CCI
CENTER FOR CARE INNOVATIONS

From Data to Action:

Key Steps and Strategies for Using Data to Improve Care

blue of california foundation

California Health Care Foundation

August 17, 2017

Webinar Reminders

1. Everyone is muted.
   - Press *7 to **unmute** and *6 to **mute** yourself.

2. Remember to chat in questions!

3. Webinar is being recorded and will be posted and sent out via email

Today's Focus

12:00-12:05	**Welcome and Overview (5 mins)**
12:05-12:45	**From Data to Action:** *Key Steps and Strategies for Using Data to Improve Care* • **Boris Kalikstein,** Consultant • Pivotal Moment Consulting
12:45-1:00pm	Questions, Next Steps & Closing (15 mins)

Voices on the Webinar

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Low-Intensity Track: 4 Part Data for Pop. Health Series

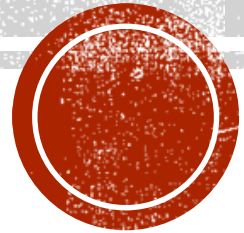
Part 1: Building a Data-Driven Culture for Pop. Health Management	• **July 19, 2017 @12-1pm** • *Faculty:* SA Kushinka, CCI & Jerry Lassa, Data Matt3rs
Part 2: Design Thinking for Data Visualization	• **July 27, 2017 @ 12-1pm** • *Faculty:* Andrew Frueh, Health Catalyst
Part 3: Tableau in Action	• **August 10, 2017 @ 2-3pm** • *Faculty:* Dr. Jason Cunningham, West County Health Centers
Part 4: From Data to Action: Key Steps and Strategies for Using Data to Improve Care	• **August 17, 2017 @ 12-1pm** • *Faculty*: Boris Kalikstein, Pivotal Moment Consulting

FROM DATA TO ACTION

KEY STEPS AND STRATEGIES FOR USING DATA TO IMPROVE CARE

Boris Kalikstein

Pivotal Moment Consulting



GOALS FOR IMPROVEMENT

- ✓ EMR
- ✓ Data
- ✓ Dashboard

SO WHAT?!

DATA TO ACTION

"The numbers have no way of speaking for themselves. We speak for them. We imbue them with meaning." – Statistician Nate Silver

Data is *bits* of information

Processed ➡ Interpreted ➡ Organized ➡ Structured ➡ Presented

Information provides context for data

DATA RICH BUT INFORMATION POOR

- Having an EMR and collecting data does not translate into action

- EMRs
  - Thousands of data points
  - Visually aggregates the data points on EMR screens
  - Providers and teams mentally evaluate the data to convert it into information that drives patient care

THE GOAL OF A DATA DRIVEN CULTURE

THE SAME THING --- MAKE A DIFFERENCE IN PATIENT LIVES

So why do I need data?

Why do I need information?

DATA DRIVEN OUTREACH

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week #1	Prenatal Chronic Pain Pap Mngt CM D	CM Dep BHP Dep Blue PR Dep				
Week #2	ADHD Coumadin Diabetes(half)	CM Dep BHP Dep Green PR Dep				
Week #3	Prenatal HTN Missing Pap	CM Dep BHP Dep Red PR Dep				
Week #4	Coumadin Diabetes(half)	CM Dep BHP Dep Orange PR Dep				

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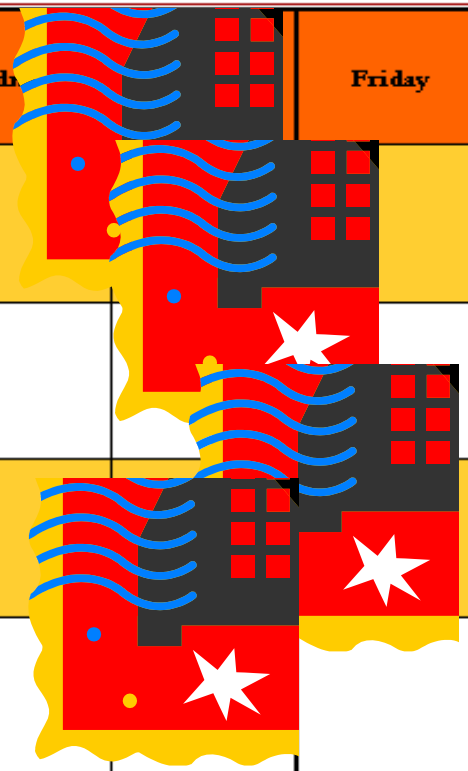

