Population Health
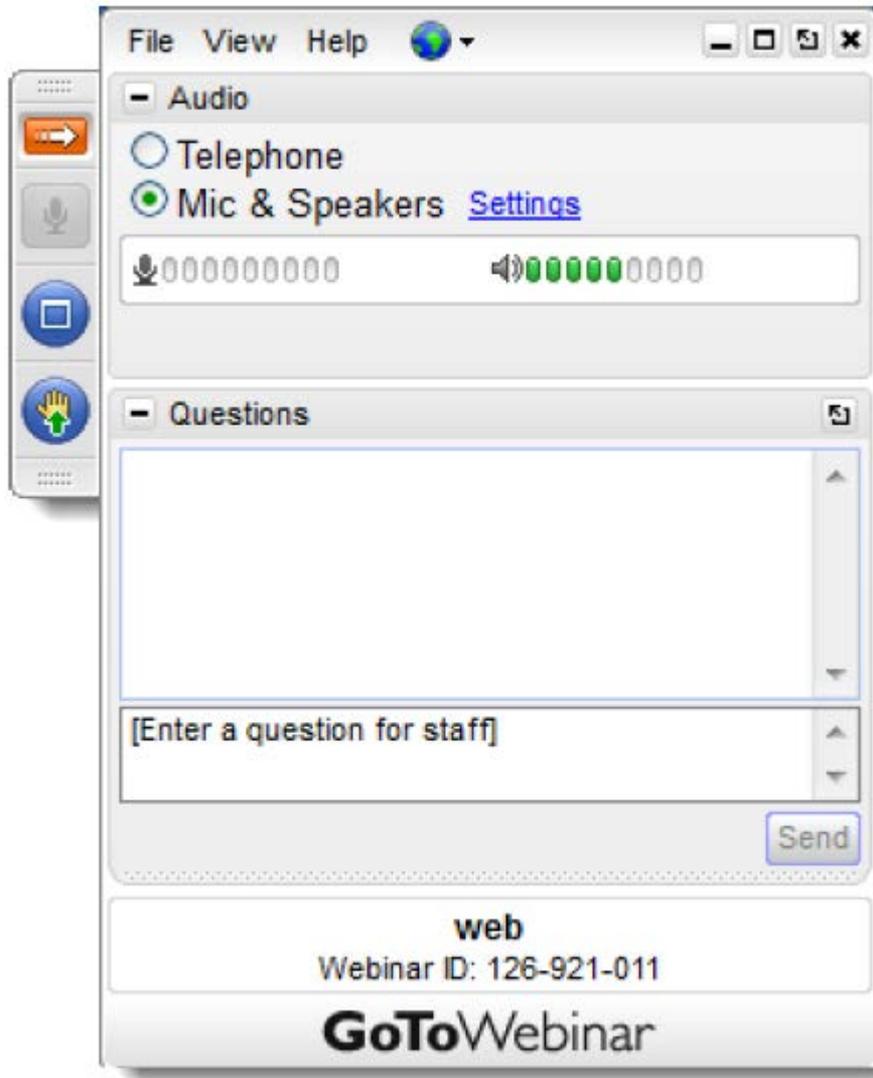
Basic Definitions and Frameworks to Inform Health Care Innovation and Reform Strategies

February 2016

VHCIP Webinar Series

Vermont Health Care Innovation Project

Before we get started…

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Before we get started…

- **We've reserved time for Q&A at the end of this event.** Submit questions via Questions pane in webinar control panel.

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- **Please complete our brief evaluation survey** at the end of the event. We value your feedback!

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Speakers

- <u>Moderator</u>: Georgia Maheras, Director, Vermont Health Care Innovation Project (VHCIP), and Deputy Director of Health Care Reform for Payment and Delivery System Reform, Agency of Administration

- <u>Speaker</u>: Heidi Klein, Director of Health Surveillance, Vermont Department of Health, and Staff, VHCIP

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Agenda

- Defining: Health and Population Health

- Sharing: Strategies for Intervention

- Q&A

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What is Health?

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

- SOURCE: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

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What is Population Health?

