- Hospital expenses grew 4.6% while revenue only increased 4.1% in 2013, compared to 2002 when the median annual expense and revenue growth rates were both 9%.
    - Moody's Investor Service
    - Second consecutive year in which hospitals' expense growth rate outpaced the revenue.
- The decline in profitability is attributed to several factors:
    - Low rate increases from commercial payers
    - Medicare and Medicaid cuts
    - The shifting payer mix
    - More high-deductible health plans and
    - Shift to ambulatory services and observations stays

Bond Rating Distribution
Health Systems vs. Stand-Alone
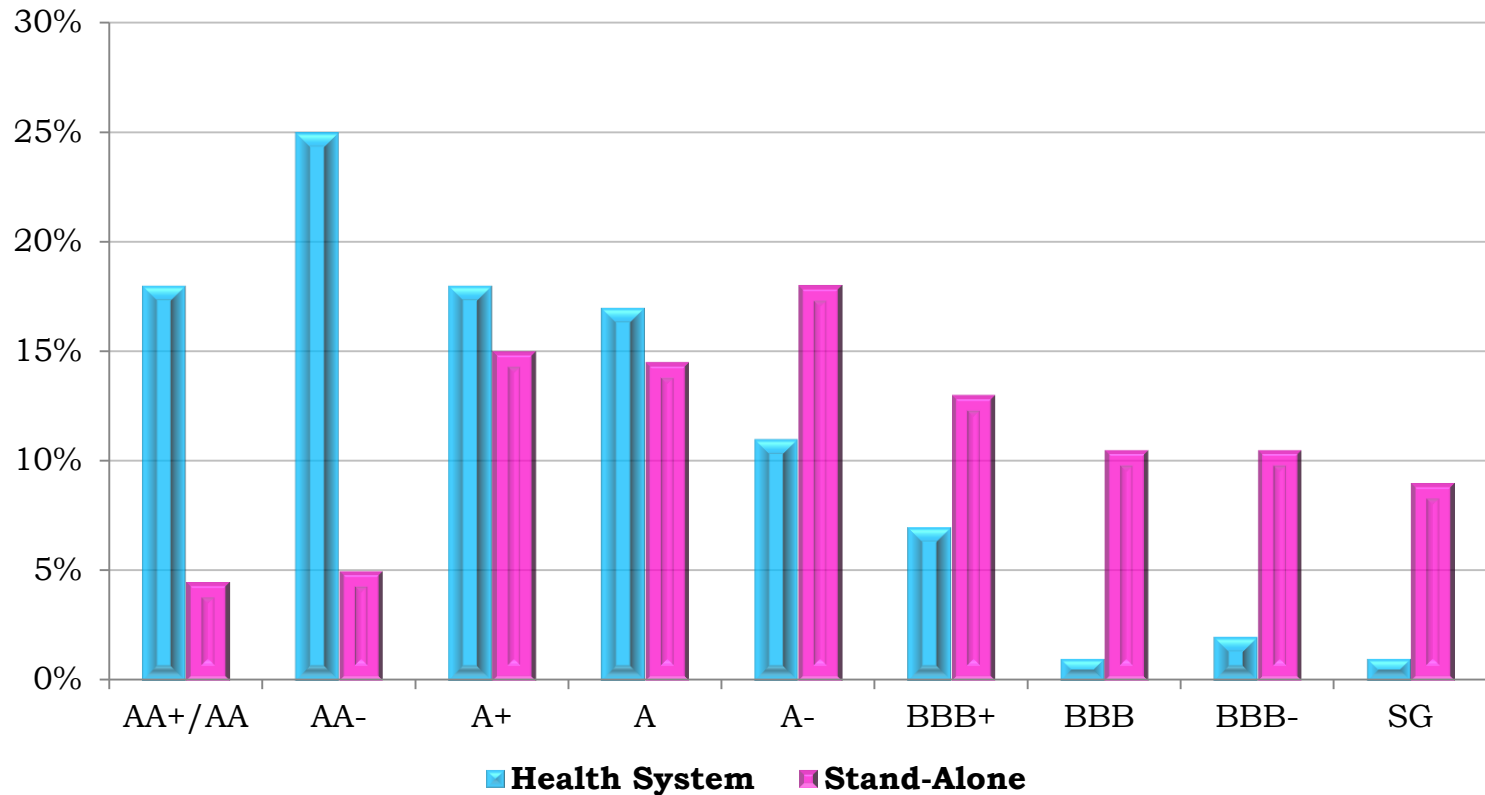
- Inpatient Discharges Decreased; Outpatient Services Increased
  - Medicare spending growth per capita from 2011-2012 (PPS and CAH):
    - 2.3% decrease for inpatient settings; 7.0% increase for outpatient settings
  - 2012 patient volume:
    - 4.5% decrease for inpatient settings; 4.3% increase for outpatient settings

