100 Million Healthier Lives

Pathways to Improving Health, Wellbeing and Equity

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CONVENED BY Institute for Healthcare Improvement

P2PH Overview

<u>GOAL:</u> To support health care organizations to make practical, meaningful, sustainable advances in health and wellbeing

1. **Create and align messaging** about what the journey to population health entails for health care organizations.
2. **Build a pathway of support** that helps systems identify where they are and where they want to go next, and puts tools and resources from the field in one place.
3. **Engage and support** health care organizations on the journey to population health.

Partners:

HRET Health Research & Educational Trust · Institute for Healthcare Improvement · nrhi Network for Regional Healthcare Improvement · Public Health Institute · Stakeholder Health

An initiative facilitated by: 100 Million Healthier Lives

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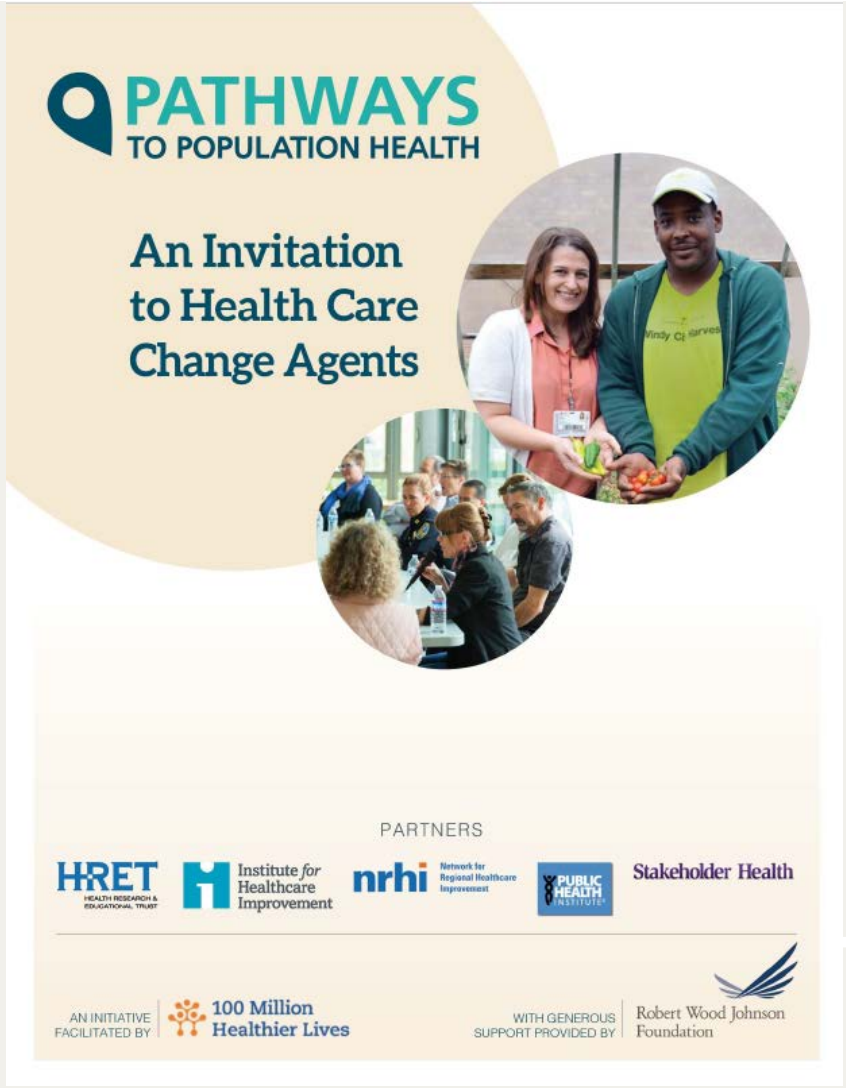
P2PH Framework



1. **Foundational Concepts and Creating a Common Language:** Defines key concepts and terms that are foundational to understanding the journey to population health (the **WHY**)
2. **Portfolios of Population Health:** Describes four interconnected portfolios of work that contribute to population health (the **WHAT**)
3. **Levers for Implementation:** Surfaces the levers that can be used to accelerate progress within and across portfolios of work to improve population health (the **HOW**)

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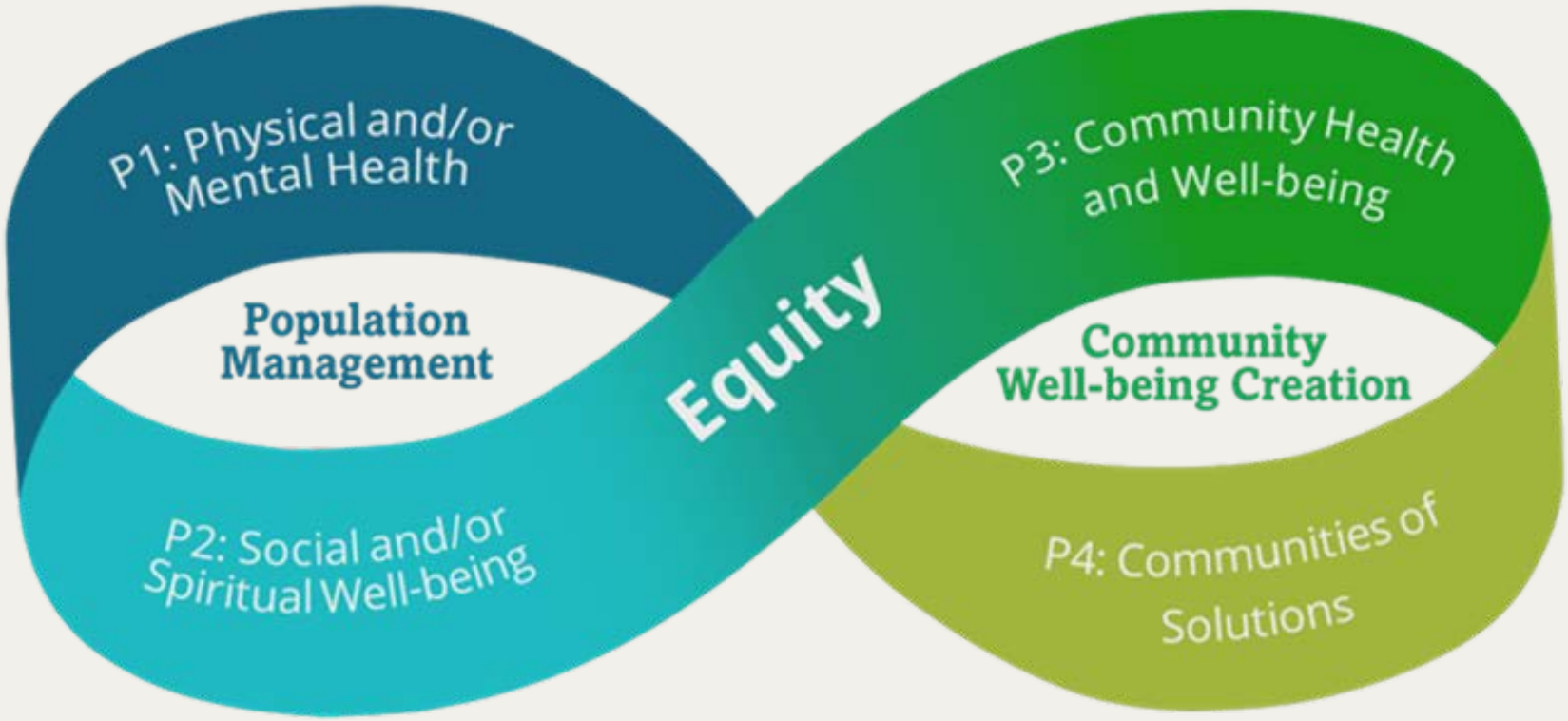
Four Portfolios of Population Health



