Healthcare ∎ (∎∎∎∎) ∎∎∎–∎∎∎

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/hjdsi

Opinion paper

From healthcare to health: A proposed pathway to population health ☆

Ursula Koch [a,b], Somava Stout [c,d,g], Bruce E. Landon [f,h], Russell S. Phillips [c,e,f,*]

[a] Department of National Prevention Programs at the Federal Office of Public Health, Schwarztorstrasse 96, Bern, 3003 Switzerland
[b] University of Zürich, Institute for Primary Care, Pestalozzistrasse 24, Zürich, 8091 Switzerland
[c] Center for Primary Care, Harvard Medical School, Boston, MA, USA
[d] Institute for Healthcare Improvement, Cambridge, MA, 02139 USA
[e] Department of Global Health and Social Medicine, Harvard Medical School, USA
[f] Beth Israel Deaconess Medical Center, Boston, MA, USA
[g] Cambridge Health Alliance, USA
[h] Department of Health Care Policy and Department of Medicine at Harvard Medical School, USA

ARTICLE INFO

Article history:
Received 17 March 2016
Received in revised form
26 May 2016
Accepted 29 June 2016

Keywords:
Population health
Population medicine
Integration with public health
Social determinants of health

ABSTRACT

Innovations in payment are encouraging clinical-community partnerships that address health determinants. However, little is known about how healthcare systems transform and partner to improve population health. We synthesized views of population health experts from nine organizations and illustrated the resulting model using examples from four health systems. The transformation requires a foundation of primary care, connectors and integrators that span the boundaries, sharing of goals among participants, aligned funding and incentives, and a supporting infrastructure, all leading to a virtuous cycle of collaboration. Policies are needed that will provide funding and incentives to encourage spread beyond early adopter organizations.

© 2016 Elsevier Inc. All rights reserved.

1. Introduction

The US has embarked on an ambitious payment and delivery reform agenda through the Affordable Care Act (ACA), with a focus on improving access to affordable health care and investment in primary care and population health. [1–3] In response, health care systems and public health agencies are beginning to design and implement new approaches to health that include clinical-community partnerships. [4–10] Several “early adopter” healthcare systems have begun efforts to achieve improvements in health by addressing the social determinants of health, such as working and living conditions, and individual health behaviors by partnering with community services.[11–16] In this context, we sought to understand how key experts and pioneering health systems are working to improve these kind of population health partnerships among community organizations, public health, healthcare providers, and community members.

2. Our approach

We identified a convenience sample of nine key experts from thought-leading organizations who had expertise in population health and we conducted structured key informant interviews (Table 1). We identified four leading healthcare organizations by reviewing the published literature and through contacts with the organizations. To guide our discussions with population health experts, we defined population health as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”[17] The nine experts were interviewed to learn about how their organizations transformed to address population health and social determinants of health, and how they approached partnerships with community and public health agencies. From these interviews, we developed a theoretical framework for a transformation from healthcare to health and then interviewed leaders of four organizations that are focusing on population health to test this framework.

We selected the early adopter organizations through literature review and recommendations from the interviewed experts. In this way, we identified four leading healthcare organizations in the United States, which were developing approaches to implementing community partnerships as a way to improve population health. We intentionally chose health systems with varying characteristics in terms of patient characteristics, organization size and ownership, approach to payment, number of payers, and degree of

☆The institutional review board at Harvard Medical School approved our interview process. The study was peformed at the Harvard Medical School Center for Primary Care.

* Corresponding author at: Center for Primary Care, Harvard Medical School, 635 Huntington Avenue, Boston, MA 02215, USA.
E-mail addresses: Ursula.koch@bag.admin.ch (U. Koch), sstout@ihi.org (S. Stout), landon@hcp.med.harvard.edu (B.E. Landon), russell_phillips@hms.harvard.edu (R.S. Phillips).

http://dx.doi.org/10.1016/j.hjdsi.2016.06.007
2213-0764/© 2016 Elsevier Inc. All rights reserved.

Please cite this article as: Koch U, et al. From healthcare to health: A proposed pathway to population health. *Healthcare* (2016), http://dx.doi.org/10.1016/j.hjdsi.2016.06.007

Table 1
Interviewed leaders' organizations.

Institute for Healthcare Improvement (Dr. Soma Stout and Dr. Trissa Torres)
National Institute for Children's Healthcare Quality (NICHQ) (Dr. Charles Homer)
Institute of Medicine Committee on Integrating Primary Care and Public Health (Dr. Paul Wallace, Chair)
Agency for Healthcare Research and Quality (AHRQ) (Dr. David Meyers)
Duke Medical School Department of Family Medicine (Dr. Lloyd Michener)
Robert Wood Johnson Foundation (RWJF) (Ms. Hilary Heishman)
Veterans Health Administration National Center for Health Promotion and Disease Prevention (Dr. Linda Kinsinger)
MacColl Center for Healthcare Innovation (Dr. Ed Wagner)
Centers for Disease Control and Prevention (CDC) (Dr. Denise Koo)

patient engagement. We highlighted the distinguishing characterstics of the four health systems in Table 2.

