EXECUTIVE BRIEFING 2

The Second Curve of Population Health

As the health care system transforms, hospitals are expanding their scope to include population health as a model to improve the health of their patients and surrounding community. Though population health traditionally is not considered a major focus of hospitals and care systems, myriad forces are driving these organizations to address both the medical and nonmedical factors that determine health status. Driving forces include:

- Shift from fee-for-service to value-based payments that incentivize positive outcomes;
- Increased access to care for underserved and vulnerable populations;
- Increased transparency of financial, quality and community benefit data;
- Economic and legislative pressures to curb spending growth;
- Demographic changes that will increase demand for health care services, along with projected shortages of primary care providers.

Population health is commonly considered "the health outcomes of a group of individuals including the distribution of outcomes within the group." By integrating preventive principles into care delivery, the goal of population health is to improve the overall health of a given population while also reducing health disparities. Population health aims to improve quality and outcomes, particularly for individuals who lack access or engage the system at the wrong place and time, and aligns with the Triple Aim's goals of improving the patient experience, improving population health and reducing per capita cost.

Population health resides at the intersection of three distinct health care mechanisms: (1) increasing the prevalence of evidence-based preventive health services and behaviors, (2) improving care quality and patient safety and (3) advancing care coordination across the health care continuum. Health status is influenced by personal behaviors, environmental and social forces, and family history and genetics, while only a small percentage of health status is attributable to medical care. This ecological model of health points to the importance of proactively addressing the upstream factors that affect health to sustainably improve the health of any population. Achieving improved population health ultimately will decrease medical costs and allow for investment in prevention.

FIRST AND SECOND CURVES

Economic futurist Ian Morrison suggests that as payment incentives shift, health care providers will modify their core models for business and service delivery. He calls this a first-curve to second-curve shift. Morrison describes the first curve as an economic paradigm driven by the volume of services provided and fee-for-service reimbursement. The second curve is concerned with value: the cost and quantity of care necessary to produce desired health outcomes within a particular population.

As hospitals and systems move from the volume-based first curve to the value-based second curve, they must transform their business and care delivery models to balance quality, cost, patient preferences and health status to achieve real value and improved health outcomes. Hospitals and systems moving to the second curve use performance metrics to identify clinical, financial and process improvements; incorporate the appropriate incentives; and evaluate results.

Population health approaches also must change to align with goals and processes aimed at improving patient and community health status. Applying the curve concept to population health provides a road map for hospitals and systems as they integrate population health into their organizations.

Adopting this approach will require a major systemic and cultural shift. Hospitals and systems will need to develop a formalized care delivery

IMAGE FROM SHUTTERSTOCK

system that addresses disease prevention and management of the patient population and reaches outside hospital walls to improve community health [see The First and Second Curves of Population Health, below].

The rate and extent of transitioning to the second curve may depend on each hospital or care system's marketplace and influence, other hospitals and care systems in the community, other providers and available resources. Significant transformation across the field is expected to occur in the next three to five years. Some markets are moving more quickly toward the second curve, based on payer, competitor and other market pressures; others are moving more slowly.

The tactics described contribute to an organizational infrastructure that supports population health and to the transitional strategies identified in the 2011 report from Hospitals in Pursuit of Excellence, "Hospitals and Care Systems of the Future." Each organization should select the tactics that are aligned with its mission and goals.

Value-based reimbursement:

• Hospitals and systems deliver defined services to a specific population at a predetermined price and quality level.

• Large hospitals and care systems provide or contract for a full continuum of services across acuity levels for regional populations.

• Providers link payment contracts and compensation models to performance results.

• Hospitals and systems participate in an accountable care organization or patient-centered medical home model across a significant population.

• Smaller providers deliver specified services to target populations, working under contract or in partnerships within networks that are managed by larger entities that function as population health managers.

• Care delivery systems align with the Triple Aim to improve the patient experience of care, improve population health and reduce per capita cost.

Seamless care across all settings:

• Preventive services are integrated into all care settings.

• Care transition programs support seamless patient handoffs and excellent communication.

• Care teams or navigators are widely used to assist in managing complicated patient cases across the care continuum.

• Hospitals and systems provide care or develop partnerships for care delivery in a community-based setting, such as clinics or patients' homes.

• Small and rural hospitals may use telemedicine to connect with remote patients and remote specialty or emergency services.

Proactive and systematic patient education:

• All patients receive holistic education about disease management and prevention.

