GEORGETOWN UNIVERSITY
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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

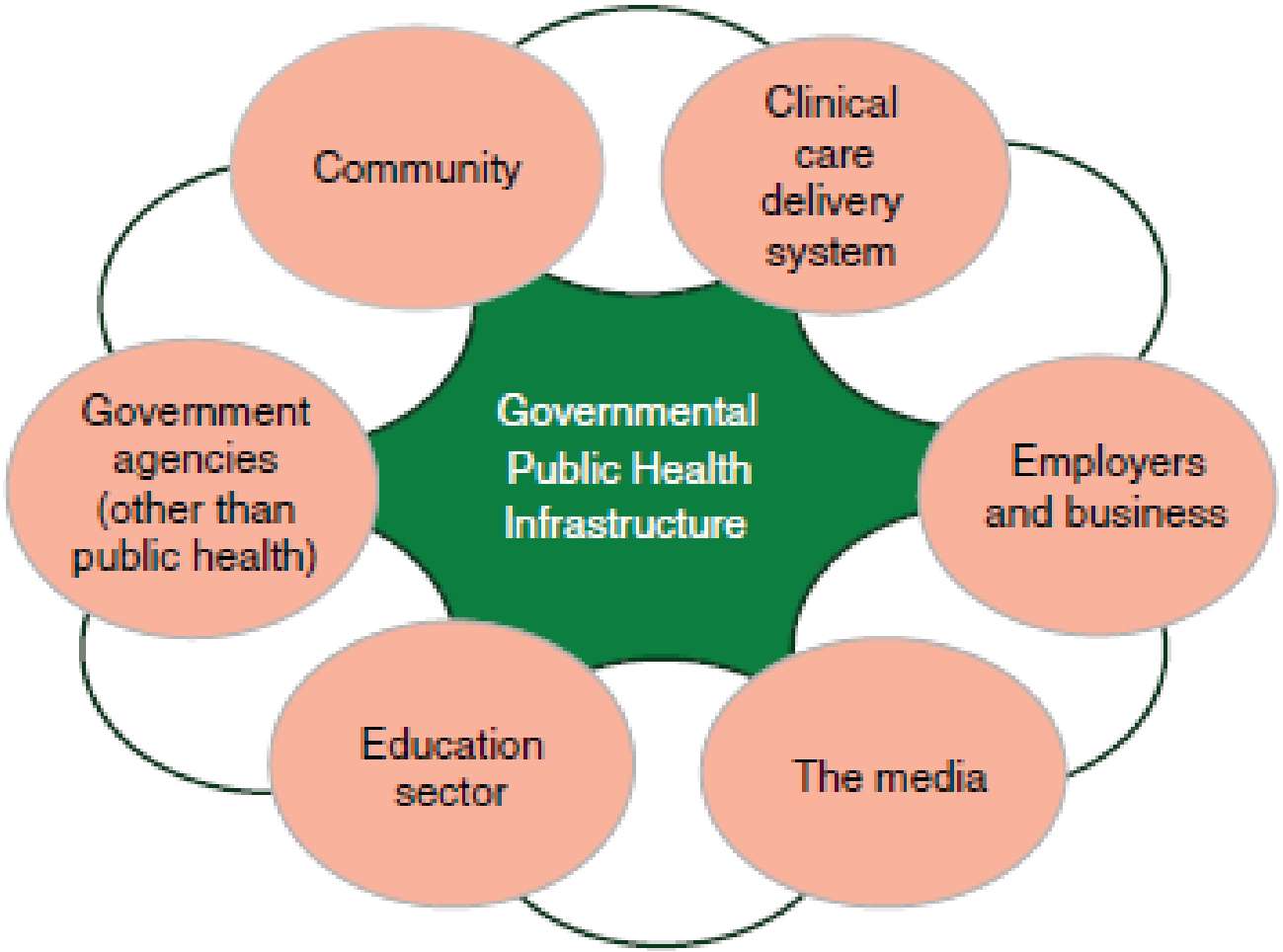
- Kindig and Stoddart: goal
  - "health outcomes of a group of individuals, including the distribution of such outcomes within the group"
  - IHI: improving the health of populations as one of 3 "Aims" for improving the U.S. healthcare system
- Dunn and Hayes: measurement system
  - "health of a population 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

