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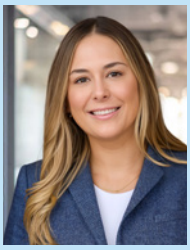
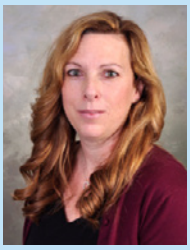
Modernizing utilization management: A case for system-level change

Barbara Vandegrift
Senior Vice President



Brooke Balster
Senior Vice President



Andrea Ortman
Vice President, Hospital Services for Geisinger Health System

For many health systems, utilization management (UM) has long been a functional necessity, but rarely a strategic priority. Originally designed to ensure clinical appropriateness and support payer requirements, UM often grew up within hospital walls, shaped by local workflows and embedded within broader care management structures. As a result, traditional UM functions today are frequently fragmented, inconsistent and outpaced by competing financial, operational and regulatory demands.

Today's healthcare environment calls for elevated utilization management performance. Capacity constraints, complex payer expectations and heightened scrutiny on patient status determinations have elevated UM's importance within the context of organizational strategy. What was once seen as a component of care management is now its own critical piece of systemwide performance. This means that health systems face a pivotal moment. The question is no longer whether to modernize UM, but how.

Limitations of traditional UM models

Legacy UM functions typically evolved at the hospital level, often with autonomy or at least variability in how, and by whom, utilization reviews were conducted. This allowed flexibility, but it also led to fragmentation. Processes varied across facilities within the same system. Decision criteria were inconsistently applied. In some systems, UM was housed under nursing; in others, it reported to finance or revenue cycle. Centralized governance was lacking, and with it, accountability.

Another challenge has been role dilution. In many hospitals, case managers or care coordinators were tasked with handling UM reviews in addition to discharge planning and patient progression. These competing responsibilities often forced staff to triage their time—focusing on immediate discharge barriers while deferring UM reviews. That delay undermined timely care decisions and exposed systems to payer denials, which jeopardized reimbursement.

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Even in systems that attempted to centralize UM, true standardization was rare. Policy differences persisted across hospitals. Staff training was inconsistent. And technological support was often lacking, with manual processes prevailing over integrated digital workflows. The result: a patchwork of practices with no unified approach.

The case for centralization

In contrast, a truly centralized UM function offers a strategic, scalable alternative. A centralized approach separates UM from other care management functions by establishing dedicated teams focused exclusively on utilization review. Staff are trained in clinical criteria and payer-specific requirements. Workflows are standardized across the enterprise. Technology enables real-time status reviews, communication with payers and audit trails.

Centralized UM brings several advantages. First, it **reduces variation**. With shared protocols and unified oversight to ensure medical necessity documentation is captured, health systems can count on consistent decisions, regardless of site, shift or reviewer. This helps reduce denials, improve documentation accuracy and support compliance with payer rules.

Second, centralization **supports financial accountability**. By aligning UM under the revenue cycle or in partnership with finance, organizations reinforce the connection between clinical decisions and reimbursement integrity. Escalation pathways for complex cases, pre-claim appeals and physician advisor reviews become embedded processes, not *ad hoc* reactions. This establishes a proactive, not reactionary, approach to securing authorization or payment.

Third, centralized UM **strengthens payer engagement**. Health plans increasingly demand timely, well-documented reviews supported by standardized clinical evidence.

Successful elements of a centralized utilization management function

1. Strong support from C-suite leadership
2. Strong partnerships with onsite clinicians and care management
3. Comprehensive staff training
4. Clear definitions of roles
5. Technological support

Today's healthcare environment calls for elevated utilization management performance. The question is no longer whether to modernize UM, but how.

A cohesive UM structure gives systems the data, scale and clout to negotiate and advocate effectively.

Governance, leadership and culture

Successfully building a centralized UM function requires more than reassigning staff. It demands system-level governance and strong, visionary leadership. UM must be anchored in executive priorities and supported across revenue cycle, operations, clinical leadership and information technology. In high-performing systems, sponsorship often comes through the chief financial officer (CFO) or revenue cycle, while nursing and hospital operations ensure day-to-day integration.

But structure alone is not enough. Culture matters. A shift to centralized UM must be framed not as a loss of local control but as a strategic evolution. Clear communication, aligned incentives and transparency about roles and expectations are essential to build buy-in and sustain momentum.

The role of physician engagement

Equally critical is physician partnership. UM functions thrive with the active involvement of physician advisors (typically reporting to the chief medical officer) who guide clinical decision-making, support appeals and bridge conversations with frontline providers. This clinical voice is vital in maintaining credibility and trust.

Yet true engagement extends beyond leadership roles. Successful UM programs cultivate collaboration between reviewers and admitting and attending physicians. This fosters shared ownership of status decisions and streamlines workflows to minimize administrative burden on clinicians. The clinician retains responsibility for the status decision, but UM provides a critical support and assist role. Under this model, UM is not merely a financial function. It's a clinical partnership.

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Case study: Geisinger's UM transformation

In 2020, Geisinger Health System was confronting a capacity crisis. Across the Danville, PA-based system's 9 hospitals, inpatient units were regularly at or above full occupancy, stalling patient throughput and creating operational strain. Upon closer analysis, Geisinger identified a critical bottleneck: its UM function, then embedded within case management and discharge planning, was delaying status determinations and contributing to financial risk.

Nurses tasked with UM reviews were also responsible for discharge planning and patient progression. Pulled toward urgent clinical needs, they often didn't initiate UM reviews until days into a patient's stay—far too late to meet payer notification requirements or support timely reimbursement.

