Population Health:
What it Means for Integrated Primary Care

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Integrated Primary Care Interest Group (IPC IG)
Chairs' Webinar Series:
Psychologists' Identity in Primary Care
hosted by the SfHP Integrated Primary Care Interest Group

No Financial Disclosures

Learning Objectives

- ✓ Participants will be able to state the basic tenets of population health and how it applies to integrated primary care.
- ✓ Participants will be appreciate the primary care redesign implications for a population-oriented system of care.

Conceptual Shifts

Start with Why

Why

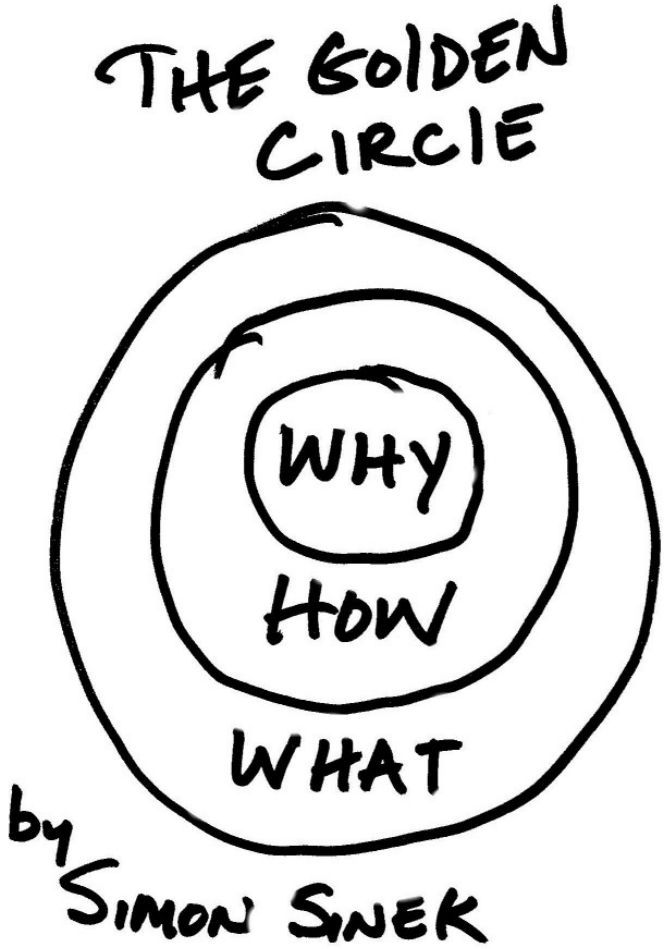
- Motivation

How

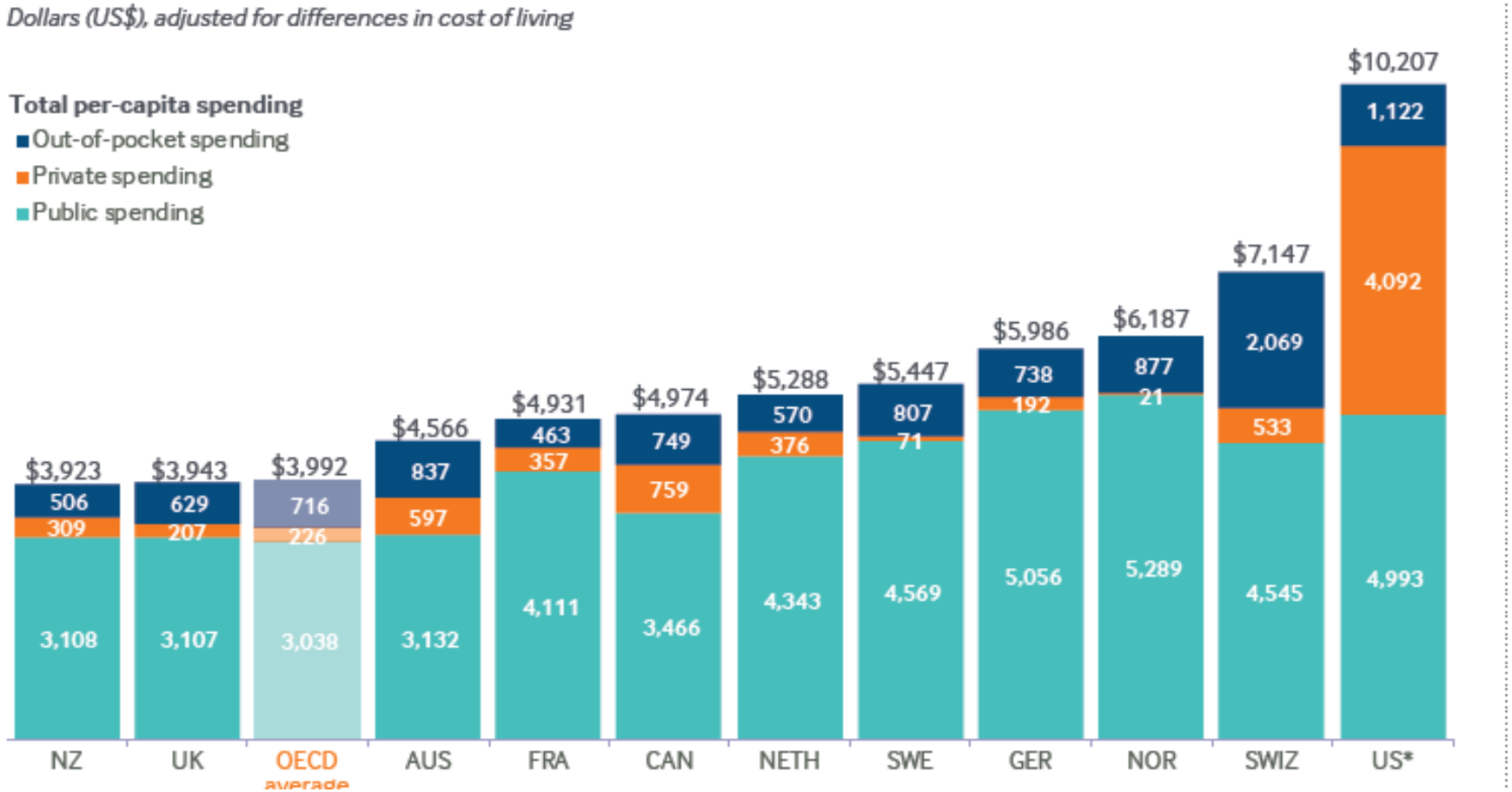
- Process

What

- Product

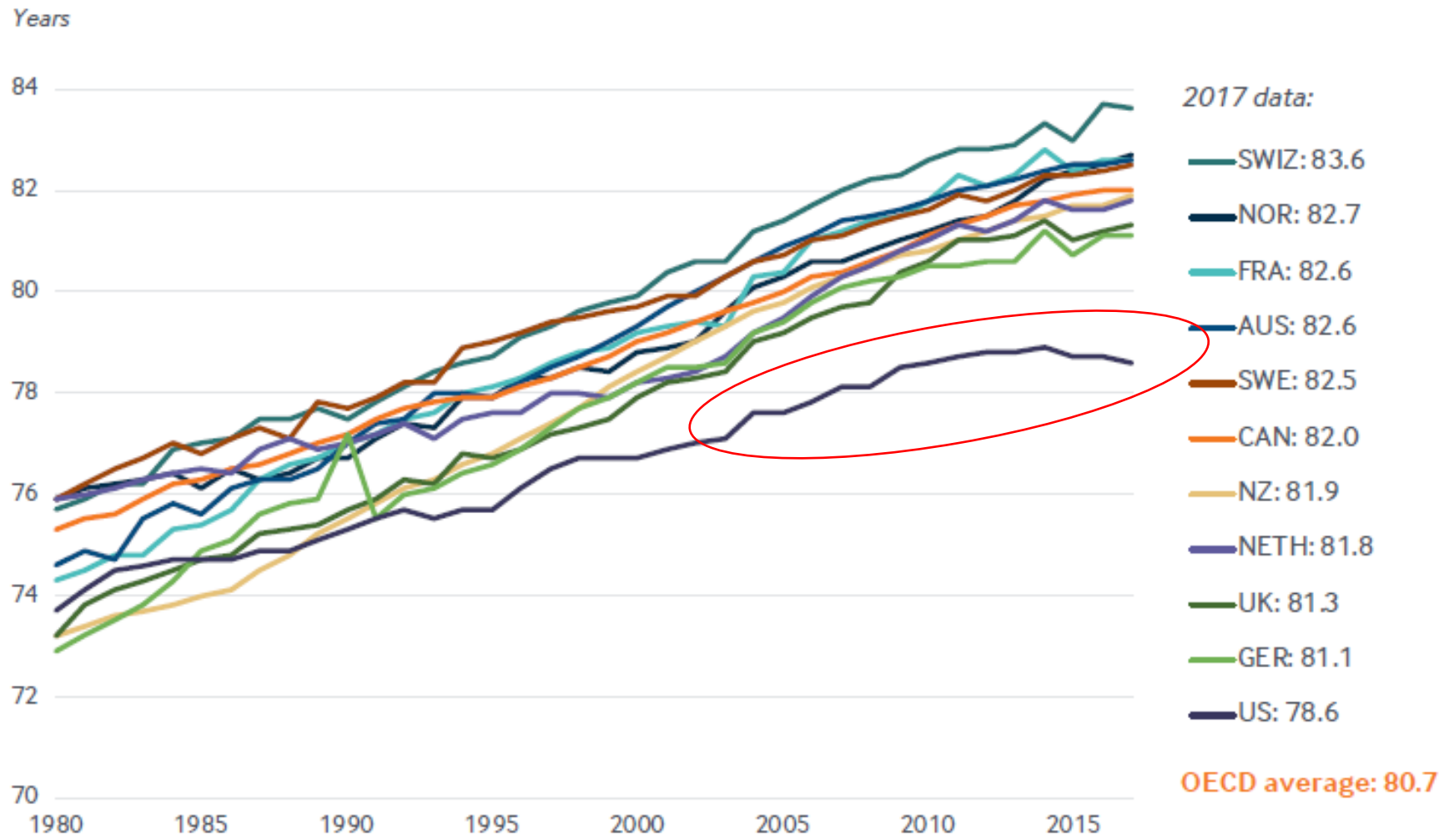


Healthcare Spending OECD countries



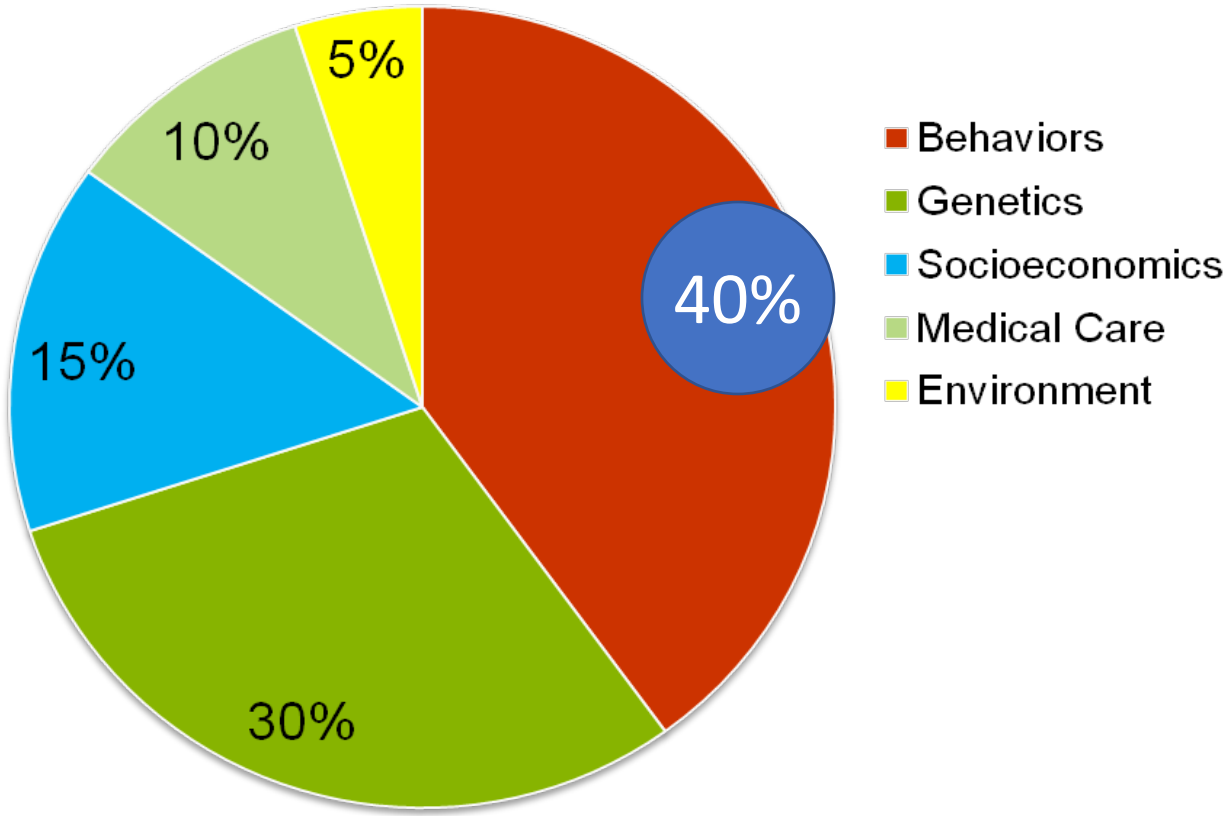
Tikkanen, & Abrams, 2020, January

Healthcare Outcomes



Tikkanen, & Abrams, 2020, January

Reasons People Die



1. McGinnis JM, Foege WH. Actual Causes of Death in the United States. JAMA 1993;270:2207-12.
2. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA 2004;291:1230-1245.