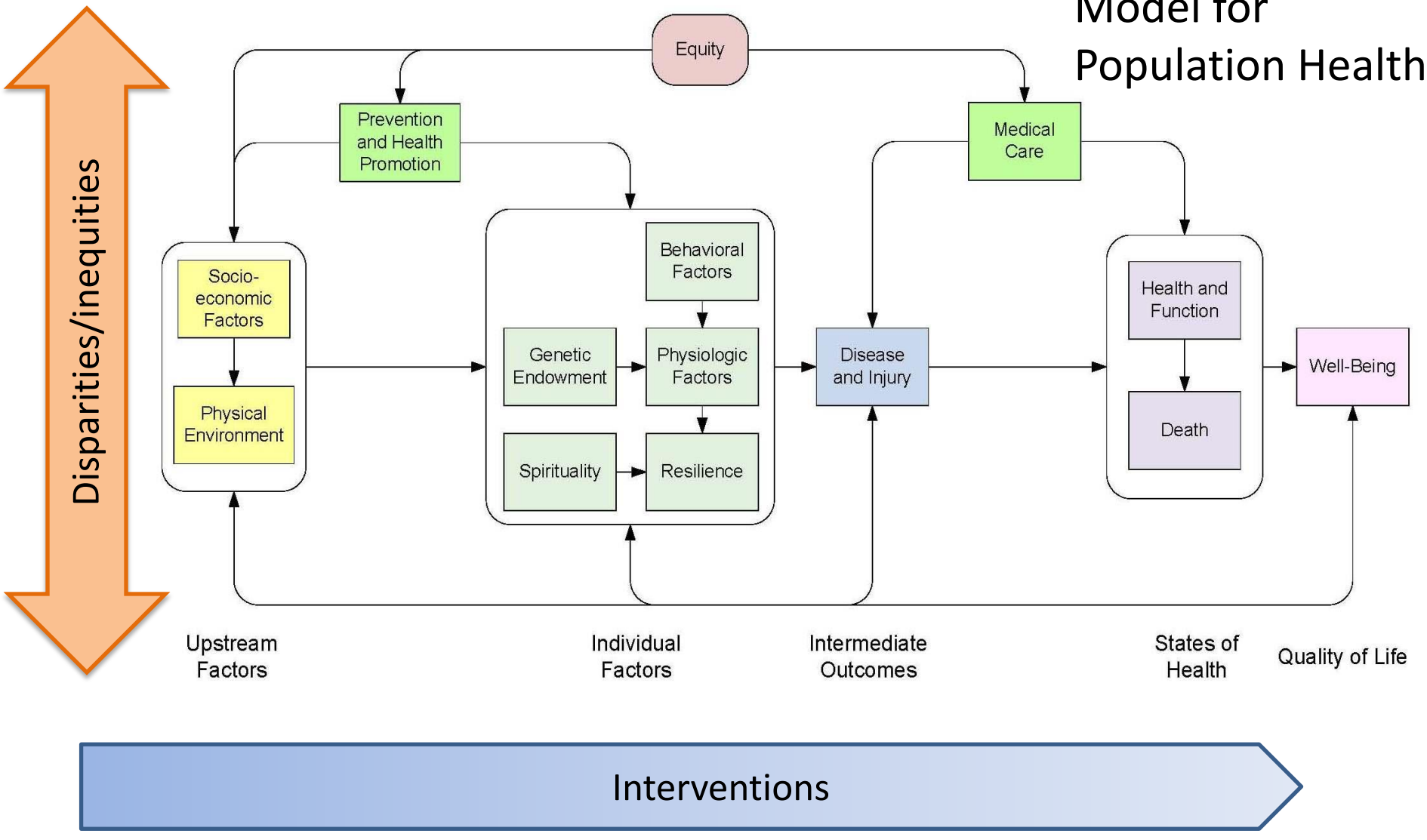
(*For the Public's Health: The Role of Measurement in Action and Accountability*, IOM, 2010)



