UMASS MEMORIAL HEALTH CARE, INC.

DETERMINATION OF NEED APPLICATION #20121712-TO

Applicant's Responses of March 8, 2021 to Questions dated February 17, 2021

1. Provide the APM contract percentages for UMass Memorial Health Care, Inc. and Harrington Memorial Hospital using the table provided below. Provide a year for the data.

APM Contract Percentages			
UMass Memorial Health Care 2021	**%**	**Harrington 2020**	**%**
ACO and APM Contracts	42.00%		52.50%
Medicare MSSP Medicare BPCI- Advanced THP risk- commercial products HPHC risk- commercial products		BACO Medicare MSSP THP risk- commercial products HPHC risk- commercial products BCBS Fallon Medicare Advantage	
Non ACO and Non APM Contracts	58%		47.50%

Factor 1a. Patient Panel Need

2. UMMHC sees approximately 8.9% of patients in HMH's primary and secondary service areas (pg.2).
    a. Provide data on the types of UMMHC services these patients utilize.

UMMHC had the following inpatient and outpatient volumes by service for patients residing in HMH's primary and secondary towns (includes MA and CT residents). Please note FY20 volumes were down due to the impact of COVID19.

	UMMHC Hospitals			% of Total		
Inpatient	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
Cardiac/Thoracic/Vascular Services	716	697	641	13.6%	13.2%	12.9%
General Medicine	1,389	1,426	1,363	26.4%	26.9%	27.5%
General Surgery	489	498	435	9.3%	9.4%	8.8%
Neurology & Neurosurgery	290	335	293	5.5%	6.3%	5.9%
OB/GYN/Neonatology	1,568	1,518	1,458	29.8%	28.7%	29.4%
Oncology	157	139	143	3.0%	2.6%	2.9%
Orthopedics	266	314	250	5.1%	5.9%	5.0%
Other	155	133	153	2.9%	2.5%	3.1%
Psychiatry	102	116	87	1.9%	2.2%	1.8%
Spine	135	121	132	2.6%	2.3%	2.7%
Inpatient Total	**5,267**	**5,297**	**4,955**	**100.0%**	**100.0%**	**100.0%**

	UMMHC Hospitals			% of Total		
	2018	2019	2020	2018	2019	2020
Outpatient						
ED	8,116	8,362	6,719	6.3%	6.2%	5.8%
Endo and Surgical Svc	5,166	5,385	3,516	4.0%	4.0%	3.1%
Infusions	2,553	2,953	3,024	2.0%	2.2%	2.6%
Labs	5,258	5,810	10,236	4.1%	4.3%	8.9%
Observation	1,407	1,525	1,198	1.1%	1.1%	1.0%
Other	103	163	83	0.1%	0.1%	0.1%
Primary Care	15,114	14,902	12,389	11.7%	11.1%	10.7%
Rad Onc	3,411	4,117	2,564	2.6%	3.1%	2.2%
Radiology	14,075	14,585	12,718	10.9%	10.8%	11.0%
Rehab Service	1,643	1,840	1,230	1.3%	1.4%	1.1%
Subspecialist: Pediatric Care	10,829	10,756	8,934	8.4%	8.0%	7.8%
Subspecialist: Behavioral Health	2,473	1,014	48	1.9%	0.8%	0.0%
Subspecialist: Cancer	4,235	4,911	4,955	3.3%	3.6%	4.3%
Subspecialist: Cardiology/Vascular	10,308	10,111	8,649	8.0%	7.5%	7.5%
Subspecialist: Dermatology	3,417	3,773	2,848	2.6%	2.8%	2.5%
Subspecialist: Diabetes and Endocrine	3,744	3,783	3,061	2.9%	2.8%	2.7%
Subspecialist: ENT	1,983	2,278	1,636	1.5%	1.7%	1.4%
Subspecialist: General Surgery	3,025	2,834	2,304	2.3%	2.1%	2.0%
Subspecialist: Neurosciences	2,528	2,739	2,481	2.0%	2.0%	2.2%
Subspecialist: OB/GYN	4,259	4,622	3,897	3.3%	3.4%	3.4%
Subspecialist: Ophthalmology	1,611	2,278	1,996	1.2%	1.7%	1.7%
Subspecialist: Ortho/Podiatry	12,451	13,133	10,668	9.6%	9.8%	9.3%
Subspecialist: Other	6,921	7,055	5,539	5.4%	5.2%	4.8%
Subspecialist: Pulmonary	2,033	2,299	1,719	1.6%	1.7%	1.5%
Subspecialist: Transplant	556	707	652	0.4%	0.5%	0.6%
Subspecialist: Urology	1,563	2,236	1,845	1.2%	1.7%	1.6%
Urgent Care	505	477	352	0.4%	0.4%	0.3%
Outpatient Total	**129,287**	**134,648**	**115,261**	**100%**	**100%**	**100%**

      i.   Are they able to access these services at HMH?

UMMHC hospitals and HMH offer many similar services at each respective entity such as low acuity inpatient care, behavioral health, emergency department, radiology, labs, and rehab services. Patient choice plays an important role in where care is received, with many patients deciding between getting their care where they live or where they work. Over time, UMMHC will need to better understand HMH's patient choices about where they seek to get care to identify areas of opportunity for greater support and collaboration, with particular focus on encouraging patients to obtain care locally rather than at UMass Memorial Medical Center (the "Medical Center") when clinically appropriate. UMMHC will work with HMH leadership to better understand the needs of the community to access specialty care in HMH's service area to determine how to best meet those needs. One

example of how UMMHC and HMH leadership have already worked together to keep care local is by providing pre- and post-delivery OB/GYN care at HMH even when the deliveries are occurring at the Medical Center.

3. The application states the proposed transaction will provide greater access by the Harrington community to the specialists and specialty care provided by UMMHC (pg.4).
   a. Describe HMH's current level of access to and utilization of UMMHC specialty care by service line.

Southern Worcester County patients currently have access to UMMHC specialty service lines primarily through the Medical Center or UMass Memorial Medical Group's off-campus physician office practices (Please refer to question 2 for patient utilization by service). UMMHC does not currently have a significant number of specialists in HMH's service area, but it is expected that HMH physicians will be integrated into the UMass Memorial Medical Group and, as provided for in the Affiliation Agreement, UMMHC will assist in the recruitment of the following physicians to the HMH service area: (i) three net new full-time primary care physicians; (ii) one net new full-time psychiatrist; and (iii) one net new full-time gastroenterologist. Over time, UMMHC anticipates that specialist care will be adjusted to meet the needs of the community that include the HMH service area. High acuity tertiary and quaternary care will most likely continue to be provided at the Medical Center because the infrastructure to support such care is more cost-effective when it is centralized in the region.

The attached charts at **Exhibit 3.a Spec Svs** describe the UMMHC specialty services currently accessed by the Harrington managed care network patients.

   i. Can HMH patients access UMMHC providers locally or do they need to travel to UMMHC to access specialty care?

Over the years, UMMHC has provided access to virtually every UMMHC specialty directly in the local Harrington community, with additional support from the Medical Center when there was a need for faster access or there were complex cases that required highly specialized services. Currently, three UMMHC specialists provide services in the HMH service area:

- Dr. Cynthia Ennis -clinic / electrophysiology procedures
- Dr. Douglas Jones and a nurse practitioner - vascular clinic
- Dr. Thomas Fitzgerald provides the radiation oncology service in the HMH Cancer Center

The Medical Center also provides HMH with eICU and teleneurology/telestroke services. As referenced above, the Affiliation Agreement also commits UMMHC to use diligent efforts to recruit a full-time gastroenterologist and a full-time psychiatrist to the HHCS service area.

   b. Explain how the proposed transaction will lead to stronger and more closely aligned provision of specialty care (pg.3).

Improving access to ambulatory services for patients and referring providers is one of UMMHC's top priorities across the system. Once HMH is part of UMMHC, this strategic focus will extend to include the HMH service area. UMMHC is investing in Ambulatory Care Transformation to allow patients faster access to primary and specialty care across UMMHC. Ambulatory Transformation looks to better utilize Advanced Practice Providers

for routine care visits to permit physicians to have more time in their schedules for new patient visits and patients with higher acuity conditions. Ambulatory Transformation also looks to find the best mix of support staff to provider ratio to maximize clinic productivity that will allow for faster access to high quality specialty care by patients in the community. HMH will be incorporated into this system-wide strategic and operational work which will strengthen access to care in the HMH local service area.

4. The application states the addition of HHCS to UMMHC will enable more ambulatory access and allow the combined organization to retain care at the local level. (pg.5)
    a. Describe how the proposed transaction will enable more ambulatory access for patients and referring providers?

The addition of HHCS to UMMHC will enable continued and increased access to ambulatory care by members of all the communities currently served by HHCS. UMMHC will bring the resources of a large centralized physician recruitment infrastructure and medical group management team to the challenge of increasing local access. In addition, UMMHC will offer the financial stability and access to state-of-the-art electronic health record systems necessary to retain high quality providers. While UMMHC and HHCS share a commitment to ensuring patients will have the ability to receive the bulk of their care locally, the full resources of the UMMHC system also will be available for HHCS patients. The extension of the UMMHC Epic electronic health record system to HHCS will further facilitate access and intra-system referrals.

Moreover, HHCS has developed a large continuum of behavioral health services, with seven outpatient clinic sites treating patients across the lifespan, as well as several structured outpatient programs such as Partial Hospitalization and Intensive Outpatient Treatment, and a new urgent care service (Addiction Immediate Care) for patients with substance use disorders. These services, in addition to the planned addition of 10 new adult psychiatric inpatient beds (for a total of 40) and UMMHC's commitment to recruit a new psychiatrist, will not only continue to provide all levels of care to the local community, but will bring more integrated resources to which UMMHC and CommunityHealth Link can refer to meet the needs of patients in the HMH service area and assist in the transition of patients from the HMH Emergency Department. Finally, the Affiliation Agreement requires UMMHC to recruit three additional primary care physicians ("PCPs").

5. The Patient Panel includes the entire UMMHC and the HMH patients.
    a. What are the benefits of this proposed merger to UMMHC patients and how will they be measured?

Most community hospitals such as HMH focus on providing lower acuity specialized care to patients in the community, while more acute specialized care is typically provided in a tertiary or specialized hospital such as the Medical Center. UMMHC does not anticipate that this structure will materially change because of the proposed project, but does believe that the UMass Memorial Medical Group can better assist in physician recruitment and retention of both PCPs and specialists in HMH's service area.

UMMHC and HMH have a long history of working collaboratively to care for patients in southern Worcester County. UMMHC anticipates that this will continue once HMH becomes a member hospital of UMMHC and HMH physicians are employed by the Medical Group. The eICU and telestroke services are two examples where

UMMHC and HMH have collaborated to provide care to southern Worcester County residents. These two programs have allowed HMH patients access to high acuity care while remaining local, except in cases where more advanced treatment is needed in a tertiary hospital.

A telestroke service at a community hospital enables the ambulance to bring the patient with suspected stoke to the local hospital and have a time-sensitive evaluation for administration of tPA, which generally must be administered within a 3 to 4.5 hour window ("Time = Brain"). Without such a program, local patients with suspected stroke would bypass the local community hospital and be diverted directly to a tertiary hospital with full stroke infrastructure, even though they may not actually be experiencing a stroke. This allows a community hospital to rule out stroke and care for suspected stroke in the community. Telemedicine programs such as this enable a community hospital to stabilize and treat patients in the closest, most appropriate setting, and only transfer the patient to a tertiary facility if needed.

UMMHC anticipates that once HMH is integrated with EPIC, there will be greater alignment of care between HMH and the entire UMMHC system. Integration is expected to help improve overall quality of care as well as reduce the need for redundant testing that often can occur when patients receive care at multiple entities.

UMMHC will monitor overall inpatient volume trends to ensure patient needs are being met, both from a community and tertiary hospital perspective. UMMHC will also work with HMH management and local community leaders to better understand the needs of the community from an ambulatory perspective to determine the best way to meet patient needs.

Factor 1b. Public Health Value, Improved Health Outcomes and Quality of Life.
Assurances of Health Equity
6. The application has cited investing in community hospitals such as UMass Memorial Health Alliance-Clinton Hospital, Leominster campus and Marlborough (pg.6).
    a. How do you plan to invest in HMH to ensure access to services for the local community?

UMMHC has invested in its community hospitals for the benefit of its patients, with an emphasis on providing local access to care. At UMass Memorial Health Alliance-Clinton Hospital, UMMHC recently completely redesigned and renovated a crowded emergency department, in addition to other renovations and enhancements elsewhere at the hospital. At Marlborough Hospital, UMMHC has developed a comprehensive Cancer Center that is convenient for patients in the community, as well as for patients seeking care in a less crowded campus than the Medical Center. This is particularly important to patients whose care requires multiple visits.

UMMHC will support HMH with best practices, including ensuring that a robust Community Health Needs Assessment (CHA) is completed that engages the area's Latino/Hispanic community and other minority and vulnerable populations. The CHA process includes the incorporation of focus groups, key stakeholder interviews, community health surveys and community forums. Additionally, from the findings and identified priorities of the CHA, UMMHC will provide shared learning for the development and implementation of a Community Health Improvement Plan (CHIP).

In collaboration with community stakeholders, UMMHC will strengthen HMH's local CHNA (Community Health Network Area) infrastructure to develop the strategies necessary to implement the CHIP, which will enhance shared ownership with community partners and stakeholders towards achieving health improvement outcomes for vulnerable and under-resourced populations. UMMHC will share best practices with HMH to develop a strategy for conducting outreach that engages multi-sectoral representation among community partners in the local CHNA. UMMHC will work with HMH to seek opportunities to partner and leverage funding to address the priorities identified in the CHA and the CHIP. UMMHC will work with HMH to forge strong linkages with the local public health sector in HMH's service area.

The transaction will also enable UMMHC to work closely with HMH on its community health improvement efforts to identify interventions based on specific community needs and how UMMHC might apply its existing, developed interventions to the area. If funding and capacity are available, some interventions could include community health worker Interventions focused on priority issues such as pediatric asthma. UMMHC will work collaboratively with Harrington in the development of a robust Community Health Needs Assessment and Community Health Improvement Plan that will identify community health needs specific to their area and outline strategies to addressing them considering their existing level of work with public health and other community stakeholders in the Harrington area. UMMHC will help in expanding those areas and building additional community/clinical linkages.

UMMHC will also work with Harrington and its local community to expand CommunityHELP – an electronic database of community organizations and resources for assistance in addressing social determinants of health – to include the Harrington service area. Once HMH is integrated into the UMMHC Epic electronic record, the fully integrated version of CommunityHELP will be available to HMH and its providers.

> b. How will these investments improve health outcomes and quality of care for HMH patients?
> > i. Provide metrics that will be used to track progress.

Given the importance of Social Determinants of Health, it is critical to develop community/clinical linkages to address community health needs. As such, UMMHC:
- Will incorporate a community/clinical linkage approach to develop an intervention(s) to address identified needs.
- Will utilize data to identify the population, looking at Social Determinants of Health and adopt evidence-based models that support community/clinical linkages to improve health outcomes among vulnerable populations.
- Will track the zip code activity in the Harrington region within CommunityHELP and add Southbridge to the monthly score card (usage data tracking) to track most prevalent Social Determinants of Health searches.

Measurements and metrics would include:
- o Identification of data indicators such as food insecurity, housing, transportation and access to care and social supports and services.
- o Utilization of data to identify the need and root cause of a disparity among vulnerable populations

- o   Development of clinical/community linkage intervention(s)
- o   Number of patients impacted
- o   Evidence of utilization of culturally competent Community Health Workers
- o   Evidence of engagement of the public health sector to develop a population-based perspective
- o   Evidence of engagement of community organizations/resources that can support the intervention(s) such as: barber shops, faith-based groups, local employers, YMCA/YWCAs and others
- o   Evidence of engagement with other health care providers such as: community health centers, local providers, and VNAs
- o   Evidence of addressing language and cultural barriers within the intervention(s)
- o   Evidence of successful adoption of evidence-based models
- o   Evidence of creating a data collection methodology that tracks outcomes and improvement
- o   Evidence of utilization of performance monitoring e.g.; ongoing quality improvement Lean methodology (Plan Do Study Act) to make necessary changes
- o   Evidence of implementing an evaluation plan for the intervention(s)
- o   Evidence of incorporation of a sustainability plan for intervention(s)
- o   Evidence of shared outcomes with the community

7. The application states UMMHC and HHCS both participate in the UMass Memorial Managed Care Network and UMass Memorial Accountable Care Organization (MSSP) (pg.4). Both organizations have collaborated to improve quality and patient outcomes and reduce total medical expenses (TME) through performance improvement initiatives, post-acute networks, and aligned care management strategies.
    a. Explain the performance improvement initiatives, post-acute networks, and aligned care management strategies undertaken.

The attached pdfs (7.a H Quality 2020; 7.a H AWV 2021; 7.a H PHO 2021; 7.a H PHO newsletter) demonstrate the performance improvement initiatives taken by HHCS in 2019, 2020 and into 2021. The UMass Memorial Office of Clinical Integration (OCI) is responsible for managing the performance of the system's value-based contracts. Because HHCS participates in the managed care network and the Medicare ACO, performance improvements and care management strategies are developed in coordination with OCI. The initiatives described in the attachment were developed through collaboration by the UMass Memorial Office of Clinical Integration's Chief Medical Officer and Senior Director of Performance Improvement, and the Harrington PHO leadership under the structure of the UMM ACO and Managed Care Network.

    b. Demonstrate how the collaborations have resulted in improved quality and patient outcomes.

Please see attached performance report (7.b perf Rpt).

8. The application states HMH's service area includes a significant Hispanic/Latino population and that UMMHC will ensure targeted outreach to the Hispanic/Latino and other ethnic groups in the area to improve access to care and health disparities (pg.16).
    a. Provide examples of specific outreach strategies that UMMHC has used to improve access to and quality of services for these groups.
        i. Describe any benchmarks and metrics that were used to track progress.

