

Pathways to
Population
Health
Case Studies

Providence St.
Joseph Health



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[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). The development of these case studies would not be possible without these organizations, whose active engagement in the movement and open sharing of insights and feedback have allowed us to spread learnings to the field.

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Introduction

The P2PH initiative began with the vision of a health care system focused on treating the whole person by building synergy across the domains of population management and community well-being creation. While health care organizations are committed to improving health outcomes for the populations they serve, they rarely have a concrete path to building and deepening awareness of the multifaceted factors that affect health and well-being and perpetuate health inequity. Thus, the P2PH partners (Network for Regional Healthcare Improvement, Stakeholder Health, American Hospital Association, and the Public Health Institute) came together to make the pathways clearer.

The P2PH Framework (pictured below) helps health care organizations understand key concepts and terms; describes four portfolios of work that contribute to improvement; and identify the levers vital to accelerating progress. By balancing each of the four portfolios, with a goal of equity at the core, organizations can chart a path to meaningful and sustainable change. The P2PH Compass helps health care organizations catalogue current population health efforts and identify opportunities to make practical and sustainable advances. These, as well as other resources, are available at www.ihl.org/p2ph.



This collection of case studies outlines the impressive work of health care change agents in utilizing the P2PH Framework, Compass, and other resources to advance in their population health improvement efforts. The narratives highlight various approaches for increasing the efficiency and effectiveness of conversations with population health stakeholders and developing practical plans to improve health and health equity for populations, grounded in the foundational concepts of the P2PH initiative.

Providence St. Joseph Health Case Study

Summary

Providence St. Joseph Health (PSJH), one of the largest nonprofit health systems in the United States, announced the creation of the PSJH Population Health Division in 2015. In 2018, Providence announced a significant systemwide pivot: shifting from health care to health, a journey they call Health 2.0 (Figure 1). While serving vulnerable populations has always been a part of their mission, PSJH has become more intentional about investing in their communities and making population health a strategic priority systemwide. This new focus includes an emphasis on integrating, improving, and aligning their care management activities in the service of community health. This P2PH story describes how PSJH has chartered the next step in this great work, incorporating the P2PH Framework and Compass to help inspire ideas, increase buy-in, and allow stakeholders to speak a common language as they continue this important work.

The P2PH Story

Building Will

Building will among organizational leaders across sectors with various, at times conflicting, priorities can be challenging. Despite the desire for a shared vision, it can be difficult to identify a unifying goal and converge on a shared approach to improving health and reducing disparities. In early 2019, the PHM division used the P2PH Framework and Compass as a part of strategy development to help align system-level population health leadership. They held a strategic planning retreat with the most senior leaders in contracting, value-based care, government programs, the Providence Health Plan, population health informatics and analytics, and care management. At this retreat, these leaders took the Compass in pairs, and then discussed their results as a team. Using the tool in pairs and then coming together to debrief proved helpful for setting strategy and recognizing the unique lenses that system-level leaders bring to population health work.

In this way, the Compass was a helpful tool to highlight both areas of agreement and differences in thinking in terms of where they were doing well and what could be improved. Leaders reported that having a shared framework has been useful in aligning their work and speaking a common language around population health. Grounding thinking in the foundation of the four P2PH portfolios pushed leaders to consciously focus on the pressing issues that needed to be called out explicitly in their strategic plan.

PHM created its three-year Population Health Strategic Plan, closely linked to the system's ISFP, laying out more specifically the division's role in catalyzing the ongoing shift of the organization toward a population health orientation. As PHM was developing this strategic plan, they were looking for a way to describe the division's unique role in advancing PSJH's transformation. While many ideas arose, organizing them into a clear and cohesive plan and story was challenging. The group stepped back, considered the available tools and included the P2PH Framework. By incorporating the Compass, grounding their ideas in the Triple Aim, and including concepts from the P2PH Framework, they iterated through to an updated strategic plan.

Using the P2PH Framework to Formulate Ideas & Execute Reliably

To help turn ideas into action, the Enterprise Care Management & Coordination (ECMC) team at PSJH created a Care Management for Population Health (CM4PH) readiness survey for each of their regions and the ministries within them. To develop the survey the team pulled concepts from the P2PH Framework and other sources to inform six functions of care management. The survey used questions from the Compass related to team-based care, behavioral health integration, community partnership/investment, and data. Following a recommendation from the Compass, the CM4PH survey also included social determinants of health data in their analytics domain, and asked ministries whether or not they use that data to prioritize or stratify the populations they work with.

The use of the P2PH Framework surfaced common areas of overemphasis within traditional care management models, which tend to focus on specific disease states, quality metrics, and care gaps. While these are important components of an effective care management approach, they are insufficient to achieve person-oriented goals or to improve outcomes in high-need, high-complexity populations. The survey was well-received in part because it allowed local teams to highlight both what they felt they did well and areas where they needed more help.

The ECMC team identified common issues, allowing them to focus initial program co-development efforts with local care management leaders on relieving pain points. These efforts related mainly to population data, patient segment stratification, and impact tracking for care management interventions, as well as training and skill-building to facilitate more effective engagement with people struggling with complex challenges. This work resulted in a shift towards a less task-oriented model to a more holistic health perspective, using data to identify and target the highest-risk populations and to deploy highly relational, person-centered care management approaches.

