Building Data Strategies and Teams to Maximize Care Delivery and Outcomes

CHAD | October 15, 2018
Agenda

Revisiting Analytics Capability
Assessment

Defining roles

Building skills

Accountability + Sustainability
Introduction
Intro to HITEQ

The HITEQ Center is a HRSA-funded National Cooperative Agreement that collaborates with HRSA partners including Health Center Controlled Networks, Primary Care Associations and other National Cooperative Agreements to support health centers in full optimization of their EHR/Health IT systems.

HITEQ identifies and disseminates resources for using health information technology (IT) to improve quality and health outcomes. HITEQ includes:

• A searchable **web-based health IT knowledgebase** with resources, toolkits, training, and a calendar of related events

• **Workshops and webinars** on health IT and QI topics

• **Technical assistance** and responsive teams of experts to work with health centers on specific challenges or needs

Contact HITEQ for training or technical assistance

HITEQ SERVICES SUPPORT:

- Health IT Enabled Quality Improvement
- EHR Selection & Implementation
- Health Information Exchange
- Health IT/QI Workforce Development
- Value-Based Payment
- Privacy & Security
- Electronic Patient Engagement
- Population Health Management & Social Determinants of Health
- Achieving Meaningful Use
- Telehealth & Telemedicine
HITEQ’s Focus

• Facilitate successful implementation and maximum benefit from health IT
  — Quality improvement
  — Understanding shared value

• Minimize health IT/EHR burden
  — Building knowledge sharing and peer learning
  — Curating key guidance

• Looking forward
  — Strategic planning
Overview and Purpose
Data Driven Culture

As we focus more on population health, value based care, and improving outcomes for all populations, the need for high quality analytics become increasingly important.
Roadmap to Population Health Management

Step 1: Establish the organizational culture and capability for PHM

Step 2: Technology and vendor assessment

Step 3: Population Stratification

Step 4: Reengineer work processes

Step 5: Develop and use patient registries

Step 6: Pilot and rollout

Step 7: Measure impact and improve
Population Health Risk Pyramid, Made Possible by Analytics

- **Super-utilizers**
  - Poly-chronic, frail, elderly, urban poor
  - Frequent hospitalizations, emergency visits
  - Psychosocial and socioeconomic barriers
  - Costs make up 45 – 50 percent

- **Limited and stable chronic conditions**
  - At risk for procedures
  - Costs make up 30 – 40 percent

- **Healthy**
  - Minor health issues
  - Costs make up 10 – 20 percent

- **Care coordinators** (RNs or social workers)
  - Address psychosocial and non-clinical barriers
  - Community resources navigation
  - Intensive transition planning
  - Frequent one-on-one interaction

- **Reduce practice variation**
  - Systematic care and evidence-base medicine
  - Team-based, coordinated care
  - Scalable care team
  - Practice at top of license

- **Focused coordination and prevention**
  - Movement toward virtual, mobile, anytime access
  - Convenience is critical

- **5% High Risk**
- **35% – 40% Medium Risk**
- **50% Low Risk**
Analytic Capability Assessment

- From **Center for Care Innovations** for health centers/safety net clinics.
- Assesses staff opinion of where you are on key aspects of people, process, and technology.

Reveal where gaps exist:
- In shared understanding → **Communication**
- In capability → **Skill + capacity building**
- In strategy and culture → **Planning**
Analytic Capability Assessment

**REACTIVE**
No evidence or very limited evidence of capability, decentralized efforts to get data, access to information for the first time, situational reporting.

**RESPONSIVE**
Some departmental evidence but not integrated or aligned, initial data marts, standardized reporting through IT, improved data capture at department level, some historical trending and analysis.

**PROACTIVE**
Evidence of an emerging integrated approach, clinical and business process improvements based on analytics, analytics driving change and strategy, culture change, integration of measure across domains (clinical, financial, operations, patient experience).

**PREDICTIVE**
Fully integrated and aligned organizationally, leading edge tools and skills, data services provide robust support across the health center, automated analytic results are fed back into predictive models for value driven health care.
Analytic Capability Assessment

People  Process  Technology

Reactive  Responsive  Proactive  Predictive
Analytic Capability Assessment Results
Most respondents reported that capability levels under People is between 5 and 7.5—between highly responsive and moderately proactive.
Analytics Capability Assessment: PEOPLE

**Sr. Leader Sponsorship:** Managers/Directors are responsible for departmental data issues and resolving problems as they relate to operations.