UMMHC has used the following outreach strategies to improve access to the quality of services for the foregoing groups:

Development and implementation of a multi-sectoral, community-wide Pediatric Asthma Intervention
   i. Number of referrals
   ii. Number of home visits conducted by Community Health Workers
   iii. Funding leveraged for home remediation
   iv. Improved school attendance
   v. Medication adherence
   vi. Tracking of hospitalizations and ED use

- Organizing and supporting the Coalition for a Healthy Greater Worcester (a Healthy Communities Coalition) that coordinates progress of the Greater Worcester Community Health Improvement Plan (CHIP)
   i. Evidence of successful tracking of CHIP priorities
   ii. Evidence of a successful infrastructure that supports the CHIP
   iii. Evidence of successful tracking of CHIP indicators

- Development of an ACE (Adverse Childhood Experience) Program in collaboration with the Worcester Youth Violence Task Force that addresses trauma in children under ten years of age
   i. Number of children served
   ii. Number of home visits conducted by Community Health Workers
   iii. Evidence of tracking of social determinants of health impacting families and children
   iv. Evidence of connectivity to social supports

- Development of Community Gardens in collaboration with neighborhood residents to address food insecurity in food desert areas
   i. Number of neighborhood youth workers employed in the Worcester Regional Environmental Council's (REC) YouthGrow program
   ii. Pounds of fresh produce grown at the community garden and distributed to food insecure areas across the City of Worcester through REC's Veggie Mobile and Mobile Markets
   iii. Number of community gardeners from the neighborhood in which the garden is located

- Improve access to medical and preventive dental care for vulnerable populations through the UMass Memorial Ronald McDonald Care Mobile at ten neighborhood sites and in 20 elementary schools serving low income populations
   i. Number of patients served
   ii. Number of schools served
   iii. Number of sealants, fluoride varnish, dental screenings provided
   iv. Number of patients diverted from unnecessary ED use

- In collaboration with the Worcester Division of Public Health and representatives of the Latino community, UMMHC provides COVID-19 Testing in multiple neighborhoods in which data have indicated a high COVID positivity prevalence
    i. Number of people tested
    ii. Patient zip code neighborhood data
    iii. Positivity rates
    iv. Successful functionality of a Community Advisory Board

- UMMHC developed a mobile COVID-19 vaccination program that partners with community-based organizations to educate and provide vaccines in the neighborhood while also providing vaccines to individuals who are homebound. The intervention collaborates with a range of community-based organizations including faith-based groups, community development corporations and the Worcester Boys & Girls Club.
    i. Number of people vaccinated onsite at neighborhood locations
    ii. Number of people vaccinated in the home
    iii. Evidence of partnerships with neighborhood/community-based organizations
    iv. Tracking of racial/ethnic data to ensure targeting populations of color with high COVID-19 positivity rates

9. The application states UMMHC has an explicit system-wide focus on addressing health disparities based on race and ethnicity. UMMHC's approach is data driven and focused on measurable progress (pg.8).
    a. Describe UMMHC's specific plans for addressing health disparities.
        i. What other outcome metrics do you track in addition to reducing disparities in well child visits for Black/African American and Hispanic/Latino patients (FY2021)?

Exhibit 9.a RE Quality describes the ambulatory measures tracked by race and ethnicity. While reduction of racial/ethnic disparities in well child visits is a strategic system goal (and included in the system annual performance incentive program), all measures are part of our performance improvement work.

        ii. How does UMMHC plan to include HHCS in its efforts to address health inequities and reduce health disparities?

Health equity and reducing health disparities is a UMMHC "True North" goal and each member entity is required to set downstream goals to achieve improvement for the system. Like the other entity presidents, the HMH president will be evaluated and incentivized based on System performance on these goals. As part of the UMMHC system, HHCS will be included in all system-led performance improvement initiatives and held accountable to meet these goals. The UMMHC Office of Clinical Integration will continue to collaborate with the HHCS population health department to set and assist it to achieve similar goals, including providing sophisticated data reporting and best practice support.

10. Describe the structure of UMMHC's current SDoH screening and referral processes for UMMHC hospital patients including when screening occurs, domains covered, and the referral process.
    a. The application mentions partnerships with CBOs and a web-based platform (CommunityHELP) to link patients to resources.
        i. Does UMMHC have a mechanism to track or follow-up with patients referred to these resources?

The UMMHC SDoH screening process is anchored in UMMHC's primary care practices. By September 30, 2021, 75% of UMMHC primary care practices will be conducting universal SDoH screening for their patients annually. The SDoH screening tool identifies needs within 14 domains, is available in 4 languages and will shortly become a component of UMMHC's patient portal pre-visit check-in process. UMMHC is working with community organizations to explore direct web linkage through the CommunityHELP platform to provide immediate linkage from SDoH screening to referrals to appropriate community-based resources (such as community legal aid, housing or food resources). UMMHC's social work team also can access the SDoH screening information.

Once an SDoH screening has been completed, the workflow tasks the patient's primary care with following up to rescreen the patient and evaluate whether identified resources have addressed the need. Social workers can escalate for emergent needs and for those patients who require support accessing community resources.

11. Language Access and other CLAS measures:
    a. Describe the structure of the UMMHC interpreter services (IS) program for UMMHC hospital patients including staffing, hours of operations, and service delivery modalities.

UMMHC has a long standing, robust Interpreter Services department which serves the UMMHC community in a variety of ways, including assisting both inpatient and ambulatory patients, and providing access to telephonic capabilities in over 100 languages. Attached **(Exhibit 11.a UM IS SOS)** is the Medical Center's Interpreter Services Scope of Services. To varying degrees, these services are provided at the UMMHC member hospitals as deemed necessary.

    i. Describe any anticipated operational changes to the IS Program as a result of the proposed transaction?

UMMHC anticipates increased sharing of best practices and procedures.

    ii. What are the Applicant's plans for integrating HHCS into its IS program.

UMMHC's plans to integrate HHCS into the IS program are as follows:
- Conduct a Language Needs Assessment that identifies the need; will incorporate feedback from patients in multiple departments, provider and community feedback
- Share IS assessment findings with leadership and community
- Develop a plan to address language needs that includes hiring and training of Medical Interpreters as well as provider training on cross cultural competency/ communication with a focus on how to effectively utilize interpreters
- Conduct on-going tracking of language needs and report to leadership
- According to the identified language needs, will utilize the different methods of interpretation to meet patients' language proficiency as well as hard of hearing needs

Currently, HHCS interpreter services is a 24/7 service with two full-time employees who work Monday – Friday, along with Stratus Video for 240+ languages that can be accessed by staff immediately and round the clock.

       b. Describe what else the Applicant is doing around CLAS to ensure that services delivered to the patient panel are effective and equitable. Refer to the guide on CLAS https://www.mass.gov/lists/making-clas-happen-six-areas-for-action - if needed.

The responsibility to integrate the CLAS six domains listed below in the organization activities is not centralized and falls under the responsibilities of various departments as described below.

1. Foster cultural competence
2. Build community partnerships
3. Collect and share diversity data
4. Benchmark: plan and evaluate
5. Reflect and respect diversity
6. Ensure language access

UMMHC is committed to ensuring that equitable health care access, and culturally and linguistically appropriate care and services are available to all of its patients. Therefore, as the COVID19 pandemic and the current public health crisis disproportionately affected the Latino/Hispanic and Limited English Proficiency (LEP) communities in the region and exposed significant health inequities, UMMHC has adopted a Health Equity strategic priority that is driven by data, community and hospital leadership engagement, and input from the affected communities. While addressing health equity issues is always a leading priority for UMMHC's work, the Health Equity Task Force solidifies this targeted approach through various efforts such as making access to linguistic and culturally appropriate services one of the top priorities of the organization's strategy to ensure equitable health care access to patients.

The IS department at the Medical Center is one of most comprehensive hospital-based programs in the country. The main goal of the IS department is to deliver high quality language services to ensure that the LEP patient population at the Medical Center have access to care that is safe, effective, patient-centered, timely, efficient, and equitable.

IS evaluates language services data that include the ratio of languages to overall population, ratio of diverse population language needs by admission and requests for interpreters. Hospital demographic data, quality performance by interpreter modalities, staffing levels, wait times for service delivery and other factors are reviewed on an ongoing basis with senior leadership to examine current conditions, identify areas of improvement, and strategically improve quality and accessibility of language services.

Ongoing training and educational sessions are provided to ensure caregivers understand cultural competence and the importance of using qualified interpreters to provide the highest quality and safest care, in a manner compatible with our patients' preferred language to receive health information.

Community Partnership: The Community Benefits Department is responsible for conducting Community Education and Outreach. Community input for program and policy development is developed through the Community Health Needs Assessment; input is gathered through the following initiatives listed below. The data and input gathered through efforts such as working with the limited English-speaking population and other racial, ethnic and linguistic groups through the UMass Memorial Care Mobile program provide deeper understanding of the critical linguistic and cultural barriers that impact health and one's ability to be healthy. This data and feedback will continue to be pursued and utilized to provide better advocacy for policy change and funding opportunities for interventions that target and more effectively address these barriers.

The Community Health Needs Assessment process includes the following methods of input:

- focus groups
- community surveys
- participates in community activities
- community outreach programs
- Other: conducts community stakeholder interviews and Community Forums in collaboration with its partners (Worcester Division of Public Health, Fallon Health, Coalition for a Healthy Greater Worcester)

Factor 1c Efficiency, Continuity of Care, Coordination of Care
The application states UMMHC is taking a multi-pronged approach to reducing out migration, including strengthening care coordination and addressing the barriers to timely access to care. (pg.5)

        a.   Describe UMMHC's multi-pronged approach to reducing outmigration.

Improving access to the ambulatory services for patients and referring providers is one of UMMHC's top priorities. The addition of HMH to UMMHC will enable more ambulatory access and allow the combined organization to retain care at the local level. The goal of UMMHC's Ambulatory Transformation is to open providers' schedules to allow patients faster access to specialty care and primary care across the health system. Ambulatory Transformation looks to better utilize Advanced Practice Providers for routine care visits so that physicians have more time in their schedules for new patient visits and those patients with higher acuity conditions. Ambulatory Transformation also looks to find the best ratio of support staff to providers to maximize clinic productivity that will allow for faster access to quality by patients in the community.

UMMHC is pursuing this strategy to improve timely access to care as UMMHC believes that this is a key element to stemming outmigration. If patients in our service area are unable to access care locally and timely, that increases the likelihood they seek care elsewhere, especially for more acute, time-sensitive, suspected conditions. This generally results in higher cost care if patients go to Boston, or even greater Boston, and reduces the coordination of care as the patients' care is fragmented across unaffiliated providers.

UMMHC has also started utilizing Sg2 Data Analytics to better understand the details of outpatient outmigration. Previously, outmigration data was more limited to inpatient analyses. Physician liaisons use this data to help educate referring physicians about the breadth and quality of services available locally and the impact on coordination of care for the benefit of their patients.

12. The application states the proposed transaction will keep appropriate care local. (pg.5)
    a. How does UMMHC's expertise in its own community hospitals to date demonstrate its ability to keep care local?

UMMHC is focused on offering patients a choice about where to receive care by providing a wide range of services at its community hospitals, including inpatient, surgical, diagnostic radiology, and ambulatory care. UMMHC encourages patients to remain local, especially when UMMHC community hospitals can provide a similar level of services as the Medical Center. The Medical Center and the UMMHC community hospitals regularly work together in conjunction with physicians to identify patients that can remain local for their care. The Medical Center looks to identify strategies to keep appropriate inpatients at the community hospitals so that it is better able to serve those requiring high tertiary level care, rather than having to transfer or redirect them to Boston for care. It is estimated that about 1,000 patients requiring tertiary level care are redirected annually to other facilities because of bed capacity issues at the Medical Center.

UMMHC has made investments in its community hospitals' subspecialty and emergency department care to enable patients to remain local for care including: replacement of a linear accelerator at UMass Memorial HealthAlliance-Clinton; the development of a cancer program at Marlborough Hospital; the renovations to UMass Memorial HealthAlliance-Clinton's Leominster Campus emergency department; and the continued investment in a highly functioning eICU program used by the community hospitals and the Medical Center's Memorial campus to keep ICU level of care patients local.

i. What types of metrics is UMMHC using to track progress?

On a monthly basis, UMMHC monitors cost center volumes at the department level in relation to budget and budget initiatives that are put in place at the beginning of every fiscal year. These budgets and budget initiatives are put in place with leadership at the Medical Center, UMass Memorial Medical Group, and the community hospitals to better manage service line care across all entities. Please also see the response below in subsection (ii) and the metrics in the UMass Memorial Health Alliance–Clinton Tracker.

ii. Provide evidence to show improvements over time.

The following areas are UMMHC's areas of focus as it relates to keeping care local:

1. Physician Recruitment: UMMHC has a large physician recruitment practice that allows us to recruit to local markets.
2. Physician Recruitment: UMMHC is able to send specialists to its community hospitals to provide part-time support.
3. Telemedicine/TeleHealth: UMMHC is able to provide tele-consults that allow community hospitals in our network to keep higher acuity patients instead of transferring them. Many of the high acuity patients do not require procedures and can stay in community, but community hospitals historically have been resistant to doing this due to the chance of a patient needing an immediate procedure that they could not provide. If a procedure that cannot be provided locally is required, community hospitals can transfer the patient to the Medical Center for care.
4. TRAC Center: UMMHC has a patient Transfer Center that monitors referrals to Worcester and seeks to divert care to our community hospitals if they can provide the right level of care for these patients.

UMMHC tracks patient transfers. Below is a snapshot of the UMass Memorial HealthAlliance-Clinton Tracker. Historically patients seen at UMass Memorial HealthAlliance-Clinton Hospital's Clinton campus were transferred to the Medical Center when more advance care was needed that couldn't be provided at Clinton. UMass

Memorial HealthAlliance-Clinton Hospital's leadership has developed a process by which patients are first evaluated to see if its Leominster campus can meet patient needs before they are considered for transfer to the Medical Center. This has allowed more patients to remain in a community hospital setting when clinically appropriate.

HealthAlliance-Clinton Hospital Transfer Dashboard

		Transfer Statistics FY21													FY20 and FY19	
Transfer From	**Transfers To**	**Oct'20**	**Nov'20**	**Dec'20**	**Jan'21**	**Feb'21**	**Mar'21**	**Apr'21**	**May'21**	**Jun'21**	**Jul'21**	**Aug'21**	**Sep'21**	*FY21 Total*	FY20 Total	FY19 Total
HA-Clinton	HA-Leominster	25	17	14	37									93	304	410
HA-Leominster	HA-Clinton	0	0	0	0									0	0	60
Other Hospitals*	Leominster-Clinton	3	1	0	6									10	64	178
Total		*28*	*18*	*14*	*43*									*103*	*368*	*648*
* Other Hospitals include:																
	Heywood/Athol	2	0	0	3									5	53	148
	Marlboro	0	1	0	1									2	6	8
	Monadnock (NH)	0	0	0	1									1	0	7
	Nashoba	0	0	0	0									0	1	2
	Umass Med Ctr	1	0	0	1									2	4	11
	Bay State Wing	0	0	0	0									0	0	1
	Holy Family	0	0	0	0									0	0	1
	Total	*3*	*1*	*0*	*6*									*10*	*64*	*178*
Missed Attempts to Transfer		**Oct'20**	**Nov'20**	**Dec'20**	**Jan'21**	**Feb'21**	**Mar'21**	**Apr'21**	**May'21**	**Jun'21**	**Jul'21**	**Aug'21**	**Sep'21**	*FY21 Total*	FY20 Total	FY19 Total
		6	2	0	0									*8*	*16*	*107*

13. How will the proposed transaction allow for better communication and more coordinated care? (pg.5)
    a. Provide details on UMMHC's coordinated plan and clinical pathways.

        i. How will HHCS be incorporated into this infrastructure?
        ii. What metrics will you use to track improvements?

Attached **(13.a Pop Hlth)** is an extensive overview of the UMMHC population health quality and performance program. This includes the structure, major strategies and performance monitoring thru metrics. HHCS is already incorporated into this program through its participation in our Medicare ACO and as part of our Managed Care Network. As mentioned previously in the response to Question 7, the UMass Memorial Office of Clinical Integration currently works closely with the HHCS population health team on shared value-based contracts to monitor and improve performance in quality and reducing total medical expense. The transaction will strengthen that relationship and allow for increased partnership and sharing of best practices on all value-based contracts at HHCS. Improvement is expected as a result of this increase in partnership and expansion of shared value-based contracts.

14. Demonstrate how EPIC has been beneficial for UMMHC hospitals and campuses (e.g., how it has brought efficiencies, consistency).

UMMHC achieved HIMSS Stage 7 recognition – a distinction shared by a very small percentage of health care organizations. UMMHC is the largest health care system in Central Massachusetts and has the region's only Level 1 Trauma Center. The HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) for hospitals and O-EMRAM for outpatient, incorporates methodology and algorithms to automatically score hospitals and ambulatory sites around the world relative to their electronic medical records (EMR) capabilities. This eight-stage (0 to 7) model measures the adoption and utilization of EMR functions. Currently, UMass Memorial Hospitals make up three of only seven hospitals in Massachusetts that have achieved HIMSS Stage 7.

The implementation of Epic has provided UMMHC with a single patient record for care of all 1.2 million of its patients, regardless of location. As patients move between care settings within UMMHC, information about their care is readily available. Providers can see everything that has occurred with their patient, including up-to-date diagnostic results. UMMHC uses Epic as both its EHR and a Practice Management (PM) solution, eliminating the need for integration technologies to share patient centric information.

Hundreds of physicians and staff from across UMMHC helped design and tailor the version of Epic that UMMHC adopted to capture a patient's entire care experience – from scheduling an appointment to receiving a bill for services. The following is an overview of what Epic provides to UMMHC:

- **Easy to use documentation tools –** tools that have been built for dozens of specialties and physicians.
- **Private secure data –** securely share clinical data via Epic, since end user access by role (e.g. nurse, medical assistant, physician, etc.) is managed by security policies and procedures. Advanced security functions are in place to protect sensitive information and to comply with HIPAA regulations.
- **Quick access to data –** Epic enables access whether caregivers are in the office, home or working in the hospital, thereby saving time, increasing productivity, and facilitating physician efficiency.
- **Patient safety –** UMMHC takes advantage of Epic drug-drug and drug-allergy interaction checking at the time of medication ordering, as well as electronic medication prescribing directly to pharmacies, thereby reducing medication errors.
- **Meaningful Use™ –** UMMHC utilizes Epic to satisfy Meaningful Use requirements qualifying UMMHC to attest for those regulatory initiatives.
- **Lab and Imaging Results –** Epic interfaces with lab and imaging results from many service providers through existing interfaces.
- **myChart –** UMMHC offers a new, system-wide patient website that allows patients to request prescription refills and appointments, view their health information and communicate with UMMHC staff electronically. There are currently over 215,000 patients sharing and accessing information through myChart with UMMHC.

UMMHC has used Epic to document care associated with:
- Over 221,000 emergency department visits
- Over 1.5 million ambulatory visits
- Over 4,500 births
- Over 49,000 discharges

HHCS currently uses two separate electronic medical records with limited integration. Physicians and others providing care for patients often must look in multiple systems to gain a full picture of what is happening with their patients. When HHCS caregivers move to Epic, they will have access to a single patient record that includes all information about the patient. Additionally, information from other health care providers who use Epic will be easily available. Epic's "Care Everywhere" system has allowed UMMHC to exchange patient information for:
- 9 million patients
- with over 2,000 hospitals
- with over 1,700 emergency departments
- with 43,000 ambulatory clinics/practices
- from all 50 states

While the migration plans have not been solidified, the current plan to move HHCS caregivers from their current Allscripts and Meditech systems is expected to be completed in a single move from their legacy systems to Epic. Little downtime and disruption is expected to occur during this migration. Until the migration to Epic, HHCS caregivers have access to UMMHC's "Epic CareLink" portal which allows UMMHC to extend patient information to external facilities and affiliated providers, helping improve continuity of care in our community. EpicCare Link is secure, real-time, and easy to roll out to users who need remote access to UMMHC's clinical data.

