

MIHS

Bond Advisory Committee



Committee Purpose

- 1 Review, prioritize and make recommendations to the Maricopa County Special Health Care District Board of Directors ("District") on proposed bond projects in support of the Maricopa Integrated Health System mission, vision and community needs.
- 2 Develop a bond proposal comprised of prioritized projects and make a recommendation to the District Board regarding the issuance of bonds or any other viable financing vehicle to fund the prioritized capital projects, including the consideration of a bond election.
- 3 Obtain public comment, community and stakeholder input, and expert opinion into bond project and proposal deliberations.

MIHS

Bond Advisory Committee



MARICOPA INTEGRATED HEALTH SYSTEM BOND ADVISORY COMMITTEE

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<u>Committee Members</u> Bill Post, Chair Lattie Coor, Vice Chair Tony Astorga Paul Charlton Kote Chundu Frank Fairbanks Nita Francis Merwin Grant Doug Hirano Len Kirschner Diane McCarthy Terrence McMahon, Ex-officio Rick Naimark Joey Ridenour Brian Spicker Ted Williams	<u>AGENDA –</u> Bond Advisory Committee Meeting Board of Directors of the Maricopa County Special Health Care District
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• Maricopa Medical Center • Administration Building • Auditoriums 1 and 2 •
• 2601 E. Roosevelt • Phoenix, AZ 85008 • Clerk's Office 602-344-5177 • Fax 602-344-0892 •

Monday, March 11, 2013
2:30 p.m.

If you wish to address the Committee, please complete a speaker's slip and deliver it to the Executive Director of Board Operations. If you have anything you wish distributed to the Committee and included in the official record, please hand it to the Executive Director who will distribute the information to the Committee Members. Speakers are limited to (3) three minutes.

ITEMS MAY BE DISCUSSED IN A DIFFERENT SEQUENCE

Call to Order

Roll Call

Call to the Public

This is the time for the public to comment. The Bond Advisory Committee may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. § 38-431.01(H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism or scheduling a matter for further consideration and decision at a later date.

General Session Presentation, Discussion and Action:

1. Welcome and Introductions 15 min
Susan Gerard, Chairman, Board of Directors
Betsey Bayless, President & CEO

Agendas are available within 24 hours of each meeting in the Board of Directors Office, Maricopa Medical Center, Administration Bldg, 2nd Floor 2601 E. Roosevelt, Phoenix, AZ 85008, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. Accommodations for individuals with disabilities, alternative format materials, sign language interpretation, and assistive listening devices are available upon 72 hours advance notice through the Clerk of the Board's Office, Maricopa Medical Center, Administration Bldg, 2nd Floor 2601 E. Roosevelt, Phoenix, Arizona 85008, (602) 344-5177. To the extent possible, additional reasonable accommodations will be made available within the time constraints of the request.

General Session Presentation, Discussion and Action:

2. Overview of Maricopa Integrated Health System **15 min**
Betsey Bayless, MIHS, President & CEO
3. Overview of Arizona's Open Meeting Laws **10 min**
Louis Gorman, MIHS, District Counsel
4. Overview of Maricopa Integrated Health System's Strategic Direction **15 min**
Susan Doria, MIHS, Vice President of Strategic Planning
5. Discuss and Review Maricopa Integrated Health System's Finances and Economic Direction **15 min**
Michael Ayres, MIHS, Chief Financial Officer
6. Facility Overview **15 min**
Bill Vanaskie, MIHS, Chief Operating Officer
7. Discuss the Scheduling of Tours **15 min**
Bill Post, Committee Chairman
8. Future Meetings and Logistics **15 min**
Bill Post, Committee Chairman

Adjourn

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
RESOLUTION NO. 2012-12-13-001
December 13, 2012

WHEREAS, the Maricopa County Special Health Care District (“**District**”) through its Board of Directors (“**District Board**”) provides for the care and maintenance of the sick in the county and maintains a hospital, health care facilities, staff and other resources for such purposes, pursuant to Arizona Revised Statutes, A.R.S. § 48-5501 et. seq. (“the Act”); and,

WHEREAS, pursuant to A.R.S. § 48-5566, the District Board may determine that bonds should be issued to carry out the provisions of the Act; and,

WHEREAS, the Board believes it to be in the best interests of and for the benefit of the District and the residents of the District to issue bonds for the creation, acquisition, construction, equipping, renovation, repair, capital improvements, or expansion of a hospital, of the Arizona Burn Center, a level one trauma unit, of a network for primary and specialty care facilities including specialty care facilities in the eastern and western portions of Maricopa County, for the current primary and specialty care facilities and the existing hospital and campus, for behavioral health facilities, and a doctor training and research center; and

WHEREAS, the Board further believes that it is prudent that prior to seeking approval from the voters of Maricopa County to issue bonds for the above purposes that the District establish a Bond Advisory Committee to assist the District in developing a bond proposal for presentation to the voters of Maricopa County.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Maricopa County Special Health Care District:

Section 1. The recital paragraphs above are incorporated by reference and adopted herein.

Section 2. The attached *Maricopa Integrated Health System Bond Advisory Committee Charter* is approved.

Section 3. The Board hereby authorizes the creation of a Maricopa Integrated Health System Bond Advisory Committee (“**Advisory Committee**”) with 17 members to serve on the Advisory Committee.

PASSED, ADOPTED, AND APPROVED by the Board of Directors of the Maricopa County Special Health Care District on December 13, 2012.

Susan Gerard, Chair

ATTEST:

Melanie Talbot, Clerk of the Board

MARICOPA INTEGRATED HEALTH SYSTEM BOND ADVISORY COMMITTEE CHARTER

Purpose

1. Review, prioritize and make recommendations to the Maricopa County Special Health Care District Board of Directors (“District”) on proposed bond projects in support of the Maricopa Integrated Health System mission, vision and community needs.
2. Develop a bond proposal comprised of prioritized projects and make a recommendation to the District Board regarding the issuance of bonds or any other viable financing vehicle to fund the prioritized capital projects, including the consideration of a bond election.
3. Obtain public comment, community and stakeholder input, and expert opinion into bond project and proposal deliberations.

Creation of Advisory Committee

1. The Maricopa County Special Health Care District Board of Directors (“Board”) will create the Bond Committee as an Advisory Committee of the Board of Directors, as authorized by A.R.S. 38-431.
2. By Board Resolution, the Board will
 - a. Identify the powers of the Advisory Committee.
 - b. Establish a budget and funding source for the Advisory Committee.
 - c. Require annual review of need for continuation of the Advisory Committee.
 - d. Identify and contract with a consultant with project management and meeting facilitation experience to staff the Advisory Committee.
 - e. Establish, in conjunction with the Chief Executive Officer, criteria by which to evaluate projects and prioritize them.
 - f. Develop a timeline for delivery of the bond proposal and a companion ballot proposal.

Membership of Advisory Committee

1. Advisory Committee members are to be appointed by the District Board.
2. The District Board will select members of the Advisory Committee, representing each District and reflecting the community at large, as well as representatives from different stakeholder groups.

3. By the majority vote of the Board of Directors, one member of the District's Board of Directors shall be selected to serve as a non-voting member of the Advisory Committee.
4. The Chair and Vice Chair of the Advisory Committee are to be appointed by the District Board.

Powers of Advisory Committee

1. Make recommendations to the District Board regarding the creation of a bond proposal and consideration of a bond election for the voters of Maricopa County whose goal is consistent with the Purpose of the Advisory Committee as stated above.
2. As directed by the Board of Directors and in conjunction with the consultant:
 - a. Develop a working knowledge of MIHS's mission, vision, strategies, services, programs, operations and finances as a foundation from which to evaluate future needs and projects, while taking into consideration recent economic challenges, future health care delivery trends and models, and healthcare workforce training education.
 - b. Tour all current MIHS facilities to understand their ability to deliver services to meet community needs today and into the future and to secure MIHS's role as a 21st century academic medical center.
 - c. Review each proposed project in terms of its overall purpose, strategy, goals, resource requirements, performance expectations and cost. Challenge underlying project assumptions regarding demand and utilization expectations as well as changes in healthcare delivery. Any recommendations for new programs or service lines need to include business plans with a five-year return on investment pro forma.
 - d. Recommend a proposed capital investment proposal that:
 - i. identifies the capital needs, and priorities of the District based on goals and objectives;
 - ii. analyze the operational cost impact of each plan component; and
 - iii. includes a recommendation regarding capital financing.
3. The Advisory Committee may at its discretion appoint subcommittees to assist the Advisory Committee.
4. Conduct hearings to review bond projects, present the bond proposal and seek input from the community.

5. Request additional Powers from the District Board, via Bond Advisory Committee charter amendments, in order to carry out its duties as defined in the Purpose of said charter.
6. Limitations on power:
 - a. The Advisory Committee may not expend District funds without the District Board prior approval.
 - b. The Advisory Committee may not make District policy.

Administrative Requirements

1. Advisory Committee and its members, and any subcommittee and its members, are subject to the Arizona Open Meeting Law and Public Records Act and Arizona and District conflict of interest laws, regulations, and policies; and therefore:
 - a. Must record and maintain minutes of all meetings.
 - b. Conduct all meetings as open to the public and noticed as required by the Arizona Open Meeting Law.
2. Make bimonthly reports of the activities of the Advisory Committee and any subcommittee to the District Board. The Advisory Committee shall meet not less than once a month.
3. The Advisory Committee's final report is due by October 31, 2013.
4. All funds held by Advisory Committee are public funds and must be held in accounts permitted for public funds and are subject to audit as public funds. Funds can only be spent in accordance with District procurement procedures.

Maricopa County Special Health Care District Board of Directors



Mary A. Harden, R.N. Representing District 1 (Chandler, Gilbert, Mesa, Phoenix, Queen Creek, Sun Lakes, Tempe)

Term of Office: 2012 – 2016

Profession: R.N.

Mary recently retired from Maricopa Medical Center after 32 years of dedicated service.



Mark Dewane, Representing District 2 (Gilbert, Mesa, Paradise Valley, Fountain Hills, Scottsdale, Carefree, Cave Creek)

Term of Office: 2012 – 2016

Profession: Senior Vice President-Wealth Management

Mark has been a Phoenix financial adviser for 27 years who also has 20 years volunteer experience in the community.



Susan Gerard, Representing District 3 (Greater Phoenix area, Paradise Valley, Desert Hills, Anthem, and New River)

Term of Office: 2010 – 2014

Profession: Health Policy and Management Consultant

Susan has been a leader in health care policy and systems in Arizona for more than two decades.

Maricopa County Special Health Care District Board of Directors (cont.)



Elbert Bicknell, Representing District 4 (Avondale, Buckeye, El Mirage, Glendale, Goodyear, Litchfield Park, Peoria, Sun City, Sun City West, Surprise, Wickenburg, Youngtown)

Term of Office: 2010 – 2014

Profession: Retired

Elbert “Bick” is a retired law enforcement officer and served in the New Hampshire House of Representatives.



Terence McMahon, Representing District 5 (Avondale, Buckeye, Gila Bend, Gila River Indian Community, Glendale, Goodyear, Guadalupe, Phoenix & Tolleson)

Term of Office: 2012 – 2016

Profession: Retired

Mark has more than 40 years of experience in the public and private sectors.



Maricopa Special Health Care District

Maricopa Health Foundation

Betsey Bayless

President and
Chief Executive Officer

Donna Andrews
Executive Assistant

Warren Whitney
Senior VP
& Chief
External Affairs Officer

Dr. Robert Fromm
Senior VP &
Chief Medical
Officer

Michael Ayres
Senior VP &
Chief Financial
Officer

Bill Vanaskie
Executive VP
& Chief Operating
Officer

Marshall Jones
Senior VP of Human
Resources

Louis Gorman
District Counsel

John Middleton
Chief Compliance
Officer

Susan Doria
Senior VP
Strategic Planning

- Marketing & Public Relations
Michael Murphy
- Legislative and Governmental Affairs
Michael Fronske
- Real Estate & Construction
(contracted as needed)
- Community Relations
Luis Gendreau
- Strategic Support
Mike Schneider
- Business Development
Scott Trenter
- Physician Outreach
Jason Moore

- Graduate Medical Education
Dr. Michael Grossman
- Quality Outcomes
Dr. Dan Hobohm
- Credentialing
Stephanie Davee
- Quality & Care Management
Jean Morris
- Research/Grants
Cheri Tomlinson
- Library
Rebecca Birr
- Medical Informatics
Dr. Prabodh Hemmady
- Clinical Support Services
Phyllis Thackrah

- Information Technology
Kelly Summers
- Maricopa Health Plan
James Stover
- Finance / Controller
Kathy Benaquista
- Revenue Cycle
Mary Lee DeCoster
- Contracts & Procurement
Brian Maness
- Supply Chain & Management
Paul Dereadt
- Strategic Planning
Joyce Graham

- Hospital Operations
Denise Atwood
- Ambulatory & Physician Services
Laurie Wood
- Behavioral Health Svc
Gene Cavallo
- Patient Care Services / Chief Nursing Officer
Sherry Stotler
- Surgical Services
Janet Dehnert
- Arizona Children's Center
Deanna Grey
- ARK Project
Mike Totherow
- Facilities Services
(Open)
- Provider Services
Tera Williamson
- Emergency Preparedness
Keith Fehr

- Patient Experience & Organization Development
(Open)
- Volunteer & Guest Services
Liz Hyatt
- Employee Health
June Mikkila
- Human Resources
Mica Goldfedder

