I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I--
I took the one less traveled by,
And that has made all the difference

Last verse from “A Road not Taken”. Poem by Robert Frost. Published in 1916
What do you get when you mix Public Health approach and Health (disease) Care Resources?

Jose Thier Montero
Director
Division of Public Health Services
NH DHHS
TOTAL POPULATION HEALTH
Total Population Health

Is it Possible? Should we try?
Forgive me my nonsense,
as I also forgive the nonsense
of those that think they talk sense

Robert L. Frost
Healthy, Young, (middle aged), Hispanic, Overweight/obese, Married, employed, Postgraduate education

Metabolic problems, CV health, Colon, Prostate, Back pain, Stress/Anxiety

Health care infrastructure, Health care coverage, Access to care

Built environment, Health behaviors, Social support, Perceptions about care

Diabetes, High Cholesterol, CV disease, Elevated PSA, Mental health, Oral health
Diabetes care: endocrinologist, podiatrist, neurologist, ophthalmologist, diabetes educator, etc.

CV: medications, catheterism, Prostate imaging, surgery.

Back Imaging

Mental and oral health treatments

Healthy Community
Walkable?
Food access and choices

Community resources
Access to technology

Diabetes care:
endocrinologist, podiatrist, neurologist, ophthalmologist, diabetes educator, etc.

CV: medications, catheterism,
Prostate imaging, surgery.

Back Imaging

Mental and oral health treatments

Type of coverage
Out of Pocket expenses

Type, variety and quality of disease care resources: Center of Excellence (PCP)
### Table 135. National Health Expenditures by Source of Funds: 1990 to 2009

[In billions of dollars (724.0 represents $724,000,000,000), except percent. Excludes Puerto Rico and Island Areas]

<table>
<thead>
<tr>
<th>Type of expenditure</th>
<th>1990</th>
<th>2000</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>National health expenditure, total</td>
<td>724.0</td>
<td>1,378.0</td>
<td>1,894.7</td>
<td>2,021.0</td>
<td>2,152.1</td>
<td>2,283.5</td>
<td>2,391.4</td>
<td>2,486.3</td>
</tr>
<tr>
<td>Annual percent change</td>
<td>11.9</td>
<td>7.1</td>
<td>6.9</td>
<td>6.7</td>
<td>6.5</td>
<td>6.1</td>
<td>4.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Percent of gross domestic product</td>
<td>12.5</td>
<td>13.8</td>
<td>16.0</td>
<td>16.0</td>
<td>16.1</td>
<td>16.2</td>
<td>16.6</td>
<td>17.6</td>
</tr>
<tr>
<td>Out of pocket</td>
<td>439.2</td>
<td>918.8</td>
<td>1,316.2</td>
<td>1,410.5</td>
<td>1,513.7</td>
<td>1,597.5</td>
<td>1,681.8</td>
<td>1,767.4</td>
</tr>
<tr>
<td>Health insurance</td>
<td>233.9</td>
<td>458.2</td>
<td>653.7</td>
<td>697.2</td>
<td>733.6</td>
<td>763.8</td>
<td>790.6</td>
<td>801.2</td>
</tr>
<tr>
<td>Private health insurance</td>
<td>110.2</td>
<td>224.4</td>
<td>311.3</td>
<td>339.9</td>
<td>403.1</td>
<td>431.4</td>
<td>465.7</td>
<td>502.3</td>
</tr>
<tr>
<td>Medicare</td>
<td>73.7</td>
<td>200.5</td>
<td>291.2</td>
<td>309.5</td>
<td>307.1</td>
<td>327.0</td>
<td>343.1</td>
<td>373.9</td>
</tr>
<tr>
<td>Medicaid (Title XIX)</td>
<td>10.4</td>
<td>13.7</td>
<td>24.9</td>
<td>26.5</td>
<td>29.7</td>
<td>32.2</td>
<td>33.9</td>
<td>36.5</td>
</tr>
<tr>
<td>CHIP (Title XIX and Title XXI)</td>
<td>10.9</td>
<td>19.1</td>
<td>28.0</td>
<td>29.8</td>
<td>31.9</td>
<td>34.0</td>
<td>38.2</td>
<td>42.4</td>
</tr>
<tr>
<td>Other third party payers and programs</td>
<td>77.4</td>
<td>124.5</td>
<td>153.9</td>
<td>159.8</td>
<td>168.5</td>
<td>179.5</td>
<td>181.2</td>
<td>186.1</td>
</tr>
</tbody>
</table>

