Lawrence General Hospital

Delivery System Transformation Initiatives
Proposal for the Massachusetts Section 1115 Waiver
Demonstration Years 15 - 17

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I. Introduction

A. Background

1. Community Context

Lawrence General Hospital is a 189-bed, 41-bassinet acute care hospital located in the City of Lawrence, a very low-income, largely Hispanic community 30 miles north of Boston. The vast majority of the patients and 70.5% of the hospital's FY2011 gross patient service revenue come from public payers, and of that 30.4% comes from low income payers, and nearly 8% of that total is care to the uninsured.

The Greater Lawrence region's population is approximately 200,000 residents and comprises the City of Lawrence, City of Methuen, and the towns of Andover and North Andover. These communities make up the hospital's primary service area. The Hospital is also the only not-for-profit hospital in the region and is an independent community provider. There are two hospitals in the primary service area, and three in the total service area, including Lawrence General. The two other hospitals in the region are for-profit and part of the Steward Health System, a private equity financed system that acquired both of the hospitals in the region within the last two years.

Lawrence General is the leading hospital in both its primary and total service area. In terms of inpatient care in its primary service area, Lawrence General's discharges represent 37.4% of the total, while Steward Holy Family Hospital, which is part of Steward Health System has 27.5% of the discharges, Massachusetts General Hospital, an academic medical center which is part of the Partners Health System, has 5%, Lahey Clinic in Burlington 3.7%, Tufts Medical Center, another academic medical center in Boston has 3.2%, and others make up 23.1%. The Hospital's secondary market area includes the City of Haverhill, and other smaller towns surrounding Greater Lawrence. In terms of discharges in the total service area, Lawrence General has 30%, Steward Holy Family 24.6%, Steward Merrimack Valley, another hospital within the private-equity for profit Steward system has 8.6%, Massachusetts General Hospital has 5.1%, Lahey Clinic 4.3% and others including Beth Israel Deaconess Hospital make up 27.3%.[1]

Outmigration of patients to higher cost academic medical centers is considerably higher in the suburban towns of Andover and North Andover but it also takes place in Lawrence where access to specialists can be limited due to socio-economic factors such as transportation barriers and the lack of health coverage. The hospital endeavors successfully to appeal to and meet the acute care hospital needs of all patients from the higher income earning suburban population and the lower income urban population by offering high quality, high value general acute care services.

The Greater Lawrence physician community is comprised of independent practitioners and two large groups, both of which rely predominantly on Lawrence General for acute care and ancillary services for their patients, neither of which however, is a part of the Hospital System. Lawrence General is a

[1] 2010 Massachusetts Health Data Consortium Report

dominant, market leader in acute care but does not own or employ a base of primary and multi-specialty group practices, or contract together with the medical community currently.

One of the two large groups aforementioned, the Greater Lawrence Family Health Center, (GLFHC) which operates as an independent Section 330 federally qualified health center, has four sites within the City of Lawrence and its flagship site is adjacent to the hospital campus. The vast majority of its providers are primary care physicians. The Health Center provides primary care for more than 47,000 residents of Lawrence primary, operates a 30-resident Lawrence Family Practice Residency jointly with the Hospital, and is an NCQA Level 3 Patient Centered Medical Home. While the Hospital and Health Center are independent entities, they have collaborated closely for more than 25 years. Both work cooperatively with the City of Lawrence and their Department of Public Health on special public health initiatives, the most recent of which was a campaign to encourage more mammography screening exams.

The region's other large medical group, Pentucket Medical Associates (PMA), is a multi-specialty group practice serving a largely suburban population. It is affiliated with Partners Community Healthcare Inc., the management services organization for the Partners network of physicians and hospitals. PMA relies primarily on Lawrence General Hospital for acute hospital care, and those ancillary services it does not provide at its own sites of care.

The remaining practitioners in the region are independent practitioners in private practice, working in solo practice or small groups. These practitioners rely significantly on Lawrence General Hospital not only for their patients' care but also for assistance adopting an EMR, and for working with them to prepare for payment reform. Until very recently, they had only contracted with health plans through an independent practice association for which the hospital provided support.

Lawrence General has demonstrated collaborations with local providers, including the GLFHC, Elder Services, and the Visiting Nurses Association. Our collaborations include sponsorship of the GLFHC residency program, support of clinical programs and sites, applications for Center of Medicare & Medicaid Innovation grants, and clinical data exchange, to name a few.

The Hospital's location approximately 30 miles north of Boston presents opportunities to enhance local access through clinical affiliations with major academic medical centers, which the Hospital has done in cardiac care with Beth Israel Deaconess Hospital in Boston, and in pediatrics with Tufts Floating Hospital for Children. The Hospital's proximity to Boston also contributes to outmigration of patients who seek care at significantly greater cost at academic medical centers. Outmigration accounts for 4,600 discharges annually in LGH's primary service area, and no one academic medical center receives more than 25% of total outmigration volume.[2] Outmigration occurs as a result of patient preference, physician referral, lack of available specialties and, with the low income populations we serve, it results from inadequate access for these populations who have higher no-show rates for appointments, and require additional services (e.g. language, financial counseling, etc.) that most local physician offices lack. Outmigration is seen as a tremendous opportunity to reduce cost. Proximity to Boston and its higher cost academic medical centers has been found to contribute to higher total medical expense for suburban residents whose income and mobility provide opportunity for them to travel to Boston for

[2] 2010 Massachusetts Health Data Consortium Report

non-tertiary care where the cost of care is significantly higher.[3] Lawrence General Hospital provides care at a cost per adjusted discharge of $4,000, over 50% less than Boston-based academic medical centers. Lahey Clinic's cost per adjusted discharge is $5,923, Brigham and Women's Hospital, a hospital in the Partners system is $9,978 and Massachusetts General Hospital is $9,838.[4]

Access for specialty care, particularly for low-income residents of Lawrence who rely predominantly on Medicaid and family practitioners at the Greater Lawrence Family Health Center ("Health Center"), and cannot easily travel to Boston for care, is a local concern and priority to address. Specialty care access at the Health Center is very limited. Of the 61 physicians practicing at the Health Center, the vast majority - 55 are family practitioners, 3 are pediatricians, 2 are obstetricians, and 1 is a general internist. In addition, the Health Center has 11 nurse practitioners, 3 physician assistants and 30 family practitioners in training. Specialty care access for health center patients, outside of dermatology and gynecological clinics with contracted physicians, is dependent upon other community providers. As independent small group practices primarily, specialists in the region practice in the suburbs of Lawrence, are not organized to accommodate the patients' linguistic needs, do not have financial counseling staff or expertise in their offices about low-income state-sponsored products, receive significantly lower rates per visit from low-income payers, and express frustration about the frequency with which Medicaid patients do not show for appointments. The Health Center's experience affirms what a challenge this can present, especially for independent specialists who are not employed or salaried but rather earn their income based on the number of patients they see. On average, 40% of the appointments each day at the Greater Lawrence Family Health Center's four sites are unscheduled, and the no-show rate for those with scheduled appointments is 35%. It is not unusual for the Health Center to experience a 50% increase in visits from one day to the next.

As a major provider of care to Medicaid and other low-income populations these specialty care access issues must be more thoroughly evaluated and improved in order to advance capacity to take on alternative payments. However, access challenges are not limited to specialty care. Improving primary care access has been a two-decade long focus for the community, and a major focal point for the Health Center and Hospital collaboration. Primary care capacity has been growing since the Lawrence Family Practice Residency was established in 1994 and it has grown from 24 residents to 30 residents because of its national reputation and appeal to those who seek to develop an expertise in delivering culturally and linguistically appropriate care for low-income populations. Through the retention of some family practice graduates and recruitment of practitioners to teach them, as well as recent expansions of the Health Center's hours and locations, the Health Center has expanded its capacity significantly. Yet within a short period of time after these expansions that new capacity is quickly consumed. This seemingly insatiable need for access at the Health Center, contributes in part to the Hospital's emergency department volume continuing to grow in spite of continued investments in primary care and Health Center capacity. The Hospital currently sees an average of 75,000 visits a year, and seeks to find innovative ways to provide novel tools to encourage more of its non-emergent patients to seek care at the Health Center.

[3] Office of Massachusetts Attorney General Report for Examination of Health Care Cost Trends and Cost Drivers, June 22, 2011
[4] Ingenix, Cost Per Adjusted Discharge Report, 2011

In addition to the primary care needs within the City of Lawrence, many of the independent primary care practitioners in the community are nearing retirement age, and recruitment of their replacements will be critical to maintaining access to primary care in the entire region. A recent survey by the Hospital of the availability of primary care access found that 40% of the region's primary care practitioner's panels are closed to new patients.

2. Population Description

Lawrence General Hospital is located in the City of Lawrence, a low-income, urban community of 76,000 whose population is largely Hispanic, and very densely populated (>11,000 per square mile). Its population grew by 6% from 2000 to 2010 – twice as much as the state with population growth of 3.1%. The Hospital is the dominant provider of acute hospital care in the Greater Lawrence area whose population is more than 200,000 and comprises the suburban communities of Andover and North Andover, as well as the cities of Methuen and Lawrence.

Lawrence has the highest concentration of Hispanic residents of any city in Massachusetts, 73.8% compared to a state average of 9.6%. Lawrence per capita income is $16,557 compared to $33,966 for the state. The percent of Lawrence residents living below poverty level is 27% vs. 10% for the state. More than thirty-five percent of Lawrence residents over 18 have less than a high school education, 36% are foreign born, and nearly 75% speak a language other than English at home.[5]

Key health status indicators and important risk factors reflect community makeup, environment and interventions to date but there is opportunity to improve. While health status indicators for Lawrence are not as good as the state average, they would likely be considerably worse if the Health Center and Hospital had not made tremendous investments in primary care access with the limited community resources available.

For example, the obesity rate is 31% compared to 21.8% for the state. The percent of poisoned cases of blood lead levels is 0.8%, double the state average of 0.4%. The diabetes hospitalization rate is 271.4 per 100,000 in Lawrence compared to 136.8 per 100,000 for the state. The homicide rate is 5.1% compared to 2.8% for the state. The percent with needed colorectal screening is 50.6% in Lawrence compared to 61.1% for the state. The percent of residents who say they are in poor health is 30.3 in Lawrence compared to 12 for the state. The percent having 15+ days of poor mental health is 13.2 for Lawrence compared to 8.9 for the state.[6]

The population and health status for the communities of Andover and North Andover are vastly different, and both communities rely on the Hospital for their hospital care more than any other provider. In these communities more than 90% of the population over 18 completed high school, only 10% are foreign born, 14% speak a language other than English at home, median home values exceed the state average, per capita income exceeds the state average and the percent living in poverty is in the single digits.[7]

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[5] United States Census 2010, census.gov
[6] Massachusetts Department of Public Health Report of Key Health Status Indicators in Massachusetts, MASSChip Report 2010
[7] United States Census 2010, census.gov

3. Health System Description

Lawrence General Hospital is a major provider of acute care services with 12,934 inpatient discharges in FY11, including nearly 1,650 births. Its emergency center cares for an average of 75,000 patients each year, and patient registrations were 221,568 in FY11. The Hospital is a high volume provider of cardiac, surgical, obstetrical and pediatric services. It has been deemed a Level III accredited Trauma Center by the American College of Surgeons, has a Level II nursery, and the only dedicated pediatric inpatient unit in the region where pediatricians provide care 24/7.

The Hospital's gross patient service revenue in FY11 was $408,732,000, and its operating margin was positive for the past three years and averaged 1.6%, a modest but very favorable reflection on the success of the organization in spite of unfavorable market conditions, and without the financial integration with the medical community that other providers use as a model for success.

The local medical community relies on Lawrence General. However, the Hospital does not have its own base of employed, primary care and specialty care physicians. More significantly, the medical community does not currently contract with health plans jointly with the Hospital, but seeks to develop the platform and systems to take on joint contracting and ultimately alternative payments. Each of the local medical groups contracts with health plans independently, through a larger organization such as PCHI (Partners Healthcare) or through an independent practice association (IPA) supported by the Hospital. The hospital did attempt to work solely with the IPA by forming a Physician Hospital Organization (PHO) in 2008 with the purpose of trying to enhance physician payment rates with payers. The PHO had 180 PCPs and specialists and just a few minor contracts. Within two years the primary care physicians moved to a different contracting affiliation and the PHO was largely dormant. The hospital is interested in re-invigorating and expanding PHO membership to encompass all of our local physicians initially and eventually other providers along the continuum of care, with a mission of clinical integration and enhancing patient-centered care, as an Integrated Care Organization (ICO).

The competitive dynamics in health care in the region and in Massachusetts is fierce. And some providers have succeeded in using their market leverage and position to win significantly greater rates of payments from health plans. In some cases the difference in prices paid by health plans to the lowest paid providers versus the highest paid can exceed 100%.[8] New transparency on prices paid by health plans to providers have been eye-opening for providers like Lawrence General who discovered that the hospital and the physicians in the community IPA were paid among the lowest in the Commonwealth. The Massachusetts Attorney General's first Report on the Examination of Health Care Cost Trends and Cost Drivers issued in April 2010 showed that disproportionate share hospitals like Lawrence General were paid on average 9 to 26% less than their non-safety net peer hospitals by the State's three largest health plans.[9] Lawrence General Hospital is not among those with market leverage, due to the larger than average proportion of low-income patient care the hospital provides. Lower rates of payment, and a greater reliance on low-income payers has been a disincentive for

[8] Massachusetts Attorney General's 2010 Examination of Health Care Cost Trends and Cost Drivers
[9] Massachusetts Health Care Cost Trends Final Report Appendix B April 2010

physicians to affiliate more closely because the rates the Hospital can extend to them through their contracts with health plans would be considerably lower than other larger systems can offer, and referrals of low-income patients offer the lowest remuneration and come with the need to provide enhanced services, such as financial counseling.

In spite of the highly competitive environment in which Lawrence General operates, it has become a high value, high quality, low cost provider whose services provide critical access to acute and ancillary care required by the local community. More patients in its primary market area depend on the Hospital than on any other single provider. In addition to the Attorney General's findings[10] as described above, the hospital's value has been demonstrated through payer tiered products where it has consistently been placed in the most favorable tier for the consumer, as measured on cost and quality.

The Hospital provides critical access, and is a high volume provider of general acute care services. For example, the Hospital met the threshold that a cadre of fewer than ten community hospitals in Massachusetts met and was given authority to provide elective angioplasty. The Hospital performs this service at a dramatically lower rate of reimbursement than the academic medical centers, and is among the highest volume providers of those hospitals that qualified, based upon the most recently published MASS Comm [11]elective angioplasty trial volume and reimbursement analysis.