**Change in Medicare
Outpatient & Inpatient Services**

* per FFS Beneficiary, 2005-2011

Source: MedPAC, 2013
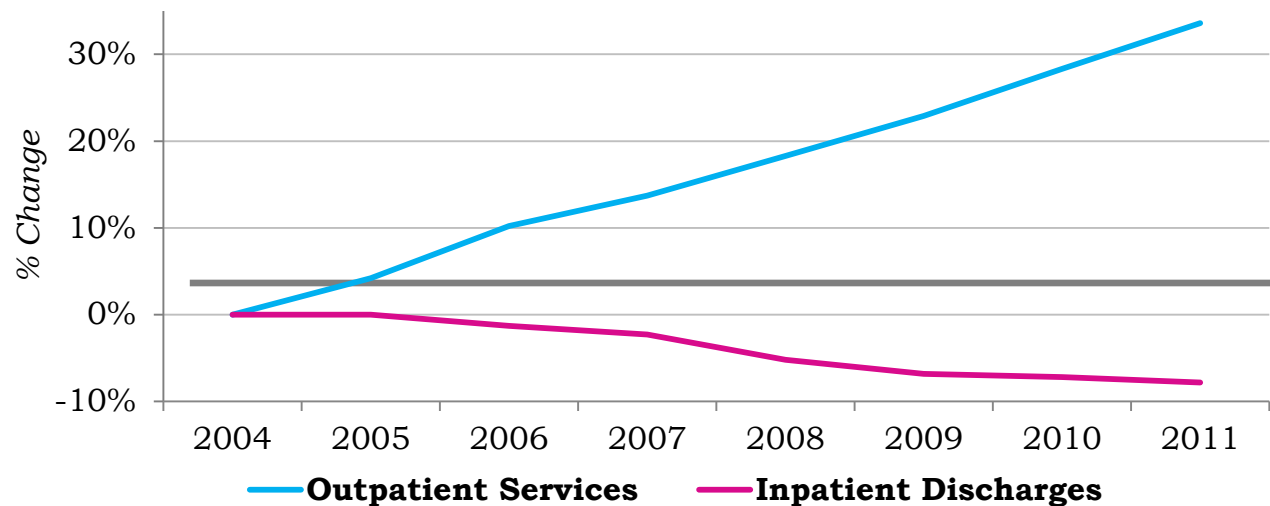
Adjusted Contribution Margin

Inpatient/ Outpatient	Service	Net Revenue per case (2011)	Net Revenue per case (2012)	Change in Net Revenue per case	Profit/Loss per case (2011)	Profit/Loss per case (2012)	Change in Profit/Loss per case
Inpatient	Cardiac Surgery	8.12	7.62	**-6%**	2.05	1.46	**-29%**
	Thoracic Surgery	2.93	2.80	**-5%**	0.95	0.85	**-10%**
	Vascular Surgery	2.36	2.29	**-3%**	0.50	0.38	**-25%**
	Cardiology	2.09	2.15	**3%**	0.39	0.31	**-20%**
Outpatient	Cardiac Cath	0.66	0.65	**-1%**	0.17	0.16	**-2%**

