The Upstream Hospital Leader: Taking Action to Improve Population Health

Ross Graham and Ryan Meili

Abstract

Canadian hospital leaders face numerous barriers when they seek to work upstream in an effort to improve population health. A noted challenge is lack of role clarity. We introduce the concept of an "upstream hospital leader" in an attempt to address this challenge, and suggest behaviours for how this role can advance population health at the individual, organizational and health system levels. These suggestions aim to contribute to the ongoing conversation and growing interest in the role of hospitals in population health improvement. We invite feedback on these suggestions and encourage leaders to explore opportunities where greater upstream action by their hospital and health system can improve population health.

Background

> "Everyone in healthcare is working to improve population health these days. Or will be very soon. Or feel that they ought to be" (Casalino et al. 2015: 819).

Widespread adoption of the Triple Aim suggests its components – patient care, population health and cost reduction – resonate as critical goals for healthcare providers and health systems (Whittington et al. 2015). Resonance of the first and third aims is unsurprising. Improving patient care aligns with traditional notions regarding the mandate of health systems and the professional responsibilities of clinicians. Similarly, there is consensus on the need to control or reduce healthcare spending (Simpson 2012). Resonance of the second aim has pleasantly surprised other health system actors who have long sought to advance population health (e.g., public health). This is because many in public health believe healthcare providers, namely, hospitals, have had little interest in population health over the past three decades (Casalino et al. 2015). Public health actors cite that while the World Health Organization (1986) has long advocated that healthcare providers "move increasingly in a health promotion direction, beyond [their] responsibility for providing clinical and curative services," progress in this area has been limited and the optimal role for hospitals in population health improvement remains unclear (Catford 2014; Hancock 2011; Nutbeam 2008).

However, evidence suggests that Canadian hospitals have long desired to become more active in illness and injury prevention and population health improvement (Cohen et al. 2014; Neudorf 2012; Poland et al. 2005, Thompson et al. 1986). Unfortunately, few hospitals have been able to make significant progress in this area because demand for treatment consistently outpaces funding, and few Canadian hospitals are held accountable or are incentivized to improve population health (Frankish et al. 2007, Graham et al. 2014).

The result is a challenging scenario for hospital leaders (Canadian Institute for Health Improvement 2014; Lalonde 1989). While leaders may wish to allocate resources towards population health improvement activities, they are subject to the "tyranny of the urgent" and are predominantly held accountable for financial and clinical performance. This is problematic because hospital financial and clinical performance has "only tenuous or very indirect linkage with the improvement of the health and well-being of a population" (Denis 2014: 8).

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Healthy populations clearly require acute care services, which are most often provided in hospitals. However, many suggest that Canadian health systems are overly acute care-centric, struggle to control costs and poorly address the needs of Canadians with chronic diseases (Daar et al. 2007; Picard 2013; Simpson 2012). This includes high-needs patients (Kuluski et al. 2013) and high-use/cost patients (Fitzpatrick et al. 2015). Acute care-centric systems also limit resources available to address the more influential determinants of population health: lifestyle factors and the social, economic, built and natural environments in which we live (Canadian Public Health Association 2015; Mikkonen and Raphael 2010). In other words, how effective are health systems that "treat people's illnesses, [but] then send them back to the conditions that made them sick?" (Bégin in Mikkonen and Raphael 2010: 5). Lewis (2010: 2) reports another issue with acute care-centric health systems: The public becomes "persuaded of the value of increasingly specialized and sophisticated healthcare and health technology, despite the clear absence of effect on health status." Serving a community that has a "symbolic and empirical devotion to health care" only exacerbates the challenge of advancing population health for hospital leaders (Lewis 2010: 2). The result is that the majority of health spending and health policy attention remains focused on improving and increasing healthcare services. While some evidence suggests that these investments have paid off (such as the 16% reduction in Canada's hospital standardized mortality ratio since 2009), rising chronic disease rates and various population health indicators (such a threefold increase in youth obesity rates over the past 30 years) demonstrate that the acute-care-centric status quo is unacceptable (CIHI 2015): "The reality is that we're treating symptoms. If we are going to flatten the cost or demand curves, the only way to do that effectively is to move upstream" (Waldner in Tremblay 2012: 15).

