PATHWAYS
TO POPULATION HEALTH

Getting Started Guide – Accelerating Population Health Progress

AN INITIATIVE FACILITATED BY 100 Million Healthier Lives
CONVENED BY Institute for Healthcare Improvement

WITH GENEROUS SUPPORT PROVIDED BY Robert Wood Johnson Foundation

Authors

Tricia Bolender, Improvement Advisor, Institute for Healthcare Improvement

Bisi Chikwendu, Project Assistant, Institute for Healthcare Improvement

Rebecca Goldberg, Project Manager, Institute for Healthcare Improvement

Sophia Keins, Project Assistant, Institute for Healthcare Improvement

Trissa Torres, Chief Operations and North America Programs Officer, Institute for Healthcare Improvement

Contributors

The following individuals and organizations have provided invaluable input into this Guide:

Karen Baldoza, Institute for Healthcare Improvement

Shelina Davis, Louisiana Public Health Institute

Kate Hilton, Institute for Healthcare Improvement

Saranya Loehrer, Institute for Healthcare Improvement

Madhura Manasabdar, MidMichigan

Mary Modayil, Alberta Health Services

Robin Reed, University of Arkansas for Medical Sciences

Betsey Rhynhart, Concord Hospital

Jolie Ritzo, Network for Regional Healthcare Improvement

Melody Robinson, Louisiana Public Health Institute

Pat Rutherford, Institute for Healthcare Improvement

Sandra Serna, Louisiana Public Health Institute

Somava Saha (Soma Stout), Institute for Healthcare Improvement

Beth Gustafson Wheeler, Foundation for Healthy Communities

Heather Whetsell, Southern Illinois University

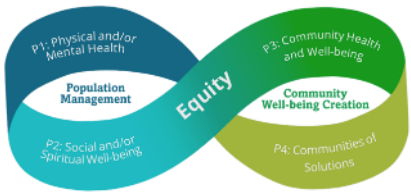
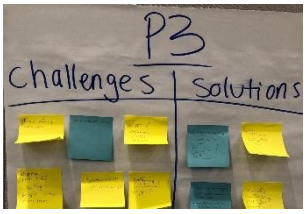
Citation:

Bolender T, Chikwendu B, Goldberg R, Keins S, Torres T. *Getting Started Guide: Accelerating Population Health Progress*. Boston: 100 Million Healthier Lives, convened by the Institute for Healthcare Improvement; 2019. (Available at http://www.ihi.org/P2PH)

Table of Contents

Introduction

"Pathways to Population Health: Getting Started Guide" is intended to bring together the various Pathways to Population Health (P2PH) tools and resources in a practical and actionable way to support health care professionals and organizations accelerate their progress towards the goals of population health, well-being, and equity. Health care organizations have a valuable contribution to make, together with other key partners, to the health of populations and communities. With this specific guidance, we aim to help health care organizations strengthen their contribution to creating equitable communities. We also intend for this to be a living document that will evolve as promising concepts and strategies emerge during our shared work in the months and years ahead. We invite you to join us — as well as your colleagues, patients, and communities — on this journey.

WHO	WHY
	
WHAT	**HOW**
	

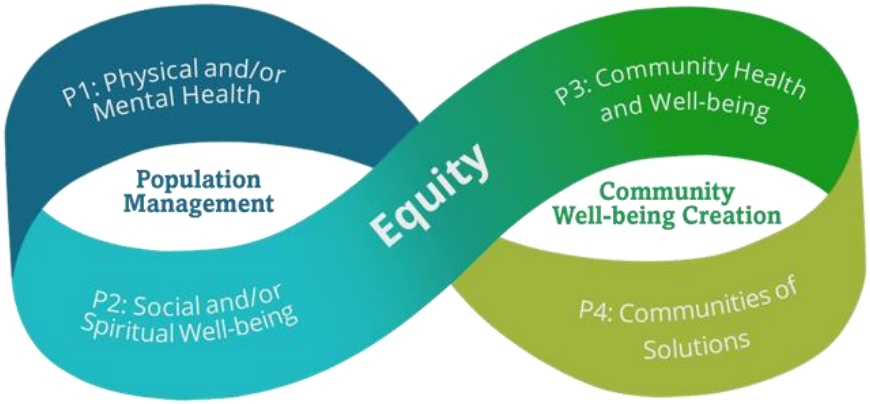
Who

This guide is intended for managers, leaders, clinicians, and change agents in health care organizations. Our objective is to support health care professionals and their organizations in growing, improving, and accelerating their contributions to population health, well-being, and equity.

