Communities Working Together to Improve Health and Reduce Disparities

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No financial relationships with any commercial interests.

Duke Community & Family Medicine
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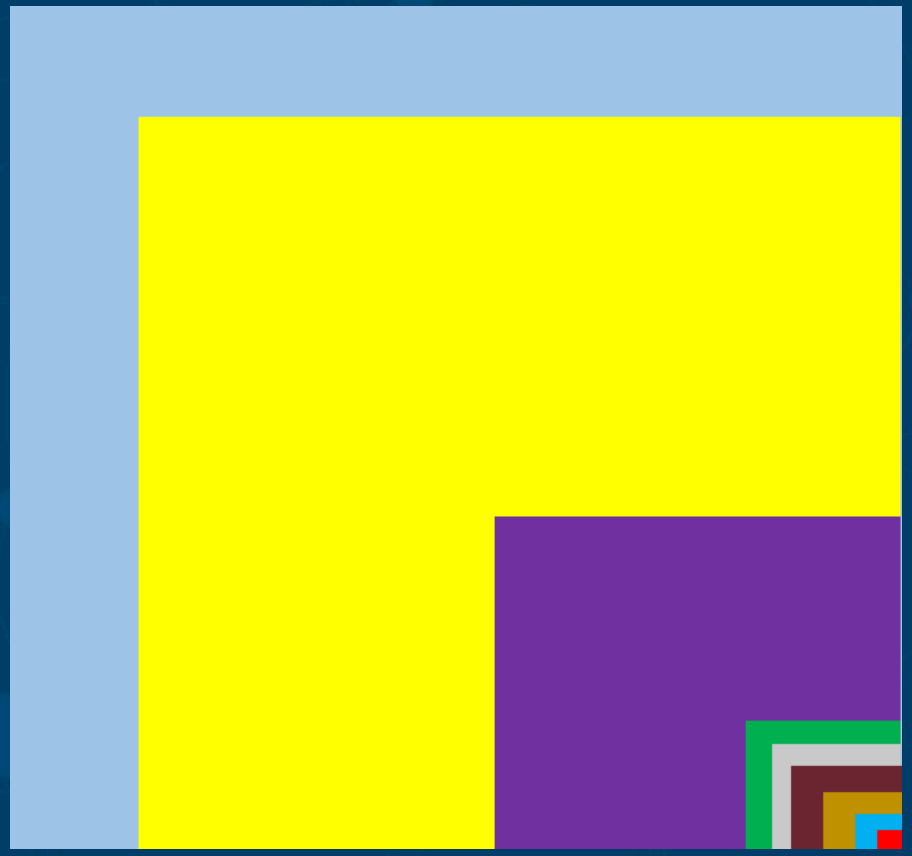
PRACTICAL PLAYBOOK®
Public Health. Primary Care. Together.®

