Community Health Care Investment and Consumer Involvement Committee of the Health Planning Council
April 10, 2013

Dianne J. Anderson
President & CEO

Lawrence General Hospital

So good. So caring. So close.

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("the best kept secret in the Merrimack Valley")

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High Quality, High Value, Low Cost Regional Medical Center

- 189 bed hospital
- Discharges: 38% to primary service area, 30% of the total service area
- 13,000 discharges
- 300,000 outpatient visits/yr
- 75,000 Emergency Room visits annually;
- Level III Trauma Center, STEMI, Stroke

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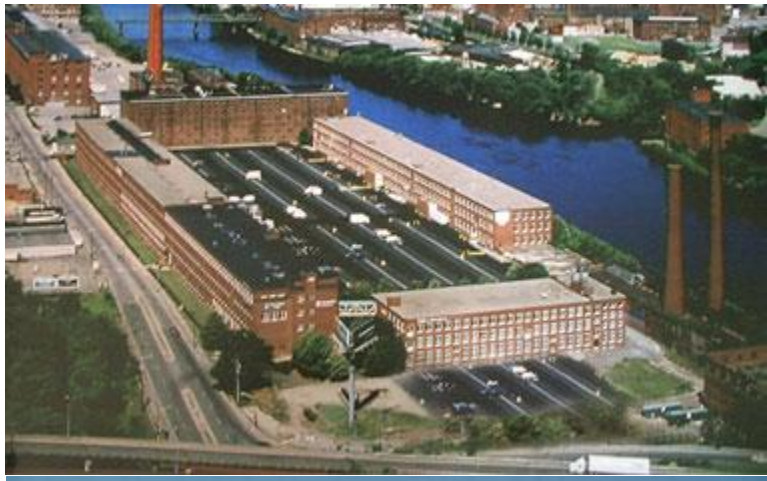
Lawrence Area

- LGH is Largest Employer
- 25 Miles North of Boston
- Lowest per capita income
- High drop out rate
- GLFHC Federally Qualified Clinic



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Clinically affiliated with Beth Israel Deaconess Medical Center & Tufts Floating Hospital for Pediatrics

Beth Israel Deaconess Medical Center
A teaching hospital of Harvard Medical School

Tufts Medical Center

LGH Community Challenges & Opportunities

- **Lower socioeconomic population characterized by chronic diseases such as**
  - **High rate of diabetes**
  - **Obesity**
  - ***Childhood obesity rate is 45%, highest in MA!***
  - **CHF,**
  - **COPD**

- **Disparate community providers/provider groups**
  - *Greater Lawrence Family Health Center*
  - *Pentucket Medical Associates (PCHI Practice)*
  - *Independent Physicians (BIDPO contracts)*

LGH Clinical/Operational Challenges & Opportunities

- **NO employment model for physicians**
- **NO care coordination across independent organizations**
- **NO PHO to manage care and reduce outmigration to Boston**
- **NO Information technology strategy for connectivity and integration**
- **NO Recruitment strategy for Primary care and Specialty care access**
- **NO succession strategy for aging medical staff**
- **NO hospital wide EMR**

Others

- **High use of ED instead of Primary care for non-emergent care**
- **New competitors in the market**

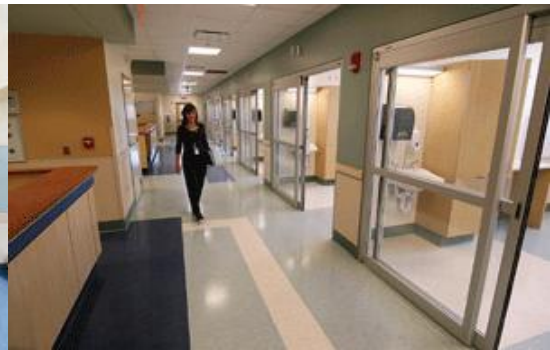
LGH Financial Challenges & Opportunities

Low cost out of necessity

- **DSH hospital –*70% governmental; Medicaid rates at 70% of costs***
- **↑Medicaid coverage ↑Medicaid volume = ↑Medicaid reimbursement shortfalls**
- **Deferred investments (ORs greater than 40 years old)**
- **30% Outmigration to Boston**
- **TME was among the lowest per the MA[1]**

