Population Health and Nursing

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Population Health Defined

Population health has been defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

Medical care is only one of many factors that affect those outcomes. Other factors include “public health interventions, aspects of the social environment (income, education, employment, social support, and culture) and of the physical environment (urban design, clean air and water), genetics, and individual behavior.”

Kendig and Stoddard 2003

Population Health

From a Clinician's or Health Care Delivery Organization Perspective

Triple Aim of the Institute for Healthcare Improvement:

- improve the experience of care
- **improve the health of populations**
- lower the per-capita cost of care

Population Health Management (PHM)

- The goal of PHM is to keep a patient population as healthy as possible, minimizing the need for expensive interventions such as emergency department visits, hospitalizations, imaging tests, and procedures.
- While PHM focuses partly on the high-risk patients who generate the majority of health costs, it systematically addresses the preventive and chronic care needs of every patient.
- Because the distribution of health risks changes over time, the objective is to modify the factors that make people sick or exacerbate their illnesses.

IHTT, Population Health, 2012

Population Health Management

- Providers that seek to do PHM must help manage personal health behavior in a systematic way. And they should work with community resources such as public health agencies, social service agencies, schools and other local organizations to improve the overall health of their populations

IHTT, Population Health, 2012

Practice-Based Population Health

The federal Agency for Healthcare Research and Quality (AHRQ) has developed a concept called "practice-based population health" (PBPH). It defines PBPH as "an approach to care that uses information on a group of patients within a primary care practice or group of practices to improve the care and clinical outcomes of patients within that practice." Other observers also define the population as a provider's patient panel.

IHTT, Population Health, 2012

Clinical-Community Linkages

1. Coordinating health care delivery, public health, and community-based activities to promote healthy behavior.
2. Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services.
3. Promoting patient, family, and community involvement in strategic planning and improvement activities.
4. Types of clinical-community linkages include coordinating services at one location, coordinating services between different locations, and developing ways to refer patients to resources.

Population Health

From a Health Department Perspective

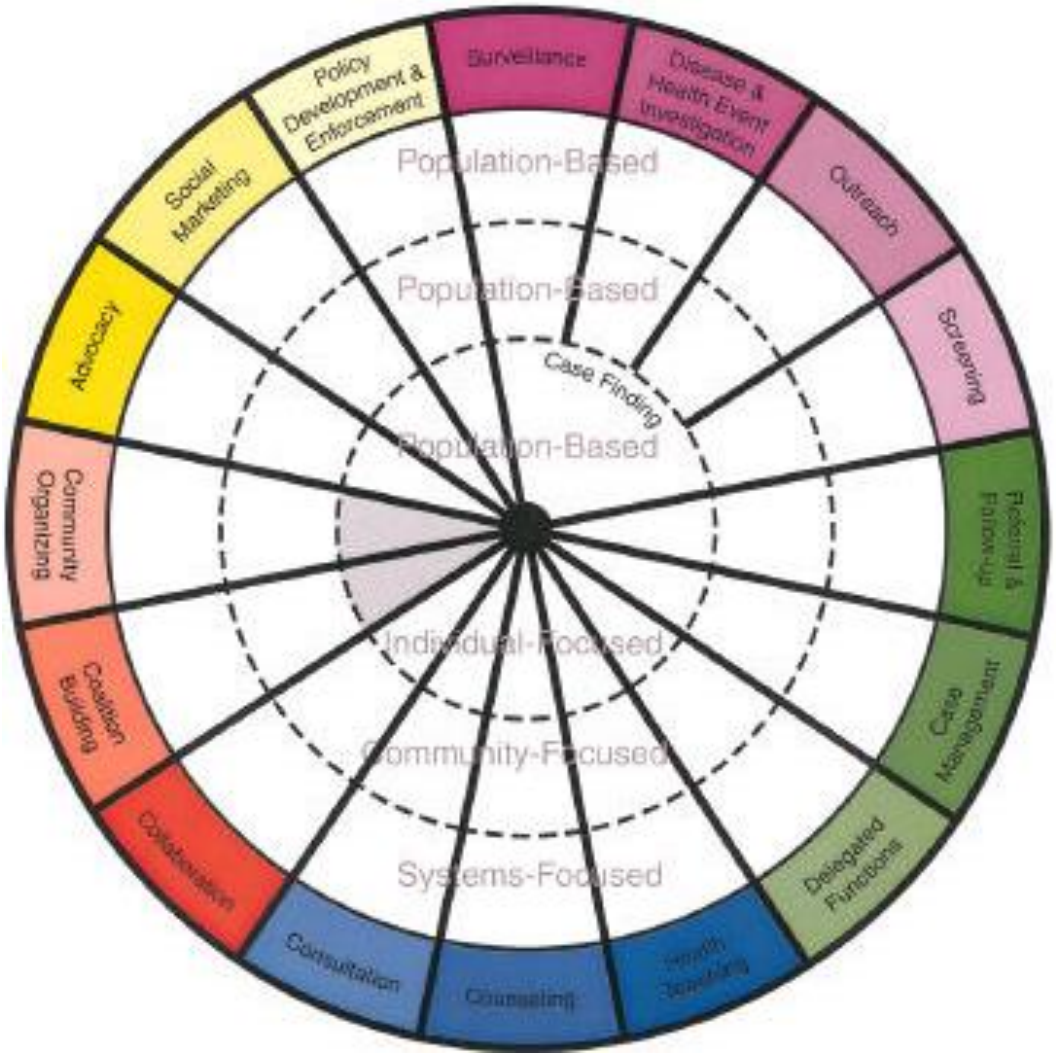
Minnesota Department of Public Health (DPH)

