

The Economy's Impact on Healthcare IT Spending

Hospital Leaders Retrench for a Continuing Recession

A Healthcare Informatics Research Study

INTRODUCTION

Because healthcare providers' margins are historically thin, managing costs is a constant challenge. Prior research from the *Healthcare Informatics Research Series* has found cost consistently cited as the number one barrier to implementing essential technology among all types of healthcare delivery organizations—and that was before the recent economic downturn. Now, with a deepening recession and rising unemployment figures, healthcare providers' budgets face further stress with declining revenues.

Belt-tightening has already begun. Spending slowdowns, pauses and freezes have already been imposed in half of the U.S.-based hospitals represented in a survey recently conducted by *Healthcare Informatics Research*.¹ Budget-stretching strategies already in practice point to impending shortfalls and increased vigilance on IT spending. Some organizations have already imposed longer IT project implementation timeframes (14%). Others have postponed purchasing for some projects (19%). And still others have postponed all non-essential projects (36%).

For more than one in three (37%), caution is the operative word. These survey respondents report that there have been no direct mandates to cut IT spending at this time—and IT projects and associated timelines are proceeding as planned—but there is deep sensitivity that plans can change at any time.

Only 15% of respondents say the economic downturn has had no effect on their IT spending and project plans. Slightly more non-hospital-based care providers (22%) are not reporting budgetary effects on IT spending. Most of this group is comprised of physician offices and ambulatory care clinics, which are typically smaller and have fewer IT services. Although physicians are reporting lighter than usual patient volumes at this time, particularly for non-essential specialist services, some primary care providers say they anticipate a slowdown in visits beginning January 1, 2009, when many patients will need to begin paying health insurance policy deductibles for the year.

In addition to a growing number of uninsured and underinsured individuals seeking charity care, many other patients are foregoing spending on elective procedures, office visits, and drugs. And many others who are still employed are delaying non-essential procedures and treatments to maintain their visibility on the job and lower their risk of being made redundant. Many of those who have chronic conditions have embarked on cost-cutting measures including delaying treatments, stretching prescribed drug regimens, or foregoing medications altogether. The inevitable declines in health status among the medically fragile will place added cost burdens on hospitals and their emergency departments.

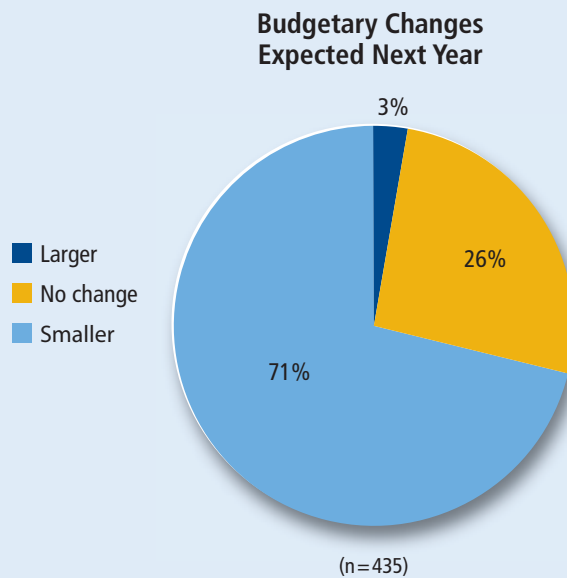
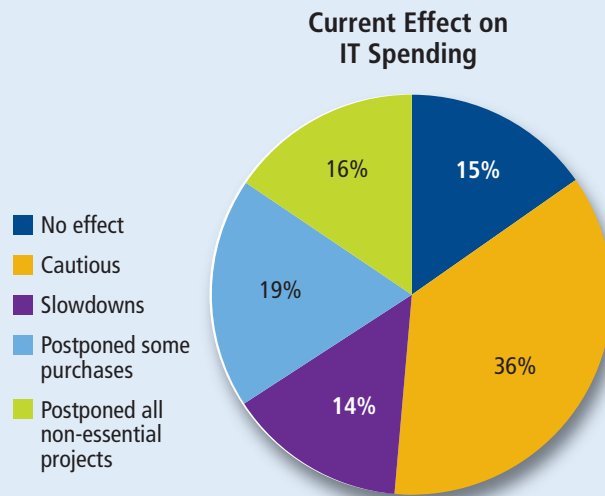
Large hospitals and healthcare delivery systems, which have typically been leaders in adopting and implementing tools and technologies to improve quality of care, decrease medical errors,

