

# Caring for Our Communities the Role of Family Physicians and Educators in Rural Population Health

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## **Disclosures:**

I am a shareholder and board member of Cascade Health Alliance, a local coordinated care organization in Klamath Falls, OR

This is the 80 acre sheep farm on which I have lived for almost 20 years.

## **Acknowledgements:**

Jen Devoe, MD and the residents and faculty of Cascades East who participated in our retreat.

- What is population health and why do we care?
- What tools or skills are needed for this work?
- Who are our partners and what is our role?
- What might be unique to rural health?



# How are we defining 'population health'?

THE MILBANK QUARTERLY  
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

## The Strange Journey of Population Health

JOSHUA M. SHARFSTEIN

ABOUT A DECADE AGO, RESEARCHERS DEFINED THE TERM "population health" to mean the "health outcomes of a group of individuals, including the distribution of such outcome within the group."<sup>2003</sup> Their goal was to broaden the discussion of health policy in the United States beyond the "biomedical paradigm" and to encourage investigation into and policy development of the "determinants of illness. As originally conceived, the term encompassed a wide range of educational differences, and unjust

PopHealth

### Population Health and the Academic Medical Center: The Time Is Right

Mark N. Gourevitch, MD, MPH

#### Abstract

Optimizing the health of populations, whether defined as persons receiving care from a health care delivery system or more broadly as persons in a region, is emerging as a core focus in the era of health care reform. To achieve this goal requires an approach in which care is valued and the determinants of patient engagement. For large, midsized academic medical centers, navigating the evolution

of population health paradigms across the domains of patient care, education, and research poses real challenges but also offers tremendous opportunities, as important objectives across academic medical centers. To understand and address population-level goals in addition to individual patient care, academic medical centers must

#### COMMENTARIES

## Creating Incentives to Move Upstream: Developing a Diversified Portfolio of Population Health Measures Within Payment and Health Care Reform

John Auerbach, MHA

I examined the feasibility of developing a balanced portfolio of population health measures that would be useful within the current deliberations about health care and payment reform. My commentary acknowledges that an obstacle to the selection of population health metrics is the differing definitions of population health, rather than choosing between these definitions, I identified five categories of indicators, ranging from traditional clinical care prevention interventions to those that measure investment in community-level nonclinical services, that in various combinations might yield the most promising results. I offer concrete examples of focus on prevention within clinical

avoidance of the utilization of expensive and sometimes unnecessary hospitalizations, and medical interventions. If the measures are not met, an accountable care organization or other provider group may lose a financial bonus and even risk future contracts with payers. Other innovative payment approaches also create opportunities for the promotion of wellness. For instance, many states are implementing delivery system reform incentive payment programs, which the federal government and state Medicaid programs, to support safety net providers who care for patients with complex socioeconomic barriers. As these discussions of public health leaders have prepared to participate. My article and specific suggestions fit into an insurance-oriented framework and have a demonstrable



## Population Health as a Means for Health Care Organizations to Deliver Value

Robert M. Jacobson, MD; George J. Isham, MD, and Lila J. Finney Rutten, PhD, MPH

Poor population-level health outcomes relative to other advanced countries, rising health care costs, the increasing prevalence of chronic disease, persisting health care disparities and access issues, and the aging population drive an urgent need for change in the US health care system to simultaneously improve health and reduce costs.<sup>1,2</sup> This imperative emerges during a time of increasing awareness of the major impact of environmental and social factors on health relative to health care, a time of expanding health data resources and health information technologies, and a time of substantial opportunity for health care reform through the Affordable Care Act.<sup>3</sup> Convergence of these trends and opportunities creates unprecedented potential for transforming health care

Commentary

## What's in a Name? The Necessary Transformation of Population Health and Accountable Care

Verdi J. DiSessa, MD, MBA, and Larry R. Kaiser, MD

#### Abstract

Academic medical centers (AMCs) and the physicians and other professionals who lead them need to recognize that they are in a business that is making a transition from a system of "sickness" care to one of "health" care, divided by the health of defined populations and how AMCs or they function

paid for the work that they do. A failure to recognize how the disruption of the mission of AMCs is changing may impair them as irrevocably as other changes caused the demise of Kodak, once the world's leader in the manufacture and sale of photographic film.

these changes and potential responses to them—a process already underway. They summarize the issues in the question "Should the words 'health' and 'system' take the place of 'medical'?"

#### MODELS FOR POPULATION HEALTH

## What Is Population Health?

David Knudt, MD, PhD, and Greg Stoddart, PhD

Issue's Name: This No. 100 issue of the journal offers an update on research in this field.

Population health is a relatively new term that has not yet been precisely defined. Is it a concept of health or a field of study of health determinants?

We propose that the definition of "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," where the concept of a determinant of health is not included, is the most influential contribution to the development of the population health approach in the United States. We present a rationale for this definition and note its differences from public health, epidemiology, and social health promotion, and social health and discussion. We invite commentary on this emerging concept. (Am J Public Health. 2003;93:382-383)

#### ALTHOUGH THE TERM

"population health" has been used more commonly since the late 1990s, a precise definition has not been agreed upon even in Canada, where the concept is denoted by the term "population health." However, the term has been used as a "umbrella" term, which is of course its intended meaning. Evans and Stoddart emphasize an understanding of the determinants of population health, "have also stated, however, that 'different concepts [of health] are neither right or wrong, they simply have different

that in Canada and the United Kingdom in the 1990s, the term has taken on the connotation of thinking about why some populations are healthier than others as well as the policy development, research agenda, and resource allocation that flow from this framework."<sup>10</sup>

However, Young also indicates that in the past, the term has been used as a "less comprehensive" term, which is of course its intended meaning. Evans and Stoddart emphasize an understanding of the determinants of population health, "have also stated, however, that 'different concepts [of health] are neither right or wrong, they simply have different

eral/Provincial/Territorial Advisory Committee on Population Health, write that "population health refers to the health of a health status indicators and as influenced by social, economic, and physical environments, individual health practices, individual human biology, early childhood development, and health services. As an approach, population health focuses on interrelated conditions and factors that influence the life course, identify systematic variations in their patterns of occurrence, and address the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those

