Advanced Reform Strategy: A Look at Massachusetts and Lahey Health

Chicago, Illinois

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Foundation of the American College of Healthcare Executives

LEADERSHIP CENTER STAGE

2015 CONGRESS ON HEALTHCARE LEADERSHIP

Today's Objectives

- Learn how to position your organization for an advanced reform market
- Learn potential initiatives to achieve desired market positioning

Agenda

- Massachusetts Health Care Reform and Current Market Dynamics
- Lahey Health's Response to Reform
- Lessons Learned: The Journey to Advanced Reform Behavior

MASSACHUSETTS HEALTH CARE REFORM AND CURRENT MARKET DYNAMICS

Massachusetts Health Care Reform

- Enacted in 2006
- Federal reform modeled on it but with some (mostly technical) differences
- Cost control legislation enacted in 2012

What Has Massachusetts Achieved Relative to its Health Coverage Goal?

- 439,000 more Massachusetts residents have gained health insurance coverage than had it before reform
- Massachusetts now has the highest rate of health insurance coverage in the nation
  - 96.9% of Massachusetts residents are insured
  - 98.1% of Massachusetts children are insured

SOURCES: Massachusetts Division of Health Care Finance and Policy, *Key Indicators,* June 2011; Massachusetts Center for Health Information and Analysis, *Massachusetts Health Insurance Survey,* January 2013.

What Has Massachusetts Achieved Relative to its Health Coverage Goal? (continued)

- Since reform, insurance coverage has increased most significantly for non-elderly adults, particularly for low-income adults
- The remaining uninsured are more likely to be young, single, male, non-elderly low-income adults, and/or of Hispanic ethnicity

SOURCES: Massachusetts Division of Health Care Finance and Policy, *Key Indicators,* June 2011; Massachusetts Center for Health Information and Analysis, *Massachusetts Health Insurance Survey,* January 2013.

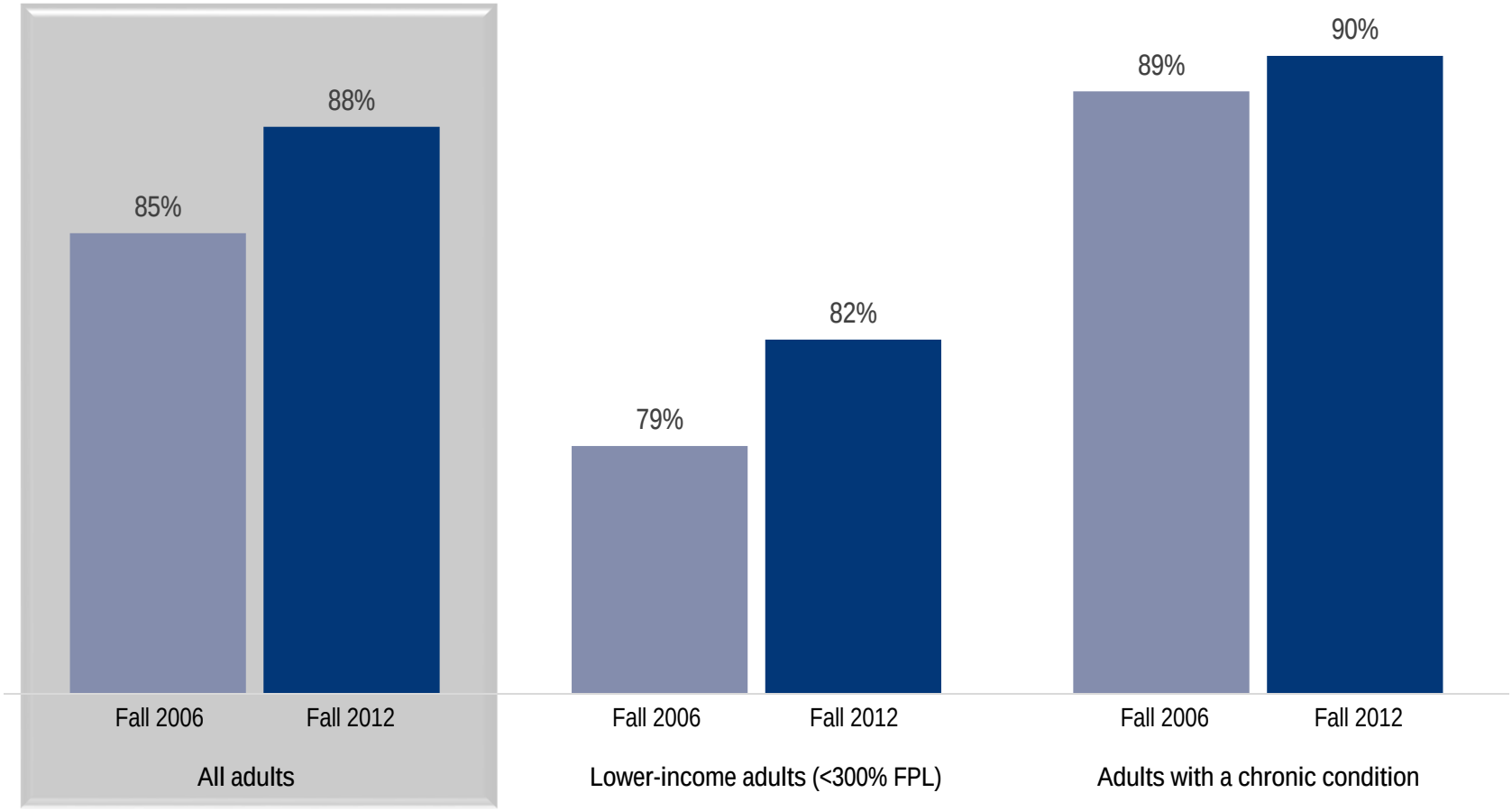
How Has Massachusetts Health Reform Affected Access and Use of Health Care?

- Access to care increased for all adults, with increases in the use of doctors, preventive care, and dental services, and in the percent of adults with a usual source of care
- Racial and ethnic disparities in access to and use of care have decreased significantly
- Even for the remaining uninsured in Massachusetts, access to care improved and barriers to care decreased

SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2010 and 2012.

The Vast Majority Of Massachusetts Adults Have a Usual Source of Care

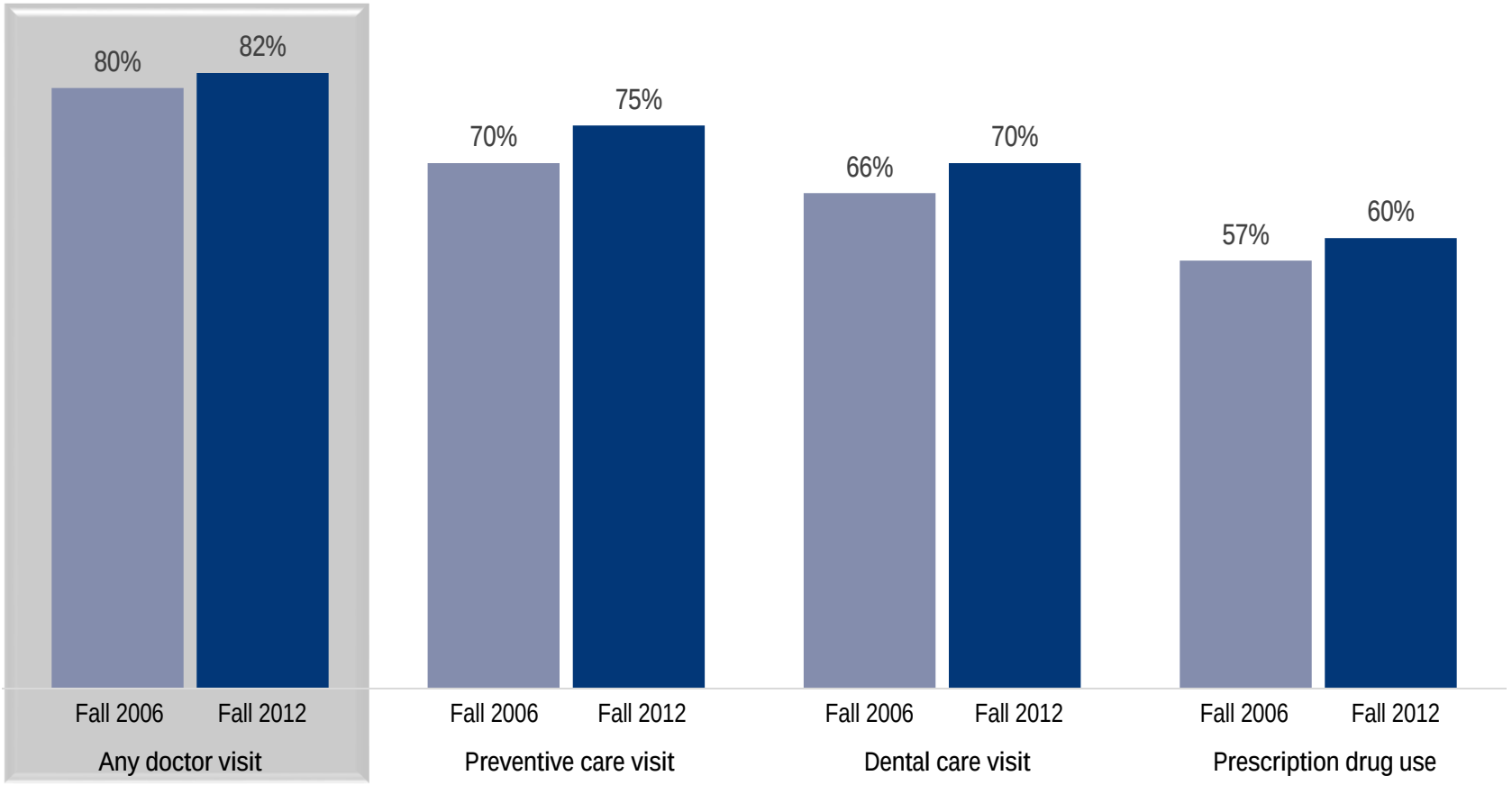
Percent of non-elderly adults reporting a usual source of care, selected populations



SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2014.

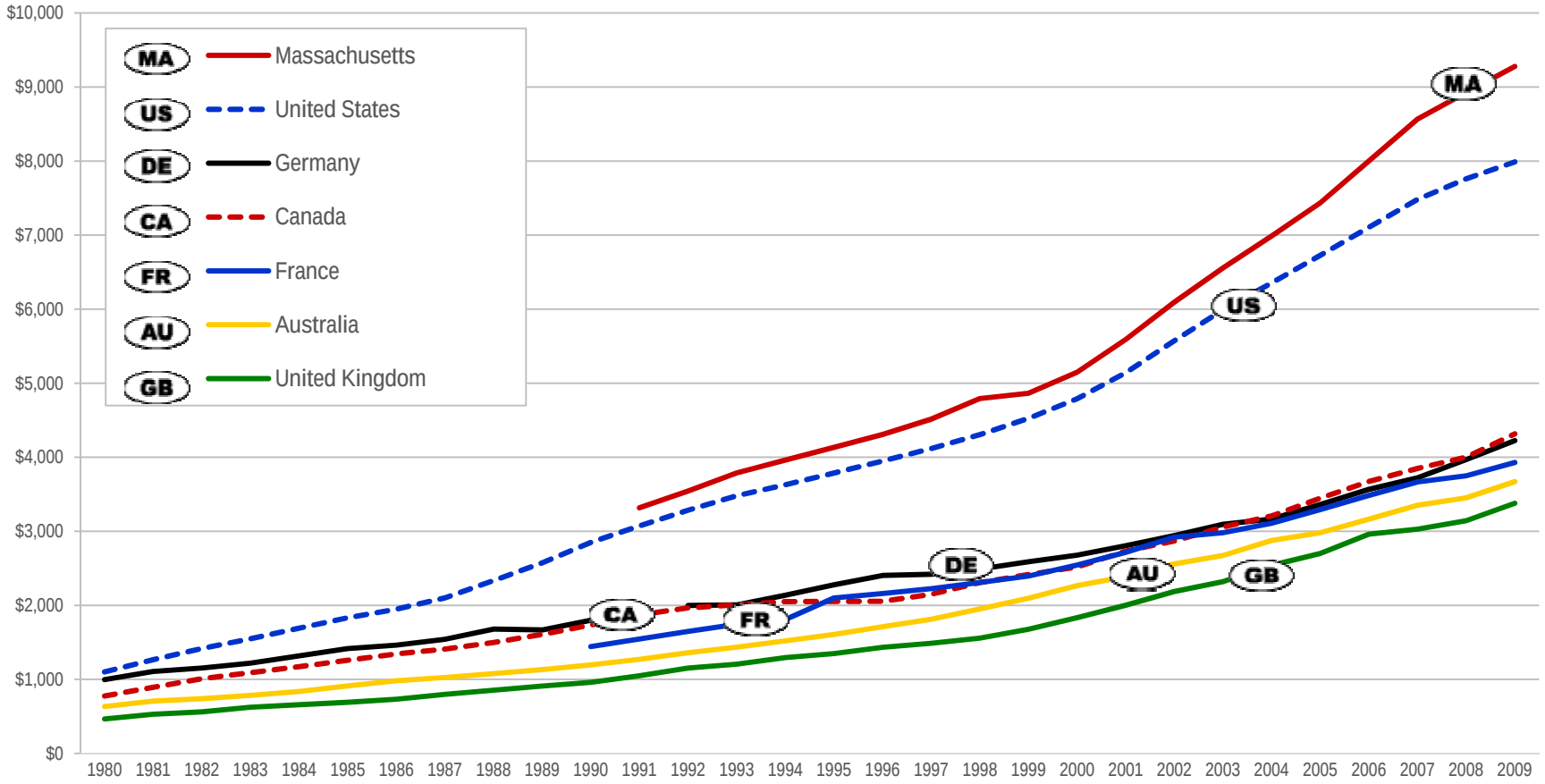
Preventive Care and Use of Other Medical Services Have Increased Among Massachusetts Adults Since Reform

Percent of non-elderly adults reporting use in prior year, by type of service



SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2014.

