

Responses to DoN Inquiries for SHC Application

May 9, 2019

- 1. Your application states “there are three sources that make up SHC’s patient panel; inpatient discharges, emergency room visits and the patients that receive ongoing primary care from Signature Medical Group.” (page 5). Does the patient panel for fiscal years 16, 17, and 18 represent the number of unique patients of the 36-month period? Is it possible that patients were double-counted either from one year to the next, or across medical groups, the hospital and the ED?**

No. The patient panel for fiscal years 16, 17 and 18 does not represent the number of unique patients of the 36 –month period.

Yes. Patients were double counted from one year to the next across the three sources of the patient panel that were identified; inpatient discharges, emergency room visits and patients that receive ongoing primary care from Signature Medical Group.

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Below is the chart that depicts the patient panel in the application.

Patient Panel	FY 16	FY 17	FY 18	Total
Discharges	12,153	11,412	11,488	35,053
E.D. Visits	63,996	60,686	60,564	185,246
Signature Medical Group-Average Panel for Three Years	see total	see total	see total	76,121
				296,420

As a result of a discussion with staff in the DoN office, below is a revised chart of the patient panel.

Patient Panel	FY 16	FY 17	FY 18	Total
Non- Signature Medical Group Discharges and E.D. Visits	10,330	8,969	6,182	25,481
Signature Medical Group-Average Panel for Three Years				76,121
				101,602

Explanation of the revised chart

Non Signature Medical Group (SMG) Discharges and E.D. visits only represent unique patients. If a non-SMG patient had a Discharge in FY 16, they were counted once even if they had other Discharges and E.D. visits in FY 16, 17 or 18.

Discharges and E.D. Visits are now combined as they are counted in a unique manner based on which encounter took place first (Discharge or E.D. visit). Utilizing this methodology of assessing the panel does not differentiate between Discharges and E.D. visits as it initially counts which encounter took place first and excludes the next type of encounter.

The SMG average panel for three years represents the total number of unique patients seen by a primary care physician within each fiscal year.

As to an explanation of the decline in the number of non-SMG patient Discharges and E.D. visits, the Applicant relates this to the ongoing shift of care from the inpatient to outpatient setting as well as attempts of healthcare organizations to control leakage and provide care within their own network.

The Applicant has an employed physician model which supports a robust and well-established patient panel of 76,121 patients (average of unique patients over FY 16, 17 and 18). The panel supports the extensive surgical growth of the Orthopedic service line as well as surgical growth in Ophthalmic and Urological procedures. The Application also demonstrated strong overall surgical growth.

This panel along with non-SMG Discharges and E.D. visits, result in the current surgical occupancy of 74% to 80%, which when combined with growth projections in Orthopedics, Plastic, Thoracic and Urological surgeries, supports the proposed addition of two new operating rooms.

2. Your application identified disparities in key behavioral risk factors within the patient panel at the County (Plymouth) and City (Brockton) level and note that these risk factors lead to increased demand for surgery. Please clarify the link between the behavioral risk factors mentioned in your Application and expansion of the proposed surgical services.

The link between obesity as a behavioral risk factor and the expansion of the proposed surgical services is made through the research efforts of the American Academy of Orthopaedic Surgeons (AAOS) and the Advisory Board.

According to the American Academy of Orthopaedic Surgeons (AAOS), individuals with obesity are at greater risk than patients of normal weight for musculoskeletal injuries like; fractures in the lower extremities, meniscal tears, rotator cuff tendonitis, heel-bone fractures and ankle injuries. In addition, the AAOS states that every pound of body weight places four to six pounds of pressure on each knee joint. Individuals with obesity are 20 times more likely to need a knee replacement than those that are not overweight. (1)American Academy of Orthopaedic Surgeons (AAOS). Position Statement: *The Impact of Obesity on Bone*

According to the Advisory Board and their 2017 report; Orthopaedics and Spine Global Market Trends, there are three main factors that support increased demand; first, the growing prevalence of osteoarthritis, diabetes, and obesity; second, an increase in the elderly population (65+); and lastly, increasing physical activity levels among younger segments of the population translating to earlier utilization (2). While it's noted in the application that physical inactivity in Plymouth County is higher than the state average, this is an indicator for all age cohorts, not just the younger segments of the population as noted in the Advisory Board findings. (2) Advisory Board. 2017. *2017 Orthopaedics and Spine Global Market Trends*.