# Remember this?

## Communities of Solution: The Folsom Report Revisited

The Folsom Group  
 American Board of Family Medicine Young  
 Leaders Advisory Group

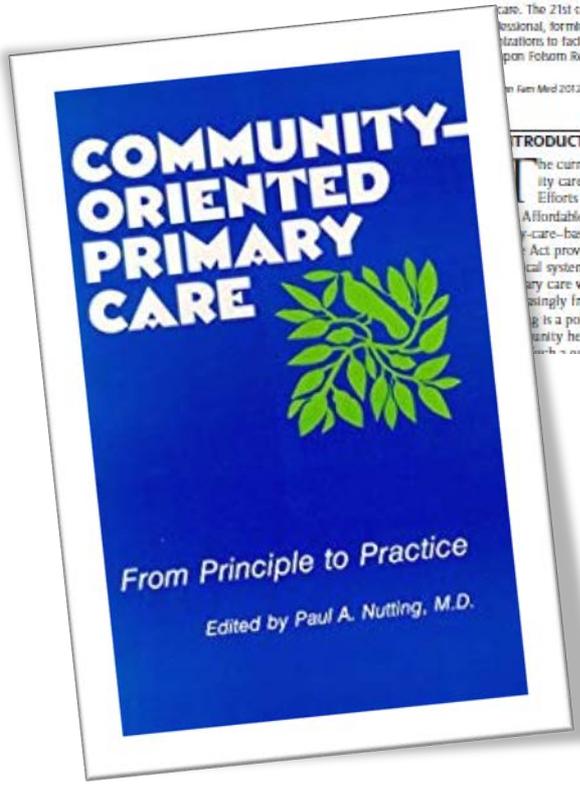
### ABSTRACT

Efforts to address the current fragmented US health care structure, including controversial federal reform, cannot succeed without a reinvigoration of community-oriented health systems. A blueprint for systematic implementation of community services exists in the 1967 Folsom Report—calling for “communities of solution.” We propose an updated vision of the Folsom Report for integrated and effective services, incorporating the principles of community-oriented primary care. The 21st century primary care physician must be a true public health professional, forming partnerships and enabling data sharing with community organizations to facilitate healthy changes. Current policy reform efforts should build upon Folsom Report’s goal of transforming

J Gen Intern Med 2012;10:250-260. doi:10.1177/0898

### INTRODUCTION

The current fragmented US health care system provides less value than most industrialized nations. Efforts to address this low value system, including the Affordable Care Act, cannot succeed without a reinvigoration of community-oriented primary care. The Affordable Care Act provides multiple provisions to improve the primary care system, including improving training and recruitment of the primary care workforce, and enabling integration of the currently fragmented health system. This report is a policy blueprint for system change that meets the needs of the community health services that meet the needs of the community.

