

# HFMA REGION V DIXIE INSTITUTE

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## Turning Data into Useful Information:

How to Effectively Collect, Analyze, and Report

Financial and Clinical Data to

Enhance Decision-Making in Health Care

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# OUTLINE



## **I. Introduction**

- **Definitions**
- **The challenges**

## **II. Meeting the Needs of the Information-Driven Organization**

## **III. Conducting an Assessment / Re-assessment**

## **IV. What's in Your Tool-Kit?**

## **V. Examples of Clinical and Financial Data Integration**

- **Service line analysis**
- **Strategic financial plan**

# DATA AND INFORMATION

**“Data refer to raw facts and figures which are collected as parts of the normal functioning of the [organization].**

**Information, on the other hand, is defined as data which have been processed and analyzed in a formal, intelligent way, so that the results are directly useful to those involved in the operation and management of the [organization].”**

# THE DECISION-MAKING MODEL

The decision-making model is made up of 5 steps:

1. Intelligence gathering
2. Devising solution alternatives
3. Choosing the best solution
4. Implementing the solution
5. Evaluating its effectiveness

*Oliveira, Jason, A Shotgun Wedding: Business Decision Support Meets Clinical Decision Support, Journal of Healthcare Information Management - Vol. 16, No. 4: 2001.*

# DECISION SUPPORT DEFINITION

A “Decision Support” system is a common information system that combines data from disparate sources into one system, and provides modeling and analysis tools to support decision-making.

**A successful DSS:**

- Integrates financial, statistical and operational data into one system
- Allows most financial and operating decisions to be made easily and in a more timely fashion
- Allows data to be “sliced” in multiple way and formats in response to changes in business needs
- Provides data in a more controlled fashion to end users in a friendly format
- Automates manual processes

# DECISION SUPPORT ARCHITECTURE

## Acquisition

Acquiring data from numerous internal operational information systems as well as external data sources



## Organization

Efficiently modeling, storing and retrieving the data with applied business and clinical rules and semantics



## Exploitation

The various retrieval, reporting, analysis and decision support tools used to derive and deliver information from the acquired and organized data.

Oliveira, Jason, *A Shotgun Wedding: Business Decision Support Meets Clinical Decision Support*, *Journal of Healthcare Information Management* - Vol. 16, No. 4: 2001.

# NEW BUZZ-WORDS

## “Decision Support”

- Providing information to make informed decisions

has given way to....

## “Performance Management”

- Results-oriented
- Actionable information

### *The decision-making model*

1. *Intelligence gathering*
2. *Devising solution alternatives*
3. *Choosing the best solution*
4. *Implementing the solution*
5. *Evaluating its effectiveness*

# THE NINE DIMENSIONS OF PERFORMANCE

## 1. Efficacy:

The degree to which patient care has actually achieved the desired outcome(s)

## 2. Appropriateness

The degree to which the care and services provided are relevant to the individual's clinical needs

## 3. Availability

The degree to which appropriate care and services can be accessed

## 4. Timeliness

The degree to which care is provided at the most beneficial or necessary time

## 5. Effectiveness

The degree to which care is provided correctly, to achieve the desired outcome(s)



# THE NINE DIMENSIONS OF PERFORMANCE (cont.)

## 6. Continuity

The degree to which care is coordinated among practitioners, among organizations, and over time

## 7. Safety

The degree to which the risk of an intervention and risk in the care environment are reduced for both patients and others

## 8. Efficiency

The relationship between the outcome and the resources used to deliver care (i.e. cost/benefit ratio)

## 9. Respect and caring

The degree to which those providing care and services do so with sensitivity to the patient's needs, expectations, and individual differences, and the degree to which the patient is involved in his or her own care decisions.

