Insights

Population Health: Learning from the Past to Shape the Future

July 11, 2019

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Niñon Lewis, a long-time leader of work to promote the IHI Triple Aim, shares five keys to population health success.

Niñon Lewis, MS, is IHI's Head of Content Portfolios. In addition, she leads content and field work for IHI in the areas of population health, the Triple Aim, and community-wide improvement efforts. In the following interview, Lewis shares her observations from playing an integral role in IHI's population health work for over a decade.

What did population health work look like 10 years ago?

One big challenge from back then — that we're still facing now — is trying to agree on what "population health" means. Coming to an agreement about definitions matters because it helps you coordinate the right stakeholders, resources, people, and energy to address the needs of a population.

In health care in the past, population health meant using the resources within your health care system to better coordinate, pay for, and deliver care for a defined group of people. At IHI we call that "population medicine" or "population management." In addition, we also saw people define population health as primarily *access* to health care services through insurance coverage, and others defining population health as under the sole jurisdiction of *public* health stakeholders, such as county or state health departments.

Now, all those lines are blurred. Hospital systems are running community health improvement plans (or CHIPs) in partnership with their local health departments. They're starting to think about population health beyond the resources of their health care system to the whole geography around their catchment area.

Another big challenge five to ten years ago was that the social determinants of health were often looked at as a fringe thing that community-based organizations addressed. Health care is slowly recognizing the significance [of social determinants] and the response from community-based organizations has been, "We've been waiting for you to acknowledge this for about 40 years." It's a wonderful thing to see all the different stakeholders in a community, including health care, start to march to the beat of the same drum.

How did pursuing the Triple Aim motivate some hospitals to address population health?

The Triple Aim was transformational. I started at IHI in 2008 on the precipice of some major changes in the US health care policy and payment environment – a truly exciting time for population health. However, at the time I remember health care leaders — especially hospital boards — saying, "Population health is not our responsibility. Our responsibility is to deliver great, efficient care to the patients that come into the hospital." The Triple Aim helped people understand that they didn't have to choose between great care delivery and population health. In fact, to deliver great care, you should be thinking at scale for your whole population.

The Triple Aim helped people expand their thinking. The Triple Aim meant being strategic because it meant looking at the experience of care, population health, and per capita cost as a set of balancing measures – a simultaneous pursuit of one aim with three dimensions. That kind of thinking made C-suite leaders lean into the conversation. Now, many hospital systems include the Triple Aim somewhere in their mission statement or on their website; the cultural uptake of the Triple Aim has been more expansive than we ever imagined because it resonates for so many people.

Of course, saying you agree with the Triple Aim and doing it are two different things. Are you willing to reallocate your resources — time, money, energy leadership roles — to redesign the services you deliver? Some people are not ready for that kind of hard work. When the going gets tough, it's often easier to default to the status quo.

With new payment models moving in the direction of shared risk and shared savings, the next frontier is [for an organization] to move beyond an aspirational view of the Triple Aim to tangibly change the way they do business so it's focused on the health of the population [and not just treating illness].

What has IHI learned about the keys to successfully addressing population health?

We've learned a tremendous amount from our Triple Aim work over the last 10 to 12 years — with now over 200 organizations around the world — and from our 100 Million Healthier Lives work. I would put what we've learned into five big buckets:

- **Understand the population to guide your work**. Whether you're a health care delivery system or part of a multi-stakeholder coalition, every decision should flow from your insights into the needs and assets of the population. We often ask, "How much do we want to accomplish by when?" We should be asking, "How much by when and *for whom*?" In addition to system-level and population-level data, we need to conduct client and provider interviews. Ask patients things like, "What is a day like for you?" or "What is it like to live with this chronic disease?" Ask health care providers, "What is it like to serve people who keep coming in and out of the health care system?" This type of quantitative and qualitative picture into what your specific population needs and the assets that individuals within the population already bring to the table allows you to make good decisions about the governance structures needed, aims and measures, and new care designs for that population.
- **Make equity a property — not an output — of the system**. We need to design equitable systems to create equity for the populations we serve. When looking at the data, this means asking, "Who isn't thriving?" and "What would it take to change that?" When you design for equity, the system benefits all, not just those who aren't thriving. Sometimes people have trouble believing that, but we've seen lots of work in the field and research that confirms this is true.
- **Partner with those who have lived experience**. In many quality improvement efforts, we see theories of change built from the perspective of the practitioner, not necessarily from those directly impacted by the changes you'll make, or those who are directly affected by health inequities. Engaging those with lived experience of the issue – individuals and families, patients,

and communities, as well as the practitioners ensures that the work you do will be most impactful for the population. The 100 Million Healthier Lives initiative has done a lot of great work on how to partner with those with lived experience and offers some excellent tools and guidance.

