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FREE REPORT

JUNE 2014

The Clinical Strategy for Financial Health:

Care Redesign & Standardization

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PERSPECTIVE

Looking at Cost-Containment and Revenue Cycle Improvements in a New Way

Hospitals are reeling from financial and compliance pressures. A combination of bad debt, newly covered patients, changing reimbursement models, and the risk of denials in the face of the migration to ICD-10 is placing already slim operating margins in greater peril. And the results of the *HealthLeaders Media 2014 Cost Control & Revenue Cycle Survey* reveal that cost containment and revenue cycle improvement continue to be business pressures healthcare leaders must address as they work to maintain or improve contribution margins.

Survey results indicate that a plurality of healthcare leaders (39%) have set a goal of a 6%–10% reduction in operating costs for the next three years, and another 19% are planning cuts greater than that. Healthcare organizations are tasked with adopting more effective and new approaches to optimizing revenue cycle management performance across the enterprise. We see that focus playing out as the industry deploys purchasing and supply-chain efficiencies on the administrative side and the efficient use of labor to provide quality patient care on the clinical side.

Importantly, survey respondents are looking to the effective utilization of IT as a means to drive additional opportunities and efficiencies to optimize revenue. From targeting inappropriate claims denials, predetermining payment information, and automating revenue cycle functions, senior healthcare leaders expect improved documentation to provide transparency in operations and have the most impact on the bottom line. Fully 80% of respondents are either planning or are underway with the development of IT solutions for cost containment and integration of clinical and financial data, with another 10% having completed the integration.

With numerous government mandates looming upon the industry—a fact that has not gone unnoticed by respondents—the timing of an IT integration solution is critical. The challenges of the pending conversion to ICD-10 offer an opportunity to implement a clinical documentation improvement (CDI) solution that can scale to meet the demands that will be placed on clinical and administrative staff and provides dramatically enhanced workflows that contribute to fair and timely reimbursement. Leveraging technology capable of processing the complexities of ICD-10 documentation, a real-time CDI program can

Perspective (continued)

automatically review inpatient records to resolve missing or inconsistent clinical information before the patient leaves the hospital or clinic.

This year's survey points out that leaders have high expectations for IT-enabled activities to deliver sustainable financial benefit in several key areas: supporting productivity monitoring with analytics; integration of clinical and financial data; and maximizing reimbursements. By automating detail-focused processes in the revenue cycle, healthcare organizations will benefit from accelerated administrative workflows and improved accuracy, allowing staff to focus on supporting the patients' need for transparency and consistency in their care experience.

In our work providing revenue cycle management services, we have documented numerous situations where efficient and effective real-time clinical documentation solutions throughout a patient encounter has a positive bottom-line effect. CDI programs have a history of improving the specificity and clinical clarity of the medical encounter, which drives a more accurate reflection of patient acuity and appropriate reimbursement. What's more, improved documentation can lead to improved care for patients, a universal goal for all healthcare providers.

Ron Jones
Interim CEO
Optum360
Eden Prairie, Minn.

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the **June 2014 HealthLeaders Media Intelligence Report.** In the full report, you'll find a wealth of additional information. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Ann Madden Rice, CEO of University of California Davis Medical Center in Sacramento, California, and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Kaleida Health in Buffalo, New York; Firelands Regional Medical Center in Sandusky, Ohio; and University of California Davis Medical Center in Sacramento, California.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

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Methodology

The *2014 Cost Control & Revenue Cycle Study* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In March 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience from hospitals, health systems, and physician organizations. A total of 344 completed surveys are included in the analysis. The bases for the individual questions range from 284 to 344 depending on whether respondents had the knowledge to provide an answer to a given question. The margin of error for a sample size of 344 is +/- 5.3% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, and region. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

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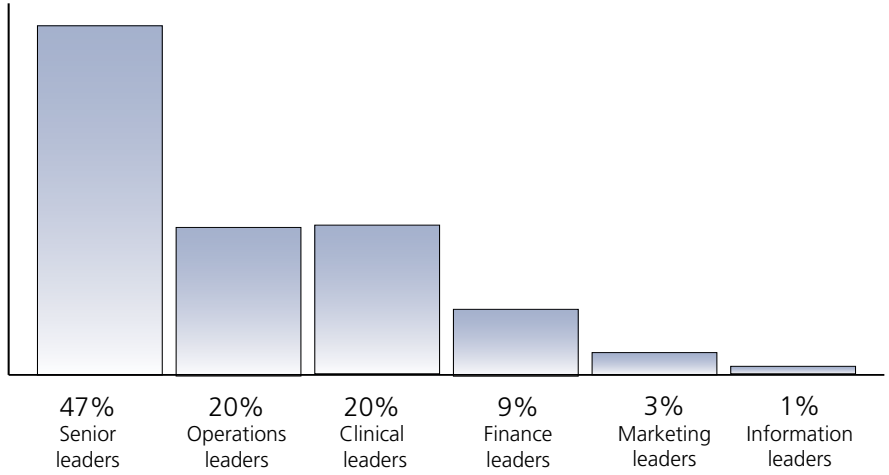
Respondent Profile

Respondents represent titles from across the various functions at hospitals, health systems, and physician organizations.

Title

Base = 344



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/ Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Financial leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 344

Hospital	52%
Health system	32%
Physician org.	17%

Number of beds

Base = 178 (Hospitals)

1–199	50%
200–499	30%
500+	20%

Number of sites

Base = 109 (Health systems)

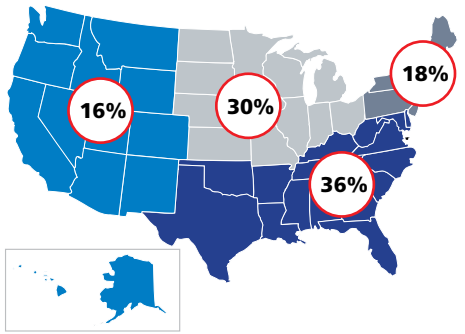
1–5	19%
6–20	35%
21+	46%

Number of physicians

Base = 57 (Physician orgs)

1–9	33%
10–49	33%
50+	33%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, D.C., Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Improving Fiscal Health by Taking a Strategic Clinical Focus

MICHAEL ZEIS

Cost containment and revenue cycle activities involve buttressing the organization's financial health through smart spending and ensuring funds that are owed to the organization are, after all, delivered to the organization. Traditional approaches to cost containment often are part of the annual budgeting process, directed by the finance team within administration. The conventional activity of the revenue cycle function is largely to confirm the accuracy and completeness of submissions to payers and troubleshoot claims denials.

With current challenges to reimbursements—including the pending need to bear risk and deliver value-based care, and a payer community that has become more aggressive about claims denial—healthcare leaders are looking for cost containment and revenue cycle to contribute to financial health in more strategic ways. Intelligence Report research results suggest that care redesign and care standardization can lead to increased provider productivity and can help drive waste out of the care delivery system. IT and analytics remain tactical tools to improve revenue cycle results. And with clinical documentation, some are focusing their improvement efforts on the hospital floor, helping the clinical team ensure that services delivered are completely and accurately recorded.

WHAT HEALTHCARE LEADERS ARE SAYING

"As an organization, we have consistently done a good job in controlling expenses through rigor and transparency. This will need to continue, along with the need for all members of our leadership team to fully understand the changing payment and performance environment so they can better understand their individual and collective parts."

—Chief compliance officer of a medium hospital

"It takes an organizationwide commitment. All employees and medical staff members must understand that the viability of their organizations will depend on being more efficient."

—CEO of a medium hospital

"Ownership of the concept and process from frontline and middle managers is absolutely essential."

—CEO of a large hospital

"The effort needs to be physician-led."

—Chief financial officer of a large health system

"They can't ensure achieving strategic and sustainable results, given the uncertainties of healthcare."

—Chief financial officer of a physician organization

"Developing organizational goals and work plans that are time-stamped and assigned to individuals who are accountable for the implementation is essential."

—Chief nursing officer of a small hospital

Analysis (continued)

With conventional approaches reaching the point of diminishing returns, healthcare organizations are viewing cost containment and revenue cycle as strategic initiatives that rely on the attention and support of the clinical team to deliver better results.

Gaining from care redesign, care standardization. At the largest organizations, those with net patient revenue greater than $1 billion, more than half cite care standardization (55%) and care redesign (53%) as being among the top sources of cost-containment gains. Smaller organizations generally rely on more traditional means to achieve gains, and only 26% (small) and 36% (medium) cite care redesign as among their top high-dollar factors in cost containment.

Change is often difficult, and when the process to be redesigned is a clinical process, buy-in from the clinical team is necessary. Advisor Daniel J. Moncher, FACHE, MBA, executive vice president and CFO for Firelands Regional Medical Center, a 233-staffed-bed nonprofit hospital with a medical staff of 200 in Sandusky, Ohio, describes the challenge. "[Some might have the perspective] that administration is telling them how to treat their patients," he says. "But remember, they're the ones at the bedside. They're the ones with the training. They're the ones that have the ultimate responsibility for treating the patients."