¹ *Healthcare Informatics Research* conducts online interviews with members of the *Healthcare Informatics Research Panel*. These panelists represent information technology professionals in healthcare provider organizations throughout the U.S.

and improve efficiency according to prior surveys published in the *Healthcare Informatics Research Series*, are now taking the lead in responding to budget cuts. One in four large hospitals with 500 or beds or more has postponed all non-essential IT projects—and another 25% say their organization has postponed purchasing for some IT projects.

Many hospitals that are stretching and cutting budgets are not optimistic about next year’s budget allocations for IT. Most expect the allocations to be smaller. Hospitals in suburban settings, in particular, are anticipating budget cuts for IT.

Effect of the Economy on IT Spending



STAFFING

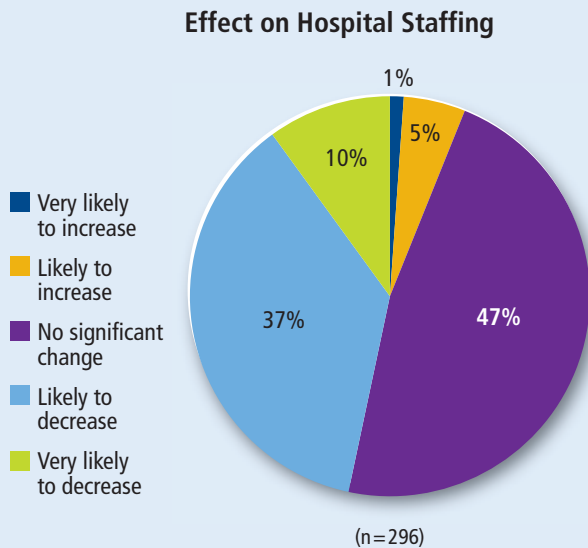
There is good news and bad news for those employed by care providers. The good news is that nearly half of all healthcare provider organizations expect no significant changes in their total number of staff positions over the next 12 months. The bad news is that some type of staff reduction is forecast for a near-equal number of providers. Cuts are “very likely” in 10% of all hospitals and “likely” in 37% of institutions. Large hospitals with 500 or more beds, as well as acute care facilities located in suburban and rural communities, are more likely than small and mid-sized facilities and those in urban settings to expect reductions.

As care providers strive to maintain their existing levels of quality care delivery, employees who are involved in direct care delivery are at lower risk than those in non-clinical positions. More than

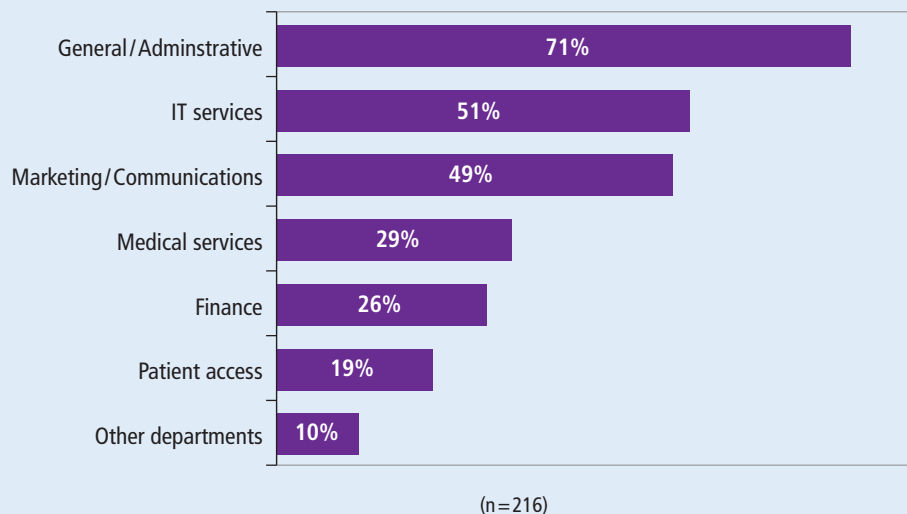
two-thirds of care providers expect personnel in administrative departments to be among the first to be let go. But also at high risk are positions in IT services and marketing/communications departments.

