

AN HFMA VALUE PROJECT REPORT

---

# Building Value-Driving Capabilities:


Business Intelligence

---



**hfma**<sup>®</sup> educational foundation  
healthcare financial management association

# ABOUT THE VALUE PROJECT

f all the transformations reshaping American health care, none is more profound than the shift toward value. Quality and patient satisfaction are being factored into Medicare reimbursement, while private payers are pushing for performance and risk-based payment structures. At the same time, rising healthcare costs are creating more price sensitivity among healthcare purchasers, including government agencies, employers, and, of course, patients themselves, who are being asked to pay higher premiums, copayments, and deductibles for their care.

Hospitals have always cared about quality because they are fundamentally dedicated to patients' well-being. But today's pressures make it financially imperative to develop collaborative approaches that combine strong clinical outcomes with effective cost containment.

HFMA's Value Project aims to help guide the transition from a volume-based to a value-based healthcare payment system. With the support of 17 leading hospitals and health systems (listed on the inside back cover of this report), which serve as the project's steering committee and research sponsors, HFMA has engaged in a series of interviews with finance and administrative leaders and their clinical partners at providers who are leading the transition to value, including:

Advocate Health Care	Lee Memorial Health System
Baptist Health South Florida	The Methodist Hospital System
Baylor Health Care System	New York-Presbyterian
Bellin Health	Novant Health
BJC HealthCare	Partners HealthCare
Bon Secours Health System	Rush University Medical Center
Catholic Health East	Scottsdale Healthcare
Catholic Healthcare West	Sharp HealthCare
Cleveland Clinic	Spectrum Health
Geisinger Health System	Texas Health Resources
HCA – Hospital Corporation of America	UAB Medicine – UAB Hospital
Intermountain Healthcare	Unity Health System

HFMA has also interviewed a range of organizations representing the perspectives of patients, employers, commercial payers, and government agencies, including:

## The Access Project

American College of Physician Executives

Blue Cross Blue Shield Association

Catalyst for Payment Reform

HFMA-UK

Institute for Healthcare Improvement

In addition, HFMA has conducted two industry surveys, the first on the current state of value in health care and the second on future directions for value in health care. For additional information, visit the Value Project website at [www.hfma.org/ValueProject](http://www.hfma.org/ValueProject).

# INTRODUCTION

**H**ealthcare providers are on the verge of a transformation in the field of business intelligence.

As providers work to implement and achieve meaningful use of electronic health records (EHRs), they are gaining access to new levels of clinical data, the accuracy of which will be heightened by the switch to ICD-10. Meanwhile, the prospect of new forms of payment—including episode-based payment bundles, shared savings programs, and capitated payment models—is exposing the limitations of traditional cost accounting methods. This has prompted providers to consider costing systems that can provide greater levels of detail regarding the costs related to specific services, processes, and physicians. For example, the ability to “drill down” into the costs associated with bundled services, specific patient groups, or practice patterns can help decision makers better understand variation and costs related to variation—and make changes that will improve value. The exhibit below illustrates how business intelligence needs will be driven by value-based payment and care delivery strategies involving varying degrees of integration and risk assumption.

As healthcare organizations gain access to more and better data, their need for business intelligence—the ability to convert data into actionable information for decision

making—is growing. To drive value, healthcare organizations will need to use business intelligence to:

- Develop a business intelligence strategy focused on converting financial and clinical data into actionable, accessible information that clearly supports an organization’s strategic goals and decision making
- Accurately capture and quantify the costs of providing services and the costs and benefits associated with efforts to improve quality of care
- Develop business cases that prioritize and reliably quantify expected clinical outcomes, financial impacts, resource needs, and “go/no go” points of value improvement projects

Although business intelligence is still in its adolescence at many healthcare organizations, organizations should begin to develop value with the data and resources available to them now, rather than wait to improve value until they have implemented systems capable of providing more refined business intelligence, organizations interviewed by HFMA’s Value Project agree. As Kevin Brennan, CFO of Geisinger Health System in Danville, Pa., notes, “The tools we have available to us are sufficient to the task. We just have to redeploy them in a manner that supports value.”

