

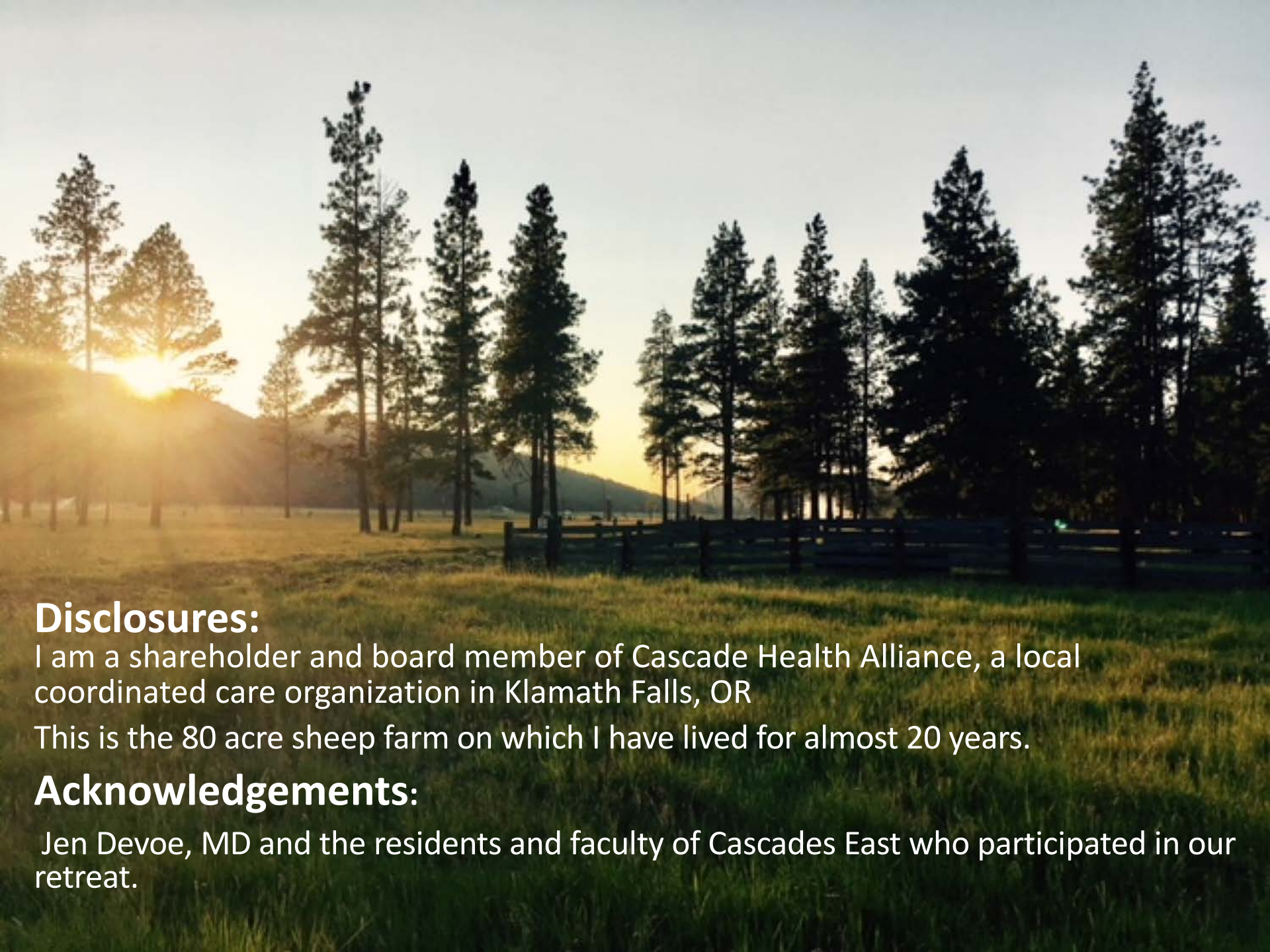


Caring for Our Communities the Role of Family Physicians and Educators in Rural Population Health

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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?



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

JOSHUA M. SHARFSTEIN

Recovery time

Marc N. Gounivitch, 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 patient care is valued and "not" determinants of patient engaged. For large, m, such as academic medi navigating the evolution

oriented paradigm across the domains of patient care, education, and research poses real challenges but also offers tremendous opportunities, as important objectives across academic disciplines

COMMENTARIES

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

John Auerbach, MBA

A central tenet of health care delivery systems is that health care delivery systems are responsible for the health of populations. Framed in this way, the "triple aim" of improved health, better health, and reduced costs makes sense. The goal of health care delivery systems is to increase delivery, efforts to improve and sustain the health of persons for whose care they are at least partially accountable. The paradigm, performance on key metrics will be best when not only traditional quality measures but also prevent and other "nonmedical" determinants of patients' health are optimized. For reimbursement entities such as academic health systems, the goal is to improve the health of the population, reduce costs, and improve the quality of care.

