HealthLeaders Media | Intelligence

2015 HEALTHLEADERS MEDIA INDUSTRY SURVEY

FREE REPORT

SUCCEEDING IN THE RISK ERA:

How to Accelerate Progress Toward a Value-Based Future

Powered by

HEALTHLEADERS MEDIA Council
Access. Insight. Analysis.

WWW.HEALTHLEADERSMEDIA.COM/INTELLIGENCE

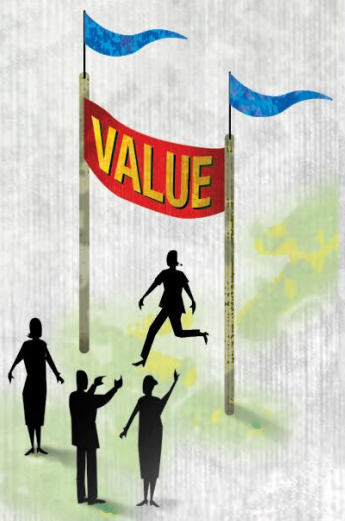
2015 Industry Survey Premium from HealthLeaders Media

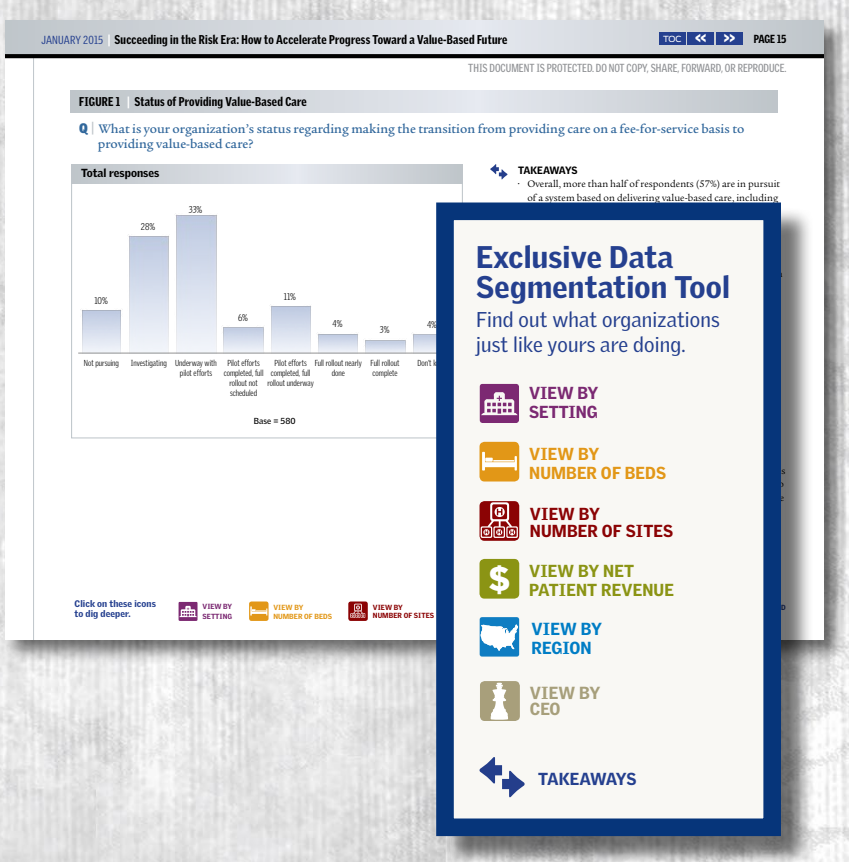
Succeeding in the Risk Era:

How to Accelerate Progress Toward a Value-Based Future

When and how will providers make the move to value-based care? Gauge the progress, anticipate the hurdles, and apply the lessons learned.

- Discover the two most compelling reasons to double down on efforts to improve care transitions
- Understand the four reasons why growth in ambulatory and outpatient care is accelerating—and learn the strategies to keep pace
- See why physician-hospital alignment is more critical than ever to providers' efforts to reach their short-term financial targets
- Learn how data analytics can help you meet clinical and financial performance targets





HealthLeaders Media Intelligence

Access. Insight. Analysis.

For more information or to purchase this report, go to ***HealthLeadersMedia.com/Intelligence*** or call **800-753-0131.**

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the report. In the full report, you'll find a wealth of additional information. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by David Pryor, MD, CEO of Ascension Clinical Holdings in St. Louis and Lead Advisor for this Intelligence Report
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

Table of Contents

Methodology

The ***2015 Industry Survey*** was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In October 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 580 completed surveys are included in the analysis. The bases for the individual questions range from from 538 to 580 depending on whether the respondent had the knowledge to provide an answer to a given question. The margin of error for a sample size of 580 is +/- 4.1% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, and region. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

John Haupert
President and CEO
Grady Health System
Atlanta

David Pryor, MD
CEO
Ascension Clinical Holdings
St. Louis

Gerald Hickson, MD
Senior Vice President for Quality, Patient Safety, and Risk Prevention
Vanderbilt University Medical Center
Nashville

UPCOMING INTELLIGENCE REPORT TOPICS

FEBRUARY
Mergers, Acquisitions, and Partnerships

MARCH
Payer-Provider Strategies

APRIL
Healthcare IT and Analytics

MAY
Emergency Department Strategies

JUNE
Strategic Cost Control

JULY
Care Continuum Coordination

Click here to subscribe.

