CALIFORNIA HEALTH CARE
SAFETY NET INSTITUTE

DATA FOR POPULATION HEALTH

Thursday, February 7, 2019
Oakland, CA

WELCOME

10:30-10:45

Data for Population Health

Giovanna Giuliani, Executive Director

Safety Net Institute

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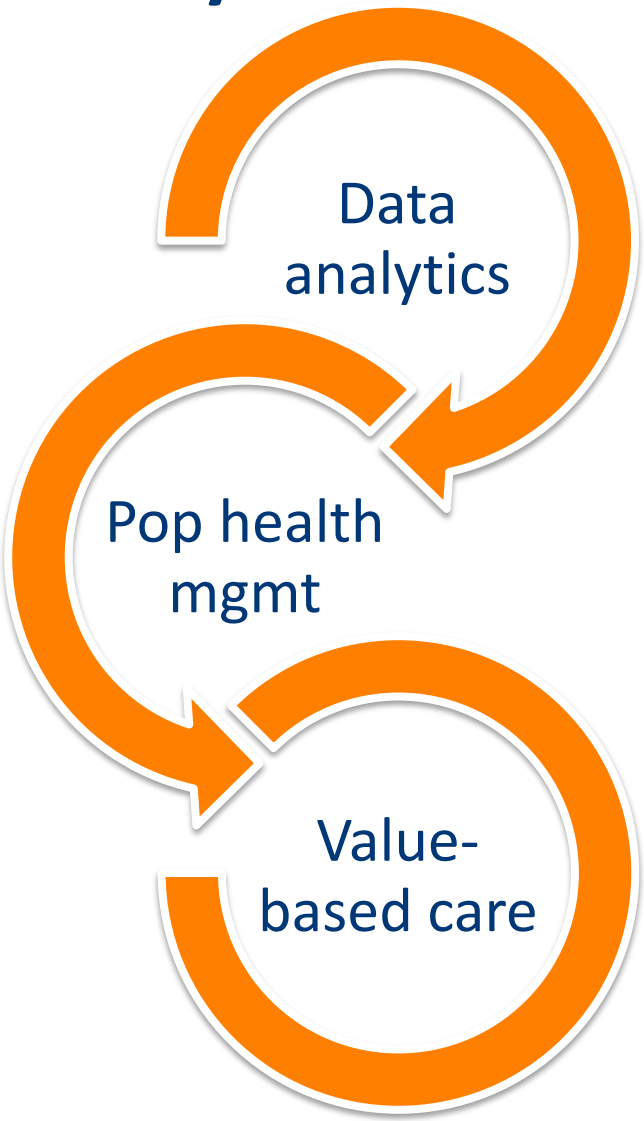
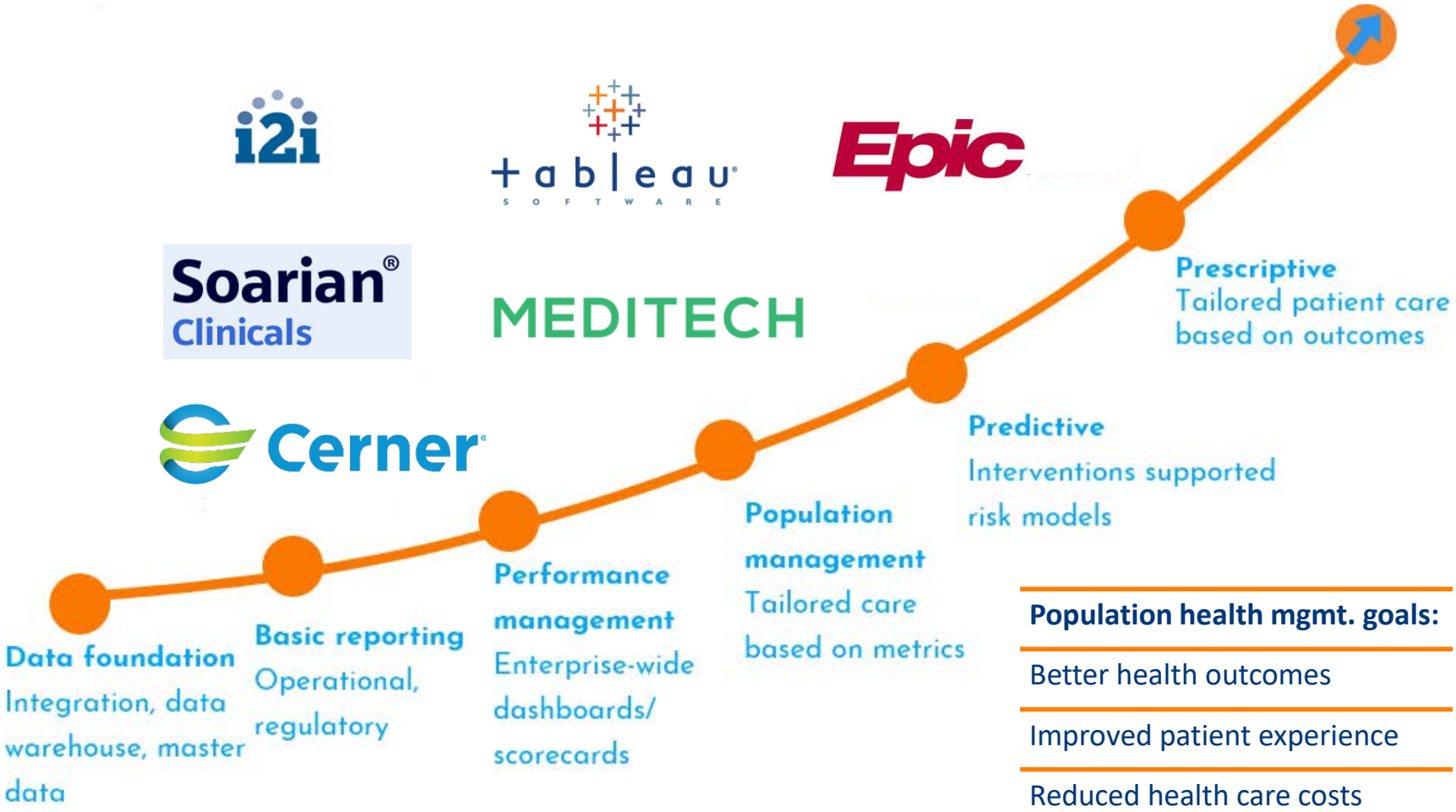
Why are we here today?



