Creating Clarity: Distinguishing Between Community and Population Health

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Community and population health are 2 similar yet distinct approaches to promoting the public's health through the use of upstream practice and prevention strategies. Recent discussion among the healthcare community has noted conceptual confusion in the means by which each term and their respective strategies are utilized in areas of patient care, public health, and research.[1,2] Given the importance of these terms for those who run accountable care organizations (ACOs), we felt it was necessary to attempt to bring clarity to the understanding of each concept by providing an overview of select definitions from the public health literature and highlighting select areas where we see distinction and overlap. Finally, we provide a model that integrates both conceptual approaches to optimize health in the communities and patient populations we serve.

Community and Population Health: Overview

Table 1 reviews select definitions from the public health literature that are used to describe both community and population health.

Community Health: Overview

Community health is generally rooted in the collective efforts of individuals and organizations who work to promote health within a geographically or culturally defined group.[3,4] Community health initiatives function as "multi-sector and multi-disciplinary collaborative enterprises"[3] that use evidence-based strategies to "engage and work with communities, in a culturally appropriate manner."[3] The progress and success of these initiatives originate from the community members, who are collectively empowered to address self-identified vulnerabilities (eg, education, employment, public safety). In other words, the community and its relevant characteristics are—in and of themselves—considered to be "an essential determinant of health"[4] for each individual who is part of, or becomes affiliated with, a community's given membership.

Population Health: Overview

Population health, alternatively, uses an outcome-driven approach to "manage" health for a specific group of individuals, typically defined by attribution.[5-7] These interventions involve the tracking and measurement of "health status indicators"[7] (eg, high blood pressure, cholesterol) within these groups to provide insight and direction on how to best prevent the onset or future development of certain health conditions (eg, ischemic cardiac disease). Health determinants, such as healthcare access, genetics, and individual behavior, also tend to be included in this description, as they play an influential role in an individual's history and current health status.[7] Given their nature, the majority of population health interventions tend to be led by healthcare organizations, including ACOs, who have a responsibility—financial or otherwise—to report outcomes involving the patients under their management or care.

Community and Population Health: Areas of Distinction and Overlap

Table 2 provides a list of dimensions (ie, key descriptors, populations targeted, interventions utilized, and measurement) that were selected to further highlight areas of distinction and overlap between these terms. Each of these dimensions has been outlined in further detail below.

Table 1. Select Community and Population Health Definitions From the Public Health Literature

TERM	YEAR	SELECT DEFINITIONS
Community health	2014	"A multi-sector and multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in defined communities."[3]
	2006	"A perspective on public health that assumes community to be an essential determinant of health and…takes into account the tangible and intangible characteristics of the community—its formal and informal networks and support systems, its norms and cultural nuances, and its institutions, politics, and belief systems."[4]
Population health	2003	"The health outcome of a group of individuals, including the distribution of such outcomes within a group."[5]
	1999	"The health of a population as measured by health status indicators; and as influenced by social, economic, and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services."[7]

Table 2. Areas of Distinction and Overlap in Community and Population Health

DIMENSIONS	Community health	Community and population health	Population health
KEY DESCRIPTORS	Collaborative, initiatives, empowerment	Disease prevention, health promotion	Outcomes, management, accountability
POPULATIONS TARGETED	Geographically and/or culturally defined	Patient population within a community-defined area	Typically defined by attribution
INTERVENTIONS UTILIZED	Broad scale (social determinants)	Disease prevention, health promotion	Population-specific (access; prevention)
MEASUREMENT	Overall health; community efforts	Community health needs assessments	Health status indicators; healthcare outcomes

Key Descriptors

Based on the overview provided above, there are key descriptors that may collectively describe each concept. The terms "collaborative," "initiatives," and "empowerment" are foundational to community health, as they emphasize the integration of multiple entities working together. Population health descriptors, on the other hand, are more generally aligned with "outcomes," "management," and the notion of "accountability," as they outline the methods by which health is managed for a targeted group of individuals. Overlap amongst each strategy can be recognized in the shared mission of enhancing disease prevention through the use of upstream health promotion strategies.

