Data Aggregation Strategies: *Ingredients for population health & equity*

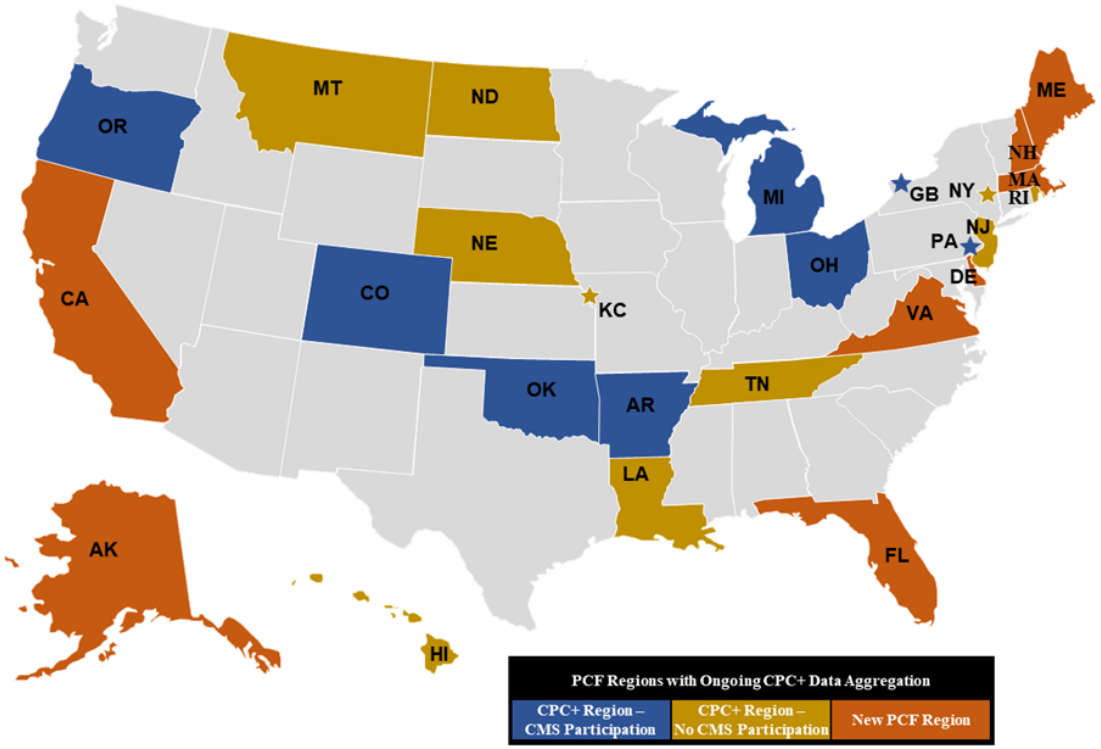
Discussion Topics

- Priorities & Use Cases
- Data Aggregation examples
- Opportunities for Rhode Island

