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98%
say revenue cycle activities have a high or moderate impact on achieving organizational financial goals

INTELLIGENCE REPORT

OCTOBER 2019

THE HIGH-IMPACT REVENUE CYCLE

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RESPONDING TO FINANCIAL DISRUPTION: STRATEGIES TO MAXIMIZE OPERATIONAL EFFICIENCY, PATIENT SATISFACTION AND CASH FLOW

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Over the past decade, new forces have emerged that are disrupting healthcare in fundamental ways. While there are many different forces influencing our industry, there are three primary disruptions gaining urgency: the shift to value-based reimbursement, the influx of consumerism and consumer-centric strategies via retail companies and technology advancements, and consolidation through elevated levels of mergers and acquisitions. These disruptions are increasingly impacting critical elements of healthcare finance, from payments to profitability to capital management.

The *2019 HealthLeaders Revenue Cycle Survey* explores how the emerging environment is impacting healthcare providers and the steps healthcare executives are taking to navigate both short- and long-term financial strategies.

Leverage Automation to Address Key Revenue Cycle Challenges

For many healthcare organizations, revenue cycle operations remain pockets of heavily-manual work. This year's survey found providers are placing a top priority on leveraging automation to improve revenue cycle functions, particularly in remittance and reconciliation. In fact, 33% of executives surveyed said revenue cycle automation would have a significant financial impact this fiscal year.

Revenue cycle automation can streamline process, delivering a frictionless payment experience, boosting staff productivity, and reducing costs. Additionally, automation can help providers address three of the biggest back-office challenges identified in this year's revenue cycle survey: managing remittance data (54%), reconciliation across management systems (41%), and turnover of back-office staff (29%).[1]

Patient Financing a Necessary Revenue Cycle Strategy

As patients take on more financial responsibility for the cost of care, healthcare organizations are now forced to address the growing importance of patient payments. Important disruption around price transparency, price estimations and pre-service payments, make proactively managing patient obligations a necessity. The adoption of price transparency and price estimates still varies widely across the industry.

While healthcare continues to make advancements in these areas, what we do know is finding alternative ways for patients to pay is a priority. For example, a patient lending program is a proven tool that can immediately help both healthcare providers and patients. With support from a strong financial institution, providers can extend a host of low and no-interest payment plans that meet patient needs without tying up capital. These programs can significantly improve the pre- and post-service collection efforts with patients, as well as enhance overall engagement and satisfaction.

While becoming more common across the industry, patient financing programs present a substantial opportunity for healthcare providers. This year's survey found 59% of respondents don't currently offer patient lending options. With numerous studies showing these programs greatly enhance collection and patient loyalty, it is a financial tool all providers should consider offering to patients.

Identify Additional Revenue Growth Opportunities

For much of the past decade, healthcare providers have approached revenue cycle challenges with a strong focus on managing and reducing costs. While these efforts are crucial, there is still considerable opportunity to grow new revenue or optimize existing streams. For example, extending virtual payment cards to suppliers can generate new or added earned revenue. Automating this process opens even more opportunities to improve efficiency and scalability, further augmenting those alternative revenue streams.

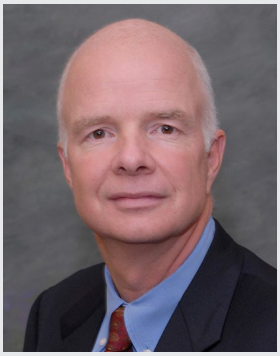
Disruptive change is already impacting the healthcare industry and will continue to do so for the foreseeable future. Responding successfully will take clear understanding of the sources of disruption and the barriers to fundamental change and innovation.

1. CommerceHealthcare® has found that system integration and automation of remittance splitting/posting/reconciliation can mitigate inefficiencies, errors and frustration induced by siloed systems and labor-intensive workflows. It can also help reduce excessive payer interchange payment fees and excess lockbox processing fees.

CommerceHealthcare® services are provided by Commerce Bank. As an industry leader in healthcare finance and payments, CommerceHealthcare® assists healthcare organizations nationwide in responding to financial disruption to ensure our clients are maximizing yield on their cash flow. It is essential providers select a financial firm with banking experience and knowledge of how healthcare finance is likely to be altered. No matter the challenge, CommerceHealthcare® is committed and ready to help prepare healthcare organizations and patients for the new healthcare financial landscape.

THE EVOLVING REVENUE CYCLE: PRICE TRANSPARENCY AND AUTOMATION BRING NECESSARY CHANGE

Revenue cycle is a key function for healthcare providers as the need to maximize patient revenue is essential to their financial well-being.



Jonathan Bees
Research Analyst

Revenue cycle is a critical function for every healthcare provider, and maximizing patient revenue through management, tracking, and collection is essential to providers' financial well-being.

In fact, 98% of respondents in our *2019 HealthLeaders Revenue Cycle Survey* say that revenue cycle activities have a high impact (70%) or moderate impact (28%) on achieving their organizations' financial goals (Figure 2).

"With industry margins in the low single digits, it doesn't take much to move the needle either into the red or the black," says Kris Zimmer, chief financial officer of St. Louis–based SSM Health, an 11,000-physician health system with 23 hospitals serving Missouri, Illinois, Oklahoma, and Wisconsin, and advisor for this HealthLeaders Intelligence Report.

"Revenue cycle is the lifeblood of any healthcare provider. If an organization is not focused on revenue cycle activities, I would be concerned because the outside world is working every day to pay less," says Zimmer. "We have to work equally hard every day to make sure we're reimbursed fairly."

70%

of respondents say that the revenue cycle activity they expect to have the greatest financial impact on their organization is minimizing denials

Activities with greatest impact. While it takes a comprehensive approach to revenue cycle to maximize both billing and collection, there are a handful of strategies and practices that generate the most financial impact. In an industry with shrinking resources, it's important for providers to focus on the activities most likely to generate return on investment.

As an example, more than two-thirds (70%) of respondents say that the revenue cycle activity that they expect to have the greatest financial impact on their organization is minimizing denials (Figure 1). The attention spent on minimizing denials is in response to payer strategies that focus on denying an ever-greater number of claims, forcing providers to constantly prove their legitimacy.

"In the past year or two, the sense I get in talking to peers across the nation is that payers have tripled and quadrupled their denial resources," says Zimmer. "The increasingly aggressive payer denial actions cause providers to be in a defensive position. So there is a lot of anxiety and frustration among the

provider community that payers have adopted a position that they never owe anything unless you prove that they do. It's flipped from historically where there was a presumption of coverage."

Perhaps as a result of such payer policies—an example is Anthem's policy that denies coverage and payment for ED visits it deems unnecessary—the response for improving clinical documentation (63%) finishes a close second to minimizing denials when it comes to the revenue cycle activities with the greatest financial impact. This is because providers must constantly challenge payer denials, and they have a strong need for accurate and detailed clinical documentation to support their claims.

