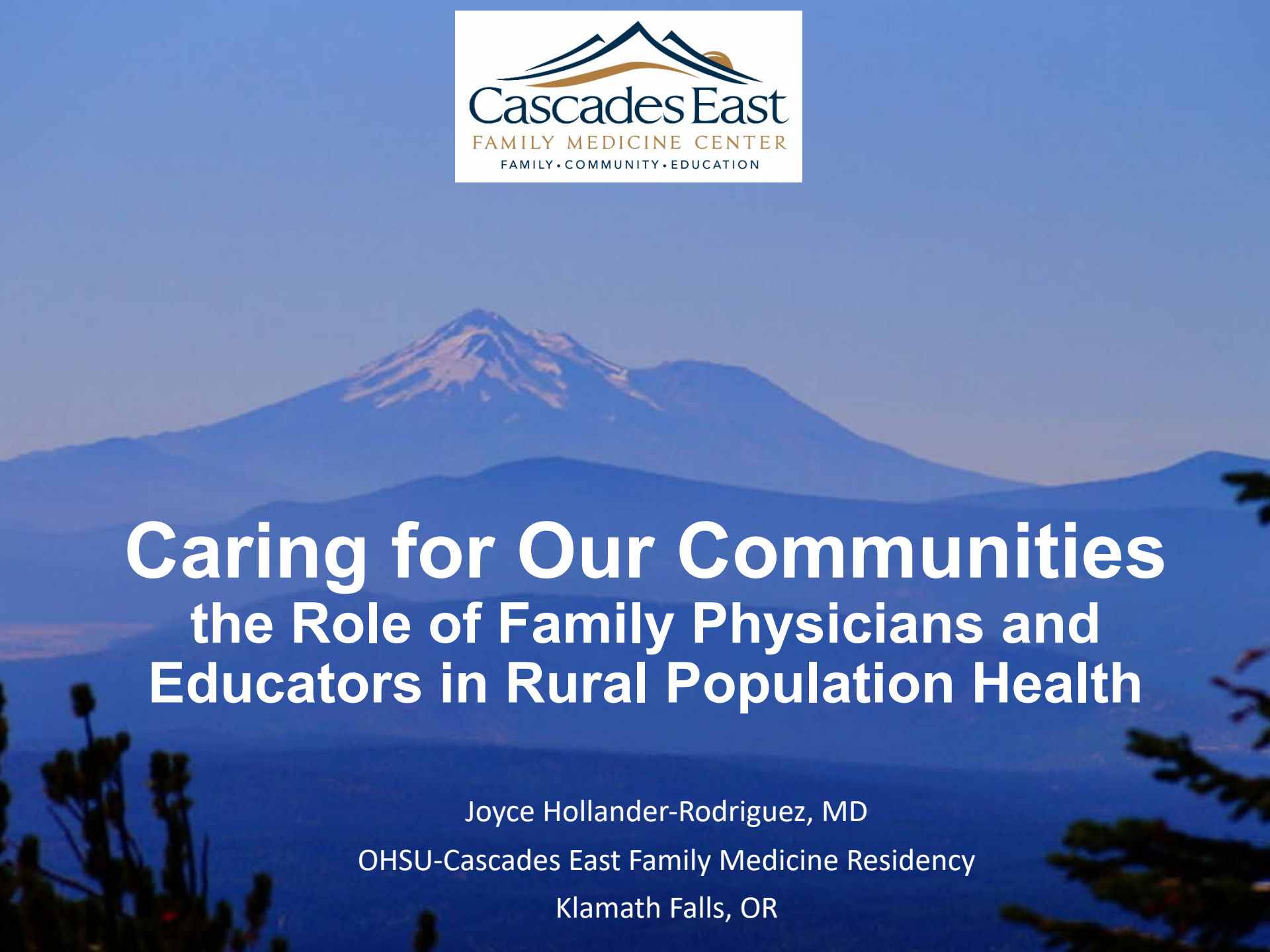


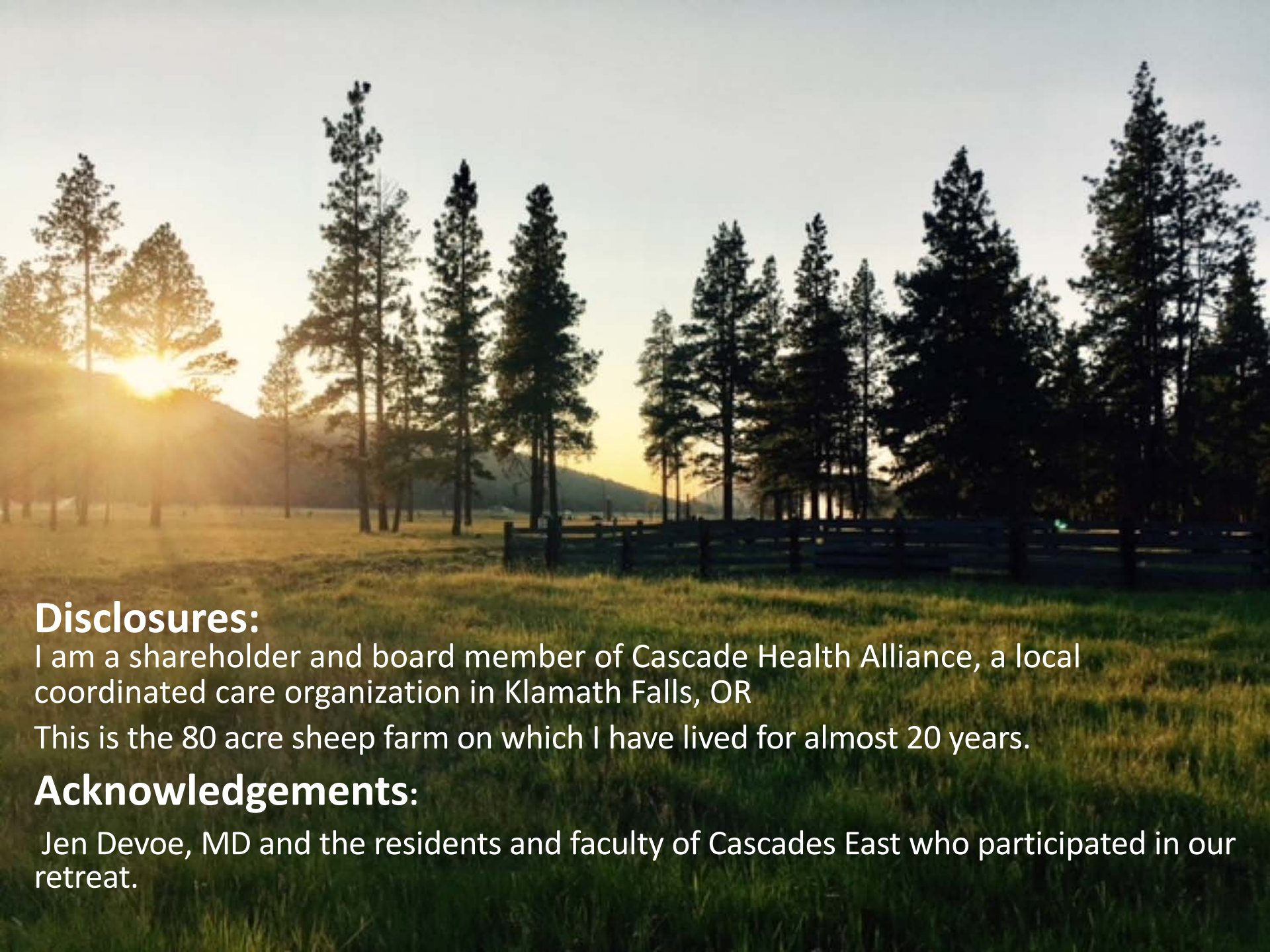
Caring for Our Communities

the Role of Family Physicians and Educators in Rural Population Health

Joyce Hollander-Rodriguez, MD

OHSU-Cascades East Family Medicine Residency

Klamath Falls, OR



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."2003 Their goal was to broaden the discussion health policy in the United States beyond the "biomedical paradigm and to encourage investigation into and policy development of the

Perspective

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

Marc N. Gourevitch, MD, MPH

Abstract

COMMENTARIES

MAYO CLINIC

COMMENTARY

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

Commentary

What's in a Name? The Necessary Transformation of the Academic Medical Center in the Era of Population Health and Accountable Care

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

Abstract

MODELS FOR POPULATION HEALTH

What Is Population Health?

David Kindig, MD, PhD, and Greg Stoddart, PhD

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

