Evidence isn’t just for medicine; it’s for the business side of the hospital or health system, as well. Data can be a competitive advantage, but as important as the data themselves are the conclusions that can be drawn to aid in developing the strategic plan. After all, how can senior leaders develop an effective strategic plan if the data aren’t all in the same place? Learn from some of the industry’s leaders in this conversation moderated by HealthLeaders Media.

Panelist Profiles

PAUL C. MatsuN, Chief Marketing and Communications Officer Cleveland Clinic Cleveland, OH

JOhN HALLiCK, President and CEO CPM Marketing Group Inc. Madison, WI

ELIZABETH PELLEGRIN, Chief Marketing Officer Charleston Area Medical Center Charleston, WV

PHILIP BETBEZE, Senior Leadership Editor HealthLeaders Media Moderator

MALCOLM ISLEY, Vice President Strategic Services Greenville Hospital System Greenville, SC
**Roundtable Highlights**

**HEALTHLEADERS**: Let’s talk about leveraging data that you have in pieces and in silos at your hospitals and health systems. How do you effectively merge that data for strategic planning?

**MALCOLM ISLEY**: South Carolina has a registry where hospitals submit all of their information, which they combine to develop market-share reports. But it’s not real transparent. Until about six months ago, we’re only allowed to see our performance. We couldn’t look at competitors and see how they perform, what markets they pulled from. South Carolina’s just changed that, so now we have better competitor information in terms of market share and service lines. That raw data is at the DRG level, so we developed an internal group that’s measuring and monitoring our outside business and our inside business. We marry it up with our internal performance measurements, whether it’s from our cost accounting system or our clinical information, so we have a feel for how we perform in the market and what that means to us in terms of our market share, our profitability per case, our source of business. It will be essential for us to bring that information together and use it in a meaningful way.

**JOHN HALLICK**: Anybody who is running a business needs metrics to make decisions. The problem is that information systems are always dynamically changing within organizations. The data flow in the system, and they’re being tampered with along the way—these systems were never designed to be connected or fit together. At CPM, we design heuristics that allow us to rapidly pull disparate data sources together. The result is a clean, singular, strategic marketing and planning database that consolidates all of these into a common format, so that multiple businesspeople can access the same data for their business problems and they can come out with answers based on the same information.

**PAUL G. MATSEN**: We’ve built a customer relationship management database that we use for marketing. But we also have the Ohio Hospital Association and the Cleveland Hospital Association data, which allows us to get all the hospitals’ reports. So we get a good look at competitive market-share position. In marketing, we partnered closely with finance and we’re able to look at growth by service line at the ZIP code level for each one of our hospitals. We use that to build a market plan for every hospital in our system. We’re building two new outpatient centers in northeast Ohio. That was based on a growth-planning matrix that we built that looked at population growth, population density, income, and payer mix.

**ELIZABETH PELLEGRIN**: We also have to pull our data from multiple points. We have a somewhat siloed process as far as collecting all that data because finance is involved, planning is involved. We have a health education research institute that manages the research portion. And then, of course, marketing has the responsibility, as well. I think we do a very consistent job in our strategic planning process. We start early; we share a lot of data. We are purchasing from outside organizations pulling that together, but as far as actually having set reports at the push of a button, we have a ways to go on that. It is pretty manual right now.

**HEALTHLEADERS**: How do you marry all these disparate sources of data, and how quickly can you do it?

**ISLEY**: We’re project-specific. One of the departments I developed when I came to Greenville was the business intelligence unit. That group is responsible for bringing those systems together, and we oversee the data warehouse, as well.

**MATSEN**: Ultimately, it’s tied to your ability to drive revenue in the future. For instance, capturing referring physician data for patient admissions is not as good as we would like it to be. And it requires training and education of the staff to make sure it’s done well, and that the right tools are in place, so it’s easy for the frontline staff to execute. That’s a critical piece of information on which the leadership team needs to align.

**HALLICK**: Healthcare is very well suited for some of the more advanced data-mining techniques because of the quality and robustness of the data. But you have to have good data—you can’t extract patterns from bad data. We pull together data from disparate sources into one common platform—we call it a convergence growth engine. It gives you a total view of your market from physicians to patients to market analytics and future forecasts.
MATSEN: At the most basic level, you have to use data to get a thorough understanding of your market, your consumer, and your physician in the marketplace. Especially if you’re operating a system, you need to understand where your patients are coming from at the ZIP code level. What markets are your primary markets, what service lines are your strongest service lines, what’s the payer mix in those service lines, and then if you have private practice physicians involved, who are the private practice physicians who are referring the patients? We take that data for each of our community hospitals, and we put that into a published report that all the hospital executives can use for a foundation for a strategic dialogue about growth, about where you want to target your marketing efforts, about where you want to target your managed care efforts, where you want to target physician recruitment.