There is little to no difference between hospital-based care providers and those in outpatient settings in areas targeted for reductions. Among the hospitals that expect to decrease total numbers of staff, general administration positions, IT services, and marketing and communications are the most vulnerable; but higher-than-average job losses in IT services and finance departments at large hospitals, where departments are typically larger, can be expected.

Effect of the Economy on Hospital Staffing



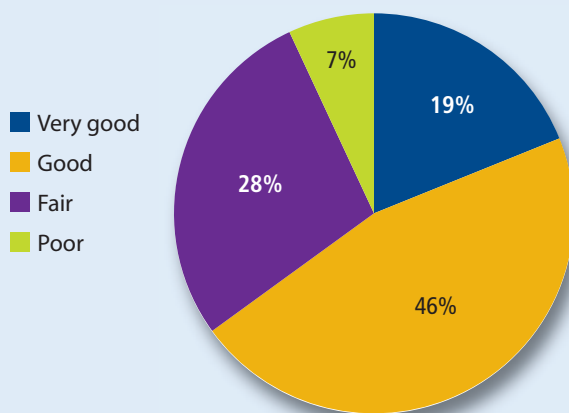
Departments Targeted for Staff Reductions



OPTIMIZING REVENUES

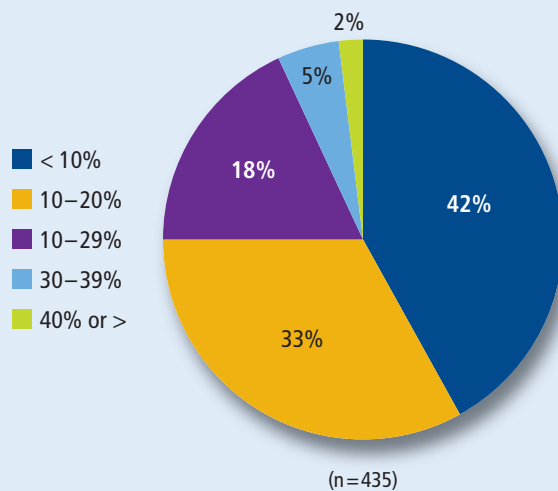
Even in the best of times, most care providers heavily rely upon reimbursements from third-party insurers for payment. But being paid—and being paid at optimal rates—is dependent upon submitting accurate data within standardized formats. Submitting claims with missing or incorrect information is guaranteed to generate denials—and trigger a claims’ review process to find and correct the errors in providers’ billing offices. Such reviews and resubmissions cost time and money, not to mention further delays in reimbursements, which result in budgetary pressures.

Integrity of Patient Data Collected at Check-In



Integrity of Patient Data and Percentage of Denied Claims

Percentage of Denied Claims



More than half of those surveyed estimate that at least one in ten claims is denied based on inaccurate or incomplete data. For one in three institutions, the rate is between 10% and 20%.

The biggest difference in the percentage of denied claims is between non-hospital-based care providers and hospitals. More than half of those in ambulatory settings (51%) vs. 38% of hospitals have fewer than 10% of denied claims.

Accurate patient information collection begins at the reception and check-in desk. But clearly, data collection via the ubiquitous clipboard with paper-based forms is a less-than-effective information-gathering tool.

Most care providers say their staff spends many hours finding missing and/or correcting inaccurate claims-related data after the patient visit. Only 19% rate their organization as “very good” and report that one hour or less per week is required post-visit to correct and update data. But nearly half of organizations (46%) say they expect their staff to devote between one and five hours per week to the clean-up process.

However, one-third of all participants are spending much more time: 28% rate their data collection process as “fair” and report that about a day, between five to 10 hours per week, is necessary to prepare claims for submissions. The few who rate their patient data collection on procedures as “poor” say that more than 10 hours per week is required to ensure submitted claims include accurate data.

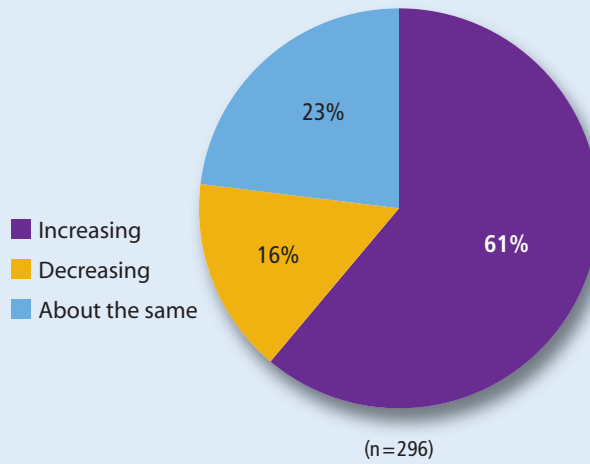
Cleaning up claims is no easy task. And although missing or incorrect patient data is a major source of claims denials, other data, such as diagnostic and billing codes, also are at risk for inaccuracies.

As healthcare providers continue to confront the expanding challenges—including delivering cost-effective care to growing numbers of an aging population, improving patient safety records, and reducing administrative costs—major changes in how and where care is delivered are already underway. They are affecting revenues in acute care institutions as procedures and treatments once confined to those facilities move to physician offices and other ambulatory service centers.

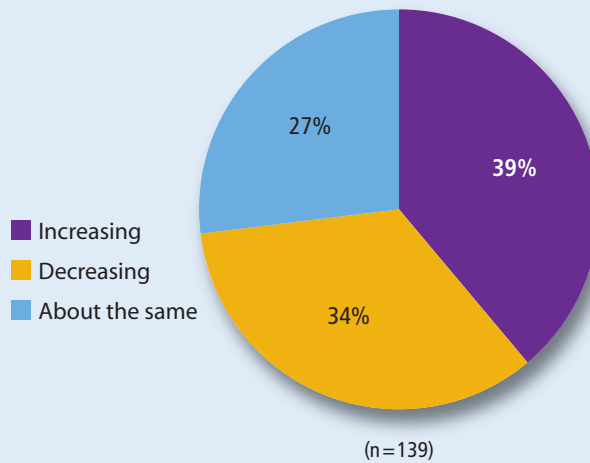
Healthcare providers confirm this transition from inpatient to outpatient centers, reporting an uptick in the number of outpatient visits at their organizations over the past year. The change is more significant among hospitals, where 61% of those representing these acute care facilities say the number of outpatient visits increased. Among those in outpatient settings, 39% report an increase in business.

Changes in Outpatient Visits: Hospitals vs. Non-Hospital-Based Care Providers

Changes in Outpatient Visits: Hospitals



Changes in Outpatient Visits: Non-Hospital-Based Care Providers



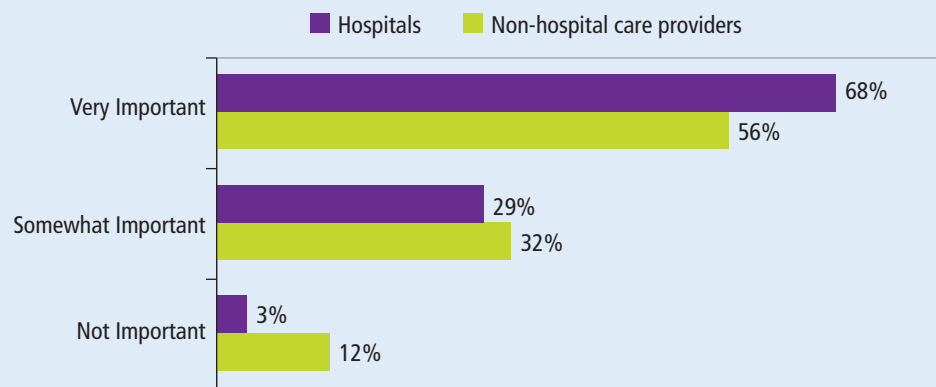
Not unexpectedly, the vast majority of care providers across all types of provider organizations say their business has a strategy to increase the number of patients they treat. Many organizations either already offer or plan to offer ambulatory services, and nearly two-thirds say increasing outpatient services is “very important” to their organization’s fiscal health. This is particularly true for hospitals, where 68% of respondents rate growing ambulatory services as “very important.”

