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In December 2014, I had the opportunity to give a closing plenary presentation—entitled ''Population Health: Where's the Beef?''—at the Population Health Forum, the annual event sponsored by the Population Health Alliance in Washington, DC. I'd like to share aspects of that presentation with you.

To close the Population Health Forum, I decided to pose 7 questions and then attempt to answer them in turn. The first question was, ''What exactly is population health?''

Because ours is the only School of Population Health, we, of course, know the correct answer! I challenged the audience to think about population health in both an academic and pragmatic framework. I asked them whether population health is a Clayton Christensen disruptive innovation[1] or a Michael Porter ''bridge to value.''[2] Or is it really a defensive posture, à la Ram Charan,[3] to prevent us from becoming obsolete? Perhaps it is none of the above.

I noted that the academic definition ties back to colleagues such as David Kindig,[4] now working at the Institute for Population Health at the University of Wisconsin in Madison. David is sometimes regarded as the ''father'' of our movement. He emphasized the social determinants of health in the definition of population health and insisted that medical care is only responsible for 15%–20% of society's well-being.

On the pragmatic side, I noted that current thinking from organizations such as Humana and others is that population health is focused on improving many metrics within a given population. For example, Humana's enterprise goal states that they will improve the health of the populations they serve by 20% by the year 2020.[5] The pragmatic definition also is focused on appropriate management of economic risks for clinical decision making. I closed the first question by describing an equation from Mark McClellan[6]: If each primary care doctor cares for 2000 patients, and each patient consumes close to $5000 per year of resources, and each doctor is driving nearly $10 million of spending, that would mean that a primary care group composed of 100 physicians would be driving nearly $1 billon of health care spending. That makes each medical group an important economic engine in the context of asking the question, ''What is population health?''.

My second question was, ''What are the ingredients of success in the accountable world?''

I noted that, in my opinion, leadership is always the key attribute that drives the success of complex organizations. If one looks at recent data from the Centers for Medicare & Medicaid Services, 22 of the 29 Accountable Care Organizations that made money in 2014 were led by physicians.[7] Physician leadership per se does not guarantee a positive margin, but there is a tight correlation. I spoke of certain managed care organizations in the late 1990s during the ascendency of managed care in California. Those successful organizations that are still with us in 2015 have a major commitment to leadership and the creation of a real culture of practice.

Other attributes that augur success included a robust information technology infrastructure, beyond electronic medical records promoted by companies like Epic Systems. What I noted was the need for a registry function, enabling primary care doctors, especially, to self-evaluate and improve. I spoke of companies like Anvita, Anceta, Phytel, Net.Orange, CrossCurrent, and others.

Other attributes that augur success included a willingness to ''stick to the knitting.'' For example, companies such as Healthgrades can tell us today how to manage the preoperative and postoperative care of patients undergoing hip and knee replacement surgery. The organizational and leadership question remains: Are we mature enough to use this information effectively to drive improvement in clinical outcomes, even if it means a change in the local culture of practice? Finally, I noted that despite the call for leadership, recent work by colleagues such as Ezekiel Emanuel[8] and others gives us pause as they discovered that most physicians are not currently engaged in the hard work of reform, and in fact they don't, generally speaking, consider the cost of medical care in their day-to-day work.

The third question I posed was, ''What should we be saying to our employer colleagues?''

I laid out a 5-point plan that called for the delivery system to engage with employees, other providers, payers, and other corporations, and with their communities. I noted that by investing in companies that promote prevention and wellness, we will not only improve our own bottom line, but we will send a strong cultural statement that we put our money where our mouth is. Here, I referred to the work of our colleagues, Ronald Goetzel[9] and Ray Fabius.[10] I admonished the audience to divest funds from companies that don't practice prevention and to actively seek organizations that publicly address this issue. In so doing, they may also improve their own return from an equity investment.

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My fourth question was, ''What changes will we need to make in health sciences education to produce leaders for the future?''

