ABOUT FUTURESCAN 2015

Futurescan 2015 is the latest edition in a series of environmental assessments for healthcare leaders that the Society for Healthcare Strategy & Market Development has published annually since 1999. Written by an expert panel, *Futurescan 2015* highlights key trends affecting the nation's healthcare organizations. The expert insight in these pages is supported by data from a survey of 496 healthcare leaders across the country.

The *Futurescan* national survey, conducted in June and July 2014, asked 1,093 CEO members of the American College of Healthcare Executives (ACHE) and 782 senior, provider-based members of the Society for Healthcare Strategy & Market Development (SHSMD) their opinions as to the likelihood of various trends occurring in their hospital's area by 2020. A total of 496 responses were received, for a combined response rate of 26.5 percent.

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FUTURESCAN™ 2015

Healthcare Trends and Implications 2015–2020

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INTRODUCTION HEALTHCARE'S INTEL MOMENT

by Don Seymour

In 2006, Intel had 80 percent of the central processing unit (CPU) market; today it is at less than 25 percent and plummeting. What happened? Primarily this: graphics and, in the words of Ian Morrison, "ithings." Advanced Micro Devices now matches Intel in personal computer CPUs even though it doesn't (yet) have a deal with the world's largest manufacturer, Dell. In smartphones and tablets, Intel's competitors have surpassed it. And more change is on the way. Estimated sales of CPUs in 2015 are as follows: personal computers, 0.3 billion; smartphones, 1.4 billion; and tablets, 1.6 billion. Similarly, Tesla (which recently opened access to many of its cherished patents) may surpass Toyota in the environmentally friendly line of cars. Sure, the Tesla, at $65,000 to $125,000, is expensive today, but the price is expected to drop by 50 percent in the next three years. And the Prius isn't cheap either. Which would you rather drive?

Of course, Intel and Toyota are not alone in this ignominy; history is littered with the detritus of once great and dominant companies that hunkered down and ignored the winds of change (e.g., Wurlitzer, Kodak, Digital Computer). As Joel Barker, the futurist who introduced us to the phrase "paradigm shift," noted 20 years ago, "change comes from the outside."

The US healthcare delivery system is not immune to change. Consider the following:

- Walmart, Walgreens, CVS, and other retailers are expanding their primary care clinics and planning to move into chronic disease management.
- These same companies and others, such as Darden, are increasingly channeling patients to a select few providers.
- Nursing associations in virtually every state are engaging in "food fights" with their physician counterparts for nurses' right to practice without physician supervision. "Right" is on the side of nurses; allowing them to practice at the top of their licenses will simultaneously improve access, quality, and patient satisfaction.
- Consumerism is on the rise. The only sector of employer-based insurance that is growing is high-deductible health plans with a savings option. Twenty-one percent of employees already have these plans, representing a phenomenal market-share growth of 17 percent since 2006. (What Fortune 100 company wouldn't kill for that?) And 50 percent of employers offer such plans that are triple tax advantaged—that is, you never pay taxes on this potential supplement to your 401(k).
- The two greatest problems with organ transplants—availability and rejection—will be addressed by 2030. Bioengineering, combined with 3-D scanners (which cost $2,000 today and

About the Author

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- are about the size of a microwave oven) and genomics ($1,000 to get your DNA sequenced), will obviate these two challenges. Seriously, 150 will become the new 40. Researchers are already at work, and the venture capitalists are flocking to One Kendall Square in Cambridge, Massachusetts, and other hotbeds.
- Tennessee-based Community Health Systems, which was not even a blip on the screen ten years ago, is becoming a major regional provider.

The list goes on.

A board member of a small healthcare system said to me recently, "We heard this all before and nothing happened. Why should we believe you this time?" Of course, he was simultaneously right and wrong. True, in the 1990s consultants across the country were predicting that in a few short years there would be four national health insurance companies and six delivery systems. In 2006, the Bumrungrad Hospital in Thailand was touted concurrently by *60 Minutes* and *Newsweek* as the future of healthcare delivery and international medical tourism. Bumrungrad and other hospitals in Thailand, India, and South America were bright and beautiful (they almost made you want to be sick), and they boasted Joint Commission International accreditation and Western-trained physicians. Their costs were ridiculously low compared to those in the United States. Patients could get the required care, take a luxurious vacation, and still return with money in their pockets. None of that came to pass. Less than 1 percent of US residents consume healthcare abroad even though the foreign medical centers are still available, are more attractive than ever, and have been joined by such US luminaries as Massachusetts General Hospital.

I laughed in response to the board member's question (appropriately noted in the speaker evaluation), then recovered when I realized he was serious. Where was he wrong? See the previous list of bullet points. Change does come from the outside, and it's coming to us. As comparative quality information becomes increasingly available between now and 2025, it will all be about cost. What this means for US providers is patently obvious: It's game over.

What should we do while we watch our market share erode? This year's *Futurescan* authors provide some great insights to help staunch the bleeding if not stop the hemorrhaging. We hope you find the following snippets from this year's essays engaging.

On healthcare reform: Achieving lower costs and higher quality will provide competitive advantages in bundled- and global-payment arrangements, give providers preferred placement in tiered-network health plans, and help them attract consumers under reference pricing arrangements.—Stuart H. Altman, PhD, HFACHE, and Robert E. Mechanic

On transparency: Identify other information sources that will help patients assess the value of the services you provide. Consider, for example, linking price information to relevant and publicly reported quality or patient-safety scores.—Joseph J. Fifer

On provider strategy: A flawless patient experience directly contributes to the likelihood of a return visit. Many hospital leaders fail to connect the patient and family experience to the likelihood of repeat business.—Jeff Goldsmith, PhD

On volume to value: All of these strategies beg the larger question of whether you need to merge or affiliate with a larger entity to succeed. Assessing your strategy based on a competitive analysis will help you make that decision.—John M. Harris and Bonnie Frazier

On innovations in primary care: Hospitals should lead efforts to promote health information exchange. Many of the most important innovations in primary care—for example, those focused on improving care for high-utilizing patients—require effective information exchange between ambulatory providers and hospitals. . . . Health systems that succeed in establishing easy-to-use electronic health information exchanges will have a leg up on systems that do not.—Michael Hochman, MD

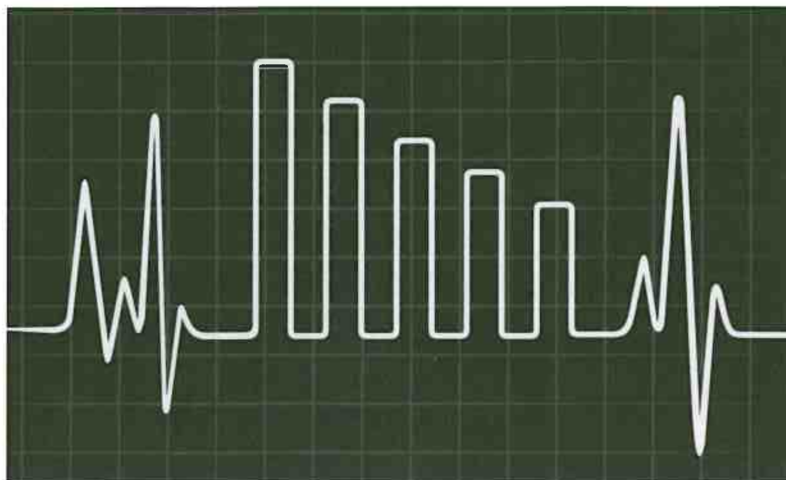
On private insurance exchanges: Depending on how the private exchange market evolves and how rapidly it expands, the exchanges could become an important new sales channel for providers, giving them an opportunity to gain new revenue streams.—Gunjan Khanna, PhD, and Shubham Singhal

On advanced care plans: Partners will spring from among community leaders, political leaders, AARP, nursing homes, home health agencies, and patients themselves. In addition, all segments of the faith community can successfully participate in the design, training, and implementation of ACP systems. Establishing an ACP system presents a significant opportunity to improve not only the health and well-being of our patients and their families but the well-being of our staff members, too.—Jeffrey E. Thompson, MD

On innovations in iMed: Some health systems, such as Allina in Minnesota, are starting to train their primary care physicians to use comprehensive handheld ultrasound devices as part of the physical exam. This protocol leverages a new, informative, and economical way of performing an exam. We have a technology that transcends the stethoscope, but its current use does not reflect its immense potential.—Eric J. Topol, MD

1. HEALTHCARE REFORM LIMITED FUTURE HEALTHCARE SPENDING GROWTH WILL FORCE PROVIDERS TO DEVELOP MORE COST-EFFECTIVE DELIVERY SYSTEMS

by Stuart H. Altman, PhD, HFACHE, and Robert E. Mechanic



Under a "reimbursement" mentality that has dominated the US healthcare system, providers expect payers to reimburse them for the cost of care as they have determined it. Alternatively, healthcare can be funded under a "payment" model, where payment is determined independently from the cost of care. This payment model requires the delivery system to operate more in relation to the resources made available by payers. The current payment system combines aspects of both approaches. In the future, however, the payment model will likely become dominant and require significant adjustment in the way providers deliver care.

Payments Relative to Costs

Most Medicaid programs eliminated cost-based reimbursement in the mid-1970s. In 1983, Medicare eliminated its cost-based system too and began paying hospitals according to the types of patients they treat and the average costs of treating such patients throughout the country (Altman 2012). Thus, both Medicare and Medicaid have now adopted more of a payment approach to paying for hospital care within the scope of budgetary limits that are less related to the cost of care. In 2012, the overall Medicare margin for both inpatient and outpatient hospital care was –5.4 percent (MedPAC 2014). As for Medicaid, payments were 89 percent of costs including special payments to select hospitals receiving disproportionate care payments (AHA 2014). As government payments fell below the cost of care, however, most hospitals were able to compensate by charging privately insured patients more than the cost of their care.

Hospital private-payment-to-cost ratios were around 120 percent in the early 1980s—that is, privately insured patients or their insurance companies paid 20 percent more than the total cost of care delivered to these patients (Exhibit 1.1). In the late 1980s and early 1990s, the ratio grew significantly to make up for the slower

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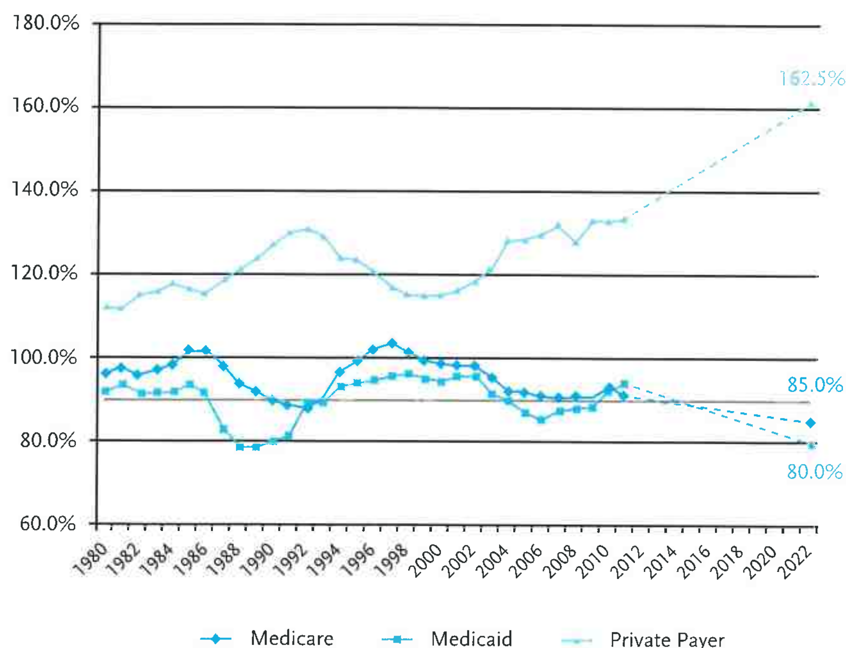
Exhibit 1.1 Hospital Payment-to-Cost Ratios, 1980 to 2022



Sources: Data from AHA and Avalere (2014); Merrill, Stocks, and Stranges (2009); and Fiegl (2011).

growth in Medicare and Medicaid hospital payments relative to costs. Following a decline during the managed-care era, the ratio grew rapidly in the early 2000s and has remained high up to the present. Although not all hospitals have the market leverage to negotiate higher private payments (Robinson 2011), hospitals in the aggregate were able to secure sufficiently high private payments to earn an average 6.5 percent operating margin in 2012 (AHA and Avalere 2014). This margin was generated despite the fact that Medicare and Medicaid payments were substantially less than costs for most hospitals. In the future, however, we believe private insurers will be less willing or able to continue providing such added funding to permit hospitals to maintain positive operating margins under their current cost structures.

The Growing Dominance of the Payment Approach

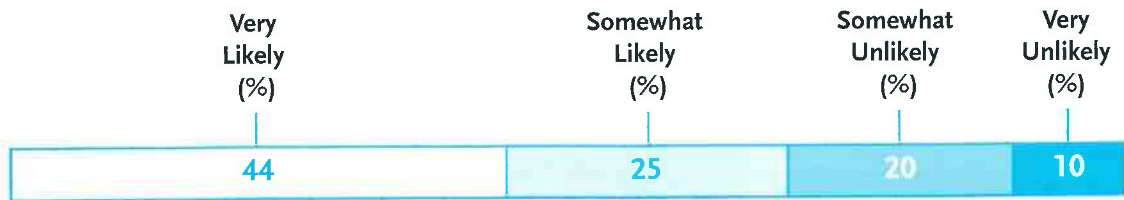
The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary estimates that Medicare and Medicaid enrollments will grow by 57 percent and 71 percent, respectively, from 2006 to 2022, whereas enrollment in private insurance will grow by only 6 percent (CMS 2013). Given the relative differences in growth rates, it is not surprising that private insurance payments are projected to fall as a percentage of total health insurance expenditures. Whereas private insurance payments made up 48.7 percent of total health payments in 2006, they are projected to decline to 43.2 percent in 2022 (Exhibit 1.2). Conversely, total government payments will grow from 46.7 percent to 51.7 percent. Equally significant, given the expected large growth in the volume of Medicaid patients, is the limited growth in Medicaid payments (CMS 2013), which suggests that state Medicaid programs will continue to impose tight budget restrictions on their healthcare payments. Although Medicare is less likely to impose such tight restrictions, we can reasonably assume that its payments also will be restricted by budgetary pressures and continue to fall short of hospital cost growth. While the projected decline in the number of uninsured patients and uncompensated care will help hospital bottom lines, it is unlikely to make up for the growing shortfalls in government payments.

Will Private Sector Payments Fill the Gap?

At the same time that hospitals require higher private payments, employers and private insurers are developing new models to reduce spending. Pressure for these models has intensified as a result of the rapid growth in premiums and workers' out-of-pocket costs over the last decade (Kaiser Family Foundation 2014).

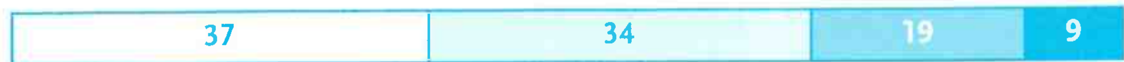
Several new approaches stand out as having potential to slow spending growth: (1) payment systems that move away from fee-for-service to some form of bundled or global payment; (2) tiered networks,

How likely is it that the following will be seen in your hospital by 2020?

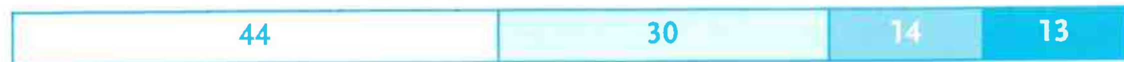


The hospital's total revenue from all sources, per patient, will be less than or equal to what it was in 2012 or 2013 (adjusting for inflation).

Non-fee-for-service payment will make up at least 30 percent of your total revenue from all sources.



Government payments to your institution will equal more than 70 percent of your total revenue from all sources.



Your organization will participate in a Medicare Shared Savings Program Accountable Care Organization or a Medicare Bundled Payments demonstration.

Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

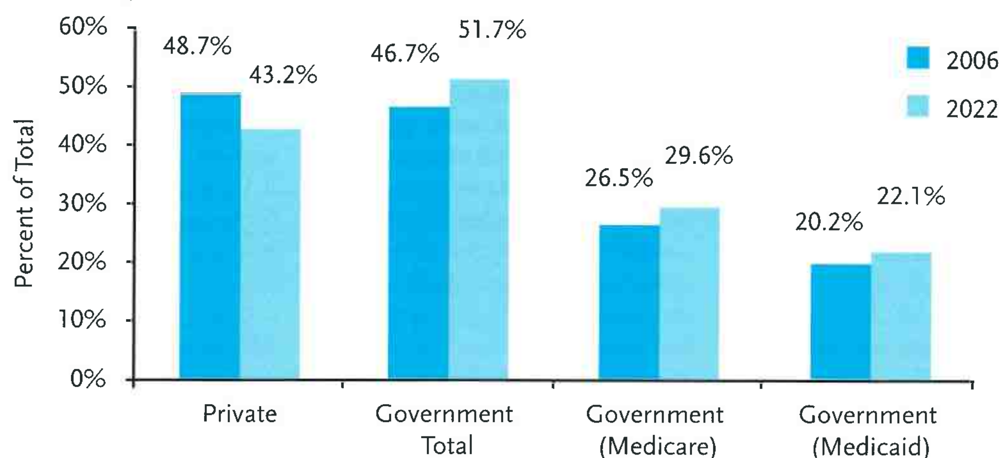
Per-patient revenue is not likely to increase. A majority (about 69 percent) of survey respondents predict that their hospital's total per-patient revenue in 2020 will be less than or equal to what it was in 2012 or 2013, adjusting for inflation.

At least 30 percent of hospital revenue will come from non-fee-for-service payments. Most (71 percent) of those responding to the survey believe that by 2020 at least 30 percent of the total revenue of their hospital will come from non-fee-for-service payments.

More than 70 percent of hospital revenue will come from government sources. Again, 71 percent of respondents predict that by 2020 more than 70 percent of their hospital's total revenue will be payments from the government.

Most hospitals will participate in at least one of two Medicare payment programs. Most (74 percent) of survey respondents predict that their organization will be participating in either a Medicare Shared Savings Program Accountable Care Organization or a Medicare Bundled Payments demonstration five years from now.

Exhibit 1.2 Total Health Insurance Payments by Payer Source, 2006 and 2022



Source: CMS (2013).

in which consumers pay a higher coinsurance rate if they choose a higher-cost provider; (3) health exchanges and defined-contribution programs, in which consumers select from a range of plan options with a fixed employer or government premium contribution and pay the full incremental cost of more expensive plans; and (4) reference pricing models, under which a plan sponsor pays a fixed amount for a service (e.g., joint replacement) that is based on, for example, the average cost of that service in the area and consumers pay the difference if they choose a higher-cost provider. The first approach rewards providers directly for lowering the cost of care, while the other approaches create financial incentives for consumers to select lower-cost providers, services, and health plans.

Outlook on Future Healthcare Spending Growth

Annual growth in national healthcare spending reached a high of 9.5 percent in 2002 and declined to 3.8 percent in 2009, a rate that has continued to the present (CMS 2013). Given the growing proportion of patients sponsored by government programs and pressure on both government and private insurers to keep payments low, these lower growth rates are likely to persist into the future. The *Futurescan* survey results indicate that many hospital leaders recognize this scenario and are seeking ways to lower their costs of care and develop a more efficient delivery system.

Implications for Hospital Leaders

Reducing operating costs is one option that hospital leaders should consider as government-sponsored patient volume grows and hospitals face a more consolidated insurance market. A growing number of healthcare organizations across the country are embracing management methods such as Lean manufacturing to reengineer clinical and administrative processes, reduce waste, empower and engage frontline workers, and become more patient centered. Virginia Mason Medical Center, for example, has developed evidence-based care processes that improve quality, reduce costs, and increase patient satisfaction (Blackmore, Mecklenburg, and Kaplan 2011). Wisconsin's ThedaCare system, another proponent of Lean manufacturing, achieved the largest annual percentage cost reduction among 32 systems in the Pioneer accountable care organization (ACO) program despite being one of the lowest-cost systems in the program to begin with (Toussaint, Milstein, and Shortell 2013). Achieving lower costs and higher quality will provide competitive advantages in bundled- and global-payment arrangements, give providers preferred placement in tiered-network health plans, and help them attract consumers under reference pricing arrangements.

Many forces in the future healthcare system will contribute to reducing hospital volume. Strategies to maintain volume will remain important but must be designed to attract value-conscious purchasers. Hospitals can pursue traditional approaches, such as building regional centers of excellence for specialty care, but to be successful they will need to demonstrate high quality and high value. Another important way to increase volume will be to make services more convenient, responsive, and consumer friendly. As consumers face higher deductibles and greater out-of-pocket spending, they will be less tolerant of poor service and high costs. New business ventures are emerging that offer improved convenience and less hassle, ranging from retail clinics to online consultations. Hospitals need to keep abreast of these developments and

make sure they have a beachhead where tomorrow's patients are likely to be.

Health systems will increasingly face pressure to enter new bundled- and global-payment models. Hospitals and health systems will have to decide whether to take the lead in these arrangements by developing population management capability or position themselves as preferred partners for local ACOs by providing high-value acute care services. ACO and bundled-payment contracts require investment in population health infrastructure, including physician engagement and leadership development, healthcare data analytics, and care coordination. Although many early ACO-type contracts, such as the Medicare Shared Savings Program, limit downside risk while offering bonuses for spending reductions and quality improvement, payers will try to increase providers' risk in these arrangements over time. These payment models create opportunities for providers to benefit financially from improved efficiency as health spending slows, but they can accelerate losses for the unprepared.

Another potential strategy for a health system is establishing a health plan partnership to market its network as a stand-alone insurance product. This is a logical step for systems that are willing to accept risk for total health spending. Some providers, such as Geisinger Health System, operate successful health plans, and other systems are considering starting new ones. But most health systems lack the core competencies in actuarial services and marketing necessary to run a successful health insurance operation. For most providers, a better approach would be partnering with an experienced health plan to create a branded health insurance product that maintains the name of the provider organization.

The strategies that hospitals and health systems select will depend on their local market characteristics. Systems located where competition is limited and payers are weak may be able to restructure gradually, but most hospitals should consider more aggressive changes. Even indispensable providers need to be aware of employer initiatives that encourage patients to seek out-of-area care for high-cost procedures. Walmart (2012), for example, offers its associates the option of heart, spine, and transplant surgery at six leading medical centers, including the Cleveland Clinic, Geisinger, and Virginia Mason, with no out-of-pocket costs. Exhibit 1.3 provides a simple schematic for considering options in the context of local market conditions.

The greatest urgency for change will come in competitive healthcare markets with a dominant insurer that is aggressively trying to manage spending growth and in areas with a high proportion of government-covered patients. Hospitals and health systems in such situations should consider a multifaceted strategy that includes aggressive cost management, development of population health management capacity, and contracts based on overall value rather than unit cost. Executing this strategy effectively will require strong physician affiliations.

Conclusion

During the past several years, growth in healthcare spending has been at historic lows. Many analysts

Exhibit 1.3 Hospital Strategies Under Different Market Conditions

Hospital Market \ Insurance Market	Consolidated	Competitive
Consolidated	Collaborate with local insurer to achieve "reasonable" spending growth	Cultivate support among local physicians and key employers
Competitive	Move aggressively to earn preferred status with high-value care and population health management	Promote status as "must have" hospital and aggressively build high-value care model

believe that these low growth rates are at least partly the result of the economic recession of 2008–2009 and that, over time, spending growth will return to prerecession levels. The analysis in this essay, however, suggests that such a recovery may not happen. Low government payments combined with an increasing proportion of patients covered by government programs and decreased growth in private payments is likely to make the current health spending growth rates the new normal. The *Futurescan* survey results support this hypothesis. A substantial majority (71 percent) of hospital executives believe that government payments will equal more than 70 percent of their hospital's total revenue and that their hospital's future revenue will not grow more than inflation.

In this essay, we suggest a number of approaches for hospitals to consider as they attempt to cope with slowing revenue growth. Again, the survey results indicate that many hospitals already anticipate the need for restructuring: More than 70 percent of survey respondents plan to participate in either Medicare's Shared Savings Program or its Bundled Payments demonstration. We caution those hospitals that are waiting to make changes in how they provide care not to wait too long. FS

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2. TRANSPARENCY MEETING EXPECTATIONS, SEIZING OPPORTUNITIES

by Joseph J. Fifer

The trend has been clear for a while now—people are paying more out of their own pockets for healthcare. Consequently, consumers want to know how much they'll be expected to pay for healthcare services. And many are frustrated because reliable price information is hard to come by.

Cost Sharing Drives Demand for Transparency

Estimated at $338 billion in 2014, Americans' out-of-pocket healthcare costs are projected to rise 22 percent by 2019 to $413.5 billion (Sisko et al. 2014). Much of this increase will take the form of higher cost sharing, including higher deductibles, co-payments, and coinsurance, across all channels in the commercial insurance market. The trend toward higher cost sharing reflects changes in benefits design and federal tax incentives that favor high-deductible health plans.

According to a National Business Group on Health survey of employers representing 7.5 million workers, 81 percent of employers will offer a high-deductible health plan (HDHP) as an option in 2015, up from 72 percent last year, and 32 percent will offer HDHPs as the only option, up from 22 percent last year (Accenture 2014). In addition, an estimated 3 million people receive employer healthcare benefits through private exchanges, which are expected to enroll 40 million by 2018. A quarter of enrollees in private exchanges buy less coverage than they previously had, presumably to decrease their premiums, but with a trade-off of higher cost sharing down the road (Accenture 2014). In the first year of public exchanges, nearly two-thirds of enrollees chose silver plans, which cover 70 percent of healthcare costs and have deductibles of $2,907 for individuals and $6,078 for families (Kennedy 2014).

Not surprisingly, with a greater stake in their healthcare expenses, consumers want more transparency in price and quality. These expectations are not unreasonable.

About the Author

Joseph J. Fifer, FHFMA, CPA, is president and CEO of the Healthcare Financial Management Association (HFMA). HFMA provides the resources healthcare organizations need to achieve sound fiscal health to provide excellent patient care. With more than 40,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. Fifer was chair of the HFMA board of directors in 2006–2007. An HFMA member since 1983, Fifer served as a chapter president and for two terms as an HFMA board member. Prior to assuming his position with HFMA in June 2012, Fifer spent 11 years as vice president of hospital finance at Spectrum Health in Grand Rapids, Michigan. He also worked for McLaren Health Care Corporation in Flint, Michigan, as vice president of finance and for Ingham Regional Medical Center in Lansing, Michigan, as senior vice president of finance and chief financial officer. Fifer started his career with nine years at Ernst & Young, also in Michigan. A Fellow of HFMA and a certified public accountant, Fifer received his bachelor's degree in business administration from Saginaw Valley State University in University Center, Michigan. In 2014, Fifer was named to *Modern Healthcare*'s list of the 100 Most Influential People in Healthcare.

Transparency Tools Have Emerged

In recent years, payers, hospitals, states, and third-party companies have emerged as sources of price

transparency information for consumers.

Payers. According to the 2013 *National Scorecard on Payment Reform* of Catalyst for Payment Reform (CPR 2013), 98 percent of health plans that responded to a survey said they offer or support a cost calculator tool for their members. Mobile apps, such as United Healthcare's (2014) Health4Me, are also starting to become available to the general public—not just health plan members. The company said in a press release that 900,000 members are using its mobile app, which provides average local prices for more than 520 services based on contracted rates or historical provider claims data.

Recognizing the importance of pairing price and quality information, a new consumer portal being developed by three of the nation's largest health insurance companies—Aetna, Humana, and United Healthcare—in collaboration with the nonprofit Health Care Cost Institute (HCCI) will supplement price data with quality data. HCCI (2014) expects other major carriers to join before the portal opens in early 2015, although each carrier will continue to offer its own price transparency tools as well.

A recent set of consensus-based recommendations from a price transparency task force led by the Healthcare Financial Management Association (HFMA 2014a) suggested that health plans serve as the principal source of information for their members, given that health plans typically have accurate, plan-specific price information for their members.

Hospitals. Price transparency is subject to a substantial and expanding number of laws at both the federal and state levels, and providers' first responsibility is to ensure that their policies and practices adhere to legal requirements. Beyond that, a proactive approach to price transparency is clearly in a hospital's best interest.

The HFMA-led price transparency task force—which included representatives from the American Hospital Association (AHA), America's Health Insurance Plans, and consumer groups, among others—recommended that providers serve as the principal source of price information for uninsured patients and patients who are seeking care from the providers on an out-of-network basis.

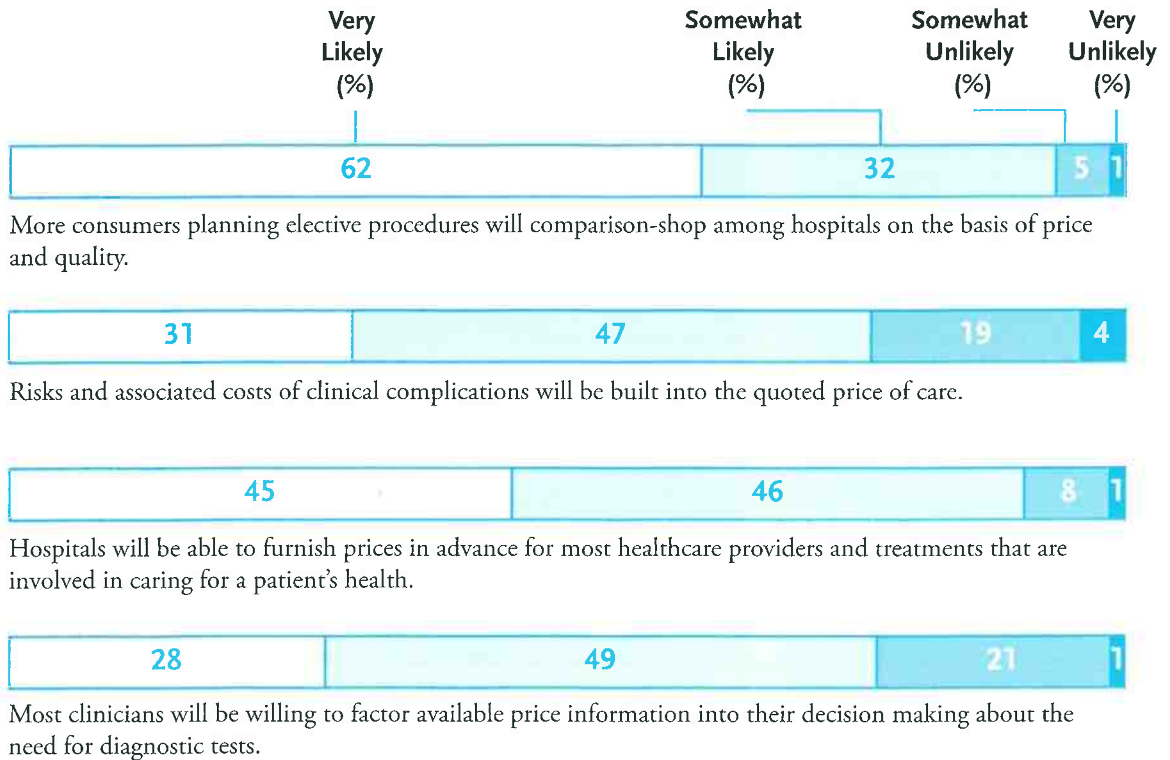
Despite challenges often posed by contractual obligations that restrict providers from releasing rates negotiated with payers, a number of hospitals have launched price transparency initiatives. For example, in 2013, Maricopa Integrated Health System, a safety-net system in Phoenix, Arizona, became the first in the state to post self-pay prices for Arizona's ten most frequent inpatient and outpatient procedures. The system is also posting single bundled prices for certain episodes of care, such as a maternity package.

Some hospital exemplars are pairing price and quality data in their transparency tools. Pennsylvania-based Geisinger Health System, for example, has integrated price and quality information in its price transparency tool, providing a link to the quality measures reports generated by The Joint Commission, Pennsylvania Health Care Cost Containment Council, Pennsylvania Health Care Quality Alliance, and Hospital Compare as well as Geisinger Health Plan's own Healthcare Effectiveness Data and Information Set (HEDIS) reports. A patient requiring heart valve replacement surgery, for example, could access both an out-of-pocket estimate for the procedure and comparative quality information through Geisinger's own quality portal.

Another example of a provider disclosing price and quality information is Spectrum Health, an integrated system based in Grand Rapids, Michigan, which contracted with Healthcare Bluebook to develop a transparency tool for the members of its health plan, Priority Health. The tool, which supplements Spectrum Health's longstanding, proactive disclosure of hospital price and charge information, addresses some 200 discretionary services that together represent approximately 20 percent of the health plan's total medical spending. The tool also links to Healthgrades, which offers quality rankings and consumer reviews of hospitals and physicians. As of December 2013, 47 percent of healthcare facilities in the Priority Health network had agreed to disclose their prices.

State initiatives. In 2014, 35 states required hospitals to release selected charge information, and 7 others relied on voluntary disclosure of charge data (AHA 2014). However, few states require release of actual price data (CPR and Health Care Incentives Improvement Institute 2014). (HFMA's price transparency task force report distinguishes between charges, defined as the dollar amount a provider sets for services rendered before negotiating any discounts, and prices, defined as the total amount a provider expects to be paid by payers and patients for healthcare services.) In addition, 11 states have passed legislation requiring payers to contribute data to all-payer claims databases that provide information on actual prices paid and are suitable for use in estimating the cost of entire care episodes (AHA 2014).