The U.S. Has the Highest Health Care Expenditures Per Capita Among Industrialized Nations, and Massachusetts Has the Highest Health Care Costs in the U.S. (1980-2009)



NOTE: U.S. dollars are current-year values. Other currencies are converted based on purchasing power parity.
SOURCES: OECD Health Data; *National Health Expenditures by State of Residence*, CMS Office of the Actuary, 2011.

Current Massachusetts Reform Focus

- Focus has shifted from coverage and access to cost control with the 2012 legislation
  - Sets target for state health care spending and regulatory oversight
  - Provider incentives for global and other alternative (to FFS) payment mechanisms
  - Increases transparency on prices of services for consumers
  - Increases regulation of provider price increases

Today's Massachusetts Provider/Insurer Landscape

- Reform has accelerated the impetus for scale and integration
- Three commercial insurers dominate the market
- Health systems are large and growing with Partners Healthcare dominant, especially in the Boston metro area

Today's Massachusetts Provider/Insurer Landscape (continued)

- A handful of independent hospitals exists; physicians moderately consolidated in Boston, less so elsewhere
- Blue Cross and Partners likely long-term players
- Lahey Health and a few other major providers and insurers positioning for long-term roles in the market

LAHEY HEALTH'S RESPONSE TO REFORM

Lahey Health System


Dr. Frank Lahey

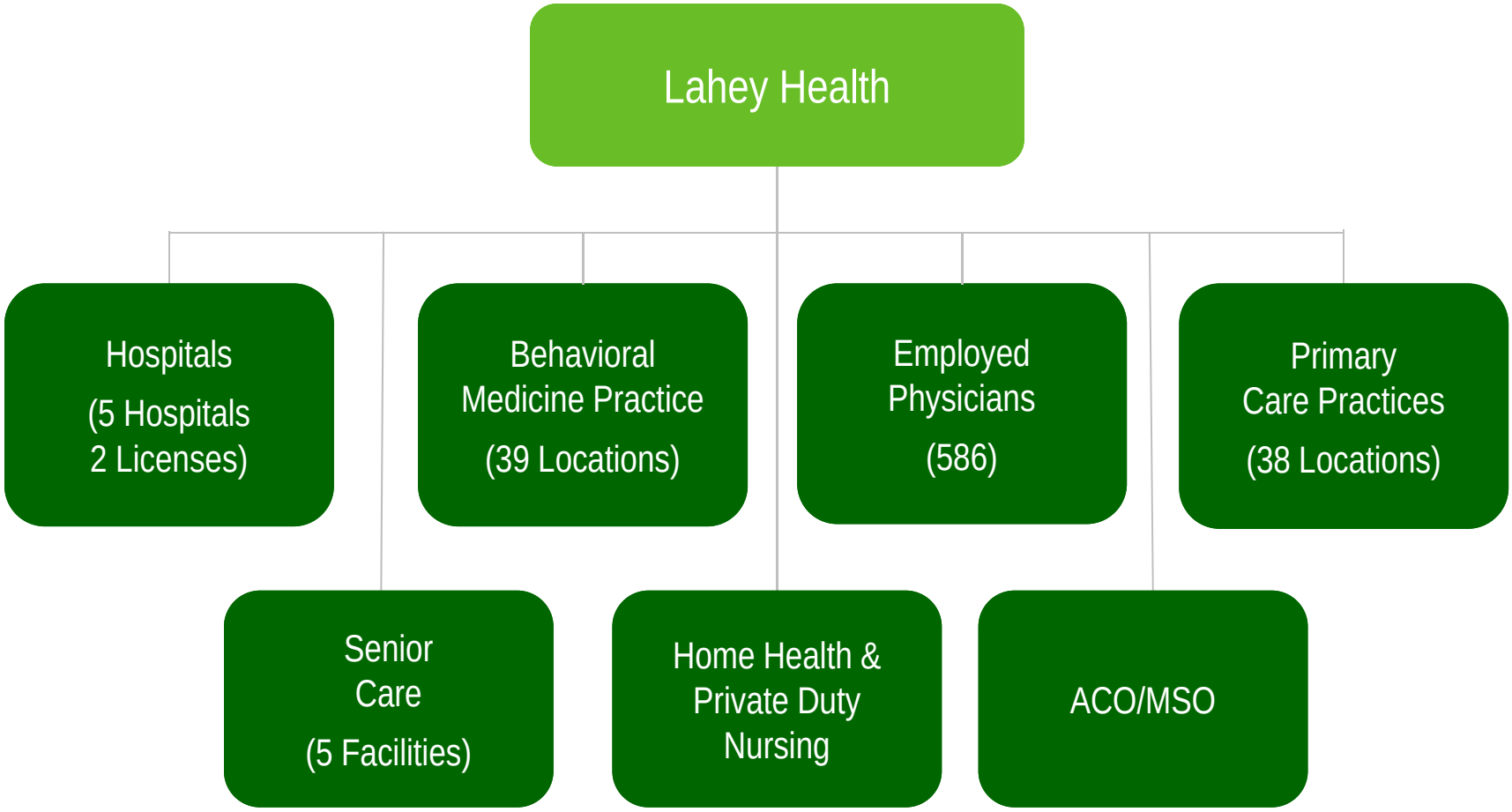
1923: Founded by Frank Lahey, M.D.

Dr. Lahey's vision was Unique:

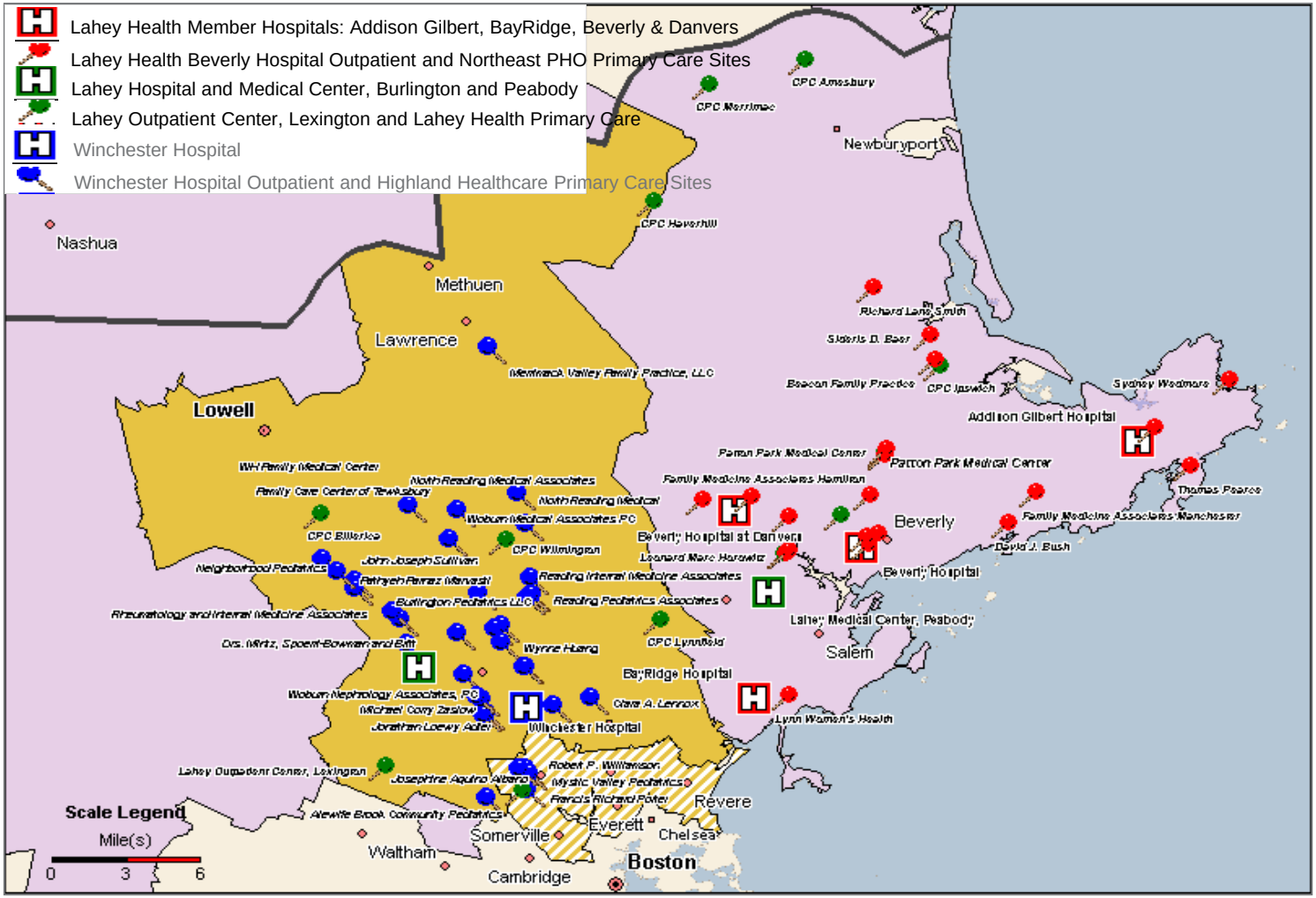
- *Every component of a patient's health care would be coordinated under one roof.*
- *He believed in delivering efficient care.*
- *He also believed that such a group practice should be a center for research and learning.*

1970 Boston		100 MDs
1980	Burlington Hospital & Clinic Open	120 MDs
1993-1998	Creation of Community Based Primary Care	150 MD
1994	Peabody Clinic Open	253 MDs
2012	Lahey Health System Formed in Merger with NE Health System	516 MDs
2014	Winchester Hospital Joined	586 MDs