Health expenditure: US spends almost 250% > OECD average

1. Health expenditure is for the insured population rather than resident population.
2. Current health expenditure.

Map 1. Average annual percent of Medicare beneficiaries who had at least one visit to a primary care clinician among hospital referral regions (2003-07)

Rates are adjusted for age, sex and race using the indirect method, with the corresponding population as the standard. The standard population is the U.S. Medicare population age 65 to 99 with Medicare Parts A and B entitlement and no HMO enrollment during the measurement period.

Average Annual Percent of Medicare Beneficiaries Who Had At Least One Visit to a Primary Care Clinician by Hospital Referral Region (2003-07)

- 82% to 89% (71)
- 80% to < 82% (70)
- 78% to < 80% (63)
- 75% to < 78% (48)
- 60% to < 75% (54)
- Not populated
Healthy Community
Walkable?
Food access and choices
Community resources
Access to technology

Diabetes care:
endocrinologist, podiatrist, neurologist, ophthalmologist, diabetes educator, etc.

CV: medications, catheterism,
Prostate imaging, surgery.
Back Imaging

Mental and oral health treatments

Type of coverage
Out of Pocket expenses
Type, variety and quality of disease care resources: Center of Excellence (PCP)

Healthy, Young, (middle aged), Hispanic, Overweight/obese, Married, employed, Postgraduate educ

Metabolic problems, CV health, Colon, Prostate, Back pain, Stress/Anxiety.

Built environment
Health behaviors
Social support
Perceptions about care

Diabetes
High Cholesterol
CV disease
Elevated PSA
Mental health
Oral health

Health care infrastructure
Health care coverage
Access to care
<table>
<thead>
<tr>
<th>Year</th>
<th>0%</th>
<th>10%–14%</th>
<th>15%–19%</th>
<th>20%–24%</th>
<th>25%–29%</th>
<th>≥30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>No Data</td>
<td>&lt;10%</td>
<td>–14%</td>
<td>15%–19%</td>
<td>20%–24%</td>
<td>≥30%</td>
</tr>
<tr>
<td>2000</td>
<td>No Data</td>
<td>10%–14%</td>
<td>15%–19%</td>
<td>20%–24%</td>
<td>25%–29%</td>
<td>≥30%</td>
</tr>
<tr>
<td>2010</td>
<td>No Data</td>
<td>10%–14%</td>
<td>15%–19%</td>
<td>20%–24%</td>
<td>25%–29%</td>
<td>≥30%</td>
</tr>
</tbody>
</table>

Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010
(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)
Obesity is increasing in all OECD countries, but is highest in US.

Australia, Czech Republic (2005), Japan, Luxembourg, New Zealand, Slovak Republic (2007), United Kingdom and US figures are based on health examination surveys, rather than health interview surveys.

County-level Estimates of Diagnosed Diabetes for Adults aged ≥ 20 years:
United States 2004

County-level Estimates of Diagnosed Diabetes for Adults aged ≥ 20 years:
United States 2005

County-level Estimates of Diagnosed Diabetes for Adults aged ≥ 20 years:
United States 2006

County-level Estimates of Diagnosed Diabetes for Adults aged ≥ 20 years:
United States 2007

Too many persons require admission for diabetes complications in US

Diabetes acute complications admission rates, population aged 15 and over, 2007

1. Does not fully exclude day cases.
2. Includes transfers from other hospital units, which marginally elevates rates.

### Table 3: Individual annual incremental medical costs attributable to obesity by weight cohort ($2009)

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost ($2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>$346</td>
</tr>
<tr>
<td>Moderately obese</td>
<td>$807</td>
</tr>
<tr>
<td>Severely obese</td>
<td>$1,566</td>
</tr>
<tr>
<td>Morbidly obese</td>
<td>$2,845</td>
</tr>
</tbody>
</table>

Source: Arterburn et al. (2005)

### Table 4: Individual annual medical costs and share of overall medical costs attributable to obesity in 2006 by expenditure type