The findings of the AAOS and the Advisory Board are trends for the catalyst of operating room efficiency and cost-effective sites of care.

3. On page 7 you provide the payor mix for SHC overall; in the same format, please provide the payor mix for surgical patients.

Outlined below is the surgical payor mix for the average of Fiscal Years 16, 17 and 18 and is based on revenues.

Blue Cross	16.00%
BMC	11.00%
Commercial	2.00%
Harvard Pilgrim	7.00%
HMO	7.00%
Liability	1.00%
Medicaid	8.00%
Medicare	21.00%
Medicare HMO	9.00%
Neighborhood Health	6.00%
Other	1.00%
Self Pay	1.00%
Tufts Health Plan	4.00%
Tufts Public Plan	4.00%
Workers Compensation	<u>1.00%</u>
Total	100.00%

3.a. Explain the nature of the managed care contracts (including such elements as upside/downside risk, bundled payments for all or specific services).

Signature Healthcare is involved in up/downside risk arrangements with two commercial payers, one Medicare Advantage arrangement, one upside only Senior Care Option (SCO) arrangement, and the BPCI Advanced CMS bundle arrangement for eleven clinical episodes.

3. b.Describe how bundled payments will affect the delivery of the total course of treatment and post-operative care through the completion of treatment (such as physical therapy for your orthopedic patients).

The Applicant does not have bundled payment agreements related to surgical procedures. There are bundled payments related to medical services, such as; CHF, COPD, Simple Pneumonia, AMI and Sepsis.

3.c. Since the HPC letter of your ACO Certification indicates that your certification is valid through 2019, do you intend to renew your certification? When?

Signature Healthcare Corporation plans to complete the Health Policy Commission's ACO certification for 2019. The HPC's guidance and application requirements will be released in early summer/ 2019, but they have not determined a required completion date yet.

4. Care coordination with primary care and necessary follow-up care.

4. a. You state that non-signature referring physicians receive follow-up communication following the patient's surgery, and that this communication can be by fax, or phone call depending on the nature of the case (page 16). How will you ensure care coordination for patients of providers that are not connected to the EHR? How will this be tracked?

The Applicant will ensure care coordination for patients of providers that are not connected to the EHR through a Forward Advantage application or the traditional mail system. Forward Advantage is already in place and will continue with approval of the proposed project.

Forward Advantage includes a flow process that starts with patient registration. At the time of registration, the registrar obtains the name of the patient's primary care physician (PCP). If the PCP is set up within Forward Advantage, they automatically receive surgical follow-up information by fax. If the PCP is not set up in Forward Advantage, surgical follow-up information is sent via mail. In all situations, if post surgical information needs to be communicated in a timely manner, the surgeon will call the primary care physician. The Applicant continues with efforts to maximize the number of PCP's within the Forward Advantage application.

In terms of tracking, faxes sent via Forward Advantage are tracked within the application and the EHR. If post surgical information is sent via mail, that information is tracked within the EHR.

4. b. Describe follow-up care (such as PT/OT) and other post-surgical care coordination for ACO members.

The majority of surgical patients that receive PT/OT have undergone an Orthopedic procedure. The plan of care regarding PT/OT, VNA services, etc. does not change depending on insurance. Non-ACO and ACO patients are treated in the same manner and are encouraged to use Signature PT/OT services for continuity of care purposes.

The following outlines post surgical care for Orthopedic patients;

- All post surgical patients are given a 10-14 day follow-up appointment in the Orthopedics department. The length of the appointment from the surgery depends on the type of surgery performed. Patients are also typically seen at 6 weeks post-op.
- Total hip and knee replacement patients have in-house PT/OT while they are in the hospital following surgery until discharge. They are then set up with home VNA services until they are deemed ready to transition to outpatient PT/OT.
- Total shoulder replacement patients are given a prescription for outpatient PT/OT at discharge from the hospital or are discharged with VNA services.
- Outpatient surgeries (not total joint replacements) have varying protocols per provider and type of surgery.

