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Only 10% of Healthcare Providers Know Their Costs — Here's Why Yale New Haven and Greenville Health are Part of That Elite Group

Written by Morgan Haefner | May 16, 2018

More than 90 percent of U.S. hospitals either don't have a cost accounting system or use an outdated and insufficient system, according to a recent survey of 100 hospital and healthcare delivery system executives conducted by Strata Decision Technology and Becker's Healthcare.

The study also revealed clinicians and physicians, who decide about 80 percent of their hospital's total spending, receive little to no cost information. The lack of actionable and accurate cost data makes it next to impossible for senior management to use cost as measurement.

Two effective ways to address cost obscurity are overhauling budget processes and marrying cost data with clinical language, two panelists said during an April 12 workshop sponsored by Strata Decision Technology at the Becker's Hospital Review 9th Annual Meeting in Chicago.

Terri Newsome, CFO of Greenville (S.C.) Health System, and Steve Allegretto, vice president of value innovation and shared value partnerships at Yale New Haven (Conn.) Health System, explained how they're raising the curtain on cost data. These are the strategies they deployed at their respective institutions.

1. How Greenville Health System gained confidence in supply cost information

The Strata/Becker's survey found only 12 percent of hospital leaders have high confidence in the accuracy of their cost information. At the same time, only 39 percent of healthcare organizations said they regularly review cost data to ensure it's the most up-to-date information.

Ms. Newsome told attendees that Greenville is not among the "lucky" 12 percent of hospitals that trust their cost accounting data. To shed light on cost, two years ago Greenville began transitioning from a static budget to a rolling forecast structure. The rolling forecast focuses on process improvement on an ongoing basis, rather than a typical 12-month budget that is obsolete one day after it's rolled out.

"As we took [static budget] out of the vernacular, we've now got folks really focused on day-to-day, month-to-month, quarter-to-quarter process improvement, and that cost data has become front and center," Ms. Newsome explained. "It changed conversations, the way people use the data and made it painfully obvious people didn't trust it."

Greenville looked to one area where mistrust in cost persisted: the supply chain. The system found while physicians often knew the cost of supplies provided by their representatives, large changes in inventory adjustment led to data inconsistencies on the clinical and financial sides.

Greenville used a tool to scrub the system's supply list, and integrated the clean supply master data into its cost accounting system. During the first year of the initiative, Greenville eliminated 15,000-plus duplicate items in its supply master and moved $15 million worth of spend into its contracted items. The change saved the system roughly $1.8 million throughout the past six months.

"We've gone through the effort to put a really tight process in place," Ms. Newsome said. Only two people at Greenville can put an item into the supply master. Greenville's budget overhaul uncovered the cost data needed to execute the new supply chain protocols, which has led to measurable change.

2. How Yale New Haven got cost and clinical data to talk

Clear data is only beneficial if it's relatable. When Yale New Haven began addressing cost obscurity on the clinical side, Mr. Allegretto found clinicians only wanted information on their patients.

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"We do that now by merging quality data into our payment analysis," Mr. Allegretto explained. "So if you want to go to a physician and talk about variation, we present to them their specific cases and provide information on patients that have had a blot clot or a punctured lung, [etc.]"

One clinical area where Yale New Haven is melding cost with clinical data is readmissions. The system decided to place cost accounting information in Epic at the time of treatment, and also enabled real-time alerts in the EHR. The real-time alerts flag a provider when their patients leave the system and if they re-enter through the emergency department.

"That ain't rocket science, but we were never able to do that before," Mr. Allegretto said. Now, when patients are readmitted, Yale New Haven tracks readmissions in a simple monthly report. System leaders distribute the report to clinicians and have face-to-face conversations with care providers about reasons the readmission occured.

Yale New Haven's ability to translate cost data into clinical terms led to the formation of its quality variation indicators. The QVIs comprise 30 categories of adverse events the system wants to eliminate. Physicians and other frontline staff developed the QVIs, which allowed Yale New Haven staff to speak the same language across financial and clinical operations.

Clear cost data is necessary for a health system's financial and clinical teams to cooperate. Greenville and Yale New Haven's experiences reveal while the strategy varies depending on the organization, making cost a priority for clinical staff is the first step in ensuring those clinicians — who decide most of a hospital's spending — are cost conscious.