Lynn COMMUNITY health CENTER

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September 2, 2014

David Seltz
Executive Director
The Commonwealth of Massachusetts Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

I am pleased to submit the enclosed written testimony regarding health care cost trends. Thank you for this opportunity to provide evidence from a community health center perspective during this time of tremendous change in the delivery and cost of health care.

In addition to the information requested on your template, I am also attaching some general background on the Lynn Community Health Center as well as trend data on utilization, revenue and expense.

As Executive Director of the Lynn Community Health Center, I am legally authorized by our Board of Directors to submit testimony on behalf of the Lynn Community Health Center. This testimony is signed under the pains and penalties of perjury.

Respectfully submitted by,

Lori Abrams Berry
Executive Director

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

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 CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:
   The Lynn Community Health Center is an FQHC serving over 38,000 patients. We provide primary care, obstetrics, behavioral health, dental and eye care services to a largely low income and immigrant population in Lynn. The health center has grown significantly during this period. This is primarily due to the impact of health reform, increasing the number of people who have become insured for the first time and seeking needed health care services, and also to the investment of the ACA CHC Trust Fund in capital projects intended to expand the capacity of CHC's to provide access to primary care. While reliable data on Total Medical Expenditures per capita for our patients is difficult to obtain, we believe that the growth in our capacity to provide cost-efficient and integrated primary care and behavioral health services has helped to restrain the overall cost of care to Lynn residents.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

      The attached data on Lynn Community Health Center utilization, revenue and operating expenses during this period demonstrate that our growth in primary care, behavioral health and other community based services is well in excess of the benchmark for growth in total medical expenditures. However, Community Health Centers do not drive health care costs. We provide a lower-cost alternative to hospital care, ER visits and specialty care. Additionally we generate savings in total medical expenditures as a result of our emphasis on aggressive chronic disease management and our ongoing efforts to reduce unnecessary emergency room and inpatient utilization through targeted case management and behavioral health services to a population of patients with both mental health and chronic medical conditions.

   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?

      Our Strategic Plan for 2011-2015 includes the following organizational priorities: to increase access to our services, to improve our metrics on quality indicators, to more fully integrate Behavioral Health and Primary

Care services, and to improve our efficiency and productivity. These are ongoing goals that we work on continuously.

We work closely with our local hospital (North Shore Medical Center) to coordinate services across the continuum of care. Since 2004 we have collaborated actively with the hospital on systems for providing follow up services at the health center for patients who have used the Emergency Room and on coordinating follow up with Discharge Planning for hospitalized patients.

LCHC operates an Urgent Care Service with evening and Saturday hours, providing over 20,000 visits per year, which otherwise might have occurred in the ER.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

In collaboration with Partners HealthCare and North Shore Medical Center we developed a pilot program in 2011 to provide intensive case management to patients with complex behavioral health and medical needs, and who have over-utilized the Emergency Room for non-emergent needs. Preliminary data from this project demonstrate significant reductions in emergency room and inpatient utilization by patients receiving case management services from our team of nurses, community health workers and behavioral health staff. Patients with Serious Mental Illness (Bi-polar disorder, Schizophrenia, Substance Abuse) seem to respond particularly well to organized wrap-around case management services. We hope our data will demonstrate that added investment in these types of services will help the Commonwealth meet and even exceed the established benchmark.

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

The low rates and restrictions on reimbursement for CHC's make it difficult to afford to provide the Behavioral Health, Case Management and social services that strong evidence suggests will help bend the cost curve.

For Integrated Behavioral Health Care to be financially viable, we need to be able to bill for the cost of the initial "warm hand off" introductory visits in the same way as medical visits. It is often not possible or reasonable to identify a mental health diagnosis in an introductory visit. These introductory visits in the primary care setting have improved access to

needed care and greatly increased the number of patients that follow through on referrals to mental health.

Payer rules prohibiting billing for two services on the same day at CHC's create barriers and inconvenience for patients, or prevent us from being able to cover our costs.