Here, I focused largely on the work of our own school and our 4 master's degrees, our various certificate programs, and our work across the board to disseminate the tenets of population health.

I made mention of our commitment to medical education; in particular, our work with colleagues at the Association of American Medical Colleges in Washington, DC and the American College of Medical Quality (ACMQ) in Bethesda, MD. For example, our school recently hosted the ACMQ annual education conference for medical students and other trainees, a program that garnered an audience of more than 50 medical students from a dozen medical schools. This was a clear demonstration of young persons' interest in the science of systems thinking, process improvement, care coordination, and error reduction.

I explained to the audience that while we move the population health agenda forward, we must not lose sight of the fact that medical error remains a very important challenge and that, by all accounts, errors are responsible for hundreds of thousands of deaths in our country.[11]

My fifth question was, ''What will population health leaders of the future look like?''

Based on aspects of my ongoing work with my colleague, Rita Numerof,[12] I noted the evolution of a new senior officer in the delivery system. Specifically, I see the transformation of the hospital-based medical director to the vice president for medical affairs, to the chief medical officer, and today, to the chief population health officer (CPHO). I noted leaders around the country with population health in their title, such as Timothy Ferris at Partners in Boston, Marc Gourevitch at New York University, and Ken Kizer at University of California, Davis. I asked, what are the attributes and competencies of a CPHO? Of course, a CPHO must have not only leadership experience but core competencies in fields that resonate with our school, such as behavioral economics, epidemiology, process improvement, and care coordination, among others.

Finally, I admonished the audience to note that the boards of trustees of most currently structured delivery systems may not be adequately prepared for the challenge of population health.[13] Specifically, governance of delivery systems must change to keep pace with the transmogrification of the delivery system itself. When an integrated delivery system owns physician practices, nursing homes, rehabilitation centers, and the like, the board of trustees bears all the fiduciary responsibilities for the outcomes across these disparate settings. What kind of competency does your board exhibit in any aspect of this evolving system?

My sixth question was, ''What will real patient engagement look like by 2020?''

Patient engagement in the next 5 years will be characterized by an explosion in new technology that will enable patients to stay connected in real time with all of their caregivers. Beyond e-mail, texting, and Skyping, I see high-fidelity telemedicine helping to shape patient engagement. I am excited about the work of Tom Delbanco[14] and his colleagues at Harvard Medical School, who demonstrated that sharing the medical record with patients not only helped providers to improve clinical outcomes but also gave them greater enthusiasm for their work.

I noted that the ''retailization'' of health insurance would demand total transparency and accountability of the health care system. I predicted that by 2020 we would see all physician-specific outcome measures that are more comprehensive than the Physician Quality Reporting System available online 24/7. I made note of the work of our colleague Tom Lee[15] at Press Ganey and some of the progress they have made toward physician-specific accountability for improved patient communication at the University of Utah and elsewhere. With complete transparency and accountability, we will create a true marketplace enabling the retail model to function.

I warned the audience that this was a provocative prediction, but I am confident that research from colleagues like Joe Kvedar[16] and others will help us see the pathway toward true transparency.

My final question was, ''What do we need to do together to advance this field?''

First, I suggested that the audience do some background reading. Work from Sarah Varney in her lead article in the November 2014 *Politico Magazine*[17] and the dreadful inequalities of medical care in states like Mississippi; the entire November 2014 issue of the *Harvard Business Review*, focused on the internet of things; and finally the entire October 22/29, 2014 issue of *JAMA*, devoted to rising health care costs. Once one gets a grounding with these references, we can more clearly visualize the road ahead.

I believe that this road will be characterized by engaging with other organizations, most especially the business community. I see groups like HERO, the National Business Coalition on Health, and even Sanofi Aventis (with their special emphasis on diabetes care), as partners in the work of the Population Health Alliance.

I asked the audience to join our school by submitting their work for consideration of publication in our journal, and I noted, once again, that solid research helps to ''raise all boats'' and disseminate progress in our field.

