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

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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
Obesity Trends* Among U.S. Adults
(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)

Source: CDC Behavioral Risk Factor Surveillance System
Disease Burden / Practice Patterns Vary

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


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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%)
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
Degrees of Integration:

Isolation — Mutual Awareness — Collaboration — Merger

Cooperation — Partnership
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

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

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.

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

<table>
<thead>
<tr>
<th>Learners:</th>
<th>medical PA, PT students</th>
<th>FM residents</th>
<th>nurse leaders</th>
<th>FM faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>F</td>
<td>F</td>
<td></td>
<td>P</td>
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<tr>
<td>Community Engagement</td>
<td>F</td>
<td>F</td>
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<td>P</td>
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<tr>
<td>Critical Thinking</td>
<td>F</td>
<td>F</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td>Team Skills</td>
<td>F</td>
<td>F</td>
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<td>P</td>
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</tbody>
</table>

F = Foundational (Basic) Awareness  
A = Applied (Intermediate) Skilled participation  
P = Proficient (Advanced) Independent practice
<table>
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<tr>
<th>Public Health</th>
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</thead>
<tbody>
<tr>
<td><strong>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</strong></td>
</tr>
<tr>
<td><strong>Foundational</strong> Discuss how these factors influence health status and health care delivery</td>
</tr>
<tr>
<td><strong>Applied</strong> Discuss potential strategies for addressing population-level determinants of health</td>
</tr>
<tr>
<td><strong>Proficient</strong> Collaborate with stakeholders to design and implement strategies to address population-level determinants of health</td>
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</table>
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

<table>
<thead>
<tr>
<th>Training levels</th>
<th>Basic</th>
<th>Intermediate</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learner types</td>
<td>• All students &amp; residents</td>
<td>• Primary care residents • CFM faculty</td>
<td>• Population Health Fellows &amp; Faculty • CH faculty</td>
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</tbody>
</table>

### Apply strategies that improve the health of populations

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</thead>
<tbody>
<tr>
<td>• Discuss potential population-based interventions to improve health</td>
<td>• Identify appropriate preventive strategies for a population, based upon literature, data assessment and stakeholder input</td>
<td>• Develop and implement population-based prevention strategies in collaboration with community partners</td>
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### Learning Method

<table>
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<th>Training levels</th>
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<th>Intermediate</th>
<th>Advanced</th>
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</thead>
<tbody>
<tr>
<td>• Project: design an intervention</td>
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### Evaluation

<table>
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<tr>
<td>• Assess intervention</td>
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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