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Posts from May 2010

05/24/2010

Reform vs. Transform



By Jonathan Fielding, MD, MPH, MA, MBA

Health insurance reform has been passed. Those of us who feel health care is a right can now see the path to get 95% of the population covered. The evidence is clear: health insurance reform can save lives. But what was missing in the rancorous debate over “health reform” was a sense of context. How important is health care compared with other factors that influence individual and collective health? Are we making investment decisions that flow from the answers to this question? The truth is that health care coverage expansion, albeit overdue and an essential social good, will have a relatively small effect on our relative position of 37th among the nations of the world in life expectancy.

If we want longer, healthier lives, lives with more years of independence and high functioning, we need to complement health insurance reform with more fundamental reform—a transformation of the health enterprise. Transformation requires answering the fundamental question: “What determines our individual and collective health?”

The studies provide a clear but surprising answer. The conditions in which we live, work, and play are the most important health influences. A high school graduate lives on average seven fewer years less than a college graduate. Smoking, other drug use, obesity, inadequate physical activity, and a diet too rich in processed foods are major contributors to our health and functioning—on balance, more important than whether we see a doctor for a routine physical. Medical care is important, and can be life prolonging—but it is only part of the opportunity to minimize most health problems.

This is not fresh news. But there is an almost total disconnect between the fight over “health reform” and what investment would provide the highest value in terms of quality and years of life along with reducing the gaping health disparities among different groups, defined by ethnicity, race, culture, and geography. What we need is a

nation that thinks differently about how we get to be healthy. We must view and act as if health is a necessary characteristic of populations, not just individuals. If we did, we would invest more heavily in evidence-based prevention—both for patients and communities.

Thinking differently about what determines our health can be transformative. We will ask better questions of ourselves and of those who make policy, both public and private. Thinking differently could cause us to encourage our elected representatives to consider how policies in agriculture, transportation, housing, and social services can support health.

Does subsidization for growing corn, the source of the inexpensive high fructose corn syrup ubiquitously present in foods, improve our health? Does it make sense to have schools with the best local playgrounds declare them off limits to neighbors in their communities? Should almost all our investment in transportation be for roads and highways rather than mass transit and more bikeable, walkable communities? Why should medical care be tax advantaged while we pay after tax for fruits and vegetables or fitness clubs or smoking cessation classes?

The passage of health insurance reform has helped answer the nagging question of access to medical care. Now we have the opportunity—and the imperative—to ask the larger questions about how to improve our health. Shouldn't the first question be, "If we want to invest cost-effectively to improve health for everyone in our country, what would we do differently—as a nation, as communities, and as individuals?"

Commissioner Jonathan Fielding, MD, MPH, MA, MBA serves as Director of Public Health and Health Officer for Los Angeles County, where he is responsible for the full range of public health activities for 10 million county residents.

Posted on 05/24/2010 in The National Policy Front | Permalink | Comments (1)

| Twee

05/18/2010

Is Population Health Finally Coming into Its Own?

Dave - Feb 2010 By David A. Kindig, MD, PhD

Why am I starting a blog on issues and perspectives in the field of population health? **It is because I believe we are at a "tipping point" in which a convergence of scholarship, policy, and practice initiatives seem poised to bring an overdue population health perspective to thinking about and acting on health and health improvement. The challenge of the next decade will be to find practical ways in which new approaches to financial and non-financial incentives and multi-sectoral partnerships can be applied to improve population health outcomes here and elsewhere.**

Although the roots of broad population health thinking go back for centuries, in the United States, the second half of the 20th century was dominated by the rise of biomedical science and clinical medicine. Many in public and population health (how are these different?) have been critics of the dominance of health care emphasis and investment, but these advances have been critical and will continue to be so. The end of the century has seen additional growing understanding and support that such behaviors as tobacco use, diet, and exercise also make substantial contributions to the health of individuals and populations. My own population health epiphany came with my exposure in the early 1990s to the thinking of Bob Evans and Greg Stoddart and their population health "field model" from the Canadian Institutes of Advanced Research (1). At once simple and profound, it captured the basic population health principles:

- that health outcomes were more than the absence of disease;
- that these outcomes were produced by complex interactions of multiple determinants (health care, behaviors, genetics, the social environment, the physical environment); and
- that in a resource-limited world, the relative cost effectiveness of these determinants was critical for policymakers.

While this Canadian work has provided an important framework for international population health scholarship and policy development, the last 15 years in the U.S. have been dominated by such issues as health care access and costs and pressing immediate public health issues like emerging communicable diseases (e.g., HIV-AIDS and H1N1). Periodic activity and reports from government agencies and foundations have addressed parts of the broad issue of outcomes and determinants, but not in visible and sustainable ways. Notable exceptions have been (A) the Institute of Medicine (IOM) and Centers for Disease Control and Prevention's (CDC) emphasis on a broad public health "system," (B) the creation of the Robert Wood Johnson Foundation's (RWJF) Health and Society Scholars Program to grow a new generation of multidisciplinary scholars for this emerging field, (C) the RWJF Commission to Build a Healthier America, and (D) the WHO Europe's 2003 report on the social determinants of health. (I will return in a future post to the challenge the social determinants of health pose for policymakers.) In 2010, however, this emerging field has still not matured in either scholarship or policy. However, the last several years have seen growing attention from a policy perspective. Here are some examples:

- Decades of work from the Dartmouth group demonstrated how communities that spend the most on health care may not have the highest quality or outcomes.
- The groundbreaking documentary Unnatural Causes provided wide exposure to the multiple determinants of health.
- The California Endowment is making a major long term investment in the broad health of 10 communities in California.
- The State of Minnesota has invested $43M in its State Health Improvement Plan to create "accountable health communities" that address obesity and tobacco through policy, systems, and environmental changes.
- The Institute for Health Improvement has endorsed population health improvement as one of the three legs of its Triple Aim strategy and is considering moving to a regional strategy
- CDC has funded a cooperative agreement with the National Business Coalition on Health to work with business-led health coalitions and the business sector on building the capacity of members to be leaders of health reform and advance value based health and health care.
- Concerns about obesity have underscored the complexity of addressing this critical issue (look for a future post on the tension between free will and the social context with regard to behavior choices).
- Obama administration officials have been discussing a "place-based" approach for social investments as well as a major Community Health Data Initiative.
- The National Quality Forum and the National Priorities Partnership are discussing the need for new broad measurement tools such as a national index of health.
- Our own Robert Wood Johnson Foundation MATCH project in February released the first ever National *County Health Rankings* of 3,014 counties in all 50 states according to a broad population health model that has been used in Wisconsin since 2003.

When I published *Purchasing Population Health: Paying for Results* in 1996, this list of activities was much shorter. Now every day we learn of some new policy, practice, or research finding that is aimed at population health improvement. Keeping track of and commenting on these exciting developments is the purpose of this blog. We plan to post on a weekly basis, with content from our own team as well as guest posts from prominent policy and practice leaders.The University of Wisconsin Robert Wood Johnson Health and Society Scholars Program will each month identify several recently published papers that make important contributions to policy, practice, or scholarship. All posts will in some way relate to our underlying population health model, including key concepts of outcomes and factors.

My hope is for this blog to prompt lively and provocative dialogue--and even action--toward improving population health.I welcome comments on this first post and all contributions to follow. I look forward to hearing from you!

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Posted on 05/18/2010 in Population Health Basics | Permalink | Comments (4)

| Twee

Dynamic Duo: Healthy Food and Jobs



By Kirstin Q. Siemering, DrPH, RD

According to PolicyLink, 23 million Americans living in low-income communities don't have access to a supermarket. In round figures, this translates to the combined populations of New York, Los Angeles, Chicago, Houston, Philadelphia, Phoenix, San Antonio, and San Diego.

Without supermarkets, people tend to have limited options when it comes to feeding themselves and their families. The corner stores and fast food outlets that often predominate in low-income areas offer an abundance of relatively inexpensive foods that are high in calories and low in nutrients—but little if any fresh fruit, vegetables, and other nutritious staples. Not surprisingly, people living in these communities suffer disproportionately high rates of diet-related chronic—and preventable—diseases such as obesity and diabetes.

But this hasn't always been the case. These "food deserts" have developed in response to various economic and social forces affecting demographic shifts over the past 30-40 years.

This transformation dates back to the 1970s and '80s, when the landscape of food availability in densely populated, largely poor city centers began to shift. Grocery stores expanded their square footage, consolidated into chains, and many closed their urban doors, taking jobs with them as they headed to the suburbs to build bigger stores more cheaply and expand their profits by serving more affluent clients. Food deserts also have sprung up in rural areas over the last decades. Hanna, Wyoming (population 800) lost its only grocery store just months ago; the nearest grocery store is now 80 miles away.

So what to do?

There's a movement afoot to turn things around, store by store, community by community. One example is the effort is being led by Pennsylvania's Fresh Food Financing Initiative (FFFI). In only four years—and with just $30 million in state seed funding—this innovative program has brought 83 supermarkets to underserved areas throughout the state and created 5,000 local jobs for local residents.

The program works by providing gap financing to prospective grocers who would like to open or renovate stores in underserved areas but have special needs that can't be met through conventional financing. For example, for his downtown Philadelphia Shop-Rite store, grocer Jeff Brown needed additional funds for training and security. Funding from the FFFI helped him put what was needed into place while keeping his prices reasonable. Brown's now profitable store caters to the ethnic and cultural food preferences of his clientele, including a pork-free meat room for Muslim customers.

The project brings together The Food Trust, The Reinvestment Fund, and the Greater Philadelphia Urban Affairs Coalition in a public-private partnership that has won national acclaim, including a Smart Growth Award from the Environmental Protection Agency and recognition from the Harvard Kennedy School of Government. Most recently, in his 2011 budget, President Obama has requested $400 million to create a national Food Financing Initiative.

With luck and favorable fiscal and political winds the national FFFI will become an important driving force to enhance the food and employment landscape in underserved communities across the country.

Kirstin Siemering DrPH, RD is a researcher with the University of Wisconsin Population Health Institute.

Posted on 05/18/2010 in Policy and Systems Change in Action | Permalink | Comments (0)

| Twee

Resources for Population Health Improvement: What About the Savings from Waste in Health Care?

Dave - Feb 2010 By David A. Kindig, MD, PhD

The release of the national *County Health Rankings* demonstrates how large the gaps are across our communities in both health outcomes and the factors producing health. Particularly in the lowest ranking counties in any state, there are significant resource constraints in all the factors producing health. These include health care access, disease prevention and health promotion programs and policies, early childhood and health literacy efforts, jobs and economic development, air and water quality, and the built environment. Where might the resources come from to make improvements toward better health—particularly for our most under-resourced communities?

One place to look is at the waste in our health care system. For years organizations as prominent as the Institute of Medicine have been observing that 25% to 33% of all of our health care expenditures may be wasted because they are ineffective in improving health. Dr. Elliott Fisher and colleagues at Dartmouth have been calling attention to the approximately threefold regional variation in per capita Medicare expenditures from $5300 to $16,300 without differences in health care quality and health outcomes (1). They have also recently observed inflation adjusted Medicare growth rates varying from 2.3% in Atlanta and Pittsburg to 5.3% in Dallas over the period 1992-2006. The Dartmouth group indicates that reducing the spending rate from the national average of 3.5% to the 2.3% experienced by San Francisco would save Medicare $1.3 trillion by 2023.

Looking at it another way, total health expenditures in 2009 were projected to be $2.5 trillion. If 25% of that could be saved, that would amount to $625 billion per year. Providing health insurance to everyone would require an estimated $100 billion per year. That would leave more than $500 billion for smoking cessation, exercise and nutrition efforts, education enhancements, job creation, and creating safer communities. To put this in context, total national expenditures in 2005-2006 for all K-12 education in the entire country was $461 billion.

However, achieving these savings is challenging. Republicans and Democrats alike are skeptical that cost-containing provisions of the Obama Health Insurance Reform law will be strong enough to reduce expenditures substantially. Even in places that have low health expenditures and good outcomes, cultures of cost effective practice have been developing

for decades; they cannot develop overnight. A current proposal is to develop Accountable Care Organizations, in which financial incentives would be provided for developing efficient practices. Discussions have begun around the concept of shared savings, in which savings are divided between the providers who produce them and insurers. Vermont has already been using savings to hire staff for community clinical prevention while leaders in Minnesota have raised the possibility of using part of the savings to create Accountable Health Communities.

These are only initial ideas and beginning steps; vast resources will be necessary to fully implement the plans described above. Dan Fox, a careful observer of American health politics, has observed that policymakers "most likely would ration spending to improve overall population health in order to avoid rationing health care…there is no reason to expect that a value dividend, if one accrues, would be used for any other purposes than slowing the growth of spending or providing more access to health care (2)." Bentley similarly observes that "as a society we may prefer to provide care to the sickest, most vulnerable patients even though our money could buy greater improvements in life span or quality of life if used for another purpose (3)."

While common sense suggests a systemic streamlining that involves exchange of ineffective resources for those shown to be most (or at least more) effective, political realities are not necessarily rooted in common sense. Paul Starr's book *The Social Transformation of American Medicine* sums up 150 years of medical history by saying that "the dream of reason did not take power into account."

We must hope that approaches to shared savings in health care develop more robustly and gain traction. But they are not the only hope. We have to look for other inefficiencies as well. Governments, philanthropies, and businesses will have to make additional resources available. Promising current examples include the California Endowment's Building Healthy Communities initiative and the Minnesota's State Health Improvement Plan (SHIP).

In summary, waste and inefficiency in our health care system are one potential source for investing in the broader determinants of health. A fundamental population health challenge is to identify incentive structures and cross-sectoral allocation models to bring such possibilities into policy and practice.

A future post will expand on these ideas and examine additional sources of funding for fundamental population health improvement.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Posts from June 2010

06/28/2010

Building Healthy Communities: What We are Doing and Why We are Doing It



By Robert K. Ross, MD

We were fortunate to have First Lady Michelle Obama join The California Endowment in the recent kick-off our 10-Year Building Healthy Communities plan for the state of California. This $1 billion plan is likely our nation's most robust strategic effort at confronting the thorniest of public health challenges: the social determinants of health.

For definitional purposes, we understand a "healthy community" as a place where children and youth are healthy, safe, and ready to learn. Since our foundation's mission focuses on the health needs of underserved communities, we now find ourselves in the business of community change and transformation, from a disinvested, unhealthy place to one that is healthy and where young people can thrive.

The public health data and literature tells us that on the matter of health disparities, "place" matters. Access to healthy foods, fitness opportunities, public safety, quality housing, good jobs, and quality schools are as critical to attaining good health as is affordable health insurance and community health clinics. Hence, comprehensiveness is critical. This is why we have selected 14 low-income, underserved communities to focus a decade of support in by working with community leaders and

residents. We invite their ideas, creativity, energy, voice, and passion in the transformation of their neighborhoods.

But while "place" and grassroots involvement are important, linking grassroots and local action to advocacy for broader policy and systems change is vital. Policy and environmental changes constitute the most sustainable path towards establishing a real "culture of prevention" in underserved communities and beyond. So, place and policy are the twin pillars of our Building Healthy Community plan. We are planning to invest roughly 60% of our grantmaking in grassroots-level activities and 40% of our resources in broader regional and statewide policy advocacy, organizing, and communications work. The "true north" of all of this: the results. We are looking at ten-year improvements in children's health coverage, childhood obesity reduction, youth violence prevention, and school attendance.

The combination of the passage of national health reform legislation, unacceptable spiraling health costs, and a stubborn and pervasive epidemic of child and adult obesity demands that public health leaders (and other advocates for prevention) stand up and stand tall with community and civic leaders around our nation. Americans at the short end of the health equity stick need us to be bolder and more powerful on their behalf. At the California Endowment, we join public health--and community health--minded colleagues in the battle.

Robert K. Ross, MD, is president and chief executive officer for The California Endowment.

Posted on 06/28/2010 in Policy and Systems Change in Action | Permalink | Comments (0)

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06/21/2010

Collaboration Breeds Success in Memphis



By Joan Fischer, MA

Memphis resident Clintonia Simmons and her teenage daughter had already resolved to lose weight and exercise more when Simmons saw a newspaper ad for a town hall meeting about childhood obesity. The description spoke to the challenges Simmons and her daughter were facing, and she felt drawn to go.Simmons was expecting a small gathering, but it turned out that some 1,000 people were in attendance, including Gov. Phil Bredesen. As part of a national initiative called Shaping America's Youth, the meeting was convened by Healthy Memphis CommonTable, a regional health and health care improvement collaborative that brings together a wide range of stakeholder groups—from government, business, health care, faith-based groups, NGOs, schools, neighborhoods, and the news media—and serves nearly one million people.

The gathering, held in 2006, changed Simmons's life. "At the time, no one was helping children with obesity," Simmons recalls. "There wasn't much out there. Learning about it made me feel more committed."

In fact, her idea for a business was born there. Healthy Memphis Common Table called for proposals, and Simmons had the idea of creating a series of "Get Fit" exercise and nutrition DVDs for young people. The Common Table helped her find resources—mostly, a network of professionals who would help her pro bono—to get the job done.

Simmons is now president of Healthy Kids & Teens, Inc., which provides exercise and nutrition classes to after school programs. She is a certified trainer and nutritionist and is working on her MBA in health management. To offer services to schools that cannot afford it, she holds an annual 5K walk/run benefit that has become one of the city's most popular.

And, between them, Simmons and her daughter have lost more than 80 pounds.

That's the kind of success story that makes the Common Table proud—and it, along with some 30 other projects targeting obesity, has dramatically improved health lifestyle awareness and behavior in greater Memphis, according to Common Table executive director Renee Frazier.

"The Memphis attitude about what we can do as a community to impact health has just totally changed," says Frazier. "Down at the waterfront, people are jogging and running. Community gardens have sprung up. People understand that we can't have as much fried food as we've always had, that we have to try to walk 30 minutes a day. And that's because of the Common Table's ability to motivate and engage the community so that people see the value of improving their health overall."

Frazier acknowledges that moving an entire community's health profile upward is a long-haul endeavor. But increased community awareness and healthy behavior changes, documented in a 2007 progress report, signify a trend in the right direction, she says.

The success of Healthy Memphis Common Table has drawn national attention. Suzanne Mercure, a consultant to the National Business Coalition on Health, calls the Common Table "a great example of broad collaboration" and cites their major accomplishments as including:

- Broad-based participation that takes projects to the local neighborhood
- Common education and messaging for wellness and healthy lifestyle
- Approaches directed for physicians and health care professionals, business/employers, and consumers
- Access to information on quality including profiles at the physician practice level
- Common evidence-based guidelines for such conditions as obesity
- Expanded options for those with diabetes for access to health care educators and support
- Grant support for quality improvement initiatives

Both Mercure and Frazier say that support from the business community, led by the Memphis Business Group on Health (MBGH), has been key to the Common Table's success. MBGH worked especially closely with the Common Table on "Aligning Forces for Quality," an initiative funded by the Robert Wood Johnson Foundation to engage consumers, providers, and payers to improve quality through public reporting of performance on key measures of quality of care.

On the Common Table website, consumers can also find quality ratings for patient experience, hospitals, and medical offices.

"We now have more transparency of information around quality of health care than we have ever had in this community, and that's thanks to the Memphis Business Group on Health," says Frazier.

Their partnership will continue to break ground with plans to create best practice guides for physicians whose ratings could stand improvement. Health plans in greater Memphis have agreed to collaborate on producing those guides, Frazier says."This is important because typically the health plans would never do this type of work together," she says. "Never in a million years."

That unlikely collaboration bears further testimony to the vision and success of the Common Table—and the potential the Common Table approach could hold for other communities around the nation.

Joan Fischer, MA is a writer and editor with the University of Wisconsin-Madison.

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| Twee

06/15/2010

How Healthy is Your Community?



By Patrick Remington, MD, MPH

Nearly everyone would like to know the answer to the question, "How healthy is your community?" One way this question is being answered is with the Robert Wood Johnson funded *County Health Rankings* which compare and contrast the health of over 3,000 counties in the 50 States nationwide, providing for the first time a standard way to measure the overall health of nearly every community in the nation.

The measures used in these Rankings are similar to those that have been used to rank the health of counties in Wisconsin over the past seven years. Last year, as we started the process of developing the national *County Health Rankings*, we contacted experts in population health measurement and asked them to review the best approaches to measuring health the health of communities. They each reported their findings in reports that have just been published in the CDC's online journal, *Preventing Chronic Disease*.

These papers are the first of three collections of essays that will be published in the journal to cover a wide range of population health measurement issues corresponding to our model of population health. Upcoming issues will focus on incentives and partnerships for population health improvement (in September and November respectively).

Papers in the current issue on metrics consider best ways to measure the health outcomes of populations including disparities; factors that contribute to health including clinical care; health behaviors; social and economic factors; the environment; and programs and policies that can be implemented at the population level.These essays serve as an important bridge between the world of population health research and people who want to know how healthy their community is. Of course, there is no perfect way to measure the health of populations, just as there is no perfect way to measure the health of an individual.

Clearly, data exist today that can be used to measure the health of the populations. However, it requires that data be collected along the continuum from individuals, to families, organizations, communities, and the broad environment. This calls for using multiple sources of data in each community. Information about individuals is sometimes collected from the entire population, or from a sample, such as through telephone surveys.

There are countless indicators that can be used to summarize the health of populations. For the *County Health Rankings* we chose five measures of health outcomes and 23 measures of health factors that were available in nearly all of the 3,000 counties in the U.S. However, communities that have access to more data may want to dig deeper and explore additional measures of population health. In addition, different metrics are needed to measure improvement in the short to medium run than are used to measure current achievement as is done in the *County Health Rankings*.

So how healthy is your community? Visit the *County Health Rankings* to get one view. Then read these essays to learn more about ways to measure the health of population. Contact us if you have ideas about better ways to measure the health of your community. And stay tuned for the two more sets of essays in the September and November issues of *Preventing Chronic Disease* which will deal with the issues of incentives and partnerships for population health improvement.

Patrick Remington, MD, MPH is Associate Dean for Public Health and Professor of Population Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 06/15/2010 in Defining and Measuring Health Outcomes | Permalink | Comments (0)

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06/07/2010

Obstacles to Population Health Policy: Is Anyone Accountable?

By David A. Kindig, MD, PhD

Population health policy has been slow to emerge as a useful way to catalyze action regarding community health improvement. What are the barriers between population health knowledge and action, and how can we overcome them? There are no easy solutions, but certainly addressing these obstacles is an essential task for the field over the coming decade.

One critical obstacle is that the multiple factors determining population health —health care, behaviors, genetics, social factors, physical environment, public health—can be seen as so broad as to be overwhelmingly inclusive and therefore resistant to realistic policy action or even scholarly analysis.

This is a significant challenge for population health policy. The "inconvenient truth" is that since the actors for this range of factors are spread across the public and private sectors (government at all levels, employers, health care organizations, school boards, community organizations), there is no one actor or agent accountable and responsible for such broad population health outcomes as mortality, morbidity, and disparities.

While governmental public health defines its role as assuring the conditions that make us healthy, in this era of shrinking resources, it is increasingly difficult for local public health agencies to carry out their own essential services (much less broader policies such as health care costs, early childhood programs, and economic

competitiveness). While some have suggested mechanisms such as a public health "system", public-private partnerships, health outcomes trusts, and an integrator function for healthcare organizations, none of these mechanisms have been established beyond theory or taken to scale. Obstacles to systematic transformation include not only the inherent tension between "bottom-up" local community approaches and more centralized state or federal "top-down" planning perspectives, but also communities' unique strengths and challenges across a broad spectrum of health-related issues.

The bottom line is that no one-size-fits-all formula exists to guide population health improvement through resource allocation and activities across multiple sectors and multiple levels. Communities find their own solutions, by figuring out what their most pressing problems are and then working to address them. Thus, we focus on piecing together only discrete, easily defined sections of the population health policy puzzle (i.e., tobacco use, obesity, child vaccinations, etc.), while leaving – quite understandably ---perhaps more root cause and comprehensive solutions unaddressed.

Few would argue against the pragmatism of concentrating effort on a single or several initiatives. In fact, there is some evidence to support such an approach. As Conrad and colleagues' assert, "Very clearly focused interventions targeted to a clearly defined community population, and implemented and managed by a small number of clearly accountable organizational entities, are more likely to produce community health improvement (1)."

That said, we must recognize that in this resource-limited world, implementation of a broader set of the most cost effective interventions will be necessary to achieve the best outcomes. The 467 objectives in Healthy People 2010 are not ranked in any way, implicitly suggesting that all are equally important—which of course cannot be the case. Highest performance on an individual policy in a given community could become an end in itself rather than a means to the population health outcome goal. It is possible, I suppose, that each individual sector (health care, public health, schools, employers) will arrive at the most robust set of cost effective investments and incentives possible under its control. However, this is unlikely to happen, given that available evidence suggests that "the broader the intervention focus and the more varied the target population, the more achievement of positive community health outcomes will depend on the integration of separate program components (1)."

Hope remains, however, in the potential of cross-sectoral integrating mechanisms. To return to the title of this post, I believe that no one entity today has accountability for population health outcomes. However, there are significant problems both with individual sector solutions described above as well as multisectoral partnerships unless they can be brought to scale and demonstrate effectiveness. Resolving this challenge will be one of several critical tasks as a population health policy framework emerges in the coming decades. I would love to hear critique of this analysis as well as examples of promising practices that might lead the way.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Posted on 06/07/2010 in Leadership and Collaboration | Permalink | Comments (0)

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06/01/2010

In the Literature: Media Messages and Menu Labeling

Each month, MATCH Project staff review a wide variety of academic journals to identify recent articles having particular relevance to population health policy, research, and practice. University of Wisconsin Robert Wood Johnson Health and Society scholars and faculty recommend one or two articles to feature on the blog. The complete set of articles is archived here.

News Media Messages and Public Perceptions of the Social Determinants of Health



We connected with Sarah Gollust, PhD, to learn more about her recent research exploring the relationship between media message framing and public perceptions on the issue of type 2 diabetes. Dr. Gollust received her graduate training in health services organization and policy at the University of Michigan and is currently a Robert Wood Johnson Health and Society Scholar at the University of Pennsylvania.

Improving Population Health (IPH): What prompted you to do this research?

SG: I was motivated after taking many courses in graduate school at the University of Michigan in which I learned about health inequalities and the social factors—such as the neighborhoods we live in, our income and education—that influence population health. In every class, I found myself wondering what the general public would have to say about these matters if they knew more about them. Would they be surprised? Upset? Would they be motivated to do more to support public health policy?

I discovered that there was little research in the U.S. on public attitudes and beliefs about health inequalities or how the news media present these issues for the public. So I decided to conduct a study about how U.S. newspapers describe type 2 diabetes and the effects of communicating about the social determinants of diabetes on Americans' opinions about public health policy. I chose to examine type 2 diabetes for two reasons: it is a leading cause of death in the United States, so developing policies to prevent the disease is critical; and its causes can be portrayed in multiple ways, including strong epidemiological evidence of the influence of social determinants.

IPH: What were your main findings?

SG: In the study, members of the public were randomly assigned to read online versions of hypothetical news articles about type 2 diabetes that differed only in how they described the causes of diabetes. One version stated that behavioral choices influence diabetes, one stated that genetic predispositions influence diabetes, one

stated that societal factors like impoverished neighborhoods and access to food influence diabetes, and another used no language about the cause of diabetes.

We observed that Republicans and Democrats responded very differently when they read the *same* information about the social factors that influence diabetes. Compared to their policy opinions after reading the article without any language about the cause of diabetes, Republicans expressed *less* support for public health policies to prevent diabetes and Democrats expressed *more* support for these policies when they read the social determinants article. This "polarization" finding signaled to us that everyone has different values and beliefs about who is responsible for improving health, and that certain ways of discussing these issues will resonate more or less with people's prior values.

IPH: Did you encounter any unexpected obstacles?

SG: The research itself went quite smoothly, but in discussing the results I've discovered that talking about politics can be very tricky. It is all too easy to lapse into using caricatures and stereotypes to portray the two sides of the political spectrum. Even a topic as seemingly politically neutral as diabetes touches deeply felt values and political beliefs, which is important to recognize.

Since I published this work during the extremely politically polarized Congressional debates over health care reform, it received more press coverage than it might otherwise have gotten, but I wanted to be especially cautious to not over-extend the lessons we can learn from this study to the politics of health policy in general.

IPH: What are the implications of this work either for further research or for practice?

SG: With that caution in mind, I do think this work offers implications for future research and practice. First, the study provides an illustration of a phenomenon well-documented in the fields of communication and political psychology, but that has not been a central concern in public health—the idea that political values strongly influence how people process and respond, both cognitively and emotionally, to messages in the media. In particular, this study, along with my other work, demonstrates the important role of beliefs about personal and social responsibility for health in shaping Americans' opinions about health policy.

Second, advocates, researchers, journalists, and policymakers who want to publicize the social determinants of health and not face resistance from subgroups of the population might consider acknowledging both the roles of individuals (i.e., healthy behavioral choices) and the roles of societal forces that constrain people's choices. However, these communication strategies should be empirically tested and grounded in theory.

Third, and related to this last point, more research is needed to investigate how the public responds to alternative ways of presenting and framing the social determinants of health and health inequalities, with particular attention to the influence of social and political values.

Showing Calories on Menus Could Make a Difference



Christina Roberto and her colleagues at the Yale University Rudd Center for Food Policy and Obesity have been engaged in both research and advocacy around restaurant menu labeling. In this post, Ms. Roberto highlights her recent article explaining the rationale and evidence for menu labeling legislation and discusses the new health reform law's national menu labeling requirement.

Restaurant menu labeling is a public health intervention aimed at improving poor diet and decreasing obesity. It requires chain restaurants to provide nutrition information (usually only calories, but some places also require information about saturated fat, sodium, etc.) on menus and menu boards so that the information is visible at the point-of-purchase. Restaurants with 20 or more locations are required to provide this information as part of the 2010 Health Care Reform bill.

Menu labeling makes sense. It provides people with information that allows them to make informed decisions about their eating. In the past, people ate at restaurants infrequently, so the occasional splurge was okay. Given how frequently people eat out today, however, the need for nutrition information about restaurant food has become more important. When we eat out, we tend to eat food that is higher in calories, of poorer nutritional quality, and served in larger portions, which promotes overeating.

How effective is menu labeling? Findings have been mixed but promising. One study conducted by researchers at New York University examined the impact of calorie labels among low-income individuals and did not see much of an effect. However, a larger study conducted by the New York City Department of Health observed reductions in calories purchased at several chain restaurants. These two studies looked at different restaurants and groups of people over varying time frames, which might explain the disparate results. Another recent study found that the calorie content of purchases at Starbucks was reduced in cities with menu labels versus those without.

A recent study we published in the *American Journal of Public Health* involved people we recruited from the New Haven community and randomly assigned to receive one of three menus. Some participants received a menu with calorie labels on it, some received a menu without calorie labels, and the last group received a menu with calorie labels and a label that read: "The average daily caloric intake for an adult is 2000 calories." Participants then ordered and ate a meal for dinner. We found that people ordered and ate fewer calories when given calorie information, suggesting that providing such information can encourage healthier food choices. In addition, this effect was maximized when people were given a menu which included a statement about recommended daily calorie intake. While our study was lab-based, unlike the other studies described, we actually measured calories consumed and were able to demonstrate a cause and effect relationship between menu labels and reduced food intake.

The menu labeling provision in the healthcare reform law is quite strong. It requires calorie labeling on chain restaurant menus and menu boards as well as on drive-through menus and vending machines. There is also a requirement that a brief statement regarding daily caloric intake be included. In addition, restaurants must provide more comprehensive nutrition information in a brochure upon request. While the restaurant industry initially opposed menu labeling (it sued New York City twice, both times unsuccessfully), the National Restaurant Association supports national standards for menu labeling for a number of reasons.

Chain restaurants that operate in many different cities and states do not want to pay the cost of compliance with different regulations for each jurisdiction. Since this law will preempt local governments from creating their own standards, it will create certainty and uniformity that is helpful to the industry. In addition, the law allows for the error that accompanies routine differences in portion sizes and menu items by requiring restaurants to provide caloric information about restaurant items that is accurate within a reasonable range. Labeling also only applies to standard menu items and does not pertain to special dishes. Given those conditions, we can hope that any remaining backlash will not affect the upcoming Federal Drug Administration rulemaking process.

Christina Roberto, MS, is a doctoral student at Yale Univerity pursuing a joint degree in Clinical Psychology and Public Health.

Posted on 06/01/2010 in Improving Health Factors | Permalink | Comments (2)

| Twee



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Posts from July 2010

07/27/2010

How Much Can Expanded Community Health Centers Do?

By David A. Kindig, MD, PhD

Many readers of this blog will not know that I "came of age" professionally as a Social Pediatric resident at the Martin Luther King Jr. Office of Economic Opportunity (OEO) Health Center in the South Bronx in the early 1970s. With vision and funding these health centers provided innovative primary care using interdisciplinary health care teams.

What some may not know (or may have forgotten) is that such centers also provided an array of broader services such as job training, legal advocacy, and school health. We didn't speak of epidemiology and disparities back then, but we understood that community health depended on more than the availability of healthcare services (and on the health of those who did not access them). I also learned an important policy lesson: grants go away—and when they do, many of the innovative services go with them.

The new Patient Protection and Affordable Care Act (PPACA) calls for a significant expansion of federal community health centers and the National Health Service Corps. In his important June 3 *New England Journal of Medicine* commentary, Dr. Eli Adashi and colleagues describe the current role and reach of such centers, including the PPACA's plan to increase the number of patients served (to 40 million annually) while adding 15,000 new primary care providers by 2015.

While applauding this initiative, the authors cite numerous challenges to such an expansion, including state Medicaid cutbacks, lack of capital and information technology

infrastructure, governmental administrative issues, and the limited production pipeline of primary care providers.

Last week I reported on a recent meeting at the Federal Reserve which highlighted potential partnerships between Community Health Centers (CHCs) and Community Development Financial Institutions (which address low-income housing, economic development, and other social services such as early childhood education).

Adashi and colleagues briefly mention the CHC role in "a broad swath of needs for coordinated disease prevention and health maintenance." However, the authors fall short of calling for the broad interventions that the OEO provided and paid for 40 years ago. It is worth noting that one of the authors, Dr. Jack Geiger, successfully ordered groceries from the OEO central pharmacy for his malnourished patients in the Mississippi Delta!

In the end, this tremendous push for expanded healthcare access may require a focused, concerted, all-hands-on-deck approach. But we should keep in mind what the OEO knew in the 1960s--that healthcare is only one determinant of health with no clear accountability for the rest.

Some CHCs continue to offer a broad spectrum of services. With the White House and the Office of Management and Budget championing "place-based" initiatives, perhaps some funds can be set aside for pilot programs. For these pilots, CHCs (defined not only as federally qualified health centers but also community-funded safety net clinics, faith-based clinics, family practice residency programs, rural health centers and free clinics) could lead the integration all health promoting investments. However, without a permanent funding stream, even successful pilots (such as OEO) can regress. If successful, perhaps long-term funding streams from Community Benefit or Accountable Care Organization (ACO) savings could be attempted.

It worked once, but was not sustained. Isn't it worth another try?

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 07/27/2010 in Improving Health Factors | Permalink | Comments (0) | TrackBack (0)

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07/20/2010

Population Health and the Federal Reserve...Are You Kidding?

By David A. Kindig, MD, PhD

I've mentioned before that a "convergence of scholarship, policy, and practice initiatives seems poised to bring an overdue population health perspective to thinking about and acting on health and health improvement." One of the purposes of this blog is to keep track of all that is bubbling up in likely—and often unlikely—places.

This convergence was exemplified by a meeting I attended last week at the Federal Reserve in Washington, DC. The event was co-sponsored by the Federal Reserve Bank of San Francisco and the Robert Wood Johnson Foundation and was titled "Healthy Communities: Exploring the Intersection of Community Development and Health."

The meeting brought together public and private sector experts in policy, community development, and finance to explore what the fields of health and community development can learn from each other (for background reading, check out this issue of *Community Development and Investment Review*).

Here are some initial impressions:

- I learned that the "other" CDC is the Community Development Financial Institutions or Corporations, which promote affordable housing and business development to keep individuals and families out of poverty. (See articles by Richter and Andrews in *Community Development and Investment Review* issue linked to above.)
- I was pleased that the multiple and social determinants of health took center stage, with significant discussion on the damaging biological stress pathways associated with lower socioeconomic status.
- The fields of health and community development share many priorities, including early childhood investments, fresh food infrastructure, and efficient and innovative healthcare delivery.
- We must aggressively advocate for health in all policies, from nonprofit hospital Community Benefit regulations to the Community Reinvestment Act.
- Both the White House and the OMB seem fully supportive of multisectoral and place-based strategies as well as redirecting financial streams in innovative and more cost-effective directions.
- There may be a major opportunity for collaboration between federal Community Health Centers (CHCs) and community development organizations as CHCs are set to greatly expand to cover 40 Million low income persons under health care reform.

As we continue to call for broad and inclusive approaches for improving population health, we need to continue to identify common ground and build alliances with partners in unlikely places.

Have any to add to the list?

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 07/20/2010 in The National Policy Front | Permalink | Comments (1) | TrackBack (0)

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A Dream Budget for America's Health



By David R. Riemer

I had a dream last night that I got a phone call from Barack Obama. It's the kind of dream that only a former city and state budget director could cook up.

B-r-r-i-n-n-g-g-g-g (Did telephones ever really go "b-r-r-i-n-g-g-g-g? Do they still?)

Me: "Hello? This is David Riemer. May I ask who's calling?"

Voice: "This is Barack Obama."

Me: "Is this a joke?"

Obama: "No, it's the President...of the United States."

Me (remember: it's a dream): "Good evening, Mr President. I think you're doing a great job. Especially with national health insurance, given the weak Congress you've got. How can I help?

Obama: "David, I'd like you to think about becoming the nation's budget director. The current director of OMB, Peter Orszag, is resigning. As I'm sure you know, he has been advocating a cross-sectoral Place Based Strategy for many of our federal investments. I just nominated Jacob Lew to replace him, but who knows what Congress will do. So I wanted a back-up. I hear you were successful budget directors for both Milwaukee Mayor John Norquist back in the late '80s and for Wisconsin Governor Doyle in Wisconsin in 2003. The nation' budget is a mess. If need be, I'd like you to come to Washington to fix it."

Me (please remember...a dream): "Mr. President, if called upon, I'd be happy to accept the challenge."

Obama: "Thanks. One more thing. The people of the United States are far less healthy than they we ought to be. You know a lot about health policy. I understand you helped design Wisconsin's wonderful BadgerCare program. And I just learned that in your current job at Community Advocates, you're helping to lead the Milwaukee Tobacco Prevention and Control Coalition. Good stuff! If you end up in DC, I'd want you to use the federal budget to make Americans healthier."

Me: "No problem."

Obama: "A lot healthier."

Me: "It can be done."

Obama: "I'd like a brief report from you on exactly how you'd make Americans healthier. OK?

Me: "You'll have it tomorrow...tomorrow...tomorrow..."

And the dream (or was it a nightmare) ends.

But if it were true--if I really did end up as new Director of OMB, and had the job of using the federal budget to make Americans healthier--what would I recommend to the President of the United States?

Continue reading "A Dream Budget for America's Health" »

Posted on 07/20/2010 in Harnessing and Allocating Resources | Permalink | Comments (0) | TrackBack (0)

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07/12/2010

Why Should People Who Care About Our Country's Health Contact the IRS Before July 22nd?

By David A. Kindig, MD, PhD

There is a looming deadline that those of us who care about health should know about.

For more than 55 years, nonprofit hospitals have had to justify their tax exempt status by providing benefits to the communities they serve. This is a big deal, since having this status amounts to a collective tax savings for the nonprofit hospitals of about $20 billion annually.

Until recently, nonprofit hospitals have mostly contributed this "community benefit" by providing care to people who can't afford it and by offering screenings, health education, and other outreach activities. Hospitals were neither required to engage in certain activities nor document or evaluate their efforts.

Over the past couple of years, however, reporting requirements have increased.

One of the newer reporting requirements is IRS Form 990 Schedule H, where nonprofit hospitals report their community benefit activities. Unfortunately, Schedule H doesn't give credit where credit is due.

The form does give credit for contributions made in the areas of charity care, health professions education, research, health education, and some types of community outreach. But it gives no credit for contributions beyond health care in areas such as housing, the environment, economic development, community coalition building, advocacy, and community workforce development. Of course, these are exactly the kind of investments we need more of to improve health outcomes and reduce disparities.

Although the IRS has not yet specified community benefit financial requirements (such as a fixed dollar amount or a revenue percentage), some are advocating that this happen sooner rather than later. Experts believe that charity care currently makes up a large part of community benefit spending, but the need for that should change with fewer uninsured as health care reform gets underway. Dollars currently used to provide healthcare for the uninsured could and should become available for other activities.

In addition, the new Patient Protection and Affordable Care Act (PPACA, PL 111-148) requires hospitals to conduct community health assessments every three years. What has not yet been decided is whether hospitals will be required to conduct these assessments independently or whether they will be allowed to collaborate with other community agencies.

The IRS is currently seeking public comment on how to best align Schedule H with the PPACA.

I urge you to submit your opinions by the July 22 deadline. Here are the points I'll be including in my own message:

- Hospitals should carry out the required community health assessments in partnership with local public agencies and other community organizations and not be forced to conduct a separate, independent needs assessment.
- The new rules should explicitly allow public health and community health improvement activities to count as community benefit
- The IRS should call for more research to recommend whether an overall dollar or revenue percentage should be required--and if so, how funds should be allocated among charity care, public health programs, and other activities.

Let's help create a permanent mechanism for making community health expenditures count—and keep coming—for population health improvement.

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I appreciate the assistance of Connie Evashwick, ScD at St Louis University and Pamela Russo, MD, MPH at the Robert Wood Johnson Foundation in providing background on this issue.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 07/12/2010 in The National Policy Front | Permalink | Comments (3) | TrackBack (0)

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07/05/2010

In the Literature: Comparing States' School Health Policies

About once a month, MATCH Project staff review a wide variety of academic journals to identify recent articles having particular relevance to population health policy, research, and practice. University of Wisconsin Robert Wood Johnson Health and Society scholars and faculty recommend an article or two to feature on the blog.



We recently connected with Professor Marilyn Nanney at the University of Minnesota to learn more about her recent research that examines the relationship between state school nutrition and physical activity environments and youth obesity.

What prompted you to do this research?

Our research team set out to explore the effectiveness of school nutrition and activity policies. This study just scratches the surface of this complex question. The daunting scale of the current childhood obesity epidemic has put tremendous pressure on policy makers to take action based on limited--but best available —evidence. Policy decisions are being made on evidence that is less than we would accept for other health interventions like drug therapy, for example. Since the problem requires that we take action now (rather than waiting until we have all the answers), I agree with this approach. However, evaluating the effectiveness, including negative consequences, of policies is important to do, especially with limited resources. This study is one tiny step towards building that evidence.

What do you think is particularly interesting and/or novel about your approach?

First, we were economical. Instead of collecting new data, we found data that already existed (from the Centers for Disease Control and Prevention) that could help us answer our research questions. Second, we took a comprehensive approach to evaluating the school obesity prevention policy environment. We looked at school vending and physical education policies, infrastructure and system supports, and expert certification and training to create as broad a picture as possible of the policy environment. We went beyond many other studies, which have tended to focus on one or two components of the school environment, such as vending or fundraising policies.

Briefly describe your findings. Did you encounter any unexpected obstacles?

Our main finding is that the "fattest" states have more state driven school nutrition policies. It seems that as the number of school policies mandated by the state increases, youth weight increases! Since it's highly unlikely that nutrition policies make kids fatter, our interpretation is that the "fattest" states (like Tennessee, Arkansas, Mississippi) are responding to the problem by instituting more state-level nutrition policies. But we need a different kind of study to test this assumption.

What are the implications of this work either for further research or for practice?

This study offers many opportunities to move forward with this line of research. First, we need a better understanding of the relationship between school policies and weight – especially over time. Second, we need to bring the focus down from the 30,000 foot view (i.e., state policies and state youth obesity prevalence) to the more proximal view (i.e., the effect of school policies upon students attending those schools). Answering these two questions will bring us closer to evaluating policy effectiveness. However, since kids' spend much of their time in out-of-school environments, a significant challenge still remains in teasing out the contribution of school policies upon weight. Do school food policies promote better food choices when kids are away from school--or not?

Posted on 07/05/2010 in Improving Health Factors | Permalink | Comments (0)

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Posts from August 2010

08/31/2010

Can Community Health Workers Help Transform Healthcare and Community Health?



By Kirstin Q. Siemering, DrPH

In these last days of summer, Dave Kindig has quit town to go fishing. But out in the stream, his thoughts are still focused on improving population health. Lately we've been thinking about how to effectively bring attention to recent and relevant scientific publications in a way that's interesting and appealing to people who aren't necessarily academics. Your ideas and suggestions for how to do this are most welcome. Please send us an email or comment below and tell us what you think!

Speaking of literature, E. Lee Rosenthal and colleagues' article Community Health Workers: Part of the Solution recently came across our desks. It appeared in the July issue of *Health Affairs* and brings attention to a topic that deserves attention in light of the recent achievements in healthcare reform.

Those of you not very familiar with Community Health Workers (CHWs) should know that they are extremely diverse and therefore not so easily defined. While many have a role in healthcare delivery (such as in health education, case management, interpreting and patient advocates), they also engage in activities that broadly support community health (such as outreach, organizing, capacity building, and even research). CHWs are often recruited and hired on the basis of their relationships to and knowledge of underserved communities

rather than their having specific health-related expertise or credentials.

One reason for the growing spotlight on CHWs is their potential to control costs while improving outcomes. CHWs are just one example of a larger trend towards decentralization that includes primary care providers doing specialty work in outpatient clinics, nurse practitioners based in retail clinics, and home-based diabetes self management.

But unlike most health professionals, CHWs have no universally accepted education or training program to formalize and legitimize their role. Training requirements vary from state to state and range from on-the-job training to very structured, state-supported credentialing programs.

The American Public Health Association's position statement in support of CHWs points to research demonstrating CHWs' effectiveness in improving healthcare access, quality, and outcomes. However, the wide range of CHW preparation, roles and activities makes evaluation of CHWs very difficult. We still have much to learn about their potential to improve the lives of underserved communities and to make public programs more effective.

The Patient Protection and Affordable Care Act of 2010 will add to our understanding by supporting the implementation and evaluation of CHW programs. Over $4 million is being made available in 2010 for Patient Navigator Outreach and Chronic Disease Prevention Demonstration projects (with additional annual allocations through 2014). Additional funds will likely be made available through other federal funding mechanisms, including Grants to Promote Positive Health Behaviors and Outcomes Community Transformation Grants.

The *Health Affairs* article noted above highlights the work of two states that have led the way on CHW policy issues. Both Massachusetts and Minnesota have implemented policies to facilitate utilization of CHWs (e.g., in Minnesota CHW services are reimbursable under Medicaid). CHW advocates have identified the following policy priorities: sustainable financing, workforce development resources, occupational regulation, and guidelines for common research and evaluation measures.

CHWs could turn out to be an important piece in solving our healthcare and community health puzzle. Time will tell, given sufficient resources to develop and test innovative and resourceful policy and practice approaches.

Kirstin Q. Siemering DrPH is a researcher with the University of Wisconsin Population Health Institute.

Posted on 08/31/2010 in Improving Health Factors | Permalink | Comments (0)

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08/24/2010

Expanding the Scope of Comparative Effectiveness Research

By David A. Kindig, MD, PhD

We were originally going to take a break from the blog this week, assuming that many readers would be on vacation. But I have decided instead to tell you about a new commentary I wrote with my colleague, John Mullahy. It appears in this week's issue of the *Journal of the American Medical Association* and is titled "Comparative effectiveness—of what? Evaluating strategies to improve population health" (subscription required).

The commentary is a call to broaden and provide dedicated resources for broadening comparative effectiveness research (CER) to help us better understand the relationship between our social investments and population health improvement.

As most of you know, the goal of most CER is to learn about the effectiveness, benefits, and harms associated with healthcare treatments such as drugs, medical devices, and even health systems. Although the emphasis in CER is currently on healthcare, there is tremendous potential for this type of research to contribute to a much deeper understanding of the many factors that influence health, including health behaviors, social, economic, cultural, environmental, and genetic factors.

I have mentioned before our need for a better understanding of how to accurately translate investments into length and quality of life. But we also need a framework to guide our spending decisions that's based on a solid understanding of the total cost, overall effectiveness, and cost effectiveness of our strategies. To get these things done will require expanding—and funding—a comparative effectiveness research portfolio that addresses not only clinical care but the many other determinants of health as well.

Check out the article and let us know if you agree or have strategies to suggest to accomplish this goal.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 08/24/2010 in Improving Health Factors | Permalink | Comments (0)

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08/16/2010

Carrots and Sticks for Population Health Improvement

By David A. Kindig, MD, PhD

Those of us who care about health are convinced that a realigning of incentives is in order to encourage the production of health rather than the treatment of disease. We recognize an imbalance in how funds are allocated, but decisions about the division of the existing pie (among healthcare access, public health, education, early childhood, housing, food access, economic development, environmental quality, etc.) are currently and unfortunately as much political as scientific. (Reflections on how we might make the pie bigger will have to await another post.)

The latest issue of Preventing Chronic Disease features a series of essays on incentives for population health improvement that were commissioned through a Robert Wood Johnson Foundation grant. This is the second in a series of three special issues (the first focused on metrics and the last will focus on partnerships).

The diverse collection of essays highlights key concepts and perspectives on the promise and pitfalls of both financial and non-financial incentives. They are accompanied by two helpful commentaries (Lewis and McGinnis).

Topics include:

- The nature and function of financial and non-financial incentives (Haveman)
- The applicability and unintended consequences of "pay for performance" systems in healthcare (Asch and Werner) and education (Witte)
- The need to make better use of and enforce existing resources and policies for population health improvement (Baxter)
- Potential roles for non-financial incentives such as rankings (Oliver), target setting (Smith), and social marketing (Rothschild)
- Whether and how savings from healthcare (a "value dividend") could be reallocated and applied for broad population health benefit (Fox)
- An economic perspective on the "production" of population health and the role that multiple sectors play as "promoters" and "inhibitors" of outcomes (Mullahy)

The pieces are relevant to policymakers, practitioners, and researchers and provide much food for thought. With resources likely to remain limited for the foreseeable future, we must continue to think very carefully and work to better understand how our investment strategies and decisions (dollar and otherwise) influence the health of our communities.

For me, the essays highlight the two most important tasks for the field of population health in the coming decade:

> 1) Identify the most cost effective balance of population health promoting investments tailored to the outcomes and determinants profile of individual communities, and
>
> 2) Find the incentive strategies to create such investments.

Can our research and policy/practice communities meet these challenges?

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 08/16/2010 in Harnessing and Allocating Resources | Permalink | Comments (0)

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08/11/2010

Want to Help Put the County Health Rankings at People's Fingertips? Submit an Idea to Health 2.0 by September 15



By Kirstin Q. Siemering, DrPH

The internet is an incredible vehicle for helping us get things done, by putting information, people, and goods right at our fingertips. However, the public and nonprofit sectors have been comparatively slow to embrace the medium's potential for innovation.

But not anymore.

We have entered the era of gov2.0 and there's no looking back.

Crowdsourcing is just one of a number of internet-based strategies that nonprofits are employing to raise awareness, generate potential solutions to challenging problems and questions, and conserve resources.

In collaboration with the Robert Wood Johnson Foundation and UWPHI, San Francisco's Health 2.0 just released a crowdsourcing challenge called The Health Factor: Using the County Health Rankings to Make Smart Decisions. The goal of this challenge is to bring the *County Health Rankings* to the places where people go to get information to inform their decisions about where to live, where to locate a business or invest, or where to target services and philanthropic support. To be considered for the $2,500 prize, ideas must be submitted by September 15, 2010.

This competition follows on the heels of the *County Health Rankings* Community Health Action Forum. The forum was initiated by the Robert Wood Johnson Foundation to gather ideas for how communities can improve health outcomes. The 110 ideas submitted by the August 6th deadline are currently under review.

Minnesota Idea Open is also a frontrunner in crowdsourcing among nonprofits, recently hosting its first $15,000 challenge to address obesity. The Saint Paul Foundation will soon be using the site to sponsor a "micro-challenge" that puts a "fresh face" on its traditional grantmaking process.

But crowdsourcing is just one approach that nonprofits are employing. In other Web 2.0 arenas, a quickly growing number of sites, apps, widgets, and other virtual gadgets are creating opportunities interactive, web-based population health improvement, such as:

- Salt Lake Valley (Utah) Health Department's "One Small Change" campaign (using Facebook, YouTube, Twitter, and Flickr)
- Pacific Disaster Center's Disaster Alert (for iPhone and iPad)
- CityLife (a mobile app to be released for local government)
- Assetmap (coming soon to help groups "inventory, visualize, and leverage" their social capital)

Please help spread the word about the Health 2.0 competition and tell us your ideas about other ways to use the web to promote population health. Leave your comments below or feel free to just send us an email. Thanks in advance for joining the conversation!

Kirstin Siemering, DrPH is a researcher with the University of Wisconsin Population Health Institute.

Posted on 08/11/2010 in County Health Rankings & Roadmaps | Permalink | Comments (0)

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08/03/2010

Do Advance Directives Have a Place in Population Health Improvement?



One of the things we're trying to accomplish with this blog is to provide insight into the many factors that influence health status and outcomes. These include health behaviors, the social, economic, and physical environments and, of course, healthcare. This week we're focusing on the quality and cost of healthcare at the end of life, and thinking specifically about how advance directives apply to population health. To shed some light on the topic, we interviewed the University of Michigan's Dr. Maria Silveira about her April 1, 2010 *New England Journal of Medicine* article (subscription required) on Advance Directives and Outcomes of Surrogate Decision Making Before Death.

What are advance directives?

Advance directives usually document patients' wishes for life-sustaining treatment in a living will, as well as their choice of a proxy decision-maker in a durable power of attorney for health care. Advance directives are sanctioned in all 50 states and can be completed for free without the aid of an attorney.

What was the motivation for doing this research?

My experience in palliative care didn't jibe with the growing belief, reinforced during the recent "death panel" debate, that advance directives are not necessary or useful.

What were the main findings of your study, and how did they differ from previous work?

A 1994 study indicated that only 21% of all seriously ill hospitalized patients had an advance directive. Our research shows that currently almost 60% of elderly have one.

Prior to our study, no one knew how many elderly adults might need others to make complex medical decisions on their behalf at the end of life. 30% of older adults need someone else to make decisions (i.e., they had lost decision-making capacity) about whether aggressive, limited, or comfort care should be provided at the end of life. Subjects who had living wills were more likely to want limited care (93%) or comfort care (96%) than all care possible (2%). We also found that among people who had prepared living wills and had also expressed a preference for or against all care possible, there was a strong agreement between their stated preference and the care they received.

Fisher and colleagues at Dartmouth assert that end of life expenditures are one category of spending that increase costs without increases in outcomes or quality of care. Is it possible that advance directives could save resources by respecting patient preferences about care?

Absolutely – there's no worse way to waste money as a health system than on care that is unwanted. Still, I'm not sure that the advance directives are as important as the conversations that take place about future care. Certainly I believe that when physicians (especially primary care physicians) have these conversations, patients are less likely to be hospitalized and to receive unwanted care. That should translate into cost savings for the system, but most importantly, it prevents undue suffering upon patients and his/her families.

What are the policy implications of your study?

Our results suggest that helping patients prepare for a time when they cannot speak for themselves is important and worthwhile—policymakers and insurers should consider reimbursing physicians appropriately for this effort. Currently, advance care planning is an activity that goes unreimbursed for most physicians.

About a year ago, Representative Earl Blumenhauer (Oregon) proposed enhancing Medicare and Medicaid coverage of advanced illness management services and requiring physicians to provide Medicare beneficiaries with information on advance directives. The proposed legislation never made it out of committee (due to the controversy surrounding "death panels"). However, the Patient Protection and Affordable Care Act (PPACA) actually does contain a couple of small but relevant end of life provisions, including a 3-year demonstration project that will explore cost and quality implications of combining curative treatment and hospice care. Representative Blumenhauer is spearheading another effort to revive legislation that would allow for reimbursement of physician time to help patients plan for the future.

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Posts from September 2010

09/28/2010

Can Healthcare Organizations Lead in Population Health Improvement?

By David A. Kindig, MD, PhD

Two weeks ago I floated the concept of a "Super-Integrator" to play an effective but neutral coordinating role in population health improvement. I believe there are multiple, equally effective forms such integrators could take. Although we don't yet have complete exemplars for this concept, we do have examples of organizations moving in the right direction. This week, we're showcasing one of them.

The Institute for Health Improvement is a highly regarded healthcare improvement organization that has moved beyond solely health care through its Triple Aim strategic initiative. The initiative illustrates how healthcare organizations are reaching beyond their traditional roles to address a broad range of health factors.



John Whittington, MD is IHI's Lead Faculty for the Triple Aim. We met through my response to IHI's Health Affairs article on the Triple Aim. I recently invited John to describe the IHI current movement into a Triple Aim regional population strategy.

DAK: John, would you first briefly describe the IHI?

JW: The Institute for Healthcare Improvement was founded in 1991 by Don Berwick and a small group of colleagues who were committed to redesigning health care into a system no longer plagued by errors, waste, delay, and unsustainable social and economic costs. Today IHI is a small, not-for-profit organization based in Cambridge, Massachusetts, helping to lead the improvement of health care – making care better, safer, and more affordable – throughout the world.

DAK: What is the Triple Aim, and how did it evolve from IHI traditional work?

JW: In 2005, IHI had a vision to work on three simultaneous aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. In 2006, research and development began on this Triple Aim. In 2007, 13 organizations joined in a partnership with IHI to work together. Today, over 70 organizations from around the world work with the IHI on the Triple Aim. Each organization that partners with IHI acts as an integrator of care for a defined population, working on five change principles: (1) encouraging prevention and health promotion, (2) improving and broadening primary care, (3) helping individuals co-create care, (4) improving front line care that builds social capital with other health producing organizations in a community, and (5) working directly on cost control.

DAK: Can you also tell us about the regional strategy that is evolving from Triple Aim work?

JW: Some of the 40 organizations that work on the Triple Aim in the US are focused on small homogenous populations, such as their own employees. The 30 international sites focus on total populations in geographic regions such as a primary care trust in England. By observing the international sites and some US sites, much has been learned about regional work. IHI sees the need to push the work of the Triple Aim to entire populations in geographic regions in the US. Our regional approach is based on the work of Tom Nolan (a key architect of the Triple Aim), and shaped by the belief that regions (1) are self-sufficient and contain all the necessary components for constructing a health system, (2) tend to have common values, (3) allow solutions to be driven by local context and expertise, (4) have existing platforms for dialogue (or opportunities for creating them), and (5) are characterized by a full range of health factors or determinants, including but not limited to healthcare.

DAK: Many readers of the blog will be aware that IHI's founder Don Berwick has recently assumed a new post as Administrator of the federal CMS (link). Who has taken over at IHI, and what impact dies this have on the Triple Aim or regional plans?

JW: IHI is honored that President Obama has chosen Don to lead CMS, and that he'll have the opportunity to advance the cause of health care improvement especially at this time. IHI's Board immediately named Maureen Bisognano, IHI's former Chief Operating Officer, as IHI's next President and CEO. Maureen has been Don's chief partner in IHI's management and vision since she joined IHI in 1995, so IHI's not missing a beat in carrying the work forward to meet the challenges ahead. Our Triple Aim work is more important than ever.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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09/21/2010

How to Spend $15 Billion to Make America Healthier

By David A. Kindig, MD, PhD

Last week, the U.S. Senate defeated the Johanns amendment to the Small Business Jobs and Credit Act of 2010. In doing so, legislators spared (for now, at least) the 10-year, $15 billion Prevention and Public Health Fund established by the Patient Protection and Affordable Care Act (PPACA). The purpose of the fund is "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." (For more information about PPACA's prevention-oriented provisions, see the recent New England Journal of Medicine perspective coauthored by Assistant Secretary for Health Howard Koh and Secretary of Health and Human Services Kathleen Sebelius.)

The landmark Prevention and Public Health fund represents a tremendous victory for health advocates throughout the country, and many have offered suggestions on what to do with the money.

Secretary Sebelius announced in June how the fund's FY 2010 $500 million would be allocated. Those of us who celebrate the fund's creation share a desire for the dollars to actually make a difference and the 2010 allocation provides a good starting point for improving population health. But we must seek out continued opportunities for advocacy as the allocation grows over time to an annual $2 billion in 2015-2020.

I've tracked the dialogue and debates surrounding the fund over the last year and have some thoughts on how a population health perspective might guide our next steps.

First, keep in mind that the fund is quite small relative to ambitious goals established by the PPACA. On an annual basis, the amount is less than 0.01% of that spent on health care services. We must be both realistic in our expectations and strategic in our spending.

Second, funding should be related to the determinants of health model. While research does not yet allow the precise identification of the investment balance across determinants, we know a balance is required. The *County Health Rankings* assigns weights of 20% to health care, 10% to the physical environment, 30% to health behaviors, and 40% to the socioeconomic environment.

I'd suggest that the Prevention and Public Health fund take a similarly broad Community Prevention approach. The relatively small amount of money will likely have the largest impact if efforts emphasize creating policies and programs that create healthy environments, as has been emphasized by Dr. Jeffrey Levi's Congressional testimony. The Convergence Partnership has urged for a similar approach, noting that "while clinical prevention is important…we must focus on changing the policies and systems that shape neighborhoods so that they foster health." Additional recommendations are likely to emerge from the new National Prevention, Health Promotion, and Public Health Council, which is mandated by the PPACA to "develop and make public a national prevention, health promotion, and public health strategy" by March 23, 2011.

Third, priority should be given to communities who have the lowest health outcomes and are improving less rapidly or even losing ground. A recent letter from prominent population health leaders to Secretary Sebelius emphasizes the importance of focusing assistance on places where health outcomes are poor and health disparities are high. Communities with comparatively healthy populations should be applauded, recognized for their achievements, and serve as examples to others – but they should receive fewer new resources. If this is rationing, so be it. With limited resources, a population health perspective requires investments that produce the most health improvement and disparity reduction per dollar invested.

What we've got is a relatively short period of time and relatively few dollars. But ten years from now, when we assess what we've accomplished through the Prevention and Public Health Fund, we should be proud of the choices we make now.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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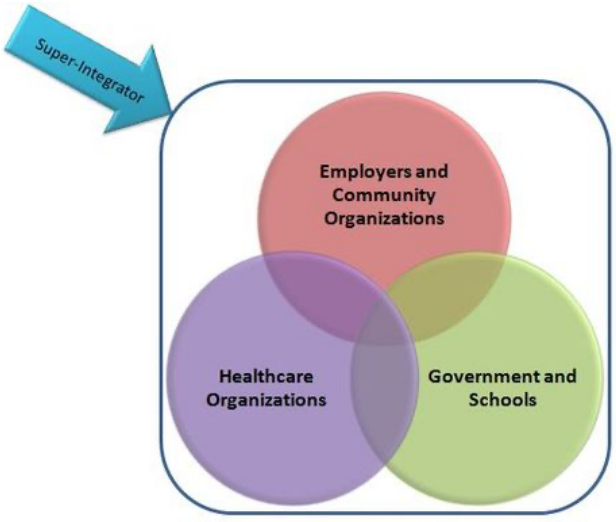
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09/14/2010

Do We Need a Population Health Super-Integrator?

By David A. Kindig, MD, PhD

In a previous post, I raised the question of who is accountable for population health outcomes, and suggested that some cross-sectoral integrating mechanism might be required. The outside line in the figure below suggests that this mechanism could be that of a Super-Health-Integrator. Such an integrator, with appropriate financial resources and authority, could align investments and activities across the multiple sectors which can impact population health, such as health care, public health, schools, employers, and community organizations.



An alternative to a super-integrator might be that one sector takes lead responsibility for population health improvement, using informal or formal authority to ensure that others play their roles. Regardless of which sector or organization took the lead (this could vary from community to community), the process would likely involve conflict and/or have limited effectiveness. Some concerns would be that healthcare organizations may overemphasize biomedical approaches, that governmental public health is too under-resourced for even its critical traditional functions, and that businesses would be challenged by competing goals. So, I believe that many communities would benefit by having a strong and neutral coordinating entity or mechanism at the helm.

Another alternative is the status quo where each sector makes investments to optimize its own goals, which may or may not include population health improvement. We have ample evidence to show that under this current situation few—if any—communities are as healthy as they could be.

This is why I proposed "health outcomes trusts" in my 1997 book and am proposing Super-Health-Integrators today. To my knowledge nothing like this has been fully developed, although pieces exist in many healthy community partnerships. Such an entity would likely not be governmental or corporate, but would certainly need active public and private sector involvement. And, as noted above, it would need some authority and financial resources to do its work (such as from a redesigned IRS Community Benefit stream). Such Integrators or Trusts might draw on the principles of social entrepreneurship by emphasizing strategic partnerships and leveraging resources to raise levels of performance and

accountability (look for the essay by Jane Wei-Skillern in the upcoming issue of *Preventing Chronic Disease*, available online in mid-October).

I am not naive about the potential challenges such non-traditional structures pose, but the "inconvenient truth" is that addressing the multiple determinants of population health to optimize our communities' health will almost certainly require some form of coordinating authority. I would love to hear the opinions of others on this point, as well as feature on this blog any examples of existing structures already performing these functions.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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09/09/2010

Will the Prevention and Public Health Fund's $15 Billion Be Spared on September 14th?

By David A. Kindig, MD, PhD

On September 14, 2010, the U.S. Senate will vote on two opposing amendments to the Small Business Jobs and Credit Act of 2010. The outcome could save or eliminate the $15 billion that has been set aside through the Prevention and Public Health Fund to support national, state, and local programs to promote health and reduce health disparities.

At issue is a small tax reporting provision within the Patient Protection and Affordable Care Act (PPACA). Specifically, the provision mandates that businesses, charities, and state and local governments file one form 1099 for each business providing in excess of $600 in property, goods and services (the current requirement is for services only and has been associated with significant underreporting).