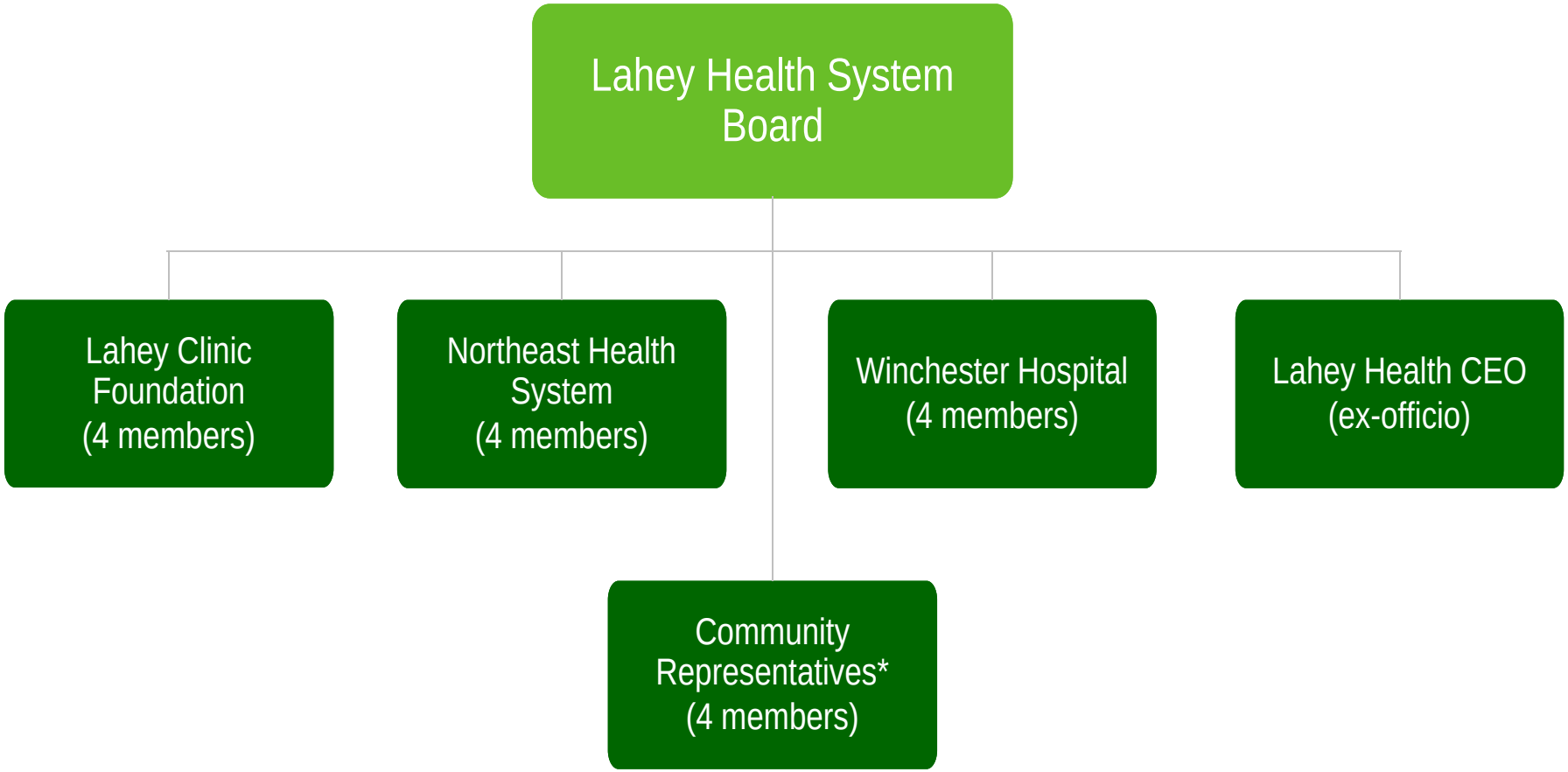
Lahey Health By The Numbers



Highly Coordinated Delivery System



Shared Governance Structure



** No prior relationship to any of the three institutions.*

STRATEGIES & DIRECTION

Value, Population Management, Superb Quality, Patient Experience

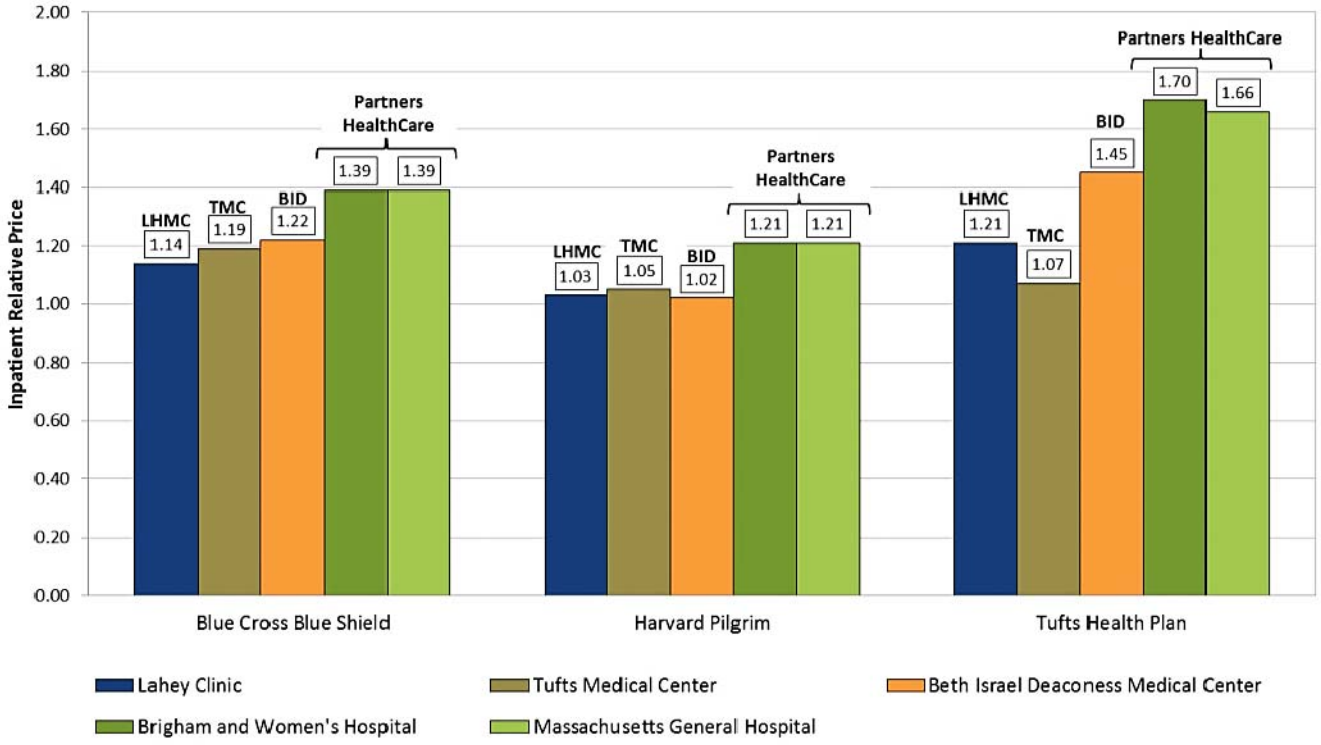
Critical Strategic Questions

- How quickly is the market migrating from fee-for-service to risk contracts?
- What is our ability to manage the transition?
  - Strategy for population management
  - Strategy for maintaining fee-for-service to support the infrastructure costs even in “risk” environment
- How efficient do we need to be to allow continued margin as fee-for-service reimbursement declines?

Value

Lahey Value Proposition

Inpatient Relative Price for Select Hospitals across Major Payers, 2012
Figure 3



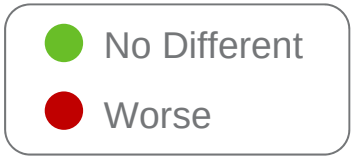
Note: Brigham and Women's Hospital and Massachusetts General Hospital are part of the Partners HealthCare system.

Source: CHIA Annual Report August 2013 Data Appendix.

Relative hospital prices for the three major commercial payers, BCBS, HPHC, and THP, consistent with the HPC's Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates Preliminary Report (HPC Preliminary Report) and representative of the transaction's overall potential impact on commercial prices given these three payers comprise 79 percent of the commercial enrollment in Massachusetts (per Annual Report on The Massachusetts Health Care Market, CHIA, August 2013).

Value | Quality

Quality – National Comparisons



Hospital	30-day Readmission Rates			Serious Complications		
	Heart Attack	Heart Failure	Pneu-monia	Composite	Serious Blood Clots After Surgery	Accidental Cuts & Tears After Medical Treatment
Lahey Hospital & Medical Center (MA)	●	●	●	●	●	●
Massachusetts General Hospital (MA)	●	●	●	●	●	●
Brigham & Women's Hospital (MA)	●	●	●	●	●	●
The Johns Hopkins Hospital (MD)	●	●	●	n/a	n/a	n/a
Cleveland Clinic Foundation (OH)	●	●	●	●	●	●
Hospital of University of Pennsylvania (PA)	●	●	●	●	●	●

SOURCE: Hospital Compare, July 1, 2009 – June 30, 2012.

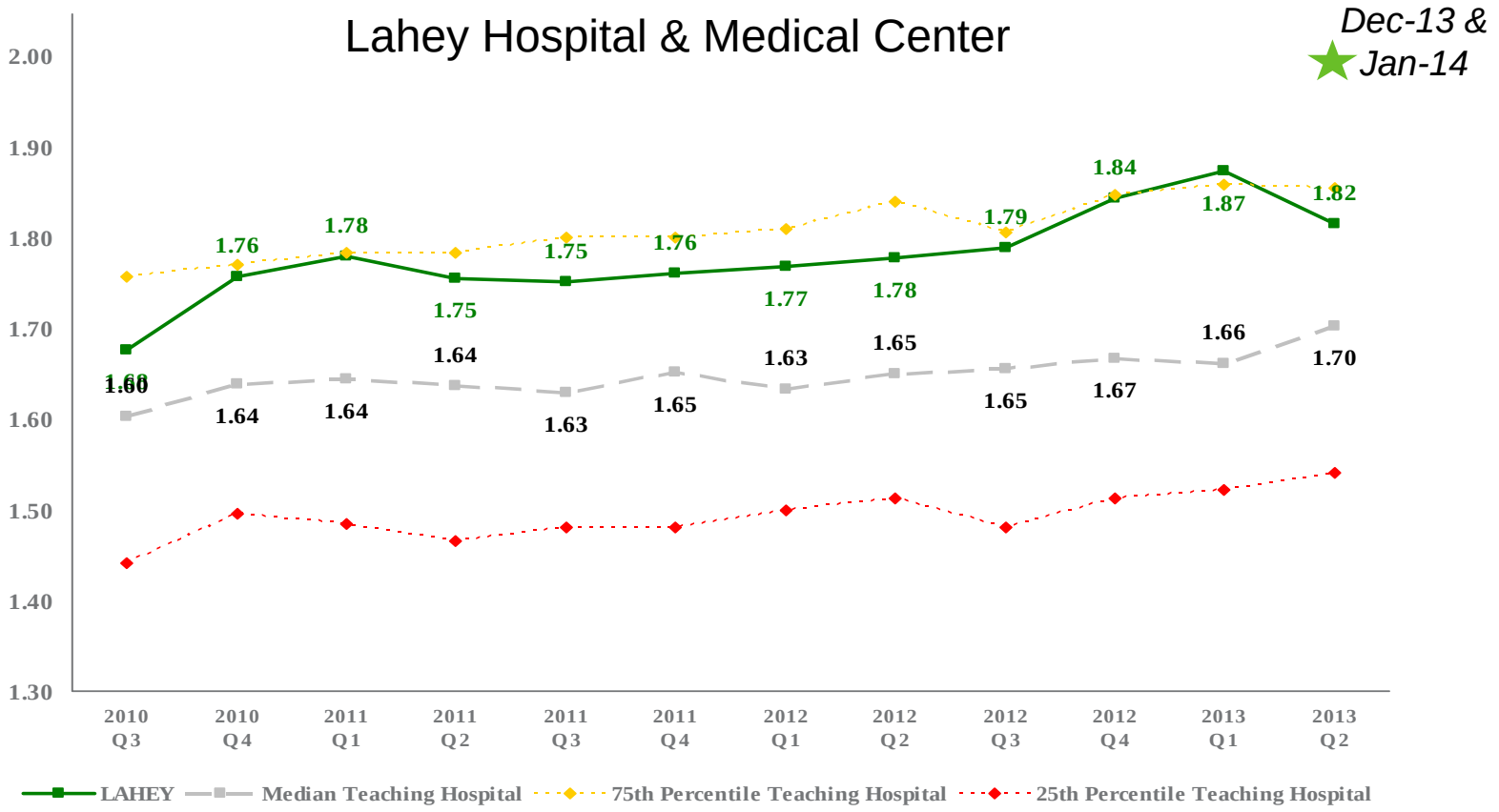
Value

Population Management

Higher is Better

Overall Hospital Case Mix Index

Benchmarked against Median Teaching Hospital



NOTE: Valid n varies from 135 to 164. Overall Hospital Case Mix Index = Overall Hospital Case Mix Index Dec-13 & Jan-14 CMI 1.9286 and 1.9196, respectively (Medicare CMI).
SOURCE: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance.