3. Observations

Our interviews with population health experts suggested that efforts to improve population health often focus on strengthening clinical-community partnerships as a way to address health determinants. This collaboration between healthcare organizations leads to an incremental and sequential process of integration across levels and care settings, based on the health needs and resources of the community. The model, illustrated in Fig. 1, includes the following building blocks: 1) organized primary care; 2) connectors of healthcare and community resources; 3) accountable integrators of information and resources that cross pre-existing boundaries; 4) multisectoral coalitions; 5) aligned resources (funding and incentives), and; 6) supportive infrastructure and culture. Below we elaborate on the model and use examples from analysis of the four organizations to provide evidence (see Table 3) that support this construct.

4. Building blocks

4.1. *Strong foundation of organized primary care*

The first building block for clinical-community partnerships is organized primary care, usually along the lines of the medical home model. Practices that learn to work in teams, measure outcomes, share information, build a quality improvement culture and establish partnerships within their teams and with their patients, recognize that the empanelment of patients and the focus on complex care management is not enough and that to improve health further they need to address health behaviors and social and environmental determinants of health. To develop such a population-based approach for patients receiving primary care, primary care teams and their healthcare systems begin to look for ways to collaborate with community and public health systems.

4.2. *Connectors between patients and community resources*

Connectors link patients in the primary care system to community and public health resources. They enable primary care practices to leverage existing resources and infrastructure available within a community to address the social determinants of health. Organizations often test different connector-models depending on the availability of resources in the community, such as community health workers, social workers, health navigators, community resource specialists, promotoras, students or community health teams that include public health and medical care professionals.

4.3. *Accountable integrators (boundary-spanning leadership)*

Integrators are multi-stakeholder bodies, often led by boundary-spanning individuals or a specific organization with stakeholder buy-in, that assume clear decision-making capacity and accountability for improved health outcomes. The integrator role might vary based on the needs and assets of the community or population, but must have sufficient authority to be accountable for achieving improved health outcomes and allocating resources.

4.4. *Shared goals and roadmap*

Multisectoral coalitions often start with a single issue (usually a single disease, such as diabetes or cardiovascular disease or a health condition such as tobacco or substance use) bringing together two or three partners based on the health needs of their patients or communities. Over time successful coalitions will cocreate shared vision and goals, and finally a shared roadmap with mutual accountability. Each contributing organization needs to understand their role in the context of the roles of others, and to constantly integrate the patient and community perspective in redesigning population health.

4.5. *Aligned resources (funding and incentives)*

Organizations must align financial incentives with clinical transformation in order to support the goals of integration to achieve improved population health. Having a financial interest in keeping their patients healthy is crucial. These approaches can include global budgets with shared risk, bundled payments, waiver funds, non-profit hospital community benefits, community trusts, grants and/or demonstration projects, and payment reforms that require all payers to fund transformation. Further, these incentives might be directed to staff whose work leads to improved population health, through changes to salaries or additional bonus for improved outcomes. Early successes lead systems to work to further align funding to support the development of a continuum of health and an infrastructure to sustain the work (e.g. accountable care organizations and health communities).

4.6. *Supportive infrastructure and culture (e.g. data systems, metrics, process for improvement and culture change, and workforce training)*

To create and sustain the changes that are needed, organizations need to support infrastructure and to foster culture change and the development of new system properties and rules. They reorient their systems to support a culture of health and invest in workforce training and ongoing improvement, building leadership and professional development programs that help to teach new skills. In addition, systems recognize the need to address their customers' social and economic context and health behaviors and to embrace the community's role as a partner in the transformation. This recognition may result in leadership and staff education and training in new competencies (e.g. motivational interviewing techniques and health risk assessments to identify and address socioeconomic barriers), data systems to support an effective flow of information among health system and community partners, shared metrics based on common taxonomies, and processes to report and analyze the data to gain a deeper knowledge of the needs of the population. The development of a learning system with constant feedback loops is important in helping organizations to develop and adapt new processes as needed.

Please cite this article as: Koch U, et al. From healthcare to health: A proposed pathway to population health. *Healthcare* (2016), http://dx.doi.org/10.1016/j.hjdsi.2016.06.007

Download English Version:

https://daneshyari.com/en/article/4966283

Download Persian Version:

https://daneshyari.com/article/4966283

Daneshyari.com