American Hospital Association

ENVIRONMENTAL SCAN

2016

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The 2016 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 2016 Environmental Scan is compiled from nationally recognized sources with recommendations from select AHA governance committees. Notable this year is the pace of change health care markets are experiencing and is a common theme running throughout the topics presented in the Environmental Scan. Moreover, health care also is a local phenomenon, with the pace of change being relative and varying from market to market.

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, leadership and business development. Lee Ann Jarousse, *H&HN*'s senior editor of custom publications, compiled the information.

CONSUMERS & PATIENTS

■ **Effectively managing the care of patients with chronic illnesses is critical** to bending the curve of health care spending in the United States. Nearly half of all Americans have at least one chronic illness or more. For those age 65 or older, the figure is 85 percent. People with chronic illnesses cost the health care system $1.5 trillion, or about 75 percent of total health care expenditures. [1]

■ **Individuals with mental illness are among the highest-need, costliest patients in the U.S. health care system,** yet they receive inadequate behavioral health care. Researchers have proposed various models that integrate behavioral health with primary care. These approaches have the capacity to improve patient care and outcomes in terms of both physical and behavioral health. However, the limited availability of behavioral health providers has been a major implementation obstacle. [2]

■ **Depression is the leading cause of disability worldwide,** and is a major contributor to the global burden of disease. Serious mental illness costs America $193.2 billion in lost earnings every year. Approximately 60 percent of adults with a mental illness received no mental health services in the previous year. [3]

■ The health care sector will begin to look and feel like those of other industries, catering to customers who expect one-click service. **A true consumer-driven market is slowly taking shape.** Patients are leading the way, bearing more of the cost of their own care — and making more care decisions. Patients are no longer satisfied with just meeting with their doctors. Increasingly, they expect to access lab results on their phones soon after leaving the medical center. [4]

■ High-cost patients will be the focus of a U.S. health care industry under pressure to contain costs. **Among the most costly patients in America are the dual eligibles** — approximately 9.6 million individuals who qualify for both Medicare and Medicaid. In 2010, the Medicare fee-for-service program spent an average of $19,418 on each of these patients, compared with $8,789 on other beneficiaries. [4]

INSURANCE & COVERAGE

■ The Centers for Medicare & Medicaid Services estimates that **Medicare and Medicaid enrollments will grow** by 57 and 71 percent, respectively, from 2006 to 2022, whereas enrollment in private insurance will grow by only 6 percent. [5]

■ PricewaterhouseCoopers estimates that **50 percent of health systems have applied or intend to apply for an insurance license.** [6]

■ When we asked privately insured adults with deductibles if they could afford them, more than **two of five (43 percent) said their deductible was somewhat, very difficult, or impossible to afford.** One rationale for adding deductibles to health plans is that they will create disincentives for consumers to use health care that might be of limited value, thereby lowering costs and limiting premium growth over time. But the survey finds evidence that deductibles also create disincentives for people to get needed care. [7]

■ While relatively few covered workers at large employers currently receive benefits through a **private or corporate health insurance exchange** (3 percent), many firms are looking at this option. Private exchanges allow employees to choose from several health benefit options offered on the exchange. Thirteen percent of large firms are considering offering benefits through a private exchange and 23 percent are considering using a defined contribution method. [8]

■ Over the past few years, forces have been aligning to make offering a health plan look increasingly attractive to health systems. Today, **13 percent of all U.S. health systems offer health plans** in one or more markets. However, history has shown that it is quite difficult to reach the level of payer-provider integration needed to succeed. A key challenge is ensuring that the provider-led plan offers a differentiated value proposition and strong branding, especially if it includes a narrow network. [9]

■ **PPO plans remain the most common plan type,** but enrollment in high-deductible plans with a savings option has increased significantly. [8]

PHYSICIANS

■ The transformation of health care toward more integrated and accountable delivery systems has brought **physician practices and other physician enterprises** into health systems, as partners and collaborators, in unprecedented numbers. With this shift has come a need to rethink and engage the leaders of these medical enterprises in new roles, including their participation in physician organization governance. [10]

■ High-performing organizations are increasingly **reporting to physicians how their personal performance compares with that of their colleagues** and providing those data in ways that intensify peer pressure. Some organizations now post individual physicians' quality-performance data publicly on their websites. Whether consumers are using these data to make decisions is unclear, but doctors, knowing that their performance is on public display, are strongly motivated to improve. [11]

