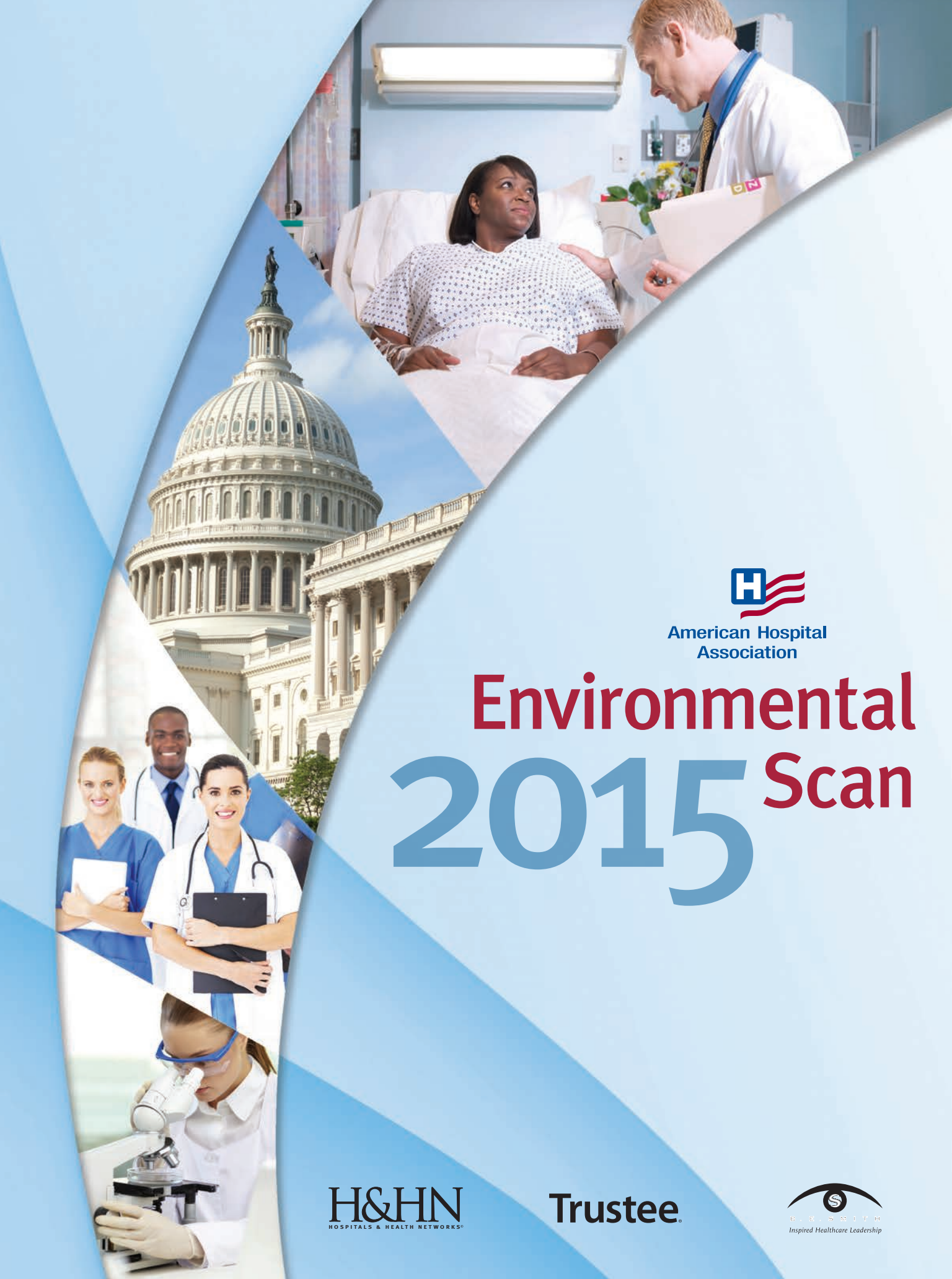

American Hospital Association

Environmental 2015 Scan

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The 2015 American Hospital Association Environmental Scan provides insight and information about market forces that have a high probability of affecting the health care field. It is designed to help hospital and health system leaders better understand the health care landscape and the critical issues and emerging trends their organizations likely will face in the foreseeable future. The 2015 Environmental Scan foldout is compiled from nationally recognized sources with recommendations from select AHA governance committees. The scan is produced by Gene J. O'Dell, the AHA's vice president for strategic planning and performance excellence, with assistance from Donna J. Aspy, planning and operations manager LBD. Lee Ann Jarousse, *H&HN*'s senior editor of custom publications, compiled the information.

Consumers & Patients

- **With 78 million baby boomers expected to live longer**, many with chronic conditions, providing adequate care for them continues to put pressure on the U.S. health care system. According to the Administration on Aging, a 65-year-old person can expect, on average, to live to the age of 84, the highest life-expectancy rate for Americans in history. Palliative care, a rapidly growing field, likely will fill many of the gaps in health care coverage in the future. (1)

- Cost-shifting is impacting affordability for many Americans. **The percentage of workers with high-deductible plans** increased from 4 percent in 2006 to 20 percent in 2013. The average patient deductible has nearly doubled since 2006 and the typical plan deductible now exceeds the typical family's available savings. (2)

- Only 10–15 percent of an individual's health status is attributable to the health care services he or she receives. The rest is driven by behavior, genetics and social determinants, including living conditions, access to food and education status. That means that the **trillions of dollars the United States spends on health care services contribute to only one-tenth of the nation's health**. An individual's behavior is, by far, the single most important contributor to his or her overall health. (3)

- Nearly 70 percent of organizations that report a transition toward value-based contracts by payers in their markets also reported an **increase in consumerism** by patients through such actions as asking for more price transparency, challenging orders for tests and negotiating payments. (4)

