

# Using Data to Drive Health Transformation

## Supporting the Regional Health Improvement Plan

January 28<sup>th</sup>, 2016

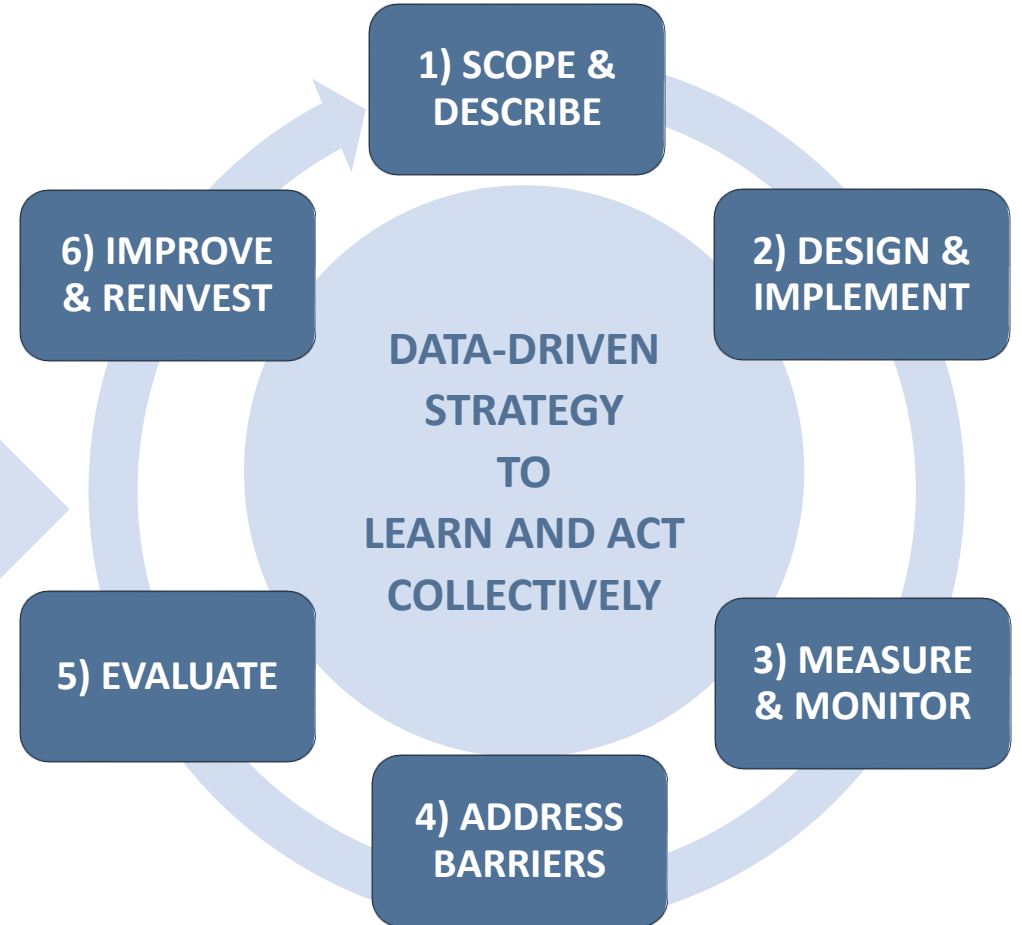
Cascade Pacific Action Alliance – Support Team Meeting

# 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 – WASHINGTON ACH ANALYTICS SUPPORT

## 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.

# CORE – WASHINGTON ACH ANALYTICS SUPPORT

CORE is working with the HCA, DOH, and DSHS to...

