The health system of tomorrow

Six ways to modernize clinical operations today

Accessible, strategic levers to drive efficiency, strengthen financial stability, and improve patient engagement and outcomes.

Modernizing amid turbulence:

The clinical ops roadmap

Many health systems today are running on operating models built for a different era—one defined by predictable volumes, stable labor, and reliable margins.

But that era is over. Margin pressure is now omnipresent. Workforce shortages are structural. Patients expect easier access, faster answers, and clearer communication about their care at every touchpoint. And advances in analytics and AI are reshaping what operational performance can and should look like. These are not short-term disruptions. They reflect permanent shifts in how care must be delivered, managed, and measured.

The fundamental challenge is that many organizations are treating the symptoms—manually adjusting schedules, chasing short-term capacity, patching together digital tools—without fixing the underlying clinical operating model. That brings temporary relief, but the constraints remain. Fragmented access stifles growth, manual workflows consume clinician time, disconnected systems delay decisions, and potential improvements don't scale because the operating model is unchanged.

The providers breaking this cycle and making measurable progress are taking a more disciplined approach. They are rebuilding clinical operations around a defined set of integrated improvements that expand capacity, protect margin, and modernize the patient journey in tandem. Access shapes anticipated patient throughput. Workforce design influences documentation, revenue, and experience. Data underpins day-to-day decisions, linking performance across functions rather than isolating it. Crucially, these enhancements reinforce each other to compound the impact and outcomes: expanding capacity without adding more beds and staff, stabilizing finances without blunt cost cuts, and improving patient experiences without adding further complexity.

This intelligent, future-ready clinical operating model isn't anchored in a single technology or initiative. It depends on disciplined execution, clear accountability, and the alignment of people, processes, and technology around measurable outcomes. Here's a closer look at six strategic improvements health systems are implementing now to strengthen performance under pressure and position themselves for sustainable growth.

#1 Fix patient access before it caps growth

Transformation begins at the entry point. But if the front door is fragmented, the entire care journey—and the revenue it generates—is at risk. Fragmentation leads to "lost patients" and revenue leakage that many systems still struggle to quantify.

What leaders are doing differently:

Centralize scheduling to make it easy.
Move away from dispersed scheduling practices toward a centralized access model that standardizes the basics: visit types and durations, provider template design, and guided scheduling logic that helps agents route patients consistently. Pair this with contact center modernization (telephony workflows, training, quality assurance) so the "one number" promise actually holds.

Deploy a logic-enabled digital front door.
Apply the same clinically aligned decision logic across phone, web, and self-service. Use consistent intake questions, referral triage, and rule-based routing so patients reach the right appointment type faster without bouncing between teams.

Reclaim capacity through dynamic recapture.
Treat cancellations and no-shows as recoverable inventory. Use demand and utilization dashboards to pinpoint unused slots, then operationalize backfill through dynamic wait lists and targeted outreach so open time is refilled quickly and consistently.

Outcomes we have seen:

- 22 percent aggregate increase in appointment capacity across multiple clinical specialties.[1]
- 9-day reduction in new patient lag time (from a prior 19-day baseline).
- First-call resolution of at least 75 percent, with average speed to answer under 30 seconds.
- 3–7 percent reduction in no-shows and measurable reductions in new patient loss.
- Identified $10 million–$15 million in new outpatient recurring revenue via access optimization.
- **The bottom line:** Patients receive more options, shorter waits, and improved overall continuity of care.

1 Unless otherwise noted, the data cited throughout this report is drawn from KPMG research and our direct experience and work with clients.

#2 Solve the labor shortage with a workforce multiplier

Health systems can't hire their way out of today's labor constraints. Demand is rising, clinician supply is not, and burnout remains a daily operating risk. The fastest path to capacity is redesigning how work gets done so clinicians can focus much more time on clinical judgment and patient-facing care.