■ **U.S. physicians typically are not trained to meet patient needs related to problems that are not fixable —** for example, frailty, aging, gradually worsening chronic illness or terminal illness. Two critical skills for clinicians to gain are how to ask the patient questions and how to listen to what the patient says, preferably with the physician talking less than 50 percent of the time during the patient's visit. [12]

■ **In the United States, we have more specialists than generalists.** While increasing the number of primary care physicians has been linked to lower mortality rates, increasing the supply of specialists has not. The reimbursement system, professional lifestyle and our beliefs about expertise reward specialty care physicians over primary care, creating a perverse incentive to create more specialists. [13]

■ Physicians anticipate that **value-based payment models will equal about 50 percent of their total compensation** in the next 10 years. But they are reluctant to participate, preferring the status quo, and are concerned about the consequences of financial risk (e.g., being held accountable for things out of their control). [14]

POLITICAL ISSUES

■ The Obama administration pledges to **tie 50 percent of payments to quality by 2016.** This announcement commits Medicare to fast-track the much more sensible approach of tying payments directly to the quality of care delivered to the patient. On the other hand, the plan heavily relies on the success of accountable care organizations — success that has yet to be fully realized. [15]

■ **Health & Human Services Secretary Sylvia Mathews Burwell** announced a bold initiative aimed at moving half of all Medicare payments away from traditional fee-for-service reimbursement by 2018 and replacing it with incentive-based payments encouraging higher quality and lower costs. Of broader significance than this initiative, potentially, is a shift in Medicare's role from a bill payer to a more proactive force, with the program using its purchasing power and leverage to drive positive change not only through Medicare, but also in the private sector. [16]

■ The American Hospital Association argues that **recovery audit contractors** have chosen to focus on inpatient claims because of the financial incentives created by these contingency fees. Inpatient claims are generally high-dollar compared with outpatient claims and, therefore, make the most lucrative targets for a contractor that receives a percentage of the claims it denies as improperly paid. [17]

■ **MedPAC recommends limiting payments to hospital outpatient departments.** MedPAC states as its general position that Medicare should base payment rates on the setting in which beneficiaries have adequate access to care at the lowest cost to the program and beneficiaries. Hospitals submit yearly data reports to Medicare that allow CMS and others to compare actual costs incurred by the hospital with the amount paid for the services provided. There are no similar centralized sources of data on the cost of performing services in other settings to help determine which payment system most accurately reflects the cost of providing services. In addition, differences between payment systems, and which items are covered by a single payment complicate the application of rates from one system to another. [18]

PROVIDER ORGANIZATIONS

■ There are **isolated pockets of extreme need in rural U.S. communities where conditions are ripe for more-for-less innovation.** These communities are facing a health care crisis because economic and regulatory pressures are pushing providers to cluster in urban centers. The consequences are dire. Last year, 13 rural hospitals closed, and a tidal wave of closures is expected over the next few years. These hospitals are caught in a vicious cycle: Rural patients with serious health problems are traveling to cities to seek care from medical specialists, causing revenue declines at rural hospitals and clinics, which respond by downsizing and offering fewer services, causing more patients to seek care in major urban centers. Virtual consultations, supported by sophisticated diagnostic instruments, high-resolution imaging and data security, are at the heart of a reconceptualization of rural hospitals (and, eventually, urban clinics and hospitals as well) because they provide access to higher-quality care at much lower costs. [19]

■ Huge opportunities to improve patient outcomes and lower costs remain to be realized from **benchmarking and standardizing clinical practices.** Physicians, nurses and other caregivers often do not know the costs associated with their treatment protocols. And administrators rarely collaborate with them to develop outcome and cost measurements that would facilitate benchmarking and opportunities to share best practices. The only sustainable way to reduce costs is to start with an in-depth analysis of the current processes used to treat each medical condition. Clinicians and administrators need to fully understand all the costs incurred over a full cycle of care, and the outcome for each treatment their facility provides. [20]

■ Being champions for healthier communities in and outside the boardroom is an important way participants said boards contribute **value through governance.** New board work also may require new governance structures, such as adding a community benefit or population health committee. Boards can help to build healthier communities by taking a more active role in the community as well. [21]

