Welcome!

• Today you will hear a presentation and have the opportunity to ask questions

• Find resources and materials at: nyspreventschronicdisease.com

• Today’s session is being recorded

Webinar Guidelines

• Please designate one person at the computer
• Adobe Features you will use today:
  • Chat Box
Evaluations
Nursing Contact Hours, CME and CHES credits are available
Please visit nyspreventschronicdisease.com to fill out your evaluation and complete the post-test

Conflict of Interest & Disclosure Statements
The planners and presenters do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity.

No commercial funding has been accepted for this activity.

Learning Objectives
By the completion of this session, the learner will be able to:

• Identify at least one new role in population health that health insurers and health systems did not have prior to the implementation of the ACA

• Describe at least two requirements for success in population health efforts

• Recall an example of population health efforts in New York State
Population Health – Why It Matters

Presented by Margaret Casey, RN MPH, Director, Bureau of Community Chronic Disease Prevention, NYS DOH

Driving Toward Population Health

Demand Forces:
- Aging population
- Population diversity
- Increasing life expectancy
- Rising chronic disease rates
- Increasing number of insured seeking care
- Gap in physician supply and demand

Performance Forces:
- Technological advances
- Emphasis on evidence-based care and prevention
- Shift to outpatient care
- Change to value-based payment
- Shared risk structures with payers

Leading Causes of Death, NYS, 2000 - 2011

Rates are age-adjusted to the 2000 U.S. population
Almost Half Of All Deaths Are Attributable To Modifiable Behaviors

Estimated number of deaths due to modifiable behaviors, NY State, 2013

Almost Half Of All Deaths Are Attributable To Modifiable Behaviors

Source: Estimates were extrapolated using the results published in: "Actual Causes of Death in the United States, 2000", JAMA, March 2004, 291 (10) and NYS 2013 death data

What Determines Health?
Proportional Contribution to Premature Death

Determinants of Health and Their Condition, Adapted from McGinnis et al

Health Impact Pyramid Framework for Improving Health

The Public Health System

Assuring the conditions for public health

Adapted from: The Future of the Public’s Health in the 21st Century. IOM 2003

Population Health – What It Means

Definitions of Population Health

Although the term Population Health started in Canada, its definition was never formalized. Variations include:

1. Common focus on trying to understand the determinants of health of populations
2. Maintain and improve the health of the entire population and reduce inequalities
3. Increased focus on health outcomes as opposed to inputs, processes and products

Definitions of Population Health

The Institute for Healthcare Improvement emphasizes the role of healthcare organizations in population health via the Triple Aim:

- Improving the patient experience of care, including quality and satisfaction
- Reducing the per capita cost of care
- Improving the health of populations


Definitions of Population Health

As defined by the Health Research & Educational Trust, population health management provides a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

- The distribution of specific health statuses and outcomes within a population;
- Factors that cause the present outcomes distribution; and
- Interventions that may modify the factors to improve health outcomes


Definitions of Population Health

The Institute of Medicine uses Kindig and Stoddard's definition:

"the health outcomes of a group of individuals, including the distribution of such outcomes within the group"

Population Health Perspective

Every definition requires attention to the influencers of the health of a community:

- Education
- Income
- Housing
- Safety
- Clean water and air
- Healthy food and places to be active
- Friendship and community support
- Affordable, quality mental and physical care
- And more...

Population Health Model


Population Health and Public Health

Differences and Similarities

<table>
<thead>
<tr>
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<th>Population Health</th>
<th>Public Health</th>
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<tr>
<td>Conceptual Framework</td>
<td>Focus on health outcomes of a group of individuals, including distribution of outcomes within the group</td>
<td>Focus on health outcomes of a group of individuals, including distribution of outcomes within the group</td>
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<td>Health of a population influenced by social, economic and physical determinants of health</td>
<td>Health of a population influenced by social, economic and physical determinants of health</td>
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<td>Inclusive of medical care and insurance providers</td>
<td>Medical care and insurance often seen as partners to public health efforts</td>
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<td>Increased emphasis on estimation of cross-sectional cost-effectiveness to drive investments in health activities</td>
<td>Resources, investments and cost-effectiveness should drive prioritization of public health expenditure and activities</td>
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<td>Not mutually exclusive, but different ways to think about ensuring the nation’s health</td>
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Differences Between Population Health and Population Medicine

