



INTERVIEW WITH JEFFREY LEVI, Ph.D.

POPULATION HEALTH MEANS DOING BUSINESS DIFFERENTLY

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HEALTH PROGRESS: First, please explain: What is the Trust for America's Health, and when was it founded?

LEVI: We're a public health advocacy organization, and we're about 12 years old. I like to say we do evidence-based policy advocacy. Our mission is really to make prevention a national priority and to assure that Americans have as healthy a life as possible.

HP: What was the impetus for founding the Trust for America's Health?

LEVI: The impetus was a recognition by our founders that in order to address the challenges the country faces today, we really need a modernized public health system and a new perspective on what prevention means. Being an organization dedicated to that mission alone, one that is independent — we take no industry money, we take no government money — allows us to play an advo-

cacy role and a watchdog role. We also try to build a consensus within the public health community around how our public health system needs to be modernized, and we try to define the best solutions to our most challenging problems.

HP: Here at CHA we hear a lot about the growing emphasis on population health and the need for public health departments and private, not-for-profit hospitals to collaborate. That seems like a historic shift, and one not easily achieved. What has to change, and why?

LEVI: The challenges we face — the big health challenges — are not solved in traditional public health settings or in traditional health care settings. They require a combination of clinical and community intervention. When you think about the biggest cost-drivers of chronic diseases in our society today, they are things like lack of physical activity and good nutrition, and tobacco use. Public health is traditionally focused on educating people, providing them with immunizations, intervening with them directly in their lives, and here we're talking about changing the context of their community to make the healthy choice the easy choice. So in both public health and in the health care systems and in hospitals, we need to be thinking differently about how we create health. I think the entire system has to change in order to achieve the goals that have been put in front of us in the context of health reform, which are to improve quality, improve health, and reduce costs. If we're going to achieve those things, hospitals have to do business differently, and public health has to do things differently.

HP: Please say a little more about what that will look like.

LEVI: In a perfect world — or even in an imperfect world — the distinction between what a public health agency does and what a hospital or a clinical setting does in terms of promoting health and in terms of doing prevention is going to become relatively seamless. As the financial incentives change, the incentives increase for a hospital to be talking about better food options in schools, more opportunities for physical activities, to be arguing for safer streets, because if the system is going to live within the global payments they're going to be given, they have to address those concerns. That's

the only way we're going to reduce costs. And similarly, public health agencies have to think not just about what has been traditionally in the public health lane, but also thinking about how, in an era of electronic health records, they will work with hospital systems to monitor quality outcomes and to determine what particular community interventions are needed for subsets of a population that a hospital serves. So it's those kinds of things that are going to create almost a seamless web of interaction among hospitals, clinics, public health agencies, community-based organizations that do a lot of this work, because ultimately that's how we create health in this country.

HP: We know that tax-exempt hospitals will now be required by the IRS to conduct community assessments every three years and develop programs to meet community needs. Is there pressure on the public health side to work with the hospitals on this agenda?

LEVI: There are two pressures, I think, on public health agencies. One is financial. As government budgets shrink, agencies have fewer resources, so

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they need to work more collaboratively with others. The second is the understanding that we are moving toward a health-in-all-policies approach, toward a recognition that housing policy and education policy and jobs policy can have as much impact on upstream prevention as anything a public health agency does. ... That means working with hospitals, with housing agencies, education agencies, planning agencies, with a whole array of partners. So just by the force of the problems we face, public health will be working in collaboration with multiple partners. Operating solo just won't work anymore.

HP: What are some of the barriers to collaboration?

LEVI: Collaboration requires a culture change on all sides, and we all know that culture change is



Jeffrey Levi: "Operating solo just won't work anymore."

not easy. I think the reality of the problems we're facing and the reality of the financial pressures everyone is going to face will make it inevitable that we work together. But there will be some tensions. Some people are more open to it than others.

