

# Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

Editor-in-Chief: *David B. Nash, MD, MBA* • Managing Editor: *Janice L. Clarke, RN, BBA* • Editorial Staff: *Dorah C. Meiris, Alexis Skoufalos, EdD*

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This newsletter was jointly developed and subject to editorial review by Jefferson School of Population Health and Lilly USA, LLC, and is supported through funding by Lilly USA, LLC. The content and viewpoints expressed are those of the individual authors, and are not necessarily those of Lilly USA, LLC or the Jefferson School of Population Health.

## Editorial

### Understanding the Patient’s Role in Health Care Reform

By *David B. Nash, MD, MBA*  
*Editor-in-Chief*

In spite of fears and uncertainty about the Patient Protection and Affordable Care Act’s (ACA’s) future impact - and perhaps its very survival - forward-looking leaders in every sector are moving ahead with the process of transforming the US health care system. The restructured system will be one in which high-quality and safe care is delivered effectively, timely, and in a patient-centered manner.

Whatever our roles in the health care industry (eg, clinicians, administrators, technicians, pharmacists, clerks) each of us will one day be a patient. As suggested by its title, patients are central to almost every provision in the ACA and, to a great extent, success will depend upon our collective cooperation as patients. In order for providers and payers to meet the ACA’s substantial requirements, we as patients must become better informed about our health, more engaged in our health care, and more attuned to the value proposition when making health-related decisions.

This realization was quite sobering, and became even more so as I read an intriguing commentary in the December 4, 2011, issue of the *Journal of the American Medical Association*.<sup>1</sup> With 30

years of experience as both practicing physician and health economics researcher as a basis, Allan S. Detsky, MD, PhD, authored a piece titled “What Patients Really Want From Health Care.” Some of our collective patient preferences and priorities, per Detsky, follow:

#### Highest Priority

- A majority of us focus on symptom relief and restoring “good health” (by our own definitions) rather than on preventing future illness - which is bad news for population health.
- Even those of us whose health is unlikely to improve want to have “hope” and to be offered options that might help (ie, more tests and treatments even when these are unlikely to be effective).

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- Most of us concur with the ACA's recommendations concerning continuity, choice, and coordination. On a positive note, we want to build relationships with our clinicians and expect them to communicate with one another.
- We want private rooms and no out-of-pocket costs.
- We want our clinicians to be “the best” as judged by other patients or trusted clinicians rather than objective information.
- We prefer medications and/or surgery (ie, treatments that require little or no effort on our part) to strategies that involve changing our behavior.

At the other end of the spectrum, Detsky observes that we, as patients, have virtually no interest in US health care costs, the percentage of our gross national product devoted to health care, or international comparisons pertaining to health. In short, we are a very self-centered bunch.

This eye-opening piece makes it patently clear that our patient priorities

work against wellness and population health initiatives and, on an even more fundamental level, against the general acceptance of evidence-based medicine. Although patient preferences may not be entirely rational, they are not irrelevant. Marketing experts surely would agree with Detsky in pointing out that policy makers must understand and appreciate public preferences as they plan and undertake reform efforts.

In this second issue of our series on how various provisions of the ACA have begun to affect health care quality and population health, we focus on patient-centeredness. “Health Care Reform: ‘Uhhhh, Do We Have to Include the Patients?’” traces the evolution of the patient’s role in health care – from passive, unquestioning subject of a physician’s assessment to full partner in all decision making concerning his or her health – a journey that hasn’t always been easy, but one that certainly is worth the effort.

The burgeoning population of seniors takes center stage in “Health Care Innovation in Medicare Advantage: The Humana Experience,” as the author details the unique health care challenges posed by this population

and discusses targeted approaches taken by a private insurer to meet the expectations of health reform.

As a strong proponent of population health, the final article really resonates with me. “For Health Reform Success, Context Matters Most,” is a thought-provoking piece that pushes the boundaries for most of us in the health care industry by reminding us that each patient is part of a family, a community, and a culture.

