Get your steps in!

Walk with Katie Commey

12:40 – 1:00 PM

Meet @ Registration Table

Population Health Management

Trissa Torres, MD, MSPH
Chief Operations and North America Programs Officer

Agenda

Definitions

Approach

Segmenting your population

Understanding your population segment

Next step… redesigning care

What Matters

It's scary when I can't breathe.

Sometimes I'm just too tired to go to the doctor.

Population Management

The design, delivery, coordination, and payment of services for a defined group of people to achieve specified cost, quality and health outcomes for that group of people.

Lewis, Ninon. "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today." *IHI Leadership Blog*. Institute for Healthcare Improvement, 19 Mar. 2014.

Population **Health** Management

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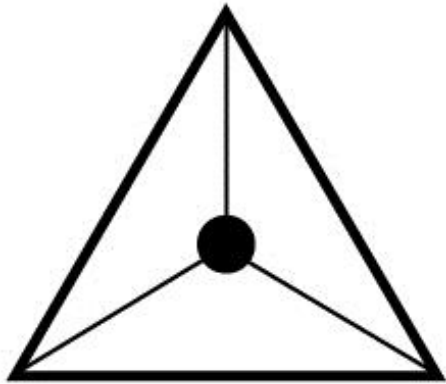
Next step… redesigning care



- System designs that simultaneously improve three dimensions:
  - Improving the **health** of the populations;
  - Improving the patient experience of **care** (including quality and satisfaction); and
  - Reducing the per capita **cost** of health care.

Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. Health Affairs. 2008 May/June;27(3):759-769

Whittington, John, Kevin Nolan, Ninon Lewis, and Trissa Torres. "Pursuing the Triple Aim: The First 7 Years." *Milbank Quarterly* 93.2 (2015): 263-300

Approach to Population Health Management

Community, Family and Individual Resources

Population Segmentation

Needs & Assets Assessment for Segment

Service Redesign and Coordination

Delivery of Services at Scale

Population Outcomes

Learning Loops

Learning Loops

Approach to Triple Aim for Populations

- Choose a relevant ***Population*** for improved health, care and lowered cost
- Conduct a ***Needs and Assets Assessment***
- Design or ***Redesign Services*** to meet the needs of the population
- Develop a ***Portfolio*** (group) of projects that will yield Triple Aim results
- Create a ***Learning System*** and ***Measures*** that will show improvement for the population
- Build a ***Team*** of individuals who can manage this work
- Use ***Improvement Methods*** to drive results
- Develop a brisk and realistic plan for ***Execution*** and ***Scale***

Whittington, John, Kevin Nolan, Ninon Lewis, and Trissa Torres. "Pursuing the Triple Aim: The First 7 Years." *Milbank Quarterly* 93.2 (2015): 263-300.

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Total Population to Target Population

- How do you currently understand your total population?
- Choose a target population segment

Total Population
Everyone in your reach

Target Population:
People (with identified characteristics) who you will focus the next round of population management

Understand Your Total Population

County
Population: X00,000

PHO
X00,000 patients

Practice
X,000
patients
-Medicaid
-Medicare
-Commercial
-Risk Contracts

Community
Services

Choose a Target Population Segment

Disease Burden

- Generally healthy
- Acute episode (expect full recovery)
- Behavioral risk factors and/or chronic disease(s) well managed
- High risk and/or high cost
  - Multiple chronic diseases and/or social risk factors
  - Disability
  - Frail
  - End of life

Stage of Life

- Children
- Pregnant Women
- Young Adults
- Older Adults

Lynn, Joanne et al. “Using Population Segmentation to Provide Better Health Care for All: The ‘Bridges to Health’ Model.” The Milbank Quarterly 85.2 (2007):

Considerations

- Prevalence
- Burden on the system
- Ability to identify and engage
- Ability to track and measure
- Ability to impact
- Partners and resources to support