The Hospital works very closely with the independent local medical community to provide high quality services their patients' need at significantly lower cost than other providers. This positions the Hospital well as a partner under alternative payments because of the high value hospital care Lawrence General provides. At the same time it requires continued innovation and collaboration with independent groups.

In November 2011 the Hospital went live with its Hospital Information System, and is working with the independent local practices to develop their electronic capabilities, connectivity and EMR. The Hospital has engaged the independent local practitioners who rely on the hospital in a process to evaluate and select systems, and ensure their compatibility with the Hospital's new information system. Due to significant financial constraints the Hospital has been under as a provider with a high concentration of Medicaid patients, the downward pressure on those rates due to the declining economy, and its related limited market clout to bargain for, the Hospital and community physicians embarked on an aggressive planning process in order to meet meaningful use opportunities. The local practice adoption of EMR is underway but has not yet been achieved.

4. Describe 5-year vision for the hospital

Lawrence General Hospital's 5-year vision is to create an integrated care organization (ICO) that provides an administrative structure, critical clinical and financial data exchange and analytics for the

[10] Massachusetts Attorney General's 2010 Examination of Health Care Cost Trends and Cost Drivers and Massachusetts Health Care Cost Trends Final Report Appendix B April 2010

[11] **The Mass COMM Trial is a randomized trial to compare percutaneous coronary intervention between Massachusetts hospitals with cardiac surgery on-site and without cardiac surgery on-site**

local medical community, contracts together with the currently disparate medical community, and successfully manages population health and risk.

The numbers of disparate physician groups, other local providers of care throughout the continuum, and distinctly different populations they serve, together with their varying current levels of reimbursement for care by the same payers, makes knitting the community together significantly more challenging than if the hospital had its own affiliated primary care, specialty care or hospital-based clinics. The hospital has not been able to compete with the rates of payments that affiliation with other providers whose greater leverage and more generous payer contracts can offer, and attract physicians who seek to realize rates at the higher end of the scale.

At the same time, the Hospital's independence and its capacity to provide care at significantly less per discharge than other providers, positions it well to be an acute care partner with local physicians and other providers under a new model of payment that reward the kinds of efficiencies Lawrence General offers. The hospital is served by three major physician constituencies—independent physicians in our Independent Practice Association (IPA), family medicine physicians in our Lawrence-based federally qualified health center and a large multi-specialty private physician group. The ICO will be comprised of all three of these groupings of doctors that will total more than 300 physicians who have never collaborated before, along with all of our local specialists, the large local Visiting Nurse Association, local skilled nursing facilities and other ancillary providers to effect the vision of more coordinated, efficient care for patients in our community. Additionally the ICO will reach out to other community organizations such as Elder Services and the local Public Health departments to incorporate their particular knowledge and strengths to address local community health needs. The ICO will be led by a volunteer Board comprised of a majority of physician and physician group representatives and a minority of hospital representatives with the possibility of future representatives from the community and other types of health care providers.

The Hospital is uniquely positioned to achieve this 5-year vision as the provider of choice in the region because of its service mix, high value, high quality care, and its longstanding commitment to meeting community needs. It has already successfully collaborated and partnered with local providers to improve care and access, overcoming barriers and forming inter-institutional programs and systems of care.

The next step is to continue to invest in an ICO infrastructure, information systems data exchange, interfaces between the disparate groups, a data warehouse and health information exchange in order to develop a fully integrated health system across the continuum of care, that can take on alternative payment methods.

As a community that has among the lowest calculated total medical expense in Massachusetts as reported in June 2011 Massachusetts Division of Health Care Finance & Policy reports, the Hospital is well positioned to be successful in taking on risk based alternative payments with the requisite investments to manage population health. Total medical expense, TME, in the Massachusetts Division of Finance and Policy's analysis accounts for *all* of the medical expenses associated with a member regardless of where those expenses are incurred (i.e., it includes physician visits as well as all hospital, laboratory, imaging, and other services, wherever those services occur). TME reflects both the volume

of services used by each member (utilization), as well as the price paid for each service (unit price). Lawrence General's TME was among the lowest.[12]

5. Related Initiatives Funded by the U.S. Department of Health and Human Services

Lawrence General Hospital is working with Elder Services of the Merrimack Valley (ESMV) and its multiple partner hospitals in the Community-based Care Transitions Program (CCTP), a Medicare demonstration project funded under section 3026 of the Affordable Care Act of 2010, to continue, expand and test an unfunded pilot care transitions program that began in May 2010 by ESMV. Through this cooperative agreement, four transition coaches hired by ESMV work at the hospital on behalf of eligible patients (i.e. Medicare fee for service or dually eligible patients). Lawrence General Hospital will also benefit from involvement in CCTP learning collaborative sessions sponsored by CMS in order to promote exchange of ideas and development of best practices. Also, LGH is planning to attend three learning collaborative sessions through the Hospital Engagement Network (HEN). There are no other related initiatives funded by the U.S. Department of Health and Human Services. LGH has collaborated on Center for Medicare & Medicaid Innovation grants. One of the innovation grants relates to patient centric electronic environment for improving acute care performance and the other grant , which has not been awarded to the Visiting Nurse Association applicant as of June 15, 2012, relates to a collaborative model of medical care delivery to support primary care physicians in the management of their high risk, medically fragile patients in our region. These grants do not overlap with our chosen DSTI projects.

Lawrence General Hospital will provide updates on our participation in any new HHS-funded initiatives related to our DSTI projects in our biannual DSTI progress reports to be submitted to the Commonwealth.

B. Executive Summary

Clinical integration and access are foundational components of the ICO Lawrence General will create. The ICO will serve as a platform for discussion and information dissemination to our partners. These partners will include all three of our PCP organizations, all the specialists on our medical staff, and key ancillary providers such as the Visiting Nurse Association. We will create a seamless continuity of care for the patients we serve. Elements of this will include EHR connectivity, referral coordination and continuous feedback among practitioners and care settings. The Hospital's Category 1 project entitled *Hospital/PCMH Practice System Integration* envisions that the Hospital and Health Center advance their clinical integration, and targets the population of patients the Health Center cares for who have diabetes, COPD and CHF. The hospital worked closely with GLFHC to identify high risk patients. The shared population of patients between GLFHC and LGH is predominantly Latino. Diabetes has been established as a significant diagnosis that affects Latinos at a higher rate than non-Hispanic whites. In addition, GLFHC PCMH has an established record of improving care to diabetics in the outpatient

[12] Massachusetts Division of Health Care Finance and Policy Report, Massachusetts Health Care Cost Trends, Price Variation in Health Care Services, May, 2011

setting. CHF and COPD are also determined to be high risk diagnoses when not effectively managed. The proposed model for diabetes will be adapted to CHF and COPD. The integration of care delivered at the Hospital with the care provided by the local Health Center, a Patient Centered Medical Home, is central to successfully managing the health of this population. The project brings together both organizations first to analyze gaps and determine priorities for the integration of care management, and ultimately advances to reporting key measures for a percentage of shared patients.

Inter-institutional collaboration surrounding care management, and the integration of hospital care with the independent Health Center is critical and the highest priority since 80% of the hospital care provided to patients of the health center is provided by Lawrence General.

The 5-year vision requires significantly enhanced integration with the Health Center, and a systematic evaluation and re-evaluation of the population health needs in terms of primary and specialty care capacity. The Hospital must have adequate local access to both primary and specialty care to reduce outmigration, provide appropriate access to care, and manage care. The Hospital's second Category 1 project entitled *Primary Care, Specialty Care and Provider Care Expansion and Development*, tackles the substantial challenge of ensuring access to essential levels of primary care and specialty care.

The Hospital's Category 2 project entitled *Identify Opportunities to develop and implement care transition interventions that lead to fewer unplanned admissions* (Project 2.1) builds on work the Hospital has undertaken for the Medicare population and spreads the interventions targeted to improve care transitions for that population to the entire adult inpatient population, and enhances care transitions using a variety of approaches in order to reduce unplanned admissions. Developing expertise in care transitions is crucial to successfully managing populations under alternative payments and this project provides for a deep and through examination of readmissions using the Hospital's new Health Information System, and the new capabilities it provides, together with other new tools and the hiring of care transitions expertise.

The Hospital's second Category 2 project entitled *Develop and co-locate a PCMH primary care site on the Hospital campus as an alternative for non-emergent ER complaints* provides for deep analysis and planning surrounding the need to drive more care from the higher cost emergency department setting to the community health center (Project 2.2), and tackles a considerable challenge for effective care and cost management. Ultimately it is expected to encourage patients who should seek care at the Health Center, and who may rely on the emergency center as another clinic, to seek care at their medical home.

The Hospital's Category 3 projects are crucial building blocks for the 5-year vision and to prepare for statewide payment transformation. The Category 3 projects the Hospital has chosen are essential undertakings for the Hospital to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service. With limited access to capital, limited to no capacity to embark on a physician employment strategy, and less favorable rates of payment to entice physicians to join the health system under the current fee-for-service construct, the Hospital has been unable to make the kinds of investments in clinical integration, financial integration and analytics necessary to be successfully positioned to take on new payment methods. Alternative payment methods and value-based purchasing provide new opportunities to turn the Hospital's high value position and cost effective care into a tremendous competitive advantage. Both Project 3.1 entitled *Develop*

organizational infrastructure to enhance capacity to alternative payment systems, and Project 3.2 entitled *Develop information management capabilities in preparation for accepting alternative payment methodologies,* provide the building blocks necessary to achieve the 5-year vision of accepting alternative payment methods.

As a high-value, high quality, cost effective provider the community relies on more than any other acute care hospital, Lawrence General is well-positioned for a successful future under alternative payments. The DSTI program and the projects the Hospital plans to undertake will not only provide critical building blocks and it will allow for advancements that would not have been possible previously. The DSTI initiatives undertaken will also allow the Hospital to pursue the development of innovative and novel care models that seek to find more effective methods for high value safety net providers to deliver care that meets the triple aim.

Category 4 measures are relevant to the hospital's 5 year vision and population/outcomes health improvement as they will focus measurement on readmissions for high risk populations, improved access, reduction of unnecessary ED visits, and improved data exchange to improve quality and manage the cost of care of our patient populations.

Through the opportunities provided by DSTI the Hospital can chart a course for future success as a more fully integrated health care delivery system that is positioned well for alternative payment models.

The table below summarizes the projects that will be addressed in this proposal.

Project Title	Description	Three -Year Goals
Category 1 – Further Development of a Fully Integrated Delivery System		
1.1 Hospital/PCMH Practice System Integration	This project brings together two independent organizations first to analyze gaps and determine priorities for the integration of care management, and ultimately advances to reporting key measures for a percentage of shared patients.	Develop an integrated system of care management and coordination between the Hospital and an NCQA-recognized PCMH to improve the care of shared patients who have diabetes, congestive heart failure, or chronic obstructive pulmonary disease.
1.2 Primary Care Physician, Specialty Care and Provider Care Expansion and Development	This project tackles the substantial challenge of providing access to essential levels of primary care and specialty care.	Expand access to medical care for communities the hospital serves resulting in better access and better coordinated care within our local medical community.
Category 2 – Improved Health Outcomes & Quality		
2.1 Identify Opportunities to Develop and Implement Care Transition Interventions that lead to Fewer Unplanned Readmissions	Starting with an assessment of the current status of care transitions as they relate to preventable 30 day readmissions, use a variety of tools to improve care transitions on the entire inpatient population.	Develop expertise in care transitions to support seamless transitions from one level of care to another through staff education, enhanced sharing of clinical data and the use of new standardized tools.
2.2 Develop and Co-locate a PCMH Primary Care Site on the Hospital Campus as an Alternative for Non-Emergent ER complaints	This project provides for the building of a site and the planning surrounding the need to drive more care from the higher cost emergency department setting to the community health center.	Implement a strategy to develop and co-locate a PCMH primary care site with an independent provider to encourage the use of primary care providers for non-emergent care.
Category 3 - Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments		
3.1 Develop Organizational Infrastructure to Enhance Capacity to Respond to Alternative Payment Systems	Develop an integrated care organization (ICO) with its own governance structure and board, physician champions, physician leadership, functional and administrative staff.	Bring together small group physician practices and larger medical group practices in the community under one organization to improve clinical integration and accept alternative payment methods in the future.
3.2 Develop Information Management Capabilities in Preparation for Accepting Alternative Payment Methodologies	This project embarks on an ambitious undertaking to determine the data, systems and processes necessary to be able to manage future payment methodologies among local providers.	With the ICO develop an inventory of data and services that are central to the success of taking on alternative payment methods, and that will identify best systems and processes to capture the data needed to manage care efficiently.

Project Title	Description	Three -Year Goals
3.3 Participate in a learning collaborative	Participation in a learning collaborative will provide a forum for eligible DSTI safety net providers to learn from other providers that share similar goals.	The Hospital will explore existing and/or potential new opportunities for participation in a learning collaborative and will either join an existing collaborative or develop a new learning collaborative structure which will facilitate and enhance the hospital's efforts to advance the Triple Aim through the sharing of information around DSTI projects.
Category 4 – Population Focused Improvements		
4.1	Care Transitions Measure Set (CTM-3)	Report Measure in DY 17
4.2	Patients who reported that staff "Always" explained about medicines before giving it to them	Report Measure in DY 16 and DY 17
4.3	Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home	Report Measure in DY 16 and DY 17
4.4	ED Wait Time: Door to Diagnostic Evaluation by a Qualified Medical Personnel	Report Measure in DY 16 and DY 17
4.5	Pneumonia Immunization	Report Measure in DY 16 and DY 17
4.6	Influenza Immunization (seasonal measure)	Report Measure in DY 16 and DY 17
4.7	Percent of discharged patients under age 75 who were hospitalized for Chronic Obstructive Pulmonary Disease (Ambulatory Sensitive – Condition Admissions Measure)	Report Measure in DY 16 and DY 17
4.8	Percent of discharged patients under age 75 who were hospitalized for Congestive Heart Failure (Ambulatory Sensitive – Condition Admissions Measure)	Report Measure in DY 16 and DY 17
4.9	Low Birth Weight Rate: number of low birth weight infants per 100 birth	Report Measure in DY 16 and DY 17

Project Title	Description	Three -Year Goals
4.10	Hospital 30-day, all cause readmission rate to the index hospital following a hospitalization for all patients 18 and older (not risk adjusted)	Report Measure in DY 16 and DY 17
4.11	Percent of Emergency Department visits for children age 18 or less with a primary diagnosis of asthma –Ambulatory Sensitive Condition	Report Measure in DY 16 and DY 17
4.12	Percent of patients with elective vaginal deliveries or elective cesarean sections at greater than or equal to 37 weeks and less than 39 weeks of gestation completed	Report Measure in DY 16 and DY 17
4.13	Hospital 30-day, all cause readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a diagnosis of diabetes	Report Measure in DY 15, 16 and 17
4.14	Using survey sampling techniques, determine time to first appointment and time to third next appointment for patients seeking care with a PCP	Report Measure in DY 15, 16 and 17
4.15	Hospital 30-day, all cause, readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a primary diagnosis of heart failure	Report Measure in DY 15, 16 and 17
4.16	Average monthly non-emergent Hospital emergency department volume that is level 3, 4, and 5 on the ESI scale, separately, as a percentage of the total ER volume	Report Measure in DY 15, 16 and 17
4.17	Percent of primary care physicians who successfully qualify for a Medicare or Medicaid EHR Incentive Program payment	Report Measure in DY 15, 16 and 17
4.18	Report of claims based utilization data for targeted population and service lines compared to benchmarks	Report Measure in DY 15, 16 and 17

II. Category 1 -Further Development of an Integrated Delivery System that Encompasses the Concepts of the Patient-Centered Medical Home

Project 1.1: Hospital/PCMH Practice Systems Integration
Master Plan Project 1.1

- **Goal:** The goal of this project is to develop an integrated system of care management and coordination between the Hospital and an NCQA-recognized Patient-Centered Medical Home (PCMH Practice) to improve the care of shared patients who have diabetes (DM), congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD). The hospital worked closely with GLFHC to identify high risk patients. DM, CHF and COPD were determined to be high risk diagnoses for the patient population served.