I hope that this issue will provoke discussion on the expanded role of patients in health care reform. As always, I welcome questions and comments from our readers. I can be reached at: david.nash@jefferson.edu.

*David B. Nash, MD, MBA, is the ~~dn~~ and the ~~DR~~Raymond C. and ~~Dis~~ N. Grandon Professor of Health Policy at the Jefferson School of Population Health (JSPH) of Thomas Jefferson University in Philadelphia, PA.*

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## A Message from Lilly Health Literacy Matters

By Jack Harris, MD

How can we expect patients to act on health information they don't understand?

According to the *National Assessment of Adult Literacy (NAAL)*, low health literacy affects more adult Americans

than obesity, diabetes, HIV/AIDS, and breast cancer combined.

Health literacy is defined by the Institute of Medicine as: “The degree to which individuals have the capacity to obtain, process, and

understand basic health information and services needed to make appropriate health decisions.”<sup>1</sup>

Health literacy varies by context and setting and is not necessarily related to level of education or general reading

ability. A person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment. With the move toward a more “patient-centric” health care system as part of an overall effort to improve the quality of health care and to reduce health care costs, being a patient is becoming more complex than ever.

Today, patients need more than the ability to read and understand important information to manage their health and successfully navigate the health care system. A global set of skills is necessary to access health services, comprehend data and information, speak up and engage openly with health care providers, understand and recall spoken information, problem solve, use technology, critically weigh options, and make decisions.

In addition, many patients need to adopt and maintain complex behaviors over time to manage a chronic disease or condition in order to enjoy the most optimal outcome.

The health literacy problem is a crisis of *understanding* medical information rather than simply being able to *access* information. The health of 90 million people in the United States may be at risk because of the difficulty many patients experience in understanding and acting on health information – which, in turn, has a negative impact on health outcomes and the broader health care system.

How does this affect us all? In general, adults with low health literacy:

- Fail to seek preventive care

- Are less likely to comply with prescribed treatment and self-care regimens
- Make more medication or treatment errors
- Are at higher risk for hospitalization than people with adequate health literacy skills
- May remain hospitalized longer

The issue of health literacy is also fundamental to efforts to reduce health disparities among various segments of the population. Clear health communication techniques can help health care organizations reduce these disparities by ensuring that health information is delivered in easy-to-understand, actionable, and culturally relevant terms.

In alignment with our corporate vision of “Improved Outcomes for Individual Patients,” Lilly believes that clear health communication is a vital component of the health care delivery system in which pharmaceutical companies play an important role. We consulted with nationally recognized thought leaders and partnered with health literacy experts to implement:

- A cross-functional corporate health literacy awareness team
- Internal health literacy awareness events
- Staff and agency trainings
- Communication redesign guidelines
- Pilot testing of resources with consumers

- Strategic planning initiatives

Over time, we strive to ensure that the communications, tools, and resources we develop for patients use plain “living room” language that can help reduce health disparities and improve health communication between patients, providers, and payers.

Admittedly, this is a lofty goal and, as with any transformational journey, we still have plenty of work to do.

According to the American Medical Association, poor health literacy is “a stronger predictor of a person’s health than age, income, employment status, education level, and race or ethnic group.”<sup>2</sup>

The impact of low health literacy has serious consequences for individual patient outcomes and the health care system as a whole. This widespread but often unrecognized public health challenge should serve as both a warning and a call to action: Understanding health information is everyone’s right; improving clear health communication is everyone’s responsibility.

*Jack Harris, MD, Vice President,  
US Medical Division at Eli Lilly and  
Company.*

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## Health Care Reform: “Uhhhh, Do We Have to Include the Patients?”

*By Samuel Lin, MD, PhD, MBA, MS*

Today’s patients have become more sophisticated in the ways and means of health care. They expect to be included in medical decision making that impacts them or their family members. This transformation from passive recipients to assertive associates in health care has come about primarily because of advances in medical tenets and information technology rather than as a consequence of concerted endeavors by the health care establishment to empower patients or to nurture their health care capacities and competencies.

