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INTRODUCTION

The data behind the most important trends in the industry

Jonathan Bees
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The ***HealthLeaders Media Healthcare Industry Data Almanac*** presents survey data on a wide range of healthcare industry trends and reveals the strategies providers are using to achieve success in this evolving industry. Based on a series of monthly thought leadership surveys of the HealthLeaders Media Council and select members of the HealthLeaders Media audience, the data reveals key insights on the challenges and opportunities providers are facing.

Providers must navigate an especially demanding gauntlet: the transition from fee-for-service to value-based care, the need to control costs while improving quality, establishing executive compensation plans that account for risk-based models, managing patient experience across the continuum, considering merger and acquisition activity as part of organizational and financial strategy, and many other factors.

Survey topics in the guide are examined in detail, and data is presented in an easy-to-read format based on charts accompanied by concise commentary and analysis. Want to know the average share of net patient revenue for value-based payment models? How about the share of patients in value-based programs? Data is available in this report for these as well as other critical questions.

Consider this: Three-quarters (75%) of respondents say they will either be exploring potential merger, acquisition, or partnership deals or completing deals underway in the next 12–18 months, and only one in four respondents (25%) say they have no MAP plans. Given that nearly all providers will be impacted by this trend in one form or another, detailed information on the merger and acquisition trend is a must-read for industry executives.

A year's worth of healthcare industry research has been collected and published in one place for your convenience. Read on to discover the data and results behind the most important trends in the industry.

Jonathan Bees is senior research analyst for HealthLeaders Media. He may be contacted at *jbees@healthleadersmedia.com*.

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METHODOLOGY

The *2016 Healthcare Industry Data Almanac* was compiled by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is a combination of a series of monthly Thought Leadership Studies. A total of roughly 250 individuals completed each survey. These of individuals, known as members of the Council, collectively offer insights on the shifting healthcare climate to inform their peers and the industry at large of operative strategies, existing challenges, and solutions. This combination of analysis and forecasting is critical for your strategic planning for 2017.

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

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SECTION ONE

Succeeding in the Risk Era:

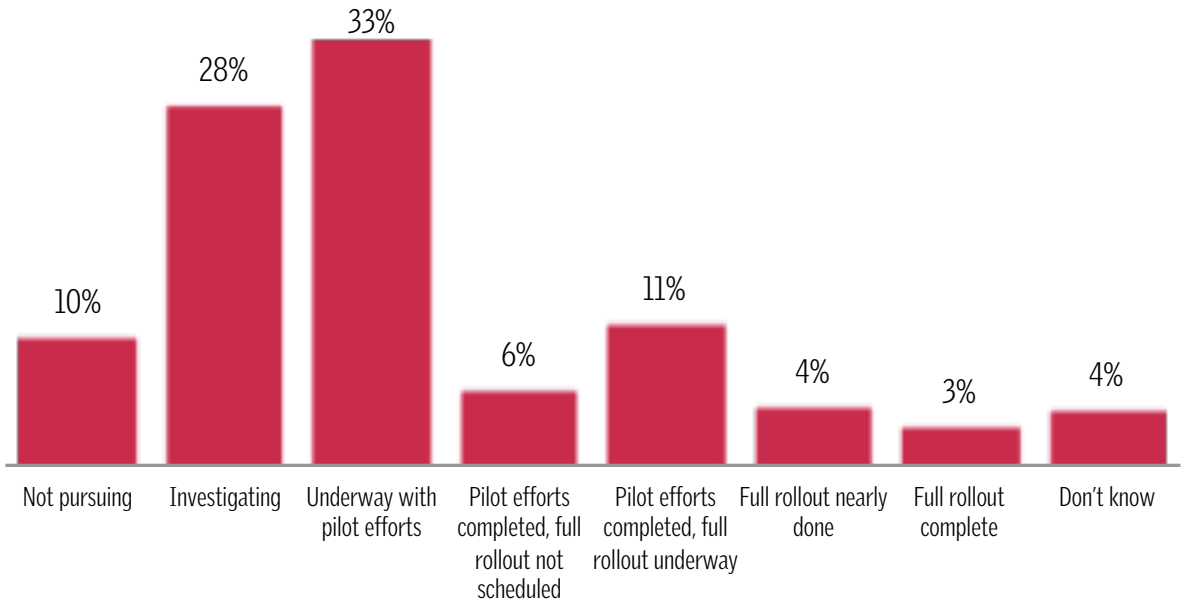
How to Accelerate Progress Toward a Value-Based Future

FROM THE HEALTHLEADERS MEDIA 2015 INDUSTRY SURVEY

SURVEY RESULTS

FIGURE 1: **Status of Providing Value-Based Care**

Q What is your organization's status regarding making the transition from providing care on a fee-for-service basis to providing value-based care?



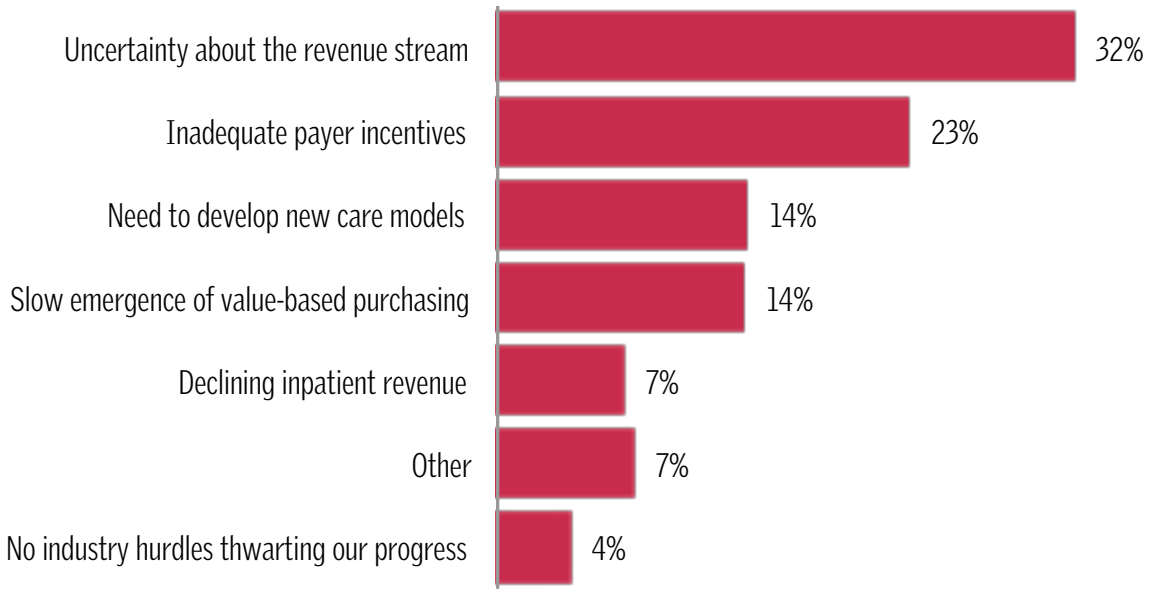
Base = 580

Scale is important, as evidenced by greater pursuit of value-based care among larger organizations compared to smaller ones. Larger organizations are able to draw from a larger patient population, have systems to monitor results in place (or the ability to develop them), and are able to effect changes needed in care provision. Of course, larger organizations also have the financial strength to embark on a resource-intensive activity while remaining somewhat unclear about when and from where a return will be realized.

SURVEY RESULTS

FIGURE 2: **Main Industry Hurdle Preventing Transition to Value-Based Care**

Q What do you see as the main *industry* hurdle preventing your organization from pursuing the transition to value-based care with more vigor?



Base = 538

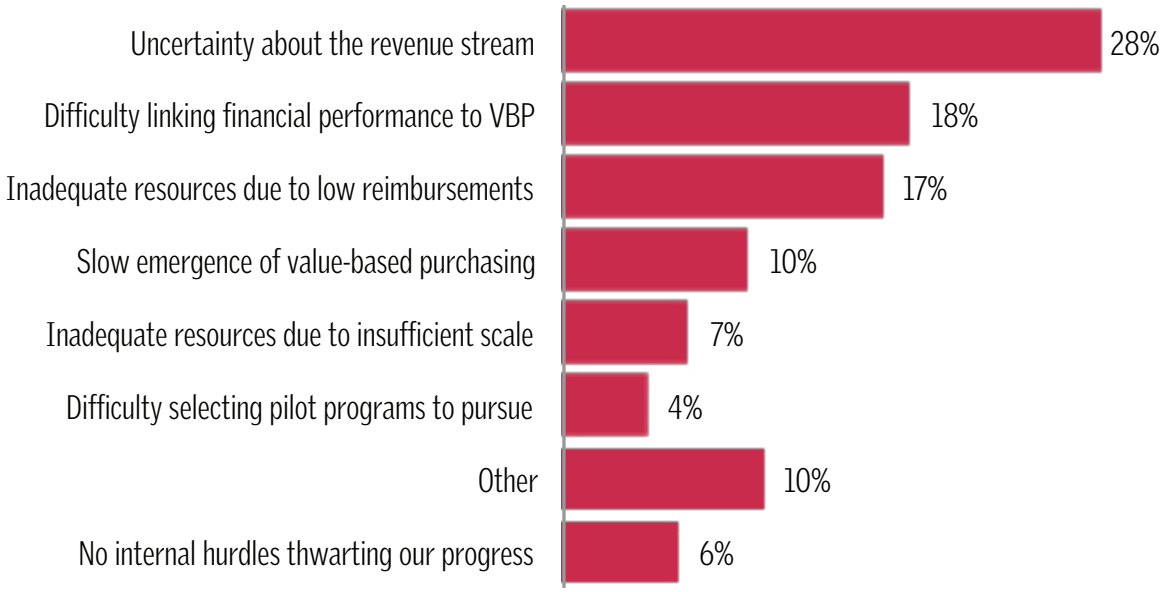
Among those who have not completed full rollout and know status.

Despite a substantial percentage of organizations investigating or pursuing value-based care, a relatively small percentage is moving beyond pilots today. Uncertainty about the revenue stream is identified as a main hurdle. A refocus from delivering episodic care to providing population health is complex and multifaceted; the investments required may force decision-makers to look for assurances that their organization's pilot efforts will ultimately be extendable. Finally, neither operational change nor capital investments can be too far ahead of anticipated reward. Hence, we see uncertainty, which can be (speaking broadly) attributed to a new and unfamiliar business model.

SURVEY RESULTS

FIGURE 3: **Main Internal Hurdle Preventing Transition to Value-Based Care**

Q What do you see as the main *internal* hurdle preventing your organization from pursuing the transition to value-based care with more vigor?



Base = 538

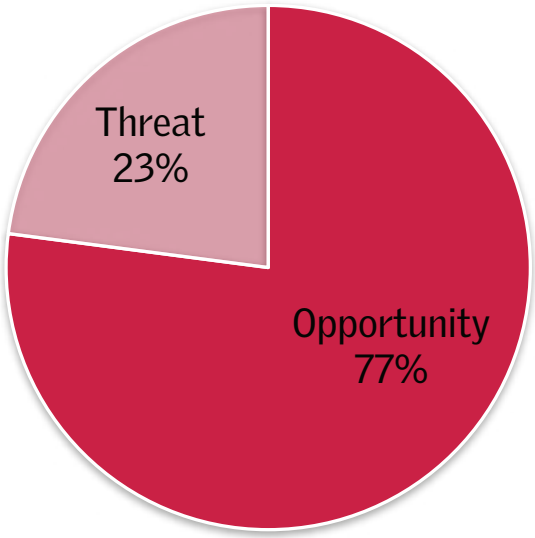
Among those who have not completed full rollout and know status.

The population health management objectives behind value-based care are real enough, and they align very closely with the direction of healthcare reform. Important steps are being made in delivering care in a more efficient and less costly manner. But the changes are significant enough that efforts can proceed only so far without a corresponding change to revenue models.

SURVEY RESULTS

FIGURE 4: **Threat or Opportunity in Outpatient Settings**

Q From a financial perspective, would you say that the trend toward more care in outpatient settings represents an opportunity or a threat for your organization?



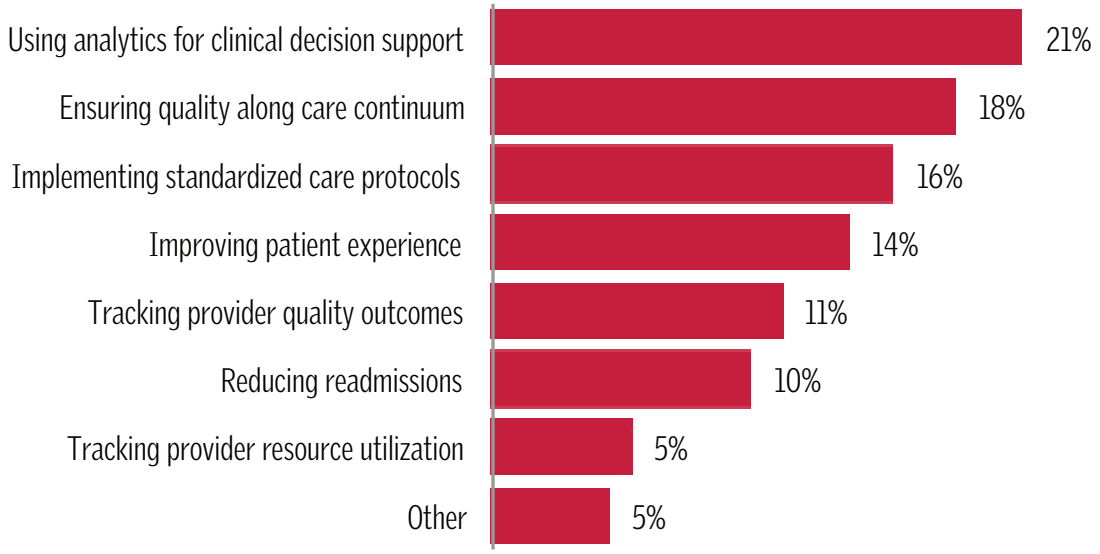
Base = 580

Caring for patients in less costly outpatient settings is seen as an opportunity by the majority of respondents, despite the likelihood of reduced utilization of acute care services. Based on follow-up comments, there is broad recognition that, considering the unsustainability of the present economics of care delivery, the outpatient setting is a way to provide care in a more economical fashion. Growth is another factor. Said an executive from a large health system, "It is the only opportunity for growth—albeit at smaller margins, and you have to learn to compete in the retail world."

SURVEY RESULTS

FIGURE 5: **Greatest Challenge in Clinical Quality Improvement**

Q Regarding clinical quality improvement, which of the following areas represents the single greatest challenge for your organization?



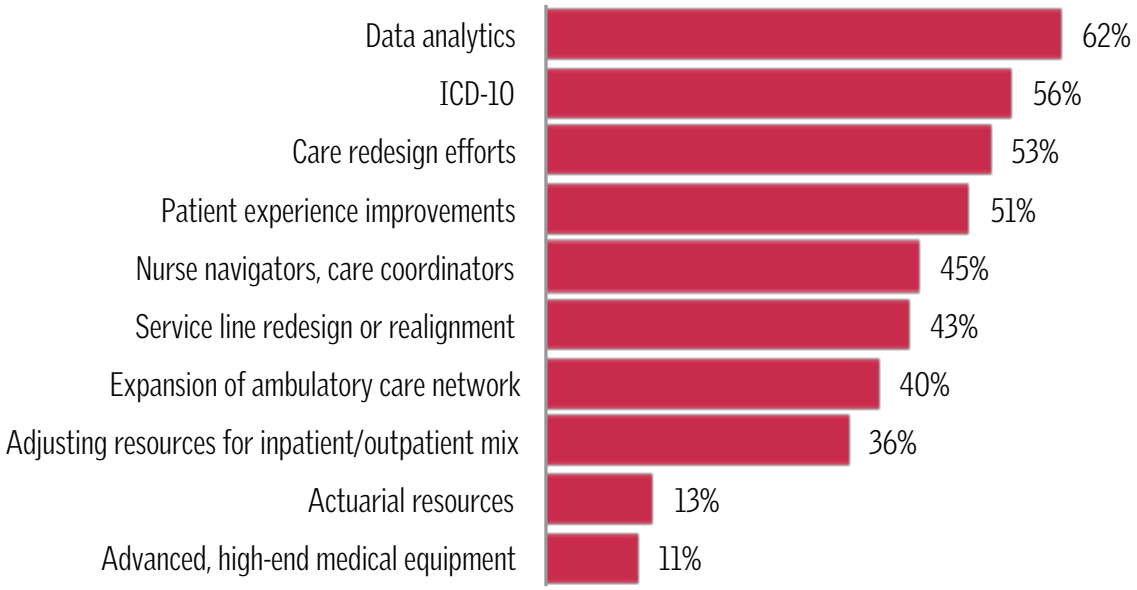
Base = 573
Among applicable

With no single item mentioned by more than 21% overall, it appears that a broad set of clinical quality issues challenge organizations. We observe 11% of respondents from hospitals saying that implementing standardized care protocols is their greatest challenge, and twice that percentage (22%) in respondents from health systems. It may be that health systems have the additional burden of standardizing across a set of hospitals, where coordinating such an activity in a stand-alone institution would be less problematic.

SURVEY RESULTS

FIGURE 6: **Investment Areas Over Next Three Years**

Q In which of the following does your organization expect to begin or increase investment over the next three years?



Base = 573, Multi-Response

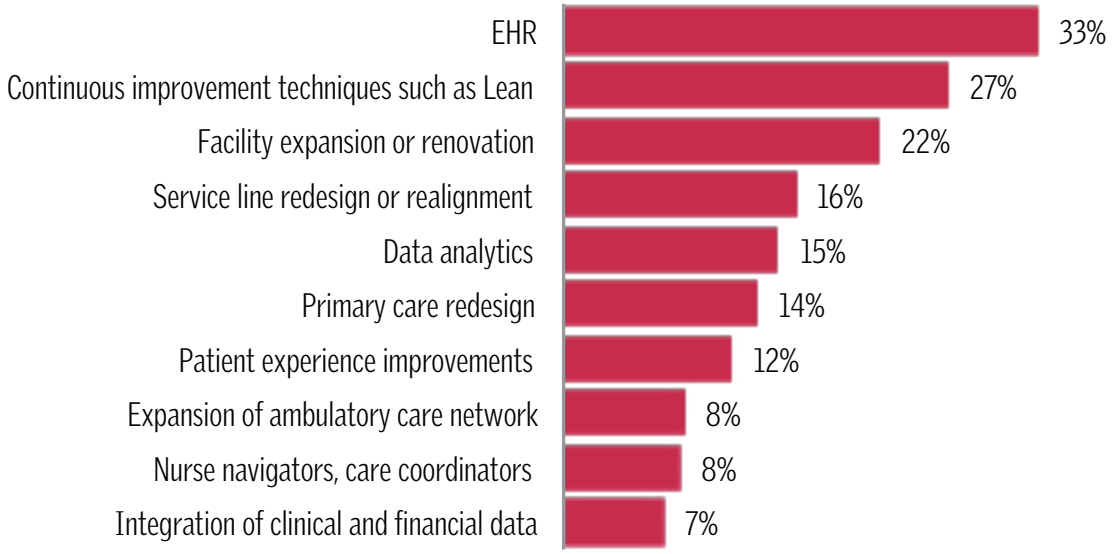
Among those who expect to begin or increase investment.

That higher percentages of health systems than hospitals expect to invest in data analytics is an indication of the complex nature of infrastructure enhancements at health systems. Larger organizations may have the scale, scope, and skilled staffing to take on more challenging activities such as care redesign and data analytics.

SURVEY RESULTS

FIGURE 7: **Investments That Have Been a Waste of Money**

Q When you reflect on your organization's investments in the following over the past few years, which would you describe as largely a waste of money?



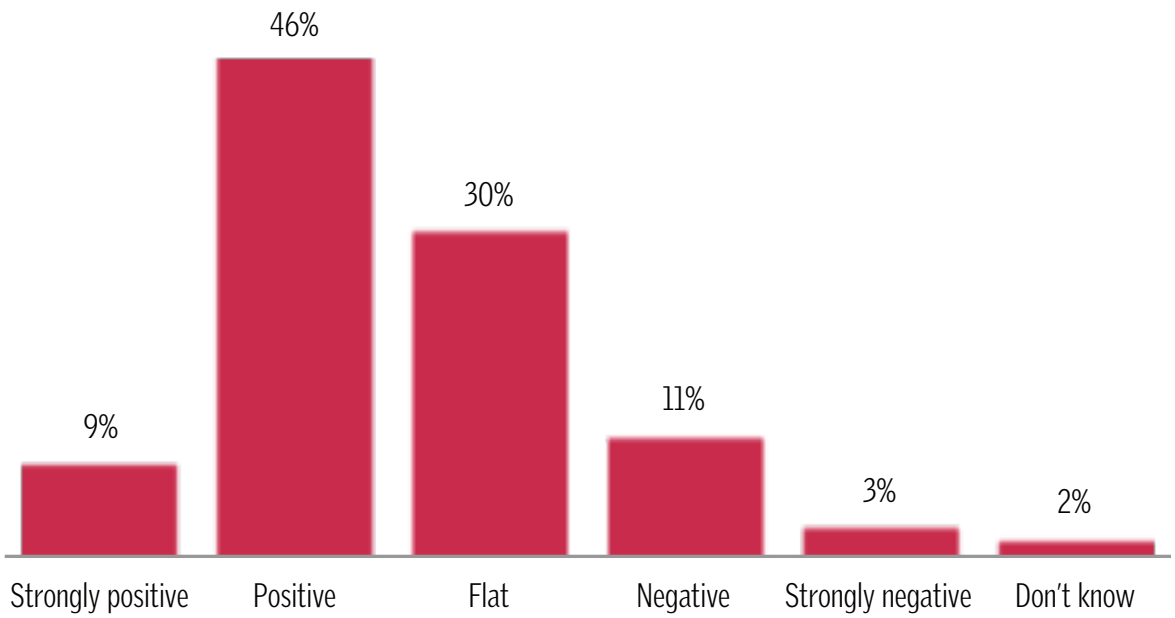
Base = 332, Multi-Response
Among those who indicate areas of waste

It is unfortunate that 57% of respondents (up from 51% last year) report that at least some of their investments proved to be largely a waste of money. Likewise, it seems quite severe that one-third of that group say their investments in EHRs have been largely a waste, considering the pivotal role that EHRs are to play in virtually all aspects of care. A report advisor suggests that while the EHR is a necessary infrastructure investment, the return on this investment depends on an organization's success in a range of activities, such as connecting sites of care, performing analytics on integrated sets of information, and eventually seeing return through a business model that rewards value.

SURVEY RESULTS

FIGURE 8: **2015 Financial Forecast**

Q What is your organization's financial forecast for the 2015 fiscal year?



Base = 580

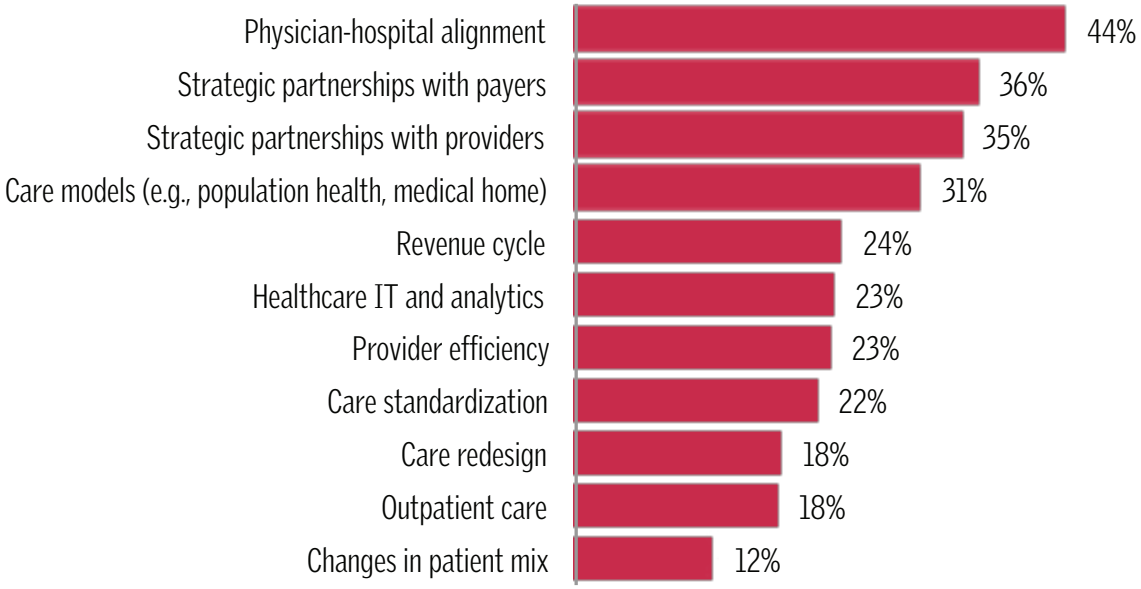
The comparative pessimism on the part of hospitals, with only 43% expecting positive financial results compared to 55% of overall respondents, might be the result of participating in an industry that favors organizational might. Even though the industry is undergoing another round of provider consolidation, healthcare payers are relatively few and comparatively powerful, which is why size is becoming more important.

The percentage of physician organizations that expect positive or strongly positive returns (63%) is slightly higher than health systems (60%). For the most part, physician organizations represent a pivotal infrastructure component in implementing healthcare reform.

SURVEY RESULTS

FIGURE 9: **Areas That Will Have Greatest Positive Influence on Reaching Financial Targets in Next Three Years**

Q Which of the following are the three areas that will have the greatest positive influence on your efforts to reach your organization's financial targets over the next three years?



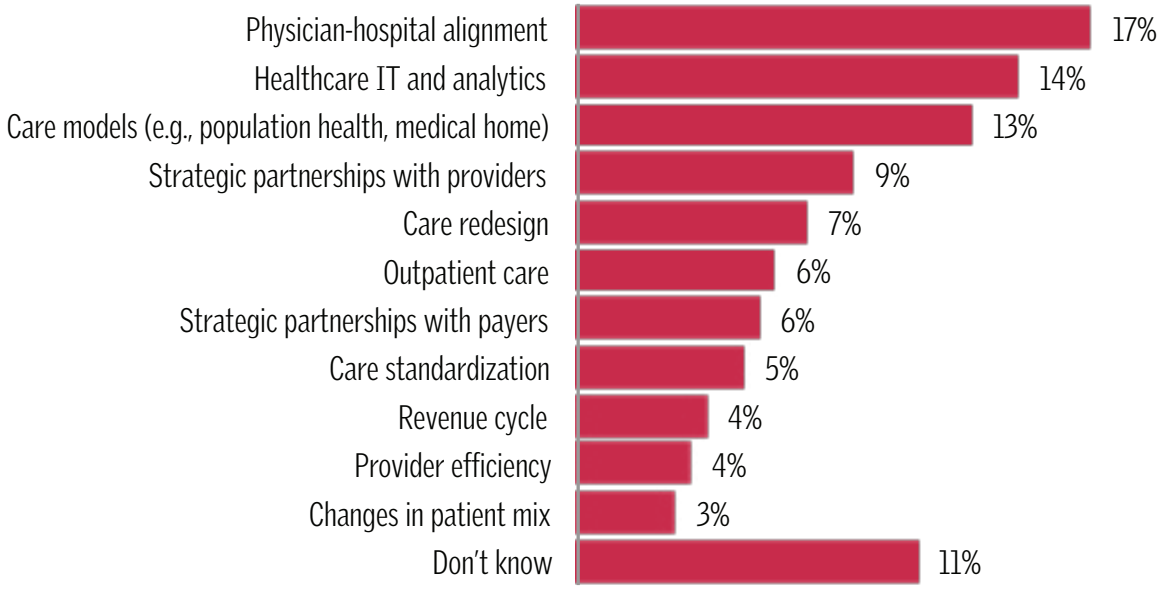
Base = 580, Multi-Response

Hospitals and health systems recognize that physicians are the key to both clinical and financial aspects of healthcare reform, so physician alignment is on the top of the list of influencers of financial success. The other items in the overall top three—strategic partnerships with payers (36%) and with providers (35%)—are indications that leaders recognize the need to forge new and stronger working relationships with both.

SURVEY RESULTS

FIGURE 10: **Area Requiring Largest Investment to Reach Financial Targets Next Three Years**

Q Of those, which area will require the largest investment?



Even though items such as care standardization (5%) and care redesign (7%) were selected by smaller percentages than physician alignment (17%) as a top influencer of financial success requiring the highest investment, those very activities will be part of the industry's move toward delivering value-based care. It is likely that physician alignment is identified by more respondents as requiring the largest investment because changes such as care standardization and care redesign require an engaged physician community.

SURVEY RESULTS

FIGURE 11: **Fueling Financial Growth Next Five Years**

Q How will your organization fuel financial growth over the next five years?

Expand outpatient services	63%
Strategic marketing campaign for existing market	43%
Develop or join an ACO or PCMH	39%
Acquire or merge with physician organizations	36%
Strategic marketing campaign for new market	34%
Acquire or merge with hospitals	27%
Develop or partner with convenient care facility	22%
Acquire or develop a health plan business unit	18%
Increase inpatient bed capacity	9%

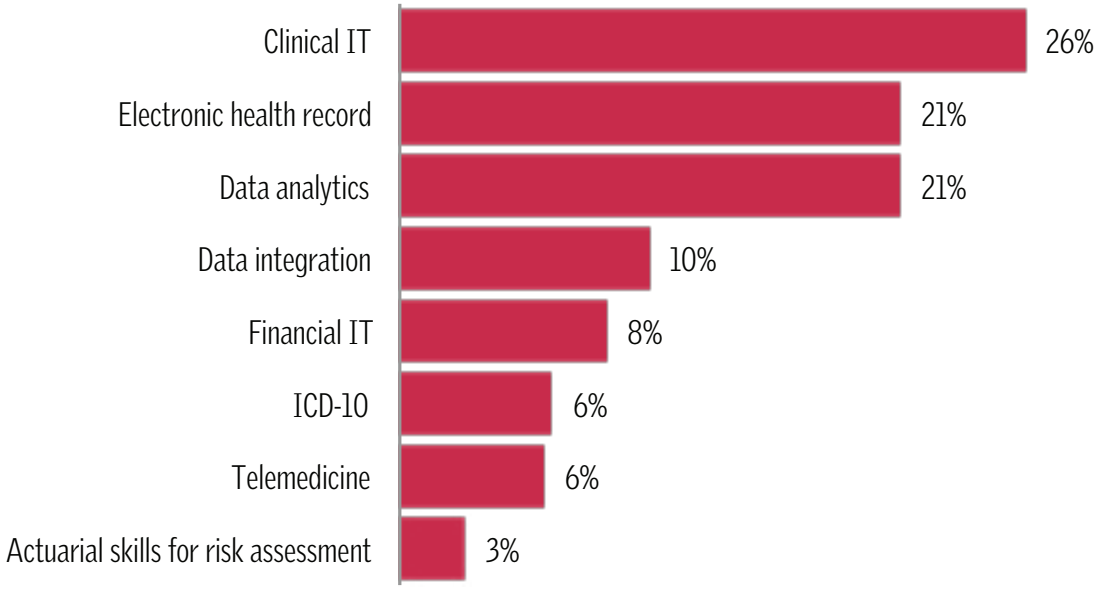
Base = 580

Observing the dominance of outpatient services as a mechanism to fuel future growth, we can see that healthcare leaders understand the need to provide care in a more cost-effective fashion while improving accessibility. This year's 63% is consistent with last year's 60%. In some cases, outpatient expansion is executed though mergers or acquisitions with physician organizations, which is considered a growth strategy by 36% of respondents, up slightly from 32% last year.

SURVEY RESULTS

FIGURE 12: **No. 1 Ranked Healthcare IT Area in Strategic Importance to Reaching Financial Targets Next Three Years**

Q Of the following areas of healthcare IT, please rank the top three according to their strategic importance in supporting your organization's efforts to reach its financial targets over the next three years.



Base = 580

Looking at the items on top of the chart, we can see how the IT function factors into the response to compelling current demands, such as supporting caregivers (clinical IT), maximizing the benefit from the organization's EHR, and supporting both clinical and administrative functions with data analytics. An important future-oriented activity, using actuarial skills to assess risk, is far down the priority list, with only 3% selecting it as No. 1 in strategic importance. In the future, as risk-based compensation becomes an important part of payer-provider relationships, approaching payer negotiations with confidence may require the application of actuarial skills to ensure an advantageous risk-reward ratio.

SURVEY RESULTS

FIGURE 12 BONUS CHART: **Investment Required for No. 1 Ranked Healthcare IT Area in Strategic Importance**

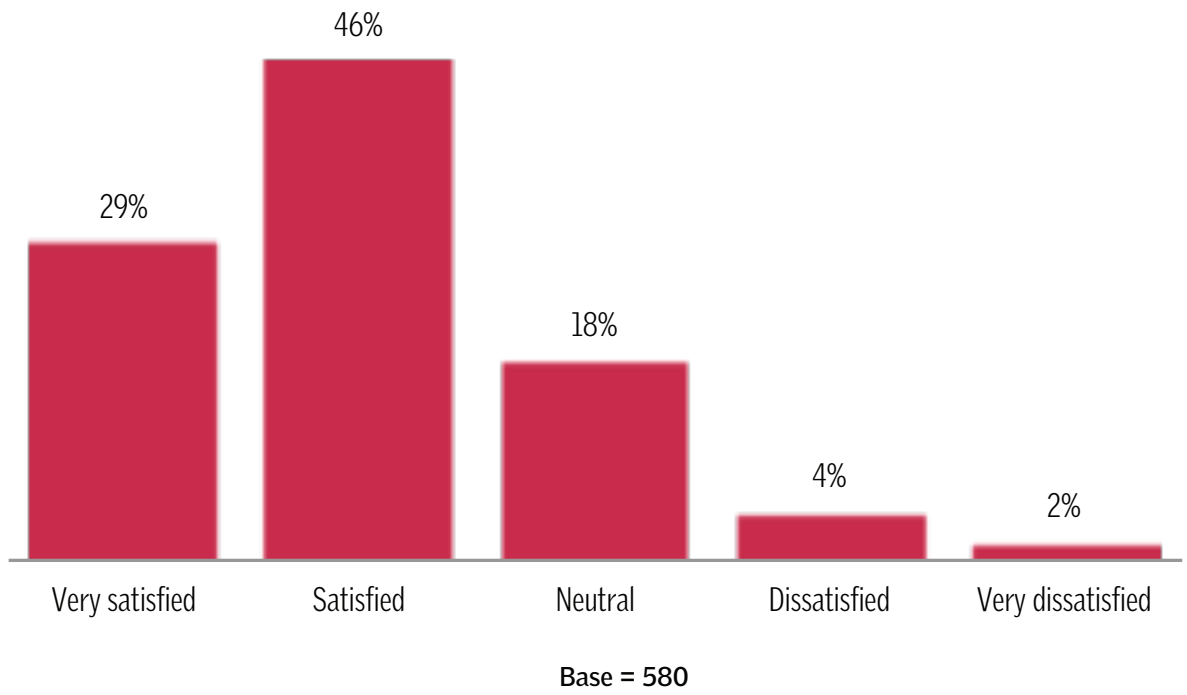
Q How would you describe the new investment required for the area of healthcare IT that you ranked as No. 1 in strategic importance?

	No new investment needed	Minor new investment needed	Major new investment needed	Don't know	Base
Clinical IT	3%	40%	53%	3%	149
Electronic health record	9%	38%	45%	8%	119
Data analytics	1%	39%	55%	5%	119
Data integration	3%	34%	51%	12%	59
Financial IT	4%	41%	43%	12%	49
ICD-10	8%	33%	42%	17%	36
Telemedicine	3%	41%	56%	0%	34
Actuarial skills for risk assessment	7%	27%	53%	13%	15

SURVEY RESULTS

FIGURE 13: **Job Satisfaction**

Q Describe your overall job satisfaction.



Base = 580

The percentage of CEOs reporting that they are satisfied or very satisfied (79%) is just about the same as recorded overall (75%). But a higher percentage of CEOs (37%) than respondents overall (29%) say they are very satisfied.

We should not take much solace in a 75% satisfaction rate. First, over the seven years that HealthLeaders Media has collected responses, we have seen slow and steady erosion. Second, 75% satisfied means that one-quarter are either dissatisfied or neutral about their jobs, which leaves a relatively high percentage of leaders that may lack enthusiasm—it's hard to imagine being an effective leader without it.

SURVEY RESULTS

FIGURE 14: **Overall Performance for Various Groups**

Q How would you rate the current overall performance of the following groups in your organization?

	Very strong	Strong	Neutral	Weak	Very weak
Leadership team	28%	43%	19%	9%	1%
Board of trustees	22%	41%	27%	6%	3%
Nursing staff	17%	51%	25%	7%	0%
Finance staff	17%	48%	24%	9%	2%
Physician staff	15%	45%	28%	11%	1%
IT staff	15%	39%	29%	13%	3%
Frontline staff	13%	49%	31%	6%	0%
Data analytics staff	8%	32%	34%	20%	5%
Midlevel managers	8%	42%	36%	13%	2%

Base = 580

As the industry strives to deliver better-quality healthcare at lower costs, IT skills in general and analytics expertise in particular will be vital. Yet when appraising their organization's strength, healthcare leaders rate both disciplines at or near the bottom of the chart. This should be of some concern because analytics is a key component in directing both decision-making and performance monitoring, including risk-bearing strategies, population health management, physician productivity, utilization, and performance-based incentives.

SURVEY RESULTS

FIGURE 15: **Performance for Various Areas**

Q How would you rate your organization's current performance in the following areas?

	Very strong	Strong	Neutral	Weak	Very weak
Fiscal management	21%	46%	24%	8%	1%
Prospects for growth	21%	46%	22%	10%	1%
Strategic planning	16%	39%	26%	15%	3%
Physician recruitment and retention	13%	41%	32%	12%	2%
Collaboration/relationships with providers	12%	48%	30%	10%	1%
Physician-hospital alignment	12%	41%	33%	12%	2%
Capacity management	9%	41%	38%	11%	1%
Collaboration/relationships with payers	9%	39%	37%	14%	2%
Strategic marketing	8%	31%	35%	21%	6%
Price transparency	6%	29%	36%	24%	5%

Base = 580

CEOs, who may indeed be more involved with strategic planning, have a more positive appraisal of strategic planning strength than the group overall. Only 11% of CEOs say their organization is very weak or weak at strategic planning, compared to 18% overall.

SURVEY RESULTS

FIGURE 16: **Performance for Various Functions**

Q How would you rate your organization's current performance in the following functions?

	Very strong	Strong	Neutral	Weak	Very weak
Dedication to mission	42%	41%	14%	3%	0%
Clinical quality and patient safety	31%	51%	16%	2%	0%
Patient experience	18%	46%	26%	10%	1%
Care coordination	11%	42%	35%	11%	1%
Cost control	11%	47%	28%	14%	1%
Financial/business analytics	10%	41%	33%	14%	2%
Healthcare IT	10%	41%	32%	14%	4%
Clinical analytics	5%	32%	37%	23%	4%
Population health management	4%	25%	38%	24%	9%

Base = 580

Population health has the dubious distinction among functions surveyed of earning the lowest percentages declaring strength (29% combined strong and very strong) and the highest declaring weakness (33% combined weak and very weak). Population health management is a multifaceted activity, quite demanding of IT support, which has two positions of its own near the bottom of the chart. However, elsewhere in our survey, IT is identified as being a top area for investment, indicating both recognition of the importance of IT and a commitment to move forward.

SECTION TWO

Ready, Set, When?

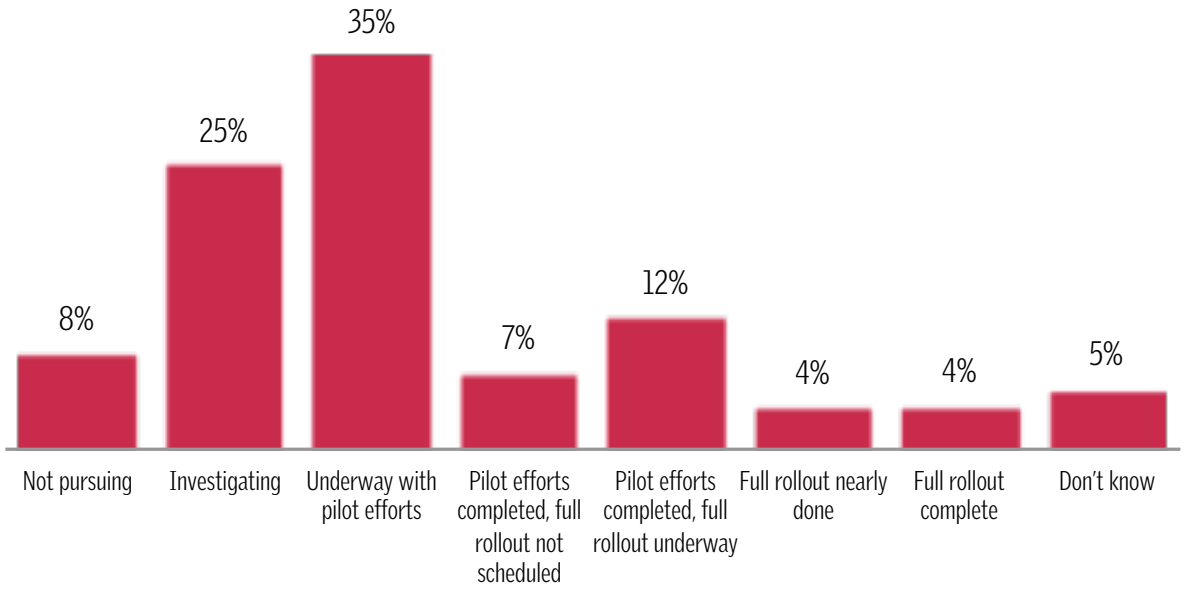
The Drawn-Out Shift to Value

FROM THE HEALTHLEADERS MEDIA 2016 INDUSTRY SURVEY

SURVEY RESULTS

FIGURE 1: **Status of Providing Value-Based Care**

Q What is your organization's status regarding making the transition from providing care on a fee-for-service basis to providing value-based care?



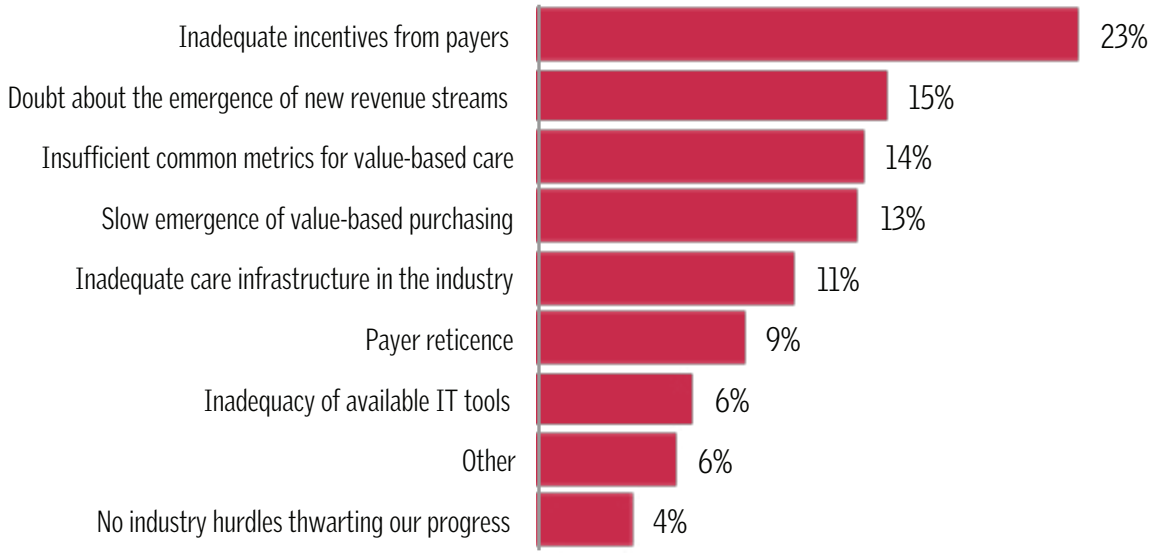
Base = 471

When comparing the response to last year's findings, we see only slight shifts, which reinforces both the magnitude of the task and leaders' reluctance to make a full commitment while details of emerging but still largely unknown payment models are unresolved.

SURVEY RESULTS

FIGURE 2: **Main Industry Hurdle Preventing Transition to Value-Based Care**

Q What do you see as the main ***industry*** hurdle preventing your organization from pursuing the transition to value-based care with more vigor?



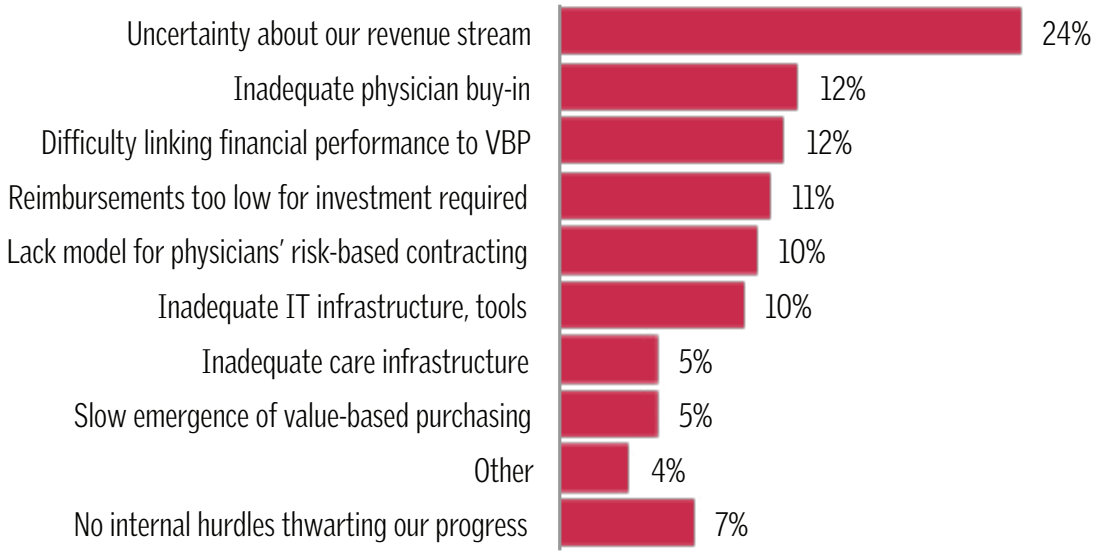
Base = 417
Among those without full rollout

As providers look toward delivering value-based care, their concern about revenue is evident. The two items mentioned most frequently—inadequate incentives from payers and doubt about revenue streams—are directly related to revenue, and other items such as metrics, mentioned nearly as often, are indirectly related to revenue.

SURVEY RESULTS

FIGURE 3: Main Internal Hurdle Preventing Transition to Value-Based Care

Q What do you see as the main ***internal*** hurdle preventing your organization from pursuing the transition to value-based care with more vigor?



Base = 417
Among those without full rollout

As we observed with industry hurdles, revenue is the hurdle cited most frequently. In the second tier, but still important, is the issue of physician engagement. With only 5% picking care infrastructure as their main hurdle, it is clear that healthcare leaders generally are confident enough about their organization's patient-care abilities.

SURVEY RESULTS

FIGURE 4: **Threats and Opportunities**

Q Does your organization consider each of the following to be mostly a threat or mostly an opportunity?

	Threat	Opportunity	Don't know
Payer consolidation	63%	18%	19%
Retail healthcare (e.g., pharmacies, big-box stores)	51%	26%	23%
Industry movement toward full capitation	47%	33%	20%
CMS' value-based payment efforts	33%	51%	16%
Provider consolidation	30%	53%	16%
Shared risk, shared reward payments	22%	63%	15%
Care continuum relationships, financial	21%	63%	16%
Clinical integration	8%	88%	4%
Health information exchange	7%	84%	9%
Patient as consumer	7%	85%	8%
Care continuum relationships, clinical	6%	88%	6%

Base = 468

With a nearly universal perception that clinical integration and care continuum relationships present opportunity, the industry shares an understanding of the core activities necessary to provide better care at lower cost.

SURVEY RESULTS

FIGURE 4a: **Threats From Provider Consolidation**

Q What is the principal way that your organization is threatened by provider consolidation, and what tactics do you use—and plan to use—to mitigate that threat? Selected responses.

PRINCIPAL THREAT FROM PROVIDER CONSOLIDATION	MITIGATION TACTIC	TITLE/SETTING
Patients are drawn into the large systems and are increasingly kept inside those systems. The issue is that risk-based payment arrangements make patient loyalty within the system a very high priority, and this activity also boosts financial performance and market share in the short term.	We must be better at the things we do than our competitors and have seamless patient transitions to (and from) the tertiary level.	CEO, large hospital
Threat from ACOs to relegate us to last tier; penalize patients from seeking our service.	Have a strong bond with our patients; have proven our value to patients, most of whom do not care about ACO, etc.	Principal owner, small physician organization
Consolidation is forcing everyone into larger systems and what will be the backlash?	We are looking for strategic partner(s) while still strong.	Chief medical officer, medium hospital
Not being able to negotiate as well with other providers and payers.	Look to consolidate ourselves with other providers and entities.	CEO, medium physician organization
More consolidation and control over reimbursement threatens the ability to have multiple revenue streams.	Achieve care excellence awards to attract more business from payers.	Director of quality, small hospital
If systems grow too big they might not need specialty services like us.	Build ties and clinical integration now.	VP of marketing and sales, medium hospital
Increased scale and leverage as a result of M&A efforts, which results in smaller number of players with greater reach and influence, creating two distinct groups of providers, where one is acquired or at worst, no longer exists.	Identify opportunities to improve scale and compelling value proposition while identifying strategic partnerships and opportunities that increase access to capital, and support improved capabilities specific to care models or geography	VP of operations, medium hospital
Larger organizations will have leverage with payers, consumers, employers.	Emphasize quality of care, value of care, access to care, patient experience.	Medical director, medium health system
Less opportunity for diversity of referrers using us. If you aren't the chosen with the big shop, you are out of business. We are long-term care, so this is not as relevant.	Relationship building, reducing ALOS faster than industry, active participation to help develop clinical pathways extending to LTC, our industry.	Chief financial officer, long-term care/SNF

SURVEY RESULTS

FIGURE 4b: **Benefits From Provider Consolidation**

Q What is the principal benefit that your organization is seeing or expects to see from the opportunity presented by provider consolidation, and what tactics do you use—and plan to use—to enhance that opportunity? Selected responses.

PRINCIPAL BENEFIT FROM PROVIDER CONSOLIDATION	ENHANCEMENT TACTIC	TITLE/SETTING
Sharing of infrastructure cost necessary to survive in the future allowing lower operating costs. Ability to have a seat at the table when decisions are made in our markets.	Cost reduction, common EMR, clinical integration with physicians.	CEO, large physician organization
Economies of scale. Consolidation of knowledge management/utilization. Continuity of care for patients, especially if patient information can be included in consolidated data repository.	Negotiation for shared services in government regulation compliance, negotiation with health plans, synchronized marketing.	Chief financial officer, small hospital
Ability to cross-subsidize lower-paying specialties from higher-revenue-producing practitioners.	ACO development to gain experience in anticipation of value-based provision of care taking hold in the commercial marketplace.	Medical director, large hospital
Aligned strategy between hospital and doctors. Ability to better control health outcomes due to reduction in care variables.	Choosing common EHR platform, engaging consolidated physician groups in bundle program.	Administrator, small health system
As a provider organization, opportunity to expand the number of practice lines we have at a given location.	Clinical integration across hospital-based departments; coordination with outpatient and community care settings.	VP of marketing & sales, large physician organization
Clinical integration with common care pathway development.	Development of multidisciplinary teams with all stakeholders having input.	Chief medical officer, large health system
Elimination of weaker SNF providers in an over-bedded state.	Promote our advanced clinical practices.	Vice president, SNF
Possible better access to capital.	Look at potential consolidation with other providers.	Chief financial officer, large hospital
Participation in a clinically integrated network will preserve our position in the food chain.	Join the network early and participate in its formation and governance.	CEO, medium physician organization
Rationalization of services across platform.	ACO formation as potential lead to economic integration.	Chief financial officer, large health system
Increase in number of lives. More access to best specialists.	Purchasing private practices.	Vice president of operations, medium health system
Mutual financial benefit. Benefit in greater patient population to serve, higher numbers, better quality.	Financial, distribution of quality data, internal and individual.	Service line director, medium health system

SURVEY RESULTS

FIGURE 5: **Investment Areas Over Next Three Years**

Q Which of the following best describes that contractual relationship?

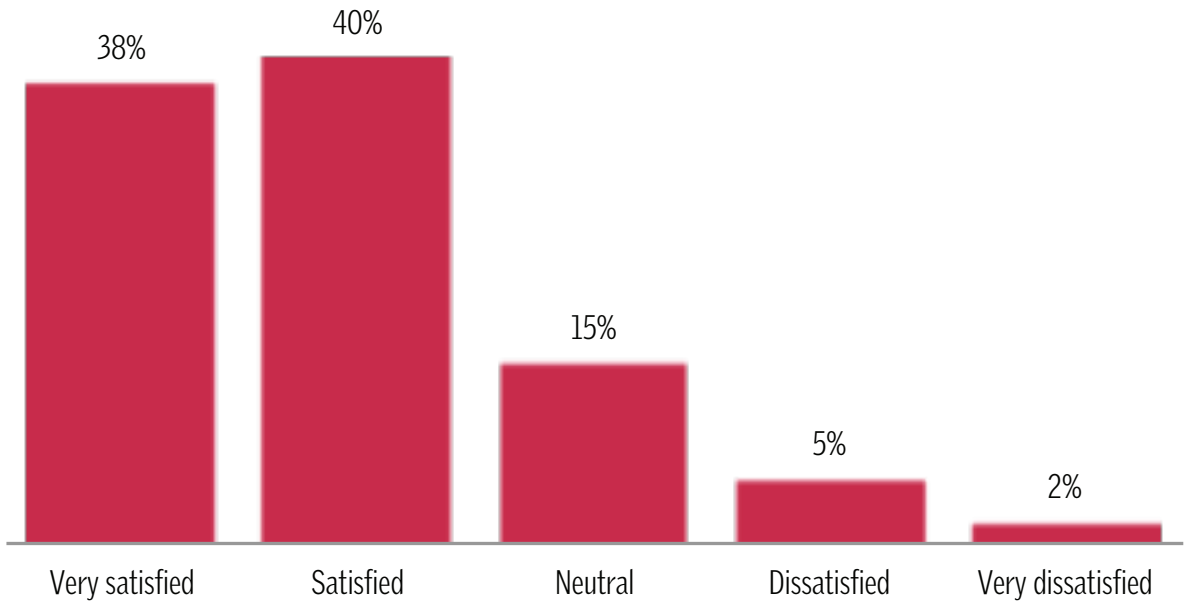
	2016 Base = 462
Data analytics	74%
Patient experience improvements	65%
Care redesign efforts	64%
Care coordinators	60%
Expansion of ambulatory care network	51%
ICD-10	49%
Service line redesign or realignment	48%
Adjusting resources for inpatient/outpatient mix	39%
Nurse navigators	33%
Actuarial resources	16%

The areas experiencing the highest increases in investment are related to continuing focus on risk-based or value-based activities. Reform-related reimbursement penalties drive investments in patient experience, up 14 points over last year. Managing populations is an analytics-driven pursuit, and the percentage expecting to invest in analytics has increased 12 points. Care redesign, up 11 points, addresses both cost efficiency via utilization management and patient-related factors such as access to care and better care coordination. Expansion of ambulatory care networks, also up 11 points over last year, improves access to care and, for many, increases efficiency through clinical integration.

SURVEY RESULTS

FIGURE 6: **Job Satisfaction**

Q Describe your overall job satisfaction.



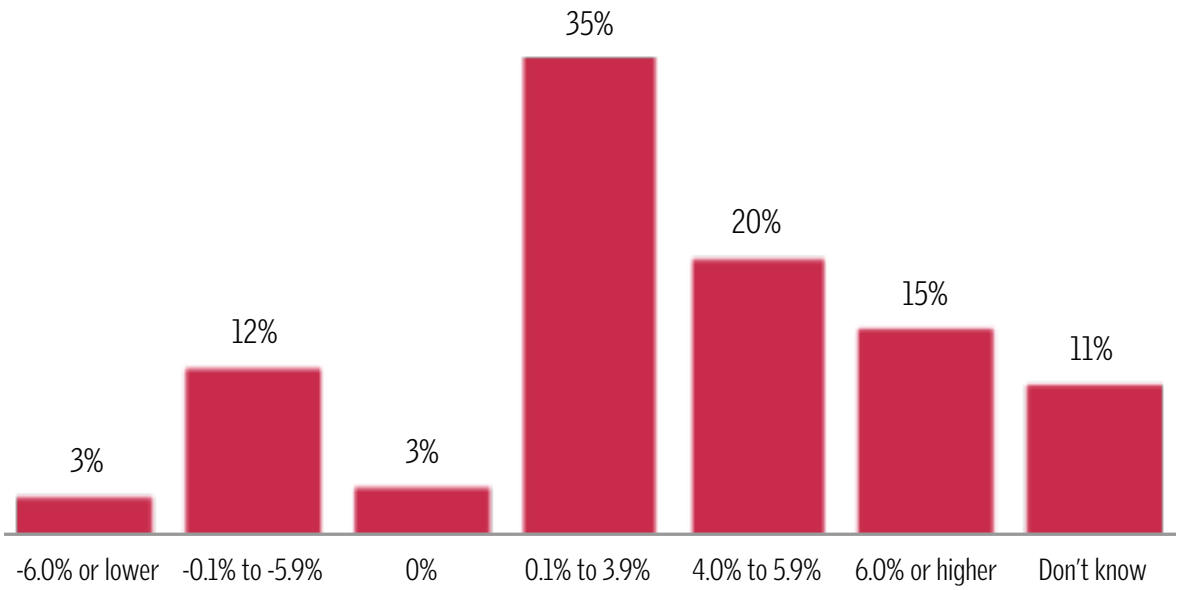
Base = 471

The executive team will be challenged by healthcare reform, with an uncertain revenue picture and the need to deliver care in a collaborative and episodic fashion. Although we see the majority reporting they are satisfied, attention must be paid to the 22% who are neutral or dissatisfied.

SURVEY RESULTS

FIGURE 7: **Operating Margin**

Q For the most recent fiscal year, what is your best estimate of your organization's operating margin, in negative or positive percentages?



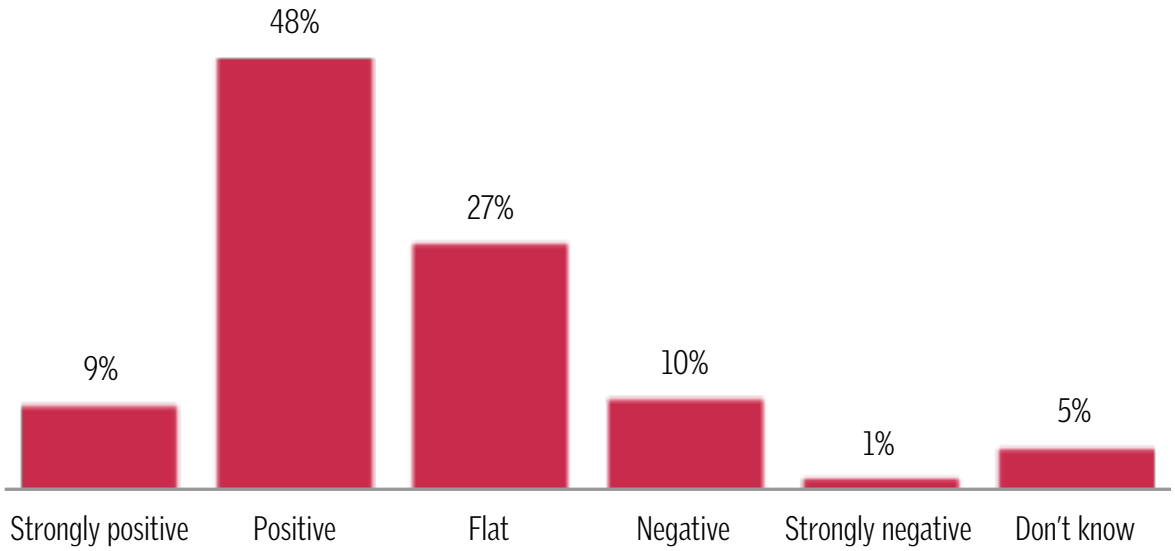
Base = 471

The response pattern helps us identify a cluster of organizations facing serious financial challenges—one-fifth of those with net patient revenue lower than $250 million report negative operating margins. Executives in those organizations must be relentless about monitoring revenue, expenses, and efficiency. Such organizations have limited ability to allocate resources. They may not be able to pursue the value-related activities that will be vital for their eventual survival.

SURVEY RESULTS

FIGURE 8: **2016 Financial Forecast**

Q What is your organization's financial forecast for the 2016 (or current) fiscal year?



Base = 471

At least a portion of low-revenue organizations may have difficulty changing course. We can see that the present environment is a difficult one for engineering a financial turnaround by observing that one-third (35%) of those who reported a negative operating margin in Figure 7 also expect negative financial results for the present fiscal year. But 25% of those who report a negative operating margin expect positive financial results. Among those reporting positive margins of between 0.1% and 3.9% in the most recent fiscal year, fully 9% expect to dip into the red in the current fiscal year.