DATA DRIVEN REGISTRY

High Risk

Last Name	First Name	DOB	Visit	BP Sys	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
	Bonnie	/1952	11/13/2008	122	80	Current	08/01/2007	11/13/08	05/15/2008	04/03/2008	59		
Group Visit	No											11/13/2008	7.80
												09/04/2008	8.00
												07/17/2008	8.00
	Angelica	/1975	03/26/2009	115	69	Never		12/11/08	03/26/2009	02/15/2008	90		
Group Visit	Yes											03/26/2009	8.90
												12/11/2008	9.50
												10/03/2008	8.60
	Elva	1942	02/12/2009	130	64	Never	01/28/2008	2/12/09	12/11/2008	02/12/2009	65		
Group Visit	Yes											02/12/2009	7.60
												12/11/2008	8.80
												11/13/2008	10.30
	Emilio	/1937	03/19/2009	124	76	Never	10/10/2008	2/12/09	03/19/2009	03/20/2009	88		
Group Visit	Yes											03/19/2009	7.00
												02/12/2009	7.70
												12/19/2008	7.60
	Teresita	/1974	03/26/2009	110	72	Never	10/10/2008	1/30/09	10/16/2008	01/30/2009	76		

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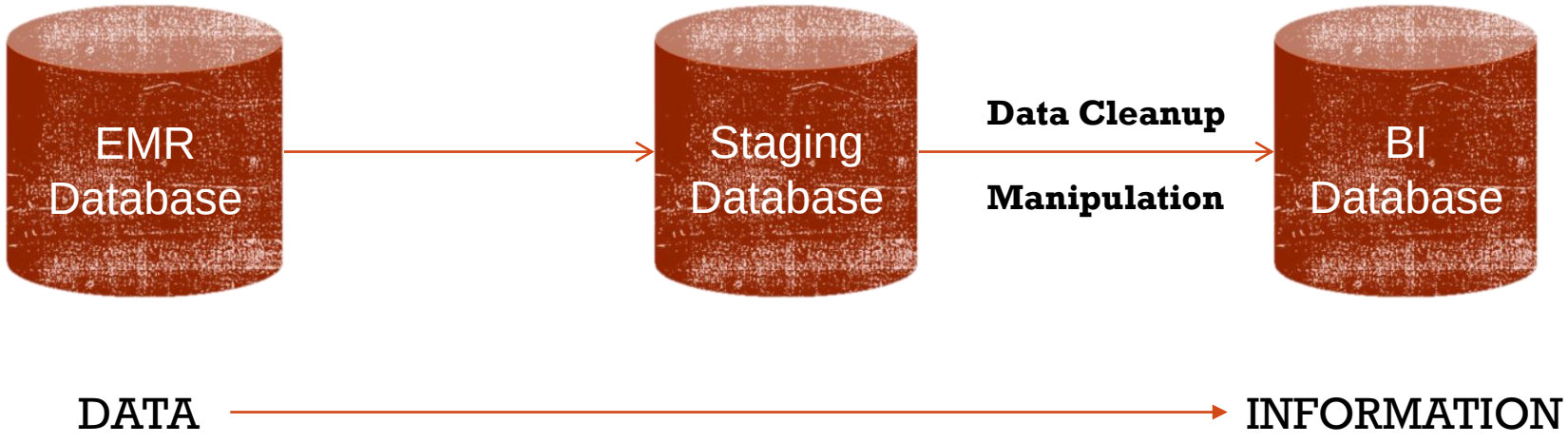
Last Name	First Name	DOB	Visit	BP Syst	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
Diabetes Planned Care Ruler			If more than six months, make appt. Otherwise, see BP, LDL & A1c rules	If above 130, appt every month	If above 80, appt every month	If current smoker, CM to review for Tobacco Cessation counseling	If not within one year, put on list for DM Eye Exam GV	If not within one year, CM to set goal with patient	If not within one year, make appt	If not within one year, make appt	If above 130, appt every month. If 100-130, appt every 3 months	If not within 3 months, make appt (6 months okay if last value less than 7.0)	If above 9, appt every month. If 7.0 - 9.0, appt every 3 months. If below 7.0, appt every 6 months

