COVERSTORY

10 Facts about Population Health

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John Morrissey

What trustees need to know about this facet of delivery system transformation

With more than 20 years in health care as a physician and administrator, it's become evident to Benjamin Chu, M.D., that providers treat people "at the end point" of a long slide, after all the factors that contributed to a medical condition have had their effect. "We're downstream, we're right at the end of all these tributaries, so we're sort of in a delta, catching all of this stuff as it's coming down," Chu says. Most determinants of serious conditions, he observes, "are amenable to early intervention."

Now chair-elect of the American Hospital Association board of trustees and group president of Kaiser Permanente's Southern California Region and Hawaii, Chu's "biggest awakening" came when he ran an emergency department in New York that not only had a high number of asthma-crisis cases but "time and time again were the same people," he recalls. "It begs the question: Could we actually do a better job of realigning some of the resources by focusing a little bit more upstream on some of those determinants?" In short, do more earlier instead of at the end?

The answer to that question should be a resounding "yes" in this emerging era of accountability for the overall health of people. Led by a range of Medicare pilot programs emanating from the Patient Protection and Affordable Care Act, providers are being held responsible for the health status of a defined population instead of just those who see a clinician or go to a hospital. This step up to population-level health involves identifying the people in a community who need attention and giving it to them.

Population health is in large part a quest to systematically find and proactively fix health care problems that afflict whole classes of people similarly. "The reason we fail as health care organizations is we only realize who we are impacting by who we see," says Donald Caruso, M.D., a family physician and medical director at Cheshire Medical Center/Dartmouth-Hitchcock Keene (N.H.). "There's a population out there that doesn't come and see us — but they don't see anyone. Yet they're the people we take care of in their 50s and 60s, 70s and 80s with all their chronic-disease problems."

His message to governing board members: "As a trustee, as a member of the community, you have an obligation to look at your community and say [for example] just treating someone's cardiovascular disease and sending them for a stent at the tertiary-care hospital can't be all we should be doing. It really has to be: How do we keep people from getting there?"

To bring the urgency and opportunity of population health closer to home for trustees of health care organizations, *Trustee* interviewed experts on it as well as executives of health systems that took a population-based and community-focused approach a number of years ago. Their advice and observations are distilled into a list of 10 things trustees should know about population health.

1 This is not voluntary. Accountability for the health status of a population is where we're headed.

So says David Nash, M.D., dean of the Jefferson School of Population Health in Philadelphia. Hospitals already are on the hook to prevent discharged patients with certain diagnoses from having to be readmitted within 30 days. "That's all about practicing effective population health to prevent a readmission," says Nash. The ACA's experiments in accountable care organizations and other value-based, outcome-oriented models of approaching health improvement are pilots now but suggest the paths the government will take.

The clear message from Medicare is that it's heading toward forms of fixed payment, recognizing the impact of health care professionals on the overall health of its beneficiaries; that reality will be upon us in three to four years based on the trajectory of the ACA, Nash asserts. No matter what happens in Washington regarding challenges to the law itself, it won't change the fact that "there's no new money; everything starts with that premise," says Nash. "That's population health: no outcome, no income."

2 Trustees have to think outside the figurative four walls of the institution.

In the new era, hospitals and physician offices become way stations in the larger health management of "covered lives," which will take the place of "patients" as the main focus of a health system's activities. "The customer under accountable care isn't just the person who enters the hospital, it's somebody who hasn't even entered the health care system yet but is part of the defined population that you are, in fact, responsible for," says Barbara Gray, vice president for accountable care collaboratives at Premier Inc. "How do you reach out and find those people — how do you engage them, and how do you work with them and empower them and educate them in a system to help them take care of themselves?"

"Board members are going to have to start asking questions like, 'What's our allocation of resources with regard to paying attention to indices of community health and well-being? How are we connected to our local community?' " Nash says. "That calls for all kinds of services not currently offered: for example, maybe it's of value for a hospital to support a local senior center — put some physicians and nurses, case managers into that center to decrease unnecessary admissions, reduce readmissions."

3 Promoting the good health of the community has to become more than a nice mission statement; trustees need a keen understanding of how to do it.

"This is going to really stretch the skill set for most boards as currently constructed," Nash says. Running a hospital and other associated facilities and offices does not get at community health. "They put it in the mission statement: 'We want to deliver the best quality of care for our community and keep our community healthy.' Oh really. Well, how exactly are you going to do that?"

A first step, he says, may be the outward moves required to extend the hospital's reach past its usual terminus of responsibility at discharge: a nurse call center to contact people recently discharged, a case manager to visit patients at home and make sure they return for follow-up appointments.

Good health also involves helping clinicians do more for patients than current care settings can accomplish. "The biggest battle that I've had is on the ground, in the exam room, getting people to change lifestyle and do the things that actually impact their health outcomes," Caruso says. "Physicians have some influence, but don't have the influence that really occurs within society."

