Partners in Building and Sustaining Primary Care – Observations and Recommendations from the Practical Playbook

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Nothing to disclose

The Value of Primary Care Training is Clear - to Us

- Phillips, R. L., Turner, B. J. (2012). The Next Phase of Title VII Funding for Training Primary Care Physicians for America's Health Care Needs. *Annals of Family Medicine.* 10(2), 163-168. www.annfammed.org.
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- Chen, R. M., Petterson, S. M., Bazemore, A. (2014). Projected Impact of the Primary Care Residency Expansion Program Using Historical Trends in Graduate Placement. *American Family Physicians.* http://www.graham-center.org/rgc/publications-reports/publications/onepagers/projected-impact-2014.html.
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- Avery, D. M., Hooper, D. E., McDonald, J. T., Love, M. W., Tucker, M. T., Parton, J. M. (2014). The Economic Impact of Rural Family Physicians Practicing Obstetrics. *The Journal of the American Board of Family Medicine*. 27(5), 602-610. http://www.jabfm.org.
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- Clasen, M. E., Budzak, M. L., Clasen, C. M. (2012, January 19). Measuring the Economic Impact of Closing a Family Medicine Residency: An e-publication of the National Conferences on Primary Health Care Access. Retrieved from http://www.coastal research.org/2012/01/19/measuring-the-economic
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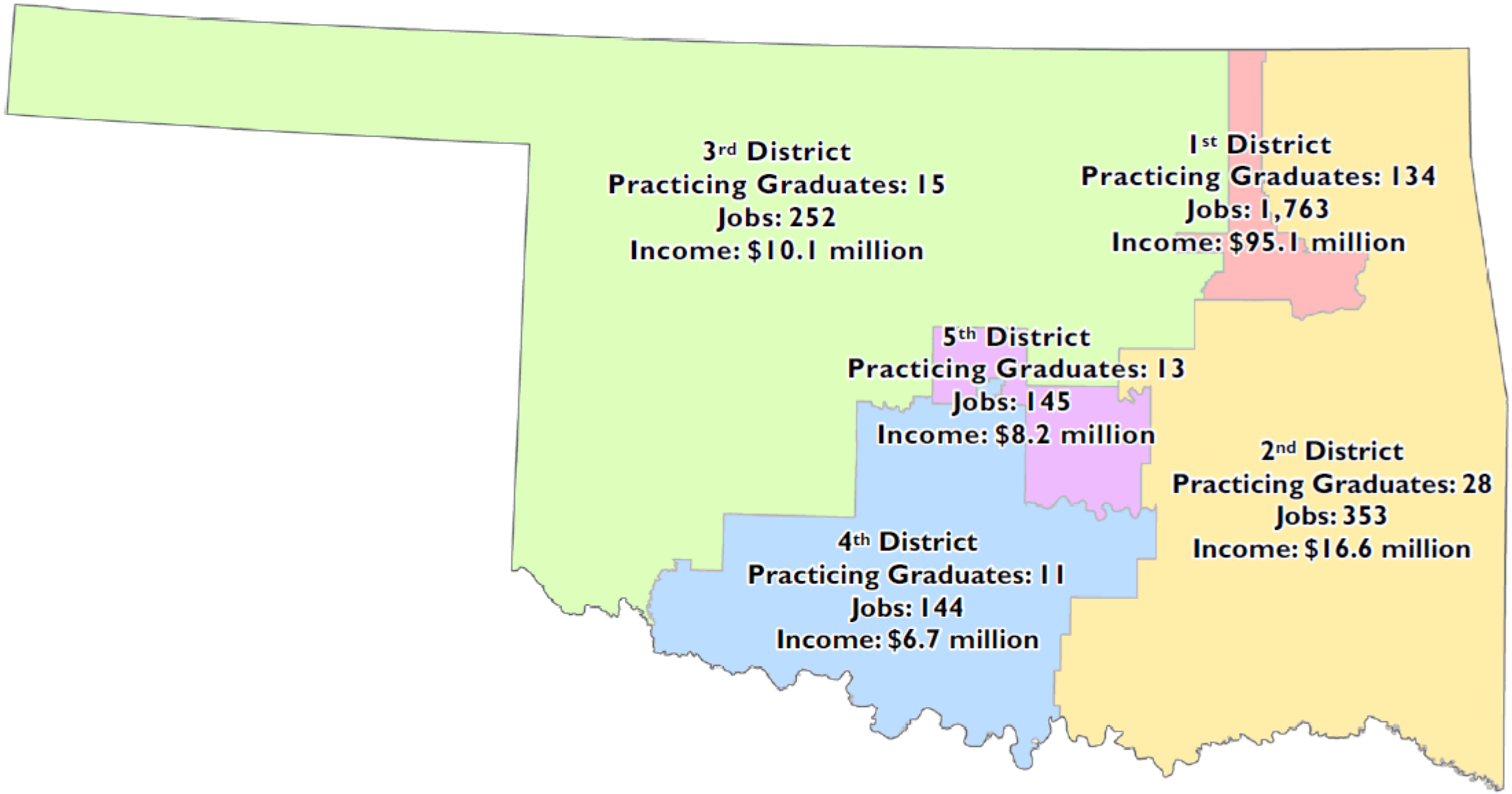
Example: The Economic Impact of Rural Family Physicians Practicing Obstetrics

