Metrics that Matter for Population Health Action

Using Metrics Locally

Institute of Medicine Roundtable on Population Health Improvement
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Dignity Health

Discussion Points

- Dignity Health primer
- Community health to population health
- Population health metrics use and considerations

Dignity Health Statistics (FY14)

One of the nation's largest health care systems

Acute Care Facilities	39
Assets:	$15.8 billion
Net Operating Revenue:	$10.7 billion
Acute Care Beds:	8,500
Skilled Nursing Beds:	700
Active Physicians:	9,000
Total Employees:	55,000
General Acute Patient Care Days:	1.6 million
Community Benefits and Care of the Poor:	$2 billion*

* Including unpaid costs of Medicare

MISSION INTEGRATION > Community Health Dept.: A Comprehensive Portfolio of Tools

Socially Responsible Investing

Ecology Initiatives

Community Benefit

Community & Social Innovation Partnership Grants

Community Investments

Global Mission Program

Population Health at Dignity Health

Population health is a **strategy** to manage health not just inside hospitals and care centers, but also outside the walls through education, programs, advocacy, resources, and partnerships.

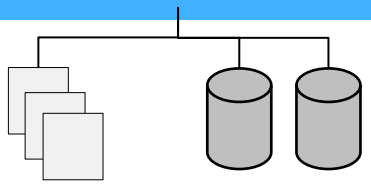
Population Health Continuum - Today

Hospital / Physicians

- Physicians, Nurses , other clinicians, Care Coordination / Social Work, SNFs, Hospice

Address:

- Physician Integration
- Clinical Integration / Payments
- Readmission

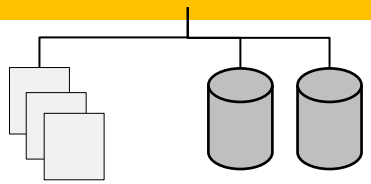


Community Health

- Mission, Community Health, Community Benefit, Health Educators

Address:

- Needs Assessment (CHNA)
- Programs and Services
- Grants and Investments
- Advocacy and Policy

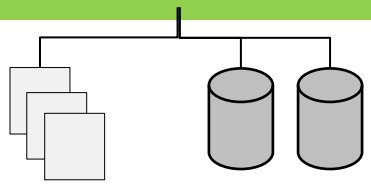


External Partners

- Faith-based, CBOs, Schools, Governments, Insurers, other Providers, Employers, Public Health Agencies

Address:

- Social determinants of health
- Upstream health factors
- Collective Impact



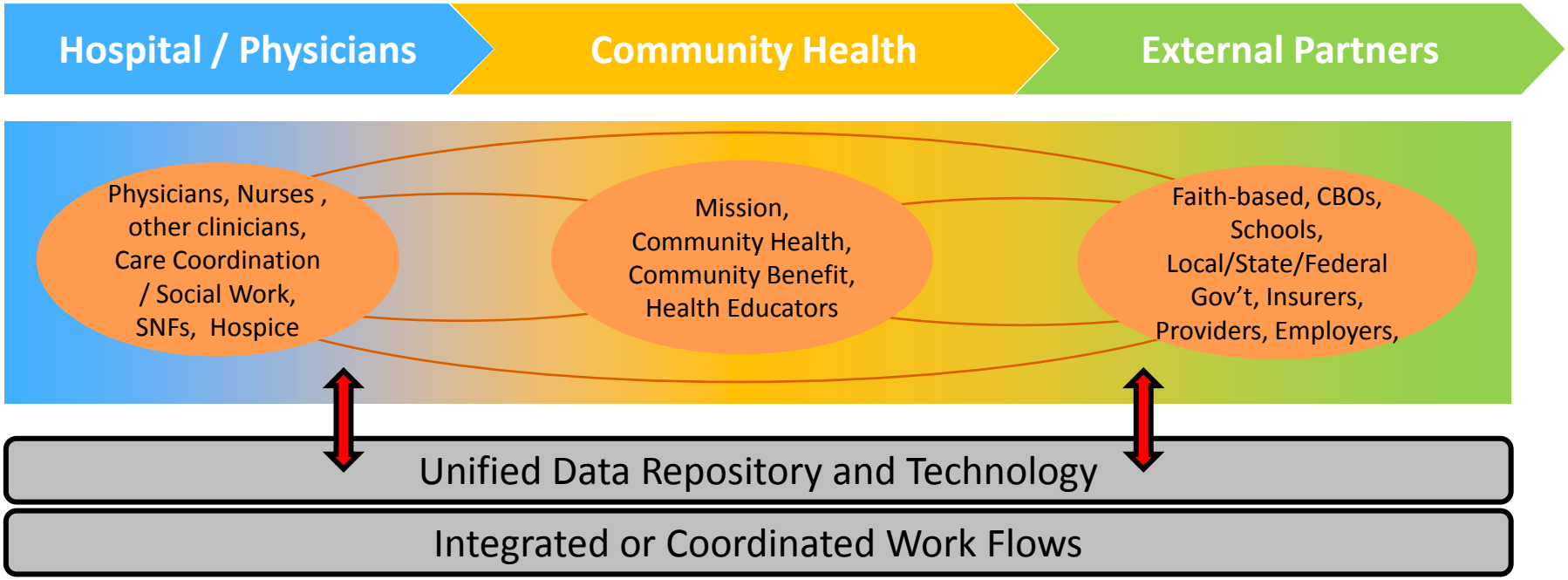
Challenges

- Communication
- Knowledge of Community Resources
- Engagement with Patient and Families
- Alignment of Resources

- Communication
- Access to Clinical Data
- Communication with Patients
- Outcome Measurement
- Infrastructure
- Alignment of Resources
- Financial Resources

- Communication
- Access to Community Health and Health Care Resources
- Infrastructure
- Financial Resources

Population Health Continuum - Tomorrow



Benefits

- Enhance Engagement
- Defined Accountability
- Increase Collaboration
- Improve Communication
- Empowered Consumers
- Accurate Outcomes Data
- Better Alignment
- Meaningful Partnerships
- Scalable Solutions
- Effective Programs

Where our “population health” metrics reside

- Community Health Needs Assessments
- Community Need Index
- Community Benefit Reports/Plans
  - “Program digests” with documented links to CHNA need, baseline data, measurable goals
- Healthcare information systems
  - Data warehouse, aggregate utilization data

Log In | Register | About the CNI

Dignity Health

Community Need Index

Step 1:
To view your Community Need Index score, start by selecting a state.

Select a state: California

Step 2:
Now, select either a city or a county.

Select a city: Oakland

or select a county: Select one...