<table>
<thead>
<tr>
<th>Expenditure Type</th>
<th>Incremental costs in 2006 ($2009)</th>
<th>Share of costs attributable to obesity (%)</th>
<th>% increase attributable to obesity from 1998 – 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$433</td>
<td>10.3</td>
<td>45.5</td>
</tr>
<tr>
<td>Non-inpatient*</td>
<td>$458</td>
<td>5.9</td>
<td>26.9</td>
</tr>
<tr>
<td>Prescription drug</td>
<td>$586</td>
<td>15.2</td>
<td>80.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,474</strong></td>
<td><strong>9.1</strong></td>
<td><strong>9.1</strong></td>
</tr>
</tbody>
</table>

*Non-inpatient care includes outpatient, office-based, dental, and home health care, emergency room, vision, and other (excluding prescription drug expenditures).

Source: Finkelstein (2009)
Map 2. Coronary artery bypass surgery (CABG) per 1,000 Medicare beneficiaries among hospital referral regions (2003-07)

The colors on the map represent the rates of CABG surgery per 1,000 Medicare beneficiaries in each HRR. Rates are adjusted for age, sex and race. The highest rate, 8.9 procedures per 1,000 beneficiaries, was seen in McAllen, Texas. The lowest rate, 1.9 procedures per 1,000, was seen in Pueblo, Colorado. In other words, patients in the McAllen HRR were more than four times more likely than patients in the Pueblo HRR to undergo CABG during 2003-07. The national average rate of CABG was 4.6 per 1,000. The greatest variation within a single HRR was seen in Denver, where the rate of CABG surgery ranged from less than 2 per 1,000 beneficiaries in the Steamboat Springs, Colorado HSA to more than 7 per 1,000 in the McCook, Nebraska HSA.\textsuperscript{v}

\textsuperscript{v}Hospital service areas can belong to hospital referral regions in different states if patients frequently cross state lines to receive care at the closest tertiary care hospital.
Map 3. Percutaneous coronary intervention (PCI) per 1,000 Medicare beneficiaries among hospital referral regions (2003-07)

The different colors represent the rates of PCI per 1,000 Medicare beneficiaries in each HRR. Rates are adjusted for age, sex and race. The highest rate, 37.3 procedures per 1,000 beneficiaries, was seen in the Elyria, Ohio HRR. The lowest rate, 3.6 procedures per 1,000, was seen in Honolulu. Medicare beneficiaries living in the Elyria HRR were more than ten times more likely to undergo PCI than beneficiaries living in Honolulu. The rate in Elyria was also more than three times the average rate across the entire U.S (11.3 per 1,000). The greatest variation within a single HRR was seen in Napa, California, where the rate of PCI ranged from a little more than 5 per 1,000 beneficiaries in the Fort Bragg HSA to nearly 42 in the Clearlake HSA.
Map 4. Back surgery per 1,000 Medicare beneficiaries among hospital referral regions (2003-07)

The colors on the map represent the rates of back surgery per 1,000 Medicare beneficiaries in each HRR. Rates are adjusted for age, sex and race. The highest rate, 10.0 surgeries per 1,000 Medicare beneficiaries, was seen in Casper, Wyoming. This rate was nearly six times higher than the lowest rate, 1.7 surgeries per 1,000, seen in the Honolulu HRR. The average rate of back surgery in the entire U.S. was 4.3 per 1,000.

The greatest variation within a single region was seen in Lexington, Kentucky, where the rate of back surgery ranged from 0.8 per 1,000 beneficiaries in the Jackson HSA to 5.4 per 1,000 in the Somerset HSA.
Map 9. Transurethral resection of the prostate (TURP) for benign prostatic hyperplasia (BPH) per 1,000 male Medicare beneficiaries among hospital referral regions (2003-07)

The colors on the map represent the rates of TURP for BPH per 1,000 male Medicare beneficiaries in each HRR. Rates are adjusted for age and race. Rates of TURP varied widely across the U.S. during 2003-07. The highest rate, 9.5 procedures per 1,000 male Medicare beneficiaries, was seen in the Idaho Falls, Idaho HRR. This rate was more than five times higher than the lowest rate, 1.7 surgeries per 1,000, in the Terre Haute, Indiana HRR. The national average rate of TURP was 4.3 per 1,000.