There is bipartisan consensus that the new provision (scheduled to go into effect in 2012) excessively burdens small businesses with paperwork, but differences in the two proposed solutions are dramatic.

On one side is Senator Mike Johanns (R-NE), who is calling for a full repeal of the tax reporting requirement. He proposes to make up the lost revenue by completely eliminating the $15 billion Prevention and Public Health Fund and by lowering the individual mandate from 8% to 5% of income.

Senator Bill Nelson (D-FL) has offered a competing amendment that keeps the Prevention Fund intact. Nelson's amendment scales back the reporting requirements: businesses with fewer than 25 employees would be exempted from the reporting, and the reporting threshold would be increased from $600 to $5,000 per vendor or service provider. Senator Nelson's amendment proposes to make up lost revenue by repealing tax cuts for the five largest oil companies.

The Senate will vote on both amendments on September 14. Each will require 60 votes to pass, and the voting is likely to be close.

Please contact your senators to express your concerns and let them know how you'd like them to vote next week.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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09/08/2010

Population Health: If It's Everything, Is It Nothing?

By David A. Kindig, MD, PhD

As you know, I'm new to blogging, and still getting used to it from a career of more academic writing. Several of you, as well as our MATCH staff, have observed that the topics seem to be a bit random and "out of the blue" from week to week. In addition, a respected colleague emailed a response to the post on advance directives that "it could imply that everything is about population health (which, as you and I agree, I hope) doesn't do much to advance the cause of purchasing population health."

Hmmm…if it's everything, is it nothing? A look at the population health model underpinning this blog and all I work on in population health, suggests that indeed it is perhaps everything: a broad set of outcomes produced by a comprehensive set of determinants which are influenced or activated by programs and policies in the public and private sectors.

You will not, however, find me blogging on each and every micro-determinant or program/policy that theoretically and actually has some detectable impact on population health outcomes. What is then the decision rule that makes a topic of program or policy of importance not only for this blog but for public and private policy makers?

In this resource-limited world, I believe the criterion should be largely based on economics, and in particular, the relative effectiveness and cost-effectiveness of the determinant or the program and policy on health outcomes. I have previously noted that we do not yet have adequate evidence to make this an easy exercise. Research is needed to explore the effectiveness and cost effectiveness of broad policies and programs designed to effect health improvement at the population level. Some investments have an evidence base, like smoking cessation and immunization and early childhood programs. Other investments, such as removing the LAST microgram of a toxic substance in a Superfund site, would probably have some marginal effectiveness but extremely low cost-effectiveness.

Of course, determining what action to take toward health improvement is hardly straightforward. Decision makers must weigh not only on available evidence on effectiveness and cost-effectiveness but must also take into account many other factors, especially resource (financial and nonfinancial) and political supports and constraints.

As we try to cover topics that address all parts of our population health model, I would welcome feedback as to whether you either KNOW or SUSPECT that any program or policy we discuss is of such low cost-effectiveness as to not meet my criterion above.

Your feedback and suggestions are always welcome and appreciated!

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 09/08/2010 in Population Health Basics | Permalink | Comments (0) | TrackBack (0)

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A New Play for Baby Carrots and Other Population Health News



By Kirstin Q. Siemering, DrPH

In Wisconsin, late summer breezes often have a certain nip that reminds us that winter is coming—whether we like it or not. Kids are heading back to school and farmers are harvesting their bounty. In past weeks we've struggle to find #2 pencils on picked-clean store shelves and had tomatoes coming out of our ears. So in honor of the role farms and schools play in promoting population health, we're drawing your attention this week to an assortment of late summer news around the themes of school health and healthy harvests.

- The Senate passed (by "unanimous consent" of all 100 members and didn't even require a vote) the long-awaited child nutrition reauthorization, called the "Healthy, Hunger-Free Kids Act." The House version also has broad support and a passing vote is expected before the end of September. For more information, check out this fact sheet and this Culinate article.

- The USDA established the People's Garden School Pilot Program to bring school gardens to low-income schools (applications are due November 8, 2010).

- The USDA has also awarded Massachusetts $20 million for a groundbreaking fruit and vegetable incentive pilot that will test whether providing incentives to low-income families to purchase fresh produce will influence food purchasing patterns.

- In San Mateo, California, where schools are facing 10% budget cuts, the Sequoia Healthcare District (which manages Sequoia Hospital) is making up some of the difference by providing $4.5 million to hire school staff, including a nurse, a counselor, a wellness coordinator, a physical education teacher, and a nurse's aide.

- General Electric Foundation has granted $2 million to the Louisiana Public Health Institute to benefit school-based health centers (this is part of a $25 million, 3-year campaign to increase access to care for underserved youth throughout the United States).

- The September issue of the *American Journal of Public Health* has many articles devoted to child and school health, including a collection on the role and value of school-based healthcare.

And finally,

- 50 carrot growers have joined Bolthouse Farms to create a new $25 million marketing campaign (watch for the new tv ads). Bolthouse CEO Jeff Dunn (former President of Coca Cola North America) says the approach takes a page out of junk food's playbook.

Kirstin Q. Siemering DrPH is a researcher with the University of Wisconsin Population Health Institute.

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Posts from October 2010

10/26/2010

Peter Orszag Has it Half Right

By David A. Kindig, MD, PhD

The former Obama Office of Management and Budget Director Peter Orszag made a compelling case in A Health Plan for Colleges (*New York Times* September 19) that when Medicaid costs increase (as they do every year), states respond by making cuts in higher education expenditures. Orszag estimates that if higher education's share of state budgets over the past 25 years had remained constant rather than being crowded out by rising Medicaid costs, allocations would be $30 billion more (about $2000 per student) than they are currently. His strong and novel argument for controlling health care costs in order to preserve more funds for higher education goes beyond the more typical goals of increasing health care affordability and improving international competitiveness.

But he should have taken the argument a step further. Better educated populations are healthier populations. A large body of evidence supports this claim. Compared to adults having some education beyond high school, premature death rates (e.g., deaths before age 75) are double among those having only a

high school education and triple among those not completing high school. Research shows that those with more education also have fewer disabilities and better physical functioning.

What role could education play in biological processes that produce death or disability? There are probably two main pathways. The first operates directly, through better knowledge about the importance of health care as well as healthy behaviors and prevention. The field of health literacy has been rapidly developing. According to the Institute of Medicine, approximately 90 million American adults lack the literacy skills needed to effectively use the US health care system. Low health literacy rates have been estimated to cost the health care system more than $100 billion per year. Also, education likely enhances the ability to make difficult short term decisions (such as stopping smoking, eating better, routinely exercising) which affect health later in life.

A second pathway is more indirect. People with more education tend to have better employment options, including access to jobs that pay more and provide better healthcare coverage. Jobs that require more education also tend to be less stressful, in part because they afford employees a greater sense of autonomy and control than typical “blue collar” jobs. A growing field of research examines how stress influences disease and mortality through endocrine and immune system response.

So to complete the argument Orszag begins: lower health care costs improve education, which improves health, which lowers health care costs. The result is an even more compelling case for health care cost containment.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 10/26/2010 in Harnessing and Allocating Resources | Permalink | Comments (1) | TrackBack (0)

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10/18/2010

Now Online: MATCH Essays on Partnerships for Population Health Improvement

By David A. Kindig, MD, PhD

As I’ve pointed out previously, no one entity today has accountability for population health outcomes. But one doesn’t have to look far to find people and organizations collaborating for population health improvement. The vast majority of federal, state, local, and foundation funders consider partnership a prerequisite for action.

Yet we know relatively little about what makes partnerships successful. We have much to learn about how and to what degree they facilitate actual health improvement. One reason for this lack of knowledge is that partnerships are difficult to evaluate. They tend to be complex, idiosyncratic, and constantly evolving with often no easy way to tease out the many factors influencing process and outcomes.

The most recent issue of *Preventing Chronic Disease* showcases a set of fresh perspectives on partnerships for population health improvement (commissioned through the Robert Wood Johnson Foundation MATCH grant). This is the final installment in a series of three special issues (the first and second focused on metrics and incentives respectively).

The essays are introduced by commentaries by Stephanie Bailey and Stephen Shortell and include a range of observations and insights on the following:

- Relationships among structure, function, and impact of multi-sectoral partnerships (Mays and Fawcett/Schultz)
- “Take home” messages from the Healthy Communities Movement (Pittman)
- Exploring models of and evidence for multisectoral partnerships (Woulfe)
- How principles of "social entrepreneurism" can help maximize use of available resources (Wei-Skillern)
- The business case for bringing employers to the partnership table (Webber)
- The role evidence plays in policy development and implementation (Fox)
- How a Vermont healthcare pilot is providing resources for a community health system (Hester)

These topics were introduced and discussed about a year ago at an Expert Meeting in Madison, Wisconsin, where many questions were raised. Overall, the essays and the conversations around them underscore:

- The relevance of metrics and incentives to partnerships.
- That research and practice on partnerships should address both structure and function as well as the broader networks and systems within which partnerships are embedded (including the contexts in which they are created and sustained).
- That individual and/or organizational motives determine in large part who comes to the table and who stays.
- The need and opportunity for partnerships to make efficient use of available resources to drive population health improvement, especially when dollars are scarce.
- The possibility of cultivating truly shared agendas among sectors (health, housing, transportation, regional planning, education, etc.).
- The importance of leadership.

Since population health improvement requires balanced investment and coordination across multiple sectors, we all need to work together more effectively in the future. We hope these essays contribute to this goal, and we invite you to share your own thoughts, questions, and ideas on partnerships here on the

blog.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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10/12/2010

Population Health Targets: Unpopular But Needed

By David A. Kindig, MD, PhD

Thinking about the upcoming release of the federal Healthy People 2020 (HP2020) report has brought me back to a 2008 JAMA commentary I wrote with Yukiko Asada and Bridget Booske titled "A Population Health Framework for Setting National and State Health Goals." Our recommendation was for a population health model framework to guide federal and state planning processes. Specifically, we called for the setting of five to ten year targets for broad outcomes. We suggested that the targets could be established based on trend comparisons across other nations or states and be set at different levels, e.g., ranging from "minimal" to "achievable" to "challenging."

It is not clear at the moment if HP2020 or similar plans in individual states will include targets for broad health outcomes, such as years of healthy life or overall disparity reductions. In the past, targets have been set for specific narrower objectives such as cancer deaths and smoking rates. I think it's time to also focus on the broader comprehensive measures of health that these narrower objectives produce.

There are both political and practical reasons why governments resist such explicit projections. As Smith and Busse say in a recent MATCH essay on the European target setting experience, one purpose of target setting is to "enhance the accountability of government to parliament and the electorate," but such future accountability may not be politically advantageous. Even in a politically progressive state like Wisconsin, neither Republican or Democratic elected officials or appointed public health leaders have set such targets; this is one reason our University of Wisconsin Population Health Institute initially developed the Wisconsin County Health Rankings in 2003 and issued the first Health of Wisconsin Report Card in 2007 in which we graded the state a "B-" for overall health and "D" for health disparities. While these reports have been widely used, the recent Healthiest Wisconsin 2020 State Health Plan does not include broad 5-10 year targets.

My management experience has taught me that you can't manage what you can't measure. Since improving broad population health outcomes requires the actions of multiple sectors, Smith and Busse identify a need for targets that transcend traditional sector boundaries and emphasize "coordination, persuasion, and engagement if they are to be successful." Of course, long term targets cannot be set precisely, but a set of minimal to challenging goals could be devised. They could be used by those community entities -- such as United Way, a local or regional health department, or a Triple Aim project -- which aspire to provide the integration that population health improvement requires. Targets should help shape community health improvement processes by helping identify local health priorities as well as corresponding sets of cost-effective policies and programs.

We can and should set reasonable, broad targets for mortality and morbidity improvement and disparity reduction at the federal, state, and community levels. These will guide investment, inform public accountability—and hopefully improve population health.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 10/12/2010 in Defining and Measuring Health Outcomes | Permalink | Comments (0) | TrackBack (0)

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10/06/2010

Help Shape the National Prevention Strategy

By David A. Kindig, MD, PhD

Last Friday, a draft framework of the National Prevention Strategy was posted on healthcare.gov. The draft strategy, required by the Patient Protection and Affordable Care Act, has been developed through the National Prevention, Health Promotion, and Public Health Council, in conjunction with the Department of Health and Human Services, the Centers for Disease Control and Prevention, and other federal departments. Surgeon General Dr. Regina Benjamin chairs the council and on October 1st she hosted a conference call to overview the draft strategy and invite questions and comments from stakeholders.

The draft framework has the following vision, goals, and strategic directions, excerpted below from the full document:

Draft Vision: Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on wellness and prevention.

Draft Goals: In order to achieve the vision for the National Prevention Strategy, efforts will be targeted toward the following goals. Each goal can be applicable to every member of the Council and to many public and private partners.

1. Create community environments that make the healthy choice the easy and affordable choice
2. Implement effective preventive practices

Draft Strategic Directions: The intent is to use the Strategic Directions a) to frame specific actionable proposals to meet the goals and achieve the vision for the Strategy, and b) as a lens through which to view federal and non-federal activities in order to identify how they can best promote wellness and effective prevention. In large part, the Strategic Directions are designed to address ways to prevent significant causes of death and disability by focusing action on the factors that underlie these causes.

The Draft Strategic Directions are:

- Active Lifestyles
- Address Specific Populations' Needs to Eliminate Health Disparities
- Counter Alcohol/Substance Misuse
- Healthy Eating
- Healthy Physical and Social Environment
- High Impact, Quality Clinical Preventive Services
- Injury-Free Living
- Mental and Emotional Wellbeing
- Strong Public Health Infrastructure
- Tobacco-Free Living

The development of this National Prevention Strategy is a welcome opportunity to ensure that health reform is not limited to health insurance reform, as important as that goal is. Population health advocates have a responsibility to help shape this effort, ensuring that it reflects the broad population health perspective which underpins this blog and the *County Health Rankings*. For example, as important as lifestyle and individual behavior changes are, we know that these are significantly influenced by upstream determinants in the social and physical environments. Their status as the first Strategic Goal is therefore appropriate and appreciated. Care will have to be taken that they are not lost as only one factor in the longer list of Strategic Directions. This is particularly important given the membership on the Council of many Cabinet Secretaries such as Education, Housing, Labor, Transportation and Energy -- a "health in all" policies perspective will be important for this work.

In addition, the draft doesn't specifically mention early childhood and prenatal environments, but given their long term health impacts, these deserve significant attention. Finally, health care cost containment should be viewed as a community prevention opportunity strategy, as these growing expenditures necessarily limit broad population health investment opportunities.

During last Friday's call, Surgeon General Benjamin responded to a very wide range of concerns, and invited additional stakeholder comments on the draft strategy. She should be commended for taking on this critical and challenging task. It is our responsibility to help her and her colleagues by submitting comments on this strategy (send to prevention.council@hhs.gov). I invite you to share your comments on the blog as well.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Posts from November 2010

11/30/2010

Healthcare Cost Containment Part I: Getting Serious About Controlling Healthcare Expenditures

By David A. Kindig, MD, PhD

For decades, attempts across the political spectrum to control health care expenditures (through either market-based or regulatory policy) have been resisted. I was privileged to represent Secretary-designate Shalala in early 1993 at the Governor's mansion in Little Rock when then President-elect Clinton was informed that his new health care plan would significantly increase costs before containing them. The expected political repercussions were clear by Clinton's quip that he might as well just slit his throat – except that would increase costs even more.

As difficult as it is, healthcare cost containment is essential for both strengthening our global economic position as well as improving population health. We must figure out a way to both eliminate excess healthcare spending and create new revenue streams for investing across key drivers of health status and outcomes.

Determining how much we should be spending has been a particularly thorny issue for policymakers, who have historically been reluctant to set spending targets. While many state and national health plans have clear and measurable objectives for health outcomes like infant mortality and smoking rates, we rarely see specific targets proposed for either annual per capita health care expenditures or expenditure growth rates. But as I've said before, you can't manage what you don't measure.

Although not well-publicized, the Patient Protection and Affordable Care Act actually contains goals for healthcare cost control: beginning in April 2013, CMS will determine whether Medicare per capita spending exceeds the average of the overall Consumer Price Index and the Medical Cost Inflation rate. If it does, CMS will be required to make recommendations for how to reduce spending. If Medicare spending exceeds the (GDP per capita + 1%) threshold by 2018, CMS will be required to submit recommendations to Congress and the President for immediate consideration. Interestingly, this is quite similar to the 1993 Clinton Health Security Act, which called for a reduction of 0.5% per year (over 5 years) in the difference between Medicare spending and GDP increases to force alignment of health care costs with overall economic growth.

A similar approach was proposed in *The New York Times*' recent interactive budget puzzle challenge for eliminating the national deficit by 2030. The puzzle offers a wide-ranging menu of options across nine categories and includes both spending cuts and tax increases. Of 39 choices provided, a cap to Medicare spending (tied to 1% over GDP per capita) would provide the greatest projected cost savings, erasing over 40% of the deficit. *New York Times* economics columnist David Leonhardt noted that this option was an overwhelming favorite among those who (tweeted their solutions and) preferred spending cuts over tax increases.

But, models themselves can't reduce expenditures. Where do we look for expenditures that do not harm us if eliminated? Stop by next week for Part II on healthcare cost containment.

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11/24/2010

Is Population Health Finally Coming Into Its Own?

By David A. Kindig, MD, PhD

No new perspectives this Thanksgiving week. We began this blog 6 months ago with the same title as above…and the following statement:

> *Why am I starting a blog on issues and perspectives in the field of population health? It is because I believe we are at a "tipping point" in which a convergence of scholarship, policy, and practice initiatives seem poised to bring an overdue population health perspective to thinking about and acting on health and health improvement. The challenge of the next decade will be to find practical ways in which new approaches to financial and non-financial incentives and multi-sectoral partnerships can be applied to improve population health outcomes here and elsewhere.*

Tune back in on December 1 as I continue our quest to meet this challenge with the first of a two-part post on healthcare cost containment and population health.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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11/17/2010

Sam Brownback of Kansas (R): A Population Health Governor?

By David A. Kindig, MD, PhD

I can understand how readers of this blog could think that population health improvement is an agenda owned by liberals. After all, reducing disparities and social determinants do not at first blush have a conservative or free market ring. But I think it is short sighted and ideologic to draw the conclusion that there cannot be substantial conceptual and political common ground.

An old friend and colleague, Dr. Robert St. Peter of the Kansas Health Institute, spoke earlier this month at the National Health Policy Forum. During his talk, he mentioned Sam Brownback's recent and successful gubernatorial campaign in Kansas, which focused on Five "Roadmap" Policy Priorities:

- Increase in net personal income
- Increase in private sector employment
- Increase in the percentage of 4th graders reading at grade level
- Increase in the percentage of high school graduates who are college or career ready
- Decrease in the percentage of Kansas children who live in poverty

If this isn't a population health agenda that everyone in our field could embrace, I've not seen one. Of course the devil is in the details and implementation, and there are some strategies that liberals will not be comfortable with. But the metrics are clear and solid; at the very least this Kansas/Brownback Roadmap deserves understanding and careful tracking over the next 12-24 months.

Last week's post highlighted the importance of income as a health determinant, operating through multiple pathways such as behavior, health insurance, health literacy, and the physical environment. Liberals often think of increasing income through income supplementation and welfare policy; these are powerful tools that need to be effectively deployed. A recent paper by two economists showed that modest increases in the Earned Income Tax Credit in 1993 produced measurable increases in physical and mental health outcomes.

Both parties are acknowledging the political and economic imperative of jobs creation, prioritizing the need for better jobs with livable wages. Common ground on this and similar population health policies needs to be cultivated not only between sides of the aisle but also with the business community. Business leaders have an inherent interest in population health policy, recognizing the importance of both employee health and education for their impact on health care costs and productivity. In the past, businesses have tended to emphasize wellness and incentives for individual behavior change. However, there is increasing recognition of the need to shift to a broader perspective. Andy Webber, CEO of the National Business Coalition on Health, recently noted in a MATCH project essay published in *Preventing Chronic Disease*:

> "An employer can do everything right to influence the health and productivity of their 'captured' workforce at the worksite, but if that same workforce and their dependents live in unhealthy communities these employer investments can be neutralized."

Certainly the Brownback Roadmap would go a long way in helping employers achieve these goals. He could make it stronger by calling for elimination of ineffective healthcare practices and using the savings to fund his roadmap. The population health agenda is too large for a single party and political perspective. Our current bipartisan concerns about the economy provide fertile common ground for a population health policy agenda that would reap benefits for decades to come. That would be political cooperation worth working for.

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11/10/2010

Are We Individually Responsible for Our Health Behavior Choices?

By David A. Kindig, MD, PhD

The answer is yes…and well, not really. This answer is often framed yes or no: either we have free-will, "just say no" responsibility for our behaviors, or we have no responsibility because of the life situations we find ourselves in. Of course the truth is somewhere in between – but what is the balance between them? The answer has important policy implications, particularly with regard to informing investment priorities.

I've often noted (as in last week's Child Health post) that currently available evidence is insufficient to effectively guide public and private policy makers' investment decisions with regard to population health improvement. That said, we must recognize the cutting edge research being done in this area. For several decades, Paula Lantz and Jim House and colleagues at the University of Michigan have used a longitudinal database called the Americans' Changing Lives Survey (ACLS) to explore answers to important questions using the most sophisticated social science methods available. The ACLS has tracked 3600 adults from 1986 to 2005, querying them 4 times over that period.

In their most recent paper (published in the May 2010 issue of *Social Science and Medicine*) they developed models to explore relationships among various factors (such as age, gender, ethnicity, education, income, smoking status, physical activity level, and many others) and risk of death. They were particularly interested in connections between income and behavior and wanted to determine if poor people have worse health because they have poor health behaviors – or if something else is going on.

Not surprisingly, the findings showed that people with lower incomes tended to have more unhealthy behaviors and people with higher incomes tended to have healthier behaviors. Regardless of income, smoking and low levels of physical activity were both associated with an increased risk of death. But more importantly for this blog, the findings revealed that unhealthy behaviors are far from the only reason low income populations are at increased risk of death. Independent of health-related behaviors and other control factors, the risk of death among those in the lowest income category was 76% greater than those in the highest income category (which was similar to the risk differential between smokers and nonsmokers). In addition, the independent effect of the lowest level of physical activity was nearly triple that of income and smoking.

The authors conclude with a call for health policy and clinical incentives to enhance income security, promote smoking cessation/prevention, and support physical activity. While these results do not tell us exactly what our population health investment strategy should be across behavioral and non-behavioral factors, they make clear that a balance is required. To improve population health, policy and programmatic resources are needed to help make the healthy choice the easy choice – not only with respect to health behaviors but for healthcare, employment, and education as well.

The concept of behavioral "choice" is often interpreted to mean individual choices independent of external (and often constraining) factors. Careful studies like this one provide evidence that keeps us from operating from such a simplistic perspective. To improve population health, we all need to make better health choices – but we also need to understand and remedy the economic and educational upstream factors which determine the extent to which this is

possible.

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11/03/2010

Can We Afford to Wait for Better Evidence on Improving Child Health?

By David A. Kindig, MD, PhD

I recently spent two days at a terrific small conference in Madison, sponsored by the Institute for Research on Poverty. The conference focused on Child Health and Well Being, with many leading thinkers and researchers on socioeconomic disparities in child health. Researchers highlighted what we're learning about the relationship among prenatal environmental factors, body system and brain development, and health outcomes over the life course. While I was extremely impressed with the meeting itself, I was quite frustrated by the lack of evidence regarding causal pathways and cost effectiveness of programs and policies. As a former pediatrician, many of these linkages seem...well...almost obvious. And they're gaining mainstream attention through popular media outlets. *Time* magazine recently ran a cover story on Annie Murphy Paul's new book entitled *Origins: How the Nine Months Before Birth Shape the Rest of Our Lives*.

From a research perspective, these complicated relationships take enormous time and effort to untangle, and researchers venturing into the sphere of policy and practice is seldom encouraged or rewarded. We also can't expect policy makers to invest resources and take political risks without sufficient evidence, especially in cases where there is a risk for potential harm. There are many examples where things we thought to be true were not, and people suffered. Remember that the first rule of medicine is "First Do No Harm."

On the other hand, the reality is that many current policies emerge from political advocacy (often not even in the public interest) rather than on the strength of scientific evidence. Former Milbank President Dan Fox has noted that "policy is the sum of anecdote." In the case of child and fetal health policy, failure to act on the best -- albeit imperfect -- evidence could potentially cause a great deal of harm. Public and private policy environments influencing maternal health, fetal development, and the first five years of life have substantial health and development ramifications over a lifetime. While we study and debate the causality and cost-effectiveness of our options over the next decade, the adult health of the 40 million children born in the United States during that time period will have already been determined. Investments in healthcare in middle and old age can only partly remedy poor health outcomes determined earlier, and often at great individual and social cost.

How can we remedy this? Unfortunately, I don't have any silver bullet answers. I've often lectured that if I were Czar, and if 25% of health care spending ($500 billion per year) is inappropriate or ineffective, I'd allocate $100 billion to covering the uninsured (we are now doing that), $100 billion to prevention and public health, and the remaining $300 billion to early childhood, prenatal, and K-12 education to have the most impact on later health. But at this point, nobody knows exactly what programs or policy packages are the most cost-effective to produce these results.

We of course need more research to figure this out – this was the point of my recent *JAMA* commentary with John Mullahy called Comparative Effectiveness – Of What? -- but not at the slow pace of the past several decades. An August *New York Times* article described the massive and coordinated public-private "moon-shot" approach in the last decade on Alzheimers research, which has led to many important recent discoveries in a challenging field. We should use a similar approach to understand what policy approaches are most cost-effective for improving the health of our children. Given the certain costs associated with inaction, we may, in the meantime, need to relax our policy investment standards somewhat. Such an approach is not without precedent. In the 1990s, while pharmaceutical researchers were working hard to develop HIV drug therapies, the seriousness of the disease resulted in conditional approval of some drugs pending more complete and relevant evidence.

We know enough right now to predict that doing nothing will result in poor adult health outcomes of babies being born today. Aside from the obvious moral dimensions, my main argument for expediency is pragmatic: the health and economic competitiveness of our nation over the next 50-100 years is at stake. Surely investing in maternal and early childhood health should be a priority. We should focus our research efforts on figuring out what approaches are most effective and waste no time in directing current investments based on the best available evidence.

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Posts from December 2010

12/27/2010

New Year's Resolutions and Population Health Improvement: Anything in Common?

By Kirstin Siemering, DrPH and David Kindig, MD, PhD

The U.S. government's official web portal lists ten ever-popular New Year's resolutions (actually, it lists 11 but we left off "take a trip" since it's a good idea but not relevant to this discussion!):

1. Drink less alcohol
2. Get a better education
3. Get a better job
4. Get fit
5. Lose weight
6. Manage debt

7. Manage stress
8. Quit smoking now
9. Save money
10. Volunteer to help others

From an individual perspective, the list is basically what we might expect. As a society, our default frame for New Year's resolutions is that they require tremendous willpower and against-the-odds discipline to accomplish. Not surprisingly, the majority of us fail in our behavior change endeavors. *Time* magazine reported at the start of this year that 35% of those who resolve to make changes don't even make it "out of the gate."

But, we were somewhat surprised to realize that these individual priorities are also population health priorities (although a balanced agenda would also have to include attention to healthcare and the physical environment). Since experts always offer advice this time of year for how to keep resolutions, we thought it would be interesting to assess if their advice also has population health relevance.

As it turns out, tips for success for New Year's resolutions have a familiar ring. Wall Street Journal Work and Family Columnist Sue Shellenbarger's suggestions are fairly typical (and actually align quite well with content from our work from the *County Health Rankings* and this blog):

1. Get a little help from your friends (Work together)
2. Take one step at a time (Pick priorities)
3. Figure out your attachment to bad habits (Assess needs and resources)
4. Change your environment (Find programs and policies that work)
5. Announce your intentions (Set ambitious but realistic goals)
6. Expect setbacks (Evaluate efforts)

So, as you're contemplating your own resolutions for 2011 (such as what approaches to adopt for losing weight and getting fit), don't forget to think about resolutions for your neighborhood, community, or even state. Mobilizing Action Toward Community Health will happen one step at a time, as we figure out our attachment to bad habits and announce our intentions. And with a little help from our friends, we'll overcome setbacks and ultimately change our environment.

Happy New Year from *Improving Population Health*!

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12/22/2010

Healthcare Cost Containment Part IV: Dollars and Sense at the End of Life

By David A. Kindig, MD, PhD

Throughout this series, I've challenged health care advocates to consider the importance of reducing healthcare costs in a resource-limited world. A balanced population health investment portfolio should include resources for prevention and the social determinants of health as well as healthcare. To create this balanced portfolio, we not only need to find new revenue streams but we have to take a hard look at our current expenditures and consider specific opportunities for reducing costs. Research by the Dartmouth group has identified two categories where healthcare costs tend to outweigh the benefits: (1) excess subspecialty visits and procedures and (2) end of life care.

Too many subspecialty visits and procedures can potentially be brought under control through a combination of market forces and regulation. But the high cost of dying is a sensitive topic that most policy makers would understandably rather avoid.

This is an area where policymakers need not and should not be involved. End of life decisions are and can be made voluntarily by individuals and families with their health professionals. They can be made solely on the basis of the kind of death an individual wishes to have. For some, trying every treatment or procedure that may hold promise of extending life or quality of life is important. Others may reject treatment of uncertain or unlikely benefit in light of potential disadvantages (such as prolonged discomfort and/or loss of dignity).

Such decisions should be made by private choice, through legal instruments called advance directives. Recent research by Dr. Maria Silveria showed that patients who had such instruments were more likely to want limited care (93%) or comfort care (96%) than all care possible (2%). This study also showed a strong correlation between having a document that explicitly stated preferences for or against all care and receiving care that reflected those preferences.

In a recent *New Yorker* article called "Letting Go", physician and author Atul Gawande highlights a 20-year effort by health care providers in La Crosse, Wisconsin to get patients to be clear about end of life wishes. By 1996 85% of patients who died had advance directives, and he reports that end of life costs were half the national average. My first wife was a skilled geriatric social worker, and spent much time encouraging patients to discuss and make their wishes known. Health care costs never entered her mind, but I always wanted to quantify the financial impact of each week of her work, which I imagined to be as great as the La Crosse experience cited above.

Containing health care costs is extremely difficult, and has frustrated policy makers and academics and policy makers for decades. I do not mean to over

simplify such decisions, which often have to be made with uncertain evidence. Both of my parents made decisions to forego treatment with possible but unlikely benefit, and died with dignity at home. This issue presents a rare win-win opportunity for personal choices to translate into significant healthcare savings. If circumstances allow, I'm planning for a less invasive death. And if someone would let me, I'd donate the savings to improving the health of low-income children.

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12/15/2010

Healthcare Cost Containment Part III: How to Bend the Curve

By David A. Kindig, MD, PhD

I've been blogging for a couple of weeks now about healthcare cost containment. I've described the Affordable Care Act's provisions for realigning Medicare expenditures with GDP increases and addressed the "R" word. The lead editorial in last Sunday's *New York Times* notes that the Bowles-Simpson deficit reduction commission sets similar targets, but says "the commission punts on what do to should the growth cap be exceeded, as many experts deem likely."

At the start of this series, my friend and colleague David Riemer, who directs Milwaukee's Community advocates Public Policy Institute, issued this challenge to me: *"I hope (you) explicitly address the multiple perverse incentives in today's health care system that drive its hyper-inflation, and how those incentives require a fundamental realignment if costs are ever to be controlled. Setting goals without realigning incentives will just be happy talk--it will get us nowhere. Sorry to be so brutal about this, but it's the brutal truth."*

We know that healthcare cost does not predict healthcare quality. Drs. Jack Wennberg, Elliott Fisher and colleagues at Dartmouth have for years been calling attention to the dramatic regional variation in per capita Medicare expenditures that bear no correlation to health outcomes. They observed Medicare growth rates varying from 2.3% in Atlanta and Pittsburg to 5.3% in Dallas over the period 1992-2006. Reducing the spending rate from the national average of 3.5% to the 2.3% experienced by Atlanta would save Medicare $1.3 trillion by 2023.

So what change in incentives would begin to "bend the curve" towards the Affordable Care Act's 2018 goals? The concept of value-based payment systems is one approach that has been gaining traction in recent years. In fact, the Affordable Care Act establishes one such approach as a new Medicare payment model: the Accountable Care Organization (ACO). ACOs are designed to improve quality and reduce costs by incentivizing (via shared savings) collaboration among health care organizations and providers. While the ACO model is certainly no silver bullet (Fisher and Shortell underscore in their recent JAMA commentary that effective tools for performance measurement and evaluation are lacking), it provides a promising place to start thinking about realigning incentives.

Using the Dartmouth observations, policymakers should be required to identify specific targets in regional per capita total health expenditures and their growth rates (such as the Affordable Care Act's goals for Medicare increases). As in the Clinton plan, geographic areas in which incentives for ACOs and other market forces are strong enough to meet these goals would avoid regulation. But in those that fail to meet targets, federal regulation should be invoked, limiting the annual increases in Medicare and private premiums that could be charged until target growth rates are achieved.

Of course value-based purchasing (as illustrated here with ACO) represents just one of many possible approaches for shifting incentives toward cost containment. The McKinsey Global Institute's 2008 report entitled "Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More" provides excellent further reading for those interested. The report frames the issue from an international perspective and devotes an entire chapter to issues of demand, supply, and intermediation which address the "perverse incentives" to which David Riemer referred (if you have just a minute or two, be sure to check out the interactive graphic).

Why does a population health advocate spend so much blog space on health care expenditures? The answer is a central theme on this blog. In our resource-limited world, we urgently need to rebalance our health investments to expand resources for prevention and the social determinants of health. While we can't presume that savings from ineffective health care could or would be redirected to these ends, we should all agree that this is a worthy goal.

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12/08/2010

Healthcare Cost Containment Part II: Can Rationing Be Rational?

By David A. Kindig, MD, PhD

Rationing: A systematic method for limiting access to a good or service when demand exceeds supply. *New World Dictionary*

Arizona has had a lot of attention this past week for its recent decision to eliminate certain transplants for Medicaid recipients. The *New York Times'* coverage alone included a general article, an analysis piece, and an op-ed that together prompted intense and mostly negative feedback from over 900 readers before comments were finally closed.

If the *Times* is correct in asserting that the Arizona cuts are a "sign of the times," we've got a challenging road ahead in navigating the politics and ethics around the difficult and often contentious topic of healthcare rationing. As I noted last week, the Affordable Care Act charges CMS with developing recommendations to keep Medicare inflation in line with GDP increases over time. But the Act specifically prohibits proposals **"that would ration care, increase revenues or change benefits."** Yet, how rationing will be defined in the context of the Affordable Care Act remains unclear. How might a population health perspective guide our thinking?

First, a population health perspective suggests that investments be prioritized according to the degree to which they will improve overall health outcomes and reduce disparities, be they racial, geographic, or socio-economic.

Second, a population health perspective encourages us to be relentless in identifying and eliminating excess and ineffective practices and procedures. This is not rationing, it is simply good medicine and good economics. A Baltimore cardiologist's alleged misuse of cardiac stents (he supposedly implanted 585 medically unnecessary stents over a 2-year period at a cost to Medicaid of $3.8 million) provides a vivid example of a relatively common problem. As Cleveland Clinic's Chief of Cardiovascular Medicine, Dr. Steven Nissen, said, "We're spending a fortune as a country on procedures that people don't need."

Finally, a population health perspective implies that the reality of scarce resources requires difficult decision-making along a cost-benefit continuum. I believe that if caps are to be put on investments with limited or very expensive benefits, they should be made with the best evidence available and with maximum transparency. The best example of this was the Oregon Health Plan, which was prompted by a commitment to expand health care coverage for the state's low-income population without additional funding. In 1989, the Oregon legislature created the Oregon Health Services Commission, which invited public input through town hall meetings on the process of ranking health care services according to importance, health impact, effectiveness, and cost. Although the approach was not perfect, it is an excellent example of a rational rationing process. This prioritization has resulted in healthcare coverage for 1.5 million Oregonians. In the United Kingdom, "league tables" are used to guide investment decisions, ranking the quality adjusted life years saved per dollar invested for a given procedure.

So, can the Arizona decision be defended from a population health perspective? Perhaps, but only if the evidence is clear that new or deeper cuts in other sectors would be more damaging, that these are the least cost-effective programs in their Medicaid program, and that this evidence is transparent. And they would get more population health points if the savings went to preserving other more cost-effective health promoting programs instead of simply balancing the overall budget or reducing tax rates. Can we lower healthcare cost increases to close to GDP increases by just getting rid of wasteful and ineffective investments? I doubt it -- reform will likely require some form of rationing and continued clashing of goals and values. Stay tuned.

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Posts from January 2011

01/26/2011

Did You Find Population Health in the State of the Union?

By David A. Kindig, MD, PhD

I listened carefully, but I don't think I heard the words population health, public health, or prevention anywhere in the speech. But I think Obama is a closet population health advocate like Sam Brownback and Peter Orszag.

There was no mention of health outcomes, disparities, or even national health performance goals -- where we have much work to do, especially in relation to other countries. However, the domestic part of the speech dealt primarily with two major drivers of health -- education and jobs (fully 40% of the health factors score in our *County Health Rankings* is made up of social and economic indicators such as these).

Effective education policies have the dual benefit of improving both educational attainment and health status across the lifespan, from the earliest intrauterine life stages through formal schooling and beyond. And, in an evening when bipartisan dating was a major sub-theme, this should appeal to liberals and conservatives alike since it expands opportunity without the government directly reallocating resources.

In my experience, much of the population health research and advocacy in the areas of income and employment has focused on more liberal-leaning public governmental policies such as tax reform, income enhancement programs like earned income tax credits (EITC), and public job creation. These are important, but job creation is primarily in the private sector, and policies

improving economic competitiveness need to be supported as well. I don't know what the right balance between these is, but it should be made on evidence rather than ideology from either side of the dating game. The President also emphasized our expanding opportunities to create jobs in the clean energy sector; weaning off coal and oil has secondary unmentioned health benefits as well.

We did hear the word health, but of course only in the context of health insurance reform. Even though the *County Health Rankings* model only ascribes 20% of health outcomes to healthcare, it is critically important that all Americans have access to it. So I applaud the President for standing firm on this. Acknowledging that the Patient Protection Act is not perfect, he expressed hope for bipartisan enhancements. Though the President did not directly address the specifics of healthcare cost containment, it must remain a high, common ground priority on the health reform agenda. I believe we could and should eliminate or rationally ration high cost treatment options that offer little or no benefit, for both deficit reduction and redirecting savings towards prevention.

So population health improvement and disparity reduction did not rise to the level of an explicit State of the Union "Winning the Future" theme. But many of the featured components are so important in their own right that the combined secondary effect could represent a bipartisan stealth attack on this critical challenge.

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01/18/2011

Assessing Today's Health...and Tomorrow's

By David A. Kindig, MD, PhD

Today I'm starting a new series on population health measurement, motivated by the idea that "you can't manage what you can't measure." While there is no shortage of measures and rankings, there's actually little consensus on what metrics are best suited to assess progress in population health improvement. Last week I urged Triple Aim architects to clarify how population health is defined in their model, but they're not the only ones with definitional issues.

Metrics can assess a single item, such as infant mortality rates, or be bundled into groups to create summary measures. America's Health Rankings (AHR) and the *County Health Rankings* (CHR) both use summary measures to annually rank, respectively, the health of states and counties within states. AHR has been ranking the health of states since 1990 and released its most recent rankings in December 2010. This important national resource informed work by the University of Wisconsin Population Health Institute to rank the health of Wisconsin counties beginning in 2003 and, for the first time in 2010, counties in every state. Dr. Pat Remington and I are proud to serve on AHR's Scientific Advisory Committee.

The AHR and CHR share a common goal of population health improvement and both projects take pride in their deliberate, systematic, and transparent approaches. Both projects create summary measures for health outcomes (using metrics such as premature death, quality of life, and poor birth outcomes) and health factors or determinants (using metrics that capture health behaviors, clinical care, and social/economic/physical/policy environments). However, while CHR uses the health outcomes summary measure to identify the healthiest counties, AHR creates its overall rankings based on both outcomes and determinants.

So what does this look like in action? From 2009 to 2010, Wisconsin dropped from 11 to 18 in AHR overall rankings. But, a look at separate outcomes and determinants rankings over the same time period tells a slightly different story. Our determinants ranking is identical to the overall ranking (we dropped from 11 to 18). However, our health outcomes ranking improved slightly, from 16 to 15.

Why is this important? In general, we think of outcomes as a reflection of our current health and determinants as a predictor of our future health. The two summary measures often move in the same direction, but not always. When we launched the national CHR in 2010 with support from the Robert Wood Johnson Foundation, some wanted to know why our rankings didn't have an overall score like AHR. The answer has to do with how the results are communicated and their implications for action. We felt strongly in the value of the two different measures to communicate different but equally important concepts about population health, particularly for policy makers.

Places with determinants better than outcomes are on the right track toward health improvement. But, for those such as Wisconsin with declining determinants, unless we act to reverse the trend, there is cause for concern about potential declines in health outcomes. It is the outcomes we are trying to improve, and the determinants that will get us there.

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01/11/2011

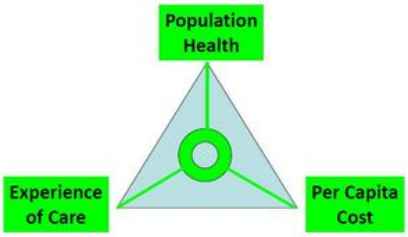
Unpacking the Triple Aim Model

By David A. Kindig, MD, PhD

Many thanks to those who offered some great blog ideas for 2011 – reader suggestions are always welcome. Jay Gold's question about the Triple Aim caught my eye because it's something I've been giving a lot of thought to recently: "How in your view does population health tie in with the other two elements (quality of care, cost-effectiveness) of Berwick's Triple Aim?"

This is a relevant and timely question, since the Triple Aim is getting much more attention since Don Berwick became the Administrator of the Center for Medicare and Medicaid Services. In a blog interview with John Whittington last fall, we explored the origins of Triple Aim within the Institute for Healthcare Improvement and their emerging regional strategy beyond individual health systems or plans.

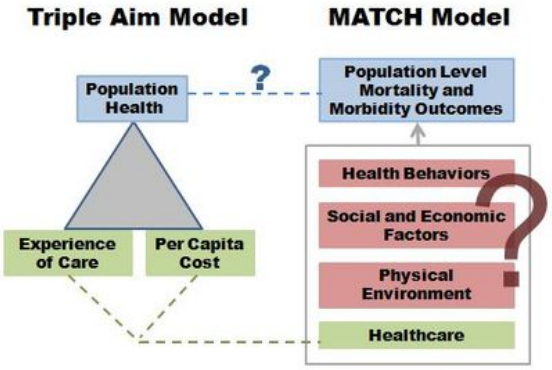
I am a big fan of Triple Aim and have been privileged to present at several of their recent meetings. My appreciation for this work is based in the belief that IHI/Triple Aim is one of the leading forces in the U.S. to motivate healthcare systems to stretch beyond traditional clinical roles and work towards broad population health improvement. In fact, population health is prominently featured at the top of the Triple Aim triangle:



It's great to see population health front and center in a model. But there's a communication problem here that needs to be acknowledged: what does "population health" in the Triple Aim model actually represent?

My concern is that people looking at the Triple Aim model won't necessarily know what to make of the "population health" leg of the triangle. As a result, they may focus on the other two more concrete goals of improving the experience of healthcare and reducing per capita costs of healthcare. In no way do I want to diminish the importance the model's clinical goals, which may represent our best short-term strategy. However, the reality is that even major progress in these two areas over the next decade will not help us achieve our goals related to healthy life expectancy and disparity reduction.

To achieve our broad population health goals we need to understand and intervene across the whole spectrum of determinants, not just health care. Triple Aim leaders understand and appreciate this, but I'm not sure this is clearly communicated by the Triple Aim model so I've drafted an alternate view that combines the Triple Aim model with our model of population health.



As the figure shows, two of the legs of the Triple Aim stool relate only to a single determinant, healthcare. I'd like to see the population health part of the Triple Aim model more clearly defined to make it clear that population health outcomes (among populations or individuals) are influenced by multiple determinants, most of which are beyond health care (note the reddish boxes in the figure above).

I have discussed this constructive criticism openly with Triple Aim leaders and will continue to do so. They have a powerful brand which is serving us well in many regards. But when Berwick and others talk about "better health" as a shorthand for "population health" in the Triple Aim model, let's be certain that everyone understands this means actions beyond just health care. Several Triple Aim sites have developed impressive population health agendas and are moving forward with broad and ambitious health goals. But I can't help but wonder if a revamped model might enhance existing efforts and spur new dialogue and action in AND out of the health care system to improve health.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 01/11/2011 in Improving Health Factors | Permalink | Comments (6) | TrackBack (0)

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01/04/2011

Improving Population Health...in 2011

By David A. Kindig, MD, PhD

I spent some time last week musing about potential blog topics for 2011, which brought me back to the population health model that underpins this blog.

Last year I touched on many parts of this model. I wrote about and offered opinions on the social determinants of health, how savings in healthcare could enhance the population health agenda, and the extent to which health-related behaviors are beyond individual control. I also addressed policy-related topics such as the IRS consideration of Community Benefit policy and whether a cross-sectoral integrator is necessary or possible. I'll revisit these topics in 2011 but will also cover other important population health issues, such as:

1. Which outcome measures are most useful in guiding population health policy?
2. How do improvement metrics differ from achievement metrics?
3. Will raising average health reduce disparities?
4. Are racial health disparities the most important ones?
5. Are genetics a modifiable determinant of population health?
6. Will climate change increase the importance of the physical determinants of health?
7. What is prevention?
8. Top down vs. bottom up approaches to population health policy

9. Why can't historical patterns of investment in healthy and unhealthy communities show the optimal path for others?
10. What are population health incentives?
11. Is there a business model for population health improvement?
12. What is the health impact of non-healthcare programs and policies?

I'd love to know what you think of this list and I welcome suggestions for additional topics anytime. This week, I'm hoping for 10 new ideas from readers on questions or issues this blog should address as we head into 2011. Thanks in advance for your contributions!

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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02/22/2011

Which Health Disparities Do We Want to Reduce?

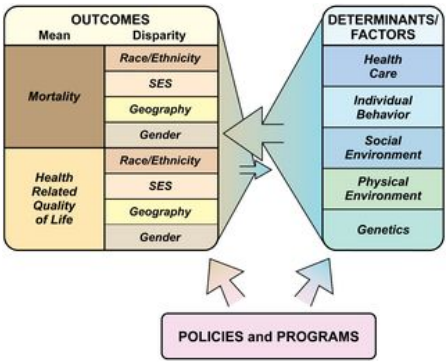
By David A. Kindig, MD, PhD

Over the past few weeks, I have been blogging on population health measurement, under the headline that you can't manage what you can't measure. While I've given quite a bit of attention to overall outcomes, I haven't directly addressed disparities.

Improving the length and/or quality of life overall doesn't necessarily translate to improved health for all population groups. Policies and programs can have a differential affect on subpopulations that exacerbate rather than diminish disparities.

Deciding which outcomes to target to improve overall health involves value judgments – whether the goal is improving overall health or reducing disparities. There is not a "correct" formula for simultaneously improving overall health and reducing disparities. The 50:50 weighting suggested by the figure below represents just one possible approach but the ethical dimensions of such choices cannot be ignored; in a resource limited world, should we focus on raising the bar overall or narrowing the gaps?

This is a value choice to be made by individuals and groups in light of their local, state or national situations and perspectives.



As the figure shows, disparities in outcomes exist across a spectrum of categories. These include race and ethnicity but also social and economic status, gender, and geography (and other dimensions as well). However, people often focus on disparities primarily in the race/ethnicity dimension. Last month the CDC released its first ever report on disparities and inequalities. Despite the report's emphasis on the social determinants of health (the first section focuses on income and education), media coverage focused on the findings about racial disparities.

Here in Wisconsin, our ethnic minority populations are relatively small and geographically concentrated, but every county in the state has substantial health disparities by education level and income. In fact, the state earned a "C-" overall for health disparities in its 2010 Health of Wisconsin Report Card (which employs an innovative multidomain disparity index). The figure below from this report shows the distribution of death rates for various population segments both above and below the state average. It illustrates the point that racial disparities are significant but that there are also other critical differences across other population segments, such as those with different levels of education.

Chronic racism has been shown to have a biologic effect on health through stress pathways, and institutional racism has created many of the disparities in income, education, and health services that influence health outcomes. We clearly need to develop and support policies to address and eliminate racism on every level in our communities.

But focusing our attention too narrowly may make us think of obstacles instead of opportunities. To improve population health, we need to think beyond race to recognize the many factors that affect health differentially. In a country still battling racial stereotypes and prejudice, this broader perspective on disparities may help create a unified and constructive approach to addressing our collective health challenges.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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For further reading:

Jones CP. (2000). Levels of racism: A theoretical framework and a gardener's tale. *American Journal of Public Health*, 90, 1212-1215.

Webb BC, Hairston KG, Simpson SL. (2011). From politics to parity: Using a health disparities index to guide legislative efforts for health equity. *American Journal of Public Health*, Published online ahead of print January 13, 2011: e1-e7. doi:10.2105/AJPH.2009.171157.

Schoeni RF, Dow WH, Miller WD, Pamuck ER. (2011). The economic value of improving the health of disadvantaged Americans. *American Journal of Preventive Medicine*, 40(1S1), S67-S72.

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I agree that focusing directly on racial disparities in health often helps identify obstacles rather solutions. Focusing rather on the social and physical environmental determinants of health may help directly answer the "what's in it for me" question and indirectly address racial/ethnic disparities.
Few who practice racism, even unconsciously, seem able to articulate the personal benefits of working to eliminate racism. Plus there's no convincing evidence base for treating racism. However, the population-level benefits of improving the physical and social environments are more apparent.
Because I am able to compensate, I am less likely to suffer from the lack of fresh fruits and vegetables in my neighborhood or the industrial haze visible in the distance from my window. Nevertheless I would love it if I were able to walk to the grocery store or see the mountains beyond the haze.
Improving the social and physical environments is likely to have a greater impact on those who suffer most from current conditions. Still, we can all see and feel the benefits. This approach may do little to mitigate the effects of racism, but a portion of the racial gap may diminish.

Posted by: Ed Donovan, James M. Anderson Center for Health Systems Excellence | 02/28/2011 at 04:04 PM
This article is featured in the March 3rd edition of the Health Wonk Review. Thanks for your submission!

http://lucidicus.org/editorials.php?nav=20110303a

Posted by: Jared | 03/03/2011 at 12:27 PM
David, I found the blog site in On Wisconsin. Interesting as usual.And of course veri different view from mi professional life.Thanks. I will be an avid follower. Bill Rock

Posted by: Bill Rock | 03/08/2011 at 10:53 PM

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02/14/2011

Doing Well or Doing Better

By David A. Kindig, MD, PhD

Our focus for the past couple of weeks has been on outcomes, both long-term and intermediate. Most of the examples mentioned have been discussed in the context of absolute achievement, such as being #1 on state or county rankings, or achieving the lowest infant mortality rate among all nations.

But is being the best the only thing we want to measure and reward? What about communities and states that are improving most rapidly, particularly from poor baselines? This issue is front and center in education policy: should we reward or incentivize schools or teachers who have the best student test scores, or those demonstrating greatest improvement?

I think both approaches are useful. Overall achievement should be measured and recognized, as with Olympic medals. But there's also a case to be made for keeping track of improvement, particularly for purposes of allocating resources to communities with formidable social and economic challenges.

From a statistical perspective, measuring improvement is even more difficult than measuring achievement. For our *County Health Rankings*, we average three consecutive years of data to assess premature death as Years of Potential Life Lost (YPLL) before age 75 while for other measures, such as smoking rates, we use up to seven years of data. Using multiple years of data allows us to measure health in nearly every county in the US. But the need to use multiple years of data to get an estimate for a *single point in time* makes it difficult to measure *change over time*, particularly for smaller communities that have greater variability in their measures.

We should not let these analytic obstacles deter us from incentivizing doing better at the same time we honor doing well. On the data side, we need to oversample rural areas and seek out non-traditional data sources such as healthcare, employer and school records (with adequate individual privacy protection of course). For measuring improvement, we should focus attention on

shorter-term metrics (such as rates of infant low birth weight) and closely track indicators that are strongly correlated with health outcomes (such as burden of chronic disease, income, and education). And we should experiment with both quantitative and qualitative metrics for assessing innovative and emerging intervention strategies.

Since no community has achieved the highest health outcomes that it can, each can aspire to do better and even be the best. The National Priorities Partnership of the National Quality Forum has set one goal that "the health of American communities will be improved according to a national index of health." But to reduce inequalities across communities (a topic I'll return to soon), those with worse outcomes need to improve at a faster rate to reduce the gap. As with our schools, learning what combination of metrics, mechanisms, and incentives maximize rates of community health improvement will be an important part of population health policy strategy in the coming decades.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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02/08/2011

Is Chronic Disease Burden a Population Health Outcome?

By David A. Kindig, MD, PhD

Responding to last week's post on which outcomes we should improve, Matt Stiefel from Kaiser Permanente asked about using the incidence or prevalence of chronic illness as a population health outcome measure. Matt's important question prompts me to continue the conversation this week.

The Institute of Medicine's 2008 State of the USA Health (SUSA) Indicators report (I served on this committee), called for an index of chronic disease prevalence among its seven other health outcome measures that "reflect the overall health of the nation and the efficiency and efficacy of U.S. health systems" such as life expectancy at birth, infant mortality, and unhealthy days (physical and mental). To my knowledge, such an index has not yet been developed. As a member of the IOM SUSA committee, I am concerned with the classification of chronic disease prevalence (and other similar factors) as outcomes per se, because improving these factors is the means, not the ultimate end that we seek (i.e., living longer healthier lives). This opens the door for the means to become the end.

One strategy might be to add a third category of "intermediate outcomes" to our model of outcomes and determinants/factors. These "intermediate outcomes" could capture those factors (like smoking rates or primary medical care or burden of chronic disease) that, if improved, are likely to directly and significantly improve our ultimate outcomes over time. (Others call these "proximal determinants" in contrast to the more "distal determinants" such as income and education.) This category of "intermediate outcomes" could be very useful for guiding population health monitoring efforts and policy priorities, and indeed may be required when we want to track or reward short term improvement.

We don't have to look far to see the potential value of this third category. The National Research Council's recent report highlights diverging paths in longevity among high-income countries. The report points to smoking rates as one main reason why life expectancy in the U.S. is increasing at a slower rate than might be expected. Thirty years ago, smoking rates were much higher among U.S. adults than they are today (37% vs. 21%); what we're seeing now is the time-delayed ripple of these "intermediate outcomes" or determinants affecting long-term health outcomes.

Thinking about smoking rates as an "intermediate outcome" can be helpful from a policy perspective as well. Later this month, New York City's Mayor Bloomberg is expected to sign a bill that will ban smoking in 1,700 city parks and along 14 miles of beaches. According to the *New York Times*, the new policy will represent the "most significant expansion of antismoking laws" since Mayor Bloomberg's 2002 push to prohibit smoking in bars and restaurants. I hope the National Research Council will be able to credit these and similar policies to declining mortality in 2040.

So, while I'd like to reserve the population health term "outcomes" for our ultimate goals of increasing the length and quality of lives, a third category of "intermediate outcomes" deserves greater attention by both policymakers and scholars. Developing consensus around which indicators would best fit into such a category – as well as what programs and policies could most cost-effectively improve these numbers – would be a great place to start.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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For further reading:

Kindig, DA. (2007). Understanding Population Health Terminology. *The Milbank Quarterly*, 85(1), 139-161.

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Comments

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This commentary is right on target. A clear chain of process, intermediate outcomes and ultimate population health outcomes tied togehter by research evidence of effectiveness is the "line of sight" required for individuals or individual organizations to know that their specific efforts approprately incented will untimately contribute to improved communty heatlh.

Posted by: George Isham, M.D., M.S., | 02/11/2011 at 05:14 PM

Primary and secondary chronic illness prevention often have both medical and non-medical determinants. This is one argument for including chronic illness burden as a measure of population health

Posted by: Ed Donovan, James M. Anderson Center for Health Systems Excellence | 02/12/2011 at 03:18 PM

Thanks to both George Isham and Ed Donovan for comments supporting using chronic illness burden as an "intermediate" population health outcome measure. Do they or anyone else know the status of the development of such an index or summary measure of chronic disease burden?

Posted by: David Kindig | 02/15/2011 at 12:08 PM

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02/01/2011

Which Outcomes Should We Improve?

By David A. Kindig, MD, PhD

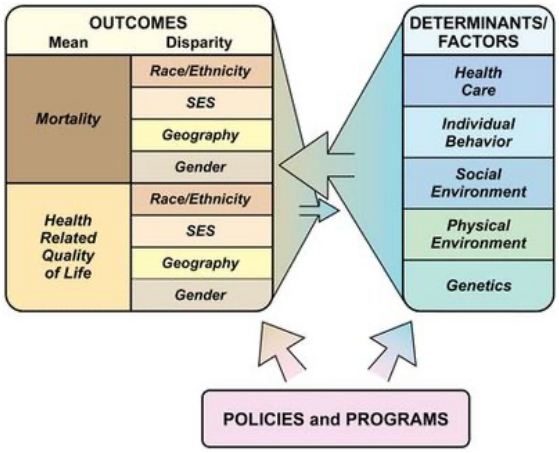
I recently argued on the importance of keeping population health outcomes and determinants separate, since the former represents today's health and the latter tomorrows' health. This week and next, I'll be digging a bit deeper to look first at outcomes and then later at determinants.

Health outcomes have been defined as "all the possible results that may stem from exposure to a causal factor from preventive or therapeutic interventions." As Gib Parrish noted in his 2010 award-winning article, there are many different ways to measure health outcomes. These include:

- Life expectancy from birth
- Age-adjusted or age –specific mortality rates
- Condition-specific changes in life expectancy and mortality rates
- Self-reports such as general level of health

Parrish notes that outcome metrics should present both the overall level of health of a population and the distribution of health among different geographic, economic, and demographic groups in the population.

The MATCH population health model underpinning this blog reflects much of this perspective. The 2X2 outcome diagram below includes both mortality and non-mortality (i.e., health related quality of life) components, as well as both population mean and population disparity metrics. This makes sense conceptually, but poses issues and choices in practice.



Of course, it is possible to separately track outcome measures in these four (or more) spaces. This is what many health planning exercises do, such as the recently released Healthy People 2020 (HP2020). In this important national process, a large number of individual measures of general health status as well as health related quality of life and health disparities will be monitored and reported on periodically.
One HP2020 indicator is "Healthy Life Expectancy," which will be assessed through three distinct measures:

- expected years of life in good or better health
- expected years of life free of limitation of activity
- expected years of life free of selected chronic diseases

These three metrics are "summary" health outcome measures, combining mortality and health related quality of life together. In a similar approach, our *County Health Rankings'* summary outcome measure assigns 50% to years of potential life lost before age 75 and 50% to 4 non-mortality measures. These weights reflect our interpretation and judgement of the relative importance of the components, but we recognize that not everyone would agree with our choices. There is no empiric "right" answer to the question "Which Outcomes Should We Improve?". This is a question of values; decisions weighting length of life versus quality of life should be made by individuals and communities.

Why does this matter? Different outcome choices require different patterns of investment in the determinants of such health outcomes. I'd like to see a web-based tool that allows communities to explore a broad set of outcomes and that leads them through a process of selecting outcome priorities that have local meaning and relevance. Having a clear sense of place-based outcome goals should help establish policy priorities and guide resource allocation.

As readers of this blog know, we don't yet precisely know which programs and policies are most cost effective for overall population heath improvement – let alone those that reduce disparities (stay tuned for more soon on this topic). But we are hopelessly lost if we aren't clear on where we are going, and what our targets are. Clear and transparent choices about outcomes have tremendous promise, serving as a sort of population health compass to guide us step by step toward a healthier tomorrow.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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For further reading on summary measures:

Stiefel MC, Perla RJ, Zell BL. (2010). A Healthy Bottom Line: Healthy Life Expectancy as an Outcome Measure for Health Improvement Efforts. *Milbank Quarterly*, 88(1), 30-53.

McKenna M, Marks J. (2002). Commentary on the uses of summary measures of population health. In: *Summary Measures of Population Health: Concepts, Ethics, Measurement, and Applications* (Eds Murray CJL et al.), WHO, 67-74.

Field MJ and MR Gold, eds. (1998). *Summarizing Population Health: Directions for the Development and Application of Population Metrics*. Washington, DC: Committee on Summary Measures of Population Health, Institute of Medicine, National Academy Press.

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Comments

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Dave: what do you think about the incidence or prevalence of chronic illness as a population health outcome measure?

Posted by: Matt Stiefel | 02/02/2011 at 12:09 PM
The IOM released today a preliminary report on recommended leading indicators for Healthy People 2020. It looks like a pretty good list. Noticeably absent for me, though, was any summary measure of overall population health! What do you think?

Their preamble:

For the past three decades, the Department of Health and Human Services (HHS) has issued a national agenda aimed at improving the health of all Americans over each 10-year span. At the request of HHS, the IOM identified a set of leading health indicators that could be used by Healthy People 2020 and developed a conceptual framework within which the topics, indicators, and objectives would be developed or selected.

For more:
http://www.iom.edu//sitecore/content/Home/Reports/2011/Leading-Health-Indicators-for-Healthy-People-2020.aspx?utm_medium=etmail&utm_source=Institute%20of%20Medicine&utm_campaign=03.15.11+Report+-+Leading+Health+Indicators+2020&utm_content=New%20Reports&utm_term=Non-profit

Posted by: Matt Stiefel | 03/15/2011 at 05:03 PM

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03/29/2011

Wake-Up Call: The 2011 County Health Rankings



By Bridget C. Booske, PhD, MHSA

Later tonight, our team at the University of Wisconsin Population Health Institute will release the 2011 *County Health Rankings*.

These rankings will provide snapshots of community health for over 3,000 counties throughout the country. In every state, people will be comparing how counties rank on their health outcomes and health factors, based on a wide variety of measures from mortality and quality of life to high school graduation rates, unemployment rates, obesity rates, and air quality. Our model emphasizes that health care is just one of many factors that determine how healthy we are and how long we live and underscores the importance of evidence-based programs and policies to drive population health improvement.

This important work is being made possible in collaboration with and support from the Robert Wood Johnson Foundation (RWJF). Tomorrow morning, Pat Remington will be joining Senior Vice President Dr. James Marks for a live teleconference and briefing on the 2011 *Rankings*. They will be joined by Mayor Joe Reardon, of Wyandotte County in Kansas (which includes Kansas City). Mr. Reardon will be talking about his community's experience using the *Rankings*. Register here to listen in, 10-11 a.m. EDT.
A few hours later, Pat will be joining RWJF President and CEO, Dr. Risa Lavizzo-Mourey, for a live Q&A session on Twitter from 2-3 p.m. EDT. We're welcoming questions to @RWJF_PubHealth and @CHRankings; you can follow the conversation through #healthrankings.

We're almost as excited about our refreshed and enhanced website as we are about the *Rankings* themselves. We've developed a variety of ways for users to explore and use the data, including state summary reports, downloadable maps, compare and sort capabilities, and both state and national data files. We'll be unveiling several new tools of our own, and linking to a new

tool created by Steven Woolf and colleagues at Virginia Commonwealth University: a county health calculator that demonstrates the relationship between education and income with premature deaths.

As we embark on our second year, we're aware that communities are looking for real-world examples to guide and inspire. Responding to this need, our 2011 website has an expanded section -- *Action Steps* -- to guide evidence-based program and policy development and a brand new section -- *Your Stories* -- to showcase how communities across the country are taking action to improve health.

For the past year, communities across the nation have been using the *County Health Rankings* to galvanize support for and take action to create healthy communities. Tomorrow's release of the 2011 *Rankings* is an opportunity to infuse new energy into this movement and bring more people on board. With the health of our communities at stake, this is one wake-up call we can't afford to let anyone sleep through.

Bridget C. Booske, PhD, MHSA is a Senior Scientist with the University of Wisconsin Population Health Institute and is Deputy Director of the County Health Rankings.

Posted on 03/29/2011 in County Health Rankings & Roadmaps | Permalink

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Comments

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Congratulations for your fantastic work! We will follow and disseminate your work from Public Health Asturias-Spain

Posted by: Rafa Cofiño | 03/29/2011 at 08:47 AM

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03/23/2011

Countdown to the 2011 County Health Rankings



By Patrick Remington, MD, MPH

The 2011 *County Health Rankings* will be released one week from today, on Wednesday, March 30. These county rankings, now in their second year, are produced by the University of Wisconsin Population Health Institute in collaboration with and support from the Robert Wood Johnson Foundation.

My experience with county health rankings dates back to 2002, when I began working with colleagues here at the University of Wisconsin to develop a model that would broadly assess community health throughout the state. Our approach is unique in that it creates a common yardstick for assessing the overall health of an entire community. Our national *County Health Rankings* also show how counties within each state compare on many different factors that influence health -- such as high school graduation rates, obesity rates, and the percent of children in poverty.

We were tremendously excited last year to put this information at people's fingertips with the *Rankings*' inaugural release. The sustained volume of traffic to the website lets us know that this type of information is needed and inspires community efforts to improve population health.

When the *Rankings* are released next week, we expect a flurry of public and media attention as communities around the country go to countyhealthrankings.org to see whether they're at the top, or at the bottom, or somewhere in between. They'll be looking for their county's snapshot, to get a sense of where they're doing well and where they need to improve. There will be over 150,000 data points reported on the website and we will be encouraging users to dig deep to explore the various measures. But the *Rankings* are much more than a fancy compilation of data; they carry

a broader meaning and message that transcends these rankings.

So what do the *Rankings* tell us?

They tell us that improvement is necessary -- and possible -- regardless of rank. They tell us that where we live, learn, work and play matters to our health. Health care is vital for healthy populations, but it is only part of the story. We must find ways to create places, policies, programs, and social structures that promote health across the lifespan, especially for those members of our communities who have the fewest resources and options.