• Education and chronic disease management initiatives target at-risk groups and include medical and behavioral approaches to preventing illness.

• Multidisciplinary teams of case managers, health coaches and nurses coordinate chronic disease cases, set goals and track progress and follow-up care after transitions.

• Providers use patient-engagement strategies, such as shift-change reports at the bedside, patient and family advisory councils, and health and wellness programs.

• Providers measure or report on patient and family engagement.

• Hospitals lead community outreach screening or health education programs.

Workplace competencies and education on population health:

• Hospitals have leadership and staff dedicated to population health.

• Existing staff and clinicians are trained in population health competencies.

• Staff have defined roles within the population health management process and receive ongoing training as it relates to their specific job duties.

• Hospitals employ care coordinators, community health workers and health educators, and augment population health staff as necessary.

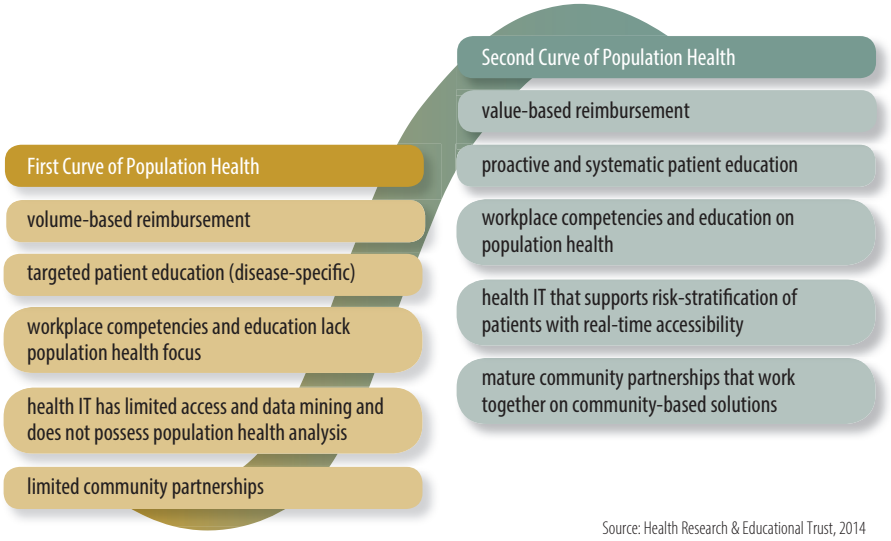
Integrated, comprehensive health information technology that supports risk stratification with real-time accessibility:

• Health IT possesses capacity for sophisticated analytics for prospective and predictive modeling to support clinical and business decisions.

• Data warehouse is fully integrated and interoperable, incorporating multiple data types for a variety of care settings (for example, clinical, financial, demographic, patient experience, participating and nonparticipating providers).

• Data from community partners are

The First and Second Curves of Population Health



Source: Health Research & Educational Trust, 2014

Population Health Metrics

Metric area	Description
Summary measures	• Health-adjusted life expectancy at birth (years) • Quality-adjusted life expectancy • Years of healthy life • Disability-adjusted life years • Quality-adjusted years
Inequality measures	• Geographic variation in age-adjusted mortality rate among counties in a state • Mortality rate stratified by sex, ethnicity, income, education level, social class or wealth • Life expectancy stratified by sex, ethnicity, income, education level, social class or wealth
Health status	• Percentage of adults who self-report fair or poor health • Percentage of children reported by their parents to be in fair or poor health • Percentage of children 3–11 years old exposed to secondhand smoke
Psychological state	• Percentage of adults with serious psychological distress • Percentage of adults who reported joint pain during the past 30 days (adults self-report) • Percentage of adults who are satisfied with their lives
Ability to function	• Percentage of adults who report a disability (for example, limitations of vision or hearing, cognitive impairment, lack of mobility) • Mean number of days in the past 30 days with limited activity due to poor mental or physical health (adults self-report)
Access to health care	• Percentage of population that is insured • Percentage of population that has a designated primary care physician
Clinical preventive services	• Adults who receive a cancer screening based on the most recent guidelines • Adults with hypertension whose blood pressure is under control • Adult diabetic population with controlled hemoglobin A1C values • Children 19–35 months old who receive the recommended vaccines
Cost of care	• Percentage of unnecessary emergency department visits • Percentage decrease in ED costs • Percentage decrease in cost of care per patient per year

Source: "The Second Curve of Population Health," March 2014, Health Research & Educational Trust

combined in regional health information exchanges and data registries to comprehensively address patient and community needs.

