Lahey Health

Howard R. Grant, JD, MD
President
Chief Executive Officer

41 Mall Road
Burlington, MA 01805

781.744.8330 P
781.744.5767 F
LaheyHealth.org

Submitted via email: HPC-Testimony@state.ma.us

September 8, 2014

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street, Sixth Floor
Boston, MA 02116

Dear Mr. Seltz,

Enclosed please find written testimony submitted on behalf of Lahey Health System, Inc. in response to the questions of the Health Policy Commission in Exhibit B and questions of the Office of the Attorney General in Exhibit C, as requested in the letter dated August 1, 2014.

In addition, written testimony submitted on behalf of Lahey Clinic Foundation, Inc. and Lahey Hospital and Medical Center are enclosed in response to select questions not specifically addressed in the Lahey Health System, Inc. testimony, and posed by the Office of the Attorney General in Exhibit C.

I, Howard R. Grant, am legally authorized and empowered to represent Lahey Health System, Inc. and all subsidiary entities, for the purposes of this testimony, and this testimony is signed under the pains and penalties of perjury.

Sincerely,

Howard R. Grant, J.D., M.D
President and Chief Executive Officer
Lahey Health System, Inc.

2014

Written Testimony Submission

On Behalf of Lahey Health System, Inc. and Subsidiaries

IN RESPONSE TO REQUEST FROM THE HEALTH POLICY COMMISSION (HPC) AND THE OFFICE OF THE ATTORNEY GENERAL (AGO)

TABLE OF CONTENTS

SECTION I	**LAHEY HEALTH Exhibit B: HPC Questions and Responses**	
Question 1		1
Question 2		3
Question 3		4
Question 4		5
Question 5		6
Question 6		6
Question 7		7
Question 8		8
Question 9		9
Question 10		10
Question 11		11
Question 12		12
Question 13		14
SECTION II	**LAHEY HEALTH Exhibit C: AGO Questions and Responses**	
Question 1		1
Question 2		1
Question 3		2
Question 4		2
SECTION III	**LAHEY CLINIC/LHMC Exhibit C: AGO Questions and Responses**	
Question 2		1
Question 4		1

Notes:

As per discussion with HPC and AGO representatives, Lahey Clinic/LHMC is required to submit a separate response only to those questions not already addressed in the Lahey Health System, Inc. response submission.

All efforts were made to conform to prescribed character limits. However, given the need to specify and describe Attachments as well as combine Summary and Response elements for select questions, a slightly modified submission format was utilized. We thank you in advance for your flexibility.

1. Chapter 224 of The Acts of 2012 (C. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY 2012- CY 2013 and CY 2013-CY 2014 is 3.6%.

Summary

Efforts to meet cost growth benchmarks are part of a broader systematic and transformational approach. The approach centers on actively ensuring appropriate utilization at the most appropriate site within a high-value health care management and delivery system. To compensate for forgone FFS revenue in the short-term, enable infrastructure investments and maintain a conservative pricing philosophy, Lahey Health employs cost management measures.

The most potentially impactful policy changes regarding cost benchmarks would ensure equitable accountability for reducing spending and effectively reward providers and payers demonstrating an earnest commitment to doing so. Examples may include policies to mitigate short-term negative financial consequences of cost containment or maximize ability to execute innovative partnership and system redesign strategies with potential high-yield cost reduction implications.

Response

a) What trends has your organization experienced in revenue, utilization, and operating expenses from CY2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

*See Attachment B1-a for detail. Data provided for all applicable years for Lahey Health (formed in May 2012). Data provided by fiscal year (October – September), following previous submission format. The same **seven months** of data (October to April) are provided for comparison purposes of FY2013 – FY2014.*

Revenue/Expense Trends

FY2012 – FY2013

- Operating revenues and expenses each increased by approximately 2.0%

FY2013 – FY2014

- Operating revenues increased by 1.8% and operating expenses increased by 1.5%

Utilization Trends

FY2012 – FY2013

- IP discharge and ambulatory surgery volumes down slightly (decrease of 2.3% and 3.0%, respectively)
- ED and physician visit volume relatively flat (up 0.4% and 1.2%, respectively)
- Observation discharges, home care visits and behavioral health visits increased (up 8.7%, 14.6% and 28.9%, respectively)

FY2013 – FY2014

- ED visit and ambulatory surgery volumes relatively flat (down 1.1% and 0.3%, respectively)
- IP discharge and physician visit volumes up slightly (increase of 1.8% and 3.1%, respectively)
- Observation discharges, home care visits and behavioral health visits increased (up 12.5%, 7.1% and 7.2%, respectively)

Factors Driving Trends

- Payor incentives to treat potential inpatients using observation beds
- IP utilization trends consistent with trends and teaching/AMC peers in MA; impacted by efforts to treat patients in lower-cost care settings

- Some patient postponement of care, particularly elective ambulatory surgery, and specifically patients with HDHPs[1]
- Efforts to decrease inappropriate ED utilization
- Growth of behavioral health and home health services programs

b) What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

- Maintained a conservative pricing methodology, whereby prices are reevaluated annually resulting in:
  - Generally lower hospital and physician commercial prices compared to most relevant peers[2]
  - Modest, if any, increases in patient cost-sharing provisions
  - Minimal year-to-year price fluctuations
- Participated in more APM contracts, including addition/expansion of commercial risk-contracts, and participation in the MSSP and BCPI[3]
- Executed acquisition of Winchester Hospital to expand our network of high-quality facilities
- Embedded behavioral health resources and support staff into primary care sites, other community settings[4] and the ED
- Invested in infrastructure and HR to improve care and performance management capabilities
- Integrated/centralized/standardized clinical and corporate functions/policies

c) What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

INNOVATIVE CARE DELIVERY

- Finalize affiliation with VNAME[5] to provide comprehensive continuing care services and integrated home care, palliative care, and hospice care
- Enact system policies that most effectively incent coordination and care delivery in the highest-value setting
- Carry out network development strategies that deemphasize the hospital (and specifically the tertiary hospital) as the "hub"

INFRASTRUCTURE INVESTMENTS

- Execute system wide roll-out of Epic EHR platform by March 2015
- Implement *Phytel Outreach* patient engagement and population health management software across the Lahey Clinical Performance Network (LCPN)
- Hire incremental care managers focused on reducing inappropriate utilization and readmissions

[1] HDHP = High deductible health plan.
[2] CHIA Hospital Profiles and Databooks (2012 and 2013 data). LHMC peers are academic/teaching hospitals with comparable CMI. Beverly and Addison Gilbert Hospital peers are community hospitals located in the same or adjacent regions, of similar size and comparable CMI.
[3] MSSP = Medicare Shared Savings Program; BPCI = Bundled Payments for Care Improvement Initiative.
[4] For additional details, please see response to Exhibit B, Q11
[5] The Visiting Nurse Association of Middlesex-East.

d) What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

At a conceptual level, the most potentially impactful policy changes are referenced in the summary; more practical policy changes focused specifically on improving efficiency while maintaining high quality include:

- Requirements for more timely and comprehensive payer data, particularly for patients with chronic disease; increased overall transparency of payer data and reporting processes
- Increased funding to pilot innovative delivery redesign models
- Modifying health plan benefit design to encourage patient engagement
- Partial subsidization of primary care and care management resources to manage the chronically ill
- Limitations on health plan administrative retention and standardization requirements
- Incentives for payer/provider collaboration to build care management infrastructure

2. C. 224 REQUIRES HEALTH PLANS TO REDUCE THE USE OF FEE-FOR-SERVICE PAYMENT MECHANISMS TO THE MAXIMUM EXTENT FEASIBLE IN ORDER TO PROMOTE HIGH QUALITY, EFFICIENT CARE DELIVERY.

SUMMARY

Lahey Health aligned physicians[6] are currently engaged in four commercial and two government payor APM (*see Attachment B2-a for detail*). Some APM contracts are held at the local accountable care unit (ACU; NEPHO and Lahey) level and some at the LCPN level. Regardless of the specific contracting entity, LCPN provides centralized infrastructure and management services (*see Attachment B2-b for detail*) which facilitates success under APM contracts by enabling higher-value care delivery.

Having five years of BCBS AQC experience, examination of NEPHO ACU performance can most tangibly demonstrate the impact of APMs on practices, patterns and performance.

RESPONSE

a) How have alternative payment methods (APMs) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?

QUALITY PERFORMANCE

See Attachments B2-c – B2-j for quality dashboards for each ACU and LCPN overall (for all available years and APM contracts).

For the BCBS Alternative Quality Contract (AQC), the NEPHO ACU gate score increased from 3.1 in 2010 to 4.4 in the most recent year, with improvements across all indicators, and for preventative screenings and diabetes care measures in particular. The Lahey ACU has been in the BCBS AQC for one full year, so no trended data exists.

Similarly, given that the Lahey Clinical Performance Accountable Care Organization (LCPACO) has been in the MSSP for one full year, no trended data is available, though LCPACO did perform in the top percentile on the majority of indicators.

REFERRAL PATTERNS

Trended NEPHO ACU hospital referral data (*see Attachment B2-k for detail*) indicate that over time under APM contracts, referrals have shifted from higher-priced hospitals (including MGH, B&W) to lower-priced substitutes (primarily LHMC, but also BIDMC and TMC)[7]

[6] *Excludes* Winchester Hospital aligned (including but not limited to employed) physicians as full establishment of the Winchester ACU and overall integration into LCPN is not yet complete.
[7] MGH = Mass General Hospital; B&W = Brigham & Women's Hospital; BIDMC = Beth Israel Deaconess Medical Center; TMC = Tufts Medical Center.

CARE DELIVERY PRACTICES AND OPERATIONS

LCPN has implemented infrastructure and care management tools/expertise to enable appropriate modification of care delivery and operational practices in furtherance of higher-value care.

- The LCPN data warehouse (via interfaces with practice EHRs and payer data feeds) facilitates identification of gaps in care and triggers patient outreach and engagement. The data warehouse also tracks and trends utilization and expenditures to help pinpoint unnecessary utilization, use of low-value providers/facilities and other cost-drivers, and enables subsequent programmatic intervention.
- LCPN contract with Dovetail Health (*see attachment B2-l for detail on Dovetail Health*) to create the Lahey Enhanced Care Program, which provides enhanced care management services for complex, high-risk Medicare ACO patients
- LCPN contract with Phytel Outreach (*see attachment B2-m for detail on Phytel Outreach*), an automated service that identifies patients in need of care and notifies them about recommended visits, test, procedures and other follow-up items

b) Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens). Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

Lahey Health/LCPN does not routinely conduct analyses regarding the impact of APM implementation on non-clinical operations. Further, current accounting practices do not specifically parse out clinical from non-clinical operational expenses related to APM management.

In general, overall PM/PM costs have increased as the number of LCPN APM contracts has increased. One potentially noteworthy observation is that administrative costs (namely HR expenses) have not fluctuated year over year to the same degree that non-administrative costs have fluctuated, even with the addition of APM contracts. This being said, the administrative burden associated with responding to each annual payer request for clinical data is extensive.

3. PLEASE COMMENT ON THE ADEQUACY OR INSUFFICIENCY OF HEALTH STATUS RISK ADJUSTMENT MEASURES USED IN ESTABLISHING RISK CONTRACTS AND OTHER APM CONTRACTS WITH PAYERS.

SUMMARY

Accurately adjusting for the risk associated with health-status is critically important to facilitating success under any risk-contract. Currently used adjustment techniques represent a substantial improvement over past methods relying primarily on age and sex alone to estimate risk. However, current adjustments still do not capture a comprehensive physical and behavioral health risk profile at the population or sub-population level. Further, the statistical legitimacy of adjustments is significantly impacted by population size, and are less valid and reliable as size decreases. Finally, adjustments do not generally account for socioeconomic factors, which considerably influence health care status, decision-making and utilization tendencies.

RESPONSE

a) Do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations or those with behavioral health conditions?

From Lahey Health's perspective, adjustments insufficiently capture the comprehensive initial risk profile in addition to insufficiently capturing changes in risk or severity over time. Most notably, adjustments for health status do not adequately incorporate:

- Socioeconomic variables, including income and education levels

- Differences in plan benefits within a sub-population (e.g., whether a pharmacy component is included or whether provider and pharmacy coverage is through the same payer/plan)
- Conditions/risk factors specific to the pediatric sub-population
- Conditions/risk factors related to behavioral health issues (and substance abuse in particular)

b) How do the health status risk adjustment measures used by different payers compare?

There appears to be minimal variation in risk-adjustment formulas used by major commercial payers in the state and region. DxCG is the preferred risk profiling/risk assessment solution used by commercial payers in the Commonwealth. However, individual plans may choose to use or weight risk-adjustment results differently or incorporate risk-adjustments into contract terms in different ways. Finally, CMS risk adjustment methodologies, particularly relevant to Medicare Advantage (MA) plans, vary from those typically used by commercial payers and by CMS for non-FFS contracts – including differences in the data sets used, differences in the way the data is organized and use of condition-specific normalization factors.

c) How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

From the provider perspective, the importance of accurate risk adjustment and risk scoring increases with the type and degree of risk shared/assumed by the provider. Other factors, including the financial model of the contract, prescribed attribution methodology and breadth of services included, along with the actual risk-adjustment methodology used, create the overall picture of performance potential for each contract.

The more accurately health status is adjusted not only initially but continuously, the more accurately the resources consumed can be estimated and recalibrated for annual budgeting purposes. Effective budgeting requires LCPN/Lahey Health to understand what drives variability in expected vs. experienced outcomes and then appropriately direct the resources to manage and improve performance. Finally, accurate and comprehensive coding and documentation policies - both to generate realistic risk profiles and to manage risk – are critical.

4. WHAT TYPES OF DATA ARE OR WOULD BE MOST VALUABLE TO YOUR ORGANIZATION IN THIS REGARD? IN YOUR RESPONSE, PLEASE ADDRESS (I) REAL TIME DATA TO MANAGE PATIENT CARE AND (II) HISTORIC DATA OR POPULATION-LEVEL DATA THAT WOULD BE HELPFUL FOR POPULATION HEALTH MANAGEMENT AND/OR FINANCIAL MODELING.

SUMMARY AND RESPONSE

Overall, health plans do not submit data to providers in a timely manner, with lag time on the order of 60 to 90 days. Further, data variables reported and format of submission varies by payer, and providers could more efficiently and effectively incorporate and leverage this data if practices were more standardized. Finally, reported payer data is not sufficiently comprehensive, and often does not include behavioral health utilization data or pharmacy claims data.

While clinical and utilization data is available immediately via EHR extraction for patients served within Lahey Health, this data provides a limited piece of the overall picture, as services not offered or not rendered by Lahey Health do not appear, nor does other related information (e.g., pharmacy utilization) that is crucial to designing comprehensive care management programs.

To effectively manage patient health, comprehensive and real-time access to all utilization data is needed. Ideally, this data would include both physical and behavioral health care utilization data, as well as pharmacy claims data, across all sites of care and all health plans.

REVIEW OF MOST VALUABLE DATA NEEDS

Real-time data for Lahey Health patients receiving care at a non-Lahey Health facility. Lahey Health may not know for up to 90 days if a patient previously treated at Lahey Health is admitted to a non-Lahey

Health facility or uses a non-Lahey Health ED. Data lag is similar for information on site of post-acute discharge.

Consistent access to behavioral health and substance abuse treatment data among plans. Several plans do not distribute information related to behavioral health conditions, including substance abuse, that would facilitate better care plan development and care delivery decisions.

Historic medical data and claims data for primary care patients. For individuals who switch to a Lahey PCP from a non-Lahey PCP, medical data is only provided on a go-forward basis. Pharmacy claims data for PCP panels is also not adequately provided, even for longstanding Lahey PCP patients.

5. C. 224 REQUIRES HEALTH PLANS TO ATTRIBUTE ALL MEMBERS TO A PRIMARY CARE PROVIDER, TO THE MAXIMUM EXTENT FEASIBLE.

SUMMARY

Lahey Health believes that the most accurate attribution methodology is to assign each patient to a PCP or medical specialist performing in a primary care capacity (e.g., gynecologist) and recommends this methodology for future attribution of all patients, regardless of health plan or plan type (e.g., HMO, PPO).

RESPONSE

a) Which attribution methodologies most accurately account for patients you care for?

See summary statement above.

Medicare's use of claims methodology to attribute patients to groups based on plurality of visits works fairly well for the Medicare population given more frequent and consistent utilization patterns, but would not capture a large proportion of commercial patients using this methodology.

b) What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

Lahey Health suggests that individuals are prompted upon plan enrollment for both HMOs and PPOs to formally document the name of their PCP or another provider of choice. Additionally, enrollees should be prompted after a defined period of enrollment to either confirm PCP/provider of choice name or inform the plan of a change. Lahey Health believes that documenting the name of advanced practice clinicians, regularly used urgent care center providers and medical specialists is important, and that this information should be captured and used in attribution logic.

6. PLEASE DISCUSS THE LEVEL OF EFFORT REQUIRED TO REPORT REQUIRED QUALITY MEASURES TO PUBLIC AND PRIVATE PAYERS, THE EXTENT TO WHICH QUALITY MEASURES VARY ACROSS PAYERS, AND THE RESULTING IMPACT(S) ON YOUR ORGANIZATION.

SUMMARY

Providing quality performance data to public and private payers is a time consuming and complex task, and payer data requirements are often in addition to data reporting requirements of other federal and state agencies. Though quality measures have become more consistent across payers (and between payers and other agencies), key challenges to efficient processes remain, and include:

- Persistence of measure variability across payers in addition to variability in performance thresholds across payers, even where measures are consistent
- Meeting commercial payer requirements to use EHRs as the sole source of patient outcome data in order to "receive credit" for performance under APMs

- Compounded by current infrastructure barriers at Lahey Health, namely multiple EMRs, that are still in the process of being integrated

– Conforming to CMS quality reporting requirements for which claims data is not deemed sufficient to evidence occurrence of an encounter

Specifics on quality measures reported, the associated administrative and other resource impacts, and barriers to efficient reporting are addressed in more detail below.

RESPONSE

Specific **barriers** to efficient reporting processes and the impact on Lahey Health include:

– Commercial payers require Lahey Health providers to share **patient outcomes from EMR systems in order to receive "full credit"** for quality performance measures. Results chart data pulls are very time consuming and it is difficult for the organization to pull the information directly from the EMR, as outcomes are not always placed in the appropriate field.

– **For most quality measures, Medicare does not allow a claim for a service to count as evidence of the service**. This results in an extremely time consuming task of reviewing patient charts and manually uploading data into Medicare's system.

– **Multiple EMRs within the Lahey Health system.** While Lahey Health is working to implement a system-wide EMR for its hospitals and most employed physician provider groups, our facilities and providers are currently not all on the same EMR, resulting in several different configuration for data to flow out of the EMR.

REPORTING REQUIREMENTS SPECIFIC TO APM CONTRACTS

While there is overlap between quality measures reported for Medicare Shared Savings ACOs and commercial payers, the list of Medicare quality measures to establish performance standards is more comprehensive (*see Attachment B6-a*). Increasingly, commercial payers are relying on CMS measures, which streamlines data capture and reporting processes.

As shown in *Attachment B6-b*, overlap occurs between the largest commercial for four process measures and one diabetes outcome measure to assess physician performance. Additional measures, such as chlamydia screenings, antidepressant medication management, pediatric measures, and avoidance of antibiotic treatment in adults with acute bronchitis, are consistent between the BCBS AQC and Harvard Pilgrim Health Care QAP contracts, though Tufts Health Plan APM contracts do not require reporting these additional measures.

Despite improvements, opportunity remains to reduce variability in quality measures and performance thresholds used across payers. Specifically, Lahey Health would like to see more consistent measures and thresholds related to process and outcome quality data for control of diabetic patients.

7. AN ISSUE ADDRESSED BOTH AT THE 2013 ANNUAL COST TRENDS HEARING AND IN THE COMMISSION'S JULY 2014 COST TRENDS REPORT SUPPLEMENT IS THE COMMONWEALTH'S HIGHER THAN AVERAGE UTILIZATION OF INPATIENT CARE AND ITS RELIANCE ON ACADEMIC MEDICAL CENTERS.

SUMMARY

Foundational Lahey Health principles related to reducing inappropriate inpatient utilization and improving appropriateness of inpatient care delivery setting are highlighted in response to Question 1 and referenced in multiple preceding and subsequent questions.

Available data/analytic substantiation regarding results is provided below. Analysis on this topic has focused almost exclusively on shifting care to the most appropriate setting within the system and reducing outmigration to Boston-based tertiary centers. Data examined includes trended tertiary transfer volume

from Beverly Hospital to LHMC, trended NEPHO hospital referral data, and trended LHMC volume from patients originating in the Winchester service area.

Response

a) Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

Tracked data on this topic have focused narrowly on legacy Northeast Hospitals and other former Northeast-aligned organizations (e.g., NEPHO) and utilization trends/patient flow between these entities and LHMC. Please reference previously noted Attachment B2-k for trended NEPHO hospital referral data and see Attachments B7-a and B7-b for ED transfer data from Beverly Hospital to tertiary facilities.

b) Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

Please refer to the response provided to Question 1 for information on Lahey Health efforts related to promoting appropriate and high-value care.

Overview of Available Results

- Improved retention of appropriate tertiary patients from the Lahey Health service area that historically out-migrated to relatively higher-priced Boston tertiary centers (*Please see attachments B7-a – B7-c*)
- Continuous reduction in the number of lower-acuity patients treated at capacity-constrained LHMC; now treated by Lahey Health community hospitals, as indicated by concurrent increases in LHMC CMI and volume/occupancy rates at community care sites (*Please see attachments B7-d – B7-e*)

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.

Summary

Though no system wide mechanism exists to confirm, Lahey Health believes that there is variation in the utilization and site of post-acute care by hospital within our system, consistent with HPC findings.

While all Lahey Health hospitals track discharge disposition to post-acute care setting, the type and format of information tracked is variable. Our recently integrated system is working to standardize post-discharge protocols and develop the infrastructure and processes to support standardization. Once a system wide baseline and infrastructure are in place, we intend to adopt system wide case/care management policies and embed decision-support pathways to facilitate consistent and appropriate utilization.

We anticipate challenges when referring outside of Lahey, given limited access to price and quality information at point of referral/discharge, and limited information regarding utilization post-discharge.

To address anticipated challenges, Lahey Health is actively developing a robust network and service scope of non-acute care services. In addition and to better coordinate and manage the spectrum of long-term, continuing care and care transition services offered in our system, we recently initiated a strategic plan to integrate the operations of all non-acute care services.

Response

a) Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

Lahey Health has not conducted any formal analyses to quantify the variability of post-acute utilization rates or post-acute sites of care across our system, as noted above.

b) How does your organization ensure optimal use of post-acute care?

Lahey Health is currently piloting a customized case management model at LHMC, to be refined over time, with the ultimate intention of implementing system wide. To carry out this pilot, staffing for nurse case managers and clinical social workers was increased by 20+ FTEs. Increased staffing enabled individual case management interviews upon admission to proactively prepare for discharge. Interdisciplinary care teams work with patients and families to develop a customized care plan, updated throughout the inpatient stay and provided upon discharge. Multiple interview questions are focused on post-acute planning, and evaluate the need for and most appropriate site of post-acute care using the following factors:

- Social support system
- Accessibility
- Patient safety
- Insurance coverage
- Personal preference

Other efforts related to fostering appropriate use of post-acute care include:

- Streamlining and standardizing internal referral processes to all care settings, including post-acute sites, as part of an effort to reduce readmissions and promote seamless transitions of care
- Developing communication and information-sharing protocols between Lahey Health facilities and non-Lahey Health post-acute care providers

While our customized case management pilot and other efforts to improve appropriateness of post-acute care and selection of high-value care sites, our experience is that patients generally select post-acute providers based on health plan recommendations. More transparent price and quality data from both health plans and post-acute care providers would greatly improve effectiveness of efforts underway by acute care providers.

9. C. 224 REQUIRES PROVIDERS TO PROVIDE PATIENTS WITH REQUESTED PRICE INFORMATION. PLEASE DESCRIBE YOUR ORGANIZATION'S PROGRESS IN THIS AREA, INCLUDING THE NUMBER OF INDIVIDUALS THAT SEEK THIS INFORMATION AND IDENTIFY THE TOP TEN ADMISSIONS, PROCEDURES AND SERVICES ABOUT WHICH INDIVIDUALS HAVE REQUESTED PRICE INFORMATION. ADDITIONALLY, PLEASE DISCUSS HOW PATIENTS USE THIS INFORMATION, ANY ANALYSES YOU HAVE CONDUCTED TO ASSESS THE ACCURACY OF ESTIMATES PROVIDED, AND/OR ANY QUALITATIVE OBSERVATIONS OF THE VALUE OF THIS INCREASED PRICE TRANSPARENCY FOR PATIENTS.

SUMMARY

In accordance with requirements, all members of Lahey Health provide patients with charge information upon request. However, given variability in charge masters across organizations, minimal knowledge of patient-specific cost sharing provisions, and often-unspecified procedure codes, it is unclear to what extent provided information supports more effective consumer decision-making.

We have implemented a formal business process to respond to any patient request related to charge information within the required two business days.

Lahey Health does not collect information regarding how patients use provided data, however, based on the type of information requested, we can infer that the information is intended to be used for comparative shopping. It is also reasonable to infer that requests are made by consumers incented to have greater sensitivity to price due to higher deductibles and/or higher cost sharing provisions

No formal analyses regarding accuracy of charges provided compared to actual costs incurred (by patients or health plans on behalf of enrollees) have been conducted to date.

Lahey Health recently purchased and is in the process of implementing software to better understand intended use of requested information, usefulness of information, whether consumers ultimately select Lahey Health, and if so, how provided estimates compared to actual costs.

RESPONSE

CY 2014 YTD LAHEY HEALTH PATIENT REQUESTED CHARGES DATA

	Website Inquiries	Phone/In-Person Inquiries	Average Estimated Response Time
Q1	N/A	850	40 hours
Q2	N/A	1,134	33 hours
Q3	N/A	1,355	32 hours
	N/A	**3,339**	**34 hours**

The formalized charge request response process was established as follows:

- Patients may request information in person or over the phone from a system financial counselor, who gathers information regarding the requested procedure or service
- Counselor collaborates with the appropriate department and financial team to develop the most accurate estimate possible
- Patient is notified of estimate promptly when information is available

Considerable progress has been made in responding to the steadily increasing number of requests, with response times improving each quarter of CY 2014.