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 health definitions of population health. Rather than choosing between these definitions, I identified five categories of metrics, ranging from traditional clinical care to prevention interventions to those that measure need for community-level nonclinical services, that in various combinations might yield the most promising results.

Jeffrey Conner, examples of

WELLNESS AND PREVENTION more and more at

avoidance of the utilization of expensive and sometimes unnecessary hospitalizations, emergency department visits, 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 that encourage closer relationships between the federal government and state Medicaid programs, to support safety net providers who care for patients with complex socioeconomic bar-

have created an environment in which unprecedented discussions are taking place on a relatively tight timeline. In state after state efforts are under way to engage public and commercial parties in an overhaul of the payment system. In the case of the SIM grants, the states are given just four years to shift to value-based contracting as the predominant reimbursement mechanism with aligned and consistent quality measures across payers. As these discussions or public health leaders have to be prepared to participate. More importantly, they need to be able to create specific suggestions that fit into an insurance-based framework and have a demonstrable impact on the system.

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

Robert M. Jacobson, MD; George J. Isham, MD,
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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.¹⁻³ 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 Affordable Care Act.^{4,5} Convergence of these trends and opportunities creates unprecedented potential for transforming health care delivery.

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

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

paid for the work that they do. A failure to recognize how the disruption of the mission of AMC's 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 under way. They summarize the issues in the question "Should the words 'health' and 'system' take the place of 'medical' and 'control' in our health care system?"

MODELS FOR POPULATION HEALTH

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

ALTHOUGH THE TERM
"population,"

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 be "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," and we argue that the field of population health includes outcomes, patterns of health determinants, and policies and interventions that link the two.

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ALTHOUGH THE TERM "population health" has been much more commonly used in Canada than in the United States, the concept is not new. It has been agreed upon even in Canada, where the concept it denotes has gained some prominence. Probably the most influential contribution to the development of the population health approach is Evans, Barer, and Macken's *Why Are Some People Healthier and Others Not? The Determinants of Health: A Discussion of the Role of the Social and Environmental Context of Health*, which is part of the work of the Canadian Institute for Advanced Studies.

The term appears in a number of the reports, but not consistently in this volume, although its authors state that the concept's "linking thread" is the common focus on trying

that in Canada and the United Kingdom in the 1990s, the term has taken on the connotation of a "conceptual framework for 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."¹⁶

However, Young also indicates that in the past, the term has been used as a "less cumbersome substitute for the health of populations," which is of course its meaning. Evans and Stoddard, while supporting an emphasis on "understanding of determinants of population health" have also stated, however, "different concepts [of health] neither right or wrong simply have different

eral/Provincial/Territorial Advisory Committee on Population Health, which that "population health refers to the health of a population as measured by health status indicators and as influenced by social, economic, and physical environments; personal 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 health of populations over the life course; identification of systematic variations in their rates of occurrence; and application of the resulting knowledge to the development and implementation of policies 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-centered health systems. A blueprint for systematic implementation of community services exists in the 1967 Fobrom Report—calling for “communities of solution.” We propose an updated version of the Fobrom 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 Fobrom Report’s goal of transformism.

J Am Fam Med 2012;10:250-260. doi:10.1170/afm.11

INTRODUCTION

The current fragmented US health care system is the least efficient and least effective of any developed country. Efforts to address this low value system through the Affordable Care Act, cannot succeed unless we move from a care-based, community-centered system to a value-based system. The Act provides multiple provisions to improve the health care system, improving training and education, increasing the health care workforce, and enabling a more integrated and consistently fragmented health system. The Act is a policy blueprint for system change that will improve the quality of health services that meet the needs of the American people. The Act is a policy blueprint for system change that will improve the quality of health services that meet the needs of the American people.

