



Population Health Management Course: Risk Stratification and Chronic Disease Programmes



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Introduction:

Population health management covering risk stratification and chronic disease programmes is a 5-day course for health cluster, payer, public health and primary care leaders and analysts, ending with a Population Health Programme Design for a case chronic-disease population. Many organisations still wait for patients with long-term conditions to present in crisis, so avoidable admissions, missed screening and widening health gaps persist. Nominees already plan primary care services, analyse utilisation data or run disease programmes, and work through case studies on registry, claims and community data. CoreConcept Training Center delivers this population health management course.

Course Objectives:

- Define a target population and build a baseline of prevalence, utilisation and avoidable admissions for a health cluster or payer
- Segment the population and apply risk stratification models with calibrated thresholds to assign healthy, rising-risk and high-risk tiers
- Set up chronic disease registries with inclusion rules and recall lists that drive proactive outreach
- Match care management, care coordination, preventive screening and social prescribing interventions to each risk tier
- Analyse linked population health data for inequality gaps and connect outcomes to value-based payment arrangements
- Evaluate intervention outcomes with comparison groups and assemble a Population Health Programme Design with risk tiers and KPIs

Target Audience:

- Health cluster and primary care network managers accountable for the health of an enrolled or catchment population
 - Payer and health insurer care management teams responsible for identifying and contacting high-need members
 - Public health managers who run screening, prevention and chronic disease initiatives
 - Population health and health intelligence analysts who build risk models, registries and dashboards
 - Primary care clinical leads who oversee long-term condition clinics and multidisciplinary care plans
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Course Outline:

Day 1: Population Health Management Foundations and Population Baseline

- Population Health Versus Public Health and Disease Management Scope
- Four Pillars of Population Health Applied to Local Needs
- Defined Population Boundaries by Enrolment, Catchment or Panel
- Avoidable Admission and Emergency Attendance Drivers Analysis
- Population Baseline Profile of Prevalence, Utilisation and Gaps

Day 2: Population Segmentation and Risk Stratification Methods

- Population Segmentation by Life Stage and Condition Burden
- Risk Tier Pyramid for Healthy, Rising-Risk and High-Risk Groups
- Predictive Risk Scores Using Utilisation, Diagnosis and Pharmacy Data
- Multimorbidity and Frailty Flags in Risk Stratification Models
- Risk Model Calibration, Thresholds and Case-Finding Accuracy Checks

Day 3: Chronic Disease Registries, Care Coordination and Prevention

- Chronic Disease Registry Fields, Inclusion Rules and Recall Lists
- Care Management Caseloads for High-Risk and Complex Patients
- Multidisciplinary Care Plans, Health Coaching and Self-Management Support
- Preventive and Screening Uptake Targets and Recall Design
- Social Prescribing Links for Social Determinants of Health

Day 4: Population Health Analytics, Value-Based Links and Evaluation

- Population Health Analytics Data Sources and Linkage Quality
- Health Inequality Gap Analysis by Segment and Neighbourhood
- Value-Based Payment Links to Shared Outcomes and Risk Tiers
- Outcome Measures for Admissions, Disease Control and Experience
- Intervention Evaluation Pitfalls Including Regression to the Mean

Day 5: Case Study: Population Health Programme Design for a Chronic-Disease Population

- Case Population Baseline and Segmentation Data Review
 - Case Risk Stratification Model and Risk Tier Allocation
 - Tiered Intervention Bundle and Care Management Capacity Plan
 - Population Health KPI Set With Targets and Review Cadence
 - Population Health Programme Design With Risk Tiers Completion
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Skills You Will Gain:

- Population Baseline Profiling
- Population Segmentation
- Risk Model Calibration
- Chronic Disease Registry Management
- Care Management Caseload Planning
- Health Inequality Analysis
- Population Outcome Evaluation
- Population Health KPI Design

Why Attend This Course:

- Deliver a Population Health Programme Design with risk tiers and KPIs to the cluster executive team, payer medical director or public health board
- Decide which patients enter care management, which receive screening recall and which need social support first
- Avoid spending care coordinator time on patients who would improve anyway while rising-risk groups go unnoticed
- Share risk tier rules, registry templates and the KPI set with clinic teams, analysts and outreach staff

Conclusion:

Back at work, the participant gives the cluster executive team, payer medical director or public health board a Population Health Programme Design that defines the case population, its segments and risk tiers, the registry and recall rules, the intervention bundle for each tier and a KPI set with targets. Leaders use it to approve care coordinator caseloads, screening recall priorities and data linkage requests. After the first review cycle, the unit should compare admissions, disease control rates and tier movement against the baseline and recalibrate the risk thresholds.

Frequently Asked Questions FAQ:

What should participants know before a population health management course?

Participants should already plan primary care or disease programmes, manage care teams or analyse health utilisation data. Bringing an anonymised extract of registry, claims or activity data from their organisation helps them apply the risk stratification and case work to their own population.

How does population health management differ from a health financing or hospital strategy course?

It focuses on identifying who in a defined population is at risk and organising proactive care, prevention and outreach for them. Health financing courses cover pooling and provider payment, and hospital strategy courses cover service lines and competition; both appear only briefly here.

Why is risk stratification central to population health management?

Risk stratification ranks people by their likelihood of future harm or high service use, so limited care coordinators and clinic slots reach those who gain most. Without it, programmes tend to enrol already visible high users, many of whom improve without intervention.

What do participants take back from a population health management course?

Participants take back a Population Health Programme Design for a case chronic-disease population, with segmentation, risk tier rules, registry and recall design, a tiered intervention bundle and a KPI set with targets they can adapt to their own population.