Ann Madden Rice, CEO of the University of California Davis Medical Center, a 619-licensed-bed acute care teaching hospital in Sacramento, California, says the key to earning support for clinical initiatives is to focus on clinical results instead of financial results. "Alignment isn't going to happen because you're telling physicians you're saving money. It's pretty hard to be passionate about that. But alignment will happen if they can see the quality benefit and see that their patients are more satisfied with the care they've received and have better outcomes. So when we look at expense reduction, we try to marry that with improving the experience and improving the outcomes for our patients."

> "The focus used to be on the transaction, the billing act. Now we're making sure that we are accurately reflecting all the good work that we did up until the point of billing."
>
> —Jennifer Nichols

Income and outflow: Optimize both. The percentage of respondents identifying revenue cycle as the bigger overall factor in maintaining or improving contribution margins (32%) and those identifying cost containment as the bigger factor (34%) are nearly equal. But in the three-year time frame, a higher percentage of respondents expects that cost-containment efforts will be a bigger overall contributor than revenue cycle to their organizations (41% in three years compared to 34% now). A higher percentage of small organizations than large expects to benefit from cost containment in the future: More than one-third (39%) of those

Analysis (continued)

with net patient revenue below $250 million expects bigger contributions from cost containment in the three-year time frame, compared to 28% now. Rice notes that pressure on operating margins requires that organizations focus on both revenue cycle and cost containment. "We need to be laser-focused on both issues. It's important to get every dollar that we're entitled to through our revenue cycle improvement efforts, and at the same time manage our costs ever more effectively."

Documentation improvements yield benefits. Research findings underscore the importance of effective documentation to revenue cycle success. Improving documentation is dominant among the standard steps used to optimize revenue cycle performance now for 72%. And 55% expect that documentation improvements will be the revenue cycle activity to deliver the most financial benefit over the next year, again making it the top overall choice. Says Rice, lead advisor to this report, "Improving documentation has been on our to-do list for decades, it seems, but it continues to be very, very important. And the electronic health record has made some improvements in that, but you still have to have well-trained professionals to accurately capture what they did for a patient, the services they provided, and then get that converted into a billable activity."

For some, the emphasis has shifted from the billing transaction itself to the entry of the documentation of the care into the record at the point of delivery. Says Jennifer Nichols, senior director of revenue cycle operations for Kaleida Health, a four-hospital health system serving the Buffalo, New York, area, "The focus used to be on the transaction, the billing act. Now we're making sure that we are accurately reflecting all the good work that we did up until the point of billing. [We want to make sure] that we're billing based on the most accurate and complete information." Nichols, an advisor to this Intelligence Report, adds that clinical documentation improvement activities have benefits beyond the revenue cycle function. "Beyond the immediate financial benefits, quality documentation plays into value-based purchasing, as well. In the long run, quality scores are improved by enhanced and appropriate documentation. And there are very few service lines that would not benefit from a very focused and effective clinical documentation integrity program."

> "When we look at expense reduction, we try to marry that with improving the experience and improving the outcomes for our patients."
>
> —Ann Madden Rice

Report advisor Moncher says Firelands' preparation for ICD-10 implementation stands to benefit its independent physicians as well as its employed medical staff. "We've educated everybody," he says. "We've got certified coders in-house who have the credentials and can educate. But even though we may be ready, if our medical staff isn't ready to

Analysis (continued)

go, it's not going to roll out smoothly, and we're going to see financial strain because of it." Outreach to independent physicians that started in October 2013 has paid off. "We cautioned them that this was coming to their practices, too," he says. "They began to realize that it was serious and we were ready to help them. It's really changed the attitude toward the medical center as a whole."

Healthcare leaders recognize that IT can help them target claims denials. Thirty-five percent now use IT to target inappropriate claims denials, and another 32%, including 35% of respondents from hospitals, expect to begin using IT to target inappropriate claims denials within the next year. With using IT to flag claims denials earning more mentions as an activity to be added than any other item, Nichols suggests that changing regulations and the need to keep up with payers provides the impetus for many. She says, "What is changing is how quickly regulations are evolving and how rapidly the payers seem to be able to respond. Payers are becoming so much more sophisticated about mining the data that's coming into them. For us it's a focus to do more predictive analytics around denials, and address denials before they occur rather than just reacting to them."

As care delivery must transform in light of healthcare reform, so must administration transform, according to Nichols. "We see organizations transforming clinically to meet quality outcomes, to meet payer and other reimbursement requirements, to be competitive in an ever-tightening landscape, to be attractive to other clinical partners, and to be the choice of referral for physician practices in the area. It's not possible for us to transform clinically without transforming financially as well." And to successfully adapt to the changes, she says, "As an industry we have to recognize that revenue cycle begins in the clinical area. Even when we centralize upstream administrative areas like scheduling, it is clinical services that drive the process."

> "We can be great with quality, we can care for people ... but if patients leave here and they're not satisfied with their experience, it's going to hurt us long term."
>
> —Daniel J. Moncher, FACHE, MBA

As Nichols suggests, the focus for more organizations is on minimizing denials through complete and accurate documentation at the point of service, on the hospital floor.

Factors that thwart containment efforts. Far and away, government mandates is the factor cited most often by industry leaders (39%) as providing the biggest barrier to achieving sustainable cost reductions. But only 17% of large hospitals pick government mandates as their top barrier to sustainable cost reductions, compared to 49% of small hospitals and 39% of medium hospitals, an indication that some have yet to come to grips with mandates.

Analysis (continued)

Nichols approaches mandates with resolve: "I can't necessarily change government mandates. But I can change how I can respond to them." Still, government mandates have a cumulative effect—there are so many. Nichols notes that many small increments in reimbursement penalties can add up to a large amount at risk. "Any individual financial penalty would not necessarily be unbearable. But there is a whole series of things lining up right now. Taken together, it becomes very, very serious. [It's going to be] 9% at risk at the end of 2017. That could be a game changer for many institutions. It may make the difference between viability and nonviability for them."

Rice suggests that the high percentage of respondents troubled by mandates may be an indication that administrators and clinical staff who should be attentive to patient care may be distracted by compliance and reporting issues. "Seeing government mandates, which are outside of our control, as the biggest barrier at 39% is very concerning. That may affect our ability to take care of the large number of patients who need our services."

Nearly one-quarter of large hospitals (23%) say that physician-hospital relationships are the top burden preventing sustainable cost reductions. Buy-in to cost initiatives presents a barrier, as well. Overall, 15% say that physician-hospital relationships hold them back, and 13% say an unsupportive culture is a barrier.

Moncher of Firelands connects patient satisfaction with the organization's financial health, and notes that the whole organization is expected to participate. "We can be great with quality, we can care for people, and we can get them to their next level of care or home in a technically competent and successful manner, but if patients leave here and they're not satisfied with their experience, it's going to hurt us long-term." This relationship between patient care and financial performance is becoming part of the organization's culture, thanks to its Head and Heart program, which was conceived about a year ago by Firelands' quality executives to stress the importance of empathy in dealing with patients. The program was reviewed and approved by the board of directors, and is actively supported by the organization's CEO to address organizational culture and the potential impact on revenue.

> "We need to be laser-focused on both issues. It's important to get every dollar that we're entitled to through our revenue cycle improvement efforts, and at the same time manage our costs ever more effectively."
>
> —Ann Madden Rice

For Kaleida's Nichols, the manner of sharing data about claims denials is important in getting the message across to clinical teams and

Analysis (continued)

strengthening physician-hospital relations. "They hunger for the data," she says. "But just sending a massive spreadsheet isn't going to do it. They didn't grow up in finance. They want somebody to come and help them understand it. We have to make the data meaningful for them, and then invite them to participate in the solution."

Rice underscores the importance of transparency—not just about the numbers, but about the strategy behind the numbers—in fostering a supportive culture. "Transparency will lead to engagement by people who are making day-to-day decisions about using resources," she says.

Bringing analytics to bear. Forty-three percent of respondents expect that IT investments aimed at revenue cycle improvements will outstrip IT investments aimed at cost containment over the next three years. This is especially the case at small organizations: Nearly half of the respondents from organizations with less than $250 million in net patient revenue (49%) expect that IT investments supporting revenue cycle will be higher than IT investments supporting cost containment, while that dips to 42% and 35% for medium and large organizations, respectively.

