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Keeneland Conference Plenary Sessions: Richard J. Umbdenstock

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Abstract

Historically individual and community health problems fed off one another, nonetheless the connection eventually became clear and individual health and population health solutions started to emerge and built off one another. Somewhere along the line, population health and patient health seemed to become divided by a brighter line into 2 separate realms, few of us crossing from one to the other. Today we are looking out for the good of our respective communities. As hospitals move from volume-based payments to value-based payments, they are more concerned about the connection between population health and their own efforts to improve outcomes, care coordination and prevention. The Affordable Care Act attempted to expand coverage for a range of prevention and wellness services and encourages partnerships between hospitals and other community health organizations. Accountable care organizations, patient-centered medical homes, workplace wellness programs, and community transformation grants are just some of the ways that hospitals, public health, and others will work together on new and innovative ways to improve health and safeguard health of our communities. We have many challenges and opportunities together, not the least of which are the citizens of our respective service areas who look to both of us for leadership, for greater collaboration, for greater efficiency and more value on either their premium dollar or their taxed dollar.

Keywords

public health services and systems research, phssr, keeneland conference

Cover Page Footnote

This manuscript edited from the plenary session given by the author at the fifth annual PHSSR Keeneland Conference. See the full version at: <http://bit.ly/NUX08t>

First of all, what's up with public health and patient health? Secondly, where do we need to go and how do we get there together? I'm honored that you'd give me time at your podium, but you might have noticed, I'd ever worked in public health, and I haven't, so you have a true outsider. But it's not as though I don't understand the histories, the respective and joint histories of public health and patient health. Once upon a time, as most stories start, neither field existed. We had individual and community health problems fed off one another, and there was very little that our more primitive societies could do for it. Then for a while, the connection became clear. Individual health and population health solutions started to emerge and even built off one another. As we got better at one, the other benefited in both directions. Somewhere along the line, population health and patient health seemed to become divided by more of a bright line into 2 separate realms, few of us crossing from one to the other. From the perspective of health care providers at least, public health folks worried a lot more about things like prevention, sanitation, food quality, large scale interventions like vaccination efforts, and so on. The large scale interventions would truly improve community conditions and, therefore, improve individual health. As health care providers, including hospitals, well, we became more focused on the individual, on the medical and surgical, on the intervention, on the curing, the treatment, rather than preventing. We all had the goal of building healthier communities, but each sector had kind of a neat and tidy role of its own.

Now, that's an oversimplification, but I don't think it's that far from the truth. We find ourselves in a very different place today. We were all along the way always looking out for the good of our respective communities. I think we also had a pretty good idea along the way, probably still do today, of what some of the reasons for the distinction, the difference, the line between us might have been. Not surprisingly, like a lot of things, not the least of them was that funding always seems to play a role. You know when I was in consulting, a guy who was a very good friend of mine tried to jab me in the ribs one day. He said, "You know, you consultants are all the same. You're coin operated." I thought for a second, and I said, "You're absolutely right. I have a wife and four kids at home that want me to be coin operated." But it's really true for all of us. Financial incentives are some of the strongest incentives we have. To borrow another line, I read *Sports Illustrated* yesterday on the plane on the way down, an article on *Jerry Maguire* and so on, you know, "follow the money." The money is changing these days, as we will talk about. I think our relationship will change as well. Funny how financial incentives drive focus and behavior, especially when funds are plentiful and when we think we can afford the professional pride that says, "My way is better. My way is a more noble way." Now the money is gone, and the public cares more about its health and the value it receives from us than it does about our professional turf or pieties. What's the answer? Is it more public health? Or is it a shift in the medical model from treatment to prevention?

Like most either/or questions, the answer is pretty clear; it is yes. Now I have already admitted that there is no public health on my resume, but it doesn't mean that I haven't had experience in population health. Let me share a little bit of that with you because population health characterized by broad scale wellness and prevention efforts has actually a long history within the medical model. When and if the financial incentives were there and the professional ethic had it valued and rewarded, you saw it and you still see it today in the medical model. I am referring to prepaid, multidisciplinary, integrated health plans. Call them HMOs or whatever you'd like. Probably in the future, we might have some of them called accountable care organizations, but it

has been there; population health has been there. I say, “Funny how much of a difference it makes when one is paid a fixed amount of money to worry about the health of a member over time rather than a unit of treatment.”