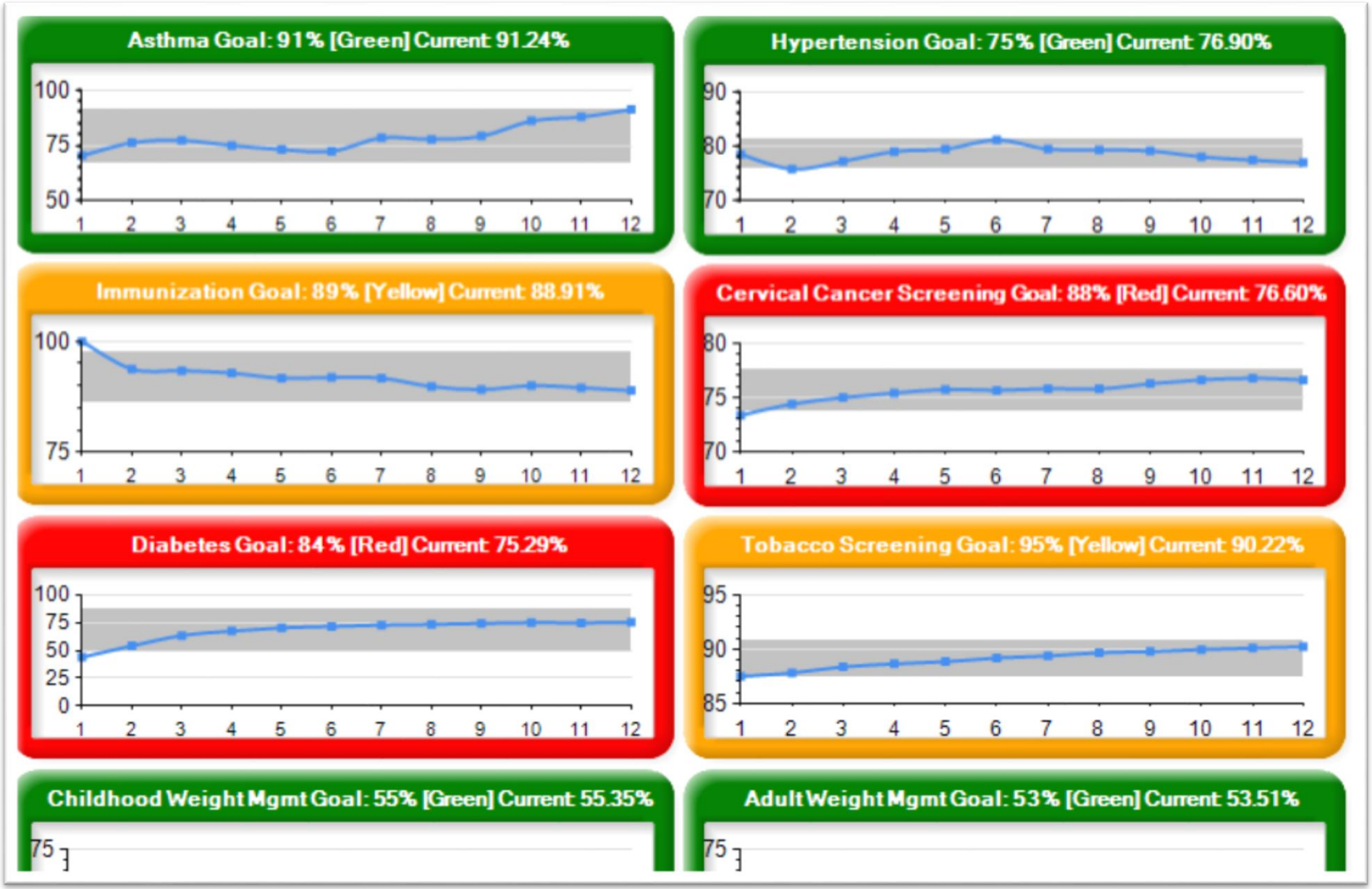
	Teresita	/1974	03/26/2009	110	72	Never	10/10/2008	1/30/09	10/16/2008	01/30/2009	76		