- A family physician practicing obstetrics in a rural area adds an additional $488,560 in economic benefit to the community in addition to the $1,000,000 from practicing family medicine, producing a total annual benefit of $1,488,560.
- The investment of $616,385 from the Alabama Family Practice Rural Health Board resulted in a $399 benefit to the community for every dollar invested.
  - Avery, D. M., Hooper, D. E., McDonald, J. T., Love, M. W., Tucker, M. T., Parton, J. M. (2014). The Economic Impact of Rural Family Physicians Practicing Obstetrics. *The Journal of the American Board of Family Medicine*. 27(5), 602-610. http://www.jabfm.org.

Measuring the Economic Impact of Closing a Family medicine Residency: An e-publication of the National Conferences on Primary Health Care Access

- The authors assessed that the economic impact of closing a family medicine residency and outpatient center in Dayton, Ohio, has cost this community $17,451,000 annually.
- This cost is the sum of loss of revenue from graduate medical education (GME) Medicare payments to a teaching hospital with residencies, and the absorbed costs from increases in emergency department (ED) visits.
  - Clasen, M. E., Budzak, M. L., Clasen, C. M. (2012, January 19). Measuring the Economic Impact of Closing a Family Medicine Residency: An e-publication of the National Conferences on Primary Health Care Access. Retrieved from http://www.coastal research.org/2012/01/19/measuring-the-economic

Total Economic Impact of OSUMC Residents by Congressional District (2004-2012)



Observation from Practical Playbook: New Data is Available to Identify Opportunities for Larger Impact

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

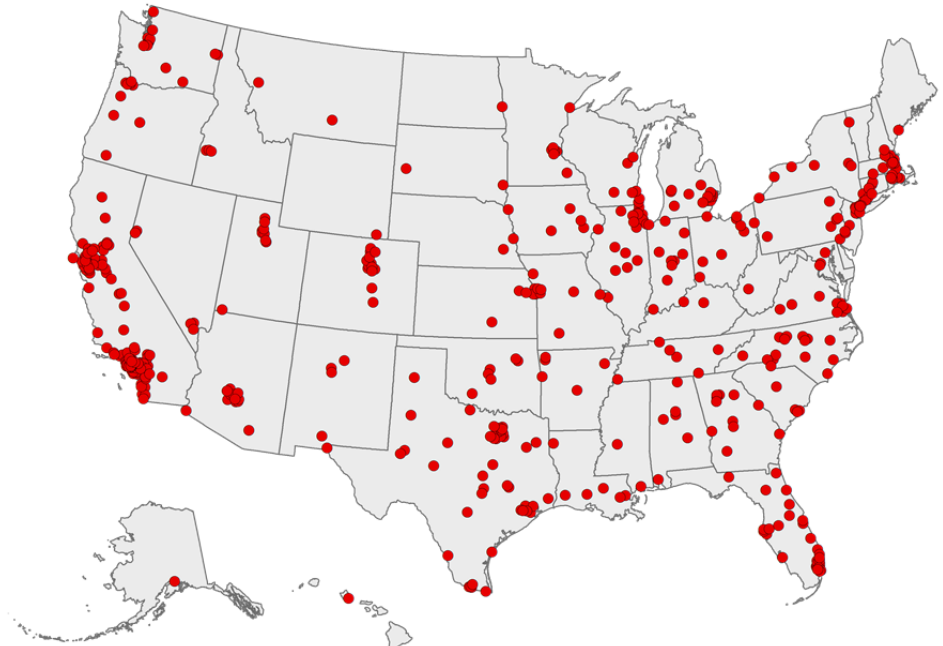
https://www.cdc.gov/500cities/

500 Cities: Local Data for Better Health

The 500 Cities project is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. These small area estimates will allow cities and local health departments to better understand the burden and geographic distribution of health-related variables in their jurisdictions, and assist them in planning public health interventions. Learn more about the 500 Cities Project.

