Using Data to Drive Health Transformation
Healthier WA Funded- ACH Dashboard Reporting Tool

February 11th , 2016
Cascade Pacific Action Alliance – Council Meeting

CORE | Center for Outcomes Research and Education
Nikki Olson - Associate Director

ACH DASHBOARD REPORTING TOOL

ACH Expectations

1. Establish collaborative decision-making on a regional basis to improve health and health systems, focusing on the social determinants of health, clinical community linkages, and whole person care.
2. Bring together all sectors that contribute to health to develop shared priorities and strategies for population health, including improved delivery systems, coordinated initiatives, and value based payment models.
3. Drive physical and behavioral health care integration by information financing and delivery system adjustments, starting with Medicaid.

Critical Element Needed to Meet these Expectations

DATA - ACHs need data and information about the people in each region in order to conduct regional health assessments, engage in planning for health improvement, and ultimately measure health outcomes.

ACH DASHBOARD REPORTING TOOL

CORE is working with the HCA, DOH, and DSHS to support ACH community health transformation by building a regularly refreshed, interactive dashboard tool.

Support Transformation

The DRT will support the Analytics, Interoperability, and Measurement (AIM) and the Accountable Communities of Health (ACH) portion of the Healthier Washington Initiative (Initiative).

The DRT will provide HCA, partners and stakeholders with information about population health in communities across Washington state.

Build Interactive Dashboard Tool

CORE is collaboratively designing and building a business intelligence and analytics tool that will allow ACHs to access population health info and metrics on their populations to aid in identifying and implementing community priorities and strategies to improve health.

The tool is interactive and the information within it will be regularly refreshed to monitor metric change over time.

The tool will be built with de-identified aggregate data using DOH small-numbers guidelines.

ACH DASHBOARD REPORTING TOOL

INITIAL DATA AND MEASURES FOR DASHBOARDS

DATA SOURCES

HCA Medicaid Claims

HCA Medicaid Enrollment

HCA PEBB Claims

DOH Immunization

DOH BRFSS (Agg)

DOH PRAMS (Agg)

MEASURES

Develop Multi-Dimensional View of a Subset of the Common Measure Set

Starter measures to be expanded month by month as ACH priority areas arise.

1. Child and Adolescent Access to PCP
2. Adult Access to Preventive/Ambulatory Health Services
3. Potentially Avoidable ED Visits

DIMENSIONS

Look at measures by different dimensions:

- Location - Geography
- Race/Ethnicity
- Age
- Gender
- Language
- Diagnoses
- Risk/Complexity/“High Utilizer”

