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’?
Remember this?
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

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health</td>
<td>• A framework for addressing why some populations are healthier than others, based on health outcomes</td>
</tr>
</tbody>
</table>
| 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**

<table>
<thead>
<tr>
<th>Quality rank</th>
<th>General practitioners per 10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td></td>
</tr>
</tbody>
</table>

**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.

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?


Time for a paradigm shift?

- Fundamental care is all we currently measure, incentivize, and support.
- Integrated & prioritized care could be supported by IT systems and primary care functions.
- Higher levels of care unintentionally devalued through relationships and continuity of 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?

• 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?

- Abiding even when healing cannot be fostered
- Fostering healing
- Integrating biotechnical & biographical care based on deep knowledge of both & connections to others
- Balancing individual, family, community & system needs & opportunities
- Integrating care across acute & chronic illness, prevention & mental health
- Management of multimorbidity
- Psychosocial care
- Proactive management of prevention & chronic illness
- Care of acute illness
- Management of patient concerns

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!