





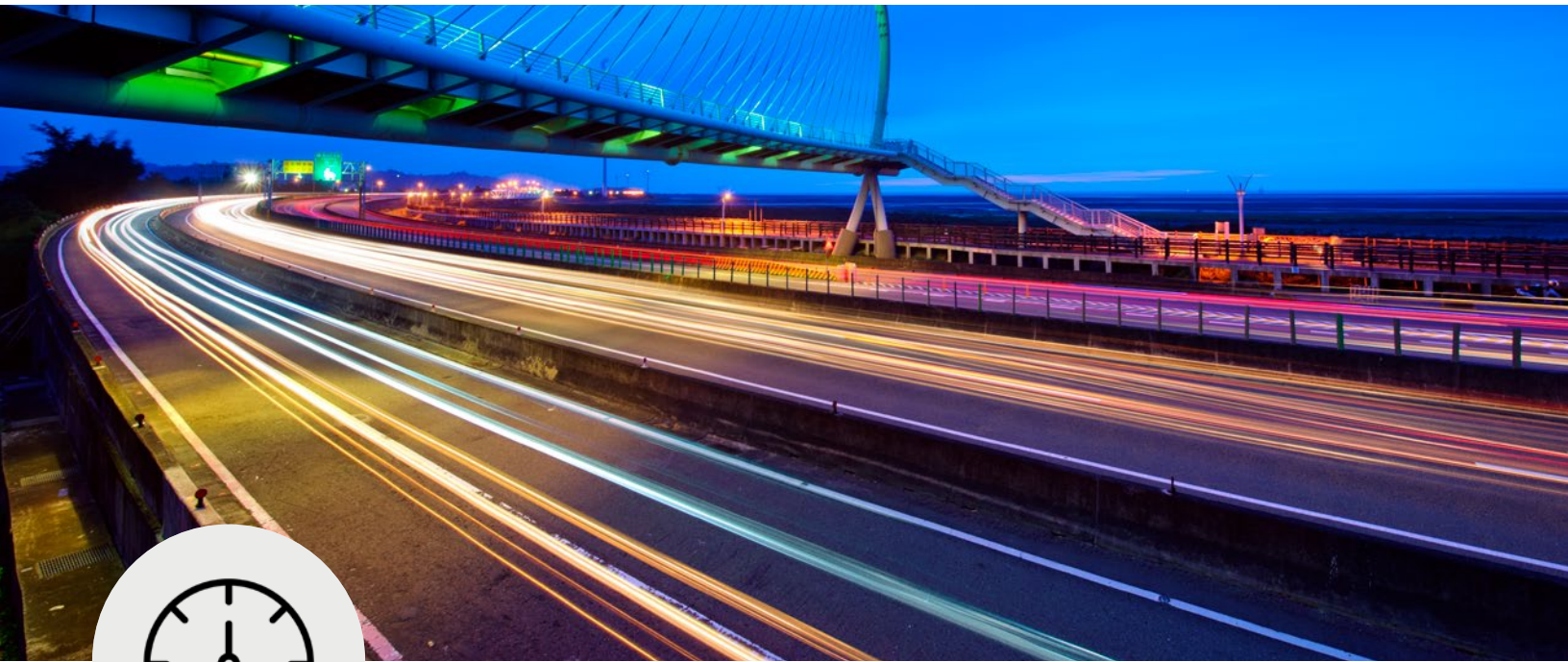


Deloitte 2017 survey of US health system CEOs:

Moving forward in an
uncertain environment

Deloitte Center *for*
Health Solutions

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Deloitte 2017 survey of US health system CEOs: Moving forward in an uncertain environment



The challenge is that health care is getting much more complex...new government rules, reimbursement reduction[s]...advancing technology, advancing expectations around cybersecurity, and really making the new expensive drugs available to patients...It's hard to plan the future when the rules today make no sense and no one is thinking about developing rational rules with transparency for the future.

—CEO of a large nonprofit health system



Introduction

Turnover among hospital and health system chief executive officers (CEOs) is higher than in other industries.¹ Along with navigating ever-changing policies and regulations, hospital CEOs must work with multiple payers, meet community obligations, stay current with evolving technology, contend with complex staffing issues, and keep their doctors and board members happy—all while delivering high-quality care. The American College of Healthcare Executives credits consolidation, industry transformation, and aging leaders with an 18 percent turnover rate among hospital CEOs for the last three years.²

As a follow-up to our 2015 Deloitte Survey of US Health System CEOs, we interviewed 20 health system CEOs in May 2017. We found that, of all the issues that may keep hospital CEOs up at night, they say they are most concerned about the future of Medicaid; CEOs also worry that the transition to value-based care is moving too slowly. Declining margins is another top concern, as are challenges in finding, recruiting,

and retaining forward-thinking and adaptable health care leaders. Keeping up with new technology—and the cybersecurity risks that accompany it—and adapting to evolving consumer expectations are also important issues. (Many of these issues are interrelated.) CEOs note that effectively addressing the above challenges is compounded by uncertainty about the new administration and its health care policies.

This Deloitte Center for Health Solutions series explores hospital CEOs' top concerns, including:

- » Potentially changing Medicaid reimbursement and other policies issues
- » Implementing population health and value-based care
- » Maintaining or improving margins
- » Recruiting and retaining top talent, including health care leaders
- » Keeping up with evolving technology and cybersecurity risks
- » Adapting to changing consumer demands and expectations.

Many CEOs say they are focusing on developing new revenue streams, lobbying and influencing policy, investing in the future (e.g., technology, growth, talent), and developing alternative payment methods. Strategies vary based on the populations each hospital serves.

While no single strategy will work for every hospital, ideas that CEOs are considering include:

- » Diversifying and identifying alternative revenue streams
- » Developing more primary care locations and alternative sites of care, including urgent care and retail clinics
- » Reducing inefficiency and rethinking how care is delivered
- » Investing in strategies to prepare for value-based care, including shifting funding from hospitalists to primary care practitioners and chronic-disease management
- » Meeting consumer demands—ultimately, the players with the most 'members' are going to do the best

About the survey

The Deloitte Center for Health Solutions interviewed 20 hospital and health system CEOs during May 2017. In 2016, their organizations collectively generated \$91 billion in annual operating revenue, with all generating more than \$1 billion annually.*

The CEOs represent a wide range of organization types, including:

- » Seven nonprofit hospitals/health systems
- » Seven academic medical centers (AMCs)
- » Three faith-based nonprofit hospitals/health systems
- » Three children's hospitals

**Based on Deloitte analysis of DACBond, Hoovers, and organization websites*



While none of the key themes emerging from our interviews have really changed since we last spoke with health system CEOs in 2015, the urgency certainly has. Instead of thinking about these issues in a futuristic sense, **CEOs are ready to address and tackle them now.**



CHAPTER 1

Uncertainty about the future of Medicaid and health care policy

Eighty-five percent of the 20 CEOs we surveyed cite uncertainty about the future of the Medicaid program as a top concern. If Congress rolls back the Medicaid expansion authorized by the Affordable Care Act (ACA), or otherwise reduces federal funding, CEOs are worried that they will see an increase in uninsured patients. Though the expansion of Medicaid reduced uncompensated care in expansion states, hospitals nationally still accrued \$35.7 billion in uncompensated care costs in 2015.³ A Commonwealth Fund report estimated that hospitals in Washington, DC and the 31 other Medicaid expansion states could see a 78 percent increase in uncompensated care costs over a next decade if the House bill, the American Health Care Act of 2017 (AHCA) went into effect. Additionally, researchers found that the impact will vary across states. Hospitals in Nevada, for example, could see uncompensated care costs double during the next decade under the proposed AHCA.⁴

In addition to uncompensated care,⁵ health system CEOs are concerned that Medicaid hospital payments will fall below existing rates. Medicaid reimbursement rates are about 45 percent lower than private rates, according to some studies.⁶ If rates fall further, hospital and health system CEOs are worried about the impact on margins.


Medicaid covers the health care of roughly two in five children.⁷ Many of the CEOs of children's hospitals we interviewed expressed concern that this is not commonly discussed. While Medicaid expansion helped low-income, childless adults, the program still serves many of the most vulnerable people in US society, including about 48 percent of those with disabilities or in

permanently poor health and half of all births.^{8,9} CEOs worry that if Medicaid is scaled back, these vulnerable populations will still need care but have no way to afford it.

