Age + Action

June 17–20, 2019 | Washington, DC

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National Council on Aging

The Quest for the Perfect Evidence-Based Program Data Management System

Celsa Bowman, Mark Cullen, Robert Mapes, Meghan Thompson, Sheeba Ibidunni

June 17, 2019

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Utah's Data Management System: **Compass**

June 17, 2019

Celsa Bowman, MS, AAS, Health Program Specialist III

UTAH DEPARTMENT OF HEALTH
Arthritis Program

MISSION & VISION

The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

Our vision is for Utah to be a place where *all* people can enjoy the best health possible, where *all* can live and thrive in healthy and safe communities.

The Utah Arthritis Program

Vision

To increase self-management skills and improve the quality of life for all Utahns affected by arthritis and other chronic conditions.

Mission Statement

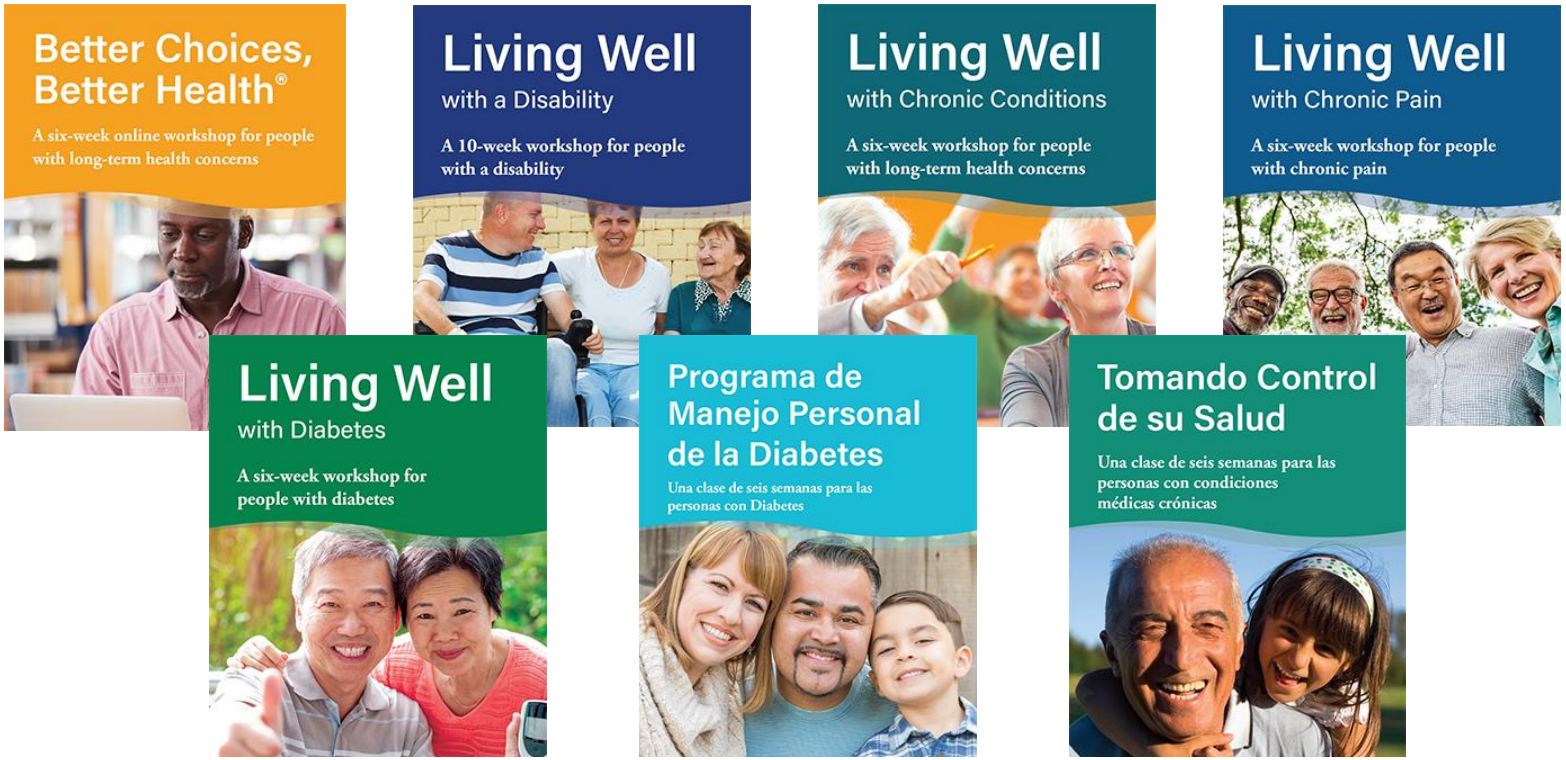
We provide technical assistance and coordination to increase awareness, expand reach and achieve sustainability of evidence-based self-management programs for all Utahns affected by arthritis and other chronic conditions through statewide partnerships.

