



Déjà Vu Again

- **Historical Perspective of PC and PH Integration**
 - **Folsom Report 1967**
 - Community Health Centers
 - **Medicine and Public Health - the power of collaboration**
 - AMA and APHA effort 1997
 - **Primary Care and Public Health: Exploring Integration to Improve Population Health**
 - IOM March 2012 Report

Expectations

- Team-based care
- Improved communication
- Improved data flow & access
- Right patient at the right time
- Patient-centered aligned incentives – outcomes, quality, cost
- Accountability – outcomes, quality, cost

Why Integrated Models - for the provider?

- Improve the quality of care
- Lower the cost of care to the healthcare system
- Reduce unnecessary and duplicated care
- Focus on populations of patients
- Improve provider compensation
- Improve work/life balance
- Allowing physicians to do “doctor things” and other providers to contribute to the collaborative effort

Why Integrated Models - for the hospital?

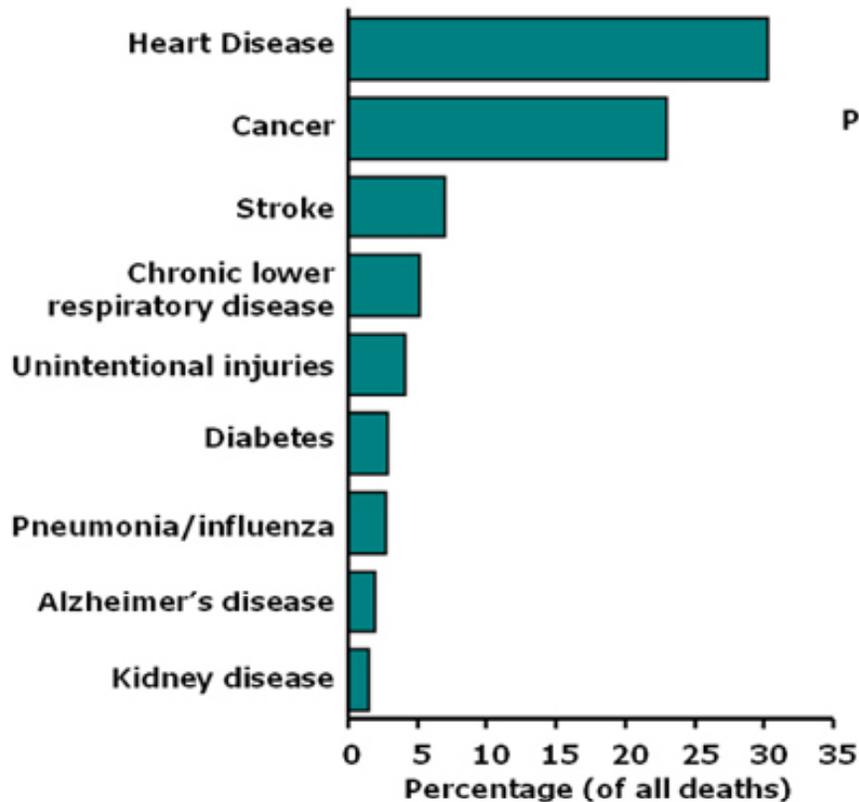
- Reduced length of stay
- Lower cost per case
- Decreased adverse events
- Reduced operating costs
- Higher employee retention rates
- Decreased malpractice claims
- Increased market share

What is Public Health?