- Physician Quality Reporting System (PQRS)
  - Incentive program for those who submit clinical data
  - Until 2014, 0.5% bonus if a physician reports on 80% of eligible claims
  - Incentives will become penalties if failure to report on 50% of claims
  - 1.5% penalty in 2015; 2.0% penalty in 2016
- Accountable Care Organizations (ACOs)
  - Shared savings program that brings risk to physicians
  - Shift from fee-for-service to pay-for-quality model
- Shared Risk Contracting
  - Negotiated with payers based upon quality metrics

- Two-Midnight Rule

  - Since October 2013, less than two consecutive midnights considered outpatient care by Medicare

  - Delays in implementation and legislative/legal challenges

  - Tens of millions of dollars potentially lost for Mount Sinai Health System

  - Increased need for Observation Services at Mount Sinai

- PACT Program: Reduce avoidable 30-day readmissions
  - Transitional services for 35 days post-discharge
  - Comprised of social workers – collaborate with inpatient team
  - Identify patients at risk of readmission
    - Use daily high risk list, conduct inpatient assessment, develop and implement plan for post-discharge follow-up

Total Cost Prior and After Enrollment into PACT Program								
	30 Days			60 Days			90 Days		
	Pts	Claims	Cost	Pts	Claims	Cost	Pts	Claims	Cost
Prior	80	1939	$ 1,470,733	74	2917	$ 1,663,482	66	3409	$ 1,816,581
After	80	1192	$ 477,592	74	1847	$ 877,346	66	2055	$ 1,032,830
Change			$ 993,141			$ 786,136			$ 783,750

- 20-bed unit adjacent to the Emergency Department

  - Opened mid-February

- Operational Data (02/18/14 –4/30/14)

  - 1282 patients

  - Average LOS – 16 Hours

  - Patients admitted – 21%

  - Decreased number and duration of wait time in ED for admitted patients

- Observation Units at other Mount Sinai Health System campuses will be operational in June