We Know Most Illness Occurs in the Community

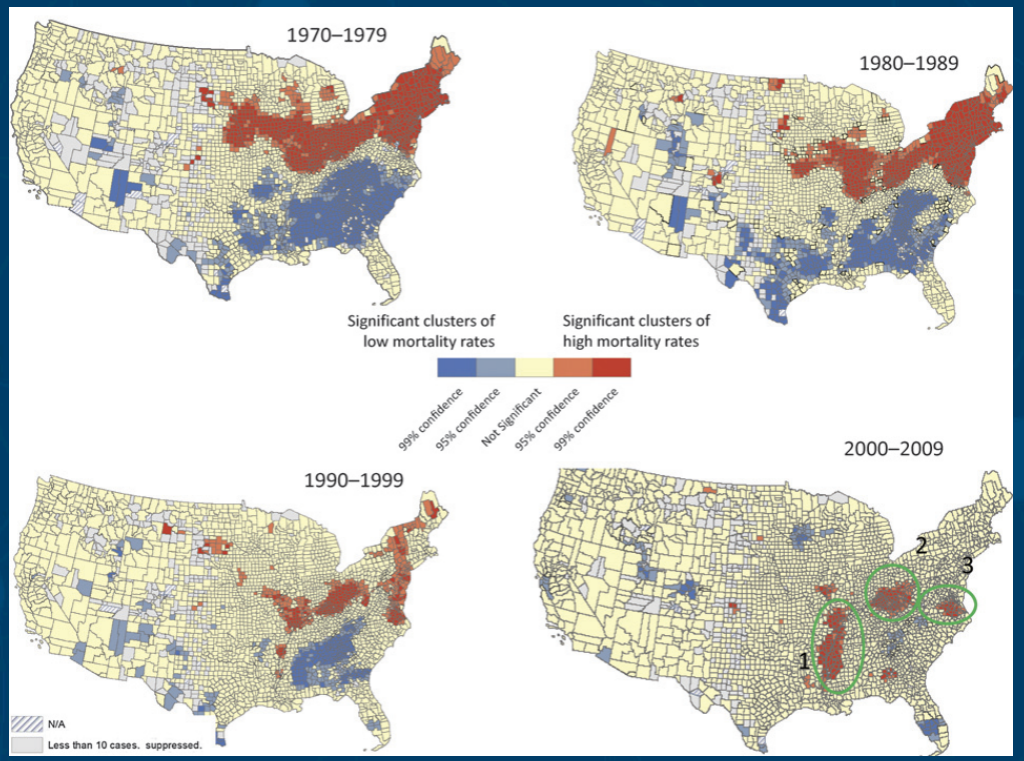


But…

Modified from: Green LA, Fryer GE Jr, Yawn BP, Lanier D, and Dovey SM. Ecology of Medical Care Revisited, NEJM 344:2021-205. June 28, 2001