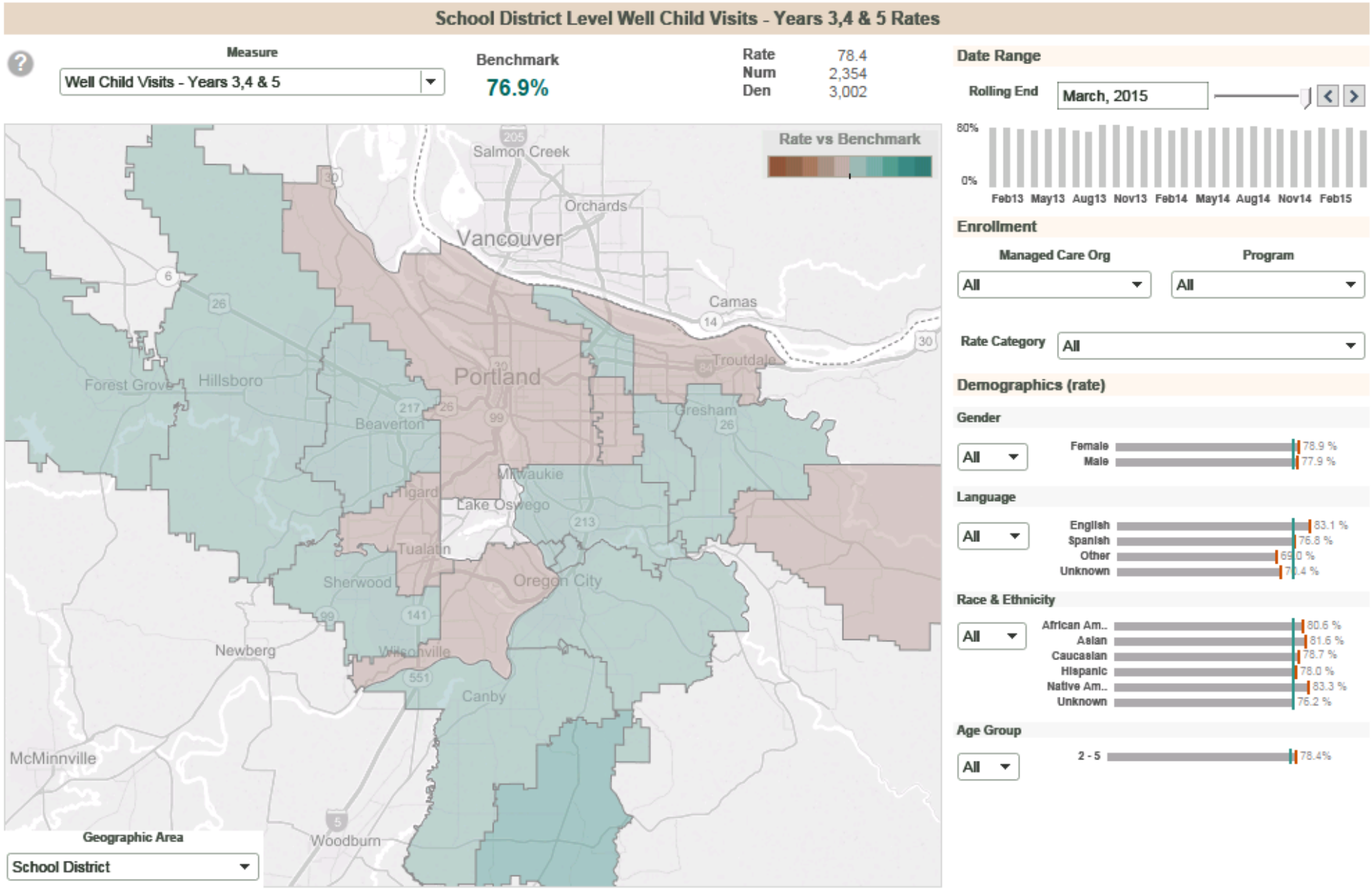
FINAL PRODUCT: REFRESHED INTERACTIVE DASHBOARDS

ACH DASHBOARD REPORTING TOOL

EXAMPLE INTERACTIVE DASHBOARD FOR MEASURE EXPLORATION

The Healthier Washington funded work is scoped to provide regularly refreshed dashboards to ACHs to look at measures geographically and by populations and dimensions of interest to assess population health and improve outcomes as a community.

Goal is to release first dashboard in May and release refreshed dashboard with new measures and content over time.



Using Data to Drive Health Transformation

Region-Specific Analytic Support

Scoped and Funded Regionally

January 28th, 2016
Cascade Pacific Action Alliance – Council Meeting

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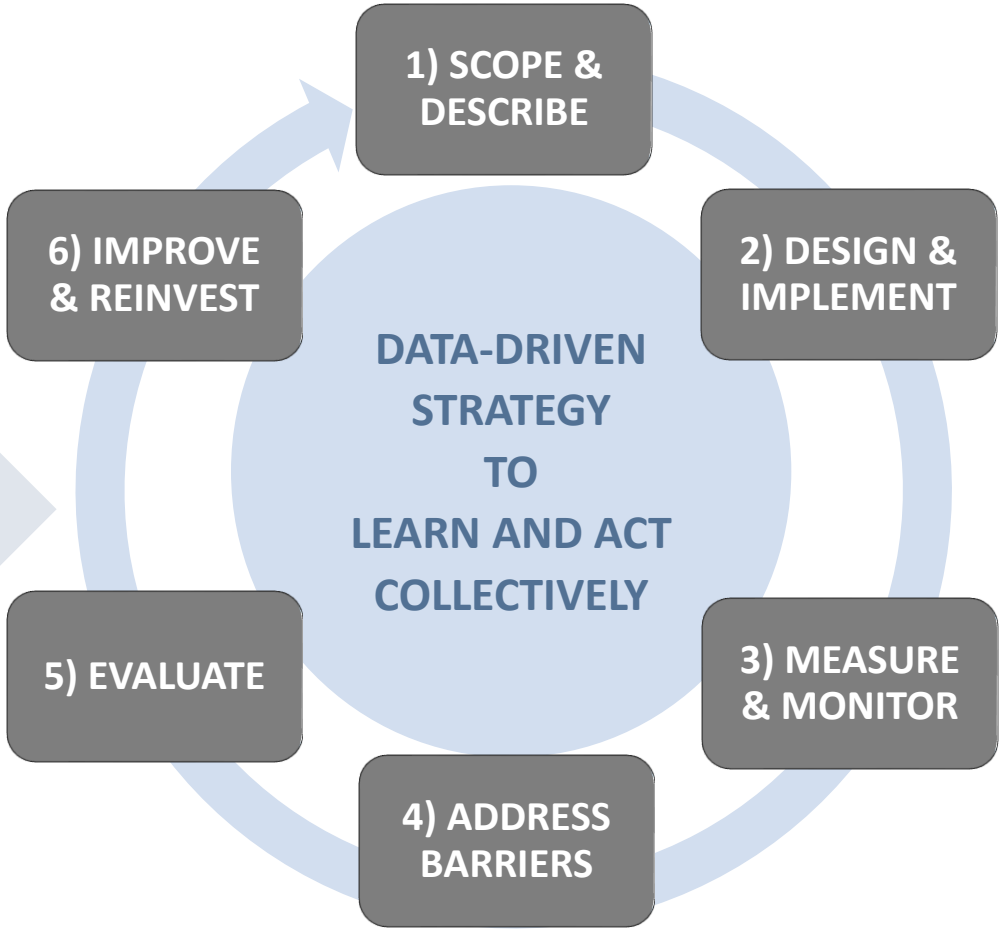
USING DATA FOR STRATEGY

Share and measure data from the outset to empower the community to learn, plan and act together for collective impact.

A Data-Driven Strategy Should Include the Following:

1) Scope & Describe Community Need
2) Design & Implement Interventions
3) Measure & Monitor Efforts
4) Identify Partners for Address Policy, System and Care Coordination Issues and Opportunities
5) Evaluate Intervention and Overall Success
6) Support Intervention Improvement & Decision-making for Re-investment of any Shared Savings