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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:
   The Lynn Community Health Center serves a predominantly low income and immigrant population. 85% of our patients are covered by Medicaid, the Medicaid MCO's, Medicare and the Health Safety Net. Our arrangements with Massachusetts Medicaid MCO's have not yet moved beyond fee-for-service payment mechanisms. NHP is using a small scale Shared Savings methodology. Network Health is developing a system somewhat like the PCPR, but we have not been able to participate thus far. We are hampered in working with Network Health because they do not contract with our local hospitals. (North Shore Medical Center operates the only two hospitals our patients can access by public transportation). Currently, the only non fee-for-service payment mechanism we use is the PCPR program for approximately 5600 MassHealth PCC patients.

   a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?

      We are currently participating in the PCPR program as well as a Shared Savings program with NHP. These arrangements are too new at this point to predict whether and how they will impact our ability to expand our capacity to invest in preventive activities that would promote more efficient care delivery and reduced total medical expenditures.

      The PCPR uses a partial capitation methodology which provides only minimal resources to primary care providers to invest in case management and other strategies that will reduce unnecessary hospital ER and inpatient utilization. We were promised Shared Savings when we participated in the Massachusetts Patient Centered Medical Home Initiative, but the Shared Savings never materialized for any of the participating health centers. It makes the possibility of receiving PCPR Shared Savings seem unlikely.

Although we are not yet ready to take on full risk, the fee-for-service and partial capitation methodologies currently available to us do not provide the resources needed to invest in case management on a large enough scale to significantly bend the cost curve in our community.

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).

None yet. We just started participating in PCPR in March 2014. Analysis of the PCPR population is made more burdensome by the unreasonable requirement that we report separately for our 3 main primary care sites within the City of Lynn. Since our patients often access more than one of our primary care sites, the PCPR reporting and our ability to analyze the data is challenging at best. Having three sets of data that sometimes have the same patients in them yields information that is confusing and not very useful to us in learning how to manage under a partial capitation arrangement. We have been unsuccessful in convincing the MassHealth leadership to allow us to use a single data set and reporting for the organization as a whole.

c. 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.

None yet.

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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:

LCHC participates in the North Shore Medical Center's APM contracts with commercial insurers, but our numbers are very small. We also participate in a shared savings arrangement with NHP, and at least theoretically within the PCPR. We think that our risk adjustment scores for the APM, NHP and the PCPR do not reflect the complexity of our patients' medical and behavioral health conditions, largely due to our providers' inexperience with diagnostic coding.

In addition, health center patients may not be more complex medically than other patient populations, but they are more complicated relative to mental health and substance abuse issues and are more often struggling with other social needs.

Every MCO seems to be using a different proprietary methodology for assessing and adjusting for risk, which makes it that much harder for us to learn how to accurately code.

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

   We are concerned about the risk adjustment methodologies currently in use. Community Health Center providers have historically been paid on a per visit basis and most of us are inexperienced in optimizing diagnostic coding for purposes of documenting patient acuity. In addition, we are concerned that while these risk adjustment measures do measure medical accuity, they do not account for the behavioral health and socio-demographic complexity of the patients seen by Community Health Centers.

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

   It is very difficult for us to figure out how similar or different these measures are or if there is any accuracy to them. Each seems to be based on a different proprietary formula that is difficult to explain and is unclear to those of us who are not actuarily sophisticated.

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?

   Unclear at this juncture.

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4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. 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:

   ANSWER:

   At the present time, we receive monthly lists of patients that are considered high risk and have high rates of ER utilization from PCPR and from many of the payers. The data however is not current. Ideally we should be able to access usable real time

utilization data on other services accessed by our patients, such as ER's, hospitals, visiting nurses, nursing homes, pharmacy etc. Better historical claims data would also be very useful for understanding trends, but claims data does not facilitate timely follow-up with patients.
We also need to develop our capacity to analyze and use this data to improve care coordination.

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY:
   This question seems aimed at health plans rather than Community Health Centers.
   a. Which attribution methodologies most accurately account for patients you care for?

