Missouri ACP Scientific Meeting

A Novel Prescription for Improving Community and Population Health

Daphne Ayn Bascom, MD, PhD
Vice President, Population Health

Saint Luke’s
HEALTH SYSTEM
Disclosures

• Daphne Ayn Bascom, MD PhD
  – I have no financial disclosure or conflicts of interest with the material presented in this presentation
Thank you...
Learning Objectives

At the conclusion of this lecture you will be able to:

• Articulate the differences between population health and community health
• Understand the concept of practice-based population health
• Critically analyze the impact that the social determinants of health have on health and wellness
• Develop a framework to apply population health to your clinical practice
Don’s Story: The Present
Poll Question

Why is Don a frequent utilizer of the Emergency Department?

• Engagement with a community health worker or community care manager
• Obtain health insurance
• Home assessment
• Engagement with a primary care medical home
• All of the above
Poll Question

What interventions can be applied to help reduce Don’s potentially avoidable utilization?
Public Health

“The science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.”

—CEA Winslow

Population Health

Population Health
The goal of population health is to transform the care delivery model and administrative practices to deliver improved outcomes and lower costs across the continuum of care for a specified population.
Population Health Vision

Patient-centered, integrated care delivery model based on
- Aligned incentives
- Coordinated, collaborative, cross-continuum processes
- Evidence-based prevention and disease management protocols
- Seamless sharing of information

Wellness and continuity of care programs that focus on
- Patient & family engagement
- Community integration & partnerships
- Prevention and health promotion

Powered by data and analytics to support quality outcomes and value-based reimbursement models
The Path from Reactive to Predictive

- **Fee for Service**
  - Visit Dominant, Reactive Model
  - “What brings you in today?”

- **Shared Savings**

- **Bundled Payments**
  - Population Focused
  - “Who is our attributed patient population?”

- **Partial Capitation**

- **Global Payments**
  - Predictive
  - “Who do we need to reach out to avoid poor outcomes?”
Proactive Population Health Management

- Focus on proactive prevention
- Engage patients/participants
- Align health and wellness goals
- Improved access to social support services
- Community partnerships
- Educate, Engage, Empower
Community Health

Community Health
WHAT IS COMMUNITY HEALTH?
A visual summary by Tony Ruth (@lunchbreath) for the Design In Tech Report
What Makes Us Healthy

- Access to Care: 10%
- Genetics: 20%
- Environment: 20%
- Healthy Behaviors: 50%

What We Spend On Being Healthy

- 88% Medical Services
- Healthy Behaviors: 4%
- Other: 8%

Source: Bipartisan Policy Center - What Makes Us Healthy vs. What We Spend on Being Healthy
Spending on...

- Healthy Behaviors: 88%
- Other: 8%
- Medical Services: 4%

Should be spending on...

- Delivery of Care: 50%
- Environment: 20%
- Human Behaviors: 20%
- Genetics: 10%
Poll Question

What are the four determinants of health?

• Genes and biology
• Health behaviors
• Social/societal characteristics
• Health services or medical care
• All of the above
State of Obesity in America

**Pediatrics**

- For children and adolescents aged 2-19 years (2015 – 2016)
- The prevalence of obesity was 18.5% and affected about 13.7 million children and adolescents.
- Obesity prevalence was 13.9% among 2- to 5-year-olds, 18.4% among 6- to 11-year-olds, and 20.6% among 12- to 19-year-olds.
- Hispanics (25.8%) and non-Hispanic blacks (22.0%) had higher obesity prevalence than non-Hispanic whites (14.1%).
- Non-Hispanic Asians (11.0%) had lower obesity prevalence than non-Hispanic blacks and Hispanics.

**Adults**

- The prevalence of obesity was 42.4% in 2017~2018.
- From 1999–2000 through 2017–2018, the prevalence of obesity increased from 30.5% to 42.4%, and the prevalence of severe obesity increased from 4.7% to 9.2%.
- The estimated annual medical cost of obesity in the United States was $147 billion in 2008 US dollars; the medical cost for people who have obesity was $1,429 higher than those of normal weight.
- Non-Hispanic blacks (49.6%) had the highest age-adjusted prevalence of obesity, followed by Hispanics (44.8%), non-Hispanic whites (42.2%) and non-Hispanic Asians (17.4%).
Prevalence of Self-Reported Physical Inactivity* Among US Adults by State and Territory, BRFSS, 2015–2018
Obesity Related Healthcare Costs

NATIONAL COST OF OBESITY

- **$315.8 BILLION**: Estimated cost of annual obesity-related healthcare
- **42%**: How much more healthcare costs for individuals affected by obesity
- **$14.1 BILLION**: The direct costs caused by childhood obesity
- **$4.3 BILLION**: Nationwide annual costs due to obesity-related absenteeism

- **2014**: $23.9 billion
- **2050**: $50 billion
Maximizing the Impact of Obesity-Prevention Strategies

- Focus on health, not just weight
- Income
- Stable and affordable housing
- Access to quality education
- Access to affordable healthy food
- Transportation
- Health literacy and health education
- Reduce exposure to marketing of less nutritious foods
- Access to safe places to be physically active
- Promotion of physical activity and health eating in school programs
- Developing partnerships and sustainable programs
Don’s Story: The Future

- Don was referred to the community care coordination team due to frequent ED admissions and multiple social factors impacting his health.
- During in-home visits the community care manager discovered many addressable barriers to good health.
- Several community services were initiated and applications for long-term assistance programs were successfully completed.
- The community care manager helped Don find a PCP and cardiologist.
- The community care manager worked closely with the high-risk care coordination team to ensure that he was able to keep his appointments.
- Now more than 120 days post referral, Don has not returned to the hospital nor experienced a fall. He now has a network of community support and can continue to thrive independently at home.
Poll Question

What was the key factor to the improvement in Don’s health?

- Health insurance
- Improved health literacy
- Access to a community health worker
- All of the above
A pandemic reinforced our belief in population health

The disproportionate impact of the pandemic on the underserved, Black Americans, Latinos, and those with chronic conditions requires an industry-wide foundational response.

By ESTEBAN LOPEZ AND DR. SANJAY DODDAMANI
Global Pandemics

SOCIAL JUSTICE  
CHRONIC DISEASE  
GLOBAL HEALTH & ENVIRONMENT
Summary Definition of Population Health

“Strategies that link clinical and non-clinical approaches (such as housing or access to food) for improving the health of a group of individuals, including the distribution of such outcomes within the group. These groups can be geographically defined (e.g., zip code or city) or they may share some characteristics (such as age or income level).”

Source: Summary of the definitions developed by Kindig D, & Stoddart G (2003) and the American Hospital Association
Whole Person Health and Wellness

The Right Care, The Right Time, The Right Place, The Right Cost

Patient Centered, Integrated, Coordinated
Focused on Primary, Secondary and Tertiary Prevention

Primary Care

Virtual Care

Specialty Care

Inpatient Care

Ambulatory Care

Community Services

Home-Based Care
Population Health Management Strategy

Advanced Patient Engagement
- Patient Portal
- Virtual Care
- Remote Monitoring

Care Management and Care Coordination
- Transitions of Care
- Longitudinal Care Management
- Longitudinal Pharmacy Management
- Chronic Condition Management
- SDoH Screening and Intervention
- Community Health Workers

Reporting and Analytics
- Data Aggregation and Analysis
- Quality Outcomes Monitoring
- Predictive Analytics

Financial Analytics
- Risk Stratification
- Total Cost of Care
- Utilization (Admits, ED Visits)
- Episodes of Care

Health and Wellness Workflow
- Pre-visit planning
- Gaps in care outreach
- Community based access