Growth in transparency. While increasing price transparency has been a goal for the healthcare industry for some time, and more recently CMS has been focused on improving it, real progress has been slow in coming. Part of the issue has to do with the inherent complexities of the payment system, which makes effective solutions difficult to achieve.

The good news is over two-thirds (70%) of respondents in our survey say their organization provides price transparency for all care provided (49%) or most care provided (21%), which suggests that solid progress is being made (Figure 4).

One method providers are using to improve transparency is publishing their chargemaster prices online. In fact, 37% of respondents currently use this tactic, and another 15% plan to in the next six months (Figure 5). Note that momentum for this particular trend is likely being driven by recent CMS regulations. On the other hand, an almost equal number (36%) say they do not publish their chargemaster prices and have no plans to do so.

53%

say that transparency is both a threat and an opportunity

There are a number of reasons why providers may be reluctant to publish their chargemaster prices, says Zimmer. Chargemaster prices can end up having little to do with what a patient will actually pay because patients may have insurance coverage through a commercial or government payer, or they may be self-pay. In addition, many patients simply have difficulty understanding their insurance coverage and are unable to determine their out-of-pocket costs.

"At SSM Health, we don't find publishing the chargemaster helpful, and feel that it confuses patients," says Zimmer. "People assume that it translates to what they're going to pay, and it never does."

"One of my wishes for our industry is to eliminate the chargemaster, unless we want to keep it for internal tracking or costing methodologies. What we should be providing is transparency of the net price to the individual patient. And while today we try to estimate that and it's getting better and better, it really should be a seamless process between insurer, patient, and provider. It shouldn't require electronic reach-outs, phone calls, and manual staffs. It ought to be a seamless automated system," he says.

Survey respondents were asked about the methods they use for providing price estimates, with the majority (43%) saying they use

revenue cycle specialists on the phone, and 19% saying they offer an online estimator tool (Figure 6). In six months, responses indicate that having revenue cycle specialists on the phone to provide estimates is expected to grow to 48% and use of an online estimator tool will grow to 27%.

The use of online estimator tools targets patients who prefer to conduct their personal activities online. Note that providers are likely offering both options rather than using one or the other exclusively, following both a revenue cycle and a patient experience trend of providing patients with an increasing array of consumer-oriented options to choose from.

However, while online estimator tools may provide patients with more options, there is some question as to whether they are a better option than person-to-person interactions.

"SSM Health does not currently use a patient-driven estimator, although we plan to evaluate one in 2020," says Zimmer. "What we've found is that it really takes a knowledgeable expert to be involved that is able to ask the right questions, such as who is your employer and which of these plans do you have at your employer? And we feel that misinformation is actually worse than no information at all," he says.

Threat or opportunity? Ultimately, the majority of respondents have an optimistic view of price transparency. Fifty-three percent say that transparency is both a threat and an opportunity, and nearly one-third (30%) say that it is purely an opportunity (Figure 7).

"At SSM Health, we view it as an opportunity. We believe not only is it the right thing to do, but we welcome the competition with our local competitors," Zimmer says.

Notably, only 4% of respondents say that transparency is purely a threat, meaning that for most providers there is always an upside to transparency.

"Transparency helps those that are prepared to compete on value, with value being a combination of both price and quality elements," says Zimmer. "I'm a little surprised by the 4% figure for threat because in the markets that I'm aware of, there are high-cost providers that enjoy a market position that would be at risk if there were greater transparency."

The rise of automation. Providers are always looking for ways to automate processes to drive efficiency and reduce costs throughout their organizations, and revenue cycle is no exception. One relatively new development in this area is the use of electronic kiosks.

One-quarter (25%) of survey respondents say that their organization uses kiosks for patient check-in (Figure 8a), which helps ensure the accuracy of patient information and keeps staffing costs down, and 17% of respondents report that their organization uses kiosks for patient payments (Figure 8b), giving patients another opportunity to pay up front and improving patient experience by giving them an additional payment method.

However, not everyone is convinced that kiosks are a better solution than using provider staff, particularly those focused on preservice collection.

"My thoughts on kiosks are that if our primary focus was staffing efficiency, we'd be using kiosks for patient check-in," says Zimmer. "But our primary focus is making sure that we use

our last preservice contact to make sure that everything looks correct in the record so that we'll be able to successfully collect from the payer. And that we also use this last preservice opportunity for point-of-service collection. We want a face-to-face connection and going through a mental process to see if there's anything that needs to be changed or fixed."

At 54%, a fairly large number of respondents indicate that their organizations require front-end, preservice payments, although it is an open question whether this policy is effective with kiosk use (Figure 12). Note that 55% of respondents say requiring preservice payments is moderately effective, and 25% say it is very effective, irrespective of kiosk use (Figure 13).

Another aspect of revenue cycle automation involves automated patient insurance verification systems. These systems are fairly common, with 60% of respondents reporting that their organization uses one, and their increasing use is part of an automation trend to free up revenue cycle staff so they are able to work on more complex tasks (Figure 10).

Also part of revenue cycle automation is the use of analytics, including systems based on artificial intelligence. For example, 13% of respondents say that they are currently using artificial intelligence to minimize denials (Figure 9). Providers are increasingly looking to use technology to level the playing field with payers as well as free up revenue cycle staff for more complex transactions.

"Our view is that the highest return-on-investment IT solutions are in back-office functions and business-to-business connections, and include advanced artificial intelligence, sophisticated analytics, and robotic process automation," says Zimmer.

Perhaps in response to this trend, some providers are placing their dedicated IT departments under revenue cycle's jurisdiction, in order to better focus IT personnel and resources on enhancing revenue cycle automation. In fact, 19% of respondents reported that their dedicated IT department falls under revenue cycle management (Figure 3).

Patient lending. Driven by the growing use of high-deductible plans and patients who are self-pay, providers are increasingly offering patient lending options as part of their revenue cycle activities. In fact, 29% of respondents in our survey say that they offer either a low-interest option (15%) or a zero-interest option (14%), and another 13% say they will add a lending option in the future (Figure 11).

"We added a zero-interest option for our hospitals about six years ago," says Zimmer. "It has been very effective and continues to grow, and we expanded it to our medical groups a little more than a year ago. At this point, more than 10% of our patient payments come through the program. It's been essential to helping patients with high-deductible plans."