- Nationally, 42.5 million adults 18 or older experienced a mental illness in the past year, corresponding to a rate of 18.2 percent. In 2012, only 62.9 percent of adults with serious mental illness (6 million) had received **mental health treatment** nationally in the past 12 months. (5)

Insurance & Coverage

■ **America's corporations are moving their employee health plans from defined benefit to defined contribution structures**. Fifty-seven percent of small firms with three to 199 workers and 99 percent of firms with 200 or more workers offer health benefits. [12]

■ Many exchange carriers are offering **limited provider networks**. Narrow networks allow insurers to reduce premiums as they exclude the most expensive providers and negotiate steep discounts with those who remain. Consumers will like the low premiums, but will be unhappy to learn that their doctors are not available and shocked to discover charges from out-of-network specialists when they go to in-network hospitals. Until now, most Affordable Care Act reforms have brought real benefits with few visible costs. [13]

■ Early signs of consumer behavior in private exchanges indicate that employees are likely to "buy down" on covered plan benefits to achieve a lower-priced premium. The effect of less generous employee health benefits and providers' exclusion from networks will be less generous and less frequent reimbursement for many doctors and hospitals. Surveys indicate that **nearly 30 percent of employers anticipate moving to private exchanges** during the next three to five years. [4]

■ **Carriers are adapting to affordability imperatives by actively excluding some higher-cost hospitals** while collaborating more closely with those hospitals willing to accept lower reimbursement rates. Seventy percent of hospital networks offered predominantly through public exchange products are "narrow" or "ultranarrow." By definition, broad networks exclude less than 30 percent of the largest hospitals in the area, narrow networks exclude 30–69 percent, and ultranarrow networks exclude 70 percent or more. [4]

Physicians

■ **Physician leaders' primary responsibility** can be described as building and maintaining a culture of accountability, a culture of commitment to excellence in care and service delivery and resource stewardship, and a culture of continued performance improvement. [9]