# **MEETING THE NEEDS OF THE “INFORMATION-DRIVEN” ORGANIZATION**

# MEETING THE NEEDS OF THE “INFORMATION-DRIVEN” ORGANIZATION

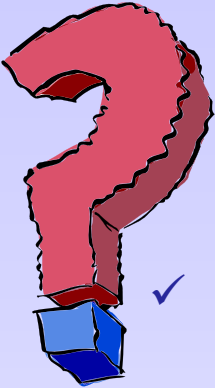
When meeting information requests, it's important to:

- Recognize the REAL question
- Anticipate future information needs
- State the problem before trying to find the solution

# HANDLING INFORMATION REQUESTS

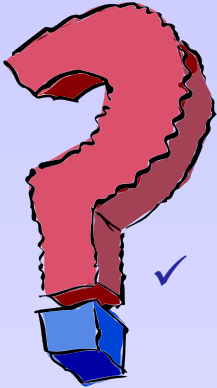
- The analyst must often revise or re-state the information request.
- Why?
- The Decision Support analyst is close to the data:
  - Audits data, notices irregularities
  - Knows what data is available from various systems in the organization
  - Know what others are looking at

# QUESTIONS TO ASK



- ✓ **What is the report for?**
  - Purpose of the report
  - Is there a premise/hypothesis that is being confirmed or disputed?
  
- ✓ **Who is it for? (ultimate recipient of the information)**
  
- ✓ **What population should be included in the report?**
  
- ✓ **What data is needed?**
  
- ✓ **Are there any exclusions? e.g.**
  - Outliers
  - Non-acute

# QUESTIONS TO ASK (cont.)



- ✓ **How should the data be organized?**
  - What detail is needed?
  - What, if any, subtotals should be reported
  - Graphs vs. tabular reports
  
- ✓ **What other information is needed to tell a story? e.g.**
  - Break out ICU from Med/Surg days
  - Break out costs by direct/indirect
  - ALWAYS show volume (no. cases)
  - Add ratios (per case, per day)
  - Add severity data if available
  
- ✓ **How frequently will the report be run in the future?**
  - Frequency affects decisions about how the report is set up
  - Consider ease of maintenance
  - Automate reports that are run frequently

# OTHER ADVICE FOR THE “INFORMATION-DRIVEN” ORGANIZATION

Develop a “QA” process for all reports distributed



# OTHER ADVICE FOR THE “INFORMATION-DRIVEN” ORGANIZATION

- Document or at least confirm the organization’s policies vis-à-vis distribution of information:
  - e.g. Who receives cost information?
- Prepare a DSS user-guide:
  - Internal guidelines and definitions (e.g. paid accounts are those with a \$0 balance)
  - Listings of necessary tables, etc.
  - Glossary of terms
  - Data dictionary (see example of a listing on next page)



## ADMISSION SOURCE

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<b>Field Name</b>	ADMISSION SOURCE
<b>Source</b>	REGISTRATION
<b>Location in Decision Support</b>	Row Sort: Patient Data Column: Patient Identification
<b>Field Type/Length</b>	1 Character Alphanumeric
<b>Definition</b>	This is the standard UB92 field which indicates the source of admission or outpatient service.

**Allowable Values**  
**Lookup Table available in**  
**Decision Support**

<b>Value</b>	<b>Description</b>
1	Physician Referral
2	Clinic Referral
3	Managed Care Referral
4	Transfer From Another Hospital
5	Transfer From Skilled Nursing Facility
6	Trans From Another Health Care Facility
7	Emergency Department
8	Court Ordered
9	Unknown
<b><u>Additional Coding Structure: Newborn</u></b>	
A	Normal Newborn – Born in Hospital
B	Premature Delivery
C	Sick Baby
D	Extramural Birth

**Issues Related to Use of Data**

For hospital A, this is not a required field; therefore, it is not consistently entered by Registration.

# **CONDUCTING AN ASSESSMENT / RE-ASSESSMENT**

# **CONDUCTING AN ASSESSMENT / REASSESSMENT**

**Many organizations are now at a point where a strategic review of Decision Support is warranted:**

- **Systems are mature (10+ years), and DSS capabilities have changed since the system was implemented.**
- **Vendors are promoting their “next generation” of DSS / Performance Management solutions.**
- **The organization needs to determine if the DSS should be replaced, upgraded, or simply improved and better utilized.**
- **Regardless of the decision, the strategic review process will consist of the same steps, and will include a thorough information needs assessment.**

# CONDUCTING AN ASSESSMENT / REASSESSMENT

The strategic review/assessment should encompass these areas:

## I. Foundation

- ✓ Review the data structures
- ✓ Determine additional data required; e.g.
  - Severity information (APR-DRG)
  - APC's
  - RUG's classification (Rehab)
  - O.R. system data
  - Comparative/benchmarking data
- ✓ Evaluate update frequency
  - Move from monthly to weekly or daily updates
- ✓ Examine any issues with data integrity
- ✓ Does the accuracy/integrity of costs or net revenue need to be improved?