Proposed changes to Medicaid

The Senate's proposed bill to replace elements of the ACA, the Better Care Reconciliation Act of 2017 (BCRA), would move Medicaid from an open-ended entitlement program to per capita caps. BCRA would authorize an annual increase for Medicaid based on per capita spending targets beginning in 2025. The House bill, AHCA, proposes using a formula that uses the Consumer Price Index for Medical Care (CPI-M) plus one percentage point to set state spending targets. The Senate bill, however, would tie spending targets to the Consumer Price Index for Urban Consumers (CPI-U) which has traditionally grown at a much slower rate than the CPI-M. This would mean an annual growth rate of about 1.3 percentage points annually over the next 10 years according to Congressional Budget Office (CBO) projections. In June, the CBO projected that this would decrease federal Medicaid outlays 26 percent over 10 years.¹⁰

The bill would also make other changes that would affect enrollment, including presumptive eligibility. Under current law, States can authorize health care providers to screen for Medicaid eligibility and immediately enroll those who appear to be eligible. Both the Senate and the House legislation proposes ending this option in 2020.



States do not want flexibility; they want cash. They want the ability to serve people.

—CEO of a large academic medical center



The Congressional debate about repealing and replacing the ACA has continued since the 2016 election, with observers speculating on whether the AHCA or BCRA will pass. The uncertainty about what policy changes will happen seems to frustrate CEOs even more than the specific policies. However, 85 percent of the CEOs say that reducing federal funding for Medicaid tops their list of concerns. They worry that if the bill passes, states would not receive enough funding to cover program costs and would react by lowering Medicaid payment rates, covering fewer services, or dropping enrollment, which would both increase the number of uninsured and hurt hospitals' bottom lines. Additionally, the health of communities, the primary focus of these hospitals, would suffer if consumers are less likely to seek preventative or primary care.

"Medicaid expansion is very important in [our] state. There's been an incredible amount of funding that has come into the health system. What would it mean if that were totally reversed? Quite frankly, it would be a disaster in the state and would be very significant for us. We have a lot of Medicaid business."

—CEO of a large nonprofit health system

Even though hospital CEOs in states that expanded Medicaid are most concerned about the potential loss of Medicaid funding, CEOs of children's hospitals and hospitals in non-expansion states also are worried about potential cuts.

"What [capping federal Medicaid contributions] does is push a 25 percent reduction to the states. That means the state has to come up with [it]. It's unlikely, and so that means that either services or benefits get cut for the people who probably need it the most. So, while that's positioned as state flexibility, it's basically a block-and-chop...The caps that are proposed now, besides being a cut of 25 percent, they also don't allow for when you have unusual things in your community that pop up, like emergent diseases."

—CEO of a large nonprofit health system

In the face of uncertainty about Medicaid's future, what are forward-looking CEOs doing to prepare their organizations? We heard about strategies to radically reduce costs, find new revenue streams, invest in alternative payment models, and access the capital needed to invest and innovate.

To address Medicaid concerns, hospital CEOs are focusing on:

- » Increasing government affairs/lobbying at both the federal and state levels
- » Keeping apprised of the Medicare budget process
- » Creating value-based contracts
- » Instating new strategies built around the core mission of delivering high-quality care
- » Emphasizing areas that transcend policy, such as quality, cost, and customer experience
- » Implementing cost-reduction strategies
- » Pursuing new revenue streams.

Other policy issues that will affect the bottom line

About half of the CEOs we interviewed say they are concerned about repeal of the individual mandate. Though roughly 10 million people have purchased coverage through the health insurance exchanges, Medicaid expansion has increased enrollment in that program by 16.7 million since 2013—a 29 percent jump—and, therefore, remains a greater concern to the CEOs.¹¹

A few CEOs note that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be the first significant government push to improve population-based health. Although many CEOs say they are unaware of the impact this could have on their margins, hospitals that have acquired physician practices and those that have a large number of Medicare patients are more aware of MACRA and have invested in the transition to value-based care or a population health model.

Finally, AMCs, children's hospitals, and other organizations that rely on federal grants are concerned about cuts to the National Institutes of Health (NIH), Health Resource and Service Administration (HRSA), or the Food and Drug Administration. Hospitals concerned about government programs like Medicaid and payment laws like MACRA may want to consider a plan of action that reflects where the hospital is located, who it serves, and its financial circumstances.

Hospitals concerned about Medicaid transitioning to a per capita or block grant program and receiving lower reimbursement per patient could consider diversifying or expanding into new geographic areas. Meanwhile, hospitals concerned about an increasing number of uninsured should consider ways to triage patients to the appropriate care setting (i.e., urgent care versus the emergency department).

Generally, all health systems should be thinking about ways to reduce inefficiency. Rather than trim around the edges, CEOs need to rethink how care is delivered: How can the hospital deliver care to patients more cost-effectively? How can data and technology drive clinical and back-office efficiency improvements?

Health care policy and market drivers are pointing in the same direction—toward tighter margins and higher value. Rather than watching and waiting to see what happens in Washington, hospital and health system CEOs should consider identifying and addressing common challenges at both a macro and enterprise level, and investing in “no regrets” strategies to better deliver care in the future.

“We feel confident that when you are building a strategy that is aligned with your mission and deliver greater outcomes per dollar spent for the people you serve, that’s always going to be a winning strategy. So, the federal framework has not caused us to take our eye off of what we know will be most beneficial to our patients and our community members going forward.”

—CEO of a large nonprofit health system





CHAPTER 2

Population health and value-based care

Transition to value-based payments slower than expected

Value-based payment models reward efforts to improve quality and reduce cost. Payments to hospitals and physicians are based, in part, on episodes of care, and providers might face some financial risk. The use of value-based payments is increasing due to policies such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), initiatives from the Center for Medicare and Medicaid Innovation, state Medicaid programs and, to some extent, private-sector health plans. Many surveyed CEOs state that population health management is the key to success under value-based care models.

Survey participants say the transition to value-based care is happening, but at a slower rate than initially anticipated. Still, many of the CEOs report that they are developing and expanding innovative delivery and payment models, and are focusing on MACRA and physician activation. Many CEOs also are looking into strategies to generate physician buy-in and encourage behavioral change, which will help them be better prepared for the transition to population health and value-based care.

“Value-based care simply means to me that the recipients see the value of the care we provide, and if we can’t distinguish ourselves by demonstrating that we can provide more value in terms of outcomes, in terms of quality, in terms of delivering care in a more effective way and in a way that better suits individuals in terms of where they live and work, then people are not going to be willing to pay for it. Fee-for-service is never going to go away, but it is going to shrink as a component in how we are going to be reimbursed. Over the next five years, we are going to be at risk for the services we provide, and that risk will be tied into demonstrating value in terms of things like readmissions, ER visits, etc.”

—CEO of a large academic medical center

What is population health?

Population health takes a broad look at the management of outcomes for all of a health system’s patients. Specifically, population health includes efforts to use health care resources effectively and efficiently to improve the lifetime health and well-being of a specific population.¹²

Population health activities include:

- » Promoting health and well-being
- » Primary, secondary, tertiary, and disease prevention

Population health requires data and analytics to identify at-risk patients and target services that reduce their use of expensive and low-quality care. Under a population health model, providers manage care—from preventive and maintenance care to acute and long-term care—for a defined population. Those who are most successful often deploy innovative delivery models; analyzing data and trends in a population’s health, quality, and costs; and bearing financial risk. Value-based payment contracts reward providers for successfully executing these processes.

According to an industry adage, “As Medicare goes, so goes the private market.” Although value-based payment models are not gaining momentum in the private market as quickly as anticipated, many health system CEOs are preparing for a future that will place greater emphasis on value-based care. Moreover, most health systems have fewer contracts requiring them to take on risk than they expected.

“[Value-based care] is a major [concern], [but] it is moving backwards. We can’t find payers, whether it be insurers or businesses, who seem tremendously interested in moving in that direction. As a large integrated delivery system, I could be stuck between a Medicare payment system that rewards outcomes, and a commercial payment system that is stuck in a fee-for-service world. That makes constructing and managing and leading an organization like this challenging as the economic incentives will essentially point to polar opposite directions.”