What leaders are doing differently:

Reduce documentation burden at the source.
Embed support directly into the clinical workflow using AI as workforce augmentation—ambient listening, structured templates, and real-time prompts that reduce repetitive entry and improve handoffs. The goal is to remove administrative drag that steals time from patients and contributes to burnout.

Redesign roles so clinicians work at the top of their license.
Shift routine tasks to the right roles, tighten interdisciplinary coordination, and reduce duplicative work across care teams. This typically requires clearer role definitions, better escalation pathways, and tighter accountability across disciplines—not just new tools.

Align staffing with demand—continuously.
Build operating rhythms that adjust deployment based on changes in patient volume and care needs. Pair clear flexing guidelines with more frequent demand signals so leaders can rebalance coverage without defaulting to premium labor.

Outcomes we have seen:

- Leading organizations have been able to reimagine up to 30 percent of workforce spend through workflow redesign and automation-enabled support.
- Health systems have recaptured 30,000-plus clinical hours annually through provider clinical full-time equivalent alignment and related workforce/capacity adjustments.

#3 Find hidden capacity through performance improvement

Organizations can improve throughput and free up bed capacity by hardwiring efficiency into redesigned clinical workflows. The biggest gains come from reducing avoidable delays—especially those that build quietly across handoffs, discharge planning, and emergency department congestion.

What leaders are doing differently:

Run patient flow like a system, not a series of handoffs.
Stand up real-time operating discipline through a command center model, clearer bed placement guidelines, and tighter bed turnover processes. Combine that with standardized discharge checklists and a stronger escalation path so barriers are addressed early instead of surfacing at the end of a stay.

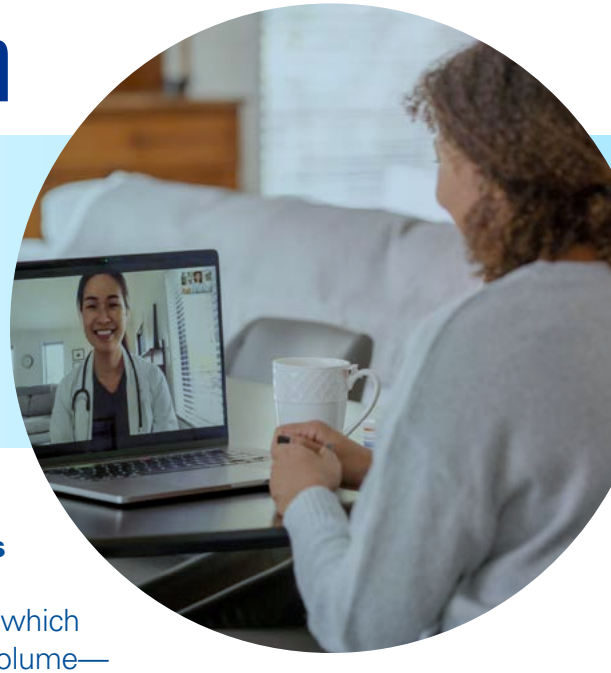
Make multidisciplinary rounds a throughput engine.
Use structured multidisciplinary rounds to align providers, nursing, case management, and ancillary teams on an estimated discharge date, what must happen to get there, and who owns each step. When the team works from the same plan, discharge becomes more predictable and throughput improves.

Redirect lower-acuity demand out of the ER.
Create clear pathways that route lower-acuity patients to the right setting—virtual primary care, urgent care, retail clinics, or rapid follow-up slots—so the emergency department can focus on true emergencies. Pair this with tighter transitions of care so patients don't boomerang back through the emergency department due to access friction, failed handoffs, or unclear next steps.

Outcomes we have seen:

- 0.4-day reduction in operational length of stay.
- $5.4 million in cumulative benefit tied to length of stay reduction and patient volume increase (example case).
- 120 fewer emergency department boarders per month and 100 fewer patients leaving without being seen per month (example case).
- A target operating benchmark of patients seen within 30 minutes and a left-without-being-seen rate of less than 1 percent as part of redesigned emergency department flow.

