100 Million Healthier Lives

Achieving breakthrough improvements in health, wellbeing and equity

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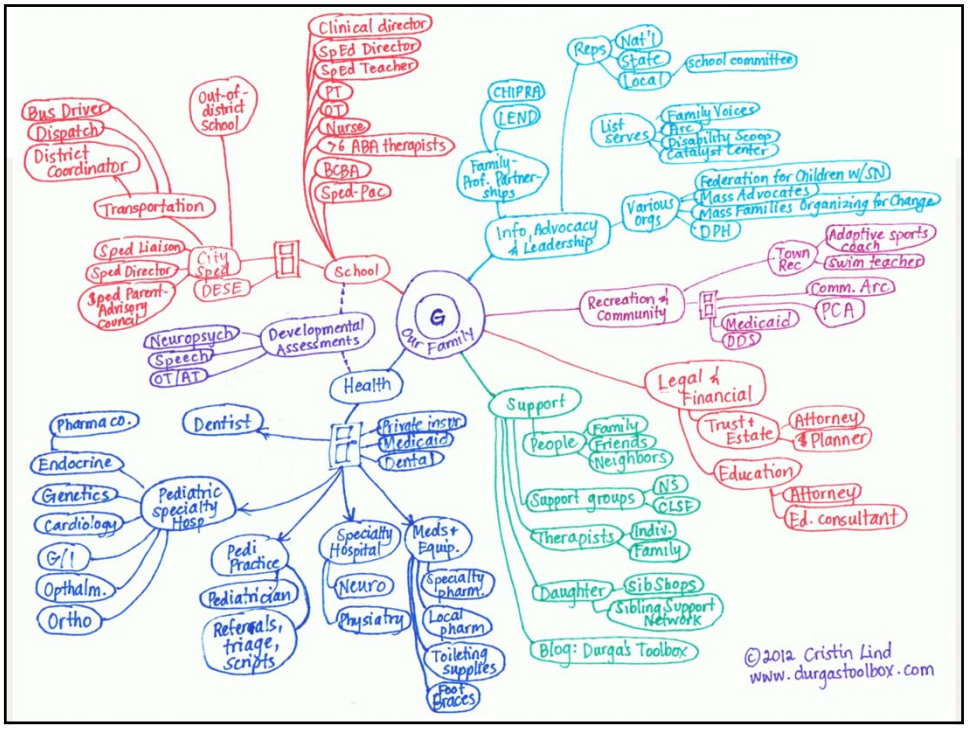
Executive Lead, 100 Million Healthier Lives

May 4, 2018 | Summit on Quality – Kansas Collaborative

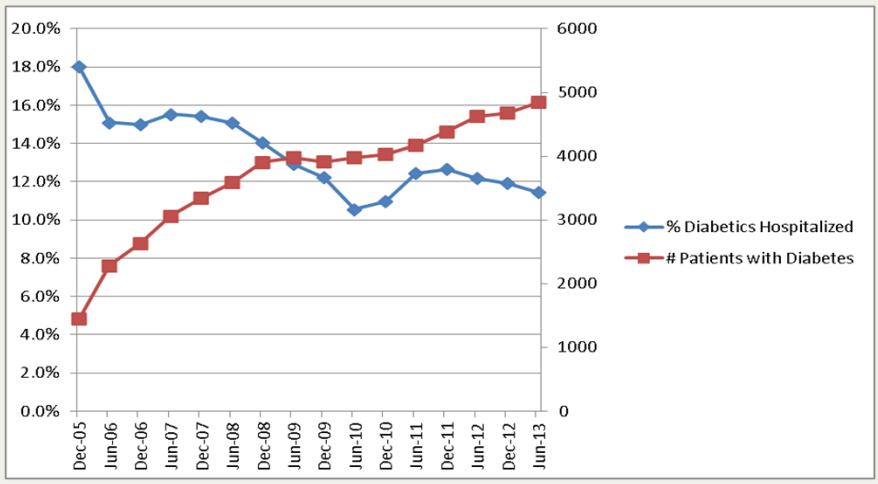
CONVENED BY Institute for Healthcare Improvement

