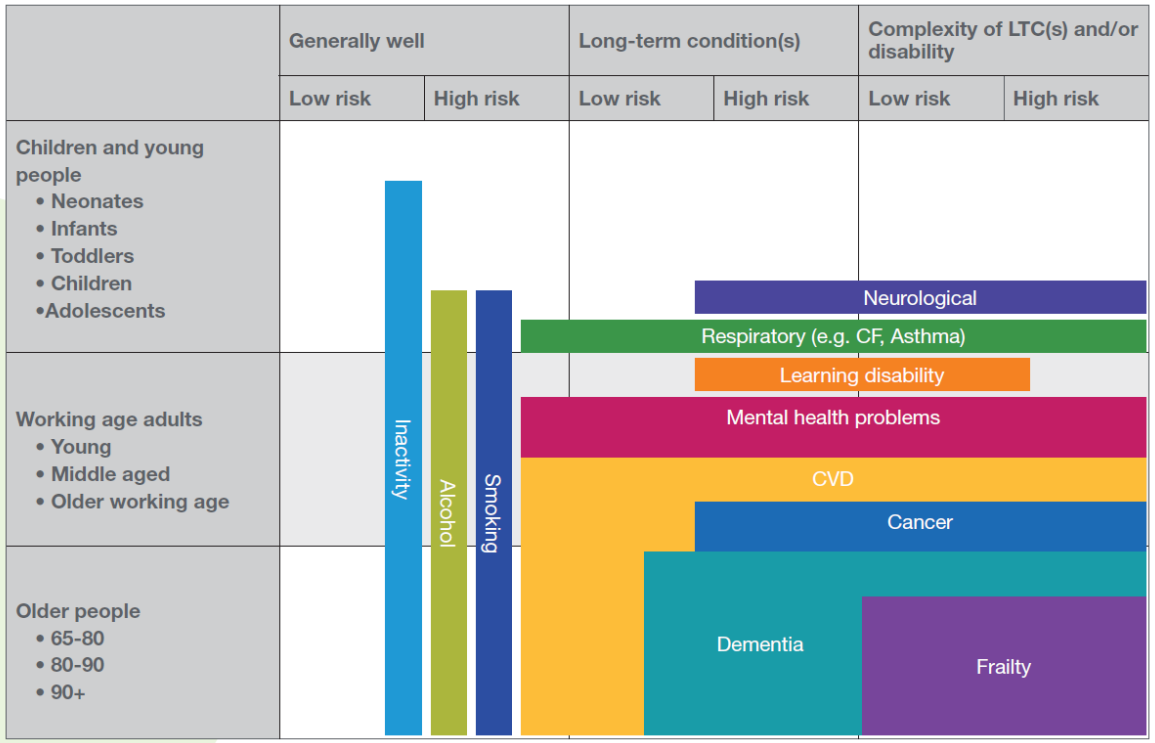
1. The ***macro-level*** at which providers, either together or with commissioners, deliver integrated care across the full spectrum of services to the populations they serve: examples include Kaiser Permanente, the Veterans Health Administration and integrated medical groups in the United States.

2. The ***meso-level*** at which providers, either together or with commissioners, deliver integrated care for a particular care group of people with the same disease or conditions: examples include care for older people, mental health, disease management programs and managed clinical networks.

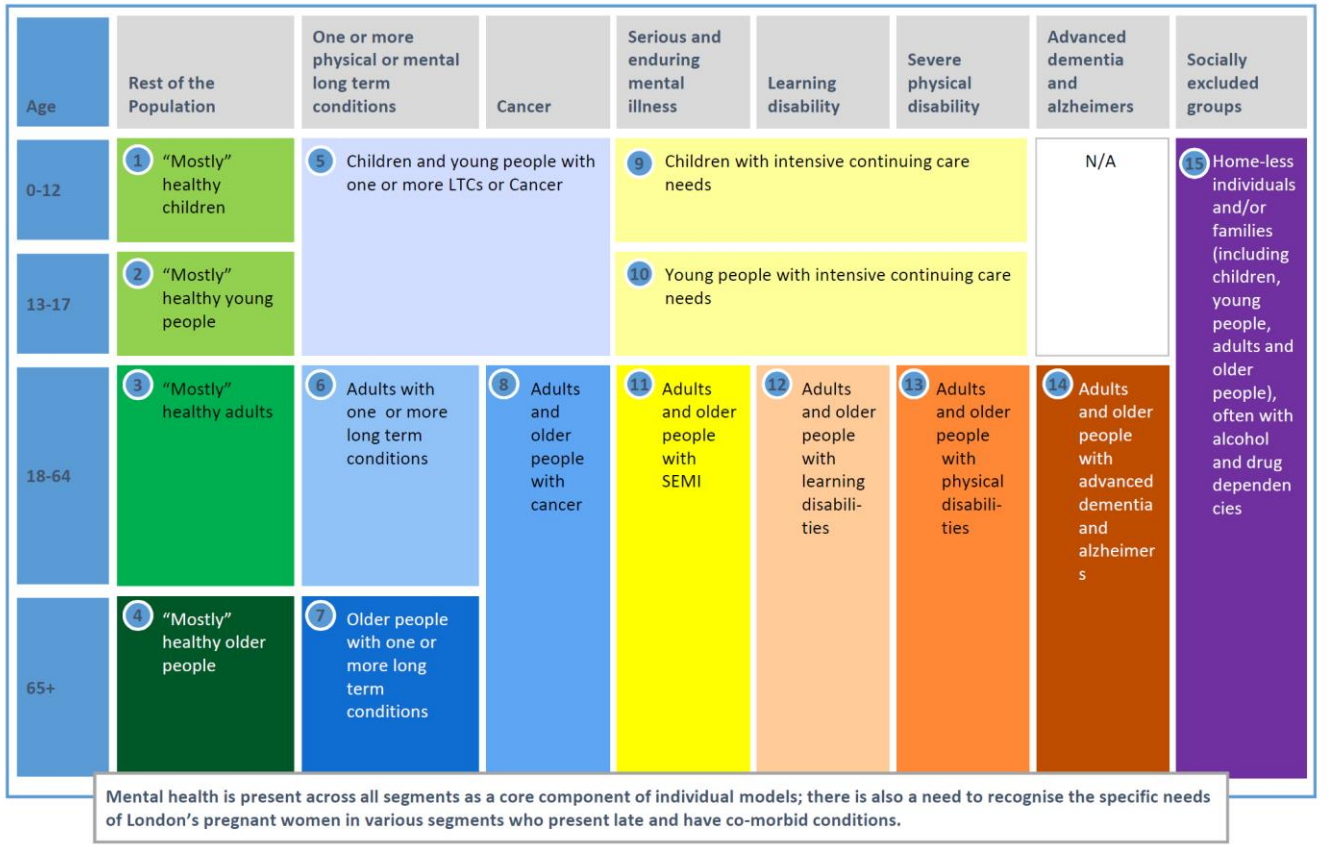
3. The ***micro-level*** at which providers, either together or with commissioners, deliver integrated care for individual service users and their carers through care co-ordination, care planning and other approaches.

From: Population Segmentation: An introduction to methods for identifying and supporting multiple diverse patient groups by Graham Head, Director Sollis, Alan Thompson, Director Johns Hopkins ACG System

Examples of different macro-level segmentation demonstrate how an entire attributed population is segmented to provide high level planning purposes.