Why

The six concepts depicted help lay the foundation for the Pathways to Population Health. They also articulate several reasons why many health care organizations have chosen to embark on this journey. The concepts represent an evolving understanding of what creates health and the ways in which health care organizations can engage. Learn more about the six concepts in the P2PH Framework.

What

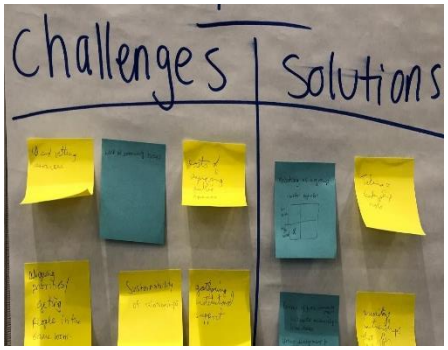


The Framework builds upon two major domains of work: efforts focused on the health and well-being of defined populations for whom health care organizations are directly responsible, such as patients or employees (Population Management); and efforts focused on the health and well-being of communities (Community Well-Being Creation). We further subdivided these domains into four Portfolios of Population Health on which improvement work is likely to focus. Together, these four interconnected portfolios represent a comprehensive scope of population-health–related improvements that a health care organization might pursue.

For meaningful transformation to occur within and across portfolios, organizations can apply eight levers: nontraditional roles, relationships, governance, financing models, policy, data, equity, and partnering with people with lived experience. Learn more and read about key activities and examples in the P2PH Framework.

How

1. Follow the 10-Step Path to Progress outlined below to prioritize immediate next steps.
2. Learn from others by reading P2PH case studies, available at www.ihi.org/p2ph
3. Measure progress and share learnings with others:
    a. The 100MLives Change Library's Health System Transformation Oasis (appendix A of the Compass) is a practical, searchable, peer-reviewed implementation library that helps change makers by sharing both the things that work and things that don't work to improve health, well-being, and equity with people and communities.
    b. Sign up for the 100MLives Measure What Matters Platform to track your progress and join the count to 100 million healthier lives by 2020.
    c. Email P2PH@ihi.org to say hello and share what you're working on!



10-Step Path to Progress: Improving population health, well-being, and equity

Using the P2PH tools and resources with the following 10 steps, your health care organization will be primed to prioritize and take the first steps towards improving the health, well-being, and equity of populations and communities you serve. It is suggested that this 10-Step Path to Progress be used in conjunction with:

a) The P2PH Framework, which helps health care organizations speak a common language and build a balanced "portfolio" of population health activities across four areas: (P1) Physical and/or mental health; (P2) Social and/or spiritual well-being; (P3) Community health and well-being; and (P4) Communities of solutions; and

b) The P2PH Compass, an assessment that helps health care organizations see the balance of current activities within and across portfolios.

In the first year of launching these tools, over 5,000 organizations have downloaded these resources to help accelerate their progress towards their health, well-being, and equity goals. At the same time, we heard similar questions and feedback from many of these organizations regarding two areas: (1) How to create buy-in for this work across their organization; and (2) What specific, practical steps could they take immediately to make progress on their population health journey?

The resulting *10-Step Path to Progress* is a response to those two questions. Through this journey, we learned that in order to make sustainable progress, "ideas" alone are not enough. Rather, these ideas need to be fueled by organizational "will" and operationalized through collective practical "execution." The 10-Step Path to Progress rests on a foundation of improvement science, and was developed in collaboration with ground-breaking organizations and experts in the population health field, collectively committed to the goal of improving health, well-being, and equity across the country.