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.

Intelligence Report Senior Research Analyst
MICHAEL ZEIS
mzeis@healthleadersmedia.com

Intelligence Report Research Editor-Analyst
JONATHAN BEES
jbees@healthleadersmedia.com

Vice President and Publisher
RAFAEL CARDOSO
rcardoso@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Intelligence Unit Director
ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor
DON COSTANZO
dcostanzo@healthleadersmedia.com

Intelligence Report Contributing Editor
PHILIP BETBEZE
pbetbeze@healthleadersmedia.com

Intelligence Report Design and Layout
KEN NEWMAN
knewman@healthleadersmedia.com

Intelligence Report Cover Art
DOUG PONTE
dponte@healthleadersmedia.com

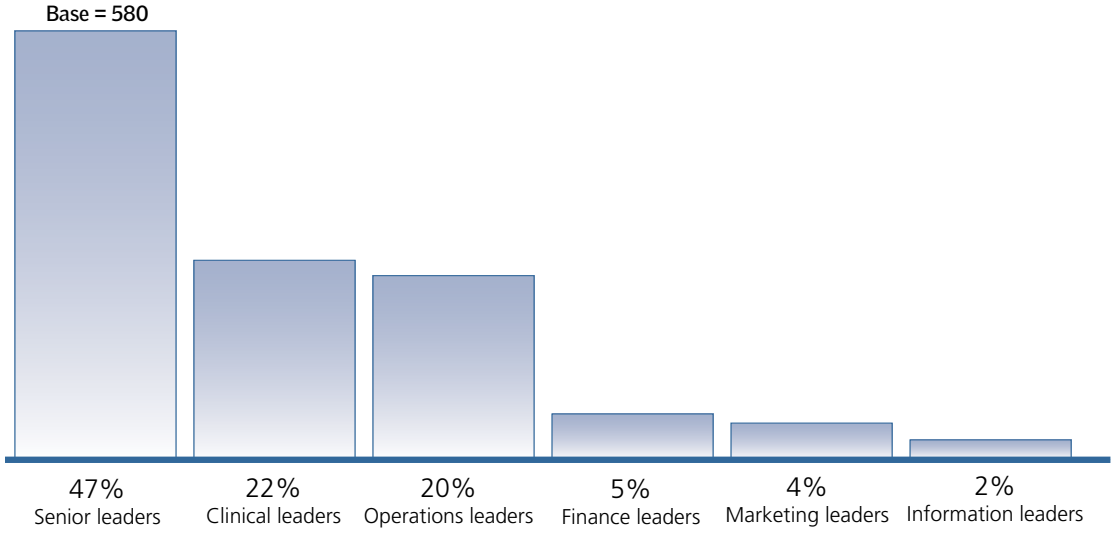
HealthLeaders Media

Respondent Profile

Respondents represent titles from across the various functional areas, including senior leaders, clinical leaders, operations leaders, finance leaders, marketing leaders, and information leaders. They are from a variety of healthcare provider organizations.

Title

Base = 580



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Cardiology, Chief of Neurology, Chief of Oncology, Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Inpatient Services, Dir. of Intensive Care Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD), VP Nursing

Operations leaders | Chief Compliance Officer, Chief Purchasing Officer, Asst. Administrator, Chief Counsel, Dir. of Patient Safety, Dir. of Purchasing, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Financial leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Patient Financial Services, Director of RAC, Director of Reimbursement, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 580

Hospital	39%
Health system	30%
Physician org.	15%
Long-term care/SNF	6%
Ancillary, allied provider	4%
Health plan/insurer	4%
Government, education/academic	2%

Number of beds

Base = 226 (Hospitals)

1–199	53%
200–499	33%
500+	15%

Number of sites

Base = 175 (Health systems)

1–5	17%
6–20	34%
21+	49%

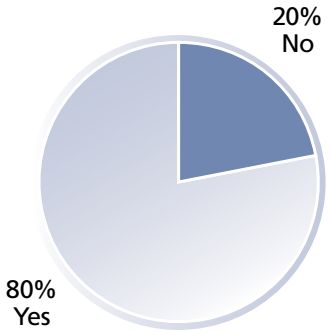
Number of physicians

Base = 85 (Physician orgs)

1–5	32%
6–20	20%
21+	48%

Respondent Profile (continued)