- **Health Care Providers**
  - Managing the health outcomes of the patients in their practice

- **Health Insurers/Payers**
  - Managing the clinical outcomes of enrolled patients and attributed lives

- **Community**
  - People who live in a geographic area

Community

Attributed lives

patients

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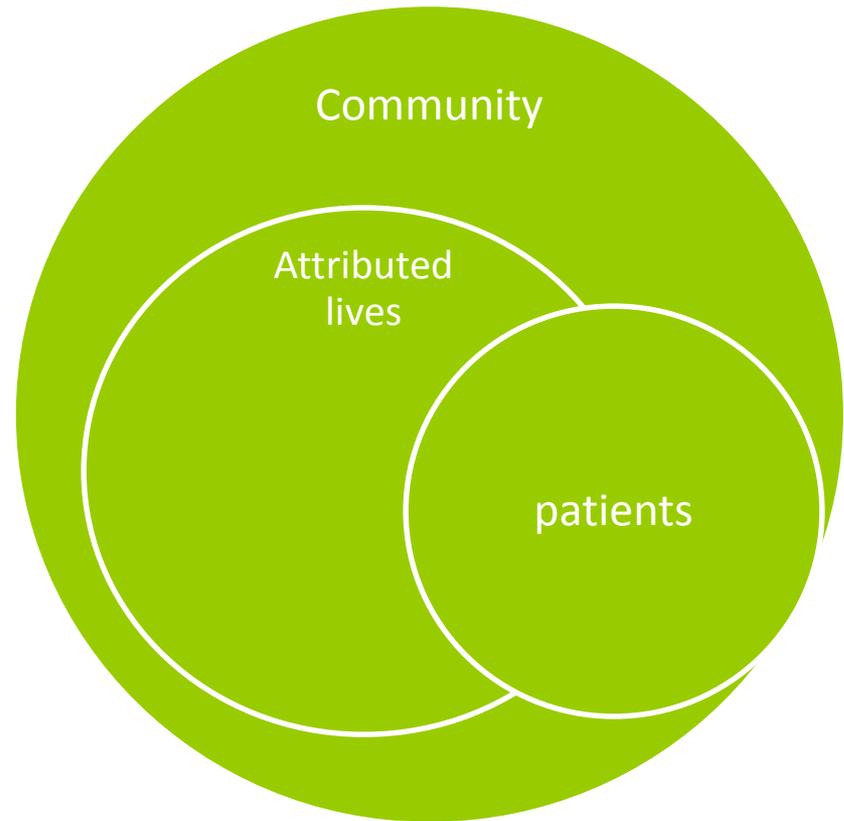
Population Health Defined

The health outcomes (morbidity mortality, quality of life) of a group of individuals, including the distribution of such outcomes within the group.

Determinants of Health

Genetics 30%

Social Circumstances 15%

Environmental Exposure 5%

Health Care 10%

Behavioral Patterns 40%

Health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.
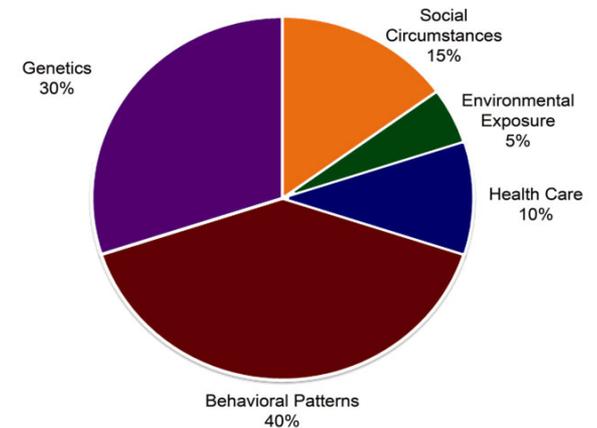
Institute of Medicine, Roundtable on Population Health Improvement

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Population Health

Focus on broader population and health outcomes

Consider the health outcomes of a group of individuals, *including the distribution of such outcomes within the group*, in order to develop priorities and target action.

Focus on prevention and wellness by patient, physician and system

Focus on actions taken to maintain wellness rather than solely on identifying and treating disease and illness.

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Population Health, Continued