1. Division of Health Care Finance and Policy Report, May 2011





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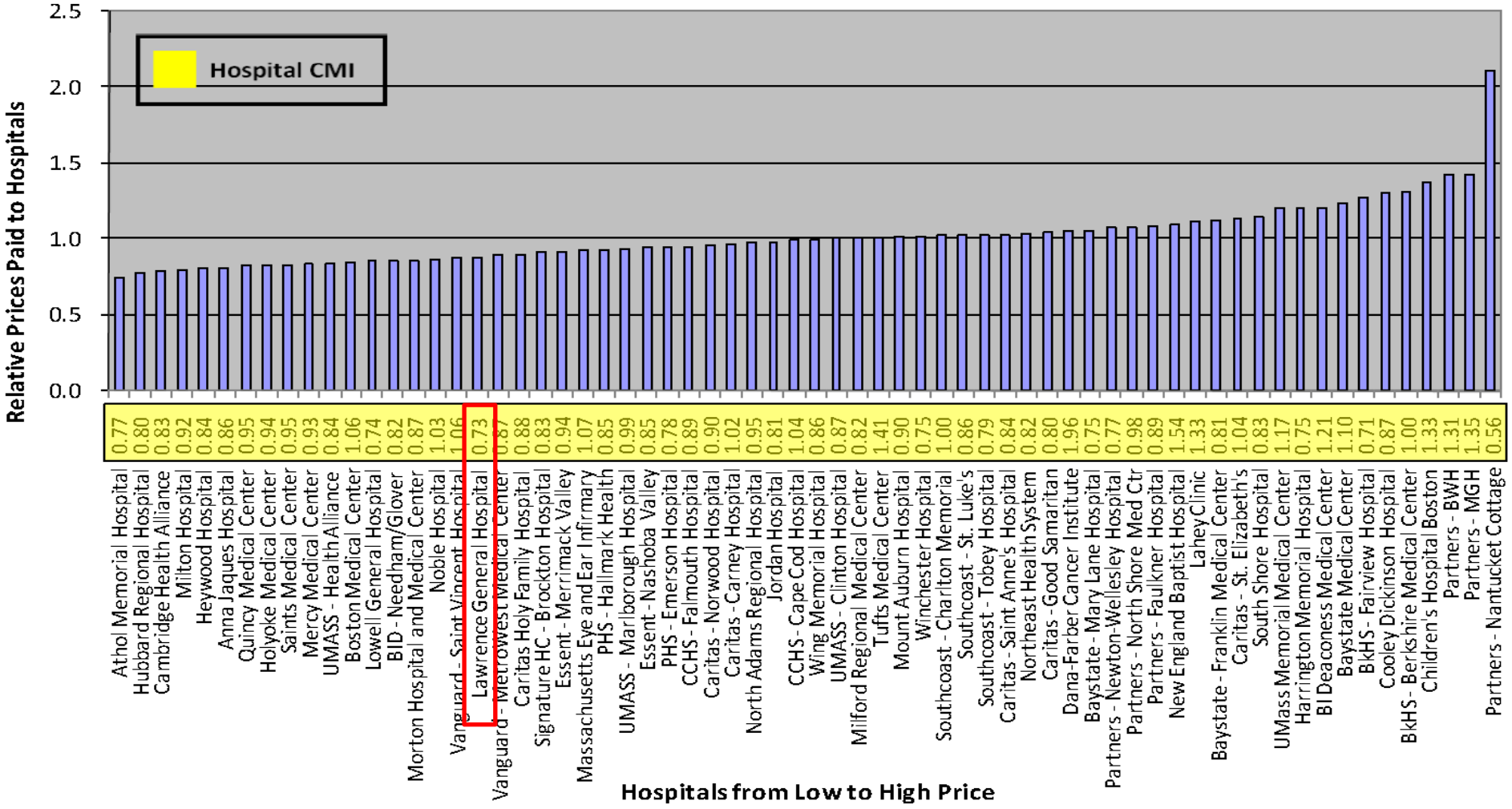
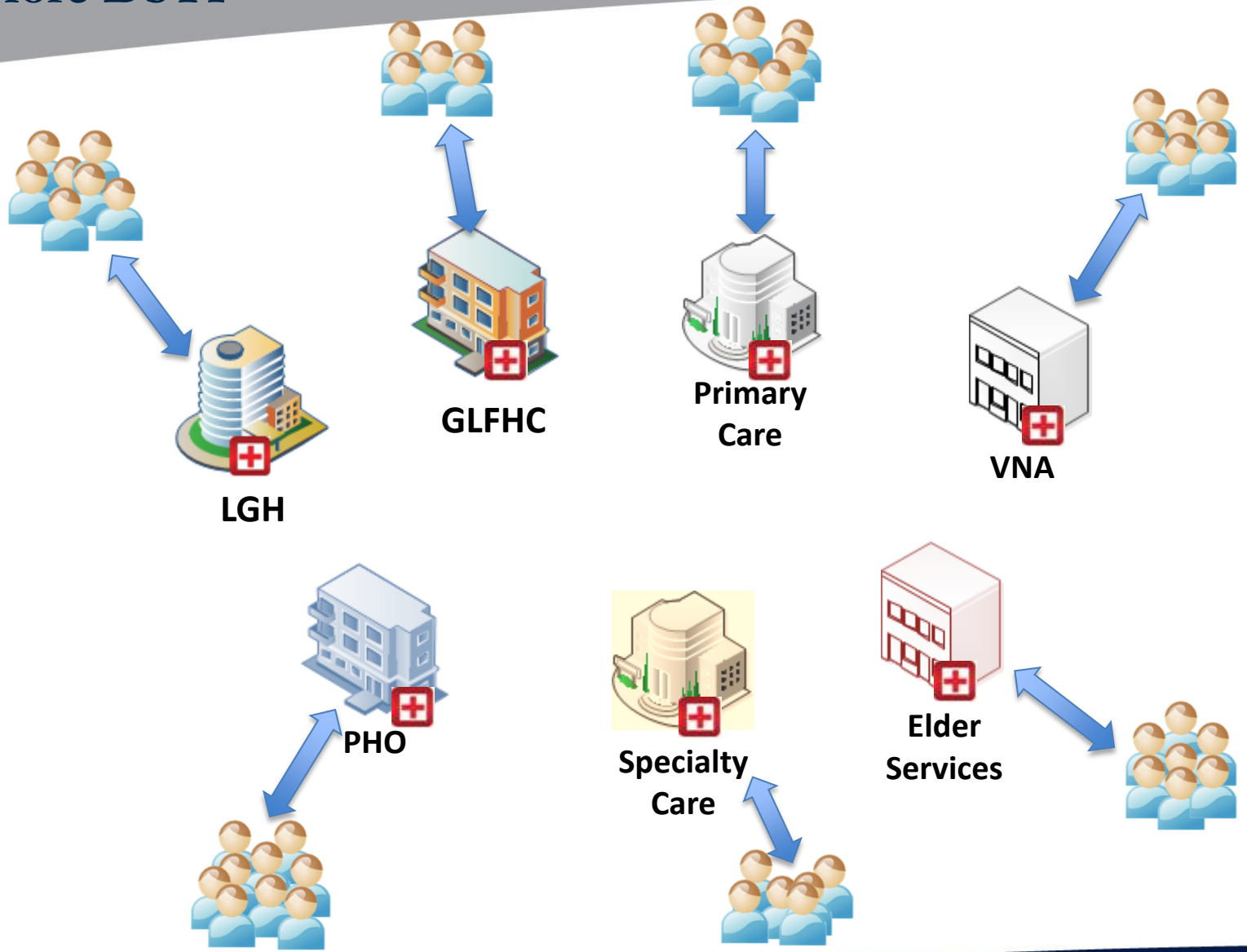