Among a range of strategies to increase outpatient services, this survey requested feedback on five main plans. Not surprisingly, hospitals are likely to have more plans than are non-hospital-based care providers, and the majority of hospitals say that they are pursuing all five plans to some extent as follows:

- Creating more community awareness through marketing and advertising.
- Streamlining operational processes to increase efficiency.
- Working with community providers to increase referrals.
- Adding new services.
- Expanding existing treatment areas.

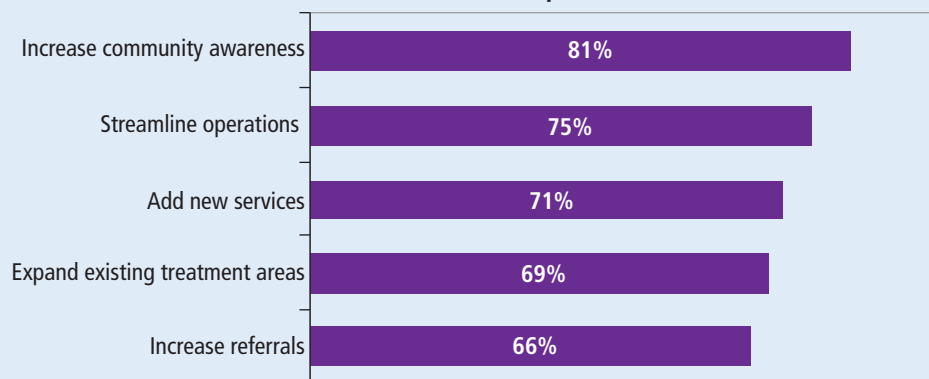
Outpatient Services: Importance and Growth Strategies

Importance of Increasing Outpatient Services



(n=422)

Outpatient Growth Strategies Hospitals



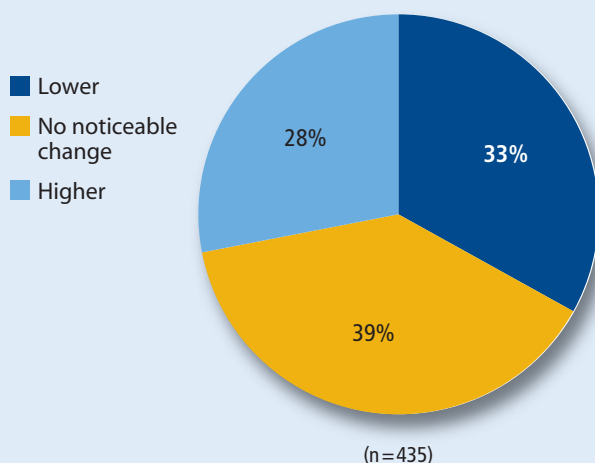
(n=316)

Recent market pressure efforts to curb healthcare costs have focused on increasing consumers' awareness of actual costs for visits, treatments and procedures, and granting them more personal responsibility. The strategy has also effectively shifted increased financial responsibility to most individuals. Indeed, three in four care providers have noticed the steady rise in patient deductibles over the past year.

Although it would be expected that increased co-pays and payments for other uncovered services would result in increased revenues for care provider organizations, that's not so, say most of those surveyed. Although 39% say there has been no change year over year in daily revenues collected from patients at the time of service, the remaining 61% are nearly equally divided into two groups: those with increased revenues (28%) and those with decreased revenues (33%).

Unfortunately, hospitals are disproportionately represented among the group receiving lower revenues. More than one in three hospitals (38%) say daily revenues collected from patients are lower this year than last.

