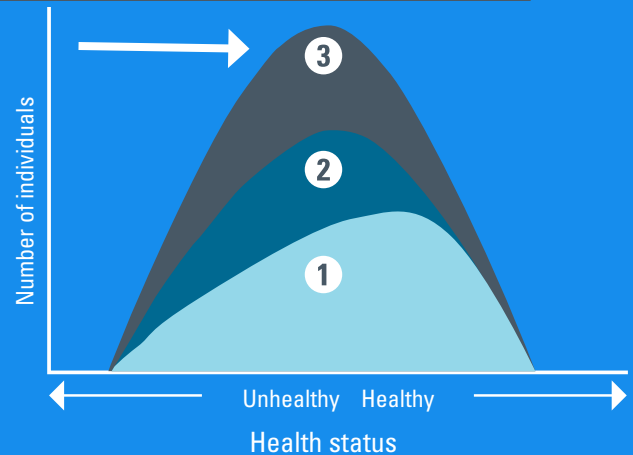
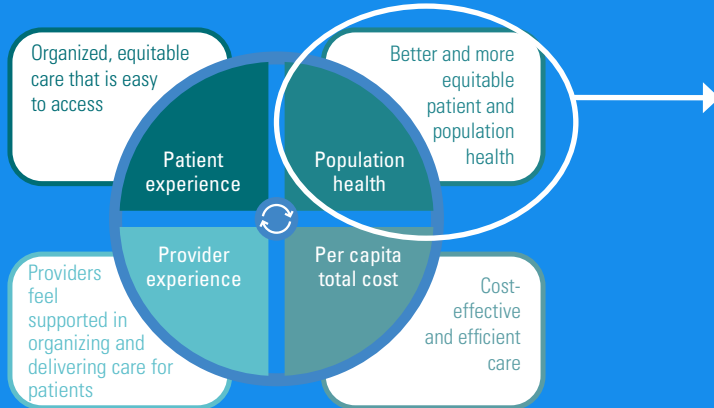


## What is population-health?

"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

### Monitor & evaluate

Using a quadruple aim approach

[to view a video recording](#)

### Implementation & reach

Creating sustainable spread

[to view a video recording](#)

START

### 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.

[to view a summary](#)

An iterative process

### Co-design person-centred care models & service mix

Adapting/adopting and testing evidence-based care delivery

Source: Adapted from Population Health Alliance, 2012