## BUSINESS INTELLIGENCE NEEDS IN AN ERA OF REFORM

Degree of Risk and Integration Required						
Lower			Higher			
Focus Area	Fee for Service	Pay for Performance	Penalties for Adverse/ Preventable Events	Episodic Bundling	Disease/Chronic Care Management	Total Health Management
Financial Reporting and Costing	Procedure-Level		Activity-Level	Longitudinal	Per Member, Per Month	
Quality Reporting	Core Measures	Process Measures	Outcome Measures		Condition Measures	Population Indicators
Business Case	Supply/Drug and Productivity		Medical/Surgical Interventions		Lifestyle Interventions	
Decision Support Systems	Financial Data	Acute Quality Data	Ambulatory Indicators	Claims and Prescription Info	Health Risk Assessment, Biometrics, and Predictive Modeling	

Low Degree Medium Degree High Degree

# MAKING INFORMATION ACTIONABLE

**H**FMA's January 2011 survey on the current state of value indicated that, while many organizations have begun collecting data in such areas as costs of adverse events, financial implications of readmissions, and the financial effects of waste in care processes, few organizations are using the data they collected as a basis for action. A significant number of respondents also indicated that they are not yet actively measuring these costs. Although these numbers may have improved over the past months as the Medicare value-based purchasing program draws closer to implementation, the findings of this survey indicate that many organizations have much room for improvement in both collecting the data needed to measure quality and cost outcomes and making that data actionable.

To move from a data-collecting organization to a data-driven organization, providers should:

- Create an enterprisewide data strategy to ensure the accurate and consistent calculation and reporting of data across the organization
- Establish clear lines of sight from individual metrics for departments and staff to organizationwide goals and executive dashboards

## MEASUREMENT AND USE OF BUSINESS INTELLIGENCE

**To what extent does your organization measure and utilize business intelligence related to value in the following areas?**

	Not	Measure	Manage
Costs of Adverse Events	43%	37%	20%
Margin Impact of Readmissions	38%	42%	20%
Cost of Waste in Care Processes (i.e. duplicative/unnecessary tests or procedures)	50%	29%	21%

**Not** We do not measure.

**Measure** We have measured the impact, but do not manage to the metrics.

**Manage** We manage to these measures (e.g. data drives actions to reduce costs or improve margin).

Source: HFMA Value Project Survey, January 2011.

- Make information available to inform the decision making of front line staff in as close to “real time” as possible, optimizing the possibility for interventions that can avoid adverse events or waste and improve results

## CREATING A DATA STRATEGY

For information to be actionable, it must be credible. And the credibility of information depends on several factors. First, all interested stakeholders must agree that what needs to be measured is being measured. Second, there must be assurance that metrics are being recorded and reported consistently—and, if more than one department is measuring the same item, that each is doing it in the same way. Third, information needs context for meaning.

**Agreeing on metrics.** Some metrics will be prescribed by government and private purchasers as a condition of reimbursement. In other instances, organizations will want to define and track their own metrics to gauge the success of an initiative or assess the quality or cost of care. In all cases, it is important that both finance and clinicians understand and agree upon the metrics that should be tracked, where and how the information should be collected, and how the data should be calculated and reviewed.

**Consistent reporting.** Value initiatives may require tracking the same metric across different departments or, in the case of a system, across different facilities. Organizations must ensure that information is being collected and reported consistently if that information is to be credible, comparable, and, ultimately, actionable.

**Providing context.** Simply reporting data on quality and cost outcomes is insufficient. Data should be presented within the context of a dashboard or scorecard that defines clear performance goals and clearly illustrates progress toward those goals. Users should be able to understand the significance of the data within the context of both internal and external performance benchmarks and use the data to identify areas most in need of improvement and areas where goals have been met or are being maintained.

At Partners HealthCare in Boston, the organization's office of clinical affairs uses a three-color system—green, yellow, and red—for its quality dashboard to indicate whether facilities are above, at, or below performance goals on a wide range of quality metrics, including both publicly reported and internal metrics. Information is arranged to allow easy comparison between facilities within the Partners system and, for publicly reported metrics, comparisons with peer academic medical centers around the country as well as competitors within the local market.

### ALIGNING METRICS WITH ORGANIZATIONAL GOALS

Internal dashboards should create clear lines of sight between organization-wide goals and the efforts of individual departments and staff. Many hospitals and health systems interviewed for the Value Project noted the problem of “data overload” within their organization: Too many targets and metrics are being tracked without a clear sense of their significance to the organization.

An effective strategy to counter data overload is to define a clear—and concise—set of strategic goals for the organization. Improvement initiatives, and the metrics and data collected to measure progress on them, can then be prioritized according to their alignment with one or more

of the organization's goals. Dashboard metrics—from the system level to the individual—should then be aligned beneath organizational goals so that everyone within the organization can understand how their performance on metrics furthers the organization's goals.