Populations Targeted

Although community and population health strategies may be created to promote health for separate groups, there are cases in which a natural overlap occurs. Community health initiatives are developed by and for individuals who either live in a common geographical region (eg, shared neighborhood or city block), or demonstrate unity with regard to a shared cultural practice (eg, speak the same language, practice the same religion). Population health interventions are generally driven by healthcare organizations to target health in patients whom they may be held accountable for (eg, members of a health plan, individuals categorized by a health status indicator). Overlap among each strategy can be recognized when members of a given community (eg, neighborhood in Baltimore County, Maryland) are also members of a prioritized patient population (eg, individuals who suffer from mental illness) within a given health plan (eg, Health Plan B).

Interventions Utilized

Community and population health programs may be utilized to target similar health outcomes, yet their strategies for implementation often differ. In community health, broader-scoped initiatives are generally introduced to reduce health inequities involving the social determinants—or the circumstances in which people are born, grow, live, work, and age.[8] Examples of community health programs may include actions to improve education, reduce unemployment, or enhance a community's built environment. Population health interventions, alternatively, are typically developed with a more specific focus to promote health in a prioritized or "at-risk" population. Examples of population health programs may include efforts to increase the frequency of child vaccinations, reduce the rate of teen pregnancy, or enhance smoking cessation for adults with chronic obstructive pulmonary disease.

Given the nature of the groups they serve, community and population health interventions may overlap in their exposure to certain individuals. As an example, consider Maria Corral who lives in City Block A and is a beneficiary of Health Plan B. In January, a community health program was introduced to provide education on dense breast tissue for women who live in City Block A. Also, during that time, a population health intervention (eg, health plan incentives) was used to increase the number of breast cancer screenings for women older than 40 years who are members of Health Plan B. This interaction of both community and population health efforts will likely increase the probability that Corral schedules and completes her preventive screening appointment and, as a result, further reduces her risk of late breast cancer detection.

Measurement

The methods and necessity by which community and population health is measured and evaluated contrasts for both conceptual models. Community health can be broadly examined with respect to the overall health and interactive health efforts of its community members. As an example, the Community Tool Box, developed at the University of Kansas, provides a framework to assess community health based on 2 basic premises: the community's comprehensive view of health and its commitment to health promotion.[9] The former is examined with respect to prerequisites such as shelter, education, food, income, and equity that exist within the community. The latter is considered with respect to the steps taken to improve and sustain a community's well-being, such as building health policy, creating supportive environments (natural, built, economic, social, etc), and strengthening community action.

The impact of individual community health initiatives may not need to be rigorously evaluated. Individuals who participate in many of the community health programs (eg, vaccination education) often do so voluntarily, and are not required to provide any follow-up data after the program's completion (eg, 30-, 60-, 90-day reports). Measurement, in these cases, can be assured at the broader community level. An alternative measurement strategy, for example, might involve the consideration of community trust, their understanding of distributed findings from a recent study, or the improvement of environmental conditions in which the community lives. In either case, community health initiatives must be measured and evaluated such that results may be considered at the broader community level.

Unlike community health, population health is grounded in the science of epidemiology, or the measurement and comparison of risks and health outcomes in different patients over time. Therefore, the measurement of population health interventions requires more rigor in the tools and methods used for evaluation. The management of population health data can be used to determine: a) the types interventions introduced to priority populations and b) the impact of an intervention on a targeted health outcome. As important, is the consideration of intermediate outcomes, which can be managed early on, to prevent the advancement in future health conditions. The management of obesity or a high body mass index, for example, may influence the future risk of developing diabetes or hypertension. Healthcare organizations that use population health interventions must be able to evaluate healthcare outcomes to ensure they are providing their patients with valued care. ACOs, for example, which aim to drive value in healthcare by improving health quality and reducing healthcare costs, have an assured responsibility to optimize patient health through the use of effective health interventions and strategies. Without the critical ability to track, evaluate, and benchmark patient outcomes, ACOs would be unable to demonstrate, or be held accountable for, the valued care they provide to the patients and families they serve.