QUALITY & PATIENT SAFETY

■ The **OpenNotes Collaborative,** now being utilized by more than 3 million patients, brings transparency in health care to a new standard by making the physician's notes available to the patient. The initiative not only brings true partnership to the doctor-patient relationship, it also enhances safety, as patients point out erroneous details, more easily remember to follow up on important information, and have an opportunity to go back and review discussions and information, rather than frantically trying to grasp it all in a 15-minute office visit. At the end of the initial trial, both physicians and patients reported being happier and more satisfied. [22]

■ Most physicians are enthusiastic about **limiting access to expensive tests** that have little or no benefit as a way to curb excessive health care costs. Nevertheless, nearly three-quarters of doctors believe that the average physician orders unnecessary tests at least once per week, most often stemming from fear of lawsuits and general clinical uncertainty. The Institute of Medicine estimates that unnecessary services represent about 10 percent of all U.S. health care spending — nearly $300 billion a year. [23]

■ **States across the country are promoting integrated care delivery** as part of their efforts to deliver high-quality, cost-effective care to Medicaid beneficiaries with comorbid physical and behavioral health conditions. State efforts to ensure that Medicaid beneficiaries have access to integrated care, however, are hindered by a fragmented behavioral health system that is administered and regulated by multiple state agencies and levels of government, and by purchasing models that segregate behavioral health services from other Medicaid-covered services. There is a large body of evidence showing that patients fare best when their physical and behavioral health needs are addressed in tandem. [24]

■ The Centers for Disease Control and Prevention reported that approximately **half of all antibiotic prescriptions are either unnecessary or used inappropriately.** This practice exposes patients to unnecessary side effects and can increase the prevalence of drug-resistant bacteria. [25]

TRANSFORMING CARE DELIVERY

■ **Walmart, Walgreens, CVS and other retailers** are expanding their primary care clinics and planning to move into chronic disease management. These same companies and others are increasingly channeling patients to a select few providers. Walmart, for example, offers its associates the option of heart, spine and transplant surgery at six leading medical centers including the Cleveland Clinic, Geisinger and Virginia Mason, with no out-of-pocket costs. [5]

■ **Nontraditional health care clinics are growing** because of accessibility and convenience. Urgent care centers have become a $13 billion market and the rise of retail clinics in drugstores and other locations has been dramatic, doubling between 2012 and 2015. [6]

■ **Hospitals need to move rapidly to make strategic calculations**. With their deep roots in acute care, hospitals face a steep challenge to identify how inpatient facilities will need to change, the appropriate channels for outpatient care, and — least familiar of all — the specific virtual care options they should offer. At the same time, hospitals need to make the even more difficult determination of calibrating all of these channels. Hospitals have to make these decisions in the midst of constantly changing purchaser expectations, technological capabilities and competitive pressures. [26]

■ Technological advances, empowered consumers, disruptive new entrants and rising demand by an aging population are ushering in **a new era in health care.** While many of those trends have been emerging for some time, never before have they been accompanied by a rapid shift in dollars, triggering major changes in behavior and fundamentally altering the business. Successful organizations will squeeze out administrative waste, improve the health of entire communities, reduce costly errors, better manage chronic conditions, understand consumer preferences or develop targeted therapies with proven advantages for a given patient group. Transparency in cost and quality will fuel these developments. [27]

■ Although hospitals **have long sought to achieve patient satisfaction and loyalty**, they have minimal experience with the more intense demands of consumers who are spending their own money. [28]

SCIENCE & TECHNOLOGY

■ **Video consultations** are projected to grow from 5.7 million in 2014 to 130 million by 2018. Geisinger has found that telemonitoring of patients improved the efficiency of care managers and delivered a 3.3 times return on Geisingers investment. [6]

■ **Technology-enabled care delivery** also may help to constrain health care spending and can play a role in payment models that hold health care providers accountable for the quality and cost of care. There has been an influx of venture capital to support the development of tools, such as data-mining applications, that can be used by accountable care organizations and others working to improve the efficiency and effectiveness of their operations. [29]

■ Every major company from Google to Samsung to Apple is working on **biometric devices.** Devices will be measuring your blood chemistries, vitamin levels, blood pressure, heart rate and everything else. This is going to become a world in which the patient is enabled to make his or her own choices in health and health care. The relationship he or she has likely will be with a Samsung or an Apple, not with a provider. [30]

■ Our research suggests that **telemedicine promises to upend health care markets where supply and demand are out of balance.** Close to 300,000 rural veterans tap into the extensive telemedicine network maintained by Veterans Affairs. Mayo Clinic in Arizona, applying a hub-and-spoke telemedicine model to provide neurological consulting for emergency treatment of stroke patients at 16 rural hospitals in four states, has reduced the need for air and ground ambulance transfers and significantly improved patient outcomes. [19]

