HCGC Regional Learning Session: Data Driven Population Health

October 9th, 2019

Welcome!
Supporters

Columbus Medical Association

pcori
CardinalHealth
Osteopathic Heritage Foundations
THE CITY OF COLUMBUS
COLUMBUS PUBLIC HEALTH
UnitedHealthcare
Central Ohio Primary Care Foundation
OhioHealth
Aetna
The Health Collaborative

100% of our Board of Directors & Staff
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Healthcare Collaborative of Greater Columbus
Our Vision
Optimal health for all people in Greater Columbus

Our Mission
is to improve the value of health care for all people in Greater Columbus by catalyzing collaboration among public and private partners: Providers, behavioral health, hospital systems, social service agencies, public and private payers, employers, government, public health and patients/consumers.

VALUE = (QUALITY + CONSUMER EXPERIENCE) ÷ COST

Healthcare Collaborative of Greater Columbus
HCGC is also focused on work to improve health disparities and engage employers as key healthcare stakeholders.

**Health Disparities:** HCGC’s mission is designed to serve “all people.” However, we are acutely aware that total population measures can hide wide-ranging disparities among different portions of our community. HCGC is committed to seeking opportunities to close health disparity gaps.

**Employers as Key Healthcare Stakeholders:** HCGC’s focus on healthcare value requires consideration of the cost component of healthcare. Employers play a special role in funding our current healthcare system. HCGC has experienced that the wide variety in the Central Ohio’s self-insured and fully-insured employer market makes singular employer strategies impractical. HCGC seeks opportunities to address cost issues whenever possible.
Our Work Toward Better Value

One of over 30 Regional Health Improvement Collaboratives (RHICs) across the country

HCGC is a non-profit organization with multi-stakeholder governance, fully supported by grants,
Regional Learning Session Year in Review
In April 2019 we...

- Explored National Efforts for Population Health
  - IHI Triple Aim for Population Health
- Shared free tools and resources for organizations to utilize to assess and improve their population health efforts
  - Pathways to Population Health
- Learned about local/regional initiatives including research and outcomes regarding population health, including the HUB
P2PH is the product of collaboration among five organizations leveraging our shared assets and unique strengths to help health care organizations accelerate population health improvement efforts.
Four Portfolios of Population Health

P1: Physical and/or Mental Health
P2: Social and/or Spiritual Well-being
P3: Community Health and Well-being
P4: Communities of Solutions
In August, we......

- Took a deeper dive into PCORI Resources for research—including results written for patients, and research references we can all use as another fantastic community asset in our work toward better population and community health

- Hosted an interactive session and began to create a common community vision toward population health to work toward and build our Central Ohio Communities of Solutions

- Engaged with CPC+ Practices
Today we will...

• Look at data, which was the one common element to the April and August discussions:
  • Sharing it
  • Using it
  • Too much, not enough, not easily digestible
  • Not available broadly to the entire community

• Small groups to have a conversation about data-driven population health
Today we will…

• Share what data *is* available in our region, including evolutions with CliniSync
• Release our newest Quality Transparency Data, with added HUB data
• Ask a community panel of experts how they use data to support individual patients and population health
• Take questions and feedback
How do you share data now for better patient/client outcomes, for quality and process improvement?

From your unique perspective, what data elements are critical to be sharing but aren’t being shared?

What data elements would be ideal for community knowledge/benchmarking and health status?
HCGC Data: Quality Transparency and HUB
Quality Transparency and Improvement

Collect, aggregate, and report 9 NQF-endorsed quality measures from over 160 practice sites serving over 800,000 lives in Columbus and surrounding counties.

Host work sessions for practices to assess data, set goals, and align improvement activities at a community level.

Percent of patients who had appropriate screening for colorectal cancer

- Actual
- Target

<table>
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<tr>
<th>Period</th>
<th>Actual</th>
<th>Target</th>
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<td>30%</td>
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<td>1/1/2015 - 12/31/2015</td>
<td>48%</td>
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<td>1/1/2016 - 12/31/2016</td>
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<td>1/1/2017 - 12/31/2017</td>
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<tr>
<td>1/1/2018 - 06/30/2018</td>
<td>57%</td>
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</table>
Current Data Use: Clinical

- Collect site-level quality data (clinical) from primary care and behavioral health providers on nine quality measures to guide improvement efforts
- Publish a regional quality report twice per year
- Provides benchmarking and trends, data gap insights
- Expanding the number of practices, specialties, and quality measures
- Limitations: data points, frequency, timeliness
Current Data Use: HUB/SDOH

• Collect patient level data on both risks and outcomes that have addressed risks in real time
• 10 community agencies contributing
• Have not established a public reporting cadence yet
• Could add insight to service delivery, trends, gaps
• Expanding rapidly—clients, services, agencies
Visioning

- Functioning integrated data system with multilevel reporting shared with providers and community partners to inform connections, performance and improvement work

- Culture evolution in Central Ohio in transparency and improvement

- Not just clinical and cost but social/public health and SDOH and at the community/regional level
Our first attempt!

