



MOVING TOWARD Population Health

AN INTERVIEW WITH
DAVID NASH, M.D., M.B.A.

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*This is the second in a series of
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AS THE HEALTHCARE SYSTEM CONTINUES TO TRANSFORM FROM VOLUME-TO VALUE-BASED REIMBURSEMENT FOR CARE, PROVIDERS HAVE A GREATER ROLE AND RESPONSIBILITY IN BUILDING A CULTURE OF HEALTH IN THEIR COMMUNITIES. HOSPITALS AND HEALTH SYSTEMS ARE RECOGNIZING THE PARADIGM SHIFT TOWARD POPULATION HEALTH MANAGEMENT AND ARE INCREASING LEADERSHIP ENGAGEMENT, COLLABORATING WITH COMMUNITY PARTNERS, AND EXPANDING THEIR SCOPE OF SERVICES TO FOCUS ON PREVENTION AND WELLNESS PROGRAMS FOR THEIR COMMUNITIES.

RAPID CHANGE IN THE HEALTHCARE MARKETPLACE IS BEING DRIVEN BY NEW FINANCIAL INCENTIVES IN THE AFFORDABLE CARE ACT, STATE REFORM INITIATIVES, AND PRIVATE INSURERS TURNING TOWARD RISK-BASED CONTRACTING. AMID THESE AND OTHER FORCES OF CHANGE, HEALTHCARE CHIEF EXECUTIVE OFFICERS (CEOS) AND THEIR GOVERNING BOARDS ARE PURSUING NEW STRATEGIES TO DELIVER COORDINATED CARE, IMPROVE QUALITY, AND REDUCE COSTS. THESE STRATEGIES, WHICH CAN INCLUDE MERGERS, NEW BUSINESS MODELS, AND DIVERSIFICATION, HAVE CREATED THE NEED FOR NEW TYPES OF LEADERSHIP SKILLS.

TO ILLUMINATE THIS ISSUE, HANYS INTERVIEWED DAVID NASH, M.D., M.B.A., DEAN, JEFFERSON SCHOOL OF POPULATION HEALTH, THOMAS JEFFERSON UNIVERSITY, WHO SHARED HIS EXPERTISE ON WHAT THE MOVE TOWARD POPULATION HEALTH MANAGEMENT MEANS FOR HEALTHCARE EXECUTIVES AND TRUSTEES.



What is population health?



Many definitions of population health are available to us in the literature. The one that we use principally was first developed by David A. Kindig, M.D., Ph.D., more than 15 years ago. It comes in three parts. The first part says that there are certain health outcomes in the population, like morbidity, mortality, and quality of life—pretty straightforward. Then there are determinants that influence those outcomes, like socioeconomic status and your environment. There are also policies that further influence this distribution, like the Affordable Care Act, for example.

It turns out that medical care itself, the actual laying on of hands, is responsible for about 20% of a society's thriving, wellness, resilience, and overall quality of life. Population health really emphasizes what has come to be called the “social determinants” of a population's well-being.

We use population health as the broadest possible umbrella term or “roof of the house” or “top of the pillar.” All those analogies work for us. Here's what I mean: Under population health, we put public health as the central pillar; health policy, healthcare quality and safety, and health economics.

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Do you see many healthcare providers moving in the direction toward population health?



I think the better question, frankly, is: who is not moving to population health? In other words, every clinically-integrated network that I'm familiar with across the country is moving toward population health, spurred on by health reform and, most importantly, the move from volume of services to value of the services that we're delivering. Population health is all about that transformation from volume to value.

There are scores of great examples: Banner Health in Arizona, the Jefferson Health System, Geisinger, Everett Clinic, and Oxnard. Most of the places I've had the privilege of visiting are moving toward a population health framework.



What are some health systems and providers doing in terms of their population health strategy?



Population health is a complete transformation of the delivery system. It's not just a strategy, it's a complete cultural change, moving from "more is better" to "less is more."

Here's why: We know that medical care is only responsible for about 15% to 20% of a society's well-being, thriving, and resilience. As a result, we have to focus on the other 80%. The other 80% is messy. It is poverty, housing, education, the environment, violence, and socioeconomic status. Provider organizations that recognize the strength of all of these social determinants are working in a much deeper way with the communities they serve.

This means working with the education system—high schools, colleges—religious organizations such as synagogues and churches, and with community groups. Population health says essentially everything that occurs outside the hospital is what is really important. Most integrated delivery systems that are hospital-based are finding this to be a difficult strategy. So, it's a total transformation.

Secondarily, you follow the dollars. As we move from volume to value, we're only going to get paid based on a good outcome. Most of the organizations that are moving toward population health have fully embraced the ever-popular saying, "no outcome/no income."

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Speaking of outcomes and income, one of the biggest challenges providers face is the lack of reimbursement in the current system as they move toward population health management. When do you see this changing? What are some of the other top challenges for health-care leaders with the shift toward population health?