Historically, the provision of health care services has been based upon a sequential logic of illness or injury followed by curative or reparative treatment. Also, the authority and decisions about patients’ health care processes have been managed within the purview and determination of the physician. Thus, it was inevitable that patients would perceive health status and medical treatment as mystical phenomena, the secrets and conduct of which were known, indisputably, only to the physician. Medicine’s forefathers and insightful sages - from Hippocrates to Oliver Wendell Holmes and beyond - promulgated this sentiment in their day.

As a consequence of the foregoing, a mantle of omniscience and infallibility was bestowed upon the physician that left little need or incentive for patients to learn about or assume any obligation for their health care. Thus, the lack of lay health knowledge and the fear of the unknown led patients to relinquish ownership of, and involvement in, addressing personal health concerns.

Another unfortunate sequela was that the parochial nature of health care, exhibited only by curing and repairing (ie, paying for encounters rather than prevention or outcomes), contributed readily to an explosive growth in direct costs (eg, diagnoses, therapies) and indirect costs (eg, loss of wages, overall societal productivity). Further, these costs escalated because uninformed, unmotivated patients allowed illnesses to progress beyond their more readily treatable states and sought care only in more advanced stages of disease when poorer prognoses require more expensive, prolonged treatments. One promulgation of this disposition led to the current burgeoning and costly use of the emergency department as the alternative norm to regular primary care.

Fortunately, the advent of several seemingly distinct phenomena encouraged a realignment of the conventional medical wisdom governing health care, and also provided sound pathways to reduce health care costs.

First, in the late 1970s, the sentiment for health promotion and disease prevention rose to national prominence as an alternative to the staid doctrines of only curing and repairing.<sup>1</sup> The premise was that practitioners and patients could improve their lot in health status and related fiscal outlays by adopting a culture of reducing disease through proven interventions of preventive health practices and modified lifestyle regimens.

Second, in the mid-1980s, a notion emerged and proliferated that positive consequences of health interventions and therapies could be standardized

and ordained by employing effective and economically sound evidence-based best practices.<sup>2</sup> Such practices would contribute to enhancing medical care in 2 ways: (1) by incorporating newly-defined objectives (eg, health status, quality of life, comparative costs, patients’ informed opinions) into the clinical decision-making processes, and (2) by facilitating documentation, measurement, and assessment in common databases.

Third, in the early 1990s, the rapidly growing age of information technology incorporated health knowledge. Thus, health information technology (HIT) became an accessible commodity and utility for all persons, from practitioners to patients. This cyberworld phenomenon was particularly instrumental in advancing the ability of patients to search for health information and become more inquisitive regarding their physicians’ decisions. If knowledge is a necessary root of power, patients now were becoming astute power brokers and partners in the construct of their health care.<sup>3</sup>

The stem principles of these 3 seemingly distinct phenomena represented potential solutions for enhancing active versus passive patient care, access, quality care, and meaningful outcomes while ameliorating rising costs. Furthermore, these determinants engendered themselves as new critical dimensions for health care (ie, patient participation, value-based care, treatment choices). Preventive measures that promote optimal health status require informed patient participation in health behavior modifications including lifestyle, diet, exercise, environment,

and regular attention to health care. In contrast, the conventional sentiment of only curing or repairing allows little forethought for advancing preventive assessments, predictive algorithms, and developing alternatives to standardized treatment modalities.

The quantifiable protocols for assessing health outcomes, effectiveness, and efficiencies substantiate the management and reduction of health care risks as indisputable justifications for health promotion and disease prevention. This accession of health economic and outcomes assessments also leads to a rethinking of traditional measures of dependent variables that resulted in either successful or failed therapies.

With public access to HIT through the media and the Internet, patients are able to savor their long-desired roles as comanagers of their own health care. And as part of their becoming informed “customers,” patients also can obtain comparative information on practitioners, treatments, costs, and alternative modalities. In essence, the health care that they are now engaging in as owners and partners can become more transparent.<sup>4,5</sup>

As stated previously, the advancement of patients into the management of their own health care processes cannot be credited to any concerted effort of the health establishment. This poignant observation is critical for practitioners to appreciate if they are to establish progressive linkages in the patient-physician partnership. Such a relationship equates to a patient-physician parity in decision making but does not imply equivalency in clinical competencies or judgements. Thus, while the patient can learn and discern the essentials about the extant disease process, the advanced clinical knowledge and practice skills needed to ultimately care for the patient remain appropriately within the purview of the physician.

