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:

As with all health systems, COVID-19 has profoundly impacted Southcoast Health. Increased volumes, staffing challenges and the emotional and physical toll of this pandemic has acutely changed our entire workforce, most notably our frontline team. One thousand - two hundred (1,200) full and part time employees were furloughed, temporary pay reductions were implemented, and our workforce was reduced by more than 100 non-patient care employees by July 2020. We have experienced increased turnover, disruptions to the labor supply, increasing labor agency rates, and significant staffing coverage challenges.

Staffing shortages have delayed access to ambulatory services, including elective procedures. The most severe impact has been on our emergency and urgent care services. We are now experiencing patient volumes at pre-COVID levels without the same levels of staff, often creating extended wait times for our patients.

In addition, the pandemic's impact on staffing has exacerbated existing access-to-care challenges. The closure of 5 post-acute facilities in Southeastern Massachusetts has created delays in our ability to discharge patients to a more appropriate care setting. This has negatively impacted throughput in our acute care hospitals. For example, if a patient is treated in the emergency department (ED) and needs to be admitted, they may board for extended periods while waiting for a staffed inpatient bed.

In response, we have strategically expanded the size of our talent acquisition team and streamlined our hiring practices. Tactically, we have increased pay rates, offered sign-on bonuses, and expanded the breadth of those bonuses to meet market demand and attract quality candidates to our region. We also added incentives to hourly rates to expand the current pool to help cover critical vacancies. Finally, we implemented creative staffing models in nursing and ancillary areas to support trained, experienced staff and minimize temporary staff use. While our response has produced positive results, staffing shortages continue to strain the system despite our increased efforts to retain and attract employees.

Moreover, patients who deferred care during the pandemic are now returning to the health care system with more advanced disease and often having a behavioral health diagnosis. In response, we embedded dedicated providers in the ED, including a full time Psychiatrist at St. Luke's Hospital in New Bedford, where volumes have been the highest, to address the increase of acute and chronic behavioral health patients. We have

also seen an increase in substance use and overdoses. In all, the burden of care has noticeably risen this year with a reduction in system and regional resources.

In the face of these challenges, we remain fully committed to safety and quality. One of the most important workforce and patient protection goals is system-wide COVID-19 and influenza vaccination of our staff. Focus groups, broad education, and individual outreach have all been coordinated to provide education and address employee concerns. Unfortunately, we anticipate some staff resignations/terminations as we approach of our mandatory vaccination date of November 15, 2021. As any departure will only add to our current staffing challenges, we are reviewing each department critically for potential consequences and have begun the process to post for positions as needed.

Throughout the organization, we are identifying and testing opportunities to improve efficiencies within the workplace and identifying solutions to reduce the need for additional staff, and/or have the potential to reduce the work effort on existing staff and providers. We are utilizing technology-based solutions, where possible, to help fill the staffing gaps. We are initiating patient self-service COVID-19 screening tools, laboratory self-registration, micro-marts for employee food self-service, robust telemedicine and teleconference workstations, and physician-to-physician e-consultations. A primary goal in our approach to technology is to preserve frontline, clinical and patient-facing services. We will continue to invest in these types of solutions to preserve the workforce in place and relieve the added work burden wherever possible.

Telehealth is a practical example of our organization's use of technology to address issues associated with access to care and throughput as part of a deliberate, balanced strategy. Well before COVID-19, Southcoast and other hospitals responded to specialty shortages in neurology with teleneurology in emergency areas and hospital units. In addition, telemedicine has become a critical component in addressing psychiatry and behavioral health specialty workforce shortages. While Boston and Providence are hubs of psychiatry and behavioral health services, the South Coast region is viewed as too distant and the clinical demands too onerous, therefore recruitment in this specialty continues to be extremely challenging.

With an aging national healthcare workforce and with no prospect of fully mitigating certain labor shortfalls, the strategic and expanded utilization of telehealth is instrumental to community-based health systems to maintain access to care for patients and prevent additional delays in assessment and throughput, increased risks, and cost. Without these services that have benefitted many of our MassHealth patients over the past two years, we face increasing challenges in health care access, safety, and equity.