Within the Application, the Applicant outlined the components of the Early Recover after Surgery Program/Colon Program which is implemented regardless of payor source. The Applicant is currently developing a similar protocol for Vascular Surgery (Early Recovery after Vascular Surgery) in order to reduce post-operative infections and it will include patients that undergo inpatient and outpatient vascular surgery. The projected implementation date of the Vascular protocol is July, 2019.

4. c. Describe follow-up care (such as PT/OT) and other post-surgical care coordination for all other patients. How will this be tracked?

As noted previously, the plan of care for post surgical Orthopedic patients regarding PT/OT, VNA services, etc. does not change depending on insurance. Non-ACO and ACO patients are treated in the same manner. In addition and as an example, Bariatric surgical patients receive the same protocols regardless of payor.

4.d. Explain how you will assess SDOH, make referrals related to SDOH, how you will track the receipt of services and any outcomes for ACO members. Describe how this will be done for other patients.

The Applicant and its affiliated providers within Signature Medical Group are sensitive to the Social Determinants of Health for the entire community, including ACO members. Both the hospital and the medical group maintain a department of Care Managers, Community Health Workers and Social Workers. At the time of check-in at all ambulatory sites, as well as at hospital registration (including surgery), data regarding homelessness and language are routinely captured.

The three most immediate social determinates relate to transportation, language and reading comprehension.

A major concern is always transportation with no car ownership and where no public transportation is available. Hospital and ambulatory personnel assist patients in applying for PT1 applications and approval for medical appointments. Approvals are recorded in the patient's EMR.

In terms of referrals and tracking as it relates to positively impacting transportation issues and this SDOH for all patients (including surgical patients), in FY 18, Signature Healthcare covered the cost of transportation via taxi for 790 patients costing \$10,089.41. In addition, fundraising from events throughout the year supports the Senator Thomas P. Kennedy Advocacy Fund and this provides funds for transportation assistance.

Signature Healthcare Brockton Hospital's Indigent Medication Program has been in place for more than 20 years and stands alone in the community by providing free medications to patients (including surgical patients) who are unable to pay for their required prescription drugs. The hospital provides up to a 30-day supply of prescription drugs to its most needy patients.

In terms of referrals and tracking for all patients related to Indigent Medication Program, in FY18 the Hospital provided 220 free medications to 85 patients valued at over \$22,000 and collaborated with local pharmacies for follow-up care as required. In addition, 341 prescriptions were provided to 105 patients valued at approximately \$45,000 through Signature Healthcare's Patient Advocacy Fund. Another 115 prescriptions were provided to 41 patients valued at approximately \$18,000 through an Elder grant.

Both the Transportation Program and the Indigent Medication Program will be available to patients receiving care in the ambulatory suite.

The Applicant has always maintained a full time department of translators focused on the particular ethnic needs of the surrounding community. Many of the ACO patients can only read in their native language or not read at all. This department is available for pre and post ambulatory visits as well as hospital and surgical visits. Educational literature is provided in languages specific to the needs of the ACO member. In scheduling procedures, the ACO social workers and staff have the ability to book transportation for ACO members. Finally, it is not uncommon for patients to become confused with their medications, especially those for chronic diseases. The Signature ACO provides an Ambulatory ACO Pharmacy staff member to review medication reconciliation for pre and post discharge planning.

The Signature ACO has a robust information system. In 2019 an integrated Meditech EMR will integrate the hospital with the medical group into one large database. Reports can be

generated to focus on ACO members' pre and post procedure. Post discharge ACO scheduled follow-up and reporting of outcomes is currently part of the Signature ACO reporting system. Finally, the Applicant maintains all ACO claims in an Arcadia database. Retrospective reporting can be drilled down to patient, procedure, utilization and outcomes.

5. Describe how this program will help you gain the efficiencies and cost savings associated with Freestanding ASC's that are well documented in the literature, including

A. How the rooms will be scheduled and blocked; The OR management team will be making it easy to schedule a case within the ambulatory suite by streamlining the booking process and allowing scheduler's control of their surgeon's time.

Service line case selection for ambulatory surgery and allocation of block time will be established by the Chief of Surgery, Section Chiefs and OR management with financial oversight by the senior administrative team. Block allocation will be given to surgeons with high volume and predictable outcomes as well as case length to fill their ambulatory block and maintain 70-90% utilization monthly.