- Creation of Overnight Ambulatory Unit

  - Six PACU rooms were converted to a short-stay unit in August 2013

  - Unit by morning so as not to delay reopening of PACU beds

  - Most cost-efficient setting for these patients

  - Began trial with ENT patients

    - Experienced reductions in denials

    - Allowed higher acuity patients to occupy these inpatient beds

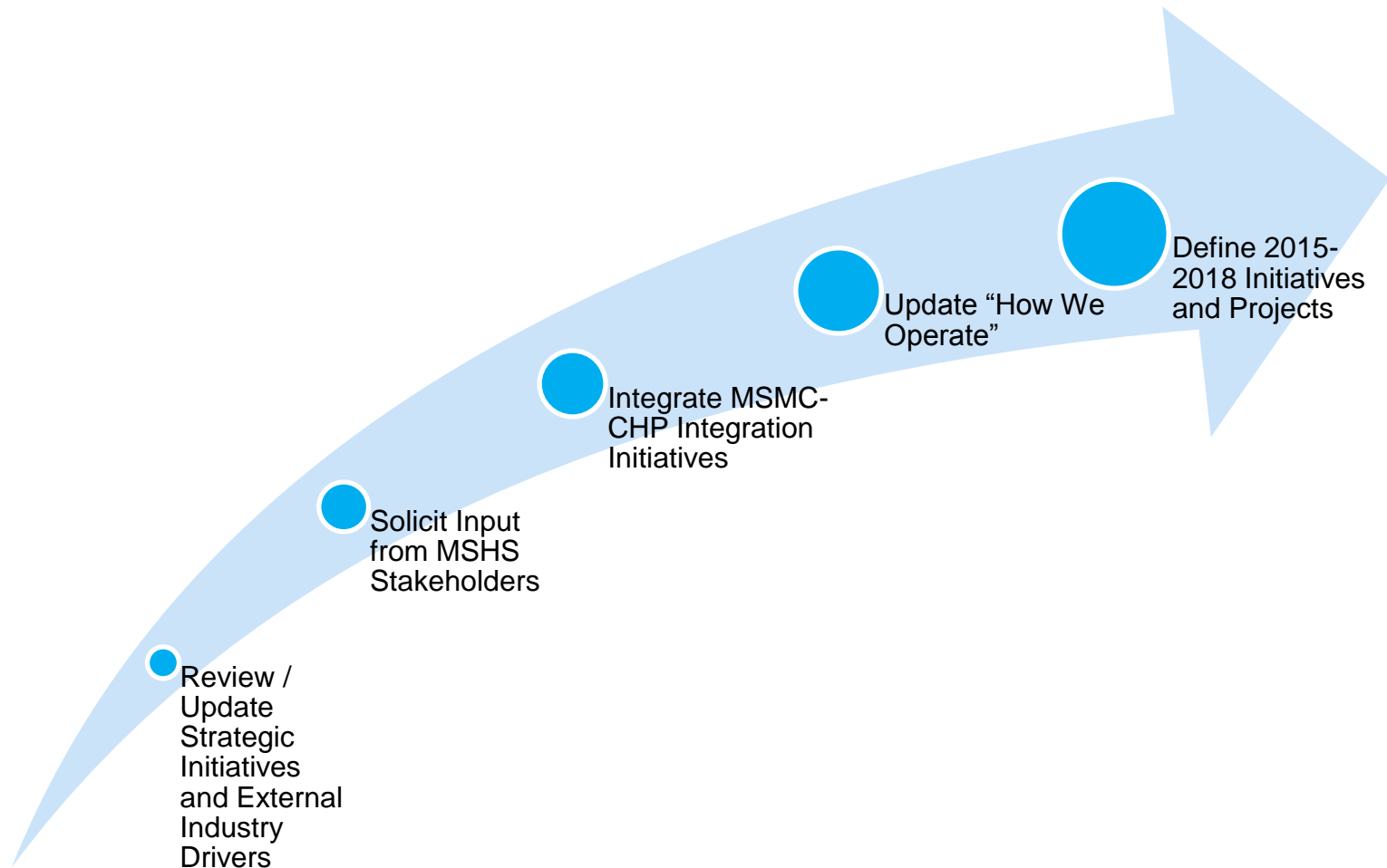| Denial Activity for ENT Procedures		
ENT Procedures		
	Denied Cases	Denied Revenue
2012	82	$ 730,000
2013	51	$ 320,000
Reduction From 2012	31 (38% Reduction)	$ 410,000 (56% Reduction)

Mount Sinai

Adapting to 21st Century Healthcare

- Major changes occurring in U.S. health care
  - Physician employment patterns
  - Shift to outpatient care
  - Decreased reimbursement

- Adaptations
  - Creation of "poly-clinics" for ambulatory care
  - Population health management to decrease health care spending
    - Shared risk with insurers to also share in health care insurance premium
  - Still dependent upon high complexity care and likely to remain so
  - Innovative programs to better manage patients in the pre- and post-acute phases of care

Mount Sinai

Going forward…

- Rapidly changing clinical and economic environment

- Revenue still mainly fee-for-service, but expectation is that population health management is future direction

- Systems forming from stand-alone medical centers to increase numbers of patients

- Accepting risk to obtain larger portion of health care insurance premiums

- Overall better health care when physicians and health systems are rewarded for better health of the population

- Academic/Tertiary care centers will still need to perform most complex care with best outcomes

Mount Sinai

IT Long Range Planning is the Foundation for IT Capital Planning

Review / Update Strategic Initiatives and External Industry Drivers

Solicit Input from MSHS Stakeholders

Integrate MSMC-CHP Integration Initiatives

Update "How We Operate"