Know your AIM

Moving from Population Segmentation to Care Redesign

Know your AIM

Full population

Population Segment

Specific Needs

Interventions & PDSAs

Agenda

- Definitions
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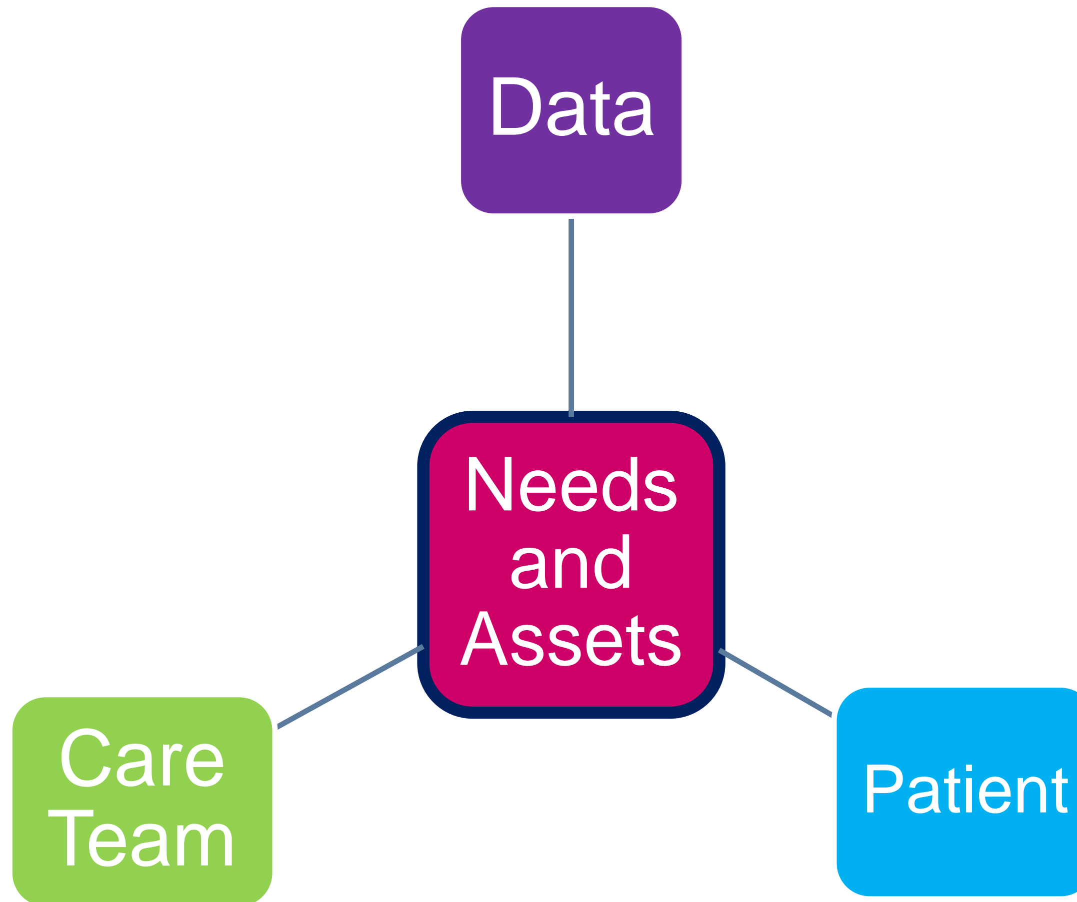
Next step… redesigning care

Understanding Needs and Assets

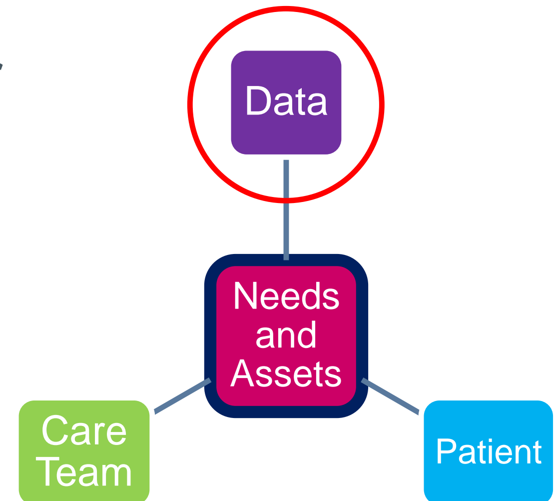


3 Part Data Review

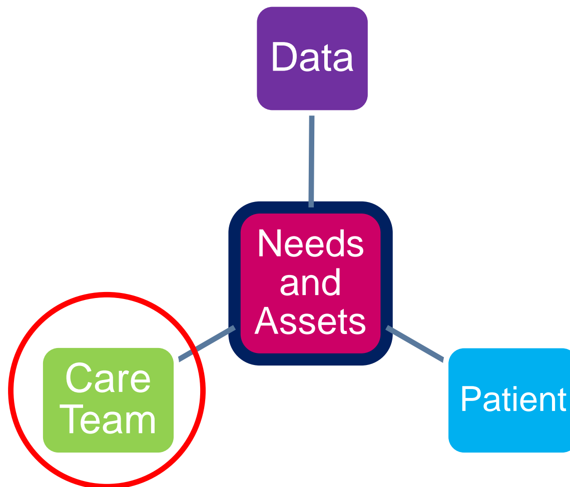
1. Review available data on your selected target population segment (and/or individuals from that segment)
2. Interview care providers to learn their perspective
3. Interview patients in the select target population to learn their perspective

Data Review: How-to

- **Review available data from HIT systems***
  - Claims/utilization data from payer or your own system (inpatient, ED, primary and specialty care visits, pharmacy)
  - Behavioral health encounter/claims data
  - EHR
  - Demographics
- **Generalized data in the literature and/or your county** (countyhealthrankings.org)



Ask the Care Team: How-to



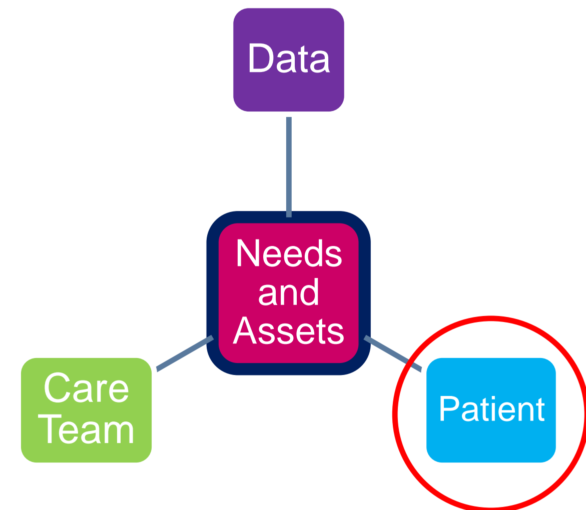
For this target population:

- What are the biggest challenges to managing these patients?
- What is working well?
- What needs do these patients have that are outside the scope of our services?
- What do you think could have the biggest impact on fostering better outcomes with these patients?

