HealthLeaders Media | Intelligence

FREE SUMMARY REPORT

DECEMBER 2013

Cost Containment: Harnessing Data to Drive Revenue Cycle and Productivity

Powered by

HEALTHLEADERS MEDIA Council
Access. Insight. Analysis.

WWW.HEALTHLEADERSMEDIA.COM/INTELLIGENCE

CLICK HERE TO LEARN MORE ABOUT OUR PREMIUM EDITION

Intelligence Report Premium from HealthLeaders Media

Cost Containment: Harnessing Data to Drive Revenue Cycle and Productivity

This report reveals how data analytics can drive meaningful cost-containment strategies without negative impacts on quality and patient satisfaction.

- Learn which labor-related cost-cutting activity delivers top savings most often. (It's not layoffs!)
- Discover how Middlesex Hospital maximized cost savings by focusing on reducing clinical errors and improving patient safety.
- Identify the greatest process-related cost savings areas.
- Deep-dive into over 400 charts with segmented peer data.
- Learn from case study examples: Henry Mayo Newhall Memorial Hospital, Middlesex Hospital, and Tenet Healthcare Corp.

For more information or to purchase this report, go to *HealthLeadersMedia.com/Intelligence* or call **800-753-0131.**

HealthLeaders Media | Intelligence

Access. Insight. Analysis.

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the December 2013 HealthLeaders Media Intelligence Report, ***Cost Containment: Harnessing Data to Drive Revenue Cycle and Productivity***. In the full report, you'll find a wealth of additional information, including the results of all the survey questions. 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 Vincent G. Capece Jr., president and CEO of Middlesex Hospital in Middletown, Conn., and lead advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Henry Mayo Newhall Memorial Hospital in Valencia, Calif.; Nashville-based Vanguard Health Systems, part of Dallas-based Tenet Healthcare Corp.; and Middlesex Hospital in Middletown, Conn.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Table of Contents

Locked items are available in the Premium and Buying Power editions.

- Foreword
- Methodology 5
- Respondent Profile 6
- Analysis 7
- Case Studies
  - How One Community Hospital Produces 98% Clean Claims
  - Improving Performance and Patient Safety as a Cost-Containment Measure
  - Productivity RVUs as a Cost-Containment Approach
- Survey Results 13
  - Figure 1: Highest Contributor to Process-Related Cost Containment
  - Figure 2: Highest Contributor to Staff-Related Cost Containment
  - Figure 3: Highest Dollar Clinical Area Cost Reduction
  - Figure 4: Steps to Optimize Revenue Cycle
  - Figure 5: Likelihood to Drop Clinical Services to Reduce Costs 13
  - Figure 6: Involvement in Mergers or Acquisitions. 15
  - Figure 7: Overall Cost Savings From Mergers and Acquisitions
  - Figure 8: Cost-Savings Expectations
  - Figure 9: Main Cost-Containment Contribution From Mergers and Acquisitions
  - Figure 10: Investing in IT Systems by Integrating Clinical and Financial Data
  - Figure 11: Delivering the Most Cost Reduction
  - Figure 12: Average Annual Savings From Cost Reduction Programs
  - Figure 13: Percentage Reduction of Operating Costs Over Next Three Years
  - Figure 14: Biggest Barrier to Achieving Sustainable Cost Reductions
- Recommendations
- Meeting Guide

This document contains privileged, copyrighted information. If you have not purchased it or are not otherwise entitled to it by agreement with HealthLeaders Media, any use, disclosure, forwarding, copying, or other communication of the contents is prohibited without permission.

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Methodology

The *Cost Containment Survey* 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 September 2013, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 328 completed surveys are included in the analysis. The bases for the individual questions range from 302–328 depending on whether the respondent had the knowledge to provide an answer to a given question. The margin of error for a sample size of 328 is +/-5.4% 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, region, purchase involvement, dollar amount influenced, and types of products/services purchased. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

Vincent G. Capece Jr.
President and CEO
Middlesex Hospital
Middletown, Conn.

