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How Hospitals Are Responding to Current Economic Challenges

HFMA's Healthcare Financial Pulse

While the healthcare industry has weathered past economic downturns, the current recession has been different, causing serious financial harm to the majority of hospitals, according to research from the HFMA's *Healthcare Financial Pulse* project. The "perfect storm" analogy has been used often in recent months to describe the situation in which health care finds itself: battered from behind by declining payment rates, bolted overhead by diminished investments and rising charity care burdens, and staring down the oncoming cyclone of health reform.

However, as with all storm patterns, there are opportunities to clean up and prepare. In the current intermission before serious reform measures are passed, healthcare financial leaders need to get their balance sheets in order while encouraging positive, strategic cost reductions and quality improvements that will help prepare their organizations for the future.

"In this environment, value will be key to success," says Richard L. Clarke, DHA, FHFMA, president and CEO, HFMA. "Healthcare finance leaders should be more focused than ever on making the structure and process changes that will create value by driving costs out of their organizations while enhancing coordination and quality."

What Hospitals Are Experiencing

As part of the *Healthcare Financial Pulse* project, HFMA is surveying healthcare financial executives on a quarterly basis to assess how the economic fallout is affecting hospitals and health systems—as well as how providers are responding in the current climate.

To date, HFMA has conducted two surveys. (Access results from both surveys at www.hfma.org/pulse.) The first survey, conducted in November 2008, shows that hospitals are experiencing unprecedented levels of financial impact from the economic recession and credit market dislocations.¹ For example, 55 percent of financial executive respondents said inpatient volumes had declined in their organizations during 2008—with 46 percent also noting a decline in outpatient volumes. In addition, more than 60 percent of respondents said that charity care and bad debt expenses were negatively impacting their hospitals' financial performance.

Not surprisingly, the majority of financial executives who responded to the first survey in November expected their organizations to suffer further financial ramifications through the first half of 2009—specifically, decreases in days cash on hand, operating margins, and total margins.

The second HFMA survey, conducted in March 2009, corroborated these earlier predictions of financial executives.² Fifty-four percent of respondents reported negative total margins. In addition, 73 percent reported a decrease in days cash on hand—with 22 percent experiencing a decline of more than 20 percent.

Additional insights can be found by looking at the research results in more detail.

Nonoperating income. While nearly 80 percent of hospital respondents reported a decrease in nonoperating income, the magnitude of the decline between June 2008 and March 2009 depended, in part, on the composition of an organization's investment portfolio.

Large hospitals with more than 500 beds reported being more reliant on nonoperating income than smaller hospitals. Thirty percent of large hospital respondents said nonoperating income represented more than 50 percent of their organizations' total margins in June 2008. In comparison, only 14 percent of respondents from medium-sized hospitals reported that great of a dependence on investment income.

"Larger hospitals have the financial wherewithal to take on more investment risk since greater hospital size tends to correlate with more diversified service lines and, hence, a more robust revenue stream," says Randy Fuller, director, thought leadership, HFMA.

Many organizations grew to depend on investment income in recent years as operating income has declined due to decreasing payment rates, a rising number of uninsured, and other factors. Two survey respondents share these insights:

- › "Earnings on cash/investments were stronger than operating margins in at least 50 percent of years."
- › "Nonoperating income represented about 80 percent of our net income prior to the economic downturn."

