Stanford HEALTH CARE
STANFORD MEDICINE

University HealthCare Alliance

Population Health Gap Project Success

UHA's patients will receive better care, and our providers will be able to deliver outstanding care more reliably and more efficiently, due to the highly successful Population Health Gap Project.

With crucial support from UHA's providers, our Health Information Management Services (HIMS) department, led by Chuck Mesrobian, and the UHA Quality department, led by David Overton, teamed up with office staff to close care gaps by doing retroactive chart abstractions across the whole organization. The goal was to review the medical records of all active patients to ensure that relevant clinical records had been abstracted appropriately (put into the right places in Epic so that providers and staff can easily access this critical information).

This process ensured that patients do not have to repeat tests if already completed, and that UHA providers have true and accurate data on their Healthy Planet dashboards. Ensuring accurate data is critical both in *providing* appropriate care and also in *demonstrating* – both to ourselves and outside observers - the high quality of the care we provide. Improving patient care while making life easier for our providers and staff is the kind of "win-win" that improves all of our professional fulfillment and helps make us proud to be a part of UHA/Stanford Medicine.

The project began back in August of 2018 where four dedicated HIMS employees were tasked with assessing 34,627 Family and Internal Medicine patients from Menlo Medical Clinic and University Medical Partners for gap measures.

The HIMS team was able to recover Population Health gap measures for 6,997 patients, totaling a 20% recovery rate. As a result of these initial findings, the HIMS team performed a subsequent review of a smaller subset of patients. In July, the HIMS team audited 1,368 patients from clinics that were part of the initial Population Health Gap project and recovered gap measures for only 2.4% of the patients. A far cry from the initial 20%. *This shows the clinics are following their chart prep workflow!*

The Population Health Gap Project was conducted to help develop workflows to identify and close care gaps that can have a huge impact on our patients' health outcomes. Our sincere thanks to the Team Based Care training performed by the Education Department, the Quality Department's involvement in providing the patient list, and for support from the Executive Team, Administrators, and Office Managers for their efforts in the Population Health Gap project.