American Hospital Association™
Advancing Health in America

Population Health
Building New Foundations Linking Care with Community

Video 1: Introduction to Population Health

Discussion Questions

1. What populations do you serve, and how does your hospital or health system understand the factors that contribute to (or impede) their ability to achieve good health?

2. What programs or services does your hospital provide to address these unmet needs?

3. How does your population health strategy intersect with your quality improvement work, delivery system reforms and patient satisfaction efforts?

4. As a board, do you review metrics to monitor the effectiveness of the population health strategies your organization engages in?

5. What resources are needed or what areas for further improvement can you identify?

Notes

KEY TAKE-AWAYS

- Health care is shifting focus from being driven by the volume of services provided to the value of those services, including helping people stay healthy in their daily lives via prevention of chronic illness and support of healthy lifestyles.
- The changes occurring in both the delivery system, as well as payment system, are causing hospital and health system leadership and boards to begin thinking differently about how to provide care and advance health for their patients in partnership with their communities. This focus on health outcomes of groups of patients or entire communities is referred to as "population health."
- Population health science provides strategies and tools to help re-shape health care to continue to to better understand and meet the needs of our patients and partner to improve the health of our communities.
- Taking a population health approach requires the ongoing development of core capabilities, including:
  - Defining and understanding the population(s) served by a hospital
  - Engaging differently with partners to best serve the population (partners include multi-disciplinary teams within the system, physicians, community organizations and payers)
  - Identifying and implementing system-level changes to improve the health of individuals and communities
  - Measuring the impact and success of new models of care or community intervention

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Video 2: Understanding Your Population

Discussion Questions

1. What sources of data are you using to understand the needs of your patient and community populations?

2. What have you identified as your key areas for improvement at the population level?

3. What do you know about the factors that are influencing health outcomes outside of the health care system?

Notes

KEY TAKE-AWAYS

- Population health management is the delivery of health care services to achieve improvement in outcomes for a defined patient population.
- In order to understand the needs of their patients and their communities in a fuller way, hospitals and health systems are integrating information collected from a variety of sources to identify:
  - The patterns of health and illness among their populations (What are our patients' diagnoses or health care needs?)
  - Non-health care factors affecting health, including those known as the social determinants of health (What other factors in our patients' lives or in their communities influence their health and health care?)
  - How individuals utilize health care services – both within their facility and at other points of care (How are people choosing to receive their care and from whom?)
  - How the delivery system is supporting individuals to become healthier (What outcomes are we tracking to understand if we are helping patients recover and maintain their health?)
- Data should be collected from across the continuum of care; common sources of data that hospitals and health systems use are:
  - Electronic health record data, to understand patients' health status needs and outcomes
  - Payer or claims data, to help in understanding patterns of patient care
  - Patient and family input, to assess how to best meet their needs
  - Community demographic and health data, including the Community Health Needs Assessment

Video 3: Engaging with Partners

Discussion Questions

1. Does your organization engage in strategic planning around clinical and community partnership development?

2. Are there new partnerships – internal teams, stronger physician alliances or external community partnerships – that you should be exploring?

3. How is your organization entering into new partnerships and financial models with payers?

4. How do you assess how your partnerships improve care coordination?

Notes

KEY TAKE-AWAYS

- Strong internal, cross-departmental, multi-disciplinary teams are vital as hospitals work to better coordinate services, improve patients' experiences while in the acute care setting, support patients and families as they transition home and address individuals' barriers to good health.
- Beyond building a strong internal team, it is important that hospitals work to strengthen their engagement with community-based physicians and other health care providers to better coordinate and integrate the care patients receive throughout their lives and across all sites of care.
- Hospitals, doctors, nurses and other caregivers cannot address all social, or even all health needs, on their own. By partnering with other organizations within the community to address social determinants of health, combine complementary services and strengthen transitions of care, the work to make communities healthier can be more impactful, have greater reach and be longer lasting.
- Payer-provider partnerships are a powerful mechanism for advancing delivery redesign, reducing costs and advancing health.

Video 4: Taking System Level Action

Discussion Questions

1. What is your organization doing to redesign care?

2. Which organizations can you look to for lessons learned?

3. How can your organization's clinical teams best work with community organizations and local public health agencies to improve health?

4. How does your organization's current infrastructure support the development and implementation of population health strategies?

Notes

KEY TAKE-AWAYS

- Population health strategies support systems' drive toward value, incorporating evidence-based, leading practices and extending care beyond medical interventions to encompass social and community-based services.
- Just as with any medical intervention, system-level strategies should be grounded in evidence-based practices; they will be a combination of interventions that have been proven to be effective, joined with data and insights from the community to develop strategies that reduce barriers to achieving health.
- There is a difference between individual interventions vs. population health approaches. A population-wide strategy identifies common, or system-level, factors that lead to better health outcomes and then redesigns care processes at the system-level.
- There are several common population strategies that many hospitals and health systems are working on today to enhance their ability to provide person-centered care:
  - Investing in or expanding care coordination or care management programs
  - Supporting the development of primary care practices in their communities
  - Redesigning their care for individuals living with chronic disease
  - Partnering with post-acute providers of care, including skilled nursing facilities and home care agencies
  - Focusing on palliative care strategies to support individuals and their caregivers

Video 5: Importance of Measurement

Discussion Questions

1. Do you have clearly defined performance goals and deliverables tied to your population health strategies?

2. Does your board receive updates on population health measures?

3. Has the board determined an appropriate time frame during which to measure improvement?

4. How do you measure the ROI for your population health programs?

Notes

KEY TAKE-AWAYS

- Population health strategies should be data-driven and tied to key performance indicators in order to judge their success at improving outcomes while containing or reducing costs. Collecting and monitoring data can help uncover gaps in care and unmet health needs.
- Measurement of key performance indicators allows hospitals and health systems to identify areas where partnerships need to be strengthened or redefined, where a clinical process or outcome still has room for improvement, or where gaps in services exist.
- Population health indicators on a balanced dashboard should include:
  - Clinical or health status measures
  - Individuals' experience of care measures
  - Financial or cost of care measures
- Identifying clear performance metrics is crucial for continuing to build the business case for population health strategies. Monitoring metrics and reviewing a measurement dashboard will help ensure interventions are strategically chosen and successful.

Video 6: Community Change

Discussion Questions

1. How is your board involved in your organization's community health needs assessment process?

2. How do the assessment's findings influence your overall population health strategy? What are the key priorities that your organization is addressing based on community assessment data?

3. What current outreach activities or community partnerships are you engaged in?

4. What performance indicators are being used to measure the impact of these programs and why they were chosen?

Notes

KEY TAKE-AWAYS

- Community Health Needs Assessments (CHNAs) identify, analyze and prioritize community needs. They are becoming more sophisticated in their approach, are drivers of community collaborations, and serve as springboards to launch community health improvement initiatives.
- Partnering with other organizations to conduct a CHNA has many benefits. It can increase community buy-in and bolster relationships with community partners, as well as facilitate organizations' abilities to develop and implement more effective programs to improve the health of the community.
- The process for conducting a CHNA consists of several stages that include: identifying key stakeholders, collecting quantitative and qualitative data and information, prioritizing community needs, implementing interventions and evaluating results.