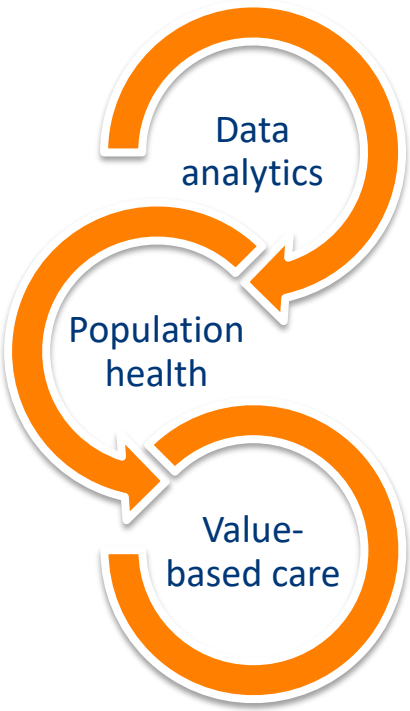
Data analytics journey

Many tools, same population health management goals



Population health mgmt. goals:
Better health outcomes
Improved patient experience
Reduced health care costs

Value-based care payments



CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	**A** APMs with Shared Savings (e.g., shared savings with upside risk only)	**A** Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**B** APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**B** Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		**C** Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	**4N** Capitated Payments NOT Linked to Quality