When you run an HMO, public health is your ally. You want the patients who come in your door to be as healthy and devoid of preventable conditions as possible, but you know that your covered population mixes every day with the entire community, and your job is to keep your members out of harm’s way, not just when they’re in your office but throughout their day, their night, anytime that they are out there because you’re on the financial hook to take care of them. You use your face-to-face encounters with patients to reinforce the principles of public health—sound living conditions, proper nutrition, health maintenance, prevention, wellness. Every intervention in a fixed payment system is an expenditure and every expenditure is one of 2 things; it is either an investment—the earlier and the less costly the better—or it’s a true cost. All costs are bad when you’re on a fixed budget. Just think about it at home. The principle is exactly the same. It’s simple, right? We could probably all go home if we just get this done by the end of the hour. All we need to do is change the financial incentives for our combined health sector and for individuals across society as well, incent health and deglamorize consumption; or to borrow a phrase from one of our recent AHA board chairs, what we need to do is create an epidemic of health.

How can we do that together? Well, like most things, it starts with a common vision. Let me speak from the hospital side. As hospitals move from volume-based payments to value-based payments, they are much more concerned about the connection between population health and their own efforts to improve outcomes, care coordination and prevention 1 patient at a time. From mobile vans and health screenings to education fairs, many hospitals have long been active in efforts to improve the population health in their community, but now they are becoming even more interested in improving the lives of their patients, not just their health care. To be blunt, they are interested in losing less money as they are more and more underpaid from government sources. Hence rather than waiting for an admission that is not going to get paid or an ED visit that is not going to get paid, they are now much more interested in getting upstream on the primary care side or coordinator care better downstream after discharge.

What are hospitals doing?

Let me give you some examples of what hospitals are doing very quickly. In Missouri, Truman Medical Centers (TMC) in Kansas City is led by our immediate Past Chairman, John Bluford. TMC is a safety net hospital that serves a highly diverse community, and one of those rare hospitals in our membership that manages and operates a county health department. They also have an active employee wellness program, and some of their novel approaches are coming out of their own employee population health efforts. They think of employees, most of whom are part of the community they serve or live in the community they serve, as ambassadors of health, so they provide a variety of continuing education and life skill classes for staff and their families because they are all dependents on their health plan, even down to and including one that makes sense, tutoring for the kids. They hold a farmers market so that staff in the community has a convenient source of fresh fruits and vegetables in a community setting that does not provide many food store options. Their employee program is aimed at providing better support for people

with multiple chronic diseases and has worked so well that they are expanding it out to their patients, so they are learning closest to home first.

In Louisiana, the Department of Health and Hospitals is partnering with the Louisiana Hospital Association, the State Medical Society, and the State's Chapter of the American College of Obstetricians and Gynecologists to encourage Louisiana's birth hospitals to implement policies that end non-medically indicated inductions before 39 weeks gestation. This helps to avoid obviously in-hospital complications for the infant, but it also helps to avoid and stave off and maybe forever reduce complications and costs out in the community for the kids, their families, and the call that they have to make sometimes on other community resources, social services, your services, schools, and others when these kids have special needs. One of the leaders in that is our current chair, Teri Fontenot, who is President of Woman's Hospital, a large birthing hospital in Baton Rouge.

In Washington State, the Choice Regional Health Network includes rural and urban hospitals, practitioners, public health agencies, clinics, community health centers, behavioral health providers, all focused on access to care, quality improvement, collaboration, community development, and joint advocacy.

In Iowa, the Center for Healthy Communities has created the Department of Iowa Health in their Des Moines region. The center links resources with identified community needs, and key partners there include the Polk and Dallas County Health Departments and the United Way.