Source: Pathways to Population Health, 2018

Key Levers for Health Care Organizations

to Accelerate Improvements Within and Across Portfolios of Population Health

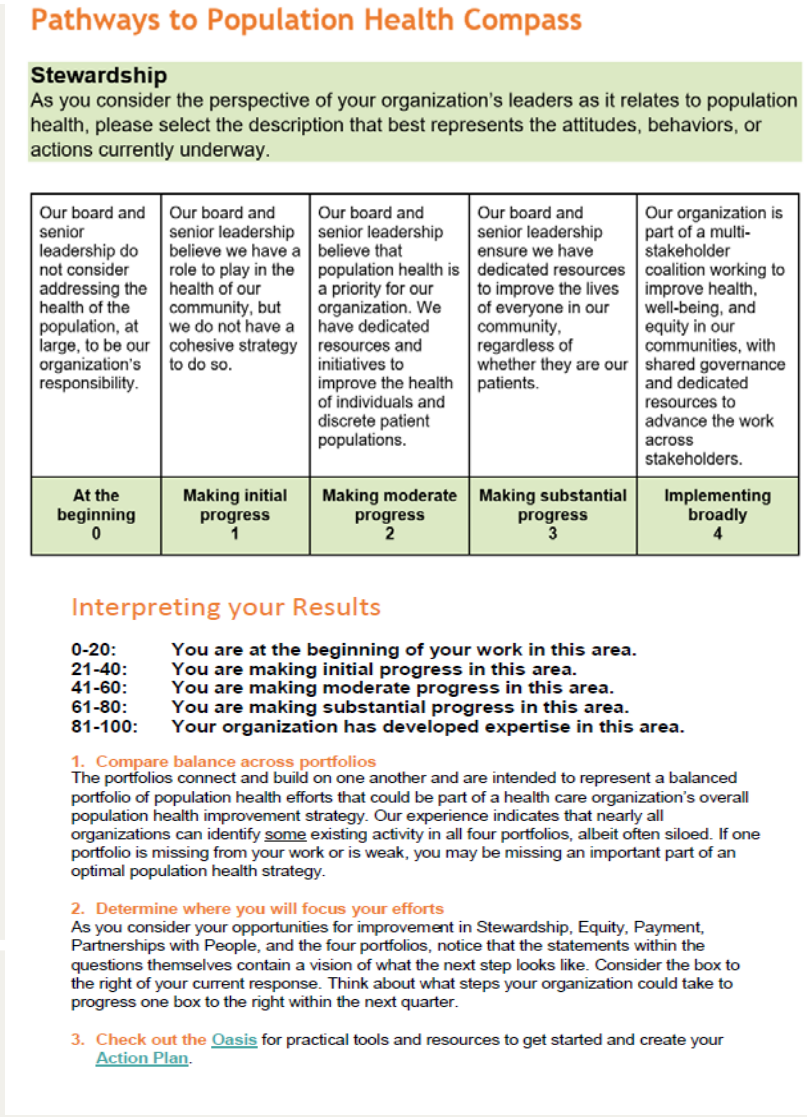
- Roles to leverage
- Relationships
- Governance
- Financing models
- Data
- Policy
- Equity
- Partner with people with lived experienc

	Portfolio 1: Mental and/or Physical Health	Portfolio 2: Social and/or Spiritual Well-Being	Portfolio 3: Community Health and Well-Being	Portfolio 4: Communities of Solution

Roles to leverage	• Care deliverer
	• Employer
	• Insurer
		• Social service and community connector	• Community partner
			• Community needs and assets assessor
			• Community funder (community benefit)
			• Community co-improver
				• Community steward (in partnership with others), leveraging roles as:
				  ○ Purchaser
				  ○ Employer
				  ○ Investor
				  ○ Policymaker
				  ○ Advocate

Relationships	• Partnerships are in place with agencies representing specific patient cohorts (e.g., National Alliance on Mental Illness, American Diabetes Association, etc.)	• Partnerships are in place with agencies defined by the social service they provide (e.g., Alcoholics Anonymous, food bank, Union Mission, etc.)	• Partnerships are in place with community-based organizations needed to effect change in a defined health or well-being topic (e.g., YMCA)	• Partnerships are in place with agencies that focus beyond sectarian or defined areas (e.g., United Way, ministerial organizations, mayor's office, etc.)
Governance	• Governance model is shifted toward educating and engaging board members to provide input prior to decisions on care redesign and related health care transformation processes • Shared governance includes patients and families	• Competencies of the board are developed and adjusted to support transition from an acute or primary care provider to a community-engaged institution • Shared governance includes social sector, community, and faith-based agencies	• A diverse, competency-based committee informs the design and monitors the impact of comprehensive community health improvement strategies • Shared governance includes partnership in multisector community coalitions	• Health system commits to being part of an independent governing board focused on health and well-being improvement that supports resource pooling, proactive investment, and shared ROI

Compass



Pathways to Population Health Compass

Stewardship
As you consider the perspective of your organization's leaders as it relates to population health, please select the description that best represents the attitudes, behaviors, or actions currently underway.

Our board and senior leadership do not consider addressing the health of the population, at large, to be our organization's responsibility.	Our board and senior leadership believe we have a role to play in the health of our community, but we do not have a cohesive strategy to do so.	Our board and senior leadership believe that population health is a priority for our organization. We have dedicated resources and initiatives to improve the health of individuals and discrete patient populations.	Our board and senior leadership ensure we have dedicated resources to improve the lives of everyone in our community, regardless of whether they are our patients.	Our organization is part of a multi-stakeholder coalition working to improve health, well-being, and equity in our communities, with shared governance and dedicated resources to advance the work across stakeholders.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Making substantial progress 3**	**Implementing broadly 4**

Interpreting your Results

0-20: **You are at the beginning of your work in this area.**
21-40: **You are making initial progress in this area.**
41-60: **You are making moderate progress in this area.**
61-80: **You are making substantial progress in this area.**
81-100: **Your organization has developed expertise in this area.**

1. Compare balance across portfolios
The portfolios connect and build on one another and are intended to represent a balanced portfolio of population health efforts that could be part of a health care organization's overall population health improvement strategy. Our experience indicates that nearly all organizations can identify some existing activity in all four portfolios, albeit often siloed. If one portfolio is missing from your work or is weak, you may be missing an important part of an optimal population health strategy.

2. Determine where you will focus your efforts
As you consider your opportunities for improvement in Stewardship, Equity, Payment, Partnerships with People, and the four portfolios, notice that the statements within the questions themselves contain a vision of what the next step looks like. Consider the box to the right of your current response. Think about what steps your organization could take to progress one box to the right within the next quarter.

3. Check out the Oasis for practical tools and resources to get started and create your Action Plan.

- The Compass includes 8 components with a series of statements to identify your organization's current state
  - Components: Stewardship, Equity, Payment, Partnerships with People with Lived Experience, P1, P2, P3, P4
  - Interpret results to building a balanced approach to population health

Pathways to Population Health (P2PH)

PATHWAYS TO POPULATION HEALTH

Five Partner Organizations	Have Come Together To

1. American Hospital Association/Health Research and Educational Trust
2. Institute for Healthcare Improvement
3. Network for Regional Healthcare Improvement
4. Public Health Institute
5. Stakeholder Health
	• **Create and align messaging** about what the journey to population health entails for health care organizations
	• **Build a pathway of support** for health care organizations that:
	  • Helps them identify where they are and where to go next
	  • Puts tools and resources from the field together in one place
	• **Engage** health care organizations on the journey to population health

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Six Foundational Concepts of Population Health Improvement

1

Health and well-being develop over a lifetime.

2

Social determinants drive health and well-being outcomes throughout the life course.

3

Place is a determinant of health, well-being, and equity.

4

The health system needs to address the key demographic shifts of our time.

5

The health system can embrace innovative financial models and deploy existing assets for greater value.

6

Health creation requires partnership because health care only holds a part of the puzzle.

What creates health?

How can health care engage?

Common language

What does population health mean to you?

What does health mean to you?

- People define health for themselves
- Adaptation of World Health Organization domains:

  "mental, physical, social, [and spiritual] wellbeing…"
- "Health is not the absence of disease but the addition of confidence, skills, knowledge and connection. But most importantly, it is simply a means to an end—which is a joyful, meaningful life."

Cristin Lind

Cristin Lind, with Gabe and Dagney

Two kinds of populations

A Defined Population

Defined by a common characteristic

- Patients at a community health center
- Children with sickle cell disease who live in the midwest
- People attending a megachurch

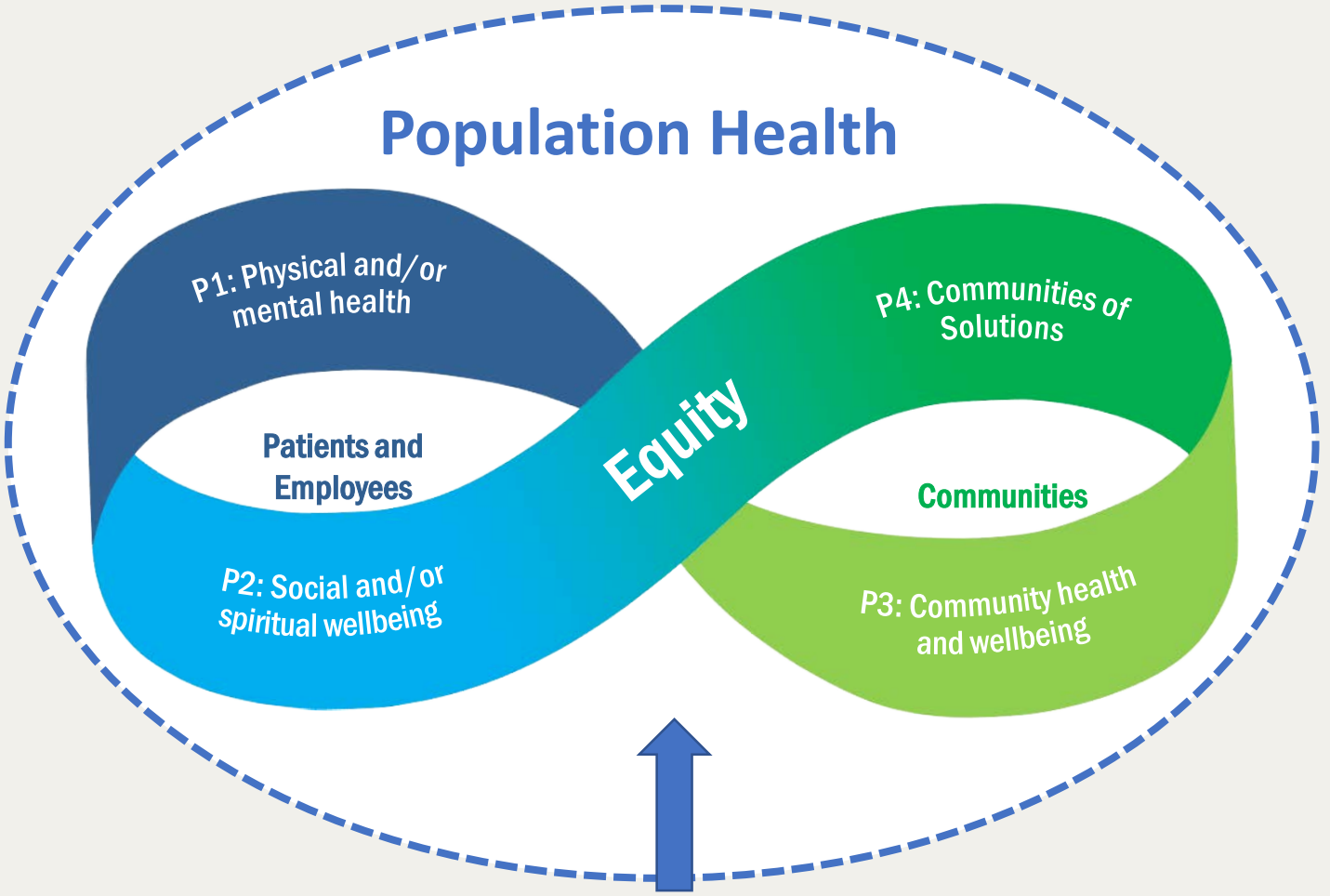
Geographic or Place-Based Population

Defined by a place

- Children living in three neighborhoods of Chicago
- Residents of rural West Virginia

4 Interconnected Portfolios of Work

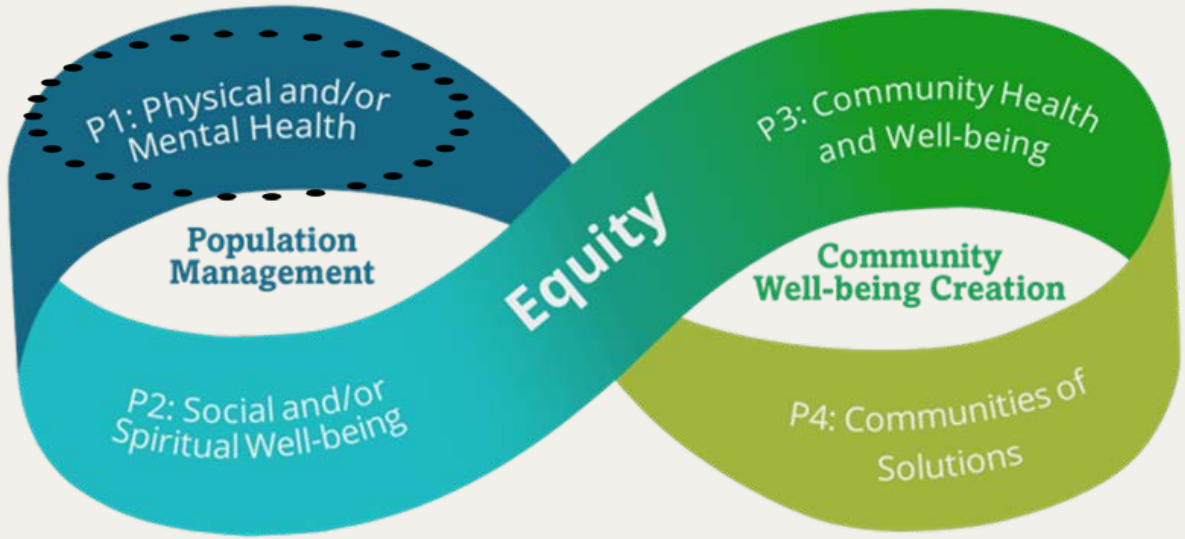
Improving the health and wellbeing of people



Improving the health and wellbeing of places

Improving the systems of society

Portfolio 1: Physical and/or Mental Health



Health care organizations are improving the physical and/or mental health of individuals within a defined population

