The Population Health Template: A Roadmap for Successful Health Improvement Initiatives

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Poll Question #1

Social determinants are an important part of health improvement initiatives.

1) Strongly disagree
2) Disagree
3) Undecided
4) Agree
5) Strongly agree
6) Unsure or not applicable
Learning Objectives

• Describe the population health template as a tool designed to assist health systems and population health care organizations to achieve and report on quintuple aim objectives of health improvement initiatives.

• Identify gaps in current health initiatives illustrating the needs for the template’s more organized approach.

• Apply the template to health improvement opportunities in group discussion with attention to:
  1. Health improvement statement.
  2. Population.
  3. Applicable social determinants of health.
  4. Metrics that demonstrate value.
The population health template was designed to assist health systems and population health care organizations to achieve and report on the quintuple aim objectives:

- Health Outcome
- Provider Experience
- Patient Experience
- Caregiver Satisfaction
- Cost
10% of health-related activity...
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Current Gaps in Population Health Programs

- Population health initiatives do not often address social determinants of health.
- Most often deal with broad populations.
- Do not follow project planning methodology.
- Health improvement issue is not clearly defined.
- Measures of success are not carefully planned.
- Program evaluation is not well organized.
Poll Question #2

Thinking about common failure points for population health improvement programs, select the areas in which you most frequently observe issues. (Select all that apply.)

a) Effective organizational change
b) Engaging in collaborative leadership
c) Client participation or program affinity
d) Meeting user requirements
e) Sustainable behavioral change
f) Unsure or not applicable
Common Failure Points for Population Health Improvement Programs
According to Population Health Experts:

- Effecting organizational change: 58.82%
- Engaging in collaborative leadership: 52.94%
- Client participation or program affinity: 35.29%
- Meeting user requirements: 23.53%
- Sustainable behavioral change: 70.59%
A Tool to Help Close the Gaps and Failure Points: The Population Health Template

This roadmap creates a standardized population health approach to project planning and execution that may be applied to all types of health improvement initiatives for a variety of populations.
Population Health Roadmap
Health Improvement Statement

- Problem statement.
- Iterative.
Population Health Roadmap
Current State

START

HEALTH CONCERN

CURRENT STATE

Population factors:
• Social determinants.
• Disparities.
• Behavioral health.

Quintuple aim metrics:
• Health outcome.
• Provider experience.
• Patient experience.
• Caregiver satisfaction.
• Cost.

• Literature review.
• Similar initiatives.
• Evidenced-based best practices.
• Patient-generated data.
• Quintuple aim data.
• Conclusions from data.

END
Population Health Roadmap
Future State

Quintuple aim metrics:
- Health outcome.
- Provider experience.
- Patient experience.
- Caregiver satisfaction.
- Cost.

Population factors:
- Social determinants.
- Disparities.
- Behavioral health.

FUTURE STATE
- Stakeholder input.
- Gap analysis.
- Initiative description.
- Ultimate outcome.
- SMART goals.
- Key deliverables.
- Behavior change.
- Budget and ROI.

START
HEALTH CONCERN
CURRENT STATE
FUTURE STATE
END
Population Health Roadmap
Project Plan & Execution

- Project charter.
- Risks/mitigation schedule and task lists.
- Logic model milestones.
- Assessment of change in pre/post social determinants.
Population Health Roadmap
Program Evaluation

- Utility.
- Feasibility.
- Propriety.
- Accuracy.
(CDC)
Population Health Roadmap
Concept Map

- **HEALTH CONCERN**
  - Problem statement.
  - Iterative.
  - Population factors:
    - Social determinants.
    - Disparities.
    - Behavioral health.

- **CURRENT STATE**
  - Literature review.
  - Similar initiatives.
  - Evidenced-based best practices.
  - Patient-generated data.
  - Quintuple aim data.
  - Conclusions from data.
  - Quintuple aim metrics:
    - Health outcome.
    - Provider experience.
    - Patient experience.
    - Caregiver satisfaction.
    - Cost.

- **FUTURE STATE**
  - Problem statement.
  - Iterative.

- **PROJECT PLAN & EXECUTION**
  - Project charter.
  - Risks/mitigation schedule and task lists.
  - Logic model milestones.
  - Assessment of change in pre/post social determinants.
  - Stakeholder input.
  - Gap analysis.
  - Initiative description.
  - Ultimate outcome.
  - SMART goals.
  - Key deliverables.
  - Behavior change.
  - Budget and ROI.

- **PROGRAM EVALUATION**
  - Utility.
  - Feasibility.
  - Propriety.
  - Accuracy.
  - (CDC)

- **Quintuple aim metrics:**
  - Health outcome.
  - Provider experience.
  - Patient experience.
  - Caregiver satisfaction.
  - Cost.

- **Logic model milestones:**
  - Assessment of change in pre/post social determinants.

- **HasSummit17**
Gap Example: Health Coaching

Vendor was asked to provide specific examples of how they would demonstrate value from coaching. They were given the template and below was their response.

• **Year 1:** Identify a baseline using the Health Assessment (HA) Score for all HA completers. Also, identify coaching goal areas for future outcome improvements.

• **Year 2:** Collect data to compare with year 1 benchmark data (coaching participant vs. non-coaching participant).

**Discussion:**
No clear statement of health issue being addressed through coaching, the population being coached, and metrics of value.
Population Health Roadmap
Table Exercise

Problem statement.

Population factors:
- Social determinants.
- Disparities.
- Behavioral health.

Quintuple aim metrics:
- Health outcome.
- Provider experience.
- Patient experience.
- Caregiver satisfaction.
- Cost.

SMART goals:
Smart measures of success related to baseline.
Table Exercise (10 minutes)

**Team Exercise Topics for Selection:** Health Coaching or Telemedicine

<table>
<thead>
<tr>
<th>Template Topic</th>
<th>Reference</th>
<th>Team Exercise:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health issue to be Improved Upon</strong></td>
<td>Succinct Problem Statement</td>
<td></td>
</tr>
<tr>
<td><strong>Current State</strong></td>
<td>Social Determinants Disparities</td>
<td></td>
</tr>
<tr>
<td><strong>Population Factors</strong></td>
<td>Behavioral Health factors</td>
<td></td>
</tr>
<tr>
<td><strong>Desired Future State</strong></td>
<td><strong>SMART Goals</strong> (specific, measurable, actionable, realistic, and timed) measures of success compared to baseline</td>
<td></td>
</tr>
</tbody>
</table>
Health Improvement Topics
Table Exercise

• **Health coaching** for patients seeking to improve the management of their diabetes.

• **Telemedicine** for urgent care conditions.
Discuss and report the following:

- Define problem.
- Population factors.
- Metrics that demonstrate value.
Key Takeaways and Lessons Learned

1. Clear articulation of the health issue being addressed, which is missing in most initiatives.

2. Thorough assessment of the sub-populations in question with attention to the social determinants, disparities, and behavioral issues.

3. Pre-and post measures of value defined in terms of the quintuple aim and clearly related to the health issue in question.
Future Plans

- Develop a workbook and website for health improvement initiative education.
- Formalize the educational approach for the population health template.
- Develop capstone course for Jefferson College of Population Health.
Thank You