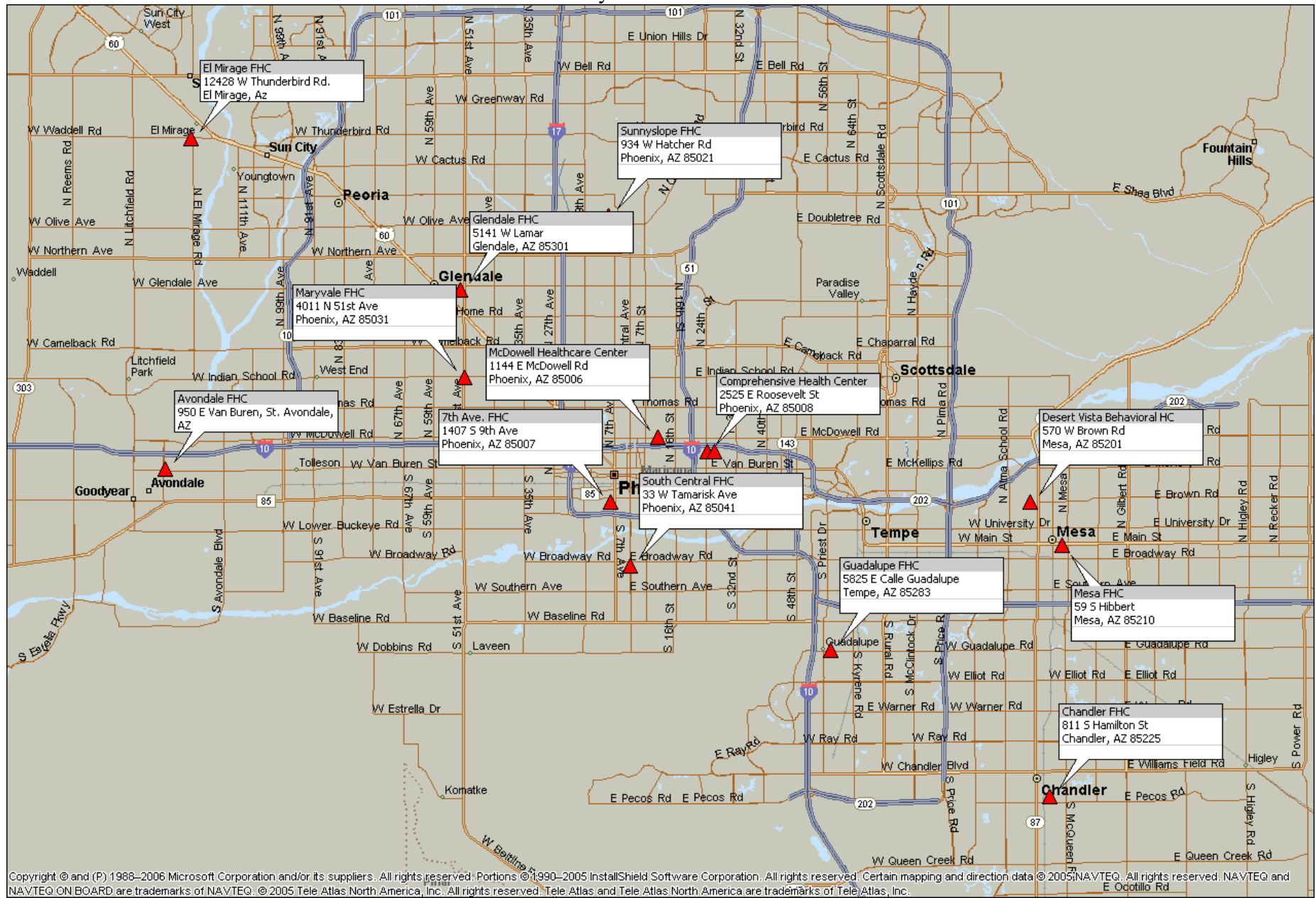
- Assistant District Counsel
Martin Demos
- Certified Paralegal
Laura Lewis

- Internal Audit (Protiviti)
Alex Robison
- Risk Management
Rocky Armfield
- Compliance
Eric Royal
- Security
Mark Pecak
- Safety Officer
Ken Bourdo
- Revenue Integrity
Armando Torres

Administration

Name	Title	Administrative Contact	Phone
Bayless, Betsey	President and Chief Executive Officer	Donna Andrews	344-5566
Doria,Susan	Senior VP of Strategic Planning	Donna Andrews	344-5566
Fromm, Robert MD	Senior VP and Chief Medical Officer	Sara Arnold	344-5503
Gorman, Louis	District Counsel	Maureen Robinson	344-1257
Jones, Marshall	Senior VP of Human Resources	Patty Teel	344-5512
Ayres, Michael	(interim) Senior VP & Chief Financial Officer	Lynn Baker	344-1230
Middleton, John	Chief Compliance Officer	Maureen Robinson	344-1257
Vanaskie, William	Executive VP & Chief Operating Officer	Lynn Baker	344-1230
Whitney, Warren	Senior VP & Chief External Affairs	Sara Arnold	344-5503

MIHS Family Health Center Locations



The Arizona Open Meeting Law A.R.S. §38-431 Et Seq. ("OML")

- ✦ It is the public policy of this state that meetings of public bodies be conducted openly
- ✦ Notices and agendas should be provided for the meeting
- ✦ Notice must contain adequate information to inform the public of the matters to be discussed and decided
- ✦ Applies to Bond Advisory Committee





THE PUBLIC'S RIGHTS

- ✦ Right to notice of meeting time & place
- ✦ Right to notice of items to be discussed, considered, or legal actions to be taken (i.e. the Agenda)
- ✦ Right to record (audio/video) the proceedings
- ✦ Right to attend the meeting and listen

WHAT IS A MEETING?

- ✦ Gathering of a quorum

- In person or
- Through technological means
- Quorum – 9 of the 16 Members



- ✦ To discuss, propose, or take legal action, including all deliberations by the quorum

- ✦ Legal Action: Collective decision, commitment or promise made by a public body

EXCEPTIONS

- ✱ Executive sessions
 - only when permitted by the OML
- ✱ Gathering of less than a quorum
- ✱ Beware of Traps:
 - social media
 - daisy-chain, hub and spoke
 - purely social gatherings





AGENDA

- ✦ Prepared by staff
- ✦ Posted 24 hours before the meeting
- ✦ Public body may discuss, consider or make decisions only on those matters listed on the agenda



CALL TO THE PUBLIC

✦ Call to public

- Can limit time, e.g. 3 minutes
- Require speakers on same side with no new comments to select a spokesperson
- Set rules for civility and language
- Public body may not discuss issues raised in the Call to the Public
- Committee or individuals may respond to criticism
- Direct staff to review the matter and add to future agenda

EXECUTIVE SESSION

✱ Used rarely but staff and Legal will help

✱ Permitted E-session bases:

- Personnel matters
- Records exempt by law from public inspection
- Legal advice
- Purchase, sale or lease of real property
- Discussion or consultation and instruction with attorneys regarding:
 - Contracts subject of negotiations
 - Pending or contemplated litigation





MINUTES

- ✱ Minutes are required
- ✱ Done and kept by staff



VIOLATIONS AND PENALTIES

- ✦ Initiated by complaint to County Attorney, State Ombudsman, or Attorney General
- ✦ If a meeting is held in violation of OML
 - Fines
 - Training
 - All legal actions taken are void, but may be subsequently ratified



ISSUES and HOT TOPICS

- ✱ Creating a quorum (intentionally or inadvertent) through phone, social media or e-mail
- ✱ Speaking as a member of the public is still OK
- ✱ But don't stop talking with your colleagues



Maricopa Integrated Health System

Phoenix, Arizona

2008 Strategic Plan Presentation to the Board of Directors

Reviewed March 30, 2011

Building infrastructure; managing short-term challenges.

The Maricopa County Special Health Care District has invested the past four years in building the infrastructure to manage a complex integrated health system. Betsey Bayless, MIHS Chief Executive Officer, has assembled a team of experienced health system leaders focused on creating management systems and processes to resolve financial and operational issues inherited from Maricopa County, and position the district for long-term success.

Planning for the future; making strategic choices.

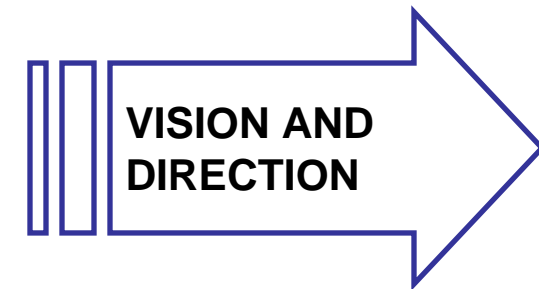
In 2007, the District Board charged the Chief Executive Officer with developing a Vision and Strategic Direction for the organization. Warren Whitney was named as Project Executive for a strategic planning effort. The focus of that planning has been to create strategies that build around the needs and preferences of the people that we serve – and to engage the voice of the public in shaping our vision and strategic plan.

Executing our strategy; measuring our results.

This plan aligns our strategies with our mission. It uses a balanced approach to measuring success across the performance dimensions of business growth, patient satisfaction, clinical quality, people engagement, and fiscal vitality. The plan will serve as a framework for work re-design and investments in people and process to create an improved Maricopa experience for patients and employees.

Charge from the Board of Directors

The Strategic Planning process will....



- **By April 2008 create a shared vision and strategic direction** for the future of Maricopa Integrated Health System that will guide and direct the organization's future growth and development;



- **By August 2008 formulate strategies and plans** to support growth and diversification, campus development, clinical programming, physician alignment, consumer readiness strategies, strategic relationships, investments and other market, clinical and operational initiatives.

Issues to address include:

- ☐ Long-range vision
- ☐ Role in the community
- ☐ Market position
- ☐ Self sufficiency
- ☐ Charity care
- ☐ Medical education
- ☐ Physician relations
- ☐ Employee retention
- ☐ Philanthropy
- ☐ Performance expectations

MISSION, VISION, AND STRATEGIC DIRECTION

Mission and Vision, and Key Strategies



Mission

- MIHS exists to provide comprehensive and safe care to all of those who live in Maricopa County, including the underserved and medically needy.



Vision

- As the region's only public integrated health system, MIHS will be a nationally-recognized leader in community health



Strategies

- Transform the Patient Care Experience
- Invest in our Network of Clinical Facilities
- Integrate Primary & Ambulatory Care Sites
- Create Exemplary Medical Education Programs
- Develop Health Care Access Models
- Engage the Philanthropic Community as Vision Partners

Six Strategies and Associated Action Steps

Strategy	Action Steps	Point Person(s)
<i>Transform the Patient Care Experience</i>	Create a new business model so that MIHS and MedPro share in the risk and reward of better quality and service by June 2009.	Bayless, Wisinger, Chundu, Westover
	Organize MIHS's operations into four business divisions (hospital, ambulatory, health plan, and medical education) by January 2009.	Bayless
	Redesign service and care processes across inpatient and ambulatory business divisions around customer needs by July 2009.	Vanaskie, Chundu
<i>Invest in our Network of Clinical Facilities</i>	Build a new hospital facility by 2014.	Whitney
	Reconfigure a geographically dispersed, patient-centric network of ambulatory campuses by 2012.	Whitney
	Bring a facility financing plan to the Board of Directors by June 2009.	Meinke
<i>Integrate Primary & Ambulatory Care Sites</i>	Create operational infrastructure for the ambulatory care division by June 2009.	MIHS Ambulatory Chief, Westover, Kuruvilla
	Integrate care among the ambulatory sites and between them and the hospital by December 2009.	Wisinger
	Use a work redesign process to deliver ease of access to customers across all primary care and ambulatory sites by January 2009.	MIHS Ambulatory Chief, Kuruvilla

Six Strategies and Associated Action Steps (cont.)

Strategy	Action Steps	Point Person(s)
Create Exemplary Medical Education Programs	Develop and implement a team-based, simulator-enabled training model for physicians and nurses by June 2009.	Wisinger
	Partner to create an MIHS nurse education program by June 2010.	Vanaskie
	Grow clinical research to draw in more resources to fund innovative training and clinical applications (continuous).	Wisinger
Develop Health Care Access Models	Build a business model for the Health Plan Division by January 2009.	Oestreich
	Develop a menu of products for targeted markets, including the transitionally unemployed; Medicare, long-term care and small business by January 2009.	Meinke
Engage the Philanthropic Community as Vision Partners	Create compelling case statements to engage individual, corporate and foundation philanthropic investments in innovative patient care, training, facility and research projects by June 2009.	Whitney
	Complete implementation of the Maricopa Foundation restructuring plan by June 2009.	Whitney
	Build a Maricopa ambassador program that inspires and trains staff, volunteers and physicians to share “our story” in the community by January 2009.	Vanaskie

TODAY

Hospital-centric.....
Physician as paid contractor.....
Employees who get paid.....
Managers of departments.....
Hard-wiring of status quo.....
Regulation compliant minimum...
Crisis management.....
“County” Hospital.....

OUR FUTURE

Patient-centric
Physician as care partner
Ambassadors who believe in mission
Leaders of public health
Innovation incubator
Performance excellence maximum
Strategic management
Community leader

Measurement and Evaluation of the Strategic Plan

Strategy	<u>Balanced Success Measures (2013)</u>				
	<i>Patient Satisfaction</i>	<i>Financial Stability</i>	<i>Clinical Quality</i>	<i>Engaged People</i>	<i>Business Growth</i>
Transform the patient care experience	Top quartile patient satisfaction	Cost per patient day	Top quartile on core measures	Top quartile employee satisfaction; Top quartile physician satisfaction	Commercial market share growth sufficient to offset more charity care
Invest in our network of clinical facilities	Top quartile patient satisfaction	Increased revenue per square foot	EMR implemented across all sites	Top quartile employee satisfaction; Top quartile physician satisfaction	Fulfill facility pro forma expectations
Integrate primary & ambulatory care sites	Top quartile patient satisfaction	Cost per visit	EMR implemented across all sites	Top quartile employee satisfaction; Top quartile physician satisfaction	5% annual volume growth in primary care and ambulatory visits
Create exemplary medical education programs	Best resident pass rate in AZ	Lowest cost-per student training	Fully certified training programs	More nurse educators trained	Increased clinical trials
Develop health care access models	Market leading retention rate	Budgeted margin produced	Top quartile AHCCS adult access to preventive health; top quartile well-child visits during the first 15 months of life	Top quartile employee satisfaction	Member enrollment
Engage the philanthropic community as vision partners		Top quartile administrative efficiency	Budgeted support for clinical innovations	Annual growth targets in numbers of donors	Single, unified foundation model



MARICOPA
INTEGRATED HEALTH SYSTEM

Bond Advisory Committee Meeting

March 11, 2013

Finances & Economic Direction



Patient Service Revenue:
(\$ in millions)

Gross Patient Revenue	\$1,746.3	
Total Deductions	<u>1,008.2</u>	
Patient Services Revenue	738.1	42.3%
Self pay/bad debt	<u>448.0</u>	
Net Patient Service Revenue	\$ 290.1	16.6%

Source: Fiscal Year 2012 Audited Financial Statements

Total Sources of Revenue:
(\$ in millions)