The topical issue of supporting high-use/cost patients by "hot-spotting" is an example of the need to work upstream. Two-thirds of Canadian healthcare resources are spent caring for only 5% of high-use patients (CIHI 2014a). Health systems across Canada have taken bold action in an attempt to better support these patients and reduce costs. However, many initial hot-spotting approaches have limited success because they focus solely on reorganizing care, and only for patients who are already high-use (Fitzpatrick et al. 2015). To address these limitations, health leaders across Canada have recognized the need for an upstream approach (CIHI 2014a). For hospital leaders, upstream hot-spotting presents an opportunity to improve patient care and reduce costs through collaborating with housing, education, transportation, justice, social services and urban planning stakeholders. It also presents an opportunity for hospital leaders to engage and educate political leaders and the public about the powerful influence of the social determinants of health (SDOH) on health and healthcare costs.

In addition to hot-spotting, a number of approaches have been suggested to support hospitals to work upstream. For example, Neudorf (2012) and Cohen et al. (2014) recommend that Canadian hospital leaders adopt a "population health lens" in decision-making. Poland et al. (2005) suggest greater collaboration between hospitals and community agencies. There is also a growing literature on the role of hospitals as "anchor institutions" in their communities, and the important role hospitals can play in local economic development through their purchasing, real estate, advocacy and hiring practices (Dragicevic 2015; Duffy & Pringle 2013). In the United States, 3,000 hospitals must now demonstrate community benefit beyond provision of medical treatment to remain exempt from federal taxes (Rubin et al. 2015). Also in the United States, Shortell has advocated for the creation of "population health organizations," where hospitals and public health are integrated to better focus on addressing the determinants of health (Casalino et al. 2015). In (mostly) Europe and Asia, over 1,000 hospitals comprise the international Health-Promoting Hospitals movement, which posits that hospitals should (1) be healing environments, (2) use 'clinical health promotion' approaches with patients, (3) be healthy workplaces and (4) form inter-sectorial partnerships to create healthy communities (Pelikan et al. 2013).

Others have suggested the rise in chronic diseases and healthcare spending in Canada requires more drastic action. This includes the recommendation from Goodfellow (2015: 148) for a "dramatic dehospitalization" of current systems. Similarly, Hancock (2011: ii267) advocated for "a profound re-orientation of our current illness-care system." However, while radical reform may be necessary, study of health system reform in Canada suggests that change will most likely be *evolutionary* not *revolutionary* (Lazar et al. 2013).

We applaud these approaches and support their continued investigation. However, a persistent challenge for hospitals across these approaches is lack of role clarity (CIHI 2014). In particular, limited attention has been paid to the role of hospital leaders in advancing this work (Wieczorek et al. 2015). This is unfortunate given the important role hospital leaders can play in population health improvement, and the challenging scenario many face when trying to advance upstream, population health-promoting activities (Cohen et al. 2014; Johnson 2001). In the remainder of this article, we introduce the concept of the "upstream hospital leader" and draw on the literature to suggest possible behaviours for this role at the personal (micro), organizational (meso) and system (macro) levels. These three levels are consistent with guidance literature for upstream family physicians (College of Family Physicians of Canada 2015).

Hospitals, as organizations, and those in leadership positions within hospitals are well-positioned to advance population health

Far from ground-breaking, our aim is to provide practical advice to busy hospital leaders interested in advancing this important and challenging area. We acknowledge that some leaders already practice these behaviours, and some Canadian hospitals are recognized as leaders in population health improvement (e.g., Winnipeg's Seven Oaks General Hospital for physical activity and Toronto's St. Michael's Hospital for health equity). We include hospital-based clinical leaders in our definition, and have developed the suggestions accordingly. Those with a specific interest in the role of hospital-based clinicians in advancing population health should review existing literature on the topic (e.g., Allen et al. 2013; College of Family Physicians of Canada 2015; Whitehead 2005).

The Upstream Hospital Leader

Hospitals, as organizations, and those in leadership positions within hospitals are well-positioned to advance population health:

> [Hospitals] represent the main concentration of health service resources, professional skills and medical technology. Communities readily identify with hospitals. They generally have substantial prestige and their staff are well respected. They are seen as credible sources of advice and expertise on health issues beyond their responsibilities for sick care services. So although hospitals are the high temples of sick care, the extensive resources they command mean that even a small shift of focus has the potential to bring about an increase in resources dedicated to health promotion and, in time, health benefits to a community (Johnson and Baum 2001: 282).