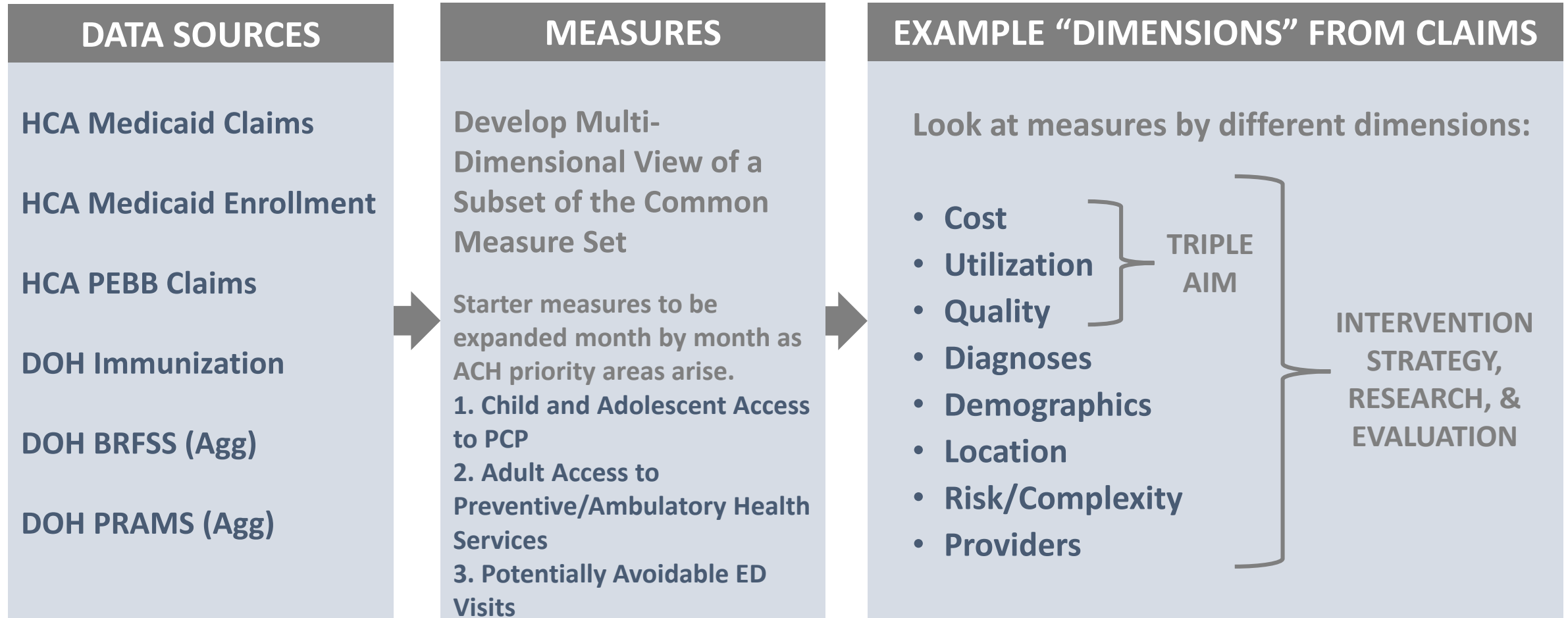
## Build an Interactive Dashboard Reporting Tool for ACH's

CORE is collaboratively designing and building a business intelligence and shared analytics tool that will allow the ACHs to [access data](#) about the [health of 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 updated](#). The tool will be built with de-identified aggregate data using DOH small-numbers guidelines.