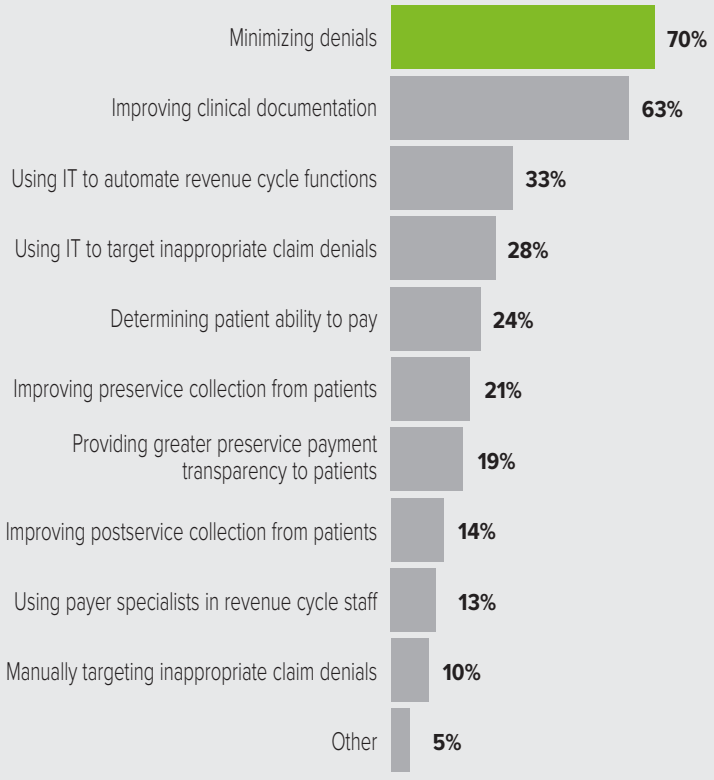
Jonathan Bees is a research analyst for HealthLeaders.

REVENUE CYCLE ACTIVITIES – GREATEST FINANCIAL IMPACT

Figure 1

Of the following revenue cycle activities, which three do you expect to have the greatest financial impact during this fiscal year?

> **Minimizing denials tops the list.** Respondents indicate that the revenue cycle activity that will have the greatest financial impact is minimizing denials (70%). Providers have been forced to counter payer strategies that focus on rejecting an ever-greater number of claims, meaning that providers must constantly prove coverage.



Base = 155, Multi-response

Percent of respondents who say minimizing denials is the revenue cycle activity that will have the greatest financial impact on their healthcare organizations.

And if they don't respond adequately to this challenge, they risk experiencing serious financial impacts to their balance sheets.

> **Improving clinical documentation close second.** The response for improving clinical documentation (63%) reflects its important role in helping to both mitigate denials and ensure accurate billing. Because providers must constantly challenge payer denials, they have a strong need for accurate and detailed clinical documentation to support their claims.

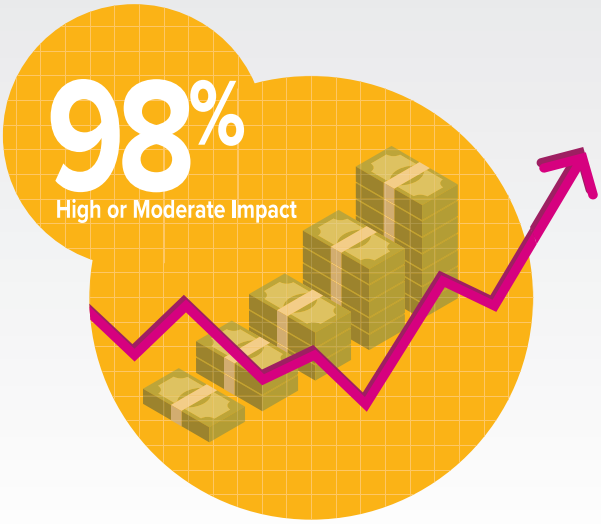
IMPACT OF REVENUE CYCLE ACTIVITIES ON FINANCIAL GOALS

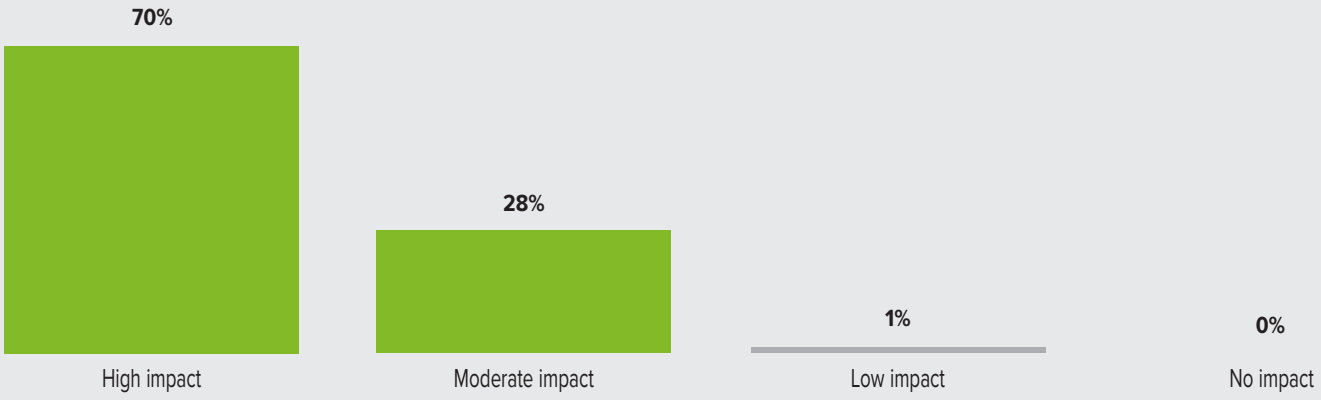
Figure 2

What impact do revenue cycle activities have on your organization's overall ability to achieve financial goals?

> **Substantial impact.** A remarkable 98% of respondents say that revenue cycle activities have a high impact (70%) or moderate impact (28%) on achieving their organizations' financial goals. Industry margins generally fall in the low single digits, so it doesn't take much to impact the bottom line.

Percent of respondents who say that revenue cycle activities have a high or moderate impact on achieving their organizations' financial goals.





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DEPARTMENTAL ORGANIZATION

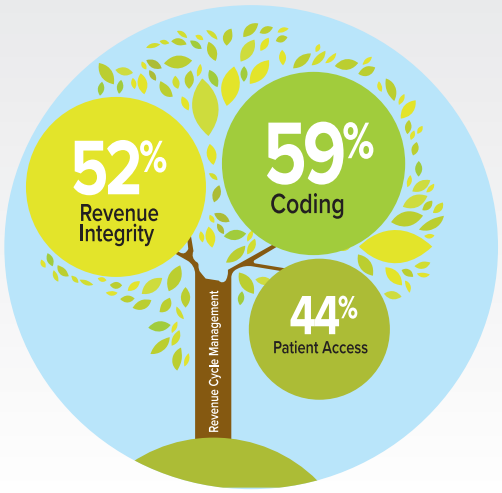
Figure 3

For each of the following departments, please indicate whether your organization has this department and whether it falls under revenue cycle management.

> **Top three departments under revenue cycle.** Coding (59%), revenue integrity (52%), and patient access (44%) are the top three departments under revenue cycle management. Note that only 6% of respondents say that their organization does not have a coding department.

> **Top three departments not under revenue cycle.** The top three departments that aren't found under revenue cycle's jurisdiction are dedicated IT (65%), quality (63%), and case management (56%). Dedicated IT has typically not been aligned with revenue cycle because it serves a variety of masters throughout an organization and is often considered part of operational infrastructure. Quality and case management are more clinical in nature, and less likely to be under revenue cycle control.

Coding, revenue integrity, and patient access are the top three departments under revenue cycle management.