Change in Daily Revenue Collected from Patients

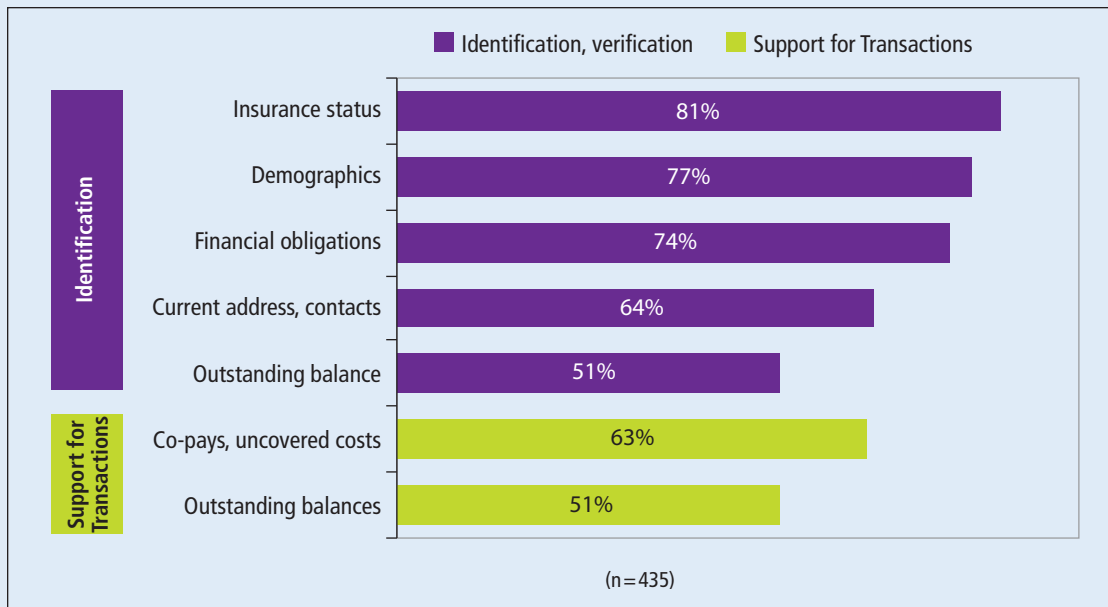


The importance of collecting accurate data is underscored in claims submissions and to organizations' revenue cycle management (RCM) process. Responses to a prior *Healthcare Informatics* survey indicate that one of the single biggest challenges in streamlining reimbursements is accuracy over insurance issues—and the need to collect detailed and complete charges, coding, and documentation to accompany all the billings for services rendered.

Automated identification and verification tools have demonstrated merit in ascertaining the current status of the patient’s insurance benefits, essential personal demographic information including current address and contact information, financial obligations, and outstanding balances—particularly when employed at the point of service.

When asked to select the type of functions they consider to be critically important to their efforts to improve RCM, more than half of all respondents chose all seven identification, verification, and transaction support functions presented as options. However, a trio of verification and identification functions—patient insurance, demographic information, and amount of money for which the patient is currently responsible—are considered the most important. They are also the functions that support the collection of accurate data—and form a concrete foundation of current, complete, and correct patient information on which the entire claims’ submission and reimbursement processes rely.

Essential RCM Functions for Patient Data at the Point of Service



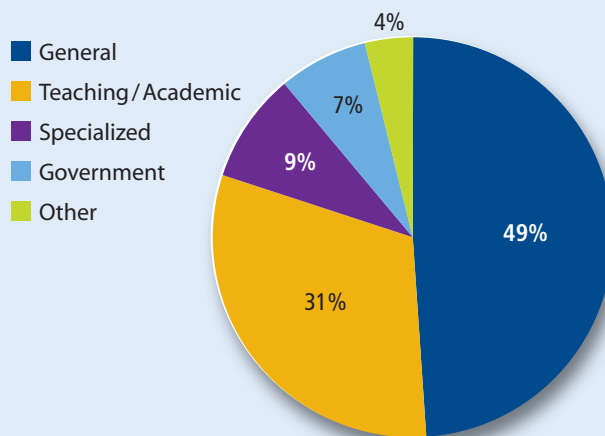
DEMOGRAPHICS AND SURVEY METHODOLOGY

A total of 435 interviews with healthcare providers were conducted online between November 25 and December 4, 2008. More than two-thirds (68%) represent general acute care hospitals, teaching and specialty hospitals, as well as small, medium, and large healthcare delivery networks in urban, suburban, and rural community settings. Among non-hospital-based care providers—of which there are 139—96 (69%) represent physician offices and ambulatory care clinics.