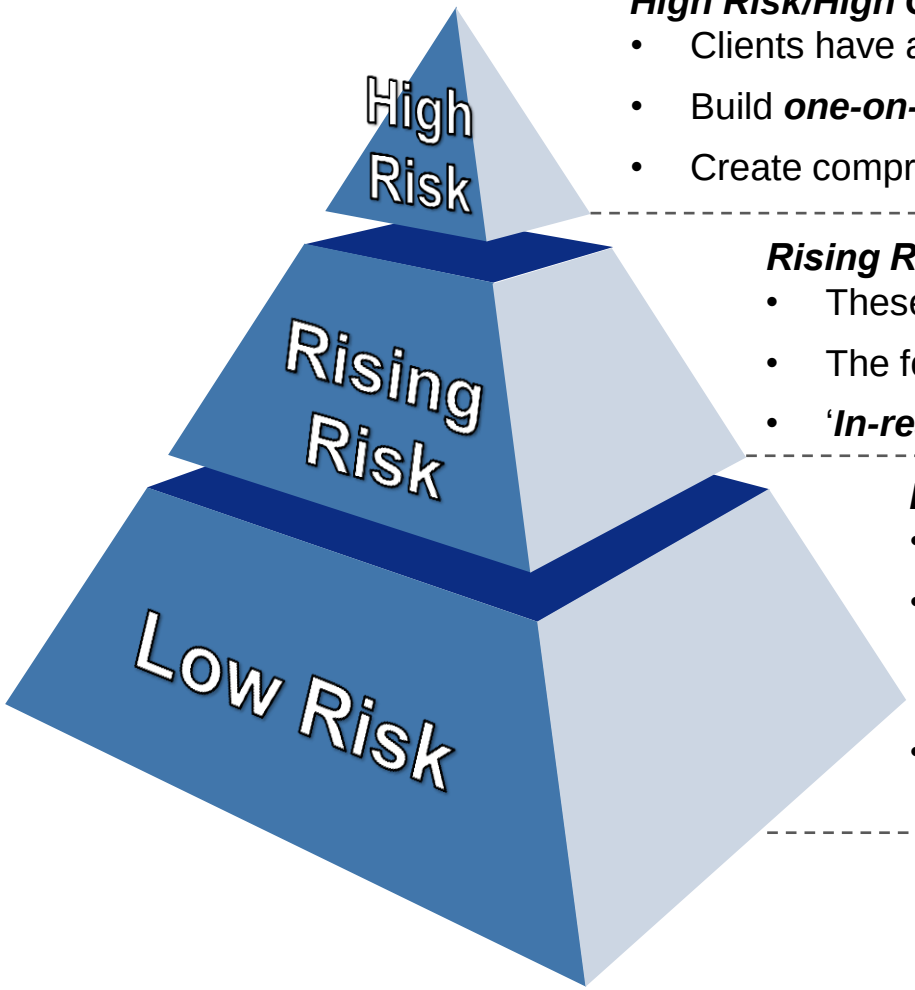


National Association of Primary Care Segmentation Model (UK)



London Health Commission Population Segmentation (UK)

Segmenting the population provides structure to create an integrated, value-based approach. A single model of care does not meet the needs of an entire population.



High Risk/High Complexity: ~1-4% of the Population

- Clients have at least one complex illness, multiple comorbidities, physical care needs & psychosocial barriers
- Build ***one-on-one relationship with high-risk care manager*** to shift use from high-cost to low-cost care
- Create comprehensive wraparound services to address full spectrum of high-risk client care needs

Rising Risk ('Messy Middle'): ~25-35% of the Population

- These clients have conditions not under control and, left unmanaged, will become high risk clients
- The focus is to ***proactively identify and engage rising-risk*** *clients* in the medical home
- '***In-reach***' clients often require ***system navigation*** for access to specialty and programmatic care.

Low Risk: ~55-80% of the Population

- This is the segment of the population that are healthy today
- Create '***out-reach services***' to begin to partner with clients at low-acuity access sites to reinforce relationships and gather client data. These clients prefer convenient access points such as online or virtual services in addition to novel, community based services.
- The ***focus is self navigation and self management***. The goal is to keep this population healthy and loyal to the system

From: Kaiser Permanente, RISE document (MOH) and discussion between Baycrest Hospital and HSCL.