C.R. (Bob) Hudson
Senior Vice President and Chief Financial Officer
Henry Mayo Newhall Memorial Hospital
Valencia, Calif.

Louis Papoff
Chief Financial Officer for Physician Services for the Chicago and Detroit markets
Tenet Healthcare Corp.
Dallas

Click to Join Now
HEALTHLEADERS MEDIA Council
Access. Insight. Analysis.

Upcoming Intelligence Report Topics

JANUARY: ***2014 Industry Survey***

FEBRUARY: ***Healthcare IT and Analytics***

MARCH: ***Cardiology Service Line***

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

HealthLeaders Media
A Division of HCPro

Intelligence Report Research Analyst
MICHAEL ZEIS
mzeis@healthleadersmedia.com

Publisher
EVILEE EBB

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Intelligence Unit Director
ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor
MARGARET DICK TOCKNELL
mtocknell@healthleadersmedia.com

Intelligence Report Contributing Editor
RENÉ LETOURNEAU
rletourneau@healthleadersmedia.com

Intelligence Report Design and Layout
STEVE DINIS
sdinis@hcpro.com

Copyright ©2013 **HealthLeaders Media**, 5115 Maryland Way, Brentwood, TN 37027
Opinions expressed are not necessarily those of **HealthLeaders Media.** Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.

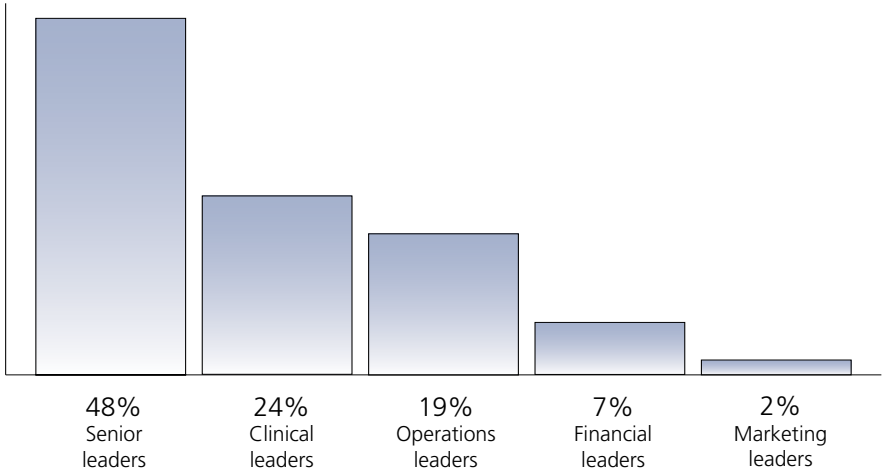
Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Respondent Profile

Respondents represent titles from across the various functions at healthcare organizations.

Title

Base = 328



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

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 = 328

Hospital	53%
Health system	34%
Physician org.	13%

Number of beds

Base = 173 (Hospitals)

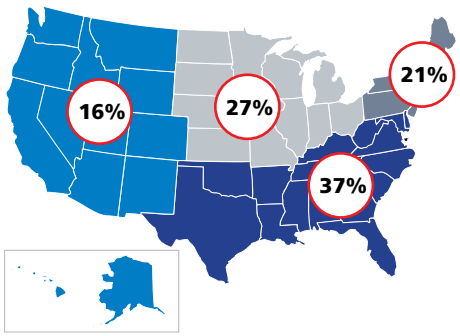
1–199	51%
200–499	34%
500+	16%

Number of sites

Base = 112 (Health systems)