The top ten requests include: office visit, screening colonoscopy, vasectomy, EKG, maternity services, lab tests, MRI, CT, ultrasound, and mammography.

10. PLEASE DESCRIBE THE MANNER AND EXTENT TO WHICH TIERED AND LIMITED NETWORK PRODUCTS AFFECT YOUR ORGANIZATION, INCLUDING BUT NOT LIMITED TO ANY EFFECTS ON CONTRACTING AND/OR REFERRAL PRACTICES, AND ATTACH ANY ANALYSES YOUR ORGANIZATION HAS CONDUCTED ON THIS ISSUE. DESCRIBE ANY ACTIONS YOUR ORGANIZATION TAKEN IN RESPONSE TO TIER PLACEMENT AND ANY IMPACTS ON VOLUME YOU HAVE EXPERIENCED BASED ON TIER PLACEMENT.

SUMMARY AND RESPONSE

The concept of tiered and limited network products is highly aligned with the Lahey Health philosophy of incentivizing care delivery at high-value provider organizations. However, the lack of transparency of factors and formulas used to establish tiers - generally "black box" methodologies - generates skepticism about whether tiering truly reflects value. The fact that the same providers and facilities fall into different tiers for different payers incites doubt that tiering is completely objective. In addition, payers are generally unwilling to provide evidence or explanation for tiering results.

Given that tiers are determined on a relative basis – community hospitals compared to community hospitals, AMCs to AMCs – we regularly encounter instances in which LHMC is in a more favorable tier than our community hospitals, despite LHMC' s absolute cost being higher. This limits our ability to shift volume to the highest-value care setting within our system.

Finally, our experience suggests that tiering decreases continuity and patient-centeredness of care, generates unnecessary fragmentation, creates delays in care, and ultimately results in less satisfied patients.

The volume impact on Lahey Health has not been substantial to date though is difficult to isolate and quantify.

Lahey Health would be interested in collaborating with a payer partner to develop a transparent and consistent narrow network product that would genuinely and effectively incentivize referrals to demonstrably higher-value providers and account for the need to maintain care continuity.

11. THE COMMISSION HAS IDENTIFIED THAT SPENDING FOR PATIENTS WITH COMORBID BEHAVIORAL HEALTH AND CHRONIC MEDICAL CONDITIONS IS 2-2.5 TIMES AS HIGH AS SPENDING FOR PATIENTS WITH A CHRONIC MEDICAL CONDITION BUT NO BEHAVIORAL HEALTH CONDITION. AS REPORTED IN THE JULY 2014 COST TRENDS REPORT SUPPLEMENT, HIGHER SPENDING FOR PATIENTS WITH BEHAVIORAL HEALTH CONDITIONS IS CONCENTRATED IN EMERGENCY DEPARTMENTS AND INPATIENT CARE.

SUMMARY

Lahey Health recognizes the substantial differences in caring for the sub-population with co-morbid physiological and behavioral health and resulting financial consequences. Lahey Health Behavioral Services works diligently to integrate physical and mental health services across the Lahey continuum and actively partners to better identify and manage inappropriate and/or excessive utilization. Efforts have focused on placing behavioral health experts and resources into non-behavioral health community-based settings to proactively mitigate inpatient and ED utilization.

Last year, Lahey Health Behavioral Services' assessment of children and adults in the community setting yielded positive results. For example, the community service agency teams of family therapists have, since program founding in 1999, worked with approximately 3,000 publicly insured families who have at least one child with significant behavioral or mental health conditions[8]. Also, placement of Lahey Health behavioral health specialists in local police stations to intervene in situations of psychiatric crisis likely to otherwise use ED care resulted in an estimated 50% of these individuals ultimately not utilizing ED services.[9]

For additional detail related to Lahey Health behavioral health programs and anticipated expansion, please see Attachments B11-a and B11-b.

RESPONSE

a) Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

In addition to and as part of community-based partnerships cited in summary comments, Lahey Health and member entities:

- Provide care coordination staff and resources to partners managing co-morbid patients
- Have organized speakers bureau for behavioral health professionals to provide expertise and programming to PCPs, municipal health departments, and community groups
- Provide access to a psychiatric emergency mobile crisis team, providing 24/7, in-person care, referral support and care management resources

For additional detail related to the programs highlighted above, please see Attachment B11-c.

b) Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

In addition to all above cited programs and efforts, Lahey Health has:

[8] Source data obtained from CSA program directors, headquartered in Haverhill and Beverly, 2014.
[9] Source data obtained from Danvers Police Department Jail Diversion Program, Report from third quarter, 2014.

- Utilized 138 detoxification beds and 18 crisis stabilization beds to avoid inpatient admission
- Created partial hospitalization programs within two IP psychiatric units that provide care on an OP basis and step-down care for those transitioning from the IP unit back to their homes
- Embedded behavioral health specialists in select primary care sites
- Launched a (pilot) self-management training program for high-risk co-morbid outpatients
- Developed a set of educational resources provided post-ED visit to identified high-risk individuals
- Developed a community service agency to assist publically-insured families access multiple levels of community-based pediatric behavioral health services
- Augmented post-discharge continuing care plans and tracking for inpatient psychiatric patients

For additional detail, please see Attachment B11-d.

c) Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

Successes have hinged on improving real-time access to behavioral health experts and resources, and pursuing innovative approaches to integrating physical and mental health care services. Specific successes exemplifying these principles (in addition to all noted above) include:

- Fast-tracking certain identified dual-diagnosis psychiatric patients to dedicated detoxification beds
- On-call behavioral health specialists for ED consults
- Expanded deployment of the mobile crisis team
- Increased procedural consistency and frequency of psychopharmacological evaluations
- Launching a system wide behavioral health EHR (Netsmart) to be implemented in parallel with system wide physically health focused EHR (Epic)

Most notable barriers include:

- Limited funding for expansion or development of programmatic initiatives and for hiring and deploying behavioral health experts and resources
- Willingness or capacity of providers, particularly PCPS, to embrace behavioral health educational principles/practice resources
- Substantial infrastructure requirements related to communication, information sharing and coordination
- Navigating extensive regulatory requirements

Please see Attachment B11-e for more detail.

d) Please describe your organization's willingness and ability to report discharge data.

Lahey Health is willing and able to report discharge data, ED data, as well as historic and current Mobile Crisis Team encounter form data.

12. DESCRIBE YOUR ORGANIZATION'S EFFORTS AND EXPERIENCE WITH IMPLEMENTATION OF PATIENT- CENTERED MEDICAL HOME (PCMH) MODEL.

SUMMARY

Increasingly, Lahey Health employed and affiliated PCP practices are embracing and implementing the PCMH model, with a subset actively pursuing or achieving accreditation status.

Today, six Lahey Health employed or affiliated practices are NCQA accredited PCMHs and seven additional employed practices are in the process of pursuing/receiving accreditation status.

Lahey Health is in the first quarter of implementing a dedicated primary care strategic plan emphasizing system wide adherence to select PCMH principles, dedicating resources to supporting accreditation and implementing tracking mechanisms and metrics to assess the impact of PCMH principles on cost and quality.

RESPONSE

a) What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

Six percent of Lahey Health's employed PCP FTEs (including physicians and advanced practice clinicians from Lahey Burlington and Peabody, Lahey Community Group Practices, Northeast Medical Practices, and Winchester Practice Associates) are accredited Level III NCQA PCMHs.

WPA has an additional seven practices in the process of obtaining accreditation, with the intent to have three practices accredited in Fall 2014.

Additionally, three NEPHO practices are accredited, accounting for 24% of total NEPHO providers.

b) What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Seven percent of primary care patients in Lahey Health's employed practice panels, as measured by annual visits/encounters, receive care from NCQA accredited providers. *Note: Lahey Health does not routinely review encounter/visit or panel size data for aligned independent NEPHO practices.*

c) Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

Given the recent accreditation status of Lahey Health's PCMHs, we are just beginning to analyze outcomes. We are in process of identifying key quality and cost metrics and solidifying the approach for capturing performance data and tracking progress. We have already begun to capture data from all PCMH accredited sites related to out-of-network specialist referrals and adherence to post-discharge follow-up protocols.

Recently, WPA completed the first wave of reporting for one PCMH practice accredited in 2011. Performance data (from practice EMR; focus on prevention/chronic care measures) is summarized below:

- Improvement in preventative screening for breast cancer, colorectal, and cervical screenings by 12%, 18%, and 4%, respectively10
- Improvements in chronic and/or acute care clinical measures for diabetes HbA1c testing two times/year of 4%; blood pressure screening for hypertension improvements of 2% over two years; and depression screening improvements of 43%[11]

13. AFTER REVIEWING THE COMMISSION'S 2013 COST TRENDS REPORT AND THE JULY 2014 SUPPLEMENT TO THAT REPORT, PROVIDE ANY COMMENTARY ON THE FINDINGS PRESENTED IN LIGHT OF YOUR ORGANIZATION'S EXPERIENCES.

SUMMARY AND RESPONSE

Generally, Lahey Health's perspectives on the regional and state market are consistent with HPC's July 2014 Supplement Report findings and conclusions; specific commentary for select Supplement Report theme areas are provided below.

[10] Source data obtained from athenaclinical. Data reported for Winchester Family Physicians from May 1, 2011 to May 21, 2013 and compared to August 8. 2012 to August 8. 2014. For data from 2012-2014: breast cancer screening data reported for 3,331 total patients, cervical cancer screening reported for 4,892 total patients age 21-64, and colorectal cancer screening reported for 3,339 total patients. For data from 2011-2013: breast cancer screening data reported for 3,175 total patients, cervical cancer screening reported for 4,946 total patients age 21-64, and colorectal cancer screening report for 3,450 total patients.

[11] Source data obtained from athenaclinical. Data reported for Winchester Family Physicians from June 2012 to June 2013 and compared to August 2013 to August 2014. From June 2012 to June 2013: depression screening data reported for 637 total patients; HbA1c screening data reported for 479 patients; blood pressure screening data reported for 246 patients. From August 2013 to August 2014: depression screening data reported for 893 total patients; HbA1c screening data reported for 480 patients; blood pressure screening data reported for 252 patients.

FINDINGS

THEME A: SPENDING LEVELS AND TRENDS

A1: Unit Price Increases as the Primary Driver of Total Medical Expenditure Increases

Lahey Health is comprised of relatively low-price facilities and providers. The increases in overall expenditures at the Commonwealth level are disproportionately impacted by the high and increasing market share of systems and provider organizations with higher-priced facilities and providers.

While systems and provider organizations are clearly accountable for decreasing spending levels, this responsibility is shared with payers and consumers. Unless and until there is broad-based payer willingness (and health system support) to implement effective value-based incentives and price transparency measures, consumers utilizing higher-priced (but not necessarily higher-value) facilities and providers will continue to subsidize consumers utilizing lower-priced facilities and providers.

A2: Variability in Post-Acute Utilization and Care Setting

A key strategic area of focus in 2014 and in 2015 with significant resources committed to improvement. See response to Question 8 for detail.

A3: Costly Utilization of Co-Morbid Behavioral Health Population

Lahey Health's Behavioral Services are particularly robust relative to peer organizations. Expansion of community-based programs to reduce inpatient and ED utilization have yielded demonstrable positive results to date. Lahey Health is hopeful that CHART Phase 2 monies are made available, in addition to continued and substantial system investments, to expand community outreach and innovative pilot programs. See response to Exhibit B, Question 11 for detail.

THEME B: DELIVERY SYSTEM TRENDS

B1: Unnecessary Outmigration to Boston

A key reason for the formation of Lahey Health and continued system wide diligence to retain care locally and at the appropriate site of care within Lahey Health. HPC findings indicate that Lahey Health's service area socioeconomic profile is particularly susceptible to outmigration, though recognize and endorse the notion that all providers are responsible for minimizing the impact of socioeconomic factors on access to high quality and affordable health care across the Commonwealth.

B2: Concentration of Commercial Inpatient Care

Clearly increasing provider-side concentration requires vigilance to ensure open and value-based competition, though note that provider-side concentration remains less extreme than commercial payer concentration. Of particular concern is the excessive and increasing concentration of the largest organizations, both on the provider and payer side.

CONCLUSIONS

Lahey Health concurs that the four opportunities to improve the health care system in Massachusetts identified by the HPC – **1.** Fostering a competitive and value-based market, **2.** Promoting and enabling the delivery of high-value care, **3.** Advancing APMs that are equitable and compel accountability, **4.** Facilitating better decision-making and performance by enhancing transparency and data availability - are logical and accurate priorities.

Lahey Health's actions have and will continue to remain aligned with capitalizing on all identified priority opportunities and anticipate that our peer organizations, payers, regulators and consumers will be held to demonstrating a similar commitment to transformative change.

1. **PLEASE SUBMIT A SUMMARY TABLE SHOWING FOR EACH YEAR 2010 TO 2013 YOUR TOTAL REVENUE UNDER PAY FOR PERFORMANCE ARRANGEMENTS, RISK CONTRACTS, AND OTHER FEE FOR SERVICE ARRANGEMENTS ACCORDING TO THE FORMAT AND PARAMETERS PROVIDED AND ATTACHED AS AGO PROVIDER EXHIBIT 1 WITH ALL APPLICABLE FIELDS COMPLETED. PLEASE ATTEMPT TO PROVIDE COMPLETE ANSWERS. TO THE EXTENT YOU ARE UNABLE TO PROVIDE COMPLETE ANSWERS FOR ANY CATEGORY OF REVENUE, PLEASE EXPLAIN THE REASONS WHY. INCLUDE IN YOUR RESPONSE ANY PORTION OF YOUR PHYSICIANS FOR WHOM YOU WERE NOT ABLE TO REPORT A CATEGORY (OR CATEGORIES) OF REVENUE.**

Please see Lahey Health Attachment C1-a.

2. **PLEASE EXPLAIN AND SUBMIT SUPPORTING DOCUMENTS THAT SHOW HOW YOU QUANTIFY, ANALYZE AND PROJECT YOUR ABILITY TO MANAGE RISK UNDER YOUR RISK CONTRACTS, INCLUDING THE PER MEMBER PER MONTH COSTS ASSOCIATED WITH BEARING RISK, SOLVENCY STANDARDS, AND PROJECTIONS AND PLANS FOR DEFICIT SCENARIOS. INCLUDE IN YOUR RESPONSE ANY ANALYSIS OF WHETHER YOU CONSIDER THE RISK YOU BEAR TO BE SIGNIFICANT.**

RESPONSE

At present, there is no global Lahey Health/LCPN risk quantification or management methodology in place. That is, there is no systematic approach to quantifying or projecting aggregate risk capacity across all risk contracts held by Lahey Health, nor one to quantify or manage risk across all local ACUs comprising LCPN. We do, however, project risk-based contract performance at the contract-specific and local ACU-specific levels. Further, there is a standardized LCPN-wide funds flow methodology to manage surpluses and deficits resulting from risk-contract performance (*see Lahey Health Attachment C2-a*).

Given that the contract-specific and local ACU-level analyses currently conducted (referenced above and explained below) do not meet the definition of supporting documents requested, none have been submitted.

The contract and ACU specific analyses referenced above are undertaken as part of risk-contract negotiations in order to evaluate the financial feasibility of proposed PM/PM budgets and risk-sharing provisions, as well as to determine the right type of [and thresholds for] risk protection measures, including caps, stop loss insurance coverage and attachment points, and policies related to outliers. Scenario modeling is done to account for potential changes in population health status and utilization rates. Resulting financial performance projections (i.e., likelihood and amount of surplus; likelihood and degree of deficit) are used to modify budgets and embed appropriate risk protection elements. *Note: while the types of risk protection elements identified above are utilized, solvency standards have not yet been considered due to the historic sufficiency of Lahey Health financial reserves.*

As an example, for the most recently negotiated Lahey ACU BCBS AQC contract, financial performance projections indicated the need to establish surplus/deficit caps of approximately $20.00-$25.00 PM/PM, after risk sharing. In addition, stop loss coverage was instituted, at a cost of $8.00 PM/PM.

Financial performance projections - namely estimates of the surplus/ (deficit) by risk arrangement – are documented and used to compare actual to projected performance over the course of a contract.

LCPN anticipates that both local ACUs – Lahey and NEPHO – will be deemed, as per the Division of Insurance regulatory standards, as bearing significant downside APM contract risk, given that that downside risk APMs are in place with each of the three major commercial insurers in the market.

3. PLEASE EXPLAIN AND SUBMIT SUPPORTING DOCUMENTS THAT SHOW THE PROCESS BY WHICH (A) YOUR PHYSICIANS REFER PATIENTS TO PROVIDERS WITHIN YOUR PROVIDER ORGANIZATION AND OUTSIDE OF YOUR PROVIDER ORGANIZATION; AND (B) YOUR PHYSICIANS RECEIVE REFERRALS FROM WITHIN YOUR PROVIDER ORGANIZATION AND OUTSIDE OF YOUR PROVIDER ORGANIZATION. PLEASE INCLUDE A DESCRIPTION OF HOW YOU USE YOUR ELECTRONIC HEALTH RECORD AND CARE MANAGEMENT SYSTEMS TO MAKE OR RECEIVE REFERRALS, ANY TECHNICAL BARRIERS TO MAKING OR RECEIVING REFERRALS, AND ANY DIFFERENCES IN HOW YOU RECEIVE REFERRALS FROM OR MAKE REFERRALS TO OTHER PROVIDER ORGANIZATIONS AS OPPOSED TO YOUR PROVIDER ORGANIZATION.

RESPONSE

Please note that no relevant supporting documentation exists.

Lahey Health is committed to providing the highest value care in the appropriate care setting. The system empowers each physician to make referral decisions based on unique patient needs and preferences, with the understanding that value and appropriateness must be considered. Unlike many other Boston-metro systems, Lahey Health does not set patient retention rate requirements.

Lahey Health providers make an effort to keep patient referrals within the system, where clinically appropriate, to maximize use of our relatively higher-value facilities and providers, and to minimize fragmentation of care. To facilitate internal referrals, an online referral process expedites insurance authorization. This process enhances communication of individual patient needs, as both referrer and referee may access the patient's medical record and associated notes.

A physician may also choose to refer a patient externally if services are unavailable or not readily accessible within the system. These referrals are facilitated and managed to the extent possible.

To facilitate efficient referrals to Lahey Health, particularly in the IP setting, a centralized, real-time referral management process is used, whereby a referral coordination team (approximately 10.0 FTEs system-wide) works with a designated physician leader on each campus to assess clinical appropriateness of care provision for that campus. This process enables external referring physicians to discuss patient needs directly with Lahey physicians. Currently, this process is carried out by phone.

Multiple barriers exist to effective referral management. Lahey Health continues to explore ways to mitigate these barriers to in order to maximize coordination, continuity and appropriateness of referrals. Regarding referral interface with payors, several barriers exist, namely no standardized processes or systems/software (all unique by health plan) to obtain authorizations. Lahey Health invests considerable administrative resources to appropriately navigate these disparate processes/systems.

4. PLEASE EXPLAIN AND SUBMIT SUPPORTING DOCUMENTS THAT DESCRIBE HOW, IF AT ALL, INFORMATION ON COST AND QUALITY IS MADE AVAILABLE TO PHYSICIANS AT THE POINT OF REFERRAL WHEN REFERRING PATIENTS TO SPECIALTY, TERTIARY, SUB-ACUTE, REHAB, OR OTHER TYPES OF CARE. INCLUDE IN YOUR RESPONSE ANY TYPE OF INFORMATION ON COSTS OR QUALITY MADE AVAILABLE TO YOUR PHYSICIANS THROUGH ELECTRONIC HEALTH MANAGEMENT, CARE MANAGEMENT, DISEASE MANAGEMENT, LARGE CASE-MANAGEMENT OR OTHER CLINICAL MANAGEMENT PROGRAMS.

RESPONSE

Price and quality information is not readily available real-time, at the point of referral, particularly for referrals to external organizations.

Lahey Health is working to develop value scorecards for our physicians to enhance appropriate decision-making; however, as noted, lack of transparent and accessible data from external organizations is a barrier. Despite barriers, the system has and will continue to make considerable efforts to obtain qualitative, in addition to quantitative, information on outside organizations to make the best referral decision for each patient.

2. FOR EACH YEAR 2010 TO PRESENT, PLEASE SUBMIT A SUMMARY TABLE SHOWING FOR EACH LINE OF BUSINESS (COMMERCIAL, GOVERNMENT, OTHER, TOTAL) YOUR INPATIENT AND OUTPATIENT REVENUE AND MARGIN FOR EACH MAJOR SERVICE CATEGORY ACCORDING TO THE FORMAT AND PARAMETERS PROVIDED AND ATTACHED AS AGO HOSPITAL EXHIBIT 2 WITH ALL APPLICABLE FIELDS COMPLETED. PLEASE SUBMIT SEPARATE SHEETS FOR PEDIATRIC AND ADULT POPULATIONS, IF NECESSARY. IF YOU ARE UNABLE TO PROVIDE COMPLETE ANSWERS, PLEASE PROVIDE THE GREATEST LEVEL OF DETAIL POSSIBLE AND EXPLAIN WHY YOUR ANSWERS ARE NOT COMPLETE.

Lahey Clinic/LHMC provides trended margin information for inpatient and outpatient services by major payer category (*please see Lahey Clinic Attachment C2-a*), however we respectfully decline to provide information regarding revenue and margin by service category. This information is highly proprietary. Furthermore, because there are no standardized approaches or definitions, for example as to service category or cost/revenue allocation, any information provided would not be comparable across the industry and therefore would be of limited, if any use, to the AGO or the HPC. Lahey Clinic remains committed to transparency and is willing to work with the HPC and the AGO to provide appropriate safeguards of proprietary information and to assure that information provided addresses the purposes of its collection. This level of information is consistent with the data provided in the 2013 response.

4. PLEASE EXPLAIN AND SUBMIT SUPPORTING DOCUMENTS THAT SHOW HOW YOU ANALYZE AND TRACK THE VOLUME OF INPATIENT AND OUTPATIENT REFERRALS TO YOUR HOSPITAL AND THE ASSOCIATED REVENUE FROM THOSE REFERRALS BY PARTICULAR PHYSICIANS OR PROVIDER GROUPS. PLEASE INCLUDE A DESCRIPTION AND EXAMPLES OF HOW YOUR ORGANIZATION USES THIS INFORMATION.

Lahey Clinic/LHMC respectfully declines to provide the information requested due to its highly proprietary nature. Lahey Clinic/LHMC remains committed to transparency and is willing to work with the HPC and the AGO to provide this information under appropriate safeguards regarding its use.

Lahey Health Utilization Trends FY2012–YTD FY2014

LAHEY HEALTH SYSTEM - OPERATING REVENUE, OPERATING EXPENSE, UTILIZATION STATISTICS							
		Fiscal	Fiscal		Year to Date April 30 (7 months)		
$ in 000's		2012	2013	Change	2013	2014	Change
Operating revenue	[1]	$ 1,475,233	$ 1,502,035	$ 26,802	$ 852,455	$ 867,447	$ 14,992
				1.8%			1.8%
Operating expenses	[1]	$ 1,422,884	$ 1,451,009	$ 28,125	$ 835,431	$ 848,305	$ 12,874
				2.0%			1.5%
Utilization Statistics [2]							
Inpatient discharges	*Acute hospitals*	42,933	41,930	(1,003)	24,192	24,635	443
Observation discharges	*Acute hospitals*	12,257	13,324	1,067	7,716	8,683	967
Ambulatory surgeries	*Acute hospitals*	26,505	25,701	(804)	14,980	14,932	(48)
Emergency visits	*Acute hospitals*	118,270	118,781	511	66,720	65,983	(737)
Physician visits	*Physician group*	1,177,466	1,191,262	13,796	684,984	706,390	21,406
Skilled nursing occupancy	*Skilled nursing facilities*	89%	92%	3%	92%	92%	0%
Home care new cases	*Home health*	3,173	3,636	463	2,125	2,275	150
Outpatient visits	*Behavioral services*	1,296,104	1,670,860	374,756	785,131	841,702	56,571

Lahey Health

(1) FY2013 revenue and expense per Lahey Health System, Inc. (LHS) audited financial statements. There are no audited financial statements for FY2012 as LHS was formed in May of 2012. The fiscal 2012 revenue and expense amounts are from internal financial documents.
(2) Utilization statistics from LHS internal documents.

LAHEY HEALTH SYSTEM - OPERATING REVENUE, OPER

	October - September 12 mos.		Cha
	FY2012	FY2013	Raw
Operating Revenue	$1,475,233	$1,502,035	$26,802
Operating Expenses	$1,422,884	$1,451,009	$28,125

UTILIZATION STATISTICS/TRENDS		October - September 12 mos.		Cha
Type	**Indicator**	**FY2012**	**FY2013**	**Raw**
Acute care hospitals	Inpatient Discharges	42,933	41,930	(1,003)
Acute care hospitals	Observation Patients	12,257	13,324	1,067
Acute care hospitals	Ambulatory Surgeries	26,505	25,701	(804)
Acute care hospitals	ED Visits	118,270	118,781	511
Physician practices	Physician Visits	1,177,466	1,191,262	13,796
SNF	Occupancy Rate	89%	92%	3%
Home care	New Patients	3,173	3,636	463
Behavioral health services	Oupatient visits	1,296,104	1,670,860	374,756

ATING EXPENSE, UTILIZATION STATISTICS

nge	October - April 7 mos.		Change	
Percent	FY2013	FY2014	Raw	Percent
1.8%	$852,455	$867,447	$14,992	1.8%
2.0%	$835,431	$848,305	$12,874	1.5%

nge	**October - April 7 mos.**		**Change**	
Percent	**FY2013**	**FY2014**	**Raw**	**Percent**
-2.3%	24,192	24,635	443	1.8%
8.7%	7,716	8,683	967	12.5%
-3.0%	14,980	14,932	(48)	-0.3%
0.4%	66,720	65,983	(737)	-1.1%
1.2%	684,984	706,390	21,406	3.1%
N/A	92%	92%	0%	N/A
14.6%	2,125	2,275	150	7.1%
28.9%	785,131	841,702	56,571	7.2%

Payor/Plan	Type of APM	Years in APM Contract		
		NEPHO ACU	Lahey ACU	LCPN ACUs Combined
BCBS (HMO)	Budget Based Risk	5 (2010 – 2014)	3 (2012,13,14)	0 *(combined contract beginning 1/15)*
Tufts (HMO)	Budget Based Risk	5 (2010 – 2014)	3 (2012,13,14)	2 (2013, 2014)
HPHC (HMO)	Budget Based Risk	1 (2014) *(prior years P4P)*	1 (2014) *(prior years P4P)*	1 (2014)
Tufts (Medicare Preferred)	Budget Based Risk	10 (2004 – 2014)	*Upside only:* 1 (2011) *Upside + downside:* 3 (2012 – 2014)	0 *(combined contract beginning 1/15)*
Medicare	Shared Savings	2 (2013,2014)	2 (2013,2014)	2 (2013, 2014)
Medicare	Bundled Payment	0	1 (2014)	N/A

Lahey Clinical Performance Network (LCPN) Overview of Local and Centralized Services

Quality Improvement:

Lahey Clinical Performance Network utilizes quality improvement specialists across the system to help network physicians and their office staff achieve the highest quality of care for our patients and obtain the quality incentives within our managed care and ACO contracts.

