HFS

OPERATIONAL PLAYBOOK

Care delivery must adopt AI strategically to survive the 21st century

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This playbook is for care delivery enterprise (health systems, hospitals, and ASCs) CIOs to leverage technology, particularly AI, to address four key existential challenges by their organizations: 1) revenue headwinds, 2) margin deterioration, 3) clinician shortages, and 4) patient expectations for speed, accuracy, and costs. It centers on AI as the core technology enabled by a new delivery paradigm framed by Services-as-Software™ (SaS).

Addressing these challenges with the specific steps in this playbook will yield tangible, quantifiable benefits such as increased revenue, reduced costs, improved clinician productivity, and higher patient engagement rates.

HFS Operational Playbooks are practical guides to solving key enterprise challenges that consume significant costs, time, and resources. The playbook provides enterprise leaders a realistic roadmap with specific “to-dos” to address their everyday challenges so they can clear mental and financial space to deliver next-level value.

The problem: Care delivery enterprises are facing an existential crisis at the nexus of multiple, compounding challenges

The US healthcare delivery landscape, despite the enormity of AI-induced opportunities, is the most economically challenged industry segment. Externally driven headwinds include the One Big Beautiful Bill Act (OBBBA), which reduced Medicaid funding by close to 10% annually, slashed reimbursement rates across the board (primarily for Medicare), and a rapidly aging population with a high prevalence of chronic conditions that will continue to drive up the cost of care. Internally driven challenges include slow and low technology investments that prevent higher productivity and efficiency, unrealized benefits from M&A activities, and slow progress in finding new sources of revenue.

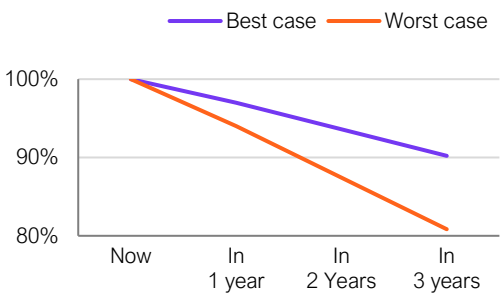
These challenges will manifest into four categories of threats that need immediate remediation. The rationale for urgency lies in the bleak data from the Cecil G. Sheps Center for Health Services Research at UNC, which identified 338 rural hospitals as particularly vulnerable. Other data points suggest that even urban and inner-city hospitals are vulnerable and at risk for closure.

Revenue headwinds

Shrinking reimbursement rates by the Centers of Medicare and Medicaid (CMS), exacerbated by site-neutral payments, increased payer friction seen in higher rates of denied or delayed payments, prior authorization, and increased uninsured rates, are reducing the number of paying patients.

These factors will reduce revenues by 3% to 6% over a 12-month period and by 7% to 14% over a three-year period for those that survive this tsunami of challenges.

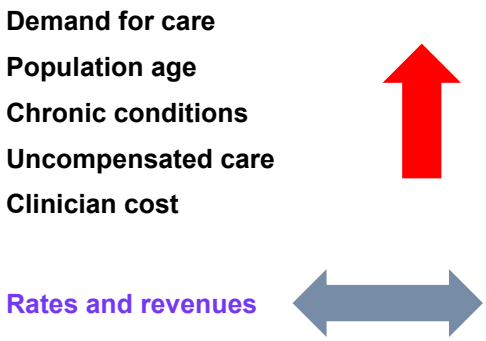
Reimbursement rates could shrink by 20% in three years



Margin deterioration

Demand for care will continue to rise as the population rapidly ages, bringing with it an increased prevalence of chronic conditions. Yet, there will not be a commensurate increase in rates or revenues.

Increased uninsurance will triple the rate of uncompensated care, while the cost to attract and retain clinicians will grow only at rates above nominal inflation. Healthcare does not have a demand problem, just a monetization problem.



Clinician shortages

Burnout rates, slow speed to train replacements, and increasing demand for care are just some of the reasons clinician adequacy rates are likely to be in the high 80% range for physicians and in the low 90% range for registered nurses.

That rate will be worse for specialties most needed by the population based on demographics, such as primary care, geriatric care, and cardiology.