Cambridge Health Alliance

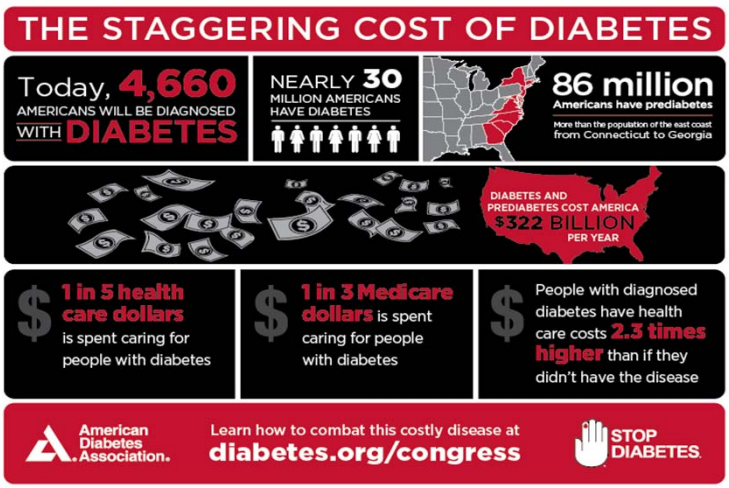
- Changed our payment model and our delivery model from fee for service to global payments (230 people to 60% population)
- Improved experience
- 10% reduction in total cost (15% reduction compared to rest of network for Medicaid managed care)
- Improved quality health outcomes for a safety net population to above the national 90%ile
- Improved joy and meaning of work for the workforce
- Chosen by HHS ASPE as “one of four innovative and effective transformations in the country”; numerous national awards



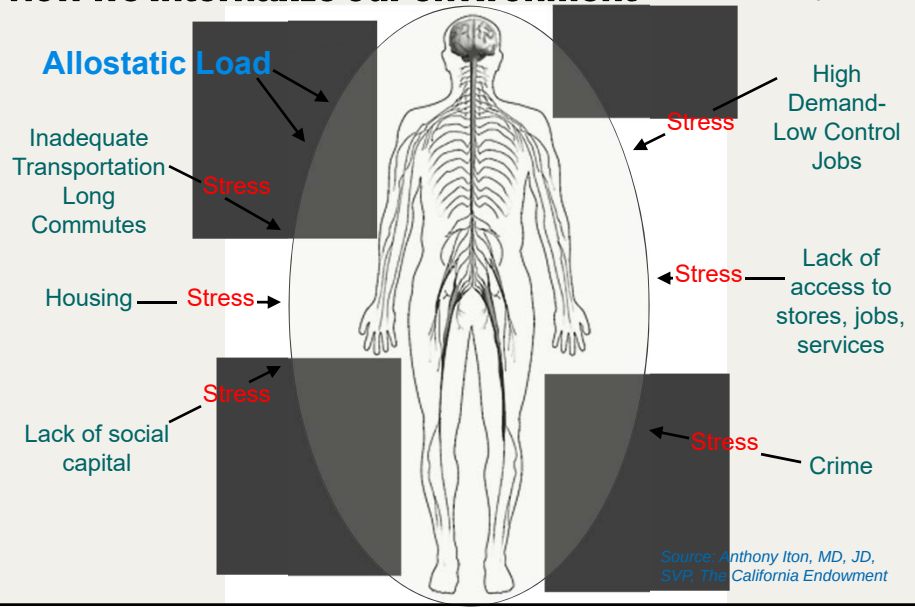
36% Reduction in Hospitalization Rate for Patients with Diabetes



Cost of chronic disease unsustainable[5]



When the external becomes internal: How we internalize our environment



Health and Social Inequity are Interconnected and Related to Place

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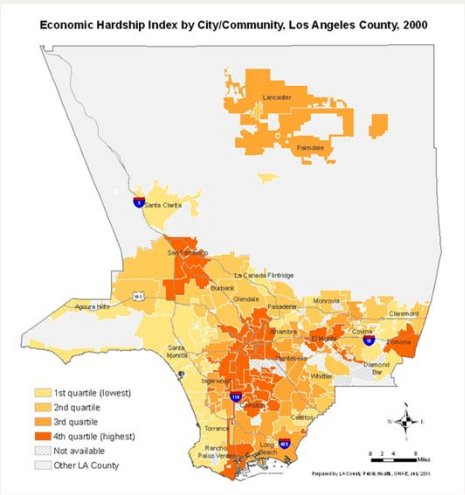