DATA TO LEARN AND ACT COLLECTIVELY

Continuous Cycle of Learning and Improvement Around Community Efforts

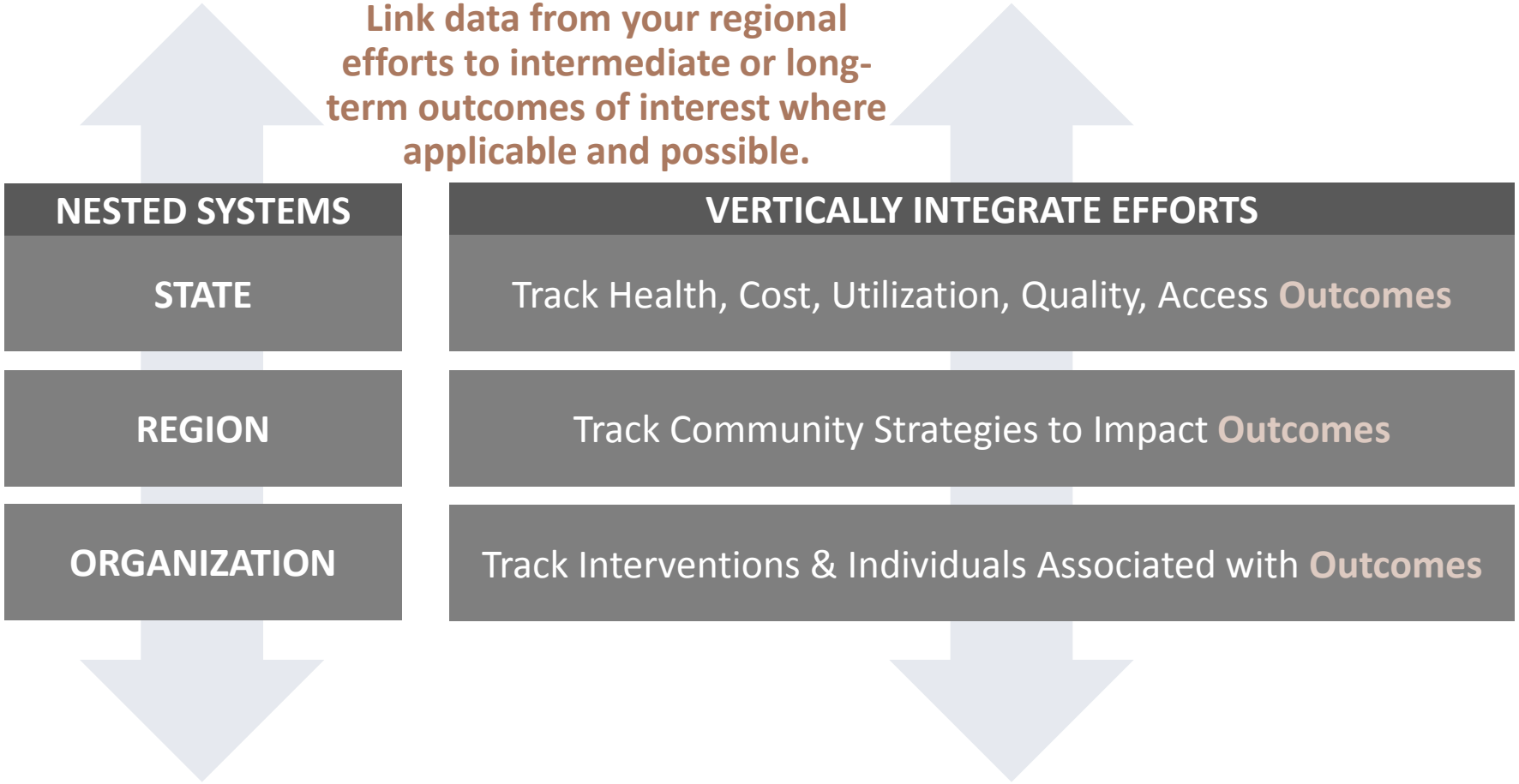
CORE – ANALYTICS, RESEARCH, & PROGRAM EVALUATION SUPPORT
Scoped and Funded Regionally

REGION-FUNDED

Some regions may need additional support to bring in **other community data** to see a richer **multi-dimensional view** of need and outcomes for planning and evaluation such as…

- -program populations
- -regional sector data
- -CHW data
- -regional survey data

