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ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

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WHAT DOES POPULATION HEALTH MEAN TO YOU IN YOUR INSTITUTION?

A Summary from Academic Family Medicine Departments

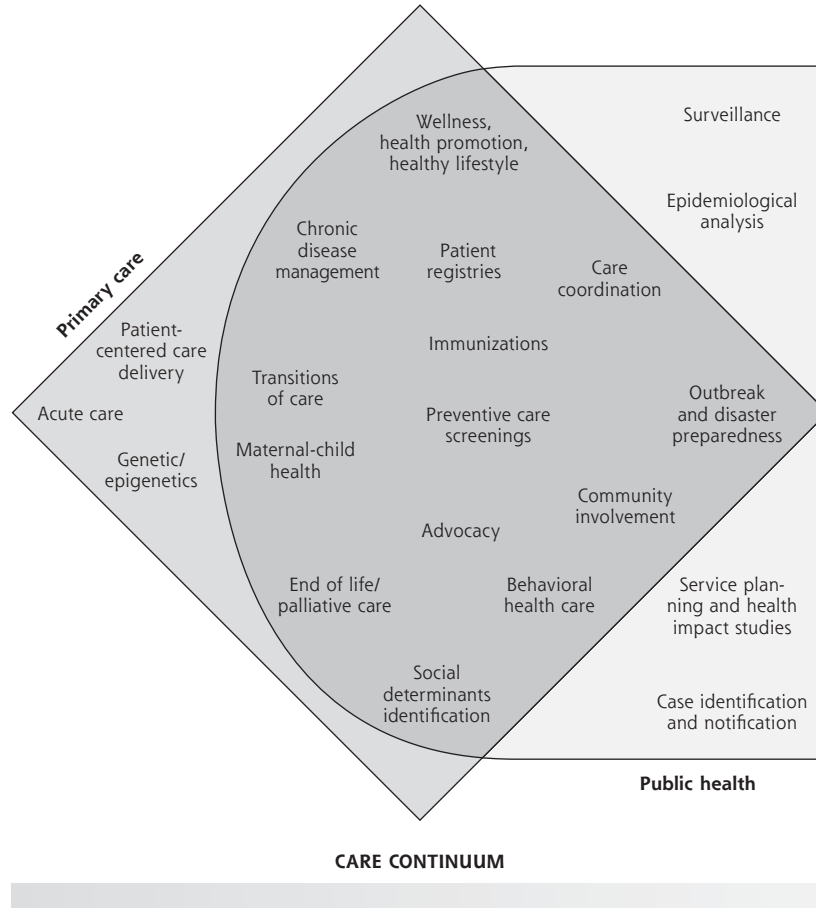
On our 2018 ADFM Annual Survey, we asked the membership, "What does population health mean to you in your institution?" Responses addressed definitions, policies, strategies, processes, and tools related to the clinical, educational, and research implications of population health. Main findings from a simple coding of themes included:

1. The plurality of departments finds a broad definition of population health useful. Attention to the population requires an emphasis on the broader community. Key elements include defining the community, assessing the needs of the community, and improving the health based on commonly agreed upon outcomes. How the broader community is defined is problematic. (Is it payor defined, a geographic entity, or some other construct?) The role of equity and justice is important to some. Attention to the social and structural determinants of health is a key driver for many. Some say population health efforts require advocacy around policy change to be authentic. Additionally, some suggest the rigor of research is necessary.

2. Some departments see their institutional efforts focusing inward on their practices; this is also called population health management or population medicine. A key part of the efforts within these institutions and departments involves community-based multidisciplinary outreach to patients who have poorly controlled chronic conditions or at-risk behaviors aligning with broader efforts to improve the health of all in the community. Advocating for improved resources within the community served by the practice may also include collaboration with public health entities, NCQA certification and alternative payment models such as CPC+.

3. A few departments indicated that their institutions relate population health to the shift to value-based payment. These departments see population

Figure 1. Integration of primary care and public health: the care continuum.



