Baystate Health

ADVANCING CARE. ENHANCING LIVES.

Mark A. Keroack, MD, MPH
President & Chief Executive Officer | Baystate Health
280 Chestnut Street | Springfield, MA 01199
413-794-5890 | Fax: 413-787-5003 | BaystateHealth.org

November 5, 2021

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street
Boston, MA 02109
Via Electronic Submission

Re: Annual Health Care Trends Testimony

Dear Mr. Seltz:

This letter transmits Baystate Health's written testimony in response to the questions from the Health Policy Commission and the Office of the Attorney General in a communication dated October 19, 2021.

Baystate Health hopes that our responses are helpful to you as we all seek to understand more about Massachusetts's dynamic health care environment, particularly amidst this unprecedented global pandemic.

Please find attached our responses to the questions in "Exhibit B," which, as CEO of Baystate Health, I attest, to the best of my knowledge, that the attached testimony is accurate and true, and sign this testimony under the pains and penalties of perjury.

Please feel free to contact me should any questions arise.

Thank you for your consideration.

Sincerely,

MKeroack MD

Mark Keroack, MD, MHA
President & Chief Executive Officer
Baystate Health

HPC QUESTIONS

1. UNDERSTANDING THE IMPACT OF COVID-19:

Please briefly describe how you believe the COVID-19 pandemic has impacted each of the following:

a. Your organization, including but not limited to the impact on your providers and other staff, and any impacts on your ability to recruit and retain staff:

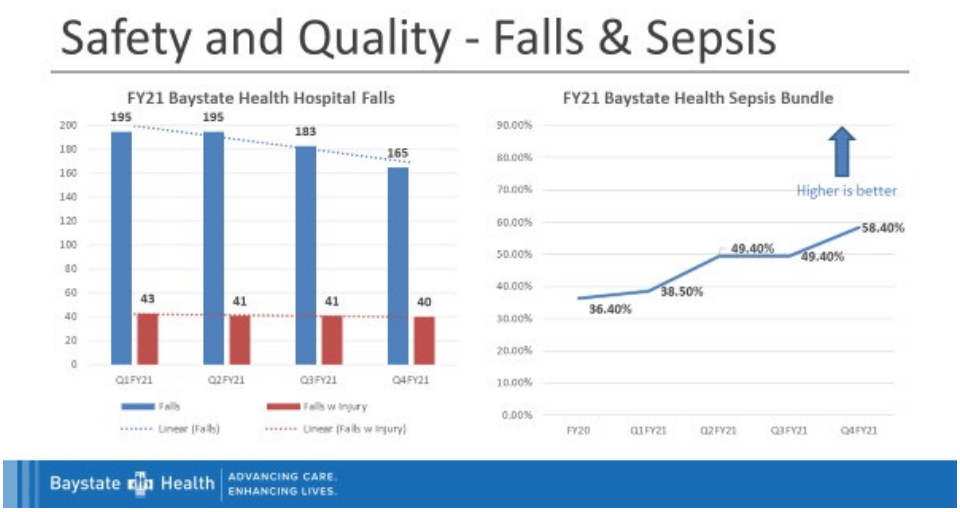
Throughout the pandemic Baystate Health has experienced increased turnover in key clinical positions (MDs, Advanced Practice Providers, RNs, Patient Care Technicians and Medical Assistants. Except for physicians, the turnover rates have increase by 20-100% of the pre-pandemic levels with Advanced Practice Providers, RNs, Patient Care Technicians still on the rise. MDs and Medical Assistants seem to have leveled off to pre-pandemic rates, however we recruitment and retention for these positions remains challenging. Overall organizational vacancy rate has increased to 17%, and we are sustaining historically high labor costs due to the substantial increase in contract labor needed to keep our facility running at acceptable ratios. Retention efforts have been expensive, and our tactics have included several costly retention bonuses for front line caregivers. This is in response to high rates offered by contract agencies, and competitive sign on and salary offers from competitor organizations. Our recruitment efforts were stalled through much of FY20 while the organization focused on internal redeployment to avoid furloughs while non-COVID patient volumes dropped. In the last year, we have been working hard to recruit in order to replace our depleted workforce and are finding first year turnover to be a challenge as people are challenged with both home and work environments. Adding to the challenges, Baystate has experienced a 10% increase in acute inpatient volumes compared to pre-pandemic levels stretching our depleted workforce even further. Since the onset of the pandemic, we have seen a steady increase in non-productive time associated with home schooling, illness (both physical and mental health) and longer orientation of new employees related to interruptions in the academic program of new graduates entering the workforce. The implementation of the MA PFML this year has brought further increases in protected leaves for extended parental leaves and attending to family members. Total absences have increased by nearly 50% from pre-pandemic levels. From an employee health perspective there has been a shift in workforce culture regarding working while sick or "presenteeism". Employees are much more mindful of not working while symptomatic and staying home if feeling unwell. The mandated vaccine policies for both COVID and FLU for all employees, including remote workers, has resulted in terminations as well as enhanced screening for new hires. Baystate is responding by taking steps to increase the labor pool by evaluating the minimum requirements for entry level positions, partnering with community agencies to identify people eager to work, enhancing our benefit plans and offering full-time benefits to those working .75 FTE or greater (decreased from .9 FTE requirement). Additionally, we have shifted to more flexible scheduling and work design, embraced remote working for those in administrative positions, and are building internal support teams focused on retention in critical jobs. Lastly how we function as a leadership team has greatly improved with more collaboration, inclusion, risk taking, and innovation based on our experiences with an Incident Command process. This includes innovative ways to