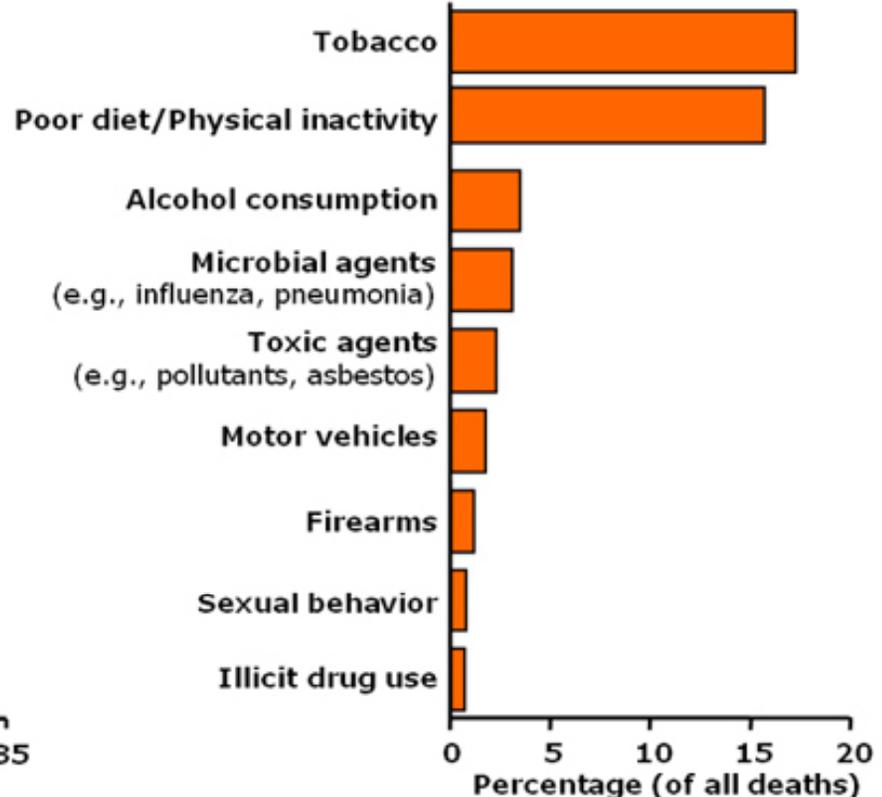
- Variety of Definitions depending on the context.
 - Public health focuses on
 - populations instead of individuals,
 - prevention, and
 - considers health outcomes in context of the big picture.

Clinical Prevention and Public Health: Actual Causes of Death

Leading Causes of Death*
United States, 2000



Actual Causes of Death†
United States, 2000



* Miniño AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15):1-120.

† Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

What are Determinants of Health?

- Income and social status
- Social support networks
- Education
- Employment/working conditions
- Social and physical environments
- Culture
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender

Impact of Chronic Disease



drive 15 chronic conditions

1. Diabetes
2. Coronary Artery Disease
3. Hypertension
4. Back Pain
5. Obesity
6. Cancer
7. Asthma
8. Arthritis
9. Allergies
10. Sinusitis
11. Depression
12. Congestive Heart Failure
13. Lung Disease (COPD)
14. Kidney Disease
15. High Cholesterol