Attorney General Martha Coakley; April, 2010

Before DSTI



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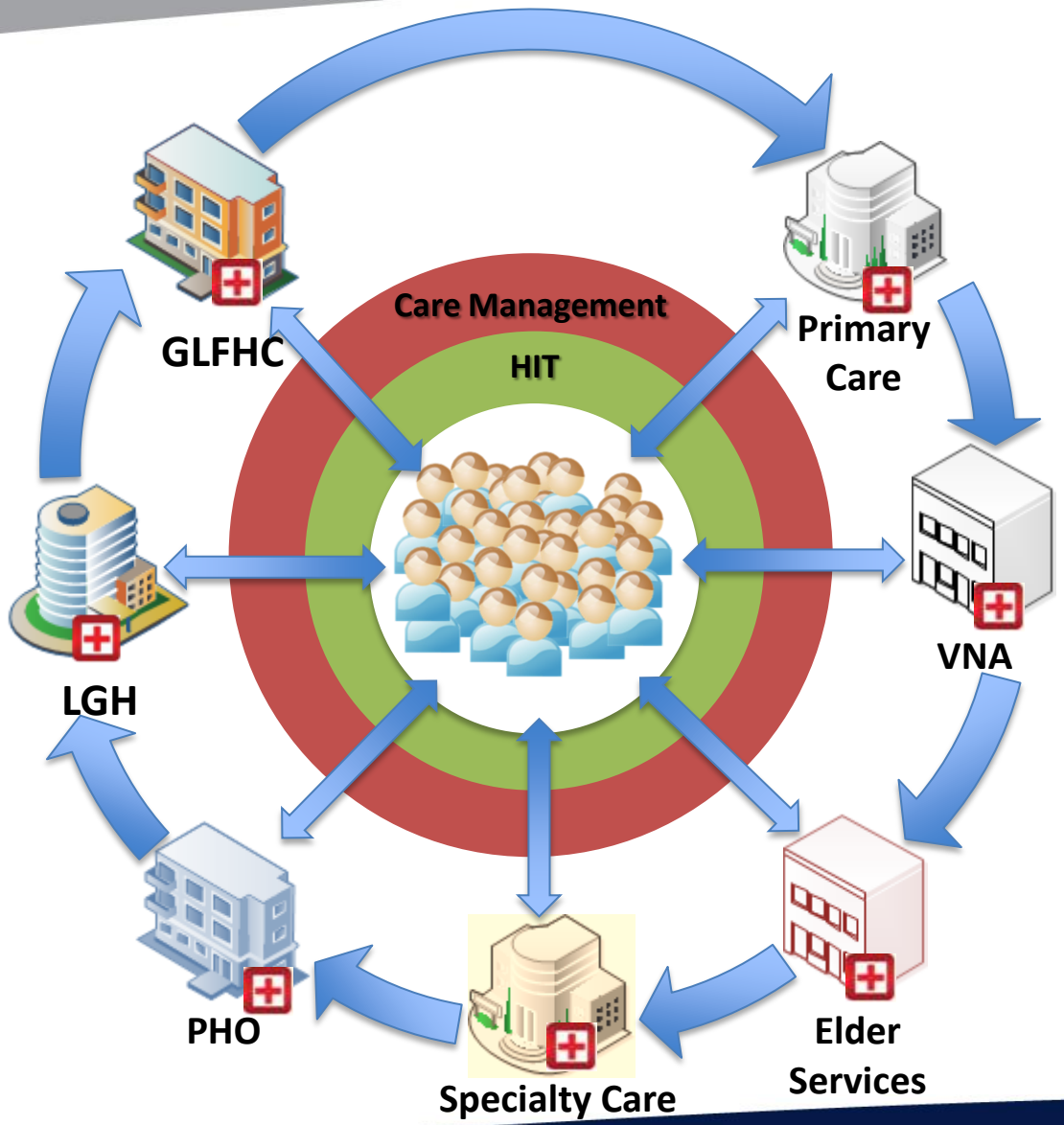
After DSTI



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LGH – Addressing Unsustainable Cost

- **DSTI funding has allowed LGH to:**
  - **Develop an integrated delivery system**
  - **Focus on improving the health outcomes and quality of care provided to our patients**
  - **Prepare for statewide transformation and to accept alternatives to fee for service payments**
  - **Expand Primary & Specialty Care locally at a lower cost**
  - **Advance Information System Integration**

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Are We Making a Difference?

- **Creating Regional Health System (ICO)**
- **Coordination of Care examples**
    - *Co-located PCMH clinic with EC*
    - *Employed Palliative Care team - ↓ LOS, ICU and other utilization*
    - *Warm handoff between hospital and PCMH*
    - *100 % Diabetic patients receive bedside medications/education*

- **IT enhancements**
    - *Created Merrimack HIE Collaborative*
    - *Funded and integrated EMRs in 15 physician practices*
    - *IT connectivity enhanced with ALL of our partners*