  This project will use the patient centered medical home NCQA guidelines for Plan and Manage Care as a framework to guide integration of care management and coordination between the Hospital and PCMH Practice. Among the six NCQA standards for Patient-Centered Medical Homes, Plan and Manage Care is central to inter-institutional collaboration and is integrally related to the other five standards.[13] Improved care management and coordination will further enhance the PCMH Practice's ability to advance the other five standards as well. Elements and factors from the Plan and Manage Care standard will be evaluated jointly by Lawrence General Hospital and Greater Lawrence Family Health Center's PCMH Practice team to improve integration of care and to design integrated roles and processes of care in order to share pertinent, patient –centered information between both parties. Key factors to achieve best practice in communication exchange will be identified and implemented in order to improve care and act as a foundation for moving toward electronic Health Information Exchange.

- **Rationale:** The PCMH Practice has been engaged in transformation for many years, especially related to care for chronic medical conditions, performance measurement, and access to care. On May 19, 2011 the Greater Lawrence Family Health Center was recognized as a Level 3 PCMH by the National Committee on Quality Assurance (NCQA), achieving over 94 of 100 points on the NCQA Standards. The Practice saw this as an important beginning step and continues to seek ways to further improve care for its approximately 47,000 patients. Among these patients, over 10% have a diagnosis of DM, CHF, or COPD. Approximately 80% of patients at the PCMH Practice also utilize services of the Lawrence General Hospital for inpatient care. Whereas the Hospital/PCMH Practice have worked together for many years, using the NCQA Standards as an assessment tool creates knowledge of how the institutions can further develop care management and coordination processes. Development of a robust care management/coordination system of care between the institutions for DM, CHF, and COPD patients will create knowledge and processes that will be transferable to other medical conditions as well. Previously much of the care management/coordination has been approached independently rather than inter-dependently. For instance, the PCMH Practice has an employee who is located in the Hospital to manage follow-up for discharged patients for the PCMH, but the establishment of the position and processes was handled predominantly through the PCMH practice. A new level of collaboration is now possible because of the growing capacity of both organizations in relevant functions. The PCMH Practice has hired two Care Managers in recent months and can further expand through this joint initiative. The Hospital is continuing to expand its approach to Integrated Care Management Services. An integrated system will result in jointly determined and supported processes of care and tracking outcomes of care across the spectrum of outpatient and in-patient care for DM, CHF, and COPD patients. The PCMH Practice has an established record of improving care for diabetes and will expand its previous work to create the basis for tracking

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[13] The PCMH 2011 draft standards are: 1) Access and Continuity; 2) Identify and Manage Patient Populations; 3) Plan and Manage Care; 4) Self-Management Support; 5) Track and Coordinate Care; 6) Performance Measurement and Quality Improvement.

care processes and outcomes of care, including functional health status, clinical outcomes, patient engagement, and costs. The model of care integration established for diabetes will be adapted to CHF and COPD.

- **Expected results:** Integration of service delivery between the Hospital and the PCMH will produce more efficient and effective care across the spectrum of outpatient and inpatient services for patients with diabetes, CHF, and COPD and will work to break down pre-existing silos of care delivery that currently exist. By the end of the project, the Hospital and PCMH Practice will be able to show improved ability to provide seamless coordination of care for patients between the two facilities and other relevant providers such as local rehab facilities, elder services organizations and the department of public health and work to break down the existing silos. Coordination and care management by sharing patient clinical data will improve overall patient care by ensuring all providers are following the appropriate patient-tailored treatment plan thereby positively impacting prevention of patient harm and unnecessary readmissions. The new level of care management will deliver extensive care oversight for these high risk populations and allow collaboration to ensure these patients receive appropriate medical care, support throughout the course of their disease, and across the continuum to manage chronic symptoms, avoid complications that lead to high utilization and link the two health care facilities in the continued pursuit of providing high quality, low cost, premium healthcare to our shared patients. The focus will be to exchange up-to-date clinical information related to the specified medical care plan of our shared patients. Information to be communicated will include treatment plans and other medical interventions, disease-specific education administered, medication reconciliation, and psychosocial, economic, environmental, and cultural factors that are identified as impacting our shared patients' health. This shared data exchange will be ongoing between the Care Management team at the hospital and the PCMH team at Greater Lawrence Family Health Center throughout the patient's hospitalization. It will also work to connect the PCMH team with other post-acute providers that are referred by the hospital and who take an active role in providing outpatient community-based services to the patient. Personnel from both LGH and the GLFHC PCMH will initially gain access to each other's electronic health records and then determine through ongoing discussion how the up to date, clinical information is best communicated in order to provide ongoing, seamless care to our patients. Given that both institutions have individually gone "live" with new health information systems within the past year, LGH's McKesson Paragon and GLFHC's GE Centricity, this initial process of information exchange as stated above will be a pre-cursor to determining how sharing electronic data elements can only improve our established processes.

- **Relation to other Projects:** This project will provide resources to enhance coordination of care for Project 1.2, Expanding Access to Specialty and Primary Care. It will create the model of care to facilitate integration among multiple practices across the spectrum of care. Participants in this project will learn from and contribute to Project 2.1 on reducing readmissions and will provide direct assistance in the management and coordination of care. Likewise, the refinement of integrated care management/coordination will facilitate Project 2.2 transformation of Emergency Department utilization, and re-direction to non-emergent care. Finally, this project will consolidate needed knowledge of care processes to facilitate effective HIE development for DM, CHF, and COPD as well as other medical conditions. This project includes metrics that substantially enhance those funded by the CCTP collaborative agreement.

  Advancing clinical integration, and through this project, care management for shared patients with chronic conditions specifically, is a means of boosting health care quality and efficiency.[14]

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[14] Commonwealth Fund, Assessing and Addressing Legal Barriers to the Clinical Integration of a Community Health Center and other Community Providers, July 15, 2011.

Project 1.1: Hospital/PCMH Practice Systems Integration (Master Plan Project 1.1)		
SFY 2012	**SFY 2013**	**SFY 2014**
Milestone: Establishment of a Joint team of the Hospital and PCMH Practice to analyze gaps and determine priorities for the integration of care management and coordination for DM, CHF and COPD **Metric: (MP-P 11)**[15] 1. Documentation of regular meetings and communications of the Joint Hospital/PCMH Practice Team. The Hospital Director of Integrative Services and the Lead Clinical Care Coordinator will co-chair the team, which will consist of other care managers and coordinators from the two institutions. The team leaders will communicate daily with personnel in their respective organizations regarding integration activities. Formal meetings of the team will be held at least monthly, and usually more frequently. Electronic communication between the institutions is readily accessible by email, and there are some team members who have access to both institutions' Electronic Health Record **Data Source:** 1. Joint team minutes **Milestone:** Identification of areas for improvement in Hospital/PCMH Practice linkages related to NCQA requirements for patient-centered medical homes. **Metric: (MP-P-12)** 2. Report of at least 3 factors for improvement	**Milestone:** Joint Hospital and PCMH Practice development of a comprehensive plan for care management and coordination including data items to be tracked, clinical roles and agreements, and care management processes among relevant providers in the area **Metrics:** 6. Report identifying the roles and community organizations needed to integrate care related to the factors (MP-P-15-B1) 7. Implement a process to refer greater than or equal to 25% (above baseline) of all shared hospitalized diabetic patients, discharged to home, to a certified diabetic educator. (MP-I-8) 8. Documented agreements between health and health-related entities in the community and the Hospital and PCMH Practice (MP-P-15-B2) 9. Mapping of Care Management Processes for Hospital/PCMH Practice patients with DM, CHF, or COPD (MP-P-15-B3) 10. Determination of baseline measurement, within a 12 month period, of the percentage of shared patients with DM, CHF or COPD who have had documented care management/coordination interventions from the hospital and the PCMH practice relating to the sharing of treatment plans and other medical interventions, disease-specific education administered, medication reconciliation, and psychosocial, economic, environmental, and cultural factors that create barriers to care as well as other defined data	**Milestone:** Implementation of a joint plan for efficient care management and coordination, and tracking of care **Metric: (MP-I-7)** 11. Repeat same measurement as per baseline to determine level of improvement [16]on the annual percentage of patients with effective care coordination documented between the Hospital and PCMH **Data Source:** 11. Hospital and PCMH Practice electronic data bases **Milestone:** Ongoing implementation of referral process to refer joint hospitalized, diabetic patients, being discharged to home, with a certified diabetic educator. **Metric: (MP-I-8)** 12. Expand referral process for greater than or equal to 50% (above baseline) of all shared hospitalized diabetic patients, being discharged to home, to a certified diabetic educator. **Data Source:** 12. Reports on shared patients with referrals made to a certified diabetic educator.

[15] MP-P-X stands for Master Plan – Process Measure #X; similarly, "MP-I-X stands for Master Plan – Improvement Measure #X.A; B references the bullet number
[16] We will set a target for improvement based upon the baseline identified in metric 10

Project 1.1: Hospital/PCMH Practice Systems Integration (Master Plan Project 1.1)		
SFY 2012	**SFY 2013**	**SFY 2014**
related to the identification of individual patients and plans for care management that will be jointly addressed by Hospital and PCMH Practice **Data Source:** 2. Gap analysis based on 2011 NCQA PCMH Documentation Tracking Tool **Milestone:** Identification of existing data related to patients with DM, CHF, and COPD. (e.g. the PCMH Practice provides primary care for over 4000 diabetic, 400 CHF, and 1000 COPD patients, and routinely tracks multiple measures of care processes and outcomes) **Metric: (MP-P-13)** 3. Report of clinical data elements that currently exist at each institution for patients with DM, CHF, and COPD **Data Source:** 3. Electronic medical record databases for each institution and joint team minutes reflecting process of analysis **Milestone**: Hospital/PCMH Practice agreement on clinical data elements that will be tracked for patients with DM, CHF, and COPD by the two institutions **Metric: (MP-P-14)** 4. Report of clinical data elements that currently exist at each institution and clinical data elements that need to be developed for the targeted conditions as agreed upon by parties from both institutions **Data Source:** 4. Electronic medical record databases for each	elements identified and agreed upon in the first year and determine a target improvement measure. (MP-P-15-B4) **Data Sources:** 6. Summaries of consultation between the joint team and professionals from other community agencies 7. Reports on shared patients with referrals made to a certified diabetic educator 8. Agreements with health related entities 9. Joint team report 10. Hospital and PCMH Practice electronic databases	

Project 1.1: Hospital/PCMH Practice Systems Integration (Master Plan Project 1.1)		
SFY 2012	**SFY 2013**	**SFY 2014**
institution and minutes of deliberations of joint team describing process of consensus development **Milestone:** Hospital/PCMH assessment of the percentage of shared hospitalized patients with diabetes with a referral to a certified diabetic educator **Metric: (MP-P-18)** 5. Determination of baseline measurement of shared hospitalized diabetic patients with a referral to a certified diabetic educator **Data Source:** 5. Report of baseline determination that includes shared diabetic patients with a referral to a certified diabetic educator		

II. Category 1 – Further Development of an Integrated Delivery System that Encompasses the Concepts of the Patient-Centered Medical Home Model

Project 1.2: Primary Care Physician, Specialty Care and Provider Care Expansion and Development
Master Plan Project 1.3

- **Goal:** The Hospital will embark on a plan to expand access to medical care for communities Lawrence General Hospital serves. The Hospital will do this by reviewing the current state and using a variety of tools to identify shortages and barriers to access in both primary and specialty care. LGH will work with its partners to bring additional necessary service lines and primary care resources to the Lawrence area, resulting in better access and better coordinated care within our local medical community. This project will improve patient access to primary care physicians and develop the resources necessary to provide more patient-centered medical home practices to the community.

- **Rationale:** There is a shortage of primary and specialty care within the communities served by Lawrence Generalas evidenced by two studies conducted by consultants. A brief overview by Kaufman Hall consultants in 2011 identified specialty care shortages and significant outmigration of patients to higher cost academic medical center-based specialists. Amore thorough report issued in 2007 compared physician supply at that time to benchmarks (need per 100,000 population).[17] The data source was the Massachusetts Health Data Consortium licensure database and the LGH medical staff roster. This report also examined market share trend data by type of service from 2004-2006. The 2007 report identified shortages in both primary and specialty care by town. However, this report is now outdated since much has changed during the past five years in the competitive landscape as well as in patients' health insurance benefit design (e.g. limited networks, self-insured plans) that have affected patient access to physicians. In addition, many of our independent primary care physicians who rely on the Hospital are nearing retirement age. Finally, a recent survey conducted by our PHO office in January, 2012, of the PCP's in our service area showed that approximately 40% are not accepting new patients. We need to perform a comprehensive assessment of the current situation for access to both primary and specialty care and create a plan for closing the identified gaps and providing appropriate and necessary access for all patients in the community for the future.