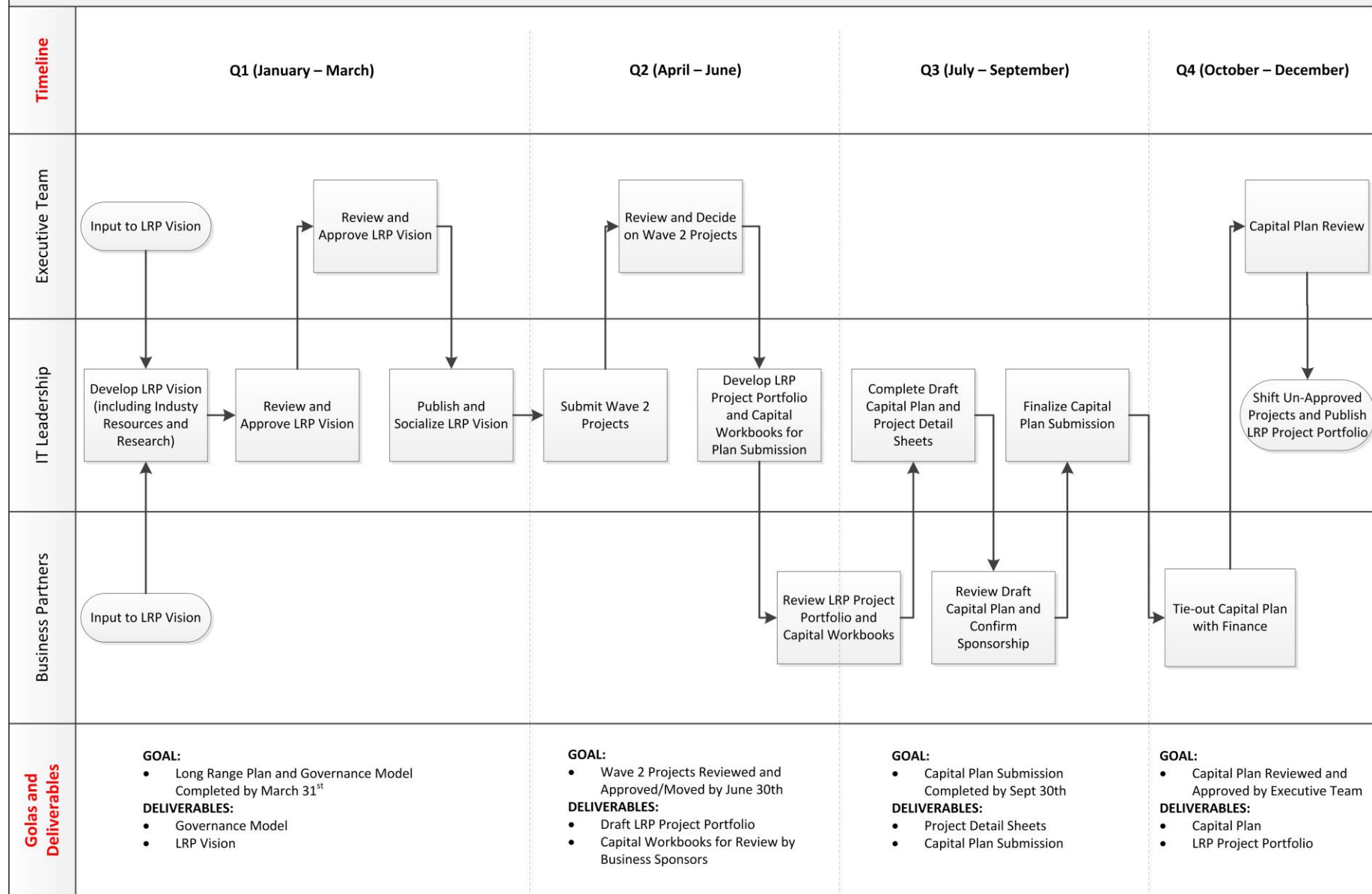Define 2015-2018 Initiatives and Projects

Are Strategic Initiatives From the Last Plan Still Valid? Anything New?

- ☑ Health Reform and Accountable Care
- ☑ Growth
- ☑ Integration of 'Omics and Clinical Care
- ☑ Data Management & Analytics
- ☑ Integrated and Enterprise-class Environment and Solutions
- ☑ Academic Informatics
- ☑ Research & Innovation
- ▸ What Else?

