Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Jamie Katz
Senior Vice President and General Counsel

Submitted Electronically via HPC-Testimony@state.ma.us

September 2, 2016

David Seltz
Executive Director
Health Policy Commission
50 Milk Street
8th Floor
Boston, MA 02109

Dear Mr. Seltz,

Enclosed please find the responses of Beth Israel Deaconess Medical Center to the written testimony requested by the Health Policy Commission.

Please note that I am empowered to represent Beth Israel Deaconess Medical Center for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please do not hesitate to contact me if you have any additional follow-up questions or Tish McMullin in my office at pmcmulli@bidmc.harvard.edu or 617-667-7324.

Very truly yours,

Jamie Katz

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Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses 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 2013, 2014, and/or 2015 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so 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.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses 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. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

As we noted in prior year's testimony, BIDMC maintains its continued focus on leading the region's efforts to reduce medical expense trends and participates in the BIDCO structure to align our hospitals and physicians in pursuing shared goals around care and quality improvement and controlling costs. We have strengthened our network of community-based providers, expanded our medical management infrastructure, and continue efforts to improve our operational efficiency, outpacing industry benchmarks. We will continue to work to reduce TME by performing health care services in lower cost settings; reducing unit costs; growing covered lives while managing risk and reducing TME; pursuing innovations in care management and care delivery; and improving care across the entire continuum of care, from primary care, to community-based acute care, to tertiary/quaternary care, to post-acute care.

Despite our vigorous efforts, there are three key areas of concern: the explosive growth in the cost of pharmaceuticals; the cost of new technology and advances in clinical capability; and wage pressure in a competitive labor market.

Explosive Growth in Cost of Pharmaceuticals. Evolution in biologic drug therapy has been very good for patients and very challenging from a cost perspective. Indeed, most diseases are treated with drug therapy, and in the absence of such therapy, uncontrolled disease or unmanaged illness result. The inflation rate for pharmaceuticals for our organization, even with cost control mechanisms and strategies in place, is approximately 7.85%. Contributing to these high costs are sole source drugs, highly specialized therapies, and drug shortages.

Cost of New Technology and Clinical Advances. One example of such new therapy is TAVR, for transcatheter aortic valve replacement, a highly costly procedure which can dramatically improve the lives of high risk patients who are unlikely to survive a heart valve replacement.

Wage Pressure. The single largest obligation of our annual operating budget is the funding of our workforce. Our physicians, nurses, allied health professionals, and our entire workforce continue to be the backbone – and the heart and soul -- of our organizations. It is a core value of our Medical Center to make BIDMC the workplace of choice for our employees, and this guides our decisions regarding compensation and benefit structure.

These cost growth in these areas gives us serious concern about the ability of providers and the Commonwealth to meet the cost growth benchmark in 2017.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

Three key areas that will benefit from changes in policy, payment, regulation or statute would include measures to encourage more insurance product designs to incent patients and consumers to choose value-based providers; to address uncontrolled pharmaceutical costs; and to address the issue of unwarranted provider price variation in Massachusetts, which continues to promote dysfunction in the health care market.

As we noted last year, unjustified and dramatic variation in prices paid to like providers continues to have a significant impact on the healthy functioning of the health care market in Massachusetts, both for low-cost community providers, and for providers of similar size and capability who provide precisely the same services and fulfill the same mission at dramatically different prices within the market. Unjustified price variation continues to contribute to the destabilization of hospitals, including community hospitals, those that serve disproportionate numbers of low income patients, and some academic medical centers. It is also clear that price variation is a major contributor to the growth of health care costs in the Commonwealth. This market dysfunction has been harmful to consumers in the Commonwealth, particularly in communities where access to care has eroded or disappeared.

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Currently Implementing

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

vii. Other: Insert Text Here
viii. Other: Insert Text Here
ix. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

As illustrated in our testimony provided in 2015, BIDMC, along with our ACO, Beth Israel Deaconess Care Organization (BIDCO), continues to identify and employ strategies to enhance access and improve integration of behavioral health care. First, within our own primary care practices, consultation with psychiatrists, psychologists and social workers is built into our usual practice of care. We have also enhanced broader integration efforts through a multidisciplinary, hospital-wide Opioid Task Force, resulting in a number of new initiatives to integrate acute and post-acute care for patients suffering with opioid addictions. Second, across a broader range of physician practices and community health centers, we have efforts in place to provide psychiatric expertise by telephone, including consultative services to PCPs and other clinicians, in order to enhance the capacity of these clinicians to treat patients with behavioral health issues in the patient's primary care location or medical home. Finally, we are engaged in a series of efforts to embed psychiatry and mental health services in primary care practices in an effort to increase access, collaborative care and consultation among clinicians, and reduce stigma for patients; implementation of a "House Calls" initiative through BIDCO, referenced in last year's testimony, which has some capacity to assist patients with behavioral health needs in order to prevent unnecessary utilization of the ED and inpatient care; to expand the "Healthy Lives" program referenced in last year's testimony, with the awarding of an HPC Innovation Investment grant; and to provide psychiatric urgent care through access by community PCPs to rapid psychiatric consultation with a psychiatrist on-call.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