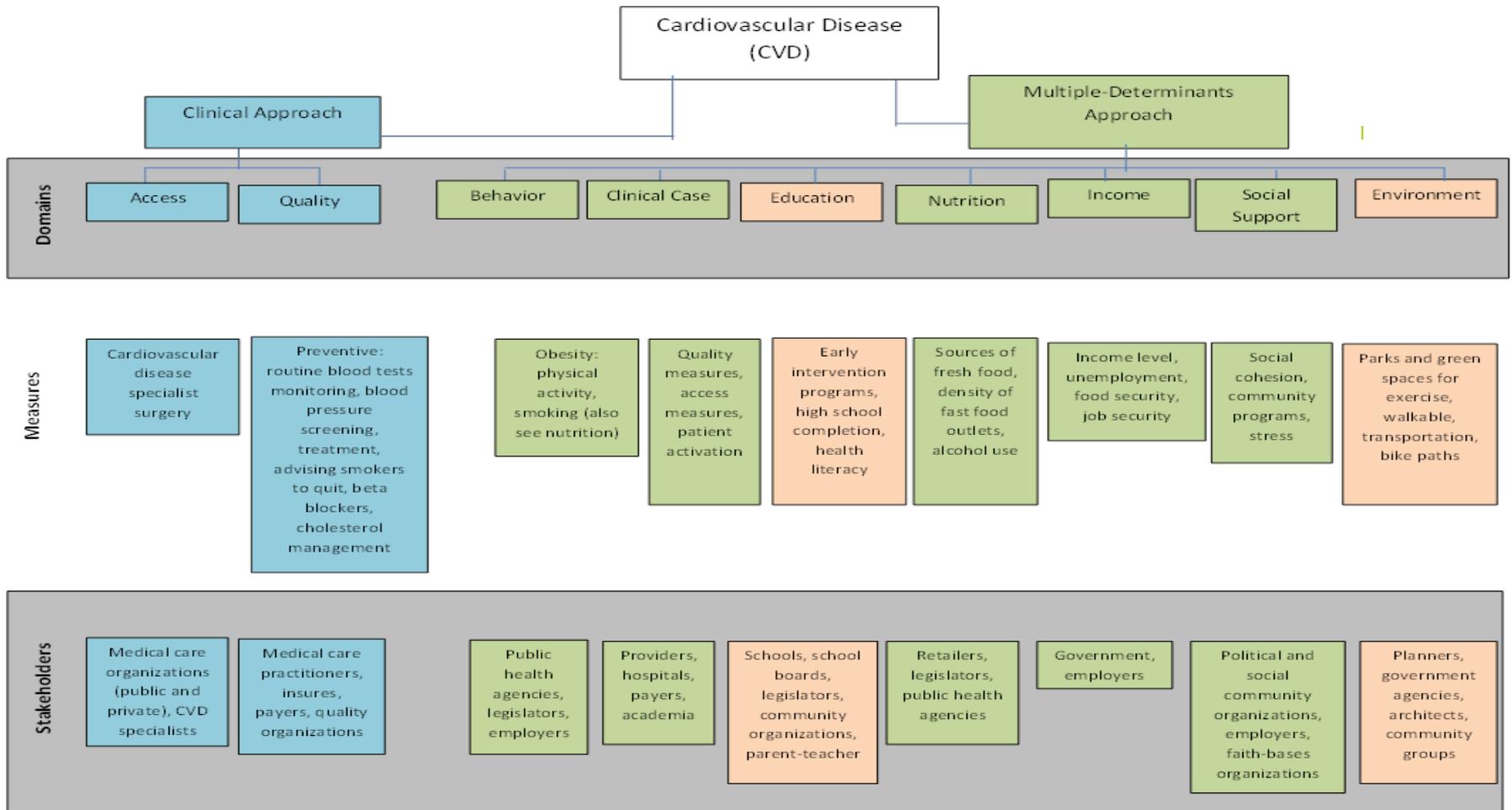**Focus upstream to include risk and protective factors**

Risk factors: Lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes.
Protective factors: Enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk.