And the *Rankings* tell us that health is everyone's business. Dramatic population health improvement will not occur using only a service-delivery paradigm. We can't relegate the creation of healthy communities to certain professions or organizations. This work doesn't require particular offices, buildings, titles, or credentials – it asks knowledge of one's community, understanding of what works and what doesn't, creativity, commitment, and patience.

Think of the 2011 *County Health Rankings* as a call to action for each one of us, living in one of the counties across the country. We're looking forward to hearing your voices and mobilizing action toward community health!

Patrick Remington, MD, MPH is Associate Dean for Public Health and Professor of Population Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Posts from March 2011

03/29/2011

Wake-Up Call: The 2011 County Health Rankings



By Bridget C. Booske, PhD, MHSA

Later tonight, our team at the University of Wisconsin Population Health Institute will release the 2011 *County Health Rankings*.

These rankings will provide snapshots of community health for over 3,000 counties throughout the country. In every state, people will be comparing how counties rank on their health outcomes and health factors, based on a wide variety of measures from mortality and quality of life to high school graduation rates, unemployment rates, obesity rates, and air quality. Our model emphasizes that health care is just one of many factors that determine how healthy we are and how long we live and underscores the importance of evidence-based programs and policies to drive population health improvement.

Continue reading "Wake-Up Call: The 2011 County Health Rankings" »

Posted on 03/29/2011 in County Health Rankings & Roadmaps | Permalink | Comments (1) | TrackBack (0)

| Twee

03/23/2011

Countdown to the 2011 County Health Rankings



By Patrick Remington, MD, MPH

The 2011 *County Health Rankings* will be released one week from today, on Wednesday, March 30. These county rankings, now in their second year, are produced by the University of Wisconsin Population Health Institute in collaboration with and support from the Robert Wood Johnson Foundation.

My experience with county health rankings dates back to 2002, when I began working with colleagues here at the University of Wisconsin to develop a model that would broadly assess community health throughout the state. Our approach is unique in that it creates a common yardstick for assessing the overall health of an entire community. Our national *County Health Rankings* also show how counties within each state compare on many different factors that influence health -- such as high school graduation rates, obesity rates, and the percent of children in poverty.

We were tremendously excited last year to put this information at people's fingertips with the *Rankings*' inaugural release. The sustained volume of traffic to the website lets us know that this type of information is needed and inspires community efforts to improve population health.

Continue reading "Countdown to the 2011 County Health Rankings" »

Posted on 03/23/2011 in County Health Rankings & Roadmaps | Permalink | Comments (0) | TrackBack (0)

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03/22/2011

Investing in Education

We're calling attention to a couple of highlights this week on the education front, with respect to both need and action:

Dr. William H. Dow, Professor of Health Economics at UC Berkeley, wrote about the first anniversary of the Affordable Care Act with a perspective on the need for improved education policy. Dow calls education the "ultimate prevention tool," noting that "two-thirds of California high school dropouts under the age of 65 are now uninsured or on Medi-Cal, compared with 12 percent of four-year college graduates."

The Obama administration announced a new set of investments to achieve its goal of adding 8 million college graduates by 2020. These include a $20 million Comprehensive Grant Program, a $123 million "First in the World" initiative as part of the proposed 2012 budget, and $50 million in College Completion Incentive Grants.

Posted on 03/22/2011 in Harnessing and Allocating Resources | Permalink | Comments (0) | TrackBack (0)

| Twee

03/15/2011

Is Overconfidence an Obstacle to Population Health Improvement?

At first glance, David Brooks' recent *New York Times* column, The Modesty Manifesto, may not be immediately applicable to this blog. But we think it raises an interesting point. What are the implications for population health improvement if we are indeed becoming a nation of navel gazers?

Posted on 03/15/2011 in Twitter Roundup: @PopHealth | Permalink | Comments (0) | TrackBack (0)

| Twee

03/14/2011

Quick Hits: What's "Collective Impact"?

If you haven't yet heard of "collective impact," this is a great time to get in-the-know. Read about this innovative approach to collaboration in the Winter 2011 issue of the *Stanford Social Innovation Review* and in several recent articles by *New York Times*' "Fixes" columnist David Bornstein ("Coming Together to Give Schools a Boost" and "The Power of Partnerships").

Posted on 03/14/2011 in Leadership and Collaboration | Permalink | Comments (0) | TrackBack (0)

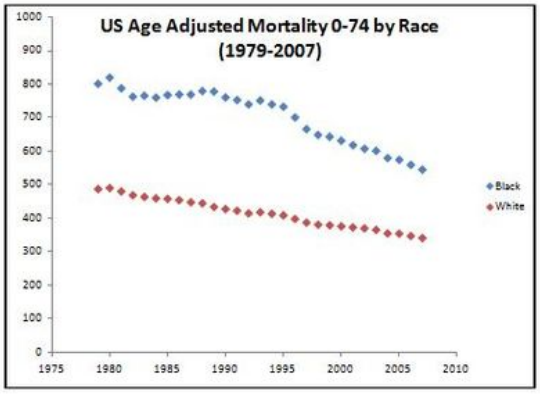
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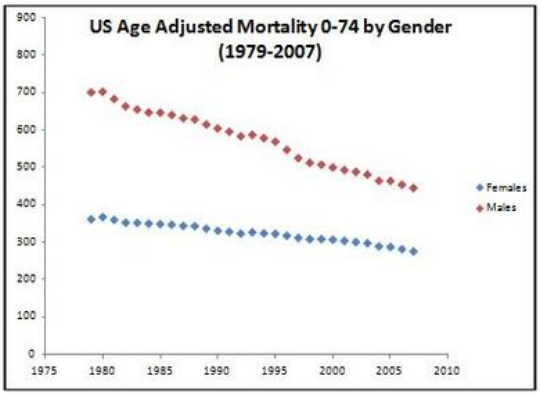
Bending Health Disparity Curves

By David A. Kindig, MD, PhD

I recently raised the issue of disparities and noted the many unacceptable health differentials that exist across U.S. subpopulations. It is very easy to claim that such disparities should be eliminated, but seldom do we set specific quantitative targets for such improvement.

These days, the phrase "bending the curve" usually applies to reducing rates of health care cost increases. But look below at two other curves -- disparities in US mortality between Blacks and Whites as well as males and females from 1979 to 2007.





Continue reading "Bending Health Disparity Curves" »

Posted on 03/14/2011 in Defining and Measuring Health Outcomes | Permalink | Comments (1) | TrackBack (0)

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03/09/2011

A Population Health Perspective on the Wisconsin Budget

By David A. Kindig, MD, PhD

Regular readers know that I often gravitate to political and fiscal issues of population health importance, such as my suggestion that Sam Brownback might be a population health governor or my commentary on the Arizona Medicaid rationing proposal. For several weeks now, several people have asked me to blog about what's been happening here in Wisconsin. With the release of the proposed budget last week, it is time to share some initial reactions.

Continue reading "A Population Health Perspective on the Wisconsin Budget" »

Posted on 03/09/2011 in Harnessing and Allocating Resources | Permalink | Comments (4) | TrackBack (0)

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Quick Hits on the Population Health Radar (March 9, 2011)

The *New York Times* published an interactive map of the Gallop-Healthways 2010 Well-Being Index. The index is based on a quality of life survey that randomly sampled 1,000 adults each day for the past three years on a variety of topics, ranging from mental and physical health to adequacy of food and shelter to job and community satisfaction.

States' Medicaid woes continue to garner a great deal of media attention and NPR's coverage of the situation in Florida caught our attention this week. Lawmakers agree that action is necessary – 1/3 of Florida's budget is devoted to Medicaid. What they aren't agreeing on is the solution. In this feature, NPR explores the tension over Medicaid managed care.

And, in a continuing nod to National Nutrition Month, we'd like to applaud New York City Schools for the incredible work they're doing to provide students with 860,000 nutritious and delicious lunches daily -- without breaking the bank.

Posted on 03/09/2011 in Twitter Roundup: @PopHealth | Permalink | Comments (0) | TrackBack (0)

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03/03/2011

Quick Hits on the Population Health Radar

We're putting the spotlight this week on a new addition to our blogging repertoire. Our weekly "quick hits" will complement our usual content by linking to relevant and recent reports and opinions of interest in the field. We are also very interested in what our readers are finding and learning, and so hope you'll share your "quick hit" ideas with us. We welcome ideas from a wide variety of sources, including news, blogs, and the scientific literature. Read on for our first installment.

Continue reading "Quick Hits on the Population Health Radar" »

Posted on 03/03/2011 in Twitter Roundup: @PopHealth | Permalink | Comments (0) | TrackBack (0)

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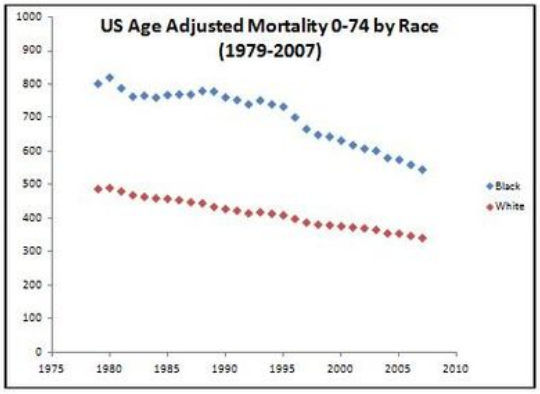
03/14/2011

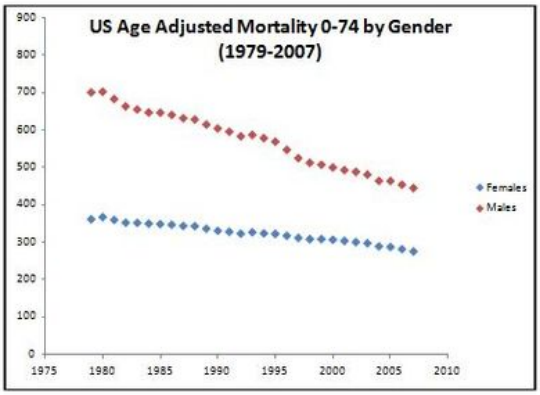
Bending Health Disparity Curves

By David A. Kindig, MD, PhD

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These days, the phrase “bending the curve” usually applies to reducing rates of health care cost increases. But look below at two other curves -- disparities in US mortality between Blacks and Whites as well as males and females from 1979 to 2007.





The figures show improvement (i.e., declining mortality) for all four groups, but the improvements are occurring at different rates (e.g., average annual rates of improvement over the period are 1.13% for Whites, 1.19% for Blacks, 1.36% for males, and 0.90% for females). The reasons for the differences are interesting and important, but not my point today. It might seem that if these trends were to continue, reduction or elimination of these disparities would happen "naturally" without additional intervention. And of course the disparity depends on both curves: if White or female rates were to improve even faster it would take even higher rates of Black or male improvement to narrow or eliminate the differences. We cannot assume that these disparities will continue to narrow over time nor should we ignore the ethical and pragmatic considerations of inaction or delay.

How rapidly should disparities be reduced? Clearly, there is no "right" answer to this question but I believe this is an important issue for communities, states, and nations to discuss explicitly and then act by adopting programs and policies help them achieve their goals. In theory, focusing available effort and resources on less healthy groups will help narrow the gaps and is particularly important in cases where disparities are increasing. For example, the gap in health between more vs. less educated people appears to be getting bigger over time instead of narrowing.

Of course the biggest challenge is what to do to improve health for the less healthy groups in order to bend the disparity curve. Here in Wisconsin, we compiled the What Works for Health database summarizing evidence on what works to *improve health*. But, despite our best intentions, we were unable to locate as much evidence on what works to *reduce disparities*. Furthermore, some programs and policies that improve overall health may actually worsen disparities. For example, media campaigns to promote smoking cessation may have the unintended effect of increasing disparities by socioeconomic status.

So, our collective challenge is to a) figure out how much of our resources we want to direct toward reducing disparities and b) find the most cost-effective ways to use those resources to narrow these gaps. Our population health research agenda must prioritize understanding what the most cost-effective disparity reduction investments are so that they may be put into practice.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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For further reading:

Koh HK, Oppenheimer SC, Massin-Short SB, Emmons KM, Geller AC, Viswanath K. (2010). Translating Research Evidence Into Practice to Reduce Health Disparities: A Social Determinants Approach. *American Journal of Public Health*, 100(S1), S72-S80.

Read JG, Gorman BK. (2011). Gender and health revisited. In BA Pescosolido, JK Martin, JD McLeod, A Rogers (eds.), *Handbook of the Sociology of Health, Illness, and Healing: A Blueprint for the 21st Century*, Part 5, 411-429.

Posted on 03/14/2011 in Defining and Measuring Health Outcomes | Permalink

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I agree that what we need to do is improve health for less healthy groups. And it is true that many public health policies and programs actually increase disparities because these policies/programs are more effective in healthier populations. But, we can do better.

We should look at each policy/program and see if it is increasing or decreasing health equity. Where it is decreasing health equity, we should modify the policy/program to address the disparity.

You mention that media programs to promote cessation are often less effective with low SES populations. How can we do better?

First, cessation advertisements can be placed where the ads reach low SES populations. This is fairly easy with radio and TV where there are good data on the demographics of viewers and listeners.

Second, cessation advertisements can be better designed to be effective in low SES populations. We should look at the language, the settings, the actors, etc. used in these ads. Of course, the ad concepts and final ads can be tested with various audiences.

On the policy front, let's look at smokefree workplace laws. In the past, many smokefree workplace laws exempted bars and restaurants. This meant that these laws were not protecting some low-income workers and certain racial/ethnic groups. Smokefree workplace laws help support people who are trying to quit smoking. And, there are data to show that low-income workers quit at the same rate as higher-income workers when their workplace goes smokefree. Removing the exemption for bars and restaurants helps increase health equity.

I believe we should look at every policy and program with an eye toward decreasing disparities. This focus on solutions can help bend the curve and lead us towards our goal of eliminating health disparities.

Posted by: Craig Mosbaek | 03/15/2011 at 09:58 AM

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03/09/2011

A Population Health Perspective on the Wisconsin Budget

By David A. Kindig, MD, PhD

Regular readers know that I often gravitate to political and fiscal issues of population health importance, such as my suggestion that Sam Brownback might be a population health governor or my commentary on the Arizona Medicaid rationing proposal. For several weeks now, several people have asked me to blog about what's been happening here in Wisconsin. With the release of the proposed budget last week, it is time to share some initial reactions.

Governor Scott Walker has proposed eliminating most of Wisconsin's $3.6 billion dollar structural deficit in two years. I've been a manager in both the public and private sector, and such situations require tough and imperfect decisions. In last fall's Wisconsin campaign, I recall Walker's Democratic opponent Tom Barrett saying he sometimes wasn't sure why he wanted the job because he knew he would have to make hard and painful decisions.

A population health perspective would argue that cuts should be made in proportion to their impact on producing health, just as when there are new resources to invest. My current sense of Governor Walker's proposed budget is that it's hard to sort out which proposals are primarily ideologic and political and which are pragmatic "least bad" choices. There is even bipartisan agreement for some proposals, such as the need for public employees to contribute more to health and pension benefits. The rationale for the most controversial element (e.g., the proposal eliminating the right for public employees to organize and bargain) is not compelling and may not itself have a substantial health impact.

However, some proposed cuts have serious health implications for Wisconsin. We know that health care access is a critical determinant of health, but that social factors like jobs and education are probably even more important. Everyone should have access to basic preventive services and have catastrophic health insurance for hospital and other health care expenses which can

bankrupt families. Reducing Medicaid eligibility is not a pro-population health policy, but if cuts are necessary, perhaps they should come from reducing less cost effective benefits…and not only for Medicaid recipients but for all covered employees (including politicians).

Jobs and income are critical determinants of health and I favor economic development investments -- but it is not clear to me that the tax cuts proposed for business will actually create jobs and increase income. The proposal to make substantial cuts to the Earned Income Tax Credit seems unfairly aimed at our state's most vulnerable population groups. I think it's also clear that cutting education and early childhood investments in the short run will reduce both health and economic productivity in the long run. A robust body of research links eliminating child poverty, lowering smoking rates, and increasing college graduation rates with improved population health.

But Medicaid, education, and social services are such large parts of state and local budgets that they can't be off the table, as Medicare and Social Security can't be for the nation. But that table should also be set with tax increases for those who can afford them, to protect programs which have put Wisconsin in the "pretty healthy" category and to keep disparities from further increasing. There is no free lunch, and we have to pay for the government we want.

I'm happy to have my state tax rate go up to help keep us from falling back. But I'd also like to see more discussion and transparency as these decisions are made. I'd like to see a state deficit calculator like the *New York Times* developed for the federal deficit (you-fix-the-deficit puzzle) which invited solutions from citizens to legislators to balance the nation's budget through a combination of cost cutting and revenue generating options.

Perhaps we should recruit the Watson supercomputer to go beyond Jeopardy and be put to good use on these issues.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 03/09/2011 in Harnessing and Allocating Resources | Permalink

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As usual a very measured and reasonable response. It is not however clear that the budget represents the thinking of reasonable people. Therefore the question inevitably is what do we do when measured reasonableness fails?

Posted by: Robert Stone Newsom, PhD | 03/09/2011 at 02:45 PM

You might be interested in the Health impact assessment of the NH state budget:
•The New Hampshire Center for Public Policy Studies, a nonpartisan, independent organization that pursues data-based research on public policy issues, will develop an HIA that will inform state lawmakers on the budget process beginning January 2011 and ending in June of the same year. The HIA will evaluate proposed state budget changes and show how funding changes in these areas might affect the health of residents. A synthesis of HIA findings and recommendations will be presented at a policy forum in mid-2011 and will be made available to legislators for their consideration during the budget process. The HIA will be guided by an interdisciplinary advisory group with participants from the legislature, state agencies and several advocacy groups to maximize the effect the information has on the budgeting process.

Posted by: Pamela Russo | 03/09/2011 at 02:52 PM

Thanks for your thoughts, Dave! Was hoping you would discuss the WI budget issues through the lens of population health.

Posted by: Sarah Gollust | 03/10/2011 at 09:28 AM

Great to get your perspective on this. I think you've hit most things right on. However, I would argue that taking away people's rights to collective bargaining has the potential to have a major impact on population health. The reasons are many, but the underlying mechanisms are likely similar. This law will likely hurt strong communities within the state. Unions are examples of organizations that work for collective good of their members and can increase people's sense of job security and enfranchisement. By increasing a sense of insecurity and disenfranchisement, this law may to lead increased stress and anxiety -- known predictors of ill health. After the passage of this bill, members of these groups may feel that their voice in the democratic process has been lost. I would anticipate higher levels of depression for these folks in the coming years and would not be surprised by other negative stress-related health outcomes. In fact, one could even invision for 'spill-over' effects in which all citizens in the state may feel more anxious and insecure because of the 'example' they see in the way the unions were treated. In sum, I think this move may actually be an important contributer to the health of Wisconsin in the coming years.

Posted by: Paul Creswell | 03/11/2011 at 02:50 PM

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03/03/2011

Quick Hits on the Population Health Radar

We're putting the spotlight this week on a new addition to our blogging repertoire. Our weekly "quick hits" will complement our usual content by linking to relevant and recent reports and opinions of interest in the field. We are also very interested in what our readers are finding and learning, and so hope you'll share your "quick hit" ideas with us. We welcome ideas from a wide variety of sources, including news, blogs, and the scientific literature. Read on for our first installment.

The White House has kicked off Women's History Month with a new report called Women in America: Indicators of Social and Economic Well-Being. The report is the first of its kind in nearly 50 years and addresses a wide range of issues including income, education, employment, health, and crime/violence.

The Pump Handle blog has attracted our attention with a couple of interesting posts, including In Praise of Cohort Studies and When Public Health Budgets are Cut, Somebody Still Pays.

The Health Affairs Blog offered its most-read posts for February. The list includes Kavita Patel's Health Care in the 2012 Budget: Looking Forward and Backward and Timothy Jost's Analyzing Judge Vinson's Opinion Invalidating the ACA.

Kaiser Health News has had great coverage on states' budget struggles vis-à-vis Medicaid, including Governors' "Wish Lists," and Health Law Ups the Ante in State-Federal Budget Battle. See also the Kaiser Foundation's new report on the Top 5 Things to Know about Medicaid.

We've recently been joining the Health Wonk Review, a biweekly compendium of posts from the health policy blogosphere. Today's edition is hosted by The Lucidicus Project and features our

recent perspective on health disparities and Avik Roy's commentary on the possibility of current Wisconsin politics to trigger Medicaid reform.

And, since March is also National Nutrition Month, we thought we'd highlight a recent interview with Professor Jan Poppendieck about her latest book that rethinks school food for the 21st century and an article on how "food czars" in a handful of large U.S. cities are tackling the twin challenges of obesity and hunger.

Posted on 03/03/2011 in Twitter Roundup: @PopHealth | Permalink

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04/26/2011

ACOs and Population Health: Strong Goals, Weak Requirements





By Daniel M. Fox, PhD and David A. Kindig, MD, PhD

The Accountable Care Organizations (ACOs) described in the draft rules for the Medicare Shared Savings Program, published in the *Federal Register* on April 7, 2011, have a "three part aim": achieving "better care for individuals…better health for populations…and lower growth in expenditures." For the first time a federal program that finances health care has set improving population health as a prominent goal.

There is, however, a contradiction in how the draft rules address population health. The rules recognize that health has multiple determinants, but they make stronger demands for engaging in clinical prevention than for addressing these multiple determinants. This post gives examples of this contradiction and suggests ways to address it. We invite readers to comment and add their suggestions; and to note that the Centers for Medicare and Medicaid Services has established a deadline of June 6th for submitting comments.

That Medicare pays for and measures health care for individuals and not populations represents an inherent challenge. Moreover, ACOs can use data in medical records and claims to document the amount and quality of the health care they provide, but they must rely on other organizations to provide and document interventions that address such determinants as the safety of homes and streets, social isolation, adequate income and access to appropriate food.

Despite these constraints, the draft rules do ask ACOs to address broad determinants of population health. They must, for example, educate Medicare beneficiaries "about the upstream causes of ill health like poor nutrition, physical inactivity, substance abuse [and] economic disparities." They must establish "community health teams" that "implement interdisciplinary…care plans that

integrate clinical and community preventive and health promotion services for patients, including children" (19535).

However, the draft provisions relating to population health lack teeth. ACOs are required to "promote evidence-based medicine" in health care, but not to encourage the use of evidence-based health research in services to populations (19546). They are urged to consult state and local health departments about evaluating the "population health needs" of their patients in the context of "community health needs" but not directed to other, often richer, sources of data about population health. They must "promote patient engagement" and offer care that "incorporates the values of…transparency, individualization, recognition, respect, dignity and choice (19547) but they are not required to seek patient input on community health improvement. ACOs must "partner with community stakeholders," but they would "be deemed to have satisfied this requirement" if they merely "have a stakeholder organization serving on their governing body" (19551).

Nor do the measures the rules propose for assessing what ACOs do and how they report about "better health for populations" (19578-19591) adequately address broad health determinants. Of 39 proposed measures, 29 assess process, mainly in clinical preventive services. Only 6 of them measure patient behaviors that are risk factors for chronic disease. A single measure—of preventing falls-- acknowledges the effects of patients' physical environment on their health.

The final rules should set a reasonably high bar with respect to population health improvement without excessive fiscal or administrative burden, such as requiring ACOs to:

- Acquire and apply data about local population health status from an array of sources such as the *County Health Rankings*
- Negotiate memoranda of understanding about data sharing, referrals and coordination with community organizations that provide services that address other determinants of health than care
- Convene groups of patients and their caregivers to discuss the determinants of health in their communities and how to address them
- Educate collaborating organizations about evidence-based interventions that address multiple determinants of health and
- Provide incentives to devote a part of shared savings to local population health improvement activities

We applaud these draft provisions and recognize the health care system's critical role in population health improvement -- but stronger provisions are needed. The eventual real-world impact of these rules will largely depend on the extent to which they require action across all three pillars of the "three part aim" (which is also known as the Triple Aim model articulated by the Institute for Health Improvement).

Daniel M. Fox, PhD is President Emeritus of the Milbank Memorial Fund. David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

*****

For further reading:

Springgate BF, Brook RH. (2011). Accountable care organizations and community empowerment. *JAMA*. Published online April 19, 2011.

Iglehart JK. (2011). The ACO regulations - some answers, more questions. *NEJM*. Published online April 13, 2011.

Berwick DM. (2011). Launching accountable care organizations - the proposed rule for the Medicare shared savings program. *NEJM*. Published online March 31, 2011.

Posted on 04/26/2011 in The National Policy Front | Permalink

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Comments

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I'd agree with the merit of most of the contentions Dan and David raise, but I think that many communities can't even get started. In my reading of the regulations, the anti-trust provisions have effectively wiped out the possibility of ACOs working across whole communities except for rural and single-hospital areas. The illusion of competition being important is striking down efforts to integrate across time and providers. I call it an illusion because I do not see the price competition for care plans for Alzheimers, strokes, and frailty generally.

I am not sure I am right, having no experience yet with anti-trust, but I do think that one strategy might be to engineer a more reasonable assessment of the merits and nature of competition as a price control. In the current rules, what matters is the combined market force of hospitals in each of a score of service lines. However, the very patients who most need integrated care are also people for whom the government already picks up most of their costs. Thus, we already have other ways to set prices for the elderly and frail and probably also for maternal-infant care. Medicare (and the VA) covers more than 80% of us as we come to the end of life, and now more than half of all babies are born in Medicaid (and another sizable group in DoD). One might argue for the FTC and DOJ to split off some populations in the Bridges to Health population segmentation model (http://www.milbank.org/quarterly/8502feat.html) and acknowledge that a community-wide approach might not run afoul of the antitrust laws because we have other governmental ways to set prices.
Some such approach is important because the best work available on improving care across settings relies upon community cooperations in setting standards, building information exchange, and learning to support self-care as a public health endeavor.

Posted by: Joanne Lynn | 05/01/2011 at 10:38 PM
The development of ACOs could be the occasion of important community organization activity especially in regard to the health of individuals within a given geographical/political jurisdiction(s). Promoting public health by identifying and modifying the particular determinants of good or bad outcomes would "take a village"! Multiple agencies each with its own agenda and funding streams as well as overlapping general purpose governmental structures each with many special purpose agencies leaves the health of the population as a whole as no one's responsibility. Since ACO development proposes a new "structure" with many interested parties (would you believe some of whom may not have "the common good" or "common goods" like the health of the population at the center of their concern) it might be the time to call to the attention of the community that these new entities both in and of themselves but as potentiating essential building blocks in community development and well being. The health of the public and its determinants should be all agencies' agendas. However what is needed is somebody(ies)to bring the community together.

Perhaps this could be the stuff of a Pulitzer Prize were a local newspaper to take this on as a cause.

Posted by: Charles Fahey | 05/03/2011 at 09:34 AM

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04/20/2011

The National Prevention Strategy Framework: Applause and Critique

By David A. Kindig, MD, PhD

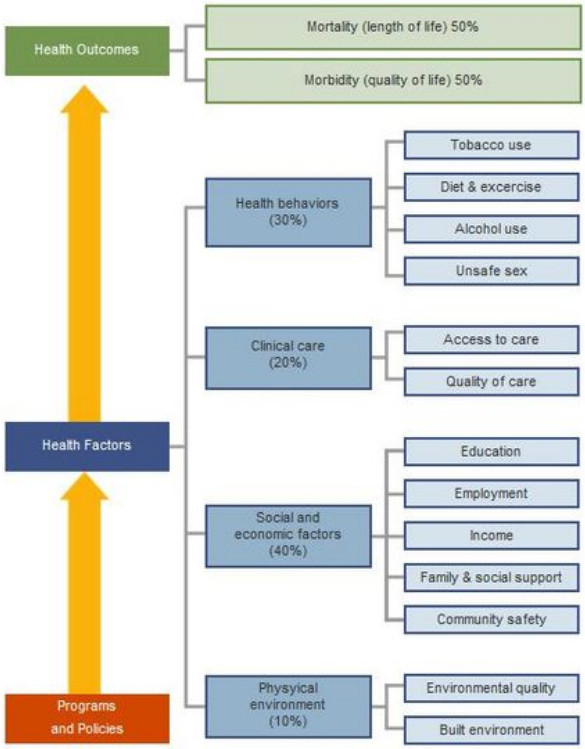
Last week the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health Council met for the first time and discussed its draft National Prevention Strategy Framework.

This Council and Strategy represent an unprecedented opportunity. By emphasizing integration across federal departments, the Council creates the possibility for a Health-in-All possibilities approach to health improvement that embraces a robust population health framework. The Advisory Group is ably chaired by Jeff Levi, CEO of the Trust for America's Health (TFAH). He and TFAH have been critically important in the efforts to promote prevention and public health in health reform and other federal budget efforts.

Given my outcomes focus, I am very pleased with the overall goal to "increase the number of Americans who are healthy at age 85" (defined as the percentage of those who reach age 85 and report being in good health). I am similarly pleased to see the elimination of health disparities as one of four main "pillars," but note that no metrics or time frame have yet been identified. This will be a critical task for the Council and Advisory group in future work.

Population health advocates should applaud the Framework's call for Healthy Environments as a "Cross-cutting Priority," acknowledging that "good physical and mental health depend on affordable and secure housing; sustainable and economically vital neighborhoods that provide access to employment opportunities and public resources (e.g. efficient transportation, good schools, and effective policing)." With respect to the "Targeted Priorities," however, advocates may be concerned by the focus (as framed by Healthy People 2020) on lifestyle and individual behavior. Improving health behaviors is important, but we can't ignore the role that social and environmental factors play in tobacco use, diet and physical activity patterns, and other targeted behavioral priorities. This concept is reflected in the *County Health Rankings* model, which assigns greater value to social, economic, and environmental factors (50% total) than to health

behaviors (30%).



It would be a shame for the Cross-cutting Priorities to get sidelined by interest group advocacy for the Targeted Priorities. To protect against this, care should be taken to develop and track specific measures to help the Cross-cutting Priorities maintain an elevated profile.

While the draft doesn't specifically mention early childhood and prenatal environments, these deserve significant attention given their long term health impacts. Also, the draft adopts a somewhat narrow view of healthcare, which is only addressed through the Cross-cutting Priority of Clinical Preventive Services. While it might be argued that healthcare is getting sufficient attention via the Affordable Care Act, this Strategy Framework represents a key opportunity for integration (including linkage to health insurance and Community Benefit reform, as well as health care quality improvement). Finally, health care cost containment should be viewed as a community prevention opportunity strategy, as these growing expenditures necessarily limit broad population health investment opportunities.

Those concerned about population health improvement should celebrate the nature and scope of our emerging National Prevention Strategy, follow it closely, and seek out opportunities to support and strengthen it as it evolves.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 04/20/2011 in The National Policy Front | Permalink

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Hi Dave -

What is the progress in knowing what % of health outcomes are attributable to the four broad domains representing the multiple determinants of health? What's the basis of the percentages you used in this blog post?

I agree with the principles and broad perspectives but am curious about the evolving science.

Posted by: Helene Nelson | 04/20/2011 at 05:52 PM

Helene, thank you for the thoughtful and important question. As you imply, the science is less than we would want, which is the reason for the commentary I wrote in JAMA last fall with John Mullahy calling for an expanded approach to comparative effectiveness research (http://jama.ama-assn.org/content/304/8/901.extract). For the County Health Rankings, we use a combination of existing evidence and expert opinion, this is summarized on the Rankings website in a working paper(http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf). With regard to behaviors and SES, the recent work of Paula Lantz and colleagues (http://www.improvingpopulationhealth.org/blog/2010/11/individual_responsibility.html) is about the best available.

Thanks for reading and please keep commenting!

Posted by: David Kindig | 04/25/2011 at 05:44 AM

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04/14/2011

Population Health Disparities: Rates or Burden?

By David A. Kindig, MD, PhD

In my March 14 post Bending Health Disparity Curves, I focused exclusively on differences in mortality ***rates,*** such as deaths per 100,000 persons. Rates are very useful measures, because they allow comparison across populations of different sizes. But from a population health perspective, rates alone are not enough, because large disparities in very small populations have a different impact than similar disparities in larger populations. Burden refers to the impact of a health problem in a population, combining both the rate and the number of people affected.

Although our disparities focus tends to be on race and ethnicity, disparities also exist in other domains such as geography, socioeconomic status, and gender. The table below shows a surprisingly high male mortality rate, but it is the size of this population (146 million) that transforms the rate into a significant population health burden.

	Mortality rate per 100,000*	Population Size
Black	1009	39 million
White	780	240 million
Male	945	146 million

Female	672	150 million

*Average rate 2003-2007. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2007. CDC WONDER On-line Database, compiled from Compressed Mortality File 1999-2007 Series 20 No. 2M, 2010.

The table above reveals disparities related to race and gender that are far more complex than I can do justice to in this brief post. However, this issue of rate vs. burden applies across disparity domains. In Wisconsin, for example, there is a similarly large mortality gap in education. Mortality rates among the 44% of the working-age population with high school or less education are significantly higher than rates among college graduates.

This does not mean that smaller populations with large rates should be ignored. As Keppel and colleagues point out, *"rates among small groups, such as the Asian and American Indian or Alaska Native populations, will seldom be high enough to warrant population-specific interventions based on reduction in total burden alone. An independent commitment to the goal to eliminate disparities would be required to warrant intervention with small racial and ethnic groups."*

However, in a resource limited world, choices will have to be made. As Keppel et al again point out, "*sizable reductions in both disparity and total burden can result when the largest group has the worst rate and effective interventions are targeted to that group*." We need to engage in robust discussion about priorities for overall outcomes versus disparity reduction, and then get quickly to identifying resources to achieve these ends. Attention to both rates and burden will be required to make the best decisions in such a process.

P.S. Feel free to comment about issues around rates versus burden, the appropriate balance between improving overall health and reducing inequities, whether you think male mortality rates are disparities or inequities (see below), or about anything else in the blog as well.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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For further reading:

The CDC's recent Health Disparities and Inequalities Report offers some helpful definitions for those with an interest in terminology:

- Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.
- Health inequalities (sometimes used interchangeably with health disparities) is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual or group-specific attributes (e.g., income, education, or race/ethnicity).
- Health inequities are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.

Keppel K, Bilheimer L, Gurley G. (2007). Improving population health and reducing health care disparities. *Health Affairs*, 26(5), 1281-1292.

Rogers RG, Everett BG, Onge JMS, Kueger PM. (2010). Social, behavioral and biological factors, and sex differences in mortality. *Demography*, 47(3), 555-578.

Pinkhasov RM, Shteynshlyuger A, Hakimian P, Lindsay GK, Samadi DB, Shabsigh R. (2010). Are men shortchanged on health? Perspective on life expectancy, morbidity, and mortality in men and women in the United States. *International Journal of Clinical Practice*, 64(4), 465-474.

Posted on 04/14/2011 in Defining and Measuring Health Outcomes | Permalink

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Readers may also find this report on "variation" useful:

http://www.kingsfund.org.uk/publications/healthcare_variation.html

Posted by: Robert Stone Newsom, PhD | 04/14/2011 at 01:58 PM
Interesting posting David thank you. How big does a population need to be for a rate to become/"qualify" as a burden? And can one assume that the answer varies across measures, i.e. is different for mortality than for disease prevalence ot incidence?

Posted by: Dominique Kim | 04/18/2011 at 07:31 PM
Dominique, thanks for reading the blog and taking the time to comment. I don't think there is some absolute cutoff where burden becomes important...it is just that with larger populations similar disparities have a greater impact on overall health (think rate X number of people in the group). I regret having to often use mortality rates as the indicator (because that data is often more available and valid for populations), but non mortality measures are also very important as you suggest. I don't however believe that rate vs burden considerations would differ between them.....I'd be interested in your or others views on this.

Posted by: David Kindig | 04/19/2011 at 04:45 PM

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Posts from April 2011

04/29/2011

Spring Has Sprung for the Health Wonk Review

While many of us were still wearing our winter coats this week in Wisconsin, spring sprung over at the Health Wonk Review. The new issue, hosted by the Incidental Economist, features our recent post by Daniel Fox and David Kindig on the new ACO draft rules and much more. Highlights include Leighton Ku (from the Health Affairs blog) on the history of the Medicaid program, Maggie Mahar (of Health Beat) on the market response to health care reform, and Avik Roy (of Forbes) on escalating healthcare costs in the U.S. vs. Britain.

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04/26/2011

ACOs and Population Health: Strong Goals, Weak Requirements




By Daniel M. Fox, PhD and David A. Kindig, MD, PhD

The Accountable Care Organizations (ACOs) described in the draft rules for the Medicare Shared Savings Program, published in the *Federal Register* on April 7, 2011, have a "three part aim": achieving "better care for individuals…better health for populations…and lower growth in expenditures." For the first time a federal program that finances health care has set improving population health as a prominent goal.

There is, however, a contradiction in how the draft rules address population health. The rules recognize that health has multiple determinants, but they make stronger demands for engaging in clinical prevention than for addressing these multiple determinants. This post gives examples of this contradiction and suggests ways to address it. We invite readers to comment and add their suggestions; and to note that the Centers for Medicare and Medicaid Services has established a deadline of June 6th for submitting comments.

Continue reading "ACOs and Population Health: Strong Goals, Weak Requirements" »

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04/20/2011

The National Prevention Strategy Framework: Applause and Critique

By David A. Kindig, MD, PhD

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This Council and Strategy represent an unprecedented opportunity. By emphasizing integration across federal departments, the Council creates the possibility for a Health-in-All possibilities approach to health improvement that embraces a robust population health framework. The Advisory Group is ably chaired by Jeff Levi, CEO of the Trust for America's Health (TFAH). He and TFAH have been critically important in the efforts to promote prevention and public health in health reform and other federal budget efforts.

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Medicare Cost-Cutting Controversy

By David A. Kindig, MD, PhD

A front page article in today's *New York Times* discusses the controversy over the yet to be appointed Medicare Payment Board. Readers may recall that I have previously and strongly advocated for eliminating Medicare (and non Medicare) expenditures that are wasteful and ineffective (see Controlling Healthcare Expenditures and Can Rationing Be Rational?). Yesterday, *New York Times* columnist David Leonhardt was awarded a 2011 Pulitzer Prize for work that included his deficit reduction interactive puzzle. Of 39 choices provided by the puzzle, a cap to Medicare spending (tied to 1% over GDP per capita) yielded the greatest projected cost savings and eliminated over 40% of the deficit. This option was an overwhelming favorite among those who preferred spending cuts over tax increases.

Most serious commentators have indicated that Medicare cost savings of some kind are necessary. Population health advocates see the potential for using these savings in part to rebalance our health investments and expand resources for prevention and the social determinants of health. Those opposing regulatory intervention when and where market forces are inadequate have a responsibility to show how other approaches will produce the needed results.

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04/12/2011

Disparities Dialogue

By David A. Kindig, MD, PhD

Over the past couple of months, I've given some attention to the issue of health disparities by asking how we should focus our efforts and giving a perspective on bending health disparity curves.

I always appreciate when readers respond, whether to agree, disagree, or offer an alternative perspective and I'd like to share a couple of comments on the disparities posts that expand on my ideas.

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04/04/2011

Honoring Population Health Heroes for National Public Health Week



By Kirstin Q. Siemering, DrPH, RD

Each year, the first week in April marks National Public Health Week (NPHW). NPHW was created in 1995 with a proclamation by President Bill Clinton who called upon "all Federal, State, and local public health agencies to join with appropriate private organizations and educational institutions in celebrating this occasion with activities to promote healthy lifestyles and to heighten awareness of the many benefits good health brings."

The NPHW proclamation underscores a major theme of this blog: that health for all remains a key challenge of our times, despite rapid advancement of healthcare technologies. Efforts to "build healthy communities, meet the needs of our diverse population, plan appropriate responses to natural disasters, educate individuals about workplace hazards, and encourage responsible behavior in all that we do" are as critical for this 16th annual NPHW as they were for the first.

Continue reading "Honoring Population Health Heroes for National Public Health Week" »

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Food Assistance: Growing Need, Shrinking Resources

Food assistance programs have had a high profile lately. Participation in the SNAP Program (Supplemental Nutrition Assistance Program) – better known as food stamps – is at an all-time high and the House is considering cutting benefits. As the debate continues, we'd like to highlight a couple of resources that may be of interest to readers:

The Map the Meal Gap interactive feature developed by Feeding America allows communities to look at food insecurity at both state and county levels.

A recent Institute of Medicine (IOM) workshop summary examined priorities for research, policy, and practice to help understand the complicated relationship between food insecurity and obesity. This workshop was held in November, 2010 at the request of the United States Department of Agriculture's Food and Nutrition Service and the report was released last month.

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04/01/2011

Mobilizing Action Toward Community Health: Community Grants Program

A new Community Grants program from the Robert Wood Johnson Foundation (RJWF) called Mobilizing Action Toward Community Health (MATCH) will help spark action in communities to address the many factors that influence health. As the *County Health Rankings* illustrate, social and economic factors such as education and employment can affect health directly and indirectly, and those negative effects may accumulate over individuals' lifetimes and continue unbroken through generations. The first round of the Community Grants program is open to communities that are ready to take action to address the social and economic factors that affect health—factors which have a significant impact on health outcomes, yet are often ignored in community health improvement activities.

An informational web conference will be held on April 5, 2011 at 2 pm ET (registration required); brief proposals are due April 27, 2011.

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I always appreciate when readers respond, whether to agree, disagree, or offer an alternative perspective and I'd like to share a couple of comments on the disparities posts that expand on my ideas.

Craig Mosbaek wrote that *"I agree that what we need to do is improve health for less healthy groups. And it is true that many public health policies and programs actually increase disparities because these policies/programs are more effective in healthier populations. But, we can do better. We should look at each policy/program and see if it is increasing or decreasing health equity. Where it is decreasing health equity, we should modify the policy/program to address the disparity."*
Likewise, Ed Donovan wrote, "*I agree that focusing directly on racial disparities in health often helps identify obstacles rather solutions. Focusing rather on the social and physical environmental determinants of health may help directly answer the "what's in it for me" question and indirectly address racial/ethnic disparities."*

In addition to working to address both overt and subtle forms of racism in our society, we must also recognize that income and education are powerful drivers of health regardless of race and ethnicity. A commitment to strengthening policies that bolster access to adequate income, employment, education, and early childhood opportunities will lift all boats, and improve overall health as well as health reduce disparities.

As Craig and Ed remind us, we need to be deliberate and broad-minded in our approach.

*****

In recent and related news, HHS Secretary Sebelius announced last week the release of two strategic plans aimed at reducing health disparities.

The *HHS Action Plan to Reduce Health Disparities* outlines the role to be taken by the federal government, while the *National Stakeholder Strategy for Achieving Health Equity* focuses on recommendations for public and private sector initiatives.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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This year's calendar of events reveals an impressive array of educational and celebratory activities from coast to coast (and Hawaii) to mark this year's "Safety is No Accident" theme. While scanning the week's planned video series, essay contests, and health fairs, we noticed a couple of interesting efforts to leverage the energy of NPHW to expand the spotlight beyond governmental public health.

The Michigan Department of Community Health (MDCH) annually recognizes "Hometown Health Heroes" and "Public Policy Champions." Contributions from last year's heroes ranged from establishing and operating free clinics to spearheading the development of a 48-mile nature trail in the Upper Peninsula. Policy champions were lauded for their leadership in passing smoke-free air legislation.

Elsewhere, both Multnomah and Clackamas Counties in Oregon honor public health heroes. Criteria for nomination include individuals or organizations that:

- Make a significant difference in the lives of the people served
- Build on individual and community strengths and assets
- Mobilize individuals and community groups to work in collaboration and cooperation
- Are unique, innovative or fill an identified gap in a specific community
- Are characterized by social justice and a celebration of diversity

In Multnomah County, awards are given in different categories, for community and policy leaders, county employees, businesses, community-based organizations, and youth or youth groups. 2010 Public Health Heroes include a former Pulitzer Prize-nominated newspaper columnist and domestic violence advocate, a program director at the Oregon Environmental Council, the Director of Health Centers Operations, the Multnomah Youth Commission, the Coalition for a Livable Future, and the Oregon Museum of Science and Industry.

As we work to improve awareness of local-level health needs and unacceptable disparities, we applaud strategic and creative efforts to foster the sense that we each have a vital role to play in building healthy communities. So, in honor of 2011 National Public Health Week, we tip our hats to sung (and unsung) "Population Health Heroes" in every state, county, and sector – who are yours?

Kirstin Q. Siemering, DrPH, RD is a Researcher with the University of Wisconsin Population Health Institute.

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05/31/2011

Have You Heard of "Primordial Prevention"?



By David A. Kindig, MD, PhD

I never had, until I started thinking about a post on prevention and went to John Last's *Dictionary of Epidemiology* to get started. His basic definition is "actions aimed at eradicating, eliminating, or minimizing the impact of disease or disability," and includes primary, secondary and tertiary prevention. Last defines primary prevention as "protection of health by personal and communal efforts such as enhancing nutritional status, immunizing against communicable diseases, and eliminating environmental risks such as contaminated water supplies."

I've given a lot of thought to the issue of prevention this spring, especially since writing about the National Prevention Council's Strategy Framework. In that post, I applauded the Framework's call for Healthy Environments (such as affordable housing, employment opportunities, efficient transportation, good schools, and effective policing) but cautioned against interest group sidelining of these "Cross-cutting Priorities" in favor of the seven behavior-related "Priority Areas" which are more closely related to the primary prevention definition shown above.

I was pleased with the Council's May 24 Webinar discussion, which indicated a new recommendation in the "Empowered People Strategic Direction" to include "improving income, education, and employment opportunities." I believe critical upstream factors should be central to all models of health, from the Prevention Framework to the Triple Aim. In the CDC's Community Guide to Preventive Services, the Social Environment is one of 18 topics with systematic reviews. Yet only three reviews currently exist in this critical area: early childhood, culturally competent healthcare, and housing. The brevity of the list speaks volumes to what we consider important and where we have invested our research dollars.

So I was delighted to read that John Last's definition of prevention includes a relatively recent classification called "primordial prevention":

> *Primordial prevention…aspires to establish and maintain conditions to minimize hazards to health…it consists of actions and measures that inhibit the emergence and establishment of environmental, economic, social and behavioral conditions, cultural patterns of living known to increase the risk of disease.*

This is, of course, the basic message of Link and Phelan's seminal article on social conditions as fundamental causes of disease. I am a strong proponent of precision with terminology, because understanding informs and drives action. I sometimes worry that the more classic definition of prevention is too rooted in the lifestyle modification efforts of the past 40 years so that equal attention is not given to the upstream social determinants -- or that it leads to taking the comfortable position that since improving income and education is so difficult we leave it to others (such as letting the Treasury and Federal Reserve worry about unemployment for us).

I hope no one doubts that I strongly support the work of the National Prevention Council and consider its strategy work fundamental to improving population health. But I also hope that a limited understanding of its name doesn't get in the way. The Council cannot fulfill its cross-sectoral purpose unless specific goals and objectives for educational quality, for job creation and economic development, and for controlling health care costs are given equal or higher priority as those for immunizations, food deserts, smoking, and physical activity.

The time has come for "primordial prevention" to take center stage, along with public and private policy and resource allocation to reflect improved understanding of the many factors that drive health.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 05/31/2011 in Population Health Basics | Permalink

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I think fellow public health advocates need to take a look at the Social Innovation sector as possible sources of great primordial prevention projects and data. eg. http://www.tacsi.org.au
http://www.asix.org.au/
http://www.socialinnovationexchange.org/
And even G8: http://www.g20-g8.com/g8-g20/g8/english/live/news/renewed-commitment-for-freedom-and-democracy.1314.html

Posted by: Kay Walker | 06/01/2011 at 07:10 PM

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05/24/2011

Business Investment in Early Childhood: Making Future Workers Healthier



By David A. Kindig, MD, PhD

Six months ago, I blogged about a child health research conference I attended and concluded that *"we know enough right now to predict that doing nothing will result in poor adult health outcomes of babies being born today. Aside from the obvious moral dimensions, my main argument for expediency is pragmatic: the health and economic competitiveness of our nation over the next 50-100 years is at stake. Surely investing in maternal and early childhood health should be a priority."*

This perspective is rooted in idea that upstream social and economic factors such as income and education are critical drivers of health. Interventions in these areas are often assumed to be the purview of the public and non-profit sectors, but this is a limited view. For-profit activity in economic development and job creation are just as important as anti-poverty public policies and programs such as the Earned Income Tax Credit (EITC). I believe that measurable and comprehensive population health improvement requires a long-term commitment of resources – we need to focus on creating and sustaining funding streams for the long haul.

From an early childhood education perspective, I was heartened to see our politically moderate *Wisconsin State Journal* address the issue in a recent editorial: "A Business Lead on Education: Early Learning is Cost-Effective and Will Boost Wisconsin's Future Work Force." The piece called attention to a summit which brought together child advocates and economic development groups to promote business involvement and private investment in efforts to promote early learning. The editorial concluded that *"despite Wisconsin's budget struggles, our state can't afford not to focus intently on getting young children off to a strong start leading to successful careers and a stronger state economy."*

While the editorial didn't specifically mention the health effects of early childhood programs, they are well-documented and account for a major part of the long-term impact on a productive future

workforce. I applaud the growing numbers of employers promoting employee wellness and fitness and rewarding healthy behavior choices. But the healthy choice is not often easy to make, particularly among lower SES populations. We need to cultivate business sector buy-in to the notion of shared responsibility for education; strategic investments now will pay off in the form of a healthy and productive workforce in years to come.

In a 2010 MATCH essay, the head of the National Business Coalition on Health said it this way: *"a compelling business case can and should be made for business leaders to look beyond the worksite to the communities where their organizations do business and their employees reside. Business leaders must understand that an employer can do everything right to influence the health and productivity of its workforce at the worksite, but if that same workforce lives in unhealthy communities, employer investments can be seriously compromised."*

Improving community health is a complex enterprise needing involvement and collaboration across many sectors. While no clear organizing entity has yet emerged, we will not get there without robust private sector support and financing that goes beyond job creation to upstream investments in education, particularly for early childhood.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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By David A. Kindig, MD, PhD

I never had, until I started thinking about a post on prevention and went to John Last's *Dictionary of Epidemiology* to get started. His basic definition is "actions aimed at eradicating, eliminating, or minimizing the impact of disease or disability," and includes primary, secondary and tertiary prevention. Last defines primary prevention as "protection of health by personal and communal efforts such as enhancing nutritional status, immunizing against communicable diseases, and eliminating environmental risks such as contaminated water supplies."

I've given a lot of thought to the issue of prevention this spring, especially since writing about the National Prevention Council's Strategy Framework. In that post, I applauded the Framework's call for Healthy Environments (such as affordable housing, employment opportunities, efficient transportation, good schools, and effective policing) but cautioned against interest group sidelining of these "Cross-cutting Priorities" in favor of the seven behavior-related "Priority Areas" which are more closely related to the primary prevention definition shown above.

Continue reading "Have You Heard of "Primordial Prevention"?" »

Posted on 05/31/2011 in Population Health Basics | Permalink | Comments (1) | TrackBack (0)

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05/24/2011

Business Investment in Early Childhood: Making Future Workers Healthier



By David A. Kindig, MD, PhD

Six months ago, I blogged about a child health research conference I attended and concluded that *"we know enough right now to predict that doing nothing will result in poor adult health outcomes of babies being born today. Aside from the obvious moral dimensions, my main argument for expediency is pragmatic: the health and economic competitiveness of our nation over the next 50-100 years is at stake. Surely investing in maternal and early childhood health should be a priority."*

This perspective is rooted in idea that upstream social and economic factors such as income and education are critical drivers of health. Interventions in these areas are often assumed to be the purview of the public and non-profit sectors, but this is a limited view. For-profit activity in economic development and job creation are just as important as anti-poverty public policies and programs such as the Earned Income Tax Credit (EITC). I believe that measurable and comprehensive population health improvement requires a long-term commitment of resources – we need to focus on creating and sustaining funding streams for the long haul.

Continue reading "Business Investment in Early Childhood: Making Future Workers Healthier" »

Posted on 05/24/2011 in Harnessing and Allocating Resources | Permalink | Comments (0) | TrackBack (0)

| Twee

On the Population Health Radar: Complete Streets

The National League of Cities has just reported the introduction of the Safe and Complete Streets Act of 2011 by U.S. Representatives Doris Matsui (D-Calif.) and Steve LaTourette (R-Ohio). The bill requires that new street and transportation projects undertaken by state departments of transportation (DOT) and metropolitan planning organizations (MPOs) be designed with "pedestrians, bicyclists, public transit users, children, older individuals, individuals with disabilities, motorists, and freight vehicles" in mind. It also calls for consideration of the "safety and convenience" of all users in "all phases of project planning and development."

This represents a major accomplishment for the National Complete Streets Coalition, which advocates for the building of road networks that are safer, more livable, and welcoming to everyone. The Coalition recently released its 2010 Complete Streets Policy Analysis: A Story of Growing Strength, which provides an analysis of the more than 200 Complete Streets policies adopted prior to January 1, 2011. The report provides a wealth of information and examples for jurisdictions considering adoption of Complete Streets policies.

Vermont is the most recent state to enact Complete Streets legislation; three other states have statewide laws: Connecticut, Hawaii, and New Jersey.

Posted on 05/24/2011 in Twitter Roundup: @PopHealth | Permalink | Comments (0) | TrackBack (0)

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05/18/2011

A Year in the Blogosphere



By David A. Kindig, MD, PhD

This week, we're celebrating the first anniversary of Improving Population Health. We began last May with a post on population health advocacy that asked, "Is Population Health Finally Coming into Its Own?" That post outlined the blog's purpose:

Why am I starting a blog on issues and perspectives in the field of population health? It is because I believe we are at a "tipping point" in which a convergence of scholarship, policy, and practice initiatives seem poised to bring an overdue population health perspective to thinking about and acting on health and health improvement. The challenge of the next decade will be to find practical ways in which new approaches to financial and non-financial incentives and multi-sectoral partnerships can be applied to improve population health outcomes here and elsewhere.

Continue reading "A Year in the Blogosphere" »

Posted on 05/18/2011 in Population Health Basics | Permalink | Comments (0) | TrackBack (0)

| Twee

On the Population Health Radar: Healthcare and Community Development

The launch of our new Eye on Population Health series provides a great forum for showcasing noteworthy efforts to help people live longer, healthier lives. But we're not the only ones with a mission to get the word out. With our "quick hits," we'll continue to link to ideas and accounts that reflect the state of population health in the U.S. and beyond.

This week's highlights:

On the Health Affairs Blog, the Indiana Health Information Exchange's Chris Schultz gives a promising status update on the Quality Health First (QHF) Program.

Kaiser Health News reports on the Voices of Detroit Initiative, an effort that is succeeding in moving underserved patients out of emergency rooms and into medical homes.

Some readers may recall last year's post, "Population Health and the Federal Reserve…Are You Kidding?" Work on this front continues with Health Affairs' recent announcement that the November 2011 issue will feature an article cluster on community development and health. Publication of this cluster is being sponsored by the Robert Wood Johnson Foundation (the foundation is also collaborating with the Federal Reserve on a larger, related project). Submissions are due no later than July 5, 2011.

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05/10/2011

Dialogue on ACO Draft Rules



Dan Fox's recent post on the new draft rules for Accountable Care Organizations (ACOs) caught the attention of Charles Fahey, who observed that "multiple agencies each with its own agenda and funding streams as well as overlapping general purposes....leaves the health of the population as a whole as no one's responsibility." Fahey's comment has relevance to today's post on the accountability framework proposed by the IOM and also brings to mind a couple of pieces in the archives (see Obstacles to Population Health Policy: Is Anyone Accountable? and Do We Need a Population Health Super-Integrator?)
This policy and funding integration question remains one of the largest challenges for our field, since improvement requires action from multiple determinant sectors such as health care, public health, health behaviors, and those influencing the social and physical environments.

Posted on 05/10/2011 in The National Policy Front | Permalink | Comments (0) | TrackBack (0)

| Twee

IOM: Measurement for Accountability in Public Health



By David A. Kindig, MD, PhD

I was privileged to appear last week before the Institute of Medicine (IOM) Committee on Public Health Strategies to Improve Health. The purpose of the meeting was to gather testimony for its third report (due out later this year), which will develop recommendations for funding state and local public health systems after health reform.

In preparation for my presentation, I reviewed the first report in this series, released December 2010, called For the Public's Health: The Role of Measurement in Action and Accountability (the second report on statutes and regulations is currently under IOM review). The report has three main chapters, including: (1) Needed: An information Enterprise to Drive Knowledge and Population Health Improvement, (2) Measuring Health for Improved Decisions and Performance, and (3) Measurement and Accountability. Given the report's strong population health message, I am focusing this post on a few of its key findings and recommendations.

Continue reading "IOM: Measurement for Accountability in Public Health" »

Posted on 05/10/2011 in Defining and Measuring Health Outcomes | Permalink | Comments (1) | TrackBack (0)

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Academy Health Pre-Conference on Community Benefit (June 11)



Readers may recall last summer's post calling for population health advocates to send comments into the IRS regarding the Community Benefit provisions of the tax code. While no IRS revisions have yet been announced, there is great potential for this stream of funding to enhance population health investments as the uninsured gain coverage.

To explore these issues more fully, St Louis University and the Hilltop Institute are sponsoring a one day Academy Health pre-conference on Community Benefit June 11 in Seattle. Information can be found here. I'll be moderating an afternoon panel and would love to see many of you there.

Posted on 05/10/2011 in The National Policy Front | Permalink | Comments (0) | TrackBack (0)

| Twee

05/04/2011

Introducing New Series with an "Eye on Population Health"



This week, we are launching a new blog series with a Population Health Eye on Oklahoma. Our goal with this new "Eye on Population Health" series will be to highlight population health improvement efforts with a real-world perspective on people, places, policies, and programs at both local and state levels. My Associate Editor, Kirstin Siemering, DrPH, will be taking the lead with the new series as we broaden our lens to highlight a variety of practical applications of population health principles.

Posted on 05/04/2011 in Policy and Systems Change in Action | Permalink | Comments (0) | TrackBack (0)

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Population Health Eye on Oklahoma



By Kirstin Q. Siemering, DrPH, RD

Oklahoma is one of the least healthy states in the country. In 2010, it ranked 46 in America's Health Rankings (AHR), beating out only Nevada (47), Arkansas (48), Louisiana (49), and last place Mississippi (50). Oklahoma has struggled for some time: the state's age-adjusted mortality rates have been consistently higher than the national average since 1981. Among Oklahoma's health challenges, tobacco is arguably one of its most serious. In the 2010 AHR, Oklahoma ranked 49 for smoking prevalence, with only 0.2% separating it from lowest ranked Kentucky.

Nationally, smoking prevalence has declined dramatically over the past two decades, from about 30% in 1990 to about 18% in 2010. While many states' statistics echo this trend, smoking rates in Oklahoma have held relatively steady since the mid 1990s, at about 25%. While these numbers paint a rather grim picture relative to the nation as a whole, Oklahoma's prevention investments offer hope for a brighter future.

Continue reading "Population Health Eye on Oklahoma" »

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05/10/2011

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- One recommendation calls on the Secretary of DHSS to integrate, align, and standardize health data and health outcome measurement at all geographic levels. This includes a summary measure of population health to estimate and track health adjusted life expectancy for the United States. More specifically, the recommendation calls for "unified guidance to build an actionable set of additional indicators to support community decision-making with respect to local health promoting initiatives."
- Another recommendation calls on DHSS to issue an annual report to policy makers, all health systems sectors, and the public about important trends and disparities in social and environmental factors that affect health. An additional recommendation calls in part for advancing the use of predictive and system-based simulation models to understand the health consequences of the underlying determinants of health. This is consistent with the call for broader use of comparative effectiveness research funding to inform cost-effective allocation of

resources across health care, public health, health behaviors, and the social and physical determinants of health.

- Most importantly, the last chapter (on measurement and accountability)) identifies the need for a population health accountability framework requiring agreement among health-system stakeholders on specific plans of action for health priorities and outcomes. The report suggests two types of accountability: “contract” accountability (which follows from financial and regulatory obligations), and “compact” or “mutual” accountability (for relationships among community-based stakeholders). The report includes criteria for assessing and ensuring accountability at state and local levels; for example, organizations should have a clear charge, measurement capacity, and tools to assess and improve effectiveness and quality. While not insisting organizations have financial and administrative control over resources as suggested in a Health Outcomes Trust, the measurement and accountability framework represents a major step in this direction.

I applaud the IOM and the Robert Wood Johnson Foundation for producing this important work. Population health advocates should stay tuned for the final two reports on laws and funding, which I hope will contribute additional insights and recommendations as to what can and should be done to deliver improved outcomes through measurement and accountability.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

*****

For further reading:

Kindig DA, Mullahy J. (2010). Comparative effectiveness – of What? Evaluating strategies to improve population health. *JAMA*, 304(8), 901-902.

Teutsch SM, Fielding JE. (2011). Applying comparative effectiveness research to public and population health initiatives. *Health Affairs*, 30, 349-355.

Posted on 05/10/2011 in Defining and Measuring Health Outcomes | Permalink

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Comments

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Dave,

Thank you for you comments on these reports. It underscores some important recommendations, that if acted upon, will move the field forward.

George

Posted by: George Isham, M.D. | 05/12/2011 at 02:15 PM

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Since the 1998 Master Settlement Agreement (MSA), a group of national organizations has reported annually on states' use of these funds to promote tobacco cessation and prevention. Their most recent report, entitled *A Broken Promise to Our Children: The 1998 State Tobacco Settlement 12 Years Later*, documents a disturbing trend to cut tobacco prevention dollars despite growing tax and settlement revenues. Oklahoma provides a notable exception. Over the past few years, while average state funding for tobacco prevention has declined by 22%, Oklahoma has increased its funding by 52%.

This investment is particularly impressive because it comes at a time when states are focused on cost-cutting. In fact, a 2005 case study of six states' use of Master Settlement Funds revealed a

diverse array of allocations beyond health and tobacco prevention, ranging from capital projects to budget shortfalls. North Carolina legislators are considering abolishing two trust funds (the Health and Wellness fund and the Tobacco fund) that receive half of the state's share of settlement funds.

So what did Oklahoma do differently? In 2000, they created the Oklahoma Tobacco Settlement Endowment Trust (TSET) through a constitutional amendment that requires available funds be used exclusively for supporting the health of Oklahomans. Three-fourths of all new MSA funds are preserved in trust, which has grown from $500,000 in 2003 to $18.5 million currently. TSET has adopted a broad and expanding health portfolio that includes but is not limited to comprehensive tobacco prevention. Nearly $5 million has been allocated to the new "Shape Your Future" campaign, which aims to reduce preventable deaths through social marketing, policy development and enforcement, and a focus on child health. TSET has also recently increased its reach to community-based nutrition and fitness initiatives, and this month will award about $10 million to 10 programs across the state.

The 2010-2014 Oklahoma Health Improvement Plan acknowledges the enormity of the challenge in the document's first line: "Oklahoma ranks near the bottom in multiple key health status indicators." But this is not a state that has accepted the status quo. We hope Oklahoma's strategic and democratic coup that created TSET and protected the MSA funding will result in the implementation of evidence-based programs and policies that will address many of Oklahoma's health challenges and serve as a population health improvement model for other places.

Kirstin Q. Siemering, DrPH, RD is a Researcher with the University of Wisconsin Population Health Institute.

Posted on 05/04/2011 in Policy and Systems Change in Action | Permalink

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05/18/2011

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So how is the field doing, and how are we doing here on the blog? We still lack the summary measure of population health the IOM has called for and better disparity metrics to answer this outcome question objectively and adequately, and as we have noted, measuring improvement is even more challenging than measuring achievement. While modest gains in health outcomes are occurring at the national level, there is palpable activity and support for taking action on moving the metrics and improving health.

Over the past year, we have put the spotlight on the many aspects of the Affordable Care Act that are relevant to and offer promise for population health improvement (such as the National Prevention Strategy Framework and the new draft rules for Accountable Care Organzations). Even in this time of fiscal restraint, resources are being devoted to local efforts such as the CDC Community Transformation Grants, the Robert Wood Johnson Foundation's MATCH Community Grants Program, the Institute for Healthcare Improvement's Triple Aim expansion to regional

strategy, and local efforts too numerous to list.

On the other hand, health care expenditures continue to rise, and federal and state budget cuts threaten resources for key drivers of population health such as education, employment, food security, and social support. In the May 11 JAMA, Steve Woolf aptly wrote that "too often policy makers and the public fail to recognize the connection between social and health policies, and this seems again to be true as proponents and critics of current budget reform wage their debates." I must admit to occasional pessimism when I look at the maps of health outcomes and disparities across the United States and realize the immense budgetary gaps in public health, schools, economic prosperity and early childhood programs that have created disparities that will take generations to reverse.

Here on the blog, we strive to illuminate population health issues with insights and commentary on a range of topics. We're adding new voices and new styles of posts, including our new Eye on Population Health series. In the coming months I'll be writing about policies and incentives to move the metrics, and we'll be revising and adding to our sidebar materials.

I started this blog last year with the idea that this type of forum was both needed and wanted. As we head into our second year, I am still convinced of the need and more confident of the potential. I am committed to leading and shaping this blog as a positive – and hopefully growing – force for advancing the field of population health. And, as always, I welcome your comments and suggestions.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Posts from June 2011

06/29/2011

The IOM Weighs in on Multisector Health Policy



By David A. Kindig, MD, PhD

A few weeks ago I wrote about the first report in the Institute of Medicine *For the Public's Health* series on The Role of Measurement in Action and Accountability. The second report, Revitalizing Law and Policy to Meet New Challenges was released last week. Its overall purpose is to review how statutes and regulations "prevent injury and disease, save lives, and improve the health of populations." This post will focus on the third chapter, "Intersectoral Action for Health."