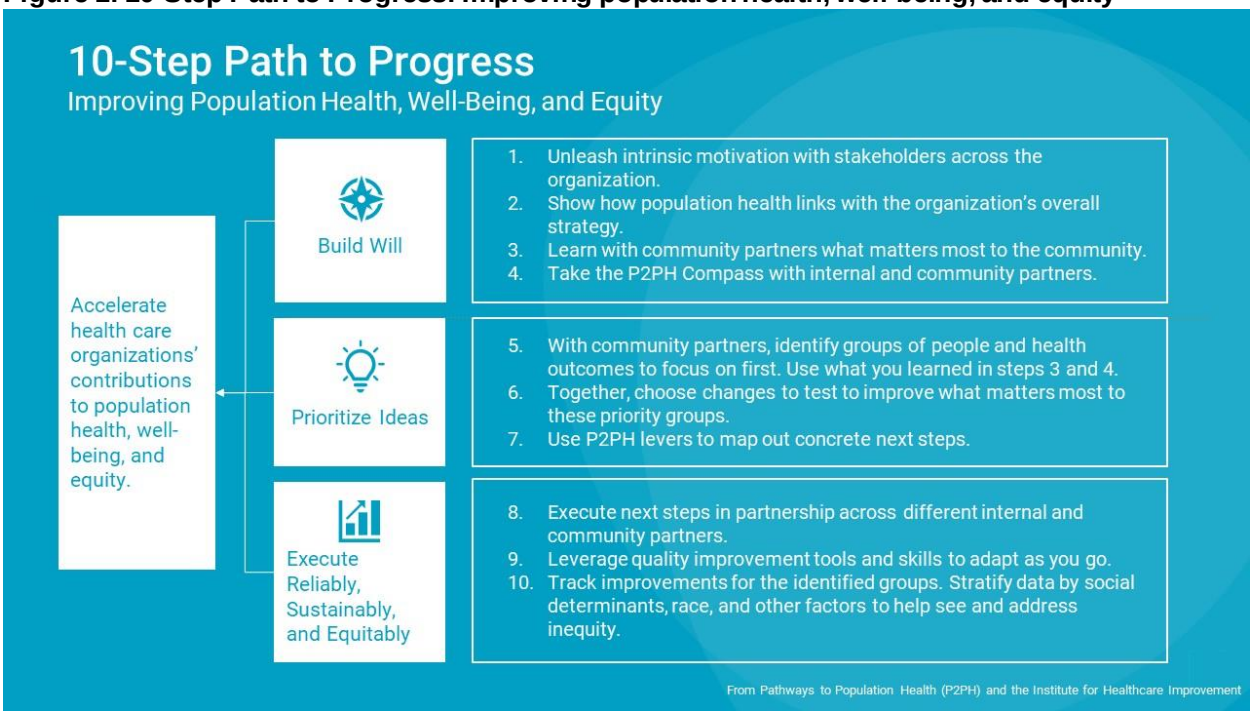
The following tables outline how to get started on each of the 10 steps, including practical actions that health care organizations can take immediately, along with links to relevant tools and resources. Besides the specific tools embedded within the 10 steps, the Oasis (see Compass: Appendix A) is a

more general curated set of tools and resources to accelerate your improvement journey in population health.

Population health work cannot be done without partnering with people with lived experience. As you move through each step, ask yourself these questions: Who are we not including in this process? How could the process or outcomes include or benefit vulnerable populations? Does our current team reflect the community we serve (in terms of race, neighborhood, socioeconomic status)? In what ways could we include a patient or a community member in this step? Intentionally partnering with people with lived experience is one method to help drive towards more equitable systems and outcomes.