John Auerbach, MBA

Remember this?

Communities of Solution: The Folsom Report Revisited

The Folsom Group

American Board of Family Medicine Young Leaders Advisory Group

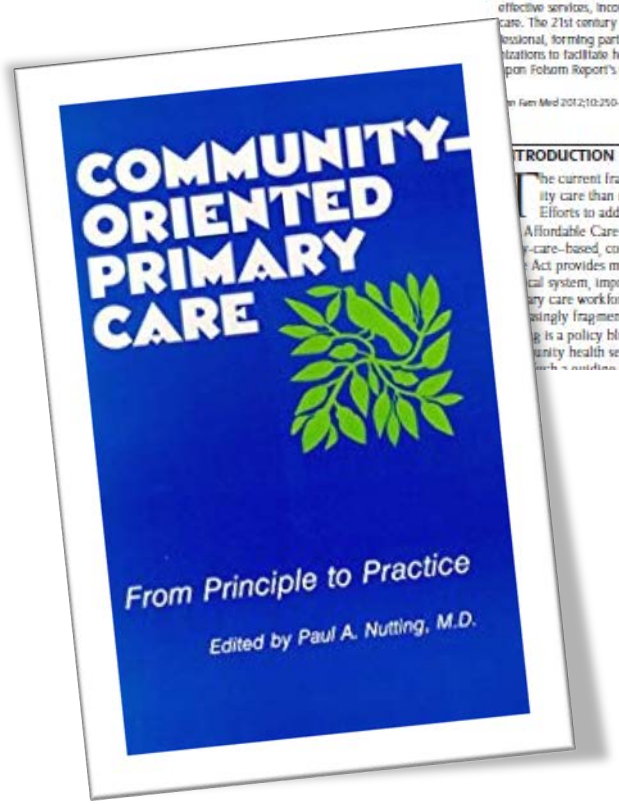
ABSTRACT

Efforts to address the current fragmented US health care structure, including controversial federal reform, cannot succeed without a reinvigoration of community-centered 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 assisting data sharing with community organizations to facilitate healthy changes. Current policy reform efforts should build upon Folsom Report's goal of transforming

Ann Fam Med 2012;10:250-260. doi:10.1370/afm.1

INTRODUCTION

The current fragmented US heal
lity care than most industrialize
Efforts to address this low value
Affordable Care Act, cannot succe
y-care–based, community-centered
Act provides multiple provisions
ical system, improving training an
ary care workforce, and enabling
singly fragmented health system
is a policy blueprint for system
unity health services that meet t



