CHAPTER 5

Dive into the Data

The next critical step for executives trying to secure physician engagement, empowerment, and ownership is to share data about cost overruns or other problems that need to be addressed. Executives who have caught the attention of physicians with a burning platform and vision will either hook them or lose them at this stage. They must, therefore, be prepared to present the data starting with understanding the role data play in physician ownership.

I often hear executives say that "physician engagement is all about the data, because physicians are scientists." They're really suggesting that good data can be motivation enough. This is not correct. In fact, communication and shared decision making are the keys to physician engagement; data are not. The true role of data is to enable shared decision making and to help physicians and executives identify and solve problems. Failure to understand this distinction puts too much reliance on the data.

Executives who make physician ownership too dependent on data will be disappointed. Operational and financial data don't usually stand up well to physician scrutiny. Take clinical variation data as an example: Physicians are always surprised to find that the source of the data is typically not the doctors' notations in the electronic health record or paper charts, but rather transactional data from billing systems. They are dismayed to learn that the cost data are often not the actual costs from an accounting system but an approximate

calculation based on cost-to-charge ratios, and that even if the data are from a good cost accounting system, it isn't practical to compare itemized costs (e.g., costs of albuterol nebulizations administered to an asthma patient versus the same costs in unaffiliated health systems across the country). Finally, physicians are irritated to learn that standard risk-adjusting of data is performed by an algorithm that assigns an illness level and complexity to their patients, rather than through a transparent and customized process determined by physicians.

Bottom line: Executives who rely too much on data also will be disappointed because creating physician ownership entails much more than just getting doctors to agree that the data accurately show a problem. Physicians can agree that problems exist without feeling any urge to help fix them.

To avoid an overreliance on the data, I begin my physician data-sharing sessions with a caveat: "The data are directional." (OK, I actually say, "The data *is* directional," but you get my meaning.) I then explain why the data are only directional. Honesty is critical.

Executives should hang a lantern on the key shortcomings of the data. But they should also mitigate physicians' concerns by explaining that peer hospitals face these same limitations. Explain that the data are directional because they do not reveal the cause of the problems; data may show that Dr. Smith used more stents than Dr. Jones but will not show why. The *why* is left to the experts, the physicians. Finally, explain the attribution problems. Whereas data often show variation in costs and quality by physician, they do not usually account for the fact that a physician may be the attending of record but may not have directed every aspect of the patient's care.

I know it is hard for executives to imagine standing in front of physicians and bashing the very data they hoped would convince them to become coleaders, but this discomfort is unwarranted. Physicians are not geeky scientists who require presentations that approximate technical dissertations. Although physicians are scientists, when listening to operational or business problems they are simply trying to understand the problem and its cause, just like

anyone else. Executives think nothing of explaining to business colleagues that a piece of financial or operational data represents an estimate, a projection, or a proxy for missing information. Executives' approach to physicians should be no different.

Further, not only are estimates, projections, and proxies OK, the data don't have to be error-free. When I worked as a consultant, I was warned by more than one CEO that the data must be "bulletproof" or we (the executives and consultants) would "lose the physicians." I've found, however, that when physicians detect errors in the data, the outcome can actually be positive, as long as the executive making the presentation has correctly framed the physicians' role. The right framing tells physicians that their role is to help interpret the data, vet whether it feels correct, and suggest additional data that will help clarify, prioritize, and explain the problems that the initial data exposed. This sets the foundation for a collaborative approach to the data and any errors they may contain.

Case in Point: I recall a correctly framed data presentation where a physician pointed out a strange acronym in a list of cost categories that contributed to the cost per case for a pneumonia condition. No one, including the finance executives in the room, could explain what the acronym meant. The chief financial officer made a few guesses and suggested the group move on, but the physician wasn't satisfied.

After the meeting, the finance executives explored further and discovered that the mysterious acronym and its accompanying costs had been created by low-level finance staff to allow completion of an obsolete field in the archaic cost accounting system that, if left empty, prevented moving to the next field. The item and its costs were fictitious!

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The doctor found an error that had been in the data for years and that even finance leadership didn't know existed. In the next meeting, the executives thanked him for improving the data by helping to identify the error.