- **Gather meaningful data more often**. Many people rely on annual [population health] measures that because of the nature of our reporting structures within the US, don't move quickly and aren't published often enough for organizations and communities to take action in a meaningful way. In the housing sector, for example, the US Department of Housing and Urban Development produces what's called a Point-in-Time count once a year that represents the number of individuals experiencing homelessness in a community. County Health Rankings provide data on health status and life expectancy once per year. This is important information, but it's not enough to provide an accurate window into the lives of people in your community. How can you combine annual measures with a set of process measures that can help you understand more? You need a dashboard of multiple measures to help you see different levels of the system to give you a line of sight between the changes you make and your level of confidence it will have a positive effect on the population over time. For example, being able to say, "We have a high degree of belief that creating more employment opportunities and increasing the minimum wage will lead to a decrease in child poverty rates when we see the data next year."

- **Plan for scale up from the start**. People often approach population health with a mindset that keeps them from seeing the big picture. Someone will say, for example, "I got funding to work on a maternal health pilot with 50 moms." But when you ask, "How many moms are you trying to reach?" their response is, "Well, my pilot is 50." The constraints of your project shouldn't narrow your thinking.

  We advise improvement teams around the world to write down a number when they start thinking about a population by asking the simple question of "when you think about your target population, what does 'all' look like for you?" For example, you might be working with a population of older adults in your community as part of your health system's aims and initially think about the estimated 20,000 older adults that live in your catchment area – that large number feels daunting to think about going to scale. However, you could break it down and make the number much more tangible – do a back of the envelope calculation of how many people over the age of 65 in your population are covered by a Medicare Advantage product. Say you estimate the number is 3,165. That's easier to get your arms around than a theoretical 20,000. Once you have that more realistic number of what "all" looks like for you and your target population, you can start planning to go to scale from the start because what you do when you're serving five people is different than what you do to get care right for 25, or 250, or 2,000. Teaching that the act of "scaling up" is a continuum, not a threshold you reach after getting results in an initial pilot population, is a big lesson we're sharing around the world.

More lessons from our work on the Triple Aim can be found in our article in *Milbank Quarterly*.

How is population health work evolving?

One of the most exciting evolutions in population health is combining health, well-being, and equity. We are broadening our definition of health to include well-being and how to measure it. Asking people, "Are you thriving in your life?" changes how we think about health because — if someone isn't thriving — it will be harder to sustain any kind of change. Just in the last 1 to 2 years, a lot of progress has been made on the way we measure health, well-being, and equity. A great resource is *Well Being In the Nation (WIN) Measurement Framework: Measures from Improving Health, Well-being, and Equity across Sectors*.

The conversations, and who is having them, have also evolved. People who have not previously been at the table with those working on health and health care — those who've been in the well-being space or working on equity for many years, for example — are being heard at the table, or in many communities are leading the charge. We're finally starting to work together. This is challenging because it means having to slow down to work on shared definitions again, for example, but it's necessary. It's the future.

What is happening with payment reform?

Payment reform and other changes are happening slowly as population health conversations broaden. I don't know that there are going to be revolutionary payment changes in the next five years, but I think there will slowly be more resources to address the social determinants of health through health care reimbursement.

We're starting to see more government programs figuring out coding and reimbursement for transportation and food prescriptions, for example. I'd love to see this extend to housing, but we'll see. Each year CMS and others seem to test new pilot programs.

This is important because [health care providers] can have goodwill and say, "We want to focus on health, well-being, and equity." But you need to address the bottom line issues to keep everyone returning week after week to the coalition table.

A few years ago, because there was so much upheaval in health care, it seemed like many organizations were taking a "wait and see"

approach before making major changes to address population health. Is that still the case?

I think people aren't waiting anymore. How they're choosing to do that varies. Some organizations that are part of the continuum of the health care delivery system are dipping their toe into accepting more financial risk. "Let's see what we can do to better manage a global budget for this particular patient population." Some are taking it a step further and saying, "We're not only going to focus on our patient population but also address our CHIP." They're not only creating their community health improvement plan but putting the plan into action with community-based partners to better deliver care and services in the community.

More health care systems are recognizing that they represent just one voice within their community. Maybe that stakeholder voice is a little bit louder because they have a lot of money and are the biggest employer in town, but more of them are seeing themselves as a humble partner in a broader decision-making group.

These type of changes that health care systems are making from patient populations to community-wide populations aren't mutually exclusive, and many health care organizations have work across all of these different areas of population health transformation. IHI has been working in partnership with other national stakeholders to articulate these pathways via the Pathways to Population Health initiative.

Editor's note: This interview has been edited for length and clarity.

The Triple Aim: Why We Still Have a Long Way to Go

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