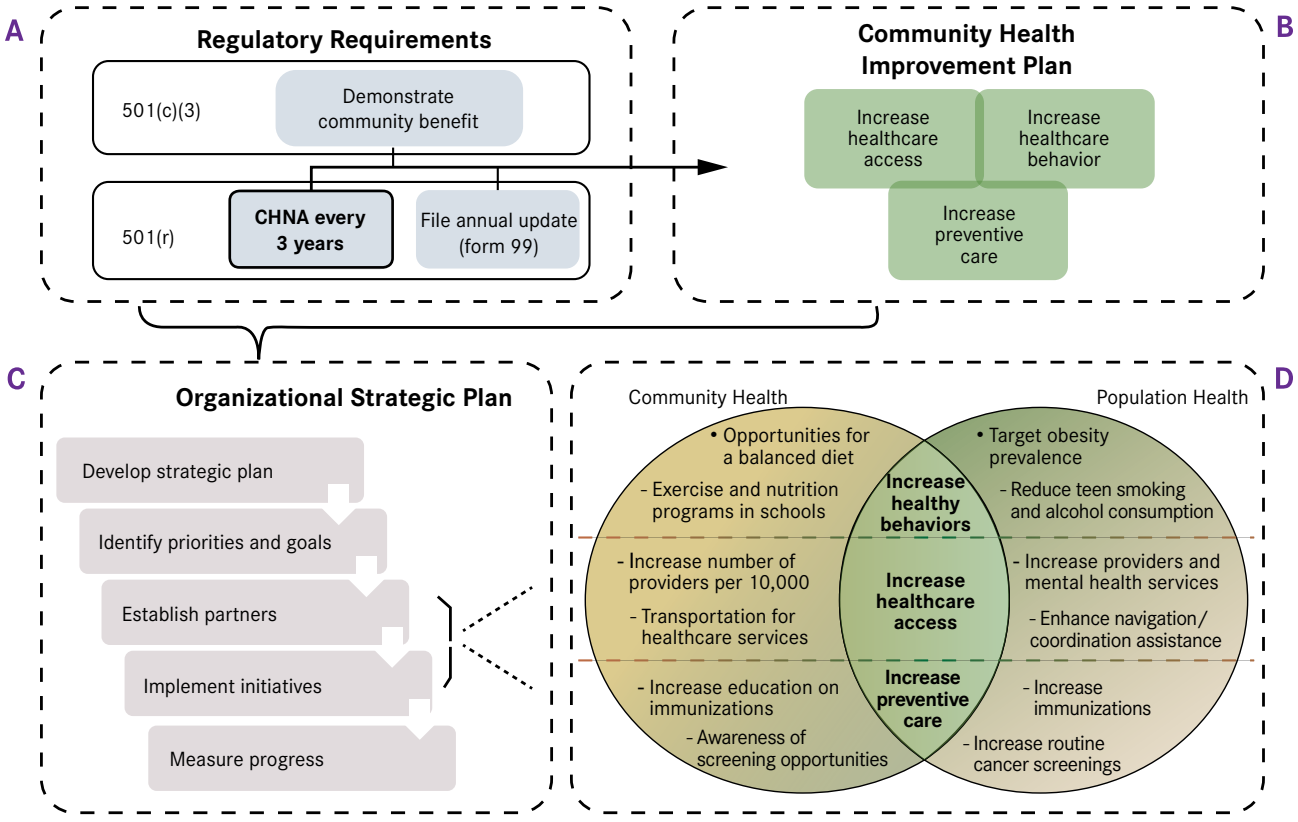
An overlap between community and population health strategies may be observed when community health initiatives are used to enhance the measurement and assurance of health outcomes in the management of population health. Nonprofit health systems serve as an important platform for this interaction to occur. Given the tenets under which they operate, nonprofit hospitals are required to provide community benefit through both community-building strategies (eg, creating physical and environmental improvements, supporting economic development) and improvement of health services (eg, hospital subsidized programs to provide free or reduced-cost clinical care).[10]

Integrating Community and Population Health

Figure 1 provides an example of how nonprofit health systems may capitalize on the use of an integrated community and population health approach to meet current regulatory requirements, and most effectively deliver health to the communities and patient populations they serve. Figure 1 panel A, lists the regulatory requirements under which nonprofit hospitals must provide community benefit to maintain their 501(c)(3) tax-exempt status.[11] Section 501(r), introduced via the enactment of the Affordable Care Act, requires that this benefit also be explicitly and publicly demonstrated by conducting a Community Health Needs Assessment (CHNA) at least once every 3 years.[11] Figure 1 panel B shows how the CHNA can yield a Community Health Improvement Plan (CHIP), which identifies the top priorities and strategies for health improvement within that particular community (eg, increase healthcare access, increase healthy behaviors, and increase preventative care strategies).