These are just a few examples, but we all know that the Affordable Care Act will speed up this process as well. The law has attempted to expand coverage for a range of prevention and wellness services and encourages partnerships between hospitals and other community health organizations, and this will and must continue regardless of what happens with the Supreme Court decision. Accountable care organizations, patient-centered medical homes, workplace wellness programs, and community transformation grants are just some of the ways that hospitals, public health, and others will work together on new and innovative ways to improve health and safeguard health of our communities. The AHA supported and continues to support the Affordable Care Act primarily for 32 million reasons—those people who would receive coverage—but also because it would move us forward in advancing a vision of health. The AHA's corporate vision has been of health for the last 15 years. It is a vision of a healthy society, a society of healthy communities where all individuals achieve their highest potential for health. We haven't put our own vision statement in hospital terms. We have always put them in community and health terms.

Health for Life

Off of that, we built something called Health For Life, which was our reform framework that guided us through the debate in 2008, 2009, and 2010. It focuses on 5 key elements:

1. Wellness-building a business case for wellness for hospitals and other providers
2. Coverage for all, paid for by all—getting everybody in the pool and sharing in our cost of that to the extent that we each can

3. Building more efficient and affordable care systems
4. Providing the highest quality of care
5. Providing the best information—best information for patients, for practitioners, but also in a transparent way for communities at large.

It also has a list of ideas for change, and I would like to go over some of them that really do focus in on the issue of public health and community health. We believe that the public health system must be appropriately funded and supported to ensure that a focus on wellness and prevention touches all individuals regardless of their insurance or employment status through the medical model and to ensure that communities have sufficient resources to protect and improve the public's health. We would like to see modernization on your side of the health equation as with the patient's side as well, particularly around information systems so that we can build and connect our respective information systems to share the most helpful and most current data. We would like to see expansion of public health programming on the underlying causes of health, like smoking, substance abuse, lipid control, lack of exercise, things that only become medical problems farther down the road, and we think it's important to identify and integrate the critical interfaces between public health and the acute care community to build more efficient and effective systems overall. Other ideas for change concerning healthy pregnancies and newborns; investing in school and community-based health; creating an objective, trusted source of consumer health information and education; providing support, coaching, and incentives to change unhealthy behaviors and encourage healthy choices are all important and all upstream from the medical care system that we now provide and a realm that we know we need to expand into.

We are all in this together, yes, both the medical system and the public health system, and we are needed if we are to generate that epidemic of health or if we are ever to achieve truly accountable health communities. This is where research can play a big, big part; not just public health research and not just medical research, but collaborative health research. We need to know the most effective collaborative models to pursue; the right timing and mix of population and patient health interventions; the most effective ways to advocate for greater personal and community responsibility side by side with the right system changes and accountability mechanisms; the right measures and indicators that will shine the brightest light on system failures and on system successes, so we know where to put future investments; and we need to know what's the best mix of funding of investments and incentives to drive all of these changes. As we work together toward an integration of public health and patient care into ongoing sustained population health, what policy and implementation potholes do we need to avoid?

I believe it is important to understand that like public health agencies, hospitals come in all shapes and sizes with vastly different resources. We have started and grown according to many different factors and incentives, and hospitals exist within very different community contexts. I do believe that there is no "typical hospital." We must recognize that significant differences exist and build on that as an opportunity. Case in point, the tax-exempt portion of my membership is under new expectations from the IRS to do community health needs assessments, a good thing. We are to collaborate with others across the community, including public health, a good thing. But the fact is that the variety of circumstances in context means that we have to go about those in ways that are most appropriate in each community, which is a good thing, because

we will learn a lot more from all of those different experiments and trials and experiences from which we can then identify down the road what works best. We look forward to that collaboration and we look forward to that experimentation to see how we can move forward together fastest and most effectively.

We have lots of challenges and opportunities together. I think that we also have lots in common, not the least of which are the citizens of our respective service areas who look to both of us for leadership, for greater collaboration, for greater efficiency and more value on either their premium dollar or their taxed dollar. I look forward to working more closely than ever before, to getting rid of those bright lines to the extent they still exist and to focus together on population health. I extend that welcome and opportunity on behalf of the nation's 5000 hospitals and health systems so that together we can truly design a real continuum of services that best meet the needs of our communities. Together we can spot health anomalies at the community level. We can look at the maybe better utilization of resources across the community settings, and we can set about addressing them effectively together. We will not only make the best use of limited resources, we will save lives, improve lives, and improve whole communities. I look forward to more opportunities to work with you.