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CONVERSATION

# Public Health and Population Health: Are They the Same Thing?

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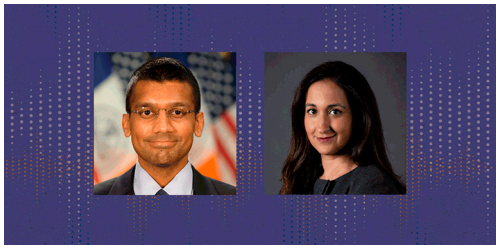

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The Commissioner of the New York City Department of Health and Mental Hygiene discusses the nexus between public health and health care delivery, and what New York City is doing to ensure care extends to Covid-19 patients once they leave the hospital. He stresses the importance of breaking down silos and earning patients' trust through health care–community partnerships that provide more equitable care.

*Namita Seth Mohta, MD, interviews Dave Chokshi, MD, MSc, the Commissioner of the New York City Department of Health and Mental Hygiene.*

**Namita Seth Mohta:** This is Namita Seth Mohta for NEJM Catalyst. I'm speaking today with Dr. Dave Chokshi, the Commissioner of the New York City Department of Health and Mental Hygiene. In this role, the Commissioner is responsible for the health of the citizens of New York City. Prior to this, Dave was Chief Population Health Officer of NYC Health + Hospitals. He sees patients as an internist at Bellevue Hospital. Dave also serves on our *NEJM Catalyst Innovations in Care Delivery* editorial board. In all of these roles and in his prior experiences, including when he and I worked together at Brigham and Women's Hospital, the Commissioner has been committed to improving the lives of the populations he serves.

We could discuss many topics today, but given his experience in both the provider and health system settings, as well as the government public health sectors, I wanted to focus on specific areas. First, Dave, I'd like to get your take on the overlap between public health and population health. Second, I look forward to discussing the opportunity and challenge of bringing innovations in public health and health care delivery. As you know, effective collaboration between the two will be especially critical as we address this next phase of the pandemic. We are delighted to have you joining us today.

**Dave Chokshi:** Thank you so much, Namita. I'm honored to be on the podcast.

**Mohta:** Let's start with clarifying some concepts. Leaders who work in the public sector use the term *public health*, leaders who work in health systems use the term *population health*, and often I find that they're referring to the same set of problems, challenges, and lists of potential solutions. From your perspective, how do you define public health and population health? What is the relationship between the two? What are the different levers and tools that organizations in these fields use to improve health?

**Chokshi:** My starting point on this is that I like to say that I'm a primary care doctor with a public health heart. What I mean by that is, the same things that drove me to pursue medicine, and that I think about every time I care for a patient, are very much the same things that I think about as the health commissioner for the city. Ultimately, whether we think of public health, population health, or health care delivery, the common thread that links all of those terms and, more importantly, all of those practices is the pursuit of health.

> *"Part of our common challenge, whether you're a public health practitioner or a physician working in a health system, is thinking about all of the things that contribute to and generate health and making sure that what we are doing with respect to delivering services and changing the structures of society actually contributes to the health of the people whom we intend to serve."*

That is simple on its face, but it is something that has been very difficult to operationalize across those different sectors over the course of decades. Part of our common challenge, whether you're a public health practitioner or a physician working in a health system, is thinking about all of the things that contribute to and generate health and making sure that what we are doing with respect to delivering services and changing the structures of society actually contributes to the health of the people whom we intend to serve.

**Mohta:** Building on that, some of our prior conversations have been about silos in our health care system, the silos of parts of the ecosystem that are pursuing that goal of health, but are oftentimes too isolated from each other. Can you share some thoughts and where you see the biggest gaps in areas of opportunity when it comes to bridging these silos? More proximally, how has Covid-19 affected your perspective on this?

**Chokshi:** To build on the first question that you asked, even though we strive to have a deep and abiding link between public health and health care delivery, that hasn't always been the case. That's the first silo that I would point to. Covid-19 has really brought this into stark relief: for example, the effectiveness of social distancing translates directly into the number of sick patients who end up in the ED and ICUs. What has always been true with respect to the policy or environmental approaches that often undergird what we think of as traditional public health, and how that translates into when people get sick enough to require health care, it's something where the connection between those things has become much more tangible and visceral — both for people like us who have been steeped in the health systems for our entire careers, but, perhaps more importantly, for the general public as well, who have now understood that there is this link between what we do in the realm of public health and how that connects to what ends up happening in clinics and hospitals.