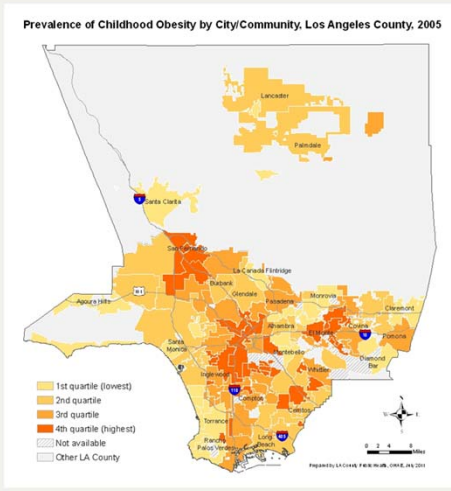

2 newborns will have a 25 year gap in life expectancy 2 miles apart based on where they grow up

Chronic place-based inequities are not accidental – there is a system in place that propagates them

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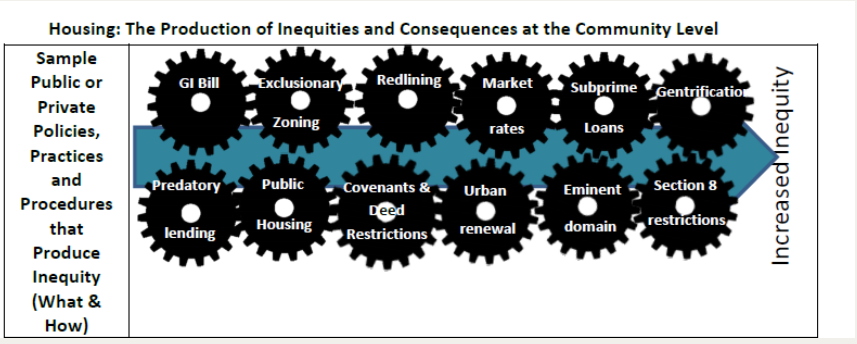
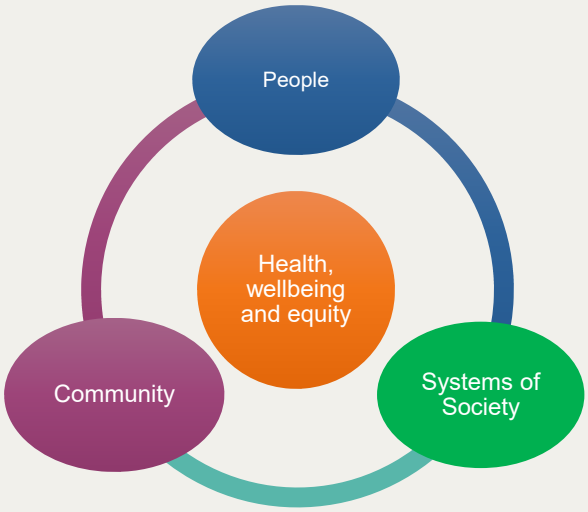


"Countering the Production of Health Inequities" Report from the Prevention Institute

Interrelationship between the health, wellbeing and equity of people, communities and populations



5 key shifts we need to make

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- From a “sick care system” to a “health and wellbeing system”
- Take our work on addressing racism and equity from “doing good” to a recognition that we are interconnected and cannot afford the price of poverty and inequity in terms of health and life outcomes or cost
- From people and communities of poverty to people and communities of trapped and untapped potential
- From pathology to vision – change is possible
- From scarcity to abundance

100 Million Healthier Lives

Identity: An unprecedented collaboration of change agents pursuing an unprecedented result:

100 million people living healthier lives by 2020

Vision: to fundamentally transform the way we think and act to improve health, wellbeing, and equity.

Equity is the "price of admission."