Burnout rate

Training duration

Demand

Adequacy rates

Physicians — high **80%**
RNs — low **90%**

Patient expectations

Despite rising uninsurance rates, consumers remain primarily in control of who they see for care and when. In that context, their evolving expectations for speed, accuracy, and cost are critical to understand and address. The Kaiser Family Foundation reported that 36% of adults in the past 12 months have skipped or postponed care they needed because of cost. Other data indicate that up to 50% of consumers will switch doctors if their expectations are not met.

These factors can cost as much as 4% of annual revenue over 12 months and will compound if left unaddressed.

Consumer expectations

Delaying care

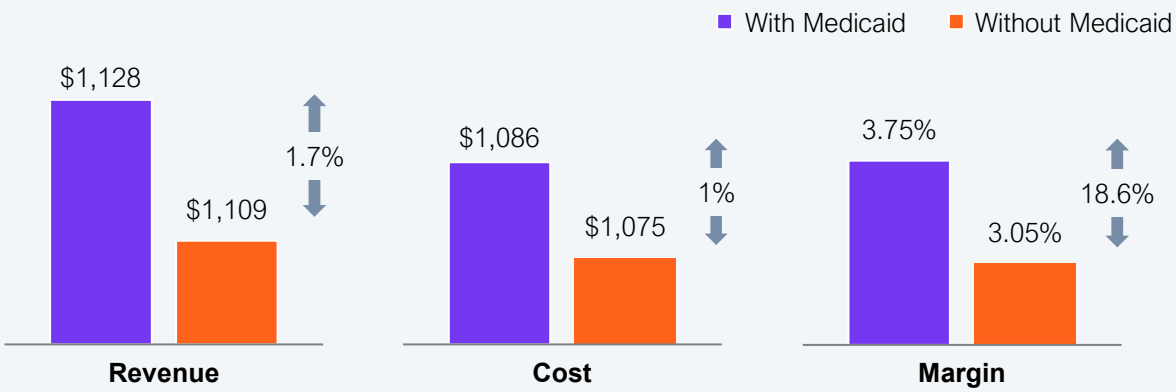
Switching providers

Revenue

4% decrease and compounding

Exhibit 1: Medicaid cuts will shave up to 20 pts of margins in 2026 alone

Financial impact of the elimination of Medicaid expansion (40 states + DC) in 2026



Source: Urban Institute, Commonwealth Fund, HFS Research, 2026

Playbook benefits: Balancing the existential crisis of survival with the future of care delivery

Health system CIOs must lean into the business of care delivery. This playbook takes a programmatic approach, enabling CIOs to execute a strategic roadmap with contained solutions that optimize their existing assets while allowing AI to deliver significant business benefits in quick succession.

Benefit 1: Tangible and quantifiable business outcomes

- **Clear revenues lift** through reduced denials and underpayments while accelerating cash realization through denial prevention and recovery, coding support, and contract variance detection.
- **Lower operating costs** by reducing waste and unit costs via automation of the back office, supply chain anomaly detection, improving forecasting, and throughput improvements.
- **Higher workforce productivity** by returning time to clinicians by cutting pajama time and admin burden through inbox message triage, ambient documentation, and grounded clinical summarization.

Benefit 2: Making AI count with legacy tech

- **Faster ROI** by leveraging existing data flows with legacy systems already producing reliable signals such as 835/837, remits, and ADT feeds that AI can leverage without having to rip-and-replace.
- **Modular** add-on delivery with tight integration, leveraging Services-as-Software as an AI-enabled delivery paradigm while avoiding getting stuck in platform re-architecture.
- Maintaining **operational control and auditability** by developing governance loops so AI is trusted, safe, and scalable inside current operating models.