The Health of Our Communities Vary – Across the Country

Where Can Colorectal Screening Have the Most Impact?



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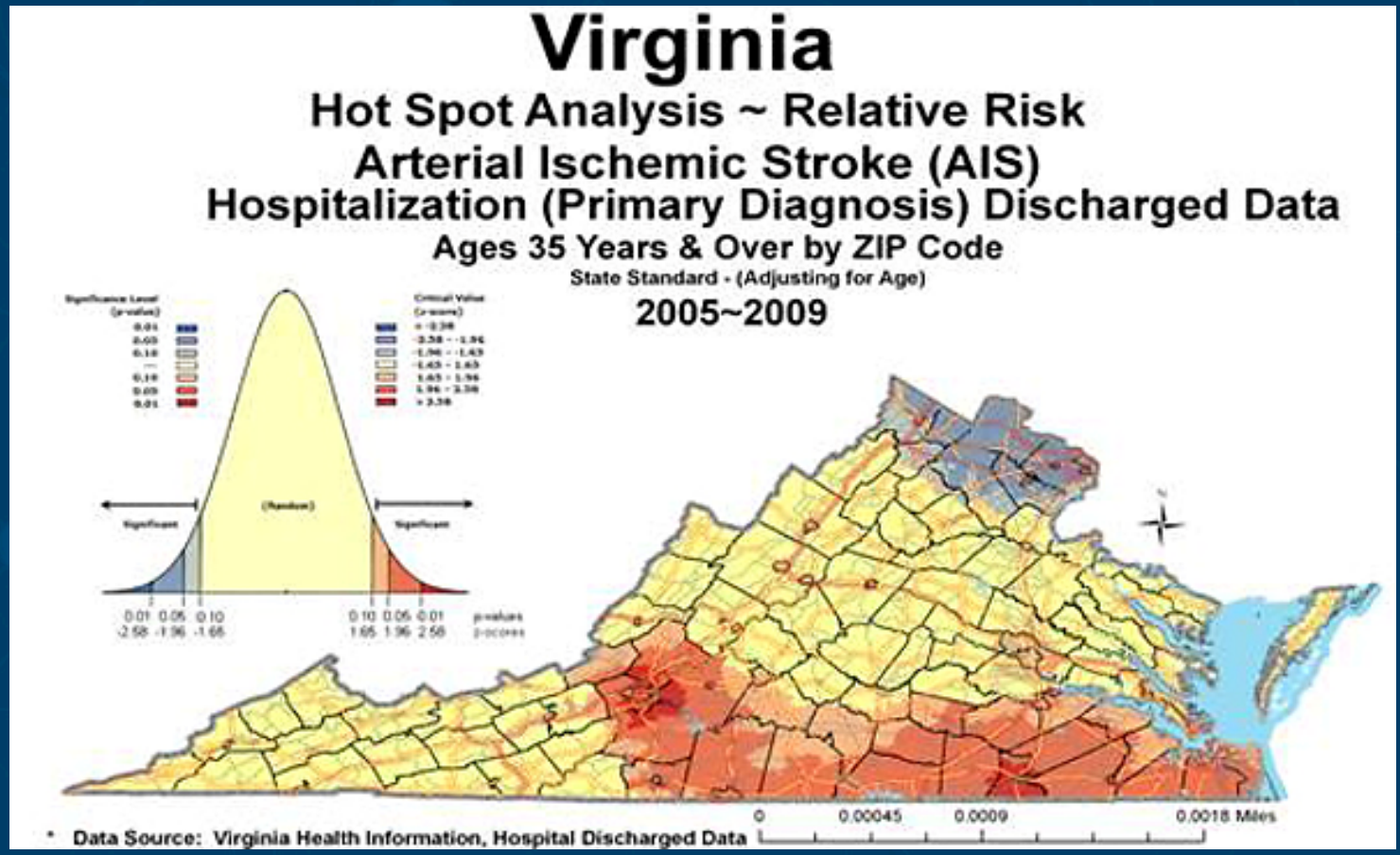
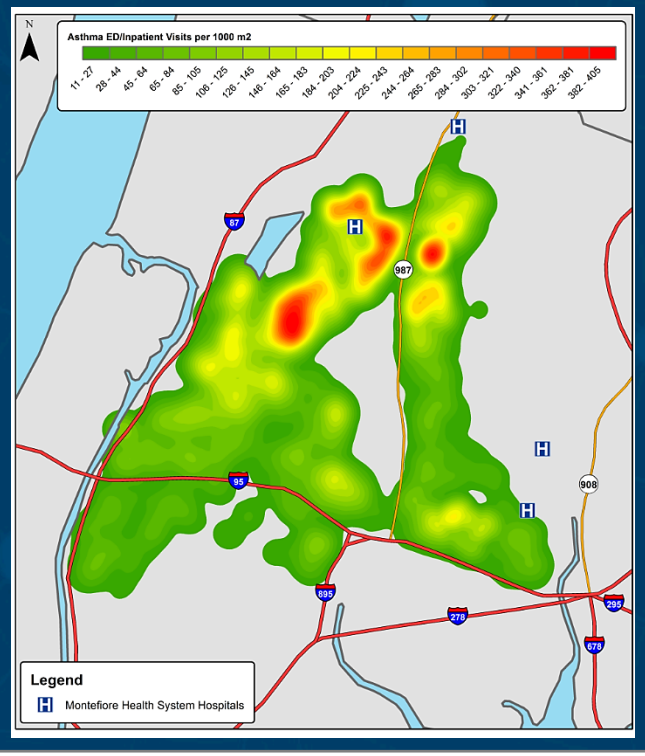
Communities Vary – Within States