Convened by IHI as a partnership.

www.100mlives.org

Core strategies + equity as the price of admission

1. Create healthy, equitable communities
2. Build bridges across sectors
3. Create a health care system that is good at health AND good at care
4. Promote peer-to-peer approaches
5. Create enabling conditions
6. Develop new mindsets

Health Systems Transformation Hub

PATHWAYS TO POPULATION HEALTH

Formed to coordinate and align efforts across organizations that support health systems in transformation efforts. P2PH grew from this effort.

Pathways to Population Health: For Health Care Change Agents

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- Developed through unprecedented collaboration and thought partnership of over 50 leading health and health care organizations together
- 5 partners took the lead in implementation of the framework:
  - American Hospital Association/HRET
  - Institute for Healthcare Improvement
  - Network for Regional Healthcare Improvement
  - Public Health Institute
  - Stakeholder Health

www.pathways2pophealth.org

Goals

PATHWAYS TO POPULATION HEALTH

1. **Develop a clear and cohesive articulation** about what the journey to population health entails for health care organizations.
2. **Build a pathway of support** that helps health care organizations 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:

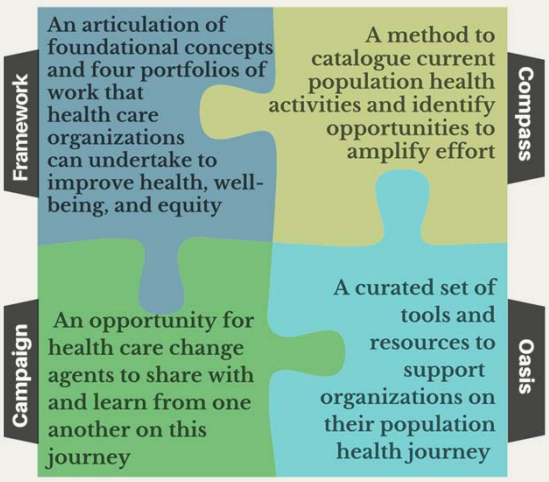
HRET Institute for Healthcare Improvement nrhi Network for Regional Healthcare Improvement Public Health Institute Stakeholder Health

An initiative facilitated by: 100 Million Healthier Lives

With generous support provided by: Robert Wood Johnson Foundation

Tools and Activities

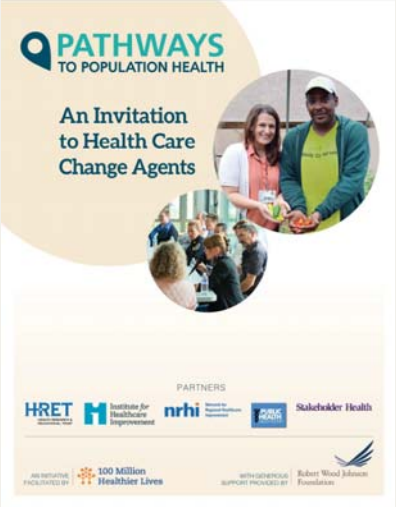
PATHWAYS TO POPULATION HEALTH



Visit www.pathways2pophealth.org to access these tools and learn more

P2PH Framework

PATHWAYS TO POPULATION HEALTH



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**);
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

PATHWAYS TO POPULATION HEALTH

Two major jobs that health care organizations need to embrace

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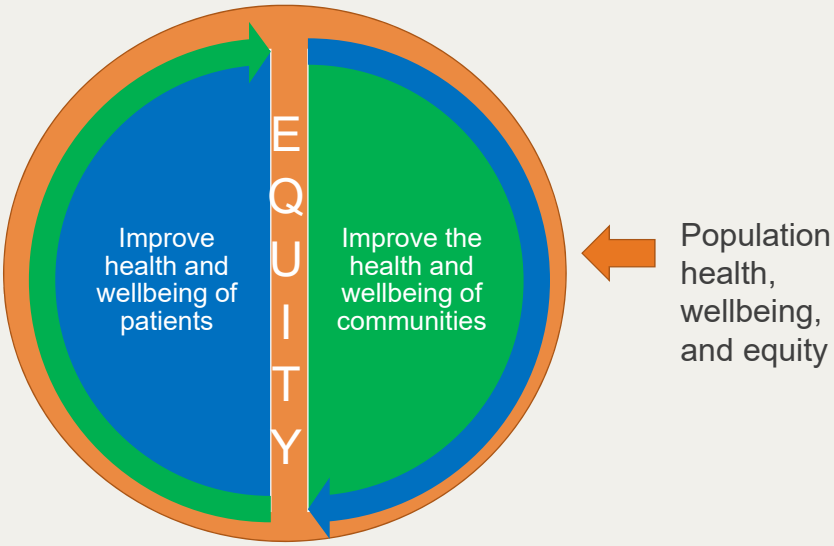

