Pathways to Population Health
Acting On and Supporting Your Roadmap
February 22, 2019

Contact:
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30200 Telegraph, Suite 105, Bingham Farms, MI 48025
Pathways to Population Health—Part 2

Pathways to Population Health: Acting on and Supporting Your Roadmap

Friday, February 22, 2019
12 p.m. to 1 p.m. EST

Presenters include:

● Kate Kohn-Parrott, President & CEO, GDAHC
● Jessica Little, Director, HealthDoers Network, NRHI
● Laura Wojtys, Manager, Business Line Development, St. Mary Mercy Livonia
● Allison Herrst, CPRC, CPRM-D, Certified Peer Recovery Coach, Growth Works, Inc.
● Kenyetta Jackson, Health Equity Specialist, Division of Maternal and Infant Health, MDHHS
**Today’s agenda**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 p.m.</td>
<td>Welcome &amp; Recap of Learning Lab 1</td>
<td>Kate Kohn Parrott, GDAHC</td>
</tr>
<tr>
<td>12:10 p.m.</td>
<td>ACT: Review of Southeast Michigan regional Compass Tool results</td>
<td>Kate Kohn-Parrott, GDAHC, Jessica Little, NRHI</td>
</tr>
<tr>
<td>12:20 p.m.</td>
<td>IMPROVE: Creating an Action Plan and Using the Oasis Toolkit</td>
<td>Jessica Little, NRHI</td>
</tr>
<tr>
<td>12:30 p.m.</td>
<td>Portfolio #1 (Physical and/or Mental Health) Partner Spotlight: St. Mary Mercy Livonia</td>
<td>Laura Wojtys, St. Mary Mercy Livonia, Allison Herrst, Growth Works, Inc.</td>
</tr>
<tr>
<td>12:42 p.m.</td>
<td>Portfolio #4 (Community of Solutions) Partner Spotlight: Michigan Department of Health and Human Services</td>
<td>Kenyetta Jackson, MDHHS</td>
</tr>
<tr>
<td>12:54 p.m.</td>
<td>Q&amp;A and Call to Action</td>
<td>Kate Kohn-Parrott, GDAHC</td>
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</table>
Welcome and Recap of First Webinar

Kate Kohn-Parrott, President & CEO, GDAHC
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.
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.

An initiative facilitated by:

With generous support provided by:
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.
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
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
Population health is defined broadly by the three descriptors contained in the process chart on this slide.

- Distribution of health outcomes within a population
- Health determinants that influence distribution
- Policies and interventions that affect those determinants

“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)”

Healthy people. Healthy economy.

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

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**What creates health?**

**How can health care engage?**

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Healthy people. Healthy economy.
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
P2PH Compass

• 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)
• 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!
Healthy people. Healthy economy.

ACT: Review of GDAHC’s Compass Tool Results

IMPROVE: Action Plan & Oasis

Kate Kohn-Parrott, President & CEO, GDAHC
Jessica Little, Director, HealthDoers Network, NRHI
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.
Framework Component Scores Summary

Stewardship: 50.0

Equity: 75.0

Payment: 25.0

Partnerships with People with Lived Experience: 25.0

Portfolio Scores Summary

Portfolio 1: 49.98

Portfolio 2: 41.25

Portfolio 3: 66.0

Portfolio 4: 33.0
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.

Compare balance across portfolios

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: Physical and/or Mental Health</td>
<td>49.98</td>
</tr>
<tr>
<td>#2: Social and/or Spiritual Well-Being</td>
<td>41.25</td>
</tr>
<tr>
<td>#3: Community Health &amp; Well-Being</td>
<td>66</td>
</tr>
<tr>
<td>#4: Communities of Solutions</td>
<td>33</td>
</tr>
</tbody>
</table>
Interpreting your Results

<table>
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<tr>
<th>Score Range</th>
<th>Description</th>
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Determine where you will focus your efforts

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<tr>
<td>#4: Communities of Solutions</td>
<td>33</td>
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Learning Lab Activities to Date: Learn

