NATIONAL
QUALITY FORUM

Essential Attributes of a High-Quality System of Care: How Communities Approach Quality Measurement

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Contents

Supported by a grant from The SCAN Foundation – advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

Executive Summary

In 2016, a working group of national experts supported by The SCAN Foundation described the four Essential Attributes of a high-quality healthcare system for adults with complex care needs. To build upon this effort, the National Quality Forum (NQF) developed case studies that demonstrate how communities (that is, systems of people and/or organizations in a specific local or regional location) have approached at least one of the Essential Attributes. NQF found that the first Essential Attribute—to identify and regularly re-evaluate a person's medical and nonmedical needs and goals on an ongoing basis for care planning—is the one most commonly being accomplished by using data, measurement tools, and instruments in innovative ways. Through the case study lens, NQF presents measure gaps for further examination and outlines lessons learned in order to help guide the development and use of quality measures for improving services received by adults with complex care needs.

Background

The SCAN Foundation recently published a report, What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Needs, which outlines elements that define a well-functioning system of care where individuals are able to live their lives with services and supports reflecting their values and preferences in the least restrictive, most independent setting possible. By bringing together a working group of diverse experts representing the interests of adults with complex care needs, this report details what matters most to individuals and their caregivers and outlines the four Essential Attributes of a high-quality system of care:

1. Each individual's range of needs and goals, both medical and nonmedical, as well as for family/caregivers, are identified and reevaluated on an ongoing basis to drive care plans.
2. Each individual's needs are addressed in a compassionate, meaningful, and person-focused way and incorporated into a care plan that is tailored, safe, and timely.
3. Individuals have a cohesive, easily navigable delivery system so that they can get the services and information they want by themselves or with support when needed, and avoid the services they do not need or want.
4. Individuals and their family/ caregivers continually inform the way the delivery system is structured to ensure that it is addressing their needs and providing resources tailored to them.

These Essential Attributes are intended to help guide future efforts to transform delivery systems and develop quality measures that capture an individual's goals, preferences, and desired outcomes. While monitoring and measuring activities require systems to collect and analyze uniform data in order to populate standardized metrics, NQF sought to determine how data, quality measurement tools, and measures are used in communities to improve the health and quality of life for adults with complex care needs. Specifically, NQF sought to determine how healthcare delivery system and social services data are combined to support better quality-of-life outcomes, and what barriers communities face in using this information to improve the lives of adults with complex care needs.

NQF mined its previous work and interviewed key informants representing health plans, providers, and health centers to identify who is using data innovatively to support older adults. The case studies summarize three exemplar groups, highlighting both how they have used information in alignment with the Essential Attributes and issues they encountered.

Summary of Findings

NQF examined how communities serving adults with complex care needs collect, analyze, and combine health system and social services system data to support one of the Essential Attributes. In its limited review, no single perfect example was found wherein data or measures are being used to measure and improve upon an Essential Attribute in its entirety. While many communities are working to improve quality, most are only in the early stages of learning how to access or integrate various sources of data and are largely not yet at the point of measuring or thinking about how to measure the quality of such care. Most of the communities examined are focusing on identifying individual needs and goals, both medical and nonmedical (Essential Attribute 1), and some communities are beginning to address these identified needs through person-centered care plans (Essential Attribute 2).

In addition to interviewing various organizations, NQF considered lessons learned from its previous work (e.g., Geneva Tower Health Collaborative). NQF narrowed its focus on how Essential Attribute 1 is currently being addressed in three exemplar communities. While NQF focused on finding communities who depicted at least one of the attributes, it was clear that the ability diminished when progressing from Essential Attribute 1 through Essential Attribute 4.

Community Exemplars

The following examples highlight how Essential Attribute 1 is addressed in specific communities. More extensive case studies and descriptions of previous related NQF projects are presented in the Appendix.

Geneva Tower Health Collaborative

The Geneva Tower Health Collaborative focuses on improving the health of the residents of Geneva Tower, a 183-unit apartment complex in Cedar Rapids, Iowa, which houses low income older adults and/or people with disabilities. Leaders from several types of organizations in the community recognized that the residents were a particularly vulnerable subpopulation, and so came together to better coordinate services, reduce barriers to care, and identify ways to improve the quality of life for the residents.