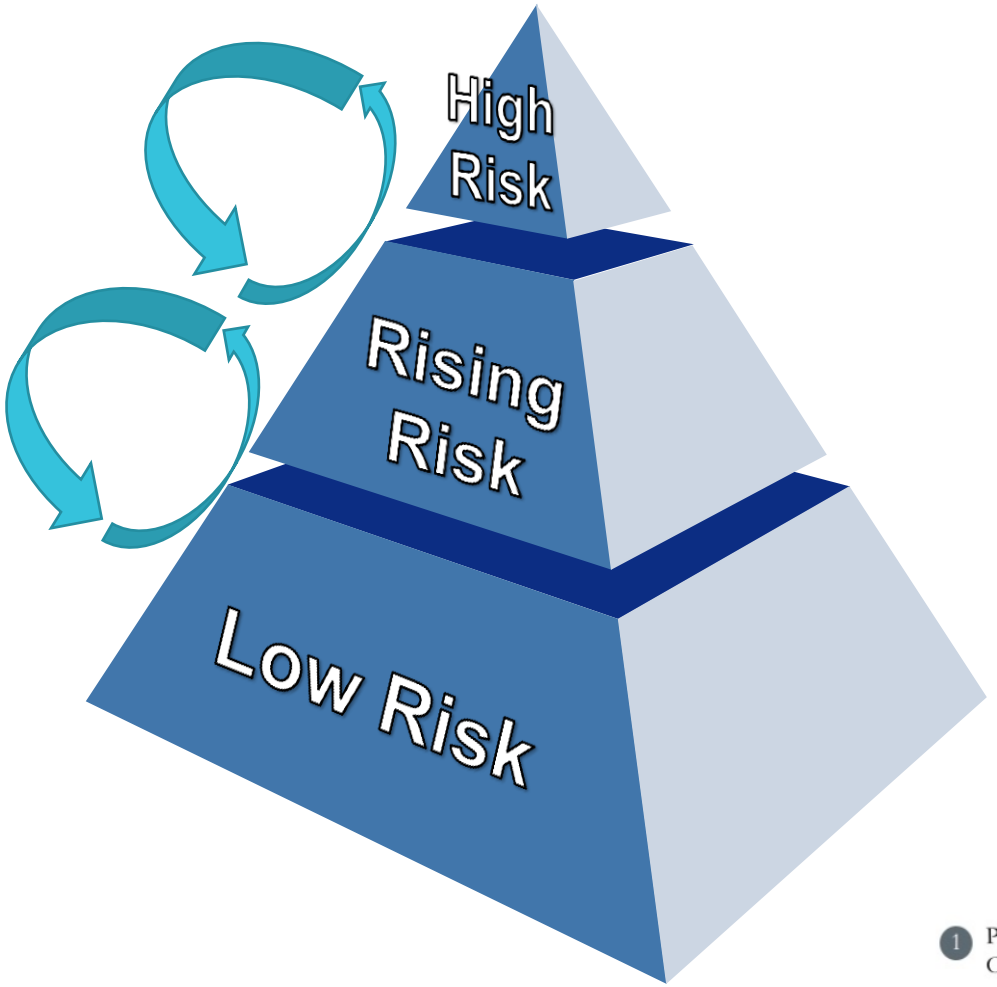
In successful population health management organizations, longer term financial sustainability is gains when the population is healthier.