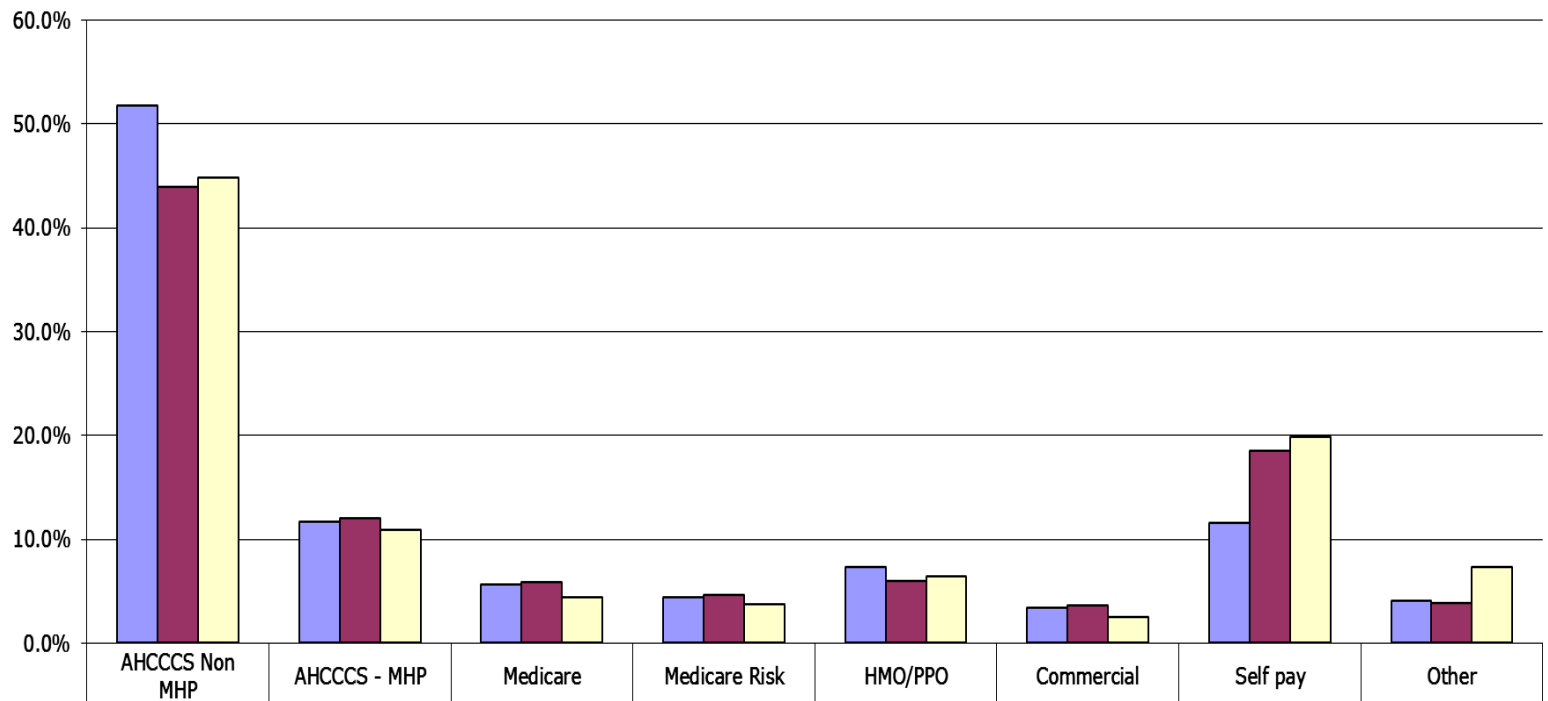
Net Patient Services Revenue	\$290.1
Capitation and Reinsurance	163.6
AHCCCS Medical Education	27.0
Other	<u>81.1</u>
Total Operating Revenue	561.8
 Non-Operating Revenue:	
Property Tax Receipts	57.9
Grants	6.4
Other	<u>3.7</u>
Total Non Operating Revenue	68.0
 Total Sources of Revenue	<u>\$629.8</u>

Summary Operating Results

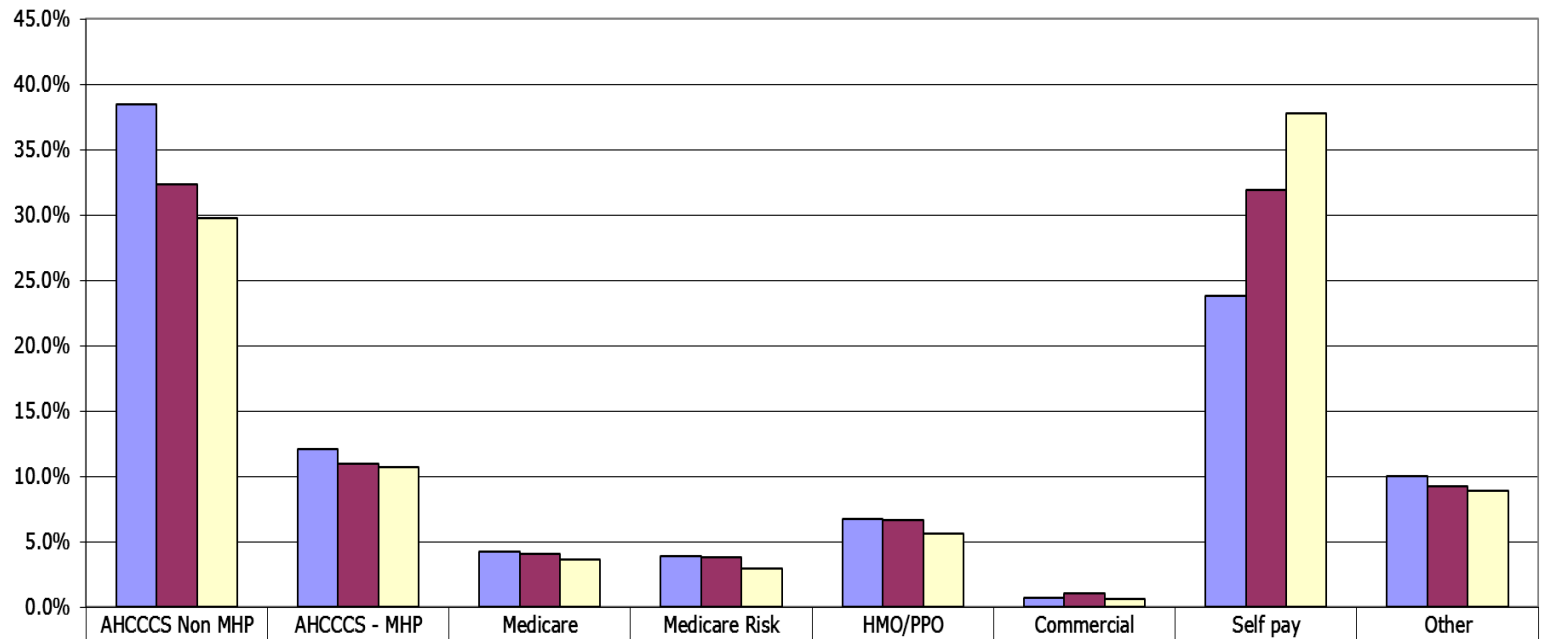
(\$ in millions)

Total Operating Revenues	\$561.8
Operating Expenses	<u>(609.8)</u>
Operating Loss	(48.0)
 Non-Operating Revenue	 <u>68.0</u>
 Increase in Net Assets	 <u>\$ 20.0</u>

Source: Fiscal Year 2012 Audited Financial Statements



■ June 30, 2011	51.8%	11.7%	5.6%	4.4%	7.3%	3.4%	11.6%	4.1%
■ June 30, 2012	43.9%	12.0%	5.8%	4.6%	6.0%	3.6%	18.5%	3.9%
■ YTD FYE 06/30/2013	44.8%	10.9%	4.4%	3.8%	6.4%	2.5%	19.8%	7.3%



	AHCCCS Non MHP	AHCCCS - MHP	Medicare	Medicare Risk	HMO/PPO	Commercial	Self pay	Other
June 30, 2011	38.5%	12.1%	4.2%	3.9%	6.7%	0.7%	23.9%	10.0%
June 30, 2012	32.4%	11.0%	4.1%	3.8%	6.7%	1.0%	31.9%	9.2%
YTD FYE 06/30/2013	29.8%	10.7%	3.6%	3.0%	5.6%	0.6%	37.8%	8.9%

■ June 30, 2011 ■ June 30, 2012 ■ YTD FYE 06/30/2013



Capital Structure

MIHS has used primarily internally generated funds for most capital purchases:

- **Total capital additions: 2010 - \$26.3 million, 2011 - \$33.4 million and 2012 - \$33.6 million.**
- **Capital leases have been used to finance some additions:
Lease obligation balance: 2010 - \$11.4 million, 2011 - \$7.5 million, 2012 - \$7.4 million.**

This has not been adequate to overcome historical under-investment in clinical equipment or adequate modernization of plant.



Financing Alternatives

- **MIHS has somewhat limited access to traditional capital markets. Its reliance on a tax levy for operations can inhibit access to credit markets.**
- **Pledging tax revenue requires voter-authorization.**
- **MIHS has tools generally available to government.**



Tax Levy – Statutory Overview

Budget and Tax Levy (ARS 48-5563) - Requires annual statement to County Board of Supervisors identifying amount needed to be raised by taxation for the following fiscal year for all operating purposes, including:

- **Maintaining and Operating Facilities**
- **Payments for professional and other services**
- **Debt Service, including debt service for voter authorized bonds**

Tax Levy for Fiscal Year 2012/13 = \$57,895,470*

- **Initial implementation of tax approved by voters**
- **Continued imposition of tax requires voter approval at least every 20 years**

** Tax Rate = \$0.1683/\$100 assessed value*



Tax Levy – Statutory Overview (continued)

Powers of Special Health Care District (ARS 48-5541) – Authorization to:

- Purchase, receive, take, hold, lease, use, enjoy property of every kind
- Control, dispose of, sell, convey, encumber, create leasehold interests

Additional Powers and Duties of Certain Special Health Care Districts (ARS 48-5541.01.K) Authorization to:

- Raise capital, borrow and invest monies, create debt, assume debt and refinance debt to carry out purposes
- Issue tax anticipation notes
- Issue revenue bonds



Tax Levy – Statutory Overview (continued)

Purchasing and Leasing Property and Equipment (ARS 48-5542) - Authorization to:

- **Purchase property and supplies necessary for equipping district facilities and operations**
- **Purchase real property**
- **Erect or rent and equip buildings or rooms necessary for district facilities and operations**

General Obligation Bonds (“G.O. Bonds”)

- **Authorizes issuance of general obligation bonds subject to voter approval**
- **G.O. Bonds limited to ten percent of District’s Secondary Assessed Value (SAV)***

*** SAV = \$34,400,455,716 (FY 2012/2013)**



Conclusion

- **MIHS needs to invest in plant and equipment to continue meeting its mission.**
- **Introduction of the Affordable Care Act will lead to competition with providers that traditionally have not accepted the poor.**
- **MIHS must move to a higher level of teaching, access, quality and cost effective service.**
- **This strategic planning process will define the MIHS future and enable the most appropriate financial structure.**



MARICOPA
INTEGRATED HEALTH SYSTEM

MIHS Programs & Services

Bill Vanaskie

Executive Vice President

Chief Operating Officer



MIHS

An integrated health system with inpatient and outpatient services and facilities and a health plan

MIHS is licensed for 588 beds including 190 psychiatric beds in 3 separate facilities:

- Maricopa Medical Center (MMC)
- Desert Vista Psychiatric Hospital in Mesa
- Psych Annex located adjacent to MMC in the 2619 Building



MMC is:

- a tertiary level acute care hospital
- an academic medical center
- an adult and pediatric Level 1 trauma center and burn center



Key services available at the hospital include:

- Emergency Services (adult and pediatric): Over 65,000 patient visits annually
- Surgical Services: 10 operating suites available with approximately 8,000 cases completed annually
- Burn Services: The Arizona Burn Center is the second largest burn center in the United States with over 800 admissions annually
- Pediatric Services with the breadth and depth of services meriting a designation as the Arizona Children's Center (AzCC), a pediatric hospital within a hospital, by Children's Hospital Association (formerly NACHRI)



Key Services (continued)

- Women's and children's services that deliver approximately 2,500 babies annually
- Psychiatric Services: The largest provider of inpatient psychiatric care available within the state. Admissions each year exceed 3,500 patients
- A full range of hospital-based outpatient ancillary services including radiology, laboratory, endoscopic and comprehensive cardiac services



Other services available in the system:

Specialty services that provide a variety of specialty clinics and care in the Comprehensive Healthcare Clinic (CHC), located on the main campus

