Population Health: What It Is, What It Is Not, and Where It Is Heading

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Creating an Integrated Child Health System Using a Population Health Perspective

Grantmakers In Health, April 29, 2014
Population health definitions

• Kindig and Stoddart: goal
  – “health outcomes of a group of individuals, including the distribution of such outcomes within the group”
  – IHI: improving the health of populations as one of 3 “Aims” for improving the U.S. healthcare system

• Dunn and Hayes: measurement system
  – “health of a population as measured by health status indicators and as influenced by social, economic and physical environments, … and health services”

• Young: conceptual framework for thinking about
  – why some populations are healthier than others
  – policy development, research agenda, and resource allocation that flow from it
Population health definitions

- Spectrum
  - Concern for health outcomes in populations defined by geography
    - Jacobson and Teutsch: total population health
    - County Health Rankings, NACCHO MAPP, ...
  - Accountability for health outcomes in populations defined by healthcare delivery systems
    - IHI Triple Aim
    - Accountable Care Organizations
    - Population management of chronic disease patients
- ≠ “public health”
  - Less tied to governmental public health departments
  - Explicitly includes the healthcare delivery system
The Health System

(For the Public's Health: The Role of Measurement in Action and Accountability, IOM, 2010)
Commonalities: population health

• Population health more than the sum of individual parts or a cross-sectional perspective
  – upstream factors included in measurement
  – (explicit) goal of reducing disparities and inequities

• Consideration of broader array of health determinants than healthcare or public health
  – IHI Composite model

• Responsibility for population health outcomes is shared but accountability is diffuse

• Measurement of
  – shared responsibility for population health outcomes
  – accountability for activities to improve health
Interventions

Disparities/inequities

IHI Composite Model for Population Health

Upstream Factors

Individual Factors

Intermediate Outcomes

States of Health

Quality of Life

Socio-economic Factors

Physical Environment

Prevention and Health Promotion

Medical Care

Behavioral Factors

Genetic Endowment

Physiologic Factors

Spirituality

Resilience

Disease and Injury

Health and Function

Death

Well-Being

Interventions

Population Health in the ACA

1. Coverage expansions
   - individual mandate, Medicaid expansions, state insurance exchanges, community health centers

2. Quality improvement
   - Center for Medicare and Medicaid Innovation, PCORI

3. Prevention and health promotion measures within the healthcare delivery system
   - ACOs providers responsibility for health outcomes
   - primary health care training
   - No cost-sharing for USPSTF preventive services
   - Medicare annual wellness visit
   - preventive services for children in Medicaid expansion
Population Health in the ACA

4. Community- and population-based activities
   – National Prevention, Health Promotion and Public Health Council - *National Prevention Strategy*
   – Prevention and Public Health Fund ($1 billion in FY 2014)
   – Community Transformation Grants
   – Workplace wellness programs & insurance discounts
   – IRS§505(r) requirements for non-profit hospitals
     • conduct a Community Health Needs Assessment (CHNA) once every 3 years
       – collaborate with health departments & community organizations
       – identify existing health care resources
       – list prioritized health needs
     • implementation plan to address identified priorities
IRS Community health needs assessment (CHNA) requirements

• § 501(r) in IRS code: non-profit hospitals must conduct CHNA once every 3 years
• CHNA = written document developed for a hospital facility including a description of
  – community served by the hospital
  – process and methods used to conduct the assessment including how the hospital took into account input from community members and public health experts
  – identification of any persons with whom the hospital has worked on the assessment
  – existing health care resources within the community available to meet community health needs
  – prioritized health needs identified through the process
IRS Community health needs assessment (CHNA) requirements

- Implementation strategy required to meet the community health needs identified through the CHNA process
- Considered as addressing a health need if the written plan either
  - describes how the hospital plans to meet the health need
  - or identifies the need as one the facility does not intend to meet and explains why
- Must be tailored to the particular hospital, taking into account its specific programs, resources, and priorities
- May be developed in collaboration with other organizations
  - must show the particular activities for the particular hospital covered by the strategy
Collective Impact

LARGE-SCALE SOCIAL CHANGE REQUIRES BROAD CROSS-SECTOR COORDINATION, YET THE SOCIAL SECTOR REMAINS FOCUSED ON THE ISOLATED INTERVENTION OF INDIVIDUAL ORGANIZATIONS.

By John Kania & Mark Kramer

- Common agenda
- Shared measurement systems
- Mutually reinforcing activities
- Continuous communication
- Backbone support organizations

Winter, 2011
Population health is a shared responsibility

- Shared Community Health Needs Assessment (CHNA) focused on health outcomes to identify priorities
- County Health Rankings, etc.
- Standard measures useful for benchmarking
  - changes over time
  - comparisons with similar communities
RWJF County Health Rankings’ model of population health improvement

Health outcomes represent how healthy a county is

Health factors influences the health of the county

Where we may be able to intervene:
- County
- Region
- State
- Nation

County Health Rankings model ©2010 UWPHI
Specific entities in community must be **accountable** for the actions that they can take to improve population health

- Measure entity-specific performance towards community-wide improvement strategy
- CMS ACO Quality-Performance Measures
- Measures for health department, voluntary organizations, etc.
- Consistent measures needed to “roll up” to whole population
Tobacco and health driver diagram

Outcome: ↓ tobacco-related mortality

1° drivers:
- ↓ smoking initiation among youth
- ↑ adult smoking cessation

2° drivers:
- Tobacco curriculum in schools
- Enforcement of tobacco sale to minor laws
- Healthcare provider counseling
- Participation in smoking cessation programs

Structure:
- Local ordinances to control environmental tobacco smoke
- Availability of cessation programs
- Health plan coverage for cessation programs

Effect

Cause
Sample performance indicator set

**Tobacco and health**

- Deaths from tobacco-related conditions
- Smoking-related residential fires
- Prevalence of smoking in adults
- Initiation of smoking among youth
- Ordinances to control ETS *(City council)*
- Local enforcement of laws on tobacco sales to youth *(shopkeepers, police)*
- Tobacco use prevention in school curricula *(school board)*
- Counseling by *health care providers*
- Availability of cessation programs *(local organizations)*
- Health plan coverage for cessation programs *(health plans, employers)*

Shared responsibility
Example: Holy Cross Hospital
Silver Spring, Maryland

Healthy Montgomery priority
- **Obesity**: 50%+ are overweight or obese

Holy Cross Hospital
- **Mission**: Outreach that improves health status and access for underserved, vulnerable populations
- **Strategic priority**: women and infants
- **Response to unmet need through Healthy Montgomery “lenses”**
  - **Lack of access**: Health centers in X, Y, Z locations; Ob/gyn clinic
  - **Unhealthy Behaviors**: Community fitness program: Kids Fit
  - **Health Inequities**: ob/gyn & perinatal obesity in pregnancy programs

- **Sample performance measures**
  - Semi-annual fitness assessments
  - # enrolled in obesity in pregnancy programs