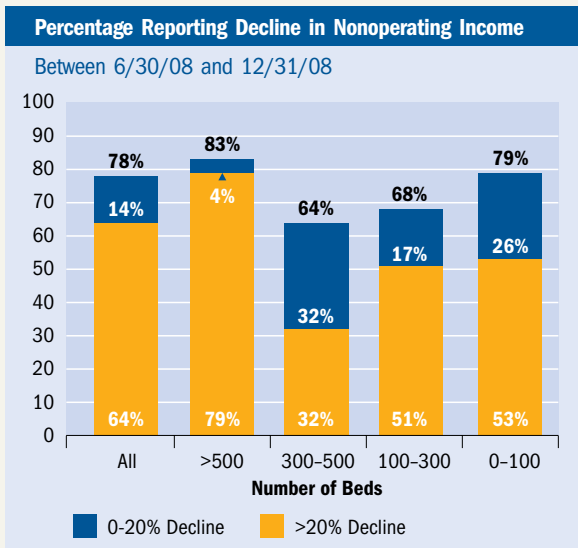
The potential to generate significant returns from investments has, of course, changed—at least through the near future. Most organizations are still reeling from recent major losses. More than 70 percent of respondents said their investment portfolios declined in the second half of 2008. Large hospital respondents reported the greatest declines in investment portfolios, with almost half losing greater than 25 percent.

Investment declines, in turn, helped predict decreases in nonoperating revenue, with larger hospitals again experiencing the greatest declines. Almost 80 percent of hospitals with more than 500 beds experienced nonoperating revenue declines greater than 20 percent. In comparison, only 48 percent of hospitals with 0 to 500 beds had such significant declines (see exhibit above).

In the words of survey respondents:

- › "Stock market losses and SWAP value losses have created large negative operating losses."
- › "Our defined pension plan is down 25 percent based on one-year trailing returns."
- › "We have taken an 'Other Than Temporary Decline' adjustment to our nonoperating revenue line due to unrealized losses that likely will not recover in one year."

In addition to investment-related losses, hospitals are seeing declines in donations from fundraising and philanthropy. About 84 percent of respondents to a December 2008 survey by the



Source: HFMA's Healthcare Financial Pulse (www.hfma.org/pulse)

Association from Healthcare Philanthropy reported that the recession was having a “somewhat negative” or “very negative” effect on their fund-raising abilities.³

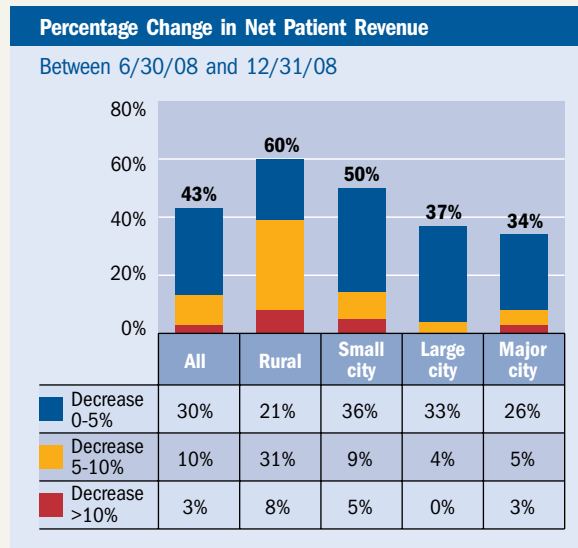
Patient revenue. Financial executive respondents in rural areas reported the most significant hits to patient revenue (see the exhibit above). Sixty percent of rural respondents to the April survey reported a decline in patient revenue. Hospitals in urban areas are also seeing decreases in patient revenue; however, the percentage of hospitals is much greater in rural and small cities than in larger urban areas. For example, 50 percent of hospitals in small cities reported patient revenue declines, compared to only 34 percent in major urban areas.

Plus, most facilities in large urban areas are only seeing declines of 5 percent or less. Almost 40 percent of rural respondents are seeing decreases greater than 5 percent.

“Rural and smaller facilities will typically have a much narrower footprint of service line offerings and their demographic base can be hurt more easily. A single employer doing a workforce reduction may be enough to put a significant dent in the revenue of a small hospital,” says Fuller.

Capital access and spending. The credit crisis has had a major effect on the ability of providers—both financially strong “have” and financially weak “have not” hospitals—to access needed capital. Back in November 2008, 24 percent of financial executive respondents from “have” hospitals and 17 percent from “have-not” hospitals reported a withdrawn or delayed bond issue. Plus, 18 percent reported difficulty securing a liquidity facility, an essential credit vehicle that would allow hospitals access to lower cost variable rate debt.