      It is unclear what attribution methodologies are in use by health plans. However, we have had continuing problems with Lynn Community Health Center patients being assigned to health plans that do not have contracts with the health center or the hospital that is most accessible to Lynn patients. For example, patients with long histories of care at our health center are auto-assigned to Fallon Health Care, which has not been interested in a contract with us. Patients with long histories of care at our health center are also auto-assigned to Network Health which does not choose to contract with Partners/North Shore Medical Center. This creates service interruption and other problems for our patients who are pregnant and want to deliver at their local hospital and for patients who are already being seen for specialty care at their local hospital.

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

      Not applicable to us.

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:
   We have invested considerable effort and resources into the capacity to report required quality measures to payers. We receive much needed assistance from the Massachusetts League of Community Health Center's central data repository (Azara DRVS).

   ANSWER:
   Despite the data available from DRVS and our EMR, there are continuing issues with proper mapping of key EMR data to be able to capture the measures accurately.

Too often, providers document inconsistently, and key clinical data is not captured in the reports, rendering the data misleading. Our current EMR (NextGen) does not make consistent documentation easy for our providers. We are in the process of getting ready to implement a new EMR, EPIC, which we hope will help us standardize documentation for the key clinical indicators used to report on quality measures. The payers seem to be moving in the direction of standardizing required quality measures.

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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:

As a community health center, our goal is to keep our patients healthy and provide as much support as possible in our community-based setting to prevent unnecessary hospital care. Our investments in extended hours for Urgent Care and in care management for patients with complicated medical and behavioral health issues have helped to prevent unnecessary ER and inpatient utilization. However, we have not had the resources to be able to make the larger investments that would be required to change patient behavior on a larger scale.

Our local hospitals, operated by North Shore Medical Center, have the reputation of being high cost hospitals, but LCHC patients that rely on public transportation will continue to need to use North Shore Medical Center, due to the distance from other hospitals. However, our use of academic medical centers is very limited.

   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.

      This data is available to plans. It is not available to us.

   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.

      The Lynn Community Health Center is a lower-cost community setting, providing an accessible alternative to hospital based care. We also work closely with North Shore Medical Center to provide next day appointments to follow up on any of our patients who have gone to the ER, for patients that do not already have a PCP, and for patients being discharged from the hospital. This is a concerted collaborative effort by the hospital and the health center to help assure that care is provided in the most appropriate setting.

Partners and North Shore Medical Center have also provided funding to the health center at key junctures to help us build the capacity needed to care for patients at the heatlh center rather than at the ER. They supported the development of our Urgent Care Center in 1999, additional primary care resources in 2002, additional behavioral health resources in 2009, capital expenses for our new building in 2010, and a pilot case management project in 2011, as just a few examples.

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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:

Not applicable to Community Health Centers.

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.

Not applicable

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

We collaborate actively with North Shore Medical Center to provide needed follow-up primary care and behavioral health services to our patients being discharged from the hospital.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) 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:

The provision of price information would only be applicable to the Lynn Community Health Center for the few services that we provide that are not covered by most public health plans or for services provided to the small number of self pay patients

who are responsible for their bills. Services typically paid out-of-pocket are Dental appliances such as dentures, crowns, and bridges, and Eyeware. We do not track inquiries, but we always provide our patients with pricing information before anyone decides to go forward with a service that is not covered by Medicaid or their health plan (i.e. dental procedure or the purchase of eye ware). For self-pay patients who are responsible for the cost of their care, we use a sliding fee scale that provides discounts from our fees for patients with incomes under 400% of the federal poverty guidelines. We see everyone, regardless of ability to pay.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: Not available

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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 (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
    SUMMARY:
    Limited network products are generally not available to patients of the Lynn Community Health Center. This is because the only geographically accessible hospitals for Lynn residents (Union and Salem) are viewed by plans developing limited network products as high cost hospitals. The limited networks therefore typically do not include our local hospitals. Lynn residents who wish to choose network products would therefore be required to travel out of the area to receive care. Unfortunately, our particular geography essentially disenfranchises Lynn residents who are asked to choose between receiving care at the Lynn Community Health Center or their local hospital and participating in a limited network in another location.
    ANSWER:

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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:

LCHC has developed and implemented a fully Integrated Primary Care and Behavioral Health model with (1) co-location of primary care and behavioral health services, (2) co-management of patients by integrated teams of medical and behavioral health providers through a "Shared Care" model, and (3) utilization of a shared electronic health record. LCHC's Integrated Health Care model has improved access to behavioral health care, reduced stigma, and greatly increased demand for additional behavioral health services. In 2013, LCHC provided 76,133 behavioral health visits to 6,143 patients, an 80% increase since 2010.

Our efforts to provide access to integrated behavioral health and primary care, and additional care management for patients with comorbid behavioral health and chronic medical conditions, are expected to demonstrate reduced total medical expenses for these patients.

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.

   LCHC is the primary provider of outpatient behavioral health in our community serving a target population with unusually large numbers of low-income, immigrants/refugees, limited English speaking, and individuals with comorbid chronic conditions. Our primary collaborative partner is the North Shore Medical Center. We have been working together for the past two years on a Complex Care Management initiative in which we have targeted care management services for patients with high ER utilization and complicated behavioral health and medical needs. Our preliminary data show significant reductions in hospital utilization when comparing pre- and post-utilization patterns.

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.

   Our organizational focus for the past several years has been on providing a robust mix of clinical and case management services to our patients with significant behavioral health needs in the interest of helping to stabilize them in the community.

We have also participated in the Blue Cross Foundation 3 year project, Making Health Care Affordable. Our program was designed to try to use the "All Payor Database" to demonstrate that integrated primary care and behavioral health services would reduce preventable ER utilization. Although it has been a challenge to access this database, we are continuing to work with the Blue Cross Foundation to provide utilization data on patients that we are serving.

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.

LCHC's Integrated Health Care model has improved access and reduced the stigma of behavioral health care, greatly increasing demand for services. In our experience, integration is highly effective in meeting the complex needs of our patients. To implement this model, we were able to develop:

•Commitment and understanding from all provider disciplines, facilitated by shared leadership and responsibilities.

•Team-based care, facilitated by co-location and co-management, instead of the traditional referral and follow-up model.

•Commitment from the board and senior leadership, including a willingness to allocate resources and time.

•Standardization of processes, such as warm hand-offs, identification and stratification, referrals for specialty BH care.

•Financial resources to support the start-up period and sustain the program.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

This question seems aimed at Hospitals.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

SUMMARY:

The Lynn Community Health Center participated in the Massachusetts PCMH Initiative. The health center was certified as a Primary Care Medical Home by The Joint Commission in December 2012 for all of our sites and locations. We received recognition from the National Committee for Quality Assurance as a Patient-

Centered Medical Home Level 2 in January 2013 for our main site at 269 Union Street. We are currently working on achieving NCQA - PCMH Level 3 for all of our sites.

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?
   100%
b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
   100%
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.
   Not applicable

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13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
    SUMMARY:
    ANSWER:
    We particularly appreciate the Commission's efforts to articulate the need for more spending on behavioral health services and additional community supports in low-income communities in your Cost Trend reports.

    There are few references, however, to Community Health Centers, which if more adequately reimbursed and funded, would offer a tremendously effective and cost-effective approach to reducing total expenditures. Following are some additional and feasible changes that would help leverage the development and expansion of preventive and primary care.

    • Invest more in training and loan repayment programs for primary care physicians and mid-level providers. The current and severe shortage of primary care providers hinders adequate access to preventive services.

    • Increase reimbursement rates for primary care services relative to specialty services, and develop mechanisms to pay for intensive case management for patients with complicated chronic medical conditions. At the current time, the financial benefit from the case management services we provide at LCHC for high-risk patients still accrues primarily to their insurers.

    • Impose a co-payment for Medicaid and other publicly insured patients who use the ER for non-emergent care. Most private insurance plans do this to help prevent unnecessary ER utilization.