Community hospital



Base = 226 Among hospitals

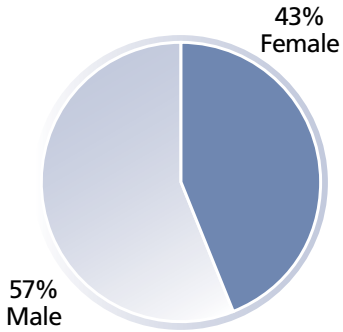
Age

Average age = 53 years

35 or younger	5%
36–45	15%
46–55	38%
56–65	37%
66 or older	6%

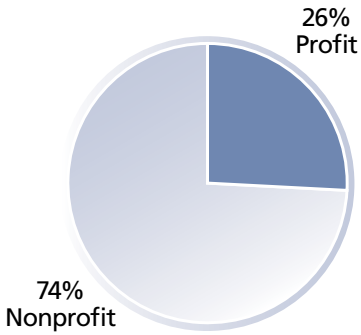
Base = 580

Gender



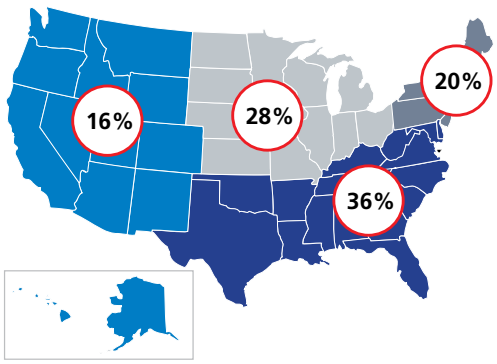
Base = 580

Profit/nonprofit



Base = 580

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, D.C., Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

INDUSTRY SURVEY ANALYSIS

Movement Toward Value

BY MICHAEL ZEIS

With broad recognition that the cost of care under the present fee-for-service reimbursement system is unsustainable, many healthcare organizations are involved in activities that anticipate change; at the same time, however, they may not firmly be committed to change.

In at least two areas, though, concrete steps forward are underway. First, providing care outside the acute care environment, when possible, offers a way to reduce overall costs while maintaining a favorable margin and, for some, generating a boost in net patient revenue. More than three-quarters (77%) of healthcare leaders participating in the annual *HealthLeaders Media Industry Survey* say that ambulatory and outpatient care offer a financial opportunity for their organizations (though a sizable 23% see it as a threat).

Second, organizations recognize that, by ownership or partnership, they need allies in managing the health of patients, so we are seeing a wave of consolidation and/or cooperation. For all but the largest health systems, the need to take on risk is accompanied by a desire to share risk, which then becomes a motivation to seek partners both in the provision of care services and with payers themselves. More than one-third (36%) of healthcare leaders include strategic partnerships with payers among the top three areas that will have positive influence on their ability to reach their financial targets. Nearly as many (35%) include strategic partnerships with providers among the keys to their organizations' financial success.

WHAT HEALTHCARE LEADERS ARE SAYING

"Walk-in clinics, urgent care centers, and extended hours can easily add to the bottom line without heavy-duty investment."
—Executive director of a physician organization

"The out-migration of outpatient services from community hospitals to these standalone facilities will result in the closure of most of the country's small community hospitals and emergency departments."
—Vice president for a small hospital

"We are a fully integrated delivery system that receives the vast majority of revenues on a prepaid basis. Therefore, moving services to the lowest-cost venues is an opportunity so long as quality is not compromised."
—Board member for a large health system

"The trend toward care in outpatient settings is more cost-efficient with less conflict related to drumming up the length of stay and upcoding the DRGs."
—CEO of a physician organization

"We recognize that our current model is unsustainable financially, and maybe more important, it is not meeting consumer preferences. We are preparing to deliver care anywhere, customized to patient preferences, and adding new consumer-paid offerings."
—Board member for a large health system

"It allows us to refocus our staffing models and gain efficiencies that may not exist in the inpatient care setting."
—Chief financial officer of a small hospital

"We don't have enough outpatient locations to make up for the lost income in the acute settings, and we have limited capital to pursue more."
—Vice president of marketing and sales for a medium health system

Analysis (continued)

David Pryor, MD, is CEO of Ascension Clinical Holdings, a physician service organization supporting the practices of more than 40,000 employed and affiliated physicians across Ascension Health, and a subsidiary of the nonprofit St. Louis–based Ascension, which operates out of more than 1,900 sites in 23 states and the District of Columbia. He reminds us of the pros and cons of consolidation: "There are a lot of reasons why consolidations make sense. From a patient-care standpoint, integrating the best care for an individual requires what is done at each point where patients receive care to be coordinated. And that coordination happens where you have integration across multiple sites. But we know from the 1990s that integration can sometimes limit consumer choice. The challenge is to do it in a way that makes consumers feel better about their care, rather than focusing on perceived limits in access. Another aspect is that there is concern about whether consolidation is being driven to improve care and lower the overall cost, or whether consolidation is, in fact, an attempt to create leverage from a pricing standpoint."

