

## POPULATION HEALTH LEADERS LEARNING NETWORK INTRODUCTION

September 14, 2017



#### WEBINAR ACCESS INFORMATION

# Thank you for joining us! We will begin shortly.

Please dial into the call using: 1-877-668-4493

**Event Number:** 649 133 279

We will not be streaming sound through your computer, so dialing in is critical to hear the audio portion of today's presentation. Thank you!

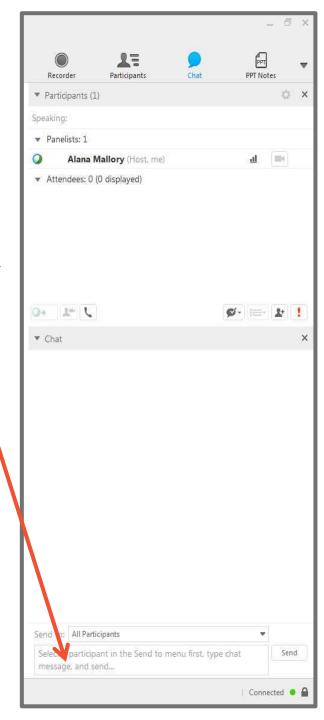


## **NEED TODAY'S SLIDES?**

Please refer to the URL in the chat box to download today's presentation materials. It should be located on the right-hand side of your screen.

#### This webinar is being recorded -

Please check the learning network website tomorrow morning for the recording and corresponding materials.





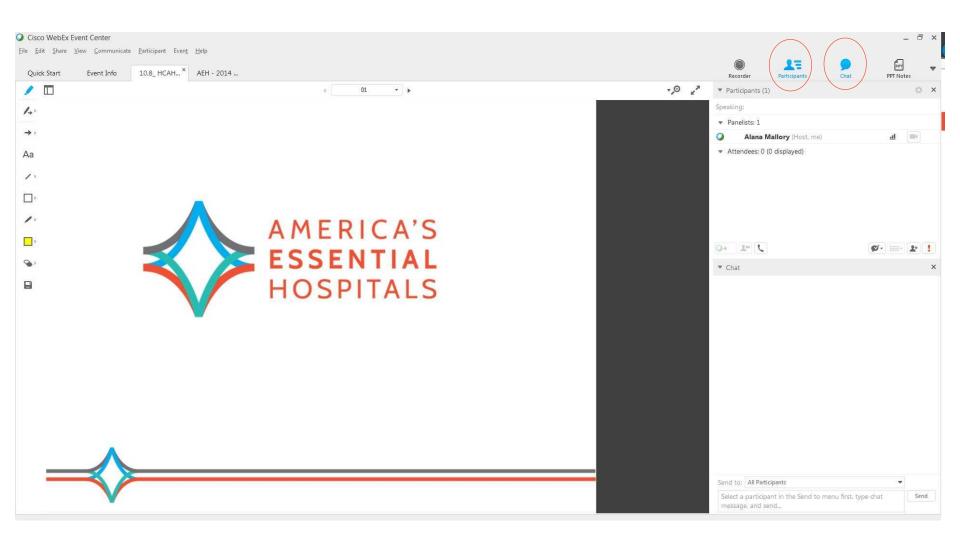
#### PARTICIPANT INTERACTION

All lines have been muted, but we still want to hear from you!

#### Ways to interact:

- Ask questions or make comments through the "chat area" located to the right of your screen
- If you wish to speak telephonically, please "raise your hand" and wait for me to unmute your line before you begin talking







## WELCOME



## PEOPLE TO KNOW



Kalpana Ramiah, DrPH Director of Research



Deborah Roseman, MPH Principal Project Specialist



Janelle Schrag, MPH Senior Program Analyst



Brian Roberson, MPA Senior Research Analyst



Madeline White Research Assistant



## TODAY'S AGENDA

- The Learning Network
- How Did We Get Here?
- What Is Population Health?
- Discussion
- What to Expect
- Q&A



## THE LEARNING NETWORK



## **GOALS OF THE NETWORK**

Advance your hospital's progress toward implementing and sustaining community-integrated healthcare by:

- Learning strategies for developing, implementing and sustaining community-integrated health care;
- Engaging with peers and share experiences to overcome common challenges; and
- Exploring tools to facilitate your efforts.