In any case, this new participatory role for patients, embodied as full partners and owners of their personal medical decision making, must be endorsed and advocated by physicians if the new order of health care reform is to be propagated equitably. Lastly, these new-found ingredients for patients, including health knowledge, information technology, reduced treatment variables, and a greater informed adherence to clinical

protocols, will contribute progressively to more prudent spending that leads to reduced outlays of health care costs as the ultimate measure of true health care reform.

*“Physicians will be called on to develop a new partnership with a public that is more responsible for its own care.”*

Jerome P. Kassirer<sup>6</sup>

*Samuel Lin, MD, PhD, MBA, MS is a former Assistant Surgeon General and retired Deputy Assistant Secretary for Health in the US Department of Health and Human Services. He can be reached at: sam.lin@comcast.net.*

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## Health Care Innovation in Medicare Advantage: The Humana Experience

By Tom James, MD

In 2010, the costs to the United States for Medicare services for its 46,589,141 beneficiaries were estimated to be \$457.6 billion dollars - 12.6% of the entire federal spend.<sup>1,2</sup> Although escalating Medicare costs have been recognized as a serious problem for more than a decade, effective solutions have been elusive.

Medicare Advantage (MA) evolved from a program called Medicare + Choice (or Part C) that was introduced through the Balanced Budget Act of 1997. With the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, changes were made to the structure and reimbursement processes

of Part C and the name was changed to Medicare Advantage. This offering of traditional Medicare plus additional benefits through private insurers was an effort to enhance benefits while controlling costs. Over the course of its history, federal modifications have made health plan participation more, or at times less, attractive.

*(continued on page 6)*

With some 4.2 million members, Humana is the second largest participant in MA. Of these members, 1.9 million are enrolled in an MA health maintenance organization (HMO) or preferred provider organization (PPO) product and 2.3 million have elected a prescription-only Part D plan. Because of Humana's position in the MA space, and because of its 25 years of continuous Medicare experience, the organization has devoted significant resources to the development of programs that identify and fill gaps in care and gaps in support services for its MA membership.

### The Current Environment for US Seniors

The United States is undergoing a demographic shock as the baby boomer generation enters the Medicare age group. Between 2006 and 2030, the senior population older than 65 years of age will grow at a rate 10 times faster than that of the working population. During 2011 alone, an estimated 7600 individuals turned 65 each day. Originally, Medicare funding was predicated on having a large enough work force population to financially support Medicare beneficiaries. As the balance between these populations has shifted, the pressure on the Centers for Medicare and Medicaid Services (CMS) to reduce costs, increase income, or develop a combination of both has increased.

MA helps to make the costs of care more predictable for CMS. Private health insurers that participate in MA are paid a capitation fee calculated on the basis of a risk-adjustment factor for each beneficiary who selects the MA plan. In return, the health plan must offer benefits that are equal or superior to those of traditional Medicare as well as additional benefits and/or cost reductions to the beneficiary. Unlike traditional Medicare, MA plans

operate much like their counterparts for commercial plans by offering HMO or PPO benefit products. Currently, 25% of Medicare-eligible people join an MA plan because many beneficiaries benefit financially from the reduced out-of-pocket expenses.

The Patient Protection and Affordable Care Act (ACA) included provisions to reduce Medicare spending by initially freezing payments to MA plans at 2010 levels. In subsequent years, the aggregate payment will be reduced by an estimated 12% per year until payment to MA plans is at the level of traditional Medicare for similar population demographics.