■ The evolution away from payment for volume of service and toward payment for value can be seen as threatening to both physicians and hospitals that historically have been rewarded for delivering more services. Yet, **value-based payment both creates incentives for integration and enhances the quality and cost efficiencies** that can be achieved through integration for patients, communities and providers themselves. Payers should move forward in developing these models and seeking relationships with institutions with the interest and capability to jointly manage care. [14]

■ The economic feasibility of an independent medical practice will continue to evaporate. The aggregate impact of declining reimbursement, growing practice overhead, mounting regulatory mandates and student loan debt is escalating physicians' pessimism about the economic feasibility of working in private practice. While estimates of physician employment vary, **more than 75 percent of physicians could be employed by hospitals or other health care companies before the end of this decade**. [8]

■ Several **cultural barriers** that may be encountered as a physician practice is acquired by a hospital include: lack of trust of unknown hospital-appointed physician leaders, imposition of measures and procedures without consensus, changes in profitability, shifts in staff loyalty, loss of relationships with team members in a more matrixed system, loss of referral networks, lack of connections and collegiality with specialists, and concern that the hospital is not providing help to improve quality in ways important to the practice. [9]

Political Issues

■ **Aligned payment strategies** will continue to evolve and become more pervasive in all markets. More formal collaborative solutions, such as accountable care organizations and patient-centered medical homes, also will expand in scope and scale, as insurers increasingly see the need to give providers the administrative, technical and clinical support necessary to fully realize the potential of payment models. Under certain scenarios, additional hospital systems and insurers may align more closely through joint ventures, mergers or acquisitions that approach or achieve more integrated delivery. (15)

■ **No member of Congress ever directly attacks the Medicare budget**; it's the "third rail" of American politics. But, at the same time, it turns out that the attack on the federal deficit is more of a bipartisan effort than one might have expected. The Republicans are clearly deficit hawks but, apparently, Democrats support at least a reduction in the size of the projected deficit. Both political parties are more than happy to reduce health care expenditures to get there. There are macroeconomic issues that are top of mind both economically and politically. And these issues are seemingly more powerful than any historical support for both Medicare and Medicaid. (4)

■ The Commonwealth Fund's "Scorecard on State Health System Performance, 2014," assesses states on 42 indicators of health care access, quality, costs and outcomes over 2007–2012. **Changes in health system performance were mixed overall**. In a few areas that were the focus of national and state attention — childhood immunizations, hospital readmissions, safe prescribing, and cancer deaths — there were widespread gains. But, more often than not, states exhibited little or no improvement. Access to care deteriorated for adults, while costs increased. Persistent disparities in performance across and within states and evidence of poor care coordination highlight the importance of insurance expansions, health care delivery reforms and payment changes in promoting a more equitable, high-quality health system. (16)

Provider Organizations

■ **Successfully integrated organizations have developed a broadly shared institutional culture**, rooted in a jointly developed common vision and characterized by a strong set of values. These values support the organization's mission and serve as "touch points" to help resolve the inevitable conflicts that arise among "partners." They include: a broader concern for both the quality and cost of services delivered to a defined population; a sense of responsibility for the long-term success and reputation of the organization that feels like "ownership" but transcends the details of organizational structure or legal ownership rights; and a commitment to performance measurement transparency and to performance improvement through collective action. (14)

■ Brand loyalty will become increasingly important, as it is in every other consumer-oriented field. **Private capital will flow readily to support organizations that deliver a positive consumer experience**. (3)

■ In the near future, **a new force could drive health care utilization upward**: the one-time effect of up to 30 million people gaining insurance coverage for the first time under health care reform. In a study on hospital utilization we found: Insurance status could well drive an increase of about 30 percent in inpatient utilization; increased coverage may actually cause emergency department utilization rates to rise by 15 percent, and the acquisition of insurance coverage could increase utilization of outpatient elective services by about 40–70 percent. (17)

