

New horizons

After reform: transformation

Featuring exclusive interviews with

Richard Gilfillan, MD,
Chair, Health Care Transformation Task Force

Robert Wah, MD,
Chief Medical Officer, Computer Sciences Corporation

Erin Fraher, PhD, MPP,
Director, Program on Health Workforce Research and Policy



Building a better
working world

To our clients
and other friends



The US health care industry is in the midst of the largest metamorphosis in its history. We are emerging from a time of reform into an era of true transformation. Unlike reform, which suggests incremental progress, transformation signifies a fundamental change in form and function to create something entirely new. In health care, the “entirely new” is a highly collaborative, exceptionally efficient, technology-enabled system that achieves the industry’s Triple Aim: better care, better health and lower costs.

In the collective quest, silos are dissolving and synergies evolving. Venues for delivery are shifting from acute care settings to community networks. Organizations are partnering, affiliating and consolidating at record rates. More payers are entering the provider marketplace; more providers are becoming payers and taking on risk. Various industries, from retail and food to consumer electronics, continue to enter the health care realm – weaving an even more complex web of players and opportunities. Patients are assuming a more active role in their health.

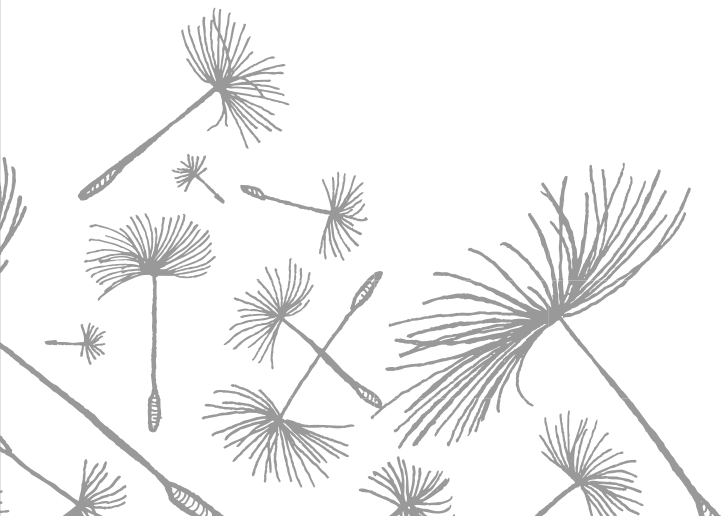
And information technology continues to revolutionize care delivery. The picture of tomorrow is one of wide-scale transformation, taking health care stakeholders to a measurably higher level of mission fulfillment.

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“Unlike reform, which suggests incremental progress, transformation signifies a fundamental change in form and function to create something entirely new.”

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In this edition of *New horizons*, we offer you succinct information on the current state of a transforming industry, along with “transformer” vignettes of exemplary initiatives. Included also are actionable questions to guide your organization in leading the charge toward lasting change. We hope the topics addressed here will assist you in the transformation of your organization – and of the industry overall – as together we arrive at the future’s new horizon.





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“The difference between reform and transformation is as if we have been trying to attach wings to a caterpillar ... it is high time we freed ourselves of attachment to old forms.”

Marilyn Ferguson, *20th-century American writer*



Prelude

Transforming health care – together

Changing shape

Goodbye, health care reform; hello, industry transformation

Reform is often described as “something done to us” – changes instilled by external forces – as opposed to transformation, “something we do together.” The steps of implementing US health care reform through the Patient Protection and Affordable Care Act (ACA), which marked its fifth anniversary in March 2015, have triggered a long-term process of substantially transforming the nation’s health care industry, where all who have a stake in the outcome are co-creating a new reality.

What does transformation look like in health care? It is a system marked by sustained structural change in the way care is accessed, delivered and paid for. Stakeholders are fully engaged with each other and are held accountable for achieving defined goals. Together, they are transforming a “sick care” system into a true “health care” system – one that is proactive, patient-centered and focused on creating a culture of health. Key elements of a transformed system, provided in the chart on the next page, are discussed in the chapters that follow.

This edition of *New horizons* is designed to help you explore what transformation means for your organization, assess how well prepared you are for fundamental change, and adapt to a future that is taking shape in a profoundly different form. Our launching point is a conversation with Richard Gilfillan, MD, who chairs the Health Care Transformation Task Force. This consortium of providers, payers, purchasers and patients, launched in January 2015 to advance value-based purchasing initiatives, reflects the direction of the industry’s future.



The new horizon: key elements of a transformed health care system

Element	Description
Aligned payment strategies	Payment is tied to value and patient outcomes. The industry creates incentives and compensates providers for enhancing access, improving quality of care and achieving desired outcomes, including preventing diseases and appropriately using fewer and less intensive services.
Collaborative structures	Models such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) offer a means for payers to bring providers the administrative, technical and clinical support they need to fully realize the potential of payment models.
Lower costs	Organizations manage costs carefully and look for ways to streamline operations, transforming care delivery through collaboration and efficiency.
Better health outcomes for patient populations	Providers and payers are focused on assigning patients to various populations based on their condition or diagnosis, optimizing health outcomes for each population and closely managing patients with chronic conditions. Registries are used to understand disease processes, health disparities and treatment trends.
Shifting venues of care	More care moves away from the acute care hospital and into ambulatory, community and home settings. Organizations develop integrated service networks that extend beyond the hospital.
Team-based, integrated care	A flexible workforce model makes optimal use of nonphysician caregivers, increases capacity to accommodate varying patient needs and delivers improved outcomes. Community partnerships and services, along with programs that address root causes of illness, help people stay healthy.
Innovative approaches to quality and safety	A continued focus on patient safety issues, such as medication errors, expands to include such challenges as preventing avoidable hospital readmissions, better managing chronic conditions and improving transitions across the care continuum. Providers receive data on their performance across quality metrics, spurring innovations that can serve as models for improvement.
Pervasive use of information technology (IT) and business intelligence	Progressive IT enables accurate, real-time communication, information sharing and actionable feedback among providers and payers – with insights that improve costs, quality and safety.
Evidence-based standards of care	Processes that have been proven to be effective in improving patient health span multiple delivery settings and hold physicians accountable for their performance.
Transparent information	Standard benefit designs and public exchanges increase transparency by enabling consumers to better compare products and services. Consumers define value by quality, convenience and the overall care experience.
Empowered consumers	Patients are informed and engaged in their care, monitoring their wellness closely with tools and information while their health is actively tracked. They are viewed by providers and payers as customers to whom the best service possible must be consistently delivered.

Source: EY analysis, 2015.



Feature

A consortium for change: working together toward better health, better care and lower costs

A conversation with Richard Gilfillan, MD, Chair, the Health Care Transformation Task Force (HCTTF)

Along with chairing HCTTF, Dr. Gilfillan is also president and CEO of Trinity Health in Livonia, Michigan. Previously, he launched and led the Center for Medicare & Medicaid Innovation, formed under the ACA to test new ways of financing and delivering health care. We talked with Dr. Gilfillan about the catalysts for forming HCTTF, along with the group's current activities and future goals.



Tell us how the Health Care Transformation Task Force came together.

When I was at CMS (the Centers for Medicare & Medicaid Services), I wished that more momentum would build in the private sector toward health system transformation. After leaving CMS, I was talking with several colleagues, and we thought that there was potential to bring stakeholders together to help drive delivery system change in a coordinated way that could effectively achieve that momentum. We spoke with peers in payer, provider, employer and consumer organizations and found real interest in this approach. Many were feeling the same pain – resulting from the conflict between their desire to change and the reality of marketplace uncertainty about the pace and path of transformation. All of us believed that coming together to create a common time frame and a simplified path could accelerate this change. We officially met for the first time in June 2014.

Give us an idea of the complexion of the Task Force. What kinds of organizations are part of the group today?

We wanted to bring together a wide mix of organizations representing the payer, provider, employer and consumer sectors. Today, we have 40 organizations represented on the Task Force, including six of the nation's top 15 health systems, four of the top 25 health insurers, two leading purchasers and a prominent consumer organization (see box). We've also had inquiries from another 50 organizations that are interested in participating.

The Task Force membership brings together a mix of industry segments. We hope to be viewed as an effective industry-wide voice of consensus – one that advocates for a simplified and accelerated path to a transformed delivery system.

What is the primary goal of the Task Force, and how will you collectively achieve it?

When we first came together, we set our overarching goal: by 2020, 75% of our business will be in value-based payment arrangements, holding organizations accountable for improving outcomes and lowering the total cost of care. This is aligned with U.S. Department of Health & Human Services (HHS) Secretary Sylvia Burwell's goal for 50% of health care reimbursement to shift to alternative payment arrangements by 2018.

Beyond that aim, we want to drive the entire system forward. We are doing this through four steps: first, by creating a leading-edge model; second, by building policy recommendations for CMS, for example, on the next generation of ACOs; third, by identifying and promoting best practices beyond what is done today, through a team-based, consensus-building approach; and fourth, by developing optimal solutions such as alternative payment models that accelerate our movement toward the 75% goal. All of these steps are designed to converge activities so that the road forward is clearer, processes are more standardized and timelines consistent. Three Task Force workgroups are meeting regularly to address three specific areas: improving the ACO model, developing a common bundled payment framework and improving care for high-cost patients.

What roadblocks has the Task Force encountered?

The biggest roadblock is changing mindsets. This is a huge transition, and it's hard work. It's reminiscent of what happened in the auto industry in the 1990s, when manufacturers were asked to produce cars that were more efficient and longer lasting while delivering to the customer a superior driving experience.

Health care organizations are being asked to produce something different than what they have produced in the past. The demands are many. Deliver great care. Give patients a better experience. Improve your outcomes. Do it for less cost. Do it in a transparent environment. And by the way, you have to change your business model because you'll now be paid for value, not volume. Although this is a lot to ask of physicians and care teams, we see them rising to the challenge.

**How will success be measured?
How will findings be communicated?**

Success for the Task Force will be continuing to monitor our progress toward our 75% goal by 2020. We want to be able to show that our outcomes of care, measured in a consistent way, have actually improved at lower costs. In communicating our findings, the most immediate approach is through our workgroups. We also realized that CMS can drive significant change.

So we're providing input to CMS and Congress on our recommendations for policy and program design.

Changing the industry's payment structure was last tried on a large scale in the 1990s when health maintenance organizations (HMOs) were created. The challenges were many. What have we learned from past mistakes, and how might results be different this time?

What's different this time around?
We're in a much better place.

We saw a lot of good intentions in the '90s in the belief that HMOs could improve health. But the mechanisms of implementation were unsophisticated. We didn't really transform care delivery. The primary focus was costs, not quality. We didn't have the infrastructure to measure quality. We didn't have true payer-provider partnerships. The interaction

between payers and providers was more opportunistic. People were forced into networks they didn't select. Rules were put on providers that were external to the actual delivery of care.

Today, organizational structures, quality measurements, electronic information sharing and other supporting frameworks are either in place or are being developed to support the move to improve outcomes and lower costs in a value-based payment system. For example, the ACO model is providing a realistic way to deliver better health, improve care and reduce costs.

At Trinity Health, where we have 86 hospitals across 21 states, we would like to see a Medicare Shared Savings Program ACO in every market, because the program aligns with our mission to be a people-centered health system. For us, that means focusing on population health management, improving the overall health of the community and creating a good experience of care.

What guidance do you have for board members and executive leaders on adapting to the new world of value-based payments?

We all know that this is a difficult and challenging time, and we are all facing the same uncertainty. The good news is that value-based care is consistent with the reasons we all went into health care. It is the right thing for our patients, our colleagues and our country. Recognize that it will take an investment, and the returns will not be immediate. Reach out to your payer/provider partners and develop a common commitment to making the transition. Involve consumer and employer representatives. Having a shared time frame, a consistent approach and sustainable business models makes this huge transition doable. Together, we can transform how health care is delivered to meet the needs of the people and communities we serve.

Task Force members

Providers

- Advocate Health Care
- Aledade, Inc.
- American Academy of Family Physicians
- Ascension Health
- Atrius Health
- Beth Israel Deaconess
- Catholic Health Initiatives
- Centra Health
- CEP America
- Dartmouth-Hitchcock Health
- Dignity Health
- Evolent Health
- Fresenius Medical Care
- Heritage Provider Network
- Montefiore
- New Mexico Health Connections
- Optum
- OSF Healthcare

- Partners HealthCare (Massachusetts)
- Premier, Inc.
- Providence Health & Services
- SCL Health
- SSM Healthcare
- TMC Healthcare
- Trinity Health
- Tucson Medical Center Healthcare

Payers

- Aetna
- Blue Shield of California
- Blue Cross Blue Shield of Massachusetts
- Blue Cross Blue Shield of Michigan
- Health Care Service Corporation

Purchasers


- Caesars Entertainment, Inc.
- Pacific Business Group on Health

Patients and families

- Community Catalyst
- National Health Law Program
- National Partnership for Women & Families

Partners, policy experts and others

- The Dartmouth Institute for Health Policy & Clinical Practice
- Mark McClellan, Brookings Institution
- PatientPing
- Remedy Partners



"It may be hard for an egg to turn into a bird:
it would be a jolly sight harder for it to learn
to fly while remaining an egg."

C.S. Lewis, *20th-century Irish novelist and essayist*

Chapter 1

Transforming care delivery and payment

Emerging into a new form

Transitions

New approaches to delivery and payment continue to transform the health care industry. Value-based models such as the accountable care organization and patient-centered medical home, along with a heightened focus on population health management, aim to rein in rising health care costs, restructure financial incentives across system stakeholders and create a transparent system of accountability – one that enables providers, payers, purchasers and patients to make more informed choices. As the shift from volume to value gains momentum, health care organizations will need to consider the likely pattern in their markets, find their foothold, and make the structural and operational changes needed to succeed in today's “new normal.”

Like a newborn bird pecking out of its shell, health care organizations are mustering all forces to break out of old forms and emerge into new ones. Much of this emergence is being driven by the ACA and a focus that has shifted from the volume of services offered to the value of care delivered. In this chapter, we look at the transformation of care delivery and payment and its implications for industry stakeholders.

The new health insurance marketplace: making an impact

June 25, 2015, marked another milestone for the US health care industry. In a 6-3 ruling on *King v. Burwell*, the Supreme Court upheld the ACA's insurance subsidies as legal. The landmark decision means that the ACA stands "as is" and that the federal government can continue subsidizing coverage to millions of Americans.

Challengers had maintained that the federal exchange, healthcare.gov, does not have the legal authority to distribute tax credits that help low- and middle-income Americans buy coverage. Since most states rely on healthcare.gov as their insurance marketplace (see Exhibit 1-1), a decision in favor of the challengers would have had sweeping repercussions. To date, 6.7 million people have enrolled through the federal and state exchanges,

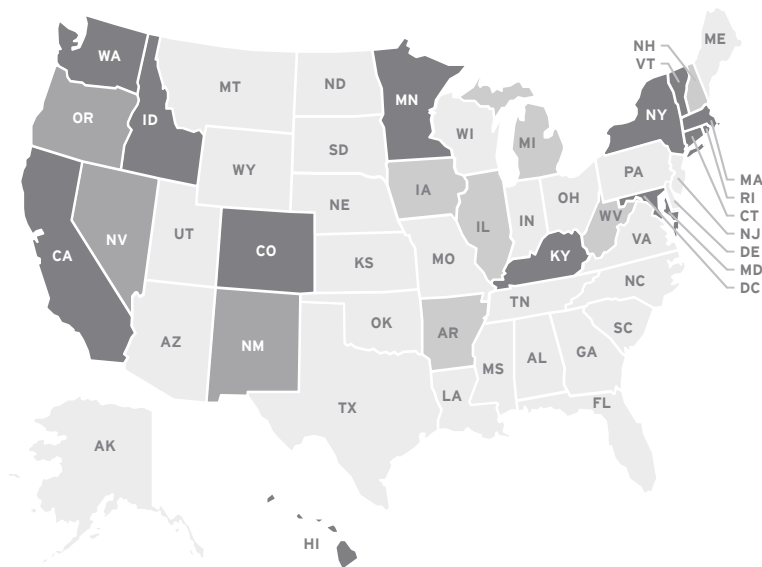
and insurers are planning to offer more products in more states. (For more on the *King v. Burwell* decision, see the Appendix of this report.)

.....
 "Congress passed the Affordable Care Act to improve health insurance markets, not destroy them."

U.S. Supreme Court Chief Justice John Roberts

The private, non-ACA health care exchanges are also experiencing growth. These exchanges facilitate insurance plans for employees of small and medium-size businesses. Surveys indicate that nearly 30% of employers anticipate moving to private exchanges in the next three to five years.

Exhibit 1-1. State health insurance marketplace types, 2015



- **State-based** (13 states and Washington, DC). States are responsible for performing all marketplace functions. Consumers in these states apply for and enroll in coverage through marketplace websites their state establishes and maintains.
- **Federally supported state-based** (three states). States are considered to have a state-based marketplace but use the federally facilitated healthcare.gov platform to enroll consumers in coverage.
- **State-federal partnership** (seven states). States administer in-person consumer assistance functions, while HHS performs the remaining marketplace functions. Consumers apply for and enroll in coverage through healthcare.gov.
- **Federally facilitated** (27 states). HHS performs all marketplace functions, and consumers apply for and enroll in coverage through healthcare.gov.

Source: Kaiser Family Foundation, *State Health Insurance Marketplace Types, 2015*, "KFF State Health Facts."

Value-based care: accelerating the shift to alternative payment models

Health care delivery in the US continues to transform from a system centered on acute care to one focused on the continuum of care and population health management. In the five years since passage of the ACA, The Centers for

Medicare & Medicaid Services (CMS) has launched numerous programs and models to help health care providers achieve large-scale transformation (see Exhibit 1-2).

In 2015, the pace of change has accelerated. In January, HHS Secretary Sylvia Mathews Burwell pledged that by 2018, Medicare will shift 50% of

its provider payments into alternative payment arrangements such as ACOs or bundled payments. To help speed the transition to value-based payment models, HHS has created the Health Care Payment Learning and Action Network, designed to share best practices in value-based care. To date, more than 2,800 partners – ranging from payers, providers and employers to patients, states and

Exhibit 1-2. Representative initiatives from CMS to help the industry move from volume-based to value-based care

Name of program	Purpose	Results to date
Community-Based Care Transitions Program (CCTP)	To enable community-based organizations to receive a bundled payment that covers the costs of services needed to help patients transition from hospital to home; up to \$300 million in total funding is available through 2015	The program's first annual report notes that four groups out of 48 studied significantly cut readmissions compared with those of a control group. CCTP now has 72 participating organizations.
Hospital-Acquired Condition (HAC) Reduction Program	To encourage hospitals to reduce HACs; hospital payments are lowered by 1% for hospitals that rank among the lowest-performing 25% in HACs	Hospital patients experienced 1.3 million fewer HACs from 2010 to 2013 – a 17% decline in HACs over three years. But a total of 721 hospitals will have their Medicare payments reduced by 1% over the fiscal year that runs from October 2014 through September 2015.
Hospital Readmissions Reduction Program (HRRP)	To penalize hospitals that have "excess readmissions"	Overall, CMS has withheld \$935 million in reimbursements from hospitals since HRRP's inception; in 2014, more than 2,600 hospitals incurred financial penalties.
Hospital Value-Based Purchasing (VBP) Program	To reward hospitals that provide high-quality care for their patients; hospitals paid under the Inpatient Prospective Payment System are paid for inpatient acute care services based on quality of care, not the volume of services they provide	In 2015, as a result of VBP, 1,714 hospitals will see a positive adjustment in their Medicare payments, and 1,375 will see a negative adjustment.
Independence at Home	To test a new model of payment and health care delivery to the sickest and frailest of Medicare patients – 5% of the Medicare beneficiary population but accounting for 43% of program spending	The program saved more than \$3,000 per Medicare beneficiary in 2014; all 17 organizations that participated in the program improved on at least three of the six quality measures, and four of the organizations improved on all six quality measures.
Transforming Clinical Practices Initiative	To support 150,000 clinician practices through 2018 in sharing, adapting and further developing their comprehensive quality improvement strategies; up to \$840 million to be awarded over four years	First awards to be made in 2015.

Source: CMS, 2015.

By the numbers

- ▶ The uninsured rate among adults in the US dropped to 11.9% the first quarter of 2015, the lowest rate since 2008 – down one percentage point from the previous quarter and 5.2 points since the end of 2013, when most of the provisions of the ACA took effect (Gallup-Healthways Well-Being Index survey, 2015).
- ▶ 40% of the health insurance market now consists of individual plans – a large jump from the 10% share of the market before implementation of the ACA (Psilos Group, 2015).
- ▶ Of small organizations with three to 199 workers, 57% offer health benefits; of those with 200 or more workers, 99% offer health benefits (Kaiser Foundation and Health Research & Educational Trust, 2013 *Employer Health Benefits Survey*, August 20, 2013).
- ▶ A survey of 146 senior financial executives finds only 12% of respondents' commercial payments are part of a value-based plan – but respondents believe that number will rise to 50% within the next three years (Healthcare Financial Management Association (HFMA), *Executive Survey: Value-Based Payment Readiness*, sponsored by Humana, 2015).
- ▶ According to a 2014 American Hospital Association (AHA) survey, nearly 60% of health system and hospital chief executive officers (CEOs) ranked population health management as the hardest skill set to find within the broader health care field; nearly 10% of executives indicated their health system had a chief population health manager (AHA, 2014).
- ▶ When complications occur after a major surgery, patients who are readmitted to the same hospital have a 26% lower risk of death within 90 days than patients who are readmitted to a different hospital (Brooke et al., "Readmission destination and risk of mortality after major surgery: an observational cohort study," *The Lancet*, June 17, 2015).
- ▶ Nearly 70% of organizations that report a transition toward value-based contracts by payers in their markets also report an increase in consumerism by patients through such actions as asking for more price transparency, challenging orders for tests and negotiating payments ("Changes in Employer-Sponsored Insurance Could Dramatically Alter Hospital Business Fundamentals," *KaufmanHall Report*, spring 2014).
- ▶ Although hospitals' performance on hand-hygiene practices has improved, 23% still fail to meet all 10 best practices that The Leapfrog Group outlines in its latest quality and safety report (The Leapfrog Group, 2015).
- ▶ A recent study finds that inadequate communication alone costs \$1.75 million annually per US hospital (Ponemon Institute LLC, *The Imprivata Report on the Economic Impact of Inefficient Communications in Healthcare*, June 2014).
- ▶ A 65-year-old person in the US can expect, on average, to live to the age of 84 – the highest life-expectancy rate for Americans in history (Administration on Aging, 2015).
- ▶ Preventable hospitalizations among seniors dropped by 6.8% in 2014, according to a new report (The United Health Foundation, *America's Health Rankings® Senior Report 2015*).

consumer groups – have pledged their participation.

"Moving from volume to value is not about basic change, but about wholesale transformation. We are not moving from the 2014 Camry to the 2015, but from the 2014 Camry to self-driving electric cars."

Stuart Pollack, MD
Medical Director, Brigham and Women's
Advanced Primary Care Associates
Writing on Health Affairs blog

Also in January, members of the Health Care Transformation Task Force, a new provider-payer alliance, announced their commitment to put 75% of their business into value-based arrangements by 2020 (see conversation with Richard Gilfillan, MD, preceding this chapter). The HHS and Task Force announcements send a clear message: the public and private sectors are moving forward together toward a future of value-based payments.

ACOs continue to be a leading model for aligning financial incentives. In an ACO, health care providers accept responsibility for the cost and quality of care for a defined population. They are paid based on reaching certain cost and quality benchmarks – with the incentive to maximize patient health rather than increase the volume of services delivered. According to recent statistics from Leavitt Partners, a leading tracker of ACO activity:

- ▶ 744 ACOs are now in place across all 50 states, covering 23.5 million people.
- ▶ 132 different health insurance payers now have at least one ACO contract.
- ▶ An estimated 72 million people could be covered by ACO contracts by 2020.

CMS ACOs

In 2014, CMS released the quality and financial results of its two leading ACO initiatives, the Medicare Shared Savings Program (MSSP) and Pioneer. For MSSP, about 26% of participants – 53 ACOs – decreased spending enough to receive bonus payments, while program participants improved on 30 of 33 quality measures. In January 2015, another 89 provider care organizations joined MSSP as ACOs, and in June, CMS published a final rule for the program, offering participants more options and more opportunities to take part in risk-sharing.

“We believe these goals [to expand new Medicare payment models] can drive transformative change, help us manage and track progress, and create accountability for measurable improvement.”

Sylvia Mathews Burwell
HHS Secretary

The Pioneer ACO program, on the other hand, has experienced considerable fallout. Many of the original 32 participants have left the program; just 19 remain today. Most of those who have exited failed to meet the benchmarks required to receive shared savings. Still, results for those remaining reflect improvement. Of the 23 Pioneer ACOs in operation in 2013, 11 earned financial bonuses totaling \$68 million, while program participants improved on 28 of the 33 quality measures. CMS reports that the program saved Medicare more than \$384 million in two years, or about \$300 per beneficiary per year for the more than 600,000 beneficiaries the program serves.

In March 2015, HHS launched a new ACO initiative from the CMS Innovation Center. Known as the “Next Generation ACO Model,” the program builds on

the successes of earlier ACO initiatives.

The goal is to determine whether stronger financial incentives for ACOs can improve health outcomes and reduce Medicare patient expenses. According to HHS, ACOs in the Next Generation ACO Model will:

- ▶ Assume greater financial risk than those in current Medicare ACO initiatives, while also potentially sharing in a greater portion of savings
- ▶ Have more predictable financial targets
- ▶ Realize greater opportunities to coordinate care and engage beneficiaries

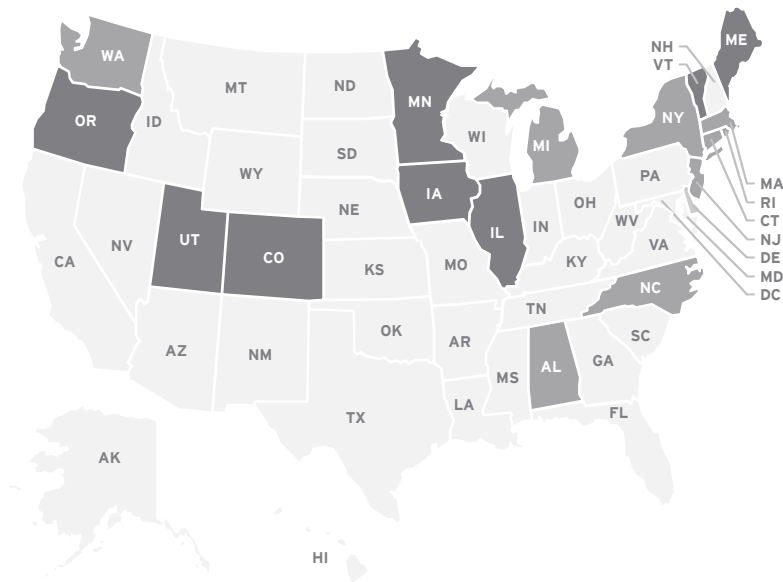
The Next Generation ACO Model will have two risk tracks and four payment systems. According to a survey from the Healthcare Intelligence Network, one-fifth of current ACOs say they will participate in the new model.

Medicaid ACOs

More states are turning to ACOs to rein in Medicaid costs. To date, eight states have launched Medicaid ACO programs, and nine more are actively pursuing them (see Exhibit 1-3). According to the Center for Health Care Strategies, results to date have yielded significant savings. For example:

- ▶ In Colorado, the state’s Regional Care Collaborative Organizations, launched in 2011, have reported more than \$30 million in net savings for Colorado Medicaid over three years.
- ▶ In Minnesota, one-year savings of \$10.5 million were attributed to the state’s Integrated Health Partnership program, launched in 2013.

Exhibit 1-3. Medicaid ACOs by state as of March 2015



■ States with active Medicaid ACO programs ■ States pursuing Medicaid ACO programs

Source: Center for Health Care Strategies, Inc., “Medicaid Accountable Care Organizations: State Update,” March 2015.

Transformers

The Complex Care Clinic: managing care for the sickest of patients

In 2011, the Virginia Commonwealth University (VCU) Medical Center established the Complex Care Clinic to improve the quality of care and decrease the costs associated with the sickest patients, who often have financial and social barriers to accessing care. Over just one year, the program reduced inpatient admissions by 44%, ED use by 38% and total hospital costs by 49%. This resulted in a total cost savings of \$4 million and an average annual cost savings of \$10,769 per patient. Along with reduced costs, improved outcomes were documented for patients with chronic conditions, such as diabetes and hypertension.

Taking a holistic approach to care, the clinic brings together in a single location a multidisciplinary team that can include a nurse case manager, social worker, psychologist, pharmacist and nutritionist. The clinic also partners with community organizations, such as the United Way and YMCA, to further enhance population health management.

Clinic staff note that the model engages patients in their care and builds a relationship of trust – helping drive the behavioral changes needed to comply with treatment plans, improve health and lower costs.

Source: VCU Medical Center, 2013 Annual Report.

- ▶ In Oregon, emergency department (ED) visits for patients served by the state's Coordinated Care Organization program, initiated in 2012, have decreased 21%, and admissions related to asthma and chronic obstructive pulmonary disease have decreased 48%.

Commercial ACOs

In many markets, commercial payers have established accountable care programs similar to the CMS initiatives. Cigna leads the way, with its ACO contracts making up 19% of total commercial contracts, followed by Aetna (9.1%) and UnitedHealthcare (4%). UnitedHealthcare estimates that by 2017, \$50 billion of its reimbursements to providers will be through the accountable care model – more than double its current payments.

“I think any doubts about whether we are transitioning to more value-based payment and care delivery models have been dispelled.”

Jim Landman
Director of Healthcare Finance Policy
Healthcare Financial Management Association

The ACO movement received another boost in June with the formation of the world's largest accountable care collaborative. Leavitt Partners' Accountable Care Cooperative and the Brookings Institution's ACO Learning Network are merging to create the nonprofit Accountable Care Learning Collaborative, co-chaired by former HHS Secretary and Governor Mike Leavitt and former CMS Administrator and US Food and Drug Administration (FDA) Commissioner Dr. Mark McClellan. The new organization is designed to help ACOs effectively scale and grow.

Population health management: sharpening the focus

Population health management (PHM) continues to be a prime catalyst for industry transformation. While the term can be broadly defined, its essence is improving the health status of a specific group while reducing the cost of care through better coordination and increased efficiencies across the care continuum. PHM requires understanding demographics and diagnoses, seamlessly sharing information about patients and using data to improve outcomes throughout the entire system.

Highlighted below are a few leading PHM initiatives nationwide:

- ▶ In California, the University of California, San Diego and VCU in Richmond have partnered to launch the Live Well San Diego project, which will test the use of big data in improving the health of the city's 3.2 million residents. Researchers will integrate data from electronic health records and other sources to prioritize health issues and create an action agenda.
- ▶ In Connecticut, St. Vincent's Health Partners in Bridgeport uses its analytics system to create monthly data reports for each member of the organization. Patients at risk are identified and physician performance is assessed. These strategies have resulted in a 25% decline in utilization and a 16% drop in inappropriate ED use and hospitalizations.
- ▶ In Indiana, through the Aging Brain Care Medical Home in Indianapolis, care coordinator assistants go to patients' homes, develop relationships with patients and caregivers, and offer support to cope with the consequences of a depression or dementia diagnosis. Researchers report at least a 50% reduction in symptoms in two-thirds of patients with depression – and a 50% reduction in stress symptoms in half of

Transformers

the caregivers of patients with dementia.

- ▶ In North Carolina, Cornerstone Healthcare, a multispecialty practice of more than 375 physicians and mid-level health professionals in more than 90 locations, has turned its practice into an “innovative population health management hub,” according to its CEO. The group has negotiated pay-for-value contracts with all major insurance companies in its coverage area; applied clinical information resources to analyze patient care, quality and outcome data and gauge progress; and is working with patients to reach health improvement goals.

Consumer-driven health care: changing behaviors, shifting venues of care

A retail mindset continues to permeate the health care industry. As patients become consumers, they are bearing more costs, making more decisions and taking more ownership of how their health care dollars are spent. Driven by expectations of high-quality service, they are becoming more knowledgeable about how the industry works, from insurance deductibles and co-pays to outcomes and safety ratings. The age of health care consumerism raises the bar even higher for providers and payers, who must develop a laser-like focus on meeting and measuring patient and customer expectations (see chapter 5).

The rise of retail health clinics

As in other sectors of the American economy today, convenience in health care is not only expected, but also demanded. Consumers are seeking the option to access care during night and weekend hours, to be seen without an appointment and to fill prescriptions on-site. To seize the market opportunity, big retail chains continue to open walk-in clinics, staffed by medical professionals such as nurse

practitioners and physician assistants. Industry statistics report almost 1,900 retail clinics in the US today – up more than sevenfold since 2007. For example:

- ▶ CVS Health Corp. offers walk-in care, seven days a week, evenings and holidays, at 1,500 MinuteClinics across the country – providing 60% of the US population access to health care. In June 2015, CVS announced it is expanding its reach into the retail health business by acquiring Target Corp.'s clinic and pharmacies for \$1.9 billion – giving CVS access to about 1,700 more locations.
- ▶ Walmart Care Clinic now has 17 clinic locations in the US, partnering with QuadMed for staffing needs.
- ▶ Walgreens has been in the retail clinic business since 2007. Today, it has 420 Healthcare Clinic locations in 23 states and Washington, DC – and has begun to treat such chronic conditions as asthma, diabetes and high blood pressure.
- ▶ Rite Aid operates 24 RediClinics inside pharmacies in Baltimore, Philadelphia and Washington, DC. In February 2015, the company announced it is paying \$2 billion to add EnvisionRx, a pharmacy-benefits manager, to its business.
- ▶ The Little Clinic, a wholly owned subsidiary of The Kroger Company, has health care clinics located inside select Kroger stores in seven states.

The retail health movement is being fueled also by changing insurance policies. In the past, patients often paid out-of-pocket to visit retail health clinics, but many can now use their insurance coverage to pay for services. Recent studies note that more than four in five visits to retail clinics operated by CVS and Walgreens are covered by insurance. The Robert Wood Johnson Foundation reports that the cost of care at a retail clinic is about \$110 for commercially insured consumers, while care at a doctor's office costs almost \$170.

Hospital-community partnerships: creating a culture of health

A guide from the AHA's Hospitals in Pursuit of Excellence initiative offers strategies for hospitals and health care systems to consider as they strive to foster a culture of health in their communities. Produced in collaboration with the Robert Wood Johnson Foundation, the guide (available at <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf416021>) identifies four roles hospitals can take in building a culture of health:

Specialist – Focuses on a few specific issues for which it is a subject matter or program expert

Promoter – Funds or contributes resources, such as employees or facility space; helps shape policy or provide community education

Convener – Brings together a broad range of multisectoral partners to address significant community health needs

Anchor – Leads initiatives in building a culture of health; has population health management as a fully integrated part of its mission

The report finds that hospitals and health care systems may play one of these roles for all their culture-of-health initiatives, or their role may vary based on the intervention or community need.

Source: AHA News Now, October 23, 2014.

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Three guiding principles: revisiting the Triple Aim

Seven years after the Institute for Healthcare Improvement (IHI) first stated the goals of the Triple Aim – to improve individual care, enhance the health of populations and reduce overall costs – a new report details what the IHI has learned so far from health care stakeholders' efforts.

“The Triple Aim has had an influence beyond our wildest dreams – in the nation and around the world.”

John W. Whittington

Lead author

Pursuing the Triple Aim: The First Seven Years

To help other organizations achieve the Triple Aim, the IHI has identified three guiding principles based on its work with 141 organizations worldwide:

- ▶ **Build the foundation to manage populations.** Identify a relevant population, create or identify a governance structure composed of individuals with the power to drive and champion the Triple Aim goals, and define a purpose around which stakeholders can rally.
- ▶ **Manage services at scale for the population.** Segment the identified population into subpopulations with

similar needs, develop a portfolio of projects to meet those needs, design or redesign services as needed, develop a plan for delivering these services at scale, and expand the capabilities of “integrator” organizations, such as community groups that want to volunteer their time.

- ▶ **Establish a learning system to drive and sustain the work over time.** Implement population-level measures such as health outcomes and disease burden, develop a rationale for system changes, learn by iterative testing (or start initiatives on a small scale and build outward), use individual cases – such as an ED super-user – to identify broader needs, and select leaders to manage and oversee the learning system.

The Triple Aim may soon become the “Quadruple Aim,” as proponents advocate to add a fourth dimension to the current three: improving the work life of health care providers. The Quadruple Aim has been advanced by such leading organizations as the Hospital Quality Institute and the Harvard School of Public Health.

Sources: IHI, “Pursuing the Triple Aim: the First Seven Years”, June 2015; Thomas Bodenheimer, MD, and Christine Sinsky, MD, “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider,” Annals of Family Medicine, November/December 2014.

Providers in the urgent care business

Like retail health clinics, urgent care centers are increasingly popular among patients because of their convenience and affordability. The number of urgent care centers nationwide is expected to grow 20% over the next five years, from 10,000 to 12,000. To maintain market share and further the goals of expanded access and improved population health management, more health care providers are getting into the urgent care arena. For example:

- ▶ HCA Inc. has spent \$5.5 billion over the past three years opening new facilities that include stand-alone emergency rooms and urgent care centers.
- ▶ Tenet Healthcare Corp. recently launched a new urgent care brand called MedPost and now operates 50 MedPost facilities across eight states.
- ▶ Dignity Health, which acquired urgent care provider U.S. Healthworks in 2012, has since expanded it from 172 locations to more than 200 across 20 states.
- ▶ New York-based North Shore-Long Island Jewish Health System, in partnership with urgent care operator Access Care Partners, plans to roll out 80 new urgent care centers over the next five years.
- ▶ In Utah, Salt Lake City's Intermountain Healthcare operates its own urgent care clinics, InstaCare, in more than 20 cities across the state.

Payer imperatives in an emerging retail industry

In the post-ACA world, as new customers and the growing presence of public and private exchanges drive competition, health insurers are responding by revising their business models to focus on individual, rather than employer, purchasers. They are ramping up their customer outreach through multichannel commerce, mobile apps and social media – and

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implementing new technologies such as automated claims adjudication and payment systems, PHM tools and tools that enable customers to access service 24/7 through multiple platforms.

To help drive their health and wellness programs, several payers have joined forces with the food industry. For example:

- ▶ UnitedHealth has partnered with Milwaukee, Wisconsin-based Roundy's Supermarkets to launch a Healthy Savings program, which offers members savings on select grocery products.
- ▶ Humana offers 10% savings to its Humana Vitality members who use a card to buy qualifying foods at Walmart stores. The company reports 40% of its members are enrolled in the program.
- ▶ Anthem Blue Cross and Blue Shield gives members coupons for food and household products that support healthy lifestyles.

.....
"Food is the most powerful clinical intervention against chronic disease doctors have. We should be able to write recipes on prescription slips, just like prescription medication."

John La Puma, MD
American internist, chef and author
.....

To adapt successfully to the new health retail environment, several health plans have drawn leadership from the retail industry. For example, Aetna hired a former Wal-Mart Stores senior vice president to lead its new consumer products and enterprise marketing organization, Humana brought in a former senior leader from Target as its chief innovation officer and Wellpoint drew its chief information officer from Coca-Cola. These leadership decisions underscore the increasing importance of consumerism in a rapidly transforming industry.

Transparency: comparing price and quality

Now that health care consumers are becoming responsible for more of the cost of care, they are looking to access and compare information about the price and quality of health care services – shopping for providers and health insurance in much the same way they look for a new car. Website comparisons, consumer reviews and social sharing all influence consumers as they make their health care decisions.

But producing reliable data for comparison has been problematic. In a June 2015 survey, TransUnion reported that only 25% of patients receive cost estimates before receiving care. And a 2014 report found that 90% of states do not provide consumers with sufficient health care pricing information. The report, issued by the Health Care Incentives Improvement Institute and Catalyst for Payment Reform, gave 45 states a failing grade and no states an "A" grade. The highest grade issued, a "B," was received by Maine and Massachusetts.

The newly formed Center for Healthcare Transparency (CHT) is leading the charge to create a more transparent system. CHT is funding 14 regional organizations to lay the foundation for making meaningful information on the cost and quality of health care available to half the US population by 2020. Led by the Network for Regional Healthcare Improvement and the Pacific Business Group on Health, CHT is "synthesizing best practices from high-performing regional organizations with track records of successful public reporting," according to its founders.

Wait time reduction: matching supply and demand

A new report from the Institute of Medicine (IOM, now called the National Academy of Medicine) finds that by using the techniques of systems engineering, new approaches to management, and increased patient and family involvement, wait times for health care services can be reduced. The study was sponsored in part by the Department of Veteran Affairs after a 2014 audit found that more than 57,000 veterans were still waiting for care 90 days after requesting an appointment.

The IOM's Committee on Optimizing Scheduling in Health Care found that wait times for services can range from same-day appointment to several months later. Long waits can lead to worse-care outcomes, lower patient satisfaction and damaged provider reputations. The report notes that a key problem in accessing care is that scheduling is based on providers' convenience, and practices are not using physician extenders appropriately.

The committee offers five recommendations for providers to reduce wait times:

1. Immediately address patient concerns.
2. Ask patients for feedback on their preferences for timing and care.
3. Set up contingency plans for patient surges.
4. Promote alternatives to in-person physician care, such as wider use of non-physician providers.
5. Continuously assess changing circumstances in each care setting.

Sources: IOM, *Transforming Health Care Scheduling and Access: Getting to Now, 2015*; Modern Healthcare, "IOM: The doctor will see you TODAY should be standard," June 30, 2015.

.....
"If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment."

Institute of Medicine
"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America"
.....

One way insurers and employers have addressed the price transparency challenge is through reference-based pricing. In this type of benefit design, the health plan sets a maximum contribution, or reference price, to pay for a particular service. Employees reap savings when they choose services at or below the reference price. If they choose services above the reference price, they are responsible for the additional cost. Employers see this type of benefit design as a way to motivate employees to consider the price of services when making care decisions. A recent study from Cigna and Safeway Inc. shows that reference-based pricing can help control lab costs when individuals are supported with education and an online shopping tool.

A scan of the industry landscape finds a range of initiatives to generate improvements in price and quality transparency:

- ▶ The AHA has unveiled a new price transparency toolkit that includes a checklist, case studies on member hospitals and online tools, such as the Wisconsin Hospital Association's PricePoint tool.
- ▶ Aetna, Humana and UnitedHealth are aggregating their claims data to create a database of reference prices for certain procedures, such as knee replacements and heart surgery, in different communities.
- ▶ Massachusetts is now requiring health insurers to post prices for several common medical procedures.

- ▶ The Oklahoma City-based Surgery Center of Oklahoma lists prices for every procedure offered.
- ▶ Blue Cross' cost estimator tool, "Find a Doctor," helps members find providers and compare out-of-pocket expenses for more than 100 medical services.
- ▶ Kaiser Permanente gives its physicians real-time quality improvement data and has launched the Permanente Online Interactive Network Tool system to give providers access to performance data for physicians, departments and medical centers.
- ▶ Advocate Health in Chicago produces an annual value report revealing its performance on several quality metrics.
- ▶ Texas Children's Hospital publishes quality metrics online, comparing its performance with that of other US children's hospitals.

Accountability: reducing readmissions, coordinating care transitions and improving patient safety

Beyond the goal of enhancing overall patient care, hospitals have an economic incentive to lower their readmissions to keep pace with the growing demands of Medicare's Hospital Readmissions Reduction Program. In fiscal year (FY) 2013, the program's first year, CMS established a penalty for excess readmissions for three conditions: pneumonia, heart failure and acute myocardial infarction. The penalty that year was 1% of regular reimbursements. In FY 2014, the conditions remained the same, but CMS increased the penalty to 2%. In FY 2015, the maximum penalty is 3% and additional conditions have been added: chronic obstructive pulmonary disease, elective total hip arthroplasty and total knee arthroplasty. CMS reports the program is producing results. Readmissions

declined by an estimated 150,000 from January 2012 to December 2013.

Several studies show that hospitals can engage in a variety of initiatives to lower their rate of readmissions, such as better managing patient medications, clarifying patient discharge instructions, coordinating with post-acute care providers and patients' primary care physicians, providing a transition coach to follow patients across settings after they leave the hospital, and giving patients specific tools and skills that help them to take a more active role in their health care, including "red flag" indicators of a worsening condition and appropriate next steps. A data-centered approach can help identify which patients, conditions and physicians are affecting hospital readmissions – and illuminate strategies with the greatest potential for long-term impact.

A 2014 report supported by the Commonwealth Fund finds that about 60% of the variation in hospital readmission rates can be correlated to the characteristics of the community surrounding the hospital. For example, having high percentages of residents who are Medicare beneficiaries, are unemployed or have never been married is associated with higher hospital readmission rates, while retirement destinations were associated with lower rates. Higher numbers of general practitioners per capita were associated with lower readmission rates, while higher numbers of specialists were tied to higher rates. In counties where nursing home quality was higher, readmissions were lower. The study concludes that instead of strictly penalizing hospitals for exceeding certain thresholds, policymakers should focus on programs that help patients transition from hospital to home.

Despite improvements in readmission rates, the industry continues to struggle with patient safety challenges. In The Leapfrog

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Group's latest safety report, about 40% of the 2,523 hospitals reviewed received an "average" grade or below for safe practices. According to a new study from the advocacy group Patient Safety America, hospital medical errors are now the third leading cause of death in the US, behind heart disease and cancer. The group notes that each year, preventable adverse events lead to the death of 210,000-400,000 patients who seek care at a hospital. These latest numbers are dramatically higher than those in the Institute of Medicine's landmark 1999 report, *To Err is Human: Building a Safer Health System*, which estimated that up to 98,000 people a year die because of hospital mistakes.

Cost reduction: changing perspectives

A 2014 report from Standard & Poor's (S&P) finds that US hospital systems saw their profitability erode in 2013 – for the first time since 2008 – as rapidly rising expenses outpaced revenue growth.

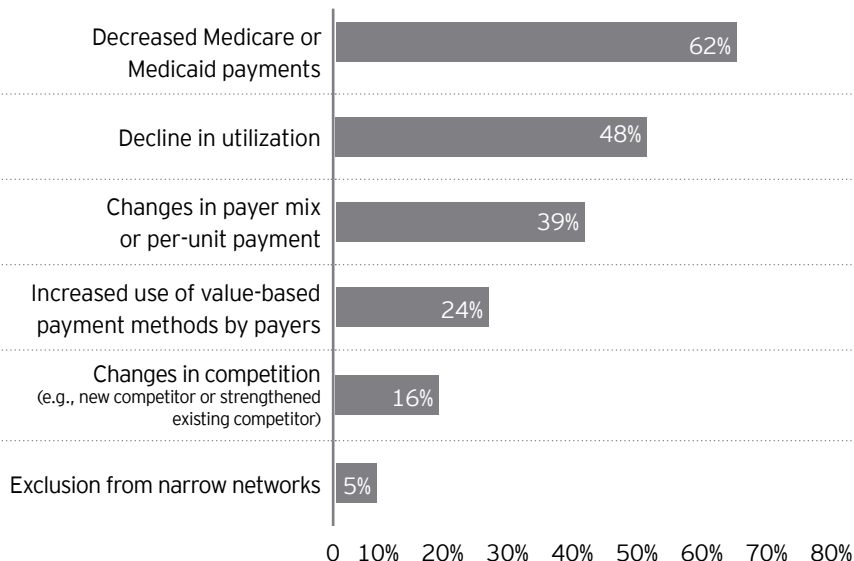
Despite a 5% increase in revenue, expenses rose an average of 7%. The average operating margin for the 138 systems in S&P's analysis was 2.2% in 2013, down from 2.9% in 2012 and 2011. For the 501 standalone hospitals studied, the average operating margin was 2.1% in 2013, a decrease from 2.6% in 2012 and 2.7% in 2011.

In the wake of reduced margins, the pressure to cut expenses has never been greater. According to a survey from the Health Information Management Systems Society (HIMSS), identifying cost reduction solutions has emerged as providers' top priority. An HFMA survey finds that the two leading external drivers of the need to control costs are decreased Medicare and Medicaid payments and decline in utilization (see Exhibit 1-4).

Health care organizations are using a variety of leading practices to cut costs:

- ▶ Designating physician champions in service lines and specialties, and relying on best performers to set the standards

Exhibit 1-4. External drivers of cost control



Source: HFMA, Strategies for Reconfiguring Cost Structure, 2015.

Adverse events: preventing emotional harm

The patient safety movement has typically focused on physical injury, but some organizations, such as Beth Israel Deaconess Medical Center (BIDMC) in Boston, are broadening their safety focus to include emotional harm. BIDMC convened a multidisciplinary Respect and Dignity Workgroup, bringing together representatives from across the medical center, including the hospital's Patient Family Advisory Council. The team defined emotional harm as something that affects a patient's dignity by the failure to demonstrate adequate respect for the patient as a person – for example, failing to conduct a sensitive conversation in a suitably private environment.

The hospital takes a systemic approach to tracking emotional harms, using the same databases set up to track physical harms. Reported emotional harms are reviewed by analyzing "root causes," from a provider's lack of training to a stressful work environment or faulty systems of care, and corrective actions are taken.

"We do not have reliable estimates of how often such harms occur, but some evidence suggests that they may be more prevalent than physical harms."

Lauge Sokol-Hessner, MD
Associate Director of Inpatient Quality,
BIDMC

Source: Dr. Lauge Sokol-Hessner et al., "Emotional harm from disrespect: the neglected preventable harm," *BMJ Quality & Safety*, June 17, 2015.

for other clinicians. Physicians play a key role in reducing health care costs. Yet they typically do not have access to cost data. Closing this gap represents one of the most significant opportunities to drive value. In a survey of physicians at six major health care systems, just 20% could estimate the cost for common orthopedic devices, yet more than 80% would consider cost as a key criterion in selecting a medical device. Keeping physicians informed of how their choices affect costs – and encouraging them to standardize patient care procedures – can help reduce costs without compromising clinical quality.

- ▶ Seeking network partners for affiliations that can create shared cost-savings initiatives. Affiliating can help health care organizations avoid the high costs of acquiring new facilities, minimize antitrust concerns and achieve economies of scale while maintaining their independence and local governance structures (see chapter 3).
- ▶ Standardizing and streamlining supply chain management. The Association for Healthcare Resource & Materials Management predicts that in another five years, medical supplies will outpace labor as the biggest expense for

hospitals and health systems. To help control those costs, organizations may optimize their supply chain activities by challenging spend management practices, contracting directly with vendors, improving logistics, developing more advanced inventory management and information management tools, sourcing and procuring for the entire enterprise, synchronizing suppliers and establishing shared services.

- ▶ Using branded mobile apps. Many surveys have shown that patients are highly trusting of their health care provider when receiving mobile health care advice. For example, a branded urgent care app, providing dynamically updated ED and urgent care wait times, along with maps to the nearest urgent care facilities, can enable health care systems to significantly reduce ED traffic and route some potential ED patients to more affordable urgent care facilities.

Breakthroughs: transforming relationships

The story of health care in the years ahead will continue to be about dramatically changing stakeholder relationships. Providers, payers, purchasers and new industry players are breaking through old models and coming together in bold new ways to reshape the system. As the industry emerges in its next form, the winners will be those that have partnered creatively, found innovative ways to deliver services and generate revenue, and invested in providing greater economic and clinical value to the center of the health care universe: the patient.

Considerations for your board and executive leaders

For providers

- ▶ As payments shift to value- and risk-based models, how is your organization building the operations, infrastructure and leadership capabilities to succeed in the new health care world?
- ▶ As patients become empowered consumers, how are you monitoring shifts in their expectations and behaviors? What strategies are in place for you to be a provider of choice?
- ▶ How are you collaborating with community partners and others to find new approaches to delivering care? Does the culture of your organization support a culture of health in your community?
- ▶ As the marketplace demands that health care be more convenient, accessible and personalized, what is your strategy for responding to new competitors, such as retail chains, that are rapidly delivering on these goals?
- ▶ How are you positioning yourself to consumers and employers as being a trusted partner in promoting wellness initiatives? What programs are in place to assist patients in preventive care?
- ▶ How are you offering incentives to health care teams to better manage population health?
- ▶ What is your organization doing to improve transparency? What challenges have you faced in this process?
- ▶ How are you working with physicians to standardize practice and eliminate undesirable variations in care that can jeopardize quality and raise costs?
- ▶ How are work teams identifying inefficient and unnecessary processes and fixing or eliminating them?
- ▶ Is your organization exploring all options to tighten up operating costs and reconfigure the overall cost structure? How are opportunities for cost savings identified, vertically and across the continuum of care?

For payers

- ▶ How are you using health insurance exchanges as a new sales channel to market to individuals?
- ▶ Have you conducted market research to understand the new consumer population?
- ▶ Are you intentionally designing the consumer experience?
- ▶ How are you enhancing price and quality transparency and providing tools to share cost information and help members understand their options?
- ▶ Do you provide real-time, 24/7 access to customer service representatives through phone, online and mobile tools?
- ▶ How can you market your offerings directly to consumers while handling the speed-to-market and cost-containment pressures typical of the retail world?
- ▶ What new programs are you putting in place to help consumers manage their own health care choices?
- ▶ Are you developing tools and support that enable providers to deliver more cost-effective care and track their performance?



“Transformation literally means going beyond your form.”

Wayne Dyer, PhD, 20th- and 21st-century American author and speaker

Transforming technologies

Illuminating decision-making

Transitions

For today's health care organizations, doing more with less, and becoming ever more agile in care delivery, are vital imperatives. In this pursuit, few trends are transforming the industry's future as significantly as health information technology. Once viewed as a support function, IT is now positioned to be the prime enabler of health care transformation. It holds the power to facilitate physician and patient decision-making, build a vast storehouse of knowledge that can be shared instantaneously, and improve health outcomes and the patient experience. Strengthening the IT infrastructure and fostering its full potential continue to be primary goals on the new horizon of care.

President Obama's budget for FY 2016 includes \$92 million in funding for the Office of the National Coordinator for Health IT (ONC) – a significant increase from the previous allocation of \$60 million. This commitment underscores the growing importance of health IT to the national agenda. In this chapter, we focus on information technology as the foundation for system transformation. We also highlight several of the IT challenges the industry faces, from battling cybercriminals to meeting stringent regulatory requirements.

Cybersecurity: heeding the call to action

The Massachusetts Institute of Technology predicted 2015 would be the "Year of the Hospital Hack." Less than two months into the year, Anthem Inc., the nation's second-largest health insurer, announced that cyber attackers may have gained access to the personal information of as many as 80 million current and former customers. This largest known breach of data in the health care industry has been a call to action for organizations to adopt a more sophisticated approach to securing patient information and managing risk (see Exhibit 2-1 on page 23). In its 2015 Data Breach Industry Forecast, Experian described health care as a "vulnerable and attractive target for cybercriminals," noting health care organizations accounted for about 42% of all major data breaches reported in 2014.