## Support Community Health 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.

# INITIAL DATA FOR DASHBOARD REPORTING TOOL



**FINAL PRODUCT: REFRESHED INTERACTIVE DASHBOARDS**

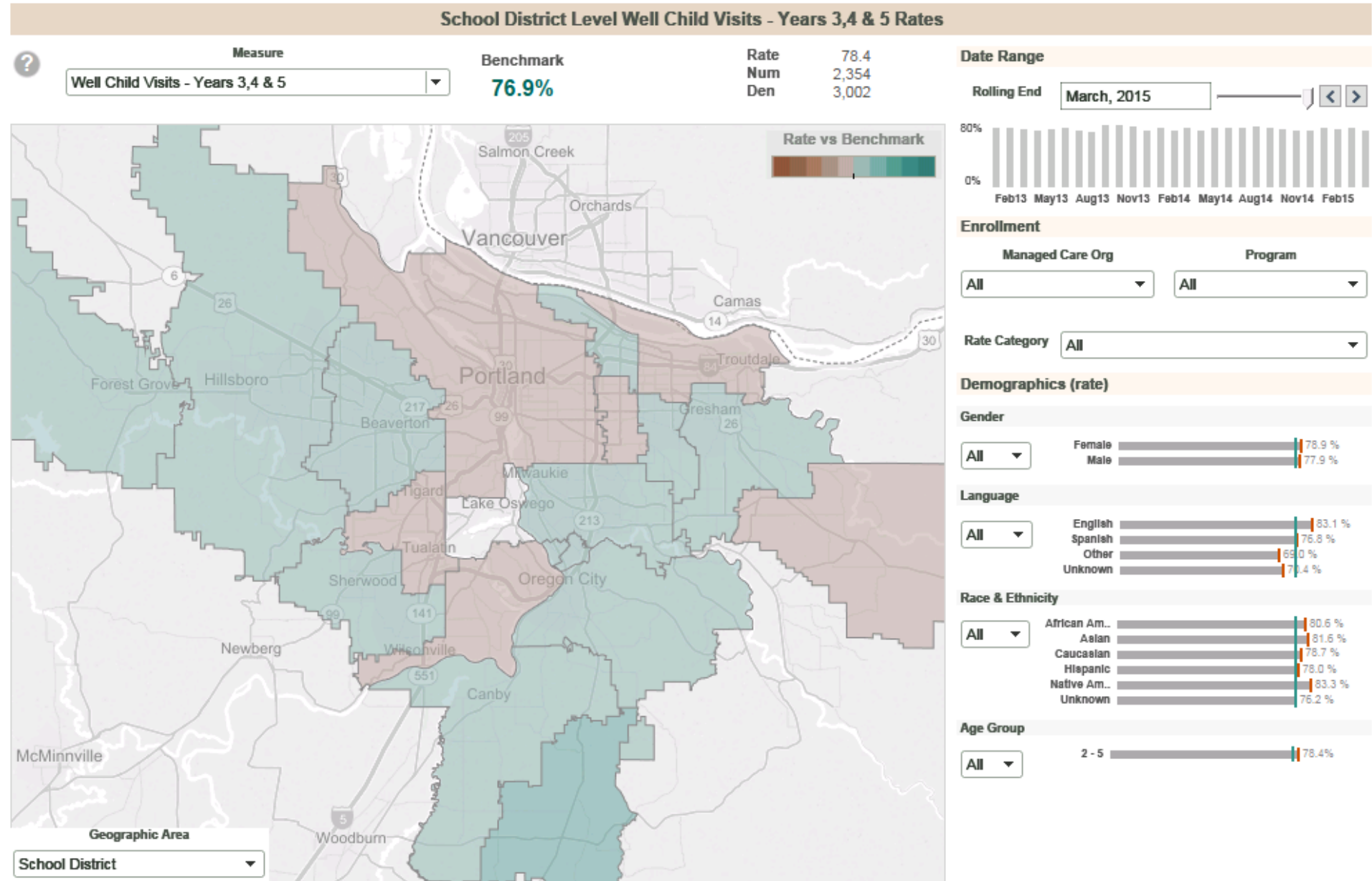
# EXAMPLE INTERACTIVE DASHBOARD - FOCUS ON MEASURES

The Healthier-WA funded work will help ACHs look at outcomes

geographically and by populations of interest to improve outcomes as a community.

