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:

Boston Medical Center's (BMC's) mission is to provide exceptional care, without exception to all patients. Our patient population has the highest public payer mix of any acute care hospital in Massachusetts at 77% – with over half of our patients receiving care funded through MassHealth or free care (i.e. uninsured). We also serve an incredibly diverse patient population - 70% of our patients identify as a person of color and 32% of our patients speak a language other than English as their primary language.

Because of our patient makeup, BMC served a disproportionate number of COVID-19 patients compared to other hospitals. At the height of the first surge, 72% of our beds served COVID-19 patients, the highest proportion among Boston hospitals. At that point, we had 10% of hospitalized COVID-19 patients statewide while we only operate 3% of the hospital beds statewide.

COVID-19 has exacerbated staffing needs, particularly the demand for nurses which remains extremely high. Like many other hospitals, BMC needed to utilize travel nurses to care for patients during the COVID-19 surges. Now, an influx of patients back to hospitals after deferring care, combined with a loss of nursing staff has made staffing equally as challenging. To meet the demand, BMC is currently utilizing six times more travel nurses than before the pandemic. Because of the competition for these nurses nationwide, we also have significantly increased our travel nurse rate compared to the rate we offered pre-pandemic. Even with an influx of travel nurses, our other staff nurses have needed to work overtime to ensure the hospital is fully staffed. BMC has spent three times as much on our premium overtime during the pandemic as in previous years. We also have increased bonuses to help retain staff as burnout and other factors have reduced our workforce. We have seen some nurses choose to take advantage of the state's new paid family and medical leave policy and some leave our hospital to become travel nurses. While we remain fully staffed, maintaining our nursing workforce continues to be challenging.

Like many other hospitals, **COVID-19 upended our operations**, shifting care to focus on COVID-19 patients, restricting other services, and requiring new processes and

additional staff to comply with new safety protocols. This has had a profound financial impact, as we expect to have $**50M in unreimbursed COVID losses across FY21 and FY22 and COVID-19 operations continue to cost $5M per month**. While other hospitals may have faced similar situations, BMC feels losses more acutely given the perpetual underfunding of safety net hospitals and the financial challenges we face. While we are grateful that we received temporary financial support to ensure our operations continued, it is not a long- term solution for the structural deficit our system continually faces, which was exacerbated by COVID losses.

While the pandemic was perhaps the most challenging that this hospital and our staff have been through, it was also an extremely inspiring time to work at BMC. Our staff not only bravely came to work in very uncertain and frightening times, but also innovated under pressure and collaborated in extraordinary ways. Some of those are described in the sections below about the impact of the pandemic on our patients and our community.

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):

- **Direct Impacts of COVID-19 on our patient population**
    - BMC serves a diverse patient population, including a large number of people experiencing homelessness who were at increased risk of COVID-19 infection due to an inability to social distance. In partnership with the state, **BMC opened at COVID-19 Recuperation Unit (CRU) in a vacant hospital building, in a matter of days**, to provide clinical care and a safe isolation space for members of this population who tested positive for COVID-19 during the first surge of the pandemic. These patients also had high rates of substance use and mental health disorders, so the CRU offered treatment for behavioral health issues, addiction consultations, initiation of medications for opioid use disorder, and harm reduction tools on site. The CRU provided essential care for people experiencing homelessness who did not require hospitalization, but needed a safe space to quarantine. This also preserved bed capacity at BMC for more acute COVID-19 patients requiring inpatient services.

- **Impacts of Deferred or Cancelled Care on BMC Patients**
    - Like many other hospitals, the need to cancel surgeries because of COVID-19 put our patients behind on care. Rebooking these procedures in addition to the rebound of in-person appointments has resulted in a referral

backlog in the thousands for surgeries and other general procedures. We are working to clinically triage the referral list for urgent or emergent threats and are booking as many as these appointments as we can. In addition to missed procedures, routine care and testing were also missed. While telemedicine was extremely helpful during the pandemic, certain tests like blood pressure readings and A1C diabetes tests could not be performed virtually. These are important population health measures and indicators of wellbeing for patients with chronic diseases. Providers are now missing a year or year and a half of these benchmarks of patients' health and are working to re-engage patients to get them back to regular testing. Additionally, now that care has rebounded, our providers have found patients are arriving or being admitted sicker than they were in the past. Our case mix index is up 5% over the prior year. While this does include COVID-19 patients, any increase in patients' acuity has a marked impact on our operations.