• Invest in community health center dental services to promote oral health and prevent dental disease. Insufficient access to preventive and restorative dentistry results in patients with acute dental pain inappropriately using ER's. Affordable community-based dental services will save teeth and resources.

• Better integrate public payment mechanisms for behavioral health services at community health centers, and provide more adequate and flexible reimbursement mechanisms or capitation payments to cover the cost of less expensive community-based care.

- Invest in systemic support for facility expansion and data analytic capacity at community health centers in order to expand access to affordable and lower cost primary care.

• Streamline government reporting requirements for Community Health Centers. Reporting requirements have become increasingly onerous in recent years resulting in added administrative expense.

Finally, in the conclusion to the 2013 Cost Trends Report, it appears that the Commission is considering developing a PCMH certification program. In my opinion, this would be a duplicative and wasteful exercise, both for the Commission and for CHC's and practices that have already been certified by either The Joint Commission or NCQA or both.

Thank you for the opportunity to comment on your comprehensive work in reporting Cost Trends in the Commonwealth.

Lynn Community Health Center
September 2014

Organization Background

The Lynn Community Health Center (LCHC) is a freestanding, nonprofit, federally qualified community health center that has served as the primary source of health care services in one of the most severely underserved communities in Massachusetts since its beginnings as a storefront mental health counseling center in 1971. LCHC has experienced significant growth and is now the largest provider of primary health care and behavioral health services in Lynn. The health center has an annual budget of $74.4 million with 115 full-time equivalent health care providers. In CY 2013, LCHC provided 241,512 medical, behavioral health and dental visits to 38,305 patients – over 40% of Lynn residents and over 40% of all Lynn children 19 and under. Our Obstetrics and Gynecology team delivered 473 babies at Salem Hospital during the year.

Our goal is to positively impact the health of our community. Access to quality and comprehensive health care allows children to focus on success in school and adults to raise healthy families, pursue gainful employment, and become productive members of our society; ultimately resulting in a stronger, more vibrant community. Our target populations are those who experience the greatest barriers to care: children and their families, the poor, minorities, non-English speaking, teens, and the frail elderly. Over 90% of the health center's patients live at or below 200% of the federal poverty level, over 80% are minorities, and over 50% are best served in a language other than English.

We accomplish our mission by providing a comprehensive array of high quality health care services, including: pediatric, family medicine, adult medicine, and OB/Gyn primary care services; specialty medical services; behavioral health and social services; health education; comprehensive HIV/AIDS services; nutrition services; a dental clinic; pharmacy; radiology; and eye care services. In addition to our main site in downtown Lynn, the health center operates two comprehensive primary care practices and behavioral health services in the West Lynn/Market Square area. The health center also manages eight School Based Health Centers in the Lynn Public Schools that provide integrated primary care and behavioral health services in three high schools, two middle schools and three elementary schools. We provide behavioral health services in four additional elementary schools. We administer the Women, Infants, and Children (WIC) nutrition program for ten North Shore cities and towns.

LCHC has been recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home Level 2. The Patient-Centered Medical Home model emphasizes enhanced access to care, patient engagement in care, coordinated care across the health system, integrated team-based care among physicians, nurses and behavioral health providers, and robust clinical information systems. LCHC is also accredited by the Joint Commission for both primary care and behavioral health since 2000, and was certified by the Joint Commission as a Primary Care Medical Home in January 2013.

The Need in our Community

LCHC has continued to grow significantly and is now the largest provider of primary health care in Lynn. ***From 1994 to 2014, LCHC experienced dramatic growth in the number of total health center patient visits from 62,000 to 285,000 visits. Since 2006, LCHC has consistently seen over 400 <u>new</u> patients every month.*** LCHC believes that this unabated demand for services is due to a combination of economic conditions in our area and the significant increase in the number of individuals with health insurance through Massachusetts Health Reform and the Affordable Care Act. Lynn is a federally designated Medically Underserved Area and a Health Professional Shortage Area. In our community, providing access to primary care, behavioral health services and dental care has been a continuing challenge. A community needs assessment completed in April 2012 in collaboration with the North Shore Medical Center documented a critical need to increase primary care, substance abuse, and mental health services in Lynn.