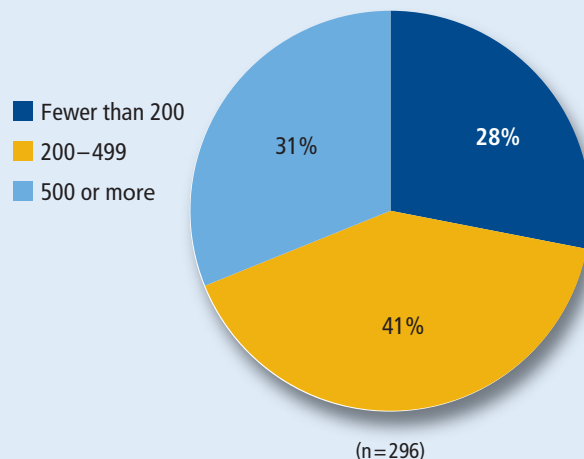
Hospitals are dominated by general acute care and teaching/academic institutions. Nearly half (49%) of the 296 hospitals represented are general acute care institutions and almost one-third (31%) are teaching facilities. In terms of size, large facilities with 500 or more beds represent 31% of this group and small institutions with fewer than 200 beds account for 28%. There are slightly more (41%) mid-sized facilities with 200 to 499 beds.

Types and Sizes of Hospitals

Types of Hospitals

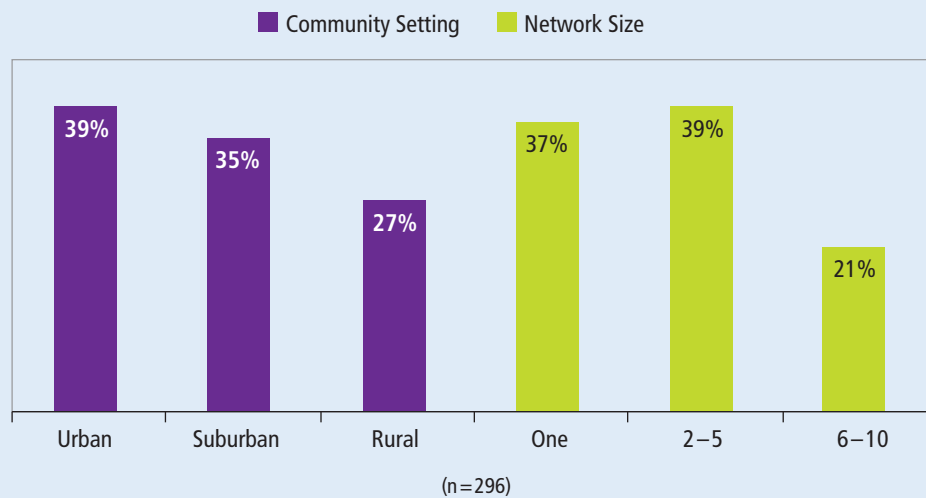


Hospital Sizes, by Number of Beds



The respondents represent care provider organizations of all sizes and community settings, with some bias toward single facilities and those in urban settings. One in three is a mid-sized organization with 200 to 499 beds and part of a healthcare delivery network comprising two to five facilities. One in four represents a large healthcare network made up of six or more facilities. And an additional one in four represents a rural organization.

Hospital Settings and Network Size



About one in three of all of those surveyed represents a non-hospital-based care provider. More than two-thirds of these (68%) are physician offices and ambulatory care clinics. The remaining group is composed of long-term care/skilled nursing facilities (3%); behavioral healthcare/psychiatric institutions (3%); laboratory and radiology service centers (2%), government and public healthcare providers (5%). Home healthcare, pharmacy, laboratory, and government/public health account for the remaining 4%.

BASE NUMBERS FOR SURVEY RESPONDENTS

Types and sizes of care provider organizations represented in this survey can be identified as:

■ Type of care delivery organization

- Hospitals (n = 296)
- Non-hospital-based care providers (n = 139)
 - Physician offices/Ambulatory care centers (n = 96)
 - Other care providers (n = 43)

■ Type of hospital

- Academic/Teaching (n = 91)
- General, acute care (n = 144)
- Specialty (n = 27)
- Government (n = 21)
- Other type (n = 13)

■ Hospital size, by number of beds

- Fewer than 200 beds (n = 83)
- 200 to 499 beds (n = 120)
- 500 beds and more (n = 93)

■ Hospitals, by size of network

- Single hospital (n = 114)
- Part of network of two to five hospitals (n = 103)
- Part of network of six to 10 hospitals (n = 29)
- Part of network of 10 or more hospitals (n = 50)

■ Hospitals, by community setting

- Rural (n = 70)
- Suburban (n = 92)
- Urban (n = 134)