There is growing consensus around the idea that multisectoral solutions are needed to address broad population health challenges. Various conceptual approaches have been suggested, such as Health Outcome Trusts, Accountable Health Communities (by Sanne Magnan, former Minnesota Commissioner of Health), and my own "Super Integrator" concept. The opportunity for the federal government to coordinate across all departments is also the charge and the promise of the new National Prevention Council. The IOM chapter on intersectoral action provides an excellent and concise summary of the evidence and arguments for such an approach, and includes three important recommendations (the report has nine recommendations altogether):

Continue reading "The IOM Weighs in on Multisector Health Policy" »

Posted on 06/29/2011 in The National Policy Front | Permalink | Comments (0) | TrackBack (0)

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Pop Health Twitter Roundup (6/29/11)

The latest and greatest from @PopHealth

- NY Times: Concerns about costs rise with hospices' use
- Geomedicine: Imagine providing physicians with info about social determinants of health
- Across Europe, stifling drivers in favor of mass transit & walking is urban policy
- Did you know the LA School District voted no on flavored milk in schools? This & much more in @RWJFCenter's weekly update
- Is bicycle commuting an under-appreciated pop health metric?
- Great interview with Austin Frakt on the contribution of blogs to research translation
- MA's new system for cutting healthcare costs not working -- cost disparities not related to quality persist
- Engaging youth in urban planning through a competition on "dream streets"

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06/22/2011

David Brooks: Pop Health Columnist?



David A. Kindig, MD, PhD

For me, reading David Brooks' twice weekly *New York Times* column is a must. Dubbed "the liberals favorite conservative," Brooks writes from a moderate and evidence based perspective that is almost always illuminating and refreshing.

In his June 13 column titled Pundit Under Protest, he complained about having to cover the upcoming Presidential campaign because "the two parties contesting this election are unusually pathetic. Their programs are unusually unimaginative. Their policies are unusually incommensurate to the problem at hand."

Brooks said that what the country needs is a political party that "would be offering a multifaceted reinvigoration agenda. It would grab growth ideas from all spots on the political spectrum and blend them together. Its program would be based on the essential political logic: If you want to get anything passed, you have to offer an intertwined package that smashes the Big Government vs. Small Government orthodoxies and gives everybody something they want."

Continue reading "David Brooks: Pop Health Columnist?" »

Posted on 06/22/2011 in The National Policy Front | Permalink | Comments (1) | TrackBack (0)

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National Prevention Strategy Released

Last week the Surgeon General and the National Prevention Council released the first National Prevention Strategy report. They are to be congratulated for this since it is a major milestone in the effort to improve population health, and should be required reading for all who share this goal. As this effort unfolds over the coming years, enhancements such as those suggested in this blog will still be required. But for now, let's read and appreciate the effort to date.

Posted on 06/22/2011 in The National Policy Front | Permalink | Comments (0) | TrackBack (0)

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Pop Health Twitter Roundup (6/22/11)

The latest and greatest from @PopHealth:

Jack in the Box will no longer offer toys in kids' meals. Great move -- will others follow suit?

Do personal health technologies contribute to health inequities? Peter Orszag weighs in

A London neighborhood creates a "Fairness Commission" to address public sector income differentials

U.S. Releases Graphic Images to Deter Smokers

A new tool for epidemiologists? Social Media.

New research on Social Security & Health: preventing poverty among seniors linked to declines in mortality

"It's everyone's responsibility and everyone's opportunity" Surgeon General on the National Prevention Strategy

KaBOOM! -- Sparking leadership and unleashing energy within to help communities create places for kids to play

Posted on 06/22/2011 in Twitter Roundup: @PopHealth | Permalink | Comments (0) | TrackBack (0)

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06/14/2011

Hospital Community Benefit: An Update on Opportunities and Challenges



By David A. Kindig, MD, PhD

Last summer, I called attention to the IRS request for comments on reporting requirements for non-profit hospitals, which must justify their tax exempt status by providing "community benefit" to the communities they serve. This is a big deal, since having this status amounts to a collective tax savings for these nonprofit hospitals of about $13 billion annually (a 2007 IRS estimate). Stories such as this one in Modern HealthCare highlight the controversial nature of this issue. Last week I attended a conference sponsored by St. Louis University and the Hilltop Institute to review current policy and research perspectives with regard to community benefit.

Continue reading "Hospital Community Benefit: An Update on Opportunities and Challenges " »

Posted on 06/14/2011 in The National Policy Front | Permalink | Comments (0) | TrackBack (0)

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Pop Health Twitter Roundup (6/14/11)

The latest and greatest from @PopHealth:

- New health policy in Ireland to focus on prevention
- *NY Times* coverage on the costs of urban diets and anti-obesity campaigns (with a focus on Louisville, KY)
- Hawaii: teacher hooks kids on running – they become "Mighty Milers" and test scores rise
- Healthy Food Financing Initiative (HFFI) brings nutritious food to 400,000 through small-scale, local establishments
- Study of preschool children shows benefits lasting into adulthood
- CDC provides updated FAQs on Community Transformation Grants
- Who is HHS Chief Technology Officer Todd Park? Check out this great feature in the *Atlantic*
- Webcasts from the 6/9/11 Health Data Initiative Forum
- The Health Care Blog hosts the 6/9/11 edition of the Health Wonk Review
- Minnesota Idea Open launches new crowdsourcing competition: CHALLENGE II to address water issues

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06/07/2011

Population Health Eye on Utah's Wasatch Front



By Kirstin Q. Siemering, DrPH, RD

When it comes to transportation policy, Utah's Wasatch Front region is a frontrunner. The Wasatch Front is an urban area in north-central Utah that consists of a chain of cities and towns stretched along the Wasatch Range. Roughly 80% of Utah's population resides in this narrow region, which contains Salt Lake City, Provo and Ogden. With strong leadership, collaboration, and advocacy, the area has become a model for transportation policy to address rapid population growth and development occurring over the last half century.

So what does this have to do with population health?

Continue reading "Population Health Eye on Utah's Wasatch Front" »

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There is growing consensus around the idea that multisectoral solutions are needed to address broad population health challenges. Various conceptual approaches have been suggested, such as Health Outcome Trusts, Accountable Health Communities (by Sanne Magnan, former Minnesota Commissioner of Health), and my own "Super Integrator" concept. The opportunity for the federal government to coordinate across all departments is also the charge and the promise of the new National Prevention Council. The IOM chapter on intersectoral action provides an excellent and concise summary of the evidence and arguments for such an approach, and includes three important recommendations (the report has nine recommendations altogether):

The committee recommends:

- *that states and the federal government develop and employ a Health in All Policies (HIAP) approach to consider the health effects—both positive and negative—of major legislation, regulations, and other policies that could potentially have a meaningful impact on the public's health.*
- *that state and local governments create health councils of relevant government agencies convened under the auspices of the chief executive; engage multiple stakeholders in a planning*

process; and develop an ongoing, cross-sector, community health improvement plan informed by a HIAP approach. Stakeholders will advise in plan development and in monitoring its implementation.

- *that state and federal governments evaluate the health effects and costs of major legislation, regulations, and policies that could have a meaningful impact on health. This evaluation should occur before and after enactment.*

If carefully and strategically implemented, these three recommendations should provide strong momentum for multisectoral collaboration for population health improvement. A report section entitled "The Role of Policy as a Determinant of Health" points out that "although many socioeconomic and environmental factors affect health, only some are under the personal control of individuals and families….in corporate boardrooms, legislatures, and the executive branches of government, decisions that ultimately affect the public's health emerge from policies that few view as health decisions." Moving to such approaches at state and local levels will be critical; whether primary responsibility for this should rest with state and local government or some broader multisectoral structure remains an open question.

The report wraps up with an appropriate warning that implementation will not be easy and that many challenges await. The report underscores that multisectoral action "cannot operate effectively without hard work to build relationships and solve interagency barriers that impede communication, collaboration, and the sharing of resources." From my perspective, the most critical task of these is a population health business model with new and realigned resources across all determinants.

Population health advocates will eagerly await the final report in this series which promises to address these serious resource challenges.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

For further reading:

Fox DM. (2006). The determinants of policy for population health. *Health Economics, Policy, and Law*, 1(4), 295-407.

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06/22/2011

David Brooks: Pop Health Columnist?



David A. Kindig, MD, PhD

For me, reading David Brooks' twice weekly *New York Times* column is a must. Dubbed "the liberals favorite conservative," Brooks writes from a moderate and evidence based perspective that is almost always illuminating and refreshing.

In his June 13 column titled Pundit Under Protest, he complained about having to cover the upcoming Presidential campaign because "the two parties contesting this election are unusually pathetic. Their programs are unusually unimaginative. Their policies are unusually incommensurate to the problem at hand."

Brooks said that what the country needs is a political party that "would be offering a multifaceted reinvigoration agenda. It would grab growth ideas from all spots on the political spectrum and blend them together. Its program would be based on the essential political logic: If you want to get anything passed, you have to offer an intertwined package that smashes the Big Government vs. Small Government orthodoxies and gives everybody something they want."

He described this reinvigoration package as four baskets (quoted below). While he sees this as an agenda for total national revitalization, think of them as you read them from a population health policy perspective.

> *There would be an entitlement reform package designed to redistribute money from health care and the elderly toward innovation and the young. Unless we get health care inflation under control by replacing the perverse fee-for-service incentive structure, there will be no money for anything else.*

> *There would be a targeted working-class basket: early childhood education, technical education, community colleges, an infrastructure bank, asset distribution to help people start businesses, a new wave industrial policy if need be — anything that might give the working class a leg up.*
>
> *There would be a political corruption basket. The Tea Parties are right about the unholy alliance between business and government that is polluting the country. It's time to drain the swamp by simplifying the tax code and streamlining the regulations businesses use to squash their smaller competitors.*
>
> *There would also be a pro-business basket: lower corporate rates, a sane visa policy for skilled immigrants, a sane patent and permitting system, more money for research.*

I am certain that Brooks was not thinking of this from a population health improvement lens, but many aspects of what he suggests support the multiple determinants of health perspective we advocate every week. Some things are missing of course like health care access, specific public health and prevention programs, and the physical environment. But the challenges are equally broad, and fresh bipartisan approaches commensurate to the scope of the problem are essential.

The contents of Brooks' baskets are certainly not new – that's not his point. No idea is immune from the capricious political processes which ultimately determine the fate of even the best proposals. Brook's major frustration is that current politics do not allow necessary action to proceed. I don't know if a new national political entity is required, or if first we need a generation of local mutisectoral partnerships with appropriate incentives to show the way. I do know that making significant improvements to population health is a huge challenge requiring action on a scale that he suggests.

So we welcome a growing list of covert population health advocates – first Sam Brownback and now David Brooks. Who's next?

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Let us know when your governor there in Wisconsin becomes a pop health advocate....

Posted by: Pamela Russo | 06/22/2011 at 12:22 PM

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06/14/2011

Hospital Community Benefit: An Update on Opportunities and Challenges



By David A. Kindig, MD, PhD

Last summer, I called attention to the IRS request for comments on reporting requirements for non-profit hospitals, which must justify their tax exempt status by providing "community benefit" to the communities they serve. This is a big deal, since having this status amounts to a collective tax savings for these nonprofit hospitals of about $13 billion annually (a 2007 IRS estimate). Stories such as this one in Modern HealthCare highlight the controversial nature of this issue. Last week I attended a conference sponsored by St. Louis University and the Hilltop Institute to review current policy and research perspectives with regard to community benefit.

From a policy perspective, Julie Trocchio, Senior Director of Community Benefit for the Catholic Health Association, reported that when the new IRS Schedule H revisions were released two months ago, some providers raised concerns about a new section asking questions related to new requirements for tax exemption in the Affordable Care Act (ACA) related to community health needs assessment, billing, collections and charges. Because of this concern, the new section will remain optional for the current year. In addition, the ACA required the IRS to provide "guidance" on community benefit separately from its Schedule H assessment; this guidance is expected soon followed by two 60 day comment periods.

Although community benefit is significantly under-researched relative to its policy importance but several research papers were presented at last week's conference; highlights include:

- From a sample of Missouri and Illinois hospitals: 77% of community benefit activities were in charity care , medical education, and unreimbursed Medicaid; 3% supported Community Health improvement activities; and 7% supported community building activities (Jason Turner and Connie Evashwick, St Louis University).

- From a sample of California hospitals: total community benefit spending was $1,146 per adjusted discharge, with $763 from government payment shortfalls, $214 from charity care, and $169 from other community benefit activity (Simone Rauscher, Georgetown University).
- Compared to for-profit hospitals, uncompensated care makes up a smaller percentage of non-profit hospitals' community benefit "portfolios" (Paula Song, Ohio State University).

Conference participants engaged in discussion regarding the policy and research challenges surrounding community benefit. Central was whether community benefit funding could become a significant and stable resource for non-healthcare community health improvement investments as the number of uninsured patients declines under health reform. I strongly believe that this type of investment is required – in addition to the vital resources currently provided by public and private grants and philanthropy.

A number of challenges will test us as we move forward with this important work. The ACA will not close all gaps and the need for uncompensated care will remain -- much of current community benefit spending supports shortfalls from government payers, which will unfortunately continue. The lack of clarity regarding exactly how much the tax exemption is really worth remains a thorny issue, along with whether one government program should fully subsidize the payment policy decisions of another. Finally, thoughtful consideration and strategy must be applied to the nature, scope, and level of direction (or regulation) of community health needs assessment, and what the relationships should be between hospitals, public health agencies, and other population health improvement stakeholders.

Stay tuned for opportunities to comment on the new IRS guidance and to support additional research to advance our understanding of this critical population health policy issue.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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06/07/2011

Population Health Eye on Utah's Wasatch Front



By Kirstin Q. Siemering, DrPH, RD

When it comes to transportation policy, Utah's Wasatch Front region is a frontrunner. The Wasatch Front is an urban area in north-central Utah that consists of a chain of cities and towns stretched along the Wasatch Range. Roughly 80% of Utah's population resides in this narrow region, which contains Salt Lake City, Provo and Ogden. With strong leadership, collaboration, and advocacy, the area has become a model for transportation policy to address rapid population growth and development occurring over the last half century.

So what does this have to do with population health?

Transportation systems are part of the "built environment," which includes all buildings, spaces and products that are created or modified by people. While the science and practice that link health and the built environment are still relatively new and emerging, there is growing support for creating transportation systems that include routes for pedestrians, bicyclists, and a variety of public transport options. The National Complete Streets Coalition has been a policy and advocacy leader in this effort. The link to healthy behaviors is clear: people need more physical activity, and one way to do this is to create environments that make walking and bicycling easy and safe. But the connection between transportation goes well beyond behavior, to critical social and economic factors that we know drive health.

Last month, the Brookings Institution released a report entitled *Missed Opportunity: Transit and Jobs in Metropolitan America*. For the report's release, Brookings' vice president and founding Director of the Metropolitan Policy Program Bruce Katz argued that "commuting in the U.S. from home to work has become an heroic act as more people are commuting further and further to

their jobs...this is becoming a burden many families cannot afford" (please see 2 minute video below for additional remarks). The report profiled the nation's largest 100 metropolitan areas to see how well public transportation connects people to jobs. Cities on the Wasatch Front were among the most highly rated, securing 3rd place (Salt Lake City), 9th place (Ogden), and 11th place (Provo).

Dr. Shaunna Burbidge is a transportation planner in the Salt Lake City area who has been working at the intersection of transportation and public health for nearly a decade. A Utah native, Burbidge did her graduate work at UC Santa Barbara, where she quickly acclimated to southern California active living. She returned to Utah in 2005 with a freshly minted PhD and a mission to build a regional vision for active transportation policy. At that time, the Wasatch Front's Regional Transportation Plan acknowledged pedestrians and bicyclists in one brief paragraph. In 2006, Burbidge wrote a technical report for the Wasatch Front Regional Council (WFRC, the region's metropolitan planning organization) on the status of the region's active modes of transport. The report started a conversation that led to the creation of a broad-based coalition of local planners, elected officials, bicycle, pedestrian, and public health advocacy groups, and university researchers. The recommendations this group created were formally adopted and retained as the first "Public Health Component" of any Regional Transportation Plan in the nation. For her contribution, Burbidge was awarded the *Active Living Research: 2009 Translating Research to Policy Award* by the Robert Wood Johnson Foundation.

With solid partnerships established, work has moved forward with impressive momentum. In late 2010, the region was awarded two federal grants, including $26 million from the U.S. Department of Transportation (TIGER II) to build a 2-mile streetcar line that will link up to existing lightrail. An additional $5 million grant from the U.S. Department of Housing and Urban Development (HUD), prepared by Burbidge and her colleagues and partners, will fund development of an affordable housing plan, a study of six transit-oriented development sites, and the creation of sustainability blueprints that can be used locally, regionally and nationally.

The transportation policy accomplishments of Wasatch Front partnerships exemplify the broad and forward thinking that will help continue to expand our dialogue on health beyond healthcare and health behaviors.

Contact Dr. Burbidge at burbidge@metroanalytics.com or 801-336-7991

Kirstin Q. Siemering, DrPH, RD is a Researcher with the University of Wisconsin Population Health Institute.

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For further reading:

- APHA has recently released an online toolkit on health, equity, and transportation to help bridge communication between planners and public health professionals.
- Also in the *Eye on Population Health* Series:

    Population Health Eye on Oklahoma

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What a great example! Mulit-modal transportation planning too often gets cast as something of interest only to liberals living on the coasts*, so it's great to see red states recognizing the benefits, too.

* E.g., George Will claiming the push for public transportation is about "diminishing Americans' individualism in order to make them more amenable to collectivism." (Shortly after this piece came out, Paul Krugman reported spotting Will stepping out of an Amtrak train.)

Posted by: Liz | 06/09/2011 at 04:14 PM

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07/27/2011

Modeling Long Run Population Health Costs and Outcomes



By David A. Kindig, MD, PhD

The broad population health model that underpins this blog and the *County Health Rankings* must have long-term relevance because quick fixes are few and far between. There is an imperative to invest now in factors we know to be strong drivers of long-term health, such as early childhood interventions (see Can We Afford to Wait for Better Evidence on Improving Child Health? and Business Investment in Early Childhood: Making Future Workers Happier). There is also a need for more research which can better estimate such long-term impacts; the IOM's recent report on Public Health Measurement and Accountability calls for advancing the use of predictive and system-based simulation models to understand the health consequences of the underlying determinants of health.

One such model does exist, and was reported on in the May 2011 *Health Affairs* issue on Environmental Health discussed last week. The article, authored by Bobby Milstein, Jack Homer and colleagues, focuses on the HealthBound policy simulation model which has been developed by the CDC over the past decade. This work seems and is ambitious, as any such analytic and projection tool has to be, but it also simplifies the sheer complexity of the U.S. health system into a tractable form that can be understood and studied by diverse stakeholders. It is built on the methodology of systems dynamics modeling, using several hundred interacting elements and differential equations tied to ten national data bases and many key reference studies.

There have been various iterations of the model over time and several published reports, including an earlier overview in the *American Journal of Public Health*. The most recent *Health Affairs* article reported the results from simulating three strategies over 10 and 25 years to reduce deaths and improve the cost effectiveness of interventions:

1. expanding health insurance coverage

2. delivering better preventive and chronic care, and
3. protecting health by enabling healthier behavior and improving environmental conditions.

The main finding was that each would alone would save lives and provide economic value, but the combination of all three was likely to be more effective. For example, adding protection to the coverage and care scenarios would save 90% more lives and reduce costs by 30% in year 10, but by year 25 the protection investment could save 140% more lives and reduce costs by 62%.

Of course, what goes into the model determines what comes out, and it is difficult for someone not intimately familiar with the inputs and equations to evaluate strengths and weaknesses. Because of the complexity of all the multiple inputs and outcomes, precise estimates for every independent interaction over time do not exist, and ranges and sensitivity analyses are usually required. The authors have extensive experience with these cutting-edge methods; however they caution that "better data…would help narrow uncertainties and yield even stronger policy insights." While the *Health Affairs* article placed more emphasis on health care elements with some behaviors and physical environmental elements in the protection scenarios, planners with more interest in these could simulate the "Pathways to Advantage" intervention, which summarizes intervention research around things like education, living wage, and job training.

While causal understanding of how such factors operate is perhaps more incomplete than those in the health care realm, the authors remain open to incorporating new findings as they emerge. They are also very interested in creating practical and relevant applications for policy makers, which is in part why a HealthBound game also exists to gain hands on familiarity with the methods and results.

The HealthBound tool is are not sufficiently precise to identify local opportunities to invest in specific programs and policies; however, other groups are moving the field in that direction. For example, the ReThink Health Initiative has begun to create simulation models and games that focus specifically on regional investments to transform health system performance. Policy makers need and want such guidance and these tools offer tremendous potential for population health policy – especially as they become increasingly robust and reliable over the coming decade.

For further reading, check out the Robert Wood Johnson Foundation's interview with Bobby Milstein about his article on NewPublicHealth.org.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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07/19/2011

Population Health and the Physical Environment: Beyond Air and Water



By David A. Kindig, MD, PhD

The population health model that underpins the *County Health Rankings* and this blog group the factors that drive health outcomes into four categories:

- Health Behaviors
- Clinical Care
- Social and Economic Factors
- Physical Environment

While we have discussed many aspects of the first three, we have (so far) focused little attention on the Physical Environment. This is partly justified; our model attributes only 10% of the total factor score to this area. But there is also the sense that environmental issues – which we all intrinsically recognize as affecting health and quality of life -- often seem a bit remote or beyond our control.

Much credit should be given to the journal *Health Affairs* and the Kresge Foundation for devoting much of the May 2011 issue to this topic. As Editor Susan Dentzer writes in her introduction, "our Nation's approach to health and health care is so famously siloed that we have long neglected the obvious: the environment plays a role in nearly 85% of all disease."

It is impossible for this brief post to do justice to the issue's impressive set of articles. If you only have time to dip into one, I'd recommend Linda Birnbaum and Paul Jung's "From Endocrine

Disruptors to Nanomaterials: Advancing Our Understanding of Environmental Health to Protect Public Health." The article begins by contrasting the classic view of environmental science (which focused primarily on how chemicals involved in air and water pollution can impact health) with the current scope of environmental policy and research (which broadly addresses pharmaceuticals, nutrition, physical activity, noise, light, stress, infections, and climate change). The authors note the increasing attention being given to the built environment and underscore the contribution of man-made surroundings such as roads and housing to health behaviors and overall health. They also call attention to the importance of environmental justice as it relates to fair and equitable treatment in the development and enforcement of environmental laws, regulations and policies.

Other noteworthy articles from the issue address:

- The environmental effects on genes and gene expression and their impact on chronic disease susceptibility (Olden and colleagues)
- The link between air pollution around schools to health and student performance (Mohai and colleagues)
- The cost ($77 billion) of environmental disease in children (Trasande and Liu)
- How Health Impact Assessments (HIA) can and are being used in urban planning and land use policies at all levels of government (Wernham)

Finally, Morell-Frosch and colleagues address the policy challenge of how to "evaluate and characterize the combined health effects of multiple environmental and social stressors on vulnerable populations." In this article, the term "environment" is used holistically, combining a more classic understanding of physical environment with social and economic factors. While I think the distinction made between these factors in our model is important, I also appreciate the authors' assertion that critical interactions exist among them. In particular, they note that "extrinsic social vulnerability factors at the individual and community levels – such as race, sex, and socioeconomic status – may amplify the adverse effects of environmental hazards and contribute to health disparities."

As we continue to work toward "health in all policies" approaches, we can't afford to ignore the physical environment. I wouldn't be surprised if future population health models give it greater emphasis, especially as our understanding of climate change and its interactions with other factor areas expands.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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07/12/2011

Population Health Eye on Food Deserts in Small Town America



By Kirstin Q. Siemering, DrPH, RD

People have been researching food access for at least 50 years, but it has only been since the mid-1990s that this has been framed primarily as a health issue. The term "food desert," which has gained recognition in recent years, was coined by University of London researcher Steven Cummins to describe places without adequate access to healthy, reasonably priced food.

The United States Department of Agriculture (USDA) was directed by the 2008 Farm Bill to study food deserts throughout the nation. This effort culminated in the 2009 National Academies report, *The Public Health Effects of Food Deserts*, which concludes with research and policy recommendations. The USDA recently unveiled its food desert locator, which is part of Michelle Obama's Let's Move campaign (and a complement to its Food Environment Atlas). Urban areas are taking up the charge to increase residents' access to healthy foods. Baltimore's Department of Planning has a Food Policy Director and Food Policy Councils are cropping up across the country (*The New York Times*' Mark Bittman recently wrote about food policy organizing in Detroit).

While this work is not easy in any environment, rural settings have unique challenges, including geographic isolation, aging populations, and poverty. The Center for Rural Affairs in Lyons, Nebraska (population 963) has been working on this issue and released two key reports last fall – one on the importance and challenges of rural grocery stores, and another on ownership models that work for rural communities. The Center emphasizes that rural grocery stores bring value on many levels. Local grocery stores provide access to healthy foods, employment opportunities, local tax revenue, and serve a vital role in strengthening communities' social fabric.

While the Center's work is national in scope, Nebraska has some great examples of rural grocery store development. The town of Arthur (population 148) lost its grocery store in the mid 1990s, which necessitated residents traveling 80 miles roundtrip for groceries. Local high school students recognized the need and responded by organizing themselves and opening Wolf Den Market (named after the high school mascot). Their efforts were so successful that a group of adults, concerned about losing the store should student interest lag, helped transition from student ownership to a cooperative.

Steph Larsen helps direct the Center's organizing activities and leads its outreach activities in this area. Larsen's recommendations reflect organizing ideals, including the imperatives of knowing one's community, listening to one's community, bringing leaders together to talk about critical issues, and moving forward with consensus. Larsen strongly believes that if the support is there, the effort will be successful.

The importance of resources for population health improvement is a recurring theme on this blog, and the dollars matter here as well. The federal government has several initiatives underway that address the issue of food access, including the Healthy Food Financing Initiative (HFFI) and the Farmers Market Promotion Program (FMPP). The HFFI is being modeled after Pennsylvania's very successful Fresh Food Financing Initiative; $10 million are slated for the first round of funding, with applications due July 11. Yet despite all the excitement around the program, funding may yet fizzle as appropriations talks continue over the coming months.

Grassroots efforts such as those underway in Nebraska will always be critical, but we're not likely to see tremendous momentum on this (or any population health issue) without buy-in from the treetops as well.

Kirstin Q. Siemering, DrPH, RD is a Researcher with the University of Wisconsin Population Health Institute.

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07/07/2011

How Much Prevention "Stuff" Does Wisconsin Need?



By David A. Kindig, MD, PhD

Well, Wisconsin is back in the national news this week, with the refusal of our State Department of Health Services to support $28 million in federal grant applications from organizations like the Milwaukee Health Department for chronic disease prevention programs aimed at smoking and diabetes. The Department Secretary is quoted as saying "Why are we asking for taxpayer money for stuff we are already doing….this is stuff that goes on all the time."

Perhaps he is wishing he hadn't said that, because there is no evidence based case that can be made for not increasing our support for such public health and prevention programs. The "stuff" that we have way too much of is not prevention but the high health care costs that result from such chronic diseases. Resolution of federal and state budgets will require effectively addressing this issue; we have to spend much more on prevention to reduce the mortality and morbidity burden that has health care budgets skyrocketing and contributing substantially to the national debt.

This is a national problem, but could it be that Wisconsin is so healthy that we don't need the resources? Nope. Our state ranks 31st in smoking rates, 34th in obesity, and if you can believe this, 48th in public health funding. The latter ranking is due in part to the historical lack of state funding for local public health, which makes federal dollars all the more important in Wisconsin.

We strive to make this blog a forum for ideas that are moderate, non-partisan, and evidence-informed. In writing about the Wisconsin budget process earlier this year, I noted the difficulty of sorting out "which proposals are primarily ideological and political and which are pragmatic 'least bad' choices." Unless the proposals have substantive flaws which have not been revealed, it strains credulity to believe that the state's refusal to endorse these applications is not primarily ideological. It can't be defended from a federal cost saving perspective since Wisconsin's loss will

be another state's gain. It is also not compatible with the state's critical job creation agenda which is threatened by increasing health care costs for employers due to in large part to adverse outcomes from preventable chronic diseases.

One reporter has noted that Governor Walker opposes federal health care reform, and that some states have been criticized for accepting federal health care dollars while opposing reform. However, the state has accepted a $37 million health care reform grant to design insurance exchanges, so the decision rules either aren't consistent or need clarification. It would be very unfortunate if the decision to not apply for the chronic disease funds reflects a perspective that government has no role or responsibility in improving the health of communities through public health and prevention programs.

Perhaps state officials will decide to reverse this decision, or perhaps Secretary Sibelius will grant Milwaukee's request to waive the requirement for a letter of state support. Or perhaps the funds will go to other states that understand what is really needed to reduce the health care burden and costs that are strangling both the public and private sectors.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 07/07/2011 in Harnessing and Allocating Resources | Permalink

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Amen to that Dave: glad to see that this blogs usual 'outside the fray' academic neutrality finds that "...it strains credulity to believe that the state's refusal to endorse these applications is not primarily ideological."

Posted by: Robert Stone Newsom, PhD | 07/07/2011 at 02:14 PM

Powerful STUFF. Thank you for this incredible post. Comprehensive, succinct, eloquent, plain-spoken, and jaw-dropping.

Posted by: Christine Harden, OD | 07/07/2011 at 04:52 PM

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Pop Health Twitter Roundup (7/27/11)

The latest and greatest from @PopHealth:

- The wealth gap between whites and minorities is at its widest in 25 years
- Academy Health announces new initiative to generate evidence & leverage findings from Beacon Communities
- McDonald's adds choice of fruit or veggies to Happy Meals and reduces french fry portion by 50% (kcals down ~20%)
- Mark Bittman proposes a solution to the Standard American Diet (also see interesting interactive timeline)
- Who are America's poor children? New report examines health disparities by race and ethnicity
- Haven't heard of Health Leads? *The Atlantic* has a great conversation with CEO (and MacArthur Fellow) Rebecca Onie
- Pop Health win: new Russian law categorizes beer as alcohol (not food)
- Important new study links increased public health spending to reduced mortality

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07/19/2011

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Pop Health Twitter Roundup (7/20/11)

The latest and greatest from @PopHealth

- According to a Gallup poll, 59% of Americans said they support a ban on smoking in all public places
- New Online Platform, likeminded.org, for stories of community change
- The Struggle to Eat: a perspective on the SNAP (formerly Food Stamp) program
- US food companies announce self-imposed regulations that limit calories, sugar, sodium, fat in foods advertised to kids
- New Study Shows Impact of San Francisco's Health Care Security Ordinance
- Dr. Barbot, Commissioner of Health for Baltimore City, MD, talks Healthy Baltimore 2015 with RWJF's New Public Health
- California smoking rates hit all-time low: 11.9% (it's the 2nd state, after Utah, to reach nat'l target of 12%)
- Pop Health win! WI State Admin reverses course to support applications for federal health grants
- New report from IOM says too many Americans lack access to dental care
- What Google's Cafeterias Can Teach Us About Health (smart labeling, vending machines where healthy food costs less)
- Minnesota Deems Child Care Subsidy Program "Not Critical" During Government Shutdown

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07/12/2011

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By Kirstin Q. Siemering, DrPH, RD

People have been researching food access for at least 50 years, but it has only been since the mid-1990s that this has been framed primarily as a health issue. The term “food desert,” which has gained recognition in recent years, was coined by University of London researcher Steven Cummins to describe places without adequate access to healthy, reasonably priced food.

The United States Department of Agriculture (USDA) was directed by the 2008 Farm Bill to study food deserts throughout the nation. This effort culminated in the 2009 National Academies report, *The Public Health Effects of Food Deserts*, which concludes with research and policy recommendations. The USDA recently unveiled its food desert locator, which is part of Michelle Obama’s Let’s Move campaign (and a complement to its Food Environment Atlas). Urban areas are taking up the charge to increase residents’ access to healthy foods. Baltimore’s Department of Planning has a Food Policy Director and Food Policy Councils are cropping up across the country (*The New York Times*’ Mark Bittman recently wrote about food policy organizing in Detroit).

Continue reading "Population Health Eye on Food Deserts in Small Town America" »

Posted on 07/12/2011 in Policy and Systems Change in Action | Permalink | Comments (0) | TrackBack (0)

| Twee

IRS Invites Comments Regarding Community Health Needs Assessments

We recognize the importance of IRS Community Benefit policy as a potential population health improvement tool and so want to call readers’ attention to the new call for comments on this issue.

From the notice:

> *This notice addresses the community health needs assessment (“CHNA”) requirements described in section 501(r)(3) of the Internal Revenue Code (“Code”) and related excise tax and reporting obligations, applicable to hospital organizations that are (or seek to be) recognized as described in section 501(c)(3) of the Code…*
>
> *…Although the CHNA requirements are not effective until taxable years beginning after March 23, 2012, Treasury and the IRS are publishing this notice regarding the CHNA requirements now because they understand that some hospital organizations may choose to start the process of conducting CHNAs and developing implementation strategies in advance of the effective date.*

Comments are due September 23, 2011.

Posted on 07/12/2011 in The National Policy Front | Permalink | Comments (0) | TrackBack (0)

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Pop Health Twitter Roundup (7/13/11)

The latest and greatest from @PopHealth

- Teaching a new generation of doctors to provide better coordinated, more patient-centered care
- Do businesses have a social responsibility to help make communities healthier?
- Gardeners in one PA community combine their growing power to create a bounty of fresh produce for local food pantries
- City vs. country: who is healthier?
- Better education = Better Health -- Q&A with Steven Woolf
- Health Leads shows that health is more than health care -- Great segment on work in Providence
- Mayo Clinic launches social media community for information and support
- First study of its kind shows that Medicaid benefits the poor
- New CA law requires all public schools to provide free, fresh drinking H2O to students at mealtimes
- RWJF, TFAH release F as in Fat 2011. Where does your state stand?

Posted on 07/12/2011 in Twitter Roundup: @PopHealth | Permalink | Comments (0) | TrackBack (0)

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07/07/2011

How Much Prevention "Stuff" Does Wisconsin Need?



By David A. Kindig, MD, PhD

Well, Wisconsin is back in the national news this week, with the refusal of our State Department of Health Services to support $28 million in federal grant applications from organizations like the Milwaukee Health Department for chronic disease prevention programs aimed at smoking and diabetes. The Department Secretary is quoted as saying “Why are we asking for taxpayer money for stuff we are already doing….this is stuff that goes on all the time.”

Perhaps he is wishing he hadn’t said that, because there is no evidence based case that can be made for not increasing our support for such public health and prevention programs. The “stuff” that we have way too much of is not prevention but the high health care costs that result from such chronic diseases. Resolution of federal and state budgets will require effectively addressing this issue; we have to spend much more on prevention to reduce the mortality and morbidity burden that has health care budgets skyrocketing and contributing substantially to the national debt.

Continue reading "How Much Prevention "Stuff" Does Wisconsin Need?" »

Posted on 07/07/2011 in Harnessing and Allocating Resources | Permalink | Comments (2) | TrackBack (0)

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Pop Health Twitter Roundup (7/7/11)

The latest and greatest from @PopHealth

- Johns Hopkins U studying whether public health trends can be tracked via Twitter
- New study calculates number of deaths caused by poverty
- Ironic tragedy: motorcyclist crashes, dies, during ride to protest helmet laws in New York
- Worrisome trend -- state preemption of local govts' adopting policies that would improve health in their communities
- State of WI blocks plans to apply for federal health grants
- The socio-economic significance of food deserts
- On the demise of Google Health, Matthew Holt @ Health Care Blog explains need for an independent health data utility
- What would happen to health inequalities if smoking were eliminated?

Posted on 07/07/2011 | Permalink | Comments (0) | TrackBack (0)

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Posts from August 2011

08/31/2011

Locally Customized Population Health Policy Packages?



By David A. Kindig, MD, PhD

In my last post I suggested that those who allocate resources must provide ample guidance to ensure that local level health improvement strategies actually align with the best available evidence. I mentioned the University of Wisconsin What Works data base as well as the approach that the previous administration allocated its State Health Improvement Plan (SHIP) resources in the state of Minnesota. But I indicated that What Works is not tailored to individual communities and that the Minnesota example is limited to health behavior interventions, not all population health determinants.

We know from the *County Health Rankings* and our own experiences that communities vary widely in both their health outcomes and the factors or determinants of those outcomes. There are many examples of both high and low ranking counties which vary on their determinant profile…some have high health care quality and access but poor behaviors, others have high social factors like education and income but poor air and water quality. Given limited resources, it is critical that investments be made carefully to have the most impact.

Would it be helpful to identify a set of Population Health Policy Packages that suggest the best options for local communities to make, given their outcomes and health determinants profile?

Continue reading "Locally Customized Population Health Policy Packages?" »

Posted on 08/31/2011 in Policy and Systems Change in Action | Permalink | Comments (3) | TrackBack (0)

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08/24/2011

Gone Fishing

Please stay tuned for a new post next week!



Posted on 08/24/2011 | Permalink | Comments (0) | TrackBack (0)

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08/16/2011

Can Policy Models be Helpful to Local Decision Makers?



By David A. Kindig, MD, PhD

Two recent posts have featured population health policy models (see Modeling Long Run Population Health Costs and Outcomes and A Population Health Opportunity Map). Such models will be increasingly important as we strive to effectively allocate resources appropriately across sectors to improve overall health outcomes and improve health equity. But to those in the local trenches, particularly in a time of resource reductions, models may seem abstract and irrelevant. What do we know NOW that can help communities make the best decisions possible in these challenging times? Can top down models or tools be helpful to communities looking for bottom up solutions?

Continue reading "Can Policy Models be Helpful to Local Decision Makers?" »

Posted on 08/16/2011 in Improving Health Factors | Permalink | Comments (0) | TrackBack (0)

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08/09/2011

A Population Health Opportunity Map



By David A. Kindig, MD, PhD

A commentary in the May 25 JAMA by Jonathan Fielding and Steve Teutsch caught my eye a couple of months ago. Both authors play influential roles in national population health policy, from their practice based experiences in the Los Angeles County Department of Public Health.

They begin by arguing that as we reform the health CARE system, complementary improvements are needed in community prevention programs and policies as well. The challenge for both national and local policy makers is to be able to "identify and implement those interventions that provide the greatest benefits and value," including the relative effectiveness of both clinical and community prevention efforts. They suggest that a first step has to be a sound framework for "identifying and organizing" the universe of interventions which have been shown to have evidence of effectiveness.

Continue reading "A Population Health Opportunity Map" »

Posted on 08/09/2011 in Improving Health Factors | Permalink | Comments (3) | TrackBack (0)

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Pop Health Twitter Roundup (8/9/11)

The latest and greatest from @PopHealth:

- New article in British Medical Journal uses Health Impact Assessment to analyze urban bicycle sharing program
- First-Ever National Healthy Eating and Physical Activity Standards Developed for Afterschool Programs
- How does education affect your community? Check out the United Way's new Common Good Forecaster to find out
- This fall, all 34,000 Cincinnati Public School students will have daily access to a school salad bar
- NYT "Well": Friendly Workplace Linked to Longer Life

- Ample Harvest is making fresh produce available to more than 4,000 food pantries across the US
- Check out the new Health Wonk Review blog carnival hosted by Joe Paduda at Managed Care Matters
- From Washington Post: Towns change programs, enlarge street signs to adapt to an older population
- Health Leads: Slashing the Price of Health with Common Sense from NYT columnist David Bornstein
- Weight, income, public food programs: A look at how the pounds add up

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08/02/2011

Population Health Eye on "Total Worker Health" in Lincoln, Nebraska



By Kirstin Q. Siemering, DrPH, RD

Lincoln Industries in Lincoln, Nebraska is the nation's leading supplier of products requiring high performance metal finishing. The company was established in 1955 and employs over 400 people in an operation that runs 24 hours per day, seven days per week.

The company's commitment to worker well-being has earned it widespread recognition. Lincoln Industries has been honored by the U.S. Dept. of Health and Human Services, the American Heart Association, Partners for Prevention, and others. The company has also been named one of the "25 Best Medium Companies to Work for in America" by the Great Place to Work Institute.

Continue reading "Population Health Eye on "Total Worker Health" in Lincoln, Nebraska" »

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Pop Health Twitter Roundup (8/2/11)

The latest and greatest from @PopHealth:

- Separate & Unequal: The Neighborhood Gap for Black, Hispanics, and Asians in Metropolitan America (via US2010 Project)
- Linking transportation policy & health -- new report from Partnership for Prevention
- New from the Commonwealth Fund: The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations
- New Canadian report sees key role for social media: "Communicating the Social Determinants of Health"
- SAMHSA announces new approach to Prevention and Promotion, incl. grants specifically for tribes & tribal communities
- NYT "Fixes" columnist David Bornstein writes about "Treating the Cause, Not the Illness" in his piece on Health Leads
- Environmentalists laud automakers for prioritzing fuel economy as carmakers back strict new rules for gas mileage
- How a park helped one town weather the recession
- UC Berkeley journalism students offer USDA ideas for revamping food labels
- Almost 50% of U.S. health care spending will come from government coffers by 2020 says new report from Health Affairs

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08/31/2011

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We know from the *County Health Rankings* and our own experiences that communities vary widely in both their health outcomes and the factors or determinants of those outcomes. There are many examples of both high and low ranking counties which vary on their determinant profile…some have high health care quality and access but poor behaviors, others have high social factors like education and income but poor air and water quality. Given limited resources, it is critical that investments be made carefully to have the most impact.

Would it be helpful to identify a set of Population Health Policy Packages that suggest the best options for local communities to make, given their outcomes and health determinants profile?

While there is enormous variation across the country in such profiles, it is likely that a reasonable number of representative situations exist for most communities/counties. For each profile, using the best evidence available from sources like What Works and the CDC Community Guide, a set of investment priorities would be developed, covering all the determinants of health. It would be as broad as the global evidence allows, but would be tailored to a community's strengths and weaknesses. Options for improving behaviors like smoking would not be as highly suggested for

places already doing well in this factor. The packages would not be prescriptive, but merely a menu of the investments likely to produce the best health outcome improvement. Where possible, options would include the strength of public and private sector policies beyond dollar investment in specific programs.
The initial set of Policy Packages would not be ideal, for a variety of reasons. We still have incomplete evidence of effectiveness of different programs and policies, particularly regarding cost-effectiveness beyond effectiveness itself. It is not clear which level of investment in a particular determinant or factor is optimal, or where diminishing return sets in and when resources should be moved to other factors. We are limited in evidence for different types of outcomes, particularly disparity reduction.

However, we shouldn't let the perfect be the enemy of the good. A beginning set such as in the Minnesota SHIP example (i.e., improving nutrition, increasing physical activity, and reducing tobacco use and exposure) might be helpful in many places where discussions are taking place regarding improving the health of their communities. It would help ensure that local passion and commitment would be channeled in an evidence based direction, while preserving autonomy and sensitivity to community preferences.

What do you think about this? How long will we say we don't have adequate evidence to guide population health investment decisions?

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 08/31/2011 in Policy and Systems Change in Action | Permalink

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Comments

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Dr. Kindig;
Actually, there may be locally customized health status in the works. The IRS is going to require all not-for-profit hospitals to complete a Community Health Needs Assessment every three years in order to maintain their tax exempt status. Those assessments must quantify both met and unmet health care needs in the hospital's service delivery area, set forth a plan to meet unmet needs and make that Assessment and plan public. The instrument is IRS Schedule 990-H.
Ron Cossman
Social Science Research Center, Mississippi State University

Posted by: Ronald Cossman | 09/06/2011 at 01:33 PM
Dear Dr. Cossman,
Thanks for raising this important point -- we are also paying close attention to how nonprofit hospital community benefits are evolving. You may be interested in a couple of previous posts on this topic: "IRS Invites Comments Regarding Community Health Needs Assessments" http://www.improvingpopulationhealth.org/blog/2011/07/irs-invites-comments-regarding-community-health-needs-assessments.html and Hospital Community Benefit: An Update on Opportunities and Challenges http://www.improvingpopulationhealth.org/blog/2011/06/community_benefit_update.html
Kirstin Siemering
IPH Associate Editor

Posted by: Kirstin Siemering | 09/08/2011 at 11:31 AM
In 5 semi-rural communities in SE Michigan we're using BRFSS, County Health Rankings, PAC & NEAT survey results to develop customized, comprehensive wellness plans for each town. Comprehensive means the towns' Wellness Coalitions will develop a plan aimed at creating a culture in which residents 'eat better, move more, avoid unhealthy substances & connect with others in a healthy way'. Altarum & researchers from the University of MI are working with us to evaluate the process & outcomes - we're hoping any successes will be supported by data & be replicable. You can learn a bit about what we're doing on our website (geared toward community members). www.5healthytowns.org

Posted by: Amy Heydlauff | 09/13/2011 at 07:29 AM

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08/16/2011

Can Policy Models be Helpful to Local Decision Makers?



By David A. Kindig, MD, PhD

Two recent posts have featured population health policy models (see Modeling Long Run Population Health Costs and Outcomes and A Population Health Opportunity Map). Such models will be increasingly important as we strive to effectively allocate resources appropriately across sectors to improve overall health outcomes and improve health equity. But to those in the local trenches, particularly in a time of resource reductions, models may seem abstract and irrelevant. What do we know NOW that can help communities make the best decisions possible in these challenging times? Can top down models or tools be helpful to communities looking for bottom up solutions?

Passion and commitment are absolutely vital to this work, but too often we ignore the evidence, mistake process for product, and wind up squandering resources and our chances of making a real impact. Despite our still incomplete understanding of the evidence, what we do know can play a valuable role in shaping local level action. But giving greater attention to the evidence will require going beyond models; we need practical tools and guidance on which strategies are likely to result in the greatest health gains.

One such tool is the University of Wisconsin Population Health Institute based tool, What Works: Policies and Programs to Improve Wisconsin's Health. This tool presents evidence of effectiveness for nearly 400 specific programs and policies across all four factors of the *County Health Rankings* model. While initially intended for use in our state, the underlying evidence is national and global in scope.

But having user-friendly access to the evidence is only one piece of the puzzle – knowledge is necessary but often not sufficient to drive needed action. Extracting the greatest value from our limited resources will take a concerted top down and bottom up effort; we need to foster a better division of responsibility that allows the treetops and grassroots to play to their strengths. Those who allocate resources must provide ample guidance and establish a system of accountability to ensure that local level health improvement strategies actually align with the best available evidence. Rather than being oppressive, such top down structures can assist communities by streamlining decision-making processes and helping them move more quickly to action.

The Minnesota Health Department used such an approach with its $47 million Statewide Health Improvement Program (SHIP). The program awarded 41 grants covering all 87 counties and 9 tribal communities. Proposals required applicants to select from a "Menu of Interventions" that addressed policy, systems, and environmental approaches for three key risk factors (unhealthy eating, physical inactivity, and tobacco use and exposure) in four different settings (schools, communities, worksites, and health care systems). The broadly prescriptive menu served as a guide for what to do, but not how to do it; communities determined how best to implement the strategies they selected. The results are quite promising, as explained in this March 2011 Progress Brief on the program's first year.

Such an approach makes eminent sense to me. We need top down thinking and guidance combined with bottom up energy and leadership. Do you have other examples of this type of coordination? If so, please let us know as we'd like to draw attention to them on the blog.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 08/16/2011 in Improving Health Factors | Permalink

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08/09/2011

A Population Health Opportunity Map



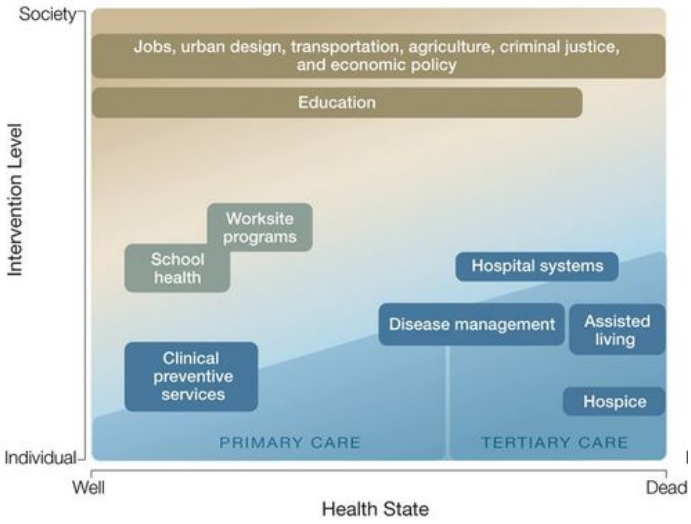
By David A. Kindig, MD, PhD

A commentary in the May 25 JAMA by Jonathan Fielding and Steve Teutsch caught my eye a couple of months ago. Both authors play influential roles in national population health policy, from their practice based experiences in the Los Angeles County Department of Public Health.

They begin by arguing that as we reform the health CARE system, complementary improvements are needed in community prevention programs and policies as well. The challenge for both national and local policy makers is to be able to "identify and implement those interventions that provide the greatest benefits and value," including the relative effectiveness of both clinical and community prevention efforts. They suggest that a first step has to be a sound framework for "identifying and organizing" the universe of interventions which have been shown to have evidence of effectiveness.

The components of such a framework are proposed to be: 1) the ecologic model, which is generally consistent with the multi-determinant population health model we advocate in this blog, 2) the life course perspective, in which health at any point in time is the "product of a person's behaviors and exposures superimposed on his or her underlying biology," and 3) the evidence of effectiveness of any intervention in either the clinical or community spheres with enough scientific evidence to support its use.

These three components make up their proposed model, called An Opportunity Map for Societal Investment in Health, pictured below.



The horizontal axis reflects the life course, from wellness through illness to death. The vertical axis reflects the spectrum of intervention strategies from the individual to the societal level. The blue shading of the bottom half highlights individual clinical investments while the brown at the top reflects community wide programs and policies. The blending of colors in the middle implies that these exist on a continuum. Another figure shows (using diabetes as an example) how this model can be applied to issue-specific clinical and community prevention efforts.

The authors explain that when "individual interests and needs predominate, there is a slide to the lower right quadrant, where costs of medical care are high and health status is poorest." They draw the conclusion that "attention to interventions in the upper left quadrant may yield greater health and economic efficiency," including individual productivity and national global competitiveness.

I believe that private and public policy makers faced with making the program and policy investments in a resource limited world are likely to find conceptual models such as this should be helpful. I would like to see a third dimension added to reflect the estimated cost-effectiveness of each program and policy choice, both clinical and societal. While most population health advocates would agree with the authors' call for more resources in the upper left corner, each individual program or policy needs to be evaluated itself on some cost-effectiveness metric (such as quality adjusted life years gained per dollar invested). The addition of this dimension would reveal some very cost effective interventions in the lower right region of the figure and some very cost ineffective interventions in the upper left. In addition, attention must be given to relative cost effectiveness to improve health equity compared to improving overall population health; certain interventions will be more effective for one than for the other.

Will such broad "top down" conceptual models be helpful to local communities faced with making difficult decisions among dwindling resources? Next week I'll try to address this question directly.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 08/09/2011 in Improving Health Factors | Permalink

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Love the map as a visual for these important investments in health. It does make me wonder, though, if the pendulum has swung too far towards policy & systems. The individual still needs a role in our efforts. It's not just 'done to them' through health care (primary & tertiary) coming up to meet society (jobs, ag, justice, policy...). Individuals, families and local communities can, & often want to, intervene on their own behalf (think Paulo Freire). That's particularly true around primary prevention - which isn't well represented on this map. (Unless you think the only way primary prevention takes place is with primary care. That idea would be a real surprise to parents teaching their kids to eat f&v.)

Posted by: Amy Heydlauff | 08/10/2011 at 12:26 PM

Perhaps, somewhat like a "cost-effectiveness" dimension, interventions could be mapped with regard to their "population reach." In this regard I also like Frieden's Health Impact Pyramid (Frieden TR, "A Framework for Public Health Action: The Health Impact Pyramid" AmJ Public Health. 2010;100:590–595), which shows the inverse correlation between "increasing population impact" and "increasing individual effort needed".

Posted by: Geof Swain | 08/10/2011 at 05:24 PM

I like the shading to depict the frontier between health care and the broader determinants. Although the horizontal axis depicts the journey from wellness through illness to death, it really doesn't provide much insight into that journey from the person's perspective, other than that it requires increasingly more resources. I think what's important to the person is how their health and functional status change over that journey, and how we might either slow the progression or make it more enjoyable along the way, as Joanne Lynn describes in her "Bridges to Health" model (http://www.milbank.org/quarterly/MILQ%2085.2%20Lynn%20et%20al..pdf).

Posted by: Matt Stiefel | 08/10/2011 at 06:31 PM

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08/02/2011

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The company's commitment to worker well-being has earned it widespread recognition. Lincoln Industries has been honored by the U.S. Dept. of Health and Human Services, the American Heart Association, Partners for Prevention, and others. The company has also been named one of the "25 Best Medium Companies to Work for in America" by the Great Place to Work Institute.

Lincoln Industries has an explicit approach to well-being:

> *Lincoln Industries Wellness encompasses the body, mind, and spirit. We support our people in making smarter, healthier, lifestyle choices. We encourage balance between work, home, and personal goals. We believe that supporting our people's health and wellness interests is a sound investment in our company and the most important asset of the company is the people.*

An intrinsic value in employee well-being initially motivated this effort, which has resulted in a dramatic return on investment in the form of decreased turnover, lower absenteeism, improved work quality, and lower health care costs. The company also has a commitment to measuring progress. In 2010, Lincoln Industries initiated a partnership with Healthways (of the Gallup-Healthways

Well-Being Index) to monitor employee health along six well-being domains, including life evaluation, healthy behavior, emotional health, work environment, physical health, and basic access.

The Healthways assessment is administered twice annually and results are compared to both the U.S. population and the city of Lincoln. Results are also compared within departments. Wellness Specialist Greg Howe has one-on-one meetings every six months with departmental vice presidents to discuss progress and set specific well-being priorities. Howe notes that the highest priorities often fall into the "basic access" domain (e.g., food, shelter, healthcare, and safety) and that many of these issues are best addressed through policy and environmental changes. Recent responses to assessment and priority-setting activities have included installation of walking paths and basketball hoops and the formalizing of flexible work schedules to promote greater work-life balance.

Lincoln Industries' "People Resources" Department (they prefer the term "people" to "employees") houses benefits, safety, and wellness activities to maximize integration of protection and prevention. The company has modeled its safety policies on the "industrial athlete" concept developed by Boeing, which applies best practices in sports medicine with respect to both injury prevention and treatment.

Lincoln Industries' concept of well-being exemplifies a recent shift in employee health that recognizes the many factors (many of which extend beyond the worksite) that play a role in productivity. But this shift is not limited to the business sector. The American College of Occupational and Environmental Medicine (ACOEM) recently released a Guidance Statement on Workplace Health Protection and Promotion that calls for a systematic integration of the two often siloed concepts of safety and wellness.

Earlier this year, the National Institute for Occupational Safety and Health (NIOSH) transitioned its *WorkLife* program to the new Total Worker HealthTM program, a strategy integrating occupational safety and health protection with health promotion to prevent worker injury and illness and to advance health and well-being. NIOSH is in the early stages of developing a broad framework for research on the integration of health protection and health promotion. For the past five years, NIOSH has supported three national *WorkLife* Centers of Excellence to research key concepts, including integration and synergy among interventions aimed at protecting workers, enhancing worksites, and promoting worker health. To receive regular updates on NIOSH's Total Worker HealthTM program, sign up here.

This is an exciting time for employee health, as both private and public stakeholders begin to work toward aligning thinking and action with the broad goals of population health improvement.

Kirstin Q. Siemering, DrPH, RD is a Researcher with the University of Wisconsin Population Health Institute.

Posted on 08/02/2011 in Policy and Systems Change in Action | Permalink

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09/29/2011

HIA: A Practical Tool for Factoring Health into Decision Making Across Sectors



By Pamela Russo, MD, MPH

Staying healthy, whether we're talking about individuals or populations, is influenced by people's access to high quality health care and clinical prevention - but there is powerful evidence that staying healthy is *more strongly influenced* by people's education, job opportunities, economic status, and the social and physical environmental conditions where they are born, grow, live work, and age. This understanding needs to be conveyed in a useful way to those making decisions on policies, programs and projects in *non-health sectors* such as transportation, energy production, labor, or education, who rarely consider the consequences of their decisions on factors that influence health. Absent the consideration of effects on human health, we have often unintentionally created conditions that are either hazardous to human health or create barriers for people to adopt and maintain healthy behaviors. How can we convert the evidence on the multiple factors that drive population health into something decision-makers can use to build health into their equations?

The National Research Council (NRC) concluded that Health Impact Assessment (HIA) is a promising and practical tool for factoring health into decisions on proposed projects and policies in sectors outside the health and health care sectors. An NRC report, *The Role of Health Impact Assessment to Improve Health in the United States*, was released on September 8th, 2011. The report provides a framework, terminology, and guidance for conducting a health impact assessment at the local, state, tribal and federal levels. The NRC committee concurred that HIAs can help decision makers identify unintended risks, reduce unnecessary costs and leverage opportunities to improve the health of their communities.

The report sets standards for the practice of HIA, and developed a six step framework. The first step is to screen – to decide whether there is a need and value to do an HIA on a proposed policy

or project. In other words, it is important to consider if health could be affected – but not all policies or projects require an HIA. A key standard is including stakeholders in the process from beginning to end - including agencies, populations that will be affected, developers and others. Another key standard is to balance the need to provide timely, valid information within the reality of data and time constraints. The committee recommended using diverse types of evidence from multiple disciplines, critically selecting the strongest available evidence and methods, and acknowledging and managing the uncertainties from the beginning of the process to ensure the credibility of the report and recommendations.

HIAs have been used extensively in other countries, by development agencies such as the World Bank, and by some international corporations as part of their project planning. The number of HIAs performed in the U.S. has risen exponentially over the past few years, with some localities and states adopting policies to integrate HIAs into decision-making. The Health Impact Project is keeping an up to date inventory that maps the sites of HIA and shows that they are occurring across the country. Places that have been active in applying HIAs have seen substantial growth in interagency collaboration and the systematic consideration of health in proposed projects and policies. It is clear that factoring health into decisions made in other sectors offers a huge opportunity to shape healthy conditions, minimize new health risks and maximize benefits for health, and ultimately reduce health care costs. The guidance from the National Research Council on HIAs gives us a way to improve the nation's health.

Pamela Russo, MD, MPH, is a Senior Program Officer with the Robert Wood Johnson Foundation's Public Health Team.

Posted on 09/29/2011 in Policy and Systems Change in Action | Permalink

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09/22/2011

Will the Jobs Bill Impact Population Health?



By David A. Kindig, MD, PhD

The last week has seen much attention devoted to the issue of jobs and unemployment in our country. Presidential elections often hinge on the state of the economy and the persistence of high unemployment rates will likely play a greater role in 2012 than in previous periods. While a growing literature shows that displaced workers (defined as individuals who lose their jobs as part of plant closings, mass layoffs, and other firm-level employment reductions) tend to experience significant long-term earnings losses as well as decreased job stability, lower employment rates, earlier retirement, lower personal spending, and decreased health insurance coverage.

In addition to these primarily economic effects, there are likely to be health effects as well. Unemployment (measured as the percent of the population age 16 and over that is unemployed but seeking work) is one of seven key measures in the *County Health Rankings' Social and Economic Factors*, but is only briefly mentioned in Healthy People 2020's new section on the Social Determinants of Health.

An extensive literature demonstrates the association of unemployment with an increased likelihood of morbidity and mortality. In a 2009 review, Bambra summarized:

> *There are clear relationships between unemployment and increased risk of poor mental health and parasuicide, higher rates of all cause and specific causes of mortality, self-reported health and limiting long-term illness and, in some studies, a higher prevalence of risky health behaviours, including problematic alcohol use and smoking. The negative health experiences of unemployment are not limited to the unemployed only but also extend to families and the wider community…..links between unemployment and poorer health have conventionally been explained through two inter-related concepts: the material consequences of unemployment (e.g., wage loss and resulting changes in access to essential goods*

and services) and the psychosocial effects of unemployment (e.g., stigma, isolation and loss of self-worth).

In the year after displacement, Sullivan and von Wachter (2009) found mortality rates among long-tenured employees were 50%–100% higher than would otherwise have been expected. This effect on mortality hazards declined sharply over time, but persisted. Even twenty years after displacement, the authors estimated a 10%–15% increase in annual death hazards. If such increases were sustained indefinitely, they would imply a loss in life expectancy of 1.0–1.5 years for a worker displaced at age forty. Similarly, Bartley and Ferrie (2010) found unemployment elevated the risk of premature death by 57% among men ages 44-54.

But what comes first – unemployment or poor health? I do not usually focus on issues of research methodology in this blog, but the unemployment and health relationship is a good place to discuss reverse causality, since it features prominently in this literature and is of critical policy importance. In the unemployment relationship, not only are the unemployed likely to be less healthy, but it is also intuitive to expect that less healthy individuals are more likely to be unemployed because they are unhealthy and, therefore, less productive employees.

But sorting out these conflicting causal pathways is difficult. Lundin and colleagues (2010) estimated that 49% of the association between unemployment and poor health was due to poor health resulting in unemployment. Of course, context plays a major role. In Germany, where citizens have access to generous unemployment benefits, long entitlement durations, and universal health insurance, health status seems to drive employment status rather than vice-versa (Schmitz, 2011).

While researchers and policymakers need to be aware of such concerns, the U.S. evidence such as that of Sullivan cited above which control for reverse causality certainly suggest that we should consider job loss and unemployment a significant determinant of population health. While impact on income will likely remain the dominant policy concern, we would do well to keep in mind the impact on health and related worker productivity as the costs and benefits of employment policy are debated in the coming months and years.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Thank you for highlighting the growing body of evidence that links unemployment, poverty, and inequality to poor health. Those who care about improving population health, however, must do much more.

Emphasizing the connection between economic determinants and poor health is essential, but it is simply the starting point. Merely asserting (without evidence) that lowering unemployment poverty and unemployment will improve health, but then failing to systematically develop the evidence, is an inadequate--indeed, an unacceptable--response.

What is urgently needed is for the government agencies and foundations that fund research into improving public health, and for public health scholars at universities and other academic institutions, to develop and implement a series of carefully controlled experiments, using large-scale experimental and control groups, that test specific interventions for reducing unemployment and poverty on health outcomes.

A number of controlled experiments on reducing poverty and unemployment, such as the New Hope Project in Milwaukee, Wisconsin, have been carried out in recent years. They were not structured, however, to yield extensive evidence about whether the strategies tested for raising earnings and employment levels--in New Hope's case, primarily through offering Transitional Jobs and supplementing earnings--yielded not only reductions in poverty and unemployment (which, in the case of New Hope, was shown to be the case) but also improvements in health.

What governments, foundations, and scholars who care about improving health need to do is put together controlled experiments aimed at reducing poverty and unemployment that specifically capture health outcomes. It's not that complicated to design such experiments. With adequate resources, it's not that hard carry them out.

The question is: Do the people who care about improving health have the will--I would say, the courage--to cross this experimental Rubicon? Or are they going to continue to talk (and talk and talk and talk and talk) about the socio-economic determinants of health, but do nothing credible about figuring out which specific changes in those determinants actually make a specific difference in health outcomes?

I hear the talk loud and clear. So far, however, I'm not seeing anyone in the public health world who's willing to cross the Rubicon.

Posted by: David R. Riemer | 09/23/2011 at 01:57 PM

David should look at the randomized trial of public housing - Moving To Opportunity (MTO) - yes, looking at health outcomes was an afterthought, but it was added.....

Posted by: Pamela Russo | 09/26/2011 at 04:48 PM

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09/07/2011

CMS Turns an Ear to Population Health



By David A. Kindig, MD, PhD

Last month I was privileged to be part of a group invited to the federal Center for Medicare and Medicaid Innovation ("Innovation Center") to discuss population health models and opportunities. Why would the federal agency with the overwhelming job of controlling health care costs and implementing health reform be concerned about this?

The reason is that the Centers for Medicare and Medicaid Services (CMS) is viewing its approach to health improvement through the lens of the Triple Aim, with its Innovation Center being a new engine for revitalizing and sustaining Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and ultimately, for improving the health care system for all Americans.

Under the Affordable Care Act, with active guidance from CMS leadership, the Innovation Center has substantial resources and flexibility to rapidly test innovative care and payment models and encourage widespread adoption of practices that promote better health and deliver better health care at lower cost.
The Innovation Center organizes its work in three major areas:

- **Patient Care Models: The right care at the right time, in the right setting – every time.**
- **Seamless Coordinated Care Models: Coordinating Care to Improve Health Outcomes for Patients.**
- **Community and Population Health Models: Keeping families and communities healthy.**

Much of the early work of the Center has been in the first two areas (for example with the recently released ACO regulations), but this "listening session" was intended to get feedback and ideas

for the third area. The focus of this third area is “to improve the health of populations – either defined geographically (health of the community), clinically (health of those with specific diseases), or by gender, race/ethnicity, or age (health of those experiencing disparities).” As stated in the materials provided to session participants, the Center will select models for testing effective community and population health approaches and interventions to improve health care quality and decrease costs for inclusion in their portfolio, with an emphasis on prevention and wellness programs which are both clinical and community-based and focused on primary and secondary prevention of chronic diseases such as cardiovascular diseases, diabetes, cancer and mental illness.

The meeting was led by Dr. Richard Gilfillan, the Innovation Center Acting Director, and Dr. Anand Parekh, Deputy Assistant Secretary for Health and Acting Director of the Population Health Models Group. The group of 30 assembled represented a wide variety of stakeholders. The conversation was stimulating and wide ranging, and it was apparent that the Center staff were actively engaged with the group in exploring challenges and opportunities.

Much of the discussion focused on how broad the population health model should and could be for CMS, given their primary responsibilities in medical care cost and quality. Many, including myself, argued that the model adopted should be a broad one, recognizing the multiple determinants of health. We argued that it would be a mistake to see population health as solely traditional chronic disease management, and as primarily focused on individual behavior change. It will be a challenge for CMS to go too far upstream, in part because they are required by law to only fund and test demonstrations which are likely to reduce Medicare or Medicaid expenditures (over an apparently unspecified time period) and in part because this would involve funding different kinds of activities and organizations than they traditionally work with. Given this, it is not clear to what degree their demonstrations would be able to reach into the social determinants.