The Alliance of Chicago Community Health Services (Alliance) and The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

The Alliance, located in Chicago, provides its member health centers detailed reports which can be drilled down to individual provider-level or patient-level detail. The reports can also be stratified by race, ethnicity, and primary language to identify disparities in care. The Alliance uses the PRAPARE model and has developed an electronic health record (EHR) implementation model that encourages standardized data entry, which can be used for individual patient care or aggregated for population-level analyses.

The PRAPARE model is a prime example of a tool that takes into account an individual's entire history and impacts on their overall health by documenting a patient's assets, risks, and experiences. It aims to empower patients, to improve point-of-service care management, to improve the health of the patient population, to inform community policies, to encourage and strengthen partnerships, and to inform state and national policies.

Supports and Services at Home (SASH)

The SASH program is a Vermont statewide initiative to create a network of person-centered, coordinated healthcare and support services that engage participants, family, and friends in order to provide the right services and supports at the right time, tailored to local conditions and participant needs. An annual assessment provides a baseline well-being status and identifies the needs and support gaps of each SASH participant, which builds the foundation of the participant's Healthy Living Plan.

Leveraging Data to Inform, Evaluate, and Advance Essential Attributes

NQF identified the following common themes and lessons learned:

1. **Exemplar communities are using data in innovative ways, particularly in efforts to identify high-need patients and assess their social supports (Essential Attribute 1).**
    - The Geneva Tower Health Collaborative focuses on a low-income apartment complex and uses a combination of population health data, clinical data, and data from residents' surveys to identify high-need, low-resource residents.
    - The Alliance uses a multilayered analytics platform to integrate data from different sources for both patient-level and population-level analyses. The data are stored in a centralized EHR data warehouse, and users can track both patient-level and provider-level improvements over time.
    - The PRAPARE model used by the Alliance offers a standardized patient risk assessment protocol to identify risk related to social determinants of health.
    - The SASH assessment gathers comprehensive well-being information about each participant on an annual basis which is used to identify support gaps.
2. **Programs still tend to use medically oriented outcomes to determine the impact of their interventions.**
    - The Geneva Tower Health Collaborative focuses on clinical measures like number of non-admission emergency department visits and percentage of residents with hypertension. They also measure self-assessed availability of social supports.
    - The Alliance uses its data platforms to examine performance on national quality measures; these measures are largely medically oriented.

- The SASH program has been extremely beneficial in reducing Medicare expenditures, reducing the number of falls, controlling hypertension, and increasing immunizations. While almost all of the benefits are medically focused, SASH is looking to improve outcome measures that focus on more nonmedical results such as social isolation.

3. **Community collaboration is essential to establishing a trusted continuum of services.**
    - The Geneva Tower Health Collaborative engages many community partners including the apartment complex; providers of care for physical, mental, and substance use issues; aging services; public health representatives, and others.
    - PRAPARE uses data to identify and support the development of needed programs, connect patients with community resources and patient navigators, target patients for specific screenings, and identify the necessary level of care management. For example:
        - A team in Iowa developed a relationship with the local transportation authority and negotiated bulk discounts for taxi vouchers and bus tokens. They also geo-mapped data to highlight areas experiencing the highest transportation need, and plan to use this to advocate for new bus routes.
        - A team in Hawaii discovered that many diabetic patients felt socially isolated. They partnered with local churches and the American Diabetes Association to offer peer support groups for diabetes management in the churches.
    - SASH coordinators and wellness nurses are “trusted guides” for the participants and their families and help connect them to community partners who can provide a continuum of supports and services that meet participants’ needs.
4. **Data sharing capabilities among providers are variable, and challenges exist for integrating healthcare data and other types of data (e.g., social determinants).**
    - The Geneva Tower Health Collaborative recognizes the limitations of self-administered surveys (e.g., challenge of collecting data, inherent biases). They also acknowledge difficulty with access to EHRs since residents are cared for in a variety of places.
    - The Alliance uses standardized documentation practices in their data analytics platform, but recognizes that EHRs were not designed for population-level data analysis or reporting, and therefore internal tools are limited. They also note that effective data capture also often requires modification of workflows.
    - PRAPARE collects data on social determinants of health (e.g., race and ethnicity, housing status, social integration) and has been incorporated into four EHRs which are used by nearly 60 percent of all health centers.
    - SASH uses DocSite, Vermont’s statewide clinical registry, which collects data on comprehensive well-being (e.g., basic health information, use of and need for social services), and is used by community health teams, physicians, and hospitals.