Primary Care Transformation Models: *Ingredients for population health & equity*

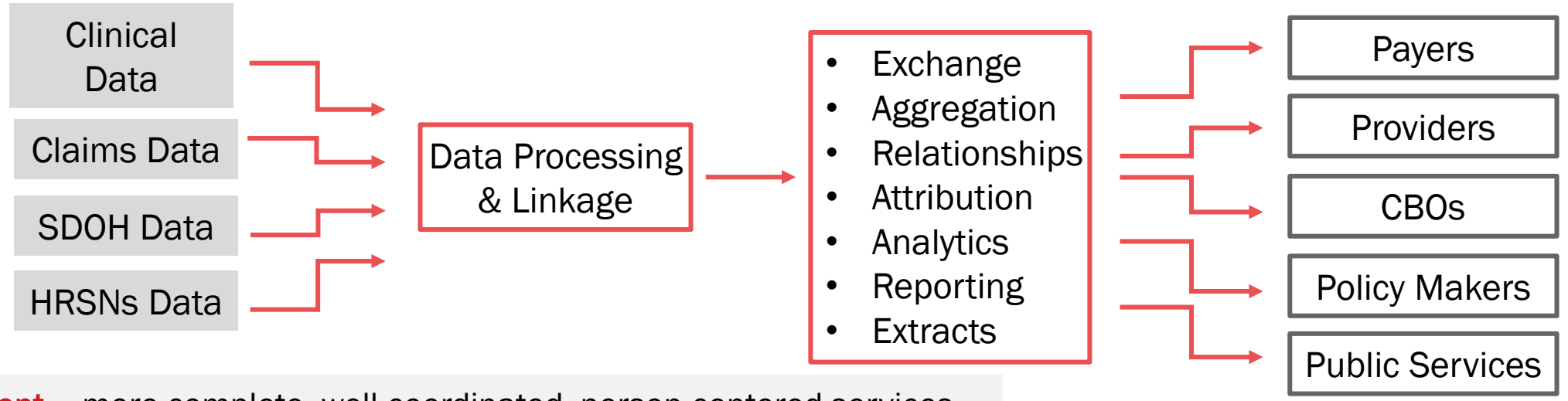
	Key Ingredients
Investment	Invest in the right places including advanced primary care, multi-disciplinary teams (practice, community), data guided insights, and information sharing that supports coordination across settings (healthcare, CBOs)
Payment	Shift from volume to value with a composite payment structure that supports reliable operations and promotes practice transformation. Incentives need to reach PCPs and staff to be effective.
Engagement	Support local decision making with meaningful input on staffing and how to deliver and coordinate services (e.g. practice and community level)
Access	Assure that patients have streamlined access to advanced primary care and support services including those that address sociodemographic needs, with effective coordination across settings
Person Centered	Incorporate strategies so that health services are oriented to help people meet their goals and health related priorities, including attention to lifestyle, cultural, and linguistic influences
Equity	Assure equal access to high quality care and recommended preventive services to address historic sociodemographic bias. Include incentives to reduce health inequities as part of the payment model. Consider regional 'place-based' teams in addition to teams in traditional healthcare settings.
Learning	Promote a culture of data use and provide opportunity for shared learning with trusted convenors and facilitators. Payment model and investments should incentivize and support participation.
Insights	Facilitate information sharing and generation of tailored data guided insights that are readily available to providers, easy to digest, and provide a comparable understanding of quality and performance