accounting for **80%** of total costs for all chronic illnesses worldwide

Risk Factors for Chronic Disease in Kansas

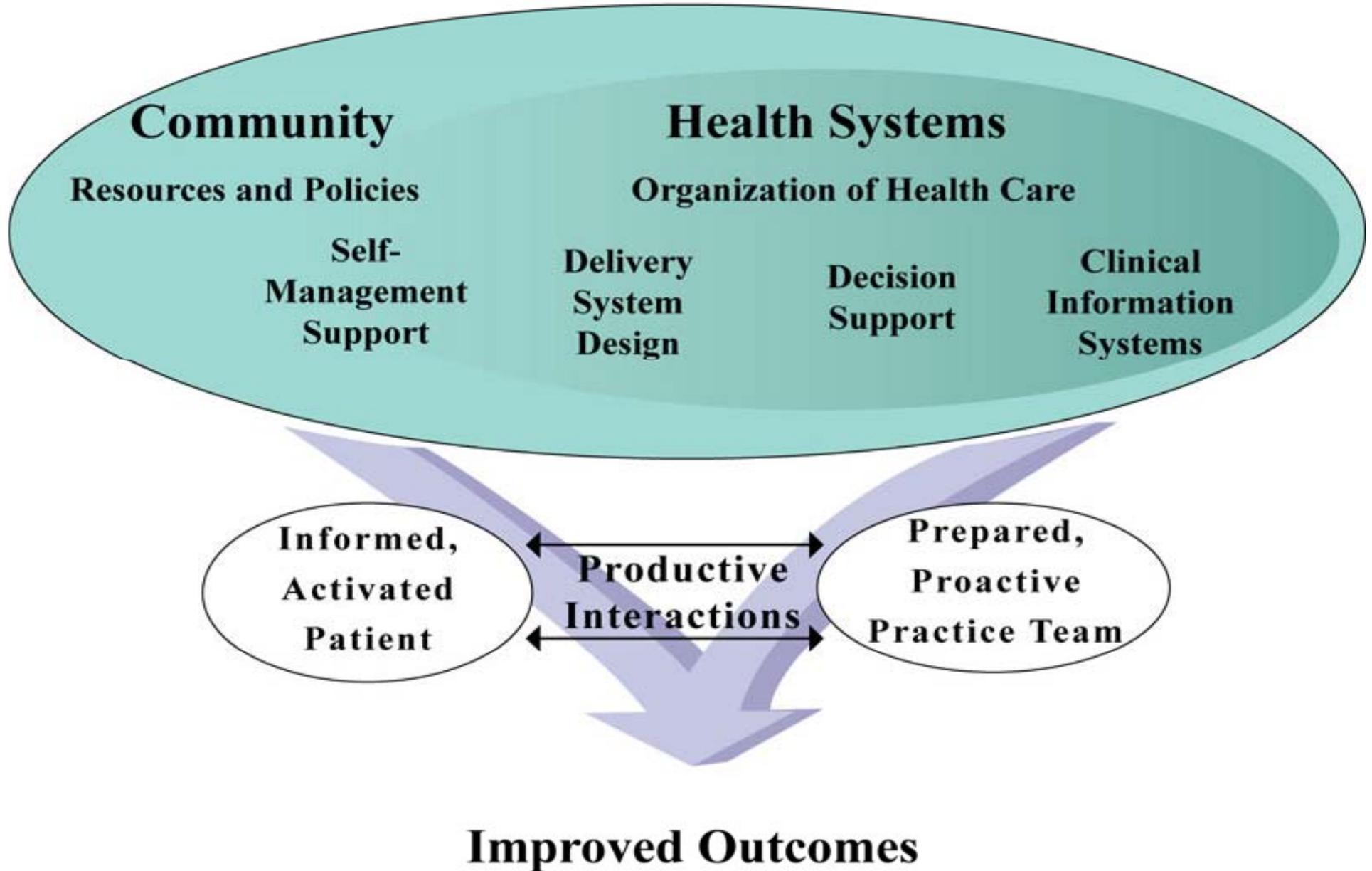
Risk Factor	Current Prevalence	Estimated Number of Adults	Trend over Last Nine Years	Comparison with National Pattern
Hypertension	28.7%	600,000	Increasing (by 24%)	Similar
High Cholesterol among those who were tested	38.6%	640,000	Increasing (by 32%)	Similar
Smoking	17.8%	376,000	Declined in last 4 years and now stable	Similar
Diabetes	*8.4%	*179,000	Increasing (by 42%)	Similar
Overweight or Obesity	64.6%	1.4 million	OW – stable; OB - increasing (by 33%)	Similar
Less than 5 times F/V Consumption	81.4%	1.7 million	Stable	Similar
No physical Activity	23.2%	490,000	Declining (by 13%)	Similar

Source: 2001-2009 Kansas BRFSS. Bureau of Health Promotion, KDHE. *2010 KS BRFSS.

The Solution?

- Public Health and Primary Care Integration
 - Learn from previous attempts
- Utilize Population Health Management
 - Define the “Population”
 - Identify Stakeholders
 - Determine “Status” and Gap Analysis
 - Determine Strategies and Tactics to Address