On the other hand, it was pointed out that if the goal is to leverage broad population health metrics including disparity reduction, effective approaches cannot be limited to health care alone. It is well known and CMS staff acknowledge that substantial aspects of individual behavior change are dependent on the social context. Even if the CMS work focuses on behavioral risk factor reduction to prevent chronic conditions and their resultant morbidity and costs, perhaps demonstrations can include components which encourage or require health care organizations to partner with public health and other community organizations to leverage the broader and more upstream determinants. One approach might be to test funding for community health teams and broadly defined prevention specialists as has been under way in Vermont. Another might be to be provide community health systems with epidemiological and cost effectiveness training and technical support to be sure that the interventions are on target for broad population health impact.

The challenges are great, but I am pleased that this critical federal agency is “listening” to population heath advocates as they design their work. And it is particularly encouraging for population health proponents to hear an agency traditionally focused exclusively on health care express interest in investing in prevention efforts and in incentivizing health care providers to become engaged in community prevention efforts. Stay tuned for the upcoming CMS announcement of funding opportunities to test population health models with the potential for metrics improvement and cost savings. If you have a model or idea you think they should be considering, you can submit it here.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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It's nice to hear that CMS is using the triple aim framework. Also - good job, Dave, on encouraging CMS to take a broad lens on determinants of health!

Gratuitously I add: The triple aim would also be great for the UW SMPH to consider as an integrating framework for its work.

Posted by: Helene Nelson | 09/07/2011 at 07:20 PM

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Posts from September 2011

09/29/2011

HIA: A Practical Tool for Factoring Health into Decision Making Across Sectors



By Pamela Russo, MD, MPH

Staying healthy, whether we're talking about individuals or populations, is influenced by people's access to high quality health care and clinical prevention - but there is powerful evidence that staying healthy is *more strongly influenced* by people's education, job opportunities, economic status, and the social and physical environmental conditions where they are born, grow, live work, and age. This understanding needs to be conveyed in a useful way to those making decisions on policies, programs and projects in *non-health sectors* such as transportation, energy production, labor, or education, who rarely consider the consequences of their decisions on factors that influence health. Absent the consideration of effects on human health, we have often unintentionally created conditions that are either hazardous to human health or create barriers for people to adopt and maintain healthy behaviors. How can we convert the evidence on the multiple factors that drive population health into something decision-makers can use to build health into their equations?

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09/22/2011

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By David A. Kindig, MD, PhD

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Pop Health Twitter Roundup (9/22/11)

The latest and greatest from @PopHealth:

Not happy with the USDA's MyPlate guidelines, Harvard professors came up with their own

Global & Local: Designing Cities with Children in Mind

Michigan's Governor Rick Snyder: "Health is the foundation for Michigan's economic transformation"

Making it in the U.S. -- More than Just Hard Work

Employment prospects for low-qualified people are much dimmer than those for their more highly qualified counterparts

Nourishing NYC: working to eliminate the correlation between obesity and poverty

Claims data from 4 major insurers to become available to researchers through new Health Care Cost Institute

2011 MacArthur Fellow Roland Fryer examines causes and consequences of economic disparity due to race and inequality

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09/14/2011

Population Health Eye on Community Colleges



By Kirstin Q. Siemering, DrPH

We've often discussed the importance of education for population health. An individual's level of educational attainment is important for ensuring both income and health. The level of education of the workforce in a community is also important for economic growth. In a 2010 Chronicle of Higher Education article, Chairman of the Salt Lake City Chamber of Commerce Mark Bouchard did a "then and now" comparison of how companies approach location decisions. Ten years ago, Bouchard said, the norm was for such efforts to be led by a firm's real estate committee. These days, leadership is more often than not provided by human resource officials wanting to "know about the quality of the work force." Since the article was published, this message has only become more relevant – and given the current 9% national unemployment rate, will likely remain so for some time.

While it may seem as if policymakers and advocates focus more on the importance of early childhood education and high school completion than on higher education, a recent and growing spotlight on community colleges has begun to draw attention to the challenges and opportunities of this piece of the puzzle. This past spring, the Brookings-Rockefeller Project on State and Metropolitan Innovation released *Community Colleges and Regional Recovery: Strategies for State Action* to promote the idea that the time is ripe for states "to maximize their return on every public investment dollar for long-term, sustainable economic growth." While the report is not framed in population health terms, its message clearly aligns with a population health framework that recognizes social and economic factors as key drivers of health.

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- Cities versus rural for healthy living
- Massachusetts Lawmaker Introduces Bill To Minimize Disparities In Health Care Prices
- Medicare Chief Donald Berwick turns 65, signs up
- Supporting Health in All Policies: National Research Council gives guidance on use of Health Impact Assessment
- Cross-state partnership creates a win-win for maternal & child health
- Heard about RWJF's new initiative to transform health care?
- New bike share program offering $15/yr memberships for low income residents & free helmet
- U.S. Census reveals current poverty rate highest since 1993

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The latest and greatest from @PopHealth:

- Families feeling sharp edge of state budget cuts
- NACCHO has released its 2010 National Profile of Local Health Departments
- Colleges increasingly inhospitable to smoking
- Announcing plans for a course on telling the stories of public and population health
- Hoping for Change: Health and Social Disparities Facing Men and Boys of Color
- Coming soon from the National Research Council -- new report on the role of Health Impact Assessment
- New report from TFAH & RWJF -- Remembering 9/11 and Anthrax: Public Health's Vital Role in Nat'l Defense
- F.D.A. to review safety of popular bone drugs
- Food for thought: revive home economics classes to fight obesity?
- Great post on struggles grocery stores find in food deserts

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Posts from October 2011

10/25/2011

Population Health Eye on Affordable and Healthy Housing for All



By Kirstin Q. Siemering, DrPH

This past summer, several news articles called attention to the *County Health Rankings'* finding that people who live in urban and suburban environments tend to be healthier than those living in rural areas. The Wall Street Journal and the CBS Early Show should be applauded for calling attention to the fact that of the more than 3,000 counties assessed in the 2011 *Rankings*, 84% of the unhealthiest were rural while 48% of the healthiest were either urban or suburban. But we need to keep in mind that cities are also home to populations facing enormous health challenges.

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10/19/2011

The ACA's Essential Health Benefits: Start Simply, Learn over Time, Make it Better



By John R. Ball, MD, JD

On October 6, the Institute of Medicine released the report *Essential Health Benefits: Balancing Coverage and Cost*. The report was in response to a request from the Department of Health and Human Services to recommend "criteria and policy foundations" for the Secretary's determination of the essential health benefits (EHB) required to be offered by qualified health plans participating in the new state health insurance exchanges established by the Patient Protection and Affordable Care Act (ACA).

Early press coverage, which is often the public's only impression of such reports, pretty much got it right: the report called for a balancing of the comprehensiveness of coverage with the affordability of the benefit package. If cost were not taken into account in constructing benefits, the resulting package would rapidly become unaffordable, frustrating the central intent of the ACA, which was to make health insurance more available to more people.

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10/11/2011

Ignoring Evidence and Economics at Our Peril



By David A. Kindig, MD, PhD

Two recent *New York Times* articles jumped off the page at me. The first, on the recommendation by the U.S. Preventive Services Task Force to forego routine screening for prostate cancer with the PSA test, received wide media coverage. The second, on an Institute of Medicine (IOM) panel recommendation that costs should explicitly be considered in deciding what benefits must be provided by insurance plans, received less attention. Both deserve attention from population health advocates and policy makers.

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10/05/2011

Do We Need Population Health Shock Therapy?



By David A. Kindig, MD, PhD

I just finished reading Thomas Friedman and Michael Mandelbaum's new book *That Used To Be Us: How America Fell Behind in the World It Invented and How We Can Come Back*. It's a sobering read as it assesses the U.S.'s position in the world and what we have to do to regain lost economic and social competitiveness.

Friedman and Mandelbaum focus on four areas we need to urgently address in order to avoid falling into second world status: globalization, the information technology revolution, deficits and debt, and energy demand and climate change. The authors express particular concern about our education performance, and argue that recent information about relative international test score performance should have prompted a response similar to the investments in science and technology spurred by Sputnik a generation ago. But that hasn't happened.

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10/25/2011

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New York City provides an excellent case-in-point: New York County (a.k.a. Manhattan) ranked 25 of 62 (total counties in the state) in the 2011 *County Health Rankings,* while neighboring Bronx ranked 62 of 62. While there are many factors driving the health differences between these two places, this post will focus on one – housing – that doesn't often come up in conversations about health.

The link between health and housing is well established. The Robert Wood Johnson Foundation's Commission to Build a Healthier America's Issue Brief on Housing and Health identified three interrelated aspects of residential housing that influence health: (1) affordability, (2) the physical conditions within homes, and (3) neighborhood environments surrounding homes. In May 2011, the Center for Housing Policy released two important research summaries on The Impacts of Affordable Housing on Health and the Impacts of Affordable Housing on Education.

Rankings data reveal stark disparities between Manhattan and the Bronx with respect to housing. In Manhattan, 39% of households have high housing costs (defined as 30% or more of household income) vs. 52% in the Bronx. New York University's Furman Center for Real Estate and Urban Policy reported that fewer than 10% of Bronx home sales were affordable to the median Bronx household in 2010.

Like many population health problems, this one has no quick fix. But those who are looking for possible solutions should know about the South Bronx's new Melody building that has "hit all the right notes." The Melody is a 63-unit LEED-Platinum housing cooperative that is open to families with incomes from $35,000 to $90,000. The development is a public-private collaboration among Blue Sea Development Company, Habitat for Humanity, and the City of New York. Financing for the $18 million building was provided through city, state, and borough funding (primarily bonds) and it is the first in the city to incorporate the 2010 Active Design Guidelines to encourage the construction of buildings that facilitate increased physical activity and mobility. The building's fitness-promoting elements earned it the first LEED Innovation Point for Active Design awarded to a multifamily project.

Building features include:

- Outdoor exercise equipment, children's play structure, rooftop patio, and indoor gym that is free for residents;
- Colorful, brightly lit sets of stairs, featuring silhouettes of dancing women and piped-in jazz (the building's one elevator is slower than average, has no music, and is less prominently placed than the stairs);
- Multiple mechanisms for maintaining high levels of air quality within the building (South Bronx asthma rates are eight times the national average), such as each unit having its own sealed ventilation and filtration systems that vent directly outdoors and low VOC materials throughout in paints, adhesives, and floor coverings.

The Melody development showcases the power of public-private, cross-sector collaboration. But without adequate incentives, this type of effort is likely to remain the exception rather than the rule. Inclusionary zoning (which requires developers to make a percentage of housing units in new developments available to low- and moderate-income families) is one policy option that has drawn praise (as well as criticism) in recent years. We need to continue to explore all policy options and examine the evidence to determine which approaches work best. The South Bronx's Melody housing co-op is an impressive example of what needs to happen on a broader scale in urban communities throughout the country to improve health. It provides hope for a trend toward expanded options for working families who have a need for – and should have a right to – healthy and affordable housing.

Kirstin Q. Siemering, DrPH is a Researcher with the University of Wisconsin Population Health Institute.

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Early press coverage, which is often the public's only impression of such reports, pretty much got it right: the report called for a balancing of the comprehensiveness of coverage with the affordability of the benefit package. If cost were not taken into account in constructing benefits, the resulting package would rapidly become unaffordable, frustrating the central intent of the ACA, which was to make health insurance more available to more people.

But early reports often miss points that will become quite important when implementation of the recommendations begins. The report recommended that the Secretary begin with what a typical small employer (who, along with individuals, will be the major purchaser in the exchanges) currently offers, supplement that benefit package with the ten categories of services specified in the ACA (for example, mental health and substance abuse services and pediatric oral and vision care), and adjust the package to fit a premium target (what a small employer would have paid in 2014 in absence of the ACA). It is that adjustment that will be very important.

In effect, the report recommended that the Secretary take a ten-pound package, add a few ounces, and put it into a ten-pound bag. This means that the Secretary must remove some items from the original ten pounds. But the report also gave the Secretary the means to do so. Building on the four policy foundations—economics, ethics, evidence-based medicine, and population health

—developed in the report (Figure 1), three types of criteria are recommended: criteria to guide the content of the aggregate EHB package, criteria to guide specific components, and criteria to guide the methods for defining and updating the EHB. For example, population health informs the criteria "address the medical concerns of greatest importance" and "demonstrate meaningful improvement in outcomes over current effective services." Ethics informs the criteria "protect the most vulnerable" and "attentive to stewardship."

How, then, does the Secretary remove the few unnecessary ounces? By first applying the aggregate criteria, then the content-specific criteria: for an individual service, is it safe? Is it effective? Does it demonstrate meaningful improvement? Is it a medical service? Is it cost effective? In effect, the report asks the Secretary to apply science to policy decisions.

But a second step is equally important. The report recommends that the Secretary apply *values,* in addition to science, to her policy decisions. Through a structured public deliberative process—not a town meeting—the Secretary can gain an understanding of how the public (people who will purchase insurance through the exchanges and ordinary taxpayers) values specific health services, and how the public would make tradeoffs between competing goods.

Start with what is—the benefits people have now; learn—from science and values; and make it better over time: a prescription for how to make health care better and more affordable.

John R. Ball, MD, JD is a retired medical executive, having served as chief executive officer of the American College of Physicians, Pennsylvania Hospital, and, most recently, the American Society for Clinical Pathology. He chaired the IOM Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans.

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Very nice summary - welcome cool head. Eventually, we will have to figure out long-term-care in our calculus of access and insurance. CLASS's demise makes that even more pressing. Would be good to include that in our scope of concern, even though we are not yet ready to include it in our scope of required insurance elements.

Posted by: Joanne Lynn | 10/20/2011 at 12:38 PM

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10/11/2011

Ignoring Evidence and Economics at Our Peril



By David A. Kindig, MD, PhD

Two recent *New York Times* articles jumped off the page at me. The first, on the recommendation by the U.S. Preventive Services Task Force to forego routine screening for prostate cancer with the PSA test, received wide media coverage. The second, on an Institute of Medicine (IOM) panel recommendation that costs should explicitly be considered in deciding what benefits must be provided by insurance plans, received less attention. Both deserve attention from population health advocates and policy makers.

The reason for the PSA recommendation is that the best scientific evidence reviewed by the panel over several years shows that such routine screening does not save lives overall and "often leads to more tests and treatments that needlessly cause pain, impotence and incontinence in many." Health care groups and patient advocates were quick to criticize the panel's findings, in a similar pushback to the recommendation two years ago against routine mammography for women in their 40s.

While most of the PSA test media coverage has focused on effective care, we should also consider the panel's recommendation from a cost-containment imperative. The fact is, resources are becoming increasingly limited and both Republican and Democratic policymakers (not necessarily office holders) agree that Medicare spending must be reduced to reduce debt – and, some argue, protect national security in the global economy. Some facts to consider:

- As much as 25% of all health care expenditures are considered ineffective;

- Miami spends twice as many Medicare dollars per person as Minneapolis but gets no better results;
- We spend much more than any other nation on health care, with worse results.

There are two ways to achieve cost savings: provide fewer services and/or charge lower prices for each service. Any mention of this triggers loaded words from "rationing" to "government death panels." I believe that while limiting services which have benefit is ethically and analytically challenging, eliminating those such as PSA screening with no benefit and even harm is not. But we must keep in mind that personal, professional, and political interests do not always align with the evidence: the *New York Times* article asserted that health reform legislation requires Medicare to pay for PSA screening regardless of the panel's findings.

That the IOM committee should have to make a case for cost consideration in benefit design indicates how far from rationality we have strayed. I believe we can get back on track by agreeing that:

- Cost containment is a national security priority;
- We are wasting resources now;
- We should channel our resources toward cost-effective investments in prevention and the social determinants of health (the Obama administration is very short-sighted in proposing $3.5 billion in cuts to the already modest Prevention and Public Health Fund);
- We have opportunities to shift resources from ineffective health care to population health through community benefit reform and innovations from the Centers for Medicare and Medicaid Services (CMS).

We can't have it both ways. We can't lower costs without considering them. If evidence is not used to guide policy choices, what is the alternative? Perhaps we do need "shock therapy" to have evidence and economics drive our policy thinking. We can't solve our health care and population health challenges without it.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Posted on 10/11/2011 in The National Policy Front | Permalink

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10/05/2011

Do We Need Population Health Shock Therapy?



By David A. Kindig, MD, PhD

I just finished reading Thomas Friedman and Michael Mandelbaum's new book *That Used To Be Us: How America Fell Behind in the World It Invented and How We Can Come Back*. It's a sobering read as it assesses the U.S.'s position in the world and what we have to do to regain lost economic and social competitiveness.

Friedman and Mandelbaum focus on four areas we need to urgently address in order to avoid falling into second world status: globalization, the information technology revolution, deficits and debt, and energy demand and climate change. The authors express particular concern about our education performance, and argue that recent information about relative international test score performance should have prompted a response similar to the investments in science and technology spurred by Sputnik a generation ago. But that hasn't happened.

I found their diagnosis compelling and sobering, so looked forward to reading their "prescription" in the final chapters. In a chapter called "Shock Therapy," they argue that the current political paralysis is not up to these challenges and that the system calls for political shock therapy -- a direct analogy to its once classic use in psychiatry -- defined by the authors as a radical centrist third party.

What does this have to do with population health? I am basically an optimist, and I do believe that more attention is being paid to population health policy now than a decade ago. Friedman and Mandelbaum call themselves "frustrated optimists" – I, too, have days when I wonder whether we will be able to assemble the will and resources to show improvement in our health outcomes, including the persistent health disparities by race, education, income, geography, and gender.

In discussing this blog and the challenges of its having traction in the world of national policy debate, a wise colleague recently mused that that the intensity and frustration of current immediate challenges may numb many of us from even more distant and difficult goals. A recent *New York Times* op-ed argued that "problems like mass joblessness and starvation can seem so daunting that we stop trying to help." Likewise, David Brooks recently commented on the limits of empathy, observing that "empathy has become a shortcut…a way to experience delicious moral emotions without confronting the weaknesses in our nature that prevent us from actually acting upon them." He argued that religious, military, social or philosophic codes are much more powerful and are sources of identity and joy that trump empathy alone.

The radical centrist third party Friedman and Mandelbaum suggest for their four challenges would go beyond empathy and compassion alone and would likely have an impact on population health policy, particularly given its emphasis on education as well as science and technology. But how realistic is it, and do we sit by the sidelines for it to happen? My prescription for the next decade may not be shock therapy, but I hope that population health advocates would support the following steps until something more promising or radical emerges:

1. Be clear on our metrics for achievement and improvement, including disparity reduction.
2. Find savings from ineffective health care spending, and reallocate them to other population health determinants through such mechanisms as IRS Community Benefit reform and ACO shared savings.
3. Identify and enhance health promoting policies and programs in non-health care areas (Health in All Policies, Health Impact Assessments).
4. Identify cross-sectoral national and local partnership models with business models and financial teeth to leverage additional resources and policies.

Are there better goals for the next decade?

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

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Posts from November 2011

11/29/2011

Berwick is Gone: The Collision of Candor and Politics



By David A. Kindig, MD, PhD

We knew it was coming, but I winced when I saw the headline: *Medicare and Medicaid Chief, Never Confirmed by Senate, Is Stepping Down*. The headline, of course, refers to Don Berwick, who has run this critical agency in the Obama administration since July 2010. He is a highly regarded pediatrician and heath policy expert, and the founder of the Institute for HealthCare Improvement (IHI), a nationally recognized organization that leads efforts to improve health care quality and contain costs. Under his leadership, CMS has released final rules for Accountable Care Organizations' (ACOs) Medicare Shared Savings Program, developed the Comprehensive Primary Care Initiative, and launched the Health Care Innovation Challenge.

Berwick is resigning because his appointment is an Obama "recess" appointment not requiring Senate confirmation.

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11/16/2011

Triple Aim: Accelerating and Sustaining Collective Regional Action




By David A. Kindig, MD, PhD and John Whittington, MD

I've been following the Institute for Healthcare Improvement's (IHI) Triple Aim for some time. The IHI was founded in 1991 by Don Berwick and a small group of colleagues who were committed to redesigning health care into a system no longer plagued by errors, waste, delay, and unsustainable social and economic costs. In 2005, IHI created a vision to work on three simultaneous aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. A year ago they embarked on a broader regional health improvement effort at the community level.

While openly enthusiastic about their work, I've also offered constrictive criticism -- especially regarding their concept of the Third Aim Population Health, and how robustly the non-health care determinants fit into their model and priorities.

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11/09/2011

Is There Synergy in Community Development Financing and Population Health?



By David A. Kindig, MD, PhD

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This week I attended a follow-up meeting called *Healthy Communities: Building Systems to Integrate Community Development and Health*. Sponsored by the Federal Reserve Bank of San Francisco, the Robert Wood Johnson Foundation, and the Pew Charitable Trusts, the meeting brought together about 120 leaders from academia, foundations, banking and finance, and the federal government (including the White House, HUD, DOE, DHHS, and EPA).

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11/02/2011

(How) Does Where You Live Get Under Your Skin?



By David A. Kindig, MD, PhD

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Last week there was significant media coverage (including the October 29 *Economist*!) of an article by Jens Ludwig and colleagues that was featured in the Oct 20 *New England Journal of Medicine*. The study reported that moving from a high poverty neighborhood to a lower poverty one showed substantial improvement in obesity rates and blood sugar levels. Why was this report deemed of such interest and importance, even by the mainstream press?

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Berwick is resigning because his appointment is an Obama "recess" appointment not requiring Senate confirmation.

Why was he so objectionable to those having the power to confirm him? Put simply, throughout his career, he has shown vision and honesty about improving value in health care – which both parties agree is essential for national and global economic security. Most of his work has been in the trenches of healthcare institutions, showing and teaching about how quality can be measured and therefore improved while controlling costs.

But along the way he spoke frankly about what he saw and what he knew had to be done. In one 2009 published interview he said what gave partisan critics all the ammunition they needed: "The decision is not whether or not we will ration care – the decision is whether we will ration with our eyes open."

Despite this concept having broad support, the "R word" remains politically anathema. In all my work with Donna Shalala I never heard this word leave her lips. Politicians are forced to use more

cautious terms like “value” and “efficiency”-- which are technically correct, but don’t catch our attention in the same way. Our attention is exactly what is critically needed now.

Why is the word rationing so charged? The New World Dictionary defines it as ***“a systematic method for limiting access to a good or service when demand exceeds supply.”*** Perhaps the idea of limiting access to anything medicine has to offer is challenging to some, but the reality is that we are living in a resource-limited world where health care is far too often wasteful and ineffective. Analysts from both sides of the aisle suggest that substantial reductions in what we spend are required if our economy is going to thrive.

The question is, will it be done in the thoughtful and rational ways “with our eyes open” that Berwick has advocated, or simply by mindless across-the-board reductions such as might be triggered by the Super Committee’s failure of leadership?

The fact that there is so much waste and inefficiency means that we can cut costs without harming anyone; I don’t think this even qualifies as rationing. We get into more difficult territory when something provides some benefit but at great cost. Many population health advocates believe that such services should also be scrutinized, particularly when we are so underfunded for the preventive and social services we know are so effective in improving health. I noted with great interest an October 27 *New York Times* editorial on the mammography screening controversy which observed that “several thousand lives saved per year is not inconsequential….but the analysis inevitable raises questions as to whether the $5 billion spent annually on mammography screening and the millions more spent urging women to get screened might better be used for other purposes.”

This kind of rationing question is substantial and difficult, but should we approach our health care cost challenge this way with our eyes open, or in closed or mindless ways out of the public eye? I have always argued that rationing can be rational, which is all that Berwick was saying. Let’s hope that those who succeed him in this position will build on his accomplishments with a similarly candid approach.

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While openly enthusiastic about their work, I've also offered constrictive criticism -- especially regarding their concept of the Third Aim Population Health, and how robustly the non-health care determinants fit into their model and priorities.

But whenever someone asks me (as someone did last week)where to look for the best examples of health care systems working to embrace a population health perspective, I always say those involved in the IHI Triple Aim.

I talk to John regularly, and last month he shared with me some of his current thinking about how Triple Aim goals can be achieved in geographic regions broader than traditional enrolled members of health care systems. Here are his thoughts:

> *Over time, the Triple Aim focus has expanded from working with small population groups and adopted a broader, more regional focus. As we move forward with strengthening our regional approach, we're asking ourselves, "What would it take to accelerate and sustain collective action on a population health project in a region that must coordinate with multiple agencies?"*

We're now testing a new approach to regional population health projects that's based on what we've learned from existing Triple Aim sites, along with helpful guidance from Kania and Kramer's 2011 article, Collective Impact. We have been working with a number of developing Triple Aim regional communities in Cincinnati, Ohio; Jackson, Michigan; 14 counties in east central Michigan; and 16 counties in North Carolina. We consider the following elements to be essential, based on our research and experience to date.

** Adaptive Leadership -- Having the ability to see the big picture and galvanize that group around a set of clear aims.*

** Community assessment -- Gaining an understanding of resources and needs. Who is already working in this project space? What should we know about the needs of those who will be served by the effort, including which existing agencies and services are most utilized?*

** Infrastructure to support the project work -- Meeting demands for core infrastructure elements, including project management, data management, quality improvement advising and logistical support.*

** Unified language and approach -- Finding ways to harness, create shared meaning, and ultimately synergy among partners' diverse training and real world experiences.*

** Measures -- Selecting and monitoring a set of high-level measures that can be used to gauge progress toward aims.*

** Funders -- Working deliberately and strategically to build relationships with funders to support overall project goals.*

** Health equity -- Ensuring that the approach addresses needs of high risk populations. In our work to so far, key challenges have included patient management and care coordination, economic or social factors, and patient and family involvement (such as for chronic disease self-management).*

** Communication -- Maintaining open lines of communication among partners and with key external entities such as the media.*

The elements listed above are being employed in a wide range of initiatives addressing issues such as infant mortality, childhood obesity, adult obesity, care coordination and other population health issues. We see promise in this approach and are interested in connecting with people in communities across the country that have an interest in engaging in this type of work.

While these elements may not seem remarkable to those in public health or community organizing, they are not what we usually see from health care strategy. While regional Triple Aim projects have not matured enough to see long lasting results, they are certainly ones to keep our eyes on.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

John Whittington, MD is the Institute for Healthcare Improvement's (IHI) Lead Faculty for the Triple Aim.

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Thank you for the brief history and evolution of the Triple Aim with regards to population health - clarifies and offers great promise. It offers a good model for broader and more collaborative interpretation of how hospital community benefits activities could evolve under the new regulations.

Posted by: Pamela Russo | 11/17/2011 at 08:20 AM

Interesting approach and glad to see they have the critical element of "funders" in the list. The question as always remains: who are these funders? Whose pocketbook (profits, wages, income) must ultimately be reduced for such population health improvement to occur? All available evidence strongly supports the supposition that neither providers nor private sector insurers have any incentive to reducing their own income and profits for such 'public good' funding. Consequently increased taxation is likely the only sustainable approach. However, recent history has demonstrated both the 1% and 99%'s inability and / or unwillingness to meaningfully address the moral hazard inherent in our current healthcare 'market' models. In healthcare markets rational self-interest may guarantee that population health continues to be the victim of the tragedy of the commons.

Posted by: Robert Stone Newsom, PhD | 11/17/2011 at 02:09 PM

At the end of the Clinton administration wuch a program was funded to provide $1M /year for 5 years to support the development of a small group of communities to develop such systems linking all important sectors. Lessons were learned and a continuing organization called Communites Joined in Acgtion continue that mission struggliing without the necessary support to achieve the spreading of the best results. That passion existsa right now in this country. Tap into it!

Posted by: Mary Lou Andersaen | 11/28/2011 at 12:26 PM

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The purpose of the conference was to "highlight promising new models and explore three areas of system reform that are urgently needed to formally align community development and health: data, capital, and policy." Morning sessions focused on "working together" (regional models, lessons, and strategies for scale) and "bending the cost curve" (integrating health and community development). Three afternoon sessions targeted system changes in the three priority areas – capital, data, and policy.

The event was coordinated with the release of the November issue of *Health Affairs*, which is devoted to Community Development and Health. Conference organizer David Erickson (of the San Francisco Federal Reserve) and Nancy Andrews (CEO of the Low Income Investment Fund) create a sense of the potential in their joint article:

> *The community development 'industry'—a network of nonprofit service providers, real estate developers, financial institutions, foundations, and government—draws on public subsidies and other financing to transform impoverished neighborhoods into better-functioning communities. Although such activity positively affects the 'upstream' causes of poor health, the community development industry rarely collaborates with the health sector or even considers health effects in its work. Examples of initiatives—such as the creation of affordable housing that avoids nursing home placement—suggest a strong potential for cross-sector collaborations to reduce health disparities and slow the growth of health care spending, while at the same time improving economic and social well-being in America's most disadvantaged communities.*

As in last year's meeting, both sides were still learning about each other's language and ideas but were much closer as to the shared purpose of their work regarding healthy communities. We learned that the community development field generates some $50 billion in annual investment for healthy housing, small business, quality community child care, education and health facilities, and now, increasingly local food systems. Population health participants stressed the need for synergistic investments early in the life course, the need for cross-sectoral business models supporting such investments, and the kinds of data that we have and need to support such investments.

For me, and many others from the health "side" of the discussion, the scope of resources in play was dazzling, but the structure and functioning of innovative funding mechanisms and vehicles (ever heard of "progressive capital"?) were still foreign territory. While the promise of health-promoting investment coming from and working synergistically with community development dollars is appealing in this austere environment, the finance experts stressed that there is no free lunch and that even these efforts need to generate cash flow or savings to work. There was discussion about government or philanthropy playing the important role of the guarantor of the initial risk of uncertain investments. The need to put a dollar value on health improvement was stressed repeatedly.

I left the meeting wanting to believe in the possibility of synergy, but with some degree of skepticism. I think there is exciting opportunity in such innovative cross-sectoral investments and partnerships. Even modest connections of population health with the many billions invested in community development would be a huge addition. We will need concrete examples of success or failures to help bridge the language and understanding gaps between the sectors, but it feels like there is a willingness and even eagerness to go forward. Let's not let this become a case of what *seems* too good to be true actually *being* too good to be true.

So, I will read all the papers in the *Health Affairs* issue carefully to increase my understanding and will continue to actively explore partnerships with Community Development Financial Institutions both nationally and locally…and I hope you will also.

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There is no disputing that these are provocative findings. While those in the field of public and population health have understood for some time that the social determinants of health are probably as important as health care and individual behaviors, this concept is not yet fully appreciated. When asked what influences health, my sense is that the public as well as many policymakers are much more likely to list health care (procedures/drugs/immunizations) and the physical environment (air/water/restaurant sanitation) than socially-mediated influences such as income, education, housing, and neighborhood "environment."

The science of how social factors get "under the skin" to indirectly produce disease is complex and the field is still in its relative infancy, which makes it that much more difficult – and that much more important -- to translate this type of research into policy.

In this study, the investigators took advantage of a policy experiment sponsored by the Department of Housing and Urban Development. From 1994 to 1998, 1800 of almost 5000 women with children living in public housing in high poverty urban areas were randomly assigned to receive vouchers allowing them to move to a low poverty census tract. Follow-up on these women was conducted from 2008-2010 on a variety of factors. Compared to the control group, the women had lower BMI over 35 (13%), BMI over 40 (19%), and HgA1c (a blood glucose diabetes indicator, 22%). The study was not designed to figure out what caused these effects, although the authors speculate that stress associated with residential segregation in poverty areas may be responsible. *The Economist* coverage suggests a possible linkage with food deserts in high poverty areas, although the study did not explore this. Other possible contributing factors include toxic exposures, parks and sidewalks, crime/violence and perceptions of safety, social connections, and the quality of local institutions like schools and employment opportunities.

It's entirely possibly – likely even – that the heightened media attention on the study reflects the current national milieu. With the recent "occupy" protests across the country, economic inequality is likely to play a prominent role in the 2012 elections. But politics aside, I believe the study deserves attention for its methodological rigor. The study employed a randomized design, which is rare due to cost and often ethical considerations. In the physical and biological sciences test tube experimental conditions often allow the manipulation of variables so that causal relationships can be made with some certainty. In social sciences we are often limited to weaker statistical relationships, which often fall short when trying to convince policy makers to invest differently.

The Ludwig study is not without some methodological limitations, and we still don't know how moving to lower poverty neighborhoods gets under the skin to reduce weight and glucose levels. But the results are consistent with theory and other studies, and give us reason to choose healthy policies in all domains. It should also encourage foundations and government to fund similar experiments. Working simultaneously on both policy and research fronts will help ensure steady progress toward our goal of determining how to best invest our scarce resources for the greatest population health gain.

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12/20/2011

Population Health Eye on Pre-Kindergarten



By Kirstin Q. Siemering, DrPH, RD

Here on the Improving Population Health blog, we recognize the important role that education plays in health outcomes. Earlier this year, David Kindig encouraged business sector investments in early childhood education as a means for improving the health of tomorrow's workforce. And back in September, our "Eye On Pop Health" series focused on higher education, paying special attention to the need for community college reform.

This month, we're celebrating the end of one impressive early learning initiative and the start of another. The Pew Center on the States' ambitious, 10-year Pre-K Now campaign will end on December 31, 2011. The campaign's goal, which was to advance high quality, voluntary pre-kindergarten for all three- and four-year old, hit many milestones as it worked toward transforming U.S. education from a K-12 system to a Pre-K-12 system. And last Friday, Domestic Policy Council Director Melody Barnes joined Education Secretary Arne Duncan and Health and Human Services Secretary Kathleen Sebelius to announce $500 million in grants to nine state winners of the Race to the Top Early Learning Challenge to spur improvement in early childhood education programs.

These investments hit particularly close to home for me, as the mother of one of over 1,800 children participating in Madison's inaugural Pre-K (known as "4K" in Wisconsin) program this school year.

As a state, Wisconsin has a unique history with respect to pre-k. It is the only state in the nation that specified education for 4-year-olds in the original, 1848 state Constitution. While there are many different ways to implement pre-k programs, about 30% of Wisconsin school districts offering pre-k use a multi-sector, collaborative "community approach" that reflects this blog's

population health ideals. Pew's Pre-K Now campaign recognized the community approach in this seven minute video that showcased efforts in Eau Claire, Wisconsin.

Instead of creating a new system from scratch, the community approach builds early childhood education programs by cultivating partnerships among existing providers, both public and private. With numerous and diverse early learning systems well-established in Madison, much effort was needed to cultivate buy-in for a universal approach among entities that have historically been more competitive than cooperative. The Madison 4K planning committee led conversations on mission and vision, curriculum and assessment, parent partnerships, communication structures, professional development, and other key areas to gather support for the fledgling coordinated program.

An essential element to Wisconsin's 4K success has been the five regional "Collaboration Coaches" who are employed by the Wisconsin Department of Public Instruction. The Collaboration Coaches work at the local level, providing information, support, and technical assistance to community leaders from a diverse array of agencies and organizations to help strengthen the state's Birth to Six systems (which includes but is not limited to 4K).

In last Friday's announcement, Secretary Sebelius said, "A strong educational system is critical not just for our children but also for our nation's economic future. The Race to the Top-Early Learning Challenge takes a holistic approach to early education, promotes innovation, and focuses on what it takes to help put young children on the path of learning, opportunity, and success." In Wisconsin, 4K is part of the state's school funding formula, but the 2011-13 state budget eliminated $1.6 billion from education. Although no district so far has dropped 4K, many are currently looking for ways to cut costs (e.g., saving on transportation by moving from 4 half days to 2-3 whole days). Nobody yet knows what affect the budget cuts will have on 4K in the 2012-13 school year.

Having a strong educational foundation should be a right, not a privilege. Let's do everything we can to build on the momentum that's been started in this area and seek out ways to overcome any challenges that might slow or derail this important work. It's not only our children that are at stake – it's our future.

Many thanks to two of Wisconsin's 4K leaders who offered information and insight for this post:

Jill Haglund -- *Early Childhood Consultant, Wisconsin Department of Public Instruction*

Ann Ramminger, MS -- *Wisconsin Early Childhood Collaborating Partners, Southern Region Collaboration Coach*

Kirstin Q. Siemering, DrPH, RD is a Researcher with the University of Wisconsin Population Health Institute.

Posted on 12/20/2011 in Policy and Systems Change in Action | Permalink

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12/14/2011

Can Leadership Come from within Health Care? Comments on the Triple Aim Regional Strategy…and Mt. Sinai Academic Health Center



By David A. Kindig, MD, PhD

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From Pamela Russo: *Thank you for the brief history and evolution of the Triple Aim with regards to population health - clarifies and offers great promise. It offers a good model for broader and more collaborative interpretation of how hospital community benefits activities could evolve under the new regulations.*

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From Robert Stone Newsom: *Interesting approach and glad to see they have the critical element of "funders" in the list. The question as always remains: who are these funders? Whose pocketbook (profits, wages, income) must ultimately be reduced for such population health improvement to occur? All available evidence strongly supports the supposition that neither providers nor private sector insurers have any incentive to reducing their own income and profits for such 'public good' funding. Consequently increased taxation is likely the only sustainable approach. However, recent history has demonstrated both the 1% and 99%'s inability and / or unwillingness to meaningfully address the moral hazard inherent in our*

current healthcare 'market' models. In healthcare markets rational self-interest may guarantee that population health continues to be the victim of the tragedy of the commons.

I continue to remain bullish in thinking about Triple Aim regional projects as emerging beacons of where healthcare organizations are pushing the boundaries beyond traditional health care concerns, to fully embrace a population health view. But will the leadership, infrastructure, and funding challenges that John Whittington outlines evolve and grow, in the face of the Newsom comments above? I think it will only happen if Triple Aim leadership continues to embrace a robust definition of population health outcomes, including disparity reduction at the regional/community level.

It's no wonder the November 22 Mt. Sinai Medical Center's *New York Times* advertised commentary caught my eye. The piece, written by Kenneth Davis, is titled "Social Service Support: Better for Individuals and Health Care," asserts that one reason for our lower health outcomes despite large health care expenditures is that *"the US spends far less than other countries on critical services such as housing, employment training, improved education, and income supplements. Most OECD nations spend between 20 and 40 percent of their GDP on health care and social services combined.....the US spends about 15 percent on each, while other nations spend two or three times more on social services.....Improving population health and reducing hospitalizations are everyone's goals, but hospitals can only provide part of the solution. In order to lower costs, we need to invest in social support services outside of our health care institutions. By doing so we will improve the nation's health and meaningfully bend the health care cost curve".*

Extremely well said, Dr. Davis. This is a perspective widely shared by those in the population and public health fields but is probably less familiar to those working in healthcare and academic health centers. Population health improvement very much needs such insight and support from leaders within the health care system. It is this perspective that needs to guide Triple Aim concepts and work on the ground to ensure development of three equally robust legs of the stool – population health, cost, and quality.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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Well, that's the problem, isn't it? Health care and public health were severed early in the 20th century, and we've been paying the price for that decision ever since. I had been a practicing critical care nurse for years when I began to wonder if preventing all the health disasters I was seeing might not be preferable to throwing technology at them. I found no support -- and I had never even heard of public health. It took me a while to find out how to proceed. When I entered my MPH program, I found that, as a clinician, I spoke a completely different language from those in public health. It was a complete re-socialization process.

I would submit that we re-think that initial disastrous decision. Training in population health should be integrated into the education of all health care professionals. As for non-clinical public health professionals -- a few clinical facts of life wouldn't hurt them either.

Posted by: Burden S Lundgren, MPH, PhD, RN | 12/15/2011 at 11:06 AM

As with provider-based improvement, population-based improvement is dependent on transparently shared, frequent observations of results. To paraphrase Lord Kelvin, as many others have, one can not improve unless one measures. Applying triple aim principles to population health requires a geographically defined population and simultaneous, frequent, transparent, interpretable measurement of population health, experience of care and cost per capita. Adherence to these principles prevents viewing only the silver lining without the cloud.

Posted by: Ed Donovan | 12/15/2011 at 01:18 PM

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12/06/2011

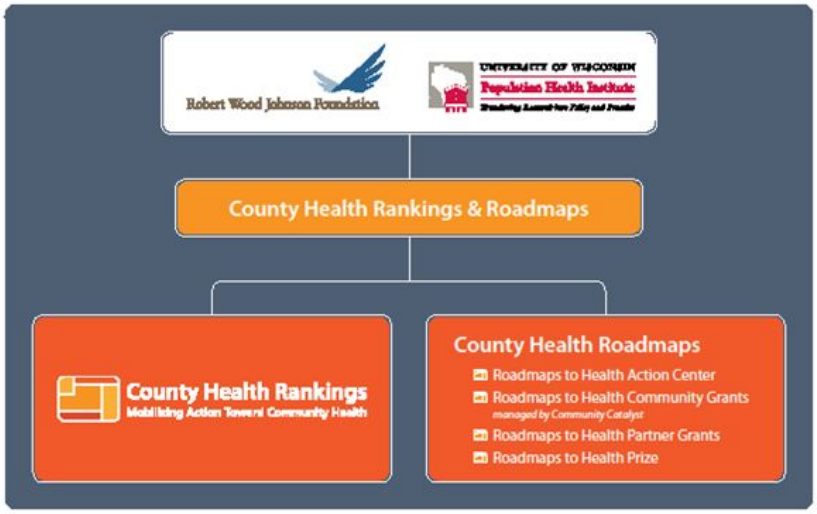
County Health Roadmaps



By Bridget Booske Catlin, PhD, MHSA

Hopefully, by now everyone who reads this blog has heard of the *County Health Rankings* but I suspect few of you have heard of the *County Health Roadmaps*. Ranking the health of nearly every county in the nation, the *County Health Rankings* illustrate what we know when it comes to what's making people sick or healthy. The new *County Health Roadmaps* show what we can do to create healthier places to live, learn, work and play. The Robert Wood Johnson Foundation (RWJF) is collaborating with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties and states across the nation.

The *County Health Roadmaps* project includes several efforts to build connections with local communities, national partners and leaders across all sectors to improve health. The project includes grants to coalitions across the U.S. that are working to improve the health of people in their communities; grants to national organizations to mobilize local leaders and affiliates to improve health; a prize program to recognize communities taking action and whose promising efforts will likely lead to better health; and tools and resources to help groups working to improve the health of people in their communities.



As shown in the graphic above, the four main components of the *County Health Roadmaps* are:

***Roadmaps to Health* Community Grants:** These grants, which support two-year state and local efforts among policymakers, business, education, health care, public health and community organizations, are managed by Community Catalyst, a national consumer health advocacy organization. The first 12 new grantees, announced earlier this month, are working to create positive policy or systems changes that address the social and economic factors that impact the health of people in their community. *Roadmaps to Health* Community Grantees have a matching fund requirement in order to engage local and national funders and other community partners invested in improving health. The Call for Proposals for the second round of Community Grants will be available by March 2012.

***Roadmaps to Health* Partner Grants:** RWJF will award *Roadmaps to Health* Partner Grants to up to six national organizations that are experienced at engaging local partners and leaders; able to deliver high-quality training and technical assistance; and committed to making communities healthier places to live, learn, work and play. Partner Grantees will increase awareness about the *County Health Rankings* to its members, affiliates and allies. The first Partner Grant was awarded to United Way Worldwide (UWW) in July 2011. Julie Willems Van Dijk, the *Roadmaps* Deputy Director, will provide more details about UWW's activities in a future post.

***Roadmaps to Health* Prize:** In 2013, RWJF and UWPHI will award *Roadmaps to Health* Prizes of $25,000 to up to six communities that are working to become healthier places to live, learn work and play. The *Roadmaps to Health* Prize is intended not only to honor successful efforts, but to inspire and stimulate similar activities in other U.S. communities. Any U.S. community can apply for the *Roadmaps to Health* Prize. The Call for Applications for the 2013 Roadmaps to Health Prizes will be available in March 2012. This effort is being led by Dave Kindig and Kirstin Siemering; they will provide more details in a future post.

***Roadmaps to Health* Action Center:** The new Action Center, based at UWPHI, will provide tools and resources to help groups working to make their communities healthier places. This includes collaborative efforts with Community Catalyst and the Roadmaps to Health Partner Grantees to capture and share stories and case examples of communities taking action to improve health. In addition to the resources currently on the *County Health Rankings* website, the Action Center will host a searchable database of evidence-informed policies and programs focused on health improvement and provide guidance on developing solutions and advocacy efforts to advance pro-health policies. Experts will provide customized consultation to local communities who are seeking to address the factors that influence health.

This project (and blog post) is a team effort among RWJF, UWPHI, and Community Catalyst, with support from Burness Communications. For more information about the *County Health Roadmaps* project, please contact me, Bridget Booske Catlin, Director of the *County Health Roadmaps,* at bbooske@wisc.edu.

Bridget Booske Catlin, PhD, MHSA directs the County Health Rankings & Roadmaps program at the University of Wisconsin Population Health Institute.

Posted on 12/06/2011 in County Health Rankings & Roadmaps | Permalink

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Posts from December 2011

12/20/2011

Population Health Eye on Pre-Kindergarten



By Kirstin Q. Siemering, DrPH, RD

Here on the Improving Population Health blog, we recognize the important role that education plays in health outcomes. Earlier this year, David Kindig encouraged business sector investments in early childhood education as a means for improving the health of tomorrow's workforce. And back in September, our "Eye On Pop Health" series focused on higher education, paying special attention to the need for community college reform.

This month, we're celebrating the end of one impressive early learning initiative and the start of another. The Pew Center on the States' ambitious, 10-year Pre-K Now campaign will end on December 31, 2011. The campaign's goal, which was to advance high quality, voluntary pre-kindergarten for all three- and four-year old, hit many milestones as it worked toward transforming U.S. education from a K-12 system to a Pre-K-12 system. And last Friday, Domestic Policy Council Director Melody Barnes joined Education Secretary Arne Duncan and Health and Human Services Secretary Kathleen Sebelius to announce $500 million in grants to nine state winners of the Race to the Top Early Learning Challenge to spur improvement in early childhood education programs.

Continue reading "Population Health Eye on Pre-Kindergarten" »

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12/14/2011

Can Leadership Come from within Health Care? Comments on the Triple Aim Regional Strategy...and Mt. Sinai Academic Health Center



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12/06/2011

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By Bridget Booske Catlin, PhD, MHSA

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01/31/2012

Population Health Financing: Beyond Grants



By David A. Kindig, MD, PhD

My professional coming of age took place the late 1960s, in one of the original Office of Economic Opportunity (OEO) neighborhood health centers in the South Bronx. Because the health centers were a part of the larger federal antipoverty strategy, they were founded on a broad view of health (we would call it a population health framework even though that terminology didn't exist then). Health care innovation was the core, with community health workers, health care teams, and the understanding that the residents who didn't use the clinic contributed to overall neighborhood heath as much as those who did.

But the OEO funding paid for much more than health care, including job training, legal advocacy, school health programs, neighborhood built environments – what we now see as the multiple determinants of health. But one of the main lessons of my entire career was the following: when the grant goes away, the programs or innovations which it supported dwindle too. Don't get me wrong: federal and foundation grants are essential for innovation to occur, and I have served productively on both the giving and receiving ends of this equation. But initial funding almost always ends at some point (through change of political priorities or foundation leadership and priorities), and additional funds must be sought for sustainability or going to scale.

I also ran a large urban hospital for four years. Among many other major lessons, I came to appreciate the beauty of funding formulas and streams that just keep on delivering resources every day or week or month. A good example are the Medicare payments supporting medical resident education; these "extra" payments are built into Medicare funding formulas and provide ongoing, regular support for this important activity. Of course, they certainly come under political scrutiny occasionally and have to be justified and defended, but by and large they are embedded as well-

established fiscal supports like mortgage interest deductions or agricultural subsidies.

Despite more than a decade of helpful and creative public and private grants, I remain extremely concerned about our slow progress in addressing health inequities by geography, by race and by economic status. These injustices are sapping our national productivity and quality of life. We need to go beyond grants to identify sustainable resource flows that are up to the magnitude of the challenge.

I have been suggesting using some of the savings realized from eliminating ineffective and wasteful health care dollars, such as a share of ACO shared savings or IRS Community Benefit reform – but these may not be entirely workable or sufficient. We need to take a close and creative look at how to maximize efficiencies and possibly consolidate multi-sector revenue streams from education, business, and community development agencies toward achieving common health goals.

Voluntary efforts are not adequate if we are serious about this task. Let's commit ourselves over the next decade to finding these more robust, dependable mechanisms and documenting real progress in the areas that will have the greatest impact on population health.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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As in all insurance schemes until / unless those without the need are willing to finance those with it, the tragedy of the commons will guarantee pop health will remain underfunded and grant dependent. The question is: how to convince the 99% of us who see no personal advantage in pop health expenditures that such spending is nevertheless for our better good? I fear that most of us don't readily grasp the connection between self-health and population health?

Posted by: Robert Stone Newsom, PhD | 02/01/2012 at 04:39 PM

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01/23/2012

Make Way for Starbucks' Community Stores



By Kirstin Q. Siemering, DrPH, RD

Population health can be a hard sell for the business sector, where the nature of the work has historically meant a focus on profits to the exclusion of most if not all other priorities. Although we applaud the current expansion of worksite wellness programs, we recognize that these efforts represent only a fraction what is needed for broad and lasting change. For broad population health improvement, we need to get beyond individual knowledge and behavior to effect policy and environmental changes that make the healthy choice the easy choice.

As we consider tangible roles for businesses to play in population health improvement, it might be helpful to think of a continuum, with worksite wellness as a starting point. Many potential roles remain unexplored, but we should all take a vested interest in shaping how work on the other end of the spectrum might look.

Starbucks is one company that's going far beyond worksite wellness. In October 2011, Starbucks announced a new model for doing business that they're calling "community stores." The first two community stores are in Harlem (New York City) and Crenshaw (Los Angeles). For this effort, Starbucks has partnered with the Abyssinian Development Corporation and the Los Angeles Urban League respectively. At the core of the model is local profit sharing, with Starbucks committing to donating at least $100,000 in the first year to each of these communities. In announcing the initiative, Starbucks CEO Howard Schultz explained, "Starbucks is partnering with two organizations doing heroic work to address the economic, social, and educational challenges in their communities. These two partnerships are intended to help us learn how our company can successfully join with change-making community organizations in a localized, coordinated, and replicable way."

A *Christian Science Monitor* article quoted Los Angeles Urban League President and CEO Blair Hamilton Taylor on the effort: "It's not going to be a million dollars a year, but if McDonald's decides to do this next week, and then Wendy's decides to do it, and Burger King decides -- now all of a sudden you have a million dollars. My hope is that is what this triggers."

Partnering with well-established and trusted organizations with successful track records helps Starbucks make sure every dollar counts. In Crenshaw, for example, the funds will be used in part to bolster the Urban League's Neighborhoods@WorkTM model, which has so far seen a 51% rise in graduation rates at Crenshaw High School and a 34% decrease in Park Mesa Heights violent crime since 2007 baseline measures.

Earlier this month, in partnership with HealthPartners (based in the Minneapolis/St. Paul suburb of Bloomington, MN) our MATCH Group at the University of Wisconsin Population Health Institute hosted a fascinating meeting that brought together a small group of health leaders from several major U.S. corporations to discuss the role of business in population health improvement. The comments of this small group were extremely eye opening with regard to the breadth of values and action reflected. We are just beginning to sort through what we learned with the expectation of broadly sharing key findings.

It may be some time before we can determine the degree to which Starbuck's grand partnership vision plays out on the ground, but we'll be watching with interest and cheering from the sidelines. In the meantime, we'll be keeping our eyes out for how businesses across the country -- both large and small -- are taking up the mantle of population health. If you know of other examples of businesses looking beyond their concerns about health care costs and working to improve community health, please let us know.

Kirstin Q. Siemering, DrPH, RD is a Researcher with the University of Wisconsin Population Health Institute.

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01/19/2012

Community Benefit in the Population Health Literature



By David A. Kindig, MD, PhD

We try to keep this blog accessible and policy relevant, and therefore carefully avoid being overly academic. However, we also regularly follow the literature, which is a challenge given the breadth of multidisciplinary scholarship underpinning the field. So periodically I will point to particularly recent and relevant articles that may be of interest to readers. The list of 11 journals we regularly scan is listed at the bottom of this post. I welcome your flagging for me other journals and articles you suggest we follow. I'm going to start this series by focusing on an article from the December 2011 issue of the *American Journal of Public Health*.

The Impact of the Individual Mandate and Internal Revenue Service Form 990 Schedule H on Community Benefits from Nonprofit Hospitals by Principe K, Adams EK, Maynard J, and Becker ER.

While the authors summarize the history of the IRS Community Benefit Standard since 1969, they primarily focus on aspects of the Affordable Care Act that have implications for this provision. One important issue is that of the threshold for what counts for meeting the community benefit standard. Currently no threshold level exists, although figures such as 5% of revenue have been suggested in the past. The authors examined the data from Maryland and found substantial variation in the amount of community benefit services provided, ranging from a minimum of 1.67% of operating expenses to a maximum of 13%, and that only 70% of hospitals met a hypothetical 5% standard. Only recently, as a result of the new 990 Schedule H, have hospitals been required to report the net value of community benefit services in the following standard categories: charity care and means-tested government programs, community health improvements, health professions education, subsidized health services, community building activities, research, and cash or in-kind contributions to community groups. As these data become available, it will be

important to determine the distribution of these investments across the categories and evaluate how well they fit population health policy goals.

The authors also comment extensively on the impact of reducing the uninsured level through ACA coverage provisions on the direction of community benefit policy. They argue that "although the composition of community benefit services may change, tax-exempt status is still necessary to ensure sufficient provision of unprofitable services and those related to preventable diseases. Such preventative services have the potential to address the pressing public health problems of diabetes, obesity, and asthma….and which are designed to respond to unmet public health needs." I am continuing to pay close attention to this evolving issue, especially as it relates to the development of dependable revenue streams for population health improvement.

Other noteworthy articles:

Lessons From San Francisco: Health Impact Assessments Have Advanced Political Conditions For Improving Population Health (Bhatia R and Corburn J).

Policy Instruments Used by States Seeking to Improve School Food Environments. (Shroff MR and colleagues).

The Many Ways that Policymakers Use Public Health Researchers. (Haynes AS and colleagues).

Understanding the Link Between Environmental Exposures and Health: Does the Exposome Promise Too Much? (Peters A and colleagues.)

Journals we follow:

American Journal of Preventive Medicine

American Journal of Public Health

Annual Review of Public Health

Health Affairs

Journal of the American Medical Association (JAMA)

Journal of Epidemiology and Community Health

Journal of Health and Social Behavior

Milbank Quarterly

New England Journal of Medicine

Preventing Chronic Disease

Social Science and Medicine

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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01/04/2012

The Best of 2011 – and an Invitation to Help Shape IPH in 2012



By David A. Kindig, MD, PhD

I don't usually make formal New Year's resolutions, but I do think about the passing of the old year and the opportunities and responsibilities in the new one. In that spirit, I'm devoting this week's post to some key pieces from our 2011 archives. Next week, we'll be looking forward to give a preview of possible topics for 2012. We welcome any and all ideas from readers – this is your chance to help shape Improving Population Health in the coming year! Please just use the comment box below or email me directly.

So whether it's for the first time -- or for a second look -- I invite you to take a look at some of my favorite posts from 2011.

Achievement vs. Improvement. As the nation prepared for the 2011 release of the *County Health Rankings*, I suggested a complementary perspective: that we not shy away from the challenges of measuring improvement as well, and should find ways to identify and recognize populations with improving health metrics, regardless of their starting points.

Triple Aim. This concept from the Institute for Healthcare Improvement has been growing in influence and acceptance, but much work to date has focused on the double aims of cost and quality. Much more attention needs to be given to the Third Aim of population heath improvement, with appropriate metrics and multi-determinant thinking and policies. As CMS transitions leadership, I'm counting on the Innovation Center's Population Health Branch making sure this key concept doesn't fall off the radar screen.

Disparity Metrics. I believe that we talk a lot about reducing disparities, but rarely commit ourselves to careful measurement and tracking -- nor have we done enough to identify and implement

policy approaches that work in this area. This was the focus of a three-post series, in which I suggested the need for a multi domain metric across race, SES, gender, and geography. But rates are not enough when considering disparities -- population burden (including the size of population affected) is also important.

Population Health Policy and Funding. Several posts touched on important developments or opportunities. Community Benefit reform could provide a new and dependable revenue stream; there are wonderful opportunities for synergy with HUD and other Community Development funding particularly in inner city communities; the importance of the growing appreciation of businesses for early childhood programs as health and therefore worker productivity enhancing; and the potential for providing guidance to local community efforts with policy package options tailored to their own outcomes and determinants profiles.

Eye On Population Health. In her monthly community profiles Kirstin has called attention to population health policy and systems change in action. In 2011 she addressed a variety of issues from early childhood education to housing to transportation.

We wish our readers a great start to the New Year! Stay tuned for next week's post on topics we're planning to touch on in 2012.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

Posted on 01/04/2012 in Population Health Basics | Permalink

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David, have a great year and congratulations for your fantastic blog. We´ll go on reading you next 12 months.

Posted by: Rafa Cofiño | 01/04/2012 at 04:32 PM

I'd love to see you discuss the incorporation of Social Determinants into Healthy People 2020.

Posted by: Dawn Alley | 01/22/2012 at 05:47 PM

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Posts from January 2012

01/31/2012

Population Health Financing: Beyond Grants



By David A. Kindig, MD, PhD

My professional coming of age took place the late 1960s, in one of the original Office of Economic Opportunity (OEO) neighborhood health centers in the South Bronx. Because the health centers were a part of the larger federal antipoverty strategy, they were founded on a broad view of health (we would call it a population health framework even though that terminology didn't exist then). Health care innovation was the core, with community health workers, health care teams, and the understanding that the residents who didn't use the clinic contributed to overall neighborhood heath as much as those who did.

But the OEO funding paid for much more than health care, including job training, legal advocacy, school health programs, neighborhood built environments – what we now see as the multiple determinants of health. But one of the main lessons of my entire career was the following: when the grant goes away, the programs or innovations which it supported dwindle too. Don't get me wrong: federal and foundation grants are essential for innovation to occur, and I have served productively on both the giving and receiving ends of this equation. But initial funding almost always ends at some point (through change of political priorities or foundation leadership and priorities), and additional funds must be sought for sustainability or going to scale.

Continue reading "Population Health Financing: Beyond Grants" »

Posted on 01/31/2012 in Harnessing and Allocating Resources | Permalink | Comments (1)

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01/23/2012

Make Way for Starbucks' Community Stores



By Kirstin Q. Siemering, DrPH, RD

Population health can be a hard sell for the business sector, where the nature of the work has historically meant a focus on profits to the exclusion of most if not all other priorities. Although we applaud the current expansion of worksite wellness programs, we recognize that these efforts represent only a fraction what is needed for broad and lasting change. For broad population health improvement, we need to get beyond individual knowledge and behavior to effect policy and environmental changes that make the healthy choice the easy choice.

As we consider tangible roles for businesses to play in population health improvement, it might be helpful to think of a continuum, with worksite wellness as a starting point. Many potential roles remain unexplored, but we should all take a vested interest in shaping how work on the other end of the spectrum might look.

Continue reading "Make Way for Starbucks' Community Stores" »

Posted on 01/23/2012 in Policy and Systems Change in Action | Permalink | Comments (0)

| Twee

01/19/2012

Community Benefit in the Population Health Literature



By David A. Kindig, MD, PhD

We try to keep this blog accessible and policy relevant, and therefore carefully avoid being overly academic. However, we also regularly follow the literature, which is a challenge given the breadth of multidisciplinary scholarship underpinning the field. So periodically I will point to particularly recent and relevant articles that may be of interest to readers. The list of 11 journals we regularly scan is listed at the bottom of this post. I welcome your flagging for me other journals and articles you suggest we follow. I'm going to start this series by focusing on an article from the December 2011 issue of the *American Journal of Public Health*.

The Impact of the Individual Mandate and Internal Revenue Service Form 990 Schedule H on Community Benefits from Nonprofit Hospitals by Principe K, Adams EK, Maynard J, and Becker ER.

Continue reading "Community Benefit in the Population Health Literature" »

Posted on 01/19/2012 in The National Policy Front | Permalink | Comments (0)

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IPH Reader Craig Mosbaek Weighs in on 2012

We were delighted to have a few takers for our recent call for readers' ideas for what's on the population health radar in 2012. We thought many would appreciate reader Craig Mosbaek's perspective:



By Craig Mosbaek, MPH

Here are six trends I think will have big impacts on public health in the coming year.

The policy approach to public health. The understanding of how policies and environments shape health behaviors and health outcomes will continue to develop. Elected officials are beginning to appreciate this more, as well as public health professionals and others. You can see this institutionalized in initiatives such as CDC's Community Transformation Grants, APHA's new policy contest, and the Public Health Accreditation standards.

Funding for public health departments. There have already been big budget cuts at many local and state health departments. With the poor economy, these cuts will persist and there may be major reductions in federal spending on the horizon. With limited resources, health departments should focus their efforts on the most important public health issues.

Healthcare costs saved by public health efforts. Public health advocates are increasingly using the argument that policies to improve population health will reduce long-term healthcare costs. More research will focus on the return on investment (ROI) of public health approaches. Effective use of this argument could help alleviate the upcoming budget cuts for health departments.

Broadening the definition of public health. When expanding the definition of public health, some people use terms such as the social determinants of health or health in all policies. We are still working on how to talk about this broadened definition in ways that engage the public and encourage collaboration with other sectors.

Health impact assessments. A corollary to the above (broadening the definition of public health) is the growing use of health impact assessments **(HIAs)**. The PEW site shows about 80 completed HIAs nationwide right now. I wouldn't be surprised to see 80 more HIAs completed in 2012 alone.

New communications technology. New media (blogs, Facebook, Twitter, video over the Internet) will continue to transform the ways we communicate. This impacts how public health professionals collaborate with each other, as well as how we interact with the public.

Craig Mosbaek, MPH, President of Mosbaek Consulting, focuses on improving public health policy through communications, research/evaluation, and strategic planning. In 2010, he worked for Congress as the American Public Health Association's Public Health Fellow in Government.

Posted on 01/19/2012 in Population Health Basics | Permalink | Comments (0)

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01/12/2012

Population Health Outlook for 2012



By David A. Kindig, MD, PhD

Last week I reflected on Improving Population Health in 2011; today I'm looking forward to the year ahead. So what are the opportunities and challenges that 2012 presents for us?

The fall elections. On the one hand this is a challenge, since health outcomes and health disparities rarely directly enter into the political discussion and debate. Health care costs do, from both political parties, but in a relatively confined way. Rarely do ideas extend beyond the cost savings to examine, for example, how waste could be directed towards non-health care investments. The overwhelming task of implementing the Affordable Care Act (ACA) and defending its legal challenges requires much time and energy and has led some to believe that the current situation necessitates focusing efforts. Perhaps we should work now to consolidate and strengthen health care access and cost issues and – at least for now – have other determinants take a back seat.

Given what we know produces health, such an approach may be appropriate and opportunistic. Access to affordable health care is an important determinant of health, but even with full ACA implementation will not reach everyone. Jobs and economic development are at the top of the political agenda, and many candidates appreciate the role of education in increasing opportunity and economic productivity. Many leading Republicans support such goals. In an unexpected twist the Occupy Wall Street movement has moved the issue of income inequality onto the front page. Influencing candidates of both parties to campaign on strong economic development and education agendas could be the most important thing population health advocates could do this year.

The science of early intervention. Nicholas Kristoff's recent op-ed, *A Poverty Solution that Starts with a Hug* summarizes the findings from an American Academy of Pediatrics policy statement in this way: "Cues of a hostile or indifferent environment flood an infant, or even a fetus, with stress hormones like cortisol in ways that can disrupt the body's metabolism or the architecture of the brains. The upshot is that children are sometimes permanently undermined. Even many years later, as adults, they are more likely to suffer heart disease, diabetes or other physical ailments. They are also more likely to struggle in school, have short tempers, and tangle with the law." This science is not unknown to scholars, but it is beginning to diffuse into the policy arena (and Kristoff is hardly a science/policy columnist). We need to keep developing more robust findings and facilitate their understanding at all levels of private and public policy.

Continue reading "Population Health Outlook for 2012" »

Posted on 01/12/2012 in Population Health Basics | Permalink | Comments (0)

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01/04/2012

The Best of 2011 – and an Invitation to Help Shape IPH in 2012



By David A. Kindig, MD, PhD

I don't usually make formal New Year's resolutions, but I do think about the passing of the old year and the opportunities and responsibilities in the new one. In that spirit, I'm devoting this week's post to some key pieces from our 2011 archives. Next week, we'll be looking forward to give a preview of possible topics for 2012. We welcome any and all ideas from readers – this is your chance to help shape Improving Population Health in the coming year! Please just use the comment box below or email me directly.

So whether it's for the first time -- or for a second look -- I invite you to take a look at some of my favorite posts from 2011.

Continue reading "The Best of 2011 – and an Invitation to Help Shape IPH in 2012" »

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Posts from February 2012

02/29/2012

Now Available: "Roadmaps to Health" Community Grants Opportunity



By Phillip O. González

Much of what influences our health happens outside of the doctor's office—in our schools, workplaces and neighborhoods. The ability to find good jobs, to prepare children for college and career success, to establish financial security, and to live in safe communities that promote positive relationships among family and friends are not usually thought of as health interventions. However, these factors play an important role in our ability to lead long and healthy lives.

The *County Health Rankings*, released annually by the University of Wisconsin Population Health Institute (UWPHI) and the Robert Wood Johnson Foundation (RWJF), rank the health of counties throughout the nation and clearly show how social and economic factors impact health. They emphasize the role that key factors such as education, income and employment, family and social connectedness, and community safety play in building healthy communities. However, efforts to address these factors often occur within individual sectors and focus on short-term goals like expanding effective programs. But what if those efforts could be broadened? How might the vision and impact be expanded if those efforts were organized to include participants from multiple sectors such as health, the business community, or policymakers? Might they achieve meaningful, long-term policy change? And what strategies and tactics would a coalition formed from a diverse group of organizations undertake?

Continue reading "Now Available: "Roadmaps to Health" Community Grants Opportunity" »

Posted on 02/29/2012 in County Health Rankings & Roadmaps | Permalink | Comments (1)

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02/21/2012

Is Lower Health Care Spending Good for Our Health?