Many other studies illuminate the extent of the problem. The Medical Identify Fraud Alliance estimates

2.3 million Americans were victims of medical identity theft in 2014, up nearly 22% in the past year. The Ponemon Institute reports that 40% of health care organizations surveyed in 2014 said their systems were attacked by malware designed to steal data, up from 20% in 2010. According to security provider Symantec, health care organizations saw a 72% increase in cyber attacks between 2013 and 2014, while National Public Radio reported that health care organizations disclosed more than 270 large data breaches during the past two years.

In managing cybersecurity risk, health IT security has been found to lag behind other major industries. Security-rating firm BitSight Technologies examined security in health care versus retail, finance and utilities. Over a year-long period (April 2013 through March 2014), health care experienced the largest growth in security incidents and also took the longest to fix the problems – on average, 5.3 days.

In many health care environments, protected health information and other sensitive data is literally everywhere – from local hard drives and email attachments to random file servers and thumb drives. The security of clinical equipment, which comes with wifi or plug-in network cards, is also a growing concern. For example, in one clinical environment, a fluoroscope was found to be infected with backdoor malware that could have been used to access the hospital's internal network from China. Health care organizations need to make it a priority to identify where all the data is and take steps to eliminate it or store it in a more central, and highly secure, repository.

From a crime standpoint, stolen medical data is highly lucrative for thieves because it often contains not only personal identification information but also financial information – enough to access bank accounts and drug prescriptions. For health care organizations, such theft can lead not only to financial harm, but also to potential class-action lawsuits, mandated multiyear corporate integrity agreements with onerous requirements and a loss of consumer trust that can undermine the entire industry.

The Obama Administration is taking steps in the fight against cybersecurity hacks, announcing a new proposal that would allow increased information sharing on cyber threats from the private sector with protection from liability. Several national organizations, such as the U.S. Department of Homeland Security National Cybersecurity and Communications Integration Center, also provide information on threats and vulnerabilities that organizations can

use to increase their security systems. Guidelines and training material for health care cybersecurity and privacy are available at www.healthit.gov/providers-professionals/cybersecurity.

ICD-10: bracing for the looming compliance date

After three delays and continued debate about benefits, costs and complexities, the transition to the World Health Organization's 10th revision of the International Statistical Classification of Diseases (ICD-10) coding standard is scheduled to happen October 1, 2015. This is the date that CMS has set for all health care providers, health plans and health care clearinghouses to transition to ICD-10. Although some in the industry

have viewed ICD-10 preparations as a major disruption, proponents maintain the granularity of the codes will yield better data for evaluating and improving the quality of patient care.

For many organizations, the 2014 postponement was viewed as a much-needed reprieve, bringing more time to ensure a smooth transition to the new code set (see Exhibit 2-2 on page 24). Others, however, that had diligently prepared for the initial 2014 deadline were discouraged by the delay and insistent that any further changes in deadline be avoided – a position backed by the AHA. Members of the House Energy and Commerce Committee's Subcommittee on Health emphasized at a

February 2015 hearing that they do not want to see another delay in the ICD-10 transition. And in late February 2015, CMS reported that of the nearly 15,000 test claims the agency received for the first round of end-to-end ICD-10 testing, 81% were accepted – a green light for moving forward.

However, a 2015 ICD-10 readiness survey from Navicure and Porter Research found just 21% of physician practices are on track in preparing for ICD-10, with many concerned about the impact of the transition on revenue and staff productivity. Along with resistance from the American Medical Association, the compliance deadline continues to be contested in some corners of Congress. In April 2015, US Rep. Ted Poe (R-TX) introduced a bill to "prohibit the Secretary of Health and Human Services from replacing ICD-9 with ICD-10 in implementing the HIPAA (Health Insurance Portability and Accountability Act) code set standards." And in May, US Rep. Diane Black (R-TN) proposed initiating an 18-month transition period for ICD-10, requiring HHS to prove it is processing and approving at least as many claims as it did in the previous year using ICD-9. As of press time for *New horizons*, the October 1 deadline holds firm.

Exhibit 2-1. Five steps for anticipating cybercrime

1. Design and implement a cyber threat intelligence strategy.

Make sure your information security function works with board members and executive leaders to help them understand how to use threat intelligence in supporting strategic business decisions and leveraging the value of cybersecurity.

2. Define and encompass your organization's extended cybersecurity ecosystem.

Work with others in your extended ecosystem to define role, responsibility and trust models, and to enact cooperation and sharing capabilities where advantageous.

3. Take a cyber economic approach.

Understand which are your organization's most vital cyber assets and their value to cybercriminals. Then, re-evaluate plans to invest in security.

4. Use forensic data analytics and cyber threat intelligence.

Deploy the latest technical tools to analyze where the likely threats are coming from and when, increasing your ability to combat them.

5. Keep your entire staff informed and vigilant.

Update employees – and keep them acting as the eyes and ears of your entire organization – through strong governance, user controls and regular communications.

Source: EY analysis; adapted from *Get ahead of cybercrime: EY's Global Information Security Survey, October 2014*.

By the numbers

- ▶ Nearly 95% of health IT professionals say complying with regulations is the chief driver of their decision-making, according to a recent poll (Peak 10, "National IT Trends in Healthcare Study," conducted from March through December 2014).
- ▶ About 60% of respondents in a recent industry survey said that spending levels for cybersecurity have increased over the last three years, while 39% indicated that they had experienced more than 10 cyber attacks over the last 12 months – with 27% of those attacks considered "successful" (IDC Health Insights, "Business Strategy: Thwarting Cyberthreats and Attacks Against Healthcare Organizations," November 2014).
- ▶ Nearly six in 10 hospitals (59%) adopted at least a basic EHR system in 2013 – an increase of 34% from 2012 to 2013, and a five-fold increase since 2008 (ONC, 2015).
- ▶ In a recent survey, 71% of physician respondents said that they could successfully attest to Stage 3 criteria, but only 38% said the government did a fair job with the Stage 3 proposed rule (QuantiaMD survey, March 2015).
- ▶ A survey of health care professionals finds 80% believe implementation of the ICD-10 coding system will happen this year, but only about 28% have performed revenue impact testing (QualiTest, ICD-10 survey, April 2015).
- ▶ A national survey of the social life of health information finds more than 70% of adult internet users have searched online for information-specific diseases and treatments, and about 26% have used social media to participate in someone else's health experience or medical issues in the past 12 months (Pew Research Center, 2014).
- ▶ 22% of employers with more than 1,000 employees offer telemedicine consultations as low-cost options to ED and primary care physician visits (Towers Watson, "2014 Health Care Changes Ahead Survey").
- ▶ On average, a telehealth visit saves about \$100 or more compared with the estimated cost of in-person care (Dale H. Yamamoto, Red Quill Consulting, Inc., "Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services," December 2014).
- ▶ A survey of 366 health care executives finds 73% of providers are using mobile health in some way, 18% are hoping to incorporate mobile into their health care delivery soon and 9% are not considering using mobile ("The State of Mobile in Healthcare Delivery," Modern Healthcare Custom Media on behalf of Verizon, 2014).
- ▶ Investors pumped a record \$6.25 billion into digital health ventures in 2014, an increase of 125% from the 2013 level (StartUp Health Insights Annual Report, "2014: The Year Digital Health Broke Out").
- ▶ US health care professionals who use Twitter make up 31% of the 75,000 worldwide total of industry professionals who turn to the social media site to tweet information (Creation Healthcare, 2013).

Exhibit 2-2. Five priorities for ICD-10 preparedness

- 1. Communicate.**
Remind employees continuously of the upcoming deadline, and meet regularly with coders, physicians and health IT management to discuss ICD-10 implementation goals and updates.
- 2. Provide coder refresher training.**
Build time for refresher training into coders' schedules for such activities as reviewing guidelines and completing online courses.
- 3. Give coders time to practice.**
Allow coders to use actual medical records when practicing instead of made-up records or diagnostic statements, as the real record will be more productive and realistic.
- 4. Offer specialty-specific training for physicians.**
Update EHR templates to include details for ICD-10. Make sure physicians know how to use the new documentation requirements.
- 5. Address staffing needs.**
Prepare for a decrease in coder productivity. Hire extra coders, consider remote coders, consider retention strategies requiring coders to stay with organizations for a defined time and ensure salaries are competitive.

Source: Adapted from ICD10monitor.

**Meaningful use:
moving toward Stage 3**

Six years ago, when President Obama signed into law the Health Information Technology for Economic and Clinical Health (HITECH) Act, a new path was laid for creating a nationwide health IT infrastructure. The goal was for every provider in the nation to use EHRs and to do so in a way that leads to better care delivered more efficiently.

HITECH provided \$30 billion in incentives for health care organizations meeting the criteria for meaningful use (MU), as

defined by CMS. The rules for MU were set up to be rolled out in three stages (see Exhibit 2-3). On March 20, 2015, the long-awaited criteria for the third and final stage of MU were released. Highlights from the proposed Stage 3 MU rule are shown in Exhibit 2-4.

The eight objectives of MU Stage 3 are designed to enable hospitals and eligible professionals (EPs) to ensure security,

prescribe electronically, use clinical decision support and share data with other providers and patients. Program participants are offered some flexibility in meeting measurements. For three of the objectives, hospitals and EPs would need to meet only the thresholds for a subset of measures. Providers could fail one of the measures for certain objectives but still successfully achieve meaningful use

Exhibit 2-3. MU stages, goals and timelines

Stage	Purpose	Timeline
1	Data capture and sharing	Went into effect in 2011; retroactive changes finalized in Stage 2
2	Advanced clinical processes	Went into effect October 2013 for eligible hospitals and January 2014 for eligible professionals
3	Improved outcomes	Optional proposed start date 2017; required date 2018 for all

Source: CMS, 2015.

Exhibit 2-4. Goals and provisions of the proposed Stage 3 MU rule

Goal	Proposes to:
Reduce program complexity	Address complaints CMS received in Stages 1 and 2 over the multiple stages of participation and the timing of reporting periods.
Simplify reporting	Synchronize the reporting period for MU with other CMS quality programs.
Align all providers on the calendar year	Change the EHR reporting period so that all providers report under a full calendar year timeline instead of the current federal fiscal year. Remove existing 90-day reporting option for hospitals and EPs in their first year of MU.
Make 2017 a transition year	Offer any hospital or EP the option of attesting to Stage 3 in 2017, with the flexibility also to attest to Stage 1 or 2.
Make Stage 3 the only stage beginning in 2018	Require all hospitals and EPs to meet Stage 3 measures whether it is their first year in the program or they have been meeting MU requirements for several years. The goal is to have everyone operating under a unified set of MU requirements beginning in 2018.
Focus on patient engagement	Establish measures for engaging patients, including the ability for patients to update the EHR with patient-generated information through such methods as electronic forms, questionnaires and secure messaging.
Eliminate the core, or required, and menu, or optional, set of measures used in Stages 1 and 2	Provide eight objectives for all hospitals and EPs, each of which would have one or more associated measures. Hospitals and EPs would be required to report on all of the measures associated with each objective.

Source: CMS, 2015.

and avoid downward payment adjustments (see Exhibit 2-5).

The thresholds for the proposed Stage 3 objectives and measures are much higher than those required for Stage 2 attestations, reflecting CMS' expectation that providers will be using more sophisticated EHR technology by 2018. For example, the proposed Stage 3 MU criteria include several measures that aim to engage patients more fully, such as the following:

- ▶ More than 25% of a health care provider's patients must actively engage with their electronic records, including viewing, downloading or transmitting data from their records. This is a five-fold increase from Stage 2 requirements, where only 5% of patients had to engage with their EHR. However, the proposed rule responds to criticisms of the Stage 2

requirement that patients must view or download health records through patient portals. Under Stage 3, providers can use an application program interface that enables third-party developers to access data for patients. The goal is to enable patients to take accountability for their health and allow for a wider span of applications for patient-generated health data (PGHD).

- ▶ After a visit with their health care provider, more than 25% of patients must receive a message through the EHR's secure messaging function. Stage 2 required only 5% of patients to exchange messages with providers, marking another significant increase in patient engagement requirements. Messages must be clinically relevant – that is, they must relate directly to the patient's visit. Responses from health care providers to

messages initiated by patients also count toward meeting this requirement.

- ▶ For more than 15% of patients, PGHD from a non-clinical setting must be collected and incorporated into the EHR. This is a new requirement; Stage 2 did not include any PGHD criteria.

The proposed rule also raises the bar on transition of care (TOC) requirements:

- ▶ For more than 50% of TOCs and referrals, EPs and hospitals must use their EHR to create a summary of care and electronically exchange it with other providers.
- ▶ In more than 40% of TOCs, the provider must incorporate in its EHR a summary of care from an EHR used by a different provider.
- ▶ In more than 80% of TOCs, the provider must perform a "clinical information reconciliation" that includes medications, allergies and patient problems.

Many industry observers note that the Stage 3 rule requires vendors to provide greater interoperability and better sharing of data with all stakeholders. That said, overall reaction to the Stage 3 rule has been mixed. The AHA, for example, has said that while the proposed rule provides "much-needed relief" and gives hospitals more time to transition to Stage 2 and meet CMS timetables, "the inclusion of numerous additional program changes at this late date risks causing confusion and added burden for hospitals on top of the elements proposed in the Stage 3 rule."

While Stage 3 will be the final MU stage, ONC and CMS are expected to continue to modify the program's requirements in the years to come to achieve the program's further aims.

Exhibit 2-5. MU Stage 3 objectives and measures

Objective	No. of measures	No. of measures required to meet objective
Protection of patient health information	One	One
Electronic prescribing (different for hospitals and EPs)	One	One
Clinical decision support	Two	Two
Computerized provider order entry	Three	Three
Patient electronic access to health information	Two	Two
Coordination of care through patient engagement	Three	Two of three
Health information exchange	Three	Two of three
Public health and clinical data registry reporting	EPs: five Hospitals: six	EPs: three of five Hospitals: four of six

Source: CMS, 2015.

“Even though we’re talking about Stage 3, what we’re really talking about is what everybody will be doing – or we’re proposing that everyone will do – in 2018 and beyond.”

Robert Anthony
Deputy Director of the Quality Measurement
and Health Assessment Group
CMS

Interoperability: following a new road map

To support information exchange, EHRs need to present data in standard ways, and disparate organizations providing services for the same patient need to share information securely. Yet many in the health care industry have long been discouraged by the lack of data interoperability among health systems and IT vendors, medical devices and financial systems, particularly as the industry moves to more advanced stages of the MU program and relies more on electronic data to coordinate care.

In January 2015, ONC released a draft “road map,” unveiling a 10-year vision for interoperability. It outlines the agency’s expectations for creating a continuous learning environment for care, revealing 3-, 6- and 10-year milestones. It also calls for interoperability requirements to be consistent at the federal, state and private levels. The plan includes three critical pathways: 1) requiring standards, 2) motivating the use of those standards through appropriate incentives and 3) creating a trusted environment for collecting, sharing and using electronic health information. The road map is hailed as the first detailed vision the federal government has provided for a path toward system-wide interoperability.

Exhibit 2-6. 10-year overarching goals of the interoperability road map

Three-year agenda (2015-17)

Send, receive, find and use a common clinical data set to improve health and health care quality

Six-year agenda (2018-20)

Expand interoperable health IT and users to improve health and lower costs

10-year agenda (2021-24)

Achieve a nationwide learning health system

Source: ONC, 2015.

Central to the ONC’s push for interoperability is the goal of establishing a Learning Health System (LHS) by 2024. At the heart of the LHS concept, first articulated by the Institute of Medicine in 2007, is instilling the capacity and commitment to learn at all levels of the health care system.

The ONC road map describes functional and business requirements for a LHS and the steps needed to make rapid progress. The process includes using data and analytics to generate knowledge, providing feedback to stakeholders, and changing behavior to transform health care and health.

“The increased complexity of health care requires a sustainable system that gets the right care to the right people when they need it, and then captures the results for improvement – the nation needs a health care system that learns.”

Institute of Medicine, 2011

The IT workforce: meeting the need

The demand for health IT professionals has never been stronger. iHealthBeat reports a shortage of 51,000 qualified health IT professionals, while a 2014 HIMSS workforce study reveals staff shortages are hindering providers in completing IT initiatives. More than one-third of respondents working for a provider organization reported scaling back or putting an IT project on hold because it could not be fully staffed – with consequences that can ultimately affect patient care.

To meet the challenge head on, the ONC has funded the Health IT Workforce Development Program, with a total allocation of \$116 million. Its goal is to train a new workforce of health IT professionals who will be ready to help providers implement EHRs and meet other IT needs.

A key part of the program is the Community College Consortia to Educate Health Information Technology Professionals, designed for professionals with an IT or health care background. Five regional groups of more than 70 community colleges in all 50 states have received \$68 million in grants to develop or improve non-degree health IT training programs that can be completed in six months or less. To date, funding recipients have trained more than 10,500 new health IT professionals.

Sources: “Shortage of Health IT Professionals Imperils Health Care Reform Effort,” iHealthBeat, April 9, 2014; 2014 HIMSS Workforce Survey; HealthIT.gov.

Transformers

Apple's HealthKit: getting patient-generated health data into the EHR

HealthKit, a new application program interface developed by Apple, has been lauded for its potential to transform the patient-physician relationship.

Introduced in 2014, HealthKit allows apps that provide health and fitness services to share data with the new Health app and with each other.

The Apple Health app features an easy-to-read dashboard for aggregating fitness and health data in one location – on the user's iPhone or iPod touch.

It enables data collection from consumer health monitoring devices such as blood pressure cuffs, diabetes monitors and weight scales, including the Apple Watch and other monitoring devices. With the Health app, users can share data with a corresponding app that automatically sends information to the patient's health record system. These apps and accessories are valuable for patients who are managing chronic conditions, which, according to the Centers for Disease Control and Prevention, account for 86% of the nation's health care costs. Apple reports that more than 1,000 health, medical and fitness apps are now integrated with HealthKit.

Reuters reports that 14 of 23 top hospitals have rolled out a pilot program of Apple's HealthKit service or are in talks to do so. For example:

- ▶ In California, Stanford Health Care's iOS 8 MyHealth mobile app for patients, developed in-house, connects directly with Epic's EHR system and with HealthKit to collect data from consumer health data monitoring devices. Patients can use the app to view test results and

medical bills, manage prescriptions, schedule appointments and participate in video visits with Stanford physicians. The MyHealth app also offers a secure messaging platform through which patients can communicate directly with caregivers.

- ▶ In Louisiana, New Orleans' Ochsner Medical Center has been working with Apple and Epic on a pilot program for high-risk patients, such as those with high blood pressure. Devices measure blood pressure and other statistics and send the data to Apple phones and tablets.
- ▶ In North Carolina, Durham-based Duke Medicine has integrated HealthKit with its Epic MyChart EHR with the goal of connecting patient-generated health data and clinical data. Ricky Bloomfield, MD, Director of Mobile Technology Strategy at Duke, shared the pilot's ongoing success story at the 2015 HIMSS conference in Chicago. Key to success, he said, is informing patients that they have control of their data. No information is shared without patient permission, and at any point, patients can easily revoke any app's access to the data. Bloomfield noted that a vision for the future is partnering with payers to demonstrate efficacy, increase efficiency and potentially subsidize device costs.

Sources: "Top L.A. hospital using HealthKit to monitor 80,000 patients," Cult of Mac, April 27, 2015; "Exclusive: Apple's health tech takes early lead among top hospitals," Reuters, February 5, 2015; "Stanford launches its HealthKit- and Epic-connected MyHealth app," VB News, February 11, 2015; "How Duke is Using HealthKit to Get Patient-Generated Data into the EHR," Health Care Informatics, April 21, 2015; "What CIOs can learn from Duke's successful Apple HealthKit pilot," Healthcare Dive, April 30, 2015.

Along with the ONC's road map, the interoperability goal has also received a boost from the private sector through the Argonaut Project. An initiative from Health Level Seven® (HL7) International, the global authority for interoperability in health care IT, the project includes 12 leading providers and vendors devoted to speeding up the development and adoption of HL7's standards framework, Fast Healthcare Interoperability Resources (FHIR). Described by HL7 as a "significant advance," FHIR is based on current internet conventions and will enable health data to flow more freely than it does today.

The next wave: preparing for patient-generated health data

Over the past 50 years, the center of the health care universe has been the hospital and physician's office. In a transforming industry, that center is readily shifting to wherever the patient happens to be. An often-cited industry statistic is that 99% of patient activity happens outside the hospital or clinic.

In this new world of empowered consumers, information collected directly from patients – patient-generated health data – is increasingly vital. PGHD is distinct from data generated in clinical settings and through encounters with providers in that patients, not providers, capture or record the data and decide how to share it with providers and others.

Meaningful Use Stage 3 criteria indicate a move toward soliciting more information from patients and family members, with providers required to capture PGHD from 15% of their patients through such devices as Fitbits. Information about sleep, diet, exercise and other patterns can give physicians more insight into patient habits and can help physicians recommend lifestyle changes that improve patient health. The proposed rule provides incentives for incorporating information controlled and generated by the patient

into their EHR, to reside with data generated in clinical settings.

Industry analysts predict that such companies as Apple, Samsung and Google will continue to push innovation and adoption of PGHD devices for consumers. Visiongain reports the global wearables technology market alone is expected to reach \$16.1 billion by the end of 2015. New arrivals range from the Apple Watch, which debuted in April 2015, to the OMSignal biometric shirt, which tracks heart rate and other fitness measures, and the Healbe GoBe™, which measures calorie intake through the skin.

The proliferation of PGHD provides a distinct opportunity to monitor and track the patient experience and to engage patients as partners in their care. This information can supplement clinical data and fill in gaps in information, providing a more complete picture of patient health. It can also yield key insights into how patients are doing between medical visits, enable information to be gathered regularly, and provide information relevant to preventive and chronic care management.

Yet PGHD also poses a host of challenges. Providers need to evaluate what information to include in the patient record, determine when to promote PGHD as part of the care plan, gauge the impact of PGHD on workflow and address liability issues and privacy protections.

"It will take a new plasticity of the medical community in facing its greatest and singular challenge since the profession's origin – its transformation by pervasive embracement of digital technology."

Eric Topol, MD, Steven Steinhubl, MD and Ali Torkamani, PhD
Viewpoint, "Digital medical tools and sensors,"
Journal of the American Medical Association,
January 27, 2015

Telehealth: pursuing the promise

Telehealth initiatives continue their movement forward. Telehealth vendor REACH Health recently released results of a benchmark survey on the state of the industry in the US. Nearly 60% of the 233 survey respondents identified telehealth as their top priority or one of the highest priorities for their organization – motivated by the desire to improve patient outcomes, provide access to specialists and leverage limited physician resources. The top driver of return on investment was "improved reputation," while reimbursement was cited as the primary obstacle to success.

In its 2015 Medicare physician fee schedule, CMS included several provisions that advance access to, and reimbursement for, telemedicine services. Starting in January 2015, CMS added seven new telehealth reimbursement codes, including annual wellness visits, psychotherapy services and prolonged services in the office. In all, Medicare payments to telehealth originating sites increased by 0.8% in 2015. The American Telemedicine Association (ATA) lobbied CMS for these changes for more than five years.

In January 2015, New York became the 22nd state to pass legislation requiring that telehealth visits be reimbursed at the same rate as in-person visits. However, adoption from state to state remains inconsistent. In an analysis from the ATA released in May 2015, the ATA compared telemedicine adoption in all 50 states and the District of Columbia. The lowest-ranking states were Connecticut and Rhode Island, while the District of Columbia and five states – Maine, New Hampshire, New Mexico, Tennessee and Virginia – were recognized as the most supportive areas for telemedicine policies.

Transformers

Thomas Jefferson University Hospitals: innovating with telehealth

At Thomas Jefferson University Hospitals (TJUH), which recently merged with Abington Health to become the largest provider system in greater Philadelphia, telehealth is becoming central to care delivery. Over four years, TJUH expects to spend \$20 million on telehealth initiatives. Through its "virtual rounds" video conferencing service, a patient's family members and family physicians can download an app and use their smartphone or computer to watch, ask questions and interact with caregiving teams.

Through a partnership with American Well®, TJUH has also created JeffConnect, offering patients video follow-up appointments through web or mobile apps. In future endeavors, Jefferson will use video physician visits for coordinating primary and urgent care.

Eventually, the hospital hopes to create a "virtual emergency department," with remote communication, including test results, between community hospitals and Jefferson specialists. TJUH CEO Stephen Klasko, MD, projects that 65% of patient visits to Jefferson could eventually be virtual.

Sources: "A Philadelphia Hospital Makes a Bet on Obamacare," Bloomberg Politics, January 26, 2015; "Thomas Jefferson University Hospitals Innovates with Telehealth," H&HN Daily, June 30, 2014; "Juicing up Jeff," Philadelphia Inquirer, October 13, 2014; "JeffConnect Puts Patients Face-to-Face with their Doctor over Video," American Well website, accessed June 2015.

Transformers

Deeper insights: leveraging the power of big data for new technologies

Despite the challenges of data-driven health care, many organizations are ahead of the curve in big-data initiatives. For example, the University of Pittsburgh Medical Center (UPMC) is teaming with Carnegie Mellon University (CMU) and the University of Pittsburgh (Pitt) to create a new data-focused group, the Pittsburgh Health Data Alliance. Funded by UPMC, the work of the new group will be carried out by Pitt-led and CMU-led centers, with participation from all three institutions.

The project is designed to transform health care big data into new technologies, products and services that will aid in diagnosing, treating and preventing diseases and engaging patients in their own care. Data will be drawn from varied sources, from EHRs to wearable sensors.

Activities will be driven by two research and development centers: 1) CMU's Center for Machine Learning and Health will produce a series of increasingly sophisticated, data-driven apps for providers, caregivers and individuals,

and 2) Pitt's Center for Commercial Applications and Global Healthcare Data will create new technologies for developing individualized therapies for various diseases.

"Through this collaboration, we will move more rapidly to immediate prevention and remediation, further accelerate the development of evidence-based medicine, and augment disease-centered models with patient-centered models of care."

Subra Suresh
President, CMU

Alliance leaders note that the project's overall goal is to streamline and accelerate the process of moving innovations from discovery to real-world application. UPMC Enterprises, the commercialization arm of UPMC, will lead the efforts to turn these innovative ideas into new companies and jobs.