■ **Eighty-six percent of health care chief executive officers believe technological advances will transform their businesses in the next five years**. And they're far more conscious than other CEOs of the huge role demographics will play — 84 percent see it as a transformative trend, compared with just 60 percent across the sample; and 94 percent plan to alter their customer growth and retention strategies. (18)

Quality & Patient Safety

■ There is solid evidence that **leadership engagement and focus drives improvements** in health care quality and reduces patient harm. Leaders at all levels in care delivery organizations are struggling with how to focus their leadership efforts and achieve Triple Aim results for the populations they serve. High-impact leadership requires leaders to adopt four new mental models: (1) individuals and families are partners in their care; (2) compete on value, with continuous reduction in operating costs; (3) reorganize services to align with new payment systems; and (4) everyone is an improver. [19]

■ Rising health care costs are an important determinant of the nation's fiscal future, and they also affect the budgets for states, businesses and families across the country. **Health care costs now approach a fifth of the economy**, and careful reviews suggest that a significant portion of those costs does not lead to better health or better care. [20]

■ **Medicare readmission rates have declined substantially since 2011** to less than 18 percent. This reduction resulted in approximately 130,000 fewer hospital readmissions between January 2012 and August 2013. [2]

■ **Consumer Reports** found that **patients in the country's top-rated hospitals are 34 percent less likely to die following surgery than in some lower-ranked hospitals**. Researchers used government reports on five different categories to rank almost 2,500 U.S. hospitals, using criteria such as death rates, readmissions, overuse of CT scans and rates of infections in the facilities, the magazine reported. Also, according to the report, only 35 hospitals earned a top rating in terms of ensuring that a patient admitted for a heart attack, heart failure or pneumonia did not die within 30 days of admission; and 66 hospitals received a low rating in this category. [21]

Transforming Care Delivery

■ As a result of unsustainable costs and an inordinate share of GDP, **the U.S. health care system has a new business model** — one that is transforming the delivery system from hospital-centric sick care to a super outpatient model that will emphasize community-based care. [22]

■ No one knows how big a health system needs to be to survive in the new marketplace, but the days of stand-alone hospitals likely are numbered — many of them are under considerable stress. Strategically, we are seeing providers increasing scale by engaging in horizontal integration (hospital-hospital acquisitions) and forming much larger entities to better collaborate, prioritize programs, increase purchasing power, consolidate services and cut costs. We are also seeing more vertical integration. **Hospitals are becoming true health systems**; they are buying physicians' practices, ambulatory centers, diagnostic centers, home care services, and durable medical equipment and wellness companies. [23]

■ **Providers will be under tremendous pressure** due to lowered reimbursement rates and increased patient volume from health insurance exchanges and expanding Medicaid rolls. Some health systems are approaching the challenge by trying to reduce costs by 20–30 percent overall. [23]

■ In the struggle to manage the cost of health care, **practitioners and policymakers increasingly are focusing on value — delivering the best possible health outcomes at a given level of cost**. We call this development competing on outcomes. The advantage of competing on outcomes is that it focuses competition on what really matters to patients and what ought to be the purpose of any health system: delivering high-quality care in a cost-efficient fashion. Transparency of patient results can align incentives so that payers, providers, suppliers and patients all work toward the same goal, making it possible for the market to effectively manage the trade-offs between cost and quality. [24]

Science & Technology

■ **Health care is moving toward a precision-based model — or "personalized medicine."** As a result of greater understanding of the human genome, together with other personalized technologies, the industry will likely transform — as have many other industries — to one that is predictive, personalized, participatory and preventive. mHealth will be a major factor in providing personal toolkits that, ultimately, will help to manage predicted vulnerabilities, chronic illness and episodic acute conditions. Enabled by technology, connectivity and data, mass customization is on the horizon, allowing mHealth solutions to flourish. (6)

■ Predictive analytics hold much promise for a health care industry that must demonstrate value in an increasingly competitive environment. **The potential of technology to positively impact patient care and coordination is profound**. Technologically, versatile computer systems can be tailored to predict when a patient is at risk of a chronic illness, the likelihood he or she may return to the hospital or even whether a more dire diagnosis looms. Most importantly, this technology can help both patients and clinicians to make informed decisions, and provide access to actionable information. (7)