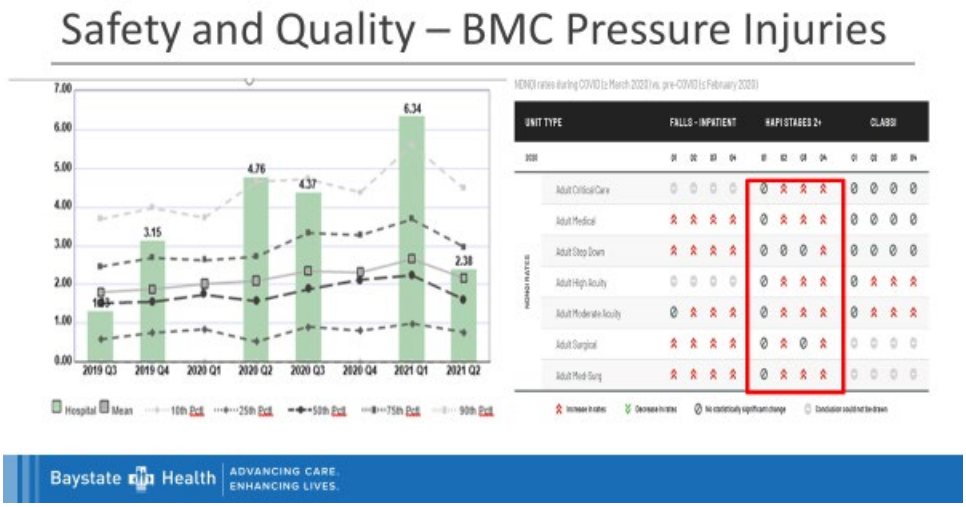
involve those closest to the work in decision making and creating ongoing venues for bidirectional exchanges of ideas between leaders and staff.

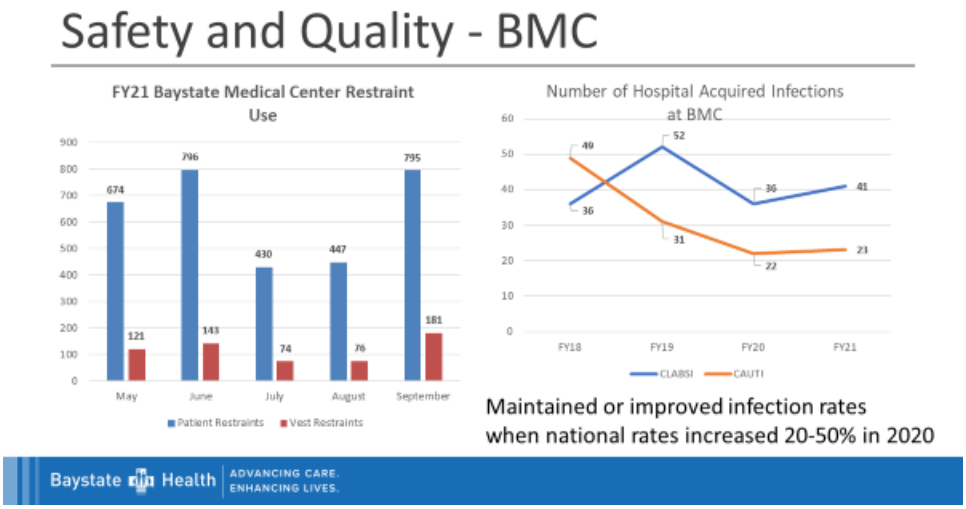
b. Your patients, including but not limited to the direct health effects of COVID-19 as well as indirect health effects, such as the effects of deferred or cancelled care, exacerbation of behavioral health and substance use conditions, and effects from economic disruption and social distancing (e.g., evictions, food security):