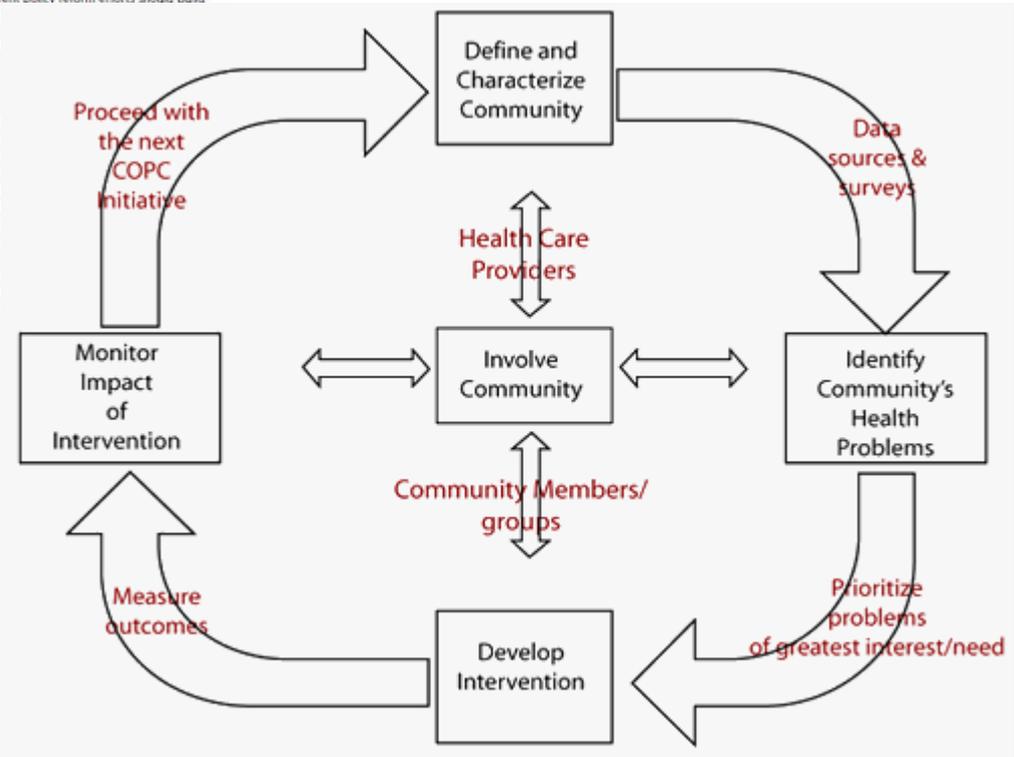


## Community Oriented Primary Care

New Directions for Health Services Delivery

Conference Proceedings  
 Edited by Eileen Connor and Fitzhugh Mullan

Division of Health Care Services  
 Institute of Medicine



# What about this?

**2017 Population Health Management**  
**3 SECRETS TO VALUE-BASED PURCHASING SUCCESS**

Cracking the Code to Value-Based Purchasing Success with Healthcare

WEDNESDAY APRIL 19th 2017

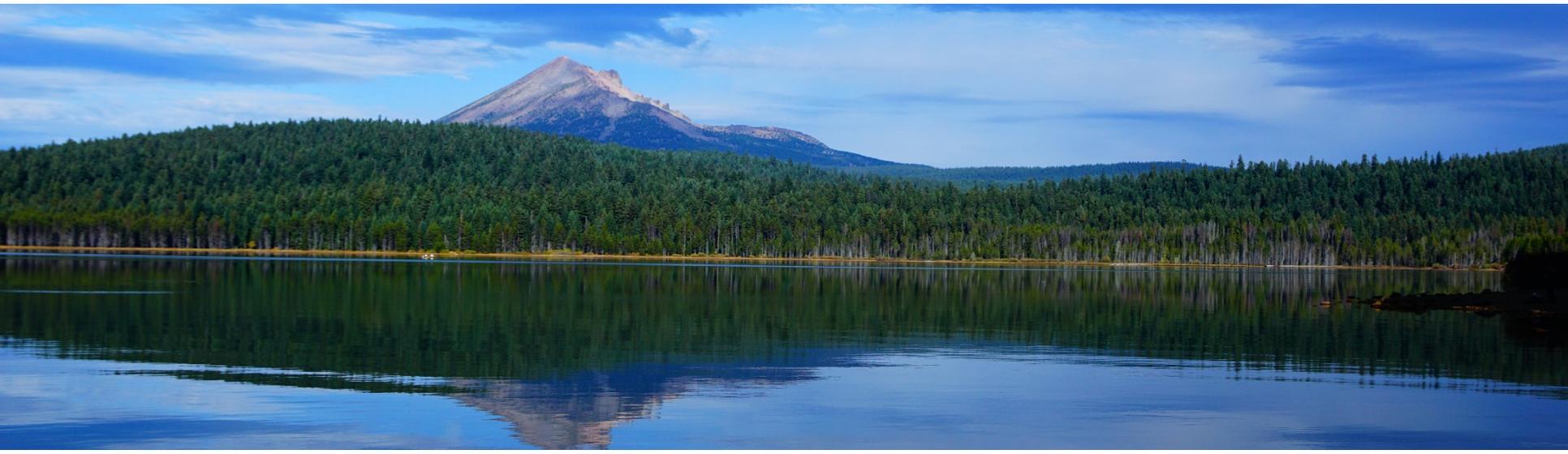
Participating Organizations: BAYADA Home Health Care, MEDICAL, EXAMINER, etc.



*The definition of population health:*

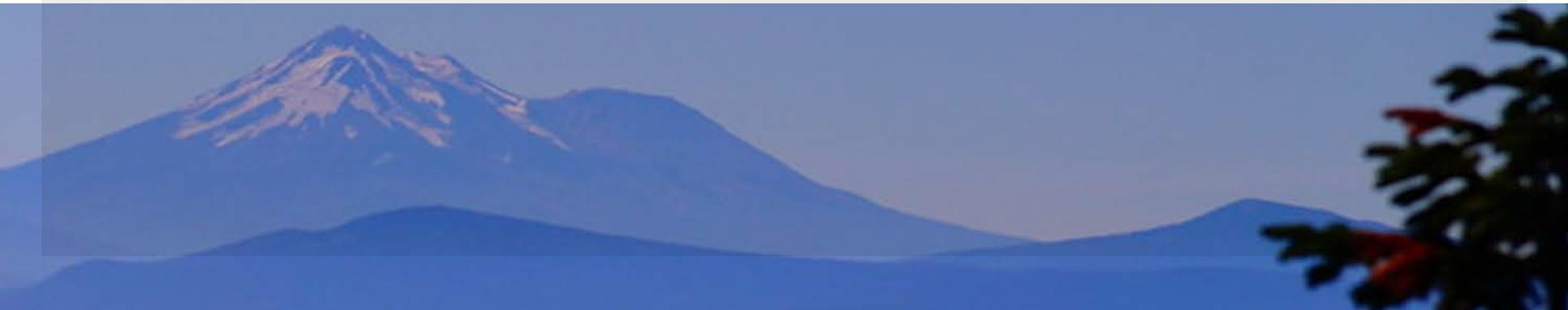
“The health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

– Kindig and Stoddart



If population health is the health of populations – then isn't this the ultimate goal?

- *Other Terminology:*
  - Population health
  - Public health
  - Community Health, Community Medicine
  - Clinical population medicine
  - Community-oriented primary care



# Population health terminology

## Population Health

- A framework for addressing why some populations are healthier than others, based on health outcomes

## Public Health

- Activities that a society undertakes to assure the conditions in which people can be healthy
  - May include formal governmental structures

## Community Health

- Assumes community to be an essential ingredient for effective public health practice

## Community-Oriented Primary Care

- Improving a community's health using principles of public health, preventive medicine, and primary care

## Clinical Population Medicine

- the conscientious, explicit and judicious application of population health approaches to care for individual patients and design health care systems

# Terminology matters!

## Population Health from a payer perspective or health system perspective

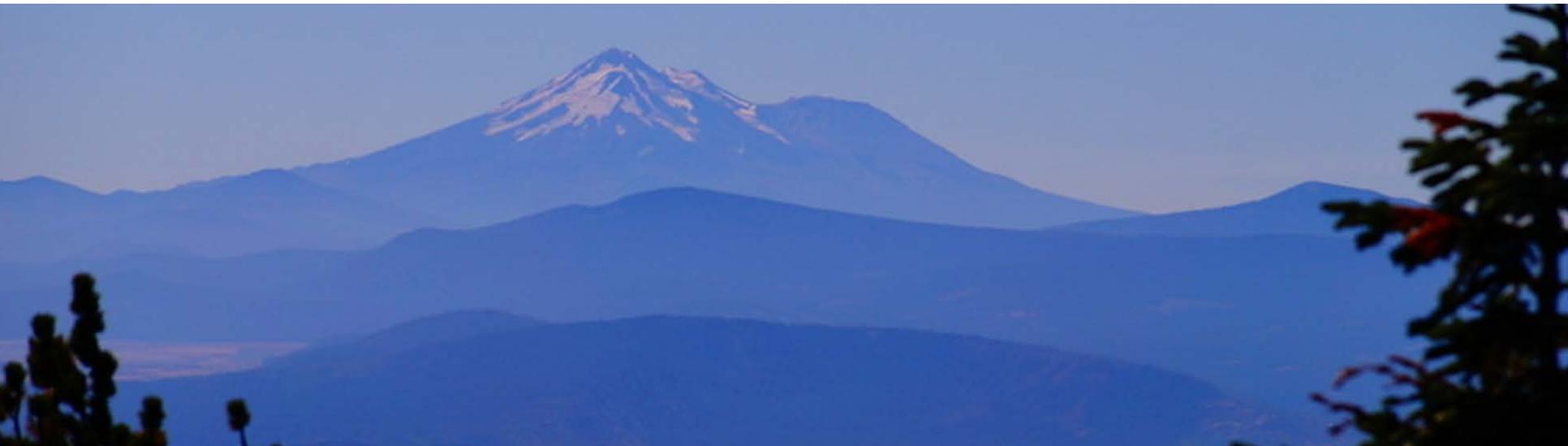
- Defined by enrollment or membership in an organization
  - Capitation/Revenue
- Defined by receipt of services
  - Clinical practice
  - Disease state
- Addressed through clinical models