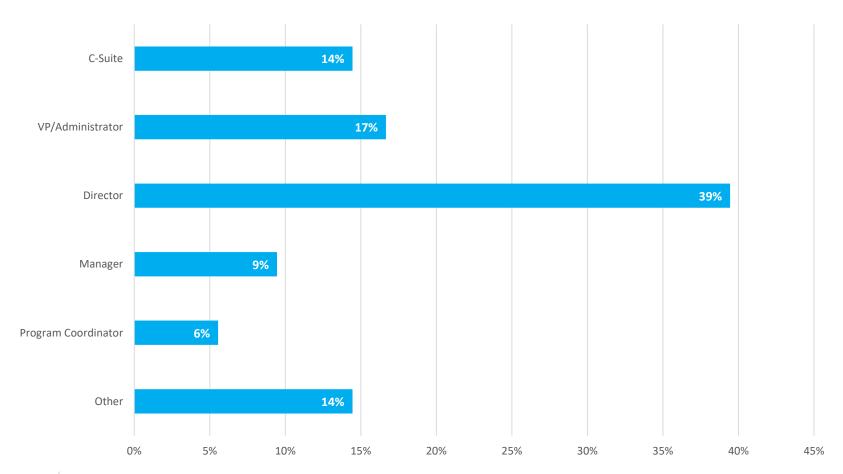


#### WHO YOU ARE

- 185 Individuals
- 81 Hospitals
- 26 Not for Profit Hospitals
- 55 Publicly Owner Hospitals

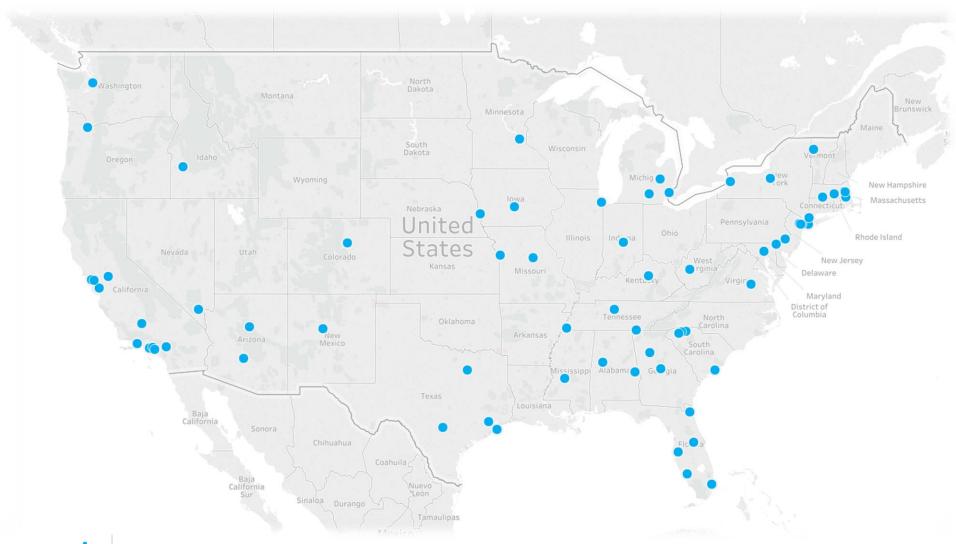


## WHO YOU ARE





## A NATIONAL COMMUNITY



## **HOW DID WE GET HERE?**



## **AMERICA'S ESSENTIAL HOSPITALS**

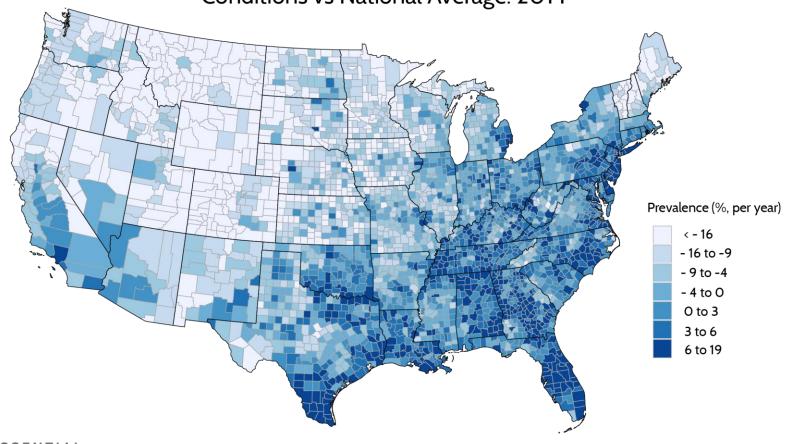
- 300+ hospitals caring for the most vulnerable
- Trauma, burn care, NICU, emergency psychiatric, disaster response
- Health professionals training
- Primary and specialty care networks