1–5	28%
6–20	24%
21+	48%

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, DC, Maryland, Delaware

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

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

ANALYSIS

Looking at the Labor Side of Cost Savings

MICHAEL ZEIS

Conventional wisdom is that cost-cutting is a painful, even futile, way to respond to reduced reimbursements. One can only cut so far before placing sustainability in jeopardy. Nonetheless, healthcare executives are very much focused on reducing the costs of providing care, with 39% saying their cost-cutting programs have resulted in savings of at least 6% every year for the past three years. More than half (56%) say they expect total cost reductions over the next three years to be 6% or more, as well. Concurrent with conventional containment activities such as inventory and supply-chain monitoring, most organizations pursue other approaches to improve the bottom line such as workforce efficiency and smarter utilization. Success at cost-containment initiatives depends on measuring and monitoring and, increasingly, using data to guide decisions.

Labor is the biggest cost, but we're avoiding layoffs

While labor generally represents the largest portion of cost in the healthcare industry—60% for many—workforce reductions are avoided by most organizations in favor of workload balancing. Although workforce reductions are mentioned by 17% as the highest dollar value contributor to cost containment, the most frequently mentioned technique in achieving staff-related cost reduction in this fiscal year is more efficient use of labor. Nearly half (45%) saw their best labor-related cost reductions through

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders regarding cost-containment projects that provided disappointing returns and what could have been done differently to have more success.

"Across-the-board wage and benefit reductions led to low employee morale. Then the highest management is upset because employee surveys show a less-than-happy workforce. Duh."

—Board member for a medium hospital

"System-level cost-reduction efforts by function (lab, radiology, etc.) were ineffective. It would be better to provide top-down targets for each area, but instead we allowed staff to provide their own targets (bottom-up). As a result, there was no buy-in or support from executive leadership to achieve results. It was viewed as a side project. With top-down targets, the higher priorities that yielded the most results would have been selected first and there would have been pressure to deliver."

—Vice president of finance for a large health system

"During centralization of business units, service standards lagged significantly during the transition, which resulted in a loss of revenue that far exceeded the value of the FTE and overhead reductions in centralization projects. Centralization has benefits, but they are limited and often result in unintended losses elsewhere related to decreased ability to accommodate regional variances and meet service targets."

—Chief medical officer for a large health system

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Analysis (continued)

more efficient use of clinical labor, and an additional 8% achieved their highest labor-related cost reductions though more efficient use of non-clinical labor.

Vincent G. Capece Jr., president and CEO of Middlesex Hospital, a 180-staffed-bed nonprofit community hospital in Middletown, Conn., relies on productivity standards to optimize staffing levels. "Labor represents the largest percentage of our operating expense, but it's our most vital resource because we are the people who deliver care. Our organization is the people. Our goal is to try to accomplish the expense reductions we have planned without having any layoffs. Instead, we're trying to manage much more tightly than we have in the past. Our managers get detailed reports on a shift-by-shift basis as to how many resources they're using, labor resources in particular, and how those resources compare to the resources they should be using. They have to explain variances."

Indeed, communication is a key component as organizations address the need to operate more efficiently. Nearly one-fifth (18%) say that unsupportive organizational culture is their biggest barrier to achieving sustainable cost reductions. Another 15% say the physician-hospital relationships are the biggest barrier. All staffers, but especially clinical staff, can be expected to place a high priority on clinical quality and patient safety, so leaders need to reassure staffers that the organization's quality and safety standards will be maintained in spite of cost-savings efforts.

Says Capece, lead advisor for this report, "They want to know how they can deliver higher-quality care, how they can deliver safer care. That resonates with everyone. It can become difficult when you try to couple maintaining quality and safety with the concept of reducing the cost of delivering care. In some people's minds, that is counterintuitive, and that's our challenge. Our challenge is to deliver higher-quality care at a lower cost."

> "Labor represents the largest percentage of our operating expense, but it's our most vital resource because we are the people who deliver care."
>
> —Vincent G. Capece Jr., president and CEO of Middlesex Hospital in Middletown, Conn.