Arthritis Program

Utah Department of Health

UTAH DEPARTMENT OF HEALTH
Arthritis Program

Our 7 Community Self-Management Workshops

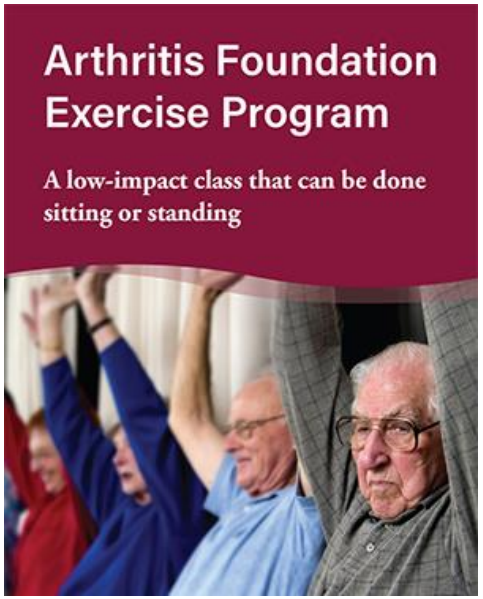


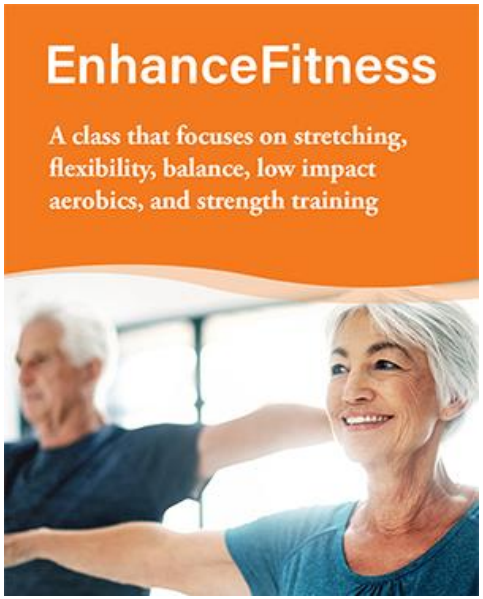
Arthritis Program

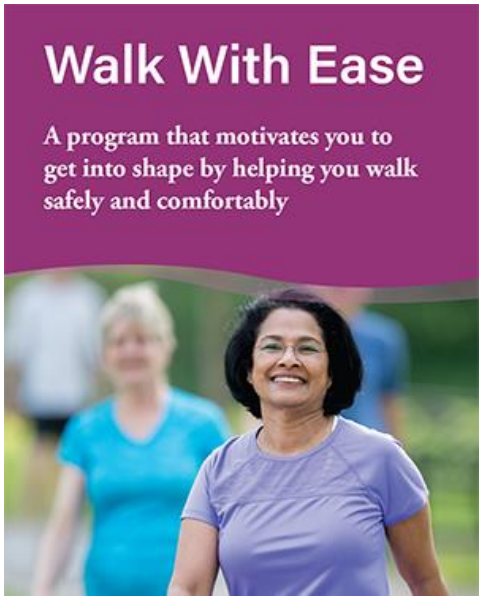
Utah Department of Health

UTAH DEPARTMENT OF HEALTH
Arthritis Program

Our 3 Community Physical Activity Classes







Program History (1999 - present)