**Data Stewardship:** Departmental data users or experts have an informally acknowledged role in assuring that data are captured consistently and accurately.

**Clinical and Business Analysts:** De facto roles for experts within the organization or limited assigned roles for analysts (no one’s primary responsibility).

**Data Driven Culture:** Data and information is available and used by department heads, but not uniformly required when making operational decisions or changing strategy.

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**Sr. Leader Sponsorship:** Senior leaders have responsibility for ensuring data is available for driving decisions and allocate resources to ensure its quality, availability, and timeliness.

**Data Stewardship:** Clearly defined, formal roles are called out for data stewardship in some high-priority areas or departments.

**Clinical and Business Analysts:** Dedicated, centralized analytics staff exist that participate in cross functional teams and support data driven decision-making; analytics staff may be provided by a support organization (e.g., network) but not always sufficient for all analytics needs.

**Data Driven Culture:** Data and information is used by managers and leaders on a regular basis, is pushed down and across the organization, and is required to support business cases and key decisions.
• Most report that PEOPLE are furthest along in analytic capability, with PROCESS and TECHNOLOGY lagging.
• No assessments indicated that health centers were at the very low end (REACTIVE) or very high end (PREDICTIVE).

**Biggest Opportunity for Improvement:** Integration
Data is integrated from multiple domains and sources in a warehouse or repository to help organizations drive toward achieving the Triple Aim.

**Biggest Current Asset:**
Performance Measurement
To what extent does your organization turn data into measures that assess performance on the organization's strategic goals?
Example Health Center Profile

**PEOPLE**

<table>
<thead>
<tr>
<th>1A</th>
<th>1B</th>
<th>1C</th>
<th>1D</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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<tr>
<td>1</td>
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<td>10</td>
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<td></td>
<td></td>
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<tr>
<td>11</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Start Here: Build shared understanding**

These questions had wide disparities as to where the health center reportedly stands, suggesting that staff have very different views:

- **1A**: To what extent are departmental staff identified as being responsible for defining data requirements and ensuring departmental or project-based data quality and effective use? **Consider as a group**: In each department, is someone responsible for ensuring needed data fields exist and are consistently captured?

- **1C**: To what extent do skills, roles, and staff exist within the organization to understand existing organization data, explore new sources of data, and to present insights from data? **Consider as a group**: Who is responsible for understanding, interpreting, and sharing data? Is that in that person’s official duties?

**Next Steps: Opportunities for Improvement**

Using this assessment, next steps in building analytic capability among the people of our organization and furthering a data-driven culture have been identified:

- When considering senior leadership involvement and support of data efforts, issues, and analytics (1A), this can be moved forward by senior leadership ensuring that data is available for driving decisions and allocate appropriate resources to ensure its quality, availability, and timeliness. **Consider who has access to key reports or data as well as what resources are dedicated to ensuring data hygiene and how that is communicated by senior leadership**.

- As part of a data-driven culture that embraces use of data in achieving organization goals and making positive change through continuous improvement, it is imperative that the organization promote data literacy and require supporting data to make decisions (1D). **For your organization, moving this forward will involve ensuring that all leaders are using data/information on a regular basis for business cases and other key decisions, and ensuring that this expectation exists across the organization**.
Moving Forward with Peer Learning

- Share Analytic Capability Profiles individually
- Peer learning session #1: Technology
- Peer learning session #2: Processes
- Peer learning session #3: People
- Peer Network Sustains
Anticipated Peer Learning Topics

**People**
- Data literacy and governance
- Building job descriptions and duties
- Assessing and building skills

**Process**
- Workflow tools
- Data Strategy tools
- Risk stratification concepts

**Technology**
- Data validation tools and approaches
- Using Data to Manage Population Health Under Risk-Based Contracts
- Choosing an analytics tool for self-serve analytics
Defining Roles
Data is the currency of advocacy.

