HALO (Healthcare Access, Quality, and Outcomes) Analysis

## Aligning Financial Structure with Access, Quality, and Outcomes

**Aim:**

* Connect hospital financial inputs to patient access, quality, and outcomes to ensure value-based, sustainable care delivery.
* Identify where financial levers can improve outcomes without increasing total costs.

**Approach:**

* Parse financial components: operating revenue (Net Patient Service + Other Operating) versus Nonoperating; costs as Adjusted Direct Expenses, Allocated Costs, and/or Total Patient Care Costs depending on schema definition.
* Normalize by service volume to evaluate value: cost per discharge/day/visit; overhead per service unit; revenue per service unit.
* Integrate clinical access proxies: staffed beds, outpatient visits, patient days, and throughput.
* Use value metrics: cost per quality-adjusted output (e.g., cost per avoided readmission proxy if available), and cost-to-access ratios (cost per staffed bed or per clinic session).
* Monitor adverse signals: rising direct expenses with stagnant outcomes; increasing overhead without access gains.

**Insights:**

* High adjusted direct expenses often reflect staffing and pharmacy pressures; these correlate with access constraints (fewer staffed beds) and can impair quality if not addressed.
* Overhead allocation decisions can obscure true care delivery efficiency; right-sizing overhead improves measured value even if direct costs are stable.
* Nonoperating revenue dependence can maintain short-term access but is fragile for quality investments over time.

**Problems:**

* Lack of explicit case-mix and quality metrics in the financial file impedes direct causal attribution between spend and outcomes.
* Possible double-counting if Total Patient Care Costs already encapsulates direct + allocated; clarity is required to ensure valid value metrics.
* Volume measures (discharges, visits) do not reflect acuity or complexity, limiting precision of cost-per-outcome comparisons.

**Recommendations:**

* Adopt a clear costing basis: if Total Patient Care Costs is a rollup, use it as the primary cost denominator in value analyses; otherwise, use Direct + Allocated with validation.
* Tie financial surveillance to access and quality KPIs: staffed beds, time-to-appointment, readmission, infection rates; evaluate cost per unit improvement.
* Focus interventions on drivers of direct costs that also improve outcomes: nurse staffing optimization, pharmacy stewardship, care pathways reducing LOS and readmissions.
* Reassess overhead allocation: align drivers with true consumption (e.g., IT users, clinical device counts), then cap growth that lacks access/quality ROI.
* Build a quarterly value dashboard: operating margin, cost per unit, overhead ratio, and at least one quality and one access metric tracked concurrently.

**Impact / Expected Outcome:**

* Improved access via stable staffing and efficient care pathways, maintaining or increasing staffed capacity.
* Reduced cost per unit of service without quality compromise; potential 2–3% reduction in direct costs through targeted clinical operations changes.
* Better alignment of spending with outcomes, leading to sustained value and resilience even with non-operating revenue fluctuations.