HOLYOKE HEALTH CENTER

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TO: Health Policy Commission
Commonwealth of Massachusetts

FROM: Jay Breines, CEO, Holyoke Health Center

DATE: September 23, 2013

SUBJ: **Written Testimony Concerning Health Care Cost Tends**

My name is Jay Breines. I am the Chief Executive Officer of the Holyoke Health Center, Inc. and as such I am legally authorized and empowered to speak on behalf of our organization, which has been providing essential health care services to the underserved residents of Holyoke since 1972. More recently, services were expanded to include residents of Chicopee, through the opening of a new health center in that community. In addition, HHC has expanded dental services to additional locations including the Chicopee Dental Center on Memorial Drive, the Western Mass Hospital in Westfield, Springfield Technical Community College, the Holyoke Soldiers Home, and the Hampden County Correctional Facility in Ludlow. In the past 10 years, HHC has developed a sophisticate pharmacy program that fills over a quarter million prescriptions annually from locations within both the Holyoke and Chicopee Health Centers. The following information is provided in response to questions submitted on August 28, 2013 by the Health Policy Commission.

1. (a.) HHC reduces health care costs by providing comprehensive primary care patient services. We actively review the value of our approach to overall quality of care through our participation in both the Joint Commission, where we have recently been re-accredited, and NCQA programs, where we have attained Level III status. These evaluations are intensive, requiring significant amounts of staff and organizational resources and funding, but they allow us to assess our own strengths and weaknesses and help us determine how best to structure our care system to meet the highest level of patient quality outcomes. Typical primary care practices do not generally undergo these evaluations and we are not actually required to. However, we believe that quality of care needs to be effectively evaluated to assure we are providing cost-effective outcomes for our population. Indeed, national studies have shown that health care delivered at community health centers is both cost effective and high quality care. Joint Commission and NCQA surveys allows us to be confident that we are at the high end of performance within the community health center cohort and that we deliver high quality and cost effective services to our patients.

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Over the course of the past 15 years, our resources have focused on chronic disease self management as well as patient centered health care. These concepts are critical for cost containment purposes. It is often said that 10% of patients account for 70% of costs to the system, and our efforts to address those patients that will yield a larger return on investment has shown some success in the past. Recent US Health Resources and Services Administration data showed our programs scored significantly higher than the national average on federal quality measures relating to diabetes, hypertension, childhood immunizations, cervical cancer screening and asthma therapy management. But unfortunately, these approaches require resources that are not covered by fee for service systems within which we operate, and as a result we have had to curtail many potentially important aspects of our system that helped produce those results. It is time consuming and expensive to keep our patients engaged in the management of their own health. It is only through this engagement with our patients that we will be able to reach best practices for cost containment and quality improvements. The fee for service system, and indeed that state's system for reimbursement, is not helping and is actually contributing to the increases in costs and delays in improved outcomes.

(b.) Although we all talk and plan about opportunities for changes that are essential for future growth in services, the means to really develop and shape our local system is not supported by the reality of the payment mechanisms in place today. Within the current system, the savings we have generated for the overall system has unfortunately not been shared with our organization, and as grants have been reduced or totally ended, we have had to reduce the investments we previously made in these areas. Presumably, this has reduced the impact our organization has on reducing the cost increases that are problematic for state and federal budgets. More importantly, these reduced services mean our patients do not have the resources we are capable of providing that would improve their care quality while reducing costs.

Building an electronic health care record, which at HHC has included medical as well as dental services, has also been a commitment of HHC over the past few years. While we receive support to accomplish this, the benefits to cost and even management of illnesses for our patients has not been realized yet. In fact, it may be that the efficiency of provider visits may not return to pre-electronic levels. However, we are hopeful that the cost savings from organized data and data retrieval, and data sharing with other providers will in the long run improve care, efficiency and cost containment. In the meantime, however, we have increased costs due to EHR system needs and decreased reimbursements due to our drop in productivity. The revenue drop just adds to our inability to maintain the chronic disease support from CHWs and other innovations we have previously developed.

2. In general, we are not in a position to have an impact on the growth in prices for health care services. One place we are in a position to make a difference is in the use of generic drugs wherever possible, and our pharmacy capabilities allow us to maximize this cost saving. Also, as stated above, staffing costs are driven by reimbursable visit definitions, and typically higher salaried providers are required for visits to be reimbursable. If we could use lower cost staff, we could have an impact on the price for visits, or at least for some visits. In most cases, reimbursement systems do not support this option.

3. (a.) HHC has had a long interest in the integration of behavioral and physical health. To that extent, we have built space to attract behavioral health organizations to actually be on site for improved patient access and more effective clinical hand offs between physical and behavioral providers. As we initiated this service, we found our space was non-compliant with Department of Public Health regulations relating to separation of licensed facilities within one physical location. We were fortunate to get a waiver, allowing both the Holyoke Health Center and our mental health partner to share a patient waiting room, with one registration desk for medical appointments and another front desk for mental health visits. The end result is that our patients are able to access behavioral health care within our own offices, understanding that we are all working together for the best patient outcomes.