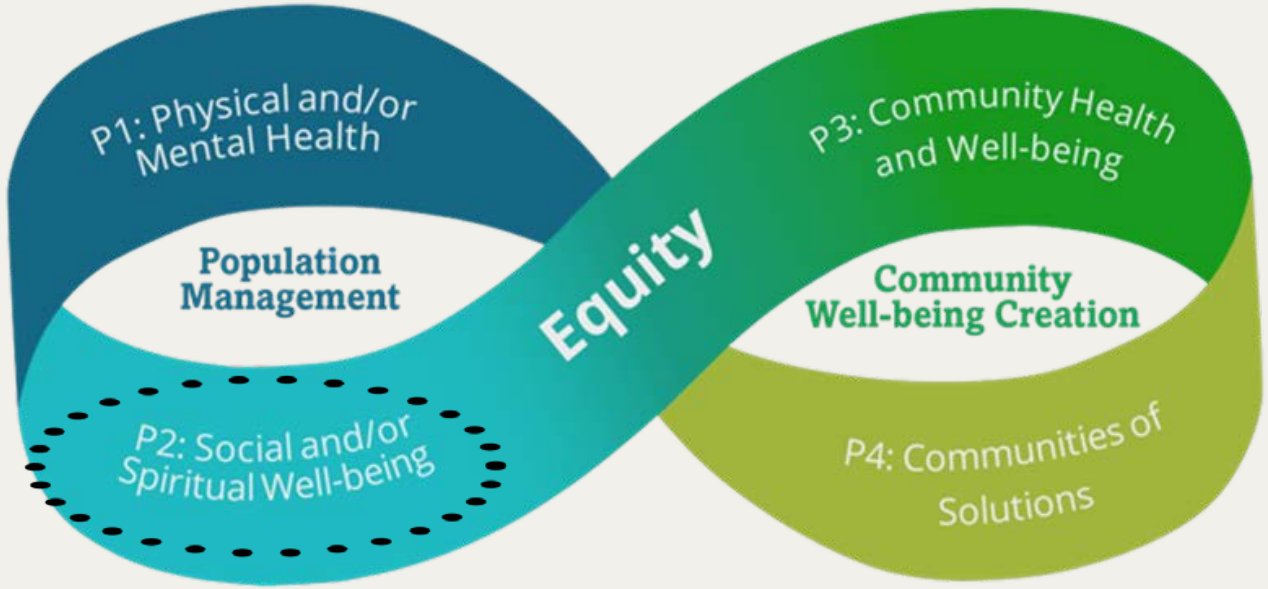
Activities for this domain may include:

- Patient empanelment and care management;
- Focus on access, evidence-based practice and risk stratification;
- Partnering with patients and families;
- Engaging in performance improvement;
- Partnering with patients and families
- Engaging in performance improvement
  - Data utilization
  - Improvement

Portfolio 1: Optimize mental and/or physical health and cost

- Intermountain Healthcare
- 22 hospitals, 1400 physicians
- High functioning primary care, behavioral health integration into primary care, telemedicine; functioning as an ACO
- Saved $500 million in medical expense alone
- Returning savings to employers and patients as reduced premiums

Portfolio 2: Social and/or Spiritual Well-being

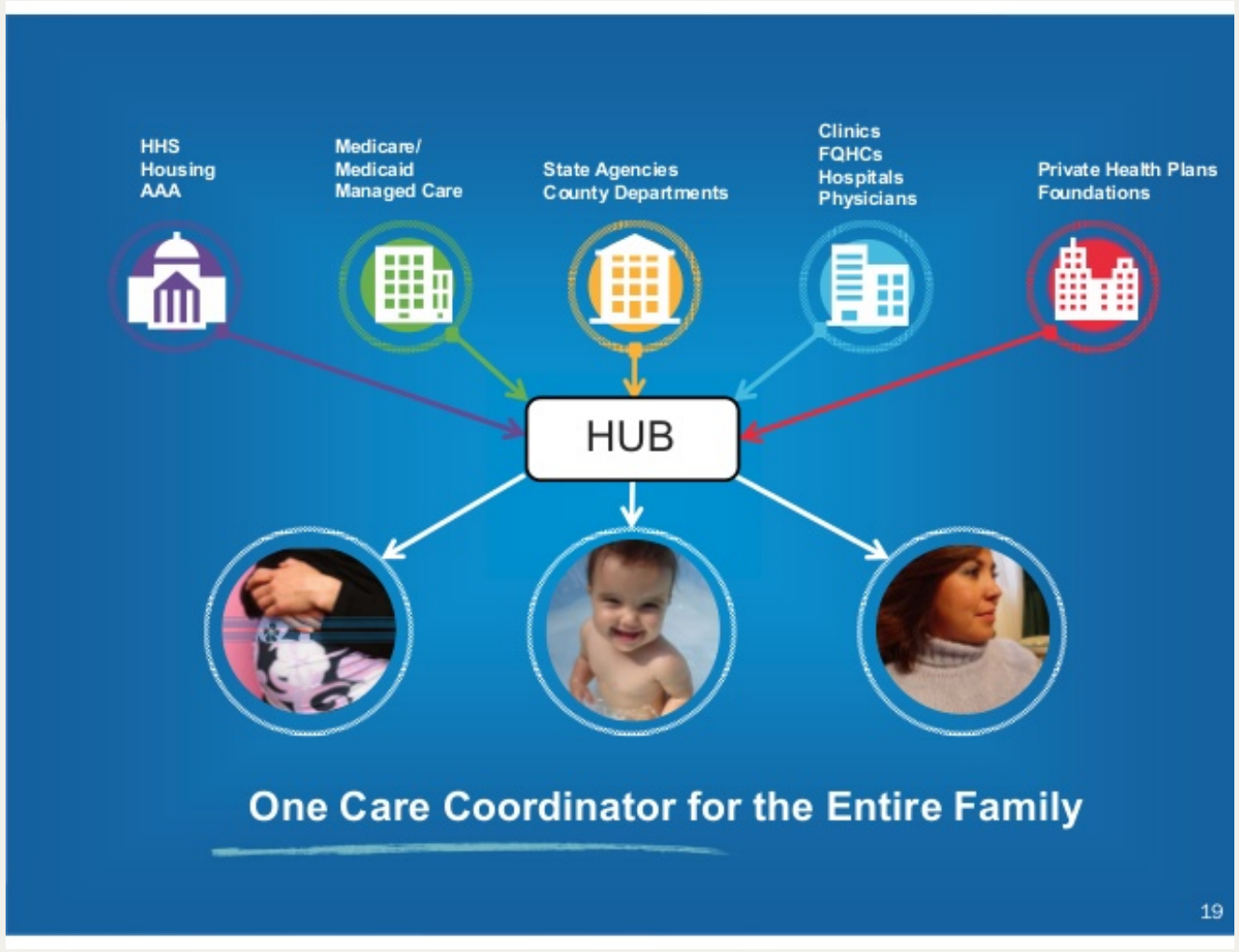


Health care organizations consistently screen for and address the social and spiritual drivers of health and well-being for a defined population.