The greatest variation within a single hospital referral region was seen in Salt Lake City, where the rate of surgery ranged from less than 1 per 1,000 male beneficiaries in the St. George, Utah HSA to more than 11 per 1,000 male beneficiaries in the Rock Springs, Wyoming HSA.
Hospital Care Intensity Index, Last Two Years of Life, by Component (Component: Overall Index; Year: 2003-2007; Region Level: HRR)
Healthy Community?
Walkable?
Food access and choices
Community resources
Access to technology

Diabetes care:
endocrinologist, podiatrist, neurologist, ophthalmologist, diabetes educator, etc.

CV: medications, catheterism,
Prostate imaging, surgery.
Back Imaging

Mental and oral health treatments

Type of coverage
Out of Pocket expenses
Type, variety and quality of disease care resources: Center of Excellence (PCP)

Diabetes care:
Metabolic problems, CV health, Colon, Prostate, Back pain, Stress/Anxiety.

Healthy, Young, (middle aged), Hispanic, Overweight/obese Married, employed Postgraduate educ

Built environment Health behaviors Social support Perceptions about care

Health care infrastructure Health care coverage Access to care

Metabolic problems, CV health, Colon, Prostate, Back pain, Stress/Anxiety.
My house
My office
The gym
Shopping, dining, movies, healthcare
What should we do?
TOTAL POPULATION HEALTH
ASTHO’s presidential challenge: To Advance the Reintegration of Public Health and Health Care
President’s Challenge Draft

Metric:
Every State and Territory will identify at least one successful experience that takes full advantage of the integration of Public Health and Health Care Delivery, decode its key elements for success and help us all to learn from it.

Should we collect/study those not really successful?
those who have control of the money, those who provide the services, and those who develop the policies.... We need to work together with those who get the services.
It is not about going back to a romanticized, idyllic past that never really existed outside our memories, and that has nothing to do with our present and it has even less to do with our future
Table 136. National Health Expenditures by Source of Funds and Type of Expenditure: 1990 to 2009

[In billions of dollars (724.0 represents $724,000,000,000). Excludes Puerto Rico and Island Areas]