What is Population Health?

- “Population health.” It is a term that is widely used in the health care world, but not universally understood (Milken Institute)
  - Some definitions emphasize
    - Outcomes
    - Measurement
    - Accountability
- First Published Definition: “The health outcome of a group of individuals, including the distribution of such outcomes within the group.”
  - Narrow focus on health comes

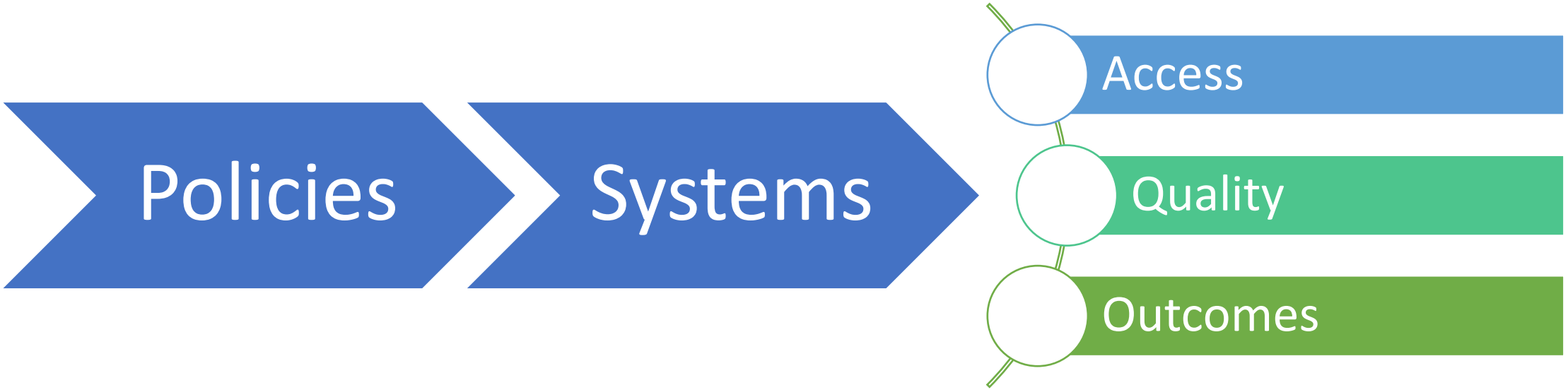
Kindig D, Stoddart G. What is population health? Am J Public Health. 2003 Mar;93(3):380-3

What is Population Health?