4 Boards have to reengineer their strategic priorities from the ground up to make population health a central theme, reallocate resources and commit to the changes.

"It's not just concentrating on doing the best job in the hospital," says Chu. "Those things are important, but boards are going to have to think about how we go upstream." It goes to the heart of what a nonprofit hospital should do to demonstrate community benefit. Typically, profits are plowed into medical education and expanding services, he says, "but a portion maybe should be devoted to thinking about what would make a bigger impact on communities overall."

Nash says trustees are "going to have to recognize this as a new agenda item that they haven't perhaps otherwise thought of, and they're going to have to approach it first by building it into the strategic planning process; second, by asking management, 'Do you have enough resources to tackle these issues?'; third, what's the board's dashboard of indicators that we're making progress in this area?; and fourth, what's the big dot we want to move? It would be analogous to reducing mortality, reducing medical error by one-third. In other words, what's the measurable population-health goal the board is working toward?"

5 The ability to identify and track target populations, then analyze preventive and interventional needs, is the foundation of population health.

One problem with undertaking population health until now was the difficulty of establishing a target. "You can only (have an) impact on the health of a larger community over time if you have good information about their characteristics — what are their health habits, what are their chronic conditions, how often do they participate in preventive health measures and screening programs that can identify conditions early enough so that you can intervene and prevent the more extreme things from happening?" Chu says. "The big gift to us is that we can actually do that with a digital or electronic record and population-management tool. We can in this day and age track the relative health of our population over time."

The two most important things to know here are an electronic health record is critical, but an EHR by itself is not enough. EHRs are "the beginning of getting data in place, but you still have to learn how to use it," says Steven Hester, M.D., senior vice president and chief medical officer of Norton Healthcare, Louisville, Ky. Once an EHR capability is in place, says Hester, "do you have an appropriate infrastructure to help you analyze and decide who needs services?" At minimum, says Caruso, a health care organization should be able to split its population into registries that

identify people with certain similar conditions and needs — diabetes or heart failure, prenatal care, obesity and the like — "and then be able to risk-stratify that population." Once that's done, the next move is to "prevent people from moving from the middle-risk category to the higher-risk categories" as well as keep low-risk individuals right where they are through preventive activities.

At Kaiser, which has all these tools, Chu can tell the characteristics of 625,000 covered lives in Southern California, which are available not just to doctors, but also any authorized caregiver who comes into contact with someone in person, on the phone or by email. That's how it has been able to control the hypertension symptoms in 87 percent of the people so diagnosed, as well as make big strides in other paths of health improvement. "You want to see ultimate declines in those end-stage outcomes that you're trying to avoid — heart attacks and strokes, colon cancer, breast cancer," Chu says. "You want all those things to either be diagnosed early so you maybe cure it, or really make some big difference in someone's quality of life."

6 Physician leadership development is a smart investment.

For those in the community who are successfully targeted and start receiving health services, the clinical vehicle for executing accountable care is a closely cooperating contingent of health professionals formulated to personalize care for people before, during and after their visits to the physical office setting, says Gray. Called a patient-centered medical home by some, and a health home by Premier, this health team is led by a primary care physician and can include physician assistants, nurse practitioners, a behavioral therapist, and health coaches for diet, exercise and lifestyle changes.

"In the new model ... the physician really is the captain of the team. That physician is going to have to learn a number of new skill sets, frankly, around communication, influence, being able to pull a team together and manage a team," Gray says. Given that, "the role of physician development is absolutely critical," she says. "Physician leadership will make or break an accountable care organization."

This new role "is a real challenge because the current training model is the autonomous decision-maker," Nash says. "What boards need to do is ask management, 'What are we doing to train clinical leaders in population-based care?' Do you have the right resources, current leadership and emphasis?"

7 Hospitals not only have to find the people in greatest need, but also leverage a community's existing resources in attempts to reach and support people where they live.

Local health departments, schools and other community resources likely are helping to keep their constituents healthy as part of their roles, says Michael Bilton, executive director of the Association for Community Health Improvement, a personal membership group of the AHA. The idea is not to reinvent services and duplicate them, but to find out what's being done already and strike mutually beneficial agreements. Many hospitals have relationships with YMCAs to help run wellness, fitness or diet-nutrition programs. But these programs don't occur enough, and as providers become accountable for outcomes beyond a procedure or episode, "these other components become more strategically important," he says.

Community partners can be social, governmental or clinical. Premier advocates establishing a "high-value network," comprising other professionals at the direction of the health home — specialists, skilled nursing facilities, public health agencies, other hospitals. Entities in the larger community "may have a great deal of information and know a whole lot more about people you're managing than perhaps the physician himself," Gray says. Besides other health sites, efforts should be on "treating people where they are," such as workplaces, community centers and churches.