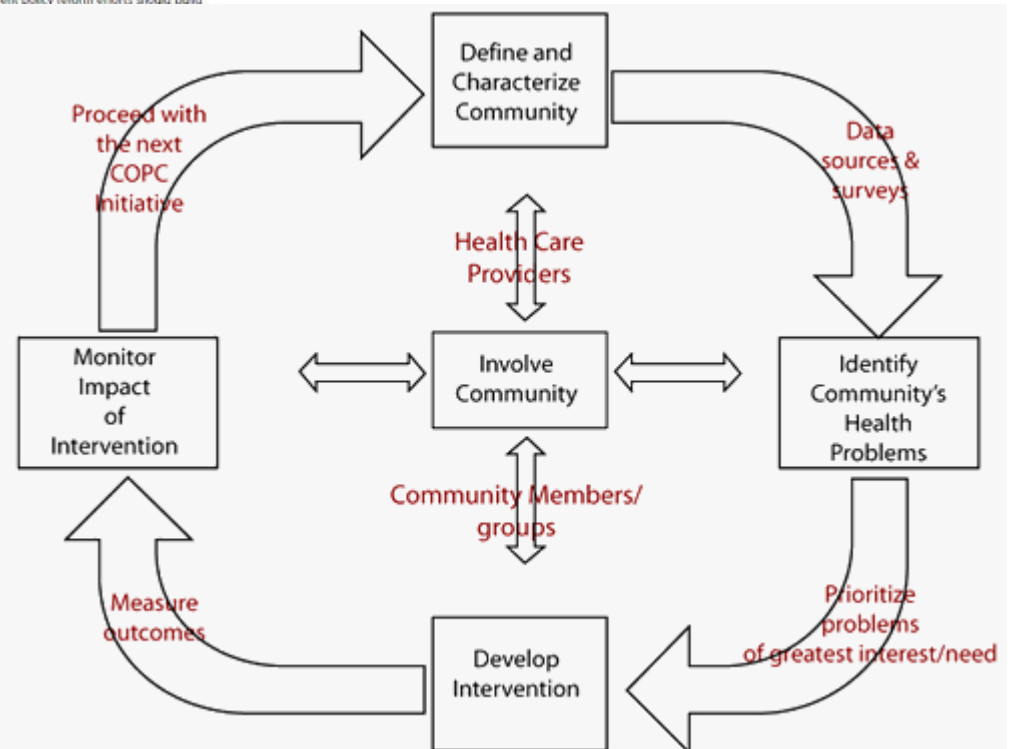
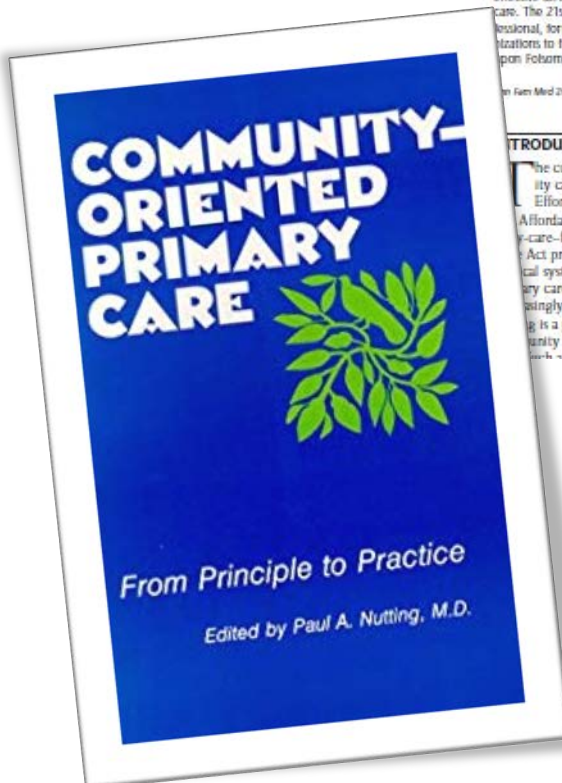
Community Oriented
Primary Care

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

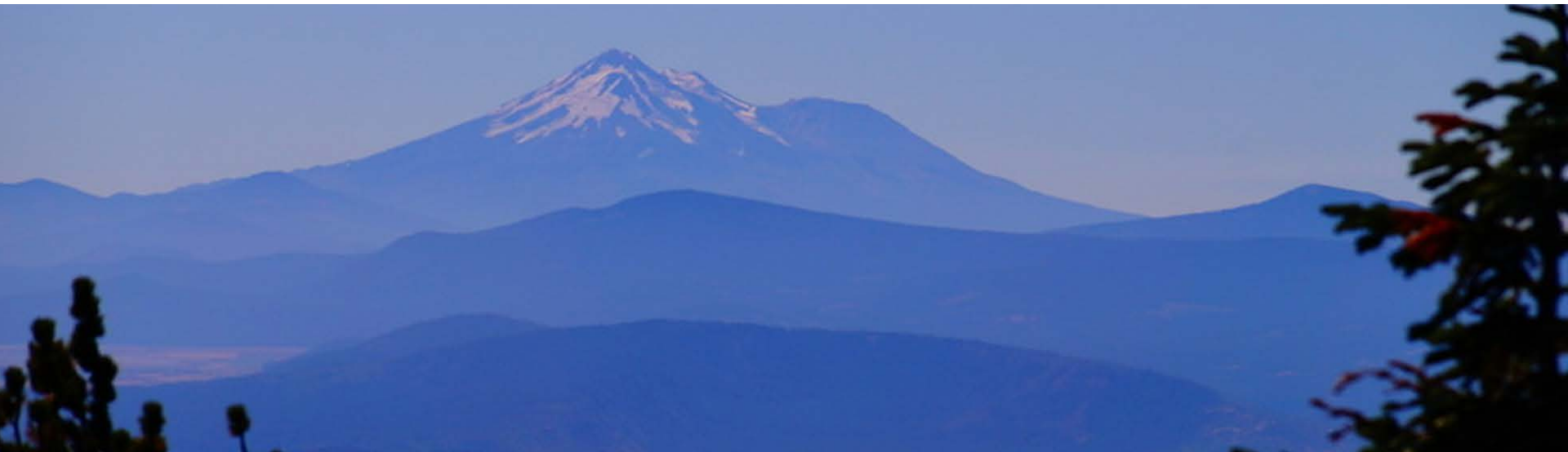
- Defined by enrollment or membership in an organization
 - Capitation/Revenue
- Defined by receipt of services
 - Clinical practice
 - Disease state
- Addressed through clinical models



