CIVITAS
Networks for Health

Civitas: Addressing Chronic Disease Prevalence

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Introducing your presenters

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Regional innovation, national impact.

Our vision: Communities across the country are thriving and healthy, realizing the full potential of data-driven, multi-stakeholder, and cross-sector approaches to health information exchange and health improvement.

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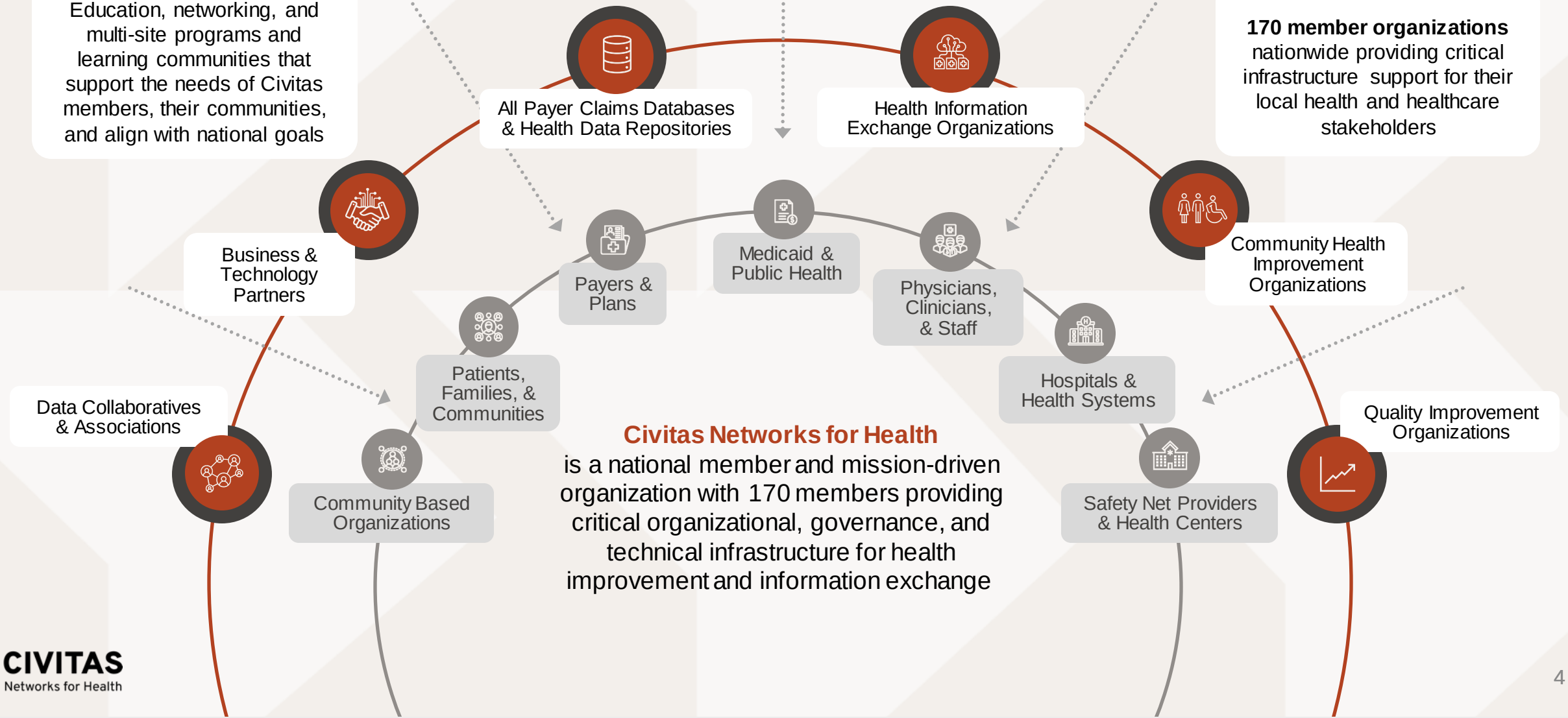
Who We Serve

Programs

Education, networking, and multi-site programs and learning communities that support the needs of Civitas members, their communities, and align with national goals

Members

170 member organizations nationwide providing critical infrastructure support for their local health and healthcare stakeholders



Civitas Networks for Health is a national member and mission-driven organization with 170 members providing critical organizational, governance, and technical infrastructure for health improvement and information exchange

WHAT IS A HEALTH DATA UTILITY (HDU)?

HDUs are statewide entities that combine, enhance, and exchange electronic health data across care and services settings for treatment, care coordination, quality improvement, and public and community health purposes through specific, defined use cases in accordance with applicable state and federal laws protecting patient privacy.