  The community relies on a mainstay of physicians who are either affiliated with the Greater Lawrence Family Health Center, are in solo or small group practices, or are affiliated with Partners Healthcare. There is an inadequate supply of primary care providers and major gaps in access to local specialists. The Hospital has had very limited financial capacity to recruit physicians to the local community or support the local physician community through employment contracts due to its significantly below average commercial rates of payment, and its reliance on Medicaid. Commercial rates of payment for physicians reflect the 2010 findings of the Massachusetts Attorney General that non-Disproportionate Share (DSH) hospitals are paid on average 9 to 26% more than their DSH counterparts. This has established a disincentive in the marketplace for physicians to align with DSH hospitals. Affiliation with non-DSH hospitals, and major tertiary providers, that are less reliant on Medicaid, provide physicians with higher rates of reimbursement in the Massachusetts marketplace through contracting. In the Greater Lawrence region, the physician community is comprised of family practice physicians working at and contracting through the health center, a large multi-specialty group that contracts with Partners Healthcare, a group that contracts with the newly formed for-profit Steward system, and a group of independent local physicians in individual or small group practices. The community relies on physicians who contract separate from the Hospital, none of whom has historically been accountable for population health, nor engaged in risk contracting. The physicians currently contract with health plans independent of the Hospital, because there have been few financial incentives to align with the Hospital.

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[17] This benchmark was developed by a consultant we utilized. LGH will consider available benchmarks to assess access to primary and specialty care.

Lack of access to specialty care services is a more important problem for community health centers than previously thought[18] but it is also a critical success factor for population management for all of the hospital's patients, and advancing alternative payment arrangements. Lack of access to specialty care is especially worrisome given the poorer health of low-income children as compared with the health of other children[19] but it is also troubling for adults whose health status indicators, as referenced in the introduction, are poorer for residents in Lawrence than the state average. The joint residency program brings primary care to the community and through our collaborative efforts, we hope to entice graduates to stay in the area and continue to provide primary care as part of our network. We will impact specialty care by our tertiary affiliations and proven experience bringing specialists to the community. LGH will continue to work with our Boston-based clinical affiliates, Beth Israel Deaconess Medical Center for adult services and Tufts Floating Hospital for pediatric services, to bring needed specialty services to the local health care community, which is a dramatically lower cost setting. For example our Beth Israel affiliate could recruit a sub-specialist, such as an endocrinologist, and have them placed locally, at Lawrence General Hospital. By offering a full range of services locally we can reduce the high level of outmigration for specialty care and its associated higher costs of care, and successfully coordinate the delivery of high quality care in our community, thereby positioning the Hospital for new payment methodologies.

- **Expected Results:** We expect to undertake a comprehensive analysis of primary and specialty care providers in our primary service area to update our understanding of physician supply compared to current benchmarks and measure access by time to appointments available locally. We will also identify access challenges and implement a plan to increase both the number of our local family practice residents who choose to remain in our area to practice and recruit other primary care providers. LGH will recruit new primary care providers, using methods in lieu of employment that have been proven successful through experience, such as embedding practitioners in existing practices, income guarantees and working with additional recruiters to fill anticipated vacancies in local PCP practices. We will seek to better understand and reduce the barriers to appropriate specialty care for underserved populations. Additionally, we expect to increase local specialty care providers in the specialties identified as a priority need. By keeping a more robust and appropriate continuum of care locally, the Hospital will be able to better integrate that care. This will result in better access for patients for both preventative and specialty care at a cost savings. Additionally, this will allow the local ICO to be better positioned to accept global payments, manage care and manage costs.

- **Relation to other Projects:** This is related to the Category 2 project, "Develop and co-locate a PCMH primary care site on the Hospital campus as an alternative for non-emergent ER complaints" as well as the Category 1 project, "Hospital/PCMH Practice Systems Integration." These three projects address the need for additional primary care capacity and create opportunities for more patients to be cared for locally in an accredited Patient-Centered Medical Home.

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[18] Access to Specialty Care and Medical Services in Community Health Centers, Health Affairs, Volume 26, Number 5, page 1459.
[19] Access to Specialty Care for Children with Public Insurance, New England Journal of Medicine, June 16, 2001.

<table>
<tr><th colspan="3">Project 1.2: Primary Care Physician, Specialty Care and Provider Care Expansion and Development (Master Plan Project 1.3)</th></tr>
<tr><th>SFY 2012</th><th>SFY 2013</th><th>SFY 2014</th></tr>
<tr>
<td>Milestone:
Assess primary and specialty provider care coverage in the community to address care needs across the continuum. This will ensure access to PCPs for our patients in a timely manner.

Our consultants, Kaufman Hall, had performed a preliminary review on specialty care needs. They identified an overall thirty percent outmigration of services from the LGH community. In particular, certain specialties such as general surgery, cardiology and neurology were quickly identified as potential specialty care areas which need to be addressed.

Metrics:
1. Identify the need for primary and specialty care services using national benchmarks for primary care panels and community size. (MP-P-2-B1)
2. Conduct interviews of key referral staff and care coordinators of 50% of the primary care practices in the area who rely primarily on the Hospital for their patient care needs, in order to confirm the specialty care access gaps of the community with particular focus on potentially underserved populations and their access to specialty care (MP-P-2-B2)
Data Sources:
1. Gap analysis according to benchmark reports.
2. Report of the access issues faced by underserved population</td>
<td>Milestone:
Develop a plan and programs to alleviate identified provider shortages and close gaps in the continuum of care
Metrics:
3. Based on gap analysis prepare a three-year plan to address identified provider shortages and close gaps in primary and specialty care. (MP-P-3-B1)
4. Survey targeted specialty practices to measure baseline time to third next available appointment. (MP-P-12)
5. Work with the independent local health center and our joint residency program leadership to devise a plan including but not limited to, practice placement, real estate consultation, and loan forgiveness to retain graduates in the area (MP-P-3-B6)
6. Establish clinical programs with affiliate partners, or independently, to address 2 specialty care gaps identified and confirmed in the baseline report (MP-I-1)
Data Sources:
3. Three year plan document and survey tool
4. Documentation of baseline targeted Specialty practice time to third next available appointment
5. Recruitment plan for residency graduates
6. Contracts with clinical affiliates, or LGH agreement with specialists</td>
<td>Milestone:
Identify ongoing barriers to specialty care access for LGH's populations
Metric: (MP-P-5)
7. Prepare report on access to specialty care compared to baseline report to determine improvements and continue to inform the three year plan
Data Source:
7. Specialty care access report

Milestone:
Continue to close gaps in the continuum of care
Metrics:
8. Implement year 1 of three year plan to include recruitment targets in[20] primary care providers and specialty care for improved access for patients (MP-I-2-B1)
9. Establish 1 additional clinical program with affiliate partners, or independently, to address specialty care gaps identified in the baseline report (MP-I-6)
10. Assess efficacy of the new clinical programs established in Year 2 (time to first available appointment). (MP-P-4)
11. We will compare time to third next available appointment for targeted specialty practices surveyed in 2013 with the goal of a 5% improvement (MP-I-13)
Data Sources:
8. Report on Year 1 Plan action items
9. Contracts with clinical affiliates, or LGH agreement with specialists</td>
</tr>
</table>

[20] The plan developed in year 2 pursuant to metric 3 will have targets for year 3 and beyond.

Project 1.2: Primary Care Physician, Specialty Care and Provider Care Expansion and Development (Master Plan Project 1.3)		
SFY 2012	**SFY 2013**	**SFY 2014**
		10. Reports on time to first appointment 11. Reports on time to third next appointment

III. Category 2 – Improved Health Care Outcomes and Quality

Project 2.1: Identify opportunities to develop and implement care transition interventions that lead to fewer unplanned admissions
Master Plan Project 2.3

- **Goal:** The hospital plans to assess the current status of care transitions as they relate to preventable 30 day readmissions. For the purposes of this project 30 day readmissions will be defined as all cause readmissions within 30 days. This information will be analyzed in order to identify opportunities to improve the care transition process. The intent is to support seamless transitions from one level of care to the other through enhanced sharing of clinical data, staff education and the use of standardized tools. Information gained from the hospital's participation with partnership for Patients and HEN as well as that from STAAR and the Community Based Care Transitions Program (CCTP) will be incorporated into this initiative. Project interventions will be selected for their potential to address the four domains identified by Eric Coleman et al in 2002 as critical to effective care transitions; Information Transfer, Patient and Caregiver Preparation, Support for Self Management and Empowerment to Assert preferences.[21] In an attempt to address each domain the hospital will focus on the following initiatives: (1) Enhanced Admission Assessment of post hospital needs; (2) Effective Patient Education; (3) Improved (real time) Handoffs communication; (4) Ensuring post hospital care follow up and (5) Enhancing communication from post acute providers back to the hospital. The focus will be on the hospital's entire patient population instead of the discrete population focus currently used with the STAAR and 3026 initiatives. Lawrence General has partnered with Elder Services of Merrimack Valley, along with 4 other hospitals, to participate in the Community Based Care Transitions Program (CCTP) Program related to care transitions. This program only applies to Medicare Fee For Service beneficiaries or dually eligible beneficiaries. The funding from this grant will go directly to Elder Services to hire four transition coaches that are working closely with Lawrence General to provide transition coaching to identified risk stratified eligible patients. Lawrence General will apply best practices and lessons learned from this initiative across all patients.

  - The hospital will have RN case managers collect data on the causes of preventable 30 day readmissions within our specific patient population via patient interviews using a standardized tool provided by the STAAR initiative which has been modified to incorporate additional data elements
  - During the first year (SFY 2012) the hospital plans the following: 1) Select an evidence based framework for reducing preventable admissions; 2) Recruit and select an expert in care transitions; 3) Implement a Health Information System that will improve collection and analysis of preventable thirty day readmission data; 4) Devise an admission assessment tool designed to identify patients at high risk for readmission; 5) Form a cross continuum team to partner with representatives from key community service based providers
  - During the second year (SFY 2013) the hospital plans to: 1) Complete an analysis of the readmission data in order to identify key contributing factors leading to preventable 30 day readmissions;. 2) Educate hospitalist and nursing staff on effective use of teach back methodology; 3) Trial

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[21] Coleman EA. Smith JD, Eilersten, TB. Frank JC, Thisre JN, Ward A and Kramer AM, Development and Testing of a Measure Designed to Assess the Quality of Care Transitions, International Journal of Care Integration 2002:2 April - June

use of warm handoffs[22] to select area rehabilitation and skilled nursing facilities; 4) Educate hospitalist and nursing staff on key contributing factors; 5) Assess opportunities for and barriers to making follow up arrangements for high risk patients prior to discharge; 6) Develop and implement an enhanced assessment tool for patients who are identified as having substance abuse or behavioral health issues; and 7) Implement follow up phone calls to patients identified as having substance abuse and mental health issues and who have been discharged home to review treatment plans and assess compliance.

- During the third year (SFY 2014) the hospital will: 1) implement a joint plan with a Patient Centered Medical Home (PCMH) for efficient care management and coordination of an identified high risk population; 2) Expand use of teach back[23] methodology by LGH clinicians; 3) Expand use of warm handoffs for adult inpatients transitioning to skilled nursing/rehabilitation facilities; and 4) Assess current contributing factors to all cause 30 day readmissions to identify changes and determine effectiveness of interventions taken to this point; 5) Increase percentage of substance abuse or behavioral health patients who undergo enhanced assessment; 6) Increase percentage of identified patients with substance abuse or behavioral health issues who receive telephone follow up calls.

- **Rationale:** The hospital's patient population is culturally and economically diverse. Factors such as language barriers, functional and/or health literacy and financial hardship act to impede effective care transitions for a significant percentage of the hospital's patient population. While there are common risk factors for readmission such as heart failure, there are also readmission risk factors specific to safety net populations.[24] Engaging an expert in care transitions will facilitate development of improved methods for providing effective care transitions. In addition, implementation of a new electronic system to provide readmission data will improve the hospital's ability to identify the major contributing factors leading to preventable thirty day readmissions.

  Partnership with the Greater Lawrence Family Health Center (GLFHC) will allow opportunity to partner directly with primary care providers for a large, multicultural high risk population. This partnership will allow for more controlled application and evaluation of select interventions than is possible with the STAAR framework alone. In addition, increased communication and collaboration with area skilled nursing and rehabilitation facilities will promote improved care coordination within the community the hospital serves. Adoption of the Coleman model will provide a framework for reduction of readmissions. Identification of contributing factors within the patient population will facilitate selection of action plans specific to the unique patient population. [25]

- **Project's Impact to Refine Innovations, Test, and Disseminate Findings:** The data collected on preventable thirty day readmissions will not only provide a basis for selection of innovations but also enable ongoing assessment regarding the efficacy of selected innovations after implementation. In this way the hospital will be able to refine innovations, test new ways of meeting the needs of target populations and disseminate findings in order to spread promising practices. Continued review of readmission data over the course of the project will enable team members to assess changes in patterns such

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[22] Warm handoffs involve structured communication between the sending and receiving caregiver at the time of transfer. Key information sharing along with the opportunity to ask questions occurs during a warm handoff.

[23] Teachback involves presenting information to a patient/caregiver and then asking them to repeat in their own words the concepts they were taught. Inability on the part of the patient/caregiver to repeat or demonstrate the new information indicates a need for further teaching.

[24] Reducing Readmissions in Safety Net Hospitals and Health Systems, National Associations of Public Hospitals and Health Systems, Research Brief, December, 2011.

[25](Jenncks, S., Williams, M., Coleman, E., (2009) Re-hospitalizations among patients in the Medicare fee-for-service program. *The New England Journal of Medicine 360* (14), 1418-28. Sutherland Cornett, E, Latimer, T. (2011), Managing hospital readmissions: an overview of the Issues, *Journal of Health Care Compliance*, 5-14)

as most common readmission diagnoses. This will provide the team with ongoing information that can be used in evaluation of the efficacy of the initiatives such as teach back and warm handoffs. Those initiatives that are deemed successful can be refined and expanded using information from patient/family feedback, chart reviews and current literature. Successful interventions and improvements can then be disseminated throughout the hospital and to community partners.

- **Expected Results:** The hospital will identify key factors essential to effective care transitions. This will set the stage for development of an integrated patient care delivery system targeted at impacting preventable thirty day readmissions in an at risk patient population. In addition, it is expected that the hospital will experience improvement in the overall patient experience especially as it relates to discharge. Other possible outcomes may involve improved patient throughput due to improved discharge processes and early establishment of patient expectations surrounding care transitions.

- **Relation to other Projects:** This project relates to the hospital's projects to develop Hospital/PCMH practice systems integration, expand Primary care and Specialty care, and implement an alternative site for non emergent ER complaints. All of these projects will support the hospital's plan to prepare for the adoption of value based purchasing and alternatives to fee for service payment.