SURVEY RESULTS

FIGURE 9: Areas That Will Have Greatest Positive Influence on Reaching Financial Targets in Next Three Years

Q Which of the following are the top three areas that will have the greatest positive influence on your efforts to reach your organization's financial targets over the next three years?

	2016 Base = 471
Cost control	46%
Physician-hospital alignment	38%
Strategic partnerships with providers	33%
Care models (e.g., population health, medical home)	31%
Strategic partnerships with payers	28%
Revenue cycle	24%
Expansion of ambulatory/outpatient care	23%
Care standardization	22%
Healthcare IT and analytics	22%
Care redesign	19%

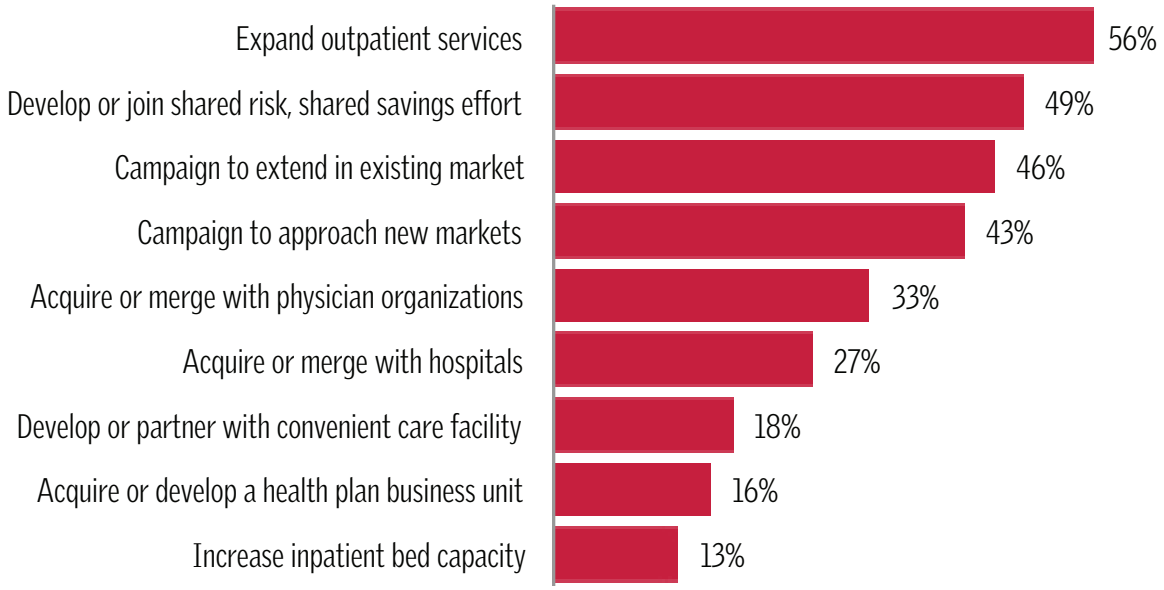
Multi-Response

Care redesign is the item mentioned fourth most frequently by those from high-revenue organizations. The connection between care redesign and delivering value-based care, and its high position among high-revenue organizations as a financial lever, is an indication that fundamental aspects of healthcare reform are being pursued.

SURVEY RESULTS

FIGURE 10: **Fueling Financial Growth Next Five Years**

Q How will your organization fuel financial growth over the next five years?



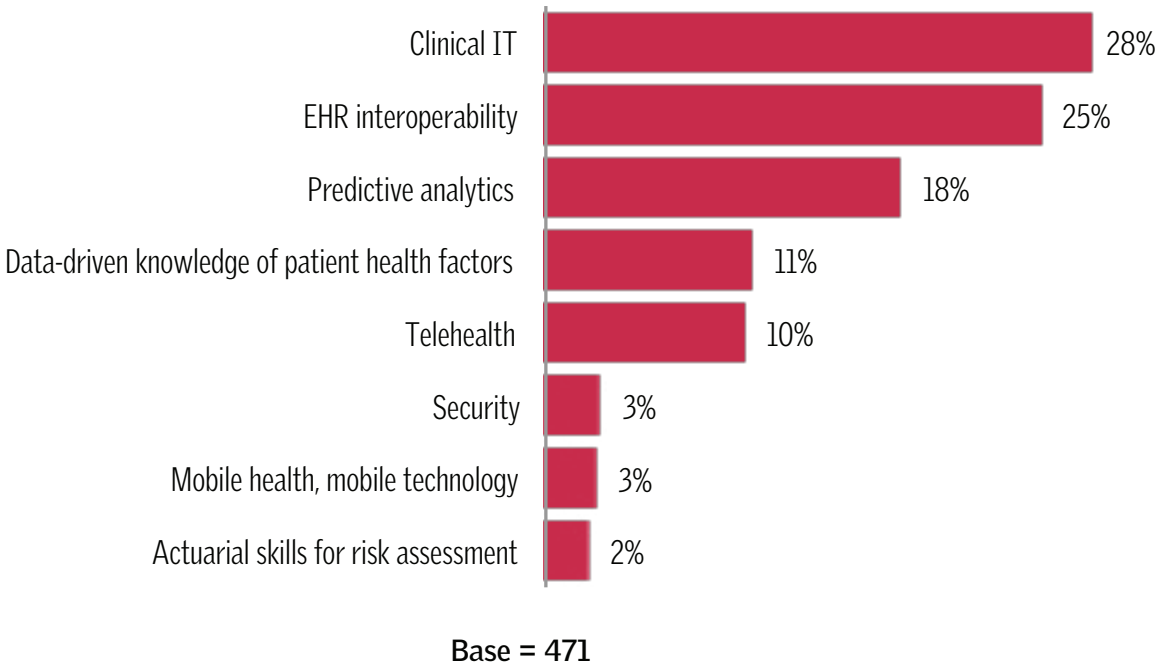
Base = 471

Last year, expansion via outpatient services clearly occupied the top position with 63%, and the item with the second most frequent mentions was marketing efforts addressing existing markets, 20 points fewer. This year, shared risk/shared savings efforts are second, separated from outpatient services by only seven points, indicating strong attention to risk-based payment models.

SURVEY RESULTS

FIGURE 11: **No. 1 Ranked Healthcare IT Area in Strategic Importance to Reaching Financial Targets Next Three Years**

Q Of the following areas of healthcare IT, please rank the top three according to their strategic importance in supporting your organization's efforts to reach its financial targets over the next three years. First-ranked responses.



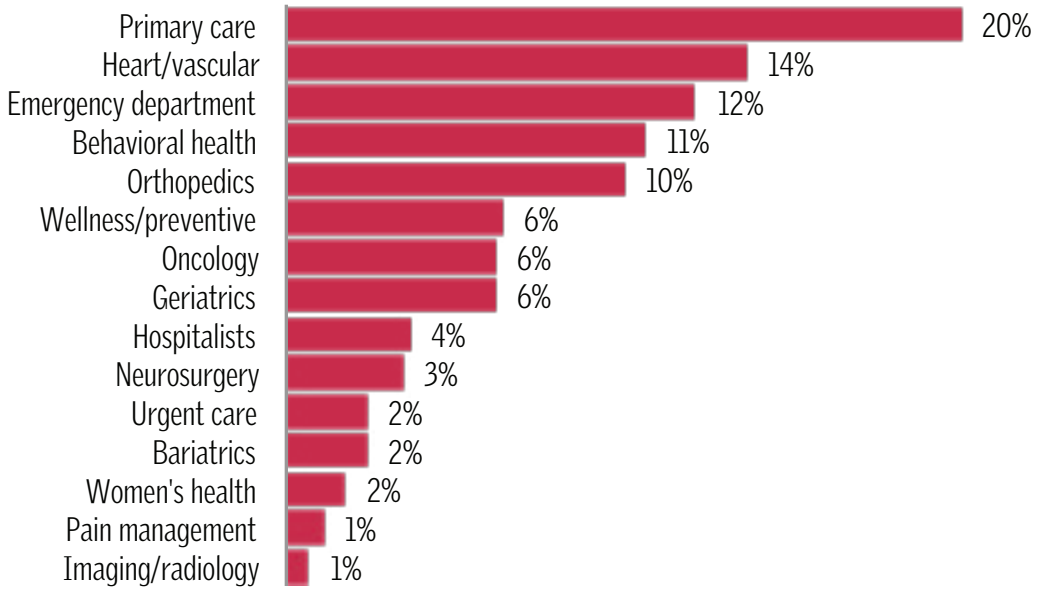
Base = 471

More than one-quarter (28%) of healthcare leaders say that extending IT into the clinical side of the enterprise is No. 1, while another 25% say extending EHRs across care delivery venues (EHR interoperability) is No. 1. Such steps represent a maturing of the IT infrastructure. Predictive analytics, the item selected as No. 1 by 18%, is an extension of IT capabilities into new areas that will allow advances in patient targeting and process enhancement.

SURVEY RESULTS

FIGURE 12: **No. 1 Ranked Strategic Service Lines Three Years From Now**

Q Three years from now, what three service lines do you expect to be your leaders in strategic significance to your organization? First-ranked responses.



Base = 471

The top-of-the-list position of primary care as a leader in strategic significance reinforces the industry's emerging patient-centered focus. Of course, a broad primary care network is important as a source of referrals for other service lines as well as acute care facilities.

SURVEY RESULTS

FIGURE 13: **Overall Performance for Various Groups**

Q How would you rate the current overall performance of the following groups or individuals in your organization?

	Very strong	Strong	Neutral	Weak	Very weak
CEO	39%	36%	16%	6%	2%
Leadership team	29%	44%	17%	9%	1%
Finance staff	25%	41%	26%	7%	1%
Board of trustees	22%	41%	27%	8%	2%
Physician staff	18%	47%	27%	7%	1%
Nursing staff	16%	52%	28%	3%	1%
IT staff	11%	40%	32%	14%	3%
Data analytics staff	8%	26%	37%	20%	9%
Midlevel managers	8%	41%	39%	9%	3%

Base = 471

This year 29% say their organization is weak or very weak at data analytics. Last year that measure was 25%, signifying little progress. Progress is important. Making early steps gives organizations a feel for the nature of the vast and complex data sets they must work with, and also a feel for the nature of the skills they will require to move forward.

SURVEY RESULTS

FIGURE 14: **Performance for Various Areas**

Q How would you rate your organization's current performance in the following areas?

	Very strong	Strong	Neutral	Weak	Very weak
Prospects for growth	24%	49%	21%	6%	0%
Fiscal management	22%	48%	21%	7%	1%
Strategic planning	18%	44%	24%	12%	2%
Collaboration/relationships with providers	15%	48%	27%	10%	1%
Physician recruitment and retention	14%	43%	28%	13%	2%
Physician-hospital alignment	14%	35%	36%	12%	3%
Capacity management	11%	43%	35%	9%	1%
Strategic marketing	10%	32%	34%	19%	5%
Collaboration/relationships with payers	10%	36%	42%	11%	1%
Price transparency	8%	24%	41%	23%	4%
Other	6%	15%	53%	18%	9%

Base = 471

Despite the pivotal positions physicians occupy as leaders and implementers of the shift to delivering value-based care, only half (49%) of organizations profess strength in the area of physician-hospital alignment. With size comes strength, though, partly because many large organizations have the wherewithal to implement the compensation portion of alignment. In addition, many large organizations have infrastructure (IT, for instance) to enhance physician alignment.

SURVEY RESULTS

FIGURE 15: **Performance for Various Functions**

Q How would you rate your organization's current performance in the following functions?

	Very strong	Strong	Neutral	Weak	Very weak
Dedication to mission	45%	38%	12%	3%	1%
Clinical quality and patient safety	37%	43%	16%	4%	1%
Patient experience	21%	45%	25%	8%	1%
Cost control	11%	47%	29%	11%	2%
Care coordination	10%	45%	30%	13%	2%
Financial/business analytics	10%	44%	30%	14%	3%
Healthcare IT	9%	38%	31%	18%	4%
Clinical analytics	7%	29%	38%	23%	4%
Population health management	6%	25%	38%	24%	8%

Base = 471

The three items with the highest percentages professing strength are all related to patient care: dedication to mission (45% very strong), clinical quality and patient safety (37%), and patient experience (21%). Several of the other items, such as cost control and IT, compose a second tier of important infrastructure elements, which are important on their own, but should, at least in the opinion of the survey respondents, be viewed in their roles of supporting the transition to delivering value-based care.

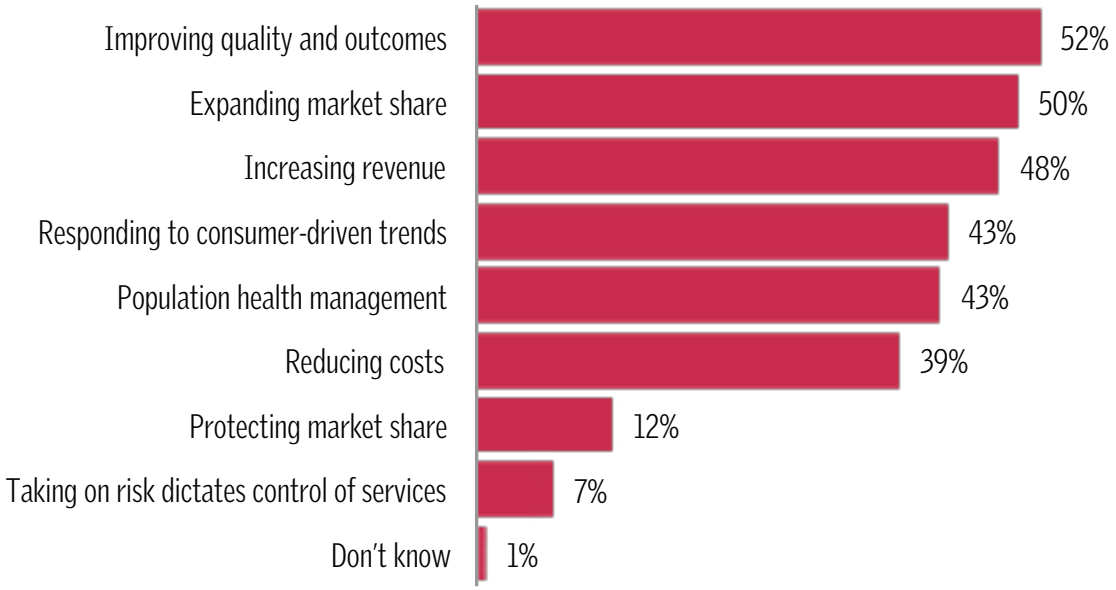
SECTION THREE

The Outpatient Opportunity:
Expanding Access, Relationships, and Revenue

SURVEY RESULTS

FIGURE 1: **Factors Driving Ambulatory/Outpatient Care Strategy**

Q What are the top three factors driving your organization's ambulatory/outpatient care strategy?



Base = 294, Multi-Response

There are a range of factors impacting ambulatory and outpatient strategy. Two of the top three—expanding market share and increasing revenue—are appropriate for an industry where the fee-for-service model continues to exist. Still, the response for population health and consumer-driven trends (43% each) indicates change is coming, and with it, increasing attention to prevention, access, and value-based care.

SURVEY RESULTS

FIGURE 2: **Tactics to Expand Ambulatory/Outpatient Network**

Q What tactics are you using to expand your ambulatory/outpatient network?

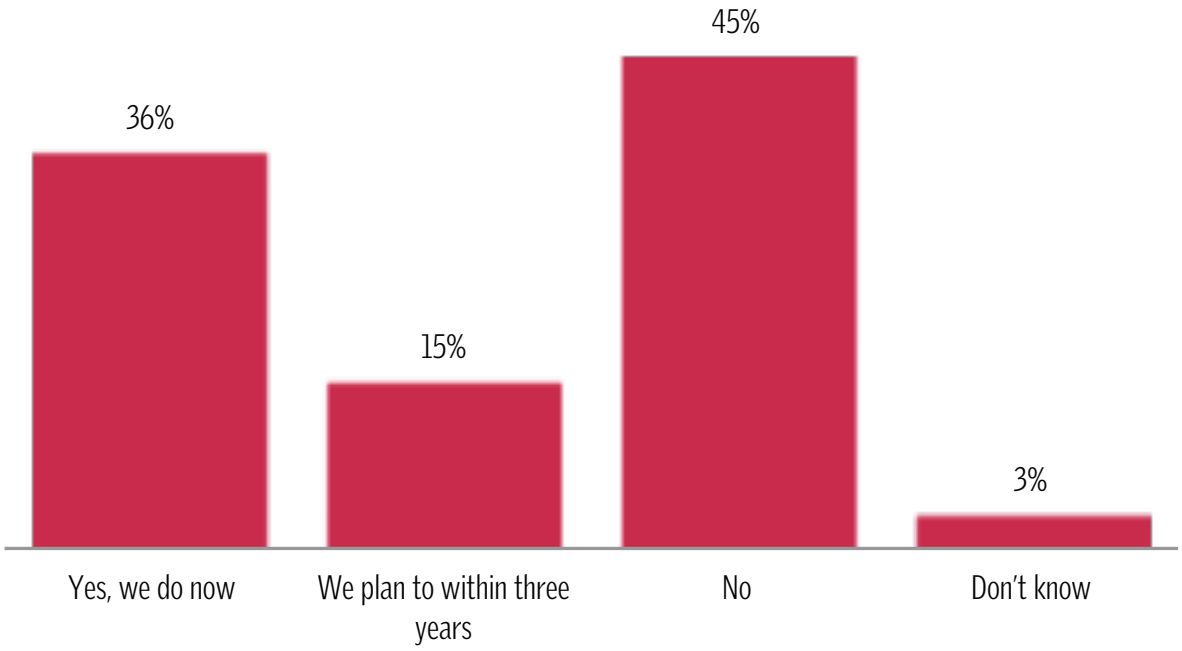
Base = 294, Multi-Response

For the moment, a greater share of respondents are focusing on physician organizations and community-based organizations as their top outpatient tactics. Urgent care clinics and convenient care clinics are not in the top tier, and respondents show a preference for acquisition or starting new rather than partnership.

SURVEY RESULTS

FIGURE 3: **Participation in Convenient Care Clinics**

Q Does your organization participate in convenient care clinics through ownership or partnership?



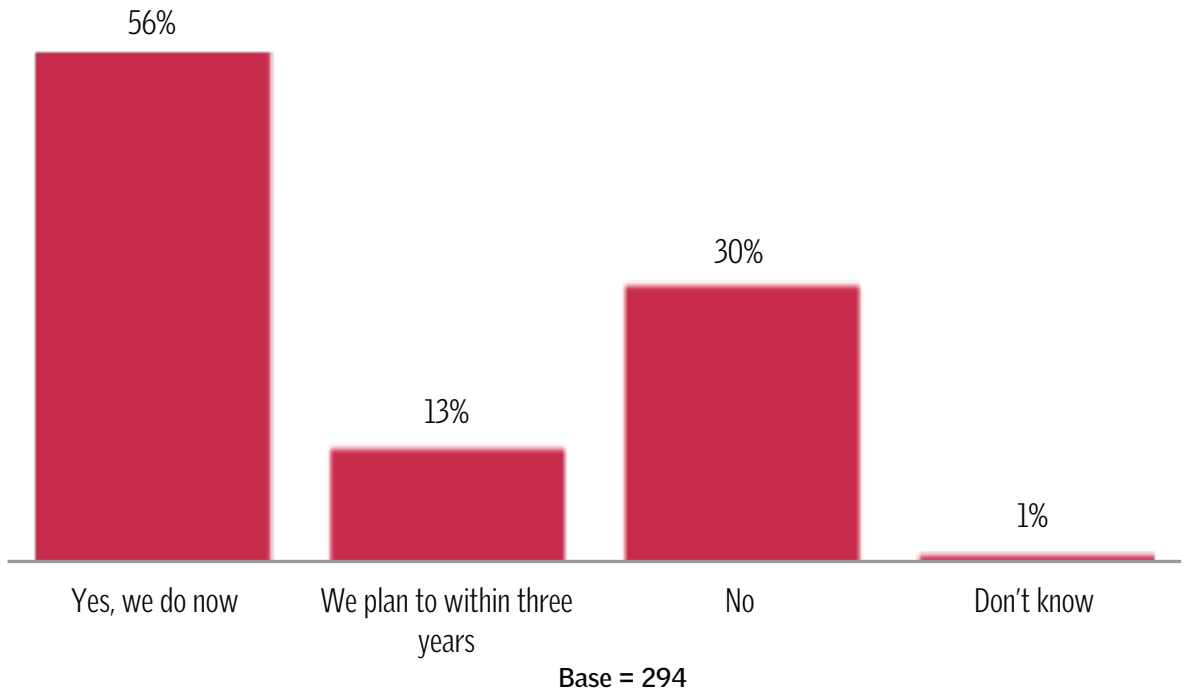
Base = 294

Expanding care network access through convenient care clinics is more common among health systems and larger organizations, likely because these organizations have the resources and executive expertise to integrate them. Further, these organizations can recruit executives with the skills to run convenient care clinics, which are different than those needed to run acute care.

SURVEY RESULTS

FIGURE 4: **Participation in Urgent Care Clinics**

Q Does your organization participate in urgent care clinics through ownership or partnership?



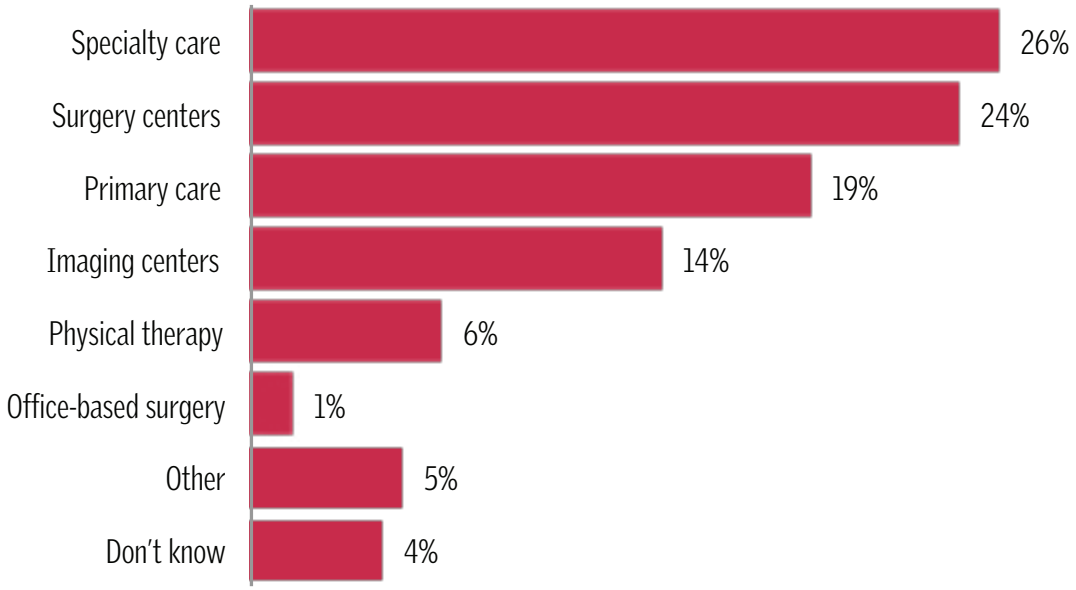
Base = 294

Responses indicate that there is more participation in urgent care clinics than convenient care clinics, and participation is highest in health systems and large organizations. Urgent care clinics are attractive because they can accept patients with higher acuity levels, thus earning correspondingly higher reimbursement. They are also a more cost-effective alternative to an emergency department, a benefit to hospitals and health systems in particular.

SURVEY RESULTS

FIGURE 5: **Ambulatory/Outpatient Area Offering Greatest Financial Contribution Today**

Q Which area of ambulatory/outpatient care offers your organization the greatest financial contribution today?



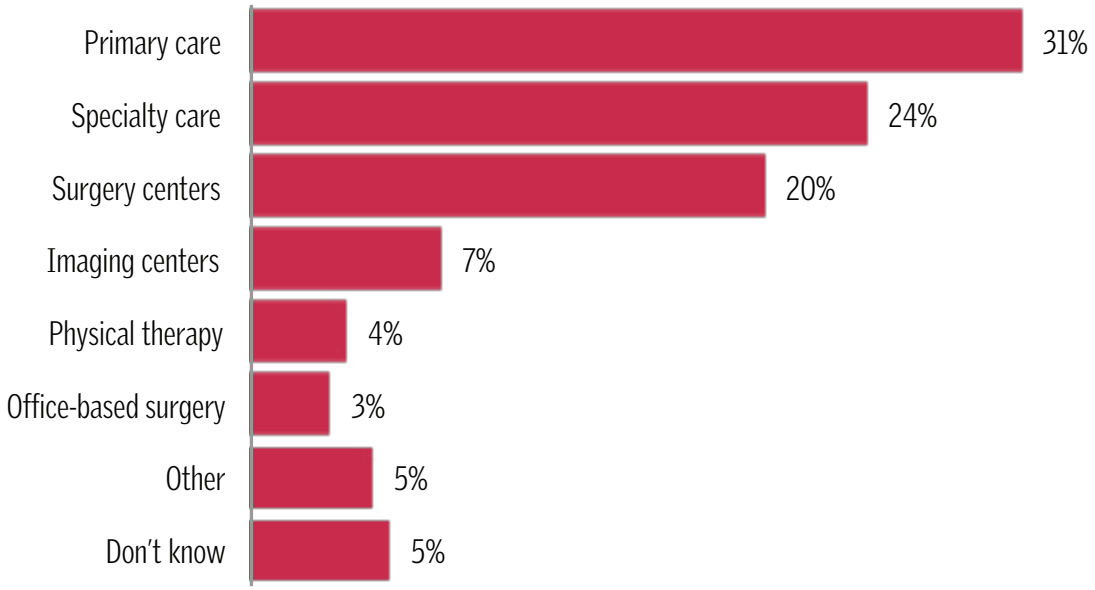
Base = 294

Specialty care and surgery centers are the top financial contribution areas in ambulatory/outpatient care today likely because they handle patients with higher acuity levels, which yields correspondingly higher reimbursements. Primary care, imaging centers, and physical therapy, because of lower average costs per medical event, require higher patient volumes in order to generate the same contribution as specialty care and surgery centers.

SURVEY RESULTS

FIGURE 6: **Ambulatory/Outpatient Area With Greatest Financial Contribution in Three Years**

Q Which area of ambulatory/outpatient care do you expect to be delivering your organization the greatest financial contribution three years from now?



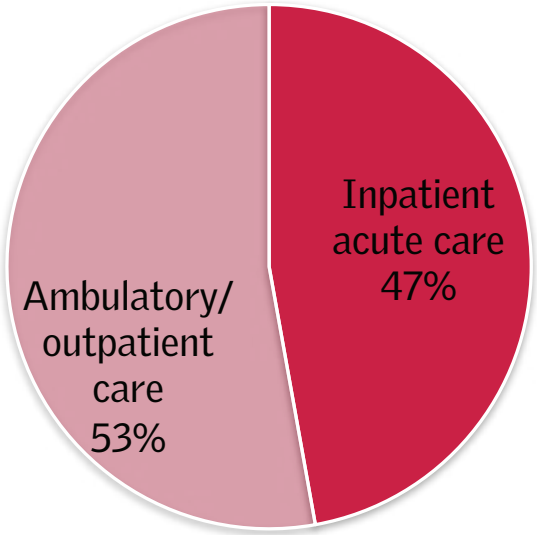
Base = 294

With approximately one-third (31%) of respondents expecting primary care to be the biggest contributor in three years, the impact of healthcare reform and the trend toward population health are readily apparent. Headed in the opposite direction are imaging centers (down to 7% from 14% today), likely reflecting the current scrutiny being given to imaging reimbursements, utilization, and duplication.

SURVEY RESULTS

FIGURE 7: **Average Net Patient Revenue Ratio for Inpatient Acute Versus Ambulatory/Outpatient Care**

Q What is your current estimated net patient revenue ratio for inpatient acute care versus ambulatory/outpatient care?



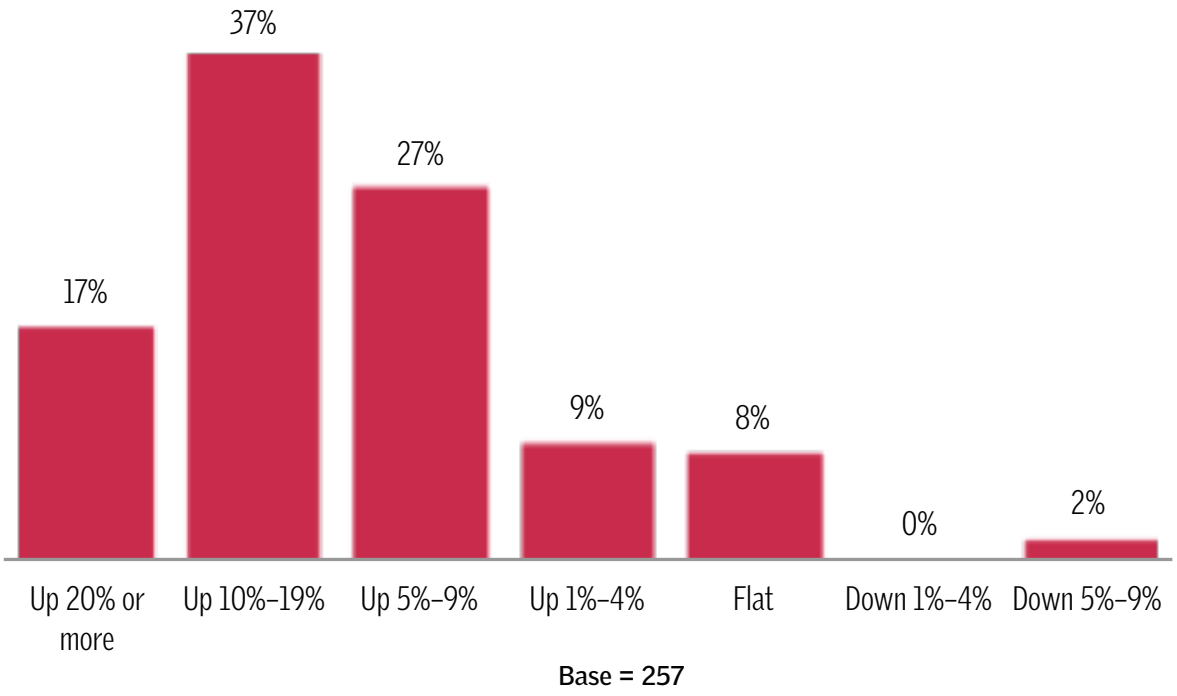
Base = 203

While responses indicate that the average net patient revenue ratio is relatively equal for most organizations, smaller organizations and for-profit organizations appear to place greater emphasis on establishing revenue outside of their inpatient acute care footprint.

SURVEY RESULTS

FIGURE 8: **Change in Ambulatory/Outpatient Care Net Patient Revenue in Three Years**

Q Please estimate the expected change in ambulatory/outpatient care net patient revenue for your organization within three years.



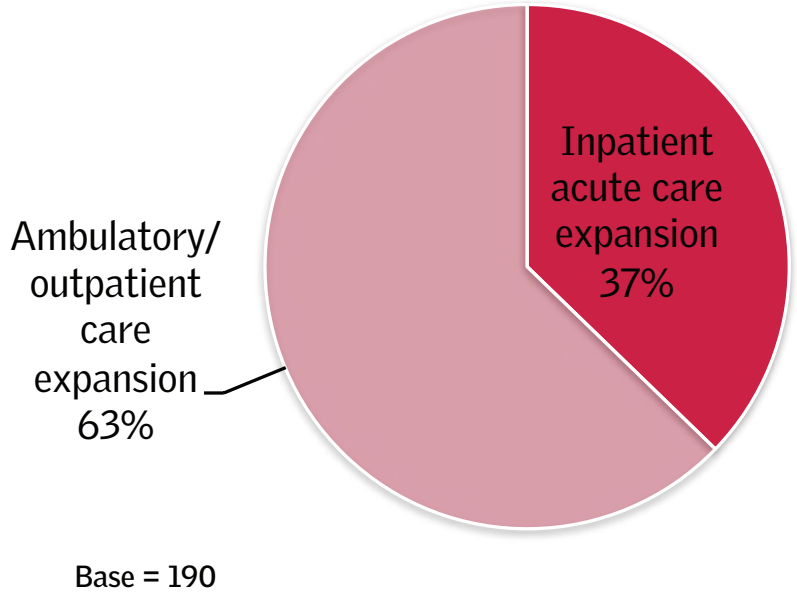
Base = 257

Expectations for ambulatory/outpatient care net patient revenue growth indicate providers are optimistic that increased accessibility, greater convenience, and a growing patient sensitivity to the cost of care will drive increasing numbers of ambulatory and outpatient visits. At the same time, advances in medicine will also contribute to the trend by allowing more, and higher-acuity, procedures to be done in outpatient settings.

SURVEY RESULTS

FIGURE 9: **Average Capital Budget Investment Ratio for Inpatient Acute Versus Ambulatory/Outpatient Care in Three Years**

Q Within three years, what is your estimated ratio of capital budget investment for new program development in inpatient acute care versus ambulatory/outpatient care?



Nearly all organizational types are dedicating more of their capital budgets to ambulatory/outpatient care than inpatient acute care. (The exception is hospitals with 200–499 beds, which expect an investment ratio to favor inpatient over outpatient, 52% to 48%.) Part of this trend may be because improvements in inpatient acute care require more capital than outpatient improvements, and organizations may see better return on investment in ambulatory/outpatient care settings. However, larger organizations, by net patient revenue, are investing proportionally more toward inpatient facilities (47%) compared to medium (41%) and small (32%) organizations, an indication that they have larger inpatient infrastructure to maintain and update.

SURVEY RESULTS

FIGURE 10: **Facility Expansion Priorities Over Next Three Years**

Q Please rank the following according to their priority (in overall cumulative dollar level of investments for new program development) when investing in facility expansion over the next three years.

	1st ranked
Ambulatory/outpatient care	55%
Acute care surgery or operating room	18%
General acute care	16%
Emergency department	11%

Base = 273

Respondents are clear about their intentions for facility expansion over the next three years, and their expectations for ambulatory/outpatient care growth. With more than half prepared to invest in this area, and very low response levels for areas such as the ED and acute care overall, providers are underscoring their focus on expanding their ambulatory/outpatient care footprint.

SURVEY RESULTS

FIGURE 11: **Expansion of Care Service Priorities Over Next Three Years**

Q Please rank the following according to their priority (in overall cumulative dollar level of investments for new program development) when investing in expansion of care services over the next three years.

	1st ranked
Ambulatory/outpatient care	63%
Acute care surgery or operating room	15%
Emergency department	11%
General acute care	11%

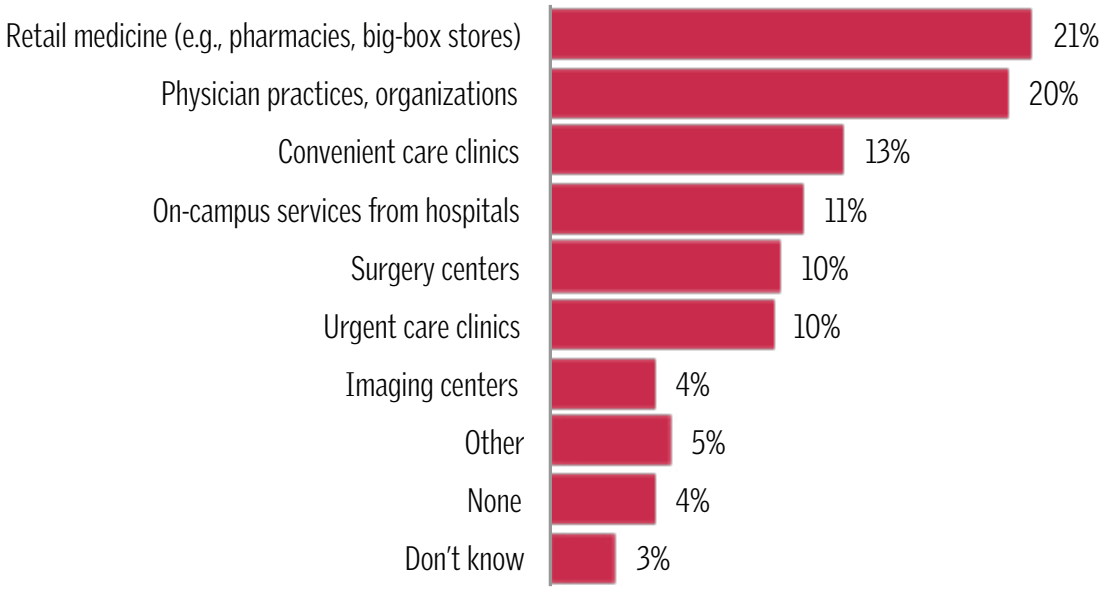
Base = 265

Responses for care services expansion generally go hand-in-hand with the results in Figure 10 for facility expansion; providers expect to increase both access to ambulatory/outpatient care as well as the range of services they provide. Health systems and large and medium organizations are especially committed to investing in outpatient care services, a sign that they expect to be dominant players.

SURVEY RESULTS

FIGURE 12: **Greatest Competitive Threat From Ambulatory/Outpatient Area**

Q Within three years, which ambulatory/outpatient area presents the greatest competitive threat to your organization?



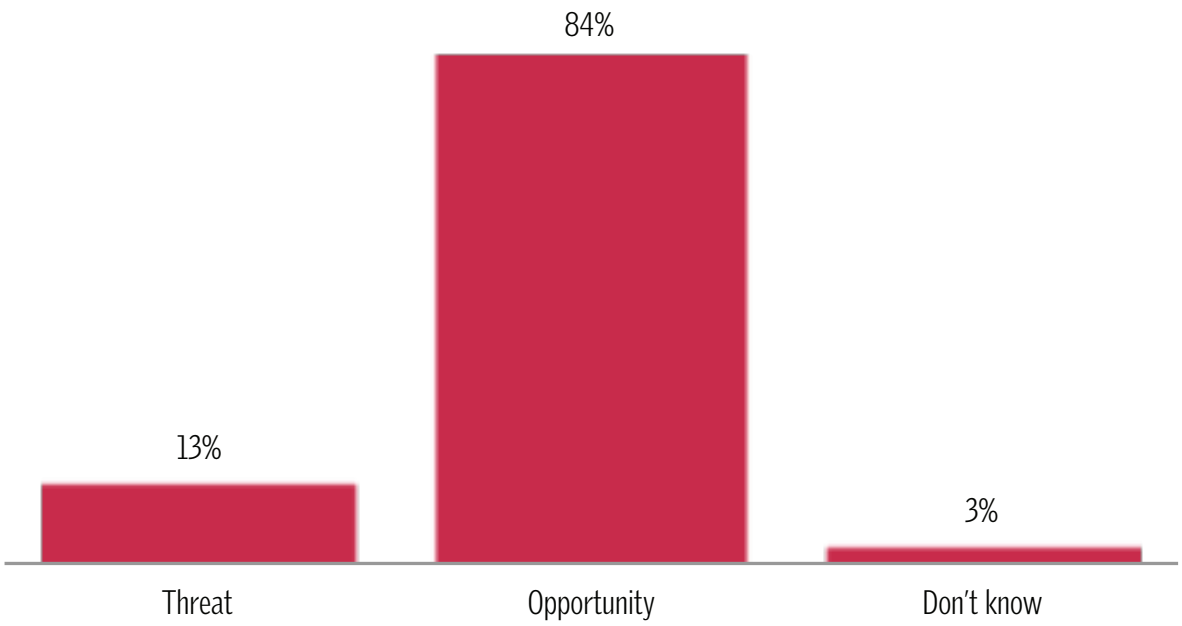
Base = 294

While providers can be threatened by retail medicine because of its pervasiveness, accessibility, customer convenience, low prices, and incompatible business model (which serves as an entry barrier for many providers), the silver lining is that retail medicine has opened the door to some interesting partnerships. While we see in Figure 3 that just 36% of organizations participate in convenient care clinics through ownership or partnership, another 15% expect to do so within three years.

SURVEY RESULTS

FIGURE 13: **Shift to Ambulatory/Outpatient Care—Threat or Opportunity?**

Q Overall, would you say that the industry shift to ambulatory/outpatient care represents a threat or an opportunity for your organization?



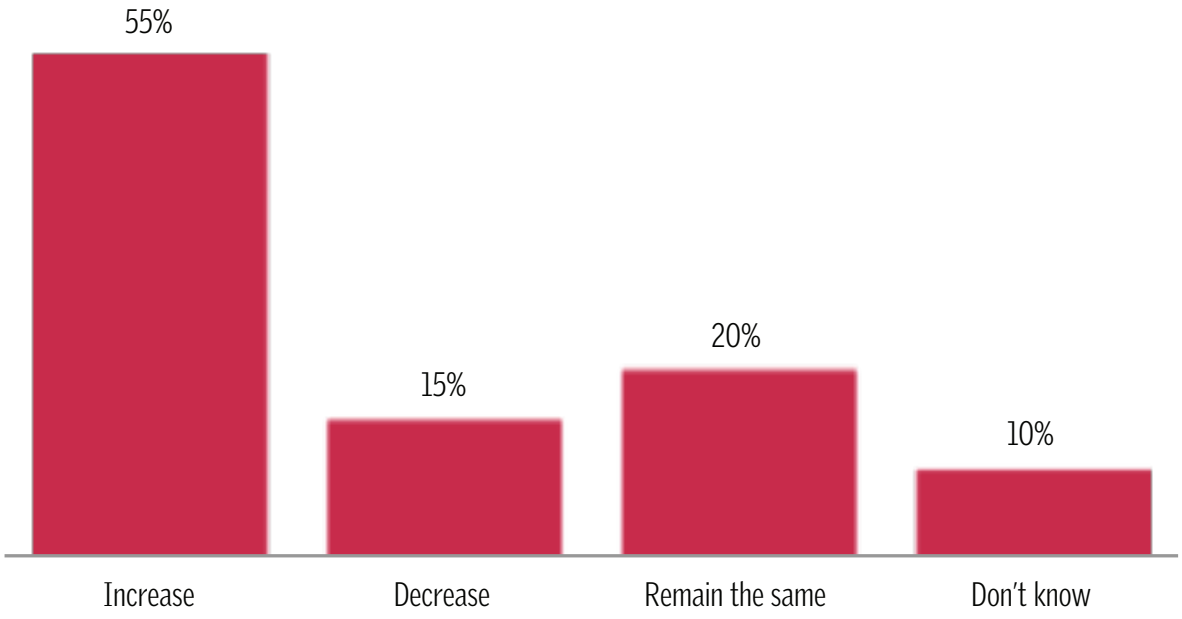
Base = 294

Judging from the high level of response for the ambulatory/outpatient care shift as an opportunity, only a small number of providers appear to have anything serious to worry about. Interestingly, physician organizations, which exist almost exclusively in the ambulatory/outpatient care domain, see little cause for concern despite all the outside interest (5% see a threat and 7% are not sure one way or the other). Indeed, they are among the most bullish on the trend (88% see it as an opportunity), which is perhaps an indication that they have confidence in their understanding of the ambulatory/outpatient care business.

SURVEY RESULTS

FIGURE 14: **Dollar Level of Self-Pay Within Three Years**

Q Within three years, will the dollar level of self-pay for ambulatory/outpatient services for your organization increase, decrease, or remain the same?



Base = 294

With healthcare services increasingly available to a growing patient population—particularly in outpatient/ambulatory care—providers are likely to be exposed to more self-pay patients, whether uninsured or those with high-deductible plans and larger copays. Furthermore, outpatient services can often include elective procedures that may not be covered by third parties even if the patient has health insurance, which also adds momentum to the trend.

SECTION FOUR

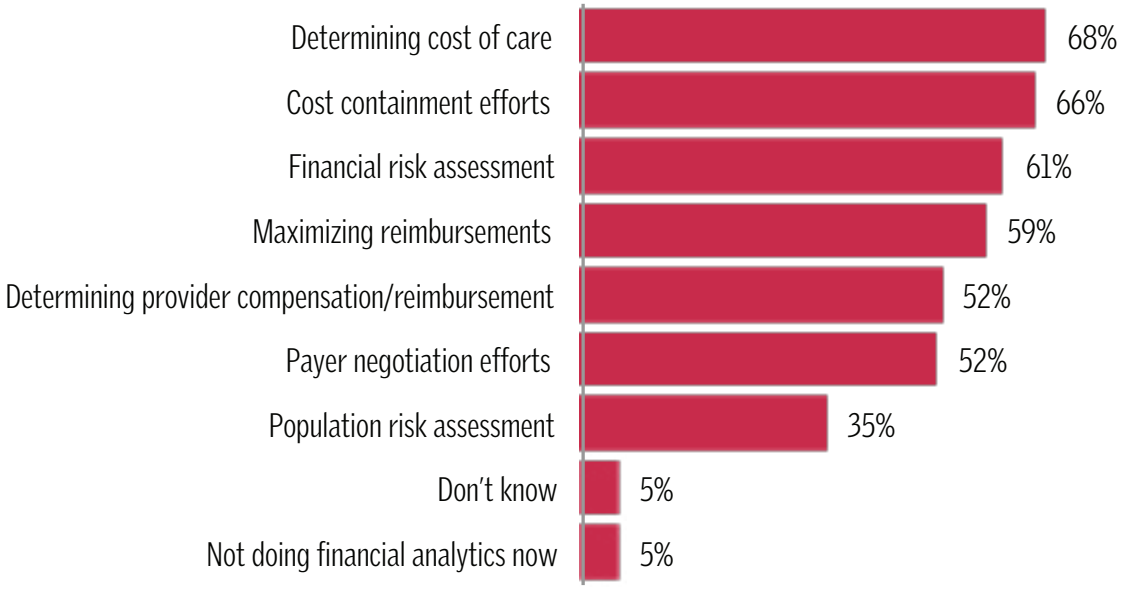
The Analytics Challenge:
Gaining Critical Insight Into Risk-Based Models

FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: FEBRUARY 2016

SURVEY RESULTS

FIGURE 1: **Use of Financial Analytics Now**

Q What does your organization use financial analytics for now?



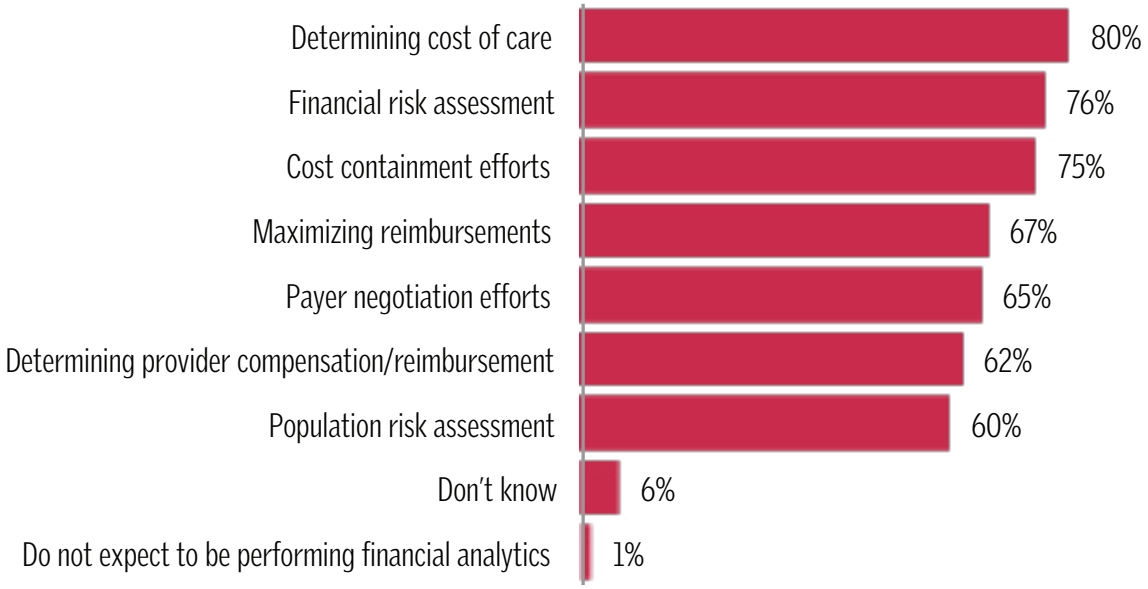
Base = 350, Multi-Response

The top four responses for financial analytics used now are traditional financial analytics applications. While the response for population risk assessment is quite modest in comparison, this will likely not always be the case. The transition to value-based care is driving an increasing need for population risk assessment data and analytics. In fact, this year's response is up six points over last year's survey result.

SURVEY RESULTS

FIGURE 2: **Use of Financial Analytics Within Three Years**

Q What do you expect to be using financial analytics for within three years?



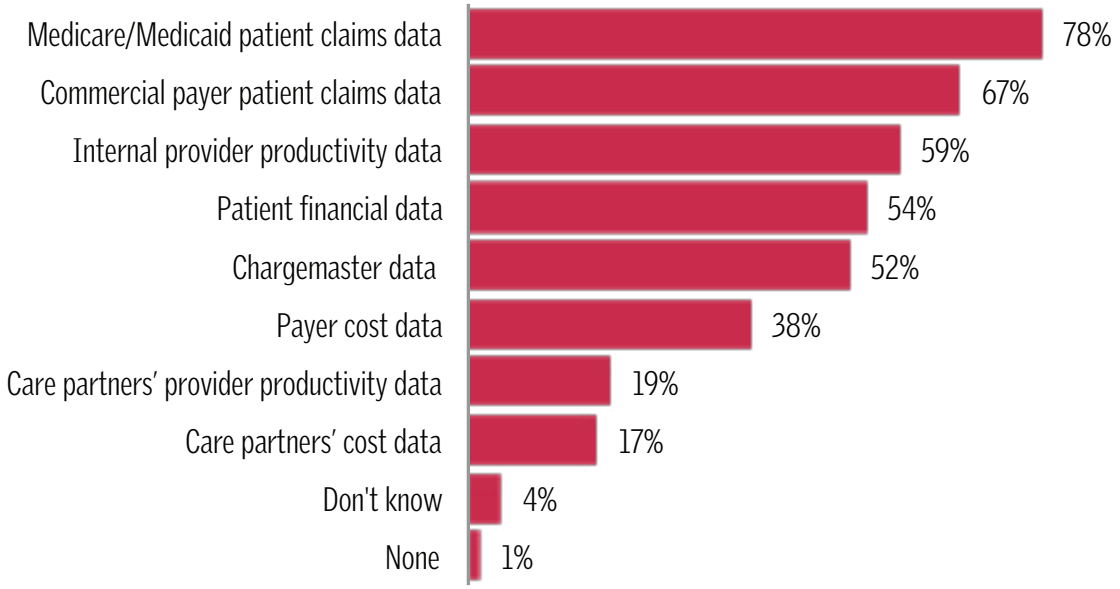
Base = 350, Multi-Response

The expected increase in using financial analytics for population risk assessment and financial risk assessment indicates that providers are weighing the consequences of assuming more risk as they move toward value-based care reimbursement. Health systems and large organizations are especially active in financial analytics, likely because they have the resources and expertise to do so.

SURVEY RESULTS

FIGURE 3: **Types of Finance Data Drawn On for Analytics Activity Now**

Q Which of the following types of finance-related data does your organization draw on now for analytics activity?



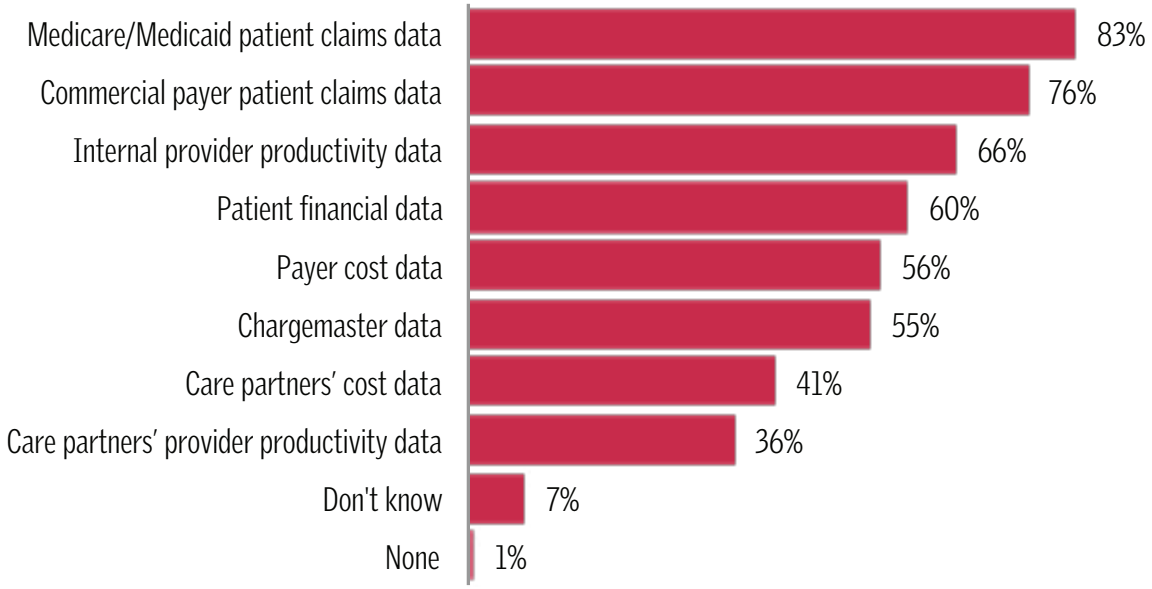
Base = 350, Multi-Response

The prevalence of payer claims data suggests the importance of analyzing the relationship between patient care and revenue. Internal provider productivity data, which is the third most frequently mentioned data source, provides insight into the cost part of the value formula, and also offers the benefit of provider-specific performance tracking.

SURVEY RESULTS

FIGURE 4: **Types of Finance Data Drawn On for Analytics Within Three Years**

Q Which of the following types of finance-related data do you expect your organization to draw on for analytics activity within three years?



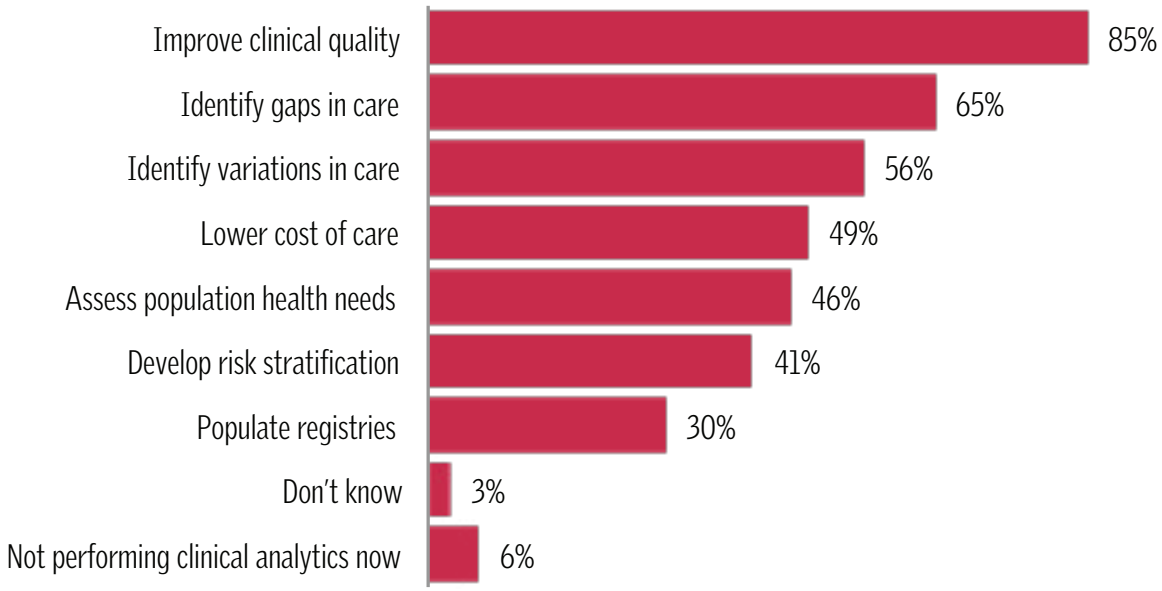
Base = 350, Multi-Response

The increasing interest in care partners' cost data and care partners' provider productivity data is an acknowledgment of the role of the care continuum in delivering value-based care. The focus on evaluating payer cost data indicates that analytics activity will target getting a better understanding of cost factors.

SURVEY RESULTS

FIGURE 5: **Use of Clinical Analytics Now**

Q What does your organization use clinical analytics for now?



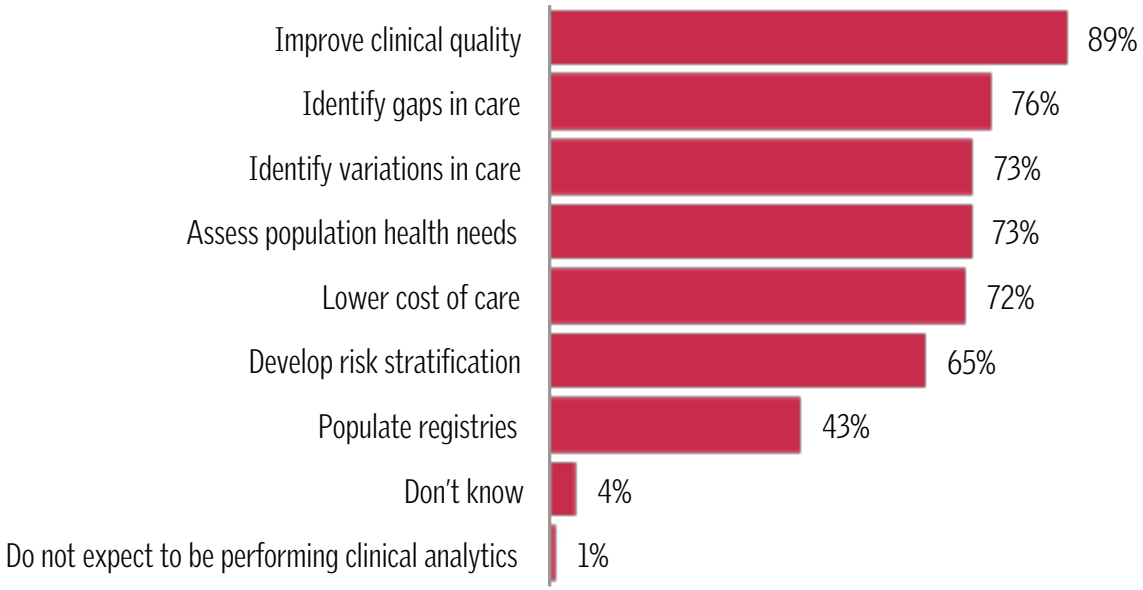
Base = 350, Multi-Response

Not surprisingly, improving clinical quality is the top response for how clinical analytics is being used now. Of increasing interest to providers is the need to identify care gaps, assess population health needs, and develop risk stratification, activities relating to value-based care and ongoing transformation efforts within the industry. Health systems and large organizations are especially active in clinical analytics.

SURVEY RESULTS

FIGURE 6: **Use of Clinical Analytics Within Three Years**

Q What do you expect to be using clinical analytics for within three years?



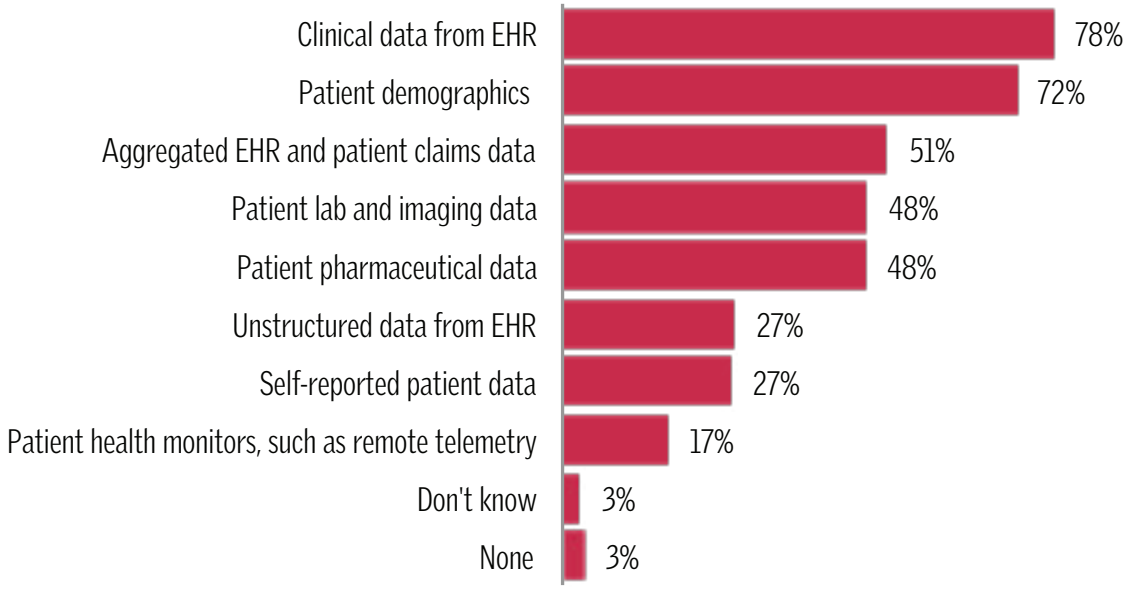
Base = 350, Multi-Response

Using analytics to improve clinical quality is expected to become nearly universal within three years. In fact, most of the analytics applications listed in the survey appear headed to widespread usage, by roughly three-quarters of respondents, indicating that providers intend to use analytics in a very broad manner.

