Welcome and Introduction
P2PH is a national effort with broad support to improve population health.

PARTNERS

An initiative facilitated by:

With generous support provided by:

Healthy people. Healthy economy.
GDAHC is a Regional Healthcare Improvement Collaborative (RHIC) serving as Southeast Michigan’s trusted convener

- A cross-sector, multi-stakeholder, non-profit, non-governmental membership organization, founded in 1944 (74 years!), serving southeast Michigan
- Partner with those who get care (patients), give care (providers), and pay for care (purchasers and plans)
- Collaborating with the community to improve health, transform health care delivery, manage costs (achieve the Health Care Quadruple Aim)
- Working to “blur the lines” to seamless, whole-person care: integrating social determinants of health; bridging health and health care delivery

Healthy people. Healthy economy. Doing more together.
GDAHC is connected to vast network of RHICs across the country through the Network for Regional Healthcare Improvement
As a RHIC, GDAHC facilitates improvements in health care delivery and health outcomes

VISION
Healthy people. Healthy economy.

PURPOSE
To improve the health and economic vitality of individuals, communities and organizations.

MISSION
Catalyzing collaboration to create healthy tomorrows. (Accomplishing “things” no one organization may do on their own.)

VALUES
* Compassion  * Equity  * Innovation  * Integrity  * Knowledge
In its role as trusted convener, GDAHC uses Collective Impact to improve health care delivery and create positive health outcomes.

Catalyst for Collective Impact

- Trusted convener
- Backbone organization
- Focal point for community alignment
- Accelerator that maximizes positive outcomes across all partners
- Program manager
- Project facilitator
- Data architect (measurement and assessment)
- Public reporter

Healthy people. Healthy economy.
The IHI developed the Healthcare Triple Aim to describe an approach to optimizing health system performance.

- **Better Health**: Improving the health of populations
- **Better Care**: Improving the patient experience of care
- **Better Value**: Reducing the per capita cost of health care

Healthy people. Healthy economy.
The “Better Health” dimension of the Triple Aim is synonymous with Population Health.

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Healthy people. Healthy economy.
To meet the needs of its diverse membership, GDAHC focuses its work on achievement of the health care quadruple aim.
Population health is defined broadly by the three descriptors contained in the process chart on this slide.

“Population health is holistic in that it seeks to:
- reveal patterns and connections within and among multiple systems
- develop approaches that respond to the needs of populations

“Population health tactics include rigorous analysis of outcomes

“Understanding population-based patterns of outcomes distribution is a critical antecedent to addressing population health management strategies (patterns inform the selection of effective population health management strategies)”


Key perspectives on population health include ...

“Considers broad array of determinants”

“Health care delivery system is an important factor”

“Responsibility for population health outcomes is shared, but accountability is diffuse”

“Upstream factors influence population health”

“Must establish and maintain partnerships to improve”

“Measurement is critical”

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Importantly, population health is not public health

Population Health

“Efforts can be lead by private sector, non-profit, or government entities”

“Can target defined subset of populations based on geography, enrollees in health plan, employees, groups with diseases, etc.”

Public Health

“Traditionally, efforts by government; more recently, emphasis on broader partnerships”

“Often focused on the entire population of a certain geographic area”

“Population health embraces a comprehensive agenda” and may encompass any and all aspects or characteristics of society.

The yellow circle on this slide reflects the ultimate goal of population health and the professionals who have important roles.

“Healthy people comprising healthy populations that create productive workforces and thriving communities”

- Health care providers
- Policy makers
- Public health professionals
- Payers
- Employers

Important changes must take place to “promote health and wellness and advance a population health agenda”

“Improved efforts to provide health insurance coverage, promote health behaviors, and prevent illness”

“The ‘silos’ in healthcare delivery must be dismantled”

“Providers must work cooperatively to advance seamless, coordinated care that traverses settings, health conditions, and reimbursement mechanisms”

“Interdisciplinary teams of healthcare providers committed to diligent management of chronic conditions and providing safe, high-quality care must have central roles”

“Policy makers will be called upon to craft policies that support illness prevention, health promotion, and public health”

“Healthcare professionals must continue efforts to enforce recommendations in communities”

Questions?

Please submit your questions in the chat box.
Additional questions can be emailed to Devon Parrott at dparrott@gdahc.org
PATHWAYS TO POPULATION HEALTH
Learn and Engage

February 11, 2019
Jessica Little, Senior Manager of Operations, NRHI
Objective

By the end of the Learning Lab series, participants will…

- Have an understanding of the Pathways to Population Health Framework to enable development or refinement of population health strategies incorporating the four portfolios of population health
- Will be equipped with tools to assess where they are in their work across the four portfolios.
Background

P2PH is the product of collaboration among five organizations leveraging our shared assets and unique strengths to help health care organizations accelerate population health improvement efforts.
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.
Tools and Activities

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

1. **Foundational Concepts and Creating a Common Language**: This section defines key concepts and terms that are foundational to understanding the journey to population health (the **WHY**); and

2. **Portfolios of Population Health**: This section describes four interconnected portfolios of work that contribute to population health (the **WHAT**); and