#4 Scale delivery through care innovation



Hospitals can't meet rising demand by relying on inpatient capacity alone. Patients want more convenient options, and health systems need safer, lower-cost ways to care for high-volume populations outside the main campus. That shift is already underway—through in-home care, telehealth, and other new "front doors" designed to expand access and reduce avoidable emergency department use.

What leaders are doing differently:

Expand hospital-level care into the home—selectively, not broadly.
Scale hospital-at-home and virtual nursing for the patient groups where it actually works: conditions with clear clinical criteria, predictable monitoring needs, and strong follow-up requirements. Combine remote monitoring with virtual check-ins and standardized escalation protocols so care teams know when to step in—and patients know what to do next.

Treat post-acute transitions as part of care delivery, not an afterthought.
Standardize referral pathways and communication between inpatient, outpatient, and post-acute teams so patients don't fall into the cracks after discharge. Population health programs can make a huge difference here, using proactive outreach and care coordination after discharge to reduce avoidable readmissions and emergency department returns. The focus is practical: confirm follow-up appointments, reduce medication confusion, coordinate services, and close the loop with clear accountability for the next step in care. This is often where avoidable readmissions start.

Use "the right site of care" as an operating model decision.
Make deliberate choices about which settings should handle which volume—especially for lower-acuity and "repeatable" procedures. In many markets, systems are pairing higher-acuity hubs (often large medical centers) with a broader network of community hospitals, ambulatory surgery centers, and virtual access points that can absorb demand and improve convenience. This is also where state-level rural transformation efforts can support new care models, when designed around local access and sustainability.

Outcomes we have seen:

- Increased patient volumes and throughput by up to 20 percent in high-margin care settings when capacity is managed deliberately across sites of care.
- Improved compliance with care plans and a measurable reduction in readmission rates; as one example, a recent meta-analysis found post-discharge follow-up visits reduced 30-day all-cause readmissions by 21 percent.[2]

2 Bilicki DJ, Reeves MJ. (September 26, 2024.) Outpatient Follow-Up Visits to Reduce 30-Day All-Cause Readmissions for Heart Failure, COPD, Myocardial Infarction, and Stroke: A Systematic Review and Meta-Analysis. Preventing Chronic Disease.

#5 Protect margins by strengthening clinical and utilization integrity

In a tighter margin environment, financial performance depends on clinical integrity: making sure care is appropriate, documented clearly, and supported by the right approvals and criteria. When utilization management, clinical documentation, and denials prevention operate in silos, teams pay twice: once in rework and write-offs, and again in avoidable delays and utilization driven by friction in the care journey.

What leaders are doing differently:

Move utilization management upstream to keep care moving.
Use utilization management (UM) as an operational discipline that starts early in the care journey—with clear criteria, timely reviews, a consistent escalation path, and faster decisions.
That discipline helps prevent avoidable delays and keeps patient flow moving. It also reduces medical necessity denials and downstream rework without turning care teams into paperwork machines.

Embed clinical documentation integrity into daily workflows.
Bring clinical documentation integrity (CDI) closer to the point of care using structured prompts and real-time support that help clinicians capture medical necessity and clinical severity accurately. The goal is to reduce back-and-forth and rework—so coding, quality reporting, and reimbursement more quickly align with patient outcomes.

Use denial trends as a feedback loop to fix underlying drivers.
Treat medical necessity denials and recurring documentation gaps as signals that point to workflow and operating model issues—handoffs, authorization timing, inconsistent criteria, or unclear ownership. Close the loop across clinical, UM, and revenue teams so improvements stick and do-over drills become a thing of the past.

Outcomes we have seen:

- Integrated front-end improvements can drive a 5–9 percent lift in revenue.
- Cleaner documentation and reduced medical necessity denials can support a 12–17 percent improvement in yield.

