Workshop

THE CHALLENGES & USE OF DATA FOR POPULATION HEALTH MANAGEMENT

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Moderators

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Private, not-for-profit foundation

Mission: *To support and benefit the work of community health centers nationally*

Primary Goal: *To help CHCs address key challenges and drive positive, sustainable change for the community health center market*
RCHN CHF Population Health Initiative

Aims

➢ To support health center-level progress toward improving population health management capacity and outcomes
  – Strengthen capacity to identify, engage and manage health in a defined population
  – Deepen features of patient- and community centered health home
  – Influence social determinants of health

➢ To encourage local and regional collaborations and broader opportunities for sharing best practices.
What is population health?

- Builds on The Triple Aim, first proposed by the Institute for Healthcare Improvement (IHI) with focus on three dimensions:
  - improving the health of the population;
  - enhancing the patient experience of care; and,
  - reducing per capita cost of care.

Adapted by the National Strategy for Quality Improvement in Health Care to include:

- Better care that is patient-centered, reliable, accessible, and safe.
- Affordable care for all stakeholders, including individuals, families, employers, and governments; and
- Healthy people/healthy communities - supporting proven interventions in addition to delivering higher quality care.
Supported projects

- **Health outcomes in defined areas:**
  - African American Infant Mortality (Erie County, Ohio)
  - Smoking reduction in New York City’s Chinatown (New York, N.Y.)

- **Patients identified with defined health center or system of care**
  - High-risk, chronically ill homeless individuals (Santa Rosa, Ca)
  - Patients with uncontrolled diabetes (Joplin, Missouri)
  - Colorectal cancer (Phoenix, Arizona) and cervical cancer screening (Colorado)
  - Pediatric emergency room utilization (Queensbury, New York)
Common data-related themes across grantees

- Managing care coordination and transitions of care with available applications, registries and “dashboards”
- Managing and using free-text input to EHRs
- Obtaining timely and actionable patient information from external care settings
- Collecting and utilizing data at total population level
- Strengthening staff skills in data collection & analysis.
Workshop Discussion Topics

- Care coordination including:
  - Care transitions
  - Care/case management
  - Translating data/information into effective care & interventions
  - Role of EHRs
  - Software for care management
Workshop discussion topics, cont.

- What are the key work processes associated with care management?
- What HIT applications, including EHRs, are in use?
- What are the most prominent issues, impediments?
- How have these been addressed in your organization?
Workshop Format

- **Introduction** (5 minutes)
- **Summary of participant pre-workshop survey (See Appendix)** (5 minutes)
- **Participant highlights of care management challenges** (10 minutes)
- **Discussion groups** (30 minutes)
  - intra & inter group discussions
- **Presentation of issues & questions from discussion groups** (5 minutes per group - total 25 min)
- **Group discussion with participation of moderators** (40 minutes)
- **Summary** (5 minutes)
Summary & Last Thoughts

- Input from participants
- Moderators’ last thoughts
What are your primary population management information needs and challenges? Consider:

- Identifying population/sub-populations, their characteristics & risks
- Enhanced access and engagement of patients/families in team based care
- Care Coordination & Care Transitions among different settings
- Clinical Decision Support for providers and teams
- Quality Improvement

What have been your big wins during the past year?

What tools, including the EHR and other software, do you use to collect & analyze data & track metrics for population health management?

What clinical decision support tools are in use?

Do you use a data warehouse or data extract for data analysis? If so, can you share one example of its impact on major population health management issues like care coordination or quality improvement?

* To be filled out on-line & returned after workshop registration
Thank You

Please feel free to contact us for more information

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