During COVID-19, we innovated using tele-infectious disease consultations consistent with the latest IDSA guidelines of care along with tele-behavioral health for ED care and decompression. With limited access to post-acute facilities, we deployed tele-SNF care to preserve access, prevent readmissions, and address delays in acute to post-acute transitions. We also used tele-consultations to support post-acute facilities in our areas on

infection prevention. Telemedicine has become a very necessary option when an in-person service/specialty is otherwise unavailable or in short supply.

We recognize that robust telemedicine care is consistent with federal standards such as the CMS guidelines on telemedicine and physician-to-physician consultation. It is also an effective modality for the care and management of certain chronic conditions and behavioral health across the continuum, including the acute/inpatient and subacute/SNF setting.

We are concerned that patients in high-risk groups, with social vulnerability indices, and with other social determinants of health will not receive optimal access if we reduce access to telemedicine in acute settings. We believe strongly that we need equitable access to, and reimbursement for, both telemedicine and in-person services in the home, office, and hospital. At this critical juncture for the Commonwealth, we need support for timely care and adequate access.

We ask the Commonwealth not to exclude hospitals and health systems from appropriate reimbursement for telemedicine services when used appropriately and effectively together with face-to-face in person care.

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):

Our patients remain our highest priority. Like many health systems, Southcoast Health patients experienced direct and indirect effects of the COVID-19 pandemic.

At the beginning of the pandemic and throughout the government mandated shutdown, Southcoast and other providers within the region developed informational communications about prevention, safety, masking, and adherence to the stay-at-home CDC guidelines that were shared broadly in the community. Although this messaging was key to slowing the spread within the region, there were unintended consequences for patient care. For many, the ongoing pandemic and concerns around safety created additional fear when faced with the need to enter a hospital or ambulatory facility and receive care. Instead, many patients began deferring or canceling treatment. Individuals who were experiencing emergent or acute symptoms, or who were due for preventative screenings or elective procedures, may have deferred care, waited longer than usual to seek medical treatment, or may have had their elective procedure cancelled.

Our ED volumes also saw a sharp decrease, including those who have traditionally used the ED for their primary form of health and social care. These patients, who were sometimes seen multiple times a week, all but disappeared during the first half of the pandemic.

In addition, the traditional ways patients received care were transformed from welcoming environments to isolating experiences. Family members and other supporters were not able to visit, be present during treatments or for appointments, and support groups became limited to virtual interactions. Many active patients stopped participating in in-person meetings due to their inability or reluctance to attend online groups. This, in addition to other on-going stresses like financial distress, job instability, and coping with losses due to the pandemic, created increased depression and anxiety for patients and their families. Specific regional barriers, including public transportation disruptions and availability of medical transportation, have added further limitations.

Once the Public Health Emergency was lifted and a sense of normalcy began to return with the introduction of the vaccine, patients began to present for care across the system with more acute symptoms and illnesses. Numerous patients experiencing a behavioral health disorder were not able to follow up with their care plans or access a range of outpatient services and programs, including obtaining medications. These patients presented with uniformly greater degree of illness, typically necessitating highest level of care, admission to a psychiatric hospital. In many instances, patients presented with severe clinical decompensation after years of stability.

There are still delays in getting acute patients to an in-patient facility to receive care because the pandemic has imposed stress on the system, resulting in ED boarding. The decrease in skilled nursing facility bed availability has led to longer hospital admissions and patients being placed geographically further away, impacting the ability of family to visit.

While the COVID-19 pandemic has had serious health consequences for those who were infected by the virus, social distancing mandates and the ensuing economic fallout have placed extreme burdens on our most economically vulnerable populations in ways that many could not predict.

Many of the issues brought to the forefront by the pandemic are the same that existed pre-pandemic and have been made worse, particularly as they relate to health equity and social determinants of health. These include issues such as homelessness, food insecurity, access to health care, mental health, and substance use.

An additional aspect of the pandemic, particularly in the cities of Fall River and New Bedford, is the substantial number of residents who had been living just at the edge of their means in better times, and for whom the pandemic has pushed or will push toward a much more precarious financial situation.

Many patients were faced with economic instability due to unemployment, causing uncertainty with insurance coverage for treatment and medication, housing and utility affordability, and food security.