The goal of all levels of population-based practice is to improve population health.

- **Population-based community-focused practice** changes community norms, attitudes, awareness, practices, and behaviors. They are directed toward entire populations within the community or *occasionally* toward target groups within those populations. Community-focused practice is measured in terms of what proportion of the population actually changes.
- **Population-based systems-focused practice** changes organizations, policies, laws, and power structures. The focus is not directly on individuals and communities but on the systems that impact health. Changing systems is often a more effective and long-lasting way to impact population health than requiring change from every single individual in a community.
- **Population-based individual-focused practice** changes knowledge, attitudes, beliefs, practices, and behaviors of individuals. This practice level is directed at individuals, alone or as part of a family, class, or group. Individuals receive services because they are identified as belonging to a population-at-risk.

Minnesota Department of Public Health Role of the Nurse

http://www.health.state.mn.us/divs/opi/cd/phn/docs/0301wheel_manual.pdf



Minnesota DPH Model

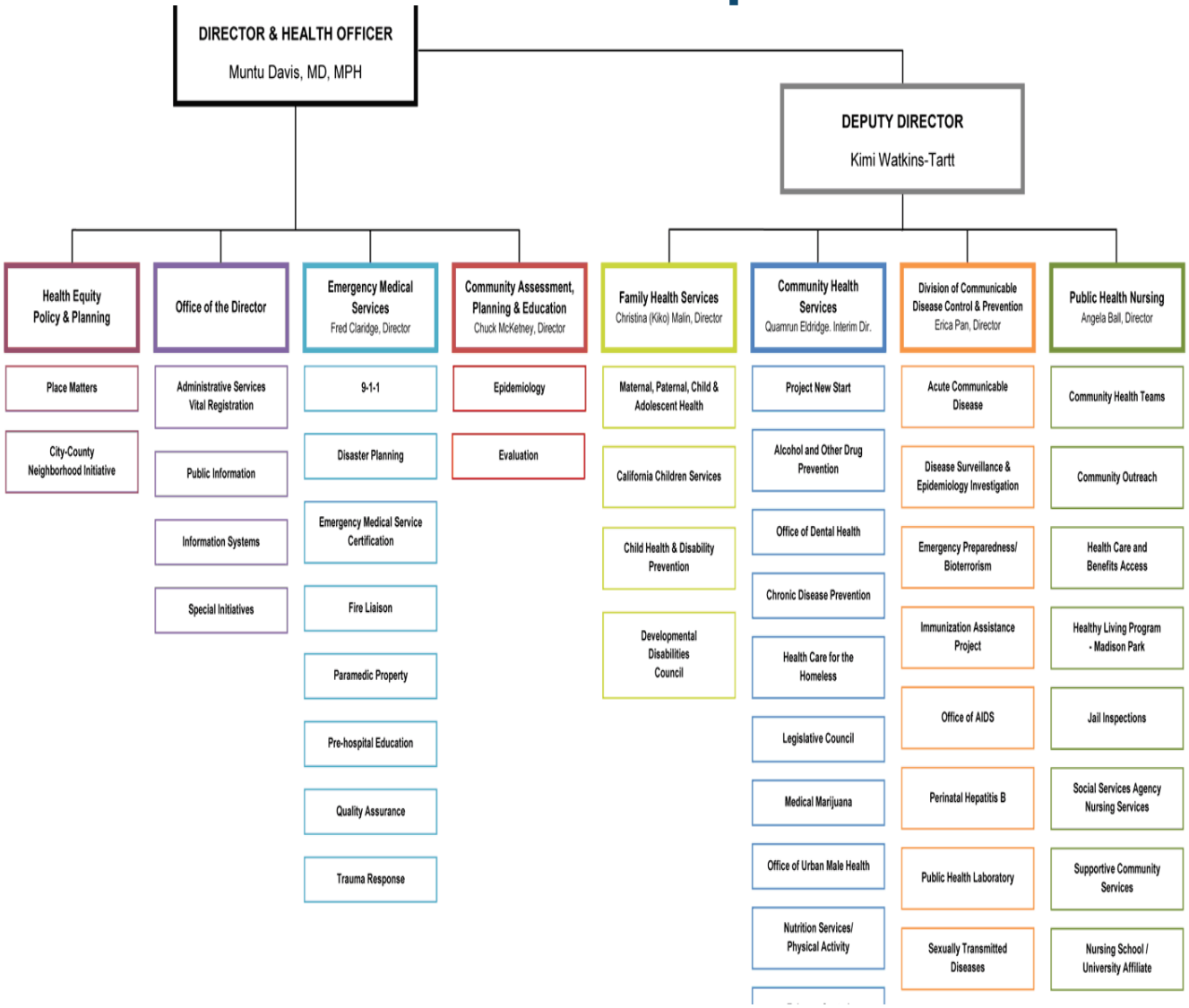
- **Coalition building** promotes and develops alliances for a common purpose. It builds linkages, solves problems, and enhances local leadership to address health concerns.
- **Community organizing** helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set.
- **Advocacy** pleads someone's cause or act on someone's behalf, with a focus on developing the community, system, individual or family's capacity to plead their own cause or act on their own behalf.

Minnesota DPH Model

- **Social marketing** utilizes commercial marketing principles and technologies for programs designed to influence the knowledge, attitudes, values, beliefs, behaviors, and practices of the population-of- interest.
- **Policy development** places health issues on decision-makers' agendas, acquires a plan of resolution, and determines needed resources. It results in laws, rules and regulations, ordinances, and policies.
- **Policy enforcement** compels others to comply with the laws, rules, regulations, ordinances and policies created in conjunction with policy development.

Are we organized for population health?

Organizational Chart
Local Health Department



Toward a Culture of Health

- **Making Health a Shared Value,** measured by indicators such as the percentage of people who strongly agree that health is influenced by their peers and their communities.
- **Fostering Cross-Sector Collaboration to Improve Well-Being**, denoted by measures like the number of local health departments that collaborate with community organizations.
- **Creating Healthier, More Equitable Communities,** using measurements such as the number of grocery stores, farmers' markets, and safe sidewalks in communities; the ratio of children attending preschool; and the affordability of housing.
- **Strengthening Integration of Health Services and Systems,** gauged by measures such as the percentage of people served by a comprehensive public health system and the percentage of physicians sharing electronic data with other clinicians, health systems and patients.

Addressing Health Equity