LCPN utilizes claims data provided by the health plans to perform analyses to identify gaps in care. We create registries of patients who have not seen their primary care doctor during the year, those who need mammograms and colonoscopies and the tests that are critical for diabetics, those with chronic obstructive pulmonary disease and congestive heart failure as well as other chronic diseases and preventative screenings. With this information, our physicians are in a better position to keep their patients healthy. We have also contracted with a company, Phytel, whose primary focus is population health management. Patients receive an automated call based on care gaps that are identified from measures selected and tailored by LCPN medical leadership.

There are several specific responsibilities of LCPN's Quality Improvement Program. The responsibilities are:

1. Providing support to the practice for population management at the POD and practice level by tracking and monitoring individual process and outcome measures for eligible managed care patients who have chronic diseases.
2. Acts as a key resource to PCP practices for the management of registries of patients who have chronic diseases to ensure that they receive the required testing and medical management to promote optimal health and clinical outcomes.
3. Utilizes Athena (our external data warehouse) for quality registry management and provides timely performance reports to Leadership, Pod Leaders, and practices.
4. Coordinates the collection of data from physician practices. Completes required submissions, audits, and appeals with supporting clinical documentation as required.
5. Provides training and support to physicians, administrative staff and select office and clinical staff on the use of Phytel web-based application as well as Lahey Accountable Care Unit's home grown Health Maintenance Registry (HMR).
6. Acts as a key resource to PCPs and practices to understand the specifics of the quality measures within established contracts.

Care Management:

LCPN structures our Care Management program to allow care management at the local level. Under the direction of the LCPN Chief Medical Officer the local units Care Managers work closely with our physicians to provide individualized support for patients, when they are hospitalized, in a skilled nursing or rehabilitation facility and for the chronically ill and frailest of patients in their homes. Case Managers are Registered Nurses or Licensed Social Workers (case specific) who work with physicians to

facilitate and coordinate the patient's discharge from the hospital. They ensure the patient is ready to be discharged, has a follow-up appointment with their primary care provider shortly after discharge and that the patient understands instructions about medicines, follow-up care, or whether home care services or equipment are needed. If home care services are needed, the Case Manager will arrange it. Patients discharged from the hospital to a skilled nursing facility will be followed by a Case Manager until discharge and at home, when needed.

LCPN has a comprehensive algorithm that identifies the highest risk patients amongst specific population, and assigns Case Managers based on the primary care provider to contact these patients. This enables the Case Manager to assess how the patient is doing at home, and identify if there are social as well as medical needs. The Case Managers communicate with the patient's physician, keeping them informed of how their patients are doing between doctor visits. Having these open lines of communication, as well as trusting relationships between provider and case manager, allows our Care Management Program to be extremely effective.

There are several specific responsibilities of LCPN's Care Management Program. The responsibilities are:

1. Letter and telephone call to patient to promote engagement and schedule initial assessment.
2. Comprehensive health assessment performed during a home visit or office visit.
3. Assessment, plan of care, and ongoing notes documented in Care Manager and patient's electronic medical record.
4. Interventions include counseling on diet, medication, self-care, lifestyle management, teaching of early warning signs of decompensation and how to access the appropriate level of care.
5. Care coordination includes referrals to disease management programs, community resources to meet the patient's and caregiver's needs, and assistance in accessing them efficiently.
6. Coordinates efforts of all health care providers who work with the patient and ensures that all providers are aware of the patient's medical status and care plan.
7. Follows patient between all sites and providers of care, focusing most intensively on transitions through hospitals, and keeping the primary care provider informed of the patient status.
8. Ongoing monitoring and follow up until patient has met goals and can be safely discharged.

LCPN has contracted with Dovetail to provide our Lahey Enhanced Care Program. Lahey Enhanced Care provides services to our highest complex risk ACO patients and engages them in their home and community. The program is tailored to each patient based on their need and support can be one month or several months. This program compliments our current care management program and assists in our goal to improve care and reduce unnecessary utilization.

Pharmacy Support:

Clinical Pharmacists are another member of the LCPN team, working at the local risk unit level. Our Clinical Pharmacists provide information and advise physicians about alternative and less costly medications and educate physicians about new and existing drugs. Pharmacy costs and co-payments have increased substantially in recent years, with multiple payment tiers depending on the product and benefit design of the patient's insurance. Reviewing the medication information on an individual patient basis, our Pharmacist is able to suggest possible substitute medicines that will be as effective while costing less. The prescribing physician decides whether a different medicine would be appropriate for

the patient. This information is highly valued as another way to improve quality and control health care costs. Our Pharmacists work closely with physician leaders and medical directors and is significantly involved with the Quality Improvement and Care Management departments to develop new strategies to improve the quality of care.

Referral Management:

LCPN offers a Referral Management Program. This program helps mitigate inappropriate out of network care which causes a break in the continuum of care and can be costly to patients and systems. LCPN has been successful in keeping routine care in our community hospitals and complex care in our tertiary hospital. This broad effort delivers assistance to practices by providing centralized practice management services at a lower cost and with more efficiency than the individual practice can. By opening this program up on a larger scale, offices are now able to utilize their staff in other areas that can have a positive impact on their practice.

The types of referrals that are being handled are:

1. In network specialist referrals
2. Prior Authorizations for non-contracting providers
3. Out of network requests
4. Routine non-physician referral requests such as physical therapy, etc.

Lahey Health 2014 HPC Written Testimony

Attachment B2-c

Blue Cross Blue Shield of Massachusetts
NEPHO
Ambulatory Measures

Measure	Minimum Denominator Reugired	Minimum Threshold	Upper Threshold	Weight	NEPHO Denominator	NEPHO Performance	NEPHO Points
Clinical Process Measures [1]		%	%			%	
Depression [2]							
Acute Phase Rx	100	65.3	80.0	1.0	117	67.5	n/a
Continuation Phase Rx	100	49.6	70.0	1.0	117	49.6	n/a
Diabetes							
HbA1c Testing (2X)	115	69.9	83.2	1.0	773	72.8	1.9
Eye Exams	140	58.0	72.1	1.0	773	66.8	3.5
Nephropathy Screening	97	79.7	91.4	1.0	773	87.8	3.8
Cholesterol Management							
Diabetes LDL-C Screening	138	85.3	93.8	1.0	773	91.7	4.0
Cardiovascular LDL-C Screening	138	85.3	93.8	1.0	213	92.0	4.2
Cancer Screening							
Breast Cancer Screening	91	77.1	90.0	1.0	4,902	80.3	2.0
Cervical Cancer Screening	148	83.5	92.4	1.0	5,081	89.1	3.5
Colorectal Cancer Screening (51 - 75)	67	65.2	83.3	1.0	5,726	69.9	2.0
Preventive Screening/Treatment							
Chlamydia Screening							
Ages 16-20	73	45.9	63.7	0.5	549	67.6	5.0
Ages 21-24	101	50.1	67.3	0.5	531	65.4	4.6
Adult Respiratory Testing/Treatment							
Acute Bronchitis *	75	80.4	93.1	*	158	44.9	*
Medication Management							
Digoxin Monitoring	207	83.9	91.6	1.0	34	91.2	N/A
Pedi: Respiratory Testing/Treatment							
Upper Respiratory Infection (URI)	86	90.6	97.7	1.0	393	91.6	1.6
Pharyngitis	13	83.1	99.6	1.0	518	96.1	4.2
Pedi: Well-visits							
< 15 months	46	91.8	99.3	1.0	262	92.0	1.1
3-6 Years	22	85.5	99.2	1.0	1,128	94.1	3.5
Adolescent Well Care Visits	27	60.0	87.7	1.0	3,685	76.5	3.4
Clinical Outcomes Measures [3]							
Diabetes							
HbA1c in Poor Control	10	45.0	4.7	3.0	748	17.5	3.7
LDL-C Control (<100mg)	17	33.4	75.6	3.0	748	62.4	3.8
Blood Pressure Control (<130/80)	114	30.9	47.3	3.0	748	42.8	3.9
Hypertension							
Controlling High Blood Pressure (140/90)	120	71.6	82.5	3.0	1,646	71.3	0.0
Cardiovascular Disease							
LDL-C Control (<100mg)	17	33.4	75.6	3.0	213	68.1	4.3
Patient Experiences (C/G CAHPS/ACES) - Adult [4]							
Communication Quality	200	91.0	98.0	1.0	798	93.7	2.6
Knowledge of Patients	200	80.0	95.0	1.0	794	88.6	3.3
Integration of Care	200	80.0	96.0	1.0	728	85.0	2.3
Access to Care	200	79.0	96.0	1.0	804	85.5	2.5
Patient Experiences (C/G CAHPS/ACES) - Pediatric [4]							
Communication Quality	200	95.0	97.0	1.0	221	96.1	3.2
Knowledge of Patients	200	89.0	93.0	1.0	221	91.7	3.7
Integration of Care	200	85.0	91.0	1.0	91	90.9	N/A
Access to Care	200	70.0	90.0	1.0	223	86.2	4.2
Total Weighted Points							112.1
# of Measures (Weighted)							36.0
Score							3.1

Notes:

[1] Source: BCBSMA CY 2010 data (with 4 months run-out) for Clinical Process measures.

[2] Depression measures are reporting only for 2010. Measures will be weighted 1.0 in subsequent measurement periods.

[3] Source: Outcome data collected from Group. Post appeal results.

[4] Source: MHQP 2010 Survey data. Results based on all-payer data.

N/A: Does not meet Minimum Denominator Required. Excluded from scoring.

lue Cross Blue Shield of Massachusetts
NEPHO
Ambulatory Measures

Measure	Minimum Denominator Reuqired	Minimum Threshold	Upper Threshold	Weight	NEPHO Denominator	NEPHO Performance	NEPHO Points
Clinical Process Measures[1]		%	%			%	
Depression							
Acute Phase Rx	100	65.3	80.0	1.0	141	73.1	3.1
Continuation Phase Rx	100	49.6	70.0	1.0	141	61.0	3.2
Diabetes							
HbA1c Testing (2X)	115	69.9	83.2	1.0	624	74.0	2.3
Eye Exams	140	58.0	72.1	1.0	624	69.4	4.2
Nephropathy Screening	97	79.7	91.4	1.0	624	88.0	3.8
Cholesterol Management							
Diabetes LDL-C Screening	138	85.3	93.8	1.0	624	92.8	4.5
Cardiovascular LDL-C Screening	138	85.3	93.8	1.0	159	93.1	4.7
Cancer Screening							
Breast Cancer Screening	91	77.1	90.0	1.0	4,069	83.7	3.1
Cervical Cancer Screening	148	83.5	92.4	1.0	4,767	86.1	2.2
Colorectal Cancer Screening (51 - 75)	67	65.2	83.3	1.0	4,801	72.7	2.7
Preventive Screening/Treatment							
Chlamydia Screening							
Ages 16-20	73	45.9	63.7	0.5	503	71.0	5.0
Ages 21-24	101	50.1	67.3	0.5	482	76.6	5.0
Adult Respiratory Testing/Treatment							
Acute Bronchitis	30	55.0	80.0	1.0	108	58.3	1.5
Medication Management							
Digoxin Monitoring	207	83.9	91.6	1.0	29	82.8	N/A
Pedi: Respiratory Testing/Treatment							
Upper Respiratory Infection (URI)	86	90.6	97.7	1.0	372	94.9	3.4
Pharyngitis	13	83.1	99.6	1.0	440	95.7	4.1
Pedi: Well-visits							
< 15 months	46	91.8	99.3	1.0	210	93.8	2.1
3-6 Years	22	85.5	99.2	1.0	1,038	94.0	3.5
Adolescent Well Care Visits	27	60.0	87.7	1.0	3,269	76.9	3.5
Clinical Outcomes Measures [2]							
Diabetes							
HbA1c in Poor Control	10	45.0	4.7	3.0	605	15.5	3.9
LDL-C Control (<100mg)	17	33.4	75.6	3.0	605	69.1	4.4
Blood Pressure Control (<140/80)	90	46.0	64.5	3.0	605	61.3	4.3
Hypertension							
Controlling High Blood Pressure (140/90	120	71.6	82.5	3.0	1,549	81.2	4.5
Cardiovascular Disease							
LDL-C Control (<100mg)	17	33.4	75.6	3.0	159	78.6	5.0
Patient Experiences (C/G CAHPS/ACES) - Adult [3]							
Communication Quality	200	91.0	98.0	1.0	333	93.7	2.6
Knowledge of Patients	200	80.0	95.0	1.0	332	89.8	3.6
Integration of Care	200	80.0	96.0	1.0	307	88.3	3.1
Access to Care	200	79.0	96.0	1.0	339	84.9	2.4
Patient Experiences (C/G CAHPS/ACES) - Pediatric [3]							
Communication Quality	200	95.0	97.0	1.0	221	96.1	3.2
Knowledge of Patients	200	89.0	93.0	1.0	221	91.7	3.7
Integration of Care	200	85.0	91.0	1.0	91	90.9	N/A
Access to Care	200	70.0	90.0	1.0	223	86.2	4.2
Total Weighted Points							145.9
# of Measures (Weighted)							39.0
Score							3.7

Notes:

1 Source: BCBSMA CY 2011 data (with 4 months run-out) for Clinical Process measures. Post-appeal resul

2 Source: Outcome data collected from Group. Post appeal results.

3 Source: MHQP/BCBSMA 2011 Survey data for Adult. Pediatric based on 2010 results.

N/A: Does not meet Minimum Denominator Required. Excluded from scoring.

Products included: HMO/POS.

HOSPITAL QUALITY AND SAFETY
Clinical Process, Outcomes and Patient Experience Measures

				BEVERLY HOSPITAL CORPORATION		
	Minimum Denominator	Minimum Threshol	Upper Threshold	Denomina tor	Perform ance	Points
Clinical Process Measures[1]		%	%		%	
AMI						
ACE/ARB for LVSD	39	89.1	98.9	28	96.0	N/A
Aspirin at arrival	109	98.3		189	99.0	5.0
Aspirin at discharge	63	98.2		124	100.0	5.0
Beta Blocker at discharge	83	98.5		123	100.0	5.0
Smoking Cessation	22	93.1	99.9	21	100.0	N/A
Heart Failure						
ACE LVSD	31	87.3	98.9	106	100.0	5.0
LVS function Evaluation	24	95.1	100.0	387	100.0	5.0
Discharge instructions	11	71.4	98.5	242	90.0	3.8
Smoking Cessation	20	88.3	99.6	45	100.0	5.0
Pneumonia						
Flu Vaccine	15	77.8	98.6	250	95.0	4.3
Pneumococcal Vaccination	19	76.0	97.4	395	97.0	4.9
Antibiotics w/in 6 hrs	65	95.6	99.8	416	99.0	4.2
Smoking Cessation	12	86.7	99.8	96	97.0	4.2
Antibiotic selection	124	87.4	95.4	228	97.0	5.0
Blood culture	91	91.0	98.0	421	97.0	4.4
Surgical Infection						
Antibiotic received	28	86.5	98.9	769	99.0	5.0
Received Appropriate Preventive Antibiotic(s)	71	94.1	99.4	771	99.0	4.7
Antibiotic discontinued	28	77.9	96.2	751	99.0	5.0
Clinical Outcomes Measures						
In-Hospital Mortality- Overall	946	2.15	0.88	20,990	1.29	3.7
Wound Infection	9457	0.30	0.09	20,933	0.06	5.0
Select Infections due to Medical Care	4149	0.18	0.02	13,499	0.03	4.8
AMI after Major Surgery	1310	0.55	0.10	1,741	0.34	2.8
Pneumonia after Major Surgery	1129	1.57	0.60	1,677	1.25	2.3
PE/DVT after Major Surgery	1007	0.93	0.22	2,379	0.46	3.6
Birth Trauma - injury to neonate	1130	0.20	0.01	2,031	0.05	4.2
Obstetrics Trauma-vaginal w/o instrument	651	3.54	1.54	1,313	1.29	5.0
Patient Experiences (HCAHPS) [1]						
Nursing communication	300	72.6	81.2		79.0	4.0
MD communication	300	78.1	85.5		79.0	1.5
Responsiveness	300	58.4	76.4		62.0	1.8
Discharge planning	300	77.7	90.4		85.0	3.3
Total Points						**117.5**
# of Measures						**28**
Score						**4.2**

Data sources:

Clinical Process Measures: HHS - Hospital Compare for 12 months ending 3Q11.
Clinical Outcomes Measures: FY 2011: October 1, 2010 - September 30, 2011.
Patient Experience (HCAHPS): Hospital Compare for 12 months ending 3Q11.

Notes:

[1] Results reflect most recent data available through HHS - Hospital Compare.

N/A: Denominators do not meet minimum requirements. Measure excluded from scoring.

Blue Cross Blue Shield of Massachusetts
NEPHO
2011 Aggregate Score

Ambulatory Score	3.7
Hospital Score	4.2
Aggregate Score	4.0

Blue Cross Blue Shield of Massachusetts
NEPHO
Ambulatory Process Measures

Measure	Minimum Denominator Required	Minimum Threshold	Upper Threshold	Weight	NEPHO Denominator	NEPHO Performance	NEPHO Points
Clinical Process Measures[1]		%	%			%	
Depression							
Acute Phase Rx	100	65.3	80.0	1.0	108	71.3	2.6
Continuation Phase Rx	100	49.6	70.0	1.0	108	51.9	1.4
Diabetes							
HbA1c Testing (2X)	115	69.9	83.2	1.0	553	84.1	5.0
Eye Exams	140	58.0	72.1	1.0	553	72.5	5.0
Nephropathy Screening	97	79.7	91.4	1.0	553	92.6	5.0
Cholesterol Management							
Diabetes LDL-C Screening	138	85.3	93.8	1.0	553	94.0	5.0
Cardiovascular LDL-C Screening	138	85.3	93.8	1.0	132	90.2	N/A
Cancer Screening							
Breast Cancer Screening	91	77.1	90.0	1.0	3,732	84.2	3.2
Cervical Cancer Screening	148	83.5	92.4	1.0	4,001	87.3	2.7
Colorectal Cancer Screening (51 - 75)	67	65.2	83.3	1.0	4,461	72.4	2.6
Preventive Screening/Treatment							
Chlamydia Screening							
Ages 16-20	73	45.9	63.7	0.5	476	76.9	5.0
Ages 21-24	101	50.1	67.3	0.5	502	75.3	5.0
Adult Respiratory Testing/Treatment							
Acute Bronchitis	30	55.0	80.0	1.0	73	74.0	4.0
Medication Management							
Digoxin Monitoring	207	83.9	91.6	1.0	25	80.0	N/A
Pedi: Respiratory Testing/Treatment							
Upper Respiratory Infection (URI)	86	90.6	97.7	1.0	330	94.2	3.1
Pharyngitis	13	83.1	99.6	1.0	291	96.6	4.3
Pedi: Well-visits							
< 15 months	46	91.8	99.3	1.0	208	94.7	2.6
3-6 Years	22	85.5	99.2	1.0	863	95.9	4.0
Adolescent Well Care Visits	27	60.0	87.7	1.0	2,839	79.5	3.8
Clinical Outcomes Measures [2]							
Diabetes							
HbA1c in Poor Control (>9)	10	45.0	4.7	3.0	553	12.1	4.3
LDL-C Control (<100mg)	17	33.4	75.6	3.0	553	70.9	4.6
Blood Pressure Control (<140/80)	90	46.0	64.5	3.0	553	70.9	5.0
Hypertension							
Controlling High Blood Pressure (140/90)	120	71.6	82.5	3.0	1,319	87.5	5.0
Cardiovascular Disease							
LDL-C Control (<100mg)	17	33.4	75.6	3.0	132	75.8	5.0
Patient Experiences - Adult [3]							
Communication Quality	200	91.0	98.0	1.0	837	94.3	2.9
Knowledge of Patients	200	80.0	95.0	1.0	837	89.3	3.5
Integration of Care	200	80.0	96.0	1.0	767	88.6	3.2
Access to Care	200	79.0	96.0	1.0	603	86.0	2.6
Patient Experiences - Pediatric [3]							
Communication Quality	200	95.0	97.0	1.0	260	96.0	3.0
Knowledge of Patients	200	89.0	93.0	1.0	260	93.1	5.0
Integration of Care	200	85.0	91.0	1.0	119	92.5	N/A
Access to Care	200	70.0	90.0	1.0	212	84.8	4.0
Total Weighted Points							155.2
# of Measures (Weighted)							38.0
Score							4.1

Notes:

[1] Source: BCBSMA CY 2012 data (with 4 months run-out) for Clinical Process measures. Post-appeal results.

[2] Source: Outcome data collected from Group. Post appeal results.

[3] Source: MHQP/BCBSMA 2012 Survey data.

n/a: Not available or not applicable.

N/A: Does not meet Minimum Denominator Required. Excluded from scoring.

BCBSMA, 10/07/13

Products included: HMO/POS.

HOSPITAL QUALITY AND SAFETY
Clinical Process, Outcomes and Patient Experience Measures

				BEVERLY HOSPITAL CORPORATION		
	Minimum Denominator	Minimum Threshol	Upper Threshold	Denomina tor	Perform ance	Points
Clinical Process Measures[1]		%	%		%	
AMI						
Aspirin at discharge	63	98.2		134	99.0	5.0
Heart Failure						
ACE LVSD	31	87.3	98.9	83	99.0	5.0
LVS function Evaluation	24	95.1	100.0	384	100.0	5.0
Discharge instructions	11	71.4	98.5	268	94.0	4.3
Pneumonia						
Antibiotic selection	124	87.4	95.4	279	99.0	5.0
Blood culture	91	91.0	98.0	508	98.0	5.0
Surgical Infection						
Antibiotic received	28	86.5	98.9	744	99.0	5.0
Received Appropriate Preventive Antibiotic(s)	71	94.1	99.4	744	99.0	4.7
Antibiotic discontinued	28	77.9	96.2	732	99.0	5.0
Clinical Outcomes Measures						
Select Infections due to Medical Care	4149	0.18	0.02	13,575	0.01	5.0
Post-Op PE/DVT	1007	0.93	0.22	2,351	0.34	4.3
Birth Trauma - injury to neonate	1130	0.20	0.01	2,126	0.09	3.3
Obstetrics Trauma-vaginal w/o instrument	651	3.54	1.54	1,411	1.70	4.7
Patient Experiences (HCAHPS) [1]						
Nursing communication	300	72.6	81.2		79.0	4.0
MD communication	300	78.1	85.5		78.0	0.0
Responsiveness	300	58.4	76.4		65.0	2.5
Discharge planning	300	77.7	90.4		87.0	3.9
Total Points						**71.7**
# of Measures						**17**
Score						**4.2**

Data sources:

Clinical Process Measures: HHS - Hospital Compare for 12 months ending 3Q12.
Clinical Outcomes Measures: FY 2012: October 1, 2011 - September 30, 2012.
Patient Experience (HCAHPS): Hospital Compare for 12 months ending 3Q12.

Notes:

[1] Results reflect most recent data available for settlement through HHS - Hospital Compare.
n/a: Data not available.
N/A: Denominators do not meet minimum requirements. Measure excluded from scoring.