There are several key barriers to effective access to and integration of behavioral health. First, as we noted in 2015, there is no reimbursement for consultative services provided by psychiatrists, despite evidence that such efforts yield cost savings in a fully-implemented global payment system. Thus, funding for innovative and critical programs remains a key challenge. Second, inadequate reimbursement for care has resulted in a highly fragile and uneven care delivery system for behavioral health patients and has contributed to shortages of inpatient beds and intermediate care options, poor conditions for effective care management, and capacity challenges for community based treatment of the chronically mentally ill. Finally, we again reference the Office of the Attorney General's 2015 Report, which provided a compelling examination of how the current insurance system with "carve outs" for mental health services works against efforts to integrate mental health care with the rest of medical care, provides little to no incentive to optimize utilization of services, and keeps reimbursement for mental health at an historic low.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

Social determinants of health are the conditions in which people are born, grow, live, work, and age. According to the World Health Organization, these circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinates of health are mostly responsible for health inequities—the unfair and avoidable differences in health status.[1] Healthy People 2020's five key areas for issues and underlying factors affecting health and well-being include economic stability (e.g, poverty, employment, food security, housing stability), education, social and community context (e.g., social cohesion), health and health care, and neighborhood and built environment (e.g., access to healthy food, crime and violence). Beth Israel Deaconess Medical Center (BIDMC) recognizes that to improve overall health, social determinant needs must be integrated with physical health needs. Social determinants affect diagnosis, treatment options and adherence, and disease prevention.

On a population-wide level, every three years, BIDMC conducts a comprehensive community health needs assessment (CHNA). The dominant theme from BIDMC's most recent CHNA key informant interviews and community forums was the continued impact that the underlying social determinants of health are having on BIDMC's Community Benefits Service Area's (CBSA) low income, underserved, diverse population cohorts. More specifically, determinants such as poverty, employment opportunities, violence, transportation, racial segregation, literacy, provider linguistic/cultural competency, social support, and community integration limit many people's ability to care for their own and/or their families' health. Although the impact of social determinants was the leading CHNA finding, a close second was the profound impact that behavioral health issues (i.e., substance abuse and mental health) are having on individuals, families and communities in every geographic region and every population segment in BIDMC's CBSA. Depression and anxiety, suicide, alcohol abuse, opioid and prescription drug abuse, and marijuana use, particularly in youth, are major health issues and are having a tremendous impact on the population as well as a burden on the service system. The important relationship between physical and behavioral health compounds the impact of these issues. Of particular concern are the increasing rates of opioid abuse.

BIDMC takes a two-pronged approach to address the social determinants and leading health risk factors (e.g., lack of nutritional food and physical activity, alcohol/illicit drug use). One is by extending our reach to address population health issues by working with a broad array of community partners (e.g., community health centers, Sociedad Latina, Jewish Vocational Services, etc.) that share our commitment to community and to improving the health, well-being and lives of our neighbors. The second is via assessment of individual patients and linking these patients directly to care and services to address identified needs. Additional information about these strategies is provided in Appendix A.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

BIDMC recognizes that it is crucial that disparities be addressed, and, to this end, BIDMC's continues to include a myriad of programs, strategic interventions, and services that are carefully targeted to address social determinants. A challenge for our ACO is how to effectively incorporate social determinants of health into our EHRs and other reporting systems to more effectively track progress. It is critical to note, however, that there is a multitude of individual, community and societal factors that work together to create these needs and corresponding inequities. The underlying issue is not only race/ethnicity, foreign born status, or language but rather a broad array of inter-related issues including economic opportunity, education, crime, and community cohesion. Arguably, these are the leading determinants of health for all urban communities in the United States, and they are daunting challenges. Many of Boston's major academic and health care institutions, including BIDMC, have been at the heart of this national dialogue for decades. BIDMC is committed to doing what it can to address these factors, and every priority area and goal in BIDMC's Community Benefits Plan is structured to address health disparities and inequities in some way.

[1] World Health Organization 2015

Overwhelmingly, the barriers to addressing social determinants are lack of funding and inadequate resources. Truly addressing most of the needs would require adequate and affordable housing stock; sufficient capacity for mental health and substance abuse treatment and resources; and capacity within diverse, low-income communities to aid and assist unemployed and under-employed residents in soft job skills and to provide adequate and affordable high quality child care and accessible, reliable transportation to and from low-income neighborhoods. The issues that we face here at BIDMC are not unique to Boston; rather, they are national issues that challenge our communities and hinder low-income, diverse cohorts from breaking the cycle of poverty.