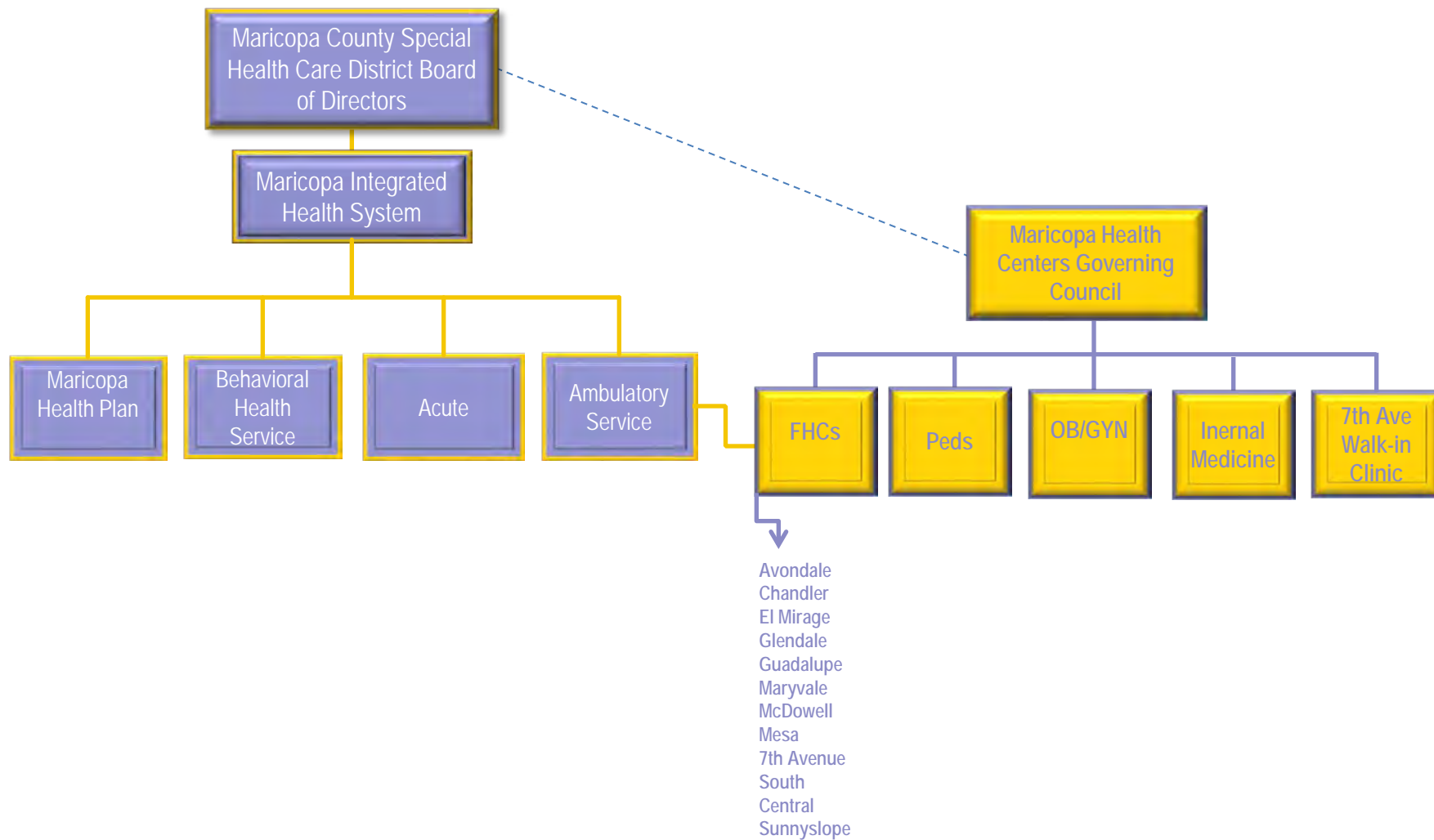
- 47 different specialty clinics monthly
- 145,000 visits annually

Ambulatory services oversees the operations of 11 Family Health Centers (FHCs) throughout the county

- FQHC designated and PCMH certified
- 180,000 visits annually
- HIV Clinic
- 8 integrated health home clinics co-located with behavioral health providers (PNOs)



Maricopa Health Centers Governing Council





Other services ... continued:

- Dental Services with clinics located within 6 of the FHCs and the CHC. These clinics see approximately 24,000 visits annually.
- Complete Comfort Care, a home-based program, provides non-skilled services in the home with over 600,000 hours of care provided annually.



Health Plan:

Maricopa Health Plan

- AHCCCS
- 1 of 6 plans in Maricopa County
- 100% owned by MIHS
- Approximately 50,000 members

AHCCCS RFP

ADHS RFP - Maricopa County RBHA

Top health industry issues of 2013

Picking up the pace on health reform

January 2013

Health Research Institute

At a glance

The pace of transformation in the health industry is certain to quicken in 2013 with the effects of technology, consumerism, budgetary pressures and the Affordable Care Act converging on a sector that represents nearly one-fifth of the economy.

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Introduction

It is almost a cliché to observe that healthcare in America is changing rapidly. Yet the pace of the transformation is certain to quicken in 2013 with the effects of technology, consumerism, budgetary pressures and the Affordable Care Act (ACA) converging on a sector that represents nearly one-fifth of the economy.

An industry that had grown accustomed to uncertainty now has a clearer picture of its future. And that future includes full implementation of the reform law, declining federal reimbursement rates, new taxes, and an influx of tens of millions of new customers who bring dollars—and unique challenges—into a fragmented system of care.

Much of the action in 2013 moves to the states, under pressure to expand their Medicaid programs and ensure that new insurance marketplaces known as exchanges suit their constituents. Employers too face fundamental decisions as many rethink their role in healthcare.

At the center of it all is a customer base that is not only growing in size but in influence. The focus is no longer on patients, but consumers, who are demanding the speed, convenience, transparency and results they get in other service industries.

A consumer survey conducted by PwC's Health Research Institute (HRI) in late 2012 found that over 50% of Americans think the biggest obstacle to improving our health system is politics.¹ Respondents identified cost as the second obstacle.

A separate HRI post-election survey showed that voters think the best way to reduce costs is to trim payments to doctors and hospitals, and reduce investment in health information technology.² Those are warning bells that the push for value is now coming directly from consumers. And even high-value companies need to do a better job of proving and articulating their worth.

For this year's Top Health Industry Issues, HRI polled 1,000 consumers about a range of healthcare topics.³ Key findings include:

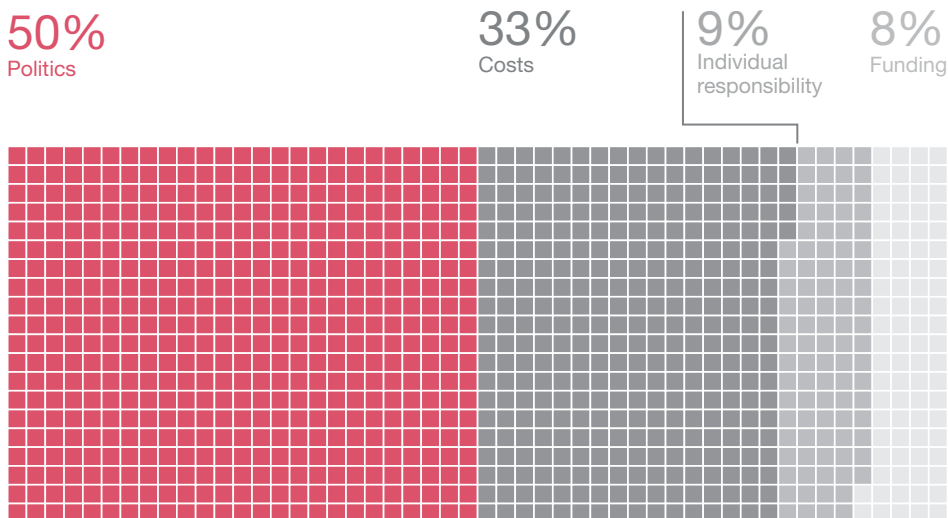
- **Digital communication is gaining traction.** More than a quarter of consumers have had caregivers use email or text messages to communicate with them, with most satisfied with the experience.

- **Concerns about data privacy remain, as access to medical data expands.** Seventy-three percent of customers are either very or somewhat concerned about the privacy of their medical information if providers were able to access it on their mobile devices.
- **There's more evidence on the impact of social media on healthcare.** More than half of consumers read reviews of healthcare providers online, with doctors and hospitals being the most viewed; this is heavily driven by younger consumers.
- **Americans view doctors as the best hope for the nation's health system.** Almost 60 % of respondents ranked physicians as first, second or third in terms of their ability to improve the nation's health system—ahead of government, consumer groups, hospitals, insurance companies, employers or pharmaceutical companies.
- **Consumers are warming up to new ways of purchasing insurance.** Individuals are more likely to buy insurance from non-traditional sources such as a retail store than they were in 2011, increasing from 18% to 23%.

- **Knowledge gaps exist about exchanges.** Though health insurance exchanges have been a major topic among industry executives and regulators, one-third of consumers don't know enough about the new marketplaces to assess whether they will make it easier to find and purchase coverage.
- **Skepticism about the value of mergers and acquisitions is rising.** Forty-seven percent of consumers surveyed believe costs would increase if their local hospital was acquired and 56% would expect quality to remain stagnant, up from 31% and 22% respectively in 2011.

For the health sector, 2013 offers enormous opportunities. Providers, insurers and life sciences companies have one year to target and capture a large new market of paying customers. New bonus payments await the innovators, while financial penalties will squeeze other players. Success in 2014 will come to those who use 2013 wisely. This year's Top Issues report—informed by new consumer research and dozens of interviews with policymakers and industry executives—offers a roadmap for navigating the reconfigured business environment.

Figure 1: What is the biggest obstacle to making the US health system better?



Source: PwC Health Research Institute

States on the frontlines of ACA implementation

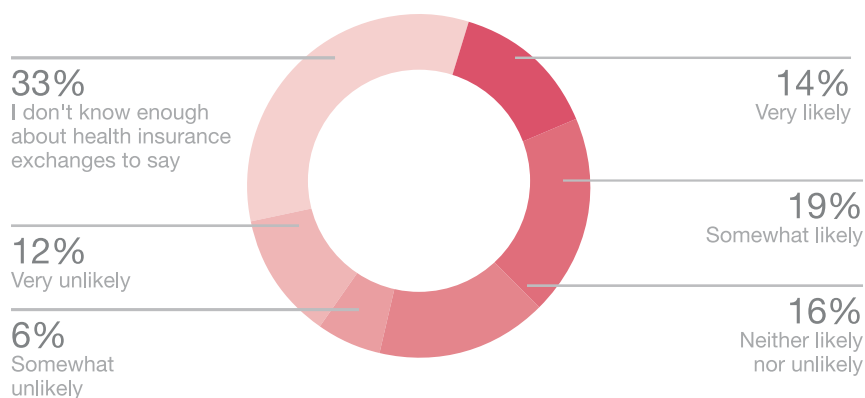
After nearly three years of polarized anticipation, the Affordable Care Act's (ACA) cornerstone healthcare coverage provisions now become reality. In 2013 the spotlight shifts to the states. Building up to 2014, when the major provisions of the law take effect, state officials must make a series of decisions about how—or if—to run their own insurance exchanges, whether to expand Medicaid coverage, and what type of insurance market regulation is needed. Tabling these decisions is not an option; where states are unable to, or choose not to, implement reforms, the federal government will step in.

States were to submit plans for state-based insurance marketplaces, known as exchanges, in December 2012, and blueprints for partnership exchanges are due in February 2013. In October 2013, an open enrollment period will kick-start the exchanges, drawing millions of people who were previously uninsured—and putting pressure on states to aid consumers in selecting coverage and determining subsidy eligibility.

State decisions about whether to expand Medicaid to 138 % of the federal poverty level (FPL), about \$15,400 for an individual, will have a direct impact on the exchanges.¹ In states that choose not to expand, some individuals who would have been eligible for Medicaid will instead receive subsidies to buy insurance through the exchanges (those with income between 100% and 138% of the FPL). Subsidies will boost exchange participation, but states and industry alike know from experience how challenging it can be to enroll new populations.

About 30 million Americans are expected to gain coverage under the ACA through Medicaid, exchanges, and employer-sponsored coverage. However, the newly insured are likely to be significantly poorer, less educated, less likely to be employed full time, and more ethnically diverse than those who are currently insured, according to demographic analysis by PwC's Health Research Institute (HRI).² States and healthcare companies must anticipate the needs of this population and devise strategies to engage and educate them. A recent HRI consumer survey indicates that

Figure 2: Do you think health insurance exchanges will make it easier for you to find and purchase a competitive health insurance plan?



Source: PwC Health Research Institute Consumer Survey, 2012

just a third of consumers believe exchanges will make shopping for coverage easier, while the same number say they don't have enough information (see Figure 2).

Guidance released by the federal government in November 2012 notes that states will oversee risk pools, develop their own effective rate review programs, establish open enrollment periods, and have a hand in certifying qualified health plans.³ States will also have flexibility to define essential community providers.⁴

The biggest challenge facing the states in 2013 is information technology. Many are overhauling their existing Medicaid eligibility systems and designing an exchange infrastructure to create a single, seamless entry point. Even states not expanding Medicaid or running their own exchanges must conduct significant upgrades to existing systems.⁵

Implications

- State exchange leaders should involve stakeholders and conduct thorough research on consumer needs, then design targeted outreach and education programs using many communication channels. For example, Colorado is

partnering with statewide organizations to conduct focus groups and has used social media, including blogging and Twitter, to reach potential participants. Colorado also plans to engage "trusted faces" to educate its citizens about the exchange.⁶

- States should creatively and efficiently build IT capabilities by partnering with other states, using commercial off-the-shelf systems, optimizing existing technical components, and/or engaging contractors with detailed expertise in systems integration. Some are relying, at least temporarily, on the federal government's infrastructure currently under development.
- Healthcare companies should get to know their new customer base and be prepared to deal with distinctive challenges, such as language barriers and frequent movement between exchange plans and Medicaid.
- Healthcare companies should closely monitor how states are interpreting new rules and regulations, and stay in close communication with state officials as they build their regulatory capacity.

Caring for the nation's most vulnerable: dual eligibles

Dual eligibles—individuals who qualify for both Medicare and Medicaid coverage—are among the nation's sickest and poorest. Many have multiple chronic conditions and more than half have annual incomes of less than \$10,000.¹ "Duals" often fall through the cracks of two programs that were not designed to work together. This lack of coordination often leads to poor quality, inefficiency, and avoidable costs.

Cash-strapped state Medicaid programs report that projected long-term costs for this population are not sustainable. Some researchers say shifting dual eligibles to managed care plans or care coordination programs could save up to \$20 billion a year.² But it will be an adjustment for patients accustomed to fee-for-service medicine in the traditional Medicare program.

With the aging of the baby boomers, the number of today's approximately 9 million duals will steadily increase, and so will the cost of caring for them. Spending on duals reached nearly \$320 billion in 2011, accounting for 39% of total Medicaid and 31% of total Medicare spending.^{3,4} Federal spending on duals is projected to reach \$3.7 trillion during the next decade.⁵ To manage the cost, the Centers for Medicare and Medicaid Services (CMS) is seeking health plans willing to take on financial risk through capitated managed care plans. Several states also intend to test a managed fee-for-service financial alignment model.