I think that's a real opportunity, even though, of course, the last [several] months have been filled with so much tragedy with respect to understanding the limitations of our pandemic response, our preparedness in many ways as a country. One of the things that I hope we will be able to draw from and move forward with over the coming years is this idea that there is that nexus between public health and health care delivery. It's something that we need to continue building on, tearing down the walls between those two worlds so that we can achieve that common cause of producing health.

The other thing that I would say on this point about silos is that, particularly when I look at it from the vantage point of someone who's more thinking about health care delivery, the silo that always struck me the most, even before my own clinical training, was how physical health, behavioral health, and what we can think of as social health are all linked. You think about a given patient whom you've taken care of, and there are so many ways in which you can draw the connections between someone's social circumstances, the risk factors that predispose them to, let's say, alcohol use disorder, and how that affects the physical health of someone, whether it's esophageal varices or liver disease. All of these things are packaged in an individual whom we take care of. Yet, in the way that we deliver those services, it's too often separate, which causes problems both for people, for the whole person whom we intend to care for, but also for the systems that we're trying to build around that care.

**Mohta:** I completely agree with you, and I would add to that the clinicians and care team who are trying to take care of that person in that system with a lot of challenges and limitations. To build on that, how could we take this physical health, behavioral health, and social health complexity and harness the power of this nexus between the health system and the public health system to make some improvements? What's on your wish list of how we could leverage that nexus and that tangible individual connection that you mentioned to make progress on this complex issue?

> *It starts with the health care system, realizing that our role in that is relatively limited. It's one where we provide resources and where we are essentially the referral mechanism rather than anything beyond that. That allowed us to make sure that those community-based organizations were the ones that were both the trusted institutions delivering the service in particular neighborhoods, but also benefited from the resources that we were able to bring to bear."*

**Chokshi:** The way that I think about this is that it really needs to be rooted in humility. It needs to be rooted in this idea even though we may have this renewed interest in thinking about the social factors that underlie health, or we want to reach out to build specific collaborations between a local health department and a local health system. The idea that we embark upon that journey with humility, particularly from the side of health care delivery, feels fundamentally important to me.

The reason is that if you start with humility, it allows you to see that there have been people who have been working at those very same issues for decades. Whether it's someone who has started a community-based organization to address food insecurity or has been thinking about whom we have recently termed "high utilizers" from the perspective of addressing their homelessness, there are so many latent natural resources that exist in our world that require a reflex to partnership. I found in my experience that just that simple step of taking a beat and saying, before we build something new, before we generate an investment in what we think of as an innovative program, let's stop and understand the ecosystem in which our patients are already living. Let's stop and think about the people who are better equipped than we are to support the people whom we intend to serve. I found that building those partnerships from that starting point allows us to be not just more tangible about our work, but also more effective.

**Mohta:** Can you share some specific examples of these partnerships and this approach of being rooted in humility from when you were at NYC Health + Hospitals, helping to lead the pandemic response, and then more recently as Commissioner?

**Chokshi:** Sure. One of the things that I think about a lot is at the height of the [first] surge in New York City back in March and April, we were, of course, as a city advising people to stay at home as much as possible. Unfortunately, for people who are living on the margins, for whom hunger and access to food were tenuous even when they weren't in a pandemic, this caused very significant issues with respect to food insecurity. That reflex to partnership allowed us to work with the food banks, the community-based organizations that had been serving specific neighborhoods in New York City for many years with respect to providing access to nutritious food. What we were able to do is provide an infusion of resources as well as some direct connections, for example, after hospital discharge, which we know is such a challenging period in terms of recovery for people, and connect people up with those services.

But it starts with the health care system, realizing that our role in that is relatively limited. It's one where we provide resources and where we are essentially the referral mechanism rather than anything beyond that. That allowed us to make sure that those community-based organizations were the ones that were both the trusted institutions delivering the service in particular neighborhoods, but also benefited from the resources that we were able to bring to bear.