To address this, Geisinger partnered with Claro Healthcare (now part of Kaufman Hall, a Vizient company) to centralize and restructure its UM function. The new model created a dedicated UM team, separate from discharge planning, with clear role definitions and focused accountability.

Several elements enabled the shift. Leadership buy-in was foundational—particularly from the CFO, revenue cycle and clinical operations. Staff were trained to apply evidence-based clinical criteria, despite the variability in payer standards. Technology enhancements linked admission orders to automated work queues within the electronic health record, enabling timely review. Physician engagement was also key; the UM team committed to minimizing unnecessary communication and maintaining clinical alignment.

The results were swift and significant. Observation rates dropped from over 26 percent to between 7 and 10 percent depending on the campus, and the system realized $54 million in revenue improvements in the first year. The division of labor also proved vital during the Covid-19 pandemic, helping discharge planners stay focused amid unprecedented demand.

Geisinger continues to refine the model. In 2023, it launched a strengthened appeals and denials management initiative, escalating payer disputes to physician advisors and initiating pre-claim appeals. Early signs point to stronger compliance and financial performance, reinforcing the value of centralized UM as both a strategic and operational asset.

Questions? Contact Barbara Vandegrift (barbara.vandegrift@kaufmanhall.com) and Brooke Balster (brooke.balster@kaufmanhall.com).

Hospitals keep losing money on physicians. Is there another way?

Hospitals are losing money on physician practices. Hospitals know this, and yet they keep hiring them. Maybe they should consider alternatives.

Today, about 55.1% of physicians are employed by hospitals or health systems. The shift away from independent practices was intended to enhance care coordination and streamline operations. But losses, stemming from generous salary and benefit packages, escalating malpractice insurance premiums and lower-than-expected returns on investment, are mounting. Hospitals currently lose an estimated $306,792 per physician per year, an increase of 5% over a year ago, according to the most recent Kaufman Hall Physician Flash report.

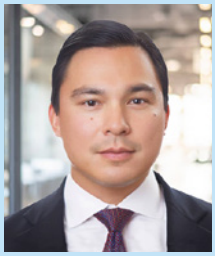
Health systems cannot sustain this kind of financial strain indefinitely. The thinking behind the broad-based employment of physicians and, in some instances, the acquisition of their practices may have made sense at the time, but the numbers are no longer working.

There are several reasons why. Start with **challenges with reimbursement**. The shift to hospital employment often leads to physician services being billed under hospital outpatient (HOPD) rates, which are higher than those of independent practices. However, regulatory changes and competition from independent ambulatory sites have reduced these reimbursement advantages, making it more difficult for hospitals to offset the costs of employing physicians.

Secondly, there is **overutilization of low- or negative-margin services**. Many hospitals incentivize physicians to increase service volume. But more isn't necessarily better. Too many hospitals have fallen into the trap of focusing on volume and/or revenue growth over margin. But more volume can actually compound the loss if the service underperforms. The continued decline of revenue per wRVU demonstrates this all too clearly.

Third is **administrative burden**. Integrating physicians and, in particular, whole practices into hospital systems requires significant investment in administrative infrastructure, including electronic health record systems and compliance programs. These integration efforts are costly and can lead to operational inefficiencies, particularly if the hospital struggles to standardize procedures across newly acquired practices.

Matthew Bates
Managing Director,
Service Line Leader,
Physician Enterprise



Kristofer Blohm
Managing Director and
Mergers & Acquisitions
Practice Co-Leader

In other words, hospitals have been acquiring physicians with little attention paid to their profitability. They've been hoping to achieve economies of scale that in many instances just haven't been there. As Ken Kaufman has pointed out: "If a factory is losing $5 on every widget it produces, the answer is not to produce more widgets. Rather, expenses need to come down."

Alternatives to physician employment

So, what to do about it? Hospitals have tried affiliation models like professional services agreements in the past, with limited success in some instances. But it might be time to consider new potential arrangements. Systems are only starting down this path, so the field does not yet have many tried-and-true models. Still, hospitals do have options—models that align their goals with physician interests without assuming full employment costs. These alternatives provide flexibility, shared risk and opportunities for sustainable financial growth or at least ways to reduce losses. Consider:

1. **Joint ventures in ambulatory surgery centers**

   Ambulatory surgery centers (ASCs) represent a strategic avenue in an increasingly decentralized care environment. By working with physicians through joint ventures that offer autonomy and align financial incentives, hospitals can retain some market share and preserve a stake in downstream profitability. These partnerships should create a shared incentive structure that supports operational efficiency and positive margin.

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2. **Converting primary care clinics into federally qualified health center look-alikes**

   Hospitals can transition primary care clinics into federally qualified health center (FQHC) look-alikes, reducing financial burden while ensuring continued patient access. FQHC look-alikes receive enhanced Medicaid and Medicare reimbursement, as well as federal grants, reducing the need for direct subsidies from the hospital. Physicians working in FQHCs often receive medical school loan forgiveness, making this an attractive alternative to hospital employment. Options to collaborate with existing FQHCs to provide primary care may also be viable options in some markets.

3. **Value-based care arrangements**

   Hospitals can align with physicians through value-based care models such as accountable care organizations, bundled payment arrangements or other revenue-sharing plans. These models reward both hospitals and physicians for cost-effective, high-quality care without requiring employment. By sharing savings and risks, providers can incentivize quality while reducing unnecessary utilization. Value-based care plans aren't new, but health systems by and large have been slow to embrace them.

By considering these alternatives, hospitals can foster stronger clinical relationships and improve financial sustainability without directly employing physicians. If they're successful, these could lead to an added benefit: improved access to care for patients.