Project 2.1: **Identify opportunities to develop and implement care transition interventions that lead to fewer unplanned admissions (Master Plan Project 2.3)**		
SFY 2012	**SFY 2013**	**SFY 2014**
Milestone: Collect data on factors contributing to preventable readmissions within 30 days **Metrics:** 1. Care managers to use a standardized tool and conduct a minimum of 10 interviews with patient/family members regarding an occurrence of a preventable 30 day hospital readmission (MP-P-2-B1) 2. Review of interview data conducted **b**y multidisciplinary team (MP-P-2-B2) 3. Improve electronic reporting of readmission data (MP-P-2-B3) 4. Analyze all cause 30 day readmission data for the hospital to provide a baseline metric (MP-P-2-B6) **Data Sources:** 1. Documented summary of interviews 2. Minutes of meetings analyzing interview results 3. Report on readmission data 4. Report of baseline metric **Milestone:** Addition of a care transitions expert **Metric: (MP-P-4)** 5. Hire lead clinician with expertise in care transitions. **Data Source:** 5. Human Resource Records **Milestone:** Develop an assessment tool to identify patients	**Milestone:** Analyze readmission data **Metric**: (MP-P-2-B7) 8. Identification of key factors including primary and additional diagnoses such as CHF, DM, COPD and mental health/substance abuse that increase likelihood of preventable 30 day readmissions **Data Source:** 8. Report listing key contributing factors **Milestone**: Educate hospitalist and nursing staff on key contributing factors **Metric: (MP-P-14)** 9. Educational sessions for greater than or equal to 80% of hospitalists and nursing staff (numerator = # of hospitalists and nursing staff educated; denominator = total # of hospitalists and nursing staff) **Data Source:** 9. Educational Records **Milestone:** Education of hospitalist and RN staff on the use of Teach back methodology **Metric: (MP-I-4)** 10. > 80 % of hospitalists, & RN staff educated on Teach back methodology (numerator = # of hospitalists and RN staff educated on teach back methodology; denominator = total # of hospitalists and RN staff educated on teach back methodology)	**Milestone**: Implement use of teach back methodology for ≥ 50% of identified high risk patients on adult inpatient units **Metric: (MP-I-5)** 14. Sample high risk patients to determine percentage who experience teach back and assess impact on readmission rates (numerator = teach back performed on identified high risk patients; denominator = total identified high risk patients) **Data Source:** 14. Report on percentage of sampled high risk patients who experienced teach back **Milestone:** Expand warm handoffs on adult inpatient units **Metric: (MP-I-3)** 15. >70% of adult inpatients will experience warm handoff on discharge to area SNF/Rehabs **Data Source:** 15. Report on sample of adult inpatients discharged to SNF or rehab including percentage where warm handoff given **Milestone:** Design and Implement joint plan for efficient care coordination for high risk hospital patients who are part of a PCMH **Metric: (MP-P-25)** 16. Report on percentage of patients who have had documented evidence of care coordination between the hospital and the PCMH[26]

[26] The customized care plans equate to the documented evidence of care coordination between the hospital and the PCMH.

Project 2.1: Identify opportunities to develop and implement care transition interventions that lead to fewer unplanned admissions (Master Plan Project 2.3)		
SFY 2012	**SFY 2013**	**SFY 2014**
who are high risk for readmission **Metric: (MP-P-5)** 6. Multidisciplinary committee approves assessment tool **Data Source:** 6. Approved sample tool and meeting minutes **Milestone:** Implement enhanced assessment tool for patients with substance abuse and behavioral health issues. **Metric: (MP-P-18)** 7. Multidisciplinary committee approves assessment tool **Data Source:** 7. Integrated Care Department forms library	**Data Source :** 10. Minutes and attendance lists of meetings/educational programs during which Teach back was presented **Milestone:** Trial use of warm handoffs for adult inpatients being discharged to area SNFS, Rehabs and PCMH **Metric: (MP-I-2)** 11. Warm Handoffs used for >35% of all transitions from adult inpatient units to area SNFS, Rehabs, and PCMH (numerator = # warm handoffs of transitions from adult inpatient units to area SNFs, Rehabs, and PCMH; denominator = # of transitions from adult inpatient units to area SNFs, Rehabs, and PCMH) **Data Source:** 11. Report on percentage of adult transfers to area SNFs, rehabs and PCMH during which warm handoff occurred **Milestone:** Implement enhanced assessment tool for patients with substance abuse and behavioral health issues. **Metric: (MP-I-12)** 12. Enhanced assessments performed on > 25% of all inpatients identified by hospital social workers as having substance abuse or mental health issues (numerator = # of enhanced assessments performed on inpatients identified by hospital social workers as having substance abuse or mental health issues; denominator = total number of inpatients identified by hospital	**Data source:** 16.Hospital and PCMH reporting tools **Milestone:** Reanalyze readmission data and assess for changes and impact of interventions to date **Metric: (MP-P-2-B7)** 17. Identify current key contributing factors to all cause 30 day readmission data for the hospital and compare with 2012 data. Assess impact (if any) of interventions to date on readmissions **Data Source:** 17. Report on data and interventions **Milestone:** Expand percentage of inpatients with substance abuse or behavioral health issues who received enhanced assessment **Metric: (MP-I-12)** 18. Increase percentage of inpatients identified as having substance abuse or behavioral health issues who undergo the enhanced assessment to > 50% **Data Source:** 18. Social work logbooks **Milestone:** Increase percentage of inpatients who have undergone the enhanced assessment for substance abuse or behavioral issues who received telephone follow up post discharge **Metric: (MP-I-13)** 19. Telephone follow up calls (two attempts)

Project 2.1: **Identify opportunities to develop and implement care transition interventions that lead to fewer unplanned admissions (Master Plan Project 2.3)**		
SFY 2012	**SFY 2013**	**SFY 2014**
	social workers as having substance abuse or mental health issues) **Data Source:** 12. Social work logbooks **Milestone:** Implement follow-up calls to inpatients discharged to home that have undergone the enhanced assessment for behavioral/mental health issues in order to review treatment plans and assess compliance. **Metric: (MP-I-13)** 13. Phone calls (two attempts) to reach > 25% of patients identified as having substance abuse or mental health issues (numerator = # of phone calls to patients identified as having substance abuse or mental health issues; denominator = # of patients identified as having substance abuse or mental health issues) **Data Source:** 13. Social work logbooks	made to >50% of those patients identified as having substance abuse or behavioral health issues **Data Source:** 19. Social work logbook

III. Category 2 – Improved Health Outcomes & Quality:

Project 2.2: Develop and co-locate a PCMH primary care site on the Hospital campus as an alternative for non-emergent ER complaints.
Master Plan Project 2.8

- **Goal:** The Hospital will implement a strategy to develop and co-locate a PCMH primary care site with the Greater Lawrence Family Health Center, an independently licensed provider that currently cares for 47,000 patients in the community, to encourage the use of primary care providers for non-emergent care and work to increase the number of patients with a PCP. Using our EMR, the Hospital will analyze complaints that present to the ER, and will stratify the population by those patients without a PCP and those patients with a PCP at GLFHC, perform an environmental scan to survey, assess and determine the reasons why patients are seeking non-emergent care at the ER setting, rather than the health center. The hospital will design and implement an educational program aimed at the two identified populations. The complexity of ED utilization compounded by the population served in the Hospital's ED located in the Gateway City of Lawrence makes this project particularly ambitious. Given the substantial proportion of the population in Lawrence who are low income, travel frequently to their native regions outside the continental United States, move within the varying low-income health coverage options in Massachusetts, the environmental scan will be very important and inform the overall project. Recognizing the challenges associated with screening for a new intervention, and appropriately targeting patients for education in an urban-centered 70,000 visit per year ER/Trauma Center, located in a challenging urban setting, as well as the language barriers, potential lack of health coverage, dental coverage, educational level, prevalence of substance abuse, adult learning challenges and overall reception of patients to receiving the education, the goal is to educate 30% of our identified population. Thirty-percent was selected to provide an incentive for the hospital to choose a larger number of patients, and target them most effectively.

- **Rationale:** The Hospital has made considerable investments, as have other local providers, to expand access to primary care (e.g. new sites, expanded sites and hours, and establishing a joint 30-resident family practice residency that vastly expanded primary care access). Yet the Emergency Department continues to treat more than 70,000 patients each year, many of whom seek non-emergent care and should be seeking care from a PCP. Reliance on the Emergency Department means patients lack continuity in their health care and use costlier services.[27] Reducing non-emergent ER use has been the focus of health plans, CMS and HRSA. HRSA and CMS have worked on Emergency Room diversion programs and awarded grants to 20 states with the goal of finding methods to reduce the use of hospital emergency room visits by Medicaid beneficiaries for non-emergent reasons.[28] Success in these states hinged upon educating the Medicaid population, promoting medical home concepts, and real-time referrals. Pioneering innovations and creative work needs to be undertaken to encourage local residents to seek care from a primary care provider to improve utilization of primary care services and discourage ER use for non-emergent care. The Hospital, in this project, will begin to advance a plan to encourage the use of PCMH PCP's for non-emergent care instead of the ER. EMTALA will be adhered to as we design an educational process. The educational process will be designed to occur after the medical screening and stabilization process.

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[27], Commonwealth Fund, Issue Brief 434, Emergency Department Use: The New York Study.
[28] Testimony of Jim McCrae, Associate Administrator for Primary Care Health, HRSA to US Senate Committee on Health, Education, Labor & Pensions, Subcommittee on Primary Health and Aging, May 11, 2011.

- **Project's Impact to Refine Innovations, Test, and Disseminate Findings:** The project will test new ways of meeting the needs of a targeted population in aiming to encourage the use of the significantly lower cost health center site, by focusing on a subset of the non-emergent patient volume, and encouraging their use of an alternative site where the reimbursement of care is only one-quarter of the average ER visit. Since the City of Lawrence is less than 7 square miles in size, and the health center will gain a 5th site, but its first on the independent hospital's site, there is tremendous opportunity to test this as a new way, in a close-knit health care community, of meeting patient need, and to spread this as a promising practice. Our success in achieving our goals could set a new standard for advancing patients to seek the right care, at the right and the most cost effective place. Findings will be disseminated to the Massachusetts College of Emergency Physicians.

- **Expected Results:** For the first time, the community will have a Greater Lawrence Family Health Center/PCMH primary care site co-located near the Hospital ER, and further encourage the use of primary care in lieu of ER care for non-emergent complaints and connect patients with a PCP.

- **Relation to other Projects**: This project will enhance access to patient-centered primary care. It relates to the Category 1 project "Hospital/PCMH Practice Systems Integration" because it will serve to encourage non-emergent patients, likely a proportion of the target population of that project, to access care at their medical home. Encouraging the use of a PCP and having a medical home relates to the Category 3 project, "Develop organizational infrastructure to enhance capacity to respond to alternative payment methods" because the cost savings, and enhanced PCP enrollment and use are all critical components of success in taking on alternative payment systems. It also supports enhanced access and availability of patient-centered care – hallmarks of an NCQA ACO accreditation.

<table>
<tr><th colspan="3">Project 2.2: Develop and co-locate a PCMH primary care site on the Hospital campus as an alternative for non-emergent ER complaints. (Master Plan Project 2.8)</th></tr>
<tr><th>SFY 2012</th><th>SFY 2013</th><th>SFY 2014</th></tr>
<tr>
<td>Milestone:
Analyze non-emergent ER complaints and identify patient population that utilizes ER for non-emergent complaints.
Metric: (MP-P-1)
1. Documentation of baseline data on most common non-emergent patient complaints for the most recent 12-month period stratified by patient demographic, and PCP. Documentation of baseline number of patients with and baseline number of patients without PCP's who use ER for non-emergent care.
Data Source:
1. Baseline Data Report from Hospital Information Systems.

Milestone:
Establish a PCMH primary care site within close proximity to Hospital ER (co-located). Staff the site, gaining approval (e.g. FTCA coverage etc.) from authorities.
Metric: (MP-I-1)
2. Alternative site open and operating.
Data Source:
2. Documentation of site opening.

Milestone:
Design a screening tool for non-emergent care, which would serve as the method to identify the primary reason a patient sought non-emergent care, and ultimately drive the determination of baseline population
Metric: (MP-P-2)
3. Documentation of screening tool and use to identify target population</td>
<td>Milestone:
Perform an environmental scan that will provide an analysis of the reasons patients seek ER care for non-emergent conditions, separate from the complaint itself, using the screening tool for non-emergent patients
Metric: (MP-P-3)
4. Identify the top 5 reasons non-emergent patients seek care at the ER
Data Source:
4. Documentation of top 5 reasons

Milestone:
Design and implement a process and develop educational materials that highlight the value to patients of having a medical home, and continuity of care, and that also encourages the use of the new PCMH primary care site for target population of patients who utilize the ER for non-emergent complaints. Develop and implement the education to population beginning in year 2 with target reached in year 3.
Metric: (MP-P-4)
5. Documentation of process and methods to encourage and educate patients to use the new site.
Data Source:
5. Documentation of deliberations of ER and PCMH Practice Collaborative.

Milestone:
Determine baseline number of patient population targeted to be encouraged and educated to use the new site through a review</td>
<td>Milestone:
Educate a specific proportion of target population of patients with non-emergent conditions about the new site
Metric: (MP-I-2)
8. Educate 30% of target population
Data Source:
8. Report of targeted population and educational efforts.

Milestone:
Schedule appointments with PCP's for patients who do not have a PCP.
Metric: (MP-I-3)
9. Schedule appointments for 15% of target population.
Data Source:
9. Documentation of appointments scheduled</td>
</tr>
</table>

Project 2.2: **Develop and co-locate a PCMH primary care site on the Hospital campus as an alternative for non-emergent ER complaints. (Master Plan Project 2.8)**		
SFY 2012	**SFY 2013**	**SFY 2014**
Data Source: 3. Reports from Hospital	of patients with non-emergent complaints, without PCP's and those who are patients of the PCMH. **Metric: (MP-P-5)** 6. Documentation of baseline number to be educated to use the new site. **Data Source:** 6. Hospital information system **Milestone:** Design and implement a process and method to educate patients without a PCP about its value to them and a process to schedule an appointment with a PCP before they leave the ER. **Metric: (MP-P-6)** 7. Report of baseline number to be educated and have an appointment with a PCP scheduled. **Data Source:** 7. Documentation of Baseline number.	

