Partners HealthCare, Brigham and Women's Hospital, and South Shore Hospital's Response to the Health Policy Commission's Preliminary CMIR Report dated December 18, 2013

January 17, 2014

Partners HealthCare System ("Partners") and South Shore Hospital ("SSH") fully embrace and have taken concrete steps to meet the quality and cost imperative in today's healthcare environment. We acknowledge and support the objectives of the Massachusetts Health Policy Commission's ("HPC's") conduct of Cost and Market Impact Reviews ("CMIRs"). However, we strongly disagree with the HPC's CMIR conclusions regarding the impact of Partners' proposed acquisition of SSH (the "Transaction") and the Brigham and Women's Physicians Organization's proposed acquisition of Harbor Medical Group (the "Harbor Transaction" and collectively with the Transaction, the "Transactions") on Massachusetts healthcare.

We submit that the December 18, 2013 Preliminary Report of CMIR findings (the "Preliminary Report") wrongly concludes that the Transactions will impute net additional cost to the Massachusetts health care system and presents misleading characterizations of the effects of the Transactions. This response to the Preliminary Report (the "Response") refutes the incorrect and incomplete analysis underlying the HPC's findings regarding "Cost Impact," "Care Delivery Impact," and "Access Impact" of the Transactions.[1]

For reasons outlined in detail in this Response, Partners and SSH request that the HPC withdraw each of the Preliminary Report's three central findings regarding "Cost Impact," "Care Delivery Impact," and "Access Impact" of the Transactions. We further submit that the Preliminary Report fails to demonstrate any basis for a referral to the Office of the Massachusetts Attorney General ("AGO") under Chapter 224, and request that the HPC withdraw the Preliminary Report's recommendation for regulatory review by the AGO.

OVERVIEW

The Preliminary Report disregards the evolving health care marketplace in which the Transactions are occurring, an environment that is notably shaped by the regulatory imperatives of the HPC's own enabling statute, Chapter 224 of the Acts of 2012 and the federal Patient Protection and Affordable Care Act (ACA). Partners and SSH fully understand that the passage of Chapter 224 compels Massachusetts health care providers to form new alignments and redesign the delivery of care in order to meet the Commonwealth's 3.6% cost growth benchmark[2] and the cost moderation expectations of payers, employers and consumers. Marketplace dynamics are shifting rapidly as Massachusetts providers, including all other community hospitals in the South Shore region, are affiliating with larger systems. These Transactions represent our best thinking and the investment of considerable resources into strategies and the implementation of plans to ensure we meet the 3.6% cost growth benchmark.

The Preliminary Report's inexplicable omission of potential efficiency gains through the Population Health Management ("PHM") initiatives of the Transaction and its misreading of payer contract provisions, seriously undermine the credibility of its "Cost Impact" finding that

[1] See Pages 54-55, Preliminary Report
[2] This 3.6% cost growth benchmark encompasses changes in both price and utilization.

the Transactions[3] will increase Massachusetts healthcare costs. In addition, the HPC's misapplication of antitrust law methodologies to an arbitrary geographic service area cannot support its conclusion that the Transaction creates market leverage.

The important synergies between the parties' respective experience, expertise and resources will bring value and efficiencies to the South Shore region resulting in a "Care Delivery Impact" that offsets any additional costs associated with the Transaction.

We also question the HPC's failure to acknowledge in its "Access Impact" findings the parties' significant behavioral health access contributions to the Massachusetts healthcare system and its failure to credit SSH and Partners' plans to increase access to primary care and behavioral health services.

After careful deliberation and analysis, SSH and Partners have each independently determined that the Transaction is the best path forward to move beyond the limitations of our successful ten-year clinical affiliation and is a foundational step in the successful development and large-scale deployment of PHM strategies on the South Shore. It provides the cost savings structure to both Partners and SSH that is critical to our collective ability to meet the 3.6% cost growth benchmark set out in Chapter 224.

Finally, we appreciate that the HPC is conducting these first CMIRs without the benefit of experience in evaluating the new health care marketplace. However, the current environment is dynamic and calls on healthcare organizations to respond rapidly to shifting incentives and market expectations. The Preliminary Report appears to reject the notion that Partners' early trends and gains are a barometer of future success. Instead, it uses flawed reasoning to cast doubt on trends that may be pathways to progress in meeting the goals of Chapter 224, and thereby does a disservice to the spirit of innovation at the core of that landmark legislation.

I. THE HPC MISCHARACTERIZES THE IMPACT OF THE TRANSACTION ON HEALTH CARE COSTS AND WRONGLY CONCLUDES THAT THE TRANSACTION WILL ADD COSTS THAT "FAR EXCEED" SAVINGS AND CREATE MARKET LEVERAGE

A. The HPC Wrongly Omits PHM Commercial Savings Impact in Its Conclusion that Health Care Cost Increases Resulting from the Transaction Will "Far Exceed" PHM Efficiencies Underlying the Transaction

Partners and SSH are adopting PHM because it sets the right course for health care providers in today's environment and lays important groundwork for success with global reimbursement and alternative payment methodologies. We submit that PHM is becoming such a sufficiently accepted approach that the HPC cannot credibly exclude commercial market PHM efficiency gains from the CMIR analysis. We fail to see how the HPC can conclude that "[o]verall increases in spending [from the Transaction] are anticipated to far exceed potential

[3] This HPC finding includes the HPC's calculations of the effects of the Harbor Transaction on physician health care costs.

cost savings from expanding Partners' PHM initiatives into the South Shore region"[4] when it omits entirely from its analysis any consideration of savings associated with PHM efficiencies in the commercial population. The HPC cannot ignore the transformative potential of PHM in all patient populations, particularly when its foundational principles of financial and clinical integration are the underpinning of the health care reform policies currently being promoted by federal and state agencies.[5]

Partners is an industry leader in embracing and advancing PHM. Partners launched a high-risk Medicare demonstration project in 2006 that generated in its first program phase an annual net health care savings of 7 percent among enrolled patients. These phase 1 savings reflected a return on investment of $2.65 for every dollar spent. In the second phase of the project, Partners expanded the number of sites, improved basic program design and delivered 19% savings on enrolled patients. Partners also has shown success as one of the nation's first CMS Pioneer Accountable Care Organizations (ACOs). During its first year as a Pioneer ACO, Partners slowed the rate of cost growth by approximately 3% over CMS's reference trend, translating to nearly $29 million to be shared with Medicare.

Today, Partners has moved beyond being an early industry adopter of PHM and into the comprehensive planning and roll-out of a system-wide program of twenty PHM tactics. These tactics address access to care, design of care and measurement across the full spectrum of primary, specialty and hospital services. Specific program initiatives to be deployed include patient portals, extended hours/same day appointments, virtual visits, referral management, assessment of appropriateness, shared decision-making, high risk case management, electronic health record decision support and order entry, expanded incentive programs and variance reporting and quality metrics.[6]

As part of its planning, Partners has developed detailed models of cost savings for eight PHM program initiatives addressing a subset of the twenty tactics that will be deployed in the South Shore region.[7] As further described in **Appendix A**, under these cost savings models, Partners estimates that these eight program initiatives will generate cumulative savings over an eight-year implementation and optimization ramp up period of approximately **$158.6 million** for the South Shore region commercial population.

Another PHM savings resulting from the Transaction is associated with keeping secondary care volume at SSH, rather than sending it to Partners' academic medical centers ("AMCs"). Partners and SSH currently have the opportunity to generate up to $5 million in annual savings through such a strategy. Partners has a proven track record for generating efficiency gains of this kind. Since 2009, healthcare spending associated with inpatient care at

[4] Page 54, Preliminary Report.
[5] Federal antitrust guidance provides no precedent for the HPC's refusal to assume a level of savings generated within the commercial population.
[6] See **Appendix A** for detailed descriptions of these tactics.
[7] These program initiatives are: iCMP (integrated case management), patient-centered medical homes, palliative care, mental health, virtual visits, Partners mobile observation units, shared decision-making and CHF telemonitoring.

the Brigham and Women's Hospital ("BWH") has been reduced by approximately **$83 million** through an initiative to shift secondary care volume from the BWH to the Faulkner Hospital, a Partners community hospital. Partners seeks to replicate this success at SSH. This proven model only makes sense when two hospitals are in the same risk contracts and share a common system margin target.[8]

Even without cost savings models available to Partners internally, the HPC could have estimated the scope of savings through commercial PHM efforts through a number of simple and reasoned proxy calculations. One such approach would be to look at potential commercial market savings that would result from reducing inpatient admissions through the implementation of PHM. While PHM's ultimate impact on Total Medical Expenditures ("TME") may not be limited to inpatient admissions, we believe that the large proportion of TME spend associated with inpatient admissions makes inpatient admission estimates a directionally sound proxy of the potential savings impact of PHM.

For example, SSH's commercial inpatient utilization rate was approximately 79 admissions per thousand in 2010. This rate is significantly higher than Newton Wellesley Hospital's ("NWH's") rate of 56 admissions per thousand.[9] Thus, there is clear opportunity for Partners and SSH to generate savings in SSH inpatient healthcare spending by reducing commercial admissions. Assuming that SSH's admissions can be reduced to a rate comparable to NWH's, SSH total admissions would decline by about 2,300 annually. Given that SSH's average net revenue per admission is approximately $8,760, this reduction in admissions translates to a reduced spending on inpatient admissions of nearly **$19 million** per year.

The HPC's decision to omit entirely any consideration of PHM efficiency gains to the commercial market is a significant flaw that undermines the Preliminary Report's central conclusion that the impact of the Transactions on Massachusetts healthcare costs will "far exceed" savings as a result of the Transactions. We reject such a conclusion and, as described in Section V below, restate our intentions to reduce costs and increase the efficiency of the healthcare system in the South Shore region through the Transaction.

B. The HPC Wrongly Concludes that the Transaction Will Create Market Leverage

The Preliminary Report's conclusions that the Transaction would create or enhance market power, cause undue market concentration, or result in anticompetitive effects are based on faulty analysis and should therefore be rejected. Notwithstanding the HPC's disclaimer of the ability to perform a thorough antitrust analysis given the time constraints of the CMIR process,[10] the Preliminary Report draws conclusions using antitrust terminology, while at the same time acknowledging that it has not applied the well-settled principles of antitrust law to support those conclusions. Those portions of the Preliminary Report that purport to analyze market shares, market concentration, or theoretical market power do so

[8] Note that the Preliminary Report asserts that Partners and SSH will do exactly the opposite of this.
[9] Newton Wellesley Hospital was chosen as the comparator because it is the community hospital most similar to SSH in the Partners system.
[10] Footnote 109 (Page 36, Preliminary Report)

without any legitimate legal basis. They are inaccurate, misleading and should be stricken from the Final Report.

Because it draws an indefensibly narrow circle around SSH and calls that a relevant geographic antitrust market, and then ignores competition from all the relevant competitors, the market analysis in the Preliminary Report is structured from the outset in a way that can only produce erroneously high market shares, erroneously high market concentration, and lead to erroneous predictions of anticompetitive effects from the Transaction. All of these conclusions are belied by the facts on the ground.

As further detailed in **Appendix B** to this Response, antitrust review of hospital mergers is governed by decades of relevant precedents applying well-established methodologies such as the DOJ-FTC Horizontal Merger Guidelines. Under all of those precedents and methodologies, the bedrock first principle of any antitrust analysis is a robust, reliable market definition produced through a rigorous process of identifying the relevant product market at issue in the relevant geographic market at issue. Metrics such as market shares and market concentration can only be calculated in the context of an appropriately defined product and geographic market. Since the HPC has not even attempted to appropriately define an antitrust relevant market in the Report, its findings concerning market share and market concentration are unreliable.

The Preliminary Report's construction of a primary service area ("PSA") around SSH based on commercially insured patients, and its use of this PSA as a proxy for a relevant geographic antitrust market, is inconsistent with the reality that patients regularly travel outside of the SSH service area to obtain health care services—a fact that the HPC itself acknowledges.[11] The fact that there is no Partners hospital in the SSH service area defined by the HPC, and yet the Preliminary Report finds that Partners has a significant market share in that geographic area, proves that the entire analysis is incorrect and unreliable. Decades of antitrust case law make clear that this analytical error is fatal to the HPC's analysis.

The Preliminary Report also inexplicably fails to consider competition from many of the most relevant competitors to SSH, namely Quincy, Milton, Jordan, Good Samaritan and Brockton hospitals, stating that the parties have not proven that they should be included in the analysis. However, that is not how competition is analyzed in antitrust cases. All of these hospitals are reasonable substitutes for SSH inpatient services and would be counted as competitors in the market in any antitrust case arising from this Transaction because they all draw patients from the same geographic area as SSH.

The Preliminary Report's attempt to have it both ways—to acknowledge that it has not undertaken an appropriate antitrust analysis, and yet to arrive at antitrust findings and conclusions—should not be accepted by the HPC. For all of these reasons, and as further explained in **Appendix B,** the Preliminary Report's market analysis is fundamentally flawed, and its conclusions that the Transaction creates market leverage cannot be relied upon or withstand scrutiny. They should be stricken from the final report.

[11] Pages 16 and 25, Preliminary Report

C. The HPC Wrongly Speculates that the Transaction Will Add $23-26 Million in Annual Physician Health Care Costs

The key "Cost Impact" finding in the Preliminary Report is that the Transactions will add $23-26 million in annual physician healthcare costs to the Massachusetts healthcare system, consisting of up to $15.8 million in reimbursement increases that Harbor and SSPHO physicians will allegedly realize through access to Partners payer contract rates (the so-called "unit price" effect) and up to $10.6 million in higher facility charges that will allegedly result from changes in referral patterns of existing and newly recruited Partners and SSH physicians (the so-called "provider mix" effect). The first assertion is based on the HPC's incomplete and incorrect understanding of Partners' payer contract terms, and therefore is merely speculation. The second assertion is based on an erroneous assumption regarding the likely sources of newly recruited physicians. Thus, neither so-called "finding" can be relied upon as a basis to draw any conclusion regarding the impact of the Transactions on Massachusetts healthcare costs.

In relation to this alleged unit price effect, even though the Preliminary Report acknowledges that there are physician growth caps in the Partners commercial payer contracts and admits that it has some uncertainty in its understanding of these contract provisions, HPC bases its assertion as to these increased health care costs on the simple statement that "there *appears (emphasis added)* to be room for new physicians to join at PCHI's prices."[12] In doing so, the HPC apparently assumed that the newly added Harbor and SSPHO physicians would automatically be assigned a Partners contract rate "slot" notwithstanding the fact that in each of Partners' three major commercial payer contracts, the number of physicians in the network currently exceeds the number of such slots (i.e. number of physicians within applicable growth caps).

The Preliminary Report also ignores the fact that Partners has a long-standing process by which these rate slots are allocated across its entire physician network. Thus, there can be no assurance that any physicians who join the Partners network as a result of the Transaction will be allocated a slot under which they would receive reimbursement at Partners contract rates. HPC ignored or misinterpreted key aspects of the provisions of Partners' commercial contracts that constrain Partners' ability to give new physician groups (such as Harbor) access to Partners' contracted physician rates.[13]

But even if Partners were to concede that the Harbor and/or SSPHO physicians would within a reasonable time gain access to Partners' contract rate slots so that these specific physicians would arguably receive higher reimbursement for their services, the assertion by HPC that this would result in an increase in overall physician costs for the healthcare system is

[12] See text at page 30 and footnote 90 of the Preliminary Report.

[13] HPC also asserted that Partners plans to develop a more tightly integrated network would also result in higher reimbursement as "affiliated" groups moved into "integrated" or "academic" rate slots and thus received higher Partners contract rates. See footnote 91 in the Preliminary Report. Again HPC overlooked the fact that under the relevant payer contract these rates slots are weighted so that as physicians occupy slots with higher reimbursement, the total number of Partners rate slots is decreased, thus holding the payers revenue neutral for these internal changes in rate slots allocations.

faulty because HPC has ignored the fact that Partners' payer contracts have been negotiated to reach an overall aggregate increase in physician revenue on a capped number of physicians. Thus, when individual physicians or groups are added to the Partners network, if they are allocated rate slots that result in higher reimbursement for them, the rate increases available to some other physicians in the network are limited to the payers' statewide fee schedule, which is their lowest reimbursement level.

In relation to the alleged provider mix effect, HPC asserts that existing physicians who are in the SSPHO (including Harbor) will alter their referral patterns and use higher cost Partners facilities (including BWH and SSH). Similarly, it asserts that the 27 primary care physicians that Partners and SSH will recruit pursuant to our proposed physician development initiative will be more inclined to use these higher cost Partners facilities. As to the first component of this alleged provider mix effect, we recognize that some referrals may shift to Partners AMCs as we seek to keep care within our system in order to provide more integrated and seamless care to our patients. That being said, we also expect to place a strong emphasis on keeping primary and secondary care in the community whenever possible, thereby generating substantial savings as we have done between BWH and Faulkner Hospital.[14]

As to the newly recruited physicians, the Preliminary Report erroneously assumes that all PCPs will be recruited from other provider systems within SSH's primary service area and that they are currently using other, lower-cost facilities. In fact, the physician recruitment initiative is intended to address SSH's secondary service areas, where analysis has demonstrated PCP shortages, thus suggesting that a substantial number of these newly recruited physicians will either come directly out of training or from outside of the service area. Moreover, HPC fails to acknowledge the possibility that placement of PCPs in these areas may actually bring down overall health care costs by reducing specialty and hospital services overuse resulting from a lack of primary care access. Finally as noted above, all of these Partners and SSH physicians, whether already in SSPHO or newly recruited to Partners and SSH, will be practicing in patient centered medical homes in support of the physician recruitment initiative's core goal of facilitating the cost savings and efficiency gains of PHM.

In sum, for the reasons described above the Preliminary Report's assertion that the Transactions will result in significant annual physician cost increases is based upon material misunderstandings of both the Partners payer contracts and the process and goals of the parties' proposed physician development efforts in the SSH service area.

D. The Transactions Will Not Increase Costs through Physician Office Facility Fees

The Preliminary Report describes in detail the practice of adding facility fees to physician group billing, with the conversion of freestanding office visits to outpatient hospital visits. Though not well documented in the Commonwealth of Massachusetts, this is a practice that can sometimes follow a hospital's acquisition of physician practices.[15] We seek to correct any misimpression created by the HPC's speculation that the Harbor Transaction may result in

[14] The impact of this work is described in more detail on page 4 of this Response.
[15] Page 43, Preliminary Report

health care cost increases through facility fees.[16] In fact, the BWPO and Harbor have no plans to institute facility fees for Harbor physician office visits.

II. THE HPC WRONGLY CONCLUDES THAT CORPORATE INTEGRATION OF THE PARTIES PRODUCES NO ADVANTAGE TO DELIVERY OF CARE

The HPC takes the position in its "Care Delivery Impact" findings that "given SSH and SSPHO's historical strong quality performance and experience in managing populations through risk-based payments, there is no clear reason why corporate integration of the parties is instrumental to raising quality performance in the South Shore."[17] This conclusion misunderstands the parties in fundamental ways and fails to appreciate the important synergies that have led the parties to mutually pursue the Transaction.

The recent surge in provider network consolidation is driven in large part by small independent providers, including the physicians of the SSPHO, seeking larger networks in which to pool their risk as well as to leverage their IT and overhead costs. Small physician practices are also seeking the centrally coordinated resources of larger networks aimed at managing TME by coordinating high cost/high risk and chronic disease populations. Counter to the HPC position, this acquisition—focused on corporate integration—is the logical way to achieve this.

SSPHO has made limited investments in case management, IT/IS and other infrastructure necessary to manage risk that are typical for an organization of its size. Without Partners, SSH is constrained by limited resources from embarking on larger scale clinical and other integration initiatives necessary to support taking on deeper levels of risk. This acquisition gives SSH and SSPHO access to the capital resources needed to scale up PHM infrastructure and risk contracting volume. With complementary experience, skills and proven success at collaboration through over ten years of clinical affiliation, SSH and Partners are the ideal combination to achieve these goals in today's evolving healthcare environment. It simply is not realistic to assume that SSPHO could implement the spectrum of PHM tactics being deployed today by Partners without Partners' direct involvement and support, a fact that SSH and SSPHO leaders fully acknowledge.

Furthermore, acquisition gives SSH access to capital to fund the primary care and specialty care initiatives that are central to successful PHM. The Preliminary Report dismisses the need for physician recruitment and asserts that Partners and SSH did not provide to the HPC information indicating a shortage of PCPs or specialists in the South Shore region.[18] This claim is wrong. SSH provided to the HPC a community need report authored by consultants Barlow-McCarthy that supports more than the net 27 new primary care physicians that SSH and Partners propose to recruit to the South Shore region. See **Appendix C** for further detailed discussion of SSH's objectives and goals for pursuing the Transaction.