500 Cities: Local data for better health

View data across the United States for the largest 500 cities



500 Cities Project: Local Data for Better Health

Interactive Map

Model-based estimates for high blood pressure among adults aged >=18 years – 2013

Start with a location, then choose a measure.

Location Type

- City data by State
- Census tract data by City

State: North Carolina

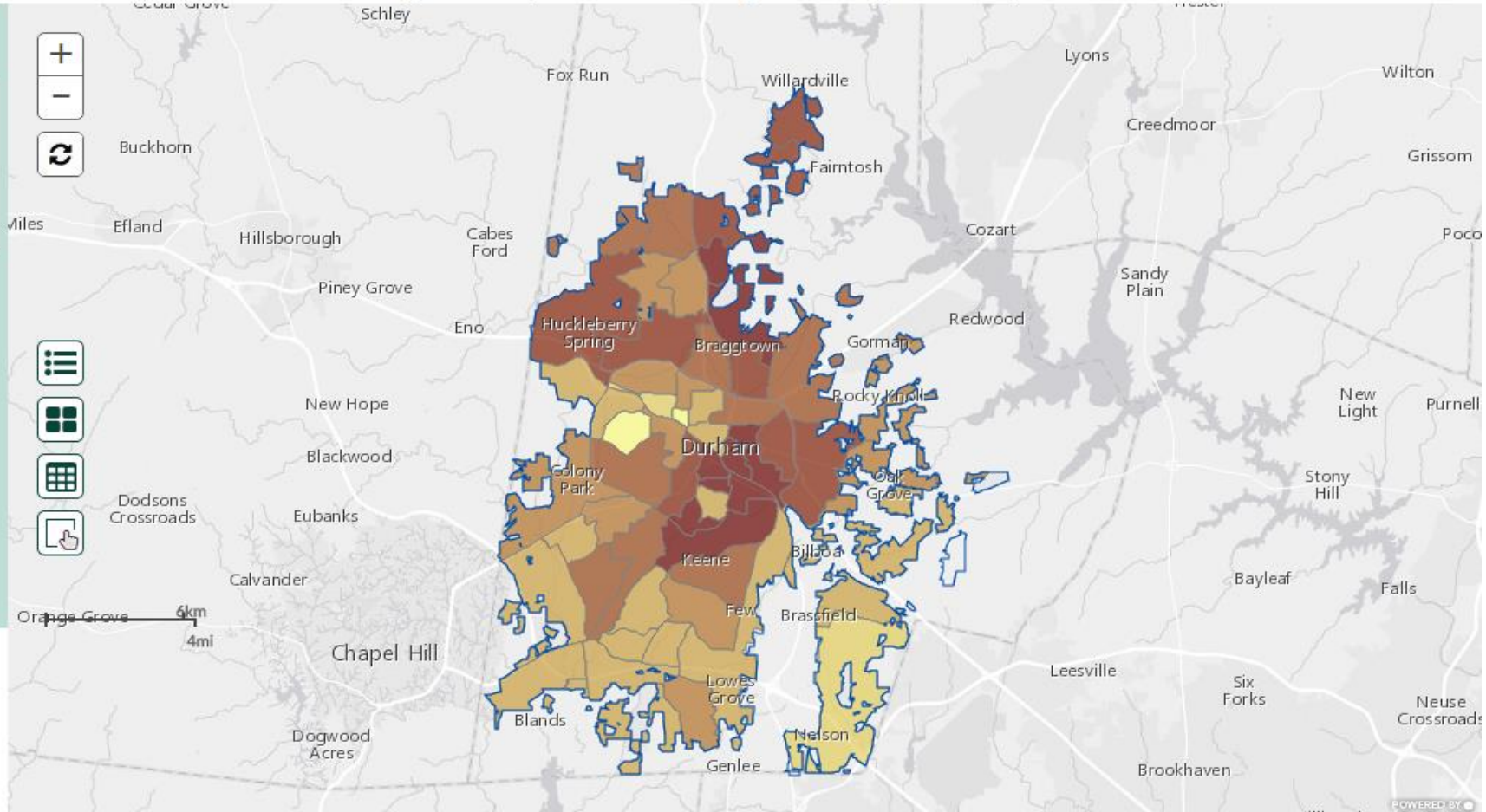
City: Durham

Category: Health Outcomes

Measure: High Blood Pressure

Measure definitions

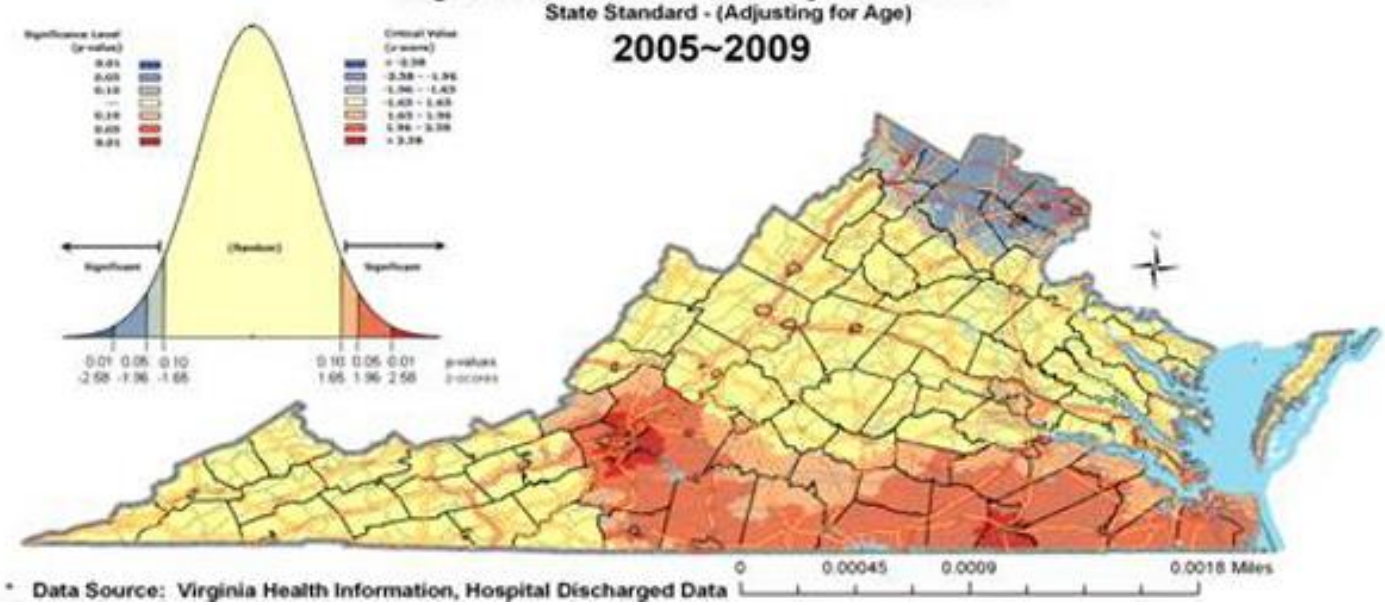
GO



Virginia

Hot Spot Analysis ~ Relative Risk
Arterial Ischemic Stroke (AIS)
Hospitalization (Primary Diagnosis) Discharged Data
Ages 35 Years & Over by ZIP Code
State Standard - (Adjusting for Age)

2005~2009



* Data Source: Virginia Health Information, Hospital Discharged Data

Observation from Practical Playbook: Multi-sector Interventions are Effective

Just For Us

Just For Us

- 350 patients since 2000
- Average age 70, multiple chronic conditions
- 44% have mental illness
- All are home-bound
- 84% African-American; many with low to no family support
- Low literacy or illiterate

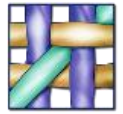
Community Partners

City of Durham, Housing Authority
Lincoln Community Health Center
Durham Council on Seniors
Area Mental Health Agency
Durham County Health Department
Durham County Department of Social Services