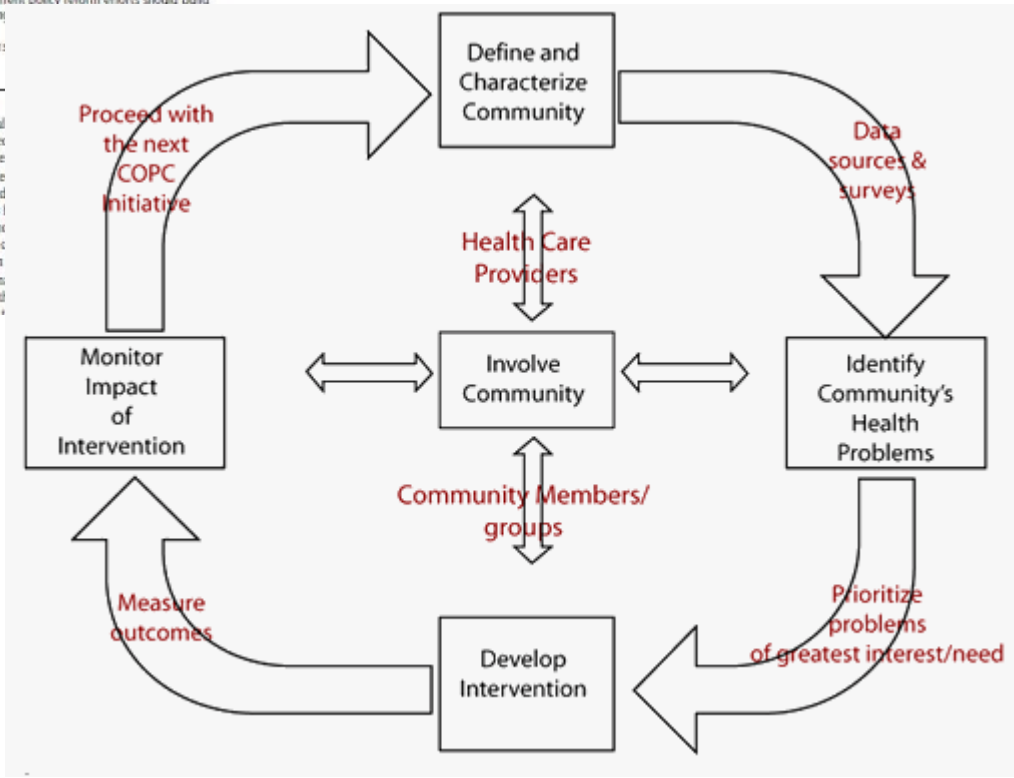
Community Oriented Primary Care

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?

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

Rozier M. When Populations Become the Patient; Providence Grand Rounds 2015

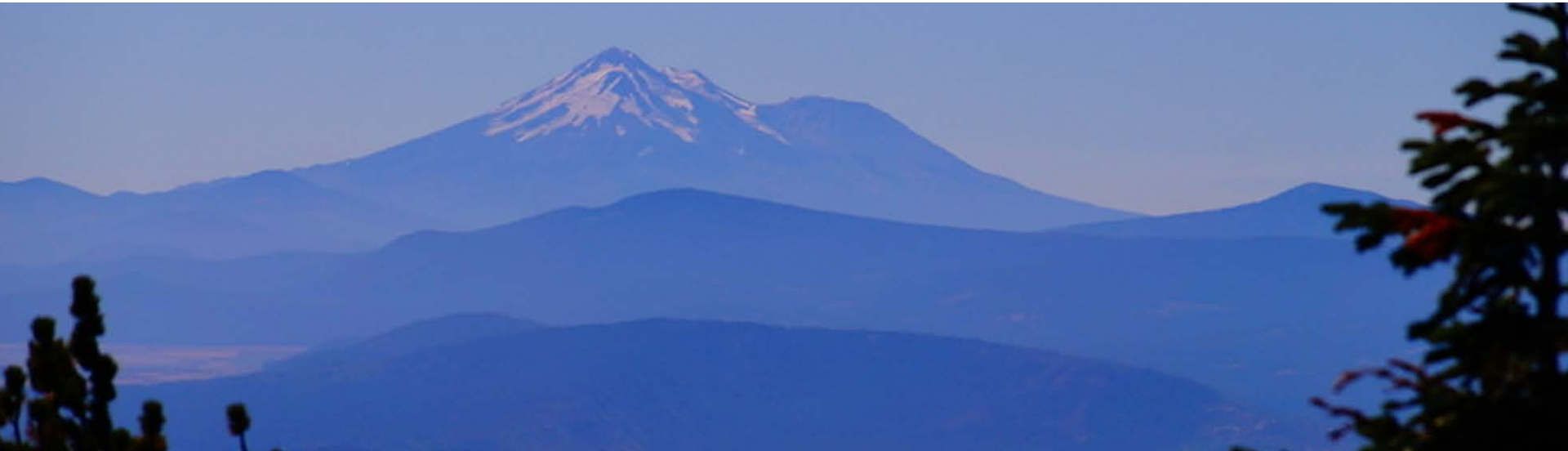
- "Poor health…is more likely to be found among those without a medical home and with no health insurance…and other barriers to care"

- Payers and clinicians may miss these groups entirely

Sharfstein J. The Strange Journey of Population Health. Milbank Quarterly, 92(4) 2014: 640-643.

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.

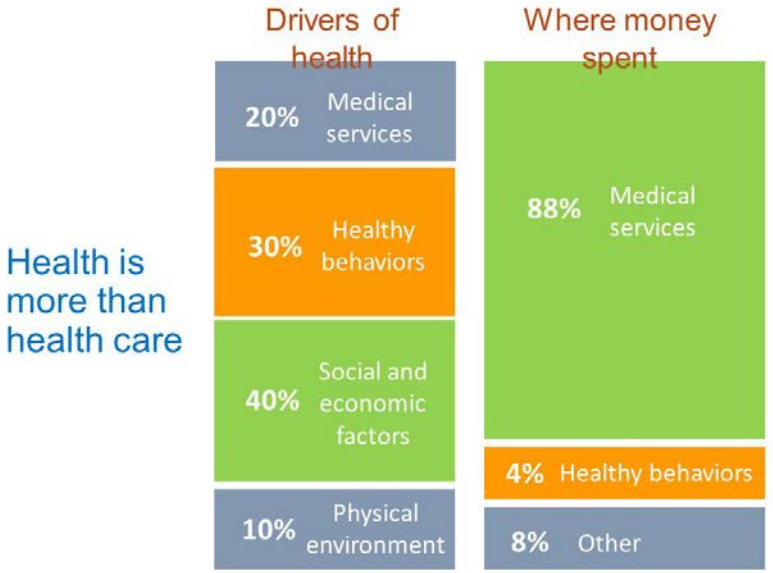
-Wendell Berry



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

Why is this uncomfortable?

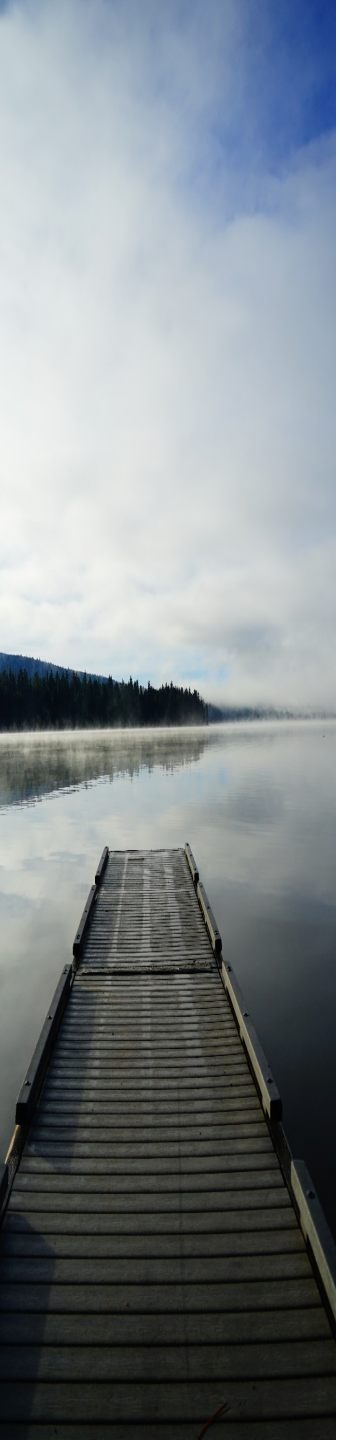
- **"the one-on-one visit and clinician-patient dyad will always be important, but that limited scope cannot address the larger concerns of the nation's overall health"**