Ask the Patients: How-to

Deep listening with patients

- Use a semi-structured set of questions to gain insight into patient perspectives
  - What is working well about how you engage with us?
  - What is most helpful in managing your condition(s)?
  - What do you need that you are having trouble accessing?
  - What do you wish we could do better or differently?
- Come together as a team to discuss what was learned
- Identify similarities, differences, and common themes
- Use an ecomap to map assets and needs



Design with the individual…
Learn for the population

Design for the population…
Adapt with the individual

From one to many

Moving from Population Segmentation to Care Redesign

Know your AIM

Full population

Population Segment

Specific Needs

Interventions & PDSAs

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MI SIM

- Implement regular reviews of targeted patient population needs including access to reports that show unique characteristics of the Practice's patient population. *(data review)*

- Identify vulnerable patients and demonstrate how clinical treatment needs are being tailored, if necessary, to address unique needs. *(interventions)*

Group Work

To Do:

- Choose a target population segment
- Understand the needs and assets of your population segment
- What possible interventions (including but not exclusive to clinical community linkages) could help improve outcomes for this population segment?

BREAK

Organizing Your Ideas/Theories

Building to Team Time: Leaving in Action with Your Next PDSA(s)

Objectives

- Learn how the Driver Diagram can be a way to organize theories and change ideas.
- Plan your next PDSA(s)
  - Includes a “refresher” ☺

What's YOUR Theory?

Driver diagram serves as tool for **building and testing** theories for improvement

by Brandon Bennett and Lloyd Provost

In 50 Words Or Less

- A driver diagram is an applicable tool for many contexts, from improving process reliability to redesigning a service to creating new products to generating enhanced user experience.
- The tool visually represents a shared theory of how things might be better, building upon knowledge gleaned from research, observation and experience.

At least it appears that we must accept a kind of double truth: There are certainties, such as those of mathematics, which concern directly what is only abstract; and there are the presentations of our sense-experience to which we seek to apply them, but with a resultant empirical truth which may be no more than probable. The nature and validity of such empirical knowledge becomes the crucial issue.
—*C.I. Lewis*[1]

IN *THE NEW ECONOMICS*, W. Edwards Deming articulated "a view from outside" that he believed was a high-level complement to subject matter expertise in the pursuit of improvement—his system of profound knowledge.[2] Deming outlined four elements—appreciation of the system, understanding variation, psychology and the theory of knowledge—which provide insight into how improvement can occur.

How do you use a Driver Diagram?

Donald Goldmann, MD, Chief Medical & Scientific Officer, IHI

https://www.youtube.com/watch?v=yfcE_Q-IRFg

Example: Driver Diagram

Aim

Reduce by 50% colonization and infection with MRSA by August 1.