> **Dedicated IT moving to revenue cycle?** Interestingly, nearly one-fifth (19%) of respondents say that their dedicated IT department falls under revenue cycle. This may be in response to the increasing automation of revenue cycle processes, the use of analytics in revenue cycle activities, and a need to bring programming talent closer to revenue cycle initiatives.

	Yes, we have this department and it's under revenue cycle management	Yes, we have this department but it's not under revenue cycle management	No, we don't have this department	Don't know
Coding	59%	30%	6%	5%
Revenue integrity	52%	15%	22%	11%
Patient access	44%	35%	15%	6%
Inpatient CDI	29%	24%	34%	14%
Case management	24%	56%	15%	5%
Quality	24%	63%	7%	6%
Outpatient CDI	23%	21%	42%	14%
Dedicated IT	19%	65%	12%	5%

* Ranked by responses for "Yes, we have this department and it's under revenue cycle management" | Base = 155, Multi-response

PRICE TRANSPARENCY FOR PATIENT CARE

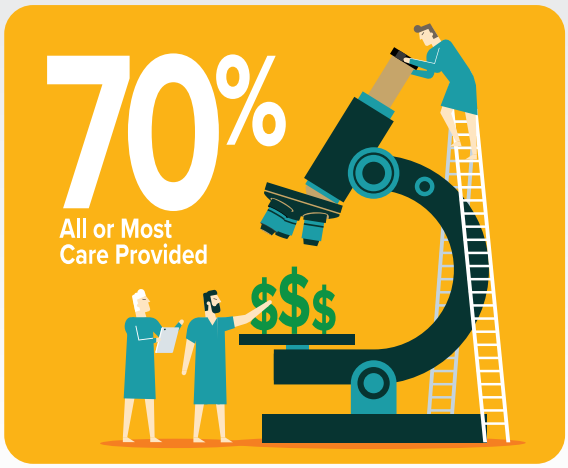
Figure 4

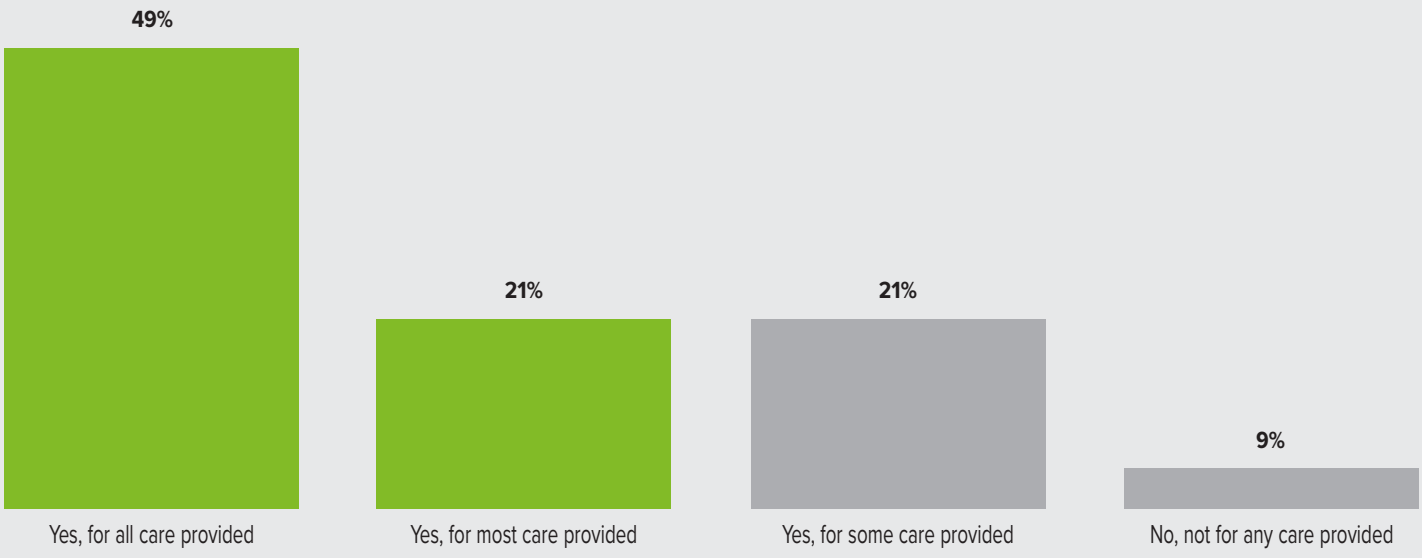
Does your organization provide price transparency to patients for care provided?

> **Focus on transparency.** Seventy percent of respondents say that their organization provides price transparency for all care provided (49%) or most care provided (21%), likely in response to governmental mandates from CMS and patient demand. However, many patients may still face challenges determining out-of-pocket costs because of difficulties deciphering their insurance plan, and organizations may offer varying levels of "transparency" (e.g., publishing the chargemaster, online estimators, preservice estimates through kiosks).

> **For-profit versus nonprofit.** Seventy-eight percent of for-profit respondents say that their organization provides price transparency for all care provided (55%) or most care provided (23%), while 65% of nonprofit respondents say that their organization provides price transparency for all care provided (45%) or most care provided (20%).

Percent of respondents who say that their organization provides price transparency for all care or most care provided.





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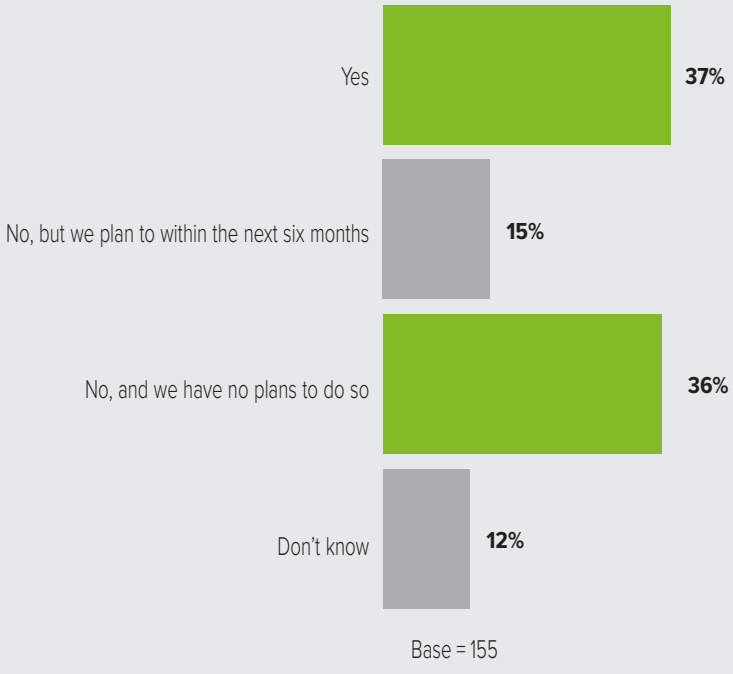
PUBLISHING CHARGEMASTER PRICES

Figure 5

Does your organization publish online chargemaster prices of standard charges for items and services?