[16] Page 44, Preliminary Report
[17] Page 54, Preliminary Report
[18] Page 51, Preliminary Report

Finally, Partners and SSH are pleased that the Commonwealth recognizes that we deliver high quality care relative to other Massachusetts hospitals. However, we vigorously disagree with the HPC's position that given the independent high quality profiles of Partners and SSH, there is no supportable quality improvement rationale for the Transaction.

Put simply, there is no ceiling on quality. The measurement of quality is a nascent science and Partners is at its forefront. Partners measures literally hundreds of processes and outcomes beyond those included in publicly reported measures and will bring this experience, knowledge and infrastructure to SSH. Partners has been a national leader in developing measures and improving care, as evidenced by the hundreds of scholarly articles published by Partners researchers and measurement experts on the subject. Partners and SSH are committed to an ever-expanding view of quality.

III. THE HPC'S EVALUATION OF THE TRANSACTION'S IMPACT ON ACCESS FAILS TO CONSIDER THE PARTIES' CONTRIBUTION TO BEHAVIORAL HEALTH AND COMMUNITY ACCESS

The Preliminary Report's "Access Impact" findings as summarized in the Preliminary Report are limited to highlighting the similarity in Partners' and SSH's higher mix of commercially insured patients and lower mix of government payer populations. The HPC concludes that a combined SSH and Partners system would reflect similar payer mix patterns and seems to find the Transaction lacking because the parties do not expressly seek to increase their proportion of government payer patients. Hospitals serve the mix of people in their markets; they do not create that mix. Therefore, we fail to see the significance in these Access Impact findings.

We are also troubled by the Preliminary Report's dismissal of SSH and Partners' plans for increased access to primary care and behavioral health services as irrelevant to its assessment of the Transaction.[19] A key element of the plan detailed in the affiliation agreement between Partners and SSH is the recruitment of primary care physicians to the South Shore and the development of patient-centered medical homes that will provide integrated primary and behavioral health care. Furthermore, Partners and SSH provided the HPC with detailed information regarding a number of Transaction work plans aimed at increasing behavioral health services for the patients served by SSH, including by embedding behavioral health services in medical homes throughout the South Shore community. The clear purpose of these initiatives is to increase convenient access by all members of the community to needed primary care and behavioral health services.

The HPC's apparent decision to overlook the benefits of these plans is especially troublesome given that it makes a point of characterizing SSH as providing "a smaller share of inpatient behavioral health services and a larger share of deliveries than other area hospitals."[20] We also question the HPC's decision to omit entirely any analysis of Partners' provision of behavioral health services, a decision that is somewhat cryptically attributed to the fact that

[19] Page 54, Preliminary Report
[20] Page 53, Preliminary Report

Partners' McLean Hospital, a specialized psychiatric hospital, may affect the inpatient behavioral health mix at other Partners hospitals.[21]

Partners' behavioral health service line is a compelling demonstration of its commitment to improving patient access to much needed services. For example, while the Commonwealth of Massachusetts decreased its Department of Mental Health intermediate care capacity by 21% or 178 beds between FY 2009 and FY 2010, Partners increased its behavioral health inpatient capacity by 7%, or 23 beds. The North Shore Medical Center (a Partners community hospital, "NSMC") and McLean Hospital now have approximately 50 child/adolescent psychiatric beds under management and an array of residential, partial hospital and ambulatory services. NSMC also opened 20 specialized geriatric inpatient beds, and Partners has expanded its outpatient addiction treatment services, including the opening of the Massachusetts General Hospital's ("MGH") Addiction Recovery Management Service ("ARMS"), which is an outpatient treatment and recovery management service for ages 14 – 26.

Finally, McLean SouthEast ("MSE"), which currently has 25 adult inpatient beds, will expand to 30 beds and will facilitate care delivery in the South Shore region by providing the full continuum of behavioral health care, including residential and partial hospital care. Partners is also expanding the adolescent acute residential treatment ("ART") program at MSE from 20 to 22 beds, adding a new partial hospital and expanding its Massachusetts Child Psychiatry Project ("MCPAP") support to pediatricians and school nurses in the region. Through these initiatives, Partners will provide access to intensive and step down adult and adolescent services that are currently very limited in the South Shore region, and will otherwise augment SSH's psychiatric resources, facilitate integration across levels of psychiatric care as well as between psychiatric and medical care, improve the quality of care, and reduce ED utilization among behavioral health patients in the region.

Partners' commitment to expanding access to behavioral health services and its plans with SSH to expand behavioral health as part of the Transaction are important factors in Access Impact findings and the Preliminary Report's complete omission of this information is misleading.

IV. COMMUNITY SUPPORT

Over the past several months, the communities surrounding SSH have voiced overwhelming support for this vision of improved, more cost-effective care close to their homes. Community leaders, including elected officials, first responders, doctors, nurses, volunteers and concerned citizens have offered their endorsement and have expressed hope that this plan is realized. Attached in **Appendix D**, please find more than three dozen examples of support from Weymouth and surrounding communities for the HPC to review and consider.

[21] Page 27, Preliminary Report

V. CONCLUSION: PARTNERS AND SSH SEEK TO ADVANCE THE COST AND QUALITY IMPERATIVES OF TODAY'S HEALTH CARE ENVIRONMENT

In conclusion, Partners and SSH jointly provide this Response to the Preliminary Report to reject the central findings of the HPC in its CMIRs of the Transactions. We believe that the Preliminary Report reaches the wrong conclusions and fails to properly characterize the intent and effects of the Transactions. We therefore restate our request that the HPC withdraw each of the Preliminary Report's three central findings regarding "Cost Impact," "Care Delivery Impact," and "Access Impact" of the Transactions and vote not to refer the Transactions to the Massachusetts Attorney General for further regulatory review.

Partners' and SSH's intentions and goals in seeking the Transaction are, in fact, the very same cost and quality imperatives underlying the HPC's enabling statute, Chapter 224. With the passage of Chapter 224, providers in the Commonwealth must, in particular, turn their focus to the cost and quality imperative and embrace further evolution of integrated delivery care systems to provide the best coordinated care possible for our patients. These public policy imperatives, along with the needs of patient populations, are catalysts for bold changes to pro-actively provide health care services in a more patient-centered manner and to moderate the rate of growth of health care expenditures. This will require the redesign of care across the full care continuum, including the redirection of resources to community based care and the development of new capabilities to deliver population health.

Partners and SSH have embraced these challenges and, in full alignment with the cost and quality imperative of Chapter 224, have developed a shared vision to redesign their delivery of health care through the implementation of a robust PHM model of care delivery. Implementation of our PHM vision will improve the availability and accessibility of care, enhance clinical offerings and yield economic and operational efficiencies, all of which will, in turn, result in the delivery of high quality, cost effective health care to all patients served in the South Shore and contribute to moderating the rate of growth in health care expenditures for the benefit of patients and employers.[22]

Implementation of this vision will require substantial investment and considerable expertise in PHM. However, SSH lacks the financial resources and PHM expertise to execute the vision alone. While Partners has both the resources and expertise, it does not have the established presence, relationships and investments in the communities served by SSH to make this vision a reality.

Each organization provides elements that will be critical to the successful implementation of PHM on the South Shore, and only full integration—achieved through an

[22] Similar synergies drive BWPO and Harbor in their mutual desire to consummate the Harbor Transaction. Harbor is an established physician group with a long history of successful risk contracting and experience deploying innovative PHM strategies such as disease management for diabetes and congestive heart failure, integrated multi-disciplinary care, utilization management and onsite use of urgent care as a less expensive alternative to emergency room services. With Partners' and Harbor's shared commitment to PHM, the combined experience, skills and resources of Partners and Harbor align in the Harbor Transaction.

acquisition—will enable the appropriate alignment of incentives and distribution of resources to facilitate success. As described above, Partners is redesigning our care delivery system to ensure our ability to conform to the cost growth mandates of Chapter 224. This Transaction would support and advance that commitment.

Appendix A: Descriptions of PHM Tactics

Please see attached publications for a high level description of the theory and general approach Partners is taking to population health management. The following appendix describes in more detail the specific programmatic initiatives that Partners is implementing throughout its system. As will be clear, no single initiative will be have a dramatic impact on cost trend, but taken as a whole set, these programs are transformative. At the end of this Appendix we have included some models used to estimate cost savings from 8 of these programs. These models remain under development but we share them to illustrate the potential power of these programs to bend the cost curve. Assumptions that we used to estimate the cost savings from these PHM programs were based on our own experiences as well as cost savings achieved by other leading health care institutions in the nation after implementing similar programs (see Bibliography).

High Risk Care Management

Research indicates the burden of chronic disease accounts for 78% of total health care spending in the U.S. Bodenheimer, et al, writing in a 2009 *Health Affairs* article suggested a multidisciplinary approach to coordinating primary and specialty care "are best suited to deliver higher-quality and lower-cost chronic care and prevention." A Commonwealth Fund report from 2012 found that studies show a growing number of delivery system managers and physicians see care coordination as an effective way to improve the quality of care.

The HPC's Preliminary Report includes a narrow and outdated description of the Partners Integrated Care Management Program (iCMP). The first phase, started in 2006, at MGH returned 7% net savings on the high risk population which equaled a 4% net savings on the overall population. Phase 2 (2009) expanded the number of sites and improved on the basic design, delivering 19% savings on the cohort (12% savings on total population). Phase 1, from 2006 to 2008, focused on integrating Care Managers in primary care practices to support an identified panel of high risk patients. Phase 2, from 2009 – 2011, focused on care transitions with non-acute partners. Our current phase, which began in 2013, has extended the program to all PHS primary care practices and is now creating system integration with sub-specialty providers. Integrating the iCMP care coordination model in key subspecialties can yield better patient outcomes and reduce the cost of care.

iCMP care coordinators are now engaging four key sub-specialty areas and developing care plans for comprehensive integration of care:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Palliative Care home visiting
- Hepatology and liver transplant

At Partners our work supports the highest quality of care for patients, both in and out of our risk contracts. In addition, this approach is aligned with episodic care initiatives.

CHF Telemonitoring

Telemonitoring is a proven innovation that allows clinicians to remotely monitor patients with heart failure for signs of clinical deterioration, thereby enabling timely and effective interventions. A Congressional Budget Office report found that this was approach was highly effective. There is a range of technologies that collect and transmit real-time patient data such as physical symptoms, blood pressure, weight changes, and electrocardiogram readings to a central location for evaluation. The Partners Connected Cardiac Care Program (CCCP) helps patients better manage their heart failure and avoid rehospitalization. Patients are provided with a suite of devices, consisting of a weight scale, blood pressure cuff, and pulse oximeter, to send their data and symptom information to the VitalNet portal via telephone line every day, at the same time each day, where telemonitoring nurses (employed by Partners HealthCare at Home) view the data and follow up accordingly. Failure to upload would generate a reminder phone call to the patients by the telemonitoring nurses. If patients uploaded data outside parameters, nurses follow standing orders given by the cardiologists, or if necessary, send the cardiology team a clinical message. Partners hospitals assess all heart failure discharges for suitability of telemonitoring and at any one time have over 400 patients actively using this technology. This technology and the monitoring is not paid for by insurance or government payers, so Partners pays for this set of services.

Improving Patient Access: Extended Hours/Same Day Appointments

Partners is committed (and 30% implemented) to transforming all primary care into patient centered medical homes (PCMHs). One of the required key changes is improved patient access for same day appointments and extended hours, used to insure patients have an alternative to the emergency room. Other tactics being employed to improve patient access across primary care and specialty care include:

- Delivering care using alternatives to billed face-to-face encounters (e.g. virtual visits) (see below)
- Ensuring coordination and minimal duplication of shared patients seeing both PCPs and specialists
- Expanding ambulatory and residential palliative care services

By improving patient access to care, including extended hours and same day appointments, we can reduce avoidable ED visits and improve the overall continuity of care provided to patients.

Patient-Centered Medical Home

As part of PHM, Partners HealthCare's primary care practices are undergoing a transformation to a more advanced model of care aimed at coordinating care and proactively keeping patients healthy. Instead of working solo with patients, primary care physicians at Partners are now becoming leaders of care teams that include nurses, physician assistants, medical assistants, nutritionists and social workers. With a heightened focus on prevention, they work together to deliver comprehensive, patient-responsive primary care and, when necessary, coordinate their patients' specialty and hospital care and help guide them through the health care system. These advanced primary care centers, known as PCMHs, give patients

reliable and rapid access to the full depth and breadth of clinical expertise at Partners. They also use innovative methods to make care more accessible to patients. Techniques include telephone visits, group doctor visits, extended hours, and same day appointments.

There is compelling evidence that PCMHs are effective at reducing costs and improving quality. Research shows that not only do patients find them to be a better and more convenient way of receiving care but PCMHs can dramatically reduce unnecessary care. For example, PCMHs can cut down on hospital admissions, readmissions and emergency room visits, which in turn reduce total medical expenses.

Partners has committed to fully transform all primary care practices by the end of 2016.

Mental Health Integration

Partners has committed to providing effective mental health care for all of the populations we serve. Mental Health includes psychiatric illness and related psychosocial problems. For Population Health it also can be construed to include 'illness related behaviors' (such as the tendency of depressed diabetics to be poorly adherent to all medications, thereby worsening diabetes outcomes) and 'wellness' (such as the stress reduction techniques that help improve post MI survival, QOL and functional capacity). "Mental Health" also includes substance use disorders and developmental issues in the pediatric population.

Mental Health problems have a significant impact on the management of other chronic illnesses (diabetes, heart disease), and blunt the effect of our efforts to implement initiatives in these areas. Among mental health problems we are focusing first on anxiety, depression and substance use disorders because of 1) the high prevalence of these disorders, 2) the availability of effective treatments, and 3) their disproportionate contribution to avoidable costs.

The programs have two separate designs – one uses our high risk care coordination program, adding mental health professionals to this team. The second approach uses screening in primary care to identify patients and then facilitated referral to local (when possible, co-located) resources as well as Internet-based self-help treatment regimens. These programs are launching in 2014.

Virtual Visits

Partners Telehealth programs aim to connect patients and providers virtually anywhere by providing innovative, easy-to-use technology platforms to foster communication, build relationships, improve access and convenience, and enhance patient care. Telehealth approaches include video conferencing, text messaging, electronic curbside, and phone/email.

Virtual visits, conducted via web portal, is one approach that has been shown to be just as effective as face-to-face visits for certain medical conditions and especially for follow up visits. This approach provides patients with a more convenient option for care, decreasing co-pays, travel, and time away from work. For example, the Mass General TeleHealth program has implemented virtual visits for ED, inpatient, post-acute follow-up, and primary-specialty triage. The following departments have virtual visit programs in these areas: Burn Service, Cardiology, Dermatology, Neurology, Psychiatry and Pediatrics.

Priority areas and goals include:

1. Virtual Visits and Consults – conversion of traditional visits to virtual visits.
2. Spaulding Rehabilitation Network – Virtual videoconference leading to reduced ED and outpatient visits, readmissions, and adequate staffing.
3. Cooley Dickenson, Martha's Vineyard Hospital, Nantucket Cottage Hospital, South Shore Hospital – Ensure access to specialists for these patients who have long distances to travel.

Virtual visits initiatives were started in 2013 and will begin expanding across Partners in 2014.

Mobile Observation Unit

The Partners Mobile Observation Unit is a collaborative effort between PHM and Partners HealthCare at Home that provides home visits to patients with complex clinical conditions or patients with frailty/home-safety concerns. Home visits are provided by advanced practice clinicians. The program aims to provide high quality care to patients in the home as an alternative to hospitalization. Frequently patients' problems are diagnosed in an emergency room and treatment is started, but they are admitted to the hospital for observation. In many situations (such as infections of the skin called cellulitis), these patients can be safely discharged if they can be closely followed for 1-3 days. The Mobile Observation Unit reduces health care costs by decreasing potentially avoidable inpatient or observation care and the length of stay. This program was piloted in 2013 at MGH and will begin rolling out across Partners in 2014.

Patient Portals

Partners' collaborative care model, using multidisciplinary healthcare teams, leverages the use of technology outside of the in-person office visit using a patient portal. The patient portal allows patients to get their health information at a time and place that is convenient for them. The portal provides 24-hour self-service access to the patients' medical records and tools to help them manage their health. Patient portals give patients and providers the ability to share data, collaborate on treatment decisions and manage medical care. The portal can also offer interventions that include the multidisciplinary team members to patients with chronic disease or in general preventive care.

Portals increase patient satisfaction and engagement. Research has shown that patients want access to a patient portal to access their medical data but also so that they can share data with their other doctors. A survey by the Commonwealth Fund found that 94% of patients indicate that easy access to their own medical records is important or very important to them. Kaiser data indicate that visits and office phone calls decrease when patients have access through a portal. Partners has committed to having 100% of our physicians on a portal by the end of 2014 (87% at the end of end of 2013).

Appropriateness and Patient Reported Outcomes

Partners is taking on responsibility for insuring that the care we deliver is appropriate and is focused on delivering the best possible outcomes for patients. We have created and deployed software (called PrOE) that organizes critical information about the patient in order to

assess whether or not a proposed procedure meets guidelines. This software is currently being used for 5 procedures including 100% of cardiac catheterizations and coronary artery bypass grafting at MGH. The Partners Patient Reported Outcome Measures (PROMs) initiative was created to deploy a platform to collect and report PROMs for the purposes of better clinical care and improving value. In addition to standard quality measure reporting (e.g. mortality, length of stay, readmissions, lab values and other process measures), PROMs collects information directly from patients regarding their systems, functional status, and mental health.

To collect PROMs, patients enter information into an electronic format (e.g. iPads, patient portal, or the web). PROMs is currently available at Partners for the following conditions:

- Coronary Artery Disease: CABG, Cardiac Catheterization
- Osteoarthritis
- Valvular Disease
- Diabetes
- Depression

In 2014, PROMs will expand to include other conditions such as Prostate Cancer, Benign Prostatic Hypertrophy, Spinal Stenosis, Osteoarthritis, and Rheumatoid Arthritis, among others.

PROMs improves care of individual patients through better monitoring and improved responsiveness and system-wide care by measuring/improving the right outcomes – those that matter most to patients.

Shared Decision Making

Patient and family engagement is a key driver in the transformation of the healthcare delivery system. Patients are in charge of protecting their health, participating in making appropriate decisions for necessary treatments and self-managing their chronic disease(s). To effectively do this, patients need to be engaged in their care. The Partners Healthcare Patient Engagement Strategy is helping to lead initiatives that span the broad categories of enhanced communication with our patients, enhanced patient portal services, one-on-one health coaching, education materials delivered through a variety of media, increased patient involvement through patient family advisory councils, and increased appointment access with our care teams. As part of this broader engagement strategy, shared decision making is being integrated into care delivery across a large number of clinical situations and procedures. Abundant evidence indicates that systematic use of these decision aids decreases costs of care.

Variance Reporting

It is critical to engage physicians in the economic realities of today's health care environment in order to responsibly improve quality and contain costs. Our hospitals and physicians face price pressure from all payers and levels of government. Without accurate group and individual information on their performance, success will be limited. Through the Pioneer ACO and similar contracts with our major commercial payers, we have already shouldered financial risk to address the per unit cost and utilization of health care services for specific populations. These contracts require that we track these populations over time,

determine the sources of cost that are most amenable to change, and guide clinicians to make these changes without unduly burdening them. Data analytics and reporting are a critical component of all these efforts.

Access to data to support the work of improvement teams, such as Care Redesign, will be critical. Furthermore, to pursue internal incentives such as physician level performance measures related to PHM goals, or even episode-based or other alternative payment models, we will need to design and report on a novel set of measures.

To help achieve these goals, we are building an enterprise data warehouse and building reporting capability to enable our clinicians to see their own performance, create targets, and continuously improve.

Currently the variation reporting creates reports that provide data for "opportunity spotting," monitoring utilization and QI efforts. Over the next five years these reporting functions will be dramatically expanded as all our clinical and administrative electronic system migrate to a single platform.