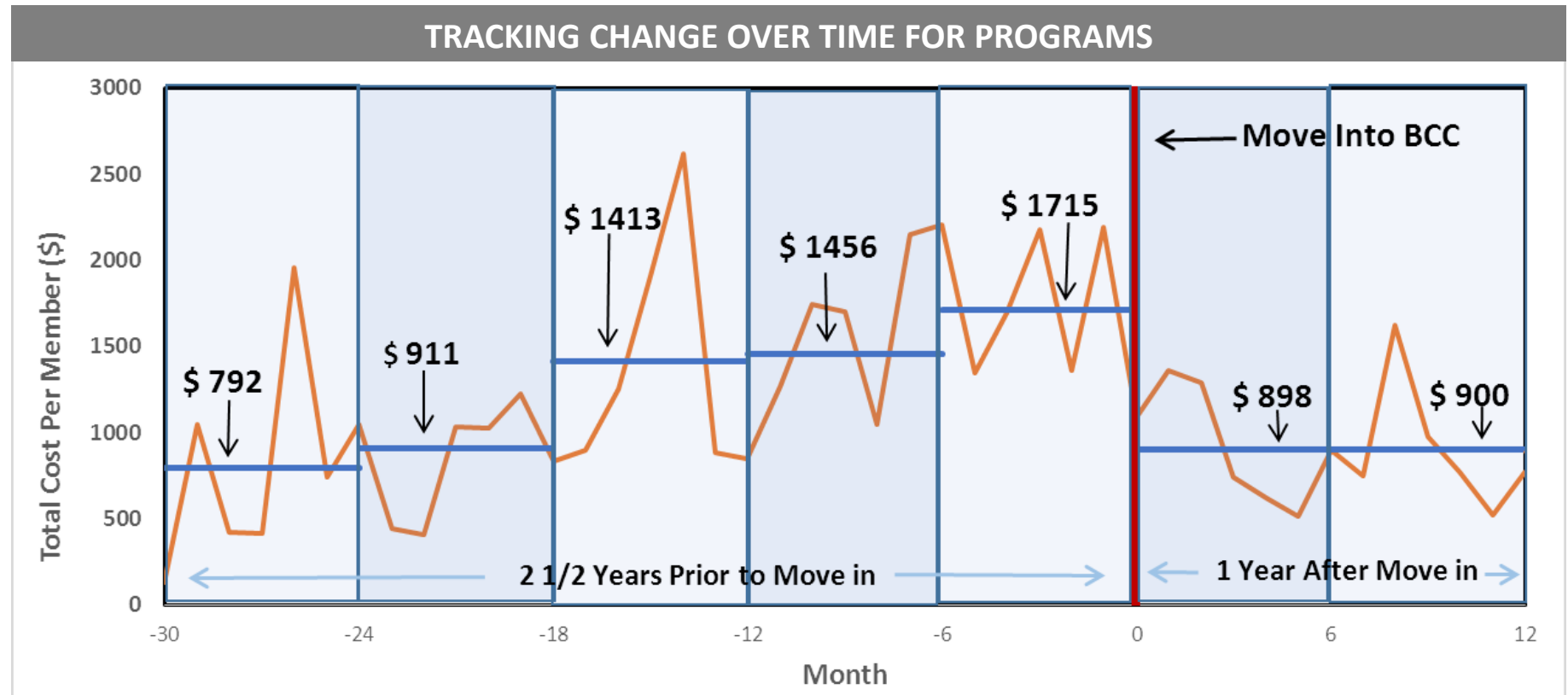
Regions can leverage this work and bring in other community data to see a richer multi-dimensional view of need and outcomes for planning and evaluation such as...

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



# 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.



## 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.

# WA STATE ACH - 3 STARTING MEASURES

## STARTING CLAIMS-BASED MEASURES FROM COMMON MEASURE SET

1. Child and Adolescent Access to Primary Care Practitioners– Child/Adolescents
2. Adult Access to Preventive/Ambulatory Health Services
3. Potentially Avoidable ED Visits

More measures will be included over time as ACH's chosen priority area arise.

What are the ACH strategies to improve upon these measures?

How can data support those strategies?

Which other priority areas do ACH's need support for?

### NESTED SYSTEMS

STATE

REGION

ORGANIZATION

### VERTICALLY INTEGRATE EFFORTS

Track Health, Cost, Utilization, Quality, Access **Outcomes**

Track Community Strategies to Impact **Outcomes**

Track Interventions and Members Associated with **Outcomes**



# POTENTIAL TO TAILOR AND BUILD UPON THIS EFFORT REGIONALLY

## REGIONAL HEALTH IMPROVEMENT PLAN

### CPAA RHIP Example

#### Care Coordination and Health Integration

#### Improve Chronic Disease Prevention and Management

#### Strategies:

- # 23: 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).
- #18: Develop and expand jail and fine alternatives as well as stronger transitions of care between criminal justice and health care (public and private)
- #9: Improve access to chronic disease self-management programs regionally.

### EXPAND TO SUPPORT STRATEGIES

1. Track additional measures from Common Measure set and beyond (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.