### TIMELINESS OF DATA

For data to be actionable, it must be put in the hands of decision makers in time for them to take action on it.

Different data have different life spans. For quality measures—especially those affecting patient safety and clinical outcomes—an organization's ultimate goal should be to make reporting as close to “real time” as possible. At Geisinger, which has an advanced, integrated electronic health record in place, evidence-based practices and treatment protocols for various procedures and conditions are embedded within the system. The system's monitoring and tracking capabilities allow section leaders to identify noncompliance within a day, often allowing corrective action while a patient is still in the hospital. For example, after 40 separate criteria for coronary artery bypass graft (CABG) procedures were embedded within the system, compliance with all 40 criteria increased from 59 percent to 99 percent, infection rates declined by 21 percent, and readmissions fell by 44 percent.

## ENGAGING CLINICIANS IN DEVELOPING A DATA STRATEGY

Spectrum Health, based in Grand Rapids, Mich., has been deeply engaged in building consensus between finance and clinicians through its work as a pilot site for the PROMETHEUS Payment® program. PROMETHEUS is a bundled payment program that pays an evidence-informed case rate for designated services within an entire episode of care, such as care related to chronic conditions, acute medical conditions, and specific procedures. Part of the PROMETHEUS case rate includes an “allowance” for *potentially avoidable conditions*—the more these conditions are avoided, the greater the potential shared savings for the provider.

Among the lessons learned as finance and clinicians at Spectrum worked to come to terms with the PROMETHEUS case rates were the following.

**Words matter.** A term like “potentially avoidable” may seem perfectly acceptable to finance, but suggests a failing to clinicians. Finance leaders may want to work with a small group of physician champions on the language used to describe a value initiative and the metrics involved before engaging with a broader clinical audience.

**Be selective.** Don't try to measure—and improve upon—everything at once. Identify a few metrics that seem most significant, and that clinicians perceive as within their control, and focus efforts on improving these.

**Lead with quality; follow with cost.** Clinicians will engage more readily with metrics that relate to the quality and safety of patient care.

## DEVELOPING CONSISTENCY IN DATA REPORTING

At Bon Secours Health System, based in Marriottsville, Md., clinical transformation efforts combine significant leeway for problem solving within local facilities with standardized reporting that allows the corporate office to compare the cost-effectiveness of local approaches.

Bon Secours' clinical transformation represents a true partnership between clinical and finance professionals. Together, they work to uncover variances, determine best practices, and quantify any potential cost savings that may result from implementation. The corporate office gives local transformation teams uniform goals, but allows them to experiment with process improvements to determine what will work best under local circumstances. For example, when the corporate office targeted aggressive reductions

in the hospital-acquired infection rate (a composite rate of seven infections) over a three-year period, targets were made uniform across the hospitals, but efforts varied from facility to facility depending on specific infections that needed the most attention locally.

For all systemwide initiatives, finance leads are included in each systemwide group to help ensure consistency in calculations and uniform reporting. The system also defines a standardized system for calculating savings related to quality improvements. A finance steering committee at the corporate level serves as the governor for all calculations, and reviews all calculations submitted by local systems before they are compiled into a single playbook that is disseminated back to the local systems.

Data on costs need not be supplied on a daily basis, but quarterly or annual cost reports are not sufficient, especially in high-volume areas where wide variations in physician preference items can quickly drive overall costs up or down. Section leaders need to be able to regularly monitor trends in the cost of supplies and labor on at least a monthly—if not weekly—basis. To the extent that health-care organizations are exposed to financial risk through a bundled or capitated payment model, the need for more timely cost reports will intensify.

An organization's ability to deliver timely data will be driven largely by the degree to which data collection and analysis can be automated. As healthcare organizations work to implement electronic health records and healthcare IT systems, the ability to deploy these systems to drive timely reporting of quality and cost data should be a priority from both a clinical and financial perspective.

# IMPROVING THE ACCURACY OF COSTING DATA

Although the timeliness of data is an issue, the healthcare industry faces a bigger challenge with respect to the accuracy of cost data. “To put it bluntly,” said Harvard Business School professors Robert Kaplan and Michael Porter in a recent article, “there is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved.”<sup>1</sup>