Data in the hands of a few data experts can be truly powerful, but data at the fingertips of many is what is truly transformational.

Understanding and Advocating for:
- Patients
- Services
- Resources
- Improvements
- Roles
- FTEs
The new QI team is tasked with working on improving colorectal cancer screening rates.

Data Literacy

The ability to collect, understand, interpret, and use data in a coherent, critical and strategic way. Staff can access data and use that data appropriately to support key decisions.
Where is the data literacy divide?

As more data is more pervasive and accessible, the expectation is that we’ll know what to do with it. But a library full of books is meaningless to someone who can’t read.

example

The new QI team is tasked with working on improving colorectal cancer screening rates.
Data Governance Team

**who**
Multi-disciplinary group representing all staff who use organization’s information systems.

**what**
Develop data-related policies that help ensure data can be turned into actionable information for end users. Guidance for data validation, workflow mapping, reporting, specs, integration, and analysis.

**how**
Regular meetings, input from other staff, and autonomy to address issues that arise with participation of the cross functional group.

Ensure that data governance team has a specific purpose, a scope with specified responsibilities.
## Who is involved?

<table>
<thead>
<tr>
<th>Role</th>
<th>Key responsibilities</th>
<th>Data Issues/ Challenges</th>
<th>Information/ Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senior Leadership</strong></td>
<td>Use data for decision making and strategic planning.</td>
<td>Understand the nitty gritty of data.</td>
<td>Strategic leadership and alignment.</td>
</tr>
<tr>
<td></td>
<td>Allocation of resources.</td>
<td>Monitor macro-level trends.</td>
<td></td>
</tr>
<tr>
<td><strong>Data Steward(s)</strong></td>
<td>Understand the sources and nature of available data, advocating for effective use of that data.</td>
<td>Ensure that data is captured as intended.</td>
<td>Identify and monitor available department data.</td>
</tr>
<tr>
<td><strong>Analysts</strong></td>
<td>Develop analysis and reports. Tracks requests, gathers necessary information about data needs.</td>
<td>Data Validation. Ad hoc reporting.</td>
<td>Maintain inventory of reports and component parts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide reports and data in user-friendly formats.</td>
</tr>
<tr>
<td><strong>Health IT/EHR Staff</strong></td>
<td>Maintain EHR functionality, updates, and needed mapping.</td>
<td>Maintain integrity and functionality of systems and interfaces.</td>
<td>Crosswalk which fields in EHR are mapped to measures.</td>
</tr>
<tr>
<td><strong>Other Clinicians</strong></td>
<td>Use data for decision making, for patient care. Input patient data.</td>
<td>Follow workflows and protocols, including data entry.</td>
<td>Changes in needed information or workflows.</td>
</tr>
<tr>
<td><strong>Other Frontline Staff</strong></td>
<td>Input intake data. Follow up on data appropriately.</td>
<td>Understand and see impact of data collected.</td>
<td>Trends in patient interactions.</td>
</tr>
</tbody>
</table>
Data Governance Moves Us Along the Path

- Reactive
- Responsive
- Proactive
- Predictive

Wisdom, Knowledge, Information, Data
What does that look like?

Staff including providers, front desk staff, etc. input data that they are told to.

Staff including providers, front desk staff, etc. input data used for decision making.

Staff including providers, front desk staff, etc. input data to inform reports and planning.

Comprehensive data proactively identifies risk; care plan based on risk and patient need.

Many aspects of CRC screening care are tracked (declined, no show, etc.), decision support is built-in, feedback loops exist.

CRC screening outcomes are tracked regularly, and shared with staff.

CRC screening outcomes are reported on UDS, as-is from EHR.
What does that look like across initiatives?

- Data steward(s) identify needed data across all initiatives, with a focus on alignment.
- Staff including providers, front desk staff, etc. input data agreed upon data.
- Data is reviewed, analyzed, synthesized, then shared with staff in user friendly formats.
- Staff including providers, front desk staff, etc. use data for decision making.
Engage the Data Creators

The information that leadership, providers, and payers use to make decisions is often ‘created’ by entry-level or front line staff that may have less training and higher turnover. For these reasons, it is critical that these ‘data creators’ be incorporated in data governance and QI activities, including training.
Identify Each Staff's Relationship with Data

• What data do they create?
  – Are they the end user of that data? If not, how accessible are they to the end user?