> a. As implementing EPIC at HMH is a multi-year effort, what are the interim plans to ensure continuity and coordination of care between UMMHC hospitals and HMH?

UMMHC is in the pilot phase of an EMR integration project which will enable HHCS EMR data to be brought into the Epic system for purposes of care coordination, performance reporting and analysis. UMMHC expects this project to go live in the spring 2021 if all regulatory approvals have been received. Attached **(14.a EMR Int)** is the most recent project plan update.

Factor 1e. Evidence of Sound Community Engagement through the Patient Panel
Factor 1e. Requires us to consider "evidence of sound community engagement and consultation throughout the development of the Proposed Project, including documentation of the Applicant's efforts to ensure engagement of community coalitions statistically representative of the Applicant's Patient Panel."

15. To date, what community engagement efforts have UMMHC undertaken during the development of the proposed transaction including types of activities, level of participation, and feedback received.

UMMHC wants to be formally engaged with the greater community of Southbridge and surrounding area. In light of the pandemic, UMMHC will adapt to the circumstances utilizing technology (i.e. Zoom, Webex) and small group interviews and gatherings throughout the geographical area, while adhering to safety protocols. Interpreting for linguistic minorities and deaf/hard of hearing will be provided whenever necessary. UMMHC is looking forward to establishing dialogue and developing solid linkages with the area's most vulnerable and under-resourced populations as we strive to have a healthier community. UMMHC considers the CHI Guidelines indispensable in working with HHCS. As such, the following actions will ensure that there is appropriate engagement that incorporates planning, evaluation and implementation, accountability that has engaged diversified community members, with transparency and reporting on interventions and outcomes to ensure having an impact on community health improvement related to identified needs.

UMMHC recognizes that building a healthy community requires a long-term effort. The following are part of a road map for long-term planning and strategies to build the pieces needed to make the south Worcester County healthier. These actions and shared learned opportunities would begin as part of our Community Benefits approach once the transaction completing the acquisition of HMH is complete and continue thereafter.

The following actions are anticipated to occur over time:
- **Community Benefits:** Develop a robust Community Benefits Advisory Committee that is ethnically diverse and representative of underserved populations residing in the area, as well as inclusion of representatives of different sectors. UMMHC will foster and sustain an on-going communication strategy to foster transparency and accountability.
- **Developing Trust and Identifying Needs-Listening Strategies: A. Forums:** UMMHC anticipates conducting a minimum of 3 forums with community stakeholders such as neighborhood leaders and personnel from local banks, police departments, public schools, academia, philanthropy, Quinisagmond

Community College, Family Health Center, social support organizations, public schools, the Renaissance Medical Group, local government, community/neighborhood leaders and grass roots groups; and **B. Conduct One-on-One Interviews and Small Groups:** UMMHC will provide interpreters to facilitate communication with Limited English speaking populations and hard of hearing.

- **Neighborhood Outreach:** Weather permitting, UMMHC will conduct a walk around the neighborhood or key locations as a strategy to outreach where vulnerable populations reside or engage/congregate.
- **Engage Local Public Health:** UMMHC will conduct outreach to the local departments of Public Health (i.e. Webster and Southbridge) as a strategy to develop trust and gain knowledge about the community. In Worcester, the Worcester Division of Public Health (WDPH) has been a partner in the development of the Community Health Assessment since 2008. In 2013-14, UMMHC's partnership with the WDPH resulted in the WDPH earning national accreditation and recognition as the first health department in the Commonwealth of Massachusetts to earn federal accreditation.
- **Community Health Needs Assessment Review and Update**: **A.** UMMHC will review with community representatives the 2019 Community Health Needs Assessment findings and identify current community needs; **B.** UMMHC will develop partnerships/collaborative efforts that will result in the development of a Community Health Improvement Plan.
- **Community Benefits Annual Report and Community Benefits Strategic Implementation Plan:** UMMHC will update the HMH Community Benefits Strategic Implementation Plan and ensure completion of a Community Benefits Annual Report in compliance with regulatory requirements.
- **Community Benefits Reporting and Regulatory Requirements:** UMMHC will ensure compliance of all reporting and regulatory requirements.
- **Integration of a Health Equity Lens**: **A.** Given that UMMHC has adopted a system-wide Health Equity agenda that is addressing inequalities in care, UMMHC would replicate this for HMH.

Factor 1f. Competition on Price, Total Medical Expenses (TME), Costs and Other Measures of Health Care Spending

16. The application states the transaction is not expected to have an adverse impact on competition, and other measures of healthcare spending. (pg.4-5)
    a. How does UMMHC plan to maintain the financial viability of HMH without impacting payment rates?
    b. Research has shown that hospital mergers can impact prices[1]. What are your plans to ensure that prices don't increase?

HMH will have access to the financial stability and resources of the UMMHC system. In addition, UMMHC will bring its proven Lean management system and centralized administrative support structure to maximize efficiencies. The Project presents a significant opportunity for UMMHC to reduce total medical expense by keeping care local within the UMMHC system, the third lowest cost system in the State, and to prevent outmigration to the higher cost facilities in Eastern Massachusetts. UMMHC is taking a multi-pronged approach to reducing outmigration, including strengthening care coordination and addressing the barriers to timely access to care. Preventing out-migration and keeping care local in Central Massachusetts will help maintain the financial viability of HMH.

---

[1] Schwartz et al. (2020). *What We Know About Provider Consolidation* (Issue Brief – 9510-2).KFF. Available: https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/#:~:text=Even%20when%20a%20hospital%20merges,unacquired%2C%20stand%E2%80%90alone%20hospitals

As a safety net system with a significant public payor – and specifically MassHealth - patient population, UMMHC is reliant on reasonable commercial rates to remain financially viable. Nonetheless, UMMHC consistently remains one of the lowest cost systems in Massachusetts. As HHCS physicians already contract through the UMMHC Managed Care Network for the three major commercial payor contracts (Tufts, HPHC and BCBSMA), the transaction is unlikely to have a material impact on pricing.

Factor 2 Cost containment, Improved Public Health Outcomes and Delivery System Transformation
17. The application states the proposed transaction will improve HMH's performance in value-based contracts. (pg.9)
    a. Describe HMH's current participation in value-based contracts and intended changes you plan to make to improve HMH's performance.

HMH currently participates in 6 value-based contracts:

1. Medicare ACO with UMMHC
2. Blue Cross - internal Managed Care Network with UMMHC
3. TUFTS- Managed Care Network with UMMHC
4. HPHC - Managed Care Network with UMMHC
5. Fallon Medicare Advantage
6. Boston ACO with BMC

The various EHRs in the Harrington system, the EPIC system at the Medical Center, and independent provider reporting platforms hinder the aggregation of patient quality data that might lead to improved patient outcomes and contract performance. Many of the data are derived from the processing of billing data, which has a six-week lag. With the acquisition and the implementation of Epic at HHCS, HMH will be able to improve patient outcomes and contract performance by having more real-time information upon which to act. HHCS also will be fully integrated into UMMHC's overall robust quality infrastructure focused on improving quality and safety of care and patient experience.

18. The application states the transaction will improve the status of the combined communities through local hiring, local purchasing, and community-based investments. (pg.7)
    a. UMMHC plans to track and improve the status of the combined communities.
        i. What key outcome metrics will be tracked? Why have these metrics been chosen?
        ii. How will you ensure local hiring and community-based investments?

Community-based Investments: All investments address a Social Determinant of Health that has been identified in the CHA or CHIP reports of UMMHC's member hospitals (the Medical Center, UMass Memorial HealthAlliance-Clinton Hospital, and Marlborough Hospital). All investments are reviewed and approved by UMMHC's Community Benefit Committee. UMMHC has committed to increasing the existing Anchor Mission investments by $1 million to a total of $3.1 million by September 30, 2021. Specific community-based investments already deployed ($2.4 million) include:
- Finally, Home Loan Fund ($500,000): to support housing for chronically homeless in Worcester.
- Creative Hub Community Arts Center ($500,000) to create community and economic hub in under-resourced neighborhood in Worcester.
- Fitchburg Arts Community ($750,000): pre-development financing for mix of 43 affordable and 19 market-rate apartments that will be preferentially available to local artists.

- Worcester Common Ground ($400,000): quick-turnaround financing to support purchase of affordable properties by first-time homeowners.
- Tiny Home Village ($300,000): predevelopment costs for the $4.6M joint venture by East Side CDC and Civico to create village of 16 tiny homes for chronically homeless

Local Hiring: UMMHC has been working with community-based partners to identify and better understand the barriers that exist in recruiting and hiring local applicants for positions available at UMMHC, with the goal of overcoming these barriers, where feasible, to achieve specific hiring goals. The work includes:
- Initial identification of five entry-level positions that have minimal education and experience requirements, which align with the client base of our community-based partners.
- Coaching both potential candidates and potential hiring managers on meeting each other in an interview setting.
- Arranging interviews with candidates proposed by our community-based partners
- Tracking candidates and outcomes, and follow the post-hire results
- Expanding to additional job categories, beyond the initial five, to leverage the relationships that have been built
- Year one (FY20) resulted in 4 hires. Year two (FY21, still in process) has totaled 13 hires
- Working on greater community outreach regarding work at UMMHC, targeting high schools
- Exploring opportunities for training and coop programs

Local partners currently include:
- MassHire
- Worcester Adult Learning Center
- Worcester Community Action Council
- Ascentria Care Alliance and Ascentria Community Services

UMMHC would seek to work with community agencies in the Harrington service area.

Initial entry level jobs identified:
- Houseworker
- PCA I-Inpatient
- Catering Associate
- Patient and Equipment Transporter
- Driver/Material Handler

Local Purchasing: The UMMHC Purchasing Sub-Committee has been working with both internal stakeholders and external community organizations to develop an actionable strategy to increase local purchasing. Its initial efforts are focused on identifying the barriers that exist with finding, developing, and building local spend. It is now working with the Healthcare Anchor Network (HAN) and collaborating with other hospitals that have adopted the HAN Impact Purchasing Commitment. A summary of the actions taken to support efforts to increase UMMHC's local, diverse and sustainable purchasing include:

- Attributed spend data to identify purchases from certificated diversity suppliers (MWBE), disadvantaged businesses, and local businesses (defined as residing within UMMHC's service areas)

- Joining other HAN members and adopted the Impact Purchasing Commitment. This commitment establishes five-year defined growth goals for the following purchasing functions:

- Increase diverse spending
- Promote sustainable spending
- Build community wealth

- Creating dashboard reporting and Key Performance Indicators that will allow UMMHC to track and monitor progress against goal

- UMMHC is in the process of amending policies, contracting processes, and purchasing workflows to support diverse, local, and sustainable purchasing

- Creating internal processes designed to support/drive purchases to diverse and local vendors, when possible

19. Harrington currently participates in the MassHealth ACO program through the Boston Accountable Care Organization (BACO)?
    a. Are there any planned changes to Harrington's participation in BACO as a result of the proposed transaction? No
    b. Are there any plans for UMMHC to participate in the MassHealth ACO program? Not at this time.

Exhibits

3.a Spec Svs

Harrington Patients Receiving Care from UMMHC Specialists

- In the past 2 years, 21% of Harrington patients have received care from a UMMHC specialist

Harrington Patients Receiving Care from UMMHC Specialists between 03/01/2019-03/01/2020
Patients in MCN Value Based Care Programs as of January 2021
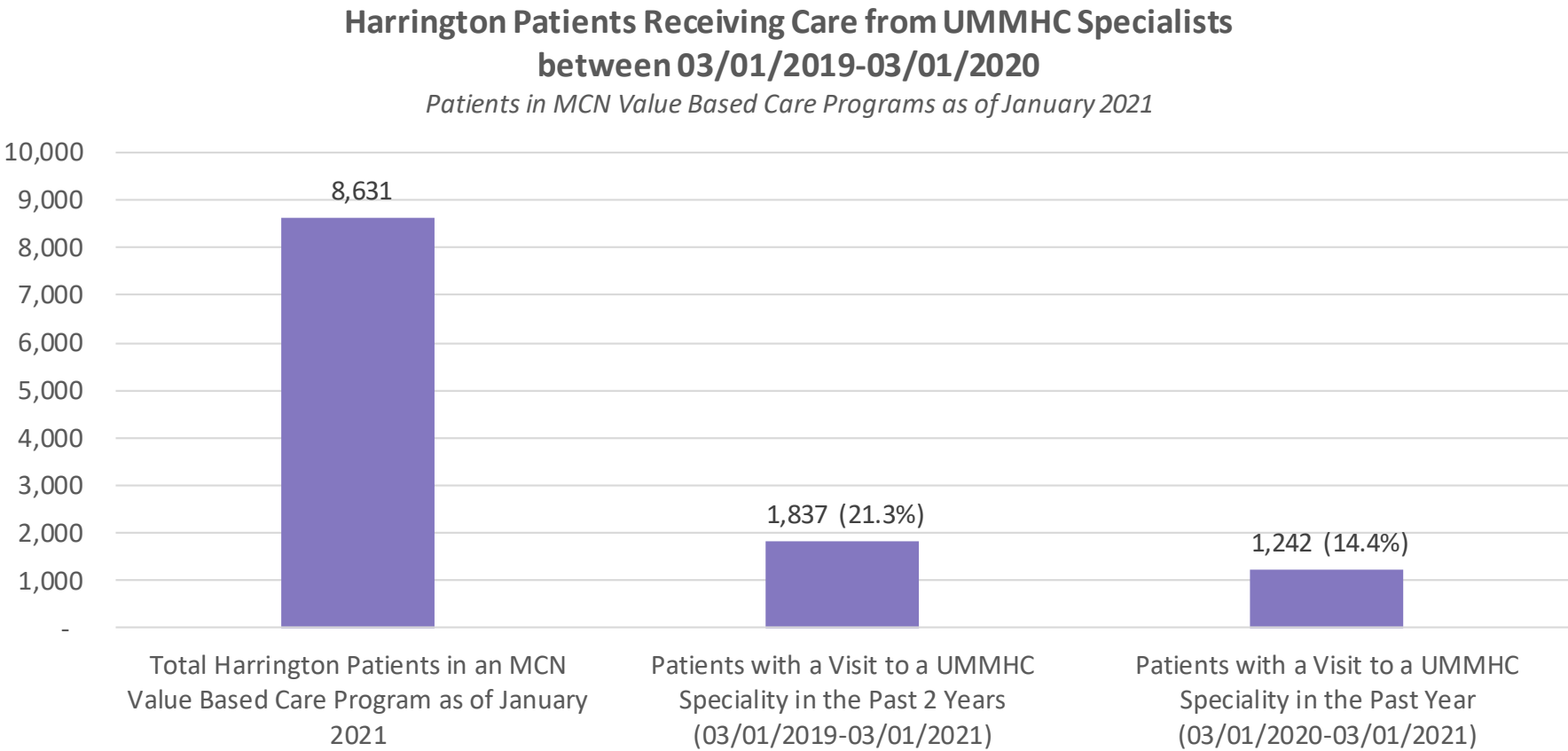
Most Frequent Types of Specialty Care

- In the past 2 years, **radiology** is the UMMHC specialty most utilized by Harrington patients, both in number of visits and in unique patients utilizing.

- Most frequent specialties:

  - Radiology
  - Cardiology / Heart and Vascular

  - Oncology / Oncology Infusion
  - Dermatology

  - Neurology

**Most Frequent UMMHC Specialties Utilized by Harrington Patients
between 03/01/2019-03/01/2021**

Patients in Value Based Care Programs as of January 2021

UMassMemorial Health Care | University of Massachusetts Medical School

Everyone, Everyday.
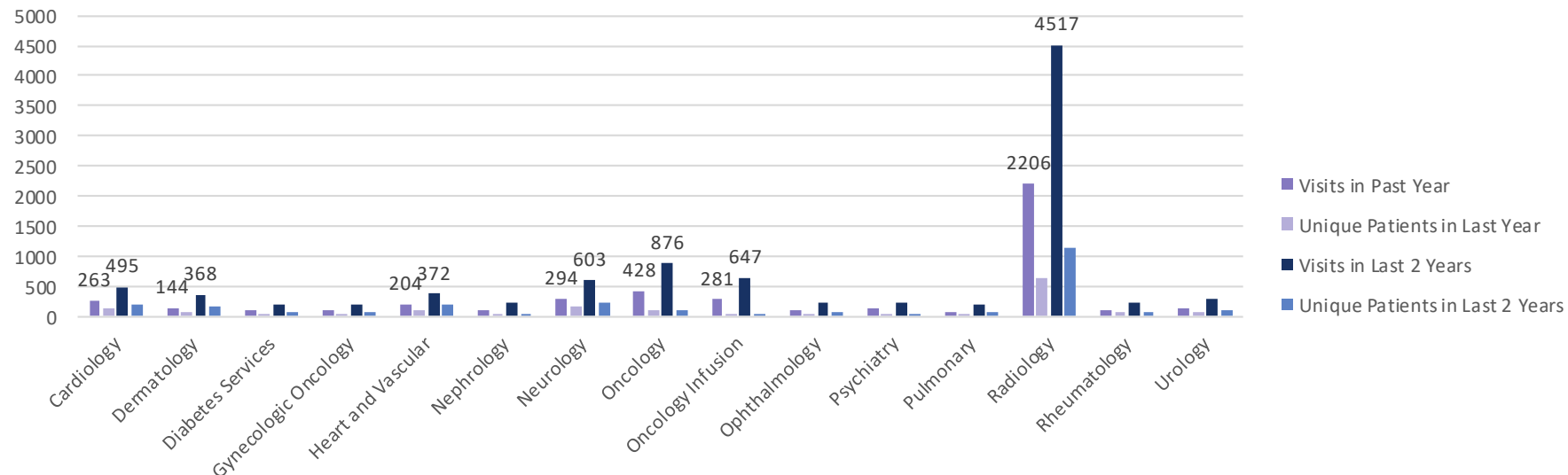
7.a PHO AWV

Harrington PHO
Annual Wellness Visit (AWV)
Focus 2021

AWV Focus

➢ Give providers their patient panel with 2020 AWV date early in 2021

➢ Review components of the AWV along with billing codes at our Q1 meetings

➢ Encourage outreach to those without an appointment in 2021

➢ Schedule the following year AWV upon patient checkout

➢ Hired 2 patient outreach coordinators to assist in scheduling appointments

Harrington
HEALTHCARE SYSTEM
Compassionate Quality Care

AWV Barriers

➢Patients not understanding the AWV vs a physical exam

➢Providers performing and billing a physical exam on Medicare patients

➢Receptionist or scheduler not noting the correct visit type on providers schedules

➢Patient refusal

7.a H PHO Newsletter

Harrington
HEALTHCARE SYSTEM

Compassionate Quality Care

PHO
In the know

GOING ON NOW:

We ask that each office schedule a visit before the end of the year for every patient who has not yet been seen in 2018 including:

>Patients with a chronic disease who may not have been seen this calendar year.

>Patients you may consider healthy, but who have not been seen in this calendar year.

>Patients who may be at high risk or have a high cost of care.