Activities for this domain may include:

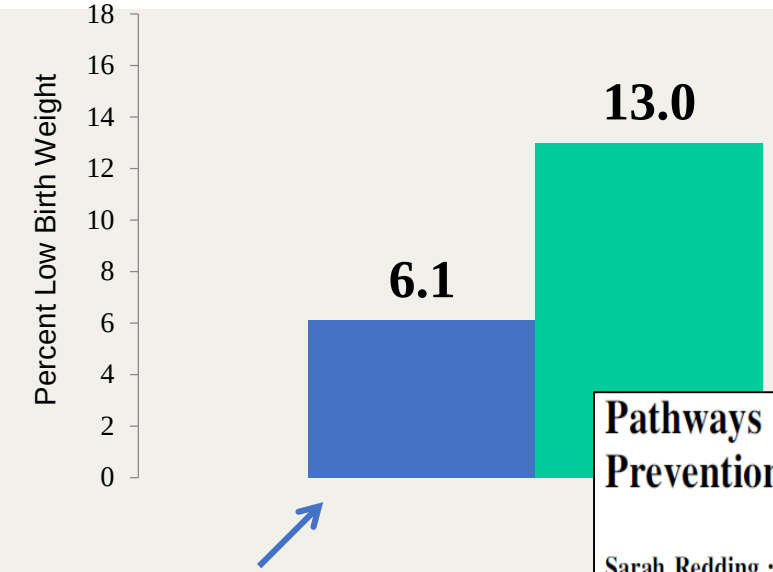
- Screening and addressing the social determinants and spiritual drivers of health and well-being;
- Developing and utilizing key partnerships;
- Tracking improvement in the activities for the defined population in order to establish the value proposition.

Portfolio 2: Address social and spiritual drivers or health and wellbeing



Pathways Community Hub Model

Pathways Hubs lead to Triple Aim Outcomes



Cost Savings: $3.36 for 1st year of life; $5.59 long-term for every $1 spent

Pathways Community Care Coordination in Low Birth Weight Prevention

Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

Abstract The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social

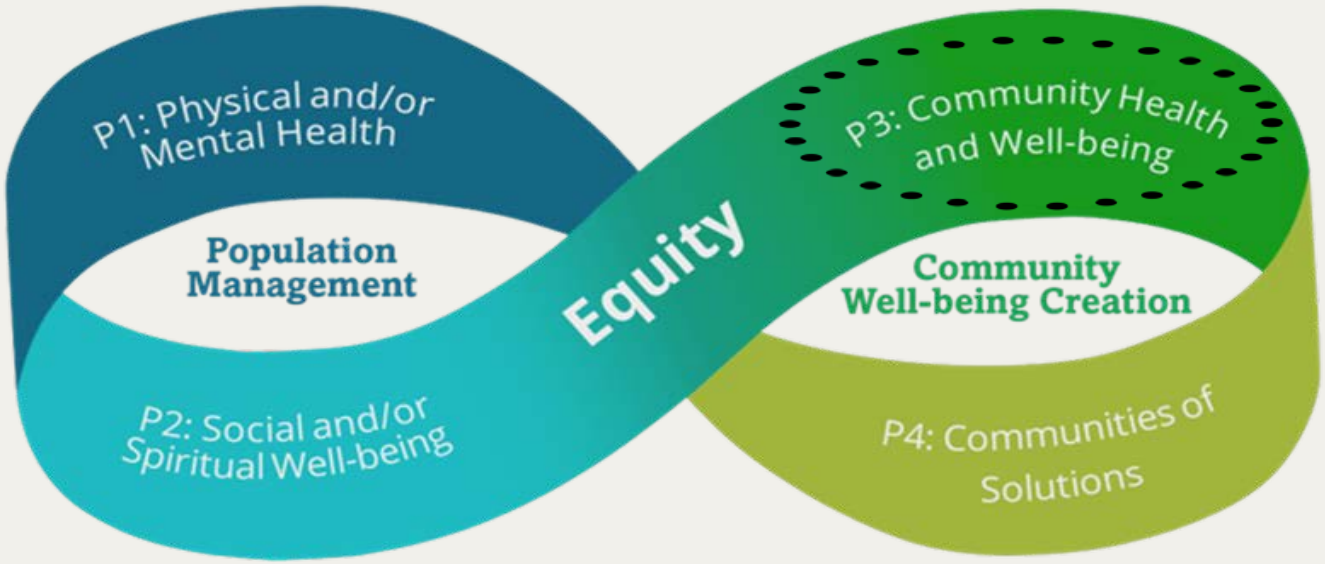
Women participating in CHAP and having a live birth in 2001 through 2004 constituted the intervention group. Using birth certificate records, each CHAP birth was matched through propensity score to a control birth from the same census tract and year. Logistic regression was used to examine the association of CHAP participation

Portfolio 2 Address social and spiritual drivers or health and wellbeing

Palo Alto Medical Foundation

Portfolio 3: Community Health and Well-being

PATHWAYS TO POPULATION HEALTH

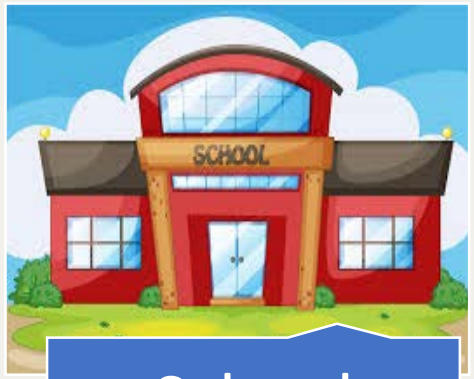


Health care organizations work together with community partners to improve specific health and well-being outcomes for a place-based population.

Activities for this domain may include:

- Collaboratively performing a community health needs assessment– CHNA's
- Setting goals and identify a collection of improvement projects.
- Establishing a learning and improvement system
- Co-investing in infrastructure that facilitates collaboration and the sharing of data, improvement methods, learning, and resources

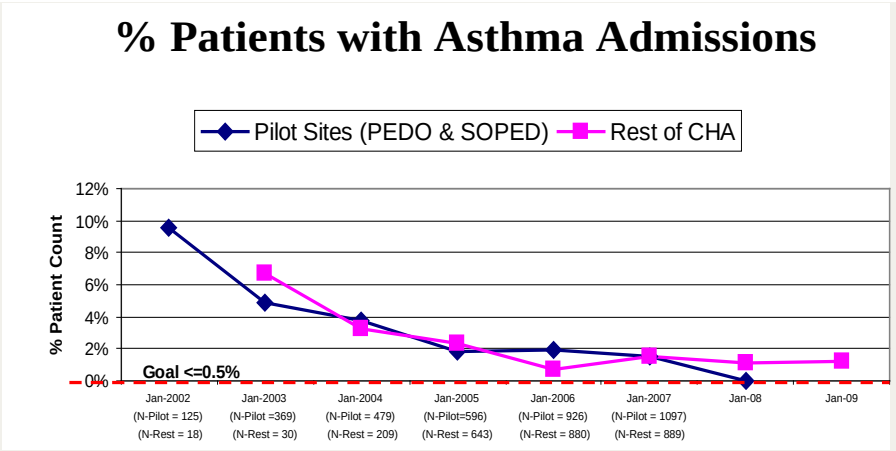
Portfolio 3 Community Health and wellbeing: Childhood Asthma Outcomes at Cambridge Health Alliance