1999: Awarded first CDC Arthritis grant

2012: Paper copies of the Participant Information Form

2014: Contracted with QTAC-NY for the *Partner Portal*

2015: Data entry into *Partner Portal* is required

2016: Developed *Compass; Physician Portal*

Overview of **Compass**

- Web-based data management tool (PHP and MySQL)
- Back-end database management system for coordinators
- Reporting features
- Data export capabilities for National DPP and NCOA
- Used for all Utah Department of Health evidence-based programs
- Bi-directional Physician Referral Portal

Key Functions of **Compass**

- Public-facing registration system at www.LivingWell.Utah.gov
- Program coordinators manage their own data
- Reporting of participant data critical for invoicing
- Data export features for National DPP and NCOA
- Bi-directional referrals for healthcare providers

What's on the Horizon for **Compass**

- Bi-directional Physician Referral Portal enhancements
- Training video for Bi-directional portal
- Texting notification for class participants
- Ongoing classes improvements (WWE, AFEP, EF)
- Automated data export into NCOA database
- Diabetes Self-Management Education registration

Contact Information

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https://arthritis.health.Utah.gov

www.LivingWell.Utah.gov

JUNIPER®

Your Health. Your Community.

A robust network
for **self-managed health**
and well-being
in Minnesota

It started with a question:

How can we help **more people benefit** from classes that promote health and wellness?