Because the role of physicians had been framed correctly, the discovery of the error did not cause the physician to doubt the data or the empowerment process. Instead, he became the biggest physician champion for physician coleadership. Identifying the error and helping the team clean up the data was a critical milestone in his journey toward ownership.

To set the right level of expectations with physicians, it is also important for executives to understand, and to communicate upfront, that business data are not as timely or detailed as the data physicians use in their work. Physicians treating diabetic ketoacidosis will often measure blood glucose and urine output hourly, venous blood gases every two hours, and blood electrolytes every 12 hours. Executives, on the other hand, base their financial and operational decisions on aggregate data that is months old. Stating this fact proactively, before presenting the data, avoids physician disappointment.

I also strongly recommend that executives present data to physicians in a dynamic, modifiable, and "drill-downable" form, rather than in a static format such as PowerPoint. This is achieved by projecting the enterprise data warehouse on a screen and using data visualization software to make it understandable. To this end, it is a good idea to bring a data analyst to the meetings to navigate the data warehouse and answer questions. A dynamic presentation allows physicians to better analyze, understand, and accept the data.

Giving physicians the ability to mine the data in real time adds a wow factor that captures physicians' attention. This practice also provides a seldom-seen level of transparency that accelerates their buy-in.

Case in Point: Orthopedic surgeons were presented with data that showed them to have a higher length of stay than benchmark hospitals. The surgeons asked to see the specific procedures and attending surgeons, the types of patients, the treatment those patients received, the days of the week the patients were discharged, and many other views of the data. Delaying the answers until follow-up meetings would have frustrated the physicians and slowed the pace to physician engagement, empowerment, and ownership.

A dynamic setup also allows physicians to modify data in the meetings, which executives should encourage. For example, I have seen a breast surgeon request that costs of the general surgeon be displayed separately from those of the plastic surgeon, and an orthopedic surgeon ask for knee joint revision costs to be removed because it skewed his data. Allowing physicians to modify the data is a way of enabling them to make the data their own rather than "data from administration."

A well-introduced and conducted data presentation, with a data analyst present, is a big step forward in the physician ownership continuum. Physicians become excited by the unprecedented amount of detail and the ability to mine and modify the data in real time. The drill-down and modification abilities, especially, facilitate physician ownership of the data.

PHYSICIAN ENGAGEMENT PEARLS

Listen to Physicians and Give Credence to Their Expertise

Executives must listen hard to what physicians have to say when it comes to issues that affect patient care. As CEOs have told me, "Last time I checked, I don't write any prescriptions," meaning that physicians, not executives, are the experts when it comes to patients. Physicians drive the quality and costs of care. This is true, but some executives fail to apply this key understanding to their day-to-day management. For example, they ignore or override physicians' opinions when it comes to changes in patient care services. In some cases, executives don't even seek those opinions.

Case in Point: Executives at a health system in the Southeast closed a low-volume, money-losing spina bifida clinic. The decision made perfect sense from a business standpoint. The problem was that the executives failed to first discuss the plan with the neurosurgeons, one of the specialty groups that had served as consultants to the clinic patients for several years.

The surgeons knew that the patients and their families would not be able to find similar services within a reasonable distance and felt that other solutions should have been explored. They also felt it was disrespectful for the executives not to have included them in decisions regarding their patients. The executives apologized for the oversight, but the neurosurgeons remained disappointed at what they interpreted as a financially motivated disregard for patient well-being.

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This situation damaged an already fragile relationship between the surgeons and the executives. Within six months, the executives paid out much more money than the savings gained from the spina bifida clinic closure to prevent the neurosurgery group from joining a competing health system.

Advising executives to listen to physicians might seem trite, but in difficult conversations between executives and physicians, a point is often reached where the executives stop listening. This usually occurs when the physicians become entrenched in what the executives feel is a predictable position, such as when physicians oppose closure of a service or reduction in staff. It is, however, precisely at this point that executives should lean in, raise the mental shutters, and listen harder, because when it comes to their specialties, the physicians are often right.

