MASSACHUSETTS
HEALTH POLICY COMMISSION

2021 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2021 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, November 5, 2021**, please electronically submit testimony to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2019, if applicable. If a question is not applicable to your organization, please indicate that in your response.

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

You are receiving questions from both the HPC and the Attorney General's Office (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact:
General Counsel Lois Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

AGO Contact Information

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov or (617) 963-2021.

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:

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The creation of the BILH system facilitated a robust, organized response to the COVID-19 pandemic, allowing BILH to play a vital role in the State's response to this unprecedented public health crisis. Our academic medical centers and teaching hospitals, community hospitals, ambulatory, behavioral health, and continuing care sites worked collaboratively in new and innovative ways and marshalled our collective resources. Together, BILH has treated more than 8,500 hospitalized patients with COVID-19, administered over 400,000 COVID-19 vaccine doses, and performed more than 700,000 COVID-19 diagnostic tests since the start of the pandemic. Given the focus on responding to the first surge of the pandemic and preparing for the second, some of BILH's integration efforts decelerated during 2020. In many areas, however, the pandemic hastened our evolution as a system, as it required teams and projects to come to fruition more rapidly to meet the demands of patient care and workforce management. For example, BILH created a system-wide Employee Health unit, Incident Command team, and centralized patient transfer center infrastructures and also developed system-wide Human Resources policies to support our staff during these difficult times.

In addition, BILH's laboratories played an essential role in the system's response to the COVID-19 pandemic. In March 2020, the laboratory at Beth Israel Deaconess Medical Center ("BIDMC") became one of the first hospital laboratories in the State to begin in-house high-throughput polymerase chain reaction ("PCR") COVID-19 testing for patients and healthcare workers. BIDMC's laboratory provided this testing capability to BILH hospitals and other community partners, including community health centers and corrections facilities, at a time when testing supply was extremely limited but critical for patient care and capacity management.

Infrastructure and resources that existed within our larger, merged enterprise proved vital to BILH's successful response to the COVID-19 pandemic. BILH leaders –across Emergency Management, Primary and Critical Care, Supply Chain and more-- organized rapid, thoughtful, and efficient deployments of resources to ensure patient and staff

safety and access to care. During the height of the pandemic the collaboration within the BILH system allowed the New England Baptist Hospital to maintain a near COVID-free environment and serve as a designated care site accepting patients from throughout the system so other hospitals could maintain more capacity to care for patients with COVID-19. This collaboration drove the development of a "systemness" at a far more rapid pace than might otherwise have been achievable. Providing this extensive level of collaboration and alignment allowed us to navigate the prolonged challenges of an emergency response. We instituted new and enhanced infection control protocols across numerous care settings and rapidly deployed a vaccination effort in communities across eastern Massachusetts and with a keen focus on equity and access.

The entire BILH workforce has been impacted by the prolonged crisis. From the earliest days of the pandemic to today, our staff across all functions and settings have faced unprecedented professional and personal challenges. Our employees are fatigued at a time when they are working even harder to care for sicker patients while the vacancies in positions across the care continuum place more burden on everyone's day to day responsibilities. The burnout rate of healthcare staff is at an all-time high and shows little signs of abating.

The pandemic has made awareness of the interdependencies within the broader healthcare system more acute, and it has made the system more fragile. We simply do not have the depth of personnel that we need in too many areas. As primary care offices seek to expand access to patients to alleviate their need to seek higher levels of care, they face significant staffing challenges from filling primary care physician openings to medical assistants to front desk staff. The staffing challenges faced by post-acute and support enterprises are also causing a direct impact on the burden of work of hospital staff. We have seen a significant increase in staff turnover and currently have nearly 5,000 job openings across the BILH system, representing a 20% increase in job openings compared to pre-pandemic times.

The Paid Family and Medical Leave Act has provided a great deal of support to employees during this continued crisis, yet with that has come a high number of long-term vacancies that prove difficult and costly for employers to fill. Employee retention is made more challenging as competition for staff within the local market reaches all-time highs. Competition for talent goes beyond the healthcare field. Candidates have endless choices, and we are competing for talent with many other industries for support staff. Industries are offering sign-on bonuses, fully remote packages, retention bonuses and salary rates at the highest percentile. We must work collectively to grow and

support the healthcare workforce and rapidly incorporate new ways of delivering care to efficiently expand the scope of services we can provide to an increasingly acute patient population.