No one knows the exact timeframe of reimbursement change. We know it's going to happen; we're already sort of ankle-deep in it. When it will get up to our waist or

our chest, nobody knows; but the best guess is in the next three to five years, no matter who is in the White House in 2016.

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But, I think the biggest challenge in addition to the change in reimbursement is the cultural change. You cannot take a community hospital medical staff that have been focused on volume for the past 50 years and overnight expect them to embrace a population health agenda. It cannot happen.

So what does that mean? Well, it means building a new leadership

team of physicians, nurses, pharmacists, and others who fully understand all the basic tenets of population health. The two top challenges, probably in this order, would be, number one, change the culture of practice and, number two, track and assiduously work toward where we believe reimbursement is going to be going.



What are some of the key opportunities for healthcare providers in population health?



That's a great question. The biggest opportunity is to influence the health of the population. We are not currently in the health business; we are in the sickness business. Most hospitals are all about the care of acute and chronically ill individuals. That's been our core business for the 31 years that I've been a physician. Population health gives us the opportunity to truly influence the well-being of the larger population. We're working on measures of exactly how to go about doing that.

These measures include well-established global measures of thriving, resilience, happiness, and days without hospitalization. I think in the short term, the measures of population health will be reduction in emergency room visits and reduction in readmissions. You appreciate nationwide the re-admissions alone for congestive heart failure are more than 700,000 annually. As a healthcare system, we have a lot of work to do.

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Who do you see from the C-suite championing population health within healthcare organizations?



This is a very complex question at the moment. Each week for the last year, I've received a phone call or an email from an organization searching for a leader of their population health agenda. And typically, that call comes from the senior-most C-suite leader, the CEO of the organization, and many times also the board chair, looking for a trained expert in population

health. As you are aware, there are a burgeoning number of medical school departments of population health and institutes of population health. Of course, we still have the only school of population health in the country. But, the emphasis is coming from the senior-most C-suite leaders who are looking for leaders in this arena.



How are healthcare providers changing the focus on population health?



I think the number one way providers are changing their focus toward population health is through education. For example, they are sending emerging leaders to our school, to other institutes, to online programs like we promote at The Jefferson School, to the American Association of Physician Leadership. The Jefferson School is debuting a two-day course on population health for physician leaders.

The second way is building the information technology infrastructure. That means creating registries so that primary care doctors and others can instantly see just how their patients are doing. For example, I'm a primary care doctor. I'm hoping for the day when I'll go into my clinical office and there will be a way for me, very easily, to look up all my patients who have diabetes, all my patients who have

heart failure, all my patients who survived an infarction last year, and have a display available as to how they're doing.

And then, how am I doing relative to a local, regional, and national benchmark because again, we know, no outcome/no income. If I'm not doing a good job, our organization is not going to get paid what we deserve. We're going to move toward population health, first, through education; second, through information technology infrastructure, and then, third, we need better measures of population health. Those are in development right now with the National Quality Forum, Agency for Healthcare Research and Quality, and others. This is a complete transformation of what we do every day at the bedside, in the office, and in the hospital.



What kind of innovations are healthcare providers including in their population health strategies?



I think the biggest zone of innovation is coming on the consumer engagement front. I hope your members are aware that Wall Street has poured billions of new dollars in the last four years alone into private sector startup companies whose sole mission is patient engagement. And when you think about it, it makes complete sense. Why? Well, we can't really improve the health of the population if they're not going to be with us on that journey.

We are seeing all kinds of new companies, like Welltok, in Denver, Colorado, an online platform for patient reward incentives and engagement. Healthgrades in

Denver has patient engagement; Health Advocates in Plymouth Meeting, Pennsylvania. I could go on. There are at least 100 new companies in the last four years alone focused on patient engagement.

And the innovation comes in several different ways: web-based, on the telephone, skyping with patients, and telemedicine. Quantified selfers [people who monitor and track their personal health and wellness data] are spreading, and they're certainly leading the social conversation about engagement. I think this is the "hotbed" for the future.



What questions do you think governing boards should ask their executive leadership about population health to ensure that their organizations are prepared and able to compete in this new healthcare environment?



That's the most important question in my mind because we all know that the ultimate fiduciary responsibility for the success of the population health strategy rests with the boards. It is important to first educate board members about population health.

The questions boards should be asking:

- **NUMBER ONE:** What are we doing today to train the population health leaders of tomorrow? That's a crucial board-level question.
- **NUMBER TWO:** Do we have the information technology infrastructure to even begin the population health journey?

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- **NUMBER THREE:** Where are the opportunities for us to improve? Let's remember, medical error is still the fourth leading cause of death. Just because we're entering into a population health strategy does not mean that we've automatically solved the issue of delivering safe care.
- **AND THEN NUMBER FOUR:** What are we doing to standardize our work and create protocols that are based on the best available evidence, and how do we close that feedback loop with practitioners?