- “Poor health...is more likely to be found among those without a medical home and with no health insurance...and other barriers to care”
- Payers and clinicians may miss these groups entirely

**Community in the fullest sense is the smallest unit of health ... to speak of the health of an isolated individual is a contradiction of terms.**

**-Wendell Berry**

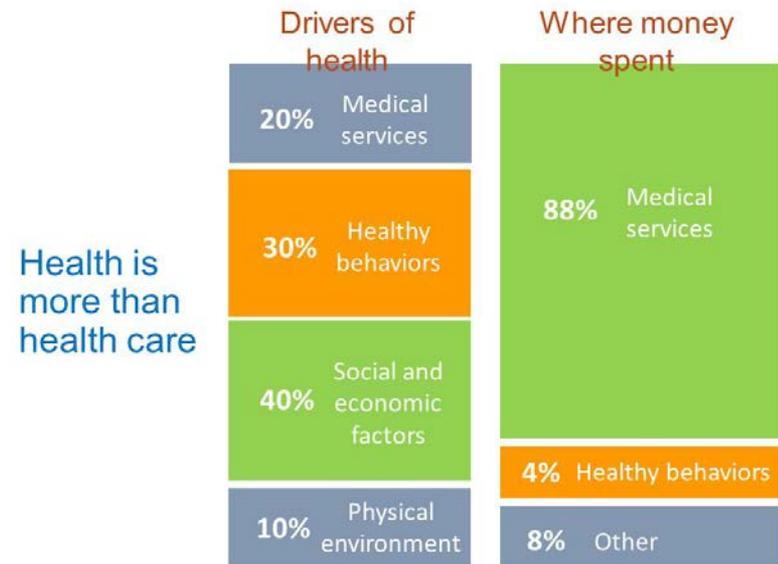


**Every patient in the context of family; every family in the context of community**



# Why is this uncomfortable?

- “the one-on-one visit and clinician-patient dyad will always be important, but that limited scope cannot address the larger concerns of the nation’s overall health”



# The opportunity and the obligation

- Work with payers and systems
  - With a broader definition of population health and community
  - COPC did not become the dominant model of our health care system
- Shift to more proactive models of primary care
- Include and advocate for vulnerable populations





# What tools do we use?

- Epidemiology
- Ecologic model of health
  - social determinants of health
- Policy work and advocacy
- Community health assessments and community health improvement plans
- Data
  - Metrics that matter
  - Metrics that help
- Quality improvement
- Expanded delivery models – PCMH
  - Payments that support the whole team



## Who works on population health?

- Interprofessional teams
- Public health organizations
  - Primary care/public health partnerships
- Health systems and institutions
- Clinicians/providers
- Payers
- Community organizations
- Researchers, epidemiologists
- Data analysts/informaticists



# Who works on population health?

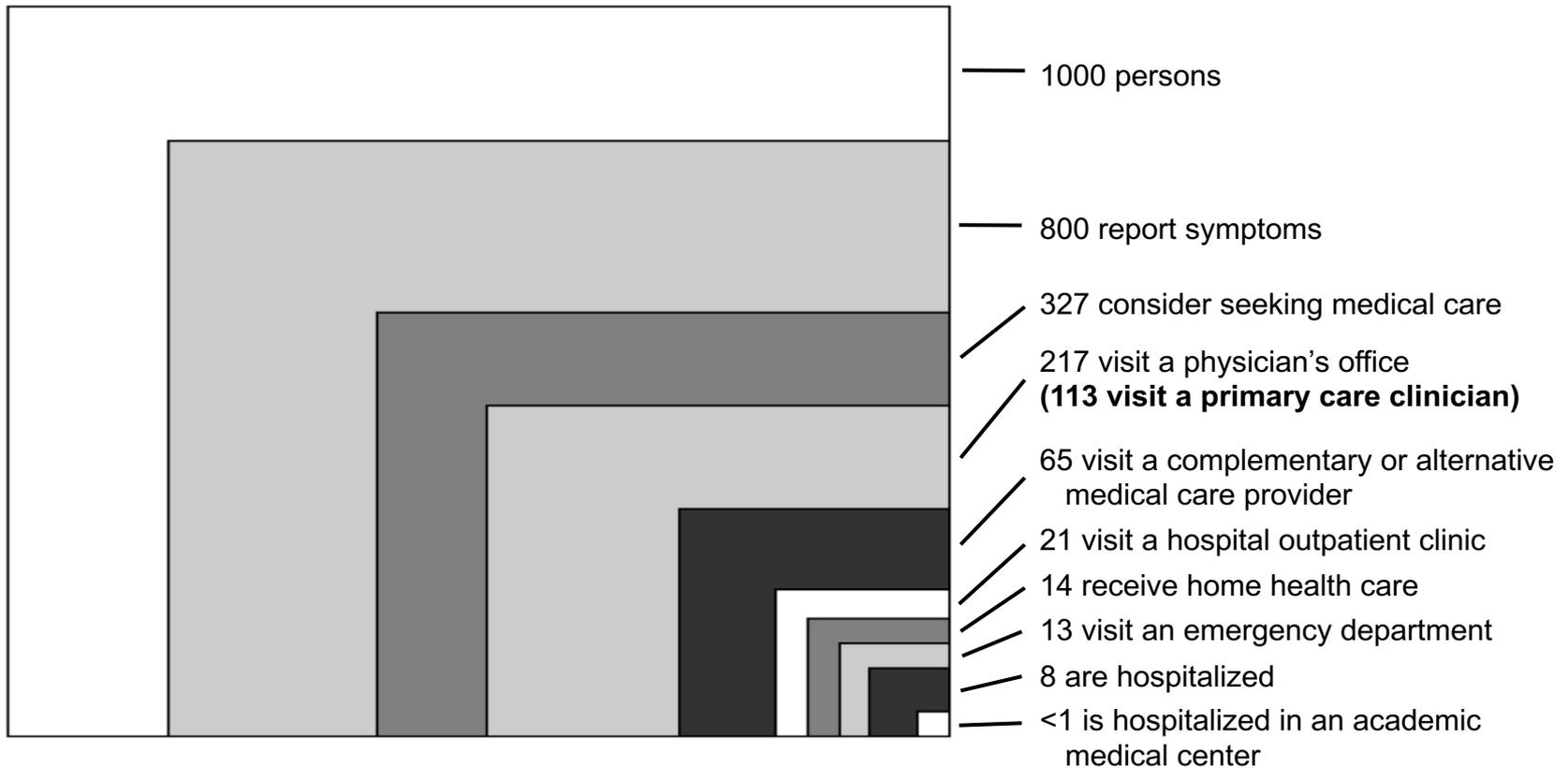
- The Community!
  - Population health is owned by the population
- Community Engaged approaches to health equity
  - Listen deeply, learn from the community
- Partner with everyone and anyone who wants to do this work
  - Build on what is already happening