Watch what you spend, watch what you use

Purchasing and supply-chain efficiencies are the most common process-related (nonlabor) cost-saving techniques, providing the highest-dollar-value reductions for 25% of respondents. In addition, nearly one-fifth (19%) see their biggest nonlabor cost savings through improved utilization of clinical resources—using tactics such as tighter inventory control and keeping close tabs on the use of lab services and imaging services.

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Analysis (continued)

Louis Papoff, CFO for physician services for the Chicago and Detroit markets of Dallas-based Tenet Healthcare Corporation, summarizes the economics of inventory. In addition to the outlay for the supplies themselves, he says, "You incur expenses for the storage of inventory. Additionally, you incur staffing expense to manage that inventory, and excessive inventory negatively impacts cash flow."

Inventory control initiatives depend on staff buy-in, so, as with labor efficiencies, communication and physician alignment can be keys to success. For C.R. (Bob) Hudson, chief financial officer at Henry Mayo Newhall Memorial Hospital, a 238-staffed-bed, not-for-profit community hospital in Valencia, Calif., comanagement agreements have been pivotal in motivating the organization's physician corps. (Because of California's Corporate Practice of Medicine Act, Henry Mayo Newhall has no employed physicians.)

"We have comanagement arrangements with many physicians and surgeons that put money on the table for them if they help us significantly reduce our supply acquisition costs," he says. "The physicians get together and agree to use this one product or this one vendor. That gets our volume up. And by having the physicians in a position where they can get some skin in the game and get some rewards, we are seeing them work with us to get some real significant discounts. With bundled payments and with comanagement agreements and shared risks and rewards, we're finally in a position where we're starting to align the physicians' interest with the hospital's interest."

Papoff, a report advisor, communicates broadly and frequently, which has sensitized the whole staff to inventory cost issues. "Inventory management tactics can be communicated more effectively by discussing with the staff who actually interact with the inventory, as well as those who are responsible for inventory management. When you actually directly interact with the staff, that's where the opportunities lie. That's where you're able to get suggestions and recommendations. They may suggest buying supplies in different sized containers to avoid unnecessary waste. So getting staff involved has been a tremendous asset."

> "Inventory management tactics can be communicated more effectively by discussing with the staff who actually interact with the inventory, as well as those who are responsible for inventory management."
>
> —Louis Papoff, CFO for physician services for the Chicago and Detroit markets of Dallas-based Tenet Healthcare Corporation

Assessing cost and contribution of clinical services

More than one-third (36%) say they are very or somewhat likely to drop clinical services in the next year in order to reduce costs or enhance

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Analysis (continued)

operating margin. Especially with increased attention to providing care in outpatient settings, both service lines and supporting clinical services such as lab and pathology services will garner additional scrutiny.

Capece observes that "there are very few services that don't provide any contribution" to the organization's margin. He notes that the healthcare industry is very fixed-cost intensive and most services help cover some portion of fixed cost. In addition, he says, "Even the least profitable services, for the most part, cover the direct cost of providing care. If you stop providing outpatient psychiatric services, for instance, how much overhead could you shed as a result of that? In most cases, it would be very little, if anything." So direct costs and variable costs stop when a service is discontinued, but most indirect costs and fixed costs continue.

Using IT to help the bottom line and the top line

Healthcare leaders have to examine the care they provide in light of business realities. To do so, most organizations are actively pursuing the integration of clinical and financial data. Respondents have either integrated clinical with financial data already (10%) or have a development program underway to do so (58%), with the specific objective of using data to help reduce costs. The integration task may be complex, but the steps are necessary to monitor and control both costs and quality.

"It can be difficult to develop a system that allows you to tie clinical data with financial data," Hudson says. "But once you've got it developed, it's really beneficial to be able to drill down and tell what programs are profitable, what payers are profitable, and what doctors are profitable. You're able to really start focusing in on expense monitoring, productivity monitoring, and identifying areas that need attention."