• What data do they use?
  – How accessible is the ‘creator’ of that data?

Creator
User
Translator
How can we support this?

• Ensure that data validation, monitoring, and related needs are in job duties.
• Ensure that staff working on ‘initiatives’ understand that the data is a bigger, more integrated picture.
• Require data for strategic changes or decision making.
• Engage ‘data creators’, beyond providers.
Comprehensive Job Duties/Functions

Job Description Matrix: Ensure that job functions include QI, process improvement, compliance, population health management, patient satisfaction, patient safety, EHR training, data analytics.
# Standardize Tasks

## Sample Quality Improvement Specialist Monthly Calendar

<table>
<thead>
<tr>
<th>Quality Specialist 1</th>
<th>Quality Specialist 2</th>
<th>Quality Specialist 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
<td><strong>Tuesday</strong></td>
<td><strong>Wednesday</strong></td>
</tr>
<tr>
<td>1. Monthly SPA Update (4 hrs)</td>
<td>1. Monthly SPA Update (4 hrs)</td>
<td>1. Data Requests/NCM questions (10 min)</td>
</tr>
<tr>
<td>2. SPA Committee Data (20 min) &amp; send email to NCM A &amp; FAB</td>
<td>2. RCA data for claims - 3 new claims from last 90 days. Base list ofpatients on 5 Drive for Clinic Management</td>
<td>2. Update Instructions (1 hr)</td>
</tr>
<tr>
<td>3. Run LDR income report - email 125 with unknown var</td>
<td>3. Email QP to intake (3 min)</td>
<td>3. Update Instructions (1 hr)</td>
</tr>
<tr>
<td><strong>Tuesday</strong></td>
<td><strong>Wednesday</strong></td>
<td><strong>Thursday</strong></td>
</tr>
<tr>
<td>1. Clinical Indicators monthly and yearly (5 hrs)</td>
<td>1. Diabetic, Hemoglobin A1C (1 hr)</td>
<td>1. Admin/Team Meeting: 12:00 - 1:00 (1 hr)</td>
</tr>
<tr>
<td>2. Clinical Indicators by provider (2 hrs)</td>
<td>2. Final and send DMR letters (1 hr)</td>
<td>2. Create quality/monthly and year (3 hrs)</td>
</tr>
<tr>
<td><strong>Friday</strong></td>
<td><strong>Saturday</strong></td>
<td><strong>Sunday</strong></td>
</tr>
<tr>
<td>1. Discharged Pt. (20 min)</td>
<td>1. Basic QP &amp; Meeting 12:00 - 1:00 (1 hr)</td>
<td>1. Project (2 hrs)</td>
</tr>
<tr>
<td>2. Monthly Letter Production (8 hrs)</td>
<td>2. Weekly LR Update (1 hr)</td>
<td>2. Admin/Team Meeting: 12:00 - 1:00 (1 hr)</td>
</tr>
<tr>
<td>3. SPA Enrollment Data (20 min), A.</td>
<td>3. Monthly LR Update (1 hr)</td>
<td>3. Admin/Team Meeting: 12:00 - 1:00 (1 hr)</td>
</tr>
<tr>
<td>4. Info/Coordinator Call 2:00 - 3:00</td>
<td>4. Admin/Team Meeting: 12:00 - 1:00 (1 hr)</td>
<td>4. Admin/Team Meeting: 12:00 - 1:00 (1 hr)</td>
</tr>
</tbody>
</table>

**Weekly Tasks:**
- **Week 1:**
  - 1. Discharged Pt. (20 min)
  - 2. Monthly Letter Production (8 hrs)
  - 3. SPA Enrollment Data (20 min)
  - 4. Info/Coordinator Call 2:00 - 3:00
- **Week 2:**
  - 1. Clinical Indicators monthly and yearly (5 hrs)
  - 2. Clinical Indicators by provider (2 hrs)
  - 3. Monthly LR Update (1 hr)
  - 4. Info/Coordinator Call 2:00 - 3:00