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Modeled Incremental Commercial Savings from PHS-SSH Merger from PHS Population Health Management Programs											
Based on Current / Planned PHS PHM Programs											
Partners Business Planning											
January 2014											
Estimated PHS Population Health Management Savings/Benefits Accrued to 'SSH' Commercial Lives											
Approach: Modeled Savings by applying PHS PHM PMPY Savings to Estimated 'SSH' Commercial Lives											
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Cumulative ($Ms)**
Est. SSH Commercial TME Savings ($Ms)			**-$5.2**	**-$12.0**	**-$17.2**	**-$21.1**	**-$24.1**	**-$25.4**	**-$26.3**	**-$27.2**	**-$158.6**
Est. 'SSH' Commercial Lives			43,680	68,328	85,488	95,160	102,960	104,520	104,520	104,520	
Key Assumptions											
1) PCPs Brought in (PHS-SSH MOU)	67										
2) Assumed Avg Panel Size	2,600										
3) Modeled SSH covered lives	174,200										
4) Modeled % Lives Commercial	60%										
5) Est. Commercial SSH Lives	104,520										
6) 3-Years to ramp up to full panel	Year 1	Year 2	Year 3								
(From Mar 2013 Primary Care Planning)	80%	100%	100%								
7) Applied the modeled PHM Commercial Savings PMPY and multiplied against 'SSH Commercial Lives'											
Modeling of 'SSH' Commercial Lives			**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	
Phasing in of 67 New 'SSH' PCPs from Ambulatory Planning			35	11	11	5	5				
Panel size target			2,600	2,600	2,600	2,600	2,600				
Incremental 'SSH' Commercial Patient Lives											
35 PCPs			43,680	54,600	54,600	54,600	54,600	54,600	54,600	54,600	
11 PCPs			0	13,728	17,160	17,160	17,160	17,160	17,160	17,160	
11 PCPs			0		13,728	17,160	17,160	17,160	17,160	17,160	
5 PCPs			0	0	0	6,240	7,800	7,800	7,800	7,800	
5 PCPs			0	0	0	0	6,240	7,800	7,800	7,800	
Est. 'SSH' Commercial Lives			**43,680**	**68,328**	**85,488**	**95,160**	**102,960**	**104,520**	**104,520**	**104,520**	
Notes/Caveats:											
a) Full savings opportunity understated because only reflects commercial savings (excludes Medicare, Medicaid/Other)											
b) Additional savings if PHM programs take on a more accelerated rollout schedule											
c) Assumes SSH lives have similar patient profiles to current PHS lives											
d) Assumes PCPs will reach target panel size of 2,600											
e) SSH currently does not employ or have network affiliations with PCPs (i.e. PCHI model); this model assumes that under PHM, local SSH physicians act comparably to											
how PCHI physicians conduct themselves under PCHI programs.											
f) Assumes -15% PMPY savings reduction to account for estimated, rough difference in rates between PHS and SSH											

A Modified "Golden Rule" for Health Care Organizations

Creagh E. Milford, DO, and Timothy G. Ferris, MD, MPH

Partners HealthCare (Partners) is an integrated health care delivery system in Boston, Massachusetts, that includes 2 large academic medical centers—Massachusetts General Hospital and Brigham and Women's Hospital—with more than 6000 physicians, including more than 1200 primary care physicians. In November 2011, Partners leadership agreed to become a Pioneer Accountable Care Organization (ACO), placing a significant fraction of their revenue at risk in a contract with the Centers for Medicare and Medicaid Services (CMS) that encourages them to hold increases in medical expense trend below the national average. Given our negative experiences with capitation in the 1990s, the decision to participate was largely based on 4 factors that differentiated the current environment and agreement terms from our prior experience.

First, efforts to reduce health care spending as a percentage of gross domestic product are likely to persist. Unlike in the 1990s, the extent to which current health care expenditures are crowding out other important programs is unsustainable. Accordingly, state and federal governments are taking a proactive role in cost-containment efforts. Second, the preservation of patient choice (as opposed to the closed networks of the 1990s) somewhat mitigates the "physician as gatekeeper" tension that contributed to the demise of capitation. Of course, this new twist also makes taking financial risk less appealing, but under the right conditions, the trade-off seems reasonable. Third, the threshold for achieving shared savings is to increase spending at a rate that is less than the national average. Such a moderate approach seems more reasonable than the steep discounts negotiated by commercial payers in the 1990s and is consistent with the scale and pace of change that will be required for success. Finally, Partners is better equipped to care for populations of patients today than we were in the 1990s. A universally adopted electronic health record, improved communication and notification tools, and real-time data tracking of patients as they move within our organization permit more precise and proactive management of quality and costs. In addition, we are better able to provide feedback on health care professional–specific variation to our physicians as part of our efforts to promote continuous improvement.

What do we plan to do differently as a Pioneer ACO? Our plan includes 3 distinct but mutually reinforcing activities: (1) managing how financial incentives flow through our system, (2) implementing programmatic initiatives for managing cost and quality trends for our primary care population, and (3) demonstrating value to other ACOs that are referring their patients to us.

Incentives

When considering incentives, the 1990's lesson is not to push budget-based risk all the way down to the individual health care professional. Such an approach puts physicians in an untenable position regarding decision making for the care of their patients.[1] In an effort to mitigate this problem but also ensure that physicians have an incentive to manage care efficiently, we will pass financial risk to large groups of physicians (typically more than 50 and salaried) using an internal performance framework (IPF). Our IPF includes rewards for adopting programmatic initiatives (see Programmatic Initiatives for Managing Populations), meeting external quality measure targets, and limiting the growth of cost–standardized medical expense trend. We used a cost-standardized approach to provide an incentive to keep care integrated within the organizational members of our delivery system. In the cost-standardized approach, primary care physicians are incentivized to refer patients within our health care delivery system, where we can control costs more efficiently. The IPF includes our specialists who were largely left on the sidelines (under discounted fee-for-service) during the 1990s. The IPF unites our specialty and primary care physicians with a common goal: to provide optimally efficient care.

Programmatic Initiatives for Managing Populations

The Figure shows the 20 tactics Partners has identified as important for improving quality and decreasing costs. We envision successful care redesign tactics along 3 core elements of care delivery: (1) providing access to high-quality care, (2) redesigning care to be more effective and more efficient, and (3) measuring our performance. Within our care redesign framework, each of these core elements falls into 1 of 3 settings in which care is actually delivered: primary care, specialty care, and hospital care.

See also pages 707, 710, 714, 721, 723, 727, 729

From the Department of Medicine, Massachusetts General Hospital (C.E.M., T.G.F.), and Partners HealthCare (T.G.F.), Boston, MA.

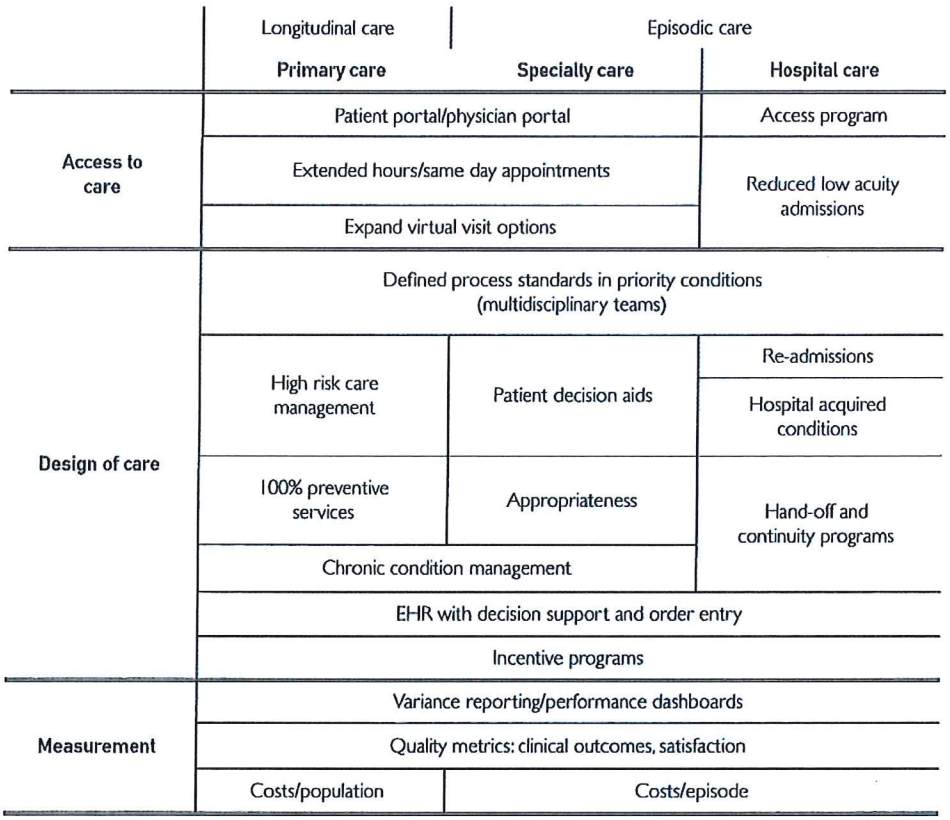

FIGURE. Evidence-based care improvement tactics.

While not shown on our tactics table, home care and postacute care are very much a part of this redesign framework and essential for integrating care across the continuum.

Several of our initiatives address access. A bidirectional Internet-based patient portal allows patients to access their medical records, request prescription renewals and referrals, make appointments, and communicate with physicians. This technology has demonstrated effectiveness in reducing unnecessary physician visits.[2] Partners also measures and reports back to practices their patient access, encouraging local efforts to extend office hours and offer same-day appointments. Some Partners sites have initiated paying primary care physicians a portion of their compensation on the basis of risk-adjusted panel sizes to encourage more effective and efficient team-based care. This helps get primary care doctors off the relative value unit "hamster wheel" and frees up time to work with care managers and manage patients by phone and Internet. This in turn frees up capacity in the office for patients who need urgent face-to-face visits. Finally, our telemedicine programs are building capacity to conduct more virtual visits, reducing the need for patients to travel in situations that do not require it and at the same time reducing our cost trend.

While these access-related initiatives are important, our program for high-risk patients is critical to our success in managing trend in a Medicare population. It is well known that Medicare spending is concentrated in a relatively small fraction of high-cost beneficiaries.[3] In 2006, Massachusetts General Hospital began a 3-year CMS demonstration project focusing on high-cost Medicare patients. The intervention relied on the assignment of a nurse care manager to each of the identified patients and leveraged information technology systems to track and communicate real-time changes in patient status and care plans. Each physician's care manager worked directly with them in their offices. Outcomes after 3 years included a 20% reduction in hospital admissions, 4% lower mortality rates, and approximately 7% net cost savings. In 2009, the CMS extended the demonstration for an additional 3 years and expanded the scope to additional Part-

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www.mayoclinicproceedings.org

ners institutions. A recent Congressional Budget Office analysis found this intervention to be the only CMS care coordination demonstration that showed statistically significant improvement in cost trend.[4]

Another key aspect to improving quality and lowering cost trend is providing our patients with enhanced access to specialists. Specialists and the tests and procedures they perform account for nearly 50% of spending in a commercially insured population. We anticipate providing rapid access to our patients for a subset of specialty services through nonbillable on-site and telemedicine processes.

Constantly measuring and improving our performance is another important tactic. Providing meaningful performance variation data to physicians is challenging, but our experience suggests that this is both practical and effective. Our hospitals have implemented computer-based electronic order entry systems with decision support.[5,6] Use of this system allows both immediate feedback as well as data collection and feedback of comparative data on test ordering. We also distribute comparative data in medication ordering and the use of some services. We plan to dramatically expand the number of clinical areas for which we provide reports as well as the number of clinicians who receive these reports.

Demonstrating Value to Referring ACOs

The previously described tactics make sense for managing a population, but most of the patients seen within an academic medical center are referred from nonaffiliated physicians. If these referring physicians are themselves in an ACO, we will need to make sure that they view us as the tertiary provider of choice. How will we do this?

Partners has begun redesigning the process by which patients receive care for individual conditions. Multidisciplinary teams gather to rationalize the steps in the delivery of a service from the patient's perspective and with an eye toward improving efficiency. We started with diabetes, acute stroke, acute myocardial infarction, coronary artery bypass grafting, and colon cancer. Each team provides recommendations to improve patient-centered outcomes while reducing the cost of providing those outcomes. Within episodic specialty care redesign, we are focusing on some core elements, including (1) patient decision aids, (2) documentation of appropriateness, and (3) decision support and order entry in the electronic health record. Finally, using our network of community hospitals, postacute care settings, and home health care, we are moving patients with less complicated health problems to community settings when this is appropriate and more convenient for patients.

Conclusion

We view the work described herein as pushing the limits of what can be expected of health care organizations, but success as a Pioneer ACO will depend on additional factors outside our control. Under the new rules of provider risk, our patients can choose to receive their care within our system or somewhere else. Obviously, we cannot control quality or costs of care outside our system, so we will work to demonstrate to our patients that they will receive the best care if they choose us. In addition, the Pioneer ACO does not appear to provide a mechanism to reduce the very high administrative and regulatory costs in our system.[7] Finally, we do not control the benefit design, so we have limited leverage when patients seek covered services that provide little or no benefit.

The path we have started down is ambitious. However, engaged health care organizations that want to be part of the solution should make the changes to the delivery of care in the way they themselves would want to be treated as a patient. The Golden Rule states that we should do unto others as we would have them do unto us. In considering the extent to which the numerous non–health care organization stakeholders in health care would dictate the terms under which care is provided, we have modified this rule. In order to define a future best suited for patient care, health care organizations should do unto themselves as they would have others do unto them.

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Balancing AMCs' Missions and Health Care Costs — Mission Impossible?

Elizabeth G. Nabel, M.D., Timothy G. Ferris, M.D., M.P.H., and Peter L. Slavin, M.D.

When major provisions of the Affordable Care Act (ACA) are implemented next January, few institutions will feel the pressure to control costs more acutely than academic medical centers (AMCs), which must balance the imperatives of clinical care with cost-intensive missions in research, teaching, and community health. Massachusetts AMCs don't have to guess at the law's likely impact: in 2006, our state launched its own health care reform involving principles and policy solutions similar to the ACA's. Massachusetts therefore provides a laboratory for gauging the effects of such reforms.

Having largely solved the insurance problem, Massachusetts passed sweeping cost-control legislation in 2012, including setting a target ceiling on growth of total medical expenses. Although Massachusetts' health care costs are among the highest in the country in absolute terms, they're among the lowest when adjusted for cost of living.[1] Nonetheless, AMCs' share of hospital admissions is higher in Massachusetts than in any other state, and AMCs' costs are typically higher than those of non-AMC providers.[2] As a national hub for medical research and education, Massachusetts must carefully limit the growth of health care costs without undermining the future of this important resource.

At the state's two largest AMCs, we've addressed this challenge in part by using known methods for improving access, continuity, and care coordination, relying heavily on data and measurement.[3] We call this approach population health management, and implementing it poses different risks and challenges for AMCs than for others. Balancing efforts to contain costs against investment in our missions involves trade-offs among important goals. We view meeting this challenge as a key contribution we can make to health care's future.

In 2011, Brigham and Women's Hospital (BWH) and Massachusetts General Hospital (MGH), through Partners HealthCare, chose to participate in risk-based contracts with commercial payers and the Centers for Medicare and Medicaid Services as a Pioneer Accountable Care Organization. Under these contracts, we share financial risk for the increase in total medical expenses for patients who see primary care physicians (PCPs) in our network. If our cost growth exceeds that of a comparison group, we pay penalties; if it's lower than that group's, we share in the savings. These contracts cover more than 400,000 patients — more than one third of the patients who receive care in our hospitals annually. In addition to the financial incentive, these contracts help us restrain cost growth by providing a measuring stick to assess our progress in developing and deploying innovative care-delivery processes that are more efficient and more satisfying to patients and that result in higher-quality care.

We've focused first on primary care as the hub for managing populations' care through preventive services, care for chronic illnesses, and care coordination for high-risk patients. We're expanding our cadre of employed PCPs and advanced practice nurses and are committed to ensuring that all our primary care practices become certified by the National Committee for Quality Assurance (NCQA) as Patient-Centered Medical Homes. So far, about 350 providers are engaged in practice redesign, and six lead practices have achieved NCQA recognition.

The most expensive component of this expanded investment is 71 "high-risk care managers" who work closely with PCPs, each coordinating the care of approximately 200 high-risk patients. This program arose from a successful Medicare demonstration project started at MGH in 2006 and expanded to BWH in 2009. Independent evaluations have found cost reductions of 2.5% to 19% for the care of multiple successive cohorts of enrollees — for total taxpayer savings of more than $50 million. The nearly three-to-one return on investment has made this program the centerpiece of our efforts and given us greater confidence to take on further cost-containment challenges.

Unlike the failed managed-care efforts of the 1990s, our initiatives involve our specialists as well. Specialists' decisions drive a large fraction of costs, especially for commercially insured populations. Having assessed our pri-

mary care population's unmet needs, we're adding clinical staff in such areas as mental health, general cardiology, dermatology, and physical therapy. We are changing the way we provide care, using innovative approaches such as referral management, virtual visits, one-time home nursing visits, team-based care, and home telemonitoring. We have a process for actively reviewing and redesigning the way we deliver care, condition by condition, that emphasizes optimizing the patient's care experience (continuity of information, management plan, and relationships) and the efficient delivery of services throughout an episode of care. For example, we've reduced admissions for transient ischemic attacks by making the required testing immediately available for outpatients; we've improved diabetes care by automating referrals to diabetes counselors; and we've begun reviewing specialist referrals to identify opportunities for providing consultations without requiring face-to-face visits. Changing these processes presents unique challenges to AMC physicians, partly because care delivery is only one of their responsibilities, in addition to research and teaching.

These changes in clinical process require additional investment in information systems and analytic resources. To ensure consistent clinical communication and assess our progress in population health management, we're consolidating our clinical and administrative systems onto a single electronic platform. This new infrastructure requires investment, which is not provided by the risk-based contracts, and success in these contracts means lower clinical revenues. Moreover, government payer rates have not kept pace with inflation for more than a decade. Therefore, funding for these new AMC costs must come from growth in regional, national, and international referrals and reductions in our cost structure — a difficult and perennial problem that we are addressing.

A second difference from 1990s managed care is our development of a coordinated process for sharing risk across our AMCs and physician groups. Our performance framework encourages shared practices for managing care for populations rather than holding each physician accountable for individual patient costs. Accordingly, the financial risk shared with payers is held at the level of the integrated delivery system. In turn, we've created an internal incentive system designed to accelerate and reinforce the adoption of primary and specialty care programs and encourage local innovation and strong performance on quality and safety metrics. Each AMC has invested in the infrastructure required for its physicians to meet the internal incentive goals.

Although we have only 18 months of experience with risk-based contracts, our approach is showing promise. Our cost trends have been lower than local and national comparison benchmarks,[4] suggesting that even at the current historically low rates of cost escalation, our efforts are paying off. Nonetheless, challenges and tensions remain — among them, balancing the imperative of cost-efficient, high-quality clinical care with our research, education, and community health missions, especially as federal budget cuts and payment rule changes impose substantial pressure. We do not yet have solutions to these difficult challenges, but we're committed to innovative approaches to solving them.

Fortunately, our teaching mission is wholly compatible with our care-delivery changes: we are educating providers and physicians-in-training about the future of clinical care. New payment systems encourage a convergence of AMCs' clinical and community health missions: investments in community health have historically been charitable but now promise to reduce medical expenses for affected populations. The impact on basic, clinical, and population-based research is less clear. Innovation distinguishes AMCs, and ensuring that basic biomedical discovery flourishes as we invest in care delivery will require vigilance.

Today's central challenge is the rising cost of health care.

AMCs' complex organizational structures and historical focus on tertiary inpatient care may appear incongruent with success in contracts requiring commitment to change and reduced use of hospital services. Charting our course under the current economic pressures won't be easy. But our AMCs have built their reputations by addressing society's most pressing health care challenges, and today's central challenge is the rising cost

of health care. Fortunately, AMCs specialize in innovation. We must now apply that capability not just to scientific aspects of medical care but also to the systems delivering it.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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BECOMING A PHYSICIAN

Signal in the Noise

Raphael P. Rush, M.D.

The first time I heard an IV pump beeping was my first time in the hospital as a medical student. Sent to examine a loud, cantankerous patient, I became concerned when his IV pump began frantically shrieking. After 30 seconds of panic and uncertainty, I pulled a resident out of the hall into the patient's room, where, in a maneuver that shocked me then but has since become part of my repertoire, she promptly hit the "Silence Alarm" button and continued with her own work.

Hospitals are noisy places, an assault on the ears. As a new visitor, I was greeted by an array of beeps, whistles, and shouts made by people and machines, each with a distinct agenda, every one of them desperate for attention. The impression was of an unholy, disorganized din.