Again, all of this is really a major cultural transformation on the delivery front. Governance leaders need to be asking some pretty powerful questions. Not just, what are the strategy and the tactics, but how are we going to even begin the cultural transformation?

I think that's probably the overarching governance question.

The answers to that question may be disruptive. I'm pretty confident that there are many hospital leaders who wish this would all go away and who grew up in a world of "more is better." So they're going to find this transformation daunting. It's going to be especially daunting at rural hospitals or in the special access hospitals. They're going to be in a real jam as they attempt to implement a population health strategy.

It will also be daunting in the big community hospitals that have been very successful on building volume over the years. They're going to find this transformation painful. So board members are going to have to reassess whether they have the right leaders in place for the future. That's going to be a critical board conversation.

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Have you seen any governing dashboards in your visits and interactions with healthcare systems across the country?



You bet. Recently, I had the privilege of working with the board of CHRISTUS Health in Texas and with Trinity Health in suburban Detroit. These are two major national systems. I had the opportunity to speak to the Catholic Health Assembly late last summer. These major national organizations

are hiring senior executives with the profile of the senior vice president for population health, under whom they are placing managed care contracting, accountable care organization development, physician leadership training, epidemiology, and community health engagement.

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These major national organizations have been working for two years now on their population health agenda. And that means getting the board educated first, and then going out and getting additional talent and beginning the cultural transformation. So this is a multi-year journey, even at the national level, with organizations that have ample resources to begin this journey.

We're promoting a population health dashboard to major organizations—like VHA. They have a population health self-assessment tool. Sg2 in Chicago has a population health self-assessment tool and dashboard. The Institute for Healthcare Improvement is promoting the Triple Aim; and within the Triple Aim, of course, is improving the health of the population, improving the individual experience of care, and reducing per capita costs. Within the population measures, we're looking at things like

reducing emergency room visits, reducing unnecessary hospitalizations, reducing readmissions, and improving community connectivity.

And then something I'm very personally proud of is my work with the Humana Corporation, where I'm a board member. Humana has as its enterprise goal for 2015 that it will improve the health of the population in cities that they serve by 20% by the year 2020. So the slogan is: 20% improvement by 2020. And Humana has developed a series of very well-regarded population health measures, mostly borrowed from the Robert Wood Johnson Foundation and other organizations.

This movement has steam, no question about it, and has a tailwind because organizations recognize it's a multi-year journey to prepare for a world of no outcome/no income.

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Any final words of advice for our healthcare leaders in New York State who may be skeptical or struggling with this population health idea?



I feel their pain, and I'm very empathetic. I think to get us to a world of no outcome/no income is going to mean a change of the very DNA of what our member organizations are all about. And the challenges are great, starting at the governance level. Of course if I put my Dean hat on, we believe the beginning of the journey is all about education, like we're doing here today, and spreading the word, educating leaders from the board on down as to the basic tenets of population health, and then creating a leadership team.

For me personally, beyond my Dean role, as a doctor, to me the biggest challenge is right at the frontline in the examining room helping our clinical colleagues to really understand that they'll have a much greater impact on the health of our patients by practicing population-based care.





ABOUT DAVID NASH, M.D., M.B.A.

David Nash, Founding Dean of the Jefferson School of Population Health and the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy, is a board certified internist who is internationally recognized for his work in public accountability for outcomes, physician leadership development, and quality-of-care improvement. Dr. Nash has governance responsibilities in both the not-for-profit and for-profit healthcare sector, including serving as a member of the Board of Directors of the Population Health Alliance in Washington, D.C., and on the National Quality Forum Task Force on Improving Population Health. Dr. Nash has authored more than 100 articles in major peer-reviewed journals and has edited 23 books. Dr. Nash received his Bachelor of Arts degree in economics from Vassar College; his Medical Doctor degree from the University of Rochester School of Medicine and Dentistry, and his Master of Business Administration in Health Administration from the Wharton School at the University of Pennsylvania.

WWW.JEFFERSON.EDU/UNIVERSITY/POPULATION_HEALTH.HTML

HANYS' Population Health website offers the latest resources and tools available about population health.


For more information about HANYS' Population Health Agenda, contact Sue Ellen Wagner, Vice President, Community Health, at (518) 431-7837 or at swagner@hanys.org.

To request additional copies of "Moving Toward Population Health," contact Sheila Taylor, Executive Assistant, at (518) 431-7717 or at staylor@hanys.org.



WWW.DATAGEN.INFO

DataGen, an affiliate of the Healthcare Association of New York State, released a white paper, *Patient-Centered Analytics for Population Health Management: A new approach to data-driven decision-making*, which discusses how in today's healthcare environment, decision makers need the right tools and resources to identify, manage, and track the progress of initiatives and interventions for the populations they serve. DataGen also has recorded a *Patient-Centered Analytics: The Intersection of Big Data and Population Health* webinar which focused on a new approach to data-driven decision-making.



Healthcare Association of New York State
One Empire Drive, Rensselaer, NY 12144
(518) 431-7600 www.hanys.org