SNI Support

Value Based Care
- Support for PRIME APM requirements
- Strengthen capabilities to accept delegated risk and adopt value-based payments

2015	2016	2017	2018	2019	2020	2021

Data Driven Organizations
- Data governance & strategy

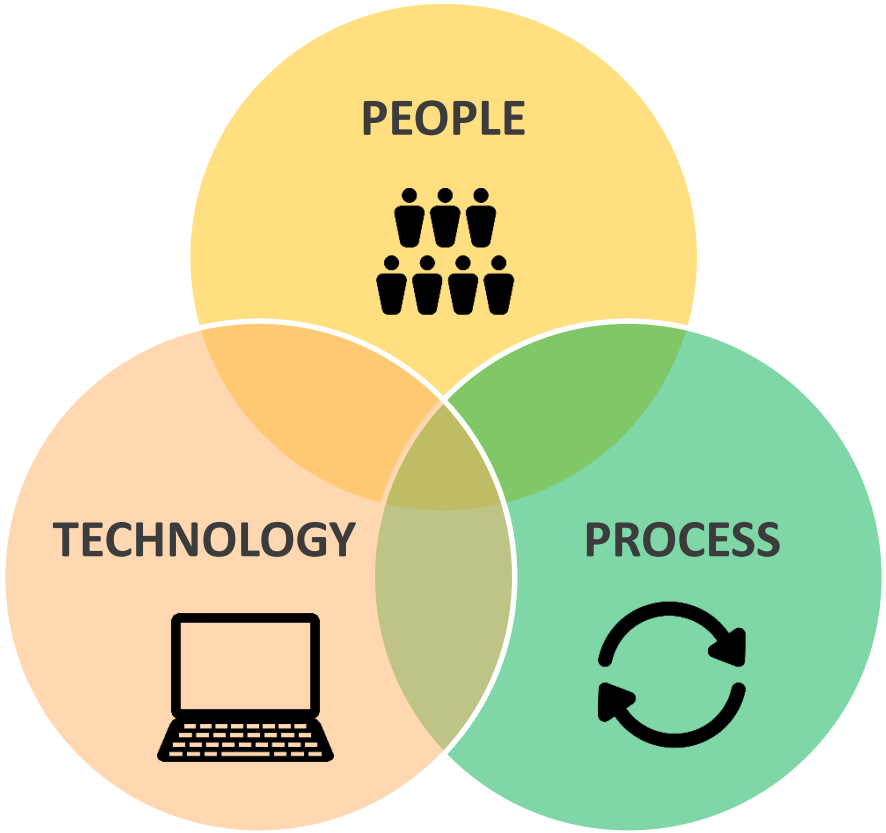
Data for Improvement
- Support for PRIME
- 4 modules: Performance Measurement, Data Quality, Visualization & Acting on Results

Data for Population Health
- Support for QIP
- Health plan data improvement
- Meet greater sophistication of data needs: analytics, EHR affinities
- Reinforce key capacities: data gov

How are you hiring and training the right staff to analyze and act on the data?

What technologies do you have at your system?

How do you use those systems to meet your population health goals?



What processes do you have that ensure most efficient and effective use of technology?

Today's agenda

8:30	**Coffee and Networking**
9:00	**Lessons Learned: EHR Implementation**
10:30	**Welcome**
10:45	**Data Governance 2.0**
11:15	**The People Perspective: Staffing and Training for Population Health**
12:15	**Lunch**
12:45	**Population Health Technology in Action - Breakout**
1:45	**Case Study Breakout Session #1**
2:30	**Case Study Breakout Session #2**
3:15	**Team Time, Snacks & Closing**
3:30	**Adjourn**

Logistics

- Materials
  - Case study handouts available in rooms
  - https://safetynetinstitute.org/data
- Restrooms
- Wifi
- Parking
- Expense reports

DATA GOVERNANCE: SF'S JOURNEY

10:45-11:15

Data for Population Health

Leslie Safier, Director, Performance Improvement
Zuckerberg San Francisco General Hospital

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Overview

- Defining Data Governance
- Creating a Data Governance Structure
- Committee Accomplishments and Lessons Learned
- Future Direction
- Questions

Defining Data Governance

What is our 2018 readmission rate?