I called for the continuation of our legacy of advocacy and wondered why the US government took so long to endorse a surgeon general[18] —one like Vivek Murthy who is committed to reducing violence from firearms. I thought social activism among physicians, led by persons like Michael Stillman[19] at the University of Louisville, is important as we return to our core professional roots.

I asked that additional organizations be brought ''into the tent,'' such as the Robert Wood Johnson Foundation, which has recently realigned all of its philanthropic efforts toward building a culture of health. Similarly, the Institute for Healthcare Improvement and their new effort to improve 100 million lives ought to be welcomed under the population health ''tent.''

Finally, I highlighted a recent press release that was the culmination of nearly a year and a half of work between the Population Health Alliance and the Jefferson School of Population Health. We hope to promote the dissemination of educational offerings, joint exploration of possible external funding from grants, and the desire to expand the membership of the Population Health Alliance.

Based on feedback that I received both in person and online, my 7 questions stimulated the audience to think about our collective future. I hope that our readers will make a renewed commitment to the field of population health and

join us at the journal to improve the well-being of our citizenry.

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References

1. Christensen CM, Grossman JH, Hwang J, eds. The innovator's prescription. A disruptive solution for health care. New York: McGraw Hill, 2009.
2. Porter ME, Teisberg EO, eds. Redefining health care. Creating value-based competition on results. Boston: Harvard Business School Press, 2006.
3. Nash DB. N = 1. American Health and Drug Benefits. In press.
4. Kindig D, Stoddart G. What is population health? Am J Pub Health 2003;93:380–383.
5. Humana. https://www.humana.com/about/company-profile/. Accessed December 31, 2014.
6. Mostashani F, Sanghavi D, McClellan M. Health reform and physician led accountable care: the paradox of primary care leadership. JAMA 2014;311:1855–1856.
7. Angood P. Keynote Presentation: Future Leaders in Quality and Safety. 2014. http://jdc.jefferson.edu/flqs/2014/. Accessed December 30, 2014.
8. Emanuel EJ, Steinmetz A. Will physicians lead on controlling health care costs? JAMA 2013;310:374–375.
9. Goetzel RZ, Henke RM, Tabrizi M, et al. Do workplace health promotion (wellness) programs work? J Occup Environ Med 2014; 9:927–934.
10. Fabius R, Thayer D, Konicki D, et al. The link between health and safety and the health of the bottom line: tracking market performance of companies that nurture a ''culture of health.'' J Occup Environ Med 2013;55:993–1000.
11. Rice S. Despite progress on patient safety, still a long way across the chasm. http://www.modernhealthcare.com/article/20141206/MAGAZINE/312069987. Accessed December 19, 2014.
12. Numerof R, Nash DB. Defining the job description for population health. http://www.modernhealthcare.com/article/20140426/MAGAZINE/304269978. Accessed December 30, 2014.
13. Morrissey J. Success factors and barriers on the journey to clinically integrated networks. Trustee 2014;November/December;8–12.
14. Delbanco T, Walker J, Bell SK, et al. Inviting patients to read their doctors' notes: a quasi-experimental study and a look ahead. Ann Intern Med 2012;157:461–470.
15. Lee T. Certifying the good physician. A work in progress. JAMA 2014;22:2340–2342.
16. Center for Connected Health. Defining the future of technology enabled care. http://connectedhealth.partners.org/about/default.aspx. Accessed December 31, 2014.
17. Varney S. Mississippi, burned. How the poorest, sickest state got left behind by Obamacare. http://www.politico.com/magazine/story/2014/10/mississippi-burned-obamacare-112181.html. Accessed December 19, 2014.
18. Curfman GD, Morrissey S, Drazen JM. Where is the surgeon general? N Engl J Med 2014;20(371):1928–1929.
19. Stillman MD. The affordable care act, one year later. N Engl J Med 2014;21(371):1960–1961.

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