> **Mixed results.** Responses indicate that a nearly equal number of organizations publish chargemaster prices (37%) as do not publish them (36%). Another 15% say that they plan to publish chargemaster prices in the next six months, meaning that eventually slightly more than half (52%) will do so. This trend is likely in response to CMS' recent focus on price transparency.



Responses indicate that a nearly equal number of organizations publish chargemaster prices (37%) as do not publish them (36%).

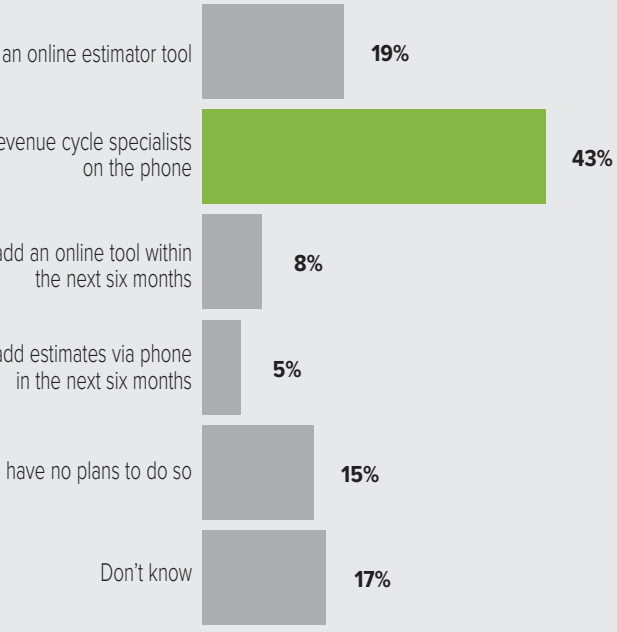
> **Will this help transparency?** Publishing chargemaster prices actually has a limited impact on price transparency. Patients may have insurance coverage through a commercial or government payer, or they may be self-pay, and as a result they rarely pay chargemaster prices.

PRICE ESTIMATES FOR COST OF STANDARD PROCEDURES

Figure 6

Does your organization offer price estimates to help patients anticipate the cost of standard procedures?

> **Personal touch.** At 43%, respondents say that the most common method of providing price estimates is through revenue cycle specialists over the phone, with responses indicating that this is expected to grow to 48% in six months.



Base = 155, Multi-response

Percent of respondents who say the most common method of providing price estimates is through revenue cycle specialists over the phone.

> **Use of online tools.** While use of an online estimator tool (19%) finishes a distant second to a phone consultation with revenue cycle specialists, this method plays an important role with patients who prefer online or mobile transactions. Providers need to use a combination of approaches to ensure price transparency is available to all patients.

PRICE TRANSPARENCY – THREAT OR OPPORTUNITY?

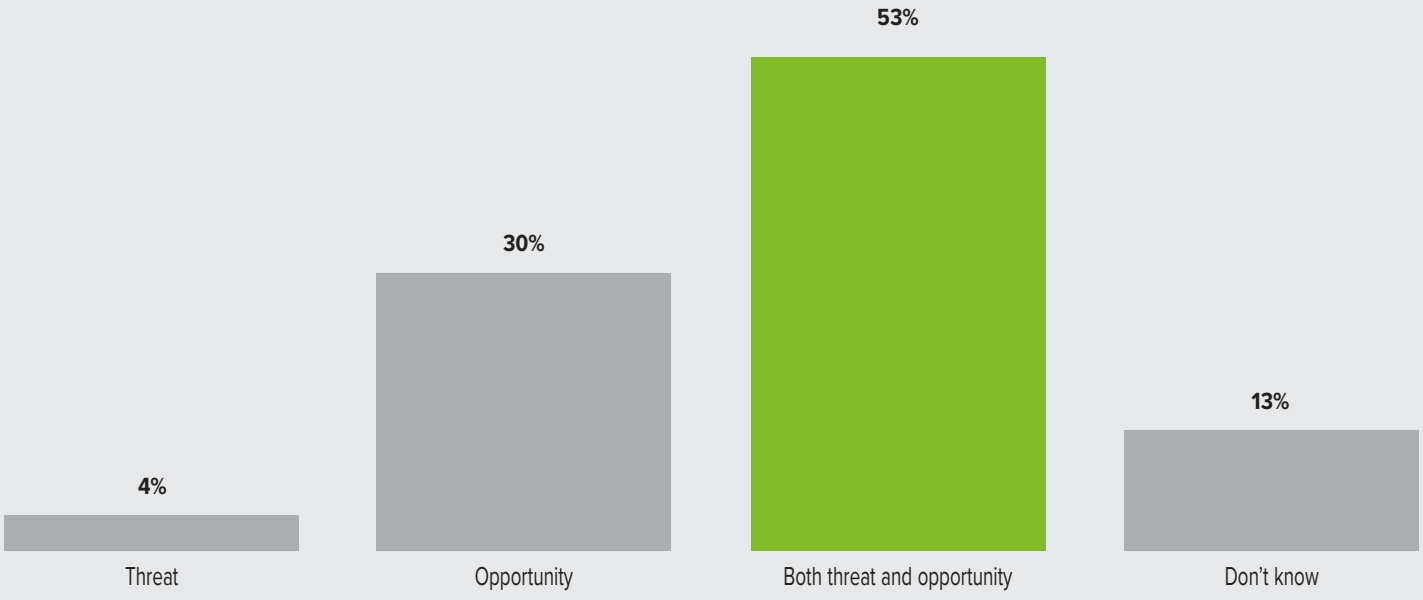
Figure 7

Does the industry shift to price transparency represent a threat or an opportunity for your organization?

> **Mostly an opportunity.** Only 4% of respondents say that price transparency is purely a threat for their organization. The majority of respondents (53%) say that it is both a threat and an opportunity, and nearly one-third (30%) say that it is purely an opportunity. This means that for most providers, there is always upside to transparency.

> **Physician organizations see opportunity.** A greater share of respondents from physician organizations (42%) than hospitals (27%) and health systems (21%) say that price transparency is purely an opportunity.

Percent of respondents who say the healthcare industry's shift to price transparency is both a threat and an opportunity.



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ELECTRONIC KIOSKS – PATIENT CHECK-IN AND PAYMENTS

Figures 8a and 8b

Does your organization use electronic kiosks for patient check-in and payments?

> **Automation from the start.** One-quarter of respondents (25%) say that their organization uses an electronic kiosk for check-in, a tool that benefits providers by ensuring accuracy of patient information and helping to keep staffing costs down.

> **Automating payment processes.** Seventeen percent of respondents say that their organization uses an electronic kiosk for patient payments, providing patients with the opportunity to pay up front and improving patient experience by giving them an additional payment method.

One-quarter of respondents say their organization uses an electronic kiosk for check-in, and 17% of respondents say that their organization uses an electronic kiosk for patient payments.