- “Interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally. This approach utilizes non-traditional partnerships among different sectors of the community – public health, industry, academia, health care, local government entities, etc. – to achieve positive health outcomes. (CDC)
- “Health behaviors and outcomes of a broad group of individuals, including the distribution of such outcomes affected by the contextual factors within the group. (CMS)

Simpler Definition

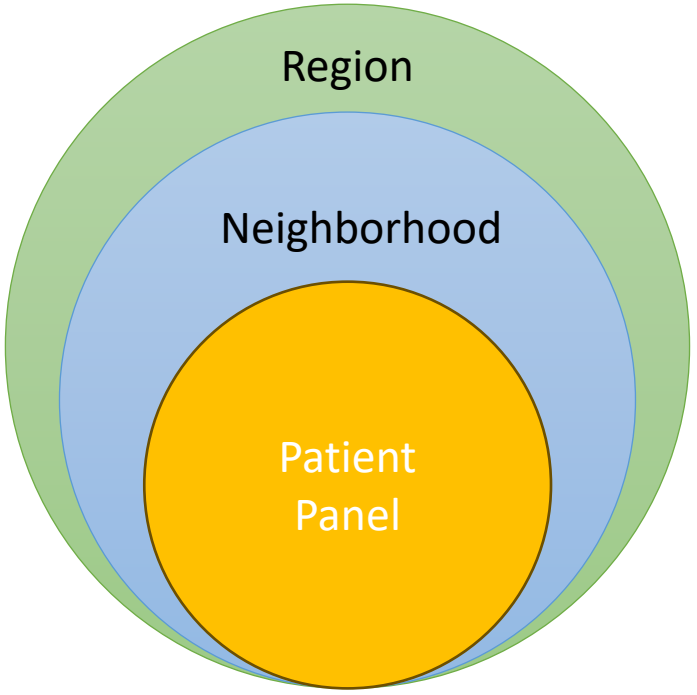
- A systematic and integrated approach to improving the health of a given population by changing policies and systems that affect health care access, quality, and outcomes (Meiris & Nash, 2008)



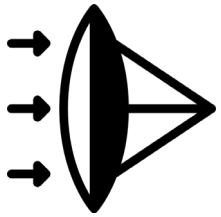
Even More Simple Definition

"You are just as concerned those who do not show in your clinic as you are for the ones who do."

- What is your population?
  - Geographic regions
  - Ethnic groups
  - Age groups
  - Medical Conditions