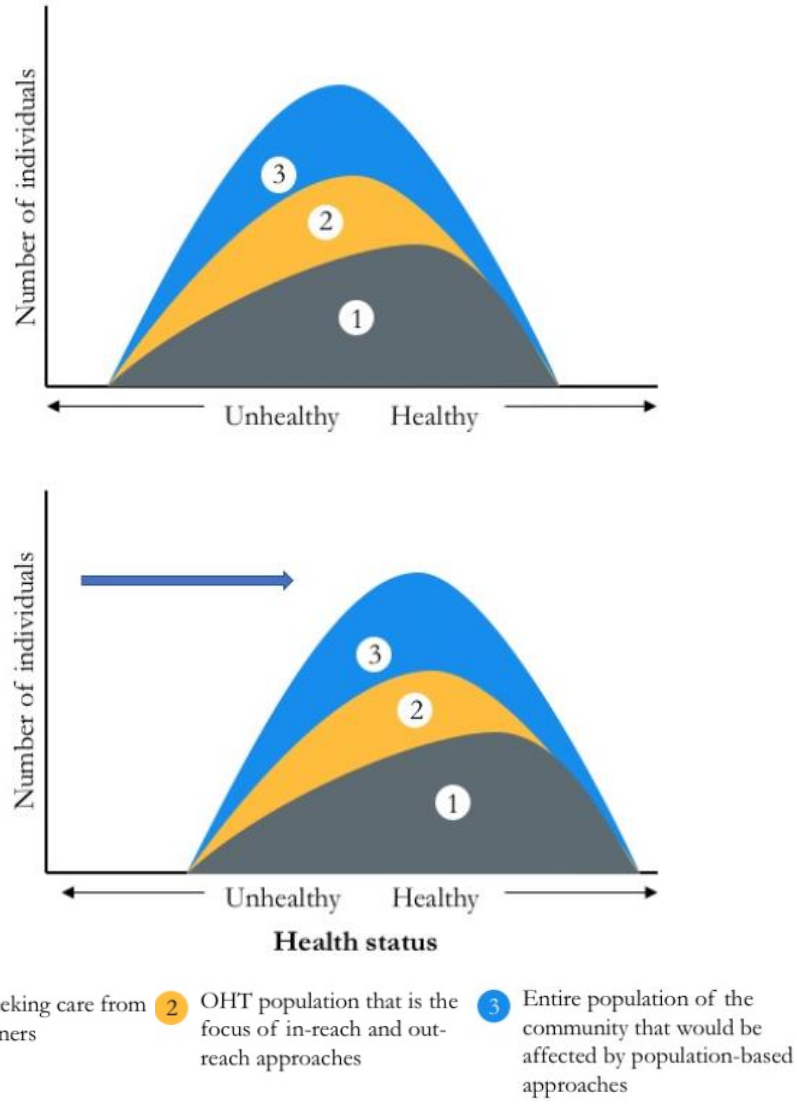
Focusing on High-Risk clients is the starting point, but long term system financial sustainability is achieved when the low-risk and rising-risk clients are managed well.

People climbing up the Kaiser Pyramid are at risk of:

- Worse health outcomes
- Higher cost of care

Greater value is created when people are maintained or climb down the Kaiser Pyramid.