### Directions in Quality of Care

Over the past several years, CMS has encouraged significant advancements in measuring quality of care as experienced by the patient. These efforts have been in concert with the work of former CMS Administrator, Donald Berwick, MD, MPP at the Institute for Healthcare Improvement (IHI). From his work at IHI, Dr. Berwick has advanced the concept of the Triple Aim: improved care for the individual, better population health, and reduced health care costs through innovation in care processes. CMS has relied primarily on public display of data and on financial incentives/disincentives to drive the Triple Aim. Most of the information contained in its public displays (ie, Hospital Compare and Physician Compare Web sites) has been obtained from self-reported data. The value of such self-reported data is limited because of variation in reporting. Financial incentives to physicians have come through direct bonus incentives from its Physician Quality Reporting System and from implementation of electronic health records through the Meaningful Use legislation.

Although MA plans may participate in such CMS activities, they have greater opportunities to influence quality outcome processes. Indeed, CMS promotes quality competition among MA plans through bonuses paid for higher performing MA plans (ie, those with 3-, 4-, or 5-star ratings).

### Humana's Approach to Improving Quality of Care for its MA members

Humana's approach to quality improvement is through measurement and analysis that recognizes the individual member's health knowledge, beliefs, and behaviors as a cornerstone - but also acknowledges the impact of caregiver influence, local medical practice patterns, and the role of population-based interventions. These concentric rings of influence on an individual member's health-seeking behaviors mean that there must be health plan strategies at a number of member touch points to truly have impact.

Programs that engage members one-on-one are directed at individuals with the greatest need; for instance, many of these are patients with catastrophic conditions. Case managers are true care coordinators and case management programs assist individuals with complex health care needs in navigating a very fragmented medical environment.

Humana Cares is a case management program that involves a team effort guided by a designated field coordinator (nurse) who visits the senior in her or his home to assess health care needs. For instance, many seniors take multiple medications and may become confused about their treatment regimens. After reviewing the medications in the member's home, the field coordinator may consult with a Humana pharmacist and the member's primary care physician to eliminate duplicate

medications, medications that have expired, and medications that are no longer on the prescribed list of drugs.

Whether the nurse connects with the senior member by phone or in person, the patient's health literacy, beliefs, and values are assessed. This assessment is a critical part of patient-centered care. Even if the MA benefits are set, Humana can tailor programs to meet the patient's goals for care. In a study of the Humana Cares program, 77% of engaged members reported that they are more prepared to manage their own health. Some 15% reported no falls in the 6 months after engagement with Humana Cares, 16% believed that their health has improved because of the program, and 14% reported that depression no longer interferes with their daily living. These are powerful outcomes from a targeted program.

Many seniors, especially those who are frail, have caregivers who tend to their needs. Often these caregivers are daughters or sons of the elderly member, and in other circumstances they may be a sibling, cousin, friend, or community advocate. Caregivers often have greater facility with electronic or cellular modes for gaining information. Although the senior may trust only communication that is in person or telephonic, a caregiver who is equally facile with Internet or mobile applications may have access to much more information. Social media is becoming a significant source of information; for example, Humana includes more information aimed at the caregiver in its Humana Medicare Advantage Web site and in the MyHumana mobile application.

### Population Management

The goals of population management for the Humana MA program are to provide care coordination services for those with catastrophic conditions and

to provide support through in-person, telephonic, and Web-directed programs for those seniors with multiple chronic conditions. However, for those who currently are functioning well, the goal is wellness maintenance. Helping to keep Humana MA members active and aging confidently at home is essential. Multiple programs are geared toward engaging the senior in Humana's Fitness and Physical Activities benefits; for example, basic fitness center membership for individual or group level exercises, and programs such as Silver Sneakers are quite popular with seniors. Nearly 300,000 Humana MA members are enrolled in these programs, and 48% of the 102,000 members who participate actively report improvement in their sense of health and well-being.

### Usable Information

In the United States, where paper medical records predominate, there is great variability in the level of appropriate care patients receive. MA health plans such as Humana's have great capacity to become information connectors for doctors and their MA patients. MA health plans are turning their large claims inventories into useful information databases. Rules engines work within the data warehouses to define clinical episodes of care, attribute those episodes to the physicians responsible for managing the patient, and determine if anticipated preventive services were provided. The National Quality Forum (NQF), the National Committee for Quality Assurance, and the National Quality Strategy have reached a consensus regarding quality standards.

