

Data Analytics Subgroup Phase One Report

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This report was prepared by the Center for Health Care Strategies for the Minnesota Accountable Health Model / State Innovation Model – Minnesota project. The quality of the content is a testament to the substantive information provided by the members of the Data Analytics Subgroup, in addition to guidance from members of the Community Task Force, the Multi-Payer Task Force, and staff of the Minnesota Department of Health and the Department of Human Services.

Executive Summary

Minnesota has made a significant commitment to a vision of shared accountability across and among health care organizations and other service providers to improve the health of individuals and communities, increase the quality of health care, and reduce health care costs. This transformation requires a commitment to a shared vision and the willingness to work through complex issues. In that vein, the Data Analytics Subgroup, formed to advise the two Task Forces for the Minnesota Accountable Health Model – SIM project, has completed initial work on the “what, why, and how” of aligning data analytics among organizations throughout Minnesota.

The advice contained in this report is a solid start on the path toward creating greater consistency in the analyzed information that is shared with and among health care and other service providers. In the process of discussing possible approaches to answer the questions posed by the Task Forces, the Subgroup clarified key assumptions, set forth definitions for key terms, and identified several philosophical considerations and practical issues, some of which require deeper consideration in the short term and others over the long run. They believe that these insights will support the ability to take the following items contained in this report and use them to achieve increased alignment in high priority areas:

- Guiding Principles
- High Priority Data Analytic Components to Align
- Suggestions for Standardization
- User Guide Outline to Support Understanding and Use of the Data Analytics
- Suggested Approach for Identifying Best Practices

The Subgroup encourages a continued commitment to working through the details of this important arena where greater coordination and collaboration is needed. They are interested in learning how this report is received and what actions will be taken next to continue on this journey toward alignment to achieve the Triple Aim.

Data Analytics Subgroup Background

Purpose and Charge

To better understand how data are being used by payers and providers to improve the management of populations involved in Integrated Health Partnerships in Minnesota, staff for the State of Minnesota's State Innovation Model / Accountable Health Model project (MN SIM / AHM) conducted a survey in the Spring of 2014. The survey asked payers involved in the MN SIM Multi-Payer Alignment Task Force (MPTF) about the types of data (e.g., analyzed information, raw files) shared with providers participating in Total Cost of Care (TCOC) or shared savings arrangements. In addition, in May 2014, the MPTF and the Community Advisory Task Force (CATF) participated in a joint meeting where providers shared their perspectives on the data they receive from payers. During the provider presentations, the Task Forces learned of a wide variability in familiarity among providers involved in Integrated Health Partnerships in Minnesota regarding the data available from payers. Some providers commented that they received too much data and were unable to incorporate it meaningfully into their practice, while others were unaware that they received any data from the payers. In subsequent conversations, members of the MPTF and the CATF discussed ways in which MN SIM / AHM could help create an environment for the transfer of data between organizations that engages all parties and supports momentum toward shared accountability for health outcomes and addressing the Triple Aim.

Out of these conversations the idea was born to create the Data Analytics Subgroup, an advisory group to the MN SIM / AHM Community Advisory Task Force and Multi-Payer Alignment Task Force. The Subgroup's purpose would be to advise the Task Forces through activities that include "develop recommendations and identify top-priority data analytic elements, to motivate and guide greater consistency in data sharing among organizations involved in Accountable Care Organization (ACO) models to support shared accountability for cost and health outcomes." As originally envisioned, the Subgroup's work would be conducted in two (potentially overlapping) phases. Phase One would focus on alignment that can take place within the current health care environment, focusing on the Integrated Health Partnerships and other models that involve shared accountability (e.g., ACOs), given current data availability, infrastructure, and analysis skills and staffing. In Phase Two, the work would broaden to include alignment of data analytic elements not yet widely available or technically possible currently, but that are essential for future work, particularly within Accountable Communities for Health. Examples of such data analytic elements might include those that address social or environmental determinants of health such housing status, transportation needs, and education levels.

Questions That Drove the Subgroup Deliverables

With assistance of the Center for Health Care Strategies, a Charter for the Subgroup (see Attachment 1) was developed following the May meeting and presented for discussion at the July meetings of the Task Forces. The deliverables listed in the Charter were developed with the following questions in mind:

- What are the guiding principles for sharing data and analytics among payers and providers and among different health care and social services providers?
- What are the recommended guidelines for high priority data analytics structure, content, and access needed for those participating in an ACO?

- What are the key elements of data, shared among payers and providers, where consistency (content, data sources, etc.) is most useful?
- How can self-insured employer plans be included in the effort to create consistency across data analytics used to inform support population management (i.e., data analytics shared between self-insured payers / TPAs and providers)?
- What are the barriers and potential solutions for providing consistent and useful data analytics? Example categories include: regulatory, technological, staffing and/or analytic skills, financial, competitive dynamics, etc.

