Transforming Healthcare in PA: Preparing for the Future

Jefferson School of Population Health Forum
Wednesday, December 10, 2014

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Senior Vice President, Clinical Integration
The Hospital & Healthsystem Association of Pennsylvania
Learning Objectives

• Discuss the ongoing trend of hospital consolidation and how this trend impacts the physical and economic health of communities in the Commonwealth.

• Appraise the current state of health in Pennsylvania and how the Hospital and Healthsystem Association of Pennsylvania plans to facilitate improvement.

• Discuss how a Federal regulation such as the Community Needs Health Assessments can be a path to population health.
General Acute Care (GAC) hospitals include community and children’s hospitals.

Source: PA Department of Health, data compiled by the Hospital & Healthsystem Association of PA (HAP)
General Acute Care (GAC) hospitals include community and children’s hospitals.

Source: PA Department of Health, data compiled by the Hospital & Healthsystem Association of PA (HAP)
Percentage of System-Owned Hospitals

- **All PA Hospitals**
- **Rural Hospitals**

<table>
<thead>
<tr>
<th>Year</th>
<th>All PA</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>41%</td>
<td>22%</td>
</tr>
<tr>
<td>2002</td>
<td>47%</td>
<td>29%</td>
</tr>
<tr>
<td>2004</td>
<td>51%</td>
<td>31%</td>
</tr>
<tr>
<td>2006</td>
<td>53%</td>
<td>33%</td>
</tr>
<tr>
<td>2008</td>
<td>59%</td>
<td>40%</td>
</tr>
<tr>
<td>2010</td>
<td>63%</td>
<td>50%</td>
</tr>
<tr>
<td>2012</td>
<td>70%</td>
<td>56%</td>
</tr>
<tr>
<td>2014</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Source: PA Department of Health, data compiled by The Hospital & Healthsystem Association of PA (HAP)
Inpatient Admissions per 1,000

Sources: PA data: Pennsylvania Department of Health; US data: AHA Annual Hospital Statistics (2013 not yet available)
Hospital Emergency Department Visits per 1,000 Population

<table>
<thead>
<tr>
<th>Year</th>
<th>PA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>412.8</td>
<td>382.9</td>
</tr>
<tr>
<td>2004</td>
<td>424.9</td>
<td>384.6</td>
</tr>
<tr>
<td>2005</td>
<td>433.2</td>
<td>388.3</td>
</tr>
<tr>
<td>2006</td>
<td>433.5</td>
<td>396.7</td>
</tr>
<tr>
<td>2007</td>
<td>445.7</td>
<td>404.6</td>
</tr>
<tr>
<td>2008</td>
<td>455.9</td>
<td>415.0</td>
</tr>
<tr>
<td>2009</td>
<td>461.7</td>
<td>411.4</td>
</tr>
<tr>
<td>2010</td>
<td>470.6</td>
<td>415.5</td>
</tr>
<tr>
<td>2011</td>
<td>475.4</td>
<td>424.4</td>
</tr>
<tr>
<td>2012</td>
<td>479.1</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>485.6</td>
<td></td>
</tr>
</tbody>
</table>

Sources: PA data: Pennsylvania Department of Health; US data: AHA Annual Hospital Statistics (2013 not yet available)
Uncompensated care continues to grow

Uncompensated care\(^1\) in PA Hospitals ($ Billions)

- FY07: $0.677
- FY08: $0.769
- FY09: $0.825
- FY10: $0.891
- FY11: $0.974
- FY12: $0.989
- FY13: $1.042

54% increase over 6 years.

Figures reflect general acute care hospital bad debt and charity care at cost.

Source: HAP analysis of Pennsylvania Health Care Cost Containment Council data.
Hospitals Role Beyond Acute Care

- Employers
- Educators
- Public Health
- Disaster Preparation
A Time of Opportunity

- Medical advances and innovation
- Transformational models of care
- Greater access to information
### Exhibit 3. State Scorecard Summary of Health System Performance Across Dimensions

<table>
<thead>
<tr>
<th>Performance Quartile</th>
<th>Access &amp; Affordability</th>
<th>Prevention &amp; Treatment</th>
<th>Avoidable Hospital Use &amp; Cost</th>
<th>Healthy Lives</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Quartile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Quartile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Quartile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bottom Quartile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 2014 Scorecard Ranking

1. Minnesota
2. Massachusetts
3. New Hampshire
4. Vermont
5. Hawaii
6. Connecticut
7. Maine
8. Wisconsin
9. Rhode Island
10. Delaware
11. Iowa
12. Colorado
13. South Dakota
14. North Dakota
15. New Jersey
16. Washington
17. Maryland
17. Nebraska
19. New York
19. Utah
21. District of Columbia
22. Pennsylvania
23. Kansas
24. Oregon
24. Virginia
26. California

#### Revised 2009 Scorecard Ranking

1. Minnesota
2. Hawaii
2. Massachusetts
2. Vermont
5. Connecticut
5. New Hampshire
5. Rhode Island
8. Iowa
9. Maine
9. North Dakota
9. Wisconsin
12. South Dakota
13. Delaware
14. Pennsylvania
15. Colorado
15. Michigan
17. Nebraska
18. New York
18. Washington
20. Kansas
20. Montana
20. Utah
23. New Jersey
24. District of Columbia
24. Maryland
24. Oregon

Source: Commonwealth Fund May 2014
### Economic Well-Being

<table>
<thead>
<tr>
<th>Measure</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in poverty</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Children whose parents lack secure employment</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Children living in households with a high housing cost burden</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Teens not in school and not working</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

### Health

<table>
<thead>
<tr>
<th>Measure</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-birthweight babies</td>
<td>8.1%</td>
<td>8.1%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Children without health insurance</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Child and teen deaths per 100,000</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Teens who abuse alcohol or drugs</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

### Family and Community

<table>
<thead>
<tr>
<th>Measure</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in single-parent families</td>
<td>35%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Children in families where the household head lacks a high school diploma</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Children living in high-poverty areas</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Teen births per 1,000</td>
<td>24</td>
<td>24</td>
<td>24</td>
</tr>
</tbody>
</table>

Pennsylvania Partnerships for Children | www.pppartnerships.org | 717.726.6660 | Learn more at pennsylvaniachilds.org/PK
Penalty Box

• Medicare’s HAC Reduction Program:
  • $23 million in penalties
  • 33% of eligible Hospitals
  • 39 out of 50 states

• Medicare Readmission Reduction Program:
  • $21 million in penalties
  • 72% of eligible Hospitals
  • 40 out of 50 states

• VBP impact:
  • FFY15 estimate: $1.3 million
  • FFY16 estimate: $4.8 million
  • worrisome trend: 30/50 to 42/50
Not Just About Rankings

People
Families
Communities
Workforce
Education
Future
HAP MISSION
To be the leading advocate for improving the health and well-being of Pennsylvanians.
VISION: A Healthy Pennsylvania

How Do We Get There?

Where HAP is NOW
- Hospital provider centric.
- Focused on sick care.
- Hospital-driven data.
- State oversight.

Where We Need to Go
- Care integration.
- Focus on community health and well-being.
- Population health metrics.
- Growing federal presence.

End Results
- Better experience for patients/consumers.
- Healthier communities.
- Lower annual growth in per capita spending.
- Ongoing financial sustainability for providers to achieve these goals.
Strategy 1

Serve as a **catalyst** for integrating care across the continuum

- Facilitate dialogue among a broad spectrum of providers.
- Share best practices.
- Support infrastructure development and financial sustainability.
- Identify and remove barriers to care coordination.
Expand HAP’s role as a **convener** to achieve higher quality and better value.

- Convene a broad spectrum of health care stakeholders.
- Encourage the development of multi-stakeholder efforts and initiatives.
- Create forums to support hospitals and partners as they participate in new payment approaches.
- Encourage stakeholders to focus on and understand consumer health needs.
Strategy 3

Engage broader health care community in advocacy and work to achieve better health.

- Identify, build relationships, and align with a broader spectrum of advocacy organizations.
- Improve credibility and advocacy effectiveness, and promote fair market conduct and the elimination of barriers to integration.
- Provide a forum for a shared vision and strong voice to advocate for solutions and financial sustainability in health care.
Strategy 4

Become more **consumer-focused.**

- Support hospitals as they connect to consumers and patients to promote health and involvement in their care.
- Share best practices from hospitals that are seen as leaders in health care transformation.
- Develop member guidance on billing transparency and charity care.
- Conduct consumer research and create a consumer advisory council.
Strategy 5

Champion hospital priorities related to strengthening health care financing and the operating environment.

- Advocate for regulatory and fiscal stability hospitals need to sustain crucial services and jobs.
- Advocate for fair Medicaid and Medicare payments.
- Increase health coverage for low-income, uninsured.
- Achieve additional improvements in hospital quality and patient safety.
Community Health Needs Assessment: Round #2
IRS released the [2014 Draft Schedule H](#) and instructions for hospitals on September 5, 2014.

The draft Schedule H reflects the requirements of Section 501(r) and the IRS proposed regulations that were issued on June 26, 2012 and April 5, 2013.

Significant changes to the 2014 Schedule H include new questions related to Part V – Community Health Needs Assessment (CHNA) and Part V – Financial Assistance Policy (FAP) sections.
Key provisions for the CHNA
The proposed regulations give hospitals the flexibility to define the communities they serve, taking into account all of the relevant facts and circumstances.

Clarification for Community Input
From groups and individuals that represent the broad interests of the community.

Requirement to seek Public Input
Public input must be considered when conducting subsequent CHNAs. Most recent CHNA must remain widely available for two subsequent CHNA reporting cycles.

Guidance allowing hospitals to collaborate with others when conducting a CHNA and produce one joint report
Each hospital collaborating must be clearly identified, and the CHNA must be adopted by an authorized body for each collaborating hospital.
The CHNA as a Path to Collaboration

- IRS changes allow multiple hospitals to complete one CHNA, thus giving way to one implementation plan for a community.

- More broad definition of community

- Collaboration could lead to funding for implementation

- Opportunity to leverage strengths in partnerships and reduce duplicative efforts
The CHNA as a Path to Collaboration

HHS Region III:
- Has convened stakeholder group (hospitals, HAP/DVHC of HAP, county health departments, community organizations) around CHNA.
- Is facilitating collaboration with Federal agencies (CDC, HRSA, CMS) to identify CHNA support resources and potential funding sources.
- Is working with HAP to pursue partnerships across the Commonwealth and with other Mid-Atlantic institutions.
The CHNA as a Path to Population Health

- 98% of CEOs believe that hospitals need to investigate and implement population health management strategies\(^1\)

- Move from checking the box to results

- Achieving the Triple Aim means addressing population health – CHNAs and implementation plans can be a tangible path.

\(^1\)The American Hospital Association (AHA) Annual Survey of Hospitals, 2012
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Core Strategies
At the core of our new roadmap are seven interrelated strategies that will drive HAP for the next decade and beyond.

1. Serve as a **catalyst** for integrating care across the continuum.

2. Expand HAP’s role as a **convener** to achieve higher quality and better value.

3. Engage broader health care **community** in advocacy and work to achieve better health.

4. Become more **consumer-focused**.

5. Continue to **champion** hospital priorities related to strengthening health care financing and the operating environment.

**Enabling Strategies:**
1. Strengthen HAP’s technology platform and data analytic capacity.
2. Develop a business model to sustain our new vision.