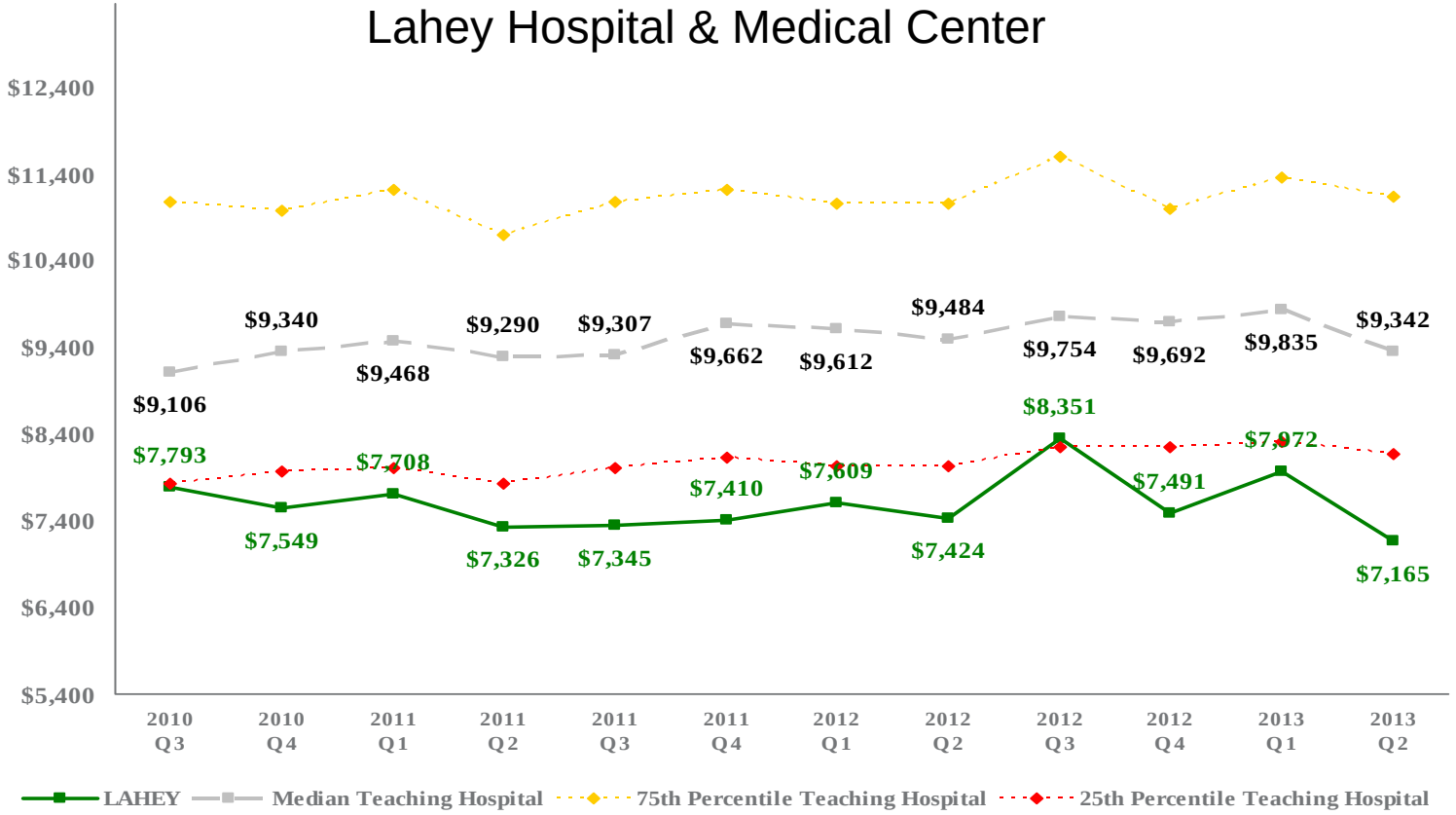
Value

Quality

Lower is Better

CMI Adjusted Expense per Adjusted Discharge

Benchmarked against Median Teaching Hospital



NOTE: Valid n varies from 135 to 164. CMI Adjusted Expense per Adjusted Discharge = (((Total Operating Expense - Total Other Operating Revenue) * (Inpatient Gross Revenue / Total Gross Revenue)) / Total Discharges) / Overall Hospital Case Mix Index.

SOURCE: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance.

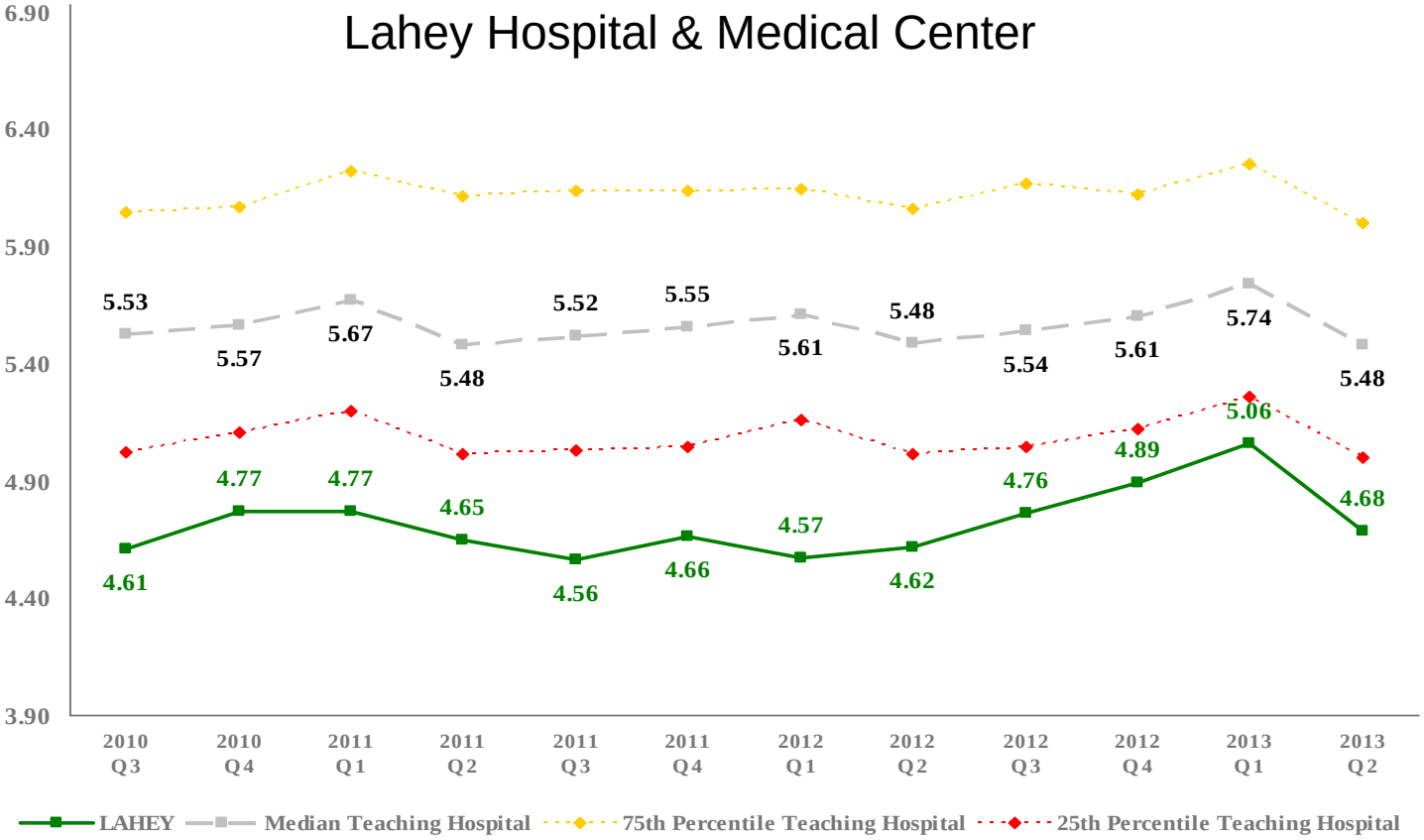
Value

Quality

Lower is Better

Average Length of Stay

Benchmarked against Median Teaching Hospital



NOTE: Valid n varies from 135 to 164. Average Length of Stay = Total Patient Days / Total Discharges.
SOURCE: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance.

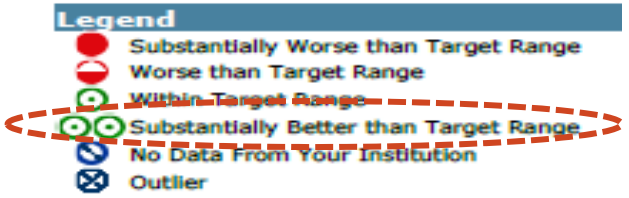
Value

Quality

Lahey Health is Top-ranked by UHC

Value=Quality/Cost

Observed/Expected Cost Ratio



		Apr - Jun 2013 (Q2)					Jul 2012 - Jun 2013 (RECENT YEAR)				
	Relative Performance	Observed	Target	UHC Median	Rank		Relative Performance	Observed	Target	UHC Median	Rank
UHC Key Performance Metrics											
Product Line Specific-CDB											
Medicine General Cost O/E Ratio (obs/exp)	⊙⊙	0.54	0.96	1.12	1/118		⊙⊙	0.55	0.96	1.11	1/118
Cardiac Surgery Cost O/E Ratio (obs/exp)	⊙⊙	0.69	0.99	1.14	3/110		⊙⊙	0.61	1.02	1.15	1/109
Thoracic Surgery Cost O/E Ratio (obs/exp)	⊙⊙	0.52	0.97	1.18	2/118		⊙⊙	0.60	1.03	1.16	2/118
Surgery General Cost O/E Ratio (obs/exp)	⊙⊙	0.55	0.97	1.15	1/118		⊙⊙	0.58	0.99	1.15	1/118
Cardiology Cost O/E Ratio (obs/exp)	⊙⊙	0.71	0.96	1.12	2/118		⊙⊙	0.66	0.98	1.11	1/118
Orthopedics Cost O/E Ratio (obs/exp)	⊙⊙	0.67	0.95	1.14	3/118		⊙⊙	0.66	0.96	1.15	3/118
Obstetrics Cost O/E Ratio (obs/exp)	⊙⊙	0.62	0.94	1.18	3/115		⊙⊙	0.56	0.95	1.19	2/115
Neurosurgery Cost O/E Ratio (obs/exp)	⊙⊙	0.61	0.92	1.09	2/116		⊙⊙	0.63	0.96	1.08	2/117
Gastroenterology Cost O/E Ratio (obs/exp)	⊙⊙	0.59	0.93	1.08	1/118		⊙⊙	0.61	0.94	1.07	1/118
Medical Oncology Cost O/E Ratio (obs/exp)	⊙⊙	0.70	0.86	1.01	8/118		⊙⊙	0.70	0.86	1.00	4/118

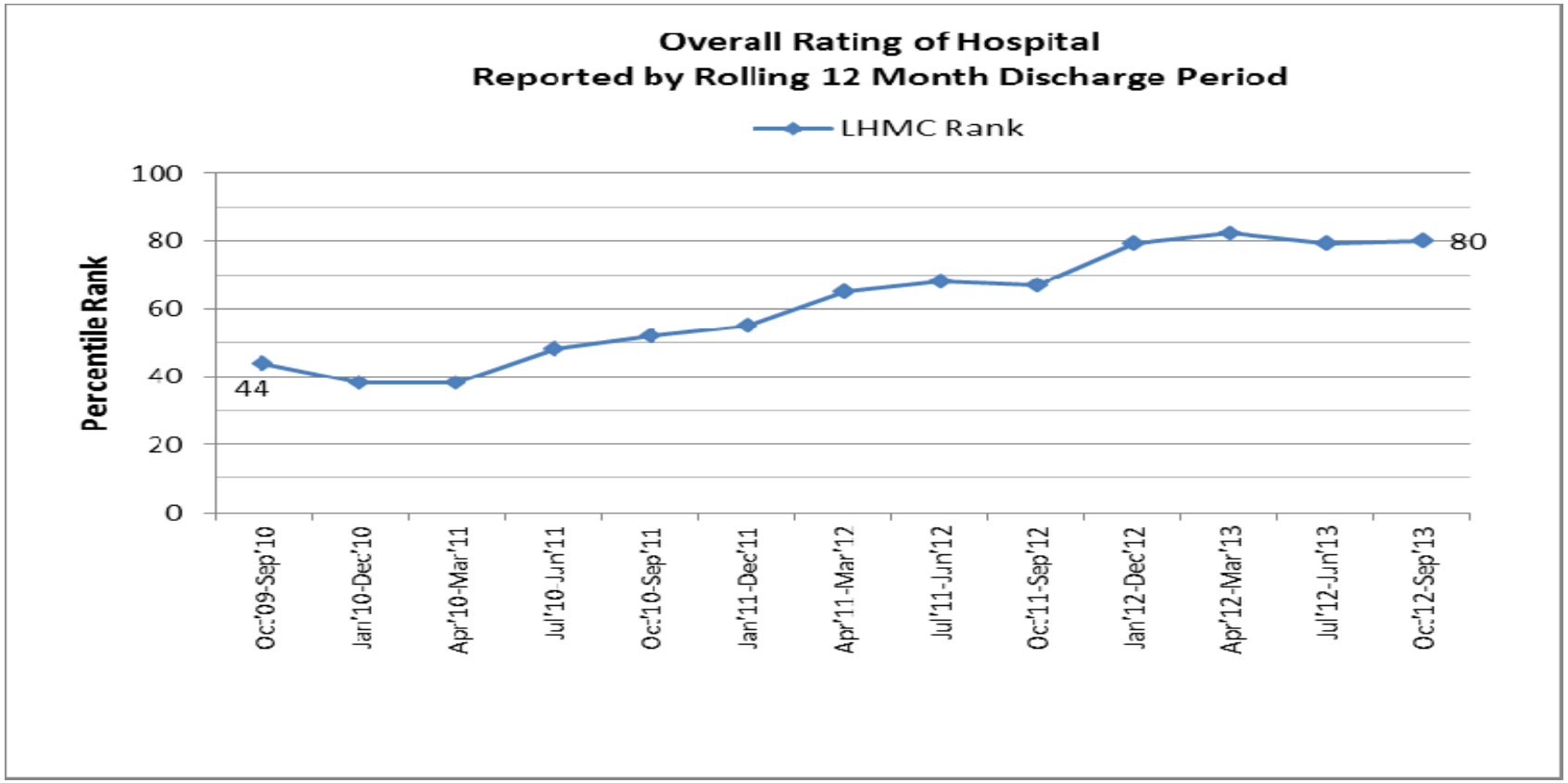
SOURCE: UHC Efficiency Management Report. Top performance level = ⊙⊙. Product lines are defined by MS-DRG;s. Cost O/E is the observed average direct cost per discharge divided by the expected average direct cost per discharge. Direct cost per discharge is estimated from the UHC CDB using a ratio of cost to charges (RCC) methodology.

Value

Population Management

Inpatient HCAHPS Survey – Percentile Rank

Overall Patient Experience



SOURCE: Press Ganey.

Value | Quality | Population Management

One of Nation's Top 100 Hospitals

TRUVEN HEALTH ANALYTICS 100 TOP HOSPITALS

Lahey Hospital & Medical Center recognized as:

- One of only five in the state
- Major Teaching Hospital
  - The only one in the greater Boston area
  - One of 15 in the Top 100

Achievement of Top Quintile compared to peer Major Teaching Hospitals across country in:

- Overall performance
- Mortality
- HCAHPS
- Average Length of Stay (ALOS)
- Core Measures

This recognition requires an institution to demonstrate excellence across all of these dimensions of care.

Value

Patient Experience

NerdWallet Ranks Most Affordable MA Hospitals

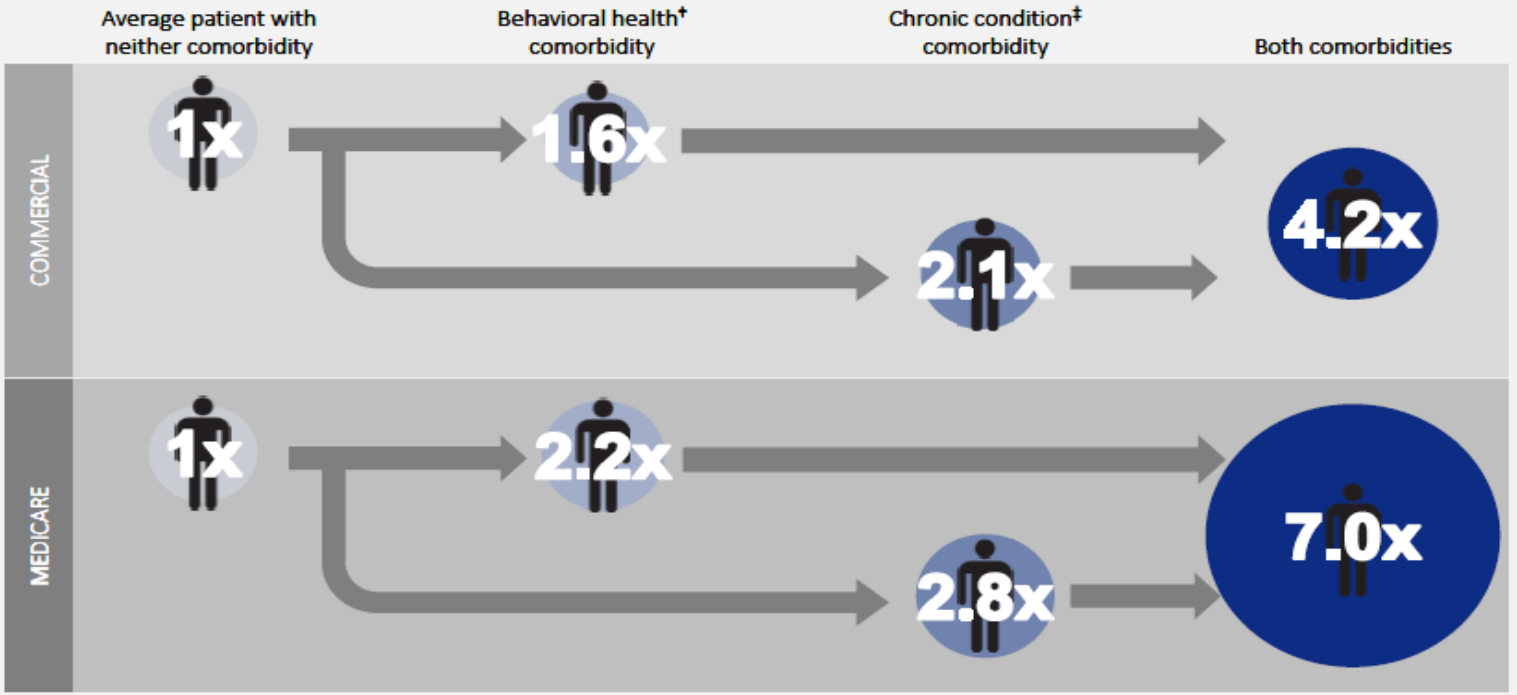
1. Winchester Hospital (Winchester, MA)
2. Morton Hospital (Taunton, MA)
3. Good Samaritan Medical Center (Brockton, MA)
4. Norwood Hospital (Norwood, MA)
5. Falmouth Hospital (Falmouth, MA)
6. Lahey Hospital & Medical Center (Burlington, MA)
7. Beverly Hospital (Beverly, MA)
8. Mount Auburn Hospital (Cambridge, MA)
9. Cape Cod Hospital (Hyannis, MA)
10. South Shore Hospital (South Weymouth, MA)

Value | Population Management | Quality | Patient Experience

The Impact of Chronic Disease and Behavioral Problems

Patients with behavioral health and chronic conditions have significantly higher medical expenditures

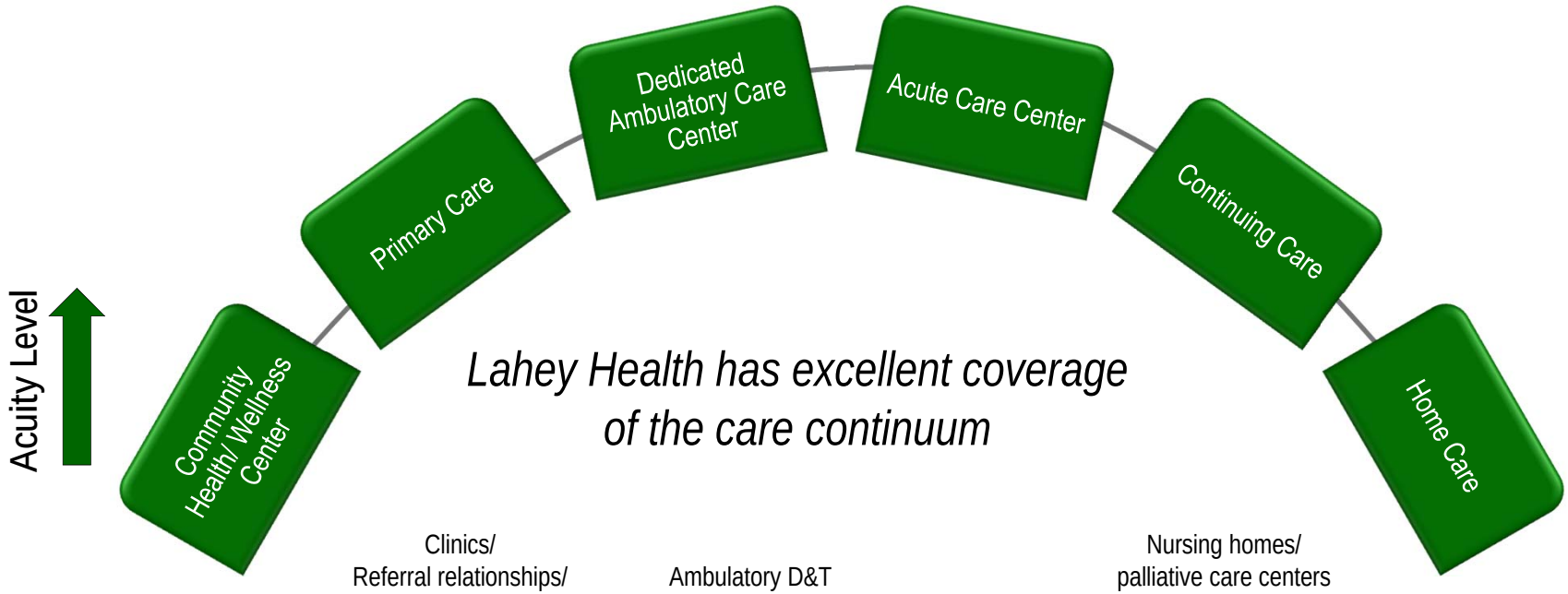
Medical expenditures per patient (excludes drug spending)*
Relative to average patient with no behavioral health or chronic comorbidity in 2010



* The sample for analysis was limited to patients who had continuous enrollment from 1/1/2010 – 12/31/2011 and costs of at least $1 in each year. Figures do not capture pharmacy costs, payments outside the claims system, Medicare cost-sharing, or end-of-life care for patients who died in 2010 or 2011.
† Behavioral health comorbidity includes child psychology, severe and persistent mental illness, mental health, psychiatry, and substance abuse
‡ Chronic condition includes arthritis, epilepsy, glaucoma, hemophilia, sickle-cell anemia, heart disease, HIV/AIDS, hyperlipidemia, hypertension, multiple sclerosis, renal, asthma, and diabetes
Source: All-Payer Claims Database; HPC analysis