IV. Category 3 – Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments.

Project 3.1: Develop organizational infrastructure to enhance capacity to respond to alternative payment systems.
Master Plan Project 3.4

- **Goal:** Lawrence General Hospital and its disparate physician groups have never been organized under one umbrella. In fact they do not, and have not, had any common contracts or database, therefore limiting their ability to receive and manage patient data. The Hospital will restructure and redesign its Physician Hospital Organization (PHO) which will be a related organization that brings independent physicians, small group practices as well as larger medical group practices in the community, together with the Hospital under one organization to advance opportunities to improve clinical integration and ultimately to accept alternatives to fee-for-service payments. The existing PHO has limited membership and limited responsibilities. The new PHO will become known as an ICO, Integrated Care Organization, with its own governance structure and board, physician champions, physician leadership, and functional and administrative staff. With the ICO, the Hospital and local medical community will have the organizational structure in place that will advance their capacity to accept and manage alternatives to fee-for-service payments. As the hospital has supported implementation of EHRs with physicians, we will build on this with additional practices and initiating connectivity with the hospital's information systems. While additional inter-related infrastructure investments are required in terms of IT and care management, the Hospital will design a proposal to take on one alternative payment methodology contract through this project, thereby improving the care within the community with a more coordinated and collaborative care management organization.

- **Rationale:** The Hospital requires the crucial building block of a robust ICO in order to develop the opportunities and requisite expertise and structure to take on alternative payment methods. The new ICO will bring together the Hospital and larger physician community, with the mission of engaging in activities which are necessary and enhance the delivery of health care by hospitals and physicians, including, but not limited to, care management, support of clinical integration, utilization review, quality improvement, data aggregation and analysis, practice management, implementation and management of electronic medical records, contract management, and marketing. As many of our patients see physicians in different, non-aligned practices, the ICO would assist in stripping away the care silos that exist in our community. We believe the physicians will join with us in this ICO in order to gain assistance in preparing for the future and remaining competitive in the marketplace through value added features. Incentives will be aligned where the ICO will support keeping care local, in their practices and at the local hospital through referral management assistance, and will provide education, access to future payment methodologies, tools to assist in quality improvement, clinical coordination, technology improvement and managing for success with future payment methodologies.

  Lawrence General Hospital has been providing the opportunity for its small independent practices to implement an HER and through this project will offer resources to additional practices. We will also pilot connectivity between the hospital and the practices focusing on delivering laboratory results initially, followed by radiology results later, as the first steps in sharing clinical data. Creating this ICO and developing ICO physician leaders are some of the key next steps for the Hospital to advance changes in care delivery, make investments in care coordination, reporting, and the sharing of financial and clinical data. Additionally this structure allows us to propose Project 3.2, "Develop information management capabilities in preparation for accepting alternative payment methodologies". Without the ICO structure it would not be possible to advance shared accountability for the cost and quality of care for a population of patients.

It is essential that the Hospital embark on this initiative that requires a substantial and sustained investment in infrastructure. According to national experts, organizations face different challenges to care delivery and infrastructure improvements but some of the challenges are nearly universal, including financing new efforts and developing appropriate sustainable infrastructure to support these efforts.[29]

- **Expected Results:** Through the establishment of this ICO infrastructure, the hiring of staff within the ICO, the training of physician leadership so that they are well-versed in alternative payment methods and related contracting opportunities, and promotion of health information technology and connectivity, the Hospital will have a critical foundational element in place that will position it to propose to take on an alternative payment methodology contract in the last year of the Waiver. Through the hospital's support of EMR implementations, independent doctors who would not otherwise have been able to afford this technology, will now able to implement the EHR in order to achieve quality improvements and meet Meaningful Use, which is paid directly to the physician, not to the hospital. The EHR will be used by the physician offices for an accurate and accessible medical record, for e-prescribing, billing and for tracking and improving HEDIS quality measures. This project will begin to expand the technology and efficiency for the offices by connecting with the hospital to provide lab results initially, then eventually radiology results, discharge summaries and then electronic orders to the hospital. Future functionality will include provider to provider secure connections and patient portal activity.

- **Relation to other Projects:** This project provides organizational infrastructure needed to enhance reporting and communication and advance the success in a Category 2 project "Identifying opportunities to develop and implement care transitions interventions that lead to fewer unplanned readmissions", Category 3 "Develop information management capabilities in preparation for accepting alternative payment methodologies" and Category 1 "PCP and Specialty Care Expansion and Development" projects.

[29] Lessons from the Field: Making Accountable Care Organizations Real, National Institute for Health Care Reform Research Brief, Number 2, January, 2011

Project 3.1: Develop organizational infrastructure to enhance capacity to respond to alternative payment systems. (Master Plan Project 3.4)		
SFY 2012	**SFY 2013**	**SFY 2014**
Milestone: Restructure and redesign the Hospital-related Physician Hospital Organization (PHO), referred to as an ICO, integrated care organization, to advance the integration of the hospital and local medical community that will serve to enhance capacity to respond to alternative payment systems in the future **Metrics:** 1. Develop and file PHO Articles of Organization and By-Laws (MP-P-1-B1) 2. Establish a governing board and hold at least one ICO Board meeting (MP-P-1-B2) **Data Sources:** 1. Secretary of State filings 2. PHO Board Meeting Minutes **Milestone**: To support clinical integration, continue support of EHR implementations in community physician offices and evaluate options for connectivity between hospital and physician practices **Metrics**: 3. Provide project manager and continue EHR implementation (MP-P-2-B1) 4. Pilot delivery of hospital laboratory results to one clinical information system in at least one physician practice allowing for greater patient safety by having more timely and accurate results. (MP-P-2-B2) 5. Create list of all ambulatory EHR vendors in our physician practices (MP-P-2-B3) **Data Sources**: 3. EHR project plan for 5 practices	**Milestone:** Design an organizational structure and build capacity to run initial critical functions of the ICO **Metrics:** 6. Draft an organizational chart for approval by ICO Board that identifies the staffing disciplines and priority required to run the ICO (MP-P-4-B1) 7. Hire at least two ICO personnel identified as high priority on the organizational chart which may comprise Care Managers, Data Analysts and administrative staff (MP-P-4-B2) 8. Create Clinical Integration Committee of the Board to devise work plan and timeframes for additional investments in IT connectivity and care management initiatives, including creating a vehicle for enhanced communication provider to provider. As referenced in Project 3.2, systems could include a central referral process which would lead to seamless continuity of care. (MP-P-4-B3) **Data Sources:** 6. Documentation of the organizational chart and ICO Board Meeting Minutes. 7. Human Resources hiring records 8. Board meeting minutes and work plan **Milestone:** Identify and develop physician leadership for ICO in order to lead clinical integration activities **Metrics:** 9. Identify at least 3 prospective ICO physician leaders from among the local medical community. (MP-P-3-B1) 10. Provide leadership training for the	**Milestone:** Further develop infrastructure necessary to enhance capacity to respond to alternative payment systems. Part of that capacity will be to improve provider to provider communication and the patient experience. **Metric: (MP-P-5)** 13. Implement critical components of Clinical Integration work plan identified in SFY2013 with the goal of concentrating on those systems that would create a seamless transfer between providers for the care of our patients. (The critical components will be those recommended by the Clinical Integration Committee, as well as identified through management expertise, physician and consultant input as necessary, and approved by the ICO Board of Directors.) **Data Source:** 13. Documentation of the work plan action undertaken to help implement the plan and hiring of staff documented in Human Resource Office **Milestone:** Design an ICO alternative payment method proposal for a payer population including quality goals **Metric: (MP-P-6)** 14. Present ICO proposal to at least one payer under an alternative payment method **Data Source:** 14. Documentation of proposal and performance metrics

Project 3.1: Develop organizational infrastructure to enhance capacity to respond to alternative payment systems. (Master Plan Project 3.4)		
SFY 2012	**SFY 2013**	**SFY 2014**
4. System report of lab results delivery activity 5. Vendor list	prospective ICO physician leaders to assist in education of our entire physician community (MP-P-3-B2) **Data Sources:** 9. Minutes documenting selected leaders 10. Attendance lists at educational sessions **Milestone:** Develop clinical integration plan to include expanding EHR implementation support and interface development **Metrics:** 11. Achieve EHR implementation with fifteen practices in total, or 75% of our independent practices resulting in better coordinated patient care. (MP-I-1-B1) 12. Extend opportunity to the 15 practices for electronic laboratory and radiology results delivery (MP-I-1-B2) **Data Sources:** 11. EHR project plan for 15 practices 12. Documentation of opportunity offered	

IV. Category 3 – Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments.

Project 3.2: Develop information management capabilities in preparation for accepting alternative payment methodologies.
Master Plan Project 3.3

- **Goal:** Lawrence General Hospital and its physician community have not had the capabilities nor the systems to track and analyze our patient utilization and quality data in order to coordinate care so that we can respond to alternative payment methodologies and better manage care. This project will first ascertain the amount and kind of data available in our health care community, then plan and implement appropriate systems or processes to be able to manage future payment methodologies. Lawrence General Hospital has numerous physician partners aligned with different academic centers and all on different systems. The project will catalog the data, the systems and their effectiveness. Through review, we will work with our ICO to centralize all the disparate data to make it useable and actionable at the local level. This will allow us to track our population and manage it more efficiently by comparing service utilization against state and national benchmarks. Additionally we could aggregate practice quality scoring on a community basis and target improvement areas. In managing the care delivered, LGH and its partners will be able to accept alternative payment methodologies while improving quality and reducing costs.

- **Rationale:** It is imperative that LGH and its community partners work together more effectively, across systems, in order to capture needed data and better manage care across the continuum. The formation of our ICO, as described in project 3.1, “Develop organizational infrastructure to enhance capacity to respond to alternative payment systems,” will provide the platform for the work of this project to analyze and develop our information management capabilities. All three of our major physician groups are on different systems and therefore the data sits separately, is disjointed and not complete. With the reformatting of our ICO, we hope to aggregate the data between the hospital and our disparate physician groups. Additionally, we have other major partners, such as the Visiting Nurses Associations (VNA), on a different and unique system, making combining data difficult. This project will explore, recommend, and implement initiatives to combine and centralize the data and make it more useable. As a result we will be able to determine needed quality improvements as well as ways to lower total medical expense. For example eventually, we could aggregate pharmacy data to indentify for different physician practices, their patients who are high risk due to multiple medications prescribed by multiple physicians they have seen, so contra-indications, cost and utilization can be managed. Tracking utilization and leakage will enable the ICO to strengthen referral management, keeping more care local and at a lower cost. This would be done in conjunction with project 1.2, bringing specialty care to our community and giving patients better (and needed) access to care closer to home.

- **Expected Results:** The hospital and its physicians will begin to work together to manage our common population. We will have a complete inventory of services and data available to our local community by working with our local partners, the Commonwealth and payers. After the collection of data is completed we will also hire a consultant and work with the ICO to identify the best systems and processes to capture the data needed to manage care more efficiently.

- **Relation to other Projects:** This is related to the Project 3.1 entitled Develop Organizational Infrastructure to Enhance Capacity to Respond to Alternative Payment Systems and to project 1.2, PCP and Specialty Care Expansion and Development.

Project 3.2: Develop information management capabilities in preparation for accepting alternative payment methodologies. (Master Plan Project 3.3)		
SFY 2012	**SFY 2013**	**SFY 2014**
Milestone: Using ICO Board structure, assess the current state of utilization and cost of care information and tools available to our health care community to control costs and improve quality **Metrics:** 1. Survey and review data available to our key provider partners (MP-P-16-B1) 2. Explore with both commercial payers and Medicaid MCOs the opportunities and criteria to secure data from existing sources. (MP-P-16-B2) 3. Plan and schedule educational seminars and written communications for provider community about health care transformation including opportunities to manage cost of care and utilize local clinical resources (MP-P-16-B3) **Data Sources:** 1. Survey sheets 2. Minutes from meetings with payers and PHO Board meetings 3. Written documentation of communications to providers about educational programs	**Milestone:** Engage a consultant to assist ICO to ascertain gaps in available information and develop a plan for types of data systems that would be required to administer and succeed under alternative payment methodologies **Metrics:** 4. Write an RFP in order to assess and engage a consultant to be hired in 2013, to assist in review of our data needs and planning process to move to alternative payments. The consultant will recommend planning steps and data needs. (MP-P-17-B1) 5. Review proposals with ICO members to choose the ideal candidate or group (MP-P-17-B2) 6. Devise a work plan and timeframes to make investments in systems or processes for data collection on quality reporting and utilization that incorporates our health care community, including physicians, hospital and ancillary care providers such as the VNA. (MP-P-17-B3) **Data Sources:** 4. RFP 5. Candidate interview evaluation forms 6. Work plan for system investments	**Milestone:** Implement systems or processes that will facilitate keeping care local, lowering cost, improving quality and accepting alternative payment methodologies **Metrics:** 7. Implement year 1 of work plan to have access to a system to help manage utilization, costs and quality improvement among ICO providers and community participants. (MP-I-5-B1) 8. Produce leakage reports which will define the types of care leaving the LGH community, the locations where that care is being given, and the cost of that care as compared to the cost at LGH. Both quality and utilization data, measured against national standards, will be reviewed by committee in order to identify action plans including peer recommendations for identified outliers. (MP-I-5-B2) **Data Sources:** 7. Work flow diagram; infrastructure investments documentation; minutes from meetings 8. Leakage reports, utilization and quality reports

Project 3.3: Participate in a Learning Collaborative
Master Plan Project 3.9

- **Goal:** Collectively, the DSTI projects proposed in Categories 1, 2 and 3 of this plan have the potential to significantly transform the care experience for Massachusetts residents served by eligible safety net hospitals. As important as individual hospital efforts will be, there is even greater potential value in leveraging the hospitals' efforts for delivery system transformation through the sharing of best practices.

- **Rationale:** Participation in learning collaborative will provide a forum for eligible DSTI safety net providers to learn from other providers that share similar goals and to capitalize on potential synergies in their efforts.

- **Expected Results:** Through this project, the Hospital will join an existing learning collaborative – such as the Brookings-Dartmouth ACO Learning Network or another ongoing learning collaborative that aligns with DSTI goals – or will develop a new learning collaborative designed to support its transformation goals. Demonstration Year 15 (SFY 2012) goals will be for eligible DSTI safety net hospitals to explore existing and/or potential new opportunities for participation in a learning collaborative relative to measure 1 below.

  Potential project elements include (All DSTI hospitals must select from among the following project elements):

  A. Explore existing and/or potential new opportunities for participation in learning collaborative whose goals align with the Triple Aim and DSTI transformation objectives.
  B. Select a learning collaborative in which to participate, which may consist of either:
     1. Identifying and joining an existing learning collaborative whose goals align with the Triple Aim and DSTI objectives; OR
     2. Developing a new learning collaborative structure designed to support the hospital's delivery system transformation goals and to align with the Triple Aim and DSTI objectives.
  C. In the case that a hospital elects to develop a new learning collaborative, establish and implement a new learning collaborative designed to support the hospital's delivery system transformation goals under DSTI and to align with the Triple Aim and DSTI objectives.
  D. Participate actively in the selected or new learning collaborative.in SFY 2013.
  E. Report on lessons learned from participation in learning collaborative as they relate to the hospital's delivery system transformation goals under DSTI.

