Population Health

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Population health management

PH can be defined as the health outcome of group of individual this population can be geographic region or other group with special characteristic

In USA 80 millions chronic disease patient

Total income impacted of chronic disease is 4 trillion in 2016

Individual health	Public health	Population health
One on one individual health service	Community based prevention Utilizing intervention targeting population (high risk group) Is the art of prevention 3 Ps: Promotion prevention Protection	Look for effective point to intervene through the public health system or through social intervention. Focus on social, cultural, environment and physical condition affecting population

Social determination act one from the important issues can affect population health

Economic stability	Neighborhood and physical environment	Education	Food	Community and social context	Healthcare system
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code/ geography				

Health outcomes
Mortality, morbidity, life expectancy, healthcare expenditures, health status, functional limitations

Challenges of social determination:

1. Lack of assessment Model
2. Screening tool not linked with evidences
3. Lack of resources to collect information

The Association of American Medical Colleagues AAMC describe 10 requirements of a comprehensive PHM

1. Data infrastructure
2. Community engagement
3. Team based care
4. Panel Management
5. Patient risk stratification
6. Care management
7. Complex care management
8. Self management support
9. Addressing social determination of health
10. Ensuring health equity

The Key part of the population health journey is to understand the needs of the patient, engaging the right partners and design effective system:

Using as asset based approach IHI provide a three part data review process:

1. Review available data
2. Understand experience of their team
3. Understand experience of their patient

To ensure the the application of PHM the National committee of Quality assurance NCQA has 4 recommendation:

1. Improve leadership buy in
2. Practitioner leadership
3. Goal setting and alignment
4. Create and communicate the PHM strategies

Pathway of population health:

1. Health and wellbeing develop over the time
2. Social determination drive health and wellbeing
3. Equity of care
4. Address demographic data
5. Health require partnership

Simply we can conclude the target :

1. Improve health wellbeing
2. Improve health equity

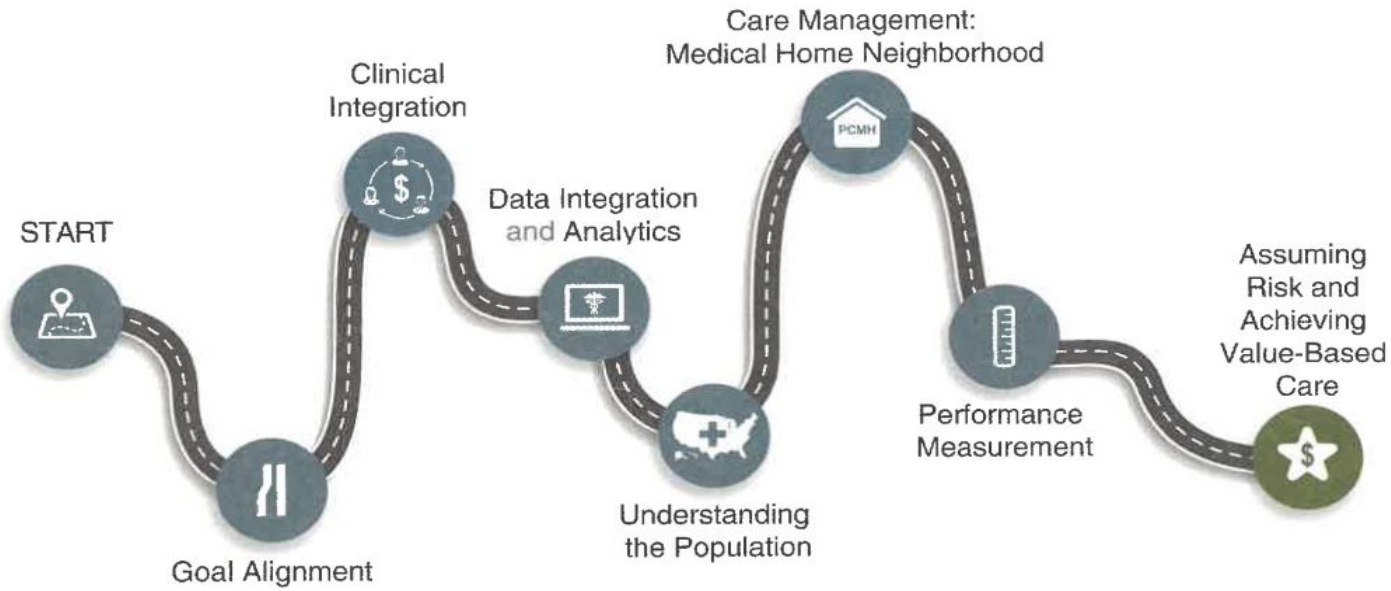

Figure 7.8 Population Health Management Roadmap for Integrated Delivery Systems

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PATHWAYS TO POPULATION HEALTH

Pathways to Population Health
is a collaboration among:

American Hospital Association/ Health Research and Educational Trust

Institute for Healthcare Improvement

Network for Regional Healthcare Improvement

Public Health Institute

Stakeholder Health

Together, these partners leverage their unique assets to help other health care organizations accelerate individual and population health initiatives.

Join health care change agents from across the country as they make practical, meaningful and sustainable advances in population health.

LEARN

- Understand the key concepts and terms that are foundational for the journey to population health.
- Explore four portfolios of work that health care organizations can do to improve health, well-being and equity.
- Identify levers that accelerate progress within and across portfolios.

