Improving health: Integrating individual and population health perspectives

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Call for Integration of Public Health and Clinical Medicine

The fields of **primary care** and **public health** in the United States have for the last century generally functioned **independently** of each other. This is **not optimal**; our current health challenges require improved efforts to work together in an **integrated** fashion to address the **root causes of illness and prevent** additional cases of disease, and to make the default choice a healthy one. Effective support of healthy behaviors will require **coordination** of the work of clinicians, particularly primary care clinicians, with public health agencies, schools, businesses, and community groups to better utilize community resources. In such an **integrated system**, primary care and public health work together to support individuals, families, patients and their caregivers, and to improve the health of **individuals and populations** (i.e., a true health system).

What health care heard...

- Population health
- Community Needs Assessments
- Community Benefits
What public health heard....
Figure 1

Impact of Different Factors on Risk of Premature Death

- Genetics: 30%
- Individual Behavior: 40%
- Health and Well Being: 20%
- Social and Environmental Factors: 20%
- Health Care: 10%

Improving the Health of the American People. NEJM. 357:1221-8.
FIGURE S-1 Degrees of integration.
Background on integration

• Indiana – ED/clinic/state HD/community nursing/FQHC; supported with grants (PP, p329)

• UCSD clinic/school/LHD – targeted population (PP, p320)
  • Have only measured process change, to date

• North Carolina – more of a one-off with clinics opting in or out (PP, p343)
What makes this project different?

• Health system transformation
  • Payment reform
  • Accountable for care of community
  • Public health is not the provider of last resort
  • Formal linkages (new opportunities, true integration)

• Scalable model
Model

CLINICAL/COMMUNITY POPULATION HEALTH INTERVENTION MODEL

INQUIRY  ASSESSMENT  ACTION

DATA COLLECTION

IDENTIFY PRIORITY HEALTH ISSUES

ENVIRONMENTAL & POLICY CHANGE

PARTNERSHIP FORMATION
• Health Care
• Public Health
• Community Organizations

COMPREHENSIVE STRATEGY DEVELOPMENT

COORDINATED CLINICAL & COMMUNITY PREVENTION ACTIVITY

OUTCOMES

IMPROVED HEALTH

COST SAVINGS

EVIDENCE-BASE FOR EFFECTIVE PRACTICE

Source: The Prevention Institute, *Community-centered health homes: Bridging the gap between health services and community prevention*, 2011.
Population Health Interventions: integrating individual and group level evidence (R01)

• What are we responding to? A call for:
  • “Research that utilizes interventions targeting multiple levels, including the individual level (behavioral, familial) and clinical/community level”
  • Projects that “address underlying social, economic and environmental condition in an effort to shift the distribution of health risks.”
Partners

University of Utah, Division of Public Health

University of Utah, Division of Family Medicine

Utah Department of Health

Salt Lake County Health Department

Sugarhouse Family Medicine Clinic

Sugarhouse Community
Specific Aims

• Identify facilitators and barriers to integration of public health and clinical medicine

• Establish and integrate new team members into clinical team to address population health
  • Address cancer prevention (the grant)
    • Diet & physical activity
    • These also impact hypertension & diabetes (the clinic)

• Evaluate clinical and population health indicators
Discussion