Primary Drivers

Reduce transmission of infection and colonization

Reduce infection once colonized

Secondary Drivers

Decolonization

Screening patients

Good hygiene

Reliable precaution routines

Bundles

Change Ideas

Try chlorhexidine washcloths

Test standing order for screening

Feedback hand hygiene adherence rates

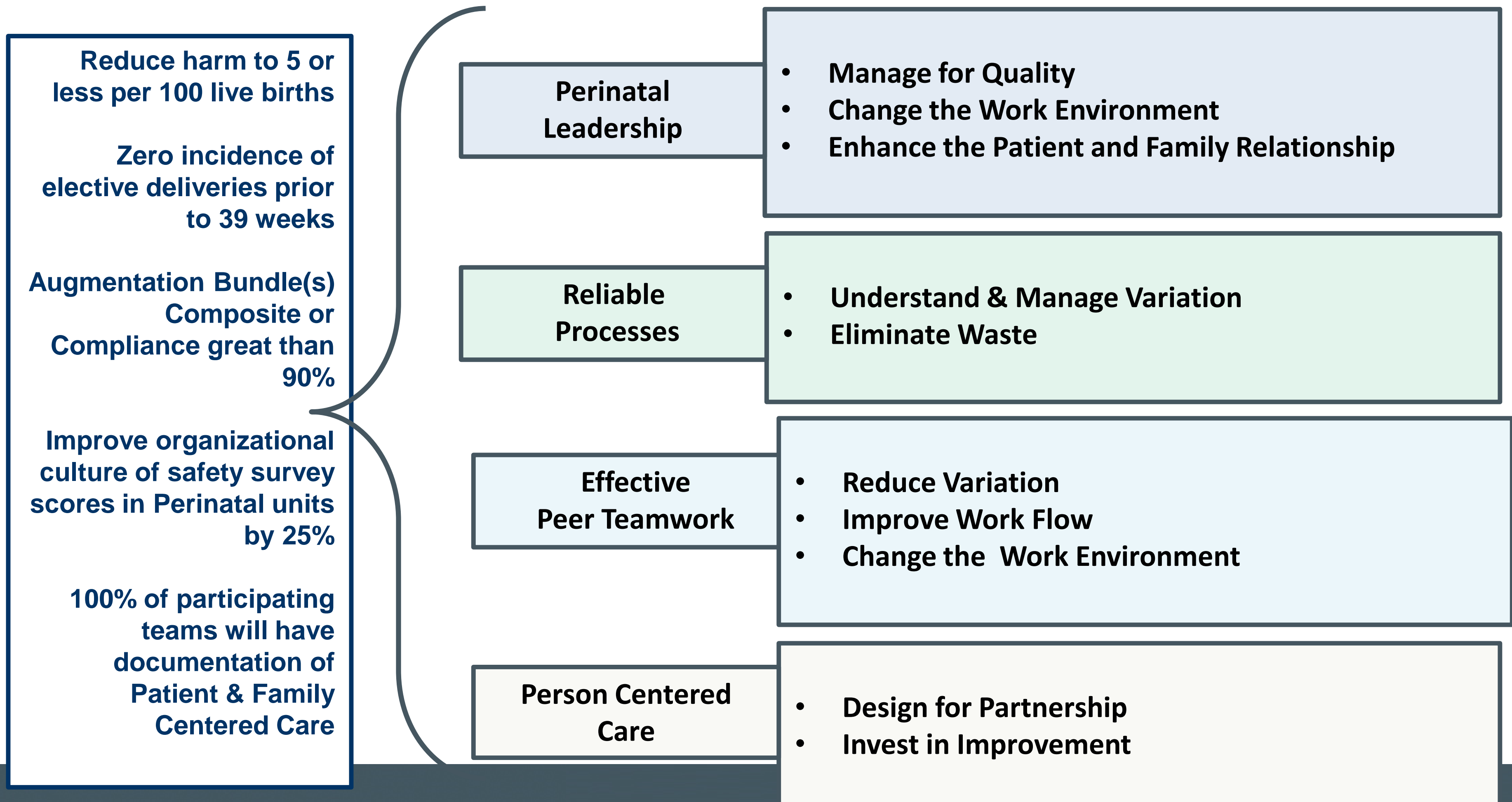
Ensure ideal placement of sanitizer

Incorporate adherence check on rounds

Institute for Healthcare Improvement

Perinatal Community:

Reducing Harm, Improving Care, Supporting Health



* See Perinatal Community Measurement Strategy

DRAFT

Aim

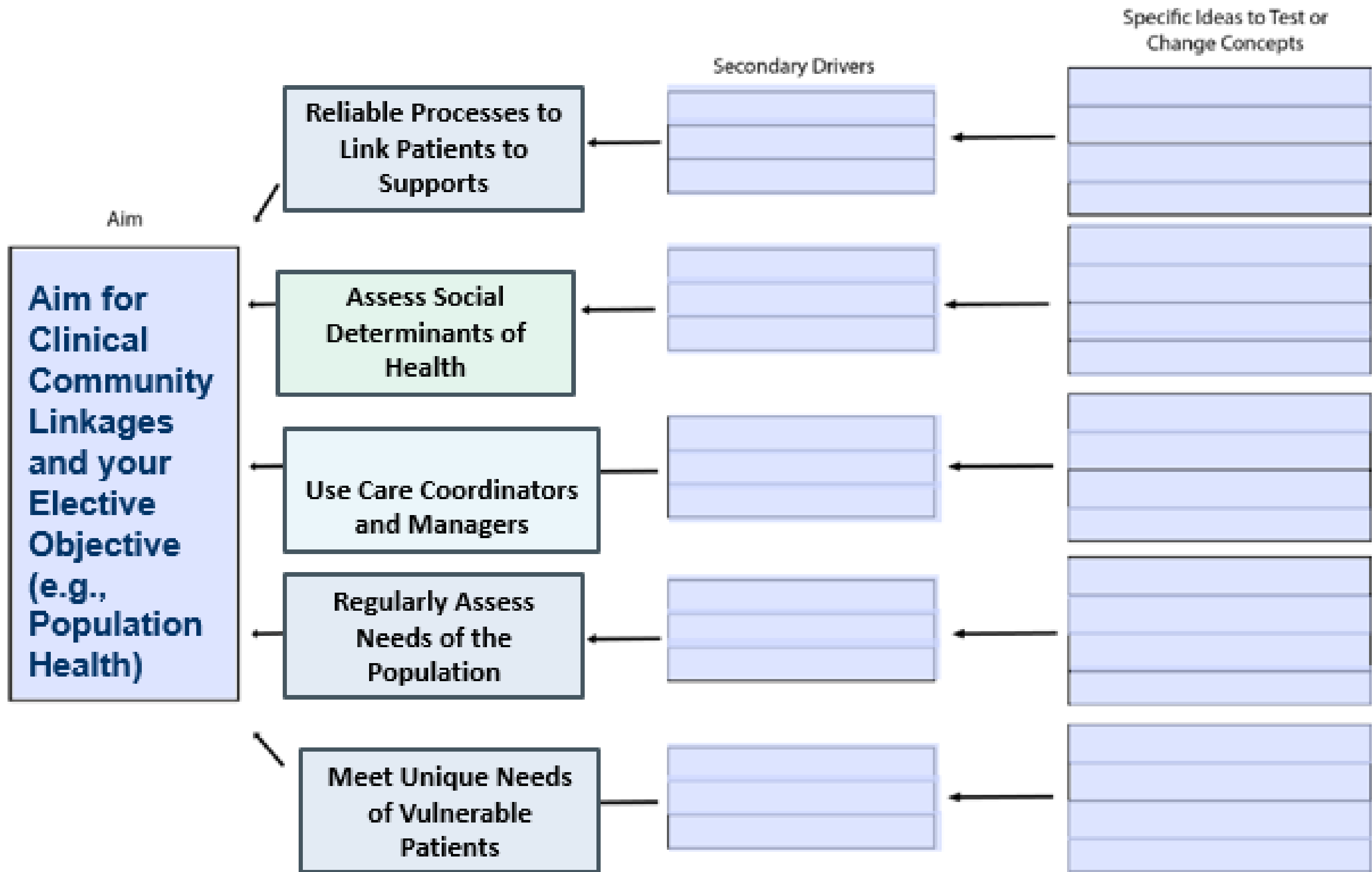
By July 31, 2019, expand the Patient Centered Medical Home Model throughout MI for up to 250 participants with a focus on an improved patient centered delivery system and a payment model that will provide and support patient-centered, safe, timely, effective, efficient, equitable, and accessible health care.