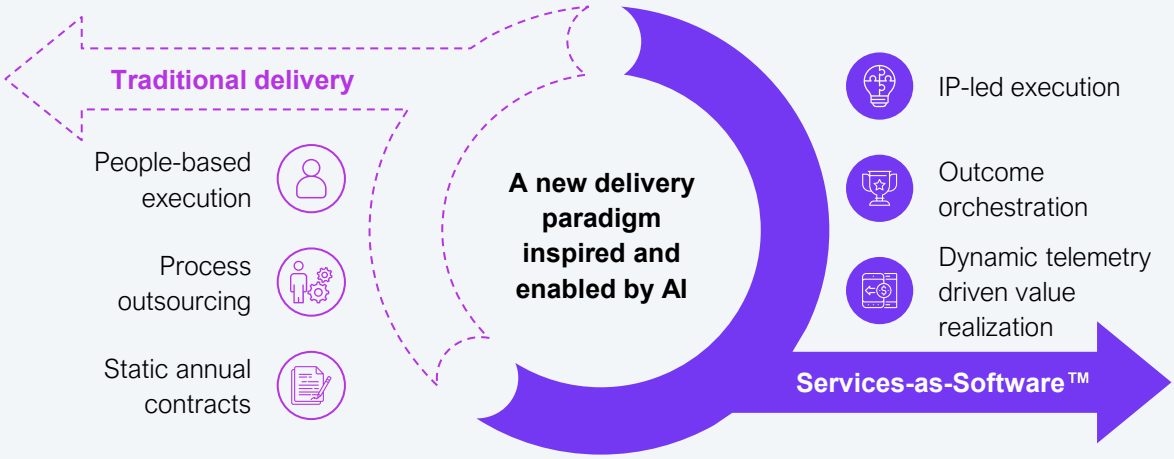
Benefit 3: Preparing for the future of care delivery

- **A command-center operating model** to drive predictive orchestration of discharge barriers, LOS risk, and staffing and bed actions so that systems can manage increasing demand with constrained labor.
- **Digital-first patient** with AI-driven access, intake, and front door capabilities to reduce leakage with no-shows, speed time-to-appointment, and improve self-serve completion.
- **More resilient care teams** with scaled virtual nursing, AI monitoring, and closed-loop results follow-up to reclaim nurse time, reduce missed follow-ups, and raise patient trust as care shifts to a digital-biased hybrid.

The solution: AI-enabled modularity delivered by SaS

Care delivery CIOs must feel comfortable with an AI-enabled, modular approach to addressing the four key business challenges, rather than relying on legacy platform enablement. Modularity will not preclude tight integration; however, that integration must be considered notional by adopting Services-as-Software™ (SaS) as the delivery paradigm (see Exhibit 2).

Exhibit 2: Services-as-Software will evolve to become the default delivery paradigm to enable AI for the next 25 to 50 years