At Baystate Health, the disruptions of the COVID pandemic created the same challenges that have been described across the state and nationally. Namely, restrictions on visitation have been shown to worsen the patient experience of care, increase risk for falls and the development of delirium in hospitalized patients. The limited visitation has also affected care team communication with family and care plan decision making. Increased pressure injuries and falls have been demonstrated through analysis of the NDNQI database and CDC has published data showing an increase in some types of healthcare associated infections in 2020 as compared to 2019. The disruptions to patient flow include decreased capacity for home health visits, skilled nursing facility beds, increased patient acuity, and massive increases in patients presenting to hospitals with behavioral health needs. The resulting increases in Emergency Department wait times and ED boarding for inpatient beds across the state has been shown for many years to affect patient outcomes adversely. In addition, the well-documented staffing shortages and healthcare worker burnout and exhaustion have made it more difficult to manage daily healthcare operations and engage in improvement efforts. For Baystate Health, some measures of hospital safety and quality followed the state and national trend with increases in pressure injuries and restraint use, but improvement was also made during the pandemic in sepsis measures of clinical process and patient falls and healthcare associated infections were largely unchanged. After the initial wave of the pandemic, Baystate patients reported decreased patient experience in standardized surveys as was seen nationally. We witnessed firsthand the suffering of patients unable to be with loved ones while in the hospital which caused us to be early adopters of more liberal visitation policies during the second and third waves. It is difficult to quantify, but we believe that has made care safer in many ways. We are proud of the preventive measures and healthcare that we delivered to patients at risk for and diagnosed with COVID-19. Like many of our peers, we quickly stood up a massive COVID testing operation and targeted vulnerable populations in Springfield with testing, in home outreach, and education about how to prevent infection and quarantine safely after infected including bringing supplies directly to the home. Analysis of our hospital COVID outcomes does not reveal differences in survival for white vs. black or Hispanic vs. non-Hispanic patients. Baystate was an early adopter of the use of monoclonal antibodies and offered them systematically to newly infected patients in our region to prevent severe disease and hospitalization. Baystate stood up a very successful vaccination hub which delivered mass vaccinations and performed outreach in the community to vulnerable populations with mobile services, events and even door to door vaccination efforts. Despite these efforts, for much of the past year, Hampden County has had the lowest vaccination rates and highest hospitalization rates for COVID in the Commonwealth. This has put a disproportionate stress on the western Massachusetts healthcare system and hospitals. We believe that the heroic efforts of healthcare workers in the Baystate system to tirelessly care for the sick, outreach to vulnerable populations, work despite staff shortages and risk to self, educate the public, and fill holes in the stressed healthcare system has saved lives, shortened illness, prevented infection, comforted individuals and

the community, and fulfilled our role as the trusted healthcare partner to the communities we serve.







c. **The health care system as a whole, including but not limited to how you think the health care system will change going forward, and any policies or innovations undertaken during the pandemic that you hope will continue (e.g., telehealth policies, licensure and scope of practice changes):**

The ability to care for patients remotely via both telephone and video visits has dramatically improved providers' ability to care for disadvantaged patients. Many patients have transportation issues, difficulty in getting time off work, childcare issues, and mobility issues. Historically these patients have had fewer visits, leading to exacerbations of avoidable conditions. Telehealth has been incredibly beneficial in allowing for meaningful care to be provided to the patients most at need. Telephone visits in particular need to continue to be covered as many patients do not have the technical skills or financial ability to conduct video visits, and if telephone visits are not covered in parity with in-person or video visits, it will create disparate access to care based on socioeconomic factors. The steps undertaken by many private carriers to address the need for telehealth solutions during this pandemic are extremely encouraging. These efforts strengthen telehealth offerings, encourage social distancing, and allow patients to receive care from the comfort of their own homes. For example, many payers decided to waive cost-sharing for telehealth visits relating to COVID-19 which aims at encouraging patients to seek care by removing financial barriers. In light of recent CMS guidance and in an effort to encourage uniformity among payers in their telehealth offerings, Baystate hopes carriers consider taking the following actions:

- Allow physicians to waive co-pays for all types of telemedicine services. While some private carriers have announced policy changes to waive cost-sharing for these visits, we urge all carriers to waive cost-sharing for all types of telehealth and telemedicine visits, including those visits for other reasons such as routine appointments and for chronic disease management to encourage physicians to offer these types of visits and to encourage patients to seek care from the safety of their homes so that they are not exposing themselves or others to the risk of infection.
- Make all types of telemedicine, including telehealth visits, virtual check-ins, phone consultations, and e-visits, available to both new and established patient s. CMS issued guidance that allows physicians to bill for telehealth visits associated with established patients, but notes that the agency will not audit claims to discern whether a relationship existed prior to the visit. Providers nationally have encouraged CMS to reimburse for both new and established patient visits. Baystate urges payers to consider asking their members to also make these visits available to both new and established patients.

"Provider" Enrollment/Credentialing: Baystate appreciates actions by payers to reduce physician burden during this challenging time. Some insurers have modified existing credentialing processes and are offering provisional credentialing. CMS has also taken emergency actions to address COVID-19 by modifying certain enrollment requirements. Baystate supports these actions and welcomes additional action by insurers to ease the credentialing process during this national emergency. Payers should consider:

- Waiving fees associated with the credentialing process.
- Establishing toll-free hotlines to enroll and receive temporary billing privileges; and

- Temporarily postponing all revalidation efforts.

Prior Authorization During COVID-19 National Emergency:

Baystate has heard from our frontline physician members regarding care delays due to prior authorization occurring during this national public health emergency. Specifically, members have raised concerns regarding patients in hospitals awaiting prior authorization approval for discharge (i.e., discharges into Skilled Nursing Facilities have been a common complaint). These delays are ranging from four days to two weeks, thus resulting in patients occupying hospital beds that could be used during this emergency. While payers recognized the need to alleviate administrative burdens the long term waive for all prior authorizations for post-acute and hospital transfers, as well as consider waiving all prior authorization requirements during this period of national emergency.

2. EFFORTS TO COLLECT DATA TO ADVANCE HEALTH EQUITY:

A. Comprehensive data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity is foundational to advancing health equity in the Commonwealth. Please describe your current efforts to collect these data on your patients. Please also describe specific barriers your organization faces in collecting such data and what policy changes or support has your organization identified as necessary to overcome such barriers.

Baystate Medical Center (BMC) collects basic race and ethnicity data required to meet state and federal requirements and uses the race and ethnicity classifications required by the state. In the past year, BMC has been focused on moving toward collecting patient race, ethnicity, and primary language data (R.E.A.L.) and has worked to modify patient registration to ensure that BMC is collecting patient demographic information that will yield meaningful data. As part of the new model, BMC defined a list of 30 granular race and ethnicity classifications. The revised list will help capture the information needed for reporting purposes and, most importantly, capture meaningful patient demographics information that can be used for assessing and improving quality of care and reducing disparities.

Progress

To identify the list of race and ethnicities to be included in the registration process, BMC sought the input of its cultural competency committee, a multi-stakeholder group. This committee was able to provide guidance on the appropriate ethnicities to include in the list and solicit feedback and recommendations from various departments and the community.
At Baystate Health we have launched a system-wide effort to measure health care disparities and take action to address gaps. The following are highlights of that ongoing effort:

In 2020, an effort was started to assess the current capture of R.E.A.L and sexual orientation and gender identity (SOGI) data across the health system. We found that for hospital-based care, fewer than 3% of patients had "Unknown" as a response to Race. However, that number is over 5% for patients with ambulatory encounters. For the Hispanic ethnicity indicator, there were 10% of patients with an "Unknown" or a blank field. Our current performance in capturing SOGI data is less robust. In addition, at our community health centers in Springfield, where most patients have MassHealth insurance, many more social determinants of health, including food and housing insecurity, as well as R.E.A.L, SOGI, and disability information, are captured systematically.