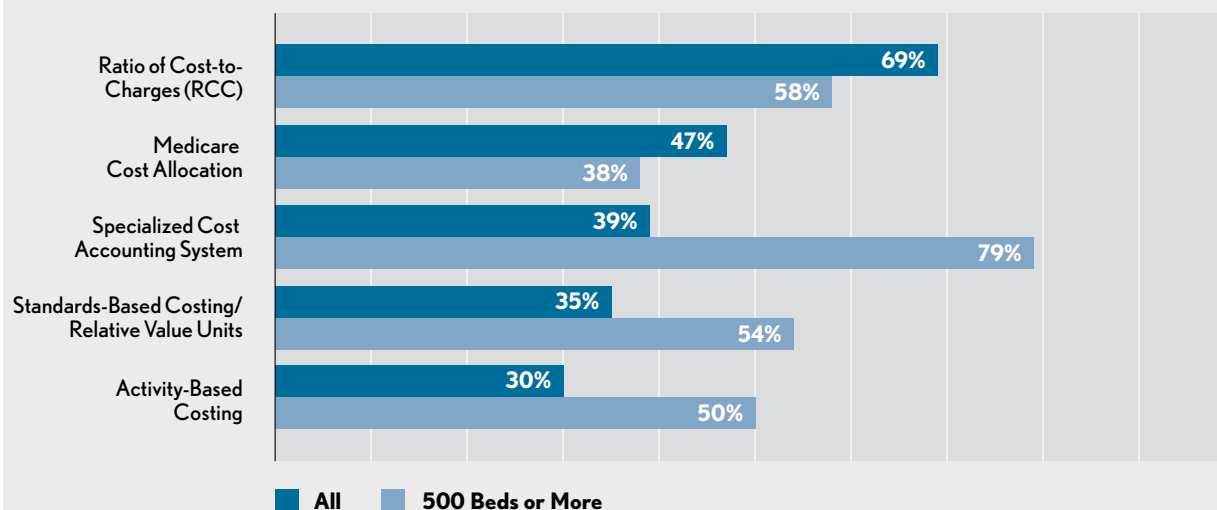
The continued prevalence of ratio of cost to charges (RCC) in hospital cost accounting contributes significantly to the healthcare industry’s difficulty in accurately estimating the costs of patient care. Over the past 50 years, charges for many services have become untethered from the actual amount paid as cost-shifting and cross-subsidization have inflated charges for some services and artificially repressed charges for others. RCC, which assumes a consistent relationship between costs and charges, makes an assumption that simply doesn’t exist because of the way in which hospitals have set charges, leading to an inaccurate allocation of costs—especially indirect costs.

A January 2011 Value Project survey confirms a continued reliance on RCC for cost accounting in many hospitals. When all hospitals responding to the survey are considered, RCC was the most prevalent method of costing. However, the survey also showed that larger hospitals and health systems are beginning to move away from RCC in favor of specialized cost accounting systems; other costing methods, including standards-based costing (RVUs) and activity-based costing, follow close behind RCC at these larger organizations.

Other evidence suggests that healthcare organizations are coming to terms with the limitations of current costing methods in a value-based payment setting. At HFMA’s 5th Annual Thought Leadership Retreat, held in early October 2011, attendees were asked whether they thought that decision makers at most provider organizations would say that costing data is accurate, timely, appropriate, and reported in a useful manner. Only 22 percent of attendees thought this statement would hold true “always” or “most of the time.” The remainder thought this statement was true only “sometimes” (61 percent) or “never” (17 percent).

## COSTING METHODS USED BY HEALTHCARE ORGANIZATIONS

What methods are in use to allocate indirect and overhead costs to departments, procedures, or activities?



Source: HFMA Value Project Survey, January 2011.

<sup>1</sup> Kaplan, R.S., and Porter, M.E., “The Big Idea: How to Solve the Cost Crisis in Health Care,” *Harvard Business Review*, September 2011, available at [hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care/ar/1](http://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care/ar/1)

## WHY COSTING METHODS NEED TO CHANGE

Healthcare veterans may understandably feel a sense of déjà vu when the issue of inadequacies in costing is raised. Calls for a move from RCC to more accurate costing methods, such as activity-based costing, were made during the 1980s and 1990s, when healthcare organizations faced the prospect of capitated managed care contracting. Several things are different this time around.