Nichols identifies three factors that may contribute to smaller organizations being more inclined to make revenue cycle–related IT investments. "First," she says, "some tools that used to be very expensive are starting to become more affordable to smaller and midtier hospitals. Second, smaller organizations are probably slightly behind larger organizations in deployment of IT-based revenue cycle solutions" and need to catch up. And then there is know-how. "There's better understanding [in the industry] of how technology tools can help, more sophistication about using analytics to support revenue cycle." Adopters at this stage will likely have a shorter learning curve than earlier users.

> "Improving documentation has been on our to-do list for decades, it seems, but it continues to be very, very important."
>
> —Ann Madden Rice

Nearly half of respondents (49%) expect to see top financial benefits in the next three years by using analytics to support productivity monitoring. This includes 57% of large hospitals. While only 10% of respondents claim to have integrated clinical and financial data, another 57% are underway. The success of cost-containment efforts on the clinical side of the business may depend on increased clinical efficiency, which makes productivity monitoring and the integration of clinical and financial data vital. Today, pursuing such efficiencies has a big-organization flavor. Nearly half of healthcare organizations with $1 billion or more of net patient revenue (45%) include identifying variances for clinical process enhancement among their top three IT-supported cost-savings tactics, compared to 24% of organizations with less than $250 million in net patient revenue.

Analysis (continued)

Impact of efficient clinical design. Pursuing financial health through care redesign and care standardization provides results that may not be as direct and may be more tenuous than financial benefits from straight-ahead cost-cutting activities or revenue cycle improvements. Further, we can expect initiatives that involve clinical efficiencies to take more time than conventional cost-cutting efforts to deliver results. For these reasons, taking a broader perspective on financial health means assuming additional levels of risk.

For Rice, determining the organization's position on risk is part of the CEO's job. "We're in a risky business. And doing nothing is taking the biggest risk of all. This involves not just looking at the ROI, and not just looking at how quickly an investment is going to pay back, but we have to ask, 'What's the risk if you don't do it?' "

At UC Davis, taking on small projects with less exposure is one way of limiting risk as one moves forward. "We're trying to get more of our staff involved in smaller rapid projects so that we can make incremental progress," says Rice. UC Davis' CFO, Tim Maurice, MBA, accepts the limitations of conventional benchmarking or budgeting, and looks at the inputs to financial health in what he calls a "holistic" way. He asks, "Are we going to continue to do cost containment the way we've done it before, which is to [establish a] benchmark and if we don't hit the benchmark, make cuts? Or are we going to take a more holistic approach and look at what are we trying to achieve in terms of quality and effectiveness, determine what inputs are needed to achieve that quality, and reduce those inputs that don't add value?"

> "There are very few service lines that would not benefit from a very focused and effective clinical documentation integrity program."
>
> —Jennifer Nichols

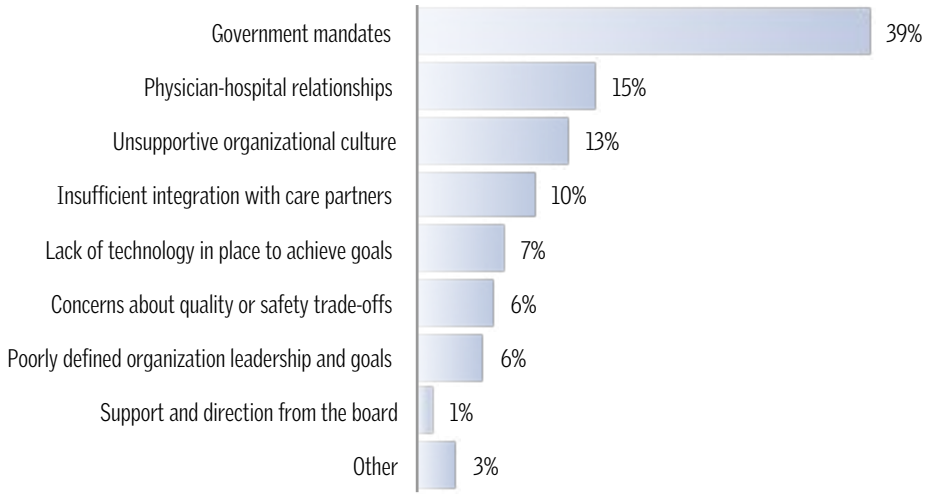
When costs can't be cut any more, and when revenue has been optimized, organizations have to focus on efficiency, which means examining processes and removing waste. We see that this next step in fostering financial health is complicated and risky. But we see that many organizations are dealing with the complexity and shouldering the risk, which means those that don't may face a serious competitive disadvantage.

Michael Zeis is senior research analyst for HealthLeaders Media. He may be contacted at mzeis@healthleadersmedia.com.

FIGURE 1 | Biggest Barrier to Sustainable Cost Reductions

Q | What is your organization's biggest barrier to achieving sustainable cost reductions?

Total responses



Base = 344

TAKEAWAYS

- The item picked most frequently (by 39% of respondents) as the factor presenting the biggest barrier to achieving sustainable cost reductions is government mandates. The percentage is fairly even across healthcare settings, generally, although there is greater variation based on size.
- Within the hospital setting, for example, a higher percentage of small organizations (49%) than medium (39%) or large (17%) say government mandates present the top barrier to cost containment.
- Insufficient integration with care partners is seen as a barrier to cost containment by 13% of respondents from health systems, 14% of physician organizations, and only 7% of hospitals.

WHAT DOES IT MEAN?

In spite of the industry's long history of responding to mandates, 39% say that government mandates are their biggest barrier to cost containment. An advisor says that some of the items with low percentages—lack of technology (7%) and concerns about quality and safety trade-offs (6%)—may reflect successful investments in technology infrastructure and process enhancement, and the expectation that those investments will lead to cost savings.

FIGURE 1 *(continued)* | Biggest Barrier to Sustainable Cost Reductions

Q | What is your organization's biggest barrier to achieving sustainable cost reductions?