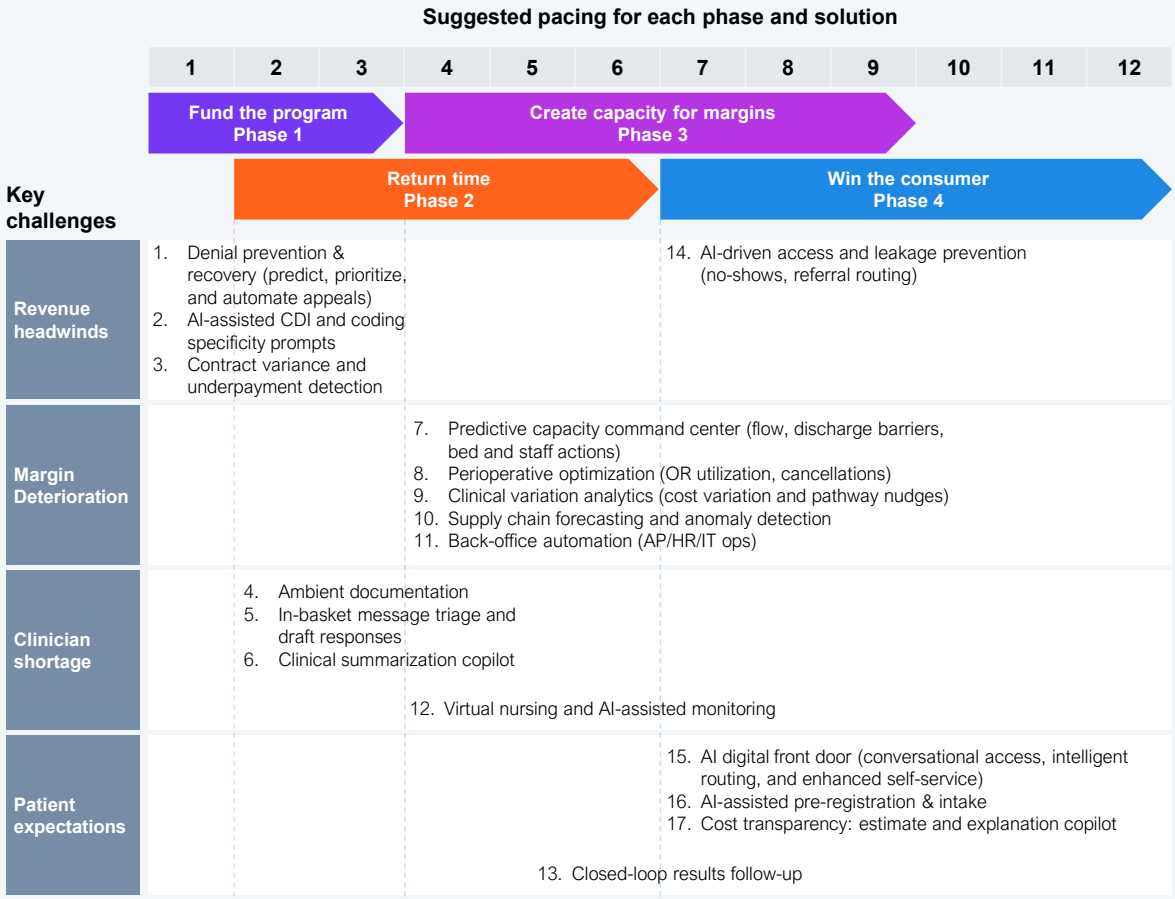


Source: HFS Research, 2026

The plan to execute practically

This playbook has identified 17 key solutions for delivering the largest bang for the buck in the least amount of time, leveraging existing tech-enabled capabilities and adopting SaS to deliver (see Exhibit 3). These solutions have been laid out in a practical sequence that will allow CIOs to achieve rapid ROI with lower risk, easier governance, and avoid the typical challenges of being stuck in pilot purgatory.

Exhibit 3: Delivering targeted business value with AI in a specific sequence to maximize outcomes



Source: HFS Research, 2026

The playbook: A roadmap that optimizes legacy with the potential of AI

This playbook has been developed with inputs from tens of practitioners, technologists, and healthcare experts. The intent is to rapidly deliver 17 solutions across four phases to directly address financial headwinds, margin deterioration, clinician shortage, and patient expectations.

Phase 1: Fund the program

Phase 1 addresses revenue headwinds. These four solutions fund the overall program and mitigate the need for capital expense or net new investments. You must implement three of these solutions in Phase 1; you can implement the fourth in Phase 4.

Solution 1: Denial prevention and recovery

Why this order matters	• It delivers the fastest measurable financial ROI • It has a low patient safety risk • It uses mature RCM data flows
Do it right	• Integrate 835/837, remits, ERA/EOB, payer edits, and authorization data • Create a denial taxonomy with root-cause mapping • Deploy denial risk scoring and pre-bill work queues • Automate appeal packet assembly with submission routing • Develop a KPI loop including denial rate, overturn rate, and days to resolution
Expected outcomes	• Initial denial rate will decrease • Denial overturn rate will increase • Days to resolution will decrease
Watch out for…	• Bad taxonomy enabling incoherent denial reasons • Payer policy drift (rules change, model degrades) • Gaming or cherry-picking easy denials to appeal to goose the stats, but has little net value

To-do list and what "complete" looks like

Productionalized	Live, in-production, and feeding work queues
Consistent results	Three consecutive monthly cycles improved
Auditability	Full audit trail for AI-generated packets

Solution 2: AI–assisted clinical documentation improvement (CDI) and coding specificity prompts

Why this order matters

- It is dependent on workflow trust and governance that can be proven with denials
- Since CDI touches clinician documentation and compliance risk, executing denials first demonstrates operational control, auditability, and change management competence
- It leverages benefits from the denial taxonomy and root-cause work