- **Exacerbation of behavioral health and substance use needs**
    - Visit volume across BMC Psychiatry increased by 25% during COVID-19. This increase was seen even at the earliest stages of the pandemic. Unlike many medical departments where volume dropped due to stopping in-person visits, Psychiatry converted to telemedicine almost immediately, thereby maintaining and substantially exceeding our typical volume. Even with this increase, there is still enormous demand for behavioral health care. Demand for Outpatient Psychiatry services has increased where we are now receiving 130-140 new referrals per week and, as a result, have a waitlist of ~600 patients. Overall, we estimate we will have 5,000 more referrals this year than in prior years. During COVID-19, our integrated behavioral health teams (behavioral health providers embedded within primary care settings) experienced roughly double the amount of referrals. About half of those patients reported COVID-19-related behavioral health stressors and needs. While our Psychiatry Emergency Service saw an initial drop in volume of patients in the early months of the pandemic as people were hesitant to visit emergency rooms for non-COVID-19 reasons, by July 2020, volume was back up above 2019 levels and has remained 11% higher throughout 2021 as compared to 2020. We have had up to 30 patients boarding per day in the emergency department, because of the severe shortage of psychiatric beds statewide. The average psychiatric hospitalization length of stay increased by 77% between 2019 and 2020, and then increased by an additional 49% between 2020 and 2021. The impacts of COVID-19 have exacerbated patients' existing

mental health needs and increased the population with mental illness across all age groups, including new psychoses in young people. Unfortunately, the mental health impacts of the pandemic will linger for years and our psychiatric clinicians expect that what we see in the future will be worse.

- While we saw an initial dip in March and April 2020, visits for substance use disorder have stayed fairly consistent at ~3,500 visits per month throughout the COVID-19 pandemic, despite the need to cancel many in-person services. As has been well-publicized, **the incidence of substance use disorder has increased during the pandemic, and we are grateful that BMC was able to adjust how we serve our patients to continue to be there for people ready to engage in treatment**. Individual programs have seen overall volume increases as telemedicine and federal flexibility to initiate buprenorphine treatment remotely have allowed them to shift or expand care virtually. For example, our low-barrier bridge clinic Faster Paths saw in-person visit volume drop by half in the beginning months of the pandemic, though the overall visits remained close to pre-COVID levels due to the expansion of telemedicine. Although many patients and people who use drugs lack the technology and private spaces for telemedicine, the program partnered with harm-reduction specialists doing street-based outreach to identify patients who were interested in treatment. They then used video and telephone connections from mobile devices to arrange impromptu telehealth visits with a medical provider at Faster Paths. Similarly, BMC's Office Based Addiction Treatment (OBAT) program was able to retain and expand patient visits through telemedicine with the program experiencing a 44% increase in visits in April 2020.

- To better address the significant behavioral health needs of our patients, of members in our ACO and in our communities generally, BMC has made the significant decision to open behavioral health beds. BMC does not have any behavioral health beds currently, representing a significant gap in our service delivery and challenging our ability to manage the care and costs of our ACO members. We have purchased a former nursing home in Brockton and plan to open 56 inpatient psychiatric beds and 26 crisis stabilization substance use disorder beds there next year. We are looking forward to better serving our members and patients in this way, but note that we need to spend over $24 million in construction and start-up costs to open the facility. While we are hopeful that reimbursement will roughly cover the costs of operation once open, those construction and start up costs will be unreimbursed expenses, even after receiving behavioral health incentive grants from MassHealth.

- **Effects from Economic Disruption**
    - Even before the pandemic, about half of BMC's patients were living at or below the federal poverty line, making them especially vulnerable to the additional economic insecurity brought on by the pandemic. Early in the pandemic, **BMC launched Project REACH, an initiative to assess the well-being of pediatric patients who were isolating in their homes**. Through telehealth assessments and home visits, our staff surveyed patients on their most critical needs and food insecurity was the most common and persistent identified need of families. **43% of families reported trouble affording groceries and 19% reported that they didn't even have enough food in the home to last 3 days.** Early in the pandemic families discussed food insecurity in the context of shortages and the inability to go to the store or access community resources; later in the pandemic, families were more likely to report financial strain as a primary concern. In addition to Project REACH, we also routinely screen primary care patients using a social determinants of health screener. We saw a decrease in positive screens for food insecurity in 2020-2021, but believe this may be skewed by decreased patient volume and increased COVID-19 related stimulus and recovery measures. Enhanced benefits that are easier to apply for and maintain, such as SNAP has been during the pandemic, are essential supports for our patients.

    - BMC families also suffered from housing insecurity throughout the pandemic. 21% of families served by Project REACH reported housing concerns including difficulty paying rent or affording moving costs, challenges navigating the subsidized housing system, or difficulty understanding evolving eviction protection and legislation. These families were referred to our housing team for support. Addressing homelessness for families as well as individuals needing low barrier housing has been a top advocacy priority for BMC.

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 COVID-19 pandemic fostered unprecedented levels of communication and coordination among healthcare providers. **We applaud the work of the state's COVID-19 Command Center** for bringing together key stakeholders, sometimes daily, to troubleshoot issues, share updates, and work together. While there already were avenues of communication, as well as goodwill across the hospital community, COVID-19 brought much **deeper collaboration and rapid sharing of best practices**. Without time to wait for clinical studies at the beginning of the pandemic, chief clinicians at area

hospitals would share information of what was working for our patients. This collaboration was truly inspiring and life-saving, and we hope to see it continue beyond the pandemic for treatment in other areas.