Beginning 12/18 we will offer monthly " Onboarding" - Getting to know the PHO. We will reach out to each provider/location to schedule these meetings. They will be held at the PHO Office during lunch hours.

Depression Screening

Patients aged 12 years and older need to be screened for clinical depression on the date of the visit using an age appropriate standardized depression screening tool AND if positive, a follow –up plan is documented on the date of the positive screen. Acceptable tools are the PHQ2 and PHQ9. The patient's file must reflect:

*Date and type of screening tool, scanned if possible

*Provider's signature

*Provider's interpretation of results- positive or negative

*If positive, a follow- up plan is required.

Who are we?

Lisa Casasanta — Executive Director

William Dunn, DO– Medical Director

Tricia Gay, MBA, RN,CCM - Quality Director

Christine LeGrand, CPC - Coder

Melissa Rivet– Executive Support

Please contact us with questions or comments: mrivet@harringtonhospital.org or 508-765-2109

Reminder . . . .
Next PCP meeting
12/18/18

Coding Corner

Depression....can you be more specific than F32.9 (Depression NOS)?

Code	Description
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.81	Premenstrual dysphoric disorder
F32.89	Other specified depressive episodes

7.a H PHO 2021

Year Ahead
PHO Focus for 2021

Harrington PHO 2021 Initiatives

1 Transitional Care Management (TCM) visits

2 Colorectal Cancer Screening

3 Diabetic Measures (HgbA1c, Retinal Eye, Pneumonia Vaccine, Microalbumin)

4 Depression screening

5 Tobacco screening and cessation

6 Immunizations

Harrington
HEALTHCARE SYSTEM
Compassionate Quality Care

Tranistional Care Management (TCM)

Transitional Care Management Visits billed by Month

TCMs billed by Month
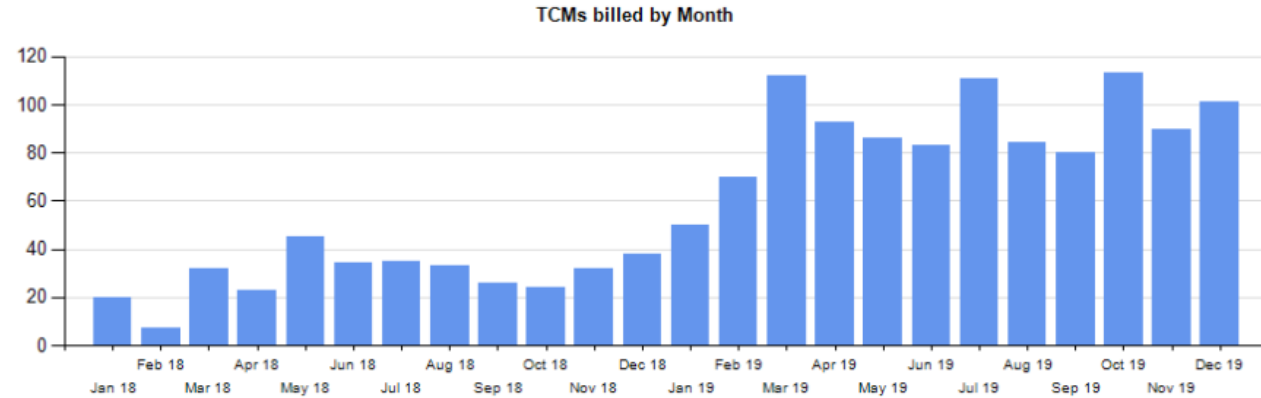
TCMs billed by Month (Year over Year)
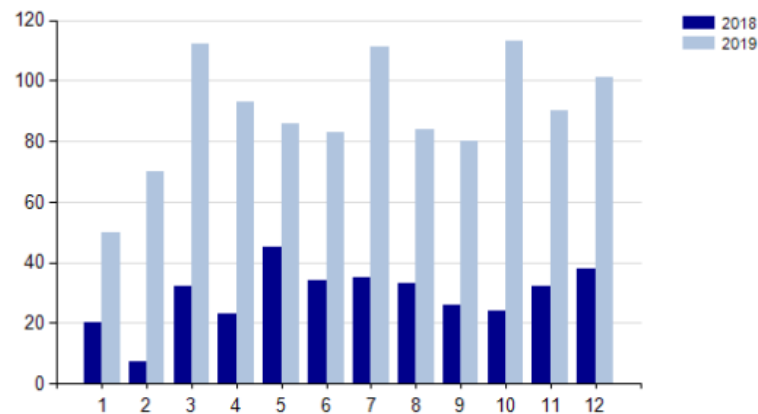
Month	2018	2019	Total
1	20	50	70
2	7	70	77
3	32	112	144
4	23	93	116
5	45	86	131
6	34	83	117
7	35	111	146
8	33	84	117
9	26	80	106
10	24	113	137
11	32	90	122
12	38	101	139
Total	349	1073	1422
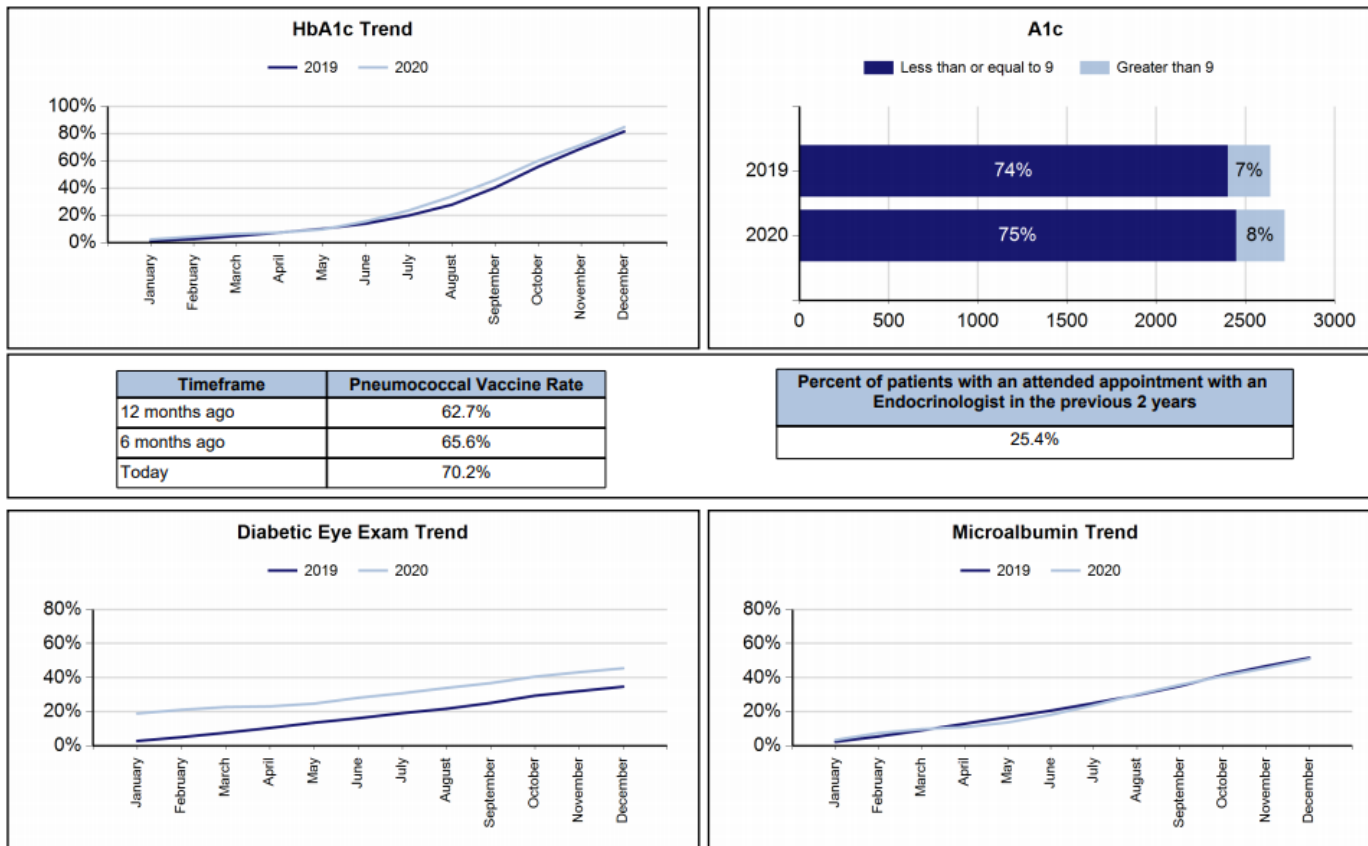
Harrington
HEALTHCARE SYSTEM
Compassionate Quality Care

Five Diabetic Measures

Colorectal CA Screening

Colorectal Cancer Screening

Colorectal Cancer Screening Rate
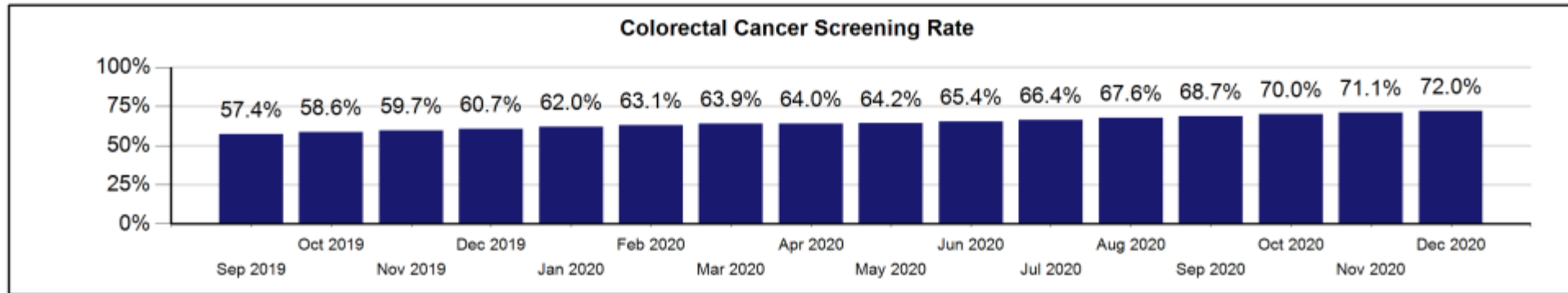
- Colorectal CA screener will continue to be a focus for the PHO in 2021
- Continue to utilize our Wellness Nurse Navigator to support providers
- New chart prep forms and process will help bring attention to patients who are non-compliant
- We are measuring the data a little differently
  - Data will be by provider rather than by patient
  - Focus will be on Primary Care Providers

Harrington
HEALTHCARE SYSTEM
Compassionate Quality Care

16

Immunizations

Childhood Immunizations

	Fully Immunized		
Cohort	2019	2020	2021
Total	24.63%	42.50%	36.17%

Adolescent Immunizations

	Fully Immunized		
Cohort	2019	2020	2021
Total	14.02%	23.40%	19.62%

Depression Screening and Follow-Up

Depression Screening and Follow-up

PHQ2		
Num	Den	Screening Rate
9,220	16,645	55.39%

Denominator: Number of patients over the age of 12 seen by an HPS PCP in the previous year
Numerator: Number of patients with a PHQ2 in the previous year

PHQ9		
Num	Den	Screening Rate
447	876	51.03%

Denominator: Number of patients over the age of 12 with a PHQ2 score >=3 in the previous year
Numerator: Number of patients with a PHQ9 on the same date as the positive PHQ2

Percent of patients who score >=3 on the PHQ2 and have a PHQ9 on the same day
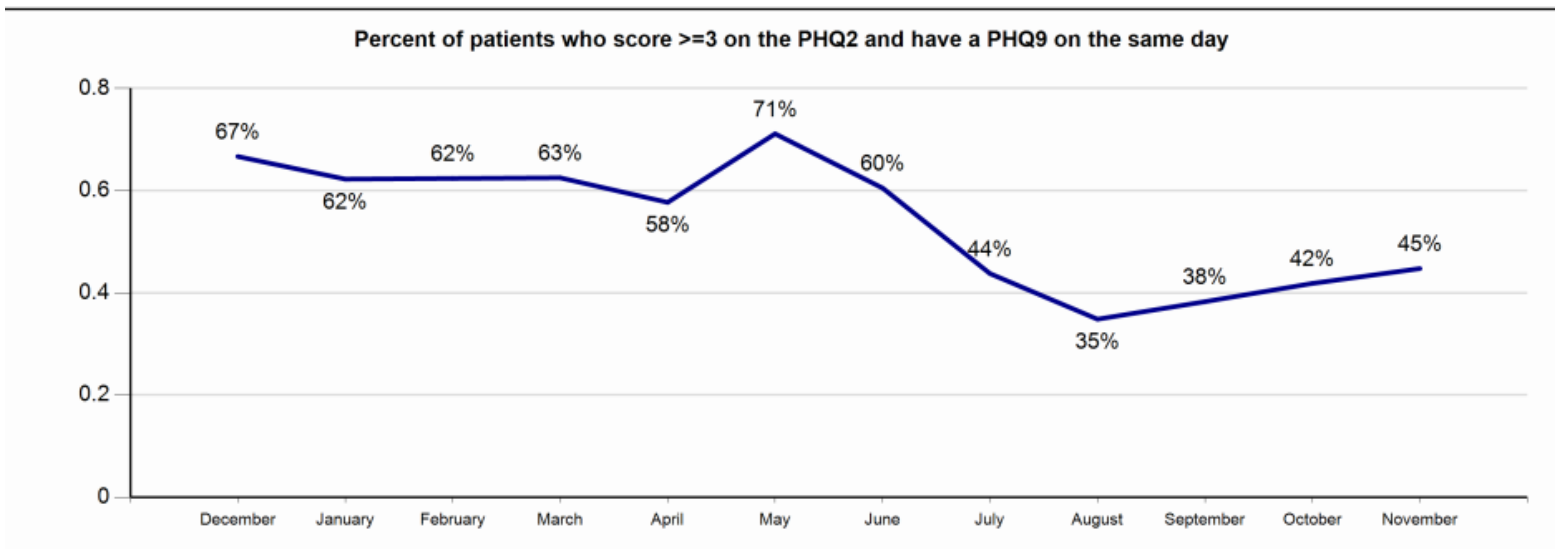
7.a H Quality 2020

Harrington 2020

We specifically targeted two quality areas:

o CRC screening
o Diabetic measures

For the end of year we are focusing on:

o TCM visits
o HCC coding

Harrington
HEALTHCARE SYSTEM
Compassionate Quality Care

CRC screening

Colorectal Cancer Screening Rate

Month	Rate
Sep 2019	58.7%
Oct 2019	59.9%
Nov 2019	61.0%
Dec 2019	62.0%
Jan 2020	63.3%
Feb 2020	64.4%
Mar 2020	65.2%
Apr 2020	65.3%
May 2020	65.5%
Jun 2020	66.6%
Jul 2020	67.7%
Aug 2020	68.8%
Sep 2020	69.9%
Oct 2020	71.2%
Nov 2020	71.6%

Diabetic Focus

HbA1c Trend

A1c
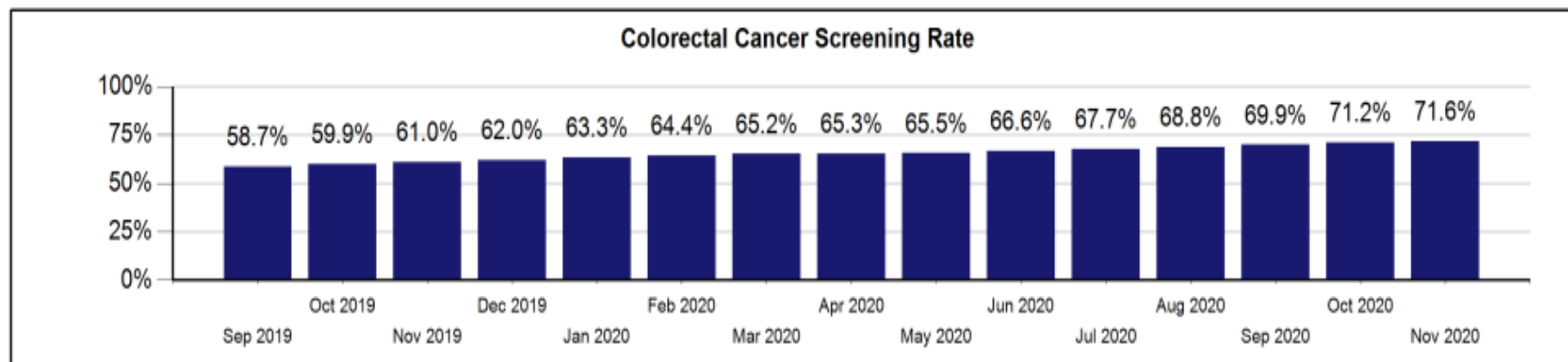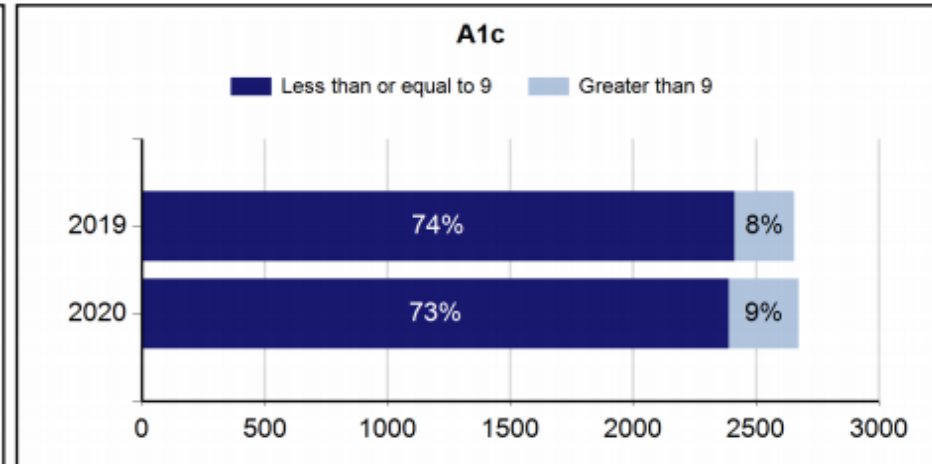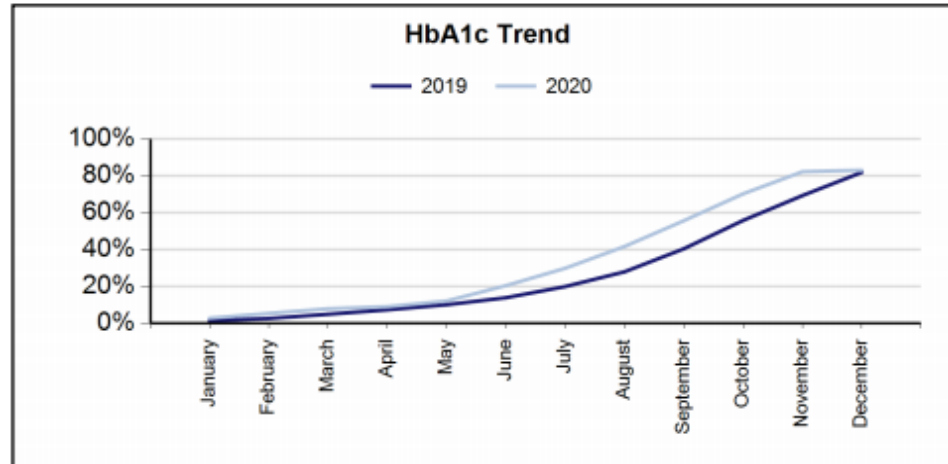
Timeframe	Pneumococcal Vaccine Rate
12 months ago	62.1%
6 months ago	65.3%
Today	69.6%

