IMPROVING AND TEACHING POPULATION HEALTH

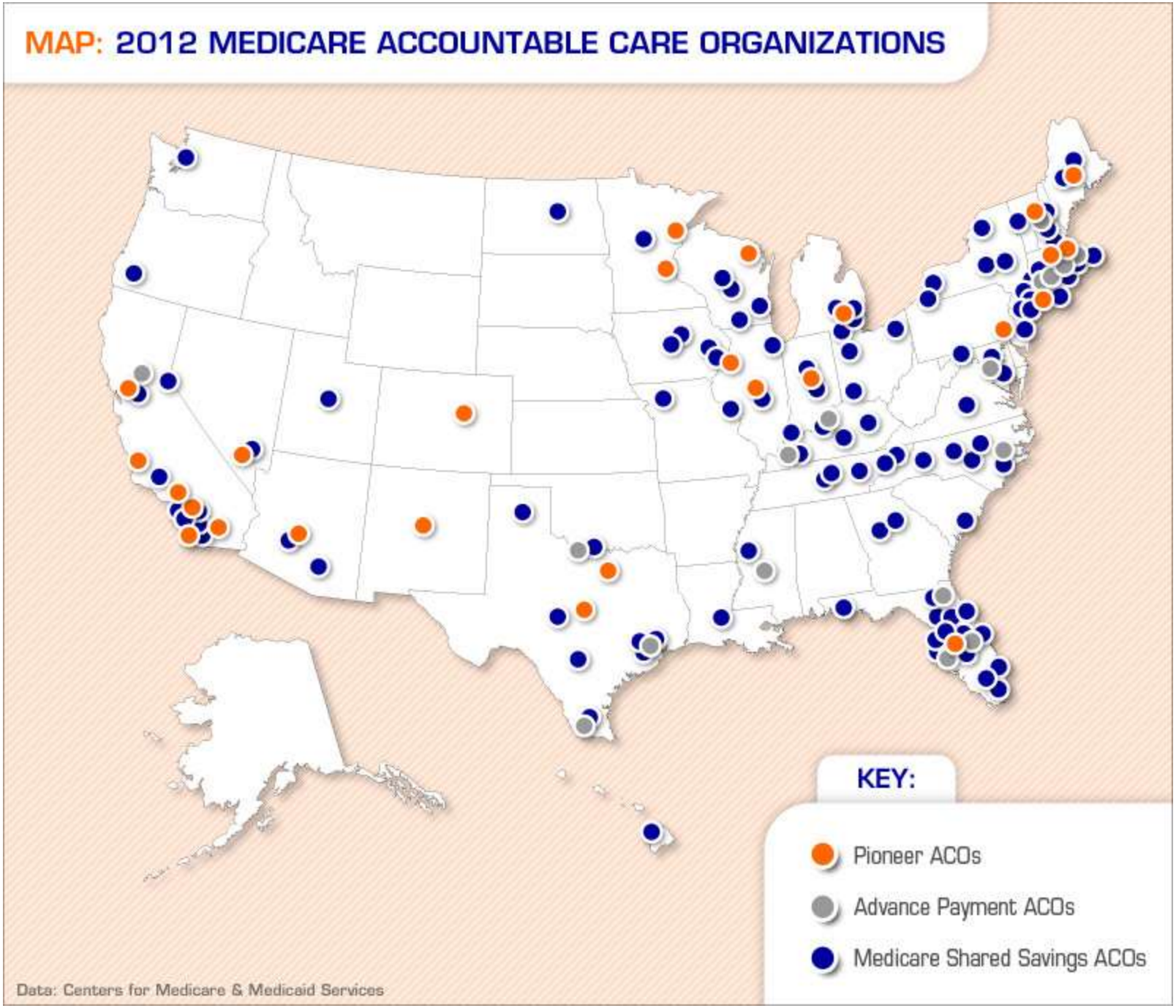
J. Lloyd Michener, MD
Professor and Chair
Department of Community and Family Medicine
Director, Duke Center for Community Research
Duke University Health System

August 21, 2013
CDC Milestones Project Meeting

Drivers Towards Population Health

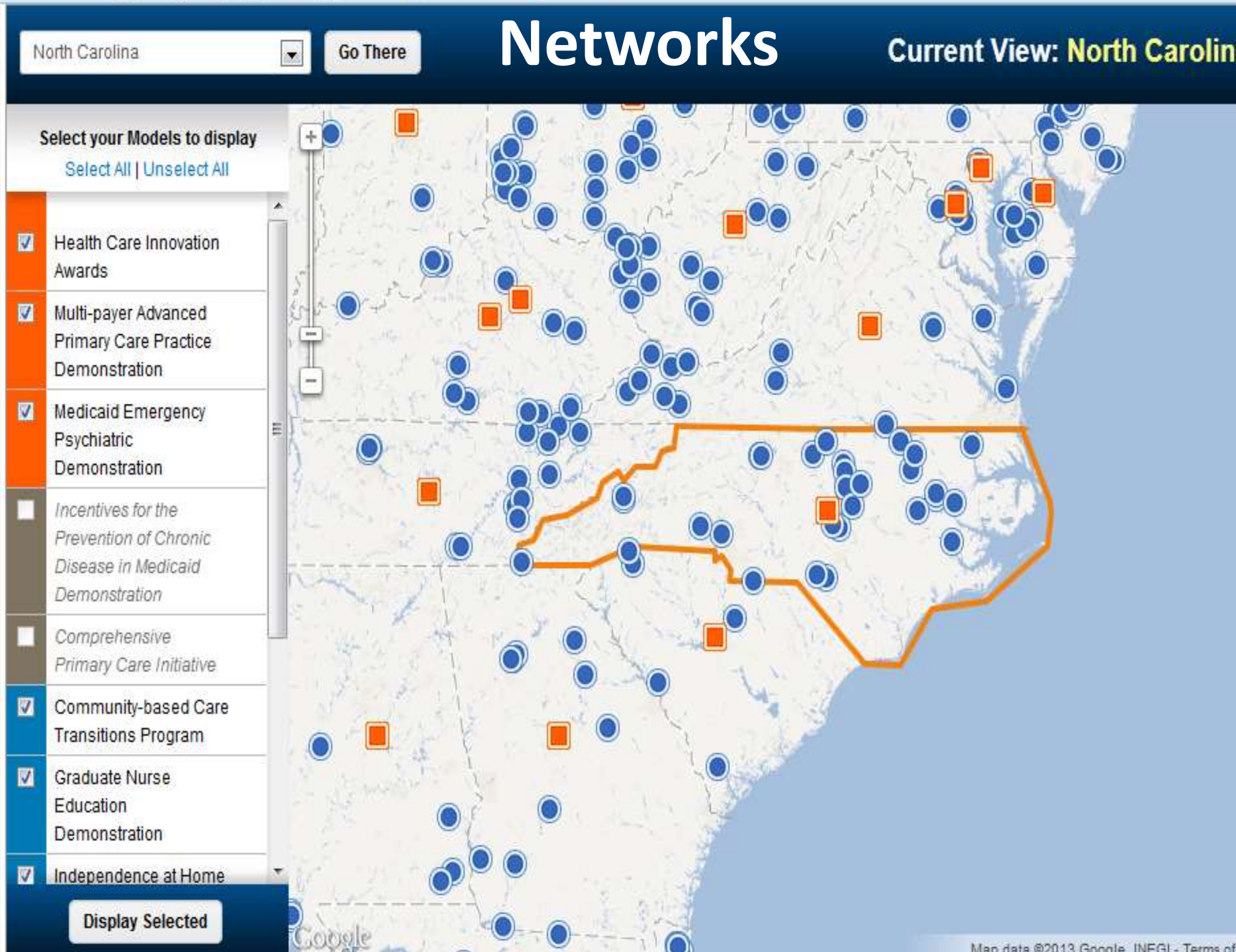
- Growth of Networks
  - Clinical Networks – HMOs, ACO, state Medicaid, etc.
  - Practice Based Research Networks :more than 150, encompassing 16,500 practices, 67,000 clinicians
- Big Data
  - Public health and EHR data
- National Strategic Imperative for Health