■ **Technology is mobilizing health care as never before**, and the expectations of a younger, more diverse and more sophisticated workforce demand innovation. (8)

■ At Geisinger, **technology has helped to spark patient activation** through the Open Notes program, which allows patients to review and comment on notes in their EHRs. Data thus far indicate 90 percent of patients review visit notes, 60 percent log in multiple times and 25 percent correct errors in the record — showing potential to fundamentally redefine the relationship between patients and providers. (9)

Economy & Finance

■ Negative pressures at U.S. nonprofit hospitals and health systems are accelerating and, after a period of strong and steady recovery from the recession and financial crisis of 2008, **the outlook for the sector is now negative**. The negative outlook is due to a multitude of factors, including: top-line revenue constraints leading to operating margin and coverage compression; the impact of health care reform readiness activities; soft demand, particularly for the financially important inpatient business; and the emerging changes in the payment environment, to value-based payments from fee-for-service payments. (10)

■ **Growth rates in hospital prices**, historically a large driver of overall health care prices, reached near-historic lows in 2013. Recent trends in hospital consolidation have not led to higher growth in hospital prices over the past several years (just 1.5 percent from December 2012 to December 2013). (2)

■ Despite a recent slowdown in the rate of medical inflation, many experts believe **the longer-term trend of health care costs significantly outpacing inflation will re-emerge** and, over the long haul, will result in an ever-greater share of U.S. gross domestic product spent on health care, which could hurt the economy. (10)

■ For both for-profit and nonprofit hospitals, a decline in the number of uninsured individuals as a result of health care reform will reduce bad debt, a credit positive. But as out-of-pocket costs to patients increase, **volume likely will remain weak**. And mergers and acquisitions will continue apace, which would be credit negative for acquirers but credit positive for struggling smaller institutions. (11)

Workforce

■ Hospital **CEO turnover** increased in 2013, tracking at 20 percent, according to a recent report from the American College of Healthcare Executives. The annual rate has fluctuated between 14 and 18 percent in the decade prior to 2013. The increase in turnover rate may be indicative of a combination of factors, including an increased number of baby boomers' seeking retirement, the emerging trend toward consolidation in our industry, and the complexity and amount of change going on in health care today. [25]

■ **Health care CEOs recognize that they'll need to build a workforce to cope with tomorrow's markets**: 53 percent want to hire more people in the next 12 months alone, and 63 percent are concerned about finding people with the right skills. [18]

■ Workplace wellness programs are increasingly popular. Employers expect them to improve **employee health and well-being**, lower medical costs, increase productivity and reduce absenteeism. [26]

■ Private-sector health care employment was essentially flat, falling by 400 jobs, according to the Bureau of Labor Statistics Employment Situation Summary released in February 2014. This is well below the 24-month average gain of 18,500. The health share of total employment fell slightly, from 10.63 to 10.62 percent. **Hospital employment lost 4,500 jobs**, compared with the 24-month average gain of 1,100. Ambulatory health care services added 9,000, well below the 24-month average gain of 14,800. And nursing and residential care facilities lost 4,900, well off the 24-month average gain of 2,600. [27]

■ In recent surveys, **44 percent of employers indicated that they are considering offering only high-deductible health plans**, while 45 percent are contemplating moving to a private insurance exchange. Defined contribution plans likely will follow. [6]

Information Technology and eHealth

■ **Data interoperability** across electronic health record systems remains a substantial barrier to the development of a robust health IT infrastructure to support new care models and to health information exchange among providers and with patients to support patient care. [20]

■ Coordinating care for patients with complex health conditions who see multiple physicians can be supported by better IT interoperability. The primary care team may be in the best position to coordinate a patient's care, but it will often need information from other providers. **Most current EHRs don't adequately support data exchange** across providers and settings, so practices communicate with outsiders primarily on paper. To support information exchange, EHRs must present data in standard ways, and separate organizations providing services for the same patient need to share information securely. [28]

