POPULATION HEALTH SERIES:

Introduction to Population Health

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CE STATEMENT

The **Georgia Board of Nursing** deems **Southwest Georgia Area Health Education Center (SOWEGA-AHEC)** as an approved provider for nursing continuing education (CE). This activity is approved for **1.0** contact hour towards the continuing education competency requirement for Georgia nursing licensure renewal. No partial credit offered. Activity #2020-02a.

Note: Submission of registration information, attendance and completed evaluation/successful post-test required for Nursing continuing education certificates.

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DISCLOSURES & COMMERCIAL SUPPORT

Planners & presenter disclosed no potential conflicts of interest at this time.

No commercial support provided for this educational activity.

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LEARNING OUTCOMES

- Describe drivers within the US health care delivery system toward value-based models of care
- Define the term "population health"
- Identify sources of data to define population health needs

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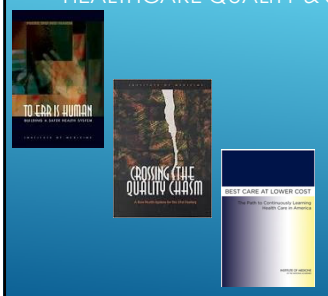
HEALTHCARE QUALITY & SAFETY



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NATIONAL QUALITY STRATEGY

Better Care: *Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.*

Healthy People, Healthy Communities: *Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.*

Affordable Care: *Reduce the cost of quality healthcare for individuals, families, employers, and government.*

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The mission of the U.S. Department of Health and Human Services (HHS) is to enhance and protect the health and well-being of all Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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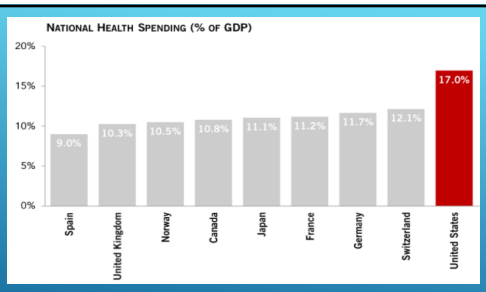

HEALTH CARE SPENDING AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT

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- Health – A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Some people have adapted this definition to also include spiritual wellbeing. World Health Organization
- Outcomes – The effect the process has had on the people targeted by it. These might include, for example, changes in their self-perceived health status or changes in the distribution of health determinants, or factors which are known to affect their health, well-being, and quality of life.

Pathways to Population Health | www.ihi.org/p2ph

DEFINITIONS FOR KEY POPULATION HEALTH TERMINOLOGY

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- Defined population – A group of people with something in common. They can be self-defined or defined by someone working with that population.
- Place-based population – A group of people who live in a geographically defined area (e.g., a neighborhood, city, county). All are impacted by policies, structures, and systems that are particular to the place they live

Pathways to Population Health | www.ihi.org/p2ph

DEFINITIONS FOR KEY POPULATION HEALTH TERMINOLOGY

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- Population health – The health outcomes of a group of individuals, including the distribution of such outcomes within the group.
- Population management – The delivery of health care services toward the achievement of specific health care-related metrics and outcomes for a defined population.
- Population health improvement – Efforts to improve health, wellbeing, and equity for defined or place-based populations.

Pathways to Population Health | www.ihi.org/p2ph

DEFINITIONS FOR KEY POPULATION HEALTH TERMINOLOGY

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- Equity – Everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and the lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.
- Health inequity – Differences in health outcomes between groups within a population that are systematic, avoidable, and unjust.

DEFINITIONS FOR KEY POPULATION HEALTH TERMINOLOGY

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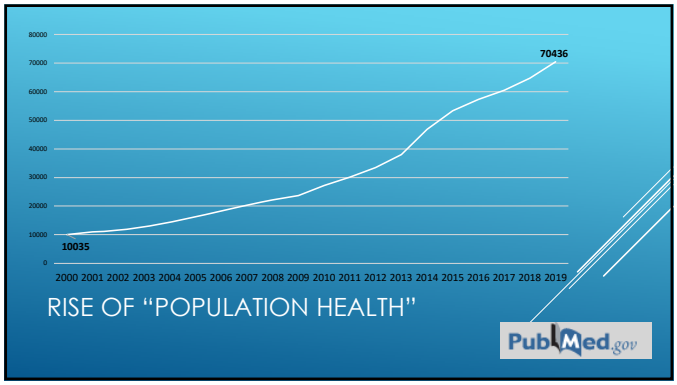
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RISE OF "POPULATION HEALTH"
PubMed.gov