## WE SERVE THE MOST VULNERABLE

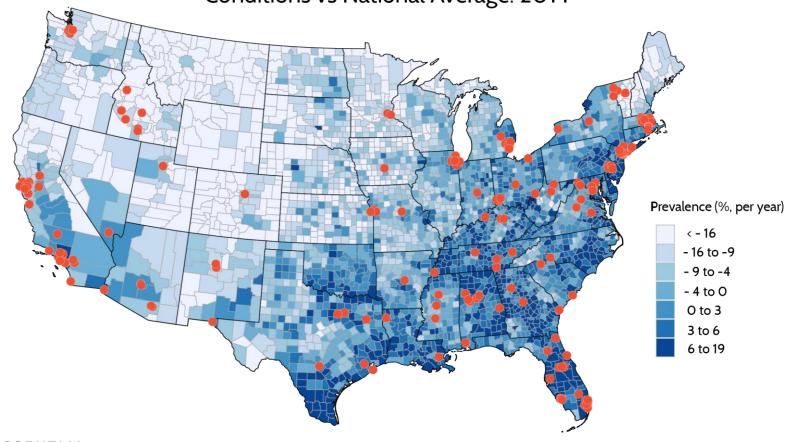






## WE SERVE THE MOST VULNERABLE

Prevalence of Three or More Medicare Claims-based Conditions vs National Average: 2014



## **MOVING TO ACTION**

- Landscape Review
- Survey
- Interviews
- Summit
- Road Map





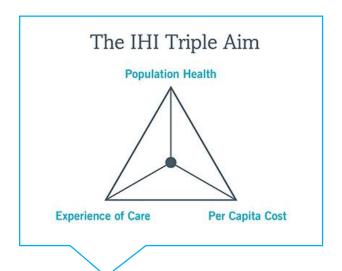


The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

 $Kindig\ orall\ Stoddart$ 









2003 2008

Kindig ぢ Stoddart



803 PPACA Sec. 9007

"(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

"(ii) the organization shall not be treated as described in subsection (c/3) with respect to any such facility for which such requirements are not separately met.

"(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

"(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

"(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

"(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

"(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment.—

"(i) takes into account input from persons who

 $\leftarrow$ 0

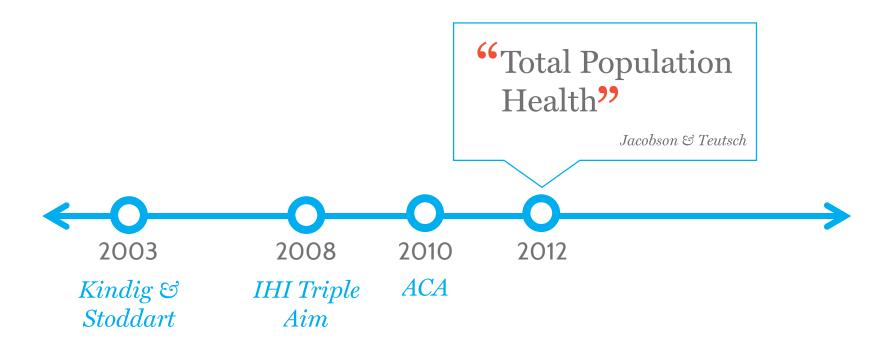
2003

Kindig ぢ Stoddart 2008

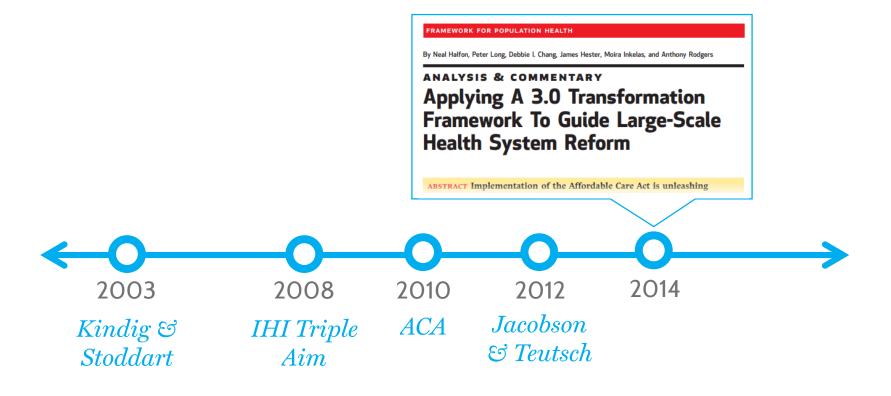
2010

IHI Triple
Aim











Community Integrated Healthcare System 3.0: COMMUNITY-INTEGRATED HEALTHCARE

Coordinated Seamless Healthcare System 2.0: OUTCOME-ACCOUNTABLE CARE

Acute Care System 1.0: EPISODIC NON-INTEGRATED CARE

Adapted from Hester et al., 2015.



