

Case Study

Orange County Health Care Agency

“Our vision was for a public health system that is responsive to the communities it serves, well-connected across various sectors, driven by data, and well-positioned to anticipate and respond to challenges and opportunities impacting health.”

– Jane Chai
MPH, Orange County Health Care Agency

At-A-Glance

Market Segment:

Health Department

Service Area:

Orange County, California

Population:

3,194,830

Customer Since:

2014

Solution:

HCI Platform and
Consulting Services

Most Visited Indicator:

Hospitalization Rate due to
Alcohol Abuse

Most Used Features:

Mapping capabilities;
School district, city, and
zip code data

Results:

- Multi-sector collaborative of more than 80 community partners with aligned goals and actions
- Addressed data gap and understanding of aging population through Older Adult Dashboard with 70 health, social, and economic indicators from community survey
- Successful grant award of \$1.3 million from the CDC's Partnerships to Improve Community Health



Aligning the Community

“Orange County (OC) is a community that has always valued collaborative efforts,” said Jane Chai, MPH, at the Orange County Health Care Agency (OCHCA). With the goal of achieving Public Health Accreditation Board (PHAB) accreditation, OC utilized Mobilizing for Action through Planning and Partnerships (MAPP), a strategic planning tool for improving community health. “We established a new collaborative, the OC Health Improvement Partnership (OCHIP), focused on aligning public and private resources to advance health for all communities in OC.” Next, they conducted the four MAPP Assessments, which uncovered a major gap in the public health system. “We found a lack of data and tools to facilitate long-term and collaborative population health planning,” said Chai.

To assess needs, the community had previously been using static reports, developed from disparate sources by various epidemiologists and research analysts. “Various community groups were looking

at different health indicators, with different definitions and data that quickly became out-dated. And on top of that, while OC often performed well against state and national goals, pockets of our population, such as in the central and northern regions, still had unmet needs that were difficult to delve into,” said Chai. One such group was OC’s aging population. “After we created our plan, we realized that we needed to better understand our starting point. We found it had been over ten years since we analyzed our older adult population system of care, which is unfortunate given that nearly one fifth of the population will be over 65 by 2030”

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Centralizing Data for Strategic Health Improvement

To address the lack of data and tools to facilitate long-term population health planning, OCHIP determined the need for a central online platform that would support multi-stakeholder collaboration, increase understanding and alignment of community needs, and support PHAB accreditation. They developed a list of criteria and community health indicators most important to be included. “We wanted it to be responsive, connected, and data-driven, as well as specifically positioned for community health,” said Chai. The extensive criteria list and competitive review process led to the selection of the Healthy Communities Institute (HCI) Platform.

“The HCI platform was easy to use and its data was robust, time-trended, and compared against national, state, and local values. The data visualizations were clear, action-oriented, and useful for OCHIP partners. With a library of evidence-based practices, the ability to add one’s own data, and funding opportunities, the decision to go with HCI was easy,” said Chai.

The Community Impact

Multi-Stakeholder Collaboration

Soon after publishing the Healthy Communities Institute Health Assessment, OCHIP launched the HCI platform, called OC Healthier Together, and led their inaugural meeting. “The platform provides common language and standard measures,” said Chai. “Each group is looking at the same indicators with the same definition, over the same time frame, so we can all be aligned in our efforts.” Today, more than eighty private and public organizations collaborate on OCHIP’s four priority areas using the HCI platform: Infant and Child Health, Older Adult Health, Obesity and Diabetes, and Behavioral Health.

Assessment and Deep Understanding of Priority Sub-Population

To better understand the needs of the aging population, the Older Adult Health workgroup launched a custom dashboard with over 70 health, social, and economic indicators specific to the aging population. The Older Adult data visualizations and analytic tools support strategic planning in this arena. An older adult report highlighting key findings of the dashboard is due out this summer and will be the first of its kind in over a decade.

Through alignment of public and private resources, the initiative is increasing early identification of safety risks, reducing complications of chronic diseases, reducing social isolation, and reducing the risk for abuse and neglect among the elderly. “With so much geographic, hospitalization, and ER data, gaps are being realized and addressed. We are able to galvanize our community in a more robust way,” said Chai.

Expanding Funding with Grants

“As our strategic planning got underway, OCHIP utilized the HCI Platform to identify an appropriate grant opportunity from the Center for Disease Control: Partnerships to Improve Community Health. Because OCHIP already had the data and health improvement platform in place, we were able to quickly and successfully respond,” said Chai. In the end, the CDC awarded OC a grant of over \$1.3 million dollars to further their work with Latinos, Asians, and Pacific Islanders who suffer from high rates of death from diabetes and other chronic diseases. Chai credits the win to “partnership, aligned goals, trust in OCHIP, and a platform to support the full lifecycle of improving health in OC.”

Visit Orange County’s Healthier Together:

www.ohealthiertogether.org

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