The need for affordable community-based health services is made more acute by the continuing growth in underserved minority, immigrant, and low-income families. Lynn is an aging, densely populated former factory town, with a population of 91,589 according to 2013 Census data. Lynn's minority population continues to grow and today comprises 57.1% of the population, compared to 24.7% statewide. Immigrant and refugee populations are also growing, with 31.7% of residents born outside the US compared to 15.0% statewide. Lynn's per capita income is $21,131, compared to $34,907 statewide, and 24.7% of the total Lynn population lives at or below the federal poverty level, compared to 11.9% statewide.

Lynn also experiences significant health disparities. The percent of births to teens is almost twice that of the state at 10.5% for Lynn compared to 5.4% for the state (2010). Chronic disease presents a challenge for the community, with the hospitalization rate per 100,000 for diabetes at 616 for Lynn compared to 488 statewide, for asthma at 190 for Lynn compared to 156 statewide, and for cardiovascular disease at 1,633 for Lynn compared to 1,537 statewide. (2007-2009). Lynn residents experience poor outcomes related to substance abuse and mental health, with an incidence of nonfatal drug overdoses that is more than double the state rate (1,222.6 compared to 546.6 per 100,000, 2009); and a suicide rate of 12.2 compared to 9.0 for the state (per 100,000, 2010). Source: Massachusetts Department of Public Health.

To meet the urgent health needs in our community, the Lynn Community Health Center continues to innovate and expand programming and services that are culturally and cognitively appropriate, and designed for immigrant, minority, and low literacy populations.

In 2012, the Lynn Community Health Center completed construction on an $18.8 million, 55,300 square foot addition to our main site. The facility includes a large Urgent Care Center on the first floor. The second floor was designed to support an innovative Integrated Health Care Team of medical and behavioral health providers. The second floor also houses a new Dental Clinic with twelve dental operatories. The lower level includes additional office space as well as a teaching kitchen and multi-purpose room for health education programs promoting prevention, wellness, nutrition, and physical activity. We have also been able to expand our space for specialty Behavioral Health Services and Eye Care at 20 Central Avenue. These expansion efforts have significantly increased our ability to carry out the health center's mission by providing the space

we need to meet the most pressing primary medical, dental, behavioral health, and health education needs of a severely underserved community.

The additional space has allowed for the development and implementation of a fully Integrated Primary Care and Behavioral Health model with (1) co-location of primary care and behavioral health services, (2) co-management of patients by medical and behavioral health providers through a "Shared Care" model, and (3) utilization of a shared electronic health record (EHR). LCHC's Integrated Health Care model has improved access to needed behavioral health care, reduced stigma, and greatly increased demand for additional behavioral health services. In 2013, LCHC provided 76,133 behavioral health visits for 6,143 patients, an 80% increase since 2010.

LCHC has developed five Integrated Health Care Teams; each with five to nine Primary Care Providers (family medicine, internal medicine and pediatric physicians, nurse practitioners, and physician assistants) and two to three licensed Behavioral Health Therapists (psychologists, social workers, mental health counselors). The integrated teams also include a psychiatrist or an advanced practice psychiatric nurse practitioner, nurses, clinical assistants, community health workers, and nurse care managers. LCHC has designed our integrated model to align with our target populations, with eight of our school based health centers (SBHC) staffed by integrated provider teams. LCHC has developed an Integrated Addictions Team to provide primary care and behavioral health for patients with substance abuse disorders, including medication-assisted therapy to treat opiate addiction. LCHC has also developed a "Reverse Co-Location" approach to target patients with serious mental illness by embedding a primary care nurse practitioner within our specialty Behavioral Health Department.

Board of Directors and Leadership

LCHC is a nonprofit 501(c) (3) organization, with a 20-member Board of Directors, representing a cross-section of the population served by the health center. Over 50% of the board members are active patients of the health center. Board members have a diversity of experience and expertise. We have, for example, members with expertise in banking, law, finance, long term care, public health research, employees of other community agencies, a union activist, a Lynn Episcopal priest, a high school student (patient of our SBHC at Classical High School), and several retirees. Ten of the current 20 members are Latino, African American, or Asian. Eleven are women.