## What skills are needed?

- Community engagement
- Collaboration and teamwork
- Leadership skills
- Data analysis, critical thinking
- Public health partnerships
- Creative problem-solving

# Primary care serves a critical role in the US healthcare system.



## Countries with strong primary care have better health outcomes.

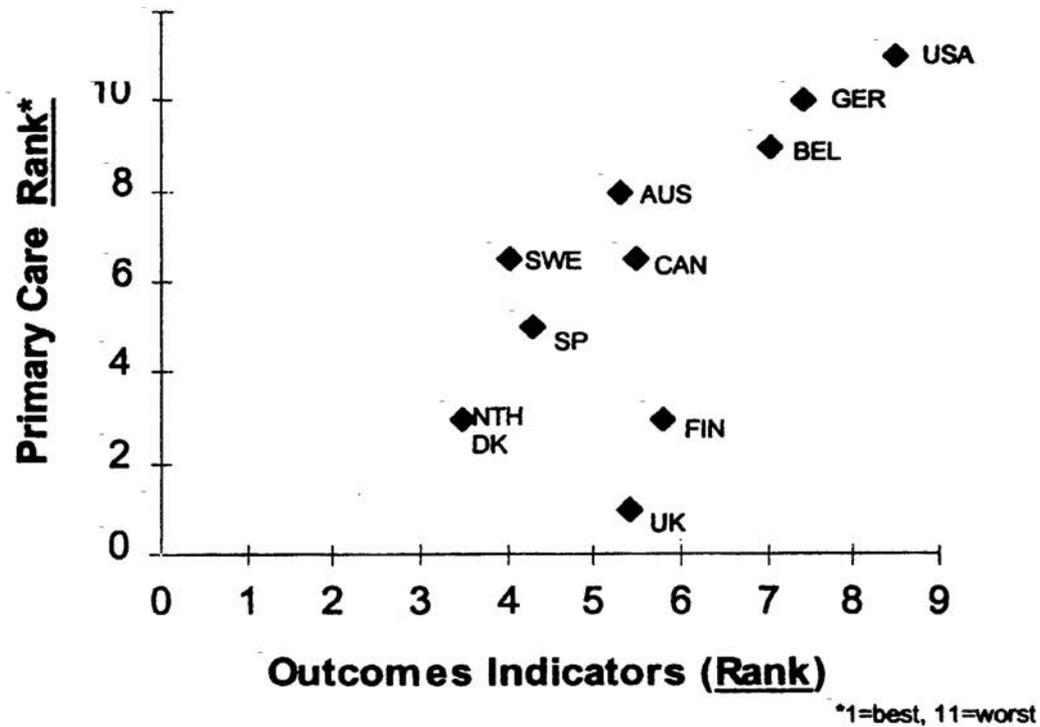
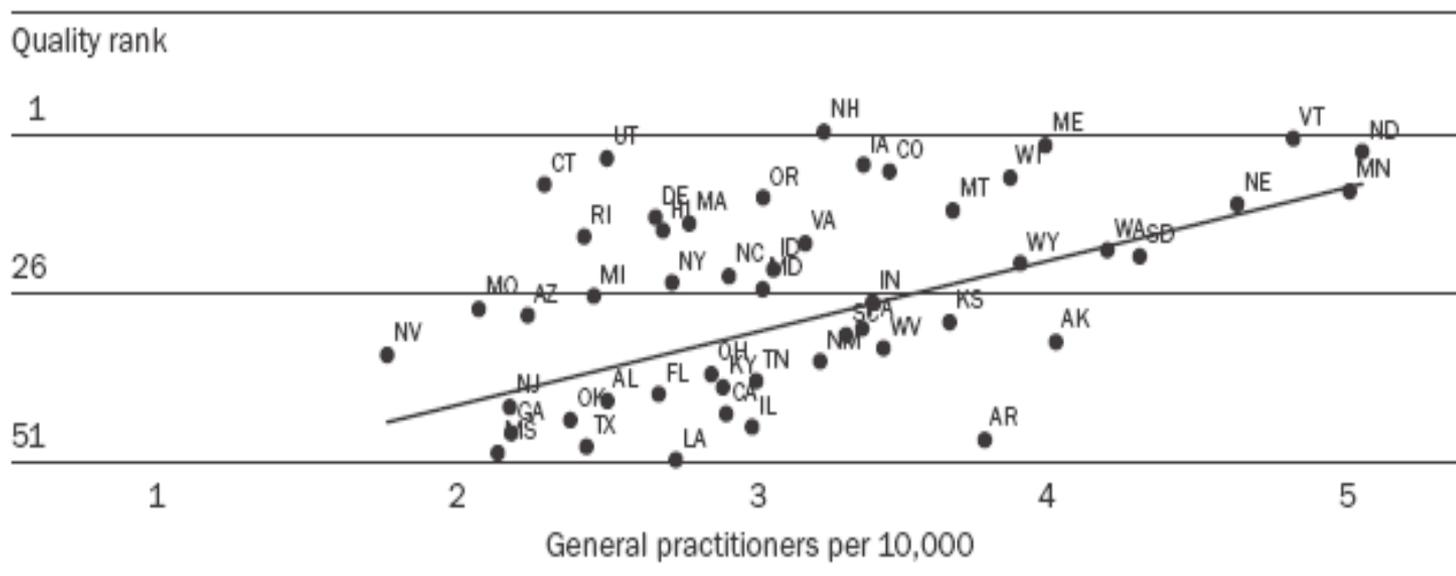


