INTRODUCTION: MANAGING "BEYOND THE WALLS"

The purpose of this book is to use the analysis of practical cases to educate health-care leaders about managing the health of populations and communities. Historically, healthcare executives have been taught how to lead and manage *within* their organizations, with minimal attention to external relationships. However, in today's health landscape—with evolving payment models and growing recognition of the importance of social determinants—this kind of internal orientation is no longer sufficient. The ability to manage "beyond the walls" of the institution has become essential to the success of any healthcare leader.

Today's healthcare leaders must understand the communities they serve, the special populations for which they assume risk, and the other organizations along the continuum of care that provide or pay for services. The cases in this book emphasize the application of healthcare management principles and skills across institutional boundaries to effectively manage the health status of a population or community.

Defining *Population Health*, *Community Health*, and *Public Health*

The concepts of population health, community health, and public health are closely intertwined, but the terms are not synonymous. An important task for a healthcare executive is to understand the distinctions between the terms and the implications for effective management.

Although consensus on these terms' precise meanings is lacking, this section will propose definitions to be used in analyzing the book's cases. We offer these definitions with the understanding that good managers will see beyond the verbiage to analyze situations and propose realistic and measurable approaches based on the desired goals and objectives. Regardless of the phrasing, common management principles apply.

Population Health
Kindig and Stoddart (2003, 381) defined *population health* as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group, and the factors affecting those outcomes." This definition has been adopted by the National Academy of Sciences Roundtable on Population Health Improvement (2019).

The concept of population health implies both a measurable numerator and a measurable denominator, and it incorporates the ability to measure changes over time. Populations can be subgroups within communities, can encompass multiple communities, or can cut across community lines.

Population health management is a more explicit term that describes active interventions to control the health status or healthcare utilization of a defined and identifiable group of individuals. For example, a managed care company might have a population health management program in which it provides all of its members who have a diagnosis of diabetes with a cellular phone loaded with an app that sends daily reminders about monitoring their hemoglobin A1c level (and perhaps even reports the results to the doctor's office automatically). The company would have the denominator of all enrollees, the numerator of all enrollees with a diagnosis of diabetes, and a way of monitoring the health status of the individuals with the app. It would therefore be able to determine whether the app made a difference in utilization of healthcare services or in the long-term health status of individuals or the aggregate population.

Community Health

Community health is a much broader term than *population health*, and it can be ambiguous. For the purpose of these cases, *community health* can be defined as the health of a group of individuals who share a bond of geography, culture, race, ethnicity, language, sexual orientation, pastime passion, or another common characteristic (Merriam-Webster 2019).

In many instances, community health offers no ability to measure either the denominator or the numerator. As a result, the success of a community health initiative in attaining its goals and objectives can be hard to demonstrate—which can be a challenge when trying to secure institutional commitment or resources for an intervention. Regardless, improving the health of populations and individuals requires improving the health of the communities in which they reside.

An example of a community health program might be a booth at a health fair at a local Catholic church at which a home care agency provides free screening for diabetes. The agency might have selected this approach because it knows that many members of the parish are Hispanic and that Hispanics have demonstrated high rates of diabetes and undiagnosed diabetes. The agency would have no idea how many people saw notices about the health fair (other than estimating based on the parish's total membership or the fair's total attendance), but it would have a record of how many people it screened and how many tested positive. Hopefully, the agency would also know how to contact those individuals whose test results called for active follow-up.

Public Health

Charles Winslow (1920, 30) defined *public health* broadly as "the science and art of preventing disease, prolonging life, and promoting physical health and efficiency"

through organized community efforts and informed choices of society, organizations, communities, and individuals. In this book, we will use the phrase *public health* in the specific context of the public health structure of the United States.

The US public health system includes a number of government agencies that have been created to fulfill the provisions of public health legislation and to carry out the government's role in safeguarding the public. This bureaucracy includes the Centers for Disease Control and Prevention, a federal agency; departments of health for every state and territory; and local health departments (LHDs). Funds for essential public health functions flow from the federal government to states and from states to local agencies.

Most health departments serve a designated geographic area, with all residents of that area considered to be the department's responsibility. For program purposes, the denominator can usually be regarded as the number of residents of a department's geography, based on the most recent census count. However, complications arise when public health programs affect residents in adjacent areas or do not reach all residents within the designated area.

An example of a public health approach to diabetes control might involve a local radio broadcast of a series of public service announcements (PSAs) that encourage women who are pregnant and have certain symptoms to be screened for gestational diabetes at their LHD or by their own physician. The LHD would know the total number of people in its catchment area, and it might also keep count of the number of new pregnant patients who come to the department's clinics for screening within a given period after the PSA broadcast. However, the LHD would not know the total number of pregnant women in its catchment area, the number of people who heard and remembered the announcement, or the number of women who were screened—unless it made a special effort to gather such information.