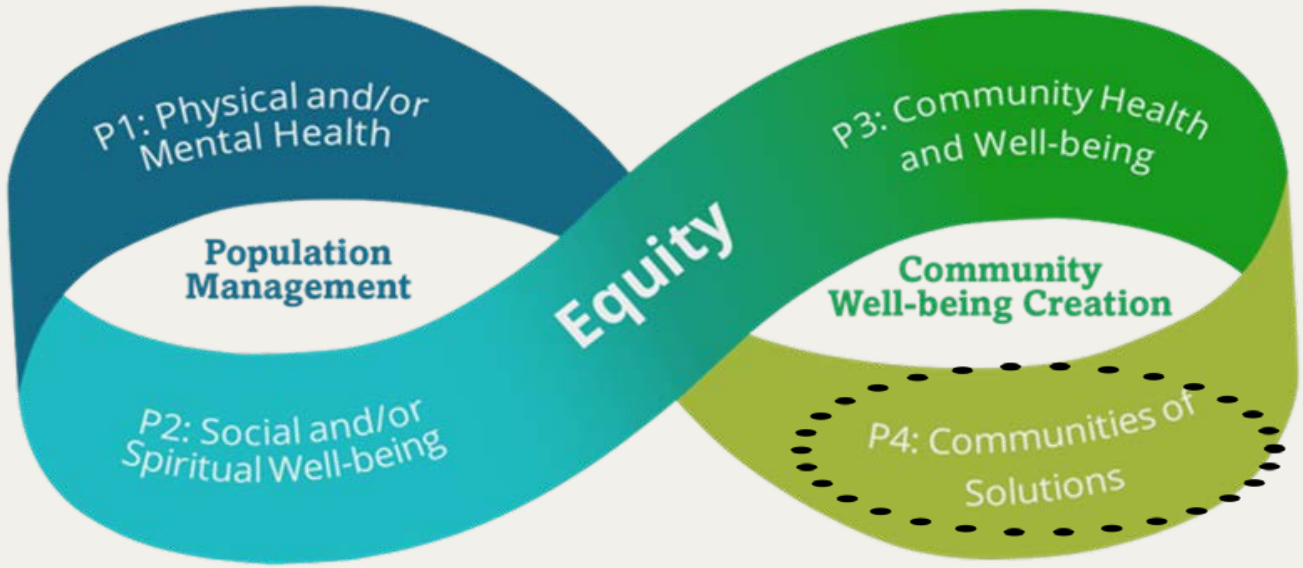
School

Home

Pediatrician



Portfolio 4: Community of Solutions



Health care organizations actively engage in contributing to the long-term, overall well-being of the community as part of their mission and responsibility.

Activities for this domain may include:

- Leveraging roles such as a purchaser, employer, investor, and an environmental steward to improve overall community well-being.
- In community coalitions, mapping assets, creating a vision for the community, and identifying leaders at multiple levels.
- Addressing policy and system changes to promote health, well-being, and equity

Portfolio 4: Communities of solution

- How could we use all our assets nimbly and creatively to move forward the priority goals of a community?
- How could we partner with people with lived experience and grow their leadership and ownership of the process of change?
- How can we work with leaders across the community across sectors and levers to creating meaningful, measurable, sustainable change?
- How could we disrupt the underlying systems that create inequity?

100 Million
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Measuring outcomes differently

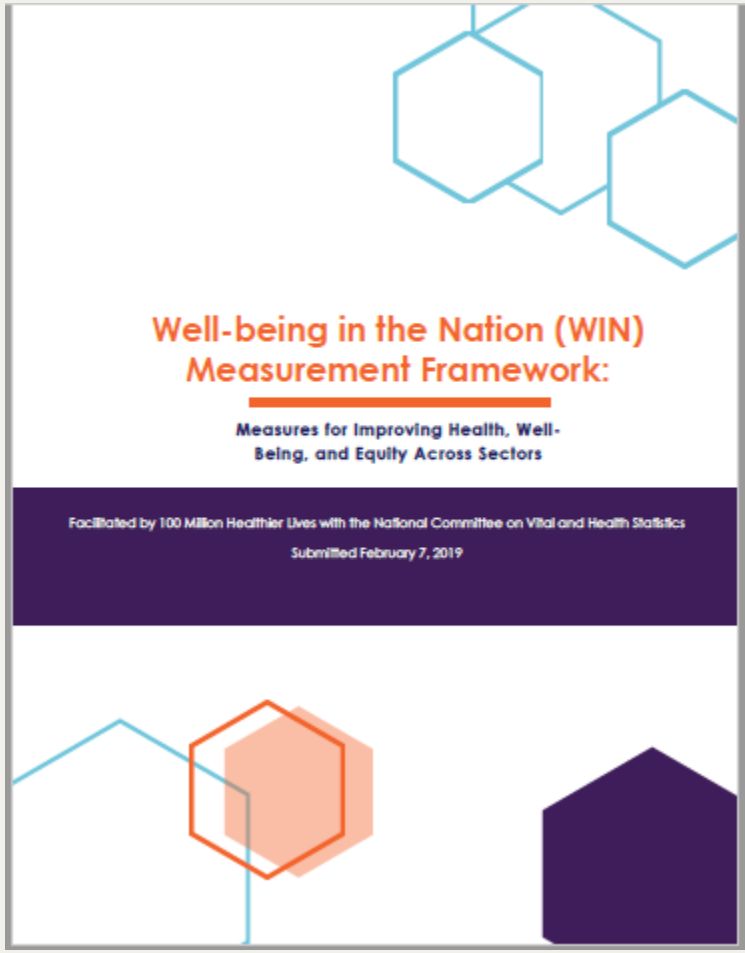
What is the Well-Being In the Nation Measurement Framework and who developed it?

- The Well-Being In the Nation (WIN) Measurement Framework offers a set of common measures to assess and improve population and community health and well-being across sectors.
- It is intended to help people address all of the drivers of health, well-being and equity together and to see the connections between them. This includes measures for the social determinants of health.
- The framework is divided into three elements: core measures, leading indicators, and a full flexible set of measures.
- The framework was developed by the National Committee on Vital and Health Statistics; measure development was facilitated by 100 Million Healthier Lives, with input from 100+ people and organizations

www.winmeasures.org

Well-being in the Nation (WIN) Measurement Framework (NCVHS Framework)

1. Core measures
    - Well-being of people
    - Well-being of places
    - Equity
2. Leading indicators
    - 12 domains and associated subdomains related to determinants of health (upstream, midstream, downstream)
3. Full flexible set (developmental measures)
    - 12 domains and associated subdomains