Population health: Many pursuing, few are there. Survey results show great levels of attention to delivering value-based care. More than half of respondents (57%) are active in transitioning from fee-for-service to value-based care, which includes one-third (33%) who are underway with a pilot effort. But 28% are merely investigating, and 10% are not pursuing value-based care at all. And while 18% say their pilots are complete and a full rollout is either done or underway, 6% say they have not scheduled their rollout despite completing their pilot. So even though there appears to be great interest and a high degree of involvement, only a few appear to have working value-based programs.

We should not be surprised that respondents' No. 1 industry hurdle to value-based care (cited by 32%) is the uncertainty about the revenue stream, which keeps them from pursuing the transition with more vigor. Second on the list (cited by 23%) is another fiscal concern: inadequate payer incentives.

> "It requires a level of investment in services to support the delivery of care in the value-based world. The question is, will there be enough of a proportion of care provided in the value-based world to support those investments?"
>
> —David Pryor, MD

The worthiness of the objective does not mask the comprehensive nature of the changes afoot. Says Pryor, "It requires a level of investment in services to support the delivery of care in the value-based world. The question is, will there be enough of a proportion of care provided in the value-based world to support those investments? Trying to figure out how to support the necessary infrastructure and services at the same time that you have different business models leaves people with uncertainty around that revenue stream."

Gerald Hickson, MD, is senior vice president for quality, patient safety, and risk prevention for Vanderbilt University Medical Center, a 1,105-bed nonprofit healthcare system in Nashville with four hospitals. He is careful about making assumptions regarding the extensibility of pilot efforts.

Analysis (continued)

"The pilots are relatively small," he says. "We are involved with one bundle initiative. It takes the organization a while to decide whether or not results have been good, bad, or indifferent. In addition, the work involved just a few services. Although the impact of that single bundle is relatively trivial, the work sets the stage for greater collaboration. That collaboration includes service lines as well as the CFO, who needs to be sure our revenue streams are healthy."

In the pursuit of value-based care, coordinating the timing of the change in service delivery with the timing of the financial transition is important, but at this stage, timing is a source of great uncertainty as well.

John Haupert is president and CEO of nonprofit Grady Health System, which serves patients in the Atlanta area with its 953-bed Grady Memorial Hospital, a safety-net facility, and operates in six Georgia counties. He has seen results that confirm the concept of new business models, but acknowledges that the extent of the pending change means that a degree of precision is required in deployment to keep outlays and income in line.

"I see high correlation between highly integrated care coordination and reduction in the cost of care and reduction in readmissions. It does pay off. But can I get ahead of the payment reduction? Can I make care more efficient and more effective, and can we gain the level of partnership with the physicians and move them toward value-based care and/or evidence-based care fast enough to stay ahead of the reimbursement reduction curve?" Haupert asks. A question industry leaders must resolve is whether their efforts along the cost, quality, and collaboration vectors will be choked off by dwindling reimbursements.

Hickson notes that the patient and the patient's family are part of value-based care. He says, "Another important element of this equation that needs to be considered is the patient and family. We broadly talk about population health, and that sounds fine. Part of the challenge, however, is figuring out how to make patients and families our true partners, and that involves thinking differently than we do right now."

> "I see high correlation between highly integrated care coordination and reduction in the cost of care and reduction in readmissions. It does pay off. But can I get ahead of the payment reduction?"
>
> —John Haupert

Financial health in an environment of change. Hickson, an advisor to this Intelligence Report, sees that 44% of respondents identify physician-hospital alignment as one of the top three areas influencing financial success, and he looks to the importance of enabling all stakeholders. "We want a model in which all of the parties are respected, bringing alignment in pursuit of our goals to deliver safe, effective care. At Vanderbilt, we want physicians, nurses, and administrators to see themselves as full partners and leaders in our efforts to pursue quality and high reliability."

Analysis (continued)

At Grady, Haupert is seeing positive results from the closer working relationships that an aligned physician staff can foster. "Look at what the evidence tells you. Put in evidence-based order sets, measure how compliant your medical staff is, and then coach physicians who are outliers. We're seeing huge improvements both clinically—outcome wise—and financially from doing that." More than one-fifth (22%) include care standardization among the top three influencers of their ability to reach financial targets, and 18% cite care redesign.

It is clear that organizations need to be able to offer patients a wide variety of care options, and at the same time provide the organization with a stable financial foundation. Therefore, providers must work with a variety of business models, and those models need to accommodate risk. Pryor, who serves as lead advisor for this Intelligence Report, talks about how that works in a system of Ascension's size.

"We were two of the original Pioneer ACOs, and we have one still continuing right now. We have five or six integrated networks. We have multiple examples of bundles. We own all or part of six different health plans." Pryor estimates that the organization "shares at least some component of risk" with some two million lives. "What we're trying to do is understand how we can be most effective at improving the quality of care that people get, taking advantage of these different kinds of vehicles to try to integrate and improve the overall service to them."