—CEO of a large nonprofit health system

Many of the surveyed CEOs express concern about operating under two different payment systems—FFS and value-based care—and having misaligned incentives. Moreover, moving towards population health and bearing financial risk likely will require a large patient population.

If we were at risk for an entire population, we would have more success than being at risk for 10-20 percent of the people under fee-for-service. It’s hard to operate both.

—CEO of a large faith-based health system

While five of seven AMC CEOs say population health is a major concern, many other survey respondents consider it to be a moderate or minor concern. They indicate that a true population health “model” does not yet exist. Many of these CEOs are more concerned about issues such as Medicaid cuts and shrinking margins.

Preparing for value-based care and population health models

“[Currently] our financial success doesn’t always equal the success of the people we care for. How do we turn towards aligning our market rewards for the things that really matter most for the people we are serving?”

—CEO of a large nonprofit health system

According to survey results, the CEOs of children’s hospitals are more likely than other CEOs to use innovative delivery and payment models such as accountable care organizations (ACOs), retail clinics, telehealth, and advanced nurse practitioners to manage their patients’ health.

“We’re beginning to [develop capacities to] work in a different risk-sharing model with payers. But, a lot of that has just been paused until people know what the feds will do. It’s like all that momentum that was building towards value-based care model[s], towards innovative, care coordination and delivery models...has pretty much been paused.”

—CEO of a large children’s hospital

Additionally, many CEOs think health plans that participate in Medicare Advantage (MA) will continue to emphasize value-based care, and that they can move health systems towards population health. Although a majority of providers are still reimbursed under FFS in MA, others have moved towards alternative payment models (APMs). The 2016 HCP-LAN survey estimated that roughly 41 percent of spending by MA plans was through population-based accountability models.¹³ Researchers found that providers in risk-based MA models had better patient outcomes than providers in FFS MA plans. For example, patients had a six percent better survival rate when treated by clinicians in risk-based APMs than patients in the FFS MA.¹⁴

"I think if MA is going to grow, or if there's going to be a successor to the exchanges, it's likely to be in a population health model rather than a FFS model."

—CEO of a large academic health center

Surveyed CEOs expect they will need to partner with other players to stay connected with patients. For example, many hospitals and health systems are partnering with outpatient ambulatory care organizations and using technology such as telehealth to expand their reach.

To connect with and care for patients outside of the hospital setting, CEOs are often looking for partnering opportunities. From triaging patients to urgent care clinics and collaborating with post-acute care (PAC) facilities to keep patients out of the hospital, these new relationships can turn traditional FFS on its head.

"The engagement along the full continuum of care is a major focus of ours as well; i.e., digital connectivity and connecting with customers, urgent care centers, micro-hospitals, in-patient activity, outpatient activity, post-acute care. We are looking at how we partner with those in that part of the world, post-acute care specifically, since that plays a huge role in our overall cost of care for that Medicare beneficiary."

—CEO of a large academic health center

Additionally, CEOs are commonly wondering how to manage a community's health needs:

"That goes back to the social determinants of health issue. I'm much more interested in defining population health as how you manage a community. That's a major concern in the long run if we want to improve health overall."

—CEO of a large academic health center



"I think the next...improvements in care delivery are going to come from new models. Getting away from physician offices [and] looking at alternative models, (e.g., more use of non-licensed professionals, more use of technology). We have to find alternatives to how we've always done it in the past, with the goal of not only reducing cost but improving care, and [gaining] more reliability in how we manage the care of patients."

—CEO of a large academic medical center



Many CEOs are uncertain how MACRA will play out but see it driving population health and physician activation initiatives

"You can really combine MACRA and population health. They are mutually overlapping; that is, MACRA is simply a form of population health. It really is our ability to deliver health care outside the four walls of our medical centers and it moves away from hospital-based care. And while all our hospitals are full, we need to reach out and learn how to deliver health care with providers who can do it better than we can and at a lower cost, and to be able to deliver care in the communities where patients live and work."

—CEO of a large academic medical center

MACRA pays clinicians five percent above their regular Medicare rates if they participate in APMs. Even clinicians who do not participate in these models will see their payments vary based on quality and cost measures. However, hospital CEOs' approaches to MACRA differ. Not surprisingly, many CEOs who previously had acquired and invested in physician practices report being more engaged and prepared for MACRA implementation than other survey respondents. However, researchers have projected that under varying models, hospitals could see Medicare cuts as high as \$250 billion by 2030.¹⁵

We've grown so much in our employed-physician model now that [MACRA] is a major concern.

—CEO of a large faith-based hospital



Many surveyed CEOs say they are concerned that physicians are largely unaware of how MACRA would affect their practices. This is consistent with the Deloitte Center for Health Solutions 2016 Survey of US Physicians, which found that 50 percent of physicians had never heard of the law, and 32 percent recognized it by name but were not familiar with its requirements.¹⁶ Though Deloitte's survey was conducted a year ago, more recent industry surveys have had similar findings.¹⁷

"Depending on how it's implemented and adjusted, it's going to have a profound impact on our physicians' ability to continue to practice, succeed, or thrive. And, they don't have the capabilities to manage the data, create the data, do what's necessary day-to-day to change the delivery model. So, there's a profound implication for our physician community that they are not capable already of delivering upon."

—CEO of a large nonprofit health system

Physician activation: Continued priority for health system CEOs

A CEO from an academic medical center mentioned that priorities have not changed but the resources his organization is putting into developing the capabilities for population health management have increased. Additionally, instead of just discussing population health management with hospital leadership, many physicians are now part of the conversation. Many organizations are striving to achieve a “quadruple” aim that adds clinician and employee engagement/activation to the triple aim of experience, health, and affordability.

“How do I create the alignment with our physicians, in particular, when they are under a different set of economic incentives than we are, to transform both the payment system and the care delivery system?”

—CEO of a large nonprofit health system

A majority of CEO respondents are having a difficult time engaging physicians in care redesign, value-based care transformation, and care coordination because of differing financial incentives, according to the report *Alignment: Driving Clinical Integration and Collaboration by Health Leaders Media*.¹⁸

In our survey, some respondents indicate they are using tools including clinical integration, employment contracts with incentives, ACOs and risk-sharing agreements, among others to better activate physicians in care delivery transformation.

Specifically, CEOs surveyed report they are:

- » Creating or partnering with payers for alternative payment models, which could result in reduced cost and improved patient care
- » Forming clinically integrated networks, partnerships, and infrastructure to support population health and create a referral base for tertiary partnering services
- » Positioning their organization to work in a risk-sharing model with payers
- » Emphasizing patient quality, safety, and experience
- » Investing in appropriate technology that will help enhance patient care
- » Changing the culture around patient access to physicians and developing communication skills at the staff and physician level.

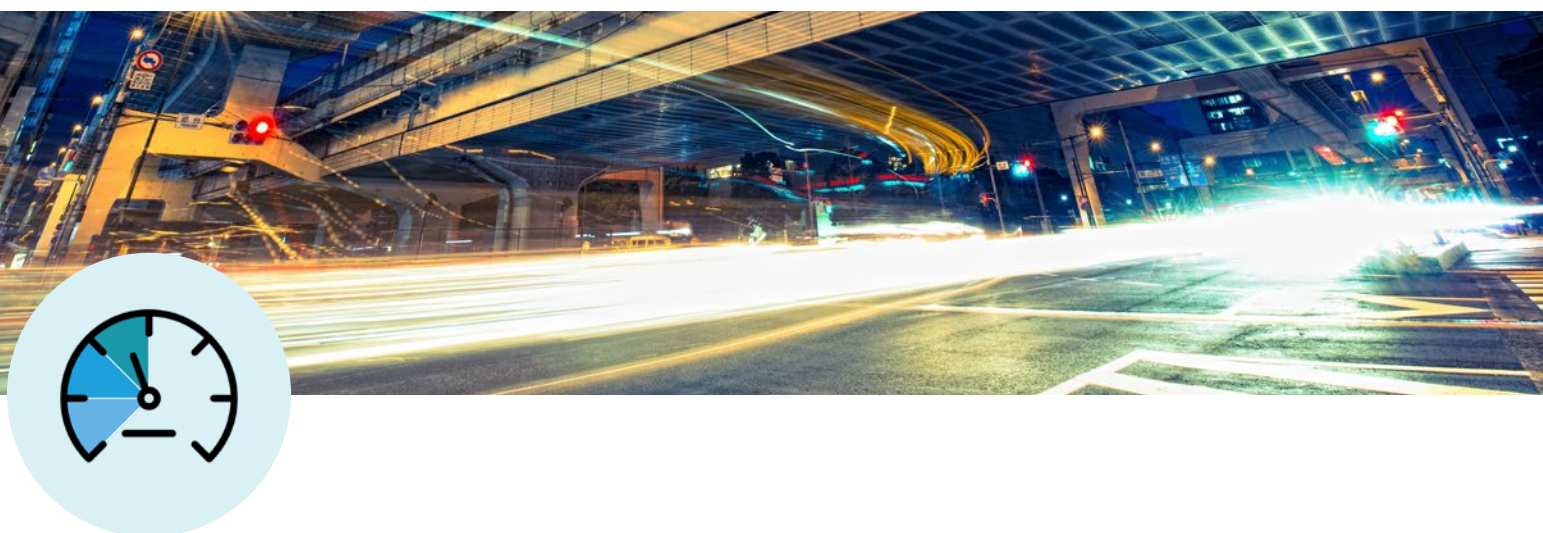
Successful transition to population health