MAP: 2012 MEDICARE ACCOUNTABLE CARE ORGANIZATIONS

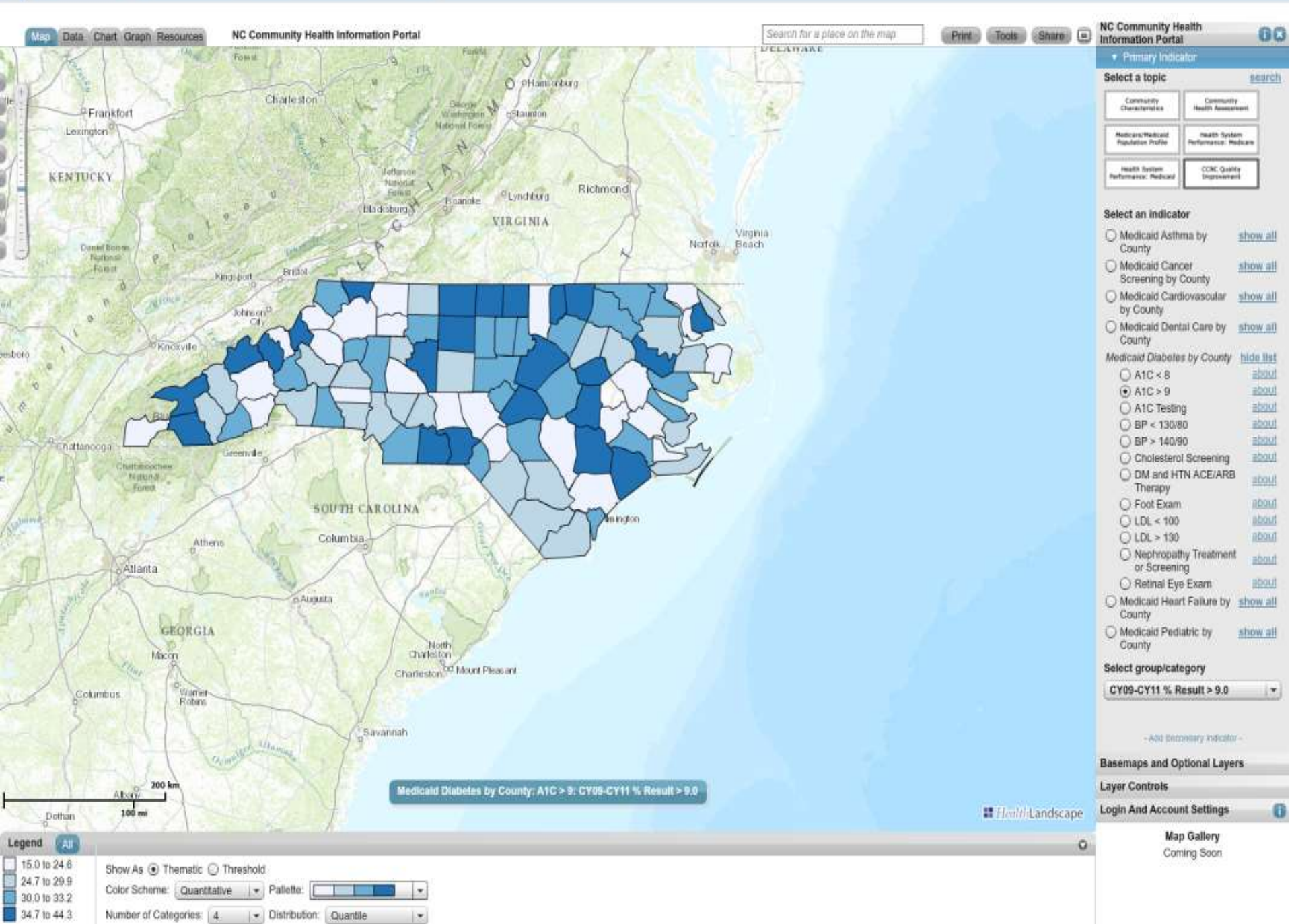


Data: Centers for Medicare & Medicaid Services

Networks


North Carolina
Go There
Current View: North Carolin
Select your Models to display
Select All | Unselect All
Health Care Innovation Awards
Multi-payer Advanced Primary Care Practice Demonstration
Medicaid Emergency Psychiatric Demonstration
Incentives for the Prevention of Chronic Disease in Medicaid Demonstration
Comprehensive Primary Care Initiative
Community-based Care Transitions Program
Graduate Nurse Education Demonstration
Independence at Home
Display Selected
Google
Map data ©2013 Google, INEGI - Terms of