Membership

After the Task Forces' approval of the Charter at their July meetings, an informal nomination process was opened then concluded at the end of August 2014. Out of that process, the following members were selected for Subgroup Phase One, providing a mix of representation from payers, providers, and social service organizations:

- Scott Gerdes, Chief Financial Officer, Zumbro Valley Mental Health Center
- Stacey Guggisberg, Director of PrimeWest Provider Services and Director of ARCH, PrimeWest/ARCH
- Rahul Koranne, Vice President, HealthEast Community Services (Subgroup Chair)¹
- David Maddox, Data Quality Analyst, CentraCare
- Ross Owen, Deputy Director, Hennepin Health
- Elizabeth Smith, Vice President of Medical Operations for Clinics, Allina
- Eric Taylor, Head of Data Department, Bluestone Physician Services
- Cathy VonRueden, Vice President of Contracting & Strategy, Essentia Health
- Alvaro Sanchez, Assistant Medical Director, UCare
- Ginelle Uhlenkamp, Director of Analysis, Health Care Cost & Quality, Blue Cross Blue Shield of Minnesota
- Bobbi Cordano, Vice President, the Wilder Foundation
- Mónica María Hurtado, Voices for Racial Justice
- George Klauser, Lutheran Social Services of Minnesota
- Kari Thurlow, LeadingAge Minnesota

Nearly every member attended all three of the in-person Subgroup meetings and contributed substantive content and comments regarding the detailed work completed between each meeting.

¹ Dr. Koranne is now Medical Director at the Minnesota Hospital Association

Insights from the Subgroup Discussions

The following section describes a series of important ideas that arose during the Subgroup's in-depth discussions as they shaped the deliverables as required under the Subgroup Charter. As with many complex issues, the Subgroup found that certain concepts needed to be clarified in the process of addressing the original tasks as outlined in the Charter. They also identified areas that will need further attention, both in the near-term and over the long run, in order for 'alignment in data analytics to support shared accountability and improved Triple Aim outcomes' to become a reality.

Meeting Progression

The Subgroup members listed earlier in this report each made substantive contributions to this work. In addition, Dr. Rahul Koranne led the process by providing guidance on the materials, and leading each meeting to guide the discussion, encourage participation by all members, and ensure that the time was as productive as possible to achieve the goals set forth in the Charter. Representatives from the Center for Health Care Strategies facilitated each meeting, developed meeting materials, and incorporated insights from the Subgroup discussions and comments on the 'homework' between each meeting. Throughout the process, staff from the Minnesota Department of Health Services and Department of Health provided direction to ensure that the advice from the Subgroup would provide value to the overall Minnesota Accountable Health Model and meet the specific needs of the Community Advisory Task Force and the Multi-Payer Alignment Task Force.

The Subgroup was extremely productive in a short period of time. They stayed engaged through three in person meetings and by providing feedback on substantive 'homework' between each meeting.

1. **Meeting #1 (November 2014):** The initial meeting included a basic orientation to the Subgroup tasks. Representatives from Minnesota Community Measurement, the Institute for Clinical Systems Improvement (ICSI) and the State Health Access Data Assistance Center (SHADAC) spoke to the Subgroup about how their current work can inform the Subgroup deliberations and offered advice based on their experience. The Subgroup then brainstormed ideas regarding the range of data analytic topics that are essential for effective approaches to shared accountability for improving health care quality, affordability, and individual and community health outcomes. In the process, the Subgroup also began to identify related issues that would require further consideration, either by the Subgroup itself or some other means.
 - **Homework (November 2014):** The brainstormed ideas from the first meeting were structured into an initial framework that would ensure that each potential data analytic component to be aligned would be assessed within a practical context. That is, the framework was a deliberate attempt by the Subgroup to show the value proposition for aligning any given data analytic component. The framework shows the overall category, the primary questions the data analytic component would answer or inform, who would use the data analytic component, the likely data sources, whether it should occur in Phase One or Phase Two, and any other important considerations. Using the content from their first discussion, Subgroup members refined the structure, combined ideas that belonged together, began to add missing information, and raised additional questions for consideration by the Subgroup.

2. **Meeting #2 (December 2014):** The Subgroup began to identify the Guiding Principles that should be a part of aligning and sharing data analytics (see Attachment 2). They also discussed shared definitions for key terms, an issue that arose during the first round of homework, then refined the definitions to ensure that everyone had the same understanding (see Attachment 3). The bulk of the meeting was spent discussing the next draft of the chart that now reflected the full range of data analytic component ideas from their brainstorming and content provided during the homework (see Attachment 4). They began to consider areas in which standardization might be needed as a precursor to enable alignment of data analytics (see Attachment 5). Throughout the discussion, as ideas arose that could inform the content of the User Guide outline and the possible approach to identifying best practices, the concepts were captured for inclusion in drafts that would be sent in the next round of homework.
 - **Homework (January 2015):** The Subgroup received a robust set of materials that reflected their guidance during the second meeting: a refined version of the data analytics chart, list of potential areas for standardization, a first draft of the guiding principles, and the agreed-upon set of definitions. They also received first drafts of a potential outline for a User Guide, and the suggested approach for identifying best practices. The Subgroup provided comments on each item, with particular focus on grouping the data analytic components into Phase One and Phase Two, and prioritizing the data analytic components. Many members identified potential barriers to success and noted issues about which they had practical or philosophical concerns.
3. **Meeting #3 (February 2015):** The third meeting of the Subgroup focused on reviewing the changes in the deliverables based on the feedback during the previous meeting and extensive homework contributions made by nearly all of the members of the Subgroup. The Subgroup discussed the resulting prioritization of the data analytic components and, based on the need to be as practical as possible while also making progress toward alignment, agreed that certain elements should be addressed in a later phase. They discussed each of the deliverables and offered further refinements, each of which have been incorporated into the versions in this report (see Attachments 2-7).

Overview of Subgroup Observations and Advice

The Subgroup agreed that wherever possible, alignment is needed to improve coordination across providers and others involved in shared accountability arrangements, and reduce duplication or inefficiencies. At the same time, they do not want to stifle innovation that results in improved care, greater affordability, and better health for individuals and across the entire community.