- “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

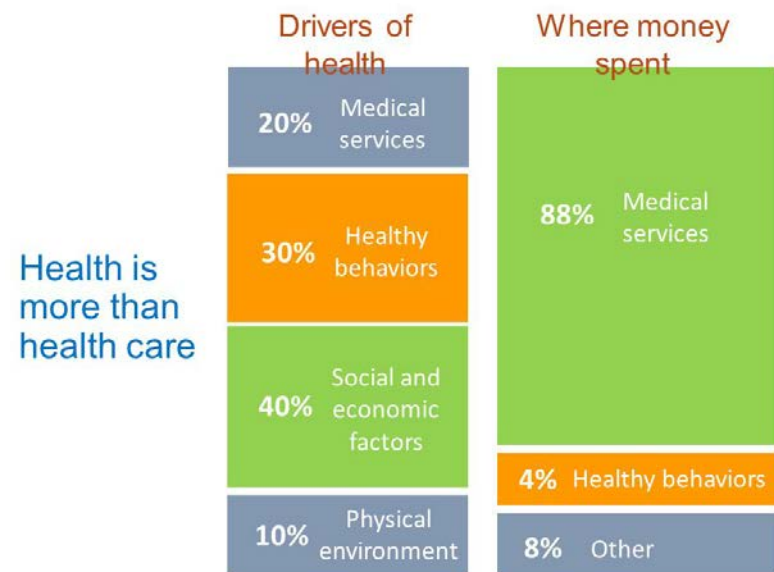


Every patient in the context of family; every family in the context of community



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?

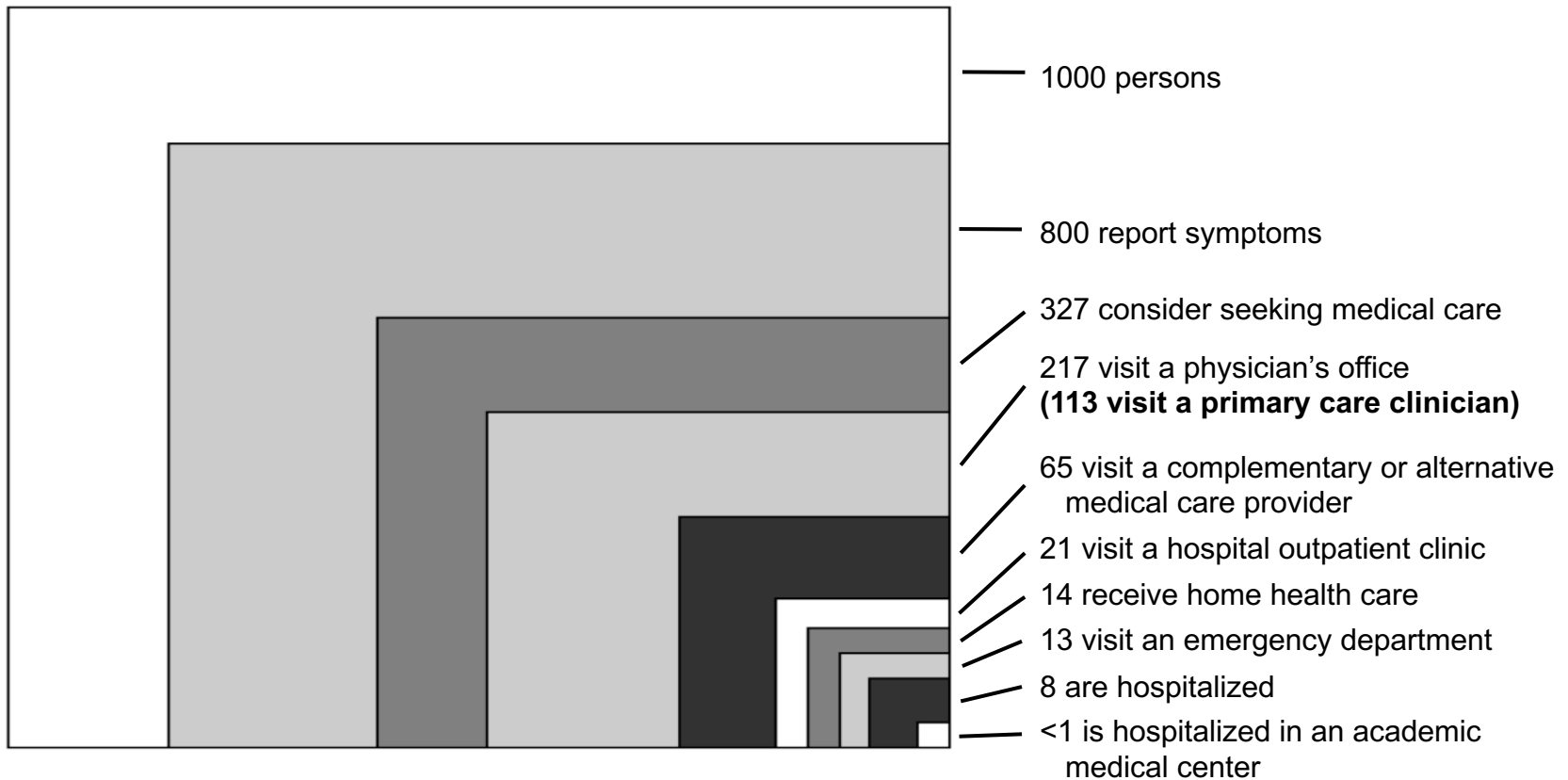
- The Community!
 - Population health is owned by the population
- Community Engaged approaches to health equity
 - Listen deeply, learn from the community
- Partner with everyone and anyone who wants to do this work
 - Build on what is already happening