PELLERGRIN: It has to be a collaborative effort whereby administrators are aware of opportunities by service line. I find that helpful also when working with the medical staff, because with physicians, there’s a certain sense that if they have a slow week, we’re having a downturn. The challenge is having real-time data, and not looking at something a year or two old, which is what we see from the many databases.

MATSEN: We found four clear opportunities for growth. Granted, any one of our competitors doing the same data analysis could have come up with the same opportunities. But we seized those opportunities, and we’re building two new facilities. We entered into an agreement to merge with another hospital that was in one of those high-growth markets. Everybody on the leadership team understands where those four growth opportunities are. They also understand where the market declines are, and that those hospitals need to be focusing on maximizing their current revenue opportunities, reducing costs, and seeking partnership opportunities if necessary. You need data to do that.

HEALTHLEADERS: Is there better, cleaner data out there? How can we get to it quicker?

HALLICK: A broader understanding at the collection points is really important. The second thing is knowing what data you need to solve your business problems and how you might want to categorize data into usable formats. CPM builds databases from raw data, so I’m sensitive to data quality and making sure we understand the business problem so we can build the right solution. The data sets tend to be vast, so we have to have a fast engine to serve up real-time data analysis. Every question answered seems to generate two more questions—real-time analytics are the only solution.

HEALTHLEADERS: The ability to slice and dice data in real time is going to become even more important with accountable care. What are some of the streams of data that your executive team is going to have to manage quicker and better?

MATSEN: What we’ve done so far is use our Epic system to populate our own internal database. And we’re able to work with our different service lines. We started with primary care and internal medicine, and we’ve looked at people who have chronic disease, diabetes, hypoglycemia, obesity, asthma, and found people who—this is very basic—had not returned for an appointment in 18 months, and used that as our simple standard. And we really didn’t customize or personalize the message. We sent a general reminder message signed by a physician that they needed to come back in for an appointment. It was very low cost, but we got extraordinary response. We’ve now expanded that to include pediatrics for well-child visits.

MATSEN: It could be outbound e-mail. But it’s that data that will trigger the mailing or trigger the message, whether it’s electronic or print, in your system. And it’s going to have to be collaboration between the medical staff and the marketing team to determine what those triggers are, what’s the appropriate time to do it.

ISLEY: What we’re looking at is populations that we’re already at risk for and understanding the health of that population. We’re doing that with our employee plan this year. We’re
taking all that claims-based information as well as internal information. We’re putting it through a tool to understand and aggregate all of the information that’s available—the tool has predictive analytics to help understand your gaps in care for this population. We haven’t fully deployed that yet, but that’s what we’re going to be looking at for managing patients under risk arrangements. Data drives programs that reach out to patients, so how do you use and serve up and make data compelling so that you achieve patient engagement? Because without patient engagement, we’ll never reach the ACO objectives.

**Pellegrin:** There’s a requirement, too, for specialization depending on the demographic assessment. And it has to be customized. Enormous resources are going to have to go toward that to engage the community and the patient. We are certainly not at the place where we are looking at all comorbidities, looking at all opportunities from a purely data and statistical standpoint. We’re doing the ones that are intuitive. Let’s say someone’s had a bariatric surgery; in 12, 18 months, they may need plastic surgery. These are the pieces that we’re looking at.

**Matson:** We are living in an era where patients are getting increasingly involved in making their own healthcare decisions as we move to high-deductible plans. Consumers who have the means are certainly doing their research and making choices. It’s an evolution, but it’s a rapid evolution. Between 70% and 80% of consumers are going to the Web to do research before they make a decision. They’re still listening to their doctor, and their referring physicians play a critical role, but as baby boomers become the primary cohort consuming healthcare, they’re different than their parents, who didn’t grow up with that kind of access to data. Providing outcomes data on the Web, providing tools to find the physician so they can look at credentials, they can see where they trained, they can see what their publications are—that’s a step in the right direction.

**HealthLeaders:**

*With the ACO coming into play, hospitals are likely to have to take on a big disease-management role. So can it work on that level as well?*

**Pellegrin:** I think so. Being a community-based hospital, we actually have already taken on that role for certain health concerns, like diabetes, asthma, and others. We’ve been proactive on the piece of wellness and prevention, especially in the pediatric population. With our immunization program, we are reaching out, actually having social workers go out and engage parents to get their children back in for immunizations. It is tough work, but mission critical. Part of the discussion that we were having earlier about market segmentation and service lines, looking for revenue growth, that’s critically important for a hospital like ours because we do so many things where we lose money, we have to maximize other revenues to support our mission.