■ **IT will be the major platform or strategy for advancing organizations in the new payment and delivery world**. Truly progressive organizations make integral use of data to develop and provide evidence-based care, to build data warehouses and analytic capabilities to predict health care outcomes, and to manage population health. [29]

■ The mobile health industry continues to grow year by year, but EHR adoption disrupted that growth a bit in 2013, according to a survey by athenahealth and Epocrates. In a survey of 1,200 health care professionals, it was apparent that a **push toward EHR implementation** in 2013 saw more doctors on computers. Ironically, that slightly decreased the number of doctors who started using tablets and mobile phones. [30]

What the experts have to say....

Gene O'Dell
AHA vice president, strategic planning and performance excellence, Chicago, producer of the 2015 AHA Environmental Scan

What are the new trends and key findings in the 2015 Environmental Scan?

Some key themes in the 2015 Environmental Scan reflect the transformation of the health care industry. Mergers, consolidations and other partnerships are increasing in response to payment pressures to reduce operating expenses and achieve economies of scale. For hospitals and health systems to gain a competitive advantage, they must adopt performance improvement strategies to achieve higher-quality patient outcomes and maximize operational efficiencies. Meanwhile, retail providers and disruptive innovators will challenge the traditional provider delivery model. And consumers are becoming increasingly assertive in when, where and how they want to receive care, and at what price.

Jim Hinton
President and CEO, Presbyterian Healthcare Services, Albuquerque, N.M., and chair of the AHA

How has Presbyterian's strategic planning process evolved during your tenure as CEO?

Three areas come to mind: the rigor of our process, the complexity of the strategic questions and the time horizon of the plan. Our organization has always invested significant time and resources into strategy. However, over the past 10 years, we've established an intentional rhythm in which we gather information and input and synthesize it into an annual plan. As for complexity, we evaluate both the short- and long-term benefits and impacts of our decisions and we do it across the spectrum of integrated delivery and financing. Our management and board have an increasing tolerance for uncertainty in today's environment. Perhaps, as a response to uncertainty, we have tightened up the time horizons of our plans. When I started as CEO, it was not uncommon to have a five- to seven-year strategic plan. Now, we certainly have long-range direction, but we fine-tune, adjust and introduce a revised plan every year.

Christine Gallery
Vice president, planning and chief strategy officer, Emerson Hospital, Concord, Mass.

What are the keys to a dynamic strategic planning process?

Dynamic strategic planning provides direction and guidance for an organization that operates in an ever-changing environment. It is a blueprint or framework within which organizational efforts can be coordinated and prioritized. This prioritization informs an organization as it allocates limited resources. The keys to a successful planning process are: to ensure that efforts are embraced and led from the top; that all key stakeholders in the organization are truly engaged in the process and rich dialogue is occurring; and that the plan is both aspirational and achievable.

How can hospitals effectively evaluate their strategic planning process to ensure that they receive the most benefit?

A strategic plan is not meant to be fixed and to detail every action that will be taken over the coming years. Rather, it is fluid and flexible, leaving room for tactical improvisation and quick response, where needed, to a rapidly changing environment. It should be thought of as a road map that identifies an endpoint rather than exactly how to get there. Today it's important to build change into the plan and have the ability to adapt it in real time because the world and markets are changing so quickly.

On the **Web**

2015 Environmental Scan webcast @ www.hhnmag.com
Hear AHA President and CEO Rich Umbdenstock and Vice President of Strategic Planning and Performance Excellence Gene O'Dell discuss critical issues and emerging trends that have the highest probability of impacting the health care field — and hospital leaders — in the foreseeable future.

The webcast will be available in January 2015.
View it on demand at your convenience at www.hhnmag.com.

Rich Umbdenstock

Gene O'Dell

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