RISE
Rapid-Improvement Support and Exchange

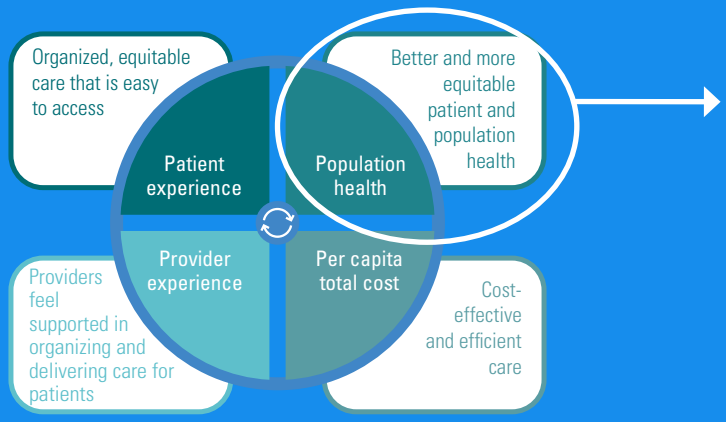
Overview of Population-Health Management

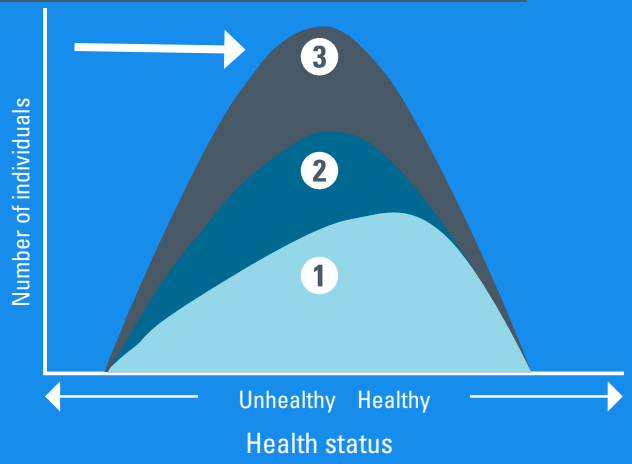
HSPRN
health system performance research network

What is population-health?

"The health outcomes of a group of individuals, including the distribution of such outcomes within a group"
- Kindig & Stoddart. AJPH 2002;93(3):380-3

Accountable Local Care Systems: Quadruple Aim





Source: Adapted from Washington AE et al. JAMA 2016 315(5); 459-460

The population health curve can be divided into three sub-curves, each building on the last.

1 Care for acute health problems

Patients seeking care from healthcare providers

- **Reactive, disjointed** care, **individually focused, no population orientation**

2 Clinical care for populations

Accountable local care systems working to improve population health and reach more of their population

- **Proactive** management of care
- **Evidence-based interventions** that ensure **integration, coordinated** for people **across healthcare providers**
- Uses an **equity lens & addresses barriers** to care

3 Population-based policies & interventions

Entire population of the community that would be affected by population-based approaches

- Focus is on **non-medical determinants of health** (e.g. food insecurity, poverty, literacy, housing)
- Oriented over the **lifespan across large populations**
- Working with **community partners** and **advocating for public policies** to improve population health

What is population-health management (PHM)?

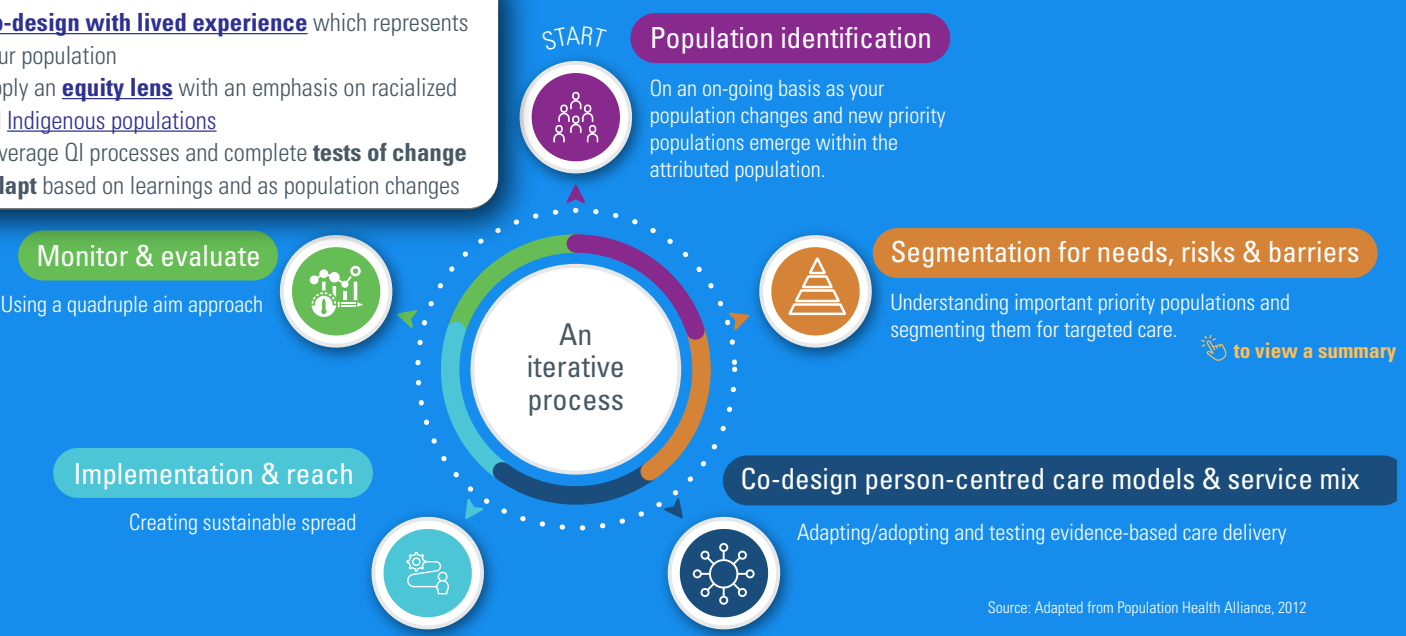
Population-health management is an iterative process which involves gathering data and insights across many partners (including non-traditional healthcare providers) about an entire defined population's health and social needs. These insights inform the co-design of proactive, integrated, person-centred, cost effective, equitable and efficient solutions with the goal of improving the health of individuals.

Source: Adapted from Population Health Alliance and Deloitte Centre for Health Solutions

There is a five component approach to implementing population-health management which can also help teams to 'move the needle' on achieving the quadruple aim.

Throughout each component:

- ✓ **Co-design with lived experience** which represents your population
- ✓ Apply an **equity lens** with an emphasis on racialized and Indigenous populations
- ✓ Leverage QI processes and complete **tests of change**
- ✓ **Adapt** based on learnings and as population changes



Source: Adapted from Population Health Alliance, 2012