Next Steps

NQF, along with policymakers and stakeholders across the health and social services sectors, plays an important role in future efforts to ensure high-quality care for adults with complex care needs. Support for communities aspiring to achieve the Essential Attributes is incumbent upon all stakeholders. At the federal level, efforts to improve interoperability and sharing of data need to have heightened focus on social services information in addition to data from the healthcare delivery system. National philanthropic initiatives, such as those by Robert Wood Johnson Foundation (e.g., Data Across Sectors for Health, or DASH) and the recently announced five foundation collaboration around high-need, high-cost individuals, can provide combined support for innovative communities to determine how to collect, integrate, and use medical and social service information effectively to improve quality of life, and to publicize these efforts to serve as examples to others. NQF, through its Measure Incubator, offers a unique opportunity to engage and facilitate the work of those focused on delivering high-quality care for adults with complex care needs. Leveraging the Measure Incubator process, NQF would convene these experts to facilitate the development of measures that align with the Essential Attributes.

Appendix A: Case Studies

Findings from Current and Prior NQF Work

NQF reviewed several current and prior projects related to the care of adults with complex care needs. These projects highlight the need for the development of measures that capture individuals' goals, preferences, and desired outcomes.

The Measuring HCBS Quality project involves the creation of a conceptual framework for measurement of Home and Community-Based Services (HCBS), an environmental scan for measures and measure concepts, the identification of gaps in quality measurement, and recommendations for prioritization in measurement. As a part of the conceptual framework, the HCBS Committee developed high-level domains of measurement for HCBS:

- Service delivery and effectiveness;
- Person-centered planning and coordination;
- Choice and control;
- Community inclusion; and
- Caregiver support.

Each of the domains also had prioritized subdomains. Next, using the conceptual framework, NQF staff completed a synthesis of evidence and an environmental scan to assess the current state of the HCBS quality measurement landscape. In the Committee's third interim report, they presented 261 measures, 394 measure concepts, and 75 instruments relevant to these domains. However, overall, the Committee found a lack of standardized measures for HCBS and a lack of or limited access to timely data. Notably, they found no measures, measure concepts, or instruments under the initial domain of "consumer voice." The Committee determined that high-quality HCBS should be delivered in a manner that "provides for a person-driven system that optimizes individual choice and control in the pursuit of self-identified goals and life preferences." Further, some of the subdomains given priority are:

- the level to which the HCBS system incorporates the HCBS consumer's goals into services and supports;
- the level to which the HCBS system and providers ascertain the HCBS consumer's needs and goals;
- the level to which the planning process is directed by the person, with support as needed, and results in an executable plan for achieving goals the person deems important; and
- the level to which services and plans describe, develop, and support individual choices and life goals.

These prioritized areas for measure development align with the attributes identified by the National Quality Framework for Complex Needs Populations project, and should serve as a starting point for future work in measure development.

In the Population Health Framework project, NQF is developing a common framework for communities to help them work collaboratively with public health and clinical care systems to improve population health. To date, the Committee for that project has developed an action guide for individuals and groups at the local, regional, and national levels. The third version of the action guide includes profiles of groups that worked collaboratively with NQF to field test the action guide. Many of these field testing groups may serve as case studies for addressing adults with complex healthcare conditions. For example, a shortened version of the Geneva Tower Health Collaborative case study as developed by the Population Health Framework project is presented below.