Data As A Driver: *Data aggregation in CMMI Primary Care Models*



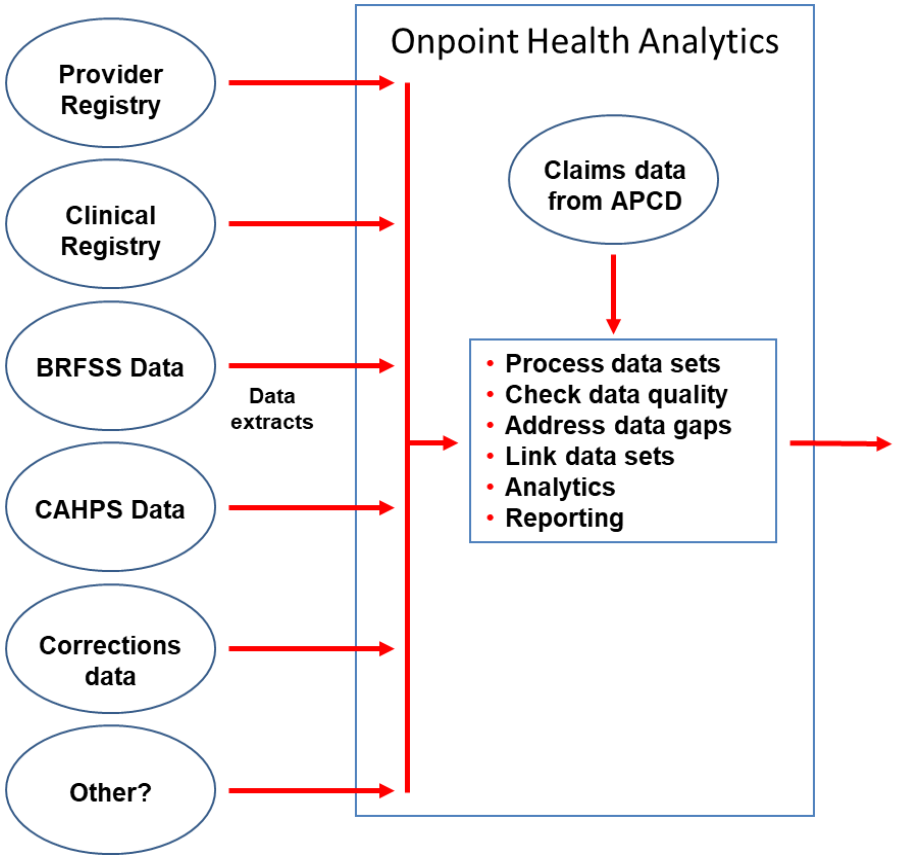
- Initially focused on claims data & measure reporting
- Expanding to incorporate other strategies & data types
- Using payer attribution rosters to guide notifications
- Enhancing the use and impact of notifications
  - Covid test status
  - Covid encounters
  - Vaccine status (e.g. 'no vaccine' report)
  - Care fragmentation reports
  - Notifications & data to state agencies
- Pushed out light 'actionable' reports
  - Care gaps
  - Medication Management
- Exploring use of linked multi-sector data
  - Claims, clinical, HRSNs, SDOH

Future of Data Aggregation As A Driver: *Priority use cases*



- **Care management** – more complete, well-coordinated, person-centered services
- **Risk stratification** – advanced insights for grouping, outreach, & proactive care
- **Risk adjustment** – understanding sociodemographic impact on performance
- **Payment** – adjust payments to account for disparities and population needs
- **Quality** – orient quality initiatives to be respond and address health inequities
- **Interoperability** – payer & provider interoperability requirements
- **Equity** – Monitor and enhance access & services for underserved populations

Vermont's Community Oriented Primary Care: *Data Use for a Learning Health System*



Measurement

- Utilization
- Expenditures
- Unit Costs
- Quality
- Patient Experience
- Social, Economic, Behavioral
- Variation & Associations