In the CMS Program of All-Inclusive Care for the Elderly, managed care providers receive capped payments to cover

medical and related services for duals. An interdisciplinary team coordinates care, enabling many duals to receive care at home. In place for over a decade, the program has reduced hospitalization rates and improved care coordination but has yet to demonstrate savings, since capitated payments have exceeded the amount Medicare would have spent on fee-for-service.⁶

In 2011, CMS announced a three-year demonstration project that covers two million duals. Of the 26 state proposals, 18 proposed a capitated model paying a combined, risk-adjusted, per-member, per-month amount.⁷ The first demonstrations begin in April 2013, in Massachusetts with a capitated approach, and in Washington with a managed fee-for-service model.^{8,9}

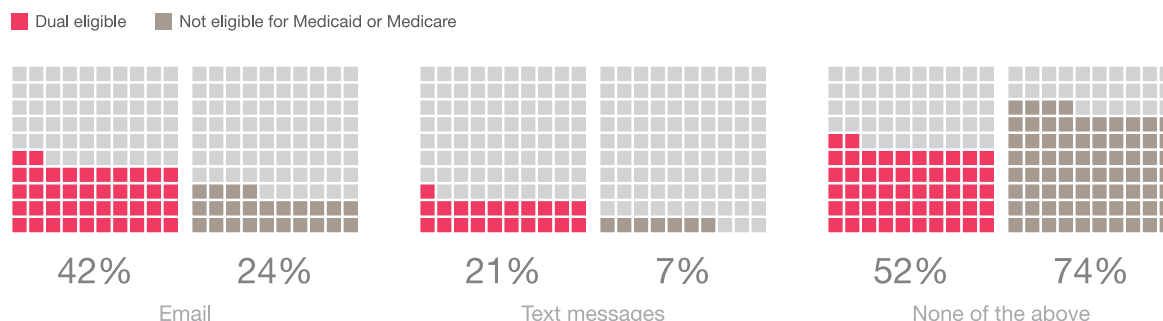
Implications

- In assuming risk for duals, managed care organizations should carefully consider the cost effectiveness of current operations and how they can refashion care delivery to better manage costs.
- While managed care may be familiar to Medicaid beneficiaries, Medicare beneficiaries historically have had freedom of choice in providers. With so many in Medicare fee-for-service, the adjustment to managed care may be difficult.
- Some duals may be receptive to using digital communication for diabetes maintenance, weight management, disease management, and chronic care

programs. A PwC's Health Research Institute (HRI) internet survey of a subset of duals found they are more likely than other consumers to use social media for healthcare purposes (63% compared with 40%). Also, 42% of duals have communicated with a caregiver via email and nearly one-quarter via text (see Figure 3). Twenty percent of duals have healthcare apps on a mobile device, compared with 12% of non-duals.¹⁰

- Plans and providers should fill education and awareness gaps to improve areas such as medication adherence. The HRI survey found that 53% of duals have participated in a prescription assistance program in which they can take advantage of free samples, discount cards, and coupons.
- States and insurers should track progress of demonstrations on reimbursement versus medical cost trends, unique contracting mechanisms between managed care and providers, care management program efficacy, and effective coordination of clinical and non-clinical services such as transportation, meal service, and in-home assistance.
- With long-term care support services accounting for 70% of state Medicaid spending on duals, plans deciding to increase those offerings must determine the most cost effective structure such as in-house coordination and referral services, partnering with state, county, and community organizations, or outsourcing to a specialty provider.¹¹

Figure 3: Have you and a doctor, nurse, or other caregiver ever communicated in the following ways about a health question you had (Dual eligibles vs. all other consumers)?



Source: PwC Health Research Institute Consumer Survey, 2012

Bigger than benefits: employers rethink their role in healthcare

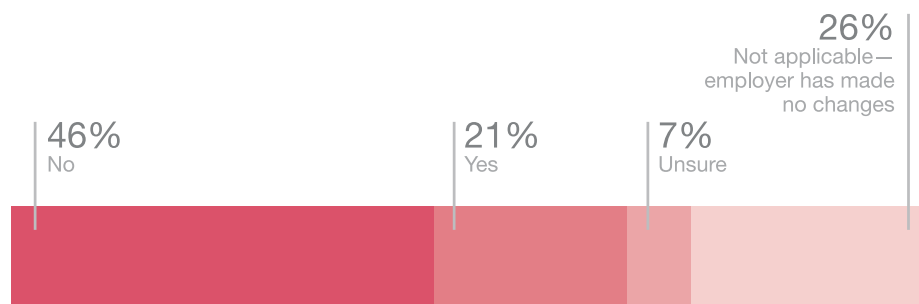
Healthcare and employers—inseparable? Maybe not. With the Supreme Court ruling to uphold the Affordable Care Act (ACA) and the president's re-election, employers have never had a better opportunity to re-examine their long term role in providing healthcare coverage. The year 2013 will likely be the turning point for the evolution of healthcare benefits over the next decade.

For almost 70 years, employer-based coverage has been a cornerstone of US healthcare. A result of wage-price controls dating back to World War II and favorable tax treatment ever since, healthcare benefits are a core component to attracting and retaining talent. But once seen as a tax-efficient way to reward employees, healthcare costs are now infringing on many corporations' efforts to compete globally.

Healthcare costs now rank second or third to wage costs. The median employer share of payroll going toward health insurance costs was 12.8% in 2010, up from 8.2% in 1999.¹ Many employers are concerned about the financial impact of new mandates, taxes (including the 40% "Cadillac" excise tax on high cost plans starting in 2018), and administrative challenges brought forth by the ACA. And, with healthcare entitlements center stage in the ongoing budget debates at both the state and federal levels, employers are concerned that cost-shifting from these programs will only accelerate in the future.

Until now, an individual insurance market seen by many as dysfunctional has left employers no choice but to continue offering coverage, even with the rising cost. But a number of provisions of the ACA, such as guaranteed coverage, elimination of pre-existing condition exclusions, and government subsidies for the poor and many in the middle class, have strengthened access and affordability for those without employer-based coverage. Now employers are beginning to consider the new state exchanges as a potential safety net for employees or retirees and are looking at private exchanges as alternatives to the status quo.

Figure 4: Have you changed your behavior as a result of changes your employer made in benefit offerings or wellness programs?



Source: PwC Health Research Institute Consumer Survey, 2012

In 2013, corporate leaders will embark on “pay or play” financial analyses and many will ask tough questions such as why they focus so many resources on something that is not core to the business. Some employers may decide to transition out of healthcare altogether: a recent third-party survey found that only 23% of employers are very confident that their organization will offer healthcare benefits a decade from now, compared with 73% in 2007.²

Others will elect to move toward a defined contribution approach, similar to 401(k) retirement plans, with the exchanges. Still others will double down on their efforts, both individually and collectively, to bend the cost curve through consumer-driven healthcare, wellness programs, and new efforts related to delivery and payment reforms. However, this will not be easy. The PwC Health Research Institute's consumer survey found that only 21% of consumers have changed their behavior as a result of their employer changing benefit offerings or wellness programs (see Figure 4).³

Implications

- Employers must determine their future role in healthcare and develop a transition strategy to support it, whether they transition out, move to private exchanges with defined contributions, or change their practices for covering certain classes.
- Insurers and providers should anticipate a changing insurance marketplace where employers increasingly participate in and defer to organized health insurance marketplaces, such as public and private exchanges.
- New delivery systems (e.g., accountable care organizations) should engage leading employers and employer coalitions to become partners to deliver improved value and enhance employee population health and productivity.
- Employers should stay in close communication with policy makers as they make technical corrections to the ACA, including the healthcare benefits tax exclusion, and tackle ongoing issues with the federal budget.

Consumer revolution in health coverage

Health insurance is about to witness a consumer revolution. Promises of Amazon-style online experiences for individuals shopping for health insurance will be put to the test in 2013, when 12 million people are expected to enroll in insurance exchanges.¹

In actuality, this revolution is more like an evolution. The 18% rise in high-deductible plans from 2011 to 2012 has pushed more consumers to feel the financial pinch.² Consumers are also demanding a greater say in how they spend their healthcare dollars, and that, along with the development of state insurance exchanges, is prompting the industry to compete differently. Healthcare consumers can expect to see a shift in the marketplace as insurers borrow three key practices from the retail industry.

Convenience

Nearly 40% of consumers surveyed by PwC's Health Research Institute (HRI) said they would purchase insurance at a private insurance company retail store³ (see Figure 5). Insurers such as Florida Blue and Highmark have opened shops to supplement their online presence.^{4,5} From a consumer perspective, buying health insurance—and perhaps participating in wellness programs—at the local shopping center is very convenient. PwC's national Experience Radar survey found that 40% of retail consumers want shopping options, whether it's online, via phone or in stores.⁶

Insurers are also partnering with retailers to bring healthcare products to where the consumer is. Costco, for example, which sells health insurance for small businesses in some states, recently began offering store members a choice of individual health plans through Aetna.⁷

Transparency

Consumers have trouble assigning an accurate value to their insurance; in fact, an HRI consumer survey found that nearly one-third overvalued their individual coverage by more than 65%.⁸ As consumers begin enrolling in the exchanges in October 2013, expect them to demand clear, simple information on prices, provider networks, and quality.

A recent HRI survey found that in addition to an easy-to-use website, 72% of consumers want a cost comparison tool to select insurance and 64% value products that match their needs and preferences.⁹ States are responding to transparency demands with such efforts as Enroll UX 2014, a public-private partnership that has designed a prototype online site for state exchanges.¹⁰

Customer insights

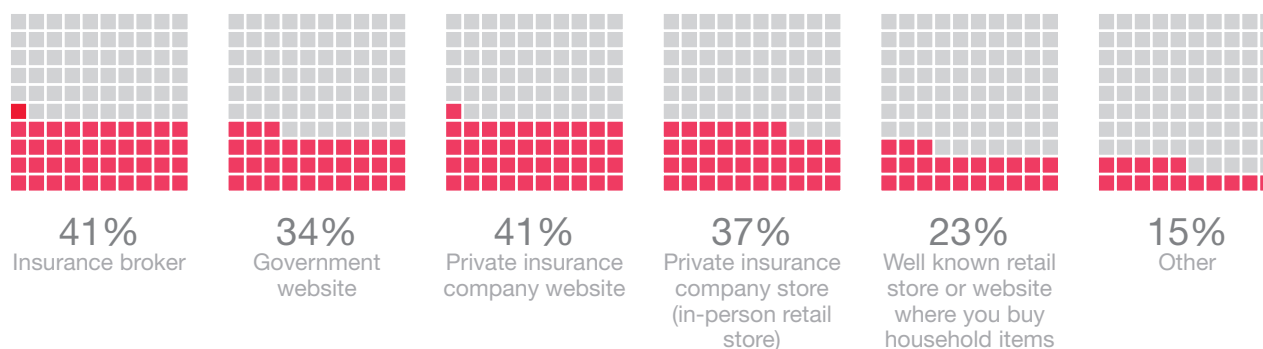
Retailers tap analytics on consumer buying patterns to stock shelves, create targeted advertising and build customer loyalty. Insurers such as Blue Cross and Blue Shield of North Carolina (BCBSNC) are

investing in data analytics to personalize care management through targeted messaging. For example, predictive data will be used to identify the best methods for communicating with members about preventive care options, such as flu shots.¹¹ The data would also allow BCBSNC to identify diabetic members who prefer more self-care resources versus those who want more direct counseling.¹²

Implications

- Consumer expectations for flexibility and transparency should spur insurers and employers to offer intuitive navigation assistance and better comparison shopping tools.
- As the retail convenience of coverage grows, providers can also expect to see a continued increase in the use of retail clinics as consumers seek lower cost options for minor ailments. Consumer use of retail clinics rose from 9.7% in 2007 to 24% in 2012 according to HRI consumer research.
- With price-sensitive customers and a competitive generic drug market, pharmaceutical companies can enhance brand loyalty through patient assistance programs such as drug discount and coupon programs.

Figure 5: How likely are you to buy insurance from the following?



Source: PwC Health Research Institute Consumer Survey, 2012

Customer ratings hit the pocketbooks of healthcare companies

The consumer experience matters to healthcare businesses, especially with its connection to financial penalties and bonuses. Private insurers who cover Medicare members were eligible for more than \$3 billion in bonus payments in 2012 based on quality ratings.¹ The program, known as the Medicare Advantage Five-star Quality Rating system, relies on consumer input for nearly half of its quality measures.²

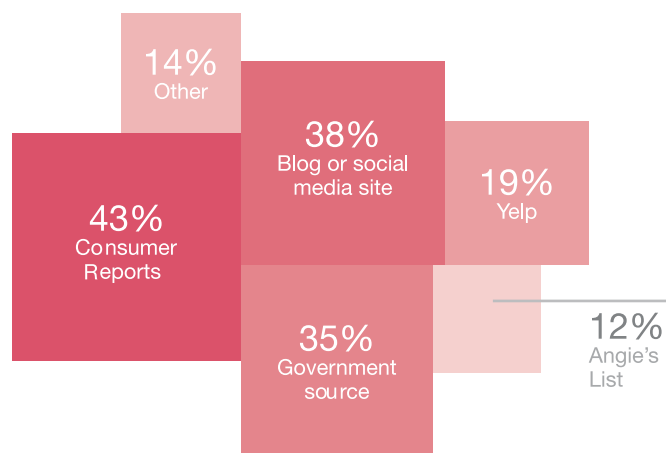
Hospitals and health systems are feeling the pinch as nearly one-third of the federal government's value payment program connects to consumer experience and satisfaction. About \$850 million, or 1% of total reimbursement in 2013, could be held back as a part of the federal government's Hospital Value-based Purchasing program.³

Customers support these effects. About half of consumers surveyed by PwC's Health Research Institute said that customer feedback should affect payments to healthcare organizations. Nearly 70% of consumers have used reviews to make healthcare decisions related to their doctor, hospital, insurance company or pharmacy. And more than 60% said that a hospital's quality of care affects their healthcare decisions.⁴

More consumers have read reviews on Consumer Reports and blogs, but consumers are also discovering government-sponsored websites such as the Centers for Medicare and Medicaid Services and the National Committee for Quality Assurance (see Figure 6).

One way providers are improving the patient experience is through the patient-centered medical home, which uses the primary care physician as a central point of coordination across the care continuum. All 50 states have medical home efforts, with 44 passing 300+ related laws, and more than 38,000 physicians affiliated with medical homes, an eight-fold increase in the past five years.⁵ Patients in medical home practices reported higher satisfaction with care, access to care, interpersonal experience, technical quality and communication.⁶ Success has been attributed to the reduction in bureaucracy, consistency in care, and providing one easy hub for patient health discussions.⁷

Figure 6: Where have you read customer reviews of healthcare companies?