# CONDUCTING AN ASSESSMENT / REASSESSMENT

The strategic review/assessment should encompass the following areas (cont.)

## II. Internal infrastructure

- ✓ Does the organizational structure help or hinder the efficient use of DSS?
- ✓ Is the information getting out of Finance?
- ✓ Staffing: Do we have the right people? Do we need cross-training?
- ✓ Documentation: Do we have the right internal documentation?

## III. Current usage

- ✓ Determine areas of under-utilization
- ✓ Conduct interviews with key “customers” to determine how DSS can better meet their information needs
- ✓ Identify any obstacles to efficient utilization of the system and determine how to remove them
- ✓ How is information being distributed, and can we improve on this? (e.g. web-based tools)

(example of assessment document on next page)

## Decision Support Assessment

Strategic	Comments	Using	Plan to use	No interest
Product Line/Service Line Reporting	Analyze proposed new programs		X	
Case-Based Budgeting	Not current budget approach			X
Market Share Analysis	Requires state data from HCMIS		X	
Patient Origin Reporting		X		
DRG Profitability Reporting	CPA will enhance net revenue info		X	
Contribution Margin	By Program	X		
Strategic Plan Development			X	
<b>Clinical</b>				
Severity Analysis	Would require APR-DRG data		X	
Acuity Analysis	ANSOS used for scheduling only			X
Outcome Analysis			X	
LOS Comparisons		X		
Physician/Peer Comparisons				
Benchmarking	Load ORYX data into CCA		X	
Case Resource Consumption		X		
Critical Pathway Development	Need training		X	
Physician Credentialing	Medical staff office has software			X
<b>Financial</b>				
Contracting/What If	CPA required		X	
Contract Performance	CPA required		X	
Cost Accounting	Plan to update standards	X		
Pricing Strategies		X		
Payor Analysis		X		
Monthly Contractuals	Done offline			X
Balance Sheet Reporting	Done in G/L			X
Consolidated Financial Reporting	Done in G/L			X
<b>Budgeting/Cost Control</b>				
Variance Analysis (Rate/Efficiency/Volume)	Load stats into HSL thru Mgmt Statistics process	X		
Flexible Budgeting			X	
Productivity Reporting	In past, measures of success	X	X	
Payroll Budgeting		X		
Net Revenue Budgeting	Can accomplish with CPA		X	
Department Profit/Loss Reporting			X	

# CONDUCTING AN ASSESSMENT / REASSESSMENT (cont.)

The strategic review/assessment should encompass the following areas (cont.):

## IV. Goals

- ✓ Final outcome of the process is a list of DSS goals, and...
- ✓ Action plan to implement the goals
- ✓ Develop a steering committee/DSS user group to monitor the progress

# WHAT'S IN YOUR TOOL-KIT?





# TOOLS FOR TURNING DATA INTO USEFUL INFORMATION

## *Comparative/Benchmark Data*

- **Most Decision Support / Performance Management systems offer the ability to load comparative & benchmark data from any source.**
- **Providers of this information fall into two categories:**
  - **“Off-the-shelf”:** use publicly available data such as the MedPar file, or patient data required by the state to be submitted on a quarterly or annual basis
  - **License /Partner agreements:** use data submitted by their member hospitals. You supply your data to add to their data base, they compile comparative reports.

