One-on-one: The data conversation

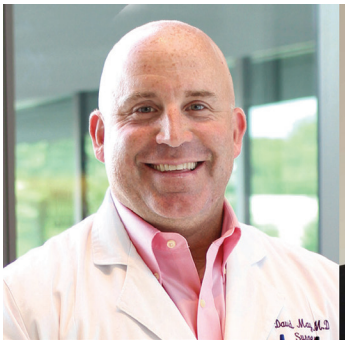
By Gale Pryor | March 23, 2017

What is the X-factor that takes an organization from good to excellent? Sometimes, it can be found in the day-to-day interactions between clinicians, staff, and patients. Here are two perspectives on a shared encounter in healthcare — a glimpse into the culture of performance.

In the transition from volume- to value-based care, the most fraught exchanges often come when administrators review performance and quality data with physicians. But at Shore Physicians Group, conversations about data tend to be positive and constructive — which practice leaders cite as one reason for their measurable success.

The multi-specialty organization, based in South Jersey, is among the top 10 percent of performers on the athenahealth network on a range of key financial and clinical metrics, and was recognized by the American Medical Group Association in 2016 for "game-changing solutions and inventive techniques to align physicians and create a unified provider/staff culture."

Here's a look at Shore Physicians Group's fine-tuned approach to reviewing data across the clinical-administrative divide, according to surgeon David P. May, M.D., president of Shore Physicians Group, and administrator Michael Miller, director of population health and physician relations at Shore Quality Partners, their clinically integrated network.



David May, M.D.

Michael Miller

1. Vet the data first through a committee of physicians

David May, M.D.: Physicians are hungry for comparative data. They don't have enough data about how they compare with other physicians, and how their patients are doing across a population.

Michael Miller: There's an array of things that might be important, but have little to do with the clinical

outcome of performance. You need a physician's expertise to let the administrator know what is clinically relevant.

May: The physician committee does the first pass on new metrics to figure out if it's accurate, come up with pitfalls or objections that may be brought up. That allows Mike to re-analyze the data from the first round of criticism before he sits down with the practices.

Miller: The first thing that most physicians do is attack the data. Every now and then I take one on the chin at a meeting, frankly, and that's completely healthy. Because once you lose credibility out in the field, it's almost impossible to get it back.

2. Focus on the data, not the doctor

Miller: When I put data in front of doctors, the message cannot be "'This is what you're doing wrong.' It has to be, 'Here's a snapshot of how we are right now. Let's see if we can help you maintain your high-functioning level.'" Or, "Now that you see this evidence, let's see how we can help you change things going forward to bring you in line with your peers."

May: That's why Mike's been so successful, and why we're more successful than most. What physicians need is some comfort that data is not going to be used in a 'gotcha' kind of way.

Miller: Their data is what's poor, not them as a physician. It's about how to make their data more robust versus changing their clinical patterns.

May: As a physician, I hear Mike's message as, "Hey, this is the data that we have. It presents some interesting findings. Let's discuss it together." It's how you get buy-in from all the physicians. Use the data as an educational tool to raise the water level for all. That's how to lower everybody's stress level.

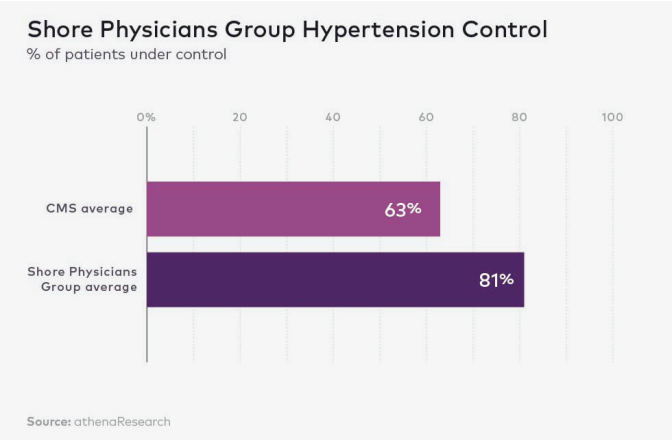
3. Select metrics that matter — and that physicians can control

Miller: If you want to be persuasive, then you've got to start small with something that's not going to evoke an emotional response. It's a lot easier to accept a pat on the back than it is criticism.

May: Linking data to the compensation structure helps. That's part of how you get everyone rowing the same direction. We say, "If you meet these metrics and you represent a shared savings based on appropriate utilization, there's money associated with that." That gets physicians' attention.

Miller: As healthcare shifts to new payment structures, a rate of change should always be attached to each raw figure. Where the data says they are now isn't always as important as where it says they're headed. Without considering the "change element," it's easy to find yourself racing toward the middle. You also need to point out what they can't control. Essentially, you're telling them, "This was out of your hands. Don't worry, you didn't do anything wrong." Then, you can point out opportunities to improve.

May: That's exactly what physicians want to hear. As long as they trust Mike, the person delivering the information, and as long as they trust the data, physicians are willing to come to the table with an open mind every time.



The physicians of Shore Physicians Group take data seriously, exceeding national averages in quality metrics such as hypertension control by large margins.

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