Primary Drivers	Secondary Drivers
* Clinical-Community Linkages	Reliable processes to link patients to supports Assess Social Determinants of Health Use Care Coordinators & Managers
Access	** Telehealth Adoption ** Group Visits ** Patient Portal
Activated Patients and Care Teams	** Improvement Plans from Patient Feedback **Self Management Monitoring & Support ** Integrated Peer Support
Continuity/ Continuum of Care	** Medication Management ** Integrated Clinical Decision Making
** Population Health Management-Knowing & Co-Managing Patients	** Care Team Review of Patient Reported Outcomes ** Cost of Care Analysis Regularly assess needs of population Meet unique needs of vulnerable patients

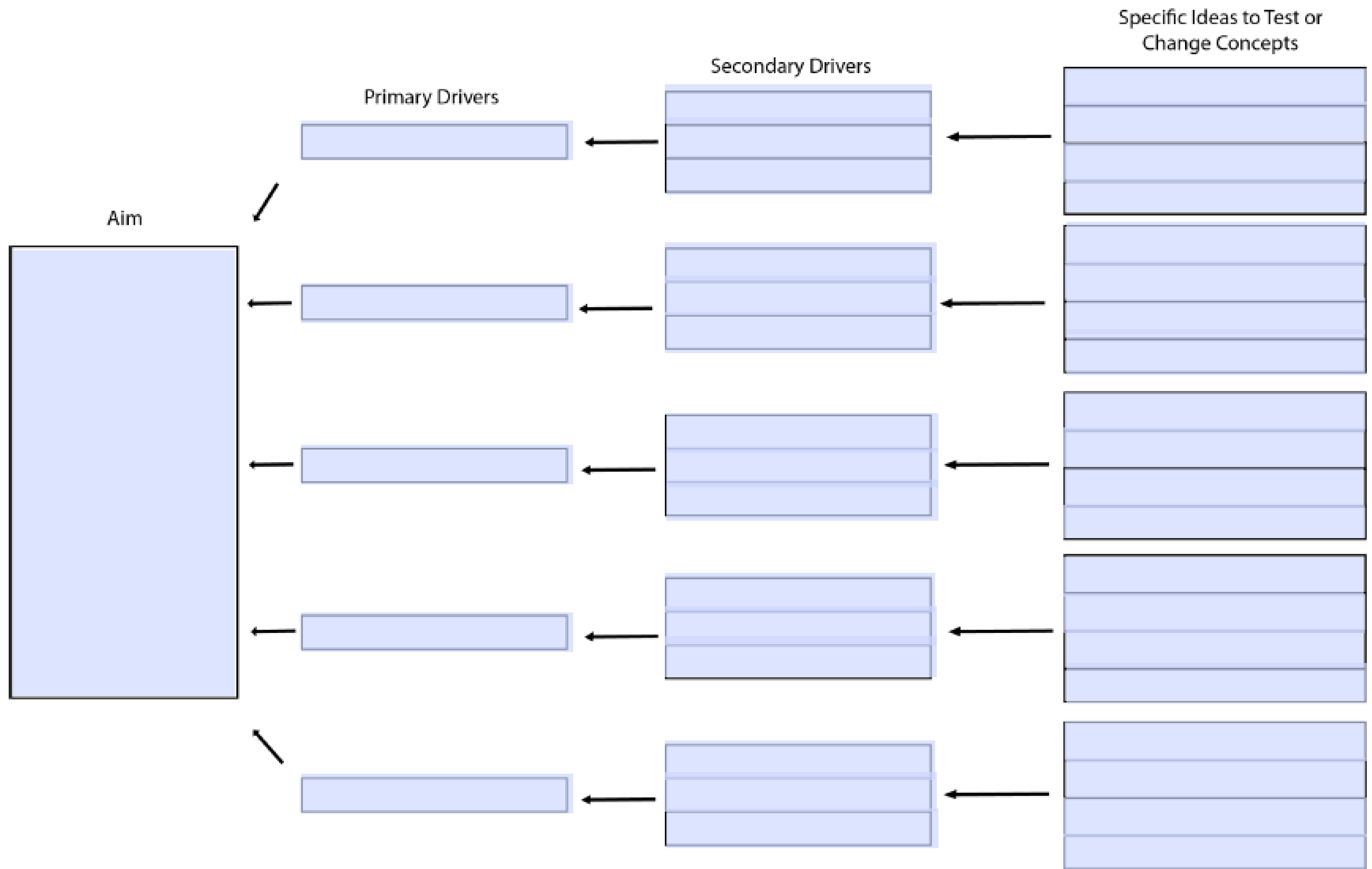
* Required objective for all participants.
** Elective objectives for participants.