Blue Cross Blue Shield of Massachusetts
NEPHO
2012 Aggregate Score

Ambulatory Score	4.1
Hospital Score	4.2
Aggregate Score	4.2

*

NEPHO Quality Scorecard

NEPHO

Measure Year 2013

COMPOSITE GATE SCORE
4.48

Row Labels	MINIMUM THRESHHOLD	MAXIMUM THRESHHOLD	WEIGHT	COMPLIANT	POPULATION	RATE	MAX SCORE	WEIGHTED POINTS
Clinical Process Measures								
Adult Respiratory Testing/Treatment								
Acute Bronchitis	55.00%	80.00%	1	57	81	70.37%	5.0	3.46
Cancer Screening								
Breast Cancer Screening	77.10%	90.00%	1	2,126	2,522	84.30%	5.0	3.23
Cervical Cancer Screening	83.50%	92.40%	1	2,461	2,755	89.33%	5.0	3.62
Colorectal Cancer Screening	65.20%	83.30%	1	2,387	3,153	75.71%	5.0	3.32
Chlamydia Screening								
Ages 16-20	45.90%	63.70%	0.5	317	371	85.44%	2.5	2.50
Ages 21-24	50.10%	67.30%	0.5	297	387	76.74%	2.5	2.50
Cholesterol Management								
Cardiovascular LDL-C Screening	85.30%	93.80%	1	79	84	94.05%	0.0	0.00
Diabetes LDL-C Screening	85.30%	93.80%	1	351	374	93.85%	5.0	5.00
Depression								
Acute Phase Rx	65.30%	80.00%	1	47	74	63.51%	0.0	0.00
Continuation Phase Rx	49.60%	70.00%	1	33	74	44.59%	0.0	0.00
Diabetes								
Eye Exams	58.00%	72.10%	1	276	374	73.80%	5.0	5.00
HbA1c Testing (2X)	69.90%	83.20%	1	331	374	88.50%	5.0	5.00
Nephropathy Screening	79.70%	91.40%	1	353	374	94.39%	5.0	5.00
Pedi: Respiratory Testing/Treatment								
Pharyngitis	83.10%	99.60%	1	319	323	98.76%	5.0	4.80
Upper Respiratory Infection	90.60%	97.70%	1	264	273	96.70%	5.0	4.44
Pedi: Well-visits								
< 15 months	91.80%	99.30%	1	178	185	96.22%	5.0	3.36
3-6 Years	85.50%	99.20%	1	723	748	96.66%	5.0	4.26
Adolescent Well Care Visits	60.00%	87.70%	1	1,980	2,385	83.02%	5.0	4.32
Clinical Outcomes Measures								
Cardiovascular Disease								
CV LDL-C Control (<100mg)	33.40%	75.60%	3	67	84	79.76%	15.0	15.00
Diabetes								
Blood Pressure Control (140/80)	46.00%	64.50%	3	253	374	67.65%	15.0	15.00
DM HbA1c Control (<= 9)	55.00%	95.30%	3	329	374	87.97%	15.0	12.82
DM LDL-C Control (<100mg)	33.40%	75.60%	3	246	374	65.78%	15.0	12.21
Hypertension								
Controlling High Blood Pressure (140/90)	71.60%	82.50%	3	724	865	83.70%	15.0	15.00

Blue Cross Blue Shield of Massachusetts
Lahey
Ambulatory Measures

Measure	Minimum Denominator Required	Minimum Threshold	Upper Threshold	Weight	Lahey Denominator	Lahey Performance	Lahey Points
Clinical Process Measures [1]		%	%			%	
Depression							
Acute Phase Rx	100	65.3	80.0	1.0	132	67.4	1.6
Continuation Phase Rx	100	49.6	70.0	1.0	132	53.0	1.7
Diabetes							
HbA1c Testing (2X)	145	71.4	83.2	0.25	814	71.9	1.2
Eye Exams	134	60.7	72.1	1.0	814	68.7	3.8
Nephropathy Screening	104	82.8	91.4	1.0	814	85.7	2.3
Cholesterol Management							
Diabetes LDL-C Screening	155	87.9	93.8	0.25	814	87.0	0.0
Cardiovascular LDL-C Screening	155	87.9	93.8	0.25	216	85.2	0.0
Cancer Screening							
Breast Cancer Screening	150	80.8	90.0	1.0	4,273	86.0	3.3
Cervical Cancer Screening	148	83.5	92.4	1.0	4,362	84.1	1.3
Colorectal Cancer Screening (51 - 75)	67	65.2	83.3	1.0	5,953	69.4	1.9
Preventive Screening/Treatment							
Chlamydia Screening							
Ages 16-20	51	54.2	77.2	0.5	118	38.1	0.0
Ages 21-24	93	59.0	75.8	0.5	311	57.6	0.0
Adult Respiratory Testing/Treatment							
Acute Bronchitis	30	55.0	80.0	1.0	263	19.4	0.0
Pedi: Respiratory Testing/Treatment							
Upper Respiratory Infection (URI)	101	93.3	97.7	1.0	36	91.7	N/A
Pharyngitis	24	90.1	99.6	1.0	40	82.5	0.0
Pedi: Well-visits							
< 15 months	46	91.8	99.3	1.0	10	100.0	N/A
3-6 Years	109	89.3	99.2	1.0	75	94.7	N/A
Adolescent Well Care Visits	45	63.6	87.7	1.0	741	73.1	2.6
Clinical Outcomes Measures							
Diabetes							
HbA1c in Poor Control	99	20.4	8.7	3.0	811	17.4	2.0
LDL-C Control (<100mg)	132	52.7	67.7	3.0	811	56.2	1.9
Blood Pressure Control (<140/80)	90	46.0	64.5	3.0	811	45.0	0.0
Hypertension							
Controlling High Blood Pressure (<140/90	147	69.5	81.7	3.0	1,519	63.9	0.0
Cardiovascular Disease							
LDL-C Control (<100mg)	69	65.7	83.4	3.0	216	73.1	2.7
Patient Experiences - Adult [2]							
Communication Quality	200	91.0	98.0	1.0	755	94.3	2.9
Knowledge of Patients	200	80.0	95.0	1.0	755	89.3	3.5
Integration of Care	200	80.0	96.0	1.0	713	89.0	3.3
Access to Care	200	79.0	96.0	1.0	483	83.0	1.9
Patient Experiences - Pediatric [2]							
Communication Quality	200	95.0	97.0	1.0	121	98.7	N/A
Knowledge of Patients	200	89.0	93.0	1.0	121	95.9	N/A
Integration of Care	200	85.0	91.0	1.0	68	94.0	N/A
Access to Care	200	70.0	90.0	1.0	95	92.1	N/A
Total Weighted Points							50.2
# of Measures (Weighted)							30.75
Score							1.6

Notes:

[1] Source: BCBSMA CY 2012 data (with 4 months run-out) for Clinical Process measures. Post-appeal results.

[2] Source: Outcome data collected from Group. Post-appeal results.

[3] Source: MHQP/BCBSMA 2012 Survey data.

n/a: Not available or not applicable.

N/A: Does not meet Minimum Denominator Required. Excluded from scoring.

HOSPITAL QUALITY AND SAFETY (HIMs)
Clinical Process, Outcomes and Patient Experience Measures

					LAHEY CLINIC HOSPITAL		
	Weight	Minimum Denominator	Minimum Threshold	Upper Threshold	Denominator	Performance	Points
Clinical Process Measures			%	%		%	
AMI							
Aspirin at discharge	1.0	39	98.0		625	100.0	5.0
Heart Failure							
ACE LVSD	1.0	71	94.0	98.0	58	97.0	N/A
LVS function Evaluation	1.0	70	98.0		290	100.0	5.0
Discharge instructions	1.0	23	92.0	98.0	220	99.0	5.0
Pneumonia							
Antibiotic selection	1.0	124	87.0	95.0	52	96.0	N/A
Blood culture	1.0	113	94.0	98.0	85	98.0	N/A
Surgical Infection							
Antibiotic received	1.0	115	97.0	98.0	409	99.0	5.0
Received Appropriate Preventive Antibiotic(s)	1.0	183	98.0		410	99.0	5.0
Antibiotic discontinued	1.0	96	96.0	98.0	397	98.0	5.0
Received appropriate VTE prophylaxsis	1.0	48	96.0	98.0	385	100.0	5.0
Recommended VTE prophylaxis ordered	1.0	37	97.0	98.0	385	100.0	5.0
Cardiac w/controlled post-op blood glucose	1.0	349	95.0	98.0	128	98.0	N/A
On BB prior to arrival and during peri-op period	1.0	38	96.0	98.0	226	100.0	5.0
Urinary Catheter Removed	1.0	20	88.0	98.0	210	100.0	5.0
Hospital Outpatient Measures							
Antibiotic received	1.0	36	92.0	98.0	301	94.0	2.3
Received Appropriate Preventive Antibiotic(s)	1.0	81	95.0	98.0	681	99.0	5.0
Clinical Process Total Points							**57.3**
# of Measures							**12**
Score							**4.8**
Clinical Outcomes Measures							
Central Venous Catheter-Related BSI	1.0	6320	0.05	0.00	12,362	0.03	2.6
PE/DVT after Major Surgery	1.0	1776	0.90	0.32	8,342	0.68	2.5
Obstetrics Trauma-vaginal w/o instrument	0.5	716	2.41	0.90	n/a	n/a	n/a
OB Trau - Vag w Instru	0.5	129	17.26	7.68	n/a	n/a	n/a
Post-operative Respiratory Failure	1.0	899	0.87	0.18	4,607	1.56	0.0
Accidential Puncture or Laceration	1.0	3,146	0.15	0.02	21,303	0.53	0.0
Iatrogenic Pneumothorax, Adult	1.0	17,756	0.03	0.01	19,361	0.06	0.0
Mortality AMI w/o Transfers	1.0	226	8.43	3.38	359	5.57	3.3
Clinical Outcome Total Points							**8.4**
# of Measures							**6**
Score							**1.4**
Patient Experiences (HCAHPS)							
Nursing communication	1.0	300	73.0	81.0		79.0	4.0
MD communication	1.0	300	78.0	86.0		82.0	3.0
Responsiveness	1.0	300	58.0	76.0		63.0	2.1
Discharge planning	1.0	300	78.0	90.0		87.0	4.0
Patient Experience Total Points							**13.1**
# of Measures							**4**
Score							**3.3**
Overall Score Total							**9.5**
# of Measure Categories							**3**
Final Score							**3.2**

Data sources:
Clinical Process Measures: HHS - Hospital Compare for 12 months ending 3Q12.
Clinical Outcomes Measures: FY 2012: October 1, 2011 - September 30, 2012.
Patient Experience (HCAHPS): Hospital Compare for 12 months ending 3Q12.

Notes:
[1] Results reflect most recent data available for settlement through HHS - Hospital Compare.
n/a: Data not available.

Lahey Quality Scorecard

(Multiple Items)

Measure Year - 2013

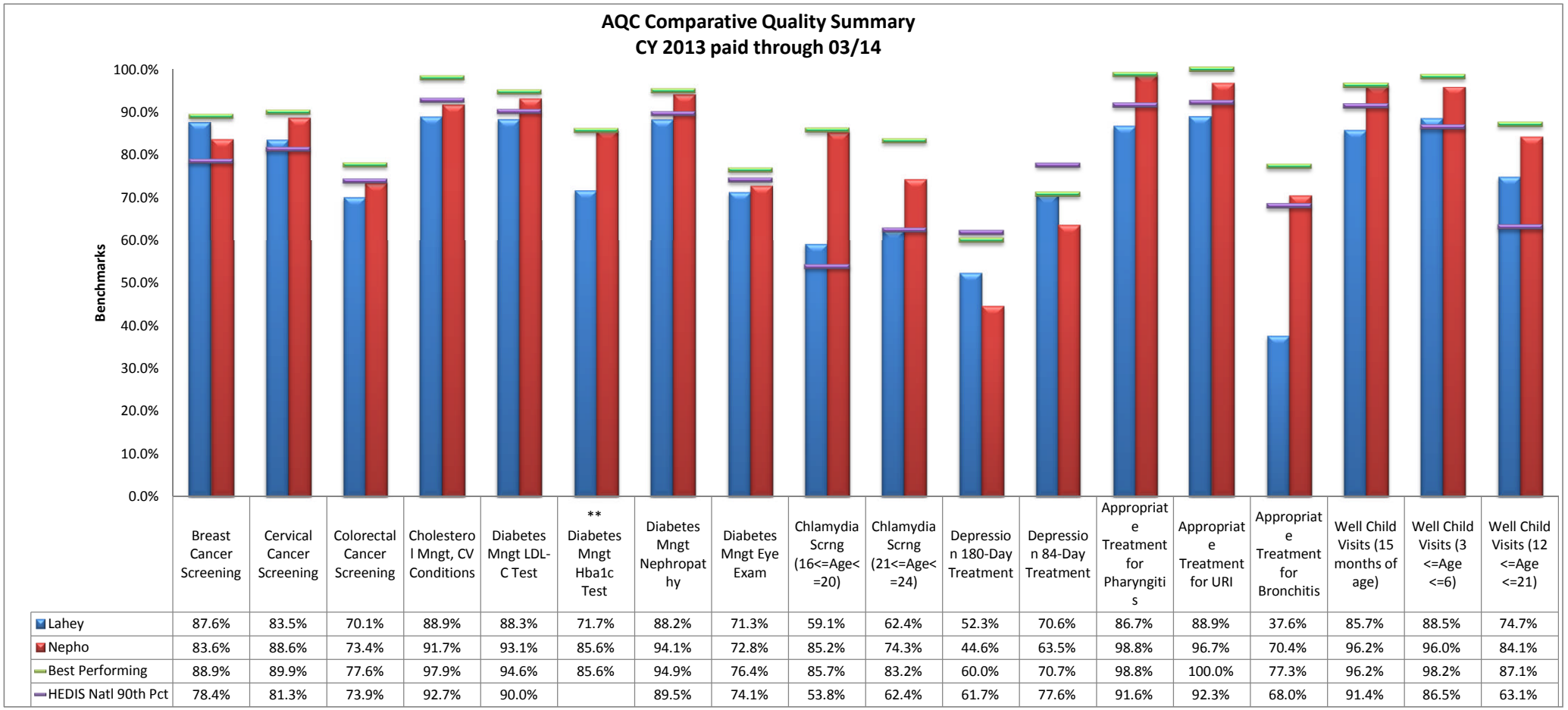
COMPOSITE GATE SCORE
2.04

Row Labels	MINIMUM THRESHHOLD	MAXIMUM THRESHHOLD	WEIGHT	COMPLIANT	POPULATION	RATE	MAX SCORE	WEIGHTED POINTS
Clinical Process Measures								
Adult Respiratory Testing/Treatment								
Acute Bronchitis	55.00%	80.00%	1	53	140	37.9%	5.0	0.00
Cancer Screening								
Breast Cancer Screening	80.80%	90.00%	1	3,484	3,964	87.9%	5.0	4.08
Cervical Cancer Screening	83.50%	92.40%	1	3,372	4,025	83.8%	5.0	1.12
Colorectal Cancer Screening	65.20%	83.30%	1	4,169	5,579	74.7%	5.0	3.11
Chlamydia Screening								
Ages 16-20	54.20%	77.20%	0.5	71	123	57.7%	2.5	0.81
Ages 21-24	59.00%	75.80%	0.5	200	318	62.9%	2.5	0.96
Cholesterol Management								
Cardiovascular LDL-C Screening	87.90%	93.80%	0.25	188	207	90.8%	1.3	0.75
Diabetes LDL-C Screening	87.90%	93.80%	0.25	668	746	89.5%	1.3	0.53
Depression								
Acute Phase Rx	65.30%	80.00%	1	77	108	71.3%	5.0	2.63
Continuation Phase Rx	49.60%	70.00%	1	57	108	52.8%	5.0	1.62
Diabetes								
Eye Exams	60.70%	72.10%	1	545	746	73.1%	5.0	5.00
HbA1c Testing (2X)	71.40%	83.20%	0.25	552	746	74.0%	1.3	0.47
Nephropathy Screening	82.80%	91.40%	1	667	746	89.4%	5.0	4.07
Pedi: Respiratory Testing/Treatment								
Pharyngitis	90.10%	99.60%	1	29	33	87.9%	5.0	0.00
Upper Respiratory Infection	93.30%	97.70%	1	33	37	89.2%	0.0	0.00
Pedi: Well-visits								
< 15 months	91.80%	99.30%	1	12	14	85.7%	0.0	0.00
3-6 Years	89.30%	99.20%	1	65	76	85.5%	0.0	0.00
Adolescent Well Care Visits	63.60%	87.70%	1	506	686	73.8%	5.0	2.69
Clinical Outcomes Measures								
Cardiovascular Disease								
CV LDL-C Control (<100mg)	65.70%	83.40%	3	147	207	71.0%	15.0	6.60
Diabetes								
Blood Pressure Control (140/80)	46.00%	64.50%	3	374	746	50.1%	15.0	5.68
DM HbA1c Control (<= 9)	79.60%	91.30%	3	608	746	81.5%	15.0	4.95
DM LDL-C Control (<100mg)	52.70%	67.70%	3	412	746	55.2%	15.0	5.02
Hypertension								
Controlling High Blood Pressure (140/90)	69.50%	81.70%	3	1,031	1,452	71.0%	15.0	4.48

* Final Composite Gate Score is determined by BCBSMA and would include Patient Experience Scores not reflected here.

Print Date
8/13/2014

LAHEY CLINICAL PERFORMANCE NETWORK
AQC QUALITY MEASURES
Time Period: CY 2013



	Breast Cancer Screening	Cervical Cancer Screening	Colorectal Cancer Screening	Cholesterol Mngt, CV Conditions	Diabetes Mngt LDL-C Test	** Diabetes Mngt Hba1c Test	Diabetes Mngt Nephropathy	Diabetes Mngt Eye Exam	Chlamydia Scrng (16<=Age<=20)	Chlamydia Scrng (21<=Age<=24)	Depression 180-Day Treatment	Depression 84-Day Treatment	Appropriate Treatment for Pharyngitis	Appropriate Treatment for URI	Appropriate Treatment for Bronchitis	Well Child Visits (15 months of age)	Well Child Visits (3 <=Age <=6)	Well Child Visits (12 <=Age <=21)
Lahey	87.6%	83.5%	70.1%	88.9%	88.3%	71.7%	88.2%	71.3%	59.1%	62.4%	52.3%	70.6%	86.7%	88.9%	37.6%	85.7%	88.5%	74.7%
Nepho	83.6%	88.6%	73.4%	91.7%	93.1%	85.6%	94.1%	72.8%	85.2%	74.3%	44.6%	63.5%	98.8%	96.7%	70.4%	96.2%	96.0%	84.1%
Best Performing	88.9%	89.9%	77.6%	97.9%	94.6%	85.6%	94.9%	76.4%	85.7%	83.2%	60.0%	70.7%	98.8%	100.0%	77.3%	96.2%	98.2%	87.1%
HEDIS Natl 90th Pct	78.4%	81.3%	73.9%	92.7%	90.0%		89.5%	74.1%	53.8%	62.4%	61.7%	77.6%	91.6%	92.3%	68.0%	91.4%	86.5%	63.1%

Note:

* 2013 Quality Compass 90th %tile - The benchmark data contained in this graph is Quality Compass 2013

** 2013 Hedis 90th %tile is not available for Diabetes Management HbA1c (2X) Testing

Prepared by Performance Measurement: B.O
5/5/2014

LAHEY CLINICAL PERFOMANCE NETWORK

ACO: 2013 Quality Performance Report

Run on 8/01/2014

DOMAINS		Actual Perfomance	WEIGHTS
PATIENT/CAREGIVER EXPERIENCE		91.4%	25%
CARE COORDINATION/PATIENT SAFETY		59.6%	25%
PREVENTIVE HEALTH		84.1%	25%
CHRONIC MEASURES/AT RISK POPULATION		88.2%	25%
QUALITY PERFORMANCE SCORE			**80.8%**

PATIENT/CAREGIVER EXPERIENCE	Pay-for-Perfomance (4)	Measure Test Name	LCPN	ACO Quality Measure Benchmarks	Quality Earned Points	Possible Points
Timely Care and Appointments (3)	P		85.30%	80 %tile	1.85	2.00
Provider Communication (3)	P		94.04%	90 %tile	2.00	2.00
Patient Ratings of Providers (3)	P		92.43%	90 %tile	2.00	2.00
Access to Specialist (3)	P		83.07%	80 %tile	1.85	2.00
Health Promotions & Education (3)	P		62.23%	90 %tile	2.00	2.00
Shared Decision Making (1)	P		72.18%	30 %tile	1.10	2.00
Health & Functional Status (1)	R		74.20%	90 %tile	2.00	2.00
Total Points					12.80	14.00

CARE COORDITANTION/PATIENT SAFETY	Pay-for-Perfomance (4)	Measure Test Name	LCPN	ACO Quality Measure Benchmarks	Quality Earned Points	Possible Points
Risk Standardized All Condition Readmissions	R		15.27%	90 %tile	2.00	2.00
ASCA: COPD and Asthma (3)	P		1.36%	<30%tile	-	2.00
ASCA: CHF (3)	P		1.35%	<30%tile	-	2.00
Med Reconciliation @D/C	P	ACO12-Medication Reconciliation	79.66%	70 %tile	1.70	2.00
Screening for Fall Risk	P	ACO13-Fall Risk Screening	23.08%	40 %tile	1.25	2.00
% PCP Quality for EHR Incentive (2)	P		82.59%	70 %tile	3.40	4.00
Total Points					8.35	14.00

PREVENTIVE HEALTH	Pay-for-Perfomance (4)	Measure Test Name	LCPN	ACO Quality Measure Benchmarks	Quality Earned Points	Possible Points
Influenza Immunization	P	ACO14-Influenza Immunization	59.08%	60 %tile	1.55	2.00
Pneumococcal Vaccination	P	ACO15-Pneumococcal Vaccination	57.24%	50 %tile	1.40	2.00
Adult Weight Screen & f/u	P	ACO16-BMI & Follow-Up	63.66%	50 %tile	1.40	2.00
Tobacco Use Assessment & Intervention	P	ACO17-Tobacco Use Screening	90.95%	90 %tile	2.00	2.00
Depression Screening	P	ACO18-Depression Screening	9.95%	30 %tile	1.10	2.00
Colorectal Cancer Screening (1)	R	ACO19-Colorectal Cancer Screening	52.15%	90 %tile	2.00	2.00
Mamography Screening (1)	R	ACO20-Breast Cancer Screening	78.43%	90 %tile	2.00	2.00
% Adults w/BP measured (1)	R	ACO21-BP	76.20%	90% tile	2.00	2.00
Total Points					13.45	16.00

AT RISK POPULATION	Pay-for-Perfomance (4)	Measure Test Name	LCPN	ACO Quality Measure Benchmarks	Quality Earned Points	Possible Points
Diabetes: HbA1c Control <=8	P	ACO22-HbA1c <8.0	78.86%			
Diabetes: LDL < 100	P	ACO23-LDL-C <100mg/dL	60.33%			
Diabetes: BP < 140/90	P	ACO24-BP <140/90	70.55%			
Diabetes: Tobacco Non-use	P	ACO25-Tobacco Non-Use	77.91%			
Diabetes: Aspirin Use	P	ACO26-Daily Aspirin or Antiplatelet Medication	79.86%			
% of Beneficiaries with diabetes who met all of the above criteria		**Diabetes Composite Score**	**28.98%**	**70%tile**	**1.70**	**2.00**
Diabetes: Mellitis : HbA1c <=9	P	ACO27-HbA1c <=9.0	85.04%	80 %tile	1.85	2.00
HTN: BP Control	P	ACO28-BP <140/90	67.10%	50 %tile	1.40	2.00
IVD: Complete Lipid & LDL<100	P	ACO29-LDL-C <100mg/dL	64.63%	70 %tile	1.70	2.00
IVD: Asp/Antithrombotic	P	ACO30-Aspirin or Other Antithrombotic	86.62%	70 %tile	1.70	2.00
HF: LVSD Beta Blocker Therapy (1)	R	ACO31-Beta-Blocker Therapy	85.22%	90 %tile	2.00	2.00
CAD Drug Therapy - Lower LDL (1)	R	ACO32-Lipid Control	81.53%			
CAD ACE/ARB Therapy (1)	R	ACO33-ACE Inhibitor or ARB Therapy	74.07%			
% of Beneficiaries with CAD who met all of above criteria:		**CAD Composite Score**	**73.64%**	**90% tile**	**2.00**	**2.00**
Total Points					12.35	14.00

Maximum possible points per domain	**46.95**	**58.00**

Notes:

(1). For 2014 these measures will be reporting only, meaning we will receive the full quality points for reporting.

(2). EHR points doubled (currently at 50%tile scoring)

(3). The data for these measures will come from Medicare and therefore the earned quality points shown above are estimates on performance and not actual performance

Northeast Physician Hospital Organization

Tertiary Admission Admissions

Case(s)	CalendarYear				
ProviderName	**2011**	**2012**	**2013**	**2014**	**Grand Total**
LAHEY CLINIC HOSPITAL	47.46%	59.43%	57.14%	66.67%	55.36%
MASS GENERAL HOSPITAL	15.25%	11.32%	18.68%	3.33%	13.91%
NORTH SHORE MEDICAL CENTER	11.02%	9.43%	6.59%	3.33%	8.70%
BETH ISRAEL DEACONESS MEDICAL CENTER, INC	5.93%	4.72%	5.49%	10.00%	5.80%
BRIGHAM AND WOMENS	11.86%	4.72%	8.79%	6.67%	8.41%
HALLMARK HEALTH SYSTEM	0.00%	1.89%	0.00%	0.00%	0.58%
NEWTON WELLESLEY HOSPITAL	0.85%	1.89%	0.00%	0.00%	0.87%
METROWEST MEDICAL CENTER	0.85%	1.89%	0.00%	0.00%	0.87%
WINCHESTER HOSPITAL	0.85%	1.89%	0.00%	0.00%	0.87%
TUFTS MEDICAL CENTER	1.69%	1.89%	2.20%	3.33%	2.03%
BOSTON MEDICAL CENTER	1.69%	0.94%	1.10%	0.00%	1.16%
CATHOLIC MEDICAL CENTER	0.85%	0.00%	0.00%	0.00%	0.29%
NEW ENGLAND BAPTIST HOSPITAL	0.00%	0.00%	0.00%	3.33%	0.29%
BETH ISRAEL DEACONESS HOSPITAL MILTON INC	0.85%	0.00%	0.00%	0.00%	0.29%
DANA FARBER CANCER INSTITUTE	0.85%	0.00%	0.00%	0.00%	0.29%
STEWARD ST ELIZABETHS MEDICAL CENTER OF BOSTON, INC	0.00%	0.00%	0.00%	3.33%	0.29%
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Northeast Physician Hospital Organization

Tertiary Admission Admissions

Lahey Health

Lahey Enhanced Care

Kathleen T. Sheehan, MS, BSN, RN-BC, CH-GCN
Director of Ambulatory and Transitional Case Management

Andrew Levitsky, Pharm.D, M. Ed, BCPS
Manager of ACU Pharmacy Services

Patrice Horgan, RN, MSN, NEA-BC
Dovetail Health

Lahey Enhanced Care Overview

- LCPN contracting with *Dovetail Health* to provide enhanced care management services for complex, high-risk Medicare ACO patients only
- This service will be referred to as *Lahey Enhanced Care*
- Enhanced services will include:
  - In home visits by pharmacists and nurses
  - Transitional (30 days post discharge) and longitudinal follow-up (several months)
  - Overseen by LACU Director of Case Management (Kathleen Sheehan) and LACU Pharmacy Manager (Andrew Levitsky)
- Implementation date – 6/26
- E-Mail blast was sent to PCPs on 6/24 describing program details
- Additional educational sessions will be scheduled as needed

ADA. V. Diabetes Care. Diabetes Care 2014;37(suppl 1):S21

Program Overview

What is the Program?