TRANSFORMING DATA INTO INFORMATION

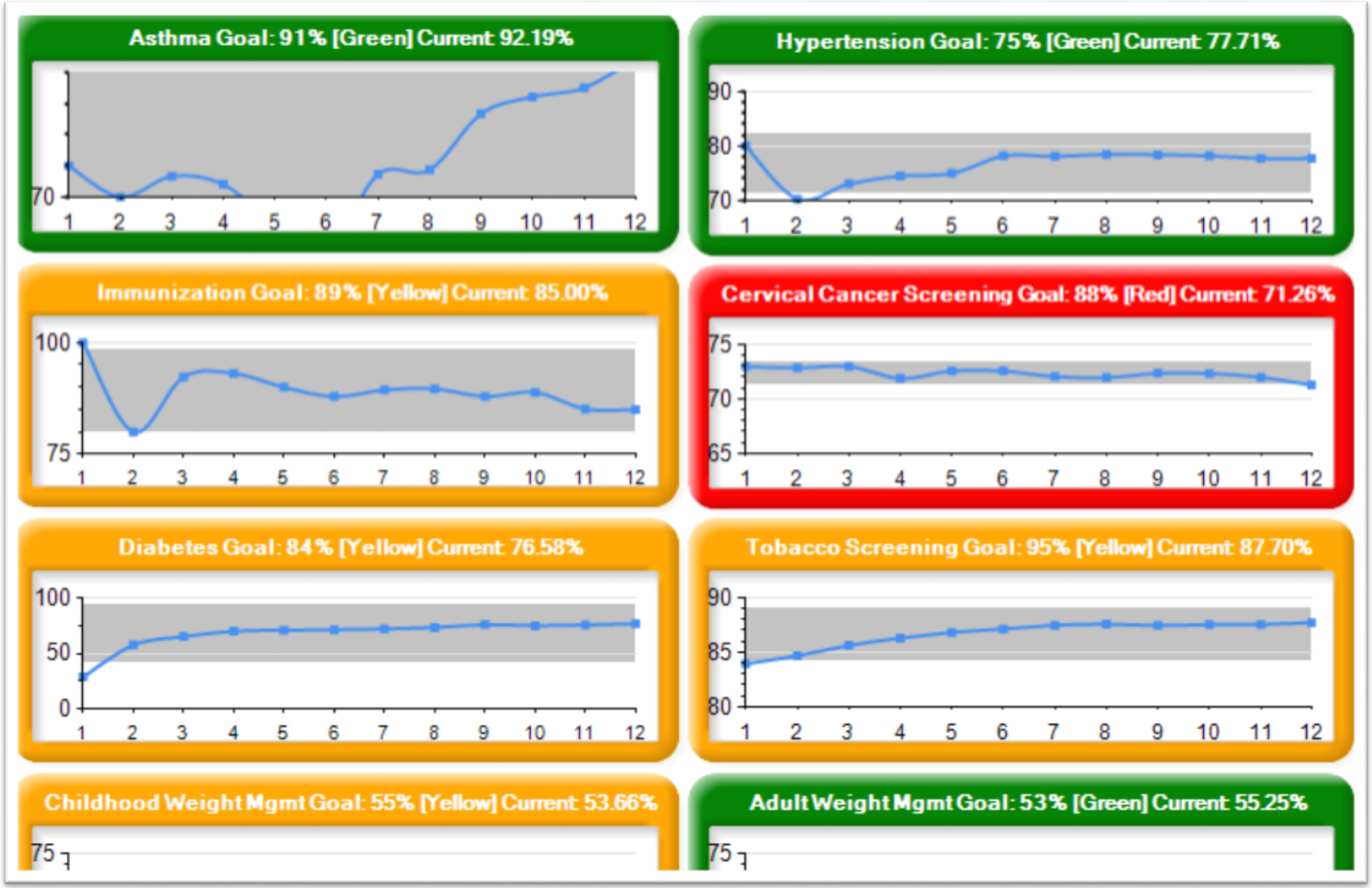
WAREHOUSING



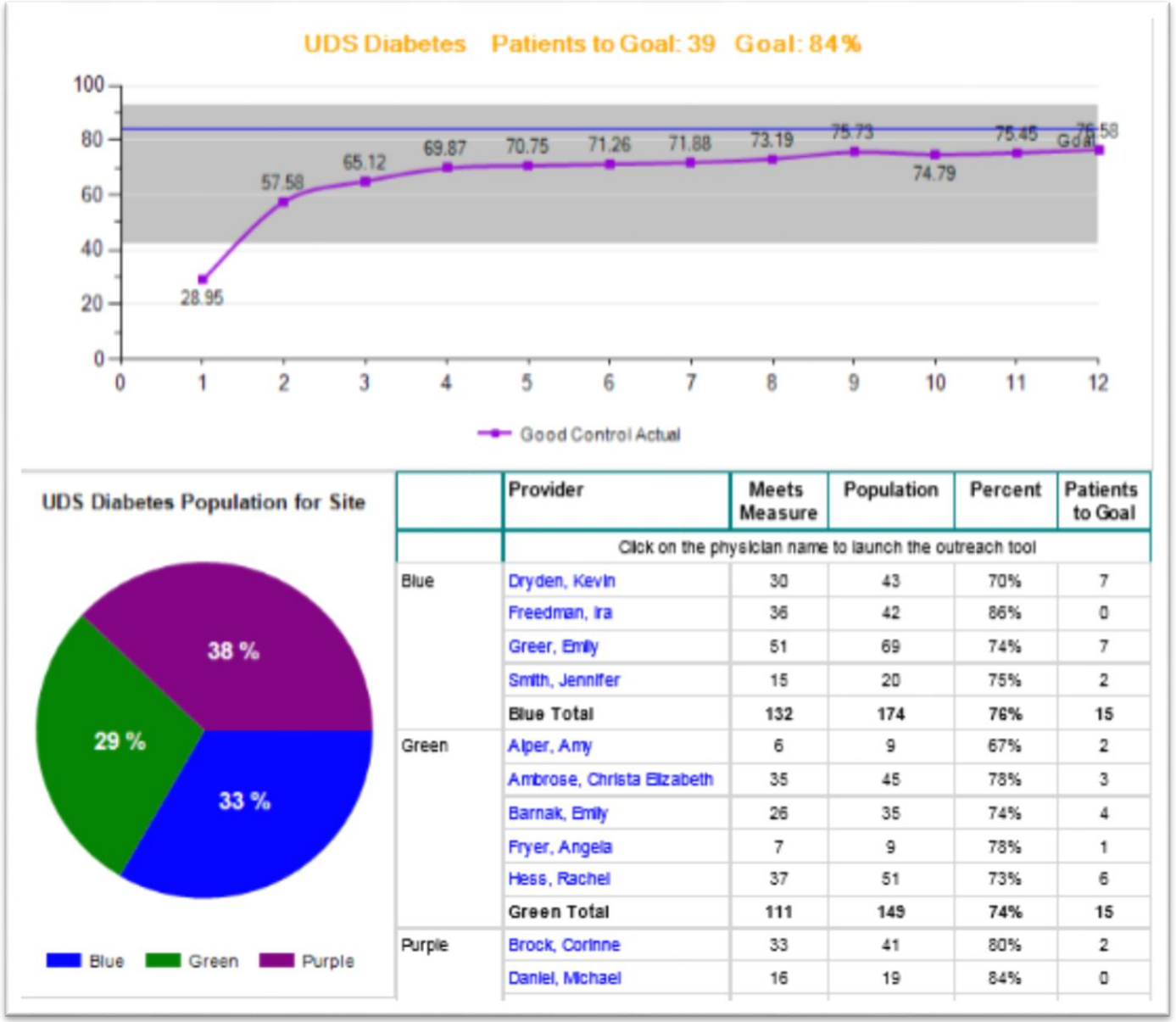
START WITH THE BIG PICTURE



CASCADE THE MESSAGE



MAKE IT MANAGEABLE



	Provider	Meets Measure	Population	Percent	Patients to Goal
	Click on the physician name to launch the outreach tool				
Blue	Dryden, Kevin	30	43	70%	7
	Freedman, Ira	36	42	86%	0
	Greer, Emily	51	69	74%	7
	Smith, Jennifer	15	20	75%	2
	Blue Total	**132**	**174**	**76%**	**15**
Green	Alper, Amy	6	9	67%	2
	Ambrose, Christa Elizabeth	35	45	78%	3
	Barnak, Emily	26	35	74%	4
	Fryer, Angela	7	9	78%	1
	Hess, Rachel	37	51	73%	6
	Green Total	**111**	**149**	**74%**	**15**
Purple	Brock, Corinne	33	41	80%	2
	Daniel, Michael	16	19	84%	0