Just as telling: Almost 40 percent of financial executive respondents reported a substantial increase in the cost of debt.



Source: HFMA's Healthcare Financial Pulse (www.hfma.org/pulse)

“Anecdotal reports from our members and industry experts suggest that access to capital is slowly starting to open up,” says Fuller. “However, the cost of debt remains high, which is cutting into hospital total margins. With a significant spread in the interest rates between AA and BBB-, the lower-rated issuers are bearing a particularly heavy financial burden.”

The scarcity and high cost of capital translates into difficult capital spending decisions. Construction spending took the biggest hit among HFMA survey respondents, with 53 percent reporting that their hospitals were holding off or substantially cutting back on new construction spending. About 30 percent of respondents said their hospitals also plan to freeze or severely restrict IT and medical technology spending.¹

What Hospitals Are Doing

HFMA research also reveals a silver lining in the current economic news: Healthcare financial leaders have not lost their dogged determinism to help ensure that their organizations remain financially viable and able to serve their communities and their patients. Healthcare organizations are implementing a variety of key strategies in an attempt to contain costs, access cash, and enhance revenues—all while preserving quality (see the sidebar on page 4).

The following response from the CFO of a small, stand-alone hospital further demonstrates the need for a wide-ranging response to current financial challenges:

“We are focusing every one of our service line and business line leaders on increasing cash, margin, and capital for the remainder of FY09 ... Our budget for FY10 is in half and may go lower ... We extended AP payment cycle by 15 days ... We have every VP/Director/Manager of all our facilities putting together and reporting monthly on an action plan on what they will do to increase their margins (it's working very well). We looked at

pension funding ... We have always been very good at point-of-service (POS) collections, but we are doing more and taking time to understand how the economy plays out with POS ... We talked about resetting productivity for nursing hours per patient day and therapy hours per day but we have always been pretty tight ... We looked at pay practices and tightening up the e-time procedures to cut back on false overtime ... We have renegotiated many of our existing vendor contracts, such as transcription and copier rentals ... We bid our excess policy premium very hard this year and got a nice reduction ... We instituted a rolling 12-month cash-flow projection for our two main business locations ... We renegotiated our line of credit terms (backfired), spend a great deal of time on debt covenants, eliminated some minor business lines, increased physician recruitment, will be utilizing vacant bed space for a new pediatric rehab unit, contracted for extended natural gas purchase, and spend a great deal of time on case mix index and increased targets ... We are selling non-core buildings (not much fun today), and we use our investment committee more heavily to see if we need to adjust allocations.”

The “right” specific responses to an economic downturn are, obviously, different for each institution. Every healthcare organization needs to base strategic and operational decisions on its unique market, scope of care, and vision/mission. That said, there are universal management principles that can be successfully applied in almost any type of economy or situation. The *Healthcare Financial Pulse* project promotes the use of four key principles:

- › Leadership and planning: Understand, address, and communicate health system changes.
- › Cost and quality: Drive value by controlling expenses while enhancing quality.
- › Preserving cash: Pursue innovations in revenue and cash management.
- › Capital: Access sources of capital and allocate scarce resources to meet vital needs.

The devil, of course, is in the details. The following stories from providers help illustrate the art and science involved in successfully implementing these four principles. Many of these stories are excerpted from resources on the *Healthcare Financial Pulse* web site. The site contains many other examples of how providers are leading change, driving value, preserving cash, and accessing capital and allocating scarce resources. Visit www.hfma.org/pulse to access all of these examples.

Leadership and planning. One key leadership lesson to be found in the proposed integration of two Michigan health systems is the benefit of a disciplined strategic planning process.

