2014

Environmental Scan

American Hospital Association

The 2014 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 2014 Environmental Scan is compiled from nationally recognized sources with recommendations from AHA governance committees. The scan is produced by Gene J. O'Dell, the AHA's vice president for strategic and business planning, 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, edited the information.

Associations

● **Strategic planning is again the No. 1 trend among associations** (along with financial concerns) and continues to be a priority for most boards. More associations are using research, hard data and metrics, making for more realistic plans based on industry reality. [1]

● Many **younger members** think they can get most of what they need through social media channels and online resources. Hosting strong networks and content communities will be increasingly important to tether members to the association. [1]

● **Dues caps and maintaining fair dues structures continue to hinder trade associations** as more industry mergers and consolidations are on the horizon. Larger companies continue to leverage their participation, asking for more concessions and leadership participation. The association value equation stays front and center and will continue to play a key role in recruitment and retention efforts as members remain concerned with their pocketbooks. Associations continue to limp along with recruitment and retention efforts with many improving only slightly. [1]

● **Remarkable associations learn from and respond to change;** although willing to change, they also know what not to change. Their mission and purpose remain the touchstones. Members and mission are at the heart of remarkable associations, and member value is the blood that keeps the heart pumping. While seeking to build and maintain a strong relationship with their members, remarkable organizations never stop being inquisitive about how they can refine and enhance the value they provide. [2]

● **Data-driven strategies** refer to a continuous loop that remarkable associations tend to exhibit: they continually track member needs and issues as well as the wider environment, then collectively analyze the data to reach a shared understanding through asking, "What do we now know? What are we going to do about it?" These associations then incorporate the findings into their strategic and operational planning. [2]

Consumers & Demographics

● Without question, the single biggest force threatening U.S. work-force productivity, as well as health care affordability and quality of life, is the **rise in chronic conditions**. American workers experience high rates of chronic disease. Almost 80 percent of workers have at least one chronic condition and 55 percent of workers have more than one chronic condition. Depression is the greatest cause of productivity loss among workers. [3]

● **Improving health outcomes relies on patients' full engagement in prevention, decision-making and self-management activities**. Health literacy, or people's ability to obtain, process, communicate and understand basic health information and services, is essential to those actions. Patient engagement in health care has been termed the "blockbuster drug of the century," with the potential to transform the practice of medicine. Unfortunately, the only national health literacy survey conducted to date shows that only 12 percent of Americans are proficient in completing tasks considered essential to successfully navigating the health system and acting on health information. [4]

● **In any given year, 25 percent of the American population experiences either a mental illness or a substance abuse problem.** Treatment capacity for behavioral services is in critically short supply and getting worse. The National Alliance on Mental Illness reports that more than half of all U.S. counties have no practicing psychiatrists, psychologists or social workers — and only 27 percent of community hospitals have an inpatient psychiatric unit. [5]

● **Medicare patients exhibit a growing prevalence of chronic conditions** and risk factors for such conditions as obesity, heart disease, cancer, hypertension, stroke and diabetes. This, in turn, is leading to a rise in Medicare beneficiaries' use of health care services and has implications for resource use and payment policy. About four out of five seniors are affected by a chronic condition. [6]

Economy & Finance

● Hospital leaders should make Medicare profitability a "must do." **Forty-three percent of all hospital revenue is generated by Medicare,** but only 40 percent of hospitals break even on Medicare inpatient payments. [7]

● **Changes in new reimbursement methodologies** such as nonpayment for high readmissions and population health management, may lead to declines in reported inpatient volumes that may not necessarily reflect a decline in demand or market share. Hospitals and health systems are rethinking their business models and developing strategies to deliver high quality, coordinated care at a lower cost. Moody's recognizes that as hospitals make these strategic shifts, the reimbursement and patient utilization data metrics that we request to inform our ratings need to evolve. [8]

● The Centers for Medicare & Medicaid Services are projecting **lower health spending over the rest of the decade** ($275 billion lower than pre-reform predictions with a cumulative reduction of $1.7 trillion over the 2011–2020 period.) Already, spending is far below the trajectory projected to result from implementation of the Affordable Care Act. In fact, reduction in utilization of health services and trims in payment rates under the ACA more than offset the projected cost of covering the uninsured. [9]

● In past decades, **nonprofit health care mergers, acquisitions, and alignment initiatives** were driven primarily by financial need. Current initiatives, in contrast, are being driven by the desire for efficiencies and economies of scale in such areas as information technology, supply costs, managed care contracting and physician alignment. New alignment strategies have been created as providers, payers and employers position themselves for change. [10]