“We are trying to consolidate. We are trying to be more efficient. But there’s only a certain amount that you can do under the current situation. As long as mixed incentives are in place [FFS vs. value], it’s going to be really hard to fix the system or more appropriately put the resources in place to serve our community.”

—CEO of a large faith-based health system

Even if health systems are not yet seeing value-based and population health management contracts, they should still prepare for their arrival. CEOs surveyed agree that the industry is moving in this direction and, therefore, say their fellow CEOs should focus on the health outcomes and costs of their patient population. CEOs tell us they intend to partner, grow business purposefully, and create incentives and support for physicians to operate under the new value-based model. Health systems preparing for value-based care and population health also should consider expanding their patient network and reach, as providers managing the care of larger populations likely will be able to better manage their margins and financial risk.





CHAPTER 3

Margin pressure and the search for new revenue streams

Improving margins is a top issue for CEOs

Improving financial performance and operating margins continues to be a top issue for many health system CEOs, with several of those surveyed citing it as their chief concern. Many health care systems are experiencing stagnating or declining margins due to costs associated with increased headcount and investments in clinical innovation and population health initiatives. The effect of possible Medicaid changes on hospital margins compounds CEOs' concern, particularly those leading health systems focused on population health and quality improvement.

"Anybody can make a margin look good if you avoid taking care of the problems of the world. I can make my margins [look good], by giving up things like mental health. But if you make the assumption that you should be providing health care services to all people—not avoiding the tough stuff—then you will have a problem with margins. Margin is manageable depending on what it is you want to do."

—CEO of a large academic medical center

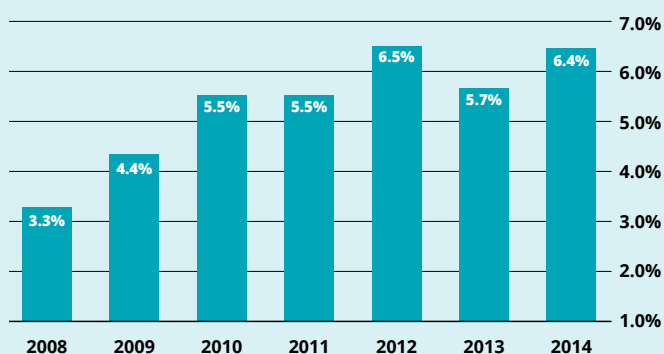
In the two years since our last CEO survey, improving financial performance and operating margins has climbed up the list of CEO concerns, influenced in part by the health care industry's transition from volume- to value-based provider

reimbursement models. Trends that are challenging these hospital leaders to make do, or—in the case of value-based care—do more for less include:

- » Medicare per-capita spending growth has been restrained. Between 2010 and 2016, average annual growth increased 1.3 percent¹⁹—significantly lower than the 7.4 percent annual average between 2000 and 2010.
- » Medicaid payments are often low, and Congress continues to debate cuts to the program. Medicaid reimbursement rates are about 45 percent lower than private rates, according to some studies.²⁰ Additionally, many commercial payers are placing greater emphasis on value-based care. For example, Humana has 63 percent of their membership in value-based care contracts.²¹
- » Even as revenues are declining, expenses keep rising—squeezing hospital operating margins (see Figure 1). According to Moody's Investors Service, expenses for nonprofit hospitals grew by 7.5 percent from 2015 to 2016 while revenue grew by 6.6 percent.²²

"What has changed is the rapid deterioration... the reimbursements cover just a bit more than 50 percent of our cost...We are operating at near capacity all the time, but that has not translated into margin improvement as it once did."

—CEO of a large academic medical center

Figure 1. Average hospital operating margins

Source: American Hospital Association Annual Chartbook, 2016

Although operating margins increased modestly after the Affordable Care Act (ACA) expanded coverage and the economy improved, they remained flat from 2012 to 2014. When the interviewed hospital and health system CEOs compare their organizations to those in other industries—or even other health care industry sectors—they conclude that three-to-six-percent margins are very low. Additionally, they fear that revenue cuts from one payer, or a needed clinical or technology investment could quickly push margins into the red.

Increasing volume may no longer be the answer to improving margins

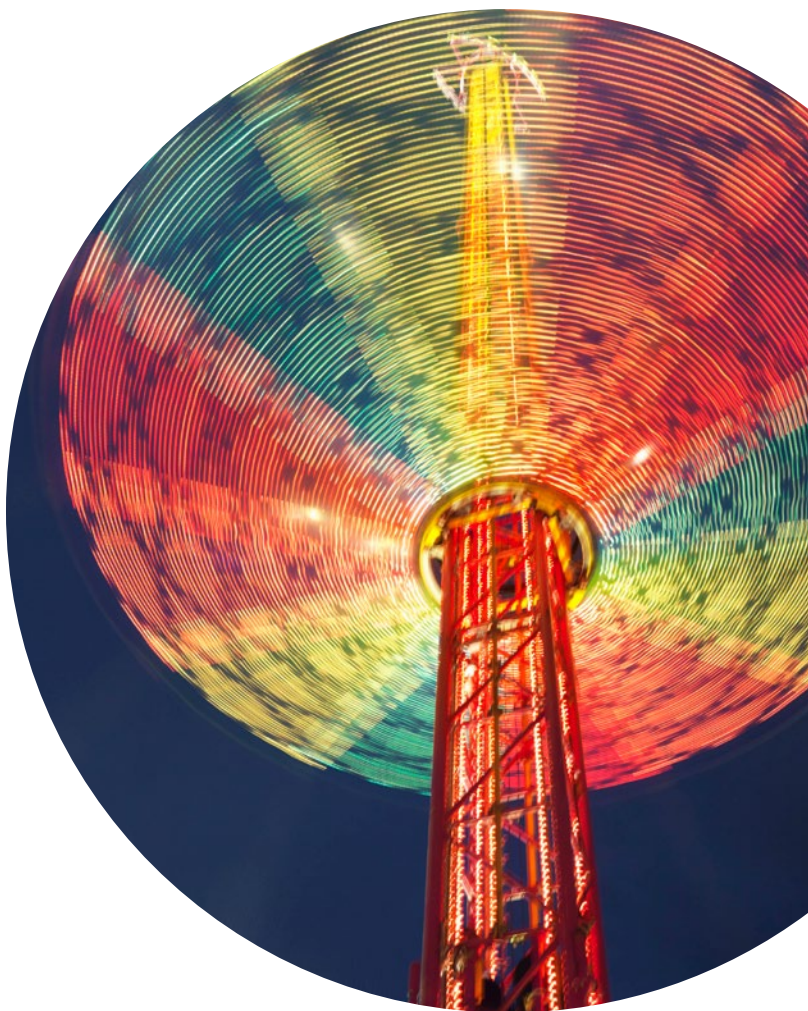
“In an industry where our core business is being commoditized and utilization is declining, there has to be ways to grow revenue. So that’s becoming an increasingly larger question. We are looking at things like urgent care; we’re looking at things like joint ventures for ambulatory surgery...things of that nature that are creating less of a reliance on the inpatient revenue stream and more on the outpatient side. We also are dabbling in a few other things, like simulation, partnering with companies to create opportunities for innovation, and training revenues in simulation environments.”