**The era of cost shifting is drawing to a close.** Most hospitals and health systems have maintained that Medicare reimburses below cost, and have accordingly shifted the unreimbursed costs of care for Medicare beneficiaries to private payers. Faced with rising healthcare costs, employers have responded by asking employees to take on an increasing share of the burden in the form of higher premiums, deductibles, and copayments and by shifting costs to their employees in other ways. The most recent Kaiser Family Foundation/Health Research & Educational Trust Employer Health Benefits Survey, released in September 2011, noted that 31 percent of the insurance

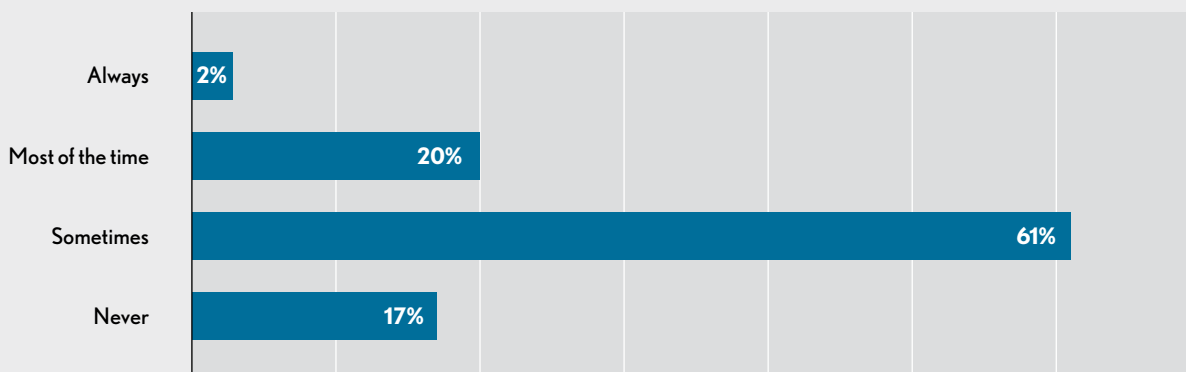
plans offered by employers are high-deductible plans (\$1,000 or more deductible for single coverage), up from 10 percent in 2006. Premiums for family coverage have increased 113 percent since 2001, compared with 34 percent for workers' wages and 27 percent increase for inflation. Such increases in healthcare costs eclipse increases in employee earnings and are clearly unsustainable.

Other measures that employers are considering as ways of pushing back on rising healthcare costs include reference pricing and moving employees toward state-run health insurance exchanges if, as required by current law, they become operational in 2014. At least one report has indicated that up to 30 percent of employers are considering dropping employer-sponsored coverage after 2014; however, the report's findings are controversial.<sup>2</sup>

In response to such measures, some healthcare organizations are seeking to rebut the assumption that Medicare pays below cost. For example, Novant Health, based in Winston-Salem, N.C., has analyzed payment trends and sees all payers moving in the direction of Medicare levels

### MEASURING THE VALUE OF HOSPITAL COSTING DATA

**Decision makers at most provider organizations would say that costing data are accurate, timely, appropriate, and reported in a useful manner:**



Source: HFMA Thought Leadership Retreat Survey, October 2011.

<sup>2</sup> See Singhal, S., et al., "How US Health Care Reform Will Affect Employee Benefits," *McKinsey Quarterly*, June 2011.



of reimbursement. Novant also noted that best performance across its top hospitals would put costs at 97 percent of Medicare reimbursement. Accordingly, it established a five-year goal for the system as a whole to bring costs below Medicare level. From 2008 to 2010, the system's cost percent of Medicare reimbursement has improved from 113 percent to 106 percent.

**Healthcare providers face increasing pressure for price transparency.** Healthcare organizations are already being asked to make public quality data relating to clinical processes and outcomes, patient safety, and patient satisfaction. A demand for similar transparency in pricing has already begun, and providers should expect this demand to intensify as consumers are asked to shoulder an increasing portion of their healthcare expenses.

A recent report by the U.S. Government Accountability Office<sup>3</sup> highlighted the difficulty most provider organizations have in providing accurate price estimates for common services. The GAO anonymously contacted 39 providers (19 hospitals and 20 primary care physician offices) in a Colorado healthcare market to request price information for full knee replacement surgery from the 19 hospitals and for diabetes screening from the 20 physician offices. Providers could at best provide only incomplete estimates or estimates within such a wide range of price (between \$33,000 and \$101,000 for knee replacement surgery) as to severely limit the usefulness of the information for identifying a "value" provider in advance of the procedure.

The GAO acknowledged that many of the difficulties providers face in providing accurate pricing information are products of both the nature of health care and the current system. For example, the unique circumstances of patients can cause significant variation in the final price for a service, and the services involved in an episode of care are often provided by multiple providers who bill for

their services separately. Providers may also have difficulty accessing an insured patient's health benefit structure, making it difficult to estimate out-of-pocket costs under a specific benefit plan, or may have contractual obligations with an insurer that prevent them from disclosing negotiated prices. Yet the GAO was able to identify two existing price transparency initiatives (New Hampshire HealthCost and Aetna Member Payment Estimator) that are able to provide complete cost estimates to consumers. This led the GAO to conclude that despite the complexities of pricing in health care, price transparency is "an attainable goal."