DATA SEGMENTATION TOOL

Click these icons to dig deeper

BUYING POWER

Who controls the money? Click on the icons to learn how they think

VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

PRODUCTS/SERVICES

Clinical products

Base = 205

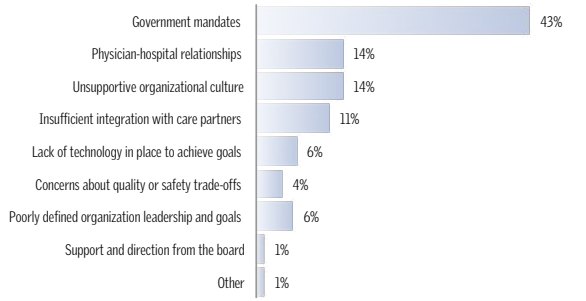
Financial services

Base = 139

Executive search

Base = 142

Consulting services

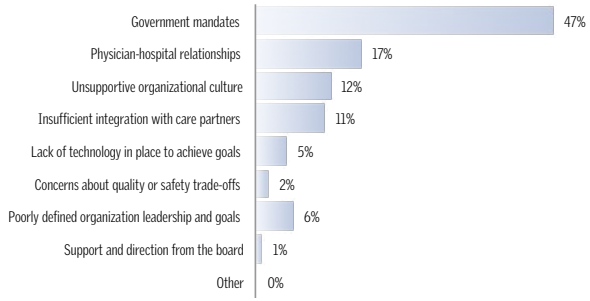


Base = 176

Outsourcing services

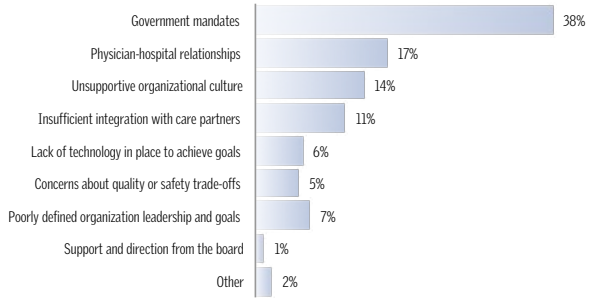
Base = 151

Legal services



Base = 102

Information technology

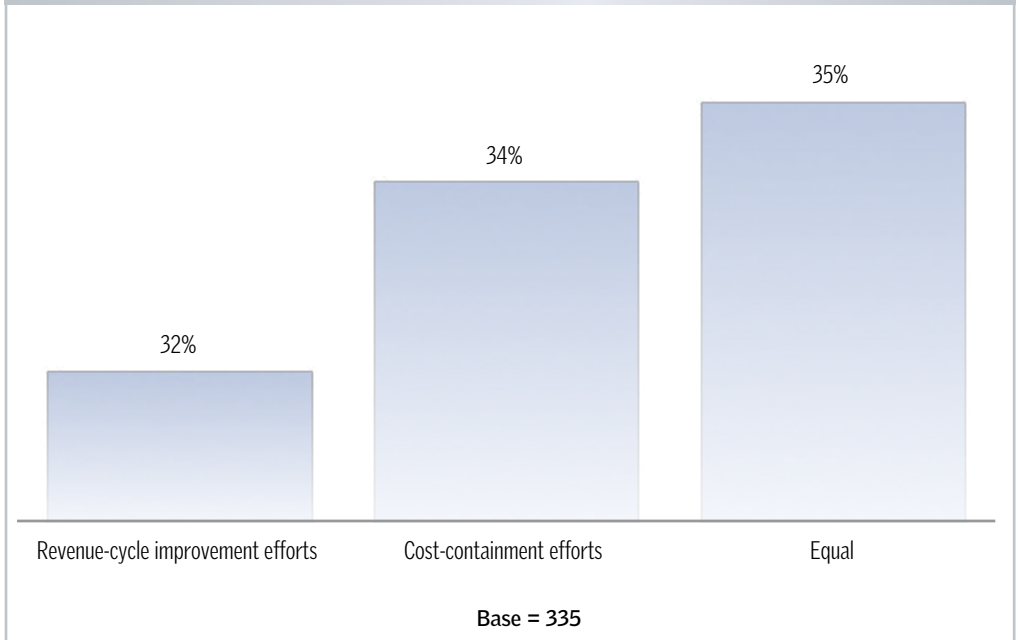


Base = 205

FIGURE 2 | Biggest Overall Contributor to Contribution Margin Now

Q | When it comes to maintaining or improving contribution margin, which of the two is the bigger overall contributor at your organization now?

Total responses



TAKEAWAYS

- Healthcare leaders are split fairly evenly about the relative contributions of cost containment and revenue cycle to financial health: 32% say revenue cycle is a bigger contributor than cost containment, and 34% say cost containment is a bigger contributor than revenue cycle. The remaining 35% say the two are equal.
- Among organizations with net patient revenue less than $250 million, 37% say revenue cycle efforts contribute more. Among organizations with $1 billion or above in net patient revenue, 43% say cost containment efforts contribute more.

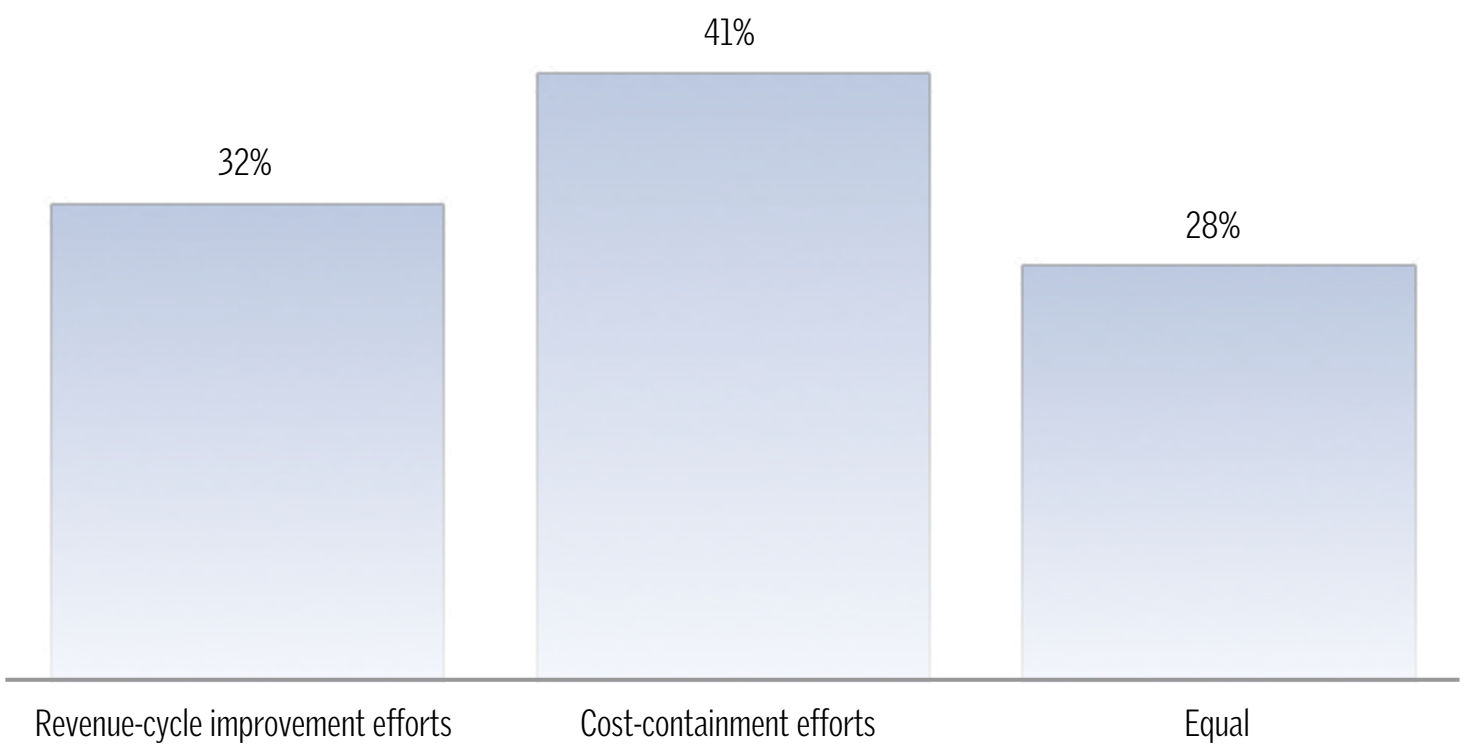
WHAT DOES IT MEAN?

The even split between revenue cycle and cost containment may be an indication that today's margin pressures require strict attention to both disciplines. That said, by a few percentage points, smaller hospitals see bigger contributions with revenue cycle improvements than with cost-containment efforts. It may be that revenue cycle improvements are more focused—generally the activity is part of the organization's finance group, and improvements may be achieved through process changes within that one department. In contrast, because they are often more far-reaching, cost-containment efforts can be more complicated to implement successfully.

FIGURE 3 | Biggest Overall Contributor to Contribution Margin in Three Years

Q | When it comes to maintaining or improving contribution margin, which of the two do you expect to be the bigger overall contributor at your organization in three years?

Total responses

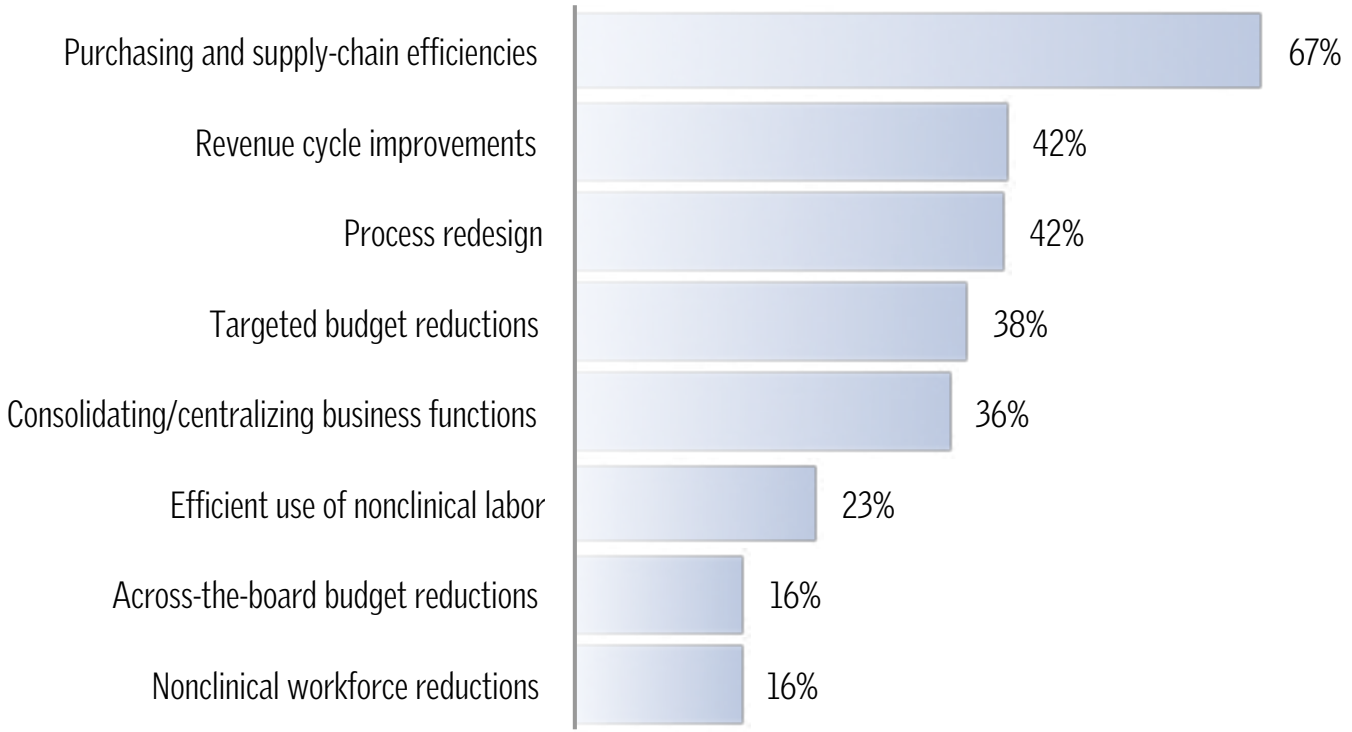


Base = 333

FIGURE 4 | Operations/Admin Activities Providing Highest Cost-Containment Contributions This Year

Q | Of the following operations or administrative activities, which three provided the highest dollar value in cost-containment contributions in this fiscal year?