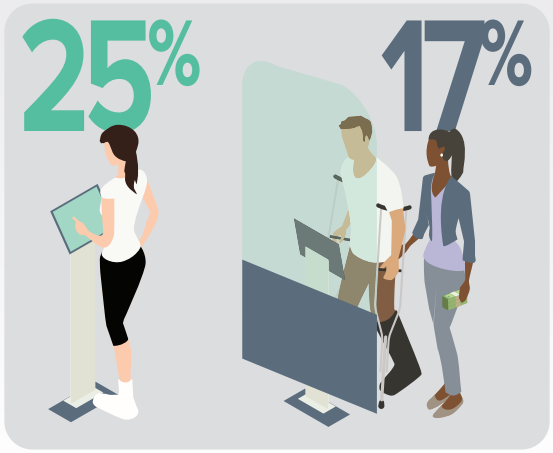

Figure 8a

Patient Check-In

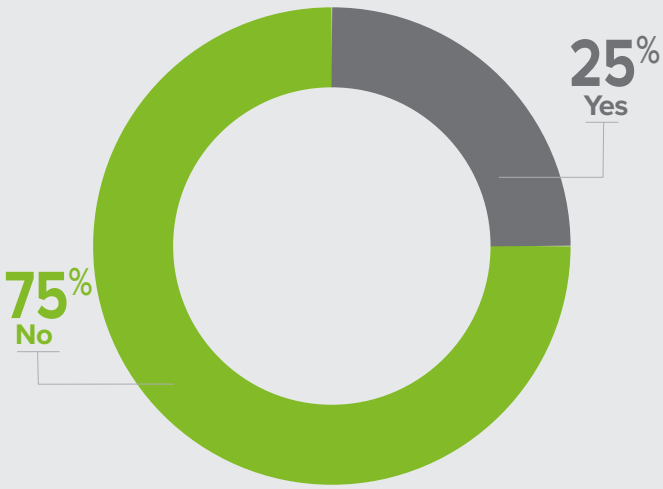

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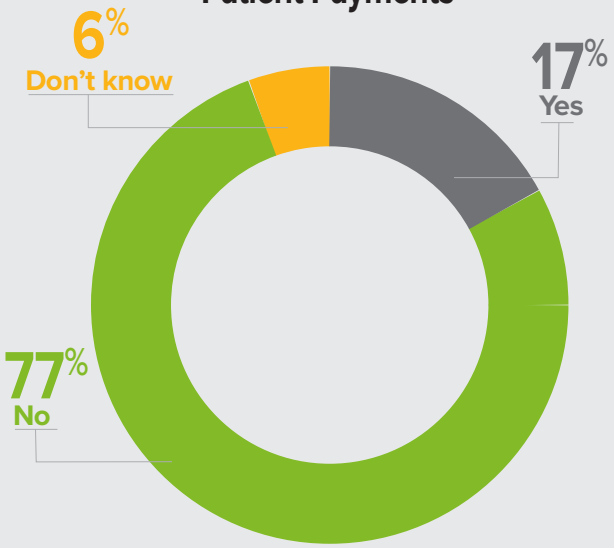
Figure 8b

Patient Payments



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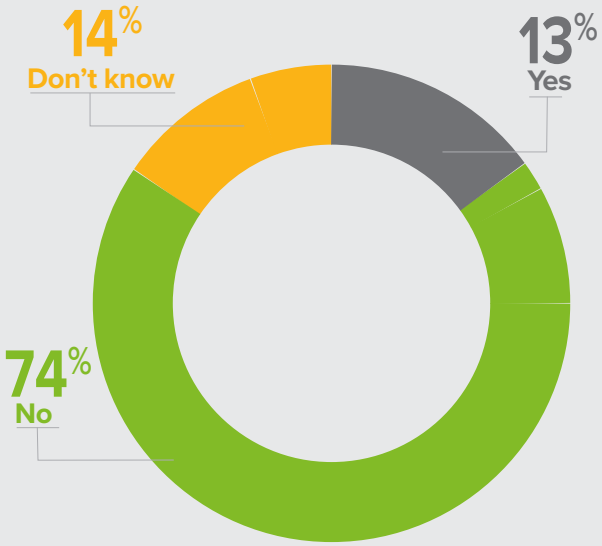
DENIALS MANAGEMENT USING ARTIFICIAL INTELLIGENCE

Percent of respondents who say their organization uses an artificial intelligence solution to manage denials.

Figure 9

Does your organization use an artificial intelligence solution to manage denials?

> **Level playing field?** Thirteen percent of respondents say that their organization uses an artificial intelligence solution to manage denials. Providers are increasingly looking to use technology to level the playing field on managing denials by payers, who are generally larger and have greater resources than providers, and to free up revenue cycle staff for more complex tasks.



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AUTOMATED PATIENT INSURANCE VERIFICATION

Percent of respondents who say their organization uses an automated patient insurance verification system.

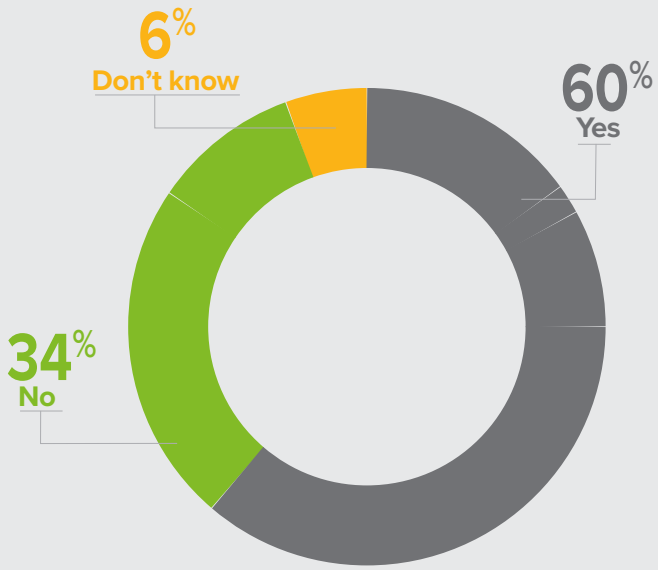
Figure 10

Does your organization use an automated patient insurance verification system?

> **Automating patient insurance verification.** Nearly two-thirds (60%) of respondents say that their organization uses an automated patient insurance verification system, further evidence of the automation of revenue cycle functions.

> **Health systems lead automation trend.** As with the use of kiosks for patient check-in and payments, a greater share of respondents from health systems (88%) than physician organizations (68%) and hospitals (54%) say that they use an automated patient insurance verification system.

> **Correlation with profit status.** A greater share of respondents from for-profit organizations (71%) than nonprofit organizations (53%) say that they use an automated patient insurance verification system.



