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Population Health Management: An Approach to Improve the Integration of the Health Care and Public Health Systems

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In a country that needs more rural physicians, the 26.1% of sponsoring institutions that are producing no rural physicians are providing a low return on investment.¹ Themes of accountability within medical education have been around a long time, but we seem to have made fitful progress. Could the overt measurement of cost and value make us realize that we now need to make more rapid progress?

Disclosures: None reported.

Kieran Walsh, FRCPI

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- 3 Williams C. Understanding the essential elements of work-based learning and its relevance to everyday clinical practice. *J Nurs Manag.* 2010;18:624–632.
- 4 Levin HM, McEwan PJ. *Cost Effectiveness Analysis: Methods and Applications*. 2nd ed. Thousand Oaks, Calif: Sage Publications; 2001.

In Reply to Walsh: I fully agree with Dr. Walsh's comments that cost is an essential element of public accountability for graduate medical education (GME). This is especially true since public money is used to fund GME programs. In fact, most discussions of GME accountability have been driven by proposals to decrease public funding of GME. The creation of accurate and reliable accountability measures as discussed in my commentary would in large part be used to drive a portion of public funding to programs and institutions that meet desired training outcomes.

As Dr. Walsh underscores, measuring the costs of GME is not completely straightforward. Some costs, such as the "direct" teaching costs reported on annual Medicare cost reports, are easier to define. These include a portion of trainee and faculty salaries and benefits and a portion of teaching-related overhead costs. Much more challenging is the calculation of "indirect" costs, the additional costs of teaching institutions ascribed to the involvement of residents and fellows in patient care. Most challenging, however, is the measurement of the increased (or decreased) revenue received by health care

institutions and providers due to the patient care provided by resident and fellows.

Despite the challenges, I agree that more careful cost analyses of GME are both feasible and necessary. The key, however, will be to ensure that all costs and all revenues are captured. In the meantime, GME measures focusing on competence, the learning environment, and workforce outcomes can be initiated immediately to incentivize better GME outcomes and provide public accountability.

Disclosures: None reported.

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Population Health Management: An Approach to Improve the Integration of the Health Care and Public Health Systems

To the Editor: The Institute of Medicine released a report titled *Primary Care and Public Health: Exploring Integration to Improve Population Health*¹ that called for the creative collaboration of health care and public health systems for the purpose of improving population health. The report stated, "The traditional separation between primary health care providers and public health professionals is impeding greater success in meeting their shared goal of ensuring the health of populations."¹ This call to action is timely as we deliver care in our transformed health care system. Hence, I maintain that one approach to answer this call involves actively intervening with the health of populations via population health management (PHM). PHM is a tool "used to describe a variety of approaches developed to foster health and quality of care improvements while managing costs."² PHM utilizes various management approaches that address the prominent disease, contributing lifestyle factors, and resultant disability issues, for instance, via integrating interventions that require input from systems that consider the determinants which most significantly affect the

health of the target population, such as employees or diabetes patients within a health system's service area.³

PHM makes ethical sense on paper but I argue that its implementation in any health care or public health system is challenging and requires a culture change and a development of skills not necessarily taught in medical education, including engaging community-based participation, or collaboration with nonmedical professionals. Similarly, public health education which addresses community health issues via a population lens needs to teach professionals to expand the practice of their skills to a setting other than the community, but to include an environment that could be a large employer corporation, health system, or hospital. Both stakeholders need to learn to integrate their philosophies and operations since their desired outcome is the same—a healthy population. Since the health care and public health systems are currently unable to implement this approach alone, an integrative method offered by PHM is required and possibly a reinvigoration of the call to reunite medical and public health education.

Furthermore, PHM has the potential to contribute to the evaluation of the effectiveness of our reformed health care system since it allows for assessing the efficiency of health care delivery, while striving to improve quality of care and reduce costs. The overarching goal of PHM is to keep populations healthy via an integrative, preventive approach so it is a model that should be embraced by the health care and public health systems, as well as their respective educational systems that produce these practicing professionals.

Disclosures: None reported.

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- 3 Birk S. Population health: Strategies that deliver value and results. *Healthc Exec.* 2013;28(4):10–12.