Percent of patients with an attended appointment with an Endocrinologist in the previous 2 years

25.7%

Diabetic Eye Exam Trend

Microalbumin Trend
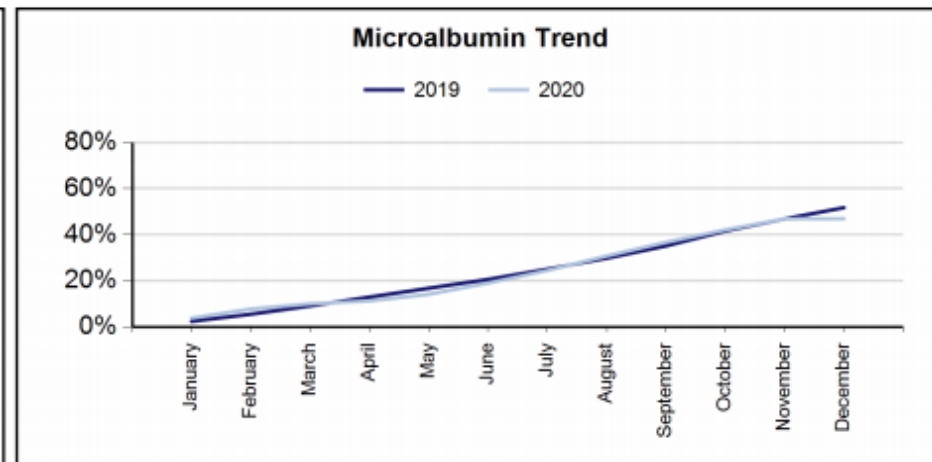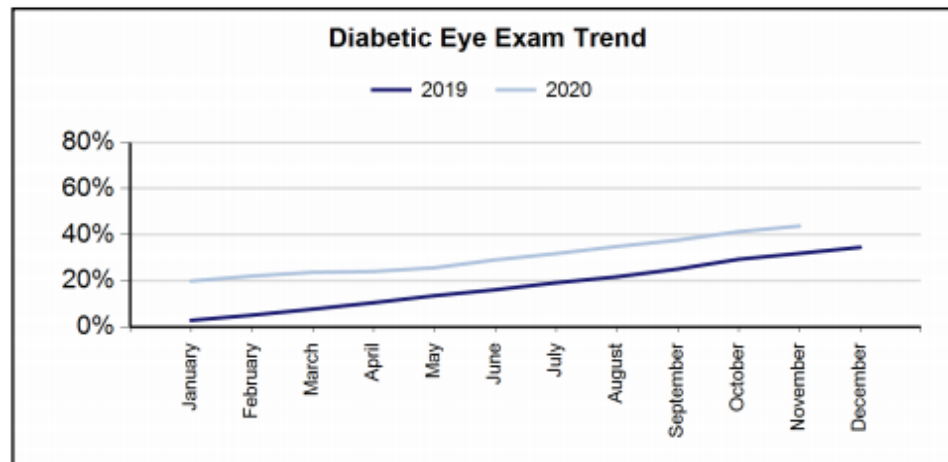
Transitional Care Management (TCM)
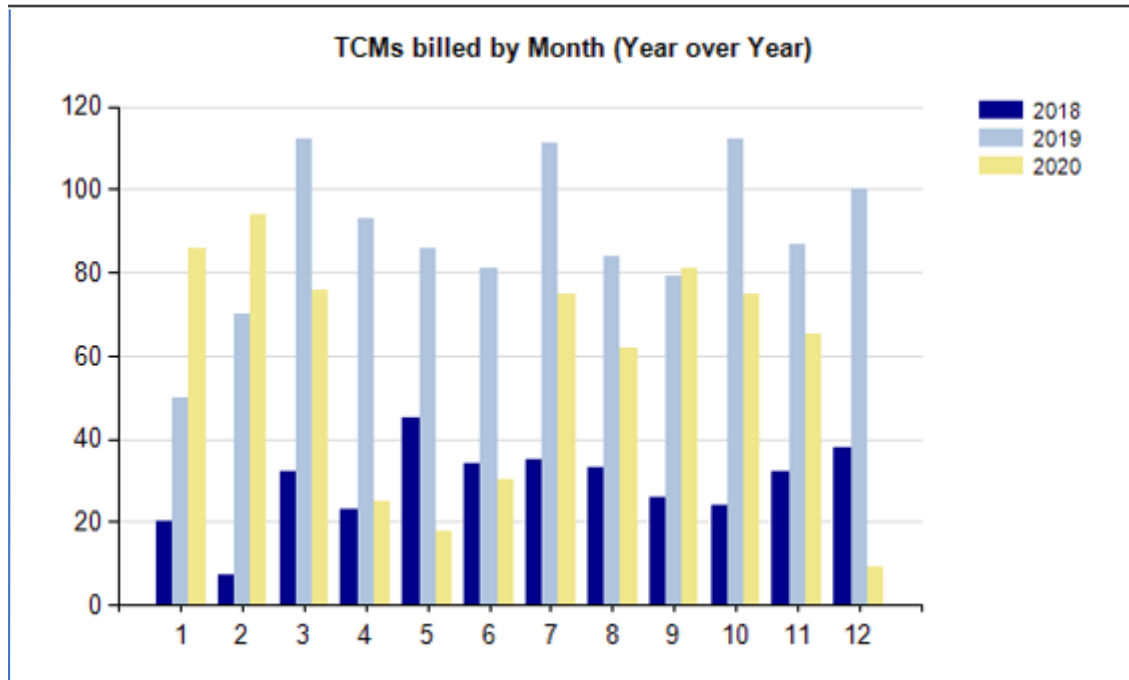
HMH discharges:

June: TCM visits 44%, total office visits 80%

July: TCM visits 45%, total OV 86%

September: TCM visits 48%, total OV 89%

October: TCM visits 46%, total OV 80%

7.b H Perf Rpts

HARR Quality Measure Performance
High Performing Measures; Full Points Earned

PROCESS MEASURES	HARR Measure Performance-- Exceeding National 90th Percentile (Full Point Earned)
Breast Cancer Screening	YES
Colorectal Cancer Screening	YES
Well Child Visit 3to6	YES
Well Child Visit 12TO21	YES
Well Infant Visit	YES
Diabetes BP Control	YES
HTN BP Control	YES

HARR Quality Measure Performance
Opportunities for Quality Improvement- No points earned

PROCESS MEASURES
Depression Acute Treatment
Diabetes A1c Screening
Diabetes Eye Exam
Diabetes Statin Adherence*
Adolescents Immunization

* Measure NOT included in CY2020 Measure Set

11.a UM IS SOS

FY20 Scope of Services

UMass Medical Center (UMMMC) provides access to care in a manner compatible with our patients' preferred language to receive health information and/or communication needs, health beliefs, and cultural practices. The Interpreter Services Department uses a comprehensive quality improvement processes to ensure that patients with Limited English Proficiency (LEP) have timely access to qualified interpreter services in over 100 languages and to auxiliary services and accommodations needed for the Deaf and Hard of Hearing (DHH) patients. Services are available 24 hours a day, seven days a week to ensure that the patient's inability to communicate in English does not interfere with the provision of medical care. Comprehensive data collection and data analysis, monitoring systems, and interpreter services educational requirements trainings are in place to ensure the quality of such services.

Population Served

- A highly diverse patient population speaking over 100 languages. 29% of Mass refugee groups settled in Worcester Area.
- **24,511** unique Limited English Proficiency (LEP) and Deaf and Hard of hearing (DHH) patients. *(20.6% increase over 5 yrs)*

Services Availability

- Qualified interpreters are available 24/7 via Video Remote Interpreting (VRI), Face to Face (F2F) Over the phone interpreting (OPI)
- Hospital interpreters: 28.3. FTEs

UMMMC Interpreter Encounters by Language

FY20 Total
Interpretation
Encounters

277,354
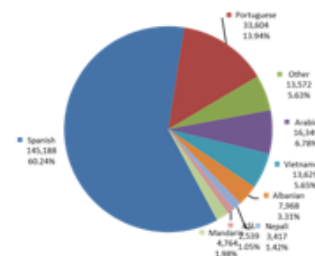
Mission

Deliver **high quality*** Language Services to ensure that the non-English speaking, and Limited English Proficient patient population at UMass have access to care that is Safe, Effective, Patient Centered, Timely, Efficient, and Equitable.

Interpreter Services at UMMMC

One of the largest and most comprehensive hospital-based programs in the country. Showcased by the AHCRQ. Selected as an exemplary program in the National Healthcare Quality Report (NHQR)National leader in education and training

- Uses comprehensive quality improvement processes, LEAN methodology, and NQPM, while maintaining the organization's financial health and compliance with Language Access federal and state regulations.
- Integrated solid data collection and optimized reporting systems to build operational efficiencies, reduce waste, decrease wait time, increase productivity with focus on value to the patient and clinical areas.
- Redesigned operational model to adopt to the COVID-19 pandemic which has presented unexpected challenges to deliver interpreter services across clinical areas. Accelerated the expansion of Video Remote Interpreting (VRI) and integrated on-site hospital interpreters in the VRI call center and Telehealth platforms.

UMassMemorial
Health Care

	Total Hospital Visits/Admissions	LEP Visits / Admissions	LEP % of Hospital
Inpatient	38,918	4,839	12%
Emergency	110,665	12,551	11%
Outpatient	966,687	111,564	12%
Grand Total	1,116,270	128,954	12%

Quality Goals

- Eliminate language barriers to provide Limited English Proficiency (LEP) patients, and those who are Deaf or hard of hearing with timely and effective culturally competent access to the highest quality, safest care and exceptional experience.
- Maintain a highly qualified Language Services work force, including onsite contractors and remote vendors.
- Delivery of high-value language services to patient-provider within $\leq$ 15 min from request.

Quality Performance Metrics

Adopting core measures is critical to set targets of improvement, identify gaps, monitor performance and strategically improve the delivery of language Services.

ST1: Percent of patients screened for their preferred spoken language	**ST2: Percent of patients receiving language services from those qualified to provide them**	**ST3: Percent of encounters in which patients waited less than fifteen minutes for a qualified medical interpreter**	**ST4: Percent of interpreter's total work time spent providing medical interpretation**
Patient's preferred language for care is a required field in the patient's EMR demographic tab. Systems are in place to monitor accuracy. This data is used to measure the actual demand for interpreter services based on patient visits and admissions.	Systematic process measures utilization of qualified interpreters or qualified bilingual providers across all clinical areas. Report is generated to identify unique LEP patients with a documented interpreter encounter during their admission or outpatient visit.	Wait time data is collected across modalities and aggregated into a central database system for reporting and monitoring processes.	Total time providing productive services is measured by combining individual interpreter encounter data with time sheets.

ST1, ST2, ST3 are part of the five standardized measures developed by the Robert Wood Johnson's "Speaking Together: National Language Services Network" and of which UMass Memorial Medical Center Interpreter Services Department was a collaborating grantee.

Strategic Plan	
1) Expand access to qualified interpreter services at all points of care 24/7.	**4)** Streamline interpreter rounding process to positively impact patient experience. Increase access to interpreters and its utilization by medical staff.
2) Systemwide educational plan to engage medical providers regarding availability and importance of using qualified interpreters from a quality, safety and regulatory standpoint	**5)** Quality improvement initiative to make a meaningful reduction in preventable 30-day readmissions of LEP patients with HF

3) Implement a standardized EPIC process to document interpreter utilization at point of care, monitor provider's adherence, and strategically set improvement targets.	**6)** Instituting systemwide policy and work process to have bilingual providers tested and vetted in language proficiency to provide patient care in a language other than English.

References: State and Federal Regulations

- Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition against National Origin Discrimination as It Affects Persons with Limited English Proficiency.
- National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)
- M.G.L. c. III § 25J
- State Law: ERIL (Chapter 66 of the Acts of 2000, Effective July 2001)
- The Americans with Disabilities Act of 1990 (ADA)

13.a Pop Hlth

Population Health – Quality Best Practice

Strategy

Population Health Sr. Mgmt. Team

Begins to monitor performance and provides leadership support where needed for operational roadblocks.

Transformation

POD Leadership Council

Council responds to plan, provides input, and assigns tasks for Council members to reach out to their health system/region to align strategy.

Tactics

Quality Committee

Develops implementation plan and Council presentation including: topic, metric, data, tactics, and plan for adopting operational tasks to work on access, etc.

Analytics

Deep Dive Team

Deep dive identifies best practices, identifies   metrics for OCI, analyzes data at practice, group and system level, and develops tactics to remove roadblocks

Reverse Engineering Team

Recommend Tactics

Practice Improvement Facilitation Model – Provides Account Management **Services** to Primary Care Physicians & Clinical Teams

Quality Improvement
- Skill Development
- Quality Program Initiatives

Communicate
- Meet every 4-6 wks.
- Email
- Phone
- Reports
- One-pagers
- Webinars

Train
- Report access/usage
- Quality Metrics
- Population Health Initiatives

Practice Improvement Facilitators

Support
- Liaison with System (e.g. Epic)
- Connection to Resources
- HCC Coding Audits
- Patient Experience Survey Process

Consult
- Best Practices
- Standard Work
- Lean Process Redesign

Monitor
- Report Review
- Progress to Goals

Physician Engagement & POD Structure

- ❑ **How do we get physicians involved?**
  - ➢ Chief Medical Officer for Population Health maintains street credibility as a practicing physician
  - ➢ Concentrate on improving care at patient level
  - ➢ Help them with practice redesign for population health work to translate into extra "time" with patients
  - ➢ Stick to the "common ground" on metrics
  - ➢ Give them a voice!!! & Best Practice sharing with colleagues

- ❑ **38 PODS with designated physician POD leaders**
  - ➢ PODs are practice type specific (IM, FM, Peds)
  - ➢ POD Leaders meet quarterly and a subset, the POD Council, meets for 2 months/quarter to provide input and guidance into pop health initiatives (many opportunities for providers to get involved)
  - ➢ Physician leaders and physician involvement in Amb. Quality, Utilization Mgmt., and Behavioral Health Integration Committees
  - ➢ Practice Improvement Facilitator assigned to each pod as "single point of contact"

Quality Measurement

*the ambulatory quality measures we manage

- Commercial Programs (BCBS, HPHC, Tufts)
  - ✓ Internal Rewards Program
- Governmental Programs
  - ✓ MIPS / MACRA
  - ✓ Overall ACO Quality
  - ✓ GPRO
- UMMHC Self-insured
  - ✓ Diabetes focus

Everyone, Everyday.

UMassMemorial Health Care | University of Massachusetts Medical School

Ambulatory Quality Metrics
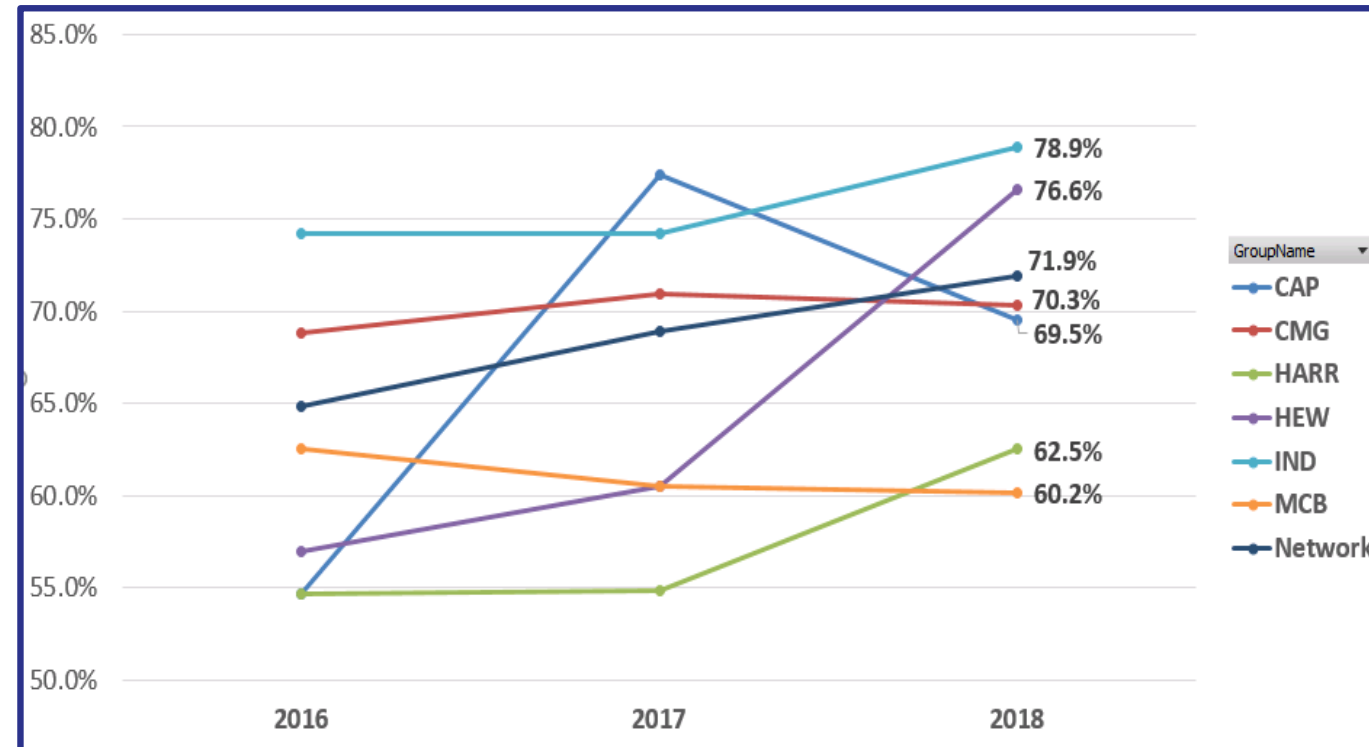
Measures
Hospital Discharges with Ambulatory Sensitive Conditions
Unplanned admission: Chronic Conditions
All-Cause Readmissions
Avoidable ED Visits
Breast Cancer Screening
Colorectal Cancer Screening
Depression Screening and Follow-up
Depression Remission at 12 Months
Fall Risk Screening
Flu Vaccine
Tobacco Screening and Cessation
Statin Therapy for CAD
HTN BP Control
Diabetes A1c Control
Diabetes BP Control
Diabetes A1c Testing
Diabetes Eye Exam
Diabetes Nephropathy Screening
WCC Adolescent 12-21
WCC3-6
WCC<15months
Immunizations for Adolescents
Anti-depressant Meds - Acute Phase
Chlamydia Screening in Women
Asthma Medication Ratio
Low Back Pain Imaging
Upper Respiratory Infection (URI)
Diabetes Statin Adherence (80%)
Monitoring on Persistent Medications