Mapping out a strategy

If some of these ideas seem familiar, that's because we've been down this road before. Hospitals have had a "can't-live-with-them, can't-live-without-them" relationship with doctors for decades. But this time around it's worth asking whether the cycle of acquiring, then divesting, then reacquiring practices is good for the long-term health of the organization. This current period—in which the cycle of physician ownership may be approaching the divestiture phase—might be an ideal time to engage in that once-and-for-all conversation.

First, **physician employment shouldn't be treated as a binary proposition**. Health systems should assess where they're consistently losing money and where they're at risk of losing high-performing physicians. Underperforming service lines may no longer justify continued investment, especially if shifting care models or reimbursement pressures make future profitability unlikely. Conversely, profitable service lines may face physician attrition as private equity-backed groups and independent ASCs offer more attractive arrangements. The strategic challenge is to identify where hospitals are already losing margin—and where they could soon lose clinical talent.

Secondly, hospitals may **contemplate partnerships with nontraditional entities**. Start with existing FQHCs and ASCs as mentioned above. Then there's the potential to work with physician groups backed by private equity, although this carries its own set of risks, so caution is required. The same is true with retail- and pharmacy-based providers; some are aggressively growing, some are pulling back, and it's best to make sure that expectations are clear and incentives are aligned. Collaborations with payers (e.g., a large managed care organization) and/or direct contracts with large employers may make sense in certain markets.

This brings us to our final point. Hospitals know their markets best and should not necessarily follow the latest trends if they don't fit the particulars of an individual situation. Neither, however, should hospitals hope the problem will go away on its own. It won't. Organizations will have to guard against nearsightedness and the temptation to please traditional stakeholders at the expense of doing the right thing for their communities. Be bold when examining opportunities and identifying threats, or you may keep losing money on physicians for years to come.

For more information, please contact Matthew Bates (matthew.bates@kaufmanhall.com), or Kristofer Blohm (kris.blohm@kaufmanhall.com).

Developing the playbook to provide patients timely access to care

If you reviewed the recent Vizient/Kaufman Hall 2025 Trends Report, Strategy is (finally) back in the driver's seat, you might have noticed one startling data point: a 1% increase in "loyal" patients (that is, patients who spend at least three quarters of their healthcare dollars within one health system) can yield a $40 million revenue boost for a $2 billion health system. It follows that loyal patients generate far more revenue than uncommitted patients do.

Unfortunately, patients usually are not loyal. A typical health system captures less than half of its patients' total healthcare spend, according to the trends report. This means that patients are shopping around, or neglecting needed care altogether. Systems lose revenue as a result.

One key to stimulating loyalty among patients, as Ken Kaufman recently pointed out, is access: making it easy for patients to get into and stay within the system. Patients want to schedule appointments on their own timeline at their own convenience. This means timely appointments and a referral appointment system that functions seamlessly and keeps patients within the hospital's care ecosystem.

But this is easier said than done. Health systems are resource constrained. Physician shortages are projected to worsen. The regulatory landscape is uncertain. In this environment, healthcare leaders should begin with a narrow scope of three distinct priorities to improve both how appointments are made and how long it takes to make them.

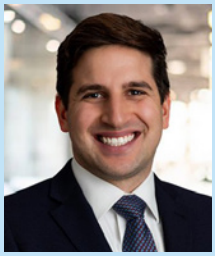
Case Study

Kaufman Hall recently engaged with a multi-hospital health system with more than 1,500 clinicians that was struggling to reduce scheduling complexities. Its complexities resulted in significant unused clinical time.

The situation

- Access was confusing to patients. Patient-facing websites listed hundreds of unique phone numbers for the system's centers and clinics. One-third of its centers and clinics did not have links to web pages.
- There were limited patient-initiated and self-scheduling options and complex scheduling algorithms and decisions trees.
- Aggregate no-show rates exceeded 20%.

Bonnie Proulx
Senior Vice President



Mitch Cooper
Assistant Vice President

- There was limited constructive collaboration and coordination between referring and specialty practices.

The Three Priorities

The system undertook a project to identify three areas to address inefficiencies. This included:

1. **Leveraging technology to activate self-scheduling for new and established patients, with sub-specialty exceptions**

   Patients have become healthcare "consumers," and their expectations have increased. Patients want the care to be technologically advanced; one recent study published in *Journal of General Internal Medicine* found that nearly half of people use technology to communicate with their providers. This health system recognized that if steps in accessing care are complicated, patients will simply switch to the competitor down the road.

2. **Reducing scheduling decision-tree algorithms to a maximum of three questions for both online and contact center platforms.**

   The system found redundancies and inefficiencies in the questions. Many scheduling questions either a) played no part in routing to a particular physician, or b) the patient or call center staff was unable to answer due to complexity of the question. The overly complex algorithms, initially thought to drive efficiency, led to patients being scheduled with potentially the wrong provider.

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3. **Allowing for cross-departmental referral scheduling (e.g., during primary care check-out, a patient is scheduled directly with a cardiologist)**

   Leadership recognized the importance of "systemness" and interdepartmental coordination. Leaders recognized that they needed to design a process that worked for patients, not the siloed structure of clinical departments, because patients do not see different departments and guidelines; they see barriers. Capturing the patient for the next visit while they are on site for a current visit allows hospitals to capture the referral in real time, saves back-and-forth and provides a cohesive, patient-focused experience.

Results

The initial implementation focused on a pilot of two clinics: an urban, high-volume clinic, and a rural, low-volume one. Initial key performance indicators were aimed at reducing appointment no-shows, increasing template utilization and driving volume of new patients seen within 10 days.