Do it right

- Standardize note templates and problem lists
- Enable structured-data capture (SNOMED/ICD mapping, orders, HCC capture where relevant)
- Deploy real-time documentation nudges in clinician workflow to facilitate CDI
- Include human-in-the-loop CDI validation with audit trail
- Measure regular and major complication and comorbidity (CC/MCC) capture rate, query rate, discharged not final billed (DNFB), and coding turnaround time

Expected outcomes

- DNFB and coding lag will decrease
- CC/MCC capture will increase
- Rework and query loop time will decrease

Watch out for…

- Compliance risk and upcoding perception
- Clinician fatigue from excessive prompts that could drive low adoption
- While models are getting better, you cannot rule out hallucinations or incorrect suggestions

To-do list and what “complete” looks like

Core function	Embedded in clinician and coder workflow
People matter	Human-in-the-loop and QA operating
Compliance	Compliance monitoring stable

Solution 3: Contract variance and underpayment detection

Why this order matters

- While the denials process is not heavily dependent upon contract-specific nuances, underpayment requires accurate contract modeling, fee schedules, carve-outs, and clean payer configuration to avoid false positives and erode trust.
- It is easier to scale contract variances reliably with remit ingestion, taxonomy discipline, and queue operational stability.

Do it right

- Build contract modeling that includes allowed amounts and DRG/APC logic
- Ingest remittances and contract terms into the analytics layer
- Deploy variance and anomaly detection rules
- Route to work queues and automate recovery letters
- Measure the recovered amount per claim, variance backlog, and days to identify

Expected outcomes

- Recovery amounts per month will increase
- Identification of variances and anomalies will speed up
- Variance backlog will decrease

Watch out for…

- False positives from incomplete contract modeling can negatively impact resources
- Missing data, such as carve-outs, modifiers, and bundled payments, could be detrimental
- Slow cash realization if payer follow-up process is weak

To-do list and what “complete” looks like

Financial reconciliation	Ensure expected vs paid reconciliation works
Variance management	Variances to create queue items with SLAs are in place
Cash	Cash posted is tied to specific variance IDs

Phase 2: Return time

Given the shortage of clinicians, the idea is to optimize clinician time by returning time to them with these four solutions. We recommend executing the first three in Phase 2 and the fourth in Phase 3.

Solution 4: In-basket and message triage with draft responses

Why this order matters	• It's before ambient documentation because it's simpler and faster to operationalize • Inbox routing uses discrete message objects and clear telemetry and doesn't require audio capture or consent workflows • It can be a change-management wedge to build clinician trust in assistive AI with lower complexity
Do it right	• Define note standards and specialty templates • Develop consent and recording governance • Design tight EHR integration (note, orders, coding support) • Support human verification, QA sampling, and guardrails • Measure after-hours EHR, note closure time, and visits per session
Expected outcomes	• Handling time for responses will decrease • Speed to first valid response will improve • Routing of clinicians will improve
Watch out for…	• Privacy and consent concerns from patients or clinicians • Note quality variability across specialties • Workflow friction reflected by extra clicks, slow turnaround

To-do list and what "complete" looks like

Standards	Routing and escalation path is approved
Safety	Safety guardrails are validated
Metrics	Measurement is live with patient experience

Solution 5: Ambient documentation

Why this order matters

- Ambient documentation requires consent, device logistics, specialty template tuning, and tighter compliance controls
- Running the inbox first creates readiness (governance, adoption habits) and reduces noise so ambient benefits are clearer

Do it right

- Standardize message categories and urgency rules
- Classify NLP with clear risk flags
- Route to team roles with draft responses
- Create safe-response policies with appropriate supervision and auditability
- Measure: Time to first response, handle time, escalation rate

Expected outcomes

- Pajama time will decrease
- Note closure will speed up
- Capacity for deployment to patient care will increase

Watch out for…

- Safety risks, such as missed urgent symptoms
- Wrong routing that can increase delays and frustration
- Medical and legal concerns about AI-drafted messages

To-do list and what “complete” looks like

Templates	EHR-integrated templates are operationalized.
Predictability	Stable QA and error taxonomy loop in place.
Compliance	Approved compliance and consent governance.