By David A. Kindig, MD, PhD

I believe the most important scholarly publication in January, 2012 was *Health Affairs*' "Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Domestic Product Was Unchanged From 2009." This annual report from the Office of the Actuary and the National Health Expenditure Accounts Team of the federal Centers for Medicare & Medicaid Services (CMS) always gets substantial coverage in the mainstream press and this year was no exception.

Why are health expenditure trends so important to improving population health? Because the amount we spend on health care in the United States is the elephant in the room regarding aligning resources appropriately to make us healthier and reduce disparities.

Continue reading "Is Lower Health Care Spending Good for Our Health?" »

Posted on 02/21/2012 in Harnessing and Allocating Resources | Permalink | Comments (0)

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02/15/2012

La Crosse Medical Health Science Consortium Moves Toward "Super-Integration"



By David A. Kindig, MD, PhD

Last week, I addressed the issue of population health resource allocation. I asked, "Where would you put the money?" and mentioned (among other possible approaches) the concept of a multi-sector "super-integrator" to take the lead in identifying and harnessing resources for population health improvement. I was delighted to hear from reader Catherine Kolkmeier, who directs the La Crosse Medical Health Science Consortium here in Wisconsin. Catherine was intrigued by the super-integrator concept and curious as to my opinion of whether the consortium fits this model.

Continue reading "La Crosse Medical Health Science Consortium Moves Toward "Super-Integration"" »

Posted on 02/15/2012 in Leadership and Collaboration | Permalink | Comments (0)

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02/08/2012

"Where Would You Put the Money?"



By David A. Kindig, MD, PhD

As regular readers know, I've been arguing consistently for the need for a regular, sustainable revenue stream to support population health improvement. However, I've not directly addressed the question of how these dollars should be allocated. As one of the authors of the important Evans-Stoddart population field model said in their 2003 AJPH article (Consuming Research, Producing Policy?), "redirecting resources means redirecting someone's income…most students of population health cannot confidently answer the question…well, where would you put the money?"

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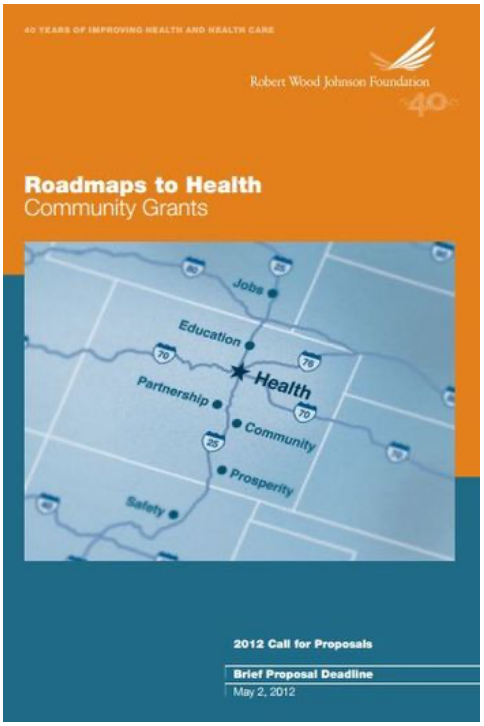
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County Health Rankings illustrate what we know, *County Health Roadmaps* show what we can do

The *Roadmaps to Health* Community Grants, a key part of the *County Health Rankings & Roadmaps* program which is led by UWPHI and RWJF, intend to answer the above questions by supporting communities so they can lead by example.

An initial round of *Roadmaps to Health* Community Grants were awarded in 2011 to 12 organizations that are working to address one of the social or economic factors to improve the health of their communities. The grantees are demonstrating how to engage policymakers, community members, and the media in addressing the social and economic issues that affect their communities. For example, Rhode Island KIDS COUNT and its partners are using their *Roadmaps to Health* Community Grant funding to increase access to high-quality early learning programs and to help Providence youth successfully enroll in and graduate from college—helping to ensure that they lead long, healthy lives. The coalition includes leaders from education, health, other nonprofits, and local elected officials. Their project is using the RWJF funding to engage in non-lobbying education and advocacy to increase funding for public pre-kindergarten, change the state's education funding formula, expand the availability of full-day kindergarten, develop an early warning system to identify students at risk of dropping out of high school, implement a more rigorous high school curriculum, and increase support for students applying to colleges and universities.

Expanding the *Roadmaps to Health Community Grants* to new communities



With a dozen projects already underway, on February 28th 2012, RWJF and Community Catalyst issued a **call for proposals for the second round of funding under the *Roadmaps to Health Community Grants* program**. Brief proposals are due on May 2nd, and interested individuals should review the call for proposals, which outlines the goals, selection criteria, and application process for this grant opportunity.

Grantees will receive up to $200,000 over two years to demonstrate how a range of partners from multiple sectors in their communities can work together to translate the *County Health Rankings* into action and work towards improving health. The $200,000 grants are coupled with community-identified matching funds of $200,000 (50% of which must be cash with the balance as in-kind support) to provide a total of $400,000 to support their efforts. Grantees must be established coalitions or networks that span multiple sectors and perspectives, including representatives such as business, education, public health, health care, community organizations, community members, policy advocates, foundations, and policymakers. Applicants must engage community members in the planning and implementation of projects, and must collaborate with organizations having expertise in improving the health of the public.

Ultimately, these grants will help communities use data and evidence to pursue policy or system changes that address the social and economic factors that most strongly influence health.

Phillip O. González is a Program Director at Community Catalyst, a national non-profit consumer advocacy organization dedicated to quality affordable health care for all.

Posted on 02/29/2012 in County Health Rankings & Roadmaps | Permalink

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Phillip - excellent post. I had the opportunity to attend a presentation today by Larry Cohen, Prevention Institute Founder and Executive Director. According to his research,70% of healthcare spend is due to poor choices that were attributed to behavior or environment. Since the actual delivery of care accounts for a mere 10% of expense, Cohen advocates development of community centered medical homes. What a wonderful world it would be if the sluggish real estate sector could obtain appropriate financing to re-purpose/construct community centered medical malls in disadvantaged areas to provide many of the necessities and services that do not exist today. Opportunities abound for tenants to sell wholesome nutritious items, deliver health screenings, primary and behavioral health services, payers to educate individuals regarding their benefits/address claims issues, technology companies to educate regarding the gadgets, apps etc and fitness gurus to aid in development of active lifestyles. In exchange for prorated rental rates, each tenant would commit to participating in a collaborative effort, subject to definitive community benefit metrics. In summary, improvements in health, wellness and safety remain the key to fueling a vibrant and self-sufficient community/economy. Sounds like a win-win to me.

Posted by: Jenifer Greenway | 02/29/2012 at 04:56 PM

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02/08/2012

"Where Would You Put the Money?"



By David A. Kindig, MD, PhD

As regular readers know, I've been arguing consistently for the need for a regular, sustainable revenue stream to support population health improvement. However, I've not directly addressed the question of how these dollars should be allocated. As one of the authors of the important Evans-Stoddart population field model said in their 2003 AJPH article (Consuming Research, Producing Policy?), "redirecting resources means redirecting someone's income…most students of population health cannot confidently answer the question…well, where would you put the money?"

Why is this so? Can't we simply link the huge variation in health outcomes we see across states and communities to financial and non-financial policy investments over time? Why have we not simply estimated community level, per capita policy and programmatic investment in each health factor area (health behaviors, clinical care, social and economic factors, and the physical environment) to derive a base level of investment needed to achieve health benchmarks?

There has been some limited national and state level research and policy analysis on this question. The Trust for America's Health (TFAH) estimated in 2008 that that investing $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking could save the country more than $16 billion annually within five years. In 2009, Kim and Jennings found that at the state level more generous education spending, progressive tax systems, and more lenient welfare program rules help to improve population health. However, the magnitudes of the effects were quite small, most likely because using the state as the unit of analysis masks much of the important variation in both outcomes and investments at

more local levels.

We have suggested that since communities have different outcomes and determinants profiles, locally tailored "policy packages" might be an effective and efficient approach. These packages could be driven by the strength and breadth of local investments affecting the multiple determinants of health. Unfortunately, we are not aware of any national or state data sets that could inform development of such investment recommendations. The relevant financial data from the multiple local, state and federal public and private funding sources does not exist or is not standardized in ways to allow policy-relevant comparisons that would be useful to public and private policy makers. But I strongly believe that making real progress in this area will require that we systematize and standardize collection of these data.

In the meantime, we should rely heavily on currently available compass points. The *County Health Rankings* encourage comparison of health factor areas with national benchmarks. Everyone needs access to healthcare services, and the TFAH guidelines for prevention investments are useful. Many local public health departments are inadequately funded for their critical work. There is a strong evidence base that investing in early childhood and other education programs has efficient long term pay off in terms of health outcomes. And a strong argument can be made for resources to support the work of emerging multisectoral super-integrators that can play a critical role in identifying and harnessing resources.

We must start with what we have, by continuing to rely on existing tools and resources. But we must also move beyond these, to advocate for and insist on development of state-of-the-art surveillance systems to promote evidence-informed investment and stewardship of our limited and extremely valuable population health resources.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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Community authority and management may be most important in altering the social conditions and prevention activities to promote health ---AND in the complex services needed for persons with serious, persistent, and progressive disabilities, mostly associated with aging. Both populations basically have to "make do" with the services that their community makes available. The populations "in the middle" with an acute or non-disabling chronic illness, if they have resources and interest, can examine the marketplace locally and at a distance and make choices. I wonder whether it is important to link the very sick and those who could be well - or whether they need different integrators and advocates, and a different set of community-based managers.

Posted by: Joanne Lynn | 02/12/2012 at 09:06 PM

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02/21/2012

Is Lower Health Care Spending Good for Our Health?



By David A. Kindig, MD, PhD

I believe the most important scholarly publication in January, 2012 was *Health Affairs*' "Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Domestic Product Was Unchanged From 2009." This annual report from the Office of the Actuary and the National Health Expenditure Accounts Team of the federal Centers for Medicare & Medicaid Services (CMS) always gets substantial coverage in the mainstream press and this year was no exception.

Why are health expenditure trends so important to improving population health? Because the amount we spend on health care in the United States is the elephant in the room regarding aligning resources appropriately to make us healthier and reduce disparities.

Some believe that our ever-increasing health care spending is a sign of market success, to be celebrated like Apple iPad sales. But the fact is we spend far more than any other country and still have poorer outcomes, and many experts believe a quarter to a third of what we spend is ineffective or wasted. In our resource-limited world, increases in health expenditures prevent investment in other health promoting areas like education. Even leaders of major health care institutions are calling for increased social service expenditures to improve the health of those seeking care in their institutions.

The article reported that health care spending reached $2.6 trillion in 2010, or $8,402 per person. Due to low annual increases of 3.8% in 2009 and 3.9% in 2010 (lower than any period in the last fifty years), the health care share of total spending stabilized at 17.9 percent of GDP. Authors attributed this to slower growth in use of hospitals, physicians, and drugs; from losses of private health insurance coverage; lower median household income; and uncertainty about the financial future. Importantly, the federal government's share of total expenditures increased to 29% (up

from 23% in 2007) while state and local government's share fell to 16% (from 18% in 2007). Employer contributions fell to 21% from 25% in 2001, while consumer out-of-pocket spending increased by 1.8%. While in previous years' growth in use of services (as opposed to population growth or price increases) has been a major factor in the overall increase, this year it contributed only 0.1% of the 3.9% increase. Governmental public health spending increased by 8.2% to $82.5 billion, but this still accounts for only 3.2% of overall spending.

So is this good or bad news? Most news coverage highlighted the welcome second year of expenditure slowing, but noted that it might be transitory as the recession ends. Any slowing is in the right direction, but 3.9% is still greater than the 1.5% increase in the Consumer Price Index in 2010, and most of the increase was from price increases -- not from greater demand. While slower growth could lead to better insurance coverage over the long haul, it likely had no impact in a single year. Consumers with economic challenges are using less health care, but this is not a good thing if due to delaying or avoiding necessary acute and preventive care. There is certainly no way to tell if lower spending rates translated into more investment in public health and other health promoting education and social service categories; any such result would have to await a longer term trend of getting health care spending close to the general inflation rate for all goods and services.

So one year during an economic slowdown does not a population improvement trend make. But we need to know how we are doing, both nationally and also at local levels where such data is often not available. Hats off to CMS and *Health Affairs* for continuing to produce and promote this important annual report card.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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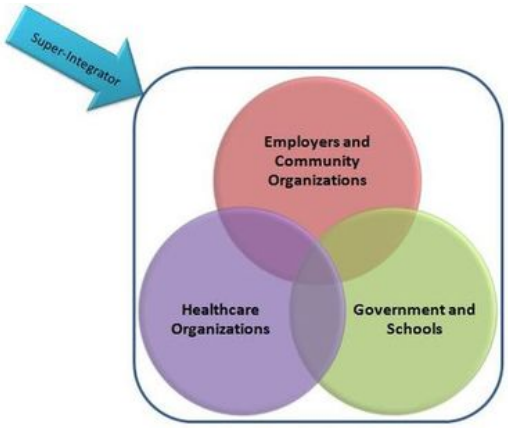
La Crosse Medical Health Science Consortium Moves Toward "Super-Integration"



By David A. Kindig, MD, PhD

Last week, I addressed the issue of population health resource allocation. I asked, "Where would you put the money?" and mentioned (among other possible approaches) the concept of a multi-sector "super-integrator" to take the lead in identifying and harnessing resources for population health improvement. I was delighted to hear from reader Catherine Kolkmeier, who directs the La Crosse Medical Health Science Consortium here in Wisconsin. Catherine was intrigued by the super-integrator concept and curious as to my opinion of whether the consortium fits this model.

I first floated the "super-integrator" concept back in 2010, after expressing skepticism that a single sector could take lead responsibility for population health improvement, rising above their own paradigmatic or practical limitations (such as health care organizations placing too much emphasis on clinical approaches or governmental public health being under-resourced) to truly serve as an effective neutral convener.



The La Crosse Medical Health Science Consortium is an independent 501(c)(3) that was founded in 1993 by a cross-sector alliance of two regional health systems and three institutions of higher education, including the University of Wisconsin La Crosse, Viterbo University, Western Technical College, Gundersen Lutheran Health System, and Mayo Clinic Health System-Franciscan Healthcare. The consortium has since expanded to include the School District of La Crosse and the La Crosse County Health Department. In creating the consortium, the founding organizations hoped to develop a space that was ruled by collaboration rather than competition, especially with regard to measuring and sharing outcomes related to health care workforce development. While healthcare workforce issues remain prominent on the consortium's agenda, the board of directors decided in 2009 to expand its focus to include population health. From this vision broadening has emerged an initiative that aims to make La Crosse County the healthiest in Wisconsin by 2015, with implementation of programs and policies across *County Health Rankings* factor areas, from transportation and tobacco to food security, obesity, and others.

Resource alignment is imperative for population health improvement, especially during periods of fiscal austerity, and I think this is a natural role for "super-integrators." According to Catherine Kolkmeier, the ethic of resource conservation, alignment, and stewardship permeates the La Crosse Consortium from the Board of Directors down. Board and committee members actively strategize how best to use available resources with the goal of maximizing impact and avoiding duplication of resources. This is no small feat in practice, given that multiple grants are administered by various partner organizations throughout the community. But, staying oriented to the big picture and having a collective commitment to resource stewardship will undoubtedly prove extremely beneficial in the long run, particularly as new, sustainable funding mechanisms emerge.

I am not naive about the potential challenges of a "super-integrator" model, but optimizing our communities' health will almost certainly require a coordinating authority of some type. The La Crosse Medical Health Science Consortium is certainly pointing in the right direction and I suspect that it represents just one of many "super-integrator-like" structures that are developing across the U.S. We look forward to finding more examples inspired by diverse initiatives, including the original healthy communities efforts and diverse federal and foundation projects such as our own *County Health Roadmaps*. Many thanks to Catherine Kolkmeier for bringing the consortium to our attention. We would love to hear from other readers as we continue to broaden the dialogue by holding up real-world examples that help us think about and work toward improving population health.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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03/13/2012

United Way as a Partner in Population Health Improvement



By Kitty Hsu Dana

United Way's mission is to advance the common good by mobilizing people and institutions to invest in Education, Financial Stability and Health, so that all people in all communities have the opportunity for a good quality of life. With a network of more than 1,200 locally-based organizations in the United States and another 500 in other countries, United Way is transforming from its traditional fundraising role to work with diverse partners across the sectors to make sustainable change in communities through multiple roles, including:

1. Compiling and summarizing data and research
2. Engaging and convening stakeholders, community leaders, corporate partners, concerned individuals/organizations, and others
3. Clarifying and advancing specific policy initiatives, and
4. Realigning fundraising for specific community-identified initiatives, objectives and practices.

These roles are similar to the idea of a "backbone organization" and to David Kindig's "Super Integrator" concept. This is not to say that United Way will always take the lead; we recognize that effective leadership can be at the front, in the middle, or from behind. Nor does it mean United Way acts alone. As a non-partisan convener, United Way ensures that all critical parties are engaged and play necessary roles to advance the common good.

The *County Health Rankings*' 2010 launch was particularly opportune for United Way's transformation and resonated with our new commitment to work in three vital areas: Education, Financial

Stability, and Health.



Most local United Ways are county-based (single or multiple counties); hence the *Rankings* are a marvelous entry point to stimulate community conversations and build a base for collaboration. United Way's business framework is also exceptionally well-aligned with the *County Health Rankings & Roadmaps* Take Action Cycle. As a trusted partner in communities, United Ways work closely with the business community, public sector, and community-based nonprofits. At the same time, they are learning to engage the community in a new way and reach out to non-traditional partners to identify common goals and solutions, align resources, and hold each other accountable for contributions and impact.

This starts with developing a comprehensive understanding of the community landscape by weaving together public knowledge, expert knowledge and evidence-based data – each necessary but insufficient by itself. A critical first step is to look outward to engage community residents as well as organizational partners and stakeholders in a spirit of authentic openness to build a wholistic understanding of the context. The *County Health Rankings* provide a common framework to help people across communities understand that many factors influence health and wellbeing. The *Rankings* help seize the attention of the media, the general public and decision makers. The *Rankings* provide a simple, elegant framework that shows that ensuring good health goes well beyond the responsibility of doctors and hospitals. As one United Way CEO said, “When I show this to my partners in the community, everyone immediately gets it!”

To advance equity, we must improve underlying socioeconomic factors and support policy, systems and environmental changes to create healthy choices where people live, work, learn, play and worship. United Way leaders see the opportunity to meet this imperative by integrating their work in all three building blocks of life – Education, Financial Stability and Health. “If we didn't connect the work, we will fail!” said one local United Way leader. “No matter how good the teachers are, and how many kids have great tutors to help them read, if their health issues are not tended to, or the fact that their family just lost their home are ignored, that child will not succeed in school.”

Our partnership with the *County Health Rankings & Roadmaps* program creates a synergy for creating sustainable change in counties and communities throughout the country – and we look forward to reporting on our progress as this movement gains traction.

Kitty Hsu Dana is Vice President of Health with United Way Worldwide.

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03/07/2012

A "Master Plan" for Population Health Improvement



By Kirstin Q. Siemering, DrPH, RD

Wikipedia defines "comprehensive planning" as:

> A term used in the United States by land use planners to describe a process that determines community goals and aspirations in terms of community development. The outcome of comprehensive planning is the Comprehensive Plan which dictates public policy in terms of transportation, utilities, land use, recreation, and housing. Comprehensive plans typically encompass large geographical areas, a broad range of topics, and cover a long-term time horizon.

Communities have been developing "Master Plans" to guide their long-range decision-making since the late 19th century (notably, concern about sanitation and the spread of disease in urban areas was the major early impetus). Amherst, Massachusetts calls its new Master Plan -- its first in 40 years -- a "statement of community intent."

Members of the Amherst Board of Health and Health Department staff, along with hundreds of Amherst citizens, were deeply involved in the two-year participatory process which led to development and adoption (in 2010) of the Town of Amherst Master Plan.

The plan addresses what population health researchers and advocates would recognize as key drivers of health: housing, economic development, natural and cultural resources, open space and recreation, services and facilities, and transportation.

Nobody's calling this a Population Health Master Plan. But health infuses the entire plan from start to finish, reflecting the vision and ideals of the *County Health Rankings Model* and the Take

Action Cycle. The 14-page "Implementation Matrix" (Appendix A of the Master Plan) is packed with plans for policies and programs across all *County Health Rankings* health factor areas.

And Amherst is not taking implementation lightly. The Master Plan's final chapter is wholly dedicated to this topic, with much attention given to resources. In principle, the Master Plan guides and coordinates resource investment for annual work programs and budgets, development approvals, capital plans, economic incentives, and private development decisions. The implementation plan spells out specific guidelines for involving a wide variety of stakeholders in implementation (including the possibility of leadership through appointed public-private partnerships), developing appropriate regulatory tools and ensuring "concurrence" with the plan, and regular reporting and full updating at least every five years.

Curious about the road to implementation, I called the Town of Amherst's offices and connected with Senior Planner Christine Brestrup. Ms. Brestrup said that although the County Select Board is still working toward formalizing the implementation plan, much progress has been made in the two years since the plan was adopted, especially with regard to targeted transportation policy and zoning by-laws. This has included a focus on complete streets (including sidewalk improvement), making buses more accessible to bicyclists, and developing growth regulations that encourages in-fill in traditional built centers and neighborhoods while keeping outlying areas less developed. Ms. Brestrup also highlighted the creation of the Safe and Healthy Neighborhoods Initiative, which is a collaborative effort among the health and fire departments, building inspectors, planning department, and town management to ensure code regulation compliance among Amherst's many landlords and (largely student) tenants.

In his inaugural post nearly two years ago, David Kindig pointed to a "convergence" of thinking and action in support of population health improvement. The Amherst Master Plan (and others like it) may be signaling such convergence, similar to the new alignment among leaders in planning, public health (via new accreditation standards), and health care (via the Affordable Care Act's new community benefit regulations).

But Dr. Kindig also likes to say, "Be careful what you wish for." This convergence represents a tremendous – yet precarious – opportunity. Without a coordinated approach, communities stand to lose valuable time and money engaged in fruitless competition and/or duplication of effort. Kudos to everyone working within and across sectors to improve health where we live, learn, work, and play. Let's continue to promote the types of coordinated effort across disciplines that community master planning fosters – but also do all we can to streamline our approaches to ensure that we continue to build synergy and momentum for population health improvement.

Many thanks to Town of Amherst Planning Department staff for assistance with this post:

Christine Brestrup, Senior Planner

Jonathan Tucker, Planning Director

Kirstin Q. Siemering, DrPH, RD is Social Media Lead with the County Health Rankings & Roadmaps *program at the University of Wisconsin Population Health Institute.*

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Posts from March 2012

03/20/2012

Coming Soon...The Roadmaps to Health Prize

By David A. Kindig MD, PhD and Kirstin Q. Siemering DrPH, RD

On April 3rd 2012, the University of Wisconsin Population Health Institute will make applications available for the inaugural *Roadmaps to Health* Prize. The Prize is part of the Robert Wood Johnson Foundation-funded *County Health Roadmaps* project and will recognize communities across the U.S. that have successfully mobilized to improve population health.

Communities throughout the country are actively engaged in finding ways to increase the health and vitality of residents. The *Roadmaps to Health* Prize is rooted in the idea that every community is on a unique journey toward better health. The prize will honor the accomplishments of communities along the continuum of this journey, from those that have achieved tremendous success to those that have struggled against great odds and may just be beginning to see results.

The *Roadmaps to Health* Prize is a place-based prize that will honor whole communities (rather than individuals or individual organizations). All U.S. communities are eligible to apply. For the purposes of the prize, “communities” are defined as towns, cities, counties, regions (such as contiguous towns, cities, or counties), tribes, and tribal communities.

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03/13/2012

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Posts from April 2012

04/25/2012

Increased Public Health Investment Is Necessary But Not Sufficient



By David A. Kindig, MD, PhD

Last week I summarized the IOM's new report on *For the Public's Health: Investing in a Healthier Future*. The entire 3-part series is extremely important from a policy perspective and should be on every population health advocate's reading list.

I praised the report as a whole but also promised a critique. The crux of my argument is that to achieve the Committee's ambitious goals, we need to think beyond governmental public health. The suggested doubling of the budget for governmental public health, which seems reasonable for the set of minimum public health services, is necessary but not nearly sufficient to achieve their population health improvement goals.

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04/19/2012

The IOM Reports on Investing in a Healthier Future



By David A. Kindig, MD, PhD

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The third report addresses the critical issue, in a time of declining resources, of public health resource needs and approaches to addressing them in a "predictable and sustainable manner to ensure a robust population health system." Given my many calls for dependable revenue streams for population health improvement, this clearly was a must-read for me.

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Posted on 04/19/2012 in Harnessing and Allocating Resources | Permalink | Comments (0)

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04/11/2012

The Link Between Income and Health



By David A. Kindig, MD, PhD

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This concept is better understood today than it was in 2003, but it is still hard to communicate. We accept the health-compromising effects of smoking and lack of health care access, but how education and income 'get under the skin" to produce disease and death is less obvious. Yet a growing body of literature supports this finding, and is the reason why we give social factors a weighting of 40% in the *County Health Rankings* model.

This week we're calling attention to a study I co-authored with one of our PhD candidates, Erika Cheng. The article, Disparities in premature mortality between high and low income U.S. counties, appears in the April 2012 issue of *Preventing Chronic Disease*.

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04/05/2012

Movin' Down the Road to Health



By Julie Willems Van Dijk, RN, PhD

On April 3rd you received your annual check-up of your community's health -- the 2012 *County Health Rankings*. You've had a chance to review what's going well for your community and where you are lagging behind others. But now what? What can you do to make your community a healthier place?

Since the inaugural release of the *County Health Rankings* in 2010, hundreds of people have contacted us to ask these questions and we've directed them to our Take Action cycle. It's a simple and straightforward process. Work with other key partners, because we know solving issues like poor high school graduation rates, unemployment, excessive drinking, unhealthy air, or inadequate health care require the wisdom and resources of people from all walks of life. Gather information. Set priorities. Find the most effective approaches to address your priorities and then just do it!

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04/01/2012

County health ranks -- Are they a'changin?



By Bridget Booske Catlin, PhD, MHSA

It's ranking season again (and I'm not talking about NCAA basketball) – the 2012 *County Health Rankings* will be available tomorrow (April 3, 2012). Since this is our third year of releasing the *Rankings* for all 50 states, we are fielding questions such as what has changed since last year? If not much has changed, why should anyone pay attention?

Continue reading "County health ranks -- Are they a'changin?" »

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04/25/2012

Increased Public Health Investment Is Necessary But Not Sufficient



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I praised the report as a whole but also promised a critique. The crux of my argument is that to achieve the Committee's ambitious goals, we need to think beyond governmental public health. The suggested doubling of the budget for governmental public health, which seems reasonable for the set of minimum public health services, is necessary but not nearly sufficient to achieve their population health improvement goals.

The members of the Committee certainly know this, and their charge was quite narrowly defined. But when goals like life expectancy reduction are called for, and the rest of the report deals exclusively with governmental public health funding, it is possible for policy makers draw the conclusion that this is all that is required. This would be a mistake because much more is needed across all health factors and we should not get lulled into thinking otherwise.

There is brief discussion of this broader point in Chapter 1; the report asserts, "The United States seems to lag behind most high-income nations in the deployment of socially protective strategies that appear to correlate with better population health. Excessive allocation of national spending on medical care services poses major societal opportunity costs and restricts funding opportunities for other essential sectors such as education, energy, water, transportation, agriculture, and employment. For example, the rise of medical care costs, and the recent recession, has contributed to a decline in state appropriations for public higher education."

The report includes Figure 1-1 below, which shows the relative proportions of health care spending and social service spending across developed nations.

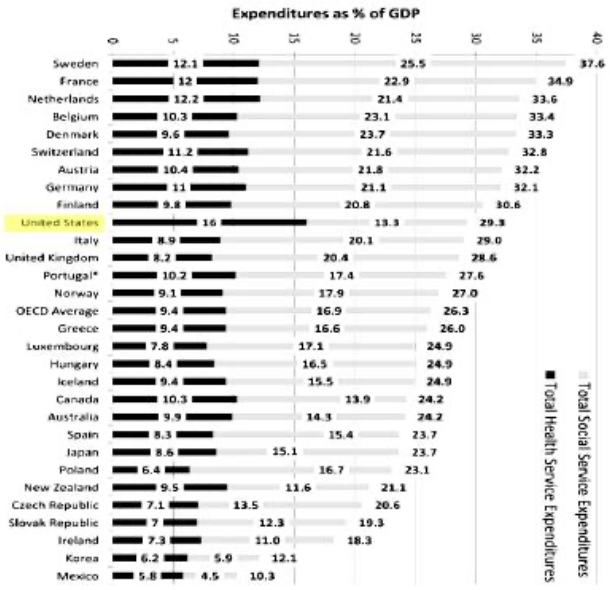


FIGURE 1-1 Average social-service expenditures versus average health-services expenditures as percentages of gross domestic product (GDP) from 1995 to 2005 by country.
SOURCE: Bradley et al., 2011:3

This figure illustrates these differences and prompts speculation as to what a more appropriate balance should be. The Committee determined that the implications of these differences and the opportunity cost of the nation's social spending were beyond its role. However, an upcoming report from a joint National Academy of Sciences–Institute of Medicine committee will consider the effect of national attention to such factors on health differences among high-income nations. Recognizing the urgent need for better understanding, the committee recommends the development of a "**robust research infrastructure for establishing the effectiveness and value of public health and prevention strategies, mechanisms for effective implementation of these strategies, the health and economic outcomes derived from this investment, and the comparative effectiveness and impact of this investment."**

In addition, I believe population health advocacy also requires precision with respect to terminology. Despite these figures solely reflecting resources for health care and governmental public health, the term *"health expenditure"* is repeatedly used throughout the report – including for the initial recommendation regarding health care expenditure reduction. Calling these ***health expenditures*** may inadvertently send the message that health care and public health are the only or the main expenditures necessary to improve health. The committee clearly understands this, but the language leads us, perhaps unconsciously, down that path. I suggest reserving the term ***health expenditure*** for all investments for improving health, with the explanation that necessary data and accounting systems do not exist at present, but are critical for accountability and financing in the future. Although a bit more clumsy, national accounts should use the longer but more accurate term ***health care and public health expenditures,*** while evidence and accounting systems develop the capacity to report on true ***total health expenditures*** that reflect investments across all health factors.

I respectfully offer this critique with the hope that the IOM and other policy groups will address these issues going forward. Just as health care is not the whole answer, neither is health care and governmental public health. I fully recognize that even this important set of reports cannot cover the full breadth of our evolving national population health policy. The investment strategy for reaching the Committee's ambitions goals must involve a multisectoral balanced portfolio of resources not yet identified or attempted in practice. However, knowing that our progress will be incremental should create an enormous imperative to define our terms in ways that maximize – rather than limit – our reach.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

Full Reference for Figure 1-1: Bradley, E. H., B. R. Elkins, J. Herrin, and B. Elbel. 2011. Health and social services expenditures: associations withhealth outcomes. *BMJ Quality & Safety* 20(10):826-831.

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I've been meaning to write about Obamacare in a sociological context but I don't have the means to state it properly. The idea is that populace morale is a necessary component of public service. Would you have any ideas?

Posted by: Harriet of RCHI | 05/14/2012 at 09:05 AM

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The third report addresses the critical issue, in a time of declining resources, of public health resource needs and approaches to addressing them in a "predictable and sustainable manner to ensure a robust population health system." Given my many calls for dependable revenue streams for population health improvement, this clearly was a must-read for me.

This is a very important and thorough report with an excellent Executive Summary for those in a rush. Today I will simply give you a preview of several of the most important recommendations and next week I will blog on a fuller critique from a population health improvement perspective.

Recommendation: The Secretary of the Department of Health and Human Services should adopt an interim explicit life expectancy target, establish data systems for a permanent health-adjusted life expectancy target, and establish a specific per capita health expenditure target to be achieved by 2030. Reaching these targets should engage all health system stakeholders in actions intended to achieve parity with averages among comparable nations on healthy life expectancy and per capita health expenditures.

This would appear to be more of a measurement recommendation, and it does follow from the first report, but the call to set specific targets not only for broad outcomes but also for per capita healthcare expenditures is the kind of challenge we need to focus our improvement efforts. This would amount to adding an average of approximately 1.33 years to the life expectancies of 50 year old women and 0.90 years to the life expectancies of 50 year old men – which is no easy task. But the authors begin to address the investment aspect by observing that "excessive spending on medical care also presents opportunity costs — less funding remains for investment in other socially important activities, such as education. Bringing health expenditures more in line with other wealthy nations will free up resources that can support other US objectives that improve not only the health of Americans, but their quality of life." This is a very clear population health resource perspective and challenge.

Several other recommendations deal with public health funding directly and also deserve attention, such as establishing a minimum package of public health services for every community and **recommending that Congress double the current federal appropriation for public health -- and make periodic adjustments to this appropriation based on the estimated cost of delivering the minimum package of public health services.**

Recommendation: The committee recommends that Congress authorize a dedicated, stable, and long-term financing structure to generate the enhanced federal revenue required to deliver the *minimum package of public health services* in every community. Such a financing structure should be established by enacting a national tax on all medical care transactions to close the gap between currently available and needed federal funds.

Not surprisingly, this was the only recommendation picked up by the *Wall Street Journal*, and certainly will be vigorously debated in the coming months or years regarding whether it is the best or most feasible potential source of such a needed funding stream.

These are only the highlights. They are extremely important considerations for a national population health improvement strategy and for enhancing public health. However, with the exclusive emphasis on governmental public health, the report falls short in advocating a broad population health strategy. Next week I'll comment on how these recommendations could be made even more important and effective.

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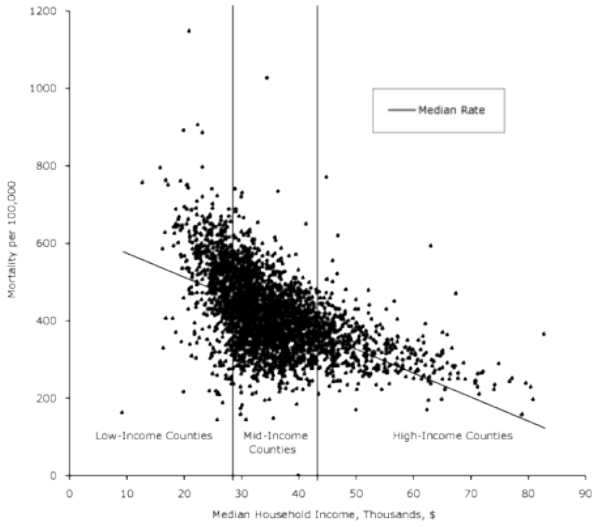
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This week we’re calling attention to a study I co-authored with one of our PhD candidates, Erika Cheng. The article, Disparities in premature mortality between high and low income U.S. counties, appears in the April 2012 issue of *Preventing Chronic Disease*.

The figure below shows the relationship between median household income and age-adjusted, all-cause mortality rates for all counties in the country.



As expected, people tend to live longer in high income counties (HIC), with the diagonal line indicating the overall relationship. However, this relationship is not as strong in HIC; an increase of $9,000 in median household income was associated with an 18% better average mortality rate among low income counties (LIC) but only 12% better in higher income counties.

Equally interesting is the very large variation in mortality rates among LIC. Some of the LIC mortality rates are comparable to those of HICs (in the 200/100,000 range), while other LIC rates are triple or quadruple this level.

Also, a more nuanced picture emerges when controlling for other factors that impact mortality. Several factors were associated with longer lifespans, including percentages of adults with a 4-year college degree and percent Hispanic in the county. Other factors were associated with shorter lifespans, including preventable hospital stays, percent black in the county, percent children living below federal poverty guidelines, and percent adult smokers.

Importantly, when these other factors were controlled for, statistically significant linkages were found between median household income and mortality in the HICs, but not the LICs. This result highlights the main point of this study - that there is an interplay, apparent at the county level, between patterns of health factors and income. For example, two variables -- the percent of children living below the federal poverty guidelines and the percent of single-parent households -- are more closely linked to mortality in LICs than in HICs. We suggest that perhaps county-level income may buffer the effects of some variables associated with poor health. This buffer may operate through coping resources; county-level income may reflect overall availability of material and social resources that enable affluent single parents' access to child care, neighborhood support, social networks, or higher-quality health care. Of course, we caution that the nature of the study and the data only allow for associations, not causal relationships.

From a policy perspective, these findings remind us that "one size fits all" does not apply to improving population health in communities. Our data reveal complicated relationships among the many factors that determine how long (not to mention how well) we live. While finding feasible and effective solutions can be difficult, we believe there's a lot that can be done -- including helping communities move on down the road toward better health and continuing to think about and work toward operationalizing the concept of locally customized policy approaches.

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On April 3rd you received your annual check-up of your community's health -- the 2012 *County Health Rankings*. You've had a chance to review what's going well for your community and where you are lagging behind others. But now what? What can you do to make your community a healthier place?

Since the inaugural release of the *County Health Rankings* in 2010, hundreds of people have contacted us to ask these questions and we've directed them to our Take Action cycle. It's a simple and straightforward process. Work with other key partners, because we know solving issues like poor high school graduation rates, unemployment, excessive drinking, unhealthy air, or inadequate health care require the wisdom and resources of people from all walks of life. Gather information. Set priorities. Find the most effective approaches to address your priorities and then just do it!

One day, I was talking with a concerned citizen who wanted to lead an effort to improve health in his lowest ranking county. We turned to a commonly referenced guide and when he saw it was 170 pages long, he decided this process was far too overwhelming to pursue. Like so many simple and straightforward processes, it can be challenging to know where to start and how to keep going when you get stuck. To help you overcome these obstacles, we've created the *Roadmaps to Health* Action Center—tools and consultation to guide you along the journey toward better health for your neighborhood, town, or county.

What will I find in the Action Center? For each of the six steps in the cycle -- Work Together, Assess Needs & Resources, Focus on What's Important, Choose Effective Policies & Programs,



Act on What's Important, and Evaluate Actions -- you will find key activities and tools. By answering a short list of Getting Started questions, you will be guided to activities and tools that are matched with your community's current progress and needs. The Action Center includes resources for those who are thinking about taking action, those who may have just started working together, and those who have some momentum but are looking for ways to enhance their efforts.

Web tools are great, but what if I have questions? Throughout the site, you will find road signs offering assistance from our team. We know it helps to have someone to consult with who can help you plan your next steps, trouble shoot when you get stuck, and motivate you when you lose energy. Our consultation can be delivered via email or telephone—whichever works best for you.

GET HELP FROM THE RANKINGS & ROADMAPS TEAM

How can we learn from other communities? A new Take Action webinar series will explore practical ways to implement the cycle with your community members. Sign up here for the April 17th session that will introduce you to the series. Each month a different step in the Take Action cycle will be explored. The webinars will include community members from around the nation sharing their stories about what worked well and what didn't and follow up discussion webinars where participants can share their own lessons learned and challenges with each other.

Aren't there lots of websites devoted to health? Why another? Yes. The *Roadmaps to Health* Action Center will link you with excellent tools from many different organizations. Our goal is to organize these tools in a way that makes your community's journey to health improvement a simple and straightforward path, accessible to all.

Whether your community is ready for small steps or giant leaps, we are here to support you as you move down the road to health. Visit us, email us, call us, and let's all work together to build a healthier nation, county by county.

Julie Willems Van Dijk RN PhD is the deputy director of the County Health Roadmaps *project at the University of Wisconsin Population Health Institute.*

Posted on 04/05/2012 in County Health Rankings & Roadmaps | Permalink

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04/01/2012

County health ranks -- Are they a'changin?



By Bridget Booske Catlin, PhD, MHSA

It's ranking season again (and I'm not talking about NCAA basketball) – the 2012 *County Health Rankings* will be available tomorrow (April 3, 2012). Since this is our third year of releasing the *Rankings* for all 50 states, we are fielding questions such as what has changed since last year? If not much has changed, why should anyone pay attention?

Has anything changed in the ranks? The answer is yes and no. Yes, in that there is fair amount of movement in rank among counties in the middle quartiles of each state. No, in terms of movement among the healthiest and least healthy counties. We purposely keep our measures of health outcomes the same each year – the only thing that changes is that we update our data – this means that for our primary health outcome measure, premature death, we add one year and remove the oldest of the three years of data on which it is based – so, only a third of the measure changes. For our other health outcome measures that are based on seven years of data (allowing us to report ranks for all but the 100 or so least-populous counties in the nation), this means we only change one-seventh of the data on which these measures are based.

Our Health Factors are a different story. Here we tend to make minor changes in measures for each of the four factors (health behaviors, clinical care, social and economic, and physical environment) as we find new and better measures or are able to draw on improvements in existing county-level measures. For example, this year we have added a measure of physical inactivity, expanded our measure of the uninsured to include children, improved our high school graduation measure, changed to a measure of limited access to healthy foods (to be more closely aligned with the idea of food deserts), and added a measure reflecting fast food restaurants. With these changes, most counties are likely to see a change in their Health Factors ranks.

So, why do we rank every year? We release updated data (and ranks) every year to continue our call to action. The *Rankings* are a starting point for new conversations across the nation that draw in people from all walks of life. Each year, more people are drawn in. They reach an "ah-ha" moment that healthy places are important for us all, and that having health care coverage for all is just a beginning step toward that goal.

How can we measure progress toward our goal of becoming a healthier nation, county by county? While looking at ranks is useful, the best way to measure progress is to look at change in the specific measures. Each year, we publish updated data so counties can begin to monitor progress in specific areas. For the first time this year, we've included graphs to show trends (progress or lack thereof) in each county's premature death rates over the most recent 10 years. Each county can compare their trend line to that for their state and for the nation as a whole. As we accumulate enough data for other measures, we will add more information like this in future years.

The inclusion of premature death trends is just one of several new features at www.countyhealthrankings.org this year. Be sure to check out the site and use our new interactive maps. And don't miss the brand new *County Health Roadmaps* section with information on the *Roadmaps to Health* Prize, the *Roadmaps to Health* Community Grants, and our *Roadmaps to Health* Action Center (more to come on that in the next blog post later this week).

Bridget Booske Catlin, PhD, MHSA directs the County Health Rankings & Roadmaps program at the University of Wisconsin Population Health Institute.

Posted on 04/01/2012 in County Health Rankings & Roadmaps | Permalink

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05/22/2012

Where I'd Put the Money: Quality of Life Investments for Frail and Disabled Elders

This week, we are very pleased to welcome guest blogger Joanne Lynn, M.D., who serves as Director for the Altarum Center for Eldercare and Advanced Illness. A few months ago, David Kindig asked readers, "Where Would You Put the Money?" Dr. Lynn responded with a provocative comment, which she expands on below (please note that this post is cross-posted on the Altarum Institute's blog, Health Policy Forum).



Where I'd Put the Money: Quality of Life Investments for Frail and Disabled Elders

By Joanne Lynn, M.D.

Readers of this blog are familiar with—and mostly supportive of—these two claims: (1) that social and environmental factors are stronger than health care services in shaping the population's health, but (2) those factors are weaker than health care services in securing funding and public attention. Most of us are convinced that sending more funds and public support toward healthy food and exercise would do more to improve health than sending those funds toward high-cost medications or surgeries.

My question here is whether we can usefully apply the same perspective to the care needed for frail and disabled elders. Some will want to stop and contend that prevention of disability would still be the priority, and that argument has merit, of course. But "prevention" of disability associated with aging is really mostly delay, and most of us will have a period of serious disability before dying, no matter how well we eat and exercise.

As we age and accumulate illnesses and disabilities, we ordinarily need more and more support to get through the day, and we become less and less able to travel to get what we need.

Furthermore, what we most need has to be local—no one travels to a referral medical center for spoon feeding or bed baths! So, we come to be tied to our communities, and to the housing, transportation, service supply and service coordination that our local system offers.

A community that has encouraged substantial new building with universal design and substantial retro-fitting of old buildings will have more elders able to stay at home longer, in comparison with one that is inattentive to making its housing stock elder-friendly. Some communities provide substantial non-medical services such as counseling for personal and financial planning, in-home nutrition and caregiver support, and keeping caregivers and elders in relationship with others. Those communities will have less reliance on nursing homes and hospitals, which is generally what aging persons strongly prefer. Senior-friendly housing and transportation are absolutely essential to the well-being of frail elders.

These claims appear to me to parallel the arguments for attention to social and environmental determinants of health generally. Indeed, the call for an "integrator" function to set priorities and manage systems to achieve population health locally seems also to be the right direction for elder care. If anything, elder care even more urgently needs integration across social services, housing, long-term-care services and health care services. A great deal of public and private funding goes into the uncoordinated cacophony of programs that aim to provide support and health care to frail elders, using probably about half of our lifetime expenditures on illness and disability and yielding remarkable waste, gaps, inefficiency and frustration. We need that integrator—and the integrator needs tools and authority.

In some other countries, care of the disabled and elderly is part of the public health system, alongside maternal-infant health and infectious disease. In the United States, however, services for the disabled and elderly have been outside of the scope of public health practitioners, who generally seem to lose interest when primary prevention fails (as it must). Indeed, at least for the elderly, the U.S. has mostly split the medical services into a quite separate category from the social supports. We fund health care with an open checkbook and we measure quality mostly as if each person faced at most one health challenge. In contrast, we primarily fund social services as poverty programs and rarely measure their quality at all.

From my perspective, engendering a way to manage the local system for elder care across medical and social issues is key to achieving "Triple Aim" goals. Can those advocating for attention to social and environmental determinants of health come to include frail elders and disabled persons in their scope? Well-being while living with serious and even fatal disabling conditions counts. Most of us will live for multiple years in this state—and some of us for much longer. Can't we come to count improved well-being while ill as part of population health, and employ the tools, perspectives and personnel that now advocate for healthy built environments?

Joanne Lynn, M.D., directs the Altarum Center for Elder Care and Advanced Illness.

Posted on 05/22/2012 in Harnessing and Allocating Resources | Permalink

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Improving health is more than just a physical cure it's also emotional. When people have things in life to look forward to, things that they enjoy and quality services to meet, and even exceed, their needs it gives them something more to live for. And that is worth everything.

Posted by: Mary | 05/28/2012 at 12:07 AM

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05/17/2012

Master Planning for Youth Comes of Age



By Kirstin Q. Siemering, DrPH, RD

This week, we're building on a recent post, continuing the theme of master planning – but with a more targeted approach.

The National League of Cities (NLC) has catalogued more than 30 comprehensive youth master plans throughout the U.S. These plans (sometimes referred to as youth agendas, city blueprints, or children's bills of rights) are typically developed through approaches similar to those used to guide land use and infrastructure decisions, but with a focus on young people. According to the NLC, these plans allow "city officials, school leaders, community partners and youth to take stock of local programs and services for young people, identify cost savings, reduce duplication of services, and strategically address pressing needs."

Even my own hometown, La Cañada Flintridge, CA, has a Youth Master Plan which primarily focuses on process and encourages "participation, communication, and collaboration" through outreach activities (such as developing a website and mentoring program). La Cañada's plan is a good start, but I believe we need to aim higher – we need to encourage the development of master plans that are outcomes focused, such as the Child & Youth Master Plan developed for Metropolitan Nashville and Davidson County, TN.

Developed in 2010 by a task force appointed by Mayor Karl Dean, the master plan focuses on 14 outcomes "for our future." Each outcome is framed both by "key findings" and "strategic objectives" across five key subcommittee areas: health, safety, out-of-school time, education/lifestyle, and mobility/stability.



In the January 2012 installment of the Ready by 21 Policy Alignment Series, the Forum for Youth Investment recommended that New Policies Should Align with Existing Goals and Plans for Children and Youth and applauded the Metropolitan Nashville/Davidson County plan for working toward collective impact by building on existing momentum where possible. The community has made significant strides in the area of healthy eating and active living with a $7.5 million investment of federal Communities Putting Prevention to Work (CPPW) dollars. Instead of starting from scratch, the Child & Youth Master Plan rallied around existing CPPW objectives. This approach saved valuable time and dollars and ensured alignment of efforts going forward.

The National League of Cities' Youth, Education, and Families (YEF) Institute website offers a wealth of information for communities interested in developing youth master plans, including examples of cities' plans and an action kit to guide development.

YEF also hosts a regular webinar series with topics that may interest IPH readers. Two are worth nothing in the context of this post:

- Using Ready by 21 Tools to Guide Youth Master Planning (aired March 21, 2012)
- Improving Outcomes for Children and Youth Through Collective Impact (aired February 15, 2012)

Dubuque, IA has also demonstrated leadership in this area, with a Youth Master Plan that focuses on five "promises," including caring adults, safe places, healthy start, effective education, and opportunities to serve others. Dubuque aims for broad citizen participation, asking business leaders, educators, foundations, faith leaders, community leaders, parents (and other caring adults) -- as well as youth -- the important question of "What can you do?" -- and answers with concrete suggestions for "What you can do."

We all can agree that any plan is only as good as what people do with it. But creating the plan is a critical first and very important step. Plans allow communities to progress from "What **can you do**?" to "What **you can do**" to "What **we can do**" to "Look what **we've done**."

So here's to master plans and youth master plans, tailored to the needs and resources of communities across the country. Here's to planning, doing, and improving population health along the way.

Kirstin Q. Siemering, DrPH, RD is Social Media Lead with the County Health Rankings & Roadmaps*program at the University of Wisconsin Population Health Institute.*

Posted on 05/17/2012 in Policy and Systems Change in Action | Permalink

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05/09/2012

Really?? A Free Population Health Textbook from Preventing Chronic Disease??



By David A. Kindig, MD, PhD

Yes, the online CDC journal *Preventing Chronic Disease* (PCD) has just released a compilation of 23 essays on current population health practice and scholarship relating broadly to population health metrics, incentives, and partnerships.

These essays were an early part of our Robert Wood Johnson Foundation funded project called Mobilizing Action Toward Community Health (MATCH) at the University of Wisconsin Population Health Institute, which many readers know has evolved into *County Health Rankings & Roadmaps* efforts. In 2009, we commissioned essays to critique underlying assumptions about metrics, incentives, and partnerships and to suggest approaches for overcoming potential barriers to population health improvement.

The essays were discussed at a 2-day meeting in late 2009 in Madison among essay authors, University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation staff, along with several guests . During the meeting, participants developed an agenda for future practice and research activities for improving population health. This agenda is featured in the final essay of the set and has already led to new initiatives such as the *Roadmaps to Health Prize*.

With the able and enthusiastic assistance of the PCD Editor, Sam Posner, the essays were initially published in the July, September and November 2010 issues of PCD. Combining them together into a “one click” collection makes for a far-reaching, robust, and provocative population health policy virtual textbook.

I've highlighted a few essays below to demonstrate the breadth of the collection and hopefully pique your interest:

- R. Gibson Parrish on Measuring Population Health Outcomes
- Paula Lantz and Andrew Pritchard on Socioeconomic Indicators That Matter for Population Health
- Michael McGinnis on Observations of Incentives to Improve Population Health
- Raymond Baxter on Making Use of the Policies and Funding We Already Have
- Glen Mays and Doug Scutchfield on Improving Public Health System Performance Through Multiorganizational Partnerships
- Andrew Webber and Suzanne Mercure on Improving Population Health: The Business Community Imperative

Thanks again to Sam Posner and his staff at *Preventing Chronic Disease* for making these essays accessible to all – just a click away:

http://www.cdc.gov/pcd/collections/pdf/PCD_MATCH_2010_web.pdf

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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05/01/2012

Don Berwick: "Waste is Theft"



By David A. Kindig, MD, PhD

I often emphasize the potential for wasted resources in ineffective health care to fund population health investments. And I have praised Don Berwick for his lifelong and more recent leadership in health care improvement.

Both of these threads came together last month when I heard Don give the George W. Gay Lecture in Medical Ethics at Harvard. Always a compelling speaker, he riveted the audience with the very human story of a newborn exchange transfusion gone very wrong when he was a pediatric resident. His immediate point was the lost opportunity then to confront the errors promptly and openly to prevent reoccurrence. He asserted that this was an ethical responsibility of physicians and health care systems if quality is to be continuously improved.

But then he went one step further. In the list of six IOM principles for a quality health care system, efficiency is the one often not fully embraced. He put it very starkly: ***"Waste is theft."*** He explained that resources spent on health care that we know doesn't work – or may even be dangerous – are not available, in a resource limited world, for other investments known to be effective. It represents theft of resources that could otherwise be used for effective treatments. He likened the prevention of such wasteful practices to the ethical responsibility of "first do no harm" and using error reporting as a path to quality.

His lecture didn't address rationing extensively (the failure of Congress to confirm him as CMS head was due in part to his views on this subject). But he did note that this concept of "theft" avoids this contentious terminology, since rationing doesn't apply to ineffective care.

Don noted, as others like the *New York Times* editorial page have recently, the new educational initiative "Choosing Wisely" issued by nine medical specialty boards which identified the top five tests and procedures in each specialty (such as routine annual electrocardiograms and antibiotics for mild sinusitis) which are costly and have no proven benefit. While only educational and voluntary, this is certainly an important first step and should be supported by those sharing concern for health care "theft."

Although Don's talk was primarily in the clinical care domain, I have no doubt he would endorse using some of the resources not "stolen" for prevention and social investments outside of the health care system. It is extremely difficult to capture these resources and then find ways to redirect them to effective purposes. The Population Health Branch of the Center for Medicare and Medicaid Innovation, established under his leadership, is considering such mechanisms.

Importantly, preventing waste is not the ethical responsibility of physicians alone; everyone in the health care system shares this responsibility. But Don's placing it as a fundamental ethical responsibility of physicians elevates it to a level not previously suggested.

Don Berwick served us well in his public role, but it is good to have him back where he can fully express his views and exhort us to where we need to go.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

Reference: Berwick DM, Hackbarth AD. (2012). Eliminating waste in US health care. *JAMA*, 307(14), 1513-1516.

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Posts from May 2012

05/29/2012

What Does a Population Health Integrator Do?

Last week, Joanne Lynn addressed issues on population health for frail and disabled elders, and suggested the need for an integrator at this life stage. This week Debbie Chang Vice President of Policy and Prevention at Nemours, an integrated child health system, further discusses the integrator role, based on a paper she presented to the CMMI Population Health Models group earlier this month. Nemours has taken on the role of an integrator to improve child health and well-being in Delaware.



What Does a Population Health Integrator Do?

By Debbie I. Chang, MPH

Achieving the Three-Part Aim – better quality of care, better health for populations, and lower costs – has become a critical area of focus for health care reform. One approach to meeting the Three-Part Aim is to work to improve population health with a place-based focus by seeding and funding integrators. Integrators operate at a population level in a geographical region. Working in a sustainable fashion with health care, public health and other community partners, integrators:

Promote prevention,

2. Improve health and well-being
3. Improve quality and reduce health care costs

An integrator is an entity that serves a convening role and works intentionally and systemically across various sectors to achieve improvements in health and well-being for an entire population in a specific geographic area. Examples of integrators range from integrated health systems and quasi-governmental agencies to community-based non-profits and coalitions. The integrator role is not one-size-fits-all, but rather must be flexible to adapt in response to the needs of the community or population it serves. Integrators, or a system of integrators, may take various forms, depending on available resources and on community strengths and needs. An integrator need not perform all of the functions listed below at once; external forces and contexts may require certain functions to take precedence at certain times.

Communities may have one or more integrators. In fact, large and/or complex communities may be most effective with multiple integrators. Integrators working within the same community may specialize. For example, one integrator may focus on children, to integrate key developmental aspects that address long-term needs and promote healthy development in the multiple sectors where children spend time such as schools, child care, primary care and neighborhoods. Another integrator in that same community may focus on another phase in the life course.

A wide array of organizations could assume an integrator role, depending on communities' goals, contexts, leadership, and stakeholder capabilities and resources. Over time, there may be an evolution in the entity or entities serving in the integrator role. Ultimately, a successful integrator or system of integrators benefits the community and its population by transforming the system thereby making it transparent to those who pay for it and who use it and by catalyzing and facilitating the integrated systems-work necessary to address the upstream social determinants of health.

Population Health Integrator Functions

Leadership and Partner Engagement

- Engage partners from multiple sectors and/or connect with other integrators to achieve the Three-Part Aim, with an emphasis on integrating services and mobilizing interventions to address upstream determinants of health.
- Serve as a trusted leader in the community that accepts accountability for and strategically drives the integration functions.
- Facilitate agreement among multi-sector stakeholders on shared goals and metrics to improve the health outcomes of a population in a geographic area.
- Assess the community resources, including workforce capabilities, that are available to reach shared goal(s); determine what gaps need to be filled and what duplication needs to be reduced; and work with partners to make appropriate adjustments

Spread, Scale and Sustainability

- Work at the systems level to make policy and practice changes in both the public and private sectors that impact populations and/or support partners or connect with other integrators in making these changes to scale up what works so that the entire population can benefit.
- Serve as a source for spreading what works at both the policy/systems level and at the practice level to reach sufficient scale.
- Sustain change by impacting policies and practices in collaboration with institutions and community partners at the local, community and state levels.
- Pursue financial sustainability via various methods, including leveraging existing and new sources of funding, developing innovative uses of current sources, and testing payment reforms that promote value and incentivize disease prevention and healthy development.

Continuous Learning and Improvement to Promote Population-Level Solutions

- Gather, analyze, monitor, integrate and learn from data at the individual and population level. Apply this knowledge to improve care and the patient experience at the individual level, improve systems at the population level, evaluate progress, and ensure that resources are targeted most efficiently, based on actual needs of communities and groups of patients.
- Identify and connect with system navigators (those roles intended to help individuals coordinate, access and manage multiple services and supports) so the integrator can harvest and aggregate data from individual cases and use the data to promote population-level solutions.
- Develop a system of ongoing and intentional communication and feedback at multiple levels including with affected sectors, systems and communities.

For an expanded discussion on this topic, please read Integrator Role and Functions in Population Health Improvement Initiatives.

Debbie I. Chang is Vice President of Policy and Prevention at Nemours.

Posted on 05/29/2012 in Leadership and Collaboration | Permalink | Comments (0)

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05/22/2012

Where I'd Put the Money: Quality of Life Investments for Frail and Disabled Elders

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Continue reading "Where I'd Put the Money: Quality of Life Investments for Frail and Disabled Elders" »

Posted on 05/22/2012 in Harnessing and Allocating Resources | Permalink | Comments (1)

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05/17/2012

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Posts from June 2012

06/26/2012

In the Literature: Alcohol Consumption Targets, Diet Cost



By David A. Kindig, MD, PhD

As previously noted, we regularly scan eleven journals for new studies of particular population health relevance (the list of journals is at the end of this post). Two recent articles caught our eye:

The Economic Gains of Achieving Reduced Alcohol Consumption Targets for Australia.

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Continue reading "In the Literature: Alcohol Consumption Targets, Diet Cost" »

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06/20/2012

National Prevention Strategy 2012: Applause and Critique, Again



By David A. Kindig, MD, PhD

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06/13/2012

Is Population Medicine Population Health?



By David A. Kindig, MD, PhD

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On this blog we have been explicit in our definition of *population health*, from the 2003 article I wrote with Greg Stoddart: "**the health outcomes of a group of individuals, including the distribution of such outcomes within the group**." *Population health* also encompasses the multiple determinants of health that produce these outcomes.

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06/06/2012

Bloomberg and Sugar: Will Regulatory Incentives Be Effective?



By David A. Kindig, MD, PhD

In his current biography *The Passage of Power*, Robert Caro recalls how four days after the Kennedy assassination, Lyndon Johnson had to decide if he would make a major civil rights push in his transition address to Congress the following week. Cautioned by his aides that it might be too controversial, he said, "Well, what the hell's the presidency for?"

I was thinking of this last week when the *New York Times* editorial page called last week's proposed removal of sugary drinks larger than 16 ounces in restaurants, theaters, stadiums and food carts by Mayor Bloomberg and Health Commissioner Farley "A Ban Too Far." They applaud other anti-obesity efforts but claim that "too much nannying with a ban might cause people to tune out." That statement does not seem to be particularly compelling itself, but how should population health advocates evaluate when regulation is appropriate or not?

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06/26/2012

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Are Socio-economic Disparities in Diet Quality Explained by Diet Cost?

It is known that socio-economic status and nutrient intake are positively correlated, but this article *(Monsivals et al. Journal of Epidemiology & Community Health. 66: 530-535)* delves deeper into this relationship to examine the effect of cost of nutritious food on these diet disparities. As foods with high nutritional value also tend to be more costly, the authors assert that that the monetary barrier of healthy food can partially mitigate the nutrient disparity once food cost is considered. The study found that mean diet cost varied considerably with education level and household income, with the better-educated and more affluent households spending significantly more in terms of food dollars per day ($1.09 and $1.37 respectively). This resulted in more educated and affluent households' nutrient density being considerably higher (11% and 9% respectively). The authors conclude that since socio-economic differences in diet quality and nutrient intake are related to the cost of food, then " food prices should be viewed as a critical component of the greater economic environment, which is a recognised determinant of health."

Commentaries of note: Because of the relevance of health care spending to population health outcomes, we recommend these two rationing essays to you as well.

Beyond the "R Word"? Medicine's New Frugality. M. Gregg Bloche. *New England Journal of Medicine*; 366:1951-1953

From an Ethics of Rationing to an Ethics of Waste Avoidance. Howard Brody. *New England Journal of Medicine*; 366:1949-1951.

I want to acknowledge the assistance of Erik Bakken, BA for his assistance in scanning the literature and drafting this post.

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American Journal of Preventive Medicine

American Journal of Public Health

Annual Review of Public Health

Health Affairs

Journal of the American Medical Association (JAMA)

Journal of Epidemiology and Community Health

Journal of Health and Social Behavior

Milbank Quarterly

New England Journal of Medicine

Preventing Chronic Disease

Social Science and Medicine

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The Status Report provides a brief summary of the year's activities, including meetings of the council, its Advisory Group, and regional meetings with public and private partners. A useful table highlights a number of featured programs and initiatives cutting across federal agencies like Green Ribbon Schools and the National Forum on Youth Violence Prevention. An Appendix lists a large number of Prevention Indicators linked to Healthy People 2020, although without performance targets.

The Action Plan is a much longer compilation. It lists more than 200 activities being taken in the 17 Departments to respond to the four cross-cutting Strategic Directions (Healthy and Safe Community Environments, Clinical and Community Preventive Services, Empowered People, and Elimination of Health Disparities) as well as the seven Strategic Priorities (Tobacco Free

Living, Preventing Drug Abuse and Excessive Alcohol Use , Healthy Eating, Active Living, Injury and Violence Free Living, Reproductive and Sexual Health, and Mental and Emotional Well-Being). It is beyond the scope of this blog to completely analyze or critique this list; it is an impressive compilation of work being done across these agencies and at the very least serves as a baseline for future reference. The Robert Wood Johnson Foundation's New Public Health blog posted an interview with Estelle Richman from HUD which gives a good flavor of how the Strategy is being implemented in one department.

While I strongly applaud this work, I do have several concerns.

1. The prevention framework still seems dominated by a health behavior framework, instead of a more upstream "primordial prevention." While many of the behavioral policies are structural, such as nutrition standards across all DOD facilities and schools, there is nothing about job creation and economic development within either the federal government or the private sector. I believe such policies deserve bipartisan support for their great potential for prevention and disparity reduction. Actually, I was surprised to realize that neither Treasury nor Commerce are represented on the Council and would encourage these be added for the important perspectives they could bring to this work.
2. While this activity is rooted in the Affordable Care Act, there does not appear to be a link to the cost containment policies of CMS. Increasing health care costs eat into resources that could be used to fund many population health improvement efforts. As Rigby says, "non health agencies will probably be more willing to incorporate greater attention to health if doing so does not deplete their own resources." And, of course, the Prevention Fund continues to face incredible political obstacles.
3. Indicators are not enough; we need targets to work towards and to hold us accountable.
4. The research community must produce evidence of the relative cost effectiveness of the wide range of policies and programs thought to drive population health improvement, including how health and prevention programs impact primary goals that agencies most care about.

Population health advocates on both sides of the aisle should recognize the potential setbacks that could result from a change in administrations. Silo-busting accomplishments such as the National Prevention Council are hard-won. They are very promising but also very fragile; progress will require that a bipartisan majority continue to value and respect this bold, innovative, and vital effort to improve the health of the nation in a cost-effective manner.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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06/13/2012

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On this blog we have been explicit in our definition of *population health*, from the 2003 article I wrote with Greg Stoddart: "**the health outcomes of a group of individuals, including the distribution of such outcomes within the group**." *Population health* also encompasses the multiple determinants of health that produce these outcomes.

The term *population medicine* has recently come into use. I was privileged to spend a few days last month in the Harvard Pilgrim Department of Population Medicine where our agenda included discussion of these definitions. They have defined population medicine as **"…the specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated."** Much of the discussion centered on how a health care organization, whose day-today work is closely tied to clinical practice, can also take action on the broader determinants of health. I think their definition gets it right. *Population medicine* is primarily concerned with clinical or health care determinants of health, but acknowledges the vital role of multi-sector partnerships (such as with public health, education, business, and social services) to influence health more broadly.

A colleague in Minnesota has taken this idea a bit further. As a part of the 2014 strategic planning process at HealthPartners in Minneapolis/St.Paul, George Isham worked with staff and board members to identify and commit to those traditional responsibilities over which the organization has influence or control (i.e., healthcare and health behavior). But they are also seeking other

opportunities aligned with their mission for which they (as a health care organization) have limited opportunity for direct influence. They are therefore developing partnerships with others to expand the scope of their influence beyond clinical care and health behaviors to the socioeconomic factors and the physical environment. Specific three-year goals were set for these partnership activities in the same way as was done for the traditional health care cost and quality goals of the organization.

Occasionally I hear *population health* being used to describe the clinical, often chronic disease, outcomes of patients enrolled in a given health plan. Certainly an enrolled patient group can be thought of and managed as a population, but defining *population health* in terms of patient populations undermines our goal of emphasizing the critical role that non-clinical factors such as education and income play in producing health. Such a view is even more limiting than *population medicine*, and certainly is not appropriately termed *population health* from a modern policy framework.

