PHLN Office hours with Boris Kalikstein 8.2.18

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Notes from session

PHLN participants captured on call:

- Ryan Tanglao, Tri-City Health Center - Quality Program Management Coordinator
- Brenda McGill, North County Health Services - Quality Improvement Specialist
- Cathy Sakansky, North County Health Services - Senior Director Quality Improvement
- Matt Kosel, North County Health Services - Senior Director of Clinical Information
- Evelyn Ho, Ravenswood Family Health Center - Quality Officer
- Javier Romo, Community Medical Centers - Data Analyst
- Brandon Bettencourt, Chapa-De Indian Health - Director of Quality Improvement
- Robert Veliz, Northeast Valley Health Corporation - Program Manager, QI
- Nancy Yu, North East Medical Services - Project Coordinator I
- Hannah Tikalsky, LifeLong Medical Care - Quality and Population Health Director
- Linda D'Agati, Open Door Community Health Centers - Chief QI Officer

Discussion categories:

1. Building Data Quality

- Documenting in the EHR
- Data governance
- Data literacy
- Reporting accuracy

2. Population Health

- Defining populations and the problem you want to solve
- Data capture and creating buy in
- Trending reporting
- Actionable reporting

DATA GOVERNANCE

- **Hannah - LifeLong Medical Care:**
    - LifeLong has fairly home-grown analysts. Versed in EHR, queries, getting ready to hire someone with sequel (sp?) knowledge and ready to jumpstart to the next level.
    - Want to implement a vision for reporting, strategy and tactics behind this vision. Including clinical, finance, ops data. Exploring moving to create an actual data warehouse. Thinking of bringing in Tableau. Have all of these big changes happening and strikes Hannah that they don't have anything other than a ticket query system for people that need a report here and there.

- Migrating to EPIC in next 9 months.
- Given all of these changes -- what should I be thinking about in terms of pulling brains and resources together; formal structure on what to move on and how?
- **Boris response:**
    - Build it so it's EHR agnostic, so you don't waste time building for NextGen/eCW and then it doesn't transfer over to EPIC.
    - Take EHR component out of it for now
    - Data governance and reporting - what's needed to be successful (these elements are EHR agnostic)
        - Want to be able to bring in data owners: business folks that understand their business (financial, operational, clinical). Bring in those people to identify key definitions. EX: How do you define a visit (an encounter?, does it have to be builable to be a visit?)
            - Finance has a different definition of a visit than from an operational standpoint (care about it at an encounter level whether or not there's a financial element)
            - What is the problem they're trying to solve? When they use terms, what do those terms mean to them?
        - Take language of what these teams need.
            - EX: Financial: look at system and the flags that match the verbal requirement/definition. How to match in system and the criteria that will be shared with every analyst.
                - whenever you pull data for finance and you're looking to define a visit, this is what it means to finance. But if you are pulling for clinical purposes, this is how you define it and document it.
        - Ownership lies with the analyst.
        - Validate data with business nad make sure the definitions are clear and make sure people follow the definitions so that every time data is pulled, it's pulled the same way.

DATA VALIDATION

- **Ryan - Tri-City Health Center:**
    - Facing similar challenges to Hannah.
    - Really like the validation of the data -- our biggest problem right now. We have different sources of truth when talking about data accuracy. Do not have a main contact person for the data - working on this. Defining the specific measures that we need to capture is also a next steps we need to focus on.
    - **Boris response:** From a validation standpoint --
        - We always seem to run into the same barrier. A lot of people have the idea that it's not the front line person's responsibility.
        - Really need to put in the upfront work to work with the data to understand where the data is coming from. When you see data

errors, sometimes it's the analyst, but a lot of times it's workflow issues that cause data issues. The people who can solve the data issues are those inputting the data in real-time. Need to carve out time to walk through workflow for data entry and where the gaps exist and why we aren't getting the data information that we need.

DATA GOVERNANCE & STEWARDSHIP/VALIDATION

- **Brandon - Chapa-De:** working to establish data owners and working into job description; figure out how to get the information that they need. Issue around definitions and terms is an issue they encounter a lot. Information comes from all different places and then people expect data to be generated and right when staff request something. Culture is to get information and use data to solve problems, but there isn't structure around this. Would be nice to have someone in each department that takes ownership over data requests and you know you have to work with them to get data needs met.
    - **Boris response:** Could you pick out a champion in one department to test this idea out and use them as an example? That test and champion helps sell the model to other staff and departments. Could you do a pilot?
    - **Brandon:** We have some people who are already champions. Could work with them to define how it would work in other departments. Have them share their story.
    - **Ryan and Linda (Open Door)** have some experience with this.
    - **Carolyn Shepherd:** At Clinica Family Health we tried to create a culture of "of course the data is not right, and we need you to help us make it 'righter'" rather than expecting perfection.