Juniper
Network

Juniper Network

External Partnerships

Innovations for Aging

Administrative Support

Technology

Centralized Contracts

Data Management

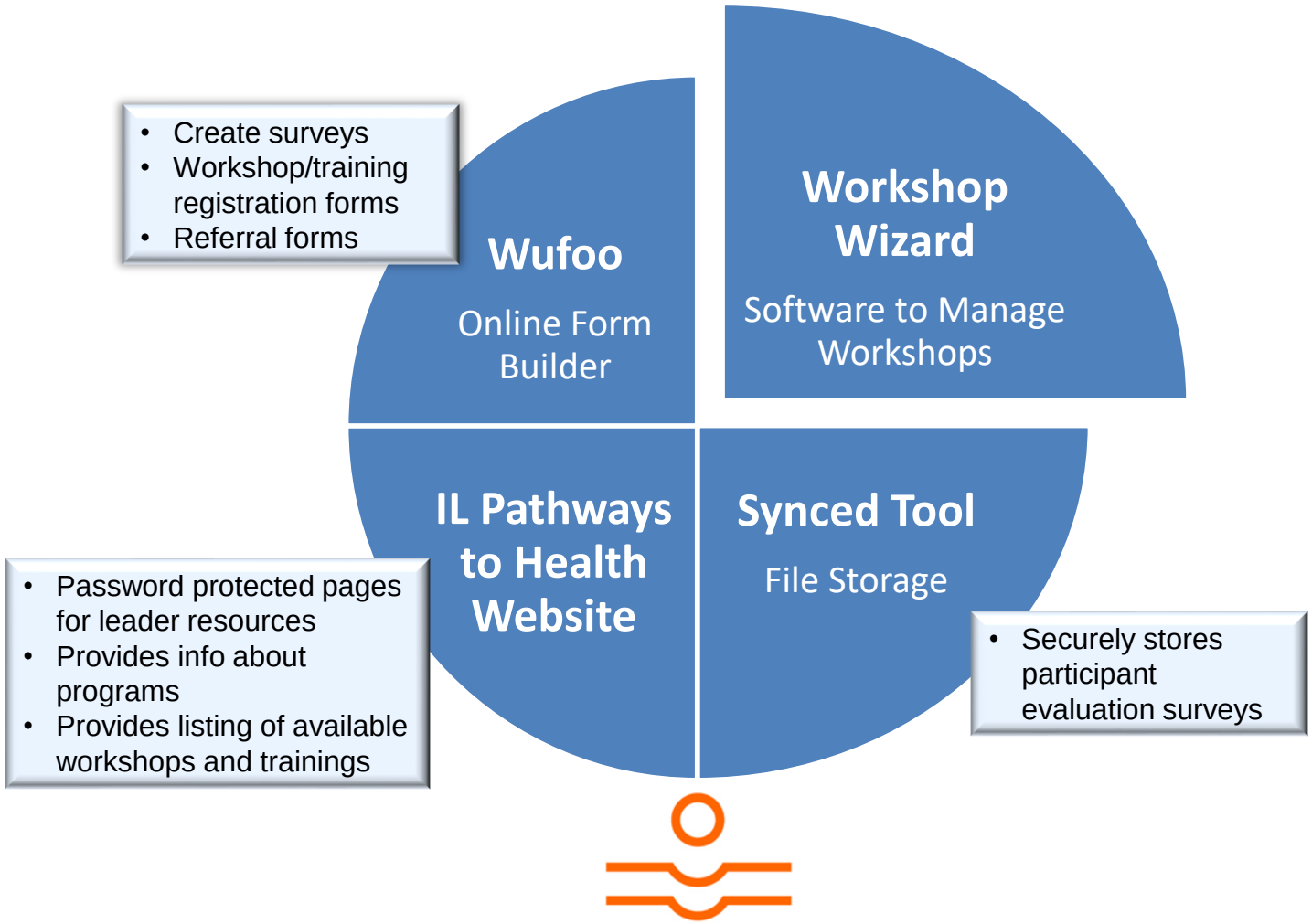
Powerful technology platform

- Web portal for finding and registering for classes
- Back-end MIS for class management
- Referral and payment systems
- Analytics for tracking results
- Hosted in secure Microsoft Azure cloud platform

NCOA Panel: The Quest for the Perfect Evidence-based Program Data Management System

Rob Mapes, Director of Program and Community Support

Evidence-Based Data Management Systems Used



Workshop Wizard

Features	Description
Workshops/Trainings	• Manages workshop/trainings info • Add any curriculum/program
Leader Certifications	• Track leader certificates, expiration dates and workshops taught
Referrals	• Track contact made with referrals
Participant Data	• Track participant attendance • Create and track custom survey data
Reports	• Generate reports for grants, participants, referrals, leaders and more
Custom Access	• Restrict access to features for specific users

Lessons, Opportunities & Integration

Lessons Learned & Opportunities

- Research all features of software before selecting to use
- May need to invest more money to customize features of software

Integration

- Import/export data from Workshop Wizard to NCOA
- Sync workshop info from Workshop Wizard to public website

Questions?

Rob Mapes

Director of Program and Community Support

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Since 1974, **AgeOptions** has established a national reputation for meeting the needs, wants and expectations of older adults in suburban Cook County. We are recognized as a leader in developing and helping to deliver innovative community-based resources and options to the evolving, diverse communities we serve.

AgeOptions.

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The Quest for the Perfect Evidence-Based Program Data Management System:

The Sound Generations Experience

Meghan Thompson | June 17, 2019

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Who we are

Sound Generations is a private non-profit organization operating in King County, WA