3. **Levers for Implementation**: This section surfaces the levers that can be used to accelerate your progress within and across portfolios of work to improve population health (the **HOW**).
Six Foundational Concepts 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?
Four Portfolios of Population Health

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

Equity

Source: Pathways to Population Health, 2018
Portfolio 1: Physical and/or Mental Health

Activities include:

- Care management
- Patient empanelment
- Access
- Risk stratification
- Discharge/readmission programs
- Behavioral health integration
- Engaging patients and families

Portfolio 2: Social and/or Spiritual Well-being

**Activities include:**

- Screening for social determinants of health
- Screen for social and spiritual needs
- Develop community partnerships
Portfolio 3: Community Health and Well-being

Activities include:

• Partner to conduct community health needs assessment
• Collectively identify improvement projects
• Establish a learning improvement system
• Create conditions to enable improvement
Portfolio 4: Community of Solutions

Activities include:

- Develop distributed leadership
- Create a learning system
- Map community assets
- Identify stakeholders and create a shared vision
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, Portfolio 1, Portfolio 2, Portfolio 3, Portfolio 4

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

Interpreting your results and building a balanced approach to population health

- The Compass provides a snapshot of your organization’s current activities and suggests some possible 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)
Using the 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.

<table>
<thead>
<tr>
<th>Our board and senior leadership do not consider addressing the health of the population at large, to be our organization’s responsibility.</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
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<tr>
<td>Our board and senior leadership believe that population health is a priority for our organization. We have developed resources and initiatives to improve the health of individuals and discrete patient populations.</td>
</tr>
<tr>
<td>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.</td>
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<tr>
<td>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.</td>
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<tr>
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<th>Making substantial progress</th>
<th>Implementing broadly</th>
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<td>3</td>
<td>4</td>
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**Equity**
As you consider your organization’s efforts to improve equity, please select the description that best represents the attitudes, behaviors, or actions currently underway.

<table>
<thead>
<tr>
<th>We do not discuss health equity in our organization.</th>
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<tbody>
<tr>
<td>We’ve had some discussions or educational sessions related to health equity, but have not taken any action to address equity issues.</td>
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<tr>
<td>We routinely collect data on race, ethnicity, language, and SES and have active improvement efforts underway to address health equity gaps.</td>
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<tr>
<td>We stratify community data based on key sociodemographic factors and work with community partners to close equity gaps.</td>
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<tr>
<td>We work with community partners to implement, evaluate, and improve programs and policies to address the root causes of inequities.</td>
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**Portfolio 1: Mental and/or Physical Health**
As you consider your organization’s efforts to improve mental and/or physical health, please select the description that best represents the attitudes, behaviors, or actions currently underway in the four components.

**Data**
Consider all the statements below about data.

- We collect data to proactively manage the physical health of discrete populations.
- We collect data to proactively manage the mental health of discrete populations.
- Our strategic planning staff present basic SES Zip code data of key patient concerns as part of our community benefit assessment.
- We use physical and mental health data in our risk stratification to proactively manage prevention, disease management, and complex care management needs for discrete populations.
- We use our data in improvement initiatives related to mental and/or physical health.

<table>
<thead>
<tr>
<th>We don’t do any of these things</th>
<th>We do a few of these things</th>
<th>We do most of these things</th>
<th>We do all these things!</th>
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**Team-Based Care**
Choose the response that best describes your organization at this time.

- We don’t use team-based care in our organization.
- We are exploring models of team-based care in our organization.
- We are starting to implement a team-based care model.
- Team-based care has been implemented throughout our organization. Our team-based care model enables each team member to work to their highest level of licensure.

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**Behavioral Health Integration**
Choose the response that best describes your organization at this time.

- We provide behavioral health and medical care in separate facilities, with separate systems. We are not trying to integrate behavioral health and medical care.
- We are examining approaches to address behavioral health needs within primary care. We are exploring which approach may work best based on our population, payment systems, and resources.
- Primary care providers routinely communicate with behavioral health providers to share information with one another in advance of patient encounters.
- Primary care and behavioral health providers, partners in a range of shared systems (scheduling or medical records), in person or virtual collaboration on care plans, sharing and learning about one another’s roles, capabilities, etc.

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Visit [www.pathways2pophealth.org](http://www.pathways2pophealth.org) to download the tools and resources!

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

### Act
- Catalogue current population health activities and identify opportunities to amplify your efforts using the **Compass**

### Improve
- Find curated tools and resources on the **Oasis** to support your journey to population health
Improve Population Health With Us

We invite you to join us on a journey to improve population health!

What we ask of you:

• Read and reflect on the Framework
• Take the Compass to assess your current portfolio of work
• Develop an Action Plan, utilize tools and resources on the Oasis, to support your progress
• Assess your progress quarterly and celebrate with us along the way!
Take Action Now

- Register for upcoming event on February 22
- Join the online discussion and access resources on the HealthDoers Hub
- Follow us on Twitter @NRHI, #Pathways2PopHealth

Read more at Pathways to Population Health website
Questions?
Homework Assignment

Complete the Compass Tool and share your results with GDAHC

Email to Devon Parrott at dparrott@gdahc.org