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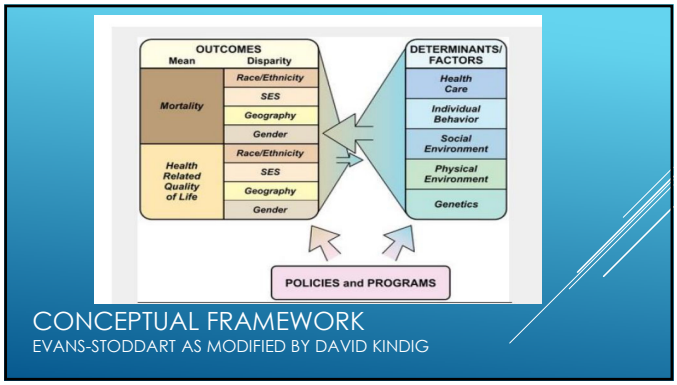
OUTCOMES
Mean
Disparity
Mortality
Race/Ethnicity
SES
Geography
Gender
Health Related Quality of Life
Race/Ethnicity
SES
Geography
Gender
DETERMINANTS/ FACTORS
Health Care
Individual Behavior
Social Environment
Physical Environment
Genetics
POLICIES and PROGRAMS
CONCEPTUAL FRAMEWORK
EVANS-STODDART AS MODIFIED BY DAVID KINDIG

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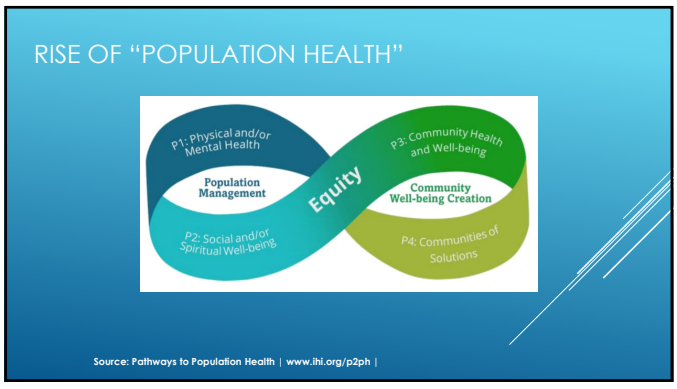
RISE OF "POPULATION HEALTH"
P1: Physical and/or Mental Health
Population Management
P2: Social and/or Spiritual Well-being
Equity
P3: Community Health and Well-being
Community Well-being Creation
P4: Communities of Solutions
Source: Pathways to Population Health | www.ihi.org/p2ph |

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Effective Healthcare:

- Right Patient Need(s) Identified
- Right Treatment(s) Provided
- By the Right Professional(s)
- At the Right Time(s)
- Producing the Right Health and Satisfaction Outcome(s)

Efficient Healthcare:

- Clinical and administrative work flow processes that operate within optimal time and cost specifications

EFFECTIVE & EFFICIENT HEALTHCARE

Source: Care Transitions Network

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1. **Population-Based Care:** Focus on caring for the whole population you are serving, not just the individuals actively seeking care.
2. **Data-Driven Care:** Utilize data and analytics in order to make informed decisions to serve those in your population who most need care.
3. **Evidence-Based Care:** Make use of the best available evidence to guide treatment decisions and delivery of care.
4. **Care Management:** Engage in actionable care management for the population you serve.

PRINCIPLES OF POPULATION HEALTH

Source: Care Transitions Network

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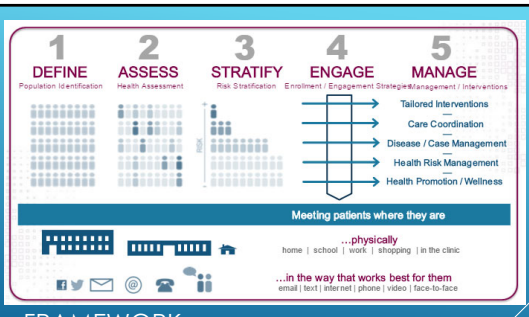