MAKE IT ACTIONABLE

Patient Details	Visits and Appointments	Outreach Details	Patient Care Alerts
Kevin			
DOB: **Age:** 49 **Preferred Contact Method:** **Home Phone:** **Day Phone:** **Alternate Phone:** **Secondary Phone:** **Email:** **Cell Phone:** **Language:**English **ACO:** N **Medicaid Nbr:** **My CLINICA Connection Status:** Enrolled **OB Status:** **Groups:**	**PCP:** Dryden, Kevin **PDP:** Missing PDP **Hygienist:** **Last Visit:** 11/18/2015 Dryden, K-DIA **Last WCC:** **Payer:** Medicaid FQHC **Next appt:** **Last Dental Visit:** **Next Dental Visit:**	**Clinical** **Date Reviewed:**12/17/2015 **Comments:** Lvm informing pt to RCTC and schedule apt for DM. IH **Call Attempt:**2nd Call **Call Status:**Left message **Dental** **Date Reviewed:** **Comments:** **Call Attempt:** **Call Status:**	**Clinical** Past Due - Diabetes Eye Exam Past Due - Diabetes Foot Exam Past Due - High Blood Pressure > = 140/90 (Diabetes,) Past Due - Last A1c > 9 on 11/18/2015 Past Due - LDL (Cholesterol) Lab Past Due - Tdap/TD Vaccine ACO Care Team Score is 3 **Dental**

CLOSE THE LOOP

Person Nbr	Patient Name	PCP/ Status	Phone Number	Age/ DOB	Gender	Last Visit	ACO
		PCP: Dryden, Kevin Status: Active Payer: Medicaid FQHC Group Visits: My CLINICA Connection Status: Enrolled		49 Year(s)	M	11/18/2015 Dryden, K Last WCC: CarePlan Rvw:	X

Alerts	Appts	Active Problem List
Past Due - Diabetes Eye Exam Past Due - Diabetes Foot Exam Past Due - LDL (Cholesterol) Lab Past Due - Last A1c > 9 on 11/18/2015 Past Due - High Blood Pressure > = 140/90 (Diabetes,) Past Due - Immunizations (Past Due - Tdap/TD Vaccine,) ACO Care Team Score is 3		11/18/2015 - Alcohol-induced chronic pancreatitis 11/18/2015 - Continuous chronic alcoholism 06/17/2014 - Alcoholism - 303.90 06/17/2014 - Iron deficiency anemia - 280.9 06/17/2014 - Methamphetamine abuse - 305.70 06/17/2014 - Pancreatitis - 577.0 06/17/2012 - Diabetes type 2, uncontrolled - 250.02

Active Medications

Start Date	Stop Date	Prescribed Elsewhere	Brand Name	Generic Name	Dose	Instructions
12/21/2015	12/20/2016		SURE COMFORT	PEN NEEDLE, DIABETIC	30 gauge X 5/16"	Inject 10 U of Levemir SQ HS
12/21/2015	12/19/2016		TRUETRACK TEST STRIP	BLOOD SUGAR DIAGNOSTIC		use 1 Strip by In Vitro route 1 - 3 times every day as needed to monitor blood glucose
12/21/2015	12/14/2016		THIN LANCETS	LANCETS		inject by Misc.(Non-Drug; Combo Route) route 1- 2 times every day for testing blood sugar.
12/03/2015	06/29/2016		WAVESENSE PRESTO	BLOOD-GLUCOSE METER		take 1 by Injection route 3 times every day for 365 days Check blood sugar TID
11/18/2015	11/11/2016		LEVEMIR FLEXTOUCH	INSULIN DETEMIR	100 unit/mL (3 mL)	inject 10 Unit by subcutaneous route every morning
11/18/2015	11/11/2016		LISINOPRIL	LISINOPRIL	5 mg	take 1 tablet by oral route every day
11/18/2015	11/11/2016		NOVOLOG FLEXPEN	INSULIN ASPART	100 unit/mL	inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization.
06/05/2015	06/19/2016		TRUETRACK BLOOD GLUCOSE SYSTEM	BLOOD-GLUCOSE METER		use 1 by Topical route every day for glucose monitoring

