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PREDICTIVE ANALYTICS ON THE IMPACT OF THE FEDERAL AFFORDABLE CARE ACT

In 2010 the 111th US Congress passed the Patient Protection and Affordable Care Act signed into law on March 23, 2010. The 2006 Massachusetts legislature passed a health reform law that served as a model for the national act. So, how are we doing in Massachusetts today and what are the national implications?

On September 20, 2019, David Seltz, Massachusetts Health Policy Commission Executive Director, spoke at a "Breakfast with Champions" event at Suffolk University, Boston MA. This was an educational program sponsored by ACHE. The Commission was established by a legislative Act (Chapter 224) in 2012 Improving the Quality of Health Care, Reducing Costs Through Increased Transparency, Efficiency and Innovation.

This law sought to control the growth of health care costs by limiting all health care spending to an annual increase of 3.6%. Today Delaware, Oregon, and Rhode Island have similar targets to Massachusetts. The law would also monitor the groundbreaking legislation in 2006 where all Massachusetts residents have access to health care.

The first two bullet highlights of David Seltz's remarks pertain to possible predictive analytics for the federal experience. The second two bullets point out some of the uniqueness of where Massachusetts residents get their care:

- ***In 2009, Massachusetts spent more on healthcare than any state in the US or any country on earth with costs growing at double-digit rates.*** The law limits annual growth in spending to 3.65%. Actual results were 2013 (2.4%), 2014 (4.2%), 2015 (4.8%), 2016 (3%), and 2017 (1.6%).
- ***In Massachusetts, 50% of the people drive by their local community hospital for care and only 23% of the population in Massachusetts use their closest hospital.*** Commercial inpatient volume at community hospitals decreased by 24% from 2010 to 2017.
- ***Where does the population get their health care?*** Nationally, 15% get their care in an academic medical center compared to 40% of Massachusetts. Massachusetts has four medical schools, with three private ones located in Boston: Boston University, Harvard, and Tufts.
- ***Hospital outpatient at 4.9% and pharmacy at 4.1% spending were the fastest-growing categories in 2017.*** Low growing categories included the "Hospital Inpatient" grew 1% and "Physician and Other Professionals" category which rose 1.5%.

The impact today of this 2012 law in Massachusetts is that healthcare spending was below the target in 2016 and 2017. As you will see in the next story the focus in 2020 is now on the Social Determinants of Health.

CHANGING WHAT USED TO BE ACCEPTED AS THE NORM
ACHE OF MASSACHUSETTS HALF DAY CONFERENCE FRIDAY, NOVEMBER 1
THE SOCIAL DETERMINANTS OF HEALTH- WHO, WHAT AND WHY THEY MATTER:

Sheraton Needham Hotel | 100 Cabot Street, Needham, MA. For more information go to http://massache.org/events.asp or call 978-692-3548

As we are now approaching a new decade and 2019 concludes, the 2016 Nobel Prize for Literature winner Bob Dylan's 60's song "The Times They Are a Changing" seems current. The change could be global warming with shrinking glaciers, or plant-based burgers substituting for beef burgers. In healthcare change is focusing on the Social Determinants of Health. Studies show that overall health is primarily -- about 60% -- is determined by the social, economic, and physical conditions in the environments in which people live, learn, work, play and worship.

Health care systems take on growing economic risk under contracts with third-party payors and government programs. Focusing on medical care delivery alone is not an effective way of managing population health. ACHE of Massachusetts presents a major conference on the Social Determinants of Health with 6 speakers (2 keynotes and 4 on a reactor panel) to provide insight and information on a topic that concerns us all.

Social Determinants of Health include housing safety, food availability, education access/quality, job opportunities, healthcare access, public safety (crime and violence), transportation, recreational opportunities, social supports and social stressors (such as racial and other forms of discrimination).

Strategies for addressing Social Determinants of Health include behavior change interventions (including personalized feedback, health coaching, social support for physical activity, adequate sleep, weight management, diabetes management, diet counseling and stress management) as well as support products and services (such as mobile health, websites, other computer-based applications, text messaging, wearable devices, body and environmental sensors, and telecommunications).

This conference will assist you in understanding the most effective responses to Social Determinants of Health that will result in improved care, lower costs and better quality of life for the populations we serve.