Total responses

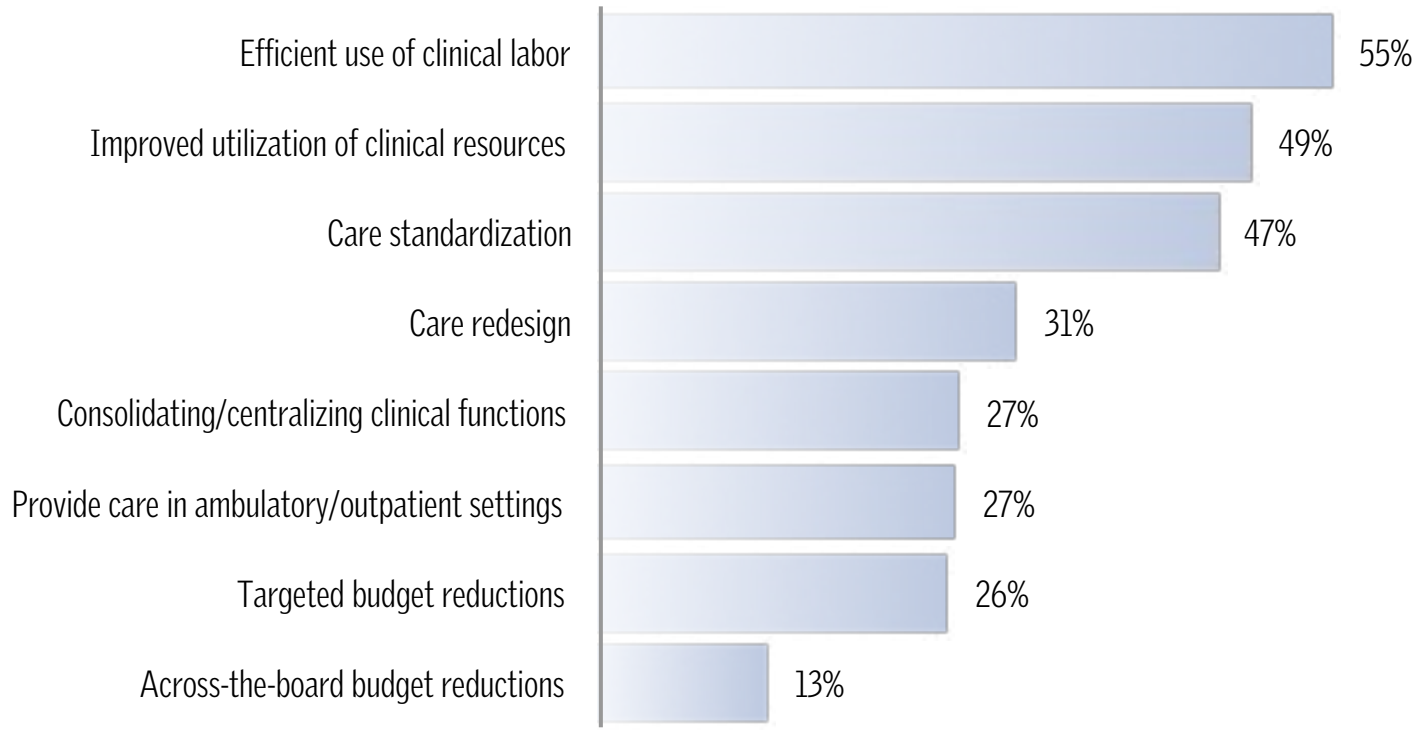


Base = 344, Multi-Response

FIGURE 5 | Clinical Activities Providing Highest Cost-Containment Contributions This Year

Q | Of the following clinical activities, which three provided the highest dollar value in cost-containment contributions in this fiscal year?

Total responses



Base = 344, Multi-Response

FIGURE 6 | Status of Clinical Performance Targets as Part of Cost Containment

Q | What is your organization's status with respect to incorporating clinical performance targets such as reduced length of stay or reduced readmissions as part of your organization's cost-containment activity?

Total responses

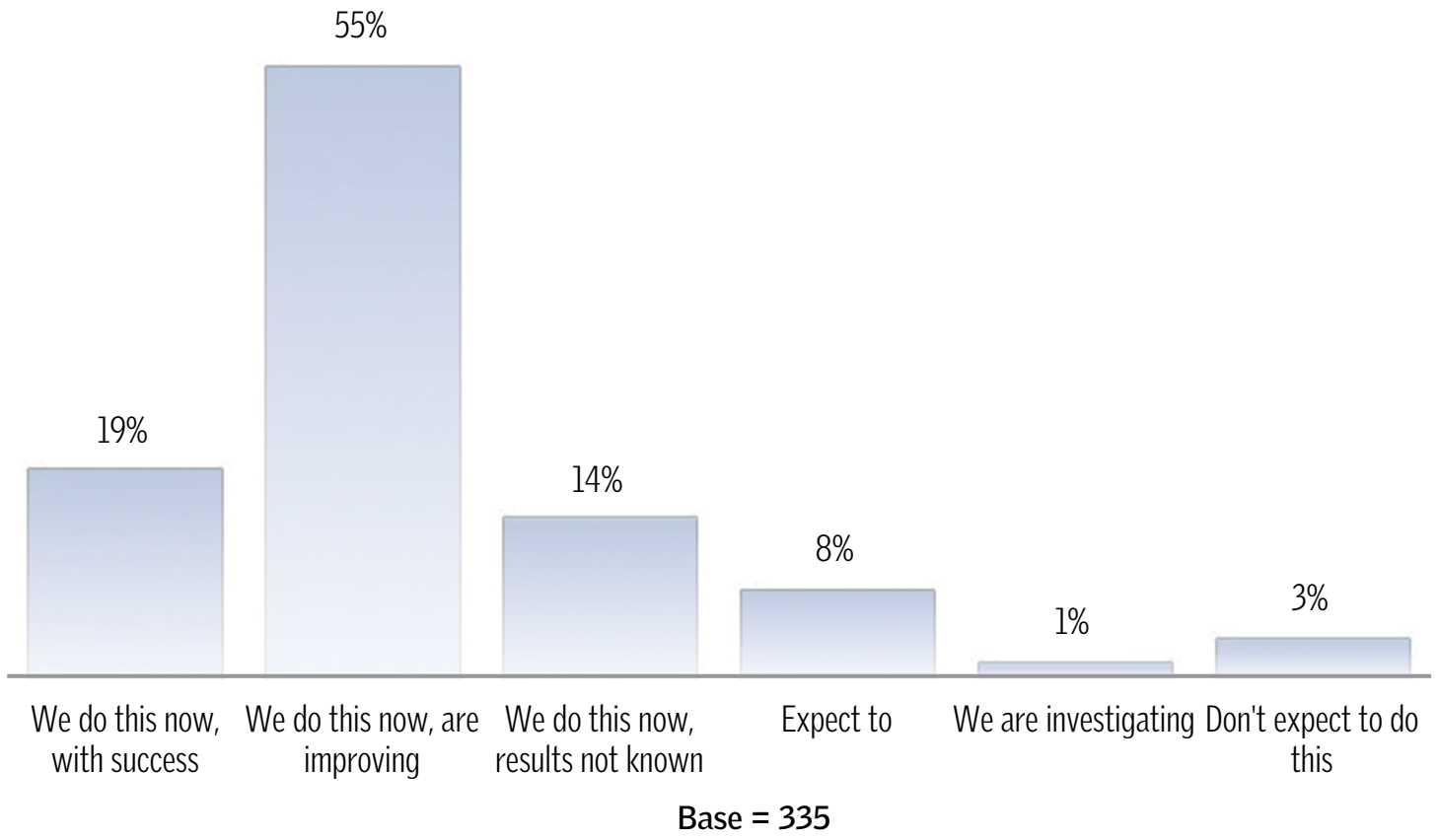
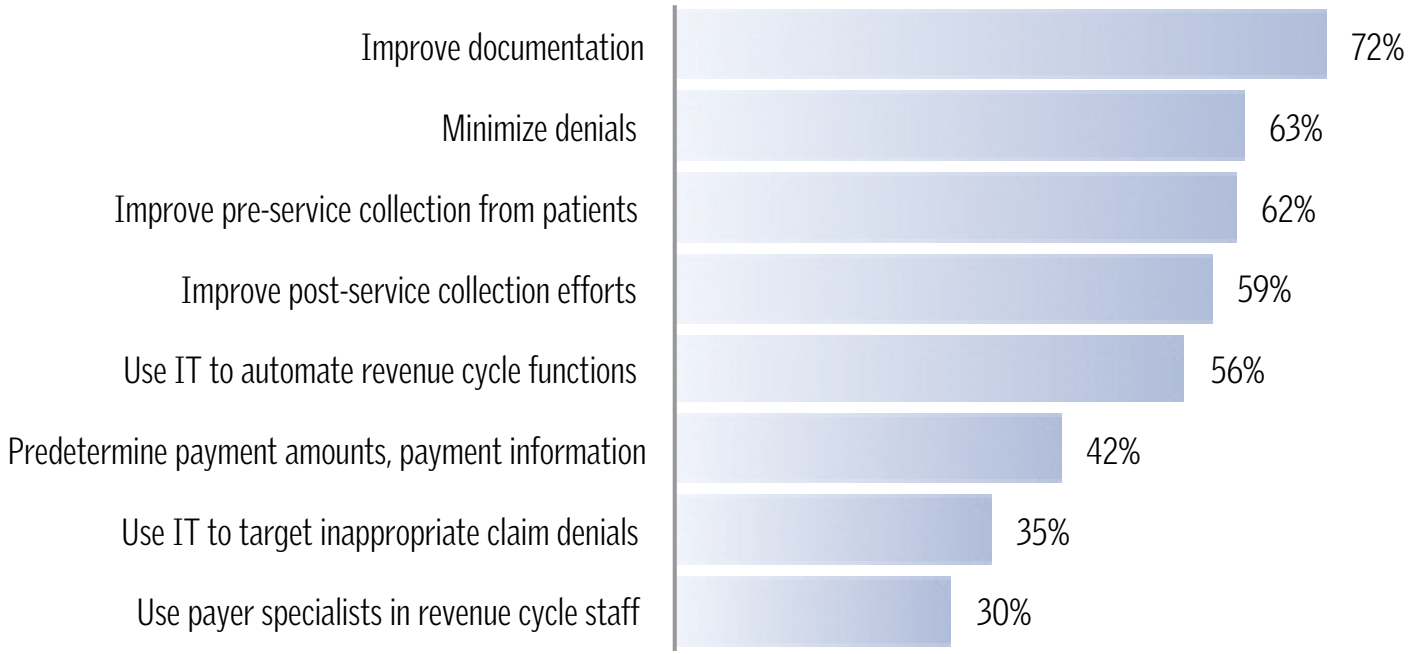