**New payment models will reward providers that can accurately cost services, and penalize those that cannot.**

New payment models designed to overcome some of the systemic issues affecting pricing identified in the GAO's report on price transparency will reward providers that are able to accurately cost their services and price them accordingly. Providers that cannot accurately cost and price their services will either be shut out of these models or put themselves at risk of significant losses.

As an example, consider bundled payments for an episode of care. An organization without an accurate sense of the actual direct and indirect costs for the services rendered across the episode is at risk of either overpricing the bundle, making it less attractive to purchasers, or underpricing the bundle, exposing the organization to financial risk.

Underlying this example is the point that new, value-based payment systems will ask providers to reconsider how they define and price units of care. A costing method that might have been sufficient under a fee-for-service payment system may well prove inadequate within a bundled payment system or a per-member, per-month capitated system that requires close tracking of utilization and costs. Changes in costing will be driven by provider realization that new payment mechanisms are exposing them to risk.

<sup>3</sup> *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care*, U.S. Government Accountability Office, September 2011.

## MAKING THE MOVE TOWARD IMPROVED COSTING

Realistically, fee-for-service payment still represents the bulk of payments for most hospitals today, and the urgency with which hospitals and health systems respond to the need for improved costing will be driven by market composition, treatment focus, penetration of managed care, and prevalence of value-based payment models (see the exhibit below).<sup>4</sup> Nonetheless, few hospitals will suffer from improving the accuracy of their costing system. Benefits include:

- The ability to better analyze contract underpayment
- The ability to develop a more defensible pricing structure reflective of actual costs
- A better understanding of profitability per physician
- Improved ability to review service lines for profitability
- The ability to understand the financial outcomes of different care alternatives
- A better understanding of the efficiency of care (including opportunities to identify where excess capacity exists)

Many hospitals and health systems have postponed investments in improved cost accounting, focusing instead on investments in electronic health records and healthcare IT infrastructure to improve the quality side of the value equation. Improved cost accounting should be next on the list, so that healthcare organizations will be better able to

understand and drive both the quality numerator and price denominator of the value equation. To begin, healthcare organizations should consider these initial steps.

**Prioritize cost enhancement efforts.** Begin by focusing costing enhancement efforts on priority areas for better cost management—where high costs are producing low or nonexistent margins or where wide variations in cost suggest opportunities for cost containment. Such areas, which hold potential for significant cost savings, might be chosen as the focus of a value-based initiative with a government or commercial payer that enables an organization to experiment with improved costing on a defined bundle of services or management of a defined population.

For example, Partners HealthCare has piloted defined episodes of care for five major procedures and chronic conditions (acute myocardial infarction, CABG, colon cancer, stroke, and diabetes). It maps care redesign processes for each procedure or condition across the episode, identifying sites of care, providers (e.g., physician specialist, nurse, nurse navigator), tests and procedures, and timing involved for each step, as well as “pause points” at which an action or intervention is indicated and where there is an opportunity to influence both care and costs by standardizing procedures or supplies, eliminating unnecessary tests, or reducing length of stay within best practice guidelines. These care redesign process maps serve both clinicians and finance staff by defining what

### EVALUATING THE NEED FOR COSTING SYSTEM ENHANCEMENT: 4 KEY FACTORS

Factor	Low Need	High Need
<b>Market composition</b>	Solo provider	Multiple hospitals Freestanding providers Entrepreneurial physicians
<b>Treatment focus</b>	Treat-and-serve or transfer	Regional referral or specialty
<b>Managed care penetration</b>	Up to 10%	20% or more with anticipated growth
<b>Payment models</b>	Charges, discounted charges	Case rates, capitation carveouts, bundling

<sup>4</sup> See Selivanoff, Paul, “The Impact of Healthcare Reform on Hospital Costing Systems,” *hfm*, May 2011.

must be managed—and, accordingly, measured—across the episode of care. Finance staff can use the maps as an inventory of labor, supply, testing, and facility costs for both a standard procedure and common variations from the standard process of care. Then, working with clinicians, finance staff can help identify realistic goals for cost savings at “pause points.” Bundled payments for episodes can then be priced to account for typical costs across the full episode of care, anticipated variations, and cost-saving goals.

