NO OUTCOME, NO INCOME

Population-health adherents want U.S. medical providers to swap volume for value in gauging success — and in setting compensation

Jeffrey G. Harris, MBA & Richard A. Skinner, PhD

After 37 years as a board-certified internist, the past 30 in academic medicine, David B. Nash, MD, MBA, is confident he knows what's wrong with the United States' beleaguered healthcare delivery system.

"Unexplained clinical variation — *that's* the root of all evil," says Nash, founding dean emeritus of Jefferson University's College of Population Health in Philadelphia. "You have to reduce unexplained clinical variation."

Ah, but of course.

Just one question, Doctor: *Huh?*

Too often, Nash says, clinicians address "one patient, one problem, one at a time" — with little or no regard for (1) the long-term efficacy, safety, or cost of a given drug or procedure, (2) the measures taken by other providers involved in the patient's care, and (3) the emotional, economic, and environmental factors that shape a patient's overall wellbeing (and may affect the patient's ability to adhere to a treatment regimen).

Nash says physicians' failure to step back and look at the big picture, coupled with their spotty adherence to data-validated best practice, contributes to considerable waste — as much as $935 billion a year, or roughly 25 percent of all U.S. health spending — and exposes patients to unnecessary risk.[1]

Nash doesn't ascribe any sinister motives, however, noting instead that most providers simply aren't trained or incentivized to do otherwise. Indeed, he says, fee-for-service providers face a "pernicious imperative to do more" — to schedule more office visits, to order more tests, to perform more procedures, to prescribe more medications.

Consider the pertinent "vital signs": In 2018, the most recent year for which data are available, U.S. healthcare spending increased by 4.6 percent to $3.6 trillion — or $11,172 for every person in the country.[2] That's 17.7 percent of the nation's gross domestic product, the highest such figure, by far, in the developed world.[3] Americans' average life expectancy, meanwhile, declined for the third straight year.[4]

If Nash is right about the problem, what's the solution?

"We have the answer to the riddle," Nash said in a just-released episode of the podcast *Innovators*. "It's all about realigning economic incentives to reduce unexplained clinical variation and to coordinate care to achieve the best outcome, at the best price."

More specifically, Nash wants to train and incentivize clinicians to monitor and improve the health of designated, similarly situated populations, paying particular attention to (1) the efficacy, safety, and cost of any drugs prescribed or procedures ordered, (2) the measures taken by other providers involved in the patients' care, and (3) the emotional, economic, and environmental factors that shape the patients' overall wellbeing. In other words, he wants them to *start* doing all the things he's convinced they're *not* doing now.

LISTEN IN

David B. Nash, MD, MBA, founding dean emeritus of Jefferson University's College of Population Health, explains his school's namesake science in the latest installment of the podcast *Innovators*. The audio series, presented by Harris Search Associates, is available on the web at harrisandassociates.com and on leading podcast platforms such as Apple Podcasts, Libsyn, Google Podcasts, Stitcher, and Spotify.

If Nash is correct about the problem and the solution, how can the appropriate corrective strategy be incorporated into the nation's healthcare delivery system?

Uh-oh. Cue the screeching-brake sound effect.

Unfortunately, that's the toughest part of the equation. As is often the case in medicine — and as Nash knows all too well — diagnosing a malady and mapping out an appropriate treatment regimen are not tantamount to *curing* it.

Nash, nevertheless, has devoted the bulk of his long career ("I'm now one year away from Medicare," he notes) to accomplishing all three.

'Solo practice' gets company — *finally*

At times, he has found it a lonely pursuit.

When the Jefferson College of Population Health was established in 2008, it was the only U.S.-based school of its kind. [5] It retained the distinction until 2016, when at least three universities — the University of New Mexico, the University of Mississippi, and the University of Toledo — established schools or colleges dedicated to population health. [6,7,8]

A study published last year in the journal *JAMA Network Open* identified "population-focused" departments at 15 U.S. medical schools. [9] Put another way: More than 90 percent of the nation's medical programs *don't* have such a department.

Nash suggests that some of the individuals and institutions that shape American healthcare — both inside and outside academic medicine — still harbor misconceptions about population health and what distinguishes it from, say, the older, better-understood field of *public health*. (Make no mistake: Nash is huge fan of the latter. "The public health community has made a huge contribution to improving the health of the population," he told *Innovators*. "Let's think about things like vaccinations, clean water, hand washing, AIDS reduction, obesity reduction, smoking cessation, bicycle helmets. I mean, these things have done more to improve health than all 150 medical schools in the United States put together.")

In Nash's view, public health is essentially one piece of the larger population-health puzzle — the other pieces being the cost, safety, and efficacy of a given treatment (or preventive measure) and the factors that contribute to the overall wellbeing of a given individual (or demographic group).