Four Interconnected Portfolios of Population Health for Health Care Organizations

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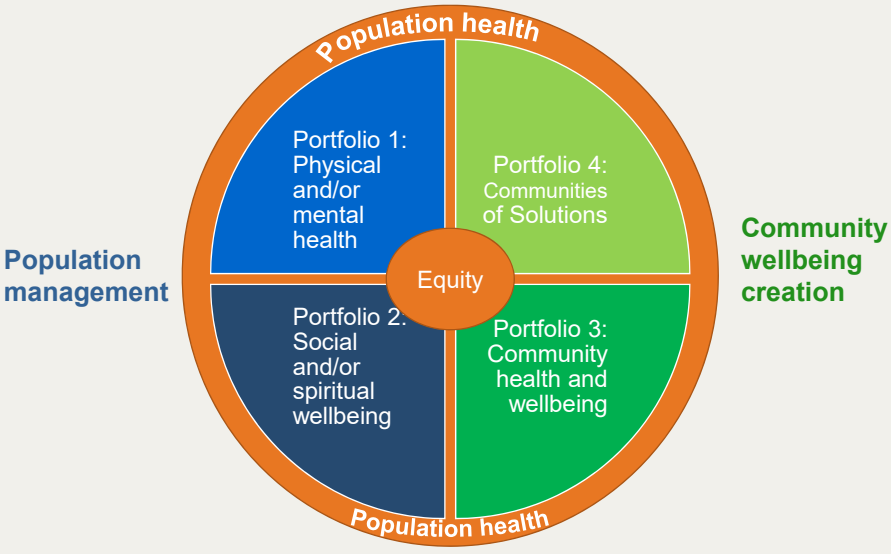
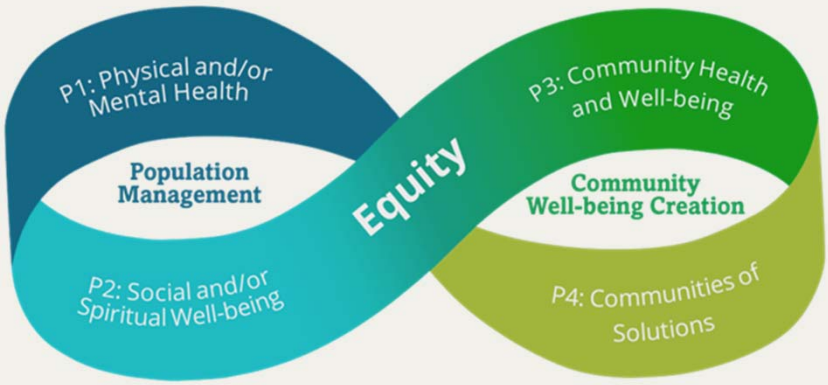