23 Quality Measures in 2019 / 10 GPRO Quality Measures

These measures are separated into four key domains that are the basis for assessing, benchmarking, rewarding, & improving ACO quality performance.		Data Source				Who is responsible?
		Patient Survey	Claims	EHR Incentive Program	GPRO Web Interface	
Patient/Care Giver Experience	ACO – 1 Getting timely care, appointments, and information	X				CMS - Approved survey vendor selected by the ACO to administer the survey
	ACO – 2 How well your providers communicate	X				
	ACO – 3 Patients' rating of provider	X				
	ACO – 4 Access to specialists	X				
	ACO – 5 Health promotion and education	X				
	ACO – 6 Shared decision making	X				
	ACO – 7 Health status/functional status	X				
	ACO – 34 Stewardship of patient resources	X				
	ACO – 45 Courteous helpful office staff	X				
	ACO – 46 Care Coordination	X				
Care Coordination and Patient Safety	ACO – 8 Risk-standardized all condition readmission		X			CMS - Claims data files, information from PECOS and NPPES, and National Level Repository
	ACO – 38 All-cause unplanned admissions for patients with multiple		X			
	ACO – 43 Ambulatory sensitive condition acute composite		X			
	ACO – 13 Screening for future fall risk				X	ACO – Via GPRO (Group Practice Reporting Option)
Preventative Health	ACO – 14 Influenza immunization				X	1. CMS will provide list for sampling of patient records
	ACO – 17 Tobacco use: screening and cessation intervention				X	2. ACO must submit data for sample patients via GPRO Web Interface
	ACO – 18 Screening for clinical depression and follow- up plan				X	
	ACO – 19 Colorectal cancer screening				X	
	ACO – 20 Breast cancer screening				X	
	ACO – 42 Statin therapy for the prevention & treatment of cardiovascular disease				X	
Clinical Care for At-Risk Population	ACO – 40 Depression remission at 12 months (Depression)				X	10 GPRO Quality Measures
	ACO – 27 Diabetes mellitus: HbA1c poor control (Diabetes)				X	
	ACO – 28 Controlling high blood pressure (Hypertension)				X	

Quality Performance Reporting & Tools

- **Provider / Group Level**
  - ✓ Action items via PIF team
- **Auditing Capabilities**
  - ✓ Conduct direct chart review and feedback
- **OCI Dashboards**
  - ✓ Align strategy, tactics, and interventions
  - ✓ Reverse engineer
- **Leverage Epic, other EHRs**

Improved engagement (citizenship) leads to improved quality

Mid-year

End of year

Avg. Quality Score

- 39.1% — Not Engaged (N=19)
- 49.4% / 10.2% — Somewhat Engaged (N=37)
- 55.4% / 16.2% — Highly Engaged (N=44)

- 49.8% — Not Engaged (N=19)
- 65.7% / 15.9% — Somewhat Engaged (N=37)
- 66.6% / 16.7% — Highly Engaged (N=44)
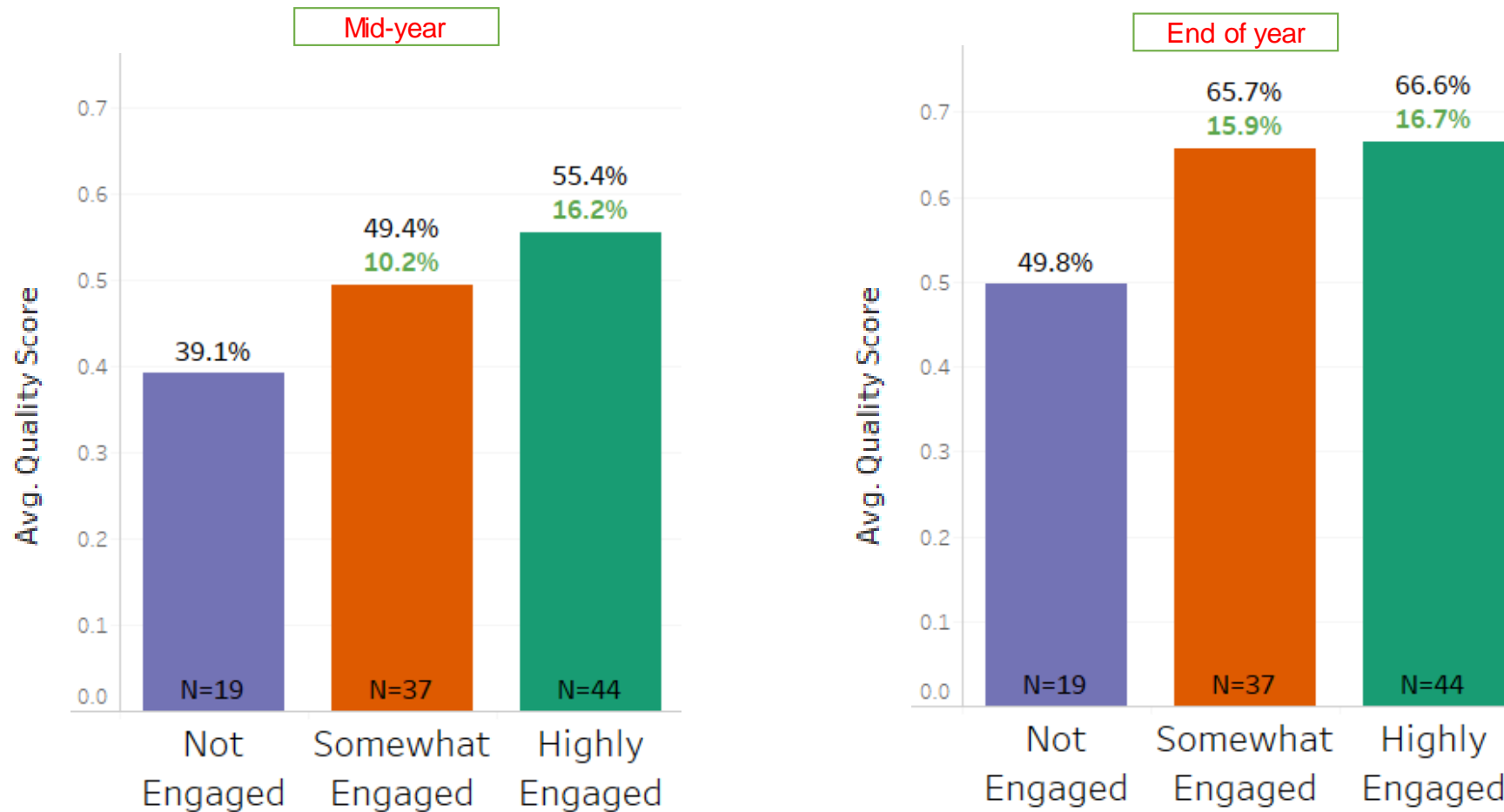
Highly Engaged: Had both PIF meeting <u>and</u> Tableau report usage in 2018.
Somewhat Engaged: Had PIF Meeting <u>or</u> Tableau report usage in 2018.
Not Engaged: No PIF meeting and no Tableau report usage in 2018.

UMMACO Epic Dashboard Review
- as of 1.21.20

2019 goals based on 90th percentile performance by measure for all MSSPs

UMMACO Measures

Population - UMMACO beneficiaries only
Time Frame - Calendar Year

	Sep 19	Oct 19	Nov 19	Dec 19	YTD	2019 GOAL
Medicare Patients Seen in the Calendar Year	90 %	90 %	92 %	94 %	26 %	90%
Breast Cancer Screening	76 %	77 %	78 %	80 %	73 %	80%
Colorectal Cancer Screening	75 %	76 %	77 %	78 %	72 %	80%
Influenza Immunization	65 %	64 %	64 %	64 %	70 %	80%
Tobacco Use: Cessation Intervention	26 %	28 %	28 %	27 %	54 %	68%
Screening for Clinical Depression and Follow-Up Plan	50 %	54 %	60 %	65 %	14 %	80%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	88 %	88 %	88 %	88 %	85 %	90%
Screening for Future Fall Risk	80 %	83 %	86 %	89 %	24 %	90%
UMMHC Hemoglobin A1c (HbA1c) Poor Control (>9%)	22 %	20 %	18 %	16 %	81 %	10%
Controlling High Blood Pressure	71 %	71 %	71 %	72 %	27 %	80%

41

Overview of GPRO audit performance - as of 1.20.20

2019 GPRO Audit Measure Performance vs. 2018 Final GPRO Performance

■ 2018 Final Measure Rate%   ■ 2019 Audit Measure Rate%   — Measure Target%

Measure	2018 Final Measure Rate%	2019 Audit Measure Rate%	Measure Target%
Breast CS	79%	80%	80%
Colon CS	76%	75%	80%
Depression Screening	57%	69%	80%
DMA1c Control	87%	85%	90%
Fall Risk Screening	89%	85%	90%
Flu Shot	67%	74%	80%
HTN BP Control	75%	77%	80%
Tobacco Use Cessation	56%	60%	68%

OCI uses internal tools to track the impact of interventions
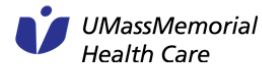
Internal tools tracking impact

Performance / Incentives

- **Commercial Programs (BCBS, HPHC, Tufts)**
  - ✓ Internal Rewards
- **Governmental Program**
  - ✓ MIPS / MACRA
  - ✓ Overall ACO Quality
  - ✓ GPRO
- **Self-insured (e-ACO)**
  - ✓ Diabetic outcomes

MCN Ambulatory Quality Measure Performance
Group Comparisons, 2016-2018

MCN Network Target Score for CY2018: >68.9% Goal achieved ✓

- MCN Independents continue to have highest quality scores
- CAP decrease in 2018 but continues to be above target
- Heywood group had biggest increase
- Medical Center Based practices continue to see lower overall quality scores compared to network

MCN Ambulatory Quality Score
Process Measures ONLY- 2018, 2019 YTD

QUALITY SCORE - 15 PROCESS MEASURES ONLY
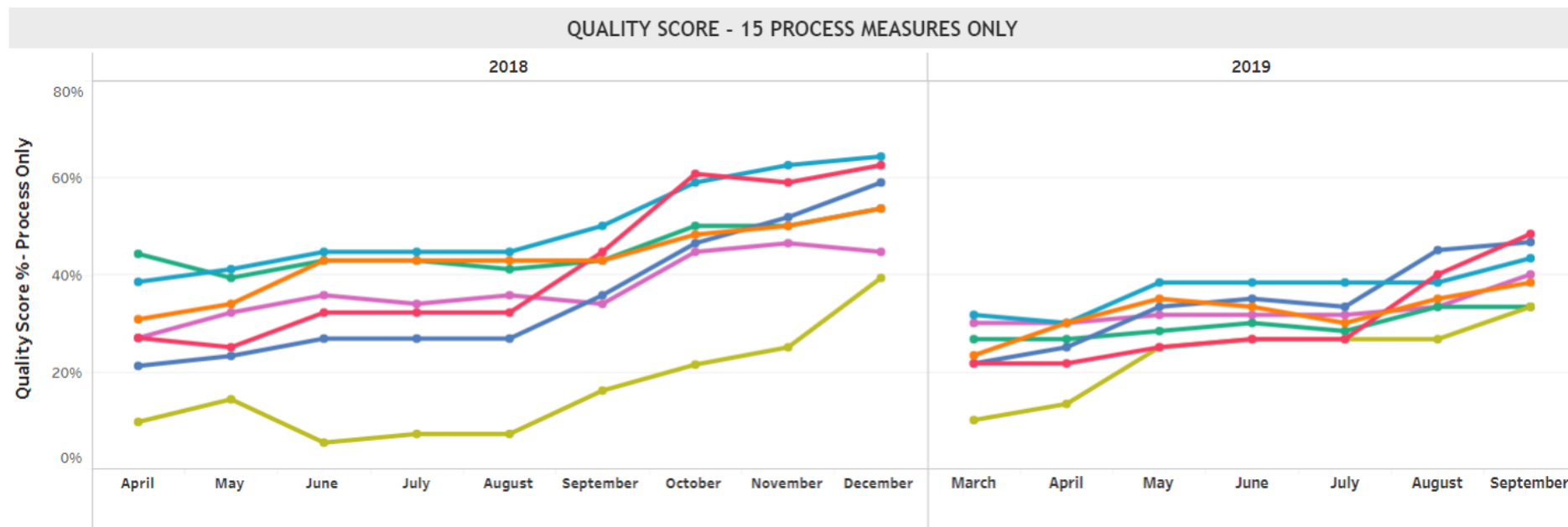
The benchmarks will continue to rise as the nation focuses on quality improvement.

Standing still is not an option!!!

Legend:
- UMMHC Network
- IND
- CAP
- HEW
- HARR
- CMG
- MCB
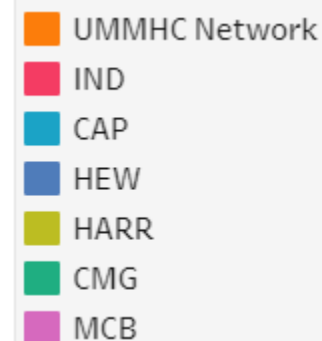
Examples of measures where we are losing ground in 2019

NCQA 90th Benchmark YOY Change by Measure vs. MCN Network Performance

(Practices above & below peer average)

Diabetes Blood Pressure Control (top left chart)
- 83.2
- 79.1
- 75.9
- Years: 2017, 2018, 2019 Update
- Y-axis: Measure Rate (%)
- 83.5 (2019 Update marker)

Diabetes Nephropathy Screening (top right chart)
- 95.0
- 92.5
- 90.1
- Years: 2017, 2018, 2019 Update
- Y-axis: Measure Rate (%)
- 95.2 (2019 Update marker)

Low Back Pain (bottom left chart)
- 82.7
- 80.6
- 78.1
- Years: 2017, 2018, 2019 Update
- Y-axis: Measure Rate (%)
- 87.3 (2019 Update marker)

Diabetes A1c Screening (bottom right chart)
- 94.8
- 92.9
- 91.0
- Years: 2017, 2018, 2019 Update
- Y-axis: Measure Rate (%)
- 95.4 (2019 Update marker)

Legend:
- --- Network Performance
- — NCQA National 90th Percentile
- --- Practices with Quality Score above Peer Average
- --- Practices with Quality Score Below Peer Average

MCN Quality Measure Performance
Measures in CY2018 program and comparison to upper thresholds

PROCESS MEASURES	Measure Performance Exceeding National 90th Percentile (Full points earned where YES)
Asthma Medication Ratio	
Breast Cancer Screening	YES
Colorectal Cancer Screening	YES
Depression Medication Management (Acute Phase)	
Diabetes Care: HbA1c Testing (1 test per year)	
Diabetes Care: Eye Exam	
Diabetes Care: Nephropathy Screening	
Diabetes Care: Adherence to Statins	
Low Back Pain Imaging	YES
Appropriate Treatment of Upper Respiratory Infection (URI)	YES
Well Child Visits - Ages 3-6	YES
Well Child Visits - Ages 12 to 21	YES
Well Child Visits - Age < 15 Months	YES
BMI Percentile Documentation for Children and Adolescents	YES
Annual Monitoring for Patients on Persistent Medications	
OUTCOMES MEASURES	
Diabetic HbA1c in Poor Control (>9.0%)	YES
Diabetes Blood Pressure Control	YES
Hypertension Blood Pressure Control	YES
PATIENT EXPERIENCE MEASURES	**MHQP Top Decile**
Adult Access to Care	
Adult Communication	
Adult Integration of Care	
Adult Knowledge of the Patient	
Pediatric Access to Care	YES
Pediatric Communication	
Pediatric Integration of Care	
Pediatric Knowledge of the Patient	

Exceeding National 90TH Percentile:
46%
(12 of 26 measures)

UMMACO CAHPS 2018 – 8 Measures 2018 vs. 2017
Patient Experience

2017 CMS results are recalibrated based on survey question changes in 2018.
CMS has adjusted benchmarks for 2018 based on the new survey.

Legend:
- - - - 2017 CMS Final Result
- 2018 30th and 90th Percentile
- ◇ 2018 All MSSP ACOs Mean Performance
- ▮ 2018 Final CMS Result

CAHPS: Patients' Rating of Provider — 92.5%, 94.3%, 90.00%, 30.00%, 92.5%

CAHPS: Getting Timely Care, Appointments, and Information — 86.1%, 85.0%, 90.00%, 30.00%, 86.1%

CAHPS: How Well Your Providers Communicate — 93.9%, 94.1%, 90.00%, 30.00%, 93.4%

CAHPS: Shared Decision Making — 61.9%, 58.0%, 62.76%, 54.75%, 58.7%

CAHPS: Access to Specialists — 81.5%, 82.3%, 90.00%, 30.00%, 81.4%

CAHPS: Health Promotion and Education — 59.3%, 64.6%, 63.44%, 54.18%, 64.5%

CAHPS: Stewardship of Patient Resources — 26.3%, 16.5%, 33.43%, 24.25%, 22.3%

CAHPS: Health Status/Functional Status (Seperate Survey) — 73.4%, 74.5%, 75.5%

Data Source: Final CMS & Press Ganey Results

Quality Measures YTD comparison
Epic practices only

YTD GPRO Quality Measure Performance - UMass Medical Group
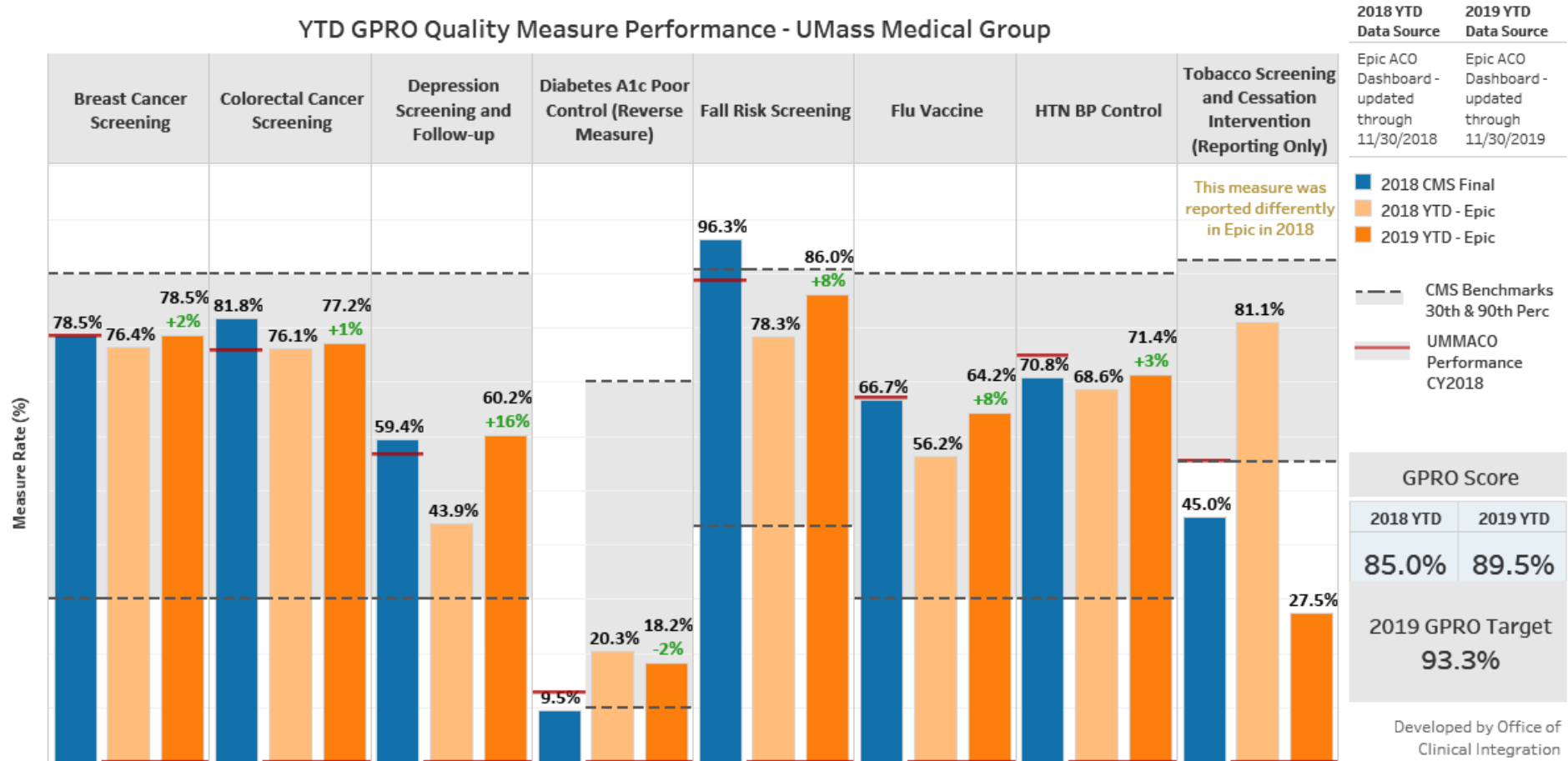
How does UMMACO quality stack up?