—CEO of a large nonprofit health system

Rather than being encouraged to increase inpatient volume to generate revenues, many health systems are being urged and incentivized to treat patients outside hospital walls. To illustrate the impact, the proportion of revenue from inpatient services relative to outpatient services has fallen 18 percentage points since 1994.²³


Unfortunately, outpatient care revenues, even if the care is provided at a hospital-owned entity, are not as high as those for inpatient stays: Medicare paid, on average \$3,002 per inpatient stay and \$1,753 per outpatient service in 2015, according to the Medicare Payment Advisory Commission.²⁴

Even as hospital admissions have fallen, overall hospital employment has risen—and labor is the largest single component of hospital costs.²⁵ Deloitte estimates that labor expenses make up roughly 50 percent of total operating costs for most hospitals.²⁶ In contrast, costs to provide care in outpatient settings are much lower; meaning that hospital operating margins could be improved, even with lower revenues. This notion has propelled many hospitals to acquire physician practices and invest in outpatient services. But even as hospitals have moved to acquire and utilize lower-cost care settings, many payers have adapted their reimbursement practices. For example, to reduce Medicare costs, the Centers for Medicare and Medicaid Services (CMS) has proposed paying lower rates to hospital-owned physician offices which, in turn, would reduce payments for outpatient services.



While reducing costs has long been a focus for health systems CEOs, many are pursuing new cost-cutting measures. Among these are developing new staffing models, shifting patients to outpatient services, and reducing administrative and supply costs.

In addition, many health systems are looking for new revenue sources to offset rising costs. But competing for funding can be rigorous: For example, teaching and research hospitals are seeing less grant support. The National Institutes of Health (NIH) distributes more than 80 percent of its funding through 50,000 grants to roughly 300,000 researchers at 2,500 universities.²⁷ However, until this year, funding has not generally increased, and inflation has eroded the value of some of these grants.²⁸ Subsequently, the grants have been harder to win—less than 20 percent of applications are funded.



Philanthropy: We've got to fill the hole somewhere or another if we're not going to be able to do it with grants from the NIH; if we're not going to be able to do it with operating income, [then] it has to come from somewhere within, and it's likely to be philanthropy.

—CEO of a large children's hospital



Some CEOs are investing in clinical and technology innovations with an eye towards generating revenue:

“One tangible example [of new revenue streams] is how we would share intellectual property that might result from some of the innovations that could be created. It could be a new revenue stream into the organization. We have two

that are on the verge of receiving FDA approval and/or patents that could be substantial...they haven't hit yet or realized themselves yet, but it's an example how we have architected a vehicle and a mechanism to benefit from some of the innovations that can occur from within our team and partnerships.”

—CEO of a large children's hospital

Additionally, many hospitals and health systems are leveraging the revenue potential of developing a physician network:

“We've created a CIN [clinically integrated network] with our referring pediatricians in our market. We will continue to focus on finding the right strategic partners to leverage innovative technology solutions to adapt our care delivery model into more nimble ways and/or completely new revenue-generating models that are new and not bound by traditional thinking.”

—CEO of a large children's hospital

Some hospitals are looking to capitalize on their intellectual property (IP). Hospitals and health systems can work with employees to develop any number of innovations—medical devices, training videos, health information technology (HIT) tools, or patient safety solutions. Once the hospital has filed for patent or copyright protections, it can sell or license the IP to other industry stakeholders.

“We are investing in joint ventures, working with private equity, commercializing a lot of our foreign assets [such as services for international patients traveling to the US for care], and I've already started a number of new companies—all for the purpose of making sure that I could come up with an alternative revenue stream to subsidize the government revenue stream, which is necessary today and would be imperative 5-10 years from now. To continue to expand and grow, you have to have access to capital. If you don't have access to capital, you can't invest. If you can't invest, you can't grow and if you can't grow, you are going to die.”

—CEO of a large academic medical center

Many health systems are continuing to pursue growth through mergers and acquisitions (M&A). They are working to increase their physician networks, expand their geographic reach, and diversify their specialized offerings and talent. Such growth can assist with building clinically integrated networks and provide the scale needed to reduce costs. Health care organizations with larger patient populations might have increased access to capital, which could mean more money to invest in the transition to value-based care.

“[W]e are looking at [if] we need to focus on partnering, merging, aligning, acquiring other health assets in the state to be able to get to more scale, drive down overall operating costs, and also have more access points and attractiveness for the consumer and—to be honest—a little more leverage with the insurers.”

—CEO of a large nonprofit health system

How do value-based payments intersect with margin concerns?

The adoption of value-based payments models is increasing due to policies such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), initiatives from CMS' Center for Medicare and Medicaid Innovation, state Medicaid programs, and, to some extent, private-sector health plans. Value-based payments reward health systems that improve quality and other outcomes, and reduce total costs of care; achieving these goals has the potential to help health systems improve margins.

Many surveyed CEOs agree that population health management is the key to success under value-based payment models (see chapter 2 on page 8). CEOs also should consider the following approaches to improve margins:

- » **Increase system efficiencies beyond what is needed to be profitable.** Many hospitals and health systems have reduced costs and increased efficiencies at the margins of their organizations, but long-term sustainability may require organizational restructuring.
- » **Operate as a consolidated system.** Many health systems have grown through acquisition, and have not fully realized new efficiencies and synergies system-wide. Consolidating where appropriate and looking for synergies across the system can improve efficiency.
- » **Pursue or expand new revenue streams.** Many forward-looking CEOs are pursuing revenues from new payers, selling IP, and launching philanthropic organizations.
- » **Diversify beyond the core hospital.** As inpatient revenues decline, many CEOs are partnering or integrating physician practices, investing in outpatient services, step-down care, urgent care, etc.
- » **Improve revenue cycle systems.** Despite upgrades to revenue cycle systems in recent years, many health systems are still leaving money on the table. They may be able to leverage scale and improve efficiency by reducing the number of supply chain vendors and non-critical employees.





CHAPTER 4

How do health systems invest in talent to create forward-looking leaders?

Many health system CEOs are concerned about talent issues: recruitment, retention, and performance management are focus areas, as well as working better with employed and affiliated physicians, referred to as physician activation. The CEOs we surveyed recognize that their businesses are changing and that they will need the right talent—now and in the future—to keep pace with the dynamic marketplace in which they operate.

Health care's fundamental business model is changing. Not only is the system moving away from a fee-for-service (FFS) model that rewards volume, hospitals are employing (versus affiliating with) more physicians,²⁹ nursing staff is aging,³⁰ margins are tighter, and technologies are altering health care delivery. Some new approaches include using more advanced-practice nurses, aligning physicians under various performance-based compensation models, and using technologies to perform certain administrative tasks so that clinical and non-clinical staff can focus on patient care and customer service. All of these trends can impact a health system's talent: physicians, nurses, administrative leaders, health information technology (IT) professionals, administrative staff, and others. CEOs surveyed, therefore, agree that their organizations require new and improved ways to recruit, retain, and engage with their physicians, clinical, and non-clinical staff.

Physician activation

"As we continue to employ more and more physicians, they've got to be the right ones. We're not used to huge turnover. They need to be brought in and aligned since it's a major component of the success of our overall care-model design, and their alignment of incentives as we employ them."

—CEO of a large faith-based health system

According to a survey by the Physicians Foundation, 54 percent of physicians rate their morale as somewhat/very negative. Eighty percent say they are overextended, and half state they often/always feel burnt out.³¹ Physicians feel this way for a variety of reasons: the loss of control of practicing medicine, increased performance measurement, greater complexity, inefficient electronic health records (EHRs), and practice environments.³² Combined with the shift to value-based care, this level of frustration shows why many health systems could benefit from transforming their relationships with physicians.

In our 2017 survey and interviews, 14 out of 20 CEOs say that recruiting and hiring the right staff is a major issue. This aligns with our findings from two years ago.³³ However, as more health

systems employ physicians, many CEOs are increasingly concerned about relationship issues with both employed and affiliated doctors.

“Physician activation” (see sidebar) is an increasingly used term among hospital administrators, payers, thought leaders, and physicians themselves to describe the actions used to engage physicians and motivate behavior change.³⁴ To transform the delivery system, CEOs are commonly working to involve physicians in improving quality and safety, and in redesigning care.