> "With bundled payments and with comanagement agreements, and shared risks and rewards, we're finally in a position where we're starting to align the physicians' interest with the hospital's interest."
>
> —C.R. (Bob) Hudson, chief financial officer for Henry Mayo Newhall Memorial Hospital in Valencia, Calif.

IT will play a key role in helping leaders find cost-cutting opportunities. One-third of respondents (33%), for example, say they will see the most savings via better monitoring of expenses and costs. Another 26% expect top-level savings through productivity monitoring. Identifying variances in order to target process enhancement will provide such savings for one-fifth (20%).

Hudson takes the presence of these three items—expense monitoring, productivity monitoring, and using variances to target process enhancements—on the top of the list of activities that will deliver the

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Analysis (continued)

most cost reduction as an indication that the industry is serious about understanding provider productivity. "We are developing better data systems and have more understanding of how we link a physician's behavior to a cost number."

Precise monitoring can help organizations balance workloads. "We're learning how to match labor more appropriately with volume," notes Capece. "In all of our departments where there is patient volume to be measured, we're developing grids or guidelines, specifying how many staff people should be on at certain volume levels. When volume goes down, people are asked to either take vacation or take time off without pay. We are pursuing optimal staffing levels so that we can flex up more often than we flex down." Middlesex also takes advantage of attrition to match workforce to workload, a tactic that works best when the time frame for accomplishing cost reductions is long enough.

At Henry Mayo Newhall, Hudson tracks acquisition costs, labor productivity, and resource consumption. "Our cost accounting systems and decision-support systems allow us to track resource consumption by physician or by payer. We can break it down between radiology lab, supplies, operating room, and so on. Having the data, being able to target those three areas, and optimizing as much as possible allows us to continue to maintain our profitability and to be prepared for changes as they come down in the future."

Like purchasing, revenue cycle is an administrative function that can have a great effect on cash flow and operating margin. Half of the respondents (48%) work to improve post-service collection efforts, a reading that may understate the case. IT plays a role in revenue cycle, as well, with 48% using IT to automate revenue cycle functions. Our research shows that some are using analytics to target their revenue-cycle efforts: one-third (35%) use IT to target inappropriate claim denial. Nearly as many (31%) use analytics to determine eligibility for charity care, while 19% use analytics to assess a patient's likelihood to pay.

> "Our managers get detailed reports on a shift-by-shift basis as to how many resources they're using, labor resources in particular, and how those resources compare to the resources they should be using. They have to explain variances."
>
> —Vincent G. Capece Jr., president and CEO of Middlesex Hospital in Middletown, Conn.

Bigger is better? Be realistic about economies of scale

Half of the survey participants (48%) have been involved in merger and acquisition activity over the past three years, with two-thirds of those

Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation

Analysis (continued)

involved in M&A (67%) expecting that the activity would yield cost savings. Indeed, that turned out to be the case. Taking advantage of economies of scale (38%), centralized purchasing (19%), and other supply-chain efficiencies (17%), about half (45%) of those who expected cost savings say their expectations were met or were exceeded. The jury is still out for another 40%, who have yet to determine whether their cost-savings expectations have been met.

Hudson cautions that, when combining businesses, there may be diminishing returns from factors such as consolidation of administrative functions and economies of scale. "Beyond a certain point," he says, "you just don't get any more out of economies of scale."

With industry contraction, focus on costs

Capece links the need to focus on cost containment with the healthcare industry's contraction. "Industries tend to be either in a revenue growth phase, where the focus is on growing revenue and expenses may not be the main focus, or they're in a revenue contraction mode, when the focus on expenses occurs. Healthcare is now in a contraction phase. So we have to focus internally to see how we can produce high-quality healthcare for less money."

Cost containment is hardly a new discipline, but the long-standing focus seems to have been anywhere and everywhere except labor, despite how often we hear that labor is the largest expense. At least for the time being, layoffs are being avoided or at least minimized through productivity enhancements and efficiency measures. But because each has a vital IT component, some organizations may find that they have to spend part of their IT budget in order to save on labor costs.

