BoardBrief

Knowledge Resources for Governing Effectiveness

A Trustee Guide to Understanding Population Health

Improving the health of the community is the driving mission for most, if not all, hospitals and health systems. The goal of population health management is closely aligned with that mission and may seem to be a logical and perhaps easy step for hospitals and health systems to take. Managing the health of a population has significant implications for hospitals and health systems that are important for trustees to understand.

Population health and value-based care are inextricably linked together. Value-based care is the shifting system in which health care providers are paid based on patient health outcomes, rather than the traditional "fee for service" system of payment. Population health is a broader focus on improving the health of individuals and communities. The Centers for Disease Control and Prevention (CDC) describes population health as an approach that utilizes non-traditional partnerships in different sectors of the community to achieve positive health outcomes.[1]

Hospital and health system trustees must have a solid grasp of the meanings and implications of population health management and why it's important to the future of their organization and the community as a whole.

Understanding Population Health

The Pathways to Population Health initiative describes six concepts that form the foundation for pathways to population health, divided into two categories: What creates health, and how health care can engage.[2]

***Foundations that create health**:*

- Health and well-being develop over a lifetime.
- Social determinants drive health and well-being outcomes throughout the life course.
- Place is a determinant of health, well-being, and equity.

How health care can engage:

- Respond to the key demographic shifts of our time.
- Embrace innovative financial models and deploy existing assets for greater value.
- Invite partnerships because health care is only one part of the puzzle.

Simply put, population health management means improving the overall health of a population. This includes identifying individuals with the highest-risks (both acute and complex health conditions), and determining the best

means for keeping them healthy. It also means determining and addressing the preventive and wellness needs of the rest of the population.

Why is Population Health So Important?

In today's value-based world, providing high quality care and improving health outcomes significantly affects hospital and health system's ability to succeed. This starts with impacting social determinants of health. Social factors are connected to increased risk for chronic health conditions, decreased access to medical care and consistently poorer health outcomes. One study found that ***medical care accounts for only 20 percent of all factors that influence health.***[4]

Mission Fulfillment. If medical care only impacts health by 20 percent, how can hospitals fulfill their community-focused mission by exclusively providing medical care? In short, they cannot. As a central component of their mission, hospitals and health systems must understand the greatest community needs and work to address those needs. That requires addressing individual needs, community-wide needs, and systemic issues that lead to poor health.

Value-Based Purchasing. Population health management isn't just an opportunity to better fulfill the mission. It's also an opportunity to positively impact the bottom line. Value-based programs link reimbursement to patient outcomes. According to CMS, value-based purchasing is part of a broader quality strategy to reform how health care is delivered and paid for. It has three aims:[6]

- Better care for individuals
- Better health for populations
- Lower costs

Understanding Determinants of Health

Social determinants of health (the conditions in which people are born, grow, live, work and age) have a significant impact on overall health and quality of life.[2]

Research has shown that social factors such as racism, social isolation, violence, inadequate housing and inadequate employment impact poor health outcomes and premature death by 50 percent more than access to health care alone.[2]

"Children born in the same hospital who grow up two miles apart might have a 10- to 25-year difference in predicted life expectancy because of place-based determinants of health." [2]

Population health management has the potential to influence all three of these areas.

