Pathways to Population Health: A Framework for Improvement
Presented by HRET HIIN and the Association for Community Health Improvement

December 6, 2018
Jessica T. Claudio, HRET HIIN
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<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker(s)</th>
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<tr>
<td>12:00 – 12:05 PM</td>
<td>Welcome</td>
<td>Jessica T. Claudio, HRET HIIN</td>
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<tr>
<td>12:05 – 12:10 PM</td>
<td>Introduction about Population Health</td>
<td>Julia Resnick, AHA</td>
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<td>12:10 – 12:45 PM</td>
<td>Pathways to Population Health: A Framework for Improvement</td>
<td>Julia Resnick, AHA</td>
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<td>12:45 – 12:55 PM</td>
<td>Questions &amp; Feedback</td>
<td>Participants and Facilitator</td>
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<td>12:55 – 1:00 PM</td>
<td>Closing Remarks</td>
<td>Jessica T. Claudio, HRET HIIN</td>
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Upcoming Health Disparities Educational Series

• **Tuesday, December 11, 2018 12-1 pm CT**
  The Power of the Patient: The Path from Engagement to Equity *(NEXT)*
  Register [here](#)

• **Wednesday, December 19, 2018 12:30-1:30 pm CT**
  Measuring What Works to Achieve Health Equity
  Register [here](#)
Julia Resnick, MPH
Senior Program Manager
The Value Initiative & Association of Community Health Improvement
American Hospital Association, Center for Health Innovation
After this session, you will be able to:

• Describe the Pathways to Population Health and its foundational principles
• Understand how social determinants of health (SDOH) impact individuals and communities
• Draw connections between Population Health and other AHA work
## Paradigm Shift in Health Care

<table>
<thead>
<tr>
<th>Today</th>
<th>Future</th>
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<tr>
<td><strong>Focus</strong></td>
<td>Community health</td>
</tr>
<tr>
<td>Individual patient</td>
<td>Coordinated, longitudinal care</td>
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<tr>
<td><strong>Care</strong></td>
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<td>Fragmented, episodic treatment</td>
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<td><strong>Goal</strong></td>
<td>Achieving wellness</td>
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<td>Treating sick</td>
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<td><strong>Rewards</strong></td>
<td>Value, outcome driven</td>
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<td>Volume driven (FFS)</td>
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<tr>
<td><strong>Setting</strong></td>
<td>Community based; range of settings</td>
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<tr>
<td>Institutional base; hospital</td>
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<tr>
<td>oriented</td>
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<td><strong>Leadership</strong></td>
<td>Systems thinking/integrated processes</td>
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<td>Managing departments/divisions</td>
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Converging Market Forces

- Increased chronic disease burden
- Risk-based contracting mechanisms
- Disruptive, consumer-focused innovation
- Enhanced focus on affordability and value
Transitioning Payment Models

Source: Health Catalyst, 2017

Source: Innosight, 2017
REDEFINING THE “H”

The “H” of the future is an interconnected ecosystem of Hospitals, Health systems and Health organizations that are:

- **Partnering and leading in our communities**
- **Creating new models of care, services and collaborators**
- **Helping our communities beyond the four walls of the hospital**
- **Striving toward the vision to advance health in America**
**AHA Path Forward**

**Vision:** A society of healthy communities where all individuals reach their highest potential for health.
Poll Question

- What factor has the largest impact on someone’s health?
  - Access to care
  - Quality of health care
  - Health behaviors
  - Socioeconomic factors
Social Determinants of Health

- **20%** of a person’s health and well-being is related to access to care and quality of services.
- The physical environment, social determinants and behavioral factors drive **80%** of health outcomes.

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014; Graphic designed by ProMedica.
Social Determinants Impact Life Expectancy

16 year life expectancy gap based on where you live in Chicago.

Source: Reprinted with permission from the VCU Center on Society and Health
## Social Determinants Impact Health Care Organizations

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<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social Integration</td>
<td>Health Coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to Healthy Options</td>
<td>Community Engagement</td>
<td>Provider Availability</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Higher Education</td>
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<td>Support Systems</td>
<td>Provider Linguistic &amp; Cultural Competency</td>
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<td>Debt</td>
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<td>Vocational Training</td>
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<td>Medical Bills</td>
<td>Playgrounds</td>
<td>Early Childhood Education</td>
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<td>Support</td>
<td>Walkability</td>
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### Health Outcomes:

- Mortality
- Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations

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Poll Question

How do you define your “population” for population health activities?