Community Integrated Healthcare System 3.0: COMMUNITY-INTEGRATED HEALTHCARE

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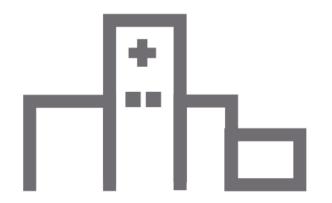
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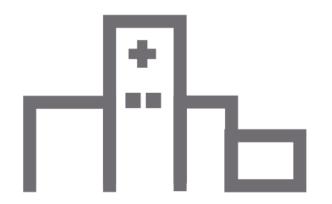






- Diabetes
- ✓ High Blood Pressure

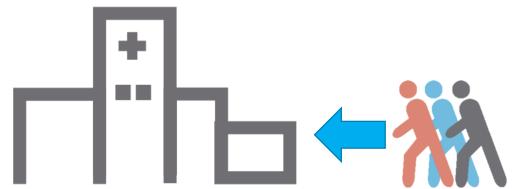






- **Diabetes**
- High Blood Pressure
- ✓ No Grocery Store
- Limited Transportation Neighborhood Blight

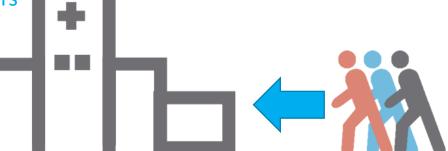




- Diabetes
- **High Blood Pressure**
- ✓ No Grocery Store✓ Limited Transportation✓ Neighborhood Blight



- + Non-Traditional Workforce+ Care Management
- + Improved EHR
- + Provider Partners
- + Financial Risk



- ✓ Diabetes
- ✓ High Blood Pressure
- √ No Grocery Store
- ✓ Limited Transportation
- ✓ Neighborhood Blight



- Non-Traditional Workforce
- + Care Management
- + Improved EHR
- + Provider Partners
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- Diabetes
- ✓ High Blood Pressure
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POPULATION HEALTH MANAGEMENT



- + Non-Traditional Workforce
  + Care Management
  + Improved EHR
  + Provider Partners
  + Financial Risk
  + Community Partners
  + Data Sharing
  + Strategic Investment
  + Needs Assessment
  + Sustainability Plans
- ✓ Diabetes
- ✓ High Blood Pressure
- ✓ No Grocery Store
- ✓ Limited Transportation
- ✓ Neighborhood Blight

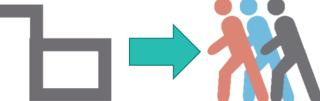
POPULATION HEALTH MANAGEMENT



- + Non-Traditional Workforce+ Care Management
- + Improved EHR+ Provider Partners
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- + Community Partners
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- ✓ Diabetes
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POPULATION HEALTH MANAGEMENT

**COMMUNITY-INTEGRATED HEALTH CARE** 



## SOCIAL DETERMINANTS OF HEALTH



### SOCIAL DETERMINANTS OF HEALTH

The conditions in which people are born, grow, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.





### HOUSING INSTABILITY

Having difficulty paying rent, spending more than 50% of household income on housing, having frequent moves, living in overcrowded conditions, or doubling up with friends and relatives.





### **HOUSING INSTABILITY**

## UVM Medical Center Burlington, VT

- Grants funds to Harbor Place motel which provides temporary, emergency housing
- Works with community partners to support Beacon Apartments – a permanent housing site
- Supports an emergency warming shelter through direct funds and daily linen services







## FAMILY & SOCIAL SUPPORTS

Interconnected relationships that provide durable patterns of interaction, interpersonal relations, nurturing, and reinforcements for coping with daily life.





### **FAMILY & SOCIAL SUPPORTS**

### Memorial Regional Hospital Hollywood, FL

- Healthy Youth Transitions program helps young adults aging out of foster care
- Life Coaches form trusting, professional relationships with program participants to help them transition to independent living
- Maintain several collaborative partnerships with health care and community organizations to strengthen social support systems







### FOOD INSECURITY

The state of being without reliable access to sufficient quantity of affordable, nutritious food.