In a recent and very thoughtful policy paper for the National Quality Forum Jacobson and Teutsch address these issues and recommend that "current use of the abbreviated phrase *population health* should be abandoned and replaced by the phrase *total population health*." They state that “this will avoid confusion as the clinical care system moves rather swiftly toward measuring the health of the subpopulations they serve. Geopolitical areas rather than simply geographic areas are recommended when measuring total population health since funding decisions and regulations are inherently political in nature.”

I think we should use the term *population medicine* to describe and promote efforts by leading clinical organizations to use their professional and financial base to actively participate and partner in improving total population health through a multi-sectoral approach to address broad health outcomes and disparity reductions.

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Dave - I greatly appreciate your continued efforts at precision in wording here. Words and definitions do matter, they matter a lot, and I think it's important that we all have a common understanding of definitions - - and, in this case, the distinctions in meaning between "population medicine" and "population health."

But I admit to remaining a bit confused. If

a) Population Health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group“, and

b) Population Medicine is “...the specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated”,

then c) what do we call "the specific activities" of anyone else (other than the medical care system) "that, by themselves or in collaboration with partners, promote population health"?

In other words, why are activities that address socioeconomic or physical environmental drivers of health called "population medicine" when the health care sector does them, but not when others do them?

Or, more bluntly, why should only the medical care sector get a special name for its activities in these areas?

Posted by: Geof Swain | 06/14/2012 at 10:05 PM

Geof raises an interesting question. Another question I have is whether pop med's primary focus is applications in the one-on-one clinical setting rather than clinicians promoting health outside the clinic. The Harvard pop med determinants schematic shows clinical care at the center with social factors influencing it and their website guides address how to bring pop med principles (largely epi) into the clinic.

This ultimately speaks to what we are preparing MD students to do. Should competencies for MD students in pop med/pop health focus on both clinical applications and going beyond the clinic? One more than the other? What does the new MD look like?

Posted by: Renie Schapiro | 06/15/2012 at 10:39 AM

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06/06/2012

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There are two issues considerations in play here: 1) which problems to tackle (since if population health is everything it could be nothing and 2) which incentive strategies to use. With regard to the former, communities consider a range of issues when setting priorities for action: What is the magnitude and severity of the issue? What is its relative contribution to health outcomes, what (if any) evidence-based interventions are available and feasible, and, what is the impact on disparities, cost effectiveness, and public demand? On most of these points, obesity would seem to qualify as well as being worth tackling; Farley claims that sweetened drinks are responsible for up to half of the increase in city obesity over the past 30 years. The evidence on the effectiveness and cost effectiveness of this particular regulation is certainly unknown however Farley has cited evidence from behavioral economics that the portion size available has been shown to influence

consumption.

Given the assessment that sugar-sweetened beverages are a policy priority, which tools should be used? Population health incentives have been divided into three broad classes:

- **remunerative or financial incentives** are those where an agent can expect some form of material reward — especially money — in exchange for acting in a particular way
- **moral incentives** are those where a particular choice is widely regarded as the *right thing to do*, or as particularly admirable, or where the failure to act in a certain way is condemned as indecent
- **regulatory or coercive incentives** are those where a person can expect that the failure to act in a particular way will result in *physical force* being used against them by others in the community — for example, by imprisonment or by confiscating or destroying their possessions

New York City has already used moral incentives in its tough anti-obesity advertising campaigns, and tried to use financial incentives with a soda tax and food stamp restrictions; these were blocked by the state and Federal governments respectively. The current proposal is perhaps a joint financial and regulatory effort; the sale of such sizes is prohibited, but the penalty is a fine -- hardly the physical force described above. It is also relatively weak in that additional purchases of smaller sizes as well as free refills would be allowed.

So is it a "Ban too Far"? From my perspective, we need to try many new approaches to combat this epidemic, and all incentive categories need to be considered. Careful population health policy analysis would have to consider the industry claim that jobs might be lost; if true, this competing socioeconomic effect on health might be important. However, just getting this level of attention and discussion has considerable value, and Bloomberg and Farley are to be commended for pushing the limits of what is possible politically and under their control as regulators. Time and careful evaluation will have to tell if this particular approach has a reasonable return on investment, measured in health improvement, for the financial and political capital expended.

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true case example of the abacus for making policy decisions to improve health - in a complex context need to weigh trade-offs and find sensitive intervention points to achieve positive social change

Posted by: pamela Russo | 06/06/2012 at 10:44 AM

This may not be a ban too far, but it is certainly a ban too dumb. What evidence exists that demonstrates that banning these obscene size sodas in selected places will affect obesity in the slightest? If one of my policy analysis students suggested this ban, his grade would be in doubt. Regulation is good when there is evidence to prove its effectiveness. Otherwise, it's just expensive and annoying --and its costs might have been better spent on something that actually works.

Posted by: Burden Lundgren | 06/06/2012 at 11:59 AM

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Posts from July 2012

07/31/2012

Disparity Improvement, Disparity Persistence



By David A. Kindig, MD, PhD

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Trends in the Black-White Life Expectancy Gap, 2003-2008 (Harper S, Rushani D, Kaufman J. *JAMA*. 2012;307(21):2257-2259).

The gap in life expectancy between non-Hispanic white and non-Hispanic blacks has continued to be one of the greatest lingering disparities of public health in the modern era. However, this brief report in *JAMA* asserts that this gap may be beginning to close. The authors have found that between 2003 and 2008 the life expectancy gap has been reduced from 6.5 to 5.4 years for men and 4.6 to 3.7 years for women. This reduction is significant, as a reduction of this magnitude has not been observed since the early 1990s, with the authors concluding “these racial inequalities among men and women in 2008 are the lowest ever recorded in the United States.” Authors attribute the narrowing gap among both men and women to declines in heart disease and HIV mortality rates, as well as a recent increase in poisoning mortality that has affected middle-aged white men more than any other group. This example illustrates that disparity rates are ratios that can be improved by worsening health among advantaged groups as well as improved health among disadvantaged groups. Overall, these results are remarkably hopeful and need to be followed in future years for clues about how such trends can be sustained.

Continue reading "Disparity Improvement, Disparity Persistence" »

Posted on 07/31/2012 in In the Literature | Permalink | Comments (0)

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07/24/2012

Taxes for Early Childhood Health in Palm Beach County, Florida



By Erik Bakken, BA

Progress in population health requires dedicated funding streams to guarantee the long-term viability of programs. However, in these cash-strapped times, securing grants can be like walking up a flight stairs doing a headstand. Seven counties in Florida are using an ingenious and unique method of continued funding through special districts to promote childhood and related family health programs. Known as children's services councils (CSCs), these organizations gain the majority of their budget from levying small, additional property taxes. As health trajectories begin at day one, these councils work to ensure that all children meet key health indicators, such as prenatal care, parenting techniques, and school preparation. One such county is Palm Beach County, Florida; I spoke with members of the Palm Beach County Children's Services Council (www.cscpbc.org) to better understand their mission and this exceptionally creative funding method for promoting childhood health.

Continue reading "Taxes for Early Childhood Health in Palm Beach County, Florida" »

Posted on 07/24/2012 in Policy and Systems Change in Action | Permalink | Comments (0)

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07/18/2012

More Perspectives on "Population Medicine"



By David A. Kindig, MD, PhD

My previous post on population medicine prompted a number of thoughtful responses which I'd like to share. This is not simply a terminology discussion. The breadth of the population health view we espouse here can be undermined if it is confused with chronic disease management of enrolled patients.

Emma Eggleston, MD, MPH Instructor, Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, Boston, MA

Population medicine…takes a population perspective from a healthcare system base. It encompasses the intersection between the health care system and other determinants of (and partners in) populationhealth e.g. public health, communities, the built and social environments,etc. In other words, it is the sum of 1) the population- specific activities of the health care system itself and 2) the intersection ofthe health care system with other determinants of population health. While the population-specific activities of the health care system are important and arguably easier to delineate and act upon, the exciting potential for long-term innovation and impact is in the intersection.

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07/10/2012

Are Male Genetic Health Differences Disparities or Inequities?



By David A. Kindig, MD, PhD

A year ago I discussed health disparities in several posts, including one on Rates and Burden, where I noted that *"rates are very useful measures, because they allow comparison across populations of different sizes. But from a population health perspective, rates alone are not enough, because large disparities in very small populations have a different impact than similar disparities in larger populations. Burden refers to the impact of a health problem in a population, combining both the rate and the number of people affected."* I went on to observe that in comparing male and female mortality, there is a surprisingly high male mortality rate, but it is the size of this population (155 million) that transforms the rate into a significant population health burden, equal or more important than those by race or socioeconomic status.

This old post came immediately to mind several months ago when I saw the *New York Times* headline "Male Genes May Explain Higher Health Disease Risk," which focuses on work by Fadi Charchar and colleagues that appeared in *The Lancet*. Findings reveal that British men have one of two variants of a cluster of genes on their Y chromosome – one of which carries a 50% increased risk of heart disease, even after controlling for smoking, diabetes, and cholesterol.

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07/05/2012

Using the County Health Rankings for Health Policy Ethics with the Kansas Legislative Health Academy



By Erika Blacksher, PhD

The *County Health Rankings* paint a granular picture of morbidity and mortality in more than 3,000 U.S. counties. By ranking counties within each state, these data depict inequalities in health at the regional level; by framing these variations in terms of geography and social determinants, these data implicate broad social structures in health and disease; and by specifying health in terms of preventable morbidity and premature mortality, these data describe an important human good. In these ways, the *County Health Rankings* make vivid an important moral question: Are these inequalities in health ethically acceptable?

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Trajectories of Health-Related Quality of Life by Socio-Economic Status in a Nationally Representative Canadian Cohort (Ross N, Garner R, Bernier J, Feeny, Kaplan M, McFarland B, Orpana H, Oderkirk J, *Journal Epidemiology & Community Health 2012; 66(7):593-598)*.

We often report population health outcomes as mortality rates or life expectancy, as in the article above, since such data are widely available. However, non-mortality outcomes are also very

important, and make up half of the health outcome rank in the *County Health Rankings*. The term health related quality of life (HRQoL) is a term used to generally describe such non-mortality or morbidity outcomes. Using one of the most sophisticated HRQoL measures (the HUI-3 in the National Population Health Survey), the authors traced social health gradients over time in a representative sample of Canadians. They report that HRQL is lower for Canadian men and women of lower education and income levels compared with those with a high education and increased affluence. This social gradient in HRQL is evident in early adulthood and continues through mid and later life, but age-related declines in quality of life do not appear to be vastly different across the social spectrum in Canada. The authors comment that "this may suggest that policies such as universal health insurance and comparatively generous old age benefits have helped to reduce the disparities in life circumstances as Canadians age"…and that "socio-economic disadvantage in early life may encompass a wide variety of both material (e.g., poverty and poor nutrition, poor quality housing) and psychosocial (e.g., stressful life events, shame from stigma, social isolation) exposures that collectively limit life chances and set up health-related quality of life deficits in early life that are never overcome at older ages."

We call this paper to your attention not only for the significance of its conclusions but for creative use of a non-mortality measure in a longitudinal study.

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Preventing Chronic Disease

Social Science and Medicine

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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07/24/2012

Taxes for Early Childhood Health in Palm Beach County, Florida



By Erik Bakken, BA

Progress in population health requires dedicated funding streams to guarantee the long-term viability of programs. However, in these cash-strapped times, securing grants can be like walking up a flight stairs doing a headstand. Seven counties in Florida are using an ingenious and unique method of continued funding through special districts to promote childhood and related family health programs. Known as children's services councils (CSCs), these organizations gain the majority of their budget from levying small, additional property taxes. As health trajectories begin at day one, these councils work to ensure that all children meet key health indicators, such as prenatal care, parenting techniques, and school preparation. One such county is Palm Beach County, Florida; I spoke with members of the Palm Beach County Children's Services Council (www.cscpbc.org) to better understand their mission and this exceptionally creative funding method for promoting childhood health.

"Children's Services Council of Palm Beach County is unique not only because of its funding source, but because of its dedication to achieving child outcomes through proven programs and its focus on a streamlined system of care for families," said Tana Ebbole, CEO of the Council.

Children's services councils began in the 1940s in Pinellas County, Florida, with the idea of providing juvenile delinquents in the county better alternatives than the criminal justice system. The original creators recognized that funding was a critical issue for the longevity of the program, and set up the nation's first special property taxing district of its kind. However, before the measure was put in place, the state determined the idea had to be voted on in county referendum, passing with an 80 to 20 margin in 1946.

Based on the success in Pinellas County, a team of Palm Beach County residents began a successful campaign for their own children's taxing district. The group advocated in Tallahassee and

saw passage of statewide legislation that allowed all counties to pursue a CSC. In Palm Beach County, CSC gained county voter approval in 1986. The levied tax cap today stands at $1 per $1,000 of taxable property in Palm Beach County. This means that a $200,000 home, omitting some tax exemptions, would pay $112.50 a year to the fund. Across all taxable properties in the county, this adds up to a serious chunk of change. The exemplary work by the Palm Beach County CSC in early child development could not be nearly as comprehensive without this funding, as more than 85 percent of its multi-million dollar budget comes from these tax resources.

The Palm Beach County Children's Services Council has been putting this money to good use, with programs centered on four outcomes of childhood development -- babies are born healthy, children are safe from abuse and neglect, children are ready for kindergarten, and children have access to quality afterschool and summer programming. Programs include promoting more accessible and affordable healthcare and nutrition for pregnant women and young children, improving the quality of child care and afterschool programming, developing parent confidence and family self-sufficiency and a host of other programs. In 2011, over 200,000 residents of Palm Beach County participated in an initiative or program run by the Palm Beach Children's Council with profound success rates. In 2009-2010, only 13.5% of high-risk pregnant woman participating in a CSC program had babies born with low birthrates, versus 22.5% for high-risk pregnant women not participating in a CSC program. Not only do these programs greatly increase child health and welfare in the county, but they are also cost-effective through preventive services in public health care or family services. CSC estimates that very low-birth weight babies can cost the public $100,000 in the first year of life, while preventing a child from entering the foster care system saves $23,000.

"In the end, the taxpayer's investment in CSC is worth it," Ebbole said. "Children who are given the fundamental tools for success early in life are much more likely to reach developmental milestones, graduate high school and go on to become productive members of our community."

The long-term success of CSC of Palm Beach County rests on its exemplary work enabled through its special district funding. If larger public health programs or agencies are to conduct similar work, more funding must be found outside of the traditional grant funding system. However, this example shows that such funding alternatives are viable, realistic, and can lead to highly fruitful public health outcomes.

Erik Bakken, BA is a graduate student at the University of Wisconsin's La Follette School of Public Affairs.

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07/18/2012

More Perspectives on "Population Medicine"



By David A. Kindig, MD, PhD

My previous post on population medicine prompted a number of thoughtful responses which I'd like to share. This is not simply a terminology discussion. The breadth of the population health view we espouse here can be undermined if it is confused with chronic disease management of enrolled patients.

Emma Eggleston, MD, MPH Instructor, Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, Boston, MA

Population medicine…takes a population perspective from a healthcare system base. It encompasses the intersection between the health care system and other determinants of (and partners in) populationhealth e.g. public health, communities, the built and social environments,etc. In other words, it is the sum of 1) the population- specific activities of the health care system itself and 2) the intersection ofthe health care system with other determinants of population health. While the population-specific activities of the health care system are important and arguably easier to delineate and act upon, the exciting potential for long-term innovation and impact is in the intersection.

Marc Gourevitch, MD, MPH Chair, Department of Population Health, New York University Medical Center, New York, NY

Defining these terms helps by providing guideposts to the broad spectrum of approaches currently in play that focus on aggregate outcomes, ranging from the most narrowly-construed version of 'panel management' within a specific delivery system, on the one hand, to a broadly framed health-in-all-policies approach adopted by a large city or state, on the other. Yet for many academic medical centers, incentive or reimbursement structures to support efforts to engage more broadly in non-clinical determinants of health lags behind understanding of the value of doing so. For this reason, while many engage in a limited fashion with the other determinants, others are more robustly addressing other determinants unrelated to their systems of

care. The value of these definitional frameworks is anchoring the various interventions and approaches that are evolving in parallel across the country.

George Isham, MD, MS Senior Advisor, Health Partners, St. Paul, MN

I think of these concepts as overlapping. Beyond individual care, broader activity that improves preventive services and acute or chronic care for populations of individuals could be thought of as "population medicine" and could also contribute to the overall health of the population. This is a particularly useful concept now because many care systems are now figuring out how to provide better preventive care, acute and chronic care to defined populations using activities such as Medical Homes, outreach, case management and other techniques. It's important to have health care organizations think about their relationship to the other determinants of health beyond health care because of the bigger potential impact of those other factors and the need to reallocate resources from health care to those other determinants. As significant community citizens, health care has the obligation, in my view, to positively impact the behavioral, socio-economic and environmental determinants of health.

Geoffrey Swain, MD, MPH Chief Medical Officer and Medical Director, City of Milwaukee Health Department, Milwaukee, WI

Words and definitions do matter a lot. But I admit to remaining a bit confused. If a) Population Health is 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group', and b) Population Medicine is '…the specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated', then c) what do we call 'the specific activities' of anyone else (other than the medical care system) 'that, by themselves or in collaboration with partners, promote population health'? In other words, why are activities that address socioeconomic or physical environmental drivers of health called 'population medicine' when the health care sector does them, but not when others do them? Or, more bluntly, why should only the medical care sector get a special name for its activities in these areas?"

Many thanks to Emma, Marc, George, and Geof for joining the conversation. Geof raises a great question, to which I would only note that the health care system is so strong and powerful that some special attention to the activities moving outside of the clinical arena is useful. This is not to diminish the health promoting activities of other sectors like public health and business and social service agencies. For these the term "population health" or even "total population health" seems appropriate. I agree with Marc that a bit of definitional conversation is useful to keep our eye on how all of us can contribute to the overall population health goal. It helps keep us on track, and prevents the fundamental aspects of the population health model from getting lost in translation.

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07/10/2012

Are Male Genetic Health Differences Disparities or Inequities?



By David A. Kindig, MD, PhD

A year ago I discussed health disparities in several posts, including one on Rates and Burden, where I noted that *"rates are very useful measures, because they allow comparison across populations of different sizes. But from a population health perspective, rates alone are not enough, because large disparities in very small populations have a different impact than similar disparities in larger populations. Burden refers to the impact of a health problem in a population, combining both the rate and the number of people affected."* I went on to observe that in comparing male and female mortality, there is a surprisingly high male mortality rate, but it is the size of this population (155 million) that transforms the rate into a significant population health burden, equal or more important than those by race or socioeconomic status.

This old post came immediately to mind several months ago when I saw the *New York Times* headline "Male Genes May Explain Higher Health Disease Risk," which focuses on work by Fadi Charchar and colleagues that appeared in *The Lancet*. Findings reveal that British men have one of two variants of a cluster of genes on their Y chromosome – one of which carries a 50% increased risk of heart disease, even after controlling for smoking, diabetes, and cholesterol.

Genetics is one of the five determinant categories in the population health model underpinning this blog; we know that our underlying genetic makeup influences both mortality and health related quality of life. In one of the most commonly cited papers on the determinants of population health, McGinnis and colleagues observed that "although only about 2 percent of deaths in the United States maybe attributed to purely genetic diseases, perhaps 60 percent of late-onset disorders—such as diabetes, cardiovascular disease, and cancer—have some genetic component."

So why haven't I blogged at all about genetics and population health, and why does genetics not appear in our closely related model underpinning the *County Health Rankings*? The reason is

that we have – until recently – viewed genetics as a non-modifiable health factor. That is, genetics are closely linked to health, but not amenable to treatment or prevention.

The New York Times asserts that the findings by Charchar et. al. put "a whole different perspective on risk factors for heart disease in men." Of course these findings need to be replicated, and the specific genes and their mechanism of action identified. Ultimately, how we view gender differences in chronic disease-related mortality will hinge on whether the Y chromosome effect can be modified genetically or therapeutically.

Disparities are only differences; inequities are those disparities that are unjust and remediable. If the Y chromosome cluster is shown to be responsible for much of the gender difference but cannot be modified or treated, it would not make sense for population health policy to target this differential health burden. So far, most complex genetic diseases have been resistant to the promise of genomic therapy and personalized medicine. In a future post I will offer a population health policy perspective on the risks and advantages of major genomic investments. For now, this study should alert us to the possibility that part of the male mortality burden may be unmodifiable and therefore a disparity but not an inequity of policy relevance.

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Well argued! However I suspect that given the promise of genomic therapy and personalized medicine today's disparity is tomorrow's inequity. We are correct to build our current models on what are current facts but we must also guard against creating inflexible models which resist future facts and thus limit our successors imaginations.

Posted by: Robert Stone Newsom, PhD | 07/11/2012 at 02:05 PM

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07/05/2012

Using the County Health Rankings for Health Policy Ethics with the Kansas Legislative Health Academy



By Erika Blacksher, PhD

The *County Health Rankings* paint a granular picture of morbidity and mortality in more than 3,000 U.S. counties. By ranking counties within each state, these data depict inequalities in health at the regional level; by framing these variations in terms of geography and social determinants, these data implicate broad social structures in health and disease; and by specifying health in terms of preventable morbidity and premature mortality, these data describe an important human good. In these ways, the *County Health Rankings* make vivid an important moral question: Are these inequalities in health ethically acceptable?

The *County Health Rankings* have brought this question home for hundreds of U.S. communities, many of which are making collective decisions to do better. But, the rankings and the moral questions they raise also are useful in other educational contexts. I have used them as a case study for the health policy ethics curriculum of the Kansas Legislative Health Academy, a program that convenes legislators from across the political spectrum to engage in constructive dialogue and innovative learning about system dynamics of health policy, ethics of health policy, and civic leadership. Created in 2009 by the Kansas Health Institute (KHI), Kansas Health Foundation, and Kansas Leadership Center, the Health Academy seeks to expose legislators to new ways of thinking through and engaging one another in the challenges of making health policy.

Those challenges include the value-laden nature of health policy. Public policy is based, implicitly or explicitly, on ethical considerations, as are the rules and procedures that guide legislators' policy debates and decision-making (i, ii). The controversy that often surrounds health policy reflects disagreements not only over facts but also underlying ethical values. Like most people, legislators are not practiced at making explicit the ethical premises that inform, often implicitly, their policy preferences. With this in mind, the ethics curriculum sought to help legislators:

- Identify the normative dimensions of health policy content and process;
- Illuminate a plurality of values and principles pertinent to health policy; and
- Frame policy disagreements as opportunities for reasoned and respectful engagement and debate.

To achieve these objectives, case studies and hands-on exercises were developed to shape and motivate small and whole group discussions. The Kansas *County Health Rankings* are used as one of these exercises. First, Academy participants are asked to locate their county on a Kansas map that displays the health rank of each county and to discuss a series of open-ended questions to elicit observations and concerns. The presupposition is that these observations will include ethical considerations, which has proven to be the case. This content generates discussion to illustrate and introduce basic concepts: (1) ethics, (2) ethics in the context of health policy; (3) policy values, i.e., norms that guide the content of policy; and (4) process values, i.e., norms that guide the process of policy making; and "morally serious persons," (i) the idea that others take their values as seriously as we take our own. Second, participants are placed in one of two small groups, one representing the county with the worst health, the other with the best. Academy participants are placed in the group least like the counties they represent and are asked to discuss a series of questions that aim to draw out their moral views about health, inequalities in health, as well as to cultivate the 'moral imagination,' i.e., their capacity to reflect and reason from a position other than their own.

Whether the Health Academy will have a long-term impact on policy making in Kansas is not yet known. But, in an era when political and public discourse seems more entrenched and polarized than ever, all efforts to cultivate habits of reasoned and respectful discourse and the capacity to think from a position other than one's own seem worthy of continued study and investment.

Erika Blacksher is an Assistant Professor of Bioethics & Humanities at the University of Washington in Seattle, Washington

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i. Kenny N, Giacomini M. Wanted: A new ethics field for health policy analysis. *Health Care Analysis* 2005;13(4).

ii. Churchill L.R. What ethics can contribute to health policy. In *Ethical Dimensions of Health Policy*, eds. Danis M., Clancey C., Churchill L.R. (New York: Oxford University Press 2002).

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Erika
Is their a link you can provide to the case studies or curriculum?
Thanks
Brad

Posted by: Brad F | 07/05/2012 at 08:28 PM

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Posts from August 2012

08/29/2012

Monitoring State Health Policy and Policy Cost Effectiveness



By David A. Kindig, MD, PhD

We regularly scan eleven journals for new studies of particular population health relevance (the list of journals is at the end of this post). Two recent papers caught our eye:

Improving State Health Policy Assessment: An Agenda for Measurement and Analysis James Macinko, PhD, and Diana Silver, PhD, MPH *American Journal of Public Health, Ahead of Print; e1-e9. Doi:10.2105*

We have argued in this blog about the potential importance of local population health "policy packages" tailored to the specific health outcomes, factors, and policy resources and climate of individual jurisdictions. Macinko and Silver go beyond speculation with a compelling and important analysis of how states have varied over time with regard to public health policy. They approach this through the lens of two policy constructs: ***intradomain***, which is the extent to which a state adopts the entire set of evidence based policies for a given policy set such as motor vehicle crashes, and ***interdomain*** referring to the extent a state adopts evidence based policies across multiple domains such as smoking, alcohol, and nutrition policies. Twenty-seven proven policies were examined, such as seatbelt laws, indoor smoking bans, and firearm restrictions, to uncover patterns within state policy environments between 1980 and 2000. One of the figures in their paper demonstrates some interesting patterns, including clustering of certain states into a few highly similar trajectory groupings which basically negates the typical red/blue state patterns in terms of health policy. The authors contend "these illustrations of state policy behavior, albeit crude, nevertheless suggest there may be patterns of state policymaking that bear further investigation." This conceptualization and tracking of state policy patterns is a fresh and important perspective that should help us move forward

with advancing a balanced investment portfolio of health in all policies.

Continue reading "Monitoring State Health Policy and Policy Cost Effectiveness" »

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08/21/2012

ReThinking Health in Pueblo, Colorado: A Stewardship Strategy to Advance the Triple Aim



By Bobby Milstein, PhD, MPH

Noted ecologist Wendell Berry, in an essay entitled "Solving for Pattern," observed that "*Good solutions recognize that they are part of a larger whole. They solve more than one problem and don't create new problems."* Berry was thinking mainly about environmental issues. But his mandate applies equally to the health system, where some of the most effective leaders routinely strive to achieve the "Triple Aim" of better health, better care, ***and*** lower cost for all.

One such endeavor is unfolding in Pueblo, Colorado (population 160,000), located about two hours south of Denver, where scores of stakeholders are now committed to the Triple Aim. According to the Institute for Healthcare Improvement, Pueblo is one of a few sites formally working at a county-wide scale. Pueblo is also an early adopter of the Collective Impact strategy, popularized by the nonprofit consulting firm FSG, and one of the first pilot sites in the ReThink Health Dynamics project. Together, these influences have shaped their approach to system-wide planning and action (see figure below).

Continue reading "ReThinking Health in Pueblo, Colorado: A Stewardship Strategy to Advance the Triple Aim " »

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08/07/2012

Do You Really Mean "Health" Expenditures?

This post originally appeared on the *Health Affairs* Blog:

> Kindig DA, Do You Really Mean "Health Expenditures?" *Health Affairs* Blog, 8/7/12, http://healthaffairs.org/blog/2012/08/07/do-you-really-mean-health-expenditures/, Copyright ©2012 *Health Affairs* by Project HOPE – The People-to-People Health Foundation, Inc.



By David A. Kindig, MD, PhD

Using the term ***health expenditures*** yields a narrow and seriously misleading view of what it will really cost to improve population health.

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In their first Recommendation, the report authors advise that the

> Secretary of the Department of Health and Human Services should adopt an interim explicit life expectancy target, establish data systems for a permanent health-adjusted life expectancy target, and establish a specific per capita health expenditure target to be achieved by 2030. Reaching these targets should engage all health system stakeholders in actions intended to achieve parity with averages among comparable nations on healthy life expectancy and per capita health expenditures.

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08/21/2012

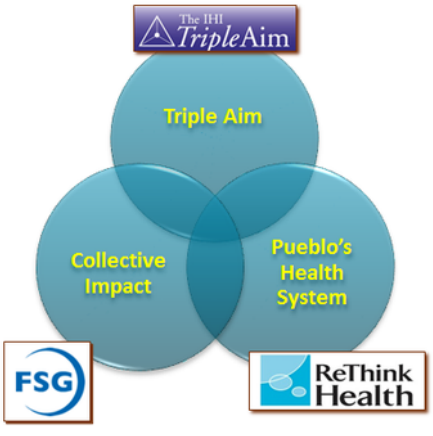
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- IHI's Triple Aim defines basic goals and an ethic of iterative improvement;
- FSG's Collective Impact emphasizes shared governance and solid infrastructure; and
- ReThink Health equips leaders to engage with one another, examine data, play out scenarios, weigh trade-offs, and strengthen their capacity for high-leverage action.

Building on these elements, the Pueblo Triple Aim Coalition (PTAC) devised a distinctive stewardship strategy that they are now poised to enact. Here is a brief summary of its features.

Recognizing & Responding to a Crisis

With health care premiums rising three times faster than wages, and *County Health Rankings* placing Pueblo 54th out of 59 Colorado counties on health outcomes, many stakeholders see a "burning platform" that compels them to act. In a brief statement written to engage fellow leaders, PTAC members explain that "*ever-rising healthcare spending weakens our local economy, threatens jobs, and has failed to deliver improved health.*"

They also identify a potentially abundant source of money, estimating that a modest decrease in health care spending (on the order of 7.5% per capita) could yield more than $75 million in annual savings, even apart from the potential boost to economic productivity. Thinking about the work ahead, they conclude that "*progress in Pueblo has been badly hampered by the absence of an overarching strategy and a coordinating institution.*" Pueblo's Triple Aim Coalition aspires to fill precisely that gap in a way that individual actors working separately could never do.

Crafting a Stewardship Strategy

After its launch in November 2010, the PTAC grew to encompass dozens of constituents including the health department, community health center, hospitals, mental health center, Kaiser Permanente, schools, business leaders, elected officials, philanthropies, and more. Aligning such diverse groups is time-consuming, but there are rewards for laying a strong initial foundation. About a year into the process, over 35 senior leaders from across Pueblo's organizational landscape voted unanimously to join the effort. Colleagues from IHI and ReThink Health support the PTAC team, but it remains a local endeavor, animated by passionate leaders who devote their time, talent, and resources to the work, with Kaiser Permanente generously paying IHI dues and the salary of a half-time coordinator.

More fundamentally, those involved maintain an unswerving commitment to go beyond fragmented, short-sighted action. Donald Moore, CEO of the Pueblo Community Health Center, explains their rationale for this critical stance: *"Most Triple Aim projects start with a project and build up from there. Instead, we have been thinking big picture and haven't selected specific projects yet. We are building governance, structure, and strategy first because we believe our work will be more successful and sustainable with this approach."*

Using the ReThink Health Dynamics model, calibrated with Pueblo's own data, team members studied scores of scenarios and eventually identified a compelling suite of initiatives that could significantly strengthen most aspects of their health system. The PTAC plan now centers on a mix of cost-saving initiatives, like care coordination and post-discharge planning, along with support for self-care, greater safety net capacity, and investments in upstream social, economic, and behavioral initiatives. Just as importantly, PTAC planners determined that it may be possible to sustain all of these activities over decades by capturing and reinvesting a portion of health care cost savings. This financing strategy is similar to one that Sanne Magnan and colleagues have proposed in their essay on Accountable Health Communities.

Christine Nevin-Woods, Executive Director of the Pueblo City-County Health Department, says that, "*ReThink Health modeling opened our eyes. It offered perspectives on big impact changes that might not pay off right away."* In addition, other supporters also see great potential in Pueblo's disciplined strategy. Just last week, for example, senior staff from the Colorado Health Foundation met with PTAC members and ReThink Health allies to consider next steps, such as establishing a backbone organization, a shared measurement system, and other elements needed for collective impact. PTAC representatives will discuss their strategy and accomplishments at the Public Health in the Rockies Conference on September 19th.

Looking beyond Pueblo, there are hundreds of organizations actively pursuing the Triple Aim, expanding its reach, and pressing toward wider, population impact. At the same time, members of the ReThink Health alliance are creating new tools and working with innovators to strengthen their capacity for stewardship, sharpen their understanding of health system dynamics, and organize more effective action. As this work goes forward, we may all learn what it takes to solve for the vital pattern of better health, better care, and lower cost for all.

Bobby Milstein, PhD, MPH, is Director of ReThink Health Dynamics and Director of Systems Strategy and Programs for the Fannie E. Rippel Foundation.

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> achieve parity with averages among comparable nations on healthy life expectancy and per capita health expenditures.

These are bold and challenging targets, worthy of critical policy attention. But here is where precise terminology is critical for population health advocacy. Throughout the report the term ***health expenditure*** is repeatedly used, referring to what is reported by the CMS Actuary in the National Health Accounts, and what we commonly refer to when we calculate the percentage that health takes of the overall GDP.

However, national health accounts only report national expenditures for health care and governmental public health. Calling these ***health expenditures*** could subtly lead many to infer that health care and public health are the only or the main expenditures necessary to improve health. But in the IOM report's words,

> The United States seems to lag behind most high-income nations in the deployment of socially protective strategies that appear to correlate with better population health. Excessive allocation of national spending on medical care services poses major societal opportunity costs and restricts funding opportunities for other essential sectors such as education, energy, water, transportation, agriculture, and employment. For example, the rise of medical care costs, and the recent recession, has contributed to a decline in state appropriations for public higher education.

Some will understand this population health resource perspective, but the terminology will lead many, perhaps unconsciously, down the path that health care — and even the doubling of governmental public health expenditures that the report calls for — are all that it takes to produce health. I would suggest ending the use of the term ***health expenditure;*** adopting the term ***population health expenditure*** for the total of all investments that will improve health; and using the longer and clumsier but more accurate term ***health care and public health expenditures*** for the numbers we currently get from the CMS actuary.

An accompanying explanation should note that evidence, data, and accounting systems do not yet exist to precisely estimate what proportions of non-health care and non-public health expenditures are health-outcome producing, but that this is a critical comparative effectiveness and health policy research priority for the future. The IOM report anticipated this need by also recommending the "development of a robust research infrastructure for establishing the effectiveness and value of public health and prevention strategies, including……the development and validation of methods for comparing the benefits and costs of alternative strategies to improve population health." Drawing on cross-national evidence, the report mentions the recent work of Bradley et al, which argues that an important reason for the poor performance of the US health system is the relative proportion of non-health care social spending to health service spending; in other developed countries it is 2.0, while in the US it is 0.91.

While the term ***health care and public health expenditures*** is longer and more clumsy, it will constantly remind us that producing health and reducing disparities will require investments across all determinants, and it will prompt us to get on with new governance and business models that will allow us to accomplish this. If the Secretary does establish the IOM panel's recommended targets, let's hope that in the future they will indeed reflect the needed per capita ***population health expenditures*** across all determinants: medical care, public health, health behaviors, the social environment, and the physical environment.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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it addresses the critical issue, in a time of budgetary austerity An accompanying explanation should note that evidence

the pet post

Posted by: petpost | 08/26/2012 at 01:37 AM

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Posts from September 2012

09/26/2012

What Works for Health – A New Tool from County Health Rankings & Roadmaps



By Bridget Booske Catlin, PhD, MHSA

When it comes to developing and implementing solutions to problems that affect our communities, evidence matters. Implementing or adapting strategies that are proven increases the likelihood of success in improving community health. Investments in strategies that are shown to work are smart investments that can stretch the impact of scarce dollars. Developed by the University of Wisconsin Population Health Institute in partnership with the Robert Wood Johnson Foundation, *What Works for Health* is an online tool that you can use to find policies and programs that have been shown to improve community health.

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09/20/2012

Race, Education, and Life Expectancy



By David A. Kindig, MD, PhD

We regularly scan eleven journals for new studies of particular population health relevance (the list of journals is at the end of this post). A recent paper caught our eye:

Differences In Life Expectancy Due to Race And Educational Differences Are Widening, And Many May Not Catch Up. S. Jay Olshansky et al. *Health Affairs (2012),* 31 (8), 1803-1813.

The two overarching goals of population health improvement are improving overall health and reducing disparities. Successive generations of Americans enjoyed upward trends in life expectancy and improved general health during the twentieth century. However, in spite of the technological advancements in modern medicine and escalating health care expenditures, disparities in longevity based on race/ethnicity and educational attainment remain persistent and damaging to our society. This article by a distinguished group of investigators from the MacArthur Research Network on an Aging Society quantifies these life expectancy disparities in terms of race and education level, using data from NCHS as well as the American Community Survey (the largest household survey in the U.S.). Investigators found the largest disparity in life expectancy at birth to be between highest educated whites and lowest educated blacks: 14.2 years for males and 10.3 years for females (2008 data). The authors found that while race plays a role in longevity, education level is even more important across all groups, except Hispanic females. Educational attainment at age 25 correlated more strongly with expected life years, both within and among racial groupings. For example, highly educated blacks had a life expectancy 7.5 years higher than their less educated white counterparts, which defies the overall racial disparity.

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09/14/2012

Can We Find Political Common Ground to Improve Population Health?



By David A. Kindig, MD, PhD

The next two months will be filled with harsh and divisive campaigning, deepening the ideological divide that characterizes our politics these days. Both conventions seemed primarily designed to energize their bases, by emphasizing the sharpest differences between the political "tribes." Perhaps this is necessary in today's politics, but it doesn't bode well for population health policy over the coming decade. Improving population health will require cutting health care costs while preserving access and quality, enabling better health behaviors, improving education, economic growth, and the physical environment while also increasing social support and social capital. These are decisions that will require careful, nuanced decisions that go far beyond simplified political exchanges.

Last Labor Day I blogged on my summer read of Friedman and Mandelbaum's book *That Used To Be Us: How America Fell Behind in the World It Invented and How We Can Come Back*, and their call for third party movement or even a new party which seeks to find common ground on such major challenges facing the country. This summer, I continued in this genre with Jonathan Haidt's *The Righteous Mind: Why Good People are Divided by Politics and Religion*. Haidt is a social/moral psychologist, now at the NYU Stern School of Business. The book is a breathtaking synthesis of psychology, philosophy, evolutionary theory, anthropology, genetics, and political science. The book jacket poses these two questions: "Why can't our political leaders work together as threats loom and problems mount? Why do people so readily assume the worst about the motives of their fellow citizens?"

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09/04/2012

"If Not Genetics, Then What?"



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Continue reading ""If Not Genetics, Then What?"" »

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09/26/2012

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When it comes to developing and implementing solutions to problems that affect our communities, evidence matters. Implementing or adapting strategies that are proven increases the likelihood of success in improving community health. Investments in strategies that are shown to work are smart investments that can stretch the impact of scarce dollars. Developed by the University of Wisconsin Population Health Institute in partnership with the Robert Wood Johnson Foundation, *What Works for Health* is an online tool that you can use to find policies and programs that have been shown to improve community health.

What Works for Health is an easy-to-use, searchable menu of policies and programs with a broad scope--it is based on the County Health Rankings model and looks at strategies that address the many factors that affect health, including health behaviors, access to care, social and economic factors, and the environment. Users can choose a health factor of interest (e.g., tobacco use, employment, or access to health care) and browse through the evidence ratings for particular programs, policies, or system changes that address the particular health factor of interest. For each strategy listed in *What Works for Health*¸ analysts search published and unpublished literature as well as the findings of other organizations that assess evidence of effectiveness and assign one of the following evidence ratings:

- **Scientifically supported:** The program, policy or systems change works – its effectiveness is supported by numerous studies or systematic review(s) with strong positive results; no existence of substantial contradictory evidence.
- **Some evidence:** The program, policy or systems change has been shown to work more than once -- research suggests positive impacts overall; further study may be warranted.

- **Expert opinion:** The program, policy or systems change has been recommended by credible groups, but research evidence on its effectiveness is limited. Credible groups are recognized for their impartial expertise in an area of interest.
- **Insufficient evidence:** It is too soon to tell how well the program, policy or systems change works -- evidence is limited or unavailable and further study is warranted.
- **Mixed evidence:** The program, policy or systems change may or may not work -- evidence is mixed and further study is warranted.
- **Evidence of ineffectiveness:** The program, policy or systems change doesn't work -- research consistently shows harm or lack of effect.

Conducting literature reviews and assessing the strength of the evidence is a time-consuming process—*What Works for Health* saves you time by summarizing lots of information, while also providing you with full documentation and links to the original evidence. There are many organizations that assess the effectiveness of policies and programs. Each organization uses its own criteria to assess and rate evidence. Rather than reinventing the wheel, *What Works for Health* summarizes and links to research from other rating organizations. Examples of other organizations include:

- The Campbell Collaboration Library of Systematic Reviews
- The Cochrane Library
- The Guide to Community Preventive Services (The Community Guide)

Ultimately, findings from the most scientifically rigorous reviews, studies, and rating organizations are used to rate each of the policies or programs included in *What Works for Health*. However, it is important to note that evidence of effectiveness is just one of many factors to consider when choosing a strategy to solve a community health challenge. Community 'fit,' readiness, priorities, capacity, and resources are also important considerations. *What Works for Health* includes information on implementation examples and guides. Also, some strategies have not been tested enough to know how well they work – but some may have lots of potential and could represent some very innovative approaches. So, yes, evidence matters but so does innovation. If communities choose to implement innovative strategies with little to no evidence of effectiveness, they should do so knowingly. Evaluating these efforts is particularly important so that they and others can learn whether they really work.

Bridget Booske Catlin, PhD, MHSA directs the County Health Rankings & Roadmaps program at the University of Wisconsin Population Health Institute.

Posted on 09/26/2012 in County Health Rankings & Roadmaps | Permalink

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To summarize, the authors conclude that this has led to two Americas, "demarcated by level of education and its socioeconomic status correlates, and related to race or ethnicity." While the

authors acknowledge that racial disparities have been narrowing in the last few decades, they express concern that the gap could expand since improving life expectancy of lower educated individuals "is particularly difficult for those who have already passed the phase in which formal education normally occurs." They argue that enhanced educational investment at all ages -- lifelong learning -- will be required to protect and build on progress on disparity improvement.
Journals we follow:

American Journal of Preventive Medicine

American Journal of Public Health

Annual Review of Public Health

Health Affairs

Journal of the American Medical Association (JAMA)

Journal of Epidemiology and Community Health

Journal of Health and Social Behavior

Milbank Quarterly

New England Journal of Medicine

Preventing Chronic Disease

Social Science and Medicine

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09/14/2012

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Haidt sets out to answer these questions by dissecting what he calls our "moral intuition" (essentially our instantaneous perceptions of the world around us), arguing that our moral intuition operates much more quickly and strongly than rational thought processes. Through exhaustive psychological research, he identifies six moral foundations that he suggests characterize, in

different proportions, global cultural and political “moral maps.” These include Care/Harm, Liberty/Oppression, Fairness/Cheating, Loyalty/Betrayal, Authority/Subversion, and Sanctity/Degradation. (NOTE: for those interested in his ideas, these terms require a fuller elaboration than I have space for here because they are more nuanced than they appear at first glance).

He argues that these different foundations have a partial genetic basis, which can be modified by early development and later life experience. In addition, he asserts they have evolved in different societies and cultures to define a dominant moral intuition that he believes plays a powerful role in explaining our beliefs and ideologies. One prominent strand of argument is that while we are basically selfish, evolution does promote group interests to some extent.

With respect to American political culture, Haidt cites evidence, mostly from studying twins, that 30-50% of political attitudes have a genetic basis, with most differences between liberal and conservatives relating to sensitivity to threats and openness to new experience. His most relevant finding is that liberals bind together and primarily operate from the first three foundations above, while conservatives have a more balanced moral map or intuition across all six foundations. He argues that this produces a conservative advantage and explains why rural and working class voters often vote Republican: they are voting their moral interests which do not only focus on “the care of victims and the pursuit of social justice” as Democrats tend to but also include attention to Authority and Sanctity as well.

So what does this have to do with improving our health? If Haidt is fundamentally correct in his assertion that our political and ideological affiliations have a substantial genetic and evolutionary basis, and that liberals and conservatives differ in some of the dominant moral foundations from which they inherently operate, we had better understand those differences more fully if we are going to find ways to work together to address our nation’s challenges, including the many policies relevant to population health improvement. Does the goal of better health only address liberal moral foundations like Care and Fairness, or are there elements of conservative moral intuition that can help in finding common ground? I don’t yet have answers to these important questions, but look forward to others joining me in pondering this provocative area.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

Posted on 09/14/2012 in Improving Health Factors | Permalink

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Here, here, Dave! I'm with you! (But you knew that already.) Great post and I've heard so much about this book that it's becoming embarrassing that I haven't read it yet.

Posted by: Sarah Gollust | 09/14/2012 at 12:04 PM

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09/04/2012

"If Not Genetics, Then What?"



By David A. Kindig, MD, PhD

"If Not Genetics, Then What?" is the title of Chapter 6 in the important 1994 population health book *Why Are Some People Healthy and Others Not: The Determinants of Health of Populations*. Canadian population health geneticist Patricia Baird contributed a chapter on "The Role of Genetics in Population Health," which concludes as follows: "There are some disorders where the inherited metabolic machinery of the individual will not allow normal functioning in the usual range of environments; the associated diseases will usually burden the earlier part of the human life cycle. These provide a real and appropriate place for genetic service programs to contribute to population health. The complexities of the web of causation for most common afflictions in adult life are likely to limit the contribution of DNA identification of at risk genotypes. The potential for wasting resources and causing harm is real and serious."

I was prompted to return to this seminal text several weeks ago after a series of *New York Times* articles on modern genomics that included a front page story on tailoring treatment for leukemia to a business page report of approval in Europe of a gene therapy for treating a rare enzyme deficiency. Genetic studies on Alzheimer's proteins in mice have also raised the hope for a similar way to way to cure or slow the progression of this serious and increasingly prevalent health issue. The growing availability to sequence complete individual human genomes raises the potential of widespread "personalized medicine," with drugs or genes available for whatever defects any person might have.

How is a population health advocate to think about the possibility of such scientific advances to improve overall health and reduce disparities? It is so tempting to be lured into the fascination and the hope of such technological cures, but why do I have significant reservations? It probably because of the ideas laid out by Geoffrey Rose in his classic article "Sick Individuals and Sick

Populations" in which he asserts that "a large number of people at small risk may give rise to more cases of disease than the small number who are at high risk." While there may be important advances with life-saving treatments for rare diseases such as mentioned above, many complex diseases like diabetes and obesity may have their genetic defects spread over many locations rendering therapy complex and less likely, and many are the result of complex gene-environment interactions. The best thinking such as from CDC Public Health Genomics expert Muin Khoury, who argued for expanded evidence-based strategies in a 2008 Health Affairs article: "the current low threshold allows unsubstantiated technologies to enter into practice with the potential to overwhelm the health system…while an excessively high threshold for evidence could slow the integration of genomics into practice…also, variable coverage and reimbursement policies can lead to differential access to technology, exacerbating health disparities."

Baird's warning about wasting resources and causing harm needs to be taken seriously. As Don Berwick says, "waste is theft." It is not anti-scientific to worry that our American belief in technology and venture capitalism could result in much waste, while less expensive investments we already know to be effective are ignored. The problem is that it is hard to predict the future, and decades from now there will certainly be important benefits from genomic research, including both treatments and preventive interventions. We can only insist that the most careful evidence on population health cost-effectiveness be used to guide investments, rather than the potential for profit from very expensive therapies that benefit few.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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Posts from October 2012

10/24/2012

Will Increased Transparency Requirements For Nonprofit Hospitals Bring Greater Community Health Investments?

This post originally appeared on the *Health Affairs* Blog:

Rosenbaum S & Kindig DA, "Will Increased Transparency Requirements For Nonprofit Hospitals Bring Greater Community Health Investments?" *Health Affairs* Blog, 10/24/12, http://healthaffairs.org/blog/2012/10/24/will-increased-transparency-requirements-for-nonprofit-hospitals-bring-greater-community-health-investments/, Copyright ©2012 *Health Affairs* by Project HOPE – The People-to-People Health Foundation, Inc.

For additional reading on this topic, please see Bakken E, Kindig DA (2012). "Is Hospital 'Community Benefit' Charity Care?" *Wisconsin Medical Journal*, 11(5), 215-219.



By Sara Rosenbaum, J.D. and David A. Kindig, M.D., Ph.D.

Sweeping reforms implemented by the IRS and Treasury in 2009 have pulled back the veil surrounding the community benefit investments required of all nonprofit hospitals seeking federal tax exempt status. Will this new transparency, in combination with important tax law reforms enacted by Congress as part of the Affordable Care Act, lead to greater hospital investment in community health?

The Evolution Of Community Benefit Law

Since the 1950s, federal tax law has recognized that in order to qualify for tax-exempt status, nonprofit hospitals owe certain duties to the communities they serve. IRS Revenue Ruling 56-185 (1956) established a "financial ability" standard that required charitable hospitals to be "operated to the extent of [their] financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." In 1969, this early ruling was amended by Revenue Ruling 69-545, which substituted a more amorphous "community benefit" standard that has essentially survived into the present time, although with important modifications under the Affordable Care Act.

As noted by the Joint Committee on Taxation, the express purpose of Revenue Ruling 69-545 was to eliminate any enforceable obligation on the part of tax-exempt hospitals to furnish financial assistance to indigent inpatients. Following an unsuccessful legal challenge to the validity of the ruling (*Eastern Kentucky Welfare Rights Organization v Simon,* 370 F. Supp. 325, 338 (D.D.C. 1973), *rev'd*, 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds*, 426 U.S. 26 (1976)), the community benefit standard remained moribund and essentially went unexplored for decades.

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Posted on 10/24/2012 in Harnessing and Allocating Resources | Permalink | Comments (1)

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10/10/2012

Population Health: If It's Everything, Is It Nothing?



By David A. Kindig, MD, PhD

A respected colleague recently emailed a response to the post on advance directives that "it could imply that everything is about population health (which, as you and I agree, I hope) doesn't do much to advance the cause of purchasing population health."

Hmmm…if it's everything, is it nothing? A look at the population health model underpinning this blog and all I work on in population health, suggests that indeed it is perhaps everything: a broad set of outcomes produced by a comprehensive set of determinants which are influenced or activated by programs and policies in the public and private sectors.

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Posted on 10/10/2012 in Defining and Measuring Health Outcomes | Permalink | Comments (0)

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10/03/2012

Doing Well or Doing Better



By David A. Kindig, MD, PhD

When it comes to population health, is being the best the only thing we want to measure and reward? What about communities and states that are improving most rapidly, particularly from poor baselines? This issue is front and center in education policy: should we reward or incentivize schools or teachers who have the best student test scores, or those demonstrating greatest improvement?

I think both approaches are useful. Overall achievement should be measured and recognized, as with Olympic medals. But there's also a case to be made for keeping track of improvement, particularly for purposes of allocating resources to communities with formidable social and economic challenges.

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Posted on 10/03/2012 in Defining and Measuring Health Outcomes | Permalink | Comments (0)

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10/24/2012

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Beginning in 2006, chiefly as a result of the intense interest of Senator Charles Grassley (R-IA), lawmakers began to devote increasing attention to the question of how much specificity tax law should impose where the conduct of nonprofit hospitals claiming tax-exempt status is concerned. Part of the impetus for this increased scrutiny was cost estimates underscoring the sizable value of the benefits derived by hospitals from their tax-exempt status. (CBO placed the value of the exemption at $12.2 billion in revenues foregone in 2002; today's figure clearly would be significantly higher). A further impetus for heightened scrutiny came from widely publicized articles, including pieces in the *Wall Street Journal* , detailing highly troubling billing and collection practices by nonprofit hospitals aimed at uninsured patients.

This interest culminated in two important developments: the creation of a special mandatory reporting system for nonprofit hospitals seeking federal tax-exempt status, and amendments to the Internal Revenue Code under the Affordable Care Act that broaden and clarify hospitals' community benefit obligations. Together these two reforms usher in far greater transparency in hospital community benefit investments and a stronger community voice in how these investments should be used to improve community health.

Schedule H

What qualifies as a community benefit? The mandatory reporting system takes the form of a special report, known as Schedule H, that must be filed as an addendum to hospitals' annual 990 Forms submitted to the IRS. Launched formally in 2009, Schedule H contains detailed instructions that define the term "community benefit" and delineate its parameters. As with the 990 form, hospitals' Schedule H forms are transparent and fully available for review and analysis.

Under Schedule H (2011), financial assistance basically takes three forms.

1. prospective discounts for uninsured patients in need of assistance,
2. participation in Medicaid and other means-tested programs, and
3. community health improvement investments in research, training and education; certain "community-building" activities that can be shown to improve health; and community-based health services that are furnished outside the four walls of the hospital and that are not billable by the hospital.

The third set of activities is particularly important. As the number of uninsured declines as a result of the Affordable Care Act, hospitals may be able to augment activities such as risk-reduction in homes, abatement of environmental hazards, community-based prevention programs in workplaces and schools, and early childhood education efforts. These may be essential to health but fall well outside insurable events.

What does not quality as a community benefit? Schedule H goes further than simply delineating what does constitute a community benefit. It also defines what does not. Under Schedule H, the definition of community benefit excludes losses attributable to Medicare as well as bad debts that go unpaid after collection efforts. Schedule H thus creates a far sharper framework for community benefit; not surprisingly, hospitals have vigorously protested the reporting system for both its detail and transparency through both agency comments and Congressional oversight hearings.

Hospitals' unhappiness is not surprising: Schedule H effectively creates a nationwide data base that can be used to create information about hospitals' community benefit investments; merged with other data, Schedule H would permit the creation of a national benchmarking system enabling communities to understand hospital community benefit activities in relation to key variables such as the characteristics of hospitals, patients, and communities themselves.

The importance of the clarity and detail brought to the subject of community benefit investment by Schedule H is evident from studies that have begun to use Schedule H to measure and report on the extent of hospitals' community benefit investment. One of the authors of this blog post (Kindig) was the senior author of the first peer-reviewed study using the first year (2009) of Schedule H data, just published in the *Wisconsin Medical Journal*. The authors posed the question of whether hospital community benefit investments are primarily charity care, and found that, by far, this is not the primary investment reported to the IRS.

Of the more than $1 billion in community benefit expenditures reported by Wisconsin's hospitals, over half was attributable to hospital losses associated with their participation in Medicaid and other means-tested entitlements. Less than 10 percent, or $98 million, of total hospital community benefit reported was attributed to financial assistance (termed "charity care" in the article). More than this amount ($121 million) was reported for subsidizing discounts for other money losing services. About 4 percent, or $47 million, of the total (ranging from zero to slightly more than 7 percent of individual hospitals' total community benefit expenditures) was invested in community health improvement activities.

The ACA Amendments

The Affordable Care Act builds on the transparency and definitional advances made by Schedule H. Under the Internal Revenue Code as amended, hospitals must undertake four specific actions as a condition of tax-exempt status. First, they must conduct triennial "community health needs assessments" that provide for community and public health input and that result in implementation strategies tying community investments to community needs. A 2011 Notice issued by the IRS and the Treasury Department offers an extensive interpretation of this requirement, which took effect for tax years beginning March, 2012.

Second, hospitals must adopt specific financial assistance policies that better assure prospective assistance to patients unable to pay for care. Proposed rules (77 Fed. Reg. 38148, June 26, 2012) similarly provide a detailed and comprehensive interpretation of this requirement. Third, hospitals must limit charges imposed on persons eligible for financial assistance to levels no greater than they generally bill insurers.

Fourth, hospitals must meet federal billing and collection requirements and must maintain written policies clarifying their compliance with EMTALA. These issues are also addressed in the 2012 notice of proposed rulemaking and – not surprisingly – also have been the subject of widespread hospital protest. Yet events continue to underscore the importance of the ACA amendments — in particular, recent news reports detailing outrageous and potentially unlawful hospital collection practices in the emergency department.

Looking Down The Road

The advent of Schedule H, coupled with the ACA amendments, potentially ushers in a new era of transparency for nonprofit hospitals' community benefit investments. One reform clearly may help spur the other, since the needs assessment and public input requirements of the ACA amendments may lead to some shift in community benefit investments. As public involvement grows,

it is possible that more emphasis will be placed on community health improvement.

The Wisconsin study shows the major community benefit role played by Medicaid losses. While claiming Medicaid losses is consistent with federal tax policy, the degree to which these losses dominate the community benefit expenditure picture (at least in Wisconsin) is jarring. It raises questions regarding the degree to which one government program (IRS) should subsidize another (Medicaid), why these discounts are appropriate for non-profits only, what the appropriate accounting baseline for the discounts should be, and what the auditable standards for other money loosing "subsidized services" should be. As Uwe Reinhardt, one of the more trenchant analysts of health care financing, has observed, hospital pricing is "chaos behind a veil of secrecy."

If the Wisconsin figures hold nationally, then fully half of the more than $12 billion spent by U.S. taxpayers on nonprofit hospitals in 2002 went to cover claimed Medicaid losses. Whether U.S. taxpayers are well served in this regard — or would be better served were hospitals to instead invest their community benefit financing in broad prevention activities that could help avert these conditions — is essentially what the transparency of Schedule H and the community health needs assessment amendments of the ACA are all about.

Sara Rosenbaum, J.D. is the Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy, George Washington University School of Public Health and Health Services.

David A. Kindig, M.D., Ph.D. is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

Posted on 10/24/2012 in Harnessing and Allocating Resources | Permalink

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Thank you for this concise and thoughtful summary. These policy changes also create potential for a grey zone between the roles of hospitals and public health agencies. As community-based preventive services, (particularly "environmental abatement" which potentially involves toxins) become part of the definition of community benefit, it raises the question of program quality and the qualification of providers. Public health agencies are addressing these through accreditation (e.g., Public Health Accreditation Board http://www.phaboard.org/) and competency-based hiring. Hospitals should adhere to no lesser standards. But if Dr. Kindig's statistics hold, this may not be an issue for awhile.

Posted by: Seth Foldy, MD MPH FAAFP | 11/03/2012 at 11:41 AM

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10/10/2012

Population Health: If It's Everything, Is It Nothing?



By David A. Kindig, MD, PhD

A respected colleague recently emailed a response to the post on advance directives that "it could imply that everything is about population health (which, as you and I agree, I hope) doesn't do much to advance the cause of purchasing population health."

Hmmm…if it's everything, is it nothing? A look at the population health model underpinning this blog and all I work on in population health, suggests that indeed it is perhaps everything: a broad set of outcomes produced by a comprehensive set of determinants which are influenced or activated by programs and policies in the public and private sectors.

You will not, however, find me blogging on each and every micro-determinant or program/policy that theoretically and actually has some detectable impact on population health outcomes. What is then the decision rule that makes a topic of program or policy of importance not only for this blog but for public and private policy makers?

In this resource-limited world, I believe the criterion should be largely based on economics, and in particular, the relative effectiveness and cost-effectiveness of the determinant or the program and policy on health outcomes. I have previously noted that we do not yet have adequate evidence to make this an easy exercise. Research is needed to explore the effectiveness and cost effectiveness of broad policies and programs designed to effect health improvement at the population level. Some investments have an evidence base, like smoking cessation and immunization and early childhood programs. Other investments, such as removing the LAST microgram of a toxic substance in a Superfund site, would probably have some marginal effectiveness but extremely low cost-effectiveness.

Of course, determining what action to take toward health improvement is hardly straightforward. Decision makers must weigh not only on available evidence on effectiveness and cost-effectiveness but must also take into account many other factors, especially resource (financial and nonfinancial) and political supports and constraints.

As we try to cover topics that address all parts of our population health model, I would welcome feedback as to whether you either KNOW or SUSPECT that any program or policy we discuss is of such low cost-effectiveness as to not meet my criterion above.

David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. He is on the road this month, conducting site visits for the Roadmaps to Health Prize. During this time we will be featuring a couple of popular posts from our archives.

Posted on 10/10/2012 in Defining and Measuring Health Outcomes | Permalink

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Posts from November 2012

11/27/2012

A Population Health Hurricane Sandy?



By David A. Kindig, MD, PhD

I was in New York City a couple of weeks ago giving several lectures. How strange it was to fly in over the city lights, cab through a recently flooded tunnel, and find my hotel without incident. Only after talking to cab drivers and old professional friends did the impact on so many reveal itself, including major hospitals still closed, and particularly the many, many stories of how those spared immediate devastation reached out to those not so fortunate.

At the beginning of my talks I acknowledged this terrible devastation, but asked if there could be a silver lining in that finally the greater public and policy makers will have to confront the realities of climate change in increasingly frequent extreme weather events. Ideally, this increased attention will lead not only to short run defensive measures like seawalls but also the more difficult but critical upstream policies like taxing carbon that will be needed to save the planet for our grandchildren.

Continue reading "A Population Health Hurricane Sandy?" »

Posted on 11/27/2012 in The National Policy Front | Permalink | Comments (1)

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11/14/2012

Can States Opt Out of Expanding Medicaid Coverage?



By David A. Kindig, MD, PhD

Of course they can, and several governors and legislatures have indicated they might. Would this improve population health?

Under the Affordable Care Act, states have the option in 2014 of expanding Medicaid coverage to all adults earning less than 133% of the federal poverty level, or about $31,000 for a family of four. The federal government will cover the full cost to the states until 2016, and gradually reduce their share to 90 percent in 2020, maintaining that rate in the following years.

The broad population health model that informs this blog's perspective recognizes health care as one of many factors that drive health outcomes. In our model, health care plays a less prominent role than either health behaviors or social/economic factors. Yet health care is a critical determinant of health, particularly when provided under cost effective conditions. People without health insurance do access care in emergency rooms and free clinics, but this generally occurs under circumstances where it is difficult for providers and the system they work within to provide high quality, low cost care.

Continue reading "Can States Opt Out of Expanding Medicaid Coverage?" »

Posted on 11/14/2012 in The National Policy Front | Permalink | Comments (0)

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11/07/2012

Can Our Environmental Stressors be Inherited by Our Children?



By David A. Kindig, MD, PhD

A while ago I presented a cautious population health perspective on the potential impact of modern genomics, ending with the observation that:

> *It is not anti-scientific to worry that our American belief in technology and venture capitalism could result in much waste, while less expensive investments we already know to be effective are ignored. The problem is that it is hard to predict the future, and decades from now there will certainly be important benefits from genomic research, including both treatments and preventive interventions. We can only insist that the most careful evidence on population health cost-effectiveness be used to guide investments, rather than the potential for profit from very expensive therapies that benefit few.*

But what to make of this quote I came upon the other day from Duke University geneticist Randy Jirtle?

Continue reading "Can Our Environmental Stressors be Inherited by Our Children?" »

Posted on 11/07/2012 in Population Health Basics | Permalink | Comments (0)

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11/01/2012

Health in All Policies & Payment Reform



By David A. Kindig, MD, PhD

We regularly scan eleven journals for new studies of particular population health relevance (the list of journals is at the end of this post). A couple of recent papers caught our eye:

Health in All Policies: The Role of the U.S. Department Of Housing And Urban Development and Present and Future Challenges

Bostic, R. et. al., Health Affairs, 31(9), 2130-2137.

This article reviews the approach that one federal department, the Department of Housing and Urban Development (HUD) has taken in response to recent calls for a health in all policies approach, both by Office of Management and Budget (OMB) and notably in the cross sectoral National Prevention Strategy. The impact of housing on health has been appreciated since the tenement reforms around the turn of the last century. More recently HUD has been active in lead abatement efforts; its1992 Moving to Opportunity for Fair Housing Demonstration used vouchers to move residents out of public housing into more affluent neighborhoods. This project showed positive health impacts, including reductions in psychological distress, depression, and obesity among adults.

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11/27/2012

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At the beginning of my talks I acknowledged this terrible devastation, but asked if there could be a silver lining in that finally the greater public and policy makers will have to confront the realities of climate change in increasingly frequent extreme weather events. Ideally, this increased attention will lead not only to short run defensive measures like seawalls but also the more difficult but critical upstream policies like taxing carbon that will be needed to save the planet for our grandchildren.

Both natural and man-made threats can catalyze impressive responses, such as the rapid expansion in scientific research and training after the Russians launched Sputnik. With climate change, we might choose to focus all of our efforts on CO2 emissions; unfortunately, there is no similar magic bullet for improving population health, given the very complex factors that determine health outcomes and health inequities.

Part of the problem is that our threats to population health are seldom cataclysmic; instead, they tend to result in declines in quality of life and economic productivity over generations. Even the recent finding that a large fraction of U.S. counties have falling female mortality rates over the past decade doesn't seem to rise to policy attention. I am reminded of the initial work on mortality from hospital errors; the national daily loss was estimated as equivalent to a Boeing 747 crashing daily. While such a visible loss would have certainly resulted in policy change, it's more difficult

to generate attention when it happens quietly and one-at-a-time behind hospital walls.

A year ago, I blogged on Thomas Friedman and Michael Mandelbaum's *That Used to Be Us: How America Fell Behind in the World It Invented and How We Can Come Back*, which assesses the U.S. position in the world and what needs to be done to regain lost economic and social competitiveness. They argue that the current political paralysis is not up to these challenges and that the system calls for political shock therapy -- a direct analogy to its once classic use in psychiatry -- defined by the authors as a radical centrist third party.

I observed then that I couldn't imagine a shock therapy for population health, but that the following steps were needed over the coming decade.

1. Be clear on our metrics for achievement and improvement, including disparity reduction.
2. Find savings from ineffective health care spending, and reallocate them to other population health determinants through such mechanisms as IRS Community Benefit reform and ACO shared savings.
3. Identify and enhance health promoting policies and programs in non-health care areas (Health in All Policies, Health Impact Assessments).
4. Identify cross-sectoral national and local partnership models with business models and financial teeth to leverage additional resources and policies.

I believe these remain worthy goals, but worry about our slow progress. Is there a way to induce a cataclysmic call to action without the cataclysm?

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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If worldwide climate change resulting from atmospheric carbon buildup, currently well past the 'avoidable' stage and well into the unavoidably serious if not catastrophic stage by the end of this century, is not a cataclysmic call to radically reconsider population health – I don't know what is. Unfortunately like most population issues climate change will first and most strongly affect the poor (say, the bottom 60%) while the rest will be merely inconvenienced and remain convinced that they have a right to exploit the commons without limitation.

