

Data Analytics Subgroup Charter: Phase Two Detail

Purpose of the Data Analytics Subgroup:

In two phases, develop recommendations, and identify top-priority data analytic elements, to motivate and guide greater consistency in data sharing among organizations involved in Accountable Care Organization (ACO) and Accountable Communities for Health (ACH) models to support shared accountability for cost and health outcomes.

What the effort to promote consistency in approaches to Data Analytics is not:

- Not about providing real-time data about an individual patient to support the direct clinical care of that individual patient, although the work may impact care at that level.
- Not about establishing data analytics or quality measures for public reporting, but insights may be useful to State or private sector reporting activities.

The two phases of the Data Analytics Subgroup work:

- **Phase One:** Subgroup will address what can be done now, given current data availability, infrastructure, and analysis skills and staffing. The current context for providers and their patients in an ACO arrangement will be the driving consideration.
- **Phase Two:** Subgroup will focus on identifying high priority data analytic elements associated with top priority social determinants of health, and developing guiding principles for the identification, possible related data collection, and consistent sharing of these data analytic elements within shared accountability and/or Total Cost of Care (TCOC) arrangements.

PHASE TWO DETAIL:

Charge to the Data Analytics Subgroup:

- Identify data analytic elements that would be essential for effectively sharing accountability for improving individual and population health status, but are not feasible in the current environment. Phase Two is to include consideration of data analytic elements that may be required to pave a path to the future in health care arrangements (e.g., involving fully operational Accountable Communities for Health [ACHs] and a broader set of partners and services within ACO models more generally). These data analytic elements likely include but are not limited to demographic elements such as race, ethnicity, language, disability and LGBT status, in addition to data addressing social determinants of health such as housing, employment and education.

Process for the Data Analytics Work in Phase Two:

- Phase Two will address a limited number of priority areas, which will vary from Phase One areas.
- Phase Two will build on the data analytic categories associated with social determinants of health that were identified in Phase One, such as: culturally specific and culture-specific data, housing, ethnicity, income, employment, language, family support, and identification of the areas of highest need in these key social determinants of health
- To the extent possible, Phase Two leverage and/or build upon current or prior community engagement efforts by partners/participating organizations to help determine which specific data analytic elements are most important for Minnesota. This may include key informant interviews or surveys to gather guiding

information directly from community members, and could also provide an opportunity to build support in the community for the collection and sharing of these types of data.

- Phase Two activities will be informed by evidence based research conducted by the Department of Human Services, the Minnesota Department of Health and other organizations in Minnesota and across the nation that have made efforts to catalogue and understand social determinants of health. Activities will start from the foundation of recent literature reviews or meta-analyses of the evidence base for the impact of social determinants and other sociodemographic factors on health outcomes.
- Utilizing knowledge gathered through the above mentioned activities, a set of high priority data analytic elements will be identified.

Composition and Timeline for Phase Two Data Analytics Subgroup Meetings:

- In Phase Two, the Subgroup will be intentionally diverse and include representatives from providers (particularly those involved in ACH arrangements), community service providers, health plans and other payers, plus representatives from groups representing minorities (e.g., ethnic, racial, disability, LBGT) as well as a mix of individuals from urban and rural settings. Membership will be drawn from the Phase One Subgroup to ensure continuity with previous Data Analytic work, and augmented with new members who have expertise in social determinants of health. Support for the Subgroup, in the form of meeting organization and facilitation, will come from State SIM staff at both DHS and MDH, with the contracted support of CHCS.
- Phase Two work will begin in early 2016, following discussion at the September and November meetings of the Community Advisory and Multi-Payer Alignment Task Forces. Phase Two work will be completed by the end of Summer 2016, to allow for both Task Forces to engage in any needed discussion, prior to the end of SIM grant funding, regarding potential implementation issues or considerations.

Important Considerations for the Phase 2 Work:

- Learning from current activities and research related to the impact of social determinants on population health improvement, and integrating this into the Subgroup work to avoid reinventing the wheel
- Identifying structures (if they exist) that support improvement in health care and community services quality and cost, and in the process involve the collection of data which may be helpful to assessing social determinants of health
- Finding examples of innovative Community Health Needs Assessments that are collecting or using data that address one or more social determinants of health
- Expanding the definition of “provider” to include social service workers, housing specialists, etc. to capture the services of those who have a significant impact on individual and population health
- Identify data and other assets that draw from Minnesota’s existing health, social service and public health resources
- Ensuring that the Data Analytics work respects the impact on people (consumer, patient, client), e.g. do not set up a process that asks a person the same questions many times in the quest for data