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

IHI Composite Model for Population Health



Interventions

Source: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

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

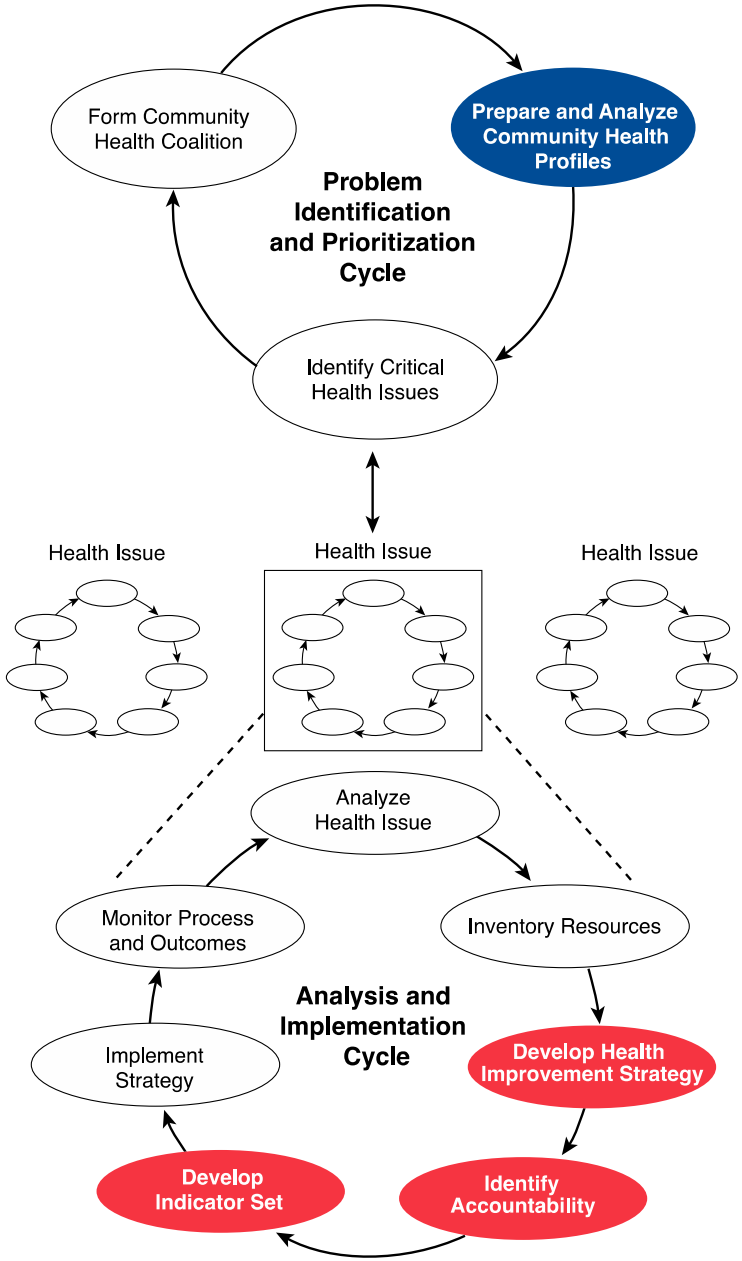
Stanford SOCIAL INNOVATION REVIEW

Winter, 2011

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

Community Health Improvement Process

(*Improving Health in the Community*, IOM, 1997)



Source: adapted from Improving Health in the Community (IOM, 1997)