The Board of Directors has responsibility for setting the policies of the corporation, managing and controlling all property of the corporation, and assuring the financial viability of the organization and the quality of its services. The Board has the responsibility for recruiting, hiring, and regularly evaluating the Executive Director, who is responsible to the Board for carrying out strategic and operational goals. The Senior Management team reports to the Executive Director. The Executive Director, Lori Abrams Berry, MSW, MPH has been at the health center since 1996 and has over 35 years of experience leading community health programs. Scott Early, MD, a licensed family medicine physician, is our Chief Medical Officer and has over two decades of community health center experience. Mark Alexakos, MD, MPP, is a licensed psychiatrist board-certified in both child/adolescent psychiatry and adult psychiatry,

and serves as our Chief Behavioral Health Officer. Andrea Gaulzetti, RN, our Chief Nursing Officer, has been with LCHC for 17 years and has over 40 years of leadership and nursing experience. We recently hired a new Chief Operating Officer, Ron Doncaster, who has many years of operations management experience at Newton Wellesley Hospital. Our medical staff members are all board eligible or board certified in their specialty areas and we have extensive credentialing and privileging procedures for all licensed clinical staff.

LCHC makes every effort to meet the diverse multicultural needs of its target populations with significant numbers of bilingual and bicultural staff. Of current employees, 55% are non-white. Staff members who are bilingual or multilingual make up 55% of our staff. Languages spoken at the health center include Spanish, Khmer, Russian, French, Kreol, Portuguese, Albanian, Vietnamese, Thai, Pashtun, Armenian, Somali, and Arabic. The health center serves many Latino, Cambodian and Russian families and individuals. As the Massachusetts Refugee and Immigrant Health Program's health assessment service for the North Shore, LCHC has also attracted patients from Iraq, Burma, Bhutan, Somalia, Liberia, Burundi, and many other countries.

The health center has made an ongoing commitment to improve organizational cultural competence and to assure the delivery of effective care that incorporates the cultural values and beliefs of the patients that are served. The health center has developed a variety of organizational systems to improve cultural and linguistic competency, including the addition of cultural sensitivity and awareness expectations to job descriptions and annual performance evaluations for all staff.

Lynn Community Health Center
Utilization, Revenue and Expense Trends

	CY 2010	CY 2011	% incr 2011/2010	CY 2012	% incr 2012/2011	CY 2013	% incr 2013/2012
LCHC Utilization							
Medical Visits	101,727	103,221	1.5%	115,009	11.4%	124,118	7.9%
Dental Visits	24,345	24,407	0.3%	34,100	39.7%	36,568	7.2%
Behavioral Health Visits	42,365	48,247	13.9%	66,190	37.2%	76,357	15.4%
Eye Care Visits	3,299	3,541	7.3%	4,570	29.1%	5,889	28.9%
Other	7,135	8,557		10,640		9,299	
Total Visits	178,871	187,973	5.1%	230,509	22.6%	252,231	9.4%
LCHC Revenue	$ 34,088,322	$ 37,514,762	10.1%	$ 45,285,694	20.7%	$ 50,818,865	12.2%
LCHC Operating Expense	$ 33,889,191	$ 37,372,820	10.3%	$ 45,756,697	22.4%	$ 50,704,680	10.8%
Surplus/(Deficit)	$ 199,131	$ 141,942	-28.7%	$ (471,003)	-431.8%	$ 114,185	-124.2%

14-Jun		14-Dec	Jan-June 14
20012		10052	
21341		10677	
12120		6005	
817		326	
460		242	
9715		4991	
8079		3340	
20524		10374	
10427		5356	
7417		4343	
13561		5787	
124473	med	61493	62980
38139	dent	18887	19252
80774	bh	36951	43823
5862	eye	2970	2892
	other		128947