Geneva Tower Health Collaborative (Collaborative)

Overview

Geneva Tower is an apartment complex in Cedar Rapids, Iowa, which houses low-income older adults and disabled adults. Mercy Medical Center and Abbe Center for Community Mental Health, both of which provide programs and services to many of the individuals living at the residence, collaborated with the Affordable Housing Network, Aging Services, Area Substance Abuse Council, and Linn County Public Health to provide additional support for the community and improve health and well-being. By providing services and support on site, the Collaborative reduces barriers to care, including a lack of transportation and financial resources.

Goals and Approach

Through analysis of population health data, the Collaborative identified Geneva Tower's ZIP code as showing disparities in access to care and above average use of emergency department services. In addition, calls to the police department from Geneva Tower residents included a high proportion of medically related issues.

Health improvement activities have included events to help residents understand their Medicaid benefits, an unused prescription drop-off program in partnership with local police, and providing a six-week chronic disease self-management program on site. Following the assessment of initial health-related outreach efforts, the Collaborative discovered that residents had several competing priorities that impede the residents' interest in participating in health improvement activities and health care. For example, some struggled to meet basic needs like consistent access to food and sufficient clothing. Engaging residents has continued to be a challenge, but the Collaborative is exploring different approaches to address this issue, including fostering trust with residents by appointing a resident representative to its board and launching a health and wellness resident committee. This committee is helping to prepare certain individuals to become champions within their own resident community and garner support among their peers and neighbors for health-related initiatives.

The Collaborative is collecting baseline data through resident surveys. However, there are challenges with this method; the surveys are self-administered, which makes information difficult to obtain due to issues recruiting participants, and data may carry inherent biases where residents are reluctant to report accurate information on certain topics.

Measures Used

PATIENT SURVEY

- Percentage of members who had a preventive care visit in last 12 months
- Percentage of residents who can identify their primary care physician
- Percentage of residents with current tobacco use
- Percentage of residents who eat three or more servings of fruits or vegetables in a day
- Percentage of residents who exercise for at least 20 minutes a day
- Percentage of residents interested in participating in health activities
- Percentage of residents who are satisfied with their health status
- Percentage of residents with diagnoses of diabetes
- Percentage of residents who have felt tense, anxious, or depressed in last 30 days
- Percentage of residents engaging in binge drinking during past seven days
- Self-assessed availability of social supports

CLINICAL AND OTHER DATA

- Number of medically related police calls to Geneva Tower
- Number of non-admission emergency department visits for individuals who are Mercy patients
- Percentage of residents with hypertension
- Percentage residents who are overweight or obese

Lessons Learned and Next Steps

Because the Collaborative is focusing on a subpopulation defined by a common residence, the value of geographically defined data sources is limited. The resident turnover rate at Geneva Tower also makes it difficult to compare rates over time to the baseline data, because the individuals involved fluctuate from one period to the next.

While Geneva Tower has partnered with Medicaid managed care plans to analyze integrated health home data, this only captures information for about half of the resident population. The clinical data provided by Mercy Medical Center also has limited relevance, since not all Geneva Tower residents are patients of that particular hospital system. Attempts to aggregate data across providers have not been successful due to issues with access to electronic health records (EHRs). The Coalition is hopeful, however, that regional data access and measure alignment will improve. Linn County's recent Community Health Assessment and Community Health Improvement Plan has prioritized data sharing and effective use of technology within the local public health system in order to identify and address emerging health trends.

New Exemplar Case Studies

In addition to a review of relevant NQF projects and consideration of the previously developed Geneva Tower case study, NQF staff also reached out to stakeholders for advice on potential new case studies.

These key informants referred staff to a variety of people and projects, confirmed that the concept of integrating and using multiple data sources across both medical and social domains was absolutely needed, and cited many examples of programs and communities that have begun this type of work. However, virtually all agreed that not many people or programs are very far along in the use of data to measure the person-centeredness of such care.

The following exemplars provide some insight into tools being used to identify adults with complex needs, approaches for providing more person-centered care that address both health care and social service needs, challenges to collecting and integrating data, and challenges in measuring success.

