# SPECTRUM OF POPULATION HEALTH

## Population Health Workgroup

VERSION 6.0 – FINAL – March 30, 2016

**Introduction**

Due to the continued discussions about the meaning of population health, the Population Health Workgroup has developed a functional definition for use by the Idaho Healthcare Coalition, Regional Health Collaboratives and SHIP partners to align conversations and provide for a more robust understanding of the spectrum of perspectives about population health.

**Background**

Depending on your perspective, whether you are part of a healthcare organization or office or are a public health practitioner, you could potentially define population health differently. The healthcare sector leans toward measuring the health of specific subpopulations they serve and for which they are accountable and paid (population health management). Public health leans toward a more broad view of populations such as groups of people living within a geographic area with specific, similar health conditions, issues or demographics, regardless of how they are counted among a patient population (total population health). Public health for example, may look at the number of low income people living in a local health district area with type 2 diabetes. We also know that your perspective and involvement in population health and population health management, impacts either very narrowly or broadly the health of the population, without necessarily considering the narrow or broad influence on the other.

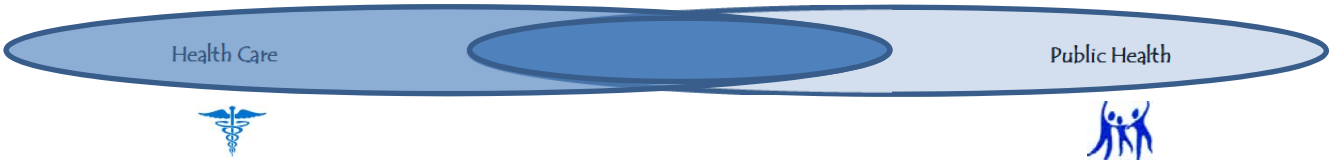
Regardless of the vantage point for population health, the fundamental premise is changing behavior and moving toward better health outcomes for populations, narrowly or broadly defined. The relationship between the individual, clinical, provider-level responses to the broader, community-wide response is important and the bridge between the local, narrow impact and broad impact and finding common ground is important. The following language and schematic forms the basis of a dialog between constituents that influence health at the local level through the constituents that influence health at the broad level and the spectrum of influence on population health in between.

To organize this conversation into areas of focus, the Centers for Disease Control and Prevention (CDC) has developed the following concept (modified) to help describe patient health, population health and prevention in terms of buckets.

- Bucket One - what we commonly understand to occur in the clinician setting with a single patient as a one-on-one interaction. When we think about factors that affect health, clinical interventions have a narrower impact.
- Bucket Two – the intersection between the individual clinical patient care with an extension into the community for support to achieve a larger health impact. This is sometimes called clinical-community linkage.
- Bucket Three - broader approach that has a larger impact on health because it helps change the environmental context to help make the individuals' choice to be healthy the easy choice. With a community wide focus and community construct it is more likely that socioeconomic factors and social determinants of health can be addressed.