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.

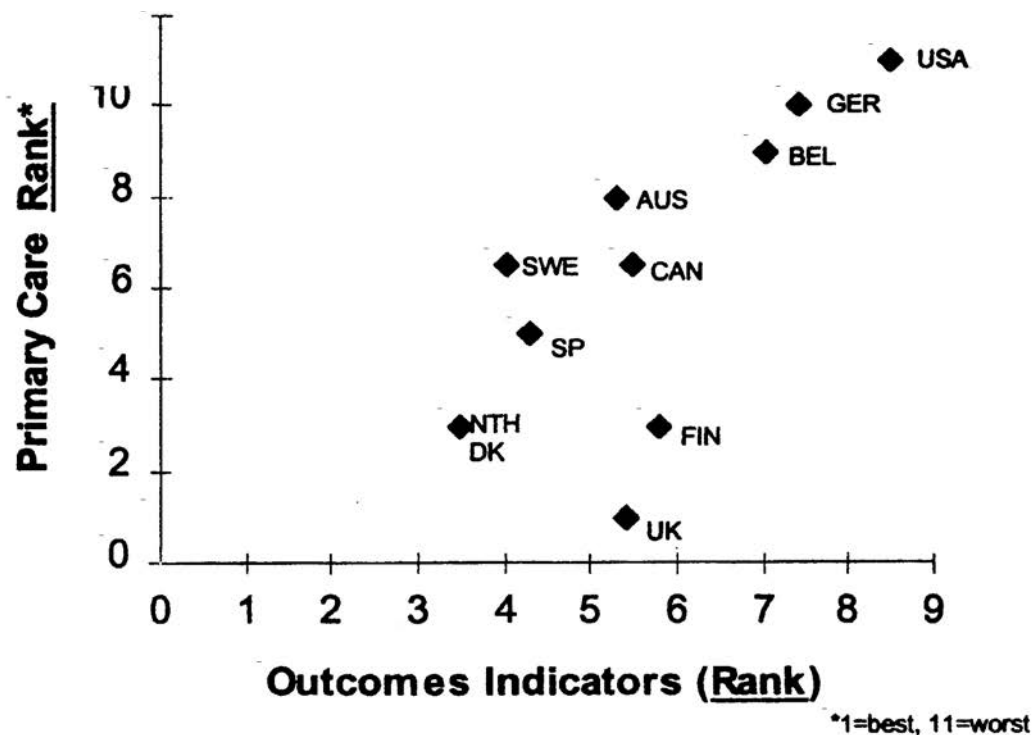
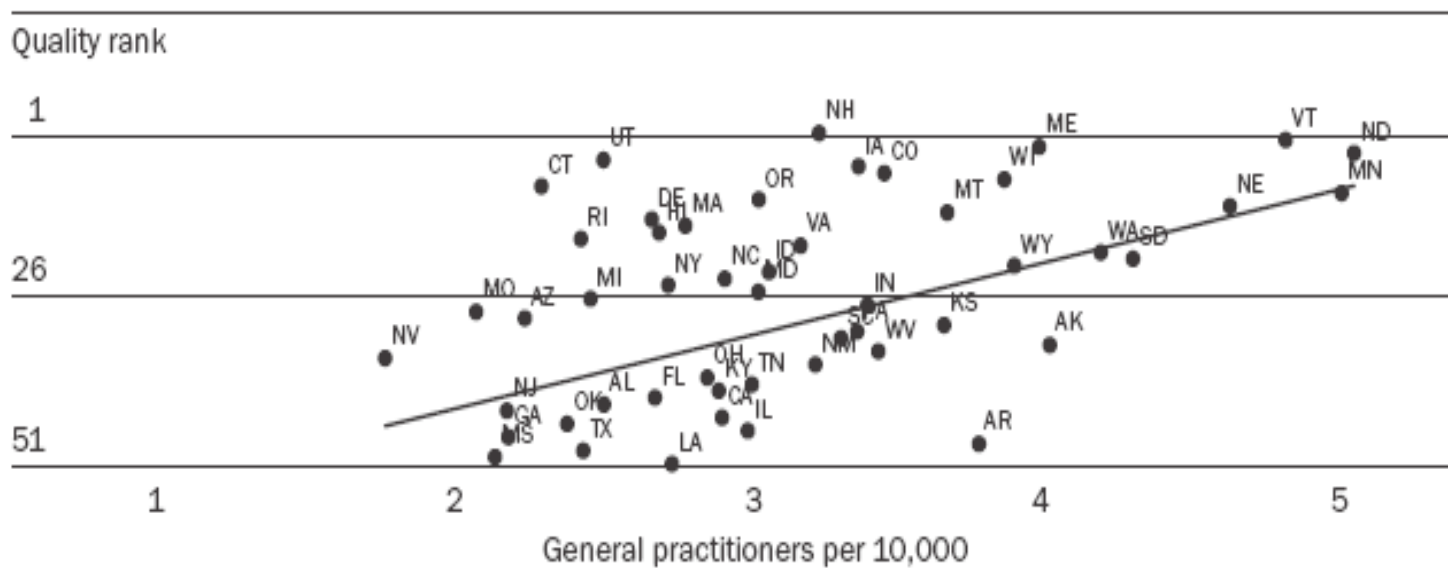