Link to social determinants and environmental factors

The circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics .
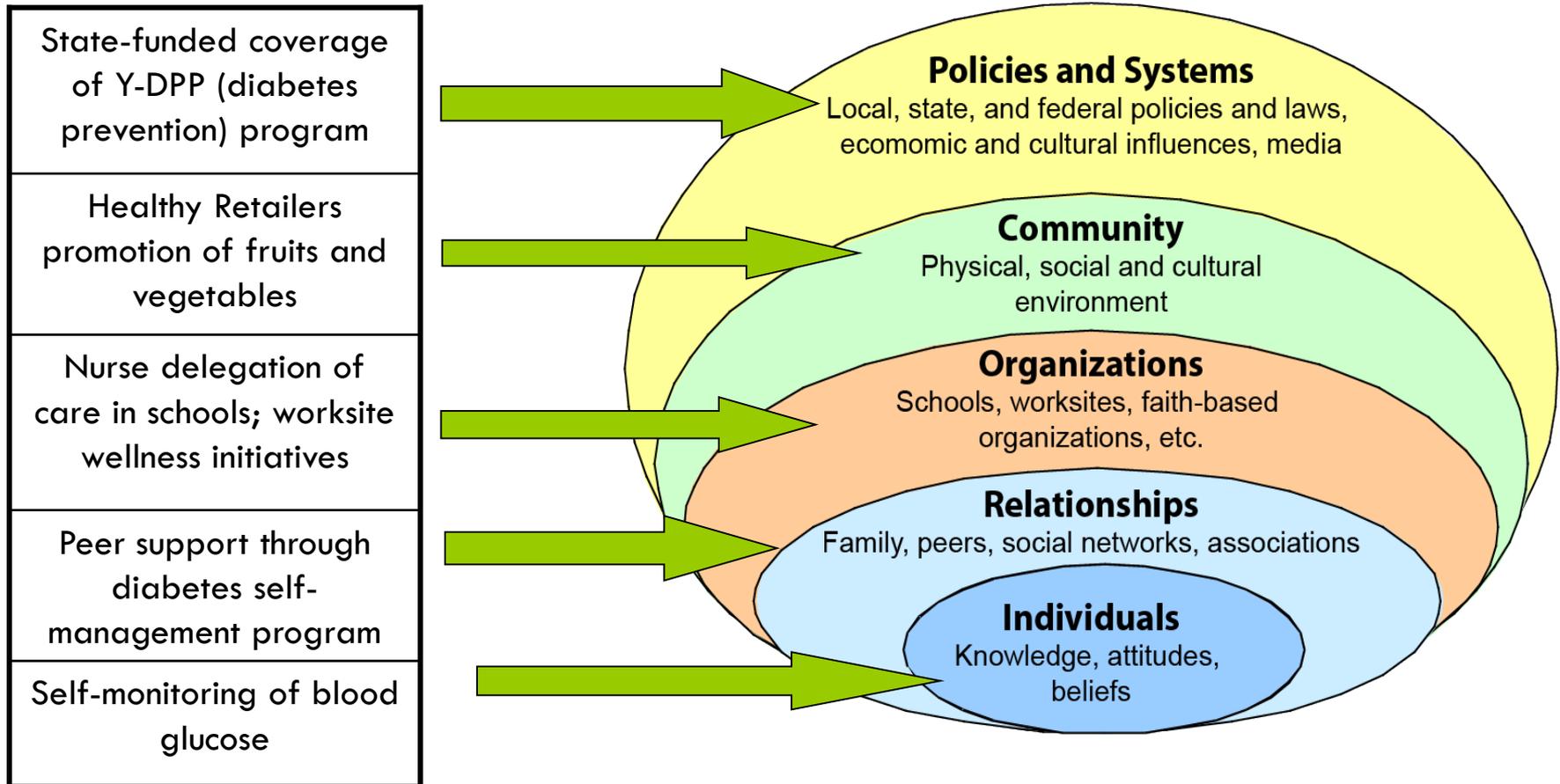
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Multiple Determinant Approach

Page 40, Chart 2-1b

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Population Health Strategies

Vermont Prevention Model

State-funded coverage of Y-DPP (diabetes prevention) program

Healthy Retailers promotion of fruits and vegetables

Nurse delegation of care in schools; worksite wellness initiatives

Peer support through diabetes self-management program

Self-monitoring of blood glucose

Policies and Systems
Local, state, and federal policies and laws, ecomomic and cultural influences, media

Community
Physical, social and cultural environment

Organizations
Schools, worksites, faith-based organizations, etc.

Relationships
Family, peers, social networks, associations

Individuals
Knowledge, attitudes, beliefs

Source: Vermont Department of Health

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Population Health Strategies

- **Traditional Clinical Approaches** focus on individual health improvement for patients who use their provider-based services

- **Innovative Patient-Centered Care and/or Community Linkages** include community services for individual patients

- **Community-Wide** strategies focus on improving health of the overall population or subpopulations