<table>
<thead>
<tr>
<th>Object of expenditure</th>
<th>1990</th>
<th>1,378.0</th>
<th>1,772.2</th>
<th>1,894.7</th>
<th>2,021.0</th>
<th>2,152.1</th>
<th>2,283.5</th>
<th>2,391.4</th>
<th>2,486.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>724.0</td>
<td>1,378.0</td>
<td>1,772.2</td>
<td>1,894.7</td>
<td>2,021.0</td>
<td>2,152.1</td>
<td>2,283.5</td>
<td>2,391.4</td>
<td>2,486.3</td>
</tr>
<tr>
<td>Source of funds:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>138.8</td>
<td>202.1</td>
<td>237.1</td>
<td>248.8</td>
<td>263.8</td>
<td>272.1</td>
<td>289.4</td>
<td>298.2</td>
<td>299.3</td>
</tr>
<tr>
<td>Health insurance[^1^]</td>
<td>439.2</td>
<td>918.8</td>
<td>1,219.2</td>
<td>1,316.2</td>
<td>1,410.5</td>
<td>1,513.7</td>
<td>1,597.5</td>
<td>1,681.8</td>
<td>1,767.4</td>
</tr>
<tr>
<td>Other third party payers and programs[^2^]</td>
<td>77.4</td>
<td>124.5</td>
<td>148.2</td>
<td>153.9</td>
<td>159.8</td>
<td>168.5</td>
<td>179.5</td>
<td>181.2</td>
<td>186.1</td>
</tr>
<tr>
<td>Public health activities[^3^]</td>
<td>20.0</td>
<td>43.0</td>
<td>53.7</td>
<td>54.0</td>
<td>56.2</td>
<td>62.6</td>
<td>68.8</td>
<td>72.9</td>
<td>77.2</td>
</tr>
<tr>
<td>Investment</td>
<td>48.7</td>
<td>89.6</td>
<td>114.0</td>
<td>121.8</td>
<td>130.7</td>
<td>135.2</td>
<td>148.4</td>
<td>157.2</td>
<td>156.2</td>
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<td>Type of expenditure:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health consumption expenditures</td>
<td>675.3</td>
<td>1,288.5</td>
<td>1,658.2</td>
<td>1,772.9</td>
<td>1,890.3</td>
<td>2,016.9</td>
<td>2,135.1</td>
<td>2,234.2</td>
<td>2,330.1</td>
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<tr>
<td>Personal health care</td>
<td>616.6</td>
<td>1,164.4</td>
<td>1,479.0</td>
<td>1,585.0</td>
<td>1,692.6</td>
<td>1,798.8</td>
<td>1,904.3</td>
<td>1,972.7</td>
<td>2,089.9</td>
</tr>
<tr>
<td>Hospital care</td>
<td>250.4</td>
<td>415.5</td>
<td>525.8</td>
<td>564.5</td>
<td>606.5</td>
<td>648.3</td>
<td>686.8</td>
<td>722.1</td>
<td>759.1</td>
</tr>
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<td>Physician and clinical services</td>
<td>158.9</td>
<td>290.0</td>
<td>368.4</td>
<td>393.6</td>
<td>419.6</td>
<td>441.6</td>
<td>462.6</td>
<td>488.5</td>
<td>509.9</td>
</tr>
<tr>
<td>Other professional services[^4^]</td>
<td>17.4</td>
<td>37.0</td>
<td>46.8</td>
<td>50.1</td>
<td>53.1</td>
<td>55.4</td>
<td>59.5</td>
<td>63.4</td>
<td>66.8</td>
</tr>
<tr>
<td>Dental services</td>
<td>31.5</td>
<td>62.0</td>
<td>76.0</td>
<td>81.8</td>
<td>86.8</td>
<td>91.4</td>
<td>97.3</td>
<td>102.3</td>
<td>102.2</td>
</tr>
<tr>
<td>Other health, residential, and personal care[^5^]</td>
<td>24.3</td>
<td>64.7</td>
<td>84.0</td>
<td>90.7</td>
<td>96.5</td>
<td>102.1</td>
<td>108.3</td>
<td>113.3</td>
<td>122.6</td>
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<tr>
<td>Home health care</td>
<td>12.6</td>
<td>32.4</td>
<td>39.8</td>
<td>43.8</td>
<td>48.7</td>
<td>52.6</td>
<td>57.8</td>
<td>62.1</td>
<td>68.3</td>
</tr>
<tr>
<td>Nursing care facilities and continuing care retirement communities</td>
<td>44.9</td>
<td>85.1</td>
<td>100.1</td>
<td>105.4</td>
<td>112.1</td>
<td>117.0</td>
<td>126.5</td>
<td>132.8</td>
<td>137.0</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>40.3</td>
<td>120.9</td>
<td>175.2</td>
<td>190.3</td>
<td>201.7</td>
<td>219.8</td>
<td>230.2</td>
<td>237.2</td>
<td>249.9</td>
</tr>
<tr>
<td>Durable medical equipment[^6^]</td>
<td>13.8</td>
<td>25.1</td>
<td>27.8</td>
<td>28.9</td>
<td>30.4</td>
<td>31.9</td>
<td>34.4</td>
<td>35.1</td>
<td>34.9</td>
</tr>
<tr>
<td>Other nondurable medical products[^7^]</td>
<td>22.4</td>
<td>31.6</td>
<td>35.1</td>
<td>35.8</td>
<td>37.2</td>
<td>38.7</td>
<td>41.1</td>
<td>42.3</td>
<td>43.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Division</th>
<th>Outlays (in millions of $)</th>
<th>Percentage of Total Outlays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>732,896</td>
<td>85.80</td>
</tr>
<tr>
<td>Administration for Children and Families</td>
<td>56,370</td>
<td>6.60</td>
</tr>
<tr>
<td>National Institutes of Health</td>
<td>33,052</td>
<td>3.87</td>
</tr>
<tr>
<td>Health Resources and Services Administration</td>
<td>8,569</td>
<td>1.00</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention</td>
<td>6,957</td>
<td>0.81</td>
</tr>
<tr>
<td>Public Health and Social Services Emergency Fund</td>
<td>4,890</td>
<td>0.57</td>
</tr>
<tr>
<td>Indian Health Service</td>
<td>4,350</td>
<td>0.51</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services</td>
<td>3,325</td>
<td>0.39</td>
</tr>
<tr>
<td>Food and Drug Administration</td>
<td>2,117</td>
<td>0.25</td>
</tr>
<tr>
<td>Administration on Aging</td>
<td>1,512</td>
<td>0.18</td>
</tr>
</tbody>
</table>
## Public Health Programs