Practice Partners

Duke CFM, SON, DUH, DRH, Center for Aging, Department of Psychiatry

Just For Us



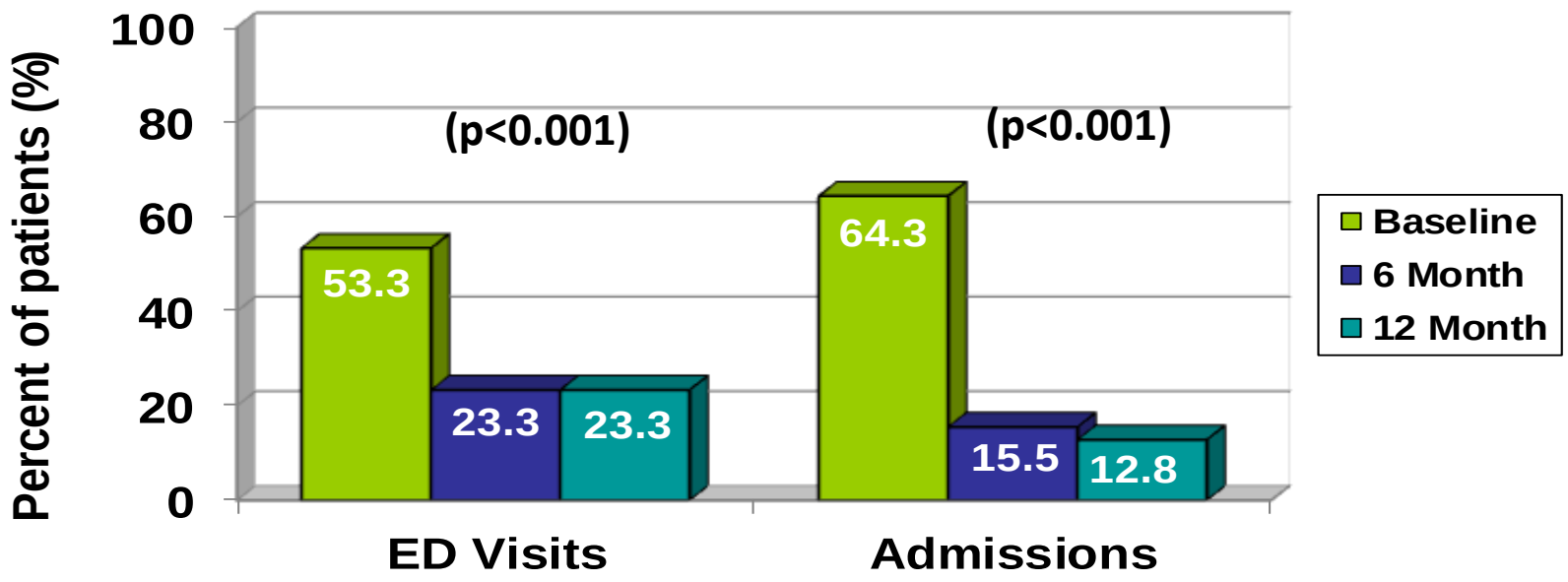
Outcomes

- Ambulance costs ↓ 49%
- ER costs ↓ 41%
- Inpatient costs ↓ 68%
- Prescription costs ↑ 25%
- Home health costs ↑ 52%

All patients with hypertension **79% ≤ 140/90**
Diabetics with hypertension **84% ≤ 140/90**

- *Boston Children's engages the community to address the broader determinants of health*
- *Boston Children's partnerships:*
  - *Boston Public Schools*
    - *Comprehensive Behavior Health Model, Children's Hospital Neighborhood Partnership, Healthy Family Fun Events*
  - *Boston Public Health Commission*
  - *Formal partnerships with 10 affiliated CHCs*
    - *Community Asthma Initiative*
    - *Martha Eliot Health Center*
    - *Fitness in the City*

Decrease in % patients with any ED Visits or Admissions due to Asthma N=1470 (through March 31, 2015)



56% decrease at 12 Months **80% decrease at 12 Months**

Woods, ER et al. Community Asthma Initiative: Evaluation of a Quality Improvement Program for Comprehensive Asthma Care. *Pediatrics*, 2012;129:465-472.