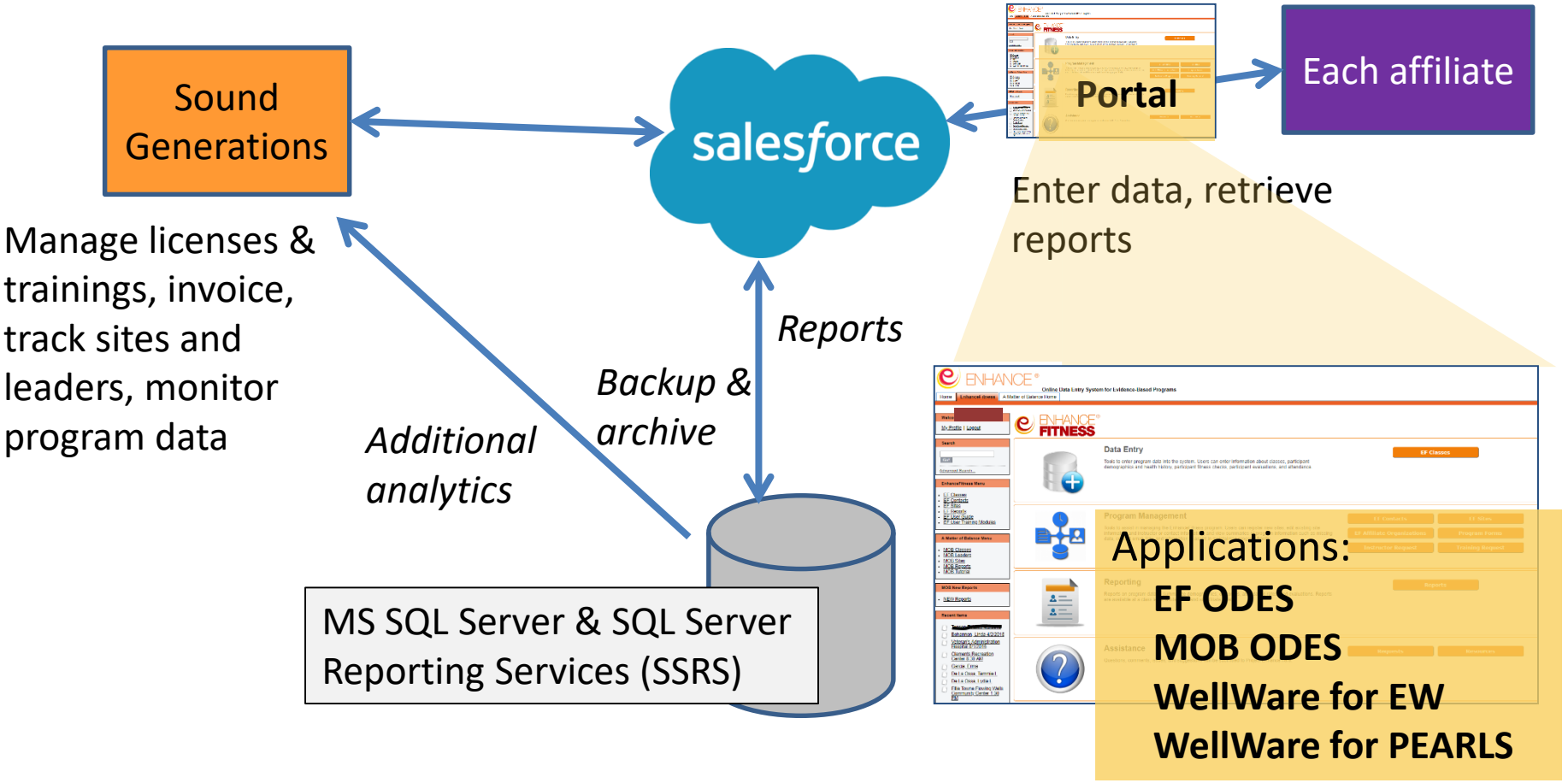
Mission: Support people on their aging journey through community connections and accessible services

- Transportation
- Meals on Wheels
- Caregiver Support
- Community Dining
- Community Partner Sites
- SHIBA/Senior Rights Assistance
- Information and Assistance
- Minor Home Repair
- Evidence-Based Health Promotion Programs

What we do

* Also manages **ACL National Falls Prevention Database** for NCOA National Falls Prevention Resource Center