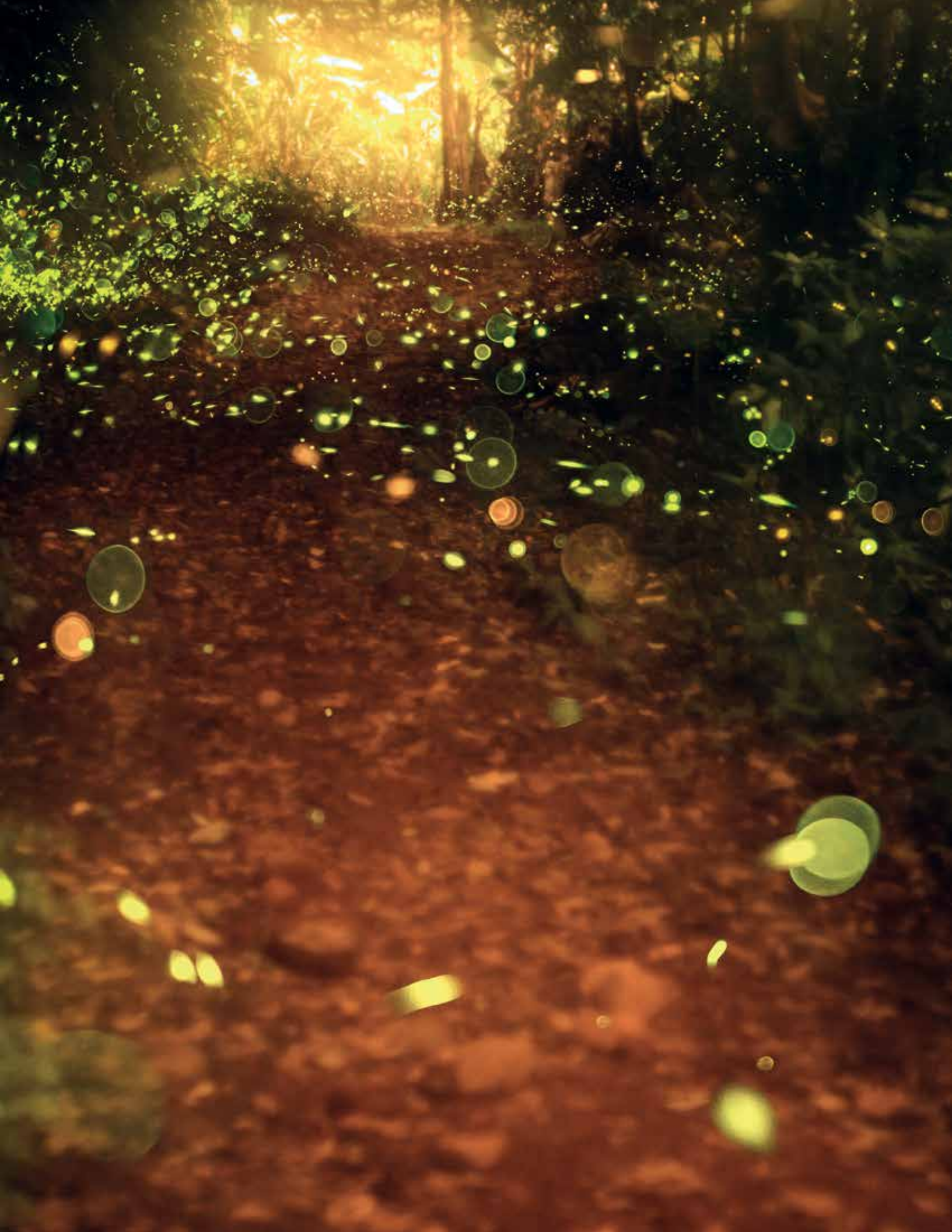
Sources: "The future of health care is in the data," Carnegie Mellon University, March 16, 2015; "UPMC teams with universities to develop data-based health innovations," FierceHealthIT, March 16, 2015.

Care transformation: gathering and analyzing data

The sheer volume of data generated in health care creates distinct challenges in technology, compliance and governance. A recent report from EMC and research firm IDC predicts that by 2020, data volume will grow to more than 2,000 exabytes. To illustrate the magnitude of this amount, report authors note that if all this information were stored on a stack of tablet computers, the tower would be more than 82,000 miles high by 2020 – or a third of the way to the moon.

This volume of data makes it imperative to invest in big-data analytics and technologies. Data analytics help organizations to gain deep insight into patients, populations and performance, to predict outcomes and to rapidly identify the actions needed for improvement. At the 2014 mHealth Summit, HHS Chief Technology Officer Bryan Sivak said he believed that the industry was "still at the same tip of the iceberg" in its ability to analyze data, particularly from consumer devices, to improve patient care.

The announcement in January 2015 of a new federal program, the Precision Medicine Initiative, may signal the next horizon for big-data analytics (see interview with the American Medical Association's (AMA) Robert Wah, MD, at the end of this chapter). The plan calls for amassing information on one million or more American volunteers who will agree to share a wide range of data from their EHRs. It is designed to analyze cancer genomes, build a cancer knowledge network and improve strategies for preventing and managing chronic diseases.



Feature

The backbone of health care transformation: strengthening the IT infrastructure

A conversation with Robert Wah, MD, Chief Medical Officer, Computer Sciences Corporation, and President, the American Medical Association (AMA), 2014-15

Dr. Wah is currently the Chief Medical Officer for Computer Sciences Corporation (CSC) and serves as the 169th president of the AMA. A nationally recognized expert in health IT, Dr. Wah is regularly ranked in Modern Healthcare magazine's "50 Most Influential Physician Executives." He began his career as a reproductive endocrinologist with a Harvard Medical School fellowship and went on to serve as Vice Chairman of the OB/GYN Department at San Diego Naval Hospital. In 2001, Dr. Wah began working on health IT for the Department of Defense and eventually became Associate Chief Information Officer for the Military Health System. In 2005, he served as First Deputy National Coordinator for Health IT at HHS. We talked with Dr. Wah about the role of health IT in health care system transformation.



As a practicing physician, you took an interest in health information technology early on. What was the catalyst for your involvement?

In my 31 years as a physician, I've always been interested in anything that can help me take better care of my patients. Health IT is a key tool in reaching that goal, with the potential of achieving better health outcomes in a more cost-efficient way. Bringing everyone onto the digital platform is a foundational step in getting our health care system to be what we want it to be.

At CSC, our viewpoint is that health IT will transform health care by delivering better information for better decisions for everyone in the health care space so that the right care is delivered at the right time in the right place. Physicians can make better decisions for their patients, and patients can make better decisions for themselves. Payers can better understand their member populations and how to keep them healthy. Policymakers can have more accurate information about cost and quality.

To what degree are physicians embracing EHRs? What are their points of frustration and of satisfaction? What is the overall physician perspective on the meaningful use incentive program?

It's often said that physicians are reluctant to use new technology. But it's been my experience that with many new technologies, from pagers to cell phones, clinicians have been among the earliest adopters. Physicians will always embrace technology that will help them take better care of their patients – but will resist what doesn't help them to do that.

“Physicians will always embrace technology that will help them take better care of their patients – but will resist what doesn't help them to do that.”

EHRs fall somewhere in between. We can see the clinical promise of this technology, but we are often frustrated when it doesn't fit into practice workflows and can impede better care. To make EHRs a successful tool, we need to focus on the user interface and workflow integration.

In September 2014, the AMA released a report calling for overhauling EHRs to improve usability. This report built on the AMA landmark study with RAND Corp., confirming that EHRs are a significant burden for physicians. To address this challenge, the AMA offered eight priorities for the vendor and regulatory communities to improve EHR usability (see box).

As for meaningful use, I think we all agree on its ultimate goal: to help us take better care of our patients. Our concern, however, is that MU has become an administrative burden, where physicians are being required to “check off boxes.” This not only gets in the way of our taking better care of patients, but also gives us an all-or-nothing proposition. Providers need to meet MU criteria 100% or face penalties. At the AMA, we've requested that the program stay true to the goal of improving care and be modified to allow partial credit for MU compliance.

Improving EHR usability for caregivers and patients: eight priorities from the AMA

Priority	EHRs should be designed to:
Enhance physicians' ability to provide high-quality patient care	Focus on effective communication and engagement between patients and physicians, fit seamlessly into the practice and not distract physicians from their patients
Support team-based care	Facilitate clinical staff in performing work as needed and to the extent their licensure and privileges permit, and also allow physicians to dynamically allocate and delegate work to appropriate team members as their organization's policies permit
Promote care coordination	Automatically track referrals and consultations, as well as ensure that the referring physician can follow the patient's progress and activity throughout the continuum of care
Offer product modularity and configurability	Offer flexibility to meet individual practice requirements, with appropriate application program interfaces
Reduce cognitive workload	Support medical decision-making by providing concise, context-sensitive and real-time data uncluttered by extraneous information; manage information flow and adjust for context, environment and user preferences
Promote data liquidity	Facilitate connected health care, including interoperability across different venues – with the ability not only to export data but also to incorporate external data from other systems into the longitudinal patient record
Facilitate digital and mobile patient engagement	Provide interoperability between a patient's mobile technology and the EHR
Expedite user input into product design and post-implementation feedback	Facilitate the incorporation of end-user feedback into product design and improvement

Source: AMA, "Improving care: priorities to improve electronic health record usability," September 2014.

What are the AMA's current priorities and how does health IT fit in with the vision?

As we move toward 2020, we have three strategic goals at AMA. We want to improve health outcomes for our patients, enhance professional satisfaction and practice sustainability by shaping delivery and payment models, and accelerate change in medical education. Clearly, the optimal use of health IT can help us reach all of these goals.

Many maintain that telecommunications and internet technologies, from telehealth to social media, are empowering patients to be more proactive about their health. What is your perspective on the benefits and challenges of these technologies?

In 2014, the AMA officially adopted a policy on telemedicine. We believe that establishing a strong patient-physician relationship – first through an in-person consultation, when possible – is the key to maximizing telemedicine's potential. Building on that foundation, physicians can then use this technology to overcome distances to coordinate care, help patients better manage chronic conditions and advance the patient relationship overall. We also believe that physicians delivering telemedicine should be licensed in the same state where their patients receive treatment so that they are aware of and comply with the local health care laws and regulations.

As for social media, the patient engagement, bonding and information-sharing it offers can clearly be beneficial to patients. But more study is needed on how to control for the internet's information accuracy.

What is the role of data analytics in a transforming industry?

Its role is huge – and growing.

Since the 2009 passage of HITECH, I've observed that the era of health IT investment has come in three waves.

The first wave is transitioning from paper to electronic records, and the second is creating health information exchanges. Those two waves have been moving in tandem. The third wave, which really took off in 2014, is accessing and analyzing information for delivering more personalized medicine and improving population health. As systems mature, they will go from simply reporting information and providing basic business intelligence to being truly predictive and offering the potential to better coordinate care.

In President Obama's 2015 State of the Union speech, we heard many times the term "precision medicine." This model will enable us to craft more personalized treatment plans that will do much more than the generalized plans we've used in the past. Big data analytics will enable precision medicine, helping us to customize care by reliably predicting which treatments and interventions will work best for which patients.

As the industry readies itself to implement ICD-10 in October 2015, what challenges remain?

At the AMA, our perspective is that it's unclear what benefits ICD-10 will bring in improving individual patient care. Also, it continues to be an expensive endeavor for physicians – tens of thousands of dollars for small practices and millions for larger.

The way the US will deploy ICD-10 is different than the way it's deployed around the world. Many countries use ICD-10 as a population health monitor. In the US, it's tightly linked to our billing process, and the conversion puts physician revenue streams at risk.

We believe we should have dual, parallel efforts of testing and transition in the rollout. We're pushing CMS to do true end-to-end testing that can verify that the system can handle the conversion and that physician revenue streams will not be disrupted, as well as transition plans to smooth the use of the new system. In preliminary testing, the Medicare claim acceptance rate dropped from 97% with ICD-9 to 81% with ICD-10. Having a nearly 20% drop will devastate the smooth running of a physician's office.

We're seeing a rise in data breaches and concerns about cybersecurity. Give us your assessment of how far along the industry is in protecting patient health records, and what it needs to do to improve.

Traditionally in health care, we've been worried about privacy intrusions into the confidential information our patients give us. Privacy of information is still paramount, but the next great threat is its security.

Theft of patient information is on an alarming rise. On the criminal (or illegal) market, a patient's health record is about 20 to 50 times more valuable than a stolen credit card number. It's a rich source of information by which criminals can build a strong false identity and commit all kinds of financial fraud. And unlike credit cards, if your health information has been stolen, you can't call a 1-800 number to stop its use.

Health care organizations need to adopt what I call "industrial-strength" methods to secure their data – similar to the fortifications we see in the financial services industry. We are in an arms race with the criminal elements and the criminals are ahead.

.....
"On the criminal (or illegal) market, a patient's health record is about 20 to 50 times more valuable than a stolen credit card number."
.....

What guidance do you have for health care executives and board members for maximizing the power of IT at their organizations?

Think about security not as an added expense, but as an enabler of your mission to improve patient health. Because without adequate security, patients won't give you the information you need to take better care of them.

Deploy all health IT initiatives with the physician – and patient – in mind. The goal is to improve patient care. Make sure that technology is part of the workflow, rather than getting in the way of it, and that it's designed to improve your clinical and business processes.

In summary, harness the technology. Don't let it harness you.

Considerations for your board and executive leaders

For all organizations

- ▶ Has your organization assessed the many significant issues facing your IT staff over the next two years, setting priorities for competing demands?
- ▶ Is your organization monitoring every day for security breaches, including using encryption and other cybersecurity safeguards to protect health data stored in databases, conducting ongoing security risk assessments, and deploying network monitoring and detection tools? If a breach does happen, are you conducting a full forensics analysis?
- ▶ What is your strategy for improving employee training in privacy and security, and for making application testing a continuous priority?
- ▶ Have you designated a chief security and privacy officer to ensure compliance with HIPAA regulations, implement the appropriate security safeguards and institute an enterprise-wide training program for privacy and security?
- ▶ Do you view data as an asset or an operational commodity? Is data analytics an investment priority for your organization's operations and decision-making?

- ▶ What technologies are you considering to improve quality of care and patient engagement?
- ▶ Are you a learning organization? Have you articulated your commitment to put data to work in driving improvement?

For providers

- ▶ Is your ICD-10 strategy viewed as an opportunity to improve operations and strengthen your ability to measure quality? Does your organization have a contingency plan in the event ICD-10 implementation or payments are delayed or bottlenecks occur in your organization?
- ▶ Has your organization invested in the products and services needed to meet MU Stage 3 requirements, such as infrastructure upgrades, security enhancements, data-sharing platforms, tools for enabling patient health information sharing, platforms that facilitate better care coordination and collaboration, advanced data analytics and reporting, and new software tools and medical devices that can integrate with EHRs?

For payers

- ▶ Have you assessed your ICD-10 implementation plans and adjusted them to address the anticipated October 1, 2015, conversion date? Have you tested your claims acceptance and processing systems with participating providers to correct any issues before the conversion date?
- ▶ Have you assessed the new, and richer, information that will be available from ICD-10 coded claims, and are you developing strategies to use this information to measure the costs and quality of care provided by each of your contracting information providers?
- ▶ Are participating providers consulted in your data analytics efforts when considering causes behind variations in costs and outcomes and in developing opportunities for new payment initiatives?
- ▶ Do you provide members with access to online sites or mobile apps that can help them actively engage in managing their health? Do you target groups at high risk for health care complications and offer monitoring tools, online health coaches or other real-time access to guide them to lower-cost alternatives or other services designed to prevent readmissions, ED visits and use of costly medications?

"In times of change, learners inherit the earth,
while the learned find themselves beautifully
equipped to deal with a world that no longer exists."

Eric Hoffer, 20th-century American moral and social philosopher



Transforming transactions

Sharing the territory

Transitions

Since the passage of the ACA in 2010, the health care industry has experienced a sustained increase in integration activity. More and more providers and payers are evaluating transaction options that complement – or extend – their capabilities or geographies, not just their overall size. In the pre-reform world, health care organizations often consolidated with the goal of increasing revenues. Today, they are evaluating integration opportunities for their ability to reduce costs, enhance operational efficiencies, and improve quality and the patient care experience. In this surging wave of health care M&A, virtually every health care player is affected. Even for those not directly involved in a deal, consolidation among industry players can rapidly transform market dynamics, leaving organizations with new competitors and shifting strategic priorities.

Convergence and consolidation continue to be a dominant health care trend. While traditional merger and acquisition (M&A) deals are proliferating, non-traditional arrangements – from creating strategic affiliations to blending for-profit and nonprofit organizations – are also emerging as organizations look for ways to scale up and adopt new competitive strategies. In this chapter, we highlight the range of recent integration activities and their ongoing role in industry transformation.

Health care transactions: surging volumes and values

The requirements of the Affordable Care Act continue to spur a major shift in the business of health care. Organizations are being driven together in unprecedented levels to gain economies of scale, control the continuum of care and compete effectively in today’s transforming marketplace. In a value-based system, M&As, affiliations and collaborations are promising strategies for success.

The latest industry statistics indicate that deal activity in the health care industry services sector increased in 2014, both in deal volume and in the dollar value of transactions (see Exhibit 3-1). According to market analysis firm Irving Levin Associates, some of the deal-making activity in 2014 was a direct result of the mega-mergers of the previous year, including

Tenet Healthcare/Vanguard Systems and Community Health Systems/Health Management Associates, as these systems realigned their portfolios. In health care services, all but one sector – laboratories, MRI and dialysis – posted gains over their 2013 totals. For the hospital sector, deal volume increased 14% in 2014 to 100 transactions, while the physician medical group sector saw strong interest from outside entities, with nearly \$3.2 billion spent on physician groups in 2014.

Transaction activity in 2015 is equally intensive. According to Irving Levin Associates, 203 deals closed in health care services during the first quarter of 2015, compared with 171 in the first quarter of 2014.

“It’s an unusual year when nearly every health care services segment bests its prior-year performance.”

Lisa E. Phillips
Editor
2015 Health Care Services Acquisition Report

Horizontal to vertical: considering the full spectrum of integration initiatives

The post-ACA environment has yielded numerous trends inspired by reform but driven by a transforming market. Stakeholders across the health care industry are adding scale to maintain or increase leverage in contract negotiations – and moving to capture more of the health care dollar by deepening or expanding service lines through acquisitions, alliances, joint ventures and partnerships. Spurred by the rise of accountable and value-driven care, as well as the proliferation of expensive care coordination technologies, numerous independent hospitals have sought partners to help fund capital needs and strengthen their financial positions. Also, many health care systems have actively sought strategic additions to expand their markets or build out existing networks.

At the same time, health care payers are narrowing provider networks for ACA plans and are exploring acquisitions of provider capabilities. High-deductible health plans are contributing to the rise in these narrow networks as more health care costs are pushed to consumers, who are seeking low-cost options.

The market is experiencing a proliferation of two types of integration: horizontal, where two or more like entities, such as hospitals, join forces; and vertical, where two or more organizations that are fundamentally different in their product or

Exhibit 3-1. Deal activity in the health care industry services sector, 2013-14

Deals	2013	2014	Percent change
Volume	637	752	+18%
Dollar value	\$52.7 billion	\$62 billion	+17%

Source: Levin Associates, The Health Care M&A Report, April 2014.

service offering, such as a hospital and a payer, consolidate. Exhibit 3-2 highlights the wide range of vertical industry integration activity, along with potential benefits and risks.

From M&As to partnerships and alliances: tracking provider trends

Reduced reimbursement, declining operating margins and the need to better coordinate care are prompting many providers to seek business partners.

Hospitals and health systems continue to acquire medical groups as more and more physicians willingly transition from being independent practitioners to full-time health system employees. Most describe the equation as a win-win: physicians gain financial security and expanded infrastructure to better manage patient care, and health systems increase their patient referrals and admissions while expanding their population health management capabilities.

Providers are also forming partnerships with rehabilitation centers, urgent care facilities and imaging centers to access these services without having to develop them on their own. Larger, for-profit operators such as HCA Holdings, Tenet Healthcare and Community Health Systems – whose M&A activities peaked in 2013 – are expected to continue looking for targets that expand current markets or provide opportunities to enter new ones.

Exhibit 3-2. Potential benefits and risks of various types of vertical integration

Acquirer	Target	Benefit	Risk
Objective: Strengthen revenue streams			
Health system	Physicians	Increase referrals and admissions	Experience a decline in provider productivity after acquisition; do not gain physician buy-in
Health system	Payer	Increase patient volume and reimbursement rates through a restricted network and reduced payer margins	Experience health plan operating losses due to underestimating member utilization and unit cost; experience erosion in financial viability and flexibility due to capital requirements to maintain and fund an insurance organization
Payer	Health system	Capture enrollment through health system regional presence and brand	Acquire disproportionately high-cost members due to health system loyalty
Objective: Improve control of costs			
Payer	Health system, physicians	Improve ability to manage population health and control medical expenses	Experience erosion in financial viability and flexibility due to a capital-intensive investment while failing to improve health cost management
Objective: Defend against disintermediation or exclusions			
Payer	Health systems	Guard against integrated delivery system contracting directly with employers or government payers	Lose network breadth due to providers' reluctance to participate in the network of a direct competitor
Health system	Payer	Offset potential exclusion from narrow networks	Lose overall managed care volume due to commercial payers' unwillingness to contract with a direct competitor
Health system	Physicians	Avoid disproportionate admissions to competing health systems	Encounter physicians' unwillingness to modify referral or admission practices

Source: EY analysis, published in Health Care Industry Post, "The quest for vertical integration: assessing the rewards and the risks," January 2015.

Recent activity reflects a wide range of provider transaction activity. For example:

- ▶ Louisville, Kentucky-based Kindred Health acquired home health services company Gentiva Health Services for \$1.8 billion. The newly combined company will be one of the largest health care firms in the country to manage post-acute care services. Kindred also closed on a \$195 million purchase of Centerre Healthcare Corp., a manager of inpatient rehabilitation hospitals. The deal bolstered Kindred's rehabilitation services, adding 11 more hospitals and 102 hospital-based acute rehabilitation units.
- ▶ In Illinois, the Chicago area's Alexian Brothers Health System and Midwest Health formed a joint operating company overseeing nine hospitals, creating the third-largest network in the state.

- ▶ Nashville-based Duke LifePoint Healthcare paid \$500 million for Johnstown, Pennsylvania's, Conemaugh Health System, the largest health system in west central Pennsylvania.
- ▶ Dallas-based Tenet Healthcare signed an agreement with United Surgical Partners International to form a joint venture, creating the largest provider of ambulatory surgery in the US.
- ▶ Salt Lake City's Intermountain Healthcare is taking full ownership of St. Louis, Missouri-based Amerinet, one of the nation's largest health care group purchasing organizations.

Alongside M&As, affiliations and partnerships have become an increasingly viable option for organizations that want to gain financial and clinical leverage yet retain their autonomy. These arrangements have key advantages over traditional

M&As in that they are not subject to the same regulatory scrutiny and are more easily undone if they do not work out. The health care marketplace reflects a flurry of affiliation activity (see Exhibit 3-3).

Academic medical centers: partnering with non-academic providers

In 2014, an advisory panel to the Association of American Medical Colleges cautioned that unless academic medical centers (AMCs) adapt to the economic realities of the post-reform world, they risk becoming "high-priced, anachronistic institutions in a landscape of highly organized health systems." The panel advised AMCs to affiliate with larger health systems to access capital, and diversify and expand their offerings.

Exhibit 3-3. A wide range of affiliation arrangements: examples of activity

State	Affiliating organizations	Stated purpose
Maryland	Ten hospitals, comprising five distinct health systems, forming the Advanced Health Collaborative	To create a network intended to share costs and patient care programs that speed the transition to value-based payment; the group will have an overarching chief executive but each affiliated system will remain a distinct provider
New Jersey	Englewood Hospital and Medical Center and Hackensack University Health Network	To allow Englewood to maintain its own identity while collaborating with Hackensack on several projects, including creating a regional cardiac surgery program
North Carolina	Vidant Health in Greenville, Wake Forest Baptist Medical Center in Winston-Salem and WakeMed Health & Hospitals in Raleigh	To create a shared services operating company, sharing supply chain management, clinical protocols and information technology infrastructure while retaining independence
Ohio and Kentucky	Cincinnati-based Christ Hospital and the University of Kentucky's Markey Cancer Center in Lexington	To expand access to cancer care
Pennsylvania	Danville-based Geisinger Health System and Camp Hill-based Holy Spirit Health System	To enable both organizations to expand care in south central Pennsylvania and allow Holy Spirit to maintain its mission-driven Catholic identity

Sources: News releases from affiliating organizations, 2014 and 2015.

Transformers

Recent activity in the AMC space demonstrates many types of combinations and purposes. For example:

- ▶ In Arizona, the Tucson-based University of Arizona (UA) Health Network was acquired by the Phoenix-based nonprofit Banner Health. Industry analysts note that the acquisition will help UA stay competitive in southern Arizona and will align Banner with the prestige of the university. Banner will invest \$500 million in the AMC over the next five years, including paying off debts and creating a \$300 million endowment for clinical research.
- ▶ In California, the University of California San Francisco Medical Center formed a jointly owned network with Walnut Creek-based John Muir Health. Both organizations remain independent but will collaborate to operate the Bay Area Accountable Care Network, offering competitively priced options for area providers.
- ▶ In Illinois, former competitors Evanston-based NorthShore University Health System and Downers Grove-based Advocate Health Care are combining. Pending Federal Trade Commission (FTC) approval, the result will be Advocate NorthShore Health Partners, a 16-hospital system with nearly 4,500 hospital beds and more than 45,000 employees – creating the largest health system in the state and the 11th-largest nonprofit health system in the country.
- ▶ In New Jersey, Hackensack University Health Network plans to merge with Neptune-based Meridian Health, forming one of the largest health networks in the state, with 11 hospitals, 25,000 employees and another 6,000 physicians on staff.

- ▶ In Pennsylvania, Penn State Milton S. Hershey Medical Center is merging with Harrisburg-based PinnacleHealth System to form a completely new health enterprise under the umbrella of Penn State Health.
- ▶ Duke LifePoint Healthcare, a three-year-old joint venture between the Nashville, Tennessee-based for-profit hospital chain LifePoint Health and the North Carolina-based Duke University Health System, added nearly half a dozen hospitals and health systems to its expanding footprint in 2014. The venture now has 12 hospitals in four states.
- ▶ In Wisconsin, UW Health, an academic health center associated with the University of Wisconsin-Madison, acquired SwedishAmericanHealth System for \$255 million.

“It’s a remarkable success, and it’s really the first time that an academic center and a health care operating company have been able to do this, have done this, and sustained it, and grown it.”

Bill Carpenter
LifePoint Chairman and CEO
Nashville Business Journal, December 18, 2014

Providers in the payer space: buying insurance companies and launching health plans

In the transforming health care world, the lines between providers and payers continue to blur. More hospital systems are looking to offer insurance products, with many doing so through acquisition. For example:

- ▶ In Arkansas, St. Vincent Health System, a wholly owned subsidiary of Colorado-based Catholic Health Initiatives, executed a stock purchase agreement to

Seven competing hospitals and a payer: looking at a unique joint venture

In California, seven rival hospitals are partnering with insurer Anthem Blue Cross – a part of WellPoint Inc. and the state’s largest for-profit health insurer – to create Anthem Blue Cross Vivity, an integrated network offering in Los Angeles and Orange counties. In combining an insurer with seven competing hospitals, this initiative has been touted as the first partnership of its kind in the US.

Through Vivity, members can access any facility within the seven-hospital system, including all affiliated physician offices, surgery centers, clinics and other outpatient facilities. Participating hospitals include Cedars-Sinai Medical Center, the UCLA Health System, MemorialCare Health System, Good Samaritan Hospital, Huntington Memorial Hospital, Torrance Memorial Medical Center and PIH Health. The seven hospital partners and Anthem will share in any profits and losses from this joint venture. They will also work together on electronic health records and referrals.

Anthem has said that if the health plan works in southern California, it will look to replicate it in some of the other 13 states where it sells Blue Cross coverage.

Source: “New Anthem Blue Cross plan takes on Kaiser,” Los Angeles Times, September 16, 2014.