NC Community Health Information Portal



NC Community Health Information Portal

▼ Primary Indicator

Select a topic search

- Community Characteristics
- Community Health Assessment
- Medicare/Medicaid Population Profile
- Health System Performance: Medicare
- Health System Performance: Medicaid
- CCNC Quality Improvement

Select an indicator

- ○ Medicaid Asthma by County — show all
- ○ Medicaid Cancer Screening by County — show all
- ○ Medicaid Cardiovascular by County — show all
- ○ Medicaid Dental Care by County — show all
- *Medicaid Diabetes by County* — hide list
  - ○ A1C < 8 — about
  - ◉ A1C > 9 — about
  - ○ A1C Testing — about
  - ○ BP < 130/80 — about
  - ○ BP > 140/90 — about
  - ○ Cholesterol Screening — about
  - ○ DM and HTN ACE/ARB Therapy — about
  - ○ Foot Exam — about
  - ○ LDL < 100 — about
  - ○ LDL > 130 — about
  - ○ Nephropathy Treatment or Screening — about
  - ○ Retinal Eye Exam — about
- ○ Medicaid Heart Failure by County — show all
- ○ Medicaid Pediatric by County — show all

Select group/category

CY09-CY11 % Result > 9.0

- Add secondary indicator -

Basemaps and Optional Layers

Layer Controls

Login And Account Settings

Map Gallery

Coming Soon

Legend All

- 15.0 to 24.6
- 24.7 to 29.9
- 30.0 to 33.2
- 34.7 to 44.3

Show As ◉ Thematic ○ Threshold

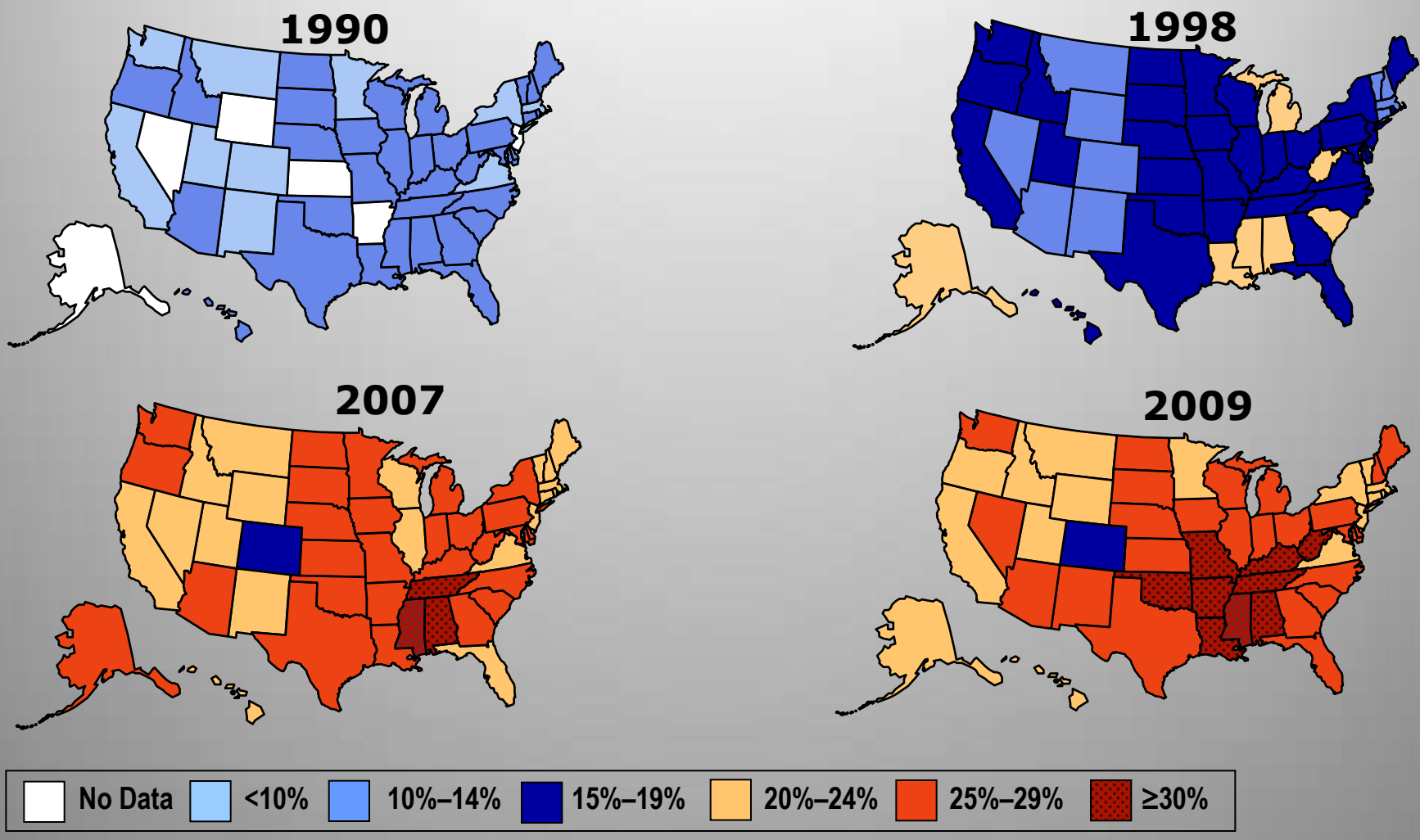
Color Scheme: Quantitative Palette:

Number of Categories: 4 Distribution: Quantile

Obesity Trends* Among U.S. Adults

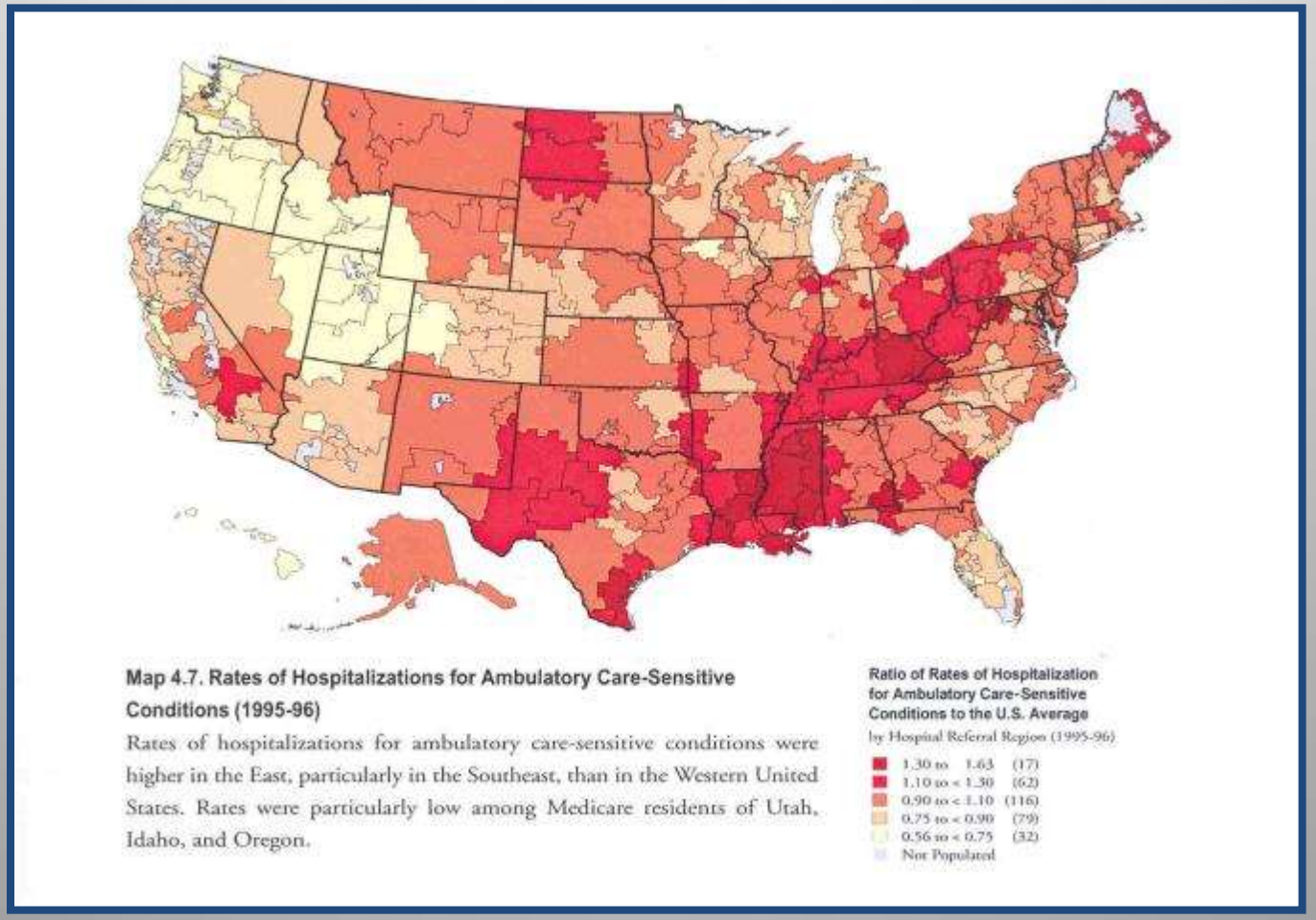
BRFSS, 1990, 1998, 2007, 2009

(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)



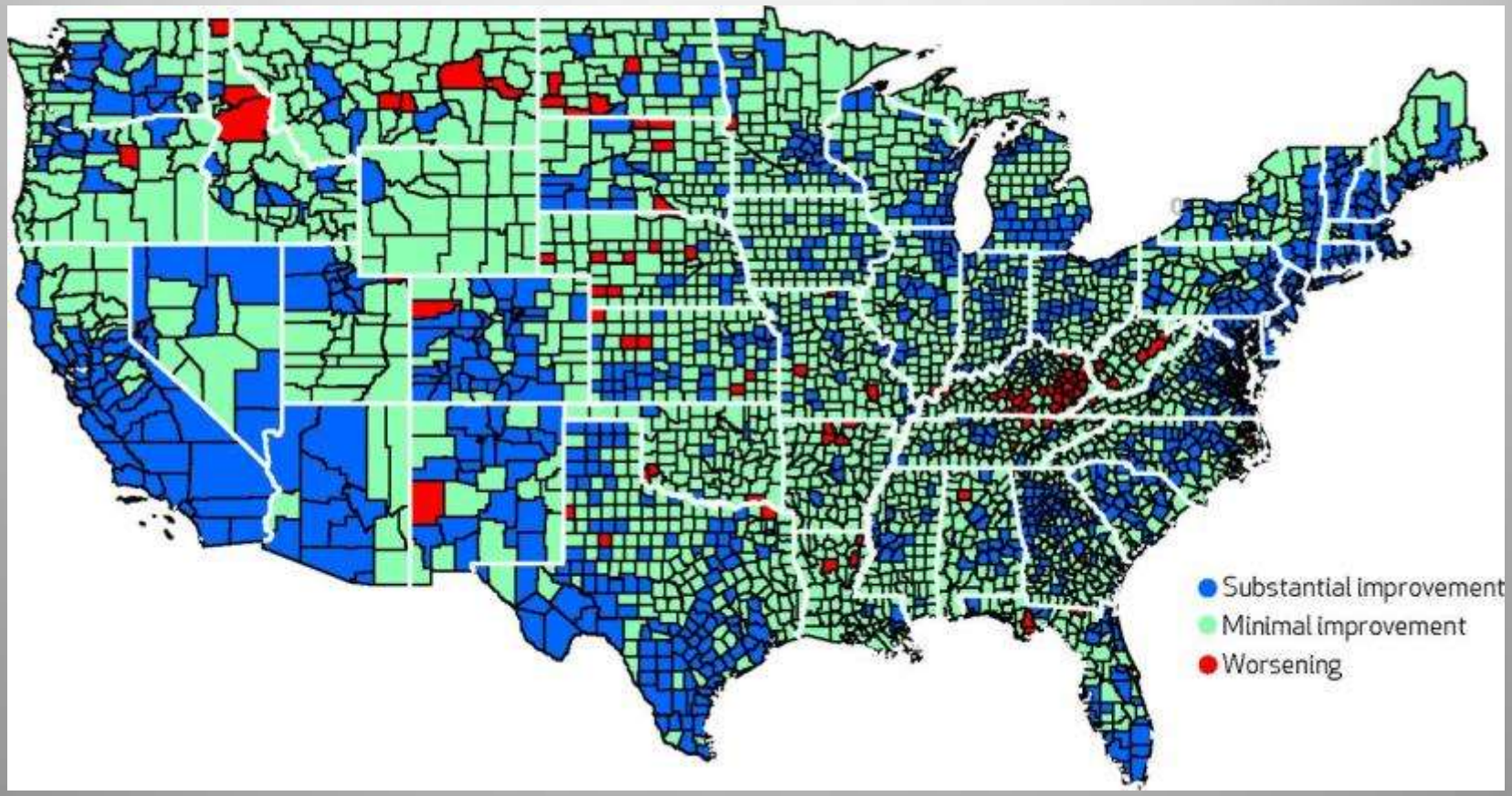
Source: CDC Behavioral Risk Factor Surveillance System