Recognizing the enormous task of **addressing vaccine hesitancy** and administering vaccines to a diverse population, BMC partnered with community groups in innovative ways to better listen to and serve our patients and neighbors. We worked with local leaders in communities of color to learn about their concerns and to share information from diverse clinicians in multiple languages, hosting town halls and conducting a multilingual media campaign. We collaborated with local churches, community health centers, and neighborhood centers to set up and staff **6 community vaccine sites** to meet patients where they are. Because we already had strong relationships in the communities we serve, local groups helped us leverage their networks and connections to engage even more people. Since May 22nd, we have hosted or planned 188 Vaccine Pop Up events in community or at local schools, including partnerships with 59 schools in the Boston Public Schools system. Besides hosting community events, we used patient data to target outreach specifically to neighborhoods with a high number of unvaccinated patients. Our teams planned pop-up sites in these areas, conducted multi-lingual canvassing in neighborhoods, engaged local businesses in the area, and called patients directly.

Deepening and expanding our local partnerships has reminded us of the power of **harnessing community connections to provide better care for our patients**. Our vaccine work strengthened our existing relationships with community groups and helped us forge new partnerships. This focus on community and outreach has allowed us to reach neighbors who may have been less engaged in healthcare and has proven to be successful in reaching diverse populations. 69% of our offsite vaccinations served Black or Latino patients and 68% of our offsite vaccinations served those who live in neighborhoods in the top 3 deciles of the Social Vulnerability Index. It is our hope we can build upon this community work on other issues such as other vaccination efforts, reminders for appointments, patient re-engagement, or other public health campaigns that may require extensive outreach in the future.

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.

As part of our mission, and in service to the individuals and communities we serve, Boston Medical Center is committed to dismantling structural racism and addressing race-related health disparities and the root causes of racial inequities. BMC has taken a concerted effort to improve our demographic data collection and analysis, as we believe it is the foundation of all other health equity work. We cannot address racial disparities in health outcomes, if we cannot measure them. As such, BMC convened a multidisciplinary workgroup with expertise from IT, operations, patient registration, the academic research community, and clinicians to improve our current demographic data collection.

We are proud to consistently collect patients' race, ethnicity and language data, with only .2% of data missing from patients. (Note: Patients who opt not to share their demographic information are recorded as such and are not reflected in the missing data percentage.) However, we recognized our current dataset could be improved to better ask these demographic questions. Our internal workgroup reviewed the many available datasets, keeping in mind that we want to ensure the data we are collecting is in service to the patient and not just in service to a complete dataset. We recently chose the CDC data set as it has an appropriate level of demographic detail, especially the numerous choices for ethnicity which lend better to BMC's diverse patient population than the other datasets available. We are now working with our electronic health record vendor to transition to this new dataset, while maintaining our old data so it is accessible for comparison in the future. We anticipate the new dataset will be implemented with staff collecting this new data from patients at registration by February 2022.

Through this process we have also encountered some challenges in improving our data collection efforts. Disability status remains difficult to collect as there is no single definition for a disability. The definition can differ when speaking in the context of insurance status as compared to patient care in the clinical setting. Our internal workgroup in partnership with BMC's Center for Transgender Medicine and Surgery had a robust discussion surrounding the best way to collect sexual orientation and gender identity (SOGI) data. Ultimately, these conversations emphasized the importance of how you ask for this data as it can be very alienating if the request is presented in the wrong way. There was also discussion on whether this data is relevant to ask in certain clinical settings and if there are different healthcare delivery outcomes based on sexual orientation or gender identity. Ultimately, BMC will not be implementing a standard workflow to collect this SOGI data on all patients. It remains up to individual clinicians to decide if this data is relevant and then ask and document this information in a patient's electronic health record.

Our team reviewed a number of demographic datasets which all had advantages and disadvantages. It would be helpful for the HPC or another sate entity to create or recommend a gold standard for what code set is best to capture desirable data on patients. Additionally, a standard playbook on whose data to collect, when to collect it, and how to collect it would be useful for the field overall.

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**	34	107
	Q2	20	105
	Q3	N/A	N/A
	Q4	N/A	N/A
CY2020	**Q1**	N/A	N/A
	Q2	N/A	N/A
	Q3	N/A	N/A
	Q4	N/A	N/A
CY2021	**Q1**	N/A	N/A
	Q2	N/A	N/A
	TOTAL:	N/A	N/A

Note: Boston Medical Center is committed to price transparency and provides price information to patients upon request. Unfortunately, BMC has had a lapse in collecting the number of these requests. We have no reason to believe the data would differ from previous years, so can provide those averages if interested. Starting this month, BMC will be implementing an electronic health record system update which provides a central way to track these requests, ensuring we will be able to easily report data on price inquires moving forward.