Figure 1.3. Relationship between strength of primary care and combined outcomes.

# Communities with higher primary care physician availability have healthier populations.

**Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000**



**SOURCES:** Medicare claims data; and Area Resource File, 2003.

**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.

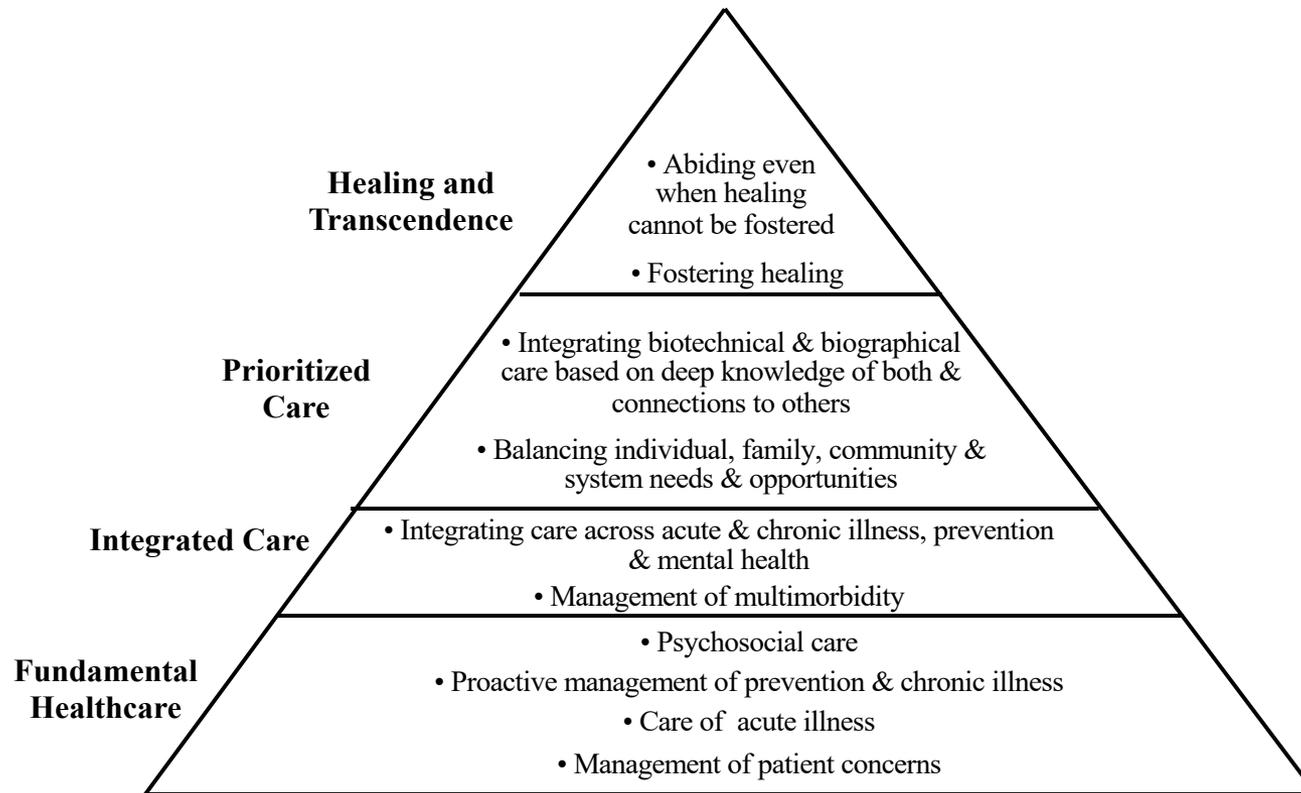


# The 'Paradox of Primary Care'

## **Primary care is associated with:**

- Inferior quality markers for individual diseases, but
- Better quality at population level
  
- Similar whole-person functional health
- Better population health
- Lower resource use and cost
- Less inequality in healthcare & health

We often measure only fundamental care when the 'Holarchy of Health Care' encompasses much more.



*Stange KC. A Science of Connectedness. Ann Fam Med. 2009;7(5):387-395.*



# If we shift the paradigm, will the paradox disappear?

- No single feature of primary care improves outcomes;
- However, with all the tenets working together, health, equity and cost outcomes are improved.
- Particularly strong effect for
  - People from disadvantaged populations
  - Patients with multiple chronic conditions
- Rural populations?

Homa L, Rose J, Hovmand PS, et al. A participatory model of the paradox of primary care. *Ann Fam Med* 2015; 456-465.

Doohan N, Coutinho AJ, Ochner J, Wohler D, DeVoe J. "A Paradox Persists When the Paradigm is Wrong": Pisacano Scholars' Reflections from the Inaugural Starfield Summit. *Journal American Board Family Medicine* 2016 11/12;29(6):793-804.