Source: PwC Health Research Institute Consumer Survey, 2011, 2012

Healthcare organizations are already using positive quality scores as marketing tools. Nearly 40% of Medicare Advantage members are currently served by four to five star health plans, which are the highest ratings available under the bonus program, and the plans with high customer satisfaction scores have increased by 20% over the last year.⁸ The industry recognizes the importance of addressing negative customer input as well. Many companies are taking advantage of social media to address a consumer issue either immediately online or via a follow-up phone call. Nearly 70% of consumers surveyed expected a response to complaints within a day, while 40% expected it within a few hours.⁹

Implications

- As healthcare companies develop new ways to raise their quality scores through improved consumer service, they need to consider how consumers use and contribute to the increasing amount of quality data.
- Providers and insurers should educate consumers on quality metrics and how to interpret and use the scores. This can be done by training call center

representatives and posting online messages during customer service inquiries. Healthcare companies should use all consumer touch points where education could be relevant.

- Moving beyond surveys and using consumer research to get a more complete picture of consumers and their health needs will be a differentiator. Safety net hospitals are particularly vulnerable, given their history of lower patient experience scores.¹⁰ (See issue on "Consumer revolution in health coverage" on page 7)
- Establishing a well-integrated and thoughtful consumer program that ties in with business needs will be more important than ever. Insurers and providers have shifted hiring practices to include individuals with the skills and talents to connect with consumers and understand how to collect and use customer data. Chief experience officers have become increasingly popular in the health sector, with one in ten hospitals giving accountability for the customer experience to a senior member of the leadership team.

Goodbye cost reduction, hello transformation

With reimbursement ready to reset under the Affordable Care Act (ACA) and in light of the ongoing federal budget debate, hospitals are scrambling to reduce costs even further. And, with more than 40% of consumers postponing care because of costs, hospitals must be competitive (see Figure 7).¹ The traditional low hanging fruit savings of labor productivity and supply cost reductions have largely been picked over. Healthcare companies must instead embark on full-scale transformation efforts to redesign how they deliver care.

Retrofitting labor management

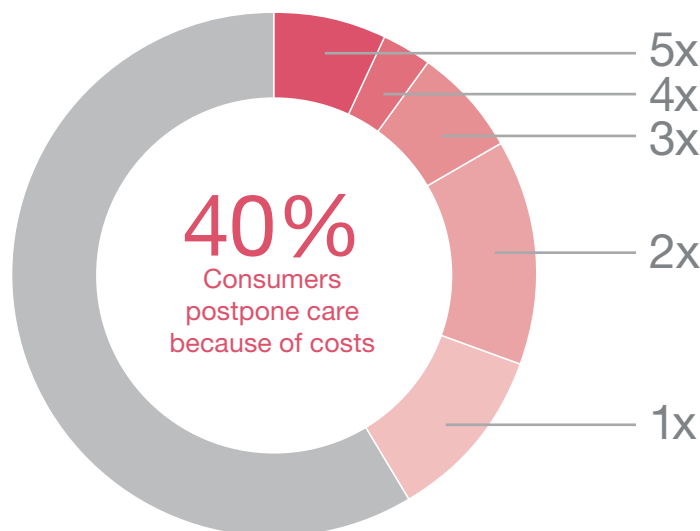
Hospitals and health systems have historically focused their productivity efforts on broad-based staffing benchmarks instead of tackling underlying issues such as workflow. In designing new processes, hospitals now face pressure to use the most appropriate venue for care, which is often lower-cost settings. This may require redeployment of existing staff and investment in continuing education and training.

Successful transformation addresses how and by whom care is delivered. To maintain high quality while implementing sustainable cost reductions, health systems are involving clinicians, staff and even patients in redesigning the delivery of care. The Mayo Clinic created a Center for Innovation that relies on a diverse design research team to connect evidence-based practices with consumer research. The center uses technology that allows it to simulate leading practices and adjust them to fit the clinic's environment. This approach helps Mayo Clinic to understand the needs of its consumer base while developing a positive and cost-effective experience.²

Reining in supply costs

Transforming organizations often requires increased stakeholder involvement and new alliances. Health systems have traditionally focused on standardizing and reducing costs of commodity supplies such as bandages and IVs, through group purchasing contracts while tiptoeing around politically charged issues such as physician preference items and the

Figure 7: How many times have you decided not to seek healthcare in the last year because of how much that care would cost you?



Source: PwC Health Research Institute Insurer Survey, 2012

comparative effectiveness of products. Hospitals are now employing more physicians and have more influence in managing physician preference purchases.

Some innovators are building upon group purchasing contracts to create regional supply chain cooperatives with other provider organizations. For example, the Texas Purchasing Coalition, a 27-hospital partnership, expanded and forged a hybrid contract with a national group purchasing organization to not only reduce supply costs but also to standardize distribution and improve decision support. As a “power buyer” with over \$800 million in combined supply costs, the coalition achieved \$54 million in savings in the first 18 months.³

Implications

- Before embarking on full transformations, healthcare companies should first master general cost management, particularly in nonpatient care areas, and assess the effectiveness of management layers in patient care and administrative areas.

- Transformation requires long term, data-driven efforts with a perpetual focus on efficiency. Hospitals may want to create a permanent project management office to lead and sustain these efforts. Chief innovation or transformation officers are emerging to lead the charge and determine which initiatives will have the greatest impact across the enterprise.
- Top leadership must approve which transformation projects move forward, focusing on projects that have broad impact and the ability to be scaled across the organization. Having a formal process, possibly through internal social media, for employees to suggest improvement projects is also critical.
- Hospitals must align individual incentives with organizational incentives which are ultimately aligned with payment incentives. If ACOs or other contracts require organizations to meet quality and efficiency targets, then clinicians and staff need to have similar incentives. Health systems need key performance indicators that measure progress and connect to compensation models.

The building blocks of population health management

Population health management shows promise in the quest for better health at a lower cost by creating an integrated system of care, rather than leaving consumers to fend for themselves. In 2013, expect to see more partnerships as companies build their population health infrastructure to include shared responsibility for patient outcomes and satisfaction, data collection and analysis, member education and engagement, and a focus on at-risk populations.

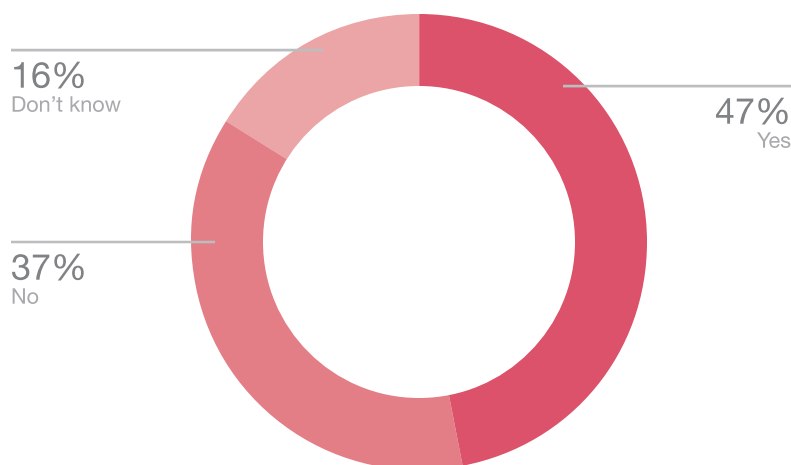
Collaborations can start small, targeting specific chronic diseases or patient groups. Bon Secours St. Francis Health System and Michelin North America collaborate to provide integrated care for Michelin employees and dependents with diabetes. Care ranges from coordination of specialists to buying groceries, providing education, and conducting work-site evaluations. Successes include patients who are able to stop insulin therapy and decreases in blood glucose levels, blood pressure, and weight.¹

Other partnerships allow large organizations to tap remote expertise. The Mayo Clinic Care Network connects nine systems, including Dartmouth-Hitchcock and Chicago's NorthShore University HealthSystem. Patients and practitioners gain from Mayo Clinic expertise through e-consultations and an online database of clinical information. Members may refer complex cases to Mayo Clinic while providing follow-up care locally.²

Population health management sometimes involves co-management, giving physicians a governance role and basing compensation on outcomes. Geisinger Health System in Pennsylvania ties about 20% of physician pay to quality and efficiency and uses a bundled payment arrangement (ProvenCare) for some procedures, such as cardiac bypass surgery, reducing costs through fewer complications and readmissions and improved patient outcomes (see Figure 8).³

But the shift to compensation based on value is only beginning to take hold. Only 47% of hospitals participating in a recent PwC Health Research Institute survey said they have a compensation plan based at least partially on metrics of quality, efficiency, or health outcomes.⁴

Figure 8: Does your hospital have a physician compensation plan that is based at least partially on metrics of quality, efficiency, and/or health outcomes?



Source: PwC Health Research Institute Human Capital Survey, 2012

In some population health approaches, navigators or care managers assess the socioeconomic environment of patients and help remove barriers to improve adherence. A diabetic patient who keeps returning to the hospital might be taking insulin as prescribed but may not have a refrigerator to store it in or electricity to run the refrigerator—and insulin loses its effectiveness when exposed to excessive heat. Only when such underlying problems are identified and addressed will patients improve.

For care management, an Arizona hospital system contracts with Optum (of United Healthcare), providing Optum nurses access to patient electronic health records. The nurses consult with patients by phone, provide instructions, and set expectations for follow-up care. This has resulted in immediate responses to after-hours queries; reduced use of on-call physicians, ER visits, and hospitalizations; and improved patient satisfaction.⁵ Other insurers and providers are following suit.

Kindred Healthcare, a post-acute provider, reduced hospital readmission rates by more than 8% by forming “joint operating committees” with hospitals. One partnership discovered that a significant

number of readmissions involved urinary tract infections acquired in the hospital. More active screening and treatment prior to patient discharge reduced readmissions.⁶

Implications

- Population health management requires major investments over multiple years, and requires trial and error. Convergence and consolidation must accelerate among otherwise disparate players.
- The push for higher quality and value requires standardization of processes and the ability to continually improve or risk losing reimbursement.
- Collaborations need a strong technology foundation, including web-based reporting tools that connect to clinical, financial, and administrative systems. Systems must support analytics across a wide spectrum of inpatient, outpatient, post-acute, and community services.

Bring your own device: convenience at a cost

For many people, mobile devices are an extension of themselves, so it's not surprising that they have found their way into the workplace—including hospitals. Once there, they easily outshine employer-issued desktop computers or laptops, and soon clinicians have switched to their own devices instead. Recognizing the associated risks and admitting that attempts to stop the trend might be futile, many hospitals now permit employees to “bring your own device” (BYOD) to work.

Currently, 85% of hospitals support clinician use of personal devices at work.¹ In 2013, expect a heightened focus on security as more employees “bring their own” and more sensitive data is made available on them.

Of the 502 breaches of protected health information reported to the Department of Health and Human Services Office of Civil Rights since September 2009, 71 involved portable electronic devices.² Loss and theft are the top threats to the information stored on mobile devices. Viruses and other software attacks targeting smart phones and tablets rose by 273% in the first half of 2011 over the first half of 2010.³ Physicians and contractors who work in multiple hospitals might inadvertently spread viruses via their mobile devices among the hospitals they visit. And patients add another wild card: one study revealed that of the 76% of hospitals allowing visitor access to the Internet on their mobile devices, 58% lack password protection for that access, putting hospitals at risk for viruses.⁴

Hospitals must balance the desire for work flexibility with creating an environment secure enough to protect sensitive patient data. According to a recent PwC Health Research Institute survey, half of consumers agree that being able to access electronic health records (EHRs) using a mobile device would help their providers work together more effectively to coordinate their care, and one-third believe that doing so would result in a quicker response to their health questions.⁵ Also, 61% of consumers are willing to communicate with a clinician via email, and 91% who have done that were satisfied with the experience.

Even so, consumers are not enthusiastic about physicians accessing their health information on a personal device, with nearly three-quarters saying they would be concerned about privacy (see Figure 9).

Indeed many hospitals are behind on security. Three-quarters of hospitals permit clinicians to access EHRs on their personal devices,⁶ but PwC's Global Information Security Survey found that 46% have a security strategy governing the use of mobile devices.⁷ More than half of IT professionals say they've experienced employees circumventing or disengaging security features like passwords and key locks.⁸

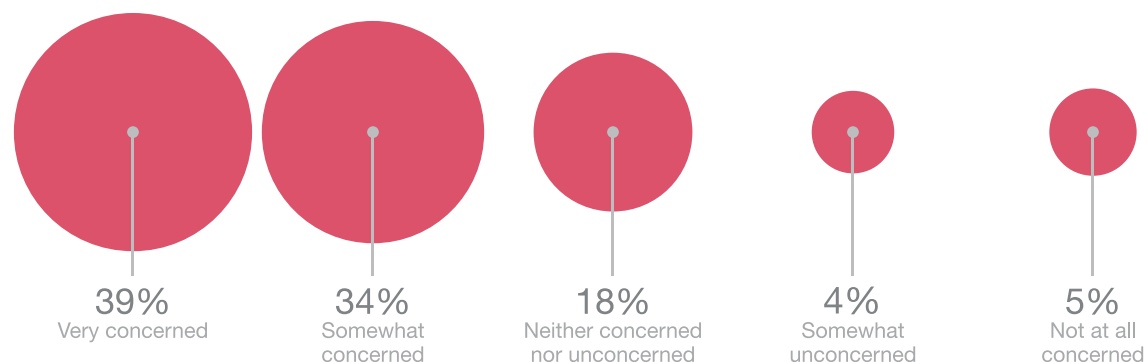
Some hospitals give staff read-only access to sensitive data; others permit interaction with it to enhance work flexibility. The Department of Veterans Affairs' program to make EHR data user-friendly on portable

devices allows providers to access a limited amount of information: demographics, allergies, medications, and lab results. Soon the VA will expand access to more medical applications that require the input of patient data. The VA uses complex pass codes, locks inactive machines, tracks data, has remote wiping, and never stores patient data on the devices.⁹

Implications

- Hospitals need an identity management approach that accounts for patient and employee mobility. This includes a centralized, integrated, and comprehensive view of people, roles, and privileges for more accurate and efficient auditing and reporting and for continuous improvement of policies and controls.
- Stage two of the government's “meaningful use” program calls for the encryption of data on end-user devices. Starting in 2014, failure to comply will mean the loss of incentive payments and, in 2015, penalties.
- Hospitals must continue to communicate privacy and security policies and practices to consumers, especially as the desire to communicate with patients via email and text gains popularity among clinicians.
- The costs of BYOD may outweigh what hospitals save in hardware costs. One study found that supporting employee personal devices can cost companies 33% more.¹⁰

Figure 9: If doctors, nurses and other caregivers were able to access your medical information from a phone/mobile device that they also used for personal use, how concerned would you be about the privacy of your medical information?