By the numbers

- ▶ In 2014, the US health care industry experienced 53 hospital M&As – representing \$1.7 billion in transactions (*The Health Care M&A Information Source*, Dec. 2014).
 - ▶ According to a recent survey of 315 health industry leaders, the top financial objective for merger, acquisition and partnership activity is to increase market share within the geography that the organization serves, cited by 68% of respondents (*The 2015 Mergers, Acquisitions, and Partnerships Survey*, HealthLeaders Media Intelligence Unit of the HealthLeaders Media Council).
 - ▶ An HFMA survey cites the quest for efficiencies and economies of scale as the most important drivers of affiliation and deal-making, cited by 58% of respondents, followed by improved and sustained competitive position (51%), physician network and clinical integration (35%), access to capital (23%) and risk contracting experience (5%) (HFMA, “Acquisition and Affiliation Strategies,” 2013).
 - ▶ The health care technology sector experienced 219 M&As in 2014 – about 50 more than in the previous year (Mercom Capital Group, “2014 Q4 and Annual Healthcare IT Funding and M&A Executive Summary”).
 - ▶ Provider-owned health plans had a 3.2% average profit margin in 2013, the same as for the entire health insurance industry that year (A.M. Best Co., 2015).
 - ▶ In 2014, 95 digital health transactions were completed at the disclosed value of more than \$20 billion. The most active acquirers were large health technology companies, followed by medical device companies and payers (Rock Health, 2015).
 - ▶ acquire QualChoice Holdings, Inc., the second-largest managed care company in the state.
 - ▶ In Massachusetts, Boston's not-for-profit Partners HealthCare acquired Neighborhood Health Plan. The plan has more than 330,000 members.
 - ▶ In Michigan, St. John Providence Health System, a subsidiary of Ascension Health, the nation's largest nonprofit and Catholic health system, acquired US Health and Life Insurance Co., a Michigan-based for-profit regional insurance company licensed in 20 states, for \$50 million.
- Other providers are opting to launch their own health plans as a pathway to gaining more control in managing population health and overall patient costs. Across 39 states, 107 health systems offer health plans in one or more markets, including commercial, Medicare Advantage and managed Medicaid. For the 2015 plan year, 75 provider-sponsored health plans offered coverage on public exchanges, according to *AIS's Directory of Health Plans* – 10 more than in 2014. Provider-owned health plans are wide ranging. For example:
- ▶ In California, the Sacramento-based Sutter Health network of 1,800 physicians and nine hospitals launched a new health plan, Sutter Health Plus. The plan's current client list includes large employers such as the City of Sacramento and County of Sacramento and several small employer groups.
 - ▶ In Georgia, Piedmont Healthcare and WellStar Health System, two leaders in the metro Atlanta health care market, formed Piedmont WellStar Health Plans. The plan initially covers the systems' combined 35,000 workers and dependents, with a five-year projected enrollment of 160,000.

Transformers

- ▶ In New York, North Shore-LIJ Health System started CareConnect, becoming the state's first provider-owned commercial health plan. As the health system's first step into the insurance business, the new plan is competing against larger, well-established carriers on New York State's health insurance exchange.
- ▶ In Ohio, Dayton's Premier Health created Premier Health Plan, covering 7,100 Medicare Advantage members and 2,000 individuals and families.
- ▶ In the Washington, DC-Baltimore area, MedStar Health, the metropolitan area's largest health system, launched the MedStar Select health plan.
- ▶ In Wisconsin, not-for-profit health system Aspirus, based in Wausau, and not-for-profit health insurer Arise Health Plan, based in De Pere, have created a co-branded health plan for individuals and small businesses with fewer than 50 workers.

.....
"We believe that health care is becoming more confusing, and we believe that we have the ability to make it less confusing."

Steve Nolte
CEO, Sutter Health Plus

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Payer expansion: acquiring insurers, providers and IT companies

Over the past three years, megadeals in the payer world – such as Aetna-Coventry (\$5.7 billion), Cigna-HealthSpring (\$3.8 billion) and WellPoint-Amerigroup (\$4.9 billion) – have created some of the largest health insurers ever seen in the US. In recent activity, Anthem (formerly WellPoint) has made bids to take over Cigna Corp., and Aetna Inc. announced it

plans to buy Humana Inc. for \$37 billion. Leading provider groups such as the AHA and American Association of Family Physicians have expressed concern that such mega-mergers will give health plans even more control over payments, provider networks and contracts – and limit choices for consumers. These deals will likely be closely scrutinized by the U.S. Department of Justice and the FTC.

Payers are also moving into the provider sector, buying everything from hospitals and physician groups to urgent care clinics and freestanding emergency rooms, and moving aggressively to acquire health information companies. Transaction goals for payers are many: to diversify their business portfolios, better manage the costs of health care delivery, offer a broader range of consumer-oriented services and technologies, and invest in big-data analytics to gain rapid ground in the movement to pay-for-value.

In recent payer activity:

- ▶ Humana purchased Deerfield Beach, Florida-based Your Home Advantage – a multistate provider of nurse practitioner in-home visits. The goal is to help the company better serve its Medicare Advantage members who are living with chronic conditions.
- ▶ UnitedHealth Group Inc. (UHG), the nation's largest insurer, paid \$12.8 billion for Schaumburg, Illinois-based Catamaran Corp., the country's fourth-largest pharmacy benefits and services subsidiary Optum paid \$1.5 billion for MedExpress, an operator of urgent care clinics nationwide, and also bought physician practice consulting firm MedSynergies, Inc.

A three-way affiliation in Michigan: creating a nonprofit system

Three Michigan health care systems have combined operations into a new \$3.8 billion not-for-profit organization, Beaumont Health. Beaumont brings together Royal Oak-based Beaumont Health System, Dearborn-based Oakwood Healthcare Inc. and Farmington Hills-based Botsford Hospital in a full-asset combination. The new Beaumont Health is the largest hospital system in the region, including eight hospitals, 3,337 beds, 153 outpatient sites, 5,000 physicians and more than 33,000 employees – and controlling a 30% share of the market.

Stated goals include better population health management, physician alignment, health IT integration, cheaper supply costs and other operational efficiencies. Executives say they expect to save \$134 million annually after the first three years of combined operations. Initial savings will be realized by operating a single EHR platform and consolidating back-office business functions, billing and collections and purchasing.

Described as an affiliation, the new system will be governed by a single 14-member board, and its executive team will be represented by the three systems.

Sources: "3.8B Beaumont, Botsford, Oakwood merger a done deal following hospital boards' approval," Crain's Detroit Business, June 24, 2014; "Beaumont, Botsford and Oakwood complete \$3.8B merger: 4 things to know," Becker's Hospital Review, September 4, 2014.

Transformers

The Maine Rural Health Collaborative: sharing knowledge to find new solutions

A recent report from the AHA, “The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform,” notes that 22% of Americans live in rural areas, yet only about 10% of physicians practice in rural America. To address this and other challenges facing rural hospitals in Maine, five independent hospital systems in the state have teamed to form the Maine Rural Health Collaborative LLC.

According to collaborative members, the group will explore ways for the five systems – Northern Maine Medical Center in Fort Kent, Cary Medical Center in Caribou, Houlton Regional Hospital in Houlton, St. Joseph Hospital in Bangor and Mount Desert Hospital in Bar Harbor – to share best practices while working to preserve and protect quality, accessible care.

“We believe the power of five is greater than the power of one.”

Tom Moakler
CEO, Houlton Regional Hospital

Collaborative members say they will look to similar initiatives in other predominantly rural states, such as Georgia, New Hampshire and Illinois, to leverage knowledge and best practices.

Source: “Five Independent Maine Hospitals Form Rural Health Collaborative,” Bangor Daily News, March 19, 2015.

- ▶ Aetna purchased privately held Bswift for \$400 million. The Chicago-based Bswift manages health benefits for employers and health insurance exchanges.

Regulatory challenges: traversing a volatile territory

Tension has emerged between the ACA bend toward industry consolidation and the FTC focus on antitrust laws. Critics of health care system mergers maintain that large-scale consolidation decreases competition and increases costs for patients. FTC scrutiny of major transactions intensified in 2014 as it successfully challenged some hospital mergers on the premise that instead of increasing care coordination, the deals would reduce competition and produce higher prices. Two major health systems have fought the FTC and lost:

- ▶ The U.S. Supreme Court refused to hear an appeal from ProMedica Health System of the ruling that blocked it from acquiring Maumee, Ohio-based St. Luke’s Hospital. The largest health system in the Toledo, Ohio, area, ProMedica merged with St. Luke’s in August 2010. After the merger, ProMedica became the dominant hospital provider in Lucas County, Ohio, controlling more than 50% of the market for primary and secondary services and more than 80% of the market for obstetrical services. Five months later, the FTC challenged the merger, concluding it would adversely affect competition in the county. As a result, the FTC ordered ProMedica to divest St. Luke’s, concluding that divestiture would be the best way to preserve competition. ProMedica’s appeal to the Supreme Court came after the 6th U.S. Circuit Court of Appeals in Cincinnati upheld the FTC’s order. The company will divest

St. Luke’s over a six-month period, with oversight by the FTC.

- ▶ In another setback for consolidating providers, a federal appeals court ruled in February 2015 against Boise, Idaho’s, St. Luke’s Health System in its acquisition of Nampa, Idaho’s Saltzer Medical Group, the state’s largest independent physicians group. The judges concluded that St. Luke’s needed to do more to prove the new entity would yield higher-quality care and better patient outcomes. The Idaho attorney general and St. Luke’s competitors joined the FTC in challenging the deal, claiming it violated antitrust laws, eliminated competition for primary care in the area and would lead to higher prices for health plans and consumers. St. Luke’s must now either dismantle the acquisition or appeal the decision to the U.S. Supreme Court.

While CMS continues to encourage integration initiatives, the FTC appears equally determined to challenge them. Industry observers maintain that antitrust and other laws will need to be reconsidered to meet the needs of transforming health care structures and a rapidly consolidating marketplace.

Not always a go: calling off the deal

Although most merger discussions start out enthusiastically, the organizations involved may not know enough about each other’s culture, operations and business models to make a truly informed decision. The due diligence period offers the opportunity to discover these nuances and work out joint agreements on future structures and operational plans. Even after all information is on the table, leaders may conclude it is best to just walk away from a deal.



Transformers

The Mayo Clinic Care Network: extending expertise through non-ownership relationships

Launched in 2011, the Mayo Clinic Care Network now has 32 member organizations spanning 19 states, Puerto Rico and Mexico. By joining the network, member organizations can gain the expertise of a prominent health system without relinquishing control, while Mayo can enlarge its referral base and extend its medical knowledge.

Member organizations work with the network to collaborate in ways designed to benefit patients and the community. Network tools and services include:

- ▶ eConsults, electronically connecting member organization physicians with Mayo specialists and subspecialists for additional input on patient care
- ▶ AskMayoExpert, providing point-of-care medical information compiled by Mayo physicians on disease management, care guidelines, treatment recommendations and reference materials for a variety of medical conditions
- ▶ eTumor Board Conferences, enabling physicians to present and discuss management of complex cancer cases with a multidisciplinary panel of Mayo specialists and other network members
- ▶ Consultations with the Mayo Clinic, offering guidance on operational and business processes

Source: "Virginia Hospital Center Becomes Mayo Clinic Care Network Member," *Mayo Clinic News Network*, February 5, 2015.

A few recent break-ups provide insights into the causes of failed transactions:

- ▶ In California, privately held Prime Healthcare withdrew its \$843 million plan to take over Daughters of Charity, a financially troubled six-hospital health system. Prime said the 300 conditions imposed by the attorney general, including keeping all the hospitals open for 10 years, were untenable.
- ▶ In Illinois, two systems – Cadence Health and Rockford Health Systems – called off merger talks two months after announcing an affiliation. The deal would have taken Cadence outside the six-county Chicago area but also posed financial challenges, as Rockford had a three-year operating loss of \$11.6 million. Rockford executives cited the deal breaker as misaligned strategic imperatives.
- ▶ In Massachusetts, talks of a merger broke down between Boston's Beth Israel Deaconess Medical Center, Lahey Health and Atrius Health, the state's largest independent doctors' group. According to *The Boston Globe*, the three parties could not agree on new system leadership.
- ▶ Rhode Island's South County Hospital, the state's last independent nonprofit community hospital, and Southcoast Health System in New Bedford, Massachusetts, called off their planned merger. The two organizations determined that they could not combine resources in a way that would "enhance services for the respective communities they serve."

- ▶ Tenet Healthcare spent two years working to acquire the five-hospital Eastern Connecticut Health Network but decided not to move forward because of conditions proposed by state regulators.

These outcomes reveal that deals can go wrong for many reasons, from misaligned strategies, cultures and leadership to failure to comply with regulations. They highlight also the importance of "looking before leaping," conducting a thorough, systematic assessment of risk before moving forward in an integration initiative.

The road ahead: converging to shape a new industry

In the industry's transformation from volume-driven to value-focused care, stakeholders are expected to pursue M&A strategies to broaden and deepen their presence across the health care delivery system and payment value chains. The current momentum – toward a consumer-centered approach where high-quality care and superior medical outcomes are the end goals – shows no signs of abating. On the road ahead, sectors that have historically been separate will continue to come together to transcend silos, offer more value and expand services to patients across the full continuum of care.

Considerations for your board and executive leaders

If you are considering a merger, acquisition, alliance or other transaction, have you:

- ▶ Assessed whether aligning with the partner will advance your long-term strategies, such as providing access to new markets and technologies, increasing revenues and lowering costs, and helping your organization better serve your stakeholders?
- ▶ Determined that you have the capability, bandwidth and financial resources to successfully manage the new venture?
- ▶ Concluded that the proposed partner is a good cultural fit for your organization?
- ▶ Detected and avoided any conflicts of interest?
- ▶ Communicated the transition plan clearly across your organization and your partner's?
- ▶ Articulated the goals of the new organization and agreed on a set of metrics across all entities to consistently drive performance toward these goals?
- ▶ Taken steps to protect patient information during the transition, including conducting a security audit of your partner organization(s) and identifying any potential gaps?
- ▶ Reviewed and inventoried all health IT systems to identify redundant systems and software and to determine the adequacy of systems planned to be used by the newly combined entity?
- ▶ Considered partners that can enhance your organization's capabilities in e-health, risk management, data analytics and population health management?
- ▶ Mapped risks and potential actions to mitigate them?
- ▶ Assessed the impact a candidate may have on your patient or member engagement and satisfaction?
- ▶ Demonstrated to your customers and business partners the value of your proposed deal and the benefits it will provide to them?
- ▶ Developed a process to assess the likelihood of FTC challenges to your planned merger or acquisition, ensuring the transaction complies with federal law as well as state fraud and abuse laws?
- ▶ Determined your exit strategy, should the endeavor fail?



“You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.”

R. Buckminster Fuller, 20th-century inventor and visionary

Transforming the workforce

Building a new foundation

Transitions

Compared with other US industries, health care faces unique pressures in matching labor supply with service demand. The entry of 32 million newly insured Americans into the insurance system as a result of ACA implementation is stretching current resources and creating new staffing needs. Demand for health care services is compounded by new team-based models of health care delivery, emphasis on risk sharing for reimbursement, an aging population and the growing pressures of health care consumerism. Although health care is adding jobs at a faster rate than most other sectors, the industry is also losing workers rapidly as those in key roles, from clinicians to medical technologists, retire. Adding to this challenge is finding enough people with the training required for a transforming health care system – and determining the appropriate roles of different types of caregivers.



With the implementation of the ACA and a steadily increasing insured population, the health care industry faces new workforce imperatives: to care for more patients, adapt to consumer-centered care and reconfigure human resources to match emerging care models. In the years ahead, health care workers will be asked to transform their environments through teamwork – finding innovative ways of re-engineering care processes and working together at unprecedented levels of collaboration to improve patient outcomes. In this chapter, we provide an overview of workforce challenges and the industry’s solutions to meet them.

A national priority: strengthening the health care workforce

President Obama’s FY 2016 budget proposes new investments in the health care workforce, with the goal of ensuring that rural communities and other underserved populations have access to providers. The budget will invest about \$14.6 billion over 10 years in three major initiatives:

- ▶ \$4 billion in expanded funding for the National Health Service Corps from FY 2015 through FY 2020, supporting 15,000 providers in the field to meet the primary care needs of more than 16 million Americans
- ▶ \$5.2 billion for a new Targeted Support for Graduate Medical Education program, designed to support ambulatory and preventive care and 13,000 residents over 10 years
- ▶ \$5.4 billion for enhanced Medicaid reimbursements for primary care, expanding eligibility for reimbursements to mid-level providers, including physician assistants (PAs) and nurse practitioners (NPs)

These priorities and goals have been underscored by recent congressional activity. In February 2015, several members of the U.S. House of Representatives introduced H.R. 1006, Building a Health Care Workforce for the Future Act. The proposed legislation would provide millions of dollars to states to help build and advance the health care workforce, focusing on the growing need for primary and specialty care providers in underserved areas.

Pressing demands: meeting the challenges

Shifting demographics, greater availability of health insurance and a nationwide focus on wellness and prevention are rapidly changing the number and mix of health providers that will be needed to meet future demands. Highlighted below are key workforce considerations.

Changing roles in primary care teams

With a looming physician shortage and a growing number of health care professionals aging out of the workforce, high-functioning, multidisciplinary health care teams are viewed as the wave of the future in

achieving better health care outcomes while maximizing the use of limited resources.

The 2014 patient-centered medical home (PCMH) standards from the National Committee for Quality Assurance emphasize team-based care and the need for primary care practices to designate specific roles and responsibilities for care-team members – including acknowledging the patient as part of the care team. Beyond PCMH requirements, external stakeholders are expecting primary care teams to manage patients with chronic conditions proactively, coordinate care across the medical neighborhood and seamlessly manage care transitions.

A landmark this past year in advancing primary care innovations is guidance from The Primary Care Team: Learning from Effective Ambulatory Practices (LEAP) initiative, sponsored by the Robert Wood Johnson Foundation and the Group Health Research Institute. In 2011, LEAP selected 31 sites nationwide – spanning 20 states – as “exemplar” primary care practices, evaluating how they are using resources creatively to maximize the contributions of health professionals and staff. In December 2014, the project released its conclusions in a free, publicly available “Primary Care Team Guide” (www.improvingprimarycare.org/start), including case studies, practical advice and tools from the LEAP study.

Site visits found that the exemplar practices:

- ▶ Have well-developed core teams surrounded by an extended team that includes care managers, pharmacists, behavior health specialists and other professionals, such as social workers
- ▶ Often involve lay persons; flow staff in most practices play key patient care roles, such as self-management support, patient navigation and outreach

- ▶ Achieve the Triple Aim (refer to page 14) not only through infrastructure and capacity but also through several critical functions: population health management, planned care, self-management support, medication management, care management and follow-up, referrals and transition management, behavioral integration and community linkages

Why teams? Findings from LEAP

1. Team involvement in care frees up provider time.
2. Practices with effective teams and teamwork report higher provider and staff career satisfaction and less burnout.
3. Development of high-functioning teams is a critical step in the journey to becoming a PCMH.
4. Studies show that practices involving medical assistants, nurses and other staff in chronic illness care have better-controlled patients.

Source: "Introducing the Primary Care Team Guide," webinar, www.youtube.com/watch?v=fU8pBI9-BwY, December 9, 2014.

The expanding role of physician assistants and nurse practitioners

To extend their reach and efficiency, many health care organizations are focusing on a new model of team-based care that relies more heavily on employing physician assistants and nurse practitioners – in particular, to help patients with multiple, chronic conditions better care for themselves. While the growth in the number of physicians is not keeping up with population growth, the number of PAs and NPs nationwide is growing.

By the numbers

- ▶ For the first time, the health care sector now employs more than 15 million people in the US, or about 10.7% of the total non-farm workforce (US Bureau of Labor Statistics, 2014).
- ▶ By 2025, the US will be short as many as 90,000 physicians (Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections from 2013 to 2015, Final Report," March 2015).
- ▶ According to the American Nurses Association (ANA), the US will need to produce 1.1 million new registered nurses by 2022 to fill jobs and replace retirees (ANA, 2015).
- ▶ A leading health staffing firm reports that the demand for health care professionals has led to a year-over-year increase in the number of temporary job orders from health care clients of 39% from 2013 to 2014 ("The implications of an outsource-based care model," The Execu/Search Group, 2015).
- ▶ A recent survey finds more than half (58%) of health care organizations expect to grow their workforce in 2015, and nearly a quarter anticipate hiring increases of more than 6% (HireRight Health Care Spotlight report, 2015).
- ▶ About 9% of the professionally active nurse workforce in the US is male (Kaiser Family Foundation, March 2015).
- ▶ A survey of more than 1,400 medical students finds that 90% will not go into private practice while 73% plan on employment with hospitals and large group practices (9th Annual Epocrates Future Physicians of America survey, 2015).
- ▶ A survey conducted for the Physicians Foundation finds that 55.6% of physicians are pessimistic about the current state of the medical profession – a decline from 68.2% in 2012 (Merritt Hawkins, 2014 Survey of America's Physicians).
- ▶ Of 617 participants in a recent survey of employed physicians, a little more than half (53%) reported being fully integrated into their health system (American College of Physician Executives survey, 2014).
- ▶ Turnover among health care CEOs fell in 2014 to 18% from 2013's record high of 20% – but this is still one of the highest rates in 15 years (American College of Healthcare Executives, 2015).
- ▶ A Gallup study finds that engaged physicians are 26% more productive than their less engaged peers, meaning they account for, on average, an extra \$460,000 annually in patient revenue per physician ("What Too Many Hospitals Are Overlooking," *Gallup Business Journal*, February 23, 2015).

According to industry statistics, the US health care workforce has more than:

- ▶ 95,000 PAs; by 2022, PA jobs are expected to climb by 38%
- ▶ 189,000 NPs, with 31% growth anticipated by 2022

For non-physician practitioners, scope of practice varies from state to state. Although all PAs require physician supervision, parameters differ; some states require the supervising physician to be physically present and others require availability by telephone. For NPs, state laws continue to vary widely in the level of physician oversight required (see Exhibit 4-1):

- ▶ In full-practice states, NPs can evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments, including

prescribing medications. Today, 21 states and the District of Columbia grant patients full and direct access to NP-provided care, and some patient-centered medical homes are fully staffed by NPs.

- ▶ In reduced-practice states, NPs can engage in at least one element of practice but are required to sign a collaborative agreement with a physician. Currently, 17 states allow reduced practice.
- ▶ In restricted-practice states, NPs must be supervised, delegated or team-managed by physicians, a requirement in effect in 13 states.

The quest to expand scope-of-practice laws has not been without opposition. The AMA, for example, has voiced the need for

sharp division between the roles of nurses and physicians because of differences in training and philosophy. But proponents maintain that along with providing wider opportunities for PAs and NPs, expanding scope of practice can help physicians increase productivity and better prepare for value-based payment models.

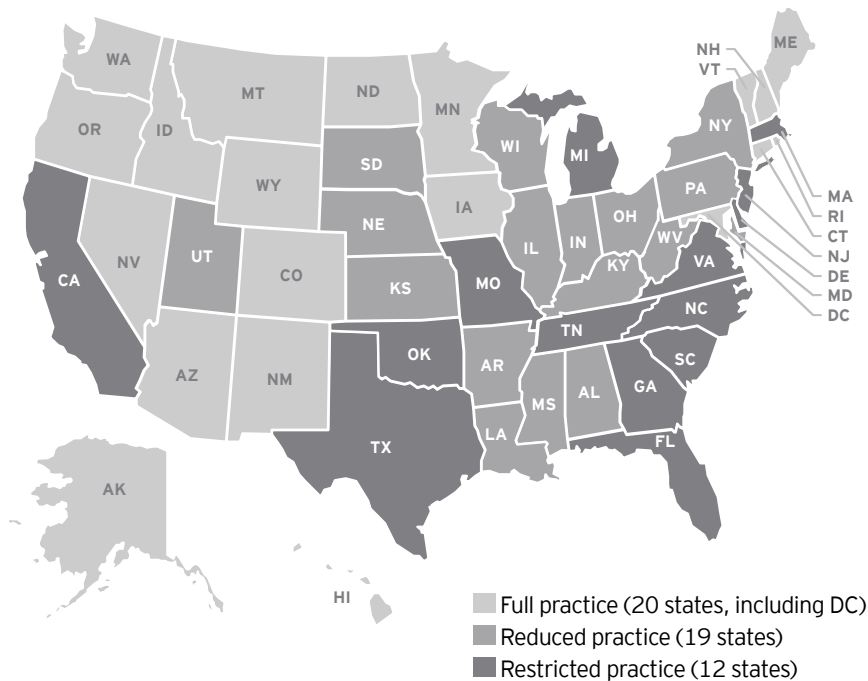
A shift from inpatient care to other care settings

Driven by a growing focus on total population health management, the availability of new technologies and the emergence of new payment models, more care delivery is leaving acute care settings and moving to ambulatory and other outpatient facilities as well as to the patient's home. US hospital occupancy rates fell to 60% in 2013 from 64% five years earlier and 77% in 1980. The trend has resulted in a high demand for care providers and non-clinical personnel to staff the growing number of outpatient care centers. Recent data from the US Bureau of Labor Statistics (BLS) shows that just 40,000 jobs were added to hospital staff in 2013 – a 30% decline from the average annual growth rates of the last two decades. In contrast, hiring in ambulatory care settings was up by 40%.

In another major industry shift, long-term care is moving from nursing homes and institutions to in-home care and adult day-care settings. Despite the aging population, the number of nursing homes, which have relied heavily on Medicare and Medicaid dollars, has shrunk by almost 350 over the past six years. At the same time, the number of in-home nursing programs nationwide has doubled since 2007, from 42 programs in 22 states to 84 programs in 29 states today.

As health care expands into new settings, clinicians and other workers will need to develop new skills, from care coordination to chronic disease management.

Exhibit 4-1. Scope of practice laws for nurse practitioners, by state



Source: American Association of Nurse Practitioners, 2015.

Transformers

Outpatient-based careers have been lauded for offering the next generation of health care workers more diverse options, including the opportunity to practice new models of care and the potential to improve work-life balance.

A rise in need for health care support occupations

A recent report by the Brookings Institution indicates that the 10 largest pre-baccalaureate health care occupations now make up nearly half (49%) of the total health care workforce in the nation's 100 largest metropolitan areas. These jobs include health aides, nursing aides, personal care aides, licensed practical nurses, medical assistants, registered nurses, physical therapists assistants/aides, diagnostic medical sonographers, occupational therapy assistants/aides and dental hygienists. National employment projections from the BLS forecast that health care support positions will grow 28% through 2022. The industry's increasing emphasis on team-based and coordinated care offers pre-baccalaureate health care workers the opportunity to take on more routine responsibilities, such as screening and outreach, while clinicians focus on diagnosing and treating patients with more complex conditions.

A growing role for community health workers

With an increased focus on improving population health, more organizations are turning to community health workers (CHWs) to help patients manage chronic diseases, encourage preventive care and provide greater access to care. The American Public Health Association defines the CHW as "a frontline public health worker who is a trusted member and/or has a close understanding of the community served." According to the US Department of Labor, about 45,000 CHWs are in the workforce today.

Physicians practicing sooner than later: considering the Missouri experiment

In the US, a defining characteristic of medical education is the slow entry of new physicians into the health care system. For a physician to practice medicine independently, one year of residency or more is typically required. Most young physicians spend at least three years in these programs, which include close supervision and on-the-job training.

But as the shortage of primary care physicians becomes increasingly pronounced, new laws are emerging to allow physicians to practice sooner. In Missouri, where federal surveys show about one-fifth of state residents do not have adequate access to physicians, the state legislature has created a new legal definition that enables medical school graduates to practice medicine without residency training.

Signed by Missouri Governor Jay Nixon in 2014, the law creates the new position of "assistant physician." These physicians would be supervised on site by a collaborative physician for 30 days. After that, they could treat patients on their own as far as 50 miles away and prescribe most medications.

The Missouri State Medical Association, which represents the state's 6,500 physicians, helped draft the legislation, saying it was needed to address the state's physician shortage.

"We felt it was time for someone to think outside the box and come up with a solution for rural health-care access, so that is what we did."