“Some of the hard work on physician integration or engagement [has been] done. A lot of the ground work was laid in bringing the academic physician practice into the health system through integration so [our organization] is truly the delivery network, the health system, and the physician practice as well. [Integration has] done a lot of really good things around alignment.”

—CEO of a large academic medical center

Many health system CEOs say activation begins with educating physicians about how to operate, lead, and transform health care organizations.

“A lot of our priorities are around physician engagement and leadership. Physician involvement has really increased dramatically. Making sure we have a good pipeline of leaders in the organization is very important.”

—CEO of a large nonprofit health system

When discussing desired qualities of their employed physicians, CEOs often emphasize adaptability. While leadership is important, many survey respondents and interviewees agree that physicians need to be continuously learning and adapting to a transforming industry and be able to effectively provide care in a new environment.

“You need to invest in your talents, invest in your staff, create leadership development programs, [and] develop succession leadership across the organization.”

—CEO of a large academic medical center

What is physician activation?

Many health system CEOs still use the term “aligning” when describing how they engage with physicians. However, this implies trying to get physicians to support a strategy that does not belong to them. Some health system CEOs, however, are talking about changing behavior through “activation” and partnership. Under these models, CEOs and physicians co-develop a strategy and work to change behavior together.



CEOs commonly say physicians still have misaligned incentives; however, new value-based reimbursement models that emphasize both cost and quality call for physicians to transform the way they practice health care. In our 2016 survey, 86 percent of surveyed physicians reported being compensated under FFS or salary arrangements. But in 2017, many CEOs agree that value-based care is a better approach. Many health systems are employing physicians to better align incentives around population health and value-based payment models. Many also are working more closely with their affiliated physicians on cost and quality improvement efforts.

Talent shortages and a changing workforce

“Talent in general ... continues to be an issue. We still see shortages in nurses, pharmacists, therapists, radiology technicians. And then you get into the physician realm, and there are still shortages there—not only in our market, but nationally—that I think are going to be exacerbated as we move into the future.”

—CEO of a large nonprofit health system

Many CEOs are concerned about the potential shortage and uneven distribution of medical professionals—physicians, nurses, technicians, and ancillary professionals. Although the Association of American Medical Colleges (AAMC) has long warned of an impending physician shortage,³⁵ other research finds that health care workers are inefficiently distributed, rather than in short supply. The Institute of Medicine determined that the combination of more mid-level professionals (such as nurse practitioners) and advancements in technology and treatments could mitigate the impacts of a physician shortage.³⁶ However, the distribution of physicians—including the mix of specialties—and other clinicians across geographic areas often continues to be an issue.

Surveyed health system CEOs also say that managing talent, especially the millennial generation, requires acknowledging and addressing different priorities. In some ways, this group can be easier to engage. Millennial physicians, for example, consider themselves to be more data-driven than their older counterparts, and 62 percent cite their reliance on EHRs as important in providing quality patient care.³⁷

Understanding and accommodating what motivates millennials may be a challenge for some health system CEOs. Unlike older physicians, millennials tend to prioritize work-life balance: 92 percent of surveyed millennials say that it is important for them to strike a balance between work, personal, and family responsibilities.³⁸ In an environment that often requires long hours and being on call, many CEOs are still learning how to meet millennial workforce expectations.

Preparing for the health care workforce of the future

With health care undergoing major transformation, CEOs often say they need forward-thinking, flexible, and innovative staff that can help their organization transform. To prepare for what may be a dramatically different future, CEOs and other health system executives should consider first identifying and understanding the many ways that health care is changing and determine how the results may shape their future workforce needs. What care can be shifted away from the hospital to outpatient and home settings? What technologies can be leveraged to better deliver care? From these answers, the health system should consider what type of clinical and non-clinical talent is required for a future delivery system.

Workforce planners then can use this knowledge to delineate roles and responsibilities, identify technology-support opportunities (e.g., task automation), activate physicians, and train the workforce. Training programs may extend beyond traditional clinical continuing education to include immersive, experiential, business, leadership, and technology topics. Training the workforce of the future can also mean empowering and engaging both clinical and non-clinical staff, as data show that an engaged workforce can lead to better patient experience and outcomes.³⁹



“Workforce recruitment and retention is probably the number-one issue that I lose the most sleep about. It’s not just nursing staff; it’s other support staff as well.

Frankly, from a recruitment standpoint, even more important is retention. We’re facing some pretty significant turnover numbers...and we are trying to figure out a better way of retaining [employees].”

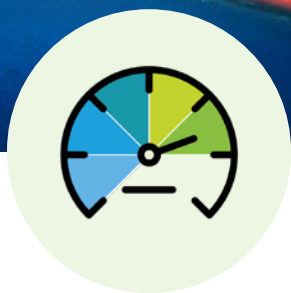
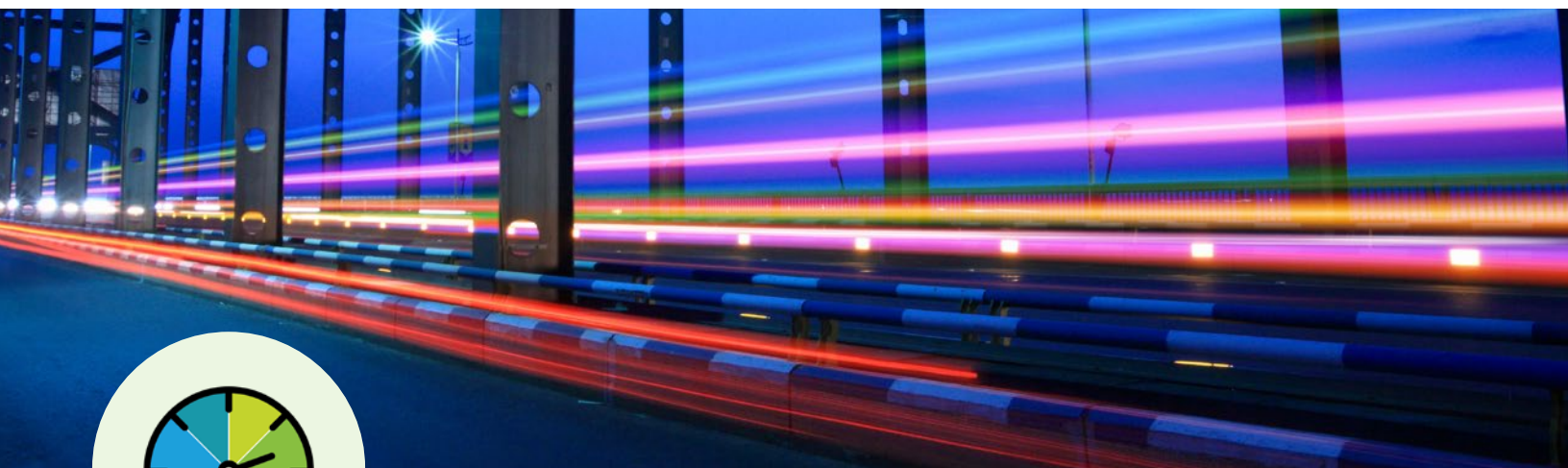
—CEO of a large academic health system



With value-based care expected to greatly influence the way health systems engage with physicians and other talent, CEOs should consider using an evidence-based approach that includes:⁴⁰

- » Activating physicians who are incented under different payment structures to transform the care delivery system
- » Using a variety of approaches to work with and incentivize employed and affiliated physicians
- » Partnering with both employed and affiliated physicians to lower costs and improve quality, patient experience, and staff experience
- » Reimagining the future of work and identifying ways to use technology to augment or automate tasks
- » Recruiting and retaining a workforce (physicians, nurses, staff, IT) that aligns with the health systems' current and future needs
- » Using data, metrics, and reporting to set and monitor performance goals for clinical and non-clinical staff
- » Investing in leadership development and recruiting more talent from outside the industry
- » Cultivating a workforce culture that supports and facilitates consumer empowerment
- » Communicating openly and honestly with employees, affiliates, and associates
- » Forming partnerships to develop innovative staffing ideas





CHAPTER 5

Enabling care transformation and mitigating cyber risks through technology

Health system CEOs we surveyed are concerned about cyber risks and the cost of Health Information Technology (HIT). Despite these concerns, health system CEOs continue to invest in technology to improve:

- » Care delivery
- » Operational efficiency
- » Consumer experience
- » Data analytics
- » Cybersecurity preparedness

In addition, some CEOs cite the need for better HIT tools to improve revenue cycle management: if the number of self-pay patients increases, the use of high-deductible health plans (HDHPs) increases and reimbursement from all payers decreases. As a result, many CEOs say they need systems in place to better capture reimbursement. This includes improving registration, collection, billing, and claims processes.