Overlapping Functions

As is evident from these examples, public health, community health, and population health programs often overlap, with multiple interventions reaching the same individuals. Conversely, public health, community health, and population health programs may occur simultaneously, with similar long-term purposes, yet remain distinct—for instance, by sending out different messages about the same condition or having different interventions aimed at the same long-term outcome.

The federal government and various private organizations have made great strides in setting up databases that collect evidence about the impact of certain interventions for specific populations (see, for example, the Community Guide, at www.thecommunityguide.org). The task of the healthcare executive is to sort out which programs apply to which target audiences and for what short-term and long-term outcomes. Ideally, health promotion programs and population health management interventions can then be organized to complement rather than compete with one another. Desired improvements in the health status of the community can be better

achieved and sustained by collaborative efforts than by individual programs, and use of resources can be maximized.

Whether a program is considered "population," "community," or "public" health, common managerial principles apply. This book aims to provide a foundation for understanding why and how to apply these principles "beyond the walls" of a single organization.

Trends

Several disparate trends are converging to amplify the importance of community and population health to the field of healthcare management. A critical underlying premise: Each of these factors plays out differently from one community to another, and thus no single way of managing will be universally appropriate. Understanding the key overarching concepts and developing the ability to apply them locally are essential for a healthcare executive's success.

The concept of the Triple Aim—first introduced by the Institute for Healthcare Improvement (IHI) in 2007 (Berwick, Nolan, and Whittington 2008)—has brought increasing attention to the health status of populations. The three components of the Triple Aim are cost, the patient experience of care, and population health (IHI 2019). The purpose of the Triple Aim is to convey, in easily repeatable terms, the three different spheres that need to be addressed to make the nation's healthcare system effective and sustainable. Whereas experts in healthcare management and policy (HMP) have long been familiar with the challenges associated with cost and quality, the inclusion of population health as part of the troika was a new development that helped bridge HMP with knowledge that had been generated in the field of public health. Healthcare executives gained a better understanding of the impact of the community on individuals' health.

A related trend involves the growing recognition of the degree to which social determinants of health (SDoH) shape an individual's health status. The field of public health has spent decades compiling concrete evidence about the health effects of factors external to the individual. Today, it is often said that people's zip codes are as important to their health as their genetic codes, reflecting the growing acknowledgment of the health impact of "where one lives, learns, works, plays, and prays." As these factors are increasingly taken into account, interventions to improve health status have expanded beyond the one-on-one patient–provider relationship to target broad communities and specific population groups. A definitive statement on the SDoH has been provided by the World Health Organization (WHO 2019).

In addition, ongoing efforts to control healthcare costs at the national level have led to new and revised payment models. The use of bundled and capitated payment models, as well as links of payment to performance, have further brought the healthcare status of populations to the forefront. Many of these models incorporate funding based on populations rather than on care for individuals, as well as payment for a set

of services rather than distinct fees for itemized procedures (Centers for Medicare & Medicaid Services 2019). The capitated systems of the health maintenance organizations (HMOs) of the 1970s and 1980s, which gave hope for more efficient use of resources, are being revisited, with a focus on revising rules to ameliorate the flaws that haunted the earlier HMO models. Some risk-adjusted payment models require that providers and payers consider a target audience of communities or populations rather than individuals. The movement toward population-based health is not limited to the United States; it is also global (Aaronson et al. 2019).

The concept of *quality* continues to evolve as an essential, distinct, measurable component of healthcare, with population health now recognized as a key aspect. The National Committee for Quality Assurance (NCQA 2018) has launched a new certification on population health management.

Finally, information systems have expanded, big data have become more readily available, and the science of informatics in healthcare has grown into its own specialty. Information systems and the accompanying technologies enable individuals to track their own data and institutions to compile these data. Hospitals and physicians have implemented electronic health records that record detailed patient information over time, and health and health-related agencies throughout a community have agreed to share data that enhance the quality of patient care. Data are now available, as never before, to understand the health of communities and to manage the health of population subgroups.

Using This Book

The case study approach in this book is based on pedagogical principles applicable to adult learners. The guiding theory is that adults learn more by analyzing problems, finding data, applying management theories, and proposing solutions than by having information dictated to them. The cases in this book present opportunities for students of all healthcare disciplines who take management courses, or for healthcare executives, to analyze real-world situations, find and apply data, and pose practical approaches to address the issues presented. Challenges and solutions should be supported with data. No single answer is expected. Critical thinking and robust discussion are desired.

Competencies and Learning Objectives
The overarching theme of the cases is the application of generic management skills to the healthcare system in the United States. Cases are intended to arm students with practical skills—identified here as *competencies*—as well as didactic knowledge, or *learning objectives.*

The learning objectives are broad in scope and might emphasize acquisition of didactic knowledge as a prerequisite or foundation for application. The competencies are drawn from those prioritized by health professions accrediting agencies, including the Council on Education for Public Health (CEPH), the Commission on Accreditation

of Healthcare Management Education (CAHME), and the Certified Health Education Specialist (CHES) credentialing body.