Disease Burden / Practice Patterns Vary



Source: The Quality of Medical Care in the United States: A Report on the Medicare Program. The Dartmouth Atlas of Health Care 1999. The Center for the Evaluative Clinical Sciences Dartmouth Medical School

Change In Male Mortality Rates From 1992–96 To 2002–06 In US Counties



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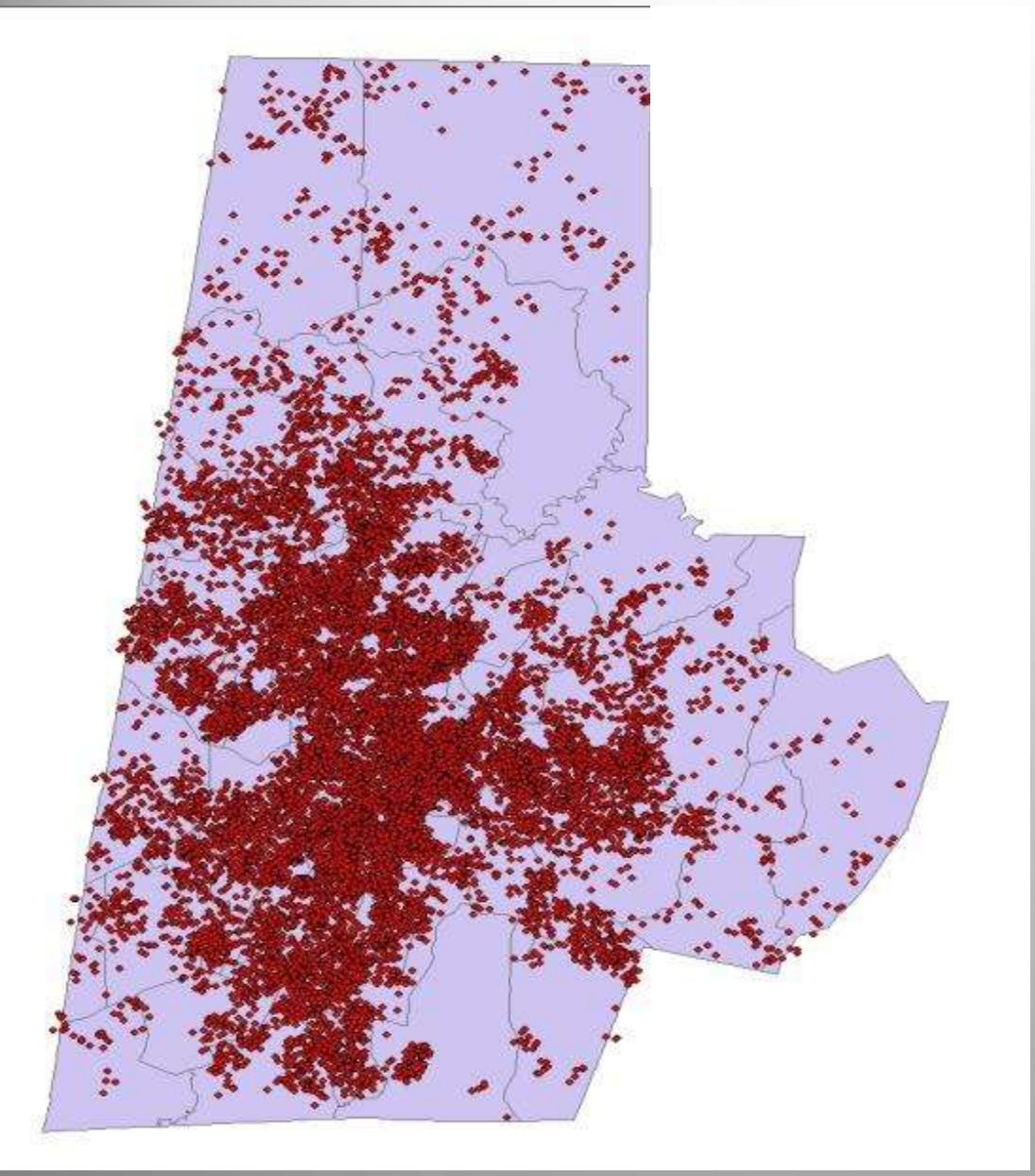
HealthAffairs



Durham residents with diabetes (2007-2009)

14,345 unique patients

8.7% of all patients >20 yo

14.3% of all patients >40 yo

Durham County Stats (per CDC):

2008 ~ 10% of adults diagnosed with diabetes

North Carolina (CDC):

2008 ~ 9% of adults diagnosed with diabetes

By Race:

8.4% White

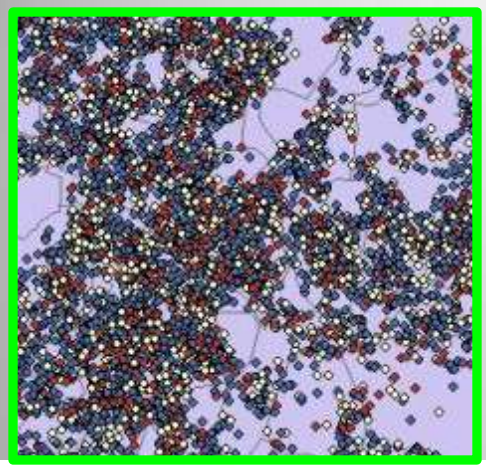
15.6% AA

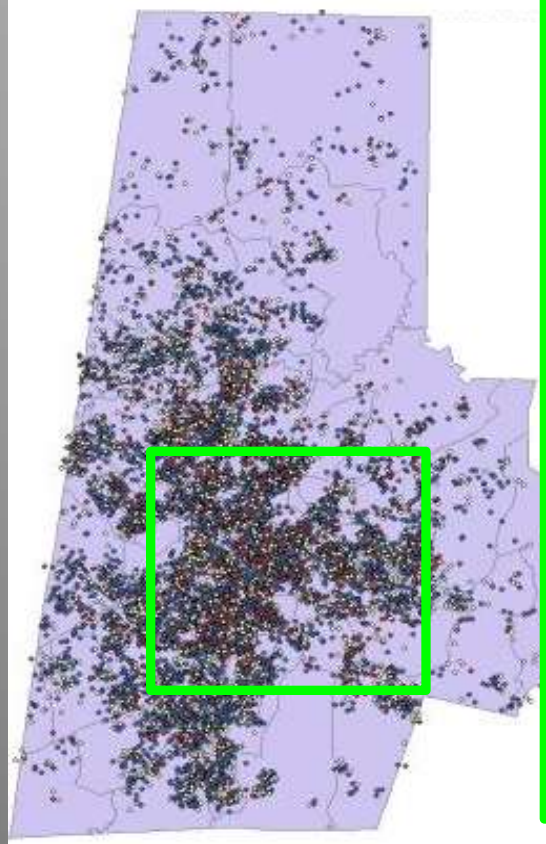
12.4% NA

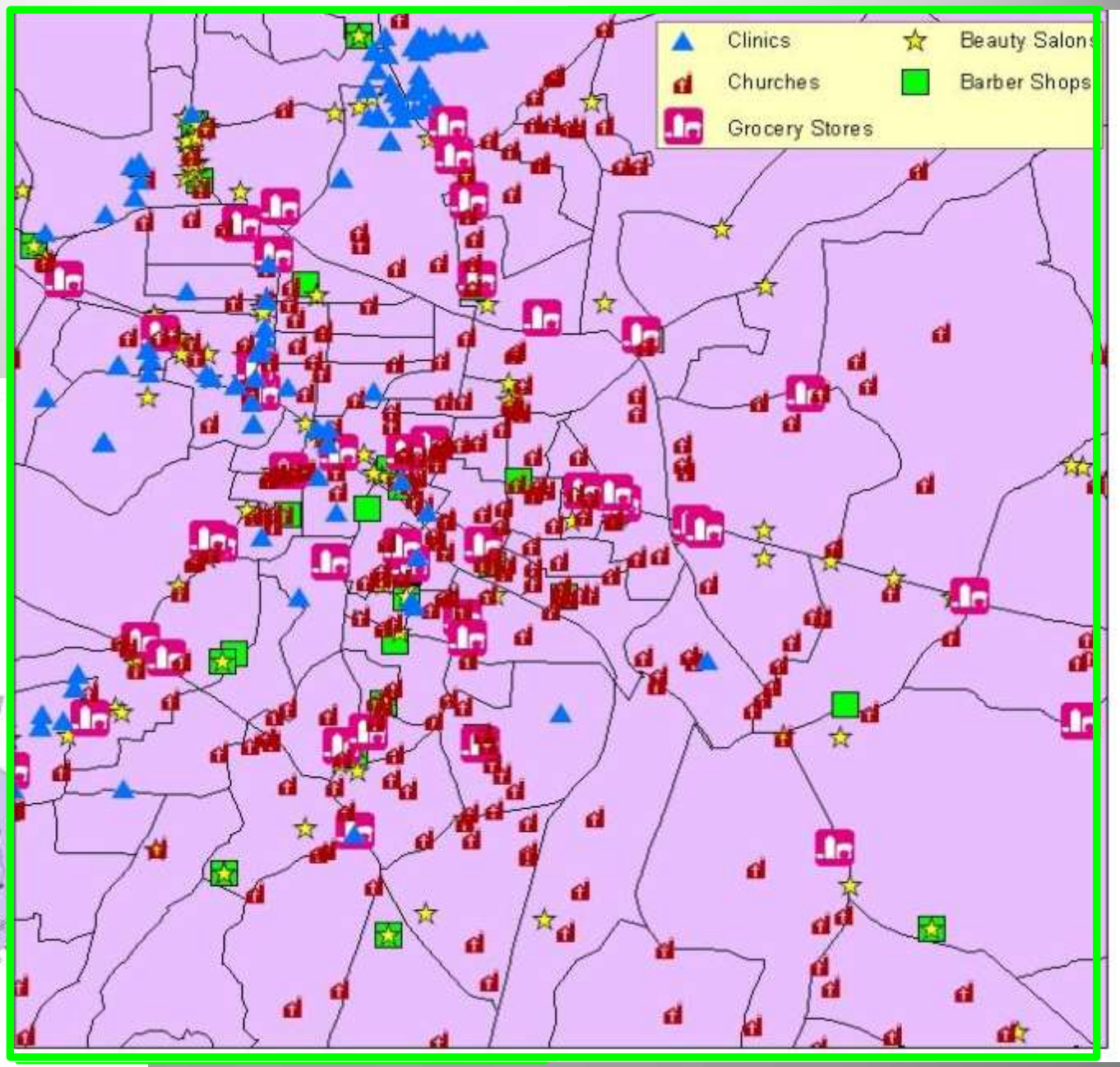
4.5% Hispanic

4.3% Other

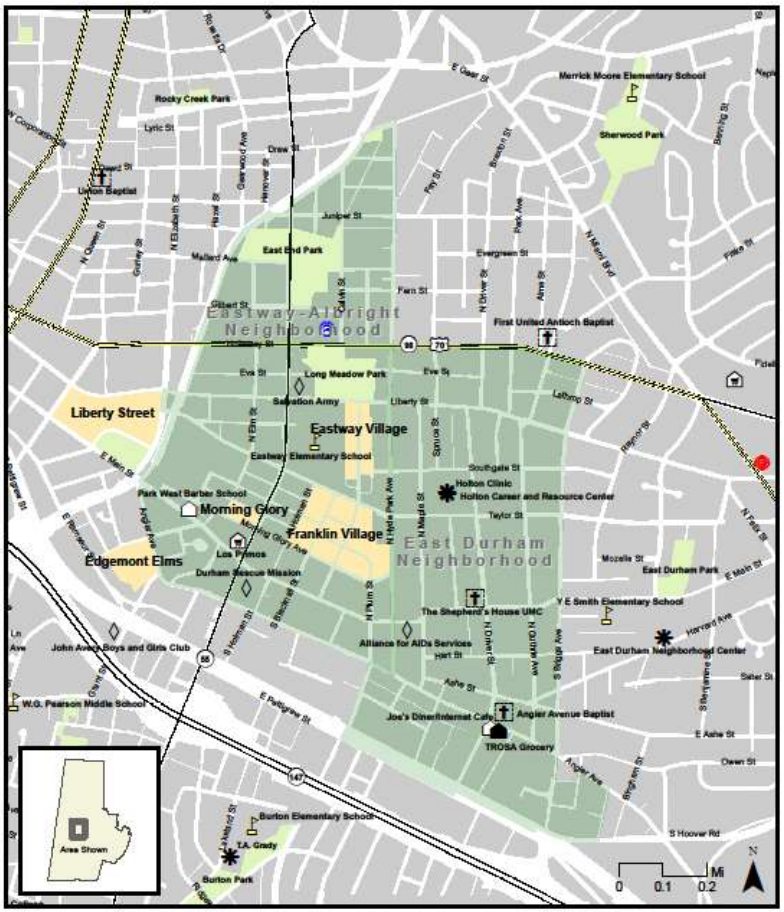
HbA1C < 7 (5817, 54%) 7 < HbA1C < 9 (3279, 30%) HbA1C > 9 (1715, 16%)







Building Health Capacity in Durham Neighborhoods



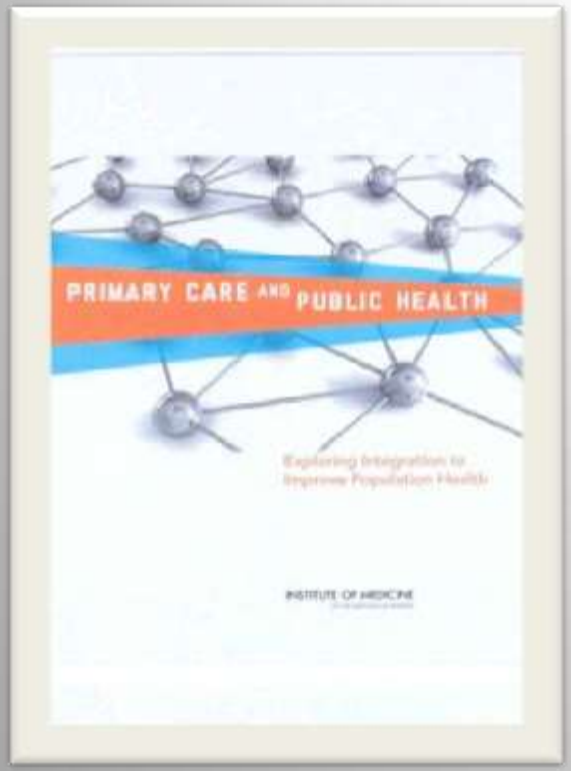
Northeast Central Durham Neighborhood Community Assets

Community/Recreation Center	Grocery	Police Station