Beth Israel and New England Deaconess Hospitals were founded to serve the underserved. To this day, BIDMC remains true to its original mission. We care for our patients regardless of insurance status or ability to pay. For nearly fifty years, we have partnered with community health centers to ensure access to care and with these and many other community based organizations worked to address social issues plaguing our vulnerable neighbors. These issues are not limited to our patients but affect a broad cohort of diverse individuals. Despite economic growth and success, income disparities are widening and we are experiencing affordable housing shortages. BIDMC continues to work to address the public health and social needs of our community and advocate for policy changes and additional resources for substance abuse treatment, mental health parity, stable and affordable housing, and transportation equity. Breaking the cycle of poverty will require creating communities in which our vulnerable and low income neighbors have access to the high quality core resources –accessible healthy food, decent wages and job opportunities, training programs and good schools, accessible transportation.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

BIDMC has been very clear that our strategy has not been to drive volume to academic medical centers. Rather, we are working hard to enhance services in local communities through a strategy of expanding the community based Primary Care Practitioner (PCP) platform, deploying specialists where gaps exist and growing clinical program capabilities in those communities. We have also expanded community-based urgent care capacity to reduce the need for emergency care in our hospitals.

It is important to note, however, that our own network already includes institutions that are among the lowest cost and highest value community sites of service in the Commonwealth, including Beth Israel Deaconess Hospital – Needham (BIDH-Needham), Beth Israel Deaconess Hospital – Milton (BIDH-Milton), Beth Israel Deaconess Hospital – Plymouth (BIDH-Plymouth), Anna Jaques Hospital, Cambridge Health Alliance, and Lawrence General Hospital. In addition, BIDMC's community hospitals (BIDH-Needham, BIDH-Milton, and BIDH-Plymouth) are among the fastest growing community hospitals in Massachusetts. a reflection of our successful execution of our strategy to maximize delivery of appropriate care at our community sites. Maintaining care within our broader system of affiliates is, of course, important to ensure optimal communication and coordination, especially in transitions of care.

In the community, we are constantly encouraging PCPs and the management team of our Affiliated Physicians Group (APG) – the organizational platform for employed community based PCPs – to utilize available specialty and ancillary care provided in their local communities. These efforts include not only utilization of community providers in lieu of AMCs, but also community providers that are lower cost within their own service areas. BIDMC clinicians in Chelsea, for example, actively encourage utilization of neighboring Whidden Hospital for appropriate emergency, specialty outpatient and ambulatory care. In

addition, our payer contracts through BIDCO appropriately incentivize use of these high value institutions further encouraging community based, lower cost sites of service for care.

Notwithstanding a lack of corporate linkage or joint contracting, we also utilize programs that have been jointly developed with other key partners or provide a unique service in the community, including, for example, Atrius Health, Signature HealthCare in Brockton, and Hebrew Senior Life. We have worked with Signature Healthcare to enhance their community capability in orthopedics and cancer care.

Outer Cape Health Services, another BIDMC clinical affiliate, utilizes the Cape Cod Health System for much of its care because of its convenience for Outer Cape patients.

Finally there are several examples of joint Atrius/BIDMC programs in the community, including collaboration around VNA services that service our population.

It is also important to note that when tertiary or quaternary care is needed, BIDMC offers a high value alternative to other, significantly more expensive AMCs.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.
38T

ii. If no, why not?

While our EHR system incorporates provider cost and quality information, such information is not readily available at the point of referral. Through BIDCO, however, member hospital and provider leaders receive cost and quality information. BIDCO notes, however, that much of the cost and quality data provided by commercial payors is lagged. BIDCO also utilizes the GIC variation reports. BIDCO is actively examining and identifying key opportunities in this area.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting,that is available at the point of referral?

No

i. If yes, please describe what information is included.
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ii. If no, why not?
Please see above answer.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?

Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

Yes, BIDMC may exchange information with other provider organizations' systems that are not corporately affiliated or jointly contracting with BIDMC (or BIDCO), such that each organization may receive the other's electronic health records. In general BIDMC offers 3 kinds of services:

"Push" – BIDMC utilizes the Mass HIWay to send patient care summaries to the next provider of care, which can be any one of the 400+ organizations that participate in the Mass HiWay. For example, we actively send Emergency Department Summaries and Discharge Summaries to such organizations every day.

"View" - BIDMC created the technology that enables any organization, which signs appropriate agreements to protect the confidentiality, privacy, security and integrity of the information, to view the records of patients we share in common.