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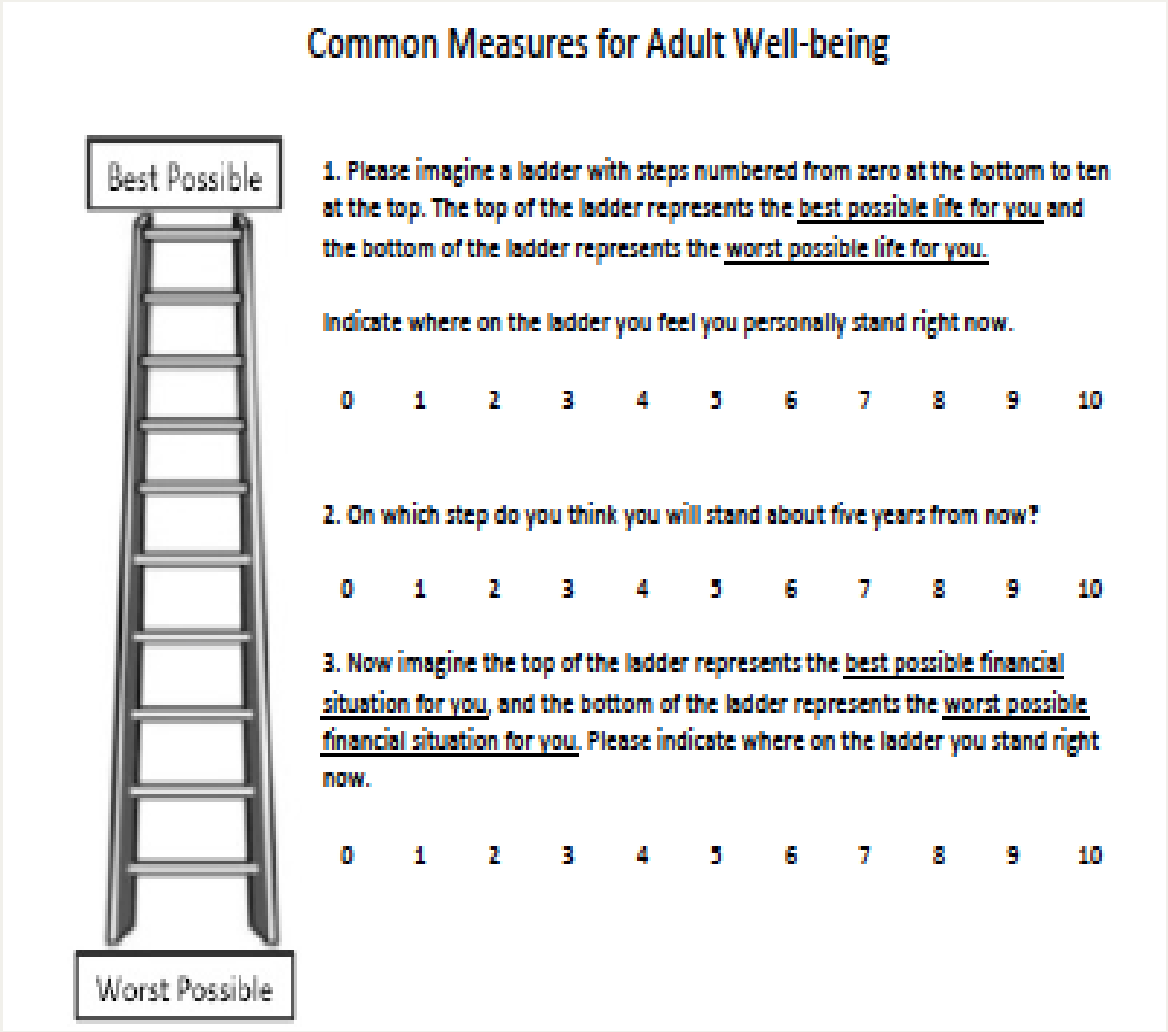
Well-being In the Nation (WIN) Core Measures

1. **Wellbeing of people**
   - People's perception of their well-being
   - Life expectancy
2. **Wellbeing of places**
   - Healthy communities index (USNWR/CHRR)
   - Child poverty
3. **Equity**
   - Differences in subjective well-being
   - Years of potential life gained
   - Income inequality, graduation rates
   - Differences by demographic variables (race, place, gender, educational level, language, etc.)

www.winmeasures.org

People reported well-being



% people thriving
% people strugglinh
% people suffering

Age
Sex
Race/Ethnicity
Education
Zip code
Veteran status

- Cantril's ladder - Two simple questions
- Administered 2.7 million times, highly validated
- Relate to morbidity, mortality, cost
- Useful for risk stratification
- Work across sectors

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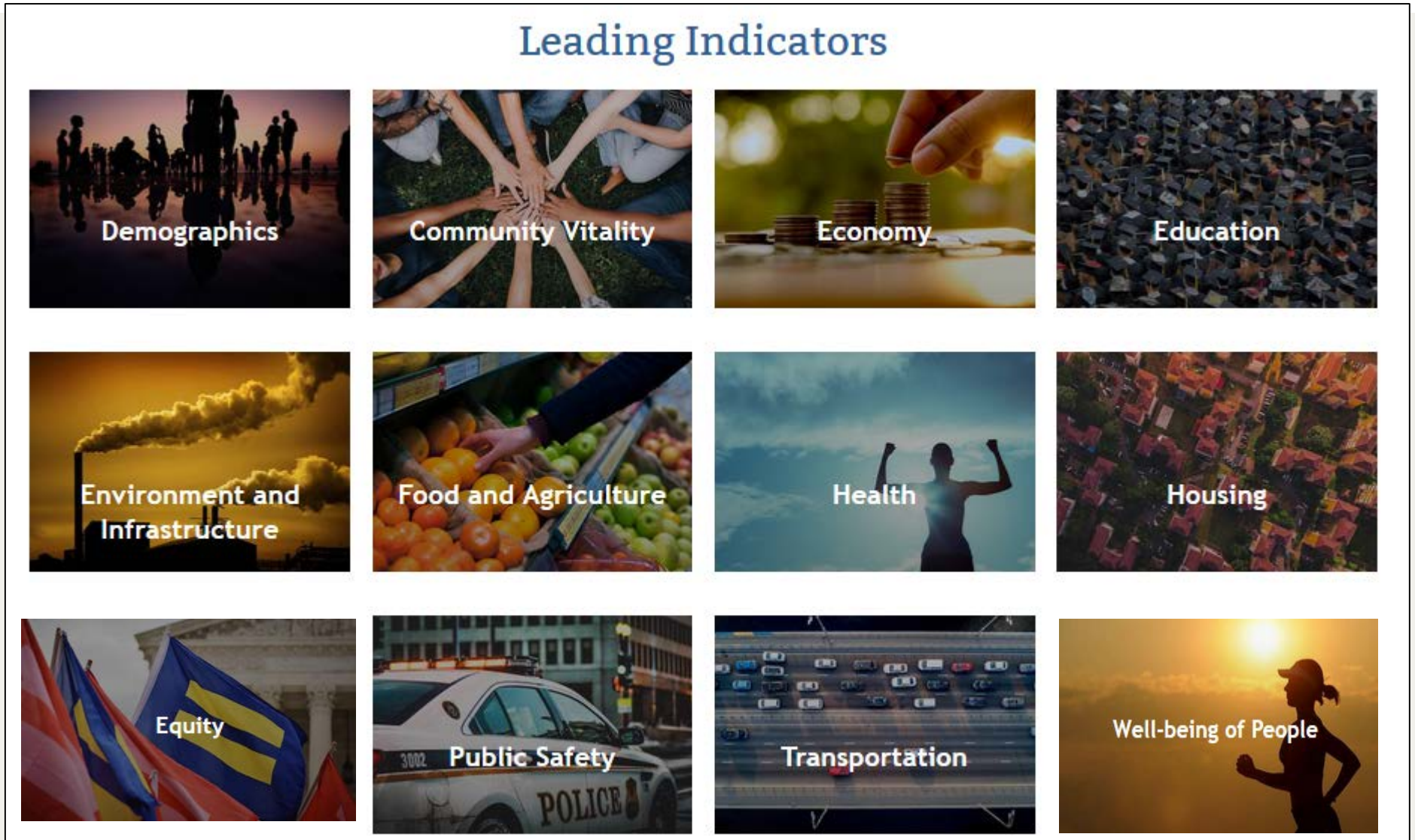
Leading Indicators