Kaprelian V., *et al*. Teaching Population Health: A competency map approach to education. *Academic Medicine.* 88(5); 2013.

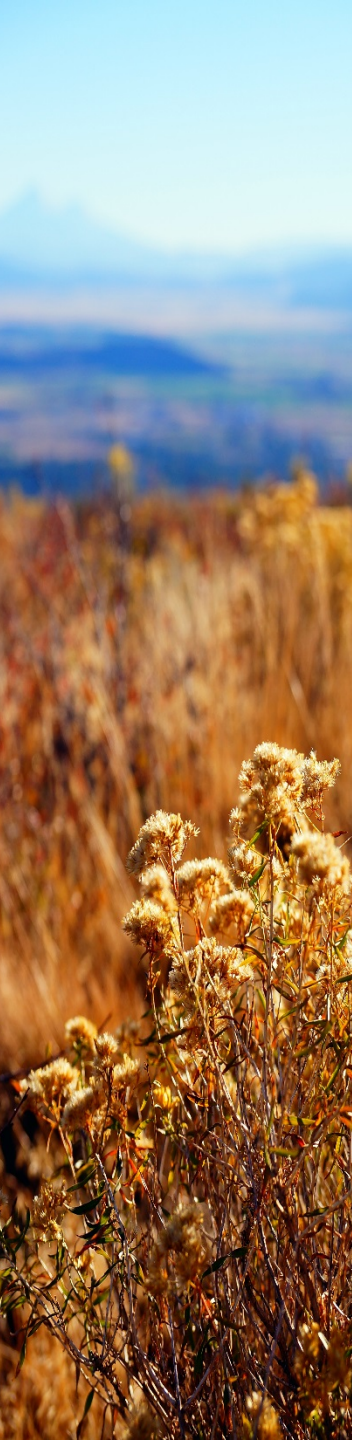
The opportunity and the obligation

- 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



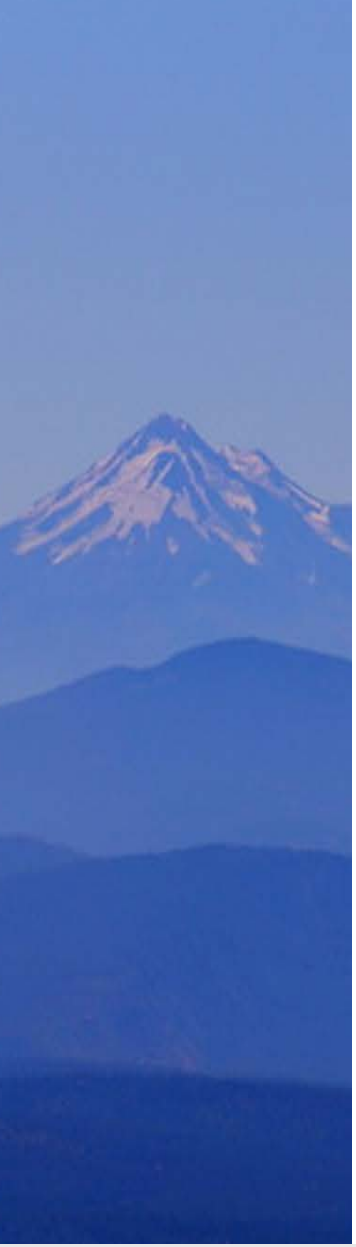
What tools do we use?

- 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?

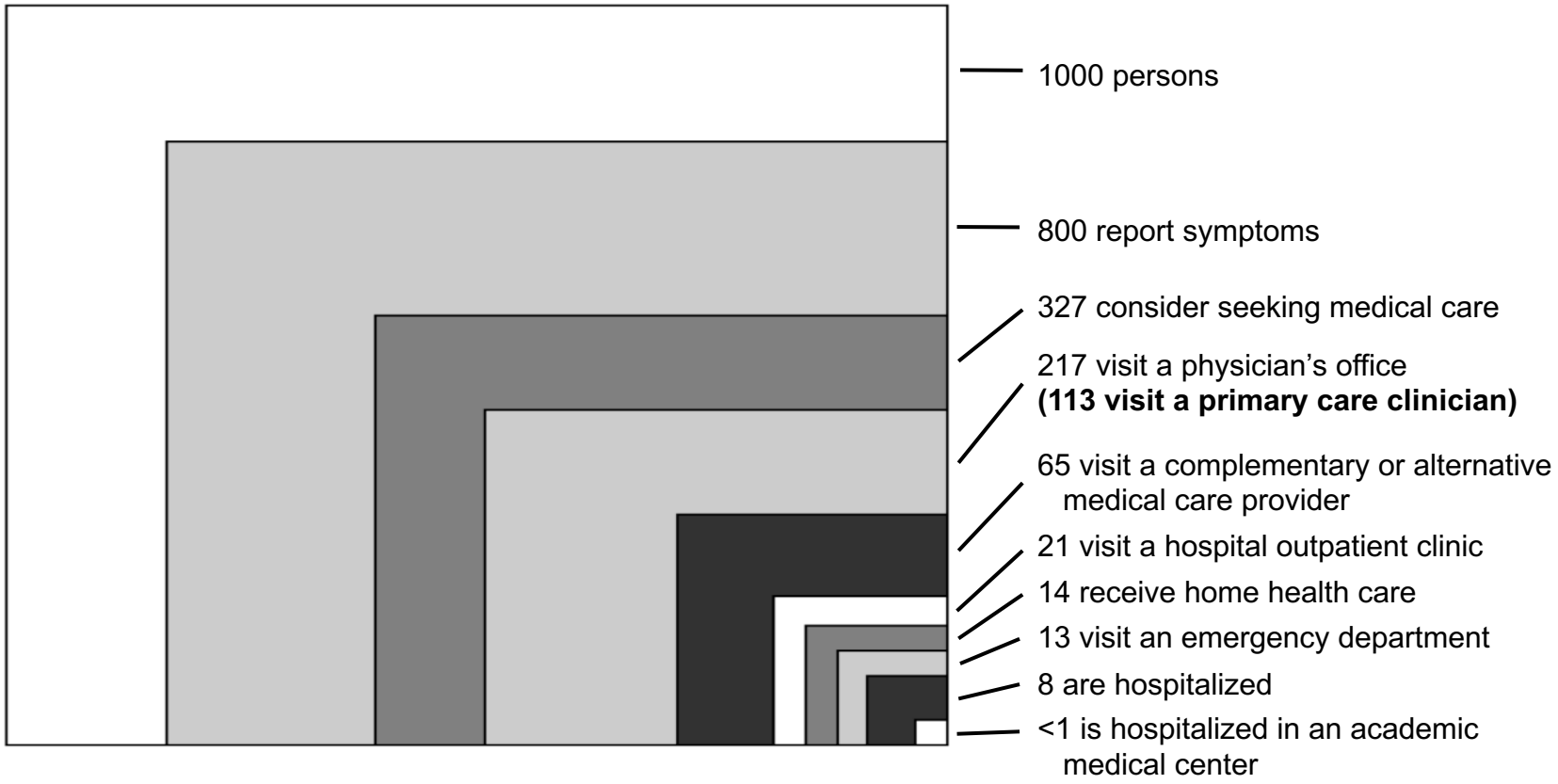
- The Community!
  - Population health is owned by the population
- Community Engaged approaches to health equity
  - Listen deeply, learn from the community
- Partner with everyone and anyone who wants to do this work
  - Build on what is already happening