8 Limited resources have to be put to the most pressing need with the biggest possible impact.

Having the characteristics of a community in hand is a mixed blessing: How do you fully serve the needs of all with a limited budget? The answer may be that you don't. Instead, focus on the medical minority that stands out, at least initially. "There's a lot of evidence that a relatively small proportion of the population accounts for a disproportionately large share of health care use and health care cost — and suffering through ill health," Bilton says. It makes sense to "identify those higher-risk or higher-using, less-healthy groups and then deploy a range of population health strategies in service to improving their health, which should help ease the burden on the health care delivery system."

Normally, the clinical objective is to apply the same standardized set of screenings and treatment for anyone with a particular medical condition, Hester says. "There's some benefit to that, but maybe not everyone needs all those intensive resources, or maybe someone needs more resources." Health data can show what's happening and where, but now it needs to predict who will benefit most from various

interventions, "a totally different utilization of data than we've done in the past." With a group of, say, 500 people, the aim is to know the 100 using health services the most and what the health system can get to them for the greatest impact.

9 Good programs and value-oriented goals are meaningless without payment that rewards population-level health management and its measurable health and cost-containment gains.

Payers should be just as interested as providers in aligning around improving quality outcomes while controlling costs and improving member experience, Gray says. Boards should ask what the role of local payers likely will be — for example, who will be responsible for care management and what the criteria are to evaluate potential payer partners.

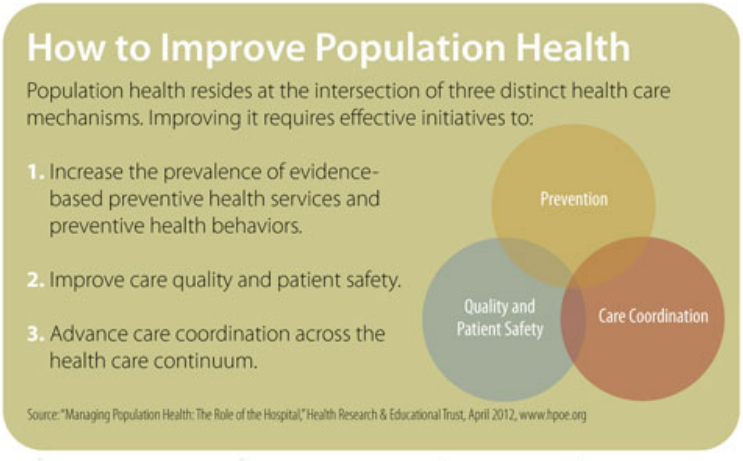
Partnership means sharing data comprehensively, and sharing savings from population management. Reducing admissions and ED visits will save money for the payer, and that savings must be shared with providers to offset the loss of revenue under the traditional business model, Gray emphasizes.

As private payers and Medicare take to population management and reward accordingly, she adds, health systems will be faced with changing their contractual arrangements as quickly as possible to erase conflicting incentives and get their workforces to produce under new emphases on outcomes and cost control. "If you're [still] being rewarded on volume vs. value, your behavior is going to be different," she notes. But it's a daunting balancing act, because the strategic and operational changes have to be accomplished ahead of the contractual changeover.

10 The health care field as currently constituted has insufficient skills for the challenge.

The need for new expertise, Nash says, may have to start at the board level: for example, representation in the fields of wellness, chronic-illness care, public health, preventive approaches, and notably epidemiology, or the study of the distribution and determinants of all things health-related, including diseases.

Hester says boards have to oversee analysis of the talent pool in the organization to ensure that the higher degree of sophistication in data management and priority-setting within identified problem populations can be well-executed. Those skills may have to come from somewhere else. "There are folks outside the health care industry who can be very valuable to us to make decisions and from an analytical standpoint," he says. They include people with actuarial experience; people who understand data and create predictive models; and experts in data interpretation.



Online Exclusive

Hospitals are extending their reach by forming partnerships with local organizations. Learn more in the Web-only feature "When the Community Comes Together".

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Sidebar - Acting on ACA

Several sections in the Affordable Care Act are driving hospitals toward population health management by promoting and incenting prevention, quality and safety, and care coordination strategies. The most actionable initiatives are:

- ACA requires tax-exempt hospitals to conduct community health needs assessments every three years and adopt implementation strategies that meet the identified needs, including identifying reasons why any such needs

are not being addressed.

- The law expands coverage for a wide range of prevention and wellness services, increasing incentives for employers that establish wellness programs and eliminating co-payments for immunizations, screenings and other clinical preventive services.
- The elimination of payment for unnecessary readmissions and the development of delivery payment pilots increase the hospital's accountability for care outside its four walls.
- Medical home demonstrations, coordination grants and increased financial support for health centers encourage partnerships between hospitals and other community organizations.
- ACA creates a fund to provide sustained national investment in preventive and public health programs, including those offered by hospitals to increase access to
clinical preventive services and create healthier communities.

Source: *"Managing Population Health: The Role of the Hospital," Health Research & Educational Trust, April 2012, www.hpoe.org*

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