> "Our challenge is to deliver higher-quality care at a lower cost."
>
> —Vincent G. Capece Jr., president and CEO of Middlesex Hospital in Middletown, Conn.

Capece underscores the strategic importance of becoming adept at cost-containment activities. "The biggest threat to every hospital," he says, "the large ones, the small ones, the medium-size ones, is the reduction in reimbursement that we're all facing. And if you can't get your costs in line with that evolving trend, you're not going to be around very long to even consider strategic options."

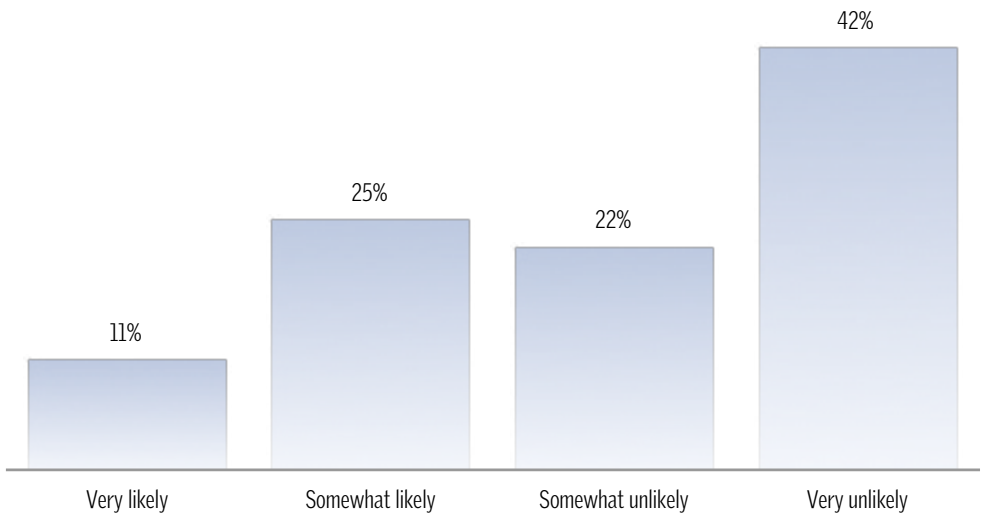
Michael Zeis is research analyst for HealthLeaders Media. He may be contacted at *mzeis@healthleadersmedia.com*.

BUYING POWER REPORT SAMPLE CHARTS Click here to order!

FIGURE 5 | Likelihood to Drop Clinical Services to Reduce Costs

Q | In the next year, what is the likelihood that your organization will drop any clinical services to further reduce costs or enhance operating margin?

Total responses



Base = 302

TAKEAWAYS

- Across all settings, 42% of respondents are very unlikely to drop clinical services to reduce costs, with little variation between hospitals (43%), health systems (39%), and physician groups (45%).
- Still, some 11% of respondents say they are very likely to drop clinical services, and another 25% are somewhat likely to discontinue clinical services.
- While the responses are fairly consistent across settings, among health systems a greater percentage of medium systems (19%) are very likely to cut clinical services than are large systems (6%) or small systems (10%).

WHAT DOES IT MEAN?

Although clinical service lines are periodically reviewed, by almost a 2:1 margin respondents are somewhat or very unlikely to drop clinical services—at least for now. However, as the healthcare delivery system changes, with reimbursements favoring value over volume and inpatient volumes declining, it is to be expected that the referral base for services will be reassessed and some difficult decisions rendered.

BUYING POWER REPORT SAMPLE CHARTS Click here to order!

FIGURE 5 *(continued)* | Likelihood to Drop Clinical Services to Reduce Costs

Q | In the next year, what is the likelihood that your organization will drop any clinical services to further reduce costs or enhance operating margin?