Hospital leaders (at all levels) have opportunities to advance population health as individuals, and as part of teams, organizations and a health system. The upstream hospital leader is someone who makes a concerted effort to seize these opportunities. This can range from leading revolutionary change to supporting a small shift of focus (Johnson 2001). The term "upstream" in this context refers to striving to prevent illness and injury by addressing root causes (rather than the notion of "swimming upstream," although this may be required on occasion). To support busy hospital leaders interested in moving upstream, example behaviours are suggested below. These suggestions, and the notion of an upstream hospital leader, also contribute to ongoing discussions about the role of health professions and organizations in population health improvement. This includes physicians (Canadian Medical Association 2013; College of Family Physicians of Canada 2015), nurses (Canadian Nurses Association 2005; Whitehead 2005), all healthcare professionals (Allen et al. 2013) and medical schools (Health Canada 2001). An "all hands on deck" approach is clearly needed to achieve any significant reorientation of Canadian health systems and service providers towards population health.

Suggested Behaviours of an Upstream Hospital Leader

At the personal (micro) level

- Learn about the impact of the SDOH and your community's health status, including key determinants and health equity issues (Neudorf 2012).
- Learn about possible interventions hospitals can use to advance population health (examples reported above) and introduce these interventions to colleagues (Johnson and Baum 2001).
- Learn about local, regional and/or national initiatives that aim to improve population health (e.g., Coalitions Linking Action and Science for Prevention [CLASP]) and determine whether your hospital could get involved (Poland et al. 2005).

At the organization (meso) level

- Test interventions that can advance population health in your setting (e.g., clinical health promotion approaches) and disseminate evaluation results (Johnson and Baum 2001).
- Assess the social challenges faced by patients who access your hospital and engage them in addressing these challenges (Ready 2014).
- Use community health assessment data to inform team, program and strategic planning (Neudorf 2012).
- Empower clinicians to explore clinical health promotion approaches with patients (Wieczorek et al. 2015).
- Empower clinicians and staff to learn about population health and be active in community partnerships that advance population health (Poland et al. 2005).

- Consider the impact on population health in the evaluation of projects, programs and services (Johnson and Baum 2001).
- Build relationships, partner and establish regular communication mechanisms with local public health leaders and community-based organizations (Poland et al. 2005).
- Communicate the importance of the SDOH to members of the public and engage the public in discussions on how you can collaborate to improve health (Johnson 2001).
- Explore the role of the hospital's board and foundation in community partnerships and advocacy (Johnson 2001).
- Develop social impact guidelines for purchasing and procurement activities (Duffy and Pringle 2013).
- Explore strategies to leverage the hospital's social capital, real estate holdings and other assets to advance local social, economic and land use planning goals (Dragicevic 2015).

At the health system (macro) level

- Support the upstream reorientation of healthcare providers and health systems (Hancock 2011).
- Advocate at municipal, provincial/territorial and federal forums about key health determinants and equity issues (e.g., healthy urban planning) (Johnson 2001).
- Promote the concept of health-in-all-policies as a means of integrating upstream thinking into policy making (Casalino et al. 2015).
- Participate in community partnerships as an individual or on behalf of your hospital (Poland et al. 2005).
- Advocate that your professional association(s) support the upstream reorientation of healthcare providers and health systems.
- Support the integration of population health into health leadership education (e.g., MHA programs; Joshi 2015).
- Engage political leaders and policy makers to enhance their understanding of the SDOH and policies that would help improve health outcomes.
- Use the platform given to you by your leadership role to speak in the media and other public venues in promotion of policies that improve health equity (Allen et al. 2013).

While appropriateness of these suggestions will vary by context, this list provides a starting place for hospital leaders to consider actions they can take to support population health improvement.

Conclusion

Canadian hospital leaders face a challenging scenario when they seek to work upstream in an effort to improve population health. Thankfully, there are a number of exciting approaches being explored to support hospitals advance this work. We have suggested some example behaviours to guide hospital leaders advance these approaches and more broadly, the reorientation of their organization and health system. We invite feedback on these suggestions and encourage leaders to have discussions with their colleagues about how best to advance population health in their setting and system. There is great need for bold, upstream leadership if we are to improve the health of Canadians. HQ

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