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

The PRAPARE model is a prime example of a tool that documents a patient's assets, risks, and experiences to empower patients, improve point-of-service care management, improve the health of the patient population, inform community policies, encourage and strengthen partnerships, and inform state and national policies. Centers using this model are promoting community integration, social supports, and care coordination while taking into account an individual's entire history and impacts on their overall health.

Overview

In September 2013, the National Association of Community Health Centers (NACHC), the Association of Asian Pacific Community Health Organizations (AAPCHO), the Oregon Primary Care Association (OPCA), and the Institute for Alternative Futures (IAF) launched a project funded by the Kresge Foundation, Kaiser Community Benefit, and Blue Shield of California Foundation to create, implement, and promote a standardized patient risk assessment protocol that goes beyond medical acuity to identify risks related to social determinants of health. The goal of this project is to develop, pilot, and disseminate a consensus-driven standardized patient risk assessment protocol. PRAPARE was developed in partnership with health centers and Health Center Controlled Networks to improve both patient and population health.

The national network of Community, Migrant, Homeless, and Public Housing Health Centers (often known as Federally Qualified Health Centers) serve over 25 million patients across the United States. More than 70 percent have incomes below poverty, and nearly all have incomes below 200 percent of the federal poverty level. Approximately two-thirds are members of racial and ethnic minority groups, and more than 1 in 5 prefer to be served in languages other than English. The vast majority is uninsured or has Medicaid.[1] Most patients experience multiple and compounding social determinants that impact their health and well-being in adverse and costly ways. Since their start more than 50 years ago, health centers have incorporated social needs into their population-focused model of care. But until recently, there had been no concerted effort to standardize data around their patients' social determinants of health.

What Is It?

PRAPARE is a national effort to help health centers and other providers collect the data needed to better understand, manage, and act on their patients' social determinants of health through a 22-question assessment. As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important that they have tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With data on the social determinants of health, health centers can define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers.

What Does PRAPARE Measure?[2]

- Race and ethnicity
- Farmworker status
- Veteran status
- Housing status
- Insurance status
- Language preference
- Education
- Employment
- Transportation
- Neighborhood
- Safety
- Domestic violence
- Material security (e.g., food, utilities, clothing)
- Social integration and support
- Stress
- Incarceration history
- Refugee status
- Country of origin

How Does PRAPARE Help?

PRAPARE propels providers who serve underserved populations toward transformed, integrated care while assisting organizations to develop interventions and partnerships to streamline care management programs. The data being captured allow health centers to document the extent to which each patient and their total patient populations are complex which in turn can be used to improve patient health, effect change at the community or population level, and sustain resources and create community partnerships necessary to improve health.

How Are Data Being Collected?

The teams that piloted PRAPARE developed workflows based on their local care team and staffing models.[3] Currently, most patient data are gathered in the waiting room or during the exam. Various staff members engaged patients in administering PRAPARE (e.g., medical assistants, care coordinators, patient navigators). A concept of “no wrong door” was adopted by one pilot team suggesting any staff member could contribute to administration of the tool based on the workflow of the center by asking questions at various stages of the clinic visit.

While the tool was designed to assess social risk across all patients, one pilot team chose to focus on medically high-risk patients during the pilot period.

PRAPARE has been incorporated into four EHRs (NextGen, eClinical Works, GW Centricity, and Epic), which are used by nearly 60 percent of all health centers. PRAPARE templates will be made freely available to anyone using these EHRs.

Who Is Involved?

Four implementation teams consisting of at least one health center and one health center network have been involved to pilot test PRAPARE.[4] These teams include:

- One primary care association
- Seven Federally Qualified Health Centers
- One health plan
- Three Health Center Controlled Networks
- 40 care delivery sites
- One technical solutions company

At the start of the pilot period (January 2015), all health center organizations had been certified or were pending certification as patient-centered medical homes. Teams have prior experience collecting and recording data on patient social history and use of enabling services which help patients overcome nonclinical barriers to accessing care (e.g., financial counseling, interpretation, case management, transportation). The data being collected through these surveys are being used to identify and support the development of needed programs, connect patients with community resources and patient navigators, target patients for specific screenings, and identify the necessary level of care management for each patient.