Nash groups those factors — "determinants" in the parlance of population health — into several broad categories: individual behavior, which he believes accounts for 40 to 50 percent of a person's or population's relative health; physical and social environment, 20 percent; genetics, 10 to 20 percent; and medical care, 10 to 20 percent. (To state what may be obvious, the order of the determinants in the foregoing list wasn't arbitrary; as far as Nash is concerned, medical care should be listed last because it *is* the least.)

"The main message that we find difficult for practitioners to get their arms around is that it's not about coming to the doctor or the hospital," Nash told *Innovators* host Richard A. Skinner, PhD. "Quite the contrary. Health is determined by a sort of witch's brew of behavior, Mom and Dad, climate change — 'all of the above.' The actual laying on of hands — healthcare services — contributes only 10 to 20 percent of a population's wellbeing.

	Conventional Healthcare	-VS-	Population Health
Purpose	■ Cure disease		■ Prevent disease ■ Keep people healthy and well
Values	■ Diagnosis, treatment and cure ■ Physician's expertise ■ Unlimited access to healthcare — if you can afford it		■ Disease prevention ■ Emphasis on wellness ■ Timely, high-quality, cost-effective care ■ Agency and self-efficacy ■ Coordinated care/medical home
Methods	■ Diagnosis and treatment ■ Fee-for-service		■ Personalized wellness plans ■ Community engagement and prevention ■ Global payments ■ Shared health information
Constraints	■ Cost ■ Continuity of care ■ Lack of access ■ Administrative burdens ■ Limited patient contact		■ Implementation cost ■ Politics
Opportunities	■ Greater autonomy		■ Cost effectiveness ■ Evidenced-based, personalized medicine ■ Increased quality/error reduction
Assumptions	■ System "rescues" patients ■ Doctor is center of authority		■ Patient is responsible for health/wellness ■ Doctor is center of care team

Thomas Jefferson University College of Population Health

"So, how do we teach practitioners and clinicians of all sizes and shapes to deal with the other 80 percent?"

Nash said the pushback from clinicians, especially physicians, is all too predicable: *That's not my job; I'm not a social worker.*

"We get that," Nash said, repeating his standard counter, "but the reason the patient isn't taking the medicine you prescribed is that (1) they can't afford it, (2) they don't own a refrigerator, and the medicine has to be refrigerated, and (3) there's a real strain on them to comply because your office is not accessible by public transportation."

Clinicians, however, "have not been trained to even *understand* the social determinants and their role in improving health," Nash said. "So, we have a big, big challenge."

Doctor seeks to ditch 'heads and beds'

Big challenges call for grand solutions, and some of Nash's ideas are indeed grand.

First, he'd like to change, once and for all, the manner in which physicians and other clinicians are compensated. Specifically, he'd shift from a fee-for-service payment system — "heads and beds," as he puts it — to an outcome-based payment system.

The 'other' vital signs

Population-health proponents maintain that vital signs and other traditional measures of health offer only a narrow window into patients' overall wellbeing. To get a complete picture, they say, clinicians should consider a long list of "health determinants," including socioeconomic status, education, housing, race, ethnicity, family history, diet, social interactivity, personal hygiene, exposure to crime, familiarity with emerging technology, access to transportation, and proximity to fresh produce and other wholesome foods.

"You ought to get paid more when you achieve a better outcome, and you ought to get paid less when you achieve a less-appropriate, less-good outcome."

In 2010, displaying a flair for marketing as well as medicine, Nash condensed his argument into a catchy, four-word slogan: "No outcome, no income." ("It *is* true that I got an 'A' in marketing at Wharton but barely passed organic chemistry.")

Nash is the first to acknowledge, however, that wholesale acceptance of the kind of change he's advocating will require more than a memorable bumper sticker.

"Making that switch to really function in an integrated delivery system that's driven by aligning economic incentives takes a different kind of doctor," he said. "My own selfish view is that you've got to tear up the undergraduate medical school curriculum and start over" — by incorporating subjects such as humanism, design thinking, and human-factors engineering.

"If I had my way, no basic science majors would be admitted to medical school because we can teach them all the science that they need. Bring me people who can think, and analyze, and write, and be critical thinkers. That's the skill set that we need."

Although he and other population-health disciples are battling what sometimes feels like stage-four intransigence, Nash remains hopeful, even optimistic. As a practical matter, he doesn't think that the "holdouts" have any choice but to alter their approach to healthcare — *eventually*.

The final question on the table — or, perhaps more fittingly in this case, the *operating* table: When?

Better to close the faucet or mop the floor?