Balance. The Subgroup was able to reach agreement on a solid starting place for where they see the greatest value in aligned data analytics. They recognized that it is important yet challenging to find the right balance between the guidance from the Community Advisory Task Force and the Multi-Payer Alignment Task Force, meeting the needs of the community and the business needs of individual organizations. This report describes a strong foundation to start the process of aligning data analytics, but the work is complex. The Subgroup agreed that a clear commitment is needed to keep this work going, because there is much more to be done to achieve the kind of value-based alignment that is needed.

Scalability. The Subgroup attempted to keep in mind that scalability is needed, so that the number of groups who are aligned will grow over time. An important consideration is the variety of types of providers. Within each type, there is a wide range of levels of skill and ability to interpret and apply data analytics to make more informed decisions that result in better care, greater affordability and healthier people. No less important is the consideration that some providers lack the financial and staff resources to be able to use the data analytics to improve their practice processes and outcomes.

Member-level Information. The Subgroup advises that collecting and providing analyzed data at the member level is essential to ensure that, over time, the data analytics can be used to guide specific actions that improve individual care and outcomes. Over the longer term, this will also enable the analyzed data to be matched with data from public health and alternate sources to identify needs and inform decisions that address individual needs that are driven by social and environmental determinants of health, such as housing and transportation.

Clarity About Next Steps. The Subgroup approached this work with the understanding that this is the beginning of a process to motivate and encourage alignment of data analytics throughout Minnesota. They advise that the Task Forces should clearly recommend what should happen with the advice in this report. Ideas include identifying how the State can incorporate it into opportunities created by the SIM grant (e.g., incentives, funding, contracting, evaluation), in addition to suggesting ways in which CMS or others could use this information in their own work, either within Minnesota or as a model for others around the country. Finally, the Subgroup would like to see the State, payers and providers lead by example in using this information, which will pave the way for others to choose to align their data analytics work too.

Assumptions

The content of this report reflects key assumptions made by the Subgroup:

- **Phase One Scope.** This report covers Phase One, which was assumed by the Subgroup to mean what can feasibly be done in the current environment. They focused on the data analytics provided by and within ACOs, which includes post-acute and long term care, but does not include 'waivered services' such as Long Term Services and Support.
- **Advice for Use by Task Forces and Others.** This report is advice intended to inform recommendations that can be made to the State by the Community Advisory Task Force and Multi-Payer Alignment Task Force regarding high priority areas in which to align data analytics. The Subgroup assumed that any effort to align will be voluntary and could be initiated by public or private sector organizations. Greater alignment can also be motivated by organizations choosing to use incentives or including data analytic expectations in contract negotiations and agreements.
- **Trust.** To be successful in supporting organizations to choose to align their approaches to data analytics, and to motivate others to use the data analytics, trust is essential. An important way to establish and maintain trust is to be as transparent as possible regarding how the data analytics are developed.

- **Sustainability.** Alignment in data analytics is more likely to be sustained if the changes are built into the infrastructure used to collect and assess data, and then share the analyzed information.
- **Stepwise Approach.** Even within Phase One, more work needs to be done before the suggested data analytic elements can be used for alignment. Examples of these additional steps are explained in greater depth in the standardization section of this report.
- **Additional Work is Needed.** Continuing into and through Phase Two is important, as there are many areas of data analytics that need to be aligned but the environment is not yet ready. This includes widespread, standardized collection and use of data on race, ethnicity and language and other cultural issues that are important for patient-centered care.

Need for Standardization in Certain Areas

The Subgroup advises that even within Phase One certain actions are needed before the suggested data analytic elements can be used in a consistent, aligned manner. After some discussion, the Subgroup arrived at this conclusion after recognizing that provider groups who work with more than one health plan or ACO need to be able to combine or aggregate data analytics provided by different organizations in order to get a complete picture of their practice. Ensuring that data analytics have a basic level of standardization will also reduce the cost and time (“hassle factor”) for providers receiving the different data analytic reports. It will also increase the likelihood that data analytic reports will be understood and used. All in all, the Subgroup advises that taking a standard approach in certain aspects of the data analytics will reduce wasted time and effort, and reduce the likelihood of missed opportunities to improve care, affordability and health outcomes.

At the most basic level, organizations that are willing to alter their approaches to align with others need to know what to align *around*. This might be as fundamental as determining the standard formats (e.g., .csv or comma delimited text files), plus names and definitions for key variables that should be included in certain types of data analytic reports.

The Subgroup was very careful to recognize the tradeoff between the value of taking a consistent approach and the value of innovation that can benefit individual patients or members. Sometimes the variation is needed to recognize market differences, while accommodating organizations that use data analytics to create a competitive advantage.

Advice from the Subgroup is to encourage organizations to standardize their approach to data analytics in certain basic areas. At the same time, the Subgroup suggests that there are other areas in which some level of standardization could be extremely valuable, but more work is needed to determine the best approach, given the complexity of the topic, market variation and other considerations. The Subgroup also discussed several other ideas and determined that further consideration is needed for those topics as part of the work in Phase Two. For more information about needed standardization work in Phase One, see the next section which describes the deliverable found in Attachment 5.

Preconditions for Success, or Barriers to Overcome

Staying focused on practical issues to the degree possible, the Subgroup recognized that there are barriers to alignment that can be addressed in the immediate next steps, should the Task Forces recommend such action. These “preconditions for success” are:

- As mentioned earlier, some of the data analytic approaches will require more definition before organizations will know what it is they are being asked to align around. Depending on the type of data analytic component, that might be a prototype template to follow or a list of data analytic elements, or specific names and definitions for key variables.
- Depending on the specifics, some of the data analytic elements in each component may require member consent before the analyzed data can be shared. It will be important to identify which of these elements requires such consent, and then determine how the member consent process will be managed.
- The implementation activities needed to align current data analytic approaches using legacy systems will require time and striking the right balance between the urgency to realize the potential value with the reality of what is required to change processes within organizations.