Surgeons assigned to the ambulatory surgery suite will have demonstrated evidence of efficient use of their current Main OR time. Efficiency strategies for booking ambulatory surgery cases will include: longer cases being done in the beginning of the schedule and shorter cases in the afternoon, clustering cases laterally to reduce room turnover time and accuracy measures as it relates to recovery time requirements will be implemented to reduce OR wait time and delays. An operational plan for the ambulatory suite that maximizes staffing, facilitates and cross training will be implemented by the OR management team.

B. If the OR's will be designated and equipped for specific procedures/specialties: Relocation of cataract surgery is planned for the ambulatory suite. Both eye surgeons will be able to increase their current volume with this new resource, and meet the needs of the aging population of Brockton who have many socioeconomic barriers to overcome in order to receive this type of surgery as well as other types of surgery.

Use of the ambulatory suite for sports medicine cases such as knee and shoulder arthroscopies, hand surgery, and minor gynecology, urology, and general surgeries are planned. Equipment and supplies for these procedures and any other designated case types will be kept in the ambulatory suite.

C. If the staff will be trained and scheduled to operate as a surgical team: All OR/PACU staff currently working in the Main OR/PACU cost centers will be trained and scheduled to work in the ambulatory suite as assigned. Cross training will be completed before the ambulatory suite is operational and staff has demonstrated competency in their new roles. Additional staff has already been added to the current staffing model to accommodate ambulatory surgery.

**6. Will these two OR's be a distinct ambulatory service line from the main hospital OR's?
Please describe:**

The appropriate surgical procedures and patients that meet the same day criteria will be cared for in the ambulatory suite. For instance, cataract surgeries will now exclusively take place in the ambulatory suite. Management will oversee operations in both the Main OR and the ambulatory suite and surgeons will be performing cases in both settings (i.e. Orthopedic Surgeons).

7. Reducing burden to outpatient surgery:

a. Describe where these new surgical suites will be located in relation to the main hospital OR.

The new surgical suites will be located within the main hospital building in the space previously occupied by Radiation Therapy. Travel to the new suites from the Main OR will primarily take place through the use of an elevator; however staff will have access to stairs. With only 197 licensed beds, the hospital has a small footprint, therefore, once off the elevator it's only a few hundred feet to the new ambulatory suite. The Emergency Department is contiguous to the new suite and will be a resource in an emergency situation.

b. How will day surgery admissions be handled to reduce burdens to patients?

It is anticipated that patients that have surgery in the ambulatory surgery center will be outpatients only. Dedicated parking will be close to the entrance of the new suite and once entering from the exterior patients will be in the reception area. The patient will go through the admissions process in a smaller setting with a smaller footprint versus the Main OR, thereby reducing the need to travel throughout the hospital which in turn should reduce the burden of stress on the patient.

c. Do you plan to have the main hospital ORs treat only inpatients when the project is complete?

The main OR will continue with certain outpatient surgeries that have extensive equipment requirements.

d. How will surgical scheduling within the main hospital be impacted?

The current staffing pattern in the hospital based surgical booking office will be able to absorb the increase in bookings for ambulatory surgery. Ambulatory surgery bookings are currently completed within a 24 hour time period for elective cases. Pre-op

optimization will determine how quickly the patient can be placed on the OR schedule in a safe and timely manner.

8. Quality of Care

b. How does the Early Recovery After Surgery Program/Colon program relate to this proposed project, and the surgeries to be performed as part of this expansion?

By having the main OR focus on inpatient surgery and more complex surgery the Applicant will be better able to implement the more complicated pathways of ERAS. Resources will be able to spend more time on their preparations before surgery, and the care plans will be easier to follow through PACU by having the team more focused on these types of cases.

Ultimately, the Applicant wants most major cases to have ERAS protocols which should be more successfully implemented in a OR that aren't also dealing with high volume throughput like cataracts.

c. If the proposed project is approved, what quality and outcomes metrics will you use to measure the outpatient surgeries performed?

The Applicant will utilize Surgical Care Improvement Project Measures (SCIP) and core measures for all cases that are applicable. The Applicant will also measure the patient experience as well as compliance with safety measures like all three stages of the WHO timeout. In addition, the Applicant will follow all standard outcome metrics that are currently followed, including; infection, bleeding, VTE, return to OR, readmission, anesthetic complications, cardiac and neuro events, mortality etc., and specialty specific quality metrics will be developed as appropriate.

