Healthy Hearts: Integrating Public Health and Primary Care

Institute of Medicine Report

- Shared goals
- Core principles
  - Improving population health
  - Involving the community in defining and addressing needs
  - Leadership
  - Collaborative use of data and analysis
  - Sustainability

Time is Right

- Awareness that our current investment in medical care is not reaping expected benefits
- Our nation spends the most on medical care but is way behind other countries in important health indicators, even some countries considered “third world”
- We need to curb our health care spending and improve outcomes and improve population health

Public health in a unique position

- Social determinants
- Disparities and equity
- Prevention
- Partnerships
- Data
- Quality Improvement
- Health in all policies

Community Health Centers: History of interest in population health

- COPC
- 51% of board must be users
- Quality indicators with benchmarking
- General understanding that health is more than medical care

Communities want to be involved

- Local Health Departments
- Community Agencies
- Bring a non medical community perspective
- Insight into community conditions that promote or discourage health

- Federal goal: reduce population with uncontrolled high BP by 10 million within 5 years.
- CDC analysis found 36 million adults with high BP not being controlled – 32 million get regular medical care
- High BP 4 x as likely to die of stroke
- 3 x as likely to die of heart disease
- Kidney failure
- Costs related to high BP exceed $130 million/year

Healthy Hearts

- Goal:
  - Increase control of high blood pressure and high cholesterol
  - Increase access to and demand for high impact quality prevention services

- Strategy: Implement strategies to translate known interventions into usual clinical care to increase control of high blood pressure and high cholesterol
- Activity: Measure utilization of best practices and provide feedback to providers regarding adherence to nationally recommended preventive treatment guidelines
- Activity: Involve local health departments and community organizations in data sharing and designing interventions at clinical and community level.

- Public Health Node:
  - Nomenclature mapping to standard concepts
  - Application of a knowledge base to a data model to detect conditions of interest
  - Messaging to a standard compliant message (CCD, HL7,)
  - Secure transport of the data

- PopHeath – open source software tool for reporting clinical quality measures developed by the Office of the National Coordinator will be integrated into the public health node to develop a dashboard of key quality measures

- Each provider site can send data to the node for installation in PopHealth in any way they can (CCD is preferred)
- Each site will get a dashboard for the site and each individual provider will get a dashboard
- Node can aggregate the data for benchmarking with national, state or regional measures and for integrating with other data sets

- Any indicators or demographics the centers and IDPH may want to examine can be developed in the public health node.

Provide technical assistance to providers to facilitate the transport of their data to the node.

- First call with 4 health centers
- Develop data sharing agreements
- Develop working group to determine prevention indicators
- Determine method of data transport.

- Shawnee Health Services – Williamson County
- Community Health Improvement Center – Macon County
- Southern Illinois Healthcare Foundation – St. Clair County
- Logan Primary Care Services – Franklin County

Partners

- Community health centers
- Local Health Departments
- Community Agencies
- Telligen (Illinois QIO)
- HHS Million Hearts Campaign
- Evaluation Team

- Outcomes:
  - Increase in patients being successfully treated for high BP and high cholesterol
  - Recognition of opportunities to offer prevention counseling and education
  - Redesign of system to create a focus on prevention
  - Community health centers and communities to offer complimentary interventions for Healthy Hearts
  - Community health centers and communities develop data driven policies to promote health of individual patients and the overall community.