Are External Drivers From the Last Plan Still Valid? Anything New?

- ☑ Big Data
- ☑ Health Reform and Accountable Care
- ☑ Security & Trust
- ☑ Personalized and Precision Medicine
- ☑ Medical Device and Remote Monitoring Integration
- ☑ Mobile Health
- ☑ Competition for "Best & Brightest" Students and Faculty
- ☑ Social Media
- ☑ Consumerism
- ☑ Cloud Computing
- ▸ What Else?

IT Long Range and Capital Projects Planning

Timeline	**Q1 (January – March)**	**Q2 (April – June)**	**Q3 (July – September)**	**Q4 (October – December)**

Executive Team

- Input to LRP Vision
- Review and Approve LRP Vision
- Review and Decide on Wave 2 Projects
- Capital Plan Review

IT Leadership

- Develop LRP Vision (including Industy Resources and Research)
- Review and Approve LRP Vision
- Publish and Socialize LRP Vision
- Submit Wave 2 Projects
- Develop LRP Project Portfolio and Capital Workbooks for Plan Submission
- Complete Draft Capital Plan and Project Detail Sheets
- Finalize Capital Plan Submission
- Shift Un-Approved Projects and Publish LRP Project Portfolio

Business Partners

- Input to LRP Vision
- Review LRP Project Portfolio and Capital Workbooks
- Review Draft Capital Plan and Confirm Sponsorship
- Tie-out Capital Plan with Finance

Golas and Deliverables

GOAL: • Long Range Plan and Governance Model Completed by March 31st **DELIVERABLES:** • Governance Model • LRP Vision	**GOAL:** • Wave 2 Projects Reviewed and Approved/Moved by June 30th **DELIVERABLES:** • Draft LRP Project Portfolio • Capital Workbooks for Review by Business Sponsors	**GOAL:** • Capital Plan Submission Completed by Sept 30th **DELIVERABLES:** • Project Detail Sheets • Capital Plan Submission	**GOAL:** • Capital Plan Reviewed and Approved by Executive Team **DELIVERABLES:** • Capital Plan • LRP Project Portfolio

Long Range Planning / Capital Planning Processes

▸ The IT capital planning process is inextricably linked with the long range planning process

▸ Assumes a more unified enterprise approach to capital planning
  – Communication amongst all parties will be critical
    • IT
    • Business Partners
    • Finance
    • Executive Leadership

▸ Capital projects will require completion of a workbook that defines the requirements (capital $, operating $, resources, etc.), benefits to be achieved and risks of not doing the project.

CAPITAL BUDGET REQUEST WORKBOOK (Version 2.5)

Request Name

IT Owner

Sponsor Name(s)

IF NO SPONSOR HAS BEEN IDENTIFIED,
DO NOT PROCEED ANY FURTHER

Request Prepared by

Request Description

Top Level Driver

Reason for Request (1)

Reason for Request (2)

Reason for Request (3)

Is this a multi-year request?
If Yes, for which year is this request?   (n of nn)

Estimated Duration   (months)

Investment Category

Proposed Wave

Has an SBAR been completed?

IF THE INVESTMENT CATEGORY IS EPIC, INFRASTRUCTURE, OR APPLICATIONS, AND AN SBAR HAS NOT BEEN COMPLETED, DO
NOT CONTINUE ANY FURTHER UNLESS AUTHORIZED BY THE CIO TO PROCEED WITHOUT ONE

Has the Sponsor identified above reviewed and
approved the content of this workbook?