Posted by: Robert Newsom | 11/28/2012 at 02:39 PM

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A growing body of research links health insurance coverage with improved population health. A recent study of Medicaid expansions in Arizona, Maine and New York found that such expansions may reduce mortality among adults (particularly those between the ages of 35 and 64 years), minorities, and those living in poorer areas (1). In a recent study by our own Population Health Institute, researchers found that a 2009 Wisconsin public insurance program for very low-income uninsured childless adults resulted in a 29% increase in outpatient visits and 46% decrease in emergency department visits, with a corresponding 59% decline in inpatient hospitalizations and fewer preventable hospitalizations after 12 months of enrollment (2).

From an economic perspective, health economist Karen Davis notes that "states that choose to forego the significant amount of federal aid available to expand Medicaid not only would deprive vulnerable families of participation in an effective program, but also would miss…the opportunity to lower the costs of uncompensated care for their hospitals and an infusion of federal dollars for traditionally underserved and rural areas. One estimate suggests that full implementation would save states at least $90 billion between 2014 and 2019 by reducing uncompensated care and expanding treatment for individuals with mental illnesses."

Why might States still refuse the expansion possible under the ACA? For states with low coverage rates like Texas and Florida, even covering 5 or 10% of the costs after 2020 is a large amount of money, and it is always possible that a future Congress or administration could change the rules later and decrease the match.

I have argued that for population health to not be "everything if it's nothing," the test of how much health outcome improvement or disparity reduction is gained per marginal dollar invested on any program or policy is the critical test. It may be that some states will reject the ACA Medicaid opportunity, but with the federal match and good care management at the low rates Medicaid pays I strongly suspect it would be a very cost effective population health investment strategy.

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3. Davis K. Medicaid Works: Public Program Continues to Provide Access to Care and Financial Protection for Society's Most Vulnerable. Published August 23, 2012 on the Commonwealth Fund Blog.

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11/07/2012

Can Our Environmental Stressors be Inherited by Our Children?



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A while ago I presented a cautious population health perspective on the potential impact of modern genomics, ending with the observation that:

> *It is not anti-scientific to worry that our American belief in technology and venture capitalism could result in much waste, while less expensive investments we already know to be effective are ignored. The problem is that it is hard to predict the future, and decades from now there will certainly be important benefits from genomic research, including both treatments and preventive interventions. We can only insist that the most careful evidence on population health cost-effectiveness be used to guide investments, rather than the potential for profit from very expensive therapies that benefit few.*

But what to make of this quote I came upon the other day from Duke University geneticist Randy Jirtle?

> *When you have a mutation in a gene, you are stuck. You feel like you have a death sentence. There is no way of treating that unless you do gene therapy which has had very few medical successes to date. The epigenetic basis of health and disease might open up other routes of intervention. You might develop drugs that target the epigenome to prevent or reduce susceptibility to disease; you might even leave drugs behind and treat yourself simply by varying your diet or the way you live (1).*

What is the epigenetics he is referring to? Wikipedia defines epigenetics as:

> *The study of heritable changes in gene expression or cellular phenotype caused by mechanisms other than changes in the underlying DNA sequence – hence the name epi- (Greek:*

> *επί- over, above, outer) -genetics. It refers to functionally relevant modifications to the genome that do not involve a change in the nucleotide sequence. Examples of such changes are DNA methylation and histone modification, both of which serve to regulate gene expression without altering the underlying DNA sequence. Conclusive evidence supporting epigenetics show that these mechanisms can enable the effects of parents' experiences to be passed down to subsequent generations.*

Doesn't this sound like the old debunked Lamarckian inheritability of acquired characteristics that got a really bad name under the Soviet geneticist Lysenko? What is the epigenetic evidence to date? Wikipedia reports that more than 100 cases of trans-generational epigenetic inheritance phenomena have been reported in a wide range of plants, and animals; for example, mice given some dietary supplements have epigenetic changes affecting expression in offspring of the agouti gene, which affects their fur color, weight, and propensity to develop cancer. Another leading researcher notes that studies in rodents "have demonstrated the transgenerational impact of nutrition and indicate that prenatal protein restriction can exert effects on growth and metabolism of offspring and grand-offspring through changes in DNA methylation." She concludes that "there is clear evidence that environmentally induced changes in brain and behavior can influence offspring and grand-offspring with implications for research perspectives on the inheritance of risk and resilience in response to social interactions" (2).

What is the relevance of this for population health? We know that stress-inducing factors in the social and economic environment get "under the skin" via biological mechanisms. Until recently, most researchers and practitioners -- even those taking a life course and developmental perspective to health improvement -- have approached genetics from a clinical (rather than a population) perspective. Additional research demonstrating the multigenerational impact of environmental influences could fuel environmental interventions to improve the quality and length of life for our children and grandchildren. Of course this research is quite new, and its full implications are yet to be demonstrated. But while we need to carefully evaluate the cost effectiveness of genomic investments, we need to also track the potential of epigenetics as a possible mechanism for population health improvement.

1. Amato, Ivan. Genes Take a Back Seat. Science/Technology April 6, 2009, p 28-32.

2. Champagne, Frances. Epigenetic Influence of Social Experience Across the Lifespan. *Developmental Psychology,* 2010.

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11/01/2012

Health in All Policies & Payment Reform



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Bostic, R. et. al., Health Affairs, 31(9), 2130-2137.

This article reviews the approach that one federal department, the Department of Housing and Urban Development (HUD) has taken in response to recent calls for a health in all policies approach, both by Office of Management and Budget (OMB) and notably in the cross sectoral National Prevention Strategy. The impact of housing on health has been appreciated since the tenement reforms around the turn of the last century. More recently HUD has been active in lead abatement efforts; its1992 Moving to Opportunity for Fair Housing Demonstration used vouchers to move residents out of public housing into more affluent neighborhoods. This project showed positive health impacts, including reductions in psychological distress, depression, and obesity among adults.

The passage of the Affordable Care Act (ACA) advanced health in all policies partnerships such as between HUD and the Department of Health and Human Services (HHS), with collaboration occurring on such projects as the Housing Capacity Building Initiative for Community Living project, providing housing and human services support to older adults or adults with disabilities. These types of partnerships could be very important in coordinating diverse, yet complementary agency interests into promoting improved public health. However, questions remain over the

long-term efficacy of such coordination, the cost/benefit ratio of community investments to health savings, and the potential for institutionalization. Such silo busting approaches are extremely hard to achieve, were federal departments to develop and sustain the type of efforts described, the population health impact could be dramatic.

The New Era of Payment Reform, Spending Targets, And Cost Containment in Massachusetts: Early Lessons for the Nation

Mechanic R., Altman S., and McDonough J. *Health Affairs*, September 2012, published online ahead of print.

This blog has often highlighted the importance of health care cost-containment for population health, as increasing costs absorb resources needed in for other non-medical determinants of health. Massachusetts' healthcare reform in 2006 provided the precursor to the eventual passage of the ACA in 2010, and therefore provides a frame into the long-term implications of such reform policies. Following Massachusetts' individual mandate in 2006, costs became of upmost importance, because the mandate hinged on state subsidies for purchasing private insurance. The expansion threatened the existence of the program by overwhelming the state public insurance rolls. In response, Massachusetts moved to stiffly regulate insurance premiums and payment systems even prior to the 2012 revision (passed in August), but concern persisted as to whether these measure were sufficient to properly cut costs. The 2012 revision strengthened cost-containment measures, including working directly with providers to monitor and enforce fee limits expanding alternative payment systems, and addressing cost disparities amongst providers. The bipartisan nature of these reforms, long-term commitments, and multiple approaches to cost-containment have valuable lessons for future federal and state policies that seek to achieve similar outcomes under the ACA framework.

I want to acknowledge the assistance of Erik Bakken, BA for his assistance in scanning the literature and drafting this post.

Journals we follow:

American Journal of Preventive Medicine

American Journal of Public Health

Annual Review of Public Health

Health Affairs

Journal of the American Medical Association (JAMA)

Journal of Epidemiology and Community Health

Journal of Health and Social Behavior

Milbank Quarterly

New England Journal of Medicine

Preventing Chronic Disease

Social Science and Medicine

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Posts from December 2012

12/27/2012

In the Literature 2012 Year-End Roundup



By David A. Kindig, MD, PhD

Best wishes for a wonderful holiday season from Improving Population Health. We regularly scan eleven journals for new studies of particular population health relevance (the list of journals is at the end of this post). For this year-end roundup, we're highlighting a couple of recent articles and also listing those we've called attention to earlier in the year.

McCullough JC, Zimmerman FJ, Fielding JE, Teutsch SM. (2012). A Health Dividend for America: The Opportunity Cost of Excess Medical Expenditures. *American Journal of Preventive Medicine*, 43(6), 650-654.

This must-read article highlights the recent IOM estimates that $750-$765 billion spent on health care in the U.S. is in excess of what should be spent to achieve our observed health outcomes. Of this amount, the IOM estimates that $421 billion accrues to the private sector which the authors say is "functionally a tax that limits the international competitiveness of the US and reduces the economic welfare of the population."

This paper focuses on the public sector which pays the remaining $337 billion and questions the "public opportunity costs of the unnecessary healthcare spending," which they call a Health Dividend and characterize as "a sizeable stream of resources that would come at no net cost to people's health and that could be invested in achieving two important objectives: stabilizing the nation's fiscal health and improving well being." The authors identify specific investments contributing to Fiscal Stability, Social Investments, and Infrastructure Investments that such a dividend

could support. The authors conclude with a clear vision: “whatever one’s values and preferences, eliminating excess medical care costs provides a monumental opportunity to reallocate those resources to strengthen U.S. international competitiveness, enhance well-being, and build a healthier nation. The result of redirecting some $750 billion per year could be transformative for Americans, and the potential uses for these funds are panoramic in both scope and possibility.”

Continue reading "In the Literature 2012 Year-End Roundup" »

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12/18/2012

Willie Sutton and Population Health



By Sanne Magnan, MD, PhD

Many governments and private households are struggling with budget deficits. For example in Minnesota over the next 20 to 25 years, rising health care costs are projected to leave little additional money for spending on other state programs such as education, affordable housing, job development, etc. that arguably contribute more to population health than health care (1). Rising health care costs means there is less money for these other factors, which contributes to less healthy populations leading to higher health care costs which leads to less money to spend on the other factors. We will be creating a vicious, downward spiral.

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12/11/2012

“Do the Math” for Population Health?



By David A. Kindig, MD, PhD

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McKibben is an environmental activist, who at age 27 wrote the *The End of Nature*. During his presentation he reflected that at the time, he thought a book was all that was needed to spark change. He now recognizes that while academic contributions are important, they’re not necessarily sufficient for social change.

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The morning after attending the presentation, I awoke at 4 AM thinking about key elements of McKibben’s work and contemplating their relevance to broad population health challenges. Here’s what he’s done:

Continue reading " “Do the Math” for Population Health?" »

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12/05/2012

In the Literature: Alcohol Policy and Mass Media Campaigns



By David A. Kindig, MD, PhD

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This article describes the impact of raising minimum alcohol prices by 10% in Saskatchewan, Canada. Saskatchewan provides a unique case study in that the provincial government has established a monopoly to control alcohol distribution. The intervention led to an 8.43% reduction in alcohol consumption, with the greatest declines from beer, spirits, and wine respectively. Notably, a significant portion of this effect was observed via retail sales, as opposed to bars and restaurant consumption. Equally interesting, the study found a differential affect by alcoholic beverage potency. High alcohol content beer and wine were associated with the largest decreases in consumption, with high alcohol beer dropping 22% compared to only 8% for low alcohol beer. The surprisingly targeted effects of the alcohol pricing legislation investigated here merits further research, including probing for broader policy application.

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12/27/2012

In the Literature 2012 Year-End Roundup



By David A. Kindig, MD, PhD

Best wishes for a wonderful holiday season from Improving Population Health. We regularly scan eleven journals for new studies of particular population health relevance (the list of journals is at the end of this post). For this year-end roundup, we're highlighting a couple of recent articles and also listing those we've called attention to earlier in the year.

McCullough JC, Zimmerman FJ, Fielding JE, Teutsch SM. (2012). A Health Dividend for America: The Opportunity Cost of Excess Medical Expenditures. *American Journal of Preventive Medicine*, 43(6), 650-654.

This must-read article highlights the recent IOM estimates that $750-$765 billion spent on health care in the U.S. is in excess of what should be spent to achieve our observed health outcomes. Of this amount, the IOM estimates that $421 billion accrues to the private sector which the authors say is "functionally a tax that limits the international competitiveness of the US and reduces the economic welfare of the population."

This paper focuses on the public sector which pays the remaining $337 billion and questions the "public opportunity costs of the unnecessary healthcare spending," which they call a Health Dividend and characterize as "a sizeable stream of resources that would come at no net cost to people's health and that could be invested in achieving two important objectives: stabilizing the nation's fiscal health and improving well being." The authors identify specific investments contributing to Fiscal Stability, Social Investments, and Infrastructure Investments that such a dividend could support. The authors conclude with a clear vision: "whatever one's values and preferences, eliminating excess medical care costs provides a monumental opportunity to reallocate those resources to strengthen U.S. international competitiveness, enhance well-being, and build a healthier nation. The result of redirecting some $750 billion per year could be transformative for

Americans, and the potential uses for these funds are panoramic in both scope and possibility."

Goetzel RZ, Pei Xiaofei P, Tabrizi MJ, Henke RM, Kowlessar N, Nelson CF, Metz RD. (2012). Ten Modifiable Health Risk Factors Are Linked to More Than One-Fifth of Employer-Employee Health Care Spending. *Health Affairs*, 31, 2472-2484.

Abstract: "An underlying premise of the Affordable Care Act provisions that encourage employers to adopt health promotion programs is an association between workers' modifiable health risks and increased health care costs. Employers, consultants, and vendors have cited risk-cost estimates developed in the 1990s and wondered whether they still hold true. Examining ten of these common health risk factors in a working population, we found that similar relationships between such risks and total medical costs documented in a widely cited study published in 1998 still hold. Based on our sample of 92,486 employees at seven organizations over an average of three years, $82,072,456, or 22.4 percent, of the $366,373,301 spent annually by the seven employers and their employees in the study was attributed to the ten risk factors studied. This amount was similar to almost a quarter of spending linked to risk factors (24.9 percent) in the 1998 study. High risk for depression remained most strongly associated with increased per capita annual medical spending (48 percent, or $2,184, higher). High blood glucose, high blood pressure, and obesity were strongly related to increased health care costs (31.8 percent, 31.6 percent, and 27.4 percent higher, respectively), as were tobacco use, physical inactivity, and high stress. These findings indicate ongoing opportunities for well-designed and properly targeted employer-sponsored health promotion programs to produce substantial savings."

Featured Articles of 2012

HEALTH OUTCOMES

Harper, Sam, et al. "Trends in the black-white life expectancy gap in the United States, 1983-2003." *JAMA* 297.11 (2007): 1224-1232.

Ross, Nancy A., et al. "Trajectories of health-related quality of life by socio-economic status in a nationally representative Canadian cohort." *Journal of Epidemiology and Community Hea*lth 66.7 (2012): 593-598.

Olshansky, S. Jay, et al. "Differences In Life Expectancy Due To Race And Educational Differences Are Widening, And Many May Not Catch Up." *Health Affairs* 31.8 (2012): 1803-1813.

POPULATION HEALTH POLICY

Macinko, James, and Diana Silver. "Improving State Health Policy Assessment: An Agenda for Measurement and Analysis." *American Journal of Public Health* 102.9 (2012): 1697-1705.

Mechanic, Robert E., Stuart H. Altman, and John E. McDonough. "The New Era Of Payment Reform, Spending Targets, And Cost Containment In Massachusetts: Early Lessons For The Nation." *Health Affairs* (2012).

Brown, David R., et al. "Stand-Alone Mass Media Campaigns to Increase Physical Activity: A Community Guide Updated Review." *American Journal of Preventive Medicine* 43.5 (2012): 551-561.

HEALTH BEHAVIORS

Magnus, Anne, et al. "The Economic Gains of Achieving Reduced Alcohol Consumption Targets for Australia." *American Journal of Public Health* 102.7 (2012): 1313-1319.

Stockwell, Tim, et al. "The Raising of Minimum Alcohol Prices in Saskatchewan, Canada: Impacts on Consumption and Implications for Public Health." American Journal of Public Health 102.12 (2012): e103-e110.

SOCIAL AND ENVIRONMENTAL FACTORS

Chokshi, Dave A., and Thomas A. Farley. "The Cost-Effectiveness of Environmental Approaches to Disease Prevention." *New England Journal of Medicine* 367.4 (2012): 295-297.

Bostic, Raphael W., et al. "Health In All Policies: The Role Of The US Department Of Housing And Urban Development And Present And Future Challenges." *Health Affairs* 31.9 (2012): 2130-2137.

Monsivais, Pablo, Anju Aggarwal, and Adam Drewnowski. "Are socio-economic disparities in diet quality explained by diet cost?" *Journal of Epidemiology and Community Health* 66.6 (2012): 530-535.

Journals we follow:

American Journal of Preventive Medicine

American Journal of Public Health

Annual Review of Public Health

Health Affairs

Journal of the American Medical Association (JAMA)

Journal of Epidemiology and Community Health

Journal of Health and Social Behavior

Milbank Quarterly

New England Journal of Medicine

Preventing Chronic Disease

Social Science and Medicine

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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As someone not politically inclined, I really wonder why the entire health care debate is a debate at all? It seems like there should be quantifiable evidence that can be leveraged in order to make policy decisions, yet most of the things you read about health care make it seem like an ideological battle instead of a scientific, factually based approach.

I couldn't imagine if other things were handled in such a way. Could you imagine if GM and Toyota were diametrically divided over whether or not seat belts are a good thing? No! Of course they are, and all cars

have them! There's no ideology at play, just sheer facts.

Posted by: Ted | 01/08/2013 at 11:51 AM

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12/18/2012

Willie Sutton and Population Health



By Sanne Magnan, MD, PhD

Many governments and private households are struggling with budget deficits. For example in Minnesota over the next 20 to 25 years, rising health care costs are projected to leave little additional money for spending on other state programs such as education, affordable housing, job development, etc. that arguably contribute more to population health than health care (1). Rising health care costs means there is less money for these other factors, which contributes to less healthy populations leading to higher health care costs which leads to less money to spend on the other factors. We will be creating a vicious, downward spiral.

There is a way out. It reminds me of the famous legendary quote of the bank robber Willie Sutton when he was asked, “Why do you rob banks? He replied, “Because that’s where the money is.“ Why should we, in population health, care about total cost of care (TCOC) or per capita costs of health care? Because that’s where the money is.

We have the most expensive health care system in the world with the highest per capita spending. Yet, we do not have commensurate quality, access or equitable outcomes. The Institute of Medicine (IOM) recently created info-graphics illustrating health care costs as well as waste in the system (2). For example since 1945, if the price of eggs had increased as quickly as health care costs, a dozen eggs would cost $55 today and a dozen oranges $134. Of the $2.3 trillion in 2009 health care costs, the IOM estimates that $765 billion is waste in unnecessary services, excessive administrative costs, inefficiently delivered services, high prices, fraud, and missed prevention opportunities.

This inexorable increase in health care costs demands our explicit attention for two reasons. One is to stop the downward unhealthy spiral, and second is to provide a mechanism for investments in the other factors that make populations healthy.

I propose that TCOC (or at least the dollars in waste) be a population health indicator. This focus will require two things. First, we must bring the topic of costs into the inner sanctum of public health, quality, equity, experience and access of care without imploding. With our colleagues and the public, we must discuss costs without inflammatory accusations of injury to the doctor-patient relationship, rationing, denials of care, death panels, etc. Since we live in a society that believes that more is better and more expensive is better, trusted voices will be needed. And with every dollar of "waste" being someone's income or revenue, it will be a challenge to identify and discuss waste.

Second, we must actively support measures of total cost of care. National Quality Forum's recent adoption of a TCOC indicator is a good beginning (3). Measures of efficiency and resource utilization are also applicable, but we must focus on total health care costs if we are to identify savings that can be captured for reinvestment in the non-clinical factors that make populations healthy.

In Willie Sutton's biography, he denied making the above quote but actually said, "Go where the money is and go there often" (4). I think we in population health could heed his words and focus our attention on TCOC. We must go where the money is (i.e., waste in health care) as a way to fund investments that will create a community reinforcing loop for health (5) – an upward spiral for healthy populations.

We must do it for our children.

Sanne Magnan, MD, PhD is President and CEO of the Institute for Clinical Systems Improvement in Bloomington, MN.

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1. http://www.slideshare.net/smalltofeds/minnesota-and-the-new-normal-by-tom-stinson-u-of-m-econonmist#btnNext; slide 17.
2. http://resources.iom.edu/widgets/vsrt/healthcare-waste.html
3. http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Resource_Use_Measures.aspx
4. http://en.wikipedia.org/wiki/Willie_Sutton
5. http://www.icsi.org/health_care_redesign_/accountable_health_communities/achieving_accountability_for_health_and_health_care/

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12/11/2012

"Do the Math" for Population Health?



By David A. Kindig, MD, PhD

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The morning after attending the presentation, I awoke at 4 AM thinking about key elements of McKibben's work and contemplating their relevance to broad population health challenges. Here's what he's done:

He has boiled down the evidence to clear Do the Math metrics

> *"It's simple math: we can burn less than **565** more gigatons of carbon dioxide and stay below **2°C of warming** — anything more than that risks catastrophe for life on earth. The only problem? Fossil fuel corporations now have **2,795 gigatons** in their reserves, five times the safe amount. And they're planning to burn it all — unless we rise up to stop them."*

He is trying to build a popular movement. In his case, he is drawing on both on the energy of young people, but also calling on elders and those with tenure to step up and lead with acts of civil disobedience that may carry more risk for young people (such as being arrested protesting the tar sands pipeline). He has enlisted scores of partner organizations across the country to join in the movement.

He has identified a specific action that may foster mobilization: urging universities and churches to divest their fossil fuel stock holdings so that the reserves aren't burned. He likens it to the moral imperative that stimulated divestment in South Africa decades ago.

He has gotten out of his academic comfort zone, organizing this certainly exhausting bus tour across the country to draw attention to the movement.

Time will tell if this approach will be effective for climate change. Even if the answer is "yes," I wonder whether the challenges we face broadly with respect to population health improvement can be addressed in this manner.

As complicated as climate change is, there is only one primary determinant – CO 2 and related greenhouse gases. Without underestimating the challenge of addressing climate change, it's worth noting that the heavy lift here is on the environmental policy complexities – not on identifying the solutions, which are relatively straightforward interventions such as taxing carbon, developing renewables, and promoting energy efficiency. With regard to population health improvement, we have a double-edged heavy lift, where neither the solutions nor the politics are straightforward. It would sure help if we could boil ours down to a few actionable Do The Math metrics, but we do not yet even have consensus on what our population health goals are.

If divestment proves an effective strategy for climate change, what would the analogous mobilization strategy be for population health? And more importantly, would the cost of confrontation undermine long-term potential for identifying and building upon political common ground? It may simply be that the diffuse nature of population health challenges lacks the economic and moral imperative to spark large-scale social movement.

While I admit I haven't become a complete McKibben convert (I haven't yet signed the petition, still pondering the effectiveness of this action and any unintended consequences), I remain in awe of how he has put himself on the line for an issue that intellectually and morally consumes him. His inspiring example helps keep my doubts at bay as I continue to consider what form a similar movement for population health improvement could take.

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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Ideally what we want to do is build a social movement and the elements of that kind of effort are well established.

Posted by: Lauri Andress | 12/12/2012 at 01:13 PM

David, I was there as well. Given the public and corporate resistance to change and the greed (by all of us who have money in retirement accounts)which makes burning that 2,795 gigatons almost irresistible: I wouldn't lose any more sleep about the effectiveness of this type of action. If it works great; if not then we have at least put our names behind doing something! You used to say "don't let the perfect be the enemy of the good" - sign the petition.

Posted by: Robert Newsom | 12/12/2012 at 03:05 PM

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12/05/2012

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Stand-Alone Mass Media Campaigns to Increase Physical Activity: A Community Guide Updated Review. DR, Brown et al. *American Journal of Preventive Medicine.* 43 (5), 562-564.
For this research, the Community Preventive Services Task Force analyzed 16 mass media campaigns promoting physical activity from 1980 to 2009. The studies varied considerably in their medium, duration, audience, and metrics used to evaluate effectiveness. Findings suggest modest gains in physical activity across the ten campaigns with comparable measures. The six other

studies also observed similar slight gains in physical activities in participants using unique outcome measures. The authors emphasize that these types of media campaigns are distinct in that they are stand-alone versus multi-faceted, comprehensive public health initiatives, which have well-established promotion effects. Notably, limitations of data and methods prevent drawing causal relationships about the specific role that media campaigns play as a part of broader intervention strategies.

I want to acknowledge the assistance of Erik Bakken, BA for his assistance in scanning the literature and drafting this post.

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American Journal of Preventive Medicine

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Health Affairs

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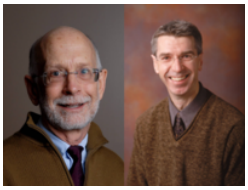




Posts from January 2013

01/30/2013

Creating Health: Finding the Path from Here to There



By Thomas Kottke, MD, MSPH and Nico Pronk, PhD

The advances in the treatment of cardiovascular disease in the past 50 years are remarkable. Automated external defibrillators (AEDs), the devices you see in airports and other public places, change out-of-hospital cardiac arrest from a death sentence to an event with some chance of survival. Coronary angioplasty (ballooning the blockages in the arteries that feed the heart) during a heart attack reduces deaths by about 50%. Implantable devices that pace and shock the heart when a life-threatening heart beat occurs reduce the risk of death by more than 40%.1

These statistics and the current emphasis on individualized medicine might suggest that, if a community can afford high tech health care, it doesn't need to invest in parks, bikeways, tobacco-free homes and workplaces, access to affordable fruits and vegetables, and the other health promoting environments.2 But the data demonstrate that the path to health for every community and every individual, rich and poor alike requires health-promoting physical and social environments.

Continue reading "Creating Health: Finding the Path from Here to There" »

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01/23/2013

Massachusetts Prevention and Wellness Trust Fund: Cutting Health Care Costs through Prevention



By Ann Batdorf-Barnes, DO, MPH

A few months ago, *Health Affairs* published Robert Mechanic and colleagues' **The New Era Of Payment Reform, Spending Targets, And Cost Containment In Massachusetts: Early Lessons For The Nation.** The article describes the cost containment bill that was signed into law in Massachusetts last August and discusses the growing pressure on policymakers to control health care spending as we expand health care to near universal coverage.

For those working in population health, the interesting story about the Massachusetts legislation is that a small group of bright and dedicated public health advocates from the **Massachusetts Public Health Association** (MPHA) brought together a broad coalition of partners across the state to call for a sizable and sustainable investment in community-level population health strategies. According to Maddie Ribble, Director of Policy and Communications at MPHA, "civic leaders and organizations coalesced around this proposal, including unusual allies such as mayors, town managers, religious leaders, and business leaders. In addition, more than one hundred legislators actively supported the effort." This monumental achievement can best be characterized as eighteen months of intensive political organizing, during which time prevention and public health were a significant part of the public debate. With widespread support, a sixty million dollar **Prevention and Wellness Trust Fund** was included in the cost containment legislation, to be used for community-based prevention strategies over four years.

The Trust will be administered by the Massachusetts Department of Public Health with most of the money awarded through competitive grants for community-level, evidence-based prevention strategies for the following purposes:

- Reduce rates of the state's most costly preventable health conditions
- Reduce health disparities
- Increase healthy behaviors
- Increase the adoption of workplace-based wellness programs
- Develop a stronger evidence-base of effective prevention programs

An evaluation of the impact of these investments was built into the legislation. According to Val Bassett, the former Executive Director of MPHA who helped advance the legislation, "advocates expect that promising results will be a basis for continuing (the investments) past four years."

The Trust, the first of its kind in the nation, makes two important contributions to population health. First, through their unified voice and strategic efforts, these public health advocates influenced legislation by making a clear and compelling case that in order to control health care spending, we must invest upstream in community-level population health strategies. Second, in our ongoing efforts to find sustainable financing mechanisms for population health, one idea is to capture a portion of the savings that are generated in a high-performance health care delivery system. In other words, as we bend the health care cost curve, a portion of the savings can be used for prevention, public health, and population-based strategies. Massachusetts goes one step further: the $60 million in the Trust is captured upfront from the health care delivery system. Health plans and large hospital systems proactively invest upstream to improve health outcomes as an integral part of their cost containment strategy. According to Bassett, beyond the obvious benefits to individuals and communities that enjoy greater health and well-being, the "upfront investors are the biggest beneficiaries of the fiscal impact of the Trust."

As the *Health Affairs* article says, we can look to Massachusetts for early lessons for the nation. With their innovative trust, Massachusetts is on the road to having the necessary resources to improve population health. If they succeed in reducing health care costs through population-based strategies, they will complete the virtuous cycle of better care, better health, and lower costs.

Links:

Health Affairs, The New Era of Payment Reform, Spending Targets, And Cost Containment In Massachusetts: Early Lessons For The Nation (October 2012)

Improving Population Health Blog : Health in All Policies & Payment Reform

Massachusetts Public Health Association

Prevention and Wellness Trust

Ann Batdorf-Barnes, DO , MPH is a consultant to the Kresge Foundation. The opinions expressed are those of the author and do not necessarily reflect the official opinion of the Foundation.

Posted on 01/23/2013 | Permalink | Comments (1)

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01/17/2013

Why Don't We Know More Precisely What To Do?



By David A. Kindig, MD, PhD

As much as I admire and support last week's NRC-IOM report on the U.S. Disadvantage, I have been reflecting on the authors' strong call for better data and research investments. Unfortunately, the report's policy recommendations don't seem on par with the extreme challenges presented.

The report's recommendations include:

- "Intensify efforts to achieve established national health objectives"
- "Organize a comprehensive media and outreach campaign" to "stimulate a national discussion"

These are reasonable things to do, but why don't we know more precisely what to recommend to policy makers to close these gaps?

Continue reading "Why Don't We Know More Precisely What To Do?" »

Posted on 01/17/2013 | Permalink | Comments (2)

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01/09/2013

How Could the United States Have a "Health Disadvantage"?



By David A. Kindig, MD, PhD

This was the question that I couldn't keep out of my mind while reading the superb new report from the National Research Council and Institute of Medicine titled *"U.S. Health in International Perspective: Shorter Lives, Poorer Health."*

Before I get to my title question, let me briefly summarize the ambitious effort that this distinguished panel, chaired by Population Health expert Steve Woolf from Virginia Commonwealth University, has produced for both scholars and policy makers. In the opening summary the authors assert, *"The United States is among the wealthiest nations in the world, but it is far from the healthiest…Americans live shorter lives and experience more injuries and illnesses than people in other high income countries….The US health disadvantage cannot be attributed solely to the adverse health status of racial or ethnic minorities or poor people, since recent studies suggest that even highly advantaged Americans may be in worse health than their counterparts in other countries."*

The report takes on the very challenging task of explaining what underlies this poor performance of the United States. Two initial chapters deal with the evidence on mortality and morbidity, while five more deal with current evidence for the explanatory factors, such as public health and health care systems, individual behaviors, social factors, and physical and social environmental factors. It is beyond the scope of this blog post to try to summarize this vast content, but suffice it to say it is an extremely comprehensive treatment of what we know about the multiple factors producing health. The report can and should be used as an evidence guide for policymakers and a population health textbook for the academic community.

Continue reading "How Could the United States Have a "Health Disadvantage"?" »

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01/01/2013

Pre-Kindergarten in San Antonio



By Erik Bakken, BA

San Antonio, Texas has recently put itself on the population health map with a program led by its new mayor, Julian Castro. During the 2012 elections, San Antonio voters approved a referendum for a 1/8th cent sales tax increase to fund an expansion of Pre-K education to address a gap in citywide enrollment.

Faced with a city performing well below the national mean, with achievement gaps for many education metrics, Mayor Castro assembled a taskforce to address the challenge, which resulted in the creation of Pre-K 4 San Antonio. The program will establish four model centers to provide preschool education for the estimated one quarter of the city's four year olds not participating in full day pre-k programming. These centers specifically target those most likely to not be receiving pre-K education, such as those living in poverty, those who are homeless, and English language learners. The program also involves parents, who will be required to take part in parenting classes. Within three years, the program aims to add 3,700 pre-K slots in San Antonio in the four centers and through contracts with schools.

Continue reading "Pre-Kindergarten in San Antonio" »

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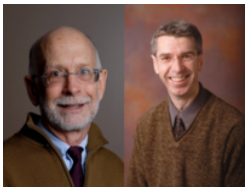
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01/30/2013

Creating Health: Finding the Path from Here to There



By Thomas Kottke, MD, MSPH and Nico Pronk, PhD

The advances in the treatment of cardiovascular disease in the past 50 years are remarkable. Automated external defibrillators (AEDs), the devices you see in airports and other public places, change out-of-hospital cardiac arrest from a death sentence to an event with some chance of survival. Coronary angioplasty (ballooning the blockages in the arteries that feed the heart) during a heart attack reduces deaths by about 50%. Implantable devices that pace and shock the heart when a life-threatening heart beat occurs reduce the risk of death by more than 40%.1

These statistics and the current emphasis on individualized medicine might suggest that, if a community can afford high tech health care, it doesn't need to invest in parks, bikeways, tobacco-free homes and workplaces, access to affordable fruits and vegetables, and the other health promoting environments.2 But the data demonstrate that the path to health for every community and every individual, rich and poor alike requires health-promoting physical and social environments.

Let's do the math for the high tech treatments of heart disease and two of the fundamental determinants of health--physical activity and healthy food. The best estimate of what will happen to an individual is what will happen to others in their community. It is simple to calculate the community impact of any intervention if just four parameters are known: (1) the extent to which an intervention will reduce "event rates," (2) the event rate for eligible individuals who participate in the intervention, (3) the number of eligible individuals who have not yet taken part in the intervention, and (4) the number of people in the community who are eligible for the intervention.

For example, using deaths that might be prevented or postponed (DPP) as "the event," we can calculate the impact of meeting the physical activity guideline for healthy Americans.

For a population of 30-84 year-old Americans:

- The mortality rate of physically active individuals is 30% lower than the mortality rate for inactive individuals;
- The death rate is 1,007/100,000;
- 70% of those able to be active are currently not active;
- In a population of 100,000, the number of apparently healthy individuals is 90,024.

Therefore, the DPP that could be achieved if the entire healthy population were to become physically active is 0.30 x 0.01007 x 0.7 x 90,024, or 190.

In 2009, we published the expected DPPs for nutrition, physical activity, tobacco and several heart disease treatments.1 We calculated the impact of improving performance from current levels to achieving 100% goal attainment. We found that the number of deaths that might be prevented or postponed in a community of 100,000 adults ages 30-84 would be:

- 1.9 if AEDs were placed in all public places and people who worked there were trained in their use,
- 15.1 if all individuals with heart attacks received angioplasty,
- 63 if all individuals who met the criteria received an implantable defibrillator or biventricular pacemaker,
- 158 if everyone met the dietary goal of 5 servings of fruits and vegetables every day,
- 159 if no one smoked and no one were exposed to second-hand smoke, and
- 334 if everyone met the physical activity goal of 150 minutes per week.

We found that improving care for acute heart disease events could at most prevent or postpone 8% of deaths in the U.S. population ages 30-84. Taking full advantage of the benefits of good nutrition, adequate physical activity, and elimination of tobacco would prevent or postpone 49% of all deaths. If our calculations considered the impact of all community determinants of health on all ages, the predicted impact would be considerably larger.

It is indisputable that access to medical care saves lives, but the math demonstrates that, regardless of the resources that might be committed to health care, there is only one path to significantly healthier communities. That path is mobilizing action to improve the physical and social environments in which we live.

Thomas Kottke, MD, MSPH is Medical Director for Population Health with HealthPartners in Bloomington, MN.

Nico Pronk, Ph.D. is Vice President and Health Science Officer with HealthPartners in Bloomington, MN.

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01/23/2013

Massachusetts Prevention and Wellness Trust Fund: Cutting Health Care Costs through Prevention



By Ann Batdorf-Barnes, DO, MPH

A few months ago, *Health Affairs* published Robert Mechanic and colleagues' **The New Era Of Payment Reform, Spending Targets, And Cost Containment In Massachusetts: Early Lessons For The Nation.** The article describes the cost containment bill that was signed into law in Massachusetts last August and discusses the growing pressure on policymakers to control health care spending as we expand health care to near universal coverage.

For those working in population health, the interesting story about the Massachusetts legislation is that a small group of bright and dedicated public health advocates from the **Massachusetts Public Health Association** (MPHA) brought together a broad coalition of partners across the state to call for a sizable and sustainable investment in community-level population health strategies. According to Maddie Ribble, Director of Policy and Communications at MPHA, "civic leaders and organizations coalesced around this proposal, including unusual allies such as mayors, town managers, religious leaders, and business leaders. In addition, more than one hundred legislators actively supported the effort." This monumental achievement can best be characterized as eighteen months of intensive political organizing, during which time prevention and public health were a significant part of the public debate. With widespread support, a sixty million dollar **Prevention and Wellness Trust Fund** was included in the cost containment legislation, to be used for community-based prevention strategies over four years.

The Trust will be administered by the Massachusetts Department of Public Health with most of the money awarded through competitive grants for community-level, evidence-based prevention strategies for the following purposes:

- Reduce rates of the state's most costly preventable health conditions
- Reduce health disparities
- Increase healthy behaviors
- Increase the adoption of workplace-based wellness programs
- Develop a stronger evidence-base of effective prevention programs

An evaluation of the impact of these investments was built into the legislation. According to Val Bassett, the former Executive Director of MPHA who helped advance the legislation, "advocates expect that promising results will be a basis for continuing (the investments) past four years."

The Trust, the first of its kind in the nation, makes two important contributions to population health. First, through their unified voice and strategic efforts, these public health advocates influenced legislation by making a clear and compelling case that in order to control health care spending, we must invest upstream in community-level population health strategies. Second, in our ongoing efforts to find sustainable financing mechanisms for population health, one idea is to capture a portion of the savings that are generated in a high-performance health care delivery system. In other words, as we bend the health care cost curve, a portion of the savings can be used for prevention, public health, and population-based strategies. Massachusetts goes one step further: the $60 million in the Trust is captured upfront from the health care delivery system. Health plans and large hospital systems proactively invest upstream to improve health outcomes as an integral part of their cost containment strategy. According to Bassett, beyond the obvious benefits to individuals and communities that enjoy greater health and well-being, the "upfront investors are the biggest beneficiaries of the fiscal impact of the Trust."

As the *Health Affairs* article says, we can look to Massachusetts for early lessons for the nation. With their innovative trust, Massachusetts is on the road to having the necessary resources to improve population health. If they succeed in reducing health care costs through population-based strategies, they will complete the virtuous cycle of better care, better health, and lower costs.

Links:

Health Affairs, The New Era of Payment Reform, Spending Targets, And Cost Containment In Massachusetts: Early Lessons For The Nation (October 2012)

Improving Population Health Blog : Health in All Policies & Payment Reform

Massachusetts Public Health Association

Prevention and Wellness Trust

Ann Batdorf-Barnes, DO , MPH is a consultant to the Kresge Foundation. The opinions expressed are those of the author and do not necessarily reflect the official opinion of the Foundation.
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Thanks for bringing attention to an option states can use to assure that there are prevention initiatives in place as health reform unfolds across the country. Congratulations to the Massachusetts Public Health Association for leading this initiative through the state legislature. Monitoring how the funds are used and the impact of the investments in community prevention will be an important next step.

Posted by: Deborah Klein Walker | 01/24/2013 at 09:16 AM

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01/17/2013

Why Don't We Know More Precisely What To Do?



By David A. Kindig, MD, PhD

As much as I admire and support last week's NRC-IOM report on the U.S. Disadvantage, I have been reflecting on the authors' strong call for better data and research investments. Unfortunately, the report's policy recommendations don't seem on par with the extreme challenges presented.

The report's recommendations include:

- "Intensify efforts to achieve established national health objectives"
- "Organize a comprehensive media and outreach campaign" to "stimulate a national discussion"

These are reasonable things to do, but why don't we know more precisely what to recommend to policy makers to close these gaps?

Two quotes come to mind, including Victor Fuchs (1974):

> *"How much, then, should go for medical care and how much for other programs affecting health, such as pollution control, fluoridation of water, accident prevention and the like. There is no simple answer, partly because the question has rarely been explicitly asked."*

And another from my own Association for Health Services Research (AHSR) Presidential Address (1996):

> "*Now that we are in a time when attention is turning to fundamental health outcomes, when performance and value purchasing are becoming discussed by business coalitions, when there*

> *is serious discussion of a new connection between medicine and public health, we find that our research community has not invested nearly enough in the knowledge and understanding we need to guide policy."*

And now this report, presenting this massive information on our poor performance, has to call for "a coordinated portfolio…of research devoted to understanding the factors responsible for the US health disadvantage and potential solutions including lessons that can be learned from other countries."

What is wrong here? It is true that going beyond simple description of differences to finding causal pathways is extremely complicated. Methods and data sets to explore these relationships are limited, and so far there are few studies even showing associations of factors producing health disparities, and even fewer on the relative cost effectiveness of policies across determinants like health care and behaviors and the social determinants of health.

However, I believe we can find answers to these important questions. I do find it possible that our national focus on clinical care and health care technology has diverted resources from understanding the contributions from other sectors that are even more critical for producing health. The wide variation in health outcomes among communities has to result largely from different levels of financial and nonfinancial policy investments over time; these natural experiments should offer investment and policy guidance for a business model for improving population health. However, little such guidance exists because of lack of comparable investment information across small units of population like communities or counties. My colleague, Tim Casper, and I examined the availability of such data in a sample of Wisconsin counties for per capita expenditures in selected categories of health care, public health, human services, income support, job development, and education. We found that even this well-resourced state is challenged by the difficulty in locating useable data, a lack of resources among public agencies to upgrade information technology systems for making data more usable and accessible to the public, and a lack of enterprise-wide coordination and geographic detail in data collection efforts.

So this is why the NRC-IOM report has to repeat the 1974 Victor Fuchs' call for better information. Perhaps the worsening results will pose enough of a threat to national productivity and even security to prompt greater action and investment. More national conversations are taking place; last month Academy Health held a planning session to develop a strategy for population health research and policy to become one of three new objectives for the organization going forward. The Robert Wood Johnson Health and Society Scholars program leaders are discussing ways that a population health research and policy "community" can be created and supported.

As the report indicates, there are many things that we can do now, and waiting will delay for generations the health improvement we need and can achieve. I'm extremely hopeful that this report and several others over the past two years will be some kind of Sputnik wake-up call where we find the will to address these knowledge and policy challenges much more aggressively so that future generations don't ask "Why didn't they do it then?"

David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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Scientific methods for testing health improvement hypotheses at the population level are not well developed. Thus, the current evidence base relies heavily on often poorly controlled, retrospective, cohort, comparative designs. Many refer to U.S. States as potential laboratories of experimentation providing sufficient homogeneity and sample size to make more rigorous studies possible. Many population-level interventions now devolve to States. Medicaid is one example. With balanced randomization (or quasi-randomization), population-level interventions could be tested with 25 assigned as intervention States and 25 as controls. Large within-State populations would provide relatively precise estimates of effect so an overall sample size of 50 might provide more useful information than currently available. Feasible? Worth a try?

Posted by: Ed Donovan | 01/18/2013 at 11:27 AM

Thanks for this post. I'm also intrigued by the policy recommendation that implies that "stimulating a national dialogue" will naturally bubble up into policy action, the hopeful assumption of many similar reports (including 2012's IOM report on obesity prevention).

Posted by: Sarah Gollust | 01/21/2013 at 08:55 AM

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01/09/2013

How Could the United States Have a "Health Disadvantage"?



By David A. Kindig, MD, PhD

This was the question that I couldn't keep out of my mind while reading the superb new report from the National Research Council and Institute of Medicine titled *"U.S. Health in International Perspective: Shorter Lives, Poorer Health."*

Before I get to my title question, let me briefly summarize the ambitious effort that this distinguished panel, chaired by Population Health expert Steve Woolf from Virginia Commonwealth University, has produced for both scholars and policy makers. In the opening summary the authors assert, *"The United States is among the wealthiest nations in the world, but it is far from the healthiest…Americans live shorter lives and experience more injuries and illnesses than people in other high income countries….The US health disadvantage cannot be attributed solely to the adverse health status of racial or ethnic minorities or poor people, since recent studies suggest that even highly advantaged Americans may be in worse health than their counterparts in other countries."*

The report takes on the very challenging task of explaining what underlies this poor performance of the United States. Two initial chapters deal with the evidence on mortality and morbidity, while five more deal with current evidence for the explanatory factors, such as public health and health care systems, individual behaviors, social factors, and physical and social environmental factors. It is beyond the scope of this blog post to try to summarize this vast content, but suffice it to say it is an extremely comprehensive treatment of what we know about the multiple factors producing health. The report can and should be used as an evidence guide for policymakers and a population health textbook for the academic community.

Concluding that no single factor can fully explain the differences in health outcomes identified in the report, the authors considered the possibility of an unidentified root cause. In a provocative

chapter on “Policy and Social Values“ they question the possible role of “characteristics of life in America that create material interests in certain behaviors or business models,” and discuss the roles of “five iconic American beliefs” such as individual freedom, free enterprise, self-reliance, religious values, and Federalism. While the committee acknowledges that no empirical evidence exists to link these factors to the poor performance they document, this chapter should certainly be the basis for much discussion and future research.

The report closes with six recommendations. Three call for major new research and data efforts aimed at “better elucidating the complex causal pathways that might explain the cross national differences in health” they document. Three are in the policy area, including calling for redoubled efforts to achieve established national health objectives and the development of a comprehensive media and outreach campaign to “stimulate a national discussion” about the findings and their implication for the nation.

The report does have some limitations worth mentioning, including its exclusive focus on aggregate health status of the US and other high income countries. The authors acknowledge that addressing disparities within countries, which can be as great as those between, was beyond the scope of the investigation. This is certainly understandable given the massive effort the report represents. But they also assert that addressing disparities is a “paramount national priority” that is worthy of equally rigorous study. As useful as cross national analysis can be, it is possible for some to dismiss the implications because of fundamental differences in national cultures and policies. This limitation is significantly less when exploring similar differences within national boundaries of even such a large and diverse country as ours. Secondly, with regard to monitoring improvement even for the nation in aggregate, the report relies primarily on a list of Healthy People 2020 objectives which are relevant to the cross national differences they highlight. This might have been an opportunity to at least discuss the potential and challenges of setting higher level goals such as life expectancy reduction targets suggested by another IOM committee last year.

So are we disadvantaged? In a footnote the report defines the term health disadvantage as “a condition of relative inferiority, reflecting the unfavorable health outcomes in the United States compared with those in other high-income countries…the term is not meant to imply that the United States, among the wealthiest countries in the world, is disadvantaged in the dictionary sense of ‚'lacking in the basic resources or conditions (as standard housing, medical and educational facilities, and civil rights) believed to be necessary for an equal position in society.'”

But in reading one of the references in the provocative social value chapter I found this definition of American disadvantage: “a unique weakness of its social safety nets, the magnitude of social inequalities, and the harshness of its poverty (1)”. Thought of this way, disadvantage is certainly a compelling hypothesis deserving serious and urgent attention of population health scholars and policy makers.

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David A. Kindig, MD, PhD is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health. Follow him on twitter: @DAKindig.

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David
I did not read the report due to length and access. However, I scanned all the press and blog coverage and have a good feel for the findings.

Observation and question:
On mortality <50yo, report conveys that 2/3 of attributable risk due to public health issues like guns, accidents, etc.

Given rates of death in younger demographic contribute to overall life expectancy, as cited, significant wake up call for public health investment. We emphasize obesity and other modifiable risks, but surprisingly, the difference between US and OECD stems from things we know about, but overlook. The collective sum of all the poisonings, shootings, car crashes add up. I was surprised much of the disparity rested in those issues.

(I cite overall life expectancy due to its use as "gold standard" for HC quality between countries, even if misapplied as a metric.)

Given the absolute levels of death from CVD, cancer, etc. (large), as compared to non-medical occurrences of "youth," (small), does the delta between USA vs other actually stem from non-clinical issues? Does the cure reside there and have we directed our efforts in the wrong places?

Of course, by posting here, a bias presents, but I think you get the crux of my question. I am very interested in the answer.
Thanks
Brad
NY, NY

Posted by: Brad F | 01/10/2013 at 08:08 PM
The difference between the US and the other countries studied is the presence of a cohesive "health system". They have one, we do not. The simple solution is to get a national health system -- is this really so difficult? I suspect the author of this blog or many other individuals could outline a great system in an afternoon.

Posted by: Ralph | 01/13/2013 at 11:10 PM
Brad and Ralph: Thanks for reading and for your comments. Brad: I know that the Committee was also surprised at how much of the differences were from non-clinical causes like injuries. Ralph: I think we do need a more systematic approach to improvement, but I can't design it in an afternoon. I hope you aren't referring only to national health CARE systems which have many advantages but alone are not adequate. I suspect that a greater level of social spending to health care spending may be partly responsible, which could be considered a HEALTH system. But even if we knew exactly what the right investment balance would be (stay tuned for Wednesday's blog) finding common ground to make it happen will probably take a generation of afternoons. Let's hope the report is a wake up call to get us moving on a serious population health improvement strategy.

Posted by: David Kindig | 01/14/2013 at 08:39 PM

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01/01/2013

Pre-Kindergarten in San Antonio



By Erik Bakken, BA

San Antonio, Texas has recently put itself on the population health map with a program led by its new mayor, Julian Castro. During the 2012 elections, San Antonio voters approved a referendum for a 1/8th cent sales tax increase to fund an expansion of Pre-K education to address a gap in citywide enrollment.

Faced with a city performing well below the national mean, with achievement gaps for many education metrics, Mayor Castro assembled a taskforce to address the challenge, which resulted in the creation of Pre-K 4 San Antonio. The program will establish four model centers to provide preschool education for the estimated one quarter of the city's four year olds not participating in full day pre-k programming. These centers specifically target those most likely to not be receiving pre-K education, such as those living in poverty, those who are homeless, and English language learners. The program also involves parents, who will be required to take part in parenting classes. Within three years, the program aims to add 3,700 pre-K slots in San Antonio in the four centers and through contracts with schools.

Educational attainment has an established link to health outcomes and is a strong predictor of employment, income, and health knowledge. With a growing body of scientific evidence demonstrating the long-term impact of early childhood education, policymakers like Mayor Castro have started pushing for investments in this area. Pre K 4 San Antonio sets ambiguous goals, including reducing kindergarten achievement gaps in language, math, and literacy by 25, 33, and 90% respectively and closing third grade gaps in standardized test scores.

The funding for this effort is noteworthy. As with our previous piece on Florida taxation districts, this 1/8th cent tax represents a viable, long-term funding mechanism that amounts to an estimated increase of just $8/family per year. San Antonio is expecting this tax to generate $31 million annually, which will cover over 80% of the projected costs. To strengthen and sustain our

social programs -- whether in health or education -- we must continue to innovate on funding as we move away from grants and toward more constant and reliable financing. Taxes are just one possible approach: Pre-K 4 San Antonio illustrates the population-level impact that even a small levy can drive.

Erik Bakken, BA is a graduate student at the University of Wisconsin's La Follette School of Public Affairs.

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Honduran village name Auka near the Nicaraguan border where Truman Cunningham, Michael Bagby, and others had set up a relief distrubution

Posted by: immediate tuition assignment | 01/02/2013 at 02:56 AM

This is a wonderful piece that highlights a good example of innovative and cost-effective ways to promote and support strategies in human and social capital. Promoting access and opportunities to a common level of education across all of society is vital in reducing social and health inequities for the most vulnerable populations. Pre-K is a time when most children are quickly developing emotionally, socially, and academically – nurturing that developmental process can help minimize future academic, behavioral, and mental health risk. Adding supportive parenting strategies for families with young children offers a multi-faceted approach in supporting the success of early intervention and opportunities for early education. We need more interventions, such as these, that are both family-centered and begin with prevention at a time when the point of intervention can actually make effective changes across the lifespan for individuals, families, and communities...such efforts can help to address health challenges and health disparities in meaningful and concrete ways over the long term. Kudos to Mayor Julian Castro of San Antonio for this initiative!

--Chau Trinh-Shevrin, New York University Department of Population Health and Center for the Study of Asian American Health

Posted by: Chau Trinh-Shevrin | 01/03/2013 at 08:23 AM

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03/20/2013

2013 County Health Rankings -- and Much More



By Bridget B. Catlin, PhD, MHSA

Today, the Robert Wood Johnson Foundation (RWJF) and the University of Wisconsin Population Health Institute (UWPHI) release the 2013 *County Health Rankings*. The *Rankings* have been produced nationally since 2010 and are an annual reminder that where we live matters to our health. We know that health is more than health care, and the *Rankings* provide all fifty states with county-by-county snapshots to help raise awareness about the many factors -- such as education, employment, community safety, and access to healthy food -- that influence how long and how well we live.

Very helpful for getting attention, the *Rankings* are meant to spark the types of long-lasting change that we know make a difference in the health of communities. So, when you visit www.countyhealthrankings.org to see how your county's health compares to other counties in your state, be sure to check out the *Roadmaps* section to see what you can do to move your community's health forward. There are several resources to answer the question "What can I do?" including the *Roadmaps to Health* Action Center (providing tools and personalized assistance for creating healthier places to live, learn, work, and play) and *What Works for Health* (providing information to help communities select and implement evidence-informed policies and programs). To answer "What can I learn from others?" the site features communities around the nation who are using the *Rankings* to take action. Visit this portion of the site to learn how *Roadmaps* Community Grantees are working on policy and systems change around social and economic factors and to read stories about local change agents--leave thinking about how **you** could lead or support similar action in your own community.

Be sure to also visit the *RWJF Roadmaps to Health Prize* section of *Roadmaps* to peruse the 2013-14 Call for Applications for the next round of prize competition. Applications are due May 23,

2013.

Last month, the Robert Wood Johnson Foundation presented the first *RWJF Roadmaps to Health Prizes* to six communities:

- Cambridge, MA
- Fall River, MA
- Manistique, MI
- Minneapolis, MN
- New Orleans, LA
- Santa Cruz County, CA

We invite you to meet these winning communities and learn about their accomplishments through the online *RWJF Roadmaps to Health Prize* multimedia winners gallery.

The prize recognizes that every community is on a unique journey toward better health and that communities' success stories are as diverse as their populations. All U.S. communities working toward better health are invited to apply. Winning communities will each receive a $25,000 cash prize and have their success stories celebrated and shared broadly with the goal of raising awareness and inspiring locally-driven change across the country.

We encourage anyone interested in the prize to join us on April 2 (1-2 p.m. ET) for an informational webinar (registration required) where we'll provide an overview of the application and selection processes and answer questions from potential applicants. Those not able to participate in the webinar may view the recording, to be made available on the prize website, at their convenience.

We are also excited to announce that in addition to our first National Partner, United Way Worldwide, two other national organizations with a local presence have joined the *County Health Rankings & Roadmaps* team—National Association of Counties and National Business Coalition on Health. These partners, together with the rest of our team at RWJF, UWPHI, and Community Catalyst are eager to be in touch with all types of communities to help and celebrate health improvement efforts across the nation.

Bridget B. Catlin, PhD, MHSA directs the County Health Rankings & Roadmaps *program at the University of Wisconsin Population Health Institute.*
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04/16/2013

Community Health Needs Assessments – An Opportunity to Bring Public Health and the Healthcare Delivery System Together to Improve Population Health



By Michael A. Stoto, PhD

Population health is fundamentally about measuring health outcomes and their upstream determinants and using these measures to coordinate the efforts of public health agencies, the healthcare delivery system, and many other entities in the community to improve health. These measures monitor how well we are managing a responsibility that we all share, and help to set priorities. Managing a shared responsibility, however, is challenging: given the many factors that influence health, no single entity can be held accountable for health outcomes. But as I came to realize in preparing a new Academy Health issue brief on population health, what seems like a minor component of the Affordable Care Act (ACA) provides the key to resolving this dilemma.

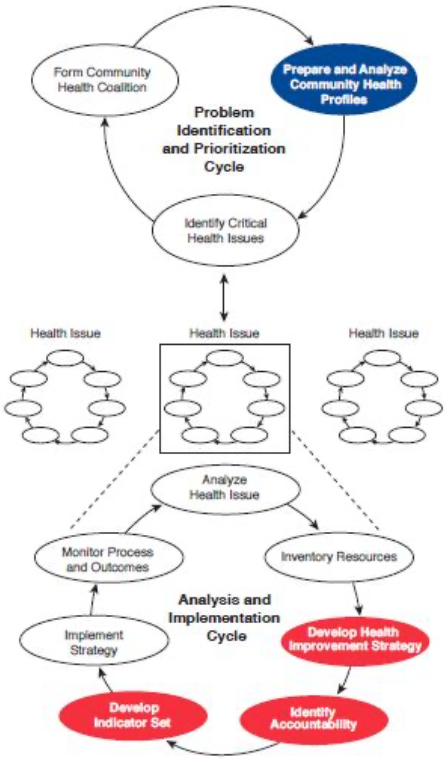
The IRS now requires that all non-profit hospitals conduct Community Health Needs Assessments (CHNA) in conjunction with local health departments and others. CHNAs must identify existing health care resources and prioritize community health needs. Hospitals also must develop an implementation strategy to meet the needs identified through their CHNA and a set of performance measures to track progress.

These requirements are mirrored in the Public Health Accreditation Board's (PHAB) standard mandating that health departments participate in or conduct a collaborative process resulting in a comprehensive Community Health Assessment. Other PHAB standards require that they conduct a comprehensive planning process resulting in a "community health improvement plan," assess

healthcare service capacity, identify and implement strategies to improve access to healthcare, and use a performance management system to monitor achievement of objectives.

Thus, although the language is different, both IRS and PHAB call on hospitals and health departments to collaborate, and propose a similar measurement strategy for improving population health. As quality measurement did in healthcare, performance measurement has the potential to transform population health, but only if the right measures are used.

Two different sets of measures are needed, as articulated in the 1997 Institute of Medicine report *Improving Health in the Community*.



Source: adapted from Improving Health in the Community (IOM, 1997)

To coordinate a community's efforts, this IOM report proposed a Community Health Improvement Process (CHIP) that begins with a CHNA to summarize a community's overall health status, for which public health agencies, healthcare providers, and many other community stake holders share responsibility. The community health profile -- another term for CHNA or CHA -- is highlighted in blue in the upper "Problem Identification and Prioritization cycle" in the figure shown above. This profile is used to identify specific activities to be conducted by different entities in the community (public health, health care providers, employers, schools, and so on) that contribute to the overall community health goals. Because comparisons can help to identify priorities, a standard set of measures, such as those developed for nearly every county in the United States by the *County Health Rankings*, is a useful starting point.

To manage this shared responsibility, communities should develop a set of valid and actionable performance measures to ensure that the entities are held accountable for their activities. Identifying accountability for specific actions is an essential component of both the Community Health Improvement Plan required by the IRS and the comprehensive planning process in the PHAB standards. The IOM CHIP model includes the red-highlighted "indicator set" in the "Analysis and Implementation" cycle. A more recent IOM report, *For the Public's Health: The Role of Measurement in Action and Accountability* (2010) lays out a very useful "Framework for Accountability" suggesting specific measures and the stakeholders (or accountable entities) associated with them. For instance, if the goal is to address diabetes, the measures might include the availability of recreation facilities and physical education programs to hold the parks department and schools accountable, as well as screening for diabetes and glycemic control in diabetes patients to assess the healthcare sector's contributions. Both improvement plans and their associated performance measures must be tailored to a community's health needs and improvement activities, so a standard set of measures is not desirable.

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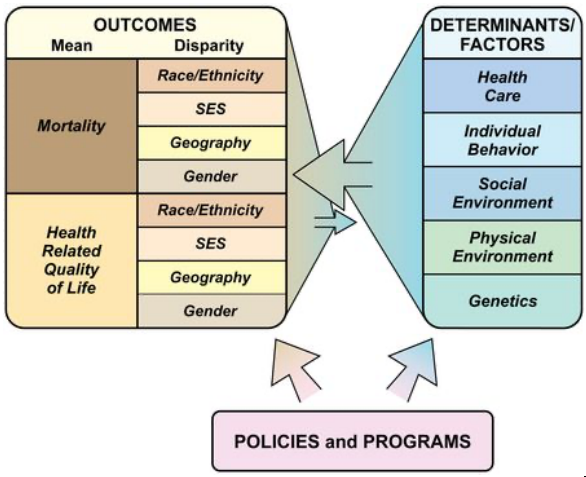
What Is Population Health?

(Also see health outcomes, health determinants/factors, and policies and programs.)

What is population health?

The population health perspective taken by this blog is a broad one, as the model below illustrates (1) [This model was adapted from the original Evans and Stoddart field model (2) and expands on Kindig and Stoddart (3)].

Policies and programs produce changes in health determinants or factors, then produce the health outcomes in the left hand box.



Population health is defined as **the health outcomes of a group of individuals, including the distribution of such outcomes within the group.** (3,4) These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group. The health outcomes of such groups are of relevance to policy makers in both the public and private sectors.

Note that population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

The right hand side of the figure indicates that there are many health determinants or factors, such as medical care systems, individual behavior, genetics, the social environment, and the physical environment. Each of these determinants has a biological impact on individual and population health outcomes.

Isn't this so broad to include everything?

Population health, as defined above, has been critiqued as being so broad as to include everything—and therefore not very useful in guiding specific research or policy. The truth is, no one in the public or private sectors currently has responsibility for overall health improvement. Policy managers, for example, tend to have responsibility for a single sector while advocacy groups likewise focus on a single disease or factor.

The inherent value of a population health perspective is that it facilitates integration of knowledge across the many factors that influence health and health outcomes. For population health research, specific investigations into a single factor, outcome measure, or policy intervention are relevant, and may even be critical in some cases--but they should be recognized as only a part and not the whole.

What is the difference between population health and public health?

The distinction between public health and population health deserves attention since it has been at times both confusing and even divisive. Traditionally, public health has been understood by many to be the critical functions of state and local public health departments such as preventing epidemics, containing environmental hazards, and encouraging healthy behaviors.

The broader current definition of the public health system offered by the Institute of Medicine reaches beyond this narrow governmental view. Its report, The Future of the Public's Health in the 21st Century, calls for significant movement in "building a new generation of intersectoral partnerships that draw on the perspectives and resources of diverse communities and actively engage them in health action (5)."

However, much of U.S. governmental public health activity does not have such a broad mandate even in its "assurance" functions, since major population health determinants like health care, education, and income remain outside public health authority and responsibility. Similarly, current resources provide inadequate support for traditional--let alone emerging--public health functions. Yet for those who define public health as the "health of the public," there is little difference from the population health framework of this blog.

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05/24/2010

Reform vs. Transform



By Jonathan Fielding, MD, MPH, MA, MBA

Health insurance reform has been passed. Those of us who feel health care is a right can now see the path to get 95% of the population covered. The evidence is clear: health insurance reform can save lives. But what was missing in the rancorous debate over “health reform” was a sense of context. How important is health care compared with other factors that influence individual and collective health? Are we making investment decisions that flow from the answers to this question? The truth is that health care coverage expansion, albeit overdue and an essential social good, will have a relatively small effect on our relative position of 37th among the nations of the world in life expectancy.

If we want longer, healthier lives, lives with more years of independence and high functioning, we need to complement health insurance reform with more fundamental reform—a transformation of the health enterprise. Transformation requires answering the fundamental question: “What determines our individual and collective health?”

The studies provide a clear but surprising answer. The conditions in which we live, work, and play are the most important health influences. A high school graduate lives on average seven fewer years less than a college graduate. Smoking, other drug use, obesity, inadequate physical activity, and a diet too rich in processed foods are major contributors to our health and functioning—on balance, more important than whether we see a doctor for a routine physical. Medical care is important, and can be life prolonging—but it is only part of the opportunity to minimize most health problems.

This is not fresh news. But there is an almost total disconnect between the fight over “health reform” and what investment would provide the highest value in terms of quality and years of life along with reducing the gaping health disparities among different groups, defined by ethnicity, race, culture, and geography. What we need is a nation that thinks differently about how we get to be healthy. We must view and act as if health is a necessary characteristic of populations, not just individuals. If we did, we would invest more heavily in evidence-based prevention—both for patients and communities.

Thinking differently about what determines our health can be transformative. We will ask better questions of ourselves and of those who make policy, both public and private. Thinking differently could cause us to encourage our elected representatives to consider how policies in agriculture, transportation, housing, and social services can support health.

Does subsidization for growing corn, the source of the inexpensive high fructose corn syrup ubiquitously present in foods, improve our health? Does it make sense to have schools with the best local playgrounds declare them off limits to neighbors in their communities? Should almost all our investment in transportation be for roads and highways rather than mass transit and more bikeable, walkable communities? Why should medical care be tax advantaged while we pay after tax for fruits and vegetables or fitness clubs or smoking cessation classes?

The passage of health insurance reform has helped answer the nagging question of access to medical care. Now we have the opportunity—and the imperative—to ask the larger questions about how to improve our health. Shouldn't the first question be, "If we want to invest cost-effectively to improve health for everyone in our country, what would we do differently—as a nation, as communities, and as individuals?"

Commissioner Jonathan Fielding, MD, MPH, MA, MBA serves as Director of Public Health and Health Officer for Los Angeles County, where he is responsible for the full range of public health activities for 10 million county residents.

Posted on 05/24/2010 in The National Policy Front | Permalink

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Great post. The questions posed in paragraph 6 are "right on" in regards to how we develop healthy, sustainable communities. It takes sharing of resources, as well as transformative thinking to integrate environmental infrastructure planning and use, change funding policies and provide support for healthy lifestyles.

Posted by: MargieWeiss | 05/25/2010 at 05:19 PM

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