HDU CHARACTERISTICS

Neutrality and flexibility in meeting stakeholders' goals

Designated authority

Sustainable financing

Connected region or state geography

Multi-stakeholder, cross-sector participation

Modular infrastructure and advanced technical services

Public-private partnerships

Inclusive governance strategy

Leverage state and local authority

A Unified Framework for Health Data Utility

- With support from the **Maryland Health Care Commission**, Civitas and our national advisory council set out to develop authoritative health data utility (HDU) resources to define and provide implementation support to organizations, regions, and states.
    - **Issue Brief** – collected relevant research, publications, and resources.
    - **HDU Framework** – detailed guide to implementation for stakeholders.

www.civitasforhealth.org/resources

Bronx RHIO in collaboration with NYS DOH

BronxRHIO
Connecting for Better Health

Functions:

Measurement:

- Estimating prevalence within a practice's patient population
- Quality measures to track quality of care provided by PCP

Registry Development:

- Classifying and tracking patients within a PCP in terms of their measure status

PCP Alerts:

- Tracking the status of a population of patients and generating alerts to PCPs

Reporting for PCP:

- Generating list of patients that meet the criteria for a measure.
- Reporting for Public Health by various factors including race and ethnicity
- Allowing the generation of zip-code, county or regional reports for a measure to support community health assessment process and development of CHIPs.

Strategies implemented:

Track and Monitor Clinical Measures shown to improve healthcare quality and identify patients with high blood pressure and high blood cholesterol

- Increase identification of patients with **undiagnosed hypertension** using EHRs/HIT
- Explore and test innovative ways to promote the adoption of evidence-based quality measurement at the provider level

Implement Team-Based Care for patients with high blood pressure and high blood cholesterol

- Explore and test innovative ways to engage non-physician team members (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers) in hypertension and cholesterol management in clinical settings

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Arizona's Public Health/Medicaid HIE Strategic Plan

2021

- Assess vulnerability of unvaccinated
- Support SDOH referrals
- High Utilizer Smart Alerts
- Psychiatric Inpatient Alerts

2022

- Master Person Index
- Integrate Clinical and Claims Data
- Bed Capacity Reporting
- Dashboards for Medicaid and Public Health
- Electronic Case Reporting

2023

- Enrich Data for PH Monitoring
- Part 2 Consent Management
- NCQA and CMS Reporting Capabilities
- Integration of Assessment Data
- Data Sharing with LTSS

2024

- Enrollment Information Sharing
- Data Sharing Across Agencies
- Maternal and Child Smart Alerts
- Increase Clinical Data Use at Practice Level

2025

- Establish single PH access point
- Vulnerable Population Modeling

5-year strategic plan identifies 190+ use cases either directly or indirectly related to Public Health & Medicaid

★ Public Health Use Case

Public Health Use Cases in Az & Co

County Public Health (Pima)

The Problem:

- Heart disease is one of top two causes of mortality in Pima County
- Pima Co. Dept. of Public Health needs comprehensive and real-time geo-located, deidentified, clinical hypertension data to analyze trends in controlled vs. uncontrolled hypertension levels within targeted areas to develop appropriate response and interventions.

Why?

- Chronic disease identified in multiple community health needs assessments done within the county.
- Beginnings of a Southern AZ HTN control collaborative with healthcare systems engaged with public health.
- Cascade of prevention, DX, treat, control is well known and relatively easy to follow algorithms.

The Solution:

- Report that analyzes all clinical data in the HIE with location of service in Pima County, Arizona:
  - Age group, gender, race, ethnicity, zip code
  - Systolic & diastolic values, units (mm[Hg]), BP cat
  - Activity date/time

Next Steps:

- Additional data elements: diagnosis code & description
- Analyzing data sources: inpatient, ambulatory, etc.
- Future phases will include census tract level reporting
- Linking public health use case to clinical interventions
- Establish Southern Arizona HTN Control Collaborative

State Public Health (Az & Co)

Many other public health initiatives to utilize data available in the HIE for public health purposes:

- Identity management to cross reference individuals across public health registries and programs
- Public health reports to advance health equity efforts, address social needs and drivers, identify more complete race & ethnicity data, and impact opioid epidemic response
- Clinical feeds to HIE as intermediary for public health reporting (immunizations, reportable labs, etc.)
- WIC eligibility determination and access to anthro data (exploration phase)
- Patient record access via portal for case investigations
- And much more…

WANT TO STAY IN TOUCH? WE HOPE SO…

- CONNECT WITH US ON SOCIAL MEDIA
- VISIT OUR WEBSITE FOR PROGRAMMING UPDATES/ANNOUNCEMENTS
- EMAIL **CONTACT@CIVITASFORHEALTH.ORG**