SURVEY RESULTS

FIGURE 7: **Types of Patient Data Drawn On for Analytics Now**

Q Which of the following types of patient-related data does your organization draw on now for analytics activity?



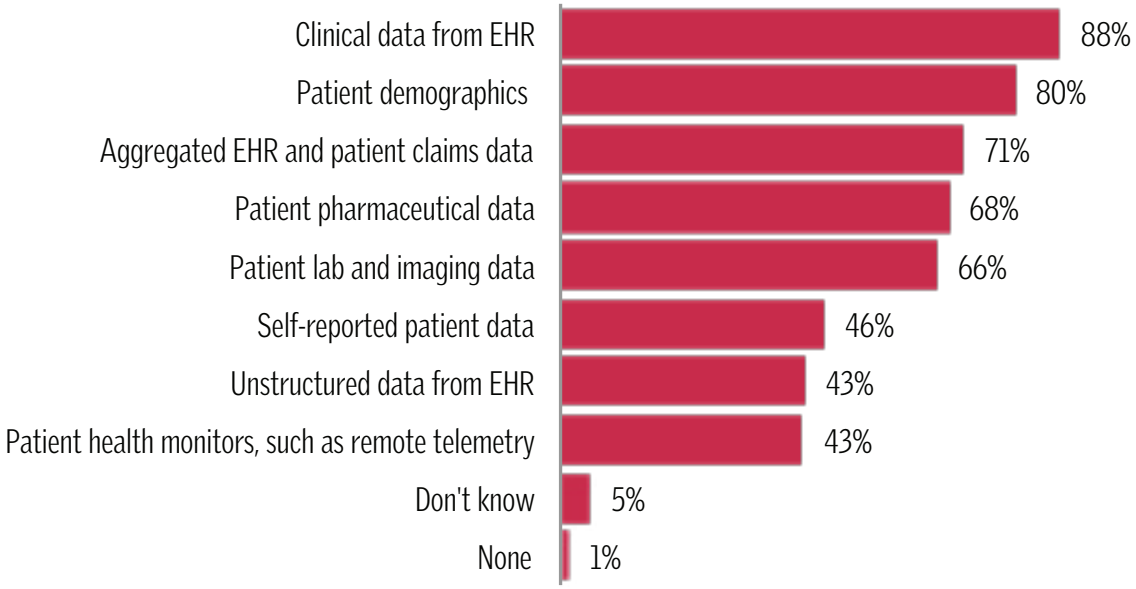
Base = 350, Multi-Response

Clinical data from EHR and patient demographics are the leading patient-related data types providers are using for analytics, part of a growing focus on gaining deeper understanding of patient care. Aggregated EHR and patient claims data, mentioned third most frequently, often is used for reporting and monitoring rather than directing patient care.

SURVEY RESULTS

FIGURE 8: **Types of Patient Data Drawn On for Analytics Within Three Years**

Q Which of the following types of patient-related data do you expect your organization to draw on for analytics activity within three years?



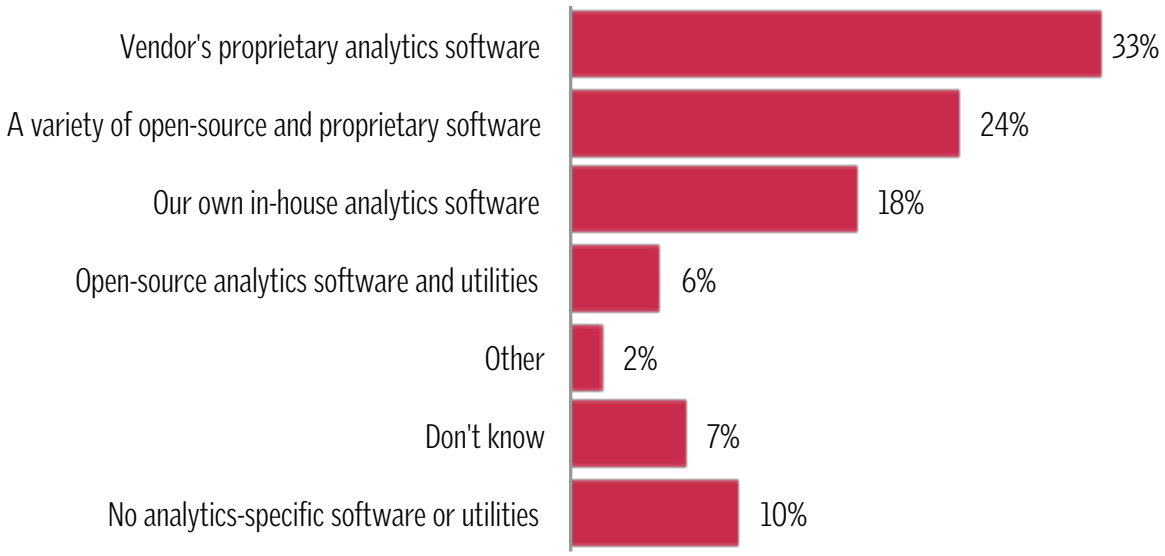
Base = 350, Multi-Response

The large increases in the percentage of respondents who expect to be drawing on data sources like patient health monitors, such as remote telemetry; aggregated EHR and patient claims data; and patient pharmaceutical data reflect provider anticipation of population health management requirements.

SURVEY RESULTS

FIGURE 9: **Current Applications for Working With Large/Complex Data Sets**

Q Which of the following best describes your current applications for working with large and/or complex data sets to reveal trends or specific insights?



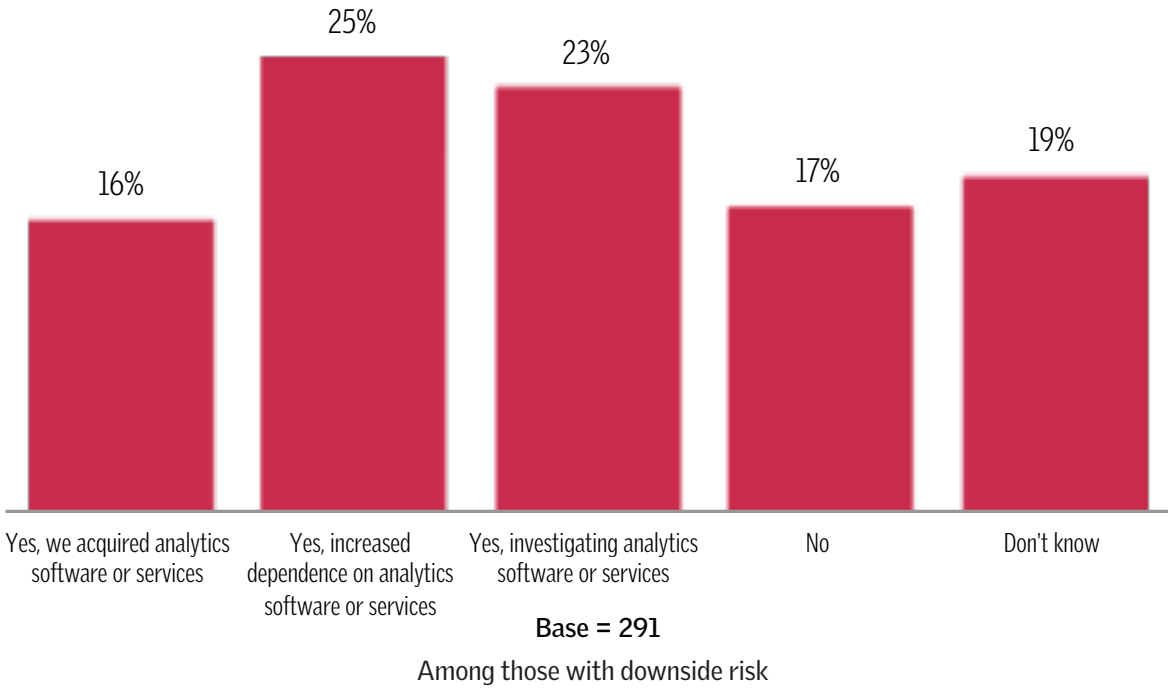
Base = 326
Among those who draw on large/complex data sets

Providers lean toward using a vendor's proprietary software, or a combination of proprietary software and open-source software, because the alternative of developing in-house analytics software can be time-consuming and tie up resources. Their analytics teams may also lack the necessary skill set to conduct software development.

SURVEY RESULTS

FIGURE 10: **Presence of Downside Risk Contracts Prompting Need for Analytics Software**

Q Has the presence of contracts with downside risk prompted the need for or increased dependence on analytics software or services?



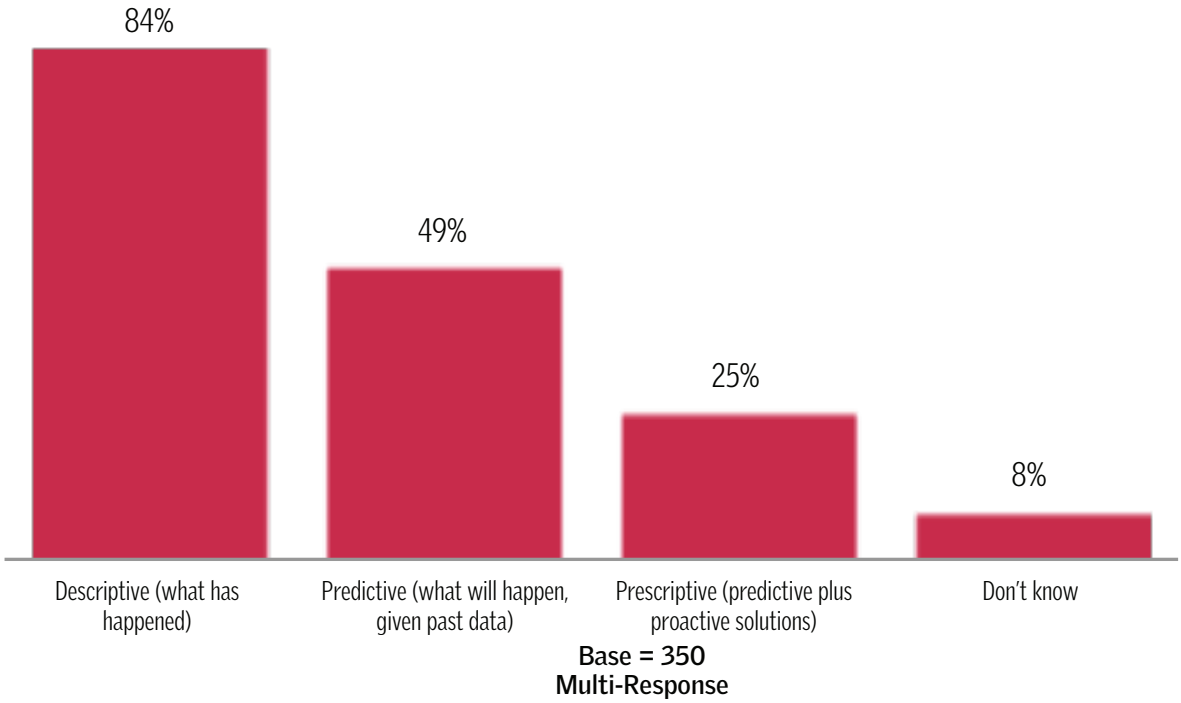
Base = 291
Among those with downside risk

As providers are exposed to increasing levels of downside risk, the need for advanced analytics to guide decision-making and monitor results has also grown. Today's analytical software and services packages will need to evolve to allow healthcare leaders to manage risk and take action based on near real-time analysis.

SURVEY RESULTS

FIGURE 11: **Financial Data Analytics Capabilities**

Q How would you describe your financial data analytics capabilities?



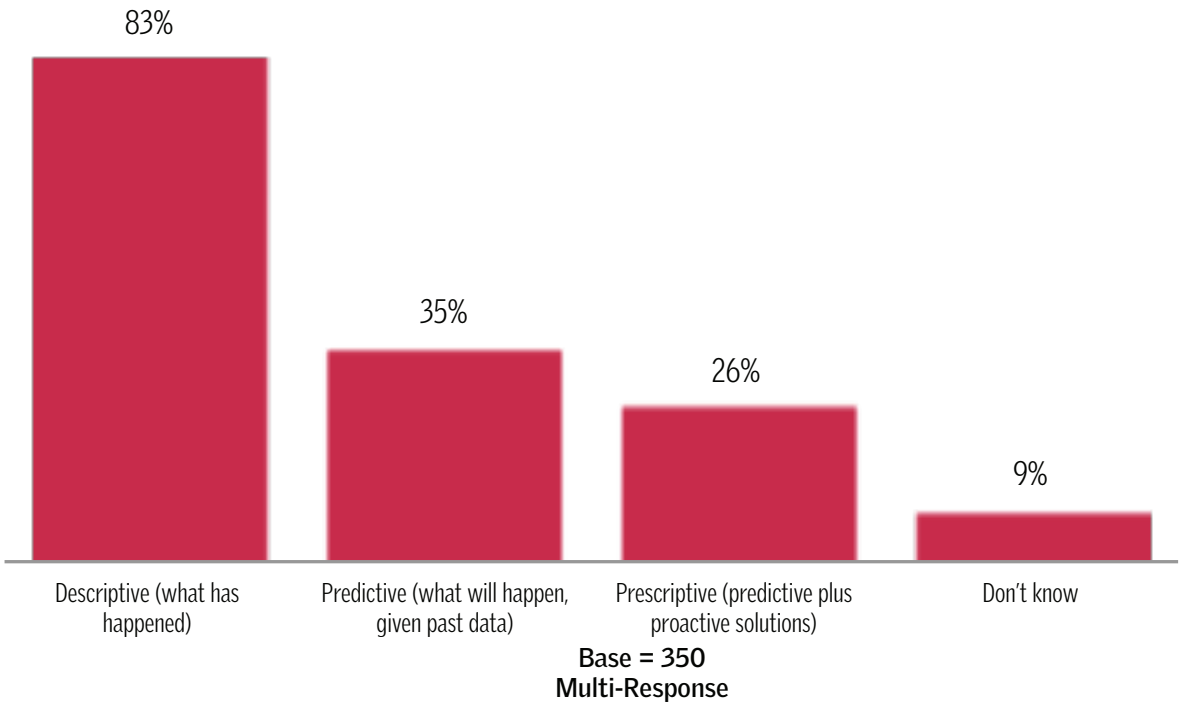
Base = 350
Multi-Response

The majority of respondents (84%) have support for descriptive financial analytics—they are able to analyze what has happened in the past. While this result is encouraging, it is also true that a substantial portion do not have the ability to apply analytics to what has happened, calling into question their ability to make informed decisions. Roughly half (49%) say they use predictive analytics, meaning they are able to read the data and foresee future possibilities. Results for prescriptive analytics (25%), while the smallest segment, are nonetheless the most encouraging: Advanced analytics of this type best enables providers to take preventive action in the future.

SURVEY RESULTS

FIGURE 12: **Clinical Data Analytics Capabilities**

Q How would you describe your clinical data analytics capabilities?



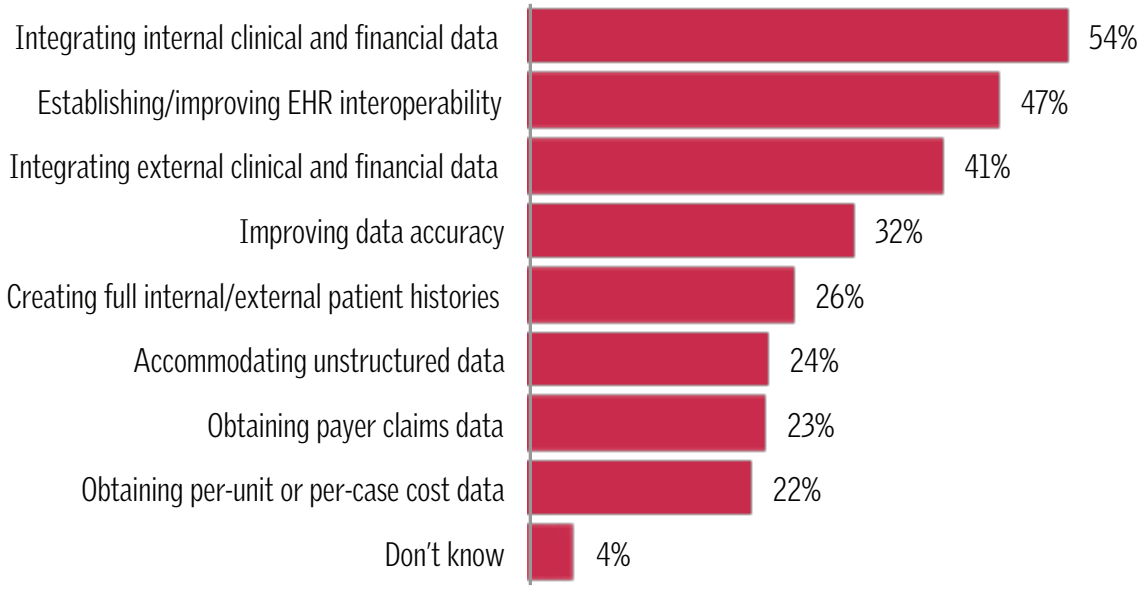
Base = 350
Multi-Response

As with financial analytics, a large percentage of respondents (83%) have support for descriptive clinical analytics. The response indicates that clinical analytics use is widespread, although it is somewhat concerning that the percentage is not higher for the ability to apply analytics retrospectively. The lower response for predictive clinical analytics compared with predictive financial analytics is perhaps an indication of the difficulty presented by applying analytics to patient health. Respondents indicate that health systems and large organizations are the leading users of analytics.

SURVEY RESULTS

FIGURE 13: **Top Data-Related Analytics Challenges Over Next Three Years**

Q Please select the top three data-related challenges your organization expects to face in performing analytics over the next three years.



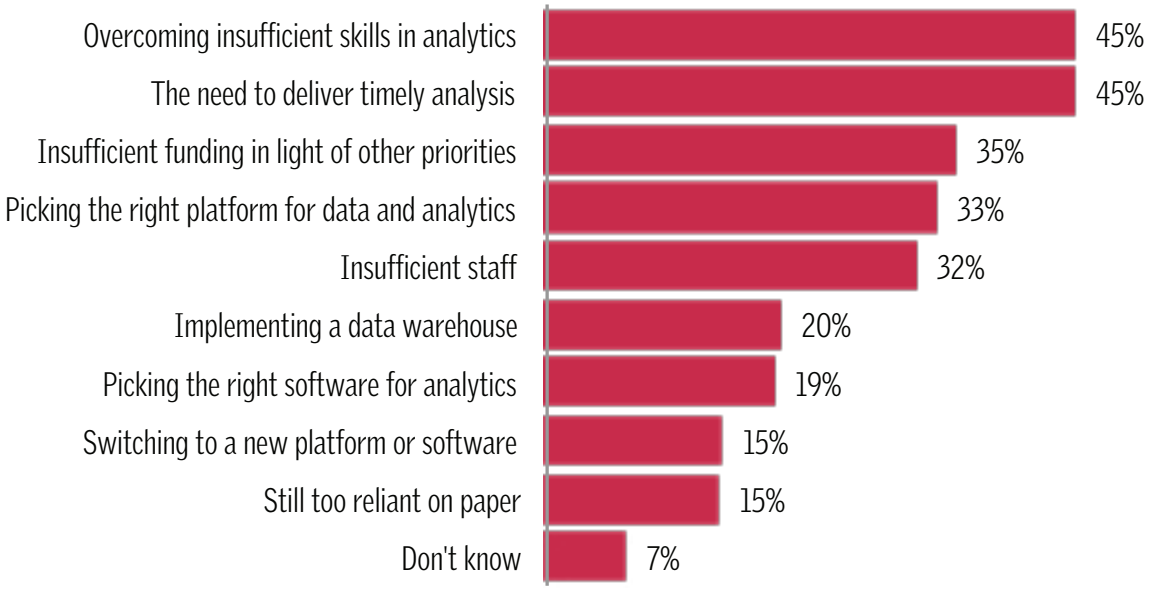
Base = 350, Multi-Response

The top data analytics challenges providers face involve integrating clinical and financial data—both internal and external—and establishing EHR interoperability. In each case, data frequently comes from a number of different sources, which is perhaps why providers find them so challenging to work with.

SURVEY RESULTS

FIGURE 14: **Top Tactical Analytics Challenges Over Next Three Years**

Q Please select the top three tactical challenges your organization expects to face in performing analytics over the next three years.



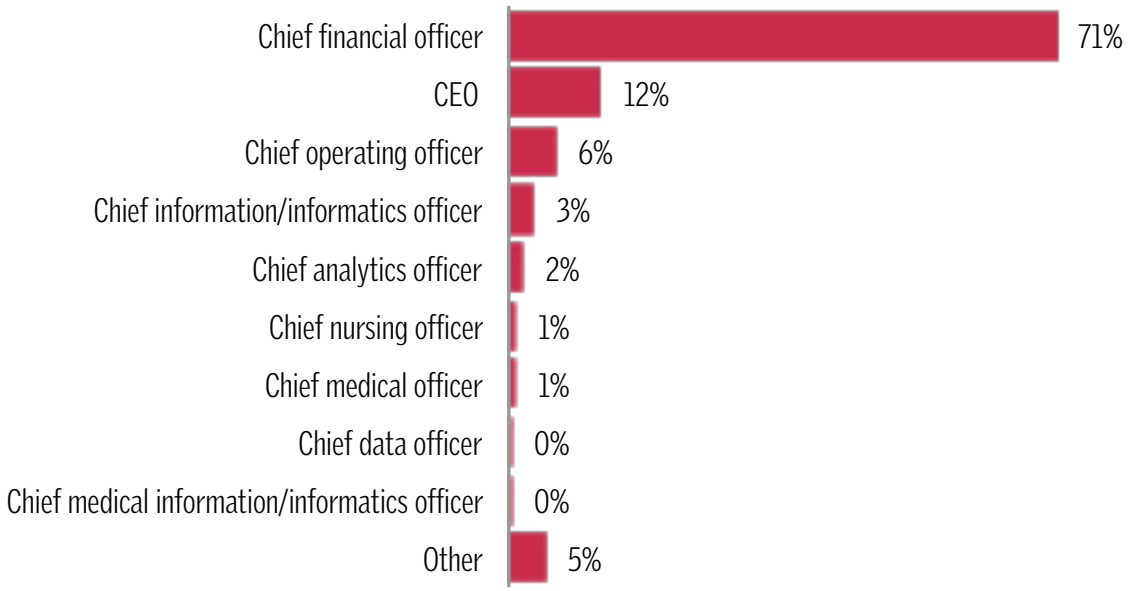
Base = 350, Multi-Response

Two of the top three tactical challenges are either indirectly or directly related to financial resources—the solution to overcoming insufficient skills in analytics requires investment in training or adding new analytics staff, and insufficient funding in light of other priorities is clear in its message. The need to deliver timely analysis is perhaps a universal problem—the world we all live in requires a real-time response to information needs, and healthcare is no different.

SURVEY RESULTS

FIGURE 15: **C-Suite Title Responsible for Financial Analytics**

Q Which C-suite title within your organization is primarily responsible for your financial analytics activities?



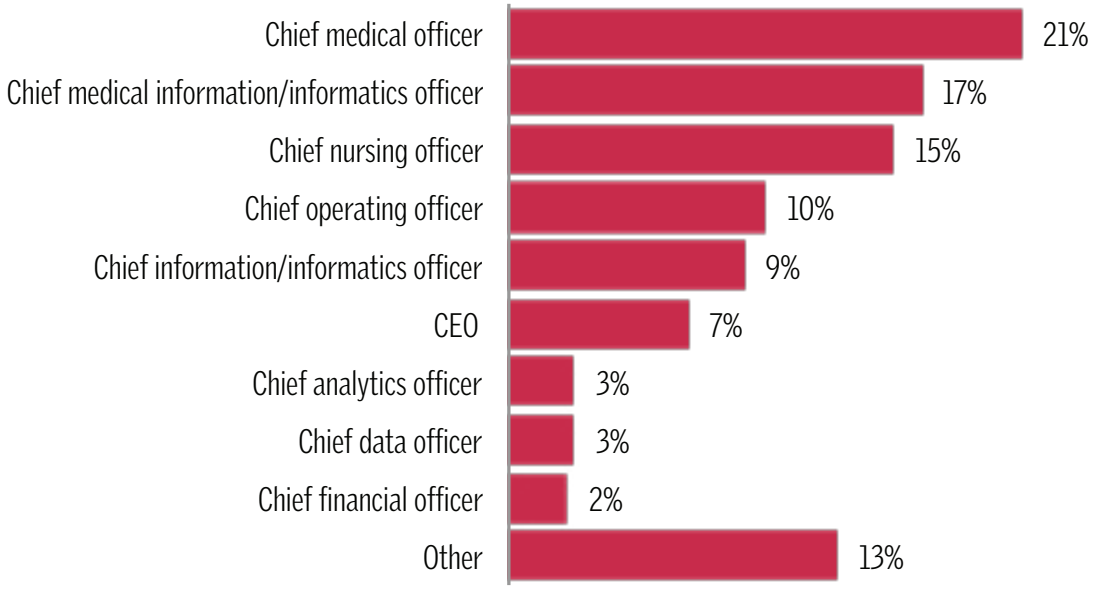
Base = 350

For most providers in our survey, the CFO (71%) is primarily responsible for financial analytics activities. Interestingly, this is not a responsibility of the chief of information/informatics technology. Physician organizations and small organizations have the lowest response for the CFO, and the highest response for the CEO, an indication that CEOs have more diverse responsibilities in these organizations.

SURVEY RESULTS

FIGURE 16: **C-Suite Title Responsible for Clinical Analytics**

Q Which C-suite title within your organization is primarily responsible for your clinical analytics activities?



Base = 350

For clinical analytics, the distribution of responses indicates a more varied mix of titles than with financial analytics. For health systems, physician organizations, and large organizations, the top response is the chief medical officer, while for hospitals and small organizations it is the chief nursing officer.

SECTION FIVE

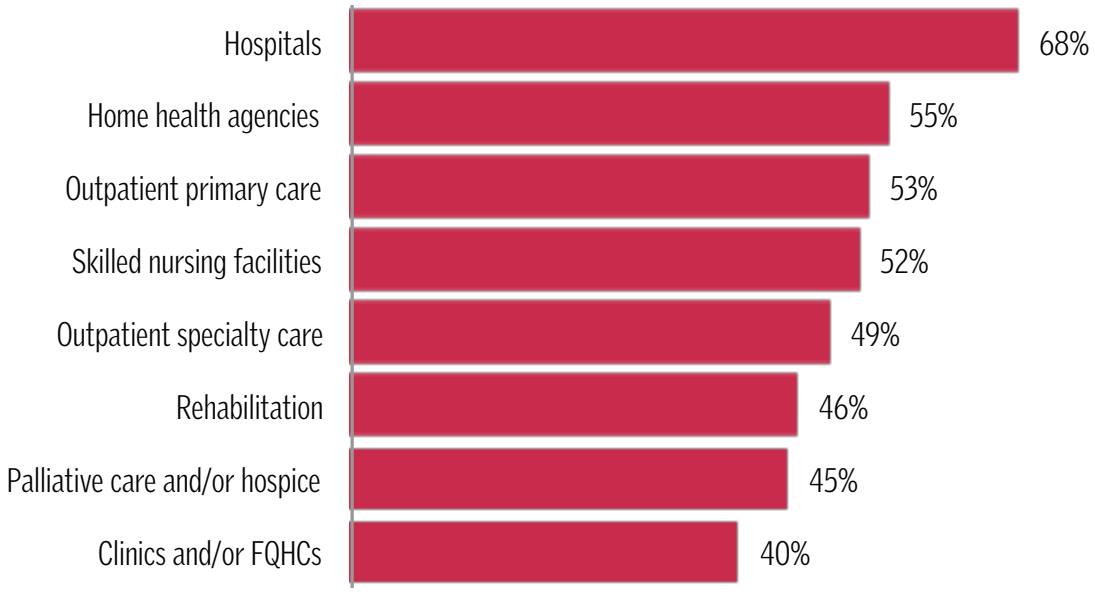
Care Coordination:
Closing the Gaps Along the Continuum

FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: JULY 2015

SURVEY RESULTS

FIGURE 1: **Care-Transition Function That Supports Patient Transfers**

Q With which of the following care continuum providers or services does your organization have a care-transition function that supports patient transfers?



Base = 397, Multi-Response

Narrow network participants pay particular attention to transfers to several settings, including outpatient primary and specialty care, rehab services, and palliative care and/or hospice. But just about equal percentages from those in narrow networks and those who are not support SNFs and home health agencies with a care-transfer function.

SURVEY RESULTS

FIGURE 2: **Status With Care Transitions**

Q What is your organization's status with care transitions for each of the following care continuum providers or services?

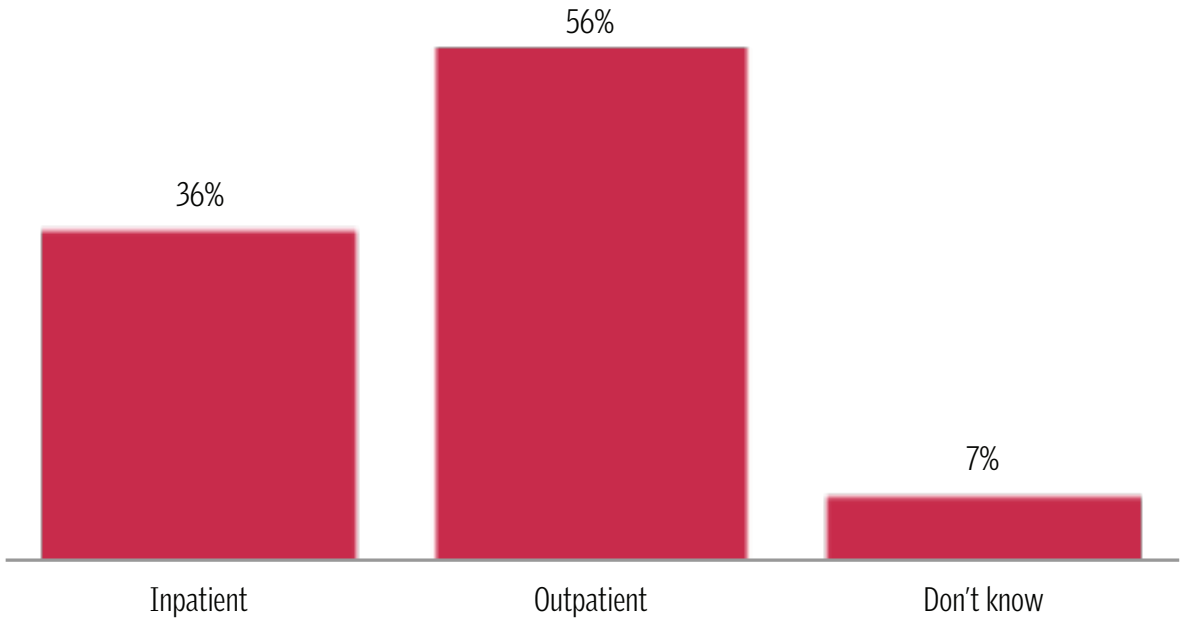
	Sufficiently strong	Not sufficiently strong	Don't know	Base
Rehabilitation	70%	28%	3%	181
Palliative care and/or hospice	64%	34%	2%	177
Hospitals	63%	33%	4%	271
Home health agencies	62%	37%	1%	218
Clinics and/or FQHCs	61%	37%	2%	157
Outpatient primary care	57%	41%	2%	210
Outpatient specialty care	56%	43%	1%	194
Skilled nursing facilities	55%	42%	3%	206

Two principal factors influence strong transitions. First is the general condition of the patients. Transfers with rehab facilities are relatively strong because rehab patients fit into a narrow band, and patients are relatively stable. Second is the capability of the organization. Transfers with hospitals are relatively strong because hospitals can care for a wide variety of conditions.

SURVEY RESULTS

FIGURE 3: **Clinical Outcomes Improvement Next Three Years**

Q Over the next three years, do you expect the greatest clinical outcomes improvement from your inpatient or outpatient care coordination activities?



Base = 250

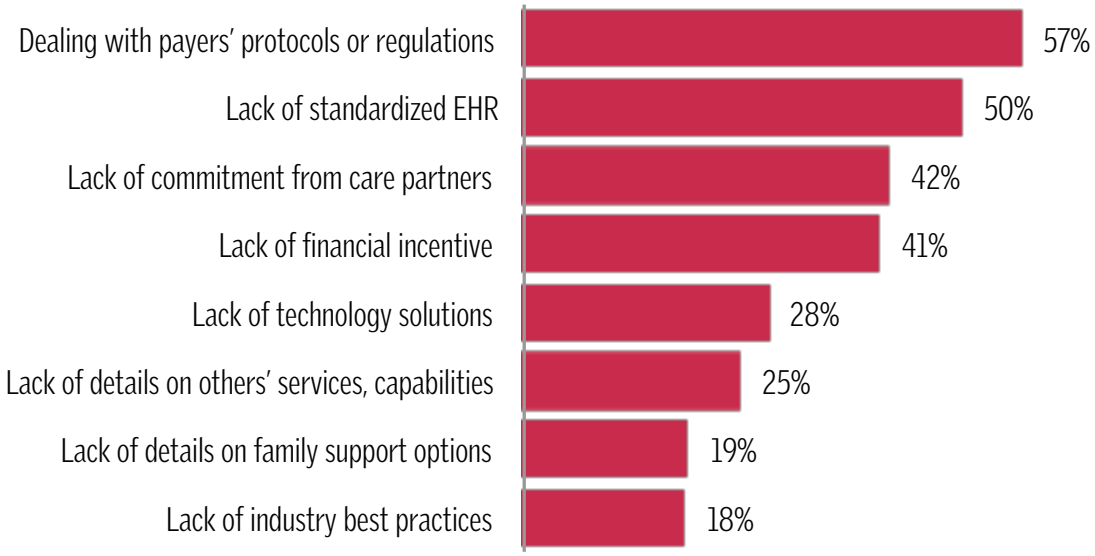
Among hospitals and health systems

Because care coordination within an organization is relatively mature, attention to outpatient venues may yield more results. An advisor observes that because hospitals specialize in providing acute care and, therefore, interact with a small portion of the overall patient population, it is the outpatient environments that will have a broader effect on population health.

SURVEY RESULTS

FIGURE 4: **Challenges in Care Continuum Collaboration**

Q What are the top three challenges your organization faces in developing and extending care continuum collaboration?



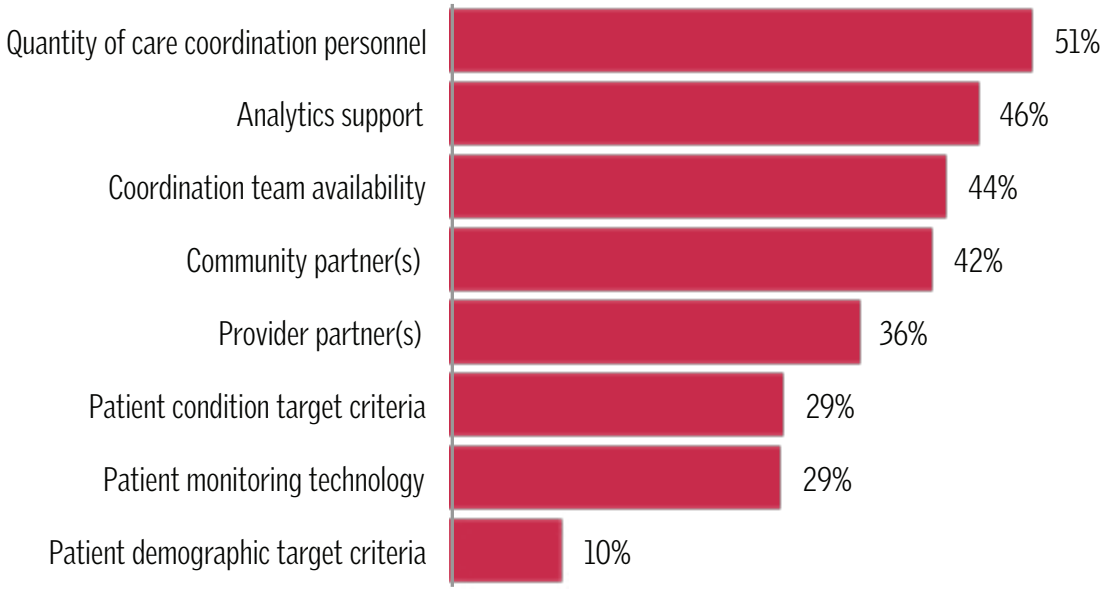
Base = 250, Multi-Response
Among hospitals and health systems

Information makes for successful care coordination. Because information about a patient's care history and care needs is fundamental, lack of EHR standardization thwarts the transfer of information. Participating in a narrow network may relieve some concern about finances: nearly half (45%) of non-narrow network participants cite lack of financial incentive, compared to only 35% of those in narrow networks.

SURVEY RESULTS

FIGURE 5: **Elements Needed to Improve Clinical Outcomes**

Q Of the following care continuum coordination elements, which three are most in need of enhancement to improve clinical outcomes for your organization?



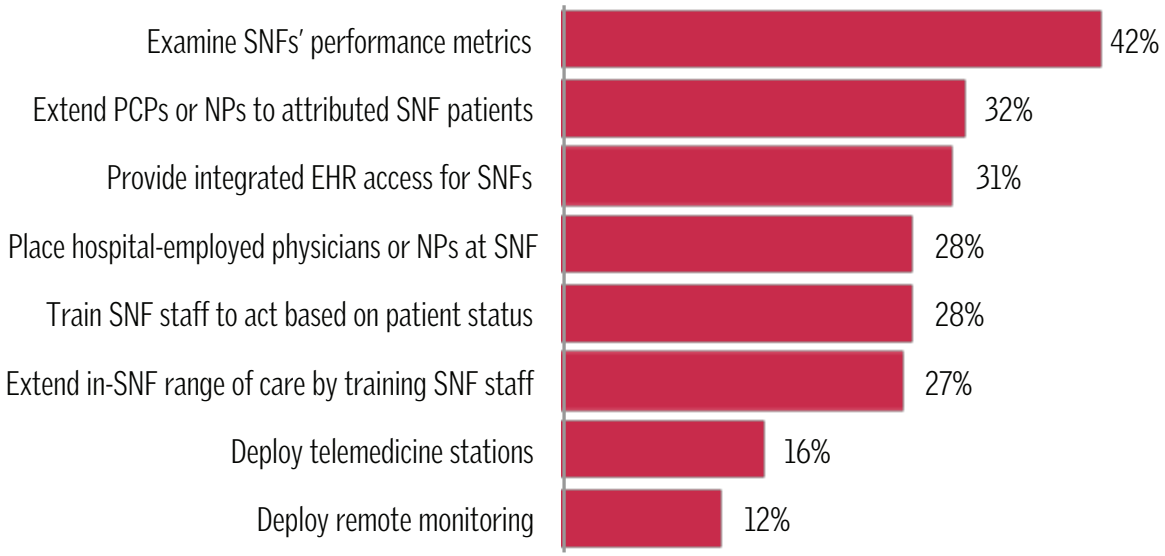
Base = 397, Multi-Response

Overall, the three items mentioned most frequently are related: Resources (personnel) are limited, which means organizations need analytics to help them target the patients most in need of coordination. And team availability is a close cousin to limited personnel resources.

SURVEY RESULTS

FIGURE 6: **Care Collaboration With SNFs**

Q Which of the following is your organization doing to improve care collaboration with SNFs?



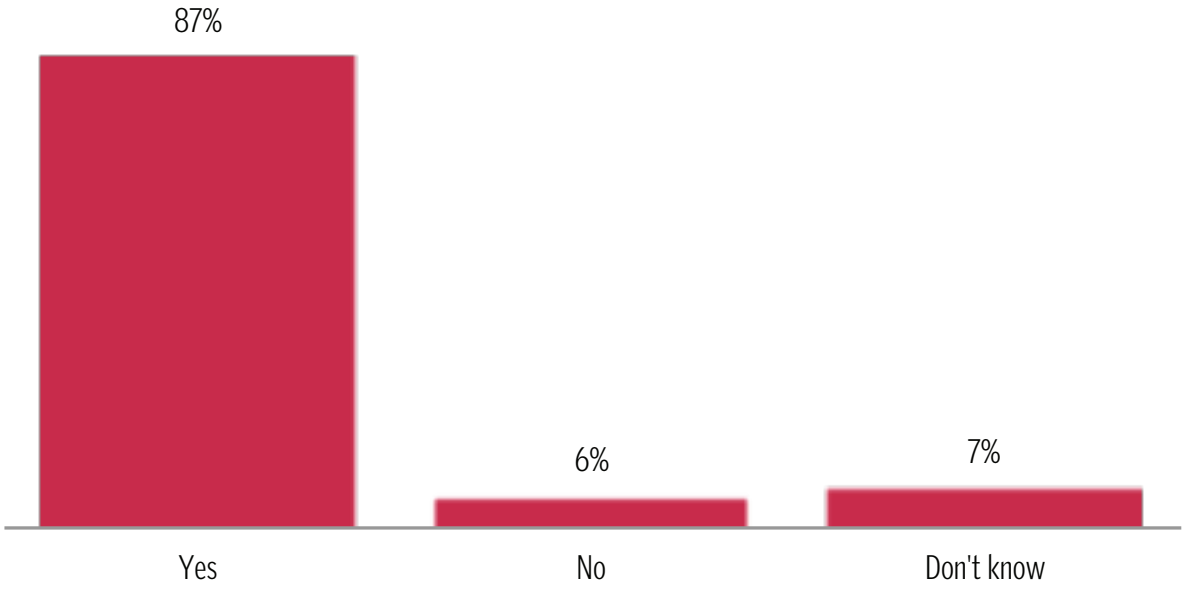
Base = 250, Multi-Response
Among hospitals and health systems

Readmission penalties are expected to affect SNF revenue, and SNFs were already a focus for acute care organizations. In the acute care/SNF relationship, we see how the CMS is prompting new activities that result in better value. Our survey results show that, either by assigning care professionals with additional skills or by training the SNF staff, better care is being provided and better care decisions are being made.

SURVEY RESULTS

FIGURE 7: **Primary Care Physician Role in Strategy**

Q Does your organization's care continuum coordination strategy take into account how, under population health management, primary care physicians will have a role in directing overall patient health?



Base = 338

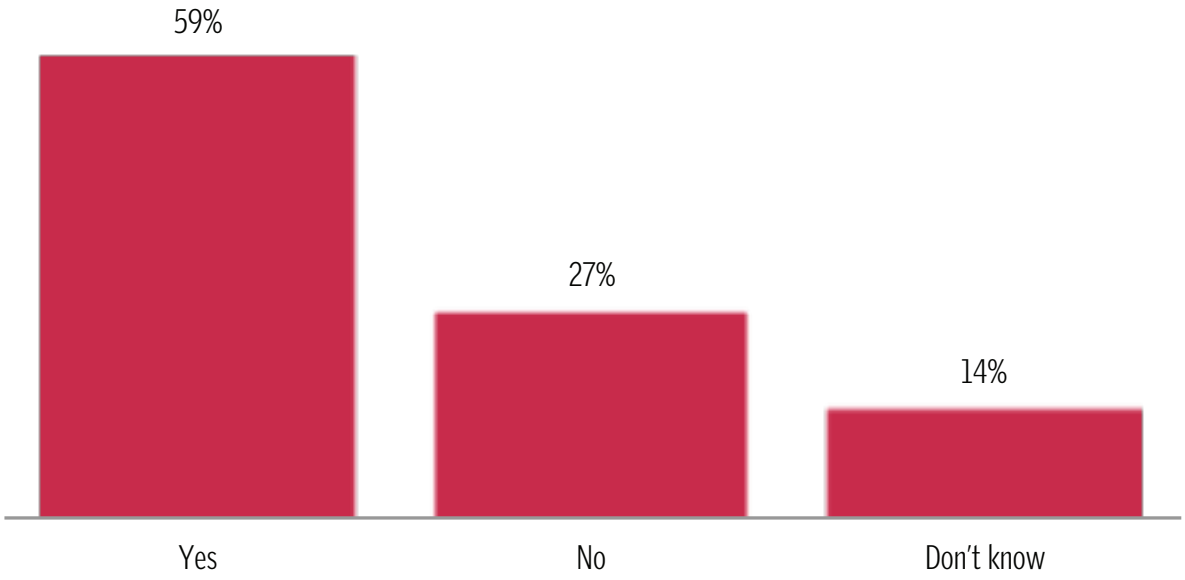
Among those with care continuum strategy

Broad recognition of the benefits of care coordination have resulted in nearly universal acceptance of the principle of the primary care physician at the center of care delivery. However, one wonders how many primary care practices are ready to take on the care coordination task.

SURVEY RESULTS

FIGURE 8: **Strategy for Non-Affiliated Provider**

Q Does your organization's care continuum coordination strategy take into account the need to direct or monitor care when the patient receives care from a provider with which you have no affiliation?



Base = 338

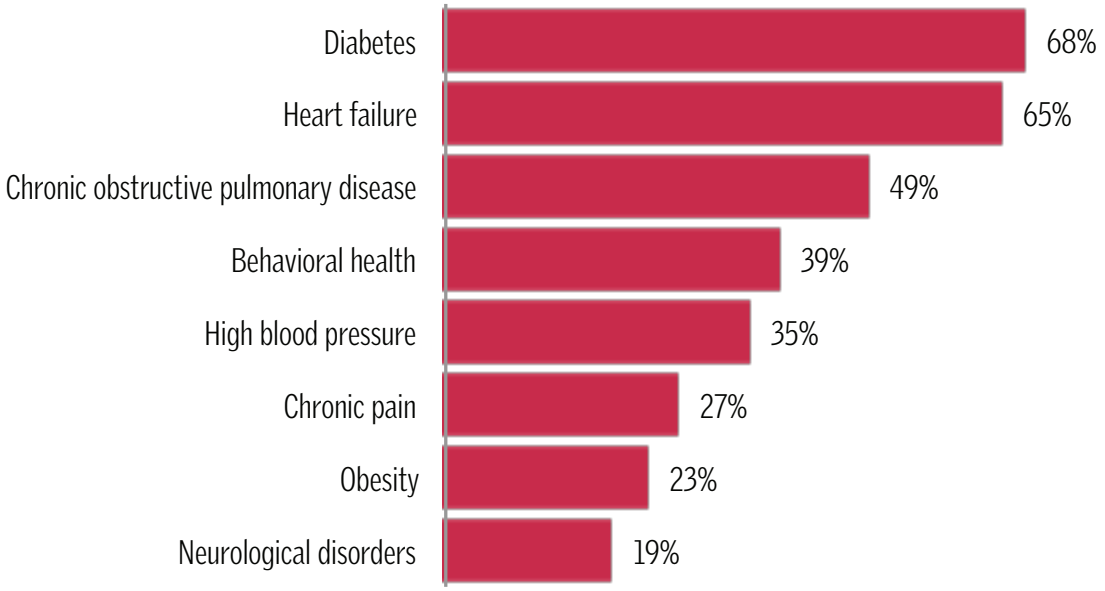
Among those with care continuum strategy

Although most (59%) have strategies that recognize their role even when care is delivered by a provider with which they have no affiliation, more than one-quarter (27%) do not.

SURVEY RESULTS

FIGURE 9: **Condition/Patient Population With Assigned Staffer**

Q For which of the following conditions or patient populations does your organization now have, or expect to develop within the next three years, a care management program with an assigned full- or part-time staffer?



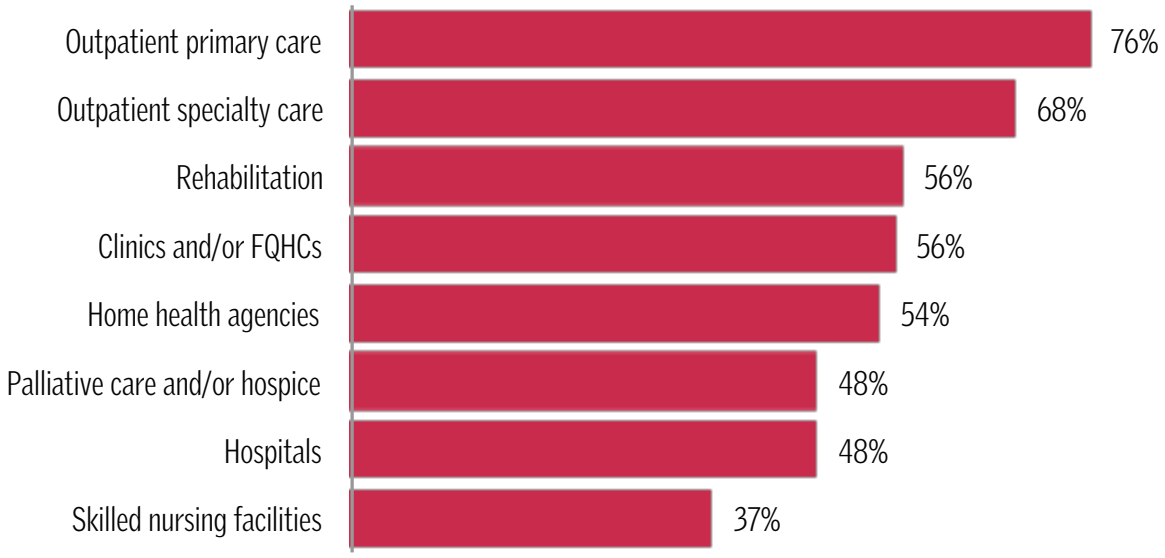
Base = 397, Multi-Response

With a more or less routine set of maintenance steps, an established set of protocols, and the clear relationship between proper care and positive outcomes, programs that address patients with diabetes and heart failure are most common. High blood pressure can be diagnosed, care prescribed and monitored in outpatient environments, so higher percentages of physician organizations than other settings have assigned care management staff to such patients.

SURVEY RESULTS

FIGURE 10: **Clinically Integrated Provider Settings**

Q Which of the following provider settings outside of inpatient acute care are clinically integrated with your organization?



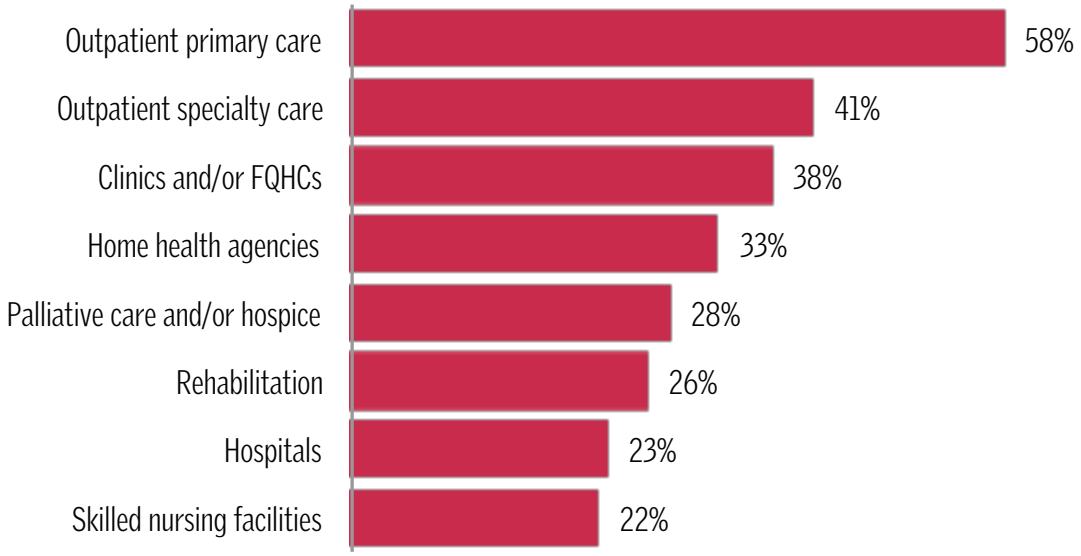
Base = 250, Multi-Response
Among hospitals and health systems

Clinical integration can be seen to be a path to better care coordination. In line with the expectation of the central role of the primary care physician in care coordination, 72% of respondents from hospitals and 81% from health systems say they are clinically integrated with outpatient primary care. But relatively few focus on improving care coordination with SNFs, and just over one-third (37%) are clinically integrated.

SURVEY RESULTS

FIGURE 11: **Clinician Deployment**

Q In which areas outside of inpatient acute care is your organization deploying nurses, nurse practitioners, or other clinicians in order to provide care continuum collaboration?



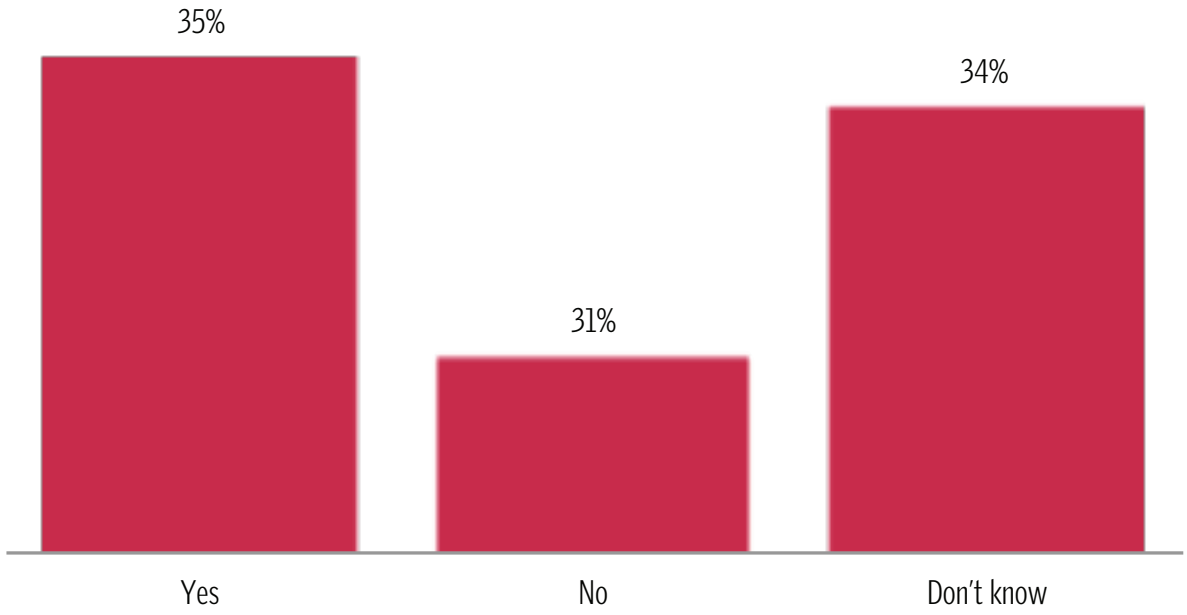
Base = 250, Multi-Response
Among hospitals and health systems

Deploying clinical staffers means investing. It's no surprise that those in narrow networks dedicate more resources than those who are not in networks. After outpatient primary and specialty care, the top staff assignments are in clinical/FQHCs and home health.

SURVEY RESULTS

FIGURE 12: **Participation in Payers' Narrow Networks**

Q Does your organization participate in payers' narrow networks?



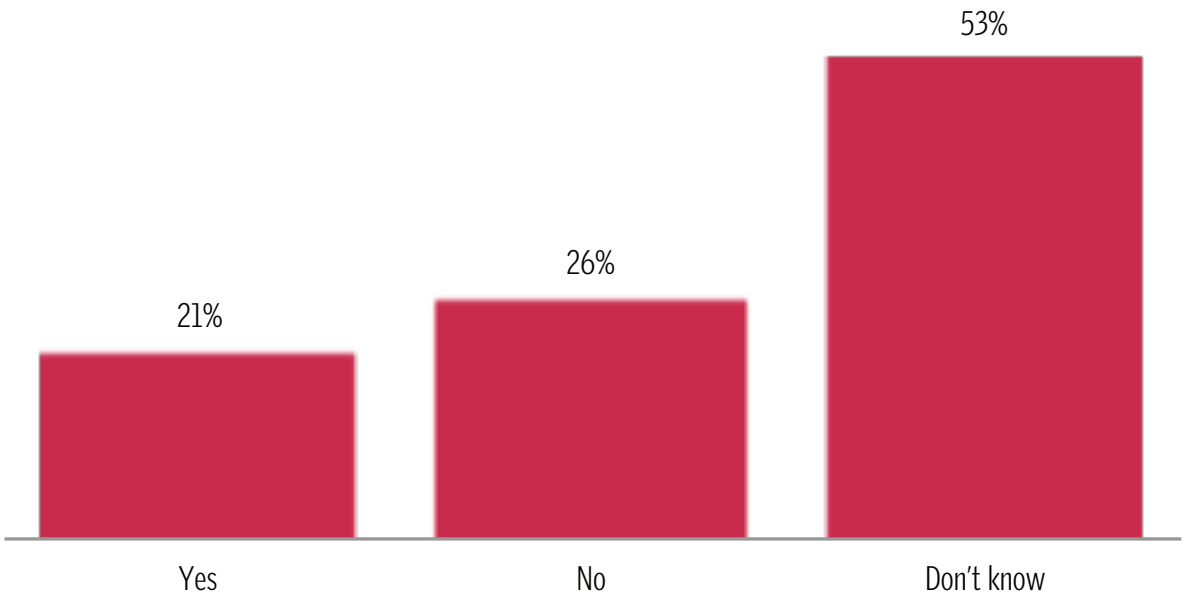
Base = 397

Care coordination is an important motivation for participating in narrow networks. But perhaps the overarching objective for organizations is the looming need to deliver value-based care, which has broad implications beyond care coordination, including financial changes as well as care-delivery consequences.

SURVEY RESULTS

FIGURE 13: **Expectation of Payers' Narrow Networks**

Q Do you expect that payers' narrow networks will lead to lower costs of care with better outcomes?



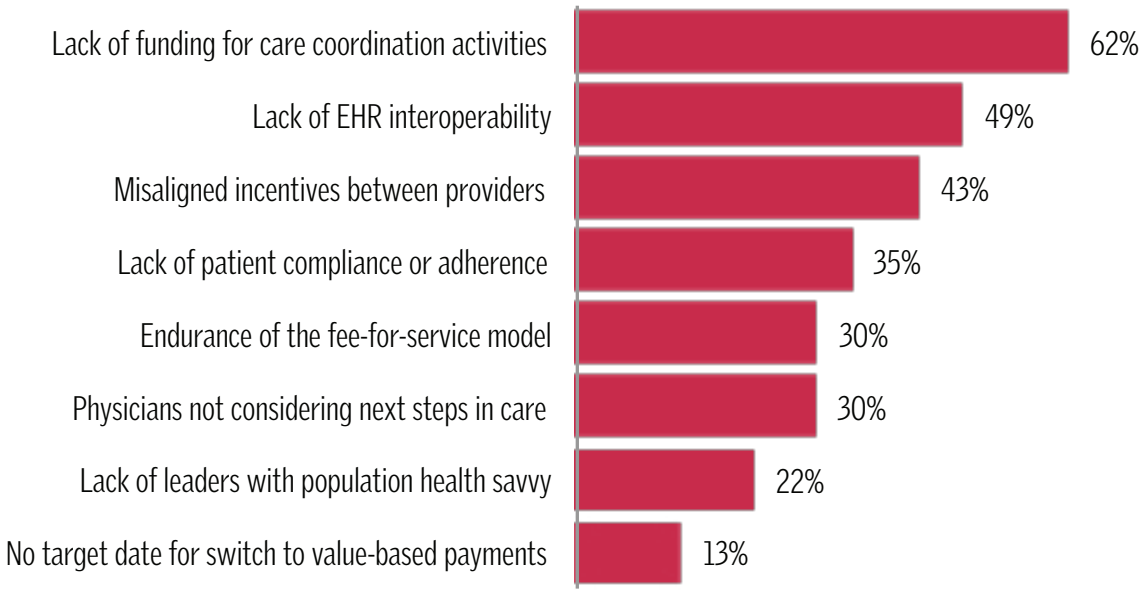
Base = 397

As with many subjects having to do with healthcare reform, uncertainty abounds, yet many organizations continue to pursue new strategies, while some sit on the sidelines, for now.

SURVEY RESULTS

FIGURE 14: **Factors Preventing Care Continuum Advancement**

Q Of the following factors, which three are most responsible for preventing industry advancement in implementing care continuum collaboration on a widespread basis?



Base = 397, Multi-Response

Lack of funding is at the top of the chart, and remains a hurdle for the industry. Responding to an earlier question, 41% include lack of financial incentive among the challenges they face in developing and extending care coordination (Figure 4). And here, we see misaligned incentives as the third most mentioned item, and it is related to funding, because incentives, revenue, and funding are all connected.