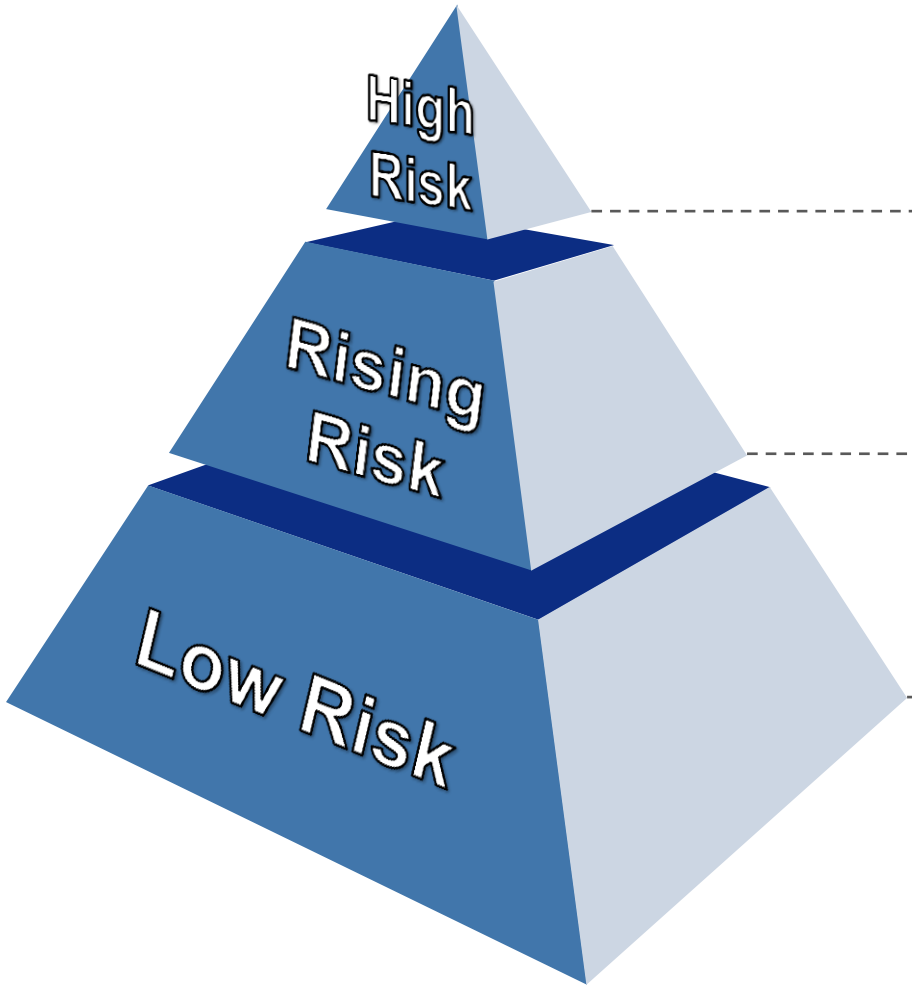


From: RISE document (MOH)

Like the development of individual care models, each segment of the target population has benefits from tailored digital solutions to meet the clients needs.

Creating shared information across the provider network is an important enabler, but integrating under a single EMR is likely prohibitively expensive. Investment in a common client portal and data warehouse, to collect and share information to create the infrastructure for completing analytics to identify rising-risk clients, is an early priority.

For example, an effective client portal can be leveraged as a central hub of activity for low-risk clients, and to support patient influencers and caregivers through information sharing. These serve as an important driver of the development of a provider-client relationship, trust and engagement.



Key Information Technology Supports

- Create Data Warehouse
- Develop HIE
- Client Portal
- Home Monitoring

- Create Data Warehouse
- Develop HIE
- Client Portal/Self Scheduling
- Predictive Risk Analysis
- Client Monitoring

- Create Data Warehouse
- Develop HIE
- Client Portal/ Online Care
- Call Center
- Instant messaging/texting

Adapted from The Health Care Advisory Board

Appendix

What is Population Health?

Health Canada Definition:

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations.

Health Canada. What is the Population Health Approach?

https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html

Note: Population Health is stated 11 times in the Full Application Template, it is on every third page.

Effective care for seniors share a number of common traits of high performing value-based healthcare providers and integrated care approaches.

Seniors with complex needs benefit from care delivered in an integrated, 'non-transactional' format. Integration should exist at the provider (team) and organizational levels.

Integrated service delivery is a core feature of value-based healthcare delivery.

While challenging to coordinate, seniors care will yield the most benefit for the management of current costs and future cost avoidance.

Conventional Care	Older-person-centred and Integrated Care
Focuses on health condition (or conditions)	Focuses on people and their goals
Goal is disease management or cure	Goal is maximizing intrinsic capacity
Older person is regarded as passive recipient of care	Older person is an active participant in care planning and self-management
Care is fragmented across conditions, health workers, settings and life course	Care is integrated across conditions, health workers, settings and life course
Links with health care and long-term care are limited or non-existent	Links with healthcare and long-term care exist and are strong
Ageing is considered to be a pathological state	Ageing is considered to be a normal and valued part of the life course

Table from: WHO World Report on Aging and Health