- 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

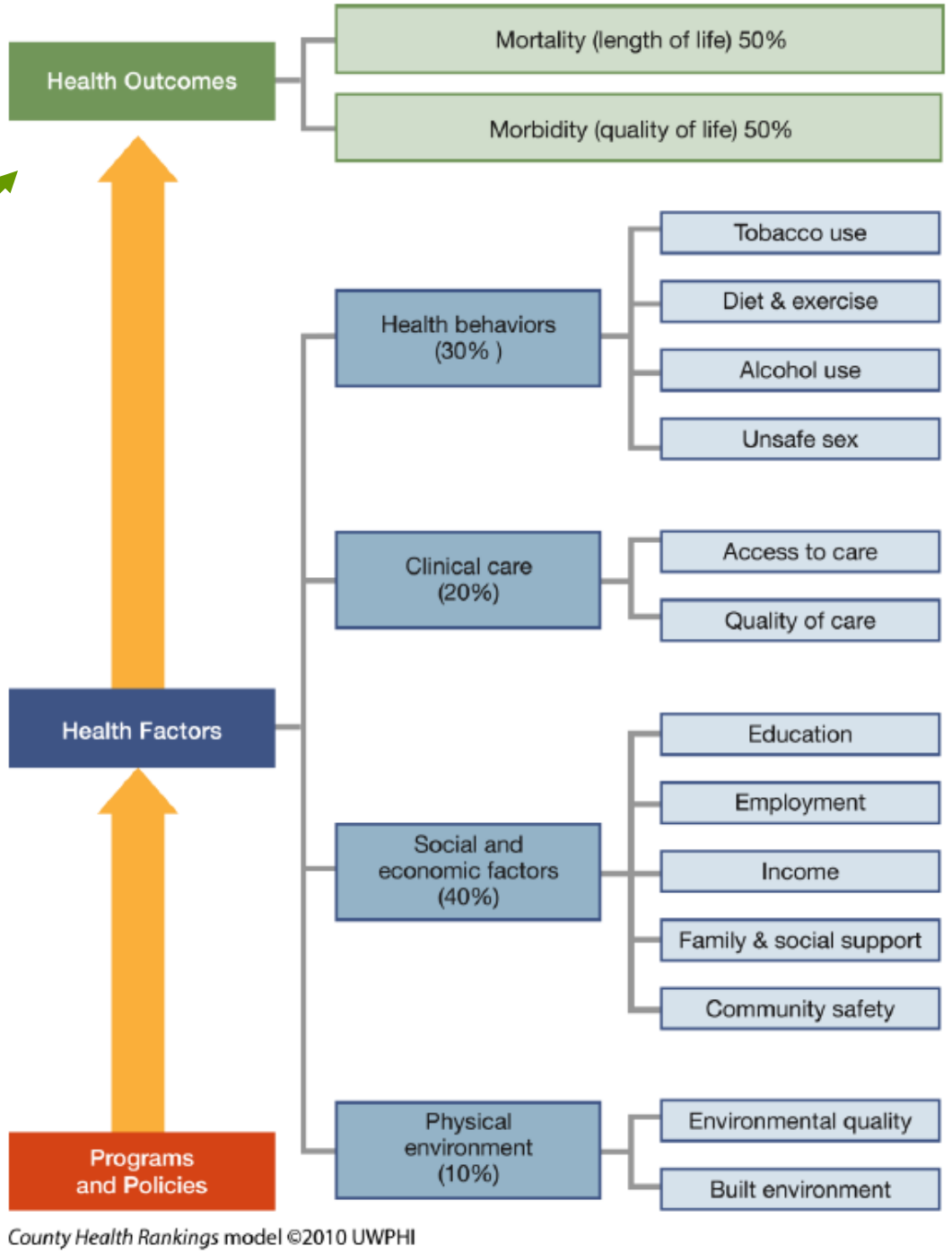
RWJF County Health Rankings' model of population health improvement