2018 shared savings/losses - New England ACOs

Gain or Loss_2018	ACO Name	ACO Track	Initial Year	N of Assigned Benes	Benchmark Minus Exp	Quality Score	Earn Save/Loss
Gained share savings	Lahey Clinical Performance ACO	Track 1	2013	43,349	24,239,494	87.53%	10,595,720
	Baptist Integrated Physician Partn...	Track 1+	2012	27,530	21,776,511	90.59%	9,666,039
	Community Care Partnership of Ma...	Track 1	2016	11,038	17,459,697	86.80%	7,426,177
	WESTMED Medical Group	Track 1	2012	15,223	15,346,591	82.49%	6,203,325
	ProHealth Physicians ACO, LLC	Track 1	2013	22,496	11,367,624	91.34%	5,087,892
	Northeast Medical Group ACO, LLC	Track 1	2015	28,750	10,324,388	91.51%	4,629,227
	Circle Health Alliance, LLC	Track 1	2012	10,300	9,020,153	89.63%	3,961,564
	Coastal Medical, Inc.	Track 1+	2012	9,675	4,896,681	89.68%	2,151,768
	BMC Integrated Care Services, Inc.	Track 1+	2015	10,712	4,329,634	89.82%	1,905,632
	Hudson Accountable Care, LLC	Track 1	2016	11,571	3,948,050	73.70%	1,425,710
Generated savings but not met min saving rate	UMASS Memorial Accountable Care...	Track 1	2015	45,382	8,110,694	88.51%	0
	CMG ACO, LLC	Track 1	2015	15,724	4,427,168	85.23%	0
	MACIPA	Track 3	2017	10,824	2,290,958	94.36%	0
	Central Maine ACO	Track 1	2012	10,340	1,783,986	90.67%	0
	Southcoast Accountable Care Orga...	Track 1	2013	21,814	794,077	88.28%	0
	Maine Community Accountable Car...	Track 1	2012	5,933	356,426	91.05%	0
Loss	Life Health Services, LLC	Track 1	2016	10,336	-179,310	89.37%	0
	NH Accountable Care Partners	Track 1	2012	54,981	-474,368	87.52%	0
	Berkshire ACO	Track 1	2018	9,241	-1,239,197	100.00%	0
	Saint Francis HealthCare Partners...	Track 1+	2013	15,012	-1,269,424	85.57%	0
	Steward National Care Network, Inc.	Track 1+	2018	19,337	-1,281,128	100.00%	-383,835
	Valley Health Alliance	Track 1	2016	6,709	-1,473,616	80.57%	0
	VillageMD New Hampshire ACO, LLC	Track 1	2017	7,085	-2,318,781	95.94%	0
	Lifespan Health Alliance, LLC	Track 2	2017	16,966	-4,400,612	97.94%	-1,813,633
	New Hampshire Rural ACO	Track 1	2016	11,859	-4,728,156	88.98%	0
	WCHN ACO	Track 1	2015	25,205	-5,729,689	84.93%	0
	Kennebec Region Health Alliance	Track 1	2017	8,142	-6,253,831	98.70%	0
	Beacon Rural Health, LLC	Track 1	2016	21,469	-7,442,559	86.77%	0
	QHI ACO	Track 1	2018	25,952	-7,738,118	100.00%	0
	HARTFORD HEALTHCARE ACCOUNT...	Track 1	2013	22,217	-8,978,793	91.39%	0
	Northwell Health ACO	Track 1	2016	67,249	-15,817,117	81.79%	0
	MaineHealth Accountable Care Org...	Track 1	2012	52,876	-26,032,982	93.81%	0

Axis labels: N of Assigned Benes (0K, 50K, 100K); Benchmark Minus Exp (-50M, 0M, 50M); Quality Score (0.00%, 100.00%); Earn Save/Loss (0M, 10M)

Source: CMS 2018 Shared Savings Program ACOs public use file (PUF)

A laser focus on quality in 2020

- ➢ Identifying opportunities
- ➢ Developing QI approach
- ➢ Prioritizing expectations
- ➢ Leveraging internal tools
- ➢ Guiding providers
- ➢ Evaluating impact

Population Health Strategic Approach

	Primary Care Providers	**Specialists**	**Office of Clinical Integration**
Quality	• Prevention • Screening • Chronic disease metrics • Annual wellness visits	• tobacco screening • fall risk • flu vax • Refer patients back to PCP for annual exams	• Monitoring • Feedback • Outreach
HCC	• <u>Chronic</u> HCC dx (such as DM) • <u>Chronic</u> HCC conditions (such as ostomy status) • Acute HCC that can be managed in ambulatory setting (such as pneumonia)	• <u>Acute</u> HCC dx that result in hospitalization • <u>Chronic</u> HCC dx that require specialist mgmt (such as CHF) • Refer patients back to PCP for annual exams	• Provider education/resources • Monitoring • Feedback • Identification of HCC opportunities
TME	• Reduce readmissions – timely hospital f/u visits (TCM) • ED avoidance • Ambulatory mgmt of some acute dx (such as acute DVT) • Advance care planning	• Reduce readmissions – timely hospital f/u visits • Reduce LOS • ED avoidance • Ambulatory surgery center • Advance care planning	• TME monitoring/feedback • Care management • SNF and hosp f/u phone calls • Specialty pharmacy • Hospice/palliative care • Post-acute preferred SNF

Prioritizing expectations by audience

	Groups	Provider/Practice	Inpatient World - ED - Hospital - Ambulatory Specialty - Dialysis	Post Acute

HCC	☑ • Educate providers
	 • Develop EMR tools locally
	 • Optimize Code Capture
	     • **Suspect diagnosis**
	     • **Dropped codes**
	     • **Green sheets**
		☑ • Understand HCC concept
		     • **Demonstrate burden of illness in practice**
		 • Pre-visit plan
		     • **Dropped codes**
		 • Reach out to unscheduled patients
		 • Use audits to find suspect diagnosis
			☑ • Understand HCC concept
			     • **Precise diagnoses since increase in complexity**
			 • Identify opportunities with CBO & Fran
				☑ • New payment reform will help with documenting acuity

Quality	☑ • Leverage GPRO Audits
	     • **Target 2nd rounders**
	 • Engage low citizens
	 • Develop AWV strategy
		☑ • Schedule AWVs or ROV
		     • **Address care gaps and prevention**
		     • **Manage chronic diagnosis outcomes**
		 • Use GPRO audits to find areas to improve
			☑ **Top 2 priorities for Chairs/Chiefs**
			     1. **Mortality**
			     2. **PSI-90**
				☑ • Quality improvement
				     • **Learn from collaboratives**
				     • **Rona shares data**
				 • GPRO documentation
				     • **Flu documentation**
				     • **Fall risk documentation**

TME	☑ • Use HCC/TME goal to target practice intervention
	     • **Identify areas of focus for each practice <goal**
	 • Use HCC cohort report to collaborate with hospital/ED for potential specialist opportunites
		☑ • Schedule TCM visits
		     • **Decreases readmission**
		 • Use clinical resources
		     • **Shield's Care Management**
		     • **DVT/PE**
		     • **Behavioral Health**
		     • **CKD**
		     • **ACP**
		 • Create urgent slots to decrease ED visits
			☑ • Improve care coordination
			     • **Leverage inpatient Care Management teams**
			 • Bundled payment programs
			 • Care plans in "Eddie" for ED
			 • ASC usage & Other Specialist collaboration opportunities (FRAN)
				☑ • Preferred SNF network
				 • Preferred HHA network
				 • Palliative care consults & Advanced Care Planning

Strategy Update – PY 2019 (part 1 of 2)

Focus	Strategy	Key Tactics
Quality Performance	• 10 GPRO Measures	• Educate providers regarding FY 19 GPRO measures • Implementation of continuous auditing of GPRO measures throughout FY19
	• Quality Improvement Target (QIT)	• Leverage data and performance analytics to establish a quality improvement (QIT) target per practice • Integrate QIT planning into quarterly Performance Practice Package visit agenda and monthly PIF visits
HCC Coding (hierarchical condition category)	• HCC Interventions	• OCI outreach to practices via multiple modalities led by Dr. Trudy Manchester (practice meetings, PH WINS webinars, POD meeting presentations, HCC Tips, *Group Talk*, etc.)
	• Epic-compatible Applications	• Further investigation into potential Epic-compatible applications

Strategy Update – PY 2019 (part 2 of 2)

Focus	Strategy	Key Tactics
Care Management	• Post-Acute	• Expansion of preferred post-acute network – evaluate additional SNFs and home health agencies
	• Transitions of Care	• Conduct follow-up phone calls to ACO patients discharged from the Med Center/Marlborough/HealthAlliance hospitals • Conduct TCM (transitional care management) pilot • Escalation of appropriate patients to RN or SW
	• Palliative Care	• Expand tools and resources promoting provider education on palliative care
Specialist Engagement	• GPRO (the Group Practice Reporting Option for quality performance reporting)	• Two (2) specialist deep dive meetings held to date to provide an update and leverage their contribution to GPRO quality measures • Recruited 3 specialists as POD leaders
	• ESRD (End Stage Renal Disease)	• Full multi-specialty meeting at HealthAlliance to evaluate ESRD care across the continuum to develop a pathway

Everyone, Everyday.

14.a EMR Int

Project Status Overview - 2021-02-19   Current Status ✅ Green

Project	Project Manager	Portfolio	Program
Optum External EMR Data Integration	**Eugene Jones**	**Applications**	

State	Phase	On hold	Project Sponsor
Work in Progress	**Executing**	**No**	**Jeanne Shirshac**

Budget Code	Cost type	Executive Sponsor	% Complete
MC20I060	**Capital**	**Thomas Scornavacca**	**67.24**

Planned Start Date	Planned End Date	Planned Cost	
2020-04-01	**2021-06-28**	**$14,249.28**	

Actual Start Date	Actual End Date	Actual Cost	
2020-06-08		**$13,364.11**	

Description

Optum External EMR Data Integration Phase 2 (FY20) - Interface Hosted Athena, e-clinical, nextgen interfaces (CCD?) to Epic for data aggregation in the Optum OPA Suite

Summary

Executive Summary

Last week the integration was approved by change control and the queries were executed. The project team was able to see data move from the individual group practices to Epic in the form of documents. The IS team is now working with the OCI team to review the content and work through a validation strategy. In addition, the IS team has started working with the BI team to determine the work involved to move the data from Clarity to Caboodle.

Last Week's Achievements

Change control approved the change, and the query has been executed against 3 provider groups with 10 patients. Content is available in Epic.

Key Activities Planned

Working with the BI team to understand the scope and the timeline to move the content from Clarity to Caboodle. OCI team to execute the validation on the content moved from the Providers to Clarity.

Current Status	Status	Comments
Overall	✅	
Schedule	✅	
Cost	✅	
Resources	✅	
Scope	✅	

Key Milestones

Pending   Completed

Short Description	Planned Start Date	Planned End Date	State	Status
Go-Live Readiness Assessment Approved	2021-05-25 08:00:00	2021-05-25 08:00:00	Pending	Green
Go Live 2 of 2 (Clarity to Caboodle)	2021-05-26 08:00:00	2021-05-26 08:00:00	Pending	Green
Execute Gate Complete	2021-05-26 08:00:00	2021-05-26 08:00:00	Pending	Green
Project Acceptance Approved	2021-06-25 08:00:00	2021-06-25 08:00:00	Pending	Green
Close/Project Complete	2021-06-28 08:00:00	2021-06-28 08:00:00	Pending	Green

1. The Application states that race/ethnicity are self-reported (pg.1), and that in FY20, 14.2% of UMMHC patients and 9.6% of HMH patients chose not to report or reported a category other than those reported.

    a. Can you provide a breakdown of the category Other/Unknown into those choosing not to report and those reporting another category? *At UMMHC, less than 1% of the patients chose not to report or were unable to provide a response. The remaining self-reported Other for their race. HMH's response is included in b.*

    b. Describe the steps for collecting race/ethnicity data from patients at UMMHC facilities and HMH, including when the information is collected, how it is collected, and how often it is collected. *For UMMHC, Race, Ethnic background, Hispanic indicator and Language are all captured via registration. The questions are asked during the registration process generally during an initial visit. Depending on the workflow, it is either a hard stop or a soft stop, meaning the fields must be completed or they can be skipped. For example, in our outpatient ambulatory clinics the fields area a hard stop, where in the ED the fields can be skipped because we may not always be able to ask the patient for the information. Patients also have the ability via myChart to complete/update the questions themselves. We also use the attached .pdf to educate users (attachment 1.b).*

    For HMH, both Meditech and Allscripts require an entry in a demographics field on the registration page. HMH asks each patient the following race-ethnicity question to complete that field: "For race and ethnicity you consider yourself to be…?" Based on the patient's response, HMH and HPS enter one of the following in the demographics field:

    African American
    Asian
    Caucasian
    Hispanic
    Native American/Alaska Native
    Native Hawaiian/ Pacific Island
    Other
    Unknown

    A patient that does not respond to the question, or any patients that are entered into the HMH system for reference laboratory services, is listed as "Unknown".

2. The Application states that while HHCS experiences annual financial losses overall and its average operating loss margin of approximately 5% is below rating agencies median. Please provide data used to make this comparison.

    a. Are there any other indicators of HHCS' financial challenges?

In responding to this question, it is noteworthy that in its 2016 Report, <u>Community Hospitals at a Crossroads</u>, the Massachusetts Health Policy Commission ("HPC") examined the many substantial challenges facing community hospitals in the Commonwealth and HPC concluded "the variety of challenges – driven both by changes to care delivery and payment models and by market dysfunction – make traditional community hospital operating and business models unsustainable."

The HPC 2016 Report identifies several characteristics of community hospitals facing this uncertain future. Among these are:

- *High public payer mix*
- *Low payment rates*
- *Low case mix*
- *Declining volume (from outmigration of patients to teaching hospitals and competition from non-hospital providers)*
- *Significant mix of low margin service lines such as Emergency and Behavioral Health services*
- *Aging facilities*
- *Difficulty recruiting physicians*
- *Lack of resources to invest in health delivery transformation (e.g., population health data and analytics, integrated health records)*

5 years after this HPC report, these uncertainties and substantial challenges to the remaining Massachusetts community hospitals, including HMH, have grown even more acute.

For HHCS, this is evidenced by the chart attached that shows certain financial ratios and other data over the past 5 years, including results of operations, debt service coverage, and day's cash on hand and average age of plant relative price and payor mix trends. The financial ratios are compared to S&P ratios (August 19, 2020). HHCS ratios have been less than the S&P published medium.

HHCS has experienced challenging operations over the past 5 years. It has generally operated at a loss. When investment activity is included, HHCS has been operating at near breakeven.

HHCS's ability to meet its debt service covenant over the past 5 years has been consistent. This calculation includes investment activity.

Day's cash on hand has been declining over time. During the last 5 years, Days Cash on Hand was 129 days. Days have declined 13 days since then to 116 days (adjusted for Medicare/Medicaid Advance Funding).

During the last 5 years, HMH's physical plant has further aged and now the average age has increased from 15 years to almost 20 years.

The chart attached reports data for HHCS, representing consolidated operations of HMH and HPS (attachment 2.b).

The chart's data demonstrate that HHCS has many of the community hospital/health system warning signs cited by HPC in its 2016 Report, Community Hospitals at a Crossroads.

Recently, HHCS has been fortunate that the stock market has been at an all-time high. The favorable stock market condition has made it possible for greater subsidization of HHCS operations from its investment activities, and allowed HHCS to have overall break even on operations which has supported HHCS's ability to meet its debt service covenant. Unfortunately, supporting operations has resulted in a decline in investments in HHCS PP&E as evidenced by the increasing age of the plant and declining days cash on hand. It has also

hampered HHCS's ability to build the infrastructure needed to support health delivery transformation for the HHCS community.

HHCS cannot expect the stock market conditions to continue to be as favorable, and in the event of a future stock market decline, HHCS will experience what at worst could be a devastating financial event and at best will continue to degrade the ability of HHCS to reinvest in the necessary resources it needs to continue to provide hospital and medical services to the south Worcester County community while maintaining adequate quality of care.

In addition, the impact of COVID has had negative impact on HHCS operation as evidenced in the 2020 ratios. The rebound from COVID has not met HHCS management's expectations.

3. In the responses to DoN follow-up questions (pg.3) the Applicant states UMMHC will assist in the recruitment of physicians to the HMH service area. Are there any plans for recruiting gerontologists?

    Under the Affiliation Agreement, UMMHC has agreed to assist HHCS with the recruitment of physicians into the HHCS service area. While HHCS, through HPS, has enjoyed some success with physician recruitment, there continues to be several long-standing and remaining gaps in certain specialties for the HHCS community that need to be addressed. Currently, as a pre-closing effort, HHCS is discussing with UMMHC a plan to address current gaps in the following medical specialties at HMH, and within the HPS medical offices: cardiology, oncology, endocrinology, ophthalmology, and primary care.