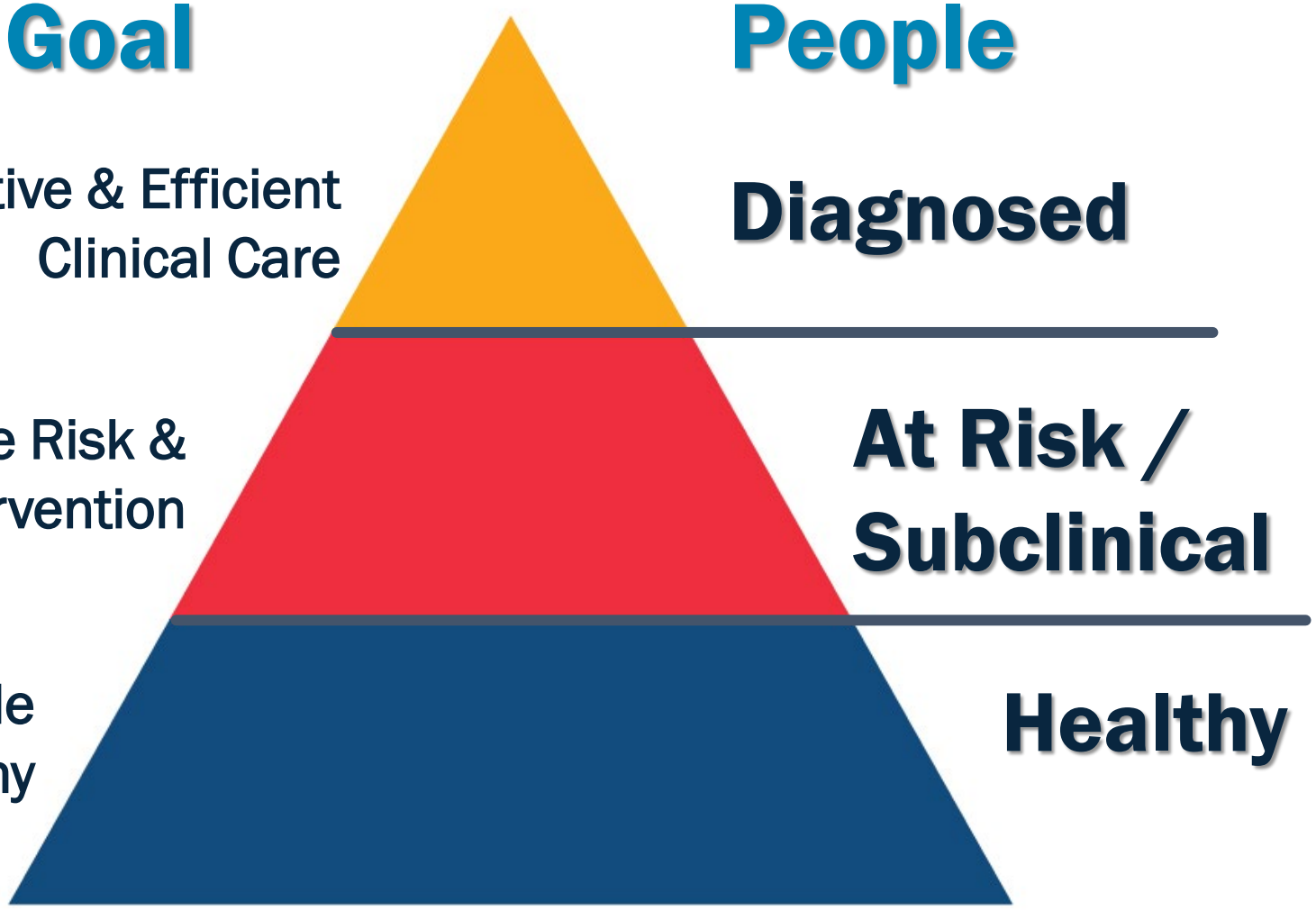
Population Health Depends on Your Lense



Public Health Director	Community Health	Managed Care Director	PCP
Prevention and Public Health Interventions to improve health outcomes of population of a geographic area	Neighborhood and small communities focusing on specific high-disparity communities	Work through provider networks to influence outcomes of covered lives. May also include Accountable Care Organizations to share financial risk	Panel of Patients whose outcomes require intentional team-based care management. May take into consideration of that which occurs outside the four walls of the clinic

Anim, Rust, Strong,& Speights 2022

Population Health Approach



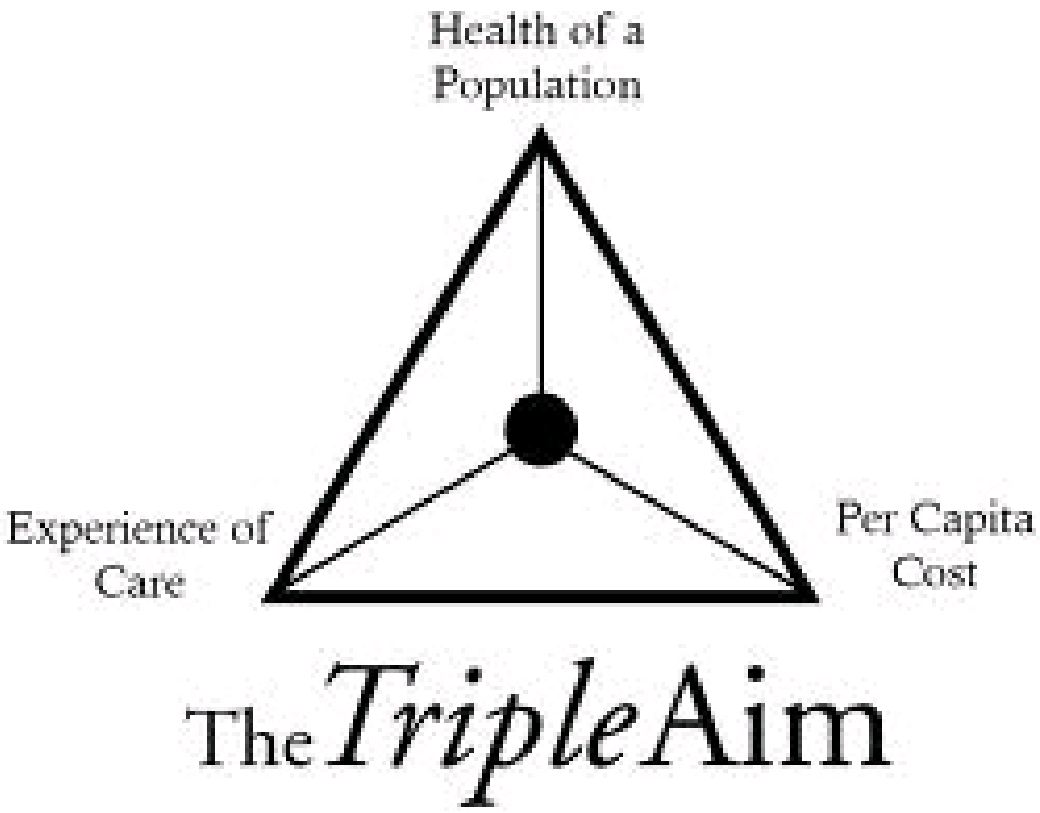
APA 2024

Population Health and Public Health

- **Public Health** plays a critical role in improving a population's health and well-being
  - Promote health and wellness and encourage healthy behaviors
  - Primary Prevention
  - Infectious disease control
  - Conditions that lead to health
  - Public Health might not focus on Social determinants of health like education and income
- **Population Health** take a more holistic approach (broad)
  - All factors that influence health
  - Broad view of Social Determinates of Health that influence outcomes
  - Provides an opportunity for health care systems, agencies and organizations to work together to improve health outcomes

(Milken Institute)

Triple Aim (Quadruple)

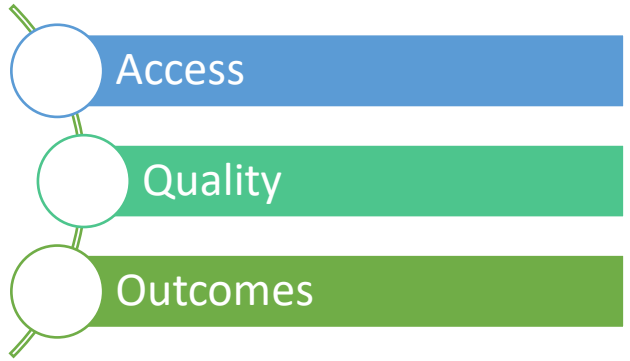


IHA 2008

Ascension Medical Group
Bodenheimer and Sinsky (2014)

