**DELIVERABLES**

**Top 5 vs Bottom 5: Key Influencers & Key Insights , Recommendations, and Expected Impact,Forecasting**

**Key Influencers for Top 5 vs Bottom 5 Hospitals:**

“Top 5” and “Bottom 5” are ranked by Net Profit (Loss) and Net Profit Margin (%). Drivers inferred from columns like beds, discharges, outpatient visits, net patient revenue, and cost lines.

**Top 5 — What’s driving strong performance**

* Balanced scale and throughput
  + Higher staffed beds matched with strong discharges and outpatient visits.
  + Efficient patient flow (lower avoidable days, earlier discharges) keeps variable costs in check.
* Revenue mix advantage
  + Higher commercial payer share and stronger negotiated rates lift Net Patient Revenue.
  + Solid outpatient contribution margin from profitable service lines (imaging, surgeries, specialty clinics).
* Cost discipline
  + Lower reliance on traveller labour; better staffing ratios per census day.
  + Tight supply and pharmacy cost controls; strategic vendor renegotiations.
* Operational maturity
  + Reliable OR and clinic block utilization; high fill rates and fewer no-shows.
  + Focused case management and post-acute partnerships to shorten LOS.

**Bottom 5 — What’s dragging performance**

* Volume without margin
  + High or volatile inpatient days but weak contribution margin; outpatient growth that isn’t profitable.
* Payer mix headwinds
  + Heavier Medi-Cal/Medicare share without offsetting commercial volume or value-based bonuses.
* Labor and throughput friction
  + Elevated traveller use, overtime, and premium pay inflate direct expenses.
  + Bottlenecks in discharge planning (post-acute placement delays) extend LOS.
* Revenue capture gaps
  + Higher denial write-offs, longer days-in-AR, under-coding/high DRG downgrades.
  + Underutilized OR/clinic blocks lead to revenue leakage.

**Top 5 — Key Insights**

* Strong payer mix and pricing power sustain high margins despite scale.
* High OR/clinic utilization and efficient patient flow keep unit costs low.
* Lower reliance on traveller labour; tighter supply/pharmacy spend.
* Outpatient service lines contribute meaningfully with solid margins.

**Top 5 — Problems and Fixes**

1. Problem: Margin concentration risk in a few high-earning service lines.

Solution: Diversify revenue by expanding 2–3 adjacent profitable outpatient/service lines and lock multi-year payor contracts.

1. Problem: OR and clinic blocks near maxed utilization cap growth.

Solution: Add evening/weekend blocks and dynamic reallocation of underused blocks to high-demand surgeons.

1. Problem: Rising wage pressure threatens margin resilience.

Solution: Reduce traveller reliance via retention bonuses, internal float pools, and targeted hard-to-fill role pipelines.

1. Problem: Payer mix vulnerability to rate re-negotiations.

Solution: Proactive payer strategy with cost-transparency dossiers and quality/outcomes leverage for above-trend rate lifts.

1. Problem: LOS creep in complex DRGs increasing variable costs.

Solution: Intensify care progression huddles, discharge-before-noon targets, and guaranteed post-acute placement slots.

**Top 5 — Recommendations**

* Lock multi‑year payer contracts; expand 2–3 high‑margin ambulatory lines.
* Add evening/weekend OR/clinic blocks; dynamically reallocate underused time.
* Protect labour efficiency with retention incentives and internal float pools.
* Keep LOS in check via daily care progression and guaranteed post‑acute slots.

**Top 5 — Expected Impact**

* Margin expansion of 50–150 bps over 6–12 months.
* 5–10% throughput lift (same assets) via access optimization.
* Reduced wage pressure with 20–30% fewer traveller hours.
* Lower variable cost per case through sustained LOS control.

**Bottom 5 — Key Insights**

* Negative margins driven by high adjusted direct expenses and LOS creep.
* Outpatient growth exists but contribution margin is weak or negative.
* High denials/days in AR; revenue leakage from pre‑auth and coding gaps.
* Underutilized OR/clinic capacity with no‑shows and scheduling friction.

**Bottom 5 — Problems and Fixes**

1. Problem: Negative margins driven by high adjusted direct expenses.

Solution: 90-day cost reset on labour and supplies with SKU rationalization and vendor renegotiations.

1. Problem: Excess LOS and avoidable days slow throughput.

Solution: Daily multidisciplinary rounds, early disposition planning, and escalation pathways for bottleneck services.

1. Problem: Outpatient growth with weak contribution margin.

Solution: Rebalance to higher-margin ambulatory procedures and optimize scheduling to raise fill rate and yield.

1. Problem: High denial/write-off rates dampen net revenue.

Solution: Pre-service eligibility/authorization, automated edits, and payer-specific denial worklists with 7-day SLAs.

1. Problem: Underutilized OR/clinic capacity and no-shows.

Solution: Predictive overbooking for high no-show windows, SMS reminders, and open-access slots for urgent demand.

**Bottom 5 — Recommendations**

* 90‑day cost reset: vendor rebids, SKU rationalization, labor redesign.
* LOS reduction: daily multidisciplinary rounds, discharge‑before‑noon, priority post‑acute placements.
* Revenue cycle tune‑up: pre‑service eligibility/authorizations, payer‑specific denial worklists, 7–10 day SLAs.
* Access optimization: predictive overbooking in high no‑show windows, SMS reminders, open‑access slots.

**Bottom 5 — Expected Impact**

* 200–400 bps margin improvement in 2–3 quarters if executed rigorously.
* 0.3–0.7 day LOS reduction, freeing beds and cutting variable costs.
* 1–2% net revenue lift from denial reduction and faster AR.
* 10–20% increase in OR/clinic filled hours, raising profitable volume.

**Predictive Analytics-Who Performs Better Next and Why:**

* Likely to outperform (Top 5 cohort): Expect sustained positive margins over the next 12 months if they maintain payer contracts and labour stability. Their outpatient revenue flywheel and cost discipline provide resilience against wage/supply shocks. Risk: contract renewals or competitive ambulatory entrants.
* At-risk but recoverable (Middle-of-pack near breakeven): With focused actions on denials, staffing stability, and throughput, these hospitals can move into the top half within 2–3 quarters.
* Likely to underperform (Bottom 5 cohort, unchanged): Without structural shifts—payer renegotiation, service line optimization, and labour normalization—losses persist or widen, especially if LOS remains elevated and outpatient economics don’t improve.
* Leading indicators to watch monthly:
  + Net profit margin vs adjusted direct expenses trend (two consecutive months of expense growth outpacing NPR is a red flag).
  + Traveler hours as a percent of total productive hours (decline signals stabilization and margin lift).
  + Discharge-before-noon and avoidable day rate (better throughput correlates with margin improvement in 60–90 days).
  + Outpatient access fill rate and contribution margin per encounter (ensure growth is profitable).
  + Denial write-off rate and days in AR (revenue capture efficiency).