Third-party sources. Increasingly, large employers are giving their employees access to mobile apps



Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

Healthcare consumers considering elective procedures will comparison-shop. Almost all (94 percent) of survey respondents expect that by 2020 healthcare consumers will comparison-shop on the basis of price and quality to choose the hospital where their elective procedures will be performed.

Quoted healthcare prices will allow for risks and complications. About three-quarters (78 percent) of respondents believe that by 2020 care prices quoted to consumers will include the cost of possible risks and complications.

Hospitals will furnish prices of care in advance of treatment. Almost all of those participating in the survey (91 percent) are in agreement that by 2020 hospitals will furnish the prices of the services of healthcare providers and treatments to consumers in advance of treatment.

Most clinicians will consider price when ordering diagnostic tests. The majority (77 percent) of respondents predict that by 2020 most clinicians will consider available price information when deciding whether diagnostic tests are needed.

developed by third-party companies to accommodate comparison shopping—and more companies are jumping into the arena. Castlight Health, ClearCost Health, and Healthcare Bluebook are just three examples of independent companies that have contracts with employers and health plans.

Employer Groups Continue to Beat the Drum

Major employer groups, such as the National Business Group on Health, urge their members to make the case for transparency to their employees: Transparency helps workers become aware of price and quality variations and of how changing their decision-making process will benefit them (as well as their employer) by enabling them to identify high-value care and reducing their out-of-pocket costs. CPR (2014), representing more than 30 major employers, has been calling for wider availability of price data for care purchasers; the group also designed certain specifications that employers and consumer groups can use to evaluate transparency tools.

Physicians Are More Willing to Talk About Price

A 2011 Bain & Company survey indicated that more than 80 percent of physicians agree that bringing healthcare costs under control is partly their responsibility. Other studies suggest that presenting physicians with price information leads them to more carefully consider the need for tests, although, as is appropriate, information on the quality of patient care is the main driver of clinician decisions (Farkas and van Biesen 2011).

Physician organizations are recognizing the importance of factoring value into clinical decision making. For example, Choosing Wisely, an initiative of the American Board of Internal Medicine Foundation that more than 60 specialty societies have joined, is a campaign to spark conversations between physicians and patients about appropriate care, including tests and procedures that do not make good use of healthcare resources. A key message of Choosing Wisely is that more care and more expensive care aren't always better. A number of major employers, such as Walmart, are opting to integrate Choosing Wisely into the third-party transparency tools they provide to employees.

Consumer Engagement Lags

Are consumers taking advantage of the growing number of price information sources? Not much; at least, not yet. According to the CPR (2013) scorecard, only 2 percent of health plan members use the tools available on their payers' websites. Similarly, a Harris Interactive (2012) poll showed that although 62 percent of people think online cost calculators are important in healthcare, only 6 percent have used one.

To a large extent, the low level of engagement reflects the need to improve information accuracy and quality and make tools more convenient and easier to use. It also reflects the reality that subjective information, informal sources, and referrals are still strong influencers of consumers' healthcare decisions. According to a structured review of the published evidence on presentation formats that support consumer decision making, evaluative, interpretive approaches that are graphics based are well received. But it's not as straightforward as it seems—for example, common, seemingly intuitive symbols such as "$$$" (denoting a high-priced item) are not always effective. Also, those with low literacy and numeracy skills and elderly consumers are consistently disadvantaged (Kurtzman 2013).

Any system of price transparency will likely need to experiment with the most effective and user-friendly means of communicating price information to a particular target audience.

Implications for Hospital Leaders

Given that 94 percent of *Futurescan* survey respondents anticipate that consumers will comparison-shop for elective procedures by 2020, hospital leaders don't need to be convinced that patients are going to start acting more like consumers when it comes to seeking price information. Perhaps more surprising is the finding that respondents believe they will be ready to meet the demand for price information: According to the survey, 91 percent of healthcare practitioners expect to be able to furnish prices in advance of service for most providers and treatments by 2020. Furthermore, about three quarters expect that the care prices quoted to consumers will include the cost of possible risks and complications—a capability that few now have and even fewer exercise.

It's unclear whether these survey results reflect leaders' belief in the importance of consumer engagement or simply their recognition that price transparency will soon be expected as a matter of routine by care purchasers. Most likely, it's a little of both. In any event, hospital leaders should recognize that the lack of price transparency threatens to erode public trust in our healthcare system. Maintaining public trust will first and foremost necessitate an aggressive commitment to transparency by hospital boards and executive teams. Other steps toward improving price transparency are described in Exhibit 2.1.

As your organization takes steps toward developing or improving price and quality transparency, it's important to realize that this is just the beginning. The bar for convenience, clarity, and accuracy of

Exhibit 2.1 Checklist for Preparing for Price Transparency

✓ **Identify a reasonable starting point.** High-demand outpatient services, such as lab tests and diagnostic imaging, will likely be of greatest interest to price-sensitive patients and are a good starting point for transparency efforts. More complex scheduled procedures with high price variations that don't correlate with clinical outcomes in a given market, such as knee replacement surgery, may also be good candidates.
✓ **Assess whether your pricing structure is transparency ready.** Does your hospital's pricing structure make sense? This is a stumbling block for many hospitals, but don't let it derail your transparency initiative.
✓ **Consider how care purchasers will access the information you provide.** Price information might be publicly posted online, made available on a password-protected website, or provided in response to an inquiry. Be sure that patients can easily find the information.
✓ **Identify other information sources that will help patients assess the value of the services you provide.** Consider, for example, linking price information to relevant and publicly reported quality or patient-safety scores.
✓ **Work collaboratively with the payers in your market.** Your administrative team should familiarize itself with the transparency tools that payers offer—and invite payers to do the same with your tools and processes.
✓ **Be prepared to explain healthcare pricing.** Healthcare prices vary for different care purchasers and payers. As prices become more transparent, be prepared to explain why prices may be different for different care purchasers.

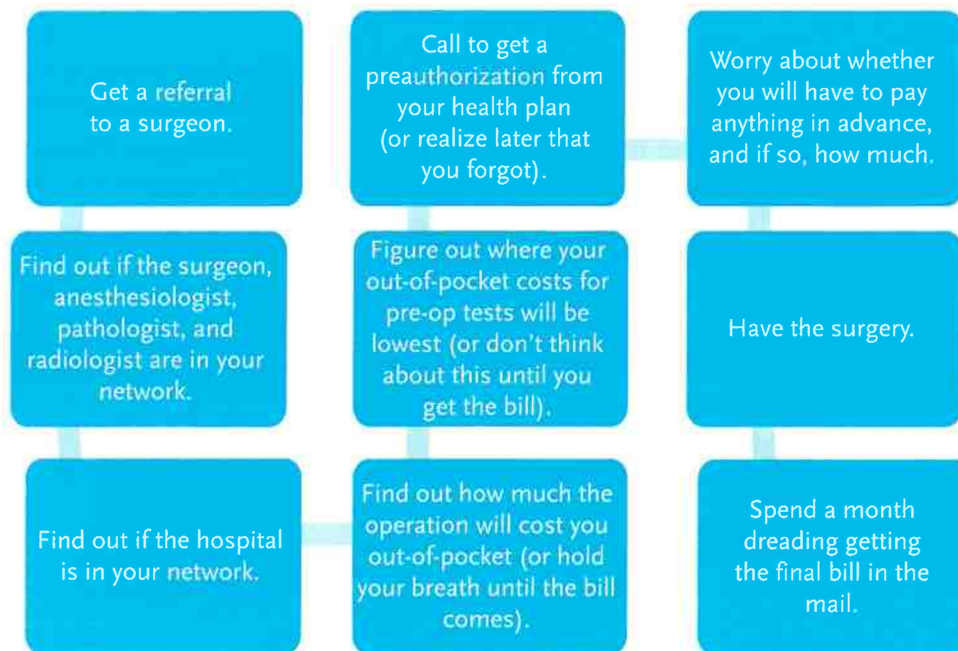
price and quality information will continue to be raised. As previously noted, few hospitals today have the ability to build risks and associated costs of clinical complications into the quoted price of care. Hospitals will be challenged to harness clinical and financial data in ways that enable them to do so.

Hospitals will also be challenged to adopt more of a retail mind-set. Hassle maps, which Adrian Slywotzky (2011) defines as all of the actual steps that characterize the customer's negative experiences, provide a useful framework for depicting the frustrations that consumers experience. Exhibit 2.2, inspired by Slywotzky's construct, depicts a hassle map for an insured patient who is seeking to arrange for an elective surgery.

And the hassles don't end when the hospital bill arrives in the mail, given that services of physician specialists, such as anesthesiologists, radiologists, and pathologists, are often billed separately. In many instances, the best we can do now is to make patients aware of these limitations and provide them with guidance on how they can secure price information, as recommended in a consumer guide developed by a subset of the price transparency task force (HFMA 2014b). That's a reality-based best practice today, but going forward, consumers will expect more. In the next few years, hospitals will have significant opportunities to integrate and organize price information for consumers across providers and care settings.

Furthermore, as transparency takes hold, hospitals will no longer be able to cite the limitations of price information when the discussion turns to price variation. Instead, they will need to address price and value issues head-on—along with all of the associated challenges and opportunities. Some hospitals may be able to make a case (based on outcomes, patient experience, or both) for why a particular procedure is more expensive in the hospital setting and why paying more is in the patient's best interest. (Doing so is no small task; among other challenges, patients may or may not perceive value in having access to more sophisticated diagnostic imaging equipment, for example, or in having all of their medical information compiled in a single electronic record.) Alternatively, hospitals may seek to reduce the cost of care to become price competitive with nonhospital providers. The other option will be to accept the migration of patients and procedures to lower-cost sites of service.

Exhibit 2.2 A Healthcare Hassle Map: Elective Surgery for an Insured Patient



Source: Based on the hassle-map construct developed by Slywotzky (2011).

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3. PROVIDER STRATEGY THE DEATH OF REIMBURSEMENT AND WHAT IT MEANS FOR STRATEGY

by Jeff Goldsmith, PhD

Even 30 years ago, something seemed wrong with using the term *reimbursement* to describe the source of a hospital's revenues. One didn't "reimburse" General Motors for a Buick or Walgreens for a prescription, even if their costs were incurred long before you received the product.

Sure, the term *reimbursement* technically described the mechanics of third-party payment, after the fact, for the provision of a health service. But there was also the unmistakably whiny subtext: "I had nothing to do with these costs. The money is spent and now you owe me." The costs of care were determined largely by professionals who were either completely independent of the hospital (e.g., independently practicing physicians) or nurses and other health professionals who, while nominally employed, fiercely defended their clinical turf from nonprofessional interference.

When I started working with Ernst & Whinney (now Ernst & Young) in the early 1980s (which at the time had a huge "reimbursement" practice), my colleagues there told me that the key to understanding the hospital business was knowing that it was built up on the revenue side. Costs simply accumulated under the revenue umbrella, and management's job was to keep expanding the umbrella to cover them.

About the Author

Jeff Goldsmith, PhD, is president of Health Futures, Inc., which specializes in corporate strategy, trend analysis, health policy, and emerging technologies. He has worked across the health system—hospitals, health plans, physician groups, and pharmaceutical, biotechnology, and health manufacturing and distribution sectors—advising senior management and boards. Goldsmith is associate professor in the Department of Public Health Sciences at the University of Virginia in Charlottesville. He is the author of *The Long Baby Boom: An Optimistic Vision for a Graying Generation* (Johns Hopkins University Press, 2008) and *The Sorcerer's Apprentice: How Medical Imaging Is Reshaping Health Care* with Bruce Hillman, MD (Oxford University Press, 2011).

Hospital Economic Outlook: Cloudy with a Chance of Showers

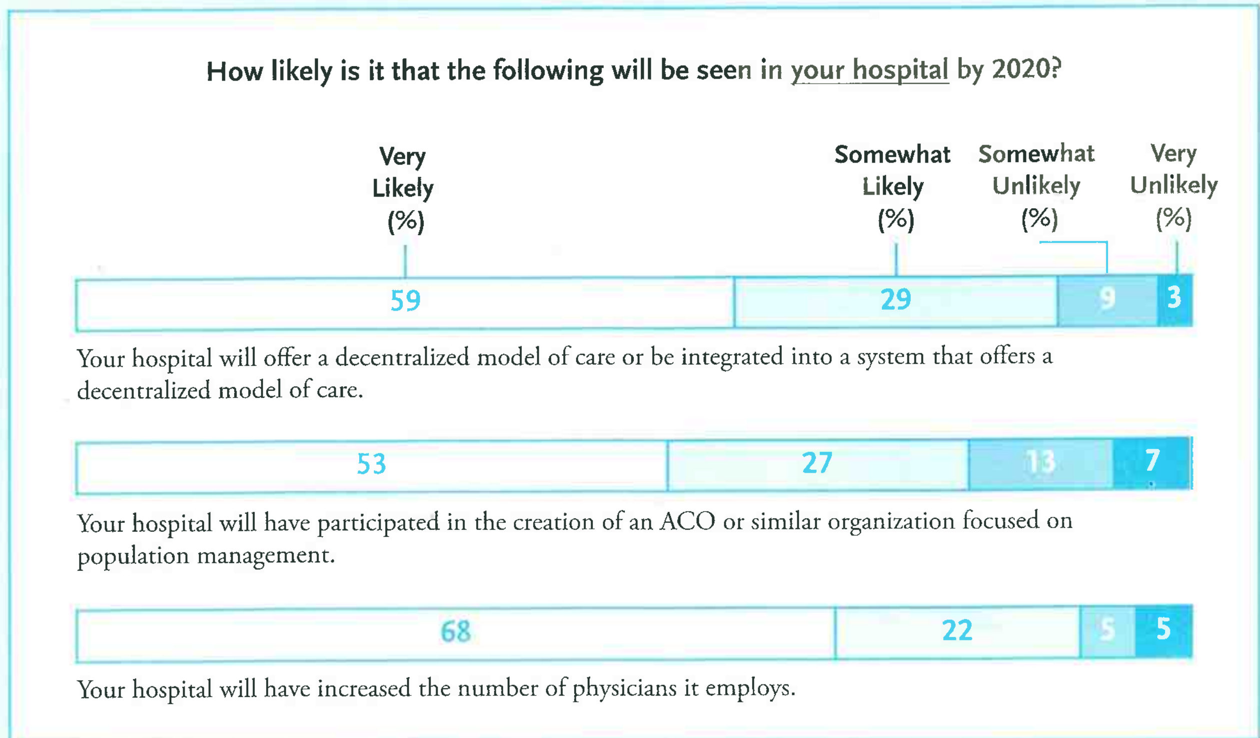
Despite all the creative efforts to maximize reimbursement, the revenue outlook for hospitals has steadily darkened in the past decade. Although I do not agree with many hospital executives that hospital revenues will shrink going forward, in the wake of the Affordable Care Act (ACA) hospital unit pricing growth declined still further into territory not seen in 50 years (see Exhibit 3.1). The stagnation of pricing growth coincided with Medicare funding reductions contained in the ACA and was compounded by the 2 percent annual reduction contained in the 2012 sequester and falling inpatient admissions.

The cessation of top-line revenue growth, when combined with continuing cost increases, has devastated the operating margins of some of the nation's most powerful regional health systems. The pressure on margins is universal. Scale, brand, and leverage do not appear to have helped much. Hospitals large and small have been unable to shift the costs of lost Medicare payment onto private insurers (Goldsmith 2014).

Another big change hospitals face is the rapid shift in economic

FUTURESCAN **SURVEY RESULTS:** Provider Structure

A **decentralized model of care** disperses health services beyond the hospital or inpatient setting to communities through ambulatory centers, physician practices, urgent care centers, nursing homes, home care and hospice agencies, and other similar entities.



Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

Decentralized models of care will become common. Eighty-eight percent of those responding to the survey believe that by 2020 their hospitals will either offer decentralized care or be part of a system offering a decentralized model of care.

Most hospitals will be part of an organization focused on population health management. Most (80 percent) of survey respondents expect that by 2020 their hospital will be part of an Accountable Care Organization or similar entity focusing on population health.

Numbers of physicians employed by hospitals will increase. Almost all (90 percent) of survey respondents predict that the number of physicians employed by their hospital will increase over the next five years.

Exhibit 3.1 Annual Percentage Change in Hospital Prices

Source: Guerin-Calvert and Maki (2014), with data from US Bureau of Labor Statistics, Producer Price Index, Hospital Services Component, 2002–2013. Used with permission.

risk from employers to consumers' household budgets through the growth of high-deductible health plans. Even prior to the ACA, high-deductible health plan enrollment was on its way to quintupling (to 30 million lives) in the wake of the recession (Kaiser Family Foundation and HRET 2014). With the ACA, the majority of the millions receiving coverage through the federal and state public health insurance exchanges have deductibles greater than $2,500 and annual out-of-pocket maximums significantly higher than that (McKinsey & Company 2014).