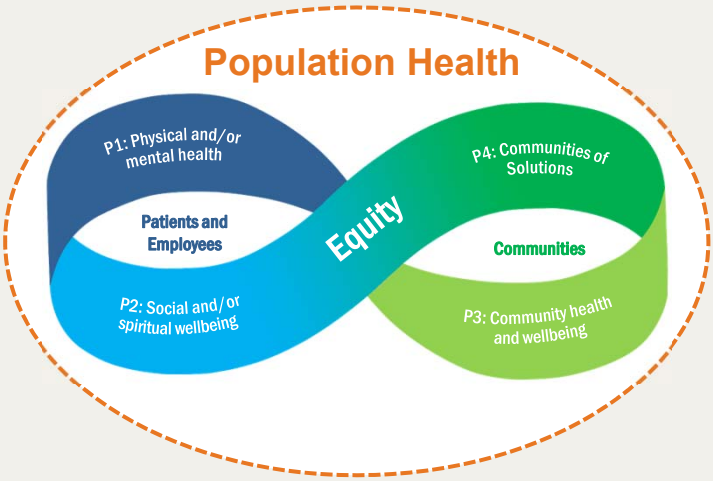
Four Portfolios of Population Health

PATHWAYS TO POPULATION HEALTH



Source: Pathways to Population Health, 2018

4 Interconnected Portfolios of Work



Common across all portfolios

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- Equity
  - Portfolio 1 & 2: Applying an equity and social determinants lens to clinical care
  - Portfolio 3 & 4: Applying a place-based equity lens; addressing structural racism using all of own's assets
  - All four:
    - Being accountable for everyday racism and structural racism inside and outside the walls
    - Partnering with people with lived experience of inequity
- Community integration

Portfolio 1: Physical and/or Mental Health

PATHWAYS TO POPULATION HEALTH

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

Spotlight Example: Signature Healthcare in Brockton, MA[1]

- Improved health outcomes for the frail-elderly segment of their patient population.
- Increased access to care and extended appointment times.
- Standardized evidence-based care in key areas: falls prevention, cognition, functional assessments, depression, and end-of-life planning.
- Assessed available community resources and established partnerships. Weekly, the medical care team and community organization representatives match individual patients with local resources that can help meet their needs.

[1]Whittington JW, Nolan K, Lewis N, Torres T. Pursuing the Triple Aim: The first seven years. *Milbank Quarterly*. 2015;93(2):263-300.

Portfolio 1: Mental and/or physical health for patients/employees

25

- 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 1: Philadelphia

26

- Integrated mental health in primary care
- 10,000+ citizens trained in mental health first aid
- Universal screening at pharmacies for mental health disorders
- Narcan available through pharmacies
- Murals created by people with and without mental health disorders
- Walks to destigmatize mental health in the community

Outside the walls: Big White Wall

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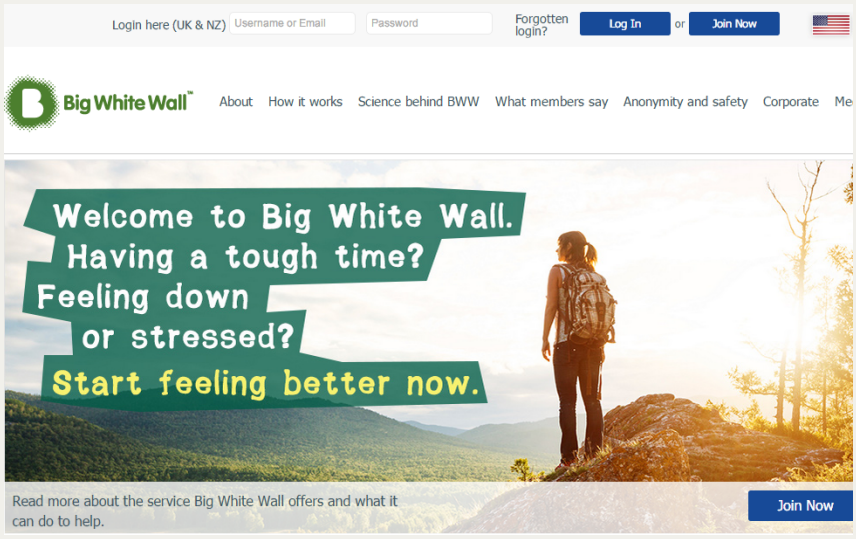

Portfolio 2 Address social and spiritual drivers of health and wellbeing

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- Screening for and addressing the social determinants of health
- Partner with local social service agencies, faith communities, housing organizations, and other community-based organizations to address social needs
- Develop faith-health partnerships
- Address social isolation, purpose and meaning in life

Portfolio 2: Social and/or Spiritual Well-being

PATHWAYS TO POPULATION HEALTH

Consistently screen for and address the social and spiritual drivers of health and well-being for a defined population.