## SOURCES OF BENCHMARK DATA

Company Name	Focus	Web Site
<b>Agency for Healthcare Research and Quality</b>	AHRQ provides info on hospital and diagnosis procedures Top reasons for admissions, most common diagnoses Maintains 22 state information database with key info from hospital discharge abstracts. See HCUP and HUCPnet	<a href="http://www.ahrq.gov">www.ahrq.gov</a>
<b>American Hospital Association</b>	The Health Forum provides communication, information, education and research products and services that advance leadership for health. The business development unit is responsible for AHA Annual Survey which has been conducted continuously since 1946. It is the nation's best source of data for profiling and characterizing the hospital field.	<a href="http://www.ahadata.com">www.ahadata.com</a>
<b>American Hospital Directory</b>	The American Hospital Directory provides on-line data for over 6,000 hospitals. Our database of information is built from Medicare claims data, cost reports, and other public use files obtained from CMS (formerly HCFA). The directory also includes AHA Annual Survey.	<a href="http://www.ahd.com">www.ahd.com</a>
<b>AMA</b>	Publishes the Clinical Performance Measurement Directory based on national survey of group practices and state medical societies, with detailed info on more than 300 performance-improvement programs.	<a href="http://www.ama-assn.org/">www.ama-assn.org/</a>
<b>CareScience, Inc.</b>	CareScience is one of the nation's leading providers of care management services to hospitals, health systems, and pharmaceutical and biotechnology companies. CareScience is the market leader in clinical quality and care management. We help hospitals and health systems improve quality by building organizational support for change, addressing challenges to improve clinical performance and expanding the role of care management.	<a href="http://www.carescience.com">www.carescience.com</a>
<b>CMS - HCFA Centers for Medicare and Medicaid Services</b>	Tracks national and state statistics on LOS, total days of care and number of discharges, inpatient, outpatient and nursing home prices. Provides hospital-specific data in similar categories	<a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a>
<b>Data Advantage</b>	Prepares hospital benchmarking reports, including pricing, reimbursement, expected cost, trending and data on the top 50 DRGs National Data and a new Data View product which allows the creation of Peer Groups.	<a href="http://www.data-advantage.com">www.data-advantage.com</a>
<b>GE Medical Systems (MECON)</b>	Benchmarks supply chain management, clinical quality mgmt, and operating consulting	<a href="http://www.gemedicalsystems.com">www.gemedicalsystems.com</a>
<b>HCUPnet (AHRQ)</b>	Provides access to national statistics and trends and selected State statistics about hospital stays. A tool for identifying, tracking, analyzing, and comparing statistics on hospitals at the national regional and state level. Part of the Healthcare Cost and Utilization project. This is the process of retrieving data.	<a href="http://www.hcup.ahrq.gov">www.hcup.ahrq.gov</a>

## SOURCES OF BENCHMARK DATA (cont.)

Company Name	Focus	Web Site
<b>Ingenix</b>	Through subsidiaries CHIPS, St. Anthony's Publishing and Medicode provides a wide range of benchmarking information and performance comparisons. Have relationships with 2000+ hospitals. Also collect Commercial Payer Claims for I/P and O/P for 30 states.	<a href="http://www.hospitalbenchmarks.com">www.hospitalbenchmarks.com</a> <a href="http://www.ingenixonline.com">www.ingenixonline.com</a> <a href="http://www.ingenixefact.com">www.ingenixefact.com</a>
<b>Mass Health Data Consortium</b>	The Massachusetts Health Data Consortium provides inpatient comparative data. Summary report can be ordered thru MHDC, or the full data base is available in ASCII or Access.	<a href="http://www.mhdc.org">www.mhdc.org</a>
<b>MetroHealth America, Inc.</b>	MetroHealth American, Inc. was formed in 1996 for the purpose of providing healthcare data to consumers and medical providers by utilizing the rapidly expanding internet. Health-mart.net is offering comparative hospital inpatient data to consumers, hospital administrators, medical professionals and managed care managers.	<a href="http://www.health-mart.net">www.health-mart.net</a>
<b>National Center for Health Statistics</b>	of the Centers for Disease Control and Prevention conducts National Hospital Discharge Survey, a compilation of utilization stats from approx. 500 hospitals	<a href="http://www.cdc.gov/nchs/">www.cdc.gov/nchs/</a>
<b>Premier</b>	Premier manages patient-level clinical, financial and abstracted hospital medical record data for over 500 US hospitals and provides Web-based subscription access to each facility's standardized data and comparative normative and peer group aggregated values through standard and ad hoc system reporting.	<a href="http://www.premierinc.com">www.premierinc.com</a>
<b>Quadramed</b>	Uses managed care transactional data to create detailed performance reports and analyses. Identifies utilization problem areas to improve quality and cost saving analyses health plan contract performance to improve future contract performance to improve future contract negotiations.	<a href="http://www.quadramed.com">www.quadramed.com</a>
<b>Solucient (HCIA-Sachs) - including Top 100 Hospitals</b>	Solucient is the leading source of health care business intelligence. Its mission is to provide comprehensive, results-oriented information to drive business growth, manage costs, and deliver quality care. Solucient's expertise and proven solutions enable providers, payers, employers, and pharmaceutical companies to achieve results and realize value. By bridging the gap between data and information, knowledge and value, Solucient drives intelligent business decisions.	<a href="http://www.solucient.com">www.solucient.com</a>