Using the rules engine from its data warehouse, Humana provides information to members in a format and font appropriate to the senior population. The same information is shared with Humana's network physicians

in a letter that was developed with input from focus groups of practicing physicians. Experience has shown that information provided to doctors by insurance companies frequently is discredited because physicians feel that many such letters have been written in a patronizing manner, because the data do not appear credible to the physician, or because the format is not compatible with the office's management of paper. Humana has received positive input on its new format for information sharing. Importantly, there has been a documented increase in adherence to NQF-endorsed quality standards compared to traditional Medicare; for example, Humana members have a 9% higher rate of breast cancer screening, an 8.5% reduction in 30-day readmissions, and a 15.7% reduction in emergency room visits. These measures represent significant improvements in meeting quality standards.

MA programs, such as those offered by Humana, have the opportunity to improve care coordination for those with catastrophic illnesses, enhance education for those with multiple chronic conditions, and promote wellness among those with good functional capacity. Such programs emphasize quality and have the data to support it. Managed care programs have the potential to improve outcomes for more Medicare beneficiaries if more widely adopted.

*Tom James, MD, is Medical Director, National Operations Network, for Humana, Inc. He can be reached at [tjames@humana.com](mailto:tjames@humana.com).*

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## For Health Reform Success, Context Matters Most

By Bonnie L. Zell, MD, MPH

Through my broad experiences as a nurse, physician, and medical administrator, it has become clear that the most influential factors in the health of my patients are not primarily addressed within the walls of the health care delivery system. As providers, we ultimately strive to help all our patients have long lives with high functionality. This requires focusing on the factors that make that possible - healthy home environments, economic security, access to fresh fruits and vegetables, and safe places for recreation - the context in which people live.

In our health care delivery system, we have a tremendous but unrealized opportunity to transform the health of our communities. As leaders in our communities, we must utilize our reach, influence, resources, and expertise to help create the conditions that sustain health.

The ultimate goal of health care and community health interventions is to promote the health of individuals and populations within their communities. The health care delivery system alone cannot achieve this aim. Rather, success requires that we understand the context for health, which is where and how people live. When we apply this understanding of context to deliver care to individuals and populations and actively contribute to community health through partnerships with other stakeholders, it is often referred to as improving *population health*.

*Population health*, as defined by Kindig and Stoddart, refers to:

- Health outcomes and the distribution of these outcomes in a population.
- The determinants that influence the distribution of health outcomes.
- Policies and interventions at the individual and population levels that impact these determinants.<sup>1,2</sup>

Health systems, payers, and policy makers are beginning to embrace population health, and 3 national initiatives exemplify this growing commitment.

1. The National Strategy for Quality Improvement in Health Care, developed through a collaborative process and coordinated by the US Department of Health and Human Services (HHS), is a strategic plan to improve health care quality and health outcomes for all Americans. Population health approaches are integrated throughout.<sup>3</sup>
2. The National Prevention Strategy, developed by HHS through a similar process, is a comprehensive plan to increase the number of Americans who are healthy at every stage of life. It calls upon employers, health systems, governments, and other sectors to promote health among their populations.<sup>4</sup>
3. The National Priorities Partnership brings together 48 leading private and public sector organizations to accelerate progress toward consensus-based national priorities for population health and health care. It is convened by the National Quality

Forum, whose leaders realized that achieving an improved health system requires fundamental transformation and adoption of population health approaches.<sup>5</sup>

### Context for Health

People's daily context-where and how they live-is the prime force that shapes their health. Population health approaches address these contextual determinants of health.<sup>1</sup>

Rough estimates of determinants of premature deaths by McGinnis et al indicate that health care services make a relatively small contribution to health (Figure 1). In comparison, three fifths of premature deaths are attributable to behavioral patterns, social circumstances, and environmental conditions.<sup>6</sup>

To effectively care for patients and populations, we need to learn more about:

- *Places where they work, learn, play, and live.* Is there secondhand smoke? What are social norms about health behaviors? What exposures increase risk for infections, injuries, and chronic conditions?
- *Their education, income, employment, and other social circumstances.* Can they afford medications? What are their health literacy capacities? Do employers provide paid time off for preventive care? How do friends and family support breast-feeding?
- *The availability and affordability of health inputs.* Is high-quality health care accessible when needed? Are people safe in their neighborhoods?