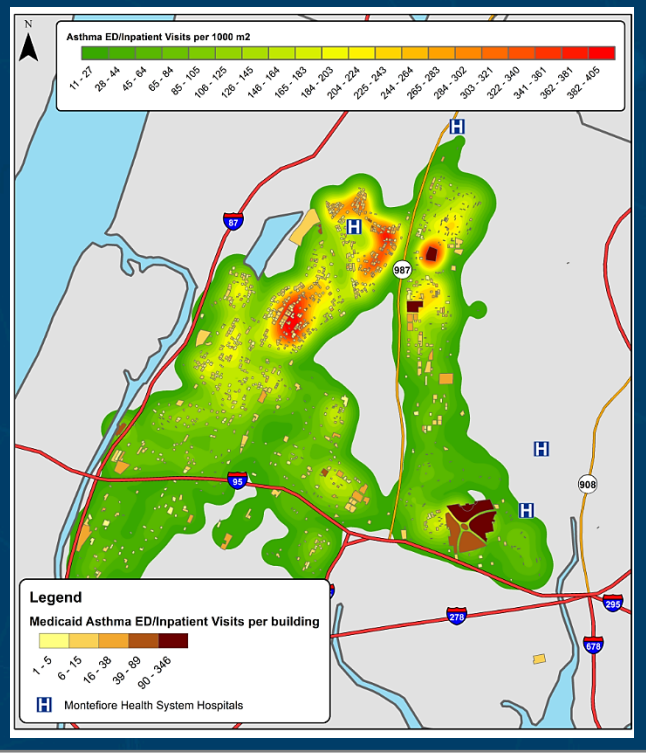


Communities Vary – Within Cities

Density of asthma visits among Medicaid patients in catchment area



More red areas have higher density of asthma visits



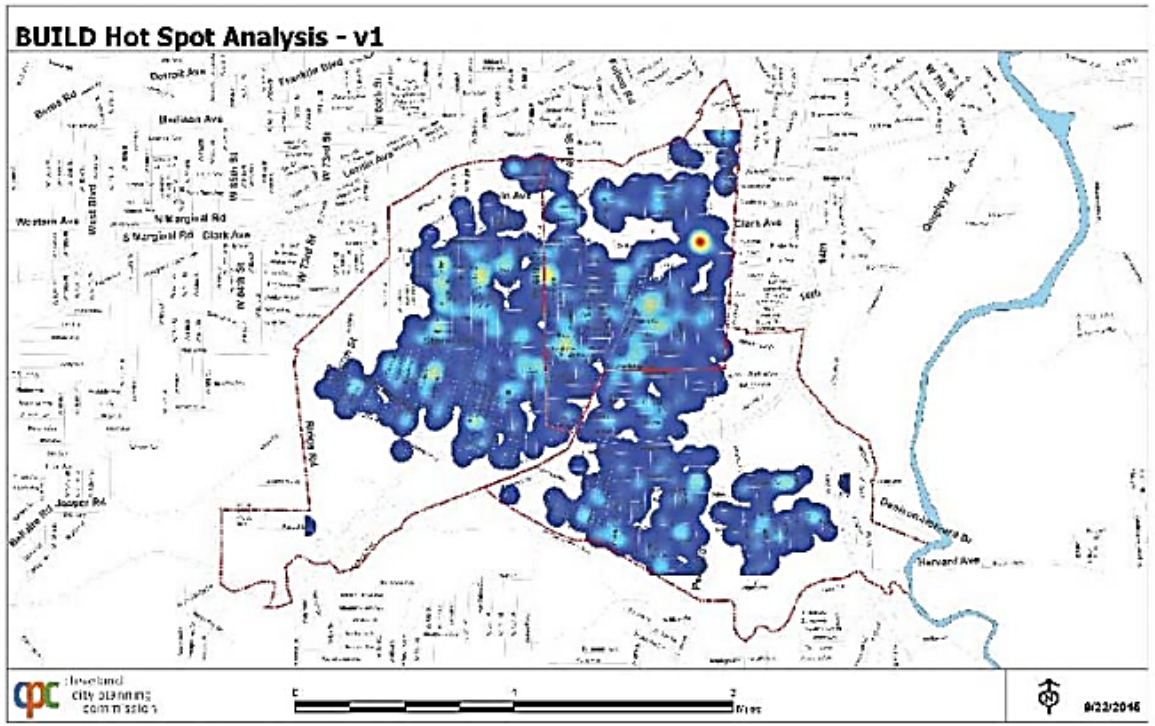