Yet cacophony gave way, over time, to music. The soft dings of arriving elevators mixed with chatter at the nursing station. The now-gentle tones of IVs provided the root chords of a melody made of the cadences of snoring patients and the trills of ringing phones.

Certain songs, with their distinctive instruments, repeated themselves. The beep of a heart monitor, accompanied by the hiss of mechanical ventilation, provided a backbeat for the trance music of the ICU. Alarms and suction and overhead pages backed up the lead vocals and heavy-metal stylings of the Code Blue team leader.

At night, after the lullaby of the overhead announcement ushered visitors out of the hospital, after the formal and choreographed day teams gave way to the improvised jazz of the nighttime residents, the wards would go dark and silence would fall. Not in the grungy emergency department, which would be louder, busier, and more frantic, but on the wards, where once the families had left and the lights were turned low, patients and house staff alike would be left alone with their to-do lists and their thoughts.

Now, I was expected to pronounce someone dead for the first time.

Silence evoked an urge to fill it, and it was in those rest beats that I often found myself crossing the threshold of a patient's room to stop, to sit, to examine again, to catch what I had missed during the day. Night was the time to notice and address the softest sounds: a subtle valvulopathy, fine crackles, quiet weeping behind a curtain after a patient had received difficult news. It was a chance to talk with my patients, hear the lyrics of their histories again, chat about the news, or do crosswords with them as I looked over their shoulders. I began rounding a second time each day, after dark, the quiet night music serving as my own lullaby before I returned to loud work in the emergency room or evanescent refuge in the stillness of the call room.

One night, early in my residency, I was listening to the patter of rain against the call-room window and sipping midnight coffee when my pager went off.

Appendix B: Response to HPC Market Analysis

The HPC Report does not provide any reliable antitrust analysis of the transaction, nor does it provide an analysis that is probative of any issue currently under consideration by the appropriate antitrust authorities, whether within the Commonwealth or the Federal Government.

The HPC is not an antitrust enforcement agency, and has no experience in antitrust analysis. The Cost and Market Impact Review process is not well-suited to performance of an appropriate antitrust analysis; the HPC acknowledges this fact in footnote 109 of the Report (at p.38), wherein it points out that it must perform an abbreviated analysis, utilizing shortcuts, in "a small fraction of the time that antitrust reviews can take." In particular, the HPC makes clear that it has not performed a relevant market analysis of the type that is required under relevant antitrust precedents. *Id*. Because a complete, reliable relevant market analysis is the essential starting point for any discussion of market concentration or market power, or the prediction of possible anticompetitive effects, none of the HPC's findings in its "market analysis" are reliable or trustworthy for any purpose.

To the contrary, the market analysis in the HPC Report is structured in a way that can reliably be expected to produce erroneously high market shares, erroneously high market concentration, and to erroneously predict anticompetitive effects from the transaction, no matter what the facts are on the ground. Were the HPC to apply this analysis to any other transaction between any other providers, the results would be similar because the outcome of the HPC Report's market analysis is determined by the structure of the analysis itself, not by the facts of the case at hand.[23] It is for this reason that all relevant antitrust precedents and guidelines reject the methodologies utilized in the HPC Report.

Antitrust review of hospital mergers is governed by decades of relevant precedents applying well-established methodologies such as the DOJ-FTC Horizontal Merger Guidelines. These methodologies are applied and enforced by courts with discipline and rigor because the outcomes of these analyses can have concrete, real-world consequences for consumers. Under all of those precedents and methodologies, the bedrock first principle of any antitrust analysis is a robust, reliable market definition produced through application of accepted principles. That market analysis requires a rigorous process of identifying the relevant product market at issue in the relevant geographic market at issue. Metrics such as market shares and market concentration can only be calculated in the context of an appropriately defined product and geographic market. If the markets are not properly defined, then the subsequent analysis is unreliable. And an unreliable antitrust analysis is as likely to harm competition by stopping a transaction that would benefit consumers as it is likely to stop an anticompetitive merger. Because the HPC has not even attempted to appropriately define an antitrust relevant market in the Report, and because it has not otherwise followed any recognized antirust

[23] This is particularly troubling if the HPC plans to apply this analysis as precedent in future reviews. The Commission risks its own legitimacy if it establishes a methodology that, by its very application, signals that the Commission intends to find a particular transaction contrary to the public interest.

methodologies, its findings concerning market share, market concentration, and potential anticompetitive effects are unreliable.

Many a challenge to a healthcare merger over the past 20 years has foundered on the rocks of geographic market definition. The shortcuts and half-measures that HPC has taken in performing its market analysis not only do not comport with established precedents, they in fact replicate errors that reviewing courts have consistently held cannot support a merger challenge. These errors include: assuming, rather than analyzing under well-established methodologies, the relevant geographic market; ignoring, rather than analyzing, market factors (including the use of steering by payors to defeat any theoretical price increase) that do not support the Report's conclusion; and relying on unpublished "modeling" supplied in secret by third parties that may or may not have anything to do with the task at hand.

The HPC has the right and duty to perform all analyses relevant to its task under the law. However, nothing in the law provides the HPC with authority to abrogate existing antitrust law or to ignore decades of antitrust precedents and methodologies. Those portions of the HPC Report that purport to analyze market shares, market concentration, or theoretical market power do so with no basis under established antitrust law, and should be stricken from the Final Report. And in any case, nothing in the Report can be relied on any antitrust authority, whether state or federal, for any reason.

A. THE REPORT'S MARKET ANALYSIS IS UNRELIABLE BECAUSE IT IS BASED ON AN ABSURD GEOGRAPHIC MARKET DEFINITION AND IGNORES RELEVANT COMPETITORS

The starting point for any governmental challenge of a hospital merger under the antitrust laws must always be a rigorous, reliable market definition. Proper definition of the purported relevant market "is a 'necessary predicate' to a successful challenge" under the antitrust laws. *FTC v. Freeman Hospital*, 69 F.3d 260, 272 (8th Cir. 1995). *See also, e.g., FTC v. ProMedica Health System, Inc.*, 2011 U.S. Dist. LEXIS 33434 at *141-142 (N.D. Ohio Mar. 29, 2011) (identifying the elements the government must satisfy to give rise to a presumption of anticompetitive effects and relying on *United States v. Philadelphia National Bank*, 374 U.S. 321, 363 (1963)).

The government's failure to properly define the relevant geographic market at the outset of a case dooms all later assertions of market power, market concentration, and anticompetitive harm, because these metrics cannot be reliable if they are not based on sound market definitions. *See, e.g., California v. Sutter Health System*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001) (rejecting government's proposed relevant geographical market); *United States v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D.N.Y. 1997) (rejecting government's proposed geographic market in the greater New York area consisting of the area immediately around the acquiring and the target hospitals.).

In its Report, the HPC disclaims the ability to perform an appropriate antitrust geographic market analysis. HPC Report at 38, n. 109. Instead, and with no reasoned explanation for doing so, the Report simply adopts the SSH primary service area ("PSA") as the relevant geographic market for analysis. This analytic shortcut dooms the remainder of the Report's market analysis for two independent (and independently sufficient) reasons.

First, the HPC Report's shorthand reliance on the SSH PSA as a proxy for an appropriately defined relevant geographic market has been long recognized as a fundamental analytical error in antitrust cases, and this error infects the entirety of the Report's market analysis. In an antitrust case, a properly defined geographic market must be drawn to include all potential suppliers who can readily offer consumers a suitable alternative to the defendant's services; the relevant market is not determined by where a particular hospital's patients typically live or where they have gone for services in the past, but rather where they *could go* to receive services after the merger. *See, e.g., FTC v. Tenet Health Care Corp*., 186 F.3d 1045, 1052 (8th Cir. 1999) (explaining the importance of properly defining the relevant geographic market by reference to availability of substitute hospitals). It is for this reason that courts reject the practice, used here by the HPC, of relying on a hospital's service area as a proxy for a properly defined relevant geographic market for antitrust analysis. *Id*. at 1052 ("A service area, however, is not necessarily a merging firm's geographic market for purposes of antitrust analysis"); *Home Health Specialists*, 1994 U.S. Dist. LEXIS 11947, *4-16 ("There is no basis for inferring that a service area constitutes a geographic market unless the Plaintiff offers evidence of elasticity of demand and barriers to entry.").

Second, and perhaps more fundamentally, the HPC Report's shorthand substitution of the SSH PSA for an appropriately defined relevant geographic market cannot possibly be the appropriate relevant antitrust geographic market because, as the Report acknowledges, other hospitals outside of the SSH PSA serve patients in that area, and one of the two merging parties—Partners—does not even have a hospital there. The Report excludes from its purported geographic market those areas where Partners operates hospitals as well as other areas where competing hospitals exist to serve patients living in the SSH PSA, while at the same time concluding that Partners somehow has market power in the SSH PSA and recognizing that other hospitals located outside of the SSH PSA draw patients from inside the SSH PSA. *See, e.g.,* HPC Report at 18 ("Partners has high market share even though it does not have a hospital located in that region; its high market share is driven by significant numbers of patients traveling from the South Shore region to obtain care at BWH and MGH.") and at 27 ("Residents of SSH's PSA also often traveled outside of the PSA to obtain care at Massachusetts tertiary hospitals.").

Under the Horizontal Merger Guidelines and all relevant antitrust precedents, this simply cannot be so.[24] *See* DOJ-FTC Horizontal Merger Guidelines § 4.2 (Geographic Market Definition); *see also Sutter Health System*, 130 F. Supp. 2d at 1125 ("Where a hospital outside of the proposed geographic market draws patients from the same region from which the merging hospitals draw their patients, the hospital located outside the test market is considered a

[24] The Report's suggestion on page 39 that its geographic market definition is "robust" because it utilized two different methodologies to define the SSH PSA is a *non sequitur* diversion. The question is not whether the Report properly defines the SSSH PSA; the question is whether the SSH PSA, however defined, is an appropriate relevant geographic antitrust market. *See, e.g., Home Health Specialists v. Liberty Health System*, 1994-2 Trade Cas. (CCH) ¶70,699, 1994 U.S. Dist. LEXIS 11947, *9-10 (E.D. Pa. 1994), *aff'd*, 65 F.3d 162 (3d Cir. 1995) (finding irrelevant a discussion of the proper definition of a service area when the relevant question is what options are available to consumers). Because the SSH PSA does not even include the other merging party in the analysis, that definition cannot be accurate.

practical alternative to which patients residing in the area of overlap can turn for acute inpatient services."). The Eighth Circuit Court of Appeals has labeled this type of market definition "absurd" because it ignores the reality that patients regularly travel outside of the alleged "market" to receive care at other hospitals. *Tenet Health Care Corp*., 186 F.3d at 1054.

It is hornbook antitrust law that if there is evidence that consumers regularly seek treatment at hospitals outside of the alleged geographic market, then that market has been drawn too narrowly and cannot form the basis of an analysis of market power, market concentration, or possible anticompetitive effects. Here, the HPC Report states plainly that its shorthand substitution of the SSH PSA for an appropriately defined relevant geographic market excludes competing hospitals in addition to excluding Partners itself—while still alleging a high market share for Partners. This sort of antitrust sleight-of-hand is forbidden by all relevant precedents.

The HPC Report also dismisses the importance of competition from many of the most relevant competitors to SSH—Quincy, Milton, Jordan, Good Samaritan, and Brockton—without any analysis or discussion, claiming that it may do so because the parties have not "described the extent to which these hospitals are able to attract commercially insured patients from SSH's PSA." HPC Report at 44. But that is not how competition is analyzed in antitrust cases. The plaintiff in an antitrust case does not get to *presume* that other competitors in the marketplace do not compete, and thereby push the burden onto the defendant to prove that they do. All of these hospitals would be counted as competitors in the market in any antitrust case arising from this transaction because they all draw patients from the same geographic area that SSH does. The HPC Report itself states that these hospitals account for 19% of commercial discharges for patients living in SSH's PSA—a percentage that, even if it were an accurate measure of these firms' market share (which it cannot be given the flaws above), would be highly relevant to an antitrust analysis of the transaction. *See, e.g., Tenet Health Care Corp*., 186 F.3d at 1053 (reversing in part because the lower court "improperly discounted the fact that over twenty-two percent of people" in the alleged relevant geographic market received care from competing hospitals located outside of the alleged relevant geographic market).

Because the HPC Report's geographic market analysis is flawed, all of the market share, market concentration, and anticompetitive effects analyses that flow from it are similarly flawed.

B. THE REPORT'S SUMMARY DISMISSAL OF THE ROLE OF PAYOR STEERING IS CONTRADICTED BY THE PAYORS' SWORN TESTIMONY ON THIS SUBJECT

The Report dismisses out of hand the ability of payors to avoid or defeat any future attempted price increase by a combined Partners/SSH through the use of steering mechanisms, which include not only tiered and limited network plan designs, but also high deductible and defined contribution plans and risk-sharing arrangements, including total medical expense ("TME") managed care plans. In the Report, the HPC chooses to credit self-serving, undocumented claims by interested parties and to ignore well-documented facts that are supported by the sworn statements of those very same interested parties, which contradict what they have told the HPC in secret. It is only by ignoring real-world facts in favor of

undocumented whispers that the HPC can dismiss the importance of payor steering in its analysis of the possible exercise of market power by a combined Partners/SSH.

It is an undeniable fact that Massachusetts payors are identifying with great specificity lower-cost providers and assembling/reassembling them in their networks, and also are incentivizing consumers and referring providers to make use of them.[25] The four major commercial payors in Massachusetts have all testified under oath to the Commonwealth that they are in the process of moving away from fee-for-service plans in favor of tiered, limited, and risk-based plan designs. Blue Cross Blue Shield of Massachusetts ("BCBSMA"), the largest payor in the Commonwealth, recently testified that it is moving away from the fee-for-service model, even in its PPO plans. 85% of BCBSMA's HMO lives now have a primary care physician who participates in an Alternative Quality Contract ("AQC"), which combines a per-patient global budget with significant performance incentives based on quality measures. These types of plan design changes are focused entirely upon lowering TME through steering and efficiency, and BCBSMA testified that its cost-reduction efforts "include working with employers and members to promote the use of lower cost care settings through product designs that incent members to use lower cost setting, tiered and limited provider networks that provide both incentives to use lower cost providers and increased transparency of lower cost providers, and active utilization management programs that help steer members to lower cost settings."[26]

Tufts Health Plan ("THP") likewise testified that over 80% of THP's HMO members are in value-based, global budget contract models. THP "employs a number of strategies to encourage the use of more cost effective care settings and providers," including benefit and network design, incenting providers to steer patients to lower cost providers, and cost transparency. As part of the product design prong of the CCM, THP has implemented tiered network products that "provide financial incentives to encourage members to select high-value providers." THP's limited network options and tiered plans (Navigator and Your Choice) "provide employer groups with meaningful premium cost savings relative to traditional full network products with equivalent member cost sharing, typically averaging 10-15%."[27]

Harvard Pilgrim Health Care ("HPHC") likewise testified that it has been increasing the use of alternative plan methodologies and that HPHC "expect[s] the vast majority of the Commonwealth's health care providers to be in alternative payment arrangements within the next year or two." Moreover, not only is HPHC itself moving away from the fee-for-service model, HPHC "believe[s] that there is general acceptance among the provider community in moving away from traditional fee-for-service payment mechanisms." HPHC's efforts to reduce medical expense trend have been focused on "a combination of plan design incentives targeting providers and members." HPHC's Hospital Prefer (a tiered plan), Choice Net (a tiered plan) and Focus (a limited network plan) "emphasize greater consumer engagement and

[25] Empirical research shows that these measures are in fact effective at changing patient behavior through steering and, as a result, effective at reducing provider prices. *See, e.g.,* James C. Robinson and Timothy T. Brown, "Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery," *Health Affairs*, 32, no. 8 (2013):1392-1397.

[26] Blue Cross Blue Shield of Massachusetts ("BCBSMA") September 16, 2013 Pre-Filed Testimony for Massachusetts Annual Cost Trends Hearing.

[27] Tufts Health Plan September 16, 2013 Pre-Filed Testimony for Massachusetts Annual Cost Trends Hearing.

provide incentives for consumers to go to providers that have lower costs but maintain a quality of care standard."[28]

Fallon Health Plan ("Fallon"), which the HPC Report refers to as the "largest limited network plan in the state," testified that its cost reduction efforts have largely involved steering members and employers towards its limited and tiered network products FCHP Direct Care (a limited network), FCHP Steward Community Care (a limited network with Steward Health Care System), and FCHP Tiered Choice (a tiered plan). Participation in these networks makes up 46% of Fallon's commercial membership, an increase from 2009 (33%). "By choosing to move to a limited or tiered network plan, employers and employees have had the ability to save premium dollars without necessarily giving up the comprehensive rich benefits package they have become accustomed to."[29]

Despite the fact that all of the major commercial payors in Massachusetts have testified under oath that they are moving away from fee-for-service plans in favor of tiered, limited, and risk-based plan designs that encourage steering and are built for the very purpose of defeating high provider prices, and despite the fact that 56% of HMO and PPO enrollees in Massachusetts are in a risk-based, tiered, limited, or tiered and risk-based plan, the HPC Report inappropriately brushes aside the significance of this undeniable trend without reason or explanation.

In a single paragraph that makes no mention of the payors' sworn testimony or the clear market trend toward alternative plan designs, the HPC Report simply concludes that these market facts do not apply in the SSH PSA. This conclusion is based on three purported reasons: first, that Fallon's plans are not available in the South Shore region; second, that the combined market share of Partners and SSH would be so high that payors could not likely avoid paying any future price increase through application of alternative plan designs since they likely could not do without them in the network; and third, that even if Partners/SSH participated in all tiered and limited networks, employers might be wary of moving their employees into a plan where Partners/SSH were in the highest-cost tier. HPC Report at 44. But these reasons are based on nothing more than inaccurate conjecture.

First, the absence of the Fallon plans from the South Short area is irrelevant since all of the other major payors offer their own tiered, limited, and risk-based plan designs.

Second, the Report's suggestion that Partners and SSH would possess a 50% market share for commercial inpatient lives, and therefore would not be subject to price discipline by the payors, is based on the "absurd" geographic market definition discussed above. Only by gerrymandering the relevant geographic market and utilizing a methodology designed from the outset to produce a finding of anti-competitive effect can the HPC Report conjure a 50% market share for a combined Partners/SSH. And even if the merging parties would possess a combined market share of 50% post-merger, that market share alone does not tell us anything at all about the ability of payors to avoid any future price increase through the use of alternative plan designs.

[28] Harvard Pilgrim Health Care September 16, 2013 Pre-Filed Testimony for Massachusetts Annual Cost Trends Hearing.
[29] Fallon Health Plan September 16, 2013 Pre-Filed Testimony for Massachusetts Annual Cost Trends Hearing.

Third, the suggestion that employers may be wary of moving *all* of their employees into a tiered or limited network plan ignores the fact that employers regularly offer more than one health plan to their employees. Employers who offer plans with alternative designs, such as provider tiering or limited networks, will frequently incentivize employees to choose those plans through lower employee premium cost-sharing, thereby encouraging consumers to make an informed, price-conscious choice of plan and provider. Employees who do not wish to make that choice can chose to remain in more traditional plan designs. Nothing about the Transaction will change the availability of those choices.

The HPC Report also references (at n. 131) an off-the-record discussion with "one major payer" in which that party "noted that membership growth in tiered and limited networks has been modest so far, having little influence on market dynamics in eastern Massachusetts." The Report furthermore relies on a statement from this unnamed payor that "if Partners and South Shore, which are in a higher tier than other network providers, were to merge, even fewer members who are tied to these providers would opt for tiered and limited network products." The Report does not identified this unnamed payor, nor does it attempt to reconcile these statements with any of the sworn testimony submitted by all of the major commercial payors in Massachusetts in which they testified that the marketplace, and the majority of their plans, are headed in this direction.

Once again the HPC has fallen into a trap that was long ago dealt with in the relevant antitrust precedents: self-serving predictions of anticipated merger effects by other market participants are given little or no weight in a legitimate antitrust analysis. In response to similar "evidence" offered by commercial payors to the Federal Trade Commission in a challenge to a previous hospital merger, the Eighth Circuit Court of Appeals warned against "reliance on the testimony of managed care payers, in the face of contrary evidence, that these for-profit entities would unhesitatingly accept a price increase rather than steer their subscribers to hospitals [outside of the alleged geographic market]. Without necessarily being disingenuous or self-serving or both, the testimony is at least contrary to the payers' economic interests and thus is suspect." *Tenet Health Care Corp*., 186 F.3d at 1054.