### Save Healthcare Dollars

<table>
<thead>
<tr>
<th>Program</th>
<th>Savings for Every $1 Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis screening and medication</td>
<td>$1.20</td>
</tr>
<tr>
<td>Women, Infants, and Children (WIC)</td>
<td>$1.92 - $4.21</td>
</tr>
<tr>
<td>Smoking Cessation for Pregnant Women</td>
<td>$6.00</td>
</tr>
<tr>
<td>Immunizations</td>
<td>$27.00</td>
</tr>
<tr>
<td>Water Fluoridation</td>
<td>$38.00</td>
</tr>
</tbody>
</table>
Institute of Medicine Report

March 2012

Primary Care and Public Health
Exploring Integration to Improve Population Health
Best Care at Lower Cost: The Path to Continuously Learning Health Care in America

Mark Smith, Robert Saunders, Leigh Stuckhardt, J. Michael McGinnis, Editors; Committee on the Learning Health Care System in America; Institute of Medicine
Policies and Systems
Local, state, and federal policies and laws, economic and cultural influences, media

Community
Physical, social and cultural environment

Organizations and Systems of Care
Medical Home, ACO, Hospital, School, Worksite, Faith-Based

Relationships
Family, peers, social networks, associations

Individual
Knowledge, attitudes, beliefs

System Approach to Health Transformation
What Do We Mean By Integration?

- The committee adopted a broad definition: *The linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health.*

- Due to variability in local strengths, needs, and resources, the committee did not want to be overly prescriptive in its definition.

- Integration can take many forms...
Degrees of Integration

Institute of Medicine
March 2012
What does Public Health bring to the table?

- Clinical Services:
  - Emergency Response
  - Clinical and Population Data
  - Patient Safety

- Policy Development
- Regulatory role

Total Population Access
“Bully Pulpit”
What are we currently doing?
Families First Demonstration Project

- Contract with Community Health Access Network
- Consultant from University of MA Medical School
- Clinical Team from Families First
- Technology Team from CHAN and JSI
- Training staff at Families First-
  - Set target measures for Ask, Assist, Refer
- Tracking provider fidelity to the system change
Quarter-4 Results  
September – December 2011

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Q-4</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask</strong></td>
<td>77%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Assist</strong></td>
<td>30%</td>
<td>34%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Refer to QW-NH</strong></td>
<td>0%</td>
<td>9%</td>
<td>20%</td>
</tr>
</tbody>
</table>
High Level Flow

Funding

$NHVA
(RSA Chapter 126-Q)

$ NH General Funds

$ CDC VFC Funding

$ CDC 317 Funding

Administration

NH Vaccine Advisory Committee

Production

Vaccine Manufacturer

Vaccine Manufacturer

Vaccine Manufacturer

NH Vaccine Selection Committee

State $ CDC

Shipping

Vaccine Distribution by McKesson

Providers

Community Health Centers

FQHC/Rural Health

Local Public Health Centers

Private Practices

NHVA: New Hampshire Vaccine Association
CDC: Centers for Disease Control and Prevention
Million Hearts

- **Community Prevention**
  - Reduce the number of people who need treatment

- **Clinical Prevention**
  - Optimize care for those who do
### Status of the ABCS

<table>
<thead>
<tr>
<th><strong>Aspirin</strong></th>
<th>People at increased risk of cardiovascular disease who are taking aspirin</th>
<th>47%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood pressure</strong></td>
<td>People with hypertension who have adequately controlled blood pressure</td>
<td>46%</td>
</tr>
<tr>
<td><strong>Cholesterol</strong></td>
<td>People with high cholesterol who have adequately controlled hyperlipidemia</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td>People trying to quit smoking who get help</td>
<td>23%</td>
</tr>
</tbody>
</table>