- **Relation to Other Projects:** The learning collaborative model supports the development of a shared culture of continuous improvement and innovation, which will facilitate and enhance the individual hospitals' efforts to advance the Triple Aim through their DSTI projects.

Project 3.3: Participate in a Learning Collaborative (Master Plan Project 3.9)		
SFY 2012	**SFY 2013**	**SFY 2014**
Milestone: Explore existing and/or potential new opportunities for participation in learning collaborative. **Metric: (MP-P-1)** 1. Hospital meeting minutes and/or documentation of research findings on learning collaboratives. **Data Source** 1. Internal hospital documentation	**Milestone:** Participate actively in learning collaborative. **Metric: (MP-P-5)** 2. Documentation of attendance at and/or participation in learning collaborative activities. **Data Source(s):** 2. Internal hospital documentation and/or learning collaborative documents **<u>Choice of one of the following options for Project Element B (select a learning collaborative in which to participate)</u>**<u>:</u> <u>Option 1 of Project Element B:</u> **Milestone:** Select and join an existing learning collaborative (if selecting option 1 of Project Element B). **Metric: (MP-P-2)** 3. Documentation of hospital joining learning collaborative. **Data Source** 3. Internal hospital documentation and/or learning collaborative documents **OR:** <u>Option 2 of Project Element B:</u> **Milestone:** Develop a new learning collaborative structure (if selecting option 2 of Project Element B). **Metric: (MP-P-3)** 3. Documentation of new learning collaborative goals, structure and membership and/or signed agreement with facilitator of new learning collaborative (if applicable). **Data Source(s):** 3. Learning collaborative documents and/or agreemen	**Milestone:** Participate actively in learning collaborative. **Metric: (MP-P-5)** 4. Documentation of attendance at and/or participation in learning collaborative activities. **Data Sources(s):** 4. Internal hospital documentation and/or learning collaborative documents **Milestone:** Report on lessons learned from participation in learning collaborative as they relate to the hospital's delivery system transformation goals under DSTI. **Metric: (MP-P-6)** 5. Hospital report on lessons learned. **Data Source:** 5. Hospital report

Category 4 – Population Focused Improvements

Pursuant to Section X of Attachment J to the Massachusetts Section 1115 Demonstration Special Terms and Conditions, the purpose of Category 4 is to evaluate the impact of the investments and system changes described in Categories 1, 2 and 3 through population-focused measures. Category 4 metrics recognize that the population-focused objectives do not guarantee outcomes but result in learning, adaptation, and progress. As such, eligible safety net hospitals will measure and report on selected measures but will not have milestones associated with the achievement of specific improvements. Hospitals shall commence reporting Category 4 measures starting in Demonstration Year 16 (SFY 2013).

Common Measures

All participating safety net hospitals will develop plans to report on a core set of Category 4 measures pursuant to Table 1 of Section X.D of Attachment J. Hospitals shall report on 11 Common Measures in Demonstration Year 16 (SFY 2013) and report on one additional Common Measure in Demonstration Year 17 (SFY 2014), for a total of 12 Common Measures in Demonstration Year 17. Because this category involves evaluating the initiatives and system changes described in Categories 1, 2, and 3 through population-focused objectives, the common measure set is organized around the Triple Aim:

Better Care: Improve the overall quality of the US health system by making health care more patient-centered, reliable, accessible, and safe. These goals, set forward by the Institute of Medicine in Crossing the Quality Chasm, are important domains for assessing the effectiveness of care improvements. In the context of the DSTI program, there is a focus on both the quality and experience of patient care.

One area of increasing national attention has been a focus on improvement of care transitions between providers or settings of care. Health care transitions, such as moves in and out of hospitals to post-acute care/nursing home care, home care (with and without home care supports), or outpatient care have been shown to be prone to medical errors; poor care coordination, infections and incorrect usage of medications—leading to potentially avoidable hospital readmissions, less than optimal patient health outcomes, and added health care costs. This is especially the case for complex care needs, patients with social acuity, and co-occurring health conditions.

Given the importance of examining patient care transitions and their effect on patient outcomes, three Common Measures, utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey focus on whether patients' felt they had a good understanding of their medications and care needs post-discharge. Medication adherence and errors are a leading source of unnecessary emergency and acute care; therefore, it is an area of shared focus.[30] Included within the HCAHPS measures is the Three-Item Care Transition Measure (CTM-3). This measure set has recently been added as a voluntary option to the HCAHPS survey.

Better Care also includes a focus on care in Emergency Departments. Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. Overcrowding and heavy emergency resource demand have led to a number of problems, including prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes.

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[30] Forster AJ, Murff HJ, et al. "The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital." *Ann Intern Med.* (2003) 138:161-167.

Lawrence General Hospital DRAFT DSTI Plan August 8, 2012

Better Care Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.1 Care Transitions Measure Set (CTM-3) *Voluntary HCAHPS questions* *Data Source: Hospital vendor or Hospital Compare as available*	Not applicable in DY16. Requires new data capture.	Not applicable in DY16. Requires new data capture.	07/01/12 – 06/30/13	7/31/14
4.2: Patients who reported that staff "Always" explained about medicines before giving it to them. *HCAHPS Composite (Questions 16 & 17)* *Data Source: Hospital Compare*	01/01/11 – 12/31/11	1/31/13	01/01/12 – 12/31/12	1/31/14
4.3: Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home. *HCAHPS Composite (Questions 19 & 20)* *Data Source: Hospital Compare*	01/01/11 – 12/31/11	1/31/13	01/01/12 – 12/31/12	1/31/14

Better Care Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.4: ED Wait Time: Door to Diagnostic Evaluation by a Qualified Medical Personnel *CMS IQR measure (OP-20)* *Data Source: Hospital Compare*	01/1/2012 - 06/30/12	1/31/13	07/1/2012 - 06/30/13	1/31/14

Better Health: Improve the health of the population by supporting proven interventions and enhancing the quality of care delivered. Many of today's individual health care processes are designed to respond to the acute needs of individual patients, rather than to anticipate and shape patterns of care for important subgroups. Population health focuses on segmenting the population, perhaps according to health status, level of support from family or others, and socioeconomic status, to facilitate efficient and appropriate care delivery. The Category 4 common measures share a focus on examining population dynamics. Two CMS Inpatient Quality Reporting/Joint Commission measures report on proven immunization interventions that can improve the health of hospitalized populations following discharge—preventing subsequent care interventions.[31] Two other ambulatory- sensitive measures examine acute admissions for chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) patients—two patient populations of particular concern given their chronic care needs. A fifth measure looks at maternal and child health—examining the incidence of low-birth weight children, a leading determinant of newborn health especially important for Medicaid populations.

Better Health Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.5: Pneumonia Immunization *CMS IQR/Joint Commission measure IMM-1a* [32] *Data Source: Hospital Compare*	01/01/12 – 06/30/12	01/31/13	07/01/12 – 06/30/13	01/31/14

[31] See Specifications Manual for National Hospital Inpatient Quality Measures for selected references on clinical effectiveness of immunizations. Available at http://www.qualitynet.org

[32] CMS and the Joint Commission began collecting this measure effective with January 1, 2012 discharges. IMM-1a includes all inpatients.

Better Health Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.6: Influenza Immunization (seasonal measure) *CMS IQR/Joint Commission measure IMM-2* [33] *Data Source: Hospital Compare*	01/01/12 - 03/30/12	01/31/13	10/01/12- 03/30/13	01/31/14
4.7: Percent of discharged patients under age 75 who were hospitalized for Chronic Obstructive Pulmonary Disease (Ambulatory Sensitive-Condition Admissions Measure) *Modified AHRQ PQI-5: denominator modified to include only discharged hospital inpatients* *Data Source: Hospital billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14
4.8: Percent of discharged patients under age 75 who were hospitalized for Congestive Heart Failure (Ambulatory Sensitive-Condition Admissions Measure) *Modified AHRQ PQI-8; denominator modified to include only discharged hospital inpatients* *Data Source: Hospital billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14
4.9: Low Birth Weight Rate: number of low birth weight infants per 100 births[34] *AHRQ PQI-9* *Data Source: Hospital records*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14

[33] CMS and the Joint Commission began collecting this measure effective with January 1, 2012 discharges. IMM-2 includes all inpatients.
[34] Hospitals without maternity services are exempted from this measure.

Cost-Effective Care: Improve cost-effectiveness of care through improved care delivery for individuals, families, employers, and the government. Measures that provide insights both into improved opportunities for health care delivery and health care cost-effectiveness are an area of particular focus in the Triple Aim. Many of the DSTI Category 1-3 projects include a specific focus on improving population health outside of the walls of the hospital (e.g. Primary Care Medical Homes, Health Information Exchanges, ACO development, etc.); therefore, it will be important to examine measures within the Category 4 Common Measures that look at hospital care indicators that are ambulatory-sensitive and that have the potential for better care coordination or care venues. Preventable readmissions are an area of nationwide focus, both for their cost and health implications, but also because many readmissions are the result of poor care hand-offs and lack of care coordination post discharge. Similarly, many pediatric asthma emergency department visits are potentially avoidable with concerted outpatient management and care plans; therefore, an ambulatory-care sensitive pediatric asthma measure, relevant to Medicaid populations, has been included. Lastly, a measure of early elective delivery examines a practice of care for which the evidence-base suggests can lead to unnecessary newborn complications and health care costs.[35]

Cost-Effective Care Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.10: Hospital 30-day, all-cause readmission rate to the index hospital following a hospitalization for all patients 18 and older (not risk adjusted) *See CMS IQR Readmissions Measures (AMI, CHF, and Pneumonia) for a list of standard exclusions, including: 1) index admissions for patients with an in-hospital death, 2) patients transferred from the index facility to another acute care facility, and 3) patients discharged against medical advice.*[36] *Data Source: Hospital billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14

[35] Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol*. 200:156.e1-156.e4.

[36] In addition, if a patient has one or more admissions within 30 days of discharge from the index admission, only one is counted as a readmission. No admissions within 30 days of discharge from an index admission are considered as additional index admissions. The next eligible admission after the 30-day time period following an index admission will be considered another index admission.

Cost-Effective Care Common Measures	**DY 16 Measure-ment Period**	**DY 16 Reporting Date(s) to EOHHS**	**DY 17 Measure-ment Period**	**DY 17 Reporting Date(s) to EOHHS**
4.11: Percent of Emergency Department visits for children age 18 or less with a primary diagnosis of asthma--Ambulatory Sensitive-Condition *See AHRQ PDI-14 for numerator specification. Denominator specification includes children ages 2 to 17 with an ED visit* *Data Source: Hospital ED billing data*	10/01/11 – 9/30/12	01/31/13	10/01/12 – 09/30/13	01/31/14
4.12: Percent of patients with elective vaginal deliveries or elective cesarean sections at greater than or equal to 37 weeks and less than 39 weeks of gestation completed[37] *MassHealth Maternity Measure-3* *Data Source: MassHealth Quality Exchange(MassQEX)*	07/01/11-06/30/12	1/31/13	07/01/12-06/30/13	1/31/14

Hospital-Specific Measures
In addition to the common measures listed in above, hospitals must select hospital-specific measures on which to report according to the projects they have selected in Categories 1-3. Hospitals must select for reporting in Category 4 a minimum of one measure per project up to a total of 15 Category 4 hospital-specific measures for projects selected in Categories 1-3. Project 3.9: Participate in a Learning Collaborative will not have associated Category 4 hospital-specific measures. Hospitals shall choose from the options listed in the Master DSTI Plan, which are associated with the project in Categories 1-3 to which they pertain.[38]

Project 1.1 Further Development of an Integrated Delivery system that Encompasses the Concept of the Patient-Centered Medical Home
Rationale for Measures

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[37] Hospitals without maternity services are exempted from this measure.
[38] Hospitals must ensure that sampling procedures consistently produce statistically valid and useful data. If a hospital's denominator population for a given measure is not sufficiently large to produce statistically valid data, then hospitals shall not be required to report the data under Category 4 measures.

The shared patient population for the hospital and the PCMH is predominantly Latino. The 2007-2009 National Health Interview Survey estimated that 11.8 percent of Hispanics are diabetic as compared with 7.1% of non-Hispanic whites. In addition the PCMH has an established record of improving care for diabetics in an outpatient setting. By improving care coordination for patients transitioning to and from the hospital and the PCMH we expect to impact the number of diabetic related 30-day readmissions. Therefore we will measure 30-day readmission rates for patients discharged with a primary diagnosis of diabetes.

Project 1.2: Primary Care Physician, Specialty Care and Provider Care Expansion and Development
Rationale for Measures
The key aspect of this project is to ensure access to appropriate care locally for the patient population in the Lawrence General Hospital community, which leads to cost efficiency and better coordinated care for the population. We will measure access to primary care services to determine the impact of this project over the three years. Access will be measured by the time to the third next available appointment at local primary care physicians' offices, compared to the baseline year.

Project 2.1 Reduction in Unplanned 30 Day Readmissions
Rationale for Measure
The goal of project 2.1 is to reduce health care costs and improve outcomes by improving care transitions between caregivers. We have previously identified CHF diagnoses as one of the top reasons for readmission within the hospital's patient population. It is expected that actions taken to improve care transitions will result in an overall impact on unplanned readmissions. By tracking readmissions related to this specific high-risk diagnosis over the length of the project we intend to identify any differences related to our interventions.

Project 2.2 Develop and co-locate a PCMH primary care site on the Hospital campus as an alternative for non-emergent ER complaints.
Rationale for Measure
In co-locating an independent but affiliated PCMH primary care site as a strategy to encourage more patients to seek care for non-emergent ER complaints at a medical home rather than the Emergency Department, we expect visits by the patients we seek to re-direct to that site, to grow. We also seek to reduce the number of non-emergent ER complaints. We expect that the interventions undertaken to educate patients and book appointments will impact the number of patients seen at this new site, as well as the number of non-emergent patients we care for in the Emergency Department. The measures we have chosen seek to measure and report the impact of this project's focused work to encourage patients to go to the PCMH site. The measures are comprehensive. Separately measuring the percentage of each non-emergent ESI level of care as a percent of the total, and reporting that annually will allow us to measure where we have been successful more accurately.

Project 3.1: Develop organizational structure to enhance capacity to respond to alternative payment systems.
Rationale for Measure
The goal of this project is to bring our entire local medical community of physicians together under one organization as an Integrated Care Organization (ICO) in order to improve clinical integration and ultimately to accept alternatives to fee for service payments. This will allow us to expand the patient population as well that will be represented by these physicians and who will benefit from enhanced care coordination between and among physician offices and the hospital. Additionally we will have helped implement an electronic health record in independent primary care practices in order to further this goal. HIT adoption supports our ICO's ability to improve quality and manage the cost of care for our patient populations. From the Medicare Shared Savings Program

quality measures, we will utilize the Care Coordination/Patient Safety domain measure of primary care physicians demonstrating Meaningful Use of an EHR system (ACO11). Achieving Meaningful Use will be an indicator of the patient-focused, high quality care being provided in our community that will support success in future alternative payment systems.