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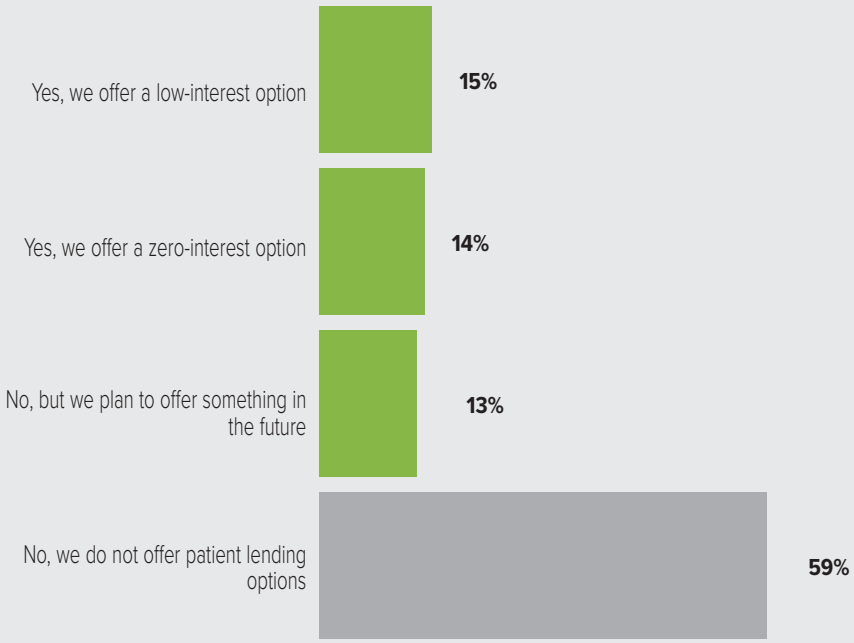
PATIENT LENDING PROGRAM

Figure 11

Does your organization offer or plan to offer a patient lending program?

> **Growth in lending programs.** Twenty-nine percent of respondents say that their organization currently offers either a low-interest lending option (15%) or a zero-interest option (14%). Another 13% say that they plan on offering some form of lending in the future, which would bring the total to 42%. These lending options are in response to the increased use of high-deductible plans and to address the needs of self-pay patients.

The percent of combined responses from those who say their organization currently offers either a low-interest lending option or a zero-interest option, and those who plan to offer lending in the future.



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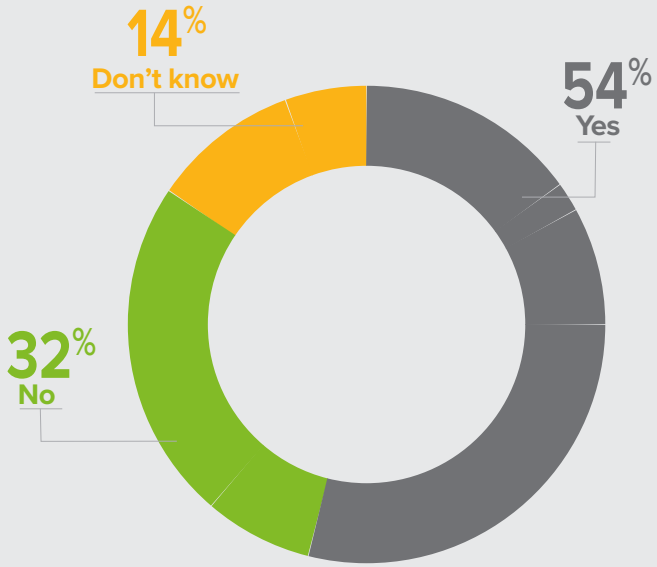
FRONT-END, PRESERVICE PAYMENT POLICY

Figure 12

Does your organization have a policy requiring front-end, preservice payments from patients?

> **Money up front.** More than half of respondents (54%) say that their organization has a policy requiring front-end, preservice payments from patients. However, while requiring preservice payments can be effective, it is not a cure-all. (See Figure 13 for respondent views on its effectiveness.) Having such a policy does not guarantee collecting the full amount due, although it certainly helps.

Percent of respondents who say their organization has a policy requiring front-end, preservice payments from patients.



Base = 155

FRONT-END, PRESERVICE PAYMENTS – TOTAL COLLECTIONS

Figure 13

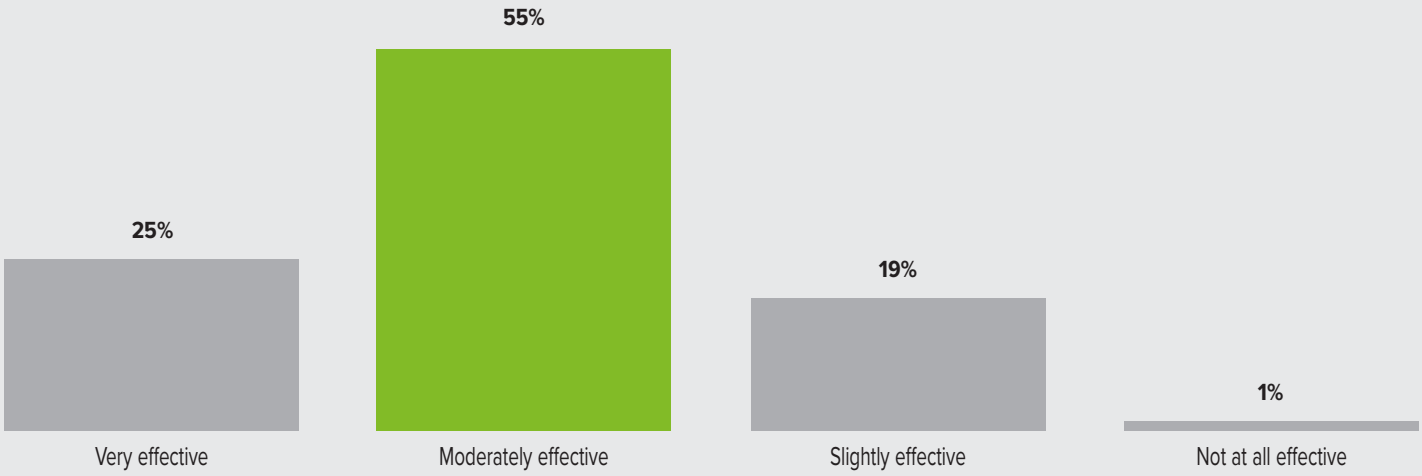
Please describe your organization's experience with the use of front-end, preservice payments in terms of total collections.

> **Preservice payments moderately effective.** Fifty-five percent of respondents say that front-end, preservice payments are moderately effective, and 25% say this is very effective. However, these payments do not necessarily ensure that all revenue due to a provider is captured. Plus, there are concerns that patients may delay or cancel care when confronted with upfront costs.

> **Physician organizations have more success.** A greater share of respondents from physician organizations (54%) than hospitals (17%) and health systems (13%) say that use of front-end, preservice payments is very effective.

Percent of respondents who say front-end, preservice payments are moderately effective for total collections.

> **For-profits also more successful.** A greater share of respondents from for-profit organizations (39%) than nonprofit organizations (15%) say that use of front-end, preservice payments is very effective.