The initial results:

- From a baseline of zero, the urban clinic increased appointments scheduled online to 20%, the rural clinic to 13%. No-show rates dropped to 7% for both clinics. (The urban no-show baseline was 11%; the rural baseline was 15%.)
- The proportion of new patients seen rose from 35% to 50% for the urban clinic. For the rural clinic, the rate rose from 79% to 90%.
- Realized template utilization for the rural clinic rose from 63% to 82%, while the urban clinic's template utilization measure remained steady at 83% following implementation.

A typical health system captures less than half of its patients' total healthcare spend, according to the trends report. This means that patients are shopping around, or neglecting needed care altogether. Systems lose revenue as a result.

Final thought

Access improvements need to start with prioritizing just a few things

Patients express their unhappiness by not showing up for appointments, which leaves systems wasting unused time dedicated to seeing patients. Systems' inability to meet consumers where they are leads to frustration, erodes trust and puts loyalty at risk. But access also represents an opportunity for health systems.

Patient access is a complex process for healthcare. Transforming this to be patient-centric and accessible demands intentionality, starting with a few focused changes. Done correctly, access can deliver a value-driven experience for patients. To quote from the Vizient/Kaufman Hall trends report: "This means developing access points that prioritize convenience, meet the needs of different segments in an individualized way, encourage engagement and build lasting trust."

Questions? Contact Bonnie Proulx (bonnie.proulx@kaufmanhall.com) and Mitch Cooper (mitch.cooper@kaufmanhall.com).

Tackling today's policy and regulatory uncertainty: The case for financial scenario planning

Note: This article was originally published in March 2025, and does not reflect subsequent policy or legislative developments.

Not-for-profit hospital and health system leaders are currently monitoring a flurry of rapidly evolving potential changes to state and federal policy with significant, long-term financial ramifications for their organizations.

The recent budget resolution passed by the House of Representatives directed the House Energy and Commerce Committee, which oversees Medicaid, to identify $880 billion in overall federal spending savings. Work requirements and the lowering of federal rate payment floors for Medicaid, changes to graduate medical education funding and the implementation of site-neutral payments for Medicare are all under consideration by congressional leaders. House leaders are also exploring the elimination of tax-exempt status for interest payments on all municipal bonds, a topic our colleagues explore in detail here.

In addition, the National Institutes of Health (NIH) has imposed caps on indirect costs for research grants, which would jeopardize financing for academic medical centers. A federal judge recently filed a preliminary injunction blocking the cuts—which NIH officials estimate would save $4 billion annually in administrative costs—from taking effect while lawsuits against the changes proceed. Providers are also concerned about potential tariffs on critical supplies, a topic our colleagues cover here.

Financial scenario planning is specifically intended to address uncertainty. Scenario exercises can help organizations estimate the magnitude of impacts, understand what they might mean for operations, the balance sheet, and capital plans—and adjust strategies and identify improvement efforts accordingly.

Gavin McDermott
Managing Director and Financial Planning and Data Analytics Practice Co-Lead

Gordy Sofyanos
Managing Director and Financial Planning and Data Analytics Practice Co-Lead

Brian Ball
Senior Vice President

For healthcare finance leaders, the current financial uncertainty is resurfacing memories of the onset of the COVID-19 pandemic in 2020 and the 2008 financial crisis, both instances where providers had to react to massive financial changes in a short period of time. And unlike the short-term financial dislocation of the initial severe impacts of COVID-19—when providers were forced to sideline outpatient operations and other services for several months—the duration of these proposed policy changes is highly uncertain.

We are currently hearing from many concerned healthcare C-suite leaders and board members who want to better understand what these proposals might mean for their organizations but are also expressing confusion on how to respond, given the uncertainty of any specific measure or policy change.

Our view is that a "wait and see," reactive approach will prove insufficient. Importantly, finance leaders should evaluate the implications of key proposed policies as they're being discussed by legislators and regulators—and not wait to act until after major changes have been approved or implemented. Financial scenario planning is specifically intended to address uncertainty. Scenario exercises can help organizations estimate the magnitude of impacts, understand what they might mean for operations, the balance sheet, and capital plans—and adjust strategies and identify improvement efforts accordingly.

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Each health system is exposed to changes in policy and legislation to varying degrees, based on factors including payer mix, state and local policies and their operating model—including their relative use of hospital outpatient departments and their academic status.