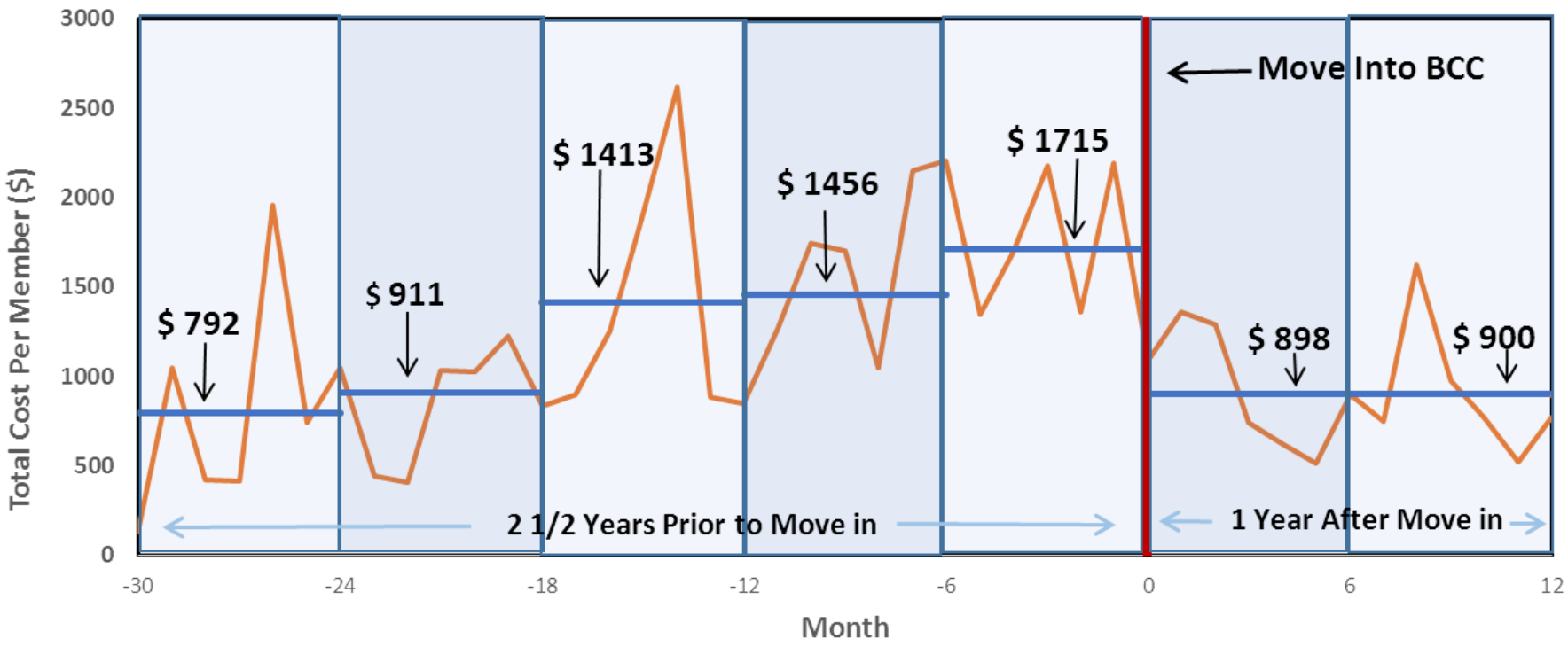
Link data from your regional efforts to intermediate or long-term outcomes of interest where applicable and possible.



EXAMPLE EVALUATION– HOUSING & HEALTH PROGRAM

When outcomes measures and program/intervention data are combined at an individual-level, evaluation and cost-savings analyses can be conducted.

TRACKING CHANGE OVER TIME FOR PROGRAMS



HOW IT WORKS

Designate target populations and key dates (such as enrollment or launch dates). Map outcome-related trends before and after using data system. Use matching techniques to identify a counterfactual group for control/comparison group. Examine and compare change in costs over time.

EXAMPLE REGION-SPECIFIC SCOPE

REGIONAL HEALTH IMPROVEMENT PLAN

CPAA RHIP Example
Care Coordination and Health Integration
Improve Chronic Disease Prevention and Management

Strategies:

- Expand screening of children and youth for behavioral health needs, and provide access to school-based and community-based intervention/treatment services for those identified in need (AKA the behavioral health pilot).
- Develop and expand jail and fine alternatives as well as stronger transitions of care between criminal justice and health care (public and private)
- Improve access to chronic disease self-management programs regionally.

EXPAND TO SUPPORT STRATEGIES

1. Track additional measures such as access and use of health care services by type.
2. Bring in other sector data (criminal justice data) to develop cross-sector measures and evaluate coordination of services.
3. Identify priority populations based on criteria (chronic disease populations) – explore geographically, demographically, etc.
4. Collect and bring in other data from CHW's, assessments, surveys, or program data to do evaluation.