### FOOD INSECURITY

## Boston Medical Center Boston, MA

- Patients are prescribed to Preventive Food Pantry for fresh produce and other healthy foods
- The Pantry works closely with Greater Boston Food Bank, as well as other community partners
- Cooking classes in the on-campus demonstration kitchen use ingredients from the Pantry







# INTERPERSONAL VIOLENCE

The intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.





### INTERPERSONAL VIOLENCE

## NYC Health + Hospitals New York, NY

- Engages youth early in long-term mentorship and development activities to divert them from involvement in violent peer groups and behaviors
- Works with concerned organizations and neighborhood residents to build community strategies
- Immediately engages people who have been violently injured to provide counsel and support







### **EDUCATION**

An individual's access to and completion of various levels of academic training, including early learning, primary, secondary, and postsecondary courses.





### **EDUCATION**

### Broadlawns Medical Center

Des Moines, IA

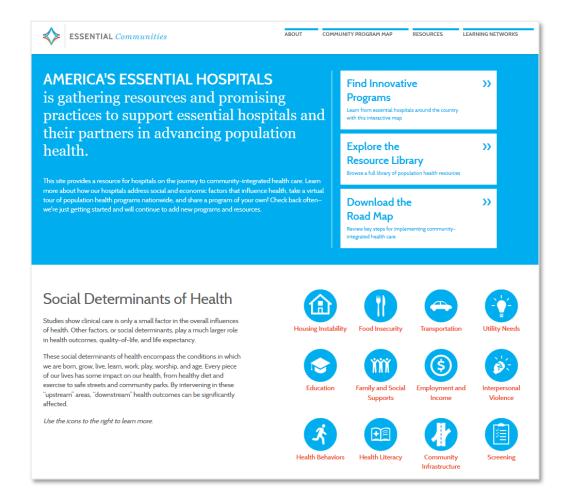
- Two programs developed to provide education, training, and awareness of career opportunities in health care
- TECH targets high school students and TEACH is geared for adults
- Participants graduate the program with a Certified Nursing Assistant degree







### **ESSENTIALCOMMUNITIES.ORG**









• Assess readiness, plan and invest strategically, assess community need









• Assess readiness, plan and invest strategically, assess community need



• Grow and develop workforce, engage partners, collect and analyze data, demonstrate value







• Assess readiness, plan and invest strategically, assess community need



• Grow and develop workforce, engage partners, collect and analyze data, demonstrate value



