Overview of Population-Health Management

**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

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 care 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.

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

**Population identification**
- On an on-going basis as your population changes and new priority populations emerge within the attributed population.

**Segmentation for needs, risks & barriers**
- Understanding important priority populations and segmenting them for targeted care.

**An iterative process**

**Implementation & reach**
- Creating sustainable spread

**Co-design person-centred care models & service mix**
- Adapting/adopting and testing evidence-based care delivery

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.