Through provider-to-provider consolidation and partnerships, organizations are positioning themselves to take on risk. In addition to new and stronger relationships with providers, payer negotiations are likely to go well beyond discussions about reimbursement rates. Pryor notes that 48% of healthcare leaders describe their relationships and collaboration with payers as strong or very strong and says, "It's clear that people are trying a number of different kinds of things. Relationships with payers are very much impacted by how you look at delivering care in the value-based world, and those relationships are evolving."

> "We broadly talk about population health, and that sounds fine. Part of the challenge, however, is figuring out how to make patients and families our true partners, and that involves thinking differently than we do right now."
>
> —Gerald Hickson, MD

Still, most respondents (52%) are unwilling to describe their payer relations as strong; 37% describe it as neutral, and 16% call it weak or very weak. Using readmissions as an example, Hickson points to a lack of collaboration and a shortage of leadership right now in payer relationships. He says, "We want to reduce hospital readmissions, right? And we are at risk for being penalized by federal programs if we fail to do so.

Analysis (continued)

And many payers also are subject to potential financial penalties when their collective networks fail. Yet I haven't seen the right leadership collaboration, where all of the parties are sitting at the table trying to solve this collectively."

Led by hospitals (74%) and health systems (72%), nearly two-thirds of respondents overall (63%) include expansion of outpatient services among the methods their organization will use to fuel financial growth over the next five years. But the challenge of maintaining acute care strength in light of the shift to outpatient care was mentioned by several of the 23% who say that attention to outpatient settings represents a threat. Overall, 43% of survey participants say they expect to begin or increase investments in redesigning or realigning their service lines over the next three years, and that is one of the keys to maintaining financial strength as outpatient services threaten acute care admissions.

Haupert explains how that has worked for Grady. "A lot of people think that a safety-net hospital is just there to take care of the poor and the underserved, and may not be able to appeal to a broader audience with clinically excellent services such as stroke and neurosciences. But we're doing that with trauma, burn, stroke, neurosciences, cardiology, oncology, and orthopedics.

"We determined that Atlanta was underserved in stroke and neurosciences, so Grady went about building, marketing, and performing outreach," he says. "Now we have one of the largest stroke treatment centers and neuroscience diagnostic centers in the country. The program is only five years old, but it has some of the best outcomes and is one of the largest programs now in the Southeast."

> "In order to do care redesign, care standardization, and so on, you have to have alignment across the system and you have to have business models with payers and providers that make it work."
>
> —David Pryor, MD

Attention to service lines included extending specialty care into outpatient environments where appropriate. Haupert continues, "We are increasing emphasis on ambulatory care and primary care in our neighborhood health centers, and expanding even subspecialties such as cardiology in those neighborhood health centers. And we are working aggressively to create a care management model for our system that covers both the ambulatory and inpatient settings."

Like the 45% of respondents who expect to begin or increase investment in nurse navigators and care coordinators over the next three years, Haupert says that care coordination is important, something Grady recognized years ago when its status as a safety-net hospital forced it to

Analysis (continued)

have smart transitions. "What really had to change is the way we manage transitions of care between ambulatory and inpatient care, and the way we maintain contact with chronic patients."

Hickson observes that acute care remains a fundamental element in the care continuum. "There is no question that I agree with the findings, but just because 77% say that there are outpatient opportunities doesn't mean a thing if a system does not then have coordinated service lines taking care of the most complex patients."

Care delivery: Synching outpatient and inpatient. As the industry approaches the delivery of value through extended collaboration, attention must be paid to maintaining and, indeed, improving clinical quality in what is becoming a more complicated environment. Ensuring clinical quality along the care continuum is identified as the single greatest quality-related challenge to their organization by 18% (second only to the 21% who cite the challenge of using analytics for clinical decision support).

Hickson suggests that, while early cross-continuum clinical quality efforts may involve a limited set of care partners, extension is inevitable.

"You can't re-engineer care, you can't maintain professional accountability, you can't hold individuals accountable for delivering evidence-based care or considering the long-term health and well-being of those we serve unless you've got a network that has the ability to set performance expectations, measure, and is willing to provide feedback based upon the nature of that performance. The reality is that you have to tighten the network," he says. "What we've accomplished to this point, we've done it because we're a relatively tight family. What we want is to take what we have learned and create the same type of relationships with a much broader network of professionals."

> "Providers are going to have to figure out how to engage patients and families so that they understand their responsibilities in pursuit of their own health."
>
> —Gerald Hickson, MD

Care redesign is among the areas where 53% of healthcare leaders expect to begin or increase investments over the next three years, placing it third on a list of 10 choices. Pryor cautions that such efforts require a receptive care team and payment models that support the effort. "In order to do care redesign, care standardization, and so on, you have to have alignment across the system and you have to have business models with payers and providers that make it work," he says.