While the 10 steps are listed sequentially, you can consider this a "choose your own adventure" support guide, based on where you are in your own population health journey. For health care organizations just embarking on population health, it may be useful to see these steps as sequential and building upon one another. At the same time, the sequence should not be a roadblock or detriment; if you find yourself getting stuck on one particular step and there is motivation and drive toward a different step, feel free to jump to that step directly. Other health care organizations that are more established in their population health journey should feel free to gravitate to the step(s) that would most move the needle towards their goals. Ultimately, this journey is an iterative process, though we recommend a balanced foundation of building will, prioritizing ideas, and executing reliably, sustainably, and equitably.

Figure 1: 10-Step Path to Progress: Improving population health, well-being, and equity



10-Step Path to Progress: Improving population health, well-being, and equity BUILD WILL		
Step	**3 Suggested Actions for Getting Started**	**Considerations and Additional Resources**
1. Unleash intrinsic motivation with stakeholders across the organization.	1. Identify which stakeholders touch population health at your organization/community; pick up the phone and ask them what matters most to them and how they make decisions related to population health (Stakeholder Identification & Planning Worksheet). 2. Share stories about why this work is meaningful to stakeholders; co-design purposeful stories about why population health matters using the Public Narrative tool found in the IHI Psychology of Change Framework (see example of "Bill's Story") 3. Review data together and share data with stakeholders; The Numbers Tell a Story: How to Use Data to Achieve Health Equity provides guidance on utilizing data to build will. a. Local Community Health Needs Assessment b. County Health Rankings c. Well-being in the Nation Measures	• Engage both the heads and hearts of stakeholders (Why Stories Matter; Power of Storytelling and Switch for Organizations). • When considering stakeholders, it is useful to think beyond the population health department to include individuals working in departments such as finance, public health, clinical areas data, IT, community benefit, and patient engagement. • Don't forget your board as a critical stakeholder: Framework for Effective Board Governance of Health System Quality. • Some of the most important stakeholders can be patients and individuals from your community (5 things you need to know about co-designing with people with lived experience). When building your pool of stakeholders, ensure they demographically represent the community you serve (racially, geographically, etc.)

		• Make sure that the data you review and stories you tell represent segments of the population at the highest risk.
2. Show how population health links with the organization's overall strategy.	1. Map population health work to your organization's mission, vision, and values in terms of the organizational and department-level strategic plans. How does population health fit into your current plan? 2. Present data to support linkage of population health to organizational strategy (using this ROI Calculator or, How to Assess the ROI of Your Population Health Initiative if relevant to organization). Link population health and social determinants of health strategies with clinical and financial outcomes to help prioritize resourcing investments. 3. Have senior leadership signal and model the importance of population health in the questions they ask, and in the ways that they make decisions, behave, and communicate with staff, patients and external partners.	• Sometimes in health care organizations, mission-driven activities (such as community benefit) and financial strategies (such as risk contracting) may not be linked. Activities to improve population health and address the social determinants of health can strategically contribute to both mission and financial efforts. • Learn from other organizations through P2PH case studies linking population health with the organization's overall strategy. • Making Health Equity a Strategic Priority reviews how to identify equity as a priority, and how leaders can demonstrate ownership and increase awareness. • The Triple Aim white paper describes one set of strategic goals that can be useful to frame this work.
3. Learn with community partners what matters most to the community.	1. Map actors and assets and build relationships in order to engage and learn what matters most to all stakeholders together.	• Health care organizations can serve as an important convener or connector in this process; practice ways of being from the Five Habits of

	2. Review data together (such as your local Community Health Needs Assessment). 3. Practice deep listening and asking open honest questions (Guide to asking Open and Honest Questions).	the Heart and practice using the One-on-One Meeting Tool for Authentic Relationship. • Asking "What matters to you" in the context of shared decision making can help converge upon a shared purpose and vision. • Learn tips on Engaging People with Lived Experience with this Community Commons Toolkit. • Consider equity when mapping actors and assets and building relationships: what populations aren't currently being included? How can you include them? See: What is Health Equity, and Why Does it Matter?
4. Take the P2PH Compass with internal and community partners.	1. Identify a cross-sector team of clinical, administrative, and community leaders who play a role in improving health for your constituents. 2. Complete the Compass assessment with the team. 3. Take time to debrief collectively to discuss strengths, weaknesses, and opportunities.	• The P2PH Compass is a useful tool to help your organization assess its strengths, gauge opportunities, and determine how "balanced" its population health activities are across the four portfolios: Physical and/or Mental Health; Social and/or Spiritual Well-being; Community Health and Well-being; and Communities of Solution. • Taken quarterly, the Compass can help track progress across the four portfolios.