DATA VALIDATION/STEWARDSHIP/CULTURE

- **Linda D'Agati - Open Door:** If you can get through the definitions, you can drive more people in and staff will feel less overwhelmed. Data validation - have to have an agreed upon workflow of how data is entered and no variation on those workflows. We've become more strict about that and we audit against those workflows. That helps keep people from drifting away from these workflows after they're trained.
    - **Boris response:** The key is showing the team members (MAs, RNs, MDs) why they should buy in. Shifting the paradigm to it's not just about the SOAP note, it's about a tool that not only captures what happens during the encounter, but it's in a way that automatically enhances population based health on the back-end. A lot of this is cultural work - what's in it for them? Also physically showing them that putting the data in the right place will give the output they want and how that benefits them.
    - **Linda:** I'm not sure we would get buy-in if we didn't have public dashboards
- **Robert - Northeast Valley** - attribute patients by empanelment. Feedback from providers that it might be better to run data by provider at a rendering level. How are other organizations doing this? Some providers don't think data is accurate when they see the numbers.

- **Boris response:** providers are responsible for their panel. Sounds like it's a culture that hasn't gotten to truly taking ownership of their panel. If you're going to go through the process of empaneling patients, the responsibility of care of patients is to that PCP. Any group that does this provides all reporting at that PCP level - all accountability/performance is to that PCP and their care team. Would encourage to continue to report at PCP level. Look at data and see if docs are actually seeing their own patients. If not, why not? (scheduling guidelines, lack of availability of the provider, etc.)
- **Javier - CMC:** At Community Medical Centers, we are working towards empanelment, which in turn, is forcing us to consider our Quality measures based on panel as well. Currently, we do rendering provider. But we are moving toward PCP as well.
- **Brandon - Chapa-De:** our organization reports everything by PCP

SELF-SERVICE ANALYTICS

- **Matt Kosel, North County:** have a data warehouse they built themselves and have pre-fabricated reports on intranet, but they can't change the reports. We want to give staff more access to data, but then you give people access that don't understand the data governance guidelines, etc. Don't have the right tools and find that users aren't savvy enough to use the excel/pivot tables.
    - **Boris response:** Self-service analytics: every time I've worked with teams on self-service analytics. Each time it's short-lasting. It's very difficult to maintain clean data governance and data definitions in a self-service environment. Unless you're creating very specific cubes, data sets that people can query off of. The data is so nuanced in terms of different flags, different things that happen in the workflows (ie; this needs to be true only when this and this happens, exclude these patients). Every time we've tried it we get different reports that are "true", but not necessarily true because people are using different definitions. Might do something in your ETL process nightly that might re-map the data differently and the gap will grow. I would recommend pushing people away from self-reporting. Unless you're a large enough company where you have enough analysts making sure all the self-reporting is accurate, self-reporting brings on a lot of risk. Even a tool with dragging and dropping is still only as good as the mapping behind it.
    - **Matt:** that echoes many of my concerns. CMC also said in the chat about using i2iTracks.
    - **Tammy:** in a different CCI program, Contra Costa presented their own self-service analytics. I can connect you with them if you're interested and they can share their challenges and successes. They've had the self-service in place for at least 18 months.
    - **Javier Romo - Community Medical Centers:** At CMC, we are on-premise Data Warehouse. We also developed data warehouses to store analytic tables and we have acquired Tableau and i2iTracks. We are in talks with Relevant Analytics to replace i2iTracks.

ACTIONABLE DATA

- **Evelyn:** translate dashboards to really drive change has been a challenge. Any best practices on how to distill the information down so care teams have the freedom to conduct PDSAs, etc.?
    - **Boris response:** If you think about a strategic plan or structure you can build. Start at the high level of your goals. Work your way down layer by layer. If your goal is 70% HTN control. Next question is how do you do that? (ie; identify population). Continue to ask the "how" questions all the way down. You want to drill down in order to make the data actionable. What specific action does a front desk person, MA, RN, provider, etc. have to take to get the next step? Build the decision tree from the bottom up. I'm going to work this list so that A, so that B, so that C...etc. I want to be able to explain to someone at any level how their action then impacts the next level, which impacts all the way up. Don't just provide outcome data - provide data specific at their actionable level for that staff (ie; list of patients who need specific follow up in the next week). Be able to provide very specific and granular data at each level, so people are looking at a specific sphere that they can control. If you just show them data at a high level, it's harder to tie line of sight of how their day to day action drives change in that metric.
        - EX: weight loss. If weight loss is your goal, you can get a number from the scale and goal is to lose 10 lbs. That doesn't make change. Behavior change moves that number. I need to walk 3x a week. I need to consume less than 2k calories a day. These are actionable steps that also yield data that connects up to the top goal.
        - Take high level outcome measures and distill them down
    - **Evelyn:** monitor things like UDS measures on a monthly level. What is a reasonable goal for interval of providing that granular level of information?
        - **Boris:** it depends on how quickly can the team act on data (ie; a list they work on in a week). If it's a task they monitor every day, then you may need to do it sub-daily. You don't always need a computer system to do that work. Daily tracking can be done on paper and by hand. Ask teams to monitor what they do. You can build systems that provider daily feedback, but you don't have to be at that place to drive granular change.
        - **Carolyn:** As a clinician at Clinica, data reported as improvement outcome measures (% with mammos, % with A1c...) wasn't as helpful to me as a clinician. But Boris' team at Clinica gave us data as tools: in-reach and out-reach that helped us get our work done and improve outcomes.

END