- Targeted at complex, high-risk patients
- Engage them in the home and community
- Tailored program for each patient based on need
- Patient support can be 1 month or several months
- Goal to improve care and reduce unnecessary utilization

Key Elements

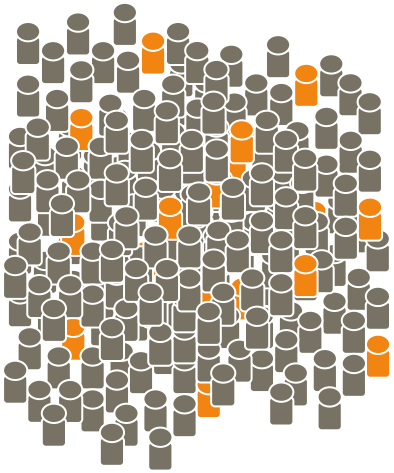
- Holistic approach, with strong medication focus
- Designed to integrate with and extend Lahey team
  - Clinicians and materials are branded as Lahey Health Enhanced Care
- Capturing and leveraging “Last Mile” of data from the home

Program Process Flow

Patient Selection & Enrollment

Program Intervention

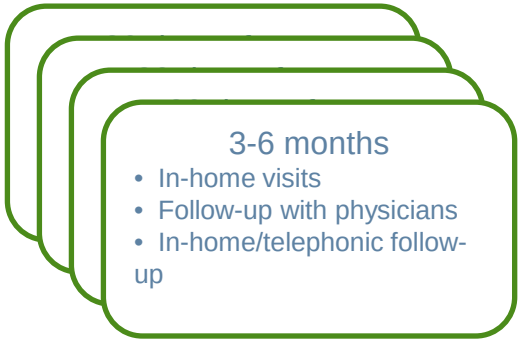
Longitudinal



Claims data

Risk Stratification

Referrals from PCPs or Care Team

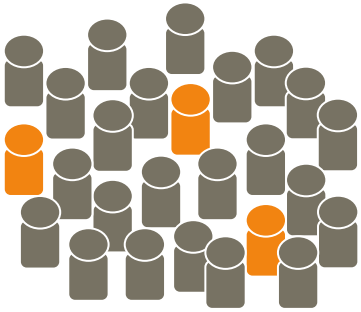


Monthly Review

Some Patients Referred to Longitudinal Program

Transition

Referrals from Care Managers and Hospital Discharge Reports



Risk Stratification

Review by care team

Some discharged

Focus of Initial Clinical Visit

Assess and help patients take the right medications tailored to their needs through analysis of their specific:

- Co-morbid conditions
- Goals of care
- Preferences for taking medications
- Ability to adhere to the prescribed regimen

Special focus on specific and non-specific geriatric syndromes in relationship to adverse drug reactions

Assess broader needs beyond medications to identify barriers and develop a holistic plan of care

Communication and Collaboration

Patient

- Detailed care plan is printed in the home and left with the patient and caregiver(s)
- Patients are supported throughout their time in the program with telephone calls and follow-up visits as needed

Physicians and Care Team

- After the initial home visit, the care plan is shared with the PCP
- Clinician will call PCP (or specialist) to discuss:
  - Discrepancies or concerns regarding the patient's care plan and/or medications
  - Simplify or optimize medication regimen
- Case conferencing with external care team members
- Ongoing communication and collaboration with PCP and other care providers throughout program to ensure continuity of care

Lahey Enhanced Care
Pre-enrollment Workflow

- Patient Selection
  - Post hospital discharge using risk stratification criteria (pulled by the ACU). *Only Medicare ACO patients meeting high risk selection criteria will be enrolled. PCPs will receive fax notification from Lahey Enhanced Care informing them of the intent to enroll their patient in the program.*
  - PCP referral using the *Lahey Enhanced Care Referral form* (via fax). *Patients must be Medicare ACO and meet one or more of the criteria specified on the form. PCP will receive faxed confirmation that the referred patient has been enrolled in the program*
  - *Referral's will be vetted through Director of ATCM and Pharmacy Manager to avoid duplication of services with Lahey ATCM*

Lahey Enhanced Care
Post-enrollment Workflow

- Communication Process (after a home visit)
  - Individual sites will receive a Lahey Enhanced Care Plan by fax, which will include recommendations from the pharmacist or nurse that made the home visit
  - Once received, the care plan should be reviewed by the physician, completed and faxed to the number provided
  - After completion, the care plan should be filed for scanning
  - Scanned Care Plans will be filed in A Chart under ATCM notes
  - ***PCPs will be contacted by phone for urgent matters***

Ambulatory Case Manager Role

- Weekly/Bi-weekly or Monthly case conference meetings with Director, Pharmacy Manager & ATCM to discuss cases
- 90 day meeting for all cases that will be referred back to Lahey ATCM for warm hand-off
- ATCM will follow these patients as needed after discharge from Lahey Enhanced Care Program

The Leader in Physician-Led Population Health Improvement

Lahey Clinical Performance Network

Phytel Outreach Product Overview

May14th , 2014

What is Phytel Outreach?

- **An automated service that identifies patients in need of care and notifies them about recommended visits, test, procedures and other follow-up items.**

How Does Phytel Outreach Work?

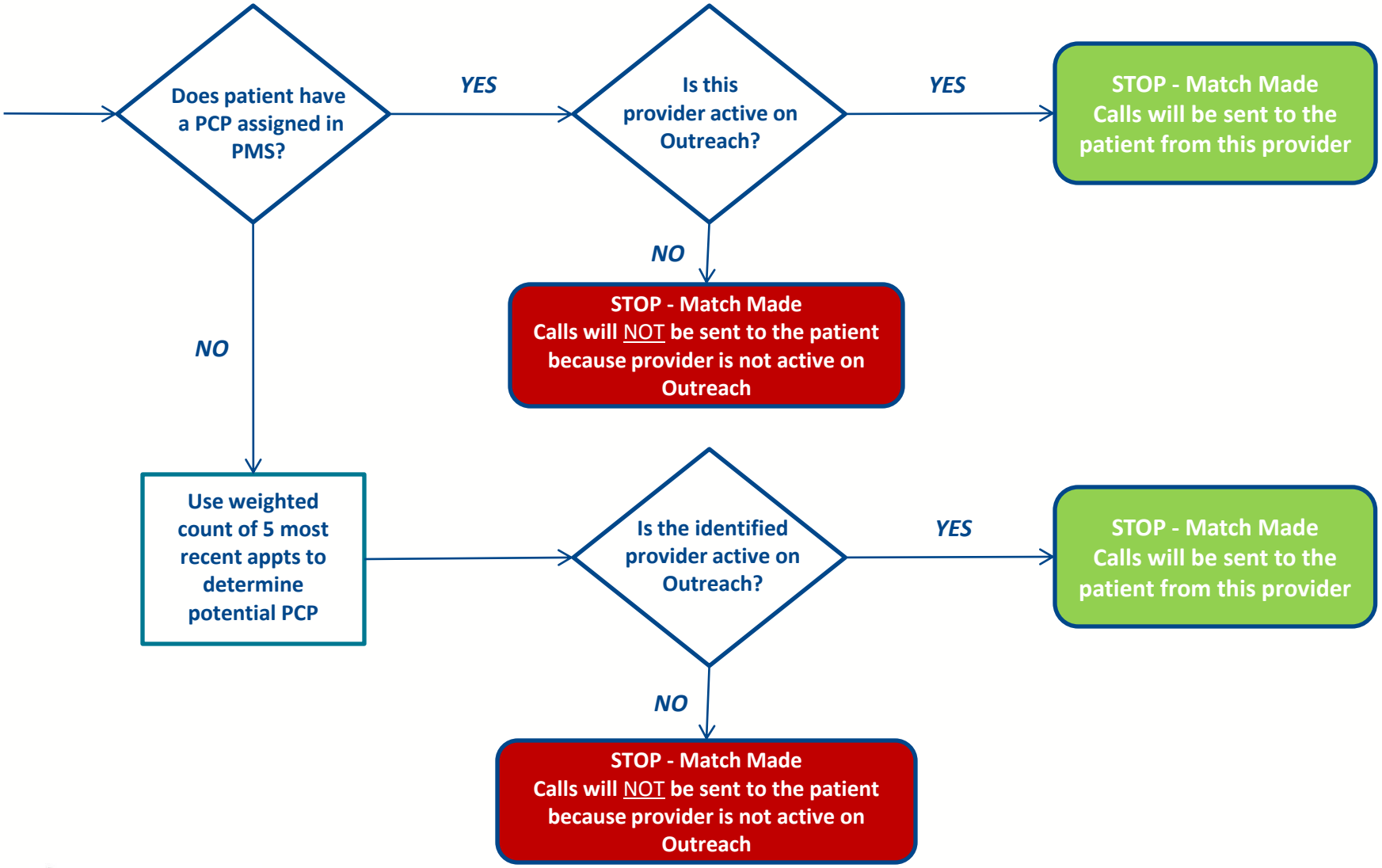
- **BUILD a Patient Registry using data from the Practice Management System (ICD-9, CPT, Appointments).**
- **IDENTIFY patients who are out of compliance with annual care or management of their chronic condition**
- **NOTIFY the patient to call the clinic and schedule an appointment**
- **TRACK to ensure the patient books an appointment in response to the recall**
- **MEASURE the effects of our outreach efforts**

Phytel Outreach Process Timeline

- **Weekly**
  - Rebuild Patient Outreach Registry
    "Weekly Snapshot: All Patients"

- **Daily**
  - Appointment/Demographic Import
  - ICD9/CPT Import
  - Release Calls to Non-Compliant Patients
    - Monday – Friday: 2pm to 7pm
    - No calls on Saturday, Sunday or Federal Holidays

PCP Specified or Weighted Recent Appointments



Phytel Outreach: Message Script

Lahey Health Primary Care *<Clinic Name>* has **a health reminder for *<Patient name>.***

Our records indicate that it is time for you to return to our office for a follow up visit. *

Please call us to schedule an appointment at *<Phone Number>.* Press 1 to replay this message. Thank you. We look forward to seeing you.

Successful vs. Unsuccessful Delivery and Call Quality

- **Our successfully delivered call rate is 97% vs. the industry standard of 90%**

- **An unsuccessful delivery response would result from an early disconnection, Dialing Error, invalid phone number, hang up or busy line**

- **Some call quality issues cannot be avoided**
  - Loud background noise
  - Multiple voicemail boxes
  - Poor cell reception / dropped calls
  - Language barrier
  - Elderly / hearing impaired

Maximum Communication Attempts

- **Maximum number of Outreach calls in 1 day is 2.**
  - 2 attempts in a day at 3 hour intervals

- **We will wait at least 1 month before attempting another Outreach communication.**
  - If the patient hasn't scheduled an appointment, the patient would be eligible for a second Outreach call.

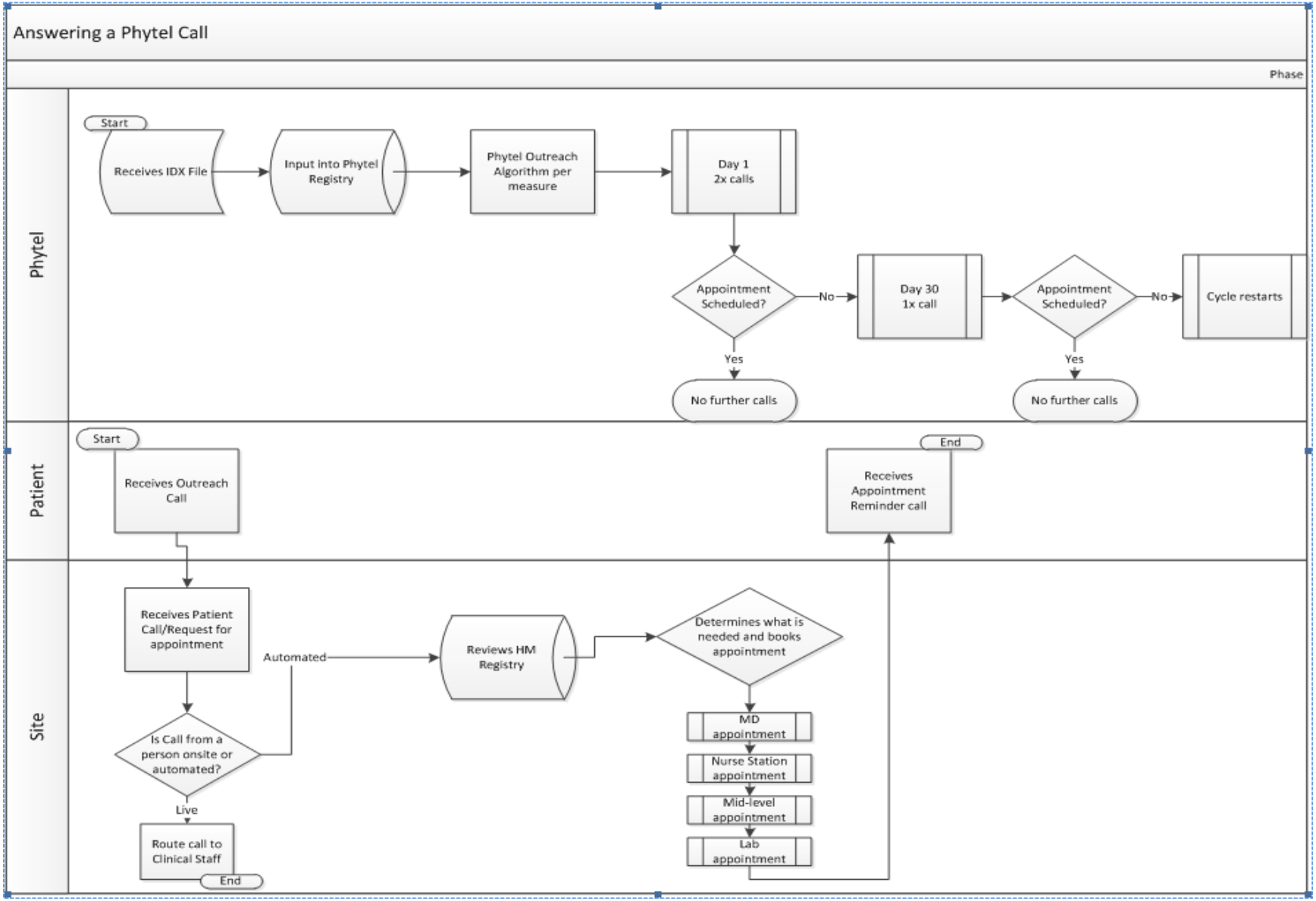
- **If no appointment is made after the first cycle of calls (3 total), the patient will not be contacted for 1 month.**
  - At that point, the patient would be available for another call cycle

Identifying Patients Not to Call

- **No Call Flag**
  - Patient who have requested to not receive automated calls

- **Deceased Patients**

Who will be interacting with these patients?



Lahey Clinical Performance Network

Phytel Outreach Product Overview

May14th, 2014

Table 1. Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings

ACO #	Domain	Measure Title	NQF Measure #/ Measure Steward	Method of Data Submission	P4P Phase-in PY1	P4P Phase-in PY2	P4P Phase-in PY3
AIM: Better Care for Individuals							
1.	Patient/Caregiver Experience	CAHPS: Getting Timely Care, Appointments, and Information	NQF #5, AHRQ	Survey	R	*P*	*P*
2.	Patient/Caregiver Experience	CAHPS: How Well Your Doctors Communicate	NQF #5 AHRQ	Survey	R	*P*	*P*
3.	Patient/Caregiver Experience	CAHPS: Patients' Rating of Doctor	NQF #5 AHRQ	Survey	R	*P*	*P*
4.	Patient/Caregiver Experience	CAHPS: Access to Specialists	NQF #5 AHRQ	Survey	R	*P*	*P*
5.	Patient/Caregiver Experience	CAHPS: Health Promotion and Education	NQF #5 AHRQ	Survey	R	*P*	*P*
6.	Patient/Caregiver Experience	CAHPS: Shared Decision Making	NQF #5 AHRQ	Survey	R	*P*	*P*
7.	Patient/Caregiver Experience	CAHPS: Health Status/Functional Status	NQF #6 AHRQ	Survey	R	R	R
8.	Care Coordination/ Patient Safety	Risk-Standardized, All Condition Readmission[1]	CMS	Claims	R	R	*P*
9.	Care Coordination/ Patient Safety	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)	NQF #275 AHRQ	Claims	R	*P*	*P*
10.	Care Coordination/ Patient Safety	Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)	NQF #277 AHRQ	Claims	R	*P*	*P*
11.	Care Coordination/ Patient Safety	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CMS	EHR Incentive Program Reporting	R	*P*	*P*

(continued)

[1] We note that this measure has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012.

Table 1. Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings (cont.)

ACO #	Domain	Measure Title	NQF Measure #/ Measure Steward	Method of Data Submission	P4P Phase-in PY1	P4P Phase-in PY2	P4P Phase-in PY3
12.	Care Coordination/ Patient Safety	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #97 AMA-PCPI/NCQA	GPRO Web Interface	R	P	P
13.	Care Coordination/ Patient Safety	Falls: Screening for Fall Risk	NQF #101 NCQA	GPRO Web Interface	R	P	P
AIM: Better Health for Populations							
14.	Preventive Health	Influenza Immunization (Claims allowed)	NQF #41. AMA-PCPI	GPRO Web Interface	R	P	P
15.	Preventive Health	Pneumococcal Vaccination (Claims allowed)	NQF #43 NCQA	GPRO Web Interface	R	P	P
16.	Preventive Health	Adult Weight Screening and Follow-up	NQF #421 CMS	GPRO Web Interface	R	P	P
17.	Preventive Health	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #28 AMA-PCPI	GPRO Web Interface	R	P	P
18.	Preventive Health	Depression Screening	NQF #418 CMS	GPRO Web Interface	R	P	P
19.	Preventive Health	Colorectal Cancer Screening (Claims allowed)	NQF #34 NCQA	GPRO Web Interface	R	R	P
20.	Preventive Health	Mammography Screening	NQF #31 NCQA	GPRO Web Interface	R	R	P
21.	Preventive Health	Screening for High Blood Pressure	CMS	GPRO Web Interface	R	R	P
22.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent)	NQF #729 MN Community Measurement	GPRO Web Interface	R	P	P
23.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100)	NQF #729 MN Community Measurement	GPRO Web Interface	R	P	P
24.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90	NQF #729 MN Community Measurement	GPRO Web Interface	R	P	P

(continued)

Table 1. Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings (cont.)

ACO #	Domain	Measure Title	NQF Measure #/ Measure Steward	Method of Data Submission	P4P Phase-in PY1	P4P Phase-in PY2	P4P Phase-in PY3
25.	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Tobacco Non Use	NQF #729 MN Community Measurement	GPRO Web Interface	R	*P*	*P*
26.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Aspirin Use	NQF #729 MN Community Measurement	GPRO Web Interface	R	*P*	*P*
27.	At Risk Population - Diabetes	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)	NQF #59 NCQA	GPRO Web Interface	R	*P*	*P*
28.	At Risk Population - Hypertension	Hypertension (HTN): Controlling High Blood Pressure	NQF #18 NCQA	GPRO Web Interface	R	*P*	*P*
29.	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	NQF #75 NCQA	GPRO Web Interface	R	*P*	*P*
30.	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #68 NCQA	GPRO Web Interface	R	*P*	*P*
31.	At Risk Population - Heart Failure	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #83 AMA-PCPI	GPRO Web Interface	R	R	*P*
32.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol	NQF #74 CMS (composite) / AMA-PCPI (individual component)	GPRO Web Interface	R	R	*P*
33.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	NQF # 66 CMS (composite) / AMA-PCPI (individual component)	GPRO Web Interface	R	R	*P*

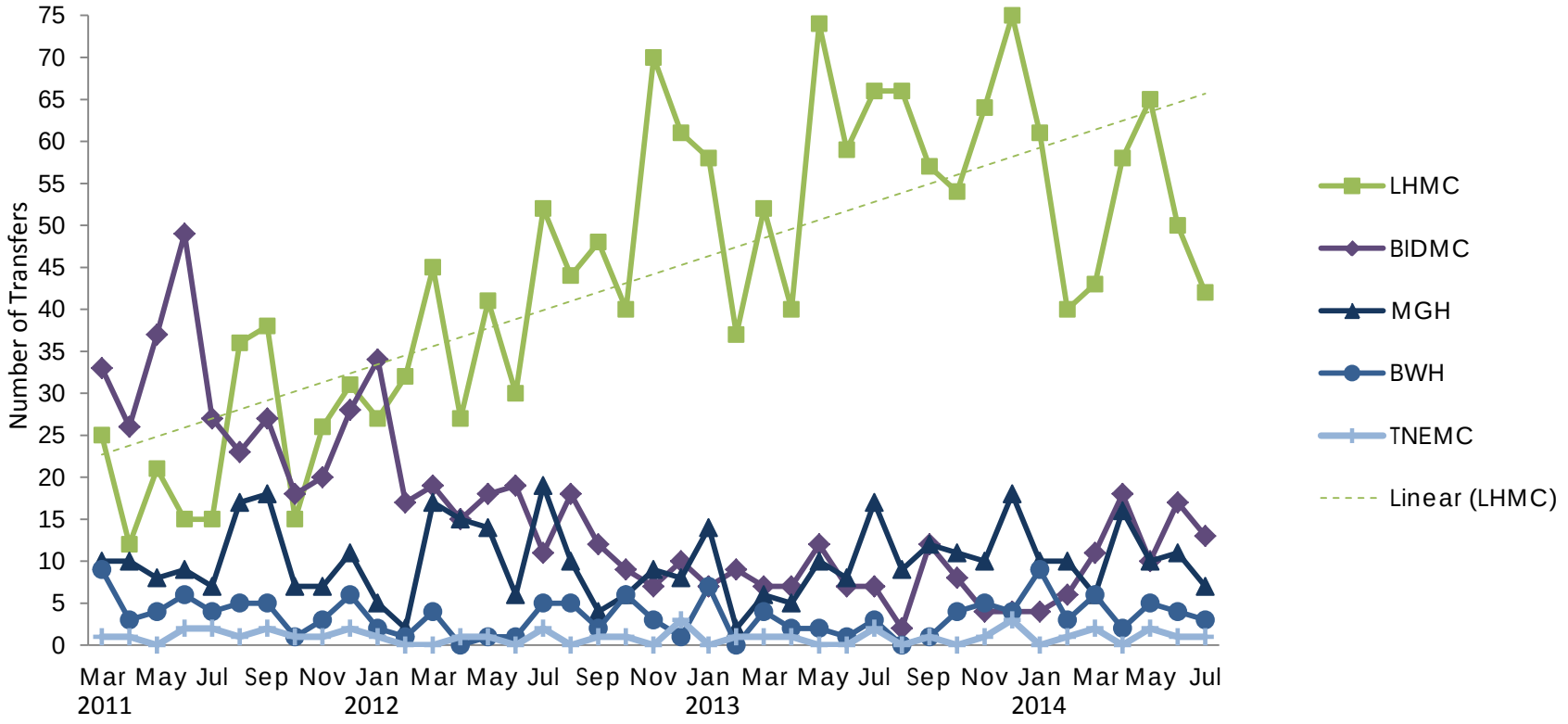
NOTE: ACO = accountable care organization; NQF = National Quality Forum; P4P = pay for performance; *P* = performance; R = reporting

PERFORMANCE MEASURES BY PAYER
SUMMARY re: HEDIS or PHYSICIAN BASED MEASURES

	PERFORMANCE YR 2014		
Measure:	**BC_AQC**	**HPHC_QAP[1]**	**THP**
1. Process Measures:			
Breast Cancer Screening	Y	Y	
Cervical Cancer Screening	Y	Y	Y
Chlamydia Screening [ages 16-20]	Y	Y	
Chlamydia Screening [ages 20-24]	Y	Y	
Colorectal Cancer Scr	Y		
Diabetes			
Diabetes HbA1c Screening [2x/yr AQC]	Y	Y but once per year	Y but once per year
Diabetes LDL-C Screening	Y	Y	Y
Diabetes Nephropathy Attention	Y	Y	Y
Diabetes Retinal Eye Exam	Y		
CVD			
Cardiac LDL-C Screening	Y	Y	Y
Depression Screening for chronic diseases			
Antidepressant Medication Mgmnt - acute phase -RX for 12 wks	Y		
Antidepressant Medication Mgmnt - effective continuation - RX for 6 mos	Y	Y	
2. Outcomes Measures:			
BP <140/80; Diabetes Pts	Y		
BP < 140/90; Hypertensive Pts	Y		
Diabetes HbA1c < 8		Y	
Diabetes HbA1c > 9 (poor control)	Y		
Diabetes HbA1c < = 9			Y
Diabetes LDL < 100 mg/dl	Y	Y	Y
Cardiac LDL < 100 mg/dl	Y		Y
Medication: Adults:			
Avoidance of antibiotic tx re: acute bronchitis	Y	Y	
Pediatric Measures:			
Asthma		Y	
Well Child Visits - <15 mos	Y	Y	
Well Child Visits - 3-6 yrs	Y	Y	
Pediatric Prevention: 3-11 yrs			
ADOL WC 12-21	Y	Y	
ADOL WC 12-18			
Appropriate treatment for URI [no antibiotic, ages 3mo-18yr]	Y	Y	
Appropriate testing for Pharyngitis [received antibiotic & strep test; ages 2-18]	Y	Y	
Patient Experience			

Amb Care Patient Exp Measures:	**Y**		

Tertiary Transfers from Northeast Health System to LHMC and other Boston-based Providers



Lahey Health

Note: Tertiary transfers from Northeast Health System Emergency Department.