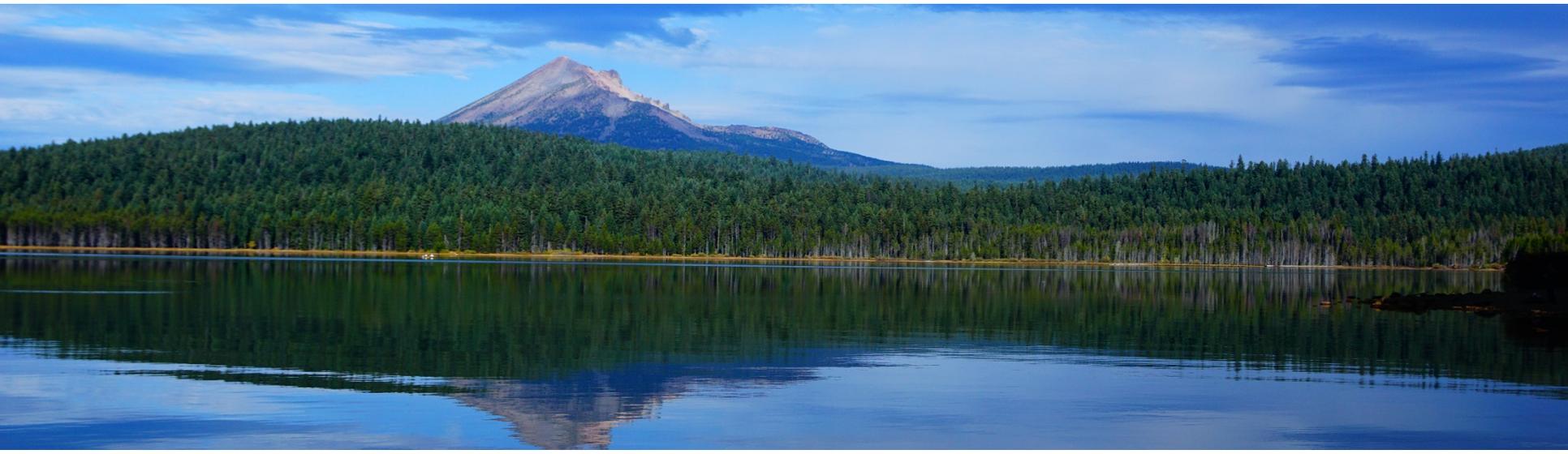


# Time for a paradigm shift?

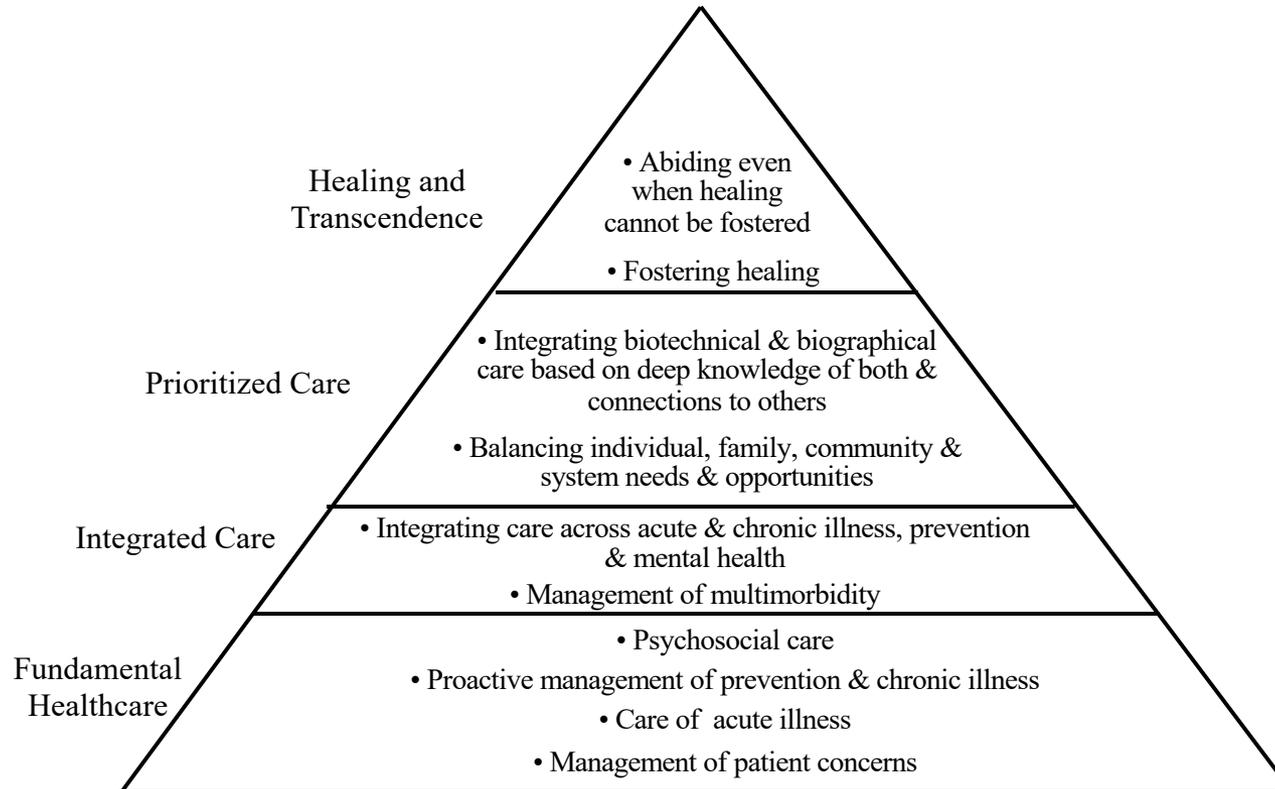
- Fundamental care is all we currently
  - Measure
  - Incentivize
  - Support
- Integrated & prioritized care
  - Could be supported by IT systems
  - Primary care functions
- Higher levels of care unintentionally devalued
  - Relationships
  - Continuity and care across place and life cycle

What do we teach our learners?

Don't we have our hands full with diabetes care and deliveries?