SECTION SIX

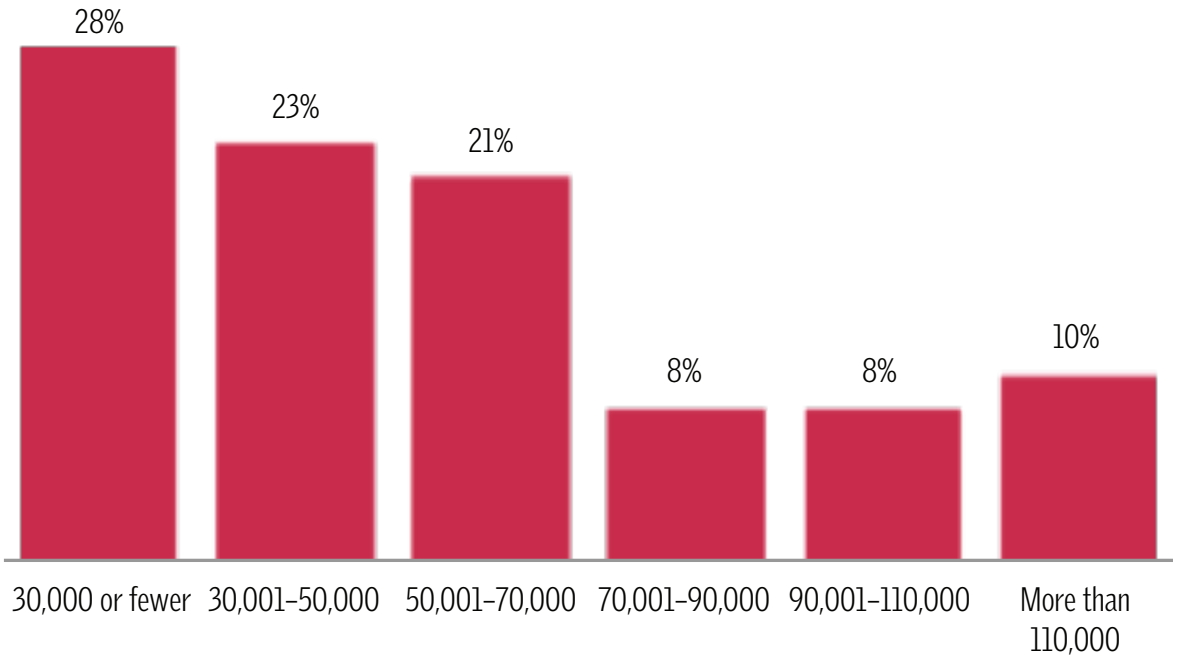
ED Success:
Coordinating Emergent and Nonemergent Care

FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: MAY 2016

SURVEY RESULTS

FIGURE 1: **Annual Visits to ED**

Q What is the approximate number of annual patient visits to your ED?



Base = 212

More than one-quarter (26%) of survey respondents report that their EDs see in excess of 70,000 visitors annually. On the low-volume side, 28% say their EDs receive 30,000 or fewer visitors annually. As one would expect, ED volume is related to net patient revenue: 26% of organizations with $1 billion or more in net patient revenue see more than 110,000 patients in their ED annually. And 42% of organizations with net patient revenues below $250 million experience 30,000 or fewer annual patient visits in their EDs.

SURVEY RESULTS

FIGURE 2: **ED Challenges**

Q Please rank the top three challenges facing your ED.

	Net Top 3	1st Rank
Accommodating mental health patients	70%	35%
Shortage of inpatient beds	42%	20%
Wait times	42%	10%
In-ED patient flow	35%	13%
Patient flow external to ED	34%	12%
Accommodating opioid/substance abuse patients	32%	3%
Accommodating nonemergent patients	29%	5%
Accommodating patients with chronic diseases	15%	1%

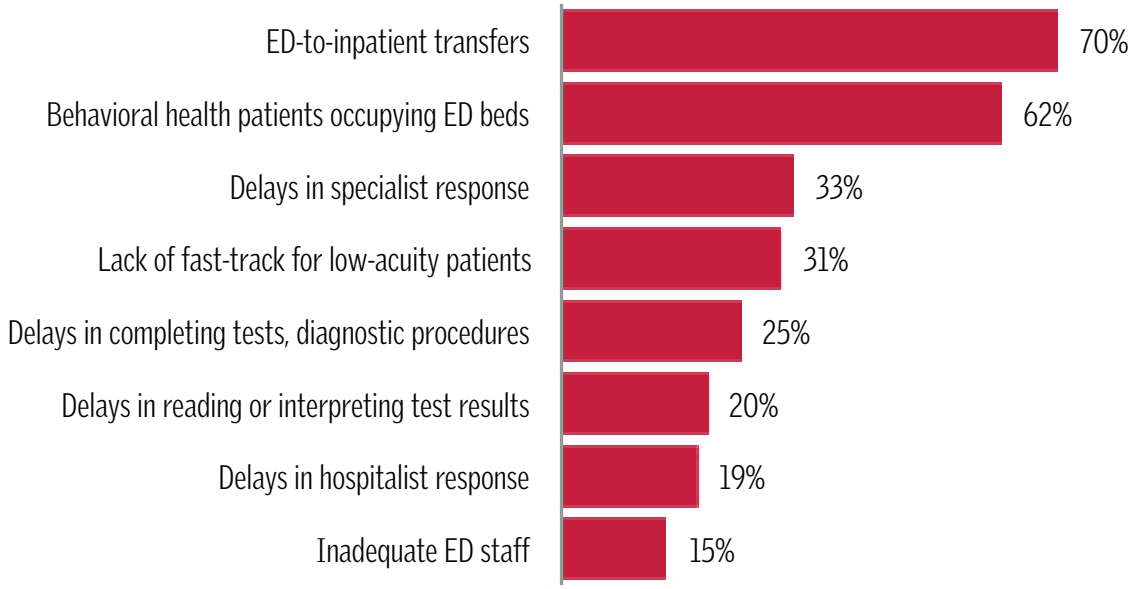
Base = 212

That EDs have difficulty with mental health patients is clear: More than one-third (35%) say that accommodating mental health patients is their No. 1 challenge, and 70% include mental health patients among their top three challenges. The item mentioned next in frequency is the shortage of inpatient beds, the top problem for 20% and among the top three for 42%. The high position of the inpatient bed problem is an example of how optimizing ED efficiency can be seen as an organizationwide activity.

SURVEY RESULTS

FIGURE 3: **Bottleneck Problems for ED Flow**

Q Please select the top three factors that present bottleneck problems for in-ED flow.



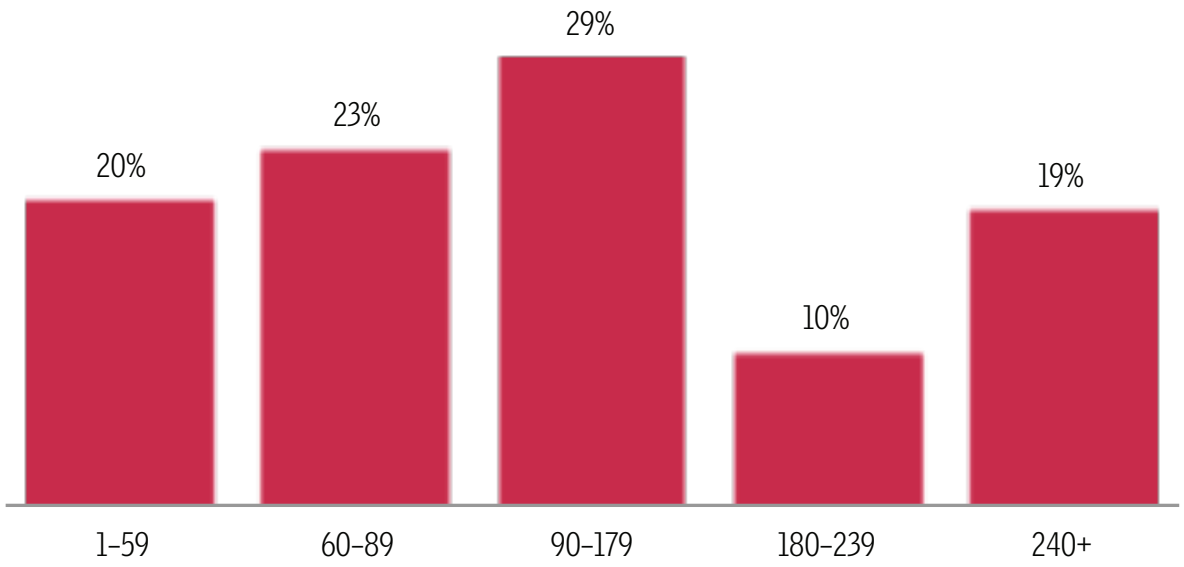
Base = 212, Multi-Response

Nearly three-quarters (70%) include ED-to-inpatient transfers among their top three reasons for stalled ED flow. Behavioral health patients occupying ED beds is the item mentioned second most frequently, by 62%. Both factors essentially diminish ED capacity as patients await the next steps in their care.

SURVEY RESULTS

FIGURE 4: **Average Time Between Decision to Admit and Time Patient Leaves ED**

Q What is the average number of minutes between the decision to admit a patient and the time the patient leaves the ED?



Base = 153

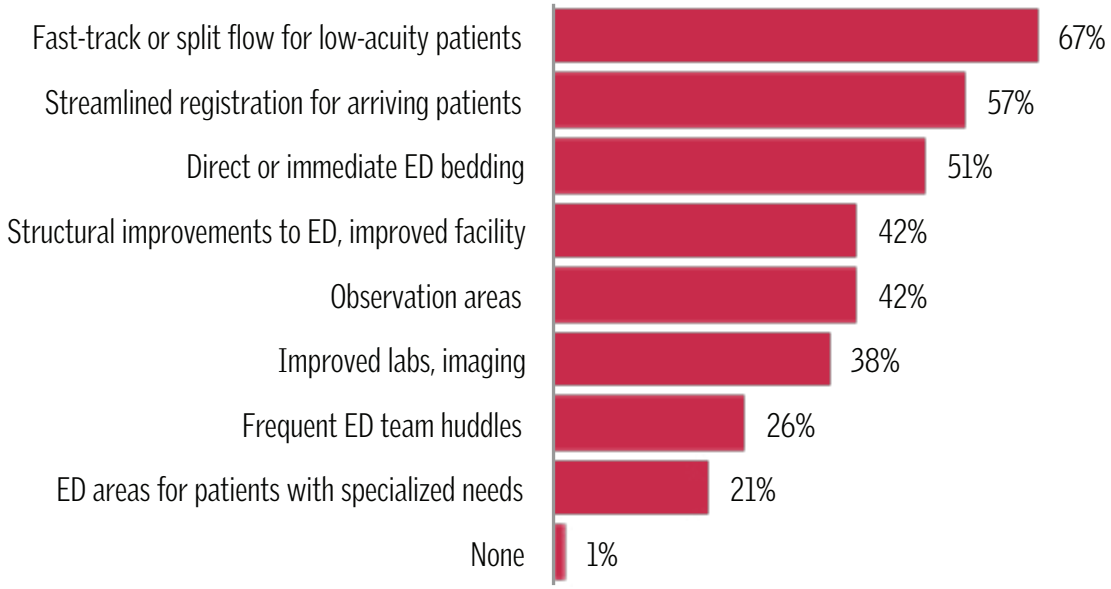
Average number of minutes = 141

One-fifth (20%) of the ED's patients who are to be admitted are moved out of the ED less than an hour after the decision to admit is made. For another one-fifth (19%), the delay after a decision is made to admit the patient is four hours or more. The average wait time is 141 minutes between the decision to admit a patient and the time the patient leaves the ED.

SURVEY RESULTS

FIGURE 5: **Operations Techniques to Increase ED Throughput**

Q Please identify the operations techniques your organization uses now to help optimize ED throughput efficiency.



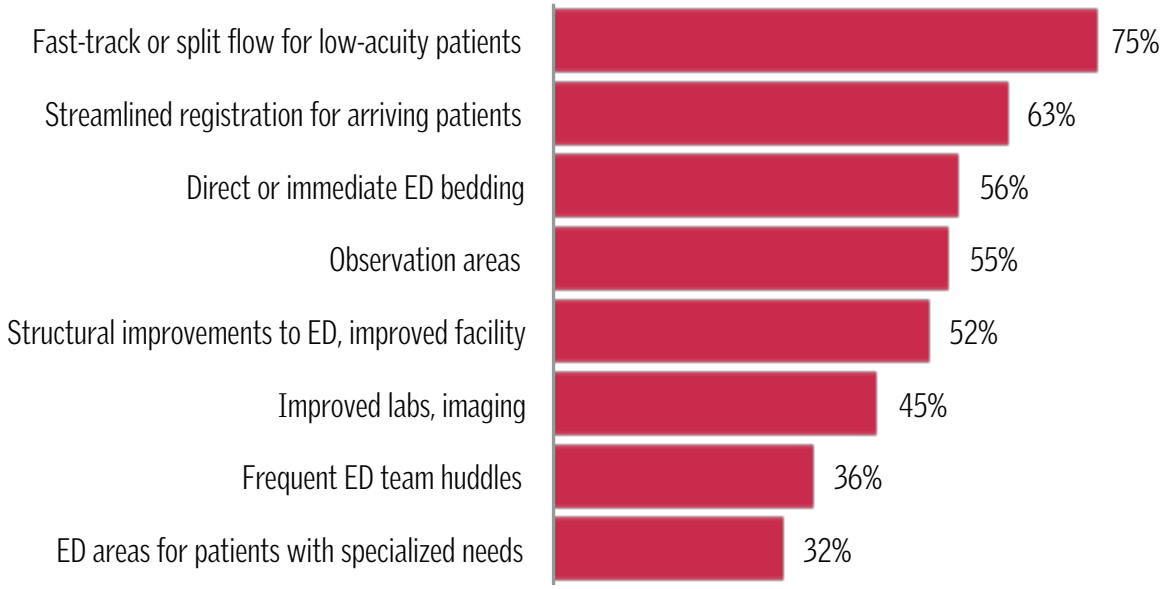
Base = 212, Multi-Response

Common techniques for managing ED throughput include fast-track or split flow for low-acuity patients (67%), streamlined registration for arriving patients (57%), and direct or immediate ED bedding (51%). However, EDs are highly individualized, and must use a set of flow-optimization tools that are appropriate for the hospitals they are part of, and are appropriate for the characteristics of the population they serve.

SURVEY RESULTS

FIGURE 6: **Operations Techniques to Optimize ED Throughput Next Three Years**

Q Please identify operations techniques that your organization expects to be using within three years to improve ED throughput efficiency.



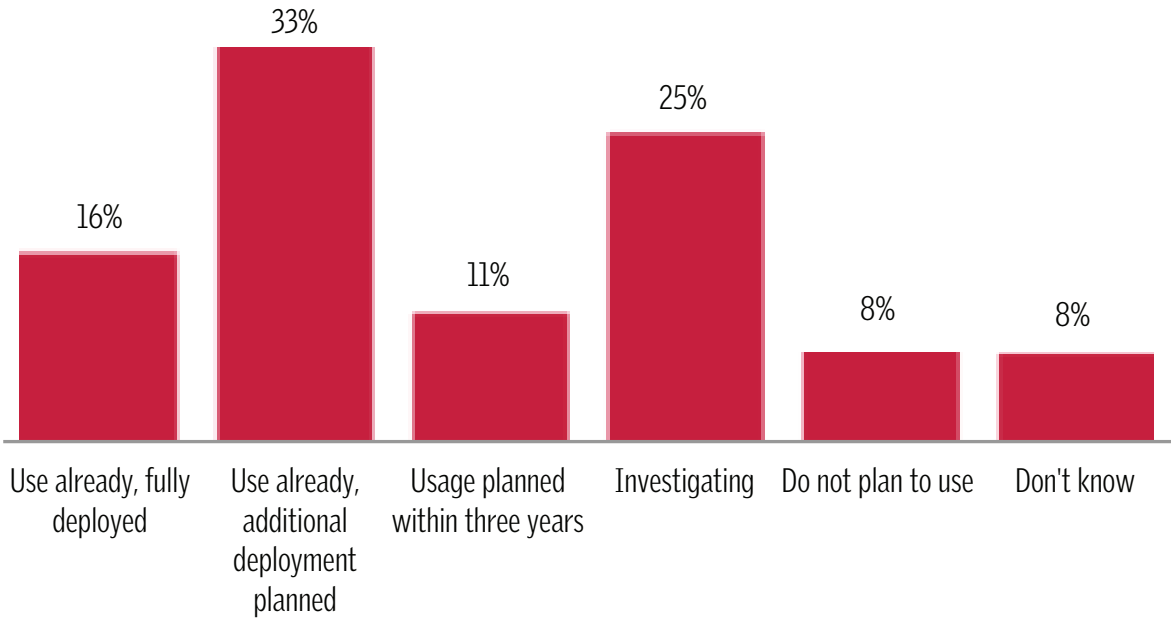
Base = 212, Multi-Response

Within three years, 75% will have a fast-track for low-acuity patients, an increase of eight percentage points over the current 67% (Figure 5). In the three-year time frame, observation areas show the largest gain, moving to 55% from a present level of 42%, an increase of 13 points. One-third (32%) expect to be using ED areas for patients with specialized needs, an increase of 11 points over the present 21% measure. Healthcare leaders are focusing on patients with conditions that delay progress through the ED for other patients by implementing tactics to accommodate such patients outside of the main ED patient flow.

SURVEY RESULTS

FIGURE 7: **Status of Telemedicine Deployment in the ED**

Q What is your organization's status regarding deployment of telemedicine in the ED?



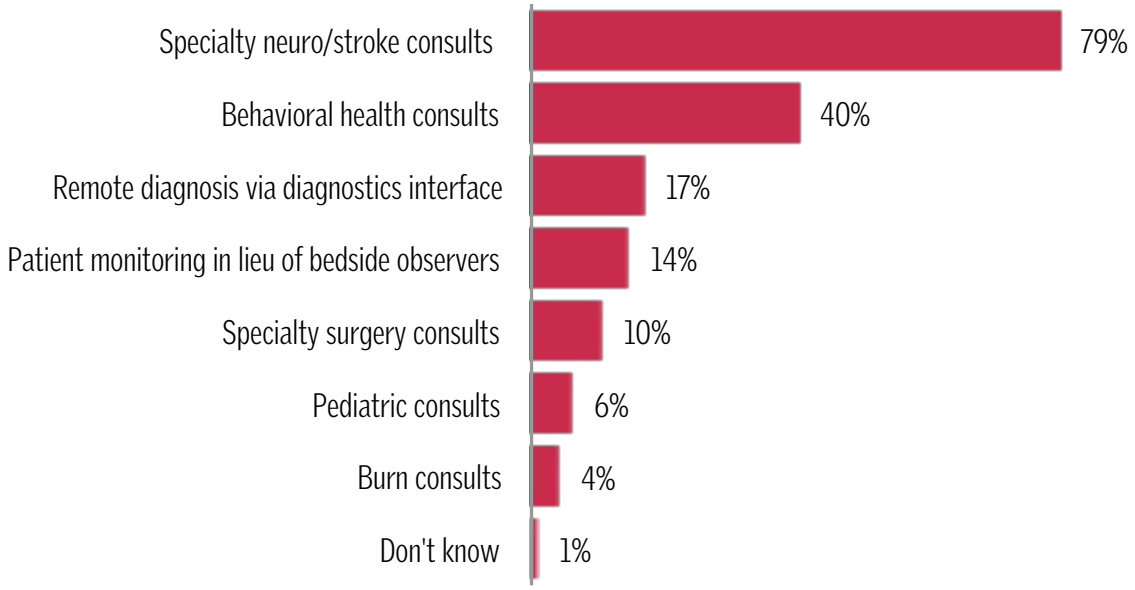
Base = 212

Nearly half of respondents (49%) use telemedicine in EDs now, with 33% planning additional deployment. Another 11% expect to use telemedicine within three years, and one-quarter are still investigating. The benefits of the technology are apparent, and it is just a matter of time until it becomes a standard ED resource.

SURVEY RESULTS

FIGURE 8: **Principal Telemedicine Applications in ED**

Q What are the principal applications for telemedicine in your ED?



Base = 125, Multi-Response

Among those who have deployed telemedicine in the ED or plan to within three years

By far, the telemedicine application mentioned most frequently is specialty neuro/stroke consultations (79%). The second most common use is for behavioral health consults (40%). However, telemedicine has broad applications. Among the other uses respondents told us about are pediatric consults (mentioned by 6%) and burn consults (mentioned by 4%).

SURVEY RESULTS

FIGURE 9: **Expected ED Area Increases Next Three Years**

Q For which of the following is your organization expecting an increase within the next three years?

	2016	2015
ED patient volume	70%	78%
ED quality outcomes	63%	64%
Volume of hospital admissions from the ED	46%	48%
Insured patients not paying deductible/copay	45%	45%
Uninsured/self-pay ED patients	41%	50%
Newly insured with nonemergent conditions	39%	NA
Percentage of nonemergent ED patients	32%	45%
ED operating margin	21%	11%
None	1%	2%
Base	212	274

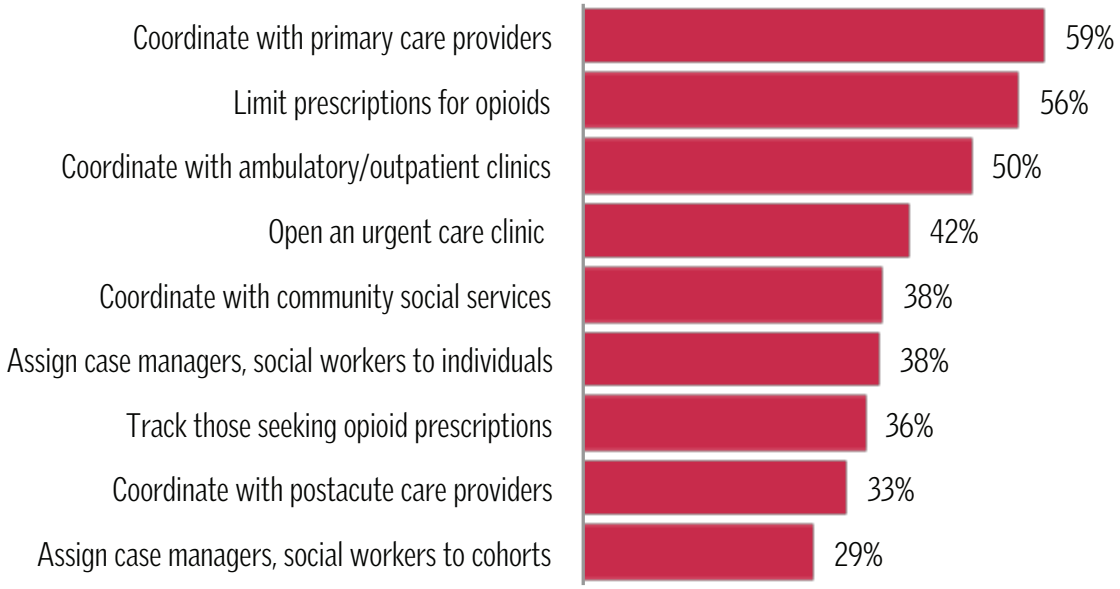
Multi-Response

Nearly three-quarters (70%) expect ED patient volume to increase within the next three years. And nearly two-thirds (63%) expect ED quality outcomes to increase. One-third (32%) say that they expect the percentage of nonemergent patients to go up over the next three years, a measure that is down from 45% who said last year they expected increases. This year the percentage who expect increases over three years in uninsured or self-pay patients has declined also, from 50% last year to 41% now. This year, 21% expect ED operating margins to increase, compared to 11% who expected an increase last year.

SURVEY RESULTS

FIGURE 10: **Tactics to Minimize Avoidable ED Visits**

Q Which tactics does your organization use to minimize avoidable visits to your ED?



Base = 212, Multi-Response

Nearly two-thirds (59%) include coordinating with primary care providers among their tactics for minimizing avoidable visits to their EDs, the item mentioned most frequently. Nearly as many (56%) say limiting prescriptions for opioids is a tactic for minimizing avoidable visits. The third-most-mentioned item is coordinating with ambulatory and outpatient clinics (50%), which, like primary care, can affect both initial ED visits and repeat ED visits.

SURVEY RESULTS

FIGURE 11: **Status of Alternative Care Settings**

Q What is your organization's status regarding each of the following care settings?

	Convenient care clinics (often in big-box retail)	Urgent care clinics (walk-in, extended hours)	Freestanding EDs (full range of emergency care)
We own	16%	51%	25%
We partner	10%	8%	4%
We have an informal working relationship	6%	8%	1%
Plan within three years	4%	8%	2%
Investigating	16%	11%	13%
Not involved, not pursuing	28%	9%	32%
Not applicable	19%	6%	22%

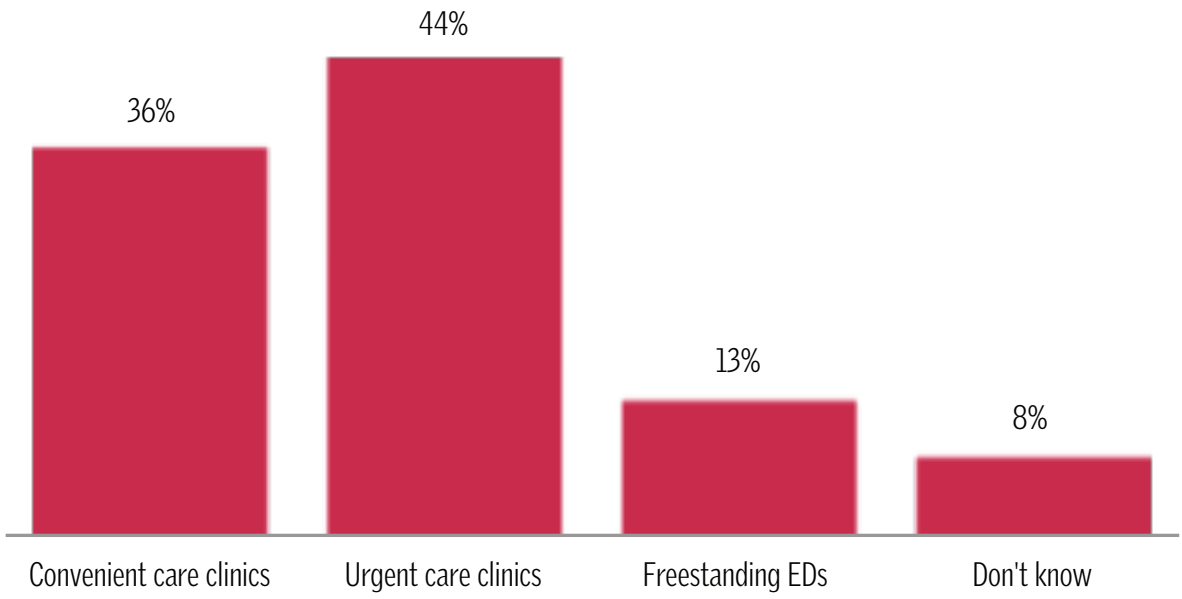
Base = 212

Fifty-nine percent either own (51%) or partner (8%) with an urgent care clinic. Slightly more than one-quarter either own (16%) or partner with (10%) convenient care clinics. Twenty-five percent own and 4% partner with a freestanding ED. Because all three provide alternatives to the ED for those seeking care, and most of the time can provide care at lower costs, they represent care settings to consider as part of efforts to improve overall efficiency and effectiveness.

SURVEY RESULTS

FIGURE 12: **Care Setting With Most Potential to Improve Industry's Ability to Deliver Value-Based Care**

Q Of the three care settings, in your appraisal, which has the most potential to improve the industry's ability to deliver value-based care?



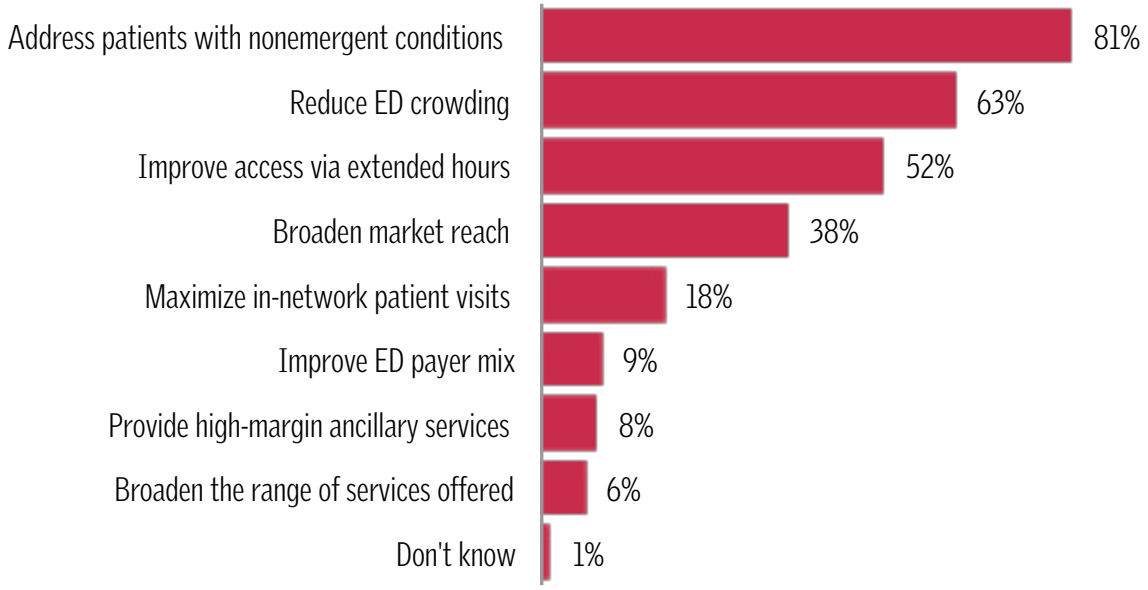
Base = 212

A higher percentage of healthcare leaders say that urgent care centers have the most potential to improve the industry's ability to deliver value-based care (44%) than those who say convenient care clinics have the most potential (36%). But the percentages are close, indicating that both settings are expected to be important to the industry's value-based future.

SURVEY RESULTS

FIGURE 13: **Motivations for Pursuing Urgent Care Clinic**

Q Which of the following are among your top three motivations for pursuing an urgent care clinic?



Base = 157, Multi-Response

Among those with or planning an urgent care clinic

Among those with or planning an urgent care clinic, top among the motivations is to provide a setting to address the needs of patients with nonemergent conditions (81%). The item mentioned second most often is related, no doubt: to reduce ED crowding (63%). More than half (52%) are pursuing urgent care centers to improve access through extended hours. Business issues are part of the mix, with 38% including the desire to broaden market reach among their top motivations.

SURVEY RESULTS

FIGURE 14: **Provider/Service Effectiveness in Helping Patients Make Appropriate Use of ED**

Q Please rank the following care continuum providers or services according to their effectiveness in helping patients make more appropriate use of your organization's ED.

	Net Top 3	1st Rank
Primary care physicians	79%	53%
Urgent care centers	54%	16%
Behavioral health services	42%	8%
Community-based clinics/FQHCs	40%	10%
Convenient care clinics	28%	5%
Social services	25%	4%
Skilled nursing facilities	15%	2%
Home health	15%	1%

Base = 210

There is wide understanding of the role for the primary care physician in helping patients make more appropriate use of EDs. More than half (53%) rank primary care physicians first in effectiveness in helping patients make more appropriate use of EDs. And 79% include primary care physicians among the top three care continuum providers in effectiveness. In comparison, only 16% rank urgent care centers first in effectiveness in helping patients make more appropriate use of their EDs, while 54% include urgent care centers in their top three.

SECTION SEVEN

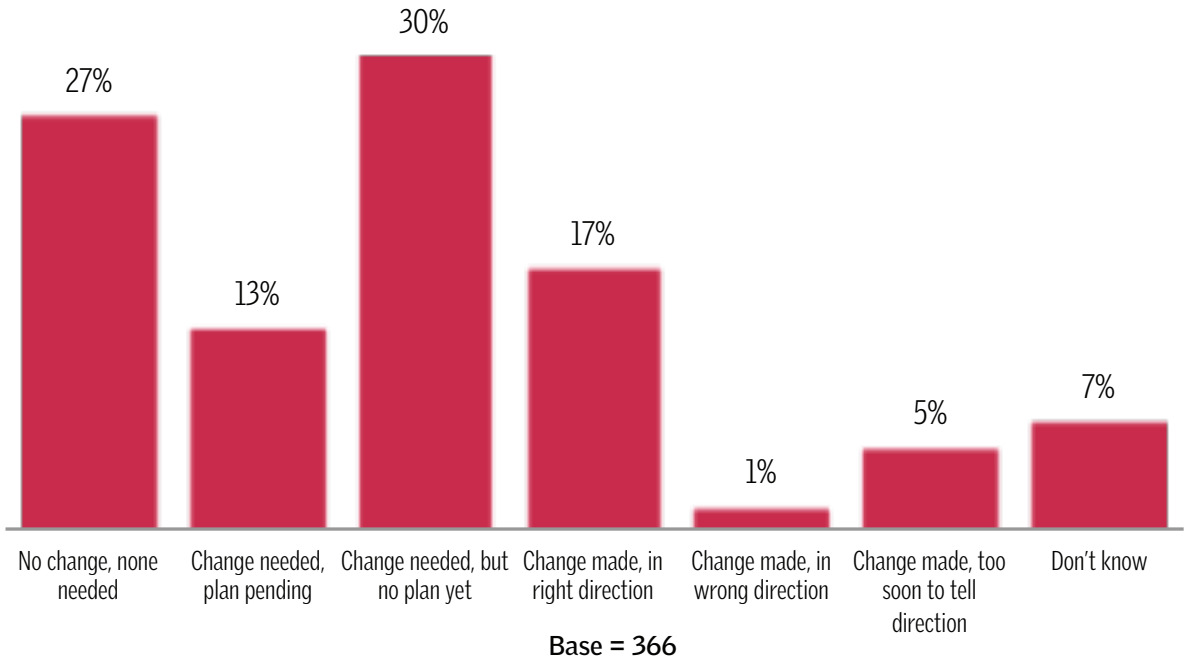
Executive Compensation:
Strategies to Align With New Directions

FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: NOVEMBER 2015

SURVEY RESULTS

FIGURE 1: **Executive Compensation Strategy Addressing Financial Realities Now**

Q Which of the following best describes how your organization's executive compensation strategy is addressing the **financial objectives** of healthcare now?

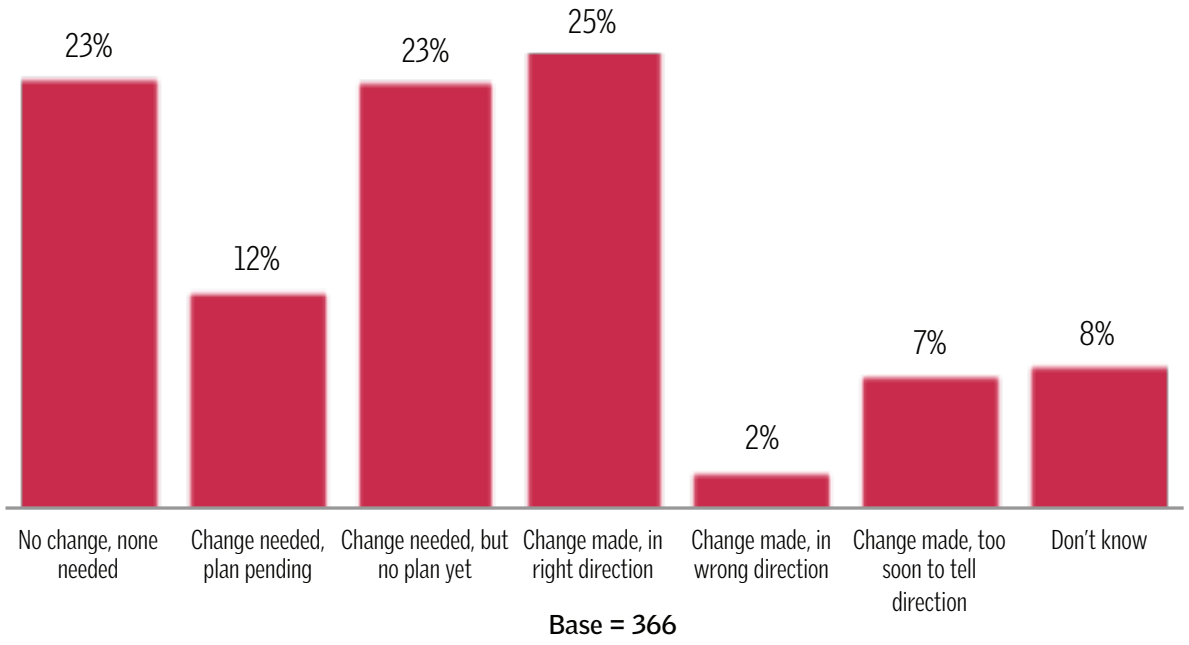


Although the majority of healthcare executives say their organization's compensation strategy either needs no change or is moving forward with at least a plan to address the financial objectives of healthcare (62%), fully 30% acknowledge that change is needed and no plan is in place. So a sizeable portion of the industry runs the risk of having an executive team that does not have its compensation package serving to inspire movement in a reform-related direction.

SURVEY RESULTS

FIGURE 2: **Executive Compensation Strategy Addressing Patient Care Objectives**

Q Which of the following best describes how your organization's executive compensation strategy is addressing the **patient care objectives** of healthcare now?

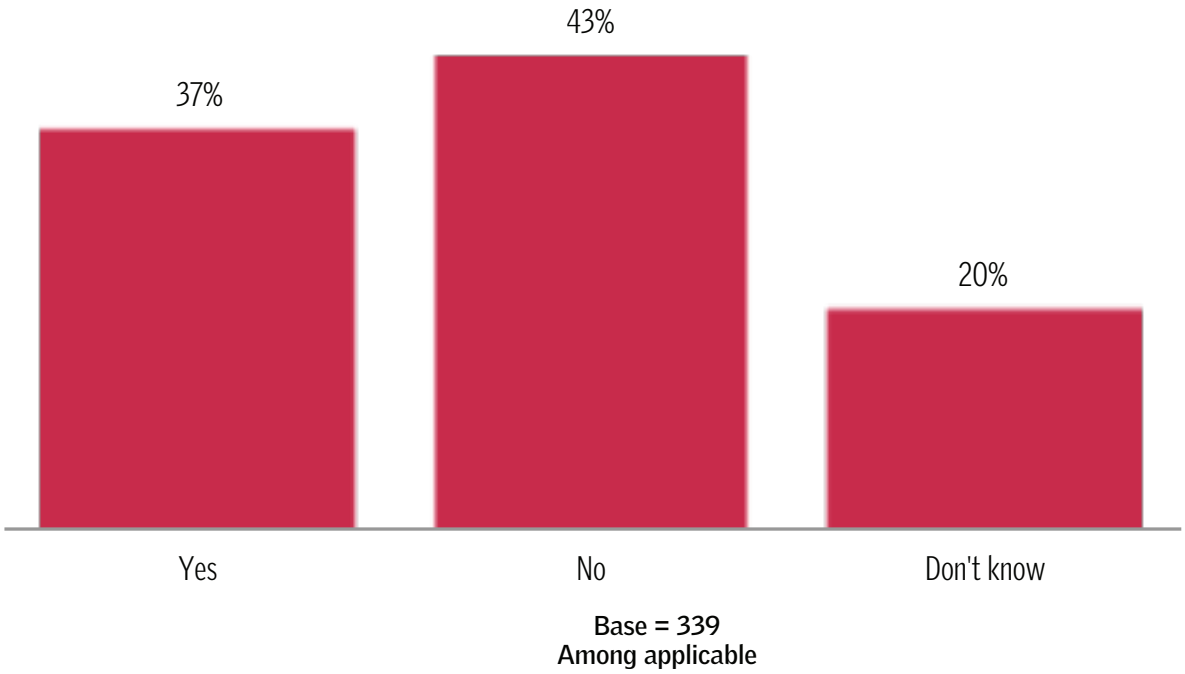


By a slight margin, a higher percentage of compensation strategies are responding to the clinical objectives of healthcare today than are responding to the financial objectives (67%, compared to 62% in Figure 1). Still, 23% say change is needed but no change is planned. An important difference between clinical and financial objectives is the high levels of experience providers have optimizing patient-care performance. The parameters for successful financial performance have become moving targets, and will become more complicated considering the pending need to share financial success or failure with a care network.

SURVEY RESULTS

FIGURE 3: **Modifying Team Incentives for Shift to Value-Based Purchasing**

Q In consideration of the shift from fee-for-service to pay-for-value, has your organization modified its group or team incentives for executive compensation packages, or is it expected to do so?



With only 37% saying their organization has modified its incentive programs to address the shift to pay-for-value reimbursements, a sizeable portion risks having incentives misaligned with industry direction.

SURVEY RESULTS

FIGURE 3a: **Comments**

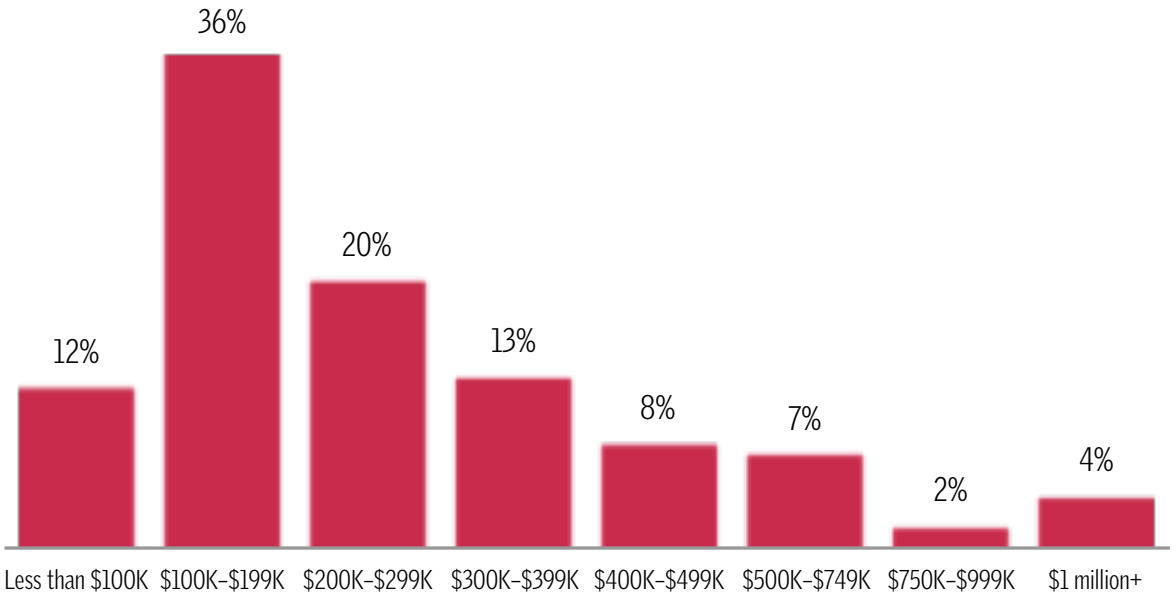
Here are selected comments, with organization type noted, from among the 125 organizations that answered Yes in Figure 3. They describe how their organization has modified (or expects to modify) group or team incentives for executive compensation that address the shift to pay-for-value.

SMALL (low revenue, $249.9 million or less)	**MEDIUM** ($250 million to $999.9 million)	**LARGE** (high revenue, $1 billion +)
ACO objectives, patient experience. (physician organization)	Outcome metrics, quality scores. (health system)	Incentives based on patient satisfaction, HCAHPS, population health, others. (health system)
Value-based outcomes. (hospital)	Value-based measures plus patient experience. (hospital)	Higher percents based on patient engagement, patient satisfaction, value-based purchasing, plus attaining certain strategic accomplishments. (health system)
Outcomes measures, readmissions. (long-term care/ SNF)	Incentives based on health plan profitability, membership. Also, growth in Medicare Advantage plan, ACO. (hospital)	Pending: To be based on improvements in population health status, development of strategic provider partnerships, improving access. (health system)
Value-based purchasing metrics, others. (hospital)	Goals based on population health preparedness. (health system)	Population health/risk now is one of five strategic goals. (health system)
Patient outcome goals. (hospital)	Clinical outcomes. (government)	Incentives tied to enterprise goals, with pay-for-value an enterprise goal. (health plan)
Population health and value-based components. (hospital)	Incentives on per-member per-month in self-insurance, and execs reaching "targets for change." (health system)	Risk value management. (physician organization)
Patient satisfaction, collaborative initiatives. (hospital)	Track cost per case and aggregated cost. Incentives based on quality, patient experience. Incentive based on patient use of MyChart for engagement. (health system)	Incentives based on covered lives, narrow network participation. (health system)

SURVEY RESULTS

FIGURE 4: **Total Compensation**

Q Which range does your total compensation package fall into? Include cash compensation, non-cash compensation, and deferred compensation.



Base = 366

Contributing to the slight upward trend in overall compensation may be the pursuit of executives with in-demand skills, individuals brought in to guide programs such as population health management or to direct analytics activities.

SURVEY RESULTS

FIGURE 5: **Allocation of Total Compensation**

Q In the current fiscal year, how is your compensation divided among cash compensation, non-cash compensation, and retirement?

	Average
Base salary (cash)	79%
Incentives for short- and long-term goals (cash)	10%
Retirement	5%
Non-cash	3%
Deferred	2%

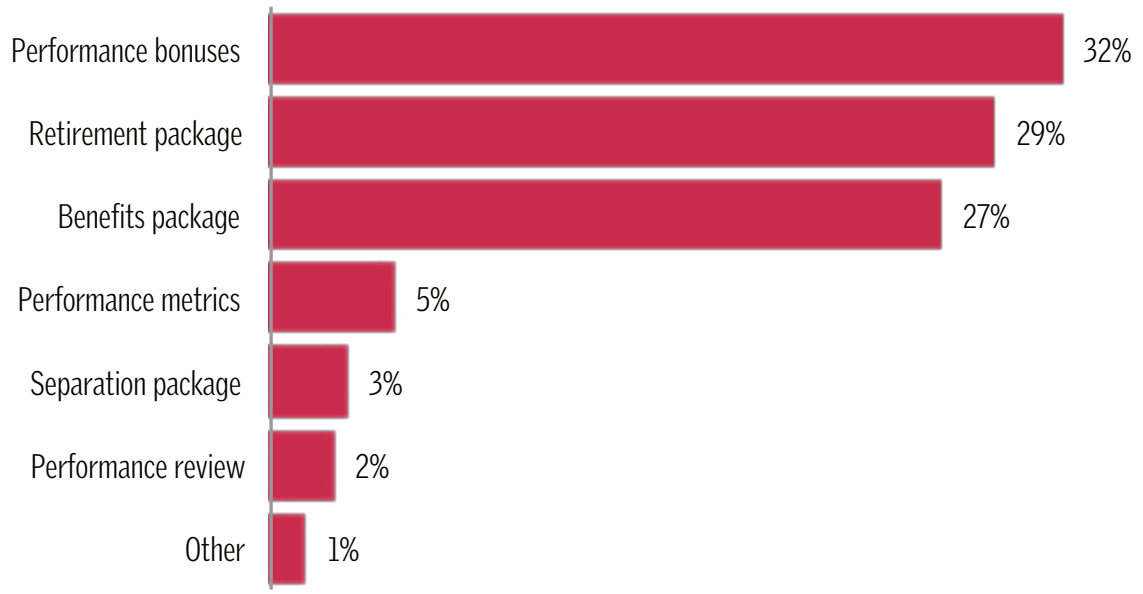
Base = 366

While we see that the percentages of at-risk or incentive payments increase as organization complexity and size (net patient revenue) increases, the percentage of at-risk compensation shows stability over time. Although we don't present the data here, this year's overall reading for incentive payment portion is just about the same as we recorded the last three years, varying by no more than one percentage point.

SURVEY RESULTS

FIGURE 6: **Most Important Aspect of Executive Compensation Excluding Base Salary**

Q Other than base salary, which aspect of executive compensation is **most** important to you, personally?



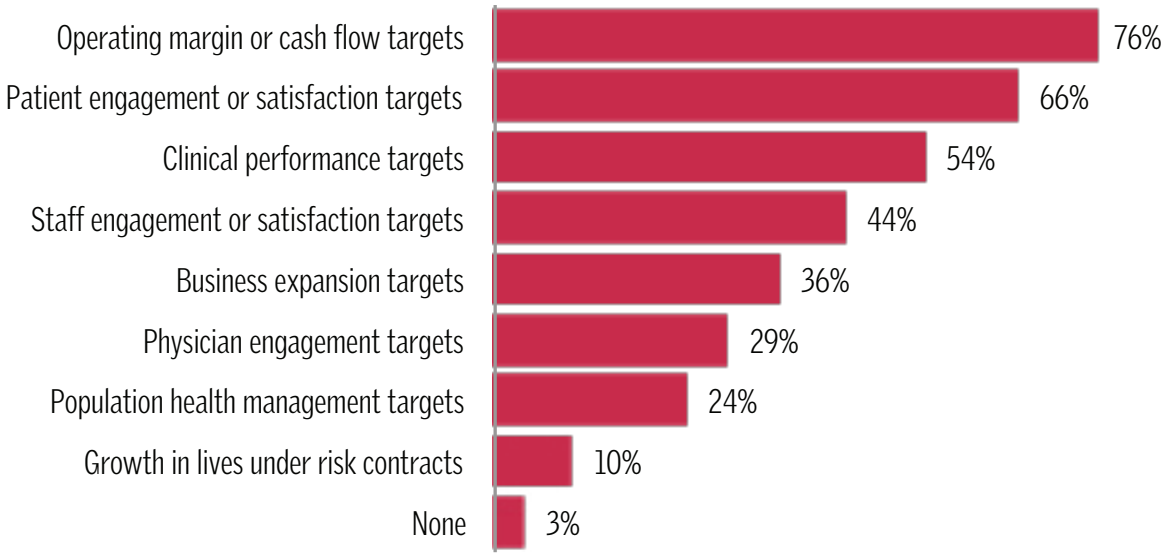
Base = 366

Despite the motivating power of incentive-based compensation, overall performance bonuses are not substantially favored over retirement packages or benefits packages. However, in the highest-revenue organizations, 43% say performance bonuses are most important to them. In organizations with net patient revenue of $1 billion or more, 20% of executives earn $500,000 or more. One can assume that both the challenges and the rewards are more significant in high-revenue organizations.

SURVEY RESULTS

FIGURE 7: **Basis for Individual Incentive Payments**

Q Which of the following general categories serve as a basis for your current **individual** executive incentive payments?



Base = 230, Multi-Response
Among those with incentives

In medium- and high-revenue organizations, patient engagement and operating margin/cash flow serve as incentives nearly equally, suggesting that patient engagement is on equal footing in larger organizations offering incentives. Objectives related to healthcare reform such as growth in lives covered under risk contracts and population health management are relatively scarce, which is an indication of the resiliency of fee-for-service both as a business foundation and as a basis for variable compensation.

SURVEY RESULTS

FIGURE 8: **Basis for Team Incentive Payments**

Q Which of the following general categories serve as a basis for your current **team** executive incentive payments?

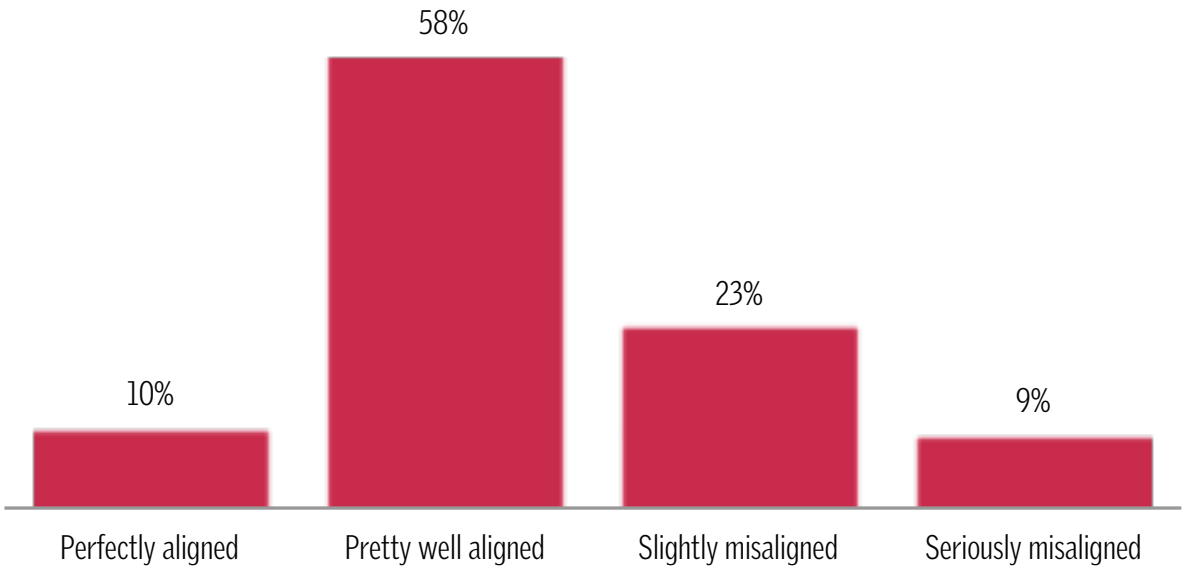
Base = 230, Multi-Response
Among those with incentives

Overall, team incentives generally match individual incentives. That holds when examining organizations by size (net patient revenue), except for the top-of-the-list operating margin/ cash flow category, which is applied evenly as an individual incentive, but is related to net patient revenue as a team incentive.

SURVEY RESULTS

FIGURE 9: **Executive Compensation Alignment With Organization's Strategies**

Q How closely are your organization's executive compensation packages aligned with your organization's strategies?



Base = 348

One would expect that CEOs are connected with industry direction, are intimate with the organization's strategies in response to industry direction, and understand both the mechanics and the intent behind compensation structures. Therefore, an increase in the percentage of CEOs seeing misalignment may be an indication of the difficulty that compensation policies have in keeping up with the rapid pace of industry changes.

SURVEY RESULTS

FIGURE 10: **Change in C-Suite Composition to Address Value-Based Care**

Q How has your organization's attention to value-based care led to a change in the composition of the organization's C-suite?

Base = 366

Organizational size brings a degree of sophistication, which can mean a degree of specialization within the executive ranks. That may be why twice the percentage of executives from high-revenue organizations (33%) than low-revenue organizations (16%) have added new C-level positions in response to the switch to value-based care. However, because a higher percentage of low-revenue organizations (39%) than high-revenue organizations (21%) have implemented little or no change to the C suite, it appears that low-revenue (and smaller) organizations are slower to respond.

SURVEY RESULTS

FIGURE 11: **Expected Changes in Executive Responsibilities**

Q What is your best appraisal of the changes in responsibility within the non-CEO executive ranks over the next three years, as your organization responds to changes in healthcare?

	Position to be added	More responsibility	No change in responsibility	Reduced responsibility	Position to be eliminated	Don't know/ not applicable
Chief financial officer	1%	53%	34%	1%	1%	10%
Chief medical officer	5%	51%	21%	1%	1%	21%
Chief information officer	2%	47%	25%	0%	2%	24%
Chief operating officer	5%	47%	22%	2%	3%	20%
Chief nursing officer	2%	46%	29%	2%	0%	20%
Chief medical information officer	5%	27%	16%	1%	1%	51%
Chief strategy officer or similar title	5%	25%	13%	1%	1%	54%
Chief analytics officer	10%	19%	7%	1%	1%	63%
Population health executive	15%	19%	6%	0%	1%	59%
Chief integration officer	5%	13%	8%	0%	1%	73%
Other	6%	13%	13%	0%	1%	66%

Base = 366

Organizations expect to take a variety of approaches when assigning responsibility. Large organizations can support a degree of specialization in the executive suite, so we see 26% of high-revenue organizations expecting to add a population health executive. But high percentages of those occupying more conventional positions in smaller organizations are to take on more responsibility to respond to changes in the healthcare industry. For instance, 58% of CFOs in organizations with net patient revenue below $250 million will take on additional responsibility.

SURVEY RESULTS

FIGURE 12: **Top Challenges in Executive Compensation**

Q What are your organization's top three challenges in executive compensation?

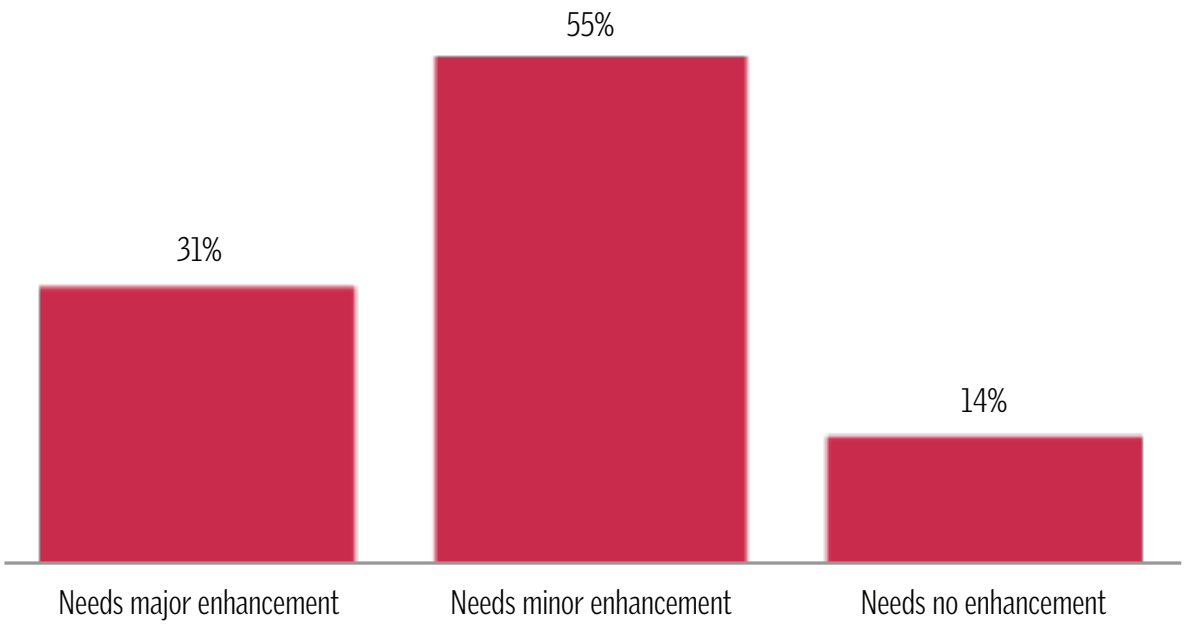
Base = 366, Multi-Response

The challenge mentioned most frequently—balancing quality and financial goals—reflects the difficulty organizations face when they need to overlay goals addressing new directions onto the financial objectives that have traditionally been the focus of healthcare executives. That same difficulty of integrating the new is also reflected in the number two item, which addresses the difficulty determining metrics that reflect new directions.

SURVEY RESULTS

FIGURE 13: **Outlook for Executive Compensation Structure**

Q To attract, retain, and engage leaders, what is the outlook for executive compensation structures at your organization?



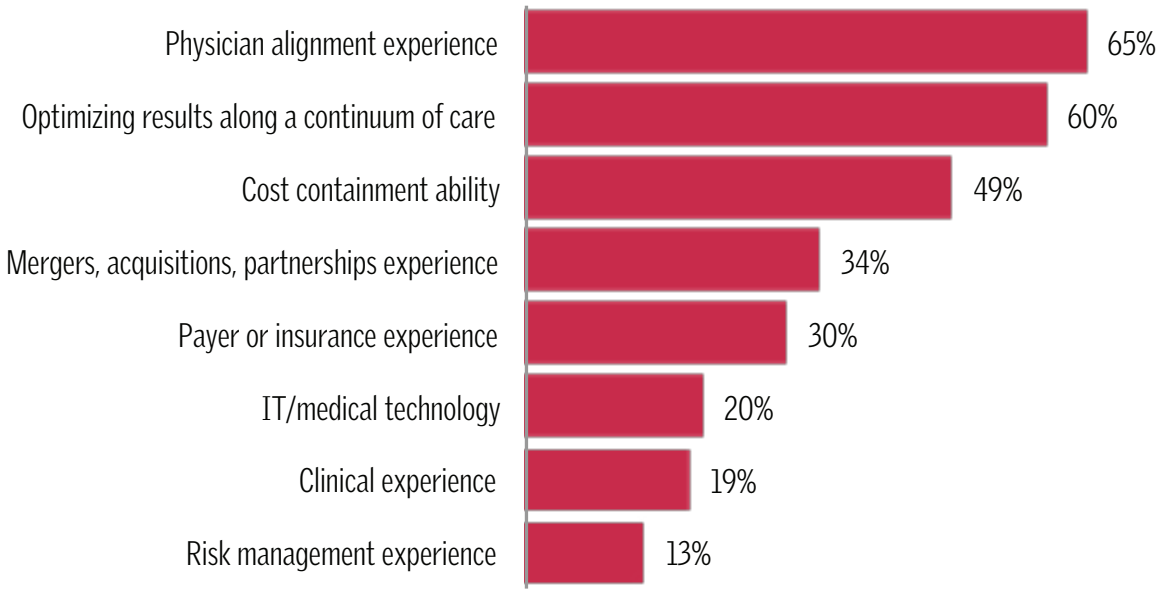
Base = 366

In Figure 9, we noted a slight increase in the percentage who say their executive compensation packages are aligned with their organization's strategy (68% this year, 60% last year), and here we see a slight reduction in the percentage who indicate their compensation packages need major enhancement. Although we note improvement, only 14% say their compensation packages need no enhancement.