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Health Equity

9-a. Do you track the provision of language interpreter services provided by in-person, video and phone?

Below are the results of the various forms of language interpreter services for the past three fiscal years.

	Face to Face	Telephonic	VRI	Total encounters
FY16	24,253	3,509	1,325	29,087
FY17	22,674	5,026	2,610	30,310
FY18	23,708	6,377	3,314	33,399
Totals	70,635	14,912	7,249	92,796

9- b. Describe how interpreter services are made available to patients along the full continuum of care (including in PCP offices, pre-operative classes, and in post-surgical care, such as PT/OT).

To facilitate the continuum of care for patients, Interpreter Services are available throughout SHC including all PCP offices/ambulatory locations. Interpreter Services are provided via Face to Face, telephonic and video remote interpreters. All ambulatory locations have been equipped with a video remote interpreting device (VRI iPad) which also has telephonic interpreting capabilities; locations with multiple floors and offices have several devices available to them. VRI and telephonic interpreters are utilized for times when Face to Face interpreters are not readily available.

Every effort is made to provide Face to Face interpreters for the following appointment types:

- pre-surgical consults
- pre-testing
- pre-operative classes
- post-surgery follow-up
- PT/OT Evaluations and re-evaluations and when video or telephonic interpreting is not appropriate

Interpreters are prescheduled through the booking systems within IDX and Meditech; both generate reports alerting Interpreter Services of upcoming patient appointments. Requests/reminders are also sent to the Interpreter Services Team via Allscripts Tasks, this enables Interpreters to easily communicate updates, etc., to the Provider Support Team.

9-c. How does clinical staff learn about providing culturally competent care?

The Applicant provides Cultural Diversity Training during orientation and annual mandatory education.

The Nurse Educators provide specific training for RN and ancillary staff. Cultural competencies are taken into consideration when developing new programs and policies in an effort to provide high quality care to patients with diverse values and beliefs. The goal of the training is to tailor care that meets patient's cultural and linguistic needs.

9. d. What strategies/approaches are you using to advance health equity in your current services and educational programs (such as the National CLAS Standards, use of Interpreter Services (IS), etc.) How will these be used with the new surgical care and follow up?

CLAS Standards and Interpreter Services

4. The Applicants workforce is educated on linguistically appropriate practices during general orientation, nursing orientation and onboarding of new physicians. The Interpreter Services policy, laws and regulations regarding the provision of qualified medical interpreters to SHC patients, their family members and anyone involved in the patient's care and appropriate interpreting resources are covered during these presentations. On an ongoing basis the workforce is educated through in-services, refresher trainings and through Annual Education which is mandatory for all SHC employees.

Communication and Language Assistance:

5. The Applicants Interpreter Services policy states that SHC offers language assistance at "no cost" to individuals who have limited English proficiency. The Applicant has in-person, telephonic and video remote interpreters available to facilitate timely access to all healthcare services throughout our organization.

6. Language posters are posted at entry points throughout SHC informing patients of languages available and staff has access to interpreting resources that can also help communicate this message to patients.

7. To ensure the competence of individuals providing language assistance; all interpreters hired at SHC must have successfully completed a 60+ hour Medical Interpreting Training course and

must present a Certificate of Completion at time of interview. They must also pass a written medical terminology test with an 85% proficiency rate for their target language(s) and pass a verbal language assessment test administered by a vetted outside agency.

Recognizing that the use of untrained individuals and/or minors as interpreters should be avoided, this information is included in the Applicants policy and is covered during general orientation, nursing orientation and on boarding of new physicians. This is also addressed during in-services and refresher trainings throughout the organization. Interpreter Services is also on the Annual Education Modules; this is mandatory for all SHC employees.

8. Patient information and mandatory signage have been translated into the languages commonly used by the populations in our service area.

Engagement, Continuous Improvement and Accountability

14. Interpreter Services works with the Patient Advocate to help resolve conflicts or complaints as they arise.

How will these be used with the new surgical care and follow up?