Considerations Specific to Each Deliverable

The expected deliverables of the Data Analytics Subgroup are described in the Subgroup charter, but the Task Forces provided leeway in the deliverable specifications to allow the Subgroup to exert ownership over the products in process, form and content. As a result, conversations among Subgroup members and the facilitation team served to further refine what could and would be delivered through this report. The process for arriving at the deliverables as contained in this report are described below.

Guiding Principles

To develop the list of guiding principles for data analytics, the Subgroup participated in a facilitated brainstorming session at the December meeting. They identified key principles associated with the concepts of (1) encouraging alignment between organizations in the type of data shared; and (2) conceptualizing the process of sharing data analytics. Subgroup members then voted using stickers to indicate the greatest areas of interest. Of note, the format for these guiding principles was loosely based on the Health Care Home Payment Methodology Principles developed by the State in 2009, informed by a task force in which the Subgroup’s chair, Rahul Koranne, had participated. Subgroup members came up with principles that would be applicable to both Phase One and Phase Two of the Data Analytics work.

After collecting the principles provided by the Subgroup members, CHCS combined and worked with the Subgroup to refine the list to a set of five key principles, designated as the highest importance by the Subgroup while also speaking to each of the Triple Aim goals. The Subgroup members reviewed this list again between the December and February meetings, and provided final input during their third meeting.

Definition of Key Terms

The Subgroup members realized that they needed a set of clearly defined common terms to ensure that everyone shared the same understanding of the concepts being discussed. These terms and the definitions, agreed upon by Subgroup members, is in Attachment 3.

Prioritized Data Analytic Components with Data Sources

After brainstorming a range of categories of data that are or should be shared among organizations in shared accountability arrangements seeking to manage the health of a population, the Subgroup discussed the importance of focusing on data analytics that offer practical value. The resulting concepts became the framework used to identify the Phase One data analytic components and the associated data sources. This framework included: 1) the purpose and goal of sharing proposed data analytics components; 2) the opportunity for these components to add value to the Minnesota health care environment; 3) questions that the data analytic components could help ask or answer; 4) data sources; and 5) which organizations or stakeholders should use the components. The Subgroup wanted to ensure that the set of data analytic components address all three Triple Aim goal. They also offered observations about implementation considerations, which are included in the notes.

Subgroup members prioritized Phase One data analytic components that have the most direct impact on management of care for subpopulations within existing Integrated Health Partnerships and other accountable care arrangements in Minnesota. Members also prioritized the data analytic elements that will be crucial to management of broader populations through Minnesota's Accountable Communities for Health. Combining these two perspectives resulted in the prioritized list of five high priority Phase One elements, and six elements to consider in Phase Two (see Attachment 4).

Suggestions for Standardization

When discussing implementation issues, the Subgroup reached agreement with the observation that in order to align, organizations will need to take a standardized approach in certain areas. Examples include defining certain terms the same way, and using the same timeframes for data analytic reports. If there is divergence in approaches, not only will this undermine the alignment of data analytics, it will also prevent providers from combining certain data analytic reports from different payers to create a more complete understanding of their patient population. The Subgroup advises that standardization be addressed in at least three waves: items that require attention right away; items that require further discussion to enable near-time attention; and, items that should be considered for possible future standardization (see Attachment 5).

Outline for a User Guide

Organizations that use data analytics in Accountable Care Organizations or Accountable Communities for Health initiatives must have access to the data analytics, be able to understand the data analytic information, and have the skills to use it to support the Triple Aim. For this to happen, the Subgroup advises that health care and social service professions who generate and share data analytics with other organizations should provide guidance to the users of the data analytics through a User Guide. While not wanting to create an undue burden on the organizations that produce data analytics, such User Guides will help ensure that those receiving data analytics trust the information, know how to interpret it, and can see how to use the analytics to improve patient care and outcomes, health outcomes, cost and quality.

The User Guide elements were framed by the set of guiding principles suggested by the Subgroup (see Attachment 2). An outline of suggested elements for a comprehensive User Guide is in Attachment 6.

Approach for Compiling Best Practices

The Subgroup’s Charter requests that the Subgroup “provide a suggested list of best practices in data sharing, or an approach for how to compile that list, as a resource for organizations engaging in new ACO development.” In examining this charge, the Subgroup did not feel ready to identify best practices in Phase One, and felt that proposing a framework for collection of best practices would be more useful at this stage. Drawing upon Subgroup discussions and Eugene Bardach’s framework for developing best practices, CHCS drafted a framework and provided it to the Subgroup for feedback between the December and February meetings.

The framework in Attachment 7 represents one possible approach, but many different frameworks could be used depending on the intended audience and goals of the organization for which the best practices are intended. As discussed at its February meeting, the Subgroup suggests more work in this area, to identify the group(s) that engage in the best practices, and who will collect this information. Aggregated information could benefit a range of organizations, and would also benefit from periodic re-examination as organizations become more adept with data analytics. Other considerations include the methods that could be used to compile best practices on a statewide basis and where that information could or should be housed so that it is widely available.

Conclusion and Next Steps

The transformation of the health care system in Minnesota to improve care, affordability and health status is no small endeavor. It requires a commitment to the larger vision of shared accountability across communities, and the willingness and ability to work through the challenging, complex details. The advice from the Data Analytics Subgroup contained in this report is a strong step in building the foundation for more effective information sharing by health plans and other payers, and improved understanding to inform decision-making by the health care professional and other service providers.