SURVEY RESULTS

FIGURE 14: **Top Skills for CEO Success in Next Five Years**

Q Considering your organization's direction and the direction of the industry, which of the following are the top three skills or experience sets that will help a CEO succeed in the next five years?



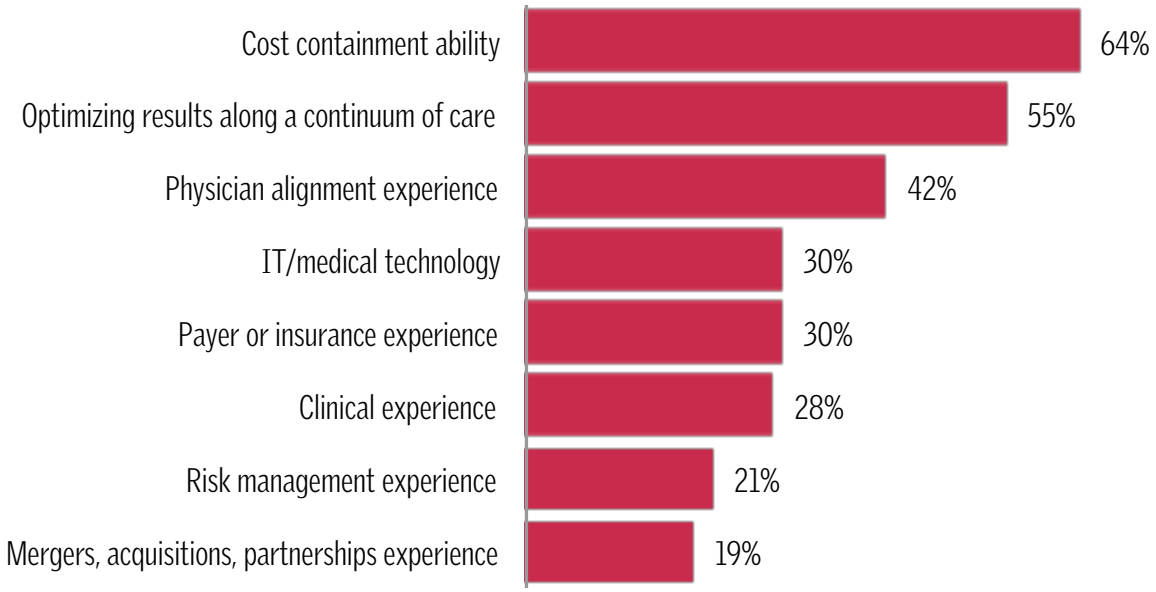
Base = 366, Multi-Response

As frontline providers of care, physicians play a key role in moving healthcare reform forward. So at the top of the list of CEO skills important for success, we see physician alignment and optimizing the care continuum, both related to directing physicians and groups of physicians.

SURVEY RESULTS

FIGURE 15: **Top Skills for C-Suite Executive (Non-CEO) in Next Five Years**

Q Considering your organization's direction and the direction of the industry, which of the following are the top three skills or experience sets that will help a non-CEO C-suite executive—such as the CFO, CIO, CMO, or COO—succeed in the next five years?

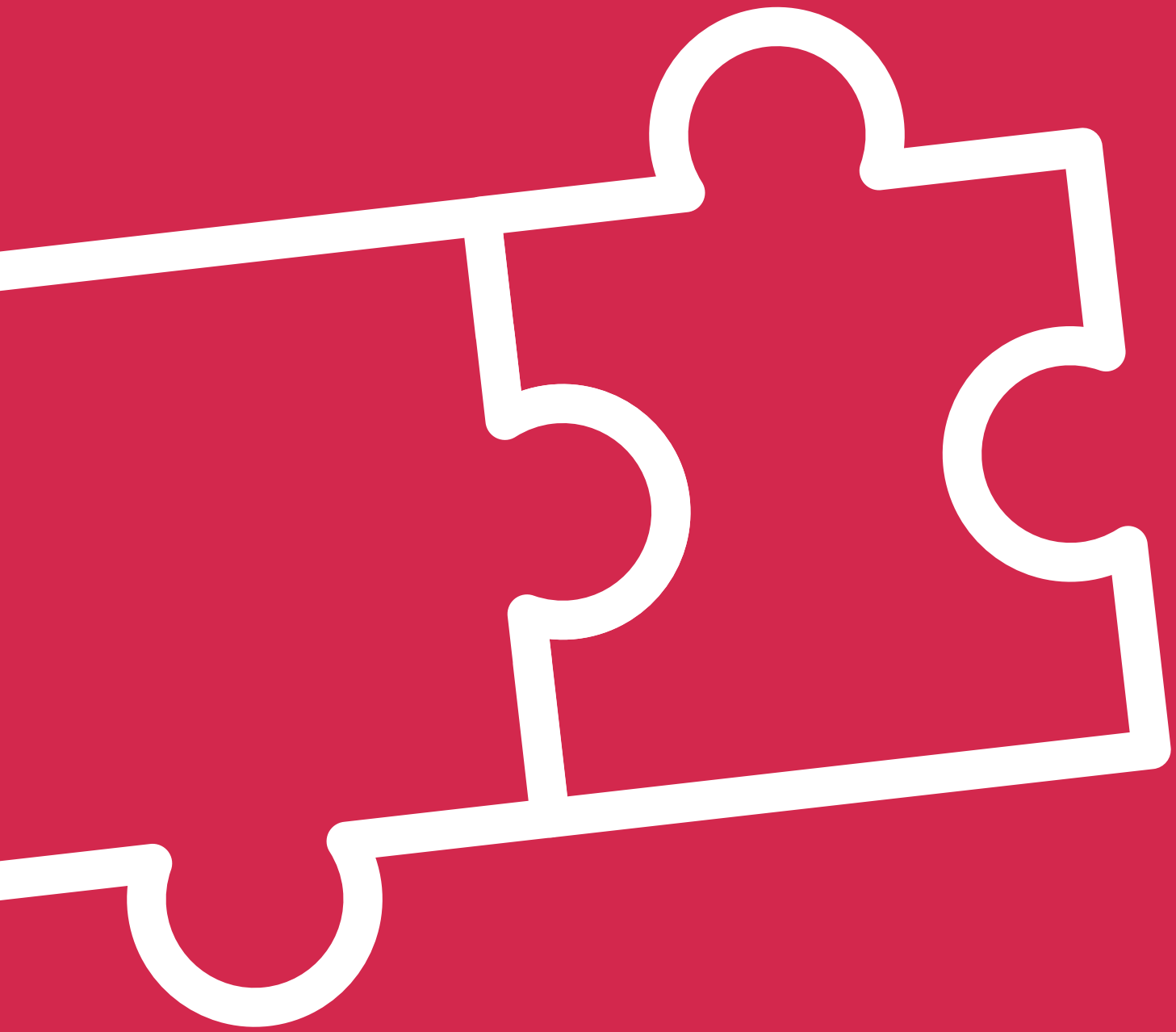


Base = 366, Multi-Response

The presence of payer or insurance experience and risk management experience in the bottom half of the chart does not mean such skills are not needed. Rather, charting an organization's course through payment reform requires an individual with highly specialized skills, whereas items at the top of the chart—cost containment, care continuum, and physician alignment—are needed to address a broad set of healthcare activities.

SECTION EIGHT

Strategic Partnerships:
Survival in Healthcare



FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: APRIL 2016

SURVEY RESULTS

FIGURE 1: **Merger/Acquisition/Partnership Financial Objectives**

Q Which of the following are among the financial objectives of your overall merger, acquisition, and/or partnership planning or activity?

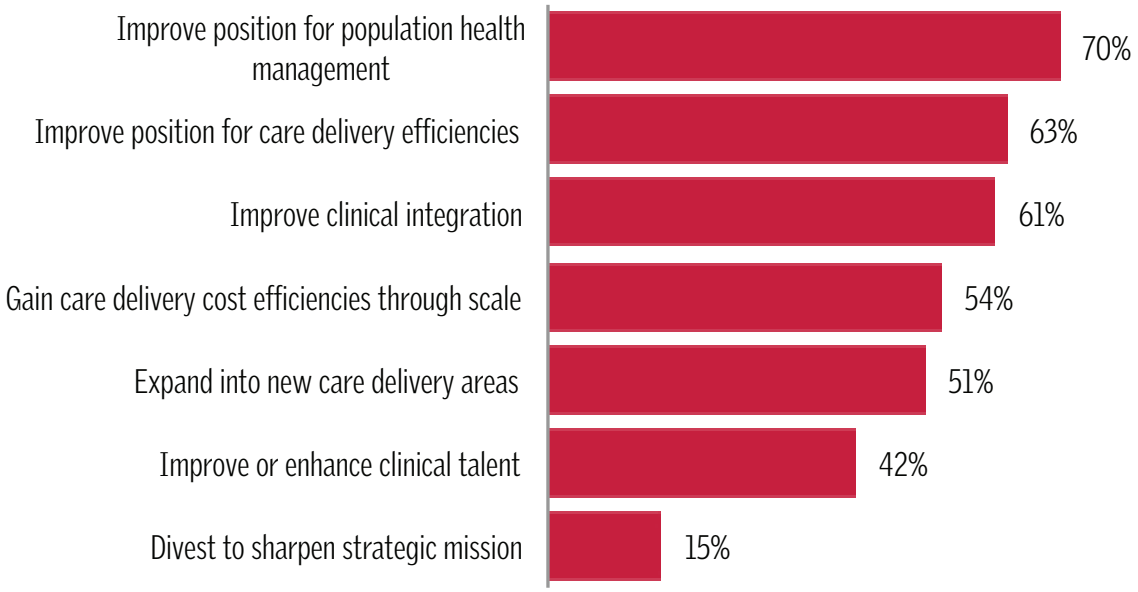
Base = 245, Multi-Response

Although increase market share within our geography (70%) is the top financial objective, there is ample support for a range of objectives, and the top five all have levels of response above 50%, indicating that no single objective is responsible for driving MAP activity.

SURVEY RESULTS

FIGURE 2: **Merger/Acquisition/Partnership Care Delivery Objectives**

Q Which of the following are among the care delivery objectives of your overall merger, acquisition, and/or partnership planning or activity?



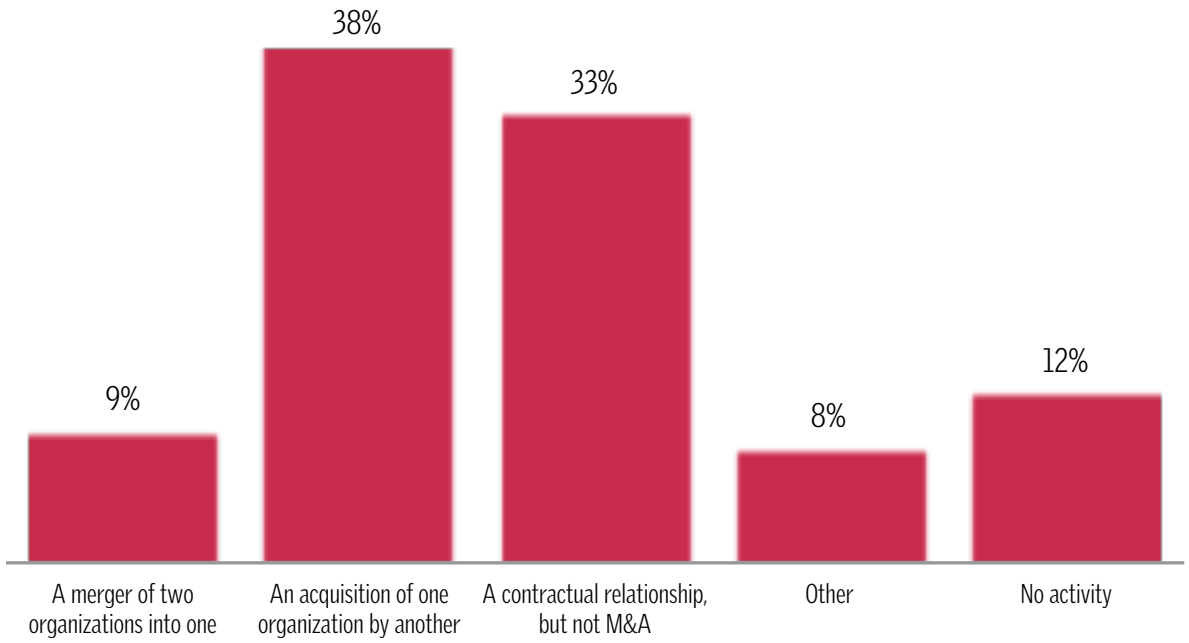
Base = 245, Multi-Response

A reform-related care delivery objective occupies the top spot—the response for improving their position for population health management (70%) makes it the No. 1 care delivery objective.

SURVEY RESULTS

FIGURE 3: **Recent Merger/Acquisition/Partnership Activity**

Q Please describe the nature of your most recent merger, acquisition, and/or partnership activity.



Base = 245

Responses for acquisition of one organization by another (38%) and a contractual relationship, but not M&A (33%) are nearly equal, and advisors say they expect non-M&A activity to grow over the next few years because it is typically less expensive than traditional M&A and doesn't require an exchange of assets or a change of local governance.

SURVEY RESULTS

FIGURE 4: **Description of Merger/Acquisition**

Q Which of the following describes that merger/acquisition?

	Percent
We acquired: Membership substitution	17%
We acquired: Asset purchase/conversion	43%
We acquired: Other transaction type	4%
We were acquired: Membership substitution	6%
We were acquired: Asset sale/conversion	18%
We were acquired: Other transaction type	1%
Other acquisition type	5%
Other sale type	4%

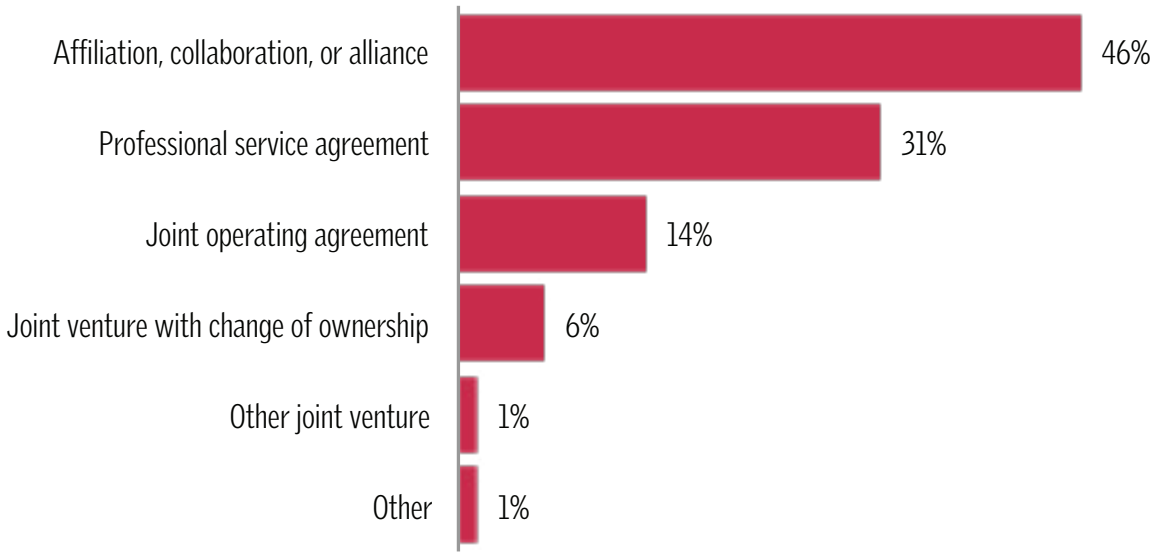
Base = 115
Among those with recent M&A activity

The top three merger/acquisition types in our survey are that the entity was acquired through asset purchase/conversion (43%); the entity was acquired through asset sale/conversion (18%); and the entity was acquired through membership substitution (17%). Other types of activity received lower response.

SURVEY RESULTS

FIGURE 5: **Description of Contractual Relationship**

Q Which of the following best describes that contractual relationship?



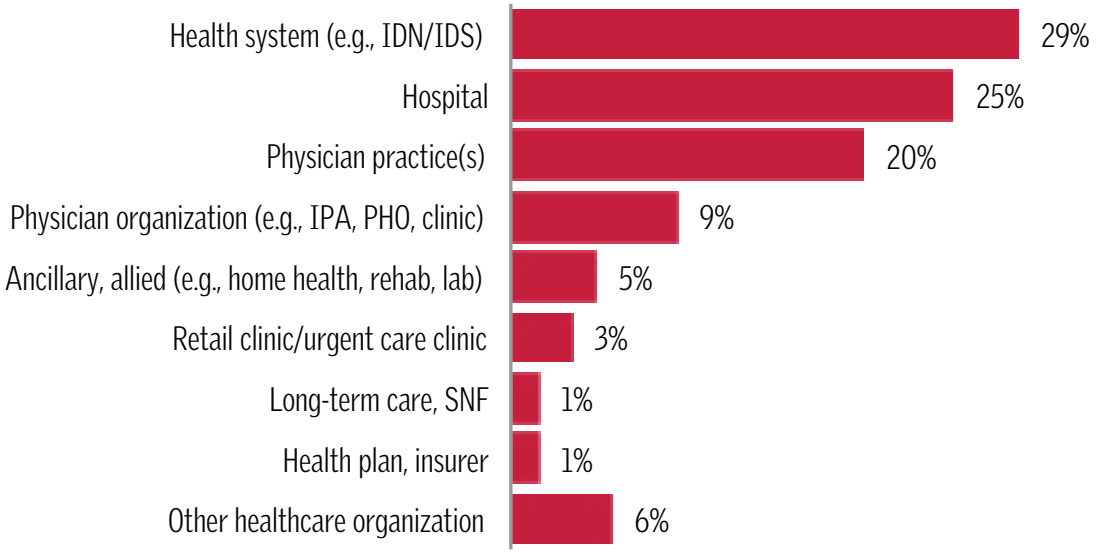
Base = 80
Among those with recent contractual relationship

Affiliation, collaboration, or alliance (46%) and professional service agreement (31%) receive high responses likely because these agreements are simpler, more flexible, and require less commitment than joint operating agreements (14%) and joint ventures with change of ownership (6%).

SURVEY RESULTS

FIGURE 6: **Entity Involved in Merger/Acquisition/Partnership**

Q What kind of entity was involved in your most recent merger, acquisition, and/or partnership activity?



Base = 215
Among those with recent activity

Health systems (29%), hospitals (25%), and physician practices (20%) topped the list of entities involved in survey respondents' most recent merger, acquisition, and/or partnership activity, which represents 74% of the activity.

SURVEY RESULTS

FIGURE 7: **Main Reasons for Considering Merger/Acquisition/Partnership**

Q If you have considered/are considering a merger, acquisition, or partnership with another organization, what were/are the main reason(s)?

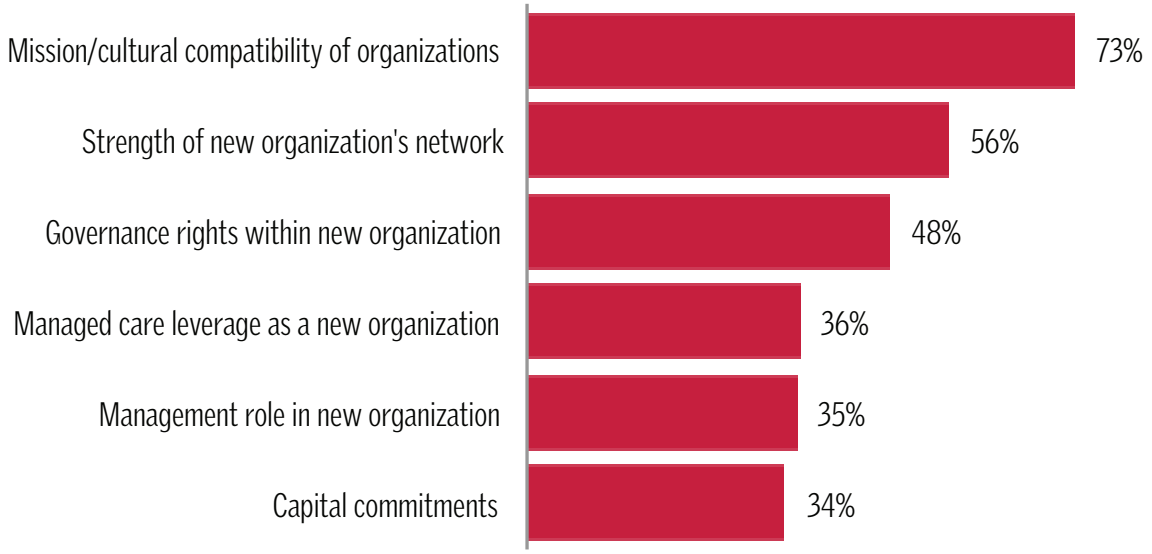
Base = 215, Multi-Response
Among those with recent activity

Two-thirds (66%) of respondents say that supporting sustainability of the long-term mission is the main reason for considering a merger, acquisition, or partnership with another organization—this indicates that providers are thinking more strategically (and less tactically) when engaged in MAP activity.

SURVEY RESULTS

FIGURE 8: **Important Considerations for Merger/Acquisition/Partnership**

Q What considerations are most important to your organization when considering a merger, acquisition, or partnership?



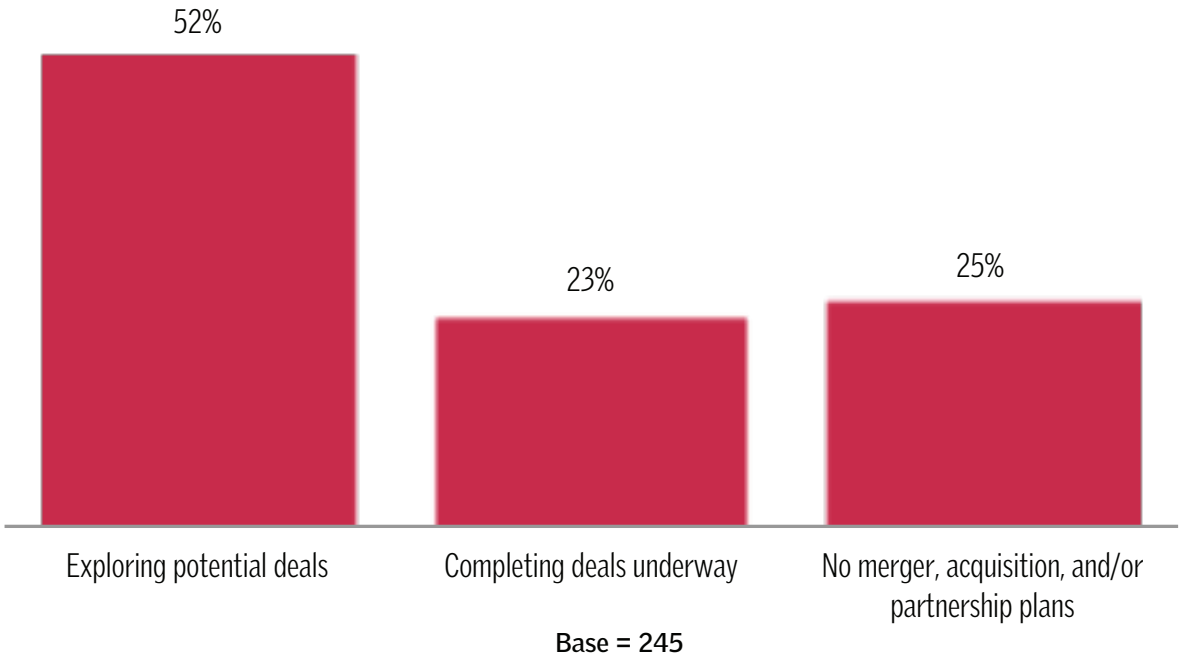
Base = 215, Multi-Response
Among those with recent activity

Mission/cultural compatibility of organizations (73%) is the top consideration for survey respondents considering a merger, acquisition, or partnership, while strength of new organization's network (56%) was the No. 2 response.

SURVEY RESULTS

FIGURE 9: **Merger/Acquisition/Partnership Plans Next 12–18 Months**

Q Please describe your organization's merger, acquisition, and/or partnership plans for the next 12–18 months.



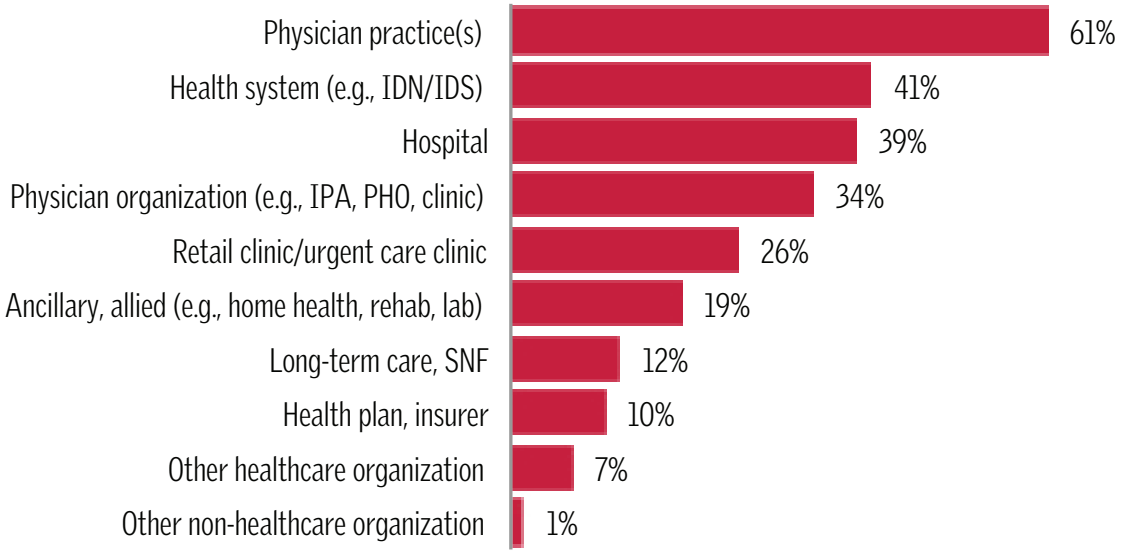
Base = 245

Three-quarters (75%) of respondents say they will either be exploring potential deals or completing deals underway in the next 12–18 months—only one in four respondents (25%) say they have no MAP plans.

SURVEY RESULTS

FIGURE 10: **Type of Organization Interested in Pursuing**

Q Which of the following would you say your organization has a high interest in pursuing through a merger, acquisition, or partnership within the next year?



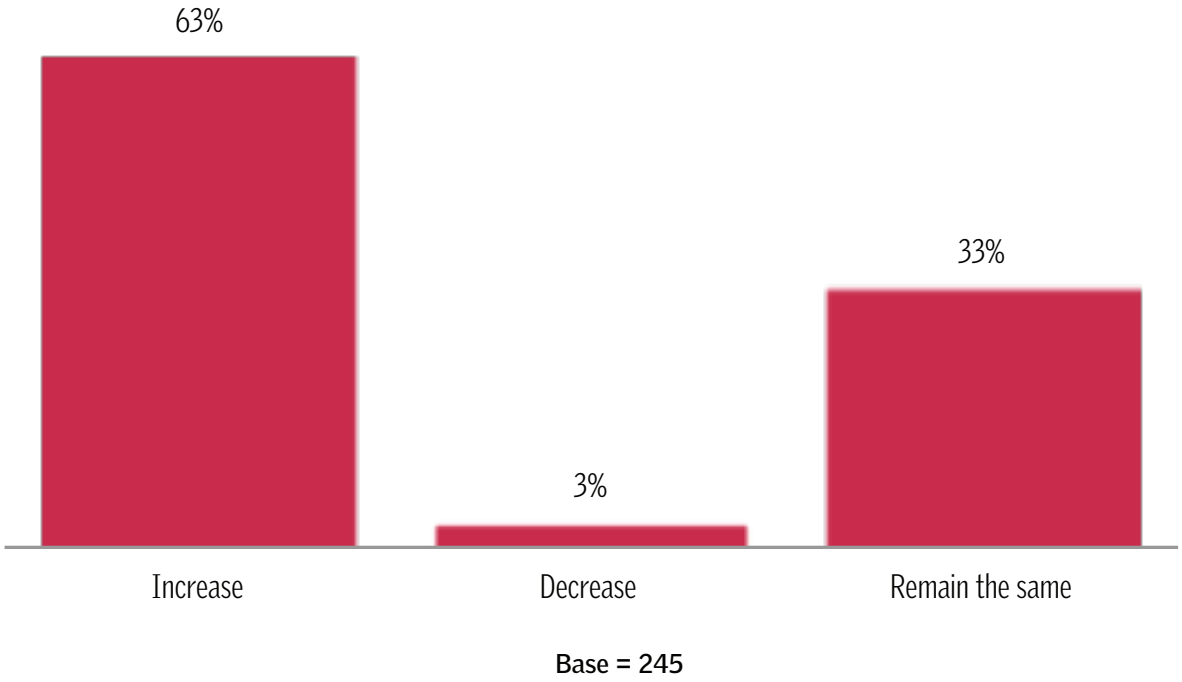
Base = 184, Multi-Response
Among those with MAP plans within next 12–18 months

Physician practices are the top organization (61%) respondents say they have a high interest in pursuing, up 11 points over last year's survey result, likely because primary care physicians are a key component of the continuum of care, and play an important role in population health management and clinical integration.

SURVEY RESULTS

FIGURE 11: **Merger/Acquisition/Partnership Activity Next Three Years**

Q Within the next three years, do you expect your organization's merger, acquisition, and/or partnership activity to increase, decrease, or remain the same?



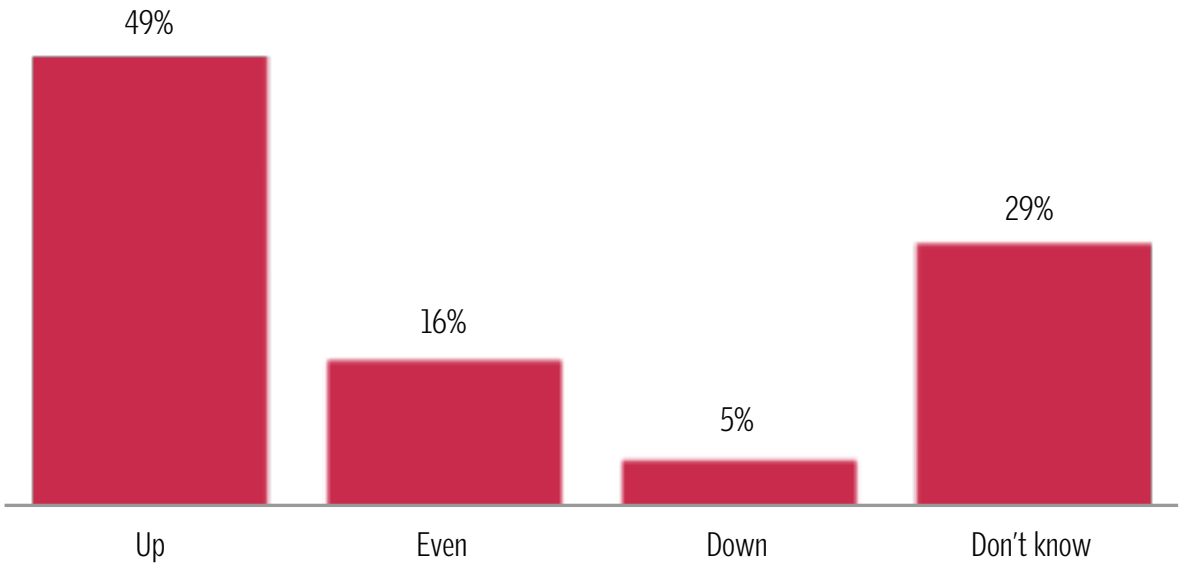
Base = 245

Nearly two-thirds of respondents (63%) say that their organization's merger, acquisition, and/or partnership activity will increase within the next three years—only 3% say it will decrease and 33% say it will stay the same.

SURVEY RESULTS

FIGURE 12: **Change in Dollar Value of Mergers/Acquisitions Next Three Years**

Q Within the next three years, do you expect the mergers and acquisitions your organization will be pursuing to go up in dollar value, remain even, or go down?



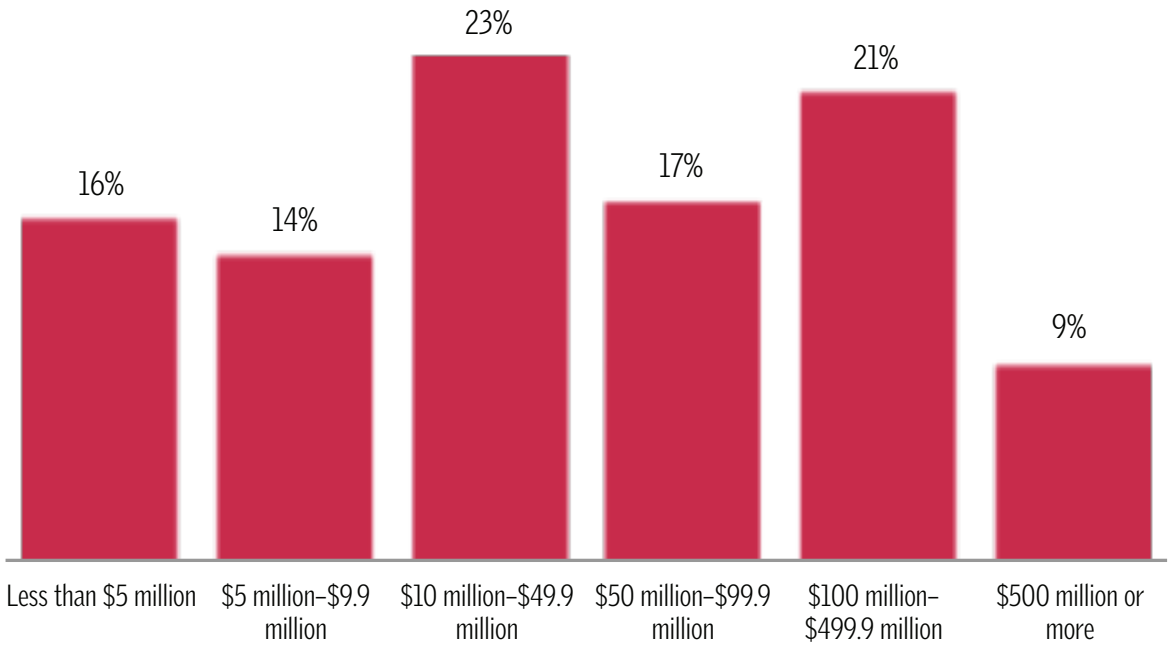
Base = 184

Nearly half of respondents (49%) say that they expect the dollar value of the mergers and acquisitions their organization will be pursuing within the next three years will increase—only 5% say the value will go down and 16% say it will remain even.

SURVEY RESULTS

FIGURE 13: **Total Dollar Value of M&A Deals Next Three Years**

Q Please estimate the cumulative total dollar value of the mergers and acquisitions your organization will be exploring over the next three years.



Base = 121

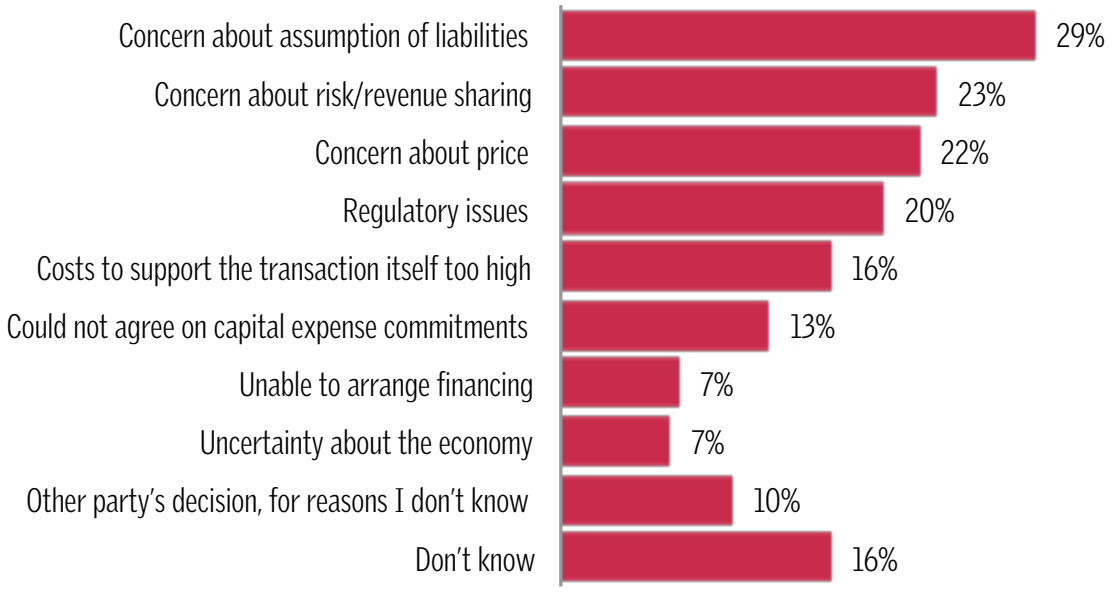
Among those who expect to explore and have MAP plans within 12–18 months

While this year's survey results are relatively comparable to last year's, there is a small shift to higher cumulative total dollar value—$50 million–$99.9 million range is up three points and $100 million–$499.9 million range is up five points. The lesser-valued $10 million–$49.9 million range is down nine points compared with last year.

SURVEY RESULTS

FIGURE 14: **Financial Reasons for Deal Not Proceeding**

Q Thinking back to the last time a merger, acquisition, or partnership involving your organization was abandoned before or during the due diligence phase, which of the following were among the financial reasons that the deal did not proceed?



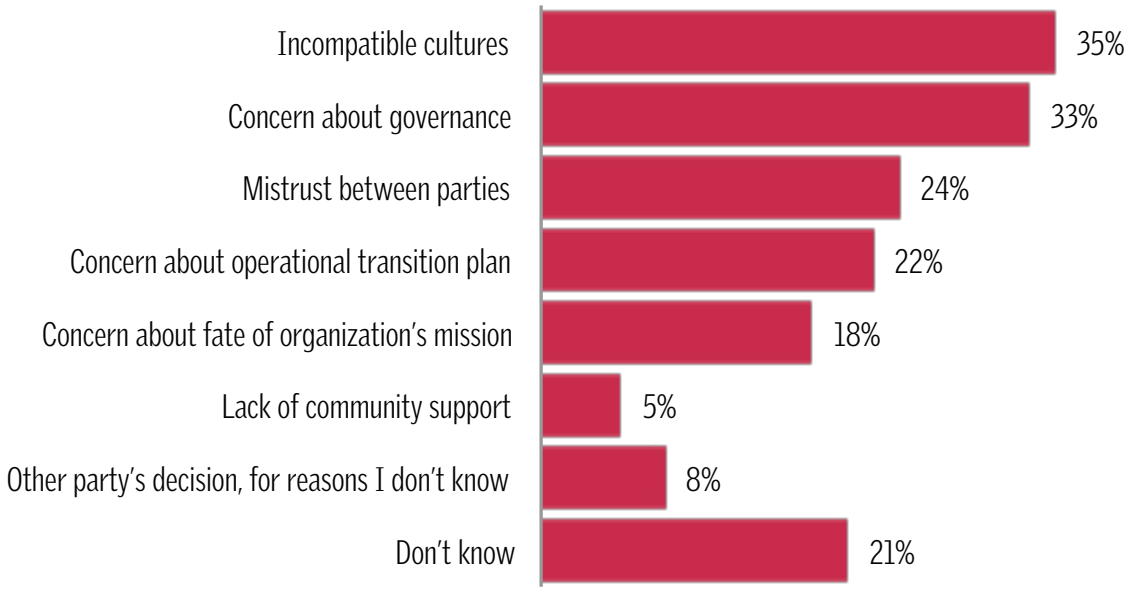
Base = 182
Multi-response
Among those who have recent activity and abandoned for financial reasons

Concern about assumption of liabilities (29%) is the top financial reason for a deal not proceeding—it was the top reason in last year's survey (28%) as well. The extent of a target organization's financial liabilities may not be apparent until the due diligence phase is completed, which may explain why this key aspect can be a deal-breaker.

SURVEY RESULTS

FIGURE 15: **Operational Reasons for Deal Not Proceeding**

Q Thinking back to the last time a merger, acquisition, or partnership involving your organization was abandoned before or during due diligence, which of the following were among the operational reasons that the deal did not proceed?



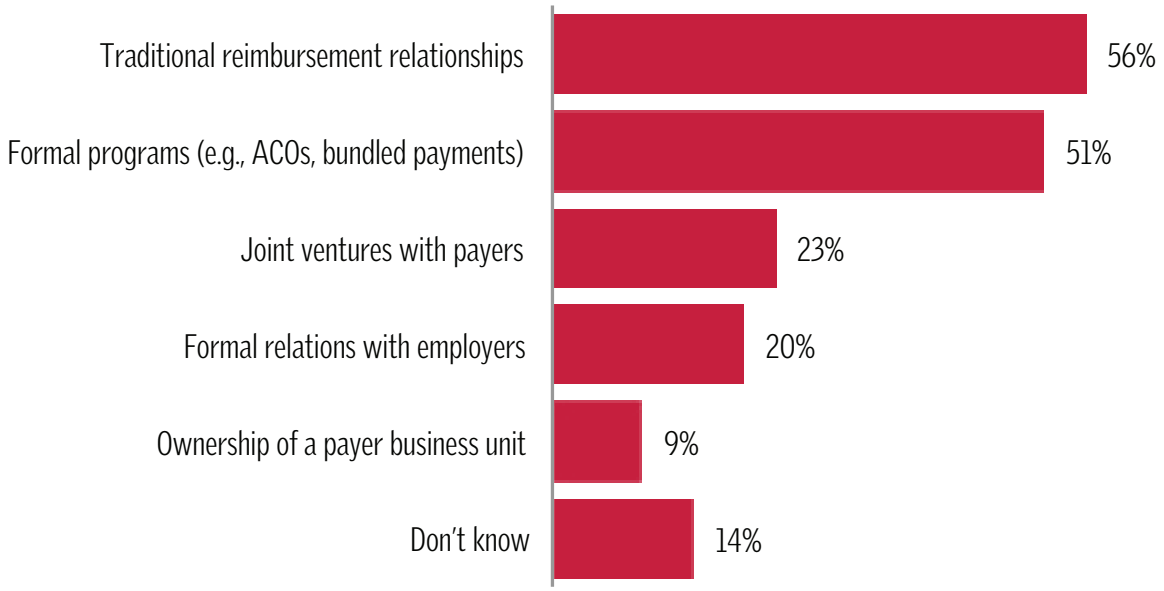
Base = 169, Multi-response
Among those who have recent activity and abandoned for operational reasons

Incompatible cultures (35%) and concern about governance (33%) are the top operational reasons for a deal not proceeding—these were the top two responses in last year's survey, although the response rates were nine points and seven points lower, respectively.

SURVEY RESULTS

FIGURE 16: **Payers' Role in Merger, Acquisition, or Partnership Strategy**

Q Which of the following describes how payers fit into your organization's merger, acquisition, and/or partnership strategy?



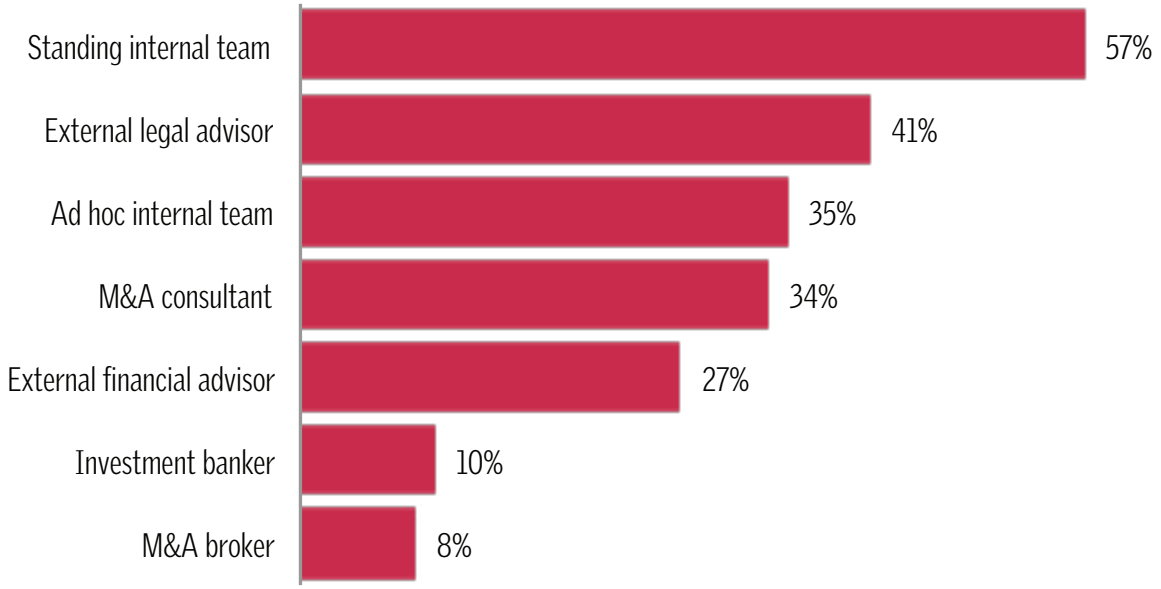
Base = 245, Multi-Response

Traditional reimbursement relationships (56%) and formal programs (51%) are the top ways that payers fit into respondents' merger, acquisition, and/or partnership strategy—these results are similar to last year's survey, although the response rates were one point and eight points lower, respectively.

SURVEY RESULTS

FIGURE 17: **Sources Relied On to Support M&A and Partnership Activities**

Q On which of the following does your organization rely to support your merger, acquisition, and/or partnership activities?

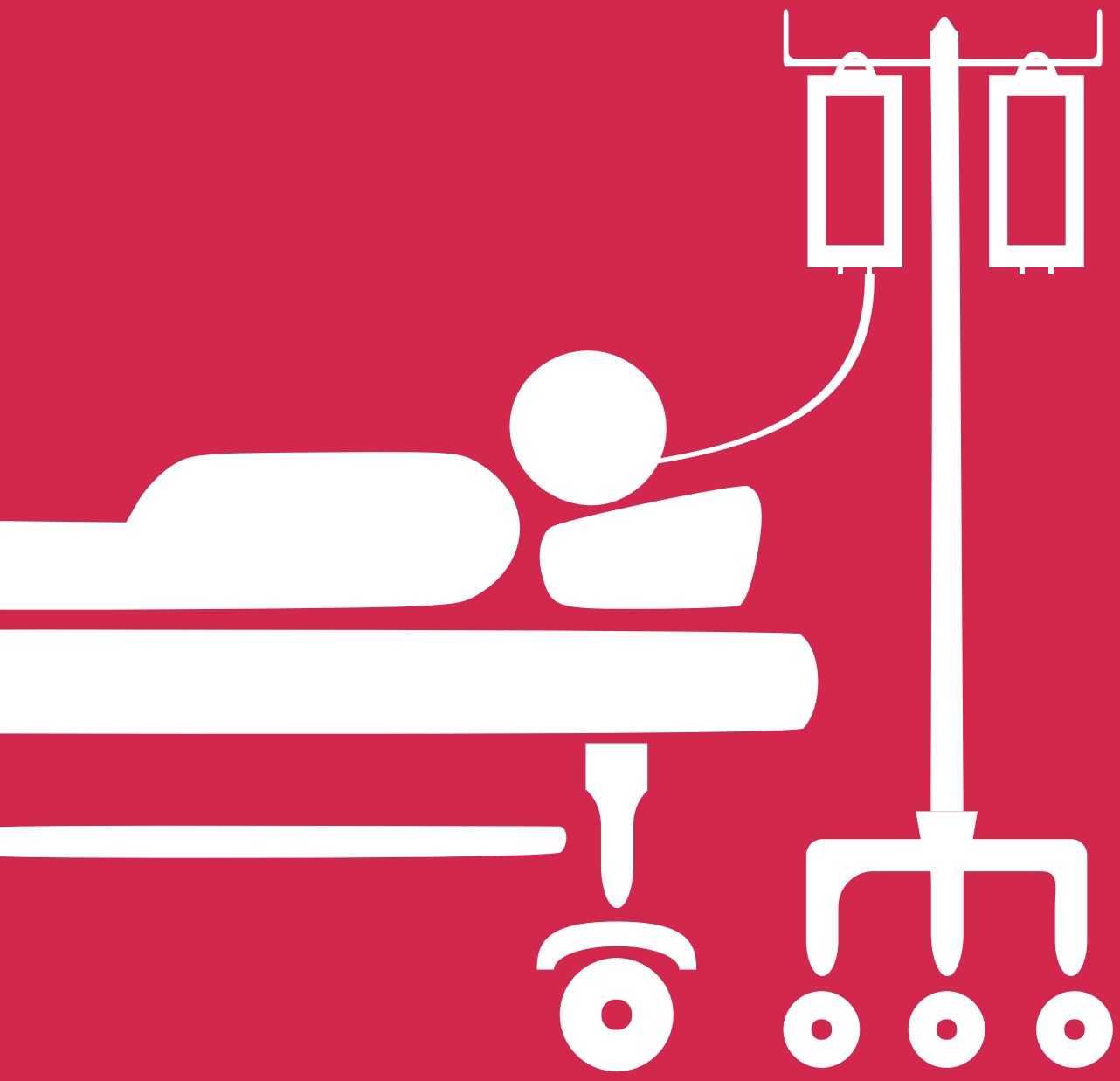


Base = 219, Multi-Response

Standing internal team (57%), external legal advisor (41%), and ad hoc internal team (35%) make up the top three responses—results are comparable to last year's survey, although the percentages were four points, two points, and five points higher in 2015, respectively.

SECTION NINE

Patient Experience:
Cultural Transformation to Move Beyond HCAHPS

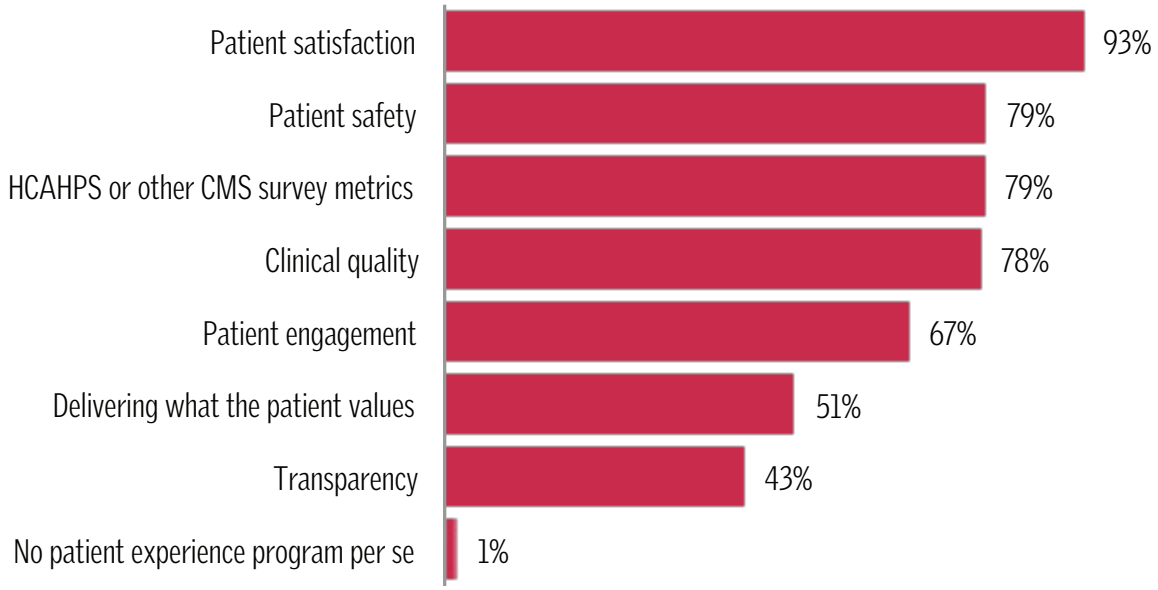


FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: AUGUST 2015

SURVEY RESULTS

FIGURE 1: **Main Concepts of Patient Experience Program**

Q Which of the following are the main concepts incorporated into your organization's patient experience program or initiative?



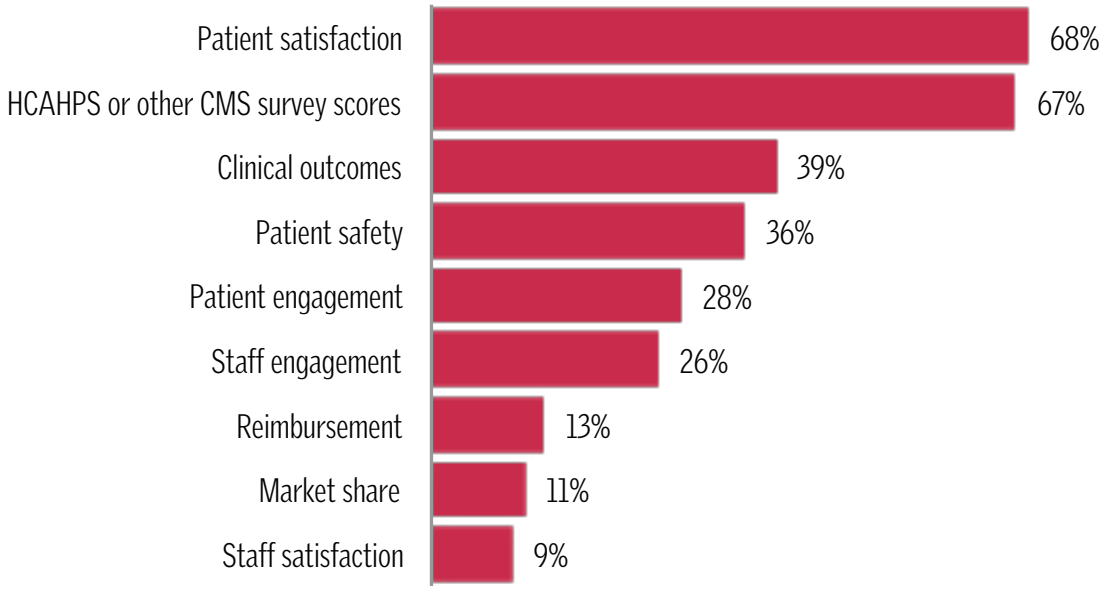
Base = 341, Multi-Response

Respondents recognize that patient satisfaction is a core aspect of patient experience, and it features prominently in their programs. Driven by clear and measurable goals defined by HCAHPS, performance is easily monitored and new strategies evaluated. Delivering what the patient values is well down the list, however, with percentages among physician organizations especially low. Measuring factors such as satisfaction, safety, and quality may be simpler to address but, at some point, understanding the patient's perspective of value must come into play.

SURVEY RESULTS

FIGURE 2: **Improvement Areas to Meet Patient Experience Goals**

Q What are the top three areas in which your organization seeks improvement in an effort to meet your patient experience goals?



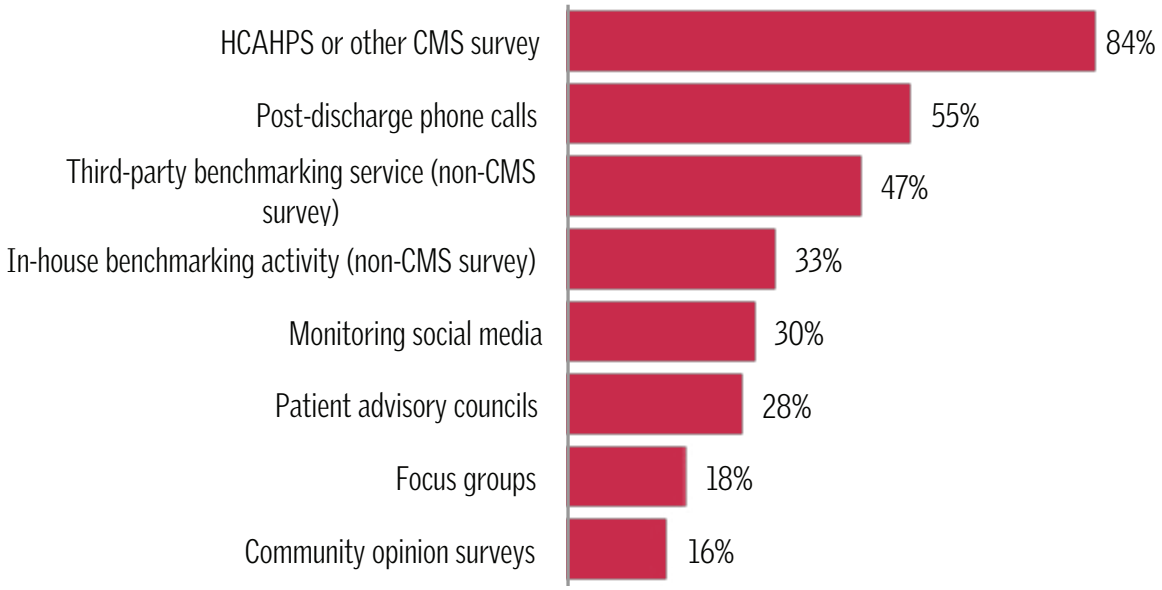
Base = 341, Multi-Response

Although there is a high degree of focus on patient satisfaction as a key concept of patient experience programs (see Figure 1), healthcare organizations still indicate there is room for improvement. Respondents are clear on two of the top three areas in which they will seek improvement, but no other item is included among areas for improvement by more than 39%. While patient satisfaction is a priority for all organizations, staff satisfaction (without which patient satisfaction is unlikely) falls at the bottom of the list.

SURVEY RESULTS

FIGURE 3: **Tracking and Measuring Patient Experience**

Q How do you track and measure the success or failure of your organization's patient experience activity?



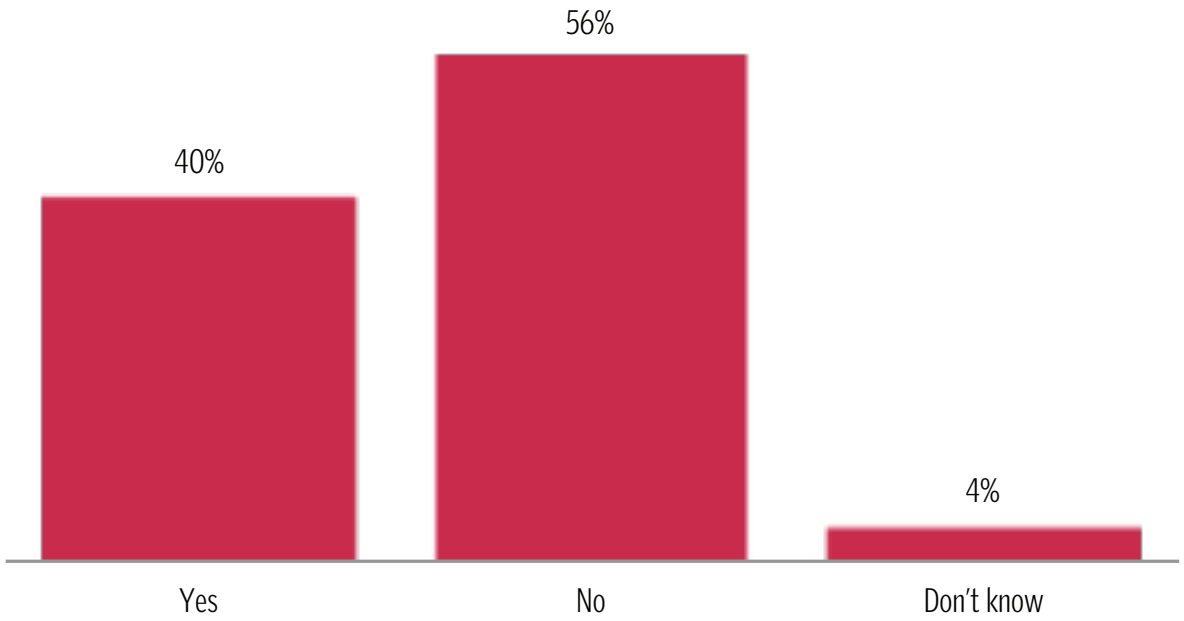
Base = 341, Multi-Response

While some healthcare organizations may complain about HCAHPS, it remains at the top of the list of measurement tools because the benchmark is a mandate for most of them. The interest in tracking and measuring patient experience activity using post-discharge telephone calls (55%) and social media (30%, up from 22% in last year's report) indicates solid interest in acquiring timely patient satisfaction data. Post-discharge calls also provide an opportunity to ensure that care coordination activities are taking place appropriately.

SURVEY RESULTS

FIGURE 4: **Chief Experience Officer Position**

Q Does your organization have a chief experience officer or individual with similar responsibilities?