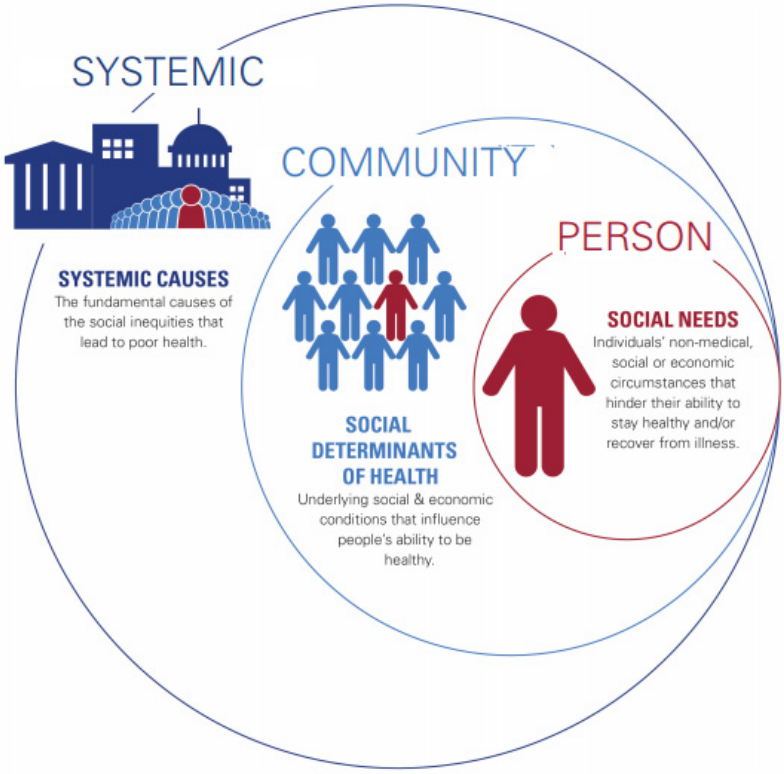
Systemic Savings. According to the American Hospital Association's Futurescan report, it is projected that $230 billion could be saved if health equity improved in the United States. A 2020 study found that every $1 invested in community health worker interventions addressing unmet social needs results in a $2.47 return to the average Medicaid payer.[4]

A study by The Commonwealth Fund reported similar findings in a study focused on meeting the needs of high-need, high-cost patients. The authors concluded that "holistically addressing the social and medical needs of such patients can improve their health outcomes and produce health care savings by reducing the use of expensive health care services such as emergency department visits and hospitalizations." The Commonwealth Fund study focused on interventions in six areas: housing, nutrition, transportation, home modification, case management and counseling (legal, financial and social supports).[5]

AHA: Societal Factors that Influence Health

Hospitals are often the cornerstone of their community. They have an opportunity and an obligation to improve the community's overall health. The American Hospital Association has developed a framework that helps hospitals guide their strategies to address the social needs of their patients and communities, focusing on systemic issues that lead to health inequities and ultimately overall health.

As hospitals and health system leaders develop strategies and collaborate with others, efforts should focus on three areas:



- **Person:** Meeting individuals' non-medical, social or economic circumstances that hinder their ability to stay healthy and/or recover from illness. Some examples include lack of stable housing, homelessness, limited access to food, loneliness or an unsafe home environment.
- **Community:** Hospitals can address underlying social and economic conditions in the community served. Examples include food deserts, lack of affordable housing, community violence or public transportation.
- **Systemic Issues:** Addressing the fundamental causes that lead to poor health, which may include racism, sexism, poverty, environmental injustice or educational systems.

Source: Societal Factors that Influence Health: A Framework for Hospitals. American Hospital Association. December 2020. www.aha.org/societalfactors.

What Is In the "Population"?

One of the first and most important steps in managing the overall health of a population is to define who's included in the "population," or group of people whose health is to be "managed." A population can be defined in multiple ways, including: 1) individuals within a specific geographic area, such as the hospital or health system's community or service area; 2) a patient population, such as a physician practice group's patients or a hospital's discharged patients; or 3) a payer group, including Medicare patients assigned to an Accountable Care Organization (ACO), patients covered under a particular insurer's benefit plans or employees of a particular employer. A population may also be defined by a particular health condition, such as diabetes, asthma or cardiac conditions.

There are a number of ways to define a group of individuals whose health the hospital or health system wants to positively impact. The key is to ensure a clear definition of the population in question from the start. The ability to measure the impact and outcomes of various health care interventions is dependent on knowing exactly what the target population is.

Taking Action

Many hospitals are already implementing population health efforts. A recent AHA survey of more than 1,000 hospitals found that:[7]

- 77% of hospitals screen patients for social needs.
- 66% document patients' social needs in their electronic health record.
- 82% of respondents include population health management in their broader organizational strategies.

At the same time, nearly 70 percent of those surveyed reported that while they do use community investment strategies, they don't yest measure the returns generated from those investments.

There is still much work to do. While the size and resources of a hospital or health system and its community may define the scope of the population health strategies the organization is able to undertake, every hospital has the potential to significantly impact population health.

Common Vision. When the board and the CEO agree upon a common vision for community and population health, and all key players, including the medical staff, are working toward that same vision, the path to achievement becomes a little easier and the outcomes are more effective. To get there, the board and CEO must agree upon and clearly articulate the extent of the commitment and engagement of the organization in community and population health efforts.