Some mismatch between “areas” with more asthma visits and “buildings” with most asthma

Notes: Visits are from 2012-7/2016. Does not include visits to non-Bronx Montefiore Health System locations

Montefiore

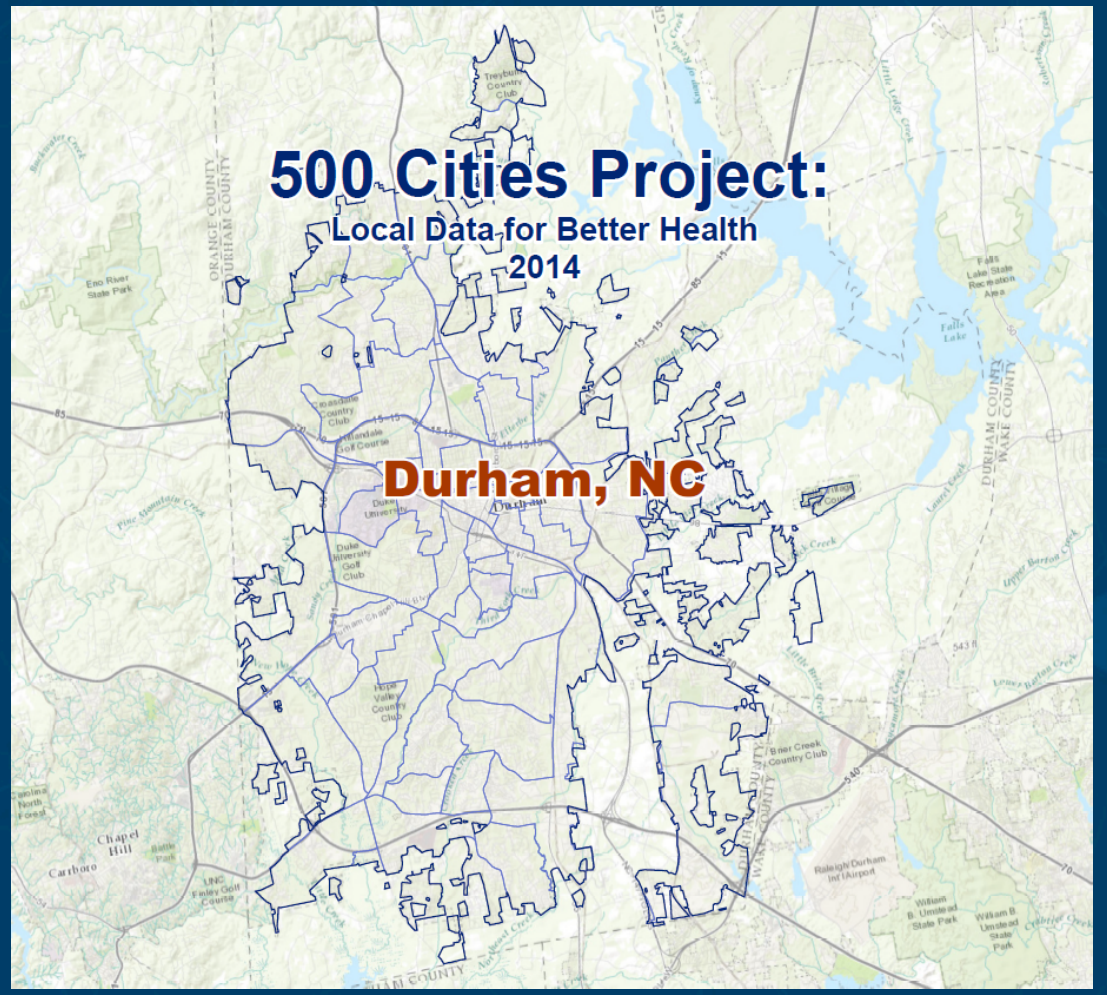
Root causes of illness are often in the community