Michener L. et al. Family Medicine's task in population health: defining it and owning it begins with the community. Family Medicine. 2019; 51(5) 444.

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.



Green LA, Fryer GE, Yawn BP, Lanier D, Dovey SM. (2001). The Ecology of Medical Care Revisited. *New England Journal of Medicine* 344:2021-5.

Countries with strong primary care have better health outcomes.

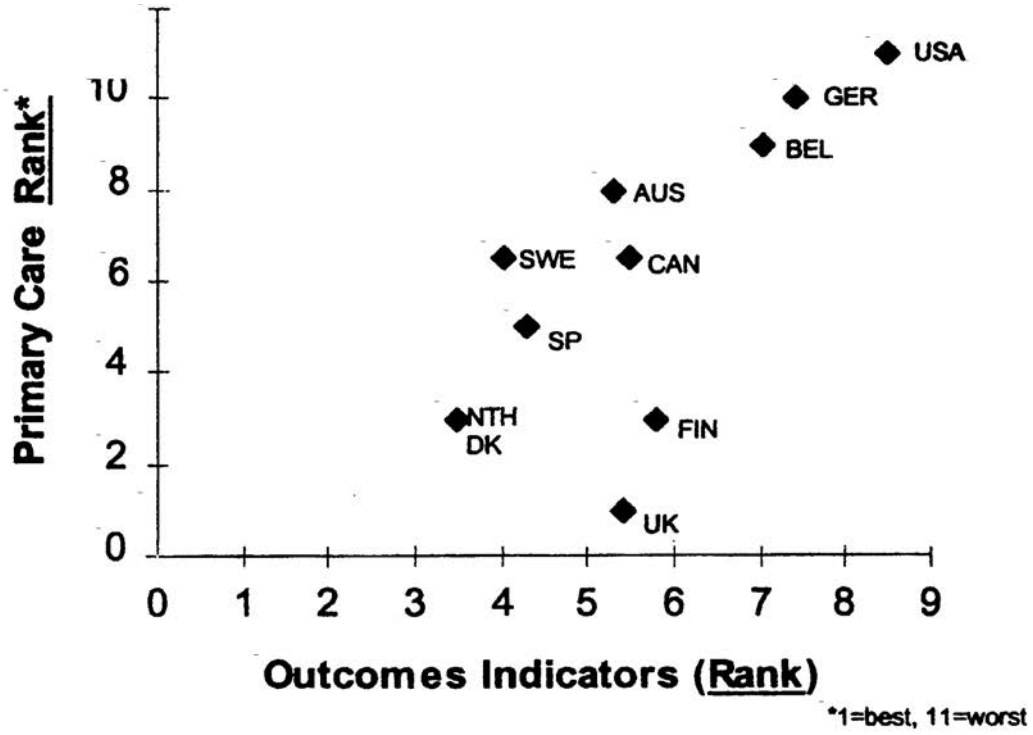
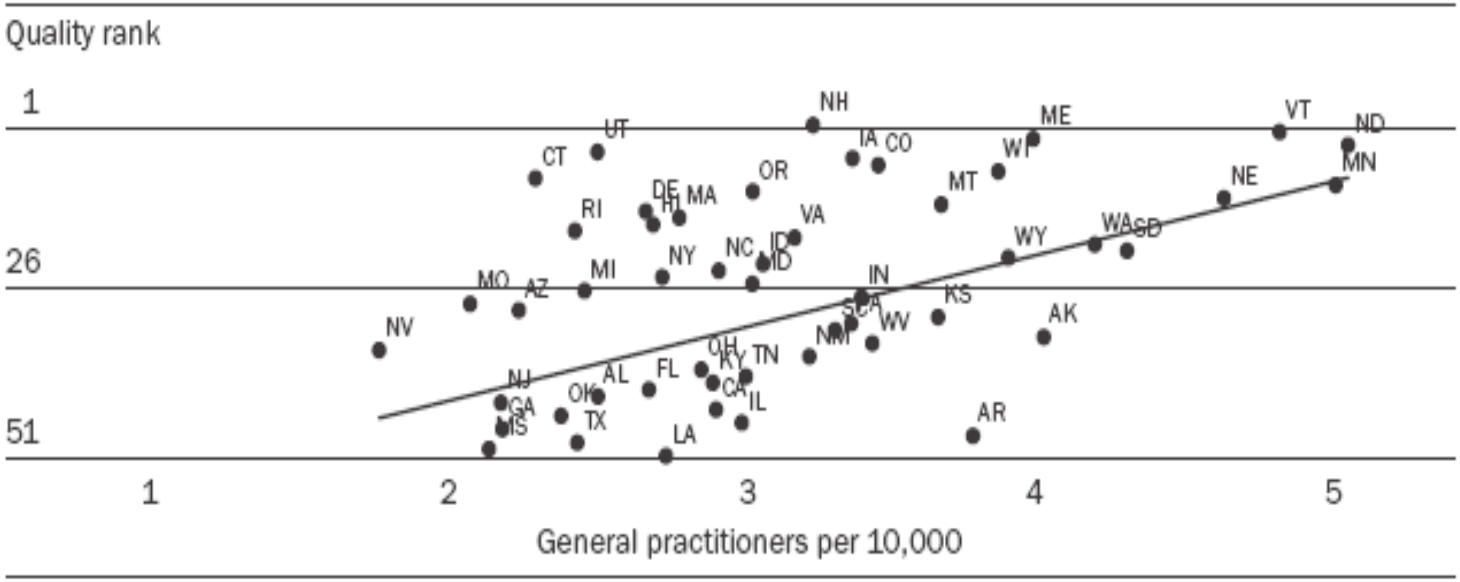