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In terms of the work that we're doing more recently, we have thought a lot about how fundamental this idea of trust is for everything that we're doing, whether it's trying to ensure that our public health guidance is followed around physical distancing and wearing masks or getting tested, to planning and preparing for vaccination, particularly given some of the historical and, in many cases justified, distrust that exists in many of the communities that we hope to serve. We have really tried to center this idea that trust is an essential ingredient for turning a vaccine into a vaccination, which again means that maybe the right way to move forward is for us as messengers of government, as messengers representing health professionals, to take a step back in some instances and allow community leaders, faith leaders, people who look like and otherwise represent the people whom we are reaching out to, to be the ones who are delivering the messages that we need.

**Mohta:** How can [this approach] be helpful as we think about accelerating our efforts to provide more equitable care to all of the communities that we serve?

**Chokshi:** This is another area that I hope will be a lasting lesson [from] the Covid-19 pandemic. What I think of is the idea that health equity is not a sideshow; it's not something that we need to do along with whatever the main event is in public health or health care. It *is* the main event. Health equity is what we have to solve if we're actually delivering on that mission of improving health. All we have to do is look at the stark and dismaying outcomes with respect to deaths and hospitalizations among Black and Brown communities in the United States to realize that that is a core part of our job.

We have tried to do this in several ways at the New York City Department of Health and Mental Hygiene. Our core values are science, equity, and compassion. Elevating equity to one of the fundamental things that we focus on has helped us ensure that it's baked into all of our work rather than being seen as a parallel path. I appointed the first-ever Chief Equity Officer, Dr. Torian Easterling, when I took the helm here as Commissioner and charged him with making sure that we both turned the spotlight inward and understand how it is that we need to think about equity within our own organization, but then link that up to our external equity efforts as well.

The final piece is what we've talked about a little bit already, which is making sure that when we think about equity, it's not just about focusing on the data around disparities, but answering the "so what" question. How do we get to that point of community engagement, whether it's around Covid-19 testing or around a Covid-19 vaccine, so that we are having the sometimes-difficult but honest conversations about how to be worthy of the trust of those communities? That is central to accomplishing our equity goals.

**Mohta:** First of all, thank you for that, Dave, and for your leadership in this critically important, fundamental way, of changing the way that we think about caring for patients and their communities. One last question: What are the one or two advances in health care delivery and public health that you are most optimistic about today?

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**Chokshi:** I look at the amazing progress that has been made with the development of the mRNA vaccines for Covid-19 in astounding record time. We've almost taken it for granted as we're seeing the news emerge. But I'm so struck by what we're seeing with respect to the pace of science and how it can be brought to bear when there is this societal will to commit to advancement in that way. It reminds me also of what I saw back in March and April, when, even though we had been working for a year on building our telehealth infrastructure, literally overnight at NYC Health + Hospitals, because we were in the stay-at-home phase of the surge, we shifted to hundreds of thousands of encounters, now millions of encounters, to telehealth within days. I also remember walking through my hospital, Bellevue Hospital, and within a matter of hours an endoscopy suite was turned into a fully functional medical ICU, taking care of patients who were intubated and struggling with critical illness from Covid-19. All of these experiences have been seared in my memory, both as tragedy in many ways, but also as a testament to what can change when that will is there.

My great hope from the public health perspective is that we not forget that, and we make sure that when we are on the other side of this pandemic, we bring that same will to bear in terms of what we need to do to support and invest in public health. I'm talking about sustained investment over the long term and not just during an emergency, to make sure that we learn the lessons of how important it is to invest in prevention, to shore up our public health surveillance systems, to create these links that we've talked about across sectors that advance health and that take the opportunity that we'll have through economic recovery to make sure that public health is central to it, because we will have learned how central public health is to the economy through this this very difficult experience that we're all going through. So that's my big hope, having seen what is possible over these last few months when smart, committed individuals band together, that we take that same volition and turn it into something that is much more durable and long-lasting.

**Mohta:** Commissioner, thank you so much for speaking with NEJM Catalyst today.

**Chokshi:** Thank you for having me.

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*Disclosures: Dave A. Chokshi has nothing to disclose. Namita Seth Mohta is Executive Editor for NEJM Catalyst.*