Figure 1.3. Relationship between strength of primary care and combined outcomes.

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.

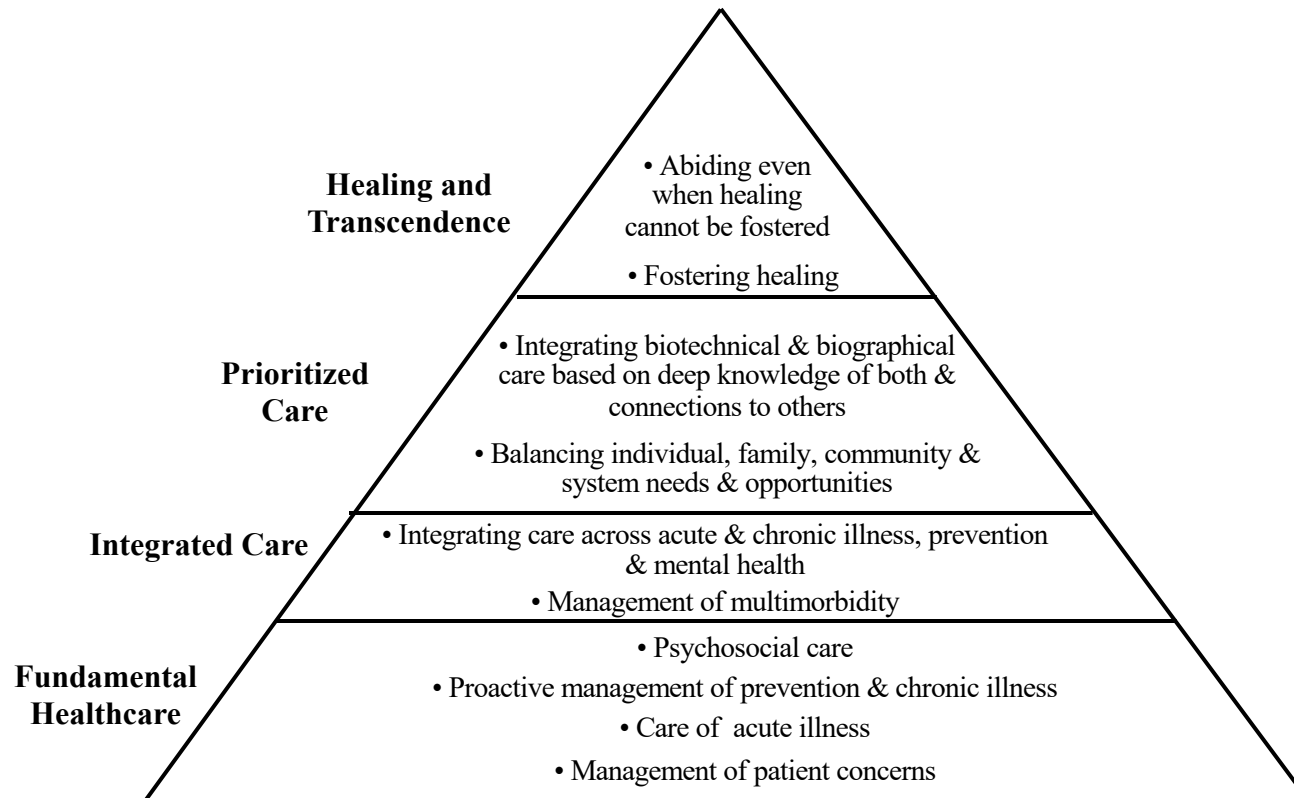


The 'Paradox of Primary Care'

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.

A vertical photograph on the left side of the slide shows a wooden dock extending from