How you might use…

Template: Driver Diagram

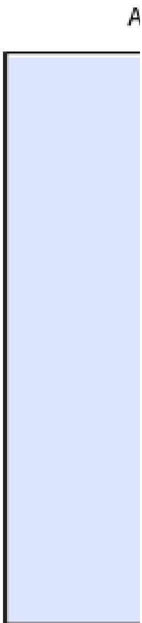


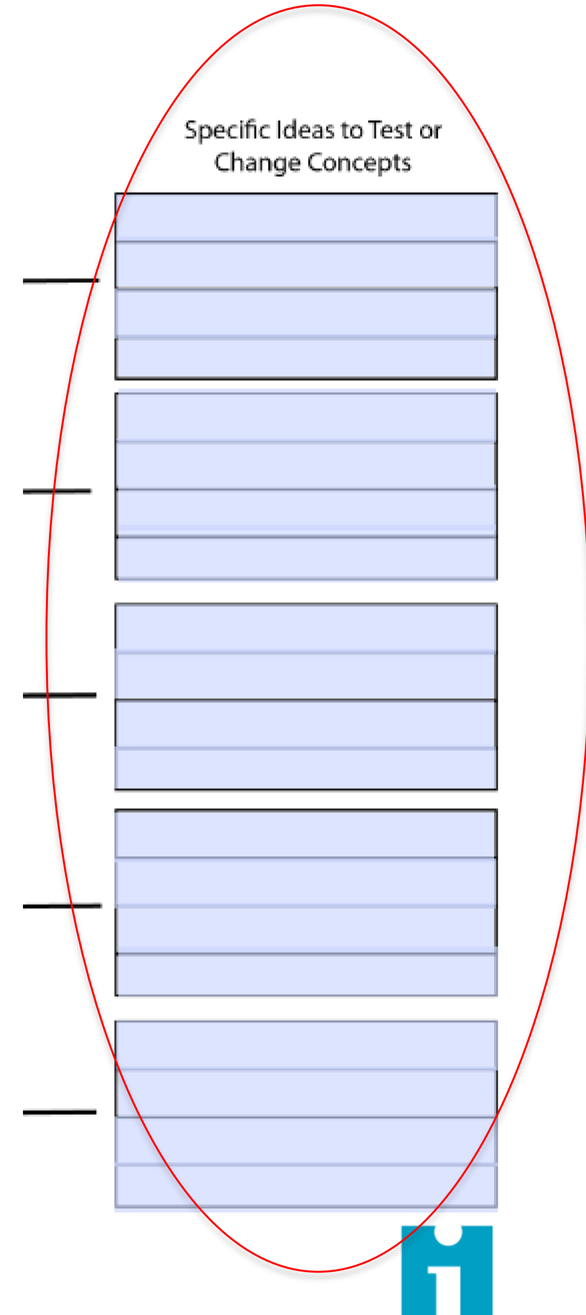
Template: Driver Diagram



Template: Driver Diagram

And we take these ideas and test using





Plan:

Objective of this cycle (hypothesis, theory, question):

What additional information will we need to take action?

Details: (who, what, where, when, why)

WHO:

WHAT:

WHERE:

WHEN:

WHY:

What do we predict will happen?

Plan (example):

Objective of this cycle (hypothesis, theory, question) Wondering if we test the SDoH assessment with one patient, will we get the information that we need or find out how we need to adapt?

What additional information will we need to take action? Need the brief assessment tool and some trained to administer.

Details: (who, what, where, when, why)

WHO: ?? (need to identify a person to test)

WHAT: the brief assessment presented at LS1

WHERE: next patient seen where applicable

WHEN: Tuesday at noon

WHY: to see how we might want to adapt

What do we predict will happen? We predict that the questions will work for now but that we will want to change them and re-test.

Do: (After you run your test per “Plan”)

Was the cycle carried out as planned?

What did we observe that was not part of our plan?

Check:

Methods of analysis:

How did or did not the results of this cycle agree with the prediction that we made earlier?

List what new knowledge we gained by this cycle:

Act:

List the actions we will take as a result of this cycle.

Are there forces in our organization that will help or hinder these changes? Explain.

Objectives of our next cycle.