Read and reflect on the Framework

http://www.pathways2pophealth.org/learn
Learning Lab Activities to Date: Act

Compass results provide insight into activities related to:

- Stewardship
- Equity
- Payment
- Partnership with peoples with lived experience
- Portfolio 1: Data, Team-based care, Behavioral health integration, Care management
- Portfolio 2: Data, Social determinant screening/referrals
- Portfolio 3: Data, Community partnerships, community benefit
- Portfolio 4: Data, Leveraging nontraditional roles, Policy

http://www.pathways2pophealth.org/act
Learning Lab Activities: Improve

Utilize Compass results to determine area of opportunity

Portfolio Scores Summary

- Portfolio 1: 58.31
- Portfolio 2: 86.625
- Portfolio 3: 66.0
- Portfolio 4: 44.0
Learning Lab Activities: Improve

Utilize Compass results to determine area of opportunity

Nontraditional Roles/Levers

Consider the kinds of nontraditional roles and levers you currently use to improve health, well-being, and equity.

- Employer (e.g., develop career pipelines in communities with poor equity outcomes; join efforts to “ban the box”; offer a living wage for all employees; invest in peer workforce from underserved communities such as community health workers; incentivize employees to live in communities that are racially segregated to help with integration)
- Purchaser (e.g., procure selectively from vendors, or in communities, that have poor equity outcomes to build community wealth)
- Investor (e.g., give low income loans to women and minority-led businesses or nonprofits working to improve health, well-being, and equity in the community)
- Food purchaser and server (e.g., offer healthy food options for patients while hospitalized; connect to local sources of healthy food in food deserts to improve market for healthy food)
- Environmental steward (e.g., be responsible for your overall environmental footprint and work to reduce emissions and health care waste)
- Funder (e.g., use community benefit dollars to support the community)
- Builder (e.g., choose to locate new facilities in communities with poorer health outcomes to support job promotion)

<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 many of these things</th>
<th>We do all of these things!</th>
</tr>
</thead>
</table>

Nontraditional Roles/Levers: 1
Learning Lab Activities: Improve

Note alignment with the key levers to accelerate improvement outlined in the Framework

<table>
<thead>
<tr>
<th>Portfolio 1: Mental and/or Physical Health</th>
<th>Portfolio 2: Social and/or Spiritual Well-Being</th>
<th>Portfolio 3: Community Health and Well-Being</th>
<th>Portfolio 4: Communities of Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roles to leverage</td>
<td>Roles to leverage</td>
<td>Roles to leverage</td>
<td>Roles to leverage</td>
</tr>
<tr>
<td>• Care deliverer</td>
<td>• Social service and community connector</td>
<td>• Community partner</td>
<td>• Community steward (in partnership with others), leveraging roles as:</td>
</tr>
<tr>
<td>• Employer</td>
<td></td>
<td>• Community needs and assets assessor</td>
<td>o Purchaser</td>
</tr>
<tr>
<td>• Insurer</td>
<td></td>
<td>• Community funder (community benefit)</td>
<td>o Employer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community co-improver</td>
<td>o Investor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Policymaker</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>o Advocate</td>
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</table>
Oasis of Tools and Resources

An oasis is a place that provides refuge, relief, and pleasant contrast (Merriam-Webster’s Dictionary, 2018). The Pathways to Population Health Oasis is a place to find a curated set of tools and resources to accelerate your improvement journey. It is also where you can find refuge and relief along your journey to population health.

This resource list will be updated periodically as Pathways to Population Health identifies helpful tools and resources. Email us at P2PH@ihi.org to nominate a resource that is helping you make progress.

Topic Areas

- Stewardship 1
- Equity 2
- Payment 2
- Data 2
- Partnerships with People with Lived Experience 3
- Portfolio 1: Physical and/or Mental Health 3
- Portfolio 2: Social and/or Spiritual Well-Being 3
- Portfolio 3: Community Health and Well-Being 4
- **Portfolio 4: Community of Solutions**
- Databases of Population Health Resources 4
Portfolio 4: Community of Solutions

23. **Hospitals Aligned for Healthy Communities**
   A set of toolkits to help hospitals and health systems build community wealth through inclusive hiring, investment, and purchasing. Created by the Democracy Collaborative.