What is the quality of health information in popular media?  
 What options are available for active recreation and healthy foods?

Focusing on context means shifting from a myopic lens of health as the purview of health care to a farsighted lens that considers context and acts at a population level.<sup>7</sup>

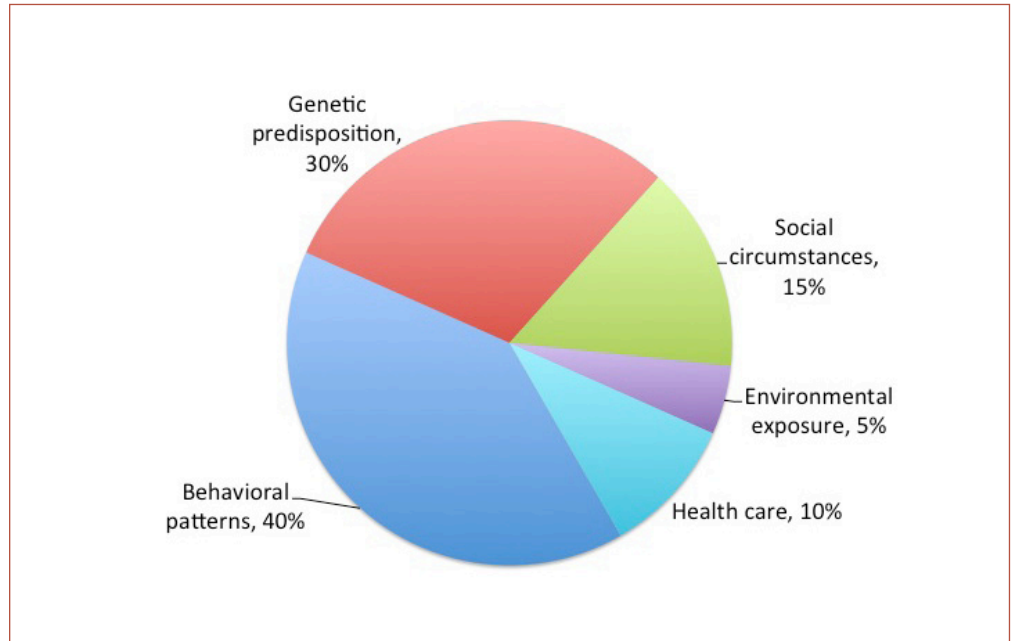
**Implications for Health Care Delivery and Community Health**

A population health approach to delivering health care explicitly assesses contextual factors for health. It goes beyond asking, “Why does this patient have this disease or condition at this time?” and prompts clinicians and administrators to ask, “What population circumstances are the underlying causes of the disease or condition incidence in this population?”

By engaging in multisector partnerships, we can improve the health of our communities in ways that the health care delivery system by itself cannot. Effective community collaborations bring together the right players (Figure 2) and align members’ interests with shared goals. These collaboratives leverage partners’ strengths, establish shared accountability, use performance measures, and align incentives for change.<sup>5</sup>

A clear success story is the anti-tobacco campaign. Sustained multistakeholder efforts in communities, states, and the nation dramatically halved adult smoking rates between 1965 and 2010 (42% to 21%).<sup>8</sup> Health systems joined with public health organizations, employers, policy makers, consumer advocates, researchers, and others to fight what was then the nation’s leading cause of death.<sup>9</sup> The partners pursued shared goals, measured progress, and aligned interventions that gradually changed behaviors.<sup>5</sup>