the bottom towards the center of a calm lake. The lake's surface is still, reflecting the sky and the distant mountains. The sky is filled with soft, white clouds, and the mountains in the background are covered in green trees.

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

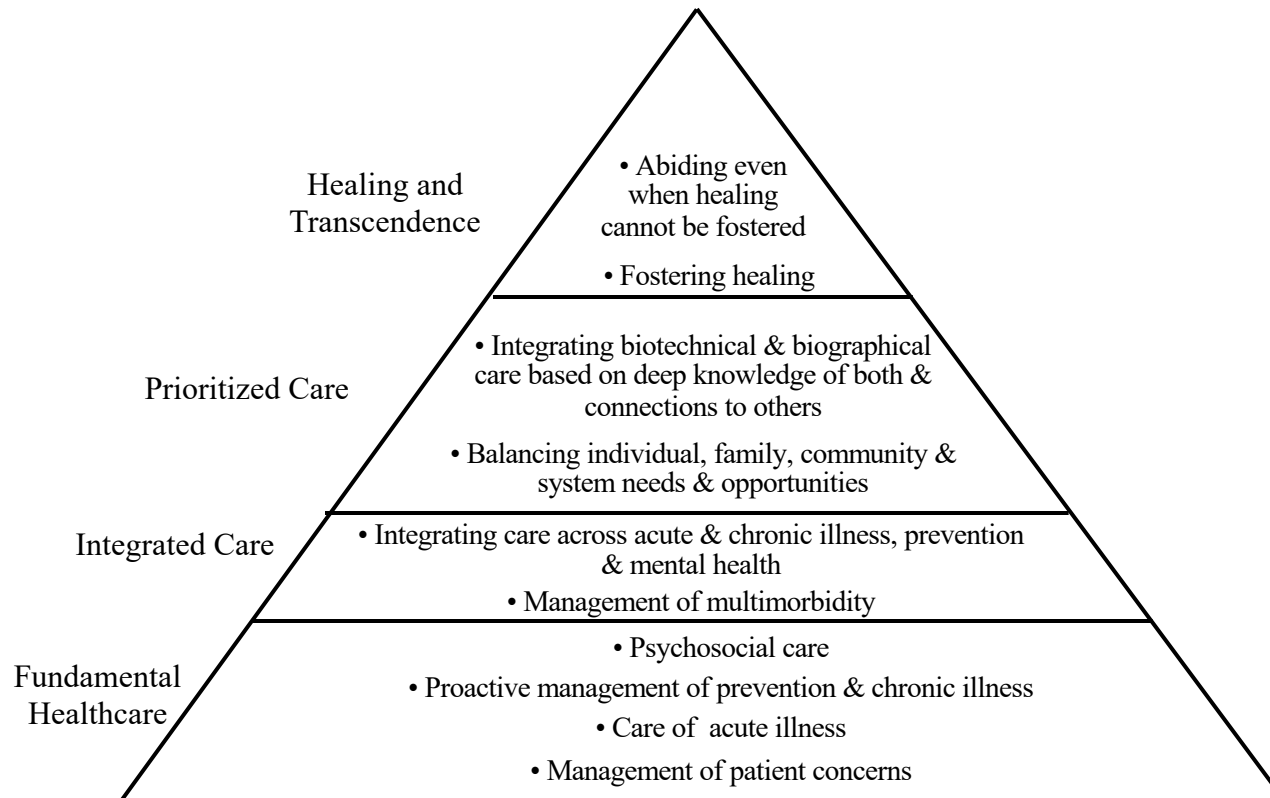
What do we teach our learners?