FIGURE 7 | Revenue Cycle Optimization Steps Now

Q | Which of the following steps are part of your organization's routine revenue cycle optimization process?

Total responses

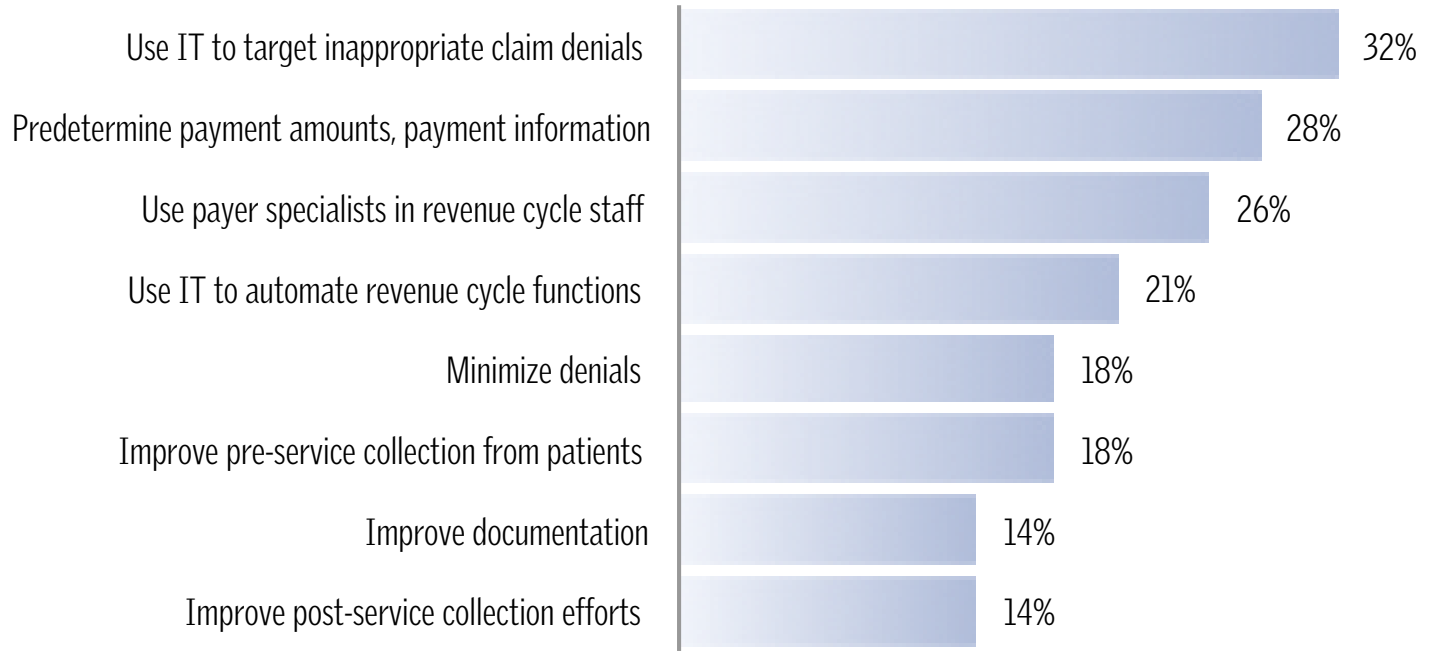


Base = 339
Multi-Response

FIGURE 8 | Revenue Cycle Optimization Steps Next Year

Q | Which of the following do you expect to pursue within the next year to optimize revenue cycle?
(Among those not currently pursuing these options, but planning to do so.)

Total responses

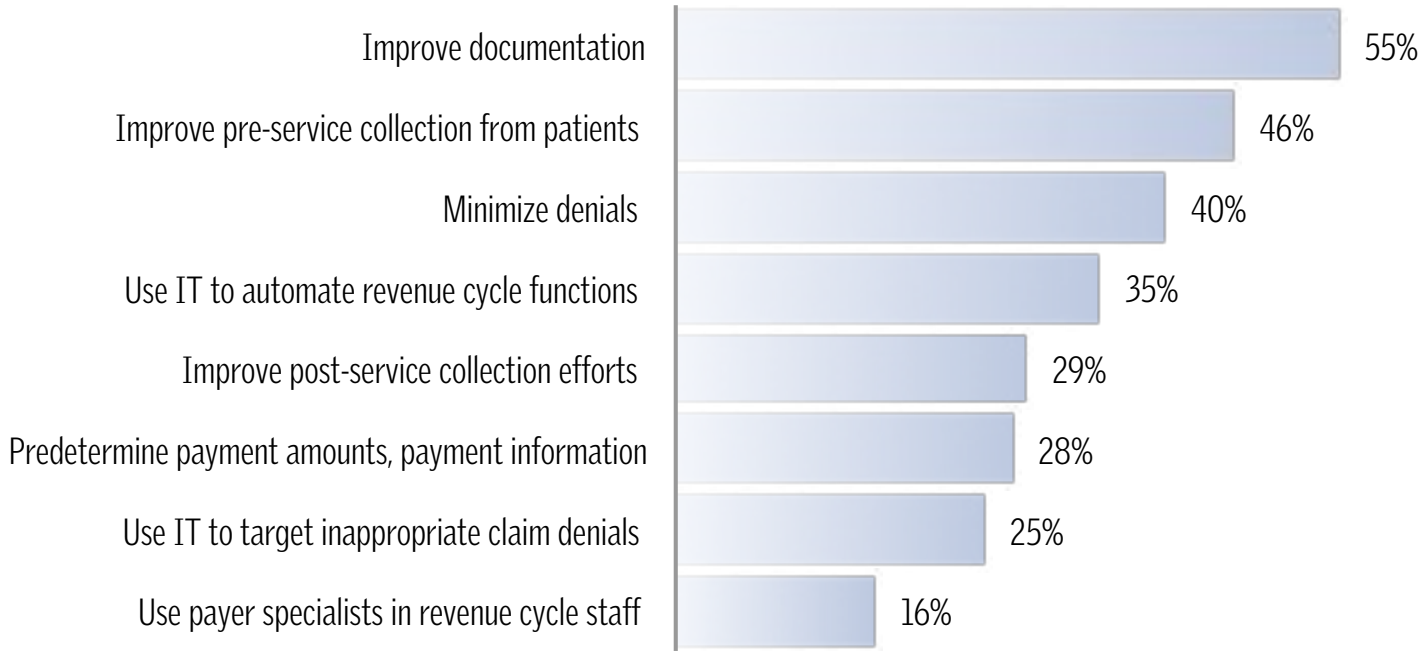


Base = 292
Multi-Response

FIGURE 9 | Most Financially Impactful Revenue Cycle Activities Next Year

Q | Of the following revenue cycle activities, which three do you expect to have the most financial impact over the next year?