Indicators with strong validity, importance, and data availability

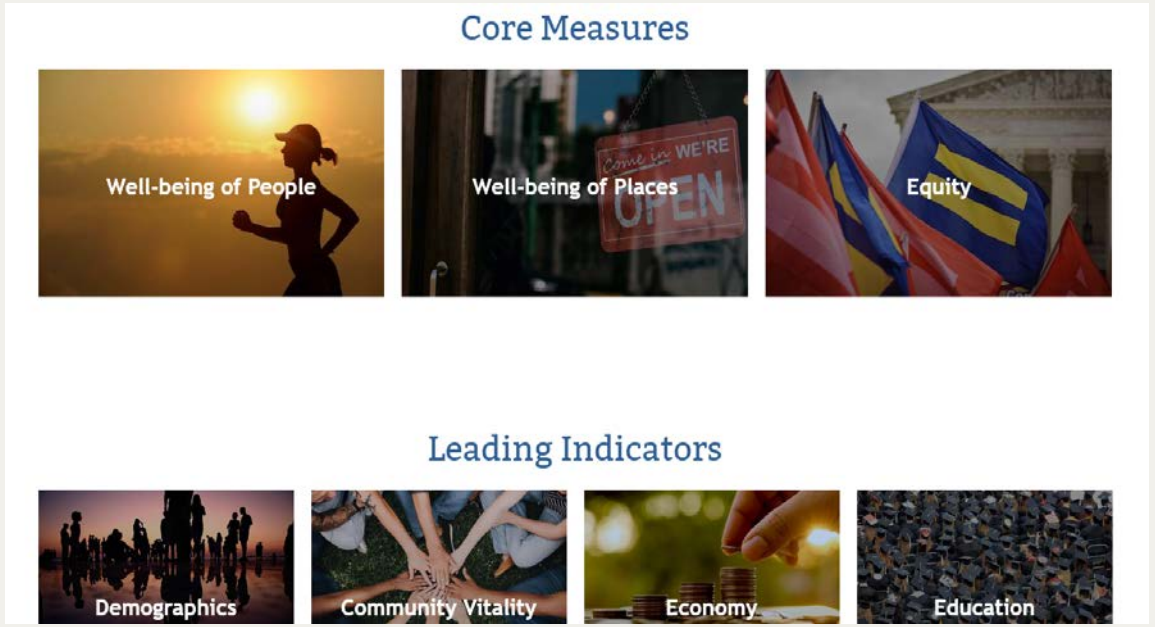


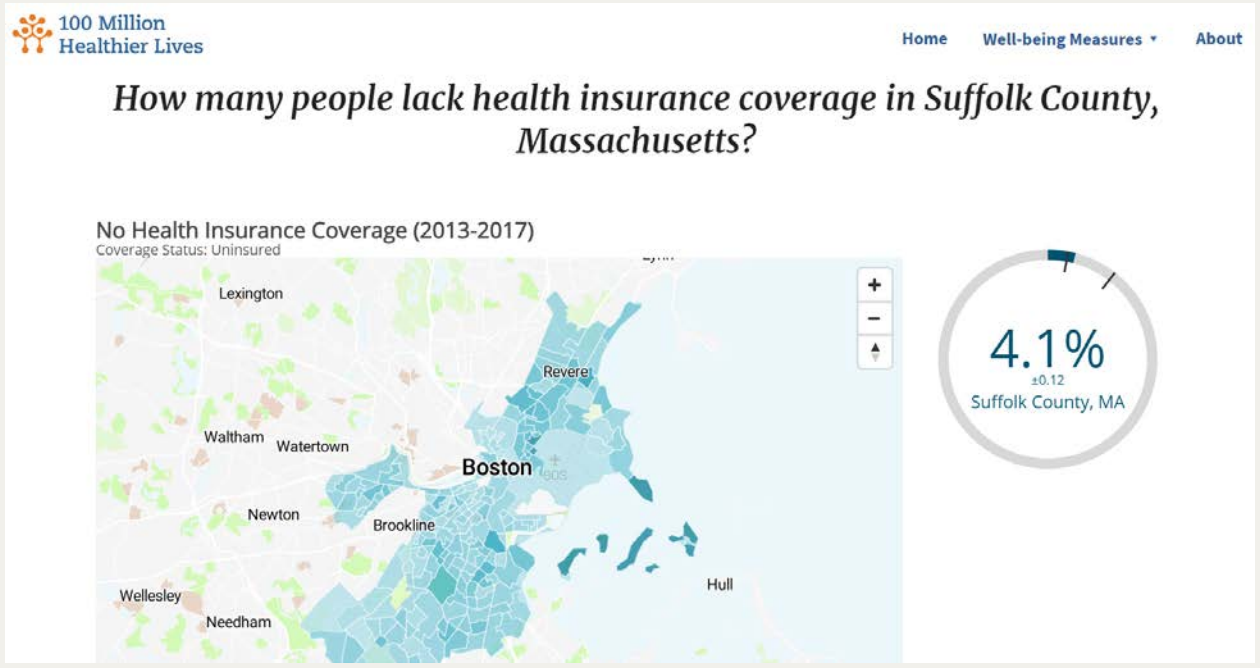
What you can use these measures to do

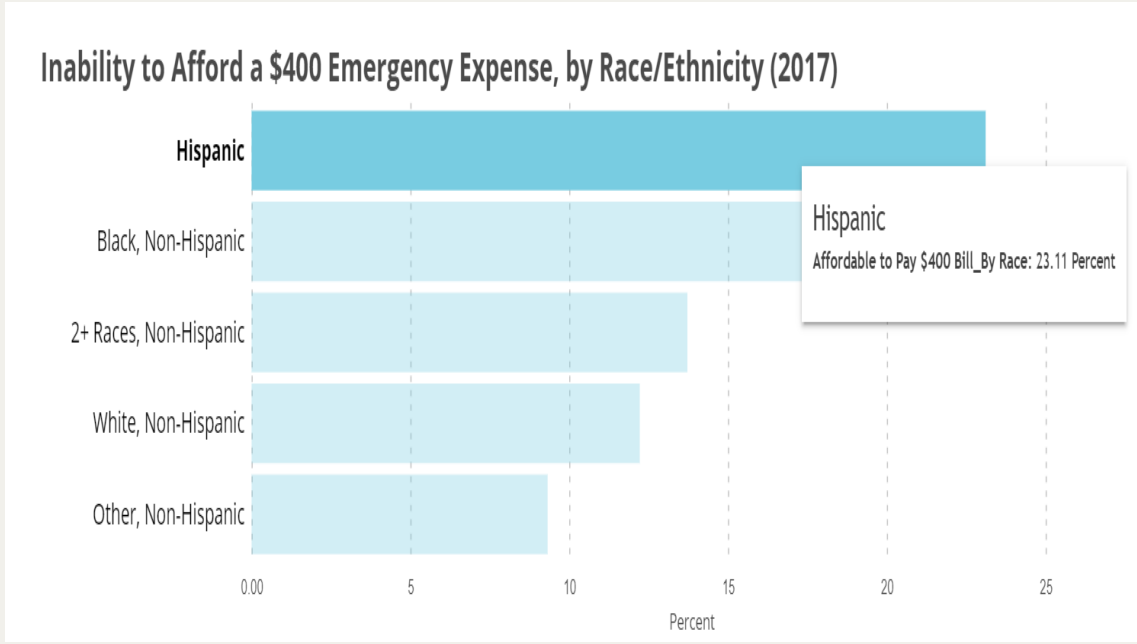
- Identify measures for national initiatives that can be applied across a wide variety of communities.
- Monitor the health, well-being, and equity of a population over time.
- Understand and drive improvements in health, well-being, and equity.
- Understand health, well-being, and equity in population segments.
- Compare the health and well-being of communities through the development of an index.

WIN Implementers

1. US News & World Report
2. American Heart Association
3. National Councils on Aging
4. HERO (Employers)
5. Health systems - Kaiser Permanente, Health Partners
6. States – Delaware, New York, California
7. Federal agencies – Veterans Administration
8. Public health agencies – Association of State and Territorial Health Officials
9. Funders – Wellbeing Trust, Robert Wood Johnson Foundation
10. Wellbeing Legacy partners
11. Technology groups: Community Commons, LiveStories
12. Other measurement efforts – CityHealth Dashboard, USNWR, Healthy Places Index, SIREN
13. Other sectors: Housing (Enterprise), CDFIs (Build Healthy Places Network), Transportation, Business, Media
14. 100 Million Healthier Lives partners – IHI, DASH, Empath, SCALE communities
15. In coordination with Healthy People 2030







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The Health Advocates In-Reach and Research Campaign (HAIR)

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