Value | Population Management | Quality | Patient Experience

Continuum of Care Gap Analysis

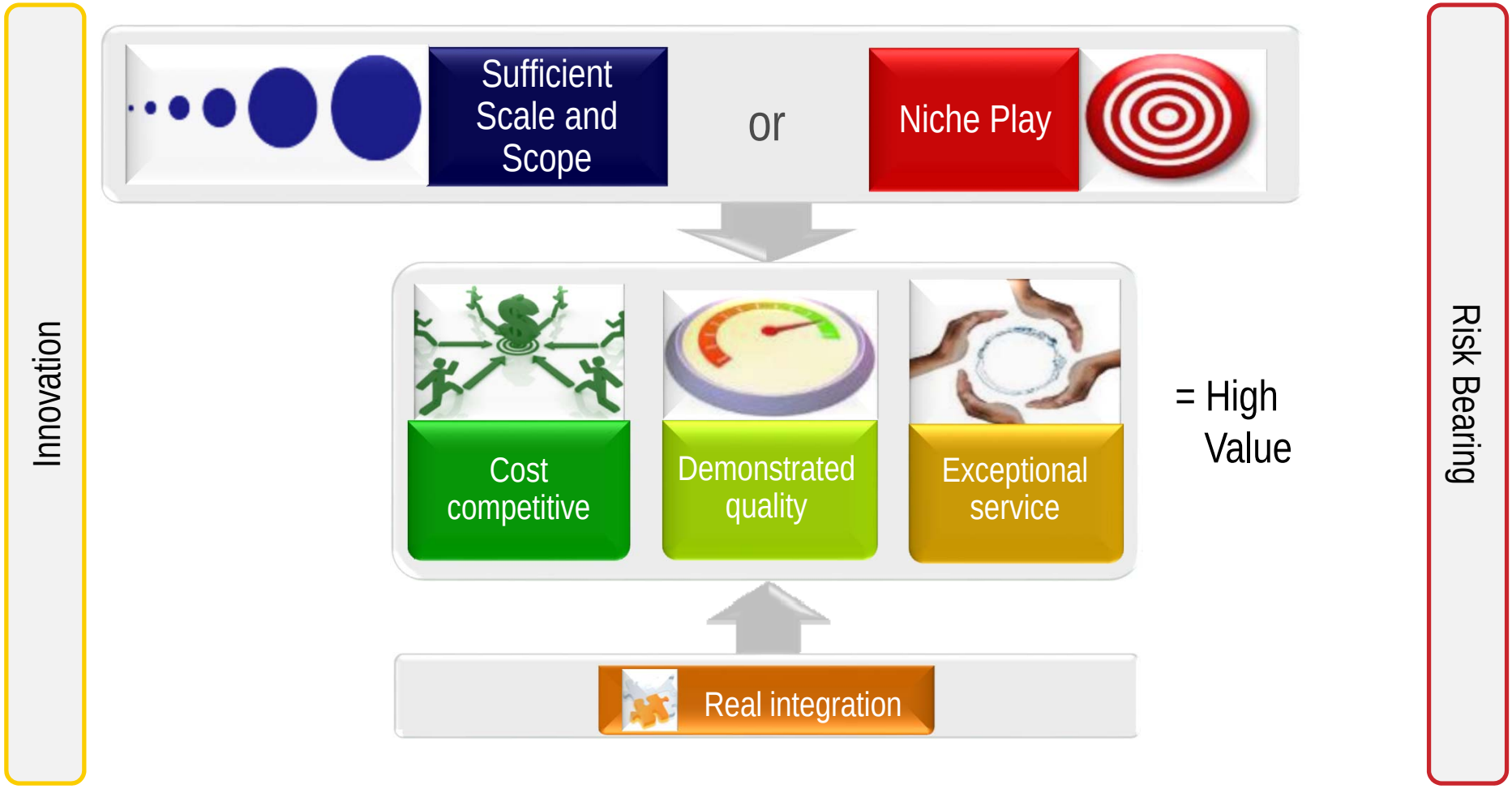


Lahey Health strives to be a complete continuum of quality care that is seamlessly delivered by a community based network of nationally recognized and locally revered primary care physicians, specialists, and organizations.

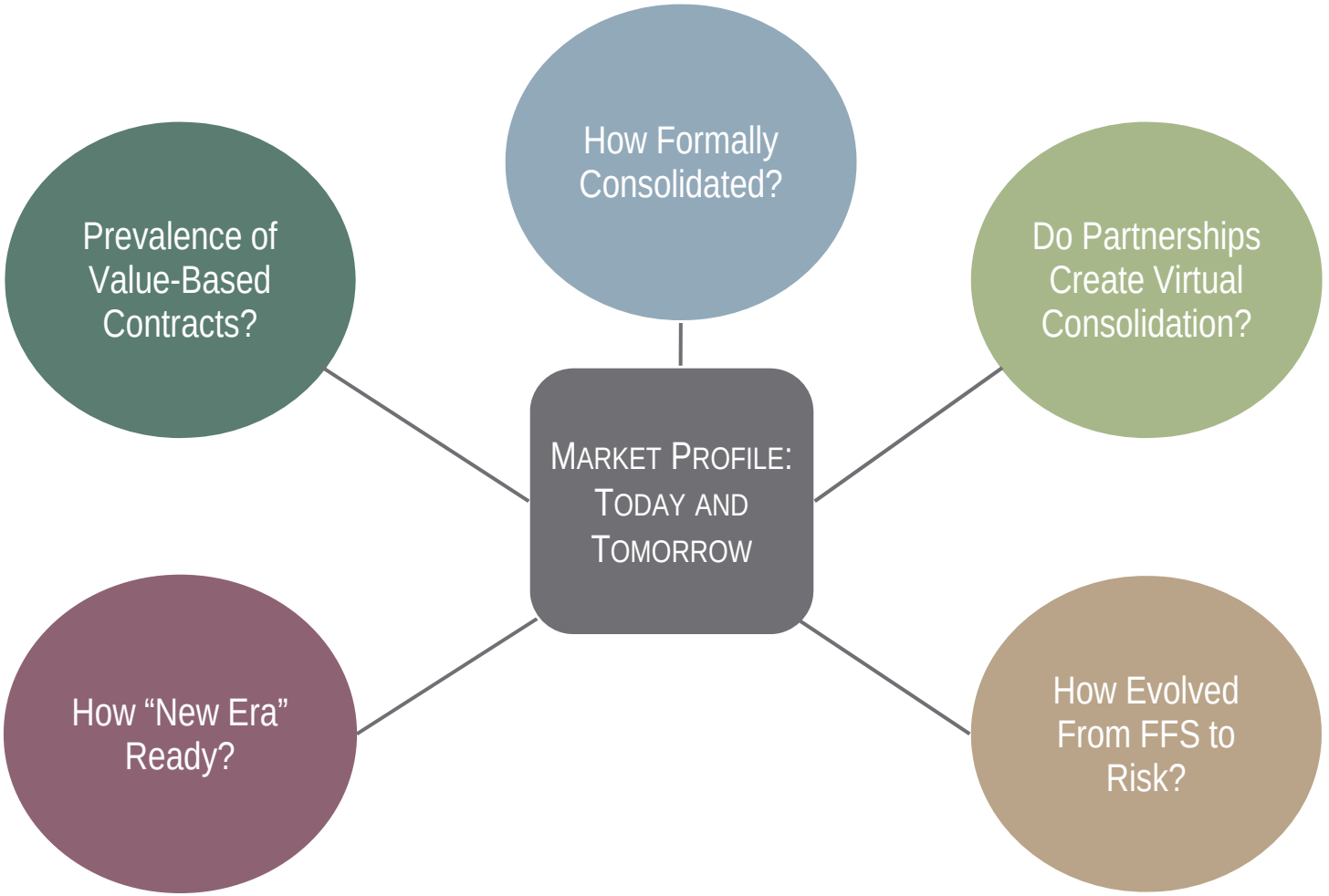
LESSONS LEARNED:
THE JOURNEY TO ADVANCED REFORM BEHAVIOR

ADAPTING TO REFORM: STRATEGIC CONTEXT

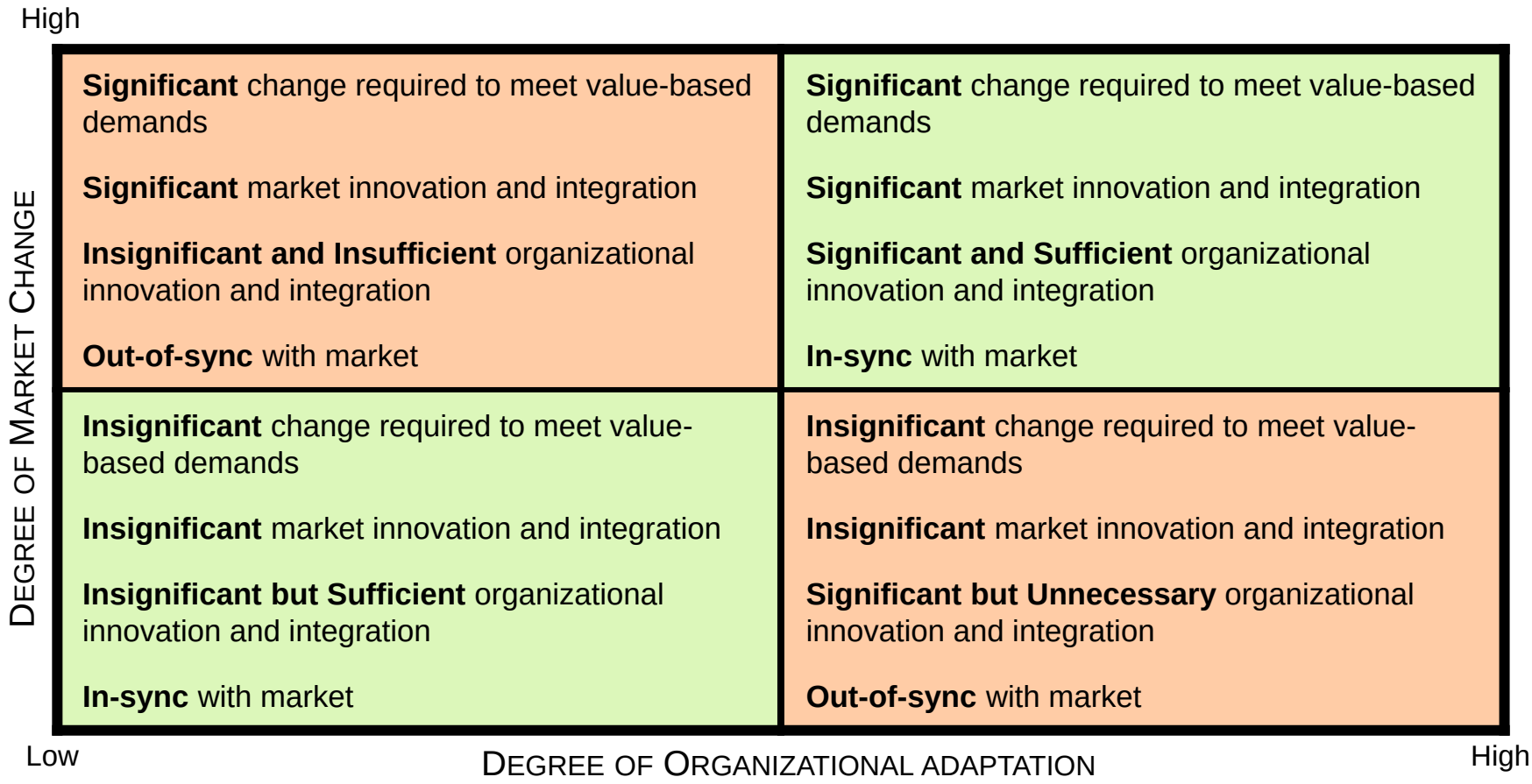
Strategic Imperatives to Win Under Health Reform