■ **The charge for a day in the hospital in the United States averages more than $4,500.** With the technology that now exists for continuous monitoring of a patient's vital signs in the comfort, safety and reduced cost of his or her own home, a shift from in-hospital to at-home monitoring increasingly appears likely. Hospitals will need to gear up for the capability of becoming data surveillance centers, which markedly extends current information system demands. [5]

ECONOMY & FINANCE

■ **Health care providers expect that the industry shift to value-based contracts will negatively impact their respective organization's bottom line.** When asked about the risk involved in moving to value-based contracts, 17 percent of hospital, system and physician practice providers said they expect a big drop in operating income. Only 4 percent were optimistic that the new model would result in a large rise in reimbursement. [31]

■ **Expense growth now outpaces revenue growth** due to softness in volumes, transition to lower-cost services, diminishing returns on expense-control initiatives, a shift to lower-reimbursement care models, and other factors. Accounts receivable days are now increasing due to factors including new IT systems, a rise in Medicaid payment delays, and an increasing number of patients with high-deductible plans and large co-pays. [32]

■ Preliminary estimates indicate that **national health spending grew by 5 percent in 2014.** The health spending share of the gross domestic product was 17.8 percent in December 2014. This is up from 16 percent at the start of the recession in December 2007. Since December 2007, real health spending (using the GDP deflator) through December 2014 has increased by 20.8 percent (an annual rate of 2.7 percent). [33]

■ **The outlook for the U.S. nonprofit health care industry in 2015 remains negative** as financial and business fundamentals will remain weak over the next 12 to 18 months, says Moody's Investors Service. Growth in operating cash flow will be weak, operating margins will continue to narrow and revenue growth will remain limited. Moody's projects that revenue growth for the industry will be slow, but steady, at 3.5 to 4.5 percent over the next several years. Operating margins will weaken further in 2015, as hospitals run out of ways to protect their margins and grapple with operating under two very different reimbursement models — the traditional fee-for-service model vs. emerging models that emphasize preventive care and avoiding hospital stays, such as those that are part of the Affordable Care Act. [34]

WORKFORCE

■ **A large proportion of primary care interactions involve mental health concerns.** For this reason, the trend toward integration of behavioral health in primary care likely will continue. Mental health professionals — such as clinical psychologists, licensed clinical social workers, marriage and family therapists, and even nurses and health educators with specialized training — will become a part of the primary care team. [5]

■ **Three-quarters of consumers say they would be comfortable seeing a nurse practitioner or physician assistant** for physicals, prescriptions, the treatment of minor injuries and ordering lab tests. Half would be comfortable going to a pharmacist instead of a doctor for some services. [4]

■ In 2015, the U.S. Bureau of Labor Statistics predicts that **millennials will be the majority in the U.S. workforce** and, by 2030, they will make up 75 percent of it, causing employers to refocus their employee benefit strategies. Leading employers are pursuing strategies and tactics aimed at specific cohorts of employees while providing all greater flexibility, convenience, relevance, education and guidance. [4]

■ **Health care is the most dangerous industry for injuries and illnesses,** with 653,000 nurses, aides, orderlies and others being injured or falling ill every year, according to a Public Citizen report. Among attendants, orderlies and nursing aides in 2011, the incidence rate of injuries requiring days off work was 486 cases per 10,000 employees, more than four times higher than the national average for all workers. More musculoskeletal injuries are suffered by orderlies, attendants, nurses and nursing aides than by workers in any other industry. Back injuries in the health care industry are estimated to cost more than $7 billion every year. [35]

■ The **supply of primary care nurse practitioners and physician assistants** is expected to increase by 30 percent and 58 percent, respectively, during the next five years. [4]

INFO TECH & eHEALTH

■ **Digital health technologies are rapidly proliferating:** There are some 40,000 mobile health apps, hundreds of platforms aimed at improving health care communication and coordination, and new types of medical sensors or wearable devices making headlines every week. Digital technologies that serve as a communication bridge between providers and consumers have the potential to disrupt the U.S. health care system by enabling consumers to get care and support when and where they need it, while also making their needs and preferences known. Unlike other sectors of the economy, the health care industry has yet to realize the potential of digital technologies. [36/29]