As the CEO of an AA-rated health system, Rick Breon of Spectrum Health is not surprised when he is approached by financially stressed organizations looking to benefit from a business arrangement with a stronger partner. What does impress Breon

Specific Strategies Hospitals Are Using to Combat the Financial Downturn

Nine specific strategies were commonly mentioned by financial executives who responded to the *Healthcare Financial Pulse* survey published in April 2009. For more details on these strategies, access this survey at www.hfma.org/pulse.

- › Creating budget contingency plans
- › Reducing capital spending
- › Containing labor costs
- › Enhancing productivity and efficiency
- › Reducing nonlabor costs
- › Changing debt structure
- › Engaging staff in financial performance improvement
- › Protecting cash flow
- › Increasing efforts to protect or expand volumes

are those occasional inquiries from organizations like Northern Michigan Regional Health System (NMRHS) that stress a strong strategic rationale for integration.

“One of the obvious questions we always ask is, ‘Why are they seeking us out? What are they looking to do?’” says Breon. “NMRHS has an answer that is very impressive. It is not just, ‘We want your money.’ They came from a much more strategic perspective in which they have analyzed what they need to do and where they need to be going, and they strongly felt they needed to partner with someone going forward. In my 35 years in this business, I find about 5 percent to 6 percent of organizations want to integrate in that way.”

NMRHS first envisioned joining a larger health system about three years ago, says Tom Mroczkowski, president and CEO. Around that time, leaders and board members committed to turning NMRHS into a first-class organization and adopted a balanced-scorecard strategic management approach to achieve that goal.

“We were looking ahead and looking at the research data, and it seemed clear that very large health systems have the capability of delivering the best health care and achieving quality, financial, and other successes,” says Mroczkowski. “NMRHS is doing fine financially now and there is nothing to indicate that our organization would not be doing fine in the future. But we believe we can do better and provide higher quality patient care by becoming part of a fully-integrated health system. When we look down the road, we envision creating the health care of the future.”

The proposed NMRHS-Spectrum Health deal is currently in due diligence. If it all plays out as planned, NMRHS will eventually convert to a membership corporation with Spectrum as the sole member. This form of integration enables NMRHS’ board to

remain in place and ensures local decision-making oversight. (Spectrum and NMRHS are about three hours apart.)

Any major partnership like this must begin with the basics, says Mroczkowski. “You really need to understand your organization, your market, and whether your organization can achieve what it needs to achieve.”

The full NMRHS-Spectrum Health story can be found at www.hfma.org/pulse—in addition to other case studies related to leadership and planning.

Costs and quality. While many healthcare organizations across the country have had to lay off employees or institute hiring freezes, there is a pervasive wariness toward across-the-board cuts. With the continuing emphasis on value-based purchasing and pay for performance, many healthcare leaders are focusing on identifying ways to drive down costs while maintaining—or even enhancing—quality.

For example, Lee Memorial Health System in Fort Myers, Fla. learned that significant labor-related dollars—to the tune of \$11 million—could be saved by helping nursing leaders more accurately match staffing needs to patient volumes.

Leaders at LMHS created a forecasting tool that would help nursing directors predict staffing needs by day and shift. With such a model, nursing leaders could determine their staffing needs and use in-house nurses hired on an as needed basis by the system’s centralized staffing department to fill “holes” in a more efficient way.

LMHS chose a staffing forecasting model that uses census points, or forecasted admissions. Census points are derived from using actual census figures and applying current and historical trends to determine the following month’s census—by shift, by day of the week, and by unit.

The system saved more than \$11 million in one year alone by eliminating the need for agency nurses. The new predictive model has also helped LMHS refine its bed management approach at our five acute hospitals, leading to a 20 percent daily increase in the number of beds filled across the system.

Staff nurses also seem satisfied with the changes. LMHS has decreased turnover slightly from 14.3 percent to 13.1 percent in two years. In FY08, nursing vacancy rates were down to 5.4 percent, as compared with 7.4 percent in FY00.

The full LMHS case study can be found at www.hfma.org/pulse. The *Healthcare Financial Pulse* web site also highlights a number of other value-oriented approaches to cost containment, including service line management and lean manufacturing approaches.