Targeted Health Needs. Identifying targeted health needs is a first step in population health management. Hospitals and health systems may choose to target quality and patient safety by selecting an area in which the organization's health outcomes measures fall short. A hospital or health system may also want to focus its efforts on one or more of the health needs identified in a community health needs assessment, or where it experiences a high rate of admissions. Many organizations are also working to improve the coordination of care between providers.

Interventions. Once a target health care need has been identified, the contributing causes or factors must be identified, and possible

Rural Hospital Examples

Population health is important for every hospital and health system, but rural hospitals face unique challenges as they work to improve the health of the community and maintain financial viability at the same time. Expert recommendations include:[8]

- Leverage existing community resources and partnerships to make the biggest impact.
- Use data in existing electronic health records to create a registry that identifies and tracks patients that would benefit from chronic care management, such as diabetes, hypertension or depression.
- Use telehealth to remove barriers and connect with individuals in the community and build a better understanding of patients' needs.

Critical Questions for Boards

- Does your board have a good understanding of population health management and its importance to your organization?
- Has your board made a commitment to improving population health?
- Does your hospital or health system have the infrastructure necessary for managing population health? If not, what actions does the board need to take to ensure the hospital or health system is able to develop population health management as a competency?
- Do you know what strategies the organization is pursuing to manage and improve population health? Does the board maintain adequate oversight to ensure successful outcomes?
- Do you know what efforts others in your community or region are pursuing to manage and improve population health? Are your efforts well-aligned or are they duplicative? Could joining forces create a more successful outcome for the community?
- Is your organization maximizing its resources, efforts and potential impact through partnerships and collaborations? If "the whole is greater than the sum of its parts," what opportunities should or could the organization pursue?

strategies for addressing them must be evaluated. Hospitals and health systems must assess and prioritize efforts to pursue. This includes consideration for where the organization can have the most critical impact or influence. It is also an opportunity for trustees to consider the long-term goals for a healthy population, to challenge common assumptions and the status quo, and to seek out new and creative partnerships and collaborations that will engage, motivate and inspire patients and the community.

Partnerships and Collaborations. Many factors are outside the hospital's control or they may exceed the hospital's resources. The network of partners and collaborative relationships that were established when the hospital conducted its community health needs assessments is a good place to begin when identifying opportunities to address a population's health concerns. Public health departments and other social service agencies have years of experience and expertise to contribute to collaborative public health efforts.

Trustees should recognize that they themselves are a good resource for identifying potential partnerships and collaborations. Lay trustees in particular can contribute new, different and community-based views of unique partnerships and collaborations. Trustees generally have networks of community contacts that can lead to new and innovative alliances for improving the community's health.

Clear Accountabilities. As hospitals and health systems forge new relationships with others in the community, the ability to navigate a path to success is often dependent on clear expectations set from the beginning, which are understood and agreed to by all parties. Expectations should include roles, responsibilities, goals and objectives, and project plans, all well-defined and agreed upon.

Measured Outcomes. To demonstrate improvement and ultimately earn revenue in a value-based system, the organization must have the ability to establish a baseline of measurement and track and measure outcomes and improvements in quality, patient safety and health.

Data and Technology. Data and technology are critical for successful population management. Technology can help identify populations with the greatest needs, identify care gaps and measure the potential and actual impact of various population health efforts.

Available Resources. Hospitals must carefully weigh the cost of potential improvements to support population health against their already strained resources. The good news is that hospitals aren't alone in population health efforts. Boards must lead the way in establishing partnerships with others who will share the responsibility for improving the community's health and best maximize the benefit of scarce resources.

Resources for Hospital Leaders

The American Hospital Association has wide-ranging resources for hospitals and health systems to help leaders understand populations, engage new partnerships, take system-level action, and measure and sustain progress. Case examples provide practical examples of actions hospitals are taking. For more, go to www.aha.org/center/population-health.

How is Success Defined?

Ultimately, the hospital or health system's board of trustees is accountable for the organization's success. In a value-based system, success is increasingly defined not only by financial viability, but by the organization's ability to fulfill its promised mission to positively impact and improve the health of its community.

Sources and Additional Information

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