The Chronic Care Model



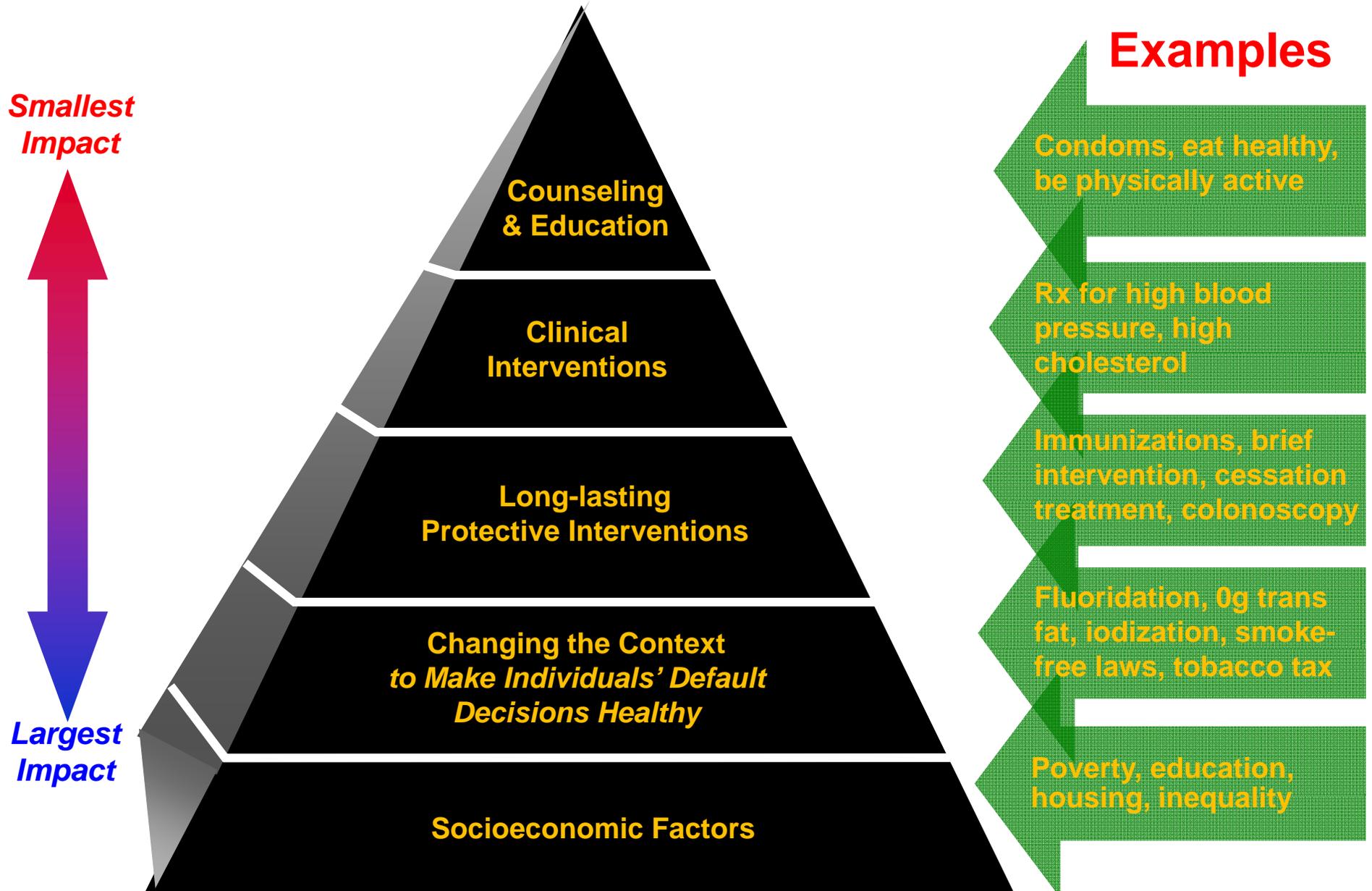
Population Health

- Benefits of a Population Health Focus
 - Improves Individual Experience
 - Improves Individual Outcomes
 - Engages more members of the care team
 - Improves provider satisfaction
 - Lower health care costs over time
- AHRQ's Concept of Practice-Based Population Health

Population Health in the Future

- Population Health Management -A culture of shared responsibility
 - Use of multidisciplinary care teams;
 - coordination across care settings;
 - enhanced access to primary care;
 - centralized resource planning for implementation
 - continuous care, both in and outside of office visits; patient self-management education;
 - a focus on health behavior and lifestyle changes;
 - use of health information technology
 - data access and reporting for communication among providers and between providers and patients
- Select Right Focus

Intervention Levels That Impact Health





What Do We Mean By Integration?

Variables Used by the Committee:

**Level
Action**

**Partners
Degree**

Degrees of Integration:



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