"Pull" - BIDMC was the demonstration site for the Mass HiWay models enabling trusted organizations to request and receive information about BIDMC patients. The technology capability exists and we understand that the Commonwealth is in the process of refining consent regulations before widely rolling out this service.

BIDMC clinicians, for example, from the emergency department to inpatient and outpatient settings, may view the medical records of key community clinical partners, thus accessing previous images, tests, and other key points of information, which improves patient care and experience, and reduces unnecessary additional imaging and testing.

ii. If no, why not?
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6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

BIDMC is engaged in Alternative Payment Methodologies (APMs) with many of the Commonwealth's major insurers. Most of our HMO population is included in APMs. Our APM's are risk-based contracts through our ACO, Beth Israel Deaconess Care Organization (BIDCO), based on global budget models. We have been involved in the Medicare Pioneer ACO program, and will be entering into the Medicare Shared Savings program in 2017. We have risk-based contract models for several Medicare Advantage Products. We are actively exploring APM opportunities with MassHealth.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Some barriers to increased adoption of APMs include the enormous administrative complexity of adding new components, such as bundled payments, which involve the sharing of a fixed amount across a number of providers and entities. In addition, proposed APMs for PPOs have been administratively very complex, and must be refined and improved in a way that works for the provider participants. For example, it is difficult for a provider to monitor quality and other metrics from 10 different products across the three major insurers, and ultimately, this must be simplified. We have begun a process internally to review and identify the best metrics for rewarding providers under APMs.

Health insurers must improve the design and communication of APM's to their self-insured employers in order to incent such employers away from the current model of paying straight claims and an administration fee, to a new model of rewarding providers for improving care and lowering overall claims and costs.

Currently, the national plans are not offering APM contracts for commercial products.

c. Are behavioral health services included in your APM contracts with payers?
Yes
    i. If no, why not?

Behavioral health services are included in APM contracts when the payer does not contract with a behavioral health company to manage its behavioral health benefit. If the APM includes behavioral health services, reimbursement terms for BIDCO's behavioral health providers are included in the terms of the APM contract, and behavioral health services are managed under the risk component of the APM.

For those BIDCO APM contracts when the payer utilizes a behavioral health company to manage its behavioral health benefit, BIDCO's APM contract does not include reimbursement terms for its behavioral health providers and the risk of managing these services is not a part of the APM.

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Our medical center is responsible for reporting approximately 300 unique measures of quality and safety to various entities, including payers, accreditation bodies, and regulators at the federal, state, and community levels. A minority of these are fully electronic. Adding to the complexity, the same measure may be defined differently by different entities, or have unique inclusion/exclusion criteria. While the complexity remains daunting, there are some encouraging trends nationally towards consensus agreement on measures and standardization of definitions. In Massachusetts specifically, we still see a lack of alignment between the requirements of the three prominent commercial payers, the requirements of MassHealth, and local and state public health departments. There are also an increasing number of program-specific reporting requirements in the state. Examples would include the birth defect registry, HIV registry, newborn registry, opioid dependent newborn related syndrome reporting, and other reporting requirements. BIDMC seeks to address these challenges by achieving maximum efficiency in data collection and automation, but in reality a large number of measures, especially those required at the state and local level, require manual collection, cleaning, and reporting.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

Entities requesting performance data should take maximum advantage of the national trend towards refinement and consensus of performance metrics, and take steps to ensure alignment in measure definitions and time frames. As is being noted nationally, process measures are becoming "topped out" and those should be avoided as it leads to artificial distinctions and aberrant conclusions (i.e. 95% compliance may be categorized as poor performance.) Measures that allow for electronic collection should be favored, but systems need to

allow hospitals adequate time to set up the infrastructure for automatic collection of such measures, and validating the data.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
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Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. For each year 2012 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

Enclosed, please find BIDMC revenue information, similar to the information provided by BIDMC in last year's testimony. At this time, we have not included the operating margin information as requested above because of the lack of standardized approaches, methodology or definitions with regard to the information requested; the highly proprietary nature of this information; the strong likelihood of significant variation across provider organizations in reporting this data; and concerns regarding the ultimate reliability, accuracy, and value of the data to the public, given the limitations and concerns described above. BIDMC remains committed to transparency, and welcomes the opportunity to work with the HPC and the AGO to provide appropriate safeguards for proprietary information and to ensure that information provided addresses the purpose of its collection.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
    a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

As we indicated in last year's testimony, BIDMC has purchased an estimator tool to help respond to these consumer inquiries. Because most estimator tools were focused on physician practice prices, we have worked with the vendor to customize the tool for hospitals and provided the vendor with considerable education in order to ensure that the tool works effectively for hospital consumers. We have set up a central email box for all estimates in order to centralize requests for the purpose of response and monitoring. We have created several tools to assist staff in determining the correct codes and DRG's to use for services. We continue to work with our physician partners at the Harvard Medical Faculty Physicians at BIDMC to ensure that all professional components are captured, and we continue to refine our process as we learn more.