Standardized care protocols, which affect both the cost and the quality component of the value calculation, are identified as the single greatest quality-related challenge by 16%, placing it third on a list of eight options. Hickson reminds us about both the importance and the difficulty of follow-through. "The question is, can you get adherence by all team members?" Describing a current quality effort at Vanderbilt, Hickson notes that more than 90% of surgeons are on target. "But the effort and attention that is needed to effectively address the remaining few is often unrecognized and not understood and not addressed. The question is

Analysis (continued)

whether you, as a system, have a plan to effectively ensure adherence by all team members."

Data analytics is mentioned most frequently (by 62% overall) as the area that will receive new or increased investment funds over the next three years. And it appears that such investments are well targeted: Only 40% say their data analytics staff is strong or very strong, the lowest reading for any of the staff segments assessed by respondents. On top of that, 25% say their data analytics staff is weak or very weak, which is the highest "weakness" count among the staff ratings.

Despite the need and despite the pending investment, 33% say that their investments in their EHR have been largely wasted, a stunning tally. Pryor helps us understand how healthcare leaders can invest in such vital areas and nonetheless feel they are coming up short. "The electronic health record and other such pieces are necessary infrastructure investments, but generating the return on those investments requires that you put it all together. Not only do you have to have the source systems in place, but also the ability to connect information across sites of care, integrate it, do the analytics. And the return on investment also depends upon having the business model in place to support it. The industry is not yet there."

Partnerships and collaboration. Although much of the industry's attention today is on care collaboration and at-risk business models, as mentioned above, success in the future may depend on how the industry accommodates the third partner in the healthcare formula—the patient. "In the next five years," says Hickson, "the relationship and our expectations of patients and families will morph. We will move toward the concept of patient/health system compacts, where the patient will choose a health system or, based upon employment, a system may be chosen for the patient. The patient will wind up on a medical team, with the expectation that the team is going to provide for comprehensive needs, the team will be part of an integrated system, and the team will be thinking about the patient's health and well-being over the long haul."

> "Look at what the evidence tells you. Put in evidence-based order sets, measure how compliant your medical staff is, and then coach physicians who are outliers. We're seeing huge improvements both clinically—outcome wise—and financially from doing that."
>
> —John Haupert

With attention to patient experience scores and comprehensive care collaboration, providers can make strides toward better patient engagement. But Hickson says more is needed. "Providers are going to have to figure out how to engage patients and families so that they understand their responsibilities in pursuit of their own health. How do we partner with those we serve to help provide a rationale that's compelling? We need to understand the answer if we are to develop the kind of healthcare

Analysis (continued)

system that really will focus on the needs of the populations we serve. Organizations such as Vanderbilt are well positioned. We bring not only our ability to deliver care, but also our ability to ask and answer those important questions."

While providers today have programs in place to foster patient engagement, Hickson's view of the future includes an element of mutual responsibility—he calls it a compact—that for the most part is not present now. The industry's current focus includes consolidation, partnerships, and new working relationships. Some of those who seek but have not found partners are grooming their organizations to emphasize assets in order for partnership discussions to be more fruitful.

Pryor describes how performance enhances positioning. "Every organization has to be able to define the role that they think they can play in that [collaborative] environment. Organizations that don't have enough of a presence in a market are going to have to partner with others in order to be able to deliver an integrated network of care. There will always be a need for hospitals in the future, and those hospitals that are able to deliver the highest quality at the lowest cost will be well-positioned to be an effective part of a network."

At least in the acute care environment, investment parameters are changing in response to healthcare reform in general and a changing patient mix specifically. Haupert sees the amount of investment required and types of new business models as evolving, and he recognizes the requirement to coordinate the operational aspects of reform with the funding stream. He asks, "Will we get to a point where the funding no longer allows us to be able to provide safe, quality care? Will reimbursement levels from Medicare, Medicaid, and private insurers get to the point where they press our system to compromise the quality of care being provided? That worries me a lot."

Pryor sees the same requirement to rationalize acute care investments. "In order to provide high quality as a hospital, you have to continue to invest in your infrastructure. And from a capital investment standpoint, hospitals are expensive places to maintain. I think a lot of hospitals will worry about how to continue to invest in their infrastructure." While such concerns are to be expected considering the nature of the change that is underway, Pryor remains optimistic because both payers and providers share the same broad objectives.