The cases can be distinguished from other forms of healthcare management literature in that they present a healthcare system that extends beyond the walls of a given organization, encompassing all of the service providers, payers, and coordinating health and social service agencies in a community and extending to the social determinants of health.

Instructors teaching these cases can adapt them to meet the accreditation requirements, pedagogical frameworks, or syllabus templates applicable to their individual program or institution. The learning objectives identified for each case should be useful regardless of which framework or accreditation body governs a given program. From an applied perspective, good management skills are equally relevant to all disciplines.

Overall, the cases in this book are intended to help students master the knowledge and skills needed to do the following:

- Characterize the residents of a community.
- Analyze the components of the healthcare system of a community, which includes identifying stakeholders.
- Apply fundamental management skills to community and population health; such skills span the areas of strategic planning, human resources, information systems, finance, marketing, communications, and project management, among others.
- Define and differentiate *community health*, *population health*, and *public health*.
- Apply the social determinants of health and Ecological Model of Health concepts.
- Analyze the health status of a defined population.
- Guide the conduct of a community health needs assessment.
- Develop a community health improvement plan.
- Assess the power structure of a community.
- Contrast collective impact with collaborative and individual initiatives.
- Evaluate the roles of state and local public health departments in influencing the health status of a community.
- Measure change in the health status of a community or population over time.
- Evaluate the impact of specific interventions on the health status of a population over time.
- Analyze the financial implications for healthcare institutions of managing the health of a defined population.
- Explain the information systems necessary to monitor and manage the health and service utilization of a population across settings and over time.
- Differentiate the methods to influence the health of a defined population from the methods to influence the health of a community.

- Contrast care of an individual patient by a single provider with care provided by a comprehensive continuum of care.
- Analyze a communications strategy designed for a specific target audience.
- Evaluate the effectiveness of communications techniques designed for population health management.
- Specify the elements essential to sustaining a community or population health program over time.
- Analyze the business case for a health organization to be involved with its community.
- Analyze the business case for a health organization to be involved with managing the health of a defined population.

Each of the book's cases presents an *overarching theme*—however, this theme should not preclude students from exploring other related topics.

The Cases

Each case is a stand-alone example of a real-world situation, and each requires understanding of a target audience and stakeholders, analysis of the problem(s), a search for relevant data to inform the issue, critical thinking to identify action options, and criteria with which to make decisions. An evidence-based approach includes projecting SMART objectives—that is, objectives that are specific, measurable, attainable, relevant, and time bound—and evaluation with measurable targets of success.

Each case is framed with a *management challenge*. Students are asked to respond to a specific task, drawing from the background information presented. However, many secondary topics are woven into the cases, proffering opportunities for students to pursue additional information about health conditions, target audiences, or management applications. Lists of questions—consisting of fact and data analysis questions as well as discussion questions—are provided at the end of each case. The questions, which are intended to spark analysis and exploration, can be supplemented based on students' interests and the pedagogical approach of the course or curriculum.

The cases present a three-dimensional matrix of management skills, health topics, and population subgroups. Management skills essential for healthcare are the primary focus of the book. Not all salient health topics or population subgroups are included. Readers are encouraged to be thorough in analyzing the problems important for every community and to be creative in finding ways to solve them.

Timeliness and Ethics

The cases in this book represent both real-world communities and organizations and ones that are fabricated but based on the authors' real experience. All real organizations have given permission to have their information included. We ask for readers' appreciation for the sensitivity of information, both that which is presented here and that which can be found on the internet or via other sources. If information has changed

or a community context has evolved, readers can regard such developments as part of real-time management, and they can modify the case accordingly.

Similarly, to emphasize the importance of acting on evidence, we have sought to provide data in both hard and fluid formats. Although we have tried to include information that will remain accessible via the internet, it is possible that, over time, some information might cease to be available. We apologize if this occurs. Our hope is that students and instructors will be able to find new and updated data and real-time cases that present similar histories and provocative futures.

The underlying purpose of this book is to apply management concepts to contemporary healthcare problems, thereby pushing the field to embrace community and population health while maintaining excellence in providing services for individual health. Although this shift in perspective can be challenging, we hope these cases will make the change meaningful and rewarding.

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Instructor Resources

This book's Instructor Resources include teaching tips for cases; assignments, both individual and group, for each case; definitions of key terms; and a sample syllabus.

For the most up-to-date information about this book and its Instructor Resources, go to ache.org/HAP and browse for the book's title, author name, or order code (2402).

This book's Instructor Resources are available to instructors who adopt this book for use in their course. For access information, please email hapbooks@ache.org.