

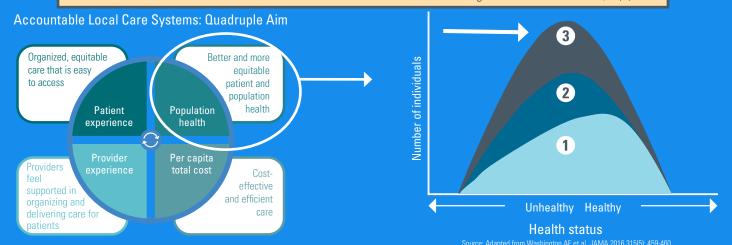
Overview of Population-Health Management



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.

- Care for acute health problems
 Patients seeking care from healthcare
 providers
 - Reactive, disjointed care, individually focused, no population orientation
- 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

Throughout each component:

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

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.

START

Population identification



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

🖔 to view a summary

Monitor & evaluate

Using a quadruple aim approach



An iterative process



Segmentation for needs, risks & barriers

Understanding important priority populations and segmenting them for targeted care.

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Implementation & reach

Creating sustainable spread



Adapting/adopting and testing evidence-based care delivery

Co-design person-centred care models & service mix

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Source: Adapted from Population Health Alliance, 201