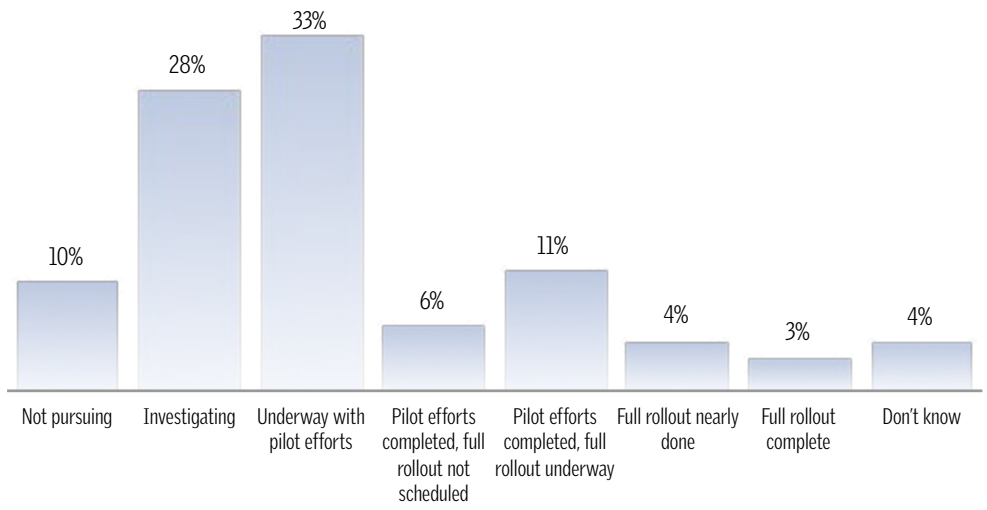
"I think we have great component pieces of the healthcare system," Pryor says. "The people who I know who run hospitals and the people who I know who run health plans are very driven to improve patients' overall outcomes, and doing so in a financially responsible way. We worry about how to get technologies to match up, how to share information in the appropriate way, how to preserve our ability to invest in resources and facilities. But I think those questions are all part of learning about how we go forward in the new model."

Michael Zeis is senior research analyst for HealthLeaders Media. He may be contacted at *mzeis@healthleadersmedia.com.*

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?

Total responses



TAKEAWAYS

- Overall, more than half of respondents (57%) are in pursuit of a system based on delivering value-based care, including one-third (33%) who are underway with a pilot effort and one-quarter (24%) who have completed pilot programs or are involved or finished with program rollout.
- With 80% of health systems underway with at least a pilot program, health systems lead hospitals (47%) and physician organizations (56%) in addressing value-based care.
- Pursuit of value-based care varies depending on organization size, especially among hospitals, where 45% of large hospitals are currently underway with a pilot effort compared to 36% of medium hospitals and only 18% of small hospitals. Indeed, 16% of small hospitals flat out say they are not pursuing value-based care.

WHAT DOES IT MEAN?

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.

FIGURE 1 *(continued)* | 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?

BUYING POWER

Who controls the money? Click on the icons to learn how they think

Click on these icons to dig deeper

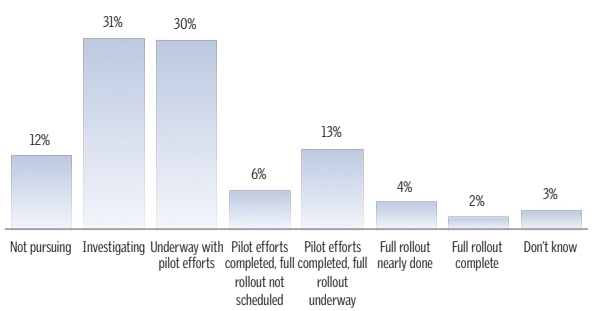
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