Although there may be variation in the methods by which each nonprofit healthcare system addresses the identified unique community needs, they will most likely share a common foundational approach for doing so. As an example (Figure 1 panel C), the nonprofit healthcare organization might work to develop a strategic plan, identify priorities and goals, establish partnerships, implement

Figure 1. Nonprofit Community Benefit Demonstration



CHNA indicates Community Health Needs Assessment.

initiatives, and measure progress. The partnership component of this approach plays a particularly important role, as the methods by which each initiative is targeted will be navigated by the clinical-, community-, and population health–focused partners involved. Figure 1 panel D provides an example of how community and population health programs can be integrated to improve health in the targeted community CHIP areas.

Following the introduction of community and population health interventions, an evaluation of their combined impact may be conducted at the population health level. Targeted health outcomes, such as decreasing obesity rates and increasing immunizations, for example, can be evaluated with respect to the prior health histories of each targeted patient population (eg, overweight adults and children, respectively). Assurance of this progression must also be considered, as the nonprofit hospital driving these initiatives will need to file an annual report (ie, Schedule H, Form 990) of recent progress toward meeting the identified health priorities (Figure 1 panel A). This includes, but is not limited to, providing a review of what the CHNA described, indicating whether or not the information has been distributed to the community, and listing what has been done to improve the identified needs.[12]

Community and Population Health: A Case Study Model

The imperative for nonprofit healthcare organizations to demonstrate how they provide benefits and deliver health to the patients and communities they serve has never been greater. Now, more than ever before, there is a growing number of health systems across the country that have had their tax-exempt status challenged because of a failure to meet 501(c)(3) requirements.[13,14] Morristown Medical Center, within the Atlantic Health System in New Jersey, is one recent example where a nonprofit hospital was asked to back-pay property taxes from 2006 to 2014.[15]

Health Institutes: Overview

A model currently being used by Renown Health to help drive community benefit in Washoe County, Nevada, involves the integration of community and population health strategies to create health "Institutes." In this model, an Institute serves as a decentralized and partnership-based initiative that works to leverage and coordinate regional expertise to improve health in a prioritized patient population. Tactical centers within each Institute then work to deliver support and solutions for these populations in 5 core areas: care delivery, social justice, advocacy, education, and research. Community benefit from the com-

bined efforts can then be evaluated with respect to reported changes in disparities found between the targeted groups' overall health and wellness compared with local, regional, or national averages.

To best deliver benefit to the Washoe County community, Renown Health uses the Institute model to target 3 priority populations: children (birth to 18 years), seniors (55 years or older), and individuals who suffer from mental illness and addiction (all ages). The Child Health Institute (CHI) targets socioeconomic factors and areas of healthcare delivery influencing pediatric health. The Healthy Aging Institute (HAI) works to build safe and supportive community environments to enrich the lives and well-being of seniors. The Behavioral Health Institute (BHI) strives to create an emotionally resilient and thriving community by addressing the mental health and additional needs of all individuals. Although the focus of each Institute is specialized to address the nuances of a targeted population, the shared used of a common tactical strategy helps to promote collaboration and seamless support for individuals who fall into more than 1 area (eg, a senior with mental illness).

