Executive summary

Data from Deloitte’s June to September 2011 interviews with 24 Chief Executive Officers (CEOs) of acute-sector hospitals and multi-hospital health systems shows that CEOs and their organizations face challenges that are at once virtually unprecedented, predictable, and unknown. They are unprecedented due to the compounding impacts of:

• Affordable Care Act (ACA) requirements to deliver services through clinically-integrated, team-based models or face financial penalties
• Accelerating changes in clinical innovation to provide state-of-the-art, evidence-based care
• Mounting pressures from independent physicians to affiliate with a hospital
• Increased costs for drugs, supplies, technologies, and staffing – the ‘supply chain’
• Increased competition from entrepreneurs who capture opportunities in attractive niches and may have the potential to ultimately reduce hospital revenues and margins
• Increased consumer interest in and use of public scorecards on hospital and physician safety, quality, and satisfaction
• Decreased reimbursement rates from third-party payers – Medicare, Medicaid, commercial health plans – accompanied by increased risk-based contracting

They are predictable because CEOs and their boards have been dealing with regulatory, clinical, budgetary, and market pressures for years. They know that the business of running hospitals and health systems is tough and that they have an extensive punch list of near-term action items that includes:

• Reprioritization of capital plans to accommodate requirements for health information technology (HIT), ICD-10, clinical program transformation, technology upgrades, and physician alignment
• Expansion of traditional programs and services to grow revenue and leverage with third-party payers, and new capabilities which may need to be added to achieve scale
• Reduction of costs – sometimes radical – beginning with workforce redesign and supply chain cuts
• Development of new relationships with physicians to accommodate risk-sharing in contracts with payers and improve outcomes to help avoid penalties
• Implementation of structural changes in leadership and governance may be necessary to optimize the organization’s performance
They are unknown because hospital CEOs and their boards face numerous uncertainties, such as:
• How the ACA will be implemented or constitutional challenges resolved
• What Medicare will pay hospitals and physicians in the near-term
• How commercial plans will respond to changing market dynamics
• Where private equity and strategic investors will place bets on the system to stimulate innovation or pursue opportunities
• How clinical research and medical education will be impacted by new regulatory and fiscal constraints
• What regulatory and/or reporting requirements might be imposed by states or federal authorities
• Whether employers will elect to drop health insurance coverage and require employees to purchase it through state health exchanges
• How the overall instability of the U.S. economy might impact utilization of services provided by hospitals and physicians

Dealing with these and other unprecedented, predictable, and unknown challenges is the “new normal” for hospital and health system CEOs. Each scenario is somewhat different – most, if not all, share challenges from trustees that might not understand the environment, physicians seeking economic security, health plans and suppliers pressing for better deals, and new competitors chipping away at profitable revenue streams and referral relationships.

The bottom line: many hospital CEOs stated that the “new normal” represents the biggest test thus far in their professional career. They anticipate two eventualities for their organization: it will be paid less for the entirety of services provided, and its portfolio of acute clinical services is likely to become a cost center in a bigger, more complex organization that is focused on care for the healthy, not just the sick.

Hospital and health system CEOs are accustomed to making tough decisions and the resulting likelihood of criticism. They are frustrated by the “tyranny of the urgent” – dealing with issues that demand immediate attention, to the detriment of longer-term initiatives. Yet, CEOs also are energized by the potential cultural and operational changes the new normal may inspire.

Looking beyond urgent issues, the surveyed CEOs are focused on four imperatives in the new normal:

**Change the culture.** Instituting the latest clinical processes and technologies is unlikely to achieve desired efficiencies if they are not meaningfully integrated into employees’ roles and accountabilities. CEOs and their executives should evaluate – and, potentially, update or redesign – existing job descriptions, operating models, reporting structures, and recruiting and compensation arrangements.

**Reduce costs.** Identifying and cutting non-strategic costs likely will require CEOs to demonstrate a combination of short-term decisiveness and long-term creativity. Job sharing, outsourcing, shared services, delayed investments, joint ventures with capital partners, and balance sheet protection are survival options that should be considered.