Solution 6: Clinical summarization copilot with grounded chart synthesis

Why this order matters

- It moves closer to clinical reasoning ahead of next phases
- It enables grounded summarization pilots once governance and auditability are working

Do it right

- Enable creation of longitudinal patient records using CCD, FHIR, and internal data
- Record citations to source notes and results
- Secure with role-based access control (RBAC) and PHI controls and enable logging
- Deploy in workflow, e.g., SMART on FHIR visualized in EHR sidebar
- Measure the time-to-decision, order latency, and satisfaction

Expected outcomes

- Spend less time finding key facts
- Duplicate work will decrease

Watch out for…

- Hallucinations and inaccurate summaries
- PHI exposure with access control gaps
- Overreliance on systems as clinicians stop checking sources

To-do list and what "complete" looks like

Attribution	Grounded citations to sources
Approvals	RBAC and PHI logging is signed off
Credibility	Accuracy thresholds are sustained

Phase 3: Creating capacity for margins

Phase 3 addresses margin deterioration with seven solutions.

Solution 7: Predictive capacity command center (flow, discharge barriers, bed/staff actions)

Why this order matters	• There is big margin impact, but the solution depends on higher integration and cross-functional workflow • It requires established and stable governance and integration proven in Phases 1 and 2
Do it right	• Enable real-time feeds, including admission, discharge, transfer (ADT); bed board; transport; environmental services (EVS); lab and radiology; staffing; and case management • Create an operational cockpit with a single pane of glass • Enable AI for prediction, LOS and discharge risk, and boarding risk • Embed playbooks across actions and activities • Measure LOS, boarding hours, throughput, and agency spend
Expected outcomes	• Average length of stay (LOS) will decrease • Boarding time will decrease • Spending on premium labor will decrease
Watch out for…	• Dashboards with insights but without action • Real-time feed fragility (ADT, EVS, and transport data latency breaks trust) • Local optimization (one unit improves at expense of another)

To-do list and what “complete” looks like

Standardization	Running daily operations with playbooks
Actionable	80% of alerts have an action or closure
Improvements	KPI lift sustained over 8–12 weeks consistently

Solution 8: Perioperative optimization

Why this order matters

- The operating room (OR) is typically considered highest-value constrained asset and needs data normalization and governance

Do it right

- Normalize OR data such as usage duration, physician preferences, turnover, staffing
- Develop predictive models toward managing duration, cancellation risk, utilization
- Deliver prescriptive recommendations to block release, adjust staffing, and sequence procedures
- Support enhanced OR governance (rules, scorecards)
- Measure utilization, cancellation rate, and add-on capacity

Expected outcomes

- Usage of OR facilities and associated resources will increase
- Cancellations will decrease
- Rate of on-time starts and on-schedule turnover will increase

Watch out for…

- Surgeon resistance to block changes
- Bad duration predictions that cause schedule chaos and distrust of AI enablement
- Incomplete perioperative data (preferences, turnover, staffing) driving suboptimal decisions

To-do list and what “complete” looks like

Schedules	Prediction-model-driven scheduling for decisions is routine
Governance	Complete governance is live and operational
Metrics	Gains persist for up to 3 months consistently

Solution 9: Clinical variation analytics and pathway nudges

Why this order matters	• It requires linking clinical and cost data with clinician governance • While a strong margin lever, it depends on data maturity and change management
Do it right	• Develop a data set linking clinical and costs (costing, item-level supply, meds, labs, imaging) • Enable AI detection of outliers of defined gold standard pathways and identify drivers • Deploy nudges and review workflows • Measure cost per case, utilization, and complications and readmissions
Expected outcomes	• Cost per case will decrease • Unnecessary utilization will decrease • Quality will stabilize or improve
Watch out for…	• Clinician distrust driven by algorithm-enabled healthcare cost-cutting • Cost accounting mismatch due to wrong attribution which will drive inaccurate conclusions • Alert fatigue from too many nudges

To-do list and what “complete” looks like

Gold standard	Pathways to be used are approved and versioned
Metrics	Adoption of embedded nudges is measured

Solution 10: Supply chain forecasting and anomaly detection

Why this order matters

- Material savings depend on item master hygiene and ERP integration
- Higher confidence returns when the organization is operating in a platform mode