The HPC's decision to credit the anonymous whispers of one or more unnamed payors over demonstrated market facts and the sworn testimony of those same payors is unjustifiable and would receive no deference by a court applying established antitrust principles.[30]

C. PORTIONS OF THE REPORT MUST BE STRICKEN

Given the problems identified above, the following portions of the Preliminary Report should be stricken from the final report:

- Any reference to market shares or market concentration, including but not limited to all assertions that Partners or SSH, or a combination of partners and

[30] The same can be said for any reliance by the HPC on the "'willingness-to-pay' analysis of the SSH acquisition produced by a competitor provider" mentioned, but never explained, at pages 42-43. The field of willingness-to-pay modeling is complex and highly controversial, and entirely dependent upon the quality and appropriateness of data used for the analysis. It would be highly inappropriate for the HPC to rely upon any willingness-to-pay modeling performed by a competitor that has not been publicly disclosed and thoroughly tested by the parties.

SSH, possess or would possess a “high” market share or result in an appropriate market concentration.

- Any reference to competitive effects or a predicted anticompetitive effect from the merger of Partners and SSH.
- Any reference to the SSH PSA as an antitrust geographic market.
- Any reference to or reliance on any third party’s willingness-to-pay modeling.
- Any suggestion that payors lack the ability to respond to any potential future price increase through steering or otherwise through application of alternative plan designs, along with any reference to or reliance on any non-public statements made by any payor to the HPC.

Appendix C: SSH's Statement of Goals for Pursuing the Transaction

The Parties submit this Appendix to the response to the HPC Preliminary CMIR ("Preliminary Report") to set forth the ways in which the HPC has misunderstood or ignored why the economic and clinical principles of Population Health Management ("PHM") require the full alignment of South Shore Hospital ("SSH"), South Shore Physician Hospital Organization ("SSPHO"), and Partners HealthCare ("Partners") under common ownership in order to effectively lower per capita medical expense, increase quality of care, and improve patient experience and access to care. This Appendix also sets forth other significant factors that the HPC has discounted in the Preliminary Report, namely the forward-looking cost-control effects of payor initiatives, and other ongoing changes in the competitive landscape.

A. EFFECTIVE IMPLEMENTATION OF PHM—WHICH SSH AND SSPHO CANNOT ACHIEVE OUTSIDE THE TRANSACTION—WILL RESULT IN SIGNIFICANT IMPROVEMENTS IN CARE AND REDUCTIONS IN COST.

- **The Transaction will enable SSH and SSPHPO to more effectively allocate risk across a broad population.**

A requirement for PHM is the ability to effectively allocate financial risk across a sufficiently broad and defined population. Virtually every commercial and regulatory initiative to control total medical expense ("TME") relies on the mechanism of provider risk allocation, and it is also core to the PHM model. As health care shifts from a fee-for-service to a fee-for-value paradigm, the ability to make PHM work depends on having access to a population with a scale and composition suitable to risk allocation; the flexibility to direct revenue to particular modes of care delivery and infrastructure investment as needed; and control over the strategies that are going to allow risk sharing to succeed. For instance, providers must have access to communities with sufficiently diverse patient socio-economic status, age, and health status in order to create a pool of covered lives over which it can spread risk. They must be able to decide what strategies will address risk most effectively, for instance by using parts of a global payment for non-medical care managers, patient transportation subsidies, patient home environment improvements and other non-traditional methods that can reduce costs associated with a patient's care.

Because of its size and resources, SSH is necessarily constrained in its ability to create a defined population of sufficient scale for effective allocation of risk in a PHM model. SSH has estimated that it would likely need to take on the order of hundreds of thousands of covered lives in order to generate the kind of savings in total medical expense that would justify the investment required to implement PHM. Moreover, even if SSH had access to a population that did justify the investment, the value captured would pale in comparison to what can be achieved if SSH became part of Partners.

Among the major barriers to SSH's ability to build a population of sufficient scale is that it lacks the resources to establish the primary care practices that provide the foundation for PHM and allow a program to scale up to a sufficient degree. As acknowledged in the Preliminary Report, the Parties have determined that the South Shore requires twenty-seven (27) net new primary care physicians, linked up to a developed network of care, to implement

PHM effectively, and Partners has committed to spending $54 million over five years to accomplish that, in addition to $55 million to establish a network of specialists in the area. Although SSH has a small scale plan to hire six primary care physicians in order to establish a single medical home over three years, that number falls far short of what would be required to implement PHM and requires a full 60% of SSH's entire capital budget over those years. Furthermore, it is far from clear that even if SSH were able to attract and retain six primary care physicians, that this initiative could ever give rise to a defined population of sufficient scale. Assuming that the South Shore Physician Hospital Organization has 5,000 existing covered patient lives under its risk contracts at the time PHM were implemented, on top of those lives, the planned medical home would add approximately 13,000 lives—if the medical home is entirely successful, and at the end of three years—to equal approximately 18,000 lives. By contrast, Partners currently manages over 500,000 covered lives via PHM and aims to add more to that pool in order to fulfill the promise of PHM. As described below, all of SSH's competitors in the South Shore area are moving to get into a position where they will have the scale necessary to undertake PHM initiatives.

- **The Transaction will enable SSH and SSPHO to effectively align provider interests.**

The primary lever available to integrated providers in achieving the benefits of PHM is the ability to track efficiency and quality metrics and provide effective incentives for component institutions and individual providers to meet established goals. Integrated providers must have an incentive to coordinate care, such that there is a compelling reason to look at the larger picture of a patient's care as a single institutional team. Fundamental to this is seamless communication, information transparency, and data gathering across a uniform electronic health record platform, enabling not only care coordination and implementation of uniform care protocols, but also close tracking of progress of quality targets and ongoing data analysis that characterizes PHM.

Although SSH has succeeded in providing care through certain contractual clinical affiliations, these affiliations in many ways demonstrate the many barriers to coordinated care delivery and risk sharing outside a fully integrated framework. Affiliated providers are on site at SSH, but SSH has no ability to align their financial interests with others who may also be delivering care, and, most importantly, no ability to link financial incentive to the achievement of quality improvements. As the health care landscape shifts to a fee-for-value system, SSH expects that it will be increasingly difficult to attract and retain physicians without a system of aligned incentives for all providers practicing in a particular system or component institution.

Most importantly, a patchwork of affiliations reinforces the delivery of care in a "siloed" model that prevents providers from coordinating care (1) within the hospital environment and (2) beyond that, from looking at care along the entire continuum in order to find opportunities to lower cost and improve outcomes. As an example, one of SSH's affiliations covers emergency care, but those doctors are not linked to all other care in the SSH system, or with primary care, specialty care, tertiary care, after care, or any of the non-medical services that have been demonstrated to lower TME and increase quality.

To understand the disparities between clinical affiliations and a truly aligned PHM model, one only has to imagine a patient with chronic diabetes who repeatedly receives care in

the emergency room. In the PHM model, every single provider involved in that patient's care has the ability and the incentive to make sure that she has access to the best services in the most effective setting at the lowest cost, all based on the best available information shared among providers. Right now, if a Brigham & Women's Hospital doctor providing emergency services at SSH sees the same patient in the emergency room, the clinical relationship with that patient begins and ends in the emergency room and decisions are made in an information vacuum. That doctor has no ability and no incentive to take a holistic look at that patient's care to determine how she could be served with better outcomes in terms of her health and the cost of care even within the hospital itself. In contrast, if that same care were delivered in a fully integrated PHM setting, the emergency room physician would have the ability and the incentive to communicate with the patient's care manager, primary care physician, and endocrinologist to report the visit in order to avert additional emergency room use; could observe best practices protocols for treatment; could see what tests had already been run to avoid duplication; could have visibility to any prescription issues that may have contributed to the visit; and generally make the data associated with the visit "count" for analysis purposes.

- **The Transaction will enable SSH, SSPHO, and aligned Partners providers to deliver coordinated care along a unified continuum.**

The key to PHM is being able to deliver care with a long view, looking to how costs can be reduced and outcomes improved at each stage of care. To achieve this, as much of the continuum of care as possible—across stages of life and across levels of primary, specialty, tertiary, rehabilitative, and other care—must be aligned. A gap in the continuum, where the incentive and ability to deliver coordinated care is not present, creates the opportunity for waste, inconsistency, error, and an information/data vacuum, all of which is fatal to the ability of PHM to achieve cost savings and quality improvements.

SSH's ability to effectively implement PHM is also hampered by the fact that it does not have access to a full continuum of care due to some critical gaps in services in the South Shore, most notably mental health and long-term and rehabilitative care, gaps that have a disproportionate impact on the community's most vulnerable patient populations. In addition, although South Shore has made strides in providing sophisticated care, there will always certain tertiary and quaternary services that it cannot offer on site. Partners has all of these resources in its network already, and would have significant incentive to provide additional care locally if SSH became part of the Partners network. SSH provides Partners with a key foothold in a community in which Partners needs a presence to fulfill its own PHM design. SSH is also not in a position to provide care across a broad geographic footprint in a variety of settings in order to effectively rationalize care. As noted above, being able to coordinate care across the spectrum of services and to provide the right care in the right setting are core aspects of PHM. The Transaction would put SSH in a position of being part of an established care network with a full continuum of high-quality care in an expanded area.

Although the Preliminary Report references the effectiveness of the contractual clinical affiliations in place at SSH, including those with Partners entities, these affiliations are of limited contractual duration and in the new care environment may prove to be unsustainable. In addition, not all of the attempted affiliations have proved to be productive and none of them

has spawned significant risk sharing or co-investment. There are no current plans to dismantle these affiliations, but it is not a revelation to say that relationships like these, which are to a large degree creatures of the fee-for-service system, may cease to be viable. The services delivered via these affiliations are already functionally off-limits with respect to fully integrating them into any care delivery model that SSH might pursue. If the affiliations become untenable for the affiliates providing the services, those services will simply be unavailable to SSH.

In sum, although SSH currently offers an impressive spectrum of acute care services in part through these affiliations, they do not form a basis for implementing PHM at SSH nor do they guarantee that SSH will be able to maintain its current array of affiliate-supported services. It bears noting that one of the reasons that SSH has achieved its current position in the market is because Partners entities and Children's Hospital have, primarily as a matter of goodwill and shared mission, provided services through clinical affiliations.

- **The Transaction will enable SSH, SSPHO, and aligned Partners providers to rationalize care to deliver it in the optimum setting.**

A goal of PHM is to provide as much of a patient's care as possible in the most appropriate setting. The site of care—with respect to both setting, geography, and the proximity to complementary providers—can have a profound impact on the cost of care and on patient access and experience. Being able to serve a broad population requires a broad footprint and access to different modes of care delivery, from home visits to the most sophisticated operating rooms. For example: In a community such as the South Shore, where there is a shortage of outpatient psychiatric care, patients with mental illness often use the emergency room as a source of care. Providing care in this setting is far more expensive, far less effective, and far more traumatic for the patient than if routine, consistent care had been delivered in a community-based outpatient setting. Only when providers have the ability to deliver the right care in the right setting can it effectively pursue PHM's most important goals.

- **The Transaction will enable SSH and SSPHO to implement and effectively manage the infrastructure supporting PHM.**

PHM is an infrastructure-heavy model of care delivery, dependent on the presence of adequate provider resources and physical plant alongside sophisticated leadership, personnel devoted to the maintenance of the PHM framework itself, as well as systems and technologies such as robust electronic health records technology and ongoing data-analysis to reduce cost and improve quality. Investment in these resources must be justified by the potential return, which may take considerable time to materialize. This infrastructure is neither "off-the-shelf," nor is it primarily the purchase or leasing of specific technologies or systems such as electronic health records. Successful PHM requires providers to design and manage a complete system involving many component parts, the considerable costs of which are defrayed across many years. Designing and managing such infrastructure requires that the integrator have the ability to access capital and the requisite professional and managerial expertise to deploy the system across large and potentially diverse populations.

The infrastructure investments required to implement PHM at SSH are several times more than the annual capital budget of SSH: The parties estimate that the electronic health

records platform alone would cost $88 million to implement and the investment in physicians would be more than $100 million over five years. These are numbers that are far out of SSH's reach. Even if SSH could marshal the necessary funds on its own, the investment that could never be justified by the scope of the population available to SSH to manage through PHM. What Partners is pursuing through the implementation of the Epic electronic health record system—universal information sharing and sophisticated data warehousing to enable the kind of data analysis that is a major driver of care and cost improvements—only underscores the disparity between what SSH could accomplish on its own and what is possible through the Transaction.

The initial outlay of money for physicians and electronic health records technology, however, is only part of what it takes to successfully implement PHM. Partners' existing expertise in succeeding with PHM, its academic connections to the leading edge in research in this area, the growing team of MDs and managers at Partners devoted to expanding and improving PHM, and the ability to meaningfully analyze and act on data is something that SSH does not have and could not replicate—something that is true of most community hospitals in the U.S.

B. THE TRANSACTION ENHANCES SSH'S ABILITY TO COMPETE IN THE RAPIDLY CHANGING LANDSCAPE.

The Preliminary Report, with its focus on the past, is blind to SSH's future prospects and its ability to achieve its mission given the rapid changes occurring in the health care landscape in Massachusetts. Just within the past year or so, **all other community hospitals in the South Shore area have affiliated with larger systems** for similar reasons cited by South Shore for joining Partners (e.g., Jordan Hospital, Brockton Hospital, and Milton Hospital have joined Beth Israel Deaconess Medical Center; Quincy Medical Center, Good Samaritan Medical Center, St. Elizabeth's Hospital, New England Sinai (Rehabilitation) Hospital, and Carney Hospital have joined Steward Health Care). There can be no question that the past is not prologue with respect to health care delivery and competition among providers in Eastern Massachusetts.

In addition, transformations in payment systems away from traditional fee-for-service arrangements to alternative payment arrangements, new insurance product designs (limited, tiered and exclusive networks) and the continued evolution of Accountable Care Organizations as purchasers of health services are also actively changing the landscape. Payors in Massachusetts have also developed new means of spurring competition by implementing a system of tiered and limited networks that challenge providers to contain costs. Tiered networks offer varied co-pays for different facilities based on the facilities' cost profiles; limited networks are assembled from lower-paid providers, and patients' coverage is restricted to those providers. Because Eastern Massachusetts is home to so many hospitals with bed capacity and broad service lines, these networks can include several facilities and the arrangements are gaining favor among consumers. In order to attract a sufficient volume of patients, hospitals must compete to be present in the tier or network likely to drive business to their doorstep. Notably, SSH's neighboring hospitals are for the most part in the lower-cost tiers and therefore are poised to capture patients who are part of tiered network plans.

Appendix D

Letters of Support and Select Testimonials

Attached are letters in favor of the merger and select testimonials extracted from the official transcript of the below hearing.

Public Hearing:	Transfer of Ownership of South Shore Hospital
By:	Department of Public Health, Commonwealth of Massachusetts
Held at:	Old South Union Church 25 Columbian Street Weymouth, Massachusetts
	Wednesday, March 6, 2013 2:01 p.m.

Town of Weymouth
Massachusetts

Susan M. Kay
Mayor

75 Middle Street
Weymouth, MA 02189

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January 15, 2014

Stuart Altman, MD
Chairman
Massachusetts Health Policy Commission
2 Boylston St., 6th Floor
Boston, MA 02116

Dear Dr. Altman:

I write to express the Town of Weymouth's strong support for the proposed merger between South Shore Hospital and Partners Health Care. I urge the Commission to consider the positive implications of this merger with respect to the long term viability of South Shore Hospital as a community health care provider, the merger's consistency with the accountable care objectives of the federal Affordable Care Act and the economic and employment opportunity this merger represents for Weymouth and the entire South Shore.

South Shore Hospital is an integral part of Weymouth's community fabric. It is our largest employer and provides a means of support for literally thousands of families. It is clear to me that there have been mergers between community hospitals and hospital networks across the Commonwealth and that indeed, mergers are an important trend in the industry, driven by pressures to reduce costs and create administrative efficiencies. South Shore Hospital's long term viability cannot possibly be immune from this trend. This merger will provide South Shore Hospital the kind of financial and industrial state of the art support that it will need to maintain its viability in this environment. This merger should not be held to a different standard than the many mergers that have already occurred.

The Town also considers South Shore Hospital to be a vital health care provider to the community and the region. Indeed, we see this merger as enhancing this mission and doing so is consistent with accountable care organization objectives that are a mainstay of the federal Affordable Care Act and state health care finance policy. The quality of care provided by Partners is unrivaled, and will be a major access benefit not just to residents of Weymouth, but also the entire South Shore. The ability to provide this kind of health care access in an accountable care environment can only be realized through this merger and accordingly is consistent with long term goals to realize health care efficiencies and better control costs.

This merger is important to the Town, to our economy and to our health care security. I hope you will consider the Town's perspective as you consider this important matter further and hope you will not hesitate to let me know any questions you might have.

Sincerely,

Susan M. Kay

Susan M. Kay
Mayor

Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON, MA 02133-1054

GARRETT J. BRADLEY
REPRESENTATIVE
3RD PLYMOUTH DISTRICT
STATE HOUSE, ROOM 478
BOSTON, MA 02133-1054
TEL: (617) 722-2520
FAX: (617) 722-2813

Assistant Majority Whip
Floor Division Leader
Committee on Rules

Garrett.Bradley@MAhouse.gov

January 15, 2014

David Seltz, Executive Director
MA Health Policy Commission
Two Boylston Street. - 6th Floor
Boston, MA 02116

Dear Mr. Seltz:

I am writing in support of the proposed merger between South Shore Hospital and Partners Health Care that is under consideration by the Health Policy Commission.

As the State Representative for the Third Plymouth District, my district – consisting of Hull, Hingham, Cohasset and North Scituate – abuts the town of Weymouth. Many of my constituents work or receive care at South Shore Hospital.

This proposed merger is an economic, access, quality of life issue, in addition to being a health care issue. I was pleased to hear that the merger's objectives include: increasing the availability of preventive, primary and specialty care; improving electronic medical records and health information exchange; and altering how care is provided to patients so that the physician is the leading force in care decisions. All of these initiatives will benefit residents of the South Shore in a positive way.

I am supportive of any move that will help my constituents – and those of the wider region- receive greater and more varied access to medical services. As part of this merger I believe it is important to preserve current jobs with an eye towards growing additional well-paying jobs for South Shore residents. I would urge that any mass layoffs of employees be avoided, while at the same time examining the impacts on current wages and benefits.

Americans deserve a health care delivery system that reduces costs, expands access and increases the quality of care available to all citizens. This merger-as long as the layoff issue I mentioned is thoughtfully addressed – would benefit both the institutions involved and the public.

Sincerely,

GARRETT J. BRADLEY
State Representative
3rd Plymouth District

Cc: Dr. Stuart Altman, Chairman, MA Health Policy Commission

Town of Weymouth
Massachusetts

Jane Hackett
Weymouth Town Council
Councilor at Large
75 Middle Street
Weymouth, MA 02189
(781) 340-5020

January 15, 2014

Stuart Altman, MD
Chairman
Massachusetts Health Policy Commission
2 Boylston St., 6th Floor
Boston, MA 02116

Dear Dr. Altman,

I'm writing in strong support of the proposed merger between Partners HealthCare and South Shore Hospital.

As a Town Councilor representing the entire town of Weymouth and a former Chief of Staff to the Mayor, I am well familiar with the important asset South Shore Hospital is to our community and the entire South Shore.

South Shore Hospital is Weymouth's largest employer and a major source of positive economic activity. As an important acute care provider, it is on the front lines of health care delivery for our residents. Given its health care mission, and its economic importance, one cannot overstate the importance of preserving South Shore Hospital for the long term. This merger is vital to that preservation.

I sincerely ask that the Commission consider the positive impact that this merger will have for our community in maintaining a vital community hospital presence and the future economic investment opportunity that it represents.

Sincerely,

Jane E. Hackett DH

Jane E. Hackett
Councilor at Large

Town of Weymouth
Massachusetts

Brian McDonald
Weymouth Town Council
Councilor at Large
75 Middle Street
Weymouth, MA 02189
(781) 340-5020

January 14, 2014

Stuart Altman, MD
Chairman
Massachusetts Health Policy Commission
2 Boylston St., 6th Floor
Boston, MA 02116

Dear Dr. Altman,

I'm writing to respectfully urge that you support Partners HealthCare's merger with South Shore Hospital.