Figure 1.3. Relationship between strength of primary care and combined outcomes.

Starfield B. Primary Care. Balancing health needs, services, and technology. New York: Oxford University Press, 1998.

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.

Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Affairs W4-185 - W4-197, 2004.

The 'Paradox of Primary Care'

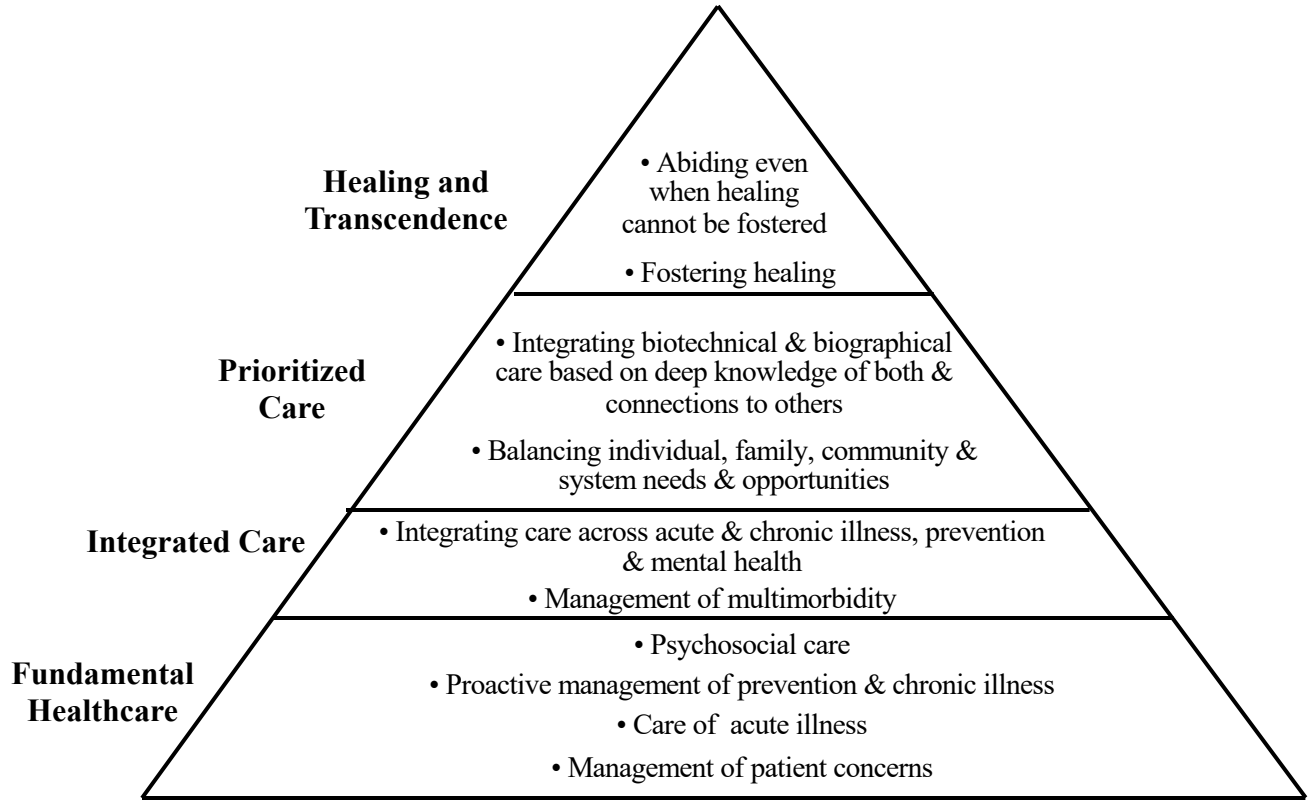
Primary care is associated with:

- Inferior quality markers for individual diseases, but
- Better quality at population level

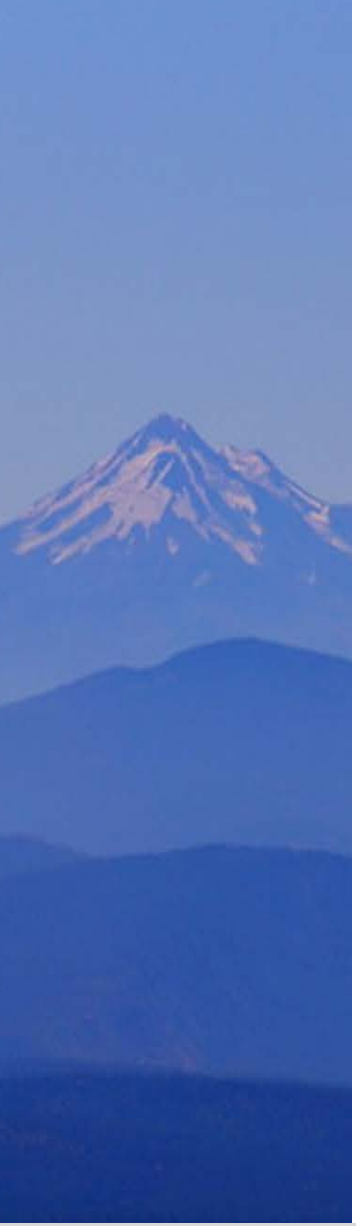
- Similar whole-person functional health
- Better population health
- Lower resource use and cost
- Less inequality in healthcare & health

Stange KC, Ferrer, RL. The paradox of primary care. *Ann. Fam. Med.* 2009;7(4):100-103.