#6 Build a foundation of trusted systems and data

Tactical wins don't last when teams can't trust the numbers. If data is fragmented, definitions vary, systems don't talk to each other, and leaders spend their time debating reports instead of acting on them. Sustainable performance requires a foundation where the right systems fit together, the data is usable, and decision-making is anchored in one version of the truth.

What leaders are doing differently:

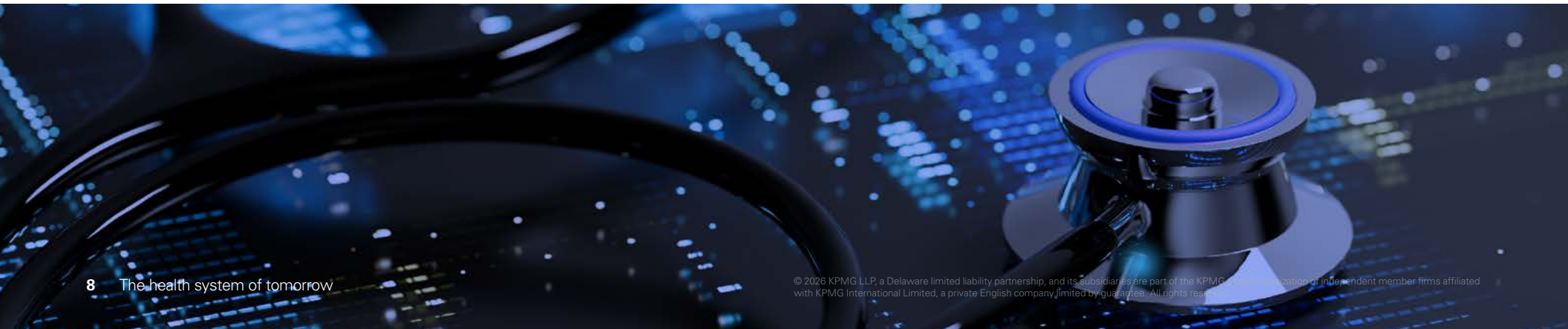
Modernize the systems stack with the outcome in mind.
Make deliberate choices about what each system is responsible for—finance, workforce, scheduling, and clinical operations—and how they connect. Leaders are asking practical questions: What's the system of record, where do we need a point solution, and where are we duplicating capabilities? For example, some organizations run Workday and Strata for finance and planning, use Laborlytics for workforce analytics, and rely on UKG for timekeeping and scheduling.

Normalize and integrate data so it's decision-ready.
Move from siloed reporting to an integrated enterprise view with consistent definitions, governance, and data quality standards. This is what enables performance visibility across access, throughput, workforce, and financial outcomes—without weeks of manual reconciliation. This data connectivity is also critical to delivering key population health drivers—risk stratification, identifying care gaps, and targeted outreach—so teams can intervene earlier, before issues become acute.

Hardwire governance so improvements stick.
Establish a clear operating rhythm and ownership for performance metrics, often led by a triad of clinical, operational, and technical leadership. This keeps teams aligned on targets, helps ensure accountability, and prevents regression to old habits.

Outcomes we have seen:

- Reporting lag reduced from weeks to minutes, allowing leaders to act as conditions change.
- Performance gains are sustained longer when governance is assigned clear ownership and run as an operating discipline, not a one-time project.



Buying wisely: How to navigate the clinical technology ecosystem

Clinical operations leaders are being pushed to make technology decisions faster than ever. And it's a dual challenge: Choose great tools and build a coherent ecosystem that supports workflow, data, and adoption across the patient journey. The categories below provide a practical way to frame vendor decisions and avoid systems that are redundant or don't integrate cleanly.