Lahey Hospital and Medical Center
Summary of Hospital Encounter Volume - Patient Origin Winchester Primary Service Area
FY 2013 and FY 2014 - YTD June

Fiscal Year 2013

Encounter Type	Hospital Encounters												Total	Monthly Avg
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
Inpatient discharge	546	535	498	597	478	492	495	568	545	506	553	523	**6,336**	**528**
Observation discharge	245	222	256	230	218	222	251	223	257	278	221	191	**2,814**	**235**
Ambulatory Surgery	280	282	229	269	238	266	273	264	260	258	271	250	**3,140**	**262**
Inpatient Casemix	**1.65**	**1.58**	**1.68**	**1.63**	**1.59**	**1.65**	**1.63**	**1.56**	**1.57**	**1.64**	**1.60**	**1.51**	**1.61**	**1.61**

Fiscal Year 2014

Encounter Type	Hospital Encounters									Total	Monthly Avg	Change in Monthly Avg	Annualized
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun				
Inpatient discharge	602	508	528	565	488	572	571	580	545	**4,959**	**551**	23	276
Observation discharge	245	242	267	295	249	309	275	284	287	**2,453**	**273**	38	457
Ambulatory Surgery	269	271	240	294	228	234	264	278	304	**2,382**	**265**	3	36
Inpatient Casemix	**1.65**	**1.58**	**1.81**	**1.71**	**1.71**	**1.67**	**1.61**	**1.66**	**1.70**	**1.68**	**1.68**		

Monthly Change - Fiscal 2013 vs. Fiscal 2014

Using Feb - Jun Averages Only

Encounter Type	Hospital Encounters									Change in Monthly Avg	Annualized
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
Inpatient	56	(27)	30	(32)	10	80	76	12	-	36	432
Observation	-	20	11	65	31	87	24	61	30	47	564
Ambulatory Surgery	(11)	(11)	11	25	(10)	(32)	(9)	14	44	1	12
Inpatient Casemix	**0.00**	**(0.00)**	**0.12**	**0.08**	**0.12**	**0.03**	**(0.02)**	**0.09**	**0.12**		

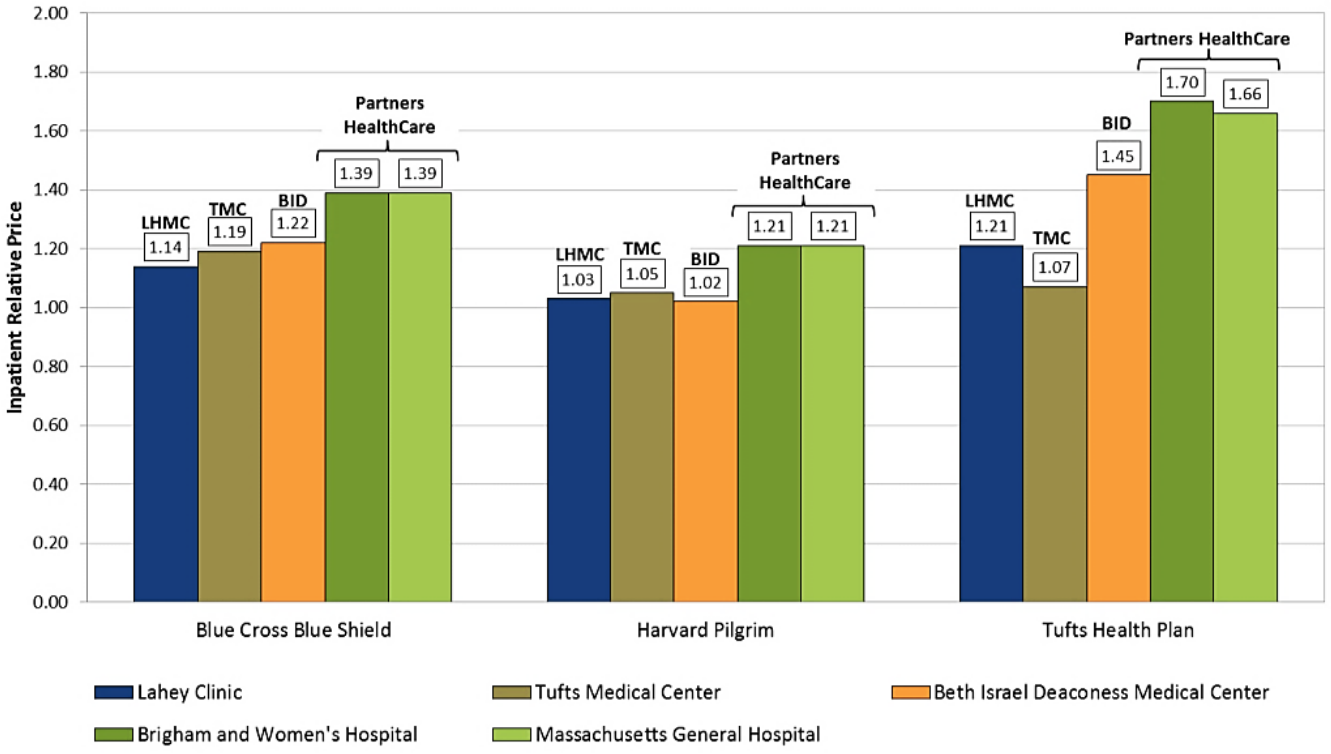
Data Source: Lahey Decision Support System (as fed by Lahey billing system)

Notes:

-Includes any patient with a hospital encounter type of inpatient, observation and / or ambulatory surgery at Lahey Burlington or Lahey Peabody with a listed zip code from Billerica, Burlington, Malden, Medford, N. Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester or Woburn.

-Ambulatory Surgery Cases only include encounters with a hospital operating room charge

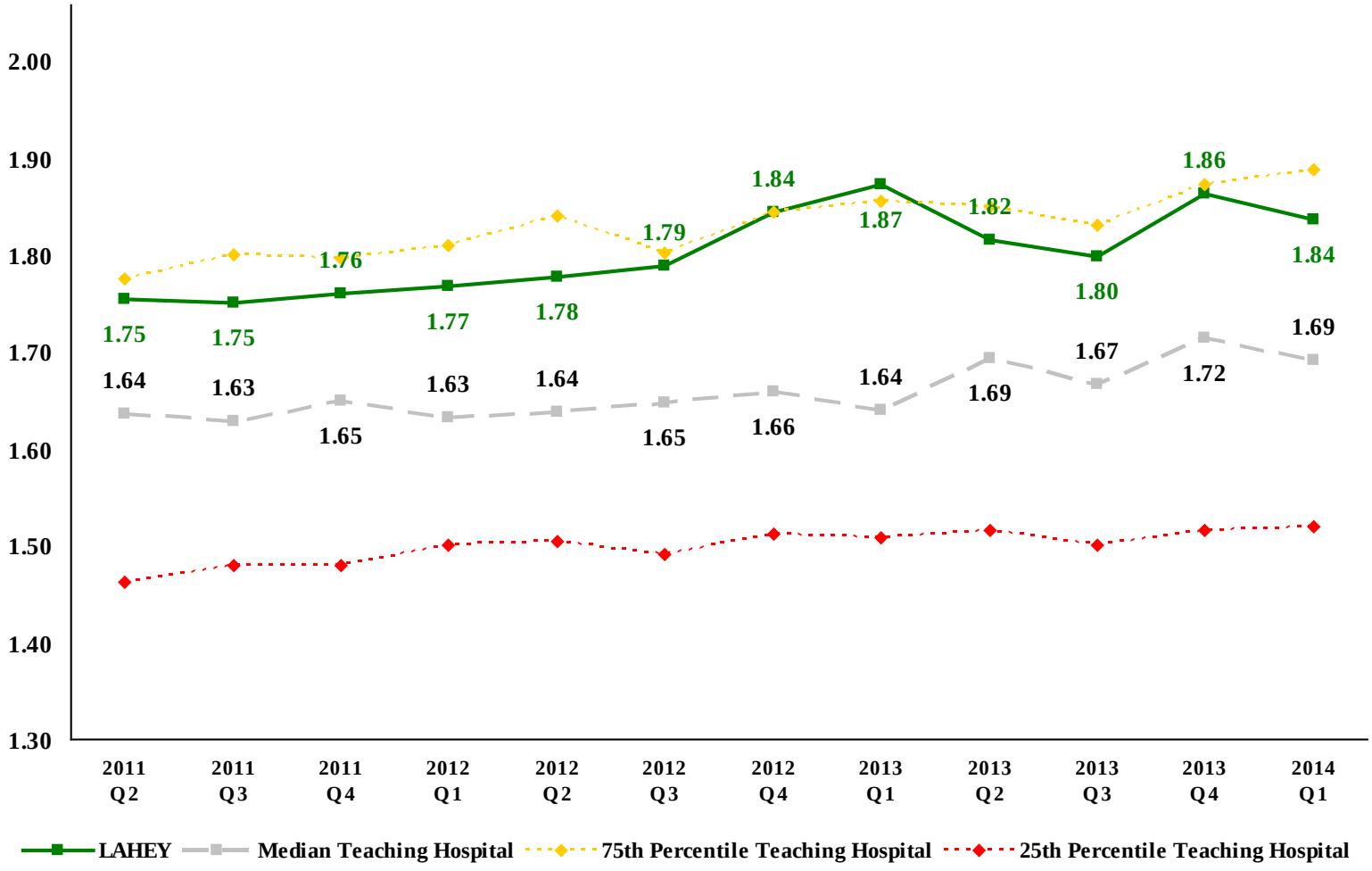
Inpatient Relative Price for Select Tertiary Providers Across Major Payers, 2012



Note: Brigham and Women's Hospital and Massachusetts General Hospital are part of the Partners HealthCare system.
Source: CHIA Annual Report August 2013 Data Appendix.

Overall Hospital Case Mix Index:

Benchmarked against Median Teaching Hospital: Twelve Most Recent Quarters



LAHEY

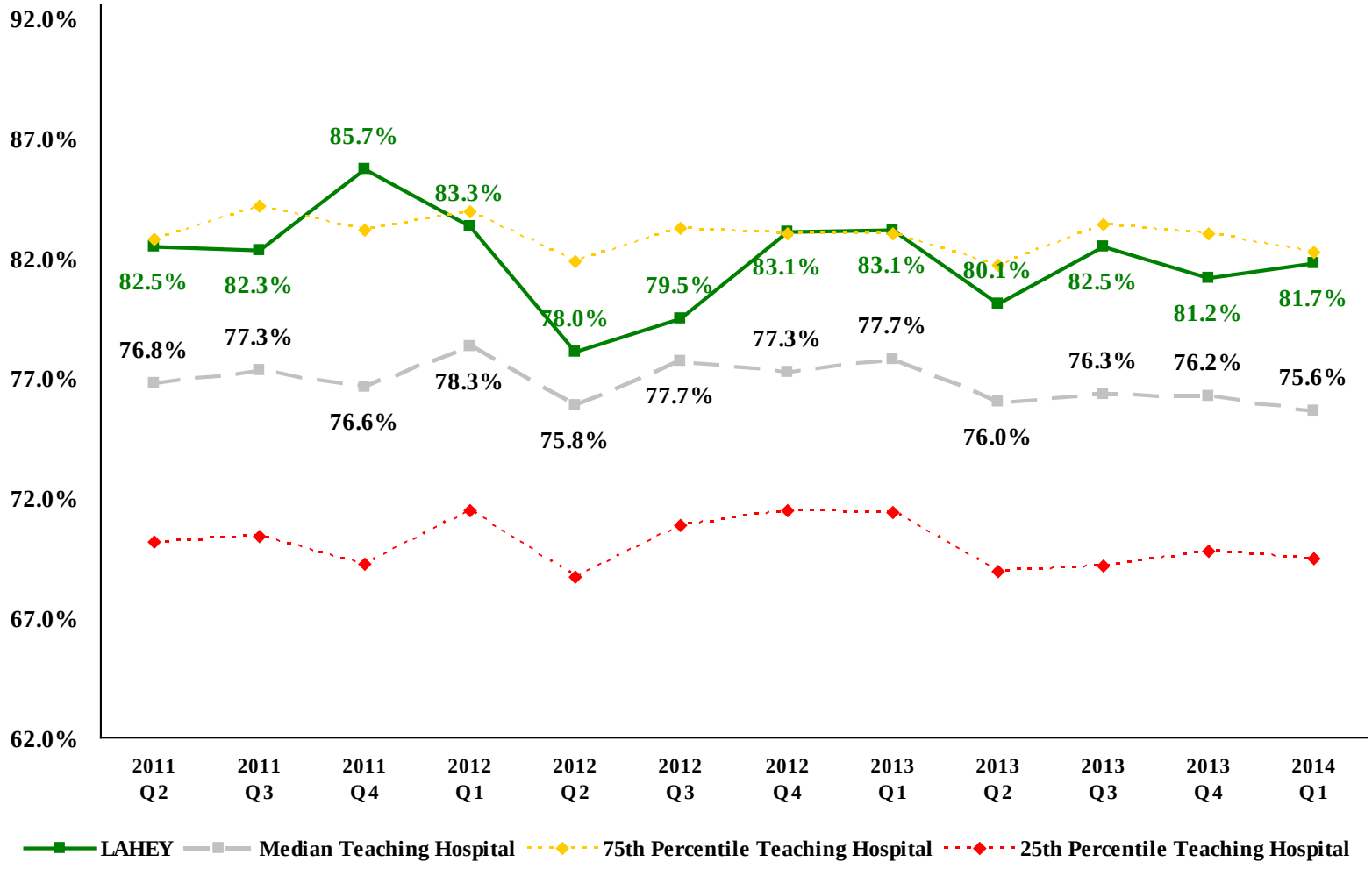
- **Quarterly Growth Rate: 0.4%**
- **Annualized Growth Rate: 1.6%**
- **Q1 2014 Variation from Median: 8.6%**
- **12Q Avg. Variation from Median: 8.7%**

Lahey Health

Source: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance, distributed in July 2014, data through March 31, 2014
Note: Valid n varies from 141 to 161. Overall Hospital Case Mix Index = Overall Hospital Case Mix Index.

Occupancy Rate:

Benchmarked against Median Teaching Hospital: Twelve Most Recent Quarters



Source: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance, distributed in July 2014, data through March 31, 2014. Note: Valid n varies from 141 to 161. Quarterly Occupancy Rate = (Total Patient Days / ((365/4) * Total Staffed Beds)) * 100.

Beverly and Addison Gilbert Hospitals
Medical/Surgical, Maternity and Observation Admissions
FY2011 - FY2014

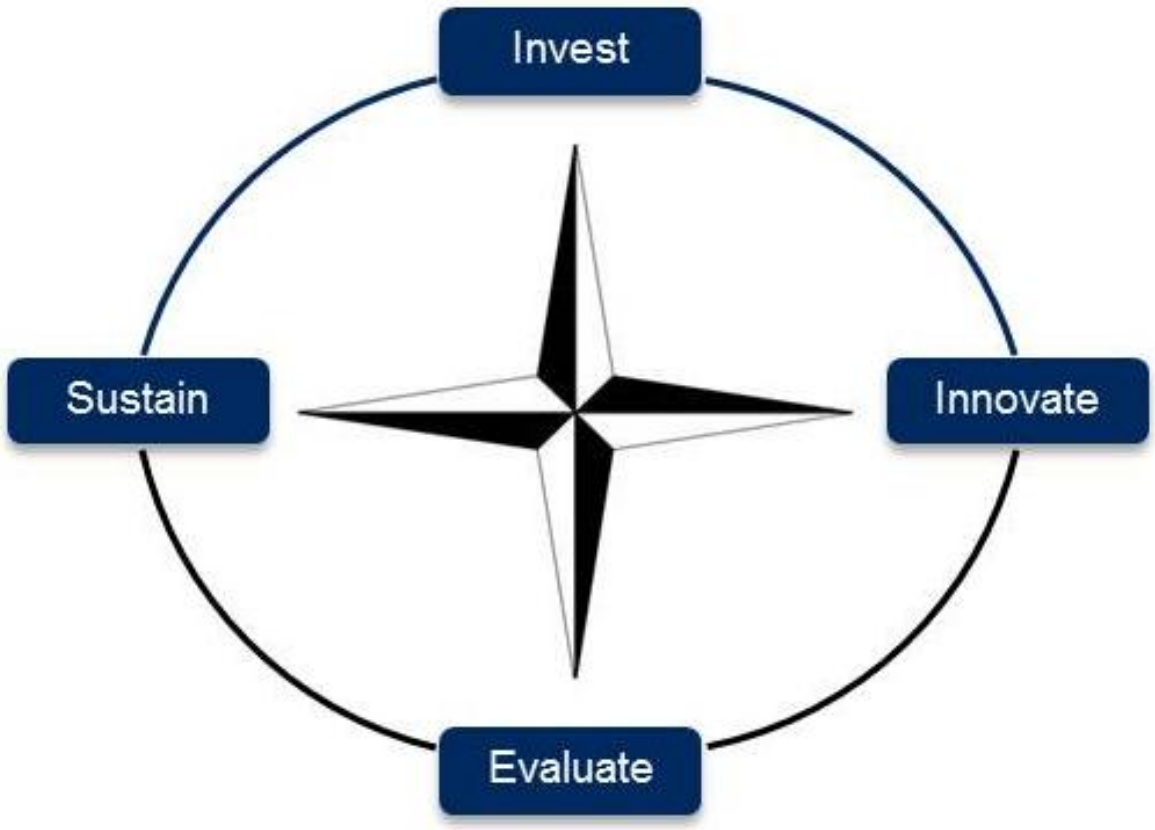
	FY11	FY12	FY13	FY14	Change
Oct	1,561	1,598	1,740	1,783	14%
Nov	1,506	1,524	1,585	1,741	16%
Dec	1,556	1,603	1,698	1,760	13%
Jan	1,527	1,685	1,777	1,823	19%
Feb	1,484	1,616	1,574	1,701	15%
Mar	1,710	1,774	1,657	1,845	8%
Apr	1,632	1,584	1,656	1,982	21%
May	1,630	1,631	1,761	1,850	13%
Jun	1,597	1,676	1,680	1,806	13%
Jul	1,545	1,664	1,817	1,950	26%
Aug	1,563	1,711	1,752	1,907	22%
Sep	1,535	1,639	1,627	*1,630*	6%
Total	**18,846**	**19,705**	**20,324**	**21,778**	**16%**
Annual % Change		**5%**	**3%**	**7%**	

Note: *Projected*

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION, & TRANSFORMATION INVESTMENTS

CHARTING A COURSE FOR THE RIGHT CARE AT THE RIGHT TIME IN THE RIGHT PLACE



HPC-CHART-002
ATTACHMENT B, EXHIBIT 1:
PROSPECTUS TEMPLATE

CHART Phase 2 Proposal Prerequisite: Prospectus

1. CHART Hospital Name(s)

Addison-Gilbert Hospital, Beverly Hospital, Winchester Hospital have confirmed joint participation in this project. In addition, we are in discussions to also include Lowell General Hospital, Lawrence General Hospital and Merrimack Valley Hospital in the ED and possibly other project components.

2. Investment Director(s)

Clinical: Barry Ginsberg, MD Chief of Psychiatry, Beverly Hospital
85 Herrick St, Beverly, MA 01915
Phone: 781-477-6964
Fax: 781-477-6967
Administrative Assistant Deborah Krinsky, dkrinsky@nhs-healthlink.org

Dr. Ginsberg is the Administrative Director and Chief of the Department of Psychiatry at Beverly Hospital and the Medical Director of BayRidge Hospital, a division of Beverly Hospital. He is certified by the American Board of Psychiatry and Neurology in both psychiatry and psychosomatic medicine, and is a distinguished life fellow of the American Psychiatric Association. He completed residency training at the Massachusetts Mental Health Center and Peter Bent Brigham Hospitals, and fellowship training at Tufts in both consultation-liaison psychiatry and psychotherapy. He was an academic consultation-liaison psychiatrist at the University of Massachusetts Medical Center and Mt. Sinai Medical Center and has been a clinical administrator in behavioral health systems since 1993. He initiated and now is the Director of the outpatient Center for Transcranial Magnetic Stimulation at Lahey Outpatient Center, Danvers. He also directs the medical student teaching program at BayRidge Hospital and is an assistant professor of psychiatry at Boston University School of Medicine, from which he received his first voluntary faculty award in 2009.

Operational: Kevin Norton, MS, MBA
Chief Executive Officer, Lahey Health Behavioral Services, Beverly Hospital
Lahey Health Behavioral Services, a division of Beverly Hospital
Zero Centennial Drive
Peabody, MA 01960
Tel: 978-968-1701
Administrative Assistant: Cheryle Feugill -- Cfeugill@nebhealth.org

Kevin has worked in the Behavioral Health field for the past 21 years. He began as a clinician working in a residential addictions program and progressed into a leadership role 17 years ago. In his career he has grown the Behavioral Health Services division at Beverly Hospital, from $5 million annual revenue to over $90 million revenue, focusing on quality care and the latest evidenced-based interventions. Since the merger with Lahey Health, Kevin has worked with his Diad partner Mary Anna Sullivan, MD to begin the process of breaking down the silos within behavioral health while simultaneously exploring avenues for integration across the healthcare continuum, with the goal of treating the entire person in the right location, at the right time, and in the most effective manner.

1. Executive Summary

Three Lahey Health community hospitals—Addison-Gilbert, Beverly and Winchester hospital, in cooperation with Lowell General Hospital and other CHART eligible hospitals, seek approximately $9 million to implement an $12 million project to create a novel model of truly integrated care that will carry across the patient lifespan. It is recognized that behavioral health (BH) and substance use conditions are major drivers of health care costs and the health of the population. Patients with comorbid BH and chronic medical conditions in Massachusetts have been found (HPC Cost Trends Report) to incur at least 2 to 2.5 times the cost as those patients without any comorbid BH conditions. Several nationwide demonstration projects have shown remarkable reductions in total medical expense with better, earlier BH and Substance Use Disorders (SUD) care. We are proposing an integrated approach to patients with BH and SUD conditions, across the continuum, to improve care, lower

overall costs, and improve patient engagement. We propose a four-pronged approach: (a) to improve the integrated care in the medical home, by embedding BH specialists in those practices most closely affiliated with our CHART hospitals; (b) To embed 24/7 BH specialists in each emergency department (ED) to screen all patients and make appropriate referrals and to follow-up with BH patients after discharge from the ED; (c) Improve acute and "intermediate" care for patients who currently have no other option than the ED for crisis interventions and wrap-around services; and (d) To develop a centralized triage function with access for all EDs and pilot primary care practices, for a more streamlined referral and handover process for patients who need to transfer to more appropriate settings for the right care at the right time and at the most efficient cost point.

By integrating behavioral health services into hospital and primary care at several points in the community-based care continuum, we believe we will be able to develop a successful integrated model of care that will improve quality, increase patient satisfaction, and contain costs for all patients who fall into this patient population. In addition, this project dovetails well with other state and federal initiatives to tame healthcare cost growth in that we believe that by integrating behavioral health into hospital, primary care, and the community will be more cost effective for payors, as well as beneficial for patients.

a. **Primary Aim(s)**

b. ☒ Maximize Appropriate Hospital Utilization

c. ☒ Enhance Behavioral Health Care

d. ☒ Improve Hospital-wide or System-wide Processes to Reduce Waste and Improve Quality and Safety

2. Aim Statement

We aim to improve the quality and safety of care at our participating CHART community hospitals and throughout the communities they serve, across the care continuum, by truly merging behavioral and physical health care into one patient-centered paradigm, while also improving system-wide processes and reducing waste across the health care continuum, which we believe will improve efficiency, reduce waste, and improve patient health care quality and patient safety.

3. Community, Safety or Hospital Efficiency need(s) this project will address

1. Attend to patient behavioral health needs in multiple environments, including urgent, emergent, home, and in the community;
2. Improve efficiencies, through shared technologies;
3. Disseminate one integrated behavioral health-healthcare model across three CHART hospitals;
4. Improve patient safety and preventative healthcare practices through screening programs, such as motivational interviewing techniques, depression and anxiety screening, alcohol and drug screening, etc.;
5. Improved access to care, leading to better health and health maintenance;
6. Increased care coordination across the care continuum;
7. Improved patient-centered care across the health care continuum.

4. Target Population(s), Relevant Hospital Service Line(s), and/or Business Unit(s)

Target Population: We will target all patients with alcohol and/or substance use and behavioral health problems that present at any of our participating hospital emergency rooms and/or intersect with the services provided under this project at any location the project encompasses.

Estimated Business Units to participate in projects: The participating joint hospitals, three of which are part of the Lahey Health system, will engage several of Lahey Health's business units in this project, including, but not limited to, the Business Development, Finance, Behavioral Health, Senior Care, Information Technology, Community Engagement, and its affiliate skilled nursing facilities and drug rehabilitation centers, surrounding the participating hospitals.

5. Proposed Initiative(s)

This project model will integrate behavioral health into hospital care and throughout the community. Beginning in the Emergency Department, we will provide 24/7 behavioral health screenings and crisis stabilization. We will

also offer ED diversion through crisis teams, crisis stabilization settings, and mobile outreach. We will also support urgent care needs of patients through a centralized triage system. Finally, we will pilot the integration of behavioral health into the primary care setting to determine best practices beyond this project period. More specific details are outlined below.

a) **Emergency and Urgent Services:** i) All patients presenting to the Emergency Department will be screened for psychiatric and substance use disorders using brief questionnaires; those whose screens are positive will be assessed by a behavioral health clinician in the E.D. The results of that assessment will be integrated into the Emergency Department physician's treatment plan and disposition. ii) We will create an urgent care behavioral health crisis triage stabilization unit that, in conjunction with Lahey Health Behavioral Services' extant crisis stabilization services, will reduce psychiatric inpatient admissions by providing a rapidly accessible, enhanced outpatient alternative (see c. below); iii) We will create an integrated behavioral health placement service, which will have access to the full spectrum of LHBS inpatient and outpatient services. This service will insure that the patients needing the most intensive inpatient care receive that care in the most appropriate setting among the large array of LHBS inpatient services, including general psychiatric and detoxification units as well as specialty units for the psychiatric and medically ill, psychotic disorders, affective disorders and dual diagnosis, senior adult and contracted child services; those patients with less severe conditions are quickly connected with the appropriate outpatient, day program or other wrap-around service in a user-friendly manner.

b) **In the Community:** The fee-for-service payment system has resulted in varying payer-specific arrays of community-based services, the most robust of which are within managed Medicaid insurance networks. LHBS has been a leader in providing such services, including designated crisis teams, crisis stabilization beds, and various community-based wraparound services for children and families. These services have NOT been available across all payors, resulting in "stuck" cases in EDs and fragmented care. Through this program we will explore ways to bridge behavioral care across the continuum providing additional psychiatric oversight and presence in these services, better integrate them with primary care, and augment our urgent care program, by establishing a telephone-linked care program that regularly "checks in" with patients and makes possible seamless, longitudinal care. By enabling LHBS to provide these services regardless of insurer, we will demonstrate their viability as cost-effective strategies in a commercially insured population.

c) **In the Primary Care setting:** We recognize that change cannot occur in a vacuum and that behavioral health integration must occur across the healthcare continuum to be truly cost effective. To this end, we will continue to pilot a behavioral health-primary care integration model to develop an evidence base for the benefits of true behavioral health in a primary care setting. In the expanded pilot, we will station Behavioral Health (BH) specialists in select primary care practices which care for patients in the communities served by the three hospitals, to screen and treat patients before their BH conditions worsen, saving valuable time for the PCPs and offering better, integrated, more cost-effective care earlier. Multiple models (e.g., Intermountain, IMPACT) have proven better care at significantly lower total medical expense, in large part through avoided emergency room visits and medical admissions. Embedded BH specialists become valuable and equal members of the medical-home team, assist with motivational interviewing, screen for BH and SUD's, and follow patients with BH/SU diagnoses, among other tasks. The proposed initiatives in this project are all linked through the integration of behavioral health into a patient-centered approach to healthcare. Depending on the needs of the patient, we will employ the appropriate initiative(s) to care for the whole patient (mentally and physically). Note that all our initiatives proposed in this project will contribute toward integrating behavioral health into the care model, (e.g., SBIRT, Motivational Interviewing, training and education on medication management, behavioral change for chronic medical conditions, etc.).