Staff hired for the new surgical suite will be part of new orientations, including nursing and new physician onboarding if appropriate. The new surgical suite will have the same resources as are currently available in the Main OR and the existing process will also apply. All efforts will be made to provide in-person interpreters for pre-testing appointments, on the day of the procedure and for post-surgical appointments. When in-person interpreters are not available video remote and telephonic interpreting will be used to meet patient needs.

CLAS Standards and Community Assessment and Engagement

SHC conducts a Community Health Needs Assessment every three years. The goal of these assessments is to identify unmet community health needs, vulnerable populations and gaps in existing community health services. The Applicant utilizes a multipronged approach when developing the assessment, which includes reviewing the most current data, holding key informant interviews and hosting focus groups within the diverse populations in which the Applicant serves.

Racial and Ethnic Approaches to Community Health (REACH) is a grant that is awarded by the YUSA (YMCA-Corporate) via the Centers for Disease Control with funding given to the Old Colony YMCA starting in 2012. Signature Healthcare is part of the work being done through this grant which focuses on the communities of Brockton and Stoughton. Through this grant, the Old Colony YMCA pulls together a variety of partners to focus on community to clinic linkages. This work occurs by engaging local faith based organizations who primarily work with

the Haitian and Cape Verdean communities. The partners provide biometric health screenings and identify individuals who need additional healthcare services. The Applicant is able to not only identify these individuals, but also to refer them to additional services including a Primary Care Physician and/or a Chronic Disease Self Management program to assist them in leading a healthier lifestyle.

9-e. What strategies/approaches are you using to accommodate for people with disabilities and how will these be applied to your out-patient surgical patients throughout their course of treatment and recovery?

The Applicant is committed to providing high quality care to all patients. Efforts to accommodate people with disabilities include; enhanced parking, easy access, comfortable waiting areas and bathroom facilities that are handicap accessible. The Applicant has foreign language interpreters on-site and provides resources for visually and hearing impaired patients.

10. From the Independent Accountant's Report please further clarify:

a. Page 9

i. What the 3% increase in Inpatient Revenue is attributed to?

The increase is attributable to a 2% labor increase and a 1% supply cost increase.

ii. The 0.8% increase for outpatient visits, does it not include surgery?

Yes, 0.8% increase for outpatient visits includes surgery.

iii. Does the 3% increase in gross revenue for all out-patient visits include all surgery and outpatient services?

Yes, it includes all surgery and outpatient services.

b. Page 10

i. Please explain the following statement: "Contractual discounts were projected to grow between 3.7% and 4.2% annually through the projection period. This growth rate exceeded the growth in gross patient service revenue each year." What is the statement's impact on the Patient Panel and payor-mix, and is this in direct relation to the proposed project?

Contractual discounts are expected to increase, resulting from projected decreases in payment, especially in Medicare and Medicaid. Patient panel and payor mix are not impacted and there is no direct relationship to the projected project.

Responses to Additional Questions

1. Provide a description of the following payor sources within your surgical payor mix.

- **Liability** – Automobile Insurance Payments
- **Other**- Includes the following payors;

VETERANS ADMINISTRATION
CHAMPUS/TRICARE EAST
MASSACHUSETTS REHABILITATION
OLD COLONY HOSPICE
HOSPICE
SKILLED NURSING FACILITIES
CHAMPVA CENTER
US FAMILY HEALTH PLAN
DEPT PUBLIC HEALTH TB CONTROL
NEW ENGLAND ORGAN BANK CL

- **Self-Pay**- Patients who pay for services in cash.

2. In terms of the Meds to Beds Program, what happens after the 30-day period when the patient is provided a prescription?

Within the Meds to Beds Program, the Applicant provides a 30-day supply of medication. However, after the 30-day supply, patients would then need to work with their PCP and pharmacy in order to obtain additional medications.

3. How do you work with patients who are uninsured to assist them with obtaining insurance?

The Social Work Department is automatically notified if a patient registers without insurance. Social Workers meet with uninsured patients and assess their needs for any services and if appropriate, generate referrals. In addition, Social Workers refer uninsured patients to Financial Counselors within SHC who work with patients to complete MassHealth applications.

4. What is the PT1 Application that you referenced?

A PT 1 Application is a Prescription for Transportation Form which is submitted to MassHealth for approval for transportation to medical appointments. The form is initiated by the PCP and is for patients who are incapacitated. Approval is based on medical need.