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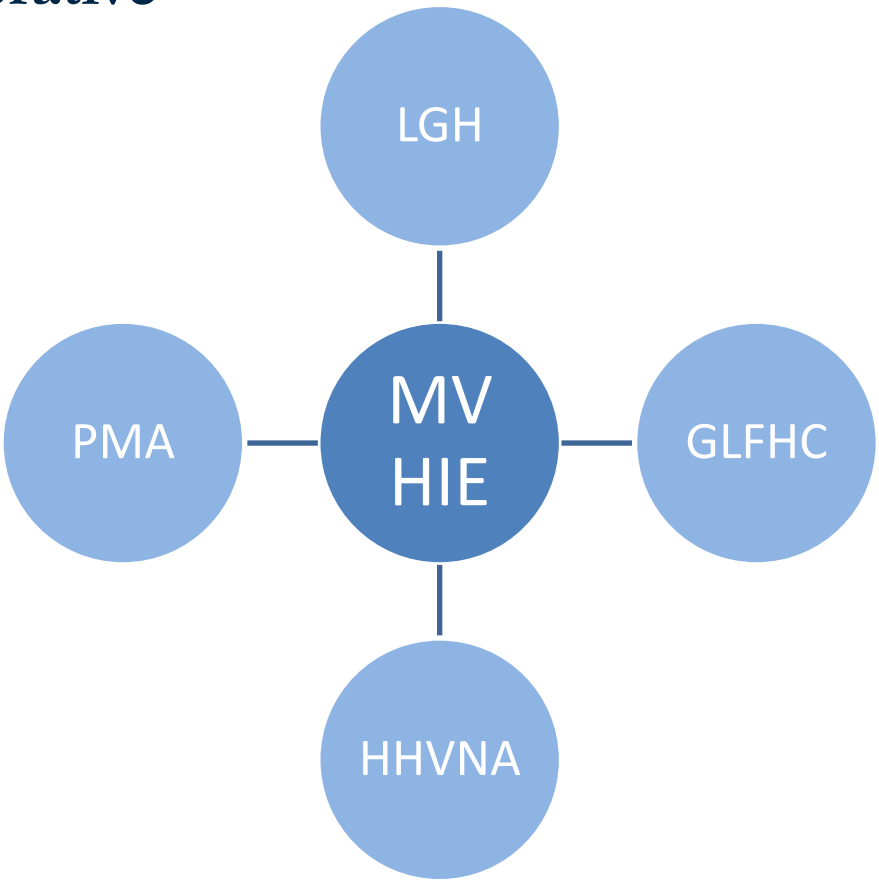
Merrimack Valley HIE Collaborative

- **Lawrence General Hospital (LGH),**
- **Greater Lawrence Family Health Center (GLFHC),**
- **Home Health VNA (HHVNA) and**
- **Pentucket Medical Associates (PMA).**



Foundation of future HIE data sharing Initiative with Mass HIE highway grant.

Outcomes include proof of concept and a successful transfer of information to all trading partners.