The public exchanges will eventually add another 15–20 million people to the "patient pays first" pool. *Private* exchanges, the safety valve for large employers with rich benefits who will pay a 40 percent excise (or so-called Cadillac) tax in 2018, could add another 30 million. And the next recession, whenever it happens, will add millions more to those with significant front-end cost exposure.

Clearly, reimbursement will no longer be a large front end of any future hospital payment. Perhaps as many as a hundred million US consumers will be self-insured for the first several thousand dollars of their encounters with the health system.

Consumers Don't Have a Lot of Cash

The theory and the reality of consumer-directed plans match up perfectly: Households spend their own money, if they have any, with profound reluctance. Narrower networks *will* channel the exchange populations to the most affordable providers and dampen down future rate negotiations. But the heavy lifting in managing costs will be done by the enormous patient cost shares.

Despite the economic recovery entering its anemic sixth year, consumers remain frightened, debt burdened, and cash poor. A recent report from the Urban Institute found that 77 million Americans have defaulted on debt and are in collection of some kind, and the consumer debt burden has fallen only 10 percent since its peak in 2009 (Ratcliffe et al. 2014).

Forty-four percent of US households are liquid-asset poor, meaning that they have saved only enough money to cover three months or less of their household expenses (Brooks et al. 2014). And 51 percent do not have enough cash to pay off their outstanding credit card balances (Kahn 2014).

Against this cash-starved backdrop, the front-end cost risk shifted to consumers is a significant problem for half or more of US families. Only 11 percent of households with $2,500 deductibles actually meet the deductible in a year, and only 4 percent of those with $5,000 deductibles meet theirs (Boland and Gibson 2014). When people have major cost-sharing responsibilities, they shy away from using healthcare if they possibly can. What's more, they don't pay the medical bills incurred when care use is unavoidable.

How Will Healthcare Payment Evolve?

Hospitals are laboring under questionable assumptions about where healthcare payment is heading in the future. The chorus is deafening: We're moving "from volume to value" and

"from fee-for-service to population-based payment." Count me a skeptic! Fee for *fill in the blank*—for example, a few pennies for each core measure achieved—is not fee for value. It's fee for compliance. Rather than fee for value, we're far more likely to see "no fee for bad value."

In any case, the ultimate arbiter of value is not going to be the Centers for Medicare & Medicaid Services or the National Committee on Quality Assurance. The final arbiter of value in a consumer-driven marketplace is going to be hard-pressed American consumers and where they choose to spend their limited household cash.

Nor is "population health–based" provider payment an inevitable outgrowth of increasing consumerism. I emphatically disagree with the conventional wisdom that activated consumers will force health insurers to shift risk to providers through population health—a model also known as capitation or two-sided risk. Because 70 percent of metropolitan health insurance markets are, to use the US Department of Justice's descriptor, "highly concentrated"—that is, dominated by one or two health plans—there is no need for these market owners to shift risk and, thus, share their profits (AMA 2013).

Whether the majority of *Futurescan* survey respondents really will participate in ACO-like arrangements, as they believe, depends on private insurers' willingness to contract with them on that basis. It might also depend on a shift of the regular Medicare program to an ACO model, which seems unlikely given the checkered results of the ACO demonstrations thus far.

Hospitals' Strategic Response to Uncertainty

How are hospitals responding strategically to the cessation of revenue growth and the rapid shift of economic risk to families? Well, in classic fashion, hospitals and systems have zeroed in on the revenue side of their business. By merging with local providers or systems, hospitals have counted on being able to drive up their prices by becoming unavoidable. Though taking out duplicative costs is given lip service in merger plans, the main event is getting tough on the marginal payers in local markets.

Hospitals have also embraced, though with greater caution, selective contracting through ACOs or captive health plans, replaying a 1990s script that, with a few notable exceptions, ended badly. Believing that payers, including Medicare, will be drawn to *their* clinically integrated network rather than others', many hospital systems have assumed that they can make up for reduced clinical volumes by taking market share from the less well-organized or less impressive local alternatives.

Neither of these revenue-focused strategies seems to be turning out much better than they did two decades ago (Goldsmith and Goran 1996).

Implications for Hospital Leaders

Managing your costs is a vital strategic lever. Future margins will depend on driving down your costs and solving the affordability problem. Consumer cost sensitivity has two different dimensions depending on the type of service: gateway costs and unavoidable costs.

Excessive gateway costs—emergency department costs, diagnostic imaging costs, primary care visit costs—will turn away patients and potentially deflect any downstream clinical volumes to other, less expensive providers. Another 1960s term that will not survive this period is "ancillary" services. Today, most hospitals barely break even on their inpatient care; the lion's share of profits comes from so-called ancillaries. In a risk-sensitive world, diagnosis is at least half of the product. Diagnosis done mindlessly will lose you both dollars and patients.

Managing down the cost of ambulatory episodes is going to be vital to avoid diverting patients to less expensive competing alternatives—whether freestanding, physician sponsored, or sponsored by less complex hospitals nearby—because more than 70 percent of today's hospital admissions come from the emergency room (ER). If the ER sends heart-stopping bills to patients, then patients will work hard to find cheaper alternatives. Creating lower-cost settings for the provision of ambulatory services through network development will be vital, as *Futurescan* survey respondents seem to realize.

Price competition will likely occur first in portable services. There's no practical reason a CT scan has to cost patients $3,000. A CT scan will eventually cost $300. If your strategy is to milk these vital diagnostics for every short-term penny, you'll end up surrendering control over the pathways that lead patients into and through your care system. Shortening visit times, using protocol-driven diagnostic pathways that avoid unnecessary testing, and substituting medium-priced nursing care for higher-priced physician care—all are components of cost-sensitive ambulatory care.

Managing unavoidable care costs is a more difficult challenge. Managing the costs of unavoidable care, such as intensive care services, trauma treatment, and scheduled complex interventions for cancer and cardiac conditions, will be required for different reasons:

to avoid incurring massive losses from the difference between your expenses and the fixed payments from Medicare and commercial payers, and to avoid accumulating bad debts from people who cannot afford the patient portion of a $50,000 hospital bill.

The reality is that "reimbursement" for Medicare inpatient costs died in 1984 with the institution of diagnosis-related group–based payment, because payment was fixed per hospitalization in advance. It is remarkable how few hospital executives fully realize that every dime they save today on avoidable care costs for regular Medicare inpatients drops through to the hospital's bottom line. Regular Medicare continues to be an untapped reservoir for hospital cash flow in most institutions.

Hospitals have important new tools for containing unavoidable care costs: their employed or contracted hospitalists and intensivists who control resource consumption during the hospital stay. Few hospitals, however, make purposive use of these providers. Excessive consultation expenses, unnecessary testing, and leisurely length-of-stay management all cost the hospital in a fixed-payment environment. And the failure to communicate effectively with the patient's primary care physician, who typically no longer visits the hospital, may diminish the probability of the patient's return.

Whether it makes sense to employ hospital-based specialists and other physicians, as *Futurescan* survey respondents seem to believe, or to contract for their services from local or national firms specializing in their clinical area, will ultimately be determined by cost, physician job satisfaction, and logistical factors.

A flawless patient experience directly contributes to the likelihood of a return visit. Many hospital leaders fail to connect the patient and family experience to the likelihood of repeat business. Clinical and management routines that waste the patient's time or inflict harm through avoidable clinical errors damage the market standing of the hospital, particularly when Hospital Consumer Assessment of Healthcare Providers and Systems patient satisfaction scores are freely available online.

Smoothing and lighting the patient's path through the hospital will increase the likelihood of repeat business. Shortening visit times, preclearing patients financially, gathering vital patient history and diagnostic information, and communicating test results electronically through a patient portal all improve the patient experience and lead to higher Net Promoter Scores.

Empowering frontline caregivers also helps control costs and improve the patient experience. Often, frontline caregivers feel powerless to affect the clinical and administrative routines that add cost and waste clinicians' and patients' time. In institutions that have adopted Lean operating principles, frontline caregivers can stop the line if they spot a quality or safety issue and initiate process improvements. Hospitals are also eliminating layers of management that separate those frontline caregivers from senior management, broadening spans of control, and increasing accountability for performance.

Although middle management is a potential reservoir of future executive talent, all too often it is a thick layer of insulation that conceals operating problems from senior management. The concept of administrative rounds is also returning to the hospital, as senior executives are making operational improvements and better communication with the shop floor a key strategic priority. Empowered frontline caregivers can change the patient value equation and are likely to stick around to teach the next generation. FS

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4. VOLUME TO VALUE CHOOSING YOUR STRATEGY FOR VALUE-BASED COMPETITION

by John M. Harris and Bonnie Frazier

About the Authors

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For decades, hospitals have vigorously competed for patients, physicians, and market prominence. But the impending transition from volume to value may transform our perspective on what it means to compete. Call it disruptive innovation, aggressive competition, game-changing strategies, or betting the farm. The coming years are likely to be a high-stakes wild ride.

In the new environment, you must decide on your best strategy based on a deeper understanding of your own organization, your competitors, and the market dynamics driving competition.

Real Competition

Many healthcare theorists have been calling for increased competition based on value as a means to drive improvement throughout the healthcare system. Now the traditional barriers to competition are starting to peel away (Exhibit 4.1), spawning a highly competitive market based on the value of services purchased. The payer world is driving much of the change through benefit design and contracting changes, which are having a profound impact on providers. The speed and degree of this impact vary and should be monitored for each local market.

With the shift from volume to value, the healthcare industry is experiencing something closer to true competition than it ever has before, forcing providers to concentrate on value. To succeed in this environment, hospitals and health systems must focus on lowering the total cost of care and improving quality and the patient experience.

Insurance marketplaces under the Affordable Care Act fuel competition by allowing individual choice. Consumers may choose to purchase insurance based on their budgets, forgoing expensive providers in exchange for lower premiums or co-payments. Consumers can also compare quality and satisfaction scores to guide their choice. Though these choices are primarily available to participants on the public insurance marketplaces, private insurance marketplaces could bring similar dynamics to a greater proportion of the population. And given that hospitals have high fixed costs, even small shifts in market share can have a significant financial impact.

As competition increasingly focuses on value, providers are seeking to manage the total cost of care while improving quality and increasing patient satisfaction.

Exhibit 4.1 Increasing Competition in Healthcare

Historical Barrier to Competition	New Competitive Environment
Employers select health plans with broad networks to avoid upsetting employees.	Individuals select health plans on insurance marketplaces, increasing the likelihood that some will choose a narrow network plan (trading choice for lower premiums).
Rich benefits plans buffer patients from costs.	High-deductible health plans increase price sensitivity among consumers.
Patient out-of-pocket costs are the same for high- and low-cost providers.	Differential co-payments based on provider pricing increase consumers' ability to shop by price.
Fee-for-service payments are adequate to meet physicians' income goals.	As fee-for-service payments tighten, physicians are more willing to take responsibility and be rewarded for managing population health costs.
Only a small minority of payers provide incentives to manage costs; insufficient incentives exist for providers to change focus and transform care delivery.	As Medicare, many Blue Cross plans, and national health plans reward providers for managing quality and cost, there is critical mass for providers to pursue these strategies.
Health plan quality is not rewarded.	Medicare Advantage payments reward high-quality plans; ACOs must meet quality standards to receive incentive payments; Medicare Bundled Payments program recognizes performance in quality metrics.
The inability to define quality and measure performance weakens purchasers' ability to compare provider value.	Increasing acceptance of quality indicators and efforts to aggregate data create more accountability for quality.
An imbalance of information means patients usually relinquish control of healthcare decision making to their physicians.	Mobile apps and Internet information sources enable patients to be more active in their medical decision making and to be more informed consumers of healthcare.

With this motivation, three major strategies are crystallizing. The first is the most commonly discussed: health systems becoming accountable for population health costs and quality. The second strategy is a reaction to possible market developments that put physician entities at the center of managing population health. The third strategy focuses on low unit costs as the means to attract market share.

Accountability for Population Health

Most advisors encourage hospitals and health systems to develop the capabilities to become accountable for population health. Strong systems can tie in patient populations and provide care at a lower overall cost by minimizing avoidable admissions and services.

A population health strategy promises to improve quality and the patient experience through better coordination of care. Our disjointed healthcare marketplace still has plenty of room for this, and a strategy focused on population health is a good vehicle for driving such improvements.

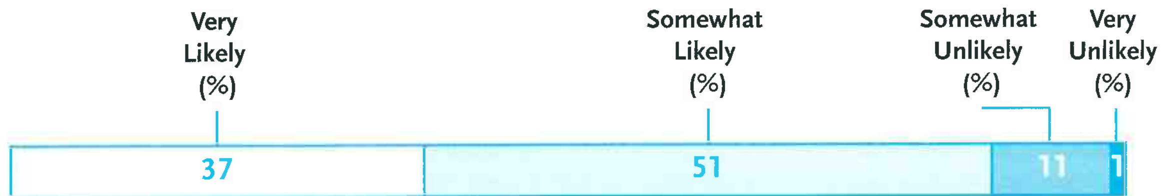
This strategy includes arrangements with payers to share savings or otherwise reward success in managing population healthcare costs. However, these models often drive down the use of hospital services, and the shared savings or other incentives typically do not make up for the revenue decline. Systems pursuing a population health strategy must gain market share to offset potential volume and revenue decreases.

Some providers have resisted population health strategies for fear of driving down utilization and not securing the necessary market share gains. However, health system leaders increasingly recognize that if they do not manage utilization, competitors will do it for them. Those competitors can be other health systems grabbing market share or physician entities such as those described in the second strategy.

FUTURESCAN **SURVEY RESULTS:** Volume to Value

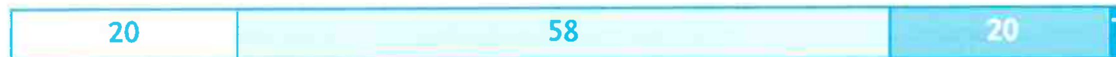
A **narrow network** provides a more limited choice of physicians and hospitals to health plans in exchange for net lower plan costs.

How likely is it that the following will be seen in your hospital's area by 2020?



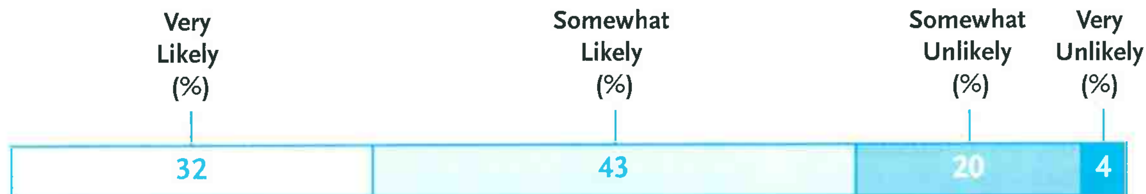
Higher-cost hospitals will see a greater decrease in volume than lower-cost hospitals.

Large independent physician entities will be more successful at managing the total cost of care than entities that include hospitals along with physicians.



Hospitals will be able to increase volume in their service lines by offering bundled payment arrangements.

How likely is it that the following will be seen in your hospital by 2020?



More than 20 percent of your hospital's patients will be covered by a narrow network insurance product in which your hospital participates.

Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

Higher-cost hospitals will experience greater decreases in volume. Most (88 percent) of those answering the survey predict that higher-cost hospitals will experience a larger decrease in volume than will lower-cost hospitals by 2020.

Total cost of care will be equally or better managed by entities that include both hospitals and physicians than by those with physicians alone. Survey respondents are more divided on this question, but the majority (60 percent) consider it unlikely that large, independent physician entities will be better able to manage the total cost of care by 2020 than will entities that include both physicians and hospitals.

Bundled payment arrangements may help increase volume in service lines. A little more than three-quarters (78 percent) of those responding to the survey predict that, over the next five years, offering bundled payment arrangements could increase volume in hospital service lines.

Narrow networks will cover at least 20 percent of patients. About 75 percent of survey respondents think that by 2020 at least one-fifth of their patients will be covered by a narrow network health plan.

While a population health management strategy allows organizations to align clinically and financially with both providers and patients, fully realizing this strategy requires significant resources and critical mass. Success requires organizational cooperation, physician onboarding, patient engagement, and a major investment in information technology and data management capabilities. All of these components require time, scale, coordination, and financial investment. Antitrust concerns could prove to be a barrier to reaching the critical mass required to support this investment, particularly in smaller markets.

The end game for some health systems is to vertically integrate and develop an insurance capacity as well. Whether health systems become insurers or simply contract with insurers on a value basis, the success of a population health strategy will depend on how competition evolves among and between providers and payers in each local market.