Jeffrey Howell
*Director of Government Affairs
The Missouri State Medical Association*

Missouri's move has had its detractors. The AMA's House of Delegates in June 2014 resolved to oppose special licensing pathways for doctors who hadn't completed at least one year of residency. The American Academy of Physician Assistants has also opposed the law, saying the "assistant physician" title could cause confusion.

Source: "Missouri to Allow Med-School Grads to Work as Assistant Physicians," The Wall Street Journal, July 16, 2014.

Transformers

Community colleges: preparing students for health care careers

The Health Professions Pathway (H2P) Consortium is galvanizing a national movement to improve health professional training.

Founded in 2011 through a \$19.6 million US Department of Labor grant, the Consortium includes nine community colleges in five states, led by Cincinnati State Technical and Community College. It focuses on preparing students for careers in the health care industry and is particularly designed for displaced workers, veterans and low-skilled or underprepared students.

Through the program, employers form partnerships with community colleges and workforce training organizations to ensure that the education process is purposefully integrated with job requirements. Participants receive career assessment services and credit for prior learning. The program typically features a competency-based core curriculum that integrates “stackable” credentials leading to certificates and degrees. Participants have access to life skills training, if needed, as well as guidance to help them find jobs in the health care industry or advance in their careers if they already hold jobs.

The Consortium plans on rolling out the program nationally with open-source licensing for its courses and curriculum.

Source: “H2P Consortium, Health Careers Collaborative Are Getting National Recognition,” Cincinnati State, June 10, 2013.

CHWs often do not have a medical background; training, accreditation and responsibilities vary by state. According to the Network for Excellence in Health Innovation (NEHI), 18 states have proposed or initiated policy processes for building a CHW infrastructure, and another 12 states have established statewide working groups to begin exploring policy options.

Effective 2014, CMS issued a new rule allowing state Medicaid agencies to reimburse for more community-based preventive services, including those of CHWs, if recommended by a physician or other licensed practitioner. Proponents maintain that this regulatory change, coupled with policy support from the ACA, may help bridge the gap between mainstream health care and community health care through expanding the CHW profession.

Initiatives throughout the country have shown that CHWs can improve population health, lower health care cost by reducing ED visits and hospitalization, and provide more cost-effective service to the elderly, who are disproportionate consumers of health care services. An October 2014 CHW Summit, sponsored by the Jewish Healthcare Foundation and NEHI, showcased the range of innovations in integrating CHWs throughout the country. For example:

- ▶ In Arkansas, the Tri-County Rural Health Network uses CHWs to identify qualified Medicaid-eligible individuals who are at risk of nursing home placement, arranging for at-risk seniors to receive home- and community-based care. The program reports a return on investment of 3 to 1.
- ▶ In New Mexico, Molina Healthcare has used CHWs to provide support services to Medicaid members considered

high consumers of resources. Results included a significant reduction in ED visits and inpatient admissions among participants – and a total savings of more than \$2 million after intervention.

- ▶ In Pennsylvania, a CHW program out of the Penn Center for Community Health Workers – called Individualized Management for Patient-Centered Targets (IMPACT™) – provides CHW support to help high-risk patients achieve their health goals. IMPACT has been adopted by the University of Pennsylvania Health System as part of routine care for more than 3,000 high-risk patients. The program has documented improvements in primary care access, post-hospital discharge and the quality of discharge processes.

The boom in hospice and palliative care

Communities throughout the country are experiencing growth in palliative care programs. The Center to Advance Palliative Care reports that in 2000, less than 20% of hospitals with more than 50 beds had a palliative care program, while about 70% have a program in place today. Numerous studies have found that palliative care improves quality of care for the seriously ill population while also reducing 30-day readmissions and in-hospital mortality rates.

However, an IOM report issued in September 2014, “Dying in America,” finds that, despite efforts over the past decade to improve access to hospice and palliative care, the number of palliative care workers has not kept pace with needs. And, with 70 million new beneficiaries entering

the Medicare program over the next two decades, the demand for workers in this field will intensify.

Several programs have been launched to expand the palliative care workforce:

- ▶ Palliative Care Leadership Centers™ provide intensive training and yearlong mentoring for palliative care programs at every stage of development and growth. They have trained more than half of the nation's hospital palliative care programs.
- ▶ The Palliative Care Center of Excellence at the University of Washington in Seattle serves as a regional hub for workforce training.
- ▶ The Hospice and Palliative Care Nurses Association and two affiliated groups have launched a \$5 million initiative – the Advancing Expert Care Campaign – to train nurses and other professionals to care for patients with serious illnesses.

New types of roles in a transformed system: considering the range of opportunities

Employment projections indicate that hundreds of thousands of jobs in the health care industry will be created over the next decade. Industry employment is projected to grow by 29% by 2022, according to the BLS (see Exhibit 4-2). This is more than twice as fast as the projected total growth in US employment overall.

These combined forces have opened up a variety of new health care positions. Examples of emerging job titles and descriptions are provided in Exhibit 4-3.

Transformers

Personal health coaches: extending care for patients with chronic diseases

The Special Care Center (SCC), part of the New Jersey-based AtlantiCare health system, uses a team-based model for patients with chronic diseases. Launched in 2007 by several partners, including an Atlantic City casino union, the SCC serves 1,600 patients at two locations. It was created in response to the need to control health care costs and to help chronically ill patients who account for most of those costs.

“We treat the patient as a whole ... it's not like we treat diabetes; we treat the patient with diabetes.”

Ines Digenio, MD
Special Care Center Medical Director

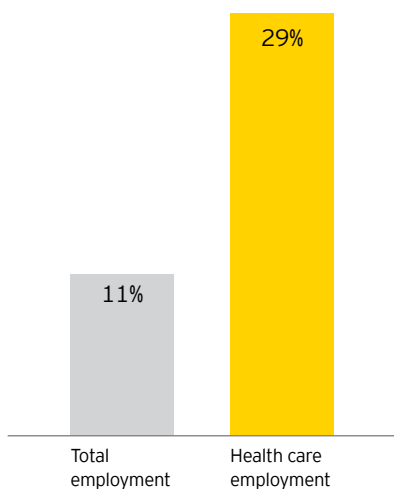
The SCC employs nine health coaches to support five providers. Each morning, teams meet to discuss the details of their patients, all of whom are assigned a personal health coach who serves as a patient advocate – assisting patients in proactively managing care and navigating the health system.

Chronically ill patients typically meet one-on-one with their health coaches up to 40 times a year and with their physicians six to eight times a year. The Special Care Center includes an onsite lab and pharmacy, and patients can reach a physician by phone at any time. The patient's employer or insurer pays the SCC a flat fee per month. Most co-pays are waived for visits and medications.

According to SCC data, the program has resulted in a 40% reduction in unnecessary hospitalizations and has brought the hospital readmission rate down to 5% compared with the national average of 18%. AtlantiCare recently created similar programs for uninsured patients and continues to roll out many of the SCC's concepts in their primary care practices.

Sources: “AtlantiCare Offers Special Care Center to Help Patients with Chronic, Costly Conditions,” NJTV News, June 23, 2014; “AtlantiCare at the Frontline of Patient Outcomes,” the Hitachi Foundation, 2015.

Exhibit 4-2. Projected health care industry employment growth, 2012-22



Source: BLS, 2015.

Exhibit 4-3. New kinds of health care jobs

Title	Role
Care transition specialist	Works with the patient and caregiver to facilitate interdisciplinary collaboration across care transitions, ensuring that the appropriate professionals are involved, critical issues are addressed, treatment goals are understood and the care plan is correctly followed
Chief experience officer	Develops and executes an enterprise-wide strategy for improving patient satisfaction
Chief population officer	Leads the organization in designing and implementing its population health strategy
Chronic illness coach	Offers personalized support and guidance to patients with chronic illnesses, helping them manage the stress of their condition
Community health worker (CHW)	Provides health education, guidance and some basic direct services to underserved populations, promoting prevention and addressing care inequities
Continuum case manager	Collaborates with the patient, his or her family and the health care team to develop an individualized treatment and discharge plan, evaluating options and services that best meet the patient's needs
Home- and community-based services navigator	Helps patients access long-term support services, from adult day care to home-delivered meals, so that they can continue to live at home and potentially avoid more expensive care in assisted living or nursing facilities
Home modification specialist	Creates safe home environments that support independent living for seniors and the disabled
Medical scribe	Charts encounters between physicians or other practitioners and patients in real time, organizing data to maximize the efficiency and productivity of clinical care
Medication coach	Assists patients with complicated medication regimens to guard against harmful drug interactions
Patient navigator/advocate	Helps patients traverse an often-confusing medical system
Physician practice coach	Focuses on building team dynamics in primary care practices and improving the way physicians deliver care, from successfully engaging patients as partners in their care to improving patient wait times

Sources: "How Boomers Can Help Improve Health Care," MetLife Foundation, 2010, and industry reports, 2015.

Transformers

Medical education: revising the curriculum

Key to health care system transformation is an evolved medical education program. In 2013, the AMA launched the Accelerating Change in Medical Education initiative, with the goal of training more physicians who are better prepared for the next horizon of care. The program provides 11 medical schools with five-year, \$1 million grants for revising the medical education curriculum to better address how care will be delivered in the future.

The schools are taking different approaches to revising the curriculum, but all are focusing on common themes, such as patient safety, quality improvement, team-based care and competency-based assessment, which can allow students to graduate in less than four years.

Approaches are wide-ranging. For example:

- ▶ At University of California Davis School of Medicine in Sacramento, students can enroll in a competency-based primary care track that will enable them to complete their medical school and graduate medical education in six years, as opposed to the traditional seven.
- ▶ At Penn State, students will gain exposure to all aspects of the health system by serving as patient navigators.
- ▶ At New York University School of Medicine and Indiana University, students can learn to better manage population health through the use of virtual EHRs containing de-identified patient data.

- ▶ At the University of Michigan, students will be trained in how to assume leadership roles and carry out quality improvement and management changes.

Along with the AMA's program, a growing number of emerging partnerships between health systems and universities are seeking to identify innovative approaches to training future physicians. For example:

- ▶ The University of Illinois at Urbana-Champaign has announced it is creating the nation's first college of medicine that is centered on the interface of engineering and medicine. A partnership with Carle Health System, the college is designed to develop a new approach to medical education that will train physicians to engineer health care solutions.
- ▶ Hackensack University Health Network has announced a joint venture with Seton Hall University to form New Jersey's first four-year private school of medicine. Seton Hall plans to co-locate its nursing and allied health programs with the new school of medicine to "mirror how health care will be delivered in the future," officials say.

Future leader education: teaching innovation

The Global Educators Network for Health Care Innovation and Entrepreneurship (GENiE) Group, created by a Harvard Business School professor, aims to make innovation a central part of educating health care's future leaders. GENiE includes more than 140 academic members who want to introduce innovation into their curricula. Also on board are several industry executives, such as the CEOs of Johnson & Johnson, the AMA, Bessemer Ventures, and athenahealth, Inc.

The GENiE Group maintains that academia has largely failed to deliver on the business imperatives of the future. The group's analysis of health care-related curricula at 26 top US schools, spanning 324 courses, found that the words used most often in course descriptions were "health" (1,049 occurrences), "policy" (259) and "organization" (262). The words "innovation" and "entrepreneur" were found only 27 times. In contrast, in interviews with 58 leading global health care sector CEOs about their future needs, the words most used were "innovation" and "change."

To advance its goals, the group has held two annual conferences with 150 global academic and stakeholder attendees at Harvard Business School and Duke University, launched courses and videos on the innovation topic and surveyed a wide range of constituents to help develop the competencies needed for an innovation curriculum. To date, 18 schools have implemented courses or programs in health care innovation.

Source: The GENiE Group; "Innovation In Health Care Education: A Call To Action," Health Affairs Blog, January 29, 2015.

Feature

Health care workforce transformation: redesigning our system around patient needs

A conversation with Erin Fraher, PhD, MPP, Director, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina (UNC)-Chapel Hill.

Dr. Fraher holds joint faculty appointments in UNC-Chapel Hill's Departments of Surgery and Family Medicine. For the past 20 years, she has worked as a health care policy analyst and researcher in the United States, Canada and England. She is often called upon by industry stakeholders to provide expertise on a variety of workforce issues, from education to regulation and payment of health care professionals. We talked with Dr. Fraher about rapidly changing industry realities – and what boards and executive leaders can do to retool their workforce for the future.



What is the greatest challenge confronting the health care workforce today? How will we solve it?

The biggest issue is this: we have a health care workforce that's not designed around patient needs. When you engage with patients and ask them what they want, their responses are consistent. They want their care to be better coordinated. They want to communicate more with their providers, and they want their providers to communicate more with each other. Each patient wants to be treated as a whole person. But in our world of siloed, highly specialized care, we're far from embracing this holistic perspective. I worry that in many states, health professionals are still fighting for turf protection instead of fighting for what the patient really needs.

We should be asking patients what they want and how they would redesign care around their particular conditions. If we did this, I think the health care workforce would be fundamentally different – more cost effective with higher-quality outcomes.

"We have a health care workforce that's not designed around patient needs."

The Affordable Care Act requires millions of Americans to enroll in health insurance, but many believe our care delivery system is unprepared to absorb the influx of Americans seeking care. What is your perspective on this challenge?

Let me be controversial here. I don't believe that the ACA is driving shortages. In fact, I don't think we're facing an overall shortage of health care workers. What we're facing is a shortage of workers adequately trained in the right skills and competencies to practice in a transformed health system.

Our modeling at the Sheps Center indicates that we're not going to face a physician shortage. We're also seeing strong growth in other roles: nurses, nurse practitioners, physician assistants and pharmacists. The fundamental issue with the newly insured, from my perspective, is that we're going to see an increased demand for more preventive care, because many of these newly insureds are healthy.

We're also going to see persistent issues around maldistribution by geography. We need to figure out how to address these inconsistencies so that newly insured groups, especially in rural areas, can access a health care system that truly meets their needs.

What kinds of new skills and competencies are required, then, in a transforming system?

As we shift from delivering expensive acute care to trying to keep patients from getting sick in the first place, we'll need more workers with skills in population health management, care coordination and patient coaching. We'll need more workers in a variety of roles: community health workers, mental health providers, social workers, dietitians, patient navigators, home health care aides and personal care aides, for instance.

We'll need workers who can truly "play on the same team" for the benefit of the patient. We'll need a team that thinks not only about the care delivered to the patient during a visit but also the care the patient needs between visits, in their homes and communities.

What are the key ingredients for success in a team-based model of care?

We need to train health care professionals to work together before they exit training, not after. We also need to foster more interprofessional care delivery models at the practice level. Often, when students are trained in the teamwork approach, they find they can't use what they've

learned because the practice they've joined is still operating under an old-school model. We need to find high-performing teams, study why they're successful and place our students in those practices that are at the forefront of new care delivery models. At the same time, we need to retool our existing workforce to function in teams so that we have more practices in which to place students during and after training. Finally, we need much more rigorous evaluations, like those being conducted by the National Center on Interprofessional Practice and Education, to better understand if interprofessional care delivery models improve health outcomes at the patient and population levels.

For health care providers who think they have good teamwork – for example, between handoffs and transitions – what would you recommend as their litmus test to make sure that they really do?

Ask your nurses what they think. Or hire a consultant to look at your processes. Do the nurses actually get to use their full scope of practice in managing patient care transitions? What were the barriers? Dig deeply into understanding the interrelationship among all team members – for example, between nurses and social workers. Right now, this is contested space. Nurses tend to do a lot of the care coordination within the health care system, but social workers know best the community supports that patients need once they're back home.

What is the role of technology in facilitating the patient-centered, team-based, wellness-focused workforce you describe?

The electronic health record can yield the data we need to better target patient care. EHRs can help us to see which patients are healthy, which have well-managed chronic conditions, and which are "frequent fliers" –

those who are juggling multiple chronic conditions and often end up in the ED.

Each group will need a different kind of care. The healthy group may need care in their workplace or episodic care for acute ailments; the chronic-condition group, better coordination among their health care providers and regular coaching to better manage their health; and the frequent fliers, community-based interventions from a variety of workers, from dieticians and pharmacists to community health workers. With this information, we can truly begin to manage population health – and deliver the wellness and preventive care that I hope will lay the foundation for our future health care system.

How can health care providers transform their current workforce to make sure workers are trained in these new skills?

Providers will need to demand of educators that they develop a new curriculum, one that helps hospitals and health systems dynamically retool their workforce. Then, they will need to demand of regulators that they support this new learning environment. We're still focused on creating "shiny new graduates." But it's our 18 million current workers who will transform care.

I would love to see hospital and health system board members engage directly with educators to say, "This is the workforce we need now. Can you develop courses for us in population health management, care coordination and patient engagement? Can we take our workers out of their positions temporarily and send them to a modular course that will help them thrive in a transformed environment?"

We need to think about roles and not about professions. For example, I've talked with several hospital CEOs who've had to lay off nurses because those nurses were trained and have practiced their entire careers in

inpatient settings. Now nurses are being asked to move into physician practices or community-based practice settings. What we need most is, in a word, flexibility – a system that enables workers to change fluidly between settings and between roles.

.....
"We're still focused on creating 'shiny new graduates.' But it's our 18 million current workers who will transform care."
.....

You've noted we have more health care workers, but they're doing less. The sector shows negative productivity. Why do you think this is? What is the solution for improving productivity?

Although I'm a health policy analyst and not an economist, I have some observations on this question. Our workforce today is rigid in its deployment. It's organized around professional hierarchy, around what people see as their role versus someone else's role. For example, a nurse can do this and only this. Some of that is defined and regulated by state licensure boards. I'm not sure regulatory boards have kept pace with the changes going on all around them.

Also, we need to revisit our work processes. Again, if we invite clinicians to describe what they want their workflow to look like – say, in the way that carmakers have done in the manufacturing industry – and we engage patients in redesigning their health care experience, we can begin to make the system more productive for all health care professionals for the ultimate benefit of the patient.

I'd offer three action steps. First, let's do some workforce planning. We've been laissez-faire in the US in our planning, and now we're paying the price for it. Second, let's engage the university and community college system in producing the workforce

we need. Third, let's develop less rigid, more flexible career ladders that help our workers move easily into new positions and take on new roles.

Tell us about the Program on Health Workforce Research and Policy. How are you informing policy decisions in health care?

A key part of our mission is providing information – in a format that stakeholders can readily understand and use. Because we're academics, we have not only the tools and analytic capabilities to conduct research, but also the freedom to voice findings that are sometimes unpopular but are based on data. Our program is completely interdisciplinary. We're not wedded to a specific profession and do not have an advocacy position, although we are strong advocates for workforce diversity.

We engage often with state and national legislatures, using data, maps and graphics to illustrate our findings. Our new physician projection model, called the "Future Docs Forecasting Tool" (<https://www2.shepscenter.unc.edu/workforce>), is one example of how data can be used to inform policy. It's been hugely popular in helping policymakers to get the full picture of their health workforce needs at the state and regional levels.

You've studied state initiatives to understand successes and failures in graduate medical education (GME). What are some of the lessons learned?

In evaluating GME activity in 17 states, we found that many state leaders don't talk about shortages. They talk instead about distributional issues. We began to think about GME not just as a blunt policy lever to address supply but more as a refined policy lever to address distribution. States are

starting to think about ways to invest in GME for rural communities and for primary care, general surgery and psychiatry so they're actually addressing their population health needs in a more intentional way.

We also realized that the need is great for educating state legislators. I would encourage boards and other health executives to make sure they're helping their legislators understand that while medical schools bring income and prestige to communities, GME programs have a bigger influence on the shape, size and specialty distribution of the future workforce.

We need to invest more in GME for community health and other kinds of ambulatory settings so that clinicians are getting more exposure to community-based practices. We need a more flexible way of allocating funds. For example, if you have funds to run an anesthesiology residency, and you don't need any more anesthesiologists, you need to be able to easily shift those funds to other specialties where they're most needed. Perhaps most importantly, we need more transparency and accountability for public investments in GME. We spend about \$11 billion in Medicare funds and \$4 billion in Medicaid funds annually on GME and yet we have no control over whether these funds are invested in producing the workforce needed to meet population health needs.

As the younger generation moves into the health care workforce, what kinds of changes might we see?

Today's recent college graduates are focused on having work-life balance. It's back to the question of productivity. If our workers are working fewer hours, how do we get the most out of them in those fewer hours?

Today's generation also wants more flexible career trajectories, to move in and out of different types of roles with ease. A surgeon may want to take a few years off to work in global public health, for example, and then return to the US system. Although it's all for the greater good, we need a regulatory and certification system that enables this kind of career flexibility.

Perhaps the most defining aspect of members of this generation is their willingness to work with technology in finding alternative ways to meet patient needs. We'll be seeing fewer office visits, more web-based provider-to-patient interactions and, as a result, more patients readily engaged in their own care.

What guidance do you have for board members and executive leaders in becoming a part of the workforce revolution?

Question the concept that all you need to do to achieve the Triple Aim is to redesign payment and care delivery. Instead, redesign your workforce and you're more likely to see the outcomes you're looking for.

How do you redesign your workforce? Envision a three-legged stool. First, train your new workers but, more importantly, retrain your existing workforce. Second, engage with your legislators to develop regulations that meet the needs of your clinicians and non-physician workers. Third, advocate for a sustainable payment model that truly supports workforce retraining for a transformed future.

Considerations for your board and executive leaders

For all health care organizations

- ▶ Do you understand the changing needs of your organization's customers, maximize in-demand resources and support a team-based approach to service delivery?
- ▶ What are your strengths as an employer, and how are you communicating those strengths in your recruitment outreach?
- ▶ How are you marketing to the next generation of health care workers?
- ▶ What measures do you use to assess a candidate's fit with your organization's culture?
- ▶ What strategies are in place to retain employees with highly valued skills and to assess their career satisfaction?
- ▶ In an environment that increasingly emphasizes teamwork, how are you cultivating an atmosphere of workplace collaboration and developing interventions to identify and address non-team-promoting behaviors? Do your policies and practices encourage teamwork and minimize hierarchy?
- ▶ How are you involving employees in the transformation process, encouraging and rewarding their efforts in finding new and better ways to do their jobs and meet customer needs?
- ▶ Do you have appropriate strategies in place, including robust succession planning, to successfully manage senior leadership changes?
- ▶ How are you integrating the values of a new generation into your workforce strategy, including more mobile workforces and more cross-functional work?

For providers

- ▶ How are you evaluating the impact of post-reform initiatives on your workforce models, including team-based delivery, clinical technology innovations and payments that influence clinician behavior?
- ▶ What are you doing to bring physicians – both employed and voluntary – to the table to achieve overall organizational goals?
- ▶ What workforce initiatives are you taking to improve patient satisfaction, patient safety and clinical outcomes?

For payers

- ▶ How are you continuing to scale up resources to adapt to health insurance exchanges, an increase in the number of insured members and a business focus on the growing individual market?
- ▶ How are you instilling new skills in your employees that support more customer-centric business operations, including focusing on relationship management and improving the member experience?



“When you are listening to somebody, completely, attentively, then you are listening not only to the words, but also to the feeling of what is being conveyed, to the whole of it, not part of it.”

Jiddu Krishnamurti, 20th-century Indian philosopher

Transforming through measurement

Listening to and gauging the customer experience

Transitions

Compared with even five years ago, when the Affordable Care Act became law, health care consumers today are in an entirely new stratosphere of expectations, interactions and empowerment. Understanding their wants, perceptions and experiences is key not only to meeting patient needs but also to managing and monitoring performance and setting benchmarks for service improvement. Providers and payers are using a variety of methods to measure the health care consumer experience, from traditional tools such as surveys and focus groups to online “listening posts” for responding to concerns and further engaging brand fans. As consumer avenues for expression continue to proliferate, providers and payers will need to amp up their listening across all channels to better serve their patients and customers – and fully leverage the power of the next consumer revolution.



Reimbursement challenges, competition for millions of new customers and an erupting ratings culture are prompting health care organizations to focus more than ever before on the patient and customer experience – with measures that go far beyond simple satisfaction checkpoints. In this chapter, we look at the current state of consumer rating systems in the health care industry and best practices for collecting, evaluating and acting on feedback to improve the patient and customer experience. The chapter concludes in a roundtable discussion with leaders in EY's Health Care Advisory Services practice, who offer observations on how best to listen to customers in the new era of consumer empowerment.

Why measurement matters: assessing the returns

With a strong emphasis on patient experience in such federal initiatives as the Medicare ACO program and Meaningful Use Stage 2, along with patient-centered medical home criteria from the National Committee for Quality Assurance, scrutiny of how well providers and payers are delivering on consumer expectations is rapidly becoming more acute. Consumers are drawing their expectations of what health care service should look like from their omni-channel experiences in other industries, from travel to banking. As expectations escalate, health systems are under increased pressure to incorporate convenient digital tools into their library of patient satisfiers.

Patient-centered quality improvement begins with the voices of patients and families. It relies on these perceptions to set priorities, drive improvements and gauge results. Measuring the patient experience can open the opportunity not only to meet patients' expectations, but also to improve care, work processes and patient outcomes.

Research has consistently demonstrated that a good patient experience has a positive effect on patients' engagement in their care. The converse is also true: patients who are already engaged in their own health are more likely to report satisfactory experiences. Thus engagement and satisfaction support each other in a virtuous circle.

The clinical case for experience measurement is paralleled by a solid business case. A Press Ganey report finds that the top 25% of US hospitals with the highest scores on the Hospital Consumer Assessment of Healthcare Providers and Systems question about performance – including the patient experience – were, on average, the most profitable. Positive patient experiences have also been linked to enhanced patient loyalty, lower employee turnover and reduced risk of medical malpractice. At the same time, health care providers can become so focused on patient satisfaction measures that they may make medical choices to please patients rather than to adhere to good medical practices. Patient experience

measures need to be considered in the context of clinical measures of care quality.

Kinds of measures: considering the options

Today, health care organizations have many tools to assess the consumer and patient perspective, from quantitative and qualitative surveys to online monitoring of customer comments about their provider or health plan experience. Profiled below are a variety of methods for helping organizations systematically measure their performance through the eyes of the health care consumer.

Quantitative surveys

Structured questionnaires that gather patient-reported outcomes are among the most common forms of quantitative methods for measuring the patient experience. A few of the leading survey tools are profiled below.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys

Funded and overseen by the U.S. Agency for Healthcare Research and Quality (AHRQ), CAHPS surveys (<https://cahps.ahrq.gov/Surveys-Guidance/index.html>) are widely considered a national standard for assessing the health care consumer experience. They have been extensively validated and are readily available in the public domain at no charge. The surveys ask consumers and patients to report on and evaluate their experiences in health care, covering such topics as communications with clinicians and ease of access to health care services.

CAHPS surveys have been created for many domains, from hospitals and clinical groups to health plans and home health agencies, to inform decision-making and improve the quality of health care services. The tools can be customized to include supplemental questions that gather a wide variety of additional information on the patient experience. The survey program

By the numbers

also provides a toolkit, the CAHPS Improvement Guide (<https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html>), to help organizations assess and improve the issues identified.

In April 2015, CMS announced its plans to roll out a five-star scale that ranks hospitals on the patient experience. The star ratings will use data from the hospital CAHPS survey, which measures patient experience at the nearly 3,500 Medicare-certified acute care hospitals according to such metrics as staff responsiveness and clinician communications.

Health plan CAHPS surveys are already an integral part of the Medicare Advantage five-star rating system, which evaluates health plan performance against a series of measures, including CAHPS scores, Healthcare Effectiveness Data and Information Set measures, and Health Outcomes Survey measures.

“Taking great care of patients is the best business model for hospitals.”