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.

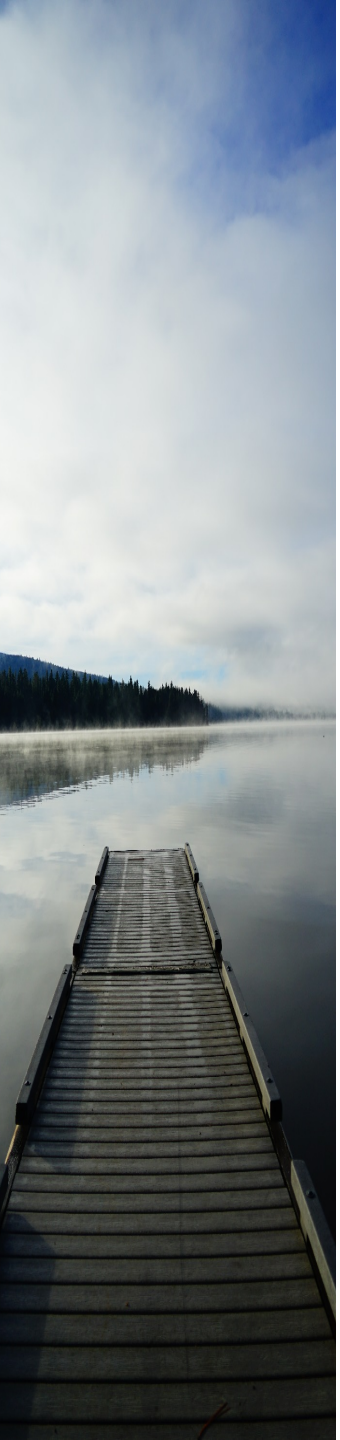


If we shift the paradigm, will the paradox disappear?

- 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.



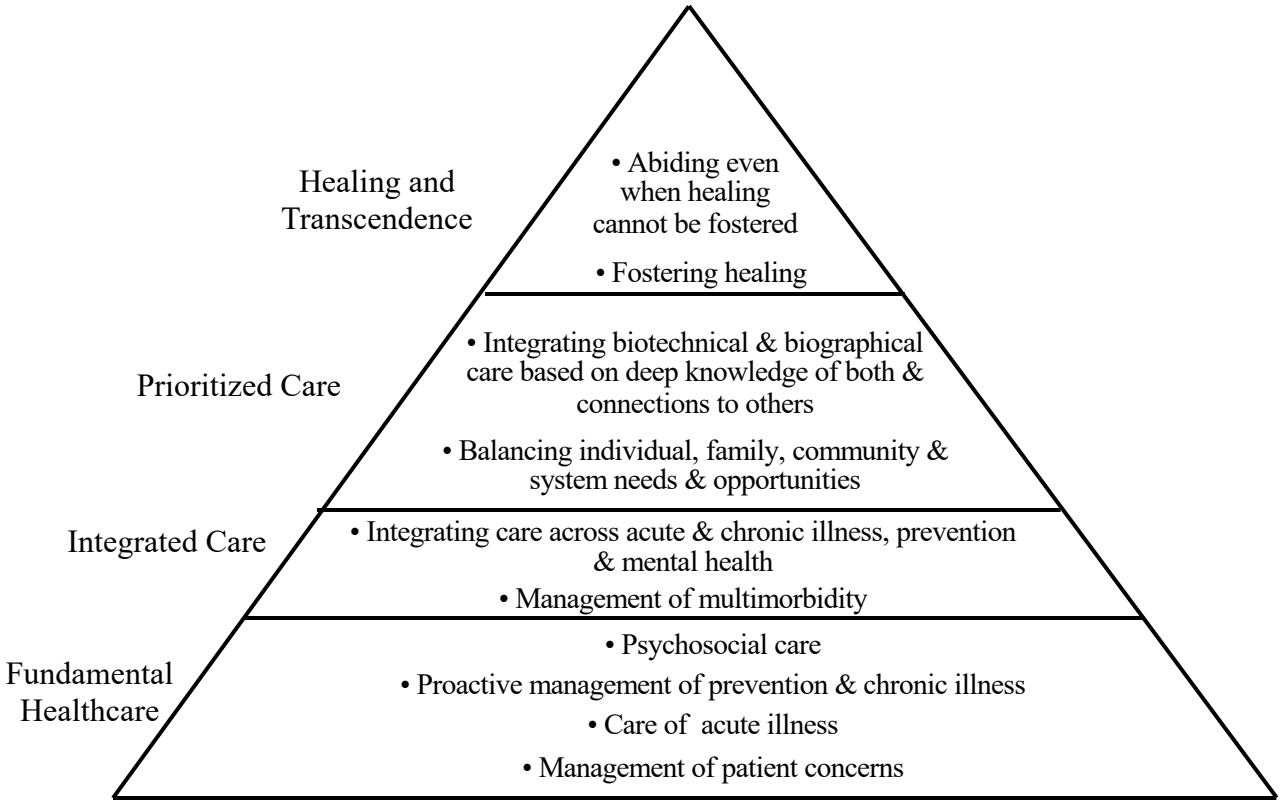
Time for a paradigm shift?