Spotlight Example: Methodist Le Bonheur Healthcare in Memphis, TN[1]

- Works with 600 congregations in the community to support the social and spiritual well-being of its patients, called the Congregational Health Network (CHN).
- Trained volunteers from within the congregation work closely with Community Navigators from the hospital to support patients after discharge.
- Patients supported through community-based trainings on topics including personal finance and healthy lifestyles.

[1] Gunderson G, Cutts T, Cochrane J. The Health of Complex Human Populations. Washington, DC: National Academies of Science, Engineering, and Medicine; 2015.

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

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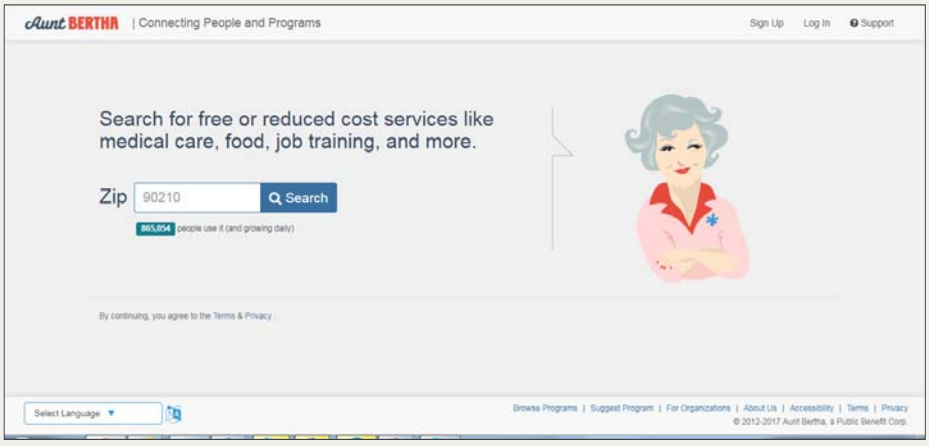

Building clinic capacity to address social and behavioral determinants strongly improves joy in work in the health care workforce

Portfolio 2: Addressing social and spiritual drivers or health and wellbeing in the community

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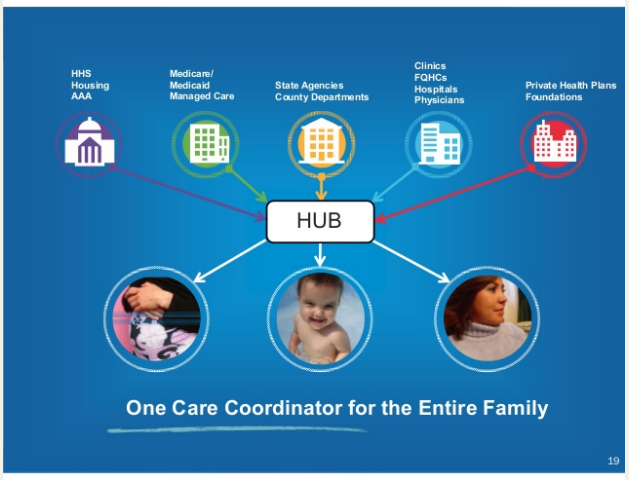

Pathways Community Hub Model

Pathways Hubs lead to Triple Aim Outcomes

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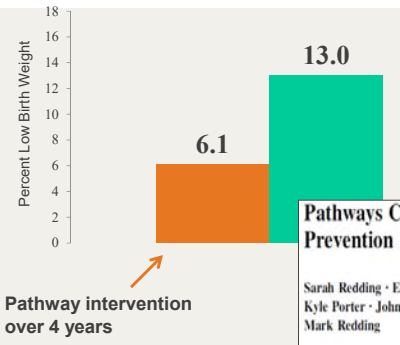


Cost Savings: $3.36 for 1st year of life; $5.59 long-term for every $1 spent

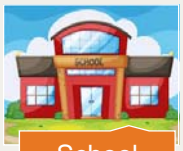
Pathways Community Care Coordination in Low Birth Weight Prevention

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 3 Community Health and wellbeing: Focused improvement in communities

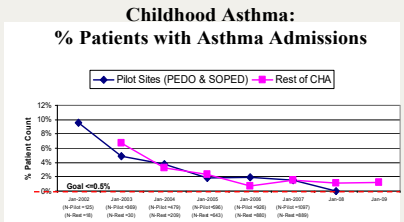


School

Home

Pediatrician

Childhood Asthma Outcomes at Cambridge Health Alliance



Portfolio 3: Community Health and Well-being

PATHWAYS TO POPULATION HEALTH

Work together with community partners to improve specific health and well-being outcomes for a place-based population.

