Population Health 360
A COMPREHENSIVE LOOK

Round Table Discussion Notes

Population Health and Data Analytics

Thursday, May 16, 2019
Bristlecone 6

Round Table Facilitators

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Topic/Question	Groups Comments/Discussion
How do you define Pop Health?	• How to define this for FQHC? • Pop health is all that we do, it's about the whole organization approach • Translating vision - pop health is vision for entire model. Is it overall? Or a piece of the action?
How to use data? Get it right?	• A lot of it is knowing where to start - our system has millions of pieces of data - Quality/safety ▪ What are we doing with new type II diabetics, drilling into specific and actionable populations and quality areas? • Difficulty – what problem are we trying to solve with the data? • Risk and FFS look entirely different on the same chart • Important if you unblind the data, make sure you're showing the right analysis, right lens • Segmenting it out, what makes sense for this department, group • Analyzing effectiveness of analytics strategy
Where do you start with data?	• Basic level - how do I start this? How do I used data? Just at the very basics • We looked at cardiology service line, picked larger practice site and worked with them on redesign on primary care side, hold onto cardiology in your primary care practice, we had new head of cardiology who was interested, innovative • Fully understanding actuarial risk in your population, how do we get to the point to use data to better do that?
What questions do you have that data can answer?	• Taking on lives in the risk arrangements • What is your payor mix? • We started with small segments/pilots

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	• How big do you go? How do you know? We didn't have enough data to know where we were to move which members into risk? • Understanding your data and PL to know where your money moves when you move away from FFS • Pilot- needed clinical champion, who is the most nimble? • We needed benchmark to ourselves! Created quartile logic – let's focus on the 3-4 quartile • Fail quickly then reboot • Milliman has top-down approach to the drivers. We encourage bottom up approach, look into your population and what do they need? • What initiatives do you take on? And look at upsides and PL • Financial alignment with providers- as we generate surplus how are we going to distribute the savings? Incentives- then you can project out initiatives. Gives focus on what the rest have to do: care management, network design. Strategy planning to get everyone to line up • We ask clients what is their care management model? Many times it's not focused, coordinated • Pop health can guide these overall initiatives and focus efforts in a system-level way • Balanced look at the data – what are the high risk members? High utilization • How do you financially sustain what you're doing with data? • Having data from a planning stand point, to figure out where to start and define strategies • Start with common purpose

Challenges of getting and sharing data	• Difficulties of sharing data? Is benchmarking helpful?
	• People fight over the data, sometimes we get in trouble for sharing
	• What has been successful?
	  - Some have philosophy that everything is transparent
	  - Usually there is rumbling in the beginning but then everyone falls inline, especially if there is a strong champion of the data
	  - Restrictive data policies makes it hard to develop solutions.
	  - If we can work through PHI/HIPAA issues then we can get through the politics
	• Bringing FQHCs and other partners to the table
	• All of the data is shared
	• Data sharing and benchmarking on board and part of the vision
	• A place like Montefiore has an advantage. Has hugely integrated data.
	• Primary care group has different challenges than integrated systems. Don't have direct relationship with the hospitals, we get data through health plans, but won't give you anything.
	• Small groups – it's hard to see the data to be able to take on risk

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	• We can see where the costs are • Opportunity – can you work bilaterally with each system? • Clinical side of the problem – you want timely information to do ED initiatives, but you have to work with these data providers. Natural barriers • You end up having your own information/your own data • Nonintegrated data between systems! • Seeing data analytics as a series of small steps • It's not easy nor straightforward, but health plans are getting to the point where if they're asking for total cost of care, they have to give you the data • If we're at risk, we better get the data • If you're taking on risk, you need to know how to price it
What metrics are the most important?	• Analytics platform that frames the conversation – data used to be one-off, needs to be focused on integrated system delivery – stitched claims show the story of the encounter • Metrics within chronic disease, how useful is each metric? Meta-analysis on the data to see what works • Metrics are based on financial rather than clinical – qualities metrics are based on CMS dings and CMS payments • Commercial – what role is the clinical data point driving in the financial analytics • Our organization used to focus on preventable ED/IP. Looking at total cost of care spend to focus the data. Have to look at the return on the investment • DSRP in New York made hospitals focus on outpatient and urgent care, and moving in on FQHC, costs are in a vertical and now being pushed to other avenues. The effort of preventing readmission, is going to home care, initiatives being focused on the highest cost • What does the data tell you and what problem are you trying to solve? Not always a straight line • Hospital system has to be more than brick and mortar, emphasis should be on wellness • Physician employment contract isn't always in alignment, if the data isn't organized then it's difficult