   We seek other partnership opportunities with area behavioral health providers wherever they are possible if we think they would improve our system of care. Currently, we are working through a SAMSA grant with a local behavioral health provider to deliver medical care to their patients at their clinic, using a nurse practitioner a few hours per week. In addition, we are currently in the discussion stages with another behavioral health provider to develop a more integrated, on-site service that would allow for greater access to the behavioral health service and reduce the "drop-out" rate of our patients from the behavioral health side of the system.

   (b.)There are two basic challenges for optimizing mental health integration. One is the lack of Spanish-language mental health providers. The nature of the patient visit in a mental health setting is obviously compromised if the interview and patient responses must pass through a third party. Area mental health providers are trying to recruit and retain Spanish language providers, but it is not obvious at this time that the dynamics of this situation will change soon. The second problem we face to make integration work is the payment methodology that relies on a fee-for-service payment that requires patients to show up in order for the agency to bill for the appointment. While this is certainly reasonable to expect, the patients we would like to have a better, integrated process with our mental health partners are often unable or unwilling to keep appointments due to issues that relate to their poor health status, their socio-economic pressures, family problems or many other factors that are common in the lower income population that we serve. The result of patient no-shows is that they shortly will be dropped as a patient from the mental health agency and it may be weeks or months until the primary medical provider is aware that the patient in not in counseling. In the absence of counseling, medical issues may deteriorate. Integration is difficult to achieve if the medical and mental health systems have different capabilities to absorb the financial realities related to payment methodologies.

   (c.) Adequate system support for nurse care managers would improve the successful implementation of an integrated system through the role they would play in facilitating our patients in the keeping of referral appointments. Improvements in the "Healthcare Electronic Record Highway" will also help allow better and faster transfer of information that would allow both the medical and mental health provider to maximize the management of the patient. No-show information as well as other helpful data might be shared between the two providers with an opportunity to make clinical decisions or change treatment options in a timely manner.

4.

(a.) In the current fee-for-service system, opportunities for improved quality and efficiency at HHC relate to appropriate reimbursement for employees at the nursing and Community Health Worker levels. Similarly, payment for telehealth management, either for patient communications or provider to provider communications, will help to improve systems of care by allowing for more patient problem management. Without reimbursement, the use of CHW, for instance, adds to provider workload due to management of staff and data associated with CHWs, while taking provider time away from reimbursable office visits. To address these opportunities, Holyoke Health Center has taken a number of steps:

Four years ago, we contracted with a Senior Care Option (SCO) vendor to initiate additional resources for our frail elders. The SCO approach would provide additional nurse management time, home services, case managers, etc.

Over ten years ago, we initiated a Chronic Disease Self Management program, funded by a significant, 4 year grant. Under this program, we trained staff in the chronic disease management, developed an internal program for the training and hiring of "Promotoras," patients who have been successfully managing their chronic illness, in order to support newly diagnosed patients with the same problems.

Recently, our nurses began a cooperative STARR initiative with the local community hospital to improve hospital discharge processes that would improve the patients successful return to the community and reduce the need the re-hospitalizations.

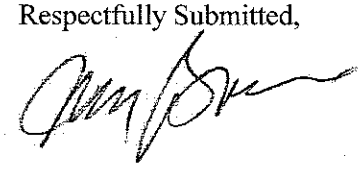
(b.) Funding for all of these initiatives has not been adequate or even available to maintain the level of effort we were prepared to invest. As a result, the cost to the health care system has not benefited from the decreases in costs that we think were possible. As our budget challenges grow, we respond by looking for revenue opportunities and cost savings. Investment in the services mentioned here are costly and have not resulted in revenue growth for the health center. As a direct result of inadequate return on investment, we have had to decrease resources to support these efforts.

(c.) Policies that would provide Global Payments for Medicaid patients would allow our organization to allocate resources based on a return on investment methodology. The current system encourages us to limit services to conventional opportunities for reimbursement. This does not allow us to go to where the need is or where the cost and quality benefit lies.

5. Our organization relies on federal benchmarks within the Health Resources and Services Administration (HRSA)'s UDS report. We compare and track against other health centers in the state and nationally.
6. Not Applicable
7. After reviewing the reports of the Attorney General (April 2013) and the CHIA (August 2013), I was struck by the disparity in opportunity for Global Payment for health centers compared to especially large system groups. For example, 35% of enrollees and 39% of payments were paid via Global Payment contracts at large system entities. MassHealth has not been able to develop similar approaches for community health centers. At the Holyoke Health Center, only 5% of our patients are commercially insured. It is impossible for our organization to develop cost effective initiatives that are based on the premise of Global Payments when so little of our revenues could be tied to that approach and yet we would have to re-direct and re-focus significant organizational resources in order to achieve the desired funding benefits. To the contrary, as we have seen before, through grants and limited contracts, we have re-designed our systems and improved quality outcomes and reduced costs to the insurance programs. But the costs savings have not been shared with the Holyoke Health Center, and so we have been unable to maintain the investments in these efforts and sadly have had to reduce or eliminate promising efforts.

Ironically, these efforts improve patient care, improve provider job satisfaction and thus increase retention, and as we lose these outcomes, care suffers, costs go up and the health center has to work harder just to maintain the status quo. We should be getting a share of the savings and re-investing the funds in our systems and programs to keep the improvements in place and to develop as many additional patient centered efforts as we can.

Respectfully Submitted,



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