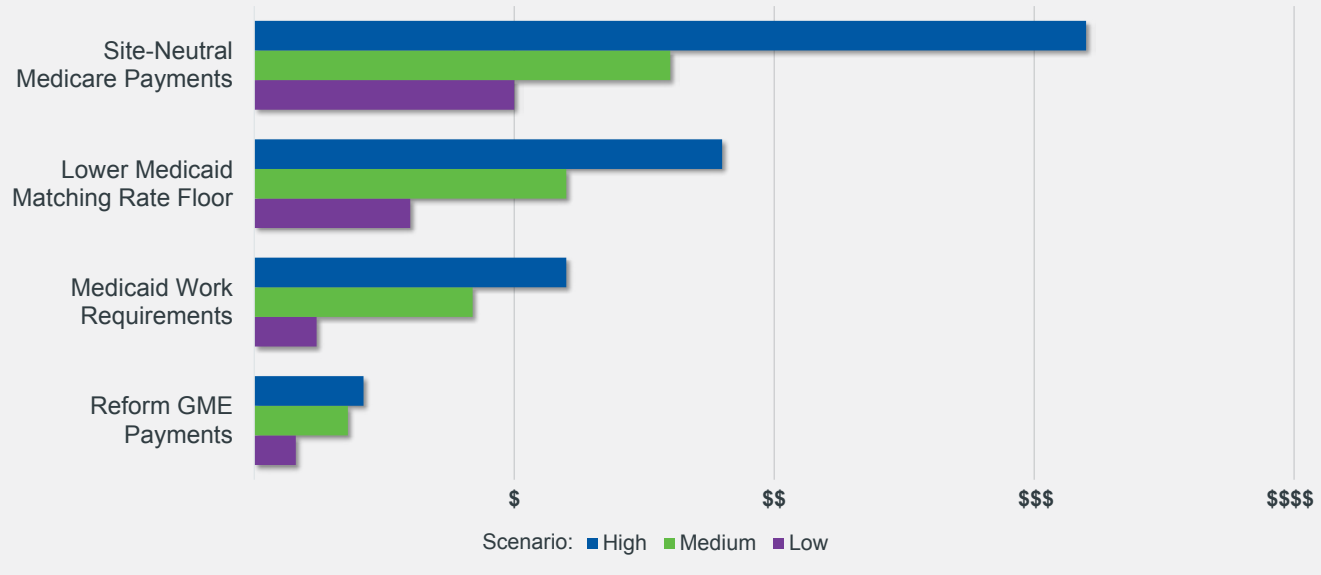
Policy changes currently under discussion could potentially result in more patients relying on self-pay options or reduce supplemental federal funding programs that will have a direct, dollar for dollar impact on the bottom line. There are a range of potential scenarios for how these policies will play out at the state and federal level (Figure 1).

Health systems should evaluate potential risk across these scenarios within the context of their unique attributes (Figure 2).

Figure 1: *A range of financial impact scenarios for key proposed policies*

	FINANCIAL IMPACT OF SCENARIO		
POLICY	**Low**	**Medium**	**High**
Site-Neutral Medicare Payments	Only Part B drug administration services	Add facility fees	All HOPD services
Establish Medicaid Work Requirements	No work requirements established	Work requirements established	
Reform GME Payments	Tilts funding from urban to rural settings	Reduces overall funding significantly, states fill in part of gap	Reduces overall funding significantly, states don't fill in
Lower Medicaid Matching Rate Floor	Reduced modestly	Reduced substantially	Reduced significantly
Municipal Bond Taxability	Retain tax-exempt status	Remove tax-exempt status	

Figure 2: *Estimated financial impacts of policy and legislative change for a sample health system*



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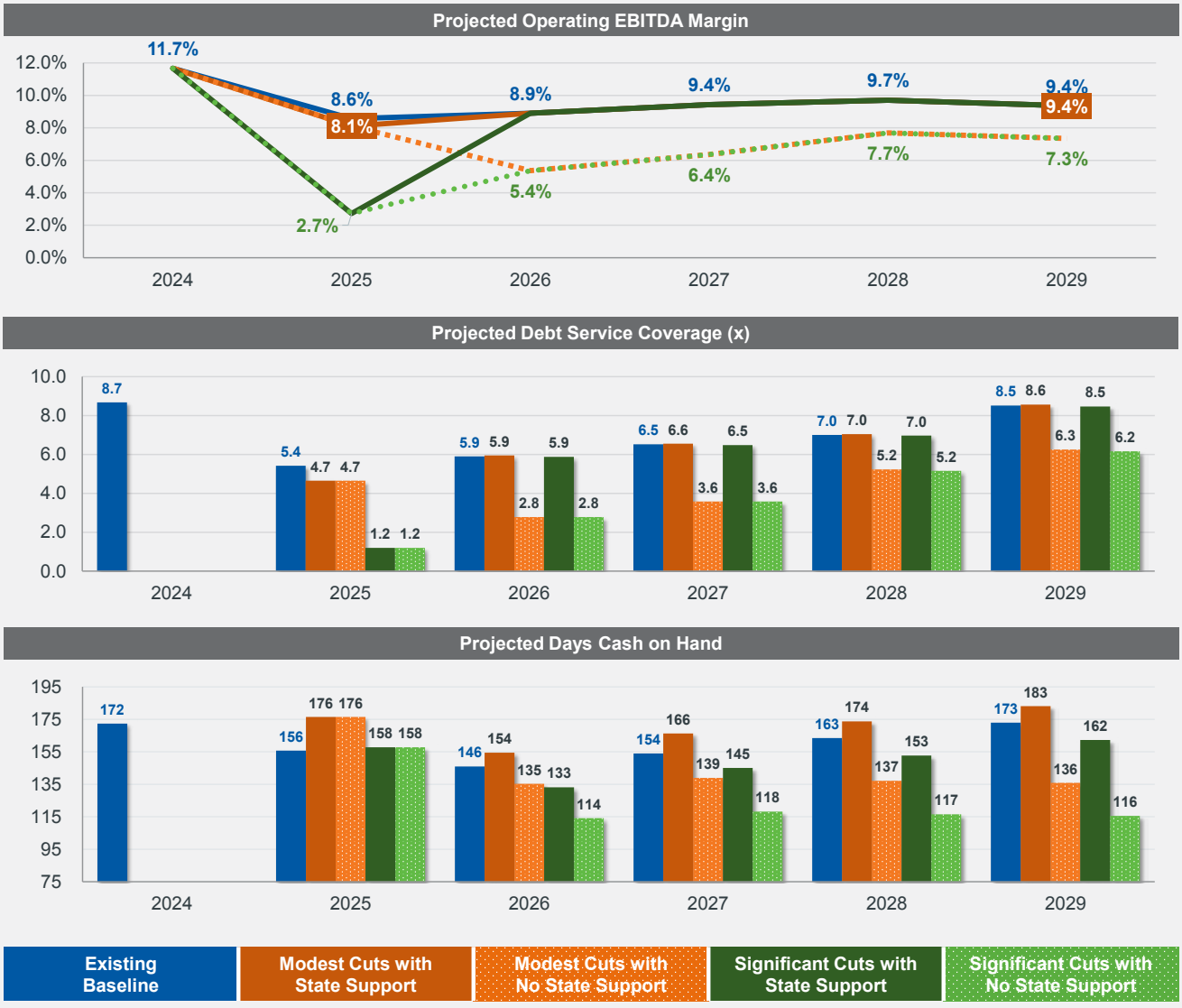
Leaders must also be able to understand potential financial implications over the immediate, medium, and long-term time horizon on their organization's long-range financial and capital plan (see Figure 3 for an illustrative example of the range of potential long-term impacts on a sample health system).