Robert Draughon
Former CEO, Press Ganey

Picker Patient Experience Questionnaires (PPE-15)

A free-to-use, 15-item survey, PPE-15 identifies patient experiences and problems in the inpatient setting. In use since 2002, its objective is to provide near real-time feedback based on patients' own perceptions of their experience. The questionnaire is typically provided to patients after discharge and can be completed by a patient in about 20 minutes. Its counterpart, the Patient Experience Questionnaire (PEQ), is used in outpatient settings to assess patient responses in five areas: outcome, communication experiences, communication barriers, experience with auxiliary staff and emotions. As is true

- ▶ After a poor customer experience, 89% of consumers begin doing business with a competitor (econsultancy.com).
- ▶ 66% of health care leaders agree that the ED is a critical area for tracking and measuring the patient experience, followed by discharge and follow-up (61%), inpatient rooms (56%), outpatient visits (48%) and non-emergent admissions (24%) (HealthLeaders Media premium report, August 2014).
- ▶ According to a major biannual study of work being done in US hospitals to improve the patient experience, 22% of the more than 1,000 hospital executives surveyed said the chief experience officer or patient experience leader has the primary responsibility of addressing the patient experience, compared with 13% in a similar study two years earlier (The Beryl Institute, *The State of Patient Experience in American Hospitals 2013: Positive Trends and Opportunities for the Future*).
- ▶ In 2014, enrollees in health insurance exchanges had an overall 61.5% satisfaction rate. In 2015, their satisfaction rate is 69.6% overall: 67% for new enrollees and 73.1% for those who renewed (JD Power 2015 Health Insurance Marketplace Exchange Shopper and Re-Enrollment StudySM).
- ▶ The mean voluntary disenrollment rate among Medicare managed care enrollees is four times higher for plans in the lowest 10% of overall CAHPS health plan survey ratings than for those in the highest 10% (Terry R. Lied et al., “Beneficiary Reported Experience and Voluntary Disenrollment in Medicare Managed Care,” *Health Care Financing Review* 2003; 25(1): 55-66).
- ▶ From 2011 to 2013, if all hospitals as a group performed similarly to hospitals receiving five stars as a group, on average, 228,426 lives might have been saved and 169,298 complications might have been avoided (*Healthgrades 2015 Report to the Nation: Making Smart Choices*).
- ▶ For each drop in patient experience score along a five-step scale of “very good” to “very poor,” the likelihood of being named in a malpractice suit increased by 21.7% (Francis Fullam et al., “The Use of Patient Satisfaction Surveys and Alternate Coding Procedures to Predict Malpractice Risk,” *Medical Care*, May 2009; 47(5): 1-7).

of PPE-15, graphing PEQ responses can provide useful feedback in understanding trends and improving the patient experience.

Press Ganey patient experience surveys

Through its Patient Voice™, Employee Voice™ and Physicians Voice™ solutions, Press Ganey, the world’s largest patient satisfaction survey vendor, offers proprietary tools designed to understand and improve the total patient experience. The company reports its surveys “help address the service and communication issues that improve all interpersonal actions” and pinpoint areas to focus resources. Patient feedback is obtained through a combination of mail, phone and email surveys.

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“A patient will define the experience from his or her unique vantage point, which is often determined by a single good or bad event. This is what patients remember.”

James Merlino, MD
*Service Fanatics:
 How to Build Superior Patient Experience
 The Cleveland Clinic Way*

Qualified Health Plan (QHP) Enrollee Experience Survey

The QHP survey builds on AHRQ’s CAHPS surveys and principles. Now in beta testing, the 76-question tool is designed to help QHPs identify strengths and weaknesses and improve the services they provide. Any health plan from the federally facilitated marketplace and/or a state-based marketplace will be required to field a survey asking members how they feel about their plan. Survey results will be publicly reported as part of the quality rating system beginning with open enrollment in 2016 for 2017 coverage. Consumers can use the published results when comparing and choosing among competing QHPs.

The Patient Activation Measure (PAM®)

Developed by a team from the University of Oregon and distributed by Insignia Health, PAM gauges the knowledge, skills and confidence patients have in measuring their own health and health care. It classifies consumers into one of four increasingly engaged levels, as shown in Exhibit 5-1.

PAM can help health care providers and payers gauge how effective they are in making the connection with their customers, and determine the level of support patients and members need from their organizations. PAM scores also matter because high PAM scores correlate to a series of key measures, including satisfaction, lower cost and fewer readmissions.

Customized surveys

Some hospitals are bypassing established survey tools and creating their own. For example:

▶ In San Antonio, Texas, CHRISTUS Santa Rosa Health System assesses the patient experience using a daily survey and a 0 to 10 scale. Each nurse in the system’s five acute-care hospitals, with the exception of its children’s hospital, is required to survey one patient a day who is not under his or her care using these three questions: 1) If you needed help getting out of bed, how quickly did we respond to your needs? 2) When you requested help – for instance, pushing your call light – how readily did we respond? 3) How effective were we in meeting your needs? Results are used to identify gaps in addressing patient concerns in as close to real-time as possible. Scores are graphed and posted publicly the next day, and any problems that surface also are noted publicly. Hospital officials report that since the daily survey was launched, patient satisfaction scores have continued to rise.

Exhibit 5-1. PAM levels of engagement

Activation level	Description	Patient characteristics	Patient perspective
1	Disengaged and overwhelmed	Passive and lacking in confidence; low knowledge, weak goal orientation and poor adherence	“My doctor is in charge of my health.”
2	Becoming aware but still struggling	Some knowledge, but large gaps remain; they believe health is largely out of their control, but can set simple goals	“I could be doing more.”
3	Taking action	Have the key facts and are building self-management skills; they strive for best practice behaviors and are goal oriented	“I’m part of my health care team.”
4	Maintaining behaviors and pushing further	Have adopted new behaviors, but may struggle in times of stress or change; maintaining a healthy lifestyle is a key focus	“I’m my own advocate.”

Source: Insignia Health, 2015.

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- ▶ In New York City, Mount Sinai Medical Center's Derald H. Ruttenberg Treatment Center offers a patient satisfaction app, "RateMyHospital." Using the app, patients can securely complete a satisfaction survey online shortly after they leave the facility, offering Mount Sinai nearly real-time, actionable information about the patient experience. After their visit, patients receive a text message with a link to a brief, 12-question survey using a five-star rating system. Since launching the app, the center estimates a tenfold increase in the number of returned surveys.
- ▶ In Minnesota, Park Nicollet Health Services tracks customer satisfaction in real time using a text messaging service, CareWire Inc. Patients receive a text message a few hours after an appointment, when they can rate their experiences on a scale of 0 to 10. Park Nicollet reports that the service provides an "early warning system" to understand when, where and even why their patients are dissatisfied. If the survey respondent gives permission to be contacted, a clinic manager follows up with an apology, which in turn helps to boost satisfaction rates.

Qualitative methods

With qualitative methods, health care organizations can move beyond the confines of structured inquiry to ask open-ended questions. Through these questions, patients are encouraged to describe their personal observations of the care experience. These methods may elicit a deeper understanding of patients' perceptions and behaviors and the meaning they attach to their experiences. A variety of qualitative methods are described below.

A turnaround in patient satisfaction scores: leading by example

When Dr. David Feinberg assumed the CEO role at the Ronald Reagan UCLA Medical Center in 2007, two out of three patients would not refer the system to a friend – even if the hospital saved their lives. Under Dr. Feinberg's tenure, completed in February 2015 (today he is the CEO of Geisinger Health), patient satisfaction scores at UCLA climbed from the 38th to the 99th percentile.

EY had the opportunity to interview Dr. Feinberg about his approach to improving the patient experience.

Key to success were several strategies:

- ▶ Same-day service is offered. When patients call, they are asked, "Would you like to be seen today?"
- ▶ When the vehicle transporting the patient is parked, the patient receives a dashboard card with a smart chip, alerting the medical center that the patient will arrive in about six minutes.
- ▶ "Waiting rooms" for patients have been eliminated. When patients arrive, they room themselves.
- ▶ When the care team arrives, team members apologize to the patient for his or her having to come to the medical center, as it means the provider has failed either in monitoring from home or in caring for the patient in the comfort of home.
- ▶ Two to three physicians are in the room for each exam. At least one wears Google glasses, enabling the physician to focus on the patient while a scribe in the back office records the visit in Epic.

- ▶ Relevant data is pushed forward by the scribe to the physician, so he or she can see any patterns. Specialists are involved either in the room or through telemedicine.
- ▶ All care providers are observed twice a month. Those receiving complaints are asked to familiarize themselves with the data. Most "self-correct"; others are put on a path to improvement and closely monitored.
- ▶ Everyone is charged with rounding and hearing, collecting and correcting stories of the patient experience. Results are used to shift the dialogue and create a more patient-centric organization. "While good stories are wonderful, it is especially instructive when they aren't," Feinberg noted. For example, a member of the executive team visited a patient and noted that the only issue the patient had was the lack of a Blackberry charger. The report was filed at 11:00 p.m. By midnight, every site had added Blackberry, iPhone and Android chargers.
- ▶ On average, patients are back to their car within 52 minutes, including valet time.

Today, UCLA is ranked in the top percentile of the nation's 6,000 hospitals. For academic medical centers, the organization ranks Number 1 on the question, "Would you refer us to a friend?"

Source: EY interview, July 22, 2014.

One-on-one interviews, focus groups and patient advisory councils

One-on-one interviews use open questions with patients or those who care for them, while focus groups are conducted among a small group of patients and/or their home caregivers to explore observations and feelings. Group discussion is facilitated by a trained, independent moderator with prepared questions designed to elicit ease of participant responses.

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“Focus groups create an unparalleled opportunity to probe health care consumers’ experiences and perceptions in depth and in their own words, and to examine not only what they think, but why they think the way they do.”

Planetree

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Patient advisory councils bring patients directly into the organization by creating a committee structure. The committee provides a forum for testing new procedures, policies and systems through the eyes of actual consumers. In the most advanced organizations, the importance of the patient advisory council is elevated by making it a subcommittee of the board. Health care providers that embrace this approach are also likely to include patients and caregivers on teams that are redesigning procedures and incorporating them in user-centered design sessions. The ultimate goal is to make sure that systems and tools really work for the people they are designed to serve.

Observational methods

Three leading observational methods can provide direct insights into the patient experience:

- ▶ In shadowing or ethnographic studies, researchers join patients and embed themselves in the patient journey. They take notes based on observations

and compile them across experiences, yielding ideas on how to redesign a care delivery process and improve patient perceptions of care.

- ▶ Through guided tours, a patient leads a data collector through the hospital environment, describing his or her surroundings and feelings about the health care experience.
- ▶ Health care mystery shoppers – educated consumers who anonymously evaluate the customer experience – can help organizations identify problem areas and positive elements in the patient journey.

Pictorial perspectives

Photovoice is a type of group activity in which participants use cameras to capture and express their experience, and several health care providers are using photovoice with patients. Participants visually capture their care experience; then in-depth interviews are conducted to encourage them to elaborate on the meaning of their pictures and how the pictures represent their perspective on care. Through this process, health care providers can get a deeper understanding of patient perception, preferences and needs.

- ▶ In New Jersey, the Clear Communication in Health Care project, a collaboration between Atlantic Health System and Zuffall Health Center, provided study participants with cameras to take photos reflecting their experience with health care communication. Patient photos and captions were shared with health care providers with the goal of improving communication clarity.
- ▶ In Ohio, at Cincinnati Children’s Hospital Medical Center, a photovoice study was conducted with pediatric bone marrow transplant (BMT) patients to examine their coping skills and interpretation of their experience during a BMT, especially when hospitalized. According to the study’s authors, BMT patients and staff concluded that photovoice helped patients express emotions about the challenges of BMT –

and reminded staff of the importance of being patient-centered and mindful of the therapeutic relationship.

- ▶ The Veterans Affairs (VA) Health Care System is testing photovoice as a tool for exploring observations and experiences of patient-centered care initiatives. In a recent study, 22 veteran patients at two VA sites were provided with cameras and asked to capture salient features in their environment that reflected their perceptions of patient-centered care. Follow-up interviews were conducted with each participant to learn more about their photographs and intended meanings. Pictures and interviews revealed a range of factors influencing patient-entered care perceptions, from hospital décor and signage to quality of patient-provider relationships.

Patient experience mapping

Experience maps capture the patient journey, including all patient experiences across the care pathway. Using this tool, organizations can see their operations through the eyes of their patients and make improvements based on what they learn through the process. The mapping method has been used by such health care providers as Mission Health in Asheville, NC, the University of Texas MD Anderson Cancer Center in Houston and the University of Michigan Health System in Ann Arbor, as well as by such health plans as Cigna and UnitedHealth Group.

Independent information service providers

Consumer Reports

Since 2008, Consumer Reports’ Health Ratings Center has published ratings on health insurance plans, physicians and more than 3,000 US hospitals, along with information to guide prescription drug choices. Ratings of hospitals include measures of the patient experience, as well as of patient outcomes and hospital

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practices (<http://www.consumerreports.org/health/doctors-hospitals/hospital-ratings.htm>), while insurance plan ratings (<http://www.consumerreports.org/health/insurance/health-insurance-plans.htm>) are based on ratings from the NCQA and include consumer satisfaction, performance in preventing and treating certain common conditions, and NCQA accreditation status.

J.D. Power & Associates

The J.D. Power Employer Health Plan StudySM can help health plans find out what members and employers are looking for in choosing a health plan. It compares the experiences of employers nationwide, defining service benchmarks and pinpointing actions that increase employer satisfaction with health plans.

Net Promoter Score (NPS)[®]

NPS, a customer loyalty metric developed by Fred Reicheld, Bain & Company and Satmetrix, has become a standard for measuring and transforming the customer experience. Generating an NPS starts with the simple question, "How likely would you be to recommend our company/product/brand to a friend or colleague?" Customers are typically asked to answer this question on a scale of 0 to 10, with 0 being "not at all likely" and 10 being "extremely likely." Responses are then grouped into three categories:

- ▶ 9-10: promoters, loyal enthusiasts who will keep buying and referring others
- ▶ 7-8: neutrals, satisfied but unenthusiastic customers who are vulnerable to competitive offerings
- ▶ 0-6: detractors, unhappy customers who can damage brand and impede growth through negative word of mouth

Subtracting the percentage of detractors from the percentage of promoters yields the Net Promoter Score. The survey can help organizations determine whether patients are returning, referring their organization to friends and family, and providing positive

word of mouth about their health care experience – all behaviors that can have a healthy impact on the bottom line.

Some organizations are taking the NPS a step further, using an Employee Net Promoter Score (eNPS) to measure employee advocacy and engagement. Researchers have found a distinct link between dissatisfied employees and dissatisfied customers.

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"Leaders must acknowledge that culture and employee engagement are their responsibility."

Barbara Porter
Executive Director, EY Americas Advisory Customer Practice

Rating sites and social media networks

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Consumers expect from their health care experience the same access to cost and quality comparison data that they have come to appreciate in other areas of their lives. The online world today offers more than 75 health care rating sites, such as healthgrades.com, vitals.com, doximity.com, betterdoctor.com and healthcare.gov, while such social media sites as Facebook, Twitter and YouTube provide ample opportunities for patients to post feedback on their health care experience.

Research has found that patients are more likely to be more outspoken about their negative experiences than their positive ones. Shortcomings that might have gone unheard in the pre-digital age can travel around the world in an instant and leave an indelibly bad mark on an organization's reputation.

Forward-thinking health care organizations are analyzing social media sites, blogs, online discussion forums and user-generated news link exchanges to understand what consumers and patients are saying about their health care experience and what they care most about.

Revenue management: partnering to improve the patient financial experience

As employers and payers reduce their coverage costs, the patient share of medical bills is steadily growing. With the increasing use of high-deductible health plans, patient obligations are changing and patients are demanding not only a better care experience but a better financial one in their health care journeys.

Increasingly, the revenue cycle is an opportunity for providers and payers to partner in better serving customers. For example, UnitedHealth's Optum360 business unit and Mayo Clinic are joining forces in a new system to streamline revenue management, from providing price estimates before patients receive care to collecting payment from patients afterward. The partnership includes a next-generation patient cost estimator, a streamlined process for prior authorization/pre-certification, enhanced claims editing functions and simplified billing for pre-care packaged pricing.

According to the two organizations, a key focus of their partnership is creating a convenient, transparent and personal experience for patients while reducing administrative costs for providers.

Source: unitedhealthcare.com, startribune.com.

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Eight dimensions of patient-centered care: understanding what matters most to patients

Researchers at the Harvard Medical School and the Picker Institute conducted thousands of interviews to understand what matters most to patients in the health care experience. That research revealed the Eight Dimensions of Patient-Centered Care, providing a platform for providers to determine the kinds of questions to ask patients about their care experience.

The eight dimensions include:

Dimension of patient-centered care	Need expressed	Action steps for providers
1. Respect for patients' values, preferences and expressed needs	To be recognized and treated as individuals by hospital staff and to be kept informed of their care	<ul style="list-style-type: none"> ▶ Provide an atmosphere respectful of the individual patient, focusing on quality of life ▶ Involve the patient in medical decisions ▶ Treat patients with dignity and respect their autonomy
2. Care coordination and integration	To feel less vulnerable and more powerful in the face of their illness by knowing their care is being well coordinated	<ul style="list-style-type: none"> ▶ Coordinate care in three key areas: clinical care, front-line care, and ancillary and support services.
3. Information and education	To be assured information is being shared with them and staff are being completely honest about their condition and prognosis	<ul style="list-style-type: none"> ▶ Focus on three aspects of strong communication, including information to provide clinical status, progress and prognosis; explain care processes and facilitate autonomy, self-care and health promotion
4. Physical comfort	To be physically comfortable	<ul style="list-style-type: none"> ▶ Focus on three areas key to physical comfort: pain management, assistance with activities and daily living needs, and hospital surroundings and environment.
5. Emotional support and alleviation of fear and anxiety	To feel less anxious and more supported throughout their treatment	<ul style="list-style-type: none"> ▶ Focus on alleviating patient anxiety in: <ul style="list-style-type: none"> ▶ Physical status, treatment and prognosis ▶ The impact of the illness on patient ▶ Family and the financial impact of the illness
6. Family and friend involvement	To lessen the impact of illness on family and friends	<ul style="list-style-type: none"> ▶ Recognize the needs of patient family and friends by providing accommodations, involving them in decision-making and supporting them as caregivers
7. Continuity and transition	To care for themselves after discharge	<ul style="list-style-type: none"> ▶ Provide understandable, detailed information about medication, physical limitations and dietary needs ▶ Coordinate and plan ongoing treatment and services after discharge ▶ Regularly provide information about access to clinical, social, physical and financial support
8. Access to care	To know where to access care when they need it	<ul style="list-style-type: none"> ▶ Focus on location of hospitals, clinics and physician offices; availability of transportation; ease of scheduling appointments; availability of appointments when needed; accessibility to specialists or specialty services when a referral is made, and clear instructions on when and how to get referrals

Source: "Eight Dimensions of Patient-Centered Care," National Research Corporation, 2015.

Those who respond promptly to complaints – and identify and empower their brand fans – are most likely to communicate that they are truly listening to their customers. This is opening a new world of “social care” where providers and health plans make sure that issues are addressed promptly and carefully communicated back into social media.

“We can only treat patients as well as we treat one another.”

Barbara Balik, RN, Ed.D
Senior faculty member
The Institute for Healthcare Improvement

From tracking to transforming: learning from the full spectrum of customer perceptions

Today’s patients and their supporters are savvy consumers, in perpetual search of the best health care experience. The definition of “best” continues to expand beyond clinical care to include the entire patient journey and the many perceptions that accompany it. Winners in today’s world of consumer empowerment, where choice is the new reality, are those that keep a vigilant watch, across all channels, on how they are measuring up through their customers’ eyes. To see the complete picture, health care organizations will need to consider the entire range of input, from the traditional to the trending.

As patient-centeredness becomes more entrenched in the health care delivery system, providers and payers have a pressing imperative: to understand not only what customers need but also how they experience the services they receive and how that experience can be continuously improved. Measuring customer perceptions can open new pathways to becoming a truly customer-centric organization – one that consistently delivers the best and most reliable experience.

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Opening doors: providing patients with easy access to their online records

Giving patients easy access to clinical data in near real time is a key goal of meaningful use requirements. Electronic access accomplishes many goals. It assures patients that all of the people who care for them have the information they need to get a complete picture of their health. Patients can use their health information to better communicate with providers, better understand their health and treatment options and confirm that their health information is accurate and complete. Studies have found that access increases engagement, and engaged patients receive better-quality care, while the potential for medical errors is reduced. Digital access has also been shown to improve PAM scores.

One program seeking to advance these goals is OpenNotes, a national initiative working to give patients online access to the visit notes their clinicians write. Proponents maintain that having the chance to read and discuss those notes can help patients take better control of their health and health care.

In 2010, more than 100 primary care doctors from three diverse medical institutions across the US – Geisinger in Pennsylvania, Beth Israel Deaconess Medical Center in Boston and Harborview Medical Center in Washington – began sharing notes online with their patients. Each site was part of a 12-month study to explore how sharing clinician notes may affect health care.

The program alerted patients by email each time their physician posted a note about the patient into the patient’s EHR. The patient could then access the note through a patient portal.

Of the patients in the experiment, 99% recommended that this transparency continue, reporting an increased sense of control, greater understanding of their medical issues and improved recall of their plans of care. The physicians found that the note sharing strengthened their relationships with some patients and may have improved patient safety and satisfaction.

Over the past four years, OpenNotes has been expanded to include other hospitals and health systems, such as Cleveland Clinic, Milwaukee’s Columbia St. Mary’s and the U.S. Department of Veterans Affairs.

Sources: www.myopennotes.org; www.rwjf.com; Jan Walker, et al., “The Road toward Fully Transparent Medical Records,” *N Engl J Med* 2014; 370:6-8, January 2, 2014.

Feature

Listening to your patients and customers: turning insights into action

A roundtable discussion with Health Care Advisory Services Leaders, Ernst & Young LLP

EY practice leaders offer their perspectives on how providers and payers can “amp up” their listening across all channels to better serve their patients and customers.



*Becky Dítmer,
Principal*



*Kristen Venum,
Principal*



*Jan Oldenburg,
Senior Manager*

Today, rating systems are driving consumer decisions in virtually every US industry. How are these systems affecting health care providers and payers? Will we ever have a “gold standard” for health care customer ratings?

Jan Oldenburg: The rating system that’s coming most to the forefront is CAHPS. An every-two-years survey, it measures customer perceptions of hospital, physician and health plan performance. CAHPS is being used in everything from Medicare STAR ratings and the Medicare Shared Savings Program to evaluations of ACOs and patient-centered medical homes. It has a way to go, though, in helping organizations to measure how they’re doing on a moment-by-moment basis. Additional tools and capabilities will still be needed.

We also see the “wisdom of the crowd” gaining ground – such online resources as Healthgrades, for example – in helping people understand the care experience in hospitals and with physicians. But I think those rating systems need to be balanced with such information as outcomes, physician performance and number of surgeries performed, since we know these factors have a direct impact on the quality of care.

Kristen Venum: I think the gold standard is more than a rating system; the gold standard is transparency – when patients can compare cost, quality and convenience data and then make informed decisions about how they’re spending their health care dollar. In any other industry that’s gone through a major consumer transformation, the imperative for transparency increases when consumers start buying things directly as opposed to businesses buying them on an employee’s behalf. Organizations that can enable that transparency, whether they are third parties or payers or providers themselves, will win in the consumer world.

How would you describe today’s health care consumer? What has been the role of digital technologies in empowering their decision-making?

Kristen Venum: EY recently published a report, Consumers on Board, that answers this very question ([http://www.ey.com/Publication/vwLUAssets/EY-consumers-on-board/\\$FILE/EY-consumers-on-board.pdf](http://www.ey.com/Publication/vwLUAssets/EY-consumers-on-board/$FILE/EY-consumers-on-board.pdf)). Today’s health care consumers – empowered by technology – are smarter, better informed and more demanding than ever. In health care, they are no longer passive “passengers” with little choice other than to comply with the direction their providers set for them. Access to technology has realigned the balance of power. In fact, the likelihood is real that consumers may soon be one step ahead and the businesses chasing them will be challenged to play catch-up.

“Today’s health care consumers – empowered by technology – are smarter, better informed and more demanding than ever.”

Jan Oldenburg: The sheer amount of medical information available today for consumers to research a condition – before they even see their provider – has a huge impact on equalizing the power imbalance. They can also access their clinical data, email their doctor and be much more informed to ask much deeper questions. And, with OpenNotes, they can get a much broader perspective on their treatment plan and be partners in decisions rather than subject to them. Patients who are part of decision-making are much more likely to agree to and follow treatment protocols.

We see a lot of surveys and listening tools designed to gauge customer perceptions. In your experience, which tools are the most beneficial?

Kristen Vennum: Each has its merits, and what matters most is the management system that surrounds customer insights as opposed to the tool selected.

What's needed is a "closed-loop system," one by which you can receive an insight, drive it through to an innovation or process improvement, measure whether or not it moved the customer perception, drove business value and shareholder value or improved organizational efficiencies – and then go back and listen again. With a closed-loop system, you can incorporate customer insights into day-to-day business decisions as well as more systemic improvements, and then have the discipline to follow that back around again and see if it had the desired impact.

Becky Ditmer: It's important, too, that we take a holistic approach to measurement. We've seen a lot of advancement in how we're gauging the different aspects of a patient's or a customer's experience, but we're still measuring it in incremental pieces. For example, maybe as a patient you had a great nursing experience, but your surgery experience wasn't so good. We need to measure the full patient experience, not just the parts. We also need to measure at the point of care, not after the patient has left the care delivery site.

Jan Oldenburg: Measuring satisfaction in a health care setting can be tricky. You don't want doctors just doing what the patient asks so the provider can get a good rating in a measurement system. For example, the patient may ask for a certain antibiotic that is in fact the wrong medical treatment. What's needed is a dialogue with the

patient, talking over the treatment options, the protocols and the evidence base to support them – and then deciding together on the right treatment.

What are some of the best practices you've seen in responding to feedback from patients?

Becky Ditmer: We've found that all the leading hospital systems have created or intend to create the position of the chief experience officer (CXO). For many years, the social worker or patient advocate has been embedded into the hospital with the primary role of listening to the patient. But what we're seeing today is the true advancement of the patient engagement office. This team is responsible not only for listening to the patient and the patient's family, but also for taking immediate action that can improve outcomes – having the management oversight to be able to say to a department head, "this has to change."

Jan Oldenburg: Several organizations have been providing empathy training for clinical and customer service staff, with the goal of instilling empathy into the core of who they are as health care workers. For example, many studies have revealed how often patients are interrupted during their visit. That's an incidence where empathy is clearly lacking. In fact, most customer service issues, from complaints about wait times all the way through to malpractice claims, are communication issues. Evidence shows that when a physician, for example, takes a more empathic posture with the patient, that alone significantly reduces malpractice risk and improves perception and service. Demonstrating empathy also sends the message, "We not only want to be different but also to illustrate how different we are by how we talk with our patients."

Kristen Vennum: In my view, the role of the CXO is to help the organization look at itself from an outside-in perspective, and at customer journeys from the perspective of what the customer is trying to accomplish, where they might get stuck and where they might have moments of delight or brand connection throughout their health care experience. Too often we see organizations creating the role but continuing to go about their siloed, internally focused decision-making on all the things that really matter to patients. The successful CXO makes the customer experience everybody's job. This requires becoming an evangelist and enabler of a methodology of a customer-centric approach, using it to really embed the customer experience into the DNA of all the organization's decisions.