It's not as if the thinking behind population health is new. Although the term itself didn't show up in medical literature until 2003, when David Kindig, MD, PhD, and Greg Stoddart, PhD, coined the phrase, the underlying concept has been part of the national dialogue for more than 50 years.[10]

Nash said managed care showed its potential from 1990 to 2003, when the emergence of capitation — an arrangement in which providers receive fixed per-capita fees rather than service reimbursements — "bent the cost curve." The enactment of the Affordable Care Act, or "Obamacare," in 2010 represented another step in the right direction, at least in terms of extending healthcare to previously uninsured (or uninsurable) Americans, he said.

"We were able to get millions of Americans increased coverage and access to care," he said. "Did that improve health? Undoubtedly, yes, based on the best available literature from multiple sources around the country."

Unfortunately, Nash said, population health has suffered setbacks, too, thanks in part to the unfounded belief that capitation — personified in "the big, bad insurance company" — prevents physicians from ordering treatments and medications that could save lives and ease chronic suffering. Nash also bemoans the ongoing campaign to dismantle the Affordable Care Act.

"If you believe in social justice, if you believe that access improves health, if you believe that access to care is a human right, then, sadly, efforts to dismantle Obamacare go against all of the higher-value work that has been accomplished in the last decade," he said.

"I think the presidential election is going to crystalize our view — one way or another — on the future of the Affordable Care Act."

Regardless of the outcome of November's vote, Nash isn't going anywhere. He said he still has enough "gas in the tank" to continue the fight for fundamental reform — to continue to promote the philosophy behind "No outcome, no income."

"It's all about moving from a world of 'the more you do, the more you get paid' to a world of going upstream and shutting off the faucet instead of downstream and mopping up the floor," he said. "If we could be guided by a no-outcome, no-income way of thinking, I think it would reduce profligate testing, reduce waste, reduce harm, and refocus us on what it is that we're in the business of doing in the first darned place." ■

References

1 Shrank WH, Rogstad TL, Parekh N. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." JAMA. 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978.

2 Hartman, Micah, et al. "National Health Care Spending In 2018: Growth Driven By Accelerations In Medicare And Private Insurance Spending." Health Affairs, 5 Dec. 2019, www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01451.

3 Woolf SH, Schoomaker H. "Life Expectancy and Mortality Rates in the United States, 1959-2017." JAMA. 2019;322(20):1996-2016. doi:10.1001/jama.2019.16932.

4 "NHE Fact Sheet." National Health Expenditure Data, Centers for Medicare and Medicaid Services, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

5 "10 Things to Know about the Jefferson College of Population Health." Becker's Hospital Review, 27 Aug. 2015, www.beckershospitalreview.com/population-health/10-things-to-know-about-the-jefferson-college-of-population-health.html.

6 Haederle, Michael. "UNM College of Population Health Dean Named." UNM Health Sciences Center, 22 Feb. 2019, hscnews.unm.edu/news/new-dean-UNM-college-of-population-health. https://www.umc.edu/SoPH/About-Us/Overview.html.

7 Beech, Bettina M. "Dean's Message." About the School of Population Health, University of Mississippi Medical Center, www.umc.edu/SoPH/About-Us/Overview.html.

8 McCray, Vanessa. "New Schools' Names OK'd to Go before UT Trustee Board." Toledo Blade, 16 Aug. 2016, www.toledoblade.com/local/education/2016/08/16/New-University-of-Toledo-schools-names-OK-d-to-go-before-trustee-board/stories/20160815279.

9 Gourevitch MN, Curtis LH, Durkin MS, et al. The Emergence of Population Health in US Academic Medicine: A Qualitative Assessment. JAMA Netw Open. 2019;2(4):e192200. doi: 10.1001/jamanetworkopen.2019.2200.

10 Kindig, David, and Greg Stoddart. "What Is Population Health?" American Journal of Public Health, National Institutes of Health, Mar. 2003, www.ncbi.nlm.nih.gov/pmc/articles/.PMC1447747/.

About Harris Search Associates

Harris Search Associates is a leading global executive search and talent advisory firm. Established in 1997 by Jeffrey G. Harris, the firm focuses on the recruitment of senior leaders to support the growth of the foremost universities, research parks, institutes, national laboratories, academic health centers, hospital enterprises, and organizations driving global innovation and discovery. Based in Dublin, Ohio, a suburb of Columbus, Harris Search Associates maintains regional offices in Dallas and San Francisco. The firm is a shareholder member of IIC Partners, one of the largest global retained executive search organizations, with 47 offices in 32 countries.

About the *Innovators* podcast

The Innovators podcast features timely conversations with global thought leaders in the areas of higher education, research, engineering, technology, and the health sciences. The audio segments, which give listeners an opportunity to learn from national leaders who are changing the landscape of innovation and discovery, are available on the web at **harrisandassociates.com** and on leading podcast platforms such as Apple Podcasts, Libsyn, Google Podcasts, Overcast, Stitcher, and Spotify.

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