Assessing Your Market's Readiness for Change



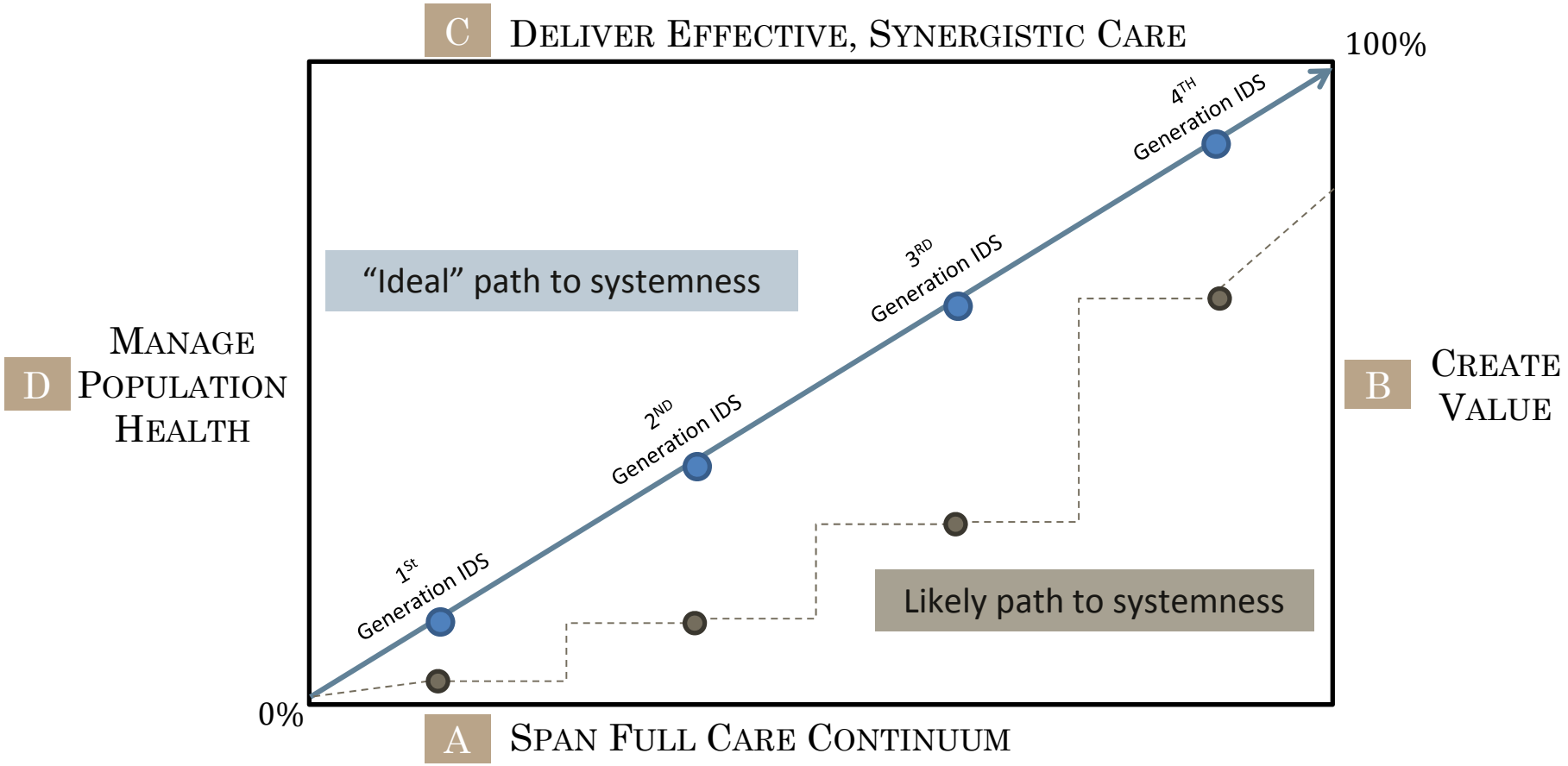
Accounting for Market Pace and Demands



LEGEND

Orange quadrants = out-of-sync with market; financial risk. Green quadrants = in-sync with market; financial sustainability.

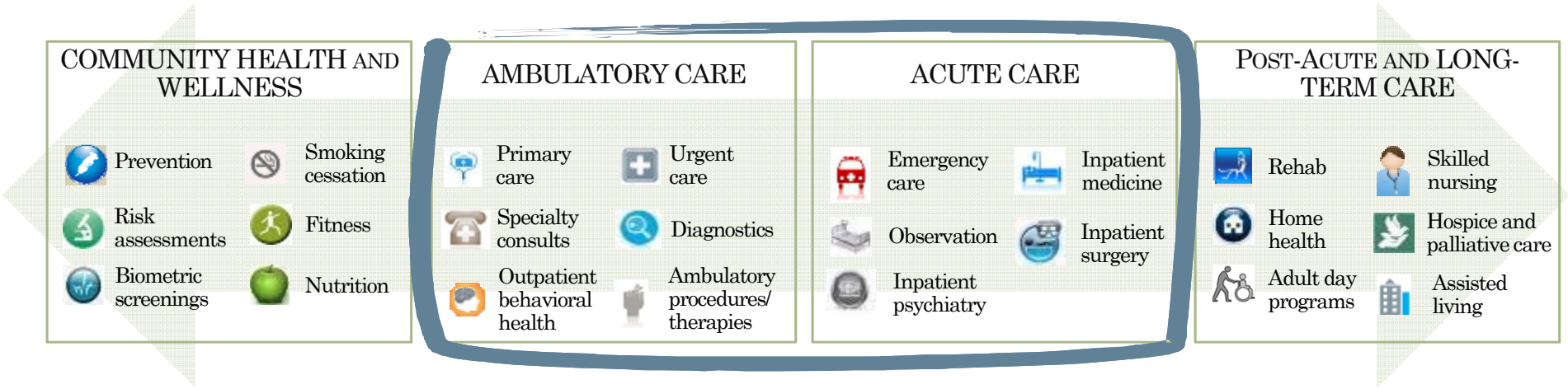
No "Right" Path to Meet Reform Imperatives



It is important to challenge the assumption that the journey to systemness follows a linear path. The reality is that progress toward systemness tends to be non-linear.

INTEGRATION ELEMENTS AND STRATEGIES

A Clinical Care Spanning the Continuum

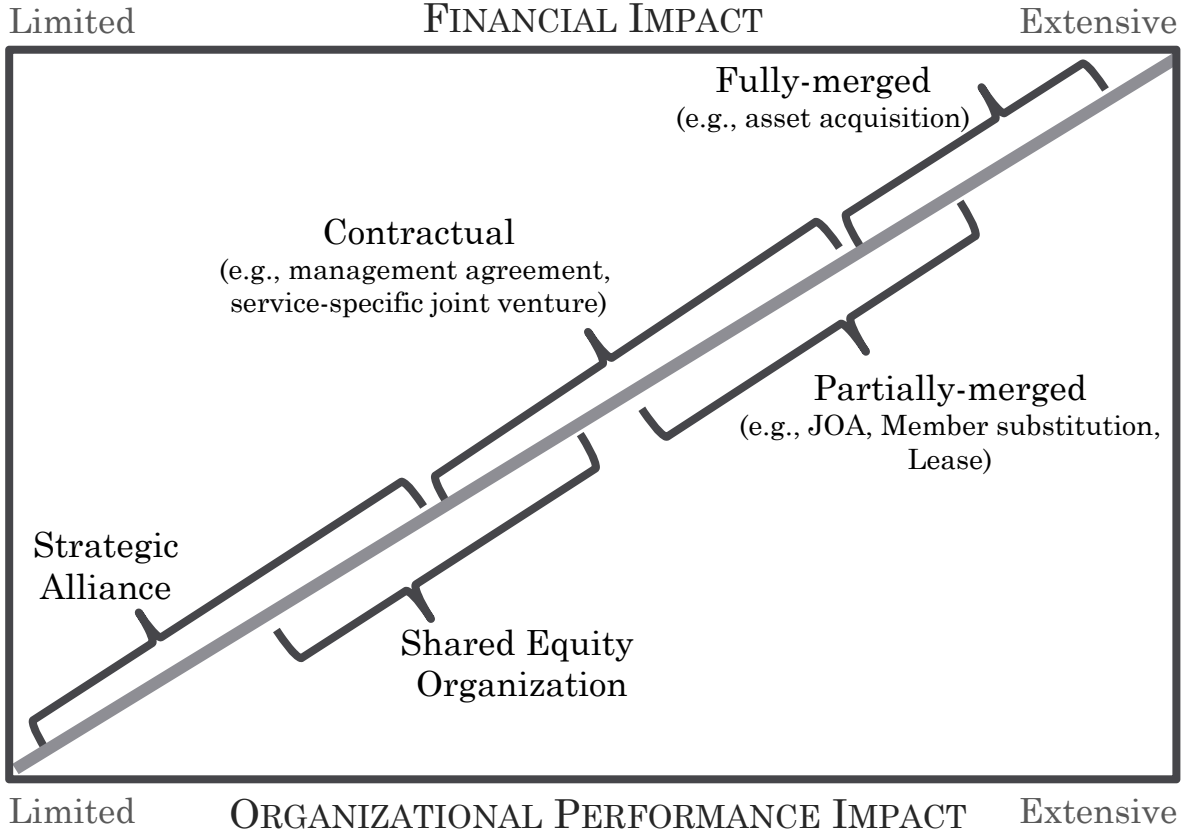


Traditional continuum elements

Early phases of system development often focus on assembling the care continuum beyond traditional ambulatory and acute care elements

A
B

Role of Partnership



Partnership (many possible forms) can facilitate achievement of care continuum scope and provide the scale to deliver value

B Creating and Delivering Value

C System Effectiveness: Organizational Design

Moving From This	To This
Operational silos create communication and service gaps	Synergy among operating units
Turf building and protection impair performance and create dissatisfaction	Morale and organizational results create a positive, mutually reinforcing cycle
Resources strained by duplication and internal competition	Resources deployed to highest strategic priorities
Cumbersome governance structure attempting to control multiple corporations	Streamlined governance structure adding value to the system
Sluggish or dysfunctional decision-making processes	Agile and coordinated decision-making processes

C System Effectiveness: Evolved Quality

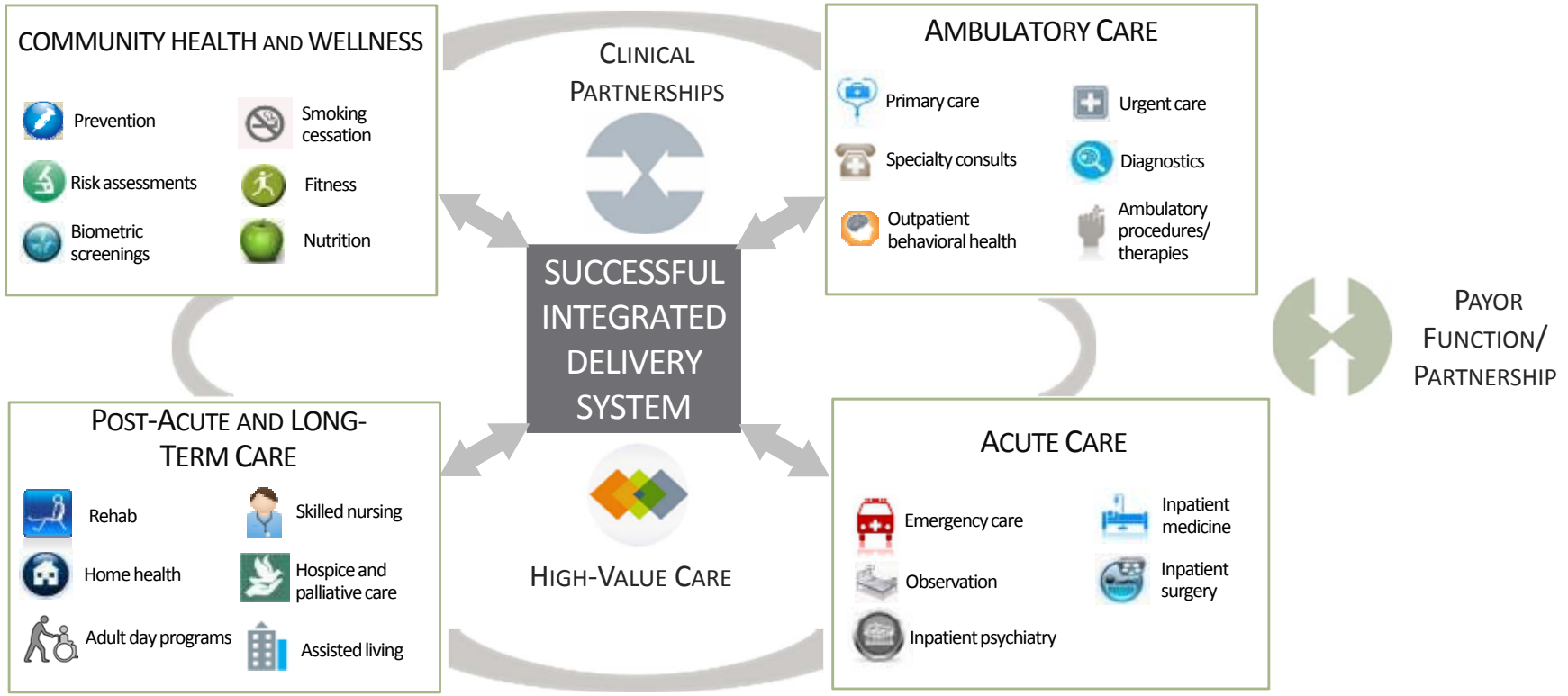
Integration / Alignment Needs / Continuum	1 2 3 TRADITIONAL	4 5 6 TRANSITIONAL	7 8 9 EVOLVED	Our Score
Focus	• Episode	• Disease category	• Prevention, population	8
Approach	• Structures	• Structures and processes	• Outcomes	6
Measurement	• Assumed • Not measured	• Highly compliance-based	• Outcomes • Across continuum	6
Tools	• Peer review • High variability among clinicians	• Early importation of industrial models • Evidence-based practice and clinical pathways	• Full transition to process redesign • "Best practices" widely utilized; low variability	8
Culture	• Culture of "blame," punitive • Hierarchical	• More team-based design and practice	• Collaborative • Non-punitive	8
Transparency	• Little to none	• Beginning to publicly report outcomes	• Widespread	7
Accountability	• Select administrators	• Select clinicians and administrators	• Everyone	7