Project 3.2: Develop information management capabilities in preparation for alternative payment methodologies.
Rationale for Measure

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
4.13 Measure Description (Project 1.1) (Customized Measure-Hospital 30-day, all-cause readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a diagnosis of diabetes)	Report Measure: Baseline report of 30 day readmission rates for patients ages 18 and older discharged from the hospital with a diagnosis of diabetes	Report Measure: Report of 30 day readmission rates for patients ages 18 and older discharged from the hospital with a diagnosis of diabetes	Report Measure: Report of 30 day readmission rates for patients ages 18 and older discharged from the hospital with a diagnosis of diabetes

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
Readmission Rate for Patients with diagnosis of DM. We will measure the baseline data for readmissions within 30 days for patients ages 18 and older who have been discharged with a diagnosis of DM. Diabetes will be defined according to the diagnosis related group data used by the AHRQ Prevention Quality Indicators. We intend to run an annual report for	from 6/1/2011-5/31/2012. (Numerator = Patients 18 and older discharged with a diagnosis of diabetes readmitted within 30 days; Denominator = All patients 18 and older discharged with a diagnosis of diabetes)	from 6/1/2012-5/31/2013	from 6/1/2013-5/31/2014

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
Diabetic readmissions over the previous 12 months.			
4.14 Measure Description (Project 1.2) (Customized Measure Using survey sampling techniques, determine time to first appointment and time to third next appointment for patients seeking care with PCP) Using survey sampling techniques, determine time to first appointment and time to third next	Baseline year survey of time to first appointment and time to third next appointment locally for a PCP (numerator=change in the time to first and third appointment shown separately; denominator =baseline	Update survey for primary care access, compare to baseline	Update survey for primary care access, compare to baseline

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
available appointment for patients accessing care at primary care physicians' offices.	time to first and third appointment shown separtately)		
4.15 Measure Description (Project 2.1) (Modified NQF 0330 – Hospital 30-day, all cause, readmission rate to the index hospital following a hospitalization for patients 18 and older discharged with a primary diagnosis of heart failure)	Report measure: 30 day CHF readmission rate for patients discharged with a primary diagnosis of CHF for the period from 6/1/2011-5/31/12 (Numerator = Patients 18	Report measure: 30 day CHF readmission rate for patients discharged with a primary diagnosis of CHF for the period from 6/1/2012-5/31/2013	Report measure: 30 day CHF readmission rate for patients discharged with a primary diagnosis of CHF for the period from 6/1/2013-5/31/2014

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
CHF Readmission Rate for Hospital. We will measure baseline data for CHF readmissions to the hospital. We have identified CHF as a high-risk diagnosis for readmission within our patient population. We will run annual reports on hospital specific unplanned 30 day readmission data for patients discharged with CHF as a primary diagnosis. Diagnosis of CHF will be defined according to the definition used for AHRQ Inpatient	and older discharged with a primary diagnosis of heart failure readmitted within 30 days; Denominator = All patients 18 and older discharged with a primary diagnosis of heart failure)		

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
Quality Indicator related to CHF			
4.16 Measure Description (Project 2.2) (Customized Measure- Average monthly non-emergent Hospital emergency department volume that is level 3, 4, and 5 on the ESI scale, separately, as a percentage of the total ER volume) Measure average monthly percent of non-emergent Hospital emergency department volume of	Report Measure: Measure average monthly non-emergent Hospital emergency department volume that is level, 3, 4 and 5 on the ESI scale, separately, as a percentage of the total ER volume to establish baseline for the period	Report Measure: Measure average monthly non-emergent Hospital emergency department volume that is level 3, 4 and 5 on the ESI scale, separately, as a percentage of the total ER volume for the period 6/1/2012-5/31/13	Report Measure: Measure average monthly non-emergent Hospital emergency department volume that is level 3, 4 and 5 on the ESI scale, separately, as a percentage of the total ER volume for the period 6/1/2013-5/31/14

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
level 3 patients on the Emergency Services Index (ESI) scale as a percentage of the total ER volume for patients to establish baseline. Perform the same measurement for the average monthly percent of level 4 patients on the ESI scale, as well as level 5 patients on the ESI scale.	6/1/2011-5/31/12 (numerator = volume of level 3, 4, and 5 on the ESI scale, separately; denominator = total ER volume)		
4.17 Measure Description (Project 3.1) (Customized Measure -Percent of primary care physicians	Report Measure: Percent of primary care physicians who	Report Measure: Percent of primary care physicians who	Report Measure: Percent of primary care physicians who

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
who successfully qualify for a Medicare or Medicaid EHR Incentive Program payment) From the Medicare Shared Savings Program quality measures, we will utilize the Care Coordination/Patient Safety domain measure of primary care physicians demonstrating Meaningful Use of an EHR system (ACO11). HIT adoption supports our ICO's ability to improve quality and	successfully qualify for a Medicare or Medicaid EHR Incentive Program payment (numerator = # of primary care physicians in our ICO who successfully qualify for a Medicare or Medicaid EHR incentive program; denominator = total # of primary care physicians in our ICO)	successfully qualify for a Medicare or Medicaid EHR Incentive Program payment compared to baseline	successfully qualify for a Medicare or Medicaid EHR Incentive Program payment compared to baseline

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
manage the cost of care of our patient populations.			
4.18 Measure Description (Project 3.2.) (Customized Measure Report of claims based utilization data for targeted population and service lines compared to benchmarks) For a targeted population, acquire baseline patient care utilization for a specified set of services and	Report Measure: Determine baseline utilization by reviewing data for a targeted population and specified set of services (no numerator/denominator - comparisons to	Report Measure: Report of claims based utilization data for targeted population and service lines compared to benchmarks	Report Measure: Report of claims based utilization data for targeted population and service lines compared to benchmarks

This project utilizes the structure of the ICO to assess information currently available from the disparate physician groups and information that will be needed to be able to manage our patient population in a cost effective, coordinated manner. One of the key areas of focus will be review of utilization data that will allow us to understand the amount and types of services being rendered for a targeted population. We can then determine the opportunities for redirecting care from Boston, for example, to the less costly local setting, or other cost reduction and quality improvement opportunities.	**DY 15**	**DY 16**	**DY 17**
Hospital-specific measures			
compare during the three years to determine opportunities for improved care efficiency and coordination.	benchmark)		

Appendix A
Metric Funding Allocation Table

Hospital Name: Lawrence General Hospital
DSTI Proportional Allotment Factor: .0689

DY 15/SFY12		
Cat 1: Integration		
Annual Metric Base Value		$3,349,333
Metric Base Value Adjusted for Proportional Allotment Factor		$230,933
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 1.1		
Metric Base Value Adjusted for # Metrics		$230,933
Metric 1		$230,933
Metric 2		$230,933
Metric 3		$230,933
Metric 4		$230,934
Metric 5		$230,934
Project Subtotal		**$1,154,667**
Project 1.2		
Metric Base Value Adjusted for # Metrics		$577,333
Metric 1		$ 577,333

DY 16/SFY13		
Cat 1: Integration		
Annual Metric Base Value		$5,024,000
Metric Base Value Adjusted for Proportional Allotment Factor		$346,400
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 1.1		
Metric Base Value Adjusted for # Metrics		$346,400
Metric 6		$346,400
Metric 7		$346,400
Metric 8		$346,400
Metric 9		$346,400
Metric 10		$346,400
Project Subtotal		**$1,732,000**
Project 1.2		
Metric Base Value Adjusted for # Metrics		$433,000
Metric 3		$ 433,000

DY 17/SFY14		
Cat 1: Integration		
Annual Metric Base Value		$5,024,000
Metric Base Value Adjusted for Proportional Allotment Factor		$346,400
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 1.1		
Metric Base Value Adjusted for # Metrics		$866,000
Metric 11		$866,000
Metric 12		$866,000
Metric		$
Metric		$
Metric		$
Project Subtotal		**$1,732,000**
Project 1.2		
Metric Base Value Adjusted for # Metrics		$346,400
Metric 7		$ 346,400

Metric 2		$577,334
Metric		$
Metric		$
Metric		$
Project Subtotal		**$1,154,667**
CAT 2: Innovations		
Annual Metric Base Value		$3,349,333
Metric Base Value Adjusted for Proportional Allotment Factor		$230,933
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 2.1		
Metric Base Value Adjusted for # Metrics		$164,952
Metric 1		$164,952
Metric 2		$164,952
Metric 3		$164,952
Metric 4		$164,952
Metric 5		$164,952
Metric 6		$164,953
Metric 7		$164,953
Project Subtotal		**$1,154,666**
Project 2.2		
Metric Base Value Adjusted for # Metrics		$384,889
Metric 1		$384,889
Metric 2		$384,889
Metric 3		$384,889
Metric		$

Metric 4		$433,000
Metric 5		$433,000
Metric 6		$433,000
		$
Project Subtotal		**$1,732,000**
CAT 2: Innovations		
Annual Metric Base Value		$5,024,000
Metric Base Value Adjusted for Proportional Allotment Factor		$346,400
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 2.1		
Metric Base Value Adjusted for # Metrics		$288,667
Metric 8		$288,667
Metric 9		$288,667
Metric 10		$288,667
Metric 11		$288,667
Metric 12		$288,666
Metric 13		$288,666
Project Subtotal		**$1,732,000**
Project 2.2		
Metric Base Value Adjusted for # Metrics		$433,000
Metric 4		$433,000
Metric 5		$433,000
Metric 6		$433,000
Metric 7		$433,000

Metric 8		$346,400
Metric 9		$346,400
Metric 10		$346,400
Metric 11		$ 346,400
Project Subtotal		**$1,732,000**
CAT 2: Innovations		
Annual Metric Base Value		$5,024,000
Metric Base Value Adjusted for Proportional Allotment Factor		$346,400
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 2.1		
Metric Base Value Adjusted for # Metrics		$288,667
Metric 14		$288,667
Metric 15		$288,667
Metric 16		$288,667
Metric 17		$288,667
Metric 18		$288,666
Metric 19		$ 288,666
Project Subtotal		**$1,732,000**
Project 2.2		
Metric Base Value Adjusted for # Metrics		$866,000
Metric 8		$866,000
Metric 9		$866,000
Metric		$
Metric		$

Project Subtotal		**$1,154,667**
CAT 3: Payment Reform		
Annual Metric Base Value		$3,349,333
Metric Base Value Adjusted for Proportional Allotment Factor		$230,933
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 3.1		
Metric Base Value Adjusted for # Metrics		$230,933
Metric 1		$230,933
Metric 2		$230,933
Metric 3		$230,933
Metric 4		$230,933
Metric 5		$230,933
Metric		$
Project Subtotal		**$1,154,665**
Project 3.2		
Metric Base Value Adjusted for # Metrics		$384,889
Metric 1		$384,889
Metric 2		$384,889
Metric 3		$384,889
Project Subtotal		**$1,154,667**
Project 3.3: Learning Collaborative		
Learning Collaborative Annual Metric Base Value		$837,333

Project Subtotal		**$1,732,000**
CAT 3: Payment Reform		
Annual Metric Base Value		$5,024,000
Metric Base Value Adjusted for Proportional Allotment Factor		$346,400
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 3.1		
Metric Base Value Adjusted for # Metrics		$247,429
Metric 6		$ 247,429
Metric 7		$247,429
Metric 8		$247,429
Metric 9		$ 247,429
Metric 10		$247,428
Metric 11 Metric 12		$247,428 $247,428
Project Subtotal		**$1,732,000**
Project 3.2		
Metric Base Value Adjusted for # Metrics		$577,333
Metric 4		$577,333
Metric 5		$577,333
Metric 6		$577,334
Project Subtotal		**$1,732,000**
Project 3.3: Learning Collaborative		
Learning Collaborative Annual Metric Base Value		$1,256,000

Project Subtotal		**$1,732,000**
CAT 3: Payment Reform		
Annual Metric Base Value		$5,024,000
Metric Base Value Adjusted for Proportional Allotment Factor		$346,400
Project/ Metric	Optional Adjust-ment (%)	Metric Value
Project 3.1		
Metric Base Value Adjusted for # Metrics		$866,000
Metric 13		$ 866,000
Metric 14		$866,000
Metric		$
Metric		$
Metric		$
Metric		$
Project Subtotal		**$1,732,000**
Project 3.2		
Metric Base Value Adjusted for # Metrics		$866,000
Metric 7		$866,000
Metric 8		$866,000
Metric		$
Project Subtotal		**$1,732,000**
Project 3.3: Learning Collaborative		
Learning Collaborative Annual Metric Base Value		$1,256,000

Metric Base Value Adjusted for Proportional Allotment Factor		$57,733
Metric Base Value Adjusted for # Metrics		$ 288,667
	OptionalAdj. (%)	
Metric 1		$288,667
Metric		$
Project Subtotal		**$288,667**
CAT 4: Population Health		
Annual Metric Base Value		N/A
Metric Base Value Adjusted for Proportional Allotment Factor		N/A
Metric Base Value Adjusted for # Metrics		N/A
# Measures Reported		N/A
Category 4 Subtotal		**$0**
Plan Approval (50% total annual allotment)		$7,216,667
Annual Target Total		**$14433333**

Metric Base Value Adjusted for Proportional Allotment Factor		$86,600
Metric Base Value Adjusted for # Metrics		$ 216,500
	OptionalAdj. (%)	
Metric 2		$216,500
Metric 3		$216,500
Project Subtotal		**$433,000**
CAT 4: Population Health		
Annual Metric Base Value		$3,078,431
Metric Base Value Adjusted for Proportional Allotment Factor		$212,255
Metric Base Value Adjusted for # Metrics		$
# Measures Reported		17
Category 4 Subtotal		**$3,608,333**
Annual Target Total		**$14433333**

Metric Base Value Adjusted for Proportional Allotment Factor		$86,600
Metric Base Value Adjusted for # Metrics		$216,500
	OptionalAdj. (%)	
Metric 4		$216,500
Metric 5		$216,500
Project Subtotal		**$433,000**
CAT 4: Population Health		
Annual Metric Base Value		$2,907,407
Metric Base Value Adjusted for Proportional Allotment Factor		$200,463
Metric Base Value Adjusted for # Metrics		$
# Measures Reported		18
Category 4 Subtotal		**$3,608,333**
Annual Target Total		**$14433333**