

Regional Learning Session: Data Driven Population Health



Healthcare Collaborative
of Greater Columbus



Opportunities and Challenges in Data Collection and Use for Population Health Efforts

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Objective:

- Share evolutions in CliniSync's Data Mart/Populations Health scope of work and understand the impact that the HIE can have on clinical decision making and data exchange

The CliniSync Network



Over 14 Million unique patients in the HIE



155 hospitals in Ohio, Kentucky and West Virginia



2,335 community organizations



500+ LTPACs

67 Home Health

31 Hospices



10 health plans including 4 Medicaid Managed Care Plans

What is Data driven Population Health

Data driven Population Health is the aggregation of **patient** data across multiple technology resources, the analysis of that data into a single, **actionable** patient record, and the actions through which care providers can **improve** clinical, quality and financial outcomes. The Patient level data is also used improve the health **outcomes** of a group by monitoring and identifying individual patients within that group

Data

- **CLAIMS DATA** is often considered the starting point for healthcare analytics due to its standardized, structured data format, completeness.
 - The data is retrospective – sometimes months or years old
 - Claims do not include many important clinical details, and do not directly illuminate the process of care, only its billable aspects.
- **ELECTRONIC HEALTH RECORD (EHR) DATA** provides many of the clinical clues that claims data leaves out. EHRs contain details about the process of care, provider impressions of their patients, and volunteered patient concerns that may not have resulted in diagnoses. They also include vital signs, medications, allergies, imaging reports, lab data, and immunization dates.



How it is working in Ohio

CliniSync brings clinical, financial and other data together from across the enterprise providing actionable data for providers and plans to help improve efficiency and patient care.

Providing real-time insights to both clinicians and administrators and help them to identify and address care gaps within the patient population. A well-developed data driven population health program is key to better outcomes and cost savings, especially in populations with chronic disease.

Challenges

- **EHR Data** has issues, however. These systems often include a high number of free-text fields, filled with unstructured data that can be incomplete, difficult to extract, and even more difficult to analyze.
- Data can also be stored as static PDF files, which cannot be analyzed without additional processing.
- **SOCIAL AND COMMUNITY DETERMINANTS OF HEALTH**
- Socioeconomic data and information about the social determinants of health are extraordinarily rich resources for data driven population health, yet much of the data remains uncollected or scattered in inaccessible formats.
 - Community and social traits, such as average incomes, English proficiency, local healthy food choices, violence rates, transportation access, unemployment rates, and education levels can all be important predictors of outcomes