The survey resulted in three successes:

- 1) Development of the Care Management for Population Health (CM4PH) model;
- 2) Partnering with the Camden Coalition to upskill their care managers through the COACH/RELATE program, an initiative to strengthen capacity for delivering better care; and
- 3) Continuing to track progress by redeploying the CM4PH survey later in the year.

Challenge: Within the PHM division of PSJH, the challenge entails effectively supporting and facilitating transformational work and a data-driven population approach amid managing short-term imperatives and financial pressures. To meet this challenge, accelerating engagement among leaders across the system, through using data in new ways, appears to be an effective strategy.

Mitigation: For care management staff, shifting care management practices in busy practices can feel overwhelming, especially where the need outstrips available resources. Building on staff's commitment to the organization's mission as well as the intrinsic motivation of those drawn to care management, the addition of new skills, techniques, and approaches combined with meaningful data appear to help mitigate this challenge.

What's Next

With local care management leaders, ECMC will continue to co-develop approaches to population identification, stratification, and care management. This work will include development of new skills and techniques for effective engagement with patients and community partners. ECMC will continue to administer the CM4PH survey and track progress. PHM will continue to work closely with regional leadership, clinicians, front-line caregivers, and communities to carry out the Population Health Strategic Plan. The impact of these efforts, together with other key initiatives across the system, should yield healthier communities throughout the area served by PSJH.

Lessons and Implications

This case study demonstrates how the P2PH Framework and Compass can be used at various levels of a system — from the leadership level to the regional and local levels — to inspire ideas and foster a common language around population health. This utilization can lead to strategic outputs (such as an organizational strategic plan) as well as tactical ones (such as an assessment and readiness survey). Additionally, the P2PH Framework and Compass can be used specifically with an organization's care management division to help align their work with other population health work across the organization.

When asked what advice she would give to others on this journey, Senior Vice President Karen Boudreau underscored the concept of “patient impatience”: balancing a sense of urgency with the recognition that transformative population health work takes time.

Appendix

Organizational Background

Providence St. Joseph Health (PSJH), one of the largest nonprofit health systems in the United States, announced a significant pivot in 2018: shifting from health care to health, a journey they call Health 2.0 (Figure 1). Based on this vision, their strategic focus has been on continuous innovation to create access to health care for all and foster healthier communities.

This focus on healthy communities and social determinants of health is not new. In recent years, the organization set up a Community Investment Fund, which provides loans to local nonprofits and businesses and aligns community benefits with place-based investing strategies. In 2015, PSJH established a new

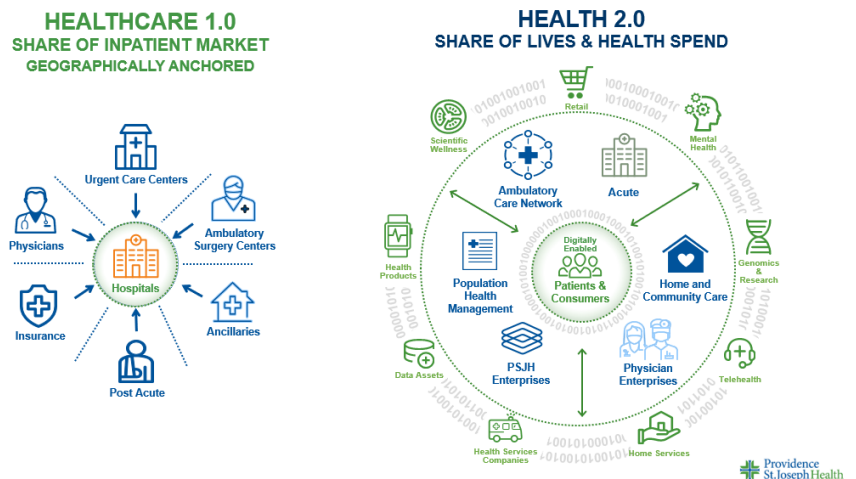


Figure 1: Providence Saint Joseph Health 2.0 Model

division of Population Health Management (PHM) to lead the organization through its transformation and integrate population health management capabilities into its delivery systems and health plans.

What *is* new is the system's explicit strategic pivot from health care to health. Its current five-year Integrated Strategic and Financial Plan (ISFP) includes a high-level commitment to population health and places community health partnerships at the center. PSJH's leadership at the system level is working across all regions to think about how to expand, refine, and improve



processes related to understanding the population they serve and improving their outcomes and cost. Specifically, PSJH is working to revamp its approach in order to pinpoint the needs of specific populations and how best to address those needs, with the ultimate goal of improving care quality and outcomes while managing costs for defined groups of people.

PSJH originally became involved with P2PH as an IHI Strategic Partner and became an early adopter and champion of the P2PH movement as a Pioneer Sponsor organization. During this time, they shared the P2PH tools and resources across their system and network to help build will and create a common language for population health leadership; inform strategy through concrete population health change ideas; and develop an assessment and readiness survey as well as tools for execution.

References

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