As a Town Councilor representing the entire town of Weymouth and a former State Senator representing much of the South Shore, I know the importance South Shore Hospital has on my town and the entire region. Whether it's the hundreds of employees that commute to South Shore Hospital every day, or the access to good quality health care to an entire region, one cannot overstate the importance of preserving South Shore Hospital.

Recently, I've been extremely disappointed with reports that the application to allow Partner's HealthCare to acquire South Shore Hospital is being held up. Why is a merger with such a positive social, economic, and health care access impact being put on hold, while so many other similar health care merger applications have been so swiftly passed?

The merger of South Shore Hospital by Partners HealthCare represents a true opportunity for my town and the entire region and because of this, I strongly urge you to support this application.

Sincerely,

Brian McDonald

Weymouth Town Council

Town of Weymouth
Massachusetts

Ed Harrington
Weymouth Town Council
District Five Councilor
75 Middle Street
Weymouth, MA 02189
(781) 340-5020

January 15, 2014

Dr. Stuart Altman,
Chair Health Policy Commission
Two Boylston Street, Sixth Floor
Boston, MA 02116

Dear Dr. Altman:

I write to express my support for the proposed merger of Partners Health Care and South Shore Hospital. As the Town Councilor from District 5 in Weymouth, which covers many of the neighborhoods immediately surrounding the hospital, the future of South Shore Hospital is an extremely important issue to my constituents. The hospital impacts us as a neighbor, as an employer, as a supporter of other businesses in town, and, of course, as our community health care provider.

Through my involvement with the hospital as a Town Councilor, and as a regular volunteer, I have made a point of trying to learn about the motivations, objectives, and potential implications of South Shore Hospital joining forces with Partners Health Care. Through this process I have reached the conclusion that this proposal will be beneficial to the Town of Weymouth by providing more coordinated health care that leads to healthier people as well as opportunities for economic growth, both at the hospital and across the community in related businesses.

Improved health and greater opportunities are the critical elements in leading to a better quality of life here in Weymouth. This is what my neighbors and I want and we believe that South Shore Hospital is better positioned to make this happen by being a member of Partners Health Care. For my community, I hope that the proposed merger is approved through the regulatory process.

Sincerely,

Ed Harrington

Ed Harrington
District 5 Councilor
54 Samoset Street
Weymouth, MA 02190

South Shore
Chamber of
Commerce

January 16, 2014

Dr. Stuart Altman, Chair
Health Policy Commission
Two Boylston St., 6th Floor
Boston, MA 02166

Dear Mr. Chairman,

As President of the South Shore Chamber of Commerce I am in the middle the healthcare triangle of providers, insurers and consumers. The South Shore is one of the fast growing regions in the state so I am keenly aware of the inherent tension between the need to expand quality resources while containing costs. The Chamber is also a business organization that understands our economic health depends on strong organizations that meet changing markets and competition.

It is for these reasons that I previously testified and wrote to the Public Health Council in support of the proposed merger between South Shore Hospital and Partners HealthCare. The merger will help sustain quality care at affordable prices for our businesses and residents. Far from disrupting the marketplace with an anti-competitive combination the merger will sustain a competitive provider in a growing marketplace that is full of competitive provider networks.

We have several other hospitals and provider networks in our footprint, many of them are Chamber members. Most providers have already re-positioned themselves and aligned with other organizations in order to access new medical specializations, management expertise, technical support or even capital. This is unavoidable and in fact almost necessary in today's healthcare/provider environment.

Today's marketplace is hardly disrupted by provider mergers and alliances. Providers are becoming less important in pricing of health services. Increasingly, Government and the consumers are setting the prices. Generally, the reimbursements won't be keeping up with the growth in actual costs and the only means of preserving or expanding services will be through strategic affiliations and mergers.

It is especially disturbing that our area's largest provider would be denied the ability to affiliate or merge in order to keep up with the market pressures and need to access new capital, technical support or medical specialties. It is hard to understand how our consumers, businesses and patients benefit from being denied the ability to succeed and deliver even higher quality care to the South Shore.

The South Shore Chamber of Commerce is one of New England's largest Chambers and one of the few regional Chambers. Our members represent tens of thousands of employees and their families.

Sincerely,

Peter Forman

Peter Forman
President & CEO

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South Shore
Health and Educational
Foundation

55 Fogg Road
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Massachusetts
02190-2455
southshorehospital.org

Phone (781) 624-8600
Fax (781) 624-4269

January 16, 2014

Dear Stuart Altman, PhD.,

We are writing to you representing the Board of Trustees for the South Shore Hospital Charitable Foundation, the fundraising arm of South Shore Hospital. As the Executive Committee of the Board of Trustees, we want to express our support for the merger of South Shore Hospital with Partners HealthCare.

As residents, clinicians and business leaders on the South Shore, we know that this partnership will allow South Shore Hospital to be better positioned to continue to provide the high level of care our region has come to expect from its local hospital. Together, the two organizations can provide greater value to our patients where they live and work by enhancing the quality and scope of services.

Over the years, philanthropy has played a critical role in advancing South Shore Hospital through capital projects, technology and programs. The Trustees of the South Shore Hospital Charitable Foundation, as well as our major benefactors, wholeheartedly believe in the proposed merger. We look forward to continuing to support South Shore Hospital in the new era of healthcare.

Sincerely,

The Executive Committee of the South Shore Hospital Charitable Foundation

Jeffrey P. DeMarco, Chair of Board
South Shore Hospital Charitable Foundation
Partner, Campanelli Companies

Thomas J. McCarthy, Immediate Past Chair
Managing Partner, KAF Financial Advisors

Helen Garvey, Vice Chair of Board
South Shore Hospital Charitable Foundation
Vice President, Rockland Trust Company

Betsy Sullivan
Managing Director, First Republic Bank

Christopher J. Flynn III
President, Harbour Planning Group, LLC

Doreen Kennedy McLaughlin, MD
Physician, Emergency Medicine

Christopher M. Duffy
Managing Partner, Capital Analysts of
New England, Inc.

Richard F. Sullivan, MD
Physician, Radiology

Jacqueline A. MacBean
Vice President, Weymouth Bank

South Shore Hospital

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(781) 624-8000

January 16, 2014

Dear Stuart Altman, Ph.D.,

We are writing on behalf of the entire Patient and Family Advisory Council (PFAC) of South Shore Hospital. Our group is made up of South Shore residents who have had much personal experience, through good times and bad, with South Shore Hospital.

Our PFAC brings together patients, their families and South Shore Hospital administrators, physicians, nurses, and allied health professionals. The Council draws upon the valuable knowledge and experience of its members to assist in the development of new services and programs, find solutions to problems or challenges and identify ways South Shore Hospital can improve the hospital and home care experience for patients and families, as well as health care providers. Patient and Family Centered Care has been shown to lead to better health outcomes, wiser allocations of resources, and greater patient and family satisfaction.

It is our belief that the proposed merger between South Shore Hospital and Partners HealthCare will lead to an even better patient and family experience. If you have ever suffered from any type of illness, or watched a loved one suffer, you know how critical it is to have seamless care. When pain or worry clouds your judgment, how often do you want to answer the same questions because your doctors have not been able to easily access your medical history or collaborate with one another?

Investments made through this merger will allow physicians better access to information about patients' "whole health care experience," making for a better patient/provider relationship and more appropriate and efficient care.

Therefore, we, the Patient Family Advisory Council of South Shore Hospital hereby respectfully submit our support of the proposed merger between South Shore Hospital and Partners HealthCare.

Sincerely,

John Emler
Chair
Patient Family Advisory Council
South Shore Hospital

Marianne Wells Clark
Vice Chair
Patient Family Advisory Council
South Shore Hospital

State Representative Jamie Murphy:

Good afternoon, everybody. Jamie Murphy, State Representative here in the Town of Weymouth, and I represent part of Hingham. Like my colleagues, Jim Cantwell and Geoff Diehl, I am in support of the merger, and I've had conversations with my other colleagues and town government and state government, but I'm here just voicing my own opinion.

I, like all of you, have probably accessed South Shore Hospital. I know that in my first campaign, they actually kept me alive. I had never run for office before, and I was struck with an emergency gallbladder surgery. I was in the hospital a week before my election and up to my election. So I'm here just because of the experience that I've had with the hospital over the years. I was born in this town, had been up there for a number of breaks and surgeries, including appendix; you name it. I've had a lot of different things done at the hospital. Call me unlucky, I guess -- or call me lucky, because I'm experienced enough to be here today and talk about it firsthand. But I've been in legislature now almost 12 years, and I serve with my colleagues who are here today and some of them who couldn't make it, but I'm here in support of the merger.

Any of us here who have accessed South Shore Hospital knows how important it is to our community, not just from an economic standpoint, but from a health care standpoint. We all know, too, that our health care system is broken, to put it in plain terms. If you walk into the emergency room at the South Shore Hospital, you see a crowd. It's not unusual to be up there for a while waiting to see a doctor, and it's like that in any hospital. And for those of you who pay for health insurance or you're an employer paying for health insurance, you know that you've seen your premiums skyrocket. I grew up in a family business, which we pay health insurance for our employees, and I've seen our premiums skyrocket, and they've gone up again this year.

We in the legislature put an awful lot of pressure on the health care industry to bring down their costs in regard to insurance premiums. We've also put pressure on the health care industry on providers, in providing more effective care. You'll see changes now in the national and state level, all made in an effort to correct what we see as a problem within our health care system.

Now, I know it makes it harder on smaller hospitals to be able to weather the storm. You see a lot of the smaller hospitals now merging into larger hospitals. But I think the world has changed; and over the years, the health care system hasn't. And we in the legislature have voted for a number of measures, which puts a lot of pressure on the health care providers to provide not just services based on fees, but we're going to be also requiring that the results be a good one. And I know the larger health care organizations now are adopting models which will only increase the effectiveness at which health care is delivered both in the City of Boston and on the South Shore and in the other communities around us.

So I'm here in support of the merger. I think it's a good one. I think it's a necessary change. And I'm here on behalf of myself as a private citizen in the Town of Weymouth and as an elected official in support of this merger. And my office stands ready to support the health care industry in regard to Partners and South Shore Hospital as you proceed with this merger if it is approved. So I thank you all for listening to me today. Thank you.

State Representative Geoff Diehl:

Thank you. So I'm a state representative for Abington, Whitman and East Bridgewater. Before I get started, I just want to say one thing. I do believe in the healthy initiative, better eating; but next year is the 75th anniversary of the Toll House Cookie, so...

I'm going to read from some statements real quickly. As State Representative for the region served by South Shore Hospital, I have continually been impressed by the strong leadership shown by President Aubut and his staff, the Board of Directors, and that they have guided the staff and facility into continued growth through logical affiliations and innovative practices that have made it one of the top performing hospitals in the state.

Given the challenges the residents of our region face due to rising costs of health care, the legislature has had to take several pretty major steps to rein in the burden placed on all of the Commonwealth. Creating accountable care organizations and similar changes in organizational structure that facilitate the coordination of care is one of the solutions towards that end. And this merger will help increase the quality of care, in tandem with a reduction in costs through the elimination of redundancies.

I'm in full support of South Shore Hospital joining together with Partners HealthCare, one of the largest health care networks in New England, and I trust you'll find through your due diligence that this merger is wanted and will prove to be a model for health care delivery across the nation.

EMS Manager Eugene Duffy:

Good afternoon. My name is Eugene Duffy. I'm the EMS manager for South Shore Hospital. And I have a partner with me today, Chief Andrew Reardon from the Norwell Fire Department. So just a little background on me. I'm from Ireland, obviously, from my accent. I do live in the community. I've been here for 16 years. I live in the community with my wife and daughter, who was born here. My wife is a Weymouth girl. I landed here from Ireland. I just want to tell you a little bit about our program.

We have a hospital-based EMS program, which is pretty unique nationally and is a credit to South Shore Hospital to have. But it's responsible for emergent and non-emergent emergency medical transports, both from South Shore Hospital and to the tertiary care centers in Boston. Our department is staffed with over 60 EMS personnel, from EMTs and paramedics, who also all live in the community and take care of patients in the community.

Our staff also has an education training and quality assurance division, which is responsible for educating community paramedics and EMTs from basically Weymouth, all the way to south of Duxbury. As a provider of emergency medical services on the South Shore, we are excited about this partnership moving forward, as this affiliation between South Shore Hospital and Partners HealthCare will bring world class medical services to the South Shore. This will enable more people to have access to care that was previously only available to Boston, meaning we had to transport patients to Boston. This will open the door to world class medicine right here in the South Shore for the patients that we respond to and serve.

This is an exciting partnership for the EMS and fire services we provide medical oversight to. And the talented resources of both organizations will provide many opportunities for the paramedics and the EMTs on the South Shore, and we hope that you consider this for a Determination of Need. Thank you.

Fire Chief Andrew Reardon:

I am not Dr. Michael Ayers, but I'm Chief Andrew Reardon for the Norwell Fire Department. I've served in that capacity for the last six and a half years. I've been a first responder for the last 37 years. And I have watched -- my career has been here in the Town of Norwell. And I have watched South Shore Hospital evolve into a first class operation in their emergency department and the other parts of the hospital. I had firsthand experience in 1964. I was a patient after being run over by a car, with a fractured femur and some internal injuries. And I was one of the lucky ones. I survived.

I now, as the Chief of the Department and the Director of our EMS service in the Town of Norwell, think that the survival rate -- or know that the survival rate of my community and the communities that I work with is far better than it was back when I was a little person. We've seen significant improvements, I think, and I would like to support the affiliation with Partners, because I think we've got more work to do, and I see this affiliation as being a benefit in bringing resources to the table that would otherwise would not be available.

So as Chief of the Fire Department of the Town of Norwell, I'd like to advocate toward this affiliation. Thank you.

Dr. John Feldman:

Good afternoon and thank you. I'm John Feldman. I'm here today in my role as President of South Shore Hospital's 800-member medical staff. And as President of the medical staff, I should also add, with full disclosure, I'm a full voting member of the Board of Directors. I'm also a board certified neurologist, and I'm a partner in an independent private urologic practice here in South Weymouth, South Shore Urology Associates, just down the street. And my wife, Jean, and I have been residents of Hingham for 22 years.

I would like to express my strong opinion that South Shore Hospital's proposed affiliation with Partners HealthCare will substantially benefit the people of our region; and frankly, that a failure to affiliate will harm the people of our region and adversely affect the ability of the hospital to provide the level of care that the community deserves and expects.

I've been a member of South Shore Hospital since 1991 and have been elected by my peers to serve as medical staff President since 2012. Prior to that, I served on numerous committees and task force. My medical staff leaders and I have worked together with the nurses, the clinical departments, and the administrative leadership to try and assure the delivery of high quality patient care every step of the way.

The physicians who are affiliated with South Shore Hospital bring a level of expertise to our region that, frankly, you don't find in most community hospitals. Most of our medical staff lives here in the South Shore, and we want to assure that high quality care remains available for our patients, who are also our friends and neighbors. We have a cardiac catheterization lab at South Shore that provides our region with what can only be described as a superior time-sensitive care when people really need it most.

Additionally, three divisions have been ranked in U.S. News & World Report in the top 50 nationwide out of almost 5,000 hospitals in the country. On a personal note, I'm very proud to say that my division, urology, ranked 37th in the country. That is a remarkable achievement for the hospital, and it's something that we want to not only maintain, but build on.

The members of South Shore Hospital's medical staff are well aware of the sweeping changes that are underway regarding how health care is provided and paid for. We discuss it daily. We recognize the opportunity and obligation that physicians have to redesign how care is provided, so that it's more accessible, effective and affordable.

As we look to the future, we see three major challenges on the horizon that must be addressed to sustain the local availability of high quality care. First, we have to be able to recruit and retain top medical talent. Very few young physicians want to start up or join a very small medical practice, as many of my colleagues did. And today's young doctor coming out of residency wants to join an established, thriving, larger organization, where they have the potential to earn a reliable, competitive salary, with flexibility in their work hours and little or no administrative headaches. The proposed affiliation with Partners is designed to enhance our

ability to recruit and retain the medical talent that our community needs. Without joining Partners, I am very confident that our ability to recruit this talent that we so desperately need will be very difficult and hard to do. Retention of talent here will also be a problem; but, frankly, not as large.

The second challenge involves information technology. The cost of purchasing, installing, upgrading and fully utilizing the hardware and software that is required to share patient care information is prohibitive. South Shore Hospital, never mind the small business owner like myself, simply can't afford on its own to make the substantial investments that are required to deliver tomorrow's care. I am in the process of throwing away a software system that's five years old and is essentially useless now and cost me well in excess of $300,000. The investment I made in a new system compromises my ability to hire physicians and staff, and further upgrades in a newer system will be impossible without the affiliation. The proposed affiliation of Partners HealthCare will jump-start our ability to make IT investments to share vital health care information among patients, physicians, hospitals and other providers.

The third challenge involves fundamentally redesigning how patient care is being provided. I can't overstate the difficulties inherent in getting patients, physicians and hospitals to work together in new ways to improve our health and wellness, while at the same time reducing costs. I believe that the proposed affiliation with Partners will provide an opportunity to bring together the best minds in our business to tackle this challenge. We have proposed an organizational structure that will foster an unprecedented level of teamwork and cooperation among the hospitals and the affiliated physicians to produce a better patient care experience.

In the past two decades, it's been my privilege to work with my colleagues at South Shore to become a leading provider of emergency inpatient and outpatient services, including home care. As a member of the Board of Directors, as a physician who practices at South Shore Hospital, and most important, as a husband and father whose family has and continues to get care at South Shore, I strongly believe that joining Partners HealthCare is the right decision to ensure that the hospital continues to thrive into the future.

I have spent many hours as a board member, both in meetings and alone, thinking about this. And I, with a clear conscious, believe that as a fiduciary for the hospital, an elected representative of the physicians, and as a member of the community that lives here and gets care here, that this affiliation is a tremendous thing for all involved.

I respectfully request that the Massachusetts Department of Public Health approves the Determination of Need application and acts favorably upon the proposed affiliation between South Shore Hospital and Partners HealthCare. And I thank you for this opportunity.

Dr. Michael Ayers:

Good afternoon. My name is Dr. Michael Ayers. I'm here to tell you why I believe the South Shore Hospital's proposed affiliation with Partners HealthCare is important for our community and the patients we serve.

I'm a lifelong resident of the South Shore. And myself and my family have received care at South Shore. I was first a patient at South Shore in 1974. I currently live in Scituate with my wife, Ginny, and my three children. I am an orthopedic surgeon and an owner of South Shore Orthopedics, located in Hingham, MA. We're an independent practice of 12 orthopedic specialists and 5 physician assistants. South Shore Orthopedics works in collaboration with South Shore Hospital to offer our community high quality orthopedic care at our Center for Orthopedics, Spine and Sports in Hingham, as well as at South Shore Hospital.

I've been a member of the South Shore Hospital medical staff for the last ten years. You heard earlier this afternoon from Dr. Feldman that the purpose of our hospital's medical staff is to bring together physicians, nurses and staff to deliver high quality patient care.

I'm also the elected chairman of an organization called the "Health Providers Services Organization" or "HPSO" for short. This organization is a not-for-profit subsidiary of South Shore Hospital Health and Education Commission. HPSO exists to align the interests of our community, our physicians in the South Shore Hospital, to improve and expand health care access, quality, availability and efficiency. This is a nine-member board that consists of five elected physicians and four hospital administrators. We are involved in strategic planning and clinical program development, as well as initiatives to improve how and where care is provided. As a chairman of HPSO, I'm also a voting member of the South Shore Hospital Health and Education Corporation's Board of Directors. I participated in the process of evaluating potential strategic affiliations between South Shore Hospital and other organizations. And I've also been actively engaged in the process of developing the proposed affiliation agreement with Partners Health System.

As a result of my involvement in these deliberations, I strongly believe that the decision to join Partners HealthCare is the right one for our patients, our community, and those who work for and support South Shore Hospital. The proposed affiliation with Partners HealthCare is designed to achieve one overriding goal: To coordinate how and where patient care is provided for greater effectiveness, efficiency and affordability.

As physicians, we recognize the reform to health care delivery and payment are changing the rules. The way we all have practiced medicine in the past will not be sustainable as we go forward. South Shore Hospital's ultimate goal in joining Partners is to redesign how care is provided. Our proposed affiliation calls for making physicians the central architects of the care redesign and delivery. Physician leaders from South Shore Hospital, Brigham & Women's Hospital, and the Partners HealthCare System have already been involved in conducting a preliminary high level assessment of the initiatives that would improve population health in our

communities. The physicians will remain actively involved in this care redesign moving forward throughout the process.