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health as a potential cover to excuse predatory practices and "gaming the system."

4. A small group see their institution as promoting the AAMC definition of population health. In this model, the care delivery system segregates patients based on their needs, with primary care taking on the less complex and working on risk reduction. Our specialty colleagues in this model are enlisted to care for medically complex patients in "specialty medical homes."

We feel these results highlight how we in medicine are still struggling to separate/integrate/find parallel play with public health. And it is ours to tackle![1] The AAFP, in the "Integration of Primary Care and Public Health,"[2] does a nice job of illustrating this struggle.

Family medicine lives at the interface of knowing (1) that your zip code is more important than your genetic code and (2) that you can treat the patient's disease, eg hypertension or diabetes, while the illness, ie poverty, abuse, prejudice, etc, may kill the person. In our patient-centered approach, we feel the tension of needing to think about context community by community (geographic community or a community defined by characteristics), not person by person, and we see the challenge and paradox of wanting to fix the zip code–level issues while recognizing that compensation systems still largely reward by the person and by the CPT code. With only 3% of the trillions of dollars spent annually on health care going explicitly towards public health, what should our role be?[3,4]

Several of our departments have been working to answer this question by engaging deeply with their local communities, partnering with local public health infrastructure and community-based organizations to improve the health of their populations. The University of New Mexico connects the academic health center with the community in numerous ways, including through community health workers in each county serving as a liaison between that community's needs and the state's education and legislation initiatives.

At Duke, upon noticing a hot spot in the Medicaid data of high rates of diabetes, obesity, and ER visits in a historically marginalized minority community, the academic health center reached out to existing stakeholders and with this data—as well as the media reporting that there were far more places to buy liquor than fresh vegetables in that neighborhood—the community was able to rezone the area with a tax abatement for a full-service grocery store that hires local community members.

Those interested in learning more about ways that primary care and public health can partner together should check out the Practical Playbook, https://www.practicalplaybook.org/, a resource for helping public health and primary care work together to improve population health.

Amanda Weidner, MPH; Allen Perkins, MD, MPH; Valerie Gilchrist, MD, MPH

References

1. Hollander-Rodriguez J, DeVoe JE. Family medicine's task in population health: defining it and owning it. *Fam Med*. 2018;50(9):659-661.
2. AAFP Integration of Primary Care and Public Health Work Group. Integration of primary care and public health (Position Paper). https://www.aafp.org/about/policies/all/integprimarycareandpublichealth.html. Published 2015. Accessed Sep 20, 2019.
3. Himmelstein DU, Woolhandler S. Public health's falling share of US health spending. *Am J Public Health*. 2016;106(1):56-57.
4. Dieleman JL, Baral R, Birger M, et al. US spending on personal health care and public health, 1996-2013. *JAMA*. 2016;316(24):2627-2646.

NAPCRG From NAPCRG

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NAPCRG ANNUAL MEETING DISTINGUISHED PAPERS

NAPCRG's Annual Meeting is a forum for primary care researchers from across the globe to gather and present their work, collaborate for new research, and foster growth for up-and-coming researchers. The 2019 Annual Meeting was held in Toronto, Ontario, November 16-20, 2019, and was attended by more than 1,000 researchers, clinicians, patients, and other stakeholder members from around the world.

Three papers from the 2019 Annual Meeting were selected and given the special designation of "distinguished paper" for excellence in research based on the following factors: overall excellence, quality of research methods, quality of writing, relevance to primary care clinical research, and overall impact of the research on primary care and/or clinical practice.

Below are brief summaries of this year's distinguished papers; complete abstracts are available on the NAPCRG website (https://www.napcrg.org/).

Health in a Hostile Environment. Migration as a Structural Determinant of Health for Refugees and Asylum Seekers

Kate O'Donnell, PhD, BSc, MPH BSc (Hons), FHEA, FRCGP (Hon); Anna Isaacs, PhD; Anna Black, BSc, MBChB

Caring for asylum seekers and refugees (ASRs) is an important activity for primary care. However, the