● It is critical that hospitals **develop a new wave of physician leaders as business partners** on the journey to becoming a successful accountable care organization. Unfortunately, most medical school curricula do not include any formal training on basic principles of business or running a practice, much less a multimillion-dollar enterprise. Sixty-six percent of health system CEOs said that no more than one-tenth of their senior leadership team comprised physicians, and only slightly more than half (52 percent) had a formal chief medical officer involved in strategic planning. With more than half of new physicians entering the field as salaried employees, the potential pool of physician leaders has grown exponentially larger. Having physician leaders as equal partners in operational and governance issues not only will be important, it will be a mandate. **(11)**

● The **transformation of the health care industry to a value-based business model** is spurring hospital and health system consolidation nationwide. The number of merger and acquisition transactions with hospitals and health systems increased 16 percent between 2010 and 2011, and is expected to sustain significant growth during the next few years — equaling or exceeding what occurred in the late 1990s. Current consolidation is strategic in nature. It is being driven by the desire for greater scale, the need to cut costs, and the desire to achieve economies of connectedness. **(12)**

● Almost all leading **health care systems own medical groups** now or plan to do so (91 percent). Health care systems recognize alignment with physicians as the key to developing a sustainable long-term business model, with a total of 98 percent viewing it as extremely/very important. **(13)**

● **Hospitals and health systems will need to be much leaner** in all ways. Leadership teams are starting to realize how difficult this task will be using traditional cost-management techniques. Some health systems are taking proactive steps beyond traditional approaches to restructure the organization and its care processes in a more optimal way. Strategies include divesting business lines that cannot be operated effectively and efficiently, optimizing service distribution across facilities and geographies, and redesigning clinical processes to reduce variation that increases costs. **(13)**

● Federal and state governments spend nearly **$300 billion each year on the medical and home care needs** of patients who are enrolled in both Medicaid and Medicare. Dual eligibles account for 31 percent of Medicare spending and 39 percent of Medicaid spending, according to the CMS. All dual eligibles are poor, two-thirds of them are older than 65, and many of them suffer from multiple chronic illnesses like diabetes and heart disease. By coordinating their care better, the system could save money by eliminating needless tests, duplicative office visits and too many hospitalizations. **(14)**

● **Medicare comprises an average 43 percent of hospital gross revenue**, representing by far the largest single source of revenue for hospitals, leaving them highly vulnerable to changes in Medicare reimbursement. Medicaid represents 11 percent of gross revenue for hospitals on a median basis and, on average, pays just 72 percent of Medicare rates for the same services. For many urban "safety net," rural and children's hospitals, Medicaid dependence is far higher, often above 20 percent. In 2011, a number of states implemented significant reductions in Medicaid spending and are expected to take additional measures to address ongoing budget deficits. **(15)**

● The number of **inpatient admissions for mental health and substance use increased in most years**, whereas medical-surgical admissions fell every year between 2007 and 2011. From 2010 to 2011, mental health admissions grew 5.9 percent and medical-surgical admissions declined 2.3 percent. Prices and out-of-pocket payments for mental health services also increased. As a result, per capita spending on these admissions grew much faster than per capita spending on medical-surgical admissions. **(16)**

● The **state-based health insurance exchanges**, a critical component of the ACA's goal to expand access to private health insurance, are required to be operational by Jan. 1, 2014. As of May 2013, 18 states have been conditionally approved to operate state-based exchanges and seven states have been conditionally approved to operate a state partnership exchange. It is unlikely that implementation of the exchanges will occur in states that joined the legal challenges to the ACA unless they are legally obligated to do so. **(17)**

● **Aligned payment strategies will continue to evolve** and become more pervasive in all markets. More formal collaborative solutions, such as ACOs 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 they need 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. **(18)**

● As policymakers grapple to rein in federal spending, they should focus on the following two interconnected strategies that will improve the health care system: **Ensure the short- and long-term financial viability of the Medicare and Medicaid programs**, and tackle the federal debt and deficit. **Restructure the system in a way that promotes and rewards accountability** — to patients, their families and their communities. We need to focus on using limited health care dollars more wisely — in ways that eliminate inefficiency and improve quality of care for patients. **(19)**

● **Transparency will grow** and data will become more available to the public, employers and purchasers. There will be increasing visibility of your organization's quality scores and pricing, making value much more important. Expect employers, organized labor, the public, health plans and, yes, even your competitors to access publicly available data to see your performance. **(20)**