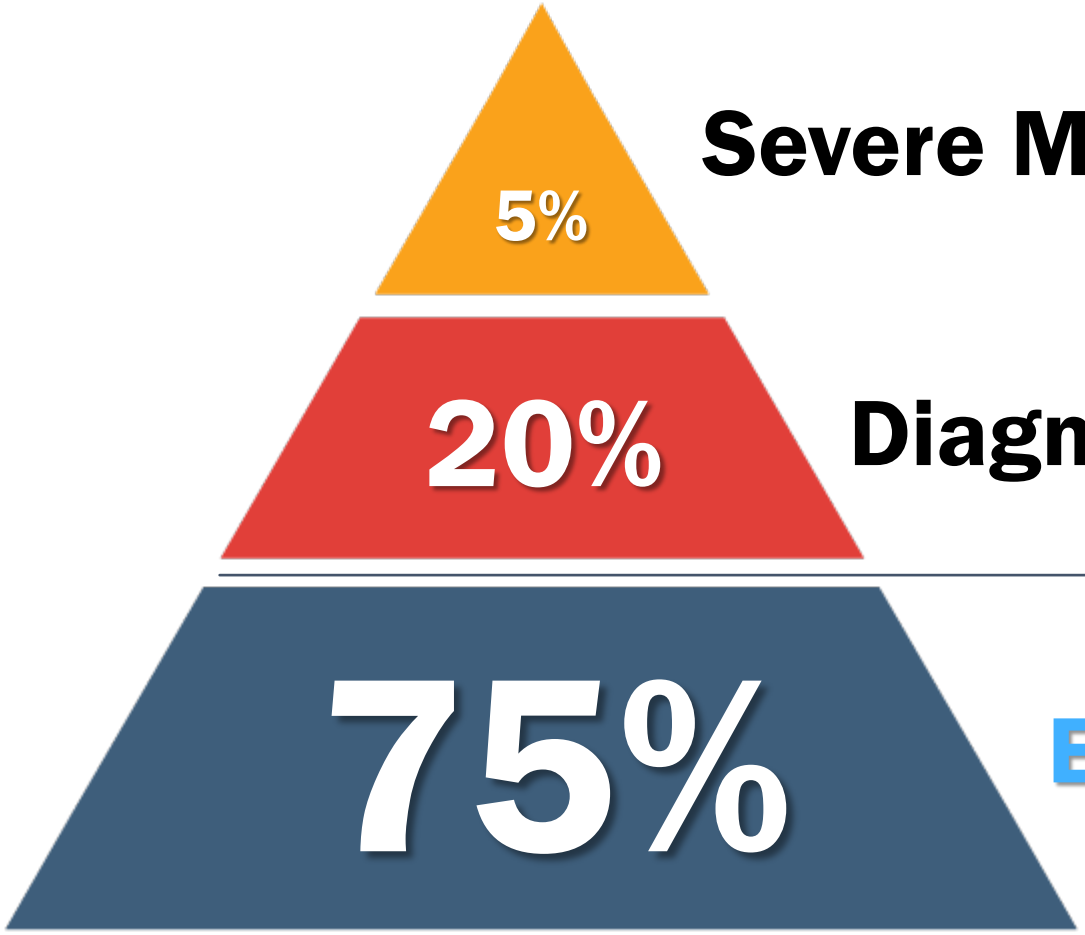
Simple Example:

- Universal screening for tobacco use given to all patients in a clinic
- If Tobacco user interested in quitting
  - Provided with low intensity intervention
    - encouraged to quit with brief intervention provided by PCP and BHC
- While low intensity intervention has low success rate, it is given to larger number of people resulting in greater impact that a more intensive intervention given to few number of patients



Hunter, Goodie, Oordt, and Dobmeyer; 2024

Current U.S. Treatment Approach for Specialty Mental Health



Severe Mental Illness

Diagnosable Mental Disorder

Everyone Else

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Growing Support for Population Health Focus

- APA Population Health Science Summit
  - September 12-13, 2023
  - *"Our disproportionate focus on assessment and treatment for those who pursue, and can access mental health services has yielded **significant health disparities**.*
  - *A strong consensus was established at the summit indicating that there is a sufficient and compelling scientific basis to support a move to a **population health approach to mental health care and prevention**."*

APA and Psychology Positioned to Advance Population Health

Council's February 2022 policy is shaping APA's:

- Approach to advocacy
  - e.g., Social determinants of health
- Partnership formation
  - e.g., YMCA (children and families)
- Content delivery

AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychology's Role in Advancing Population Health

FEBRUARY 2022

Population health focuses on improving the health, health equity, safety, and wellbeing of entire populations, including individuals within those populations. This approach is supported by a multidisciplinary science base from psychology as well as sociology, cultural anthropology, medicine, economics, education, and other disciplines. Population health aims to address the cultural, economic, systemic, historical, environmental, relational, and occupational contexts that influence health status, wellbeing, and functioning across the lifespan. Its ultimate goal is to foster equitable human flourishing.

Many of today's key population health issues—including vaccination, climate change, addiction, violence, and trauma—involve important psychological components. The science and expertise that psychology brings to these challenges should continue to be recognized and promoted. Psychological scientists, educators, consultants, practitioners, and trainees are encouraged to engage in the design, implementation, operation, and evaluation of new and existing population health models. It is crucial for such models to be grounded in, and to promote, human rights and ethics. Because the pace of change in society is so rapid.