19.2%

14.9%

17%

I thought it was a simple question…

Psychiatric patients?

Hospice patients?

What ages?

It depends how you define readmissions.

What is Data Governance?

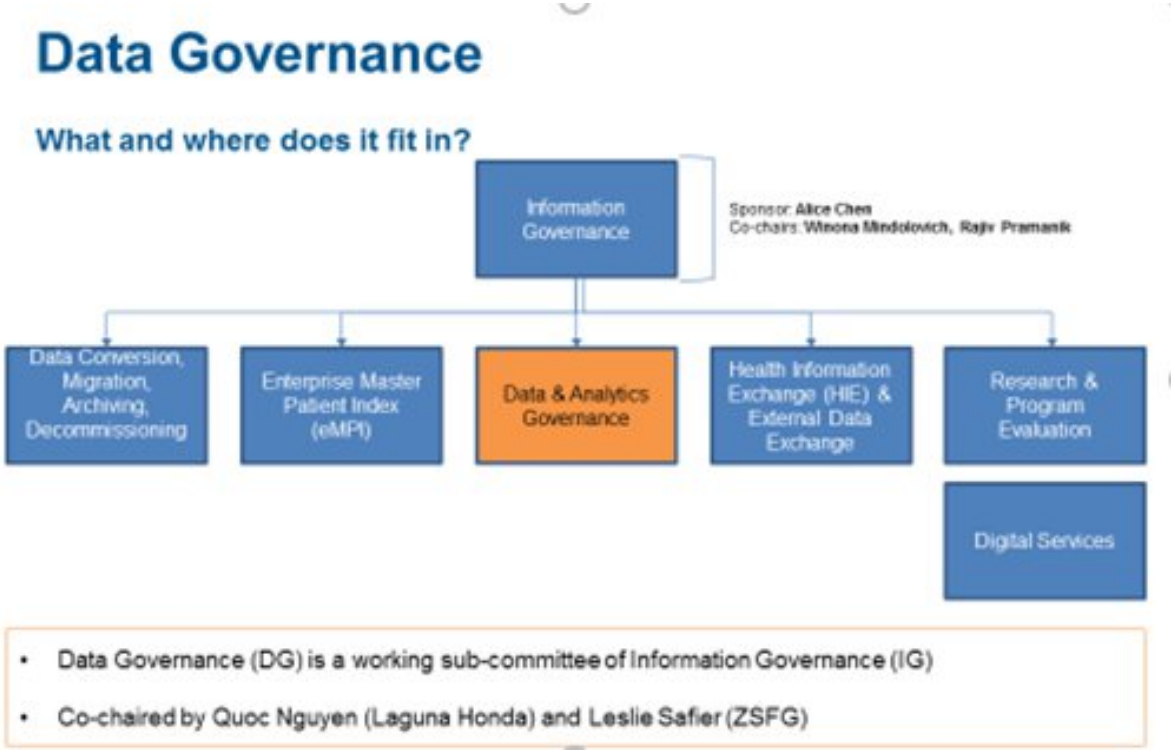
An organization-wide framework for managing health information throughout its lifecycle—from the moment a patient's information is first entered in the system until well after they are discharged. [American Health Information Management Association]

