An Argument for the Integration of Healthcare Management With Public Health Practice

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As the U.S. healthcare system anticipates the requirements of legislated healthcare reform, front and center is the challenge of improving the U.S. healthcare value equation—the need to improve the value received for the health dollar spent.

As is often the case, the psychology of change is at play here, whereby humans turn to what they know best as a response. As many health system leaders face the uncharted waters of U.S. reform and related downturns in service utilization, pressured reimbursement levels, and restrictive access to markets, managers’ responses often return to the familiar calls to action:

- Enhance operating efficiencies
- Reduce case costs
- Implement more standardized clinical protocols and evidence-based best practices
- Add provider-side integration (hospitals and physicians)
- Step up marketing to improve penetration of historically profitable clinical markets (e.g., cardiovascular, orthopedics).

While such responses are important and helpful, the missing factors in this set of solutions may be time-tested principles of public health practice, which leads to the central thesis of the argument presented here: the need for U.S. healthcare systems to adopt useful principles and models of public health practice as new core competencies for health system management.

IF YES, WHY NOW?

Historically, healthcare administration has largely existed to manage the business of “illness services” delivery, principally one patient at a time. Public health practice, on the other hand, has sought to protect and manage the well-being of populations, with a focus on such basic services as clean water, safe food, disease surveillance, disease prevention, and the epidemiology of various factors and environmental conditions.

To be sure, these disciplines have been necessary and complementary to healthcare delivery, especially when disease affects the individual and the population at the same time under such conditions as epidemics.
Now, however, a constellation of market and policy factors and conditions has created a need for the integration of complementary disciplines through the adoption of useful principles of public health practice by healthcare providers (and health systems) to enhance the U.S. health services delivery value equation.

What arguments can be made for integration at this time?

- An undeniably unaffordable U.S. health cost inflation rate
- Rankings for U.S. healthcare in worldwide outcome measures that land at the 30th position or lower among developed countries (Robert Wood Johnson Foundation, 2009)
- An economic model that rewards doing more regardless of outcomes
- A consumer who is virtually blind to real costs and quality
- A clinical education and delivery model that recognizes the next physician involved with any patient as the “captain of the ship,” whose mandate is to do all possible at the moment of care on the basis of an interpretation of the presenting clinical facts and circumstances as encountered.

Enter the demands for the enhanced value equation—demands that do, and should, fundamentally transmogrify our existing approach to health services organization and care delivery:

1. The acceleration of consolidation and integration on the provider side of the field (hospitals and hospital systems with physicians and other components of the delivery system)
2. The consolidation and transformation of the payer side (the insurers of commercial and governmental healthcare) toward seeking to transfer financial risk for covered populations to the provider side
3. Large, sophisticated health systems seeking to “lock in” defined populations through the assumption of financial risk, which will carry with it the assumption of the health risk of populations under contract
4. A need to engender the customer and brand loyalty of populations that will likely remain free to move from health system to health system (Zismer, 2012)

So, how do principles and models of public health practice factor into the future picture as painted, and what is the likelihood that the health value equation can be enhanced?

Public health practice offers a guide for the healthcare leader to integrate new competencies with the traditions of health administration education, training, and practice in ways that have not been valued until, perhaps, now. Such competencies include the following:

1. Population health surveillance, evaluation, and risk quantification and stratification—the understanding of how a specific population (under contract)
is likely to manifest acute and chronic disease and how such conditions “load” onto health systems’ delivery capacity (create demand) under evidence-based, clinical best practices

2. Total-cost-of-care management—the evaluation (and valuation) of how a health system’s approach to the treatment of acute and chronic conditions compares with others and how these costs influence the terms and conditions of financial contracts with parties that aggregate lives and transfer risk (the insurers)

3. The social psychology of health and health behaviors—the understanding of how specific populations can and do behave under various real and perceived environmental, psychological, and economic conditions that affect health and health behaviors, including social determinants of health

4. Social engagement—the conditions that bind people to each other and to social (and health) conditions; the opportunities to create health system loyalties, which is an essential first step in managing longer-term health behaviors

5. Health informatics—the ability to formulate useful population health and managerial questions that are answerable from readily available descriptive clinical and populations data

6. Health intervention modeling and predictive forecasting—the ability to build useful theoretical models to test the potential for required returns on future clinical and related programmatic investments

7. Working from interprofessional team models of care management—the design, education, and application of interprofessional teams to effectively manage total care, over time, for specific clinical populations “attributed” to health systems by third-party payer agreements

While the above is not an exhaustive list, these competencies provide a starting point for managing the reform transition.