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):

The pandemic has caused prolonged disruption across all areas of healthcare. The disruption in the management of chronic diseases is one of the most impactful drivers of patients' being sicker. In community and tertiary/quaternary hospitals throughout the BILH system, we have seen patient acuity increasing significantly, due in large part to patients delaying care throughout the pandemic. In addition, patients are remaining in the hospital for longer periods of time, often as a result of not being able to secure a bed in a post-acute care setting due to the staffing constraints in these settings. Emergency Departments throughout BILH are seeing record numbers of patients. The largest increase in patients seeking care in the ED are patients needing behavioral health services. Increasing stressors have grown the demand for behavioral health services at all levels; conversely, COVID-19 has driven changes throughout the behavioral health system that have decreased access to services. Many of the regular support programs that previously existed reduced or suspended services due to restrictions during the height of the pandemic. An example of this is the closure of many group partial hospitalization programs and intensive outpatient therapies that are important bridges supporting patients in transitions from care settings. Without the regular supports and services to manage behavioral health conditions patients have had their conditions worsen and reach crisis levels. As more and more patients reach this crisis point, they are turning to the Emergency Department to try to access to much needed behavioral health services; in turn this strains an Emergency Department's ability to care for the increasing number of emergent and acute care patients seeking help.

b. 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 COVID-19 pandemic drove BILH system integration at a faster pace. The scale of a larger system allowed us to share scarce resources, transfer patients to available settings

and provide critical supports like testing and vaccination to patients and communities throughout Eastern Massachusetts. That integration, planning and triaging continues to be critical to supporting a healthcare system that is being stressed to its limits. The ongoing pandemic has highlighted the fragility of the healthcare system and the services most in need of investment and innovation.

Throughout the pandemic we saw with more clarity than ever the inequities embedded in our healthcare and public health systems. The intentional focus and deliberate approach to eradicating disparities in health outcomes will be one of the most important changes we can perpetuate as a collective healthcare system.

Another critical element highlighted during this pandemic is the importance of meaningful patient data. As an example, BILH was able to use the patient data throughout our system to reach over a million patients with health and services alerts in a short period of time. This data was critical, but it was also limited by the depth and accuracy of the data that exists across a number of various electronic health records systems. Maximizing the usability of the data required significant work-arounds within a very tight timeframe. BILH was also able to use the richness of a large trove of patient information to address issues of equity and access. We relied heavily on data to help inform and guide our outreach and engagement efforts throughout the pandemic. Our biggest learning from our data-driven approach is that the same strategy can be deployed to address other population health and public health challenges, such as diabetes. Across healthcare, organizations are using data as the foundation to understanding and addressing health disparities and to foster equitable, culturally competent care and to identify and address complex problems.

The ongoing pandemic and continued pressures the healthcare system is facing have driven an inflection point in the industry that will drive long-term change. Not only has the experience of receiving digital care laid the foundation for a new level for location-agnostic, virtual-first preferences among patients, it has broadened their acceptance of care delivery in any number of locations: phone, home, car, grocery store, retail pharmacy or big box store. To address the current access challenges and to meet the future demands and expanding expectations of healthcare consumers' health systems will need on-going flexibility around reimbursement, site of care, and ways to expand the professional scope of services.

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.

We realized there were varying practices in the capture of a patient's race, ethnicity, language, disability status and sexual orientation/gender identity across all of our care settings, and that by supporting a more uniform approach to capturing patient information we have the opportunity to identify health disparities and target solutions to a much larger patient population spanning across Eastern Massachusetts. To address this BILH convened a multi-disciplinary REaL Data Team to create system-wide standards for capturing self-reported race, ethnicity, language, and sexual orientation/gender identity during patient registration. The team identified best practice classifications and nomenclature which were then implemented within all BILH hospital electronic health record systems. As of September 2021, questions to gather this data must be asked during the patient registration process. Previously information could be bypassed but it is now a required set of fields necessary to complete a patient registration. To ensure our staff are informed about the importance of collecting this patient information and are educated to solicit this information from patients in an appropriate and culturally sensitive manner, we developed and shared a toolkit with our staff that includes background on the initiative, best practices, and sample responses to patient questions. If a question is asked and a patient is unable or unwilling to provide this information, staff is able to reflect that in the EHR by choosing options such as "unable to obtain" or "prefer not to say." However, through staff training and establishment of a standard and more accurate set of descriptors available, we expect it will lead to better capturing of important patient information to more effectively understand and address disparities in patient outcomes.

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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**	0	385
	Q2	0	525
	Q3	0	647
	Q4	0	705
CY2020	**Q1**	0	627
	Q2	0	171
	Q3	0	575
	Q4	0	563
CY2021	**Q1**	0	537
	Q2	0	574
	TOTAL:	0	5,309

Notes:
Reflects price inquiries for the following entities: Beth Israel Deaconess Medical Center, all Lahey and Winchester Hospital locations, including: LHMC, Lahey Medical Center in Peabody, all primary care, urgent care, and specialist locations. Beginning in December 2020, it also reflects inquiries for Northeast Hospital Co, which includes Beverly Hospital, Addison Gilbert Hospital, Northeast Medical Practice locations, and specialist locations.