Community based organizations experienced a drastic increase in residents seeking and accessing resources. While increased funding helped improve the capacity of

organizations to respond, many of the resources were not accessible to patients without transportation and some patients declined home care services due to fear of having other people in their home. Southcoast staff continue to report caring for patients with heightened needs, requiring additional emotional and social support along with referrals to community resources.

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):

Through the perseverance and commitment of our staff, along with their passion to serve our patients and community, Southcoast Health has remained a trusted community health system and resource. Nonetheless, in early Spring 2020 Southcoast began to struggle with the many challenges brought on by the pandemic, like other health care providers across the Commonwealth.

We experienced a reduction of personal protective equipment (PPE) as supply chains were disrupted throughout the world. Yet through staff engagement, effective planning, and support from our state and federal government, we were able to provide our team with the resources they needed to provide safe and effective care. With stay-at-home restrictions mandated by the Public Health Emergency, and patients deferring care, our emergency department, inpatient, and outpatient visits decreased significantly while front line staff heroically treated patients, consciously aware of the potential risks for them and their families.

Southcoast Health worked closely with the Baker Administration to secure PPE supplies, ventilators, testing equipment and vaccines; stand up a field hospital and step-down facilities; streamline the process of establishing satellite vaccine clinics; and allow our system to move patients within our hospital setting to accommodate areas of greatest need, including the ICU and Emergency Department.

Through Executive Orders, DPH Guidance and DOI Bulletins, the Baker Administration expanded the scope of practice for providers; they allowed college seniors, recent graduates of nursing programs, and recently retired healthcare workers with expired licenses to practice in their respective fields. They allowed out-of-state nurses to practice within Massachusetts and created a robust telehealth program that allowed providers to care for patients and stay safe from the threat of COVID-19.

What took months to accomplish before the pandemic, took weeks, if not days. Government agencies working with providers and insurers – all with vigor and determination – streamlined regulatory processes to protect patients and providers alike. However, despite universal streamlined efforts to adjust to the daily challenges of the pandemic, high public pay, community hospitals like Southcoast continue to struggle. The state-mandated moratorium on elective procedures combined with patients that deferred care has strained all aspects of the health care delivery system. Early in the pandemic, when volumes were low, and our operating margin stressed, Southcoast furloughed more than 1,200 employees. Now, nineteen months later and with lower regional vaccination rates, staff shortages and staff burn-out continue to impact our ability to return to pre-pandemic levels.

The pandemic has highlighted the shortage of nurses and other key care givers not just in Massachusetts, but throughout the country. Struggling with staffing shortages has been an ongoing theme throughout the pandemic and something that is not going away soon. Without a robust plan to attract and train clinicians, nurses and those that may be interested in entering the healthcare field, healthcare providers will continue to compete for limited personnel, and community hospitals outside of greater Boston will continue to bear the burden.

We ask the Commonwealth to continue the use of telehealth services, permissible licensure exemptions, changes made to scope of practice, and regulations or procedures that allow hospitals and hospital systems to care for the patients until such time that a viable plan is implemented to mitigate systemic clinical staffing shortages.

In addition, we ask for the prioritization of support for healthcare systems and providers and to those who proactively care for vulnerable populations. COVID highlighted many challenges and disparities that unfortunately exist in our society today; we must address these areas of opportunity with a focused investment in the communities, providers and people who are committed to serving these vulnerable populations.

The COVID-19 pandemic has changed the way health care is delivered. The health care system, now more than ever, must be innovative and nimble. Many of the lessons learned and strategies implemented will continue to be applied long after this pandemic is over. We look forward to using these lessons to continue to build upon the best practices for the ongoing delivery of high-quality care close to home.

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.**

Southcoast Health appreciates the value of accurate, complete, and meaningful data. These data points include clinical and demographic information along with information related to social vulnerability, and other valuable datasets that will allow us to provide optimal care and service to our patients and community.

While we have placed significant emphasis on robust data collection for many years, we had the opportunity to optimize our processes with the implementation of our enterprise Electronic Medical Record (EMR) software, Epic. As a result, all entry points into Southcoast Health are expected to maintain a uniform approach to capturing data including race, ethnicity, language, and disability, regardless of where a patient is registered or scheduled within our organization.

In March of 2020, we realized we would need to respond quickly to the changing needs of our patient population as we navigated the pandemic. Southcoast invested in telehealth services among many other remote patient offerings, to increase access to care and reduce deferment of care for our patients.