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



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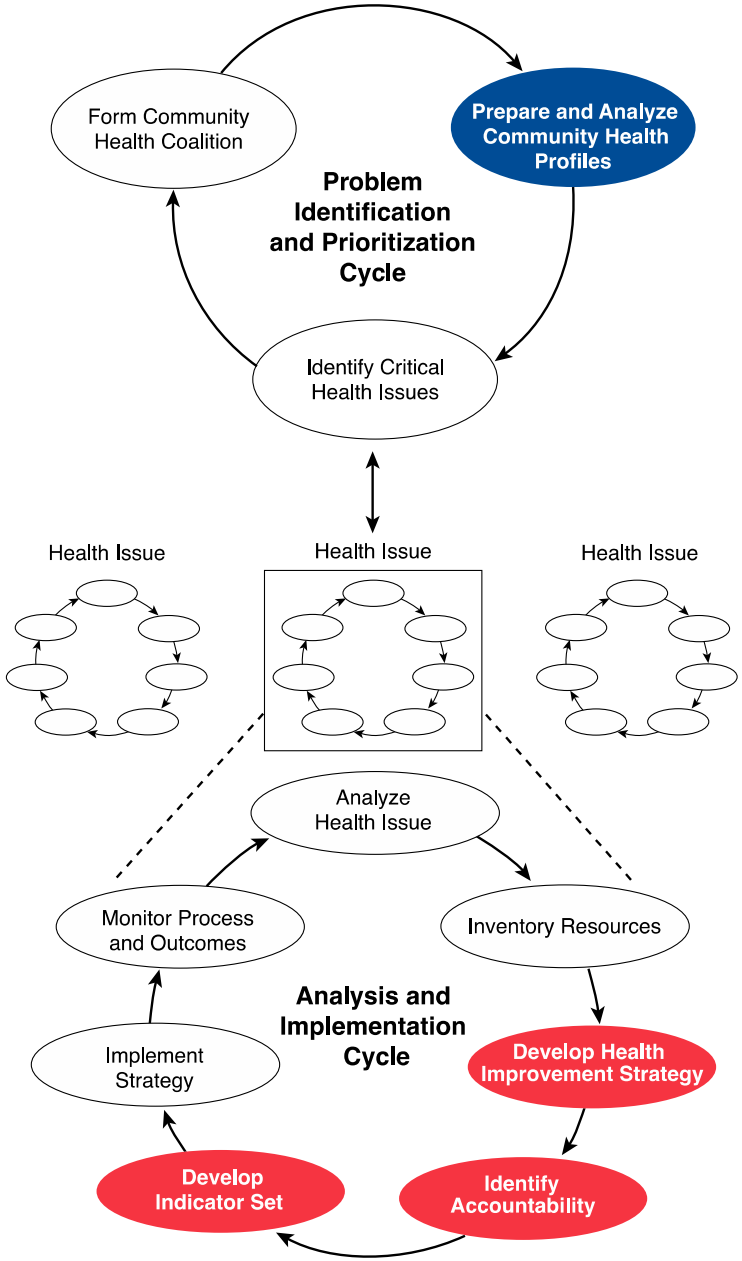

