

Mississippi ChimeMaps 2.0

Community Analysis Module – Business Use Case

Overview

The Mississippi ChimeMaps Community Analysis module provides timely and relevant data that illustrates the burden of health issues in the community and illustrates areas where hospitals might create targeted outreach and intervention strategies.

User Profile

Hospital users focused on population health and community health use Mississippi ChimeMaps to support the development of federally mandated Community Health Needs Assessments and to identify health disparities and ways to improve community health. The information in Mississippi ChimeMaps supports development of target interventions for high-risk neighborhoods and health conditions.

Mississippi ChimeMaps includes detailed patient information such as demographic characteristics, encounter history, attending and operating physicians, and payer information. The information is valuable to users in the case management and disease management functions, allowing users to gain insight into patients in a specific disease or condition category, to explore the clinical and neighborhood characteristics of frequent utilizers, and to generate and export case lists to integrate into care coordination workflows.

Business Uses

- Mississippi ChimeMaps plays a vital role in providing data and exhibits to support the Community Health Needs Assessment process. Timely and relevant data, aligned with industry-wide focus areas and public health concerns, help pinpoint the needs and issues for particular communities. Social determinants of health data can help pinpoint non-clinical factors affecting health, including poverty, education levels, and neighborhood housing characteristics.
- Hospitals can identify high-frequency users by medical condition. Hospitals can target health outreach and interventions, resulting in reduced readmissions and measurable improvement in community health.
- Hospitals can identify patient encounters for specific health disparity indicators, identify high-frequency users by patient setting, and extract patient demographic and neighborhood socioeconomic measures to help in targeting areas of need.
- Target interventions to high-risk neighborhoods based on clusters of patients with specific health conditions such as heart failure, asthma, or diabetes.
- Enable staff to develop prevention activities and education outreach for specific areas as part of their community health implementation plan.

Benefits

Hospitals can reduce readmissions and improve community health, and measure success through timely data and metrics. In accountable care arrangements and quality-based incentive programs, insight into underlying neighborhood characteristics is essential in addressing populations at risk and the root causes of health issues. These insights contribute to the development of population health strategies that can lead to improved well-being, a reduction in inappropriate utilization, and a measurable improvement in community health.