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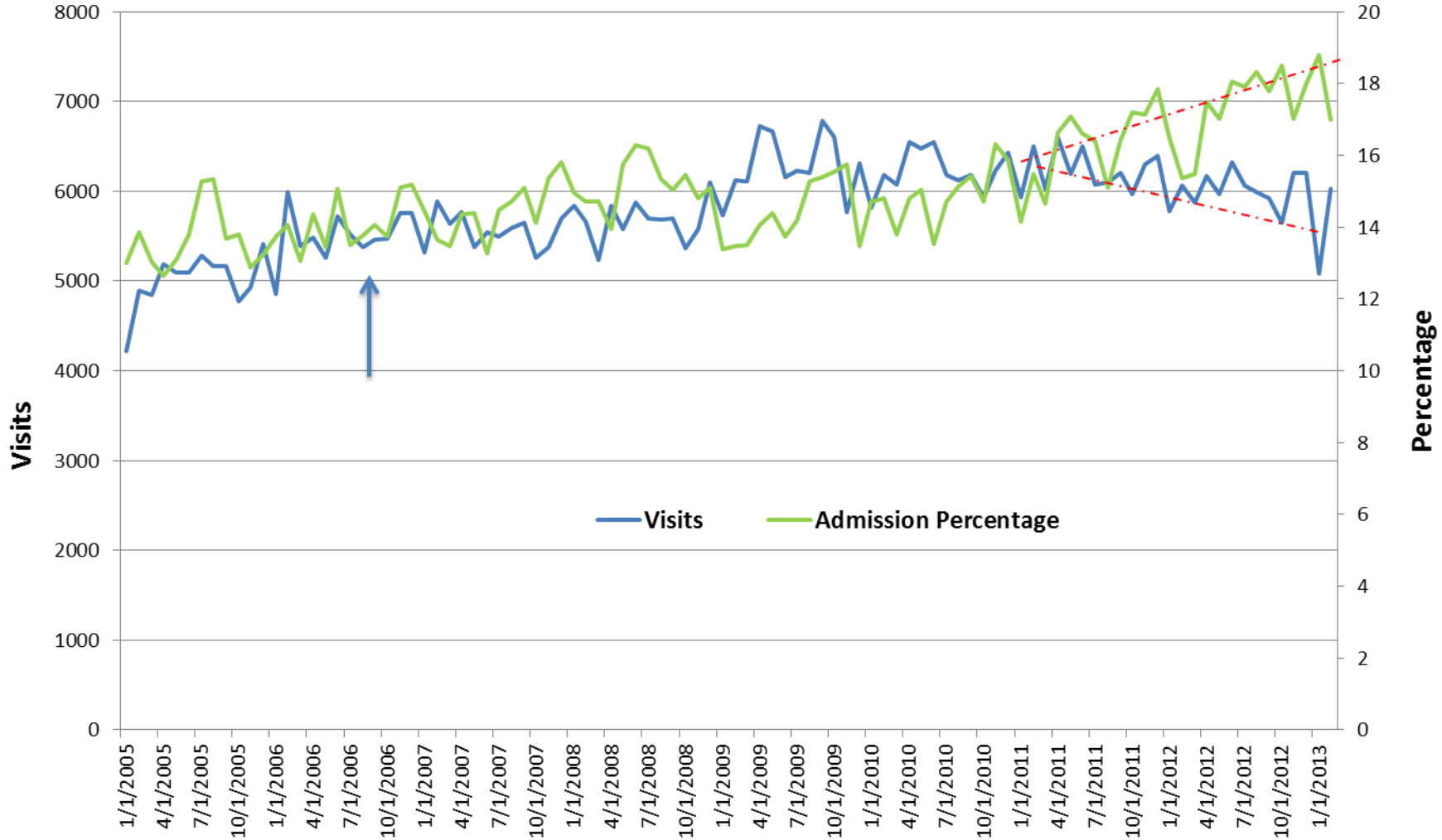
2005 - 2013 EC Visits vs. Admissions



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Are We Making a Difference? - Addressing the Gaps

- **New clinical programs :**

Adult Medicine	Pediatrics
– *GYN oncologic surgery*	- *Maternal Fetal Medicine*
– *Bariatrics*	- *Cardiology*
– *Endocrinology*	- *Gastroenterology*
– *Psychiatry*	- *General Surgery*
– *24/7 ICU coverage*	- *Neurology*
– *Minimally Invasive Thoracic Surgery*	- *Nephrology*

- **Increased PCP recruitment with PMA and GLGHC residency**
  - *4 -5 graduating Family Practice stay in the area*
  - *2 more PCPs recruited; plan to increase primary care by 10 PCPs*
- **Reduced overall cost of care**
  - *Cardiac cases cost $10,000 more in Boston*
  - *Pediatric cases costs $3,000 more in Boston*

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Are We Making a Difference?

- **Learning Collaborative with DSTI**
- **Hospital Specific Population Health Measures**
  - *Hospital 30-Day all cause readmissions*
  - *Access (third next appointment)*
  - *Non-emergent ED volume*
  - *% PCPs that qualify for Medicare and Medicaid EHR incentive program*
  - *Claims based utilization compared to benchmarks*
- **Common Population Health Measures**
  - *Care Transitions* - *COPD admissions*
  - *Explanation of Medicines* - *CHF admissions*
  - *Discharge instructions* - *Low Birth Rate*
  - *ED wait time* - *30 day all cause readmission rate*
  - *Pneumonia* - *Asthma ED admits for children*
  - *Influenza* - *Deliveries less 37 – 39 weeks of gestation*

Lessons Learned

- **DSH hospitals and community systems are an important part of solving the economic problem**
- **Funding is necessary to redesign systems of care**
- **Transformation and integration require significant new capabilities and financial investments in low cost organizations**
- **DSTI Transformational work is adding value**
- **Sustainability is critical to insure that this population receives high quality, high value, low cost care**

The best kept Secret in the Merrimack Valley!

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