Total responses



Base = 342
Among those expecting activities to have financial impact
Multi-Response

FIGURE 10 | IT Investment to Maximize Contribution Margin Next Three Years

Q | Of the two, which will see more IT investment in support of maximizing contribution margin over the next three years?

Total responses

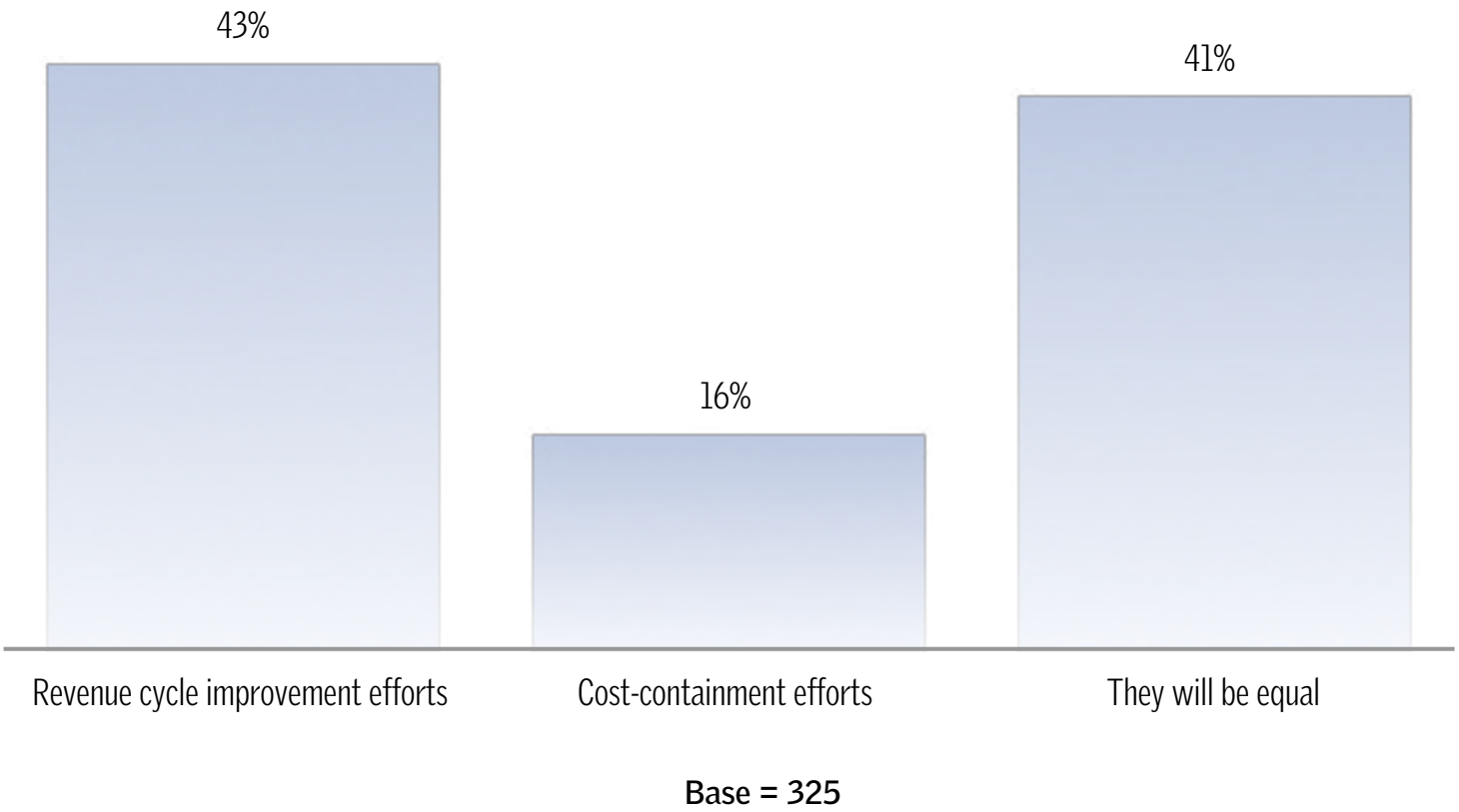


FIGURE 11 | Investing in IT Systems by Integrating Clinical and Financial Data

Q | Are you investing in your IT systems by integrating clinical and financial data, with a main benefit or side benefit of cost containment?

Total responses

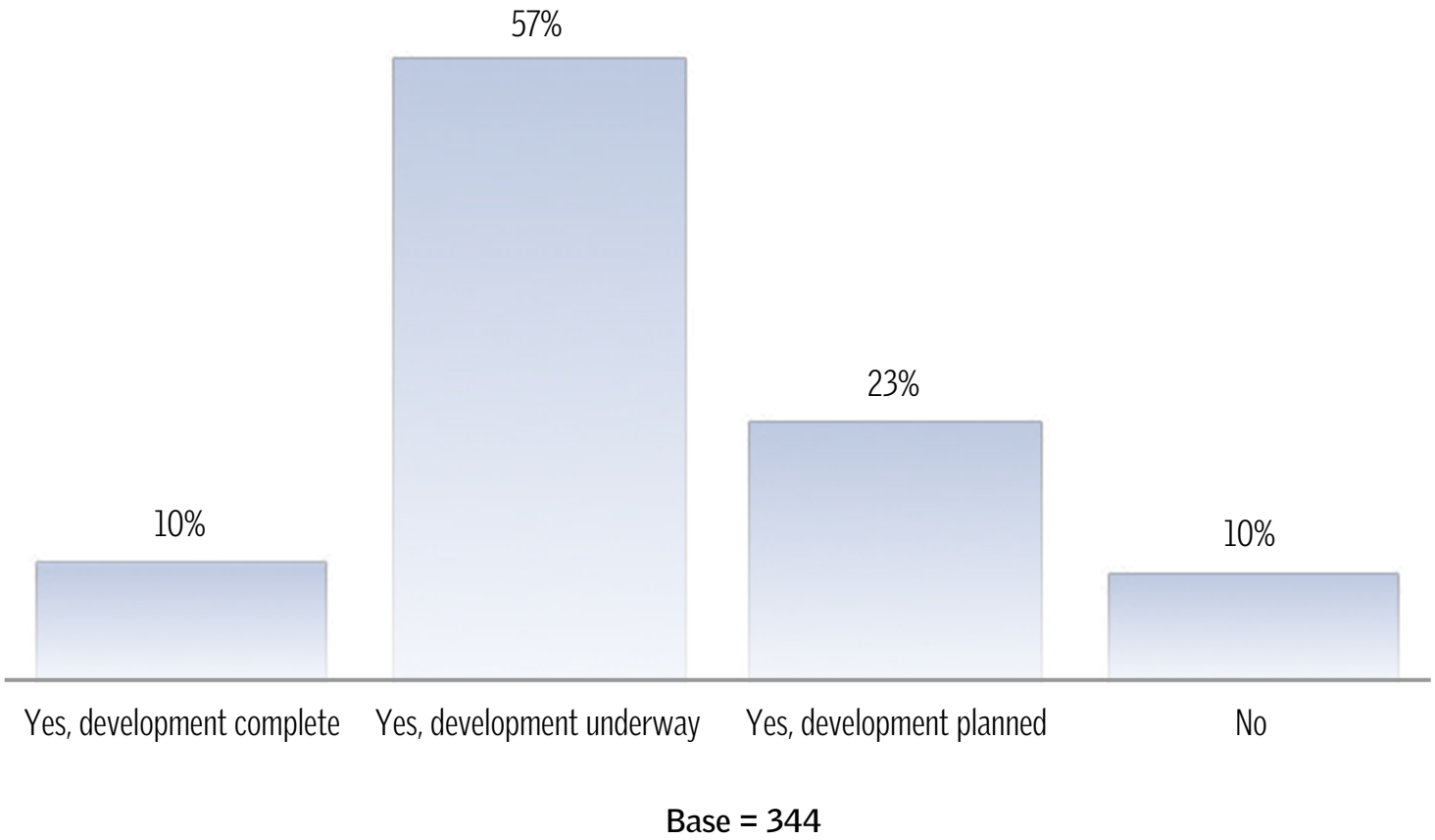


FIGURE 12 | IT Activities Delivering Most Cost Reduction Next Three Years

Q | Of the following IT-enabled activities, which three are delivering or will deliver the most cost reduction (or financial benefit) for your organization over the next three years?