APA 2024

Conceptual Shifts toward Population Health

Moving Upstream	• Social Determinates of Health
Shifting Focus	• From individual patient visits to the entire population
Measurement	• What we measure, we can change
Target At Risk Populations	• Identify needs that limit access care received
Boundary Spanning Role	• Unique Qualities of Primary care

Moving Upstream

Health People 2030

- Multiple methods of affecting health
  - Medical Interventions
  - Public Health interventions
    - Social environment
    - Physical Environment
  - Individual Behavior

  Interactions Between Factors
- Prevention Measures
  - Primary and Secondary

Example of Primary Care Intervention

- Page-Reeves et al. (2016) developed an 11-item survey to screen patients for social determinants of health in 3 family medicine clinics in Albuquerque, New Mexico
  - Food insecurity
  - Housing insecurity
  - Financial insecurity
  - Feeling Unsafe
- A total of 3,048 patients were screened over a 90 day period.
- 46% screened positive for at least 1 area of social need, and 63% of those had multiple needs
- Medical assistants and community health workers then offered to connect patients with appropriate services and resources to address the identified needs

J Am Board Fam Med 2016;29: 414 – 418.)

Shifting Focus from Individual to Population

- **Empanelment**: Ensuring each patient has an assigned physician or care team
- **Risk stratification**: Identifying patients that need extra help
- **Care planning**: Plan care based on EBT and related patient needs and preferences, including social determinants of health
- **Care management**: ensuring that no patient "falls through the cracks"
  - Use population data or registries to guide improvement
- **Medical neighborhood:** Coordinate care: Provide effective care coordination across the medical neighborhood

Managing a Population – The Primary Care Perspective, CMS

Stakeholder Engagement

- Involve Community members and organizations
  - FQHC model
- Reach out to local community organizations and local governments that address social needs. (e.g., soup kitchens and homeless shelters)
  - They can provide important input as to the gaps in population health, the drivers of improvement, and the benefits of improvement

Population Measures

- Community Health Needs Assessment
- Research Social Determinants of Health and Social Risk Factors
- Healthy People 2020/2030
- Existing Population Health Measures (quality indicators)

> “You cannot improve what you do not measure.”
>
> Peter Drucker

Applicable Clinician-level measures

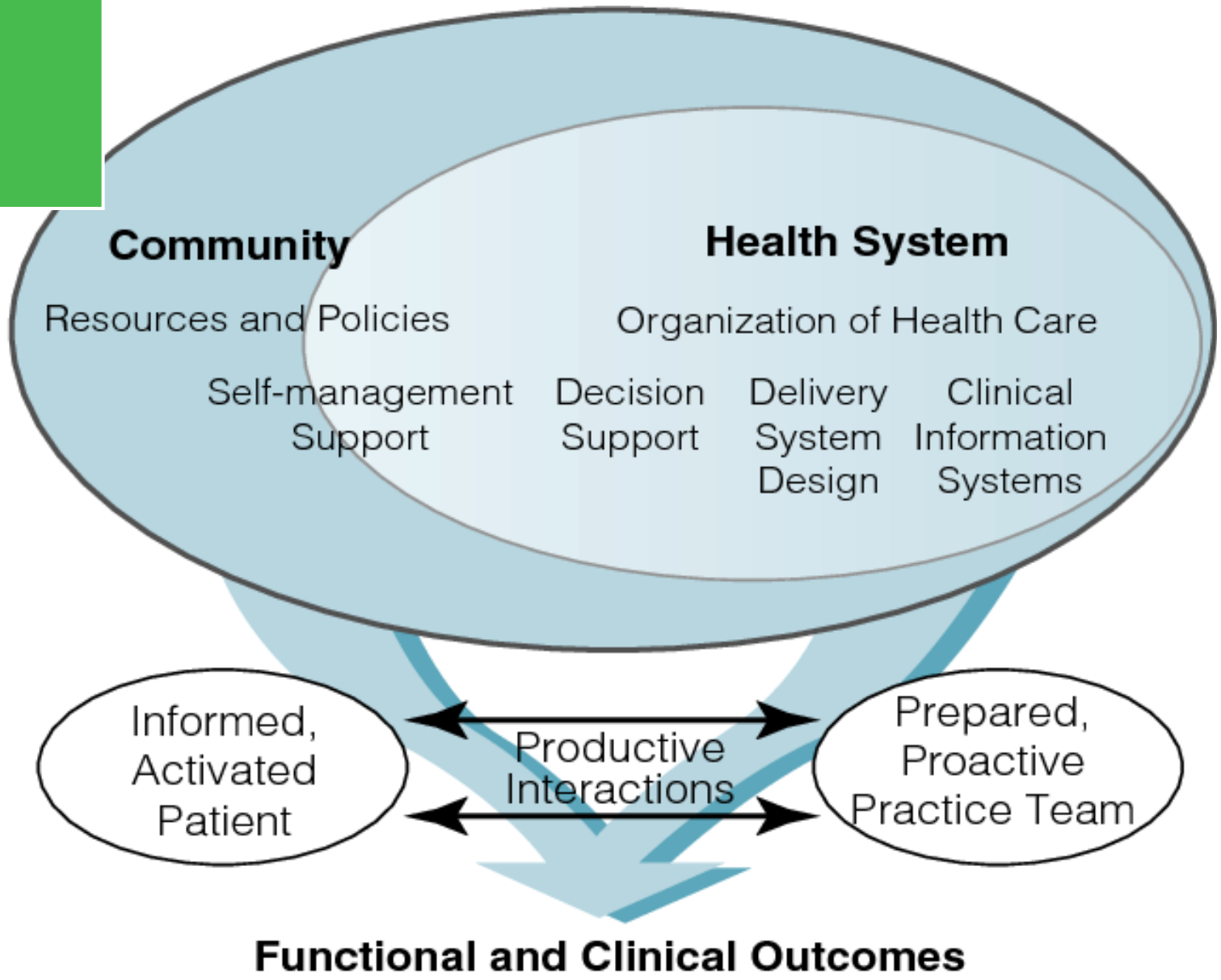
- Access to care
- Clinical outcomes
- Coordination of care and community services
- Health behaviors
- Preventive care and screening
- Utilization of health services

- Start with those over which providers have high-level of control (i.e. rate of a flu shots)
- Move from Process to Intermediate outcomes
  - We cannot *control* patient behaviors but we can *influence* them.