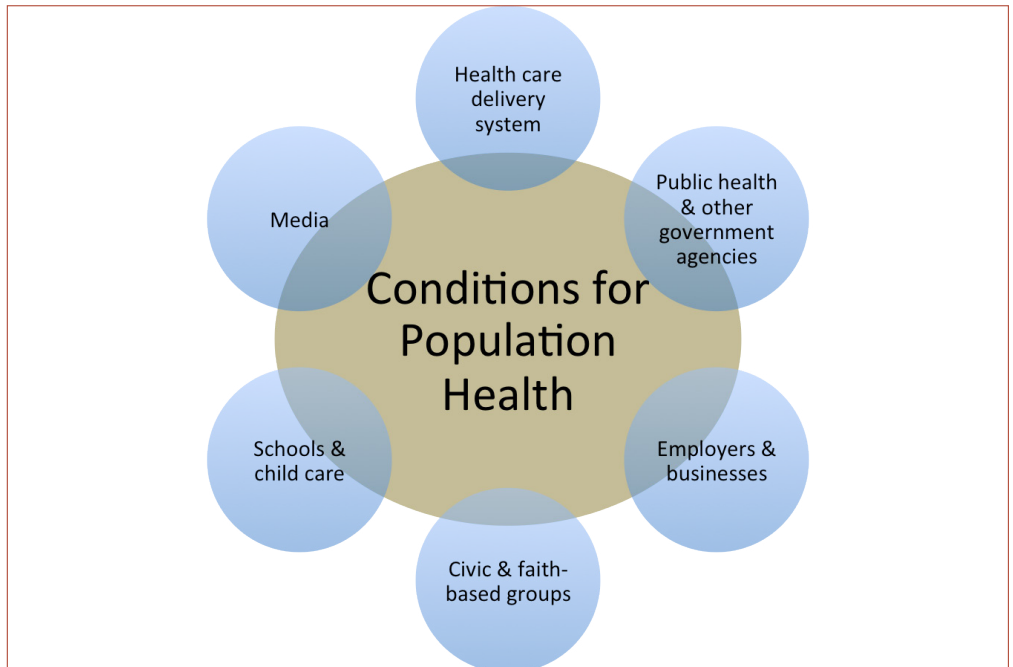
**Figure 1. Determinants of Health and Proportional Contribution to Premature Death**



Source: McGinnis et al (2002)<sup>6</sup>

NOTE: Because of research limitations, the percentages presented are rough estimates and should be interpreted only as relative contributions to premature deaths.

**Figure 2: Actors that Influence the Context for Health**



Adapted from: Committee on Assuring the Health of the Public in the 21st Century, Institute of Medicine (2003)<sup>10</sup>

This example points to roles for the health care delivery system in community health collaborations.

- Join community health coalitions.
- Advocate as experts for policy changes that protect the health of populations,

*(continued on page 10)*

especially the most vulnerable.

- Direct community-benefit dollars to support local health initiatives.
- Become an exemplary employer in worksite health promotion.
- Monitor patient populations to improve the delivery of evidence-based interventions.

### **Nationwide Infrastructure for Population Health**

To be successful, health information networks that enable robust surveillance of population health metrics at the community level are required. Workforce training in partnership development, tools and technical assistance to help community health partnerships use data to design evidence-based interventions, and relevant health services research (eg, developing validated process measures closely linked to population health outcomes) would facilitate this approach as well.

In conclusion, enabling Americans to live long, healthy lives cannot be accomplished solely by delivering better personal health care. Health “happens” 1 person at a time, 1 day at a time, and 1 decision at a time, and aggregates to populations. For both individuals and populations, health is context specific.

To create the conditions for health in communities, we must apply population health approaches that create favorable cultural, social, economic, and environmental contexts for health. This work will engage us in partnerships with other stakeholders to transform our communities.

*Bonnie L. Zell, MD, MPH, is Principal, Zell Community Health Strategies, LLC, in San Francisco, California. She can be reached at: bzell@comcast.net.*

*∂Zell acknowledges Molly French for her assistance in preparing this manuscript.*

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