**Review working definitions and methods of allocating cost categories.** “Depending on the relevant time frame, almost all costs are variable,” says Richard L. Clarke, DHA, FHFMA, President and CEO of HFMA. Staff size can be increased or decreased; wages and benefits can be renegotiated; facilities can be downsized or repurposed. Instead of permanently assigning a group of costs to the “fixed” category, organizations should define both the period within which costs operate as “fixed” and the point at which those costs might become variable so they do not lose sight of the opportunity to change “fixed” costs.

Organizations should also consider how factors like volume fluctuations might affect the categorization of a cost as fixed or variable. For example, minimum staffing needs may establish fixed labor costs on a unit below a

certain volume, but additional staffing needs above the minimum to accommodate increased volumes would represent variable labor costs.<sup>5</sup>

The distinction between direct and indirect costs should also be examined, with an eye toward identifying those indirect costs that can be assigned more directly. Overhead costs for lab and radiology, for example, should be assigned only to lab and imaging services.

**Enhance the specificity of costing data.** The more specific the costing data, the better the information available for decision support. Greater specificity will typically require a greater dedication of resources, so initial efforts might focus on high-volume procedures or procedures with wide variations in costs, where better cost information might help in identifying opportunities for significant savings.

For healthcare organizations that have an acuity system, a first step might be developing costs per acuity level for a given procedure. At a more advanced level, organizations should consider adopting “job costing” over “standards costing”—capturing actual labor, supply, and pharmaceutical costs as they are consumed by individual patients.<sup>6</sup> Although this is a potentially laborious effort, technological solutions—such as bar coding, radio frequency identification, and “smart rooms” that identify staff—can be deployed to automate accurate capture of costs.

<sup>5</sup> See Selivanoff, “Impact of Healthcare Reform,” pp. 113–14.

<sup>6</sup> Selivanoff, pp. 112–13.

# DEVELOPING BUSINESS CASES FOR ACTIONABLE DATA

Even with actionable, accurate data in hand, every organization has a limit on the number of projects it can pursue at any given time. Defining a clear process for business plan development and review helps ensure that decision makers are getting the appropriate information they need to prioritize projects that have the greatest potential benefit for the organization.

A consistent business case development process that requires the identification of clear project goals, metrics to measure progress toward those goals, and solid estimates of the resources required to reach those goals also will serve an organization's business intelligence needs by focusing attention on information-based approaches to value improvement and the collection and analysis of quality and cost data.

The first step is to establish basic priorities for the organization against which individual business plans can be judged. For example, organizations may wish to prioritize projects that:

- Align with the organization's strategic vision and goals
- Are designed to strengthen one or more fundamentals of value creation: patient satisfaction, clinical outcomes, and financial results
- Have an impact across multiple departments
- Focus on areas that are primary drivers of the organization's costs or volume
- Demonstrate growth potential for the organization

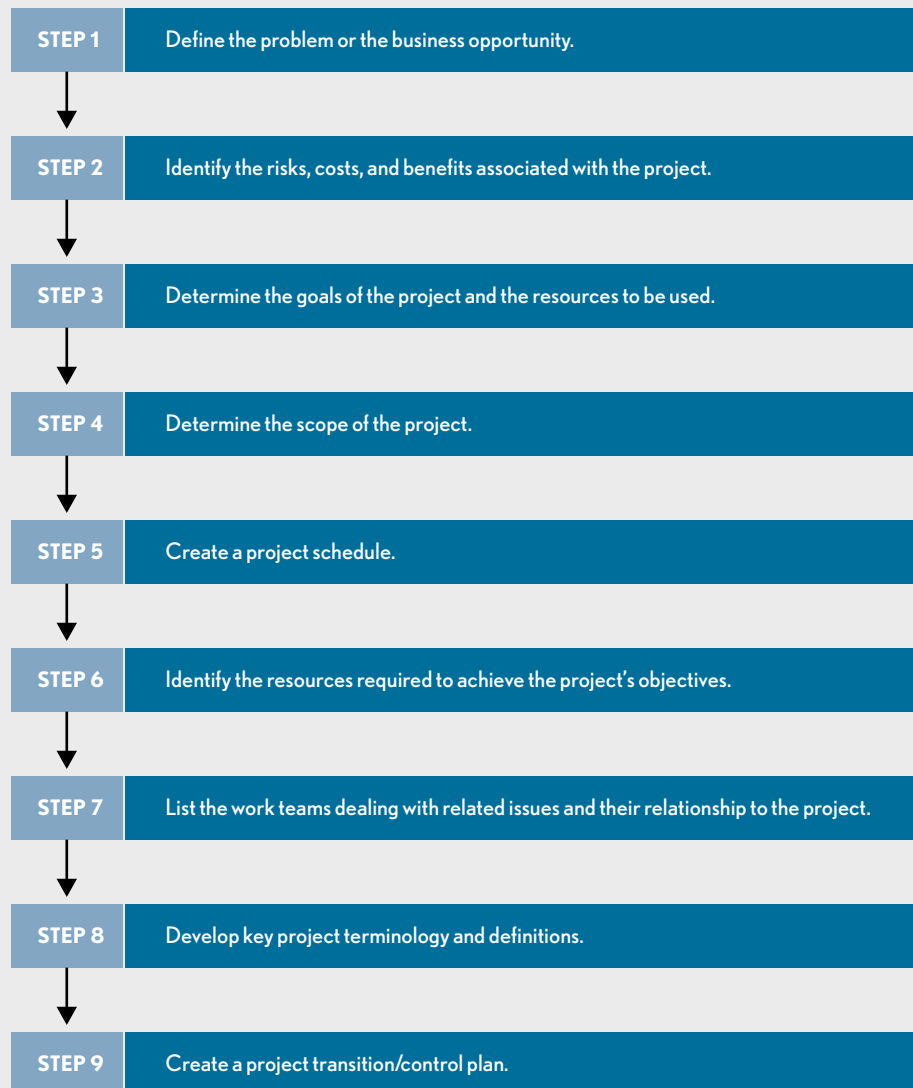
- Have clearly defined metrics for determining the project's success in terms of quality, cost, or both
- Have clear sponsors or champions within the organization