FRAMEWORK

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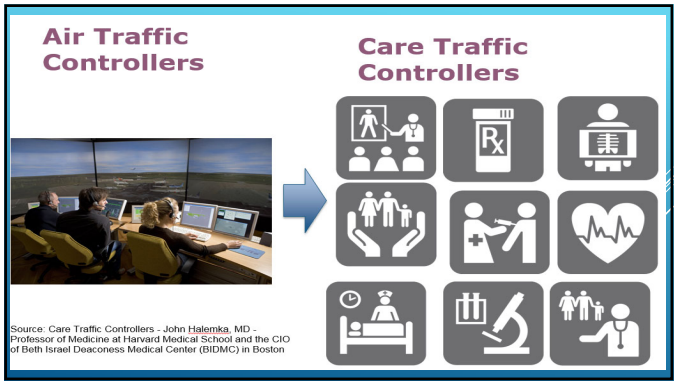
Air Traffic Controllers
Care Traffic Controllers
Source: Care Traffic Controllers - John Halemka, MD - Professor of Medicine at Harvard Medical School and the CIO of Beth Israel Deaconess Medical Center (BIDMC) in Boston

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UNDERSTANDING YOUR POPULATION

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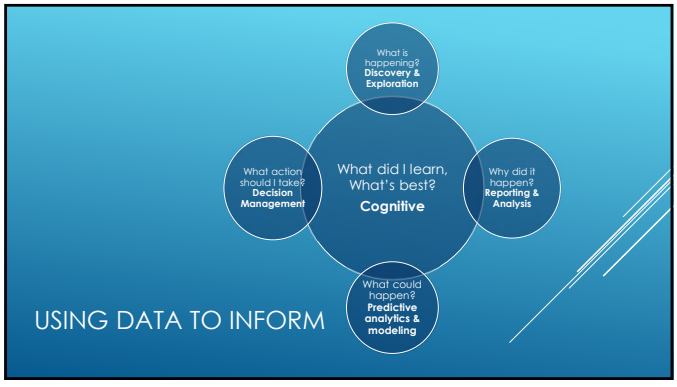
What is happening? Discovery & Exploration
What action should I take? Decision Management
What did I learn, What's best? Cognitive
Why did it happen? Reporting & Analysis
What could happen? Predictive analytics & modeling
USING DATA TO INFORM

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The healthcare transformation is driving healthcare organizations to be able to manage patient populations to improve health, improve outcomes and reduce costs. They must gain deeper insight into population chronic disease cohorts to enable proactive interventions.

This insight requires the capture and centralization of disparate **data** sources to enable enterprise wide reporting.

The movement to value based care requires population insights to get the **right data to the right place at the right time** in order to truly impact patient care.

DATA DRIVEN SOLUTIONS

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- Claims Data
- Electronic Health Record Data
- Social and Community Determinants of Health
- Patient Generated Data
- Prescription and Medication Adherence Data

WHICH HEALTHCARE DATA IS IMPORTANT FOR POPULATION HEALTH MANAGEMENT?

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- Web and social media data: Clickstream and interaction data from social media such as Facebook, Twitter, LinkedIn, and blogs. It can also include health plan websites, smartphone apps, etc.
- Machine-to-machine data: Readings from sensors, meters, and other devices.
- Big transaction data: Health care claims and other billing records increasingly available in semi-structured and unstructured formats.
- Biometric data: Fingerprints, genetics, handwriting, retinal scans, and similar types of data. This would also include X-rays and other medical images, blood pressure, pulse and pulse-oximetry readings, and other similar types of data.
- Human-generated data: Unstructured and semi-structured data such as electronic medical records (EMRs), physicians' notes, email, and paper documents.

WHAT EXACTLY IS BIG DATA?

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- Personal health history for key chronic conditions, such as cancer or heart disease
- Lifestyle behaviors that contribute to chronic conditions,
- Biometrics
- Applicable preventive services
- Substance use or abuse
- Symptoms of depression risk
- Readiness to change

Questions for Medicare and Medicaid populations might include questions on Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), or whether an individual has transportation issues.