PDSA Tip: "Oneness"

How small? Appropriate Scope for next PDSA Cycle

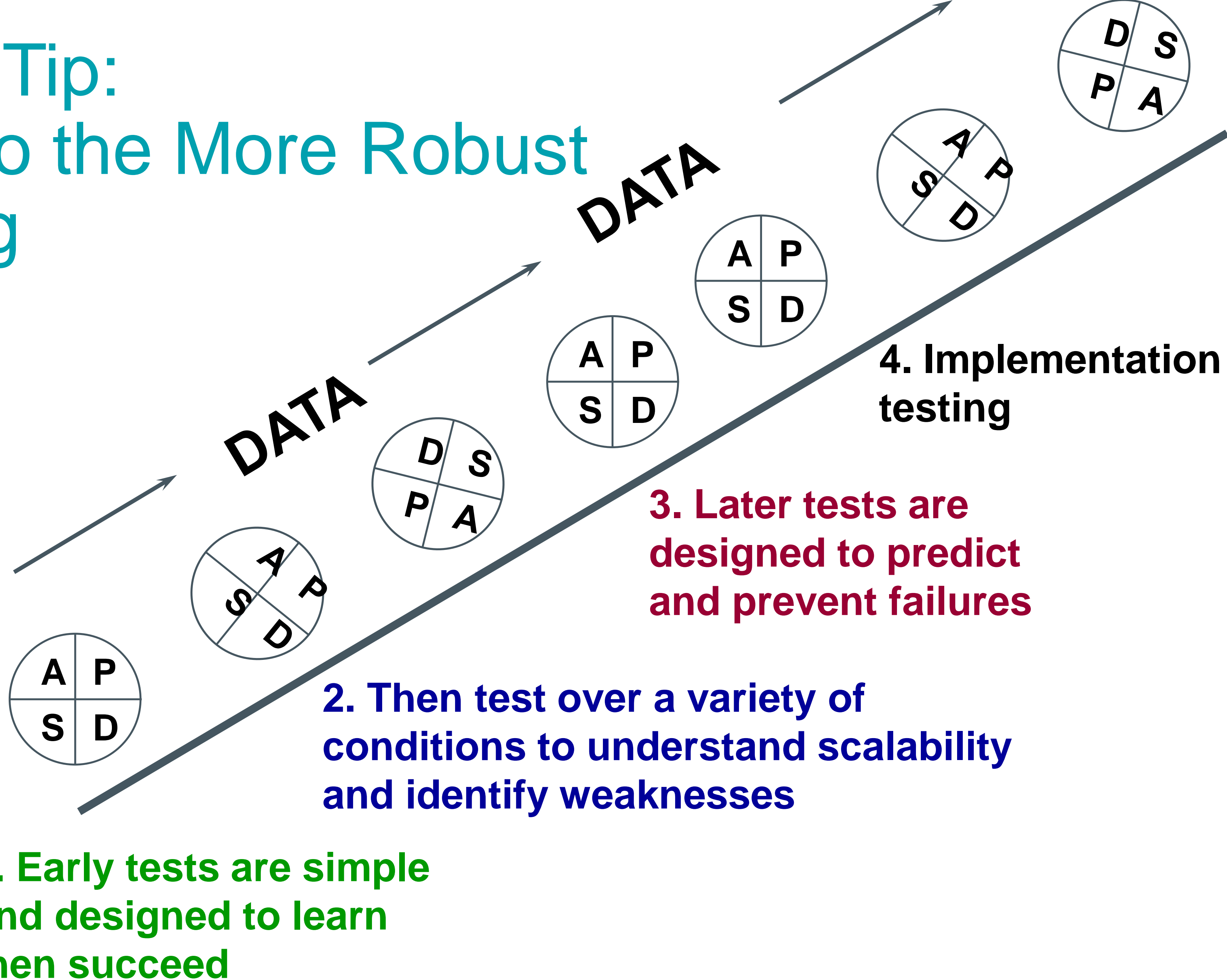
(concept developed by Lloyd Provost)

Staff Readiness to Make Change

Current Situation		Resistant	Indifferent	Ready
Low Confidence that current change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Very Small Scale Test	Very Small Scale Test
	Cost of failure small	Very Small Scale Test	Very Small Scale Test	Small Scale Test
High Confidence that current change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Small Scale Test	Large Scale Test
	Cost of failure small	Small Scale Test	Large Scale Test	Implement

Source: Lloyd Provost, Associates in Process Improvement

PDSA Tip:
Build to the More Robust Testing



Source: IHI

Your Turn…

- Using the PDSA handout, complete the "Plan" portion for something that you will test by next Tuesday.
- Remember, think small—think one patient, one assessment, one community partner, one time…

Institute for Healthcare Improvement

Close, Q&A, Evaluate

Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

Login Instructions

Open School

How to Access the IHI Open School Online Courses

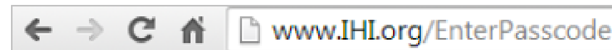
Step 1: Log in to IHI.org.

- Log in to IHI.org here.
    - If you are not yet registered, do so at www.IHI.org/RegisterFull.

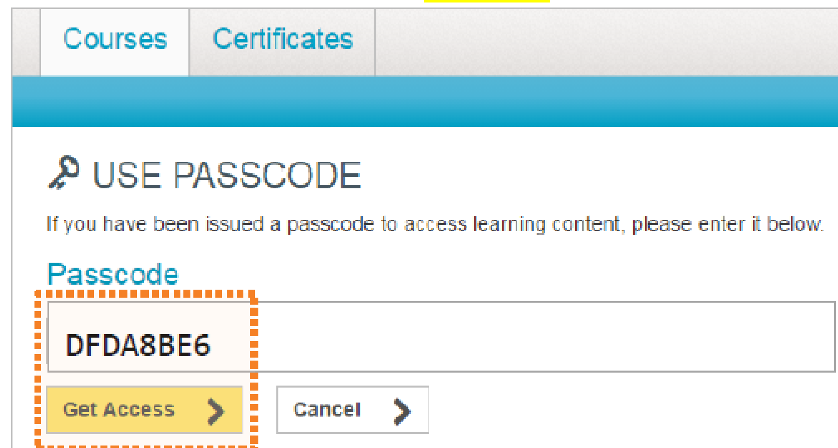
Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

Step 2: Enter your group's passcode.