If this request is for over $500,000 in capital, has an ROI
been completed? (NOT required for BRACE or Regulatory requests)

Have anticipated Key Performance Indicators been documented
in this workbook? (NOT required for BRACE or Regulatory requests)

Request #: 0

Mark with an X for each
for each applicable site:

	MSH
	MSQ
	ISMMS
	MSSL
	MSR
	MSBI
	MSBIB
	NYEE
	Other

If "Other", please specify:

Version # 0
Date of Last Update: 01/00/00

Capital Budget Summary

	Total Capital	CAPITAL			OPERATING		
		Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
Total Hardware	$0	$0	$0	$0	$0	$0	$0
Total Software	$0	$0	$0	$0	$0	$0	$0
Total Interface	$0	$0	$0	$0	$0	$0	$0
Total Professional Services	$0	$0	$0	$0			
Total IT Staffing	$0	$0	$0	$0	$0	$0	$0
Total Travel	$0	$0	$0	$0			
Total Training					$0	$0	$0
Total Other Operating					$0	$0	$0
TOTALS	$0	$0	$0	$0	$0	$0	$0

Priority	Request Name	Request Description	Sponsor(s)	Top Level Driver	Capital Year 1	Capital 3 Years	Operating Year 1	Operating 3 Years
High	CVI PACS Storage Expansion	Increase SAN/NAS capacity to accommodate future image storage from Cath, echo, nuclear, vascular labs, and other non-cardiology departments (ED, L&D, etc.).	Betty White	Sustain or Improve Finances	$$	$$$	$	$
High	Fetal Monitoring Server Refresh	Upgrade of the aging servers which support the fetal monitoring system used in Labor & Delivery at MSH	Carol King	Improve Quality	$	$	$0	$0
High	Interoperability for Emergency Management Coordination	This solution will allow for interoperability of the radio systems across the Health System. This connectivity is essential to effective coordination of Health System resources for Emergency Management and other functions.	Kevin Costner	Improve Stakeholder Access and Engagement	$$	$$	$	$$
High	Continued EMPI clean up and integration	Continuation of eMPI clean up and integration across the health system to support clean enterprise master patient index	Taylor Swift	Improve Quality	$$$$$	$$$$$	$$	$$
High	HIE	Implementation of a new, robust Health Information Exchange platform	David Decovney	Improve Quality	$$$$	$$$$$	$$$	$$$$
High	Unified Patient Portal	Patient Portal Solution across the enterprise to provide ubiquitous patient access to hospital services	Jerry Baker	Improve Stakeholder Access and Engagement	$$$$$	$$$$$	$$	$$
High	Electronic Prescribing - continuation	To implement electronic medication prescribing. It is believed that NY State DEA will mandate electronic medication prescribing by end of year 2014.	Neal Young	Improve Quality	$$$	$$$	$$	$$
High	Meaningful Use Phase 2 and 3	Government Regulations for MU continuation of stages 2 and beginning of Stage 3. Note: Budget is estimate won't know until stage 3 is released.	Bob Dylan	Improve Quality	$$	$$	$0	$$
Med	Echo PACS & Reporting System Replacement	The existing Echo PACS and reporting system functionality does not meet with the latest advancements in the field of echocardiography. In order to meet these requirements existing systems need to be replaced.	Betty White	Improve Quality	$$$	$$$$$	$$	$$$
Med	Planner for Emergency Management and Business Continuity	This system will be used to collect and manage the documents necessary for the Health System's Emergency Management and Business Continuity programs.	Kevin Costner	Improve Stakeholder Access and Engagement	$	$	$	$$
Med	Bed Management System	Implement a new Bed Management System to enhance our ability to manage patient flow throughout the institution.	Jerry Baker	Improve Quality	$$$$$	$$$$$	$	$$$

Proposed 2015 IT Capital Requests

Projects supporting ancillary and departmental systems at hospitals, Academic Informatics, Library, and Research

Projects supporting EMRs at all campuses and Integrated Billing

Support for population health initiatives such as ACO and DSRIP

Multi-year projects with a 2015 capital component

Including ePrescribing and Meaningful Use (does NOT include ICD-10)

Includes Critical Infrastructure Refresh, IT Security, and Other Infrastructure Projects

Projects that support IT and Service Line Integration across all campuses

G. Applications & School ($$$)

A. On-Going Projects ($$$)

B. Regulatory ($)

F. EMRs & Billing ($$$$$)

E. Population Health ($$)

C. Infrastructure ($$$$)

D. Health System Integration ($$$)