# Systems vs. individuals: What do we teach students and residents?

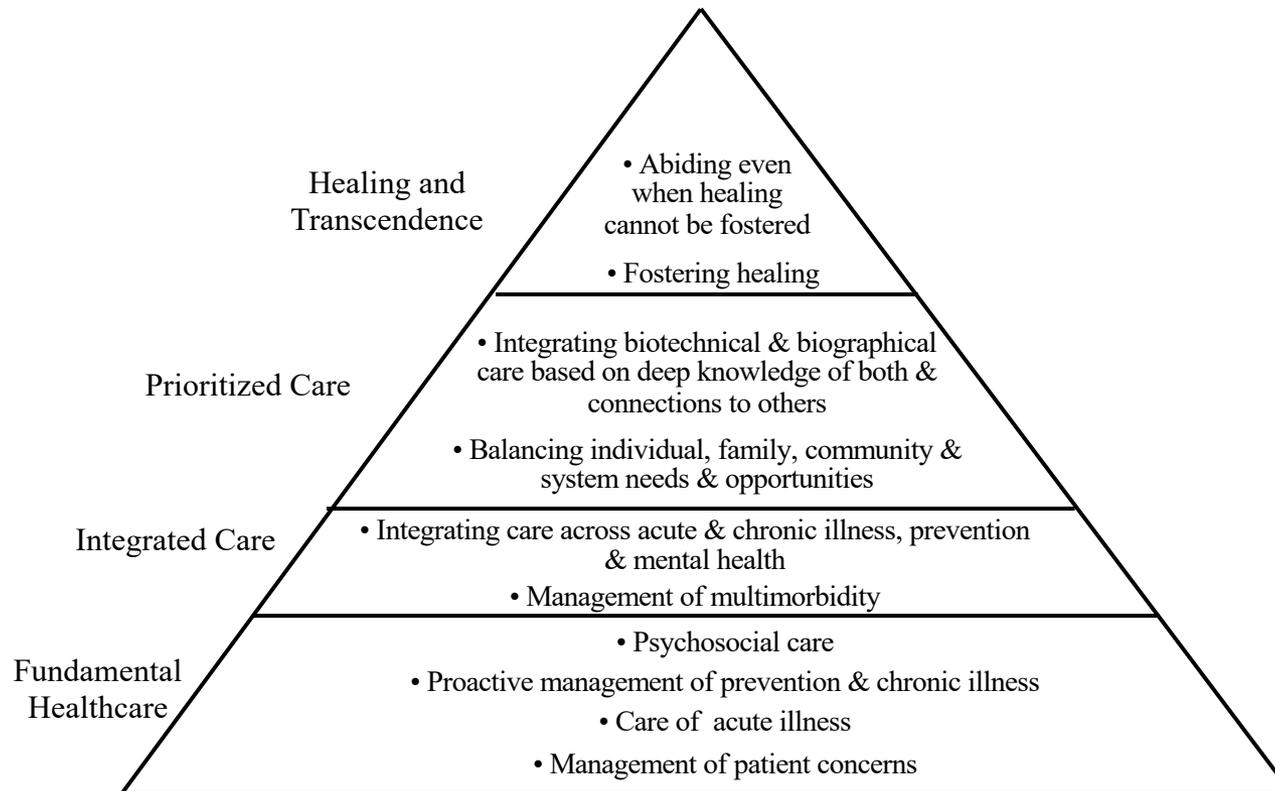


*Stange KC. A Science of Connectedness. Ann Fam Med. 2009;7(5):387-395.*



- Systems-thinking can be an antidote to frustration and burnout
- Remind ourselves that statistics are people and communities
- Our learners need an aspirational vision

# What do we teach students and residents?

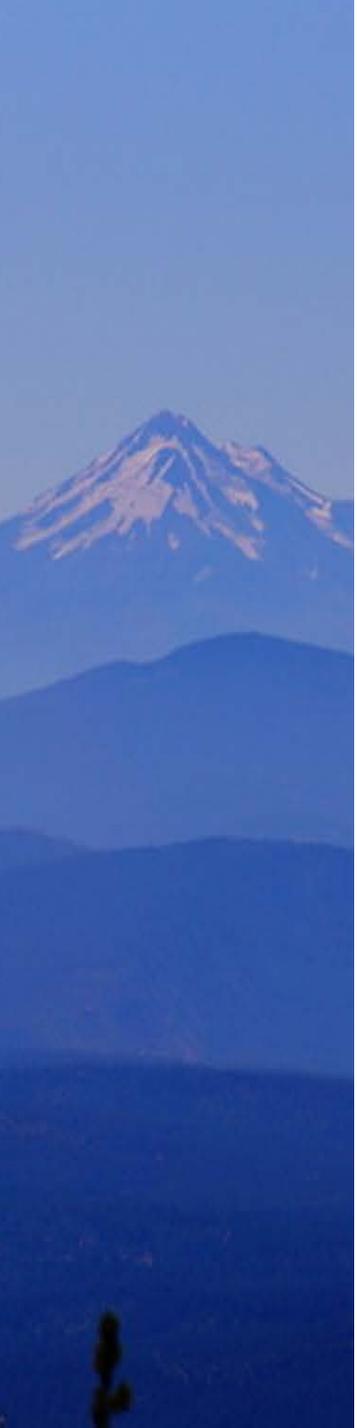


*Stange KC. A Science of Connectedness. Ann Fam Med. 2009;7(5):387-395.*



# How do we teach students and residents?

- Structured curricular time in community work
  - Not extra-curricular
  - Longitudinal faculty presence on community projects
- Panel management
  - Time to respond to data and plan the next step
  - Team-members to work with



# What might be unique to rural?

- Rural populations have higher mortality rates
- Levels of rurality magnify disparities with poverty, ethnicity, race
- Could rural settings magnify the paradox of primary care?



# What might be unique to rural?

- A defined community
- Collaborative interactions
  - Sometimes out of necessity
- Creative solutions
- Continuity of community partners or providers
  - Defined partners

# What might be unique to rural?

Adaptability

Agency and Courage

Comprehensiveness

Collaboration and Community-responsiveness

Integrity

Abundance in the face of scarcity

Reflective practice

Resilience



# Summary

- Population health is the health outcomes of a group
- How we define the population is critical for vulnerable populations
- We must partner with others doing this work and never forget to engage the community itself
- Learners must be inspired to see the highest levels of systems-based work and have the tools to engage, innovate and lead



The population is our community.

The community is our patient.

**Thank You!**