For organizations that are just beginning to focus on value improvement, it is especially important that early projects take on "easy wins"—areas where improvements are clearly needed, staff are motivated to make improvements, and sufficient data are available to quantify successes clearly.

Based on these priorities, the organization can then develop a template or "project charter" for use throughout the organization on value improvement projects. The use of a standard template or charter ensures that similar information is being gathered for each proposed initiative so that decision makers can easily compare and prioritize projects. (An example of a project charter template, provided by Bellin Health in Green Bay, Wis., is available in the "Business Intelligence" section of the Value Project web tool, under the "Business Case Development" focus area. The web tool can be accessed at [www.hfma.org/valueprojecttool](http://www.hfma.org/valueprojecttool). View the steps for Bellin Health's project management process at right.)

Organizations should also use a project charter to define "no-go" points for new initiatives. If an initiative is not meeting quality improvement or cost saving objectives specified in the project charter within a defined period of time, organizational resources can be dedicated to other initiatives with greater potential to improve value.

## A TOOL FOR PROJECT MANAGEMENT: BELLIN HEALTH



*View the project charter that teams at Bellin Health use in managing projects at [www.hfma.org/valueprojecttool](http://www.hfma.org/valueprojecttool).*

# CONCLUSION

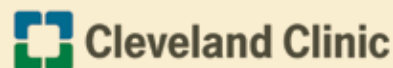
**H**ealth care is an industry awash in data, but the industry is just beginning to unlock the potential of that data to drive the changes in the quality and cost of care that a value-based healthcare system will require. To fully realize the potential of business intelligence in creating value, healthcare organizations will have to reach beyond their walls to collaborate with payers, government agencies, and other providers on the collection, sharing, and analysis of quality and cost data.

Business intelligence will be an ongoing focus of HFMA's Value Project; It should be a focus for all healthcare organizations as well. Healthcare organizations should take steps now to harness the data they have on hand to prepare for the shift toward value-based business models of care. Such actions will help providers adjust to these new models—and, ultimately, improve value for consumers and purchasers.

## RESEARCH SPONSORS AND ACKNOWLEDGEMENTS

---

Research for this report was sponsored by the 17 hospitals and health systems represented on HFMA's Value Steering Group, including:



## PUBLISHED BY

---



**hfma**

healthcare financial management association

The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 35,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. We provide education, analysis, and guidance; we lead change and innovative thinking; and we create practical tools and solutions that help our members get results. Addressing capital access to improved patient care to technology advancement, HFMA is an indispensable resource on healthcare finance issues.

## **BUILDING VALUE-DRIVING CAPABILITIES: BUSINESS INTELLIGENCE**

**January 2012  
Copyright 2012**

**Healthcare Financial Management Association  
3 Westbrook Corporate Center, Suite 600  
Westchester, IL 60154-5732**

**All rights reserved.  
Correspondence: [resourcecenter@hfma.org](mailto:resourcecenter@hfma.org)**

## PUBLICATION SPONSORS

---