		• Having key stakeholders within the organization and externally (e.g., community partners) individually take the Compass and discuss can be a powerful tool to see where there is consensus for change (taking the Compass individually can be a way to address potential power imbalances). • Learn from other organizations that have used the Compass through case studies.

10-Step Path to Progress: Improving population health, well-being, and equity PRIORITIZE IDEAS		
Step	**3 Suggested Actions for Getting Started**	**Considerations and Additional Resources**
5. With community partners, identify groups of people and health outcomes to focus on first. Use what you learned in steps 3 and 4.	1. Review your Compass results: do you need to focus on your specific patient panel (P1/P2) or the community more broadly (P3/P4)? Or, some of both? For example: do you want to start by helping your patients with diabetes manage their condition and mental health? Assess and address food insecurity for the patients who visit your clinics? Partner with local, faith-based organizations to address loneliness for aging folks in your community? 2. Return to your patients' and community's data and stories — what populations and health outcomes stand out the most? Look out for who isn't thriving. a. Consider using the County Health Rankings guide to using data 3. Convene a focus group to see if those with lived experience select similar priorities and adjust based on their suggestions.	• Consider segmenting population data by race and other socio-economic factors to identify disparities and help focus efforts; refer to Liberation in the Exam Room: Racial Justice and Equity in Health Care • Engage those with lived experience. • Ask patients and community members questions like, "What is a day like for you?" or "What is it like to live with this chronic disease?" Ask health care providers, "What is it like to serve people who keep coming in and out of the health care system?" • Avoid "tokenism" when recruiting and working with patients and community; work to build authentic relationships and distribute and build real power to, with, and around others; invite others to be the first to speak; cede power.

		• Use Liberating Structures to guide your interactions with partners; learn from past initiatives (Population Health: Learning from the Past to Shape the Future).
6. Together, choose changes to test to improve what matters most to these priority groups.	1. Follow the 3-Part Data Review Interview Guide to explore the assets and needs of your sub-population. 2. Determine a list of changes: a. Explore the evidence base *(see Other Resources in next column).* b. Gather best practices from similar organizations/communities. c. Brainstorm changes with involved stakeholders and those with lived experience. d. Determine root causes, drivers, and associated change ideas using the QI Essentials Toolkit. 3. Ensure the changes align with the needs and desires of those with lived experience and the will of those who will be involved in the testing/eventual implementation (gathered from focus groups, surveys, and 1:1 interviews). 4. Analyze your organization and patients/ community to select highest leverage changes. a. Conduct a Pareto analysis using the QI Essentials Toolkit or White Board video to determine which factors are having the greatest impact on	• Ensure that you are capturing the needs and aspirations of the whole sub-population by matching the demographics of your focus group, interviewees, and survey respondents to those of the population. Consider: race, gender, socio-economic status, place/neighborhood. Refer to Advancing Equity in Health Systems by Addressing Racial Justice for examples of initiatives to advance racial equity across very different settings. • When brainstorming changes, take an asset-based approach. Consider the resources available to the population, where they live, their financial situation, primary language, level of education, and access to transportation. • In focus groups and interviews, ask Open and Honest Questions,