6. Key Quantifiable Outcomes and Process Metrics

Key quantifiable outcomes will include, but not be limited to: (a) reduction in 30-day all-cause hospital readmission rates; (b) reduction in ED visits, compared to the year prior; (c) depression score reductions, as self-reported by patients; (d) increase in medication adherence among patients; (e) chronic disease self-management

increases over six months, compared to one year prior.
Some process metrics include: (a) number of patients served in the ED, participating PCP offices and at home by this program; (b) number of patients and families trained on medication adherence, number of SBIRT interviews; (c) number of motivational interviews, and adherence to time-task chart and budget.
All program activities will be monitored by a professional monitoring and evaluation specialist and data will be regularly collected and analyzed. Our hope is to demonstrate the value of this integration in improving care and reducing costs to all payers, thereby ensuring sustainability beyond the grant period.

7. Key Staff

Key staff members on this project include the Investment Directors, a Project Director, Data Analyst(s), Biostatistician, Monitor(s), Grant Administrator/Manager, Community Relations Specialist, Business Development Manager, Psychiatrists, Pharmacists, and Behavioral Health Specialists and coordinators from each participating community hospital.

8. Community Partnerships

Participating joint hospitals will engage with the communities they serve, including the school and municipal systems (e.g., police and fire departments). Lahey Health Behavioral Services as the main partner to this application already provides emergency psychiatric services at Lowell General Hospital, Lawrence General Hospital, Merrimack Valley, North Shore Medical Center, and Anna Jacques Hospital. We will continue to explore enhancing these emergency services in these settings under this project. In addition, we will engage with our multiple community partners in this project, including rehabilitation units, senior centers, visiting nurse associations, religious institutions, and others. We will also engage and collaborate with members of the active patient and family advisory councils at each participating hospital as well as the Human Rights Committee at BayRidge Hospital, a subsidiary of Beverly Hospital.

9. Subcontractor Hospitals

N/A

10. Enabling Technologies

We will ensure that all three hospitals are up and running on the MA HIway, as required under this grant. Other enabling technologies to be used include a new Electronic Health Record module for Behavioral Health patient records, called Netsmart which will be compatible with Lahey Health's new EPIC Electronic Health Record system, being implemented at Addison Gilbert, Beverly, and Winchester Hospitals over the next two years. In addition, system tools to be contributed toward this project include data evaluation, analysis, project monitoring, grants administration and business development strategy consultation for the Lahey Health system hospitals.

11. Estimated HPC CHART Funding Request (2 years)

☐ <$1M ☐ $1M ☐ $2M ☐ $3M ☐ $4M ☐ $5M ☐ $6M ☒ >$6M _$9 million, with an approximate $3 million contribution from each Lahey Health affiliate hospital member._____

12. Estimated Total Budget (2 years)

☐ <$1M ☐ $1M ☐ $2M ☐ $3M ☐ $4M ☐ $5M ☐ $6M ☒ >$6M _Approximately_$12 million_____

13. Budget Plan

The $9 million in Investment Funds will be used for staffing, training, contracted services and general operating costs to provide services in the Emergency Departments, Primary Care settings and throughout the communities served by participating joint hospital members. Funds will also be used for enabling technologies such as the Mass HIway, a centralized triage system, behavioral health EHR for improved communication across the continuum. More specifically, we anticipate spending approximately $5 million in direct service staff for our four-pronged approach. In kind contributions include personnel costs of senior leaders throughout the system, including members of the accountable care organization and at each hospital. We also anticipate providing in-kind contributions for performance improvement, performance measurement, data analysis, finance, pharmacy,

Information technology, and business development.

14. Strategic Planning

This project in itself is one of the key components of the strategic plan of Lahey Health, the parent ACO affiliated with three of the four participating joint hospitals. Behavioral-physical healthcare integration is the core of quality care-- treating patients holistically. Some key strategic initiatives under this project include:

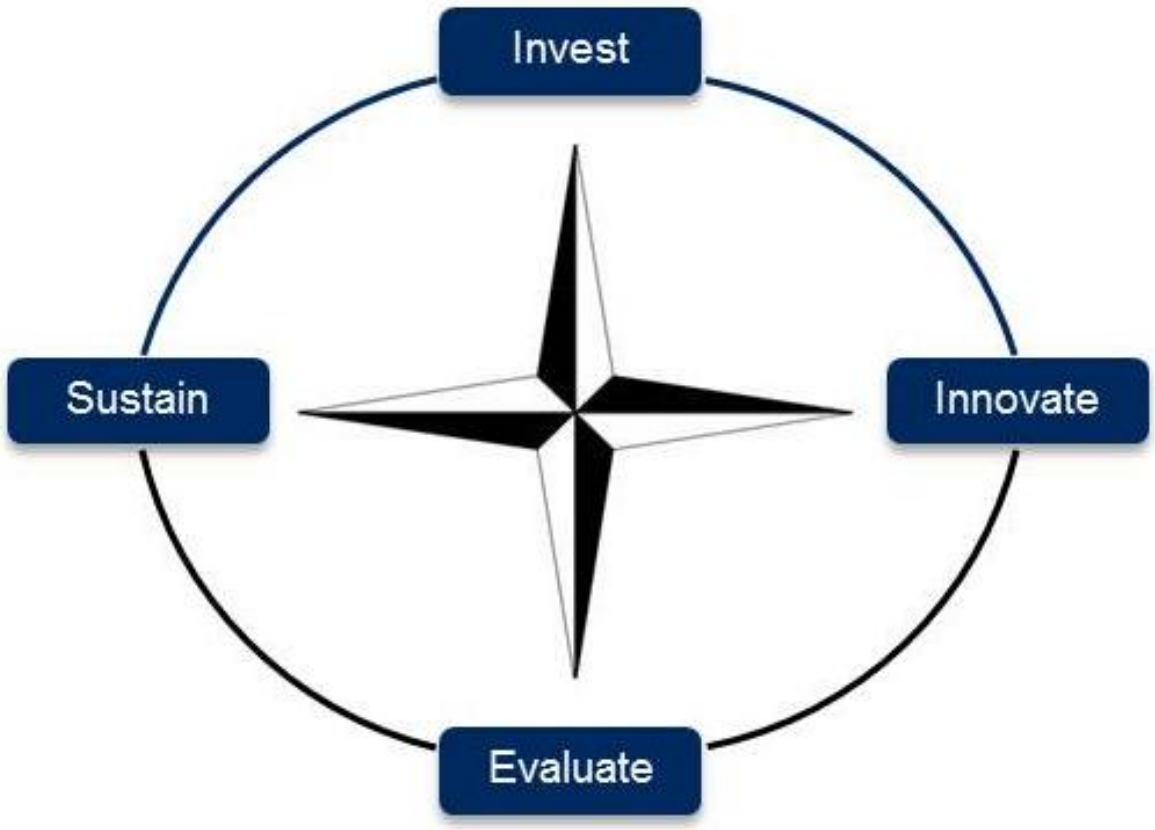
a. What can we learn from our communities and how can we integrate that learning into more holistic care at each community hospital in a meaningful, cost effective, and high-quality manner?
b. How will the integration of behavioral health into the community hospital setting and across the care continuum help lower the cost of healthcare?
c. What BH services do patients want most and how can we provide the highest quality services to them at the right time, when they need it?
d. How will we improve the quality of care through the integration of BH services?

0

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION, & TRANSFORMATION INVESTMENTS

CHARTING A COURSE FOR THE RIGHT CARE AT THE RIGHT TIME IN THE RIGHT PLACE



HPC-CHART-002
ATTACHMENT B, EXHIBIT 1:
PROSPECTUS TEMPLATE

1. CHART Hospital Name(s)

Winchester Hospital

2. Investment Director(s)

Clinical Investment Director:
Richard J. Mazandi Iseke, MD
Vice President, Medical Affairs, Chief Medical Officer, Winchester Hospital
E-mail: riseke@winhosp.org
Phone: 781-756-4776
Fax: 781-756-2923
Assistant: Stephanie Wall, swall@winhosp.org, 781-756-2128
Role/Qualifications: Dr. Iseke has been VP for Medical Affairs and CMO at WH since 2007. He is a physician executive with more than 32 years of clinical and leadership experience. Board certified in internal medicine and emergency medicine, Dr. Iseke is a fellow of the American College of Emergency Physicians and a member of the American College of Physician Executives and the Massachusetts Medical Society.

Operational Investment Director:
Kathy A. Schuler, MS, RN, NE-BC
Vice President, Patient Care Services, Chief Nursing Officer, Winchester Hospital
E-mail: kschuler@winhosp.org
Phone: 781-756-2127
Fax: 781-756-2923
Assistant: Bonnie Harding, bharding@winhosp.org, 781-756-2216
Role/Qualifications: Kathy Schuler has been VP of Patient Services and CNO at WH since 2006, following three years as Director of Emergency Services. Ms. Schuler has held patient care and leadership positions on a medical surgical unit, in an intensive care unit, as a clinical nurse specialist, and as a nursing educator and trainer. Ms. Schuler has also served as the President of the Organization of Nurse Leaders of Massachusetts and Rhode Island.

3. Executive Summary

30-day readmission rates have long been recognized as a breakdown point in both quality and patient safety, keystones of successful hospital care. An article in The Commonwealth Fund's April 2014 e-newsletter reporting on its study of readmission rates across the United States stated, "Readmission to the hospital shortly after discharge has been recognized as an indicator of poor health system coordination."[i] This proposal will focus on improving health care coordination, both within the care team and across the care continuum, to reduce readmission rates at Winchester Hospital.

In FY13, Winchester Hospital (WH) discharged an estimated 9,870 medical surgical patients age > 21 years (excluding Obstetrics/Maternity and Pediatrics). An estimated 976 (9.9 %) of these patients were readmitted to inpatient care within 30 days of discharge. These numbers represent the high-risk, complex care patients who will benefit from the initiatives described in Section 8.

Winchester Hospital's source of readmissions are as follows:

- Home - 50%
- SNF - 27%
- Home with Services - 22%
- Rehab - 1%

Winchester Hospital seeks to reduce unnecessary and avoidable hospital readmissions for all adult medical surgical patients age > 21 years (excluding Obstetrics/Maternity and Pediatrics). The hospital recognizes that to reduce readmissions requires extending health and social services beyond the walls of the institution. Patients are vulnerable when care is fragmented as they transition from the hospital to post-acute facilities and/or the community.

The most common opportunities for reducing readmissions are:

- Continuing to enhance efforts around identifying and referring patients appropriate for end- of- life services (palliative care and hospice services).
- Improving medication reconciliation and education to ensure adherence.
- Enhancing adherence to health care recommendations and life style choices.
- Improving communication across the continuum, including PCP, SNF, Home Care, Hospice, Community Care Management and Behavioral Health providers.
- Creating a comprehensive care plan that translates across the continuum, including PCP, SNF, Home Care, Hospice, Community Care Management and Behavioral Health providers.
- Identifying, assuring, and partnering with patients so they are discharged to the appropriate next level of care.
- Supporting family caregivers to navigate the health care system.
- Using an assessment tool to identify risk, address care needs and plan patient specific interventions.
- Identifying subtle declines in clinical status of home care patients to mitigate exacerbation and reduce use of emergent care and acute care hospitalization.

To address the opportunities stated above, WH proposes the following care initiatives:

- To build a dedicated multidisciplinary care team that includes nurses, nurse practitioners, physicians, pharmacists, and social workers to ensure our most complex patients are identified and a cohesive, comprehensive, and viable care plan is developed and carried through across the continuum.
- To work with patients and patients' families during hospitalization and sustaining that relationship after discharge whether the patient transitions to the community, to the Winchester Hospital Home Care (WHHC), another home care agency, post-acute/skilled nursing facility, or acute rehabilitation facility. A key component of sustaining the relationship is to ensure complete and accurate information exchange with other providers, including use of both the hospital HIE and Mass HiWay to enhance continuity of care.
- To utilize enabling technology (Telehealth) to allow WHHC to monitor the most vulnerable patients and to identify a change in health status in advance of a need for an ED visit or hospitalization.
- To extend pharmacy oversight beyond hospital discharge to address the challenges of high-risk medications and poly pharmaceuticals including sharing essential pharmaceutical information with PCPs and post-acute facilities and providers.

4. Primary Aim(s)

a. ☒Maximize Appropriate Hospital Utilization

b. ☐ Enhance Behavioral Health Care

c. ☒ Improve Hospital-wide or System-wide Processes to Reduce Waste and Improve Quality and Safety

5. Aim Statement

By February 1, 2017, reduce avoidable hospital adult (>21 years) medical surgical inpatient readmission rate by 15%.

6. Community, Safety or Hospital Efficiency need(s) this project will address

Identified needs to be addressed by this project include:

- Improved coordination of appropriate patients to end-of- life services (palliative care and hospice services)
- Improved medication reconciliation and education to ensure adherence
- Enhanced adherence to health care and life style choices recommendations
- Improved communication across the continuum, including PCP, SNF, Home Care, Hospice, Community Care Management and Behavioral Health providers
- Improved comprehensive care plans that translate across the continuum, including PCP, SNF, Home Care, Hospice, Community Care Management and Behavioral Health providers
- Improved assessment of patients so they are discharged to the appropriate next level of care.

- Family care giver support to navigate the health care system
- An assessment tool to identify risk, address care needs and plan patient specific intervention
- Enabling technology (Telehealth monitors) to allow early identification of subtle and potentially problematic changes in health status resulting in an ED visit and/or inpatient admission.
- Fragmentation of services
- Integration of patient specific interventions into the electronic health record

7. Target Population(s), Relevant Hospital Service Line(s), and/or Business Unit(s

We will target high-risk medical surgical patients, over age 21. Approximately 66% of the adult medical surgical inpatient population is estimated to be high risk.

8. Proposed Initiative(s)

During the proposed two year period of performance, we plan to implement the following three initiatives:

1. **Inpatient Complex Care Team:** Design, create and implement a dedicated multidisciplinary complex care team for the most at risk patients.
2. **Community Care Management:** Building off the success of CHART I, enroll high-risk patients into care management upon admission. Assure an effective and safe discharge plan and where indicated follow the patient to the SNF and home. Care will include hospital visits, home visits, SNF visits, and follow-up appointments with PCP visits. Included is interaction with the patient, family members, inpatient case managers, home care providers, SNF discharge planners, PCPs and others.
3. **Home Health Telehealth:** Utilize enabling technology to allow WH Home Care to monitor the most vulnerable patients to identify a change in health status in advance of a need for an ED visit or hospitalization.

Across these three initiatives, we will be deploying the use of both the hospital HIE and Mass HiWay to enhance continuity of care.

9. Key Quantifiable Outcomes and Process Metrics

For the cohort of medical surgical patients over the age of 21 years, the metrics that will be collected and analyzed will include, but are not limited to the following (also excluded will be patients discharged to WH hospice care and patients who die in hospital):

Outcome Metrics:

- Readmission rate
- Acute care hospitalization rate for home health patients
- Emergent care rate for home health patients

Process Metrics:

- Number of patients enrolled in each initiative: complex care team management, care management, and home health Telehealth.
- Number of pharmacy consults
- Number of palliative care consults
- Number of hospice consults
- Number of patients evaluated within 24 hours by complex care team
- Number of care management contacts with patients, providers and care givers
- Number of admitted patients screened with high-risk tool
- Number of patients utilizing Telehealth
- Number of interventions based on Telehealth alerts

10. Key Staff

Clinical Investment Director
Initiative Leadership Team (Clinical Directors)

Finance Staff
Finance Investment Director
Health Information Exchange (HIE) Director
HIE Staff
Information System (IS) Staff
Nursing Informatics/ IS Consultant
Clinical Staff (RNs, Clinical Nurse Specialists, Nurse Case Managers, Pharmacist, MD/NP, Social Worker)
Operational Investment Director
Project Assistant
Project Manager
Quality Care Associate
Quality Manager
Quality Staff

11. Community Partnerships

Winchester Hospital (WH) will engage with behavioral health providers, post-acute care providers, and community service organizations in the 25 communities in its primary and secondary service areas. These community partnerships include, but are not limited to the following:

- Winchester Nursing Center, Winchester
- Aberjona Nursing Center, Winchester
- Woburn Nursing Center, Woburn
- Woodbriar Nursing Center, Wilmington
- Bearhill Nursing Center, Stoneham
- Glenridge Nursing Center, Malden
- Wingate Nursing Center, Reading
- Wilmington Health Care, Wilmington
- New England Rehabilitation Hospital, Woburn, MA
- Mystic Valley Elder Services, Malden, MA
- Minuteman Senior Services, Burlington, MA
- Care Dimensions Hospice and Palliative Care, Danvers, MA
- Tewksbury State Hospital, Tewksbury, MA

12. Subcontractor Hospitals

None

13. Enabling Technologies

Enabling technologies include:

- Winchester Hospital Health Information Exchange (HIE) to increase communication between the hospital, primary care physicians, specialty physicians, skilled nursing facilities, and rehabilitation hospitals.
- Mass Highway for communication with community partners
- Patient portal for patients and families to access personal health information.
- Telehealth monitoring of Winchester Hospital Home Care patients deemed to be at risk for a change in health status that could lead to a preventable ED visit and/or hospital readmission.

14. Estimated HPC CHART Funding Request (2 years) ☐ <$1M ☐ $1M ☐ $2M ☒ $3M ☐ $4M ☐ $5M ☐ $6M ☐ >$6M _____

15. Estimated Total Budget (2 years)

☐ <$1M ☐ $1M ☐ $2M ☐ $3M ☐ $4M ☐ $5M ☐$6M ☒>$6M $6.2

16. Budget Plan.

The total budget for the CHART 2 initiative is $6.2 million. Of the $6.2 million budget, $3.2 million (51%) is in kind contribution by Winchester Hospital and $3 million is our grant request. Eighty two percent (82%) of the budget will be used to fund human resources and training, 7% for IT Infrastructure, 5% for IT consulting, and 6% (in-kind) for capital build out to accommodate the new staff.

The majority of the human resources needed to implement the initiatives are comprised of clinical staff (RNs, Social Workers, NPs, and Pharmacists) at 64% of the salary budget. The human resources needed to oversee and manage the initiatives include executive-level support (e.g., clinical, finance, and operational investment directors) at 15% of the salary budget and management support (initiative directors, project manager and project assistant) at 13% of the salary budget. In addition, support from information systems, quality and finance will be needed to provide the infrastructure needed to implement the initiatives as well as report on the progress. The IT support is 5% of the salary budget and quality/finance support accounts for 3% of the salary budget. An additional expense to support the extensive amount of information systems resources needed is a consultant at 5% of the overall budget. Fifty seven percent (57%) of the staff needed would be new staff and 43% would be existing (in-kind contribution) staff.

In addition to the hospital in-kind contributions, Lahey Health, our system partner, will establish an executive steering committee to provide system-wide advice, leadership, and feedback on our project, as requested by each member hospital. Members will include senior level executives from Lahey Health's departments of Quality Improvement and Patient Safety, Finance, Primary Care, Behavioral Health, and the ACO. The committee will convene quarterly.

17. Strategic Planning

Winchester Hospital as a member of Lahey Health is committed to providing high quality, low cost care in the appropriate setting.

Winchester Hospital aims to utilize the CHART 2 investment monies to maximize appropriate hospital use by transforming the delivery of health care services from an historical focus on treating patients in an acute care setting to an integrated care delivery model, maximizing care across the continuum and in the community.

As we strive for change and improvement, we anticipate that the existing hospital structures and services will also evolve and change. A few key questions we will ask that pertain to strategic planning during this ongoing change process include:

- Do our new patient-centered services match the patient population needs of the community?
- What will be the appropriate mix of inpatient and outpatient services provided by the hospital?
- How can we represent the patient's perspective in our care management plan?
- How can we sustain the model of low readmission rates after the project end period?
- What efforts must we make to truly engage key stakeholders (i.e., providers, staff, patients, community based organization, etc) to successfully transition to a new care and payment model that will contain costs, improve health and raise patient satisfaction levels in a sustainable manner?
- What process and program evaluation metrics need to be applied to this new model of care for successful sustainability?

[i] http://www.commonwealthfund.org/publications/in-the-literature/2014/apr/community-factors-and-hospital-readmission-rates

Lahey Health Initiatives to Integrate Physical and Behavioral Health Care Services

Lahey Health and its member enties are currently underway on several initiatives with multiple provider and community partners to better integrate physician and behavioral health care services, including:

(A1) In 2013, we launched a primary care-behavioral health integration program across four of our Lahey Health primacy care sites in Arlington, Burlington, Ipswich, and Peabody. At these sites, we have embedded behavioral health specialists who conduct PHQ-9 and Cage-Aid screening for depression and substance use. All new patients and all patients getting their annual physical examinations now receive these screenings. In the past year, 600+ patients with challenging medical and psychiatric co-morbidities have been screened.

(A2) We are anticipating funding of a $250,000 grant which would fund an educational and train-the-trainer-styled program in which staff at one of our largest behavioral health sites will become more involved in coaching psychiatric outpatients in self-managing their (patients') chronic physical conditions. Staff will receive 8 weeks of training, including how to teach their behavioral health patients a number of skills, including effective self-management; how to form stronger 'partnerships' with their medical providers; how to use brief interventions to assist behavioral health outpatients to better manage common physical symptoms of insomnia, pain, and fatigue; and how to better coordinate their treatment efforts with those of patients' primary care and specialty medical providers. This grant will allow for an initial pilot program in which we train 50-60 of our behavioral health providers. Long-term, we will extend this initial pilot across most or all of our behavioral health sites.

(A3) The health promotion advocate or s/a liaison in Addison Gilbert Hospital's Emergency Department. Gloucester has consistently shown a higher than state rate opioid use and overdose rate, so the health promotion program is targeted at substance abuse patients who come to the ER for care. The liaison works to get these patients into post-ER or longer-term behavioral health treatment or referrals.

(A4) Community Services Program: Helps mental health and s/a patients to get transportation, care coordination between healthcare providers, housing applications, social services. Works with chronically co-morbid populations in Essex County.

(A5) The Lahey Community Relations Department is actively constructing a speakers bureau in which s/a and m/h professionals will provide expertise and programming to primary care practices and/or municipal health departments and community groups.

(A6) The psychiatric emergency mobile crisis teams (4), which provides 24/7, face-to-face care to adults and children, serve all towns and cities in the North Shore and the Merrimack Valley (west to Lowell). The mobile crisis teams collaborate with many referral sources, including pediatric practices, local

hospitals, police departments and schools to change the culture around using the ER for child and adult psychiatric crisis. The collaborations include the establishment of formal affiliation business agreements with healthcare organizations within and outside of Lahey Health. These organizations include: Haverhill Pentucket Medical PC practices, especially pediatricians, Lowell General Hospital, Holy Family, Lawrence General, Merrimack Valley, Salem, and Anna Jaques Hospitals. Internally, we collaborate cross-refer with Lahey Medical Center, Peabody, Addison Gilbert, and Beverly Hospitals

Lahey Health Initiatives to Reduce Unnecessary ER Visits and Inpatient Psychiatric Care

(B1) The 24/7 mobile crisis teams (described above) work with adults, families and children who are in psychiatric crisis. The teams work with patients in their communities, in the schools, or in the Emergency Services clinics (4). Many of these clients are families or individuals with multiple and complex mental and physical health issues, and some live in areas of high-population immigrant communities in which the presenting psychiatric or behavioral condition is sometimes somatic (of underlying physical health problems) or is self-reported in the culturally more acceptable symptoms of physical, not mental health.

Statistics: From June 2013 – May 2014, 70.8% of all children assessed or visited by the mobile crisis team in greater Lawrence were seen in community settings (not the E.R.). This exceeds the state average of 58% and the state target of 60%.

On the North Shore, 30% of adults assessed and/or triaged for psychiatric emergencies were now seen in community settings, not the ER. 62% of children assessed by the team were seen in community settings.

(B2) The Jail Diversion program, in which a Lahey Health Behavioral Services clinician is embedded in the police departments in Danvers, Topsfield, Middleton and Salem to provide appropriate care for those police calls that involve psychiatric-crisis individuals. The clinician also provides police education and helps to connect the person to appropriate mental health care or substance use treatment.

Examples of usage and results: From May to July 2014, at the **Danvers Police Station,** the embedded clinician saw 39 cases; 62% were diverted from the ER to more suitable care for police-involved subjects with mental health or substance use issues. Estimated ER cost savings: $84,000.

From May to July 2014 at the **Salem Police Station**, the Lahey Health clinician was involved in 53 cases, 42% of which were diverted from ER care to more suitable mental health settings. Estimated ER cost savings: $77,000.

(B3) Community Service Agency works with publicly insured families who have one or more child with serious behavioral or mental health issues. The goal of the program is to help families to access multiple levels of care and to keep children in community and home-based settings while giving the families the skills to access services and advocate for their child.

Statistics/numbers of families seen: Haverhill 1,470 families in five years.

Cape Ann/North Shore: 1,400 families (approx.)