What's exciting about some of the new requirements from the IRS around community benefit funds is that, to the degree there hasn't been collaboration and cooperation with public health agencies, there will now be that conversation. In my mind, it would really be tragic if the collaborations stopped with community health needs assessments and did not continue through the decision-making around implementation so that everyone's investment is coordinated and maximized. It doesn't mean all the money has to be put together in one pot, but it would be a shame if programs were duplicative, or investments worked at cross purposes.

HP: Prevention costs money. Given growing financial pressures on hospitals, and pervasive public budget shortfalls, where will that money come from?

LEVI: Some prevention costs money; some prevention saves money. If we think about the Triple Aim,¹ one of the goals is better health outcomes,

and we shouldn't be afraid to invest in prevention interventions. These interventions really can save money. ... But public health always takes a very long perspective, and I think we have to recognize that, as much as they would like to think about everyone being healthier 20 years from now, hospitals and health plans have costs to meet today. We need to frame those interventions and find resources for those interventions in a balanced sort of way.

One source [of funds] is the community transformation grants that are created in the Affordable Care Act, which are designed to identify barriers to prevention. Where do we need to make sure that we have safe streets? Where do we need to make sure that it's safe for kids to play outside? Where do we need to work to make sure that there are healthy food offerings in corner grocery stores or in schools? That physical activity increases in the schools? And then, we need to define the partners that can help support that. Sometimes it will come from public health funds; sometimes it may come from community benefit investments that hospitals make; sometimes it may come from working collaboratively with other government agencies, such as the department of transportation. For instance, a community transformation grant program in North Carolina involves work-

ing with the state department of transportation to make it a priority that the state is walkable and bike-able, and to identify communities with the highest obesity rates as the places where they're going to start that investment process.

HP: What about the financial risks to hospitals, which have traditionally derived their major income from providing acute care? Are there compensations?

LEVI: That's a challenge we face. A lot of prevention investments do take some time to pay off. But in some cases, particularly around obesity and diabetes, for example, which is a very big cost driver, the returns happen very quickly. Very modest weight loss, very modest increase in physical activity can really stop the progression of diabetes and sometimes reverse it, and that's where the cost savings come in. I think the trick here is, in order to get people more comfortable with community-based prevention activities, to start with conditions and challenges where there will be a relatively quick return. People will see that value, and then, I think, feel more comfortable making further investments.

HP: You have said that a lot of health expenditures could be saved with better injury prevention. That makes sense, but how is that kind of prevention achieved?

LEVI: The big challenge in prevention for public health, and for everyone, is to stop thinking disease by disease and to start thinking about interventions. We have constructed a public health system that thinks about cancer, thinks about obesity, thinks about diabetes, thinks about smoking, thinks about depression. I could go on and on. We run our programs body part by body part, when many interventions are cross-cutting. So we know, for instance, that increased physical activity helps reduce depression, prevents heart disease and cancer; actually even reduces sexual activity among teenagers, and reduces falls among the elderly. So if we think about cross-cutting interventions like physical activity, like good nutrition, we're going to be addressing multiple diseases and multiple conditions. Not only are falls

among the elderly one of the biggest health care cost drivers; it is also one of our greatest tragedies that people have to end their lives with broken hips, becoming disabled and nonfunctional. That doesn't have to be.

HP: With so much work to be done, how would you prioritize?

LEVI: To me, the first priority is really to think about investing in the programs that create healthier and more resilient communities so that we can deal with multiple threats, whether it's obesity or a hurricane. The strengthened vibrancy of those

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communities and the social capital we create make it possible for us to respond as individuals and as communities.

The second thing I would think about is: How, in a reforming health care system, and particularly in a reforming health care financing system, can we assure the resources for prevention so that our downstream costs are ultimately reduced?

And the third is, from a public health perspective, how we realign our own structures to foster partnerships with the health care setting, with the housing community, with all of the sectors that have an influence on health.

HP: What gives you hope?

LEVI: My hope is in traveling around the country and meeting literally thousands of people on the front lines doing this work already and seeing it begin to pay off.

NOTE

1. The IHI Triple Aim, a framework developed by the Institute for Healthcare Improvement, is based on pursuit of three goals: improving the quality of health care and patient satisfaction, improving the health of populations, and reducing per capita health care costs.

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