**Source:** MMWR: Million Hearts: Strategies to Reduce the Prevalence of Leading Cardiovascular Disease Risk Factors --- United States, 2011, Early Release, Vol. 60
Outbreak Detection and Response

- Sep. 18, 2012, TN clinician reports case of rare *Aspergillus* meningitis from epidural steroid injection
- CDC notified; by Sep. 25, active surveillance identified 7 more patients with fungal meningitis from same TN clinic and one from NC clinic
- These 9 patients received injections of preservative-free methylprednisolone acetate from New England Compounding Center (NECC) in Framingham, MA
- Sep. 26, 2012, FDA and NECC issued voluntary recall of the three lots of methylprednisolone
- Since May 21, 2012, vials from these lots were distributed to 76 facilities in 23 states
- Sep. 28, 2012, CDC notified all affected states
Multi-state Fungal Meningitis Outbreak - Current Case Count
02-19-13
Goals:

- Identify population at risk (those exposed to the 3 implicated lots of steroid)
- Identify period of risk (initial data suggested up to 6 weeks or longer incubation period)
- Identify cases of fungal meningitis as early as possible
- Elucidate risk factors for infection
- Facilitate early treatment

Nationally, 14,000 patients received MPA injections from the three implicated lots
IHD for mgmt team discussion
suggested dashboard based on mtg 3 18 mtg
How are we going to make this happen and keep track?
Implement Integrated Efforts that Improve Population Health and Lower Health Cost

A. Identify and Create Demonstrated Successes
   1. Identify What Works at the National, State and Local Levels
   2. Create New Innovative Integration Successes
   3. Capitalize on Public & Private Programs to Foster a Laboratory for Creating Successes
   4. Encourage Coordinated Care Models to Emphasize Population Health Outcomes
   5. Use Existing Incentive Programs to Promote Community-Oriented Primary Care

B. Realign Funding to Support Coordination and Sustainability
   1. Create the Value Proposition and Business Case for Integrating Primary Care & Public Health
   2. Promote Funding Transformation to Support Integration Goals
   3. Tap into New and Emerging Funding Streams and Required Programs
   4. Engage in Value-Added Public and Private Reimbursement Conversations

C. Disseminate and Scale Effective Approaches and Systems
   1. Implement a Mechanism to Capture Successes and Best Practices
   2. Align Federal Policies and Programs with Scalable Implementation
   3. Strengthen Training and Evaluation of Health Care & Public Health Professionals
   4. Develop and Implement Marketing Plan

D. Develop & Implement Effective Measures of Population Health
   1. Identify Top Population Health Priorities Using Agreed Upon Criteria
   2. Develop and Secure Agreement on Key Measures for Each Priority
   3. Align Identification & Utilization of Key Measures Across All Stakeholders/Payers
   4. Use Key Measures to Report Outcomes to Providers, Plans and the Public

E. Create the Infrastructure to Support Collaboration & Sustainability
   1. Create Compelling Cases for Integration with Stakeholders at Local, State and Federal Levels
   2. Implement Multidirectional HIE Infrastructure
   3. Develop Current and Emerging Leaders in Using Integration to Improve Outcomes
   4. Promote Integrated Public Health and Primary Care Quality Improvement Processes
   5. Use the Primary Care Extension Program to Support Integration

F. Build the Committed Engagement of the Public, Communities and Stakeholders at All Levels

G. Expand and Strengthen Collaboration and Partnerships
Primary Care and Public Health Integration
Strategic Map: 2012-2014

Implement Integrated Efforts that Improve Population Health and Lower Health Cost

Central Challenge
Primary Care and Public Health Integration
Strategic Map: 2012-2014

Implement Integrated Efforts that Improve Population Health and Lower Health Cost

Strategic Priorities:
A. Identify and Create Demonstrated Successes
B. Realign Funding to Support Coordination and Sustainability
C. Disseminate and Scale Effective Approaches and Systems
D. Develop & Implement Effective Measures of Population Health
E. Create the Infrastructure to Support Collaboration & Sustainability
Expand and Strengthen Collaboration and Partnerships

Primary Care and Public Health Integration
Strategic Map: 2012-2014

Implement Integrated Efforts that Improve Population Health and Lower Health Cost