Leaders should evaluate the implications of proposed policies and not wait to act until after major changes.

Figure 3: *Evaluating impacts of potential changes over the long run*



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Closing thoughts: A proactive playbook for navigating an uncertain policy landscape

The prospect of major shifts in reimbursement, grant funds, other governmental funding sources, and cost inflation can be a daunting one for not-for-profit health system leaders, but inertia is not an option.

Organizations can start preparing for these changes by stress-testing their long-range financial and capital plan:

1. What is required to reach a sustainable operating path for our organization? What are key associated assumptions and factors driving current uncertainty?
2. What are the range of possible political and regulatory outcomes that might impact our financial operations?
3. How will these potential changes affect our operations and balance sheet, in light of organization-specific factors like our payer mix, care model, and state and local policies?
4. How do we ensure the resiliency of our organization by pivoting our decision-making? What mitigation levers are available?

> Executive leaders can take immediate actions to prepare their organizations. Inertia is not an option.

From there, executive leaders can take immediate actions to prepare their organizations to weather the storm:

1. Develop mitigation plans that can respond to a wide range of potential policy outcomes, including performance improvement opportunities and capital plan flexibility
2. Help the Board, Finance Committee and other key leaders understand the implications of proposed policies on the organization
3. Inform other key internal and external stakeholders of new developments
4. Identify particularly high-risk proposals negatively impacting the organization and the communities it serves, and consider communicating these risks to local, state, and federal officials

Questions? Contact Gavin McDermott (gavin.mcdermott@kaufmanhall.com); Gordy Sofyanos (gordy.sofyanos@kaufmanhall.com); and Brian Ball (brian.ball@kaufmanhall.com).

Four strategies to reduce emergency department overcrowding

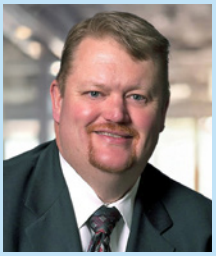
Emergency department overcrowding has been a problem for decades, but there is evidence that it is getting worse. Recent studies are quantifying what news reports tell us: Americans are waiting longer than ever to get seen and treated in the ED. Several factors contribute to this: patient volumes are increasing while ED and inpatient bed capacity decline; individuals without a regular primary care provider often turn to the ED as their first option for care; and persistent staffing shortages strain resources.

Patient boarding—the practice of holding admitted patients in the ED due to a lack of available inpatient beds—heightens patient distress, increases the risk of adverse events and limits the ED's ability to manage new emergencies effectively. At times, patients become frustrated and leave without being seen (LWBS); LWBS rates have doubled nationally and have reached at least 5% in a handful of states. This often leads to delayed diagnoses and treatments, potentially resulting in worse outcomes.

Boarding and high LWBS rates cost health systems money. Boarding has been shown to be financially costly, while it is estimated that each patient who leaves without being seen costs a system an average of approximately $550, equating to millions of dollars in annual losses for busy hospitals. Then there are indirect costs: the psychological toll on healthcare workers. Clinicians report that boarding contributes to burnout, including verbal and/or physical abuse from boarded patients; this burnout, in turn, tends to lead to higher staff turnover, particularly among ED nurses, exacerbating the situation. EDs are becoming pressure cookers, with rising incidents of violence and escalating tensions among patients and staff.

It adds up to a problem that cannot be ignored. ED overcrowding, once considered a temporary surge issue during flu season or mass casualty events, has become a chronic, systemwide failure. Patient outcomes, hospital finances and workforce sustainability all suffer as a result.

Understanding overcrowding from the patient's perspective



Roy Boland
Vice President

Patients may not understand why EDs are overcrowded. But they can understand the results. There are too many stories of patients dying waiting to be seen in the ED. Boarding and high LWBS rates both have well-documented serious negative effects for patients on patient safety and healthcare quality.

Research indicates that patients admitted during periods of high ED occupancy face a higher risk of in-hospital mortality. Overcrowding's associated delays in treatment leads to adverse outcomes. One systematic review further highlights that ED overcrowding contributes to negative outcomes, including increased morbidity and mortality.

Patient satisfaction is a critical factor in reducing tension within the ED. To improve patient flow, EDs must align three key variables: direct care nurses, physician/advanced practice practitioner capacity and physical capacity. While hospitals often focus on outcome metrics like length of stay and LWBS rates, patients prioritize one thing above all: speed. Time to provider (TTP) is the strongest predictor of patient satisfaction—more than total visit length, discharge process or communication with staff. Patients who waited longer than 30 minutes to see a provider were 40% more likely to rate their ED experience negatively. Patients associate faster provider access with higher-quality care, meaning that long wait times increase anxiety, frustration and dissatisfaction.