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"The successful CXO makes the customer experience everybody's job."
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What is a "listening culture"? Can you offer a few examples?

Becky Ditmer: Little touches can make all the difference. For example, instead of the physician sitting across from you sharing lab results, what a difference it makes if he or she sits beside you and shares what's being written about you so you can see it. Sharing actual notes has been controversial for some of the older generation of physicians, but research has shown that when notes are shared, patients are more engaged, have more trust and can be proactive in correcting any mistakes. Those little touches are clear demonstrations of a listening culture at work – asking patients what they want. Empathy training

needs to start at our medical and nursing schools so that not only the clinical aspect of care is taught but also the empathic one.

Kristen Vennum: The question we're really trying to get at here is this: who is sitting at the table when decisions are made, and how is the customer's voice being represented? For starters, you need to have listening posts of different kinds and frequencies. Then, you need to be able to distill the massive amounts of customer data you collect and turn it into action. To become a listening organization, you also need to create customer experience guideposts for your employees, such as demonstrating empathy, getting the basics right, speaking with one voice and making it easy for the customer. The guideposts need to consider the rational and the emotional aspects of the customer experience. Then, you need to include the customer experience in every decision you make, from capital investments to human resources. Your leadership team needs to lead by example, living the customer experience as your organization's number one value.

How can leaders effectively execute on feedback to improve care delivery?

Becky Ditmer: It starts with asking patients what they want, and then creating the culture that enables everyone to be empowered around patient needs. The correlation between employee engagement and customer engagement is a proven one. More and more organizations are hungry to understand how they can better take care of their employees so their employees can better take care of their customers. At EY, we're consulting with many clients on "purpose-led transformation." That's about connecting

the individual to the organization's purpose – and relying on this connection to drive performance and growth. When those two points are aligned, the individual and the collective "reason for being," employees are happier and they perform better. Ultimately, their satisfaction shows up in the customer experience data.

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"The correlation between employee engagement and customer engagement is a proven one."
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Kristen Vennum: Health care is an industry with a trust gap. Patients question that the payer has their best interest in mind, that the physician really cares about them and their issues and will actually spend time with them, that their employer is providing them with the best plan and that the government is developing the policies that will truly transform our system of care.

As we've looked at all these different organizations trying to improve their customer experience, we often find that the conversation comes back around to trust. Did you do what you said you were going to do? Did you follow through on your promise of answering my question or helping me through one of the most difficult times of my life? Did you do so in a way that leaves me more confident in your organization or feeling that I matter to you as an individual? Our view is that trusted organizations are more successful, more profitable and more likely to grow than organizations that break trust.

What guidance do you have for health care executives and board members to help their organizations thrive in this new era of consumer empowerment?

Becky Ditmer: I believe everyone has been wanting to focus on the patient experience for many years. What we need to do now is make this part of the dashboard, from how management evaluates organizational performance and determines profit and loss to how employees are compensated. That starts to make it real.

Kristen Vennum: I would offer three guidelines. First, learn from other industries to uncover the patterns. Second, embrace innovation – look for really different ways to break the old system and build your organization for the future. Third, focus on and invest in employee engagement.

Jan Oldenburg: I'm going to return for a minute to the whole concept of consumer empowerment. Often in health care we have not taken into account the perspective of the consumers and patients because we're still stuck in a doctor-knows-best kind of culture. But increasingly, we're finding that consumers really do know what they need. And that when we take that into account and really bring them into the conversations with us and empower them with the data and information, they really become our partners. They aren't choosing the most expensive options just because; they're often choosing them because they lack the data to understand what is a better or more cost-effective treatment plan. This whole idea of listening to consumers really means embracing them as partners in every aspect of how we think about, and deliver, health care.

Considerations for your board and executive leaders

- ▶ What experience do you want your customers to have in each step of your service delivery process? Are you listening to what they really want – and delivering it?
- ▶ How does your organization gather and measure customer feedback, bringing the customer's voice into the conversation across all areas of your organization?
- ▶ How do you transform this information into useful, actionable data? Do you showcase areas where you have changed your operations as a result of customer feedback?
- ▶ Are you analyzing the customer experience across the continuum of care rather than in individual silos of interaction?
- ▶ Do you have a structured plan for engaging employees in improving the customer experience? How are you communicating that the customer experience is everyone's job?
- ▶ Is your chosen customer-relationship metric or metrics helping employees to understand the goal of improving the customer experience?
- ▶ How are you using data to identify systemic problems as well as problems specific to individual employees?
- ▶ Are you including customer experience data in any payment incentive structures for employees?
- ▶ Are you analyzing patient experience data by patient demographics, such as ethnicity, health status and patient characteristics, to better understand the expectations of specific patient populations?
- ▶ Have you created a customer experience map defining the ideal experience and the tipping points that could negatively affect your customers' perceptions of you?
- ▶ Are you investing in finding and keeping staff with superior interpersonal skills?
- ▶ Are you focusing on the human as well as the digital touch points in your customers' journeys?
- ▶ How are you taking charge of your organization's online reputation? Do you have a social media strategy to respond effectively to negative comments and build brand fans?
- ▶ Do you have a designated chief experience officer or chief customer officer to drive improvements?
- ▶ How are you engaging customers in helping to design your customer experience?

“You must be the change you wish
to see in the world.”

Mahatma Gandhi, 20th-century Indian leader



Postscript

Transformational leadership

Reaching full potential

Like a butterfly leaving a cocoon, what is emerging in health care bears little resemblance to its previous form

As traditional boundaries dissolve and new horizons open for all industry stakeholders, leaders are called to be masters of strategy. They must hone the ability to nimbly capitalize on the many changes presented by a highly complex, continuously transforming system.

As you review this edition of *New horizons*, consider the skills, knowledge and perspective of your leadership team in adapting to the industry's evolving structure. How equipped are you to lead your organization in:

- ▶ Creating and moving toward a viable vision for the future?
- ▶ Finding solutions to improve system efficiency and address organizational effectiveness?
- ▶ Developing new service delivery models that are more agile, responsive and integrated?
- ▶ Exploring payment systems that reward high-value care while looking internally to curtail costs?
- ▶ Redesigning clinical processes and making the best use of resources?
- ▶ Analyzing and using data for strategic decision-making?
- ▶ Pursuing partnership opportunities and fostering collaboration?
- ▶ Understanding, improving and measuring the patient and customer experience?
- ▶ Creating a learning organization and a culture of trust, teamwork and empowerment – the foundation for true transformation?

For leaders who want to create something entirely new, few industries today offer more promise than health care. As the system emerges from its old form and finds new wings, opportunities are abundant to innovate, inspire and ignite the change you want to see.

“Never look for birds of this
year in the nests of the last.”

Miguel de Cervantes, *17th-century Spanish author*



Appendix

Highlights of current health care legislative activity

As implementation of the Affordable Care Act continues, health care has remained a front-burner issue in Washington, DC. In this Appendix, we offer highlights of federal legislative activity that provide a backdrop to the topics discussed in this edition of *New horizons*.

The legislative climate: looking toward the 2016 elections

- ▶ Victories in the 2014 midterm elections gave Republicans a stronger position to shape the public message and oversee ACA implementation. Yet full repeal of the law will remain out of reach while President Obama is in office, and any changes to the ACA will require the support of Democrats to clear procedural requirements in the Senate.
- ▶ While the political debate over repealing and replacing the ACA is expected to be a central issue in the 2016 elections and beyond, signs of bipartisanship have begun to emerge. Republicans and Democrats have jointly introduced multiple bills that aim to change various ACA provisions.
- ▶ Looking beyond the ACA, Congress has made notable progress in 2015 in advancing bipartisan health care legislation that aims to reform Medicare payment, extend Children's Health Insurance Program (CHIP) coverage and accelerate the discovery and development of new cures through National Institutes of Health (NIH) and FDA reforms.

King v. Burwell: upholding IRS rules under the health care law

- ▶ In the first half of 2015, the U.S. Supreme Court's consideration of *King v. Burwell* loomed over ACA-related legislative action. The case challenged final regulations by the US Department of the Treasury and the IRS that made premium assistance tax credits under the ACA available through exchanges run by the federal government and by states to purchase qualified health plans.

- ▶ On June 25, in a 6-3 decision, Justice Roberts, joined by Justices Kennedy, Ginsburg, Breyer, Sotomayor and Kagan, concluded that Congress intended to make tax credits available in state- and federally facilitated exchanges. This decision affirmed the IRS interpretation that the ACA made available tax credits to qualified individuals to purchase qualified health plans through state- and federally facilitated exchanges.
- ▶ By affirming the IRS interpretation, tax credits will remain available on an ongoing basis for eligible enrollees in all states, regardless of the governmental entity operating the exchange.
- ▶ With the Court's decision, compliance efforts are expected to move ahead. Major ACA provisions for employer shared responsibility and reporting are in effect for most employers in 2015.
- ▶ Today, 13 states and the District of Columbia are operating their own exchanges. HHS reports that three other state-based exchanges are using HealthCare.gov, the federal information technology platform, for individual eligibility and that the agency is running federally facilitated exchanges in the remaining 34 states.
- ▶ According to the HHS March Enrollment Report, of the 8.8 million people who selected plans through the federally facilitated exchanges during open enrollment for 2015, 7.7 million were determined eligible for advanced premium assistance tax credits to help purchase exchange coverage. With the Court's decision, these individuals will continue receiving tax credits to offset the cost of coverage. Overall, 11.7 million people selected health plans

through state-based and federally facilitated exchanges for the 2015 open enrollment period.

- ▶ The Court's ruling will not end the political debate over health care, which is expected to remain a central issue in the 2016 elections and beyond. Repeal of the ACA has been a primary focus of congressional Republicans, and efforts to shift the debate to the political realm and the next presidential election are expected to intensify.

ACA coverage expansion: continuing the forward momentum

- ▶ In March 2015, HHS released the following new data on the effect of the ACA on the health insurance marketplace. About 16.4 million Americans have gained insurance coverage since the ACA was implemented:
 - ▶ The rates of uninsured Americans dropped from 20.3% in mid-2013 to 13.2% in March 2015 – called “the largest reduction in the uninsured in four decades,” according to HHS Secretary Burwell.
 - ▶ 14.1 million of the newly insured are adults, and 3.4 million of those are young adults, aged 19 to 25. The baseline uninsured rate for young adults dropped from 34.1% in mid-2010 to 26.7% in mid-2013.
 - ▶ Insurance coverage gains were strong in Medicaid expansion states; there, uninsurance rates dropped from 18.2% before ACA implementation to 10.8% as of March 2015. In the non-expansion states, the uninsurance rate dropped from 23.4% to 16.5% over the same time frame.

- ▶ 25% more insurers offered plans in the second open enrollment period compared with the first one.
- ▶ The Administration reports that enrollment in Medicaid has increased by 11.2 million since October 2013. As of July 1, 2015, 29 states and the District of Columbia have expanded Medicaid under the ACA. Discussions are continuing in at least two states, but winning support from Republican-dominated legislatures has so far proven difficult. The President has embarked on a renewed effort to encourage non-expansion states to expand Medicaid to newly eligible populations.
- ▶ Looking forward to open enrollment in 2016 and beyond, interest will be focused on premium rate increases in the exchanges, whether enrollment growth in exchanges will continue, and changing state decisions around exchange management and operations (as some states choose to revert to the federal architecture of healthcare.gov, and others decide to run their own exchanges).
- ▶ Renewed attention will also focus on State Innovation Waivers, authorized under Section 1332 of the ACA beginning in 2017. Under these so-called 1332 waivers, if a state meets certain conditions, the HHS Secretary may waive key ACA requirements, including: marketplaces, tax credits and cost-sharing subsidies made available through the marketplaces, and the individual and employer mandates. In order to obtain a five-year, renewable 1332 waiver, a state must submit a plan for approval by the HHS Secretary that: 1) provides coverage

that is at least as comprehensive as that offered through the marketplaces; 2) provides cost-sharing protections and coverage at least as affordable as what is available in the marketplaces; 3) provides coverage to a comparable number of state residents as would have occurred absent the waiver; and 4) does not increase the federal deficit. A number of states, including Vermont, Rhode Island, Hawaii and Minnesota, have expressed interest in exploring the waiver opportunity. In addition, Arkansas has signaled interest in using a 1332 waiver to allow for continuation of its innovative “private option” Medicaid expansion. The combination of a state 1115 waiver under Medicaid with a 1332 waiver could give non-expansion states a powerful and flexible new tool with which to expand coverage under a more tailored approach in line with the values and needs of the local community.

- ▶ As ACA implementation moves forward full speed ahead, members of Congress have introduced legislation that would make a number of changes to various provisions, including legislation that would address benefit design flexibility, provide relief under the employer mandate, streamline employer reporting provisions while improving the accuracy of the eligibility determination process for tax credits under the ACA, and provide states with additional flexibility in designing their Medicaid programs.

Medicare Access and CHIP Reauthorization Act (MACRA): reforming Medicare payment

- ▶ On April 16, 2015, in the wake of overwhelming bipartisan support from both chambers of Congress, the President signed landmark Medicare reform legislation – MACRA – into law. MACRA reforms the Medicare physician reimbursement framework and includes other Medicare payment, program integrity and policy provisions.
- ▶ The legislation repeals the sustainable growth rate formula for payments to health care providers under the Medicare physician fee schedule, ending a long cycle of Medicare physician fee schedule cuts being triggered automatically and then followed by congressional action to override the cuts with temporary patches. MACRA ushers in a new era of Medicare physician payment that aims to accelerate the transition away from payment based on the volume of services performed and toward payment based on the value and quality of services provided.
- ▶ In the near term, the legislation provides for an update to Medicare payments to health care providers of 0.5% for July through December 2015 and for subsequent annual updates of 0.5% for 2016 through 2019. Payment rates in 2019 will be maintained through 2025.
- ▶ Existing Medicare incentive programs will be streamlined and consolidated, and a new Merit-Based Incentive Payment System will provide for additional payment adjustments to participating health care providers beginning in 2025.

- ▶ Beginning in 2026, health care providers who receive a significant portion of their revenue from alternative payment models, such as ACOs, bundled payments and PCMHs, will receive payment adjustments.
- ▶ MACRA also extends funding for CHIP through fiscal year 2017, without making policy changes to the program – setting up a key debate in 2017 about the future of CHIP in a post-ACA environment. The law also extends mandatory funding for community health centers and certain temporary Medicare payment policies, the so-called Medicare extenders, through fiscal year 2017.
- ▶ To offset part of the cost to the federal government of the overall legislation, MACRA includes other changes to Medicare payment policy and requires greater means testing of beneficiary premiums.
- ▶ Passage of the legislation is expected to kick off an open-ended rule-making process that will inform how the mechanisms to shift to payment based on quality and value will be structured and implemented.

FY2016 budget resolution and appropriations activity: preparing for battle

- ▶ The annual budget and appropriations process has been dominated by debate over the ACA's future.
- ▶ In the spring, on strict party-line votes in both chambers, the House and Senate adopted a FY2016 budget conference report that sets FY2016 discretionary spending at sequester levels agreed to as part of the Budget Control Act of 2011. It also paves

the way for Republican leaders to use expedited procedures in the House and Senate to repeal the ACA later in the year.

Potential health care activity through reconciliation

- ▶ Under reconciliation, a bill is subject to a simple majority vote, which would permit Senate Republicans, who hold the majority with 54 seats, to pass legislation with 51 votes.
- ▶ The budget conference agreement instructs five congressional committees to each report legislative changes that produce at least \$1 billion in net deficit reduction by July 24, 2015 (although this deadline is more of a general guide than a strict requirement). According to a Joint Explanatory Statement accompanying the budget agreement, the agreement "provides a path through reconciliation to repeal the Affordable Care Act with its burdensome mandates and restrictions." Such legislation could repeal or alter 1) key coverage expansion provisions, such as the availability of premium tax credits and the expansion of Medicaid, 2) employer and individual mandates, and 3) various industry taxes and fees, such as the medical device excise tax.
- ▶ In the wake of the *King v. Burwell* decision, Republicans are reconsidering whether to use reconciliation to repeal the ACA in its entirety or to use a more targeted approach that repeals a smaller subset of ACA provisions, such as the individual mandate, employer mandate, medical device excise tax and the Independent Payment Advisory Board. Although using reconciliation procedures will speed legislation to President Obama's

desk, legislation that significantly changes the ACA's coverage expansion is expected to be vetoed by the President. Republicans alone do not have the two-thirds supermajority needed in the Senate or the House to override a veto.

- ▶ The decision to use reconciliation was further complicated by a June 19, 2015, report from the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) saying that federal deficits would increase by \$353 billion over the 2016-25 period if the ACA were fully repealed – making the reconciliation requirements to produce deficit reduction that much more difficult to achieve through full repeal.
- ▶ The CBO and JCT also estimated that, as a result of fully repealing the ACA, the number of non-elderly people who are uninsured would increase by about 24 million in 2020 and beyond, compared with the number projected to be uninsured under the ACA. At the same time, the number of people with employment-based coverage would increase by about 8 million, while those with individually obtained or Medicaid coverage would decrease by between 30 and 32 million.

Health care budget challenges in the appropriations process

- ▶ The FY2016 budget conference agreement also set in motion the annual appropriations process, although leaders continue to disagree about the overall funding levels included in that budget. President Obama and Congressional Democrats continue to press for raising FY2016 discretionary spending caps in

exchange for revenue increases and mandatory spending cuts.

Nevertheless, in late June, the House and Senate Appropriations Committees, on strict party-line votes, advanced appropriations bills to fund HHS. In both chambers, Republican Committee Chairs reduced or eliminated funding for ACA implementation and health services research, while increasing funding for basic science research at NIH.

- ▶ The partisan dispute over top-line funding levels, as well as disagreements over health policy and continued funding for ACA implementation, sets up a tough appropriations battle this fall before the end of the fiscal year. The dispute could require protracted negotiations as Congress and the Administration work to find resolution on FY2016 funding. Budget observers are closely watching whether a budget deal could be reached whereby discretionary budget caps for FY2016 are raised in exchange for corresponding cuts in mandatory spending, which could include additional cuts to Medicare reimbursement. These negotiations may coincide from a timing perspective with the need to once again raise the debt limit.
- ▶ The absence of a funding agreement could lead to the application of a continuing resolution to keep the federal government funded at last year's funding level.

Biomedical innovation: pursuing a shared priority

- ▶ Advancing opportunities for biomedical innovation have emerged as a shared priority among the House Energy and Commerce Committee, the Senate Committee on Health, Education, Labor and Pensions (HELP Committee) and the Obama Administration, potentially boosting the prospects for legislative activity in this area during the 114th Congress. For example, the two committees and the Administration have indicated an interest in provisions intended to update the clinical trial process to better reflect the current state of biomedical development and to update regulations governing data sharing. The goal is to accelerate the discovery, development and approval of treatments and medical devices.
- ▶ Congressional efforts in both chambers may result in additional funding for NIH and the FDA. On July 10, 2015, the House passed the 21st Century Cures Act (HR 6) on a strong bipartisan vote (344-77). The legislation is intended to facilitate the delivery of innovative pharmaceutical drugs and medical devices to patients through faster approvals and streamlined clinical trials, and would provide increased funding over several years for the NIH (\$8.75 billion) and the FDA (\$550 million). The Senate HELP Committee is continuing its own bipartisan efforts to develop legislation that would advance biomedical innovation. The Administration already has begun work aimed at facilitating broader exchange and use of electronic health information with the goal of improving health care quality.

Cadillac tax: riding toward 2018

- ▶ The ACA's excise tax, referred to as the "Cadillac tax," is scheduled to go into effect in 2018. According to the law, employers are subject to the tax on higher-value health plans they sponsor: individual plans valued at more than \$10,200 and family plans valued at more than \$27,500.
- ▶ On February 23, 2015, the Treasury Department and the IRS issued their first guidance on the Cadillac tax. Some employers already have begun making changes to the benefits they offer employees in hopes of delaying incurring this tax for as long as possible.
- ▶ Employer efforts to avoid the Cadillac tax could have significant implications for employer-sponsored coverage overall, including greater use of narrow networks of health care providers and more limited coverage for some health care services, prescription drugs and medical devices that could result in higher deductibles and other out-of-pocket costs for insured individuals.
- ▶ As Treasury and the IRS continue their work to implement the Cadillac tax through the rule-making process, employers, unions and other stakeholders have stepped up efforts to educate Congress about the implications of the tax and to urge Congress to mitigate it. More than 40% of members in the House of Representatives have co-sponsored legislation to repeal the tax altogether.

Frequently used acronyms

ACA	Affordable Care Act	ED	Emergency Department	IOM	Institute of Medicine
AHA	American Hospital Association	EHR	electronic health record	IT	information technology
AMA	American Medical Association	HFMA	Healthcare Financial Management Association	M&As	mergers and acquisitions
ACO	accountable care organization	HHS	US Department of Health and Human Services	MSSP	Medicare Shared Savings Program
BLS	US Bureau of Labor Statistics	HIMSS	Health Information Management Systems Society	MU	meaningful use
CAHPS	Consumer Assessment of Healthcare Providers and Systems	ICD-10	International Classification of Diseases, 10th edition	ONC	Office of the National Coordinator for Health Information Technology
CHIP	Children's Health Insurance Program			PCMH	patient-centered medical home
CMS	Centers for Medicare & Medicaid Services			PHM	population health management



Acknowledgments

Project leadership

Jon Weaver served as executive sponsor for *New horizons: After reform, transformation*, providing strategic vision and overall guidance. He also offered valuable input on chapter drafts and served as lead interviewer for our conversations with external contributors **Richard Gilfillan, MD**, **Robert Wah, MD**, and **Erin Fraher, PhD**, as well as with our Health Care Advisory Services Leaders **Becky Ditmer**, **Kristen Vennum** and **Jan Oldenburg**.

We are grateful also to our EY Americas Health Care Sector Region Leaders, **Brad Duncan**, **Carole Faig**, **David Copley**, **John Simon** and **Tom Griffith**, many of whom served as final reviewers.

Sue Carrington, Managing Editor, developed the theme, visuals and chapter direction for *New horizons*, engaged project resources and managed the book's production. She researched, wrote and edited chapters and interviews and was responsible for the publication's overall content and quality.

Chip Clark, **Greg Park**, **Jeff McMahon** and **Patrick Hynes** provided helpful comments on content. **Bill Fera** also offered input and reviewed the entire publication before press.

Sarah Egge led the development of the legislative and regulatory Appendix.

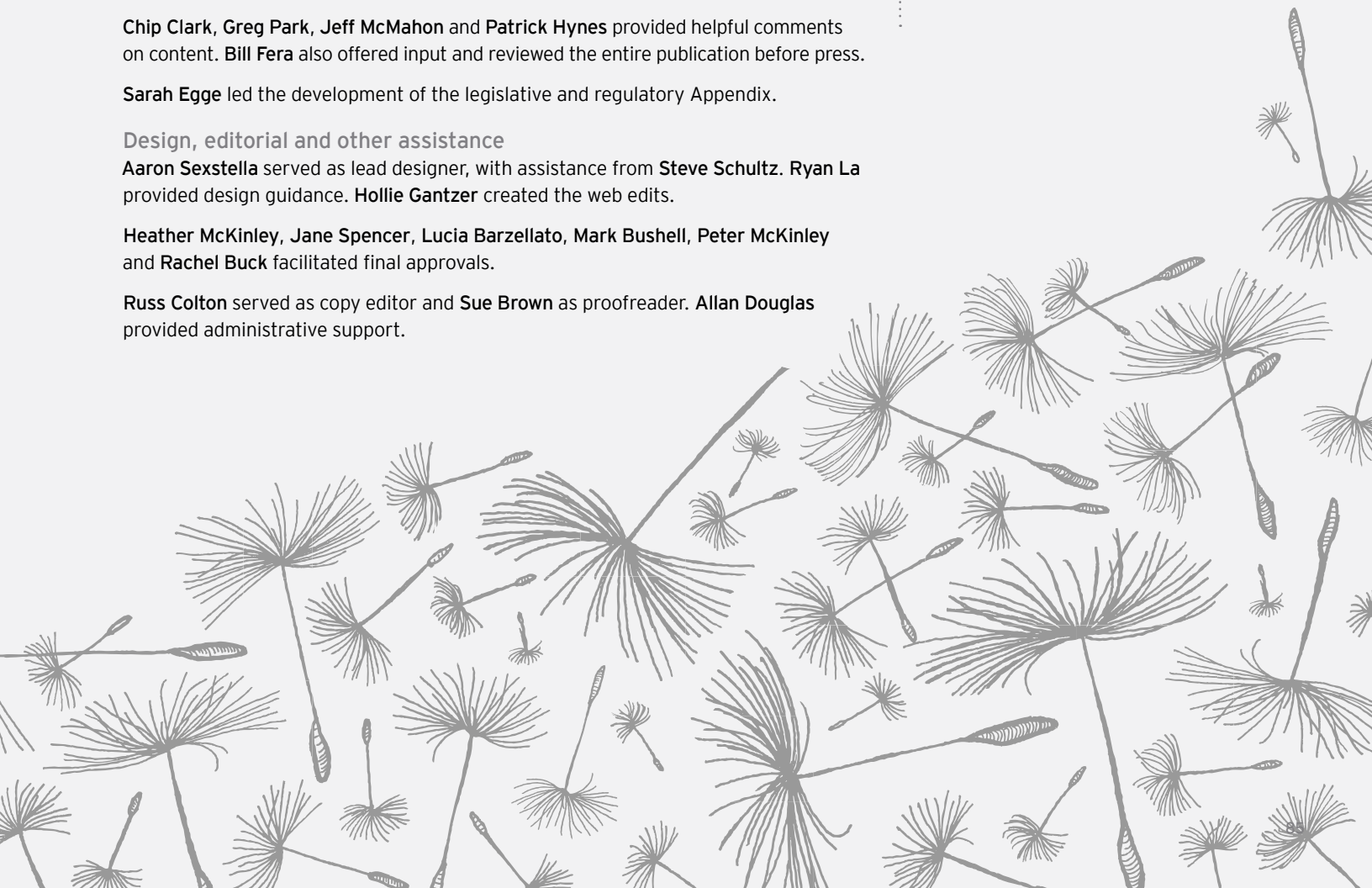
Design, editorial and other assistance

Aaron Sexstella served as lead designer, with assistance from **Steve Schultz**. **Ryan La** provided design guidance. **Hollie Gantzer** created the web edits.

Heather McKinley, **Jane Spencer**, **Lucia Barzellato**, **Mark Bushell**, **Peter McKinley** and **Rachel Buck** facilitated final approvals.

Russ Colton served as copy editor and **Sue Brown** as proofreader. **Allan Douglas** provided administrative support.

New horizons is published by EY's US Health Sector practice. It is designed to help the firm's health sector clients successfully navigate the challenges and opportunities that market changes, government activities and technology innovations present. For more information, contact a partner in your local EY office. Access additional resources at www.ey.com/health



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About EY's Health Reimagined initiative

Health care is in the midst of a once-in-a-lifetime transformation that is blurring traditional boundaries and redefining health care as we know it. The move to "Health 2.0" – the patient-centric, technology-enabled, prevention-focused future of health care – is being catalyzed by nontraditional entrants from far-flung sectors, including technology, telecommunications, retail trade and more. These disruptive forces demand bold new approaches, alliances and business models.

EY's Health Reimagined initiative is a cross-sector program that brings together professionals and perspectives from multiple industries to develop insights and solutions that are aligned with the future of health. We can help you navigate your way forward and achieve success as you transition to Health 2.0.

ey.com/healthreimagined

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SCORE No. EC0026

1502-1399858

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