Church	Non-Profit	Fire Station
Business	Housing Community	School (K-12)
Multiple		Public Park

DHI teams are connecting community partners and working with neighborhood residents to ensure:

- **Healthy schools and neighborhoods**
- **Safe places to exercise**
- **Access to healthy foods**
- **Access to health information**

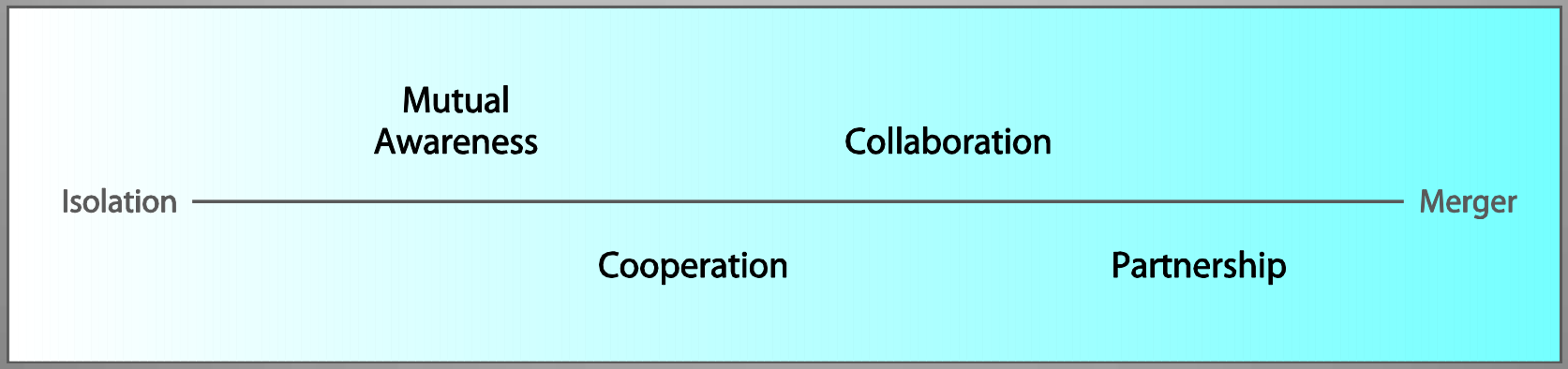
DURHAM Health INNOVATIONS



INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Www.iom.edu/primarycarepublichealth