Housing Code Violations – Cleveland

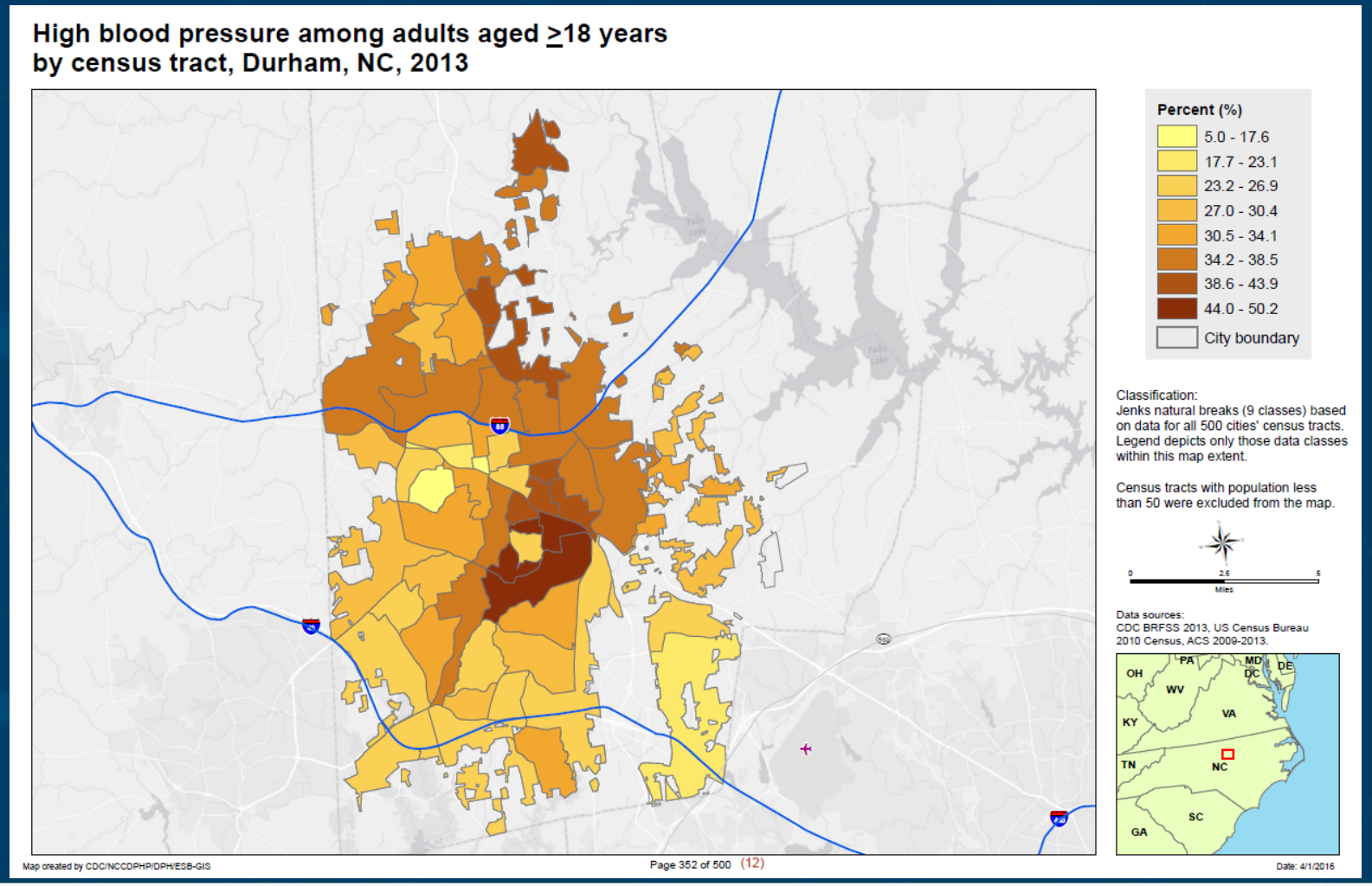


Houses that had open violations within the last 5 years. Source: Cleveland City Planning Commission

Data is Now Available for Targeted Interventions



Data is Now Available for Targeted Interventions



Targeted, Coordinated Interventions Work

Just For Us – Low Income Seniors in Durham, NC

- 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

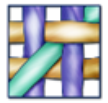
City of Durham, Housing Authority
Lincoln Community Health Center
Durham Council on Seniors
Area Mental Health Agency
Durham County Health Department
Durham County Department of Social Services

Practice Partners

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

Targeted, Coordinated Interventions Work

Just For Us



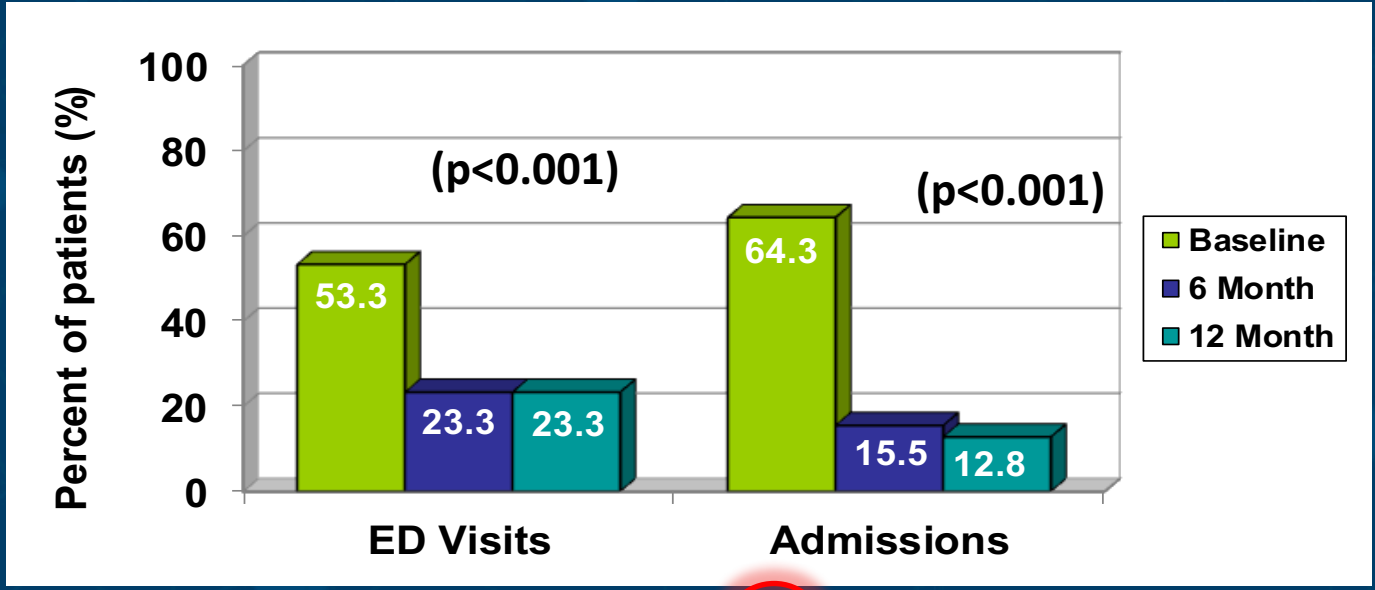
Outcomes

- 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

Targeted, Coordinated Interventions Work

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**

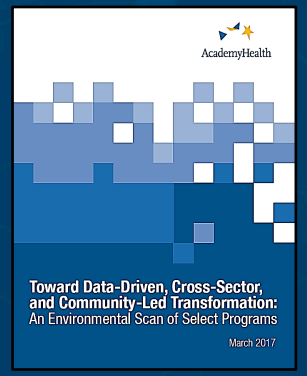
Woods, ER et al. Community Asthma Initiative: Evaluation of a Quality Improvement Program for Comprehensive Asthma Care. *Pediatrics*, 2012;129:465-472.