Keynote Speakers

- **Sandro Galea, MD, MPH, DrPH**, Dean and Robert A. Knox Professor, Boston University School of Public Health
- **Douglas Brown**, President, UMass Memorial Community Hospitals and Chief Administrative Officer, UMass Memorial Health Care System

Panel

- **Abigail Averbach, MSc,** Assistant Commissioner and Director, Office of Population Health, MA Department of Public Health
- **Nissa James, Ph.D.,** Director of Communications and Legislative Affairs, Department of Vermont Health Access
- **Philly Laptiste,** Executive Director, Bowdoin Street Health Center
- **Dan Slater,** MD, Chair of Pediatrics and Medical Director of Mass Health ACO Program, Atrius Health

Labor Benchmarking

How does your hospital measure up? Benchmarking provides the answers

AMS's hallmark service is labor benchmarking. Only by identifying a hospital's actual staffing levels and comparing it to our proprietary industry labor benchmark database can an institution confidently begin the process of optimizing productivity. We perform both hospital-wide and department-level benchmarks.

Typical initial savings identified is up to 10% of total labor expense

Immediate Benefits

- Identify, by department and cost center, staffing based on AMS work-function level benchmarks
- Identify departments with potential for productivity and operating system improvement
- Provide a focal point for senior management to discuss labor resource issues
- Establish a starting point for improvement efforts
- Assist with development of long-term labor strategies

Recent Results

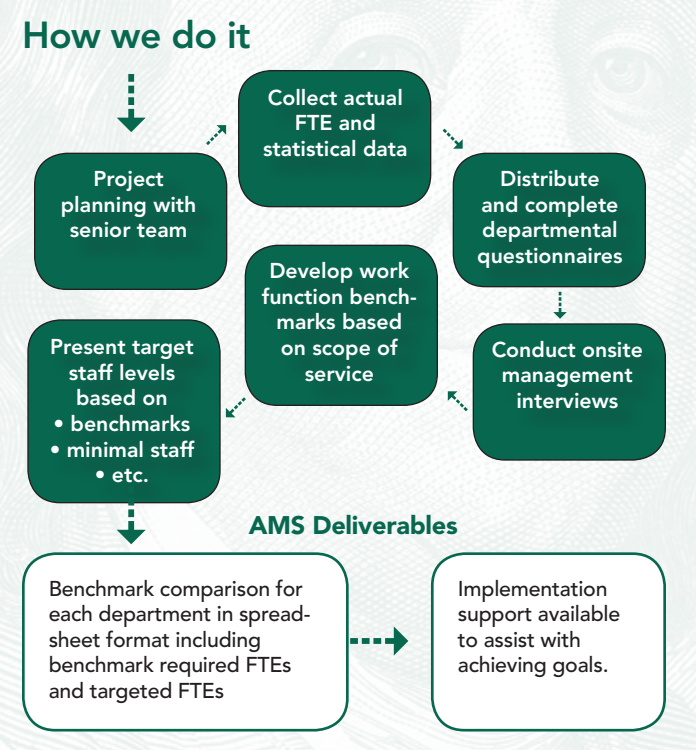
200-bed community hospital: AMS identified a labor improvement opportunity of 108 FTEs of the hospital's 1,250 FTEs. Eight outlier departments accounted for 50% of the opportunity.

3-hospital, 600-bed regional system: AMS identified areas with staffing opportunity equal to 3% (136 FTEs) of the system's 4,500 FTEs.

Critical access hospital: AMS identified an 8% staffing opportunity (48 FTEs) in a system of 600 FTEs comprised of a 25-bed acute care, 25-bed nursing home, 10-bed rehab unit, and support staff for physician practices.

Average ROI = more than 30 times

How we do it



The AMS Benchmarking Advantage

- Hospital-wide benchmarks compare your hospital/health system to similar institutions (size, type, and case mix) on a global basis.
- Department benchmarks are based upon a key volume indicator and paid hours per indicator for each department or area of the hospital.
- AMS's proprietary benchmarking database is based primarily on:
  - Actual studies AMS performs for its clients
  - Best practice targets developed by AMS content experts who specialize in all facets of health care.

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