# TOOLS (continued)

## *Business Intelligence Solutions*

- **Web-based**
- **New tools for “paperless” distribution of information**
- **Pull data from virtually any source (DSS and other)**
- **Offer graphing, dashboard, drill-down capabilities**
- **Information recipient has greater flexibility (e.g. can add arithmetic columns, change sort levels, rank, etc.)**
- **Intuitive, quick learning curve**

# TOOLS (continued)

## *Dashboard Display*

- **Executive summary of organization's performance in crucial areas**
- **Condensed, at a glance**
- **Usually includes a 12-month history in graphic form**
- **Software companies offer solutions that enhance the dashboard with easy-to-interpret graphics:**
  - **Green/red/yellow color coding**
  - **Ability to flag variances, and send email alerts**

# TOOLS (continued)

## *Balanced Scorecards*

- Developed in the mid-1990's at Harvard Business School
- A strategic management approach that helps align and sustain four broad performance areas:

### Business

Financial Performance  
Customer Knowledge  
Internal Business Processes  
Learning and Growth

### Healthcare

Financial Performance  
Satisfaction  
Performance Improvement  
Strategic

- Underlying concept is that the four areas should be equally balanced
- Organization sets goals for each area, and determines metrics for each

**EXAMPLES  
OF  
CLINICAL AND FINANCIAL  
DATA INTEGRATION**

# SERVICE LINE ANALYSIS

**“Service lines are back.”** (March 2004 HFM article)

**What’s different this time around?**

**“Service line strategy is not viewed as just a marketing function this time around. This time, senior managers seem to be on board, and they realize that the concept not only hold great financial promise, but also offers potential for gaining a competitive edge.”**

**“The second wave of service-line strategy - driven by more competitive forces and constrained payment - is likely to garner greater attention and improved execution as it is seen as more organizationally pervasive and market relevant.”**



# SERVICE LINE ANALYSIS

**What's different this time around?**

- **Service Line Definitions: We've had more experience with defining service lines, and now understand the need for service line definitions to be;**
  - Data driven,**
  - Market comparable**
  - Logical from an organizational perspective.**
- **Profit/Loss Analysis: More attention is being paid to accuracy of assigning both costs and net revenue to the service line level.**

# **SERVICE LINE ANALYSIS: STRATEGIES TO IMPROVE COSTING ACCURACY**

- **Assign direct costs to service lines wherever possible; e.g.**
  - Program-specific costs such as Diabetes Educ or Organ Acquisition
- **Move to “patient-level” costing by integrating patient-specific data such as;**
  - Nursing acuity data
  - O.R. system data (supply utilization and O.R. times)
  - RUG’s data (Rehab patients)
- **Reclassify costs from indirect to direct; e.g.**
  - Departmental support costs (Radiology transcription, Psych Admin, Cardiology Admin)
  - Teaching costs / direct patient care portion
  - FICA and other benefits
  - Major movable equipment depreciation
- **Review and revise methods of allocating fixed and overhead costs to the charge code (and hence, patient) level:**
  - Assign fixed and overhead to procedures and not to chargeable supplies or purchased services

# SERVICE LINE ANALYSIS:

## STRATEGIES TO IMPROVE NET REVENUE ACCURACY

- Ideally, information from a Contract Management System is used for net revenue.
  - Integrate other data into the Contract Management System as necessary; APC's, RUG's
- If a Contract Management System has not been fully implemented for all payers, collection ratios based on paid accounts would be an alternative.
  - Collection ratios should be detailed by DRG and/or Service in addition to payer
- Adjustments and settlements need to be factored into a service line analysis, since they are specific to payers and service lines.
  - Prior year settlements
  - DSH payments (allocate to Medicaid patients rather than Medicare)
  - Capitation payments
  - GME and other pass-through payments
- Bad debt can be handled as an expense or net revenue.