The Movement is Growing

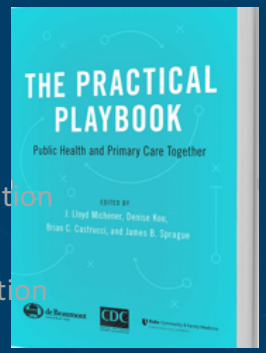
A New "Movement": Nearly **450** local initiatives awarded or soon to be awarded

Program Duration: **8 months** to **5 years**

Spread and Scale: Neighborhoods, counties, Multicounty, cities

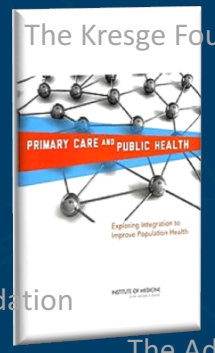


John D. and Catherine T. MacArthur Foundation



Robert Wood Johnson Foundation

The Kresge Foundation



Trinity Health

The Pew Charitable Trusts

Rippel Foundation

The Advisory Board Company

The Colorado Health Foundation

The BUILD HEALTH Challenge

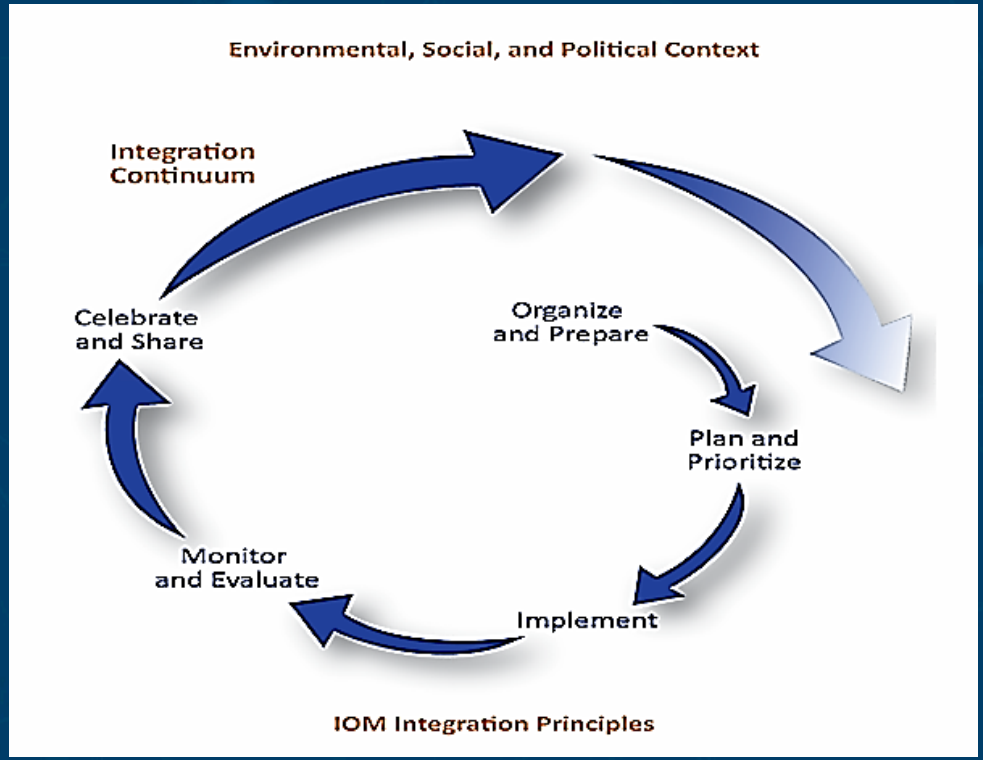
Vital Directions for Health and Health Care
A National Academy of Medicine Initiative

Bloomberg Philanthropies

de Beaumont Foundation

Lessons Learned:

Process Matters



Common Barriers: culture/language

Common Facilitators: "bridge" organizations

Lessons Learned:

Multi-Sector, Multi-Stakeholder Partnerships are Key

Adapted from countyhealthrankings.org

States are Engaging

Focusing on the Common Problem of Improving Population Health

Rick Brajer

To move the dial and drive the factors that impact 70% of health outcomes, we need a health and social services system that has the capacity and flexibility to address social determinants, and we need to better engage individuals in taking ownership of the factors they can control. The foundation on improving North Carolina's population health – when integrated – are Medicaid policy and metrics, social determinants, whole-person-centered models of care, and work-force development.

Rick Brajer former secretary, North Carolina Department of Health and Human Services, Raleigh, North Carolina.