Total responses

Support expense and cost monitoring with analytics	57%
Integrate clinical and financial data	49%
Support productivity monitoring with analytics	49%
Support efforts to maximize reimbursements	39%
ID variances for clinical process enhancement	30%
Predictive modeling to flex staff levels	24%
Confirm data and necessity for RAC audit success	17%
ID variances for nonclinical process enhancement	6%
Don't know	4%
None	1%

Base = 344, Multi-Response

FIGURE 13 | Year-Over-Year Savings From Cost Reduction Programs

Q | For the most recent fiscal year, what is your best estimate of your organization's year-over-year savings from cost-reduction programs?

Total responses

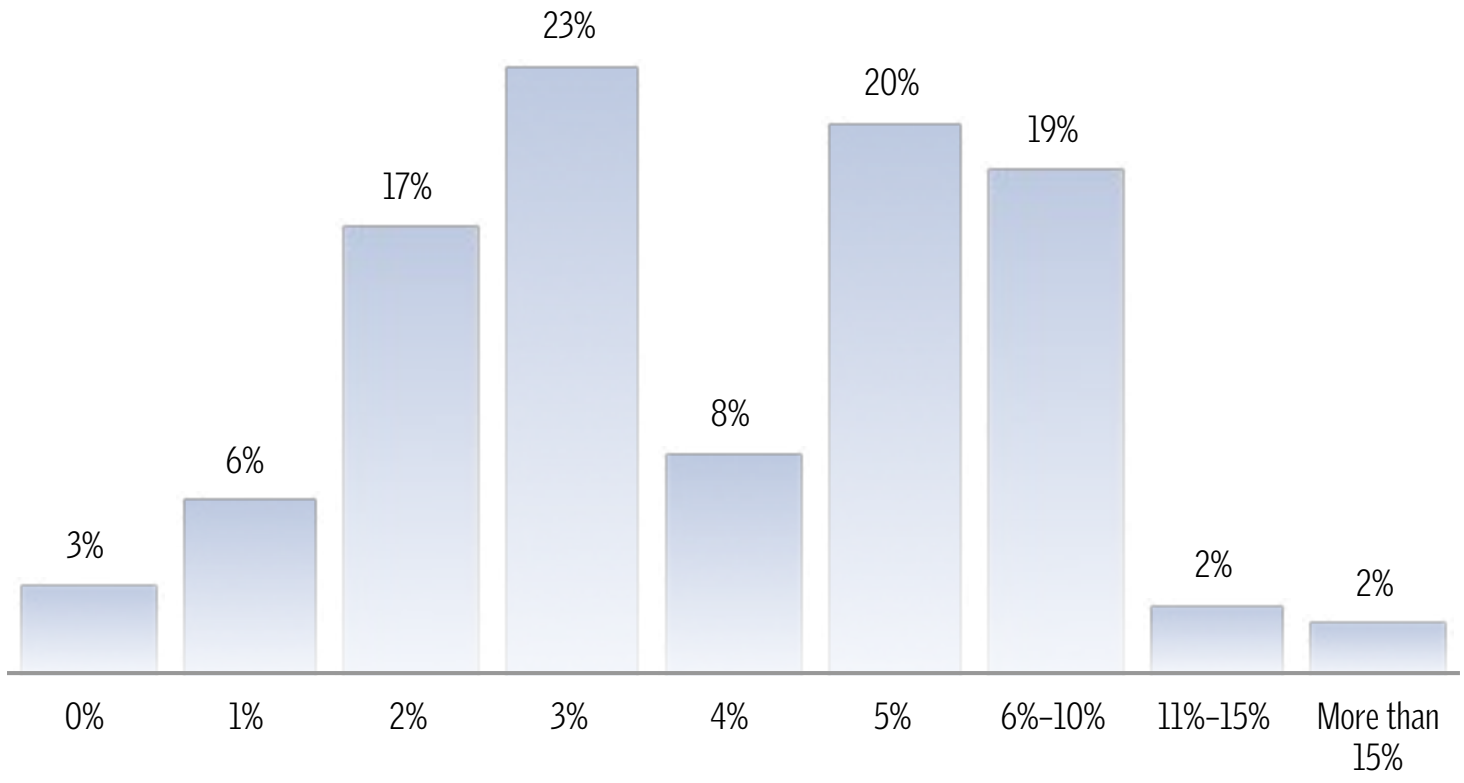
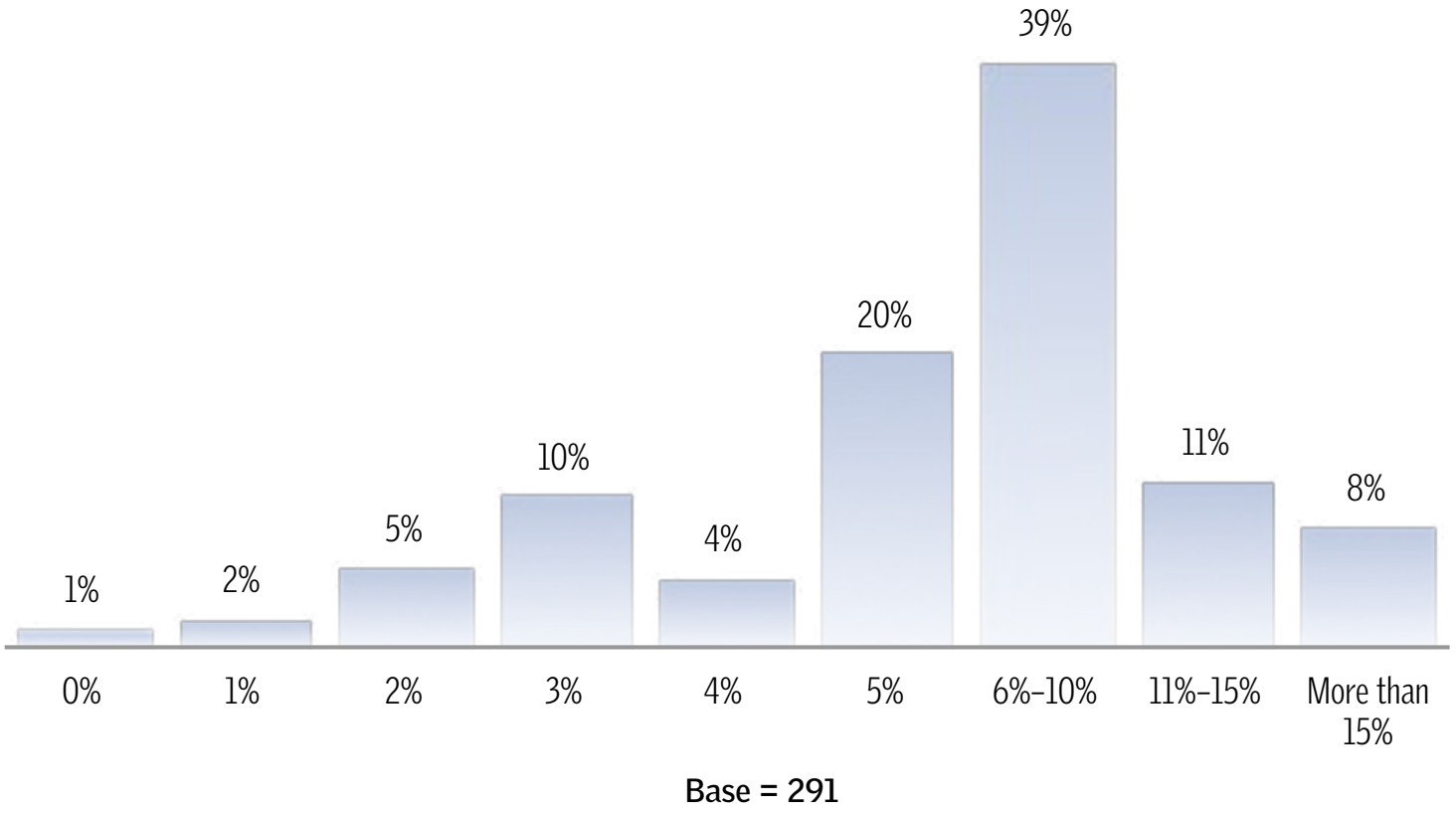


FIGURE 14 | Percentage Reduction Goal of Operating Costs Next Three Years

Q | What is the percentage reduction of overall operating costs that your healthcare organization has as a goal over the next three years?

Total responses



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