24. **Anchor Mission Playbook**
   Recommendations to help hospitals and health systems align their institutional resources (including hiring, purchasing, investment, and volunteer base) with community needs. Prepared by Rush University Medical Center and the Democracy Collaborative.
Learning Lab Activities:
Improve

Inclusive, Local Sourcing

Purchasing for People and Place

The Hospitals Aligned for Healthy Communities toolkit series
Learning Lab Activities: Improve

Simple Policy Fixes

SMALL PROJECTS WITH BIG IMPACT

1. Create department and staff positions dedicated to inclusive, local sourcing
2. Require that local and/or diverse vendors are considered in Request for Proposal (RFP) pool
3. Make inclusive, local sourcing an explicit goal in the strategic plan and other policy documents
## Learning Lab Activities: Improve

identify current assets and set quarterly goals to work towards your vision

<table>
<thead>
<tr>
<th>Portfolio &amp; Associated Components</th>
<th>Assets, Where We Are Strong Now or Gains in the Last Quarter</th>
<th>Overall Vision for this Area</th>
<th>Actions this Quarter to Get Us Closer to Our Overall Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portfolio 4 (Communities of Solutions):</td>
<td>senior leadership and board of directors support</td>
<td>To promote the health of the community by supporting economic growth through utilization of local vendors to fill supply chain needs</td>
<td>resource allocation - identify dedicated resource generate baseline date identifying spend by type of service, location of vendor, and diversity of vendors survey current procurement policies and bid process establish Q3 goals</td>
</tr>
<tr>
<td>Data</td>
<td>supply chain leaders support the program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leveraging Nontraditional Roles</td>
<td></td>
<td></td>
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<tr>
<td>Policy</td>
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</tbody>
</table>
Learning Lab Activities: Improve

**Actions for Stewardship, Equity, Payment, and Partnerships with People with Lived Experience**

In the grid below, note your current strengths or recent wins, your vision for each area, and any actions in this quarter. You may not have actions in all areas (far right column) for this quarter.

<table>
<thead>
<tr>
<th>Area</th>
<th>Assets, Where We Are Strong Now or Gains in the Last Quarter</th>
<th>Overall Vision for this Area</th>
<th>Actions this Quarter to Get Us Closer to Our Overall Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stewardship</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Equity</td>
<td></td>
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<tr>
<td>Payment</td>
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<tr>
<td>Partnerships</td>
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# Learning Lab Activities: Improve

<table>
<thead>
<tr>
<th>Portfolio &amp; Associated Components</th>
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<th>Overall Vision for this Area</th>
<th>Actions this Quarter to Get Us Closer to Our Overall Vision</th>
</tr>
</thead>
</table>
| Portfolio 1 (Mental and/or physical health): | □ Data  
□ Behavioral Health Integration  
□ Team Based Care  
□ Care Management | | |
| Portfolio 2 (Social and/or spiritual wellbeing): | □ Data  
□ Social Determinant Screening and Referrals | | |
| Portfolio 3 (Community health and wellbeing): | □ Data  
□ Community Partnerships  
□ Community Benefit | | |
Questions?
St. Mary Mercy Livonia & Growth Works:
Peer Recovery Coaching Program

Presenters:
Laura Wojtys, St. Mary Mercy Livonia
Manager of Business Development

Allison Herrst, Growth Works
Lead Peer Recovery Coach
Growth Works Coaching

• Patients who come into the St. Mary Mercy Emergency Department with an opioid addiction will be offered the Peer Recovery Program as a resource by the Social Worker.

• The Peer Recovery Coach will meet the patient at the hospital and provide support through their journey to recovery, specific to the individual's needs and situation.

• Peer Recovery Coaches have real life experience in addiction and recovery as well as training and resources to begin the recovery process.
Breaking the Cycle

- **Individuals repeatedly abuse substances**
- **Patients visit the Emergency Room to detox**
- **Patients are discharged from the Hospital**
- **Hospital treat patients detox symptoms (ER & CDU)**
- **Patients choose whether or not to be connected with a Coach**

Recovery is Possible!