● Hospitals compete in two different markets — **the economic marketplace**, against other hospitals for market share; and the **political marketplace**, against other segments of the economy for government funding. Hospitals are at greater financial risk in the political marketplace. With potentially large fiscal deficits and shrinking government payments, competing interest groups — farmers, teachers, auto manufacturers — will seek to protect their government subsidies at the expense of others. **(21)**

● Hospital **value-based purchasing programs** will pay hospitals based on their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal 2013. The VBP program will include 12 clinical quality measures as well as the Hospital Consumer Assessment of Healthcare Providers and Systems patient experiences with care survey. The clinical measures will account for 70 percent of a hospital's VBP score and the HCAHPS survey for 30 percent. **(22)**

● Information technology is going to 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. **(10)**

● The **top IT priorities** for the next two years are achieving meaningful use (28 percent); optimizing use of current systems (20 percent); and leveraging information (17 percent). **(23)**

● The volume and complexity of health care transactions is rapidly expanding. **Today, less than 20 percent of clinical data are electronic**, with little standardization across data fields. Digitizing, standardizing and normalizing clinical data so that they can be used for operational and clinical decision-making will require large capital investments and create ongoing operating costs. Few health care industry players have the scale or sophistication to manage these issues on their own. Resulting in part from this systemwide complexity, industry administrative costs will grow by about 10 percent annually over the coming years — higher than the medical inflation growth rate . **(24)**

● Coordinating care for patients with complex health conditions who see multiple physicians also can be supported by better health information technology interoperability. The primary care team may be in the best position to coordinate a patient's care, but often it will need information from other providers. Most current **electronic health records** 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. **(25)**

● **Population health management** has become the focus of patient-centered medical homes, ACOs and health care systems that are concerned about changing dynamics in reimbursement. Unlike the current model of delivery, population health management requires that care be patient-centered, proactive, coordinated, continuous and comprehensive. Health care organizations are gravitating toward population health management as an approach to keep people as healthy as possible and to prevent patients with chronic disease from getting sicker. **(26)**

● **Palliative medicine is a fast-growing medical specialty** — palliative care programs are now in place at nearly 90 percent of large (>300 beds) U.S. hospitals. Palliative care enhances patient and family satisfaction, improves quality and can prolong survival, at a fraction of the cost of usual care. Palliative care programs can save hospitals millions of dollars per year. **(18)**

● **Better communication** between patients and physicians and between primary care physicians and specialists is a key component of care coordination and leads to improved patient outcomes. Yet, patient and clinician levels of satisfaction with interpersonal communication have declined. **(26)**

● **Patient engagement is as important as provider interventions in improving population health,** because medical care is only one factor — and in many cases, not the most important one — in determining health outcomes. The more engaged patients are in managing their own care, the more likely they are to remain healthy or improve their health. **(27)**

Gene J. O'Dell
AHA vice president, strategic and business planning, Chicago, producer of the 2014 AHA Environmental Scan

What are the new trends and key findings in the 2014 Environmental Scan?
The key new themes in the 2014 Environmental Scan primarily relate to how organizations are responding to health reform and the associated challenges of moving from volume- to value-based payment. Patient engagement is critical as improving health outcomes relies on patients' full engagement throughout their care processes. Population health management is growing as the focus of patient-centered medical homes, accountable care organizations and health care systems are concerned about impending changes in reimbursement. Transparency is also critical as employers, the public, health plans and competitors increasingly will access publicly available data to evaluate performance. Consequently, hospital and health system governance is responsible for promoting the clinical and financial integrity to ensure a high-performing organization. Many CEOs are restructuring their organizations to better achieve a dual strategy of meeting the clinical interests of physicians and the business interests of the hospital to ensure long-term viability of the organization.

How is the board involved in AHA's strategic planning process?
The board of trustees takes very seriously our responsibility to guide and affirm the strategic direction of the American Hospital Association. We review the Environmental Scan on an annual basis and discuss and modify the three-year strategic plan as needed.

Benjamin K. Chu, M.D.
Regional president, Southern California, Kaiser Foundation Health Plan and Hospital, Pasadena, Calif., and AHA chairman

How is your organization's board involved in the strategic planning process?
Our board plays an active role in strategic planning. There is an organized strategic planning process culminating in a yearly board retreat to review the strategic plan and a formal approval process. The board tracks the progress toward meeting the plan on a regular basis during the year. It also bases its decisions on capital expenditures and oversight for quality, compliance, budget and other areas of concern using the strategic plan and the monitoring metrics as a guide.