Do it right

- Begin with item master cleanup, including UDI in the ERP or supply chain system of record
- Integrate ERP (procurement) or other system of record, usage data, and physician preference cards
- Enable demand forecasting and set par levels to reduce wastage
- Detect and report price anomalies and substitutions and automate approvals
- Measure inventory turns, expirations, price variances (PPV), and stockouts

Expected outcomes

- Inventory waste will decrease
- Turns without stockouts will improve
- PPV anomalies will decrease

Watch out for…

- Item master chaos due to duplicate SKUs and inconsistent units
- Clinician preference conflicts (substitution rejected)
- Stockout risk if pars cut too aggressively

To-do list and what “complete” looks like

Technology	Item master and ERP integration are stable
Analytics	Forecasting drives pars used in practice
Metrics	Savings validated with resolution workflows

Solution 11: Back-office automation

Why this order matters	• There is low clinical risk, but enterprise workflow standardization is needed • It's easiest to scale after Phase 1 proves automation governance
Do it right	• Ingest all relevant documents such as invoices, contracts, and tickets • Leverage AI extraction for classification and high confidence scoring • Leverage industry-standard workflow routing with exceptions sent to humans and otherwise straight-through processing • Embrace standard controls for audits and segregation of duties • Measure the cost per invoice or ticket, cycle time, and hours saved
Expected outcomes	• Average cost of transactions across the supply chain landscape will decrease • Cycle time to optimize inventory will decrease • Straight-through processing will increase
Watch out for…	• Control failures that manifest in incorrect postings, audit findings • Low accuracy due to significant exceptions that prevent standardization • Shadow workflows that bypass automation

To-do list and what "complete" looks like

Operational	Meets confidence thresholds with low exceptions in production
Compliance	Separation of duties and compliance validated
Metrics	Gains sustained across three purchase cycles

Solution 12: Virtual nursing and AI–assisted monitoring

Why this order matters	• It requires operating model and device or network readiness with practical escalation pathways • It has a higher level of implementation complexity and requires an explicit business decision to adopt virtual nursing
Do it right	• Develop device and network readiness (QoS, Wi-Fi) to support virtual nursing and physician consultation • Enable alert logic and escalation workflows • Integrate tasks back into EHR • Measure RN time reclaimed, falls, response times, and LOS
Expected outcomes	• Amount of nurse time reclaimed • Faster response to adverse events and identified alerts • Reduced number of falls and adverse events (where applicable)
Watch out for…	• Operating model failure (lack of clarity of roles, distrust) • Alarm fatigue due to too many alerts • Infrastructure issues with network or device uptime

To-do list and what "complete" looks like

Op model	Operating model is fully staffed
Stability	Stable (99.999% uptime) device, network, and EHR integration
KPI	Sustained KPI and adoption thresholds met

Solution 13: Closed-loop results follow-up

Why this order matters	• There must be established standardized rules for routing, outreach workflows, and audit dashboards, given the high value for trust safety
Do it right	• Normalize routing rules with critical value policies • Set up AI-enabled triage for at-risk follow-ups • Automate outreach by channel of choice, tasking and escalations • Create a dashboard for audit and compliance reporting • Measure closed-loop percentage, time-to-follow-up, and missed follow-up
Expected outcomes	• Percentage of closed-loop interactions will increase • Percentage of missed follow-ups will decrease • Speed to follow-up appointments will increase
Watch out for…	• False negatives such as missed abnormal results • Lack of role clarity leading to accountability gaps • Outreach failures due to wrong contact info or lack of patient engagement

To-do list and what "complete" looks like

Routing	Approved standardized policies for routing
Engagement	Automation of tasks for outreach
Auditability	Safety monitoring with chart audits, and approved fail-safes

Phase 4: Patient expectations

Patients' evolving expectations are biased toward increased digital tool usage. We recommend these four solutions to address patients' needs for faster care, higher diagnostic accuracy, and lower costs.