HIT and technology investments: Staying current and strategic

The CEOs we spoke with describe the dangers of making tactical HIT investments that lack clear ties to broader organizational goals of using technology to improve care delivery. Among more strategic investments are technologies

that better connect patients, lower cost of care, or improve administrative process efficiency.

As health care becomes increasingly digitalized, more hospitals and health systems are welcoming technology experts into the C-suite and including more business and clinical experts among their IT leadership.⁴¹

“Health IT is a big, big, big concern, [but is] the tail wagging the dog? Are we an IT institute that happens to care for children occasionally? A lot of our IT people think so.”

—CEO of a large children's hospital



Such staffing changes can be important because a number of CEOs say they are focused on developing and applying an organizational strategy for HIT versus making one-off investments.

A common investment focus area for CEOs is integrating legacy systems as part of a merger or acquisition. Getting to a standard IT platform is often a priority because it can help improve efficiency and enable operational integration. In addition, merging IT systems can help dismantle “silos” of clinical and other data which, in turn, can improve analytical capabilities, create a more unified patient experience, and support quality tracking and other improvements.

“It is a high priority to get to a standard platform. Getting to one platform we think will add a lot of efficiencies and help us act more like a system. [We are] behind [our] peers in this regard.”

—CEO of a large faith-based health system

HIT spending is high and it continues to grow, according to interviewees. Also, because technology evolves quickly, years-long IT projects can be made obsolete within months

unless sufficient funding is designated for ongoing system enhancements. And despite HIT’s potential to drive organization-wide improvements, many executives say they have yet to see a tangible return on their technology investments. HIT ROI can be difficult to calculate, which can make justifying investments challenging and complex.⁴² Many executives describe a wide range of systems that contribute to technology spending, each of which could require unique ROI calculations.

“[Technology investment] has actually realized the fewest benefits. We continue to spend more and more in technology but we have not seen the return.”

—CEO of a large faith-based health system

Transforming care and embracing change

Despite concerns about necessary and growing HIT spending, many executives report investing in digital consumer-engagement capabilities to improve patient access and care delivery. These include online scheduling, patient portals, and telehealth. Some executives see these capabilities as just the beginning of transforming care.

“More and more...care is going to be delivered through telemedicine and digital medicine, and that’s an area that we are focusing on—big time. All we have to do is look and see the younger generations these days and figure out how it is that they access information and manipulate information, and then do the same for health care.”

—CEO of a large academic medical center

While some executives lament the need for continual and large technology investments, the opportunities that accompany them should not be ignored. HIT spend is unlikely to decline in the future, and cyber risk is unlikely to disappear. Cultivating a thorough understanding of the organization’s long-term HIT strategy, including risk-mitigation, can be critical.

“I just believe that there will be a disruptive technology or a disruptive innovation. And much like you can’t imagine leaving without your iPhone for one day, I think we are going to be receiving health care and demanding things from the health care system that we can’t even imagine as we sit here today.”

—CEO of a large nonprofit health system

Cyber risk and security: Maintaining the “sacred trust” is a top concern

Nearly all executives are aware of their institutions’ cyber risks, particularly since our interviews were conducted during the widely reported WannaCry cyberattack. The number and magnitude of cyberattacks is increasing across all industries,⁴³ and health systems’ increasing technology use makes them vulnerable to such attacks. Additionally, malware has evolved to spread laterally throughout organizations and can have real operational and safety impacts.⁴⁴

CEOs’ perspectives on cybersecurity ranged from passionate, citing the “sacred trust” that providers must protect the people they serve; to more pragmatic, noting its necessity but lamenting its cost.

“This cybersecurity issue that broke loose over in Europe is far larger than people realize. Cybersecurity... will continue to be [an issue], and I think what happened this past weekend [the WannaCry cyberattack] will become the new norm.”

—CEO of a large faith-based health system

Health care is second only to the finance industry in the number of cyberattacks annually.⁴⁵ Of note, 80 percent of health industry attacks in 2017 targeted providers.⁴⁶ An average of one health care breach incident per day was reported in the first half of 2017, with at least half of the incidents perpetrated by hackers.⁴⁷ Globally, the average total cost of a health care

data breach to an organization reached \$3.62 million in 2017. The overall organizational cost per breached health care record reached \$380, leading all other industries.⁴⁸

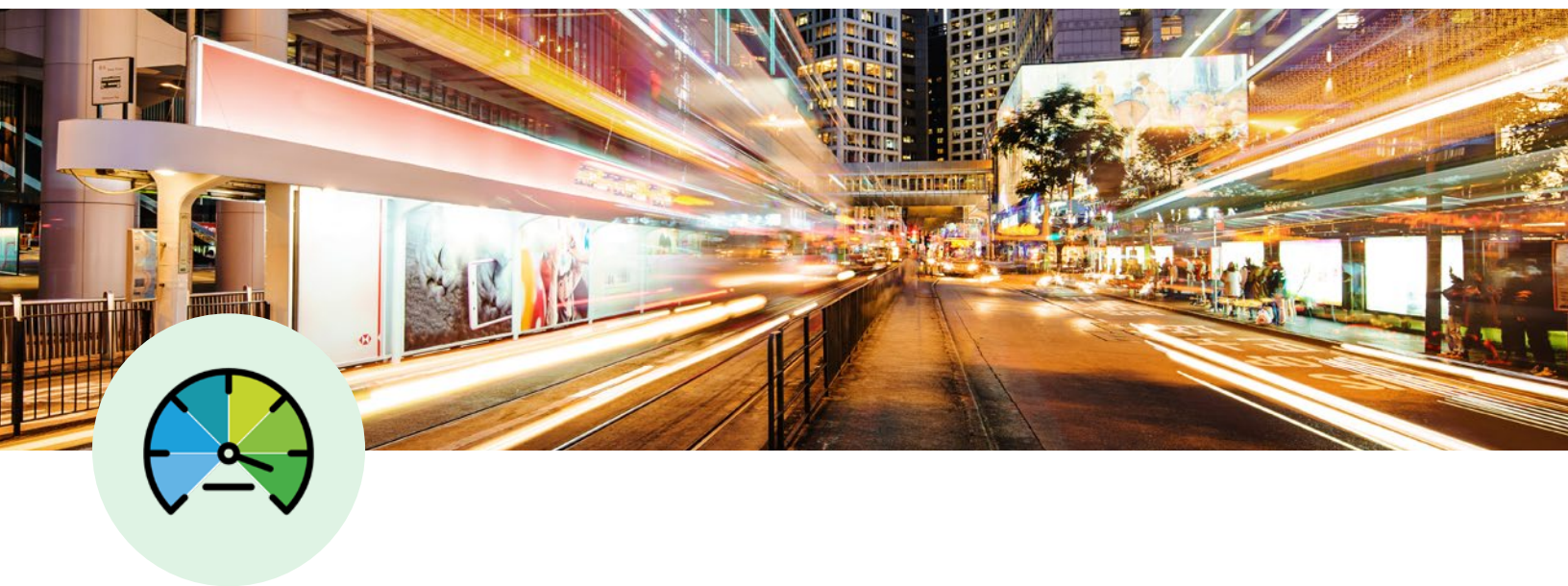
Cybersecurity is a priority for most CEOs, but it exists as one issue among many that demand their attention. Several executives note that they have been focused on cyber for some time already, but are aware that they may never be completely safe. A large academic medical center, for example, could contain 500 to 1,000 different HIT systems, each interacting with the organization’s very large electronic health record (EHR) and enterprise resource planning (ERP) systems, which can result in many points of potential failure.