Preserving cash. With a critical need to preserve cash, financial leaders should completely rethink the way they approach revenue management, suggests David Hammer, MBA, MHS, BBA, FHFMA, CHF, vice president of revenue cycle solutions for McKesson.

“Current systems and processes won’t solve the overwhelming challenges and changes to come in healthcare reimbursement,” he says. “Reinventing processes, relationships, and organizational structures associated with patient or consumer management, access management, and business management will vastly improve the economic of care.”

At a tactical level, financial managers should also focus on front-end collections and shoring up traditional cost drain areas, such as the emergency department (ED). “Effective preservice financial clearance services will prevent patients from being surprised or shocked when they get their bill, and therefore, they can make informed and better payment choices,” says Dave Mason, vice president and general manager at RelayHealth. “The hospital can work with patients to determine the optimal payment method before service instead of relegating financial matters to the back end of the patient encounter.”

When St. Elizabeth Medical Center in Edgewood, Ky., automated its preservice financial clearance process, hospital administrators quickly identified valid insurance coverage for 3 percent of its self-pay accounts that previously had been written off as bad debt. This provided an immediate \$375,000 boost to the hospital’s bottom line.

Another example: Florida Hospital Organization has done a considerable amount of programming over the past year to improve accuracy of patients’ financial estimates for the services they will receive as well as their out-of-pocket costs. The four-hospital system drills down 12-month data by payer, physician, diagnosis code, and individual physician to generate a patient responsibility estimator that gives preregistration and registration staffs a valuable tool for communicating to patients their anticipated financial responsibilities. The system then audits adjudications and payments to determine how closely the estimate actually meets the total charges on an account or the out-of-pocket expenditures.

Another way to preserve cash, says McKesson’s David Hammer, is to automate charge capture and coding compliance in your ED. “The ED is the front door for more than 40 percent of clinical experiences, but it’s also one of the greatest areas of lost revenue,” says Hammer. “Our audits have found ED losses ranging from \$14 to \$260 per patient visit. Based on these findings, a hospital that does 50,000 in ED visits annually has a gross charge opportunity that may range from \$738,181 to \$13.2 million. Assuming a conservative 25 percent collection of the prior totals, this yields \$184,545 to \$3.2 million in potential revenue.”

Learn more by accessing *Leveraging Business Intelligence for Revenue Improvement* at www.hfma.org/pulse. Additional how-to strategies for preserving cash can also be found on the *Healthcare Financial Pulse* web site.

Capital. With access to capital still sluggish, some organizations are turning to alternative sources of funding. For example, some

hospitals are using federal mortgage insurance—i.e., the Section 242 Program—to obtain affordable financings for replacement facilities.

Fall River Hospital in Hot Springs, S.D., was an aging critical access hospital with no room to meet the demand for additional services and advanced technology. Fall River had limited ability to provide equity, and it needed to finance as much of the project as possible. The hospital discussed issuing unenhanced bonds, but pricing was not favorable. A request for a letter of credit to support financing of 90 percent of the project cost received limited interest, despite the hospital's strong financials and a credit profile that would have been received favorably by the private sector in previous months. The market was just starting to tighten, and small hospitals were some of the first to feel the impact.

Fall River's overall financial strength and its ability to provide evidence of community support were key factors in securing Section 242 mortgage insurance. The 242 credit enhancement enabled Fall River to borrow 90 percent of the project's value. A \$500,000 Community Development Block Grant and donated land made up the rest of the equity contribution.

As a result, the hospital was able to fully finance its new facility. The commitment to a new building already has helped the hospital recruit several new physicians and clinical staff.

Learn more about alternative approaches for accessing capital—as well as how to allocate scarce capital—at www.hfma.org/pulse.

Success Factors

The country is now 1½ years into the current recession, according to the *National Bureau of Economic Research*, which has pinpointed the start in December 2007.⁴ Whether the economy is yet showing signs of recovery is debatable.