# **SERVICE LINE ANALYSIS: AN APPROACH FOR ORGANIZATIONS WITHOUT A DSS**

- ✓ **Define service lines based on data that is readily available and not overly detailed;**
  - **Inpatient: group DRG's (see example on following page)**
  - **Outpatient: use Medical Service codes or other classification**
  
- ✓ **Obtain detailed utilization data to determine costs at a service line level:**
  - **Inpatient: by DRG, payer, and department**
  - **Outpatient: by Medical Service, payer and department**
  
- ✓ **Obtain charges and payments (based on paid accounts only):**
  - **Inpatient: by DRG and payer**
  - **Outpatient: by Medical Service and payer**
  
- ✓ **COSTS: Use ratios of costs to charges, apply to departmental charges.**
  
- ✓ **NET REVENUE: use collection ratios based on paid accounts**
  - **Allocate net revenue adjustments and settlements across payers and service lines, as appropriate.**

# INPATIENT PRODUCT LINE SCHEME

PRODUCT LINE	DRG VALUES
1 NEUROSURGERY	1-4,6-8,27-30
2 NEUROLOGY	9,12-26,31-35
3 ONCOLOGY	10-11,64,82,172-173,199,203, 274-275,346-347,366-367, 400-405,409-414,473,492
4 OPHTHALMOLOGY	36-48
5 OTOLARYNGOLOGY	49-63,65-74
6 THORACIC SURGERY	75-77,83-84,103,482-483,495
7 PULMONARY	78-81,85-102,475
8 OPEN HEART	104-108
9 CARDIOLOGY	110-112,115-118,121-123, 126-145
10 CARDIAC CATHS	124-125
11 DENTISTRY	168-169,185-187
12 GASTROENTEROLOGY	174-184,188-190,202,204-208
13 ORTHOPEDICS	209-241,243,248-255,441,471, 491,496-503
14 RHEUMATOLOGY	242,244-247,256
15 GENERAL SURGERY	146-167,170-171,191-198, 200-201,257-270,285-293, 392-394,406-408,415,424, 439-440,442-446,458-459,461, 472,493-494
16 DERMATOLOGY	271-273,276-284
17 ENDOCRINE	294-301
18 UROLOGY	302-315,318-330,334-345, 348-352,476
19 NEPHROLOGY	316-317,331-333
20 GYNECOLOGY	353-365,368-369
21 OB/DELIVERY	370-375
22 OTHER OB	376-384
23 NEONATOLOGY	385-390
24 NORMAL NEWBORN	391
25 HEMATOLOGY	395-399,480-481
26 GENERAL MEDICINE	416-423,447-457,460,462-467
27 PSYCHIATRY	425-437
28 OTHER	468-470,477
29 VASCULAR SURGERY	5,113-114,119-120,478-479
30 TRAUMA	484-487
31 HIV	488-490