**Monthly Tasks:**
- Monthly SPA Update (4 hrs)
- SPA Committee Data (20 min)
- Run LDR income report - email 125 with unknown var
- Clinical Indicators monthly and yearly (5 hrs)
- Clinical Indicators by provider (2 hrs)
- Monthly LR Update (1 hr)
- Info/Coordinator Call 2:00 - 3:00
Monitor Tasks + Related Outcomes

Create an Excel file or other mechanism to track all metrics.
Building Skills
# Skill and Knowledge Building

## Key Concepts
- Overview of existing initiatives
- Inventory of available EHR, health IT, and analytics packages
- Triple Aim
- Health center program

## Key Knowledge
- Where to find eCQMs
- How to read logic statements
- Value Sets
- Basics of UDS, PCMH, MU/PI and other programs, plus where to find details.
- Access EHR-specific training or guidance

## Key Skills
- Excel, including filtering, conditional formatting, pivot tables, VLOOKUP
- Query writing (MS Access, report writing software)
- Basic data visualization
Staff Orientation to HIT for the Triple Aim

- HITEQ has a three part eLearning module for new staff to orient them to the Health IT and the Triple Aim within the health center program.
## Alignment Across Initiatives

<table>
<thead>
<tr>
<th>HIT Consideration/Capability</th>
<th>NCQA PCMH 17</th>
<th>Promoting Interoperability Program</th>
<th>MIPS Promoting Interoperability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Certified EHR</td>
<td>TC 04</td>
<td>Security Risk Analysis</td>
<td>Security Risk Analysis</td>
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<tr>
<td></td>
<td>TC 05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Security</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Clinical Decision Support</td>
<td>KM 20</td>
<td>Clinical Decision Support</td>
<td></td>
</tr>
<tr>
<td>4. Patient Portal</td>
<td>AC 07</td>
<td>Secure Messaging</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td></td>
<td>AC 08</td>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coordination of Care</td>
<td>View, Download, Transmit</td>
</tr>
<tr>
<td>5. E-Prescribing</td>
<td>KM 14</td>
<td>eRX</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td></td>
<td>KM 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Medication Reconciliation</td>
<td></td>
<td>Medication Reconciliation</td>
<td></td>
</tr>
<tr>
<td>7. Health Information</td>
<td>CC 21</td>
<td>Health Information Exchange</td>
<td>Send Summary of Care Request/Accept Summary Care</td>
</tr>
<tr>
<td>Exchange</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Reporting</td>
<td>QI 01</td>
<td>Promoting Interoperability Data</td>
<td>Promoting Interoperability Data</td>
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<tr>
<td></td>
<td>QI 02</td>
<td>Clinical Quality Measures</td>
<td>Clinical Quality Measures</td>
</tr>
<tr>
<td></td>
<td>QI 12</td>
<td></td>
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</tr>
</tbody>
</table>

eCQM + Value Set Example

To access detailed specs, scroll down:

Specifications

CMS122v6.html

Uniform Data System
Reporting Instructions for the 2018 Health Center Data

Select Table 6B / 7 Measure Required

Value Set on USHIK Site

Click on Measure Hyperlink

Face Page, Population Criteria, and Data Criteria

eCQI Resource Center

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

eCQMs for 2018 Performance Period

CMS Measure ID: CMS130v6
Version: 6
NQF Number: 0034

Measure Description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer

Click on Measure Hyperlink

Value Set on USHIK Site

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9 percent) (Columns 3a–3f), CMS122v6

Measure Description

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period
Assessing Excel Skills

Gauging Basic Data Knowledge and Abilities
HITEQ tool is intended to gauge an applicant’s basic data knowledge and abilities. Users go through all the tabs in order and follow the instructions in the red boxes.
Addressing Skill Gaps

- Microsoft Excel References and Trainings
  https://support.office.com/en-us/article/excel-for-windows-training-9bc05390-e94c-46af-a5b3-d7c22f6990bb

- Stack Overflow
  (for specific questions)
  https://stackoverflow.com

- YouTube

<table>
<thead>
<tr>
<th>Test</th>
<th>Your Result</th>
<th>Standard Range</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platelet Count (PLT)</td>
<td>135</td>
<td>150-400</td>
<td>$x10^9/L$</td>
</tr>
</tbody>
</table>