(B4) 138 detoxification beds, providing 24/7 admissions and substance-abuse specific care at a lower-cost of care than ER or inpatient beds. The newest detoxification unit, opened in May 2013 (32 beds) was opened to specifically address a verified and growing need for treatment in the Merrimack Valley.

(B5) 18 Crisis stabilization beds providing 5-day care and stabilization for those seen by mobile crisis teams. These patients would otherwise be in an inpatient psychiatric hospital. There are six patients per unit, who receive intensive, 24/7 care management.

(B6) Decreasing psych inpatient care: Two partial hospitalization programs sited within our inpatient psychiatric hospitals in Lynn and Beverly. Both of the partial hospitalization programs offer a viable alternative to inpatient hospitalization and offer same modalities but on an outpatient bases. We also transfer inpatient individuals into these programs as a transition from hospital to the community.

(B7) Our inpatient psychiatric team have created a post-discharge continuing care plan that tracks the percentage of discharged patients who are successfully transferred to the next level of care.

Lahey Health Successes and Challenges in the Integration of Behavioral Health Services

Successes in integration/removal of barriers:

- Emergency Services has worked with addiction treatment services to allocate one detoxification treatment bed specially reserved for emergency psychiatric patients, particularly those exhibiting suicidality. By fast-tracking these emergency, dual-diagnosed patients into a guaranteed, reserved detoxification bed, it increases the likelihood and immediacy of the patient accessing care.
- For certain patients in crisis who need remediation, the mobile crisis teams can provide urgent access to psychopharmacological evaluation and support. These patients can get a psychiatric consult and be prescribed needed medications in a relatively rapid time frame (approximately one week).
- Emergency physicians and administrators are on call across all four mobile crisis teams. This provides consistency of care and instant access to psychiatric or administrative consults.
- Institution of system-wide electronic health record system for Lahey Health acute and primary care and a companion system for community behavioral health. The two systems will be integrate-able and scale-able to enable information sharing, diagnosis, medication tracking of dual-diagnosis and patients with physical and behavioral health issues.

Challenges:

- Technology/sharing of medical records between providers;
- Allocation of time to review/discuss shared complex cases between primary care and behavioral health providers. Even when co-located, the services can become silo-ed.
- Educating primary care providers on behavioral health principles/practices, as physicians or nurse practitioners often have a range of knowledge and comfort with addressing behavioral health in their practices;
- Space allocation in a co-located service;
- Addressing new operational requirements, from scheduling to billing;
- Managing and sustaining behavioral health services over time – what type of clinician will see the patient initially and for follow-up, who carries the patient for management of behavioral health services (BH versus primary care) and for how long.
- Regulatory requirements, including CFR42, Part 2, in which , without patient authorization, sharing information regarding substance abuse treatment cannot occur
- Physical geography and distances, in that sites or clinics are often at a distance from each other
- Physical space or treatment environments. Due to poor or static reimbursement rates for behavioral health services, some of our sites are functional, compliant, but not equal to primary care or specialty practices in terms of aesthetics or geographic accessibility.

Lahey Health

Includes

I. Northeast Health System
    a roll up of;
    Northeast Hospital Corporation
    Northeast Behavioral Health Corporation
    Northeast Senior Health Corporation
    Northeast Medical Practice, Inc.

II. Lahey Hospital & Medical Center
    a roll up of;
    Lahey Clinic Hospital, Inc.
    Lahey Clinic, Inc.

Lahey Health

Health Policy Commission
AGO Exhibit 1 Questions to Providers and Hospitals
Calendar Year 2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 135,094,047	$ 136,081,599	$ 8,587,809	$ 7,853,824	$ 27,608,358	$ -	$ 1,331,068	$ -	$ 1,784,491	$ -	$ 6,002,558	$ -	$ 847,713	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 6,148,262	$ -	$ -	$ -	$ 21,130	$ -	$ 56,178,422	$ 20,386,467	$ 198,805	$ -	$ -
HPHC	$ 69,219,224	$ 29,001,114	$ 499,140	$ 201,691	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,288,356	$ 21,015	$ -	$ -	$ -
Fallon	$ 9,729,744	$ 1,843,401	$ 58,185	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 226,976	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,632,827	$ 14,389,608	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,243,956	$ 12,245,924	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,868,686	$ 17,502,088	$ -	$ -	$ -
Other Commercial	$ 7,353,422	$ -	$ 10,211	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 469,649	$ 54,589,649	$ -	$ -	$ -
Total Commercial	$ 221,396,437	$ 166,926,115	$ 9,155,345	$ 8,055,515	$ 33,756,620	$ -	$ 1,331,068	$ -	$ 1,805,620	$ -	$ 88,911,432	$ 119,134,750	$ 1,046,519	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,783,858	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 22,147,683	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,524,906	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,333,615	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,864,263	$ 1,069,541	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 69,654,325	$ 1,069,541	$ -	$ -	$ -
Mass Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,485,108	$ 35,680,926	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 40,844,237	$ -	$ 825,000	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,038,018	$ 122,530	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 52,268,946	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 254,731	$ 10,397,390	$ -	$ 137,500	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,155,627	$ 685,218	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 58,292,613	$ 63,474,084	$ 825,000	$ 137,500	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 342,520,877	$ -	$ 9,484,294	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,547	$ 57,777,447	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 35,136	$ 7,189,919	$ -	$ 3,980,579	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 62,684	$ 64,967,366	$ -	$ 3,980,579	$ -
GRAND TOTAL	$ 221,396,437	$ 166,926,115	$ 9,155,345	$ 8,055,515	$ 33,756,620	$ -	$ 1,331,068	$ -	$ 1,805,620	$ -	$ 225,406,162	$ 626,847,545	$ 1,871,519	$ 13,602,373	$ -

Lahey Health

Health Policy Commission
AGO Exhibit 1 Questions to Providers and Hospitals
Calendar Year 2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 123,768,830	$ 139,805,797	$ 8,481,705	$ 8,469,927	$ 28,342,495	$ -	$ 912,025	$ -	$ 2,391,573	$ -	$ 4,953,311	$ -	$ 738,920	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 28,480,483	$ -	$ 508,252	$ -	$ 138,336	$ -	$ 35,164,469	$ 20,613,793	$ 268,902	$ -	$ -
HPHC	$ 66,423,970	$ 25,410,805	$ 688,297	$ 190,029	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,219,278	$ 57	$ -	$ -	$ -
Fallon	$ 7,614,926	$ 1,388,116	$ 37,752	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 233,987	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,296,365	$ 18,884,620	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,530,580	$ 14,844,861	$ -	$ -	$ -
Aetna	$ 2,336,004	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 347,121	$ 19,579,887	$ -	$ -	$ -
Other Commercial	$ 6,838,616	$ -	$ 15,048	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 478,318	$ 57,964,638	$ -	$ -	$ -
Total Commercial	$ 206,982,347	$ 166,604,718	$ 9,222,802	$ 8,659,955	$ 56,822,978	$ -	$ 1,420,277	$ -	$ 2,529,908	$ -	$ 74,223,429	$ 131,887,855	$ 1,007,822	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,293,809	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,479,756	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,434,232	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,242,870	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,033,113	$ 1,160,344	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 80,483,781	$ 1,160,344	$ -	$ -	$ -
Mass Health	$ 7,678,860	$ 4,946,769	$ 102,238	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,940,741	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 66,619,301	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,225,327	$ 360,871	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 755,800	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 271,183	$ 11,577,320	$ -	$ 262,007	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,445,705	$ 1,733,316	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 88,561,516	$ 14,427,307	$ -	$ 262,007	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 391,256,099	$ -	$ 7,327,913	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,768	$ 57,832,347	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,765	$ 8,115,342	$ -	$ 3,273,061	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 64,534	$ 65,947,689	$ -	$ 3,273,061	$ -
GRAND TOTAL	$ 214,661,206	$ 171,551,487	$ 9,325,039	$ 8,659,955	$ 56,822,978	$ -	$ 1,420,277	$ -	$ 2,529,908	$ -	$ 243,333,259	$ 634,620,036	$ 1,007,822	$ 10,862,981	$ -

Lahey Health

Health Policy Commission
AGO Exhibit 1 Questions to Providers and Hospitals
Calendar Year 2012

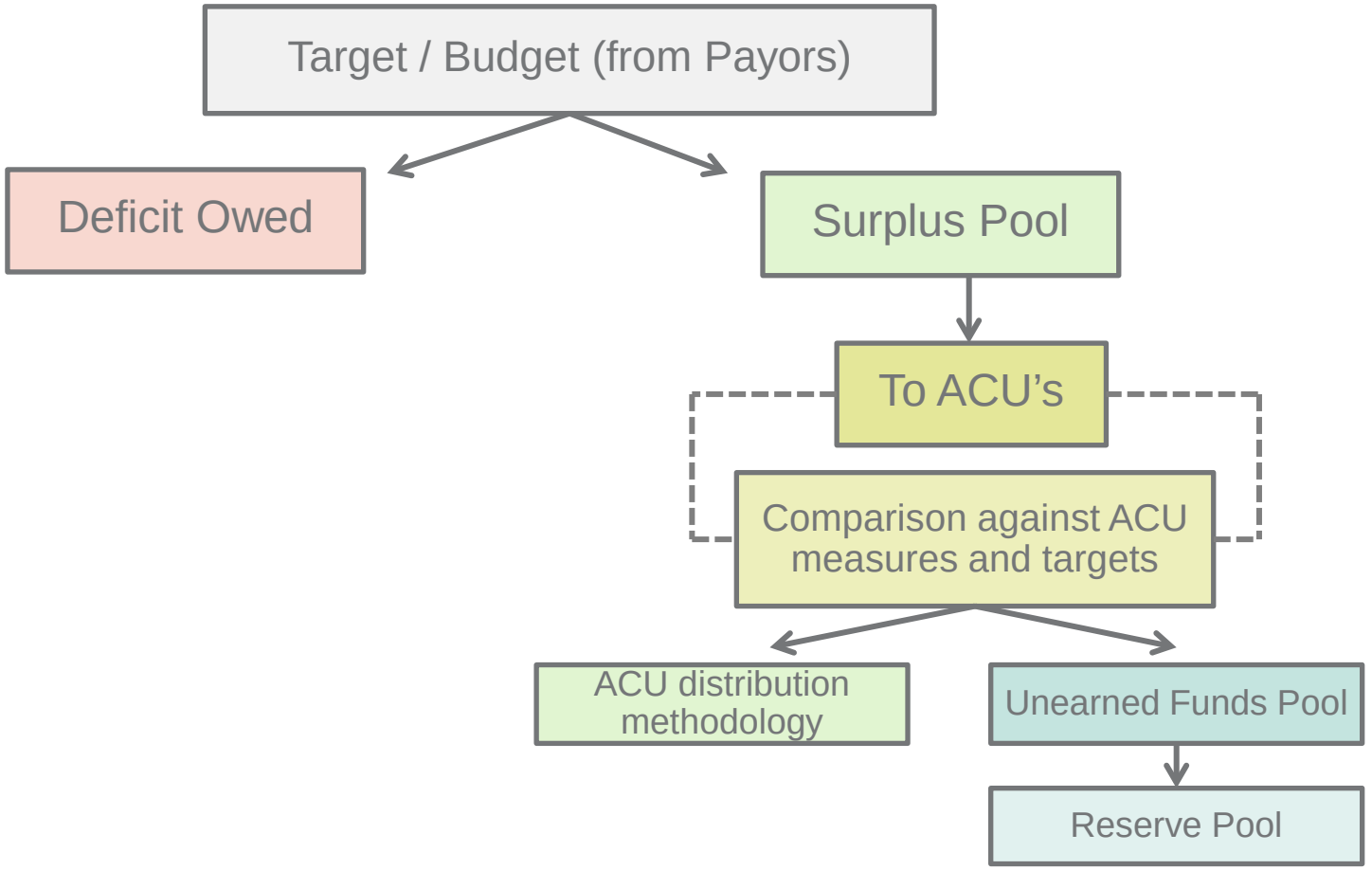
	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 48,287,380	$ 141,955,390	$ 2,399,998	$ 8,525,710	$ 84,121,108	$ -	$ (1,450,219)	$ -	$ 6,323,072	$ -	$ 4,139,909	$ -	$ 552,920	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 25,814,259	$ -	$ 439,793	$ -	$ 103,923	$ -	$ 19,830,759	$ 26,285,754	$ 192,863	$ -	$ -
HPHC	$ 92,239,987	$ 26,060,693	$ 497,916	$ 147,339	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,326,977	$ 42	$ -	$ -	$ -
Fallon	$ 9,075,505	$ 2,011,682	$ 37,301	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 249,513	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,675,762	$ 24,610,276	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,681,038	$ 18,172,791	$ -	$ -	$ -
Aetna	$ 2,346,529	$ -	$ 300,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 226,302	$ 21,608,542	$ -	$ -	$ -
Other Commercial	$ 6,264,682	$ -	$ 13,441	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 528,226	$ 55,959,800	$ -	$ -	$ -
Total Commercial	$ 158,214,082	$ 170,027,765	$ 3,248,656	$ 8,673,049	$ 109,935,367	$ -	$ (1,010,426)	$ -	$ 6,426,995	$ -	$ 56,658,486	$ 146,637,205	$ 745,783	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,248,753	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,948,139	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,576,154	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,130,863	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,222,736	$ 1,615,082	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 91,126,645	$ 1,615,082	$ -	$ -	$ -
Mass Health	$ 8,072,118	$ 6,154,116	$ -	$ 389,595	$ -	$ -	$ -	$ -	$ -	$ -	$ 389	$ 31,581,150	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 33,135,936	$ -	$ 265,360	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,088,100	$ 751,714	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 111,264	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 291,496	$ 12,502,481	$ -	$ 200,000	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,746,732	$ 1,454,025	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 57,262,263	$ 14,819,484	$ 265,360	$ 200,000	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 423,328,632	$ -	$ 11,280,059	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,019	$ 52,226,714	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 74,813	$ 8,755,627	$ -	$ 5,264,213	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 81,832	$ 60,982,341	$ -	$ 5,264,213	$ -
GRAND TOTAL	$ 166,286,201	$ 176,181,881	$ 3,248,656	$ 9,062,644	$ 152,425,358	$ -	$ (2,602,922)	$ -	$ 7,057,235	$ -	$ 205,129,615	$ 678,963,895	$ 1,011,143	$ 16,744,272	$ -

Lahey Health

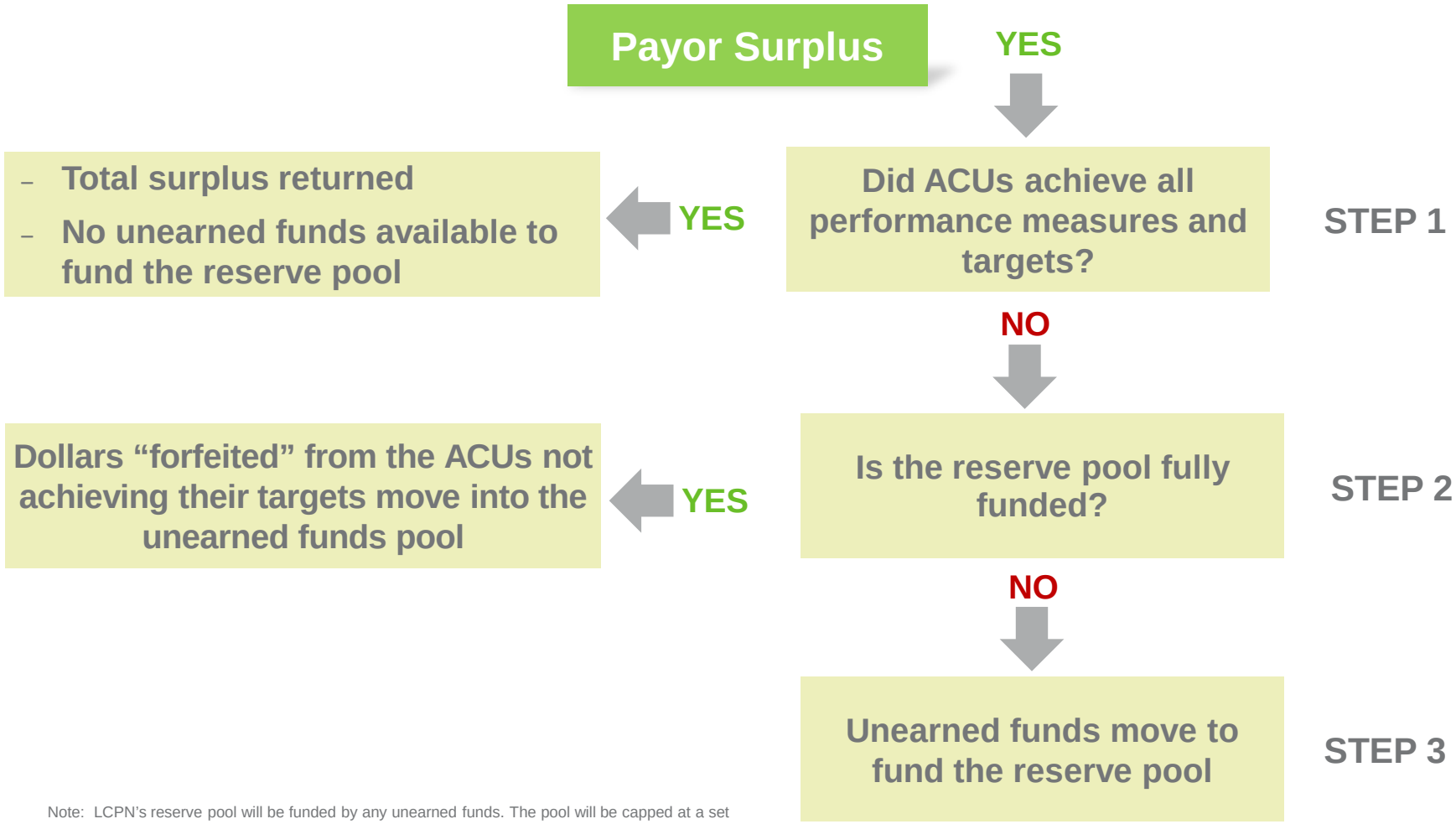
Health Policy Commission
AGO Exhibit 1 Questions to Providers and Hospitals
Calendar Year 2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 41,003,405	$ 141,416,481	$ 2,140,546	$ 8,798,849	$ 72,014,989	$ -	$ 91,856	$ -	$ 5,482,026	$ -	$ 3,915,204	$ -	$ 417,132	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 24,279,912	$ -	$ 45,897	$ -	$ 22,949	$ -	$ 19,723,075	$ 30,598,997	$ 317,188	$ -	$ -
HPHC	$ 89,607,012	$ 34,870,999	$ 494,123	$ 279,669	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,199,542	$ 2,196	$ -	$ -	$ -
Fallon	$ 9,507,234	$ 2,410,610	$ 38,874	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 263,024	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,660,202	$ 24,542,245	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,244,022	$ 28,057,185	$ -	$ -	$ -
Aetna	$ 1,642,769	$ -	$ 90,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 200,162	$ 20,774,429	$ -	$ -	$ -
Other Commercial	$ 5,899,647	$ -	$ 13,746	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 603,904	$ 49,545,931	$ -	$ -	$ -
Total Commercial	$ 147,660,066	$ 178,698,090	$ 2,777,289	$ 9,078,518	$ 96,294,902	$ -	$ 137,753	$ -	$ 5,504,975	$ -	$ 47,809,136	$ 153,520,983	$ 734,320	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,877,238	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 38,310,802	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,863,427	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,392,629	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 34,500,674	$ 1,967,516	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,944,770	$ 1,967,516	$ -	$ -	$ -
Mass Health	$ 7,836,828	$ 6,484,071	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,605,495	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 30,146,927	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,537,650	$ -	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,202,128	$ -	$ 230,999	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,093,667	$ 1,870,705	$ -	$ 5,101	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 60,778,244	$ 15,072,833	$ -	$ 236,100	$ -
Medicare	$ -	$ -	$ -	$ -	$ 83,038,348	$ -	$ -	$ -	$ -	$ -	$ -	$ 353,028,231	$ -	$ 11,914,365	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,296	$ 55,625,452	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 44,730	$ 8,946,541	$ -	$ 2,914,220	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 63,025	$ 64,571,993	$ -	$ 2,914,220	$ -
GRAND TOTAL	$ 155,496,894	$ 185,182,161	$ 2,777,289	$ 9,078,518	$ 222,912,663	$ -	$ (1,201,764)	$ -	$ 5,504,975	$ -	$ 216,595,176	$ 614,767,051	$ 734,320	$ 15,064,685	$ -

APM Risk Management Funds Flow Overview

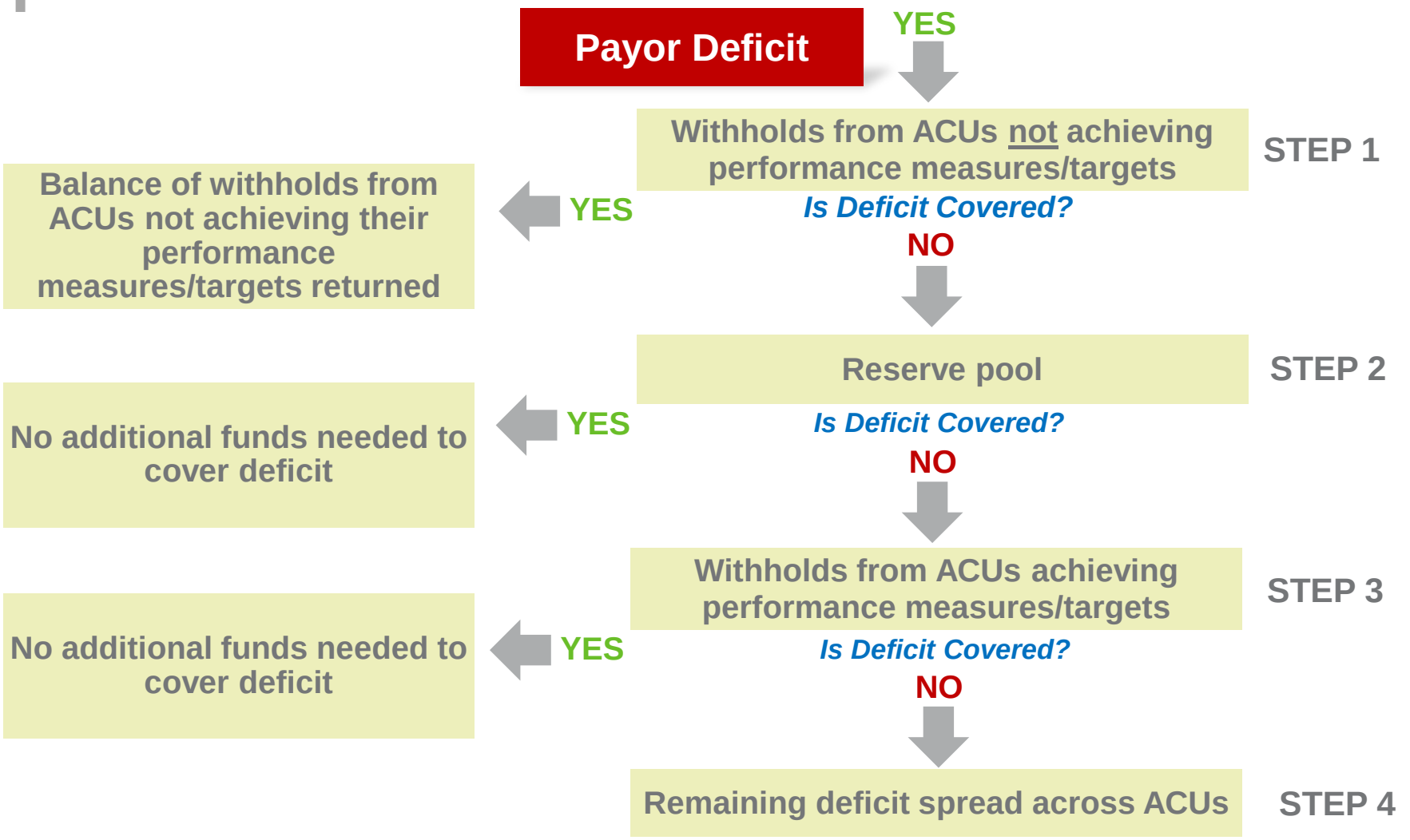


Surplus Settlement Decision Tree



Note: LCPN's reserve pool will be funded by any unearned funds. The pool will be capped at a set dollar amount determined by the amount of downside risk LCPN holds within our contracts versus the withhold being collected.

Deficit Settlement Decision Tree



Lahey Hospital & Medical Center

Exhibit C - Attachment C2a
Margin by Major Payor Category

	Commercial		Government		All Other		Total	
$ in 000's	Percent of Total Business	Operating Margin (%)	Percent of Total Business	Operating Margin (%)	Percent of Total Business	Operating Margin (%)	Percent of Total Business	Operating Margin (%)
FY2010	53.5%	16.1%	43.2%	-14.8%	3.3%	23.9%	100.0%	2.8%
FY2011	52.7%	18.5%	43.8%	-21.4%	3.5%	15.0%	100.0%	1.2%
FY2012	51.0%	22.3%	45.7%	-16.0%	3.3%	22.6%	100.0%	5.5%
FY2013	49.6%	22.1%	47.3%	-15.5%	3.1%	17.7%	100.0%	4.8%

Note: Includes Lahey Clinic Foundation and Affiliates.

Lahey Hospital & Medical Center

Exhibit C-Attachment C2a
Margin By Major Payor Category

Updated Version

	Commercial		Government		All Other		Total	
	Percent of Total Business	Operating Margin (%)	Percent of Total Business	Operating Margin (%)	Percent of Total Business	Operating Margin (%)	Percent of Total Business	Operating Margin (%)
FY2010	53.6%	19.5%	43.1%	-20.3%	3.3%	16.1%	100.0%	2.3%
FY2011	52.6%	22.3%	43.8%	-16.0%	3.5%	22.6%	100.0%	5.5%
FY2012	51.0%	22.1%	45.7%	-15.5%	3.3%	17.7%	100.0%	4.8%
FY2013	49.5%	23.1%	47.4%	-15.8%	3.1%	12.4%	100.0%	4.3%