    b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

We track everything that we respond to and doublecheck our estimates for accuracy and we use historical data to continue to modify our procedure sets and improve our accuracy. We continue to make changes and improvements to the system based on these analyses. We also run our estimates against real-time data in order to identify the correct procedure sets.

    c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

Perhaps the most significant barrier is not having a clear understanding from the consumer regarding what is needed. A significant amount of information is needed from the patient in order to provide an accurate estimate. We always ask the patient for as much information as possible, but a patient will often just describe the service- which could translate to multiple codes.

BIDMC will continue to provide estimates to consumers based on their requests, but we acknowledge that these will not always be as accurate as estimates provided based on codes. For example, a patient may indicate a need for an image, but not indicate more information beyond that.

Another barrier is that plans may change during a patient visit or procedure, based on unanticipated needs or complications. We work hard to provide an accurate range, but occasionally, things may change.

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.

8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

BIDMC - 2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 102.5	$ 129.1			
Tufts Health Plan											$ 28.8	$ 40.9			
Harvard Pilgrim Health Care											$ 104.8	$ 45.6			
Fallon Community Health Plan											$ 3.2				
CIGNA											$ 7.1				
United Healthcare											$ 10.6				
Aetna											$ 19.3				
Other Commercial											$ 25.7				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 302.1	$ 215.6	$ -	$ -	$ -
Network Health											$ 28.0				
Neighborhood Health Plan											$ 27.5				
BMC HealthNet, Inc.											$ 7.4				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 62.9	$ -	$ -	$ -	$ -
MassHealth											$ 56.6				
Tufts Medicare Preferred											$ 26.6				
Blue Cross Senior Options											$ 8.2				
Other Comm Medicare											$ 10.8				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 45.6	$ -	$ -	$ -	$ -
Medicare											$ 306.7				
Other											$ 55.9				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 829.8	$ 215.6	$ -	$ -	$ -

Total	$ 1,045.4
Financials	$ 1,045.4
Variance	$ 0.0

BIDMC - 2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 95.3	$ 127.0			
Tufts Health Plan											$ 27.4	$ 46.0			
Harvard Pilgrim Health Care											$ 113.0	$ 39.8			
Fallon Community Health Plan											$ 3.5				
CIGNA											$ 8.7				
United Healthcare											$ 10.1				
Aetna											$ 18.5				
Other Commercial											$ 25.7				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 302.2	$ 212.8	$ -	$ -	$ -
Network Health											$ 29.0				
Neighborhood Health Plan											$ 31.1				
BMC HealthNet, Inc.											$ 11.2				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 71.3	$ -	$ -	$ -	$ -
MassHealth											$ 50.0				
Tufts Medicare Preferred											$ 30.2				
Blue Cross Senior Options											$ 10.0				
Other Comm Medicare											$ 13.0				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 53.3	$ -	$ -	$ -	$ -
Medicare											$ 317.8				
Other											$ 44.1				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 838.7	$ 212.8	$ -	$ -	$ -

Total	$ 1,051.5
Financials	$ 1,051.5
Variance	$ (0.0)

BIDMC - 2014

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 98.1	$ 136.7			
Tufts Health Plan											$ 29.1	$ 46.7			
Harvard Pilgrim Health Care											$ 142.7	$ 17.4			
Fallon Community Health Plan											$ 5.2				
CIGNA											$ 8.8				
United Healthcare											$ 9.0				
Aetna											$ 18.2				
Other Commercial											$ 39.5				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 350.6	$ 200.8	$ -	$ -	$ -
Network Health											$ 35.2				
Neighborhood Health Plan											$ 37.8				
BMC HealthNet, Inc.											$ 11.7				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 84.7	$ -	$ -	$ -	$ -
MassHealth											$ 49.3				
Tufts Medicare Preferred											$ 32.8				
Blue Cross Senior Options											$ 12.2				
Other Comm Medicare											$ 13.6				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 58.6	$ -	$ -	$ -	$ -
Medicare											$ 332.0				
Other											$ 37.5				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 912.7	$ 200.8	$ -	$ -	$ -

Total	$ 1,113.5
Financials	$ 1,113.5
Variance	$ (0.0)