Target At Risk Populations

- People with access and functional needs (temporary or permanent) that may interfere with their ability to access or receive medical care
- Might include (not limited to)
  - Children, pregnant women, older adults, people with disabilities, people from diverse cultures, people with limited English proficiency, people with limited access to transportation, people with limited access to financial resources, people experiencing homelessness, people who have chronic health conditions, and people who have pharmacological dependency

Chronic Disease Management



The Challenge of Primary Care

- Quality of health care most commonly is measured by the application of **disease-specific**, evidence-based process-of-care guidelines.
  - consistently shows that primary care clinicians deliver poorer quality care than specialists (Stange KC, Ferrer RL, 2023)
- Yet primary care is associated with similar functional health status at **lower cost** and **better quality**, **better equity**.
- Can primary care serve as a force for integration of systems to influence health?
  - **"Boundary Spanning"** Role to integrate and personalize the many factors from which population health emerges.

Stange KC, Ferrer RL. The paradox of primary care. Ann Fam Med. 2009 Jul-Aug;7(4):293-9.
Stange KC, Miller WL, Etz RS. The Role of Primary Care in Improving Population Health. Milbank Q. 2023 Apr;101(S1):795-840.

Boundary Spanning Role

- Personalize care
- Integrating care
  - Behavioral Health
- Finding safety
- Know the individual and the family
- Know the community
  - Community oriented primary care

Stange KC, Ferrer RL. The paradox of primary care. Ann Fam Med. 2009 Jul-Aug;7(4):293-9.

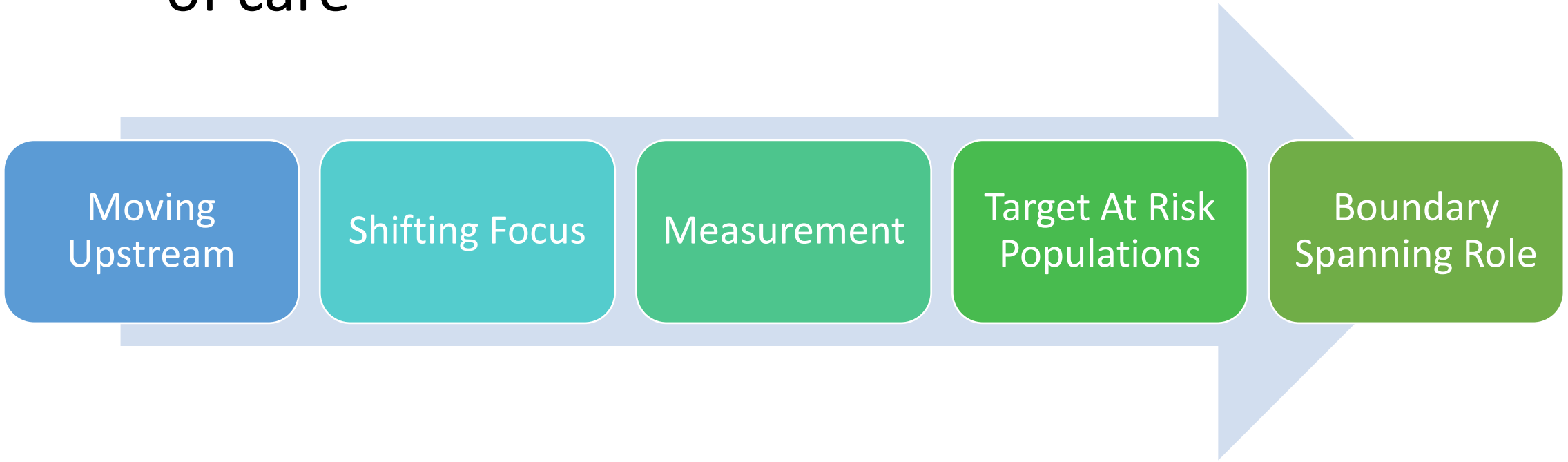
Next Steps

- Look for population health efforts
  - What is happing at your institution
  - Look for research and outreach opportunities
  - Collaborate with other organizations in your area
- Think more broadly
  - What is happening in your clinics community
  - What resources can you identify and share with patient
    - Neighborhood Navigator https://navigator.aafp.org/

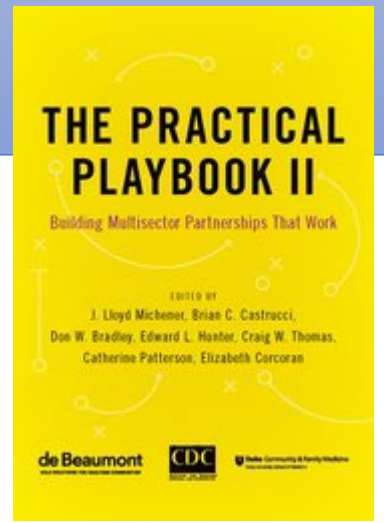
The EveryONE Project™
Advancing health equity in every community

Summary

- ✓ Basic tenets of population health
- ✓ How it applies to integrated primary care
- ✓ Conceptual shifts to a population-oriented system of care



Resources



- The Practical Playbook II: Building Multisector Partnerships That Work, Ed Michener, Castrucci, Bradley, Hunter, Thomas, Patterson, & Corcoran

- Managing a Population – The Primary Care Perspective - The TCPI Change Package
- www.cms.gov > priorities >innovation> files

Questions and Discussion