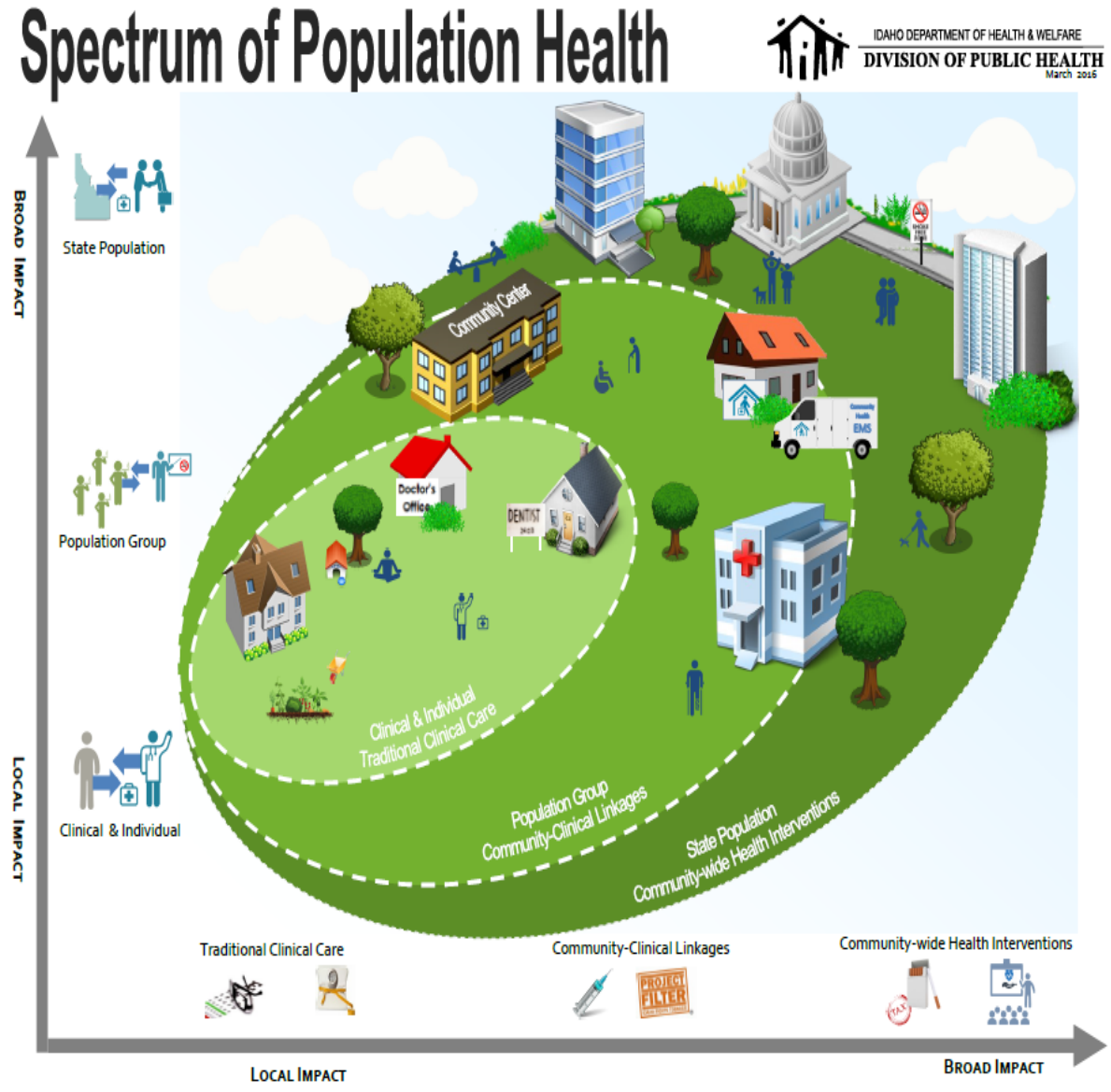
Further elaborating on the three buckets and their intersection and fluidity, a healthcare provider operating in a small rural clinic might not consider how their practice for managing their patient population who smokes might influence the smoking behaviors of the surrounding community. Conversely, the policies, practices and culture in their community related to smoking might influence the behavior of their patients who smoke. The provider might simply tell an individual patient to quit smoking without providing any resources. Or they might have a referral mechanism to cessation resources – either in person, online and/or telephonic – that are free. The cultural norm of the community, however, might be very supportive of smokers through limited clean indoor air policies, easy access to tobacco products and an "everyone is doing it" mentality. Or, the cultural norm of the community might be the opposite and support people in quitting, limit where smoking is allowed, having an active public health district and city council on which the physician can participate to influence the cultural norm through policy change so the healthy choice for their patient population of smokers is the easy choice.

| **Bucket #1:**<br>**Traditional Clinical Approaches** | **Bucket #2:**<br>**Innovative Clinical Care Patient-Centered** | **Bucket #3:**<br>**Community Wide Health** |
|---|---|---|
| Focused on an individual; patient construct | | Focused on broad population; community construct |
| Typical clinical services done in a one on one patient interaction | Linkages that support patients in the community and that provide services outside the clinical setting | Broader, mostly policy-focused aimed at supporting the broad community and the overall health of the population in the community |
| **DIABETES Example** | | |
| Screening for pre-diabetes, diagnosis, treatment, medication, clinical guidance, A1C monitoring, eye exam, foot exam | Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietitian-Nutritionist referral, dental referral, CHW or CHEMS support for blood sugar monitoring and medication management | Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; policies to reduce tobacco usage and trans fats in foods |
| **OBESITY Example** | | |
| Diagnosis, medication, weight and height to calculate body mass index and monitor, blood pressure, cholesterol screening, physician/patient counseling | Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietician-Nutritionist referral, dental referral and cavity risk assessment, CHW or CHEMS support for blood sugar monitoring and medication management | Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; mandatory changes in school vending and physical education courses |
| **TOBACCO Example** | | |
| Screening patients for smoking, ensuring smoking cessation referral, physician/patient counseling | Linkages that support patients in community or medical-health neighborhood, linking patient to cessation class or quit line | Practices and policies that support lower smoking rates statewide (clean indoor air policies, tobacco tax, etc.) |



**The Spectrum of Population Health**

The graphic below depicts the spectrum of population health from the individual, provider and local impact to the broader impact of the community at large including policies, community supports, etc.  Social determinants of health influence all levels of the spectrum.



## Conclusion

The purpose of the Population Health Workgroup, as an arm of the Idaho Healthcare Coalition, is to support the Regional Health Collaboratives in the development of tools and messages that support their work to help transform primary care within their region and improve the health outcomes of the patients served in the clinics and the people living within their communities.

This is done through educating the clinics and medical-health neighborhood about what the spectrum of population health entails and how each level or point in the spectrum (bucket) is interrelated with the next. Collectively, population health is shared accountability for improving health outcomes for all Idahoans by bridging the gap of community determinants of health and the emphasis on healthier lifestyles through interventions, policies and data, to include preventative care, physical activity, nutrition and behavioral risk reduction as they relate to the Triple Aim.

***Adopted by the Idaho Healthcare Coalition 3/9/16***