Products

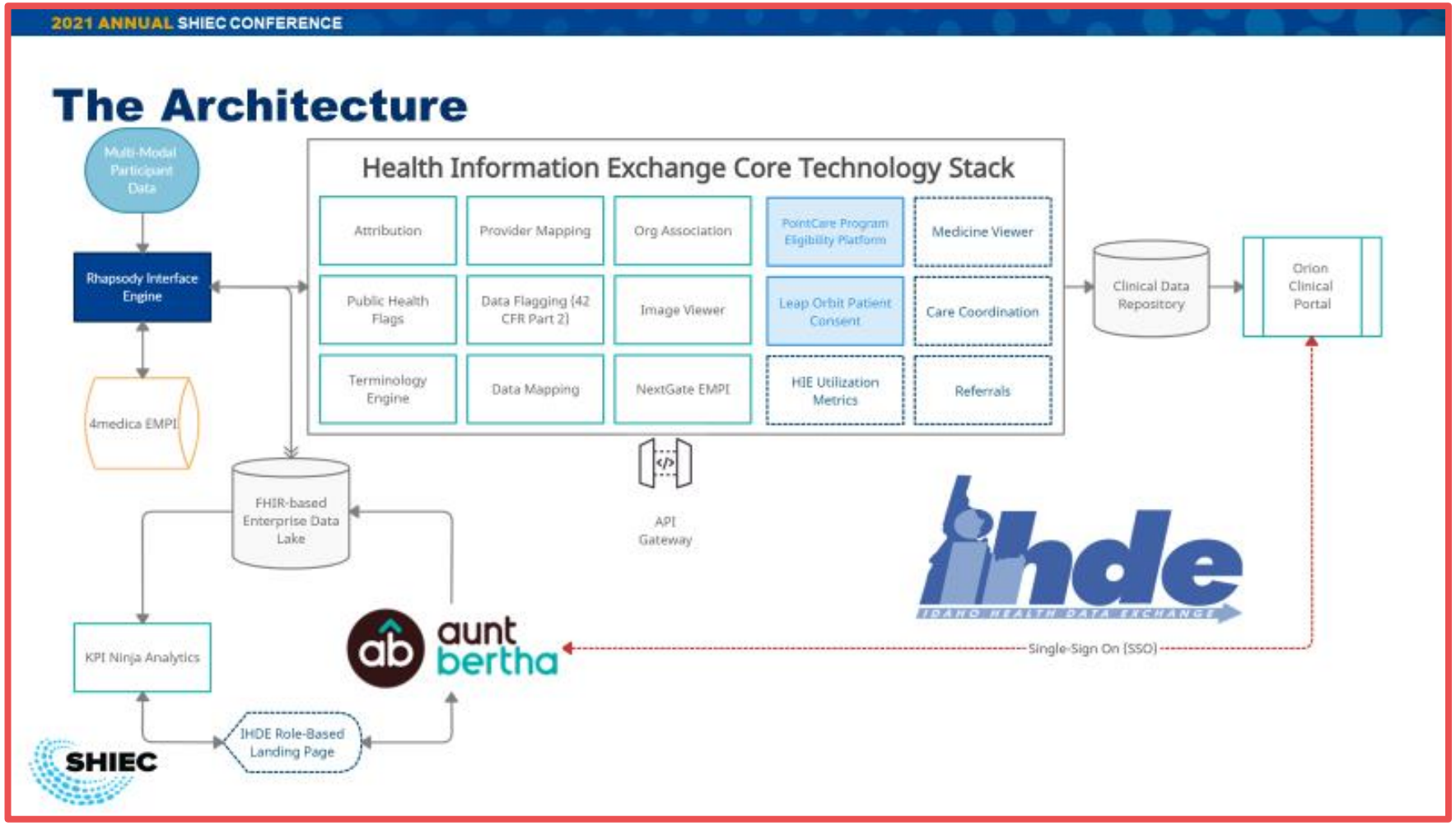
- Practice Profiles
- HSA Profiles
- Learning System Support
- Performance Payments
- Program Impact & Publications
  - PCMH + CHT
  - Opioid Program
- Predictive Models