- **YES**
- **NO**
# Peer Recovery Coaching Statistics

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Asked to Participate (Total)</td>
<td>622</td>
</tr>
<tr>
<td>Patients Declined (Total)</td>
<td>84</td>
</tr>
<tr>
<td>Patients Consented (Total)</td>
<td>538</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>209</td>
</tr>
<tr>
<td>IOP</td>
<td>50</td>
</tr>
<tr>
<td>Medical Floor</td>
<td>85</td>
</tr>
<tr>
<td>CDU</td>
<td>122</td>
</tr>
<tr>
<td>BHU</td>
<td>71</td>
</tr>
</tbody>
</table>
Peer Recovery Coaching Statistics

Monthly Consents

April: 3
May: 9
June: 15
July: 31
August: 68
September: 88
October: 92
November: 94
December: 80
January: 95
February: 47
Growth Works: Western Wayne Rescue Recovery

- We are people who have maintained long-term recovery and want to help make this a reality for those who struggle with addiction.
- We help connect patients with resources to aid in their recovery process.
  - Ranging from treatment and support services to basic necessities like food and shelter.
- We relate to the patient by sharing our experiences and restore hope that they, too, can recover.
GDAHC Pathways to Population Health

- **Portfolio 1:** Physical and/or mental health, health care organizations are focused on improving the physical and/or mental health of individuals within a defined population
  - Coaches provide ongoing **care management** to support recovery
  - Coaches help individuals **access** services beyond hospital resources
  - Coaches are essential in the **discharge** with the goal of preventing unnecessary **readmissions**
  - Coaches acknowledge the Behavioral component of Substance Use Disorder
  - Coaches not only beneficial to **patients**, but are a great resource for **families** as well
Questions?
Laura Wojtys  Laura.Wojtys@stjoeshealth.org

Allison Herrst  Allison.Herrst@gwcares.org
Relating Mother Infant Health and Equity to the Pathways to Population Health Framework

February 22, 2019
Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files, and infant mortality files, Division for Vital Records and Health Statistics, MDHHS
Strategic Focus Areas

- Reducing disparities
- Addressing the primary causes of preventable maternal deaths
- Addressing the primary causes of preventable infant deaths
Call to Action for Health Equity

Four action steps starting in Year 1 and moving down the road towards Year 3

- **2019**
  - Data-informed interventions

- **Future years**
  - Identification of systemic inequities
  - Inclusive decision-making
  - Continued Stakeholder engagement and feedback from families
Population Health Model


**Measurement**
Measure outcomes to determine the impact.

**Implementation**
Clinical and community alignment of interventions using a quality improvement framework.

**Interventions**
Selection of evidence-based interventions tailored to each tiered population.

**Data-Informed**
Use qualitative and quantitative data to identify needs in each community.

**Population Identification**
Identify vulnerable populations.

**Stratification**
Tier the population into high, moderate, and low groups based on the likelihood of adverse outcomes.
Communities of Solutions

Portfolio 4 of the Path to Population Health Framework

For health care organizations, individually:

Leverage nontraditional roles, levers, and assets: Leverage roles such as a purchaser, employer, investor, and an environmental steward to improve overall community well-being.

For community coalitions, including health care organizations:

Develop distributed leadership: Identify leaders at multiple levels in the community to drive change within each area of the coalition’s portfolio.
Communities of Solutions
Portfolio 4 of the Path to Population Health Framework

For community coalitions, including health care organizations:

Create a learning system: Identify and use measures that are meaningful to multiple stakeholders in the community and develop a comprehensive learning system to drive the work.

Address policy and system changes to promote health, well-being, and equity: Actively address, advocate for, and advance the policies and system changes that will create sustainable, long-term improvement in health and well-being and address the historic root causes of inequity.
Kenyetta Jackson
email: JacksonK29@michigan.gov
GREATER DETROIT AREA HEALTH COUNCIL

30200 Telegraph, Suite 105, Bingham Farms, MI 48025

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