**A**
Identify and Create Demonstrated Successes

**B**
Realign Funding to Support Coordination and Sustainability

**C**
Disseminate and Scale Effective Approaches and Systems

**D**
Develop & Implement Effective Measures of Population Health

**E**
Create the Infrastructure to Support Collaboration & Sustainability

**Strategic Priorities**

**Cross-Cutting Strategic Priorities**

**Build the Committed Engagement of the Public, Communities and Stakeholders at All Levels**

**Expand and Strengthen Collaboration and Partnerships**

Draft
07/26/12
Tracks of Work

Value Proposition/Business Case

- Create the Value Proposition and Business Case for Integrating Primary Care & Public Health
- Promote Integrated Public Health and Primary Care Quality Improvement Processes
- Create Compelling Cases for Integration with Stakeholders at Local, State and Federal Levels

Successes

- Identify What Works at the National, State and Local Levels
- Implement a Mechanism to Capture Successes and Best Practices
Tracks of Work (cont.)

Measures

- Identify Top Population Health Priorities Using Agreed Upon Criteria
- Develop and Secure Agreement on Key Measures for Each Priority
- Align Identification & Utilization of Key Measures Across All Stakeholders/Payers
Health Indicators

- National Prevention Strategy
- National Health Equity Strategy
- National Quality Strategy
- National Tobacco Control Strategy
- National Physical Activity Strategy
- Prescription Drug Abuse Prevention Plan
Tracks of Work (cont.)

Resources

- Promote Funding Transformation to Support Integration Goals
- Align Federal Policies and Programs with Scalable Implementation
The Inter-sectorial Public Health System

Communities

Government Public health Infrastructure

Ensuring the Conditions for Population Health

Health Care Delivery System

Employers And Businesses

Academia

The media
ASTHO has started a resource website to house materials related to the presidential challenge

ASTHO has started a resource website to house materials related to the strategic map

The page includes the strategic map, presentation PowerPoint, and some additional articles

The page will continue to grow as the tracks of work are more clearly defined

Website: http://www.astho.org/Programs/Access/Primary-Care-and-Public-Health-Integration/Primary-Care-and-Public-Health-Integration/

State Health Agency Profile:
http://www.astho.org/Research/Data-and-Analysis/

State and Local Health Governance Structures:
http://www.astho.org/Display/AssetDisplay.aspx?id=7151

Institute of Medicine, Primary Care and Public health : Exploring Integration to Improve Population Health:  http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx
Opportunities on ACA for PH and PC Integration

- Community health needs assessments
- Medicaid Preventive Services
- Community health centers
- Community transformation grants
- National Prevention, Health Promotion, and Public Health Council
- National prevention strategy
- CMS Innovation Center
- Accountable Care organizations
- Patient-Centered Medical Homes
- Primary care Extension programs
- National Health Service Corps
- Teaching health centers
Communities of Solution: The Folsom Report Revisited

The Folsom Group
American Board of Family Medicine Young Leaders Advisory Group

ABSTRACT
Efforts to address the current fragmented US health care structure, including controversial federal reform, cannot succeed without a reinvigoration of community-centered health systems. A blueprint for systematic implementation of community services exists in the 1967 Folsom Report—calling for "communities of solution." We propose an updated vision of the Folsom Report for integrated and effective services, incorporating the principles of community oriented primary care. The 21st century primary care physician must be a true public health professional, forming partnerships and assisting data sharing with community organizations to facilitate healthy changes. Current policy reform efforts should build upon Folsom Report's goal of transforming personal and population health.

Health is essentially a community affair. This premise has been basic to the activities of the National Commission on Community Health Services. The National Commission, which will bring its operations to a conclusion in August 1966, is a private, nonprofit study group established in 1962 by the National Health Council and the American Public Health Association, yet independent of both. It is financed approximately equally from private and public funds. Thirty-two commissioners, representing a cross-section from medicine, business, labor, voluntary groups, government, and other fields, under the chairmanship of Marion B. Folsom, direct its activities. This month, the final report of the Commission was released.
Total Population Health
If not now, when?
TOTAL POPULATION HEALTH
But I have promises to keep, and miles to go before I sleep, and miles to go before I sleep.

Robert L. Frost
Thank You

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jmontero@dhhs.state.nh.us