



# From Resilience to Reinvention

*Healthcare Trends for 2026*

# Healthcare Trends

Health systems are confronting a new era defined by converging challenges and unique opportunities. In 2026, we expect artificial intelligence (AI) to reshape care delivery, payment models and regulatory reforms, rising costs for both labor and supplies, and a demand shift pushing providers to deliver wellness and prevention services. These trends will likely ratchet up already high margin pressure and unleash new, competitive entrants — driving a rethink on how care is experienced in the community.

In this environment, C-suite leaders can no longer afford to merely preserve enterprise effectiveness or manage incrementally. They must drive optimal performance today while building the infrastructure for a fundamentally restructured marketplace tomorrow. The next generation of market leaders will be those who turn disruption into design, harnessing technology, partnerships and scale to reimagine strategy, operations, systems and capabilities.

Premier's 2026 market trends report explores the drivers shaping healthcare's next horizon, offering insights and actionable strategies for leaders ready to build adaptive, data-driven systems that enable providers to put consumers first and thrive amid volatility. In this report, we explore the key levers of change and strategic considerations for leaders ready to move their organizations from **resilience to reinvention in 2026 and beyond**.

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# Trend 01

## Taming the AI Wild West

AI is rapidly reshaping healthcare, promising transformative potential across clinical, operational and financial domains. As of late 2025, [approximately 71 percent of U.S. hospitals](#) have integrated some form of AI into daily operations, up from 66 percent in 2023.

Many of these AI initiatives are generating benefits. For instance, [one report](#) found that generative AI to support scheduling and call center operations increased productivity by 15 to 30 percent, enabling better use of scarce labor resources. [Another uncovered](#) that use of AI to optimize service line utilization and/or detect potential safety events could save up to \$360 billion a year. And [Premier data](#) found that AI implementations in the billing and claims submission process could help providers avoid up to \$18 billion a year in unnecessary adjudication costs.

While the power of AI adoption is clear, the path forward is murky. AI deployments are increasing yet most health systems (80 percent) lack internal governance standards guiding future adoption. Without these fundamentals, health systems risk moving forward with siloed point solutions stitched together like Frankenstein's monster rather than creating a thoughtful AI ecosystem.

Taming this AI "wild west" requires careful leadership and a use-case-first mentality to solve discrete challenges.

Rather than adopting AI because it is novel or hyped, health systems should start with the specific challenges they want AI to solve. This ensures efforts are targeted, stakeholders are aligned and performance metrics maximize ROI while minimizing risk. By combining a use-case approach with rigorous governance, health systems can move beyond experimentation to leverage AI as a strategic lever.

For 2026, four use cases are emerging as core areas of focus in healthcare.

## Use Case #1

In 2026, we predict more health systems will use AI to manage the earliest touchpoints of care, with digital assistants intaking symptoms and severity via chatbots and making recommendations to patients about when to seek an appointment for further care and where that care is best delivered. Not only is this a nod toward consumerism, it's also critical to managing throughput and total costs. Such an assistant could help steer patients to the lowest-cost setting of care appropriate for the condition, thus avoiding utilization and/or overcrowding of high-cost emergency rooms for ambulatory care while also managing scheduling to ensure a consistent flow of visits.

## Use Case #2

There is [\*growing adoption\*](#) of AI-enabled stewardship applications that, at the time of treatment, flag medications and diagnostic tests that are unlikely to have clinical benefit based on established medical standards. Leveraging AI, these applications are also able to surface information on the supply costs and nudge providers to make budget-friendly choices. Informed by the clinical evidence base, such applications have been shown to help providers reduce costs by nearly \$100 per inpatient admission, with no identified negative effects on outcomes.

## Use Case #3

Applications to optimize staffing will heat up this year. AI-powered analytics are increasingly being used to analyze historical data, seasonal trends and real-time variables to predict staffing needs, ensuring adequate coverage without overstaffing. AI is also facilitating dynamic scheduling systems that consider clinician preferences, skill sets and regulatory requirements. Taken together, these workforce apps balance workloads, reduce burnout, contain labor costs for overtime and agency staff, and improve efficiency.

## Use Case #4

[\*Research suggests\*](#) that the average hospital has more than 1,200 national and local contracts in its portfolio and activates contract pricing for more than 40,000 new line items every six months. With a large volume of contracts, automating this process can deliver both operational and financial benefits. Using tools like robotic process automation (RPA), providers can better manage repetitive and lower-value work, using technology to act as a digital employee to go through the tedious steps of repeatedly activating new contracts using natural language processing and machine learning to understand contract tier information, comments and price, effective date for all activations, as well as distribution options.

# Case in Point

## Unlocking Smarter, More Cost-Effective Care with Stewardship

MultiCare Health System, a 2,064-bed provider based in Tacoma, Washington, sought to eliminate wasteful practices by embedding stewardship at the point of care.

Partnering with Premier, the health system implemented [Premier's Stanson Health](#) stewardship app, designed to reduce unnecessary medications, labs and imaging tests. Unlike traditional tools, the app delivers precise, patient-specific nudges only when clinically appropriate, surfacing cost-effective alternatives while preserving provider autonomy.

The initial rollout was conservative yet delivered clear early returns. Starting with four medications and three lab tests, MultiCare saw average savings of \$179 per accepted recommendation and approximately \$81 per discharge.

**Across industries, executives are seeing the significant benefits of RPA:**

**63%**

say it's a major component in digital transformation.

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**60%**

agree RPA enables people to focus on more strategic work.

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**57%**

say it reduces manual errors.

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**92%**

agree RPA has 'met or exceeded expectations' for better compliance.

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**57%**

say RPA increases employee engagement.

# Trend 02

## Think Local, Win Big

### Partnering with Public Health

When COVID-19 struck, local health departments (LHDs) became the backbone of community response, leading testing, tracing and trust-building while hospitals fought on the clinical front lines.

That experience was more than an emergency response; it was a preview of healthcare's future.

Joined in addressing the community's needs, clinicians and public health leaders discovered that when their missions converge, everyone benefits from a more efficient, equitable and resilient healthcare operating model.

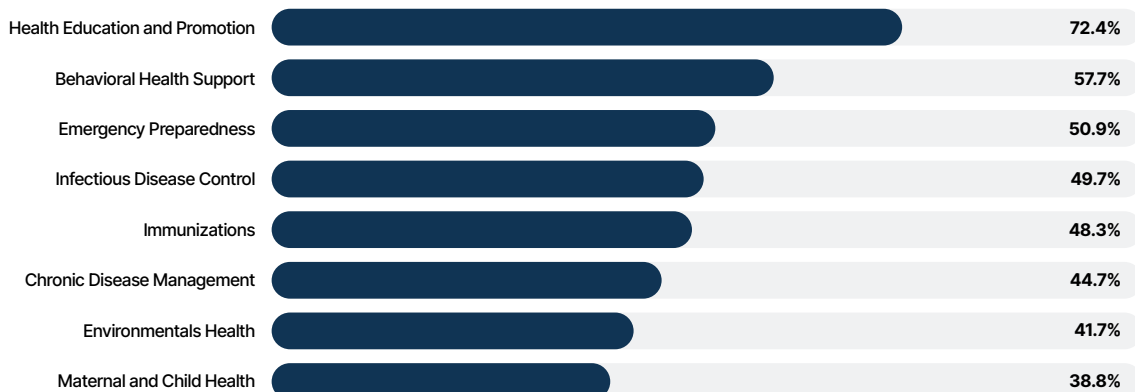
Despite these advantages, the partnerships with public health were short-lived. Once the pandemic crisis passed, healthcare returned to familiar silos, with public health agencies focused on community health assessments and chronic

disease prevention, while health systems pursued population health management under value-based payment (VBP) models. Even though both aim to improve health at scale, differing funding streams, data systems and accountability frameworks create disconnects, which is why today ***only about half of health systems*** continue to engage with LHDs regularly or strategically.

But as the industry increasingly moves from a model of cure to one of prevention, the partnership models of the pandemic again make strategic sense. Where once it was too costly to identify and engage patients upstream, today's technology and reimbursement structures make it both feasible and financially rewarding. Providers can now "prescribe" social and behavioral supports with the same rigor as clinical care. Value-based models such as ACO REACH and Medicare Advantage reward providers for avoiding complications, not just treating them. And consumer engagement platforms and FHIR-based APIs make data sharing seamless, ensuring care continuity and performance visibility across the continuum.

### Ranking of Most Valuable LHD Services

Which LHD service do you consider more valuable for advancing your organization's community health goals or care approach?



Source: [Premier data from Health System Collaboration with Public Health Entities](#)

Savvy health systems that pursue a comprehensive community health strategy can expect to reap myriad advantages:

- **Reach and credibility:** LHDs already serve historically hard-to-reach populations. By collaborating, health systems can close care gaps, improve value-based performance and deliver services where people live and work.
- **Operational efficiency:** Leveraging LHD networks and community programs allows health systems to address social drivers of health — housing, food access, transportation — without building costly, duplicative programs internally.
- **Resiliency and foresight:** LHDs provide early warning for emerging threats, from infectious disease to environmental hazards, helping health systems anticipate challenges and respond proactively.
- **Growth through trust:** In an era when “systemness” is defined not by physical assets but by the consumer experience, partnerships that provide care where people are, regardless of access point, are key to maintaining relevance and loyalty.

These capabilities make the ROI of prevention and community partnerships quantifiable, where investments in community health yield measurable reductions in emergency visits and readmissions.

To take advantage of these gains in 2026, leaders should [evaluate where partnerships with LHDs](#) and community organizations could extend market presence and enhance performance in risk-based

contracts. This means treating LHDs as extensions of core operations, co-developing care models that align clinical services with social support such as housing, food access and transportation. The goal: to ensure that data, referrals and services follow the individual for more proactive, community-integrated population health management.

Health systems should also conduct a systemwide inventory of community-facing programs and services, specifically identifying overlap with those provided by LHDs or community organizations to prevent duplication of effort. Once identified, leaders can explore opportunities for consolidation, co-investment or shared service models to improve impact and financial sustainability, as well as a more seamless experience.

Data sharing with LHDs can also be enhanced by integrating community health data into enterprise dashboards, inviting LHD leaders into joint planning and policy forums, and investing in shared data platforms, workforce pipelines and joint advocacy efforts that strengthen resilience against public health and external shocks.

Taken together, these efforts work to ensure that every touchpoint — whether hospital, clinic or community program — works together to create a cohesive ecosystem of trust, access and prevention. Over the long term, providers that think locally by partnering deeply with public health will ultimately win big in outcomes, in cost control and in the loyalty of the communities they serve.

### Ranking of Shared Data Types by Health Systems

What types of data do you currently share with Health Information Exchanges (HIEs) or public health entities?



Source: [Premier data from Health System Collaboration with Public Health Entities](#)



# Trend 03

## The Consumer Imperative

### *Competing on Value, Trust, Innovation and Access*

Healthcare is no longer just about providing high-quality care: It's about competing for consumer choice to protect market share and long-term financial resilience.

As consumerism accelerates, organizations must rethink how they attract, retain and engage their patient populations. Today's consumer is looking for high-quality services that conveniently deliver health and wellness at a transparent price point, while avoiding scheduling delays, impersonal service, cultural incompetence, and clunky and surprise billing.

To attract their patronage (and their premium dollars) in 2026, health systems must now prove they can deliver the best value, trust, innovation and access, all while maintaining the clinical excellence that remains their core differentiator.

*This starts with transparency.*



## Improve Competitive Positioning Using Premier's 100 Top Hospitals®

For health systems looking for a viable, unbiased program to prove value to payers, patients and local communities, look no further than [Premier's 100 Top Hospitals®](#) program.

100 Top Hospitals is an unbiased, transparent approach to determine the top performing hospitals and health systems nationwide. The program creates balanced scorecards of performance that focus on clinical, operational and financial metrics, as well as patient perception. Unlike other ranking programs, 100 Top Hospitals is strictly based on transparent, publicly available data. In addition, the program provides health systems with detailed insights, national benchmarks and trend reports for focused improvement efforts.

Leading brands such as [University Hospitals](#), [AdventHealth](#) and [Ascension](#) are embracing this imperative with easy-to-use pricing tools that allow prospective patients to estimate their total costs for medical services in advance and online. [Others](#) have taken this approach all the way through payment, redesigning billing statements to break down what the patient owes, what was covered by insurance and a detailed explanation of services provided.

Hospitals can also build trust by publicly sharing outcome metrics, patient satisfaction scores and accreditation achievements openly in easy-to-digest dashboards that facilitate comparisons. Similarly, health systems that aggressively report on their innovation strategies can establish leadership in high-reimbursement specialties, attract patients willing to pay for superior expertise and build community credibility.

Beyond transparency, health systems also need to rethink delivery systems to attract patients who value timely, frictionless access to care.

In this new world, three-tiered networks that prioritize digital engagement and leverage technology are core to future competitiveness.

An AI-first layer is at the top of this model. Using predictive analytics and algorithmic triage, systems can guide patients to the right care pathway quickly and accurately. The second layer, telemedicine, serves as a flexible, on-demand option that bridges the gap between digital triage and in-person care, maintaining engagement while optimizing resource utilization. Finally, the physical layer anchors the network with strategically concentrated sites of care, supporting multidisciplinary services.

By putting AI at the front end, telemedicine as the connective tissue and physical facilities as the high-value anchor, health systems can create a seamless, omnichannel experience that drives loyalty, expands reach beyond traditional geographies and positions the organization for sustainable growth.



# Trend 04

## Doing Less, Winning More

### *Rationalizing Service Lines*

Hospitals and health systems often feel compelled to offer a full spectrum of services, striving to be a one-stop destination for care. While this approach can seem patient-centric and a pathway to market share, overextending in this way carries hidden costs. Low-volume or non-differentiated services generate minimal margins while consuming expensive capital, specialized staff and administrative attention, taking resources away from specialties that produce competitive advantage.

Particularly in a year where health systems must prepare for sweeping reimbursement cuts imposed by the [One Big Beautiful Bill Act \(OBBBA\)](#), 2026 is shaping up to be the time when C-suite leaders rationalize service lines and double down on areas of true excellence.

Rationalization is not about cutting services indiscriminately. It's about strategic alignment and focus. Leading systems will identify their high-performing service lines by analyzing patient demand, reimbursement potential and clinical outcomes, concentrating investments where they can achieve scale, quality and differentiation.

For example, hospitals known for cardiology, oncology or orthopedics are increasingly creating centers of excellence that consolidate resources, standardize care pathways and deliver exceptional outcomes. By contrast, low-volume, low-margin procedures may be scaled back or partnered out to specialty providers, reducing operational complexity and improving financial sustainability.

Beyond financial benefits, a focused approach enhances strategic clarity and brand strength. Patients increasingly shop for quality and outcomes, not breadth of services. By emphasizing core strengths, health systems can communicate a clear value proposition and maintain market leadership in areas where they truly excel.

*Despite the benefits of a service line focus, it's a goal that's easier to articulate than implement. These potential barriers are beatable yet call for careful planning:*

### **Cultural and Organizational Resistance**

Physicians and staff may worry that reducing offerings will negatively impact patient access, damage reputation or open the door for competitors. To combat this, leaders must clearly articulate the rationale for service line focus, emphasizing that the goal is not to eliminate care but build for true clinical excellence and high-value impact.

### **Interdependencies and Unintended Consequences**

Interdependencies between services mean that changes in one area can ripple across the organization. Leaders should map all interdependencies and analyze patient pathways from admission through post-discharge follow-up. This allows for decisions that optimize core competencies while maintaining continuity of care.

### **Regulatory and Community Obligations**

Health systems must balance finances against the need to maintain essential services and comply with payer or accreditation requirements. To navigate this, leaders should engage regulatory, legal and compliance teams early in the planning process to ensure that service reductions or consolidations do not violate contractual or licensure obligations.

### **Data Limitations**

Fragmented systems, inconsistent coding and incomplete utilization and outcomes data make it difficult to assess which services are truly strategic or profitable. To address these limitations, leaders should obtain consolidated data across financial, clinical and operational domains to create a unified view of performance. Leveraging analytics platforms or partnering with data partners can accelerate this process and enable predictive modeling and scenario analysis.



## **Built for Insights, Designed for Results**

Premier's end-to-end quality improvement platform helps health systems benchmark against top performers, track key quality metrics and execute transformative strategies — from bedside to boardroom — using a single feed of information to support performance improvement.

With deep clinical expertise, intelligent analytics and regulatory support, these comprehensive solutions empower providers to improve care delivery, reduce variation and meet the demands of value-based care.

- **Actionable analytics and benchmarking:** Clinically driven risk adjustment for all patients and all outcomes across service lines (inpatient and outpatient), with customized benchmarking capabilities to drive targeted improvements.
- **Clinician performance management:** Mitigate accreditation risks and foster continuous physician development through practitioner evaluations with automated features supporting processes and workflows.
- **Public ratings tracking and forecasting:** Navigate the complex maze of reporting programs while continuously tracking performance with predictive modeling.
- **Chart-abstracted measures support:** Calculate quality measures results based on abstracted data for consistent evaluations of performance.
- **Clinical advisory services:** From rapid opportunity assessments to care model redesign, Premier advisors can evaluate service line performance, reduce unwanted variation and improve margins with data-driven insight.
- **Quality collaboratives:** Join strategic collaboratives to share data, learn best practices from high performers and receive expert coaching.

# Trend 05

## Pills, Policy and Pressure

### *The Pharmaceutical Supply Chain Shake-Up*

Pharmacy has become one of the most volatile and strategically consequential domains in healthcare. And in 2026, health system leaders must either get ahead of the change or pay for being reactive.

Clinically, drug shortages remain pervasive, with essential generics, sterile injectables and oncology drugs frequently in limited supply. According to the American Society of Health-System Pharmacists (ASHP), more than [250 active drug shortages](#) were reported in 2025.

These disruptions force clinicians into suboptimal substitutions or delayed treatments that compromise outcomes. Shortages also consume time as clinical teams scramble to source alternatives and adjust protocols. The result is a [growing threat](#) to quality, safety and staff morale, especially in high-acuity service lines.

These shortages are exacerbated by limited visibility into sourcing and production. Many hospital systems still rely on [fragmented procurement systems](#) or outdated inventory management tools that lack real-time tracking or predictive analytics. This lack of transparency increases waste, hoarding behaviors and the potential for stockouts.

*In 2026, the most resilient health systems will take a proactive, multi-pronged approach to better manage shortages in the pharmacy supply chain, pulling on three principal levers:*

- 01** Use of pharmacy compounding options, which support bridging the availability of shortage drugs. By increasingly integrating compounding into pharmacy operations, hospitals can help ensure critical drugs are available for patient care while preserving quality and safety standards.
- 02** Commitment-based shortage programs are another option to ensure priority access to scarce medications based on clinical need and committed purchasing. Engaging with these programs enables systems to plan care more effectively, allocate resources efficiently, and maintain trust with patients and clinicians.
- 03** Data-driven analytics and integrated supply chain management are essential to anticipate shortages before they occur. Real-time inventory tracking, predictive modeling and scenario planning allow leaders to adjust protocols, optimize stock levels and reduce the burden of last-minute substitutions.

Outside of the shortage problem, high-cost drugs in oncology, immunotherapy and rare disease care, for instance, continue to [outpace inflation and payer reimbursement growth](#). The threat of new tariffs on imported drugs are also exacerbating the problem. Meanwhile, policy changes to the 340B Drug Pricing Program, aggressive payer utilization management and the proliferation of pharmacy benefit managers (PBMs) have reduced the predictability of revenue streams. The cost-to-serve model has shifted dramatically, with many hospitals absorbing unreimbursed drug costs or losing access to preferred pricing due to shifting eligibility standards.

To address these pressures, health system leaders should focus on strategic contract management and financial modeling to anticipate cost pressures. Leaders can then renegotiate commercial contracts, explore risk-sharing or outcomes-based arrangements with manufacturers for high-cost specialty agents and align incentives to protect profitability while maintaining patient access.

Centralizing procurement across outpatient clinics and hospitals, coupled with GPO contracts and management services, is also a key to gaining purchasing leverage and reducing variability in costs. Coordinated inventory management across sites, for instance, can mitigate stock-outs and ensure maximum utilization of 340B-eligible medications.



## Pharmacy Savings and Supply Optimization\*

*Premier's pharmacy solutions are among the most extensive in the industry, consistently delivering savings and improved performance.*

- **Brand portfolio:** 3,800 contracted products with 110 suppliers and more than 60 added-value programs.
- **Generics portfolio:** Thousands of products from hundreds of manufacturers, generating 20 percent savings in 2025 over 2024 pricing levels for many generic injectables.
- **Biosimilars portfolio:** 50 biosimilars on contract coupled with 10 value-added programs to drive market-leading savings.
- **Intersectta®:** Specialty and oncology-focused GPO that delivers an average of 10+ percent savings on more than 100 high-priced, specialty products.
- **Compounding and 503B solutions:** Offering a broad contract portfolio, 503B site evaluations, member collaboratives, product cross-walks, regulatory insights and financial analyses that support an average ~20 percent savings.
- **PremierProRx:** Premier's manufacturer and private label program that generates 30 percent savings year over year.
- **ProvideGx:** Drug shortage sourcing program that not only provides access to 110 shortage NDCs but does so with an average savings of 9 percent.
- **Pharmacy technology:** Premier offers a host of AI-enabled solutions that can assess real-time demand signals and market anomalies, with a track record of accurately predicting 85 percent of shortages before they occur.

*\* Results may vary according to use of the portfolio.*



# Trend 06

## Pick, Partner, Prosper

### *Strategic Payer Moves for Margin and Growth*

In 2026, hospital and health system leaders face a critical inflection point in how they manage relationships with payers.

There is tremendous potential to rethink strategy, particularly in Medicare Advantage (MA), where enrollment has been on an upward trajectory, [\*reaching 54 percent\*](#) of eligible beneficiaries. Steady growth in enrollment means that in most markets, multiple MA plans are competing for health system contracts, giving providers more control over rate setting, administrative requirements and utilization controls.

Strategy-minded systems will capitalize on this opportunity, moving from a “cover-all-bases” approach to cherry-picking MA partners that protect financial performance, align with clinical strengths and enable scale.



## Evaluating Payer Plans Through Collaboration

Supporting members in building sustainable population health strategies and optimizing strategic relationships across payers, the Population Health Management Collaborative (PHMC) consistently outperforms national benchmarks in total cost of care models.

The Collaborative drives success in commercial, Medicare Advantage (MA) and Medicaid models and leads employer-based care initiatives with nationwide impact.

Proven results: While individual results may vary, a record number of PHMC members in 2025 have [achieved shared savings payments](#) with payers, outperforming the national average for all ACOs. This equates to more than \$302 million in performance payments for PHMC members in the Medicare programs alone.

To do this effectively, leaders must evaluate each plan's reimbursement rates, utilization management practices and network adequacy standards, as well as the reliability of their data-sharing and care-coordination infrastructure. The most strategic systems are building payer scorecards that track financial yield, administrative friction and downstream quality performance to inform contracting decisions. Others are forming collaborative partnerships based on jointly designed care pathways, shared risk and aligned incentives that replace transactional relationships with strategic ones. In some markets, systems are even creating preferred payer networks with select MA plans that share a commitment to quality, access and transparency. The goal isn't to reduce participation for its own sake but to ensure every contract strengthens the system's position in a competitive landscape.

Similarly, Medicaid programs are shifting under the influence of new policy initiatives, including the OBBBA, which is set to reduce support for states and providers, placing additional financial strain on

hospitals already operating under thin margins. At the same time, work requirements and increased cost-sharing for higher-income enrollees adds complexity to enrollment and benefits management.

To offset these hits, leading systems are leveraging advanced analytics to identify the highest-need, highest-cost Medicaid patients and coordinating care more effectively with community partners and targeted interventions. At the same time, health systems should evaluate opportunities to participate in state-directed payment programs, value-based arrangements or supplemental funding pools that reward quality and access improvements. Operationally, hospitals should also invest in integrated data platforms that link financial, clinical and operational performance to model the impact of OBBBA and better manage reimbursement and compliance.

Ultimately, success in 2026 and beyond will depend on hospitals' ability to align financial discipline with mission-driven care, protecting access for Medicaid populations while sustaining the economic viability of the enterprise.



# Trend 07

## Align, Analyze, Amplify

### Smarter Management of Physician Networks

The building of comprehensive physician networks began as an effort to ensure referral capture and care coordination. It has since evolved into a complex, high-cost business line that accounts for a growing share of health system operating losses.

Recent [data](#) underscores this shift. Medical groups owned by health systems have experienced a 6 percent increase in overall patient volumes over the past 18 months. However, new patient growth as a percentage of total volume has declined by 6 percent over the same 18-month period, driven by access bottlenecks that now exceed 30 days across all specialties, rising to 40-plus days in primary care. This data indicates that volume measures alone lack the granularity needed to evaluate performance against strategic objectives including value-based care metrics, patient experience improvements and total cost management.

At the same time, physician compensation increased 8 percent more than volumes, contributing to the degradation of operating margins per provider [\(which worsened by 13 percent this year\)](#).

These twin challenges prove that traditional physician incentives based on work relative value units (RVUs) are often misaligned with health system strategic priorities of access and growth.

To enhance the performance of owned medical groups, accurately pinpoint areas of inefficiency and identify opportunities to strategically shift resources, leading health systems in 2026 will invest in unified analytics that consolidate financial, operational and clinical data into a single source of truth. These platforms enable granular analysis of access, service-line performance, patient outcomes, payer mix and revenue streams. Advanced predictive modeling can forecast the financial impact of care redesign, site-of-service shifts or staffing changes before they are implemented, allowing leaders to act proactively.

Benchmarking and comparative analytics also play a critical role. By comparing physician performance across peers, service lines and industry standards, leaders can identify variation in cost, utilization and outcomes. These insights inform incentive redesign, targeted interventions and operational changes that directly support margin improvement. Additionally, dashboards that provide near-real-time visibility into key performance indicators — such as patient access metrics and contribution to enterprise goals — enable continuous monitoring and timely course correction.

Finally, integrating patient experience and quality data alongside financial metrics ensures that margin optimization does not come at the expense of outcomes or satisfaction. By linking operational decisions to both financial and clinical performance, health systems can make evidence-based choices that strengthen the physician enterprise, improve access and sustain long-term profitability.



## PIVOT to Optimize Physician Group Performance

[Premier's Performance Insights Value Optimization Tool \(PIVOT\)](#) gives health system leaders the tools to minimize variation, learn from leading internal and external practices and benchmark operations in real-time against industry standards.

PIVOT provides a detailed, comprehensive view of medical group performance, from systemwide insights to individual provider analytics. With this platform, savvy systems can:

- **Meet patient demand** effectively by optimizing provider capacity and services.
- **Improve the efficiency of patient access** and throughput systems.
- **Deploy staffing models and skill mixes** to boost agility and productivity.
- **Foster collaboration** among physicians and advanced practitioners for improved care.
- **Analyze physician and advanced practitioner compensation trends** and align with productivity goals.
- **Understand patient demographics** and complexity to tailor services and address community needs effectively.

# From Insight to Action

## *Building the Next Generation Health System with Premier*

2026 is a year that will demand reinvention. Between the financial compression triggered by OBBBA reimbursement reforms, rising tariffs on critical supplies, volatile pharmaceutical markets and intensifying consumer expectations, the economics of healthcare delivery are being rewritten in real time. Margin pressures are no longer cyclical, rather they are structural. To compete, health systems must re-engineer how they operate, redesigning service lines, payer relationships, workforce models, community engagement and supply chain infrastructure with the same rigor they apply to clinical care.

This level of transformation can feel daunting, but it is also a moment of opportunity. Health systems that act now will not simply weather disruption; they will define the next standard of value in American healthcare.

At Premier, we are helping health systems do exactly that. Our data-driven collaboratives, AI-powered analytics and deep clinical and operational expertise work synergistically to translate complexity into clarity, accelerating improvement, strengthening financial performance and creating sustainable competitive advantage. Whether through advanced supply chain solutions that insulate against volatility, pharmacy programs that mitigate cost pressures or data-driven technologies that benchmark and elevate performance, Premier partners with health systems to unlock measurable, enterprise-wide results.

As 2026 unfolds, success will belong to the organizations that act with speed, precision and purpose. The time for incremental change has passed.

***Partner with Premier to turn disruption into design — and lead healthcare's next era of reinvention.***

**[premierinc.com](https://premierinc.com)**