Skeptics may respond: “We do that now.” If so, maybe the important question is one of degree. Many, if not most, U.S. health system leaders would be hard-pressed to argue that such competencies are currently considered core management capabilities and strategies of the systems they lead.

What do others say? John Finnegan Jr., PhD, dean of the School of Public Health at the University of Minnesota, comments:

Intentionally or not, we [the U.S. health system] crafted incentives to provide excessive treatments irrespective of the evidence for effectiveness or improved outcomes. At the same time, we starved the upstream approaches of public health that address the conditions shaping the “big picture” of health in the first place. As the Institute of Medicine recently reported, the U.S. public health system has been chronically under developed and underfunded compared to its counterparts among the richest nations.

Frank Cerra, MD, McKnight Professor of Surgery and former dean of the Medical School and vice president of the Academic Health Center at the University of
Minnesota, is directing a sizable portion of his professional efforts to the development of the field of interprofessional teams and teamwork in healthcare. Cerra says:

For the U.S. healthcare system to achieve the goals defined by the Triple Aim [strategic initiative of the Institute for Healthcare Improvement], disruptive innovation is required. The foundation on which we have built healthcare delivery (including our educational models and methods) must change. There needs to be a shift to the prominence of interprofessional teams. To be effective with the design and application of interprofessional teams will require the integration and effective application of lessons learned and competencies developed within the disciplines of public health practice. The innovation that will result will be practical, economic, and generalizable across systems of care.

Ken Paulus, CEO of Allina Health in Minneapolis, Minnesota, believes in the concept of interprofessional teamwork to the point of changing his health system’s name and brand promise:

Until late 2012, we were Allina Hospitals and Clinics, which was reflective of our organizational design, not our vision or mission. We were a collection of what we assembled—hospitals and clinics. Our name has now changed to Allina Health, which is an appropriate description of the business we’re in and the organizational development path we’re on. We are in the health business. With this transformation we are acutely aware of what we need to learn, and much of our internal competencies development journey will take us directly to the world of population health and total-cost-of-care management as well as better understanding of the design and management of health status interventions focused on populations, including larger-scale community health intervention strategies.

Today our organization is investing considerable resources in the acquisition and practical applications of public health practice competencies. As important will be how those competencies blend with our history of being in the “illness business” to shape our mission and strategy going forward.

Peter Person, MD, CEO of Essentia Health, a multistate, integrated system of care based in Duluth, Minnesota, discusses his perspectives on the future of management competencies for his health system:

I have concluded that given the direction and speed of change in healthcare delivery and financing in the United States, it is (or at least will be) impossible to effectively manage health services delivery without efficient access to reliable information and analytics that deliver actionable [knowledge] of how we are (or are not) managing the health status and healthcare use behaviors and patterns of those we serve. Our system serves hundreds of thousands of patients annually across largely rural communities situated within a wide and ranging geography. Many of these communities are aging, slow- or no-growth markets. In most, three payers dominate: Medicare, Medicaid, and one commercial payer. We have a growing proportion of our operating revenue base at risk. As a consequence, we will require the availability of population-based information supported by analytics to understand our quality, outcomes, and care delivery practices and the over-value received by patients and communities per health dollar consumed.

It is clear to me that even at our size and scale it is impossible to “home-grow” the internal competencies, infrastructure, and processes required to meet these demands [in
a timely way]. This conclusion begs the important question for our health system: If the competencies we’ve discussed are required and we can’t home-grow them, how do we find them, integrate them, and apply them with sufficient speed and affordably? This question has risen to the top of our board-level discussions. An answer to the question is central to how we proceed as a health system responsible for and accountable to communities.

CONCLUSION

To this point in the development of healthcare delivery in the United States, the integration of principles of healthcare management and public health practice has spawned interesting discussion and debate but little effort.

With the healthcare reform mandates as they are envisioned today, coupled with conditions of a long-recovering U.S. healthcare economy, the clinical and business models of the healthcare system will necessarily change. The result is likely to be fewer, larger, regional and national health systems with “tighter” financial relationships and fewer, larger health insurers that will drive the need for health systems’ importation of management competencies that have heretofore not been evident in or, for that matter, useful to health systems. If the thesis presented here plays out, the implications for the future of educational models for the health professions are profound.

Critics of the thesis might respond with: “Financial margins are thin and getting thinner. We can’t afford to add overhead to our operating cost structure. Who will pay for new staff with competencies as described?”

These competencies should not be judged as overhead. Rather, they must be seen as essential to the success of health systems and their care delivery clinical and business models moving forward.

REFERENCES