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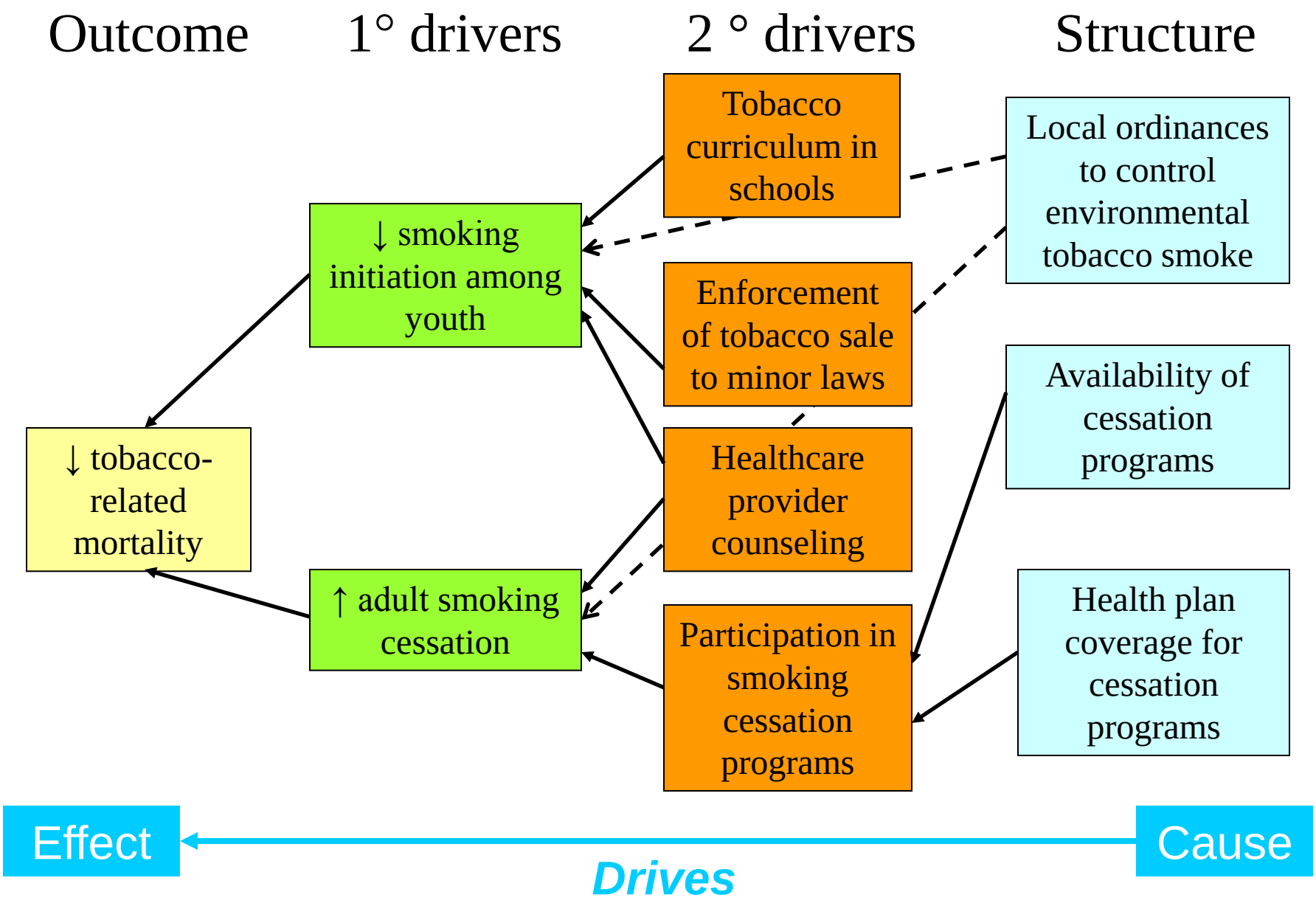
- Specific entities in community must be *accountable* for the *actions* that they can take to improve population health
  - Measure entity-specific performance towards community-wide improvement strategy
  - CMS ACO Quality-Performance Measures
  - Measures for health department, voluntary organizations, etc.
  - Consistent measures needed to "roll up" to whole population

Tobacco and health driver diagram



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

Shared responsibility

- 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)*

Example: Holy Cross Hospital
Silver Spring, Maryland

Figure 2. HCH Four market area

HCH Percent Distribution of Patient Discharges

- Core (42%)
- Northern Prince George's (14%)
- Prince George's Referral (11%)
- Montgomery Referral (16%)

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