Predicting Success in Population Health

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Given my experience at Jefferson College of Population Health, I am often asked to make predictions about the future of population health. Recently, a research team from a prominent consultancy in Chicago asked me to focus on “the best practices for health systems looking to optimize organizational structures as their population health efforts mature.” Surely a tall order!

A team of senior leaders from the firm joined me on the phone, as we went through my list of 6 key attributes that I believe are central to the successful implementation of a population health strategy from the perspective of a large multi-hospital delivery system. Naturally, I am biased, having spent nearly 30 years inside “the belly of the beast” at Jefferson Health, a 16-hospital delivery system that is now the largest provider in our geographic region.

I’d like to share my 6 key attributes for the successful implementation of a population health strategy, recognizing that at the moment, although there is good evidence to support each of my assertions, there is no single silver bullet that predicts success in population health (that is, after my review of the organizational and leadership peer-reviewed literature). I regret that I cannot provide a succinct evidence-based summary about what the key ingredients are; rather, I can distill my experience at Jefferson and my leadership of the nation’s first college devoted to these issues.

Not surprising, I believe that the first key attribute that predicts success is an unwavering commitment on the part of the most senior leadership of the organization. Although this is surely hackneyed for some, I cannot overemphasize how important a visible, enduring, and constant commitment on the part of the most senior clinical leaders is to an organization that is embarking on the implementation of a population health strategy.

These leaders should be able to articulate, in 30 seconds or less, the reasons why the organization is taking on such a strategy. In this 30-second “elevator speech,” there should be some mention of what the central mission is, as well as a clear commitment to improving the health of the persons we serve, not only of expanding our network or competing with other networks, or with other market-related goals.

Closely following a senior commitment is the establishment of clear lines of “clinical authority,” preferably nested in a physician-led organizational structure, with a highly trained and experienced physician leader at the helm. Whether we call this person the Chief Physician Executive, the Senior Vice President of Clinical Affairs, or some related title does not much matter. What matters is that this individual is publicly anointed as the top doctor. This individual must have the authority and responsibility to implement the vision as articulated by senior leadership.

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In my view, all chairs of clinical departments should have at least a dotted line to this Chief Physician Executive to maximize the organization’s ability to tackle our chief clinical challenge, namely, unexplained clinical variation. It is impossible to implement a robust population health management strategy without first tackling the key components of care, namely, reducing unexplained clinical variation and other forms of waste, thereby rendering care that is safe, high quality, and of course, less expensive.

The third predictor of the success of population health is an information technology infrastructure built on top of an electronic health record. Let me explain. I would imagine that most multi-hospital systems by now have implemented one of the usual electronic health records such as Epic, Cerner, or Allscripts Professional. Although these systems have their own strengths and weaknesses, I believe that they are not sufficient for the implementation of a population health strategy. Using technology from firms such as Innovaccer gives physician...
leaders an opportunity to create detailed physician practice profiles, which, in turn, leads to the closure of the feedback loop and of gaps in care. Regrettably, our conversation about these issues is fraught with jargon. Organizations such as Philips Wellcentive, Lumeris, and many other competitors are also working in this space. There are even expert consultant companies, such as Navvis, in St Louis, MO, that guide this implementation and can educate the medical staff as to its utility. In short, this third predictor could be summarized as the organization’s ability to obtain actionable information from all the clinical data it currently collects.

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The fourth predictor of success is a visible and transparent ambulatory performance improvement measurement system. I am searching here for a way to mirror what we’ve done for years regarding the inpatient side, as we have historically measured our progress against a multitude of process and outcome measures at the bedside. We need a comparable leaner structure on the outpatient side, perhaps an ambulatory performance improvement committee, or a value-based care committee, as we call it at Jefferson. There must be a team of actuaries, analysts, clinicians, and practice improvement experts who regularly review what goes on outside the 4 walls of the inpatient facility, as we recognize that the bulk of spending, especially into the future, is (and will be) in the postacute and home care settings.

This value-based care committee must create dashboards and related tools that are readily available for clinicians at the front lines of care, especially those delivering all aspects of primary care. This committee must sift through the plethora of ambulatory measures and carefully discriminate among them to focus on the measures that make the most sense at the local level. Remember the adage that we will only improve that which we measure.

The fifth predictor of success is absolute transparency and accountability for money that is generated under any value-based care bundled payment or under related risk-bearing contract. Far too often, I see economic rewards that are unevenly distributed and at times are so opaque that they rather obfuscate the entire process. Clinicians at the front line, doctors, nurses, pharmacists, and other team members must be rewarded for their improved performance; otherwise, the entire foundation of value-based contracting is at risk. Whether the rewards are allocated along drug lines, departments, or actual geographic sites is less important than complete transparency in how the process is implemented.

Finally, the sixth key attribute must be suffused throughout the entire organization, and it is what others have called “a disciplined approach to meeting consumers’ needs.” This has been well-described by the innovation scholar, Clayton M. Christensen, MPhil, MBA, DBA, who has formalized this idea and calls this novel solution focusing on “the job to be done.” Dr Christensen suggests homing in on “the progress that the customer is trying to make in a given circumstance—what the customer hopes to accomplish.”

Furthermore, Dr Christensen notes, organizations should not ask customers (or patients) which existing drugs they prefer; instead, they should work to understand their underlying needs, and then work to satisfy those needs. In short, large multi-hospital delivery systems, as they are currently construed, do not ask often enough what the needs of their patients are. Indeed, we can argue that the needs of busy clinicians have helped to shape the actual organizational design and structure of the current multi-hospital delivery system. It will take truly transformative leadership to implement Dr Christensen’s radical idea of truly paying attention to, and focusing on, the needs of our patients.

I’m confident that there are more than these 6 key variables that currently may predict success in the implementation of a population health strategy. I’m equally confident that without all these 6 attributes, most systems will be unable to navigate the currently tortuous road toward achieving improvement in the health of the population.

As always, I am interested in your views, and you can reach me via e-mail at David.Nash@jefferson.edu.

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References