Overview of our system



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Unite Us: Building Healthier Communities Together

Software Connecting Health & Social Service Providers

Sheeba Ibidunni, MHSA | June 17, 2019

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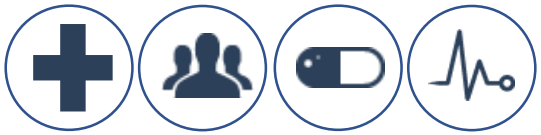
THE PROBLEM
Service Providers are Fragmented

Community

Government



Healthcare

1. Healthcare and social service providers both **lose visibility** after their patients are discharged.
2. Co-occurring health & social needs are often **under-addressed** across the community.
3. Vulnerable patients are **seeking clinical care for social problems.**

IT'S YOUR CHOICE: HOW YOU BUILD YOUR NETWORK

#1: IDENTIFYING NEEDS

Resource Directory
List of community organizations that is manually updated. Providers have no idea they are on that list or workflows to accountably care for your patients.

Referral Tool
Referral from organization to PATIENT with no outcome measurement or holistic tracking of patient.

#2: FOCUS ON OUTCOMES

Connectivity and Collaboration
Software that connects ALL community partners.

True Visibility Across the Community
Software that provides ALL community partners with visibility around service delivery and every outcome beyond their four walls.

Real-Time Tracking and Reporting
Software that supports the complex data and reporting needs of community partners to ensure that all partners stay on the same page.

MUST EXTEND REACH, VISIBILITY, AND IMPACT

THE PATIENT-CENTERED SOLUTION & EXPERIENCE

Software: Easy-to-use platform tracks every step of the patient health journey inside and outside hospital walls.

Knowhow: Create quality, collaborative and accountable community networks.

PROPRIETARY & CONFIDENTIAL

UNITED ACROSS THE COMMUNITY

EMPOWERING COMMUNITY PARTNERS

Inter-connecting healthcare & social services into one accountable coordinated ecosystem.

Empowering health systems & communities to work **seamlessly together** to impact every person's health and social needs.

ACCESSING CARE & SERVICES

WORKING AS ONE COMMUNITY CARE TEAM TO IMPROVE HEALTH

Tom shows up at Sue's organization or requests care digitally.

Sue is a clinical provider & identifies Tom as having additional needs.

Sue uses Unite Us to gain digital consent & electronically refers Tom to multiple community partners.

Housing

Employment

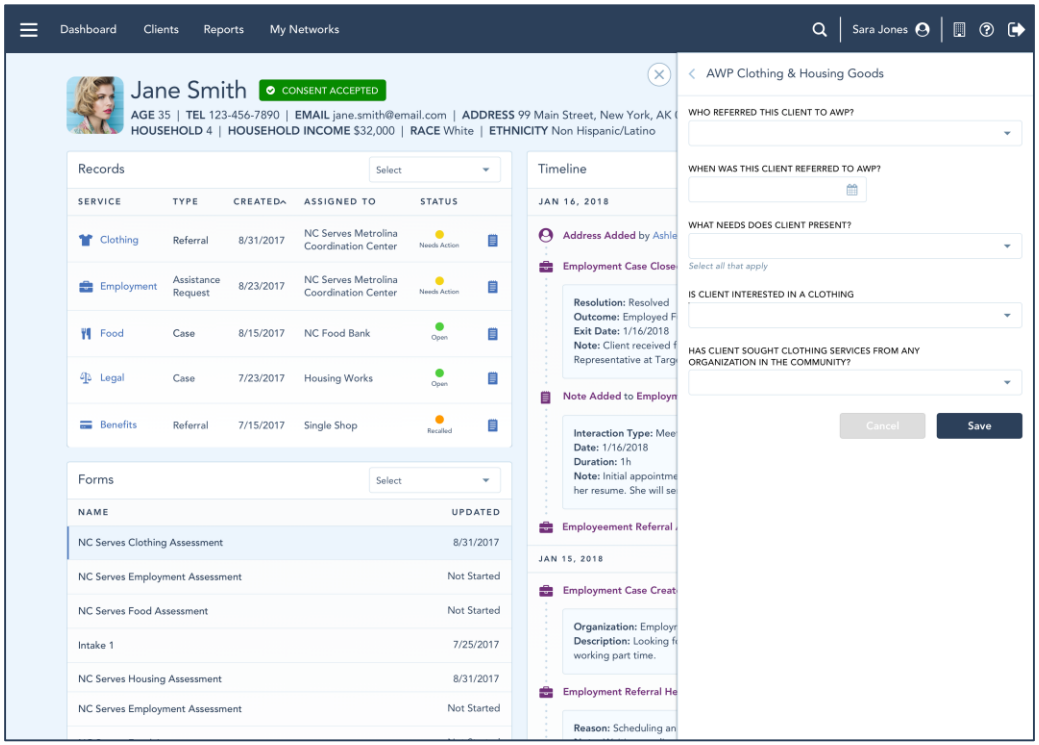
Behavioral Health

As Tom receives care, Sue coordinates in real-time with Tom's "community care team," receiving **automated** updates and tracking his total health journey through the SDoH Dashboard.

PROPRIETARY & CONFIDENTIAL

FROM HELLO TO OUTCOME, YOU ARE CONNECTED

AUTOMATED WORKFLOWS BETWEEN YOUR EXTERNAL PARTNERS AT SCALE



Configurable Screening:
Patient and/or provider facing algorithmic screenings to stratify risk and identify specific co-occurring needs

Electronic Referral Management:
Seamless referral workflow sends the right data to the right provider(s) to address specific needs

Assessment/Care Plan Management:
Custom care plans for each service need that are attached to referrals so receiving providers get a head start

Bi-Directional Communication/Alerts:
Automated notifications keep all organizations up to date, while care team members can securely communicate with each other

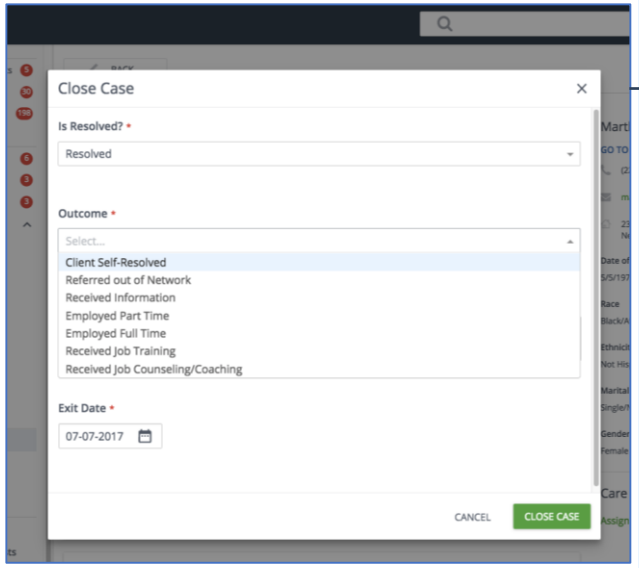
Outcomes:
You get to know exactly what services were delivered, and the entire history for every intervention by your external partners

PROPRIETARY & CONFIDENTIAL

CONFIGURABLE & STRUCTURED REPORTING

GRANULAR AND DETAILED OUTCOMES FOR EVERY TYPE OF SERVICE

Employment Service Type Example



ARCHITECTURE SUPPORTING ALL SYSTEMS

UNITE US INTEGRATES WITH OTHER PLATFORMS ENSURING SEAMLESS WORKFLOWS

2-1-1	EHRs	Community	VA
iCarol	Epic	salesforce	VA
Used by +50% National 2-1-1 Market	App Orchard & Health Planet Team	Various tools used in the community	Kiosks in VAMCs

Sheeba Ibidunni

Director of Network Development

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