• Focus on HUB adult (18+, non-pregnant, non-mothers) clients to align with QT
• Highlighted hypertension data to align with QT
• Not apples to apples-HUB is patient level data, self reported; QT report is currently self reported at the practice level
• We recognize this isn’t actionable yet-building blocks of information
QT Reporting Practice & HUB Adult Client Zip Code Comparison

Zip codes with Practice Sharing Data in QT Report

Zip codes with 4+ Adult HUB Clients
QT Reporting Practice & HUB Adult Clients w/ Medical Home Pathway Zip Code Comparison

Zip codes with Practice Sharing Data in QT Report

Zip codes with 4+ Adult HUB Clients w/ Med Home Pathway
HUB Chronic Conditions

Top Chronic Conditions Self-Reported by # of Adult Clients

- Hypertension (high blood pressure): 34
- Depression: 31
- Arthritis: 25
- Asthma: 22
- Diabetes Type II: 21
- Anxiety disorder: 20
- Obesity: 18
- Vision loss or impairment: 18
Additional Unmet Needs for Adult Clients w/ Hypertension

- Trouble Providing Transportation: 8
- Client or Someone in Home is Tobacco User: 10
- Food Insecure: 14
- Scored Positive on PHQ-9: 16
- Trouble Paying for Medication: 16
- # of Adult Clients w/ Hypertension: 34
- # of Adult Clients: 125

Healthcare Collaborative of Greater Columbus
## Central Ohio Pathways HUB

<table>
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<tr>
<th>Pathway</th>
<th>Initiated</th>
<th>Finished Incomplete Delta</th>
<th>Completed</th>
<th>Median Duration Days</th>
<th># Clients with PW</th>
<th>% Clients with PW</th>
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<td>650</td>
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<td>Education</td>
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<td>43</td>
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<td>1</td>
<td>16</td>
<td>1</td>
<td>.26</td>
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| Total                  | 2949      | 560                        | 1650      |                      |                  |                   |
Additional Data Reporting Opportunities

- Depression/PHQ-9
- Breast health
- Pregnancy/infant mortality
- Diabetes A1C
- Tobacco cessation
Questions/Feedback?
Community Reaction Panel

Maria Courser, MD, FAAP
Mount Carmel Medical Group

Joshua J. Joseph, M.D., FAHA
The Ohio State University Wexner Medical Center

Buhari Mohammed, MD, MBA, CHCEF
Heart of Ohio Family Health Centers

Greg Sawchyn, MD, MBA
OhioHealth

Healthcare Collaborative of Greater Columbus
Community Reaction Panel: Strategic Questions

- Share with us your organization’s journey in obtaining and using data for positive patient outcomes and clinical quality improvement.
- In the past five years, social determinants of health have become a major focus in delivering care. How has this changed the way your organization operates and have you seen significant outcomes?
Questions/Feedback?
PCORI Research

Eliminating disparities in health and health care could save the United States over $230 billion annually in direct medical costs. Disparities lead to preventable suffering.

The roughly 46 MILLION Americans who live in rural areas are more likely than their urban counterparts to die from heart disease, cancer, and stroke.

Non-Hispanic black adults are at least 1.5 TIMES as likely to die of heart disease or stroke prematurely as their non-Hispanic white counterparts.

Source: Centers for Disease Control and Prevention

To address this problem, PCORI has funded 89 comparative clinical effectiveness research studies and related projects to help patients at risk for disparities and those who care for them make better-informed decisions about their options to improve their health.

Healthcare Collaborative of Greater Columbus

As of August 2019
PCORI Research

Finding PCORI Research on their website:

- [https://www.pcori.org/](https://www.pcori.org/)
Next Steps and Closing Out

• Thank you for your fantastic contributions today
• Remember to fill out your harvest sheets!
• 2020 programming will be announced in December-please sign-up/follow/like us on our website and social media