SCOTTSDALE INSTITUTE 2019 ANALYTICS SUMMIT

Driving Innovation and Transformation with Analytics

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Executive Summary

Health data have been around since the beginning of modern medicine. But with the proliferation of electronic medical records, claims data, consumer data and other emerging data sources, practitioners need analytics to sift through a growing body of information to extract relevant insights. Combined with the right expertise and informed decisions, novel insights will accelerate collaboration and drive lower costs, better quality and health outcomes while improving patient and clinician satisfaction.

Simply having more data doesn’t drive business or clinical outcomes. While the opportunity for data and analytics in healthcare may be rich, we will generate an ROI only if we understand how to gather, translate and measure it and turn insight into action.

The Scottsdale Institute’s 2019 Analytics Summit sponsored by Optum gathered 21 leading analytics executives from 19 health systems across the country to discuss how analytics investments help their organizations achieve their strategic objectives. While each health system approached data and analytics uniquely, they all face similar challenges:

» Lack of clarity on how analytics drives value;
» Limited talent in key analytics areas;
» Fragmented analytics capabilities throughout the enterprise.
Summit Participants

Craig Anderson, Director of Innovation, BayCare Health System
Julius Bogdan, Director of Analytics & Data Innovation, SCL Health
Mel Chung, Executive Director, Data & Analytics, John Muir Health
Tina Esposito, MBA, RHIA, FACHE, SVP & CHIO, Advocate Aurora Health
Mark Hohulin, SVP, Healthcare Analytics, OSF Innovation, OSF HealthCare System
Trey Hyberger, Executive Director, Analytics, Baptist Health
Tricia Julian, CIO, Baptist Health
Mark Lantzy, CIO, IU Health
John Long, VP, Enterprise Analytics, UW Health
Tristan Markwell, Principal Strategic Scientist, Providence St. Joseph Health
Jon McManus, VP, Enterprise Analytics, Sharp HealthCare
Gil Mendez, PhD, Director of Analytics & Innovation, Banner Health
Lance Millburg, System Director, Decision Sciences, Memorial Health System
Lonny Northrup, Senior Medical Informaticist, Intermountain Healthcare
Nnaemeka Okafor, MD, MS, VP & CHIO, Memorial Hermann Healthcare System
Bernard Porter, AVP, Analytics, Baptist Health
Peter Prina, Director, Data Warehouse & Business Intelligence, Spectrum Health
John Pyhtila, PhD, Chief Data & Analytics Officer, Partners HealthCare System Inc.
Danny Sama, VP, Analytics & Chief Data Executive, Northwestern Medicine
David Torgerson, VP, Enterprise Analytics, Sentara Healthcare
Michael Wall, PharmD, Chief Analytics Officer, University of Chicago Medicine

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Improving Analytics’ Impact

DEMONSTRATING THE VALUE OF ANALYTICS

Executive participants at the 2019 SI Analytics Summit asked a fundamental question: How can we demonstrate and deliver on the value of analytics investments, especially as data volume increases and the analytics talent pool shrinks due to competition?

While the analytics competence required to generate targeted results is one level of value, participants aspired to a higher level of value: achieving positive change across the entire enterprise.

“If our analysts are producing exactly what they’re asked, but we’re still not seeing any results within our operations, that’s not producing value,” said Lance Millburg, System Director, Decision Services, Memorial Health System, Springfield, Ill. “It’s not so much a quality or quantity equation, but more a question of evaluating the impact it makes on the organization. Ultimately, the business does want to see the outcome in the bottom line, either financially or from a quality perspective.”

Mark Lantzy, CIO, IU Health, Indianapolis, echoed a sentiment many participants expressed. “We have as good a handle on the data as anybody. However, we have not yet made that transition to really understanding the data in a way that impacts care.”

Documenting improvements in care as a result of innovative data analytics was a challenge for nearly everybody. Financial impact was more straightforward, but calculating dollar value of analytics initiatives was a common conundrum among the group. John Pyhtila, PhD, Chief Data & Analytics Officer, Partners HealthCare System, Boston, summarized this dilemma: “I’ll echo what my CFO would say: ‘Is it hard savings? Did you actually reduce expenses? Or did you just make employees more efficient?’ Because we’re all looking to reduce costs overall, right? But if the answer is just, ‘Well, it’s more efficient,’ now that resource is getting sucked up into something else. You’re not actually saving money.”

Julius Bogdan, Director of Analytics & Data Innovation, SCL Health, Denver, said that value ultimately must be measured in dollars at SCL. “We may want to separate healthcare from the financials, but honestly, we can’t,” he said. “On our intake and prioritization, we rely heavily on our business partners to provide that ROI. And then we validate it and track it with them to ensure that we can be comfortable within the range they’re reporting. But we have to include financials for everything. Otherwise we wouldn’t be able to continue to grow as we’ve been doing.”

Some executives were able to justify the analytics function using strategic measures. Danny Sama, VP, Analytics & Chief Data Executive, Northwestern Medicine, Chicago, suggested that analytics leaders consider their roles from the CEO perspective. Does the CEO believe that analytics is providing the right value for the organization? Are data and analytics moving the organization in a strategic direction? For Sama the answer was yes.
“Everything we are putting our resources behind is directly connected to an incentive goal or one of the 20 key initiatives that comes from the CEO's office,” he said.

It's often difficult to isolate analytics' impact. Analytics, like its parent IT, typically enables business processes that actually generate the value. Gil Mendez, PhD, Director of Analytics & Innovation, Banner Health, Phoenix, said measuring value within a large health system has its own complications.

“Anything that we create—from a dashboard, an insightful analysis, or a predictive model—trying to measure that value becomes a challenge. It becomes very hard to quantify the value of something that we build that led to a realized improvement in an outcome, because there are just so many other things that are going on in parallel. With that said, it should be evident that analytics is a critical part of that process,” Mendez said.

Another large, western health system—Intermountain Healthcare, Salt Lake City—has been integrating data and analytics into its clinical and financial processes for more than half a century. And, while it experiences similar challenges as other health systems represented at the Summit, analytics is an integral part of Intermountain's culture.

“Our approach is mission first rather than money first,” said Lonny Northrup, Senior Medical Informaticist at Intermountain. “For example, we provide hundreds of millions of dollars of charity care every year. Obviously, that's mission-driven and not driven by an ROI for business gain. Analytics is just as integral to who we are, and it’s embedded in our focus on continuous improvement. For example, analytics-driven reports and dashboards are accessed more than 66,000 times every business day to help clinical and operational leaders make better decisions and drive better outcomes.”

### MAKING HEALTH SYSTEMS MORE DATA LITERATE

Healthcare analytics professionals pride themselves on developing data-backed solutions that result in better quality-and-cost outcomes. But leaders at the Summit said analytics is valued only to the degree health systems can apply it practically. Operationalizing data and analytics remains a universal challenge.

Tristan Markwell, Principal Strategic Scientist for Providence St. Joseph Health, Renton, Wash., discussed a specific case where a vendor claimed to save his health system hundreds of thousands of dollars in a pressure-ulcer intervention initiated by the nursing informatics office. But when he visited the nurses in the pilot units, he found no evidence they were using the intervention.
“The nurses looked at the model and found they didn’t have the authority to do half of the recommendations,” Markwell said. “They didn’t have the equipment; they couldn’t order the drugs. This intervention was not preventing pressure ulcers because nobody was using it. That’s just one example of the thing I’m struggling with the most right now: recommending and tracking interventions.”

Disconnects between theory and practice present one obstacle to putting analytics to work. Another is a general lack of understanding of the value of data and analytics among clinical and financial staff. All health-system employees could benefit from learning how data impacts the system and enhances the way they do their own jobs.

Emphasizing data literacy has become a norm in other industries where success is more obviously dependent on data. Airbnb, the online house-sharing marketplace, requires every new employee to go through its data university. Jon McManus, VP, Enterprise Analytics, Sharp HealthCare, San Diego, believes health systems like his can learn something from this example.

“Whatever we’re producing, we could ask ourselves, ‘How do you make it really convenient and easy for people to engage within the organization?’ I think that’s incredibly important for scaling,” he said. “While I don’t know that we can all sustain something like a data university for all employees, I do think we need a consumer mindset so we can help employees effectively engage the analytics tools we’re generating.”

In addition to data literacy, an important responsibility of analytics organizations is to provide translators who can explain complex data and analytics concepts into simple, easy-to-understand terms for business stakeholders. Because analytics can be a difficult discipline for employees to grasp, education programs must go beyond “one-and-done” projects, said Bernie Porter, AVP, Analytics, Baptist Health, Louisville, Ky.

“When we set up a literacy program, we accept the fact that it’s going to take concerted efforts over time,” he said. “But the more we train our analysts and the more effective they become, I think they can then help those literacy efforts as they work with people and teach them.”

Nnaemeka Okafor, MD, VP & CHIO, Memorial Hermann Health System, Houston, is considering teaching data literacy at his health system. But before developing courses, he’s been concentrating on identifying and aligning the workforce and resources to help the organization transform.

“Most of our executives thought I was joking, but I really value people who have an anthropology degree,” he said. “Those are the people I want to pull into this space because they understand cultures. They may be better able to help people determine the problem they’re trying to solve and then taking it to the next step.”
Where the analytics function resides in an organization can maximize its potential or limit its progress. For analytics to drive clinical and business change, it needs to be optimally positioned within the organization—which will vary from health system to health system.

One executive summarized the optimum location: Switzerland. In other words, identify a place where information can be neutrally or objectively evaluated so it can generate the best decisions.

“It’s all very dependent on the organization and the nature of its politics, to be very blunt about it. But my mantra is to figure out where Switzerland is and go live there,” said David Torgerson, VP, Enterprise Analytics, Sentara Healthcare, Norfolk, Va. “We deal in facts and objectivity and if you’re not in Switzerland or the closest that you can find to it, you’re going to have some adverse pressure where your ability to do that is limited.”

Torgerson reports to the chief physician executive at Sentara and believes most health systems will gravitate toward analytics residing in the clinical space. But opinions varied among Summit participants as to where the analytics function should sit in the organizational chart and how that positioning would shape its effectiveness.

Placing analytics under the CIO has both benefits and drawbacks. “Analytics and technology go together,” said Northwestern Medicine’s Danny Sama. “If your CIO can be Switzerland, that would make a ton of sense.”

Memorial Health System’s Lance Millburg countered: “Analytics shouldn’t be a pusher of technology; it should be focused on aligning with operations. We’re tied directly into quality, and there are a lot of benefits to that. It is very much a Switzerland for us. If nothing else, it’s a watchdog type in that it’s very independent.”

Baptist Health in Louisville places analytics under the oversight of the CFO and CIO, but has developed a new governance structure that involves leaders from multiple disciplines.

“This informatics governance will have 20 vice presidents from throughout our organization, and they are thinking with us about how to use our data,” said Tricia Julian, CIO, Baptist Health, Louisville. “We’ll do the hard work of that in IT, but the governance committee will help us answer all the questions about what challenges we are trying to solve and how it ties to the initiatives across departments in the organization.”
The ‘org chart’ is only part of the equation. How an organization is structured can affect analytics’ impact. Intermountain Healthcare changed its operating model in part to ensure the organization utilized the care-process models its analysts helped develop. Until recently, the health system was governed by regional executives, and those executives sometimes opted out of adopting best practices developed at the system level.

“Now, we’re more centralized and we are making a concerted effort to expand the adoption of our care-process models system-wide. Where we consistently apply these better approaches, we see significant cost and outcomes impact,” said Intermountain’s Lonny Northrup. “While we’ve had significant success where we have consistently followed these prescriptive analytics for care delivery, we still have room for improvement.”

Partners HealthCare’s John Pyhtila said analytics should be an enabler of operations and not the focus. “Consider the operating models of business, not of analytics. You think about the other industries that are adopting analytics and are really driving it. They are top-down; they have consistent operations across the country. But health systems don’t typically work that way. Within Partners, we have multiple ASCs [ambulatory surgery centers], multiple community hospitals and multiple specialty hospitals, each running their own business, to an extent. And so to think that we can actually drive analytics with a consistency into highly variable operations is highly unlikely. You’ve really got to pick your battles to figure out where you can be impactful and stay away from areas where you can’t.”

While Summit participants considered success factors such as employee education on analytics’ value, enhancing analytics’ role within the organization, and measuring its effectiveness, they all agreed that building the analytics team was the most impactful factor of all.

**Advancing Analytics Talent**

**FINDING AND RETAINING ANALYTICS TALENT**

Data and analytics arguably drive most industries’ performance today. For analytics to transform their organizations, the analytics function must permeate the organization. And that requires the right talent.

“Talent is an ongoing challenge,” said David Jackson, VP, Optum Advisory Services, a Summit moderator. “Even if you have the talent you need today, that may not be true tomorrow or next week. You have to continue to keep that talent and retain them and keep them growing. The need
to look at talent as a strategic long-term investment has never been more critical for healthcare organizations looking to stay ahead of the competitive curve.”

Finding the analytics talent required to meet their corporate mandate is an ongoing challenge for most health-system leaders. While most agreed they had the necessary staff resources today, they still need new ways to retain and grow those employees. Creating the right work environment and offering the right incentives are imperative.

For Mark Lantzy of IU Health, a major tech company’s arrival in Indianapolis made it harder to retain analytics and IT employees. Sentara’s David Torgerson was challenged by a dearth of analytics experts on the Virginia and Carolina coasts.

Mel Chung, Executive Director, Data & Analytics at John Muir Health in Walnut Creek, Calif., faced his own unique issues. “We have a challenge because our competitors for talent in the San Francisco Bay Area—whether healthcare or high-tech companies—are pilfering our IT analysts. So that’s the challenge. And the way we have decided to address it is through a vendor partnership. It’s a big deal for us; we’re partnering to help us with innovation, scaling our resources. That’s how we plan to attack this.”

Peter Prina, Director, Data Warehouse & Business Intelligence, Spectrum Health, Grand Rapids, Mich., said that a lack of analytical opportunities in the past led to job dissatisfaction for data scientists. They have focused on clear role definition and providing the right opportunities to help exercise the analytics mindset. This will allow the data scientists and analysts to connect with Spectrum Health’s mission.

Torgerson suggested an innovative approach might be to identify talented professionals with non-traditional analytics backgrounds. “This is the kind of person who may have discovered their strength in analytics later in life but have a passion for what they do. The problem is these people are harder to find,” he said.

It’s a challenge to find the right talent mix among a diverse pool of professionals, some of whom may crave mobility and leadership opportunities, and others who are fulfilled by independence and even solitude. However, once he finds a great employee, Torgerson believes that setting expectations upfront and providing an attractive work environment is the key to retention.

“The most important factor in analytics success: building the analytics team.
Although he competes against a major EMR vendor and other tech companies in southern Wisconsin, John Long, VP, Enterprise Analytics, UW Health, has had good luck attracting and keeping talent by understanding what motivates people.

“The number one reason people leave their job is their direct supervisor. The number two reason is opportunities to grow and to learn,” he said. “So, we've put a lot of focus on leader development. And I don't just mean org-chart leaders, but individuals and staff who are a key liaison to a business area, that's a leadership position. Project Management is a leadership position. Leadership by influence and all of those kinds of skills.”

Bernard Porter, AVP, Analytics, Baptist Health, said, “Analysts love to see their work used. So it's not just the paycheck and the career path, it's also keeping them connected with stakeholders. When they see the results, they get more refined and better at what they're doing. You wind up with happier stakeholders, too. I think there is a lesson there. But it's much harder than any technical aspects of the program.”

**ANALYTICS AS A TEAM SPORT AND THE NOTION OF A “COMPOSITE DATA SCIENTIST”**

Healthcare’s complexity exacerbates the challenge of finding the right analytics staff. The varied skill sets required by health-data science are rarely found in any single individual. Instead, the discipline calls for teams with technical, strategic and operational skills.

“I think it's important that we untether, so to speak, the technical capability from analytics,” said Tina Esposito, SVP & CHIO, Advocate Aurora Health, Oak Brook, Ill. “There's a business-insight component; I think we all know that, but I'm not sure that's well understood everywhere. You still need someone who is going to do more than just write a query, pull it off and think you're going to answer a question,” she said.

“Our observation is that data science is a team sport,” said Intermountain's Northrup. “We have what we call the composite data scientist. It's a team comprised of three primary roles. First, it has someone who knows the data. Where did it come from? How complete is it? What's the integrity of the data? Second, someone who would be more the traditional statistical analyst or data scientist who knows the statistical methods and machine-learning methods, how to use the tools, how to write some code. And then the third person is a business or clinical expert, a person who can intelligently assess the validity of the insights and recommendations generated from the analysis.”

Advocate Aurora’s Esposito noted, “What I've seen—what might, at times, be driving the fact that we can’t get a decent laptop or the infrastructure we need—is at an organizational level, at a very macro level, there needs to be an understanding that data science is a discipline. And it isn’t the analyst here or there that is going to change the world or give you the answers you're looking for. It's like a kitchen in a restaurant. I need more than just a chef. With analytics, I need people that can work their way through a very complicated data model or set of data models.”
ALIGNING SKILL SET WITH INDUSTRY TRENDS

The right skill set today may not be the skill set needed in five or 10 years. The function of data and analytics is growing and changing. Where is the industry headed in the next five-to-15 years, and how does that change the way health systems hire and train?

As analytics advances by integrating artificial intelligence (AI), the analyst role will surely evolve. Machine-learning (ML) engines will be able to query and answer with little human intervention. Analysts will require new skill sets to interpret the results of such automated processes.

“I think a lot of things have quickly become commoditized, whether we want to acknowledge that or not,” said Sharp HealthCare’s Jon McManus. “Do I need people who know SQL (structured query language)? Do I want people to know how to write a SQL statement? Because doesn’t that get me in more trouble, in some ways? Today, I need those people if I don’t have another vehicle to empower them with intelligence and with the ability to create and innovate and support business processes. But if I did, would I choose to hire SQL talent as a prerequisite? It’s an interesting thing to think about going forward with commoditized capabilities like data science.”

Danny Sama, Northwestern Medicine, said at least one role may vanish. “I think we’re at a point where we’re going to automate away the data scientist. What the data science role should be is operationalization: getting clinicians to understand and create and adopt and build this into their workflows and their models,” he said.

As innovation increases, it may become more difficult to justify large teams of technically-skilled people.

“The ability for any one organization to sort of out-innovate the market is really, really hard,” Torgerson said. “The Intermountains and the Mayo Clinics of the world may be able to do that once, but it’s not likely to be a viable business model. I think for providers, most predictive and prescriptive capability will ultimately be partnered or outsourced. You’ll either outsource it or it will already be automated for you.”

New skill sets are required to interpret the results of automated thinking such as AI and Machine Learning.

Operationalizing Analytic Capability

CONNECTING ANALYTICS WITH PERFORMANCE IMPROVEMENT

While data might seem like a valuable commodity and new technology could turn some analytics tools into a data-product factory, the real power of analytics lies in its ability to identify opportunities for organizations to make incrementally significant changes to continually improve workflow, care processes, cost structures and other critical functions.

“I think a lot depends on how your organization perceives the value of analytics and whether it’s an executive-level agenda item,” said Tushar Mehrotra, SVP, Analytics, Optum, and a Summit
moderator. “If you look at financial services or pharma, those industries have all elevated the role of analytics. There’s a chief analytics officer and a chief data officer. It’s a strategic lever that the CEO has on driving a competitive advantage in the market. I believe that health systems are in the early stage of this journey.”

To avoid data commoditization, some organizations have aligned analytics with performance improvement.

“If someone comes to me and tells me they want to build a business model and they need analytics resources, I say, ‘Great. Let me connect you with a process-improvement leader,’” said Northwestern’s Sama. “The project will immediately turn from an analytics project to a process-improvement project. And the first step to beginning the project is you must have an executive owner. Then you have to document what you will do differently, either fiscally or clinically for redeployment of resources. And if you can’t make that kind of commitment, then the project is over. This is for anything that you build or buy.”

Intermountain has made continuous improvement such a priority that each of its 40,000 employees is trained in continuous quality improvement. In 2018, Intermountain implemented more than 49,000 employee ideas, submitted by nearly a third of its employees. Also, six tiers of daily huddle boards driven by thousands of reports and dashboards allow communication and improvement to occur daily from front-line clinical and operations personnel to, literally, the CEO and his direct reports.

“The only way those huddle boards work is with statistics and data driving those decisions,” Northrup said. “Employees have to come up with KPIs [key performance indicators] for how they will measure the improvement of their work compared to a starting baseline measurement.”

PRIORITIZING PROJECTS

Protecting and optimizing analytic assets is critical. While analytics can be a powerful tool for improvement, it can also become a resource drain that has little impact if used without thoughtful management.

Resource capacity is an issue for most organizations. Because querying and writing reports is a time-consuming task, Partners’ John Pyhtila has created a policy that manual reports are limited to only three runs before the business user must commit a formal budget request.

“Once prototyping is done, it can’t stay with the analytics team. It has to move toward an automated production query,” said Pyhtila.

For large centralized analytics teams like the one overseen by John Long at UW Health, it’s difficult to keep up with demand. His solution included allowing specially trained people within the health system to perform some analytics functions.
“We’ve structured what we call our matrix-analyst program,” Long said. “There are probably 60 of them now across the system. If they meet certain criteria and have the proper training, they can build their own dashboards and put them into production as long as they follow our standards. It’s been an enormous boost for us.”

University of Chicago Medicine has a similar program. Leaders have enabled 30 users outside of their centralized analytics function to produce data solutions.

“Connecting those folks directly to the value of our unified data platform is a critical value-add, and a clear signal to the enterprise,” said Michael Wall, PharmD, Chief Analytics Officer, University of Chicago Medicine. “Enabling these analytical staff—who are not SQL-trained or just happen to not be on one of the major data teams—with access to powerful data, has been a major win.”

Many such organizations manage their analytics-project requests through various tiering systems. Providence St. Joseph certified its projects using a standard systems-development life cycle. Northwestern Medicine has a two-tiered system, where one level is highly governed, and another level is loosely governed. Intermountain has three levels, from strategic to enterprise to ad hoc.

Sharp HealthCare built a portal where staff could request projects, track them and view results. While a portal may seem like a way to commoditize such requests, Sharp has found it a good means of engaging employees with analytics and creating a feedback loop to identify what issues are most important internally.

“We’re promoting the idea that everyone in the organization can know the entire inventory of analytic assets,” said Sharp’s Jon McManus. “The potential for self-healing with this type of transparency can be immense. If you promote a culture of visibility for all your intelligence assets through one front door, then you start to create a place where you can govern and some of this complexity starts to heal itself.”

FORMULAS FOR SUCCESS

While a few pillars for success seemed obvious to Summit participants—a focus on providing value, and recruiting and retaining talent—each health system approached these issues differently. Technology stacks and platforms varied widely and, while there was reference to analytics platforms as the future, there was no single, unified and ideal analytics architecture. And, while EMRs continue to move toward analytics, no EMR has stood out as an analytics engine.

Baptist Health has access to analytics tools through their EMR, but system leaders still have questions about operationalizing those tools. “We are looking at some models that they’re producing,” said Trey Hyberger, Executive Director of Analytics, Baptist Health, Louisville. “And we’re asking ourselves, ‘How do we implement those models? Do we need the data science team to start evaluating those models and ensure that they’re right for our organization?’”

Analytics' real power is in identifying opportunities to make incrementally significant changes to continually improve workflow, care processes, cost structures and other critical functions.
Although there was no call to action for any specific emerging technology, the analytics executives acknowledged the role of AI and ML as key elements of next-generation analytics.

“My responsibility in the world of analytics is to make sure that we are prepared to respond to my health system’s needs with a suite of options, some of which may be driven by AI or ML,” said Sentara’s Torgerson. “So I’m going to be knowledgeable. I’m going to be up-to-speed on what the options are. And when my leaders decide they are interested in solving a problem, I’ll step in and say, okay, here is my opinion on how I think advanced analytics can help with that solution.”

Indeed, health systems are innovating—and getting results. For example, Peoria, Ill.-based OSF Healthcare used a form of AI—natural language processing (NLP)—to help identify abnormal ejection fractions in patients without heart-failure diagnoses.

“We identified over 2,500 more patients,” said Mark Hohulin, SVP, Healthcare Analytics, OSF Innovation. “Now that registry is up to date, and clinicians can interact with these patients and provide appropriate interventions.”

Clearwater, Fla.-based BayCare has partnered with the Publix grocery store chain to engage customers in their own health. They have placed health clinics with telemedicine capabilities in 22 Publix stores in central Florida. They also derive data from “HIGI” stations in stores that offer free blood-pressure checks.

“We pull data from those and combine that with what we already know about the patient to try to learn a little bit more about them and learn it more frequently,” said Craig Anderson, Director of Innovation, BayCare. “People in Florida visit a Publix on average 2.2 times a week. That’s a lot more frequently than we see them. We’re trying to capture that longitudinal vital data set for the folks who check their blood pressure there. The big question is, how do we use it?”

Innovation in analytics can only occur when it is aligned to a health system’s strategic goals.

“Health analytics is sort of like managing a restaurant that’s trying to get a Michelin star,” said Memorial Hermann’s Nnaemeka Okafor, MD. “The customers are going to come in with requests that are on the menu or off the menu. You’ve got to make sure you have the appropriate ingredients to get those things. Our fresh ingredients are the data. The technology/software stack is like the modern equipment in the kitchen. It needs to be modernized and up to date, but it’s not the sole thing. You need the best ingredients—data quality. You need the analytics people who are like the chefs. But you also need the waiters, you need the staff, the runners and the hosts in the front who are greeting people. You need all of that to have a high-quality operation.”
Conclusion

In a steadily transforming healthcare industry, data and analytics and the expertise to utilize them have become strategic assets. By sharing best practices and lessons learned at the 2019 Scottsdale Institute Analytics Summit, analytics executives are finding that successfully navigating this transformation requires a collaborative effort.
About the sponsors

The Scottsdale Institute (SI) is a not-for-profit membership organization of prominent healthcare systems whose goal is to support our members as they strive to achieve clinical integration and transformation through information technology (IT). SI facilitates knowledge sharing by providing intimate and informal forums that embrace SI’s “Three Pillars:”

> Collaboration
> Education
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