Case in Point: I was present in a meeting between executives of a health system and employed obstetrics and gynecology (OB/GYN) physicians to get the physicians to decrease their cesarean section (C-section) rate. Existing data on deliveries showed that the health system's rate was well above the national average, and the belief among executives was that the variance resulted from the physicians' resistance to change.

The physicians argued that their C-sections were all evidence-based, and that their patients were higher-risk because the health system was an academic medical center. The executives became frustrated and stopped listening. Instead,

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they expressed disappointment at the OB/GYN department's lack of willingness to embrace change and contemporary practice. Not surprisingly, the meeting did not go well; no punches were thrown, but there wasn't any progress either.

A follow-up meeting was scheduled for a couple of months later. Meanwhile, the health system purchased a sophisticated enterprise data warehouse from a consulting firm. When the firm analyzed the health system's data in detail, they found that the physicians were not properly documenting severity. Taking this into account and benchmarking the health system against other academic systems, rather than against a mix of academic and non-academic systems, its C-section rate was *better* than average. The real opportunity lay in length of stay.

Fortunately, the OB/GYN physicians received the news graciously. In the next meeting, they focused collaboratively on how to improve documentation and length of stay. The executives could have arrived at this insight sooner, and with less drama, if they had listened harder, asked the right questions, and remembered that the last time anyone checked, they were not writing any prescriptions.

Develop Some Clinical Knowledge

An executive once asked me jokingly, "How come doctors can go and get MBAs and become businesspeople but executives can't just go and get an MD degree?"

This is actually a profound question. Executives should be able, perhaps be required, to get some clinical training. Executives who

boast (and I have met several) "I don't know anything about hospitals, but I do know about [insert managing people, growing value, or suchlike]" can rarely be as effective in engaging physicians as executives who have taken the time to learn about the clinical work of health systems.

Case in Point: One of the most effective executives I have met could converse knowledgeably with physicians of almost any specialty. When I asked him how he came to be so clinically informed, he told me that, early in his career as a CEO, he embarrassed himself in front of surgeons at a dinner. The surgeons were advising him to buy a CT scanner that could handle extremely obese patients. One of the physicians said, "We need this particular CT scan if we are to perform fundoplications at your hospital." The executive responded, "That's all very well, but my interest lies in starting a bariatric surgery program."

His chief medical officer tried to kick him under the table, but he repeated this viewpoint several times. Eventually, a physician gently informed him that fundoplication is a form of bariatric surgery.

After this gaffe, the CEO made it his mission to buy and read as many medical textbooks as possible. Today, even seasoned physicians find his knowledge of medicine to be impressive.

Executives do not need to go to this extreme but should educate themselves clinically on their areas of responsibility rather than relying on acquiring the information passively.

INSIDE TIPS

1. Buy or create an enterprise data warehouse for cost and clinical data covering outpatient and inpatient care. Be sure the data warehouse features visualization software.
2. Designate your data analytics or decision-support group as owners of the data and the data preparation for presentations. If you don't have a data analytics group, contact similarly sized health systems for models and create one. In the meantime, the finance department can own the data.
3. Designate one or more data analysts to drive the presentations, explaining and modifying data as needed. Some consulting firms will install the data warehouse and provide data analysts for the presentations.
4. Schedule a session to introduce the data and the process to the physician leaders. Keep this presentation at a high level, keeping in mind the main goals: to show the capability of the data warehouse, explain what will be done with the data, and whet their appetites for the detailed drill-down in upcoming specialty-specific meetings (detailed in chapter 6). Although the aim is to keep the presentation at a high level, some detail is necessary. Therefore, choose one or two specialties beforehand for this. Show the data to the physician leaders for those areas before the larger group meeting. This avoids surprising and potentially offending them in front of their peers.
5. Begin to educate yourself clinically. There are many sources of easy-to-review information online and at bookstores. Some companies provide quick reviews of scholarly articles. UpToDate (www.uptodate.com), for example, synthesizes multiple articles into easy-to-understand information and recommendations. Other

useful resources are peer-reviewed articles in the *New England Journal of Medicine* (www.nejm.org) and the *Journal of the American Medical Association* (http://jamanetwork.com/journals/jama). Many physicians use these same sources to keep informed.