Population Health

What is it?

The CDC views population health as an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally. This approach utilizes non-traditional partnerships among different sectors of the community — public health, industry, academia, health care, local government entities, etc. – to achieve positive health outcomes. Population health “brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population.”

It is a way to view a group of patients and measure outcomes based for that group.

As part of the transformation to Medicaid Managed Care, the state of NC requires a prevention and population health program for the Tailored Plans. The state’s population health priorities include the following:

- Diabetes.
- Asthma.
- Obesity.
- Hypertension.
- Tobacco cessation.
- Infant mortality.
- Low birth weight.
- Early childhood health and development.
- Additional programs to encourage improved health and wellness.

How to do Population Health Management

The use of data from claims, care management comprehensive assessments, referrals is an integral part of population health. The first step of creating a population health management program will be conducting a data pull, doing data analysis, defining who is in the population and creating agency processes and policies; using evidence-based guidelines. Define how to incorporate, integrate and coordinate care within the population you have defined.
Reminders for Population Health Programs:

1. Focus on outcomes.
2. Collaborate with community resources.
3. Collect and assess the impact of unmet health-related needs.
4. Implement whole-person, patient centered interventions.

Why is Population Health Management Important?

✓ Allows a high-level view of any given population.
✓ Empowers prioritization of work based on health of entire population.
✓ Provides ability to see trends with the population.
✓ Enables delivery of care to impact group of individual members with similar healthcare needs.
✓ Results in knowledge leading to policies, procedures and measurements.
✓ Includes health outcomes and patterns of determinants not realized one member at a time.
✓ Enables member engagement.