Practical Population Health Management

A Workshop for the Virginia Association of Free & Charitable Clinics

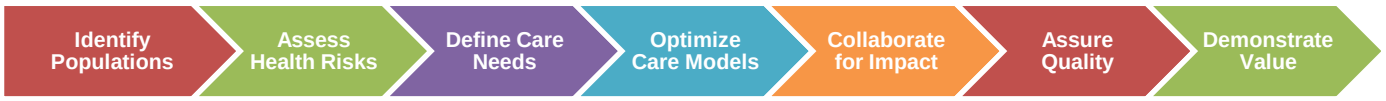
November 10, 2015

Community Health Solutions

Introduction

The term *population health* is widely used, but it is not always clearly defined. As a working definition, a good place to start is with David Kindig and Greg Stoddart in their 2003 article, *What Is Population Health?* In this article Kindig and Stoddart proposed that population health can be defined **as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group,**" and argued that "the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two."[1] This definition is not universally adopted today, but it is probably the most widely cited definition in use.

Another important term in use today is *population health management*. While *population health* refers to the health outcomes of a defined population, *population health management* refers to efforts undertaken to improve health outcomes for the population. As with population health, there is no standard definition of population health management. **As a practical working definition, we can define population health management as the daily practice of improving health and health care relative to cost for defined populations**. We can also define seven core capabilities for health care organizations engaged in population health management as outlined below.



Practical Population Health Management[2]

In this workshop we will learn how to apply the key elements of population health management for defined populations within the context of a free & charitable clinic environment. We will begin with some background on the push for population health management and how the health system is changing in response. We will then apply each of the steps in the population health management model for a population of your choosing. The intended result is for you to be able to apply this model for specific populations within your clinic and community.

On behalf of our entire team at Community Health Solutions, we appreciate the opportunity to present this workshop, and we thank you for the extraordinary work your organizations perform on a daily basis.

Stephen Horan, PhD
Community Health Solutions
9603 Gayton Road Suite 201
Richmond, VA23238
804.673.0166
shoran@chsresults.com

[1] Kindig, D and Stoddart, G. *What Is Population Health?* March 2003, Vol 93, No. 3 | American Journal of Public Health

[2] *Practical Population Health Management* and this workbook are

1. Identify the Population

The first core capability for population health management is the ability to identify the focus population for the initiative. Depending on your purpose, the focus population may include all of your patients or a defined subgroup based on health status and other relevant factors.

1. Who are your patient population groups who could most benefit from population health management? Why?	
2. Choose **one population group** from the list above as the focus population for this workshop.	
3. Can you readily identify the focus population from your records system?	
4. What particular patient data elements are you missing that you would like to have?	
5. What types of information capabilities do you need to build in order to identify populations for population health management?	
Notes	

2. Assess Health Risks

The second core capability for population health management is the ability to determine the health risks present within defined populations. The objective is to examine the health status of the population compared to appropriate goals or benchmarks, and identify opportunities for health improvement. In determining risk it is important to look beyond strictly clinical data to understand the social and environmental factors that influence the health of the population. It is often helpful to classify (or 'stratify') patients into groups based on level of risk as the basis for defining care needs and optimizing care models.

1. What are the key **health risks** you believe are present within your focus population?	
2. Can you readily identify these health risks from your records system?	
3. What are the key **social, economic, and and environmental risks** you believe are present within your focus population?	
4. Can you readily identify these social, economic, and environmental risks from your records system?	
5. What capabilities do you need to build in order to systematically assess the health risks and social/economic/environmental risks for your focus population?	
Notes	

3. Define Care Needs

The third core capability is the ability to define the care needs of specific populations based on examination of their health risks and related factors. Here it is important to consider the complete spectrum of care needs across the clinical and community setting. This is important not only for the populations you serve, but also for your organization, so that you can understand where your scope of influence on population health begins and ends. We suggest using the CHS Health Asset Model as a framework for considering the care needs of the focus population. The Health Asset Model has nine asset categories as outlined below.

Health Asset Category	What are needs of the focus population in each asset category?
1. Knowledge	
2. Motivation	
3. Skills	
4. Behaviors	
5. Financial Capacity	
6. Social Supports	
7. Health Services	
8. Community Services	
9. Supportive Environment	
Notes	

4. Optimize the Care Model

The fourth core capability is the ability to continually optimize your care models for specific populations. Here as in #3, you can use the Health Asset Model as a framework for identifying areas where the current model is strong or needs improvement. Consider the population needs you identified in **Step 3**, and use this section to define specific ways to optimize the care model for the population. For the moment, do not hesitate to identify care elements that your organization or unit cannot provide. Population health management requires collaboration for collective impact, and no single organization is expected to do everything on its own.

Health Asset Category	What would be an optimal care model for the focus population?
1. Knowledge Supports	
2. Motivation Supports	
3. Skill Supports	
4. Behavior Supports	
5. Financial Supports	
6. Social Supports	
7. Health Services	
8. Community Services	
9. Supportive Environment	
Notes	

5. Collaborate for Impact

The fifth core capability is collaboration with external partners. Few if any organizations today can provide the full spectrum of services and supports required for improving the health of specific populations. Clinical and community partnerships are essential for achieving collective impact. Think about the focus population needs you identified in **Step 3**, and the optimal care model you outlined in **Step 4**. Then identify a set of **community partners** who might be willing to collaborate in serving and supporting the focus population.

Health Asset Category	Who could be our partners in serving and supporting the focus population?
1. Knowledge Supports	
2. Motivation Supports	
3. Skill Supports	
4. Behavior Supports	
5. Financial Supports	
6. Social Supports	
7. Health Services	
8. Community Services	
9. Supportive Environment	
Notes	

6. Assure Quality

The sixth core capability for population health management is to assure quality for defined populations. Quality assurance is obviously important for any program of health service or support. In population-based initiatives, it is important to define quality assurance processes for specific populations across the continuum of care. Each service partner must have appropriate quality assurance procedures and measures in place. Also, each service partner must understand the total quality profile for the population, so that each can assure that they are doing their part to achieve the population health objectives.

Health Asset Category	What are the key quality indicators for each type of service or support?
1. Knowledge Supports	
2. Motivation Supports	
3. Skill Supports	
4. Behavior Supports	
5. Financial Supports	
6. Social Supports	
7. Health Services	
8. Community Services	
9. Supportive Environment	
Notes	

7. Demonstrate Value

The seventh core capability for population health management is to define and demonstrate value to key stakeholders. In a given initiative the range of stakeholders may include the population members, service partners, payers, funders, regulatory agencies, public officials, and others. The definition of value is likely to vary across stakeholders, and in some cases, value may be defined in ways that are conflicting or impossible to meet. Given this risk, we strongly encourage health service providers to proactively define your value proposition in terms that make sense within your specific context. Use the framework below to get started on designing your value model.

Health Asset Category	What are the key quality indicators for each type of service or support?
Who are our key audiences for value reporting?	
How can we demonstrate value in terms of:	
1. Number of Patients Served	
2. Patient Engagement	
3. Access to Services & Supports	
4. Utilization of Services & Supports	
5. Quality of Services & Supports	
6. Health Outcomes	
7. Quality of Life Outcomes	
8. Cost Effectiveness	
9. Community Collaboration	
10. Community Impacts	
Other key value indicators:	

Notes & Assignments: