Leveraging HIE partnerships to support population health analytics: DC's innovative approach

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WELCOME AND MEET OUR SPEAKERS

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The Department of Health Care Finance Administers Washington D.C.'s Medicaid program

&

Oversees the D.C. Health Information Exchange Marketplace

State Health IT Coordinator

DHCF leads digital health policy and strategy as well as implementation of HIE services across D.C.

Regulator

DHCF regulates HIE and manages the registration and designation process for HIEs operating in the District

Strategic leader and convener

DHCF convenes stakeholders through the DC HIE Policy Board and elsewhere to remain responsive to evolving digital health needs

Funder and partner

DHCF leverages local & federal funds to support HIE infrastructure and partners with other health and human services cluster agencies to collaboratively sustain HIE

Data Steward

DHCF serves as the steward for DHCF claims data that can be accessed via DC HIE tools

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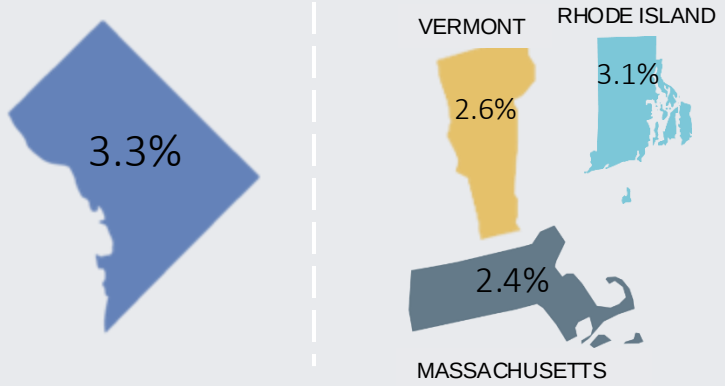
The District of Columbia has made a significant investment in health coverage

Near Universal Coverage

DC has the fourth lowest uninsured rate

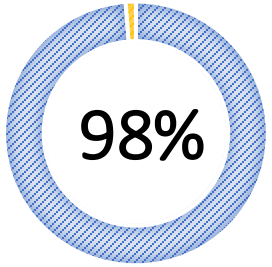


DC Medicaid covers approximately 280,000 individuals

4 out of 10 District residents

7 out of 10 children

DC Health Care Alliance provides insurance to **15,000 residents** who are not eligible for Medicaid



Of all eligible DC children are enrolled in Medicaid

DC Medicaid has a **$3 billion annual budget**, most of which is spent on payments to providers (e.g. doctors, hospitals, etc.)

96% Annual budget spent on provider payments

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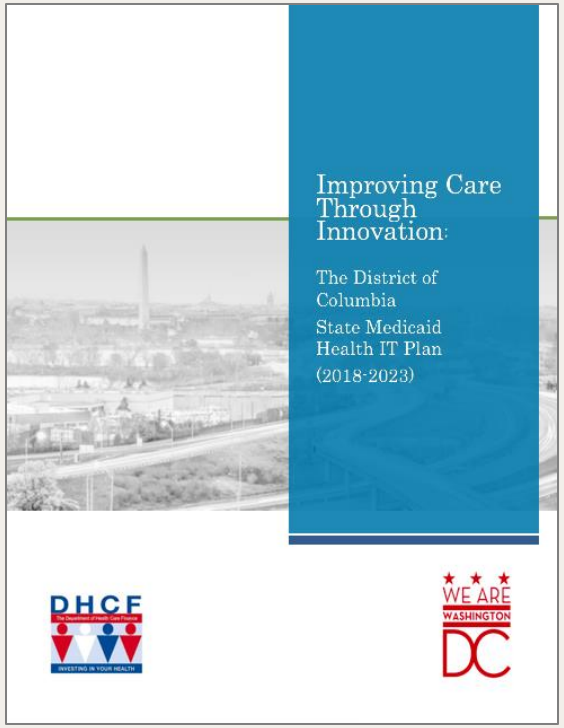
Digital Health can help overcome fragmented care and facilitate a patient-centered, data-driven approach to care delivery

- Tools (e.g., HIE at point of care, population health analytics, telehealth, RPM) enable navigation across providers and care settings
- Stakeholders and data are connected and support clinical efforts to improve health outcomes
- Technology itself is never the end goal!

Community input drives DC's Digital Health program and priority areas

- DC's stakeholder-informed digital health strategic plan and update has prioritized the development of basic and advanced analytic population health management capabilities in the DC HIE
- Strategy, development, user experience, and clinically tailored TA to support the use of DC HIE tools in workflows is all enabled through partnership
- Population health analytics initiative is just one example of how DC's Digital Health program **is a *partnership in practice*** across the HIE, providers, and community associations!



2022 SMHP Update released March 2022: https://dhcf.dc.gov/hitroadmap

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Critical Partnerships For Innovative Engagement

- HRSA-funded PCA representing **15 Health Center members that deliver integrated medical, dental, behavioral health, and enabling services** to nearly 180K District residents

- Implements and **manages the Health Centers' HIT/HIE and data analytics infrastructure** to support population health management and the sharing of health information

- Deliver **'high-touch' technical assistance** services to a variety of healthcare organizations to facilitate their **adoption of digital health technologies including connecting to the HIE**

- Leveraged our collaborative relationships with DHCF and CRISP DC to establish our network of FQHCs and CHCs into a **strategic launchpad for implementing new HIE tools and capabilities**

Policy and Advocacy

Health Center Support

HIT/HIE Management and Support

Thanks to building these Federal, District, Health Care, and Social Care partnerships:

- ✓ DCPCA was the first network of primary care providers in DC to connect to the HIE
- ✓ Plays a key role in HIE stakeholder engagement, developing critical feedback loops with HIE users to foster discussions, workgroups, and iterative improvement projects

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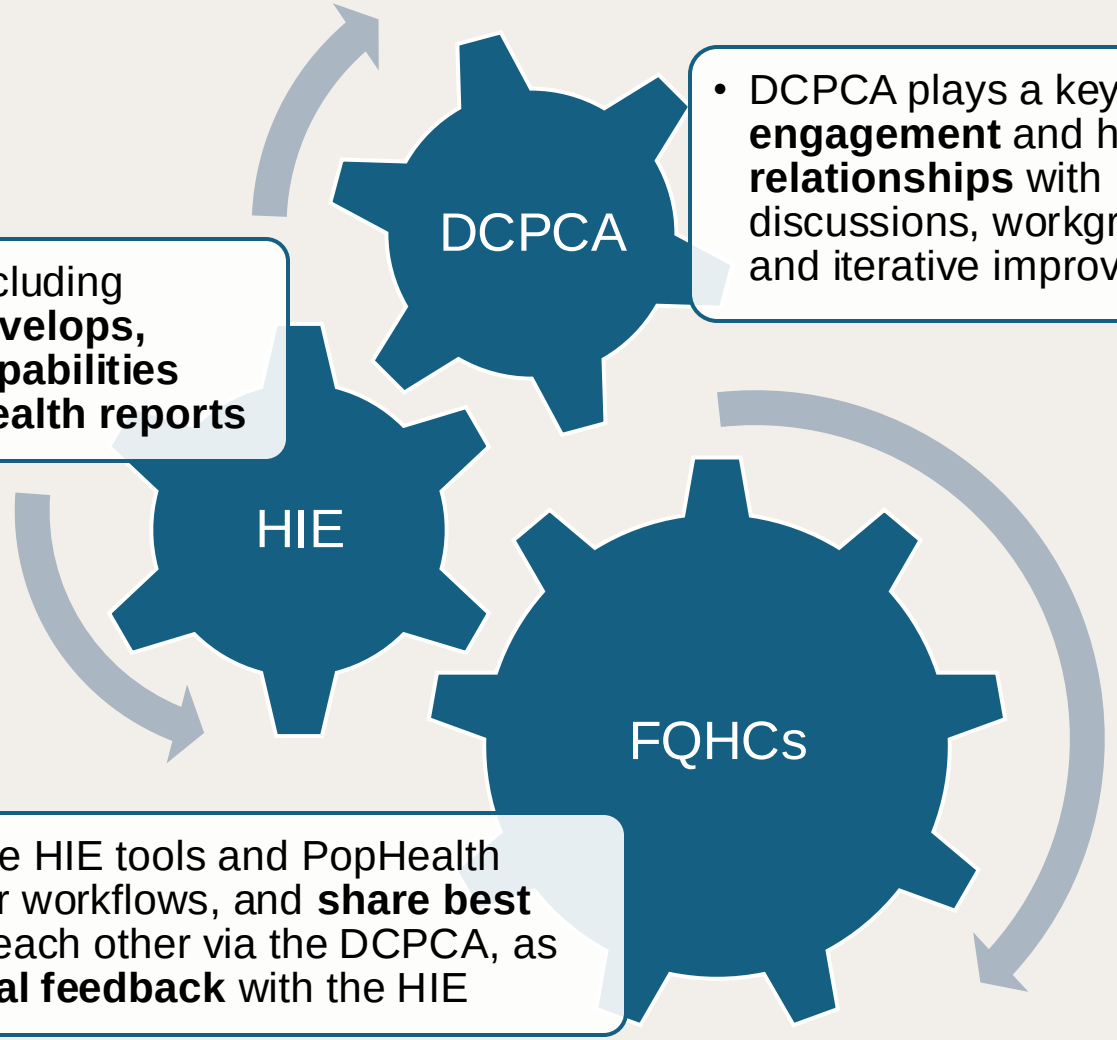
Partnerships in Practice: Establishing and Maintaining Trust



- DCPCA plays a key role in **stakeholder engagement** and has developed **trusted relationships** with HIE users to foster discussions, workgroups, technical assistance, and iterative improvement projects.

- In conversation with partners, including DCPCA and FQHCs, the **HIE develops, refines, and optimizes core capabilities** within the HIE, **including PopHealth reports**

- FQHCs integrate HIE tools and PopHealth reports into their workflows, and **share best practices** with each other via the DCPCA, as well as **technical feedback** with the HIE

An Evolving History of Engaging FQHCs + the HIE

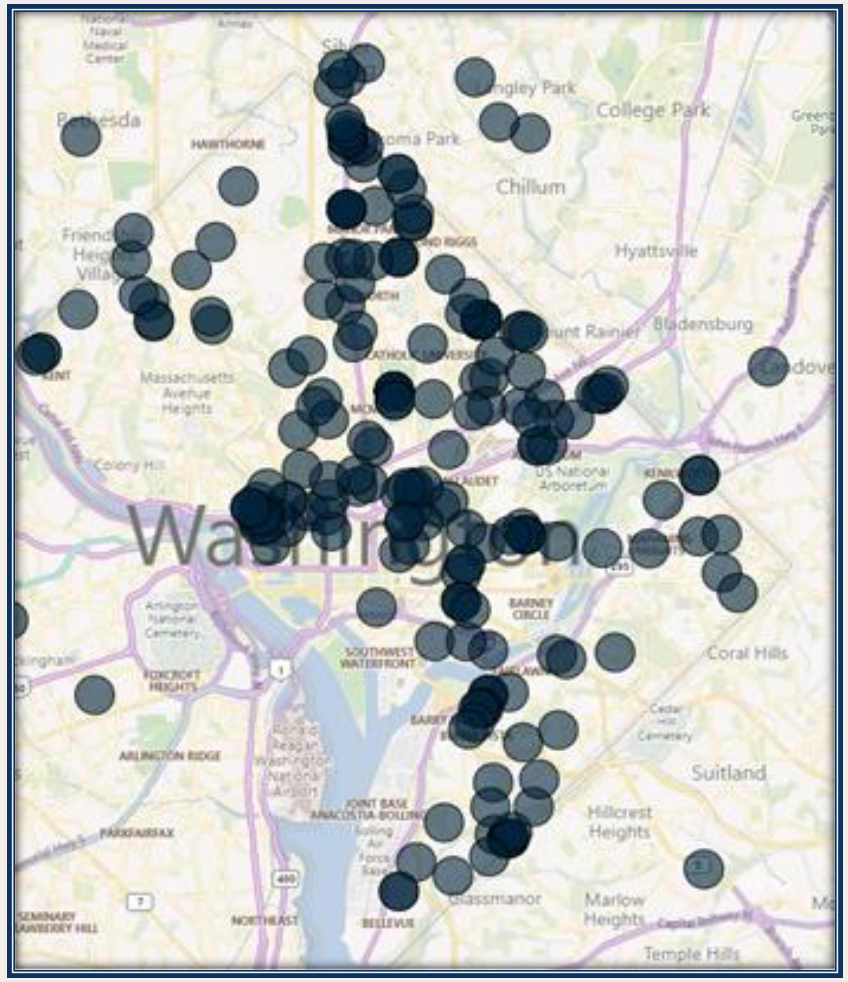
- Established a partnership with CRISP DC to enhance the connectivity of its FQHC and CHC network to the HIE by first implementing ‘single sign on’ and then ‘in context app’ access from within the EHR
- Advocated for the integration of Medicaid claims-based population health reporting tools within the HIE- the genesis of the PopHealth Analytics tool
- Piloted use of CRISP DC’s PopHealth platform within its FQHC network and collaborated with DHCF and CRISP on the enhancement and expansion of PopHealth tools and reporting capabilities
- Encouraged the use and expansion of PopHealth functions that support multiple patient panel views to enable providers to segment their patient populations based on a variety of selection criteria
- Continue advocating for new HIE capabilities based on FQHC and CHC provider needs to facilitate care management, coordinate QI activities, and enable self-monitoring of P4P engagements

CRISP DC is Washington DC's Designated HIE

14,000+
DC Healthcare Professionals
Utilizing the HIE

1,400,000+
Patients Served Through the HIE

980+
Organizations Accessing
and Contributing Data



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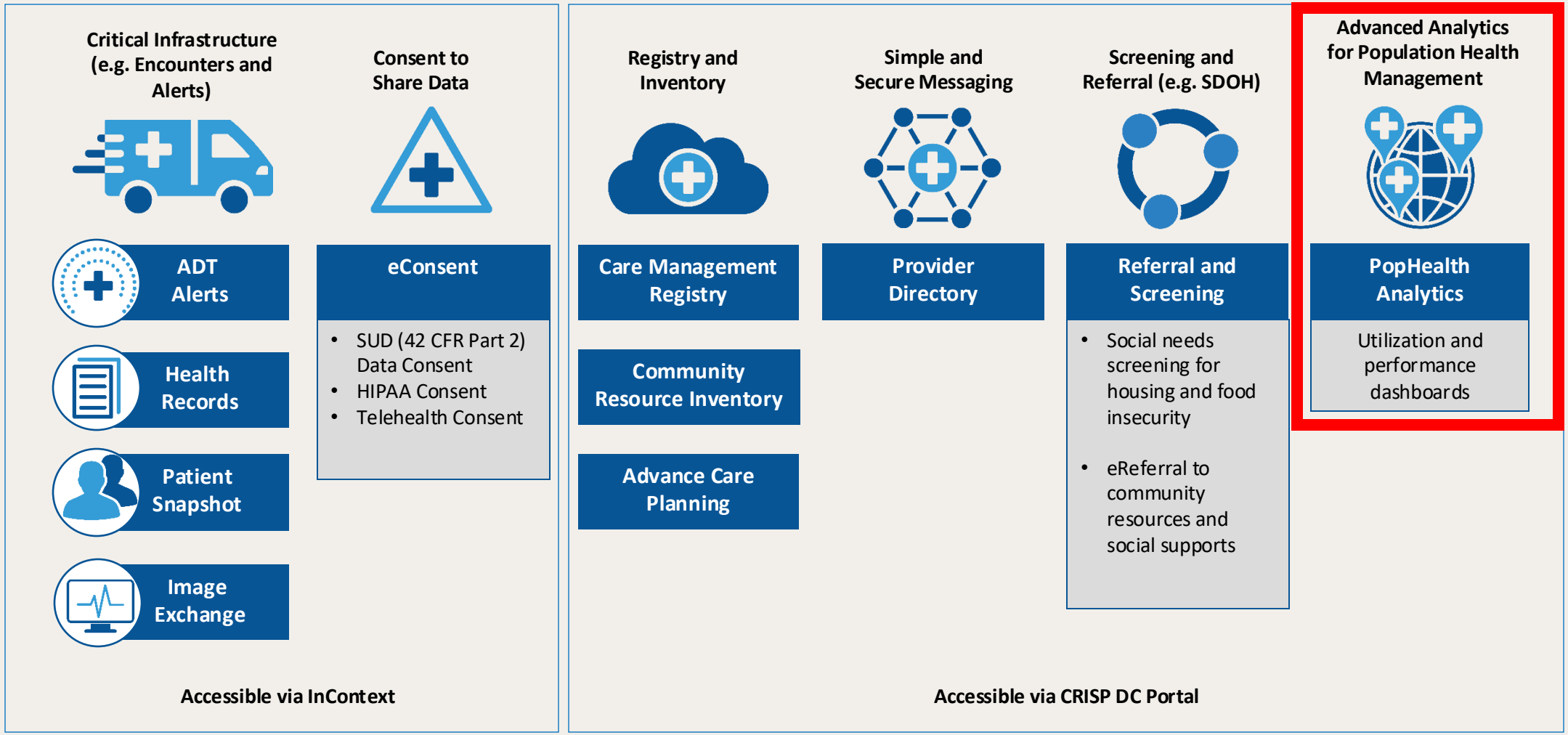
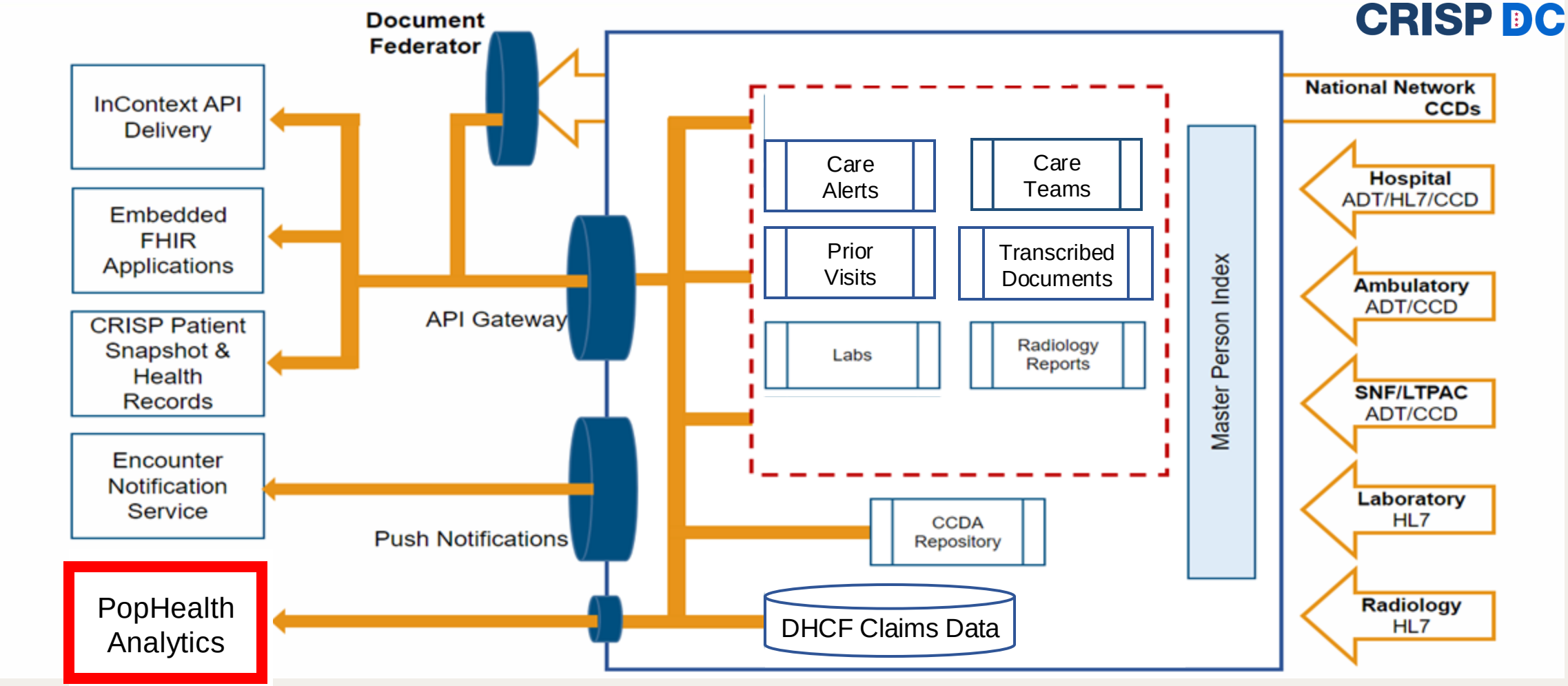
Six Core Capabilities Make Up the DC HIE Infrastructure and Enable Access Through User-facing Tools



Data from disparate sources flows into the HIE and is viewable through a set of user-facing tools or capabilities



CRISP DC PopHealth Analytics

- HIE infrastructure can support population-level and panel-level management across providers, managed care organizations, government entities, and other health system stakeholders

- PopHealth Analytics leverages data from disparate sources to populate a suite of reports and tools, which can enhance a provider's system-wide understanding of their patient population

- These HIE-based dashboards are supported by clinical, claims, and social needs data, which are used to support targeted interventions and care coordination

Users are able to:

- ✓ Analyze aggregate demographic data.
- ✓ Stratify, compare and drill down data points for populations by chronic disease, SDOH, high risk, timeframes and other classifications.
- ✓ Monitor progress on nationally recognized quality measures.
- ✓ Visualize data to help strengthen communication across clinical and non-clinical settings
- ✓ Plan and develop care coordination initiatives for specific chronic conditions, beneficiaries of interest, and more!

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Analytics Enabled Through Partnerships

- PopHealth Analytics is designed with a diverse group of DC HIE users in mind to support their analyses and interventions

- Community partnerships have supported:
  - Development of tool functionality
  - Creation of analytical features
  - Customization of reports and dashboards
  - Gathering feedback to remain responsive to user needs
  - Providing clinically tailored technical assistance

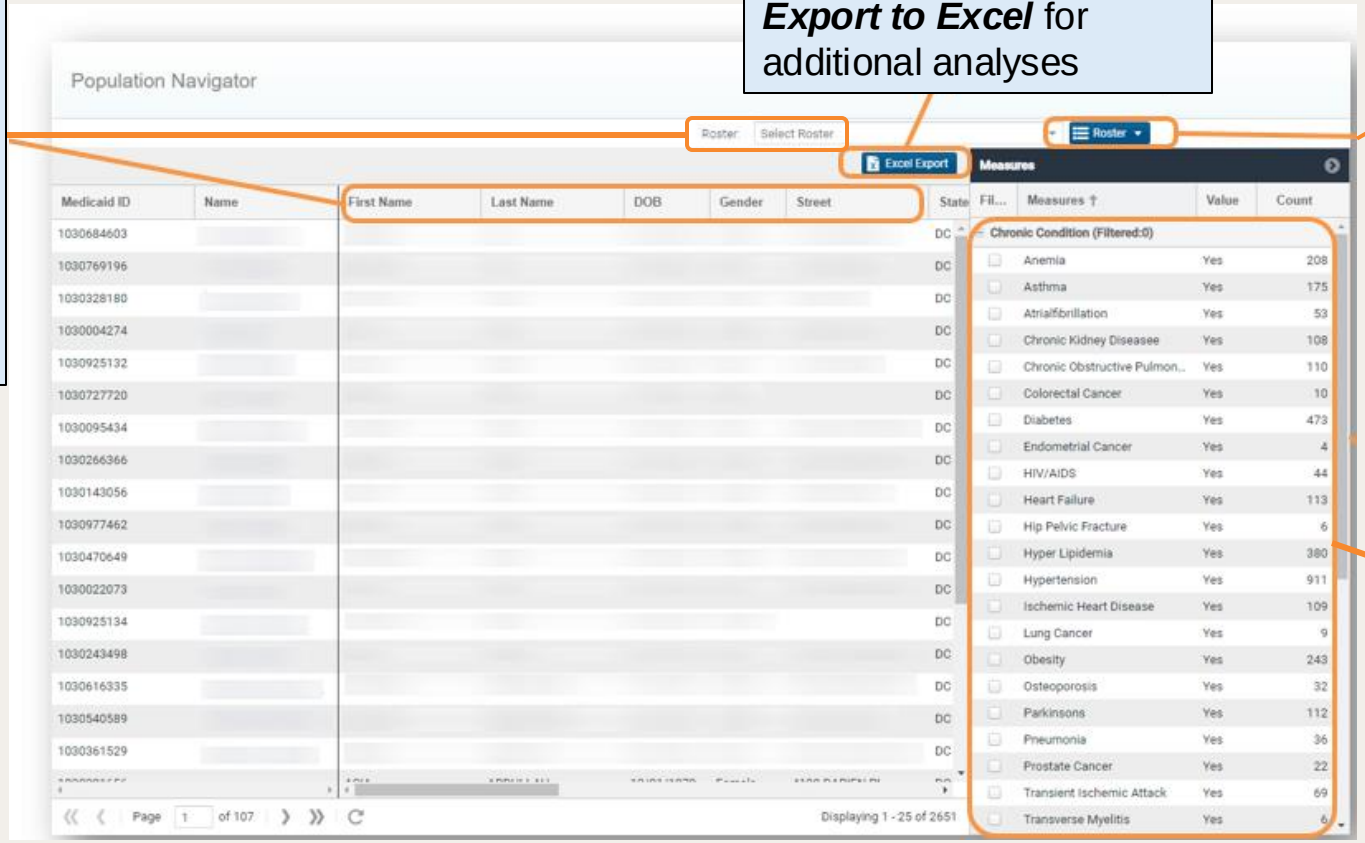
- Two examples of **partnership in practice**:
  - Population Navigator
  - SDOH report development and utilization

Enabling deeper patient population insights and analysis with Population Navigator

Panel and sub-panel views allow users to view their attributed patients and create subsets (roster) that can be used to filter PopHealth Reports

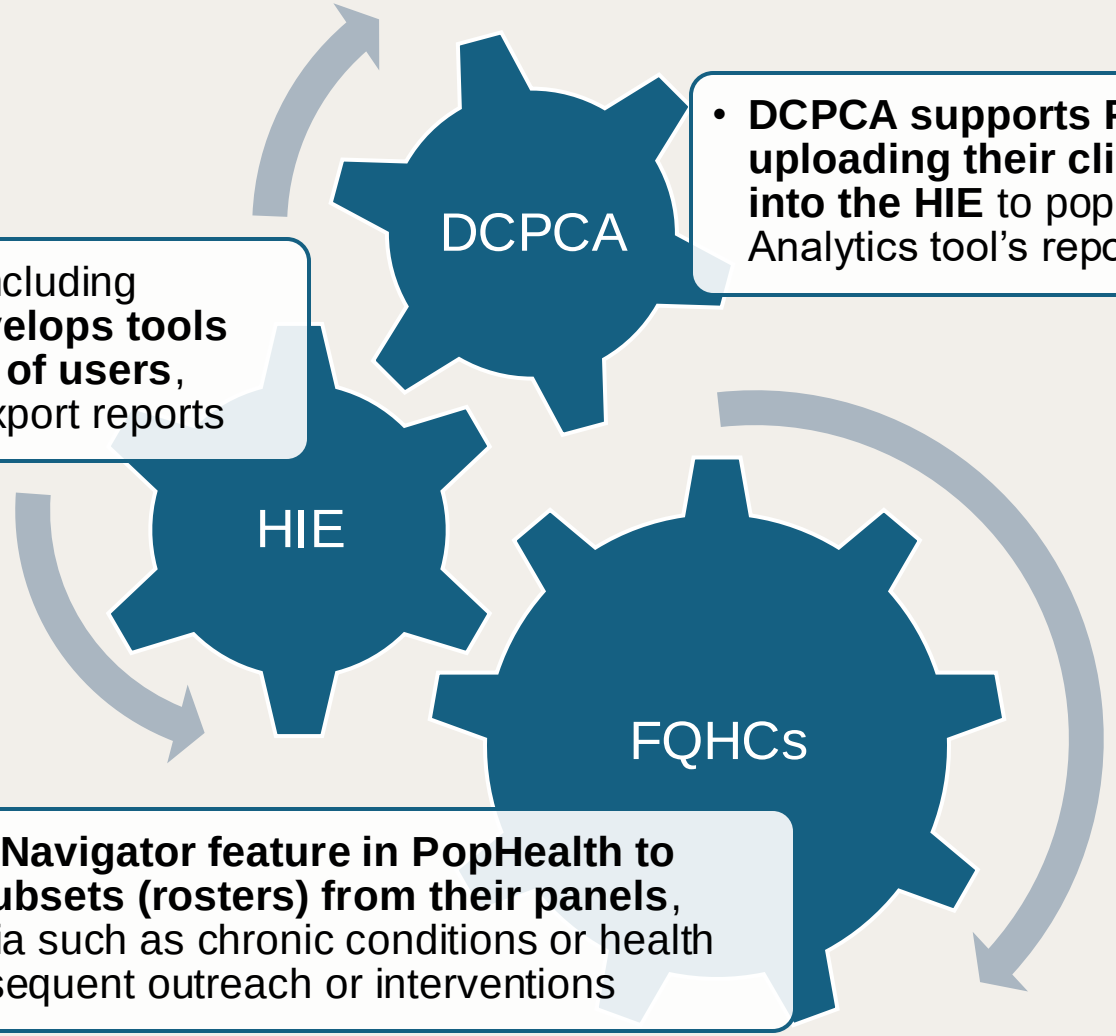
Export to Excel for additional analyses

Combine and export existing rosters to find patients common to, or excluded from, multiple rosters, and export those results for **custom intervention**



Filters to stratify and analyze population – Demographics, Medicaid enrollment, chronic conditions, Prevention Quality Indicators (PQIs), social needs, and more

Partnerships in Practice: Population Navigator Functionality



- **DCPCA supports FQHCs with uploading their clinical patient panels into the HIE** to populate the PopHealth Analytics tool's reports and dashboards

- **With feedback from partners**, including DCPCA and FQHCs, the **HIE develops tools and features to meet the needs of users**, including the ability to filter and export reports

- **FQHCs use the Population Navigator feature in PopHealth to build custom beneficiary subsets (rosters) from their panels**, based on customizable criteria such as chronic conditions or health related social needs, for subsequent outreach or interventions

Supporting HIE users' ability to identify and understand their patients' social needs

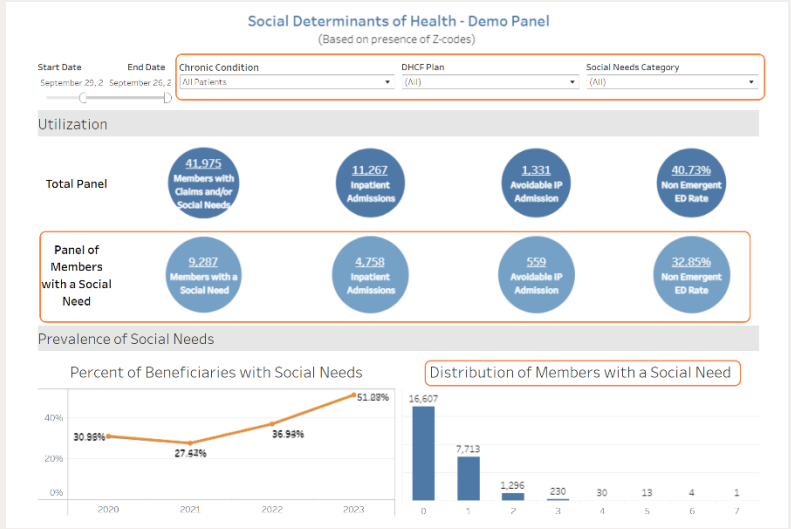
- ***Enables whole-person care approach –*** Displays prevalence and distribution of social needs, allowing stakeholders to developing targeted interventions, policies, and programs to address needs and improve health outcomes

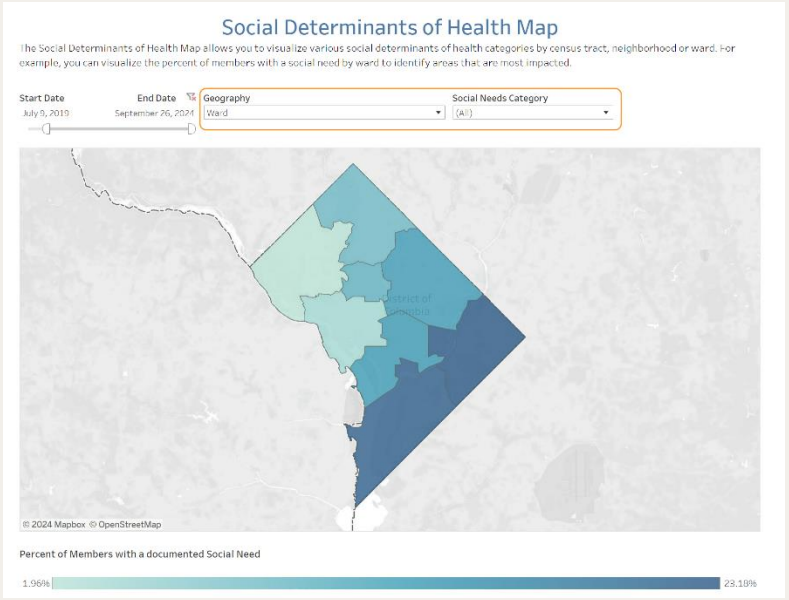
- ***Leverages Z-Codes Parsed from claims, ADTs, and CCDs –*** Provides views of homelessness or housing instability, lack of adequate food, and financial insecurity

- ***Aligned w/ latest SDoH data standards***– HRSNs are categorized according to Gravity Project definitions

- ***District-wide map view*** – Visualize SDoH by census tract, neighborhood, or Ward

- ***Use w/ Population Navigator –*** roster functionality allows view of SDoH for a custom subset of patient panel and supports drill-throughs patient details





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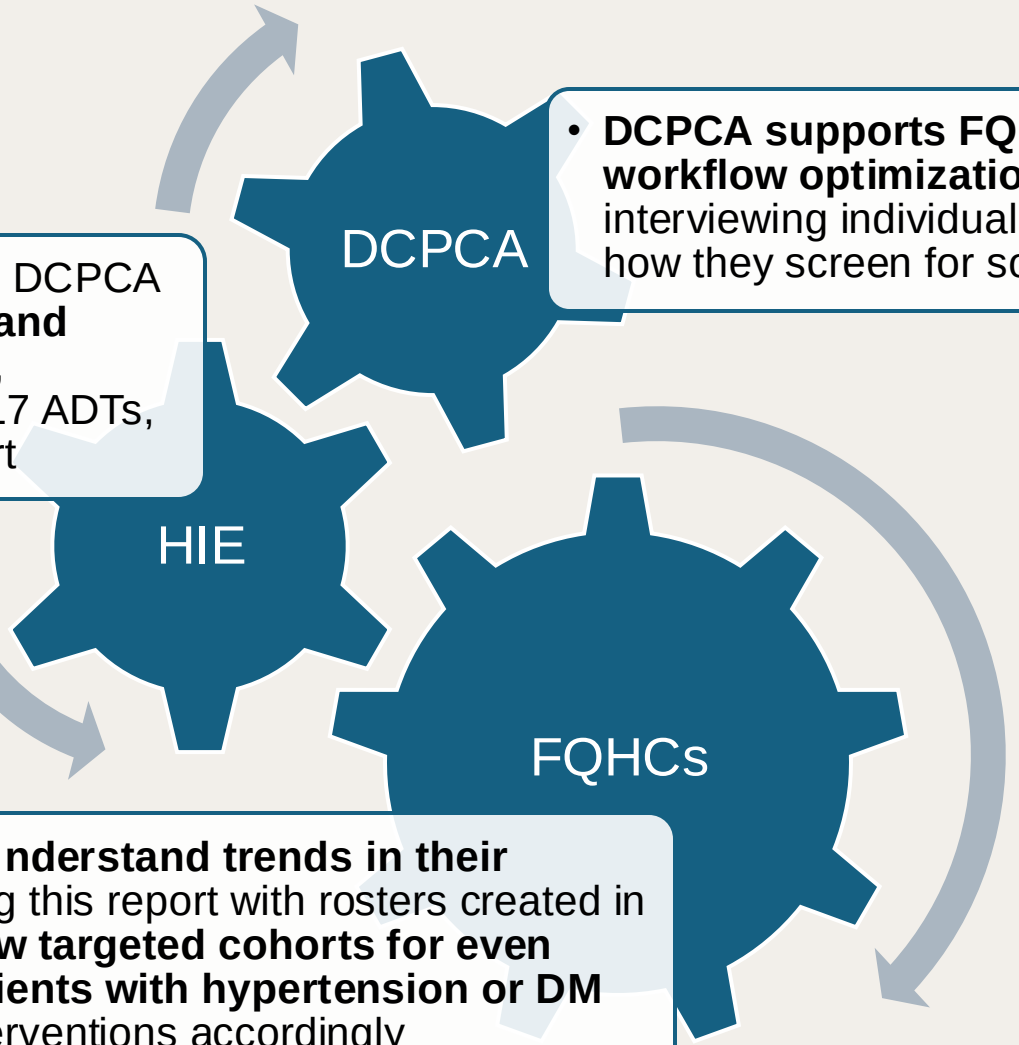
Partnerships in Practice: SDoH Report Development



- **DCPCA supports FQHCs with EMR and workflow optimization**, including interviewing individual clinics to understand how they screen for social needs

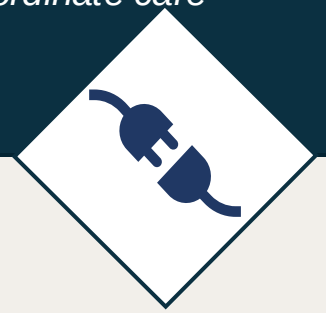
- With feedback from partners, including DCPCA and FQHCs, **the HIE develops tools and features to meet the needs of users**, including ingesting z-codes, parsed HL7 ADTs, and CCDs to generate the SDoH report

- **FQHCs use the SDoH report to understand trends in their patient populations**. By combining this report with rosters created in Population Navigator, they can **view targeted cohorts for even deeper insights**, for example, **patients with hypertension or DM and food insecurity**, and plan interventions accordingly

Evolution of PopHealth Analytics Features

PopHealth Beginnings

- *Primarily claims-based data*
- *Basic demographic, utilization, and cost metrics*
- *Ability to define and/or compare populations by groupings*
- *Focused on FQHC-based users to monitor P4P and coordinate care*



Technical Assistance and User Feedback

- *Expanding access and growing awareness*
- *Tailored approach to coaching and engagement*
- *Building features, enhancements, and reports based on user feedback*

Advanced Analytics

- *Combining administrative and clinical data*
- *CMS Core Set and other standardized quality measures*
- *Visualization tools to strengthen communication across clinical and non-clinical settings*

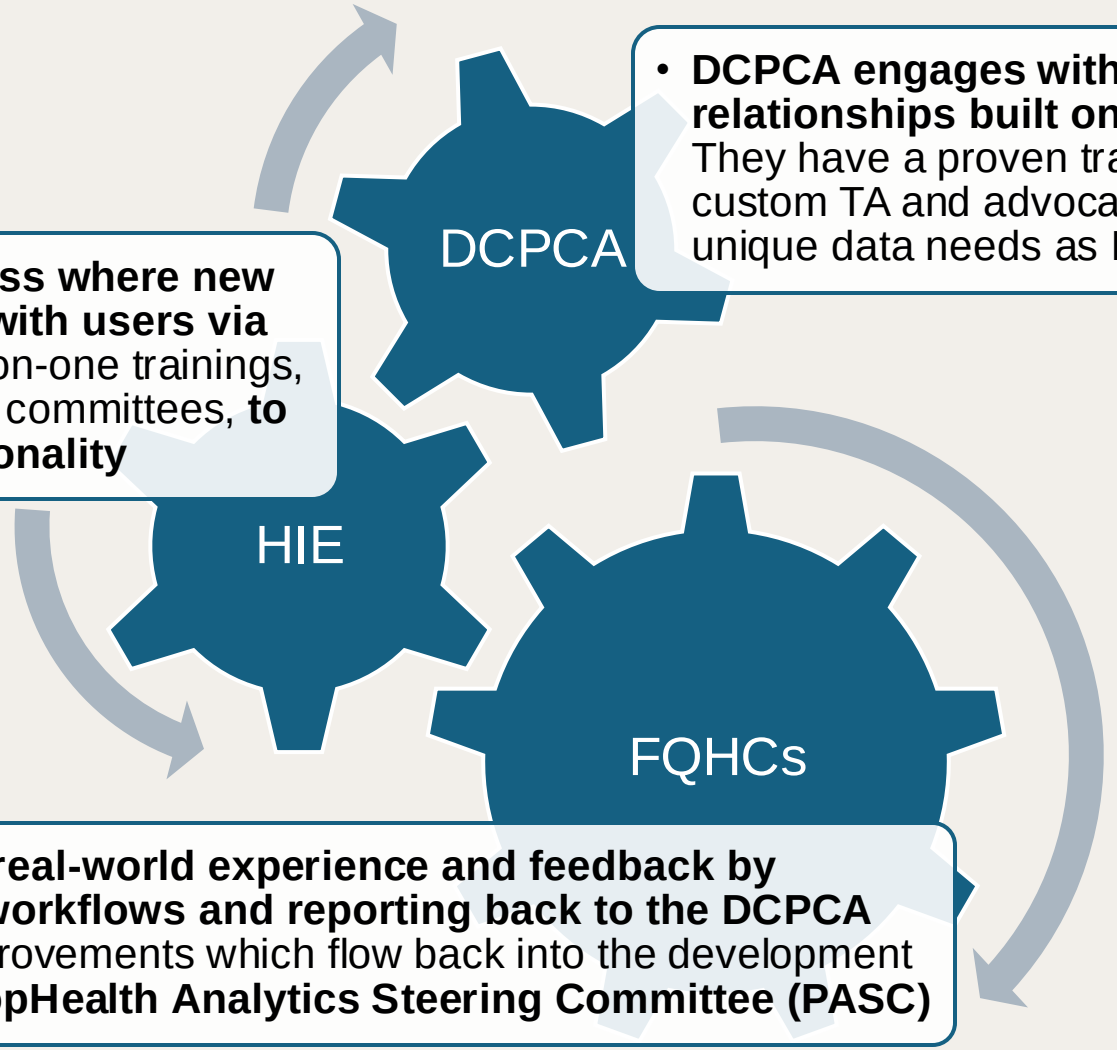
Future State Innovations

- *Risk stratification*
- *Predictive modeling to support medication adherence*
- *Alignment with VBP arrangements*
- *Actionable data for Quality Improvement interventions*
- *AND more…*

Partnerships in Practice: Driving Community-led Innovation

- **DCPCA engages with users and cultivates relationships built on mutual support and trust**. They have a proven track record of delivering custom TA and advocating for FQHCs and their unique data needs as HIE users

- The HIE follows an **iterative process where new and existing reports are shared with users via multiple channels**, including one-on-one trainings, DCPCA forums, and targeted SME committees, **to develop and enhance tool functionality**



- **FQHC users provide invaluable real-world experience and feedback by utilizing HIE tools in their daily workflows and reporting back to the DCPCA and HIE** with suggestions and improvements which flow back into the development cycle through the newly formed **PopHealth Analytics Steering Committee (PASC)**

Innovating Public-Private Partnerships to Sustain DC HIE Infrastructure and Tools

- As HITECH funds sunsetted in September 2021, DC was one of the first jurisdictions to successfully transition to Medicaid Enterprise Systems (MES) funding for the continuation of their health information technology/exchange projects.
- Today the DC HIE is a stable, sustainable network, with committed partners and tools that are widely adopted across the care continuum.
- By prioritizing data sharing across the health system and building stakeholder-driven HIE infrastructure over time, DC has created a culture of shared responsibility for ensuring the availability and quality of actionable information.
- The PASC regularly convenes stakeholders in a dedicated forum to review up and coming PopHealth reports and features.
- Shared commitment to supporting and sustaining these common technical solutions enables person-centered care delivery for DC's Medicaid population.

DHCF
Department of Health Care Finance

CRISP DC

DCPCA
DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

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