Image courtesy of Center for Care Innovations

Creating a Governance Structure

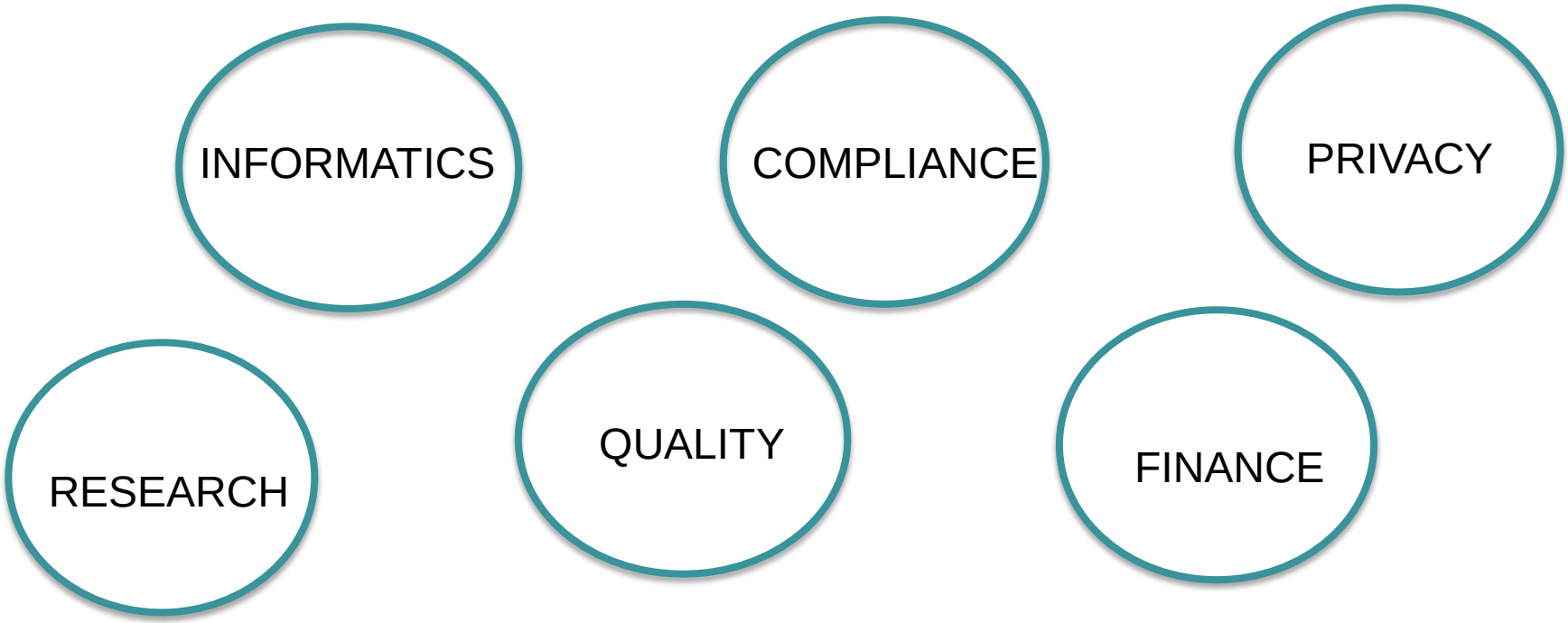
Key Influencers

Committee Structure



Committee Membership

- Members selected and appointed by DG Committee



Purpose of Data Governance

The Committee is created for the purpose of establishing a sustainable organizational data governance structure, developing centralized accepted data dictionaries and prioritizing organizational data and analytic needs. The scope of the committee includes the following functions:

- Establish Data and Analytics Governance Framework for EHR readiness and perpetuity
- Establish a plan for governing the priorities for the creation and of data and analytical reporting that will be part of the implementation of the EHR
- Establish a plan for governing the many requests for data management from various organizations, programs, business owners, and other entities while ensuring appropriate and timely decisions on behalf of DPH.
- Assist with oversight of current reporting needs and other issues as they arise as requested by the IG Steering Committee

Committee Accomplishments and Lessons Learned

Pathways to Data

Can I have a readmission report for all the providers in my clinic?

Let me ask Judy. She usually helps me with these types of requests.

Fill out a data request form for the Quality Data Center.

Call the Business Intelligence Unit.

Submit an IT support ticket.