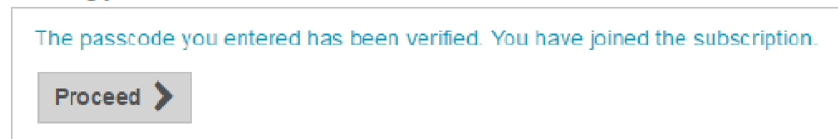
- After you have successfully logged in, go to www.IHI.org/EnterPasscode.



- Enter your group's 8-digit passcode DFDA8BE6 and click the "Get Access" button.



- A confirmation message will appear, indicating you have joined your group and inviting you into the courses.



Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

Step 3: Take courses.

- Now that you are registered for the courses, return directly to your learning using the following link: www.IHI.org/OnlineCourses. Bookmark the link for easy access.

Course Examples

<u>**PFC 101: Introduction to Person- and Family-Centered Care**</u>

The relationship between patient and provider is changing. Many health care systems aim to provide not only high-quality services, but also patient-centered care that advances the unique health goals of each person and family. In this course, you'll learn about the ideal relationship to promote health — especially for underserved people who face the greatest barriers to health — as well as some practical skills to make the relationship a reality.

- Lesson 1: *Patient-Provider Partnerships for Health*
- Lesson 2: *Understanding Patients as People*
- Lesson 3: *Skills for Patient-Provider Partnerships*

After completing this course, you will be able to:

- 1. Describe the partnership model of patient-provider relationships.
- 2. Explain why the partnership model can improve health.
- 3. Discuss how social conditions, faith, culture, and trust affect the patient-provider relationship.
- 4. Identify at least four skills to improve clinical interactions with patients.

Estimated Time of Completion: 1 hours 30 minutes

Course Examples

Triple Aim for Populations

TA 101: Introduction to the Triple Aim for Populations

You might think we do a pretty good job of providing care to individuals with illnesses and diseases. But it's important to take a step back and consider the factors contributing to illness. It's important to realize that things like education, the environment, and wealth (and how it's distributed) play an enormous role in health outcomes, too.

In this course, you'll learn that to make progress against many of the most important threats to human health, it's not enough to improve clinical care for one patient at a time. We also have to focus on improving the health of entire populations.

The Triple Aim for populations is a three-part aim: better care for individuals, better health for populations, all at a lower cost. This course will explore why each dimension is an essential part of improving health and health care, and how you can promote the Triple Aim in your organization and daily work.

- Lesson 1: Improving Population Health
- Lesson 2: Providing Better Care
- Lesson 3: Lowering Costs of Care

After completing this course, you will be able to:

- 1. Describe the three components of the IHI Triple Aim for populations.
- 2. Explain the responsibilities of clinicians and health care systems in optimizing population-level outcomes with available resources.
- 3. Understand medical care as one determinant of the overall health of a population, and the relationship of health care quality and safety to population health.
- 4. Provide examples of population-level interventions designed to improve overall health and reduce costs of care.

Estimated Time of Completion: 2 hours

Course Examples

TA 102: Improving Health Equity

This three-lesson course will explore health disparities — what they are, why they occur, and how you can help reduce them in your local setting. After discussing the current (and alarming) picture in Lesson 1, we'll dive into Lesson 2 and learn about some of the promising work that is reducing disparities in health and health care around the world. Then, in Lesson 3, we'll suggest how you can start improving health equity in your health system and community.

- Lesson 1: Understanding Health Disparities
- Lesson 2: Initiatives to Improve Health Equity
- Lesson 3: Your Role in Improving Health Equity

After completing this course, you will be able to:

- 1. Recognize at least two causes of health disparities in the US and around the world.
- 2. Describe at least three initiatives to reduce disparities in health and health care.
- 3. Identify several ways you can help reduce health disparities.

"How"
IHI Breakthrough Series Model

Select Topic (Develop Mission)

Participants (10-100 Teams)

Prework

Expert Meetin g

Develop Framework & Changes

Planning Group

P D S A

LS 1 → AP 1 → LS 2 → AP 2 → LS 3 → AP3*

Dissemination

Publications, Congress. etc.

Holding the Gains

*AP3 –continue reporting data as needed to document success

Supports

Email (listserv) Phone
Conferences
Visits Assessments
Sponsors Monthly Team Reports

LS – Learning Session

AP – Action Period

"How"—Year 1
MI PCMH Transformation Collaborative

Participants **(43 Teams representing 346 practices)**

3/2017

Prework

Select Topic (Develop Mission)

Develop Framework & Changes

Planning Group

P D S A

LS 1 **4/2017**

AP 1

P D S A

LS 2 **6/2017**

AP 2

July 2017-on

Hold Gains & Continued Work on Additional Categories.

Supports

Phone Calls

Webinars

Visits

Assessments

Affinity Groups

Team Reports

LS – Learning Session

AP – Action Period

Reminders and Next Steps

- Next Action Period Call:
  - Thursday, July 13, 2017
- Next Coaching Calls:
  - July 18-21, 2017