What Are the Positive Impacts Already Being Seen?

One team in Iowa started going to the local transportation authority’s meetings and developed a relationship with them. The health center invited the transportation authority staff to visit their health center. As a result, they have been able to negotiate bulk discounts for taxi vouchers and bus tokens. The team also geo-mapped their data to highlight areas experiencing the highest transportation need, and plan to show this data to the regional transportation authority to advocate for new bus routes to those areas.

One team in Hawaii discovered that many of their diabetic patients felt socially isolated. Subsequently, they teamed up with local churches and the American Diabetes Association to offer peer support groups for diabetes management in the local churches to provide health care and health education in a supportive environment.

What Are the Long-term Goals?[5]

1. Improve health, reduce disparities, and prevent avoidable use of costly health care services.
2. Better identify, manage, and address patients' full range of needs.
3. Better understand and manage the patient population.
4. Provide data to the community to support policy change in areas strongly related to health in order to reduce social determinants of health-related risks for individuals and the community.
5. Provide data to other local health care providers to target social determinants of health-related actions, including transforming care delivery models to create integrated community partnerships and sustainable interventions.
6. Improve health center capacity for serving complex patients, including ensuring that that payment for health care adequately incentivizes addressing those social determinants which adversely affect health, and supports population-based interventions and partnerships involved in managing or addressing social determinants of health.

Lessons Learned

- Staff are able to implement PRAPARE under various workflows.
- Staff report that PRAPARE helps build relationships with patients, aligns with transformation efforts, identifies new needs from patients, and leads to new community partnerships.
- Staff report minimum burden.
- Generally, PRAPARE takes less than nine minutes to administer, although some health centers report that the time responding to a patient's social circumstances can be lengthy.
- Patients reported positive reactions to the questions, saying that the health centers cared about them beyond their clinical needs or complaints.

Next Steps

Health centers from across the nation, other providers, national partners, researchers, and others have expressed interest in or eagerness to adopt PRAPARE, and there is a growing number of health centers that are already using PRAPARE. To help bring PRAPARE to scale, NACHC, AAPCHO, OPCA, and IAF will soon release a *PRAPARE Implementation and Action Toolkit* that will contain resources any potential user would need to implement PRAPARE, ranging from change management materials, technical implementation resources like the four EHR templates, workflow diagrams to collect the data, and examples to use the data to address social determinants of health.

In addition, NACHC, AAPCHO, and OPCA are working to launch a National PRAPARE Learning Network that will facilitate spread and augment efforts to use standardized data on patient social risk to drive transformation at the patient and population levels. At the same time, the network will lay the groundwork for aggregating data across providers and more effectively putting the data to use. The PRAPARE Learning Network would build off the successes of Phase 1, and serve as an umbrella for multiple complementary efforts, including:

1. A “Live University” to promote the use of PRAPARE and serve as a forum for all implementation resources, shared learning, and tracking innovations;
2. Data validation and aggregation to document social risks and evaluate the impact social determinants of health have on health, utilization, and/or cost;
3. Broaden the collection of standardized data on nonclinical health risks and interventions provided; and
4. Leverage existing and create new partnerships that can directly contribute to building health center capacity to implement and effectively use PRAPARE for population health and systemic change.

Alliance of Chicago Community Health Services

Alliance of Chicago Community Health Services (Alliance) is one of the sites using the PRAPARE model. The EHR implementation model developed by the Alliance encourages standardized data entry such that data can be used for individual patient care, or aggregated for population-level analyses. Two of the critical uses of data by the Alliance are for research and tracking performance on quality measures (performance improvement). The Alliance provides its member health centers detailed dashboard reports of performance on national quality measures on a monthly basis. These reports can be drilled down to individual provider-level or patient-level detail by each health center, and can also be stratified by race, ethnicity, and primary language to identify disparities in care. In using this model, Alliance is providing users with the ability to share information about the individuals they serve and their goals, preferences, strengths, and values.

