

A Bold Proposal for Advancing Population Health

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The emergence of Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs), and related payment and delivery system innovations provides an unparalleled opportunity to advance the health of the U.S. population. The key to understanding this opportunity, however, is to distinguish between the health of populations enrolled in ACOs and PCMHs and the health of the much broader population of the entire geographic community (Noble and Casalino, 2013; Shortell, 2013). Reducing the burden of illness on the U.S. health care system will require more than the payment reforms and incentives currently associated with the ACOs and PCMHs. The question is how best to link the health care delivery system with the public health system and the community and social services sectors, including education, housing, transportation, public safety, and others involved with the upstream environmental and social determinants of health. In other words, how can we move from a culture of sickness and a culture of care to creating a culture of health? Or, alternatively, how do we move away from a market that rewards caring for sick people to a market that also rewards keeping people well?

The key to this transition will be changes in payment. If the goal is to improve population health, then we must pay for population health (Kindig, 1997). The Centers for Medicare & Medicaid Services (CMS) can start by initiating a bold proposal to pay selected communities for meeting community-wide population health improvement objectives (Shortell, 2013). The core idea is to offer a risk-adjusted community-wide population health budget to a community-wide accountable entity for achieving predetermined quality and health status targets for, initially, a defined set of conditions. Examples might include reducing the prevalence of diabetes, reducing the percent of children and adults who are obese, reducing infant mortality among target populations, and reducing community-wide preventable hospital readmissions and emergency department visits. As experience is gained, a greater range of conditions can be incorporated and population-wide cross-cutting measures such as reducing disability and work-loss days and population-wide functional health status scores can be included.

In addition to actions by CMS, private-sector commercial insurers might offer similar risk-adjusted, population-wide payments for given conditions to community-care entities encompassing delivery systems, public health agencies, and social and community health groups in defined areas. State Medicaid programs could do likewise. For example, Oregon's implementation of Coordinated Care Organizations (CCOs) could evolve into population-wide risk-bearing arrangements (Oregon Health Policy Board, 2013). Providing cross-organization, cross-sector, and cross-boundary financial incentives provides motivation for engaging the difficult work of building the cross-sector, cross-boundary partnerships that will be needed to achieve the desired results (Shortell, 2010). It will be particularly important to target communities where the "soil has already been tilled," as evidenced by established ongoing collaboration among the three sectors. A community-wide entity, such as a community health management system board, should be developed to accept and distribute the funds and house data systems to assess and report results.

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A framework to guide the implementation of paying for population health is shown in Figure 1 (page 3). The framework includes four components—strategic, structural, cultural, and technical. Strategically, communities will need to define their high-priority issues, the areas in which the greatest improvements in population health can be made over a defined period of time. Issues, problems, and opportunities can be selected that engage all three sectors such that each sees what is “in it for them” to collaborate. Without this, as shown in Figure 1, nothing important will occur.

Structurally, as previously noted, an entity such as a community health management system needs to be established that can select the priorities noted above and make decisions. This body needs to be able to collect and distribute funds to the different organizations across the three sectors to accomplish the predetermined population health goals. Most importantly, forums will need to be established to develop a community-wide population health learning system (quick data feedback, quick learning from mistakes and rapid sharing of the learnings across the three sectors). The common financial incentive will facilitate this cross-sector, cross-boundary learning. Without the structural component, the impact of efforts will be suboptimal because learning will not be spread across the sectors.

Perhaps the largest barrier to the development of a population-wide payment approach is cultural. Professionals and leaders in all three sectors—health care delivery, public health, and social and community services—have been educated differently, often share somewhat different values and norms of behavior, and have different knowledge bases, professional identities, and reward systems. Forming common cultural ground, even within each sector, is often difficult, as the long history of hospital and physician relationships can attest. How is it possible to achieve sufficient cultural “buy-in” from the three sectors to work together in meeting agreed-upon population health goals? The common financial payment, while helpful, is not sufficient. In addition, the key leaders and “power brokers” in the three sectors in a given community need to understand that improving population health will require a close integration of upstream and downstream determinants. They need to work to develop an actively engaged community with shared goals, a common language, and the ability to manage tensions and conflicts constructively and to celebrate and reinforce healthy behaviors and actions on the part of all. Without the cultural component, as shown in Figure 1, only temporary effects will take place.

Finally, there needs to be substantial investment in the technical skills needed to achieve the system-wide population health goals (Gourevitch, et al. 2012). These include the implementation of health information exchanges to collect and analyze relevant data across the sectors, to understand not only the epidemiology of the patient population (Hacker and Walker, 2013), but also the community-wide health indicators such as air pollution readings, water and sanitation quality, traffic accidents, domestic violence data, and related indicators. Geographic information systems that facilitate “hot spot” mapping of particular needs in the community must be put in place. Tools, such as health status needs assessments, community asset mapping, cross-sector team-building modules, and performance monitoring are needed. Of special note is the development of skills to manage partnerships over time (Shortell, 2010). To facilitate these developments, incentives could be provided to existing ACOs, public health agencies and community organizations if they agree to partner to achieve population health goals. The incentives could be in the form of additional payments for the implementation of electronic health records, health information exchanges, and/or additional payments for care coordination or to train and hire community health workers. As shown in Figure 1, without the technical skill investment, there will be frequent frustrations and false starts. It is only when all four components—strategic,

structural, cultural, and technical—are addressed that the community can expect to achieve the desired improvement in population health. This is a very big challenge but also a very large opportunity.

Paying for accountable care within the silos of the health care delivery system and its segmented populations, however laudable in its own right, will not get us to where we need to go. There is need to broaden the horizon to pay for population-wide health and identify communities willing to start the nation on a path to sustainable, improved health for all.

Strategic	Structural	Cultural	Technical	Result
0	1	1	1	No significant impact on anything really important
1	0	1	1	Inability to capture the learning and spread it throughout the system
1	1	0	1	Small, temporary effects; no lasting impact
1	1	1	0	Frustration and false starts
1	1	1	1	Lasting system-wide impact

FIGURE 1 Components needed to achieve population-based health.

Note: 0= dimension is not at all present; 1= dimension is fully present

SOURCE: Shortell et al., 2000.

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