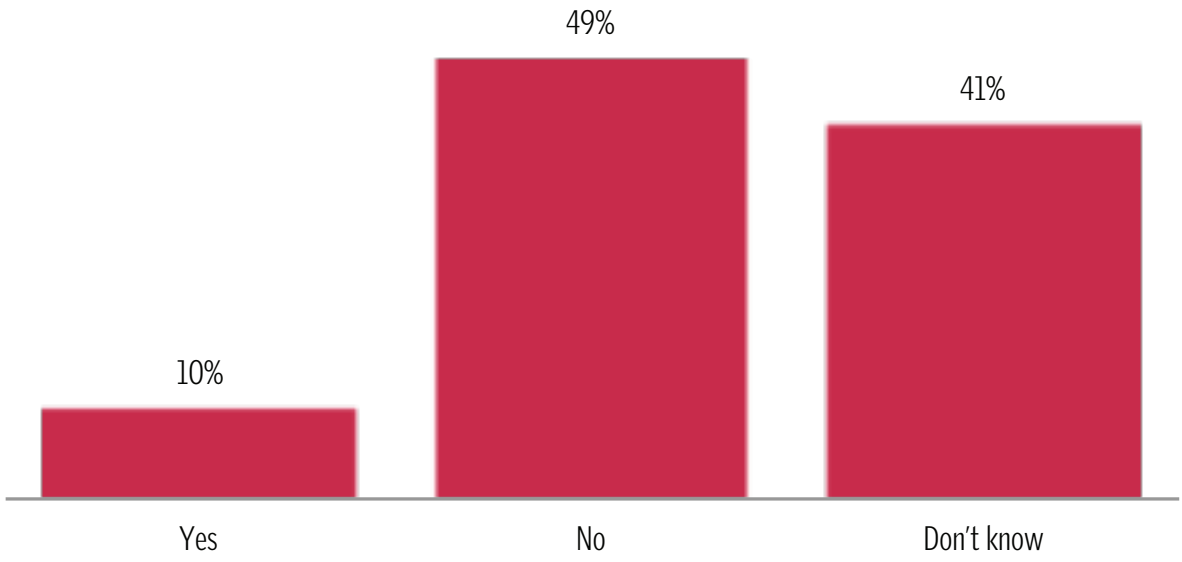
Base = 341

Healthcare organizations are embracing the need for a chief experience officer. Given the difficulty changing organizational culture (cited as the top stumbling block to creating an effective patient experience program, Figure 14), having a patient experience executive dedicated to driving organizational change makes sense.

SURVEY RESULTS

FIGURE 5: **Plans to Create Chief Experience Officer Position Next Three Years**

Q Do you plan to create a chief experience officer position or position with similar responsibilities in your organization within the next three years?



Base = 191

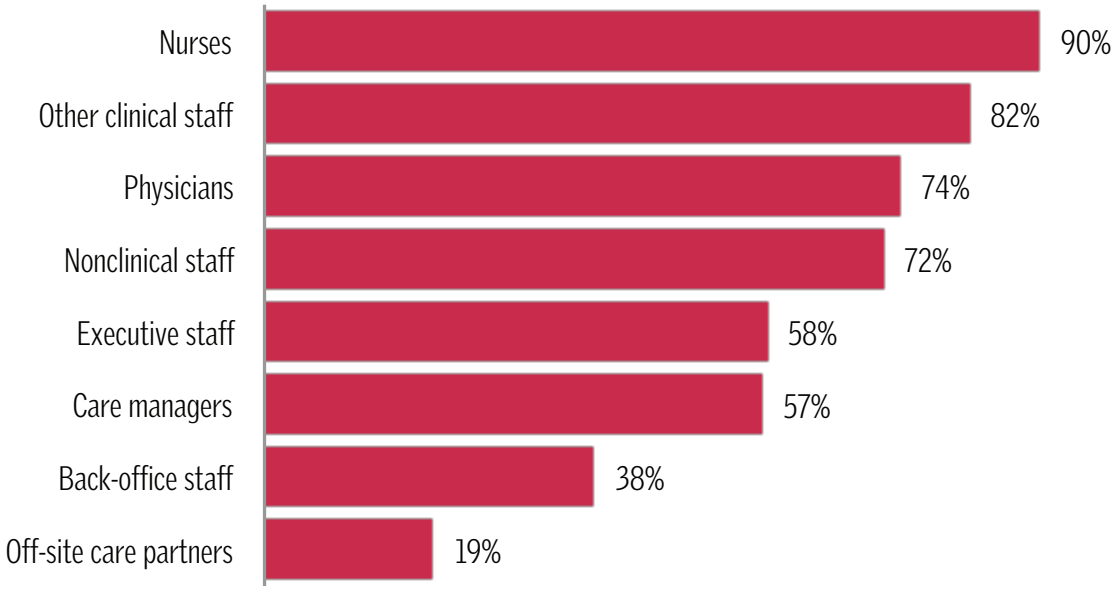
Among those currently without a chief experience officer or similar title

More than half of the organizations in our survey don't currently have a chief experience officer (Figure 4), and of those, approximately half don't plan on creating such a position within the next three years. There is much uncertainty on the issue, with 41% saying that they don't know whether the position would be created within the next three years. All of this suggests that while there has been a steady growth in converts, respondents are divided as to whether a dedicated C-suite presence is needed.

SURVEY RESULTS

FIGURE 6: **Groups Trained in Patient Experience Communication**

Q With what groups in your organization do you conduct patient experience training to improve communication with patients?



Base = 341, Multi-Response

Nurses play an important role in influencing a patient's experience, given their frequent interaction. Not surprisingly, nurses are the top priority for patient experience training to improve communication with patients. Of course, respondents also recognize the influence that doctors have on patient experience both as care team leaders and as the subject of CMS surveys, so training for the physicians is high. A missed opportunity, however, is in training executives (58%); they set the tone and they set the example for the organization, and meaningful patient experience training could have wide-ranging influence.

SURVEY RESULTS

FIGURE 7: **Patient Experience Improvements Next Three Years**

Q On which of the following do you expect your organization to focus, either as new activities or with additional emphasis, over the next three years for patient experience improvements?

Base = 341, Multi-Response

While the areas of improvement focus are in nearly the same order of response as in last year's report, the response percentages themselves are much lower across the board. This suggests that it's not any one area that drives patient experience, but the sum total of many different patient interactions. Certainly, care coordination inside your organization, increased rounding, and identifying concerns while patients are still on-site remain the top areas, but they are just a few of the many components that comprise an organization's patient experience culture.

SURVEY RESULTS

FIGURE 8: **Area Expected to Provide Biggest Improvement**

Q Of those areas, which one do you expect will provide the biggest improvement?

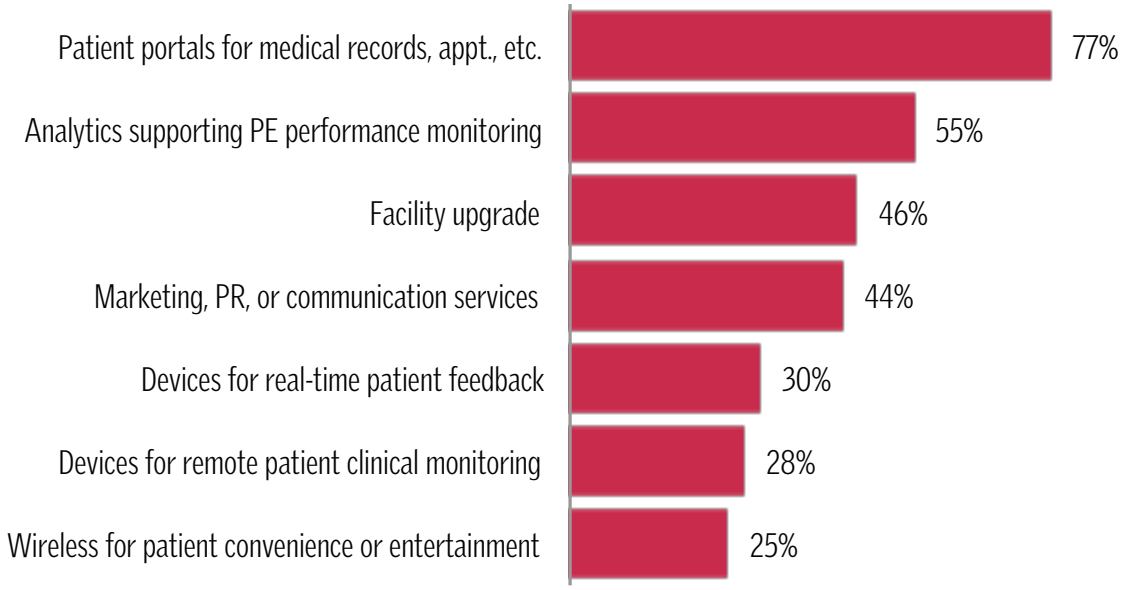
Base = 341

The results for this question track similarly to those for Figure 7, but again, with no strong favorite. And while providers seem to have a clear idea of where they will focus their patient experience activities, the relative parity among responses in Figure 8 indicates a lack of consensus as to which areas will produce the biggest improvement. This suggests that there are opportunities to better measure patient experience, and better assess the methods and tools that can improve experience outcomes.

SURVEY RESULTS

FIGURE 9: **Infrastructure Improvements Next Three Years**

Q On which of the following infrastructure elements do you expect your organization to focus, either as new activities or with additional emphasis, over the next three years for patient experience improvements?



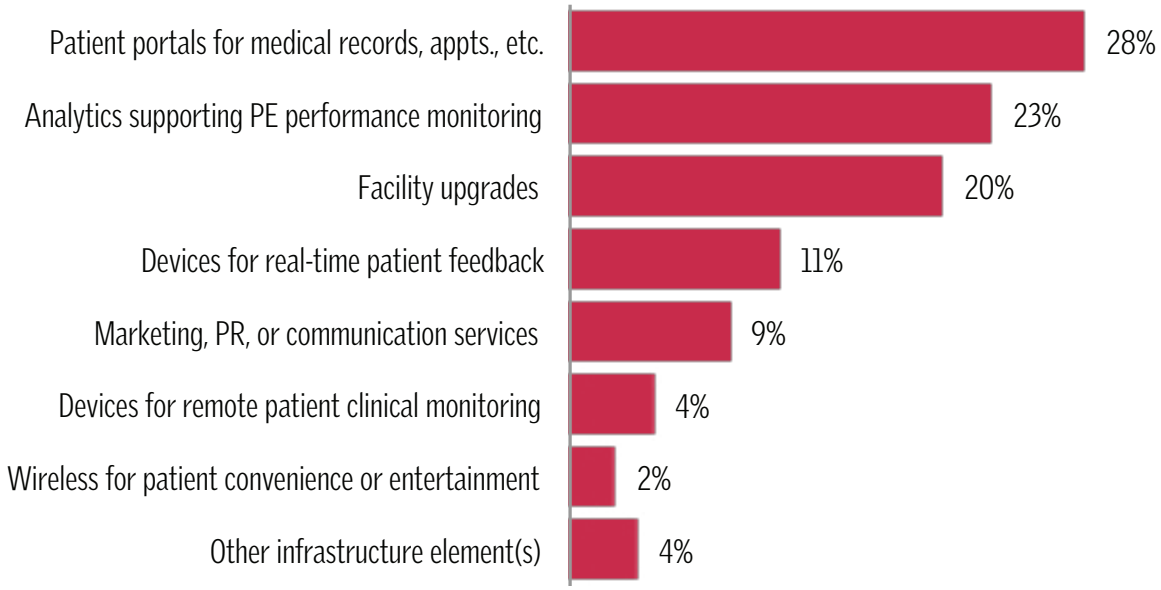
Base = 341, Multi-Response

Patient portals and analytics to engage the patient have the highest responses, with physician organizations especially focused on portals; some of this may be because it is a requirement of the stage 2 meaningful use EHR incentive program. Interest in facility upgrades may be part of an effort to improve HCAHPS scores related to facility noise and cleanliness.

SURVEY RESULTS

FIGURE 10: **Infrastructure Expected to Provide Biggest Improvement**

Q Of those areas, which one do you expect will provide the biggest improvement?



Base = 341

While the overall results for this question track closely with those in Figure 9, no single response exceeds 28%. This indicates a lack of consensus from respondents as to which infrastructure areas will produce the biggest improvement. On the other hand, there is some consensus within settings, with physician organizations favoring patient portals for improvement (51%), health systems looking to analytics (32%), and hospitals citing facility upgrades (25%) and patient portals (26%).

SURVEY RESULTS

FIGURE 11: **Agree/Disagree Statements**

Q Please indicate your level of agreement with the following statements.

	Agree completely	Agree somewhat	Disagree somewhat	Disagree completely
For progress in patient experience, an organization has to shift from implementing a series of targeted projects to developing a culture that improves by being guided by patient needs	79%	20%	1%	0%
Providing better patient experiences will eventually result in improved business	71%	27%	2%	0%
If our organization is committed to delivering positive patient experiences, then better quality, safety, clinical outcomes, and value for the patient will follow	65%	32%	3%	0%
HCAHPS and other CMS surveys are an insufficient set of metrics for measuring patient experience	37%	47%	14%	2%
Our patient experience effort is mostly aimed at improving HCAHPS or other CMS survey scores and patient satisfaction	22%	51%	22%	5%

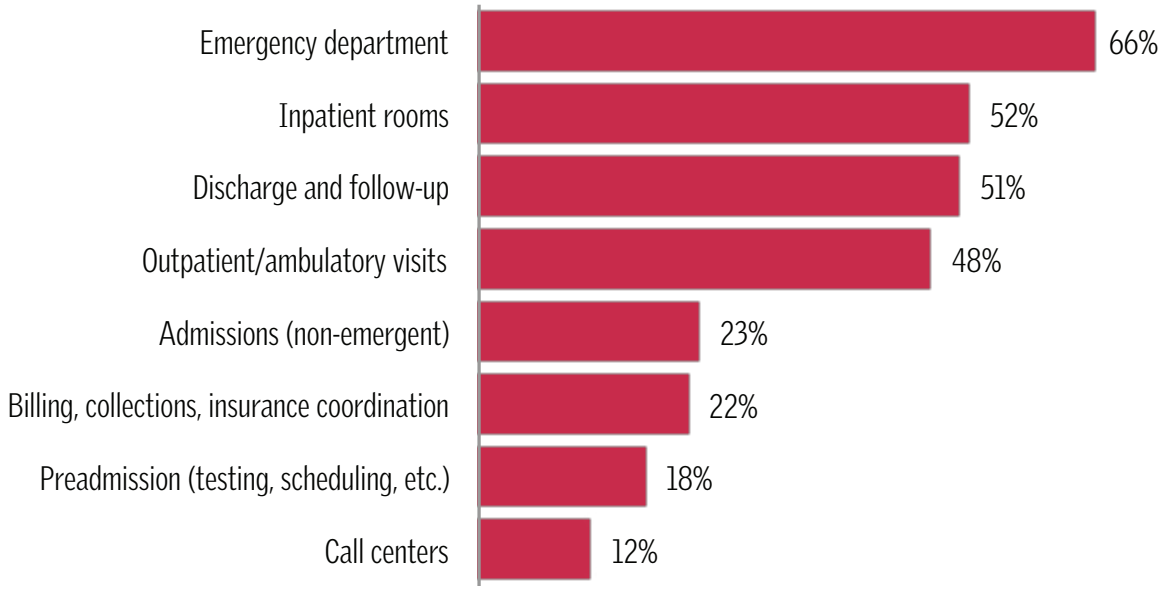
Base = 341

Clearly, patient satisfaction is an important metric, and while most organizations acknowledge that the main focus of their patient experience effort is aimed mostly at CMS survey scores, it is worth noting that they also admit that such surveys, alone, represent an insufficient means of measuring patient experience. Respondents recognize the important role culture plays in patient experience, and they have moved beyond focusing exclusively on tactical elements such as HCAHPS scores. In this year's survey, 22% agree completely that the focus of their patient experience effort is mostly aimed at improving HCAHPS and patient satisfaction, down from 30% in last year's survey.

SURVEY RESULTS

FIGURE 12: **Most Important Patient Experience Areas**

Q What are the top three areas in which a positive patient experience is most important for your organization?



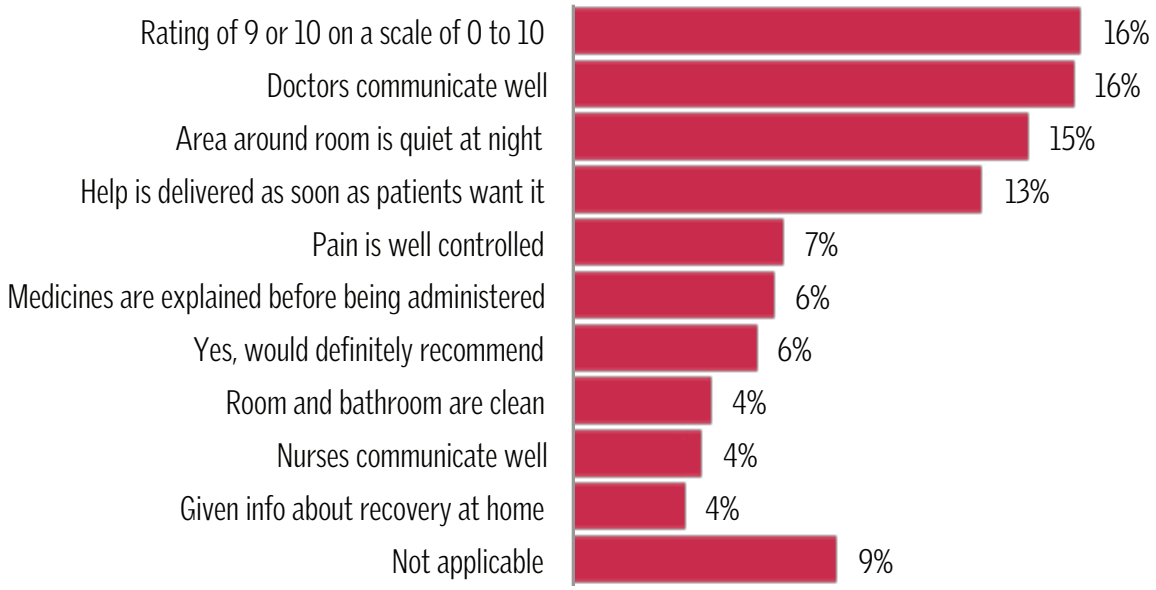
Base = 341, Multi-Response

Respondents understand that a positive experience in the ED helps patients form a first impression that is conducive to using other hospital services in the future. Further, because patients spend a lot of time in inpatient rooms, this offers ample opportunities to evaluate a room's cleanliness and noise levels. And, performing well at discharge and follow-up can also help reduce hospital readmissions and decrease negative patient experiences. All of these areas are critical to forming an opinion of an organization, and that opinion is likely to be passed on to others.

SURVEY RESULTS

FIGURE 13: **Most Difficult HCAHPS Survey Component**

Q With which component of the HCAHPS survey measures does your organization have the most difficulty?



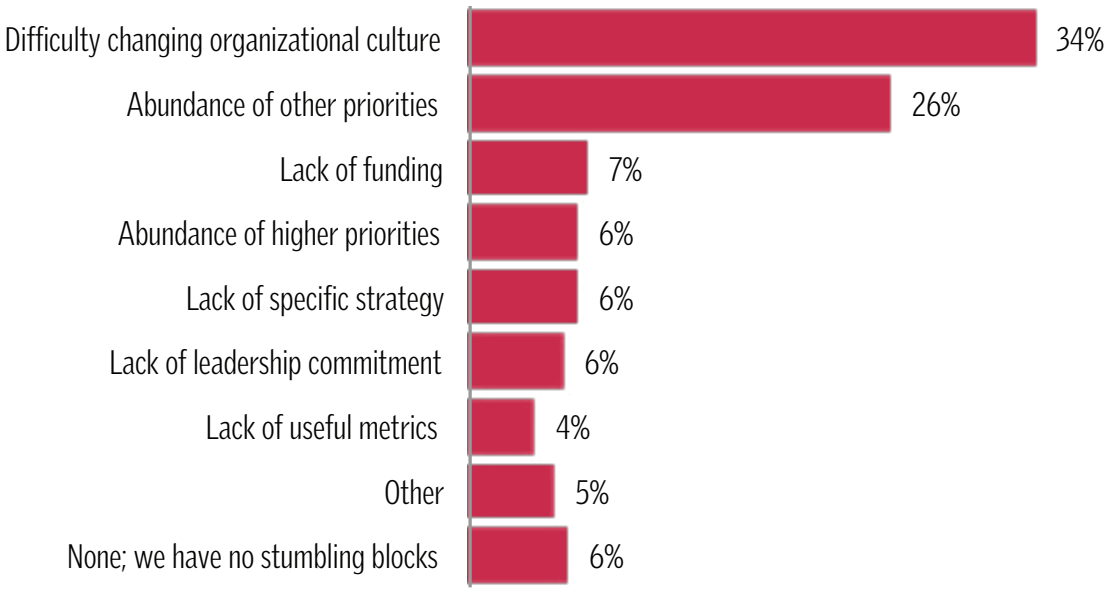
Base = 341

Patient experience training programs have traditionally focused more on nurses, although physicians are increasingly on the list. That additional nurse training appears to be paying off, as only 4% of respondents list nurses communicate well as most difficult to achieve. Note that one of the most difficult metrics is doctors communicate well. Advisors indicate that physicians often resist training, but it is much too important to ignore.

SURVEY RESULTS

FIGURE 14: **Stumbling Blocks to Effective Patient Experience Program**

Q What is the biggest stumbling block to creating an effective patient experience program at your organization?



Base = 341

Thirty-four percent of respondents cite difficulty changing organizational culture as their biggest stumbling block, an indication that there is much work to be done in patient experience. Interestingly, achieving organizational culture change is typically driven by senior leadership, yet only 6% of respondents say that lack of leadership commitment is their biggest problem. Perhaps the answer may be found in the second most frequently mentioned stumbling block—abundance of ***other*** priorities (26%). The fact that the problem is not abundance of ***higher*** priorities (6%) indicates that healthcare organization CEOs must set the agenda for culture change, and ensure that funding, resources, and commitment are present to back it up.

SECTION TEN

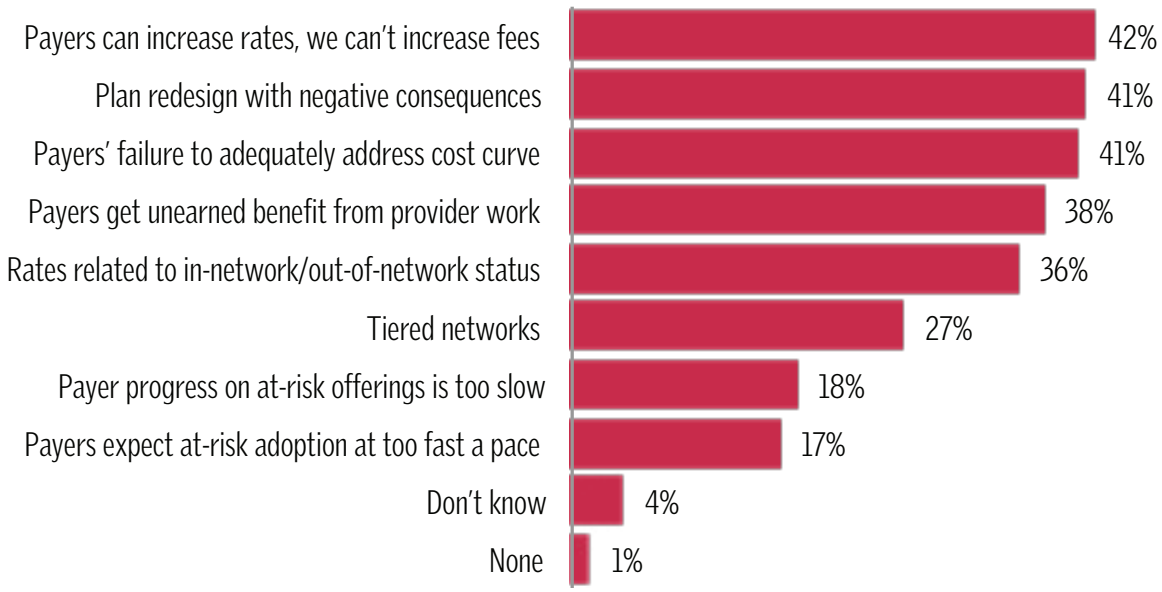
Payers and Providers:
Developing At-Risk Programs

FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: MARCH 2016

SURVEY RESULTS

FIGURE 1: **Top Areas of Conflict Between Organization and Payer**

Q Which of the following are the top three areas of conflict between your organization and your top-tier payers?



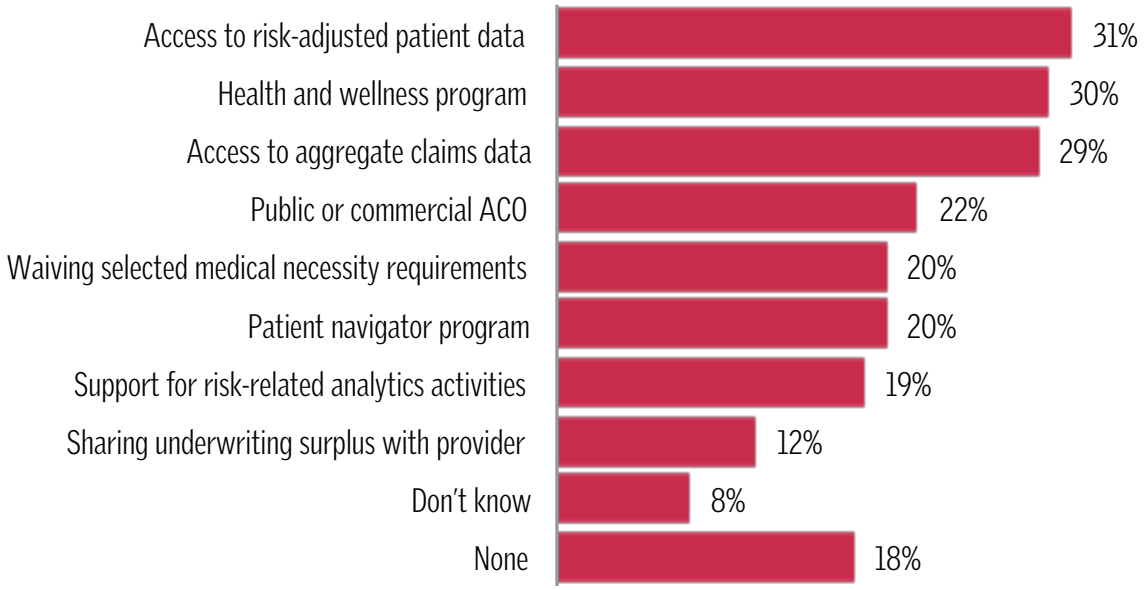
Base = 150, Multi-Response

The three items at the top of the list reflect providers' concern about financial performance. The fourth item (which is the item mentioned most frequently by medium- and high-revenue organizations) is different, because it includes a value-based component.

SURVEY RESULTS

FIGURE 2: **Top Beneficial Payer Activities for Organization**

Q What are the top three payer activities that presently provide your organization with the most benefit?



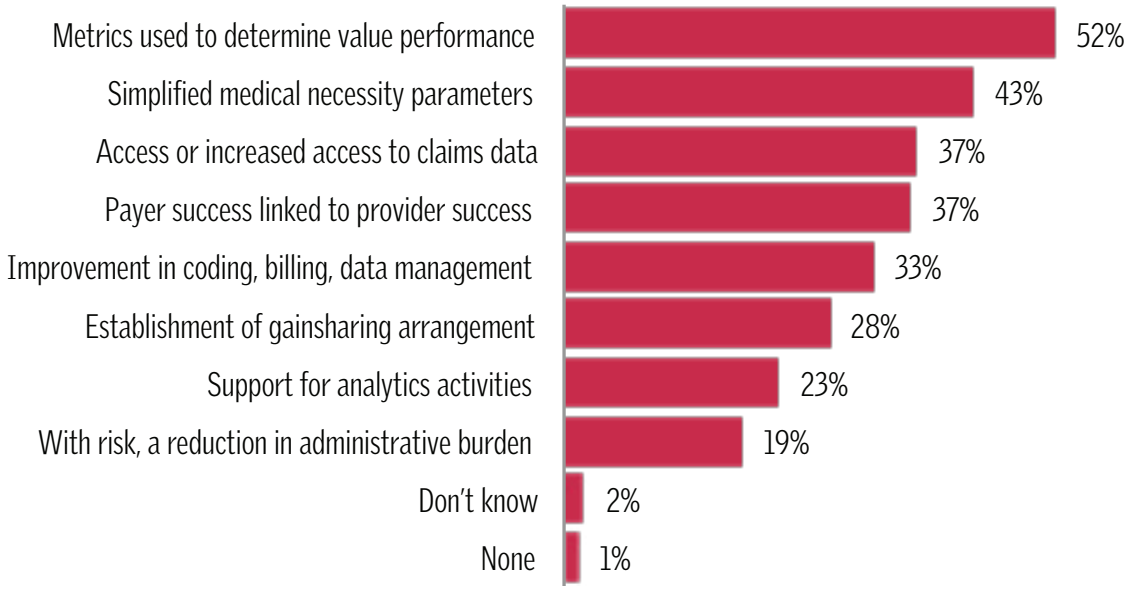
Base = 150, Multi-Response

The item mentioned most frequently by high-revenue organizations is ACO participation (29%), indicating that high-revenue organizations place more emphasis on joint value-based activities. Data access is the item mentioned most frequently by low-revenue organizations (aggregate claims data, 39%) and medium-revenue organizations (risk-adjusted patient data, 42%).

SURVEY RESULTS

FIGURE 3: **Top Areas to Achieve or Improve in Next Payer Negotiation**

Q During your organization's next commercial payer negotiation, what are the top three items or areas that you would like to achieve or improve?



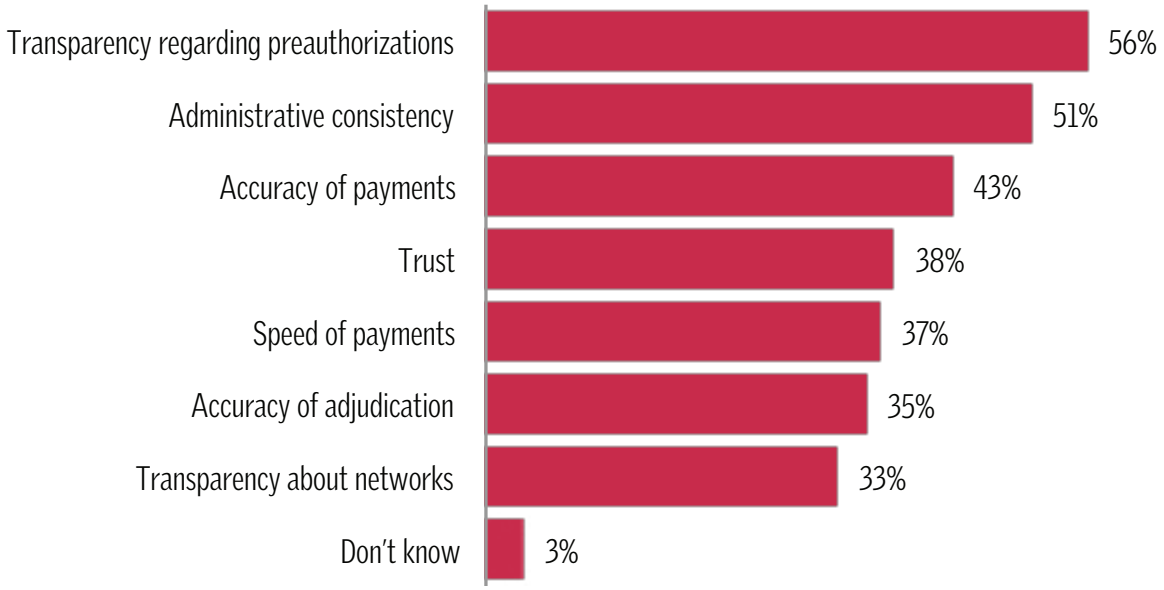
Base = 150, Multi-Response

With metrics topping the list of items organizations want to achieve in their next negotiation, we see an indication of the desire to resolve a key unknown. Providers know how to deliver care, and they have an established set of procedures to optimize care-delivery performance. But as value-based relationships emerge, financial results and clinical performance parameters will be linked more tightly.

SURVEY RESULTS

FIGURE 4: **Improvements Needed in Commercial Payer Reimbursement**

Q Regarding commercial payer reimbursements, what needs to be improved for that fundamental transaction to work better for your organization?



Base = 150, Multi-Response

Although the two items on top of the list are related to predictability (knowing what to expect from the payer), their impact is felt in different ways. First, care is provided based on preauthorizations, and if the status of payment changes at a later time, the expected level of payment is in jeopardy, which presents challenges from an accounts-receivable perspective. Second, regarding consistency, providers and payers alike have large teams to administer payments. Shifting administrative sands increase cycle time, decrease worker productivity, and can increase the chance of errors.

SURVEY RESULTS

FIGURE 5: **Organizational Status When Negotiating With Commercial Payers**

Q Please rate the current status of each of the following aspects of your provider organization according to its significance when negotiating with commercial payers.

	Very strong	Strong	Neutral	Weak	Very weak	Not applicable
Large market share	29%	40%	13%	12%	3%	2%
Broad spectrum of care	29%	43%	22%	2%	3%	1%
Large geographic footprint	28%	40%	17%	9%	3%	2%
Robust access to care	27%	43%	20%	5%	3%	1%
Solid and demonstrable value proposition	27%	41%	18%	10%	3%	2%
Skilled negotiators on our team	24%	35%	27%	9%	3%	2%
Strong negotiator-payer relationships	15%	37%	27%	14%	4%	2%

Base = 150

Healthcare leaders see a future where offering a broad set of care services, making care available through a variety of settings, and having strong market position in geography and market share will help their organizations win favorable terms in payer negotiations.

SURVEY RESULTS

FIGURE 6: **Effects of Health Insurance Exchanges on Organization**

Q So far, what effect have the health insurance exchanges had on these aspects of your organization?

	Up	Even	Down	NA/don't know
Ambulatory/outpatient visits	44%	38%	5%	13%
Emergency department visits	39%	34%	5%	23%
Bad debt from acute care patient admissions	38%	24%	19%	19%
Bad debt from ED visits	35%	18%	17%	30%
Bad debt from ambulatory/outpatient visits	33%	25%	21%	21%
Acute care patient admissions	31%	36%	14%	19%
Charity care from acute care patient admissions	25%	27%	30%	18%
Charity care from ED patient admissions	23%	23%	25%	29%
Charity care from ambulatory/outpatient visits	19%	31%	25%	25%

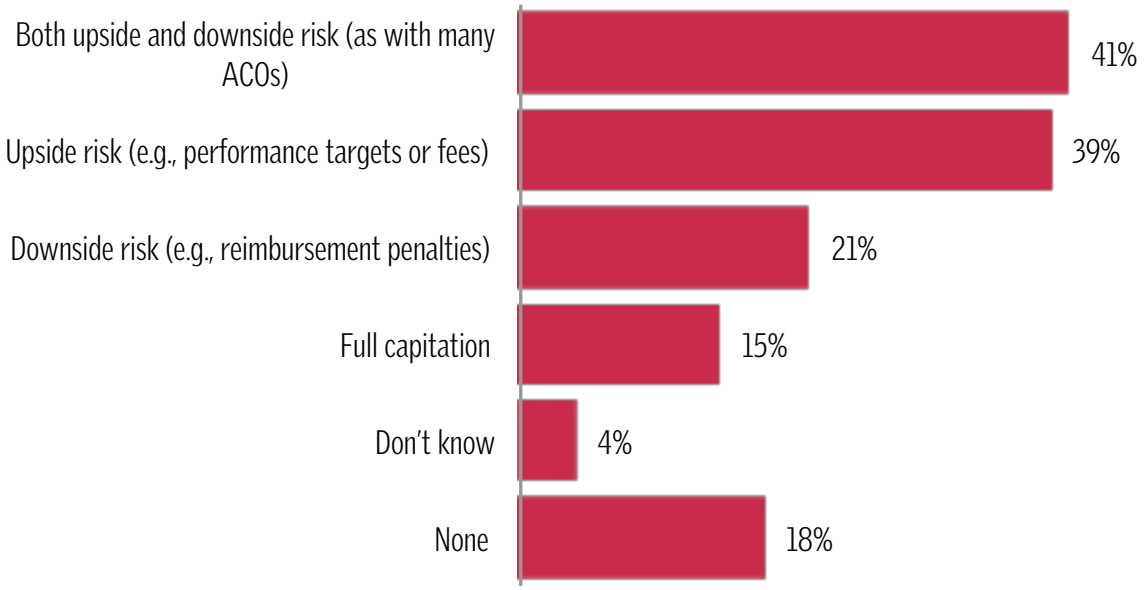
Base = 150

So far, exchanges, and the resulting increase in the portion of the population covered by insurance, have not resulted in a decrease in ED visits. Regarding bad debt or charity care, there are mixed results.

SURVEY RESULTS

FIGURE 7: **Participation in Types of At-Risk Programs**

Q In which of the following types of at-risk programs are you participating?



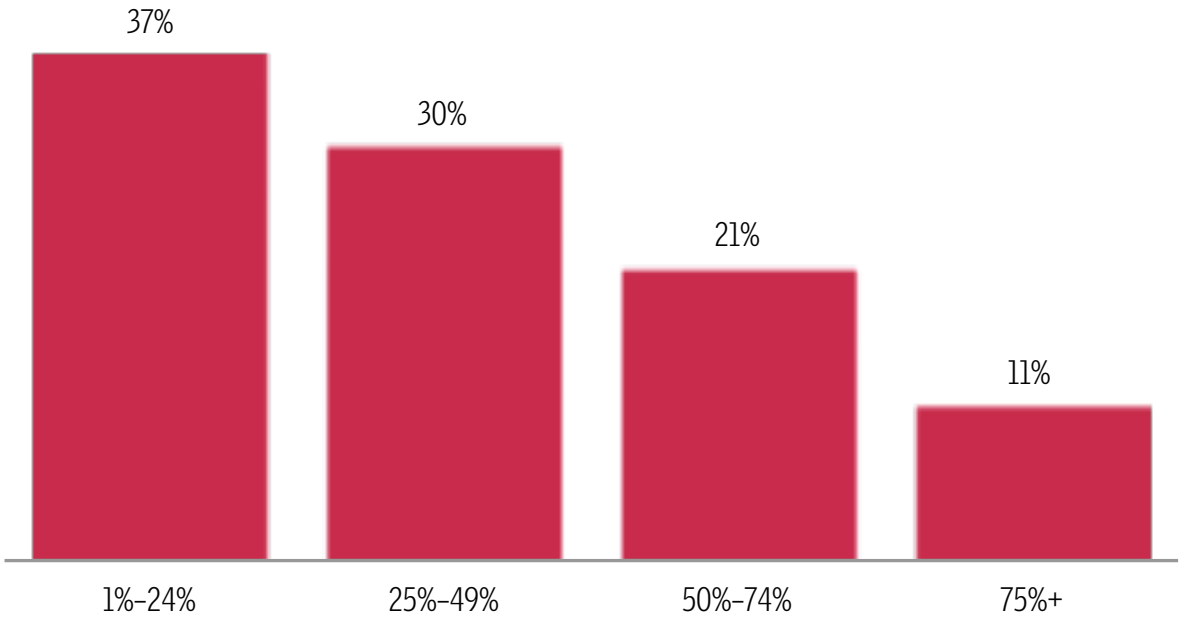
Base = 150, Multi-Response

Although overall 18% say they are not involved in at-risk programs, most are in organizations with net patient revenue lower than $250 million. Participation in at-risk programs is common in medium- and high-revenue organizations, suggesting a broad understanding of the industry's move toward delivering value-based care, and a degree of progress toward that objective.

SURVEY RESULTS

FIGURE 8: **Percentage of Patients Covered by Payer Contracts With Fee-for-Value Component**

Q What percentage of your organization's patients is covered by payer contracts that include fee-for-value components?



Base = 89
Median = 35%

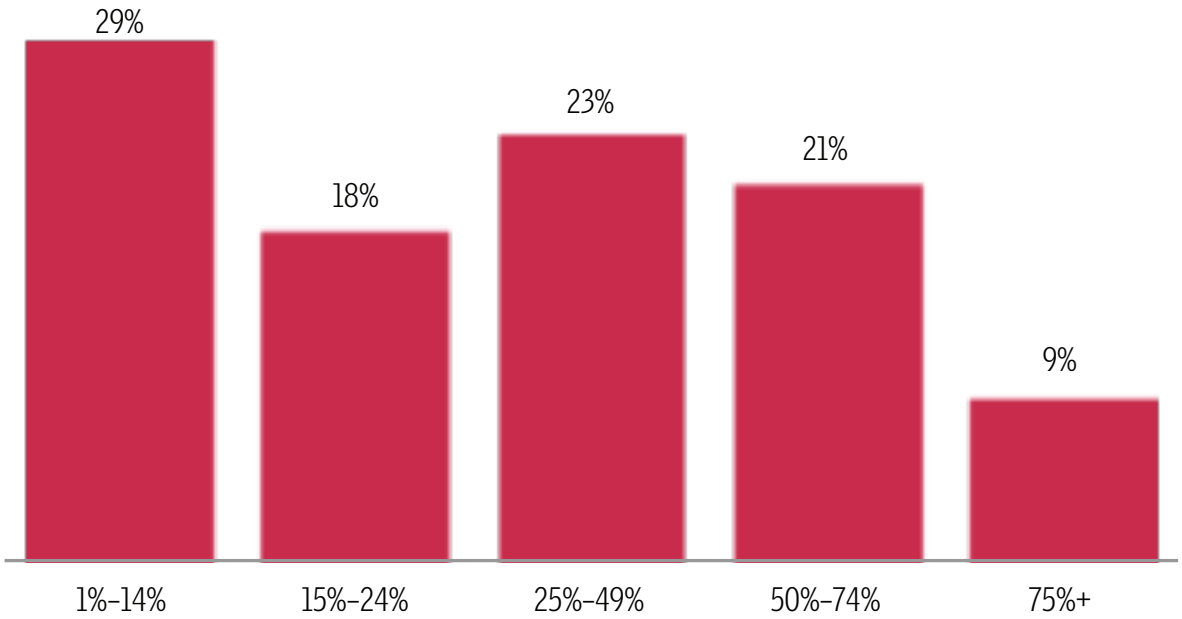
Among those who have patients covered by payer contracts and know percentage.

The relative stability from one year to the next confirms that movement of organizations toward at-risk programs remains somewhat tentative. In fact, the transition may never be complete—in conversations with healthcare leaders, we hear that there may always be a component of fee-for-service reimbursement.

SURVEY RESULTS

FIGURE 9: **Percentage of Net Patient Revenue Derived From Payer Contract With Fee-for-Value Component**

Q What percentage of your organization's net patient revenue is derived from payer contracts that include fee-for-value components?



Base = 77
Median = 25%

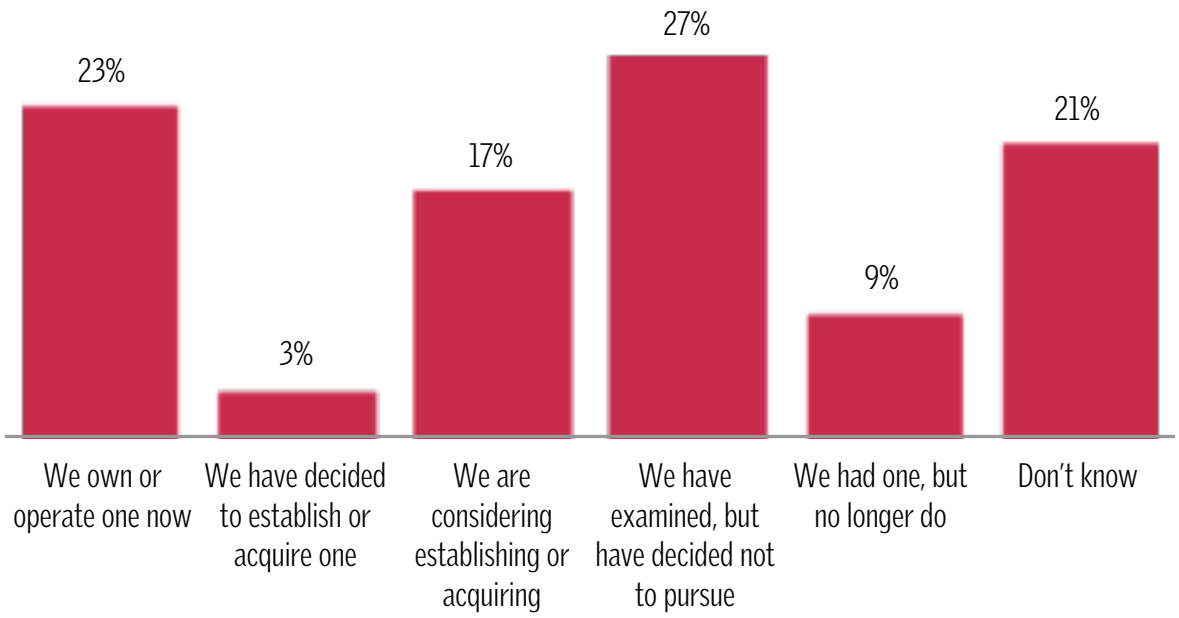
Among those who have payer contracts that include fee-for-value components and know percentage.

Looking at median values and the distribution of responses, we see percent of revenue (Figure 9) lagging percent of covered lives (Figure 8). This is an expected result considering the emerging nature of at-risk or value-based care. Payers are still rolling out new reimbursement models, and providers are still developing new care models.

SURVEY RESULTS

FIGURE 10: **Status of Owning or Operating a Payer Business/Health Plan**

Q What is your organization's status regarding owning or operating a payer business unit or health plan?



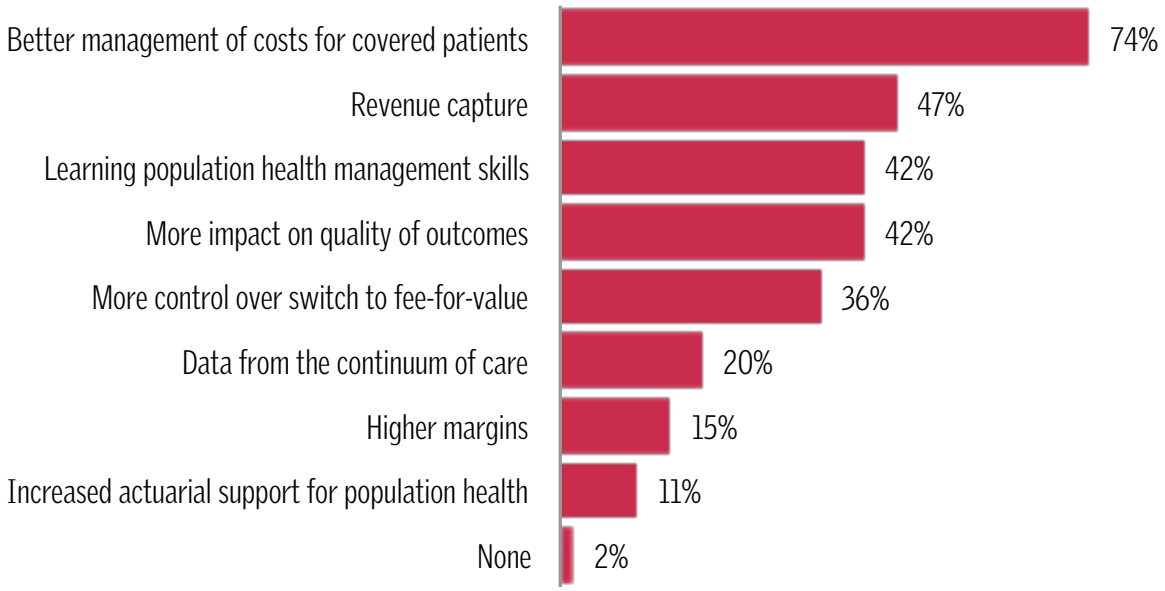
Base = 150

The relatively high percentage of low- and medium-revenue organizations that are not proceeding after having investigated owning or operating a payer business unit may be an indication that, while there may be the desire for a higher degree of control over revenue and operating margin, the activities that a payer needs to master are significantly different and sufficiently complex that establishing a payer business unit is seen as too costly or too risky.

SURVEY RESULTS

FIGURE 11: **Motivations for Pursuing Payer Business Unit**

Q What are your top three motivations for pursuing or establishing a payer business unit?



Base = 66, Multi-Response

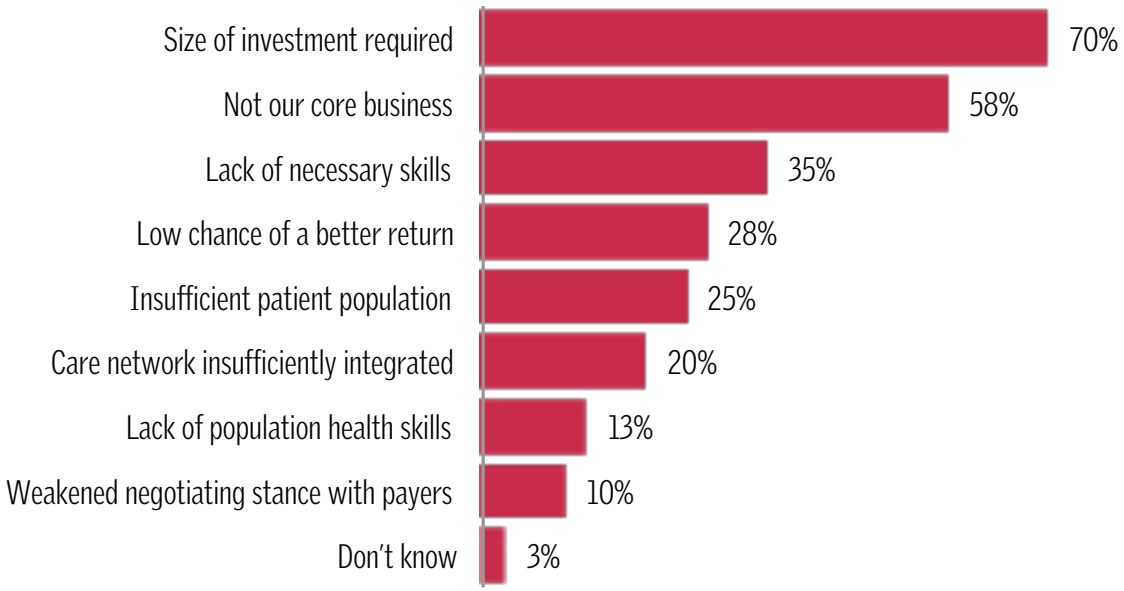
Among those who own or operate one now, or have decided or have considered establishing or acquiring a payer business unit or health plan.

Today's focus on the cost part of the value formula is clear, especially considering the relatively low percentage (15%) who say they are motivated by the prospects of higher margins. The presence of four items with similar percentages in the second tier may indicate that, after cost, a variety of objectives motivate providers.

SURVEY RESULTS

FIGURE 12: **Reasons for Not Pursuing Payer Business Unit**

Q What are the top three reasons you are not pursuing a payer business unit?



Base = 40, Multi-Response

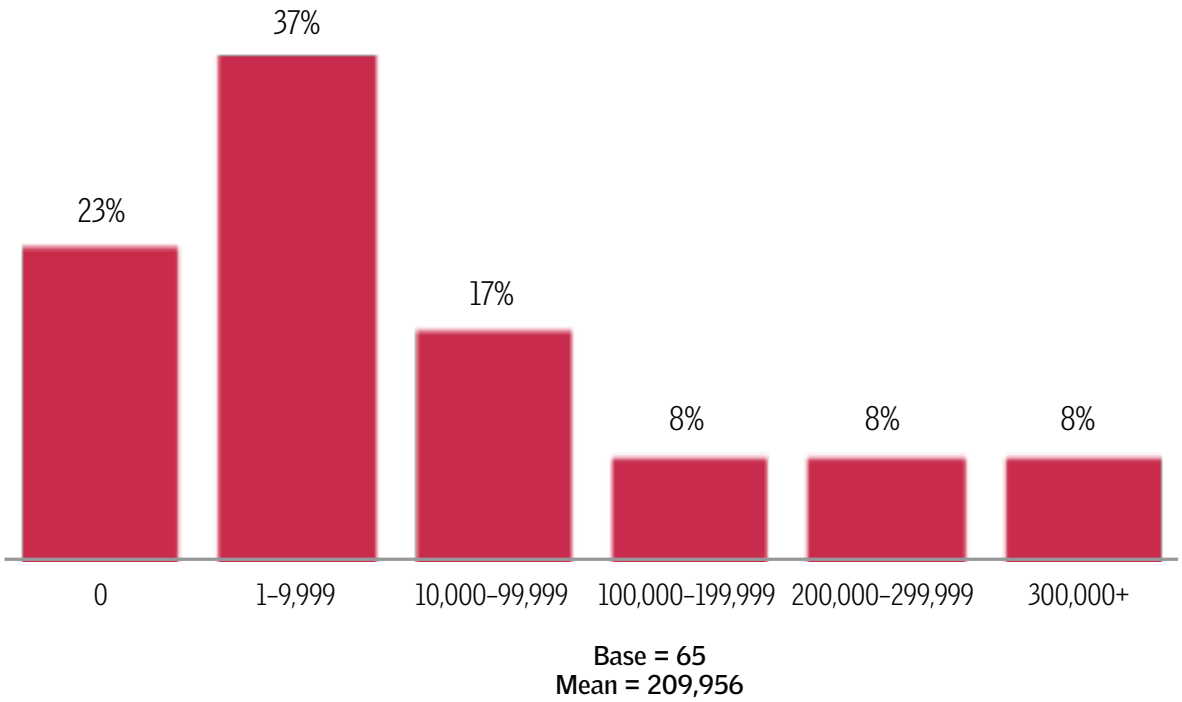
Among those who examined but decided not to pursue a payer business unit or health plan.

The reason for not pursuing a payer business unit mentioned most frequently is the size of investment, which can be understood in relation to the prospects for resulting return. The second-most frequent item—that insurance is not the provider's core business—is related to the investment issue, but adds the element of concern about directing resources away from a provider organization's core mission.

SURVEY RESULTS

FIGURE 13: **Number of Patients Covered by At-Risk Contracts Now**

Q How many of your patients are covered by at-risk contracts now?



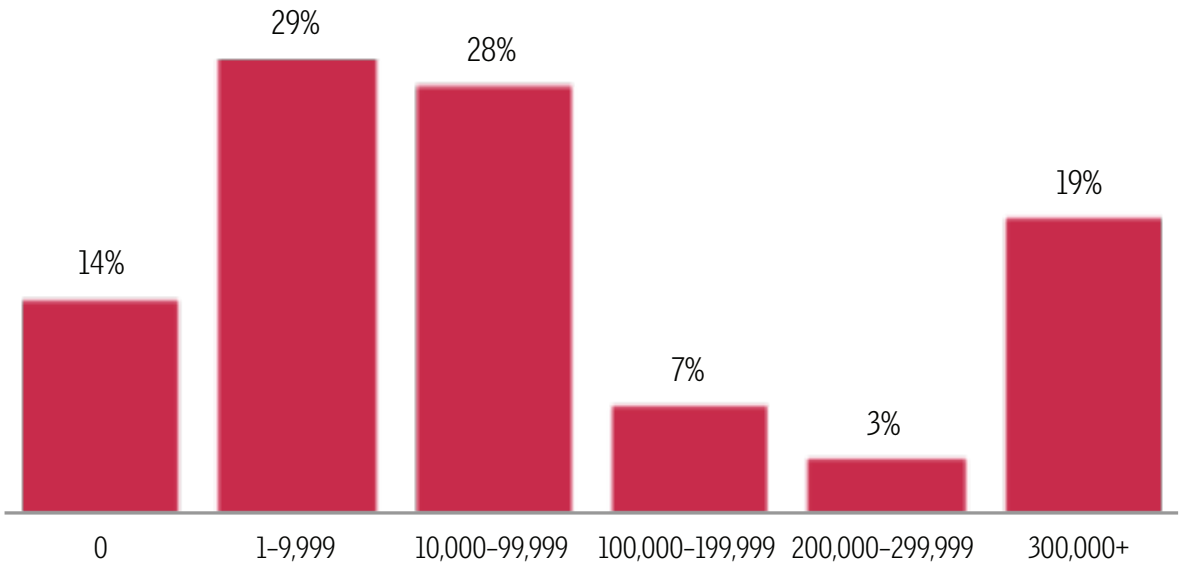
Base = 65
Mean = 209,956

Although more than half (60%) of the organizations participating in this question have fewer than 10,000 patients covered by at-risk contracts, the mean is in excess of 200,000 patients. Included in the group with 300,000 or more covered patients is one outlier with millions of covered lives. With that outlier removed, the mean decreases substantially.

SURVEY RESULTS

FIGURE 14: **Number of Patients Covered by At-Risk Contracts in Three Years**

Q What is your estimate of the number of patients who will be covered by at-risk contracts in three years?



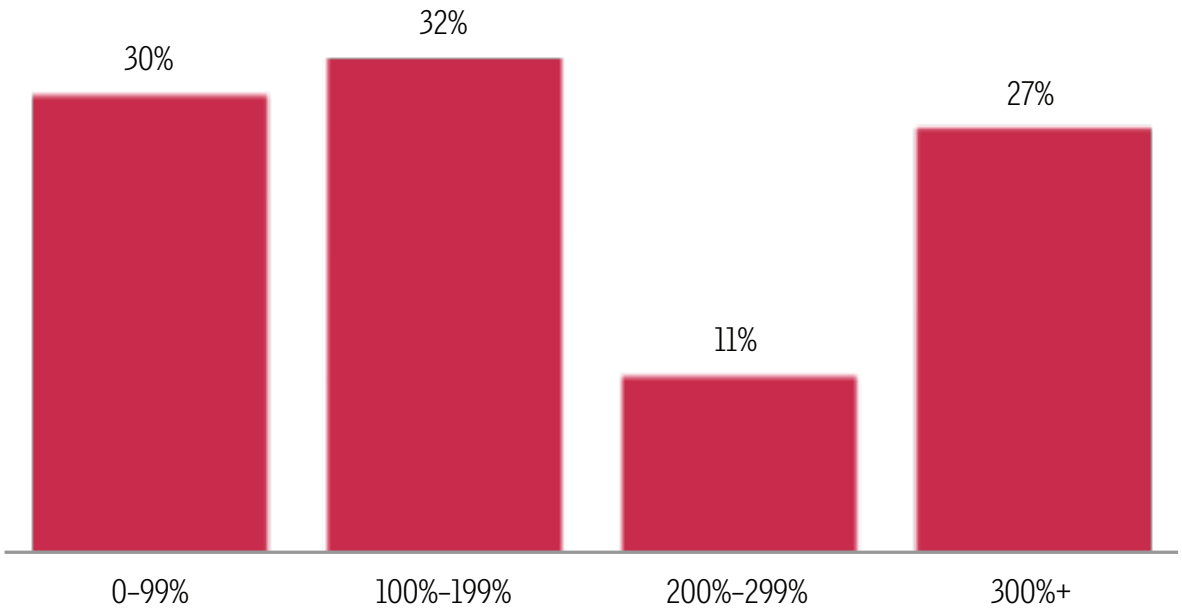
Base = 58
Mean = 353,426

With the percentage of those reporting no patients covered decreasing from 23% now to 14% in three years, there is a group that expects to begin covering patients with at-risk contracts for the first time. Decreases in the one-to-9,999 category are somewhat matched by increases in the 10,000 to 99,000 and 300,000+ categories. (As we noted in Figure 13, with the provider who counts covered lives in the millions removed, the mean for covered lives in three years drops substantially.)

SURVEY RESULTS

FIGURE 15: **Percentage Increase in Covered Lives**

Q What is the percentage increase in at-risk covered lives in three years?



Base = 44
% increase = 54%

Organizations participating in this question expect moderate increases in their at-risk populations. (With the outlier mentioned in Figures 13 and 14 removed from the calculation, there is a substantially higher overall percent increase.)

SURVEY RESULTS

FIGURE 16: **Status of Using Data Obtained From Payer to Support Risk Assessment Function**

Q What is your status regarding the use of data obtained from a payer to support your organization's risk-assessment function?

We do this now	30%
We are in discussions or negotiations to do so	25%
We are considering	23%
We have considered but have decided not to	3%
Other	3%
Don't know	16%

Base = 150

We see one-quarter in discussions and negotiations to begin using payer data to support at-risk assessments. With 23% of those with lower than $250 million in net patient revenue and 29% of those with revenue of $250 million or more pursuing payer data for risk assessment, awareness and interest is broad based.