Diabetes - High Risk

Systolic	Diastolic	Eye Exam	Foot Exam	A1c (Last 3)
140	80			11/18/2015 - 11.5 03/10/2015 - 14.6 06/14/2014 - 14.6

Group Visit: No

Open Referrals	Future Labs	Diagnostics

WHAT DOES IT TAKE?

NOT A BETTER EMR!

NOT IT STAFF!

- SQL developers / Analysts
- Executive buy-in
- Clinical leadership
- Prioritization of where to start
- Accountability
- Iteration

DISCUSSION

- What are your barriers / challenges?
  - Engage leadership
  - Frontline staff
  - Current culture
- What would help you be successful?
- How will you make it actionable?
  - Would someone know what do to by looking at it?

QUESTIONS?

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Pivotal Moment Consulting

pivotalmomentconsulting.com

Upcoming CCI Webinar & Workshop

Effective Communication Strategies for Strengthening Patient-Clinician Relationships

Webinar: August 29, 11:00 am – 12:00 pm
Workshop: September 7, 9:30 am – 4:00 pm

Objective: Learn and apply techniques to discover and identify **patient vulnerabilities and resilience** through eliciting patient narratives and developing shared care plans

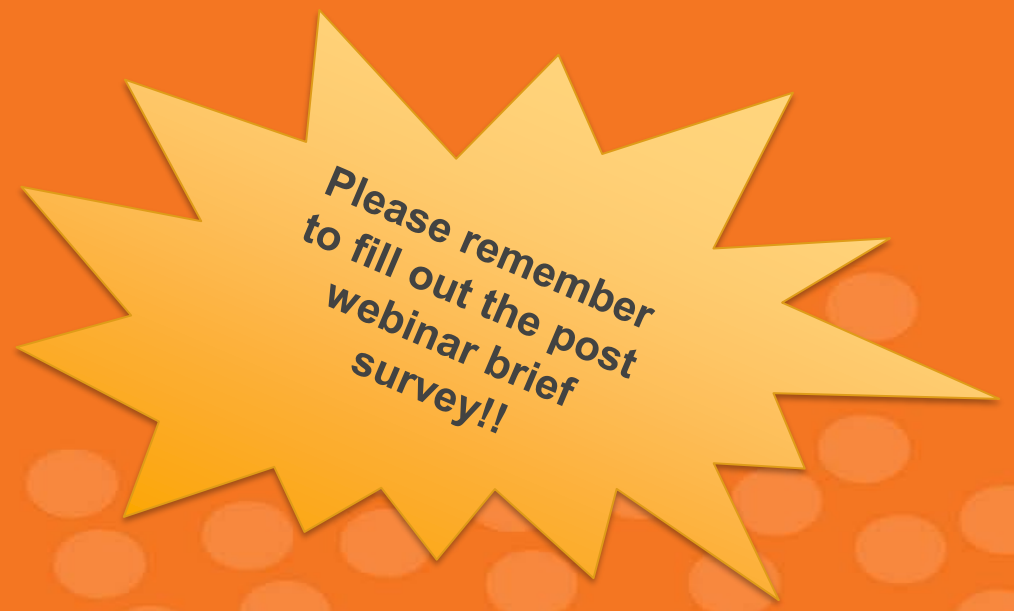
Open To: Clinicians and members of their care team. Participants should plan to attend both the webinar and workshop

Limited 40 spots available
Register separately ASAP:

Webinar: Register **here**
Workshop: Register **here**

CONTACT INFORMATION

- Tammy Fisher: tammy@careinnovations.org
- Megan O'Brien: mobrien@careinnovations.org



THANK YOU!