	the process or outcome you are trying to improve. b. Plot changes on an impact/effort grid to identify high-impact, low-effort changes. c. Map your assets and consider which changes align with your organizational strengths, priorities, and existing resources.	Yes/no and leading questions can hinder receiving important information. • It is essential to include those with lived experience throughout the entire process of brainstorming and selecting changes. *Resources to help you explore the evidence base include:* • County Health Rankings Action Guides • Pursuing the Triple Aim for Populations • Playbook for High-Risk-High-Cost Populations • The Role of the Hospital in Managing Population Health • Hospitals Aligned for Healthy Communities Toolkit • Achieving Health Equity
7. Use P2PH levers to map out concrete next steps.	• Convene a multidisciplinary team and use this worksheet to map out potential barriers within the key levers of population health (p. 16 of the P2PH framework) that influence the work (roles, relationships, governance, financing, policy, data, equity, and partnerships) and draft a plan to overcome them to make your changes successful. • Make a plan for your first test of change using a PDSA worksheet:	• Ensure that the multidisciplinary team includes and engages people with lived experience, who will have invaluable insights into potential barriers and ways to overcome them. • Human-centered design is a powerful approach that starts with the people you are designing for and ends

	○ Ask questions and make predictions. ○ Think about the who, what, where, and when. ○ Make a plan for collecting data on how you will know the change is an improvement. ● Plan for how you will learn: learn from others (find and connect with exemplars), learn from data and stories during the tests of change, learn from history. Historical context matters: what has worked before and what hasn't? Where has trust been broken in the past?	with new solutions that fit their needs. Resources for human-centered design include the following: IDEO's An Introduction to Human-Centered Design, d.school bootleg bootcamp, and Human Centered Design @ KP Pocket Guide

10-Step Path to Progress: Improving population health, well-being, and equity EXECUTE RELIABLY, SUSTAINABLY, AND EQUITABLY		
Step	**3 Suggested Actions for Getting Started**	**Considerations and Additional Resources**
8. Execute next steps in partnership across different internal and community partners	1. Strengthen internal alignment across leadership, frontline clinical providers, functional departments (i.e., finance, HR, quality) and build external partnerships (i.e., community partners, patient advisory boards, etc.); develop distributed leadership structure and leverage people's unique roles and responsibilities using the distribute power tool in the IHI Psychology of Change Framework.	● Creating opportunities to collaborate and communicate with patients and their families on their health care can provide unique perspectives for more effective policies and practices that get at the heart of patient/family needs; the AHRQ Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families and ASTHO's Introduction to Multi-Sector Intersections and Collaborations to Advance Health Equity contain guidance on how to promote stronger engagement and collaboration.

	2. Identify the key steps and resources needed to engage community residents with lived experience and community leaders with help from the SCALE Toolkit for Engaging Community Members. 3. Utilize the AHA/HRET Guide for Creating Effective Hospital Community Partnerships to explore best practices in identifying community health needs and building sustainable partnerships.	• Individuals with lived experience are an untapped source of leadership, resources, and knowledge. The following posts can help with co-executing in authentic relationship: Using Meaningful Community Partnerships to Attain Health Equity • The Community of Solutions model depicts a dynamic approach to community change, including interconnected skills and behaviors for the work
9. Leverage quality improvement tools and skills to adapt as you go.	5. Utilize the Model for Improvement as an effective framework that can help you set an aim, determine measures, and test changes; IHI Open School Courses (QI 101, 102, & 103) provide foundational concepts in quality improvement principles and the QI Essentials Toolkit includes QI tools and templates for improvement. 6. Leverage the Australian Council for Safety and Quality in Health Care guide on how you can use data for quality improvement to understand the role of data in quality improvement and how to apply some basic	• When developing an improvement goal, review your aim for the components of a **SMART** AIM: **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imely. We recommend adding an 'E' for **Equitable** (see Equity of Care: A Toolkit for Eliminating Health Care Disparities and 6 Tips for Measuring Health Equity at Your Organization)**.** • "Shrinking your change" and enacting smaller, incremental shifts can make altering long-held norms more manageable in order to enact truly meaningful systems change. • Three core questions of the Model for Improvement can help guide any improvement work: ○ What are we trying to accomplish? (aim)