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Working With Communities is in Our Roots

Definition of the Family Physician

The family Physician is one who: 1) serves as the physician of first contact with the patient and provides a means of entry into the health care system; 2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; 3) assumes responsibility for the patient's comprehensive and continuous health care and acts as leader or coordinator of the team that provides health services; and 4) accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit.

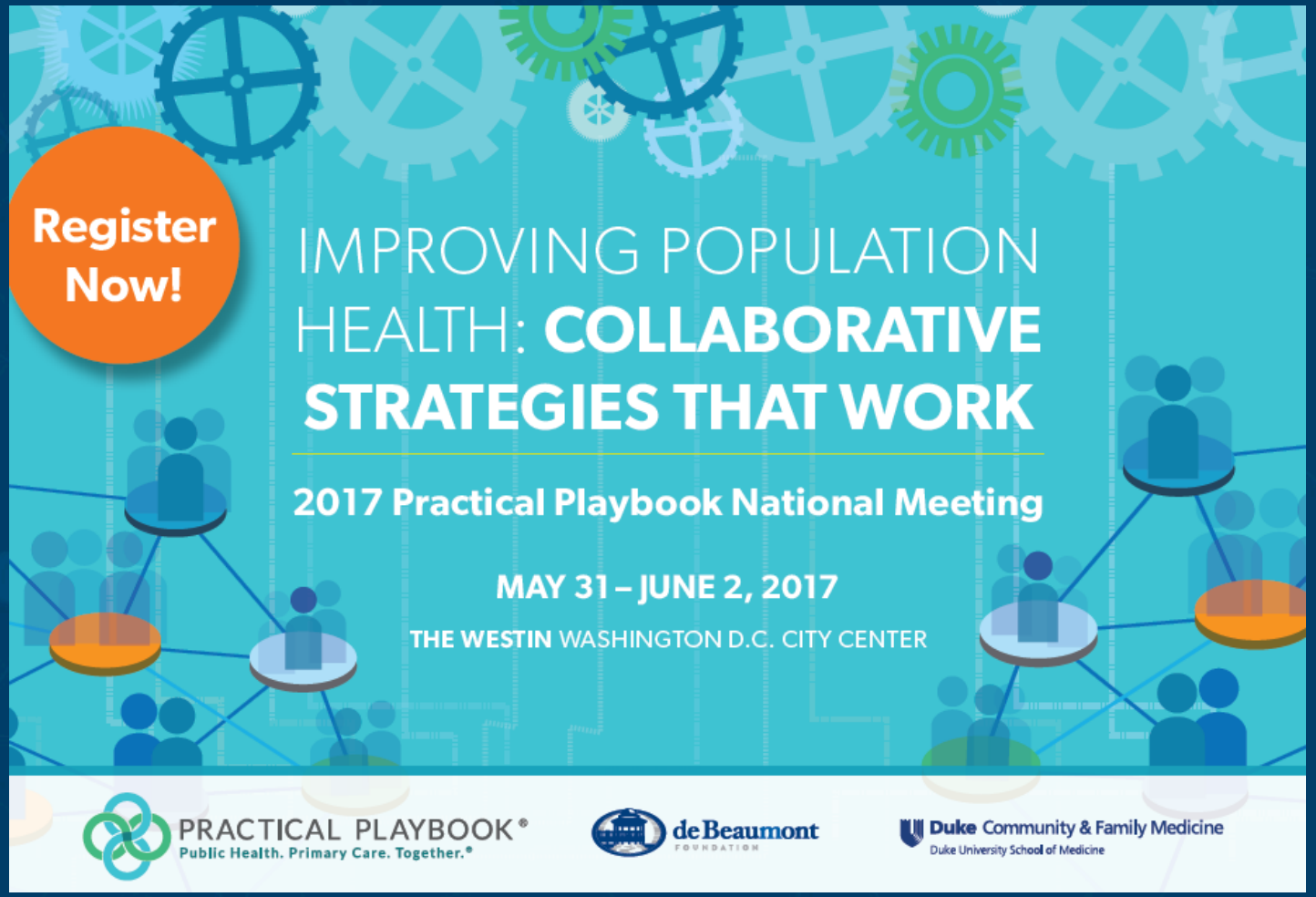
Source: Meeting the Challenge of Family Practice. The Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education, American Medical Association, 1966 (The Willard Report)

HEALTH IS PRIMARY

- Doctors are working in partnership with community leaders to address individual and population health
- Health disparities are reduced by increasing access to primary care

Health is Primary® BROUGHT TO YOU BY AMERICA'S FAMILY PHYSICIANS

Join the Movement!



Portland, Oregon — April 22-25, 2017

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