• Engage the community, plan for sustainability



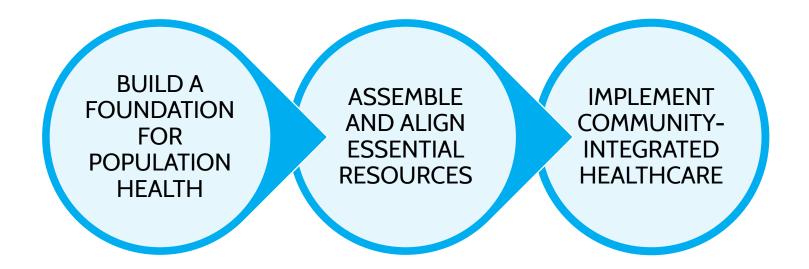
## Q&A



### WHAT TO EXPECT



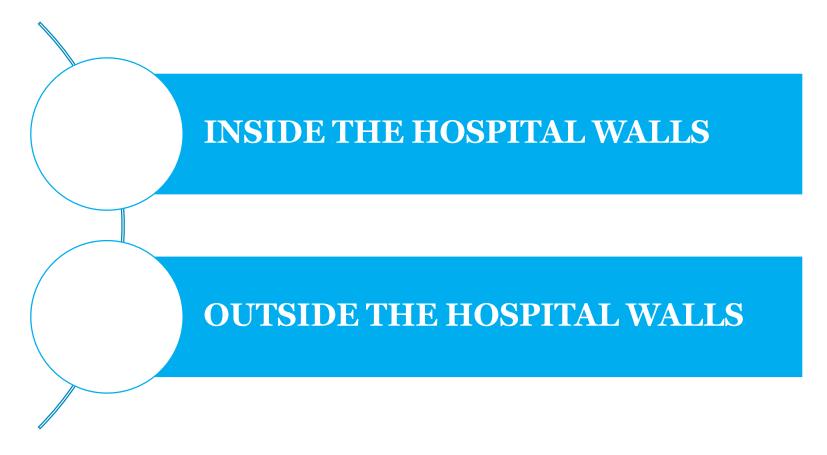
### THREE MODULES





41

### **MODULE 1: BUILD A FOUNDATION**





# MODULE 2: ASSEMBLE AND ALIGN ESSENTIAL RESOURCES



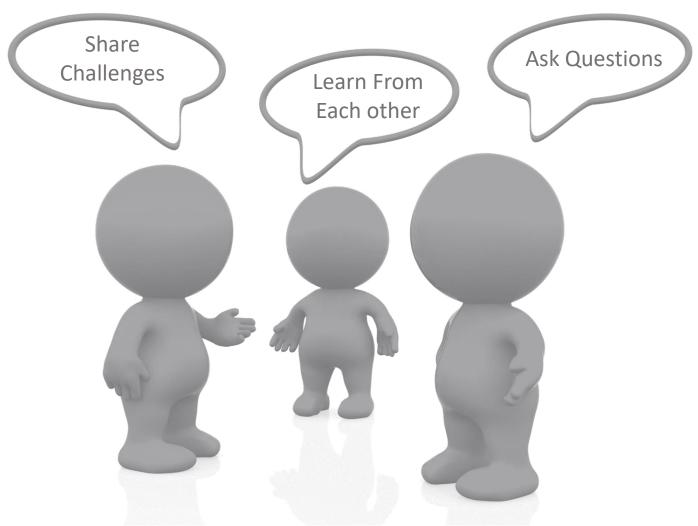


# MODULE 3: IMPLEMENT COMMUNITY-INTEGRATED HEALTHCARE



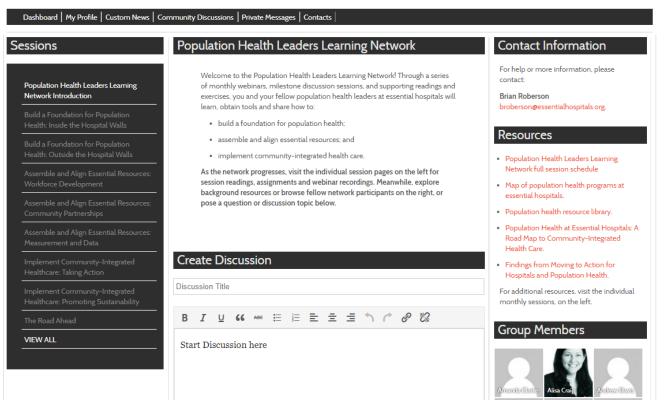


### **CRITICAL CONVERSATIONS**



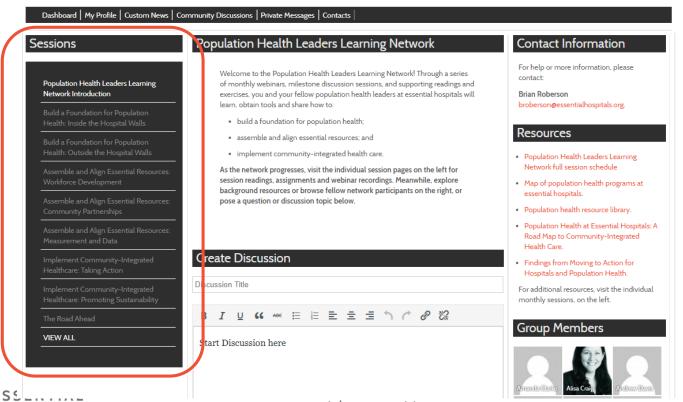






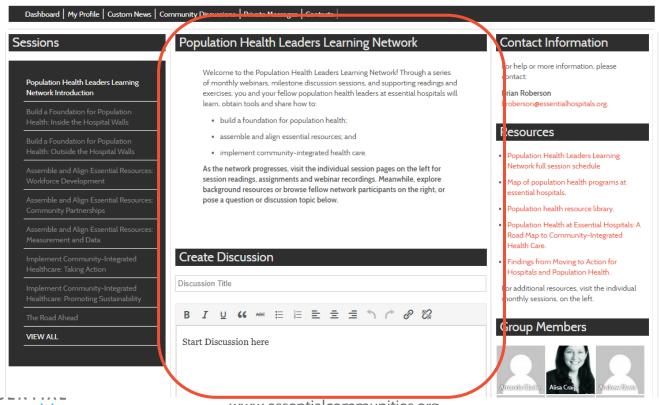






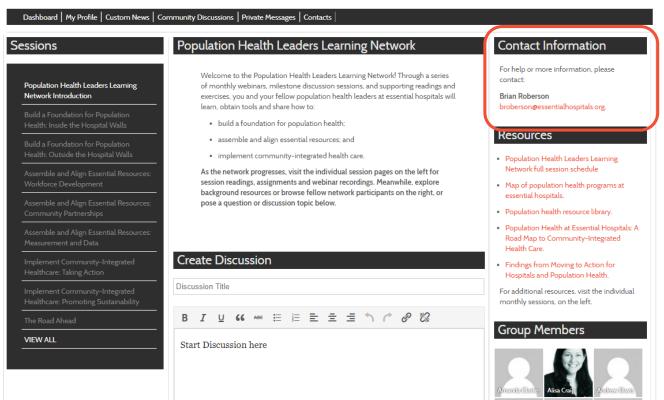






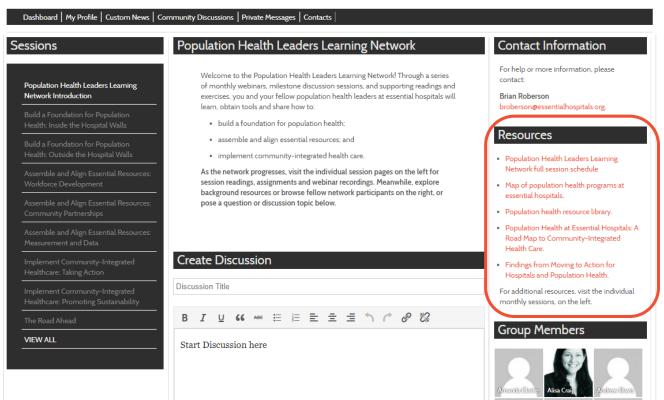






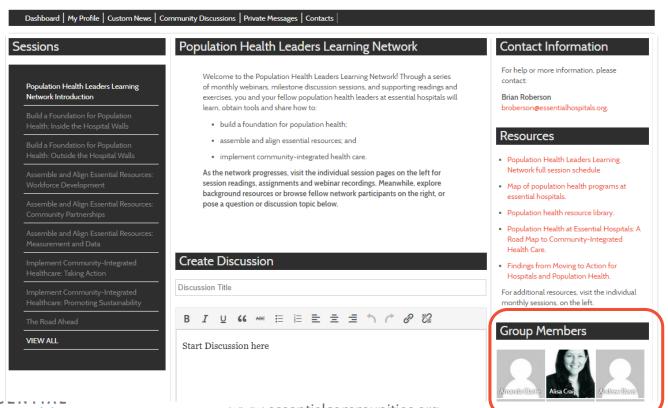






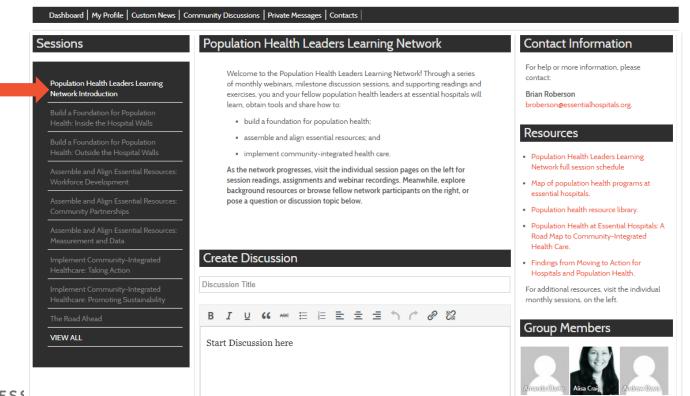
















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### Population Health Leaders Learning Network Introduction

Date: Thursday, September 14, 2017

Time: 2:00 PM EDT

JOIN WEBINAR

This kickoff webinar for the Population Health Leaders Learning Network will introduce participants to the Road Map to Community-Integrated Health Care and how it will guide the learning network's journey. Essential Hospitals Institute staff will give an overview of population health and the social determinants of health and share milestones for essential hospitals working to address them. Participants will preview the learning network content, meet the population health leaders who will accompany them on their journey, and explore the network's tools for engaging with fellow participants.