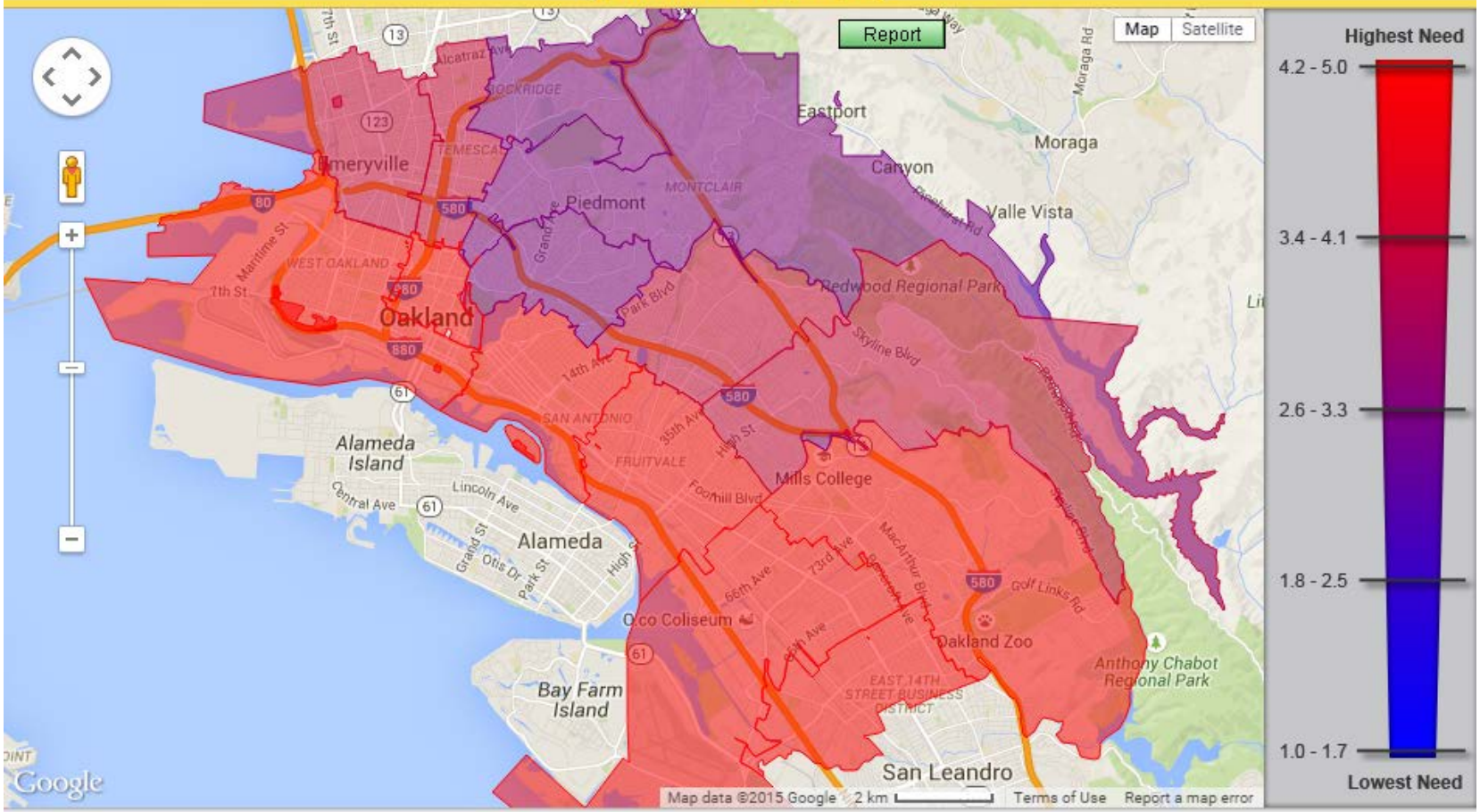
Step 3:
Click draw map to view your Community Need Index report.

Draw Map

CNI Statistics:
Based on what you selected:
Weighted Average CNI Score: **4.1**
Median CNI Score: **4.4**

Click here to generate report

Show More Search Options



How we use population health metrics

- CHNA significant health needs → Implementation Strategies
  - Conditions, populations/disparities, geographic locations
- Evaluate actions taken to address needs
- Focus community grants program requirements/awards
- Grant-seeking at local and system-wide levels
- Inform policy advocacy (including with community partners)
- Delivery system population health management
  (e.g. risk stratification, cost, outcomes, etc.)

Health Care, Social Factors, and Pop. Health

Community Factors and Hospital Readmission Rates

Health Services Research, April 2014

Risk Adjustment for Sociodemographic Factors

National Quality Forum, August 2014

Capturing Social and Behavioral Domains and Measures in Electronic Health Records

Institute of Medicine, November 2014

Making population health metrics “matter for action”

- **Establish a context**
  - Benchmarks, trends, rankings, quintiles, disparities, etc.
- **Present clearly and tell a story**
  - Infographics, correlations, if-then logic models that convey action
- **Set goals or targets**
- **Keep to a manageable number; consider a dashboard**
- **Relate the global** (and possibly abstract) **to the actionable**
  - Broad: **Condition X morbidity at the state or county level**
  - Localized / more specific: **Neighborhoods, sub-populations, contributing factors**
  - Programmatic / performance: **Outputs and outcomes for a defined population**
  - Organizational impact: **Return (outcome, cost) on investment, votes, reputation**

Thank you

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