Overview

Alliance (www.alliancechicago.org) has over 15 years of experience in working with community health centers (CHCs) to develop infrastructure to support clinical quality improvement. As a key element of this infrastructure, Alliance hosts an EHR system and has maintained a customized data warehouse since 2007. Alliance now supports the four founding Alliance partner CHCs, as well as an additional 29 CHCs nationally. These CHCs operate out for more than 250 urban and rural sites in 18 states. The centers serve a diverse, underserved, high-risk set of populations including the uninsured, poor, minority, non-English speaking, older adult, and homeless. All Alliance CHCs utilize the common EHR system with uniform data definitions and capture methods.

What Data Sources or Tools Are They Using?

One of the most valuable Alliance assets is its data analytics platform. Alliance operates a multilayered analytics platform designed to integrate data from different sources and by users of varying degrees of sophistication. The flexible platform can be accessed by a variety of analytic and reporting tools, and allows reporting at both the patient and population level. This flexibility provides the CHCs with greater insights into the populations they serve, and allows them to coordinate care among various settings and disciplines, working toward high-quality equitable care.

How Are the Data Being Captured?

Alliance data are stored in a centralized EHR data warehouse and offers clinical application abilities including a dashboard for users, a common environment for network-level reporting, ease of merging data from other systems, clinical decision support, and advanced analytics. CHC staff requires ongoing training to understand these processes and access to resources and leadership mentorship as needed.

What Are the Impacts?

Using the data analytics platform, Alliance has built and is disseminating a highly dynamic quality reporting tool for use in Uniform Data System quality measures. This tool allows CHC staff to stratify reports to identify and drill down to areas of concern, track improvements over time, and benchmark against the larger Alliance community. It is dynamic and allows for the selection of multiple levels of granularity and analysis at real time. Analysis is user friendly so even inexperienced users can carry out these analyses instantaneously using familiar terms.

What Are the Long-term Goals?

Alliance will extend the data analytics platform to all CHCs, train them on its use, and support quality improvement activities. Practice coaches will assure that reports are run monthly to facilitate improvement on the measures. Improvement is further facilitated by the ability to generate views of specific patients and providers tied to failed measures, offering an opportunity for patient-level outreach and provider training.

What Lessons Have they Learned?

To promote the collection of complete and reliable data to support data integration, clinical decision support, and analytics, it is essential that users appreciate the importance of adhering to standardized documentation practices and the recording of relevant information as discrete usable elements. Data capture design must be well-integrated into clinical workflows to support this adherence and completeness and timeliness of information. EHRs were not designed for population-level data analysis or reporting, and therefore internal tools are limited. Reporting functionality needs to support patients, staff, and quality of care, and address the emerging importance of incorporating information from outside the CHCs' walls. Therefore, CHCs require a data repository to aggregate information, and appropriate functionality to carry out advanced analytics and reporting. Quality measures are expected to evolve over the coming years and will need to be tested to meet measure specifications, capture and display data effectively, and promote improvement initiatives, as well as meet reporting requirements. Effective data capture also often requires modification of workflows. Successfully meeting these needs requires close collaboration between CHC staff and data/informatics experts.

Support and Services at Home (SASH)

The SASH program is a Vermont-wide initiative to create a network of person-centered, coordinated health care and support services that engage participants, family, and friends in order to provide the right services and supports at the right time, tailored to local conditions and participant needs. An annual assessment provides a baseline well-being status and identifies the needs and support gaps of each SASH participant, which builds the foundation of the participant's Healthy Living Plan.

Overview

In 2008, the nonprofit Cathedral Square Corporation (CSC) in South Burlington, Vt., began developing the SASH program out of concern that frail residents in its properties were not able to access or receive adequate supports to remain safely in their homes. The SASH model is part of the Blueprint for Health, Vermont's statewide health care reform initiative and helps older adults and individuals with special needs access the care and support they need to stay healthy while living comfortably and safely at home. SASH is available throughout Vermont, serves primarily persons 65 and older or with disabilities, and uses data and tools to improve care.