Spotlight Example: Proviso Partners for Health (PP4H) in Maywood, IL[1]

- A coalition of local institutions and community groups, including: Loyola University Health System, Proviso-Leyden Council for Community Action, Proviso East High School, and the Quinn Community Center, among others.
- Focused on addressing childhood obesity and increasing access to healthy food in the community.
- Portfolio of projects includes a school wellness committees, changes in school food environments, and an entrepreneurial garden to improve food access and provide jobs and enrichment for local youth.

[1] Proviso Partners for Health. PP4H Healthy Food Access and Economic Development. Retrieved from: https://insight.livestories.com/s/v2/pp4h-healthy-food-access-and-economic-development/b79633cf-b624-4080-9c6c-e78d3637b65e/

Portfolio 4: Communities of solution

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- Shared long-term stewardship between community residents and system leaders across sectors to improve health, wellbeing and structural inequity
- Trust and governance to leverage shared resources to achieve goals
- Using assets nimbly and creatively to move forward the priority goals of the community (anchor approach)
- Growing the leadership of people with lived experience of inequity as a core strategy
- Processes to create rapid change through unprecedented collaboration, innovative improvement and system transformation

Using All Our Levers

- Care provider)
- Employer
- Restauranteur
- Purchaser
- Investor
- Advocate / Policymaker
- Environmental Steward
- Insurer
- Needs assessor
- Funder
- Community partner
- Placemaker
- Systems change agent
- Trusted advisor
- Others?

Portfolio 4: Communities of Solutions

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- University Hospitals in Cleveland – Addressing equity in poorest 7 zip codes surrounding the hospital.
  - "Buy local, hire local, live local" in addition to community benefits.
  - Impact: 5200 jobs created, $500 million infused into communities with worst life expectancy.
- Dignity health – invest a part of the retirement portfolio to give low income loans to community-based businesses, low income housing developers

What you can do

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1. Commit to thinking and acting differently.
   - Consider becoming a pioneer sponsor of the Pathways to Population Health framework. www.pathways2pophealth.org.
   - Approach population health as mental, physical, social and spiritual wellbeing for people and communities together.
   - Look at your outcome data by race, class, and place—and close the gap together with your patients, your workforce and your community.
   - Approach this work from a mindset of abundance; bring your assets together. Consider coopetition in communities.
2. Take a step forward—big or small.
3. Find partners—join tables where people have been waiting for you.

Join the Movement!

PATHWAYS TO POPULATION HEALTH

Pioneer Sponsors are organizations that want to:

- **Champion** the movement by sharing P2PH tools and resources within their organizations and networks
- **Support** a cohort of health care organizations on this journey to population health.
- **Share** progress with us including Bright Spots and fail forward stories each quarter.

Population Health Activators are individuals that want to:

- Download and use P2PH tools and resources (Framework, Compass, and Action Plan).
- Assess their progress over time
- Celebrate and share progress with others.
- Get access to P2PH virtual and in person opportunities for peer learning and support.

Improve Population Health with Us!

PATHWAYS TO POPULATION HEALTH

Engage with IHI

Engagement "Waves" are comprised of a series of webinars to help you accelerate your population health improvement efforts as well as share with and learn from likeminded health care change agents.

Free to join • Wave 1 Kicks-Off in June 2018

Learn more and sign up at
www.100mlives.org/p2ph

Discussion

PATHWAYS TO POPULATION HEALTH

- What is your health care organization doing to address population health across the four portfolios?
- What are successful examples you've heard about? What contributed to success?
- Where are the biggest opportunities to impact population health for a target population or in a community?

100 Million Healthier Lives

Join the movement!
www.100mlives.org

@100MLives 100MLives@ihi.org

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