DATA DRIVEN SOLUTIONS – HEALTH RISK ASSESSMENT

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A data driven process for the timely identification of extreme patterns in a defined region of the healthcare system

Used to guide targeted intervention and follow up to better address patient needs, reshape ineffective utilization, and reduce costs

HOT SPOTTING

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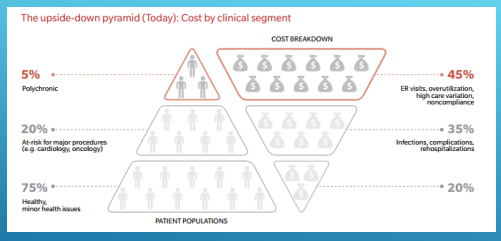

STRATIFICATION

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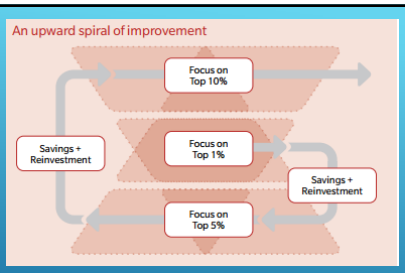

PRIORITIZATION

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PROMISING DATA SOURCES
HEALTH INFORMATION EXCHANGES

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DATA SOURCES TO FUEL POPULATION HEALTH

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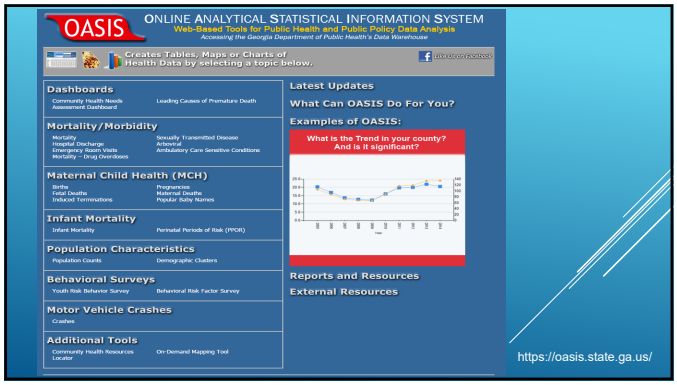
OASIS
ONLINE ANALYTICAL STATISTICAL INFORMATION SYSTEM
Web-Based Tools for Public Health and Public Policy Data Analysis
Accessing the Georgia Department of Public Health's Data Warehouse
Creates Tables, Maps or Charts of Health Data by selecting a topic below.
Dashboards
Community Health Needs Assessment Dashboard
Leading Causes of Premature Death
Mortality/Morbidity
Mortality
Hospital Discharge
Emergency Room Visits
Mortality – Drug Overdoses
Sexually Transmitted Disease
Arboviral
Ambulatory Care Sensitive Conditions
Maternal Child Health (MCH)
Births
Fetal Deaths
Induced Terminations
Pregnancies
Maternal Deaths
Popular Baby Names
Infant Mortality
Infant Mortality
Perinatal Periods of Risk (PPOR)
Population Characteristics
Population Counts
Demographic Clusters
Behavioral Surveys
Youth Risk Behavior Survey
Behavioral Risk Factor Survey
Motor Vehicle Crashes
Crashes
Additional Tools
Community Health Resources Locator
On-Demand Mapping Tool
Latest Updates
What Can OASIS Do For You?
Examples of OASIS:
What is the Trend in your county? And is it significant?
Reports and Resources
External Resources
https://oasis.state.ga.us/

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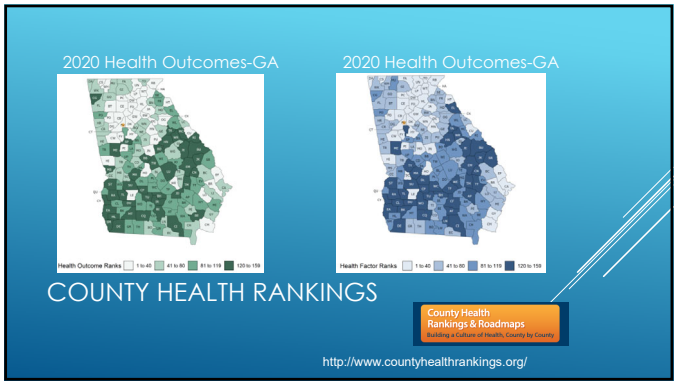
2020 Health Outcomes-GA
Health Outcome Ranks
2020 Health Outcomes-GA
Health Factor Ranks
COUNTY HEALTH RANKINGS
County Health Rankings & Roadmaps
Building a Culture of Health, County by County
http://www.countyhealthrankings.org/