This program is working to improve/maintain the health, function, quality of life, and independence of Vermonters; creating a network of person-centered, coordinated health care and support services; engaging participants in the design of their program and their individual healthy aging plans; engaging family and friends; and providing the right services and supports at the right time, tailored to local conditions and participant needs. Thus, SASH exemplifies a number of sub-attributes including the identification of adults with complex care needs and the promotion of community integration, social supports, and care coordination.

What Is It?

The SASH program is a Vermont-wide initiative coordinated at the state, regional, and local level. CSC oversees the program at the state level and is responsible for defining and implementing the programmatic elements along with coordinating program expansion and training. At the regional level, six Designated Regional Housing Organizations are responsible for planning the roll-out of the SASH program across their geographic regions. The program is delivered at the community level through SASH panels, which are operated by the housing host organizations.[6]

When individuals choose to participate in the SASH program, they consent to allowing the SASH staff and community partners to share information about them with each other and their health care providers. With this consent, SASH staff work with the participants' healthcare providers when necessary to ensure proper medication usage, successful hospital discharges, and overall coordination and continuity of care. Importantly, the SASH program does not "discharge" participants. Rather, the SASH program provides a continuum of support and services that meet participants' needs whether they are extremely healthy and looking for minimal supports or very frail participants in need of more robust support from the full SASH team.

How Does SASH Help?

The SASH program strives for an organized, person-centered approach to wellness in the housing community. SASH staff work to develop personal relationships and build trust with participants and the people who support them. Specific staff members (e.g., SASH coordinator embedded at the facility, a wellness nurse) are "trusted guides" and integral to the success of the model. They focus their efforts around three types of interventions: transitions support, self-management education, and care coordination. These staff members are a resource not just for residents, but also for family members and community service providers. SASH staff has significantly increased participants' ability to access their primary care providers

What Data Are Being Collected?

The SASH Assessment gathers comprehensive well-being information about each SASH participant on an annual basis. The assessment is a combination of self-report (by person, family, or caregiver) with follow-up questions and observation by the assessor. Staff inputs the assessment information directly into the DocSite clinical registry during the assessment interview. DocSite is Vermont's statewide clinical registry used by Blueprint for Health community health teams, physicians, and hospitals. The assessment provides a baseline well-being status and identifies the needs and support gaps of each SASH participant, which builds the foundation of the participant's Healthy Living Plan. It assists the SASH team in determining what services, if any, the participant may need and in facilitating the coordination of care among health care and social service providers. Lastly, the information guides the SASH team in creating a structure to implement evidence-based and promising prevention programs. The assessment collects:

- Basic health information including diagnosed health conditions, medications, treatments received, and providers of care;
- Information regarding a participant's past health history including history of recent falls, nursing home admissions, emergency department visits, and hospitalizations;
- A falls risk assessment;
- An assessment of a participant's ability to perform activities of daily living and instrumental activities of daily living;
- Support services currently being used by the participant, and services or supports needed; and
- Information on mental health, nutrition, and cognition status using validated screening tools.

How Are Data Being Collected?

SASH coordinators and wellness nurses are the state's largest users of DocSite for primary entry. SASH staff created a large dataset within DocSite that is being used by the health department, community health teams, and providers for data analytics on a population level. As DocSite continues to add more clinical data to its system, SASH staff are some of the first and most robust users of SASH's integrated health records functionality. This will enable SASH to better link with community health teams and more efficiently utilize available resources and coordinate care for participants.[7]

What are the benefits to SASH participants?

- Improved quality of life
- Comprehensive health and wellness assessments
- Individualized Healthy Living Plan developed by the patient and SASH coordinator to highlight their health and wellness goals and identify areas where assistance is needed
- Money savings through preventive health care
- Check-ins and health coaching
- Convenient access to a wellness coach
- Planning for successful transitions
- A trusted guide to help navigate long-term care
- An informed team to help in a crisis

- Access to prevention and wellness programs
- Medication management assistance

Next Steps

SASH has proven to be extremely beneficial in reducing Medicare expenditures, reducing the number of falls, controlling hypertension, and increasing immunizations. While almost all of the benefits are medically focused, SASH is looking to improve outcome measures that focus on more nonmedical results such as social isolation.

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