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<th>Population Health Medicine/Management</th>
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<tr>
<td>Refers to the health of the total population in a geopolitical area or the health of subpopulations of at-risk persons to whom health improvement strategies are targeted.</td>
<td>Within the clinical care system, more narrowly defined as either persons using a clinical care facility within a designated period of time, members of an insurance plan, or individuals receiving care for a specific diagnosis.</td>
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<td>Addresses ALL the factors influencing health, including socioeconomic, environmental and behavioral.</td>
<td>Particular responsibility to improve meaningful health outcomes for those in their care and for society at large.</td>
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Overarching Goal

Population health sits at the junction of clinicians caring for individuals and public health practitioners working with communities, but they share the same goal – long, healthy lives for all.


Population Health – Strategies
Requirements for Success

- Partnerships
- Appropriate goals
- Data to help determine goals and to measure baselines, processes and outcomes
- Cultural competence

Partners

- Physicians and other clinicians
- Hospitals and health systems
- Payers – commercial and government
- Employers
- Public health agencies
- Social and community services
- Local, state and federal policy makers
- Educational institutions

Patients, Families and Community

Appropriate Goals

- Are goals data-driven, considering number of people affected and the human and financial costs?
- Are goals feasible? Will they have an impact? Can they be done given available resources?
- Are there available evidence-based interventions?
Data

- Frequency, causes, and consequences of health conditions in population
- Demographics and social factors that affect health in population, such as poverty, education, and social networks
- Effectiveness of interventions
- Health outcomes

Cultural Competence

- Considering the values and beliefs of the individuals and communities involved in change initiatives is key
- Authentic engagement involves
  - Community-based participatory research
  - Ongoing dialogue with the community for the entire length of the project
  - Structures explicitly focused on reaching out to those least powerful in the process

### Issues and Barriers

- **Financial:** Population health requires financial resources especially for community organizations asked to do the heavy lifting on social determinants.
- **Human Capital:** Difficult to find individuals with the skills and experience needed.
- **Inadequate Infrastructure:** There may not be organizations in the community to address the goals selected.

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- **Lack of Relevant Data:**
  - Community members need to relate to the data presented, so national, state and even regional data may not serve.
  - People get engaged when they see themselves as part of the solution, so appropriate data are needed to understand the “diversity within disparities.” Low rates for a population can disguise higher rates of a subgroup.
  - Personal health data must be held confidential and secure. Aggregating data in small, rural communities may jeopardize this.

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**Population Health in New York**
PREVENTION AGENDA

Priority Areas:
- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote healthy women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections

STATE HEALTH INNOVATION PLAN (SHIP)

Pillars and Enablers:
- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology
- Performance measurement & evaluation

MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Key Themes:
- Integrate delivery – create Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & health system sustainability
New York State Health Initiatives

**POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)**

PHIP Regional Contractors:

- Identify, share, disseminate, and help implement best practices and strategies to promote population health
- Support and advance the Prevention Agenda
- Support and advance the SHIP
- Serve as resources to DSRIP Performing Provider Systems

**STATE HEALTH INNOVATION PLAN (SHIP)**

- Reduce disease and deaths for all New Yorkers
- Integrate care to address patient needs holistically
- Ensure the cost and quality of care is transparent
- Pay providers for value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology
- Performance measurement & evaluation

**MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM**

- Integrate delivery - create Performing Provider Systems
- Performance-based payments
- Long-term transformation & health system sustainability
- Align Medicaid

**ALIGNMENT**

- Improve Population Health
- Transform Health Care Delivery
- Eliminate Health Disparities

**Questions?**

Complete your evaluation and post test at: http://www.albany.edu/sph/cphce/prevention_agenda_webinar_population_health.shtml

For more information about the New York State Prevention Agenda, visit: http://www.nyspreventchronicdisease.com/