BIDMC - 2015

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 106.9	$ 149.5			
Tufts Health Plan											$ 27.2	$ 49.0			
Harvard Pilgrim Health Care											$ 152.0	$ 21.1			
Fallon Community Health Plan											$ 5.2				
CIGNA											$ 10.3				
United Healthcare											$ 9.1				
Aetna											$ 20.0				
Other Commercial											$ 38.3				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 369.0	$ 219.6	$ -	$ -	$ -
Network Health											$ 34.3				
Neighborhood Health Plan											$ 49.1				
BMC HealthNet, Inc.											$ 12.6				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 96.0	$ -	$ -	$ -	$ -
MassHealth											$ 59.0				
Tufts Medicare Preferred											$ 34.3				
Blue Cross Senior Options											$ 16.4				
Other Comm Medicare											$ 16.8				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 67.5	$ -	$ -	$ -	$ -
Medicare											$ 342.6				
Other											$ 45.1				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 979.2	$ 219.6	$ -	$ -	$ -

Total	$ 1,198.8
Financials	$ 1,198.8
Variance	$ (0.0)

APPENDIX A

QUESTION 2. Strategies to Address Pharmaceutical Spending

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. **Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)**

Yes, BIDMC is currently implementing this strategy. Providing education and information on cost-effectiveness of clinically appropriate drug choices, as well as treatment alternatives and drug therapy alternatives are built into our everyday pharmacy practice at BIDMC. We accomplish this through the work of our Pharmacy & Therapeutics Committee (P & T), and P & T subcommittees that review specialty drugs for oncology, antibiotic management and other areas.

The P & T Committee is a standing committee of the Medical Staff and Medical Executive Committee, comprised of physicians, pharmacists, nurses and other health professionals. It is a policy-recommending body to the medical staff and administration on matters related to the therapeutic use of drugs.

The P & T committee evaluates the clinical use of drugs, develops policies for managing drug use and drug administration, and manages the formulary system. The primary areas of focus of the Committee include:

- Formulary Management
- Cost-Effective Drug Therapy
- Medication Use Evaluation
- Clinical Quality Value Analysis (CQVA) and
- Medication Safety and Reliability

The P & T program runs a large stewardship program for antibiotics. Formulary management is also controlled by the P & T Committee and this is the primary mechanism we use to promote cost-effectiveness. Pharmacists work on patient floors to monitor patient drugs on a daily basis. In addition, many of our strategies for cost-effectiveness are built into the decision support for our Physician Order Entry System (POES), and clinical practice guidelines that we have developed. So, for example, there may be 20 potential drug therapies for hypertension, but BIDMC's formulary will promote the two most cost-effective options.

For our risk contract patients, BIDCO pharmacists assist providers with cost-effective pharmacologic management of acute and chronic conditions. Providers are provided with educational resources identifying opportunities to reduce pharmacy expenditures while maximizing patient outcomes. The BIDCO clinical pharmacists utilize the athenaNet suite of reporting tools to analyze pharmacy utilization data. Clinical pharmacists attend quarterly meetings with the primary care providers, and are also available for individual patient consultation.

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Yes, BIDMC is currently implementing this strategy. BIDMC monitors variation in provider prescribing patterns and trends, and conducts outreach to providers with outlier trends. We conduct medication use evaluations and collect data to identify outliers at floor, department and/or individual provider levels. Outreach is occasionally brought to a department's own Quality Assurance (QA) meeting. We review expanded uses of drugs to ensure that the expanded use is appropriate (e.g. oncology drugs). We identify variations based on cost increases, safety concerns or increases in utilization and conduct reviews to understand how, why and who are using particular drugs.

Given that our practitioners treat most diseases with drug therapy, we also see the value of such therapy as compared to the cost and consequences of unmanaged and uncontrolled disease and illness.

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Yes, BIDMC is implementing this strategy. BIDMC has protocols and guidelines in place both to ensure appropriate drug use and cost-containment. It is critical, for example, to manage the use of intravenous Tylenol at a very high cost compared to extremely low cost for oral Tylenol tablets. The use of order sets and protocols guide physician drug utilization to more cost-effective drug therapy and appropriate doses. Additionally, clinical pharmacy programs such as the antibiotic stewardship and transplant programs ensures best practices in pharmaceutical costs are implemented.

BIDMC also has a Transition of Care program in place which has proven that a pharmacy component to managing post-acute patients made a difference in patient compliance and lowering readmissions.

iv. Establishing internal formularies for prescribing of high-cost drugs

Yes, BIDMC is implementing this strategy. BIDMC has internal formularies for all of our drugs. We review these formularies by individual drug, drug classes, requests for non-formulary drugs and utilization of non-formulary drugs.

v. Implementing programs or strategies to improve medication adherence/compliance

Yes, BIDMC is implementing this strategy. On the outpatient side, BIDMC has created a Transitions of Care Program, and employs Transition of Care pharmacists associated with several outpatient clinics and practices, to engage in medication review with patients and discharge counseling. Pharmacists help support patient care in the ambulatory arena in the anticoagulant, hypertension, transplant, hepatology, and infectious disease clinics to improve patient outcomes and medication adherence.

