Population Health Framework: 6 Core Components in Practice

6 Core Components	Individual Patient	Population Level
Health assessment	In every patient interaction, we gather available data from the referral, Electronic Medical Record, and/or lab data and combine with a thorough patient health assessment that includes the physical, emotional, and social health of the patient. We understand the lived world of the patient in the context of their disease management and potential disruptors to care and health outcomes.	Using the Electronic Medical Record, laboratory and claims data, and so on, we can assess the health status of our organization's patient population. We can assist in developing a robust electronic patient list (called a patient registry) to include important fields that go beyond traditional clinical results, to also comprise critical social determinants of health factors that often drive patient outcomes.
Risk stratification	Based on available data and health assessment, we establish risk and prioritize care for each patient based on both health care team– and patient-identified needs.	We can categorize patients based on their assessed health status from those at highest risk through to those at lowest risk and prioritize, plan, and implement evidence-based standardized care. We can assist in developing clinical management pathways, ensuring patient-centered care remains a focus.
Engagement	Effective self-care behavior goes well beyond knowledge and skill acquisition. Our ability to connect with our patients and maintain motivation and engagement through identified strategies of "value" for patients and family or support persons is what we do best. We can identify and implement strategies that reduce isolation in both rural and urban settings. The person with diabetes is at the heart of who we are and what we do as diabetes educators.	We can assist in identifying, developing, and utilizing available engagement strategies and tools we have to increase the value proposition across our diabetes population. Engagement strategies might consist of telephonic or virtual health platforms, monitoring and mobile devices, online-portals, social networking, or incentive programs as examples. Patient risk or desire may guide selection of the engagement approach(es).
Communication modality	We identify the best strategies for effective communication and reach—in person and by phone, patient portal, device technology, social media, or connected health.	Identify all available communication tools and strategies and utilize these in the most effective means to address the stratified needs of the population. Utilize more face-to face and remote follow-up communication modalities for higher risk patients and more remote options for lower risk patients.
Patient-centered interventions	We provide multidisciplinary DSMES, and due to our detailed assessment and professional connections, we provide expanded care through guidelines and protocols and connect patients to other required system and community resources.	Provide DSMES at scale, using technology to provide greater access to people with diabetes. Utilize our skill set to identify and assist development or drive the best line of services and resources for segments of our population. We can utilize our education skills to implement workforce training and leveraging to increase system effectiveness, efficiencies, and provider and patient satisfaction.
Outcomes	We typically measure clinical, behavioral, and satisfaction metrics with our patients. We may also assess the experience of our referring providers regarding our services.	In addressing the 4 core goals of the Quadruple Aim (better outcomes, lower costs, improved patient experience, improved provider experience),[6] we have the ability to directly impact system initiatives that derive from alternate payment options, such as grants and state-funded programs.

Population Health: It's What We Do! An Educator's Perspective
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