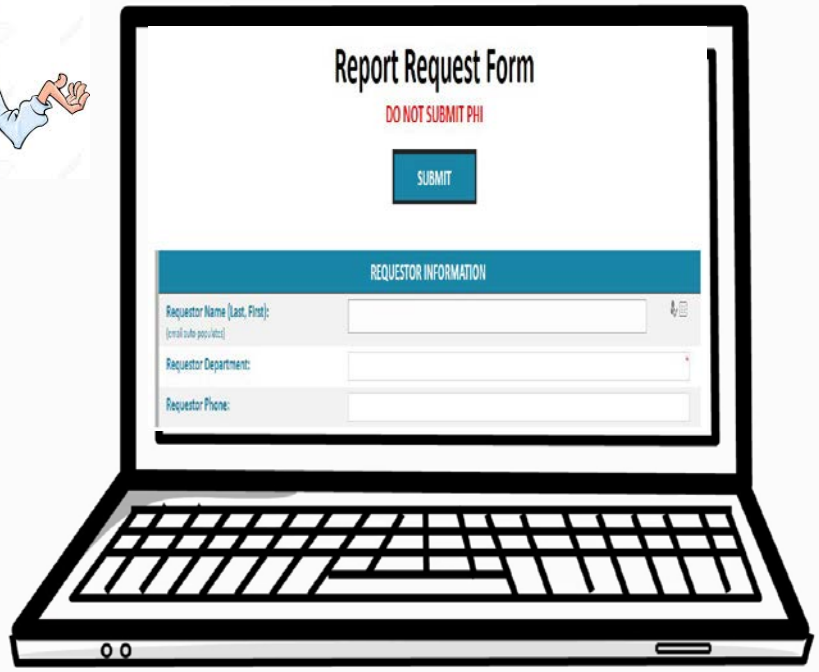
Fill out the report request form.

Can I have a readmission report for all the providers in my clinic?

Fill out the report request form.

Fill out the report request form.

Fill out the report request form.



Prioritization Criteria

Population Size

Impact on the health outcomes of the target populations. How many will be effected by this intervention:

- ○ 1-10,000 lives
- ○ 10,001 to 50,000 lives
- ○ 50,000 or more lives
- ○ N/A

Legal/Regulatory Requirements

Required by local, state, federal law or regulatory certifying bodies such as CMS, Joint Commission, FDA, etc. What is the legal/regulatory requirement need:

- ○ In compliance, nice to have
- ○ In compliance, maintain status
- ○ Out of compliance, need action
- ○ N/A

Financial Impact

What is the financial impact of the data request:

- ○ $100k-$250k
- ○ $251k-$500k
- ○ $500k+
- ○ N/A

Patient Safety

Some reports involve data that help maintain patient safety. If this report impacts patients safety, what is the frequency the report will need to be run:

- ○ Quarterly/Annually
- ○ Monthly
- ○ Daily/Weekly
- ○ N/A (the report does not relate to patient safety)

Organizational Impact & Feasibility

This report will generate an organizational impact to the business. Of the 7 sections of DPH (Population Health, Jail Health, ZSFG, LHH, BHS, MCAH, Primary Care), how many will be effected by this report?

- ○ 1 section of DPH
- ○ 2 sections of DPH
- ○ 3 or more sections of DPH
- ○ N/A

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Data Stewards

Data stewardship refers to individuals in the organization who own specific data domains (e.g. Lab) and are responsible for standardization of terms, definitions, business rules, data access, and reports. The goal of data stewardship is to assure data is available and usable with documented standards and assure a common understanding of information being reported

Accomplishments 2018

- ✓ Formed Data Governance Committee under Information Governance
- ✓ Developed prioritization criteria for data requests
- ✓ Approved Data Steward Roles & Responsibilities
- ✓ Identified new Report Request process
- ✓ Identified future state Reporting Levels in Epic