Gradient Line:

![Gradient Line Image]
User-Friendly Format = Data Visualization

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>CY (Rating: Not Rated)</th>
<th>CY (Rating: Acceptable)</th>
<th>% Change</th>
<th>CY - PY</th>
<th>PY National Avg</th>
<th>PY State Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section K, Line 19: Colorectal Cancer Screening</td>
<td>Universe</td>
<td>Universe</td>
<td>8.50%</td>
<td>384</td>
<td>98.02%</td>
<td>93.72%</td>
</tr>
<tr>
<td>Number of patients in colorectal cancer screening universe</td>
<td>4,902</td>
<td>4,518</td>
<td>8.50%</td>
<td>384</td>
<td>98.02%</td>
<td>93.72%</td>
</tr>
<tr>
<td>Estimated number of medical patients age 50-75</td>
<td>4,517</td>
<td>4,455</td>
<td>1.39%</td>
<td>62</td>
<td>98.02%</td>
<td>93.72%</td>
</tr>
<tr>
<td>Number of patients age 50-75 (from 3A)</td>
<td>6,001</td>
<td>6,014</td>
<td>1.11%</td>
<td>67</td>
<td>98.02%</td>
<td>93.72%</td>
</tr>
<tr>
<td>Universe as a percent of estimated medical patients age 50-75</td>
<td>108.52%</td>
<td>101.41%</td>
<td>7.01%</td>
<td>7.11%</td>
<td>98.02%</td>
<td>93.72%</td>
</tr>
<tr>
<td>Colorectal cancer screening compliance rate</td>
<td>30.95%</td>
<td>30.57%</td>
<td>1.24%</td>
<td>0.38%</td>
<td>38.08%</td>
<td>44.83%</td>
</tr>
</tbody>
</table>

Colororectal Cancer Performance Compared to Goal and Average

Nearly 7 out of 10 of our patients have not had their needed colorectal cancer screening.
User-Friendly Format Ideas

Storytelling with Data
http://www.storytellingwithdata.com/

Chart Chooser
http://labs.juiceanalytics.com/chartchooser/index.html

Tableau Gallery

Information is Beautiful
https://informationisbeautiful.net/
Skills for Data Dashboards
Accountability + Sustainability
Make data a part of every meeting

Whether it is an executive team, clinician, finance, or all-staff meeting, have leaders, clinicians and staff use data reports together to guide discussions and decisions.

Example

Risk-bearing provider groups report that sharing cost/utilization data alongside quality data with clinical staff can be very helpful for identifying and acting on opportunities for quality improvement and improved financial performance.
Show how data can move.

Ensure that no one’s ‘data role’ feels futile by ensuring that those tasked with various responsibility can actually DO something about the data, and that that information is actually used.

*Example*

When rolling out SDoH collection, which is time consuming, staff may feel like this information is invasive or not needed. If they also don’t see anything changing as a result, the effort feels wasted.
Use Feedback Loops

Show how what portion of patients have had SDoH collected, what percentage of patients with SDoH identified have received referral to appropriate services—anything that shows how the needle is moving and why this matters!
Interaction with data builds trust in data.

“Trusting the data” is a longstanding challenge—the more staff interact with and understand where information comes from, the more trust can be built.

Example

Rates of uncontrolled diabetes seem stuck at 40%, higher than providers believe is accurate. The team that understands the processes and numbers behind that rate is able to overcome the skepticism.
Be on the same team.

Data capture, monitoring, analysis, and reporting must be transparent, just as workflows and care processes must be. Transparency, leadership, and team dynamics prevent blame games and improve collaboration on the same goal.
Avoid initiative overload.

Avoid looking at data governance or quality improvement as a ‘project’, instead focus on using data throughout all efforts.

example

There may be a dozen initiatives going on at any given point across the organization, then there may be departmental projects as well.
Consider what can be sunset.

Consider beginning with a big discussion about what initiatives exist to identify what can be aligned, what can be sunset, and what needs to continue. Look at business cases and dedicated resources for each. Remember, the goal is to have data in all activities, rather than many initiatives.
Questions or thoughts?

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