	techniques to use data to support your efforts. 7. Explore the Well-being in the Nation (WIN) Framework to get a high-level view of your community's needs with particular attention to the core measures that affect community health, well-being, and equity.	○ How will we know if a change is an improvement? (measures) ○ What changes can we make that will result in improvement? (ideas) • Adapting in action includes rapid tests of change and comfort in "failing forward" a critical part of the learning and improvement process.
10. Track improvements for the identified groups. Stratify data by social determinants, race, and other factors to help see and address inequity.	1. Stratify patient race, ethnicity, and language data to help identify and address health care disparities, using guidance from the AHA/HRET Framework for Stratifying REL Data. 2. Review the IHI white paper on Sustaining Improvement to better understand how to navigate the challenges and pitfalls of sustainability in a constantly changing and evolving health care system. 3. Utilize the QI Essentials Toolkit for worksheets and resources on how to track and implement tests of change.	• Stratifying data by equity factors is an important way to track improvements for the defined population; Reducing Health Care Disparities: Collection and Use of REL Data provides guidance on this approach. • Well-being in the Nation Measures show connections between social conditions, health, community, and well-being. • Review data regularly with key stakeholders to assess what is working and what is not; Successful Measurement for Improvement provides useful guidance.

Conclusion: What's Next?

We would love to hear from you! How did these 10 steps help you in making progress toward improved health, well-being, and equity of the populations and communities you serve? We are all on this journey together and continue to learn from one another's work: "all teach, all learn." Please get in touch with P2PH (p2ph@ihi.org) to share your learnings and reflections.

While the north star of this work — health, well-being, and equity — is clear, the path itself is an inherently iterative process. We hope that you continue to turn to these 10 steps and revisit any actions that can benefit your organization and community as you advance on your journey. Used in conjunction with the P2PH Framework, Compass, and case studies, you now have a powerful toolkit to build will, prioritize ideas, and execute reliably, sustainably, and equitably. We commit to learning and improving with you along the way.

Acknowledgments

100 Million Healthier Lives (100MLives) is an unprecedented collaboration of change agents across sectors who are working to transform the way we think and act to create health, well-being, and equity. As part of 100MLives, the Robert Wood Johnson Foundation generously funded Spreading Community Accelerators through Learning and Evaluation (SCALE), which began in January 2015 and ended its second iteration in April 2019. The second iteration of SCALE, SCALE 2.0, included the initiative SCALE Health Care (now known as the Pathways to Population Health, or P2PH). P2PH is committed to providing a clearer and more coherent understanding of what it means for health care organizations to be on the journey toward population health. Five organizations partnered together to make P2PH become a reality: American Hospital Association (AHA) / Health Research & Educational Trust (HRET), Institute for Healthcare Improvement (IHI), Network for Regional Healthcare Improvement (NRHI), Stakeholder Health, and Public Health Institute (PHI).

In support of creating a health system that is good at health and good at care, the 100 Million Healthier Lives team convened the Health Systems Transformation (HST) Hub. The HST Hub brings together more than 25 partner organizations that represent a wide array of perspectives in health care transformation. Over the past years, the HST Hub examined the landscape of how health care organizations operationalize their work in population health and was instrumental in the development of the P2PH tools and resources, together with 40 health care leaders who convened at a design meeting in September 2017. All of this work is built off of the 100MLives' Core Principles.

In the first year of P2PH being released into the field, a group of 30 Pioneer Sponsors championed the movement by helping us spread the word, support organizations as they joined, and share learnings with us. We are grateful for their help in spreading the word, which will allow us to truly achieve a common language and shift in the field. A number of Partners, Pioneer Sponsors, HST Hub members, and population health experts came together in April 2019 to understand the value of the P2PH tools and what gaps we could fill to make them even more useful to health care organizations. Their contributions played a large role in the development of this document.

The following organizations/individuals have pooled their collective assets and expertise in service of helping health care organizations to accelerate their population health improvement efforts:

P2PH Founding Partners

100 Million Healthier Lives Health Systems Transformation (HST) Hub members

September 2017 Design Meeting participants

P2PH Pioneer Sponsors

April 2019 Design Meeting participants