Financial and Clinical Dashboard Development: “The Devil is in the Detail”

This year, the United States inaugurated our 44th President...During the campaign, both political parties vowed to tackle the economy, the war in Iraq, and the continually increasing healthcare costs. To focus on healthcare, consider the facts: In 2008, U.S. consumers spent $2.8 trillion ($7,868 per person) on healthcare, compared to just $356 per person in 1970. In addition, $50 - $100 billion was spent paying for inefficient and poor quality care. Of the “top ten” most expensive medical conditions, heart conditions topped the list at an estimated $76 billion. This steady increase in healthcare costs over the last 30 years can, in part, be attributed to rapid advances in technology, increased availability of advanced treatment options, expanded patient eligibility criteria, and the greater pool of patients as the “baby boomers” are now within the over-45 age group.

For many years, hospitals around the country reaped the financial benefits of the lucrative cardiovascular service line, which resulted in high contribution and profit margins, even in the midst of advancing technology that was quickly and proportionally outpacing reimbursement. As reimbursement continues to change, cardiac services can continue to be a lucrative specialty, but must be managed tightly to sustain / maintain a high margin level.

So, what does this have to do with dashboard development in the cardiac catheterization lab?

Corazon’s answer: “Everything!”

Now more than ever, the quality and cost of healthcare is increasingly under scrutiny. For example, in 2003, CMS established the Recovery Audit Contractor program, initially as a demonstration project for identifying over and/or underpayments for services rendered over the previous four years. More specifically, a patient’s “classification” as either an inpatient or outpatient for certain procedures was being put under the microscope, with special attention given to percutaneous coronary interventions, pacemaker insertions, and diagnostic electrophysiology studies.

As the push to the outpatient setting continues due to patient preference and the potential for cost-savings, reimbursement will be less, even though the intensity of resources remains the same. This will have a direct impact on the overall contribution margin. Given the rapid changes in technology, costs, procedures, and reimbursement, cardiovascular managers need to have a system in place that can immediately answer questions regarding fluctuations in contribution margins, whether positive or negative.

So how can hospitals devise a system that will measure costs, revenues, and quality? Corazon has worked closely with many hospitals to assist them in their quest to develop dashboards that review the financial, clinical, and operational aspects of program performance. In Corazon’s experience, it is best to begin the process with a few parameters and build on them once you have determined that the information is accurate.

To begin the process, Corazon recommends that a hospital consider financial parameters such as total discharge volume, average length of stay, average payment, and direct cost per case. The direct cost per case can be further broken down to include procedural supplies, stents, and pharmaceuticals. Moving forward, it will be important to clearly define parameters so that everyone understands what costs are included and how they are derived. For example: the average direct cost per case will most likely include all costs associated with the patients’ care across the continuum from admission to discharge. Although you may not have direct control over the costs outside your area, it is important to realize the overall cost impact as patients travel though your system, keeping in mind that the highest cost of care will occur during the patient’s time in the cardiac catheterization laboratory.

Below are samples that Corazon provides to clients as building blocks for financial dashboards. Figure 1 provides a sample of financial indicators with sample corresponding data. Figure 2 takes the financial data and analyzes it as compared to internal and external benchmarks. From the analysis, an organization can visualize trends and differences of the contribution margins for specific procedures as compared to current and previous years, and also as compared to peer hospitals across the country.

Industry benchmarks used to compare supply and pharmaceutical costs indicated that this particular facility’s costs were in line with other “like” facilities. Case mix index for this particular set of patients had a slight decrease from the previous year. Other factors contributing to the decrease in contribution margin included an increase in length of stay for these patients as well as the continued shift to the outpatient setting. In order to impact the contribution margin, the length of stay needed to be evaluated as well as the guidelines reviewed to ensure that patients were being classified appropriately.

As hospitals continue to transition from the standard DRGs to MS-DRGs and manage case mix index, Corazon suggests hospitals monitor and evaluate all clinical documentation around the patient’s condition, and ensure that it is appropriately and accurately reflects the patient condition.

Just as hospitals define financial indicators, it is equally important to include clinical and operational indicators in the dashboard as well. Clinical indicators may include reviewing the number of elective, urgent, emergent, and salvage coronary intervention volumes; in-hospital mortality; and complication rates. Operationally, indicators can range from room turn-over-time, average weekly discretionary overtime...
Corazon firmly believes that managers who are able to successfully measure costs against the quality of care provided will be best prepared to anticipate and respond to the challenges in healthcare. For a hospital to become and remain a market leader in this ever challenging healthcare environment, managers will need to have a “finger on the pulse” as to how their service line performs clinically, operationally, and financially. Margins are indeed important, but are not the only indicator of program quality or efficiency.

The new presidential administration seeks to require full transparency regarding healthcare quality and costs. Until now, patients have had limited access to this information, even though it is well known that costs and quality can vary significantly between and among hospitals and providers. Both the President and Vice President have indicated they would like to move towards requiring hospitals and providers to publicly report healthcare costs and quality. Given the current healthcare “State of the Union,” along with a savvy managers’ “know-how” regarding quality and costs, Corazon cautions that as you build your dashboard(s), remember: “the devil is in the detail”.

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