C

System Effectiveness: Evolved Physician Alignment

Integration/Alignment Needs / Continuum	1 2 3 TRADITIONAL	4 5 6 TRANSITIONAL	7 8 9 EVOLVED	Our Score
Clinical alignment	• High levels of autonomy and variability • Volume-based	• Emphasis on continuity of services • Focus on minimizing variability	• Accountable for the continuum of care and standardization of care	7
Economic payment/ alignment	• Little risk sharing • On-call contracts	• Integrated P4P • Service-specific joint ventures	• High level of risk-sharing and shared contracting strategies • Fully value-based	6
Physician leadership/ governance	• Department/program leaders are elected volunteers • Medical directorship	• Some clinical co-management of services	• Physician executives in highest roles in the organization	8
Operational integration	• PHO/MSO structures provide support • Some IT connectivity	• Clinically-focused EMR • Shared service arrangements	• Fully integrated EMR (financial and clinical)	7
Care coordination/ accountability	• Punitive approach • Episodic FFS medicine	• Expectations are clearly set and compliance is incentivized	• Implied and jointly held expectations from system and peers/global risk	7
Primary care alignment	• <20% PCPs • Few (<20%) PCPs employed	• 20-35% PCPs on staff • 20-40% of PCPs employed	• >35% PCPs on staff • >40% of PCPs employed	8

D Connecting the Elements of a Successful IDS



Advanced and highly successful systems have scope and scale, and also assume risk for managing the delivery of high-value, cross-continuum care for a defined population

Where is Your Organization on the Systemness Journey?

Key Attributes of Effective Integrated Systems	Beginning	Modestly Developed	Moderately Developed	Highly Developed
A central, unified physician enterprise manages all system-physician relationships				
The majority of physicians are tightly financially and strategically aligned; compensation methodologies and incentive systems are value-based				
Sufficiently sized and distributed primary and ambulatory care network				
Coordinated and geographically distributed management of the full physical and behavioral health care continuum				
Systematic deployment of team-based, interdisciplinary, person- centered care models supported by centralized management/coordination resources				
Consumers and caregivers are highly satisfied with transitions across sites and continuum				
All sites/providers leverage a common EHR and data management platform				
Full adoption of system wide evidence-based clinical pathways				
Demonstrated willingness and ability to manage value contracts and assume risk				
The totality of the system is not in competition with its component parts				
Adequate capital to invest/reinvest in population management infrastructure				

Systemness in Tomorrow's Environment

Layer in a future-oriented perspective - even today's highest-functioning integrated systems must evolve

High-performing integrated systems in 3 or 5 years may need to:

- Assume financial risk for a defined population with a single signature
- Effectively manage total quality and cost of care to acceptable year-over-year benchmark rates
- Engage patients and health plan members as accountable and active participants in their health, modifying behaviors and care-seeking patterns that link most closely to demand for health services
- Bear responsibility for providing real-time and comprehensive value data (price, outcomes) to consumers
- Deliver uniform care from clinical service lines across multiple geographic sites with effective coordinators of care at and between locations

Are there other future-oriented attributes you would add?

EXECUTING ON INTEGRATION

Operationalizing Systemness: Key Factors

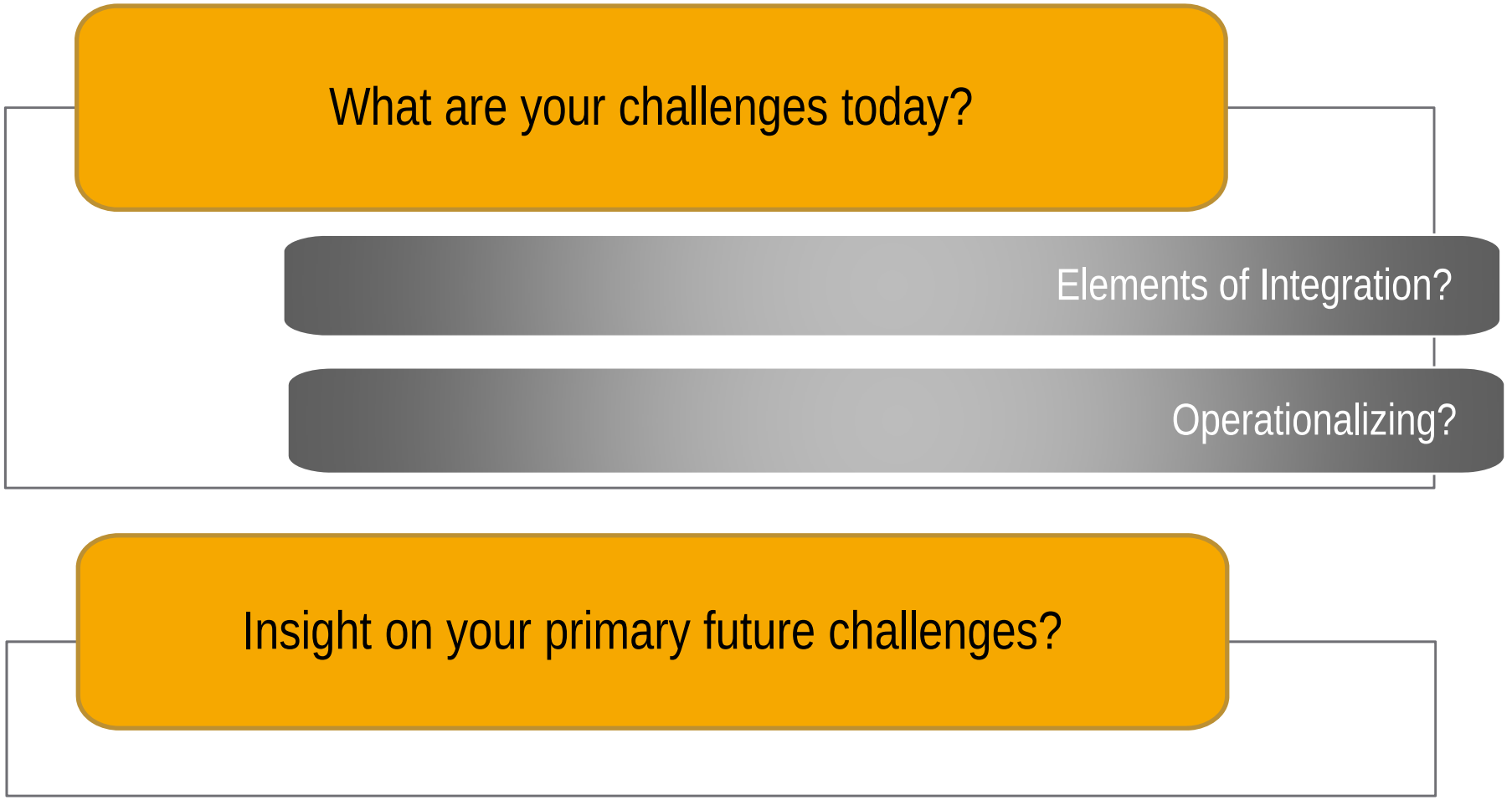
Integration Component	Dimensions of Health System Integration			
	Strategic	Skills/ Competencies	Behavioral	Structural
Leadership	How **committed and effective** are **leadership and management** in fostering integration?			
Physician	To what extent do **physicians and the health system** agree on vision and purpose, and **work together** to achieve mutually shared goals?			
Clinical	What degree of **coordination and interconnectivity exists to integrate** functions and sites to maximize the value of patient care?			
Infrastructure	How **integrated and effective** are **corporate functions** (e.g. financial, marketing, IT) to facilitate integration across operating units?			

Other factors impacting the ability to execute on integration include availability of resources, competitor threats, and legal and regulatory constraints

Operationalizing Integration: Focus on People

- Bold and creative executive leadership
- Enlightened governance
- Layers of talent
- Sophisticated financial management skills
- A culture that supports change

Journey To Systemness: Participant Perspectives



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BIOGRAPHIES

Howard R. Grant

A physician, attorney and health care chief executive, Howard R. Grant, J.D., M.D., the president and chief executive officer of Lahey Hospital & Medical Center since November 2010, has played a vital role in influencing patient safety and superior clinical care for more than two decades at some of the nation's most preeminent health care institutions.

In May 2012, Lahey Clinic Foundation and Northeast Health System formed Lahey Health, a next generation health care system comprised of award-winning hospitals, primary care providers, specialist physicians, behavioral health, and senior care resources and services throughout Eastern Massachusetts and Southern New Hampshire. As president and CEO of Lahey Health, Dr. Grant is building what is next in integrated health care: making high-quality health care more personal, innovative and accessible.

While at Geisinger Health System in Danville, Pennsylvania, Dr. Grant led the clinical enterprise which included a group practice with 60 locations, 1,200 providers and three hospital campuses. Dr. Grant was the executive vice president and chief medical officer responsible for operations and budgets for 27 clinical service lines. He was also charged with aligning clinical operations with Geisinger Health Plan, a not-for-profit insurance company.

Howard R. Grant (continued)

Prior to joining Geisinger, Dr. Grant had a long tenure at Temple University Health System in Philadelphia, where he served in a succession of leadership roles, including EVP for Hospital Operations, Senior Associate Dean for Clinical Affairs and Chief Medical Officer.

He was responsible for performance improvement, risk management and patient safety: integration of clinical and operational programs across five facilities; and clinical leadership of case and disease management.

Dr. Grant began his medical career at the Children's Hospital of Philadelphia. In addition to serving as a staff pediatrician, he directed quality assurance, risk management and utilization management programs while developing and managing home care programs. From 1992 to 1997, he served as corporate vice president for medical affairs at the Chester County Hospital in West Chester, Pennsylvania.

Dr. Grant earned both his medical and law degrees from George Washington University. He also holds a bachelor's degree in political science from the University of Pennsylvania. He competed his pediatrics residency at the Children's Hospital of Philadelphia. He is a member of the American Medical Association, the American College of Physician Executives, the Massachusetts Medical Society and is a fellow of the American Academy of Pediatrics.

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Alan M. Zuckerman

Alan M. Zuckerman, FACHE, FAAHC, president of Health Strategies & Solutions, Inc., is one of the nation's leading health care strategists and industry thought leaders, having helped many of the top hospitals and health systems in the country develop advanced competitive strategies and pursue merger and affiliation activities.

Alan is highly skilled at identifying how to redesign complex organization structures, align cultures, and accelerate organization transformation. He is recognized for his ability to bring unique strategic solutions to providers in highly dynamic markets and for his expertise in developing consensus among board members, medical staff, and management.

A nationally recognized author and speaker, Alan has written over 75 articles and six books, including *Healthcare Strategic Planning: Approaches for the 21st Century*, which won the American College of Healthcare Executives James A. Hamilton Award for health care book of the year, and *Leading Your Healthcare Organization through a Merger or Acquisition*, published by Health Administration Press in 2010.

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