Mark Parrington
Vice president, strategic transactions, Catholic Health Initiatives, Englewood, Colo., and president-elect, Society for Healthcare Strategy and Market Development

How has strategic planning assisted your organization in its transformation from volume to value?
At Catholic Health Initiatives, strategic planning embodies a dual role, both challenging and informing the organization's thinking. We have defined the transformation from volume to value as the "Next Era of Healthy Communities." This journey requires us to assess our ability to continually and effectively contribute recognizable value in the communities we serve and understand the appropriate roles we will assume in each of those communities. The process encourages us to recognize the increasingly important role of clinical leadership and community partnership to effectively organize networks of care and engage in the management of a population's health. Recognizing the assumption of this more expansive mandate, it is incumbent on the strategic planning process to inform the organization of the broader array of new capabilities and Next Era value-based metrics that must be considered as we forge decisions in this new and evolving environment.

Science & Technology
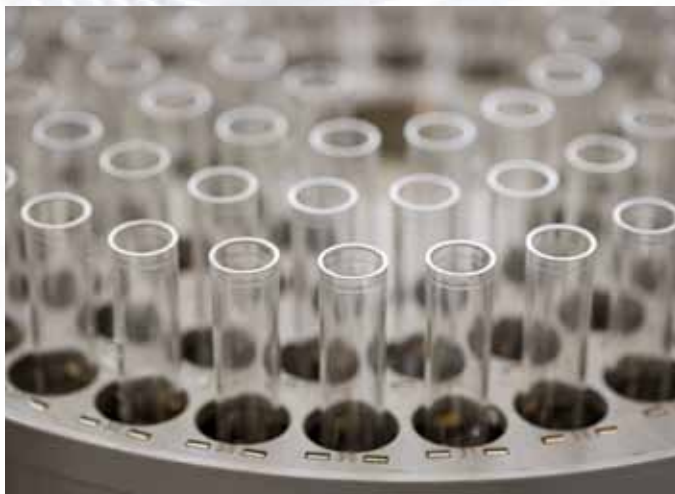
● **Telemedicine has been growing rapidly** because it offers four fundamental benefits: improved access, cost efficiencies, improved quality and patient demand.[28]

● Tablet and other mobile technology may help to put **shared decision-making** aids in the hands of more physicians and patients. John Waller, professor and former director of the medical informatics program at the Medical University of South Carolina, points to new research that shows that 75 percent of physicians have the technology to accomplish this already in their pockets or briefcase. Waller says that cost isn't going to be a barrier for very long because the technology will become pervasive. [29]

● **Smartphones, iPads and other tablets** are now in use in 80 percent of health care organizations. The BYOD (bring your own device) revolution is well under way, yet 50 percent of respondents in a recent health care IT poll say nothing is being done to protect data on those devices. [30]

● Proactively **engaging consumers in taking better care of their health**, forward-thinking organizations are offering a hospital-branded, consumer-facing portal to employers in their marketplace. Hospitals are reaping impressive benefits because these portals facilitate continuous interaction with consumers on behalf of the hospital to promote service lines, special programs and physician practices. They build top-of-mind awareness as the hospital's brand is front and center, along with the ability to connect directly with hospital-based services. [11]

● Real-world analytics are using the potential **big data** to efficiently develop new business services and reimbursement models. We are seeing patient-specific longitudinal EHR data coming together with genomic and genetic data, financial data and electronic patient-reported data to deliver real insights into optimizing care management and evaluating which therapies provide the highest overall value to patients and health care systems. [31]

Human Resources

● **Primary care in the United States is already struggling to meet patients' needs**. Solutions must enable nurses, as well as other health professionals, to practice to the full extent of their education and training in a team-based model of care delivery. In many settings, advance practice registered nurses can be used to address the primary care staffing shortage and free up physicians to care for more complex cases. Yet, many states have outdated regulations and barriers that prevent nurses from practicing to the full extent of their education and training. [18]

● **Higher turnover, staff reductions and early retirements in the C-suite will continue**. The C-suite will become more demanding, with more conflict from competing interests among physicians and greater demand for fewer resources. Many CEOs recognize that they will have to reduce the number of their own C-suite staff and restructure the organization, and many are worn out from the stress of the past four years. [20]

● Nearly 30 percent of large, nonprofit, health care system CEOs responding to a recent survey identified **the importance of adding more clinical expertise to the board**. Physician and nurse involvement on the board in the development and implementation of patient safety and quality goals and strategies are, and will continue to be, important into the future. [32]

● There is **growing interest in workplace disease prevention and wellness programs** to improve health and lower costs. Medical costs fall by about $3.27 for every dollar spent on wellness programs, and absenteeism costs fall by about $2.73 for every dollar spent. This return on investment suggests that wider adoption of such programs could prove beneficial for health outcomes as well as budgets and productivity. [33]

Resources

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