ACT

- Celebrate where you are on your population health journey and evaluate your balance across the four portfolios.
- Create and implement a plan to improve your organization's population health initiatives.

IMPROVE

- Access a curated set of tools and resources to support your progress.
- Create benchmarks to evaluate and guide your path forward.
- Join health care change agents from across the country to share and improve together.

JOIN

- Sign up to stay connected to the larger Pathways to Population Health community.

FOUNDATIONAL CONCEPTS

The six concepts described below help lay the foundation for the **Pathways to Population Health**. They also articulate several reasons why many health care organizations have chosen to embark on this journey. The concepts represent an evolving understanding of what creates health and the ways in which health care organizations can engage.

1. Health and well-being develop over a lifetime.
2. Social determinants drive health and well-being outcomes throughout the life course.
3. Place is a determinant of health, well-being and equity.
4. The health system needs to address the key demographic shifts out of silos.
5. The health system can embrace innovative financial models and deploy existing assets for greater value.
6. Health creation requires partnership because health care only holds a part of the puzzle.

What creates health ← → How can health care engage?

FOUR PORTFOLIOS OF POPULATION HEALTH

TOOLS AND ACTIVITIES

Access a curated set of tools and resources to support and accelerate your progress

PATHWAYS TO POPULATION HEALTH

For more information please visit:

http://pathways2pophealth.org/learn.html

HRET
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Stakeholder Health

Shifting from reimbursement to healthcare:

Value based Health care	Value based Reimbursement
Focus: This is a broader concept that emphasizes providing high-quality, efficient healthcare services while reducing costs **Key principles:** 1. **Quality over quantity:** Prioritizes outcomes over the number of services provided 2. **Coordination of care:** Ensures seamless care across different providers and settings 3. **Patient engagement:** Involves patients in decision-making and care planning. 4. **Population health:** Focuses on the health of entire communities, not just individuals.	**Focus:** This specifically refers to how healthcare providers are paid for their services **Key characteristics: Payment tied to outcomes:** Providers are rewarded based on the quality of care they deliver and the health outcomes achieved **Risk-sharing:** Providers may share financial risk with payers, such as insurers **Bundled payments:** Payments are made for a group of related services, rather than individual procedures

Importance of continuity of PHM:

Strategy:

1. Needs assessment (physical, social, psychological)
2. Health promotion (Primary prevention, behavior modification,
3. Coordination of care)

Components:

1. Leadership role
2. Patient involvement
3. Care coordination

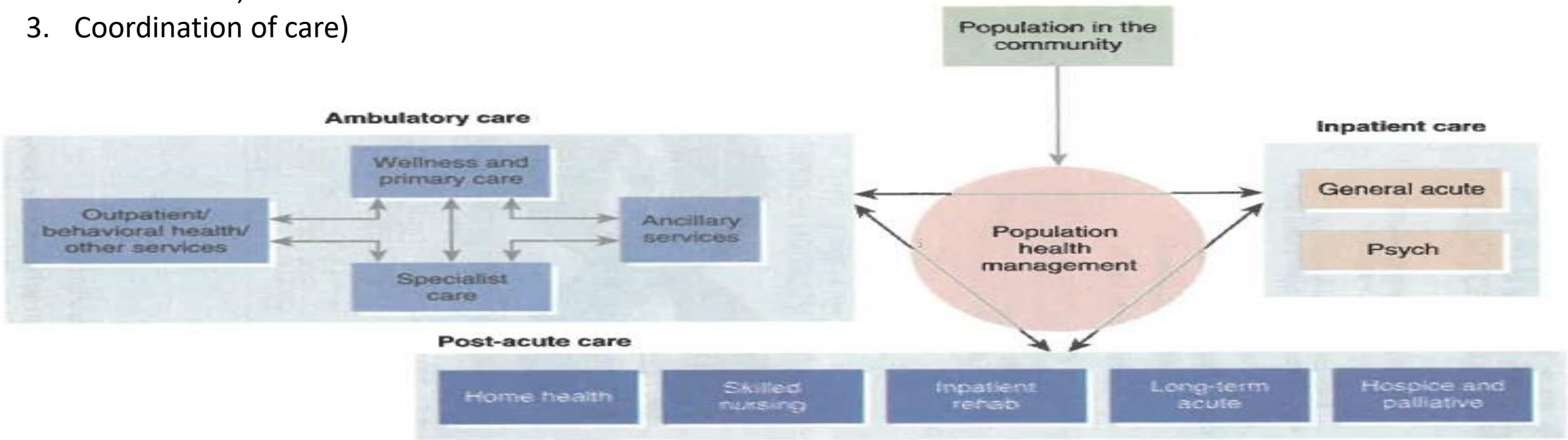

Figure 7.10 Provider Care Continuum for Population Health Management

Quadrable aim:

We agreed before that we have triple aim but with VBHC shifted to Quadrable

1. Affordable service
2. High Quality
3. Good outcome
4. Staff well being

How to promote Quadrable aim:

1. Identify population
2. Design care model
3. Partner for success
4. Derive appropriate utilization
5. Continuously improvement

Care transition: Moving one patient from one health care provider to another

American care management Association ACMA set standard should be followed to ensure the effective transfer:

Standard 1	Standard 2	Standard 3	Standard 4	Standard 5
Identify patients at risk for poor transitions	Complete a comprehensive transition assessment	Perform and communicate a medication reconciliation	Establish a dynamic care management plan that addresses all settings throughout the continuum of care	Communicate essential care transition information to key stakeholders across the continuum of care

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