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

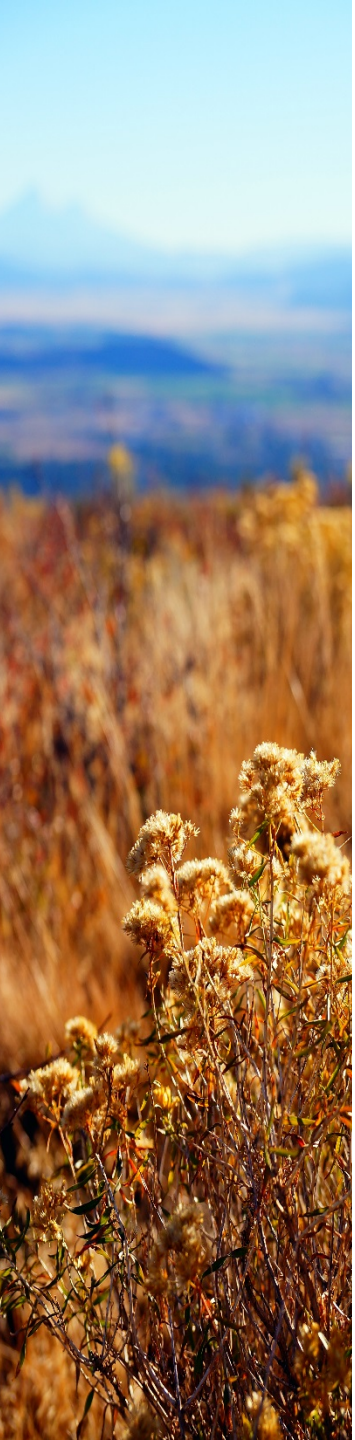


Systems vs. individuals:

What do we teach students and residents?

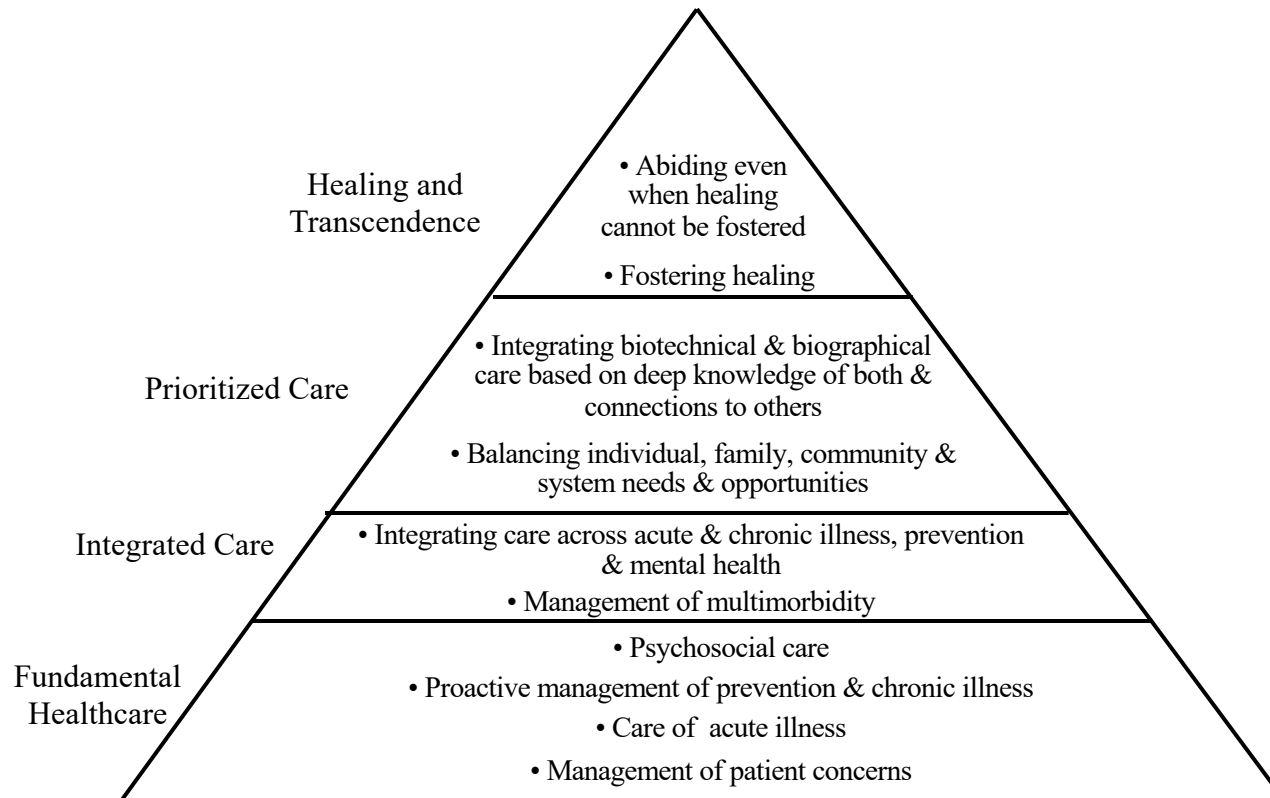


Stange KC. A Science of Connectedness. Ann Fam Med. 2009;7(5):387-395.



- 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!