a. Individuals for whom you have a financial risk
b. Individuals who may utilize your hospital or health care system
c. Individuals experiencing a certain disease or condition
d. Individuals living in a specified geographic area or community
e. Individuals with specific age or life phase-related health needs
Definition of Population Health
"the health outcomes of a group of individuals, including the distribution of such outcomes within the group."
- Kindig & Stoddard, 2003

- Population Health is **not only**:  
  ✓ Population Management or  
  ✓ Population Health Improvement or  
  ✓ Accountable Care Organizations or  
  ✓ Social Determinants of Health  
  ✓ Or...
THE OUTCOME

HEALTH & WELL-BEING

POPULATION HEALTH IS THE VEHICLE TO GET US THERE
Population Health is…

Advancing Health and Well-Being by Bridging Care and Community
Population Health is Aligned with Mission

Voices from the Field

“Need to link social determinants strategies with clinical outcomes to provide value proposition to leadership.”

“Addressing social determinants is all about relationships and networks with patients and community stakeholders”

“Given slim margins for most non-for profit hospitals, limited dollars for investing in population health strategies”

“Health disparities and equity must be prominent in any discussion of population health or social determinants”

“Hospitals can’t be at the center or have primary responsibility – we should be a convener or connector in the process.”

“...frustrated that after years of effort we’re not making more progress toward health improvement goals.”
Two Jobs for Health Care Organizations to Embrace

Improve the health and well-being of patients

Improve the well-being of communities

Population health, well-being and equity
Tools and Activities

Visit [www.pathways2pophealth.org](http://www.pathways2pophealth.org) to access these tools and learn more!
P2PH Framework

Three primary sections:

1. Foundational Concepts and Creating a Common Language
2. Portfolios of Population Health
3. Levers for Implementation

Download the Framework now at www.pathways2pophealth.org
Foundational Principles of Population Health

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?
Pathways to Population Health

P1: Physical and/or Mental Health
P2: Social and/or Spiritual Well-being
P3: Community Health Well-being
P4: Communities of Solutions

Equity

Portfolio 1: Physical and/or Mental Health

Improving the physical and/or mental health of individuals within a defined population.

Activities for this domain include:
- Patient empanelment and care management;
- Access, evidence-based practice and risk stratification;
- Partnering with patients and families;
- Engaging in performance improvement
Portfolio 2: Social and/or Spiritual Well-being

Activities for this domain include:
- Screening and addressing the social determinants of health;
- Developing key partnerships;
- Tracking improvement in the activities to establish the value proposition.

Screening for and addressing the social and spiritual drivers of health and well-being for a defined population.
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 include:
- Cross-sector partnerships
- Collaborative CHNAs
- Setting goals and developing improvement projects
- Establishing a learning and improvement system
- Facilitate collaboration around the sharing of data, improvement methods, learning and resources
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 include:

- Anchor organization roles such as a purchaser, employer and investor
- In community coalitions, mapping assets, creating a vision for the community, and identifying leaders at multiple levels.
- Address policy and system changes
Pathways to Population Health – An Example

P1: Physical and/or Mental Health
P2: Social and/or Spiritual Well-being
P3: Community Health Well-being
P4: Communities of Solutions

Equity

P2PH Compass

- 8 components to identify your organization’s current state
  - Components: Stewardship, Equity, Payment, Partnerships with People with Lived Experience, Portfolio 1, Portfolio 2, Portfolio 3, Portfolio 4

- For each statement, select the description that best represents the attitudes, behaviors, or actions currently underway

- Interpret your results and build a balanced approach to population health
  - The Compass provides a snapshot of your organization’s current activities and suggests ideas for next steps to help your organization progress to where it wants to be (ideally, making progress in all components and striving for balance between the four portfolios)
Compass Scoring

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.
Learn Act Improve

Download the Framework to learn the four portfolios of population health and how to improve health, equity, and well-being

Catalogue current population health activities and identify opportunities to amplify your efforts using the Compass

Find curated tools and resources on the Oasis to support your journey to population health

Visit www.pathways2pophealth.org to download the tools and resources!
Your Organization’s Current Assets and Activities

What is your organization doing in each of these portfolios?
Pulse Check

Join us on our journey towards population health! We are committed to learning together how to better support health care organizations make meaningful, measurable progress towards population health goals. Please fill out this brief survey and mention the American Hospital Association!

Poll Questions

- I feel I have made progress in my population health work as a result of P2PH tools, resources and framework. (Yes/No)
- Would you recommend P2PH to other health care organizations trying to make progress in population health? (Yes/No)
Join HRET HIIN Health Disparities LISTSERV®

HRET HIIN uses the Health Disparities LISTSERV® platform to encourage peer-to-peer networking, share HRET HIIN events and resources, and highlight innovative approaches to reduce harm.

Register here
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