Lessons Learned

- ✓ Start small
- ✓ Balance individual needs with organizational needs
- ✓ Do not underestimate the importance of a charter
- ✓ Communicate broadly
- ✓ Send out materials for review prior to meetings
- ✓ Codify how the Committee will make decisions
- ✓ Strong meeting facilitation and project management support are key
- ✓ Lead into the void

Future Direction

Goals for 2019

- ❑ Formalize Data Steward model
- ❑ Standardize definitions for top 75 terms prioritized by Data Governance
- ❑ Establish Data Dictionary to capture standard terms, definitions, business rules, and standard reports
- ❑ Implement transparent processes for prioritization and completion of new report requests
- ❑ Identify Key Performance Indicators to measure efficiency of new processes

Questions (or advice!)

THE PEOPLE PERSPECTIVE: STAFFING & TRAINING FOR POPULATION HEALTH

11:15-12:00

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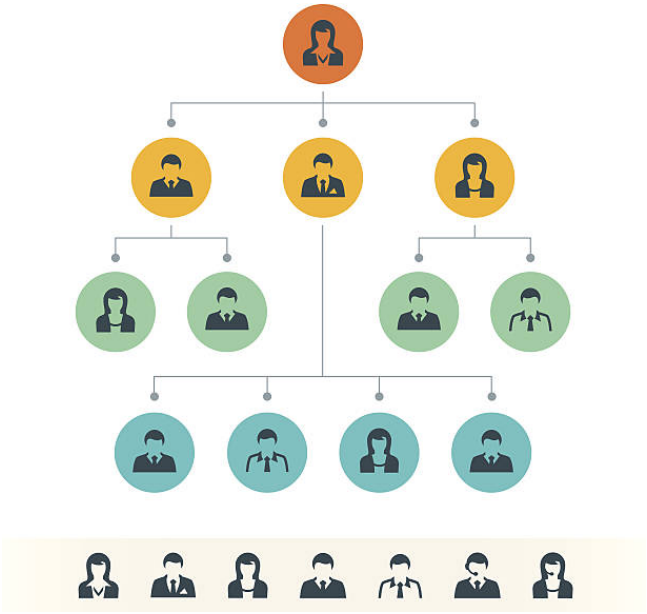
Two themes

How are PHS staffing population health departments at their organizations?



How are PHS attracting, recruiting and retaining business intelligence staff?

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Let's acknowledge known challenges

(and not get stuck)

Need inspiration?
Thanks to systems for sharing org charts (in your packets)
AHS, CCRMC, LA, SJ, UCSD

Group discussion

How are PHS staffing population health departments at their organizations?

How are PHS attracting, recruiting and retaining business intelligence staff?

1. Divide and conquer

- See # on your badge, and head to that table #

2. Discuss

- Identify facilitator
- Introductions: name, organization, role
- Review questions & answer as group
- Facilitator: move conversation along; make sure all participants get a chance to speak

- **Timing**
  - 20 minutes to discuss 1 topic, then repeat for second
  - Warning @ 5 min to wrap up

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LUNCH

12:15-1:00

Optional networking opportunity:

Bring your lunch to discuss 1 of 3 topics:

Behavioral Health Data Systems

Telehealth Strategy

Correctional Health Data Systems

POPULATION HEALTH TECHNOLOGY IN ACTION

12:45-1:45

CASE STUDY BREAKOUTS

1:45-3:15

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Population Health Technology in Action 12:45-1:45

	Epic Healthy Planet	Cerner HealtheIntent
System	UC San Diego	Los Angeles Department of Health Services
Presenters	**Amy M. Sitapati,** MD, Clinical Professor, Department of Medicine and Chief Medical Information Officer of Population Health	**Tyler Seto, MD,** Director of Clinical Quality
Location	International Ballroom (this room)	California Room (next door)

