Broadening the Use of Financial Data to Improve Patient Care

Healthcare CFOs can use financial data not only to reduce utilization and supply costs, but also to identify variability in physician practices, increase adherence to evidence-based guidelines, and ultimately improve quality of care. By relating financial measures such as full cost, variable cost, direct cost, and even charges to clinical metrics such as 30-day readmissions, admission severity, complications, and adherence to evidence-based guidelines, hospitals can identify physicians who are not providing cost-effective or clinically superior care.

To effectively use financial data to compare physicians' patterns of care for a given procedure, diagnosis, or similar set, it is necessary to break down utilization or charges into specific cost areas, typically corresponding to standard revenue codes, such as medical/surgical, ICU, operating room, and laboratory.

Exhibit 1 illustrates this point by providing a full cost breakdown by attending physician for all of a hospital's patients with congestive heart failure (CHF—DRG 127).

Physicians A and B are at the upper end of the spectrum in total utilization and appear to be providing much more ICU time (and associated drugs and therapeutics) than their peers, particularly physician H. Although higher utilization could be a result of higher patient severity, in this instance, a separate analysis discloses that patient severity is similar for the three physicians.

When asked for their motives for increased ICU utilization, physicians A and B said they wished to reduce readmissions. However, an analysis of readmission rates (Exhibit 2) shows that physicians A and B had higher 30-day readmission rates than physician H, despite the increased ICU time. Finally, further analysis found that, although physicians A and B had higher overall drug costs, they also had lower utilization of ACE inhibitors at discharge—a key evidence-based measure for preventing CHF readmissions (Exhibit 3).

The hospital used these findings to promote more consistent prescribing of ACE inhibitors to patients with CHF at discharge, thereby reducing overall cost for a key service line.

Data for this analysis were collected by GE Medical Systems *Healthcare Services*. For more information, contact Matt Quinn at matthew.quinn@med.ge.com or visit www.gemedicalhcs.com. ■

EXHIBIT 1: **DRG 127—CONGESTIVE HEART FAILURE: DIRECT COST VERSUS COST BREAKDOWN, BY ATTENDING PHYSICIAN**

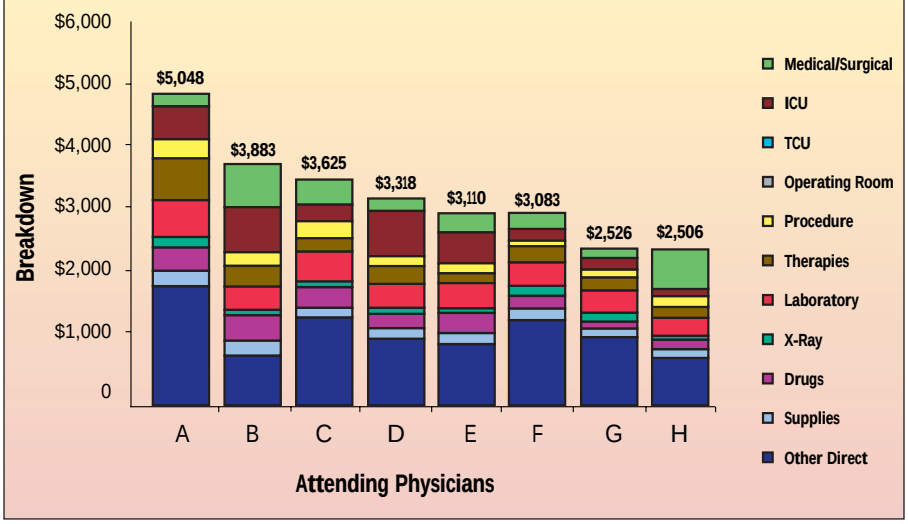

EXHIBIT 2: **DRG 127, 30-DAY READMISSION RATE**

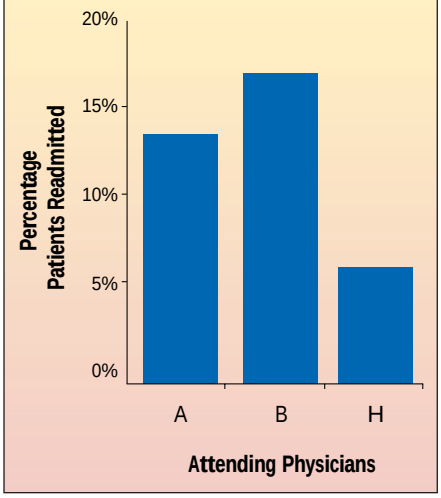

EXHIBIT 3: **DRG 127, ACE INHIBITOR GIVEN ON DISCHARGE**