- 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

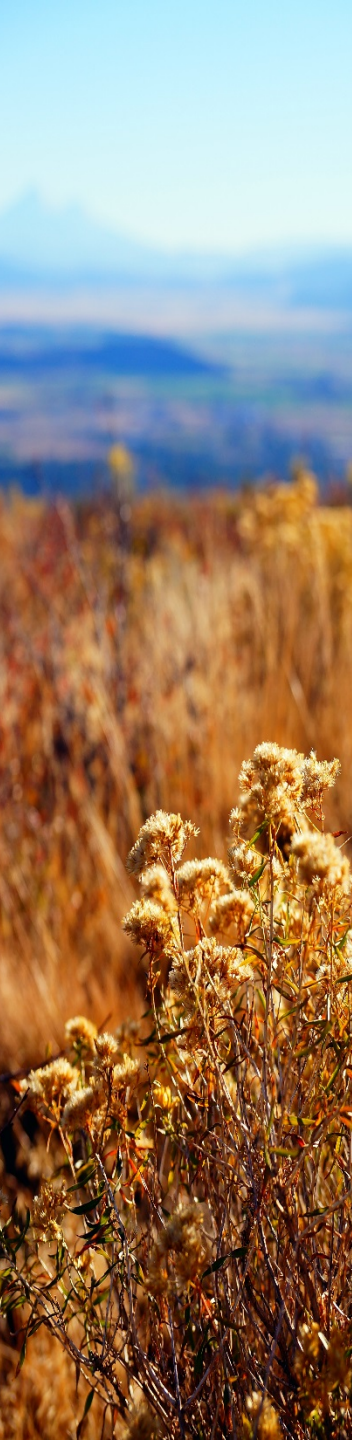
What do we teach our learners?

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

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

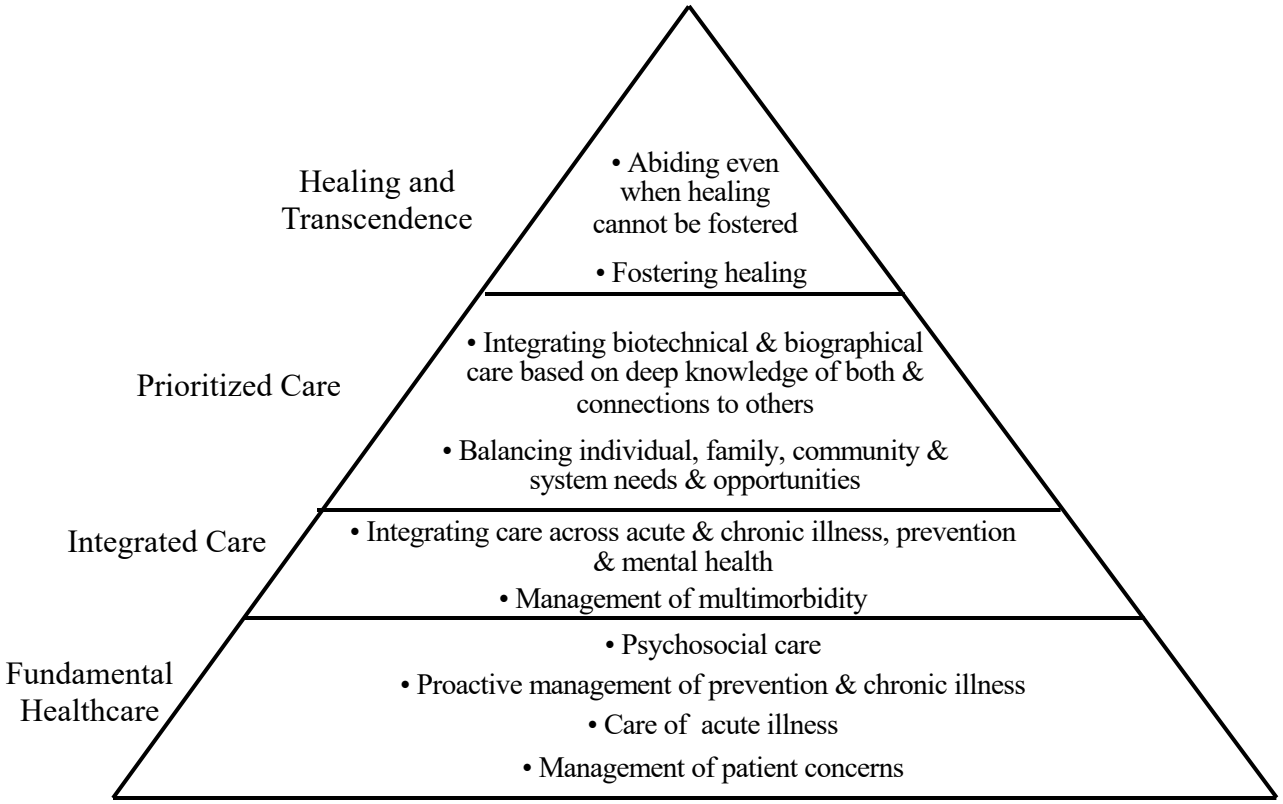


Stange KC. A Science of Connectedness. Ann Fam Med. 2009;7(5):387-395.



- 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.

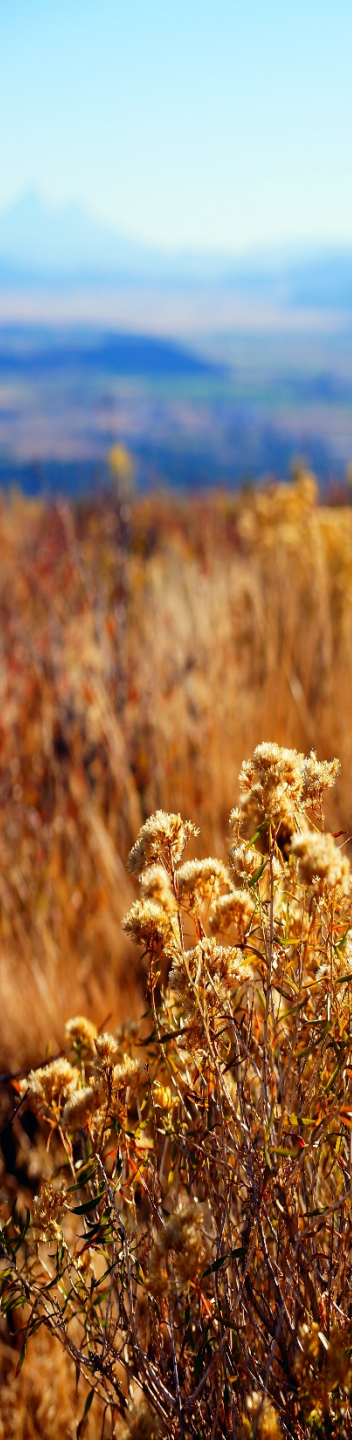
How do we teach students and residents?

- 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

Kaprelian V., *et al*. Teaching Population Health: A competency map approach to education. *Academic Medicine.* 88(5); 2013.

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.