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Improving TTP metrics is critical for financial sustainability. TTP optimizes length of stay by accelerating clinical decision-making, hastening throughput and reducing ED bottlenecks. TTP also has a direct impact on key quality metrics, including sepsis bundle compliance, stroke and heart attack response time, and patient safety. By improving TTP, hospitals can drive efficiency, enhance quality scores, and improve both patient and provider experiences.

Proven strategies to reduce overcrowding

Fortunately, overcrowding is not an unsolvable problem. An analysis of data reveals that hospitals often staff EDs based on average patient volume rather than peak demand, leading to early-morning mismatch of staffing to demand that causes patient arrivals to outpace clinical provider capacity. This initial lag creates a compounding effect, ultimately resulting in overcrowding in the waiting room. Health systems can analyze their ED data to implement operational improvements that address staffing, patient flow and capacity constraints. Here are four approaches that systems can employ:

1. **Queuing strategies:** Better queuing strategies—that is, methods to manage patient flow and reduce wait times—can improve efficiency up to 30%. These strategies include dynamic staffing (adjusting staff levels based on real-time demand), predictive modeling and split-flow triage (separating patients by urgency to speed up care). The alignment of three key variables—direct care nurses, physician/advanced practice practitioner capacity and physical capacity—with attention on staying ahead of patient arrivals curves can yield significant improvement in multiple outcome metrics.
2. **Real-time bed management:** During peak periods, any single moment that an inpatient bed is unoccupied represents waste. Hospitals using real-time bed tracking systems experience faster inpatient admissions, significantly reducing boarding. Systems should automate bed tracking to optimize admissions; implement early discharge protocols and structured multidisciplinary rounds to open inpatient capacity; and create processes reduce ED boarding to free up treatment areas.

Overcrowding is not an unsolvable problem. Hospitals can employ queuing strategies, real-time bed management, predictive analytics and dynamic triage as strategies to alleviate it.

Case study

A 350-bed academic medical center launched an ED optimization project to address inefficiencies in patient flow. Patients were waiting an average 37 minutes before being placed in a room and 59 minutes before being seen; the LWBS, patient elopement, and leaving against medical advice (AMA) combined rate was 5.3%. Operational inefficiencies were causing bottlenecks, which strained staffs and led to lower revenues and patient satisfaction scores.

It implemented a two-pronged strategy to optimize patient flow. First, it undertook process optimization, introducing a quick-sort triage system to prioritize patients based on acuity, adopting a split-flow model and enhancing bed management. Secondly, it launched a staff training initiative, deploying rapid assessment teams and retraining frontline staff to ensure adherence to new workflows.

The results were immediate and quantifiable. Arrival to room time went from 37 minutes to 4; TTP went from 59 minutes to 14; and the LWBS/elopement/AMA rate fell from 5.3% to 2.4%. The hospital estimated it recovered $1.7 million in revenue. The ED optimization project demonstrated that strategic process redesign and technology adoption can result in measurable improvements, and the hospital is now exploring additional AI-driven predictive analytics and automation tools to enhance decision-making and operational efficiency.

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3. **AI-driven predictive analytics:** Artificial intelligence's capacity to forecast patient surges in the ED and expedite care is unmatched. In one instance, an AI-based clinical assistant reduced wait times by 50%. AI-driven workload balancing can significantly reduce diagnostic turnaround times, improving throughput. Predictive scheduling adjusts workforce allocations based on real-time demand. Hospitals should employ AI-powered scheduling and clinical decision tools to adjust staffing in real time based on patient volume predictions and implement automated workload distribution to optimize lab and imaging processing.
4. **Dynamic triage and parallel processing:** Dynamic triage—also known as split triage, in which patients are categorized into different care pathways depending on the urgency and severity of their presentation—can significantly reduce ED length of stay and LWBS rates, according to studies. This model fast-tracks low-acuity patients while ensuring high-acuity cases receive immediate care.

The case for addressing ED overcrowding

Failing to fix ED overcrowding will lead to clinical consequences that harm patients, and to financial consequences that jeopardize long-term sustainability. Hospitals cannot afford to ignore ED inefficiencies. But hospitals that focus on ED overcrowding can expect to see a return on their investment in a number of ways:

- Improved patient safety and clinical outcomes;
- Improved patient satisfaction (as gauged in Press Ganey scores);
- Improved reputation in their community, which can be a market differentiator;
- Lower LWBS rates; and
- Higher clinician and staff satisfaction, which in turn leads to lower turnover rates.

Some of these returns can easily be quantified as a financial savings. Others, such as improved reputation, are less directly tied to performance. But all matter to hospitals and to the communities they serve.

For more information, contact Roy Boland at roy.boland@kaufmanhall.com.

A rural-academic partnership that's working: Q&A with Columbia Memorial Hospital CEO Erik Thorsen

In a conversation that could easily double as a blueprint for rural healthcare innovation, Erik Thorsen, CEO of Columbia Memorial Hospital (CMH) in Astoria, Oregon, shared insights on the success of CMH's long-standing partnership with Oregon Health & Science University (OHSU). This isn't your typical affiliation story: This is a collaboration built on independence, trust and community-centered design. Below is an edited excerpt of my conversation with Erik.

John Andersen: Let's start with the big picture. What's the primary advantage of CMH's partnership with OHSU?

Erik Thorsen: The biggest advantage has been improving access to care, especially specialty care, in our community. Before OHSU, many of these specialties simply didn't exist locally. Now, not only do we offer them, but about 80% of the specialists actually live in Astoria. They're part of the community—you see them at ball games and the grocery store. That local presence makes a huge difference.

Andersen: That's a rare model for a rural hospital. What made this partnership model successful?

Thorsen: We created a structure where providers are employed by the academic medical center but live and practice full-time in our rural setting. They benefit from the professional support of OHSU while enjoying the lifestyle of a smaller town. It's attractive for specialists who might otherwise overlook a 25-bed critical access hospital (CAH).