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare

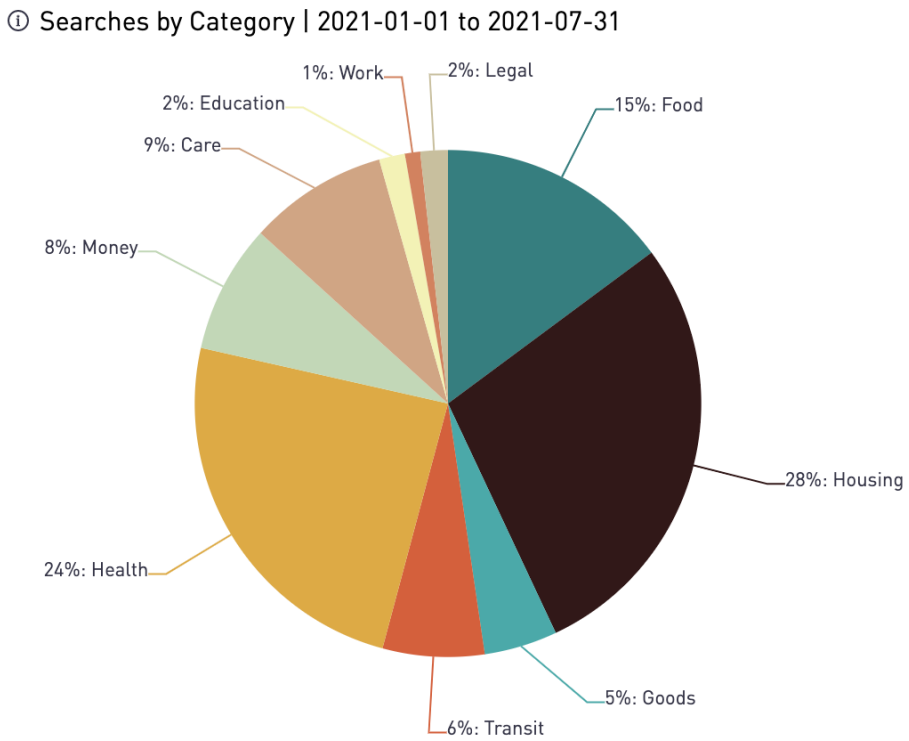
59

Idaho's Community Oriented HIE: *Addressing Health Related Social Needs*



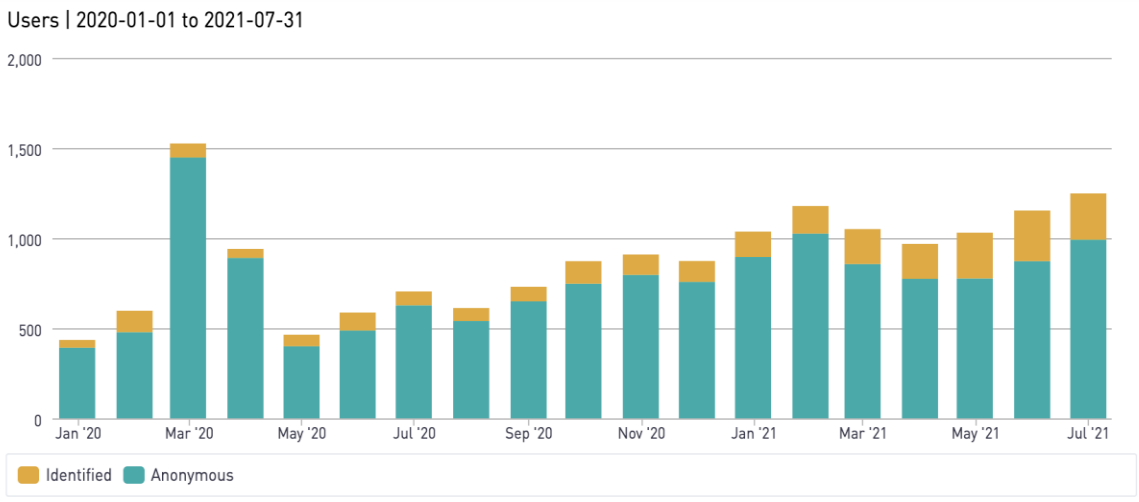
Idaho's Community Oriented HIE

Addressing Health Related Social Needs



Over 34K searches on Aunt Bertha for community-based services in 2021 throughout all of Idaho, with the most significant need being **Housing**

IHDE has embraced the role of providing statewide access to a social needs platform that is linked with patient's clinical record, and steadily being integrated with the HIEs exchange, aggregation, and analytic services



1,521

Distinct Identified Users

13,369

Distinct Anonymous Users

RHODE ISLAND

Differentiated Approach

Community Care is Local

- Enabling the platform through the HIE allows staff from independent practices, community hospitals, and home health workers to have access to the platform which helps support patients in need in any setting.
- Local data enhancements ensure even rural areas have their most-used resources available.

Data Aggregation

- IHDE is able to share state trends in data, such as zip codes with high searches for housing with few housing support resources to state decision makers. Together, we can drive to better outcomes with the HIE as a public data utility.
- Able to aggregate data from other Aunt Bertha customers in the state to share insight into social care referrals across multiple user bases and regions within the state.

Search activity grew 131% in the state of Idaho since IHDE made Aunt Bertha available through the HIE

Questions & Discussion

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