Another anticipated benefit of joining Partners will be access to information technology, as has been discussed in detail earlier, required to deliver this high quality, cost-effective medical care. Our proposed affiliation for expanding the local availability of primary care and specialty care to meet identified community needs, so that we can develop patient-centered medical home models, previously described, will be critical to our future success.

It's my belief that the proposed affiliation with Partners HealthCare will help South Shore Hospital and its medical staff going forward to be successful in what will continue to be a challenging health care environment. I ask the Massachusetts Department of Public Health to act favorably on the proposed affiliation between South Shore Hospital and Partners HealthCare System. Thank you.

Mr. Benjamin Asfaw:

Good afternoon. My name is Benjamin Asfaw. I'm the Vice President of Quality of South Shore Hospital. I'm here today to speak at this public hearing regarding how the proposed merger between South Shore Hospital and Partners HealthCare System will further enhance the quality of care delivered at South Shore Hospital.

Health care in the United States is under increasing pressure to deliver high quality and cost-efficient care while ensuring access to services for all who need them. Initiatives such as the Healthcare Reform Act have put added pressure on hospitals and other health care providers to improve our ability to not only deliver, but demonstrate that the care provided is safe, efficient and appropriate. South Shore Hospital is challenged to offer innovative, cost-effective care that is scalable, versatile, and able to adapt to the changing population.

Ensuring high quality health care is what our organization continually strives for. It's what we expect of ourselves; and more importantly, it's what our community expects of us. Quality health care is doing the right thing, at the right time, for the right patient. A very simple concept, but oftentimes it's the simple things that are most challenging to accomplish.

Quality can be viewed from several lenses. First, from the level of the patient. Did the patient have a good experience? Did the provider meet the needs of the patient? Did we listen to the patients' concerns? Was the patient cared for in a safe environment? Second, did we meet standards of care of how best to help our patients. For example, we look at how fast we were able to treat a patient who is having a heart attack. These standards are set at the federal and state level by insurers, and most importantly, by our own internal expectations. Finally, we look at our outcomes. Are our patients getting better? How often do they come back? All of these lenses need to be in focus for South Shore Hospital to continue its mission of healing, caring and comforting.

Our proposed partnership with Partners HealthCare will further sharpen our focus on providing the best quality care possible for our community. How? Our ability to leverage resources in a more effective and efficient manner will be enhanced. We will be part of a consortium of hospitals committed to giving superior patient service and health outcomes, while adhering to best practices. We can share, as well as greatly contribute to the best practices and innovation recognized as the best in our profession. As part of a system of care, we can enhance our ability to reduce readmissions, expedite treatment, and improve patient satisfaction.

Health care is a team sport. Moving forward, keeping all aspects of quality in focus will be nearly impossible if we go it alone. South Shore Hospital continues to work collaboratively within our walls and among our community. But we know that to truly advance, we need to be part of a team of like-minded organizations committed to improving healthcare for all.

Our proposed merger with Partners will further advance our ability to provide quality care for our community. It is for all these reasons that I strongly support the plan to join Partners HealthCare. Thank you.

Ms. Marjorie Tose:

Hi. My name is Marjorie Tose. I am a registered nurse, and I've worked at South Shore Hospital for over 30 years. Over that period of time, I have witnessed South Shore Hospital change from a small community hospital, a hospital that initially only provided the basic services, to a large regional medical center that currently offers many specialized services. As a resident of South Shore, my family and I have also utilized those services. Though time prohibits me from listing all the changes I've seen or been a part of, I certainly will highlight a few I feel have been outstanding.

Our cancer patients, as just mentioned, can now receive their care locally and have the expertise of the Dana Farber. Our high-risk mothers have the security of having a Level 3 NICU when they deliver. Our ability to bring our acute MI patients to the cath lab quickly and not have to wait for transport to Boston is a life-safer for many. Joining Partners can only help us expand our access to even more specialty care in a very coordinated way.

Our administration and Board of Directors over the years have successfully guided South Shore Hospital through the changing times in health care. They have responded to the health care priorities of the community. And they have been accountable in keeping the hospital financially healthy.

As our health care environment continues to change and evolve, this will become more difficult. There will be new demands and expectations of how we provide care. With health care reform, it seems we will need to do even more with fewer resources. Despite this, I hope to see South Shore Hospital continue to grow in the services we can provide our community. We need to continue to earn our patient's trust and satisfaction by providing them with the highest quality care possible.

I trust our leadership to do right by our communities and our employees in continuing to improve the health care of our region. I believe this joint venture with Partners is a huge opportunity to do just that. The benefits of being part of a larger health care system are great. It will give the people of our region access to even more services in a coordinated cost-efficient manner. If a joint venture with a larger health care system can help us accomplish this, then why wouldn't we partner with one of the best health care systems out there, Partners. I do support and endorse this proposal.

Ms. Helen Garvey:

Good afternoon. My name is Helen Garvey. I'm a lifelong South Shore resident. I presently live in Norwell. I work at Rockland Trust Company as the Vice President of Commercial Lending, and I'm also a volunteer fund-raiser at the hospital, presently serving as Vice Chair of the Board of Trustees. Like many of who have spoken before me, I, too, have had a lot of experience at the hospital. My daughter was born here. My family's had various trips to the ER care. And the wonderful care and compassion that we received every time is what compelled me to become such a passionate fund-raiser for the hospital.

I truly believe that South Shore Hospital's entrance into the Partners HealthCare System could only serve to strengthen and expand the medical services offered here at the South Shore. Having been very closely involved in fund-raising for the cancer center and with intimate knowledge of several patient experiences at the center, I've had a good chance to see how wonderful this type of collaboration can work.

It's my opinion that formalizing a relationship with Partners would only further enhance this type of collaboration and provide care along many clinical lines, as opposed to just the cancer center. I have a young daughter who has had some health issues and had to have some care at Mass. General. And as a working mother, it would have been nice to come here, instead of driving into Boston. And I foresee that being the case in the future with the merger.

From an economic standpoint, it is my opinion that the proposed affiliation with Partners will also help maximize efficiencies and minimize potential negative financial issues that will come up as we navigate through this federal health care reform and it's implemented over the coming years. It's my sincere belief that this proposed merger will have an enormous benefit for the South Shore community, and I enthusiastically request that the Mass. Department of Public Health approve the Determination of Need and the proposed merger. Thank you.

Ms. Lauren Ells:

Hi, everyone. My name is Lauren Ells. I'm a lifelong Weymouth resident. And I was born at South Shore Hospital. My dad was a Weymouth fire-fighter, and my grandfather was a Weymouth policeman. So you can see my Weymouth roots run very deep. I have been a nurse for 25 years at the home care division of South Shore Hospital. There has never been a time in my life when South Shore Hospital was not there to provide health care services for my family and my community. I have watched the hospital grow from one small building to the world class health center that it is today.

South Shore Hospital has always been committed to assessing and meeting the health care needs of the South Shore community as its demographics grow and change. To have an institution of this caliber right here in the South Shore community is a gift beyond measure. As health care changes, reimbursement decreases, and the demands to create healthier communities increase, it is clear that South Shore Hospital may not be able to meet all of these challenges alone.

An alliance with Partners HealthCare will create the opportunity to continue to grow and provide services that are vital to the health of our community. Joining the prestigious Partners HealthCare System will keep South Shore Hospital on the cutting edge of health care information technology and the ability to be successful in population management, which is the future of health care.

I am completely in support of a formal partnership between South Shore Hospital and Partners HealthCare, so that our community can continue to receive the highest quality health care close to home. Thank you.

Ms. Carolyn Stanne:

Good afternoon. My name is Carolyn Stanne. I've been a nurse at South Shore Hospital for 35 years. I've also lived on the South Shore -- Plymouth, to be specific -- for 35 years. Myself and my family have all been patients at one time or another at the hospital. When I started at South Shore, I worked briefly on a medical-surgical floor and then moved on to pediatrics, where I worked for seven years, and then to the mother-infant unit, where I still work.

I've watched South Shore grow from a small community hospital to a magnet-designated hospital that offers a wide variety of services. Since I started in obstetrics, South Shore Hospital has added a level 2 NICU, which was soon followed by a Level 3 NICU, and now an MFM program has been added. That has grown to a Level 3 MFM program, maternal-fetal medicine, and it now has a high-risk antepartum inpatient unit associated with it. The emergency room is one of the busiest in the state. It now offers the pediatric emergency room and a Level 2 trauma center. Care for our cancer patients, we've heard over and over, locally, but associated with Dana Farber and the Brigham. Cardiac care, also in collaboration with the Brigham, but offered locally. All of these changes have made it a very exciting and wonderful place to work. As health care continues to change, South Shore Hospital wants to continue to offer these wonderful services to the community within the community.

Partners, being New England's largest health care network, will bring world class experience and resources to the community of the South Shore, while allowing South Shore Hospital to function as an independent facility. There will be access to even broader specialty services. Communication between a patient-physician will be available electronically through integrated medical records.

A partnership between South Shore Hospital and Partners will ensure our ability to continue to offer this wide scope of care on a community level. Thank you.

Mr. John Boucher:

My name is John Boucher. And I am a community director of South Shore Hospital. But I actually want to speak to you in my other role; No. 1, as an employer. I'm the President and CEO of South Shore Bank, and we employ about 200 people on the South Shore. I'm also a parent and a grandparent. And as CEO of the bank, my role as director of the hospital I also take very seriously. And how the hospital affects our community is very important to me.

62 years ago I was born at South Shore Hospital, and sometime in the next three weeks my sixth grandchild will be born at South Shore Hospital. So the hospital is very important to me. It has been all throughout my life, for not only my family, but all of the employees that we have. And over that period of time, I've watched South Shore Hospital grow from really a small local hospital into a large regional health care center that I feel provides superior services.

But the thing that I've been most impressed with is over the last few years, the affiliation that the hospital has had with groups like Brigham & Women's and Dana Farber and Children's Hospital has elevated the level of service in our local hospital to world class types of activities. And that being said, I feel that this merger will just take that to the next level. So I wholeheartedly and enthusiastically on behalf of my children, my grandchildren and our 200 employees, support and endorse this merger. Thank you.

Dr. John Stevenson:

Good afternoon. Thank you. My name is John Stevenson. I joined the South Shore Hospital medical staff 12 years ago to develop our inpatient hospitalist program. And I am now our chief medical officer. My responsibilities include assuring that the thousands of local residents who use our services each year receive the best possible medical and surgical care.

Over the past decade, our clinical affiliation with Brigham & Women's Hospital has allowed residents of our community to receive advanced care without traveling into Boston. You've heard a number of compelling examples this afternoon. Certainly, they include our cardiovascular center, where we perform lifesaving emergency angioplasty with patients with acute myocardial infarctions. They also include our new cancer center, where patients receive state-of-the-art treatment without having to leave the region. Other successful collaborative programs include advanced maternal services, our trauma program, our surgical department, and our rapidly expanding neurology department.

In the course of building these programs together, not only have we laid the important groundwork of trust and respect, but we've also demonstrated to ourselves and to others in the community that we can execute our strategic goals, and we can deliver these advanced clinical programs to benefit the people of our region.

As we move forward with Partners, our goals have become even more ambitious. They now include not only improving care for individual patients, but they contemplate improving the care and help of our entire South Shore region. And they propose undertaking this work while reducing the overall cost of our health care system.

These ambitious goals require resources and investments that are beyond the scope of South Shore Hospital alone. Working together, we would develop an integrated and seamless electronic health record, one that would allow patients to access their own information and one that would allow primary care physicians and specialists to coordinate the best possible care.

Working together, we would build new models of primary care, focusing on the prevention of illness, not just the treatment of disease. We would focus on psychosocial needs and not just medical needs. And we would consider the needs and experiences of patients in multiple settings, not just in the hospital.

Last, but not least, working together, we would explore effective new payment models that create the right incentives for everyone working in the system, incentives for the right outcomes, not simply payment for services. It's for all these reasons that I strongly support the plan to join Partners HealthCare. Thank you.

Mr. Walter Fraser:

Thank you for this opportunity. My name is Walt Fraser. And I am in full support of the application of South Shore Hospital to join Partners HealthCare System. My wife, Sue, and I have been residents of the South Shore for 38 years. We raised three very active children, have six grandchildren, and cared for three of our parents in our home until their passing. In that time, we have used South Shore Hospital from maternity to Hospice and just about everything in between.

I am currently a member of the South Shore Hospital Patient Family Advisory Council, or what we call "PFAC," since its inception in January of 2010. South Shore Hospital has evolved into one of the finest community hospitals in the Commonwealth and in the nation through its organic growth, division of its leaders, and the quality and reputation of its medical staff, as well as the affiliations with some of the finest institutions in the country. The delivery of care has changed substantially over the past two decades. And the current national and local health care reform legislation will continue to drive even greater changes in the next decade.

The system of care that my family and my community will depend upon will extend beyond the hospital campus, into the primary care offices, through a wide range of medical specialists, to state-of-the-art imaging centers, to high-tech treatment and rehab facilities, to home care specialists, and it will demand changes to life-styles and a renewed focus on wellness. Let me repeat; a renewed focus on wellness.

At the same time, the cost of care must be understood and controlled. In my opinion, the proposed affiliation of South Shore Hospital and Partners HealthCare will provide the means, the leadership and the talent to bring those improvements to the communities of the South Shore. I believe the proposal will increase health care education and chronic illness prevention, as well as provide better access to primary and specialized care. Through its affiliation, the implementation of top-rated medical information technology shared among health care providers can only serve to a better coordination of care. The bottom line is all of this should provide improved patient outcomes and will likely reduce costs. And as a member of South Shore Hospital's Patient Family Advisory Council involving me and my family and my wife and my care, that won't hurt either.

A few weeks ago at the gym I bumped into a friend, a neighbor that I've known for 35 years. And we didn't know until that day that I was on South Shore Hospital's PFAC, and Phil was on the PFAC at Mass. General. Well, we were so excited about that knowledge, that we agreed to have breakfast. A few days later, we had a two-hour breakfast. And it didn't take long before it became crystal clear that our PFACs are for the very same purpose. Our PFACs are all about involving patients and families in the direct care; that our mission under PFAC is about improved patient experience and improved outcomes. Thank you. I urge your favorable consideration.

Ms. Elizabeth Sulger:

Welcome. My name is Beth Sulger, and I am an employee of South Shore Hospital's Home Care Division in Rockland as a financial analyst, as well as a neighbor and patient of South Shore Hospital. I want to express my personal support for the Determination of Need for South Shore Hospital to join the Partners HealthCare System in Project 3C19.

The project between South Shore Hospital and Partners HealthCare is an amazing opportunity for us to grow in our community. It will open up new avenues for us to better serve our neighbors and meet the needs of the patients. It will also provide care that is more coordinated and seamless for patients and families and will to be able to improve methods of electronically sharing information between doctors and hospitals, in order to improve the patient experience. The importance of health care providers working together, which will improve coordination, accessibility and affordable care, is crucial in today's market.

With the new payment models that are only around the corner, there is now a need for a tighter integration among hospitals, physicians and community-based providers of health care. The major reforms by the federal and state government envision a healthier population, an improved experience in the health care system, and a lower cost of care.

In order to accomplish this Triple Aim, fundamental changes need to occur between providers and how health care is delivered. By joining Partners, South Shore Hospital will be able to develop a network and technology system to coordinate care in a much more comprehensive and effective manner than it would be feasible to do on its own.

I support the South Shore Hospital to join Partners HealthCare and strongly recommend that this Determination of Need is approved. Thank you for your time.

Dr. Matthew Weiss:

Good afternoon. My name is Matthew Weiss, and I am here today to speak in support of the proposed merger between South Shore Hospital and Brigham & Women's Hospital as a community physician.

For the past five and a half years, I've practiced at Harbor Medical Associates as a pulmonologist and sleep specialist, and I've cared for inpatients in pulmonary medicine at South Shore Hospital. Before beginning my practice in Weymouth, I completed my medical residency in subspecialty fellowships in the Partners System, including a significant amount of time spent training at Brigham & Women's Hospital. I also currently live in Brookline, where the Brigham is my community hospital, and the place where our daughters were born. So I know the place very well from a number of perspectives. When I finished my training in the Harvard system, I had a number of employment offers from around New England and throughout the country, but chose to establish my career in Weymouth, at Harbor Medical Associates and South Shore Hospital. The main reason I found the prospect of practicing in Weymouth so attractive at the time and still do, by the way, was the close collaboration between South Shore Hospital and the Brigham on clinical programs, as well as the presence of Brigham & Women's physicians on the South Shore Hospital medical staff.

The thoracic surgeons I work closely with, taking care of lung transplant patients at the Brigham as a fellow, were the same individuals practicing at South Shore. So I had immediate confidence that I would be able to handle nearly any patient with a chest disease who came into my office where the hospital provided world class care close to home. The convenience of having a Brigham & Women's Dana Farber Cancer Center satellite across the street from South Shore Hospital is a perfect illustration of the very real benefits of this proposed merger.

Every day I drive to work heading south to Brookline and see a long line of slow-moving vehicles across the median, pointed in the other direction of Boston. Whenever I see that, I hope that none of my patients are in that procession. In particular, because of our cancer center here in Weymouth, patients with cancer, often nauseated, fatigued and short of breath from chemotherapy, can park close to our state-of-the-art cancer center on Columbian Street, walk right in, and have access to the very best physicians, nurses and other providers, as they receive cutting-edge cancer treatment and access to clinical trials, without having to brave the Longwood medical area. One of my daughters still attends preschool in the Longwood medical area, so I have intimate knowledge of the hassle involved for even an ostensibly healthy person making that trek from just two miles away. It takes me only twice as long to travel ten times the distance to South Shore Hospital as it does to drive to Longwood. I can say with conviction that no ill person or their family should have to make that trip into town unnecessarily for care that can be delivered locally and at the same level of quality and far greater convenience.

A merger between South Shore Hospital and Brigham & Women's Hospital is a logical progression of cooperative efforts already underway. I look forward to the possibility of expanding clinical programs beyond cancer care to other medical specialties. The Brigham is

able to attract a steady stream of young trainees and fully trained physicians, who will be necessary to replace local physicians when they choose to retire. Physician recruitment is no easy feat in Massachusetts. Furthermore, the highly developed information technology infrastructure at the Brigham and across the Partners network will be absolutely essential for South Shore Hospital to keep pace with the change necessary for our local community's medical resources to respond to the new demands of health care reform.

The opportunity for South Shore Hospital and its physicians to plug into the Partners' information network to exchange clinical data, measure outcomes and rapidly spread innovative and cost-effective ideas to improve how we care for our patients will catapult the Weymouth medical community and the patients we serve into the future.

In Massachusetts, we've led the nation on a path to reforming health care to provide coverage to all our systems. And now we need to lead the way on improving care and controlling costs. The competitive environment in health care nationwide and here on the South Shore is forcing medical providers and institutions work to ring ways out of the system and streamline processes.

As someone personally familiar with the patient and family experience, as well as the skill and dedication that exists in abundance at Brigham & Women's Hospital, I strongly believe that there's no better partner for South Shore Hospital to ensure outstanding care for the local residents we serve now and in the future. Thank you.

Mr. John Emler:

Good afternoon, and thank you very much for bringing this hearing to the South Shore. I am John Emler. Just up front, I feel very strongly that the proposed affiliation between Partners and our hospital is a good thing for the residents of South Shore. And by the way, I'm not an employee of the hospital, nor have I ever been.

My wife and I have been residents in Hingham for more than 30 years and consider South Shore Hospital to be our hospital. Both of us and our four adult children at one time or another have been patients of the hospital. Most recently, my wife, Sandy, had a heart attack just two months ago. And because we have such a fantastic cardiac care unit, she was treated and sent home within two days. We got home last night from visiting my 100-year-old mother.

For the past three years, I've volunteered in the emergency department and serve on the Hospital's Patient and Family Advisory Council. And Chuck has talked to you about what we do. And I'll tell you, it's a fantastic opportunity. And the whole concept of patient family centered care is really what it's all about.

Our country's health care system is at a tipping point. Costs are spiraling, population health is declining and outcomes are not consistent with cost.

The disconnect between primary care, the hospital and outpatient services is an imperative that must be addressed. The lack of accessibility of primary care, resulting in the overflow of emergency rooms by patients having no alternative is unacceptable. The lack of an effective focus on population health that addresses mental and behavioral health, chronic disease management and long-term care is unacceptable. The lack of standardized integrated electronic medical records permitting the sharing of information among patients, families and health care providers is a hindrance to providing quality and cost-effective care.