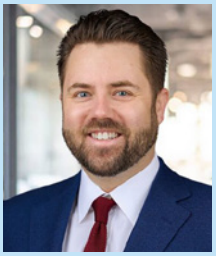
The OHSU name helps too—on résumés, in recruitment and in the clinic. The association with OHSU builds trust in the care we're providing. That trust has translated to more patients staying local rather than traveling to Portland.

Andersen: How financially integrated are CMH and OHSU?

Thorsen: Our cancer program is the only specialty that is financially integrated with OHSU. For all other specialties, we essentially "lease" providers from OHSU—we pay their salaries, benefits, malpractice and a small administrative fee. That simplicity has spared us a lot of governance headaches and keeps our focus on patient care rather than audits and profit-sharing negotiations.

Andersen: Was there a template for this model or did you build it from scratch?

Thorsen: It was mostly homegrown. OHSU had a similar relationship with another rural hospital in Oregon, so we collaborated with them and learned from their experience.



John Andersen
Senior Vice President

Andersen: Have others shown interest in replicating your model?

Thorsen: At conferences, yes. People are genuinely interested when we present. But once they go home, follow-up is rare. It's not necessarily easy to replicate—you need the right leadership on both sides. Trust and flexibility are key.

Andersen: What about downsides? Are there any risks in the model?

Thorsen: Because we are not fully integrated our relationship is bound by a collaboration agreement. Agreements can be terminated, which poses risk to both parties. To safeguard against that we've built long termination runways into our agreements.

Andersen: You mentioned CMH's Cancer Center earlier in our conversation. How did that evolve?

Thorsen: That's the one area where we have a mor formal joint operating agreement. We needed tighter integration because of the technical demands of cancer care. OHSU contributed capital and their brand, which was the first major co-branded initiative. Now, patients can get the same quality of cancer treatment in Astoria as they would in Portland. It's been a game-changer for our community and a model of success.

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Andersen: You recently transitioned all CMH-employed providers into the OHSU system. What drove that move?

Thorsen: Over time, more than half our providers were already employed by OHSU. That created logistical inconsistencies—different hours, benefits and policies. It made sense to unify under one umbrella. The transition to the CMH-OHSU Health Medical Group went smoothly—we didn't lose a single provider.

Andersen: Let's shift to inpatient care. Like many rural hospitals, CMH faces a declining census. What's driving that?

Thorsen: Several things—more procedures are performed as outpatient now, especially in orthopedics. But we're also seeing a drop in births. Our county's birth rate is declining, and that threatens the sustainability of maternity services. That's a concern, especially in rural settings where maternity care is already vulnerable.

Andersen: Are there strategies to address underutilized inpatient capacity?

Thorsen: Yes. We're exploring ways to take post-op or post-acute patients from OHSU to recover here. Swing beds are another opportunity. We're also looking at service gaps—like inpatient dialysis—that currently force us to transfer patients out.

Andersen: Tell us about CMH's hospital expansion project. What's driving it?

Thorsen: Four things: infrastructure age, space limitations, resilience, and patient experience. Our current facility is 50+ years old, in a tsunami inundation zone and built for an inpatient era. The new hospital will feature a tsunami-resistant design with a rooftop safe refuge area for up to 1,900 people and a helipad for evacuation.

Andersen: That's impressive. How did you include the community in the design?

Thorsen: We had over 250 participants across six design sessions, including frontline caregivers, providers, leaders and our patient-family advisory committee. It wasn't just architects and administrators. Everyone who will use the facility had input.

Andersen: What role did Kaufman Hall play in the expansion planning?

Thorsen: We started planning in 2017 and spent three years modeling financial scenarios. Kaufman Hall helped stress-test those scenarios and communicate clearly with our board. That work gave us confidence to work with Kaufman Hall's Treasury & Capital Markets team on one of the largest debt issuances we've ever tackled and, we believe, one of the largest CAH debt issuances ever.

Andersen: Has CAH status played a role in your sustainability?

Thorsen: Absolutely. We wouldn't be here without it. The "tweener" hospitals—too big to be CAHs but not big enough to compete with urban centers—are really struggling. CAH status helps us keep key services running even when they are lower margin.

Andersen: Do you think your model is replicable in other communities?

Thorsen: I do—if the conditions are right. Start small. Build trust. Don't begin with something massive like an EHR conversion. Focus on services you can provide safely and sustainably. And if you can bring in a respected academic partner, that branding alone can shift community perception and retention.

Andersen: Lastly, what's your outlook on rural healthcare in general?

Thorsen: It's tough. More closures are likely. We need honest conversations about what level of care can be sustained safely in rural communities. More hospitals may transition to rural emergency hospitals. We also need more collaboration—less isolation. The appetite for acquisitions in rural healthcare may be fading, but there's still space for creative partnerships like ours.

Andersen: Any final advice?

Thorsen: Match your growth to your mission and community needs. Make sure it's sustainable, and don't underestimate the power of perception. When your community believes in your hospital, everything else gets a little easier.

For more information, contact John Andersen at john.andersen@kaufmanhall.com.

2025 Upcoming Events

Rating Agency Summer Webinar

SAVE THE DATE: JULY 29

Registration opens in late June for this complimentary annual webinar. Questions? Send an email to info@kaufmanhall.com

Healthcare Leadership Conference

OCTOBER 23-24

This is now an invitation only event.

Registration opens in late June.

The imperative to adapt, grow and evolve forms the theme of this year's annual conference.

Questions? Send an email to hlc@kaufmanhall.com