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Crucial questions for a population health strategy

By Michael DeGere, DPM | April 20, 2017

When considering population health strategy, sometimes the most difficult task is knowing where to start. Even "starting" is a conflicting concept. Aren't we, as healthcare providers, already fully engaged in improving the health of the populations we serve?

That's part of the challenge: Population health is about as broad a healthcare concept as it gets. In fact, the definition I use often — "the relationship between health determinants and health outcomes" — is terrifically non-specific. One tactic I have found to be of great value when approaching population health strategy is continuous attention to specificity. It makes an enormous subject much more manageable.

> "Population health strategy needs to be practical and specific to be successful"

So when it comes to a population health endeavor, consider: Exactly which population are we talking about? Do we have the capability to know, at any given time, who is in that population? Which care teams interact with that population? What specific outcomes do we wish to measure? Are they measurable? If they are, how close can we get to knowing how we are doing in real time? As rudimentary as these questions may seem, answers are often elusive. Charging forward without acceptable answers is perilous at best and futile at worst.

My background is clinical. Before joining executive leadership, I practiced for 12 years as a podiatrist and a foot and ankle surgeon. That experience has framed my viewpoint of how population health strategy needs to be practical and specific to be successful.

An example from my field: A given foot operation may require that a patient bears no weight on that foot for six weeks after surgery, or the operation may fail. Of course, that outcome requires much more than a simple instruction to stay off the foot. It requires consideration of how. How is this specific population (of one person) going to accomplish it? Crutches? Walker? Wheelchair? Is there anyone at home to help, including coordinating or providing transportation? Is there a flight of stairs at home?

You can appreciate that no matter how important the "what" may be (bear no weight on your foot), the "how" requires detailed individual consideration. And as difficult as "how" can be, "why" is even more powerful — specifically, why a treatment plan can or cannot be accomplished. "Why" can empower, or

overpower, everything else. That is what we mean when we talk about determinants of health.

Paradoxically, care providers are often not the authors of population health metrics concerning their own patients. The "what" of population health, therefore, can be frustrating and sometimes even controversial. The counterbalance is designing strategy together, being inclusive of as many stakeholders as possible. This most certainly must include the patients themselves.

Patients are experts in the "why" of their own circumstances. They have reasons for not taking medications as prescribed or not showing up for an appointment, and those reasons are not the same for everyone. Connecting with patients throughout the care continuum is central to our population health strategy at Agnesian HealthCare. It is rooted in a model of care coordination across all settings, including the home. Real-life circumstances determine population health — and population illness.

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There are constraints at all times — in resources, technology, people, connectivity, interoperability, you name it. Because of constraints, and perhaps thanks to them, you cannot work on everything, for everybody, all the time. That's OK. It is actually helpful in focusing your efforts. Since you cannot do everything, what would you like to do every time, and for whom?

The questions as well as the answers require specificity. Constraints also demand prioritization and timely outcomes. With timely outcomes, you can make timely adjustments when things are not working. You can also commit much more confidently to scaling up what is working well. Discovering what is successful also requires recognizing what is not working, and being OK with learning both as you go.

Today, we have access to analytics that can help us organize our work and correlate our findings so that we can apply successful programming across populations. But the enormity of population health management is made much more manageable by getting back to the intuitive basics of one patient at a time.

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