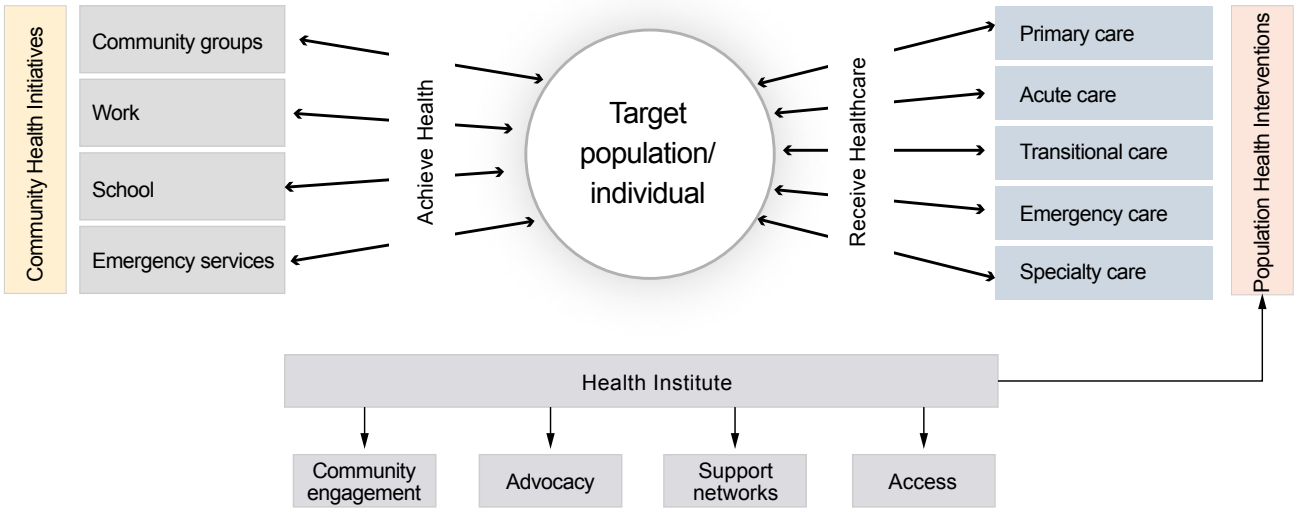
Health Institutes: Example

Figure 2 provides a visual representation of how each Institute model is used to impact health within its targeted population. To begin, the target population/individual is strategically placed at the center. Using the Institutes at Renown Health, as an example, these populations/individuals include children (CHI), seniors (HAI), or individuals who suffer from mental illness or addiction (BHI) within Washoe County. Moving outward, the bi-directional arrows on the left illustrate the environments in which an individual's health may be affected and influenced during decisions in their daily life, including community group, work, school, and emergency service environments. To target health beyond the individual and create impact at the broader community level, community health initiatives (eg, exercise or nutrition programs) may be introduced in similar environments through the community. Also, given the nature of community health initiatives, the individuals who benefit from these community health programs (eg, walking programs at work) may have played a role in their development.

Next, located to the right of the target population in Figure 2, are the methods by which an individual receives healthcare. As a nonprofit health system, healthcare is delivered to patients via primary, acute, transitional, emergency, or specialty care services. The bi-directional arrows are provided to illustrate the essential interactive nature of patients and families throughout this healthcare delivery process. By engaging patients and their families with pertinent healthcare decisions, healthcare providers will likely see greater compliance and, as a result, greater improvements in the patients' overall health outcomes. Further, to best manage similar outcomes at the greater population level, population health management interventions (eg, flu vaccinations) may be utilized during and between visits within the nonprofit health system.

Finally, located along the bottom of Figure 2, is the given health Institute. Each Institute serves as integral coordinating entity, which combines community and population health strategies, to most effectively promote engagement, advocacy, support, and access for the Institutes' target population. For the CHI, this may include connecting caregivers and families with community resources, establishing a pediatric residency with the local medical school, building partnerships with social services, or working to create healthcare access for children without homes. Strategies for the HAI may include building community structures to support active senior living, partnering

Figure 2. Health Institute Framework



with local organizations to provide opportunities for social interaction, or delivering education to families about how to best care for their aging family members. Lastly, for the BHI, objectives may be formed to integrate mental health and addiction care into regular primary care services, measure and leverage outcomes research for ongoing improvement, integrate best practices with partners who provide recovery-focused housing, or develop psychoeducation materials for the community and general public.

Conclusions

Community health and population health are 2 similar yet distinct concepts that attempt to enhance health in a defined group of individuals. Each strategy is uniquely valuable and, when integrated, can provide significant benefit to the community. Through the use of innovative strategies that incorporate ommunity health initiatives and population health interventions, nonprofit hospitals and ACOs will be able to most effectively deliver health in the communities and patient populations they serve.

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