One thing is certain, this is not a waiting game. HFMA research indicates that healthcare financial executives were quick to respond at the first signs of economic downturn in 2008, and they continue to implement additional measures as needed.



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Tactics range from “good sense” or prudent measures that make sense in any economic environment to hard choice, permanent expense reductions.

The keys to succeeding in this environment are, in some ways, no different than what is required to effectively lead a healthcare organization in any economy. However, good financial leaders recognize that this downturn is “not just a recession, but a major realignment of financial practices” as hospitals adjust to difficult-to-access and more expensive credit, write Keith Moore, Dean Coddington, and Deirdre Byrne of McManis Consulting in their analysis *The Long View: How the Financial Downturn Will Change Healthcare*. (This article is posted at www.hfma.org/pulse.)

There is also change in the air—in the form of state and federal health reforms—that healthcare leaders need to prepare for over the next several years if they want to be successful in the future. (See *The Burning Platform: Producing Change in Difficult Economic Times* at www.hfma.org/pulse for more.)

Given these issues, leaders should pay special attention to the following success factors:

Plan, monitor, revise. “In other words, know your markets, monitor them closely, and make adjustments based on the realities of the current marketplace, as necessary,” says Fuller. “Since many of the situations that we see in today's market are without historical precedence, providers will need to be particularly nimble to succeed in this current environment.”

“In dealing with ‘what's next,’ we inevitably deal with probabilities, not certainties,” write Moore, Coddington, and Byrne. Yet, organizations that implement a strategic planning process—such as the one NMRHS has—can respond more nimbly when the economy turns sour or other challenges arise. “Everything we do is derived from our strategic planning document that is continually reviewed and tweaked so that if something changes we can pretty much turn the organization on a dime by adjusting metrics and objectives,” says NMRHS president and CEO Tom Mroczkowski.

Strategic focus, of course, will vary, depending on how financially strong or weak an organization is, write Moore, Coddington, and Bryne. “Leaders of organizations with poor operating margins are sweating to improve those margins. Leaders of safety net organizations, which expect to be deluged with patients but not funding, could not be more concerned ... Meanwhile, strong systems are looking ahead. A leader of one of the country's strongest systems said, ‘We've prepared for the downturn. How do we prepare for, and take advantage of, what's next?’”

Emphasize bread and butter financial management. “Successfully preserving cash flow comes down to being diligent about budgeting, revenue cycle management, and supply chain management,” says Fuller. “Financial executives need to understand and control all facets of cash inflows and outflows for their organization.”

Place a priority on value. “In the past, it was very difficult to discern either cost or quality given the lack of transparency and dependable, consumer-friendly sources of this information,” writes HFMA president and CEO Clarke.⁵ “Now, however, data on both quality and cost are becoming more widely available ... In today’s environment, healthcare leaders must focus on quality *and* cost—in other words, they must focus on value.”

Healthcare organizations need to approach this issue strategically, focusing attention first on processes that are high-cost, high-volume, or prone to problems. They need to ask “why do we do it this way?” questions to eliminate unnecessary steps. And they need to examine ways to better leverage partnerships and technology to increase efficiencies and shore up core competencies.

Focusing on improving patient satisfaction is the key to enhancing quality and efficiency—as well as an improved bottom line, argues Melvin F. Hall, PhD, president and CEO, Press Ganey Associates, Inc. “The most profitable hospitals generally have the highest levels of patient satisfaction, while the least profitable hospitals often have the lowest,” he writes. (See *Looking to Improve Financial Results? Listen to Your Patients* at www.hfma.org/pulse.)

Balance risk. “Risk is a diverse, omnipresent factor today,” writes Clarke.⁶ “The risk inherent in the allocation to equity or fixed income on the asset side of the balance sheet must be considered within the context of the risk to revenues and expenses from operations. In provider organizations, the risks are even more complex and must also consider the risks inherent in the liability side of the balance sheet. Financing structures using swaps, variable rate issues, and credit and liquidity enhancements all carry components of risk.”