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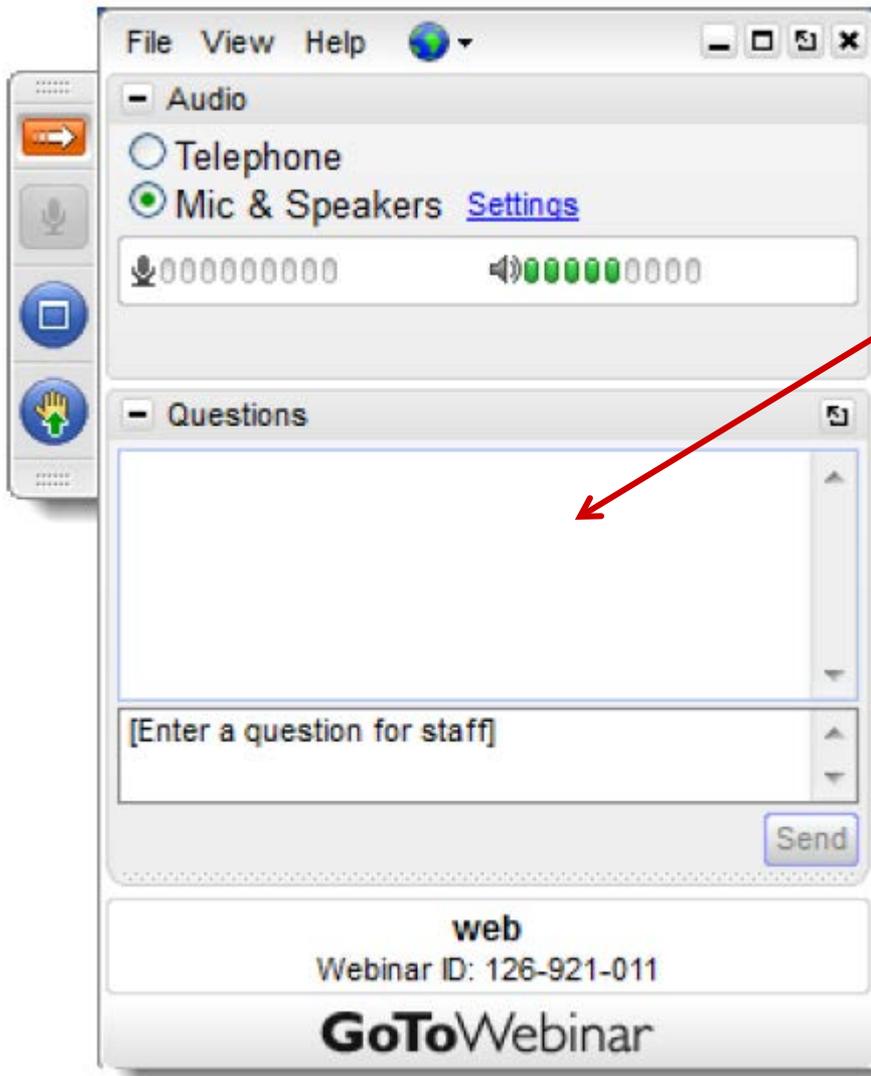# Strategies to Improve Developmental Screening Rates

The following table highlights evidence-based strategies and best practices to improve developmental screening rates in clinical and community settings.

<u>ACO Measure</u>: **Core-8 (NCQA HEDIS): Developmental Screening in the First Three Years of Life**
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life, that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Strategies
Patient education & tools • Adopt *Bright Futures* (i.e. pre-visit questionnaires, documentation, education handouts) • Educate families on developmental milestones • Establish a multidisciplinary team within your practice to implement universal developmental screening **Validated screening tool and protocol** • Review and identify a primary structured, validated developmental screening tool • Implement structured developmental screening using a validated tool at the 9, 18 and 30 month well visits • Implement developmental screening at other visits **Training and roles** • Ensure practitioners and staff are trained on accurate administration of screening tool • Identify and assign roles/responsibilities across the practice	**Parent/Family resources** • Increase parental education on early child development • Provide parents/caregivers with 2-1-1- phone number and encourage outreach to *Help Me Grow* (HMG) • Provide informational materials customized for specific audiences to increase knowledge of HMG resources • Provide information on community-based resources and education in support of early childhood development (e.g. parenting classes, library services) **Partnership building/referral resources** • Promote educational resources and materials with providers and partners (e.g. *Bright Futures*, Learn the Signs Act Early) • Outreach to community stakeholders (e.g. early care and education providers, CIS, schools) • Identify appropriate referral resources and capacity	**Help Me Grow** • Enhance utilization of *Help Me Grow* (HMG) by providers, families, and community resources • Collect feedback from HMG community stakeholders and families to improve service delivery **Quality improvement** • Integrate QI activities in support of universal developmental screening (i.e. medical home, early care and education, Unified Community Collaboratives) • Connect providers (medical home and early care and education) to VCHIP-supported quality improvement activities • Spread VCHIP's early care and education learning collaboratives by adding new regions each year **Improvements to the system of care** • Strengthen referral and evaluation systems at the community-level • Build relationships to improve communication and collaboration around referrals • Conduct a community-level gap analysis and needs assessment to identify levers to enhance the system of care

Revised 12/9/15

Questions?

- Enter questions in Questions pane of GoToWebinar control panel.

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Thank you!

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