Define the Problem

A population health approach is designed to address a health issue in a given population. Clear definitions can help with planning interventions and evaluation. Below are some recommended steps:

Identify populations of focus

Populations may be defined by shared characteristics or health concerns. For example: all patients with diabetes; Medicaid patients with diabetes; patients 55 and older with diabetes. Looking at your assessment, which population groups show disparate health outcomes? Are there specific groups that experience unique barriers to health and wellness? Are social and environmental factors impacting some populations more than others? Once a population is identified, it’s important to define it as specifically as possible to help with determining metrics.

Quantify the issue

What health issue stands out in your assessment? Be as specific as possible in quantifying the issue, whether by incidence rates, prevalence within a population, trends over time, or another criteria agreed upon by partners.

Develop a concise issue statement

A clear statement of what issue your community will address, why it is important, and what you hope to achieve can help with planning interventions and achieving desired outcomes. Some considerations when developing a statement:

- Include background information. What informed the decision to focus on this issue? This population?
- Solicit input from stakeholders, including those who will be engaged in the work, affected by the interventions, and involved in decision making.
- Briefly describe the intended approach to the issue and outcomes the community hopes to achieve.

Determine goals and metrics

Progress on improving population health requires a shared goal that is specific enough to be measured. Goals should be determined based on assessed needs, resources and feasibility, with input from multiple partners and stakeholders.
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Health outcomes involve a complex set of factors, so it is helpful to include metrics inside and outside the health care systems, including social determinants.

Because desired outcomes may be long term, intermediate measures can be identified that serve as progress markers.

For additional help, see Resources at the end of this page.

Challenges

**Challenge:** Health care providers are focused on practice transformation with their patient population. Other partners may want to focus on total population health, or a specific subpopulation, in your community.

Try: Build bridges between health care and community services around common goals. Some examples include supporting home visiting, mobile health care in schools and worksites, and community health workers. Enlist provider help in ways that are not time consuming; for example, signing a letter of support for a health-related policy.

**Challenge:** It can be tough to develop strategies that serve a geographically defined region and still take into consideration specific populations that have unique characteristics and needs.

Try: Ask your local health jurisdiction for help identifying subpopulations in your region, and connect with community organizations and nonprofit agencies for ideas on how to best serve them. As mentioned under Health Equity, go to the communities themselves; they are the experts.

Resources

- “Problem Description,” Centers for Disease Control and Prevention
- “Guide to Prioritization Techniques,” National Association of County and City Health Officials