#### **Learning Objectives**

- 1. Create a shared understanding of population health
- 2. Explore America's Essential Hospitals road map for population health
- 3. Discover current population health efforts at your hospital

#### Pre-Webinar Readings:

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Kindig, D., & Stoddart, G. (2003). What is population health? American Journal of Public Health, 93(3), 380-3.

Halfon, N., Long, P., Chang, D. I., Hester, J., Inkelas, M., & Rodgers, A. (2014). Applying a 3.0 transformation framework to guide large-scale health system reform. *Health Affairs*, 33(11), 2003–2011.

#### **Speakers**

- lalpana Ramiah, DrPH
- I irector of Research
- America's Essential Hospitals
- nelle Schrag, MPH
- enior Program Analyst
- merica's Essential Hospitals
- Frian Roberson, MPA
- enior Research Analyst
- merica's Essential Hospitals

#### Webinar Attendees







SEE ALL MEMBERS



Brian
Senior Research Analyst
America's Essential
Hospitals

[EDIT PROFILE]

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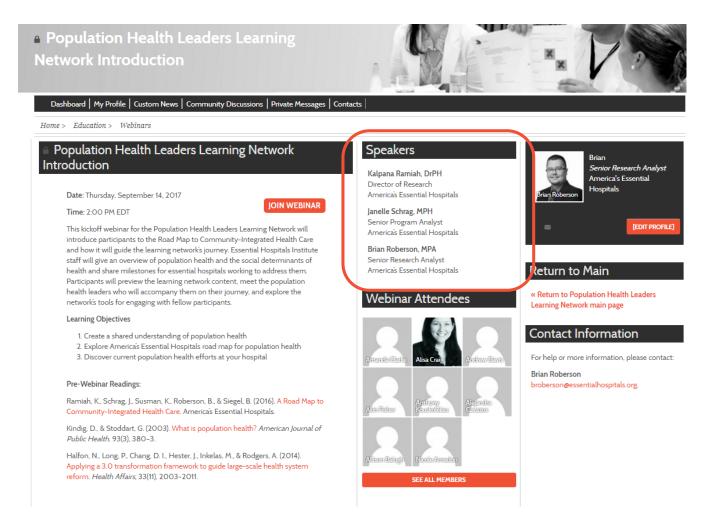
#### Contact Information

For help or more information, please contact:

#### Brian Roberson

broberson@essentialhospitals.org.











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America's Essential Hospitals

#### Janelle Schrag, MPH

Senior Program Analyst America's Essential Hospitals

#### Brian Roberson, MPA

Senior Research Analyst America's Essential Hospitals

#### Webinar Attendees





SEE ALL MEMBERS



Senior Research Analyst America's Essential

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#### Contact Information

For help or more information, please contact:

#### Brian Roberson

broberson@essentialhospitals.org.



### FIRST HOMEWORK

#### Population Health Leaders Learning Network Homework #1

1. Contact Information:						
(a) Name						
(b) Title						
(c) Organization						
(d) Email Address						
						<b>+</b>
2. To what extent are the following in place at your hospital?						
		Not at all	Very little	Somewhat	To a great extent	t Not sure
(a) Buy-in at the leadership (C-suite, Board) level to address social determinants of health in your community		0	0	0	0	0
$(b) \ Willingness \ at the \ leadership \ level \ to \ direct \ resources \ toward \ addressing \ social \ determinants \ of \ health$		0	0	0	0	0
(c) An understanding of community need and assets regarding social determinants of health		$\circ$	0	0	0	0
(d) Staff with time and capability to do this work		0	0	0	0	0
(e) Awareness across the hospital staff of the nature and importance of this work		$\circ$	0	0	0	0
$(f)\ Partnerships\ with\ local\ public\ and/or\ private\ entities\ to\ address\ social\ determinants\ of\ health$		0	0	0	0	0
(g) Data collection on social determinants of health		0	$\circ$	0	0	0
(h) Data sharing with partners regarding social determinants of health		0	$\circ$	0	0	0
(i) Sustainable funding to support population health efforts			0	0	0	0



## FIRST HOMEWORK

3. Please tell us about any programs your hospital has in place to address the social determinants of health. Keep in mind that t different departments across your hospitals. If possible, list the program's name, the social determinant(s) it seeks to address partners it includes.	hese programs may exist in many s, and (if applicable) any community
Characters Remaining: 999	
4. What progress would you like to make toward addressing social determinants of health in your community as a result of part	icipating in this learning network?
Characters Remaining: 999	
5. How will you know if/when you have achieved your goal?	



## Q&A