**Isley:** It’s all about understanding each area’s contribution. We’re going through this now. We have a lot of components to our system: subacute, acute care hospital, physician practices, mental health facilities. What’s their upstream, downstream value? What’s their in-store value? You try to project out what it looks like under a capitated arrangement. Does the value proposition change? How is it performing? Is it performing well to established benchmarks where there’s a mental health hospital and an acute care hospital? Because we’re not going to be able to afford to run our systems in the future the way we’re running them right now.

**Hallick:** Over the last year, we executed about 3,000 communications campaigns. Every campaign is analyzed to see what worked and how to improve. Campaigns are synergistic. You could look at one discretely and think it didn’t do what it was supposed to do. Then you look more broadly and see that it did have a secondary effect on another campaign. The bottom line is you have to look at both the individual campaign and the aggregate.

**HealthLeaders:** Let’s talk about data credibility with physicians. How do you present data so that they actually believe what you’re trying to tell them?

**Hallick:** We spent the last year and a half working on bringing physician marketing to the same state of the art as consumer marketing. What are the potential data sources? How do we aggregate and align them? Our goal is simple: If you want to build a cardiovascular center, you need to determine not only who are patients out there that you need to talk to, but also who are the doctors who would impact admissions. So we developed a system that would analyze physician data to find key physicians who would impact the business. The system works on a number of devices, including an iPad, so liaisons could use it in the field. Pre-call targeting is critical.
PELLEGRIN: We’re doing this through Six Sigma processes on the floors and through physician leadership sharing evidence-based medicine measures. Of course, administration and physicians are reviewing patient satisfaction in many forums. A significant challenge in physician satisfaction and patient satisfaction is a lack of capital. Operating a health system in an economically challenged region means that even if we need more ORs, that issue joins a list of capital needs that have to be accessible within a tight budget.

ISLEY: Fifty percent of our medical staff is employed, but they’re driving 85% of our activity. We really rely on our employee doctors, and that number continues to grow. We’re going to add another 150 employed physicians in the next 18 months.

PELLEGRIN: We’re seeing that trend, as well. In the last few years, we have employed a number of physicians, mainly to support our trauma center. But we continue to see growth, especially in our hospitalist program. We have 600 physicians who are credentialed to practice at CAMC. Do they actually practice at the hospital? That number’s dipping much lower.

MATSSEN: The demand for the integration of e medical records in our organizations, malpractice insurance, and lifestyle is a big factor for our doctors. By coming here, they’re free to focus on medicine, whether it’s clinical, education, or research, and it improves their quality of life. We are also out recruiting. We had physicians who were Cleveland Clinic employee group practice, but we also had physicians who were employed through our regional hospitals. Those are now all being condensed into the one main group. So we’ll add another 100, 150 physicians to that group. This simplifies our marketing challenge greatly.

PELLEGRIN: Certainly we do traditional media in our market, being a somewhat contained market in a relatively affordable purchase area. We can do more direct mail, and with better data and more resources, that is our intent. Our primary focus right now is to redesign our website, CAMC.org. This will better position us to focus on search engine optimization and search engine marketing and give us more measurable ROI, as well. And we have recently begun engaging in social media in a more meaningful way.

ISLEY: In the last three years, we have shifted a lot of our dollars from doing traditional media to community relations and community events. Our organization has been Greenville Hospital System: big buildings, somewhat removed from what the community is. So we’re trying to change that perception by connecting more with the community through these events and a partnership with the YMCA. We’ve developed a number of new primary care sites and urgent care sites. We’ve revamped our website, as well—driving people to the Web is what we want to do. We also are using some social media, with mixed results. We do e-mercials where our A/V department interviews our physicians. Based on our database we target that information to patients who might be interested and referring physicians.

MATSSEN: We have a pretty active community outreach program. We do have a separate community outreach group at the Cleveland Clinic. But we do some terrific programs there, probably most notably a minority men’s health fair for the community, which does extensive screenings, and then we also do a minority women’s health program called Universal Sisters, which is terrific. We run the gamut from traditional to nontraditional. We sponsor the Browns, the Indians, and the Cavaliers and provide sports medicine for them. Beyond that, we are active in social media. We do have a Facebook page; not surprisingly, that’s growing at over 100% a year. We have a million page views since we launched it. We are excited about YouTube. We have posted over 300 videos on YouTube, and that’s grown over 200% for us this year in views.

HALICK: We’ve done some research on all of these initiatives, and overwhelmingly, by a four-to-one margin, people wanted to be contacted, believe it or not, by traditional mail first. This may change in the future, but it’s true now. Once they are contacted, people will go to the Internet or the call center. People are typically either assisted-service, through the call center, or they’re self-service, through the Internet. There are many communications channels to get your message to the consumer. The key is the ability to maintain the integrity of the conversation while switching from one channel to the other without losing track of the conversation. That’s the exciting vision we’re working on right now.
We know how to listen.

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