In addition, we partnered with Epic to extend our EMR to local privately operated COVID-19 rehab centers, which allowed for ease of information sharing without the lengthy, difficult, or expensive implementation of an EMR system. Other process enhancements included an electronic signature system for consent and other documents that negated the need for human contact, and the installation of a "Welcome" registration system for patient self-registration at many of our clinics. This allowed us to identify patients using a COVID testing or vaccination site and track this information separately from other laboratory and vaccination services.

These efforts have allowed for robust data collection, reporting and the production of dashboards for displaying, tracking, and responding to disparities by race, ethnicity, gender, age, and zip code. This was especially helpful during the early days of the pandemic, allowing for "real-time" monitoring for prevalence of disease within certain locations and populations, as well as in utilization and access to services. This data was also used to inform outreach and education in the community.

We have been able to leverage data to assist in scheduling patients for COVID testing, COVID vaccinations and COVID Antibody therapy. Southcoast chose to match the Social Vulnerability Index (SVI) metric with our patient population in our database. When scheduling randomized lotteries for services such as antibody therapy, the SVI and

demographic data were critical to ensure that we were appropriately and equitably serving our population. Elders who lacked technological capabilities, and those experiencing language barriers, continuously expressed their gratitude for our supportive process and patient centered approach.

In addition to the efforts above, the utilization of Epic was extended to our mobile health services on our Southcoast Wellness Van. These updates enabled Southcoast to capture and track demographic data for services administered directly in the community. Tracking demographic data, together with the utilization of SVI, enhanced our ability to develop, interact and deliver targeted outreach, messaging, and services to the most at-risk and underserved populations in our region.

The Southcoast Wellness Van became a beacon of hope to those individuals', bringing lifesaving vaccines and education to overcome severe hesitancy due to lack of accurate information and mistrust of government and traditional health care systems. We increased access to testing and vaccination for vulnerable populations and played an instrumental role in keeping patients safe and local economies intact. We provided testing and then vaccination to fishermen and workers at local fish processing plants.

While our efforts to standardize data collection have produced success in many areas, we have identified gaps that we intend to focus on in the coming months. Recently, we launched a "LGBTQ Welcoming and Knowledgeable" initiative to support the collection of important data informing the sexual orientation and gender identity of our patients.

We recognize that the introduction of these fields needs to be implemented thoughtfully, not just from a technical perspective, but especially from both patient and clinical perspectives. We are planning to offer extensive clinical and change management training through partnerships such as The Fenway Institute to ensure our providers and staff understand how they play a critical role in optimizing quality, cost-effective health care for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people. Going forward, we will continue our commitment to identify opportunities to build upon how we collect and utilize demographic data to advance health equity for our patients and community.

As a health system rooted in our community, the patients we care for are more than simply patients. They are our family, friends, and neighbors, whom we are committed to serving with exceptional care and service.

All health care providers maintain a primary focus of providing great care and service to their patients. It is our secondary focus that often differs. While some organizations may maintain a secondary focus on academics, training, and research – and receive significant funding to do so – providers such as Southcoast are focused on community health and wellness, proactively engaging, and serving underserved populations while acting as a convener of community-based organizations.

Regrettably, the prioritization of resources and support for organizations focused on community health and wellness do not match the resources provided to those focused on academics, training, and research.

Southcoast remains committed to developing and advancing upstream approaches to achieve true transformational change in the long-term health status and economic opportunity for all residents of our region. We have established strong and trusted relationships with our community partners that enhance our reach and impact. It is critical that the Commonwealth recognize the significance of the work being done every day by nonprofit community-based hospitals and health systems, especially those serving socially vulnerable communities like Southcoast Health. And, in turn provide equivalent resources that will enable us to continue to deliver exceptional care and service, while advancing vital population health initiatives.

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.

(Southcoast Health no longer uses a written form for completion.)

Health Care Service Price Inquiries Calendar Years (CY) 2019-2021			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2019	**Q1**	0	120
	Q2	0	128
	Q3	0	91
	Q4	0	179
CY2020	**Q1**	0	271
	Q2	0	44
	Q3	0	209
	Q4	0	229
CY2021	**Q1**	0	385
	Q2	0	267
	TOTAL:	0	1757