Process Change

- BMC revised the registration process to move away from front-line staff verbally asking patients about race and ethnicity. The process caused problems, because patients are

sometimes reluctant to divulge this information, and staff is hesitant to invade patients' privacy. BMC plans to shift to a self-administered questionnaire, so patients have more privacy and confidence in responding to the questions.

- To allow patients to self-identify, BMC selected a list of races and ethnicities from among a list of 300, which was representative of the community it serves. The new list is comprehensive but not burdensome for patients, and it is compatible with our data systems. The granular list was also informed by the languages included in patients' requests for interpretation.
- As part of System Goals for 2022, the leadership team at Baystate has made a commitment to report on all priority quality, safety, patient experience, and value goals by Race and Ethnicity by the end of the first quarter of the year. In addition, Baystate participates in a national perinatal collaborative, which is focused on eliminating disparities in care for pregnant moms and their babies. Ongoing work in the collaborative has targeted elimination of structural biases in care and awareness of individual biases, as well as outreach to vulnerable populations.
- A project team is directed at standardizing and synchronizing the R.E.A.L and SOGI data in all registration and applications across the health system.
- A multidisciplinary team including patients has been formed to review best practices in engaging patients to more accurately collect these data and get them in our systems. The group will create standard process and educate all contact center and registration employees on the new methods for data collection and entry. In addition, this group will perform assessments of the quality of data currently in our systems.
- COVID-19: During the course of the pandemic, vaccination rates for both employees and patients were regularly reported stratified by race and ethnicity. Additionally, COVID outcomes data were regularly reported stratified by race, ethnicity, and language.

Challenges

Staff training is essential, since the data collected is only as good as the commitment of those collecting it. Staff training will enable staff to overcome reservations about collecting R.E.A.L data from patients and motivate staff to participate in quality improvement. The new system involved changing the online system for registering patients, which required considerable work from the Information Technology department.

Lessons Learned

- Set a well-defined goal for collecting patient race, ethnicity, and primary language data. BMC was able to define the goal for the R.E.A.L. data initiative as an approach to collecting patient demographics that will enable BMC to compare patient health outcomes and reduce disparities.
- Solicit broad multi-stakeholder and multidepartment involvement in data collection efforts. BMC involved multiple departments in identifying the granular list of races and ethnicities to be collected, ensuring the categories are relevant and representative. Multi-stakeholder involvement also helped ensure that the effort fulfilled the needs of departments involved in data collection and reporting requirements to the state and other funding sources. And involving multiple departments eliminated duplicative efforts.
- Establish and report metrics for R.E.A.L. data collection and use. The quality leadership team at BMC is actively involved in pushing data collection and use and has included written data collection as a metric to be reported as part of Health Equity and Shared Decision-Making Collaboration with many of the regional Health Plans. As such, BMC must meet specific metrics for data collection and for qualifying for certain kinds of value-based initiatives.

Baystate Medical Center Key Strategies for Collecting Race, Ethnicity, and Language Data:

Key Strategies for Collecting Patient Race, Ethnicity, and Language Data	
Strategy	Rationale
1. Engage senior leadership	○ Helps to make efforts a priority for the organization ○ Maintains sustainability and accountability
2. Define goals for data	○ Communicates to clinicians and staff that the effort does not end with data collection
3. Combine disparities data collection with existing reporting requirements	○ Streamlines activities across multiple departments ○ Builds on existing hospital/system efforts ○ Ensures broad-based input
4. Track and report progress on an organization-wide basis	○ Periodically disseminating information on patient demographics serves to further engage leadership and staff as they see the diversity in the patient population increase
5. Build data collection into quality	○ Ensures accountability for accuracy and consistency in collecting data
6. Utilize national, regional, and state resources available	○ Eliminates the need to start from scratch and presents a learning opportunity, with tools and guidance from various national organizations, such as NCQA, and the Joint Commission, and state governmental agencies, such as state departments of public health
7. Review, revise, and refine process and categories constantly	○ Ensures that data collected is relevant - Helps facilitate incremental changes, which could include moving from data collection to data analysis and use

AGO QUESTION

Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request. In the table below, please provide available data regarding the number of individuals that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2019-2021			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2019	**Q1**		55
	Q2		90
	Q3		144
	Q4		176
CY2020	**Q1**	3	149
	Q2	2	60
	Q3	3	80
	Q4	4	109
CY2021	**Q1**	11	118
	Q2	0	72
	TOTAL:	23	1,053