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Yes, BIDMC is implementing this strategy. BIDMC is accountable for pharmaceutical spending as part of our total medical expense (TME) and therefor has incentive to control costs on pharmaceutical spending.

vii. Other: Insert Text Here
viii. Other: Insert Text Here
ix. Other: Insert Text Here

QUESTION 4 (CONTINUED). There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

1. Population-level/community-based efforts:

Services designed to improve the health of the patients in our communities are woven throughout the BIDMC's tapestry with programs sponsored, housed, and owned by the Department(s) best suited to deliver the care and services necessary. Certain services are delivered directly to specific patients while others are offered to the community at large. Some highlights include:

- Physical activity (nutrition, exercise) – BIDMC built a Wellness Center in the heart of the Bowdoin-Geneva neighborhood at our Bowdoin Street Health Center facility. That community is faced joblessness, violence, trauma and a lack of community cohesion, all of which have links to the health of the individuals who live there. The Wellness Center recently implemented Train4Change, an evidence-based program that trains community residents to become certified fitness class instructors. Graduates of the program can teach their neighbors at the Wellness Center and can also seek jobs at other fitness/exercise facilities. Not only does this create job prospects and economic opportunity, it reinforces the importance of being physically active to improve an individual's health and it increases community cohesion –as neighbors teach neighbors.

- Healthy eating (nutrition, food access) – Working with BIDMC's Office of Community Relations, the Department of Surgery's Committee for Social Responsibility has created and sustained a "Food is Medicine" initiative. This initiative partners with the Greater Boston Food Bank (GBFB) to raise awareness and support efforts to feed hungry families throughout eastern Massachusetts. Most recently, this partnership was expanded as BIDMC supports the Charles River Community Health, a BIDMC affiliated health center, as they partner with the GBFB to increase access to healthy foods on-site at the health center. Additionally, BIDMC supports and collaborates with the Boston Public Health Commission and other community-based organizations (e.g., to promote accessible/affordable healthy food) including Bounty Bucks, Farmers Markets, and Community Supported Agriculture (CSA) programs.

- Economic Stability/Employment – In early 2016, BIDMC raised our starting wage to $15 an hour, increasing the wages of 13% of our workforce. Committed to doing the right thing for our employees, we also have a strong commitment to developing our workforce by enhancing the skills of our diverse employees and providing career advancement opportunities. In FY 2015, BIDMC offered incumbent employees five "pipeline" programs to train for the following professions: Centering Processing Technician, Pharmacy Technician, Medical Coder, Patient Care Technician, and Medical Laboratory Technician to Medical Technologist.

  Learn to Earn Program: This year, BIDMC is implementing a program with Bunker Hill Community College. BIDMC has hired Certified Nursing Assistants and is paying while training these individuals to become Patient Care Tech (PCT).

  Employee Career Initiative (ECI): BIDMC's ECI provides career and academic counseling, on-site academic assessment, and on-site pre-college and college-level science courses to employees at no charge. Tuition reimbursement and competitive scholarships as well as ESOL, GED prep, basic computer skills and citizenship classes are offered. BIDMC also offers employees the opportunity to take the course "Moving from Debt to Assets," which helped employees build financial literacy skills.

  Jobs and careers for community residents: BIDMC is committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies such as St. Mary's Center for Women and Children and YMCA Training, Inc. We also provide feedback to community organizations such as International Institute of Boston, Bottom Line, and Career Collaborative on adults applying to jobs at BIDMC. In FY 2015, BIDMC Interpreter Services, Workforce Development, and Human Resources partnered with a community-based organization called Found in Translation to provide a career workshop for bilingual low-income women pursuing a career in medical interpreting.

  Introductory opportunities for middle and high school students: Recognizing our commitment to the Boston area's student population, the medical center provides summer jobs and mid-year internships to introduce high school students and out-of-school youth to careers in the medical field. In partnership with the Boston Private Industry Council, we host students from Boston public high schools in an annual Job Shadow Day with additional student groups touring our skills lab throughout the year. BIDMC is also a presenting sponsor of the Red Sox Scholars Program that pairs BIDMC Medical Champions with 8 academically talented, economically disadvantaged 8th grade students from Boston Public Schools. The program includes opportunities for professional development such as Shadow Day at BIDMC clinical sites. Finally,

BIDMC hosts high school students (age 14-17) for seven weeks during the summer, where the teens can explore various careers while gaining experience in a hospital setting.