Observation from Practical Playbook:

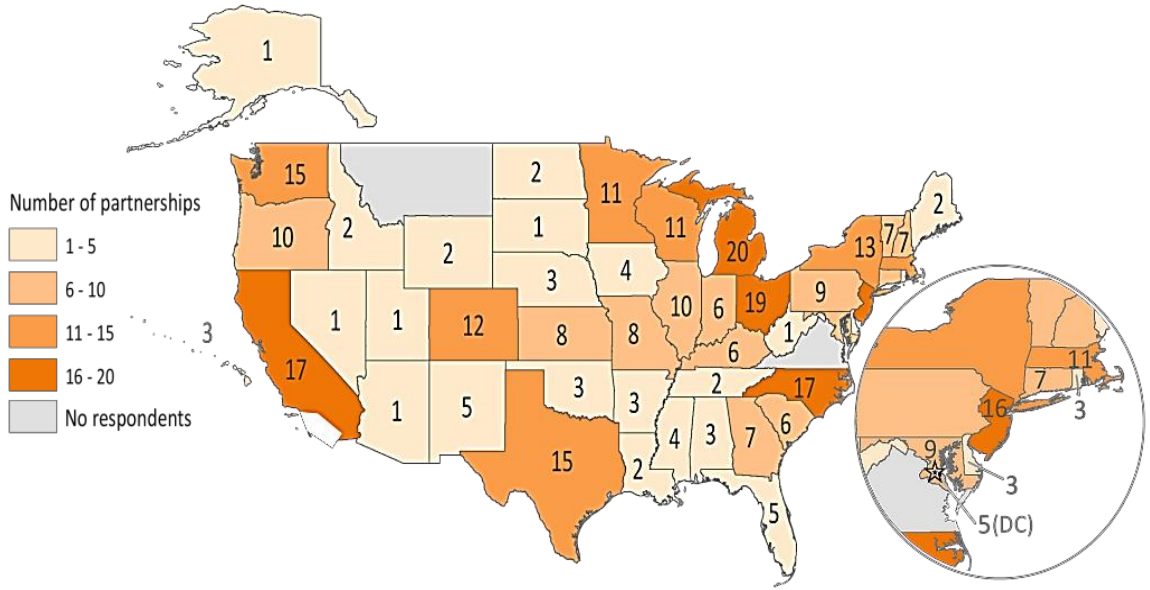
New Partners Bring New Tools and Resources
CDC: 6/18 Initiative

- Through the 6/18 Initiative, CDC is partnering with healthcare purchasers, payers, and providers to improve the health of the U.S. population and control healthcare costs. CDC provides partners with rigorous evidence about **six high-burden health conditions-tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and diabetes**-along with associated interventions to address these conditions and have the greatest impact on health and cost within five years.
  - Developing state plan amendments.
  - Assessing baseline coverage and using interventions.
  - Implementing billing changes and payment pilots.
  - Negotiating contracts with managed care organizations.
  - Creating new scope of practice legislative authority.
  - Conducting provider and member outreach and education.
- CDC: 6/18 Initiative website: https://www.cdc.gov/sixeighteen/