**Add core competencies to fill gaps.** Plotting the path to a comprehensive, clinically integrated care delivery system may require that CEOs add capabilities to fill gaps in four areas: (1) risk management capabilities and infrastructure to optimize clinical and financial performance, avoid penalties, and optimize safety and outcomes; (2) physician leaders equipped with business and clinical skills to manage clinical processes aggressively; (3) informatics and HIT expertise to respond to meaningful use requirements and translate data into useful clinical and financial information; and (4) strategic planning and marketing expertise to manage opportunities, partnerships, and fresh approaches to positioning strategies with online consumers.

**Create a vision for the new normal.** Identifying opportunities, sidestepping pitfalls, and building understanding about the realities of the new normal will call for CEOs to continually inform, engage, and enlist the assistance of trustees, other C-suite executives, senior managers, and affiliated physicians.

The new normal is not an insurmountable problem to hospital and health system CEOs; rather, it is a sobering reality they embrace knowing the stakes are high and failure to survive is a possibility unless the hospital or health system carefully, strategically, and objectively navigates its course.
Methodology

Between June and September 2011, senior leaders from Deloitte Consulting LLP interviewed 24 CEOs from a cross section of America’s acute health care systems (with revenues greater than $1 billion), using a standardized questionnaire developed by the Deloitte Center for Health Solutions. Interviewees’ responses were anonymous.

The study’s intent was to capture an aggregate view representative of leaders of major standalone and multi-hospital systems, looking at the short-term (next three to five years) and long-term future (to 2020). This report is based on content analysis of verbatim responses, using a standardized approach to code and cluster comments.

As a qualitative study, the findings are representative but not quantitatively projectable to a larger population of health system executives.

Key findings

Overall state of mind: Health system CEOs are guardedly optimistic that their organizations will survive and thrive in the future, but anticipate that necessary changes may challenge their leadership. Organizational survival is contingent on factors such as substantial growth and scale, access to capital to integrate new lines of business, and development of new business relationships in the supply chain and with collaborators.

Current preparedness: Most CEOs participating in the interviews think their organization is in a good position to survive and prosper. They are confident that the balance sheet is strong and that their relationship with core physicians is positive. Areas demanding CEO attention include cost structure sustainability, uncertainty about health reform, board readiness, and strategic investments in HIT and clinical program innovation (Figure 1).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our balance sheet is strong; we can access adequate capital at favorable rates</td>
<td>8.8</td>
<td>8-10</td>
</tr>
<tr>
<td>We enjoy the trust and confidence of our core medical staff</td>
<td>8.6</td>
<td>7-10</td>
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<tr>
<td>Our competitive position is strong relative to our local competitors</td>
<td>7.4</td>
<td>3-10</td>
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<tr>
<td>Our physicians are well informed about the industry and changes that will impact their future</td>
<td>7.2</td>
<td>3-9</td>
</tr>
<tr>
<td>Our relationship and structure with our physicians is well positioned to share risk with insurance plans</td>
<td>7.1</td>
<td>7-10</td>
</tr>
<tr>
<td>Our board is well informed about the industry and its future challenges</td>
<td>6.7</td>
<td>5-10</td>
</tr>
<tr>
<td>Our culture lends itself to innovation</td>
<td>6.7</td>
<td>3-10</td>
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<tr>
<td>Our clinical programs are the right balance of acute and ambulatory services</td>
<td>6.7</td>
<td>3-10</td>
</tr>
<tr>
<td>We have the information systems necessary to prepare for the future</td>
<td>6.7</td>
<td>3-8</td>
</tr>
<tr>
<td>We are prepared for the eventualities that might come from health reform</td>
<td>6.1</td>
<td>2-8</td>
</tr>
<tr>
<td>Our current cost structure is optimal for value-based purchasing by Medicare and payers</td>
<td>6.0</td>
<td>4-9</td>
</tr>
</tbody>
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Note: Based upon a rating scale of 1 to 10 with 10 indicating a high level of preparedness and 1 indicating a low level of preparedness.
**Near-term challenges:** CEOs view their organizations’ major challenges as being internal rather than external. Needed improvements in workforce training and development, integration of information technologies (ICD-10, meaningful use), upgrades and expansions of clinical services, physician alignment, and cost reduction are expected to require major investments. Of particular note, CEOs face obstacles with frontline senior and middle managers, as well as physicians, in implementing short-term strategies to address these challenges. In most organizations, CEOs think that convincing physicians and managers that these changes are “table stakes” will be a tough sell and will require a substantial amount of CEO energy and attention.