Base = 84

*Of those respondents who have a policy requiring front-end preservice payments from patients

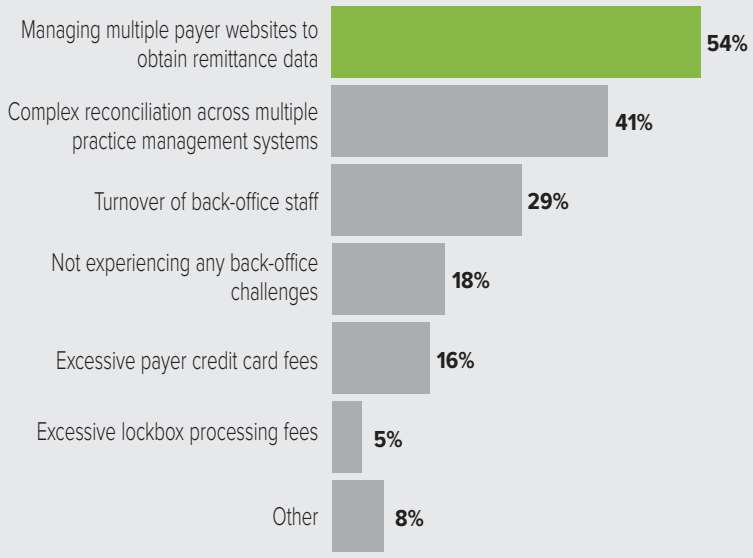
BACK-OFFICE CHALLENGES

Figure 14

Which of the following back-office challenges is your organization currently experiencing?

> **Top two back-office challenges.** Respondents say that the top two back-office challenges their organization is currently experiencing are managing multiple payer websites to obtain remittance data (54%) and complex reconciliation across multiple practice management systems (41%). Both challenges are external in nature, making them difficult to manage.

Percent of respondents who say the top back-office challenge their organization is currently experiencing is managing multiple payer websites to obtain remittance data.



Base = 155, Multi-response

METHODOLOGY

The *2019 HealthLeaders Revenue Cycle Survey* was conducted by the HealthLeaders Intelligence Unit, powered by the HealthLeaders Council. It is part of a series of thought leadership studies. In July 2019, an online survey was sent to the HealthLeaders Council and select members of the HealthLeaders audience at healthcare provider organizations. A total of 155 completed surveys are included in the analysis. Base size varies between 84 and 155 according to respondents' knowledge of the question. The margin of error for a base of 155 is +/-7.9% at the 95% confidence interval. Survey results do not always add to 100% due to rounding.

What Healthcare Leaders Are Saying

Here are selected comments from leaders regarding what new program or initiative their organization implemented over the past year that most improved the effectiveness of their revenue cycle operations.

"Upfront collections."

—CFO at a large health system

"Front-end denials management and education with case management."

—CEO at a large health system

"Updated online patient price estimator."

—CFO at a small health system

"Created an express check-in process."

—VP/Director Revenue Cycle at a medium hospital

"We are in the process of implementing an IT solution to revenue cycle management."

—CEO at a large hospital

"Working with bank to offer interest-free loan, payments via portal, upfront collections (copays, cosmetic procedures), reworking EHR build for practice panels."

—VP/Director of Operations at a medium hospital

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.

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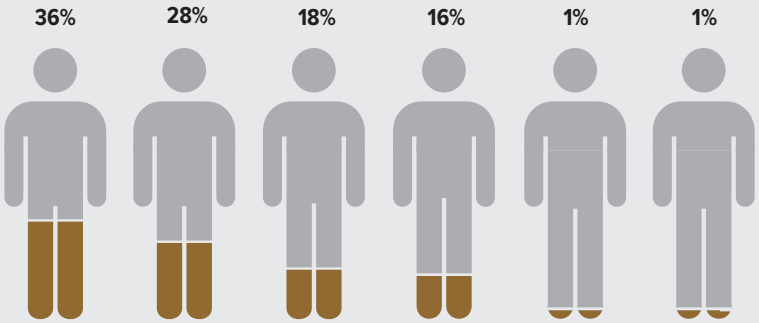
RESPONDENT PROFILE

TITLE

Base = 155



CEO, PRESIDENT

- CEO, President
- Chief Executive Administrator
- Chief Administrative Officer
- Board Member
- Executive Director
- Managing Director
- Partner, Chief of Staff
- Principal
- Owner

CLINICAL LEADERSHIP

- Chief Medical Officer
- Chief Nursing Officer
- Chief of Medical Specialty or Service Line
- VP/Director of Medical Specialty or Service Line
- VP/Director of Nursing
- Chief Population Health Officer
- Chief Quality Officer
- Medical Director
- VP/Director Ambulatory Services
- VP/Director Clinical Services
- VP/Director Quality
- VP/Director Patient Safety
- VP/Director Postacute Services
- VP/Director Behavioral Services
- VP/Director Medical Affairs/Physician Management
- VP/Director Population Health
- VP/Director Case Management
- VP/Director Patient Engagement, Experience

FINANCIAL LEADERSHIP

- Chief Financial Officer
- VP/Director Finance
- VP/Director Patient Financial Services
- VP/Director Revenue Cycle
- VP/Director Managed Care
- VP/Director Reimbursement
- VP/Director HIM

IT LEADERSHIP

- Chief Information Security Officer
- Chief Information Officer
- Chief Technology Officer
- Chief Medical Information Officer
- Chief Nursing Information Officer
- VP/Director IT/Technology
- VP/Director Informatics/ Analytics
- VP/Director Data Security

MARKETING LEADERSHIP

- Chief Marketing Officer
- VP/Director Marketing
- VP/Director Business Development/Sales

OPERATIONS LEADERSHIP

- Chief Operations Officer
- Chief Strategy Officer
- Chief Compliance Officer
- Chief Purchasing Officer
- VP/Director Operations/ Administration
- VP/Director of Compliance
- Chief Human Resources Officer
- VP/Director HR/People
- VP/Director Supply Chain/ Purchasing

TYPE OF ORGANIZATION

Base = 155

Hospital	**38%**
SNF/nursing home/assisted living facility/home health agency/hospice/inpatient rehab facility	**27%**
Health system (IDN/IDS)	**15%**
Physician organization (MSO, IPA, PHO, clinic)	**12%**
Ambulatory surgical center	**4%**
Ancillary services provider (diagnostic/therapeutic/custodial)	**1%**
Payer/health plan/insurer (HMO/PPO/MCO/PBM)	**1%**
Convenient care/retail care clinic	**1%**

NUMBER OF PHYSICIANS

Base = 155

1–9	**18%**
10–49	**19%**
50+	**60%**
Not applicable	**3%**

NUMBER OF BEDS

Base = 155

1–199	**49%**
200–499	**15%**
500+	**17%**
Do not have a standard number of beds	**19%**

PROFIT STATUS

Base = 155

Nonprofit	**60%**
For-profit	**40%**

NET PATIENT REVENUE

Base = 155

$249.9 million or less (small)	**57%**
$250 million–$999.9 million (medium)	**12%**
$1 billion or more (large)	**13%**
None of the above	**17%**

RESPONDENT REGIONS