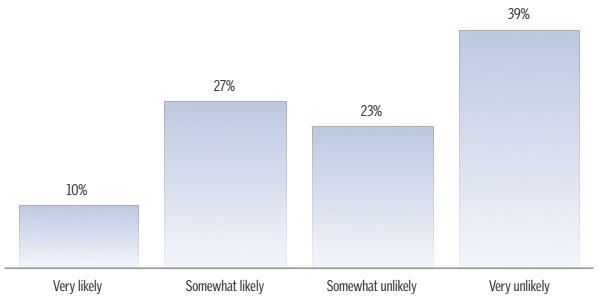
Click on these icons to dig deeper

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

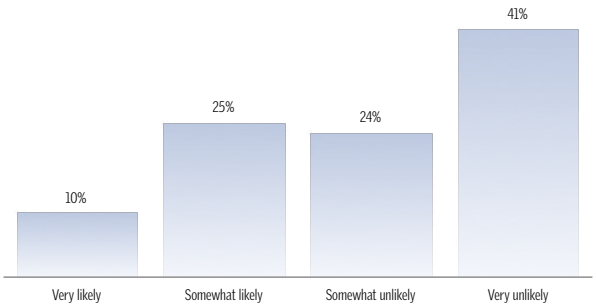
Information technology



Base = 168

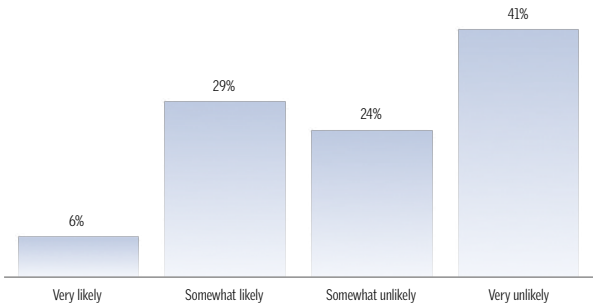
PRODUCTS/SERVICES

Clinical products



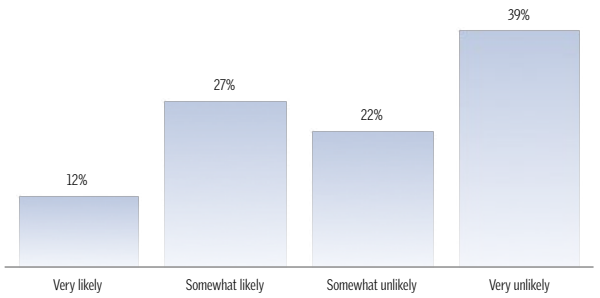
Base = 194

Financial services



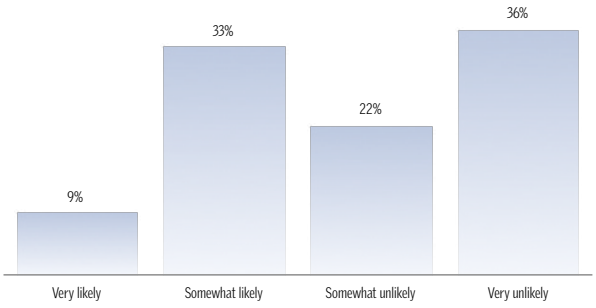
Base = 108

Executive search



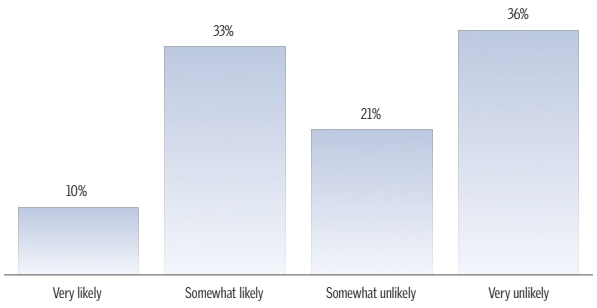
Base = 121

Consulting services



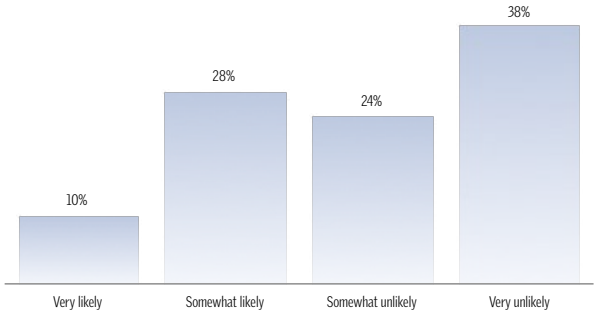
Base = 156

Outsourcing services



Base = 123

Legal services



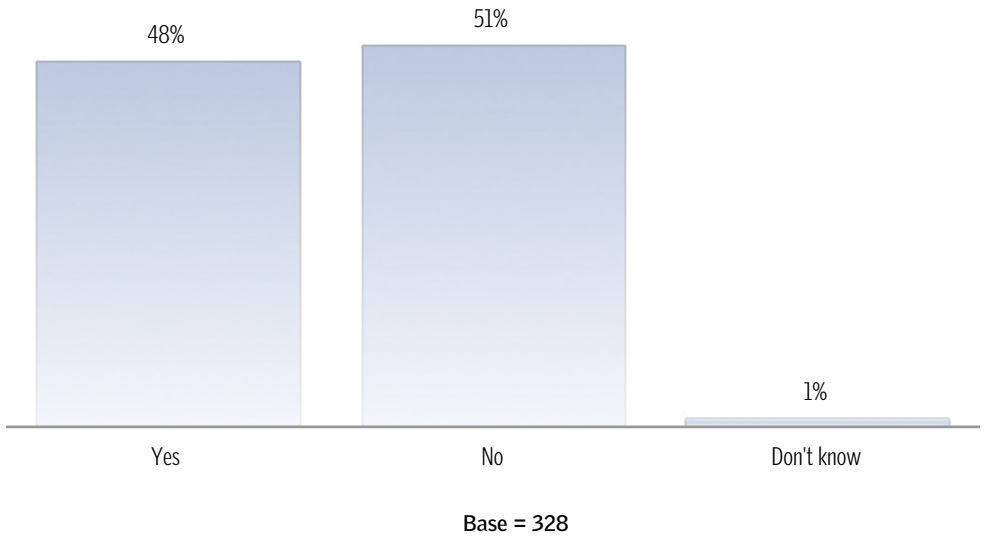
Base = 82

PREMIUM REPORT SAMPLE CHART Click here to order!

FIGURE 6 | Involvement in Mergers or Acquisitions

Q | Over the past three years, has your organization been involved in mergers or acquisitions?

Total responses



TAKEAWAYS

- As one would expect, three-quarters of health systems (71%) have been involved in M&As, versus 38% of hospitals and 33% of physician groups.
- Medium (74%) and large (81%) health systems are more likely to have been involved in M&As than small health systems (52%).
- More than half of large hospitals (56%) have been involved in M&As versus 38% of medium and 32% of small hospitals.

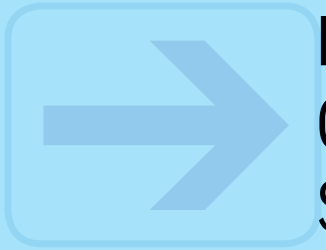
WHAT DOES IT MEAN?

Although the overall results are almost evenly divided between yes (51%) and no (48%), large hospitals and health systems are more likely to take the M&A route. The healthcare delivery system is famously fragmented, but healthcare reform is pushing the industry to expand its networks to control cost and quality. For many, acquiring that network is preferable to building one from scratch.

Access. Insight. Analysis.

Council

The nation's most exclusive healthcare intelligence community



Be a voice
Gain insight from your peers
Shape the direction of the industry

Join today at *www.healthleadersmediacouncil.com*