CEOs’ top ten near-term challenges (mentions out of 24) are:

1. Facilitating physician alignment and integration into leadership roles (23)
2. Reducing operating costs to respond to cuts from payers (21)
3. Integrating non-acute services to become a system of care (20)
4. Managing in uncertainty as a result of health reform, payer consolidation, fiscal constraints (20)
5. Implementing health information technologies and integrating them into evidence-based care (13)
6. Building new/non-conventional relationships with commercial health plans to share risk and savings (12)
7. Engaging more directly with employers and consumers (8)
8. Redesigning current acute clinical programs to be responsive to innovations in diagnostics and therapeutics (8)
9. Engaging consumers in wellness, preventive health, and personal accountability (8)
10. Protecting or enhancing the brand and reputation of the system (7)

**CEOs’ illustrative comments:**

- We have to see ourselves as a system of care, not a hospital. It’s hard to change that culture.
- Hospitals need a diversified portfolio of patients, but they can’t do everything. We must focus on what we do well.
- In the future, the hospital will no longer be the golden goose. Physicians will have free rein on where the profit will be, especially if they are organized and have access to capital. When they do organize, I hope they include us. They may or may not.
- We need a stronger primary care base... but we have a problem there. We have not been primary care-focused so how do we start now?
- Leadership structures need to be flatter to allow for flexibility in decisions.
- Regionalization of clinical program development, deals with doctors, and dealing with employers more directly are challenges in most acute-centric organizations.
- There is no value add to partner with pharmaceutical companies unless it is in the development of a specific drug.

**Health care reform:** Of the CEOs interviewed, many view health care reform as a work in progress, likely to change, and disruptive to the organization. CEOs are not fixated on reform; they understand it but are more concerned with market and fiscal pressures at the state and federal levels than the possibilities around the ACA. Also, state Medicaid funding constraints are a bigger near-term threat than Medicare reimbursement and deficit reduction efforts in Congress. Specifically, 15 of 24 CEOs said they believe that
ACA is likely to change; most believe that payment reforms (pre-existing condition, health insurance exchanges, etc.) will be implemented while delivery system programs (accountable care organizations (ACOs), value-based purchasing, etc.) might be modified or discontinued. The majority of CEOs said they believe that ACA falls short in addressing systemic issues in the U.S. health system.

**Long-term outlook:** Of the CEOs interviewed, many say that market (external) pressures are significant. Sources of concern include competing with both traditional and nontraditional players; adapting to risk-based contracting with Medicare and commercial plans; complying with ACA; and dealing with volatile state Medicaid payments, scheduled Medicare cuts, and pressure from consumers. CEOs do not know how things will play out; however, they cite two “inevitables”: their organization will be forced to operate at Medicare payment rates, and it will be paid substantially less by payers. The majority of CEOs also believe that provider consolidation will increase, and that many providers will implement their own health plans in addition to growing their long-term, chronic, and primary health services programs.

**CEOs’ illustrative comments:**
The states are a bigger concern than the federal government. Most are already under water. The addition of Medicaid enrollees will lead to lower payments to providers and increased bad debt.

So much about health reform is unknown about how it will be implemented…and some things will go wrong.

The court will likely find the mandate unconstitutional, but reform will play out anyway, and the rest of the law will stay.

Much of the reform is payment reform today; we are really not doing health reform.

Some aspects of accountable care will be in place, but not the government model.

We are unsure about accountable care organizations and not particularly interested. They’re a non-starter. For us, bundled payments are substantially more relevant and disruptive.

We expect substantial consolidation in the insurance industry. It is already challenged to demonstrate value. Some will transition to a business model built around information management replacing care management.

How the health exchanges play out is what we’re following closely. We anticipate a shift to an individual insurance market and the possibility employers might exit benefits once exchanges are up and running.

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**CEOs’ illustrative comments:**
We need to be nimble and flexible to deal with the uncertainty. That’s a skill set we do not have today.

We need to be bold and courageous like Wall Street. We need focus and discipline and courage. We have a lot of work to do.

The big three capabilities we need to embrace are predictive analytics, clinical decision support, population management.

There will be significant consolidation of payers. That would be incredibly gratifying.

We need to bend the cost curve, but we also need to own the premium dollars…and focus on the revenue side.

I envision a time when everyone will be running around with health cards that have their medical records and everyone will be in a medical home.