The Subgroup collectively stated a strong interest in learning how the Community Task Force and Multi-Payer Task Force receive the advice in this report and the degree to which the Task Forces carry the advice forward as recommendations to the State and others involved in the Minnesota Accountable Health Model – SIM program. In addition, several of the members of the Subgroup expressed desire to continue in their role on the Subgroup, working on the crucial next steps to encourage and motivate alignment in data analytics across organizations throughout Minnesota.

Deliverables

Attachment 1: Data Analytics Subgroup Charter

Purpose of the Data Analytics Subgroup:

Develop recommendations and identify top-priority data analytic elements, to motivate and guide greater consistency in data sharing among organizations involved in Accountable Care Organization (ACO) models to support shared accountability for cost and health outcomes.

The approach to the Data Analytics Subgroup will have two phases:

- **Phase One:** Subgroup will address what can be done now, given current data availability, infrastructure, and analysis skills and staffing. The current context for providers and their patients in an ACO arrangement will be the driving consideration.
- **Phase Two:** Subgroup will address what is essential for effective shared accountability but not possible in the current environment. This should include consideration of data elements that may be required to pave a path to the future (e.g., fully operational Accountable Communities for Health), such as social determinants of health, housing data, etc.

PHASE ONE:

Charge to the Data Analytics Subgroup:

- **Guiding Principles** - Create guidelines and principles to motivate and guide greater consistency across the data analytics shared among public and private purchasers, health plans, other payers (e.g., TPAs), and providers in order to support shared accountability for improving quality, cost, health outcomes and consumer experience.
- **Prioritized Data Components** - Provide recommendations to the Multi-Payer Alignment Task Force and the Community Advisory Task Force on a set of common data analytic elements that should be consistently provided by and/or made available to payers, providers and other stakeholders involved in shared accountability arrangements.
- **Data Sources** - Identify the source of each common data element that is recommended, selecting the most appropriate source if multiple sources of the data are available.
- **Best Practices** - Provide a suggested list of best practices in data sharing, or an approach for how to compile that list, as a resource for organizations engaging in new ACO development.
- **User Guide** - Develop an outline for a data analytics user guide that includes descriptions of how the data analytics were developed (e.g., measurements, methodology), plus data definitions, formats, and sources.

Composition and Frequency of Data Analytics Subgroup Meetings:

- The subgroup will consist of 8-12 members, drawn from a subset of the Multi-Payer Alignment Task Force and the Community Advisory Task Force, plus State staff, and others who have relevant expertise.
- Subgroup members will be chosen to ensure a diversity of perspectives, with emphasis on providers in prioritized settings, existing public-private data collaboratives, and employer-sponsored health insurance.
- The subgroup will meet three times, concluding by February 2015.

Sample Questions the Data Analytics Subgroup will address:

- What are the guiding principles for sharing data and analytics among payers and providers and among different health care and social services providers?
- What are the recommended guidelines for high priority data analytics structure, content, and access needed for those participating in an ACO?
- What are the key elements of data, shared among payers and providers, where consistency (content, data sources, etc.) is most useful?
- How can self-insured employer plans be included in the effort to create consistency across data analytics used to inform support population management (i.e., data analytics shared between self-insured payers / TPAs and providers)?
- What are the barriers and potential solutions for providing consistent and useful data analytics? Example categories include: regulatory, technological, staffing and/or analytic skills, financial, competitive dynamics, etc.

PHASE TWO:

The following parameters will be defined after the Multi-payer Alignment Task Force and the Community Task Force consider the Phase One Subgroup recommendations:

- Charge to the Data Analytics Subgroup
- Composition and Frequency of Data Analytics Subgroup Meetings
- Sample Questions the Data Analytics Subgroup will Address

Note: The effort to promote consistency in approaches to Data Analytics is:

- Not about providing real-time data about an individual patient to support the direct clinical care of that individual patient.
- Not about quality assessment, cost or any other data intended for public reporting.

Attachment 2: Guiding Principles

1. The State of Minnesota and other payers, purchasers and providers should “lead by example,” placing top priority on alignment, consistency, and sharing of data on physical health, behavioral health (including mental health and substance abuse disorders), and social factors to achieve greater integration of care and better management of populations (including the use of comparison groups) across health organizations. Entities should encourage such alignment through contracting, regulatory authority, or other means, while acknowledging the need for unique approaches when necessary.
2. Payers, providers, and other stakeholders should be able to tailor systems of data collection and analysis to accommodate the range of care settings in Minnesota (e.g., urban to rural, large integrated organizations to individual providers) and to align with the various health information technology structures across Minnesota.
3. Systems should build upon existing data integration efforts, reducing parallel data collection and maximizing the use of common technology and process platforms (including consent management).
4. Data analytics should support the Triple Aim, including a wide range of demographic data (e.g., race, ethnicity, language, and tribal affiliation, both existing and under development) to foster organizational collaboration across geographic and demographic boundaries.
5. When looking to change existing approaches to data analytics, each organization should strive to achieve an appropriate balance between the benefits of the new system to achieving the Triple Aim for the community large and the costs of new system development, maintenance, and staffing.

Attachment 3: Definition of Terms

Term	Definition	Example(s)
Raw data	Single units of data, typically aggregated into data sources held and managed by health plans and other payers and providers.	<ul style="list-style-type: none"> • Patient name • Date of birth • Diagnosis code • Treatment location • Provider name
Data source	A place where raw data is routinely stored and can be retrieved	<ul style="list-style-type: none"> • Claims data in health plan, payer or providers systems • Clinical data in electronic medical records, charts • Public health data in public health agency systems or hospital community health needs assessments
Data analysis	Process of turning raw data into information from which to derive meaning or insight. Payers or others who have direct access to relevant data source conduct such analyses.	
Data analytic element (or component)	Any piece of analyzed data that gives insight to improving one or more parts of the Triple Aim (quality, affordability, and/or patient or population health)	<ul style="list-style-type: none"> • Demographic mix of a panel of patients or members; • Risk of a panel of patients for needing hospitalization in upcoming year
Common data analytic elements	Subset of data analytic elements that should be consistently provided by and/or made available to payers, providers and others involved in shared accountability arrangements	<i>See attachment 4 for Phase One recommendations</i>

Term	Definition	Example(s)
Data sharing	Practice of making data analytics (or sometimes raw data) available to other organizations involved in an ACO or other arrangement to support shared accountability for cost, quality and health outcomes	
Descriptive information about the data analytics	Information that describes the data analytic element or component.	<ul style="list-style-type: none"> • Definitions of terms used • Timeframe of the data used • How to use this component to improve cost, care or health status

Attachment 4: Prioritized Data Analytic Components, with Data Sources

Phase One/ High Priority Elements

1. Contact Information, and Identified Primary Care Provider

Data analytic element²: Accurate and up-to-date contact information (full name*, DOB*, address*, phone number, health plan); Information about primary care provider (by payer)

Purpose and Goal: Find the people: Know the ACO / ACH population you need to manage (descriptive information) *TO* Improve population health; Improve the patient experience of care; Lower the total cost of care.

Addresses the Triple Aim Goals of Better Care, Better Health, and Lower Costs

Opportunity to add value: Establishing a relationship with primary care and care coordination. Ability to identify people who aren't receiving needed care.

Questions to ask or answer: How do I locate the patients in my population who are at high risk but are disconnected from care? Who are the people the ACO is responsible for managing?

Data sources: Health plan (including Medicaid) enrollment data; electronic health record; social services data as possible

Who Should Use This Data Element? Providers, Caregivers, Health Plans, Payers, ACO (Phase2: ACH)

Subgroup Notes: This is a foundational building block of an ACO. Basic contact information is a barrier for socially complex populations. The problem has worsened with MNSure's inability to process "life changes"; System-wide success in accountable care means expanding beyond attributed populations already in primary care. Need broader conception of risk for the health of a population.

2. Health Status and Risk Level

Data analytic element²: Risk level of different sub-populations of patients (patient mix grouped by risk level*); Diagnoses; Current spend* / cost; Primary care utilization

Purpose and Goal: Understand health status and risk level (predictive analysis) *TO* Improve quality; Improve population health; Lower the total cost of care

Addresses the Triple Aim Goals of Better Care, Better Health, and Lower Costs

² Must-have data elements indicated with an asterisk (*)

Opportunity to add value: Reduce cost; Reduce avoidable hospital admissions and ED visits; Increase preventive care; Avoid unnecessary care (duplication); Focus spending in right setting

Questions to ask or answer: Who in my ACO population is currently healthy and/or at risk for being unhealthy? Who are my highest risk patients / individuals / members? (Population Health Stratification) Are patients getting necessary care? Who do I have to enroll in care coordination? Who do I have to outreach to with gaps in care?

Data sources: Claims data from CMS, DHS, Health Plans & PBM's; Clinical Data

Who Should Use This Data Element? Providers, Caregivers, Health Plans, Payers, ACO (Phase2: ACH)

Subgroup Notes: Must include ability to identify individual patients for interventions; must include cost related information. How to target the population to focus on? Often missing is more longitudinal data across payers. How to coordinate this data across the provider network? Will there be a common risk grouper or Identification/ Stratification process?

3. Total Cost of Care

Data analytic element²: Medical cost, Hospital IP and ED, PAC (SNF, HH, AL, Behavioral Health), Pharmacy, Specialty MD, PCP, OP/ASC, Laboratory, Radiology

Purpose and Goal: Assess high cost areas *TO* Lower the total cost of care

Addresses the Triple Aim Goal of Lower Costs

Opportunity to add value: Understand cost trends, performance for overall medical spending; Improve service delivery efficiency

Questions to ask or answer: What does it cost (TCOC, episode) for an attributed population? Are overall costs for specific services increasing or decreasing? What services are the high cost drivers?

Data sources: Claims data from CMS, DHS, Health Plans & PBM's

Who Should Use This Data Element? Providers, health plans, payers, finance, ACOs, (Phase2: ACH)

Subgroup Notes: Should the content, definitions, timing, etc. for these data elements be standardized? Will a common grouper be utilized to define an episode?

4. Health Status, Grouped by Demographics

Data analytic element²: Health status indicators, stratified by demographic characteristic; Patient sub-populations, grouped by demographic characteristic.

Purpose and Goal: Understand demographics *TO* Improve individual health; Improve population health

Addresses the Triple Aim Goals of Better Care and Better Health

Opportunity to add value: Reduce disparities; Identify high risk patients; Build trust to engage patients; Identify gaps in care in populations

Questions to ask or answer: What are the demographic characteristics of my patients / ACO members? (race, ethnicity, primary language, LGBT, disabilities, etc.)

Data sources: Health plan (including Medicaid) enrollment data; Claims data from CMS, DHS, Health Plans & PBM's; Clinical data

Who Should Use This Data Element? Providers, ACO leaders, Payers

Subgroup Notes: Need to be able to collect key demographic data for each individual; Determines resources and tools needed in ACO for management. Need common identifiers (providers may have Managed Care Organization identifier vs Medical Assistance identifier).

5. Patterns of Care Within and Outside of ACO Providers

Data analytic element²: Patterns of care within and outside of the ACO providers (utilization and cost), including: frequency of insurance shifts, number of outside providers engaged in patient care (by location and/or specialty), profile of patients seeking outside care

Purpose and Goal: Assess care coordination TO Improve population health; Lower the total cost of care; Improve quality

Addresses the Triple Aim Goals of Better Care and Lower Costs

Opportunity to add value: Determine effectiveness of the ACO; Improve care coordination; Improve patient engagement

Questions to ask or answer: How much care and what type of care is being provided to our patients by providers outside of our ACO (or other parent system)? How do we keep our people in our own ACO? How can we support an open structure for people who shift insurance often? Who is inside and who is outside for providers?

Data sources: Claims data from CMS, DHS, Health Plans & PBM's; Clinical Data

Who Should Use This Data Element? Providers, health plans, payers, ACOs

Subgroup Notes: Who is responsible for patients seeking care inside and outside of the ACO? Should the content, definitions, timing, etc. for this be standardized?

Phase Two Elements

#	DATA ANALYTIC ELEMENT (Must-haves indicated with *)	PURPOSE and GOAL	OPPORTUNITY TO ADD VALUE	QUESTIONS TO ASK OR ANSWER	DATA SOURCE(S)	Who Should Use This Data Element?	Better Care (Quality)	Better Health	Lower Costs	NOTES
6	Health outcomes / results for key metrics such as: medication adherence; generic drug fill rates; end of life (hospice use, palliative care use, existence of an advance directive); 30 day readmissions and 30 day ED use; avoidable admissions; non-evidence based interventions (Choosing wisely, imaging, Cancer drugs in last 3 days of life, etc), mental health/ substance abuse outcomes	Assess quality of care (retrospective analysis) TO Determine gaps in care quality and/or avoidable cost	Identify best practices, opportunity to improve	How well does my population meet standard metrics (i.e. ICSI, MNMCM)?	Payers, Clinical providers, Medical records	Providers, health plans, payers	X	X	X	Should content, definitions, timing, etc. for these data elements be standardized? Are different metrics needed by different providers? Use quality results from existing groups (eg ICSI, MNMCM), but what about providers for whom there are no standard metrics and scores generated? How to simplify measures so they are more widely available and used? Prep in Phase 1
7	Cost and Utilization; Clinical Outcomes Data	Determine high performing providers TO Improve quality and efficiency of care	Improve care/cost with best providers, Drive care to the most efficient and highest quality providers	Who are the best providers I should be referring my patients to? Who can I learn best practices from? Based on cost and quality, who are the high performing providers to refer to?	Claims data from CMS, DHS, Health Plans & PBM's; Clinical Data	Providers, health plans, payers, ACOs	X	X	X	"Best" Providers will need a common definition, Risk Adjusted TCOC, MNMCM, HEDIS Prep in Phase 1
8	Culturally specific and culture-specific data, housing, ethnicity, income, employment, language, family support	Understand demographics and social determinants TO Improve population health by culture and socio-economics	Define what is unique about the socio-economic status and culture as to target the specific needs	How do we know who is healthy in a culture as defined by that culture? How can an ACO improve health status based on this information?	Health plans, Social service agencies, Provider-collected data	Providers, ACO leaders	X	X		How do we dig into cultures to define how they value health? This work is crucial but very hard to do. (phase score 1.85)- prep in Phase 1
9	Most prevalent domains of need in the key social, environmental or behavioral determinants of health; Identify the intersection of these needs and high medical cost risk	Understand impact of unmet needs in social, environmental and behavioral determinants of health TO Improve population health; Improve patient experience; reduce total cost of health care	Develop social service interventions that clearly impact health care utilization and improve health	What are the key social and behavioral domains impacting a population? (e.g. housing, social support/family, employment, criminal justice involvement, transportation, etc.)	Assessments at intake or point of care; Multiple separate existing data sources outside of health care, often administered by DHS or counties	Providers, Payers, ACOs		X	X	Predicated on belief that interventions produce health care ROI; Assessment would be most useful the further upstream and more universally it is collected (e.g. MA eligibility assessment); Given the scope, need to prioritize 1-3 domains/ measures based on known impact on health care utilization and availability of data Prep in Phase 1
10	Cost and utilization at the ACO level	Improve financial performance TO Identify best practices and motivate improvement	Benchmarking and comparison to identify best practices. Improve stability of the ACO. Identify outlier areas to focus improvement.	How do ACO populations compare? How is my ACO performing compared to contract, peer group, other benchmarks? What areas in my ACO are an outlier?	Claims data from CMS, DHS, Health Plans & PBM's	Providers, health plans, payers, ACOs	X		X	How will ACO/ACH performance be compared for TCOC (metro or state average?), Medicare or National Medicaid benchmark? Need consistency re: what is in TCOC – for Medicaid this includes LTC funding yet few ACOs feel equipped yet to impact
11	Risk/Reward and financial metrics for incentivizing the providers	Ensure providers know about their incentives to achieve better outcomes TO Create financial incentives for performance	Achieve better outcomes through motivation and reward for staff	How do you define success and improvement by area especially for those clients that have co-morbid conditions	Defined clinical outcomes	Providers, health plans	X	X	X	Share information relevant to each provider. Does this require, customized analytics and financial models? Is this more of an attribution standardization issue rather than a separate data element?

Attachment 5: Suggestions for Standardization

Consensus Suggestions for Standardization

1. **Standardize measurement and reporting periods** by Calendar Year and Calendar Quarters for all arrangements.

Opportunity to Add Value: Enables comparison of the 'same' data analytic elements from different payers / ACOs. Contributes to the ability to combine files from different sources.

Goal: Improve usefulness and usability of data analytics.

Subgroup Notes: The concept of “claims run-out” is also important when determining the relationship between measurement and reporting periods, as how close to the time of data sharing the service dates occurred may affect the accuracy of the data shared. Determining how close the time of aggregated data sharing and service dates can be is dependent on tools used for data aggregation and resources.

2. **Consistent formatting** for data sets and reports (e.g., granular data sets using standard file types such as SAS or .csv, standard names for variables).

Opportunity to Add Value: Contributes to the ability to combine files from different sources, simplify reporting and reduce administrative costs for providers.

Goal: Improve usefulness and usability of data analytics.

Guiding Questions: Does each assessment of clinical outcome mean the same across the board? How do we use clinical data consistently across all providers internally or externally of an ACO? How do all professional EP's define an outcome?

Subgroup Notes: Consistent formatting is particularly important in places where there is a shortage of Health Information Technology-skilled professionals, such as small, rural providers and community partners.

3. Clear definitions.

Goal: Improve usefulness and usability of data analytics; increase impact.

Opportunity to Add Value: Contributes to the ability to understand the reports, and to combine files from different sources. Simplifies reporting and reduces administrative costs for providers.

Guiding Questions: Does each assessment of clinical outcome mean the same across the board?
How do we use clinical data consistently across all providers internally or externally of an ACO?
How do all professional EP's define an outcome?

Subgroup Notes: Achieving shared definitions of "clinical outcome" is very broad and will be hard to do in Phase One. It may be better to identify a small set of measures and make sure that all definitions for those measures are clear, for example for key measures such as: primary care office visits; ED visits; and Inpatient admissions/ days.

Other Important Areas of Standardization That Require Further Discussion

Acknowledging the tension between alignment and individual organizations' approaches, more 'standardization' discussion is needed regarding:

- Approach to patient attribution across payers, Third-Party Administrators, purchasers and providers;
- Approach to risk adjustment and identification of high-risk patients; and
- Identification of clear targets and benchmarks.

Attachment 6: User Guide Outline

Organizations that use data analytics in ACO or ACH initiatives must have access to the data analytics, be able to understand the data analytic information, and have the skills to use it to support the Triple Aim. For this to happen, any organization that generates and shares data analytics with other organizations should provide guidance to the user of the data analytics in the form of a User Guide. One User Guide can be developed to apply to many types of analytic reports. For ease of use, the User Guide should be as brief as possible while addressing the following elements:

1. Welcome Statement, Purpose and Audience
2. Recognition of the common Guiding Principles for creation and use of the data analytics³, including use of plain language when possible
3. Description of training opportunities to help users understand what they are receiving, what it means, and how to use it
4. Basic descriptive information for each data analytic topic or item provided:
 - a. Is the data analytic element consistent with the common set of prioritized data components developed as part of the Accountable Communities for Health⁴
 - b. Definitions of key terms
 - c. Explanation of the granular data elements that are components of the data analytic topic
 - d. A description of how each data analytic topic was developed
 - i. The relevant time frame of the data used in the analysis
 - ii. The data source(s) used for each data analytic topic or item
 - e. A description of how each data analytic topic can or may be used
 - i. The context in which the information is most relevant
 - ii. Who is intended to use the data analytic topic (i.e., type of professional)
 - iii. Examples of the types of questions it can help answer, and the types of decisions the data analytic topic can inform
5. Description of the file types used and the variable names to enable Users to know when it is appropriate to combine “the same” data analytics provided to them by different sources
6. Description of the level of confidentiality of the data analytics, and recommended processes to protect the data from improper release
7. Contact information so that the user can ask questions, request additional information or seek another type of follow-up

³ This is the set of guiding principles suggested by the Data Analytics Subgroup and recommended or agreed to by the two SIM / ACH Task Forces

⁴ This is the set of data analytic elements suggested by the Data Analytics Subgroup and recommended or agreed to by the two SIM / ACH Task Forces

Attachment 7: Approach to Identify Best Practices

Developing best practices for data analytics is an iterative process that will emerge as various stakeholders achieve greater integration of health care. Considerations should be given to compiling best practices in a more public arena so that various stakeholders can learn from the successes of others. A possible framework⁵ for collecting best practices follows:

1. Identify the specific situations and stakeholders for which best practices are needed. This will assist entities in identifying practices that are tailored to the entity's situation and providing positive results. For example, an entity may search for best practices for selecting elements to match data records between diverse data systems.
2. Identify and analyze the "low-hanging fruit"- practices that require little additional expenditure and low risk. This may include challenging assumptions and conventions, seeking ways to streamline processes in novel ways. For example, an entity may find ways to leverage elements from multiple data sources to create matches between previously un-linked data.
3. Find the "essence" of a best practice, identifying the primary mechanisms, supporting structures, and optional features of an implementation. Direct observation or "ride-along" may help entities better understand how a best practice can be adapted and applied in a different organization or situation.
4. Describe weaknesses that could lead a practice to fail, and develop safeguards or mitigation plans for failures.
5. Conduct a final review of the practice, identifying overall suitability of a practice for further implementation.

⁵ Loosely adapted from Eugene Bardach, "A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving."