

Minnesota Accountable Health Model: SIM Task Forces

Data Analytics Subgroup

Monday, December 8, 2014, 12 p.m. – 3 p.m.

Department of Human Services, 444 Lafayette Rd., St. Paul, Conference Room L3148

MEETING MINUTES

Welcome and Overview of Agenda

Dr. Rahul Koranne, Chair, welcomed everyone to the second of three Phase One meetings and provided an overview of the meeting agenda, noting that how the Subgroup does the work is up to the Subgroup, so agenda modifications are welcome. Dr. Koranne then asked Subgroup members for their impressions at the beginning of the meeting. Comments focused on a draft document of Data Analytics Components distributed to the Subgroup, noting the quantity of good information in the document and a need to prioritize and synthesize where there are points of alignment between the members.

Review of the November Subgroup Meeting and MN SIM Task Force conversations

Dr. Koranne provided a review of the November 17 Subgroup meeting and presentations that he gave at the November 19 Community Advisory and Multi-Payer Alignment Task Force meetings:

- The first Subgroup meeting attempted to create delineation between Phase One (focusing on what can be done now, with an eye toward the Integrated Health Partnerships and other ACOs) and Phase Two (which will focus on future-state data with a higher emphasis on social services data, and will incorporate lessons from the Accountable Communities for Health).
- The Task Forces are looking for the Subgroup to make these recommendations, and the intent is to create a product good enough that it can stand on its own, and will be sought out by organizations looking to do Data Analytics. Commissioner Lucinda Jesson, DHS, attended the Community Advisory Task Force meeting.

Subgroup members asked a number of questions related to the Task Force meetings:

- Bobbi Cordano, Wilder Foundation, asked whether the Multi-Payer Alignment Task Force had interest in complexity analysis or risk adjustment when discussing cost, or whether any Subgroup members had insight into how payers are thinking about cost. Ginelle Uhrencamp, Blue Cross and Blue Shield of Minnesota, noted that Blue Cross uses multiple methodologies to determine cost, both raw and risk-adjusted. Diane Stollenwerk, CHCS, commented that the Multi-Payer Alignment Task Force is very aware of the need to do risk adjustment when appropriate, but that organizations needed to be careful because risk adjustment can sometimes hide variation.
- Dr. Koranne noted the interest in potential overlap between the Administrative Uniformity Committee (AUC) and the Subgroup, as brought up by both Nancy Garrett and Nathan Moracco. Heather Petermann, DHS, added that there is some symmetry between the groups, but more of a focus in the AUC on claims and administrative information, while the Subgroup could focus more broadly on information going to the ACOs and (in Phase Two) the ACHs. Ross Owen, Hennepin Health, asked for clarification, since he saw the standard claims feed as a logical way to receive the raw information needed for Data Analytics, and that the Subgroup may want to think of the AUC as it is making recommendations. Heather replied that the AUC had specific tasks around

information exchanged on 837 claim forms, while the Subgroup could encourage alignment on data elements, and that she was not concerned about duplicating AUC's efforts. George Klauser, Lutheran Social Services, stated that he thought it best if the Subgroup chose its path. If the work of the AUC or the e-Health Advisory Committee fit within those paths, that's fine, but don't spend too much effort trying to work them in. Dr. Koranne replied that it would be good to learn from the AUC and the e-Health Advisory Committee as new information comes up.

- Cathy VonRueden, Essentia, noted that she received a call from a health plan after the last Multi-Payer Alignment Task Force meeting from an individual asking whether the intent was for plans to report information in a consistent format, noting that plans have already spent a lot of money developing reporting systems. Are there things that providers should be collecting that they do not today? If so, we should consider the development cost.

Discussion of Shared Definitions and Basic Assumptions

Diane Stollenwerk, CHCS, introduced the need to arrive at shared definitions and basic assumptions, as a number of Subgroup members suggested in the homework they submitted. Diane noted that the Subgroup homework is deliberately structured to reflect the format of the products that will be sent back to the Task Forces.

The Subgroup was given a few minutes to review the proposed definitions:

- Dr. Koranne asked to change the meta-information definition to "Descriptive information about the data analytic element or component."
- Ross Owen asked whether it made sense to refer to "clinical data" as "EHR data." Diane Stollenwerk noted that there may be providers that should be part of the data analytics work that do not have access to Electronic Health Records; Scott Gerdes, Zumbro, confirmed that there are some small family-owned businesses that are still operating on paper charts. Cathy VonRueden noted that referring to "claims data or clinical data" would be appropriate.
- Bobbi Cordano asked whether community needs assessments should be mentioned in items that federal law requires from hospitals. Ross Owen replied that the Subgroup should agree that the examples are not exhaustive.
- Diane Stollenwerk noted that one of the assumptions is that data analytics are limited by the available data sources. What data sources fit into today's world (Phase One)?
- Cathy VonRueden recommended re-ordering definitions in order of increasing complexity (raw data first, then data source). Dr. Koranne recommended removing the brackets from the definition of data source, as they could be from varying discussions.

The Subgroup then reviewed the basic assumptions, some of which repeat what was in the Charter, while others come from the conversations of the first Subgroup meeting:

- Diane Stollenwerk noted that there isn't anything in the assumptions about Phase One being voluntary – that this work is not informing a regulatory requirement, either through carrot or stick. The Task Force has also asked the Subgroup what would help motivate folks using recommendations to align.
- Dr. Koranne noted that some of the assumptions could and should inform the guiding principles. If data analytics is not being used, it should be a guiding principle. The Subgroup should think of this work as developing over-arching principles.
- Heather Petermann asked to add an assumption that "having inconsistencies in data analytics formats or processes is costly," therefore payers will ask if this is going to be required. Heather thinks the response is that wasting resources on making sense of disparate data is also expensive. Dr. Koranne stated that he would expand on that statement, that not only is it costly, but it leads to inaction. If receiving multiple sources of data from payers, an organization can't do anything with

that. For example, if multiple payers identify various conditions that a provider should act on (diabetes, or generics, or back & spine procedures, depending on the payer), the provider cannot decide which recommendation to take. You aren't comparing apples to apples. Diane Stollenwerk noted that a physician once told her "I get so many reports with nuanced differences that I ignore them all."

- Ross Owen noted that there is value from both ends of that transaction. Ginelle Uhlenkamp agreed, stating that the Subgroup would be in a bad situation if it was told to roll out one standard format - consistency is important, but need to think about the variation/customization that we're expected to provide to individual practices/ providers.

Discussion of Data Analytic Elements and Data Sources

Diane Stollenwerk facilitated a review of the chart of Data Analytic Elements and Data Sources compiled from the feedback received from the Subgroup through the first homework:

- The chart presented in the meeting was a draft document, compiled quickly to serve the quick turn-around between the first two Subgroup meetings.
- On further review, Diane found 28 lines in the chart that could be combined, and another 24 lines that may be better candidates for principles - e.g., "will the guidelines offer value to payers or providers?"
- The intention for today's work is to receive the Subgroup's first reaction on the elements and sources, for example whether some elements are high-priority, or whether some should be flagged for Phase Two. Once discussed in the meeting, the chart will be further consolidated and refined, then sent out as part of the second homework so that members can further digest and think about the material.
- Dr. Koranne noted that many Subgroup members reached out to other individuals in their organizations for feedback, which he encouraged.

Subgroup members discussed the Data Analytic Elements and Data Sources chart:

- Ross Owen proposed grouping the data elements with an eye toward addressing cost:
 - Who are the people? (attribution methodology) How do I find them? Demographic profile
 - Where are the cost opportunities? (utilization patterns, comparisons of use, chronic conditions)
 - How should I intervene? (Does quality or care improvement fit in here?)
 - Cathy VonRueden recommended adding the category "Where are the quality opportunities?"
- Diane Stollenwerk proposed adding "Where is the opportunity to improve health outcomes?"
- Stacey Guggisberg, Prime West, noted that she can go out to three different providers with the same set of data, and because of population mix, she ends up customizing reports to fit the needs of the provider and their population mix.
- Bobbi Cordano advocated for a better understanding of where the cost savings is seen, and understand that it is not just cost shifting. There is a danger to looking only at the health payer, because cost may be shifted to community.
- David Maddox, Centra Care, asked whether it would be possible to see an aggregated list of what data sources and elements are available, then the Subgroup could look at them and check off what would be valuable. Need a standard body of data to work on.
- Diane Stollenwerk asked what data sources are universally available. Ross Owen replied that it is primarily claims data – 80 percent of the time the data elements mentioned in the homework can be found in claims data.

- Heather Petermann understand the question about what information is available regardless of payer source, but stated that the question to the Subgroup is what data are needed to make a difference in the health care of an individual. Is it transportation, is it housing, is it ESL?
- Bobbi Cordano noted that a number of gap analyses have already been done by the State (e.g., a DHS report on gaps in mental health). How should those already-identified gaps be used in the Subgroup's work?
- Diane Stollenwerk recommended including information on whether a patient is receiving care in-network or out-of-network.
- Ginelle Uhrencamp underlined the distinction between member versus aggregate reporting. She then raised the issue of consent management for members without EHRs. If members have opted out of data sharing at Health Partners, then what does that mean when they become a BCBS member?
- Kari Thurlow, LeadingAge Minnesota, noted the importance of who is in an ACO, cost opportunity, provider level, ACO level, population level, and member level. Not sure if "we" know what elements will make a difference, not sure what data is needed. Haven't figured out what the cost drivers are. Don't necessarily know what is impacting cost and quality.
- Scott Gerdes asked how to bring all of the pieces together in all of the different areas of care (medical, social, behavioral health, community, specialty)?
- Heather Petermann noted that consent management needs to be a priority item, because without it, sharing the information that will impact health and bring all of the pieces together becomes impossible.
- Bobbi Cordano stated that we have the data sources, but do we have the information to identify "who?"
- Diane Stollenwerk asked "If the goal is to ensure that organizations understand their patient mix, do they have the information needed?"

Cathy VonRueden asked if providers are capturing the data, can they find the common data element to capture that in an EHR.

Brainstorming Guiding Principles to Motivate and Guide Greater Consistency in Data Analytics Shared Across Payers and Providers

Diane Stollenwerk led the Subgroup through a brainstorming exercise to identify guiding principles, writing principles on note paper on the wall, then voting for important principles with stickers. Below are the transcribed notes from the brainstorming exercise:

Principles for Encouraging Alignment

- Without standardization (alignment) there can be no benchmarking (comparison).
- Have a shared commitment to a consent process that allows data sharing between public and private entities to allow alignment of member-level data.
- Goal of achieving health equity in Minnesota
- Coordinate data sets to all providers in the patient provider set
 - Relevant to what the provider needs
 - How it fits together
- A common methodology to attribute/ link people to providers (and ID community members not attributed) adds value
- Consent from member to share data/ consent management consistency
- Goal of achieving greater integration of care – physical, mental health and social supports through shared data.
 - Focus on an integrated social and medical person/patient data set

- Use leverage the state has to incorporate guidelines in public programs/ procedures (e.g. Managed Care Procurement)
- Encourage interoperable HIT (supports) across provider types
- Increase ability to identify health trends by geography (e.g. zipcode), creating an opportunity to collaborate to improve (achieve) Triple Aim goals.
- First identify one to three “social determinant” domains related to health care utilization (starting broadly)
 - ? What are some suggested domains?
 - o Identify where these data elements are being collected; motivate providers and others to collect them for each patient
- Collect and analyze data as far upstream (as close to the patient?) as possible
 - o But acknowledge the staffing needs to analyze the data
 - ? Where will the majority of the analysis be done? FTEs from payers, DHS/MDH, providers, third-party source (e.g. MNCM)?
- Purchasers can be effective in influencing employees (patients / family members) regarding utilization and engagement; provider incentives; plan contracting, etc.
- Guidelines must add value to purchasers, payers, providers, and others, with the goal of reducing cost/ achieving shared savings.
- Ensure data analytics is useful for all involved, providing scalability between rural and urban organizations, small and large providers.
- Ensure consistency with state and federal laws and regulations, and endeavor to coordinate where possible.

Principles for Sharing Data Analytics, To Be Applied by Anyone Engaged in Data Analytics

- Ability to match members between entities – e.g. common demographics (also an alignment principle)
- Be able to pass needed data to the providers who need it – reduce burden on patients/ members to repeat information
- Analyses should include a “geek” section with technical specs, SQL, etc. so the analysis can be reproduced for a different population – enable learning and replication.
- Articulate ethical standards for the use of data and information
 - ? Who should have access to the data?
- Recognize individual, family, social group population assumptions
- Clarify what standards should be applied for the transmission of raw data (e.g., claims from payer to provider) as well as analytics for all involved providers.
 - o Task Force should address, data analytics sharers use)
- Have applicable peer group comparisons to identify areas of improvement/ outliers in cost/utilization/quality
- Purpose of this work is to collaborate where and when it matters for people, families and communities – not just providers and payers
- Long-Term Care and Post-Acute Care is important and needs to be assumed to be part of this from the outset
- Keep a focus on transparency, and the potential use of data analytics in public reporting
 - ? What are the guiding principles around “value sharing” – will all relationships need to be gain and risk sharing? Should all relationships follow the same progression (as in MSSP)?
- Efforts should work towards more real-time exchange of data between EHR systems (think one ACO’s patient is admitted at another ACO’s hospital) and notification from hospitals to outside primary care providers

Additional comments from Subgroup members:

- Guidelines for Task Force and State – what is the business case? That will motivate the use of the deliverables.
- Guidelines and principles to someone who is engaged in providing data analytics – understanding demographic data.
- Key social determinant – are we identifying an “individual’s health” or are we recognizing that a person is part of a larger system (family) and that system impacts their health?
- Kari Thurlow noted that the AUC has done great work regarding standards in primary and acute care, but not in long term care or post-acute, home and community based care. Ross Owen stated that we need to make LTC/ post-acute care a stand-alone item to identify their importance and that they are assumed to be part of this work.

Wrap-up and Next Steps

Diane Stollenwerk and Chris Heiss, CHCS, listed next steps and asked Subgroup members for their thoughts for the report to the Task Forces at the conclusion of the second Subgroup meeting.

- Diane and Chris will consolidate the information and provide back to members for comment between now and February.
- The Subgroup indicated that they are willing to provide feedback on a couple of rounds of the documents to get them as close as possible to a final version prior to the last Phase One Subgroup meeting on February 9.
- Subgroup members commented that the work in the second meeting narrowed the scope of the work of the Subgroup, and though it is a daunting task, progress is being made.
- Ginelle Uhlenkamp reminded the Subgroup to keep scalability in mind.
- Bobbi Cordano wanted to ensure thoughts included both ACOs and ACHs (in Phase Two).
- Bobbi Cordano asked for Subgroup feedback to be consolidated when sent out, so that everyone could see the comments that others made. CHCS will provide unedited, consolidated comments as well as the edited, smoother versions for further comment.