The schizophrenic reimbursement system that doesn’t today reward preventive services will hopefully get straightened out.

Change will be incremental until a crisis hits, then it will be transformational.
The fundamentals: CEOs believe that merger/consolidation in the delivery system, combined with new models for physician engagement, are necessary changes. They acknowledge radical cost reduction as a requisite, and recognize that HIT investments are “table stakes” that may defer capital investments in other areas of opportunity.

Key takeaways
Health system CEOs face enormous pressure to transform their organizations from acute-centric care facilities into cost-effective managers of care across the preventive, chronic, acute, and long-term continuum. These leaders are realistic, and they understand their greatest challenges are internal, aligning physician, trustee, and supply chain relationships, and implementing change aggressively.

Many CEOs do not anticipate that ACA will necessarily improve the performance of the U.S. health care system; most of its proposed changes to the delivery system (accountable care, bundled payments, avoidable re-admissions) are “trial and error.” Concerns requiring immediate attention include the fiscal constraints of state Medicaid programs, budgetary cuts by Medicare as part of Congress’ overall deficit reduction effort, and looming dis-intermediation of “core physicians” attracted to the income security offered by competitors or health plans.

CEOs anticipate that changes in the insurance market might have significant impact on revenue growth. They believe that the commercial health insurance industry will consolidate and that many large surviving health plans will become more vertically integrated and emerge as competitors to health systems.

Increase revenues by transitioning to a risk-bearing integrated health system: CEOs are likely to focus on issues such as (1) accepting risk for clinical and financial results to avoid penalties and optimize safety and outcomes; (2) responding to increased transparency demands from employers, health plans, credit rating agencies, and consumers; and (3) re-engineering the acute clinical portfolio to maximize volume and efficiency for value-based purchasing and episode-based payments.
Think system: CEOs see opportunities to provide health services to new markets locally, regionally, and in select cases, globally. Many CEOs recognize that expanding into new markets is necessary; they are reluctant to be commoditized by a lack of scale or failure to respond to competitive challenges.

CEOs want to play offense, not defense.

CEOs expect to concentrate their efforts in four areas: innovate the operating model, reduce costs, add core competencies to fill gaps, and create a vision for the “new normal.” To achieve these goals, CEOs expect to execute in ten key areas:

1. **Strategic planning:** conducting scenario planning activities to engage trustees, physicians, and managers in thinking about the future and its implications for the organization. Aligning leaders around a more integrated operating model that can deliver the new strategy and ensuring a capability to monitor and communicate events, regulations, and implications of ACA to stakeholders.

2. **Workforce re-design:** training and equipping managers to facilitate system-based decision-making, improved workforce productivity and effectiveness, and reduced operating costs (fixed and direct). Design key jobs/positions to ensure “best and highest” use of physicians, extenders, registered nurses (RNs), nurse practitioners (NPs), and others.

3. **Clinical portfolio improvements:** transforming traditional acute and ambulatory services to adhere to evidence-based practices, regulatory compliance (safety), outcomes reporting, and team-based clinical delivery. Identifying and consistently reducing cost variability within high volume disease-related groups (DRGs).

4. **Information systems updates:** implementing ICD-10, electronic health records, and clinical information systems to seamlessly support ambulatory, acute, and long-term care services.

5. **Payer contracting:** developing capabilities and infrastructure to support risk-based contracting with employers and third-party payers.

6. **New sources of revenue and access to patients:** securing new sources of capital to sustain growth and achieve scalability, including partnerships/collaborations, non-traditional revenue channels such as wellness and healthy living, retail health care, alternative medicine, long-term care.

7. **Supply chain management:** developing innovative approaches to address supply chain relationships and costs, including exclusive contracting, shared risk, restrictive formularies, and others.

8. **Integrated business analytics:** accessing dashboards and processes that monitor the entire organization’s clinical and financial performance and facilitate real-time management decision-making (especially if accompanied by peer group comparisons and learning community interactions).

9. **Digital health management:** implementing enhanced, web-based tools to leverage relationships with consumers, employers, and affiliated physicians. Included is the capability around enhanced intensive care units (eICU) to extend access, improve quality, and lower the cost of care.

10. **Talent strategy and leadership development:** establishing a talent strategy for the system. Finding or developing talent for senior leaders who can manage in a dynamic environment and developing the next generation talent to lead in an environment that may look very different than today.
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