You've heard already that our government, both at the state and federal level, are mandating changes to address this situation. But these changes require resources of a multifaceted organization.

The proposed affiliation of South Shore Hospital and Partners HealthCare lays the groundwork and institutional strength to address these issues. In my various volunteer roles at the hospital, I spend many hours each week trying to represent the voice of our patients. I urge you to listen to those voices and approve their proposed affiliation. Thank you.

Mr. David Capelle:

Good afternoon. My name is David Capelle. And thank you for the opportunity to speak today. I am here today to express my personal support for the Determination of Need application for South Shore Hospital to join Partners HealthCare System.

I am a member of the executive Board for the Friends of South Shore Hospital, the Links Committee -- I'm a Links Committee member, where we raise money for the pediatric department. And I've been a patient as well at South Shore Hospital. Also, in the interest of full disclosure, the two most important in my life, my mother, Diane Capelle, is a 22-year loyal employee of South Shore Hospital, and my wife, Beth Capelle, is a nurse at Mass. General Hospital, another Partners hospital.

We are currently experiencing transformative shifts in our health care system with regards to landmark legislative challenges, merging insurance products, and proliferation of alternative sites for care. These rapid changes and realignments highlight the fact that no community hospital has the resources or expertise necessary to develop a population health management network on its own.

The vision of transforming care, in line with the Triple Aim, requires hospitals like South Shore Hospital to align with others, to optimize the full continuum of care services for patients, families and communities encompassing accessible and affordable delivery of prevention and wellness services, chronic disease management, behavioral health and acute episodic care, regardless of complexity.

By joining Partners, the South Shore Hospital would be able to develop a network of providers and invest in technology systems to coordinate care in a much more comprehensive and effective manner. I believe that the benefits of the community in which South Shore Hospital serves will be improved with the affiliation of Partners by expanding local access to expert primary and specialty care, care that is coordinated and seamless for patients and families, and having the world class experience and resources at New England's largest health care network.

With this being said, I am in support for the South Shore Hospital to join Partners HealthCare and strongly recommend that the Determination of Need application be approved. Thank you.

Ms. Jennifer Green:

My name is Jennifer Green. I am speaking on both a professional and a personal level. I did work the nightshift last night -- I'm an ER nurse -- so I'm going to lose about 30 hours of sleep here, but I felt that it was very important that I came today for several reasons. Professionally, I've only been here 13 years. I came from a Level 1 trauma center in Pittsburgh and was a flight nurse. So the bar for me was very high when we moved here, as far as the care that South Shore was providing, the opportunities.

And when I looked at a hospital to come work at, I wanted to be at a hospital that I felt would grow, that would still give me opportunities to advance my skill and knowledge and at the same time, I knew it was going to be my community hospital, because I lived in Bridgewater.

So I felt that this was a great place to not only work, but I also would be able to have my family come here and know that the care that they were getting was superb and that there were a lot of other connections that if they needed care outside of this, that we would be able to have that accessible. So it is one of the things that I think if you live in this community and you see it and you work in the ER -- we are kind of the front door for the hospital, so we do see every aspect of emergency care, of cardiac, of trauma, pediatrics, labor and delivery. So I just think that the partnership with Partners allows us to enhance that and to provide that to our community and to our service.

I think from a personal level -- I am going to tell a personal story, because it affected my family very dramatically. My husband is a police officer -- at the time in Abington; he's now in Boston. But I probably got the worst phone call that anyone could get as a police officer's wife. It was that on the way to a funeral for another officer on a motorcycle, that he got hit by a car. And it turned out fine. But I got the call from the ambulance that it was one of our crews that were picking him up and letting me know that he was coming to South Shore.

At the time our baby was probably five months old. I said, "I'll be right there. Who's on?" So I knew who the trauma surgeon was, I knew who the ER physician was. And it was that sense of, "Okay, they're going to take care of them." And if they need care outside of that, I knew that there were resources available.

So when I came in and I saw that my husband, Scott, was being cared for by people that I trusted, that I knew, that I had respect for, I just realized that I was in the right place. And what South Shore does for this community is a huge, huge service. And I think the expansion and the merger with Partners just enhances that so much, in knowing that there's trauma surgeons from Brigham. And that the resources, whether it's radiology that they can, you know, see them, that they are able to view those, that there is a transition of care, that there is a seamless transfer of care when it's needed, but also knowing that the same physicians that are there are also at South Shore.

And I think that is a service that if we have that opportunity to give this to the community, that it is something that I wholeheartedly support and just wish and hope that everyone realizes the impact in a positive manner. And I just want to say thank you.

Ms. Susan Meighan: (Court Reporter's note: Testimony of Susan Meighan began without court reporter)

...we have become a Level 2 trauma center. We have a designated stroke center. We have a pediatric emergency department that is now open 24 hours a day, seven days a week. And we have a cardiac cath lab to provide cardiac catheterization for those patients presenting to the emergency department with a myocardial infarction, or simply stated, the patient is having a heart attack.

As an employee, I am very proud of what the hospital has accomplished. I am also proud to say that I choose South Shore Hospital when I need medical care, and my family does as well. With the implementation of health care reform, the way we deliver health care is changing. We need to provide quality care to our patients while being very cost-efficient.

Becoming part of the Partners community gives South Shore Hospital the ability to continue to provide these services we have been delivering, while allowing us to improve efficiency, quality and cost effectiveness.

What I am most excited about is the investment that Partners is going to make in information technology. The ability to share information between the Partners facilities is invaluable to both patients and providers. I will be able to access patients -- a patient medication list that may have been recently changed within minutes. That obviously improves patient safety and quality. The providers can access recent labs and testing that may have just been recently done on the patient. This will avoid duplication of services and keep us more cost-effective.

Having this access also saves time and improves ease of practice for both nurses and providers. This improves our efficiency. In conclusion, being a part of the Partners community allows South Shore Hospital to continue to offer the best services to our community and allows us to continue to grow in this ever-changing health care environment. Thank you.

Mr. Peter Forman:

Good afternoon. My name is Peter Forman. I'm President and CEO of the South Shore Chamber of Commerce. The Chamber is the largest business association on the South Shore representing businesses and communities from Randolph to Plymouth. The South Shore will be one of the fastest growing regions in New England for the next 10 to 20 years. And the Hospital is one of the region's largest employers, a significant driver in economic development throughout the area, and a recognized organization of excellence which helps attract residents and businesses to the South Shore. Therefore, the entire region has a stake in the Hospital's future in this application. And that is why the Chamber of Commerce supports the application.

New health care models are calling for new strategies to control costs and deliver excellence. Among these are collaboration with flexible and often shared provider networks, access into new geographic markets and greater efficiency in administrative operations. And the Chamber, having looked at this proposal, believes that the proposal will achieve all three goals.

Looking ahead to the growth and the changes coming to the South Shore and the changes to health care, we believe this proposal is not merely practical for the hospital, but it's beneficial to the entire South Shore's economy, residents and future. Thank you.

Ms. Lori DiBona:

Good afternoon. My name is Lori DiBona, and I'm the Vice President of the Columbian Square Business Association. We work closely with Alan McDonald and South Shore Hospital, who is a beneficial member of the CSBA, and has created that support and voice for the local businesses.

As Vice President of and on behalf of Columbian Square Business Association, we really feel this is a great opportunity for South Shore Hospital and the community. It not only supports all the local businesses around town, but it's a huge asset to have an expanding hospital right here in the Town of Weymouth.

This will not only provide job opportunities, but also many medical specialties needed for patients in and around as many as over 23 surrounding town it supports. Again, we welcome and support this opportunity and change. Thank you.

Ms. Maureen Donnelly:

Hello. My name is Maureen Donnelly. I work in the acute dialysis program at South Shore Hospital. I've been here for 24 years. I've been through a lot of ups and downs at South Shore Hospital, a lot of changes in health care. And I've found that the decisions that the Board of Trustees and the CEOs have made here have always been very beneficial. I've always seen very positive outcomes come from them, and I've never been disappointed.

So I feel as if in hearing all that's going on, I know all about the new health care reform and changes. I'm actually active and I've been very active on quality councils, in making sure that quality care is provided here at South Shore Hospital. And I feel that there has to be some changes, and I think moving forward with the merger with Partners is only going to give us more resources to provide that quality care, especially getting into the new informatics that they're able to offer us. My type of clientele, they are chronic patients, and I have a lot of association with their outpatient units, which is very key for continuation of care for them. So the more we improve that communication with them, the better care they can have in follow-up and hopefully keep them out of the acute hospital phase and keep them at their outpatient and get better care.

So I really support this. And everything that's been said today, unfortunately, when you come this late, a lot of what I was going to say has been said, so I don't need to repeat it. But I am in support of this. Thank you.

Ms. Jann Ahern:

Good afternoon. My name is Jann Ahern. And I'm the Executive Director of the Home Care Division of South Shore Hospital. I have responsibility for South Shore VNA, Hospice of the South Shore and Home and Health Care Facilities. And I am speaking today in favor of joining Partners HealthCare System.

Our VNA is 102 years old. And in those 102 years, there have been many partnerships and mergers that made us able to be where we are today. One of those was a merger between South Shore VNA and South Shore Hospital. Each one helps us improve care to the residents of the community.

Joining Partners HealthCare System will allow us to continue to improve our technology and improve our best practices for care. We currently give care to residents in over 30 communities in the South Shore.

Last year, we gave care to 1,592 Weymouth residents. They were cared for by our VNA colleagues, and 60 of those colleagues live right here in Weymouth. We are neighbors taking care of neighbors. And we look forward to a new partnership with Partners HealthCare System that will enable us to bring outstanding care to even more Weymouth residents. Thank you.

Ms . Debra Ayers:

Good afternoon. My name is Debra Ayers, and I'm a lifelong resident of the Town of Holbrook, which is right next door, as most of you, I'm sure, are aware. I took a position in the emergency room 12 years ago when my parents decided to retire and move to Florida. And they had been watching my three small children, and they could no longer do it. Although I was very upset they couldn't baby-sit for me anymore, I took a job in the ER as a unit coordinator working nights. And I can't believe how much this job has changed my life. I worked alongside some of the most caring, compassionate individuals that I have ever met in the emergency room, who gave me the confidence to go to school and become a nurse.

I graduated from nursing school in 2007, and I'm very proud to say that I am a nurse at South Shore Hospital. I enjoy my job. They are very good to me. As an employer, they have been fantastic. I have been able to go back to school and get my bachelor's degree through the program that was offered at the hospital. And I use South Shore Hospital myself. All four of my children were born there. I have two children with chronic disease, and I come here with the confidence that I know that they'll be taken care of very well.

Just as recently as last week, one of my daughters was actually admitted into the emergency room and had to have emergency surgery. I am proud to say that I am very confident that the care that she got was fantastic. She was released and went back to school yesterday and is feeling much better.

The affiliation with Partners I think is going to be one that's going to benefit our community immensely. Not having to drive that 13-mile ride on the Southeast expressway is going to be fantastic for people, because it's probably one of the worst rides in the city. So I'm strongly in agreement with this merger, and I hope that it is approved. Thank you.

Mr. Tom Murphy:

Hi. I'm Tom Murphy. I work in information systems at South Shore Hospital. I have worked there for over 12 years, and I'm also a local South Shore resident. It was obvious from a lot of the discussion we've heard today that patient care is what it's all about. But I think what we've also heard is that coordinated patient care is really what it's all about.

And back in 2004, one of the strategic goals of the hospital was to initiate health information exchange in our community. I recall back, we used to create these diagrams of what the community looked like. It looked like the United Nations, in terms of the electronic medical record systems. There were probably 35 or 40 different systems used in the community. So that's been a tremendous challenge to try to create coordinated care, when you have such disparate systems. So I think as we moved forward -- in fact, we were one of the first in the state with health information exchanges. We established a health information exchange with Atrius Health.

That was a critical first step when you talk about giving an emergency physician access to a patient's problems and medications and allergies and giving the primary care physician discharge information after the patient leaves. It was a great first step in terms of coordinated care.

So over the last decade, we've been spending quite a bit of time, incrementally trying to make these improvements and connect with different major physician groups in our community. We have a talented group of people, but it's really evident as we move forward that moving from simple exchange to really full services in terms of quality reporting and population health and just a more detailed exchange requires a significant investment.

So it's something that we really push for. It will provide just so much more capability from a care coordination perspective. So we really ask that you support this to give us that opportunity to integrate both the electronic medical records, as well as create a more robust platform for health information exchange throughout our community. Thank you.

Ms. Pattijean Horton:

Good afternoon. My name is Pattijean Horton. And I am here on behalf of the South Shore Community Partners in Prevention, also known as the Community Health Network Area, CHNA 23. In addition to my role as the volunteer chairperson of CHNA 23, I am also a sexual assault counselor and advocate with a program called, "A New Day," which is a program of Health Imperatives of Brockton.

CHNA 23 strongly supports South Shore Hospital's Determination of Need application to join Partners HealthCare. CHNA 23 is a volunteer coalition of individuals and organizations who work together to make our communities healthier places to live and work. We represent the Towns of Carver, Duxbury, Halifax, Hanover, Hanson, Kingston, Marshfield Pembroke, Plymouth, Plympton and Rockland. We support sustainable health improvements through networking, education, advocacy and grant-making. Channel 23 has worked closely with South Shore Hospital for the last five years. Our network receives funding from South Shore Hospital through the Massachusetts Department of Public Health Determination of Need Community Health Initiative Program. In addition, an executive from South Shore Hospital is an active member of our steering committee and plays a key role in helping us assess and respond to community health needs. The partnership between CHNA 23 and South Shore Hospital is a successful one. We are currently working together to improve health literacy, which emerged as a health priority for action in our most recent health assessment. We define "health literacy" as "the capacity of individuals to obtain, process and understand the basic health information and services needed to make appropriate health decisions."

South Shore Hospital's funding will make it possible for CHNA 23 to advance sustainable policy, system and environmental changes in support of improved health literacy. CHNA 23 looks forward to South Shore Hospital's proposed affiliation with Partners HealthCare so that our network may leverage improved services and new care-delivery models to advance its own efforts in this community. We request that the Massachusetts Department of Public Health approve South Shore Hospital's proposed affiliation with Partners HealthCare. And we thank you.

Ms. Julie Kembel:

Hello. My name is Julie Kembel. I come as a private citizen and resident of Hingham. I came here to this community five years ago, I and my family of five. And in that period of time, we've needed pediatric care, surgical care, in-hospital care, and my cancer care. And I say to you that we have been on the receiving end of a most affluent institution. The quality of cultural excellence at South Shore Hospital is like none I have experienced. I am a health educator, and I am well acquainted with hospitals in other parts of this country. I had not seen the likes of the relationships the hospital builds with its patients anywhere else.

The hospital has a lot to bring to the Partners merger, a lot, in how it relates to its patients. I am now part of the Patient Family Advisory Council. I see the work that's being done there. I'm on the board of the Friends of South Shore Hospital. And I do community outreach programs for families -- children who have family members with cancer.

And so while I support the Determination of Need application, I do so with the hope that Partners learns from us as much as we learn from you. Thank you.

Ms. Lisa Murphy:

Hi. My name is Lisa Murphy, and I've been a resident of Marshfield for 28 years. I've been part of the surgical nursing staff at South Shore Hospital for eight years. And I will have to admit for the 25 years before that, I worked at an academic medical center in the big city. So I know what this is all about. I have so many stories I could tell, I had to think about what to pick.

I have seen firsthand the benefits of our affiliation that we have now with the Brigham, with our Brigham residents. And you think about, What does the Brigham -- what can they get from being affiliated with us. And what I see that we teach the Brigham residents is how it is to care for someone in our community. We really have so much to offer here. And what's important about South Shore Hospital will not change with this merger. It's the culture and the caring of the people that work at South Shore that make us South Shore. We have so much to offer them on top of what they have to offer us.

About a year ago I got a call from my sister, and one of our close family members in Northampton was coming to South Shore Hospital for lung surgery. And my first thing is, Why are they coming here. No offense to anybody. But come to find out that her son lives in Scituate and had asked his neighbor, a renowned oncologist, where to go. And he recommended Dr. Ducko, and he wouldn't have sent his family member to anybody but Dr. Ducko, which I firmly agree with. So she drove two hours to come here. She could have gone to any hospital in the city, and she drove two hours to come here for her lung surgery and came back for subsequent treatments here, because her experience was so good. So when I think of these things -- the care that we have to offer and everything else -- is why people would still want to be at South Shore Hospital, with the added advantage of the expanded surgical program, because that's the world I live in, that we will have to offer.

So I am in full cooperation and agreement with this merger. I think not only does the Brigham have so much in Partners to offer us, but we have so much to offer them as well. Thank you.

Ms. Lyn Frano:

Hi, good afternoon. My name is Lyn Frano, and I am a member of the Steering Committee of the Blue Hills Community Health Alliance, also known as the "CHNA 20." The CHNA 20 is an inclusive partnership that brings together the Massachusetts Department of Public Health, area hospitals, health centers, social and human health agencies, schools, civic organizations and groups, businesses, local boards of health, and residents that collaboratively and favorably work towards the identification of health needs of a community and the thoughtful deployment of the resources to address these needs and to improve the health of the community. The Blue Hills CHNA consists of the Towns of Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth. CHNA 20 has the distinct pleasure and opportunity to work alongside South Shore Hospital as CHNA 20 contributors, participants and leaders through the CHNA 20's general membership and respect of the Steering Committee.

In part, with the support, commitment and participation of South Shore Hospital through CHNA 20, there are noteworthy and reportable accomplishments. And these will include, but are not limited to, completion and dissemination of a comprehensive community health assessment report issued in May 2012, grant-making that in the last two cycles made possible 25 unique and innovative community health projects, expanded membership capacity, fortified financial management policies and procedures, delivery of general membership meetings that provide a shared opportunity for education, new learning, CHNA's camaraderie, health improvement planning and resource sharing.

In closing -- I am speaking on behalf of the Steering Committee of the CHNA 20 -- we enthusiastically and unanimously support South Shore Hospital's proposed affiliation with Partners HealthCare. We are pleased to partner with South Shore Hospital in the purposeful work of prioritizing, assessing and improving the health of the community we together serve. Thank you.

Ms. Judith Chute:

Hi, I'm Judith Chute from Cohasset. And I just want to say how grateful I am to the South Shore Hospital. I grew up in another South Shore town. And whenever there was a serious medical problem, Boston was the place to go. I moved to Cohasset about 44 years ago, and I sort of continued with that. I came here for X-rays and other things. And then my husband, Paul, was seriously ill for a number of years. And I drove him into the city again and again. Between the traffic and my concern for his health and comfort, these trips were exhausting for both of us.

Later, when he was able to be at home, thanks to the hospice of the South Shore, it was very different. I was suddenly this year, just before Christmas, I was hit with double pneumonia, plus the flu. My daughter was in London; my brother in Southeast Asia. I felt alone and terrified. Thanks to the Cohasset Police Department, I ended up very speedily in the South Shore emergency unit, where I was immediately attended and later transferred to the hospital itself.

I was very impressed with the South Shore Hospital. I had never been a patient there in a hospital room before. The staff was pleasant, efficient, attentive. The room was clean and comfortable. The food was delicious. And I was even able to order my no soy, no gluten, no dairy diet. Friends were able to visit, especially my friends from the South Shore Hospice. And I was very, very glad to be home, so close to home. And I think that's one reason why I got better so quickly.

I am relieved, as I grow older, to have access to the best medical care right here in Weymouth. And I am thrilled that by joining with Partners could probably only improve the situation; to have excellent medical care close to home. And I am very grateful for that. Thank you.

Mr. Robert Zondelman:

My name is Robert Chuck Zondelman. For 47 years, my wife and I have resided here in South Weymouth. We've used South Shore Hospital as our base hospital since the late '60s and raised three sons also here in this community. I now volunteer at South Shore Hospital. I'm one of the members of the Patient Family Advisory Council here at South Shore Hospital. Most of the time I work with med-surge units, the home health care division, and the orthopedic department. And when I say I work with them, what I do is help spread patient family centered care. This is the culture the hospital now has.

I know that this merger with Partners HealthCare has been talked about for quite a while. I cannot see where the merger would change the culture here at South Shore Hospital of patient family centered care.
And knowing and working with the administration and the staff, I also know that patient family centered care will still be here, and it will still be a community hospital. And that's one of the big fears I hear from my neighbors; that South Shore Hospital won't be a community hospital anymore. It certainly will.

And also, we have to realize that -- and it's been stated here -- that by joining with Partners, it can do nothing but enhance the care for the South Weymouth people and for the whole South Shore. Thank you.