• Timely and local data that identify community health issues are accessible by clinical staff in real time to guide the care of individuals.

Mature partnerships that collaborate on community-based solutions:

• Hospitals and systems engage the community by providing resources, sharing knowledge, and developing relationships and skills to manage communitywide challenges and leverage collective advantages.

• Extensive and diverse partnerships between hospitals and local organizations address specific and general health needs of the community.

• Hospitals and systems partner with the community and public health departments to address gaps and limitations in health care delivery and to target community health needs.

• Hospitals and systems provide balanced leadership that recognizes the resources and contributions of community partners, and they include community representatives in their

leadership structure.

- Hospital-led initiatives address community issues such as environmental hazards, poverty, unemployment, housing and other socioeconomic factors.
- Community partners collaborate to develop health metrics to measure progress and community needs.

BRIDGING THE GAP

Every hospital and system approaches population health differently depending on organizational priorities, resources and population needs. A survey by the American Hospital Association and the Association for Community Health Improvement confirmed anecdotal evidence that implementation of population health initiatives varies widely across hospitals. To move to the second curve of population health, hospitals and care systems will need to align their mission, organizational culture and services with a population health approach that addresses the needs of the community. Each organization's alignment is unique because its structure and resources, along with the surrounding community, influence and shape the transformation.

Many organizations are moving toward the second curve by incorporating population health initiatives into their operations. A common impetus for initially engaging in population health is community benefit regulations that require nonprofit hospitals to demonstrate their positive community impact. Hospitals can meet their requirement through community health promotion, education, charity care or other activities.

Part of this regulation requires hospitals to conduct community health needs assessments at least once every three years and develop implementation plans to address identified needs in the population. By bringing together stakeholders from across the system and community, the CHNA process encourages collaboration among organizations to address the health issues unique to their community.

Some hospitals and systems take a narrow approach to population health by focusing improvement efforts on their own patient population. Many are developing accountable care organizations and patient-centered medical homes to manage care across the continuum for a specific population of patients. While these pilot programs are showing promising results for patient health and cost savings, these approaches do not necessarily address the needs of the greater community, particularly those individuals who do not have access to care.

Second-curve organizations go beyond community benefit regulations and accountable care organizations to develop a culture that integrates a population health approach into all facets of the organization. Leaders should define the target population and associated health goals. As health care moves to the second curve, hospitals and care systems may be challenged to expand their defined population into the broader community to address growing health issues.

As established stakeholders and leaders, hospitals and systems should play a significant role in population health transformation. Hospitals can leverage their clinical expertise and extensive resources to promote wellness and support a variety of external collaborative relationships to achieve their population health goals. As the public health and provider sectors become better aligned, hospitals will need to engage in challenging but necessary changes to improve the health of the patient and community population as well as the organization's financial bottom line.

MEASURING THE TRANSFORMATION

Organizations that move toward the second curve of population health should evaluate process metrics, but prioritize outcomes measures. Leaders can collaborate with clinical staff and community leaders to develop metrics. The metrics that measure transformation to the second curve of population health must be:

- simple, robust, credible, impartial, actionable and reflective of community values;
- useful over time and for specific geographic, membership or demographically defined populations;
- verifiable, independently from the entity being measured;
- responsive to factors that may influence population health during the time that inducement is offered;
- sensitive to the level and distribution of disease in a population [see Population Health Metrics, Page 19].

DEVELOP YOUR ROAD MAP

To improve the health of a population, hospitals and systems need to provide high-quality care and proactively address the environmental and social factors that affect health status. While most organizations do not have the resources or desire to assume all of the health needs of their community, they can leverage their resources and influence to lead community health transformation.

Moving to the second curve of population health will require challenging cultural and systemic shifts alongside commitment from hospital leadership. Transformation will not occur overnight; forward-thinking organizations should engage their leaders, staff and community to develop a road map to the second curve that aligns with the hospital and community's needs and resources. Innovative approaches can be implemented to address rising costs and an increased demand for services, but also to improve outcomes, reduce the cost of care, enhance the patient experience and improve population health. **T**

This is an excerpt from the Hospitals in Pursuit of Excellence report "The Second Curve of Population Health." To read the complete report, including case studies, go to www.hpoe.org/pophealthsecondcurve.

Hospitals in Pursuit of Excellence, *the American Hospital Association's strategic platform to accelerate performance improvement, is managed by the Health Research & Educational Trust (www.hret.org), an AHA affiliate.*