Solution 14: AI–driven access and leakage prevention

Why this order matters

- It requires capacity management and RCM optimization
- Demand capture is improved after fixing throughput and staffing constraints
- It is dependent upon a clean provider directory and service catalog and integrated scheduling and referral data

Do it right

- Create a unified provider directory and services catalog
- Integrate scheduling, referral orders, and CRM for call center operations
- Enable predictive analytics for no-shows to allow strategic overbooking
- Incorporate referral routing intelligence
- Measure leakage percentage, fill rate, and no-show rate

Expected outcomes

- Patient no-show rate will decrease
- Loss of revenue due to missed appointments will decrease
- Speed of time-to-appointment will increase

Watch out for…

- Inequity where no-show models may penalize disadvantaged groups
- Operational mismatch where overbooking causes clinician burnout or longer waits
- Directory and scheduling data quality

To-do list and what "complete" looks like

Analytics	Predictive analytics fully operationalized
Referrals	Closed-loop referral tracking is consistent and stable
Equity	Equity monitoring and an actionable override process have been established

Solution 15: AI–assisted pre–registration and intake

Why this order matters	• Patient-facing AI is best when internal ops can deliver on optimal capacity, scheduling integrity, and stable workflows
Do it right	• Digitally enable a standardized, version-controlled service catalog and reason-for-visit mapping • Integrate scheduling with provider search, and associated insurance rules • Deploy conversational AI with containment analytics • Allow for human handoff with context preserved • Measure abandonment, self-serve completion, and time-to-schedule
Expected outcomes	• Registration accuracy will increase • Time to check in will decrease • Volume of claim rework driven by registration errors will decrease
Watch out for…	• Bad routing to the wrong specialty and location that could trigger safety issues • Knowledge base drift, such as when answers are not kept accurate and current • Suboptimal handoff to humans losing context and requiring rework

To-do list and what “complete” looks like

Live	Eligibility and document extraction is operational
Identity	Patient identity and consent is validated

Solution 16: AI digital front door

Why this order matters	• It relies on clean identity matching, eligibility integrations, and exception workflows • It is optimized with foundational controls and front-end standardization
Do it right	• Convert paper to digital and integrate patient registration forms with identity matching and eligibility • Enable AI extraction of all patient information, such as IDs, insurance, and payment type • Develop real-time validation of coverage, demographics, and authorization triggers • Measure reg accuracy, check-in time, auth delays, and claim rework
Expected outcomes	• Patient care abandonment rate will decrease • Self-serve completion rate will increase • Time-to-schedule will improve
Watch out for…	• Identity matching errors, such as duplicate medical record numbers or wrong patient • Eligibility inaccuracies lead to claims rejections • Limited patient digital savviness reduces completion

To-do list and what "complete" looks like

Containment	Validated end-to-end containment and handoff
Library	Agreed to knowledge base and service catalog governance
Routing	Confirmed safety routing

Solution 17: Price transparency

Why this order matters	• It depends on reliable contract information, benefit logic, and robust billing ops
Do it right	• Modernize the patient portal with AI-enabled estimation to include covered benefits and out-of-pocket spend • Enable digital, plain-language explanation of care and coverage with scenarios • Include payment plans and financing workflows to drive further real-time self-service • Integrate patient portal with call center (CRM) • Measure estimate accuracy, pre-service collections, and complaints
Expected outcomes	• Estimate accuracy will improve • Rate of pre-care collections and payment plan uptake will increase • Billing complaints will decrease
Watch out for…	• Inaccurate estimates that will further erode trust • Complex benefit designs can create outliers • Regulatory and legal exposure due to misleading estimates

To-do list and what "complete" looks like

Estimates	Reconciles to posted claims within finance approved tolerance
Compliance	Estimate explanations are compliant and aligned with customer service scripts

Our perspective

The following list includes relevant HFS perspectives on care delivery operations in a shifting market; watch for our series on executing Services-as-Software within a health plan and on selecting the right partner for success.

- Part 1: Stop waiting for a healthcare workforce miracle—embrace Agentic AI now
- Part 2: Accelerate multi-agentic AI adoption to give doctors their day jobs back
- Part 3: Clinical agentic is the next-gen care delivery operating layer—execute it now
- Health system CIO agenda holds the keys to disrupting and rebuilding care delivery
- $1.5 trillion Services-as-Software market takes off—three swimlanes emerge
- Stop waiting for certainty—it's time to rewrite the enterprise IT playbook

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