Observation from Practical Playbook: Partnerships are Now Widespread

Location, Age, Geographic Reach, Population Size Served

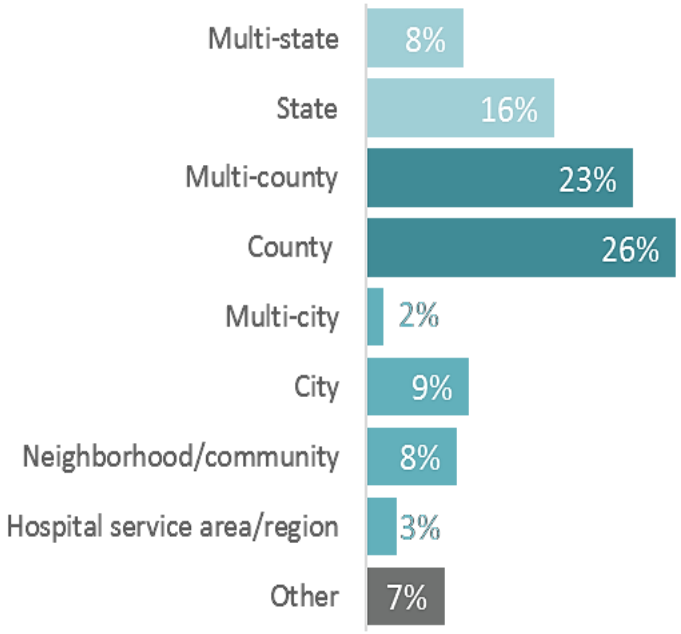
236 partnerships working in 42 states



ReThink Health®

Location, Age, Geographic Reach, Population Size Served

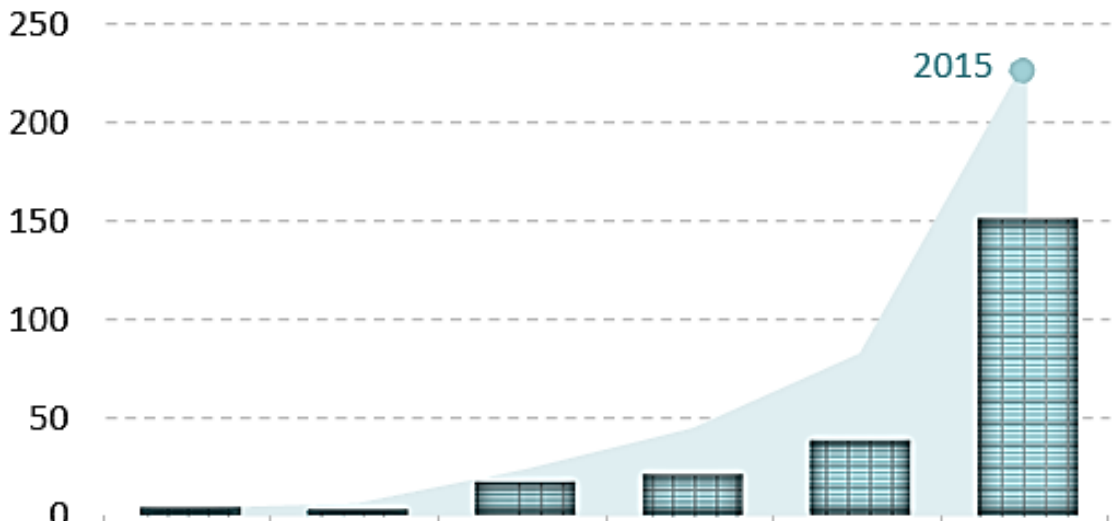
Distribution of responding partnerships (n=195)



ReThink Health®

Location, Age, Geographic Reach, Population Size Served

Number and timing of partnerships formed (n=234)



	1985-1989	1990-1994	1995-1999	2000-2004	2005-2009	2010-2015
Cumulative	4	7	24	45	83	234
New	4	3	17	21	38	151

ReThink Health

Observation from Practical Playbook: Funders are Engaging: Focus on Multisector Collaborations

Building the Business Case for Community Partnership

Lessons from the Build Health Challenge

https://www.advisory.com/research/population-health-advisor/resources/2016/building-the-business-case-for-community-partnership

Tremendous Innovation Driven by Community Partnerships

Focus on Social Determinants of Health Driving Short- and Long-Term Impact

Overview of the BUILD Health Challenge Communities

Source: Population Health Advisor research and analysis.

Observation from Practical Playbook: Lessons are Emerging

1

Engage leadership by building a compelling business case to garner executive buy-in and needed resources

Health systems play a pivotal role in supporting their communities. However, these efforts are often seen as separate from larger strategic aims. As the industry shifts toward value-based care and holistically addressing consumers' needs, leaders should integrate community partnerships to achieve quality, cost, and experience imperatives.

To do this effectively, leaders must apply the same rigor to community partnerships as other types of affiliation agreements. This includes identifying leaders, setting expectations around commitment of resources, and defining metrics to track and measure partnerships success.

