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Measuring Progress Towards a Population Health Perspective: A Framework for a New Type of Population Health Scorecard

Anthony Shih, MD, MPH and Shara Siegel, MS

Authors

Anthony Shih, MD, MPH
Executive Vice President, The New York Academy of Medicine

Shara Siegel, MS
Policy Associate, The New York Academy of Medicine

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Introduction

It certainly feels like the term "population health" is coming up more frequently in health policy and health care delivery circles. What does it mean, and how do we know that movement is being made on this front? As this term is not used consistently in the field, it is useful to define it, at least for the purposes of this essay. Here, we use population health to mean the health of the total population in a geographic area. A universally recognized and recommended set of core population health measures does not exist, but there are certainly ways one could measure the health of a geographic region. For instance, the County Health Rankings & Roadmaps program supported by the Robert Wood Johnson Foundation and developed by the University of Wisconsin Population Health Institute, measures both health outcomes (e.g., length and quality of life), and vital health factors (e.g., health behaviors, clinical care, social and economic, and physical environment factors).[I] In addition, the National Quality Forum (NQF), has endorsed 63 measures "related" to population health across varying levels of analysis, including healthcare providers and communities.[II] Although these and other measures are useful tools, serious data challenges still exist. In general, these measures, particularly the outcome measures, take time to change and suffer from "data lag" (the period between data collection and publication). In other words, the data may not be reflective of current action.

What is needed is a more real-time assessment of progress towards a population health perspective – key factors that we should track to know whether or not a particular area, such as a state or other geographic region, is moving towards effectively promoting population health outcomes. We propose a framework that includes five domains to provide a guidepost on whether or not we're moving in the right direction. We acknowledge that these fields are not easy to measure, nor are they easy to translate into "grades" for a scorecard per se. Even so, we believe that the domains are a useful supplement to our thinking about population health.

1. Payment Reform. Does the health care payment system in the geographic area promote population health?

In 2012, the United States spent 17.9 percent of its gross domestic product (GDP) on health care,[III] which is far more than what our peer countries spent, yet we do not achieve better health outcomes. There are numerous contributing factors to this, including our payment system. Under the predominant fee-for-service (FFS) system that rewards tests and interventions, providers are rewarded for "doing" more, and effectively punished (with reduced revenue) for keeping people healthy. It is clear that the current FFS system does not reward population health outcomes, and in fact, may even be a barrier.[IV] Changing the payment system to promote health and wellness, rather than to solely reward procedures, tests, and other interventions is certainly important. So a key

question we should then ask is whether the health care payment system is moving in a direction that rewards or otherwise provides incentives for promoting population health.

Examples of payment systems that promote population health include more bundled forms of payment like capitation, where providers are paid a set amount for each enrolled person assigned to them, coupled with quality incentives based on health outcomes. Other options include shared savings models, where providers are rewarded for both controlling costs and achieving quality targets for defined populations. Population-based incentives can also work within a FFS system, and additional progress might include enhanced payment for prevention and wellness services, as well as non-medical interventions that promote health.

2. Financial resources and beyond. Are there sustainable resources available for driving population health?

There are several concerns with relying on payment changes alone to finance population health.[1] Therefore, it is reasonable to ask if there are other sustainable resources for population health activities in a given region. One such resource may be from hospital community benefit spending. In order for not-for-profit hospitals to maintain their tax-exempt status under section 501(c)(3) of Federal Internal Revenue Code, they have to provide benefit to the community that they serve. Recent changes in legislation encourage hospitals to go beyond their traditional role of medical treatment centers by requiring hospitals to conduct community health needs assessments (CHNAs) and adopt an implementation strategy to meet the identified health needs of their communities.[V]

Another example of potential additional financial resources for population health activities are social impact bonds (SIBs), where private investors devote funds for public projects as a way to reduce long-term government spending while improving social outcomes. For instance, with a loan from Goldman Sachs Bank's Urban Investment, a New York City program aims to lower government costs associated with inmate recidivism at the Rikers Island Correctional Facility.[VI] There are other SIBs that are working on addressing asthma and infant mortality.

1 Some concerns with relying on payment reforms alone include: 1. Payment incentives are generally tied to the population that is covered under that particular payer, such as Medicare, Medicaid or a program at a specific hospital. This makes it harder to justify a community-based intervention that would help patients of all payers; 2. Providers are often faced with multiple competing incentives from different payers, resulting in failure to substantively act in response to any one incentive; 3. There is a free-rider problem when providers have overlapping services areas – that is, one might reap the benefits of a community-based intervention conducted by another provider or payer regardless of participation; 4. There may be community-based interventions that are effective but do not necessarily return savings back to the payer or provider (the savings might accrue elsewhere), or may not occur in a reasonable time frame; 5. Frequent switching of health plans, or churning, decreases the incentives for providers and payers to make longer-term investments in population health.