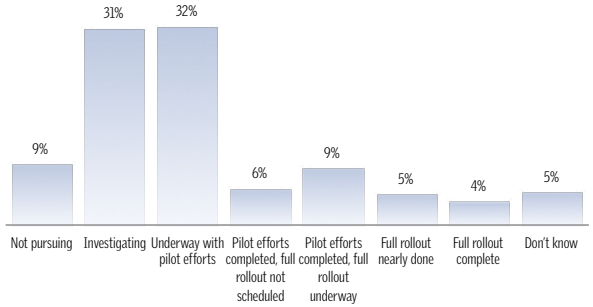
PRODUCTS/SERVICES

Information technology



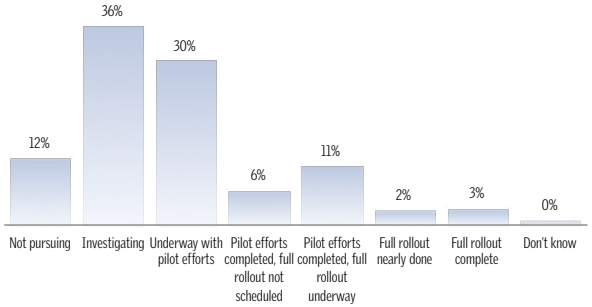
Base = 344

Clinical products



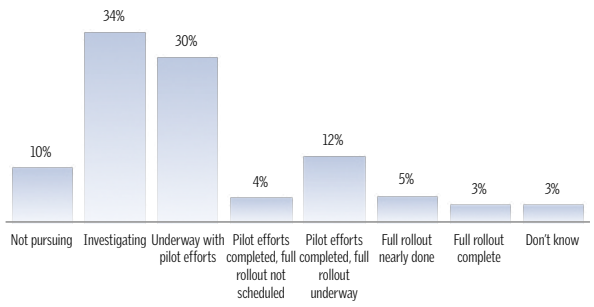
Base = 339

Financial services



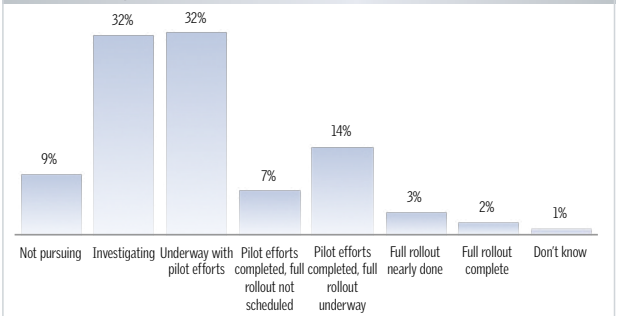
Base = 218

Executive search



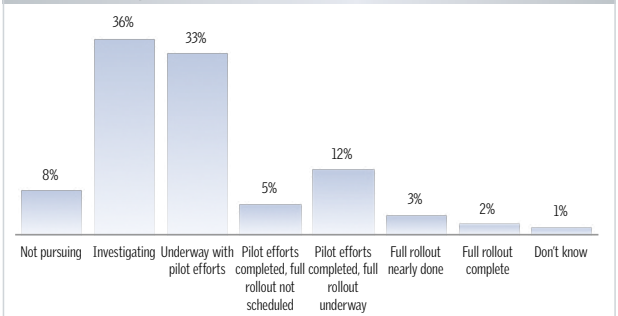
Base = 239

Consulting services



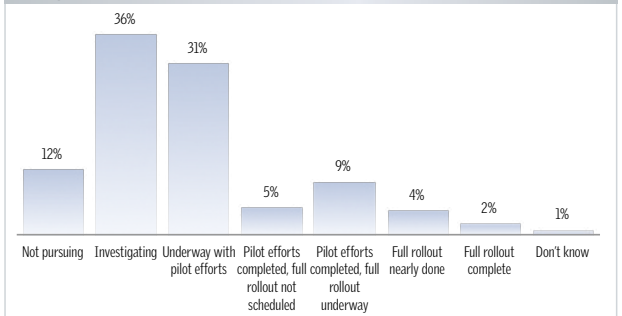
Base = 296

Outsourcing services



Base = 240

Legal services

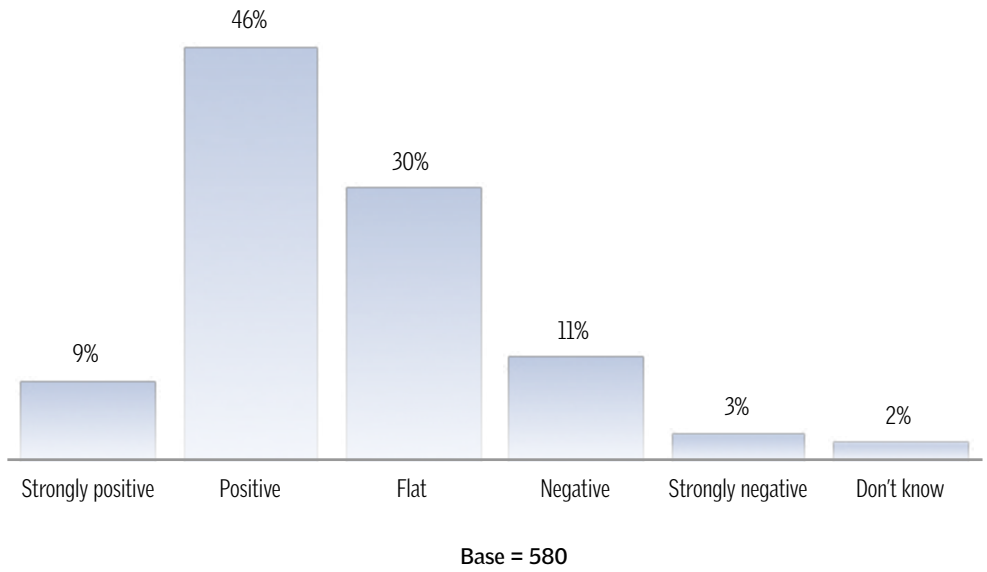


Base = 170

FIGURE 8 | 2015 Financial Forecast

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

Total responses



TAKEAWAYS

- Compared to last year, there is a slight increase in the percentage who expect overall positive near-term financial results. More than half (55%) of respondents to this year's survey say they expect positive or strongly positive financial performance, up from 47% last year.
- A higher percentage of organizations (63%) with $1 billion or more in net patient revenue than those with low (50%) or medium (59%) NPR expect positive financial results.
- A majority of respondents from the West (52%), South (56%), and Midwest (60%) expect positive or strongly positive financial results in 2015, compared to 46% from the Northeast.

WHAT DOES IT MEAN?

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.

Access.
Insight.
Analysis.

Council

The nation's most exclusive
healthcare intelligence community

Be a voice
Gain insight from your peers
Shape the direction of the industry

Join today at *www.healthleadersmediacouncil.com*