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COMMUNITY COMMONS
Enrich your community work with maps and data reports that can be shared and saved.
Make a Map
Build a Report
https://www.communitycommons.org/

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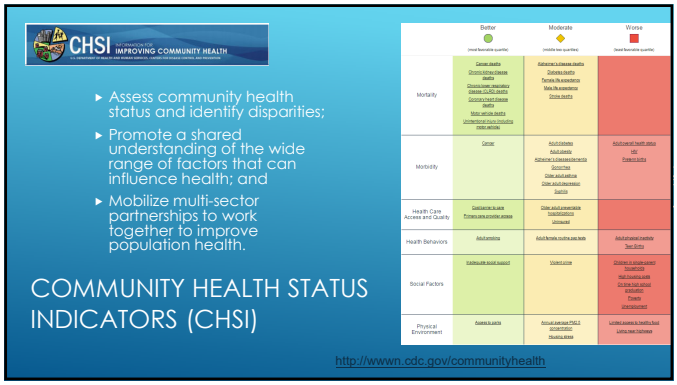
CHSI
IMPROVING COMMUNITY HEALTH
Assess community health status and identify disparities;
Promote a shared understanding of the wide range of factors that can influence health; and
Mobilize multi-sector partnerships to work together to improve population health.
COMMUNITY HEALTH STATUS INDICATORS (CHSI)
Better
Moderate
Worse
Mortality
Morbidity
Health Care Access and Quality
Health Behaviors
Social Factors
Physical Environment
http://wwwn.cdc.gov/communityhealth

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1. Identify needs and priority populations
Browse objectives to learn about national goals to improve health
See how national goals align with your priorities
Consider focusing on groups affected by health disparities
Use this information to make the case for your program, secure resources, and build partnerships.
2. Set your own targets
Find data related to your work
Use national data to set goals for your program
Healthy People 2030 establishes objectives and targets for the entire United States, but setting local targets contributes to national success.
3. Find inspiration and practical tools
Explore critical public health topics relevant to your work
Learn about successful programs, policies, and interventions
Look for evidence-based resources and tools your community, state, or organization can use
4. Monitor national progress — and use our data as a benchmark
Check for updates on progress toward achieving national objectives
Use our data to inform your policy and program planning
See how your progress compares to national data
HEALTHY PEOPLE 2030
https://health.gov/healthypeople/tools-action

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Chronic Conditions Data Warehouse
Your source for national CMS Medicare and Medicaid research data
Home
Medicare Data
Medicaid Data
Data Dictionaries
Condition Categories
Analytic Guidance
Pricing
Welcome to the Chronic Conditions Data Warehouse
Quick Links
About CCW
Data Availability
The Beneficiary Link
Requesting VRDC Access
How to Request Data
News & Events
Provide Feedback
CMS receives numerous requests for data which are used to develop aggregated statistics, charts and graphs. The CCW's Medicare Web Tables have been updated and are now available with 2014 data. Additionally, the corresponding summary statistics charts & graphs are also available, including 2014 Medicare Enrollment Charts, Chronic Condition Charts, and Part D Charts
https://www.ccwdata.org/web/guest/home

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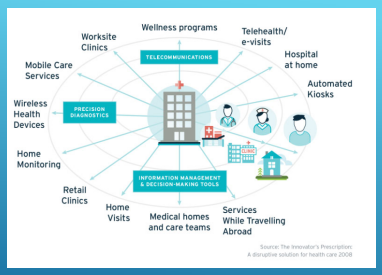

HEALTHCARE DELIVERY MODELS

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Identify opportunities to impact health earlier and **act on** those opportunities

ANALYTICS	PREVENTION	DISEASE MGMT	CARE MGMT SYSTEM

We need to think differently about how to **activate** our patients and communities

PATIENT ENGAGEMENT	COMMUNITY ENGAGEMENT	WELLNESS

And how we **interact** with them

ACCESS	CARE COORDINATION	PALLIATIVE CARE	CARE TRANSITIONS

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"If I had nine hours to cut down a tree, I would spend six hours sharpening my axe."

-- Abraham Lincoln

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LEARNING OUTCOMES

- Describe drivers within the US health care delivery system toward value-based models of care
- Define the term "population health"
- Identify sources of data to define population health needs

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EVALUATION

Submission of registration information, attendance and completed evaluation/successful post-test required for CE certificates.

https://www.surveymonkey.com/r/pophealthondemand6

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