Source: PwC Health Research Institute Consumer Survey, 2012

Meeting the new expectations of pharma value

Pharmaceuticals and medical devices play a pivotal role in health outcomes. But the path from lab to bedside is often long, arduous, and expensive. Today, the final hurdle is no longer regulatory approval; it's reimbursement.

Physicians, once the primary arbiters of pharma value, now have less say in payment decisions than insurers and large providers. If purchasers don't see evidence that a new drug fills an unmet need or outperforms similar products at a more reasonable cost, the drug won't receive preferred formulary placement and may not even be covered by insurance. The industry has largely shielded customers from the price of medication, but as costs shift to individuals, drug and device makers will be under greater pressure to prove value.

Memorial Sloan-Kettering Cancer Center recently refused to pay for a new colorectal cancer drug, citing data that it performed no better than a similar medicine at less than half the cost.¹ The manufacturer responded by lowering the price to that of the competing therapy barely two months after launch.²

Outcomes-based contracts help prove the value of drugs and devices. EMD Serono, the biopharmaceutical division of Merck KGaA, has forged separate contracts with insurer Cigna and pharmacy benefits manager Prime Therapeutics to provide adherence-based discounts on Rebif, a multiple sclerosis therapy. Cigna claims data has shown that Rebif helped reduce hospitalizations by 43% the first year of its agreement with EMD Serono.³

Such partnerships could yield substantial savings. A recent study found that medication adherence by diabetics could save between \$4.7 and \$8.3 billion in annual US healthcare costs.⁴ However, only 74% of consumers surveyed by PwC's Health Research Institute (HRI) said they very closely adhere to prescription instructions.⁵

Interest is growing among insurers to partner with pharma to determine unmet medical needs, and improve medication adherence and clinical outcomes. In a recent HRI insurer survey 43% of insurers agreed that they would benefit from a data sharing partnership with pharma companies (see Figure 10).⁶ Drug maker Pfizer and insurer Humana have formed a five-year partnership focused on improving cost, quality and access to appropriate care. They seek to better understand patient care needs by tapping into clinical evidence and comparative effectiveness research. Specifically, they hope to improve the treatment and management of chronic conditions including cardiovascular disease and Alzheimer's disease.⁷

Comparative effectiveness studies can help build pharma's value case. Britain's National Institute for Health and Clinical Excellence (NICE), which makes reimbursement recommendations for England and Wales, initially recommended against a highly touted, FDA-approved melanoma medication because it had not been compared with other drugs used for the same indication.⁸ It recently reversed the decision after the manufacturer offered to discount the drug.⁹

In Germany, if a company cannot demonstrate that a new therapy provides clinical benefit over established treatments, reimbursement starts at the same level as existing clinically equivalent medicines.¹⁰

Collaborating with regulators early in drug development is another approach. For its psoriasis medication, Novartis collaborated with NICE on trial design, product selection for comparative effectiveness, study population, and economic evaluation.¹¹ Following the pilot, NICE established its Scientific Advice program to provide fee-for-service advice to pharma and medtech companies. The agency reviews product development plans to ensure that they produce relevant evidence for submission.

Implications

- The pharmaceutical industry must provide robust and reliable data to purchasers on cost-effectiveness, using mock formulary evidence audits, data-sharing partnerships, and outcomes-dependent contracts.
- Pharma and its partners should monitor costs and outcomes as they aggregate and interpret data. Underused data from electronic health records, patient registries, medical devices, nutrition studies, and social media can often supplement claims and prescription information.
- Drug and device makers can prove value by including a comparative effectiveness component in clinical trials and pairing products with diagnostics targeting patients who can benefit the most.

Figure 10: How much do you agree with the following: our organization would benefit from a data sharing partnership with biopharmaceutical companies?



Source: PwC Health Research Institute Insurer Survey, 2012; 3% did not respond

Medtech industry braces for excise tax impact

Effective January 1, 2013, the 2.3% excise tax on medical devices could prompt consolidation in a \$308 billion global industry consisting mainly of small start-ups with lean product portfolios and fewer than 50 employees.¹ Some could owe more in taxes than they generate in profits, making them less attractive to investors but enticing to larger companies that are better positioned to absorb the tax and looking to expand their portfolio.

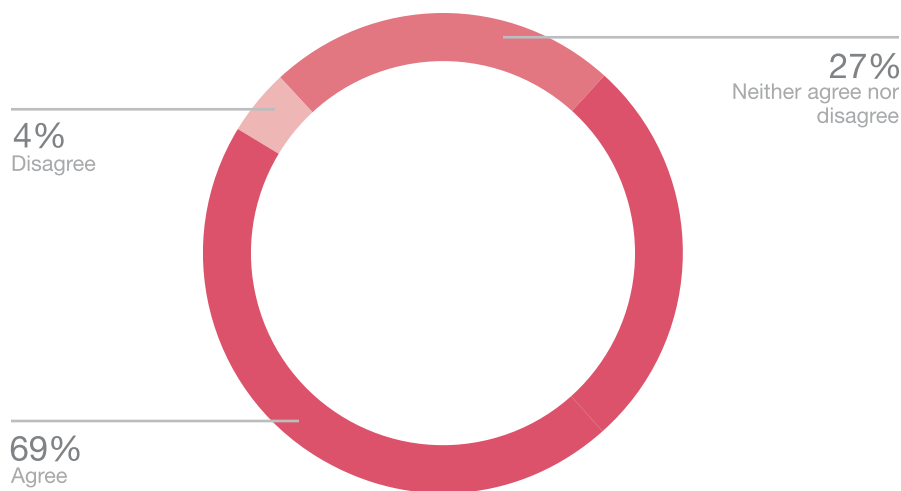
Federal coffers stand to gain \$29.1 billion over the next ten years from this tax, which was included in the Affordable Care Act (ACA).² Much of the industry has labeled the tax a job and innovation killer—predicting nearly 39,000 US job losses.³

Some companies say it's just another cost pressure in an evolving market, but others have already blamed it for shelved domestic expansion plans and layoffs. One company is cutting its workforce by 10% and plans to move some operations overseas.⁴ Medtronic, a large medical device manufacturer, estimates that the tax will increase its annual tax liability by \$125 million to \$175 million, or 1%–2% of US sales.⁵

Medtech companies are unlikely to pass on the tax to customers for several reasons. A group of hospital associations opposes pass-through of the tax and has urged the IRS to prevent them from doing so; and industry analysts predict that companies dealing in commodities, such as coronary stents or tongue depressors, are unable to pass it on because of pricing pressure and competition. Unless companies offer a novel product without direct competition, they will have to bear the cost.

As manufacturers look to shift costs, they must also innovate. Nearly 70% of consumers surveyed by PwC's Health Research Institute say that pharmaceutical and biomedical research is an important contributor to economic health (see Figure 10).⁶ While some companies expect

Figure 11: To what extent do you agree or disagree with the following statement: Pharmaceutical and biomedical research is an important engine for economic growth in this country?



Source: PwC Health Research Institute Consumer Survey, 2012

to absorb the tax and reduce expenses elsewhere, others are recalibrating operations, resources, and investments to spur strategic growth in other areas to offset it. Because the tax applies only to US sales, medical device makers with robust sales abroad should fare better.

Implications

- Manufacturers that have been waiting and hoping for repeal have run out of time. They should have a basic system for calculating tax liability, or they risk overpaying or underpaying the IRS.
- The supply chain may become volatile as manufacturers, contractors, distributors, and other third parties maneuver to avoid responsibility for the tax. Medtech companies should assess the potential for supply chain disruptions before changing pricing policies.

- Medtech companies should consider working with providers on comparative effectiveness studies of products before they are distributed. Doing so may help reduce write-offs on consignment products, demonstrate value to purchasers, and streamline the portfolio.
- Industry consolidation could give medtech companies greater pricing power in negotiations with insurers, providers, and suppliers.

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About this research

This annual report discusses the top issues for healthcare providers, health insurers, pharmaceutical and life sciences companies and employers. In fall 2012 PwC's Health Research Institute commissioned an online survey of 1,000 US adults representing a cross-section of the population in terms of insurance status, age, gender, income, and geography. The survey collected data on consumers' perspectives on the healthcare landscape and preferences related to their healthcare usage.

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Health Research Institute

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Environmental Scan 2013



The 2013 American Hospital Association Environmental Scan provides insight and information about market forces that have a high probability of affecting the health care field. It is designed to help hospital and health system leaders better understand the health care landscape and the critical issues and emerging trends their organizations likely will face in the foreseeable future. The 2013 AHA Environmental Scan foldout is compiled from nationally recognized sources with recommendations from select AHA governance committees. The scan is produced by Gene J. O'Dell, the AHA's vice president for strategic and business planning, with assistance from Donna J. Aspy, program manager, strategic and business planning. Lee Ann Jarousse, *H&HN's* senior editor of custom publications, compiled the information.

Associations



● **Data-driven strategies** refer to a continuous loop that remarkable associations tend to exhibit: they continually track member needs and issues as well as the wider environment, then collectively analyze the data to reach a shared understanding through asking, "What do we now know, and what are we going to do about it?" These associations then incorporate the findings into their strategic and operational planning. ⁽¹⁾

● Textbook strategic plans — complete with **clearly outlined goals, objectives and strategies** that were reviewed and adjusted on a consistent basis — were present in many associations. But, remarkable associations don't just emphasize thinking strategically, they find it equally important to act strategically; they consistently implement their priorities. ⁽¹⁾

● Remarkable associations learn from and respond to change; although willing to change, they also know what not to change. **Their mission and purpose remain the touchstones.** Members and mission are at the heart of remarkable associations — and member value is the blood that keeps the heart pumping. While seeking to build and maintain a strong relationship with their members, remarkable organizations never stop being inquisitive about how they can refine and enhance the value they provide. ⁽¹⁾

● **Social media has fast become an invaluable tool for associations.** It can be inexpensive and quick to launch, promote discussion among participants with common interests, help identify new prospects and categories of members, and provide users with more immediate access to association services. In short, it helps associations remain relevant to their members and true to their mission. Finding the right balance between taking appropriate business risks and minimizing legal ones can be particularly tricky in the rapidly changing realm of social media. If an association's policy is too lax, it might invite greater exposure to legal risks. If a policy is too restrictive, it may not hold up to legal scrutiny. ⁽²⁾

Consumers & Demographics



● Nearly **half of Americans will develop a mental illness** and 27 percent will suffer from a substance abuse problem during their lifetimes. In any given year, 25 percent of the American population experiences either a mental illness or a substance abuse problem. Treatment capacity for behavioral services is in critically short supply and getting worse. ⁽³⁾

● Rates of **adult and childhood obesity** in the United States vary significantly by region, race, ethnicity and age, but overall rates are high. Among adults ages 20 or older, nearly 34 percent have weight levels in the obese range, and another 34 percent are classified as overweight; thus, the combined prevalence of those who are obese and overweight is 68 percent. Among children and adolescents ages 2 through 19, nearly 17 percent are classified as obese and 15 percent as overweight; thus, close to 32 percent are either obese or overweight. ⁽⁴⁾

● Without question, the single biggest force threatening U.S. workforce productivity, as well as health care affordability and quality of life, is the **rise in chronic conditions**. American workers experience high rates of chronic disease. Almost 80 percent of workers have at least one chronic condition. Fifty-five percent of workers have more than one chronic condition. Depression is the greatest cause of productivity loss among workers. ⁽⁵⁾

● In both 2008 and 2009, **5 percent of the population accounted for nearly 50 percent of health care expenditures**. Similarly, 10 percent of the population accounted for 63.6 percent of overall health care expenditures. ⁽⁶⁾

● **Most boomers are going to be working after age 65**. Far from demanding wellness and lifestyle enhancement from the health system and paying for it with discretionary dollars, most boomers will be desperate to remain healthy enough to continue working into their 70s or even 80s. ⁽⁷⁾

● **Families are the principal caregivers for our nation's older people**, providing more than 80 percent of so-called chronic care services. For economic reasons, many baby boomers are going to end up relying extensively on their children for support as they struggle with chronic illnesses. ⁽⁸⁾

Economy & Finance



● Moody's is maintaining its **negative outlook for the U.S. nonprofit health care industry**. The outlook has remained negative for the last three years and is expected to remain negative for at least the next several years. The negative outlook is based on modest projections for hospital revenue growth over the next 18 months, the expectation of ongoing economic softness throughout the country, financial and operating pressures resulting from regulatory challenges and continued balance sheet challenges. ⁽⁸⁾

● In the past, **hospital mergers and acquisitions** were the primary vehicles to consolidation with a goal to increase market share and leverage with payers. Consolidation offers the promise of greater operating efficiency and risk diversification across larger organizations. The ability to demonstrate lower costs while providing high-quality care will be the key driver in governmental and commercial reimbursement going forward. Physician alignment, another form of consolidation that many are pursuing, is also a strategy to control costs and drive improved quality by adopting evidence-based medicine. The growing trend toward nonprofit hospital consolidation is positive for the financial health of many, but not all, hospitals. Unfortunately, given current looming headwinds confronting the health care sector, those hospitals left out of consolidations, especially smaller stand-alone hospitals that cannot match the financial, managerial or market access capabilities of larger multihospital systems, will face greater negative rating pressure going forward. ⁽⁹⁾

● The Institute of Medicine estimates that high administrative costs for insurers, physicians and hospitals account for **\$200 billion of waste**. Overuse of tests and the use of brand name drugs instead of generics account for another \$200 billion. Errors and avoidable complications and fraud each tally to \$75 billion. ⁽¹⁰⁾

Information Technology & E-Health



- **Health & Human Services delayed implementation of ICD-10** for use in administrative health care transactions by one year, from Oct. 1, 2013, to Oct. 1, 2014. A Workgroup for Electronic Data Interchange poll showed that nearly half of health providers don't know when they will complete their impact assessment, a key milestone that should have been met in 2011. Although one-third of providers expect to begin external testing in 2013, another half of respondents said they didn't know when testing would occur. The poll also found that most health plans do not expect to begin external testing until 2013 and, although more than a third of health plans have completed their assessment, one quarter are less than halfway through. About one-half of vendors said they are less than halfway through their product development cycle. ⁽¹⁹⁾

- Providers get paid based on volume of services delivered, and **mobile health has been shown to reduce the need for hospital admissions and physician office visits**. Forty percent of physicians surveyed said they could eliminate 11 to 30 percent of office visits through the use of mobile health technologies like remote monitoring, email or text messaging with patients. Estimates of annual consumer market for remote and mobile monitoring devices is \$7.7 billion to \$43 billion. ⁽¹⁵⁾

- "Big data" is a new term that refers to the massive data sets that are generated by all the activity in an increasingly digital world. **This past year alone, health care generated an estimated 150 exabytes of information**. McKinsey & Co. estimates that big data could create \$300 billion in value by reducing health care spending by 8 percent. The consulting firm notes that big data add value to industries by: making information transparent and usable more quickly; enabling better performance measurement through digital capture; and improving business analytics and decision support. ⁽²⁰⁾

- **Coordinating care for patients with complex health conditions** who see multiple physicians also can be supported by better health information technology interoperability. The primary care team may be in the best position to coordinate a patient's care, but often it will need information from other providers. Most current electronic medical records don't adequately support data exchange across providers and settings, so practices communicate with outsiders primarily on paper. To support information exchange, EHRs must present data in standard ways, and separate organizations providing services for the same patient need to share information securely. ⁽²¹⁾

- A majority of **hospital executives say they are very concerned about both the cost and the process of fully integrating EHRs** into their hospital's operations and culture, including retention and training of staff and physicians. ⁽²²⁾

Insurance & Coverage



- In fiscal 2012, the **majority of states experienced Medicaid spending and enrollment growth equal to or below original projections**, and 10 states reported mid-year Medicaid cuts. The outlook for 2013 and beyond remains difficult with continued pressure to find Medicaid cuts, although few options for additional savings remain. Medicaid remains front and center in state budget discussions as governors release proposed budgets for fiscal 2013. After successive years of budget cutting and cost containment, many states are planning to take advantage of new integration opportunities for dual eligibles with the hope of health care improvements for this vulnerable population, but just as importantly, state budget savings. ⁽¹⁶⁾

- **Health care costs continue to grow at a faster rate than wages**. With the recession as a backdrop, employers sought to moderate their bottom-line impact by continuing to increase the portion of health care costs borne by employees. Cost sharing for public employees already is increasing in some markets and likely will accelerate. Consumer-driven health plans are likely to become the only health benefit offered in more instances. More mid-sized firms, especially those with relatively healthy workforces, are likely to pursue self-insurance in an attempt to reduce health benefit costs and avoid minimum essential benefit requirements under health reform. While there is disagreement about how the number of employers offering health insurance will change — estimates range from a 9 percent increase to a 22 percent reduction — employer opt-out decisions are likely to be influenced heavily by labor market conditions that vary across geographic areas and industries. ⁽²³⁾

- The U.S. system of **billing third parties for health care services is complex, expensive and inefficient**. Physicians end up using nearly 12 percent of their net patient service revenue to cover the costs of excessive administrative complexity. A single transparent set of payment rules for multiple payers, a single claim form, and standard rules of submission, among other innovations, would reduce the burden on the billing offices of physician organizations. These changes could translate into \$7 billion of savings annually and save four hours of professional time per physician and five hours of practice support staff time. ⁽²⁴⁾

- **Only slightly more than 10 percent of hospitals have Medicare costs below Medicare rates**, and an alarming number recover 90 percent or less of their costs. ⁽²⁵⁾

Political Issues



- **Reducing Medicare provider rates** will remain a discussion in deficit talks. Combine that with other efforts under way to reduce volume, and the squeeze is on hospitals. ⁽²⁷⁾

- The **Supreme Court ruled unconstitutional ACA's provision penalizing states that do not expand their Medicaid programs**. The result of the ruling is two opposing incentives. On the one hand, there's a deep pot of federal money for states to expand Medicaid. On the other, there's fear of getting even more saddled with bills from an increasingly expensive entitlement program. The federal government won't cover bills for Medicaid enrollees who already were eligible for the program but never signed up. States worry about those people showing up to enroll and having to accept them at the regular match rate. Meanwhile, the 100 percent match rate doesn't last forever. After the first three years, the federal government's match rate starts dropping: it will pay 95 percent of the cost beginning in 2017 and then, in 2020, foot only 90 percent of the bill. States fear that the federal government might decide to ratchet back that number. ⁽²⁸⁾

- There is uncanny **bipartisan consensus to reduce federal support for the Medicaid and Medicare programs for U.S. hospitals**. The ACA is scheduled to remove \$550 billion during the next 10 years in federal support for the Medicaid and Medicare programs. Many state legislatures have dramatically reduced Medicaid funding, and hundreds of hospitals are reeling in an effort to balance their budgets as a consequence. A 2 percent across-the-board cut in Medicare payments is scheduled for Jan. 1, 2013, if Congress and the president fail to reach agreement on a deficit-reduction plan. This is a blow to communities with a heavy Medicare patient care load. An 8 to 12 percent cut in federal support to the Medicaid and Medicare programs is predicted during the next five years. This will close hundreds of U.S. hospitals and cripple essential community providers across the United States. ⁽²⁹⁾

- Nationwide **physician shortages are expected to balloon** to 62,900 in five years, up more than 50 percent from previous estimates. To counter shortages, the American Academy of Medical Colleges is urging federal officials to lift limits on Medicare funding for residency positions, which have been capped at 100,000 slots since 1997. HHS estimates that the physician supply will increase by just 7 percent in the next decade. ⁽²⁵⁾

Provider Organizations & Physicians



● New delivery models are going to be essential, including more primary care-based, easy-access, low-cost models for patients to receive certain services such as immunizations and school physicals. **Relying on the current primary care system (physician offices and hospital EDs) is not going to be adequate;** there are not enough primary care physicians, and hospital EDs are expensive. New physicians are not going into primary care, so access to traditional primary care will be increasingly limited. This leaves the door wide open for retail options to address such basic needs as flu shots, sore throats or routine physicals — all services for which it can be difficult to get into a doctor's office on a timely basis. Furthermore, a primary care office visit can cost more than a visit to a walk-in clinic in a retail environment, and people will be increasingly looking for more cost-effective alternatives. ⁽⁸⁾

● **A culture of performance excellence and accountability** for results was exhibited strongly by high performing health systems. This was defined through cultural markers such as: focusing on continuous improvement, driving toward dramatic improvement or perfection versus incremental change, emphasizing patient-centeredness, adopting a philosophy that embraces internal and external transparency with regard to performance, and having a clear set of defined values and expectations that form the basis for accountability of results. ⁽³¹⁾

● Hospitals and health systems **will need to be much leaner in all ways.** Leadership teams are starting to realize how difficult this task will be using traditional cost management techniques. Some health systems are taking proactive steps beyond traditional approaches to restructure the organization and its care processes in a more optimal way. Strategies include divesting business lines that cannot be effectively and efficiently operated, optimizing service distribution across facilities and geographies, and redesigning clinical processes to reduce variation, which increases costs. ⁽¹⁶⁾

Quality & Patient Safety



● **Medical schools are not doing an adequate job** of facilitating student understanding of basic knowledge and the development of skills required for the provision of safe patient care, including: systems thinking, problem analysis, application of human factors science, communication skills, patient-centered care, teaming concepts and skills, and dealing with feelings of doubt, fear and uncertainty with respect to medical errors. These competencies should become fully developed during the residency training period. ⁽²⁷⁾

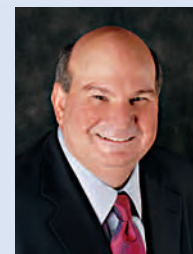
● A major **cost savings opportunity in health care lies with supply-sensitive care:** inpatient days (avoidable hospitalizations, readmissions and end-of-life care); physician visits (unnecessary visits and specialist referrals); unnecessary diagnostic tests and minor procedures. If every area of the country achieved the performance level seen in the lowest-spending regions, an estimated 30 percent of the hospital beds could be closed. ⁽²⁸⁾

● Beginning in 2015, a 300-bed hospital with **poor quality metrics could be penalized** by more than \$1.3 million per year. Even more important, these hospitals could suffer reputational damage as these metrics are published online, which is now the most popular place for consumers to seek health information. ⁽²⁹⁾

● Programs aimed at **enhancing care coordination during hospital-to-home transitions** have shown the most consistent beneficial effects on cost and quality. ⁽³⁰⁾

● Providers are particularly **concerned that public reports fairly and accurately reflect their performance,** and not things that are beyond their control, such as the risk profile of the population they treat. ⁽³¹⁾

What the experts have to say...

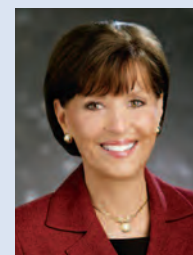


Gene J. O'Dell

Vice president, strategic and business planning, American Hospital Association, Chicago, producer of the 2013 AHA Environmental Scan

What are the new trends and key findings in the 2013 AHA Environmental Scan?

Although only 40 percent of hospitals today break even on Medicare inpatient payments, Medicare represents 43 percent of all hospital revenue; that percentage is expected to increase in the future. With a predicted 8 to 12 percent cut in Medicare and Medicaid support over the next five years, it's imperative that hospitals pursue strategies to improve operational performance by delivering strong operating margins. Exacerbating the situation, the Supreme Court's ruling on the Affordable Care Act and its impact on the Medicaid expansion decision has states carefully evaluating the potential influx of significant federal dollars while remaining anxious about how to cover the growing Medicaid population and this increasingly expensive entitlement program.



Teri Fontenot

President and CEO, Woman's Hospital, Baton Rouge, La., and chair of the AHA

How will your organization reassess its strategic plan in light of the Supreme Court's ruling?

Woman's Hospital is committed to transforming from the first curve to the second curve; that is, from a volume-based focus of providing individual medical care to caring for women and infants in a manner that focuses on wellness, prevention and avoidance of inpatient services by keeping people healthy. As a result, the Supreme Court decision had little effect on our strategic plan.

What is your role in the strategic planning process?

As CEO, my responsibility is to set the vision, inspire our team through communication in action and word, and provide the necessary resources for success.



Holli Salls

Vice president, public relations, marketing and physician services, Northwestern Memorial Hospital, Chicago, and president-elect of the Society for Healthcare Strategy and Market Development

What are the most important elements of a hospital's strategic planning process?

At Northwestern Memorial Hospital, we start our review with the broader health care environment, followed by our local market and then within our organization. We also talk with our leadership, medical staff and board to gain their insights and identify trends. This step is important as it helps set the early framework for our strategic planning process and successful development of our tandem long-term financial plan. Once a future vision or destination is set and a plan is drafted, clear milestones and metrics are defined. It is then widely disseminated and feedback is incorporated. The success of a good strategic plan is that it remains dynamic and can be adjusted according to changing market conditions.



2013 Environmental Scan webcast @ www.hhnmag.com

Hear AHA President and CEO Rich Umbdenstock and Vice President of Strategic and Business Planning Gene O'Dell discuss critical issues and emerging trends that have the highest probability of impacting the health care field — and hospital leaders — in the foreseeable future.

The webcast will be available in January, 2013.
View it on demand at your convenience at www.hhnmag.com.



Umbdenstock



O'Dell

Science & Technology



- The full potential of the technology-enabled home health care market remains to be tapped. **In the United States, home care accounts for about 3 percent (\$68 billion a year) of national health spending.** The market is increasing by about 9 percent annually, solid but hardly booming growth, especially since labor accounts for about two-thirds of the expenditure and home-monitoring technology represents a small fraction of it. The most important value offered by technology-enabled home care is preventing or delaying the shift of patients to acute- or long-term care settings. ⁽³²⁾

- **Technology and informatics also can be used to build and enhance provider networks,** linking community and rural providers to specialists, linking patients to providers virtually, and remotely monitoring patients' health status and medication compliance. ⁽²²⁾

- **Mobile medical applications** that can be downloaded on smart phones, and tablets are proliferating. New apps will enable organizations to efficiently develop and distribute best-practice standards and protocols to clinicians. ⁽⁷⁾

- **Smart phones, iPads and other tablets** are now in use in 80 percent of health care organizations. The BYOD (bring your own device) revolution is well under way, yet 50 percent of respondents in a recent health care IT poll say nothing is being done to protect data on those devices. ⁽³³⁾

- Get ready for e-visits. **Texting and emailing have been shown to be effective tools to connect patients and physicians efficiently.** Additionally, the use of email communications and telephone visits cuts office visits by 26 percent, improving the efficiency of ambulatory care. ⁽³⁴⁾

- The **quality of care in the hospital setting can be facilitated through wireless technologies.** This includes the ability to track every medication that is ingested, using pills tagged with digestible sensors that are activated in the stomach by the change in pH. Wireless sensors can monitor even routine procedures, such as physician and nurse hand washing. ⁽³⁴⁾

Human Resources



- Finding a primary care physician and getting timely care are increasingly difficult, even among Medicare beneficiaries and privately insured adults. **Sixty-five million people live in areas designated by the federal government as having a shortage of primary care providers.** As the population grows and ages and a declining share of physicians choose primary care careers, gaps in access are expected to widen. By 2020, the United States will face an estimated shortage of 91,000 physicians, split about evenly between primary care physicians and specialists. ⁽¹¹⁾

- **Trust — never a natural instinct between physicians and hospitals — remains a barrier.** When asked whether they trust hospitals, 20 percent of physicians surveyed said “no” and 57 percent said “sometimes.” However, physicians want financial security from their hospital relationships, and money may win out over trust issues. Nearly three-fourths of physicians surveyed said they’re already aligned financially in some way with hospitals. Such relationships include directorships, employment and joint ventures. In addition, 24 percent said that they already work primarily in hospital practice settings. ⁽¹²⁾

- The **transformation of the health care industry** is proving to be — and will continue to be — hard work, requiring significant investments and resources. An area of great demand is human capital — highly skilled people with specific job experiences and relevant talent. ⁽¹³⁾

- **CEO turnover is high.** In health care, 25 CEOs left their positions in January 2012, compared with only nine year-over-year. If the January data are any indication of turnover and mimic last year's numbers, health care once again could see the highest CEO turnover rates of all sectors. Health care organizations saw the heaviest CEO turnover among all industries in 2011. ⁽¹⁴⁾

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