Degrees of Integration:



Moving Forward the National Strategic Imperative of Health

Health Futures Collaborative Roundtable on Network Leadership, Innovation, And Global Health Engagement

August 13-14, 2013

Community Health Engagement

Strategy Leadership

Identify critical partners needed to be at the table for this to work - NAACHO ASTHO, foundations (NBGH) and employers both as payers and enablers

Make sure communities have the information they need to identify priorities for themselves - identify positive deviance and prioritize what they want to work on

Strategy Innovation

Use research grants and tools to help enable community involvement

Strategy Culture

Focus on children: Healthy food choices (thanks, cookie monster for eating more fruits & veggies); healthy activities; get parents on board

Celebrate and build on the "bright spots" already in the community; those innovative strategies are most likely to succeed

Use the concept of Town Hall - literally or figuratively - to help define health, determine needs; leaders engage and focus on how best to communicate with community

Operations Leadership

Assess: Know what your community assets are - providers, organizations, resources, leaders, community health needs, health strategy.

Develop/Execute: Unified community action plan with all players based on assessment tied to outcomes. Coordination, collaboration, and facilitation. Eliminate unecessary duplication.

Sustain: Require state/federal strategic support; share best practices; identify/develop leaders; re-evaluate action plan/outcomes

Operations Innovation

Create a community health improvement innovation fund/ marketing plan to foster innovation; include a school challenge to involve children and an annual award.

Break down goals/strategy into smaller steps that a community can understand. Allow a regional/local plan based on culture/values and understanding of local health issues.

Provide analytics to community health teams to inform strategies

Create a community collaborative with regional teams/champions to collect best practices and share knowledge; expand regional teams to include a variety of stakeholders.

Operations Culture

Understanding health is local; develop community action plans built WITH communities not FOR them. It's about stakeholder buy-in. Maximize community accepted norms and local leaders

Convene and align; utilize diverse groups to host/frame discussions onagency strengths and weaknesses. Build swim lanes and connect local - state - federal as well as in the private sector

Tactics Leadership

Leaders must be from community: parents, church, employers, school boards, risk takers. There must be network leadership who developed trust with community

Use proactive metrics to assess community stakeholders in order to determine who to engage

Engage business community and show how health improves their bottom line

Tactics Innovation

Education is key - starting early and continuing throughout life. Engage the community at all levels to build and educate on health. Use local sports stars, celebrities to help motivate youth

Incentivize successful ideas and practices, e.g., school competitions with programs like the President's Fitness program. Leverage the media to tell the story of health and healthy communities

Tactics Culture

Cultural change has to start at the community level. Use community advocates (teachers, grandmothers, clergy, colonel's, etc.)

Use what the literature says works: targeted behavior change interventions; social media, etc.

Next steps – define what doctors need to know and do in and with the community

The Population Health Competency Map

Training Levels:

1. **Foundational** — Basic **awareness** of the principles and appreciation for their impact and importance in community health.

2. **Applied** — An intermediate level of learning, enabling **skilled participation** in community-engaged population health activities.

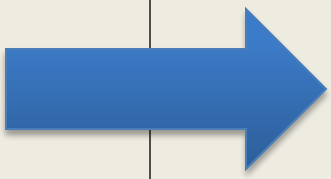
3. **Proficient** — Advanced learners who achieve competence for **independent practice** or leadership of the design and implementation of community-engaged health improvement activities.

Competencies

- Public Health
- Community Engagement
- Critical Thinking
- Team Skills

Competency Map:
Integrating Population Health into Clinician Education

Learners:	medical PA, PT students	FM residents	nurse leaders	FM faculty
Competency:				
Public Health	F			P
Community Engagement	F			P
Critical Thinking	F			P
Team Skills	F			P



F = Foundational (Basic) Awareness

A = Applied (Intermediate) Skilled participation

P = Proficient (Advanced) Independent practice

Public Health

Address the role of socioeconomic, environmental, cultural, and other population-level determinants of health on the health status and health care of individuals and populations

Foundational
Discuss how these factors influence health status and health care delivery

Applied
Discuss potential strategies for addressing population-level determinants of health

Proficient
Collaborate with stakeholders to design and implement strategies to address population-level determinants of health

Community Engagement

Discuss the principles of community engagement and how they contribute to creation of community–academic partnerships	Foundational Recognize the principles of CEnR as defined by the Centers for Disease Control and Prevention (CDC)	Applied Discuss the application of the CEnR principles within a specific community	Proficient Apply the principles of community-engaged research to improve health among diverse populations

Critical Thinking

Assess process and outcome of interventions

Foundational
Discuss different methods of data collection, both qualitative and quantitative

Applied
Critique methods and instruments for collecting valid and reliable quantitative and qualitative data

Proficient
Independently develop a plan for collecting and analyzing new data

Team Skills

Lead interprofessional teams in health improvement

Foundational
Observe and reflect on performance including one's own

Applied
Assess one's own emotional intelligence and develop plans for ongoing self-improvement

Proficient
Lead broad-based teams in developing and implementing community-based health improvement initiatives

Population Health Curriculum

Training levels	Basic	Intermediate	Advanced
Learner types	• All students & residents	• Primary care residents • CFM faculty	• Population Health Fellows & Faculty • CH faculty
Apply strategies that improve the health of populations	• **Discuss potential population-based interventions to improve health**	• **Identify appropriate preventive strategies for a population, based upon literature, data assessment and stakeholder input**	• **Develop and implement population-based prevention strategies in collaboration with community partners**
Learning Method	• Project: design an intervention		
Evaluation	• Assess intervention		

Population Health Curriculum learning methods

- Readings
- Small group discussions
- Access to data sets
- Projects – participate in design and evaluation of projects in the office and in the community

Population Health Curriculum evaluation methods

- Tests along the way
- Project assessment (“final exam”)
- Real test – health improvement in home communities

Population Health Curriculum

The result:

Physicians who can care for their patients in the context of their communities