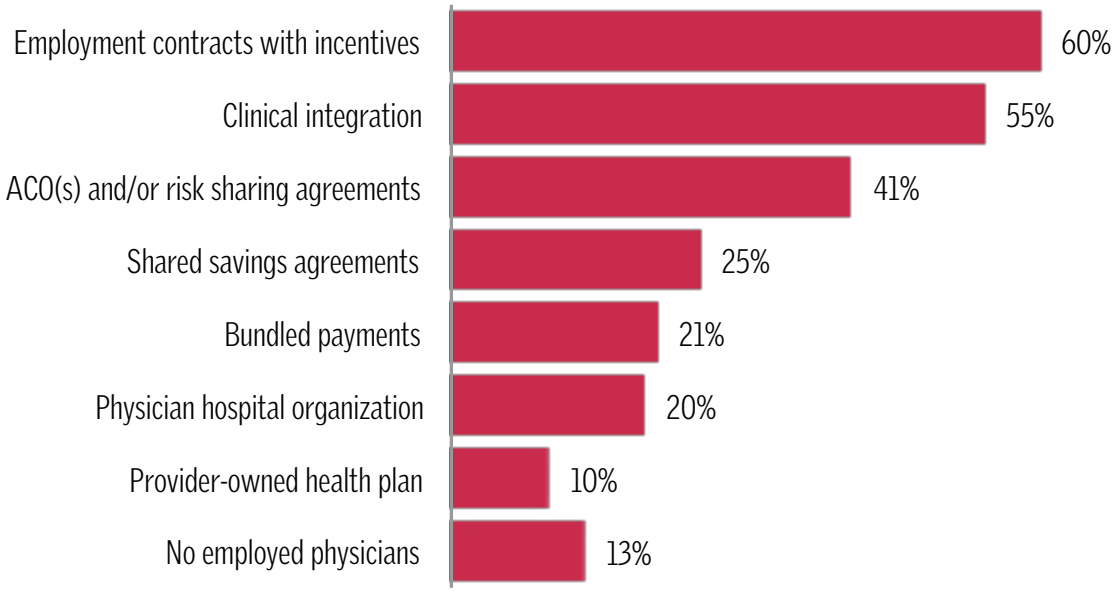
SECTION ELEVEN

Physician Alignment:
Today's Strategies Require Risk and Clinical Integration

SURVEY RESULTS

FIGURE 1: **Physician Alignment Mechanisms for Employed Physicians Now**

Q With employed physicians, which of the following physician alignment mechanisms is your organization undertaking now?



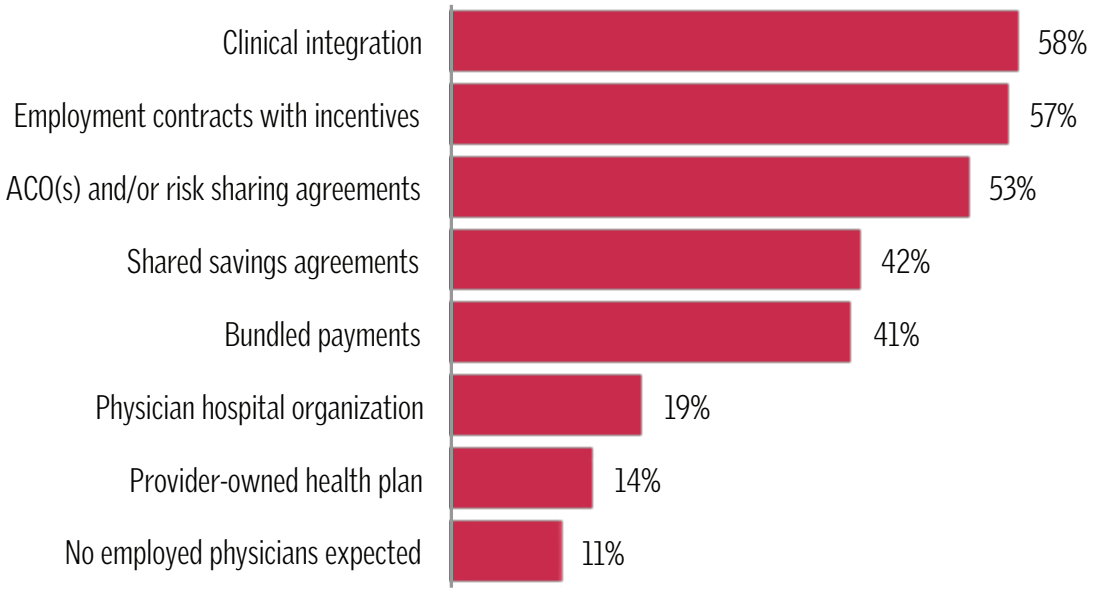
Base = 334, Multi-Response

Classic employment contracts lead the chart (60%), but nearly as many say they use clinical integration (55%) for employed physicians. Health systems use clinical integration much more than hospitals. And ACOs, more complicated arrangements to establish, are used for physician alignment by 41% overall, and 56% of health systems, which generally are better positioned to make the investments and tolerate the risks involved.

SURVEY RESULTS

FIGURE 2: **Physician Alignment Mechanisms for Employed Physicians Next Three Years**

Q Which of the following alignment mechanisms do you expect your organization to emphasize regarding employed physicians over the next three years?



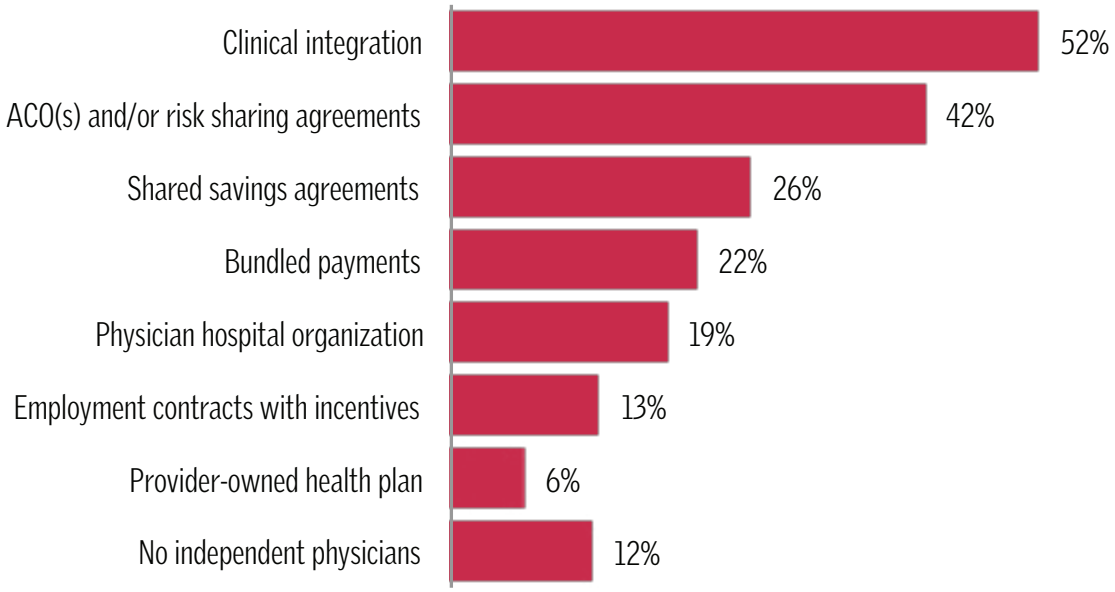
Base = 334, Multi-Response

Although incentives incorporated into employment contracts and clinical integration top the list in the three-year time frame as they do now, there are virtually no changes in the levels. Not so with shared savings (up 17 points), bundled payments (up 20 points), and ACOs (up 12 points). Gains in these alignment mechanisms may be an indication that healthcare leaders understand the need to shift their working relationships with physicians to a value-based foundation.

SURVEY RESULTS

FIGURE 3: **Physician Alignment Mechanisms for Independent Physicians Now**

Q With independent physicians, which of the following physician alignment mechanisms is your organization undertaking now?



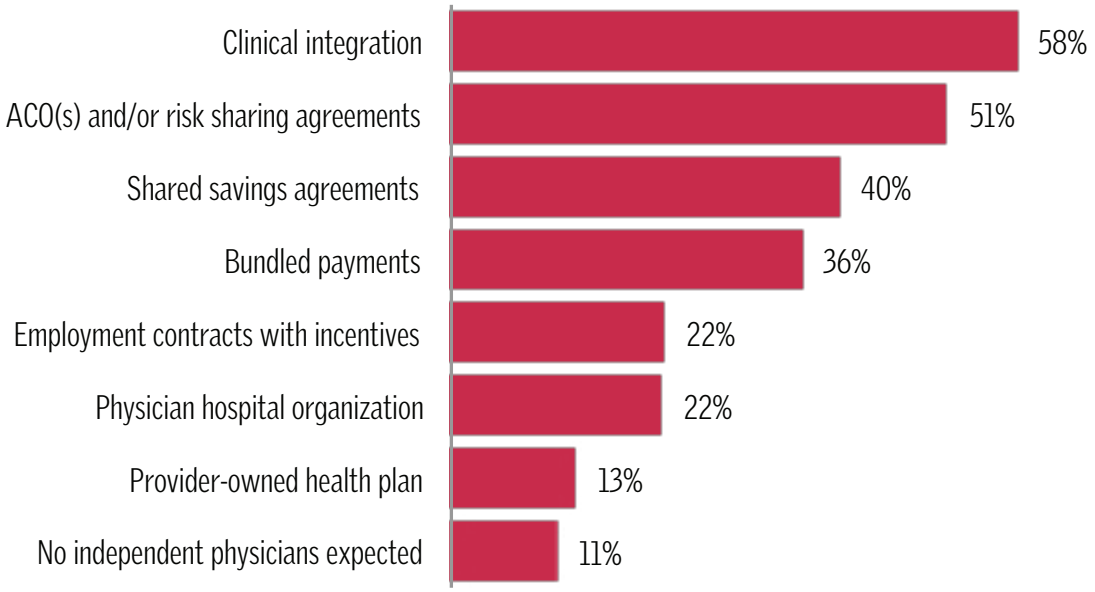
Base = 334, Multi-Response

There is little difference in the level of use of alignment mechanisms for employed (Figure 1) versus independent, except, of course, for employment contracts with incentives. Higher percentages of organizations participate in clinically integrated networks than those that do not use shared savings (35% vs. 27%) or ACO/risk-based alignment mechanisms (52% vs. 48%) with independent physicians.

SURVEY RESULTS

FIGURE 4: **Physician Alignment Mechanisms for Independent Physicians Next Three Years**

Q Which of the following alignment mechanisms do you expect your organization to emphasize regarding independent physicians over the next three years?



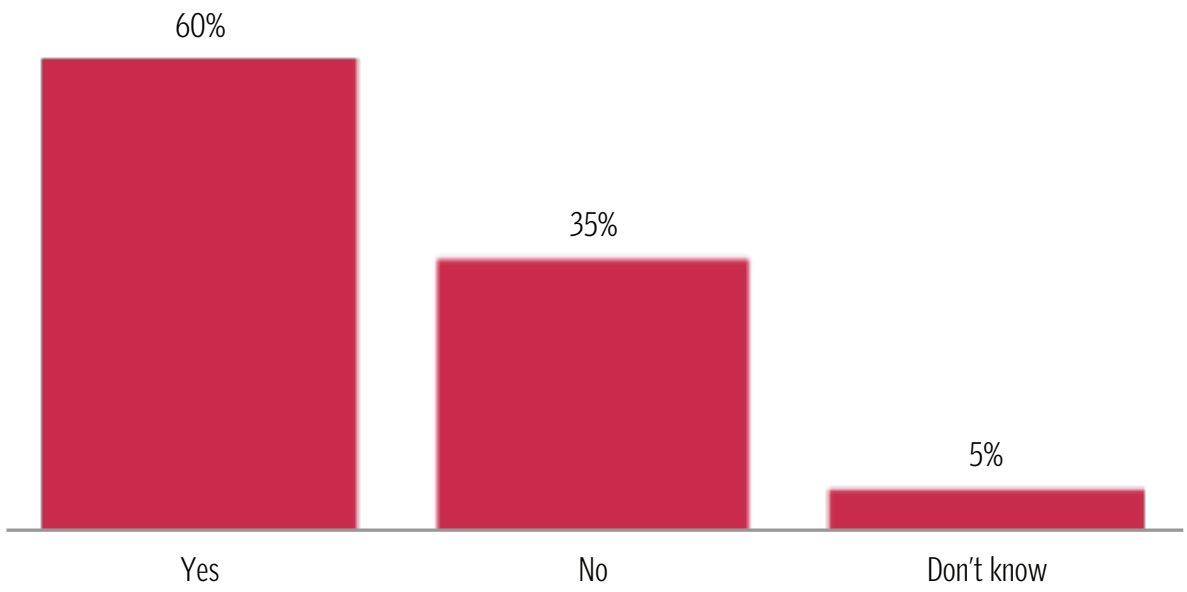
Base = 334, Multi-Response

Observing increases on the part of those who expect to have their independent physicians involved in bundled payments, shared savings, and ACOs, we see support for integrating independents into value-based programs. This may be an indication that organizations anticipate reaching a limit on the number of physicians that can be employed, or realize a limit on the degree to which employment influences alignment, or both.

SURVEY RESULTS

FIGURE 5: **Participation in Clinically Integrated Network**

Q Does your organization participate in a clinically integrated network?



Base = 234

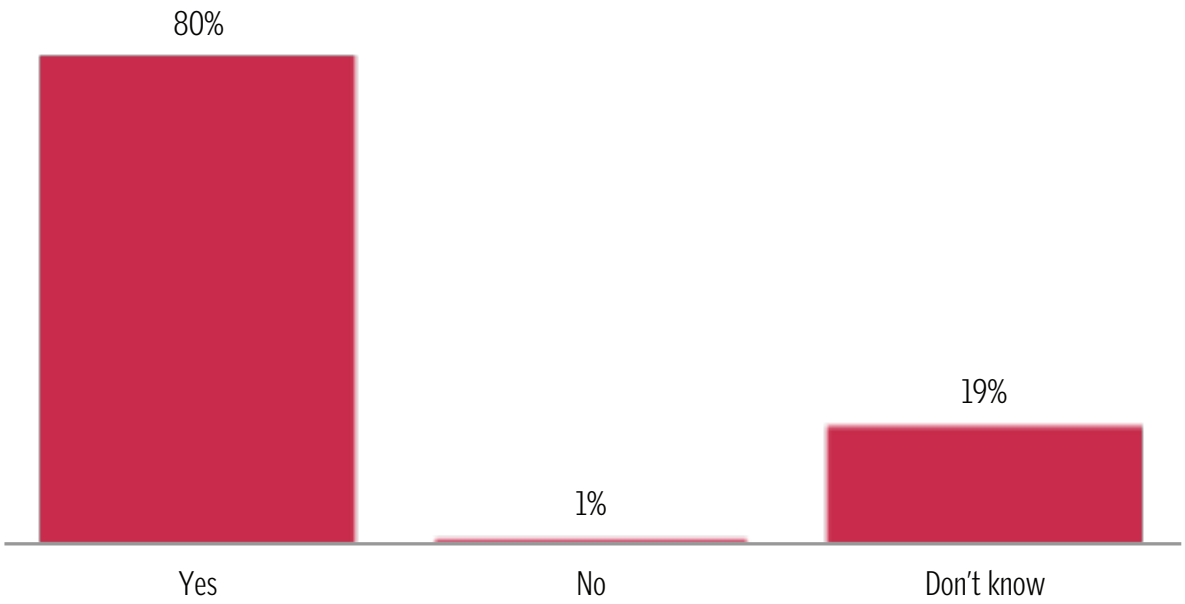
Among those now using clinical integration as an alignment mechanism

When "network" is added to "clinical integration," the implication is that more rigor is applied. More rigor often takes the form of conditional reimbursement—shared savings or shared risk or both. With the additional performance requirements and the need to provide administration and infrastructure, it is not surprising to see larger or more complex organizations participating in clinically integrated networks.

SURVEY RESULTS

FIGURE 6: **Clinically Integrated Network Compliance**

Q Is your clinically integrated network compliant with Federal Trade Commission and/or Department of Justice regulations?



Base = 141

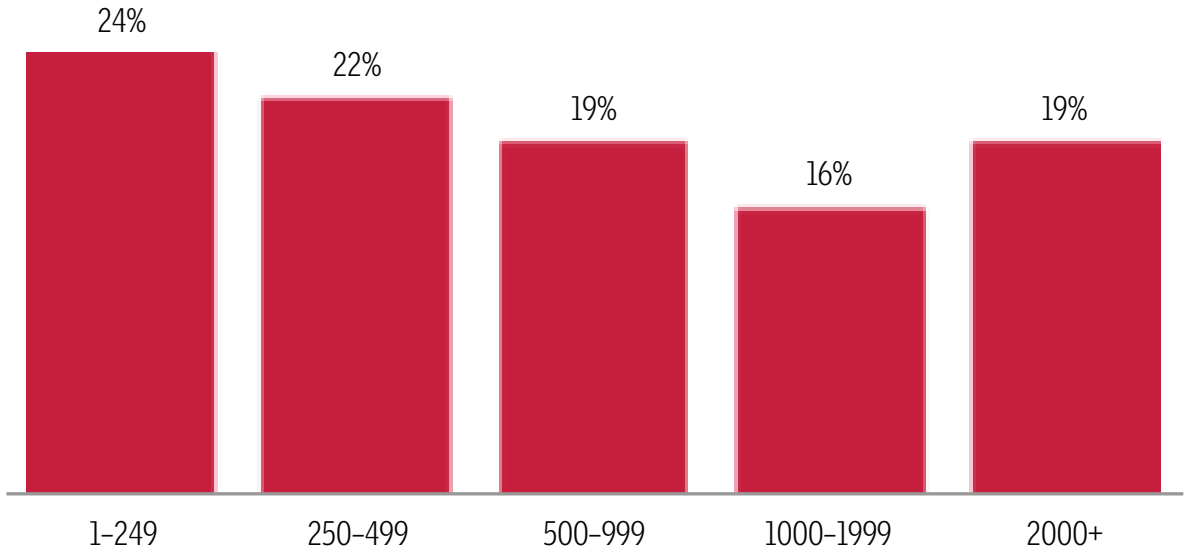
Among those now participating in a clinical integration network

Compliance with regulatory requirements represents an additional hurdle for those who are pursuing a clinically integrated network. While the presence of a CIN may be well known in an organization, the compliance status may not be, resulting in a fairly high percentage of "don't know" responses. Because it is likely that most who pursue clinically integrated networks do so with compliance in mind, we would expect the number of "don't know" responses to decline over time.

SURVEY RESULTS

FIGURE 7: **Number of Medical Staff Physicians**

Q What is your best estimate of the number of physicians on your combined medical staff?



Base = 83
Average = 979

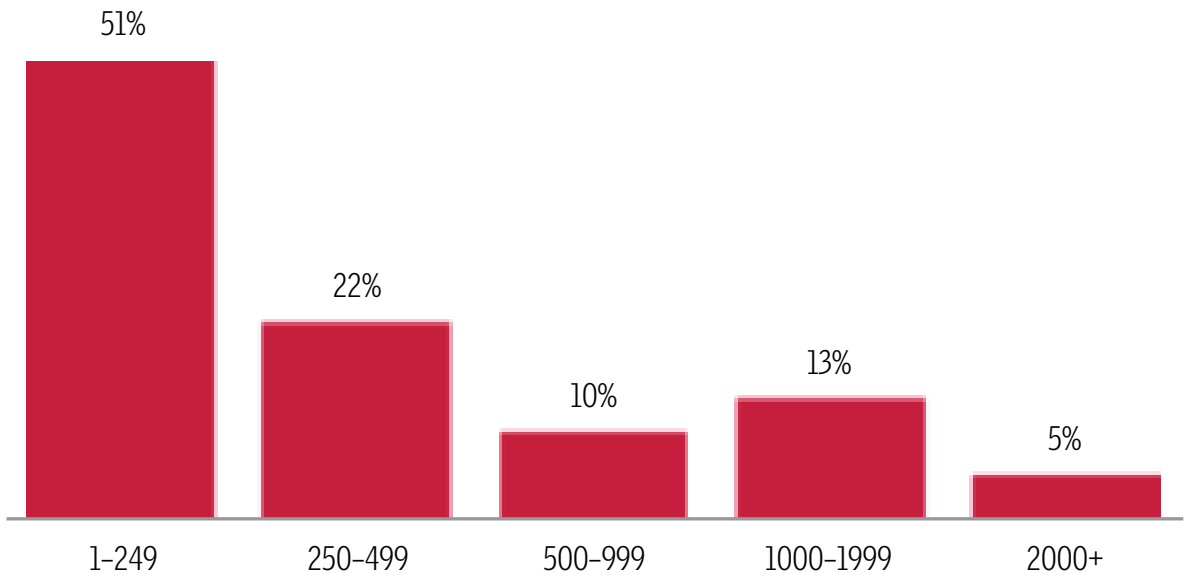
Includes CIN participants with medical and clinically integrated staff counts, for now and three years

For CIN participating organizations, the average physician population for health systems is 1,154, nearly double the 676 calculated for hospitals. The average count varies by organization size, of course, but overall, the average is 979 physicians on the medical staff. That is larger than the number of physicians who are actually in their clinically integrated network, which is 506 (Figure 8).

SURVEY RESULTS

FIGURE 8: **Number of Medical Staff Physicians in Integrated Network**

Q How many of those are in your clinically integrated network?



Base = 83
Average = 506

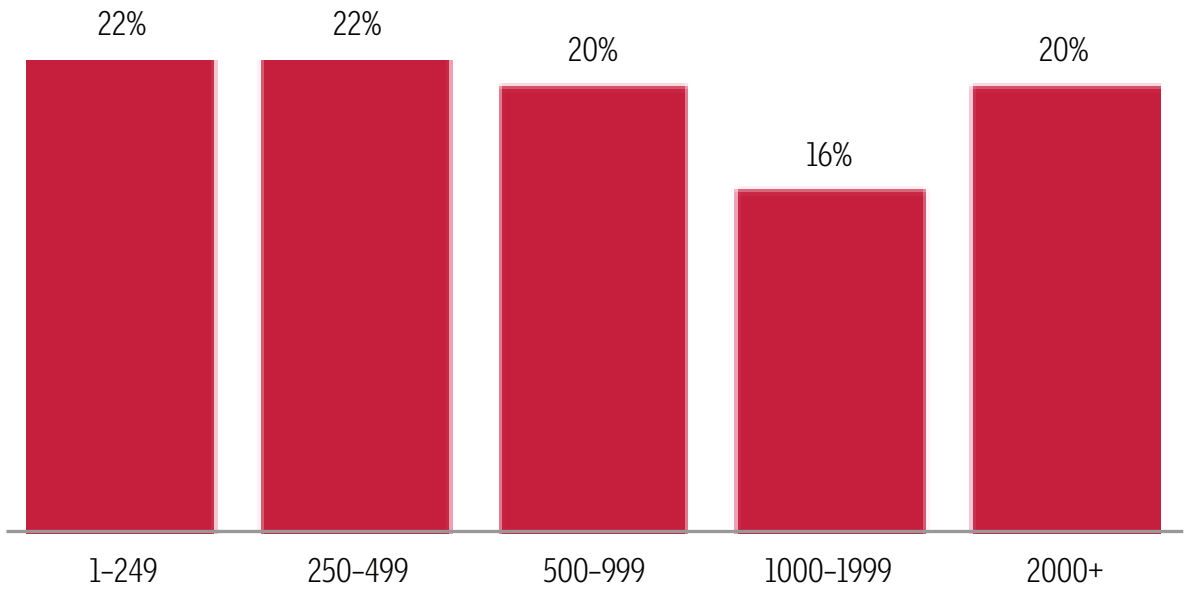
Includes CIN participants with medical and clinically integrated staff counts, for now and three years

As expected, health systems have higher employed staff counts (Figure 7) and have higher counts of employed physicians participating in clinically integrated networks. But for both hospitals and health systems, even among organizations that participate in a CIN, there is room for growth in terms of the share of physicians involved. CIN expansion among primary and specialty care doctors will likely cause these numbers to grow. Overall, about 52% of physicians on staff are in the clinically integrated network (506 of 979).

SURVEY RESULTS

FIGURE 9: **Number of Medical Staff Physicians in Three Years**

Q What is your best estimate of the number of physicians you expect to be on your combined medical staff three years from now?



Base = 83
Average = 1076

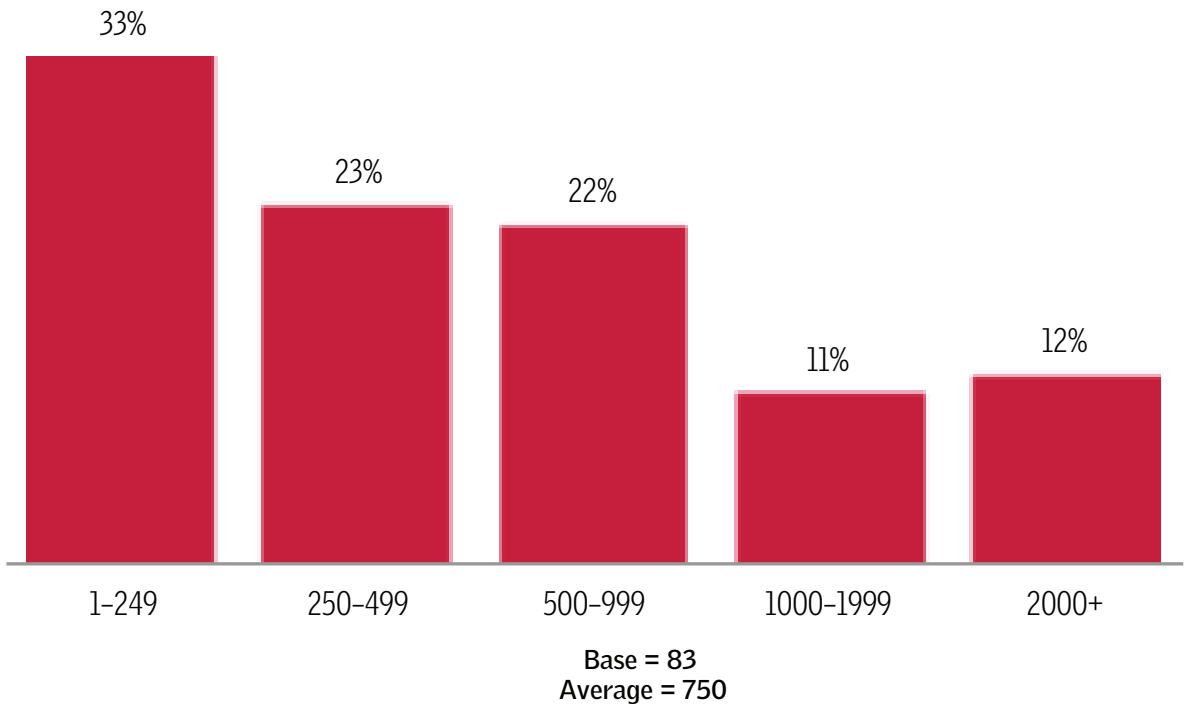
Includes CIN participants with medical and clinically integrated staff counts, for now and three years

Although we see modest growth in medical staff overall, an advisor suggests that an aging medical staff and a decline in physician interest in segments of healthcare such as primary care will dampen medical staff growth prospects. This could be an area of concern, as the role of the primary care physician is expected to be important in the effectiveness of the CIN.

SURVEY RESULTS

FIGURE 10: **Number of Medical Staff Physicians in Integrated Network in Three Years**

Q In the three-year time frame, how many of those might be in your clinically integrated network?



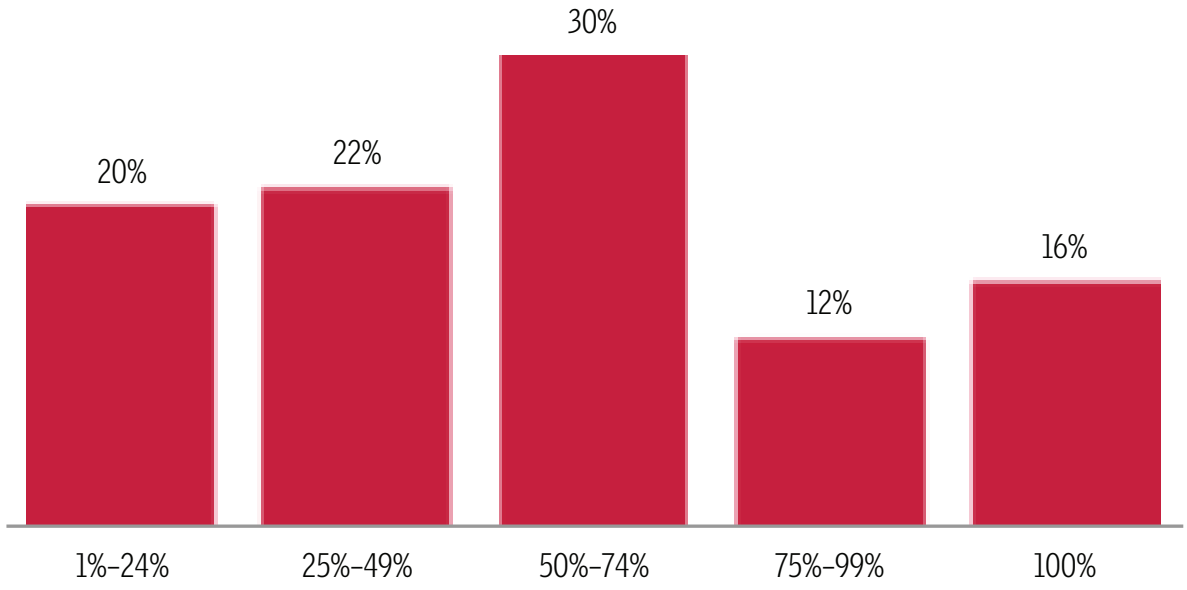
Includes CIN participants with medical and clinically integrated staff counts, for now and three years

Although medical staff overall is expected to grow by 10%, participation of medical staff in clinically integrated networks will increase greatly, at nearly five times that rate, as the industry begins to require physician participation in reform-related care transformation aimed at improving efficiency and reducing costs.

SURVEY RESULTS

FIGURE 11: **Percent Clinically Integrated Now**

Q Percent clinically integrated now.



Base = 83
Average = 52%

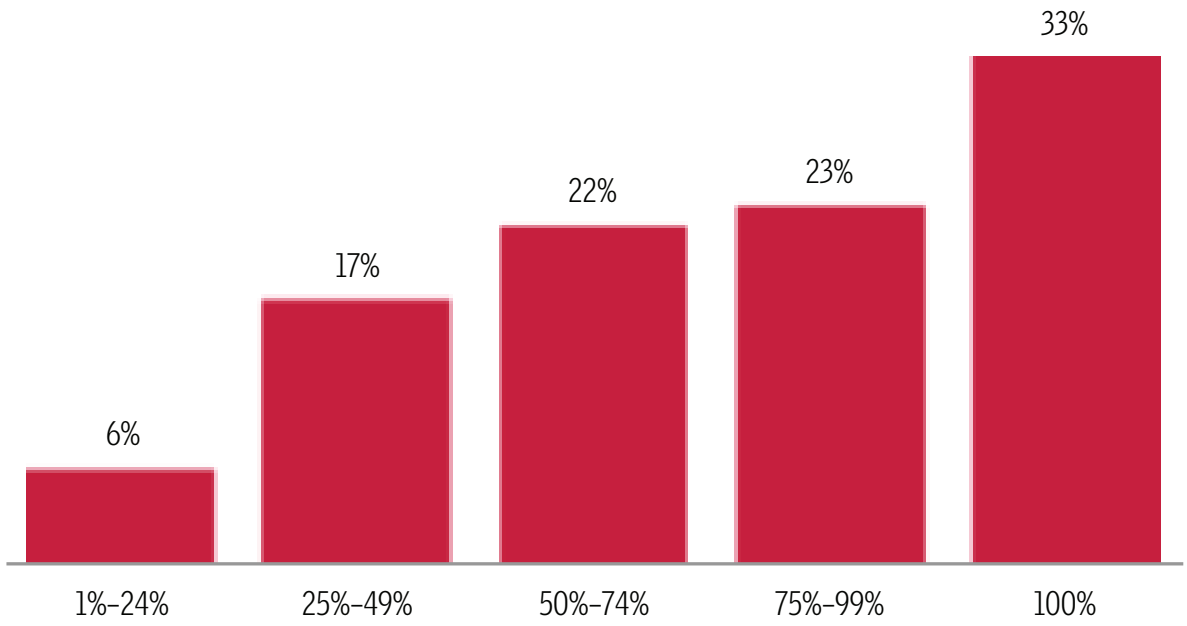
Includes CIN participants with medical and clinically integrated staff counts, for now and three years.
Supplemental chart based on responses obtained for Figure 7 and Figure 8

Overall, of organizations that participate in a CIN, about half of the medical staff is involved in the CIN (52%). This is a foundation for growth as participation in clinically integrated networks becomes more common, among organizations themselves and the physicians who make up the medical team.

SURVEY RESULTS

FIGURE 12: **Percent Clinically Integrated in Three Years**

Q Percent clinically integrated in three years.



Base = 83
Average = 70%

Includes CIN participants with medical and clinically integrated staff counts, for now and three years.
Supplemental chart based on responses obtained for Figure 9 and Figure 10.

The relatively high degree of transfer of medical staff to clinically integrated networks over the next three years by organizations that are now involved in CINs is an indication of growing strength of clinical integration as an alignment mechanism and, by extension, as a mechanism to improve both financial and clinical performance.

SURVEY RESULTS

FIGURE 13: **Clinically Integrated Staffing Trends: Data Highlights**

Q Clinically integrated staffing trends: Data highlights.

	Now	Three Years	Expected Growth
Medical staff (average)	979	1076	10%
Clinically integrated (average)	506	750	48%
Percent clinically integrated	52%	70%	35%

Base = 83

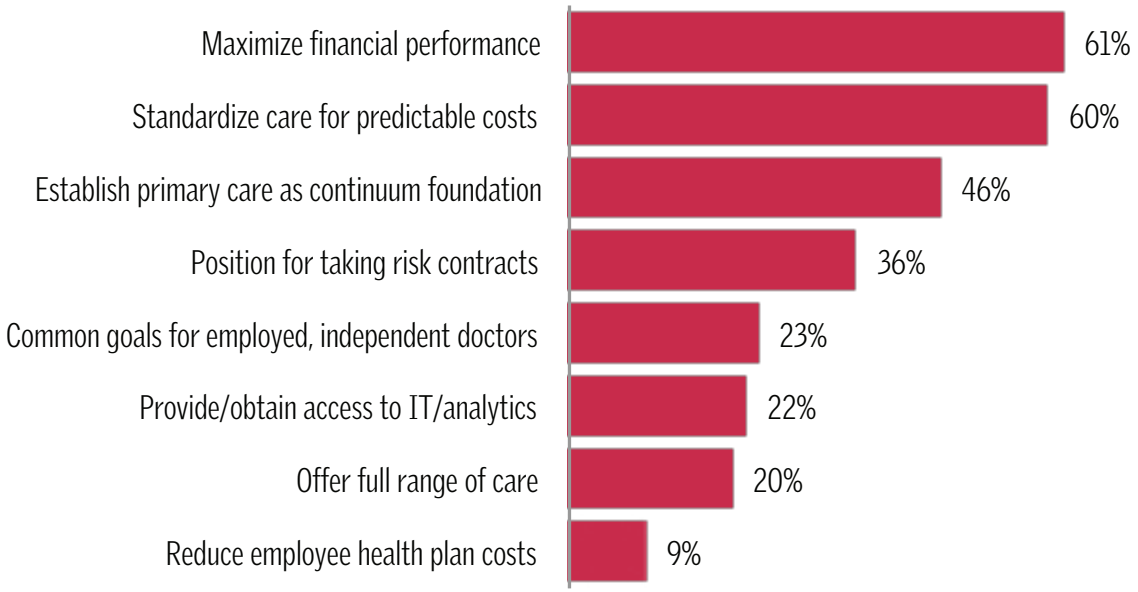
Includes CIN participants with medical and clinically integrated staff counts, for now and three years

It is expected that health systems will lead hospitals in many aspects of healthcare, including, as we have seen above, in the use of physician alignment mechanisms. But within this group of clinical integration network participants, the medical staff involvement in the clinical networks for hospitals tracks very closely to health systems, now and in the future. This indicates a likely correlation between CIN participation and a degree of sophistication regarding reform-related activities.

SURVEY RESULTS

FIGURE 14: **Physician Alignment Strategy Business Objectives**

Q Please identify the top three business objectives behind your physician alignment strategy.



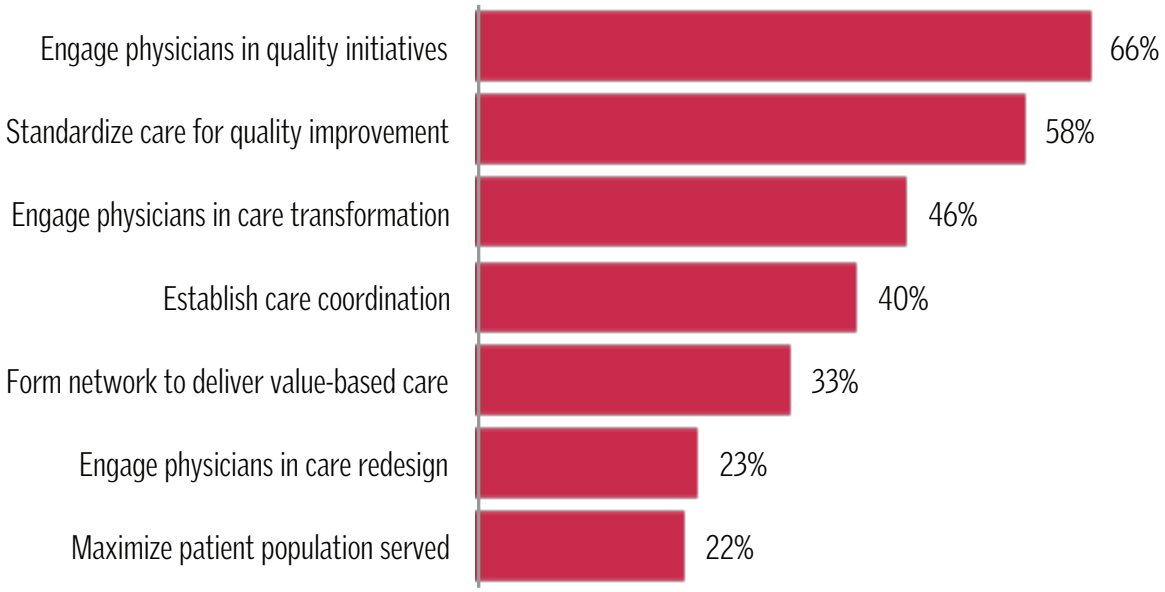
Base = 334, Multi-Response

Care standardization for cost performance and at-risk positioning are mentioned most frequently as a top objective by health systems and high-revenue organizations. Maximizing financial performance and care standardization for cost are mentioned most frequently by hospitals and low-revenue organizations. Clearly, physician alignment is critical to controlling costs and delivering value-based care.

SURVEY RESULTS

FIGURE 15: **Physician Alignment Strategy Patient Care Objectives**

Q Please identify the top three patient care objectives behind your physician alignment strategy.



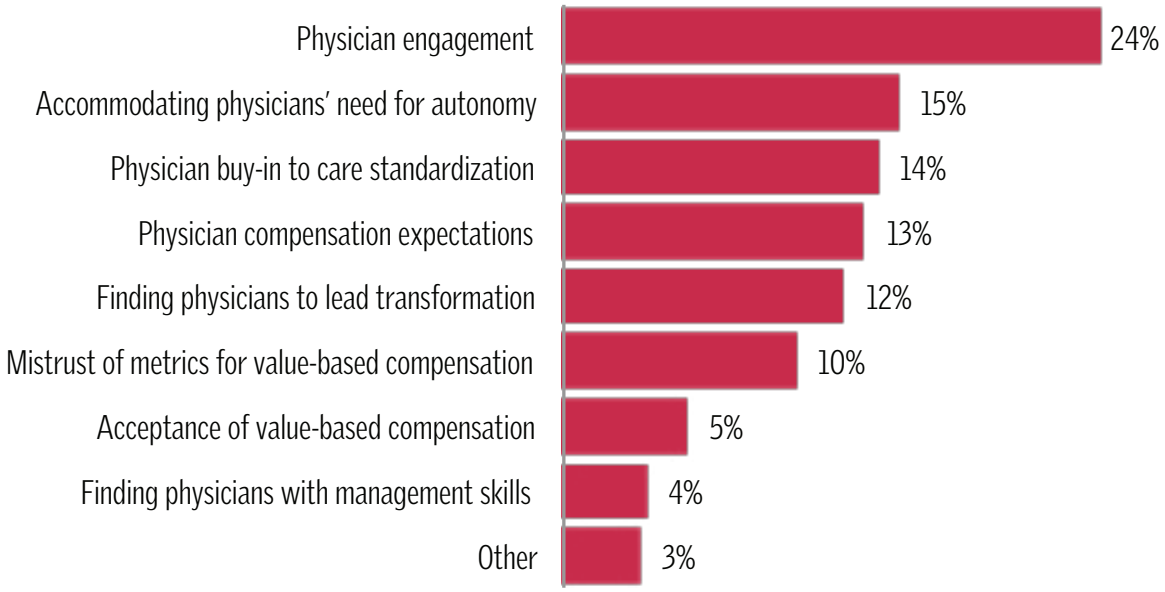
Base = 334, Multi-Response

Attention to quality of care is represented by the two items mentioned most frequently: engaging physicians in quality initiatives and standardizing for quality improvement. Both of these objectives are supported by coordination; it's included among the top objectives by 40% now, but that number will likely increase as networks expand and as quality initiatives migrate across the care continuum.

SURVEY RESULTS

FIGURE 16: **Most Difficult Aspect of Aligning Physicians**

Q What aspect of aligning physicians has been the most difficult for your hospital or health system?



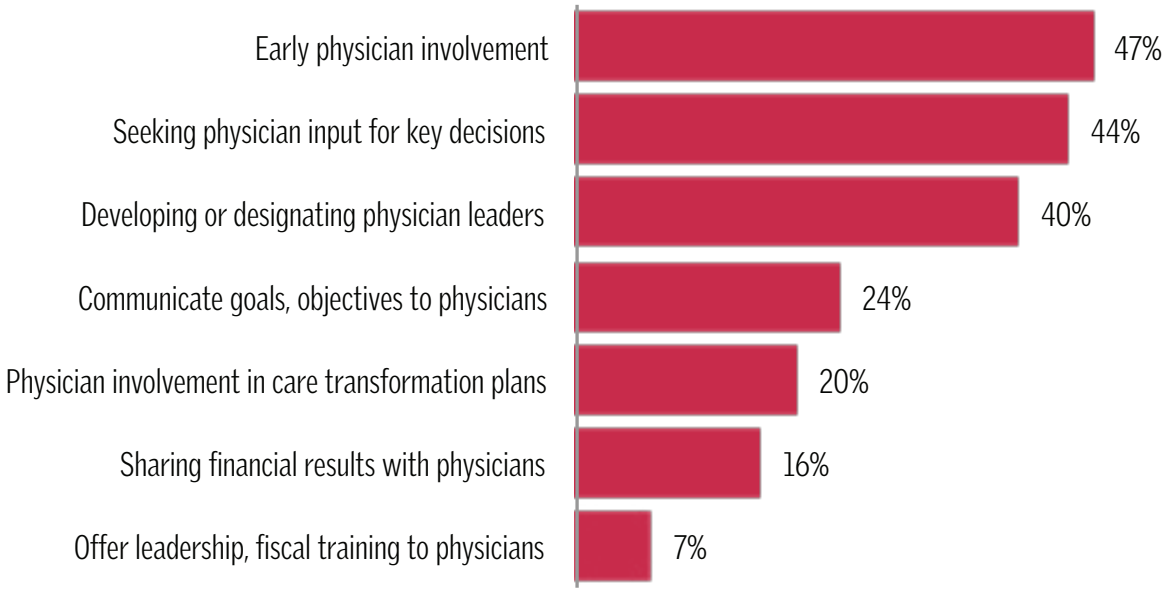
Base = 334

Although physician engagement is cited most frequently as a problem area, several of the other challenges may actually be less challenging with better engagement. Engaged physicians may not strive as much for autonomy, and may be more inclined to understand and support care standardization. Some who are engaged enough to understand the need for transformation may be moved to lead transformation.

SURVEY RESULTS

FIGURE 17: **Most Effective Actions to Engage Physicians in Strategic Planning**

Q What two actions are most effective when engaging physicians in strategic planning?



Base = 334, Multi-Response

In Figure 16, leaders emphasize the importance of physician engagement as an alignment objective. And here we see physician engagement top the list of alignment aspects presenting the most difficulty. This important aspect of alignment should guide most activities, because physicians and the care facilities where they work have challenging transformations to accomplish, and individuals and organizations may stumble unless there are high degrees of commitment and cooperation.

SECTION TWELVE

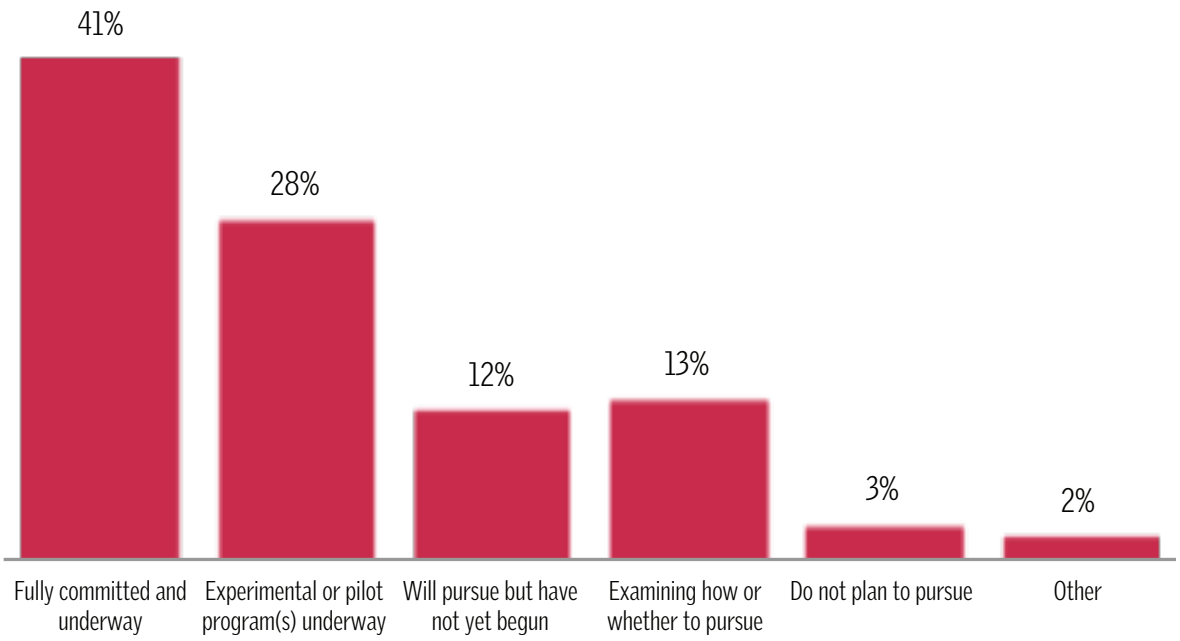
Population Health:
Investing in a Risk-Based Future

FROM THE HEALTHLEADERS MEDIA INTELIGENCE REPORT: OCTOBER 2015

SURVEY RESULTS

FIGURE 1: **Status of Managing Population Health**

Q What is your organization's status in regard to managing the overall health of a defined population?



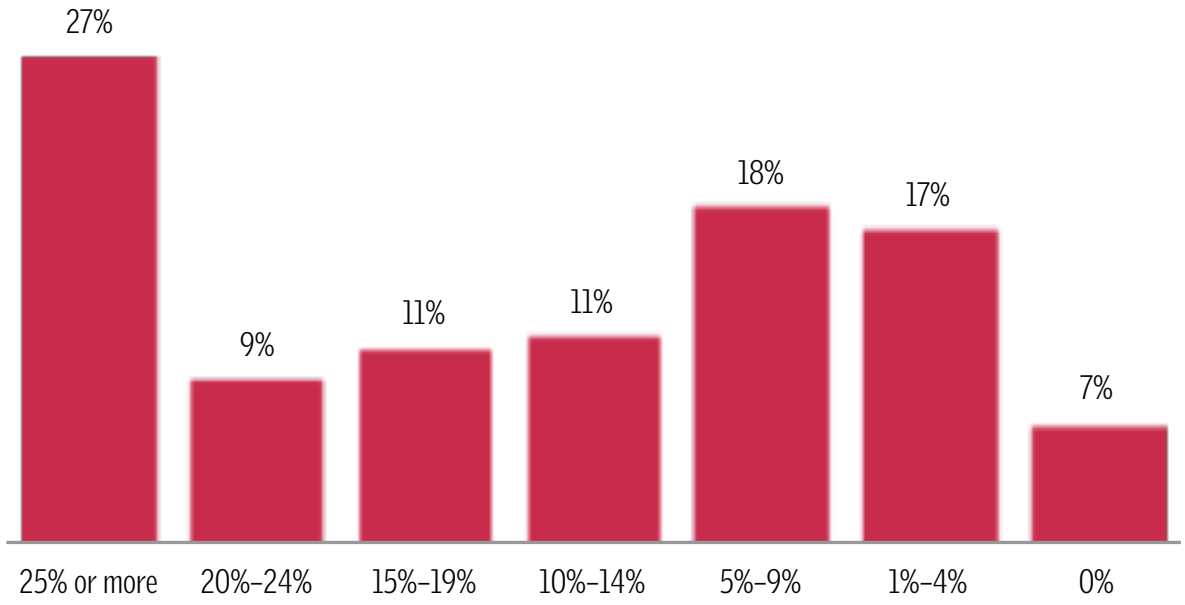
Base = 316

Although the industry remains committed to population health, the expectations for the pace of adoption may be moderating. Twenty-five percent of respondents report that they will either pursue it but have not begun yet or are examining how or whether to pursue it, up from 18% in last year's survey. Healthcare leaders are taking a serious look at population health, but they are making sure their organizations are fully prepared before taking it on.

SURVEY RESULTS

FIGURE 2: **Percent of Net Patient Revenue Attributed to Risk-Based Population Health Management**

Q What percent of your organization's net patient revenue is attributed to risk-based population health management activities that have exposure to profit and loss?



Base = 168

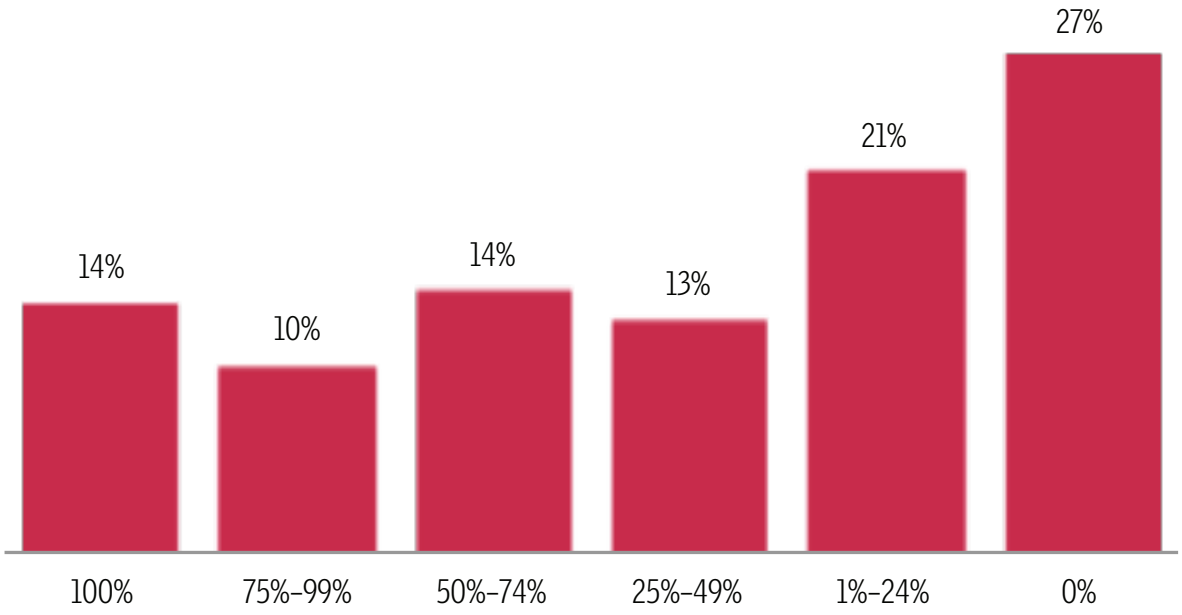
Among those fully committed to population health management or underway with pilot programs

The relatively modest response for risk-based population health management revenue greater than 25% (27%) indicates that providers are still feeling their way when it comes to taking on risk. The fact that 42% of respondents have risk-based revenue less than 10% also indicates that reimbursement models for population health will take time to take hold industrywide.

SURVEY RESULTS

FIGURE 3: **Percent of Employed Physicians With Portion of Compensation at Risk for Quality Outcomes**

Q What percent of your organization's employed physician staff now has at least some portion of their compensation at risk for quality-based outcomes?



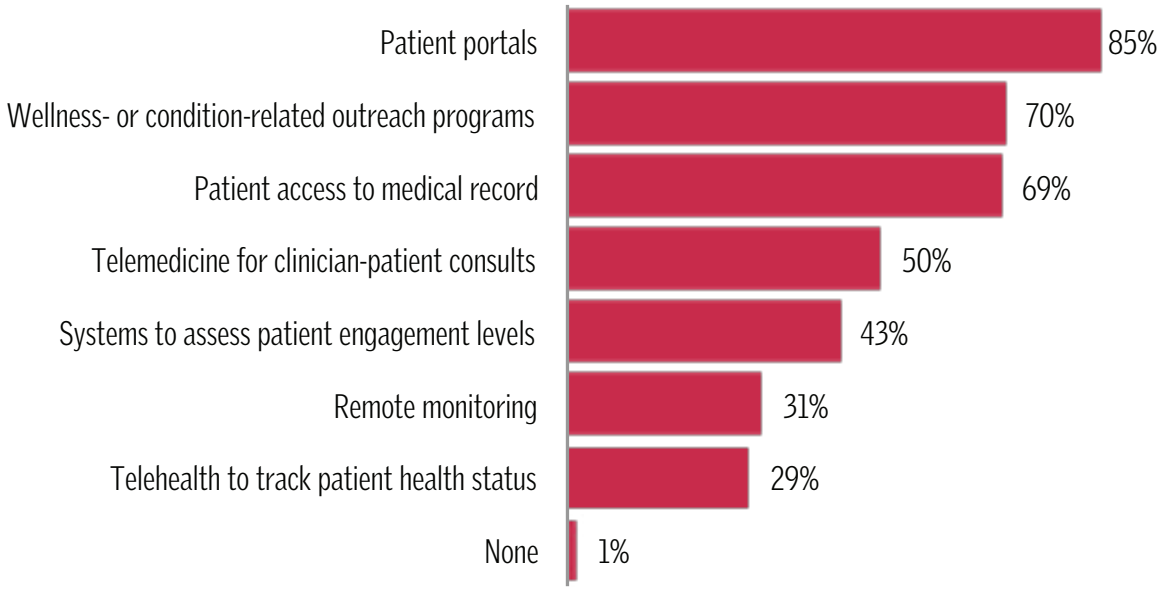
Base = 318

Respondents indicate the majority (73%) of employed physicians have at least some compensation exposed to risk for quality-based outcomes. While it is somewhat surprising, given the changing nature of healthcare, that 27% have no compensation at risk at all, the transition to value-based care and the adoption of risk-based reimbursement models will likely drive this number lower.

SURVEY RESULTS

FIGURE 4: **Investment in Patient Engagement Areas to Support Population Health**

Q In which patient engagement areas is your organization investing with the intent of supporting population health management?



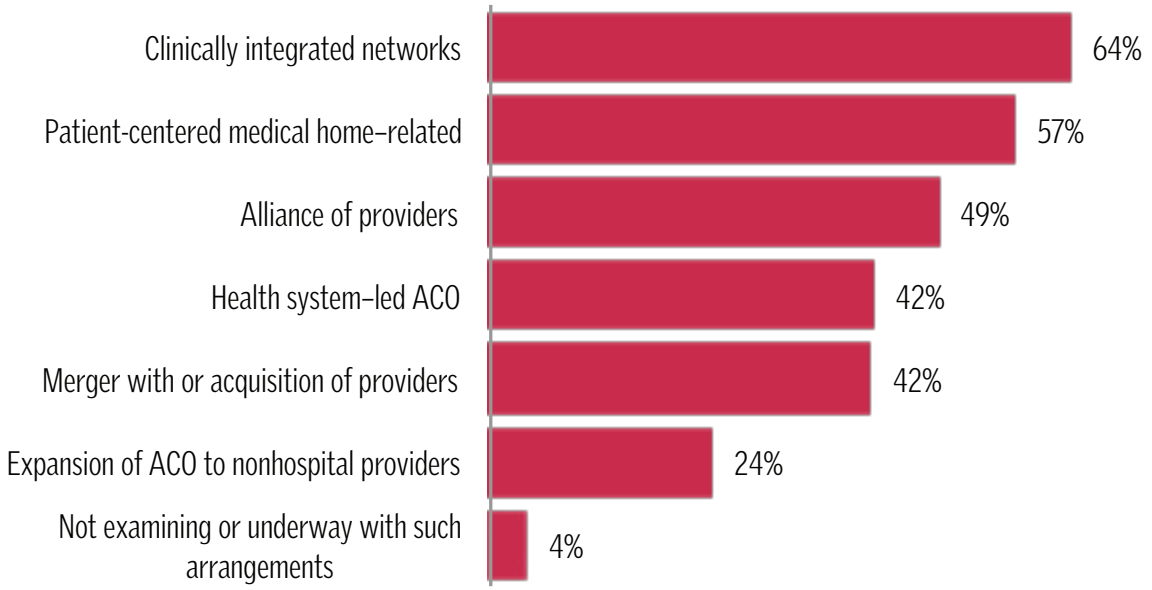
Base = 312, Multi-Response

Healthcare organizations are embracing the need for greater patient engagement, and traditional approaches are at the top of the list. Increasingly, however, organizations are looking to technology to enhance their engagement efforts, and those with the most resources are leading the way.

SURVEY RESULTS

FIGURE 5: **Population Health Strategic Initiatives**

Q What strategic initiatives is your organization engaged in or exploring to improve the health of a defined population?



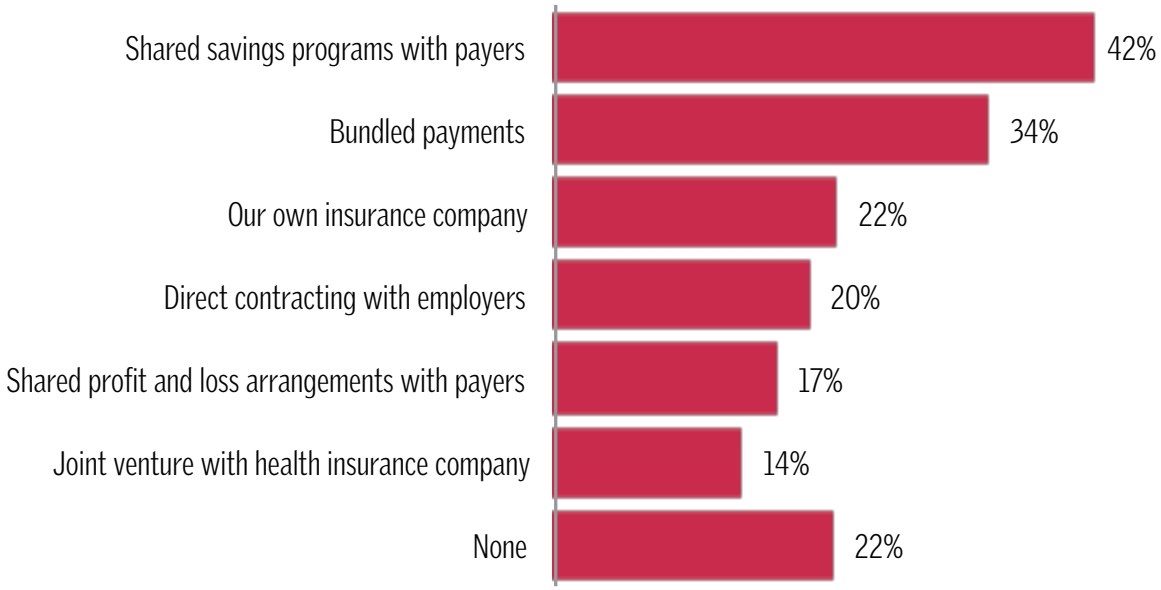
Base = 310, Multi-Response

While healthcare organizations of all types are exploring population health initiatives, health systems and larger organizations in general are leading the move to population health, perhaps because of the breadth of their care networks and ability to support the investment costs.

SURVEY RESULTS

FIGURE 6: **Financial Risk Structures Used Now for Population Health**

Q Which financial risk structures does your organization currently use in caring for an identified population?