Case Study Breakouts 1:45-2:25

	Identifying, Addressing and Reducing Care Gaps	**Risk Stratification at UCD: Current Tools, Use Cases and Work in Progress**
System	Contra Costa Regional Health System	UC Davis
Presenters	**Bhumil Shah**, Chief Analytics Officer, Contra Costa Health Services **Rajiv Pramanik**, MD, Chief Health Informatics Officer, Contra Costa Health Services	**Michael Hooper**, MD, Medical Director Care Services and Innovation, UC Davis
Location	International Ballroom (this room)	California Room (next door)

Case Study Breakouts 2:30-3:10

	Designing and Implementing Alameda's Social Health Information Exchange	**Risk Adjustment of Primary Care Panel Sizes: Lessons from a Large Practice**
Organization	Alameda County Care Connect (WPC)	Center for Care Innovations
Presenters	**Cristi Iannuzzi,** Director of Strategy & Implementation, Data Exchange Unit	**Michael Rothman**, Executive Director
Location	International Ballroom (this room)	California Room (next door)

- Take your belongings
- Remember: you have three sessions!
- Consider splitting up among teams
- See you back @ 3:15 for final reflections (& **snacks**)

WHAT'S NEXT & CLOSING

3:15-3:30

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Team time

Now that you're back together as a team:

- **What was one key takeaway you heard today?**
- **How can <u>you</u> share and use that info at your organization?**

Please fill out your evaluation before you leave!

Communications

WHOLE PERSON CARE

In California's Public Health Care Systems

CAPH PUBLIC HOSPITALS AND HEALTH SYSTEMS

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For people in low-income communities, medical problems can be caused and exacerbated by factors related to poverty such as poor nutrition, lack of safe and stable housing, incarceration, unemployment, and the chronic anxiety of income insecurity.

Whole Person Care (WPC) recognizes that the best way to care for people with complex needs is to address their full spectrum of care, including medical, social, and economic. WPC has two primary goals:

- Build partnerships and develop infrastructure to coordinate care seamlessly across providers, including health care systems, social services, behavioral health, law enforcement, managed care plans, and community based organizations
- Provide tailored, integrated care for high-risk individuals to improve health

In 2016, 25 WPC pilots were selected by California's Department of Health Care Services (DHCS) as part of the Medicaid 1115 Waiver. As of September 2018, more than 85,000 patients were enrolled in WPC.

Core Interventions and Services

Supportive Housing Services
Patients are connected to a range of supportive housing services, including housing navigators, financial assistance for security deposits and move-in fees, and support maintaining relationships with landlords.

Community Re-entry after Jail
Care teams intervene at the time of release to help parolees transition safely to the community by connecting them to case management, medical care, and housing options.

Behavioral Health & Substance Use Disorder Treatment
Each patient is screened for behavioral health needs and linked to the appropriate level of care, including detox and rehabilitation centers, medication assisted treatment, psychiatric recuperative care, and intensive outpatient services.

Shared Care Planning
WPC streamlines the care planning process by requiring that each patient has a single, comprehensive care plan, accessible by every member of the care team across partner organizations.

Engaging the Most Vulnerable
By employing a talented workforce of community health workers and peer navigators, WPC draws on the lived experience of staff to foster trust with vulnerable patients and actively engage them in self-care.

Sharing Data
WPC funds innovative health information technology that allows different types of providers to communicate and share data in real time.

January 2019 1

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- Events / Webinars
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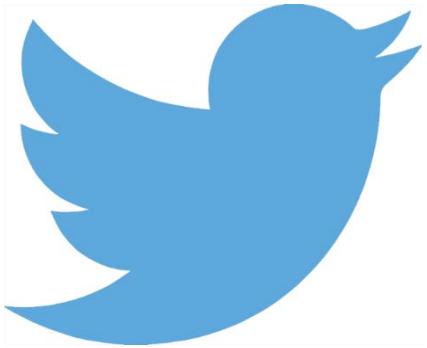

Recent publications, including PRIME and Whole Person Care progress

caph.org/publications

THANK YOU!

Don’t forget to complete your evaluation

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