Yet another example of an innovative funding stream to support population health is a dedicated trust fund. For instance, the Massachusetts legislature started the Prevention and Wellness Trust Fund in July 2012 with a unique investment of $60 million for population based health promotion efforts for four years.[VII] The fund does not require annual approval through an appropriations process, the funding source does not come from taxpayers, and it includes opportunities to link clinical providers with community partners.

While it is a large factor, resources are not only financial. In addition to finding creative ways to bring dollars to a region, it is also important to ask to what other resources have been made available? These resources may range from workforce infrastructure, including the expertise of individual leaders and organizations, to supplies, to health information technology infrastructure. Total capacity is important in assessing the progress of a region towards a population health perspective.

3. Policy Environment. Are there policies in place that explicitly promote population health?

Beyond payment policy, there are a variety of regulatory and programmatic activities and initiatives that can promote population health. Policy is effective for improving health outcomes because policies can make healthier choices second nature. In fact, each of the 10 great public health achievements of the 20th century, such as safer and healthier foods and safer workplaces, was influenced by policy change.[VIII] Policies may include smoking restrictions, a tax on sugary beverages, or larger state-sponsored programs like regional population health improvement entities. For example, the Community Preventive Services Task Force recommends implementing interventions that increase the unit price of tobacco products based on strong evidence of its effectiveness in reducing tobacco use. A 20% increase in tobacco unit price would be associated with a 3.6% median reduction in the proportion of adults who use tobacco and a 7.2% median reduction in the proportion of young adults who use tobacco.[IX] A review of policies in a region is important to assess its willingness and commitment to promoting population health.

4. Engagement of Other Sectors. Are other sectors engaged in efforts to promote health?

We know that population health is determined by numerous factors outside the health system. As such, a “health in all policies” approach is gaining momentum alongside the population health concept to encourage all sectors, whether that be housing, transportation, education, or business, to work together to impact the health of a population in a positive way. These sectors all affect each other and can no longer be thought of in isolation. To that end, the U.S. Environmental

Protection Agency, the U.S. Department of Housing and Urban Development, and the U. S. Department of Transportation formed the Partnership for Sustainable Communities in 2009 as an interagency effort to help communities thrive.[X] Its key initiative, The Sustainable Communities Regional Planning (SCRP) Grant Program, places a priority on investing in nontraditional partnerships, such as arts and culture, recreation, public health, food systems, regional planning agencies and public education to support locally-led collaborative efforts.[XI] The importance of cross sector collaboration was also recognized in the Affordable Care Act, which created the National Prevention Council, comprised of 20 federal departments, agencies and offices, working together to promote the health and well-being of Americans.[XII] Similar efforts can be replicated at the state and local level, for both overall health promotion efforts, as well as more targeted activities such as obesity prevention.

5. Population Health Activity. Is there evidence of activity on the ground?

Improving population health is not a passive activity, and sweeping policy and payment changes by themselves are limited and take time. After all, at some point, there needs to be action on the ground. We should see evidence of health care systems and other sectors coming together to invest in community health improvement and to create healthy communities.

There are numerous evidence-based programs that already have proven results and can be remodeled to support population health. A report by Trust for America's Health (TFAH) and The New York Academy of Medicine (NYAM) entitled *A Compendium of Proven Community-based Prevention Programs*[XIII] highlights 79 evidence-based disease and injury prevention programs across the country that have saved lives and improved health. The Community Guide,[XVI] County Health Rankings and Roadmaps: What Works for Health,[XV] Agency for Healthcare Research and Quality (AHRQ) Innovations Exchange[XVI] and Healthy Communities Institute[XVII] also have recommendations for evidence-based interventions. In a region that has embraced population health, one should see not only evidence of activities on the ground, but also particular attention paid to differences in health status for vulnerable populations, and efforts specifically aimed at promoting health equity.

Again, we recognize that there are a lot of existing measures and data around population health, including the ultimate measures of population health outcomes. This framework is not meant to replace those, but rather supplement those measures with a more holistic, real-time framework that allows us to track progress on whether or not a region is moving towards a population health perspective. It is also useful to highlight the areas that may need the most attention and may then be used to spur a call to action to further advance population health.

Endnotes

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