■ Almost **30 percent of clinicians aren't satisfied with the technology used by their organizations.** Of that number, 68 percent say the problems arise from different people using different technologies — those technologies might not work well together or create gaps that lead to security issues — and 55 percent indicate that not all members of the care team have access to the communications platform. Another telling statistic: For clinicians needing to communicate with another clinician about a patient's medical condition, the electronic health record is used as a communications platform only 12 percent of the time. [37]

■ While other industries have been far more successful at harnessing the value from large-scale integration and **analysis of big data**, health care is just getting its feet wet. The vast amount of data generated and collected by a multitude of agents in health care today comes in so many different forms — from insurance claims to physician notes within the medical record, images from patient scans, conversations about health in social media, and information from wearables and other monitoring devices. One of the earliest uses of big data to generate new insights has been around predictive analytics. These predictions may help to identify areas to improve both quality and efficiency in health care in such areas as readmissions, adverse events, treatment optimization and early identification of worsening health states or highest-need populations. [38]

What the experts have to say ...

Gene J. O'Dell
AHA vice president, strategic planning and performance excellence, Chicago, producer of the 2016 AHA Environmental Scan

What are the new trends and key findings of the 2016 Environmental Scan?

Retailers (e.g., Walgreens, CVS, Walmart) are proliferating in the primary health care market and have doubled their number of retail clinics since 2012. These disruptive innovators are now expanding into chronic disease management, which comprises about 75 percent of health care dollars, positioning themselves as fierce competitors for the most profitable health care dollars. Consumer-driven health care is becoming more relevant and driving new models of care delivery. Now, more than ever, consumers are looking to "own" their health and developing a trusted partnership with their doctors in medical decisions. Another important trend is that more health care organizations are taking on greater financial risk by owning their own health plans.

Jonathan Perlin, M.D.
president, clinical services and chief medical officer, HCA, Nashville, Tenn., and chair of the AHA

What is unique about HCA's strategic planning process?

HCA's planning process is unique, in part, due to HCA's size and scale. Given that HCA operates in 20 states, the United Kingdom, and in more than 40 U.S. markets, no single plan can meet the distinct needs of every community. As a result, HCA has planning processes at the enterprise, market and facility levels, as well as across several lines of business. From an enterprise level, the organization sets several overarching strategic objectives, many of which are based on observations of both national and local trends. These enterprise objectives are translated into a portfolio of strategic initiatives. Each market and facility develops its own strategic plan in alignment with the enterprise objectives, but tailored to its competitive environment. As the enterprise strategic initiatives are rolled out, there are some initiatives that are broadly implemented at the local level, while others are adopted by local management as appropriate based on their applicability to local dynamics.

Larry Margolis
managing partner of SPM Marketing & Communications, LaGrange, Ill., and president-elect, Society for Healthcare Strategy and Market Development, Chicago.

What are the keys to a successful strategic planning process for hospitals and health systems?

Some of the keys to a successful strategic planning process are as follows:

- First, know your point of view and who you want to be.
- Be prepared to disrupt yourself before someone does it to you.
- Remember, planning is all about focus and sacrifice.
- In today's environment, strategy is all about access.
- You must implement and then measure the results.
- Ultimately, strategy is a framework around which to improvise.

And, finally, strategic planning cannot be done simply in the CEO's office. It must be an inclusive process.

On the **Web**

2016 Environmental Scan webcast @ www.hhnmag.com
Hear AHA President and CEO Rick Pollack 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 2016.
View it on demand at your convenience at www.hhnmag.com.

Rick Pollack

Gene O'Dell

RESOURCES

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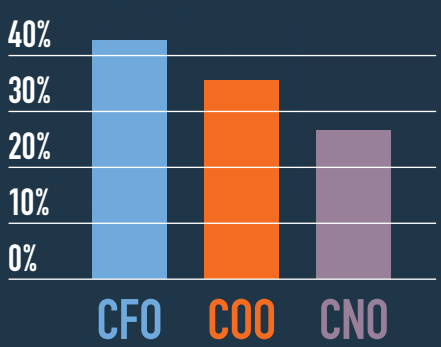
Proven Healthcare Leadership

CEO Turnover is on the rise.

The rate has increased from

— 14% in 2001 to 18% in 2014 —

and the effects of this turnover can be far-reaching. In a B. E. Smith executive survey, respondents indicated which executives are likely to leave after a CEO departure:



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