**PRODUCT LINE FINANCIAL STATEMENT**

	<b>Cardiac</b>	<b>Medical</b>	<b>Mental Health</b>	<b>Neuro</b>	<b>Obstetrics</b>	<b>Oncology</b>	<b>Orthopedics</b>	<b>Surg Other</b>
<b>GROSS REVENUE</b>								
<b>PATIENT SERVICE CHARGES:</b>								
INPATIENT CHARITY	0	0	0	0	0	0	0	0
INPATIENT COMMERCIAL	0	126,904	0	0	20,851	0	0	85,188
INPATIENT HMO	91,568	469,776	0	29,755	47,152	20,366	43,440	153,920
INPATIENT INDIGENT	87,907	1,189,217	66,925	80,657	21,060	39,431	120,315	539,670
INPATIENT MEDICAID	571,240	5,191,219	225,687	184,093	2,410,179	171,266	423,176	2,198,141
INPATIENT MEDICARE	2,780,710	14,627,091	123,600	1,286,036	25,686	1,408,177	1,949,276	5,652,592
INPATIENT PPO	356,987	1,666,529	16,894	136,138	271,805	181,919	320,412	1,546,716
INPATIENT PRIVATE	11,176	544,860	55,387	46,285	87,699	15,202	49,113	292,293
INPATIENT WORK COMP	0	172,747	0	0	0	0	187,328	13,848
<b>TOTAL PATIENT REVENUE</b>	<b>3,899,588</b>	<b>23,988,343</b>	<b>488,493</b>	<b>1,762,964</b>	<b>2,884,433</b>	<b>1,836,362</b>	<b>3,093,060</b>	<b>10,482,369</b>
<b>NET REVENUE</b>								
INPATIENT CHARITY	0	0	0	0	0	0	0	0
INPATIENT COMMERCIAL	0	59,876	0	0	17,566	0	0	73,334
INPATIENT HMO	12,113	240,209	0	6,816	23,030	16,039	18,003	27,359
INPATIENT INDIGENT	26,910	433,990	26,492	28,845	5,337	11,618	43,665	197,453
INPATIENT MEDICAID	211,718	2,029,908	104,728	71,659	1,049,467	78,055	183,303	940,100
INPATIENT MEDICARE	677,081	3,098,265	21,826	374,995	2,072	357,791	438,109	1,365,252
INPATIENT PPO	273,237	809,773	7,212	92,106	85,023	169,217	117,403	844,823
INPATIENT PRIVATE	0	21,490	11,173	8,287	0	0	15,991	39,728
INPATIENT WORK COMP	0	64,242	0	0	0	0	38,221	2,284
<b>NET PATIENT REVENUE</b>	<b>1,201,059</b>	<b>6,757,754</b>	<b>171,432</b>	<b>582,709</b>	<b>1,182,493</b>	<b>632,720</b>	<b>854,695</b>	<b>3,490,333</b>
DSH PAYMENTS	5,405	49,115	2,135	1,742	22,803	1,620	4,004	20,797
SETTLEMENTS - PRIOR YEAR	68,473	360,184	3,044	31,668	632	34,676	48,000	139,192
<b>TOTAL NET PATIENT REVENUE</b>	<b>1,274,937</b>	<b>7,167,054</b>	<b>176,611</b>	<b>616,119</b>	<b>1,205,929</b>	<b>669,016</b>	<b>906,699</b>	<b>3,650,322</b>
OTHER REVENUE	13,240	74,429	1,834	6,398	12,523	6,948	9,416	37,908
<b>TOTAL REVENUE</b>	<b>1,288,177</b>	<b>7,241,483</b>	<b>178,445</b>	<b>622,517</b>	<b>1,218,453</b>	<b>675,964</b>	<b>916,115</b>	<b>3,688,231</b>
<b>OPERATING EXPENSES</b>								
DIRECT EXPENSES	688,506	4,045,225	90,195	329,794	1,136,842	320,218	577,499	1,885,828
<b>CONTRIBUTION MARGIN( DEFICIT)</b>	<b>599,671</b>	<b>3,196,258</b>	<b>88,250</b>	<b>292,723</b>	<b>81,610</b>	<b>355,746</b>	<b>338,616</b>	<b>1,802,402</b>
OVERHEAD EXPENSES	308,330	1,856,062	40,858	154,206	481,061	147,092	264,065	832,116
<b>NET INCOME (LOSS)</b>	<b>291,341</b>	<b>1,340,196</b>	<b>47,393</b>	<b>138,517</b>	<b>(399,451)</b>	<b>208,654</b>	<b>74,551</b>	<b>970,286</b>

# IN CONCLUSION...

- Our job is to keep our organizations from being “DRIP” (data-rich, information-poor).
- As the volume of available data increases in healthcare organizations, it becomes more challenging to turn this into meaningful information. In essence, our challenge is to *condense* information:

“The real issue for future technology does not appear to be production of information, and certainly not transmission. Almost anybody can *add* information. The difficult question is how to *reduce* it.”

Eli Noam  
Columbia University

## **Questions or follow-up:**

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