BUILD leaders identified three specific actions for driving success:

- **Establish organizational commitment** including best practice sharing, planning, and shared decision making
- **Provide forums for community involvement** including launching or expanding community advisory groups
- **Define resources for specific projects** including forums for staff to learn about initiatives and community resources

Identify Metrics to Build the Business Case

Initial Measure Selection Informed by System-Wide Imperatives and Availability of Data

Advice from BUILD Leaders:

- **Define key terms upfront**. For example, there may be multiple concepts of "community" even within a single institution (e.g., metro region, adjacent neighborhoods, specific zip codes)
- **Balance accessibility with meaningfulness of data.** Useful measure sets should capture both community conditions (e.g., whether housing is affordable and people are healthy) and institutional effort (e.g., dollars spent, staff hired)
- **Partner with community groups to collect data.** While hospitals have robust clinical data, other partners have ready access to other helpful data points such as home environment.
- **Include a mix of process and outcome metrics.** Demonstrating outcomes can be slow given the pace of work and long-tail of certain interventions, so ensure metrics provide helpful guideposts for progress in the interim.
- **Aim for "good enough."** There are no perfect metrics or perfect methods for isolating impact in interventions with multiple partners and confounding factors.

Strong Metrics Facilitate ROI Calculations, Transparency, Accountability

Select a Range of Metrics to Capture Both Short- and Long-Term Successes

Metric Pick List: Community Health Initiatives

Competency	Sample Metrics	
Service Volume and Reach	• New users and/or total users of service (e.g., community garden, walking path, playground, supportive housing) • Scale of service (e.g., miles of walking path, number of affordable housing units, number of sites or counties served) • Frequency of service interaction (e.g., number of community gatherings held, monthly encounters per patient)	• Duration of services (average) • Adherence to scheduled patient reassessments/outreach standards • Community referral completion rates • Dollars invested • Staff or volunteer hours committed • Existence of partnership center or community advisory board
Health Access and Awareness	• Percentage of uninsured patients • Percentage of patients with regular PCP • Medical home enrollment rate • CAHPS composite: access to care • Average appointment wait time	• No-show appointments as a percentage of total scheduled appointments or sessions • Awareness of service availability (e.g., walking paths, health fairs) • Percentage of patients "very confident" in accessing or understanding health information
Preventive Care	• Percent of patients not at risk out of those who complete a health assessment for alcohol consumption, exercise, stress management, nutrition, tobacco use	• Completion rates for specialty screenings (e.g., food insecurity, health literacy, depression, alcohol or other substance misuse screening) • Completion rates for preventive services (e.g., immunizations)
Patient Satisfaction and Health Status	• CAHPS composite: satisfaction with care	• Percentage of adults rating their health as " good" or better
Care Utilization	• Hospital admissions per 1,000 patients • Asthma- or other acute exacerbation-related hospitalization • ED visits per 1,000 patients	• Per-member per-month cost of care • 30-, 60-, and 90-day readmissions rates for medical group patients admitted
Changes in Individual Behavior	• Increases in positive behaviors (e.g., physical activity, school attendance, consumption of fresh fruits and vegetables, savings rate)	• Decreases in negative behaviors or experiences (e.g., adverse childhood experiences, caregiver burden, substance misuse, school mobility of children, tobacco use)
Changes in Population Health/Community Goals	• School readiness • Academic proficiency scores • Graduation rate • Prevalence of specific chronic diseases or conditions (e.g., obesity) • Unemployment rate • Poverty rate; children in poverty • Homelessness rate • Crime rate (e.g., juvenile, violent, property) • Property values	• Voter turnout • Food desert designated areas or grocery stores per zip code • Greenhealth index rating • Sense of community/social connectedness • Feeling of safety • Carbon emissions • STARS index rating • Civic health index rating

Source: Population Health Advisor research and analysis.

3

Build or strengthen partner relationships by leveraging unique strengths of community organizations to extend care team reach

With a prioritized list of opportunities, the next step is assembling the right group of stakeholders. The BUILD Health Challenge illustrates the tremendous range of organizations with shared objectives for community health.

However, shared goals do not ensure a seamless working relationship. Formalizing partnerships with these groups extends reach while building on the skillsets, relationships, data, or tools each partner brings to the table.

Building effective partnerships starts with these key steps identified by BUILD leaders:

- **Build trust with your community** by sending hospital leaders to community meetings, learning from community partners, and integrating existing partnership structures
- **Create positive working relationships with public health and community-based organizations** by identifying the strengths of each partner, avoiding duplication of effort, and outlining processes for information sharing and decision making
- **Surface community priorities** , noting areas of alignment or areas where prioritization differs

Closing Observation: Be Clear About Accountability - Especially of Funds

- State are focusing on fiscal accountability and population health more than workforce outcomes

What are the next steps you can do or would recommend doing?

What can we do to help you?
If we were to do a short Playbook for you, what should it include?