    While these current discussions have not yet focused specifically on the recruitment of a gerontologist for HMH/HPS, HHCS and UMMHC leadership plan to undergo a more thorough and detailed physician staffing needs study. Through this study, both entities will obtain a greater understanding of what the short and long term needs are for provider recruitment to the HHCS service area and, after the transaction is consummated, the two Systems will be able to engage in a larger collaborative study, established strategy and implementation plan for physician recruitment. Should the recruitment of a gerontologist for the HHCS service area emerge as a priority through this study, or through various other UMMHC community system efforts, HHCS leadership would support the recruitment and hiring of a gerontologist into the HHCS service area.

4. The Application states that improving ambulatory services for patients and referring providers is one of UMMHC's top priorities across the system (pg.5). Describe plans for improving ambulatory services for referring providers. *UMMHC has been working diligently with many referring providers to understand and redefine processes when it comes to how patient referrals and care is provided throughout UMMHC's system. UMMHC is utilizing lean management principles to improve clinical and non-clinical pathways to enable an easier process for referring physicians and patients to be seen by the most appropriate physician in a timely manner. These efforts have focused on many different touch points that is involved with ambulatory patient care areas such as: central scheduling, physician templates, clinic staffing needs, and physician recruitment.*

5. The Application states that UMMHC is taking a multi-pronged approach to reducing outmigration (pg.5).
    a. Provide a definition of outmigration. *Outmigration is defined as patients residing in UMMHC's service area who receive healthcare outside of UMMHC's service area.*

b. Based on this definition, provide a description of the major contributors to outmigration. *There are a number of contributing factors that influence where a patient seeks care. Some of the major contributing factors to outmigration are the following: inpatient bed capacity at the Medical Center has been at high levels limiting tertiary patients access to care thus requiring patients to be transported to Boston area hospitals; patients choosing Boston area hospitals because of the branding efforts they have undertaken to attract commercial patients with the idea that their patient safety and quality is superior to local community hospitals in Central Massachusetts; and a certain level of outmigration to Boston area hospitals that occurs because some patients require more specialized care than UMMHC can provide such as: heart transplants, high acuity children's care, and high acuity cancer care.*

6. Define the specific measures you will use to assess the impact of the Proposed Project.
   A primary outcome of the proposed project is the maintenance of high quality care for the Harrington community. UMMHC and HHCS will specifically track and monitor:
   (1) the level of care being provided to the community as evidenced by hospital discharges, emergency department visits, primary care visits and ancillary services provided by HHCS caregivers.
   (2) HHCS quality measures as described in the Exhibits to the previous response.
   (3) Specific population health initiatives identified prior to the start of each calendar year and revised as necessary during the year. These measures include but are not limited to annual well visits, telehealth visits, potentially avoidable emergency department visits, transition of care visits and advanced care planning visits.

7. In the responses to DoN follow-up questions, the Applicant states that Interpreter Services (IS) are provided at UMMHC member hospitals to varying degrees, as deemed necessary.
   a. Describe how IS services vary between member hospitals and the reasons for the variation. *Full IS services are provided at each facility through multiple platforms with varying utilization. Each facility has a specific focus of in-person interpreters based on the needs of that community. Aside from the in-person IS each facility utilizes the system agreements for both virtual IS and phone IS. UMMHC is able to access a myriad of services and is able to do so on every unit in its hospital. UMMHC has virtual systems and phone equipment that is available and can be operational within a few minutes.*
   b. How are member hospitals ensuring appropriate and timely access to IS? *On a monthly basis, UMMHC monitors the utilization between in-person, virtual, and phone IS services. If there are changes in service requirement over a period of time – UMMHC makes adjustments to the mix of offerings by time of day based on the trended needs (including language options for in-person). UMMHC is also in the process of reviewing its IS services to determine how best to provide service across entities – increasing access to in-person services for a wider array of needs. UMMHC also continues to monitor the virtual IS world as technology is continuing to change and looks to make adjustments in real time.*

8. In the responses to DoN questions, the Applicant states that the SDoH screening tool identifies needs in 14 domains

a. What are the 14 domains? *Food, Housing, Utilities, Transportation, Employment, Budget Strain, Education, Childcare, Social Support, Legal Assistance, Health Insurance, Dental Health, Material Needs (clothing, furniture, diapers, etc.), and Stress*

b. List the measures used to track progress and assess performance.

    i. Distinct patients screened

        1. Overall and by primary care practice

        2. Percent of primary care practice attributed patients screened in the past year (12 rolling calendar months)

        3. For screened patients:

            a. Percentage with identified needs

            b. Percentage with no identified needs

            c. Percentage declined or unable to complete survey

    ii. CommunityHELP resource database:

        1. Resource searches per month

        2. Top 3 areas of need searched within CommunityHELP

            a. Overall

            b. By central MA municipality (Clinton, Fitchburg, Leominster, Marlborough, Worcester; Southbridge addition in progress)

        3. Top 3 search terms within each of the 3 top need categories

            a. Overall

            b. By central MA municipality (Clinton, Fitchburg, Leominster, Marlborough, Worcester; Southbridge addition in progress)

9. In the responses to DoN questions, the Applicant states UMMHC is in the pilot phase of an EMR integration project that will enable HHCS EMR data to be brought into the Epic system and that UMMHC expects this project to go live in the spring 2021 (pg. 16).

    a. Are you still on track to complete migration by Spring 2021? *For clarification, the integration that was previously mentioned refers to an effort by which certain quality and population health information will be transmitted from Harrington's EMR to the UMMHC EMR via an Information Exchange system. This integration does not create a UMMHC medical record for each Harrington patient and bringing HHCS onto the Epic system will take several years. The timeline for go live for this exchange is summer 2021. While the migration plans have not been solidified, the current plan to move HHCS caregivers from their current Allscripts and Meditech systems is expected to be completed in a single move from their legacy systems to Epic. Little downtime and disruption is expected to occur during this migration. Until the migration to Epic, HHCS caregivers have access to UMMHC's "Epic CareLink" portal which allows UMMHC to extend patient information to external facilities and affiliated providers, helping improve continuity of care in our community. EpicCare Link is secure, real-time, and easy to roll out to users who need remote access to UMMHC's clinical data.*

    b. Are there any plans to provide Epic training to clinical and support staff? *There are no plans to provide Epic training to clinical and support staff as a result of this integration effort.*

10. The Application and responses to DoN questions state that HHCS has developed a large continuum of behavioral health services in its service area and that the Proposed Project will allow HHCS to continue to

provide and further develop these services. Describe how the transaction is expected to sustain and improve HHCS' behavioral health services.

Through the integration of the UMMHC and HHCS behavioral health programs, the Proposed Project will allow the affiliated health systems to be more able to develop a full continuum of care using complementary services from each system to treat a wider scope of patients. UMMHC has an established interventional psychiatry service employing ECT and other treatments that would become more accessible to patients in the HHCS area, and potentially develop satellite clinics in the HHCS service area. Likewise, HHCS has recently created an Addiction Immediate Care center which would integrate into the larger UMMHC system allowing patients throughout central Massachusetts in need of urgent assessment and treatment to have better access to such behavioral health services. Because of the expected future capital commitments from UMMHC, HHCS was able to respond to the Commonwealth's request (via DMH/BSAS/MassHealth) for additional psychiatric beds and is in the process of constructing a new 24-bed inpatient unit on its Webster campus. These additional psychiatric beds will help address the large number of behavioral health patients boarding in the emergency departments in all UMMHC, HMH and other area hospitals. If the Proposed project is approved, UMMHC and HHCS as affiliates will establish a coordinated daily "bed huddle" effort to address the on-going crisis in the delay for inpatient psychiatric placement. Through the development of such a regional coordinated effort with HHCS becoming an affiliate of UMMHC, the focus will remain on filling service gaps rather than unnecessary duplication, and patients will have more treatment options available in the central Massachusetts region without the difficulty and cost of needing to seek services in the Boston area.

14847116_1

UMassMemorial

Collecting Patient
Race, Ethnicity, and Language Information

Training Tutorial

Our Patient Population

- Our UMass Memorial Healthcare patient population is highly diverse.

- They speak over **100** different languages and come from over **70** different ethnic and racial backgrounds

- Our ability to communication may be inhibited by language and cultural differences

UMassMemorial

Objectives

- To define Race and Ethnicity

- Review the importance of accurate collection of race/ethnicity/language data

- Learn best practices to collect the data and to respond to patient questions & concerns

UMassMemorial

Race vs. Ethnicity (Ethnic Background)

RACE: A person's self-identification with one or more social groups which may be based on shared physical, social and/or biological characteristics and geographic origins; the US Government identifies the following race categories:

❖ **Race Categories:** American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, White, Other

Hispanic Indicator: Combination of Origin (ancestry, nationality, lineage or country) reflecting ancestry or origin in Spain, Mexico or any of the Spanish speaking countries of the Caribbean or Central or South America

❖ **Indicators:** Hispanic or Latino or Not Hispanic or Latino

Ethnicity or Ethnic Background: An individual's background, heritage, culture, ancestry, or sometimes the country where there were born.

❖ **Examples of Ethnic Background:** African, African American, American, Brazilian, Chinese, Mexican/Mex Amer/Chicano, Puerto Rican, Russian, South African, Thai, Swedish, Vietnamese

UMassMemorial

Race vs. Ethnicity (Ethnic Background)

- A person can identify as being of more than one race and Epic can capture that information
  - For example, a person can identify as both Asian and Black or African American
- A person who identifies as Hispanic can be of any race

What Does this Information Have to Do With Health?

There are disparities in access to health care treatment and in the quality of care and health care outcomes between racial, ethnic, and language groups in the US.

To eliminate these disparities:

1. We need to identify them

If we find these disparities:

1. We will work to reduce those gaps
2. We will work to improve quality of care for all patients

This means we need complete and accurate data about all of the patient we serve.

UMassMemorial

Why do We Need to Collect this Information?

Language information is essential to provide safe and quality care to our patients

Errors in Language information impact multiple points of the organization including patient care.

We are required by :
- ✓ Federal Government (CMS) for <u>meaningful use incentives</u>
- ✓ Joint Commission standards <u>to improve patient provider communication</u>
- ✓ Department of Public Health for <u>hospital licensure</u>

UMassMemorial

Key Points of Data Collection

❖ All patients **must** be asked for their Primary Language, Race, Ethnicity, and Ethnic Background

❖ Patients must self identify these items. **Do not** guess for them

❖ Patients can have more then one Race or Ethnicity

UMassMemorial

Why Every Patient Needs to Be Asked?

Below are some images from a recent *New York Times* article about ethnicity and race in the U.S. Could you have guessed each individual's ethnic/racial background?

Japanese/Spanish

Black/White

Source: "Black? White? Asian? More Young Americans Choose All of the Above" *New York Times*, Susan Saulny, January 29, 2011. Photo credit: Stephen Crowley, The New York Times Company.

UMassMemorial

Making a Brief Introduction:

"Now I'm going to ask a few questions about your racial and ethnic background, as well as your language preferences.

"We collect this information from all of our patients and use it to make sure that we are providing high quality and personalized care to everyone."

"The information collected is for hospital use only and not shared with immigration "

UMassMemorial

Asking About Hispanic Indicator

" Would you describe yourself as Hispanic or Latino?"

"If response is some, partly, a little, or half, please enter Yes"

Defined as someone who comes
from (or whose family comes from)
a country in Latin America
or another Spanish-speaking
Country

Asking About Ethnic Background

"How would you describe your ethnicity, or cultural background?
You can choose more than one option."

Asking About Race

"How would you describe your racial background? You can choose more than one option."

UMassMemorial

Asking About Language

" In what language would you prefer to receive your health information?"

Tips:
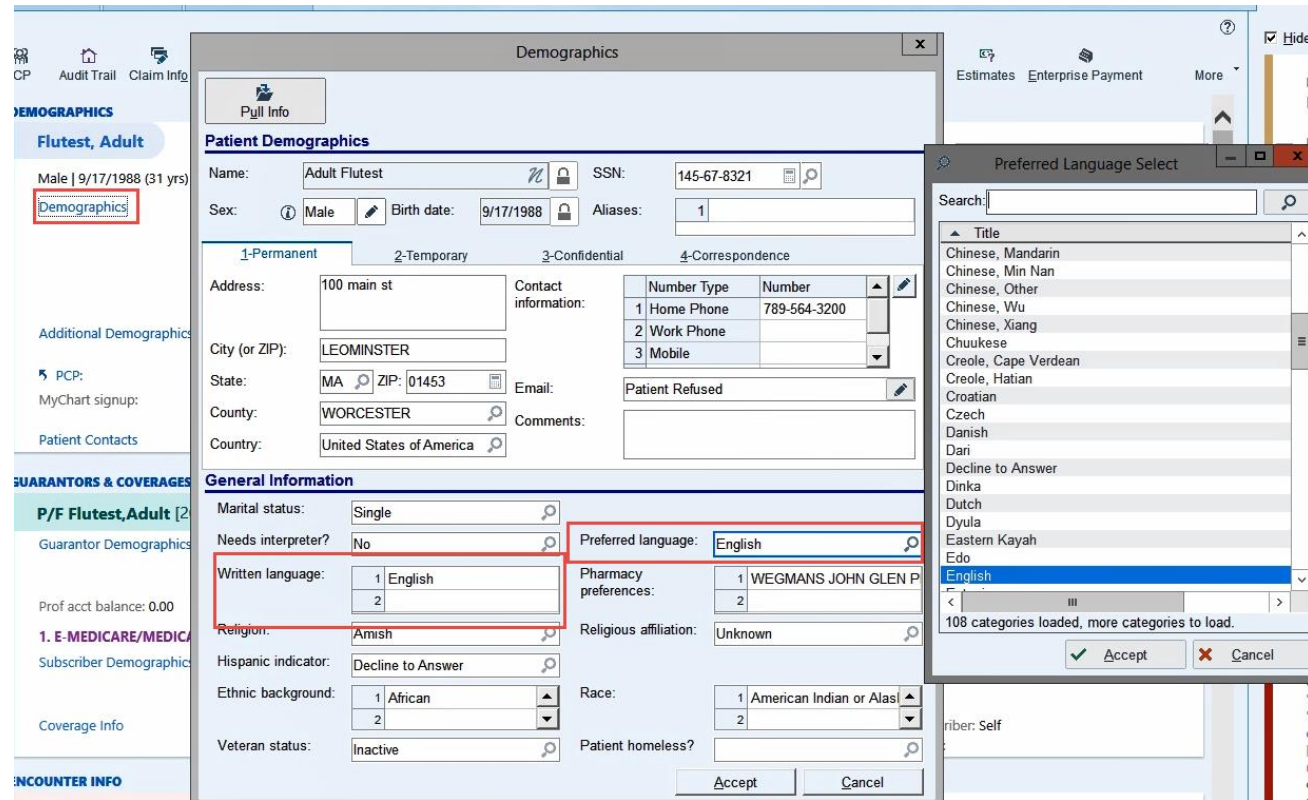
1. Preferred language may be different than the language the patient speaks at home.

2. Don't confuse the patient's social fluency in English with their ability to understand medical information.

3. Don't make assumptions based on the patient's appearance, name, nationality or language similarities.

Don't ask "Do you speak Spanish?" or Do you speak X language?"
Patients may answer yes even if that is not their preferred language.

Frequently Asked Questions

UMassMemorial

If a patient asks "Why are you collecting this information?"

- We are Collecting this information from **All** of our patients.

- This information helps us to learn more about the communities we serve, which helps us better meet everyone's needs.

- This information will only be used to make sure that we are giving all patients the best care possible.

UMassMemorial

If a patient says "I don't know my race/ethnicity"

- Explain what race/ethnicity means.

- Explain that patients can select more than one option.

- Provide examples (use Ethnicity Tool if possible).

- If still unable to identify race/ethnicity, let patient know that they can select "Other."

- Do not select "Unknown."

If a patient says "Can't you tell just by looking at me?"

"I understand that you think the answers are obvious, but I do have to ask every patient. And since I can't always be sure of the answers, we think it is better to let people tell us. It is important that we record *your* response."

If a patient says "I'm American"

"Are there any other options you would like to select, in addition to American?"

UMassMemorial

If a patient says "How is my information kept private?"

"Your privacy is protected. The users of this information have very strict rules about how the data are reported. We will protect this information like we protect your health."

UMassMemorial

If a patient says "Can I still receive services if I don't give you this information?"

"Yes, you can still receive services even if you choose not to answer these questions. Answering these questions is voluntary. However, the more complete the data we collect, the better we are able to serve you and our entire patient population."

UMassMemorial

If a patient declines to answer

- Do not force an answer—answering these questions is voluntary.

- Select 'Declined to Answer.' Do not select 'Unknown.'

- It is important to record a "Declined to Answer" response because that means we should NOT ask the patient for this information again.

UMassMemorial

When should I mark "Unknown"?

This is to be used only when the patient is unable to directly communicate to staff for some reason. (In the Emergency Department this field can be left blank for any visit that a patient is unable to communicate)

Entries of "Unknown" will prompt a user via the side bar checklist to update the value on the patient's next visit.

If a patient refuses to answer, select "Declined to Answer."

UMassMemorial

Please keep in mind…

- Your work is incredibly important for ensuring that we have **accurate and complete** information about our patients.

- Data quality is in your hands!

- For questions contact the interpreter services department in your hospital.

:

	2016	2017	2018	2019	2020	Adjusted for Pension Termination 2020 (1)
Operating Margin %	-1.8%	-5.0%	-2.9%	0.5%	-12.8%	-5.9%
S&P Ratio	2.4%	2.2%	2.3%	2.7%		
Excess Margin% (includes investment activity)	-0.2%	-1.2%	0.0%	1.6%	-5.6%	1.3%
S&P Ratio	3.7%	4.5%	3.9%	4.3%		
Debt Service Ratio	3.9	2.4	3.5	4.2	(0.8)	4.1 (2)
S&P Ratio	4.3	4.5	4.4	4.4		
Days Cash	127	129	120	114	143	116
S&P Ratio	197	205	213	218		
Average Age of Plant	14.71	15.27	16.67	17.53	19.95	19.95
S&P Ratio	10.6	10.8	10.6	11.0		
Relative Price	0.90	0.90	0.85			(3)
Medicare Payor Mix		40.02%	40.90%	42.32%	43.74%	(4)
Medicaid Payor Mix		25.28%	25.62%	24.68%	23.80%	
Governmental Payor Mix		65.30%	66.52%	66.99%	67.54%	
Commercial Payor Mix		34.70%	33.48%	33.01%	32.46%	
Total		100.00%	100.00%	100.00%	100.00%	

(1) HHCS incurred a one time pension termination expense of $11,041,000
(2) HHCS received $9.3m is Federal and State COVID Grants
(3) CHIA Realtive Price Report 2018
(4) Internal Data
  S&P report August 19,2020