Vendor	What it supports	What's changing	Buying considerations	Common pitfalls
EHR and clinical departmental systems	**Clinical documentation, ordering, results, workflows (ED, OR, imaging, lab, pharmacy)**	• More pressure to standardize workflows and reduce customization • Interoperability expectations are rising • Growing demand for decision support and documentation relief directly inside clinician workflows through AI integration	• Where to standardize vs. customize • What stays in the EHR vs. departmental systems • Integration with other systems; governance	"Point solutions" proliferate without an owner and a clear path to scaling them
Medical devices and clinical engineering	**Device connectivity, monitoring, infusion, imaging equipment, maintenance, compliance**	• Device data is increasingly expected to feed real-time ops and documentation • Cybersecurity risks are expanding • More emphasis on using device data to anticipate equipment issues and intervene earlier	• Connectivity standards • Cybersecurity risks • Lifecycle management • Data integration with clinical systems	Device data exists, but never becomes usable for operational insights
Telehealth and virtual care	**Virtual visits, remote patient monitoring, virtual nursing, hospital-at-home support**	• Virtual care is shifting from "channel" to "care model," with staffing and strategy implications • Scaling depends on better digital intake and early identification of patients who need escalation	• Which cohorts and workflows will be touched • Integration with scheduling, documentation, and care coordination	Virtual care stands alone and increases fragmentation
Workforce management	**Scheduling, timekeeping, staffing optimization, labor analytics**	• Push for demand-based staffing and better visibility into productivity without increased reporting burden • Forecasting and predictive schedule optimization that can reduce premium labor and improve coverage	• System of record vs. point solutions • Integration with finance/ERP/EPM systems • Adoption by frontline leaders	Multiple tools measure labor differently—and there is no single trusted view
Data, analytics, and reporting	**Enterprise reporting, operational dashboards, quality metrics, performance management**	• Expectation that "decision-ready" data will move faster • More cross-functional KPIs • Leaders want self-serve answers and earlier visibility into anomalies instead of waiting on analysts and static reports	• Identifying a single source of truth • Data governance, interoperability, definitions, and real-time vs. batch needs	Lack of trust in data slows decision-making
Financial transparency	**Processes that make costs clearer and keep care plans on track—before, during, and after care**	• Financial steps are activated earlier in the pathway • Tighter linkage to discharge and post-acute handoffs • More focus on preventing rework that pulls care teams off the floor	• Integration with scheduling, care management, and discharge flows • Real-time authorization status visible to the care team • Patient-friendly estimates that reduce confusion and cancellations	Clearance and authorizations sit outside care workflows

How KPMG can help:

We work with health systems to strengthen clinical operations with practical, outcomes-focused support. We help leaders align access, throughput, workforce performance, care delivery, and revenue cycle enhancements so that progress in one area reinforces the others.

- **Patient access and experience:** Improve scheduling, referrals, and contact center performance using leading practices, playbooks, and analytics to reclaim capacity and reduce patient friction—including our patient access framework and analytics tools.
- **Throughput and length of stay:** Strengthen patient flow—bed placement, discharge readiness, operating rhythms, and escalation paths—to reduce avoidable delays and free up capacity.
- **Workforce performance:** Redesign roles and workflows so clinicians spend more time on care and less on administrative work, supported by targeted automation and AI augmentation such as ambient documentation support, workflow prompts, and decision support.
- **Care model innovation:** Define and scale hospital-at-home, virtual nursing, and right-site-of-care strategies with clear clinical criteria, transition planning, and performance tracking.
- **Clinical and utilization integrity:** Reduce denials and rework by improving front-end clearance, documentation accuracy, and clinical documentation integrity, integrated into day-to-day operations rather than treated as a back-end clean-up effort.
- **Systems and data foundation:** Align systems, data, and reporting so leaders can act on one version of the truth, supported by governance that helps improvements hold over time.

Where to start:

If you're ready to learn more—and you want to move quickly—we can help you identify which operational constraints are limiting capacity and margin most, and then build a practical, prioritized roadmap to address them.

About the team

The KPMG LLP clinical operations team is anchored by clinicians, operators, and technology specialists with experience supporting hospitals and health systems across performance improvement, access transformation, care delivery redesign, and revenue cycle efforts. We work side by side with client leaders to diagnose constraints, redesign workflows, implement practical improvements, and set up governance and measurement so gains last.

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