With a well-developed HIT strategy, CEOs and HIT leaders can prioritize resources and invest in updates and emergent technologies that have potential to improve care delivery, cost, quality, and consumer engagement. Executives should think strategically about how each HIT investment brings the most value, and how it enables new, different, or better care. Forward looking CEOs are commonly:

- » Defining a strategy to drive HIT investments and decisions across the entire organization
- » Developing new models of delivering patient care through technology
- » Investing in exponential technologies such as:
 - Robotics and artificial intelligence for administrative and clinical process automation
 - Cloud solutions to enable access to continually updated systems, rather than housing, maintaining, and updating complex HIT systems on-site
 - Blockchain for the safe transfer of information to, from, and within the hospital, including among patients and other health care provider organizations
 - Clinical developments, including gene therapy, that improve care and quality
- » Using predictive analytics to deliver population health capabilities such as identifying patients who are most at risk for medical complications including diabetes and cardiac arrest
- » Finding ways to integrate data across the organization and address regulatory barriers and data silos
- » Sharing information to create smarter ways of working with multiple stakeholders
- » Leveraging data and technology for decision-making in care delivery and process improvement efforts.

The idea that you are going to be fool-proof against hackers of one kind or another would be foolish. You just have to make sure that you can do the best you possibly can to protect yourself as much as you can, but you can never be foolproof.

—CEO of a large academic medical center



CHAPTER 6

Making the business of health care consumer-centric

Many health system CEOs say that being consumer-centric is a top priority for their institutions, especially as organizations move from a business-to-business (B2B) model (with employers, health plans, and physicians as their main customers) toward a business-to-consumer (B2C) orientation. Many CEOs realize that consumers are becoming more involved in their health care decisions, which can make positive health system-consumer connections and interactions increasingly important. CEOs interviewed stated they expect their leadership to understand consumers' evolving expectations, and that a focus on the consumer has become a fundamental part of how some organizations see themselves. One CEO of a large, nonprofit health system notes that the organization's mission and vision now includes being "consumer-obsessed" and "continuously earning the trust of others."

Many CEOs are preparing their organizations for the future by focusing on the patient/consumer experience (e.g., quality outcomes, safety, integration, access) and exploring direct-to-consumer care delivery (such as telehealth). They are also seeking to better understand consumers. One nonprofit hospital CEO explains that making health care "easier" for consumers to access—and providing high-quality care—are distinct aims, both of which can improve consumers' lives. Technology can assist health care organizations in reaching these goals. More and more, health care providers should begin to view their customers as members. As health systems

take more risk for outcomes, engaging with their patients as members—or subscribers—can require a whole new set of capabilities for health care providers.

Improving the patient experience not only can help reduce challenges in accessing health care; it can improve profit margins and quality scores. Recent Deloitte Center for Health Solutions research found that hospitals with higher patient experience scores are generally more profitable than those with lower scores.⁴⁹ Hospitals with more positive patient-experience scores also rank higher in certain quality scores than those with lower experience scores. Many CEOs are learning that there are benefits to addressing consumers' needs and they are striving to create positive patient experiences.

Treating patients as informed consumers with purchasing options is increasingly important as they become more financially responsible for their health care costs. The growing prevalence of high-deductible health plans (HDHPs)—in which consumers pay more out of their own pocket—is helping drive this heightened focus. Roughly 42 percent of Americans are enrolled in a HDHP with an annual deductible of \$1,300 or more.⁵⁰ One CEO of a large, nonprofit health system says that HDHPs that require patients to pay more out of pocket contribute to the health system's bad debt and uncompensated care.

In November 2015, Geisinger Health System in Pennsylvania announced a revolutionary policy: a warranty offering patients their money back if they were unsatisfied with their care—no questions asked. The health system had already implemented a successful program where it agreed to absorb extra expenses for care (e.g., extra hospital days) if a patient experienced complications after care. Over the first nine months of the program, the monthly average for adjustments (i.e., returned copayments, forgiven deductibles) was about \$30,000—roughly the same amount offered prior to the program. The health system did not see a substantial change in financial adjustments.⁵¹

Driving patient engagement

“Consumerism is important because we need engaged consumers to make intelligent decisions on where to seek care and when.”

—CEO of a large children’s hospital

Many CEOs agree that an informed and engaged consumer is necessary for the health care system overall. Recent research found that health care providers are becoming increasingly responsible for patients’ health literacy and that providing assistance in this area can directly enhance patient loyalty.⁵²

“Consumers are driving some of the desires for the innovations and shifts in delivery models or innovative ways to receive health care.”

—CEO of a large children’s hospital

Because of consumer demand and changing incentives around value-based care, many health systems are investing in retail clinics, telehealth services, and other types of care delivery models. One CEO notes that learning about consumer preferences forced the organization to think creatively about care delivery.

Technology can support a health system’s efforts to be consumer-centric. As responses to Deloitte’s 2016 Survey of US Health Care Consumers show, patients want to use technology for their care. For example, 17 percent of consumers report going online for reminders to take medication. Other popular uses of technology in health care include telehealth, connected

devices, and the Internet of Things (IoT). Many caregivers are also interested in connected devices. Many hospital systems are investing in technologies including mobile health (mHealth) apps, consumer-friendly websites, and online scheduling to enhance patient-provider connections.

Emphasizing patient convenience over that of the clinician by providing care through specialty clinics, telehealth, primary care clinics, and urgent care centers is another consumer-centric strategy, says a children’s hospital CEO. The CEO adds that making care more convenient can help keep patients, including those with behavioral health issues, out of the emergency department and the hospital overall.

As many millennials become parents, some children’s hospitals are changing the way they interact with these typically tech-savvy and health-aware consumers. One physician says that millennial parents often come to physician or hospital visits already informed, having done research.⁵³ Many millennials do not want a traditional patient-clinician relationship; instead, they are looking for new ways of relating. For example, a children’s hospital CEO notes that often millennial parents want mobile and telehealth connections with their children’s health care providers.



Many CEOs are taking action to improve the patient experience, in part, to increase consumer loyalty to the health system and its clinicians. CEOs say they recognize the importance of loyalty and branding when it comes to consumer engagement and population health efforts.

- » “Consumers count,” says one CEO from a nonprofit health system. However, a CEO from a different nonprofit notes that the concept of loyalty has changed—people are more concerned about convenience than staying with a particular physician. A Deloitte survey of health insurance consumers found that 20 percent would accept a network with fewer hospitals, and 20 percent would accept a network without their current primary care provider. These results suggest that stakes are high for hospitals, and that patients are not necessarily loyal to one hospital or clinician.
- » Another CEO of a large nonprofit health system states that it is important to help patients move easily among a health system’s departments or facilities because they do not see them as separate entities. This CEO also says that he wants patients to see the components of the system as “all part of one family.”
- » A third nonprofit CEO describes a broader relationship between hospitals and patients’ health in which the hospital is responsible for the community’s overall health, not just interacting with individuals during episodes of illness. Broad access will be necessary to realize this goal.

One AMC CEO sums up health systems’ perspective on consumerism, saying that the system seeks to understand consumers, their preferences, and their behaviors. Understanding and addressing consumer preferences may be key to the system’s survival and all of the hospital’s leaders say they try to listen and respond to consumers.

Investing to become consumer-centric

Many leading health systems are investing in technology and improving the patient experience to better connect with consumers. But many of them still have a long way to go to become truly consumer-centric. Health care can look to other industries—airlines, travel/hospitality, and financial services—to identify effective strategies for interacting with consumers.

To address consumerism, many hospital CEOs are:

- » Realizing that meeting an individual’s expectations as a consumer may be as important as meeting their clinical needs.
- » Keeping clinical care at the center of a patient’s experience, rather than merely focusing on appearances or amenities.
- » Investing in technologies to make health care easier to understand and access, such as:
 - Creating an online experience to find relevant and personalized content for a condition based on cost, the patient’s medical situation, etc.
 - Improving their scheduling systems and processes, and using telehealth, e-visits, and remote patient monitoring to make care easier to access.
- » Establishing and nurturing a two-way relationship with consumers to build long-term loyalty.

These types of changes are helping move the traditional hospital-patient relationship toward a member relationship. Ultimately, surveyed health system CEOs predicted that the hospitals with the most members are going to do the best in the new world of health care.

Conclusion

Consumerism is helping drive a shift in the US health care delivery system. Increasing focus on the consumer may be key for hospitals’ and health systems’ survival; surveyed CEOs know they need to move their organizations toward becoming patient-centric. Consumers are looking more closely at their health care options and are increasingly focused on value as they take on more financial responsibility. Hospital leaders should to take steps to adapt to this changing consumer dynamic.



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