There are also legal risks to consider in the financial meltdown, write Paul DeMuro, JD, FHFMA, CPA, in *Financial Meltdown: Key Legal Issues for Healthcare Organizations*. For example, organizations may face litigation due to failing to maintain debt covenants. “Key finance personnel at healthcare organizations should be intimately familiar with the provisions of the debt/bond documents and the covenants set forth therein. They should be tracking compliance and when they are likely to trigger a covenant to plan for same. They should retain counsel expert in financial issues to assist them, and such counsel should know their debt/bond documents and how to address issues as they might arise,” writes Muro who is a partner, Latham & Watkins, LLP, San Francisco. (Visit www.hfma.org/pulse to access this entire article.)

Engage and communicate effectively. Even the best laid strategy can fail if leaders do not communicate effectively. Whether a hospital is getting ready to announce a salary freeze, layoffs, or a proposed merger, it is vital to be as open and clear as possible with staff and the community.

“The most important thing you can do in this case is communicate, communicate, communicate. Be as transparent as possible and scrupulously honest. When you have information you can share, let your staff know right away. If you have news that must be confidential, tell staff that you cannot share the information at the moment, but will do so as soon as you are able, write Kathy Sanford, CNO, Catholic Health Initiatives, in the *Healthcare Financial Pulse* resource “*Communicating Layoffs to Nurse Leaders*.” (Posted at www.hfma.org/pulse.)

Good communication was at the heart of a successful labor cost reduction effort at Beth Israel Deaconess Medical Center. CEO Paul Levy used email, online forums, and town hall meetings to engage staff in identifying ways to resolve a \$20 million budget shortfall. Levy received hundreds and hundreds of employee e-mails suggesting cuts that have collectively resulted in savings of more than \$16 million so far.

An Opportunity or a Challenge?

Replace scarcity thinking with abundance thinking, advised Tim Sanders, former chief solutions officer of Yahoo at HFMA’s chapter and regional leadership conference in April. “Sanders’ message resonated with many of us because it provided a different way to frame an environment that often feels hopeless,” writes Clarke.⁷

Abundance thinking encourages leaders to focus on their organizations’ strengths and future possibilities—rather than dwelling entirely on the negative financial turmoil. Several resources on the *Healthcare Financial Pulse* site rally providers to recognize opportunities in the current financial challenges. For example, the current cash flow problems are forcing hospitals to make cost containment and quality improvement a priority. All this scrambling to contain costs now could fare well for hospitals in the future when Medicare and other payers start basing payments on value.

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HFMA's Healthcare Financial Pulse Project

Cost containment, cash management, capital access, and quality improvements are key issues confronting healthcare leaders today. The *Healthcare Financial Pulse* project represents HFMA's commitment to providing financial leaders with the latest information about healthcare organizations' performance, the challenges facing health care, and the advice and tools needed to lead change. Visit www.hfma.org/pulse often for new and updated content, including the latest research findings, case studies, poll results, and opinion pieces. Here's a sampling of the types of resources you will find.

- › Survey Results: How Hospitals Are Combating the Financial Downturn
- › Integration Insights: NMRHS and Spectrum Health Discuss Their Proposed Union
- › Managing Cost Reductions: The Beth Israel Deaconess Approach
- › Improving Your Hospital's Credit Rating: Advice from Moody's Investors Service
- › Case Study: Give Nurses the Right Tools ... and Labor Costs Go Down
- › The Burning Platform: Producing Change in Difficult Economic Times
- › Case Studies: How Three Hospitals Obtained Section 242 Financing Amid the Market Meltdown
- › The Long View: How the Financial Downturn Will Change Health Care
- › Optimizing Margins Through Non-Labor Cost Reduction
- › Benchmarking Tools for Reducing Costs of Care
- › Case Study: Seamless Service Line Management
- › Case Study: Denials Management and Appeals: Rooting Out the Cause
- › Case Studies: Reexamining Charity Care Policies
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