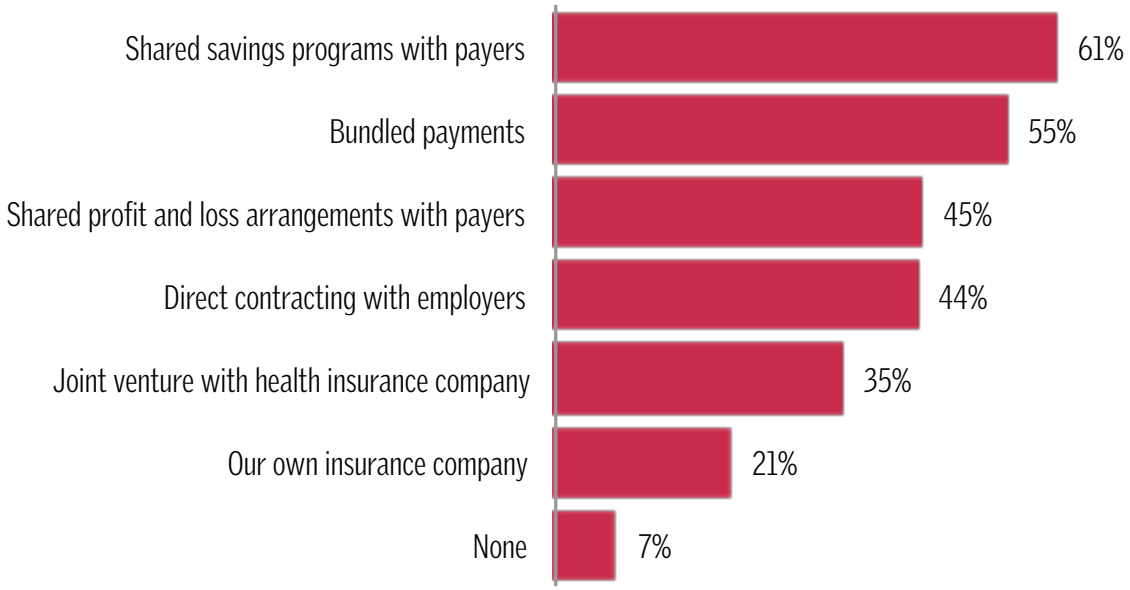
Base = 318, Multi-Response

A key element in the transition to population health is the adoption of risk-sharing financial models. The use of shared savings programs with payers is fairly common, likely because of its absence of downside risk. Bundled payments, cited by roughly one-third of respondents, entail some risk. However, with shared profit and loss arrangements with payers at 17%, there is still a long way to go.

SURVEY RESULTS

FIGURE 7: **Population Health Financial Risk Structures in Three Years**

Q Within three years, which financial risk structures do you expect your organization to be using in caring for an identified population?



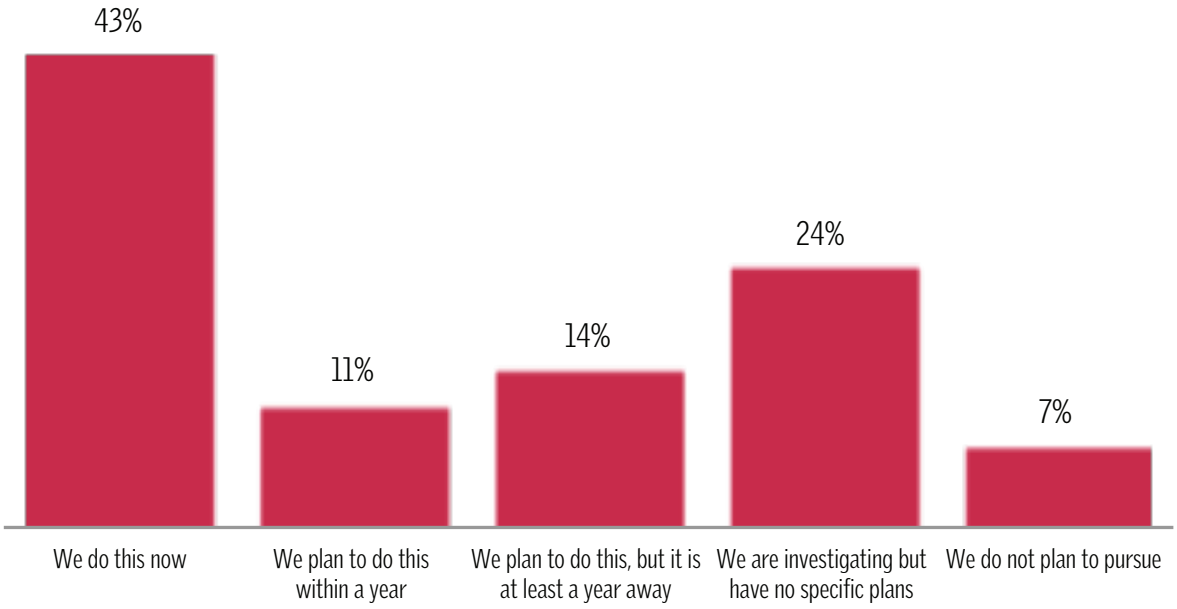
Base = 318, Multi-Response

While respondents indicate that shared savings programs with payers are expected to remain the dominant financial model for the next three years, they also indicate that shared profit and loss arrangements with payers will play an increasingly prominent role. This is an important development—providers will need to develop expertise managing risk-based models as the industry transitions to population health management.

SURVEY RESULTS

FIGURE 8: **Status of Attributing Responsibility for a Panel of Patients**

Q As part of your organization's population health effort, what is the status of your organization's efforts to attribute responsibility or accountability for a panel of patients to a particular physician or physician group?



Base = 286

Attributing responsibility for a panel of patients is an indication that providers are engaged in population health management activities. Nearly half of respondents (43%) say they are currently doing this, which means that progress is being made toward population health. However, as seen elsewhere in these survey results, the industry has a way to go.

SURVEY RESULTS

FIGURE 9: **Status of Establishing Team-Based Care for Top-of-License Performance Efficiencies**

Q What is the status of your organization's efforts to establish team-based care to take into account top-of-license performance efficiencies?

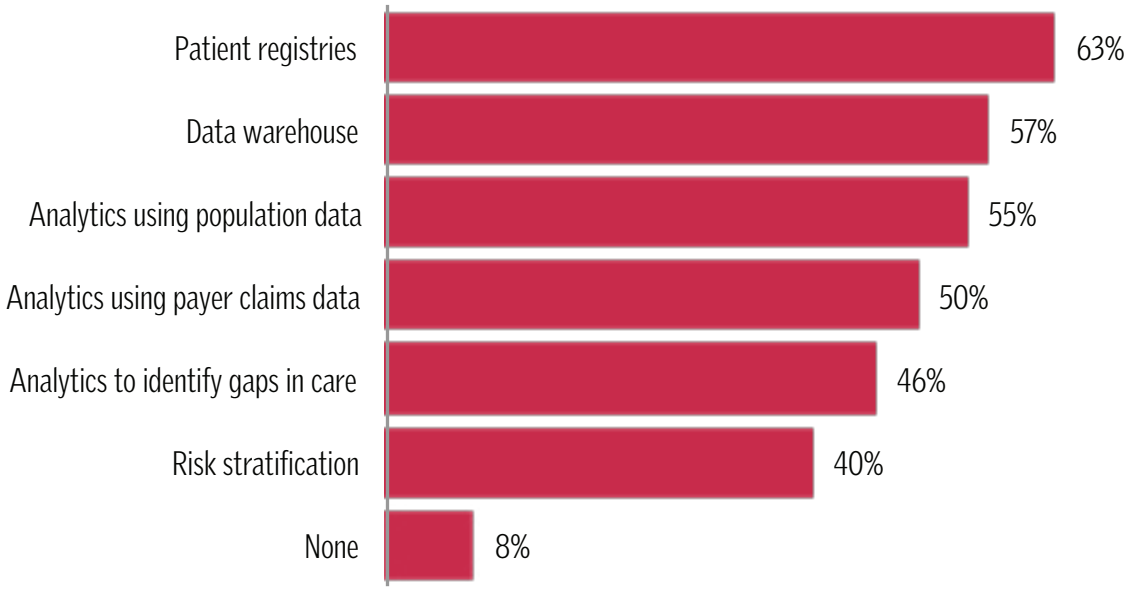
Base = 286

Whether an organization is committed to population health or not, team-based care to take into account top-of-license performance efficiencies is an important part of providing effective healthcare. While team-based care has value in the fee-for-service world, its benefits are particularly suited to the successful implementation of population health management, and we expect its use will continue to grow.

SURVEY RESULTS

FIGURE 10: **IT Infrastructure Investments to Support Population Health Now**

Q In which areas has your organization invested in IT infrastructure capabilities that are directed toward population health management?



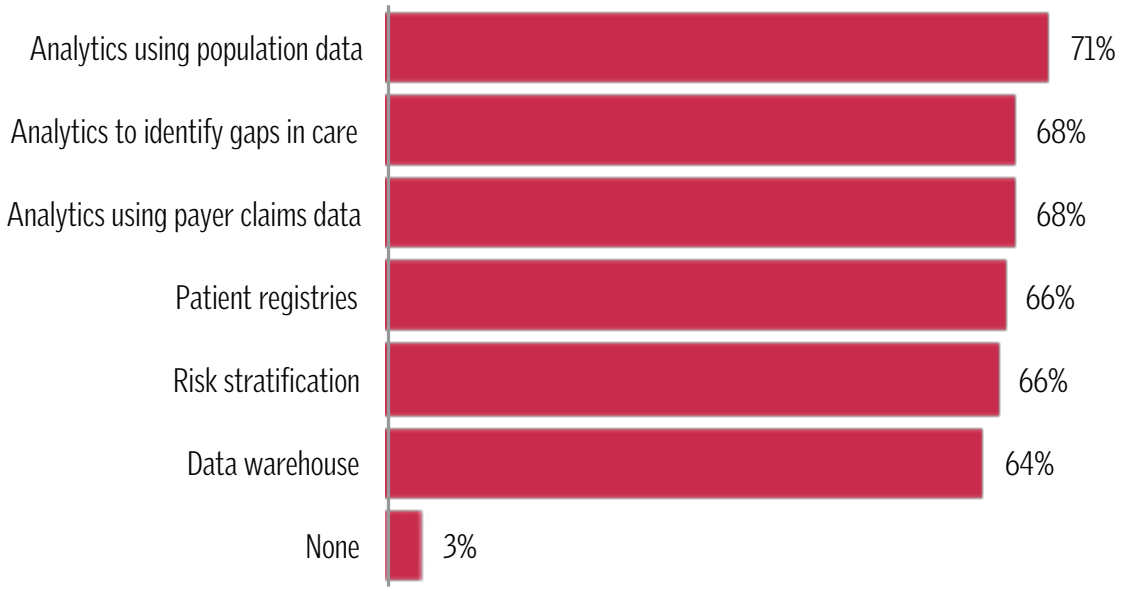
Base = 300, Multi-Response

The size of an organization's financial resources is generally correlated with investment in IT infrastructure. This shows up in the lower levels of response for small organizations, particularly small hospitals (17% of these say they are making no investment). However, the share of physician organizations that are demonstrating a willingness to invest is comparable to those of health systems. While some smaller players may be holding back, at some point, the dollars will need to be committed if the transition to population health is to be successful.

SURVEY RESULTS

FIGURE 11: **IT Infrastructure Investments to Support Population Health in Three Years**

Q Within three years, in which areas does your organization expect to be investing in IT infrastructure capabilities that are directed toward population health management?



Base = 265, Multi-Response

Clearly, analytics is an active and important area of future investment in IT infrastructure for population health. And while greater percentages of medium and large organizations expect to increase investments, such double-digit growth is expected over the next three years among large and small alike.

SURVEY RESULTS

FIGURE 12: **Status of Actuarial Services to Support Risk Assessment**

Q What is your organization's status regarding obtaining actuarial services to support risk assessment? You may select one from 'Actuaries on staff' and/or one or more as appropriate from 'Actuarial consultants.'

Actuaries on staff	
Actuaries on staff	13%
No actuaries on staff, but actively recruiting	3%
No actuaries on staff, but investigating	59%
Actuarial consultants	
Now using consultants for actuarial services	33%
Now recruiting consultants for actuarial services	5%
No consultants now, but investigating	48%

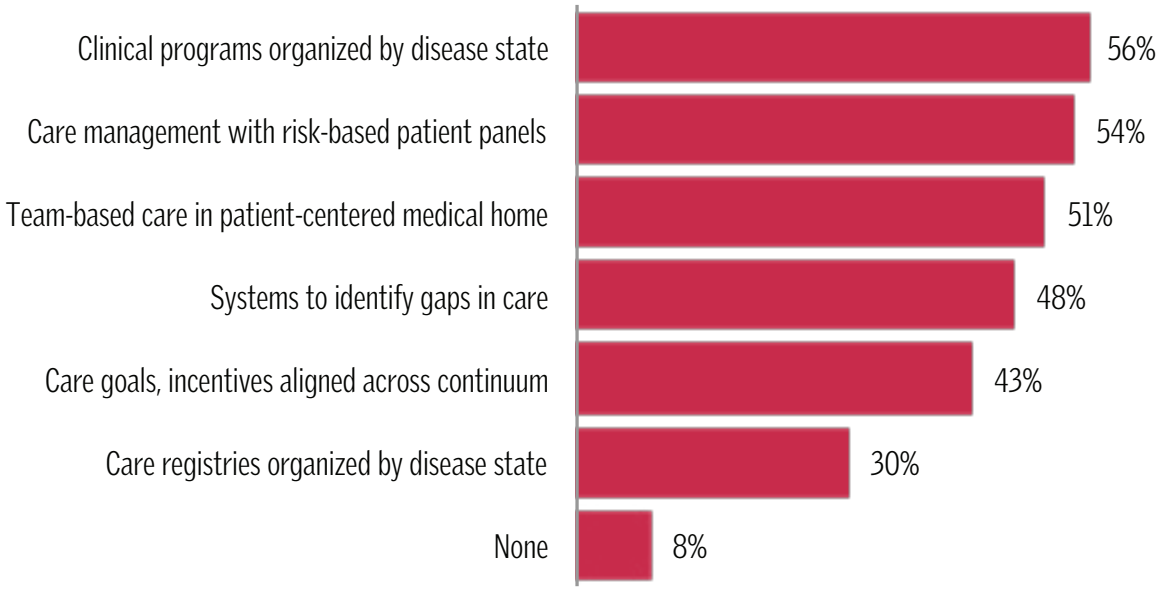
Base = 239, Multi-Response

As the industry transitions to population health management, it will need to develop competencies around managing risk-based care and reimbursement models. Having either an actuary on staff or having access to one through consultancy are critical tools for managing risk. However, the results for actuarial staff and consultants are troubling—while the high response for investigating them is encouraging, the very low levels of active recruiting (3% and 5%, respectively) are not.

SURVEY RESULTS

FIGURE 13: **Delivery of Care Areas Redesigned to Support Population Health**

Q In which areas has your organization redesigned the delivery of care with the intent of supporting population health management?



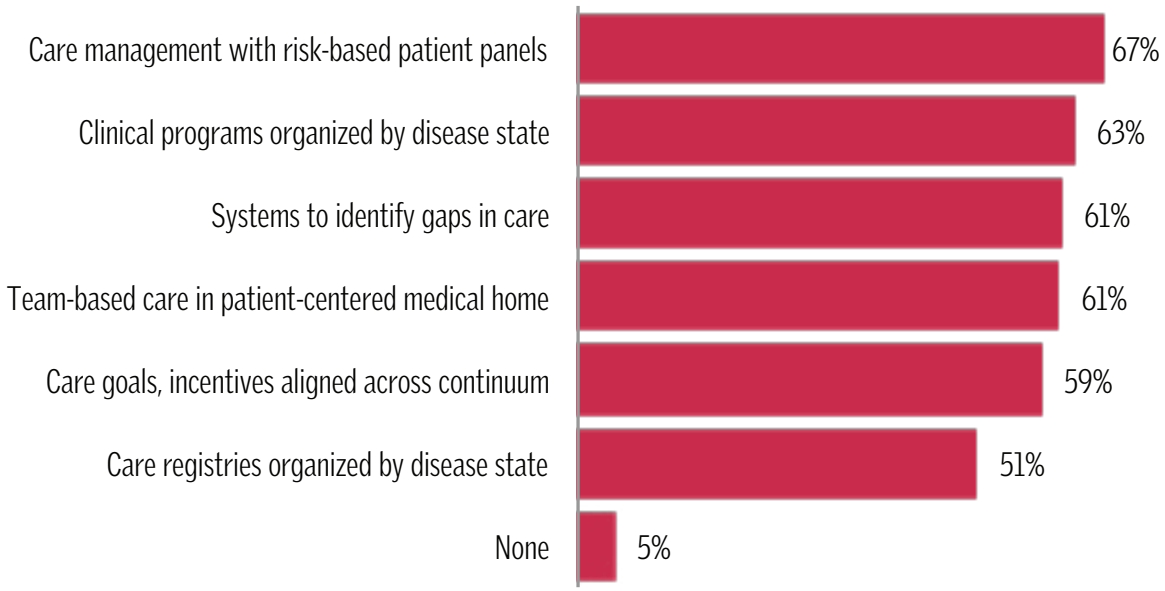
Base = 305, Multi-Response

Judging from the relatively high levels of response, care redesign efforts are well underway, likely driven by both value-based reimbursement and population health efforts. Note that responses for care goals, incentives aligned across the continuum (43%) trail most other redesign areas, probably as a result of its complexity and uncertainty around reimbursement.

SURVEY RESULTS

FIGURE 14: **Delivery of Care Areas to Be Redesigned to Support Population Health in Three Years**

Q Within three years, in which areas does your organization expect to have redesigned the delivery of care with the intent of supporting population health management?



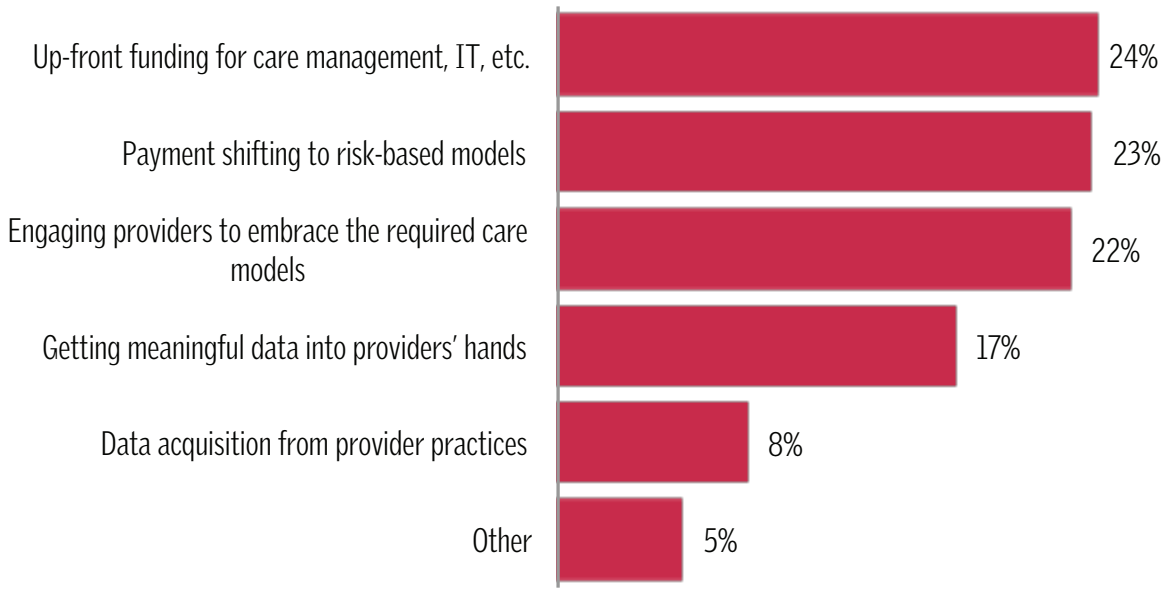
Base = 287, Multi-Response

The high percentages of response and relative parity among care redesign areas indicate that organizations are exploring a wide variety of options when it comes to population health. Because there is uncertainty as to the best approaches, organizations are going with a shotgun approach, something that analytics will help focus going forward.

SURVEY RESULTS

FIGURE 15: **Biggest Barrier to Population Health**

Q What is your organization's biggest barrier to successfully deploying population health management programs?



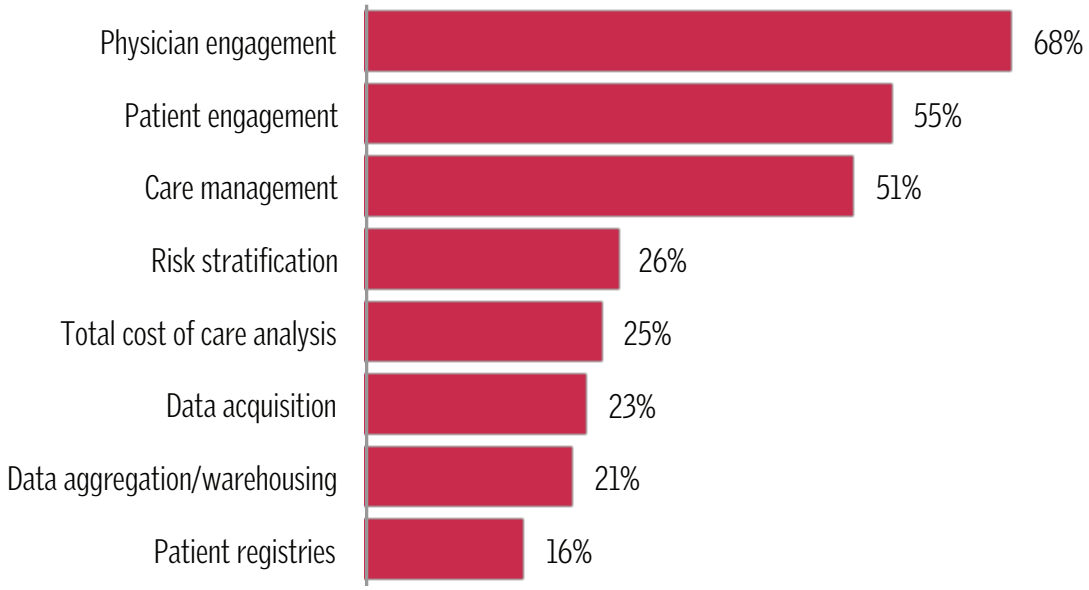
Base = 318

One of the challenges for organizations deploying population health initiatives is reconciling up-front investments in infrastructure with the uncertainty around risk-based reimbursement models. Organizations cannot face the prospect of making a leap of faith that the numbers will work out, which is why many are focusing so heavily on analytics. And the promise of analytics is that it will generate meaningful data, but as we see from our survey, it's one thing to have the data but another to get it into the right hands.

SURVEY RESULTS

FIGURE 16: **Most Important Population Health Initiatives**

Q What are your organization's three most important population health initiatives?



Base = 318, Multi-Response

Healthcare organizations are used to focusing on physician and patient engagement and care management. And those are, of course, important initiatives in today's healthcare environment and in tomorrow's population health environment. But leaders must not neglect the importance of risk stratification and getting a grasp on data and analytics, because those efforts are essential for a successful population health management strategy.

SECTION THIRTEEN

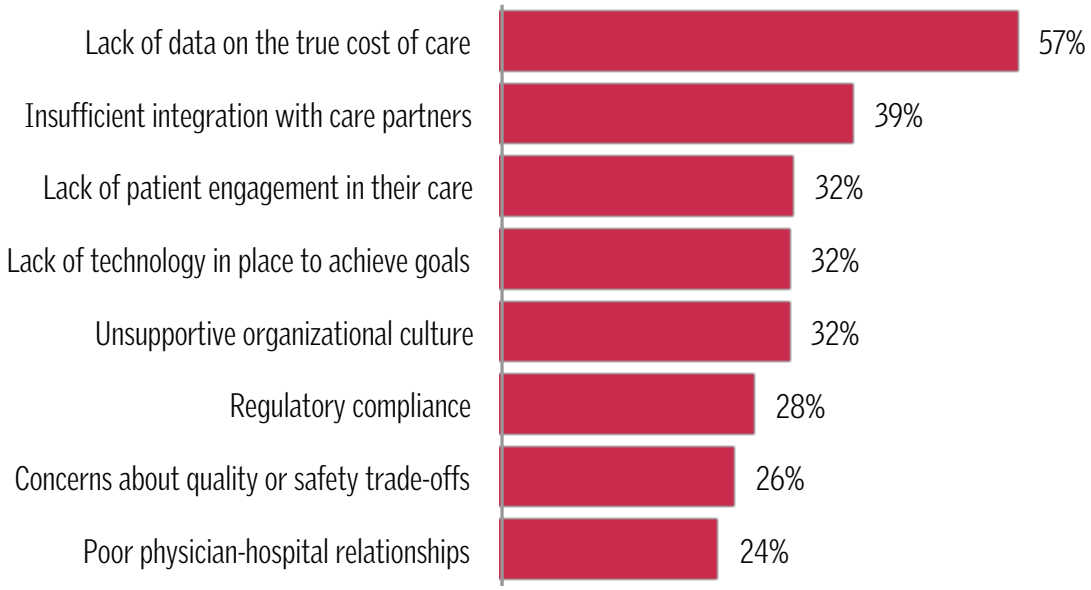
Strategic Cost Control:
True Cost, Process Redesign, and IT Integration

FROM THE HEALTHLEADERS MEDIA INTELLIGENCE REPORT: JUNE 2015

SURVEY RESULTS

FIGURE 1: **Biggest Barriers to Sustainable Cost Reduction**

Q What are your organization's three biggest barriers to achieving sustainable cost reductions?



Base = 225, Multi-Response

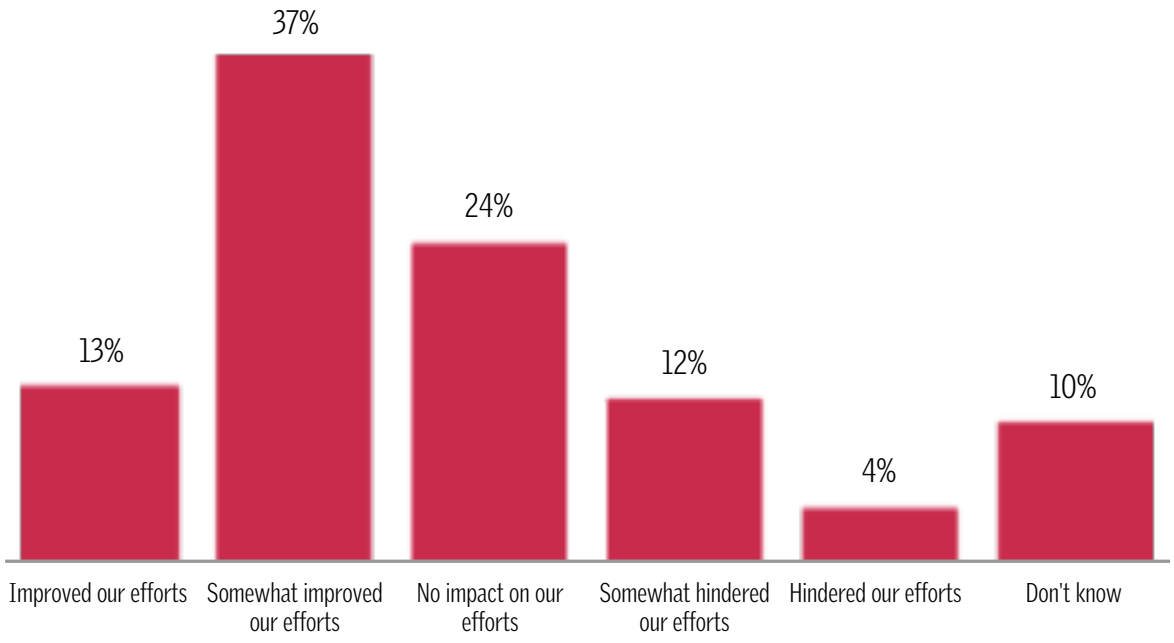
The factor identified as the biggest barrier to sustainable cost reduction is lack of data on the true cost of care (57%).

The next tier of responses are tightly grouped, and includes a variety of disparate areas: insufficient integration with care partners (39%), lack of patient engagement in their care (32%), lack of technology in place to achieve goals (32%), and unsupportive organizational culture (32%).

SURVEY RESULTS

FIGURE 2: **Impact of Transition From Fee-for-Service to Value-Based Care**

Q How has the transition from fee-for-service to value-based care impacted your organization's cost-containment efforts?



Base = 225

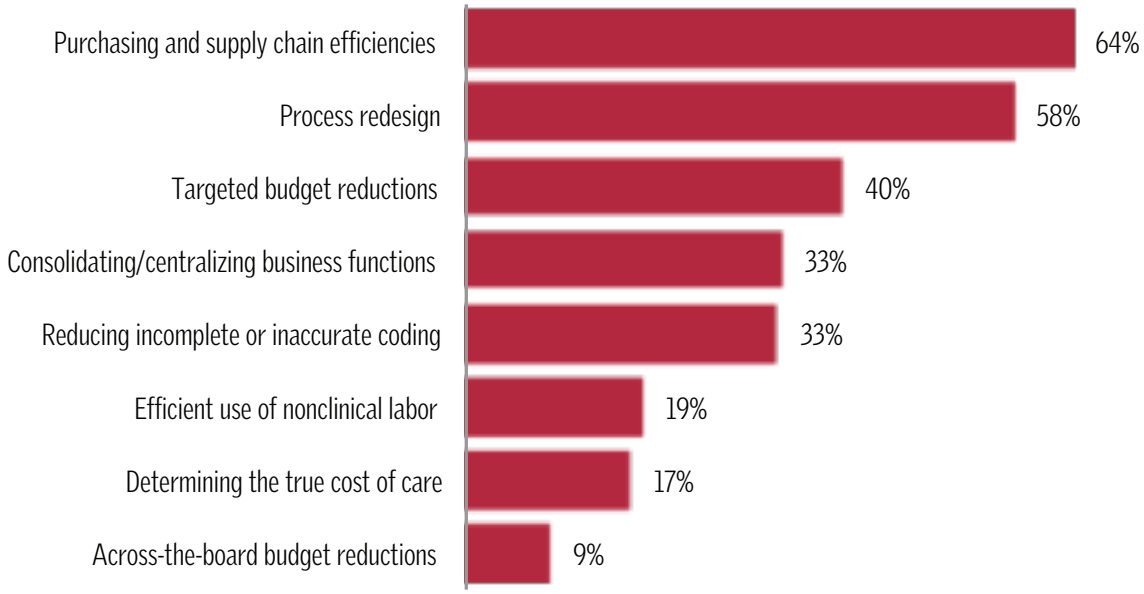
Among those expecting positive financial impact

Despite concerns about the ability to adapt to fundamental changes taking place through the industry, 50% of respondents say that the transition from fee-for-service to value-based care has either improved or somewhat improved their cost-containment efforts, and only 16% say that this has hindered or somewhat hindered their efforts. Twenty-four percent say that the transition has had no impact.

SURVEY RESULTS

FIGURE 3: **Operations/Admin Activities Providing Highest Contributions This Year**

Q Of the following operations or administrative activities, which three provided the highest dollar value in cost-containment contributions during this fiscal year?



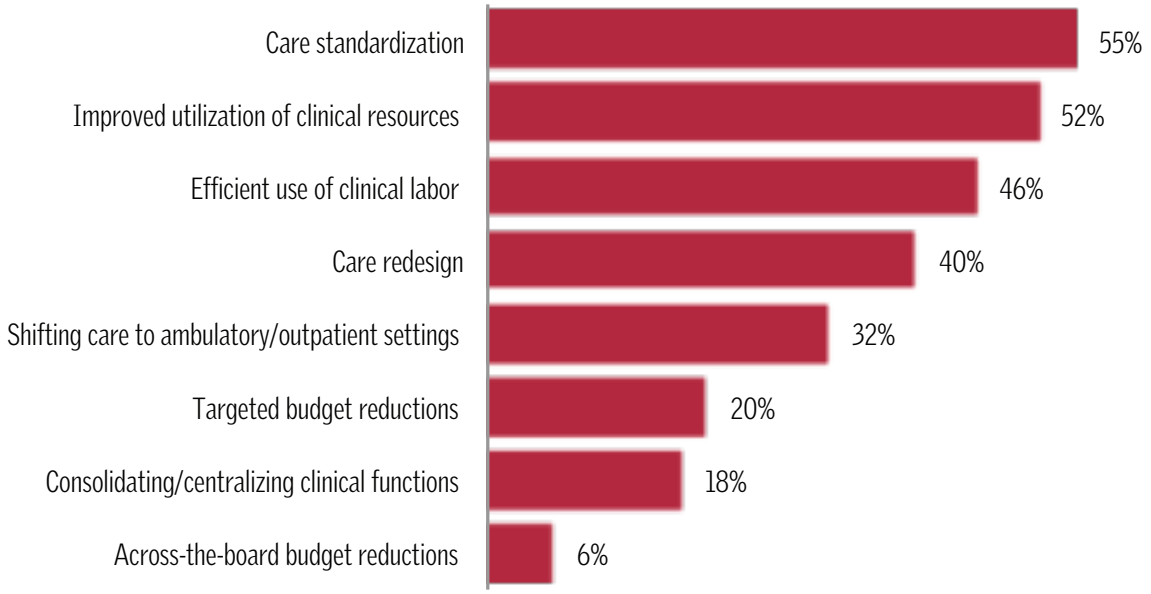
Base = 225, Multi-Response

Purchasing and supply chain efficiencies (64%) and process redesign (58%) are the two most productive operations/administrative cost-containment activities—the results are identical to last year's survey. Responses for purchasing and supply chain efficiencies are highest among respondents who say they can determine the true cost of care for some care provided (72%), followed by all or most care provided (63%), and only 45% among those who have no data on the true cost for any care provided. Similarly, responses for process redesign are highest among respondents who say they can determine the true cost of care for some care provided (62%), followed by all or most care provided (58%), and only 48% among those who have no data on the true cost for any care provided.

SURVEY RESULTS

FIGURE 4: **Clinical Activities Providing Highest Contributions This Year**

Q Of the following clinical activities, which three provided the highest dollar value in cost-containment contributions during this fiscal year?



Base = 225, Multi-Response

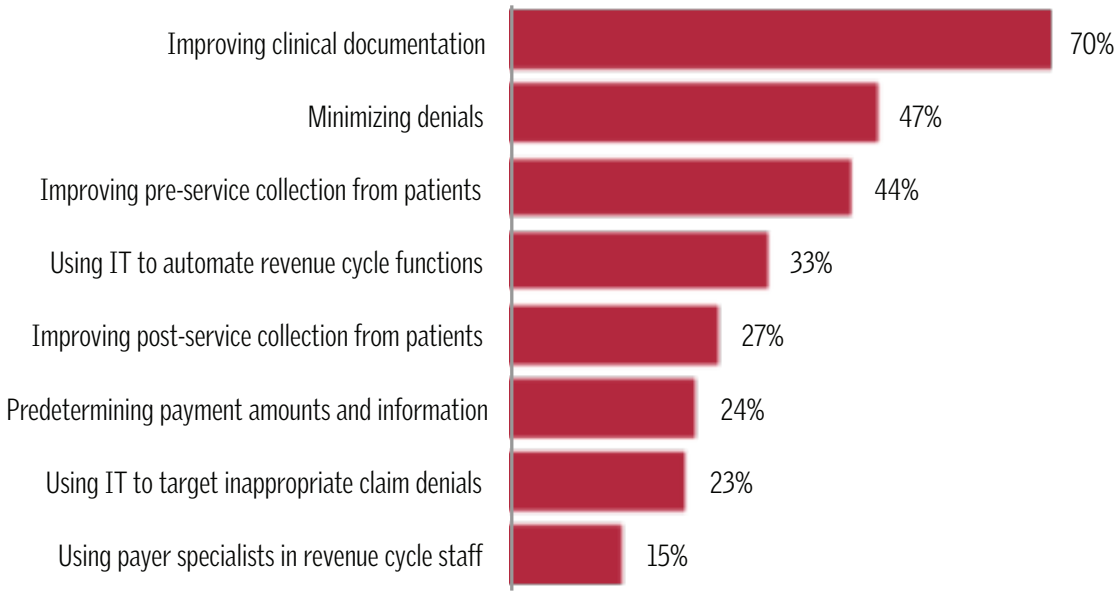
Care standardization (55%), improved utilization of clinical resources (52%), and efficient use of clinical labor (46%) are the top three contributors to clinical cost containment. These results are similar to last year's report (efficient use of clinical labor at 55%, care standardization at 54%, and improved utilization of clinical resources at 54%).

Responses for care standardization are highest among respondents who say they can determine the true cost of care for some care provided (59%), followed by all or most care provided (55%), and only 39% among those who have no data on the true cost for any care provided.

SURVEY RESULTS

FIGURE 5: **Most Financially Impactful Revenue Cycle Activities**

Q Of the following revenue cycle activities, which three do you expect to have the most positive financial impact during this fiscal year?



Base = 220, Multi-Response

Among those expecting positive financial impact

Improving clinical documentation (70%) is the revenue cycle activity expected to have the most positive financial impact by a wide margin. It is followed by minimizing denials (47%) and improving pre-service collection from patients (44%). Such up-front patient-focused efforts have been among the top three efforts for several years, and continue to be an important approach as organizations develop financial engagement strategies for patients.

SURVEY RESULTS

FIGURE 6: **IT Activities Delivering Most Cost Reduction Next Three Years**

Q Of the following IT-enabled activities, which three will deliver the most cost reduction (or financial benefit) for your organization over the next three years?

Base = 225, Multi-Response

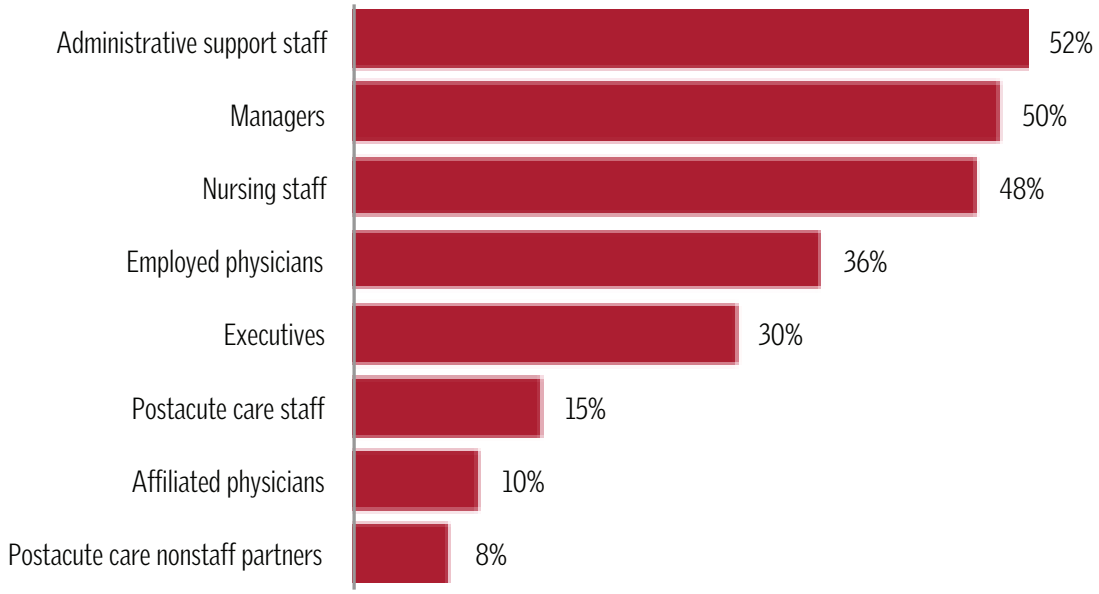
The top three IT-enabled activities driving cost reduction are integrating clinical and financial data (51%), analytics support for expense and cost monitoring (51%), and identifying clinical process variation (45%). These results are comparable to last year's report.

Responses for identifying clinical process variation are higher among respondents who say the transition from fee-for-service to value-based care has either improved or somewhat improved their cost-containment efforts (56%), compared with respondents who say that this has had no impact on their efforts (34%) or hindered or somewhat hindered their efforts (31%).

SURVEY RESULTS

FIGURE 7: **Staffing Areas With Greatest Success in Cost Containment**

Q Please indicate the three staffing areas in which you have had the greatest success in achieving cost-containment goals.



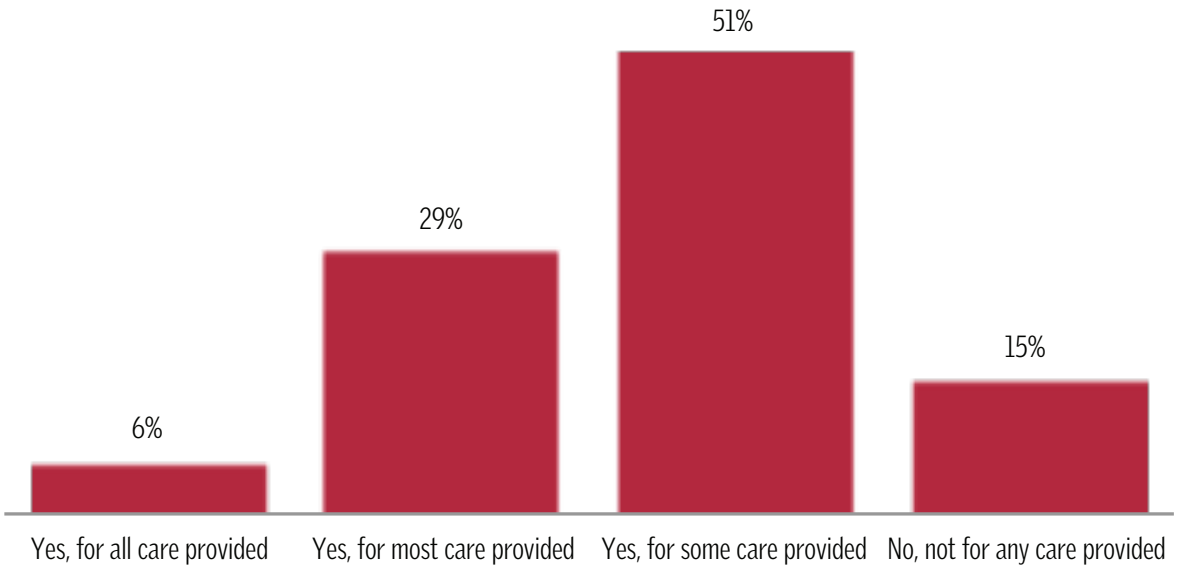
Base = 225, Multi-Response

Administrative support staff (52%), managers (50%), and nursing staff (48%) are the top staffing areas in which respondents say they have had the greatest success in achieving cost-containment goals. Thirty-six percent of respondents put success with employed physicians in the top three, well above the 10% response regarding affiliated physicians.

SURVEY RESULTS

FIGURE 8: **Determining True Cost of Providing Care**

Q Is your organization able to determine the true cost of providing care?



Base = 211

Slightly more than one-third (35%) of respondents say that they can determine the true cost of care for all or most care provided, 51% say they can do this for some care provided, and 15% are unable to determine the true cost for any of the care they provide. These results are comparable to last year's survey, but improvement will be needed if providers expect to control costs while delivering high-quality care.

SURVEY RESULTS

FIGURE 9: **Breakdown of True Cost of Care for Service Lines**

Q Please provide a breakdown of your organization's efforts to determine the true cost of providing care for your organization's set of service lines.

	Average percentage
Service lines with known cost of care	43%
Service lines with evaluation underway	28%
Service lines not yet being evaluated	21%
Service lines with no plans to evaluate	8%

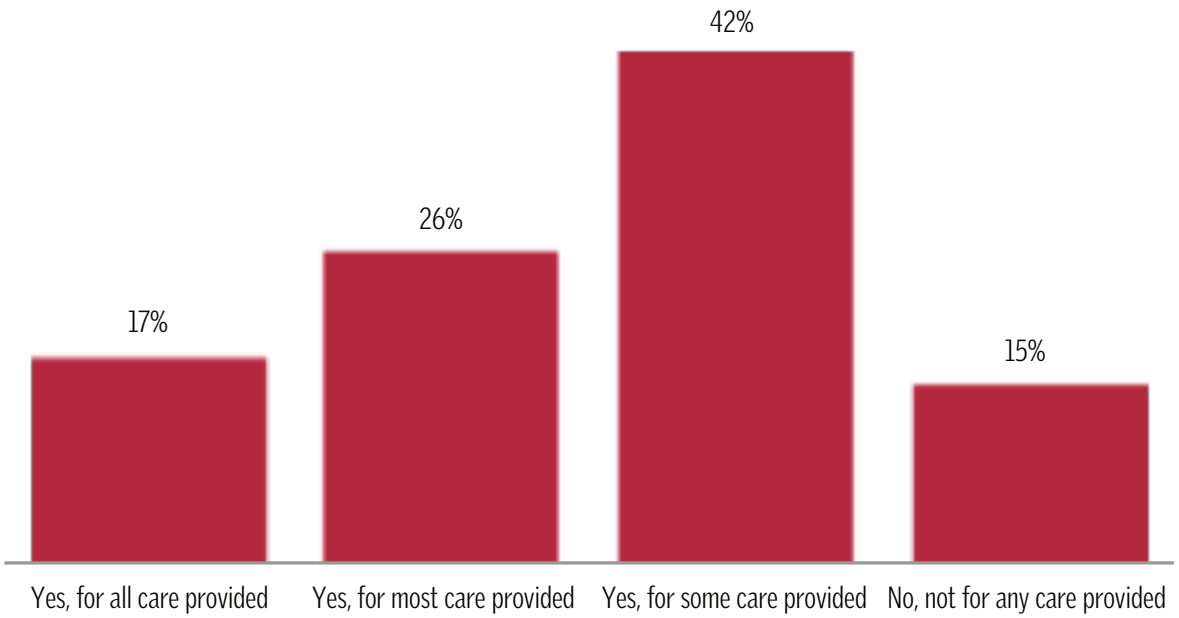
Base = 115

Respondents indicate that they know the true cost of care for 43% of their service lines. For 28% of service lines, a cost evaluation is underway, but for 21%, no evaluation has been started, and no evaluation is planned for 8% of their service lines. These results are comparable to last year's survey and will need to improve as value-based care and at-risk reimbursement models continue to develop in the industry.

SURVEY RESULTS

FIGURE 10: **Price Transparency for Cost of Care**

Q Does your organization provide price transparency to patients for care provided?



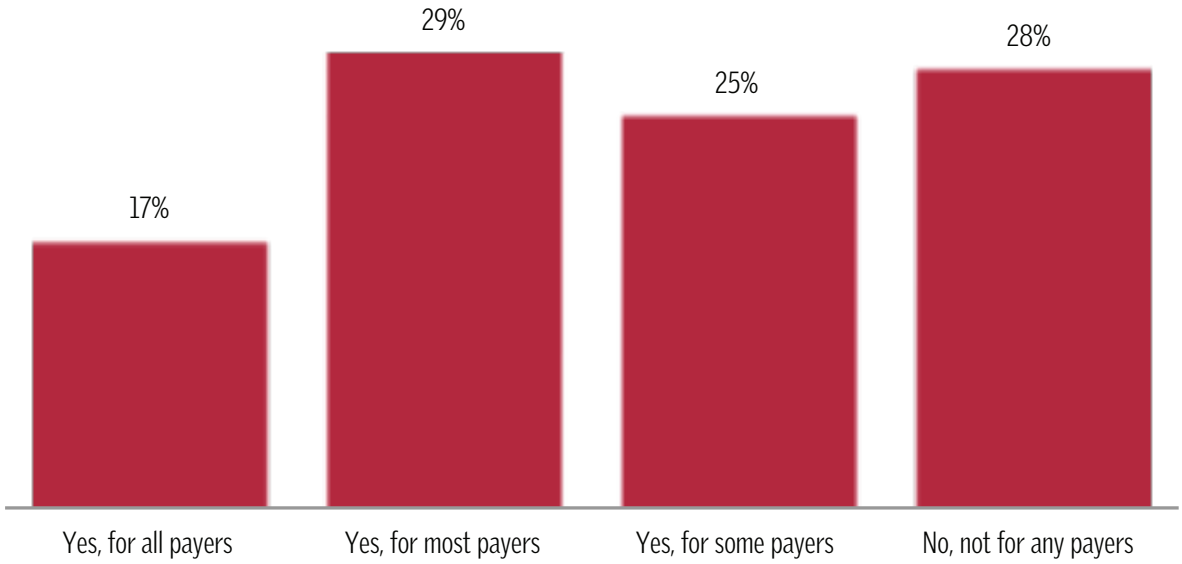
Base = 210

Forty-three percent of respondents say that they provide price transparency to patients for all or most care provided, 42% say they can do this for some care provided, and 15% are unable to do this for any of the care they provide. As patients become more involved as healthcare consumers, such information will become necessary.

SURVEY RESULTS

FIGURE 11: **Price Transparency for Payers' Share**

Q Does your organization provide transparency to patients regarding payers' share of the cost of care?



Base = 198

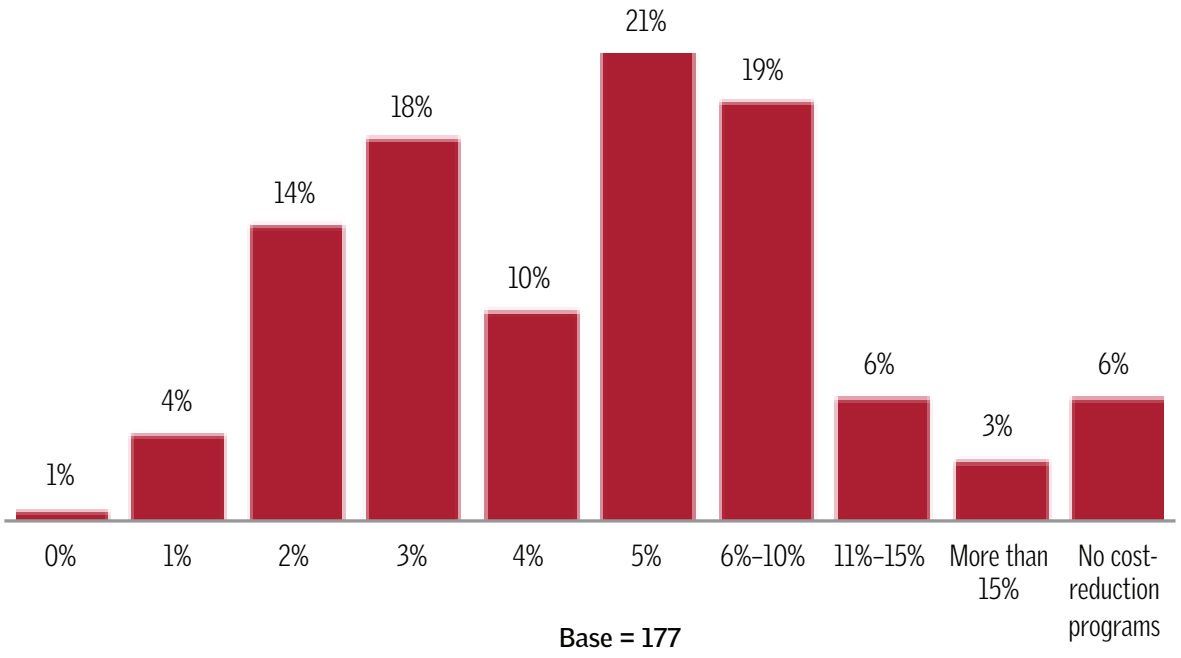
Forty-six percent of respondents say that they provide transparency to patients regarding payers' share for all or most payers, 25% say they can do this for some payers, and 28% are unable to do this for any of the payers.

A greater share of for-profit (56%) than nonprofit (42%) organizations say that they provide transparency to patients regarding most or all payers. To create a useful financial engagement program for patients, providers will need to take the lead and work with payers so that greater transparency is available for healthcare consumers.

SURVEY RESULTS

FIGURE 12: **Year-Over-Year Savings From Cost-Reduction Programs**

Q For the most recent fiscal year, what is your best estimate of your organization's year-over-year savings from cost-reduction programs?



Base = 177

Forty-nine percent of respondents indicate that cost-reduction efforts yielded year-over-year savings of 5% or more. At the upper end of the scale, 9% of respondents had reductions of 11% or more.

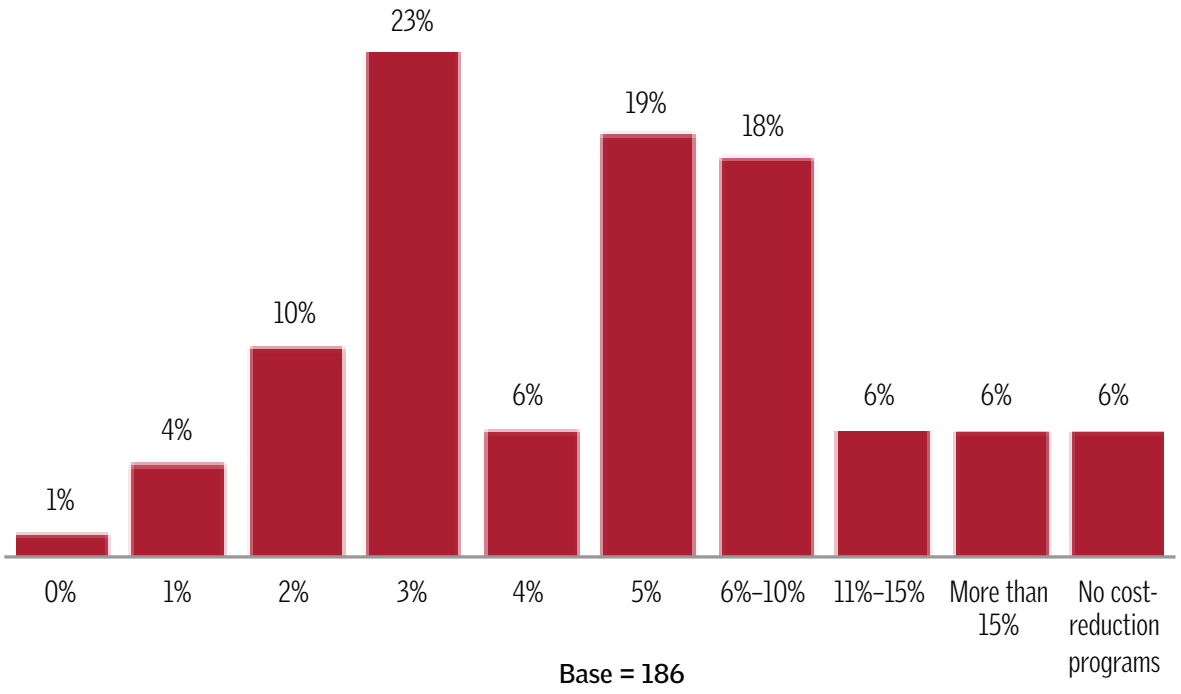
There is a correlation between the level of savings respondents say they receive from cost-reduction programs and their organizations' abilities to determine the true cost of care. Fifty-one percent of those who are able to determine the true cost of care for most or all of their care report year-over-year savings of 5% or more, while just 38% of those who are unable to determine the true cost for any of their care are achieving such deep savings.

There is also a relationship of note: Among those who report that cost-reduction efforts yielded savings of 5% or more, a greater share of respondents (54%) say the transition from fee-for-service to value-based care has either improved or somewhat improved their cost-containment efforts than respondents who say this has had no impact on their efforts (40%), or who say this hindered or somewhat hindered their efforts (40%).

SURVEY RESULTS

FIGURE 13: **Goal for Average Percentage Reduction in Operating Cost Next Three Years**

Q What is your organization's goal for average annual percentage reduction of overall operating costs in each of the next three years?



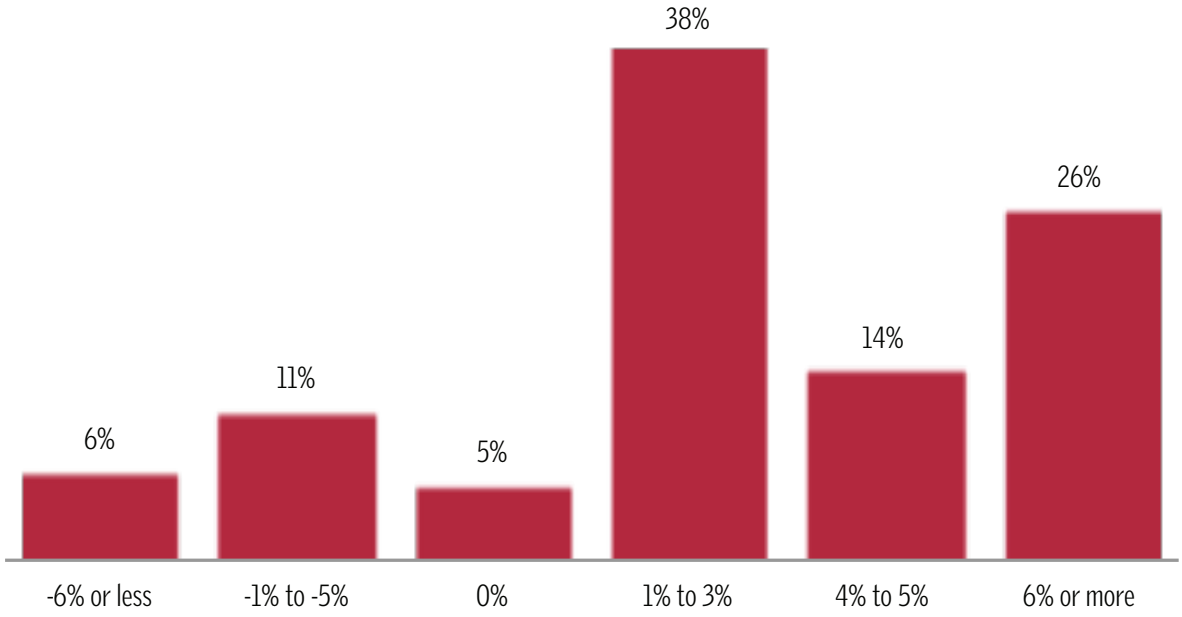
Base = 186

Forty-nine percent of respondents expect average annual cost reductions of 5% or more over the next three years. At the upper end of the scale, 12% of respondents are expecting reductions of 11% or more. Observers have long cited an inefficient healthcare system and a need to bend the cost curve, and the prospect that so many providers expect to reduce operating cost consistently over many years suggests real movement—or at least an earnest attempt—to do so.

SURVEY RESULTS

FIGURE 14: **Operating Margin**

Q For the most recent fiscal year, what is your best estimate of your organization's operating margin, in negative or positive percentages?



Base = 202

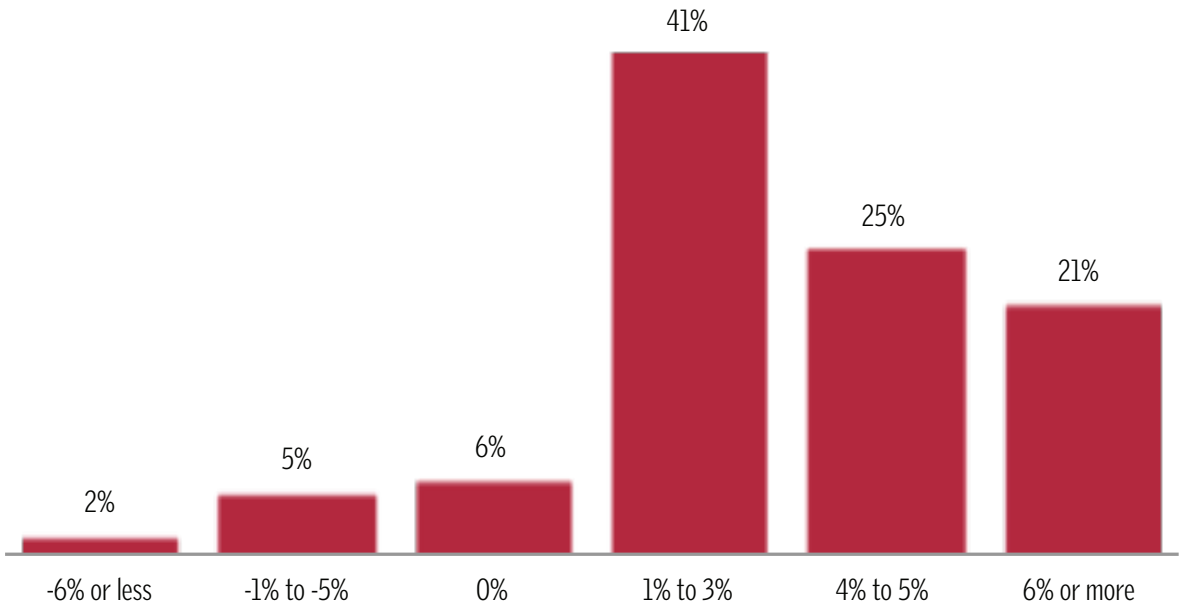
Seventeen percent of respondents reported negative operating margin for the most recent fiscal year, and 78% posted positive margin. These results are comparable to last year's survey in which 21% reported negative operating margin and 77% positive margin.

For-profit (15%) and nonprofit organizations (18%) have similar percentages reporting negative margin. But the for-profits do better in the high end of the positive range, with 43% reporting 6% or more margin, while just 20% of nonprofits are in that range.

SURVEY RESULTS

FIGURE 15: **Average Annual Operating Margin Goal Next Three Years**

Q What is your organization's average annual operating margin goal for each of the next three years, in negative or positive percentages?



Base = 198

Seven percent of respondents say that they expect, on average, to post negative operating margin for each of the next three years, and 87% expect positive margin. These results are comparable to last year's survey in which 9% expected negative operating margin and 85% positive margin.

For-profit (9%) and nonprofit organizations (5%) have similar expectations for negative operating margin for each of the next three years. However, the for-profits expect to do better in the high end of the positive range, with 43% indicating 6% or more margin, while just 13% of nonprofits are projecting that range. Further, a greater share of nonprofit organizations (48%) than for-profits (24%) are forecasting a modest 1%–3% range.

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