- Violence Prevention – BIDMC's Center for Violence Prevention and Recovery facilitates a comprehensive, integrated approach to addressing multiple forms of violence experienced in people's lives. The Center provides services to victims/survivors of interpersonal violence, trains healthcare providers to identify and respond to patients who are experiencing or have previously experienced violence in their lives, and improves the connection between health care providers and community agencies that provide violence prevention and recovery services. Additionally, Bowdoin Street Health Center's Youth Leadership Program empowers youth to develop leadership skills, prevent violence and create change in their community.

- Substance Use – Please see answer to Question 3. Some examples of the outlined strategies include the provision of psychiatric consultation and technical assistance to build primary care providers' ability to diagnose and treat behavioral health issues in the primary care setting; Emergency Department screening, brief intervention and referral to treatment; supporting the expansion and renovation of The Dimock Center's inpatient detoxification unit, CSS Renewal program to link women in recovery with access to gynecologic preventive care, and to grow Dimock's OBOT program. In addition, Health Care Associates (HCA), The Dimock Center and Bowdoin Street Health Center are collaborating on the integration of behavioral health and primary care through the HMS AIC.

2. At the individual patient level, we screen patients for individual social determinants needs and develop different mechanisms for linking them to needed services:

- <u>Screenings/Assessment</u> – BIDMC screens patients for a number of social determinants and this information is recorded and updated in WebOMR, BIDMC's electronic health record (EHR). Assessments are typically completed by a licensed social worker, nurse case manager, or a community resource specialist. The assessments include questions on the patient's current living situation (i.e., stability of housing), food security, financial security (i.e., employment, disability), transportation, insurance, prescription coverage, violence/domestic violence concerns, substance abuse and/or mental health (typically done by clinical social worker), etc. Patients seen in our Infectious Disease department are also screened for housing, disability, and need of prescription coverage (e.g., HDAP).

  Additionally, BIDMC's Post-Acute Care Transition (PACT) program conducts a detailed assessment of patients related to the patient's understanding of medical diagnoses/clinical status and the patient's social situation. Upon enrollment in PACT, the team assesses understanding of current hospitalization/diagnosis/plan of care, current living situation (i.e. who they live with), family/neighborhood supports/ADL assistance—cooking, shopping, cleaning, active/past VNA/Elder service assistance, medication management/access, and transportation to appointments.

3. Linking/Addressing the Needs: BIDMC has a multitude of qualified staff to assist patients with identified social determinant needs. These include:

- Community Resource Specialists (CRS) – BIDMC has CRS throughout the BIDMC inpatient and outpatient system who assist patients with a myriad of needs including housing, insurance, medication, etc. A CRS is assigned to all Health Care Associate teams, which ensures that patients

referred by their clinician receive a resource assessment that addresses the social determinants of health including food, shelter, financial needs, heat/hot water, insurance etc. Additionally, the PACT team has its own CRS who meets with patients prior to discharge and continues after discharge to assist patients with access to the areas identified during their needs assessment. Such resources include elder service referrals, transportation, etc. The CRS can also address needs such as addiction, domestic violence, elder abuse, etc.

- Care Managers: Nurse and/or social work case managers assist patients throughout our system. Some case managers are 'on-the-ground' as they are embedded in BIDMC primary care practices (i.e., Bowdoin Street Health Center, certain APG practices and HCA), ambulatory departments (e.g., Emergency Department, etc.), and inpatient floors. BIDMC's Affiliated Physician Group (APG) and Beth Israel Deaconess Care Organization also have centralized nurse case managers. Patients are assisted by these case managers to identify social determinant needs and connect these patients with resources in their community to address needs such as transportation, housing, meals, food, etc. The PACT nurse also continues to be available to the patient after discharge providing phone follow-up to do ongoing teaching with diagnoses/symptoms that require evaluation/etc., strengthen the relationship between patients/PCPs and connect the patient services should their needs change when they have returned home.

- Community health workers (CHW) – BIDMC's Bowdoin Street Health Center has four full-time who work with the health center's highest risk patients. Serving primary care and Obstetric patients, the CHWs engage with the patient, visit the patient in their home and community and work with the patient to address social needs such as housing, transportation, medication access and adherence, food security, etc. The CHW's also work in the Bowdoin Geneva neighborhood to facilitate community cohesion in an effort to stem the tide of violence. They also organize and participate in community events to facilitate neighbors coming together.

- Wellist – is an application that connects people in BIDMC's community with needed services. BIDMC is piloting this application in HCA, Hematology/Oncology and Gerontology. The targeted cohort are those patients whose incomes are too high for public assistance programs but who still need resources. The application allows the individual to enter their needs and preferences such as geography, language, restrictions, (e.g., need meals but have diabetes or salt restriction). The Wellist then connects the individual with a service provider who, for a charge, can provide these services. The application also has a feature to provide a service plan for the patient and a registry function if the family members or friends would like to purchase these services for the patient.