Physician Networks: Partnering with Potential Disruptors

Health systems will need to keep an eye on physician networks because these potential disruptors can leverage their patient relationships and be rewarded by health plans for managing population health. Patient-centered medical homes, physician-sponsored ACOs, and risk deals give primary care physicians the opportunity to partner with health plans and keep population health savings for themselves, treating hospitals as cost centers. In a more extreme extension of this approach, some health plans are acquiring primary care practices.

Will physicians succeed at this strategy? Fewer than half (40 percent) of *Futurescan* survey respondents think it likely that large, independent physician entities will be more successful at managing the total cost of care than will a joint physician–hospital entity. It can be difficult for physicians to invest sufficiently to succeed in these models. Half-hearted efforts are likely to yield poor results.

Yet physician groups do have the potential to compete successfully. Many physician groups could be fierce competitors. Even relatively small groups can drive down hospital utilization and shift referrals to lower-cost or more cooperative hospitals.

Physician disruptors are not limited to primary care. In a more narrowly focused example of this strategy, some specialists are using bundled payments to retain the savings they achieve in orthopedics and cardiac care. If this is the situation in your market, it may be beneficial to position yourself as a potential partner to these physician groups, bringing them under an umbrella of affiliation and integration from which both parties benefit. Close alignments can provide some of the benefits of physician employment without the high price tag that most employment models bring.

Connecting to physician networks that are pursuing population health strategies comes with a price tag. They will expect cooperation and support in managing the flow of care and good pricing to support payer contracts that reward them for managing care costs. Finally, physicians will want to be sure that care is provided in the most cost-effective setting. High-priced hospital outpatient services will likely be bypassed in favor of lower-cost freestanding alternatives.

Lower Unit Costs: The Alternative

If robust population health capabilities are not on your organization's horizon, the path to success could be in becoming a low-cost provider. Although less trendy than a population health focus, this strategy can be effective.

At its core, the total cost of care is a function of the number of units multiplied by the cost per unit. Even in value-based payment models, somewhere in the mix there is a unit of service and a cost identified for that unit.

The population health strategies described in this essay focus on reducing the number of units, particularly units of service that can be avoided, such as hospitalizations for uncontrolled diabetes. In a market with competition based on total cost of care, hospitals focus on population health strategies so they can retain higher per-unit payments by not wasting resources on avoidable services.

As prices of healthcare services become more transparent, hospitals and health systems that are able to point to good quality scores and low costs may be able to compete effectively with market-specific brands, attracting the volume required for success. Looking toward 2020, almost 90 percent of *Futurescan* survey respondents believe that higher-cost hospitals will see a greater decrease in volume than lower-cost hospitals.

Several competitive mechanisms may drive this shift. Consumers at risk for costs may choose lower-cost providers. Physician entities pursuing population health strategies may steer patients to lower-cost providers so they can perform better in their insurance contracts. Health plans may narrow or tier their provider networks to steer patients to lower-cost providers.

When competing for inpatients, lower-cost hospitals will be able to tap into these competitive mechanisms to gain market share.

However, competing for outpatient services will be more difficult. Almost every hospital is high cost relative to a freestanding outpatient provider.

A key risk of the lower-unit-cost strategy is being squeezed out of the market by hospitals that pursue a population health management strategy and control referrals. In the long run, those hospitals will not be able to maintain pricing that is above what the market will bear, but in the short run they could limit patient access to lower-cost providers. Be sure you have access to patients through payer contracts and alignment with physicians.

For some organizations in certain markets, focusing on becoming a lower-cost provider may be a better strategy than developing population health management capabilities.

Implications for Hospital Leaders

Understand market players. Consider your competitors and their strategies. Going head-to-head with the strongest competitor is rarely the best strategy. Instead, determine what opportunities that competitor's strategy creates for your organization.

You will need to determine which strategy will support success in your market—and whether or not you will be able to achieve that success on your own. Conducting a full evaluation of potential partners will help you decide which healthcare organizations or physician groups, if any, might be a good fit.

Consider physician strategy. If you are pursuing a population health strategy, including both independent and hospital-employed physicians in a clinically integrated network (CIN) can be an effective approach. Be sure physicians have a strong leadership role and see the value of the CIN through appropriate rewards.

Although many organizations believe that employment is a surefire way to secure your market position, you can never "own" your physicians. Contracts eventually end, and physicians who are uninspired by their employment arrangements and role in the health system may seek alternatives. If independent groups are being rewarded by health plans in a population health strategy, they may be able to offer higher compensation.

Set a payer strategy. Monitor payer initiatives closely. The traditional strategy of negotiating for the highest rate may drive away volume as consumers or physicians choose lower-cost providers. If payers are driving change through physician incentives, then that behavior will bolster a population health strategy led by physician groups. If payers are willing to partner with hospitals for population health, a hospital-driven population health strategy may be viable.

Slim down. Whether your organization pursues a population health management or a lower-cost strategy, keeping the cost of operations under control will increase the chances of success. If you are pursuing a population health strategy through a CIN, traditional approaches to managing operating costs can be bolstered through actively engaging physicians in these efforts.

Consider teaming up. All of these strategies beg the larger question of whether you need to merge or affiliate with a larger entity to succeed. Assessing your strategy based on a competitive analysis will help you make that decision.

Getting on Board or Going Overboard?

In this new competitive environment, there will be winners and losers.

The challenge will be to select your strategy and gauge how much, how quickly, and in what way your local market will move into this age of intensified competition. If you move too quickly, you may reduce operating margins. At the same time, being last to the party will also threaten market share.

Conclusion

The best strategy for your organization will depend on the degree and speed of transformation toward value-based competition in your market. The days of five-year plans and linear projections of utilization and revenue are long gone. As the shift from volume to value causes competition to intensify, healthcare organizations will need new and more sophisticated ways to analyze strategic alternatives. FS

5. INNOVATIONS IN PRIMARY CARE THE KEYS TO EFFECTIVE AMBULATORY–HOSPITAL INTEGRATION

by Michael Hochman, MD

About the Author

Michael Hochman, MD, MPH, is a board-certified general internist who graduated from Harvard Medical School. He completed his residency in internal medicine at the Cambridge Health Alliance in Cambridge, Massachusetts. He also completed a Robert Wood Johnson Foundation Clinical Scholars fellowship at the University of California, Los Angeles. Currently, Dr. Hochman is the medical director for innovation at AltaMed Health Services, a multisite medical group in Southern California and the largest independent community health center in the nation. At AltaMed, Dr. Hochman leads efforts to refine the patient-centered medical home model of care. Dr. Hochman also has published original research in top medical journals and recently authored *50 Studies Every Doctor Should Know* (Oxford University Press, 2013).

In response to pressures to deliver high-quality, patient-centered care at low cost, health systems are scrambling to integrate ambulatory and inpatient care. Indeed, the *Futurescan* survey results indicate that most healthcare executives (87 percent of respondents) believe accountable care networks that share risk between hospitals and ambulatory providers will be established in their area by 2020.

Health system integration offers a myriad of opportunities—a coordinated experience for patients as they transition between the inpatient and outpatient settings; improved information exchange between hospitals and ambulatory providers; economies of scale from the sharing of resources; and the opportunity for more sophisticated payment models that reward comprehensive longitudinal care, to name a few.

Key to the success of health system integration will be primary care. Data indicate that health systems built on a solid primary care infrastructure provide better value than do systems with poorly developed primary care (Starfield, Shi, and Macinko 2005). In addition, through innovation and creative thinking, primary care providers can bring even more value to health systems in the years ahead.

Trends

Demand for primary care health professionals will rise. Primary care capacity correlates directly with a health system's ability to grow. A large proportion of Americans are already enrolled in managed care insurance products that attribute patients to health systems on the basis of their primary care provider, and 75 percent of *Futurescan* respondents believe that by 2020 more than half of the patients in their area will be covered through managed care products. Additionally, patients with fee-for-service insurance will increasingly become part of networks, such as accountable care organizations, that attribute patients on the basis of their primary care provider.

Thus, health systems that hope to grow will need to expand their primary care capacity. They can do so either by increasing the supply of primary care providers or through thoughtful innovation.

Primary care delivery will evolve toward a team-based approach. Despite the growing demand for primary care providers, fewer physicians are choosing careers in primary care, particularly in adult medicine.

To meet the growing demand for primary care capacity in the face of this supply-versus-demand

mismatch, an increased emphasis will likely be placed on team-based care (Bodenheimer and Smith 2013). By optimally using different team members, primary care clinics will be able to care for more patients without necessarily hiring more primary care physicians. Studies have demonstrated, for example, that clinical pharmacists can safely and effectively manage medications for patients with chronic conditions such as diabetes, hypertension, and even heart failure (Johnson et al. 2010). Similarly, medical assistants under protocol can provide routine preventive care, such as vaccinations and cancer screenings; nurses, health educators, and dieticians can provide counseling and education to patients; and midlevel providers (physician assistants and nurse practitioners) can provide most stable chronic disease care and basic acute care services.

To promote this team-based approach, the role of primary care physicians will likely evolve. Currently, the majority of primary care physicians spend most of their time delivering direct patient care, mostly to relatively healthy patients. Greater use of team members such as pharmacists, medical assistants, nurses, and health educators will enable physicians to focus their attention on the most complex medical situations. Physicians, particularly those with strong leadership skills, will also increasingly be called on to serve in leadership roles and to help improve systems of care.

Patients will interact with primary care teams in new ways. Most patient interaction with primary care providers currently occurs in office settings. In response to the growing demand for primary care services coupled with patient demands for convenience, patient–physician interaction will likely shift away from the traditional office visit and toward alternative mechanisms.

Specifically, patients will increasingly interact with their care team by phone, e-mail, and other forms of electronic communication (e.g., patient portals). Much of what currently occurs during a traditional office visit could be done just as effectively—and more efficiently for both the patient and the health system—by phone or electronic communication. For example, rather than scheduling an office visit to review blood sugar readings, a patient could e-mail this information through a secure portal to a physician or pharmacist, who could then review the readings and adjust medications.

Growing evidence also suggests that many patients enjoy and benefit from group visits (Burke and O'Grady 2012). At such visits, patients with chronic conditions, such as diabetes or depression, can learn from each other while receiving tailored advice from healthcare providers.

Finally, new technologies will enable more specialty care to occur in the primary care setting. For example, retinal cameras allow patients with diabetes to be screened for visual complications in the primary care office, with the images then sent to an ophthalmologist for review. In addition, through "e-consult" programs that enable primary care providers to receive advice from specialist providers without a formal referral, conditions such as hepatitis C can be managed in the primary care setting.

Most of the technologies that will enable these new types of interactions—telephones, e-mail, and even retinal cameras—are not new. The biggest barriers to implementation are reimbursement systems that cover primarily face-to-face interactions and a medical culture that is skeptical of change. However, as payment systems evolve and the need for more primary care capacity grows, use of these alternative forms of interaction will steadily increase.

There will be greater integration of behavioral health in primary care. It is becoming increasingly clear that behavioral health and primary care overlap significantly (Tew, Klaus, and Oslin 2010). Indeed, a large proportion of primary care interactions involve mental health concerns, and mental and physical health are clearly intimately related.

For this reason, the trend toward integration of behavioral health in primary care will likely continue. Specifically, mental health professionals—such as clinical psychologists, licensed clinical social workers, marriage and family therapists, and even nurses and health educators with specialized training—will become a part of the primary care team.

Innovations will focus on high-utilizing patients. Some of the most successful and cost-effective primary care innovations have focused on patients who utilize the emergency room (ER) or hospital frequently. For example, as part of a successful primary care redesign effort at the Group Health Cooperative in the Pacific Northwest, patients with acute illnesses were encouraged to contact their primary care provider before visiting the ER, and the clinic team provided outreach to patients admitted to the ER and hospital (Reid et al. 2010). Other successful demonstrations have revealed that care coordination at the time of hospital discharge is an effective strategy for transitioning patients back to their primary care team and reducing readmissions (Jack et al. 2009).

Results from the *Futurescan* survey indicate that many hospital systems are well on their way to

How likely is it that the following will be seen in your hospital's area by 2020?

Accountable care networks with at least some degree of joint financial risk sharing between hospitals and ambulatory providers will be established.

Electronic health information exchange will take place between hospitals and more than half of the ambulatory practices in the community.

Care coordinators will regularly work with most patients over time across inpatient and ambulatory settings.

The majority (more than 50 percent) of insured patients will be enrolled in a managed care product that reimburses ambulatory providers through capitated arrangements (rather than fee-for-service).

Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

Accountable care networks will be established. Most respondents (87 percent) think that accountable care networks that share risk between hospitals and ambulatory providers will be established in their hospital's area by 2020.

Electronic health information sharing between hospitals and most ambulatory care providers will be established. Almost all (93 percent) of those responding to the survey predict that hospitals will be exchanging electronic health information with more than 50 percent of the ambulatory care providers in their area within the next five years.

Patient care will be coordinated across settings. Those participating in the survey agree that care coordinators, who will manage patient care over time and across treatment settings, will become common. About 95 percent of survey respondents predict that this coordination will be in place in their hospital's area by 2020.

Most patients will be enrolled in managed care products. Of the survey's respondents, 75 percent consider it likely that more than half of the patients in their area will be covered through capitated arrangements, rather than fee-for-service, by 2020.

providing longitudinal care coordination for their high-utilizing patients. About 95 percent of survey respondents predict that care coordinators, who manage patient care over time and across treatment settings, will be in place in their hospital's area by 2020.

Implications for Hospital Leaders

The trends in primary care described in this essay have important implications for hospital leaders as health system integration proceeds in the coming years.

Health systems should demand collaboration from primary care professionals in exchange for greater reimbursement. The growing demand for primary care providers will likely lead to an increase in salaries for many primary care professionals, including physicians, midlevel providers, nurses, pharmacists, medical assistants, and other ancillary staff. Indeed, this appears to have happened in Massachusetts following implementation of statewide healthcare reform and already seems to be happening nationwide as a result of the Affordable Care Act.

Choosing good primary care partners is, of course, no easy task. Hospital and health system leaders will need to invest considerable time in identifying primary care professionals (both physicians and other staff) who possess the skills and personality needed to be effective clinical leaders. Such qualifications are not always easily measured through traditional quality scores or a single interview. Hospitals and health systems will need to recruit primary care providers who are willing to check on their patients after they are admitted to the hospital, to call specialists to discuss complex situations, and to collaborate to address system challenges.

Hospitals and health systems might also consider specifying in contracts how primary care providers will be held accountable for their outcomes. What will happen if their quality scores, utilization rates, or patient experience scores are worse than industry benchmarks? Both carrots and sticks will likely be necessary.

Health systems should align financial incentives to promote effective primary care innovation. Most of the innovations described in this essay are contingent on appropriate alignment of financial incentives. Traditional fee-for-service reimbursement encourages "churning" through patients, with less emphasis on quality, service, and care coordination. In contrast, risk-bearing contracts that reward high-quality, cost-efficient care promote innovations that achieve these outcomes.

The literature suggests that where fee-for-service payment systems prevail, primary care reform efforts have led to only modest improvements in the quality of care and have not controlled costs (Crabtree et al. 2010). However, where financial incentives are aligned, reforms have had a more favorable impact. For example, at the Group Health Cooperative—an integrated delivery system that assumes full financial responsibility for its members—a primary care demonstration led to improved quality and lower overall costs (Reid et al. 2010).Thus, to promote effective primary care innovations, hospitals and health systems should favor contracts that effectively reward high-value care and should ensure that these incentives are relevant for primary care providers. Such contracts will enable primary care providers to be creative and innovate to improve value (Schroeder and Frist 2013).

Hospitals should lead efforts to promote health information exchange. Many of the most important innovations in primary care—for example, those focused on improving care for high-utilizing patients—require effective information exchange between ambulatory providers and hospitals. Real-time notification of primary care providers when their patients are admitted and discharged from the hospital and timely transmission of discharge information can greatly improve care coordination during high-risk care transitions. Health systems that succeed in establishing easy-to-use electronic health information exchanges will have a leg up on systems that do not.

Results from the *Futurescan* survey indicate that almost all respondents (93 percent) predict that hospitals will be exchanging electronic health information with more than 50 percent of the ambulatory care providers in their area within the next five years. Yet, in many settings, health information exchange has proven more challenging than many had anticipated because of technical glitches, concerns about protected health information, and proprietary interests. Hospitals are best equipped to overcome these barriers, and those that do will take important strides toward effective partnerships with ambulatory providers.

Conclusion

In the coming years, integration of hospital and ambulatory care is likely to grow, and the success of these efforts will depend greatly on the development of effective primary care systems. To enable primary care to thrive, hospitals and health systems must ensure appropriate financial alignment so that primary care providers can innovate effectively. This alignment likely means a shift towards risk-bearing arrangements with incentives for

high-value care. Hospitals and health systems can also facilitate collaboration and partnership with primary care providers by leading efforts to develop electronic health information exchange. In return, hospitals and health systems must demand collaboration from primary care providers. When effectively integrated, primary care providers can play a central role in driving value across a health system. FS

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6. PRIVATE INSURANCE EXCHANGES THE IMPACT OF PRIVATE EXCHANGES ON HEALTHCARE PROVIDERS

by Gunjan Khanna, PhD, and Shubham Singhal

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Since World War II, employers have provided health insurance for a large percentage of Americans. In 2000, for example, 65 percent of the population had healthcare coverage through their employer or a family member's employer (DeNavas-Walt, Proctor, and Smith 2013). In recent years, the number of people covered by employer-sponsored insurance (ESI) has shrunk because of demographic changes, economic pressures (especially ever-rising healthcare costs), and other factors. Nevertheless, McKinsey research shows that ESI remains the largest segment of the health insurance marketplace, currently covering about 52 percent of Americans.[1]

McKinsey research also indicates that ESI is likely to remain the predominant form of health insurance for at least the next several years. The ESI landscape, however, is shifting. Some employers have dropped coverage for spouses, retirees, or part-time employees. Others have migrated employees to individual coverage on the public exchanges. A growing number of employers are moving to private exchanges, often under a defined contribution model.

Private Exchanges Today

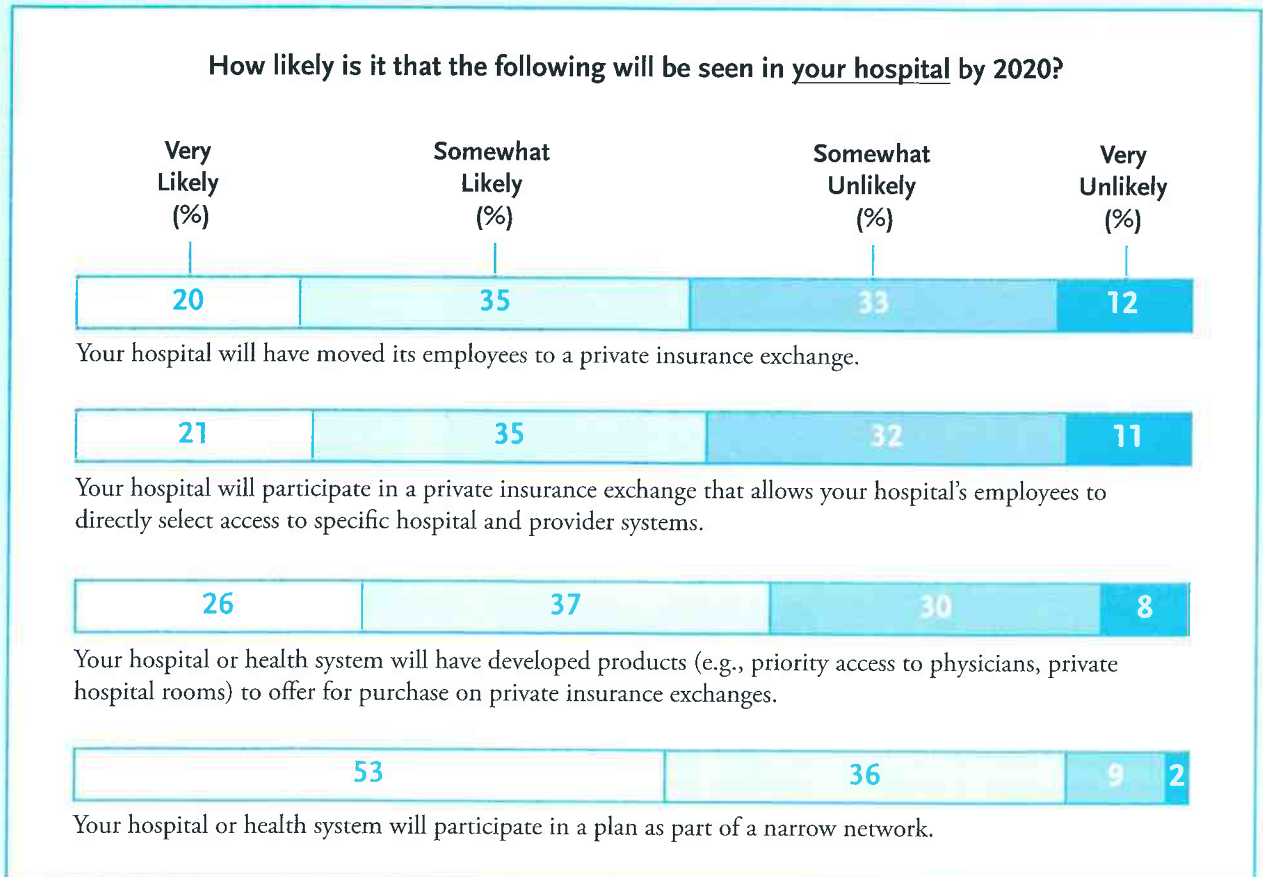
Private exchanges can be defined in multiple ways. In their simplest form, they are online, employer-sponsored marketplaces that enable employees or retirees with ESI to select the coverage they want from among a variety of health plans with different features. In many cases, employers contribute a fixed sum (the defined contribution) for each employee or retiree, which that person can use to purchase a health plan and, often, other types of products (e.g., vision or dental coverage, wellness programs, life or disability insurance). The range of choices enables employees to select the products that best meet their needs and forgo those from which they think they will derive little or no value.

Because private exchanges are relatively new, their market remains in flux. Benefits consultants currently dominate the market, offering employers either exchanges containing several health plans from the same insurer or platforms with plans from multiple carriers. Some health insurers, however, have already developed their own exchanges, and others are likely to follow their example.

Private exchanges for retirees have existed for at least five years. We estimate that these exchanges currently cover about 1.1 million of the country's 12–15 million retirees with ESI. Government regulations permit employers to fund individual Medicare Advantage (MA) or Medicare Supplement plans, which have broader risk pools than traditional ESI plans typically have. Furthermore, the retail Medicare market (individual MA or Medicare Supplement) is highly competitive. As a result, individual MA or Medicare Supplement plans are usually less costly than traditional group Medicare coverage. McKinsey research suggests that most organizations providing ESI coverage to retirees are likely to consider private exchanges,

Private insurance exchanges are marketplaces run by employers solely for their employees. On these marketplaces, employers contribute a fixed monthly amount (defined contribution) and employees select their own healthcare plan. Many exchanges also offer supplemental benefits (e.g., dental, life) for purchase by employees.

A **narrow network** provides a more limited choice of physicians and hospitals to health plans in exchange for net lower plan costs.



Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

Practitioners are divided about the likelihood of providing coverage to hospital employees through private insurance exchanges. Those responding to the survey disagree about whether their hospital's employees will be covered by a private insurance exchange product within the next five years. A slight majority (55 percent) think it likely, while 45 percent think it unlikely. Survey respondents are divided in nearly identical proportions about whether hospitals will participate in private exchanges that allow their employees to directly select access to specific hospitals and provider systems, with about 56 percent believing such participation is likely by 2020 and the remainder believing it is not.

Hospitals may develop products for purchase on private exchanges. A small majority (about 63 percent) of survey respondents think that by 2020 their hospital or health system will have developed products, such as priority access to particular physicians or private hospital rooms, for purchase on a private insurance exchange.

Most hospitals will participate in narrow networks. Almost all (89 percent) of those surveyed predict that their hospital will participate in a narrow network by 2020.

and many will make the move. Although some analysts have predicted that almost all such retirees will be switched to these exchanges in the not-too-distant future (Benjamin and Taylor 2013), our analysis suggests a large-scale migration is unlikely given that in some cases (e.g., heavily unionized companies) the move may not be feasible.

Private exchanges for active employees are newer. Our estimates suggest that these exchanges currently cover only about 1.6 million people[2]—less than 1 percent of the more than 170 million employees and family members insured under ESI plans. At present, private exchanges for active employees are being implemented largely by cost-pressured companies with lower-wage employees, in the belief that the exchanges will enable the companies to better control their healthcare spending (Khanna et al. 2014). Whether this belief is accurate remains to be proved.

The Future of Private Exchanges

How widely (and quickly) the active employee exchanges will spread remains unclear. McKinsey research indicates that most employers remain committed to supporting their employees' health and are cautious about making major changes to their benefits structure. Nevertheless, we expect that an increasing number of cost-pressured companies will adopt private exchanges, especially if the exchanges are proved to help control employers' healthcare spending.

As private exchanges mature, they may become attractive to a wider range of employers, especially if the options they include continue to expand. According to McKinsey research, two types of employers are most likely to join cost-pressured companies in adopting private exchanges (Khanna et al. 2014). The first is employers focused on talent attraction, retention, and satisfaction (e.g., financial, insurance, and technical firms). These employers could use the exchanges to gain competitive advantage by offering especially rich benefits packages. The second is organizations whose current benefits structure leaves them at risk for paying an excise tax on high-cost employer-sponsored health coverage, commonly referred to as the Cadillac tax, in 2018 (e.g., many healthcare providers, public sector and educational groups, unionized companies). Fixed contributions to private exchanges might enable these organizations to continue offering generous benefits while reducing their exposure to that tax (Adams 2013).

Depending on the rate of employer adoption, anywhere between about 3 million and 38 million active employees and their family members could be covered through private exchanges within five years (Exhibit 6.1). Assuming a moderate rate of adoption (which we believe is the likely scenario), approximately 21 million people could be covered under exchanges for active employees by 2019 (Khanna et al. 2014).

Futurescan Survey Results

The *Futurescan* survey results largely support our view that the adoption rate of private exchanges is likely to be moderate and that even employers at risk for the Cadillac tax (e.g., many healthcare providers) will be cautious about making a switch to these exchanges. The survey respondents were clearly split in terms of whether they saw such a move as a real opportunity for their employees. Only 20 percent of them indicated that they would be very likely to adopt private exchanges, and almost equal percentages of respondents said that such a move was somewhat likely or somewhat unlikely. Furthermore, the percentages did not change appreciably when the respondents were asked specifically about private exchanges that would enable their employees to directly select their providers.

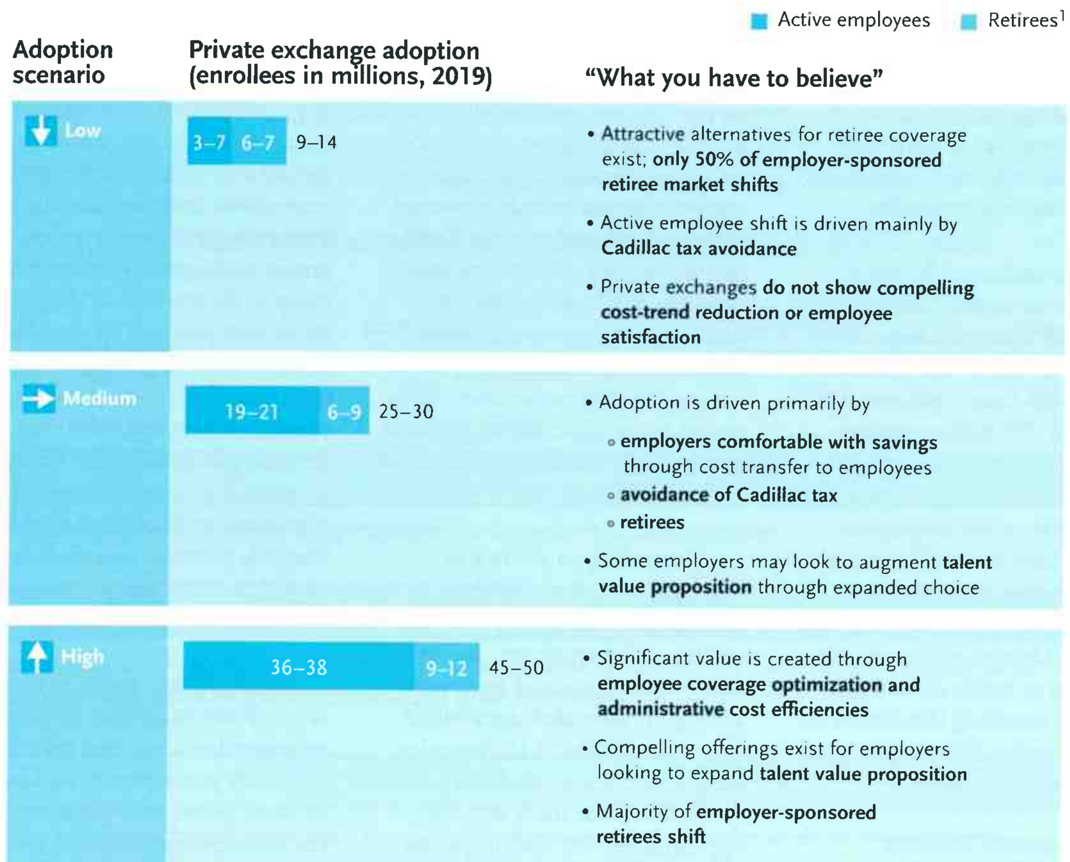
In our experience, many provider executives currently view private exchanges more as a sales opportunity than as an option for their employees. This position may explain why a larger percentage of respondents indicated that their institutions will develop products for private exchanges. We suspect that many of those who said they would create new products are executives at health systems that offer a broad spectrum of services or have a large network of hospitals. However, the examples listed in the survey question (e.g., priority access to a physician) could be developed by hospitals or health systems as supplemental products that consumers could buy on top of their insurance.

Given current industry trends, it is not surprising that 89 percent of respondents reported that they will likely participate in narrow-network plans. Such plans may be the most straightforward way for them to enter the private exchange market. However, we caution hospitals and health systems that negotiate with insurers about narrow-network participation to carefully estimate how many of the people who will be referred to them by the narrow networks will come from their existing patient population.

Implications for Hospital Leaders

If private exchanges become common, they will present both challenges and opportunities for healthcare providers. Our research, including a private exchange simulation involving more than 3,000 consumers, suggests that many of the people who are shifted to private exchanges may purchase health plans that cost less than their defined contribution and then spend the balance of that contribution on supplemental or ancillary products, such as dental, vision, or

Exhibit 6.1 Private Exchange Enrollment Under Different Adoption Scenarios



Source: McKinsey & Company.

[1] Retirees covered by employer-sponsored insurance.

life insurance. However, a sizeable number of employees purchasing family coverage on the private exchanges may be willing to pay out of pocket for richer health benefits.

In comparison with traditional ESI, the less expensive health plans offered through private exchanges are likely to have lower coverage levels and require increased consumer funding (e.g., higher deductibles, co-payments, out-of-pocket limits). The lower coverage levels are likely to include the use of narrow networks, which would intensify the trend toward these networks that has already taken place on the public exchanges (Coe et al. 2014). To succeed in narrow networks, providers must have a granular understanding of their local markets so that they can weigh carefully—and accurately—the trade-offs involved in network inclusion and exclusion (Bauman et al. 2013). In some cases, participation could allow a provider to gain market share and new revenues if the network steers patients away from other providers. But in other cases, participation could result in a loss. In our experience, many of the providers that agreed to participate in narrow-network plans during the 2014 open enrollment period negotiated discounts at levels not commensurate with the net economic benefit. This may change as providers gain more experience with narrow networks, but it highlights the need for them to strengthen their contracting skills and be aggressive when negotiating rates.

If the less expensive plans require increased consumer funding, providers' bad-debt levels could rise. However, their ability to collect on bad debt is also likely to rise because much of the debt will be incurred by employed individuals rather than self-pay or uninsured patients (Bayley et al. 2013). To deal with this debt, providers will have to strengthen their billing, payment, and other revenue cycle management capabilities.

In theory, private exchanges give consumers greater responsibility for their healthcare choices. If consumers accept this responsibility, they

may become more willing to take charge of their health and more involved in decisions about medical care (Cordina et al. 2015). Whether this shift presents an opportunity or a threat may depend on how providers choose to interact with more empowered consumers. Providers that can service these consumers in ways that support—rather than conflict with—their sense of empowerment could win volume.

Depending on how the private exchange market evolves and how rapidly it expands, the exchanges could become an important new sales channel for providers, giving them an opportunity to gain new revenue streams. In the near term, providers could offer products that complement an insurer's health plans, such as concierge services (e.g., private rooms, same-day appointments) or prepaid packages for certain types of treatment (e.g., knee replacement) or therapeutic areas (e.g., in vitro fertilization). These ancillary products could be attractive to employees willing to pay out of pocket for richer benefits as well as to those working for companies with generous defined contributions. In the future, some providers may be able to use the exchanges to market accountable care organizations directly to consumers or to create their own narrow network plans, disintermediating insurers. (These latter options require a high level of market maturity, however.)

A provider that wants to develop new products for the private exchanges should proceed carefully to ensure that the products offer consumers a unique value proposition. The provider should also understand which employers it wants to go after (Khanna et al. 2014). For example, if most of the private exchanges in its region are being offered by cost-pressured companies, the provider might be wise to develop basic products geared to lower-wage employees. Conversely, the provider might benefit by creating higher-end, concierge plans if it wants to target talent-focused companies. If the employers the provider wants to go after are national companies or use private exchanges only with retirees, it should make certain it has the necessary geographic scope.

Notes

1. This percentage includes lives covered by administrative services–only, large group, small group, and group Medicare plans. It is derived from a proprietary McKinsey microsimulation model (MPACT) that analyzes how insurance coverage has changed recently and may further change in the years ahead.
2. Many industry observers estimate the current number of people covered on private exchanges at about 3 million. However, those estimates do not differentiate between retirees and active employees and their families, the approach we have used here.

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7. ADVANCE CARE PLANS THE PATIENT'S VOICE AND OUR RESPONSIBILITY

by Jeffrey E. Thompson, MD

Advance care planning (ACP) has moved from the periphery to the mainstream of healthcare organizations' responsibilities. ACP cannot be left to stressful confrontations in the intensive care unit (Cook and Rocker 2014). It cannot be pushed to the sidelines or mired in grandstanding political rhetoric. Moving from "what is the matter with the patient" to "what matters to the patient" is rapidly becoming a core activity of healthcare organizations (Bisognano 2013).

Trends

The rapid evolution toward ACP is not happening by accident. Major trends in the industry continue to push us toward a more disciplined approach to ACP in our strategic plans and in our daily activities. One of the most consistent trends is increased discussion and activity focused on patient-centered and patient-directed care.

Patients and their wishes are a fast-growing dimension in all parts of medicine. Although some increased engagement is a result of better health literacy, much of it is driven by increased risk-bearing responsibilities of patients, families, and many healthcare organizations. As the possibility of better-coordinated care is enhanced by the availability of electronic health records across organizations, these records, although far from perfect, have supported cross-system and cross-community capabilities. At the same time, the boomer generation is adding thousands per day to the senior citizen cohort, and complex medical therapies are becoming increasingly available.

These changes in the healthcare environment will put added pressure on organizations to have an approach to ACP beyond simply hoping that someone at some time filled out an advance directive. The social and system complexity sounds daunting, but in the past five years we have shifted our focus from delivery system struggles when patients are near death to open discussions about how they want to live (Hammes 2012). In addition, the inflammatory and distractive rhetoric of "death panels" has been roundly dismissed by most serious observers. In its place is an expanding body of national and international peer-reviewed literature demonstrating how community-based systems focused on the health and well-being of patients, families, and healthcare staff have shown

About the Author

Jeffrey E. Thompson, MD, is CEO, chairman of the boards, and a pediatric intensivist and neonatologist at Gundersen Health System in La Crosse, Wisconsin. He is board certified in pediatrics and neonatal and perinatal medicine. Dr. Thompson is a founding member and past board chair of the Wisconsin Collaborative for Healthcare Quality and past board chair of the La Crosse Medical Health Science Consortium. He also serves on the boards of the ThedaCare Center for Healthcare Value, the Wisconsin Statewide Value Committee, the Wisconsin About Health Network (as chair), and Practice Greenhealth. In 2013, the White House honored him with a Champions of Change award. During Dr. Thompson's tenure at Gundersen, the health system has been recognized time and again for its high-quality patient care by independent healthcare ratings organizations. Most recently, Gundersen was a recipient of Healthgrades America's 50 Best Award for 2014. The organization's Envision (environmental stewardship), Respecting Choices (end-of-life planning) and 500 Club (healthy eating) programs have been highlighted by news organizations and health systems across the country and around the world.

Advance Care Planning Defined

Advanced care planning (ACP) is a process of planning for future medical decisions. To be effective, this process needs to meet standards that are similar to those used for informed consent. That is, the person planning needs to

- understand possible future situations and choices,
- reason and reflect about what is best, and
- discuss the choices and plan selected with those who may need to carry out the plan.

Ideally, ACP clarifies what is in the patient's best interest. The patient participates in a process of shared decision making to create a way forward that represents the patient's informed plan.

markedly improved outcomes for all involved.

An example of the broadening of the discussion and of ACP's supportive base is the publication of *Having Your Own Say: Getting the Right Care When It Matters Most*—a collection of essays contributed by a wide-ranging coalition of healthcare organizations, business leaders, politicians, and prominent national organizations including the American Association of Retired People (AARP) (Hammes 2012). The book addresses multiple facets of ACP across broad geographies and widely varied social settings. The publication, along with many others, has fostered the understanding that a system of activities, as opposed to a simple document, is necessary to meet our commitment to patients. This system, as outlined in Exhibit 7.1, has been implemented across many diverse settings using the approach conceived and developed at Gundersen Health System (Hammes and Briggs 2011).

Multiple coalitions have been led by healthcare systems such as Gundersen, Sutter, and Kaiser; state medical societies such as Honoring Choices Minnesota and Honoring Choices Wisconsin; and business-led groups such as the Coalition to Transform Advanced Care, to name a few. Australia, Singapore, and a European coalition are all at various stages of implementation of ACP programs, demonstrating the universality and portability of this approach.

Possibly the most important of all the changes in ACP is the fundamental understanding that it requires more than a legal document to deliver what really matters to the patient. It requires the initial conversations, follow-up discussions, broad community connectedness, availability of the documentation for healthcare providers, training of healthcare providers, provision of the level of care that fits the patient's wants and needs (aggressive, palliative, or hospice), and continuing quality improvement to make sure the system works.

Implications for Hospital Leaders

To lead organizations into the next decade, we must understand that patients and their families are willing to have advance care discussions and that increasing numbers will demand them. We need to recognize that being patient- and family-centered is consistent with the mission, vision, and values of most of our organizations. We need to understand that because ACP is consistent with our mission, we are responsible for taking the lead in developing a comprehensive community-based plan that includes not only the initial conversation but follow-up discussions, documentation, staff training, and follow-through on the patient's wishes.

Taking on this work provides many opportunities for healthcare organizations to demonstrate leadership in their region and commitment to their values. Partners will spring from among community leaders, political leaders, AARP, nursing homes, home health agencies, and patients themselves. In addition, all segments of the faith community can successfully participate in the design, training, and implementation of ACP systems. Establishing an ACP system presents a significant opportunity to improve not only the health and well-being of our patients and their families but also the well-being of our staff members. Research has shown ACP systems to decrease caregivers' stress and improve their ability to help patients and families make these difficult transitions (Detering et al. 2010).

ACP also has implications for organizations that take on financial risk for their patients. Patients who have become more involved in their ACP almost always choose a less costly approach to care. When planning is done well, no part of the conversation urges or suggests that patients get less care than what they desire or what is appropriate. A broad ACP system results in care that is more consistent with the patient's wishes, greater patient satisfaction, greater staff satisfaction, and, incidentally, care that is less expensive (because patients who are encouraged to discuss their treatment goals in light of their values often choose fewer interventions at the end of life). The lower cost of care is a secondary but welcome side effect for those who are taking on risk or will take on risk in the near future. For those providers still under fee for service, it is unlikely any would want to balance their budgets by treating patients against their wishes.

Exhibit 7.1 Advance Care Planning Implementation

Futurescan Survey Results

The *Futurescan* survey results imply great optimism in moving from where most hospitals are today to transformational performance within five years. To have the conversations, documentation, and peer review processes of ACP all functioning would be a strong achievement for an organization. Perhaps the five-year timeframe for broad ACP adoption is possible with the help of strong leadership, expanded education, legislative mandates, or fiscal incentives. However, what hospital leaders may underestimate is the substantial cultural shift across clinicians, families, and communities that is required to consistently obtain, make available, and honor patients' informed plans.

Healthcare leaders who share the optimism expressed by respondents to the *Futurescan* survey have some support, however (Teno et al. 2013). The ability to sustain gains in La Crosse, Wisconsin (home of Gundersen Health System), have been well studied (Hammes, Rooney, and Gundrum 2010), and efforts to spread this approach to markedly different environments also have been successful (Hammes et al. 2014).

Action Steps

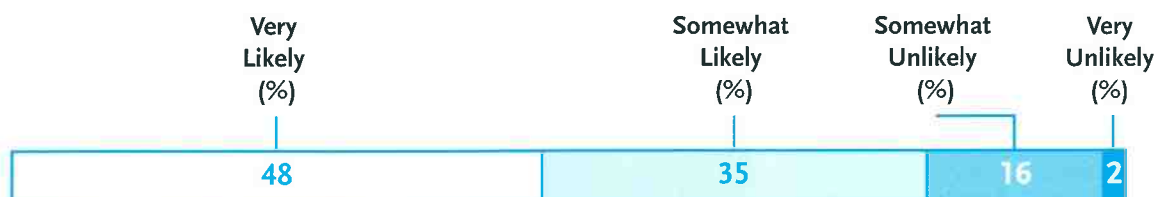
With our current understanding of trends and opportunities, a reasonable course for an organization and its leaders would be as follows:

- Develop an organization plan that reaches out to community leaders of faith organizations, AARP, nursing homes, healthcare agencies, and the like to be partners in promoting ACP.
- Develop a standardized, patient-centered, and staged approach to ACP conversations.
- Develop staff training programs so that ACP is consistent and understandable across all sectors of your community.
- Develop a system of processing ACP information and making it available, ideally through an

FUTURESCAN **SURVEY RESULTS:** Advance Care Plans

An **advance care plan (ACP)** details what a patient wishes to occur if he or she cannot speak for himself or herself in a medical situation. An advance care plan is sometimes formalized in a legal document such as an advance directive.

How likely is it that the following will be seen in your hospital by 2020?



Physicians or physician extenders (physician assistants/nurse practitioners) in your hospital will assist patients in the completion of their advance care planning.

Staff in your hospital **other than** physicians or physician extenders (physician assistants/nurse practitioners) will assist patients in the completion of their advance care planning.

Medical records will be designed to make the advance care plan easily available in a patient encounter.

A system will be in place in your hospital to ensure that providers make decisions that are consistent with the patient's advance care plan.

Note: Percentages may not total to exactly 100% due to rounding.
◊ Less than 0.5%

What Practitioners Predict

Hospital staff will assist patients with their advance care planning. Most of those answering the survey believe that by 2020 their hospital's staff will assist patients with advance care planning. About 83 percent predict that physicians or physician extenders (physician assistants/nurse practitioners) will provide this assistance. An even greater proportion of respondents (94 percent) expect that hospital staff other than physicians or physician extenders will help patients specify their advance care plans.

Hospitals will ensure adherence to advance care plans. Almost all (97 percent) of the survey respondents predict that by 2020 their medical records design will make advance plans readily available in patient encounters. Similarly, 98 percent of respondents think that in the next five years, procedures will be in place in their organization to ensure provider compliance with patients' advance care plans.

electronic health record, so that the advance care plan can be built into routine care.
- Provide and ensure the availability of palliative and hospice care.
- Conduct ongoing assessments of every element of the system and engage in continuous quality improvement to make sure all parts function at the highest level possible for patients, families, and staff.

We can shift our conversations from discussions about death to the more fundamental question about how we want to live. We can transition our organizations from a focus on what is the matter *with* the patient to a community-based effort that honors and respects what matters *to* the patient. These efforts will then establish the clearest and most accepted pathway for patients, families, and staff. Now is the perfect time for us as healthcare leaders to use our leadership roles locally, as well as regionally and nationally, to help improve health and well-being. Few other activities will provide such rewarding outcomes to our hospitals, healthcare systems, and communities. FS

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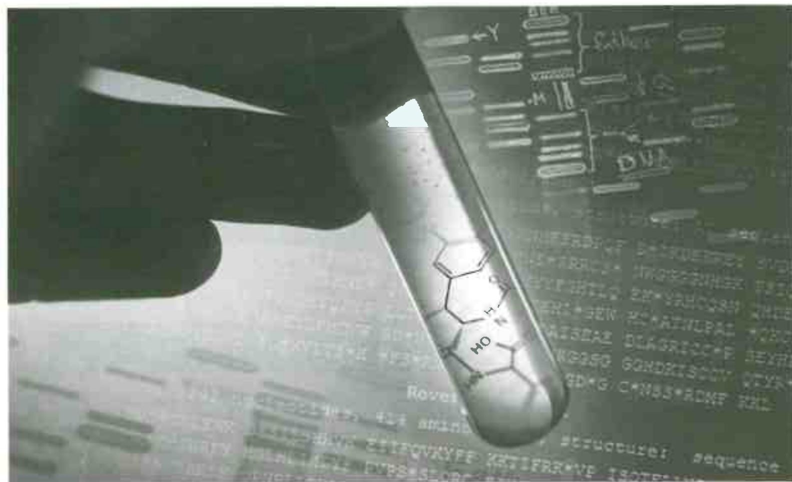
8. INNOVATIONS IN iMED THE ERA OF INDIVIDUALIZED MEDICINE

by Eric J. Topol, MD



The information era is finally arriving in healthcare at full force. It transcends electronic health records and health information systems, and rather than centering on the health system, the new information era focuses on the individual.

We now have the capability of creating a digitized, multidimensional map of a person's body to define its medical essence through ten layers of integrated information (Exhibit 8.1): the electronic health record; the social graph (phenome); information from sensors (physiome), imaging (anatome), and biologic assessments, including DNA sequencing (genome, proteome, metabolome, microbiome, and epigenome); and the individual's environmental exposures (exposome) (Topol 2014).

Although the scope of this essay does not allow me to delve into all of the map's layers and the technology behind them, I would like to highlight three: the physiome, the anatome, and the genome.

Physiome

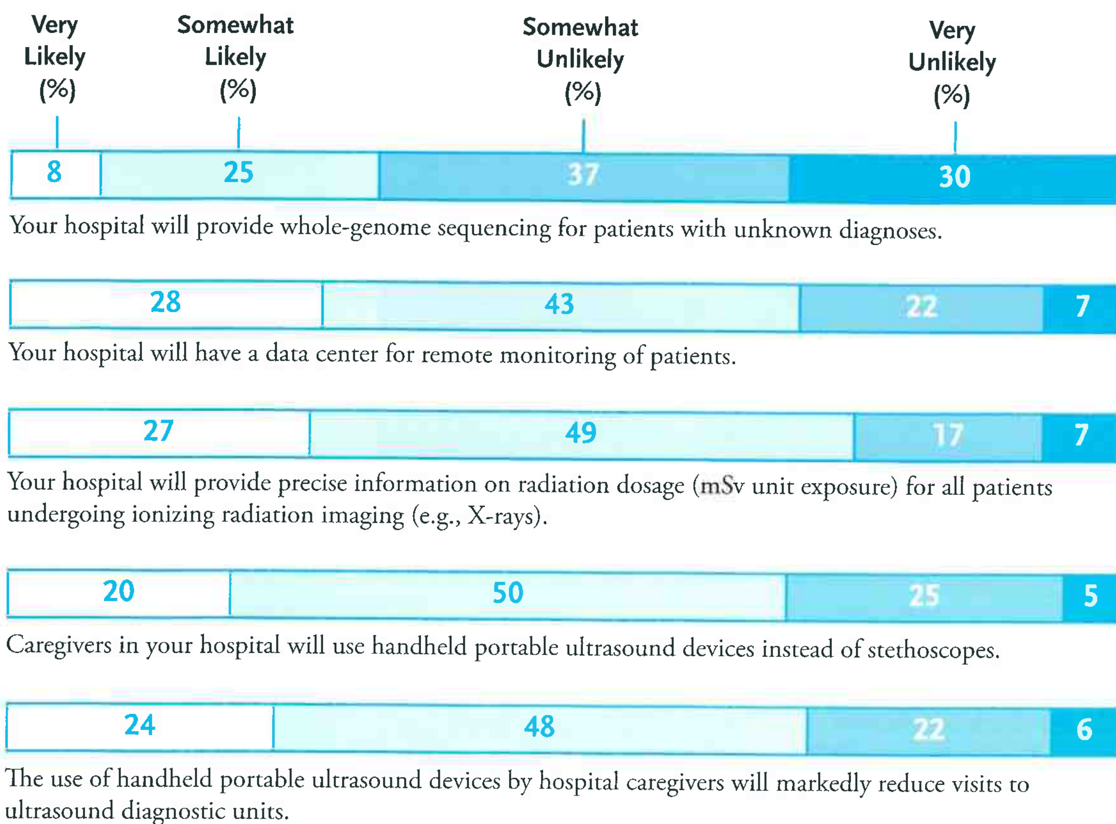
A biosensor can assess almost any physiologic metric. Most biosensors are wearable and embedded in adhesive bandages, glasses, earbuds, wristbands, headbands, necklaces, contact lenses, and garments. These sensors capture blood pressure, heart rate, heart rhythm, respiratory rate, blood oxygen concentration, cardiac output, eye pressure, glucose, brain waves, and many other medical indices. Beyond wearable sensors, smartphones can capture data on tone and inflection of voice, communications (texts, e-mails, phone calls), and location. In addition, a variety of hardware attachments or "add-ons" to smartphones are available, such as microfluidics to perform lab tests or breath analyzers to detect cancer or monitor lung function. Collectively, the ability to map relevant features of an individual's physiome, on either an intermittent or a continuous basis, in the real-world ambulatory setting is rapidly emerging.

Anatome

How we image the body, or obtain the anatome, is displaying a parallel path of disruption. The number of medical scans performed in the United States each year—including X-ray, ultrasound, CT, MRI, and nuclear imaging—is remarkable. The use of scans has now reached

About the Author

Eric J. Topol, MD, works on innovative genomic and wireless digital technologies to reshape the future of medicine. In 2012, he placed first on *Modern Healthcare*'s list of 50 Most Influential Physician Executives and Leaders. He is a practicing cardiologist at Scripps Health in La Jolla, California. Since 2006, Dr. Topol has led the NIH-supported Scripps Translational Science Institute. He also serves as chief academic officer of Scripps Health and professor of genomics at The Scripps Research Institute. Prior to joining Scripps Health, Dr. Topol practiced at the Cleveland Clinic. He is widely credited for leading the Cleveland Clinic to be named the top-ranked center for heart care on *U.S. News & World Report*'s Best Hospitals list. While at the Cleveland Clinic, he started a new medical school, led many worldwide clinical trials to advance care for patients with heart disease, and spearheaded the discovery of multiple genes that increase susceptibility to heart attacks. Dr. Topol is a member of the Institute of Medicine of the National Academy of Sciences. He is one of the ten most-cited researchers in medicine, the author of the best-selling book *The Creative Destruction of Medicine*, and editor-in-chief at Medscape.



Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

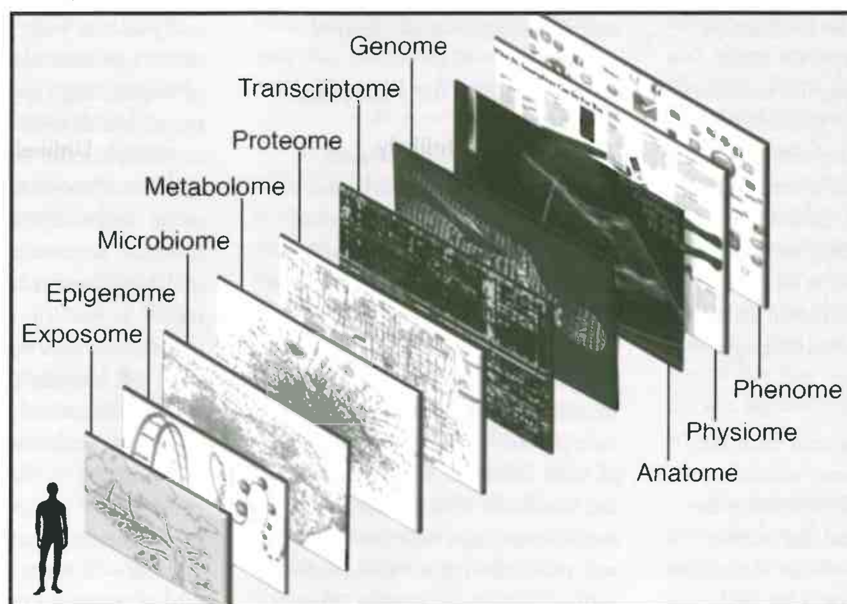
A minority of organizations will offer whole genome sequencing. The majority (67 percent) of survey respondents think it unlikely that their organization will offer whole genome sequencing to patients with unknown diagnoses within the next five years.

Remote monitoring of patients will be more common. Almost three-quarters (about 71 percent) of those responding to the survey think that their organization will have a data center for remote monitoring of patients by 2020.

Most hospitals will provide radiation dosage information. Seventy-six percent of survey respondents predict that by 2020 their hospital will provide precise information about radiation dosage to all patients undergoing ionizing radiation imaging (e.g., X-rays).

Handheld portable ultrasound devices will be in common use. Seventy percent of survey respondents believe that their hospital's staff will use handheld portable ultrasound devices instead of stethoscopes in 2020. In addition, 72 percent predict that the use of these handheld ultrasound devices will significantly reduce visits to ultrasound diagnostic facilities.

Exhibit 8.1 Digitizing the Human Body Through Ten Integrated Layers of Information



more than 300 per 1,000 people per year in the United States, far more than in any other country in the world (Landro 2013b). Many modalities use ionized radiation, and many patients have multiple scans in a given year, such that cumulatively—over the course of a lifetime—these patients are put at risk for cancer. Just one nuclear scan can expose an individual to the equivalent of 2,000 chest X-rays. Indeed, concerns have been raised that 3 to 5 percent of cancers are caused by excessive medical imaging (Redberg and Smith-Bindman 2014). Yet, with rare exceptions, hospitals and doctors do not inform patients of the amount of radiation exposure in milliSievert (mSv) units or chest X-ray equivalents before they order the scan; nor do providers inform patients of the actual radiation dose when they obtain the image.

Concurrent with the unbridled use of medical imaging, a new modality of high-resolution pocket ultrasound has become available. At Scripps Health, we validated that the quality of the pocket ultrasound images for heart examination is equivalent to that of the hospital-based ultrasound machine, which costs 50 times more (Liebo et al. 2011). Using handheld echocardiography, we also showed that most in-hospital cardiac studies could be done during bedside rounds without the need for a formal, expensive exam and transport of the patient (Khan et al. 2014). I have not used a stethoscope to examine my heart patients in clinic for nearly five years because the pocket echo device quickly provides considerably more information at no cost (beyond the initial purchase of the device). Handheld ultrasound can be used as a screening tool to decide whether a formal exam is necessary (most are not).

In 2011, 125 million ultrasound exams were performed (Landro 2013b). We now have the technological capability to move from the listening "lub-dub" era of heart exams to a new era of digitizing the heart and instantaneously defining the structure and function of each chamber and the valves. Not only does ultrasound preempt the need for risky ionized radiation, but its eminent portability and low cost also make it attractive as a routine part of the modern physical exam. Image loops can be shared with the patient in real time and, when the interpretation is uncertain, with colleagues in radiology or cardiology for consultation.

Genome

The cost of whole genome sequencing, which defines more than 6 billion letters that compose an individual's DNA, has plummeted. Whereas sequencing a human-sized genome cost $29 million in 2004, the price has now decreased to less than $2,000 (Topol 2012). And the price will continue to drop with relentless improvement in sequencing technologies. Still, the use of sequencing in clinical care has been limited thus far.

The most successful application to date has been for patients with an unknown and undiagnosed yet serious condition. For these patients, the use of sequencing that includes samples from parents or at least two family members

has often yielded the root-cause, molecular diagnosis. In the case of some individuals, this diagnosis has proven to be the foundation for definitive therapy. Of note, patients with idiopathic, unknown diseases historically go from one medical center to another in search of a diagnosis. Their cumulative medical bills often exceed $1 million. So if sequencing becomes the first-line diagnostic, it will likely improve both the efficiency and the economics of establishing the diagnosis.

Sequencing has also been useful in treating cancer, which is a genomic disease. By mapping the tumor's genome and the native (germline) DNA, we can determine what mutations have appeared and which ones are driving the cancer. This information allows a far more precise approach to therapy—biologically attacking the culprit pathway—without wasting new cancer drugs that often cost more than $100,000 per course of therapy. Moreover, the time lost in using the wrong drug for a patient may result in tumor progression and metastasis. Clinical trials to test such a sequencing strategy while tracking patient outcomes and net costs are under way (Topol 2012).

Sequencing has also been used to rapidly diagnose an infectious disease, although it is the pathogen that is sequenced, rather than the host patient. In one case, a young boy with incessant seizures and encephalopathy had not received a diagnosis even after a brain biopsy. Sequencing of his cerebrospinal fluid led to a diagnosis and life-saving antibiotic treatment (Zimmer 2014). Newborn sequencing, performed within 48 hours after birth, has been particularly useful in diagnosing sick babies long before results typically come back from the classic heel blood-stick screening for metabolic disorders. This sequencing application is especially promising because it can lead to the prevention of irrevocable end-stage organ damage that can occur when neonatal diagnoses are delayed.

Implications for Hospital Leaders

The results of the *Futurescan* national survey indicate a positive outlook for the adoption of remote monitoring and handheld ultrasound testing in the next five years. Approximately 70–80 percent of respondents think it likely that hospitals will be involved in remote data monitoring, will provide precise information to patients of their radiation exposure, and will use handheld ultrasound instead of stethoscopes and that these devices will markedly reduce the need for formal ultrasound studies. However, hospital leaders are doubtful that hospitals will provide whole-genome sequencing for patients with unknown diagnoses—only 33 percent of those responding to the survey believe their hospital will provide such sequencing by 2020.

The mixed survey results suggest that hospital and health system leaders have not entirely accepted that a revolution fostering individualized medicine is here. This view is understandable because change is never easy in healthcare, and providers are currently expending effort and resources on other challenges, such as those associated with the Affordable Care Act.

Let me provide the rationale for embracing the changes described earlier in this article. Adopting these changes will not only lead to more efficient healthcare, but it will also serve as a differentiating feature for those hospitals and health systems that have the plasticity and willingness to adapt.

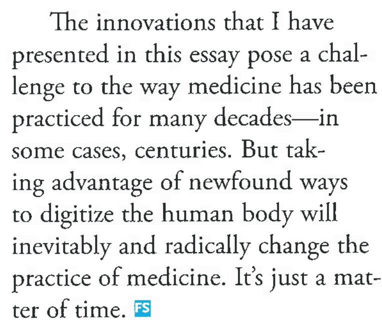
In the next five years, millions of individuals of diverse ancestries and phenotypes will undergo whole genome sequencing, making the data far more informative. Sequencing will play an increasing role in clinical care for many indications, and patients with unknown diagnoses represent only one segment of sequencing's application. What's more, health insurers have begun to reimburse for sequencing. Does this mean hospitals will need to make major capital investments in in-house sequencing equipment, including sequencers that cost nearly $1 million each (not including reagent and maintenance costs)? And will hospitals need to hire bioinformatic teams? I do not believe such large-scale investments will be necessary in the future. Given the promise of medical sequencing, it makes sense that leading health systems will forge relationships with partners to provide the service. These relationships could mean working with academic research groups that are part of a health system or collaborating with one of the many emerging sequencing companies. If providers do not offer innovative medicine, informed patients will migrate to centers that can provide sequencing and state-of-the-art care for unknown diseases, cancer, neonatal conditions, serious infections, and other indications.

The charge for a day in the hospital in the United States averages more than $4,500 (Topol 2012). With the technology that now exists for continuous monitoring of a patient's vital signs in the comfort, safety, and reduced cost of his own home, a shift from in-hospital to at-home monitoring appears increasingly likely. The major remaining question is, will data be sent to the local health system facility for analysis or to a centralized, dedicated company? I find considerable appeal in keeping at-home monitoring local, given the advantage of patient care continuity. When monitoring indicates a red flag, the patient's physician and health system would be the logical

points of contact and care. But hospitals will then need to gear up for the capability of becoming data surveillance centers, which markedly extends current information system demands. Although the migration of patients from hospital bed to home may take a couple of years, planning today for the new mode of monitoring seems prudent.

Providers must also address the issue of medical imaging (Landro 2013a). We grossly overuse scans, and we currently do not acknowledge the cancer risks that ionized radiation poses or respect the right of patients to know the amount of radiation to which they are exposed. Many patients may opt out of having a scan if they receive the appropriate information on mSv, risks, and alternatives. To date, only Intermountain Healthcare in Salt Lake City has initiated a program to provide such information to patients. Informing patients is only the beginning. Every individual should have the mSv exposure from medical scans carefully and cumulatively recorded from birth because it is total exposure that correlates most closely with risk.

Some health systems, such as Allina in Minnesota, are starting to train their primary care physicians to use comprehensive handheld ultrasound devices as part of the physical exam. This protocol leverages a new, informative, and economical way of performing an exam. We have a technology that transcends the stethoscope, but its current use does not reflect its immense potential. In 1816, physicians rebelled against using Laennec's invention (the stethoscope) for almost 20 years, chiefly because they were unwilling to learn all the sounds emanating from the heart, lungs, and abdomen. Now, 200 years later, US physicians and hospitals are reluctant to use a *real* stethoscope—a device that looks into the body rather than simply transmits sounds. Unlike the original stethoscope, the handheld ultrasound device archives data and allows immediate sharing of the video loops to other physicians for added interpretive expertise when necessary. The main reasons providers have not adopted it are a reluctance to learn a new skill and a lack of incentives. Payers do not reimburse for ultrasound performed as part of the physical exam, and hospitals that use portable ultrasound lose the opportunity to bill for the technical fees of a formal lab study.



The innovations that I have presented in this essay pose a challenge to the way medicine has been practiced for many decades—in some cases, centuries. But taking advantage of newfound ways to digitize the human body will inevitably and radically change the practice of medicine. It's just a matter of time. FS

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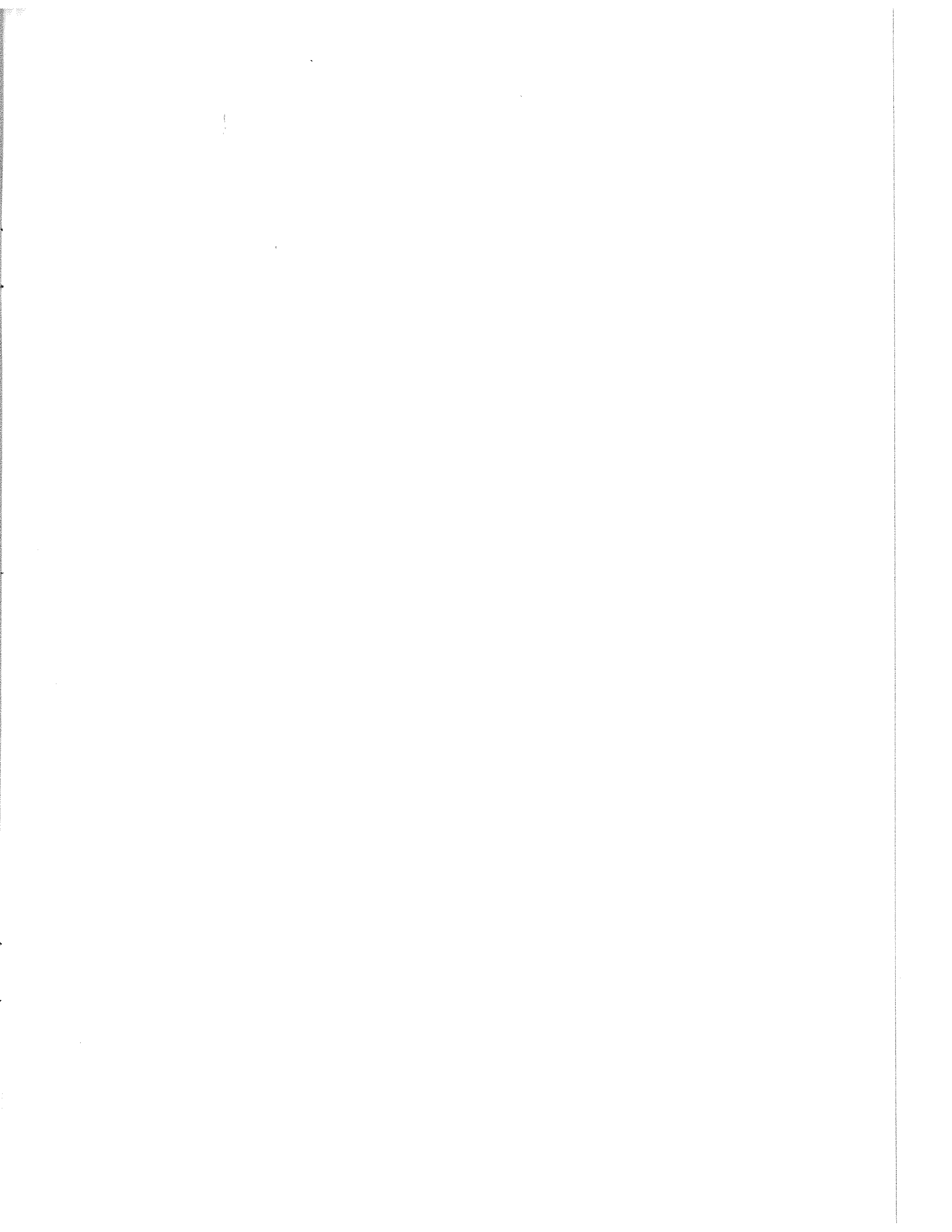

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